Nottinghamshire County Council

Health and Wellbeing Board

Wednesday, 03 September 2014 at 14:00

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

AGENDA

12	Work Programme	197 - 202

Notes

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

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

Customer Services Centre 0300 500 80 80

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

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

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

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

Nottinghamshire County Council

minutes

Meeting	HEALTH AND WELLBEING BOARD
Date	Wednesday, 2 July 2014 (commencing at 2.00 pm)

Membership
Persons absent are marked with an 'A'

COUNTY COUNCILLORS

Joyce Bosnjak (Chair)
Kate Foale
Stan Heptinstall
Martin Suthers MBE
Muriel Weisz

DISTRICT COUNCILLORS

Jim Aspinall	-	Ashfield District Council
Simon Greaves	-	Bassetlaw District Council
Jacky Williams	-	Broxtowe Borough Council
Vacancy	-	Gedling Borough Council
Debbie Mason	-	Rushcliffe Borough Council
Tony Roberts MBE	-	Newark and Sherwood District Council
Phil Shields	-	Mansfield District Council

OFFICERS

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

CLINICAL COMMISSIONING GROUPS

	Dr Jeremy Griffiths	-	Rushcliffe Clinical Commissioning Group
	Dr Steve Kell OBE	-	Bassetlaw Clinical Commissioning Group (Vice-Chairman)
A	Dr Judy Jones	-	Mansfield and Ashfield Clinical Commissioning Group
	Dr Mark Jefford	-	Newark & Sherwood Clinical Commissioning Group

A	Dr Guy Mansford	-	Nottingham West Clinical Commissioning Group
	Dr Paul Oliver	-	Nottingham North & East Clinical Commissioning Group

LOCAL HEALTHWATCH

	Joe Pidgeon	-	Healthwatch Nottinghamshire

NHS ENGLAND

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

NOTTINGHAMSHIRE POLICE AND CRIME COMMISSIONER

A	Paddy Tipping	-	Police and Crime Commissioner

SUBSTITUTE MEMBERS IN ATTENDANCE

Councillor Griff Wynne	-	Bassetlaw District Council
Councillor Henry Wheeler	-	Gedling Borough Council
Tracy Madge	-	NHS England
Jon Wilson	-	Adult Social Care and Health Department

OFFICERS IN ATTENDANCE

Kate Allen	-	Public Health
David Banks	-	Rushcliffe Borough Council
Peter Barker	-	Democratic Services
Paul Davies	-	Democratic Services
Lucy Dadge	-	Mansfield and Ashfield CCG
Jonathan Gribbin	-	Public Health
Nicola Lane	-	Public Health
Cathy Quinn	-	Public Health
Helen Ross	-	Public Health

APPOINTMENT OF CHAIR

RESOLVED 2014/026

That the appointment of Councillor Joyce Bosnjak as Chair of the Health and Wellbeing Board by the County Council on 15 May 2014 for the ensuing year be noted.

APPOINTMENT OF VICE CHAIR

RESOLVED 2014/027

That Dr Steve Kell OBE be appointed Vice Chair of the Health and Wellbeing Board.

The Board extended congratulations to Dr Kell for the recent award of his OBE.

MINUTES

The minutes of the last meeting held on 7 May 2014 having been previously circulated were confirmed and signed by the Chair.

MATTER ARISING

Joe Pidgeon queried the absence of a reference in the minutes to Healthcare for Carers being included in the primary care strategy. Tracy Madge confirmed a relevant target had been included in the strategy.

APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Simon Greaves, David Pearson and Helen Pledger.

DECLARATIONS OF INTEREST BY MEMBERS AND OFFICERS

None.

MEMBERSHIP OF THE HEALTH AND WELLBEING BOARD

RESOLVED 2014/028

That the membership of the Board for 2014/15 as shown above be noted.

CLINICAL COMMISSIONING GROUP FIVE YEAR PLANS 2014-19

Dr Mark Jefford gave a presentation, first giving an overview of all of the CCG plans followed by a presentation regarding the Mid Nottinghamshire plan. The Board had considered initial proposals in March. He apologised for the late distribution of the plans, but the submission date to the NHS had been 20 June, and some plans had yet to go to the relevant CCG's governing body.

Asked about the estate strategy Dr Jefford confirmed that although the strategy was only in its early stages, consideration of joint/shared facilities would be a fundamental part of the strategy. In response to a question as to why 60% of GPs who train in Nottinghamshire leave the county, Dr Jefford replied that there was still work to be done to identify the reasons. Dr Jefford confirmed that Healthchecks featured strongly in CCGs' preventative work, for example, on the NHS Prism project.

Dr Chris Kenny stated that there is presently much work being undertaken on the subject of Healthchecks and that reports will be brought to future meetings of the Board.

Dr Paul Oliver gave a presentation on the South Notts Plan. It was noted that a whole system change was required and that it was important for this to be undertaken collectively. There was discussion about the shift of funding from secondary to primary care which was necessary.

Dr Steve Kell gave a presentation on the Bassetlaw plan, the risks to delivery of the plan, and how they could be mitigated.

Comments on the plans included:

- The impenetrability of some of the plans; the degree to which secondary care understood the direction of travel, and the recruitment and retention of GPs. Tracy Gaskill referred to work by NHS England in this regard. There was a need to look beyond medical models of care. There was unprecedented GP involvement in commissioning. It was observed that Nottingham University Hospitals were supportive of developments, but these would have to be phased over a period of time.

- There should be more cross references between the plans and the Health and Wellbeing Strategy. This would help promote an understanding of the Board's role.
  - The plans had to comply with an NHS template, but it was accepted that the links might be shown more clearly.

- The Secretary of State saw CCGs as accountable organisations to be paid on the quality of services they deliver, which was a change from existing systems. This required examination of the interfaces between primary and secondary care, and between health and social care, and new contracting mechanisms.

- Co-commissioning was essential, given that commissioning responsibilities were split between organisations. With correct alignment of commissioning plans, and delivery of the Better Care Fund plans, the CCG plans would be achievable.

The Chair thanked those involved in the hard work that had gone into the production of all of the plans and emphasised the need to measure the success of the plans.

RESOLVED: 2014/026

That the updated CCG Five Year Plans be noted.

BETTER CARE FUND – REVISED PROCESS

Lucy Dadge introduced the report and updated the Board on developments about the Better Care Fund since the previous report in April. While there had been no significant assurance issues with the plans for Nottinghamshire, there had been concerns nationally about insufficient financial assurances and lack of alignment with acute hospitals' plans. This had led the Department of Health to seek further information, and the submission of new BCF assurance templates

Since the report had been written, the Department of Health had asked 14 boards, including Nottinghamshire, to fast track their submissions. Plans now needed to be

resubmitted by 9 July, although changes could be made up to 1 August. She explained that the intention behind the fast tracking was to provide exemplars for other boards and give them confidence when developing their own plans.

During discussion, reference was made to the need for the Board to develop a communications strategy to inform the public of the changes arising from the Better Care Fund. Ms Dadge was asked about how the budget for social care would be protected and confirmed that this was addressed in the revised submission. However, it was not possible in this plan to take account of future challenges.

It was pointed out that work streams under the BCF plans had already started.

RESOLVED: 2014/027

(1) That the requirement to resubmit the Nottinghamshire BCF plan according to the revised process and timelines be noted.

(2) That authority to approve the BCF assurance plan be delegated to the Chief Executive of Nottinghamshire County Council (as chair of the Nottinghamshire BCF Working Group) in consultation with the co-chair of the BCF Working Group, and the Chair and Vice-Chair of the Health and Wellbeing Board.

LOCAL NATURE PARTNERSHIP

Councillor Suthers gave a presentation on the work of the Lowland Derbyshire and Nottinghamshire Local Nature Partnership. The partnership aimed to influence the work of the Local Enterprise Partnership (LEP) to ensure that the positive effects of the natural environment were fully appreciated. Funds had been raised to employ an officer for three days per week, based in the LEP offices.

Councillor Suthers was asked how the Board could engage more productively with the Partnership and replied that at this stage what was required was a two way communication process to raise awareness of the work undertaken by the various organisations. The Partnership was looking at the strategies of the boards in the Partnership area to see how the Partnership could best engage with them. A discussion followed about the various projects that were already under way, including those concerning allotments, and the beneficial effects of these projects on health and wellbeing. Councillor Suthers stated that there was no central register where people could find information on all of the various projects that are being undertaken.

RESOLVED: 2014/028

That the presentation be received.

AIR QUALITY AND HEALTH: DELIVERING LONGER, HEALTHIER LIVES IN NOTTINGHAMSHIRE COUNTY

Jonathan Gribbin and David Banks gave a presentation about the effects of air quality on health. It was confirmed that it was not just the size of the particles that was significant but also their origin. It was likely that the smallest particles (which were not measured currently) originated from agriculture rather than transport. A representative

of SUSTRANS who was present in the audience referred to two recent SUSTRANS publications which might be of particular interest. A link to these would be sent to Board members. Following further discussion, the Chair encouraged members to raise the issue in their own organisations.

RESOLVED: 2014/029

(1) That the public health significance of good air quality be noted.

(2) That it be noted that the adverse health impact on our residents of long term exposure to air pollution is modifiable.

(3) That shared oversight be exercised with the Nottingham City Health and Wellbeing Board of the work of the Nottinghamshire Environmental Protection Working Group, in order to raise the profile of the health impacts of air quality, and to secure partner engagement to the review and subsequent implementation of the Nottinghamshire Air Quality Improvement Strategy.

(4) That the inclusion of a chapter on air quality in the JSNA be endorsed.

(5) That a draft of the Nottinghamshire Air Quality Improvement Strategy be received at a future meeting for review and comment.

PROGRESS ON HEALTH AND WELLBEING DELIVERY PLAN

Cathy Quinn presented the report on the development of the Health and Wellbeing Delivery Plan. Anthony May confirmed that when the information is posted on the website it will be possible to navigate to the required area using a topic search. The Vice Chair and Anthony May emphasised the importance of members, in times of scarce resources, identifying subject areas that would affect all members of the Board and bring those subjects to the Board's attention. The Chair encouraged all members of the Board to study the plan and before the next Board meeting identify topics where they might be willing to become 'Champions'.

RESOLVED: 2014/030

(1) That the Board approves the proposed structure for the Health and Wellbeing Delivery Plan.

(2) That the Board supports the review and restructuring of supporting structures, to align with and ensure delivery of, the Health and Wellbeing Strategy.

(3) That the Board receives the final Delivery Plan and associated structures at the September 2014 meeting.

HEALTH AND WELLBEING IMPLEMENTATION GROUP REPORT

Anthony May presented the report. Board members confirmed that the format of the report met their expectations. The Chair encouraged the Board to ask questions on aspects of the report.

RESOLVED: 2014/031

(1) That the Board note the contents of the report.

(2) That the work programme for the Health and Wellbeing Implementation Group to deliver the Health and Wellbeing Strategy be endorsed.

CHAIR'S REPORT

The Chair encouraged CCG representatives to invite her to attend their clinical executive groups or governing bodies.

In relation to the Peer Challenge, Dr Kenny referred to his positive experience when involved in a pilot peer challenge in the south of England. An expression of interest was submitted by officers on 25 June.

The Chair referred to the recent stakeholder network meeting with the voluntary sector. At the meeting, frustration had been expressed at the difficulty of engaging with GPs as the stakeholders felt they had a lot to offer. It was explained to the Board that each CCG did have a mechanism for engagement with the voluntary sector. The Chair added that the voluntary sector had accepted that it would not be given representation on the Board, but would be involved through the stakeholder network, for example. The Probation Service was to be represented on the Health and Wellbeing Implementation Group.

RESOLVED: 2014/032

That the report be noted.

WORK PROGRAMME

In response to a question, Cathy Quinn confirmed that a Communications Strategy had been approved previously by the Board, and would be updated as part of the delivery plan.

It was also explained that a broad report about Public Health nursing would be presented to Public Health Committee. Any significant changes would be referred to the Board.

RESOLVED: 2014/033

That the Board's work programme be noted.

The meeting closed at 4.40 pm.

CHAIR

Nottinghamshire County Council

Report to the Health and Wellbeing Board

3 September 2014

Agenda Item: 4

REPORT OF THE CLINICAL LEAD, NHS NOTTINGHAM NORTH AND EAST CCG ON BEHALF OF THE BETTER CARE FUND WORKING GROUP

FINAL SUBMISSION OF THE BETTER CARE FUND PLAN

Purpose of the Report

1. To inform the Health and Wellbeing Board of the further revised process and submission of the Better Care Fund (BCF) plan for Nottinghamshire.

2. To receive the final BCF plan following delegated approval by the Chief Executive of Nottinghamshire County Council (as chair of the Nottinghamshire BCF Working Group) in consultation with the co-chair of the BCF Working Group, and the Chair and Vice-Chair of the HWB.

Information and Advice

3. The BCF was originally announced in June 2013 within the Government's spending review. It was described as creating a national £3.8 billion pool of NHS and Local Authority monies intended to support an increase in the scale and pace of integration, whilst also promoting joint planning for the sustainability of local health and care economies.

4. At its meetings on 5 February 2014 and 2 April 2014, the Health & Wellbeing Board considered the original draft and final BCF plans before submission to the NHS England Area Team on the 14 February and 4 April 2014 respectively.

5. At the last meeting, the Board granted delegated authority to approve the BCF plan to the Chief Executive of Nottinghamshire County Council (as chair of the Nottinghamshire BCF Working Group) in consultation with the co-chair of the BCF Working Group, and the Chair and Vice-Chair of the HWB.

6. The plan was submitted as intended on 9 July 2014. However since this time, there has been a further requirement to review the plan in light of new templates and guidance. The BCF working group has undertaken the required review taking account feedback through an extended assurance process.

7. The BCF plan is being resubmitted by 29 August 2014 incorporating key changes as follows:

a. Strengthened narrative to address the new technical guidance supporting the development of the plan
b. Completion of revised templates accompanying the new guidance
c. Identification of £1.9million as part of the BCF allocation to support the implementation of part 1 of the Care Act across Nottinghamshire.
d. Revised planning assumptions to achieve a reduction in total emergency admissions.

8. The Nottinghamshire BCF plan remains one of the top national plans, and submission has been fast tracked to allow the opportunity of achieving exemplar status. If exemplar status is achieved the Nottinghamshire plan will be shared with other Health and Wellbeing Board areas by way of best practice.

9. The final plan submitted to NHS England will be available on Nottinghamshire County Council website after 29 August 2014 at the following site: http://www.nottinghamshire.gov.uk/caring/yourhealth/developing-health-services/health-and-wellbeing-board/bettercarefund/

10. A further report will be presented to the Health & Wellbeing Board following announcement of the outcome of the BCF submission.

Statutory and Policy Implications

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

Implications for Service Users

12. It is expected that integrated systems will improve the service user journey and experience. Information on existing service provision has been gathered by the local planning groups and the impact of resource redirection ascertained to ensure that the impact on service users is not detrimental.

Financial Implications

13. The financial implications are outlined in the Nottinghamshire BCF plan.

Equalities Implications

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

Legal Implications

15. The Care Act facilitates the establishment of the BCF by providing a mechanism that will allow the sharing of NHS funding with local authorities to be made mandatory. The wider powers to use Health Act flexibilities to pool funds, share information and staff are unaffected. Ongoing engagement will be necessary as well as an Equalities Impact Assessment with regard to how monies are spent.

16. Services will need to be jointly commissioned by Local Authorities and CCGs. Agreement will need to be reached on contract leads for particular aspects of delivery.

RECOMMENDATION/S

1. That the Health & Wellbeing Board notes the further revised process and submission for Better Care Fund plan following delegated approval by the Chief Executive of Nottinghamshire County Council (as chair of the Nottinghamshire BCF Working Group) in consultation with the co-chair of the BCF Working Group, and the Chair and Vice-Chair of the HWB.

Dr Paul Oliver

Clinical Lead, NHS Nottingham North and East CCG
Co-chair of the Better Care Fund Working Group

For any enquiries about this report please contact:

Lucy Dadge, Director of Transformation
lucy.dadge@mansfieldandashfieldccg.nhs.uk / 01623 673330.

Constitutional Comments

17. As this report is for noting no constitutional comments are required.

Financial Comments

18. The financial implications are contained within the Nottinghamshire BCF Plan.

Background Papers and Published Documents

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

- Better Care Fund (formerly the Health & Social Care Integration Transformation Fund.) Report to the Health & Wellbeing Board 8 January 2014
- Better Care Fund. Report to the Health & Wellbeing Board 5 February 2014

- Better Care Fund – Final Plans. Report to the Health & Wellbeing Board 2 April 2014
- Better Care Fund – Revised Process. Report to the Health & Wellbeing Board 2 July 2014

Electoral Division(s) and Member(s) Affected

All

Nottinghamshire County Council

Report to the Health and Wellbeing Board

3 September 2014

Agenda Item: 5

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

CARE ACT 2014 – LOCAL IMPLEMENTATION AND THE IMPLICATIONS FOR NOTTINGHAMSHIRE COUNTY COUNCIL AND PARTNER ORGANISATIONS

Purpose of the Report

1. To update the Health and Wellbeing Board (HWB) on the changes that are required arising from the Care Act and to highlight the implications for the Council and partner organisations in relation to care and support for adults.

Information and Advice

Introduction

2. Implementation of the Care Act will totally change the way that care and support for adults and support for carers is provided in Nottinghamshire. It provides a new legal framework which governs responsibilities and duties; it will change the way that social care and health is delivered, and the way that care and support is paid for in England.

3. The Care Act sets out new and extended responsibilities for social care, health and housing. On the one hand it gives opportunities to review and improve services and ensure that people's needs are met, promoting their wellbeing and providing or arranging services or resources to help prevent, delay or reduce the development of needs for care and support. On the other hand it presents new challenges to Nottinghamshire County Council (NCC) and its partners. There are very significant financial and resource implications to meet the new statutory requirements. Financial modelling under way by local authorities supports the view that the reforms will be under-funded by Government. Implementation is also challenging, with very tight timescales; the social care changes need to be in place for April 2015 and the funding changes by April 2016. The Care Act became law in May 2014, and the draft social care regulations and guidance were released in June 2014 for consultation; these will be finalised in late October 2014. Draft regulations and guidance on the funding reforms is expected in late autumn 2014 for consultation, but it is anticipated these will not be finalised until late 2015. These timescales present significant risks around readiness for workforce, informatics and developing and embedding alternative methods of access and delivery of social care in order to manage demand.

4. The Care Act together with the Better Care Fund and provides a framework for co-operation and integration with health, housing and other health related services. This framework includes the following areas:

   - strategic commissioning and planning, including developing a diverse, sustainable and high quality market place to buy social care and health support
   - access, assessment and planning for care and support, including integrated personal health budgets
   - integrated advice and information across health, district councils and other partners
   - joined up service delivery.

5. In response to these challenges, the Care Act and Integration with Health programme is a key area of activity within the Council's Transformation Programme as described in the document 'Redefining Your Council' and the implementation of the Adult Social Care Strategy will ensure that we deliver these new duties and responsibilities in the most effective and cost effective way.

Care Act Programme and governance

6. In May 2014 the Adult Social Care and Health Committee (ASCHC) agreed to fund a dedicated programme team to assess the financial and resource implications and then to plan and implement the required changes. The programme team was in place by July 2014.

7. Governance arrangements are in place and progress is being reported on a quarterly basis to the ASCHC and provides reports into the HWB.

8. A total of 10 work streams and 4 enabling work streams have been set up with identified leads to ensure statutory timescales for the new and extended duties and responsibilities will be met.

9. Some of the work is briefly outlined below:

   - Assessment, personalisation and eligibility -
     - Review of assessment and support planning tools and development of alternative ways of access and assessment for care and support, including online, telephone or clinic based assessments and reviews.
     - Revision of all guidance, policies and tools to accommodate the national minimum eligibility threshold.

   - Carers -
     - Ensuring compliance with new and extended requirements of the Care Act, including the right to assessment and to meet a carer's needs for support and the duties to assess a young carer or parent carer.
     - Assessing the impact of the new requirements on cost and demand and exploring cost effective and efficient approaches to meet new requirements.

- Prevention and housing
    - Reviewing the breadth and coverage of information and advice and preventative services and the extent to which integrated services with housing and health partners might deliver better outcomes.
    - Development of a more integrated solution to accommodation needs.

- Advice, Information and advocacy
    - Develop a universal and comprehensive information and advice offer for all citizens of Nottinghamshire, including social care, housing, health and financial information

- Strategic market development and quality and risk
    - New home-based support and supported living services have been commissioned, jointly with the CCGs, from independent sector providers which embed reablement principles, placing emphasis on promoting independence and self care.
    - Reviewing and updating Market Position Statement to ensure full compliance with the Care Act.
    - Development of process to undertake to assess and maintain an overview of provider viability and potential provider failure.
    - Active participation in national work on market shaping (to be published at the end of the year).

Consultation and assessment of the draft guidance and regulations

10. The Government consulted on the draft regulations and guidance from June 2014 to 15 August 2014. The Council set up an intranet page to invite responses from staff and Members on the questions in the consultation. A Nottinghamshire Care Act newsletter circulated to wider stakeholders (including the community and voluntary sector) promoted the consultation. In addition, specific briefings were provided for the Health & Wellbeing Board, Clinical Commission Groups and Housing to encourage partners to respond on behalf of their individual organisation to key areas around integration. Two sessions with ASCHC Members helped finalise the comprehensive response from the Council.

11. The Care Act programme has completed an impact assessment on the draft regulations and guidance and considered the implications for the Council. This has informed the programme of work to implement the new and extended responsibilities and these findings in key areas are covered through this update report.

National Local Authority Stocktake

12. The Care Act Local Authority Stocktake was completed by all local authorities in May 2014 and will be repeated every quarter. Its completion is a condition of the Care Bill Implementation Grant 2014/15**,** which is a one off grant of £125,000 to contribute to implementation costs in 2014/5.

13. The purpose of the stocktake is to assure the government of progress in implementing the requirements of the Care Act across the country. Each local authority was required to complete a self assessment with nine proxy measures as an overall indicator of readiness.

14. Although the findings from the stocktake are awaited, the council's self-assessment indicated that they are largely on track for the delivery of the Care Act and are fairly

confident that it will be delivered. However, the stocktake does highlight a number of risks that are logged on the risk register, including the late release of national guidance and regulations; development of digital, IT and financial systems required within a short time frame and communications to the wider public on the reforms and affordability. These areas of concern are shared with other local authorities.

Progress on key areas

Workforce

15. The Council is a pilot site for the Skills for Care workforce capacity planning model to model the impact of the Care Act on its workforce and understands what changes it will need to make. Although the Care Act will impact on the workforce across the Council, modelling has started in some key areas that will be affected by the changes, including assessment and care management teams, Adult Care Financial Services and the front end, including the Customer Service Centre and the Adult Access Service.

ICT, Advice and Information

16. The provision of good quality information and advice by the local authority, in partnership with others, underpins the reforms. There is a requirement to provide a comprehensive universal information and advice service that covers social care, health, housing and financial information.

17. A new strategy is in place which reflects the Care Act principles and a review has been undertaken of 'Choose My Support', the online directory, which provides information and signposting. Alternative systems are being looked into and evaluated against the requirements laid out in the Act. The aim will be to align this, wherever possible, with the information tools used by district/borough councils and health colleagues.

Prisoners

18. A new responsibility for local authorities is assessing and meeting eligible social care needs of adult prisoners (not just on discharge from prison, but also while they are in custody). This change in legislation will affect Nottinghamshire which has a number of prisons and bail accommodation within its boundaries. Work is under way to make contact with all the prison governors to scope the impact of this new responsibility and understand the numbers of prisoners who could be eligible for a social care assessment.

Wellbeing and national eligibility criteria

19. For the first time the reforms set a national *minimum* eligibility threshold based on wellbeing, which is intended to help achieve more consistency and fairness across the country by putting an end to different thresholds set by different local authorities. The government intended for the national *minimum* threshold to be set at the equivalent of substantial, which is where most local authorities, including Nottinghamshire, currently operate. However, the new draft national eligibility criteria are very different to those in current usage, with one significant difference being the basis on the impact to wellbeing rather than risks to independence. There is a general concern from local authorities that

the new framework is looser and will lower most councils' thresholds, thus generating more demand on their services.

20. The Council has actively participated in national surveys to test the new eligibility threshold. Based on preliminary work carried out by the London School of Economics, the first draft of the proposed changes would have increased the numbers of 'definitely eligible' and 'probably eligible' by almost 20%. In response to these findings, the draft guidance and regulations were again revised and a further survey commissioned, in which NCC participated. Although this report has not been released to date, the findings based on our very small sample suggest older adults could gain whilst some groups could lose out. Consideration is now being given to how the national *minimum* eligibility threshold would be locally implemented within the framework of the Adult Social Care Strategy.

Rights for carers

21. The Care Act gives carers the same rights as those of the person they look after and does away with the requirement that the carer must provide a substantial amount of care on a regular basis.

22. In response to these new and extended responsibilities, new models of access, assessment and service provision are being considered to meet these new demands in the most cost effective way. Specifically, there will be an increase in the number of requests for assessment – from initial assessment to financial assessment and review. These additional assessments will need to be carried out in a flexible way, which builds upon the successful telephone-based service at the Adult Access Service and which will maximise the use of all available resources including online assessments, supported self assessment and joint assessments with the person being carried for.

23. The Care Act entitles a carer to services to meet their eligible needs and these additional services that the carer will be entitled to represent a financial risk if the money identified in the Better Care Fund is not sufficient.

Self-funders and assessments

24. The Care Act fundamentally changes who and how people pay for their care. From April 2016, the financial reforms extend the means tested threshold of £23,250 for residential care to £118,000 and introduces for the first time a cap on lifetime costs of £72,000 (this excludes living cost of £12,000 per annum). During 2015/16 it is anticipated that there will be a high demand for assessments from self-funders. Based on local data and an extensive survey carried out with care providers, estimates suggest current assessment activity could double.

25. In response to this anticipated demand, NCC needs to carry out these assessments in the most efficient way possible. Working in collaboration with the Digital Team, plans are progressing to develop an initial contact assessment online, which could then be developed and expanded with a full online assessment for identifying eligible care needs and a financial assessment.

26. In addition, the Council needs to explore other alternatives to the way that we currently assess, yet recognising for some groups of service users and carers that a face-to-face

assessment is still required. Other ways of delivering an assessment include telephone based assessment, clinics for face-to-face, supported self assessment and working more closely with partners and providers in completing assessments, support plans and reviews.

Financial Contributions, Fees and Charging

27. The Care Act sets out several powers that local authorities have in relation to charging, including: a contribution to the cost of arranging and/or providing care and support for people above the upper financial threshold (self-funders); charging interest and administrative fees against the deferred payment scheme and charging carers for services and support provided.

28. The deferred payment scheme and the support planning and brokerage functions for self-funders are intended to be cost neutral; therefore an authority is entitled to charge for those fees as long as it does not charge more than what it costs to provide those services.

29. Currently, it is not possible to charge carers for services in the same way as service users are charged, but the Act will make it lawful for local authorities to charge. Charging carers for support and services could bring in additional income, but the full impact of charging carers needs to be considered.

Financial Modelling: understanding the costs of the reform

30. The Department of Health, Local Government Association and the Association of Directors of Social Services are working closely to model the costs of both the social care reforms in 2015 and funding reform taking effect in 2016.

31. The Care Act is funded through the following:

    - Care Bill Implementation Grant**,** which is a one off grant of £125,000 to contribute to implementation costs in 2014/5
    - Better Care Fund to cover new costs in 2015/16 with an allocation of £2.6 million with £0.7 million capital.

    In addition, there is consideration to a financial settlement from the government to meet costs *not* covered by the Better Care Fund. These include new assessments for self-funders, deferred payments and new responsibilities for prisoners.

32. All Councils are undertaking financial modelling to understand the impact of the Care Act.

33. Local authorities are very concerned that the Government has under-estimated the costs of the reforms and the current funding allocations identified above will be insufficient. This is supported by early modelling by county local authorities who have found the numbers of self-funders and carers have been underestimated.

Statutory and Policy Implications

34. 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

35. The Care Act has considerable implications for service users and carers, including people who fund their own care. Detailed consideration will need to be given to the full implications as part of the programme of work to scope, plan and implement the changes.

Financial Implications

36. These are covered within the body of the report.

Equalities Implications

37. The changes arising from the Care Act will impact on all vulnerable groups of adults and children across Nottinghamshire's communities. Equality Impact Assessment(s) will be completed to enable detailed understanding of the impact of the changes on people with protected characteristics and these will in turn help inform the changes that will be required to local policies and procedures.

Human Resources Implications

38. These are covered within the body of the report.

RECOMMENDATION/S

It is recommended that Committee:

1) note the implications of the new and extended responsibilities for local authorities and partners arising from the Care Act, including the financial and resource demands
2) note and comment on the update on the programme of work.

DAVID PEARSON
Corporate Director for Adult Social Care, Health & Public Protection

For any enquiries about this report please contact:
Jane North
Programme Manager
Email: jane.north@nottscc.gov.uk

Constitutional Comments

39. The proposals in this report are with the remit of the Health and Wellbeing Board.

Financial Comments (KAS 22/08/14)

40. The financial implications are contained within paragraphs 30 to 33 of the report.

Background Papers and Published Documents

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

- The Care Act Local Authority Stocktake completed May 2014.

Electoral Division(s) and Member(s) Affected

- All.

Nottinghamshire County Council

Report to the Health and Wellbeing Board

3 September 2014

Agenda Item: 6

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

HEALTH AND WELLBEING STRATEGY DELIVERY PLAN

Purpose of the Report

1. To update the Board on progress to develop an online Delivery plan for the Health and Wellbeing Strategy and to seek their approval to release the online content developed to date and inform the Board of the need for champions for each of the priorities within the strategy.

Information and Advice

2. The Health and Wellbeing Strategy was agreed by the Board in March 2014.

3. The Board agreed that a Delivery Plan should be developed which would support the Strategy and give more information about the actions to be undertaken to support the ambitions and the partners involved in delivery and to show clear links to supporting strategies and plan.

4. Internet content has been developed and will be demonstrated to the Board at the meeting.

5. The web pages will be available through the Nottinghamshire County Council website and have been designed within corporate guidelines.

6. The Council website is currently being reviewed and so new content has to be designed within current templates and resources. The Delivery Plan has been developed within these constraints and pages are now available which include:

   - An overview of the strategy
   - Links to the Joint Strategic Needs Assessment (JSNA) and Health and Wellbeing Board (HWB)
   - Information and actions for each priority area
   - A feedback form

7. Further development will be undertaken which will ensure that there are links to relevant pages within the Council website as well as links to sections of the JSNA and to partner plans and strategies and websites.

8. There is also potential to include progress reports on each priority.

9. The internet content will be published through the Council's website following approval by the HWB.

10. Administration rights for each priority will be delegated to each Integrated Commissioning Group to ensure that each priority page is maintained and updated including progress against actions.

11. Integrated Commissioning Groups have been confirmed to deliver each of the priority areas and member organisations will be shown on the website. These groups will report on progress through the Health and Wellbeing Implementation Group who will monitor performance on behalf of the Board. An outline of these groups is attached as Appendix 1.

12. A meeting of the Chairs of the Integrated Commissioning Groups is scheduled for 25 September 2014 and will focus on performance monitoring and reporting arrangements. This will be coordinated by the Health and Wellbeing Implementation Group and an initial report will be presented to the Board in December 2014.

13. At the Board meeting in July it was suggested that Board members could act as champions for each of the twenty priority areas within the Strategy. Champions for each of the priority areas are sought to maintain an overview of progress and support delivery, through liaison with the responsible integrated commissioning group.

Statutory and Policy Implications

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

RECOMMENDATION/S

The Health and Wellbeing Board is asked to:

1) Note the content of the report.

2) Approve the release of the internet based Delivery Plan for the Health and Wellbeing Strategy for Nottinghamshire.

3) Appoint Health and Wellbeing Board champions for each of the priorities within the Strategy.

Anthony May
Corporate Director, Children, Families and Cultural Services

For any enquiries about this report please contact:
Cathy Quinn, Associate Director of Public Health
Cathy.quinn@nottscc.gov.uk
Tel: 0115 977 2882

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

Constitutional Comments

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

Financial Comments

As this report is for noting only no financial comments are required.

Background Papers and Published Documents

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

- Nottinghamshire County Council Health and Wellbeing internet page: http://www.nottinghamshire.gov.uk/caring/yourhealth/developing-health-services/health-and-wellbeing-board/

- Our strategy for Health and Wellbeing in Nottinghamshire 2014 – 2017 http://www.nottinghamshire.gov.uk/caring/yourhealth/developing-health-services/health-and-wellbeing-board/strategy

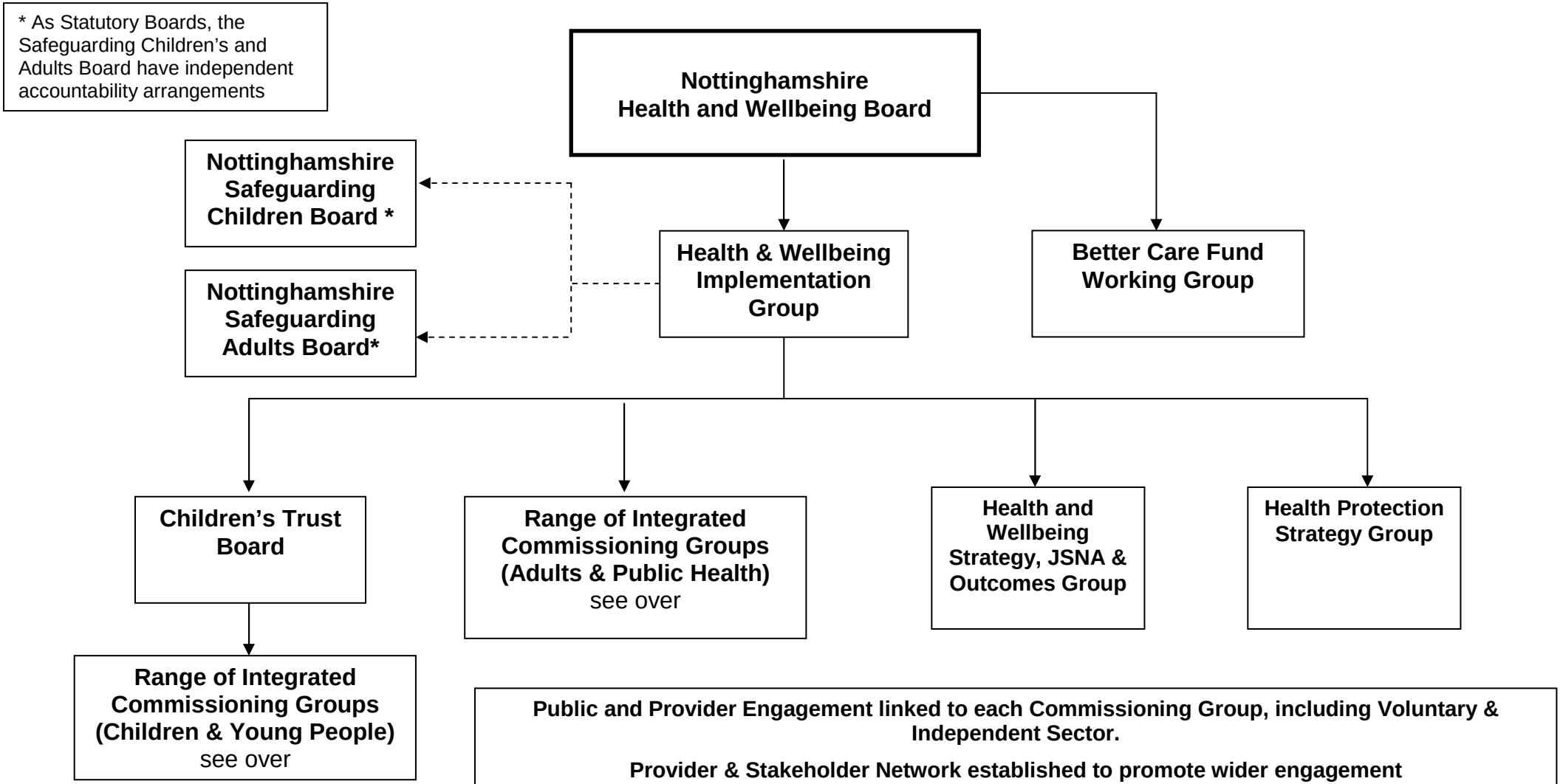
Electoral Division(s) and Member(s) Affected

- All

Nottinghamshire County Council

Health & Wellbeing Board Supporting Structures

* As Statutory Boards, the Safeguarding Children's and Adults Board have independent accountability arrangements



Range of Integrated Commissioning Groups as follows:

Priority area	Integrated Commissioning Group	Comments
Closing the gap in educational attainment	Children's Trust Board	
Deliver integrated services for children & young people with complex needs or disabilities	Children's Trust Board	
Improve children & young people's health outcomes through the integrated commissioning of services	Children's Trust Board	
Provide children & young people with the early help support that they need	Children's Trust Board	
Work together to keep children & young people safe	Children's Trust Board	
Improving the quality of life for carers by providing appropriate support for carers & the cared for	Older People's Integrated Commissioning Group	
Improving services to support victims of domestic abuse	Safer Nottinghamshire Board Domestic and Sexual Abuse Executive Group (SNB DSA Exec)	Reports to Safer Nottinghamshire Board & Health & Wellbeing Board
Provide coordinated services for people with mental ill health	Older People's Integrated Commissioning Group/Younger Adults Integrated Commissioning Group	
Providing services which work together to support individuals with dementia & their carers	Older People's Integrated Commissioning Group	
Support people with long term conditions	Younger Adults Integrated Commissioning Group	
Supporting older people to be independent, safe & well	Older People's Integrated Commissioning Group	
Supporting people with learning disabilities & Autistic Spectrum Conditions	Younger Adults Integrated Commissioning Group	
Improve services to reduce drug and alcohol	Nottinghamshire Adult Substance Misuse	Also reports to Safer Nottinghamshire Board

misuse	Integrated Commissioning Group	
Increase the number of eligible people who have had a Healthcheck	NHS Health Check Commissioning and Implementation Group	City and county group.
Reduce sexually transmitted disease & unplanned pregnancies	Sexual Health Strategic Commissioning Group	City and county group.
Reduce the number of people who are overweight & obese	Obesity Integrated Commissioning Group	
Reduce the number of people who smoke	Strategic Tobacco Alliance	
Ensuring we have sufficient & suitable housing, particularly for vulnerable people	To be confirmed	
Improving access to primary care doctors & nurses	NHS England	
Improving workplace health & wellbeing	To be confirmed	

Nottinghamshire County Council

Report to Health and Wellbeing Board

3 September 2014

Agenda Item: 7

REPORT OF THE ASSOCIATE DIRECTOR OF PUBLIC HEALTH

ANNUAL REPORT ON THE JOINT STRATEGIC NEEDS ASSESSMENT 2014

Purpose of the Report

1. This report provides information on the progress of the Joint Strategic Needs Assessment (JSNA) for Nottinghamshire during 2013/2014 and plans to further develop the Joint Strategic Needs Assessment during 2014/15.

Information and Advice

Introduction and context

2. The current Joint Strategic Needs Assessment (JSNA) has been jointly developed by NHS and Local Authority partners over the past five years. Government reforms have now placed a new emphasis on an expanded role for the Joint Strategic Needs Assessment particularly regarding: ensuring links between the Joint Strategic Needs Assessment, Health and Wellbeing Strategy and commissioning plans are clear; and embedding involvement and engagement with partners, public and the voluntary sector within the Joint Strategic Needs Assessment process.

3. In addition, services will continue to be commissioned in challenging financial times and in order to do this effectively, the commissioning plans will be developed from a robust and objective intelligence and evidence base.

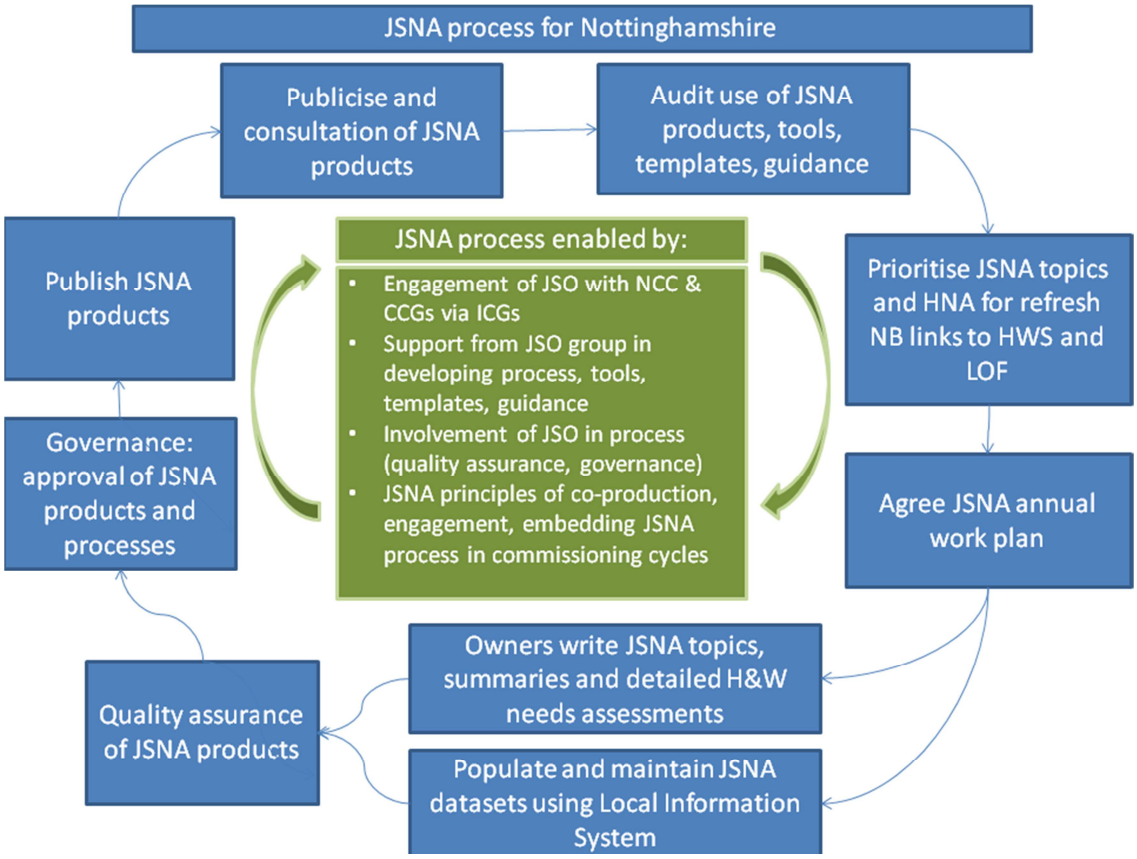
4. The Joint Strategic Needs Assessment objectives:

- The JSNA should be easy to use and understood.
- Commissioners and Commissioning Groups should routinely use the JSNA to inform and justify their commissioning decisions.
- Local District Partnerships should use the JSNA to help identify local needs and priorities.
- Providers of care and treatment will be able to use the JSNA to obtain information about local needs and opportunities to support their business plans.
- The General Public, Patients and their Representatives (including Healthwatch) should be encouraged to contribute their experience and opinions to the JSNA. Together the JSNA, Health and Wellbeing Strategy (HWS) and Local Outcomes Framework (LOF) should be used to understand the health and wellbeing needs of different populations in Nottinghamshire County; what public organisations are going to do and what difference this will make.

5. The JSNA should enable Council, Clinical Commissioning Groups (CCGs) and wider stakeholders to understand, improve and address people's health and wellbeing: determine the HWS, Commissioning Plans and how inequalities are to be addressed. Through the JSNA process it is hoped to achieve:

   - Delivery of high quality JSNA products
   - Confidence in and use of JSNA products
   - Clarity of priority issues
   - Understanding of gaps in knowledge
   - Strengthened partnership approach
   - More effective, integrated, targeted commissioning

6. The JSNA is a process. It is not just a document or a website. It needs to be a clear process whereby a consensus is reached in the light of the available evidence. The principles by which the JSNA is delivered include: joint ownership and co-production; engagement with partners and public; embedding the process in the commissioning cycle; and making clear links between JSNA, HWS and LOF and other outcomes frameworks.

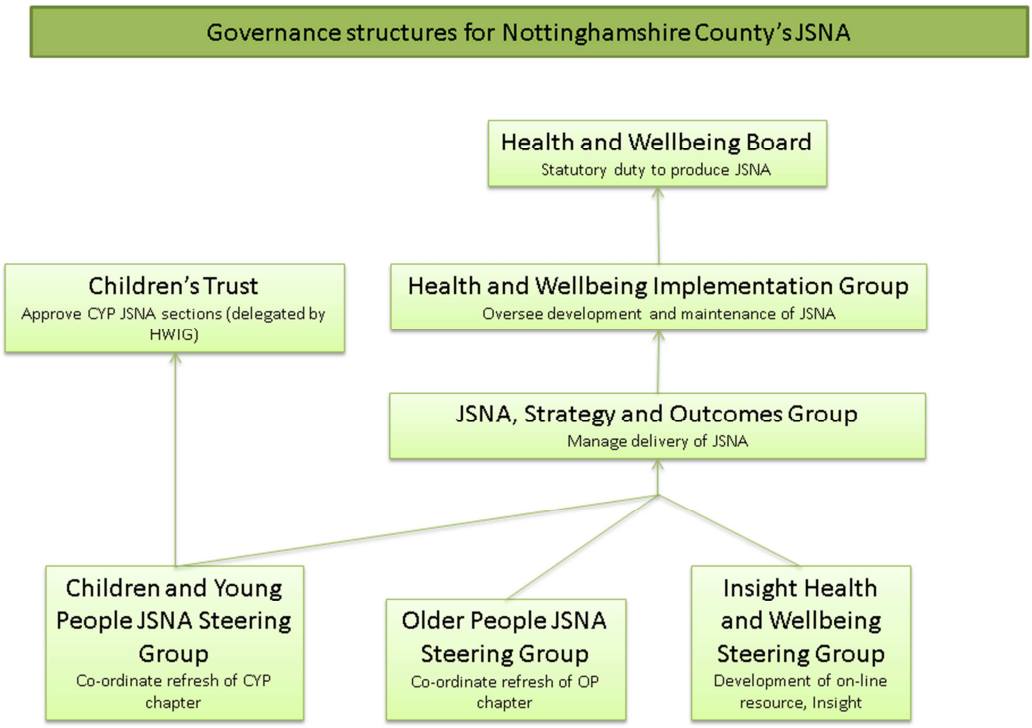


7. Work areas for the JSNA come under three main themes: governance and process; topic and section refreshes; and Local Information System. This report presents progress over the past 18 months and development plans for each of these work areas.

Joint Strategic Needs Assessment governance

8. The overall governance for the JSNA has developed over the past year and is presented in the diagram below. The HWB approves the JSNA annually and the Health and Wellbeing Implementation Group (HWIG) oversee the development and maintenance of the JSNA on behalf of the HWB. HWIG (or a delegated authority such as the Children's Trust) approves individual JSNA topics which have been refreshed during the year. The Health and Wellbeing: JSNA, Strategy and Outcomes Group (JSO) is responsible for delivering the JSNA. It monitors the JSNA process, quality and content and ensures that the appropriate resources are available for its development and management. The Health and Wellbeing: JSO is supported by a number of groups which co-ordinate the delivery of specific areas of the JSNA.

9. Each JSNA topic is 'owned' by a group with strategic commissioning responsibilities and multi-agency membership, preferably an integrated commissioning group. The role of the owning group is to identify authors to refresh or develop chapters, provide expert opinions regarding content and endorse their JSNA chapter prior to final approval by the HWIG. This new approach is anticipated to improve quality through the following benefits: wider involvement; better integration into commissioning cycles; enhanced commitment to support the JSNA; and clarity of priority issues.



Joint Strategic Needs Assessment process

10. Developments have been made to the JSNA process over the past year to improve the consistency and quality of the JSNA products. A standard template with guidance has been introduced for JSNA topics. This template informs the interactive JSNA pages on Nottinghamshire Insight (see below). A peer review process has also been established by which officers across the Council review final drafts of JSNA topics. Reviewers are prompted by specific quality review questions and guidance. Feedback from an audit of these developments has been very positive.

11. Further plans for 2014/15 include developing wider stakeholder engagement in the JSNA process, particularly with the voluntary and community sector and Healthwatch.

Joint Strategic Needs Assessment topic and section refreshes

12. The table in Appendix A shows which sections have been refreshed since March 2013 or are expected to be completed in 2014/15. 46 topics have been refreshed over the past 15 months. A further 17 are expected to be refreshed by early 2015. All the completed JSNA topics listed above can be accessed via http://jsna.nottinghamcity.gov.uk/insight/Strategic-Framework/Nottinghamshire-JSNA.aspx.

13. There are a number of additional topics within the JSNA which are due to be reviewed for refresh after March 2015 and include a wide range of topics such as cancer, disability and coronary heart disease.

Joint Strategic Needs Assessment local information system: Nottinghamshire Insight

14. The JSNA process delivers a range of JSNA products: topic summaries, executive summary, CCG/district summaries, detailed datasets, maps and a document library. Nottinghamshire County Council has recently commissioned the JSNA products to be delivered via a web-based interface, Nottinghamshire Insight. Development of Insight is co-ordinated and managed by the Insight Health and Wellbeing Steering Group. The aim of the group is to oversee the development of effective on-line sharing of data and intelligence through Insight to meet the needs of JSNA and wider requirements across Nottinghamshire County Council.

15. A work programme is being developed and includes: the development of the internet pages for Insight to improve the content of the pages and how the user moves around and between the different pages; updating and maintaining the JSNA area of Insight and how the user views the JSNA documents; reviewing and improving the data, profiles and the document library; clarifying the roles of partners in maintaining and developing Insight and communications and training.

16. Nottinghamshire Insight will be formally launched at a future HWB stakeholder event.

JSNA: Summary of development plans for 2014/15

Developments plans for the JSNA are summarised as:

- further support to ‘owning groups’ to ensure they understand and can implement their responsibilities for JSNA topic chapters;

- continue the ongoing refresh of JSNA topic sections;
- implement the work programme for Nottinghamshire Insight to improve the experience for users in finding resources, the content of Insight and the role of partners in developing Insight;
- develop wider stakeholder engagement in the JSNA process, particularly with the voluntary and community sector and Healthwatch.

Statutory and Policy Implications

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

Financial Implications

18. There are no financial implications in this report.

RECOMMENDATION/S

The Health & Wellbeing Board is asked to:

1) Note the work programme in place and the progress being made to ensure the continual quality improvements, refresh and accessibility of the Joint Strategic Needs Assessment.

2) Invite expressions of interest from members in being involved in the development of the JSNA.

3) Approve the proposed plans for development of the Joint Strategic Needs Assessment

Chris Kenny
Director of Public Health

For any enquiries about this report please contact:
Kristina McCormick
Kristina.mccormick@nottscc.gov.uk
ext. 72800

For any enquiries about this report please contact:

Constitutional Comments (SLB 14/08/2014)

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

Financial Comments (NS 14/08/14)

20. There are no specific financial implications arising from this report.

Background Papers and Published Documents

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

- None

Electoral Divisions and Members Affected

- All

Appendix A

Joint Strategic Needs Assessment topic refresh: progress since March 2013		
JSNA chapter	**JSNA section**	**Refresh date**
	Children and Young People	
	Population and Demography: Current population & projected population Ethnicity Religion or belief Births and life expectancy Special Educational Needs and Disability Young carers Socio-economic profile Child poverty	Approved 2013
	Health: Childhood vaccination and immunisation Maternity and Early Years Breastfeeding and Healthy Start Child oral health Emotional health and well-being Teenage pregnancy Transitions Health needs of young offenders Experience of maternity services Disability Health of looked after children	 Approved 2013 Approved July 2014 Approved July 2014 Approved July 2014 Approved July 2014 Approved July 2014 Completed June 2014 Completed June 2014 Due 2014 Due 2014 Due 2014
	Lifestyles: Tobacco control Substance misuse Participation in the community and in recreation Library usage Excess weight Sexual health	 Approved 2013 Approved July 2014 Due 2014
	Education and attainment: Early years School attendance and exclusions Quality of education provision Educational attainment Educated otherwise than at school NEET Skills levels	 Approved 2013
	Safety: Safeguarding children Sexual exploitation Missing children Looked after children Recorded crimes committed against children Domestic violence Interventions with families Youth justice Bullying and e-safety	 Approved 2013

Adults		
	Domestic abuse	Approved March 2014
	Sexual violence	Due to be completed August 2014
	Communicable diseases: Hepatitis B & C	Due to be completed August 2014
	Sexual health	DUE 2014
	Substance misuse: alcohol and drugs	DUE 2015
Older people		
	Excess winter deaths	Approved March 2014
	Dementia	Approved March 2014
	End of Life Care	DUE 2015
	Mobility and falls (incl Physical activity)	DUE 2015
	Loneliness	DUE 2015
Cross cutting themes		
	Road Safety	Approved Sept 2013
	The People of Nottinghamshire: population, demography & wider determinants	Approved March 2014
	Housing	Due to be completed August 2014
	Carers (adults and OP)	Due to be completed August 2014
	Tobacco control	Due to be completed August 2014
	Health Impacts of Air Quality	DUE 2014
	Health care associated infections in community settings	DUE 2014
	Diet and nutrition	DUE 2015
	Obesity	DUE 2015
	Physical activity	DUE 2015
Summaries		
	Executive summary	DUE 2014
	CCG/District overview	DUE 2014

Nottinghamshire County Council

Report to Health and Wellbeing Board

3rd September 2014

Agenda Item:8

REPORT OF THE CHAIR OF THE HEALTH AND WELLBEING BOARD

HEALTHWATCH NOTTINGHAMSHIRE – ANNUAL REPORT 2013/14 AND BUSINESS PLAN 2014/16

Purpose of the Report

1. To update the Board on Healthwatch Nottinghamshire.

Information and Advice

2. Joe Pidgeon, Chair of Healthwatch Nottinghamshire, and Claire Grainger, Chief Executive of Healthwatch Nottinghamshire, will give a presentation on the organisation's Annual Report 2013/014 and the Business Plan 2014/16.

3. The Report and Plan are appended to this report.

Statutory and Policy Implications

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

RECOMMENDATION/S

1) That the Board receive the presentation.

Councillor Joyce Bosnjak
Chair of the Health and Wellbeing Board

For any enquiries about this report please contact:
Joe Pidgeon, Chair of Healthwatch Nottinghamshire, tel 0115 963 5179

Constitutional Comments

This report is for noting so does not require a legal comment.

Financial Comments

There are no direct financial implications arising from this report.

Background Papers and Published Documents

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

- None

Electoral Division(s) and Member(s) Affected

- All

healthwatch
Nottinghamshire

Annual report 2013/14

Foreword

This is the first annual report describing the founding year of Healthwatch Nottinghamshire. It's been a busy, demanding and successful first year of operation.

We have established our basic organisation and infrastructure which now stands us in good stead for responding to the voices of our local service users, and helping them get the best from their local services. The Healthwatch team, our Board, Advisory Group and our many users and partners have all been part of the process of debating, and testing out, our developing sense of identity and our mission. It's still developing. I sense everyone now feels on much firmer ground about what we represent and our direction of travel.

We were fortunate in having a basic infrastructure in place to get us started on April 1st and for that I would like to thank the Implementation Team, with members from NAVO and County Hall. They worked hard in those first months to get us off the ground, and with such great efficiency, energy and belief! We are also grateful for the contributions of Nottinghamshire LINk employees and volunteers, many of whom continue in their work with us. I want to pay tribute to the capability of our Chief Executive, Claire Grainger, all the team members, and the volunteers we've recruited. Together they are proving to be a fantastic force for gathering and taking forward the voices of local people.

The world of health and social care, into which Healthwatch has been born, is a particularly challenging one. It is being pressured on both sides; grappling with austerity measures with severe downward budgetary pressure on both health and social care services, whilst at the same time, the NHS is undergoing its biggest changes since it was formed in 1948. Amidst all this the role of Healthwatch Nottinghamshire is more important than ever to make sure that service users, patients, carers and the wider public's views are taken on board by planners and commissioners.

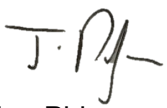
We can only be effective by working closely with local statutory and commissioning bodies, whilst
at the same time being an independent and trusted voice for local people. Our Prioritisation Panel, coming together for first time in the autumn, consists of 7 volunteers. It has now considered at least 40 major issues. They are wide-ranging from, for example: GP access, the East Midlands Ambulance Service, to problems with electronic prescriptions, ophthalmology waiting times and community mental health services.

We are working in a complex county. We work with six Clinical Commissioning Groups (CCGs), two NHS England Area Teams, seven District and Borough Councils, children and adults social care of the County Council, five large NHS Trusts, the Care Quality Commission and a diverse range of voluntary sector organisations. Substantial efforts in this first year have been spent in establishing good working relationships with all. Our feedback tells us that to a large extent, we have been successful in this endeavour. We have also worked hard in developing working arrangements with neighbouring Healthwatch across the East Midlands and we share two important team posts with Healthwatch Nottingham.

Our long term mission is:

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

We know from our recent survey that we now need to get better known by the public. This we will do and I am confident that we can make our second year an even more productive one

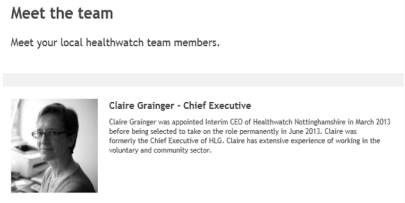


Joe Pidgeon, Chair of the Board

Contents...

The year at a glance…

We've now got a sound organisational base and presence to deliver our statutory work. Here are some of our highlights…


Meet the team

Meet your local healthwatch team members.

Claire Grainger - Chief Executive

Claire Grainger was appointed Interim CEO of Healthwatch Nottinghamshire in March 2013 before being selected to take on the role permanently in June 2013. Claire was formerly the Chief Executive of HLG. Claire has extensive experience of working in the voluntary and community sector.

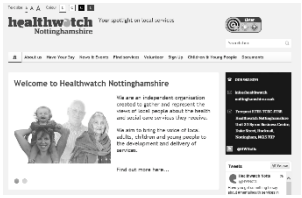
Recruited six members of staff, including a new Chief Executive, to ensure that we were fully staffed and prepared to take on the challenge ahead.

Opened a new satellite office in the Bassetlaw Community and Voluntary Service building. This will help to make sure that the people of Bassetlaw are able to have their say about health and social care services.

BCVS
Bassetlaw Community and Voluntary Service
Encouraging Community Action

Recruited 45 volunteers and delivered at least 21 hours of training to help them in their roles as Champion, Outreach and Prioritisation Panel volunteers.

Attended over 300 events and meetings to raise awareness of Healthwatch Nottinghamshire and help us deliver our statutory activities.



Achieved over 4,000 hits on our website.
http://www.healthwatchnottinghamshire.co.uk/

Sent over 1500 tweets and gained almost 400 followers on twitter. Follow us @HWNotts.

Started Joe Blogs, an online blog by our Chair, who has posted 8 articles on Health and Social Care issues in 2013/14.
http://joehwnotts.wordpress.com/

Initiated a bi-monthly column in the Nottingham Post and had articles published in other local newspapers. Our Chair, Joe Pidgeon, has also been interviewed on BBC Radio Nottingham and appeared on ITV central news.

Signed over 1,000 people up to our mailing list and published 14 newsletters and reports to keep local people updated on what we're doing and how they can get involved.

Making a difference through statutory activities

Government legislation gives us some statutory powers and requires us to undertake particular activities. This section details how we have undertaken these activities over the last year.

Promoting and supporting the involvement of local people in the commissioning, provision and scrutiny of local services

We have worked with service providers and commissioners to promote and support the involvement of local people in the design and delivery of local services. Our evidence suggests that we are starting to be successful; half of all providers and commissioners responding to our first annual survey agreed that we are making a difference to their organisation's work. When asked how we're making a difference, service commissioners said…

> *…offer a supportive and critical voice on behalf of the public which is appreciated and essential.*
>
> **Service commissioner**

> *They are already promoting the independent scrutiny of patient experience and the representation of patients…*
>
> **Service commissioner**

These are some examples to illustrate our work in this area:

Better Together - Mid Nottinghamshire Integrated Care Transformation Programme...

We've played an active role in this programme from the outset, to ensure that local people know about, and are involved in, this major change programme for health and social care services. Healthwatch Nottinghamshire staff and volunteers have been able get involved in communication and engagement with local people and in helping to shape the blueprint for the future of services in the area.

> *Healthwatch Nottinghamshire have been a valuable partner...their Champions have been actively engaged in the clinical design groups and have representation on our Better Together Citizens' Board. At an operational level, their officers have acted as a critical friends and have provided confirmation and challenge as we move forward to implementation planning. Our relationship with Healthwatch is a positive one, ensuring that at all stages, the patient voice is heard.*
>
> **Wendy Tomlinson, Better Together, Mansfield and Ashfield CCG**

South Nottinghamshire Transformation Board...

We're participating observers on the board which oversees the transformation of the health and social care system across Broxtowe, Gedling and Rushcliffe Boroughs and Nottingham City, to deliver improved outcomes for patients. Through working with the lead for engagement on the Board, we have supported the development of their engagement activities with local people, to make sure they know about the plans for the re-design of services.

Public Health Commissioning...

We have helped Public Health to plan consultation work with local people as part of their review of the commissioning of services, this includes drug and alcohol and obesity services.

As well as promoting the involvement of local people in other organisations we're doing this too! Since the appointment of our specialist volunteer co-ordinator, we have developed our Volunteering Strategy to give local people the opportunity to be part of our organisation, and help us achieve our mission. As part of this, we've developed a range of volunteer roles including:

Champion volunteers are a link into our local community and help us to give a voice to seldom heard groups. They also represent Healthwatch in existing forums and groups of which they are members.
This year we've recruited and trained 25 Champion volunteers, who have represented and raised awareness of Healthwatch in 11 different meetings.

Outreach volunteers - They are part of our public face of Healthwatch, supporting a range of events we deliver and attend. They've helped to raise awareness of and promote Healthwatch Nottinghamshire, and supported the collection of needs and experiences from local people.
This year we've recruited and trained five outreach volunteers; they've helped support six different outreach events.

We're also encouraging local young people to get involved in decision making about services by joining our Youth Forum. Through the Forum young people help us to identify what actions we as an organisation need to take to improve services. They will be able to run campaigns and short term projects which will make a difference to their services in the future.

128 Is the number of hours our volunteers have given to support Healthwatch Nottinghamshire during 2013/14.

We wanted to ensure that Equality and Diversity is at the heart of Healthwatch Nottinghamshire.
To achieve this we invited a number of people to help us to develop our Equality and Diversity Policy at a half day workshop. Healthwatch Nottinghamshire staff and volunteers met up with people from community organisations, providers and commissioners to look at how Healthwatch Nottinghamshire could ensure that it reaches ALL of the communities in the county. We consulted widely on our draft policy and we feel confident that it gives us a good framework for Equality and Diversity in all aspects of our work. A copy of this policy can be found on our website:
http://www.healthwatchnottinghamshire.co.uk/strategies-plans

Enabling local people to monitor the standard of care

This year we've focused on making sure that we get our programme of Enter and View visits right, learning from the experiences of our predecessor. In partnership with our Advisory Group, we have developed our strategy for how our visits will be undertaken, and how we will assist and support service providers and commissioners when undertaking their similar activities. For example…

Place surveys...

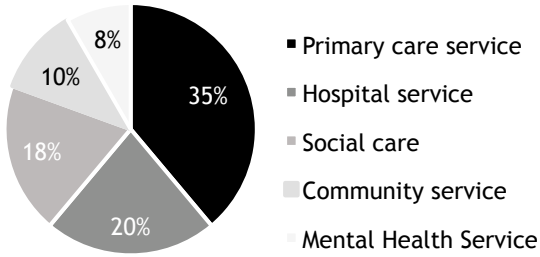
We know there are a number of ways that local people can get involved in monitoring the standard of care in health services, and we are keen that our Enter and View volunteers have a range of opportunities they can get involved in. To support this we have been talking to our local hospital trusts about how our volunteers can support their 'Place Surveys'.

Volunteers will be key in helping us to undertake this work, and this year we have gathered expressions of interest from 7 local people who would like to support us as an Enter and View volunteer. Recruitment and training of these volunteers will be undertaken this year.

Providing advice and guidance

Healthwatch Nottinghamshire is not commissioned to provide advice and guidance, this continues to be provided by local Patient Advice and Liaison Services (PALS) and the Nottinghamshire County Council Customer Service Centre. However, people do contact us to ask questions and report issues or concerns to us. We staff a phone line between 9am and 5pm daily to take these calls. Our staff also provide responses to questions asked through emails, our website and their face to face contact with local people.

Figure 1 Subject of enquiries



Over a third of all issues logged were about primary care services, the majority (almost eight out of ten) regarding GP surgeries/health centres.

Just over half of all issues related to primary care services requested information and details of services in their area. We provided this information directly or were able to signpost them to online services such as NHS Choices or Choose My Support.

Obtaining the views and experiences of local people

The views and experiences of local people have been gathered by telephone, through a 'Have Your Say' form on our website, attending a range of community events and delivering engagement events where we talked to people face to face.

Through this work we've promoted our message and the need to 'have your say' on local services to over 2000 people.

Reaching out to priority groups

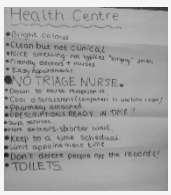
Over half (57%) of the service commissioners and providers who responded to our annual survey agreed that we identify and represent the needs of seldom heard groups. To reach out to people from disadvantaged and seldom heard communities we have used a variety of methods to raise awareness of Healthwatch and gather their needs and experiences. Here are some examples of this work…

Children and young people…

In November 2013 we employed a specialist community and partnerships worker to gather the needs and experiences of our local children and young people through a variety of different methods. Through this targeted work we have delivered 26 activities across all 7 districts in Nottinghamshire, gathering feedback from over 100 children and young people. Here is how we've done it…

The Dressing Up Box (3-7 years): We have delivered three of these events in children's centres and schools across the county. Using our dressing up box, children have pretended to be nurses, doctors, paramedics and surgeons. Through play, we have talked to children, parents/carers and teachers about younger children's experiences of health and social care services.

Healthwatchers Club (7-11 years): In January we started to promote our Healthwatchers Club in primary schools. After interactive quizzes and games we ask the children to tell us about their own experiences. 'Healthwatchers' have been sent a member's pack including a certificate and a Rewards Prescription. Every time they tell us about a visit to a local service they put a sticker on their Rewards Prescription. When the card is full we'll send them a small reward.



HWYouth (12-24 years): We've delivered 6 Pizza with Healthwatch events, participated in a Personal, Social and Health Education (PSHE) day at a secondary school, held an information stand at two further education colleges and delivered a lesson to a group of A level Health and Social Care students. We've also ran a workshop in a special school, visited a residential project for young adults with complex needs and delivered an outdoor adventure workshop for young adults with learning difficulties.

Older people…

We've linked up with community and voluntary services supporting older people in our local community. Through these events we've reached over 140 older people.

- We've attended Age UK events launching Fit for the future, a project supporting older people living with long term health conditions.
- Delivered an engagement event at the Older People's Resource Centre in Bassetlaw.
- Attended a Veterans and Armed Forces Event to raise awareness of issues and support available for veterans and serving armed forces personnel.
- Supported an older people's day to promote awareness of Healthwatch and provide an opportunity for older people to talk to us about their experiences.

The Deputy Chair of Nottinghamshire Older Persons Advisory Group is also an active member of our Advisory Group and provides feedback to us on the views and experiences of the people they support.

Disadvantaged and vulnerable groups…

During our first year we've been supporting events and activities delivered by other organisations to raise awareness of Healthwatch Nottinghamshire and the need for local people to 'have their say'. This includes:

- People suffering from mental health conditions through the Rushcliffe 'Unwind Your Mind' open event during Mental Health Awareness Week, and the Nottinghamshire Healthcare Trust AGM.
- People with learning disabilities through the Learning Disability Partnership Board; and the Sherwood Forest Hospitals Trust Learning Disability Steering Group.
- People with diabetes through information events run by the CCGs.

Formulating views on the standard of provision

We take all the needs and experiences we've gathered from local people to identify trends and concerns in provision. These were the three most frequently identified concerns and what people told us about them…

Access to services…

People were very concerned about the time it can take to get an appointment with their GP. Being able to get an appointment for the same day, or booking in advance and having appointments in the evening and weekends were all identified as problematic.

Services closing were also a worry, particularly community services that provide people with treatment and support for those suffering from mental health problems or learning disabilities. People also wanted local access to services currently provided some distance from their home.

Treatment and care…

Medication was a main topic of concern, we received examples of people being given medication they were allergic too and not being given the correct medication for their illness. Issues around the dispensing of medication were also raised by multiple people.

Waiting times…

The time it takes from referral to appointment is too long, people identified that during this time conditions can often deteriorate. The time between a first appointment and a follow up appointment was also identified as a problem.

These experiences and trends are taken to our Prioritisation Panel, a group of volunteers who help us to prioritise our work. More details of how this panel operates can be found in the section about how we make decisions. **46 concerns have been assessed by our prioritisation panel since its inception in September 2013.**

Making reports and recommendations

Following our Prioritisation Panel discussions we've contacted service providers 14 times, and commissioners 10 times, to either formally or informally discuss the concerns raised. We've produced reports and recommendations for how our local services could be improved. For example, these two issues both scored highly at our Prioritisation Panel and have been or are subjects of reports...

Ophthalmology service...

Waiting times were identified as being too long in the Ophthalmology department at the Queens Medical Centre. Although the total number of comments we received was not large, it was the most commented on individual service. We worked in partnership with Healthwatch Nottingham to provide a report on concerns that were raised to us both by people within the County and City of Nottingham. Our report was forwarded to the hospital. They acknowledged the issues we had raised and forwarded us an action plan of their activities to improve their service. As part of this, they invited a Heathwatch Nottinghamshire volunteer to join their patient experience group.

GP access...

Over the last few months of 2013 we heard comments from people in all areas of Nottinghamshire about waiting times of up to one month for a routine appointment with a nurse or GP, particularly if they wanted to see a named doctor. We felt that this could be improved; we are now working on a report on this to be submitted to NHS England.

Through the work we have done with children and young people our first quarterly report identified a series of recommendations including:

- Having more age appropriate toys and magazines in waiting areas. Games consoles, televisions and free wireless internet connections were the most frequently requested improvements.
- Health professionals treating young people as equals and talking to the young person directly rather than their parent/carer who attends appointments with them.
- Improving the transition from children's to adult care, particularly social care. Young people identified that adult social services don't have the same level of social and emotional support they have been used to, and that they wanted professionals to recognise them as 'young adults' and not 'older adults'.

Building relationships with our local service providers and commissioners was a key focus for this year, we wanted to ensure we had a strong and positive relationship to be a challenging and critical friend. We know that this has been successful. Results from our annual survey show that from responding service providers and commissioners…

83% had a positive experience working with us

80% value Healthwatch Nottinghamshire as an organisation

78% have a strong relationship with us

> *We particularly valued the work you have done with children and young people - a group often forgotten in healthcare planning. Their views and experiences are valuable to shape service redesign and provision.*
>
> **Service commissioner**

> *Healthwatch are able to present at most meetings and offer a supportive and critical voice on behalf of the public which is appreciated and essential.*
>
> **Service commissioner**

Where appropriate we have taken our reports and recommendations to groups that scrutinise the relevant services. We've regularly attended the county Health Scrutiny Committee and the joint Health Scrutiny Committee for the county and the city of Nottingham. We've also reported trends in the concerns being raised to us to both the Nottinghamshire and Derbyshire, and South Yorkshire and Bassetlaw Quality Surveillance Groups.

> *Healthwatch have been regular attenders to Health Scrutiny Committee. Their role in bringing patients and potential service users' views and concerns to the centre of our work has been excellent. It has enabled us to bring a sharper and better informed focus on scrutinising service delivery. Their contribution is always insightful and evidence based and so much appreciated by members of the committee.*
>
> **Councillor Kate Foale, Chair of Nottinghamshire Health Scrutiny Committee**

Working with Healthwatch England

Healthwatch England came to our Board meeting in January 2014, which gave us the opportunity to raise concerns that our local people had reported to us. As well as this, we have also worked with Healthwatch England on the care.data programme…

care.data programme…

We raised our concerns to Healthwatch England about this new programme to share patient data across services. Our local people told us that they had not received information about this. They felt that the short deadlines to opt out of sharing data, and the confusing methods through which they had to opt out unfair. Many other local Healthwatch raised the same concerns and the programme has now been delayed to raise awareness and listen to the views of patients.

As well as working with Healthwatch England we've also worked with the local Healthwatch network…

- We have worked with Healthwatch Derbyshire to develop protocols for working across borders with neighbouring Healthwatch. We've subsequently agreed working arrangements with three of our neighbouring Healthwatch and have more in the pipeline.
- Recruited two staff posts jointly with Healthwatch Nottingham so that we can better co-ordinate our communications and research activities.
- Shared some of our policies and plans with other local Healthwatch.
- Initiated a forum for board members to come together every three months as a peer learning network. We've supported and maintained this network in the East Midlands.

Being active on the Health and Well-being Board

Local Healthwatch have a seat on their local Health and Well-being Board; leaders from local services who work together to improve the health and well-being of local people. This section illustrates how we've been an active member of the Nottinghamshire Board.

We've exercised our responsibility on the Board by, amongst other things, keeping an eye on what patients, users and carers are saying about the services that sit under the Board's priorities. In January we reported back to them the issues being reported to us and what action we have taken, this report was well received by the board.

Here are some examples of the issues we've raised at the Board…

Homelessness

We said: In November 2013 during an item on the health needs of homeless people we reminded the Board that the County Council was proposing to significantly reduce the Supporting People budget, particularly relating to funding direct access homelessness facilities. We felt that this could have a direct negative impact on the health of homeless people across the County.
They said: Homelessness was suggested as a topic for a future stakeholder event and it was agreed there should be a further report being brought to the Board.

Budget reductions

We said: During an item in Novembers meeting at the Health and Well-being Board's Implementation Group, we voiced our concern that the priorities of the Group did not contain any reference to the impact of the Nottinghamshire County Council and NHS budget cuts over the next three years.
They said: It was recommended that the Board, or its Implementation Group, should monitor the impact on health and well-being of budget reductions in local authorities and the NHS.

Commissioning services for children's health

We said: In October 2013 we informed the Board that we would be appointing a specialist children and young people's worker and that we supported the Department of Health's 'You're Welcome' quality standards.
They said: In March 2014, in an item reviewing the progress and proposed priorities for 2014-16 for the integrated commissioning arrangements for children's health services, the Board recognised that their engagement activities should be co-ordinated with ours.

We've also supported the Health and Well-being Board with its engagement work, for example…

Health and Well-being Strategy for Nottinghamshire…

We've supported the public consultation on the new Health and Well-being Strategy for the County. We made sure local people were aware of the consultation and we attended the public meetings. During this meeting our Chair of the Board delivered a presentation to raise awareness of our role in this strategy, and stress the importance of people providing their thoughts and opinions about the new proposals.

We've also approached the Chairs of the Health and Well-being Board and the Scrutiny Committees recommending that a protocol of roles and responsibilities between these two bodies and Healthwatch Nottinghamshire be developed. This has been supported and will help ensure that councillors and the public have a better understanding of how they work together.

Making decisions at Healthwatch Nottinghamshire

Local Healthwatch are required to have a procedure to make decisions and involve local people in making decisions. We have three ways of doing this.

The Healthwatch Nottinghamshire Board

Our board is comprised of four local people. The Chair of the Board and two other members were recruited by our commissioners, Nottinghamshire County Council, through an open process with an independent interviewing panel. One board member was co-opted on the board in September 2013 to increase our insight into the NHS. The board meet every 6 weeks, and a joint board and staff meeting is held every 6 months. Board members also represent Healthwatch Nottinghamshire in various public forums. The Board help us to make decision about how we plan and deliver our activities, and how much we spend on our activities.

You can find out more about our board members here:
http://www.healthwatchnottinghamshire.co.uk/content/meet-board

The minutes of the Board meetings are published on our website:
http://www.healthwatchnottinghamshire.co.uk/board

Our Advisory Group

To support the Board in developing the organisations strategic direction we have appointed an Advisory Group. A stakeholder workshop recommended the make-up of the Advisory Group in order to maximise its public accountability. It also identified positions in these roles in organisations across the county. The group has a representative from our CCG's, some of our key service providers, two district councils, members of community and voluntary sector organisations and local people. Like our board, the advisory group meet every 6 weeks, and minutes of the meetings are published on our website:
http://www.healthwatchnottinghamshire.co.uk/advisory-group

The Prioritisation Panel

Our Prioritisation Panel has a key role in deciding the work that Healthwatch Nottinghamshire undertakes. The panel are a group of specialist volunteers recruited through an application process to ensure we have knowledge of health and social care services in Nottinghamshire.

The panel meets once a month to provide an independent assessment of the information that Healthwatch Nottinghamshire has gathered. This could be patient experience gained directly through Healthwatch work, or information that we've collected through other sources. They assess the priority of issues using set criteria, they also make decisions about what actions should be taken and what services our work should be focussing. This includes whether we request further information, make a report or a recommendation, which premises to enter and view and when they should be visited.

The meetings are public, held in different locations across the county, so that local people can understand how we prioritise our work based on their needs and experiences. The minutes from meetings, outlining decisions made and the reasons for those decisions, are also published on our website:
http://www.healthwatchnottinghamshire.co.uk/prioritisation-panel

Our financial report

Funding for local Healthwatch comes from the Department of Health to the Local Authority. Our contract is with Nottinghamshire County Council and we received £465,000 to fund the work of Healthwatch Nottinghamshire in 2013/14, of which £15,000 was for set up costs.

Table 1 Healthwatch Nottinghamshire income and expenditure 2013/14

Income	Cost
Nottinghamshire County Council	£465,000
Bank interest and sundry income	£169
Total	**£465,169**

Expenditure	Cost	% of total
People costs – staff, volunteers and board	£178,268	38%
Premises costs – e.g. rent, utilities, maintenance	£11,676	3%
Running costs – e.g. insurance, professional fees,	£12,263	3%
Office costs – e.g. phones, printing, stationery	£9,173	2%
Publicity and marketing	£6,220	1%
Set up and equipment	£13,330	3%
Depreciation	£5,579	1%
Transfer to reserves	£228,660	49%
Total	**£465,169**	**100%**

As we were not fully up and running for all of the year, we did not spend all of the funds allocated. However, we have been informed during the year that our funding from Nottinghamshire County Council will be reduced by 30% over the next two years. The surplus will be carried forward to the next two years and will enable us to set up a financial reserve to ensure the future stability of the organisation and sustain Healthwatch services until March 2016, subject to continued grant funding from the County Council.

Using the Healthwatch trademarks

The Healthwatch logo is a registered trademark and is protected under trademark law. If an external party uses it without permission, this constitutes infringement of the trademark. The use of the logo is controlled by Healthwatch England www.healthwatch.co.uk

Healthwatch Nottinghamshire is licensed to use the Healthwatch trademark (including the logo and the Healthwatch brand) as per our license agreement with Healthwatch England and the Care Quality Commission.

The future

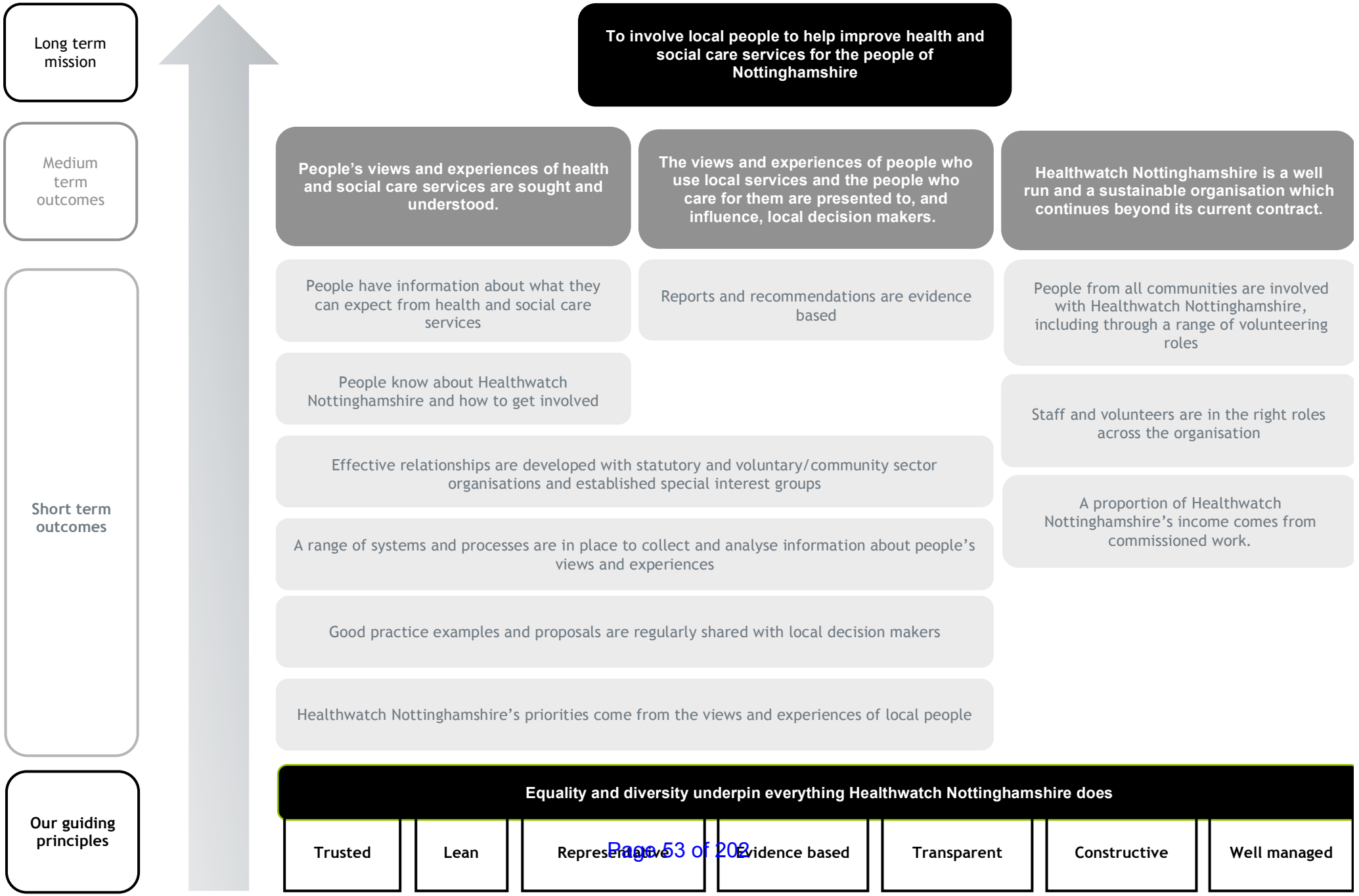
With another two years to run on our current contract we've developed a business plan for delivering our core activities and achieving a longer-term, sustainable future for Healthwatch Nottinghamshire. We've used the feedback from our first Annual Survey to help us to develop this plan, for example…

You told us…
We need to make more people aware of Healthwatch Nottinghamshire and the work that we do.
We know we need to prioritise this so we're launching our Healthwatch 'Have Your Say Points' in locations across the county that are widely used and accessible to the public such as advice centres, youth centres, community centres and many more.

We need to do more to demonstrate our value to the local people of Nottinghamshire.
We've developed a new framework and system for monitoring and evaluating our activities, and will be publishing our reports and recommendations online. We think these will help us in demonstrating the influence we have.

A full copy of our business plan can be found on our website, but here's a summary of what we're setting out to achieve over the next two years…

Figure 2 Mission and outcomes 2014-2016



About us

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Company number: 8407721

Board of Directors

Chair: Joe Pidgeon
Alan Sutton
Shirley Inskip
Juliet Woodin

Staff team

Claire Grainger – Chief Executive
Charlotte Daniel – Information and Administration Worker
Chris Watson – Community and Partnerships Worker for Bassetlaw and county-wide organisations
Andrea Sharp – Community and Partnerships Worker for Mid Nottinghamshire
Jane Kingswood – Community and Partnerships Worker for South Nottinghamshire
Alison Duckers – Community and Partnerships Worker for Children and Young People
Deb Morton – Volunteer Co-ordinator
Donna Clarke – Evidence and Insight Manager
Loren Maclachlan – Administration Assistant

healthwatch Nottinghamshire

Business Plan 2014-16

Final June 2014

1 Introduction

Healthwatch Nottinghamshire is one of 152 local Healthwatch across England. Healthwatch is the consumer champion for health and social care which aims to ensure that the voices of users of health and social care are heard by decision makers. Healthwatch England has been established to support Healthwatch activity across the country and to provide a focus for feedback about services at a national level. The statutory role and function of Healthwatch is laid down in the NHS and Social Care Act of 2012, but local areas have discretion about how their local Healthwatch delivers its services.

Healthwatch Nottinghamshire has replaced the Nottinghamshire Local Involvement Network (LINk), which came to an end on March 31 2013. Healthwatch Nottinghamshire is committed to taking forward the best of the LINk into the development of the new organisation and its activities and we took account of the LINk legacy document and of the good practice that it recommends in developing our plans for year one of our operation.

We developed a Business Plan for the first year of our operation. We now have two more years of our initial three year contract to deliver Healthwatch for Nottinghamshire. This plan develops on our first year of operation and identifies what we aim to achieve over the next two years and looks towards a longer-term, sustainable future for Healthwatch Nottinghamshire. We have used the feedback from our first Annual Survey to help us to develop this plan and we hope it reflects what the people and organisations of Nottinghamshire want from their Healthwatch.

2 Functions of Healthwatch

Nationally the local Healthwatch model includes a number of functions, but all the functions contribute to the overall aim of empowering individuals and groups to influence the health and social care services they receive. Healthwatch covers all statutory health and social care services and services for adults and children.

The range of functions that can be delivered by local Healthwatch are:

- Providing information and signposting about health and social care services
- Monitoring concerns and complaints
- Enabling people to feedback about their experiences of health and social care services
- Collating information and compiling reports about people's experiences and views
- Providing independent advocacy for people who want to make a complaint about NHS service

Different areas have made different decisions about which functions are delivered by Healthwatch and which are delivered by other organisations. In Nottinghamshire the commissioners have decided that Healthwatch would not have responsibility for the delivering of the independent complaints advocacy service and this has been separately commissioned. In addition PALS (Patient Advice and Liaison Service) services continue to be provided by the Clinical Commissioning Groups, hospitals and trusts across the County, and so there is not a requirement that Healthwatch Nottinghamshire provides information and signposting services.

The Triangle of Activities

The activities of Healthwatch Nottinghamshire fall into three main areas, illustrated in figure 1:

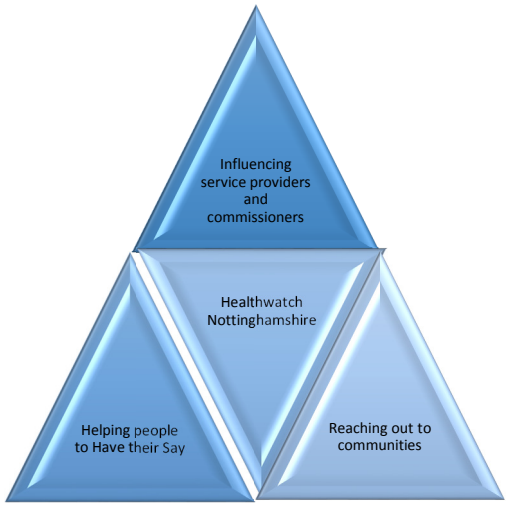

Figure 1 Triangle of activities for Healthwatch Nottinghamshire

Helping people to have their say - providing a means for people to express their views and concerns, providing information where appropriate, working with providers of information and signposting, linking with advocacy services

Reaching out to communities - on our own or though other engagement mechanisms, telling people about Healthwatch, encouraging them to input their views, feeding back about outcomes

Influencing Service Providers and Commissioners- collecting and analysing data, producing reports, representation on key forums

3 Governance and Management

Healthwatch Nottinghamshire has been set up as a social enterprise to deliver Healthwatch in the county. It is a Company Limited by Guarantee and has an asset lock in place, which locks assets in favour of the County Council if the company should cease trading. The Board has decided to register Healthwatch Nottinghamshire as a Charity with the Charity Commission and this registration will take place during 2014. They decided that charitable status would help to establish Healthwatch Nottinghamshire's position as an organisation that exists for the benefit of the people of Nottinghamshire and to open up other sources of funding in the future.

The organisational structure and functions of Healthwatch Nottinghamshire are illustrated and explained in figure 2.

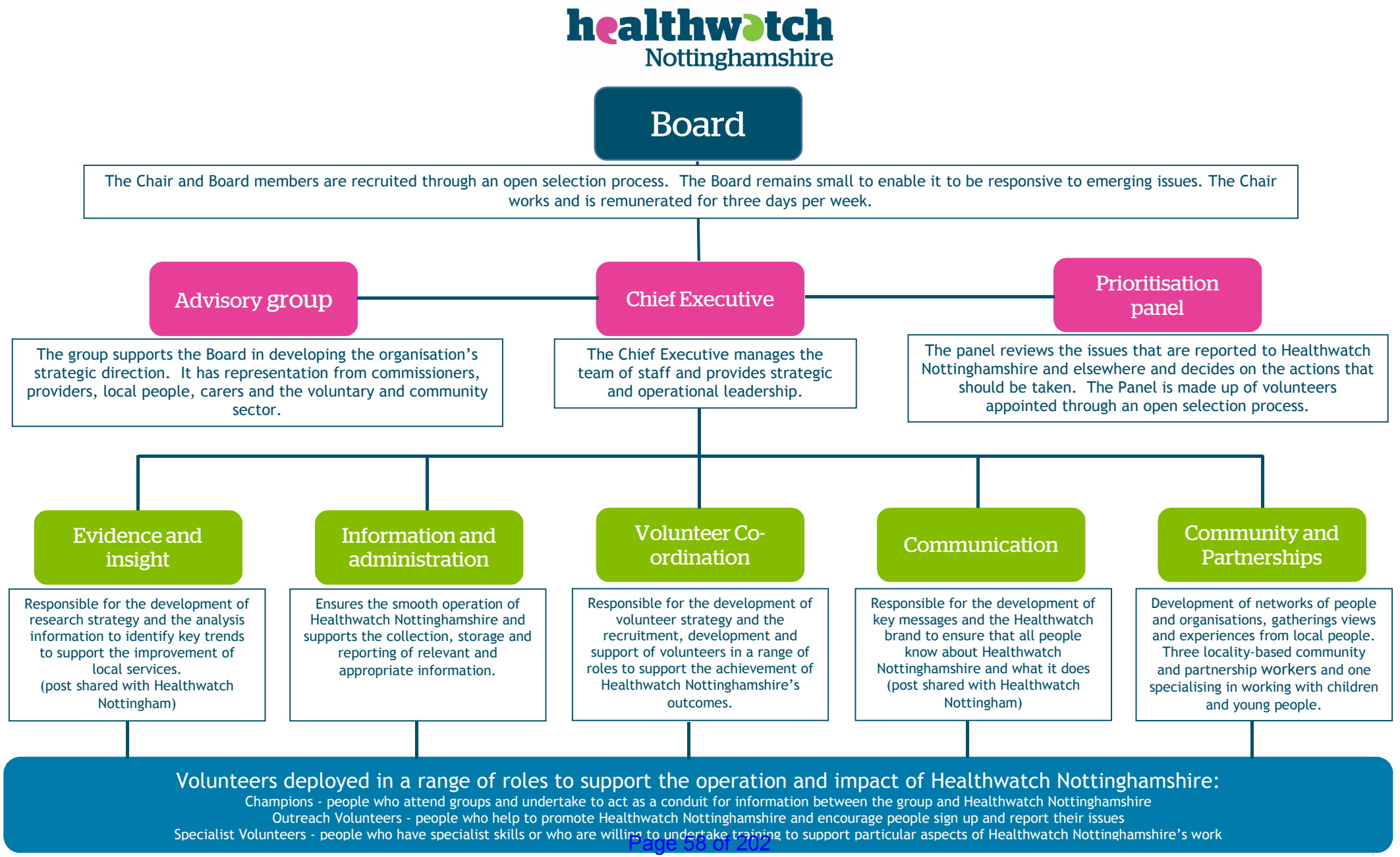

Figure 2 Organisational structure and function of Healthwatch Nottinghamshire

4 Volunteers

The involvement of members of the public, and particularly of volunteers is central to the success of Healthwatch Nottinghamshire. The scope of our activities, both the geography and the number of organisations, groups and individuals with an interest in health and social care means that there is a need for involvement from people other than the staff at all levels of the organisation

We have developed a Volunteering Strategy which details how we believe volunteers enhance different aspects of our work. The strategy is supported by comprehensive policies covering how we will recruit, support and develop volunteers in Healthwatch Nottinghamshire. We have developed a model of engagement and volunteering that allows for people to have as much or as little involvement with Healthwatch Nottinghamshire as they want and to increase or decrease that involvement over time.

At the end of our first year we have 50 volunteers, of whom 42 are active. This includes 25 Champions, 7 Prioritisation Panel members, 1 Have Your Say Point volunteers and 3 Board members. Some of our Champions are also supporting us as Outreach Volunteers. During 2014, we will be recruiting and training our first group of Enter and View volunteers as well as continuing to recruit people for other volunteering roles.

5 Our principles

As part of developing the model for Healthwatch Nottinghamshire, the commissioners carried out consultation events across the county. The people who attended the consultation events were clear about what they wanted from their local Healthwatch, and from their feedback we developed the following principles for Healthwatch Nottinghamshire to:

- be credible and trusted in the local community
- have a simple and lean structure to maximise agility as a social enterprise
- be representative of local people
- use data and evidence to support its work
- have clear and transparent prioritising and decision making
- work constructively with the public, health and social care sectors and voluntary and community sector
- be well managed with knowledge and integrity at its core

6 Equality and Diversity

During our first year we have developed our Equality and Diversity Policy, with input from a range of people and organisations. Our Equality and Diversity policy statement is as follows:

> The aim of Healthwatch Nottinghamshire is to provide a robust voice for the children, young people and adults of Nottinghamshire and for the voices of the people to influence how health and social care services are planned, purchased and delivered in the County.
>
> Healthwatch Nottinghamshire commits to do all it can to:
>
> - ensure that all Nottinghamshire children, young people and adults are able to contribute and participate as much as they want to
> - ensure that the voices of all people are heard, including the people whose voices are sometimes not heard or listened to
> - identify and highlight good and poor equality & diversity practice in health and social care
> - challenge examples of discrimination and disadvantage when they arise
> - value people's individuality and respect differences
> - take positive action to address inequalities, where appropriate
>
> Furthermore, Healthwatch Nottinghamshire aims to be an excellent employer and to recruit, develop and support a diverse workforce that can effectively work with and for the people of the County.

Following the development of the Equality and Diversity Policy, an Equalities Impact Assessment will be carried out and an action plan will be developed to ensure that we fulfil our aim of putting Equality and Diversity at the heart of everything we do

7 Update on the 2013 - 14 Business Plan

Much of our 2013-14 plan focussed on establishing Healthwatch Nottinghamshire as an organisation. This involved:

- Developing working relationships with commissioners and providers of services
- Developing our working practices in the areas of responding to queries from the public, engagement with local people and communities and volunteering
- Developing our staffing structure and recruiting new team members

- Recruiting volunteers to a range of roles
- Developing our communications strategy
- Developing our methods of responding to and prioritising issues that come to us from the public
- Developing key policies and procedures, such as our Equality and Diversity Policy

As part of preparing for our Annual Report we have undertaken a survey of our stakeholders and asked them how we have done in our first year. Their feedback in the following areas is reflected in our plans for the next two years:

- Healthwatch Nottinghamshire is valued by the majority of those who responded to our survey. This includes 100% of the 11 commissioners and almost three quarters (74%) of the 19 service providers responding.
    - We need to do more to demonstrate our value to the local people of Nottinghamshire, 38% of the 48 local people responding couldn't make a judgement about this.

- We need to raise awareness of our organisation amongst local people. Almost two thirds (65%) of all respondents disagreed that the majority of local people know about Healthwatch Nottinghamshire.
    - Getting ourselves known to and talking regularly with local people emerged as one of the most frequently identified suggestion when local people were asked what difference Healthwatch Nottinghamshire could make to them in the future.
    - Providers and commissioners agreed that raising public awareness of our organisation and engaging with local communities was going to be our biggest challenge over the next year.

8 Mission and outcomes for 2014-16

The outcomes in the 2013-14 Business Plan came from the feedback that people provided to the Implementation Team for Healthwatch Nottinghamshire during 2012. For this plan, we have revised the outcomes based on the progress we made in 2013-14 and on the feedback we have received from the Annual Survey and other feedback. Our long term mission and outcomes are identified in figure 3.

Healthwatch England has developed an outcomes framework for local Healthwatch. The Board has reviewed the Healthwatch Nottinghamshire outcomes against this framework and is satisfied that our outcomes cover all areas that the framework identifies for a successful local Healthwatch.

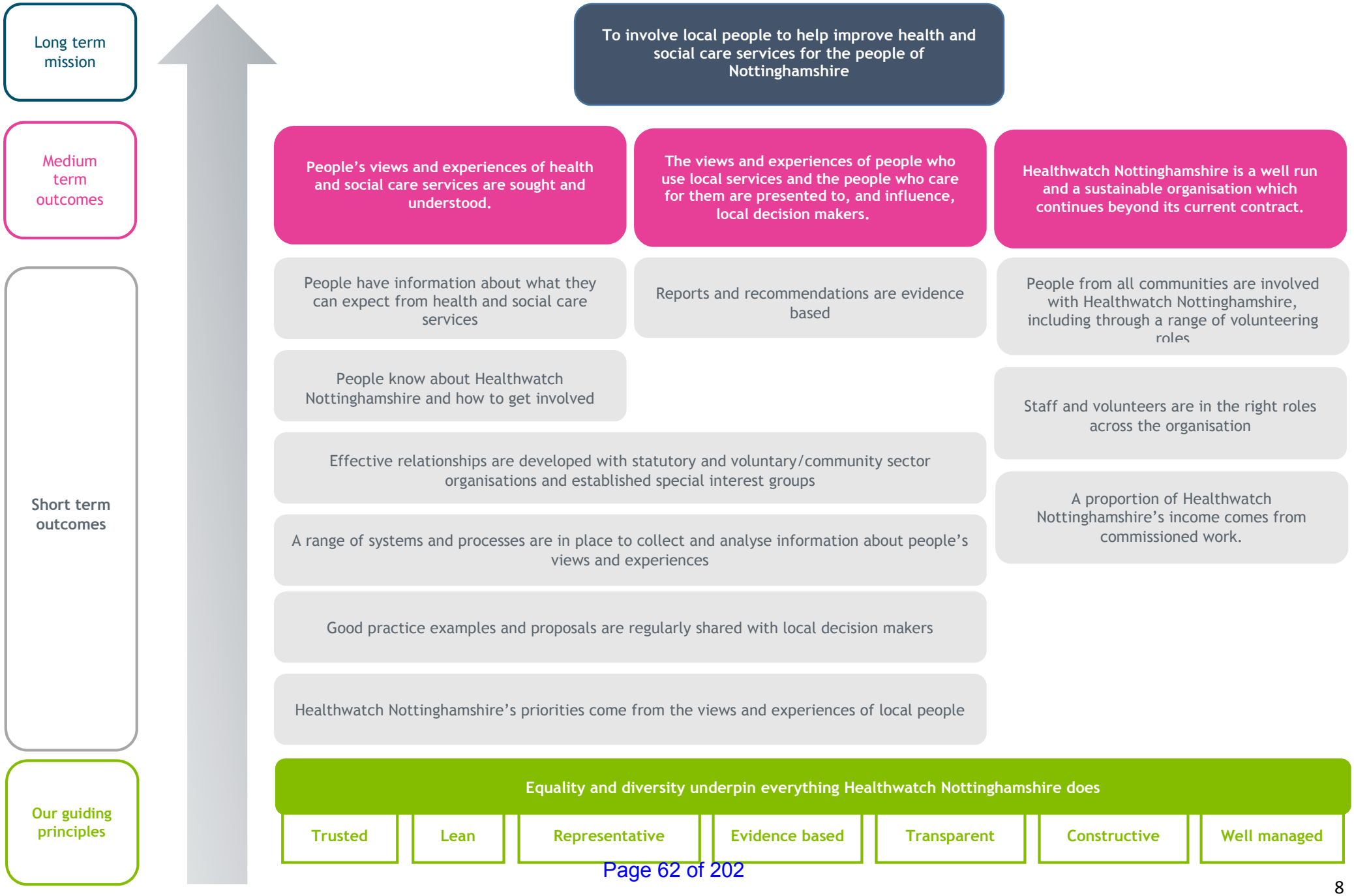

Figure 4 Healthwatch Nottinghamshire's aim and outcomes for 2014-16

9 Delivering our mission and outcomes 2014-16

This section identifies what the Healthwatch Nottinghamshire Board and staff will do to deliver the long term mission and outcomes identified for 2014-16. The detail of how the activities will be delivered is contained in the Healthwatch Nottinghamshire Action Plan, which is refreshed on a six monthly basis.

Our long term mission	How we will know if we've been successful
To involve local people to help improve health and social care services for the people of Nottinghamshire	More members of the public are involved in consultation and engagement activities Evidence shows that people's views have influenced service design and delivery Fewer complaints and negative experiences about targeted services we have engaged with

Medium term outcome	How we will know if we've been successful			
People's views and experiences of health and social care services are heard and understood	Responses to our annual survey shows an increasing percentage of local people, providers and commissioners feel that Healthwatch Nottinghamshire is effective at collecting and reporting on people's views and experiences			
Related short term outcomes	**What we will do**	**When will we do it by**	**How we will know if we've been successful**	**How we will measure it**
People have information about what they can expect from health and social care services	Continue to develop the website as a hub of information about local services and link to our website through every publication	31.3.15	An increase in the number of website hits People tell us that they find the website a useful source of information	Monthly monitoring of website hits Website survey
	Continue to work closely with PALS and other staff offering advice, signposting and complaints services	31.3.15	Improved communication with providers of information and signposting services Information is shared with Healthwatch Nottinghamshire	Information sharing protocols in place Annual survey

	Participate in the local development of Care Connect	31.3.13	Healthwatch is able to access information collected through Care Connect Information about Care Connect is widely available to local people	Experience reports from database
People know about Healthwatch Nottinghamshire and how to get involved	Continue to use a range of communications methods to promote Healthwatch Nottinghamshire in line with the Communications Strategy	31.3.15	There is an increase in the public's knowledge and awareness of Healthwatch Nottinghamshire	Annual Survey Citizen Panel Survey Contact reports from database Number of social media followers
	Continue to develop media contacts and issue regular press releases about issues and campaigns	31.3.16	Increased coverage of Healthwatch Nottinghamshire in the local media	Media log
Effective relationships are developed with statutory and voluntary and community sector organisations and established special interest groups	Continue to work with Voluntary and Community Sector Infrastructure organisations to raise awareness of Healthwatch Nottinghamshire across the county	31.3.15	All Infrastructure organisations are forwarding information about Healthwatch Nottinghamshire to their networks Volunteering opportunities are promoted within all of the CVS/Volunteer Bureaux in the county Regular presentations are delivered to organisations about the work of Healthwatch Nottinghamshire	Activity reports from the database CVS newsletters and websites Annual survey
	Roll out the model developed with the MS Society to recruit and support volunteers within voluntary and community organisations	31.3.16	There are 6 Champions within voluntary and community organisations across the county Champions report experiences from local people in their group	Volunteer report from database Experience reports from database

	Develop a network for BME groups and organisations involved in health and social care	31.12.14	The network is up and running and contributing to Healthwatch Nottinghamshire and its members tell us they find it useful	Annual review of the network
	Undertake a campaign to promote Healthwatch Nottinghamshire to elected representatives and set up regular meetings with MPs	31.3.15	Increased communication between Healthwatch Nottinghamshire and elected representatives	Activity reports from database
A range of systems and processes are in place to collect and analyse information about people's views and experiences of services	Continue to develop Have Your Say Points (HYSPs) in every district of the County	31.3.16	There are at least 3 Have Your Say Points in each district An increase in the number of experiences being reported through HYSPs	Records of HYSPs Experience reports from database
	Review and develop the website to act as a portal for people to input their concerns, views and experiences	31.3.15	More comments are coming in via the website	Experience reports from database
	Continue to develop engagement tools and techniques that enable people from all communities to have their say about services	31.3.16	We have identified gaps in our skills and have trained our staff where needed We have developed partnerships with other organisations who are in contact with particular groups or communities	Database Annual survey
	Involve volunteers in collecting feedback from patients, carers and service users	31.12.14	Have Your Say Point volunteers are collecting views and experience Two groups of Enter and View (Review and Report) volunteers have been recruited and trained and have undertaken pieces of work	Volunteer records Reports from projects

Good practice examples and proposals about areas for improvement are used to influence local decision makers	Develop methods for collecting more detailed patient/service user/carer stories	31.12.14	We have a bank of case studies and good practice examples	Number of case studies collected
Healthwatch Nottinghamshire's priorities come from the views and experiences of the public	Promote and report on the work of the Prioritisation Panel and the opportunity for the public to attend the meetings	31.3.15	An increased number of people attend Prioritisation Panel meetings Reports are produced and published about the issues discussed by the panel and the outcomes achieved	Papers and reports from Prioritisation Panel meetings
	Develop research projects based on the priorities set by the Prioritisation Panel	31.3.16	It is clear that research projects have been developed from reports from local people	Prioritisation Panel papers 'You Said We Did' reports
	Include data about patient/service user/carer experience of services from other sources in the prioritisation process	31.3.15	Information from at least four sources contribute to the prioritisation process	Papers and reports from Prioritisation Panel meetings

Medium term outcome	**How we will know if we've been successful**			
The views and experiences of people who use local services and the people who care for them are presented to, and influence, local decision makers.	Responses to our annual survey shows that an increasing percentage of local people, providers and commissioners feel that Healthwatch Nottinghamshire is influential			
Outcome	**What we will do**	**When will we do it by**	**How we will know if we've been successful**	**How we will show it**
Effective relationships are developed with statutory and voluntary and community sector organisations and	Continue to develop protocols for sharing information from the public with commissioners and providers of services	31.12.14	Information is being shared between Healthwatch Nottinghamshire and other organisations in line with an information sharing protocol	Information sharing protocols in place Number of patient experiences being

established special interest groups				received from other organisations
	Ensure that Healthwatch Nottinghamshire priorities and actions are in line with other organisations' planning and commissioning cycles	31.12.14	We have a comprehensive list of commissioning cycles and a member of staff responsible for keeping it up to date Evidence is collected and fed into the relevant processes	Visible examples of evidence feeding into strategies, commissioning plans and tenders
	Develop communication and escalation protocols with key boards, committees and regulators	31.3.15	Protocols are in place Regular reports are presented Issues are escalated	Number and types of reports presented
	Collect and analyse information from a range of sources to give a broader picture of people's views and experiences of services	31.12.14	New software has been purchased and installed and is producing reports that draw on a range of sources	Reports
	Develop a range of reporting methods, including dashboards that can be shared with partners	31.3.15	Commissioners and providers receive regular reports on patient experiences and needs Commissioners and providers report that Healthwatch Nottinghamshire is making a difference to their work.	Dashboards and reports produced Annual survey
Reports and recommendations are based on evidence and research	Use credible evidence and undertake research projects to contribute to reports	31.12.14	Reports include evidence and research Commissioners and providers respond to the recommendations of reports	Reports Annual survey
	Continue to develop links with Universities and other research bodies	31.3.15	Academic staff are advising Healthwatch Nottinghamshire's Evidence and Insight activity	Reports and papers

			Healthwatch Nottinghamshire is a partner in research work	
Good practice examples and proposals are regularly shared with local and national decision makers	Develop methods for logging and researching examples of good practice Use good practice examples in reports	31.3.16	Good practice examples are used in reports Services change as a result of information about good practice elsewhere	Reports and papers Annual Survey
Healthwatch Nottinghamshire's priorities come from the views and experiences of the public	Use the priorities that come from the Prioritisation Panel and other sources of patient/service user/carer feedback to develop research projects	31.3.16	It is clear how the prioritisation process and other sources of feedback have influenced what projects we take on	Prioritisation Panel papers Reports
	Undertake a review of the Prioritisation process and make any changes to the process needed	31.12.14	The review has taken place and any recommendations have been implemented	

Medium term outcome	**How we will know if we've been successful**			
Healthwatch Nottinghamshire is a well-run and sustainable organisation which continues beyond the life of its current contract	Staff and volunteers value being part of Healthwatch Nottinghamshire We have a sustainability plan in place which takes the organisation beyond March 2016			
Outcome	**What we will do**	**When will we do it by**	**How we will know if we've been successful**	**How we will show it**
People from all communities are able to be involved in Healthwatch Nottinghamshire, including a range of volunteering roles	Undertake an Equalities Impact Assessment of Healthwatch Nottinghamshire and develop an action plan	30.9.14	The EIA has been completed and the actions have been carried out	EIA action plan
	Continue to promote volunteering opportunities and encourage applications from people from all communities	31.3.16	Increased number of volunteers Increased number of volunteers from across the communities of Nottinghamshire	Volunteer records

	Review the work of the Advisory Group and make any changes to the membership and terms of reference as needed	31.12.14	The review has been carried out and any changes have been made	Review report
	Select and introduce additional Board members to broaden the skills and contribution of the Board	31.12.15	At least 2 new Board members have been selected in 2014 Board members retire by rotation and future Board members are selected in 2015	Volunteer records
Staff and volunteers are in the right roles across the organisation	Recruit associates to assist with additional work as needed	31.3.15	Associates are recruited	Staff records
	Undertake a review of the staff and volunteer structure in the light of changes to the work and available resources	30.9.15	Any changes are made as needed	Board papers
A proportion of Healthwatch Nottinghamshire's income comes from commissioned work	Develop a Sustainability Plan for Healthwatch Nottinghamshire	30.9.14	Healthwatch Nottinghamshire has funded work beyond April 2016	Board papers
	Develop our proposal for collection and analysis of patient experience data for discussion with commissioners	30.9.14	The model is developed and has been presented to commissioners	Board papers

10 Quality Assurance

During the first year of the plan, we will improve how we collect and monitor data about our activities and performance, including improving the computer software we use and purchasing new software when needed.

Nottinghamshire County Council as the commissioners of Healthwatch Nottinghamshire monitor our performance against a range of outputs and against the outcomes identified in this plan. Reports are presented to the Health and Wellbeing Board and the Health and Wellbeing Implementation Group on a regular basis about the progress and performance of the organisation.

People who are in contact with Healthwatch Nottinghamshire will be invited to give feedback about their experience of working with us and an Annual Review is undertaken each year where feedback will requested from all stakeholders to rigorously assess the performance of Healthwatch Nottinghamshire against its aims and objectives.

We produce an Annual Report and publish it with our annual accounts on our website by 30th June each year,

11 Finance and sustainability

The funding for local Healthwatch comes from the Department of Health to the local authority. The current contract with Nottinghamshire County Council for the delivery of Healthwatch is for two years initially, with a possible extension for a further year, subject to funding being available.

In year one, the maximum funding available from the County Council was £480,000, of which £450,000 was allocated to Healthwatch Nottinghamshire. Due to the funding pressures faced by the County Council the level of funding available to Healthwatch Nottinghamshire will be reduced by 30% during 2014-16.

Due to delays in recruiting staff and starting to deliver Healthwatch Nottinghamshire activities, an underspend was generated in the first year of operation, which will help to sustain the existing levels of staff and activity during the life of this plan (subject to continued funding being available in 2015-16). The underspend has also enabled Healthwatch Nottinghamshire to establish its financial reserves at its target of 25% of annual running costs.

As a social enterprise HWN Ltd. will look to develop additional income streams over the next two years. However, the delivery of the contract for Healthwatch services will remain a priority. During the first six months of this plan, we will develop our plan for the future sustainability of the organisation which will include:

- Maintaining the core business of Healthwatch Nottinghamshire
- Identifying additional areas of work that commissioners and providers may be interested in purchasing
- Developing business models for these areas of work
- Researching the demand for this activities
- Looking at the organisational structure that would be needed to support future income generation

12 Risk Assessment

The Board has undertaken a full risk assessment of Healthwatch Nottinghamshire's activities. An assessment of the risks that particularly related to the success of this plan are available on the Healthwatch Nottinghamshire website or from the office.

Nottinghamshire County Council

Report to Health and Wellbeing Board

3 September 2014

Agenda Item: 9

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

COMMUNICATIONS AND ENGAGEMENT ACTIVITY PLAN

Purpose of the Report

1. To update the Board on communications and engagement activity since the approval of the last plan in January 2013 and to propose an updated activity plan for the Health and Wellbeing Board (HWB), the Joint Strategic Needs Assessment (JSNA) and Health and Wellbeing Strategy.

Information and Advice

2. The Health and Wellbeing Board is required to communicate and engage with the population it serves and to consider the views of the population in the development of plans and priorities. All formal consultations are currently coordinated though a central database.

3. Communication and engagement is a fundamental part of the work of the HWB. The Board needs to engage with:
   a. Board member organisations, stakeholders and partners
   b. Service users and general public

4. A Communications and Engagement plan was approved by the Health and Wellbeing Board in January 2013.

5. The plan included activity to review the online information, to develop the stakeholder network and to consult on the draft Health and Wellbeing Strategy. All of these elements of the plan have now been completed including the following:

   Health and Wellbeing Strategy
   - Consultation with the public and stakeholders
   - An HWB workshop to identify priorities for action
   - Three papers have been presented to the HWB on the Health and Wellbeing Strategy and the JSNA (June 2013, November 2013 and March 2014)
   - Ten papers have been presented to the Health and Wellbeing Implementation Group around the JSNA and Health and Wellbeing Strategy
   - Press releases have been issued for relevant Health and Wellbeing Board papers

Review online information

- The JSNA has been published on Nottinghamshire Insight
- Board summaries available on line

Stakeholder network

- Five network events were held attracting over 350 delegates

6. As a result of the activity undertaken since January 2013 there has been media activity within Nottinghamshire including:

   - Twenty two items of media coverage around the Health and Wellbeing Strategy consultation and publication
   - Media coverage of consultations and approval of new strategies including; Mental Health, Avoidable Injuries, obesity services, substance misuse services, Pharmaceutical Needs Assessment
   - The Chair of the Board quoted as a key spokesperson for high profile media campaigns such as Stoptober, Be Clear on Cancer, Mental Health Awareness, Child Safety Week, Change4Life, Breastfeeding Awareness
   - Quotes from the Health and Wellbeing Chair on key topical health issues such as child obesity, tobacco control, electronic cigarettes, substance misuse services, air quality, mental health and infectious diseases.

7. The Stakeholder Network event in June 2014 focussed on the relationship between the HWB and the voluntary and community sector. One of the issues raised at this event was the importance of regular and accessible communications between the Board and stakeholders.

8. As a result of this a summary of the HWB has been developed and is now circulated to partners (attached as Appendix 1). Work is continuing to improve the range and frequency of communication available and will focus on developing a virtual network, utilising the Health and Wellbeing Board internet pages as a hub for communication wherever possible, including the opportunity for partners to contribute and to signpost to wider public health messages where appropriate.

9. The activity plan attached to this report as Appendix 2 is an update on the plan agreed in January 2013 and builds on work done at that point and subsequently to identify key stakeholders, communications channels and proposed communications activity.

10. There is some resource within Nottinghamshire County Council's communications and marketing team for communications activity and co-ordination with partners, and within Public Health for engagement work, although both resources are limited.

11. The HWB has both a strategic leadership role and a responsibility to promote joint working to improve outcomes. Since the Board is a partnership organisation, it is recognised that individual organisations represented on the Board will have their own communications needs and objectives. However, the Board's role means there is also a need for some umbrella communications, and coordination of messages.

12. A coordinated approach across the County Council and HWB partners would ensure that communication, consultation and engagement work was focussed to support the overall

priorities of the HWB. In this way, duplication could be avoided and the public perception of the Board improved through a joint approach across health and social care. There may also be opportunities for potential synergy from such an integrated approach.

13. The draft Communication and Engagement Activity Plan (attached as Appendix 2).

14. The plan recommends:

- Continuing to establish the key credentials of the Health and Wellbeing board in terms of strategic leadership, and in joint working to improve health outcomes and reduce health inequalities in Nottinghamshire.
- Building on existing engagement work with the Health and Wellbeing Stakeholder Network to keep the network connected with the work of the Board and to improve opportunities for partners to contribute.
- Developing more frequent communication with stakeholder and partner organisations by targeting their existing internal communications channels with information about the board and regular news updates. Utilising Nottinghamshire County Council internal communications channels to inform colleagues about news and developments from the HWB.
- Ongoing media relations out of HWB meetings, and within day to day media activity in areas covered by the Board's remit. Encouraging partners to increasingly reference the HWB and Strategy within their own media relations.
- Utilising digital and social media owned channels to further communicate news and messages as and when appropriate to those audiences.

Other Options Considered

15. None

Reasons for Recommendations

16. The HWB has a duty to consult engage and communicate with stakeholders and the local population in developing priorities and services.

17. Stakeholders and the general public have a right to know what decisions the board is taking, how it is progressing on delivery of the Strategy, and how they can engage with it.

Statutory and Policy Implications

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

RECOMMENDATION/S

1. That the Board accepts the Communication and Engagement Activity Plan proposed as Appendix 2.

2. That work be undertaken to coordinate communications and engagement activity across the County Council and with key partners under this overarching plan.

Anthony May
Corporate Director For Children, Families And Cultural Services

For any enquiries about this report please contact:
Nicola Lane, Public Health Manager

Constitutional Comments (SLB 15/08/2014)

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

Financial Comments (NS 14/08/14)

20. There are no specific financial implications arising from this report.

Background Papers

Paper to the Health and Wellbeing Board January 2013 – Communications and Engagement Activity Plan

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

Electoral Division(s) and Member(s) Affected

All

Health & Wellbeing Board Summary – 2 July 2014

Membership

Councillor Joyce Bosnjak opened the meeting & confirmed that the Council had reappointed her as Chair of the Board. Dr Steve Kell was reappointed as Vice Chair.
Click here for full membership

CCG 5 year plans

There are three planning areas in the County – Bassetlaw, Mid Notts & South Notts. Each presented their 5 year plans, which had been submitted to NHS England. Each plan is supported by a more detailed 2 year operating plan.

The plans showed that CCGs were now well established & had identified what they need to do to address issues within their areas. They were now in a position to commission those services. All the plans identified urgent care as a priority – providing the right care, at the right time, in the right place including integrating GPs into A&E departments.

Proactive care for long term conditions and elective care were also priorities by Mid & South Notts. Improving elective care would involve looking at referrals to outpatient departments to make sure that people are referred to the right person & that care is integrated to make sure that patients don't have to go back to hospital for other tests or to see other departments.

The Plan for Mid Notts also prioritised women and children, recognising that maternity and early years care was fundamental to a good start in life.

The Plan for NHS Bassetlaw CCG included care of elderly people in the community, ensuring consistency of care in care homes, mental health services & supporting people after illness.

This meeting at a glance:

CCG 5 year plans – plans to improve services in primary care, the community & hospitals.

Better Care Fund – changes to the national process & fast tracking Nottinghamshire's bid

Local nature partnership – linking the natural environment to health & wellbeing

Air quality – how it affects health & how it's monitored

Health & Wellbeing Strategy Delivery Plan – to be internet based & published in September

HWIG update – progress by the Group on the JSNA, delivering the Health & Wellbeing Strategy & engagement between the Board & partners.

Workforce development was key to the success of all of the plans, as was working with the hospital trusts. Within Nottinghamshire & Derbyshire the CCGs were working with NHS England to look at commissioning primary care & this also supported the implementation of the 3 Nottinghamshire plans. NHS England had also secured funding from the Prime Ministers Challenge Fund to pilot some of the changes more quickly.

Better Care Fund

The government have introduced the £3.8bn Better Care Fund to transform services & make sure that health and social care work more closely together.

There had been a change in the national process for approval of local plans. The Nottinghamshire Plan was one of 14 to be fast tracked through the process though. The deadline for resubmission

was 9 July 2013 – an extremely tight timescale. The Plan needed extra detail on the impact it would have on the Joint Strategic Needs Assessment (JSNA), Health & Wellbeing Strategy and the implementation of the Care Act as well as sign off by the local hospital trusts.

Local Nature Partnership

Councillor Martin Suthers & Helen Ross, Public Health Manager gave an overview of the work of the Lowland Derbyshire & Nottinghamshire Local Nature Partnership. The Partnership had representatives from business, local government, health and the voluntary sector and aimed to make sure that natural environment was part of all decision making locally.

The presentation highlighted the role of the environment in maintaining & developing health & wellbeing.

The Partnership welcomed support from the Board & were reviewing how the Partnership could support the Health & Wellbeing Strategy.

Air quality

Jonathan Gribbin, Consultant in Public Health & David Banks, Executive Manager – Neighbourhoods at Rushcliffe Borough Council gave a presentation on air quality in Nottinghamshire. While air quality had improved there were still issues around pollution, the most serious issue was the smallest particles in the air which weren't visible as smog would have been in the past. They were mostly related to transport so all Board members were asked to go back to their organisations to raise the issue and review workplace travel plans.

Impact of air quality on people in Nottinghamshire
Health & Wellbeing Board, July 2014

All of the district council representatives agreed to raise the issue within their councils.

Health & Wellbeing Strategy – Delivery Plan

Cathy Quinn, Associate Director of Public Health presented the ideas for the Delivery Plan which would support the Health & Wellbeing Strategy.

The Delivery Plan would be internet based & would be accessible to everyone. It would give an overview of the ambitions & priorities in the Strategy & access to more detailed plans & actions. Case studies from people who had been affected by the work to deliver each priority would also be included wherever possible to show 'what the Strategy means to me'

The Plan will be available on line in September 2014.

HWIG progress report

Anthony May, Director of Children Families & Cultural Services presented the report which gave an overview of the work of the Health & Wellbeing Implementation Group (HWIG). The Group was made up of representatives from health, local government, the police, fire & rescue and the probation service and is responsible for making sure that the work of the Board is done. The report gave an update on progress made on the JSNA, the delivery of the priorities in the Health & Wellbeing Strategy & improving links between the Board & other partners.

Chairs Report

Click here to see the Chairs report including Health & Wellbeing Board Peer Challenge, visits to CCGs & the Care & Support Act consultation.

Nottinghamshire County Council

APPENDIX 2

Nottinghamshire Health & Wellbeing Board

Communications & Engagement Activity Plan, September 2014

Aims:

- Continue to raise awareness of the Health and Wellbeing Board, it's responsibilities, function, decisions and progress amongst:
    A. Board members, key partners and stakeholders
    B. General public (n.b. public are more interested in issues, services and real life case studies than functions of Boards)
- Promote the Health and Wellbeing Strategy for Nottinghamshire 2014-17, and the JSNA
- Engage with stakeholders to increase real and perceived involvement with the H&WB

Activity	Cost? Y/N	Who	Audience	When
Engagement				
Stakeholder Network events (x3 p/a)	Y	PH	Stakeholders / partners	X3 pa
Reformatted H&WB meeting summaries issued to Network members following each meeting, extend distribution to other stakeholder organisations	N	PH	Stakeholders / partners	Bi-monthly following meetings
Stakeholder comms				
Re-vamped meeting summaries distributed to wider stakeholder network	N	PH	Stakeholders / partners	Bi-monthly following meetings
Develop graphical 'one-pager' detailing the H&WB structure, functions and members, issued via stakeholder comms channels, on the H&WB web page and internally in within NCC	Y (design time)	Graphics	Stakeholders / partners / public	Sept '14
Regularly disseminate information to partners for use in their owned internal comms channels (intranets, newsletters etc), e.g., • H&WB 'one pager' • Strategy	N	PH Digital Comms	Stakeholders / partners	From Sept '14

• Delivery plan launch • Peer challenge				
Utilise links with Integrated Commissioning Groups to highlight good news / successes related to H&W strategy and priorities	N	PH Comms	Stakeholders / partners	From Sept '14
Media relations				
Target an average of one press release per H&WB meeting (n.b dependent on content of papers), for example from the forward programme: September - Encompass pilots October - Health Inequalities / Child & Adolescent Mental Health report December - Excess Winter deaths / breastfeeding *If services can provide real life case studies to accompany press releases will increase the amount of and quality of coverage* *Other partner organisations with ownership of Board reports may want to produce own press releases, although would be requested to reference H&WB and quote the chair*	N	Comms	Public / Stakeholders / partners	From Sep '14
H&WB chair quoted and credited in that role with press releases on eg public health press releases, proactive opportunities etc	N	Comms	Public / Stakeholders / partners	Ongoing
Request partners approach us for comment in press releases related to health / social care to include comment from Chair	N	Comms	Public / Stakeholders / partners	From Sept '14
Explore links with Healthwatch Notts for opportunities for joint comms activity / comment. Signpost public to Healthwatch as the independent organisation to have their say on health and social care	N	Comms	Public / Stakeholders / partners	From Sept '14
Leverage larger news stories to deliver coverage on leadership of H&WB, e.g. Better Care Fund	N	Comms	Public / Stakeholders / partners	Ad hoc
Digital				
Graphical 'one-pager' on website	Y (design time)	Graphics Digital	Public / Stakeholders / partners	By Sept '14
Delivery plan directory online	N	Digital	Public / Stakeholders / partners	July '14

Ad hoc social media appropriate to the H&WB (and of interest to the audience)	N	Digital	Public / Stakeholders / partners	Ongoing
Key Board news items included in monthly Health and Wellbeing 'email me' newsletters	N	Digital	Public / Stakeholders / partners	Ongoing
Internal comms				
Utilise internal comms routes for informing colleagues of key news, events and developments, e.g., • Intranet • Team Talk • Chief Exec bulletin • Frontline	N	Comms Digital PH	NCC colleagues	Ongoing
Marketing				
Banners x 2 to promote H&WB and the H&W Strategy at key stakeholder events	Y (design & print)	Graphics	Public / Stakeholders / partners	Sept '14
Evaluation				
Survey Monkey evaluation with key stakeholders and partners to ascertain perceived level of engagement and communication from the Health and Wellbeing Board. Repeated after one year to demonstrate effectiveness of activity	N	Comms Digital	Public / Stakeholders	Sept '14 Sept '15

Nottinghamshire County Council

Report to Health and Wellbeing Board

3 September 2014

Agenda Item: 10

REPORT OF THE DIRECTOR OF PUBLIC HEALTH

NO HEALTH WITHOUT MENTAL HEALTH: NOTTINGHAMSHIRE'S MENTAL HEALTH STRATEGY AND SUICIDE PREVENTION STRATEGY (DRAFT) 2014/17

Purpose of the Report

1. The Health and Wellbeing Board (HWB) is requested to approve and sign off the final version of the 'No Health without Mental Health, Nottinghamshire's Mental Health Strategy 2014/17' (Full strategy and summary attached as Appendix 1)
2. HWB to note the 10 September 2014 start of the consultation period on the local draft 'Nottinghamshire and Nottingham City Suicide Prevention Strategy - 2014/17' (Appendix 2).

Information and Advice

3. Mental health is a key partnership issue for Nottinghamshire, and the stakeholder consultation has demonstrated widespread support for a mental health strategy. This strategy provides an opportunity to bring together actions to address mental health and wellbeing across all ages in Nottinghamshire.

4. Improving mental health is associated with significant positive impacts for individuals, their families and wider society including better physical health, improved academic achievement, reduced sickness absence, enhanced productivity and reduced costs to welfare, health and social care services and reduce the incidents of self-harm and suicide deaths. This can only be achieved by preventing mental health problems, building mental resilience and ensuring good quality, personalised treatment and care which is vital for people with mental health problems.

5. In order to see significant improvements in mental health and emotional wellbeing, the profile of mental health needs to be raised further and to be embedded across all health and social care activity. Understanding of the causes and impacts of poor mental health needs to be realised across communities and within partner organisations. The HWB is fundamental in providing leadership and championing the mental health agenda in order to drive these improvements.

6. At the HWB Adult Mental Health workshop on 2 April 2014, the HWB cited the Nottinghamshire Mental Health strategy and were given the opportunity to comment on the strategy and the five strategic priorities. Since that event Nottinghamshire County

Council (NCC) has committed to prioritising mental health by signing up to the Mental Health Challenge and a consultation on the strategy has been undertaken.

7. In developing the No Health without Mental Health Nottinghamshire's Mental Health strategy and the draft Nottinghamshire and Nottingham City Suicide Prevention strategy, consideration has been given to the relevant national and local strategies (see sections 7 & 8 of this report).

8. The draft 'Nottinghamshire and Nottingham City Suicide Prevention Strategy - 2014/17' has been developed by a range of health, social care, police and emergency services and third sector partners. This strategy covers both Nottinghamshire and Nottingham City. However, this report focuses predominantly on the issues affecting Nottinghamshire.

Background

9. In England, at least one in four people will encounter mental health problems* at some stage of life[1] and approximately one person dies every two hours as a result of suicide[2]. The causes and influences on mental health problems are wide ranging and interacting. Often they are a result of adverse life events, but interacting circumstances such as poverty, level of education, employment and social networks as well as individual biological, lifestyle and psychological factors have a significant impact on resilience to these challenges. Many of these wider determinants of poor mental health are higher in the deprived areas of Nottinghamshire than in England as a whole.

10. Mental health problems often arise in childhood and cause more disability than any other chronic illness. They cost England around £105 billion each year and consume around 13% of NHS spending.

11. Preventing mental health problems will impact on reducing the self-harm and suicide death rate in Nottinghamshire. Therefore, the Suicide Prevention Strategy will contribute to the overall Mental Health and Health and Wellbeing strategies

Outcomes of the Nottinghamshire Mental Health strategy consultation

12. A wide range of stakeholders' views were gathered in the development phase of the draft mental health strategy. A public and partner consultation was undertaken to form the development of the local No Health without Mental Health Nottinghamshire's Mental Health strategy. NCC used a variety of communication channels to publicise the strategy during consultation including:

    - a link to a web based survey, with named contact to obtain paper version where required
    - named contact for responses with email, telephone number and address available to enable people to use other formats to the web based survey

* The phrase 'mental health problem' mirrors the terminology used in the National Strategy 'No Health Without Mental Health', and is used as an umbrella term to describe the full range of diagnosable mental illnesses and disorders, including personality disorder.
[1] HM Government. No health without mental health: A cross government outcomes strategy for people of all ages, 2011
[2] HM Government. September 2012. Preventing suicide in England. A cross-government outcomes strategy to save lives.

- hard copies of the strategy and survey were available in all libraries across Nottinghamshire
- the consultation was advertised in all GP practices across Nottinghamshire
- email communication to relevant heads of service across health and social care services and the voluntary sector with request to cascade to relevant partners and staff
- cascades through organisations and individuals with links to relevant communities of interest and third sector and community groups
- presentations at relevant forums such as the Clinical Commissioning Groups (CCG) Mental Health groups (where mental health and service user representatives attend), HWB, CCG Mental Health commissioning groups and Mental Health Integrated Children's Adults and Older People Commissioning groups.
- engagement through the Nottinghamshire NHS Healthcare Trust Involvement Centre for service users
- internal communications within NCC, CCG and Nottinghamshire NHS Healthcare Trust
- press release and promotion via social media
- discussion at various health and social meetings and events.

13. The consultation demonstrated a high level of support for improving mental health across Nottinghamshire and the need to produce a strategy that covered the mental health across all ages. Specific needs were identified as:

    - promoting mental resilience early in life
    - promoting mental wellbeing in the workplace
    - improving physical activity to build mental resilience
    - raising awareness of mental health symptoms and reduce stigma
    - capitalising on inter-agency working to improve access and pathways of care particularly in relation to early identification of mental health problems and those experiencing a mental health crisis
    - accessing longer term therapies for people experiencing trauma related stress and anxiety
    - ensuring a good level of social care support and settled accommodation for people with mental health problems.

14. To prevent carers from developing mental health problems, it was identified as a need that increased level of support is required for young carers when their parents have a mental health problem and carers of all ages for those with a long term physical condition. Also, to enable recovery from mental health problems, it was recommended that a holistic approach was required which would address the physical and mental health and wellbeing and social needs of people.

15. Following the consultation, the main change required within the strategy was the wording of priority 4 from ensuring *'adequate'* support to ensuring *'effective'* support as a number of respondents identified that *'adequate'* support was not based on NICE guidance.

16. The five priorities in this strategy have clear, ambitious aims to improve Nottinghamshire residents' mental health and wellbeing:

- Promoting mental resilience and preventing mental health problems
- Identifying problems early and supporting effective interventions
- Improving outcomes through effective treatment and relapse prevention
- Ensuring effective support for those with mental health problems
- Improving the wellbeing and physical health of those with mental health problems

17. For each objective, a number of key areas for action will be developed through a review of the evidence base and highlighted by stakeholders.

Proposed Nottinghamshire Suicide Prevention strategic priorities for consultation:

18. A wide range of stakeholder views was gathered in the development phase of the draft suicide prevention strategy and has identified priorities that will have an impact on reducing self-harm incidents and suicide deaths in Nottinghamshire.

19. The proposed self-harm and suicide prevention strategic priorities to be consulted on are:
    - Identify early those groups at high risk of suicide and self-harm and support effective interventions
    - Review of timely suicide and self-harm data in order to better understand the local needs
    - Access effective support for those bereaved or affected by suicide
    - Engage with media personnel to agree on sensitive approaches to reporting suicide and suicidal behaviour
    - Improve the understanding and care for people at risk of suicide and self-harm through training of frontline staff to deal with those at risk of suicide and self-harm behaviour.

20. It is envisaged that the consultation will be launched in September 2014 in line with the World Health Organisation (WHO) Suicide Prevention Awareness Day.

Governance

21. The strategies are owned by the Nottinghamshire HWB and steered by the Public Health Mental Health lead. Implementation and progress of this strategy will be monitored by the Nottinghamshire Health and Wellbeing Implementation Group (HWIG). The HWIG will be responsible for reporting the strategy progress to the HWB.

22. The Nottinghamshire CAMHS, Adult and Older People's Mental Health Strategy Integrated Commissioning Groups (ICGs) which comprises key stakeholders will be responsible for driving the key actions of these strategies forward and reporting quarterly the progress to the HWIG.

23. The overarching leadership for each of the proposed mental health and suicide prevention priorities will be developed and consist of the most appropriate mental health leaders and champions.

Next steps

24. In partnership with the ICGs a comprehensive No Health without Mental Health Nottinghamshire's Mental Health strategy 2014/15 action/delivery plan will be developed.

25. Local Mental Health working groups will be set up to achieve each of the proposed five mental health strategic priorities.

26. Public Health will undertake a public consultation in September 2014 on the draft 'Nottinghamshire and Nottingham City Suicide Prevention Strategy - 2014/17', to ensure this strategy is aligned where applicable to public opinions and their perceptions of need.

27. Following the consultation, the Nottinghamshire and Nottingham City Suicide Prevention Steering group will develop a detailed suicide prevention action/delivery plan.

Financial Implications

28. There are no immediate additional financial implications resulting from adoption of the No Health without Mental Health Nottinghamshire's strategy – 2014/17. The focus is initially on optimising ways of working across organisations in order to produce the desired outcomes.

29. The proposed cost for undertaking a consultation on the draft Nottinghamshire Suicide Prevention Strategy 201/17 is approximately £500.

Equality Impact Assessment

30. A full summary of the Mental Health strategy consultation results with regard to equality impact is also given in the associated Equality Impact Assessment and is attached to this report. (refer to Appendix 3)

31. A full Equality Impact Assessment of Suicide Prevention strategy will be undertaken in accordance with the NCC Equality and Diversity Policies following the consultation.

RECOMMENDATION/S

1) To endorse the final No Health Without Mental Health – Nottinghamshire's Mental Health Strategy – 2014/17
2) To support the proposed public consultation on the draft Nottinghamshire Suicide Prevention Strategy 2014/17
3) To endorse the next steps in the development of these strategies

Chris Kenny
Director of Public Health

For any enquiries about this report please contact:

Susan March – Senior Public Health Manager
Susan.march@nottscc.gov.uk

Constitutional Comments (SB 14/08/14))

32. HWB is the appropriate body to review the strategy and recommend it for adoption by Policy Committee

Financial Comments (NS 13/08/14)

33. The financial implications are outlined in paragraphs 28 and 29 of this report.

Background Papers and Published Documents

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

- No health without mental health: A Cross-Government Mental Health Outcomes
- Strategy for People of All Ages, DH 2011
- HM Government. September 2012. Preventing suicide in England. A cross government outcomes strategy to save lives.
- Department of Health. December 2013. No health without Mental Health. Mental Health Dashboard
- Health and Social Care Act (2012)
- Public Health, NHS and Adult Social Care Outcomes Frameworks
- Care Act (2014)
- Nottinghamshire Joint Strategic Needs Assessment (JSNA)
- Nottinghamshire Health and Wellbeing Strategy 2014/16
- Nottinghamshire Dementia Strategy 2013
- Nottinghamshire Children and Young People Mental Health and Emotional
- Wellbeing Strategy 2014-16
- The Mental Health and Emotional Well-being of Children and Young People in Nottinghamshire – Health Needs Assessment 2013
- Nottinghamshire Workplace Health strategy 2014-2017 (draft**)**

Appendix 1:

NO HEALTH WITHOUT MENTAL HEALTH NOTTINGHAMSHIRE'S MENTAL HEALTH STRATEGY 2014-2017 - FINAL

EXECUTIVE SUMMARY:

The ***No Health without Mental Health, Nottinghamshire's Mental Health Strategy, 2014-2017***, demonstrates Nottinghamshire County ambition to improve the mental health and wellbeing of its residents of all ages.*

Mental health is defined by the World Health Organisation as a *"state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community."*[i] Mental health is fundamental to our physical health, our relationships, our education and our work. There is no health without mental health.

Mental health problems** impact on individuals, families, communities and society as a whole, with immense associated social and financial costs and they contribute to perpetuating cycles of inequality through generations. Mental illness is an important cause of social inequality as well as a consequence. Mental health problems contribute a higher percentage of total disability adjusted life years in the UK than any other chronic illness[ii]. Recent estimates put the full cost of mental health problems in England at £105.2 billion[iii], and mental illness accounts for about 13% of total National Health Service (NHS) spend[iv].

The causes and influences of mental health problems are wide ranging and interacting. Often they occur because of adverse events in our lives, and other circumstances, such as poverty, unemployment, levels of supportive networks, levels of education and the broader social environment interact and affect how resilient we are in coping with these challenges.

Good quality personalised treatment and care is vital for people of all ages with mental health problems and achieving equal status for mental and physical healthcare is a key national driver. However, it has been estimated that even if all those with mental illness were given the best available treatment, the total burden of disability across the population would still be considerable[v], demonstrating the importance of wider supportive networks in enabling people to live full and meaningful lives. Since mental illness is under diagnosed, and treatment is only part of an effective response, this

* This strategy takes a life course approach which recognises that mental health problems often start in childhood, and that opportunities to promote and protect good mental health arise from pre conception through to old age. Aligned to this strategy is the **Nottinghamshire Children and Young People Mental Health and Emotional Wellbeing Strategy 2014-16** which promotes mental health and wellbeing prevention and effective interventions in children and young people. Dementia is covered in the **Nottinghamshire Dementia Strategy – 2013.**

** 'Mental health problems' is an umbrella term used to describe the full range of diagnosable mental illnesses and disorders, including personality disorder.

highlights the need to address the wider risk factors for poor mental health and increase the protective factors.

As well, as enhancing these protective factors for mental health, there is a good evidence base for a number of interventions that improve mental wellbeing[vi]. Improving mental health and wellbeing is associated with significant impacts for individuals and society, including better physical health, longer life expectancy, reduced inequalities, healthier lifestyles, improved academic achievement, enhanced community participation, reduced sickness absence and improved productivity as well as reduced costs from welfare, health and social care[vii].

Mental health problems are very common- at least one in four people will experience mental distress[viii]. Mental health and physical health are interlinked, with people with mental illness experiencing higher rates of physical illness and lower life expectancy, and people with chronic physical health problems often experiencing mental health problems. Due to the continuing stigma that exist many individuals are reluctant to talk about any mental health problems they may have experienced. It is therefore easy to underestimate how widespread these issues are.

In Nottinghamshire, using national estimates, there are around 10,215 children and young people between the ages of 5 to 16 years that have 'any mental health disorder' and approximately 146,468 adults aged between 16 to 74 years experiencing common mental disorders (CMD) such as depression and anxiety, and over 3,000 adults with a severe mental illness (SMI). However, in deprived districts such as Bassetlaw, Mansfield and Ashfield where there are higher levels of risk factors for poor mental health contribute to higher levels of mental health problems.

In developing this strategy, as well as considering the objectives outlined in the national mental health strategy, No Health without Mental Health (2011)[ix] and the Nottinghamshire Joint Strategic Needs Assessment (JSNA)[x] for mental health, a wide range of stakeholders' views have been gathered in order to identify gaps in current services and what our key priorities in Nottinghamshire should be for improving mental health and wellbeing.

A wide range of stakeholders views were gathered in the development phase of the draft mental health strategy. A public and partner consultation was undertaken to form the development of the local No Health without Mental Health Nottinghamshire's Mental Health strategy which demonstrated a high level of support for improving mental health across Nottinghamshire and the need to produce a strategy that covered the mental health across all ages. Specific needs were identified as:

- Promoting mental resilience early in life
- Raise awareness of mental health symptoms and reduce stigma
- Capitalise on inter-agency working to improve pathways of care particularly in relation to early identification of mental health problems and those experiencing a mental health crisis
- Ensure that a good level of social care support and settle accommodation for people with mental health problems

To prevent carers from developing mental health problems it was identified as a need that increased level of support is required for young carers when their parents have a mental health problem and carers of all ages for those with a long term physical condition. Also, to enable recovery from mental health problems it was recommended that a holistic approach was required which would address the physical, mental health and wellbeing and social needs of people.

The five priorities in this strategy have clear, ambitious aims to improve Nottinghamshire residents' mental health and wellbeing:

(1) Promoting mental resilience and preventing mental health problems
(2) Identifying problems early and supporting effective interventions
(3) Improving outcomes through effective treatment and relapse prevention
(4) Ensuring effective support for those with mental health problems
(5) Improving the wellbeing and physical health of those with mental health problems

For each objective, a number of key areas for action will be developed through a review of the evidence base and highlighted by stakeholders.

Appendix 2:

NOTTINGHAMSHIRE AND NOTTINGHAM CITY SUICIDE PREVENTION STRATEGY 2014-2017 - DRAFT

EXECUTIVE SUMMARY:

In England, approximately one person dies every two hours as a result of suicide[xi]. Suicide is a major issue for society and a serious but preventable public health problem. Suicide can have lasting harmful impact- economically, psychologically and spiritually on individuals, families, and communities. While its causes are complex and no strategy can be expected to completely remove the tragedy of suicide, there is much that can be done to ensure that we reduce the likelihood of suicide and to ensure support is available for those at their most vulnerable.

There has been a slight increase in the Nottinghamshire and Nottingham City average rate of death by suicide or injury of undetermined intention. For the period 2008-10 Nottinghamshire rate of 6.9 per 100,000 population increased to 9.7 per 100,000 population in 2010-12, whilst the rate for Nottingham City for the same period was 7.8 per 100,000 population increasing slightly to 8.8 per 100,000 population, which is below the England average of 10.2 per 100,000 population.

Nationally more men die of suicide than women, the ratio of male to female suicide deaths is 3:1. For Nottinghamshire and Nottingham City the gender split in the suicide rate is in line with national suicide rates with men accounting for around three quarters of suicides.

There is a socio-economic gradient in suicide risk. Those in the poorest socio-economic group are 10 times more at risk of suicide than those in the most affluent group living in the most affluent areas. Nottinghamshire has a similar pattern, although due to small numbers we need to be cautious in interpretation of our local data. In Nottinghamshire and Nottingham City, for the period 2008-10 the highest rate of suicide occurred in the 35-64 age group, which is similar to the picture nationally. However, Nottinghamshire has a higher than the national rate in those aged 75 or over. These differences are not statistically significant due to the small numbers.

Suicide prevention goes hand in hand with addressing self- harm. People who self-harm are at increased risk of suicide. UK studies have estimated that in the year after an act of deliberate self-harm the risk of suicide is 30–50 times higher than in the general population. Non-fatal self-harm leading to hospital attendance is the strongest risk factor for completed suicide[xii]. Self-harm is one of the top five causes of acute medical admission and those who self-harm have a 1 in 6 chance of repeat attendance at A&E within the year[xiii].

For the period 2010-13, the Nottinghamshire rate of hospital admissions caused by unintentional and deliberate injuries in children (aged 0 -14years) was 85.2 per 100,000

population and for Nottingham City the rate was 86.4 per 100,000 population. For the age range of 15-24, the Nottinghamshire rate was 120.4 per 100,000 per population and for Nottingham City the rate was 94.7 per 100,000 population. Both rates are better than the national averages of 103.8 per 100,000 and 130.7 per 100,000 population, respectively.

This strategy outlines the ways in which Nottinghamshire County and Nottingham City Public Health and local partners aim to work towards a reduction in suicides and self-harm amongst the population of Nottinghamshire and Nottingham City in line with the national suicide prevention strategy for England (2012)[xi] and the national mental health strategy – No health without mental health (2011)[ix].

Overall proposed aims of this strategy:

- ***To reduce the rate of suicide and self-harm in the Nottinghamshire and Nottingham City population***

The following proposed priorities have been identified as the local key areas for action in Nottinghamshire and Nottingham City:

Proposed priority 1: ***Identify early those groups at high risk of suicide and self-harm groups*** and support effective interventions

Proposed priority 2: Review of ***timely suicide and self-harm data*** in order to better understand the local needs

Proposed priority 3: Access effective support for those ***bereaved or affected by suicide***

Proposed priority 4: ***Engage with media personnel*** to agree on sensitive approaches to reporting suicide and suicidal behaviour

Proposed priority 5: Improve the understanding and care for people at risk of suicide and self-harm through ***training of frontline staff*** to deal with at risk of suicide and self-harm behaviour

This strategy is aligned and supports the delivery of a number of other local strategies, including:

- No health without mental health, Nottinghamshire's Mental Health strategy (draft) 2014-17
- Nottingham City Wellness in Mind – Mental Health Strategy for Nottingham (draft) 2014-2017
- Nottinghamshire Children and Young People (CYP) Mental Health and Emotional Wellbeing Strategy 2014-16.
- Nottingham City Children's and Young Peoples plan 2010-14

All of the above strategies place an emphasis on prevention, early identification and intervention to ensure that people of all ages have the opportunity to enjoy good mental health and wellbeing.

Prevention of suicide calls for working across sectors at local and national level. There is need to tackle all the factors which may increase the risk of suicide and self-harm in the communities where they occur if our efforts are to be effective. Suicide prevention is most effective when it is addressed across the life course and when combined with wider prevention strategies that address improving the mental health and wellbeing of the population and the wider determinants that impact on health, such as: employment, low income and housing.

Appendix 3: EQUALITY IMPACT ASSESSMENT (EIA) FORM

Name of strategy, policy or plan:
No Health without Mental Health Nottinghamshire's Mental Health Strategy – 2014-2017

One in four people will encounter mental health problems[3] at some stage of life. Mental health is a key priority for Nottingham City because there is evidence to suggest that people living in Nottingham City have lower levels of good mental health and wellbeing compared to the national level.

Mental health has been recognised as a key issue for Nottinghamshire and this strategy has been developed in partnership - by the Children's, Adults and Older People Integrated Commissioning Groups, Nottinghamshire Clinical Commissioning Groups Nottinghamshire Healthcare NHS Trust, and Nottinghamshire County Council, in addition to other partners represented at the Health and Wellbeing Board. Mental health has already been identified as a priority in the Nottinghamshire Health and Wellbeing Strategy 2014/17.

The national strategy for mental health published in February 2011, was entitled 'No Health Without Mental Health' in recognition of the fact that mental health and physical are inseparable. It also gave weight to the campaign for mental health to be given equal status to physical health, both by health professionals and by society as a whole. We wish to ensure that this is fully implemented in Nottinghamshire, by bringing together efforts to improve mental health and wellbeing across the whole of the county.

A new county wide strategy entitled No Health without Mental Health Nottinghamshire's Mental Health Strategy 2014/17 has been developed to co-ordinate this work. The strategy aims to:

- ensure improvements in mental wellbeing for the whole population
- result in fewer people suffering from mental health problems
- result in fewer people suffering disability due to mental health conditions
- ensure that those with mental health problems and their carers feel supported to live with their condition
- enable communities to take their own actions to foster positive mental health and mental wellbeing.
- reduce the stigma associated with mental health problems, and ensure equality with physical health

Name of person leading the EIA:	Susan March

[3] The phrase 'mental health problem' mirrors the terminology used in the National Strategy 'No Health Without Mental Health', and is used as an umbrella term to describe the full range of diagnosable mental illnesses and disorders, including personality disorder.

Name(s) of other person(s) involved:	Barbara Brady

Authors initial assessment of adverse impact on minority groups:	High ☐ Medium √☐ Low ☐

Date EIA completed:	29th of July 2014

Are there any connected plans that have already had an EIA undertaken?	Yes ☐ No √☐ If yes, please state:

Who has been consulted in the completion of the EIA? (Please give individual or group names as appropriate.)

Include a summary of any comments they have made. (Please state if they didn't comment.)

Information used to analyse the effects on equality

The Joint Strategic Needs Assessment for Nottinghamshire has been used as a source of information for considering equity in relation to the strategy.

The strategy has been consulted on in two stages. During the first phase of its development, key stakeholders have been consulted on its content and structure following early stakeholder workshops to identify its strategic priorities. Once the strategy was in final draft stage, Nottinghamshire County Council undertook a full formal public and partner consultation exercise between the 12th of May and 4th of July 2014

The council used a variety of communication channels to publicise the strategy during consultation including:

- a link to a web based survey, with named contact to obtain paper version where required
- named contact for responses with email, telephone number and address available to enable people to use other formats to the web based survey
- hard copies of the strategy and survey were available in all libraries across Nottinghamshire
- the consultation was advertised in all GP practises across Nottinghamshire
- email communication to relevant heads of service across health and social care services and the voluntary sector with request to cascade to relevant partners and staff
- cascades through organisations and individuals with links to relevant communities of interest and third sector and community groups
- presentations at relevant forums such as the Clinical Commissioning Groups (CCG) Mental Health groups (where mental health and services users representative attend), Health and Wellbeing Board, CCG Mental Health commissioning groups and Mental Health Integrated Children's Adults and Older People Commissioning

groups.

- engagement through the Nottinghamshire NHS Healthcare Trust Involvement Centre for service users
- internal communications within Nottinghamshire County Council, CCG and Nottinghamshire NHS Healthcare Trust
- press release and promotion via social media
- discussion at various health and social meetings and events

Most respondents, rated between 90 to 95% to strongly agree and/or to agree that each of the 5 priorities was needed.

Specific needs were identified as:

- Promoting mental resilience early in life
- Promoting mental wellbeing in the workplace
- Improving physical activity to build mental resilience
- Raising awareness of mental health symptoms and reduce stigma
- Capitalising on inter-agency working to improve access and pathways of care particularly in relation to early identification of mental health problems and those experiencing a mental health crisis
- Access to longer term therapies for people experiencing trauma related stress and anxiety
- Ensure that a good level of social care support and settle accommodation for people with mental health problems.

The responses produced the following key headlines:

- To prevent carers from developing mental health problems it was identified as a need that increased level of support is required for young carers when their parents have a mental health problem and carers of all ages for those with a long term physical condition.
- More needs to be done to tackle the causes of mental health problems, such as, unemployment, financial problems and reducing stress levels
- Reduce waiting times to psychological therapies
- Improve access to mental health training for frontline workers
- Improve information on available mental health services
- To enable recovery from mental health problems it was recommended that a holistic approach was required which would address the physical, mental health and wellbeing and social needs of people.

Following the consultation the main change required within the strategy was the wording of priority 4 from ensuring *'adequate'* support to ensuring *'effective'* support as a number of respondents identified that *'adequate'* support was not based on NICE guidance.

Terms of reference
• To cover all equality strands, i.e. age, disability, gender, gender reassignment, race, religion or belief, sexual orientation, other area of social exclusion. • To consider the transparency and methodology of the decision making. • To extrapolate and apply in a meaningful way through action planning, a strategy to consider its impact on the equality strands. • To identify any areas for improvement and development of the services arising out of the EIA in the seven equality areas inclusive of any others. • To develop an appropriate action plan for any identified issues through consultation. • To apply the findings of the EIA in a practical way by sharing the findings with our partners and utilising data as the basis of training in this area.

Equality / Diversity Area	Positive Impact (please select)		Adverse Impact (please select)		Unmet need in relation to equalities (please select)		Evidence
	Yes	No	Yes	No	Yes	No	
Age	√☐	☐	☐	☐	☐	☐	The strategy may have a mix of positive and negative effects of the following groups: Older or younger people • Younger people will benefit from improved adult mental health across the population, • Children and young people have mental health needs that are addressed through the Strategy and the Children and Young People's Strategy, and review of services. However, transition into adult hood and adult services are a potential gap • Older people have specific mental health needs that will be addressed through this strategy Actions: • Strategies to build mental resilience in children and young people • Consider direct and indirect effects of adult mental health on children's wellbeing • Include specific interventions that will impact on children's wellbeing such as positive parenting, and maternity services • Work with children's services to improve transition between young peoples' and adult services • Involve older people's groups in ensuring that specific mental health and wellbeing needs of older people are addressed
Disability	√☐	☐	☐	☐	☐	☐	Disabled people or carers • Disabled people and those with long term conditions are at increased risk of mental health problems • Carers are also at risk of problems with their physical and

							mental health due to the strain of their caring role • Based upon previous audit in 2011[i], despite higher levels of need amongst adults with learning disabilities or sensory impairments, they were found to access services less than the general population. • The Nottingham autism strategy has identified that there is a need for better recording of Autism Spectrum Conditions (ASC) in order to understand the needs of this group and their carers. It is understood that people with ASC experience higher rates of mental health problems. . Actions: • Involve carers in the development and implementation of the action plans • Consider ways in which carers can be screened for signs of mental health problem • Make links with the Autism Strategy to increase identification and appropriate support for people with ASC
Gender / Gender reassignment	√☐	☐	☐	☐	☐	☐	Lesbian, gay or bisexual people • Lesbian, gay and bisexual people have a higher risk of mental health problems Actions: • Work closely with LGBT community of interest groups to ensure services are responsive to their needs
Race	√☐	☐	☐	☐	☐	☐	Ethnicity • Black persons (British and non-British) and various ethnic minority groups are known to have different levels of risk for mental health problems. There may however be problems at times with under or over diagnosis of conditions in some groups. • Expressions of cultural beliefs can sometimes be perceived

							as mental health problems by public and professionals • Cultural responses to mental health problems differ between ethnic groups, often affecting the likelihood of seeking or accepting professional help. • Previous audit[xiv] has shown that Asian/Asian British groups use the services less than would be expected, and that Black/Black British groups had a significantly poorer outcome than White ethnic groups. Actions: • Work closely with BME groups to ensure services are responsive to cultural needs • Further explore the reasons why BME groups access services less • Repeat audit of access to and outcomes from services by ethnic group, either as a discrete audit or as part of service reviews
Religion or belief	√☐	☐	☐	☐	☐	☐	People from different faith groups • Faith is an important part of life for many people belonging to an ethnic minority group and is therefore highly relevant for this reason • Certain faith groups may experience tensions between different faith communities, or at the extreme may be victims of crime based upon their religion which will adversely affect mental health Actions: • Support faith groups in understanding the needs of, and in providing support to people with mental health problems • Support interfaith projects linked with mental health that will help to increase understanding and community cohesion
Sexual orientation	√☐	☐	☐	☐	☐	☐	Sex • Prevalence of certain mental health problems differs by sex • The way that men and women respond to mental health problems differs as a whole

							• Women are at risk of specific mental health problems due to pregnancy and childbirth, other issues may include sexual violence • Transgender people are at higher risk of mental health problems Actions: • Work with providers of services to ensure services meet specific needs based on sex and other protected characteristics
Other area of social exclusion	√☐	☐	☐	☐	☐	☐	Other • Reduction in stigma is linked closely to community cohesion and vice versa • Promotion of mental wellbeing and increasing resilience in communities through community development will have positive impacts for mental health and enhance relationships • Adults with enduring mental health problems are also likely to be defined as vulnerable adults, provision of adequate support is key to enabling them to maximise their own mental wellbeing Actions: • Raise awareness on mental health problems • Work with employers to consider recruiting and/or maintaining people with mental health problems in the workplace • Ensure that services meet needs of vulnerable adults

Conclusions and recommendations (these should include the way in which the assessment has addressed any comments from those who have been consulted).			
Identified Issues	Action required	Lead Officer	Timescale

References: (List any relevant background papers)	
Validation: (state how the strategy will be validated)	The strategy will be endorsed and signed off by the Health and Wellbeing Board, The EIA for the strategy should be reviewed in 6 months, by which time all action plans will be in place. Each of the three action plans should have an EIA completed to ensure that effects on all protected groups are considered, for example in any changes to ways of working as a result of the strategy. Monitoring of the implementation of the action plans, and data on access to services by specific groups will form part of the indicators to be monitored.

When you have completed this EIA, send it to the Business Manager for your division.

Business manager to complete:

Date approved by Service Director:	
Date sent for publication:	

REFEENCES:

[i] World Health Organisation (2005) Mental Health Action plan for Europe: Facing the challenges, building solutions. Copenhagen: WHO

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[v] Andrews G, Issakidis C, Sanderson K, Corry J, Lapsley H. Utilising survey data to inform public policy: comparison of the cost-effectiveness of treatment of ten mental disorders. British Journal of Psychiatry 2004; 184:526-33

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[viii] McManus S, et all. *Adult Psychiatric Morbidity in England, 2007: Results of a household survey.*: NHS Information centre for health and social care. 2009

[ix] Department of Health (2011) *No health without mental health: a cross-government mental health outcomes strategy for people of all ages.* Available online: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213761/dh_124058.pdf

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[xi] HM Government. September 2012. Preventing suicide in England. A cross-government outcomes strategy to save lives.

[xii] Owens D, Horrocks J, House A. Fatal and non-fatal repetition of self-harm. Systematic review. Br J Psychiatry 2002 ; 181: 193– 9.

[xiii] Runeson B, Tidemalm D, Ddahlin M et al. (2010) Method of attempted suicide as predictor of subsequent successful suicide: national long term cohort study. British Medical Journal 341: c3222.

Nottinghamshire County Council

APPENDIX 1

No Health without Mental Health, Nottinghamshire's Mental Health Strategy

2014-2017
(Final – July 2014)

Developed by the Nottinghamshire Mental Health/Learning Disability/Autism and the CAMHS Integrated Commissioning Groups in partnership with the Nottinghamshire Health and Wellbeing Board.

Welcome to the Mental Health Strategy

Foreword:

Welcome to the Nottinghamshire Mental Health Strategy 2014 – 2017. Here we set out our ambition over the next three years to improve the mental health and emotional wellbeing of our Nottinghamshire residents and meet the aims of the national mental health strategy.

We are already rising to the challenge of improving mental health and wellbeing and have achieved some key successes in recent years - but we know we need to go further to achieve our ambitions for Nottinghamshire.

Mental health is ***'everybody's business'***. Change on this scale cannot be delivered by organisations working alone. We are committed to working together with individuals, families, employers, educators, communities and the public, private and voluntary sectors to promote better mental health and to drive transformation.

I am delighted that Nottinghamshire County Council has recently signed up to the Mental Health Challenge Programme. As part of that challenge programme I have taken up the role of Mental Health Champion for the Council. I am proud to undertake this role, one of my new responsibilities is to ensure that the Council considers mental health issues in relation to all its policies and procedures. Developing this strategy is the first step to improving the mental health and well-being of all our residents. I know together we can rise to this challenge successfully.

I would like to take this opportunity to thank all of the organisations that have contributed to this strategy and committed to making it a success. Our partnership approach will help us to drive forward improvement and make a positive impact on the support and services for local people in Nottinghamshire.

Councillor Joyce Bosnjak
Chair of the Nottinghamshire Health and Wellbeing Board

Mental health is something that affects – how we think and feel about ourselves and others, how we cope with difficult situations and how we manage our lives. Good mental health and wellbeing have been shown to result in health, social and economic benefits for individuals, communities and society. The Nottinghamshire Health and Well being Board understands how widespread mental health problems are in Nottinghamshire, from someone experiencing a period of depression due to personal hardship, to an individual living with psychosis.

Good mental health and resilience are fundamental to our physical health, our relationships, our education, our training, and our work to achieving our potential. This is why improving mental health outcomes for local people remains one of our top priorities.

This strategy takes a life course approach. This means we will focus on the needs of children and young people, adults and older people in Nottinghamshire, and particularly those who are more vulnerable to developing mental health and emotional wellbeing problems. To improve mental health we need to take a more proactive approach – by

doing more in building resilience, preventing ill health, intervening early and improving the physical health and promoting recovery for those with mental health problems.

Stigma and discrimination surrounding mental health problems may still exist in our community. This means that for some people, they do not openly talk about their mental health problems. This can leave those people with a mental health problem and their families/carers feeling socially isolated and alone. We need to do more in breaking down these barriers so that people get the right help at the right time and families/carers get the right support.

Our strategy sets out an integrated approach with all our partners to make a real difference to the lives of people in Nottinghamshire with mental health problems and their families. We welcome your comments on the strategy.

Dr Chris Kenny
Director of Public Health
Nottinghamshire County and Nottingham City

Barbara Brady
Consultant in Public Health

Contents

Executive summary

The ***No Health without Mental Health, Nottinghamshire's Mental Health Strategy, 2014-2017***, demonstrates Nottinghamshire County ambition to improve the mental health and wellbeing of its residents of all ages.*

Mental health is defined by the World Health Organisation as a *"state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community."*[1] Mental health is fundamental to our physical health, our relationships, our education and our work. There is no health without mental health.

Mental health problems** impact on individuals, families, communities and society as a whole, with immense associated social and financial costs and they contribute to perpetuating cycles of inequality through generations. Mental illness is an important cause of social inequality as well as a consequence. Mental health problems contribute a higher percentage of total disability adjusted life years in the UK than any other chronic illness[2]. Recent estimates put the full cost of mental health problems in England at £105.2 billion[3], and mental illness accounts for about 13% of total National Health Service (NHS) spend[4].

The causes and influences of mental health problems are wide ranging and interacting. Often they occur because of adverse events in our lives, and other circumstances, such as poverty, unemployment, levels of supportive networks, levels of education and the broader social environment interact and affect how resilient we are in coping with these challenges.

Good quality personalised treatment and care is vital for people of all ages with mental health problems and achieving equal status for mental and physical healthcare is a key national driver. However, it has been estimated that even if all those with mental illness were given the best available treatment, the total burden of disability across the population would still be considerable[5], demonstrating the importance of wider supportive networks in enabling people to live full and meaningful lives. Since mental illness is under diagnosed, and treatment is only part of an effective response, this highlights the need to address the wider risk factors for poor mental health and increase the protective factors.

As well, as enhancing these protective factors for mental health, there is a good evidence base for a number of interventions that improve mental wellbeing[6]. Improving mental health and wellbeing is associated with significant impacts for individuals and society, including better physical health, longer life expectancy, reduced inequalities,

* This strategy takes a life course approach which recognises that mental health problems often start in childhood, and that opportunities to promote and protect good mental health arise from pre conception through to old age. Aligned to this strategy is the **Nottinghamshire Children and Young People Mental Health and Emotional Wellbeing Strategy 2014-16** which promotes mental health and wellbeing prevention and effective interventions in children and young people. Dementia is covered in the **Nottinghamshire Dementia Strategy – 2013.**

** 'Mental health problems' is an umbrella term used to describe the full range of diagnosable mental illnesses and disorders, including personality disorder.

healthier lifestyles, improved academic achievement, enhanced community participation, reduced sickness absence and improved productivity as well as reduced costs from welfare, health and social care[7].

Mental health problems are very common- at least one in four people will experience mental distress[8]. Mental health and physical health are interlinked, with people with mental illness experiencing higher rates of physical illness and lower life expectancy, and people with chronic physical health problems often experiencing mental health problems. Due to the continuing stigma that exist many individuals are reluctant to talk about any mental health problems they may have experienced. It is therefore easy to underestimate how widespread these issues are.

In Nottinghamshire, using national estimates, there are around 10,215 children and young people between the ages of 5 to 16 years that have 'any mental health disorder' and approximately 146,468 adults aged between 16 to 74 years experiencing common mental disorders (CMD) such as depression and anxiety, and over 3,000 adults with a severe mental illness (SMI). However, in deprived districts such as Bassetlaw, Mansfield and Ashfield where there are higher levels of risk factors for poor mental health contribute to higher levels of mental health problems.

In developing this strategy, as well as considering the objectives outlined in the national mental health strategy, No Health without Mental Health (2011)[9] and the Nottinghamshire Joint Strategic Needs Assessment (JSNA)[10] for mental health, a wide range of stakeholders' views have been gathered in order to identify gaps in current services and what our key priorities in Nottinghamshire should be for improving mental health and wellbeing.

A wide range of stakeholders views were gathered in the development phase of the draft mental health strategy. A public and partner consultation was undertaken to form the development of the local No Health without Mental Health Nottinghamshire's Mental Health strategy which demonstrated a high level of support for improving mental health across Nottinghamshire and the need to produce a strategy that covered the mental health across all ages. Specific needs were identified as:

- Promoting mental resilience early in life
- Raise awareness of mental health symptoms and reduce stigma
- Capitalise on inter-agency working to improve pathways of care particularly in relation to early identification of mental health problems and those experiencing a mental health crisis
- Ensure that a good level of social care support and settle accommodation for people with mental health problems

To prevent carers from developing mental health problems it was identified as a need that increased level of support is required for young carers when their parents have a mental health problem and carers of all ages for those with a long term physical condition. Also, to enable recovery from mental health problems it was recommended that a holistic approach was required which would address the physical, mental health and wellbeing and social needs of people.

The five priorities in this strategy have clear, ambitious aims to improve Nottinghamshire residents' mental health and wellbeing:

(1) Promoting mental resilience and preventing mental health problems
(2) Identifying problems early and supporting effective interventions
(3) Improving outcomes through effective treatment and relapse prevention
(4) Ensuring effective support for those with mental health problems
(5) Improving the wellbeing and physical health of those with mental health problems

For each objective, a number of key areas for action will be developed through a review of the evidence base and highlighted by stakeholders.

1. OUR VISION FOR NOTTINGHAMSHIRE

This strategy titled *'**No Health without Mental Health, Nottinghamshire's Mental Health Strategy - 2014-2017'*** demonstrates our ambition to meet the objectives set out in the government's No Health without Mental Health, a national strategy for mental health in England, published by the Department of Health in 2011[9].

We have made good progress in improving and developing services for people with mental health problems* in Nottinghamshire through increasing access to psychological therapies, offering support for people to recover from their mental health conditions and improving access to suitable long term accommodation in the community. However, we are committed to making further progress to ensure we support all our residents, especially the most vulnerable. This is reflected in our vision for the Nottinghamshire outlined in box 1.

Box 1: Nottinghamshire Mental Health strategic vision

"For everyone in Nottinghamshire, our vision is to work together to give equal status to mental health and physical health, promoting positive mental health, preventing mental ill health and intervening early when people become unwell. We aim to inspire confidence in people and families using mental health services by ensuring that mental health services are safe and effective, and promote recovery from mental health problems, so that, all using the services will reach their full potential, be encouraged to live independently and have an enhanced quality of life."

* Mental health problems' is an umbrella term used to describe the full range of diagnosable mental illnesses and disorders, including personality disorder.

2. NATIONAL DRIVERS

This strategy responds to the national mental health strategy, **No health without mental health (2011)**[9] which defines the outcomes that health and social care organisations should seek to achieve for their populations, along with recommendations for action. The outcomes are listed in box 2 below:

Box 2: National No health without mental health strategy six outcomes

NO HEALTH WITHOUT MENTAL HEALTH OUTCOMES
1. More people will have good mental health
2. More people with mental health problems will recover
3. More people with mental health problems will have good physical health
4. More people will have a positive experience of care and support
5. Fewer people will suffer avoidable harm
6. Fewer people will experience stigma and discrimination

There are three national outcomes frameworks that include specific indicators for mental health (including the wider determinants of mental health) of adults, young people and children: the **Public Health Outcomes Framework**[11], the **NHS Outcomes Framework**[12] and the **Adult Social Care Outcomes Framework**[13]. Appendix 1.

In 2012 the Government published **Preventing Suicide in England**[14], a cross-government strategy which aims to reduce the suicide rate in England and better support those bereaved or affected by suicide. In common with No health without mental health (2011)[9] it aims to improve mental health and improve early support for people experiencing mental health problems. It also focuses on improving monitoring of suicide and particularly tailoring support to high risk groups.

Closing the Gap: Priorities for essential change in mental health[15] was published by government in January 2014 to support the delivery of the national No Health without Mental Health strategy(2011)[9] and the national Suicide Prevention Strategy. It is intended to bridge the gap between long term strategic ambitions and short term actions through 25 priorities for action.

Mental Health Crisis Care Concordat: Improving outcomes for people experiencing mental health crisis[16] was published by the government in February 2014. The concordat outlines a vision for health, social care and emergency services work together to deliver a high quality response when people of all ages with mental health problems urgently need help.

Care Act Chapter 23[17] was published by the government in June 2014 to make provision to reform the law relating to care and support for adults and the law relating to

support for carers; to make provision about safeguarding adults from abuse or neglect; to make provision about care standards; to establish and make provision about Health Education England; to establish and make provision about the Health Research Authority; to make provision about integrating care and support with health services; and for connected purposes.

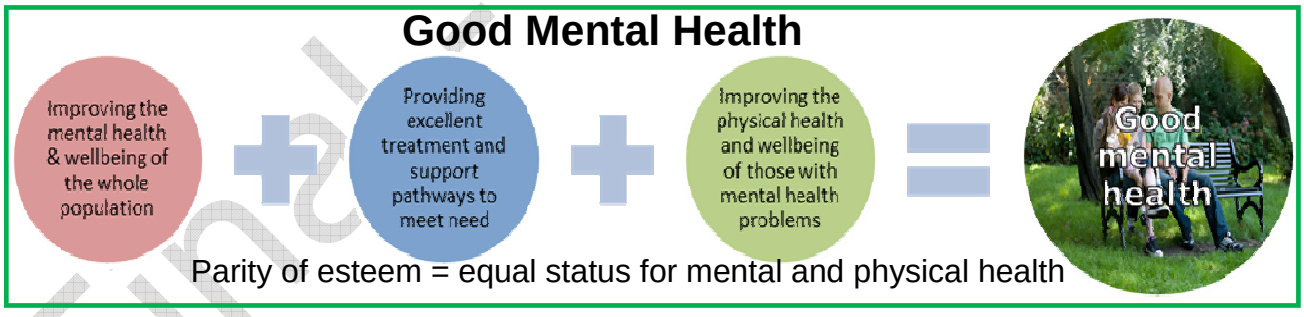
Parity of esteem

Most importantly, the **Health and Social Care Act (2012)**[18] requires the NHS, local authority including social care services to deliver ***"parity of esteem"*** between mental and physical health by providing a holistic, 'whole person' approach to every individual, whatever their needs are. A ***"parity approach"*** gives equal status to mental health and physical healthcare. This means that the standards of care for people with mental health problems are at least as good as those for people with physical health problems.

The Royal College of Psychiatrists report titled 'Whole-person care: from rhetoric to reality' (March 2013)[19] identifies the following implications in achieving 'parity approach' and include:

- Equal access to the most effective and safe care and treatment
- Equal efforts to improve care
- Equal allocation of time, effort and resources in relation to need
- Equal status within healthcare education and practice
- Equally high aspirations of service users and
- Equal status to the measurement of health outcomes.
-

In summary the ***three key elements*** to improving the population's mental health have been identified, as shown below:



This strategy encompasses all the parity of esteem elements.

3. OVERVIEW OF OUR AIMS AND PRIORITIES FOR THIS STRATEGY

Our strategic priorities are ambitious and far reaching, but we are confident these priorities will prevent mental health problems from developing and support people with a mental health problem to recover.

The aims of this Nottinghamshire strategy are outlined in box 3 below:

Box 3: Aims of the No Health without Mental Health, Nottinghamshire's Strategy

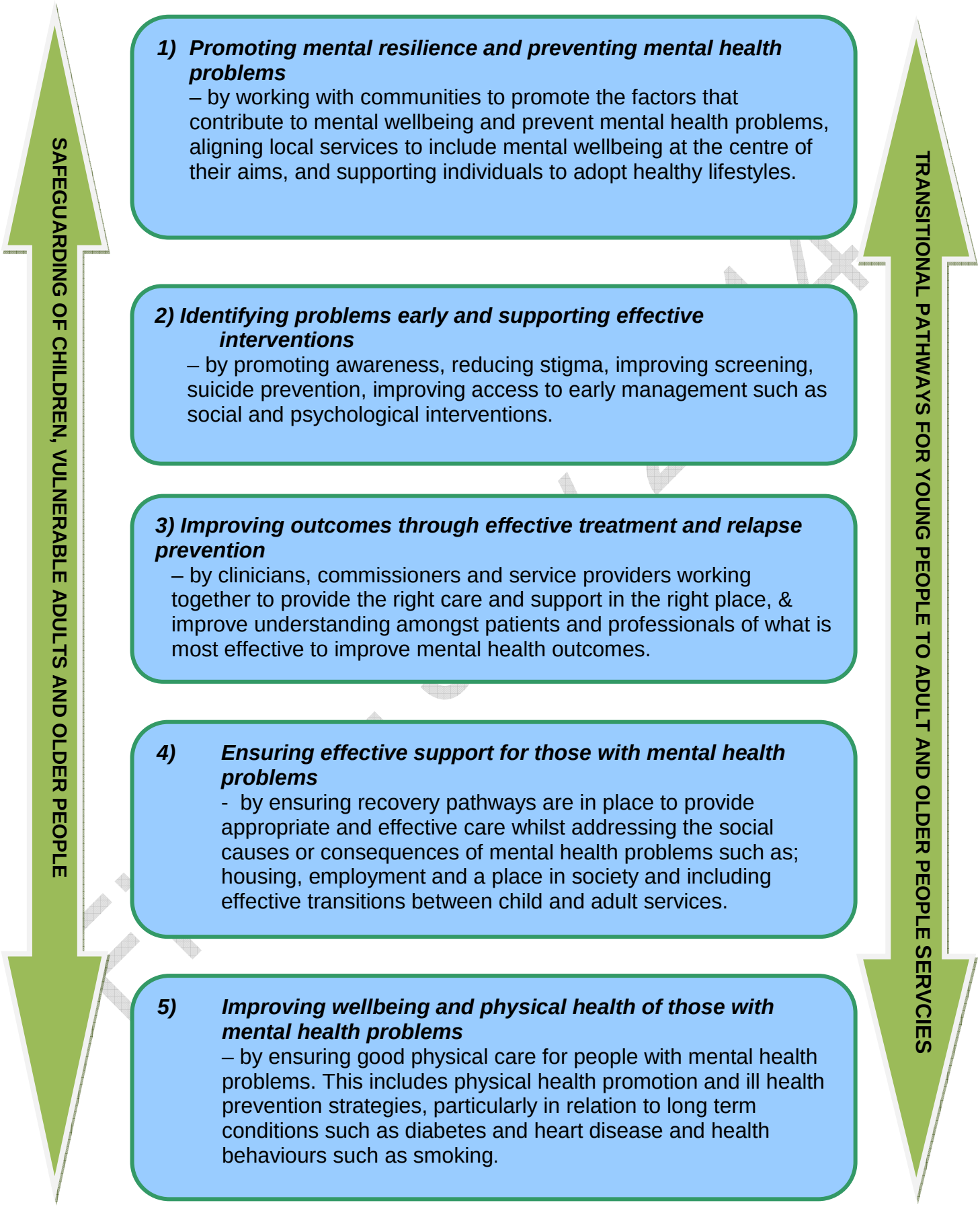
- Taking a ***life course approach*** ensuring a good start in life in order to prevent and reduce the causes of mental ill health
- Addressing ***stigma and discrimination*** and ensuring that mental health is ***everybody's business***
- ***Identifying mental health problems*** and promoting early intervention
- Ensuring that the ***physical health needs*** of those with mental health problems are addressed
- Improving ***access to psychological therapies*****,** including therapies for children and young people with a serious mental health conditions
- Ensuring mental health services embed a ***recovery model of care*** into all services to promote independence and choice

This strategy takes a life course approach which recognises that mental health problems often start in childhood, and that opportunities to promote and protect good mental health arise from pre conception through to old age.

This strategy incorporates the main elements of the **Nottinghamshire Children and Young People (CYP) Mental Health and Emotional Wellbeing Strategy 2014-16.** The CYP strategy places an emphasis on prevention, early identification and intervention to ensure that all children and young people enjoy good mental health and wellbeing, including the most vulnerable such as children looked after by the local authority. Dementia is covered in the **Nottinghamshire Dementia Strategy – 2013.**

This strategy is also aligned with other local strategies and plans detailed in Appendix 3.

The strategic priorities are;



1) ***Promoting mental resilience and preventing mental health problems***
– by working with communities to promote the factors that contribute to mental wellbeing and prevent mental health problems, aligning local services to include mental wellbeing at the centre of their aims, and supporting individuals to adopt healthy lifestyles.

2) Identifying problems early and supporting effective interventions
– by promoting awareness, reducing stigma, improving screening, suicide prevention, improving access to early management such as social and psychological interventions.

3) Improving outcomes through effective treatment and relapse prevention
– by clinicians, commissioners and service providers working together to provide the right care and support in the right place, & improve understanding amongst patients and professionals of what is most effective to improve mental health outcomes.

4) Ensuring effective support for those with mental health problems
- by ensuring recovery pathways are in place to provide appropriate and effective care whilst addressing the social causes or consequences of mental health problems such as; housing, employment and a place in society and including effective transitions between child and adult services.

5) Improving wellbeing and physical health of those with mental health problems
– by ensuring good physical care for people with mental health problems. This includes physical health promotion and ill health prevention strategies, particularly in relation to long term conditions such as diabetes and heart disease and health behaviours such as smoking.

4. What is mental health?

What is good mental health?

Mental health is not just the absence of a mental health conditions, but the foundation for wellbeing and effective functioning of individuals and communities[20]. It is defined as '*a state of wellbeing in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community. Where health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity*[21].'

What is mental wellbeing?

Mental wellbeing is a ***'dynamic state'***, in which the individual is able to develop their potential, work productively and creatively, build strong and positive relationships with others, and contribute to their community. It is enhanced when an individual is able to fulfil their personal and social goals and achieve a sense of purpose in society[22].'

The New Economics Foundation (nef) describe wellbeing as conceptualising people's subjective experience and feeling, where it is the interaction between one's circumstances, activities and psychological resources ***(sometimes also called 'mental capital')*** that matter.

The nef concepts of wellbeing include:

- ***Personal wellbeing*** = positive functioning, vitality, resilience and self-esteem, life satisfaction and emotional wellbeing
- ***Social wellbeing*** = supportive relationships, trust and belonging
- ***Wellbeing at work*** = job security, job satisfaction, work-life balance satisfaction, working conditions and emotional experience at work[23].

Mental wellbeing is a fundamental component of good health. Mental health problems are hugely costly to the individual and to society, and lack of mental wellbeing underpins many physical diseases, unhealthy lifestyles and social inequalities in health.

Therefore, mental health and wellbeing are fundamental to the quality of life and productivity of all of us, as well as our family, community and nation. Good mental health enables us to experience life as meaningful, creative and active citizens[21].

Good mental health and wellbeing has many benefits, which include:[9]

- Better physical health;
- Reductions in health damaging behaviour;
- Greater educational achievement;

- Improved productivity;
- Higher incomes
- Reduced absenteeism;
- Less crime;
- More participation in community life;
- Improved overall functioning; and
- Reduced premature mortality.

What is mental ill health?

Mental Illness is generally categorised into Common Mental Disorders (CMD) and Severe Mental Illness (SMI). Box 4 below describes these mental illness categories.

Box 4: Mental illness categories

What is a common mental health disorder (CMD)?[24]	**What is a severe mental health illness (SMI)?**[24]
Common mental health disorders are those which tend to occur most often. People with CMD have more severe reactions to emotional experiences than the average person. For example, this may mean developing depression rather than feeling low, or having panic attacks rather than experiencing feelings of mild anxiety. This includes conditions such as depression, anxiety disorders, obsessive compulsive disorders and post traumatic stress disorder. In the past common mental health disorders were called neurotic conditions'.	Severe mental health problems are less common. They disrupt a person's perception of reality, their thoughts and judgement, and affect their ability to think clearly. People affected may see, hear, smell or feel things that nobody else can. This includes conditions such as schizophrenia and bipolar disorder (formerly known as manic depression); paranoia and hallucinations Severe mental health illness may be referred to as psychotic conditions.

Why is mental health a priority?

Mental health problems are common, disabling and costly.

- Mental health problems represents up to ***23% of the total burden of ill health*** (includes dementia and substance misuse) in the UK and is the largest single cause of disability compared to 16% each for cardiovascular disease and cancer)[25]

- ***At least one in four people*** will experience a mental health problem and almost half of all adults will experience at least one episode of depression during their lifetime[26]

- At any one time ***1 in 6 people will suffer from a CMD***, like depression or anxiety[27] which can be wide ranging in severity.

- Mental health problems can affect approximately ***10% of children aged between five and sixteen[28]***

- People with mental health problems have ***poor physical health outcomes*** and research show that they die far younger (up to 20 years younger for people with schizophrenia)[29,30]

- Around 30% of people with a long-term physical health condition will also have a mental health problem, and of those with a mental health problem, around 45% will also have a long-term physical health condition[31]

- Mental health problems are responsible for ***more sickness absence*** than any other illness[32,33]

- Mental, emotional or psychological problems, many of which fall short of diagnosable mental health conditions, together ***account for more disability than all physical health problems*** put together[34]

- ***Mental health problems are under diagnosed and under treated*** - only a minority of people with clinically recognisable mental health conditions in the UK receive and treatment[35]

- Mental health problems ***represent the largest single cost to the NHS*** (13% of current spending)[36]

- Mental health conditions ***costs England approximately £105 billion each year*** once its impact on work, crime and violence has been taken into account[37]

- Protection against mental health conditions by ***reducing risk factors and increasing protective factors is important*** because treatment for mental health conditions is only partially effective. It has been estimated that if all those with mental health conditions were given the best available treatment, the total burden of mental health conditions would reduce by only 28%[38]

- By 2026, the number of people in England who experience a mental health problem is ***projected to increase*** by 14% from 8.65million in 2007 to 9.88 million[39], however this does not take account of the current economic climate which is likely to increase prevalence.

Mental health problems: Cause and consequence of social inequality

Mental health problems are an ***important cause of social inequality, violence and unemployment as well as a consequence***. Mental health problems in childhood and adolescence can result in:

- Reduce educational achievement and employability[40,41] and also
- Increase the risk of impaired relationships, drug and alcohol misuse, violence and crime[42,43].

The experience of mental health problems ***further exacerbates social inequalities*** because of its impact on employment and housing status. Half of all mental health conditions start by the age of 14[44],[45] and 75% by mid 20s[46].

Low income[47], debt[48], violence[49], stressful life events[50] and unemployment[51,52] are ***key risk factors for mental health problems.*** The two-way relationship between mental health conditions and social inequality can prove difficult to unravel.

What is public mental health?

Public mental health is about improving mental health and wellbeing and preventing mental health problems through the organized efforts and informed choices of society, organisations, public and private, communities and individuals.

Public mental health aims to improve the mental wellbeing and reduce the burden of mental health problems across the ***whole population.*** This can be achieved through:

- Assessing the risk factors and understanding the level of mental health problems and what works to help us have good mental wellbeing

- Delivering appropriate evidence based interventions that promote emotional wellbeing and prevent mental health problems

- Ensuring those people at 'higher risk' of mental health problems and poor emotional wellbeing have access to mental health treatments early and are prioritised for services in proportion to their needs.

Latest evidence suggests taking a ***population level approach*** is needed to promote wellbeing that enables individuals to function in families, communities and society[53]. A population approach recognises the importance of good mental wellbeing in childhood and adolescence for positive mental wellbeing in adulthood and old age. The more people there are in a community who have high levels of emotional and social wellbeing, the more resilient a community is to support those with acute mental health problems[54].

The New Economics Foundation (nef) was commissioned by the Government's Foresight project on ***Mental Capital and Wellbeing*** to develop a set of evidence-based actions to improve personal wellbeing[53]. From this report ***The Five Ways of Wellbeing (2008)[23]*** was developed which sets out the evidenced-based actions which promote well-being. The five actions important for wellbeing are shown in box 5 below:

Box 5: The Five Ways of Wellbeing actions

Five actions important for wellbeing:

1. *Connect* – make time to build relationships with other people

2. *Be active* – take part in regular exercise and activity

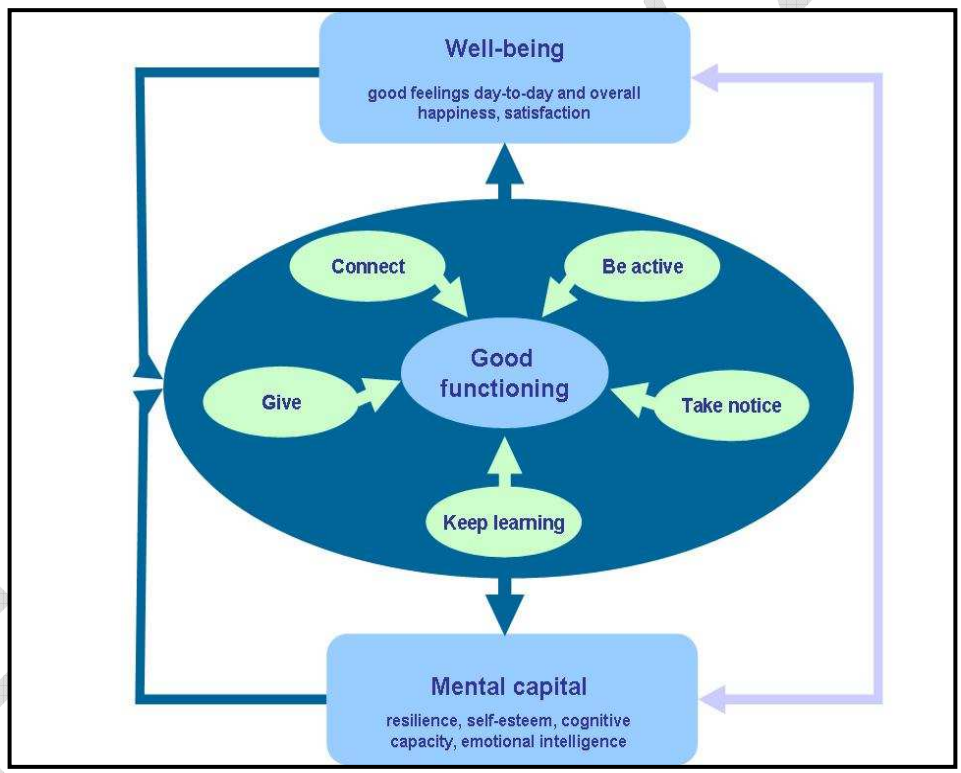
3. *Take notice* – be aware of what is taking place in the present and savour the moment

4. *Keep learning* – continue learning and try new things throughout your life

5. *Giving* – helping others and carrying out acts of kindness

Figure 1 gives a diagrammatic representation of ***The Five Ways of Wellbeing (2008)***[23] and shows that approaches to improving mental wellbeing has a positive effect up mental wellbeing and improvements in mental capital across the population.

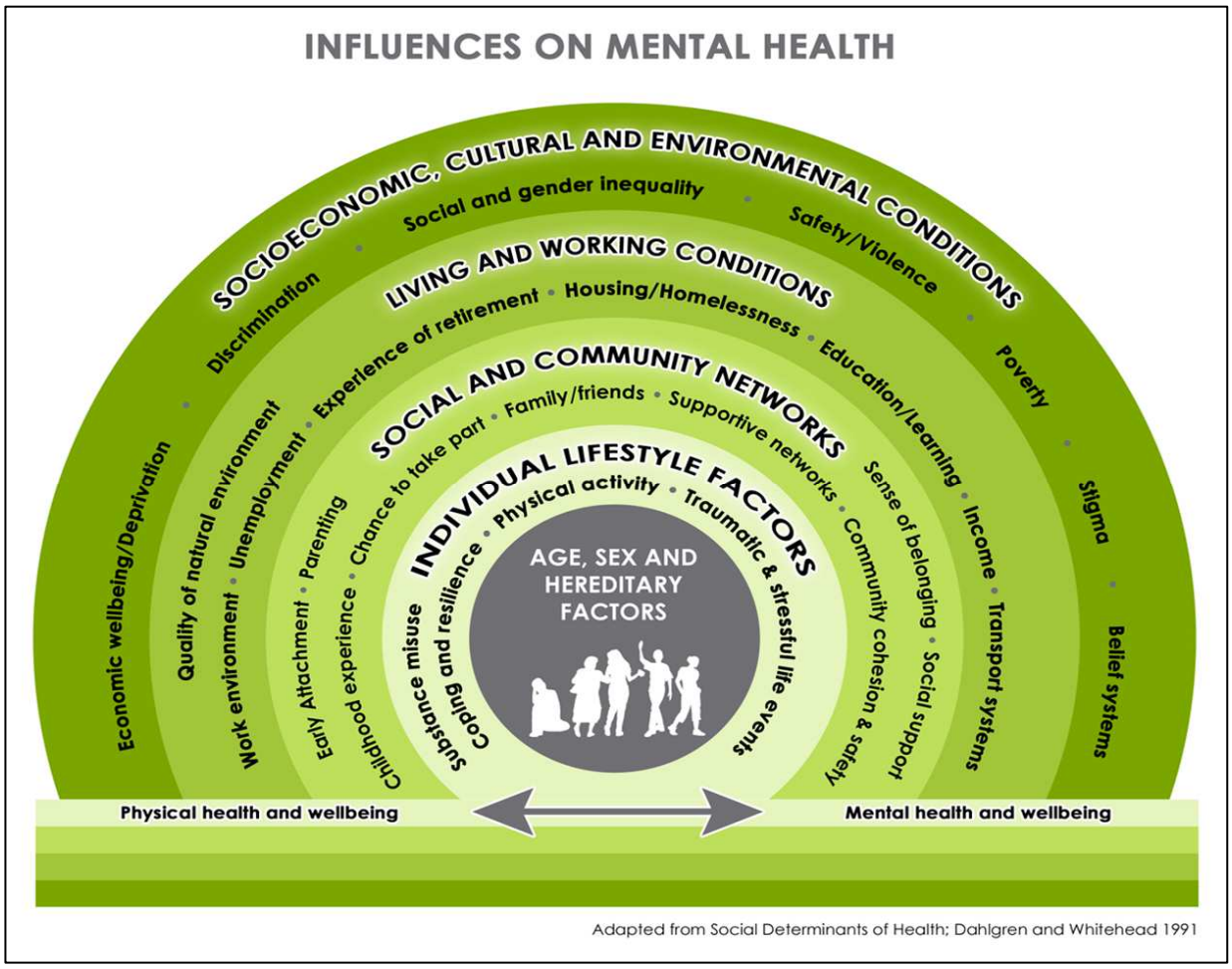
Figure 1: Five Ways to Wellbeing (from the Foresight Report 2008)



Are some people more likely to develop mental health problems than others?

The determinants or influences on a person's mental health and wellbeing are shown in figure 2.

Figure 2: Influencing factors on mental health



Multiple social, psychological, and biological factors determine the level of mental health of a person at any point of time. These determinants for example, persistent socio-economic pressures, are recognized risks to mental health for individuals and communities. The clearest evidence is associated with indicators of poverty, including low levels of education.

Poor mental health is also associated with rapid social change, stressful work conditions, gender, age and race discrimination, social exclusion, unhealthy lifestyles, risks of violence and physical ill-health and human rights violations.

There are also specific psychological and personality factors that make people vulnerable to mental disorders. Also, some biological causes of mental disorders including genetic factors and imbalances in chemicals in the brain. In order to prevent mental health problems, it is important that we understand why some people are more likely to become unwell because the effects can be serious and debilitating[55].

There are a number of groups who are at particular risk of developing mental health problems:

1) WOMEN DURING PREGNANCY AND THE POST-NATAL PERIOD

As many as one in seven women will experience a mental health disorder in the perinatal* period with approximately 10% of new mothers experiencing post natal depression[56]. To help minimise maternal ill health and limit adverse effects on the baby and other family members, early detection and identification, followed by prompt intervention at all levels of healthcare provision will be needed[57].

2) CHILDREN AND YOUNG PEOPLE

Risk factors for emotional and mental health problems in children and young people are summarized in box 6 below.

Box 6: Risk factors for emotional and mental health problems in children and young people

Child abuse	Poor parental mental health
Substance misuse	Parental substance misuse
Being in the youth justice system	Parental unemployment
Homelessness	Parent in prison
Physical and learning disability	Lone parent
Physical illness	Poor parenting skills
Special Educational Needs	Maternal stress during pregnancy
Gypsy or Traveller	Low household income
Not in training education or employment	Living in deprived areas
Lesbian, gay, bisexual or transgender	Living in social housing

Some children and young people may experience more than one of these risk factors at the same time.

The circumstances of children's early years are hugely important in terms of building emotional resilience and reducing the risk of developing mental ill health later in life. Mental health problems often have their roots in childhood. One in ten children aged between five and sixteen has a mental health problem, with a significant number continuing into adulthood. Half of those with lifetime mental health problems first experience symptoms by the age of 14, and three-quarters before their mid- twenties[58]. Between 10% - 13% of 15 – 16 year olds self-harm. The prevalence of mental health conditions is higher in specific groups of children and young people:

- 36% of children and young people with learning disabilities[59]
- About 40% of deaf children have a mental health problem[60]
- About 60% of looked after children have a mental disorder[61]

*Describes the period surrounding birth, and traditionally includes the time from foetal viability from about 24 weeks of pregnancy up to either 7 or 28 days of life.

Mental health problems in childhood are associated with poor outcomes in adulthood. Those who had severe conduct problems in childhood are more likely to have no educational qualifications, be economically inactive and be known to the criminal justice system.

The following are some of the groups of children who are recognised to have disproportionately high levels of mental and emotional health disorders.

CHILDHOOD SEXUAL ABUSE

There is a strong association between childhood sexual abuse and mental health problems in adult life such as depressive symptoms, anxiety symptoms, substance abuse and personality disorders, eating disorders and post-traumatic stress disorders[62]. Women who have been sexually abused in childhood are also more likely to experience physical or sexual abuse as adults.

LOOKED AFTER CHILDREN

The emotional and mental health of looked after children is affected by both the factors that lead them to enter care, and their experiences as a looked after child[63]. Estimates suggest that about 45% of children in local authority care have a clinically recognisable mental health disorder compared to 10% of the general population[64]. The prevalence of mental health problems rises to 70% for children living in residential care[63].

YOUNG OFFENDERS

The prevalence of mental health problems among young offenders has been estimated as about 40%, rising to about 90% among those in custody[65].Most but not all recurrent juvenile offenders have conduct disorder.[66]

3) OLDER PEOPLE

The most common mental health problem in older people is depression. The number of older people in Nottinghamshire is expected to increase by 30-40% by 2025 as the population ages the increase in severe depression is expected to be 42%. Older people experience events and situations that may trigger depression.

RETIREMENT

Retirement can be a stressful event leading to feelings of low self-esteem and emptiness. Many people may find it difficult to adjust after many years of work, and relationships can be affected as couples spend much more time together.

BEREAVEMENT

Older people are more likely to experience the loss of someone close such as a partner, family member or friends.

LIMITED ABILITY TO BE PHYSICALLY ACTIVE

Physical activity has positive benefits for both physical and mental health and is particularly beneficial for certain conditions such as depression. But physical ability changes as people age and many older people find it more difficult to be physically active.

ALCOHOL MISUSE

About a third of older people with drinking problems (mainly women) develop them for the first time in later life and may resort to drinking due to bereavement, physical ill-

health and pain, difficulty getting around and social isolation can lead to boredom and depression[67].

For the period 2005/06 to 2009/10, in Nottinghamshire hospital admissions 100% attributable to alcohol increased by almost 50% in the over 65 age group from 835 6o 1,227[68].

SOCIAL ISOLATION/LONELINESS

Regular contact with relatives and friends has been shown to be beneficial to the mental health of older people. Poverty and mobility problems may impact on the ability to maintain an active social life, and the death of friends or absence of family members living nearby may increase social isolation of older people.

PHYSICAL ILL HEALTH AND FRAILTY

Long term physical ill health and disability can have a profound effect on mental health and wellbeing. Older people are more likely to have long term physical health problems.

CARING RESPONSIBILITIES

Many older people have caring responsibilities either for a partner, an adult relative or grandchildren. Caring for someone with a physical or mental health problem can be stressful and impact on the mental wellbeing of the care giver.

MENTAL HEALTH PROBLEMS UNDIAGNOSED

Mental health conditions in older people may be undiagnosed, as older people are more reluctant to seek help, or it may be misdiagnosed as symptoms in older people can differ from those in younger age groups. In addition, symptoms such as agitation and anxiety may be mistaken for Parkinson's disease or Alzheimer's disease. Symptoms of depression such as lack of concentration, forgetfulness and loss of thinking ability may be misdiagnosed as dementia.

4) OTHER RISK FACTORS

SUBSTANCE MISUSE

A clear association exists between mental health conditions and drug and alcohol dependence, but the relationship is complex. People who misuse drugs and alcohol are at greater risk of both CMD and SMI. The term dual diagnosis is normally only used when a person has severe mental health problems and severe substance misuse problems that meet the criteria for specialist services[24], but many people with less severe substance misuse problems will experience mental health conditions.

LESBIAN, GAY, BISEXUAL OR TRANSGENDER (LGBT)

The National Institute for Mental Health in England (NIMHE) carried out a review that showed that LGBT people are at greater risk of suicidal behaviour and self harm. The risk of suicide is four times more likely in gay and bisexual men, whilst the risk of depression and anxiety were one and half times higher in LGBT people[69]. Stonewall's "Prescription for Change" report found higher rates of suicidal thoughts and self-harm in lesbian and bisexual women compared to women in general[70]. In addition, LGB people can face discrimination and poor experiences of care which can also impact on mental health.

HOMELESSNESS

People who are homeless or living in insecure accommodation have much higher rates of mental health conditions than the general population - around 70% of people accessing homelessness services have a mental health problem[71]. People who are homeless can experience stigmatisation, isolation, the disruption of supportive relationships, substance misuse, physical illness and difficulty in obtaining medical care all combine to reduce the individual's likelihood of addressing their mental health problem successfully.

INVOLVEMENT WITH THE CRIMINAL JUSTICE SYSTEM

People with mental health problems are overrepresented in all parts of the criminal justice system. 90% of prisoners have a mental health problem and over 70% have two or more mental disorders. Yet less than 1% of offenders in the community are referred for mental health treatment[72].

MILITARY SERVICE

Service in Her Majesty Forces is generally associated with good mental and physical health. However, recent cases have drawn attention to Post Traumatic Stress Disorder (PTSD) and, more generally, to service-related mental health problems including mild traumatic brain injury (MTBI)[73]. Alcohol abuse is associated with service in the Armed Forces and there is evidence that it is more common among combat veterans[74].

WORKLESSNESS

It is well known that work is generally good for physical and mental health. The majority of people with mental health problems are working age adults, but mental health conditions can have a severe impact on an individual's ability to obtain and maintain employment.

CARING RESPONSIBILITIES

Many carers have little time for themselves and may neglect eating, taking regular physical exercise and maintaining a social life. Caring can be emotionally draining, stressful and affect sleep. As a consequence carers are at greater risk of mental health conditions.

DOMESTIC VIOLENCE

Women who experience domestic violence are more likely to have mental health problems including Post-Traumatic Stress Disorder (PTSD), depression, anxiety and suicidal thoughts[75].

ETHNIC AND CULTURAL BACKGROUNDS

Ethnic differences in mental health are controversial. Most of the data are based on treatment rates, which show that Black and Minority Ethnic (BME) people are much more likely to receive a diagnosis of mental health conditions than the White British population. However, surveys on the prevalence of mental health problems in the community show smaller ethnic differences. There is evidence of ethnic differences in risk factors that operate before a patient comes into contact with the health services, such as discrimination, social exclusion and urban living[76].

LONG TERM PHYSICAL HEALTH CONDITIONS

More than 15 million people in England (30% of the population) have one or more long term physical health conditions. At least 30% of all people with a long term condition also have a mental health problem[77]. Co-morbid mental health problems are particularly

common among people with multiple long term conditions. People with two or more long term conditions are seven times more likely to have depression than people without a long term condition[78].

5. WHAT IS THE CURRENT MENTAL HEALTH PICTURE IN NOTTINGHAMSHIRE?

It is important that we understand the mental and emotional wellbeing needs of Nottinghamshire residents.

To do this successfully, we need to know:

- Which people are more likely to experience mental health problems compare to the rest of the population?
- How many people currently have mental health problems?

The Nottinghamshire Joint Strategic Needs Assessment

A ***Joint Strategic Needs Assessment (JSNA)*** is the assessment of the current and future health and social care needs of a local community[79]. The ***JSNA*** for Nottinghamshire[10] provides a starting point to identify the estimated number of children, young people and adults that currently have mental health problems. These figures are based on national prevalence rates and have been broken down into the two main types of mental health problems – 'common' and 'severe'.

A full description of mental health and other related issues and need are outlined in the Nottinghamshire JSNA and can be accessed via:
http://www.nottinghamshireinsight.org.uk/insight/jsna/county-jsna-home.aspx

Nottinghamshire population demographics

Box 7 below gives a brief overview of the demographic variations across the Nottinghamshire Districts.

Box 7: A brief demographic description of Nottinghamshire

- There are ***approximately 786,000 people living*** within the Nottinghamshire area.
- Of these, around ***18% are under 16*** (similar to England, 18.9%) ***and 19% are over 65*** (slightly higher to England, 17%).
- The NCC area is ***divided into seven geographical districts*** (Ashfield, Bassetlaw, Broxtowe, Gedling, Mansfield, Newark and Sherwood and Rushcliffe).
- The ***economic landscape is varied***. Some parts of the county are affluent while others, particularly in the former mining areas[80].
- ***Deprivation is largely concentrated geographically in the north-west of the county***, particularly in Mansfield, Ashfield and western Bassetlaw. Conversely, Rushcliffe is the least deprived district in the county.
- People living within the more deprived areas of Nottinghamshire have higher levels of unemployment and lower levels of qualifications.
- ***Unemployment rates*** in Nottinghamshire are historically lower than national levels, 2.6% October 2013 compared with 2.9% in the East Midlands. However, for those aged 18-24 years, unemployment rates have been higher than the region for the past six years and were 6.5% in October 2013, compared with 5.5% in the East Midlands.
- ***Black and minority ethnic (BME) populations*** are relatively low in Nottinghamshire as a whole, 4% compared with 15% nationally, within the districts of Broxtowe, Gedling and Rushcliffe there are larger population groups (7% each district), mainly Asian and Mixed/Multiple Ethnic groups.

CHILDREN AND YOUNG PEOPLE

- There are approximately 171,865 children and young people aged 0-18 years old living in Nottinghamshire. Of which, approximately 15,905 between the ages of 5 to 19 years) have *'any mental health disorder'* (includes a broad range of conditions from behavioural disorders such as oppositional defiant disorders and Attention Deficit Hyperactivity Disorder (ADHD) to emotional disorders such as separation anxiety, phobias and depression. Table 1 below.
- The variation in the prevalence of mental health conditions for children and young people between districts in Nottinghamshire, broadly reflects the variation in levels of multiple deprivation
- For primary school age children it is estimated that there are approximately 4,000 with any mental health condition
- For secondary age children it is estimated that 6,400 with any mental health conditions
- It is estimated that approximately 5,540 young people aged 16-19 have a neurotic disorder.

Table 1: Estimated numbers of children and young people aged 5-19 with a mental health disorder, according to district

Nottinghamshire District	Children (Aged 5-10)	Children (Aged 11-16)	Young People (Aged 16 - 19 years)	Total
	Any type of mental health disorder		Neurotic Disorder	
Ashfield	626	998	846	**2470**
Bassetlaw	559	952	822	**2333**
Broxtowe	499	842	742	**2083**
Gedling	567	920	791	**2278**
Mansfield	509	842	760	**2111**
Newark and Sherwood	590	957	813	**2360**
Rushcliffe	592	911	767	**2270**
Total	**3942**	**6422**	**5541**	**15905**

Source: Child and Maternal Health Observatory, based on the 2011 Census

ADULTS AND OLDER PEOPLE

- Prevalence estimates indicate there are approximately 146,468 people between the ages of 16 to 74 years in Nottinghamshire experiencing common mental disorders (CMD) such as depression and anxiety in 2012 and over 3,000 suffering from severe mental illness in 2007
- There is significant variation in the prevalence of CMD, between CCGs in Nottinghamshire, broadly reflecting the variation in levels of multiple deprivation. Table 2 below
- In terms of common mental problems, across all age groups the prevalence is higher amongst females than males, and the highest prevalence is found among females aged 45-54
- As at August 2012, 39% of unemployment claims are due to mental or behavioural disorders
- For men under 35, suicide is the most common cause of death and men are three times more likely than women to take their own lives. Overall, people aged 40-49 have the highest suicide rate
- Nottinghamshire the rate of death by suicide is similar to the England average, but a higher rate of suicides in people over 75.

Table 2: Estimated prevalence of CMD by Local Authority based on 2000 Psychiatric Morbidity Survey

Local authority	Prevalence of any CMD (rate/1000 pop)
Ashfield	150.9
Bassetlaw	121.3
Broxtowe	143.2
Gedling	147.3
Mansfield	155.1
Newark & Sherwood	117.6
Rushcliffe	115.6
Nottinghamshire	**135.8**

Source: East Midlands Public Health Observatory, Nottinghamshire Mental Health Needs Assessment 2011

The 2007 Survey of Psychiatric Morbidity Among Adults found the prevalence rate for probable psychotic disorder in the year prior to interview (2006) was 0.4%.

As a result any estimation of the local prevalence can be based only on a crude application of the England rate to the Nottinghamshire population. The results of this analysis are presented in table 3. However, the analysis should be treated with some caution. It takes into account age and sex of the local population but does not take into account the risk factors associated with mental health problems.

Table 3: Estimated prevalence of psychotic disorders by CCG

Clinical Commissioning Group	Population total	Estimated prevalence of psychotic disorder at 0.4%
Bassetlaw	109,774	439
Mansfield & Ashfield	182,857	731
Nottingham North & East	144,258	577
Newark & Sherwood	127,201	509
Nottingham West	93,122	372
Rushcliffe	121,560	486
Total	**778,772**	**3115**

Source: East Midlands Public Health Observatory, Nottinghamshire Mental Health Needs Assessment 2011

Nottinghamshire Community Mental Health Profile (2013)

The Nottinghamshire Community Mental Health Profile (CMHP) 2013 gives a range of mental health local information compiled nationally. The profile is designed to give an overview of mental health risk factors, prevalence and services at a local, regional and national level.

The CMHP comprises of 31 mental health indicators covering the following themes:

- Wider determinants of health
- Risk factors

- Levels of mental health and illness
- Treatment
- Outcomes[81]

These mental health wider determinants for Nottinghamshire are shown in figure 3 [82]. For Nottinghamshire, most factors appear better than the England average with the exception of long term illness and first time entrants into the youth justice system which are higher. As the CMHP is for Nottinghamshire County as a whole, this will mask the risk factors within each district. However, it is predicted that the deprived Nottinghamshire districts such as Mansfield, Ashfield and Bassetlaw would have higher levels of mental health risk factors when compared to the more affluent districts, such as Rushcliffe.

Figure 3: Wider determinants of health and risk factors affecting mental health in Nottinghamshire (2013)

Wider Determinants of Health	Local value	Eng. value	Eng. worst*	England Range	Eng. best*
The wider determinants have been described as 'the causes of the causes'. They are the social, economic and environmental conditions that influence the health of individuals and populations. They determine the extent to which a person has the right physical, social and personal resources to achieve their goals, meet needs and deal with changes to their circumstances.					
1 Percentage of 16-18 year olds not in employment, education or training, 2011	4.5	6.2	11.9		1.9
2 Episodes of violent crime, rate per 1,000 population, 2010/11	11.0	14.6	34.5		6.3
3 Percentage of the relevant population living in the 20% most deprived areas in England, 2010	15.9	19.8	83.0		0.3
4 Working age adults who are unemployed, rate per 1,000 population, 2010/11	21.1	59.4	105.2		8.3
5 Rate of hospital admissions for alcohol attributable conditions, per 1,000 population, 2011/12	22.4	23.0	38.6		11.4
6 Numbers of people (aged 18-75) in drug treatment, rate per 1,000 population, 2011/12	5.4	5.2	0.8		18.4
Risk Factors					
A risk factor is any attribute, characteristic or exposure of an individual that increases the likelihood of developing a disease, injury or mental health problem. Some examples of the more important risk factors in mental health are under and over weight, low levels of physical activity, drug abuse, tobacco and alcohol consumption, and homelessness.					
7 Statutory homeless households, rate per 1,000 households, all ages, 2010/11	1.14	2.03	10.36		0.13
8 Percentage of the population with a limiting long term illness, 2001	19.0	16.9	24.4		10.2
9 First time entrants into the youth justice system 10 to 17 year olds, 2001 to 2011	1,189	876	2,436		343
10 Percentage of adults (16+) participating in recommended level of physical activity, 2009/10 to 2011/12	11.5	11.2	5.7		17.3

Source: Produced by the North East Public Health Observatory on behalf of the Public Health Observatories in England 2013

Where are the current gaps?

In order to set the strategic priorities and actions we needed to know what the current situation was in Nottinghamshire. We undertook a review of current strategies, commissioning intentions and NHS, social care and third sector service mapping exercise. Gaps were identified by comparing the results of this mapping against the local mental health JSNA data and the CMHP profile. This enabled us to identify the five strategic priority areas and where we need to focus.

Box 8 below outlines where the current gaps exist against the five strategic priority areas.

Box 8: summary of Nottinghamshire current service mapping gaps

1) Promoting mental resilience and preventing mental health problems

- Evidence based mental health preventative approaches needs to be identified. This should include universal interventions to promote resilience and wellbeing in the population and targeted intervention for particular at risk groups

2) Identifying problems early and supporting effective interventions

- Promoting mental health awareness to community groups and health and social care professionals to reduce stigma and discrimination is required
- Supporting the improvement of access, particularly around reducing waiting times, to psychological therapies for children, young people and older people
- Detecting mental health problems early by introducing mental health screening, particularly for older people and support universal services in the detection of emerging emotional and mental health problems in children and young people.

3) Improving outcomes through effective treatment and relapse prevention

- Developing care pathways to ensure those experiencing a mental health crisis have access to timely effective interventions
- A whole family approach is required to support families and carers when a family member has a mental health condition
- Mental health services need to be easily assessable and delivery to be aligned on patient choices

4) Ensuring effective support for those with mental health problems

- Wider access to community resources tailored to the needs of patients with mental illness is needed
- Mental health services need effective transition pathways for young people to adult services and adults to older people mental health services
- Supporting for finding appropriate housing, employment and education to support recovery

5) Improving wellbeing and physical health of those with mental health problems

- Improvements in screening for physical health condition
- For those identified need support to access to treatment for the physical health condition is required
- Strategies to promote healthier lifestyles is required

6. WHAT WILL SUCCESS OF THE STRATEGY LOOK LIKE?

The overall strategic success measures are outlined below.

1) There will be a positive impact on the mental health of the whole population

- We want to have a positive effect on mental health and wellbeing across the whole population. Interventions that span the needs of whole families and help to build good foundations for mental health in childhood are key, and are covered in the ***Children and Young People's Mental Health Strategy***. These include antenatal screening for maternal mental health problems and access to high quality parenting interventions.

- ***For adults*** we wish to see improvements in mental wellbeing, fewer people suffering from mental health problems, fewer people suffering disability due to mental health problems, and communities taking their own actions to maintain positive mental health and mental wellbeing.

- ***For older people*** we would like to see these positive foundations help people to remain healthy in to older age.

2) Changing attitudes to stigma surrounding mental health problems

- People with mental health problems ***should not face social exclusion.*** By talking about mental health and mental wellbeing across all sectors within Nottinghamshire will raise awareness and ensure it is viewed as everybody's concern.

- Mental health should be viewed with equal status and importance compared to physical health problems as per ***'parity of esteem'*** on page 9.

3) Children, Young People, Adults and Older People with mental health problems will have a positive experience of care

- We would like all children, young people, adults and older people with mental health problems to have a ***positive experience of all care*** that they receive and for relatives and carers of people with mental health problems to be effectively supported in their role.

- People with serious mental health conditions often have complex health and social care needs. We want to ensure that ***good social care is available to enable people*** to live well with their condition, and promote wellbeing and recovery wherever possible.

- We would like to see all services that come into contact with people with mental health problems ***feel confident in their role and be able to demonstrate commitment to making a positive contribution.***

- The strategy aims to bring together non-clinical services such as housing, police, fire and rescue, youth services, third sector groups (such as not for profit or community groups), voluntary groups, faith groups, education, drug and alcohol services and the business sector to address the ***need for co-ordinated provision*** through the development of the Action Plan.

4) Continued improvements in access to psychological therapies

Common mental health problems are the biggest contributor to mental ill health and can be effectively addressed through;

- Talking therapies such as cognitive behavioural therapy. All the partners within the strategy wish to ensure ***appropriate access to psychological therapies***.

- There is continued commitment to ***ensuring adequate capacity and the right type of services*** are offered to enable groups with higher levels of need (but who currently access the service less) such as;

- children and young people
- those with long-term physical conditions frequently affected by poor mental health
- older people
- those from LGBT groups
- BME groups identified with particular needs
- those in contact with the criminal justice system.

5) Those with mental health needs will be able to get the services they require

- We want to ensure that services can be ***easily accessed*** by those who need them. In particular we would like to see that some groups (such as older people and ethnic minority groups) who currently do not use treatment services to the same extent as the rest of the population are able to do so in a way that suits them.

- We would like to see a ***range of services*** that will meet the needs of different groups based upon evidence of need.

6) The physical health of people with poor mental health will be improved, and vice versa

- We want to see the ***physical health of those with mental health problems raised*** across all agendas, as per the parity of esteem' approach (see page 9).

- We also wish to see an ***improvement in the mental health of those with long term conditions*** and other physical health problems.

7) A reduction in deaths associated with mental health problems

- ***Suicide is still a concern for Nottinghamshire*** and it is intended that this strategy will dovetail with the new joint strategy currently in development across Nottingham City and Nottinghamshire County to further reduce the number of deaths from suicide.

- ***A reduction in the gap in life expectancy between those with and without mental health problems*** will take some years to come into effect. Our aim is that this strategy will begin to lay the foundations for benefits in this area over several decades to come, and advances towards this goal will begin to be evident through other indicators such as those in the NHS and Public Health outcomes frameworks (see appendix 1)

7. OUR STRATEGIC PRIORITIES FOR NOTTINGHAMSHIRE

Priority 1: ***Promoting mental resilience and preventing mental health problems***

– by working with communities to promote the factors that contribute to mental wellbeing and preventing mental health problems, aligning local services to include mental wellbeing at the centre of their aims, and supporting individuals to adopt healthy lifestyles.

Central to this priority is preventing mental health problems from starting and making sure more people can reach their full potential. The focus is on making sure that more people will have good mental health and wellbeing throughout their lives - in childhood, in adulthood and in their later years.

We can make a positive impact by:

- ***Raising awareness of the importance of good mental health and wellbeing*** by promoting The Five Ways to Wellbeing[23].There are simple activities that individuals can do in their everyday lives outlined in box 9:

Box 9: Examples of wellbeing activities

Mental health's '5-A-Day'	Partnership action to support this activity:
Connect	• Support interventions that improve relationships and reduce loneliness and social isolation • Encourage a sense of community and social cohesion • Develop environments that encourage wellbeing, are inclusive, promote self-esteem are non-stigmatising. • Promote wellbeing in the workplace • Reduce stigma and discrimination
Be active	• Encourage active travel • Build and maintain environments that encourage physical activity in everyday lives • Provide accessible, well maintained, safe green spaces • Promote and provide a variety of exercise and sporting opportunities, including community based activities
Take notice	• Raise the profile of the concept of 'mindfulness'[†].
Learn	• Improve academic achievement • Provide lifelong learning and educational opportunities • Support people to stay in work and develop new skills • Promote access to the arts, creativity and cultural opportunities • Encourage individuals to become more financially literate • Improve self management of long term conditions
Give	• Support and encourage volunteering • Promote citizen participation

[†] ***Mindfulness*** is a technique that teaches people the skills to pay more attention to the present moment – to your own thoughts and feelings, and to the world around you – can improve your mental wellbeing.

- ***Improving general wellbeing -*** wellbeing involves both the mind and the body and further work needs to be done to help people to view mental health and wellbeing in the same way as physical health and wellbeing. Initiatives focusing on tobacco and drug use (which are both associated with an increased risk of mental health problems), sexual health promotion, physical activity and nutrition all have much to contribute to mental wellbeing.

- ***Promoting good parenting skills*** - through universal as well as targeted early intervention programmes for common parenting problems and more intensive interventions for high risk families, to ensure a good start in life.

- ***Tackling the social determinants of mental ill health*** – mental wellbeing can be enhanced through the support from families, friends and community. Opportunities to learn and a good education enable people to achieve their full potential.

- The ways in which urban areas are planned, designed and built have a major significance to good mental health. Also, access to high quality housing in safe neighbourhoods, green spaces, strong communities with good transport systems all contribute. Factors such as air pollution, traffic, noise, lack of space, feeling unsafe and insecure, anti-social behaviour and limited options for physical activity also impact on mental wellbeing.

  Reducing isolation and loneliness, especially amongst older people, safeguarding children and young people at risk of emotional harm, commissioning high quality mental health services to ensure those at risk of developing a mental health problem have a good quality of life.

- ***Work closely with communities to identify the best approaches*** - mental health and wellbeing differs between communities, e.g. people of different cultural and ethnic backgrounds, sexual orientation or age. Making the most of a community's own assets (a community development approach) can bring mental health benefits to individuals. Addressing loneliness and isolation is also a key part of improving individuals' mental wellbeing.

- ***Maintaining and improving mental health and wellbeing through work*** - work is an important part of maintaining and improving mental health and wellbeing, as well as contributing to effective ill-health recovery[83]. By addressing issues such as the working environment and work-life balance, employers can create a culture where their staff wellbeing increases, resulting in increased productivity, loyalty and a reduction in sickness absence. Being out of work, or never having been in work, increases the risk of developing mental health problems.

Our vision for 3 years from now

The people of Nottinghamshire, of all ages and backgrounds, will have better mental health and wellbeing.

Some of the suggested key actions to achieve:

- Promote population wide good mental wellbeing and reduce stigma by raising awareness and understanding of mental health problems

- Work closely with communities to provide effective mental health promotion interventions such as the Five Ways to Wellbeing[23], targeted at those groups who are most at risk

- Align policy, strategy and services across health, care and the wider determinants such as housing, planning, leisure and employment to improve their impact on mental health and wellbeing

- Build resilient communities that enhance control, promote opportunities for participation, reduce isolation and loneliness, and encourage healthy lifestyles

- Encourage the development of healthy working environments that promote wellbeing and guide employers to the best practice and interventions for those with mental health problems

- Work with partners to ensure evidence based intervention such as parenting support and the Social and Emotional Aspects of Learning (SEAL) are delivered.

Priority 2*: Identifying problems early and supporting effective interventions*
– by promoting awareness, reducing stigma, improving screening, suicide prevention, improving access to early management such as social and psychological interventions.

This priority is about making sure that people that have mental health problems are identified and offered effective interventions quickly early stop problems escalating.

We can make a positive impact on this by:

- ***Intervening early –*** by identifying mental health problems at the earliest opportunity, including in the antenatal period, and providing access to treatment as quickly as possible.

  Certain groups such as those with long term physical conditions, those with disabilities including those with sensory impairment, students, older people, carers, LGBT and some BME groups have a particular risk of mental health problems. Services already in contact with groups known to be at higher risk can help by improving early detection and signposting or referring to services.

  Involving carers can help to alert professionals to symptoms that patients may not disclose, and 'early warning systems' can be developed to enable people to receive help earlier.

- ***Taking a whole family approach*** – by working with all the members of a family when a person is ill and taking into account all the interrelated problems which are linked with mental health conditions, such as alcohol misuse and domestic violence, and by ensuring that maternal mental health problems are identified antenatally and women with mental health problems are supported through their transition to parenthood.

- ***Providing equal access to psychological therapies*** – by making sure that everyone can access psychological interventions and waiting times to psychological therapies are reduced.

  There are significant barriers such as the onset of mental health problems going unrecognised, ignored or explained in different ways both by individuals and professionals particularly in BME groups.

  Fear of stigmatisation may deter people from seeking help early. There is a need to raise awareness of mental health issues, to dispel myths, and to support a wide range of professional groups to spot problems early and ensure that they feel confident in referring on or signposting to other services.

  Clear pathways are needed to help service users, carers and professionals navigate to the right mental health services quickly, and gain a clearer understanding of the entry and exit points.

- ***Taking a personal approach*** – this means making sure that services meet the needs of the individual, instead of making the individual choose the type of support they can have based on a list of the services that are available. This personalised approach will provide a better chance of recovery and help individuals to manage their condition well.

- ***Providing information*** – by making sure that people have good quality information about the services and treatments available. Also, there is a role for self-help resources such as, 'Reading Well, a national books on prescription scheme which is available across England.

Our vision for 3 years from now

To promote early interventions, so that people recover from mental health problems by making sure effective support is in place at every stage, and to further develop support in the community.

Some of the suggested key actions to achieve:

- Increase access to psychological therapies for a broad range of mental health problems, particularly for those groups who are identified as being at higher risk

- Involve local people, particularly those with mental health problems, their families and carers, in the co-production of pathways for assessment, advice and support of common mental health problems

- Increase the ability of professionals and front-line staff to identify mental health problems, to understand how to reduce stigma and to make appropriate referrals

- Raise awareness across a wide range of services including housing providers, police, educational establishments and emergency services so that they better understand the needs of those experiencing mental health problems and how they can support and signpost citizens to receive the best care

- Improve opportunistic screening for individuals to reduce suicide risk

- Linking adult and childhood mental health work more closely. Future mental health work should consider how strategies could be even better aligned across the life course to create a clear pathway from pre-conception in to older age

- Finding better ways of identifying problems early in groups such as looked after children, students, people with long term conditions, carers, those in the youth or criminal justice system to enable them to receive early intervention.

Priority 3: ***Improving outcomes through effective treatment and relapse prevention***

– by clinicians, commissioners and providers working together to provide the right care and support in the right place, & improve understanding amongst patients and professionals of what is most effective to improve mental health outcomes.

This priority is about providing people with effective quality services based on the National Institute for Health and Care Excellence (NICE) clinical guidelines and to give them as much control as possible over their own care. This means giving people (including their parents/carers where appropriate) the best available evidenced based information to make choices about the support they want to have. Taking this approach is particularly important because when people are put in control of their own life it helps them to recover.

We can make positive impact on this by:

- ***Robust commissioning and review process*** **-** as clinical practice advances and the needs of the population change, commissioners and service providers need to review crisis management, treatments and pathways of care with those who use their services. Robust commissioning and review processes will ensure that the quality of care is maintained so that the best outcomes are achieved for all patients.

- Improving early identification and access to Nottinghamshire CAMHS pathways and services is required and a review is currently being undertaken with the aim to improve access particularly for children and young people in crisis sand reduce waiting times.

- ***Connecting services*** - when people move from one service to another the transition between the services should be seamless. For example, the transition of children into adult care and adults into older peoples services allowing for continuity of care.

  For those with serious mental health problems in the community, medical care is often shared between primary and secondary care teams. New treatment and care options need to be implemented in a coordinated way. This will be supported by excellent education and continuous professional development for providers of these services.

- ***Personalising services*** – services should be flexible and sensitive to the needs and the age of the patient, respect their privacy and dignity, and be accessible to all regardless of their background.

  Holistic support for people living with mental health problems needs to address issues such as loneliness, isolation and stigma associated with their condition.

  Nottingham has good systems in place with NHS Nottinghamshire Healthcare Trust to ensure patient and carer involvement in the way that care is delivered.

Patient involvement systems in community based care tend to be less focused on mental health, but it is essential that we actively seek the views of those with mental health problems who may find difficulty in expressing their needs. The newly formed Healthwatch[84] will ensure users of mental health services locally have a 'voice'.

- ***Promoting liberty*** - when decisions are made for an individual under the Mental Health Act (because they are not able to make them for themselves) they should always give the person the maximum amount of freedom possible.

- ***Providing information*** – clear, appropriate and accessible information should be available so people can take part in making informed and effective choices about their own care.

Our vision for 3 years from now

To ensure that the services available in Nottinghamshire to support people with mental health problems are good quality, so that as many people as possible have a positive experience of care and support.

Some of the suggested key actions to achieve:

- Continuing to support joint work through local groups of clinicians with expertise in mental health care in order to implement changes in line with evidenced based best practice

- Developing and putting in place shared care arrangements, including professional development to support new care pathways

- Ensuring that pathways of care are flexible enough to provide opportunity for patients to access care at the most appropriate point for their needs and move throughout the system quickly as their condition changes

- Ensuring that transition of children into adult care and older peoples services allows for continuity of care and ensures that needs are met across the life course

- Considering how local pathways need to support people with on-going problems who may be known to services elsewhere such as students, travelling communities and those who are homeless

- Understanding the cultural needs of particular at risk groups to reduce barriers and improve outcomes

- Ensuring an emphasis on how mental health providers address people's physical healthcare needs by working with commissioners and other service providers

- Continually reviewing outcome measures and quality incentive schemes for hospital care as a way of focusing on recovery and improving patient outcomes

- Reviewing referrals to secondary care services to make sure that care is as far as possible given at the right place and time

- Ensure pathways between health and social care are integrated to avoid any duplication of service delivery and to ensure the right level of care is delivered

- Working with service users and carers to improve services based upon their experience of care.

Priority 4: Ensuring effective support for those with mental health problems

- by ensuring recovery pathways are in place to provide appropriate and effective care whilst addressing the social caused or consequences of mental health problems such as; housing, employment and a place in society and including effective transitions between child and adult services.

This priority is about making sure that people that have mental health problems are able to recover well and manage their condition effectively so they have a better quality of life. People with serious or on-going mental health problems are often prevented from being able to care for themselves effectively and to access opportunities to live with greater independence. They often have complex needs linked to their poor mental health and may be frequently vulnerable.

We can make a positive impact on this by:

- ***Support recovery*** – some people are likely to have a continuing need for care. In each case, each person should be a partner in the planning and delivery of support that is orientate towards opportunities for their recovery. This should include access to appropriate care, housing and employment to find a place in society, and to live according to their needs, choices and preferences.

- ***Providing equal access*** *to services* – by making sure that everyone can access both physical and mental healthcare.

- ***Taking a personal approach*** – this means making sure that the individual contributes to the development of their care plan to provide a better chance of recovery and help individuals to manage their condition well.

- ***Providing appropriate environments for treatment*** – by making sure that when people with severe mental health problems need treatment they receive it in the least restrictive environment possible. People should not be admitted to hospital or residential care if there are other options available where, with the right support, they can keep more of their independence.

- ***Working with the whole family*** – where one member of a family has a mental health condition we should work with the whole family and put together a package of support together for all family members.

Our vision for 3 years from now

To promote recovery from mental health problems by making sure effective support is in place at every stage, and to further develop support in the community.

Some of the suggested key actions to achieve:

- Ensuring those with mental health problems have effective support offered in their recovery and rehabilitation by ensuring evidenced based care pathways are in place to provide appropriate care, housing, employment and a place in society

- Commissioning appropriate support to empower individuals, their families and carers to cope with the hurdles on the path to recovery

- Working with providers of services such as police, housing, employment support, benefits support and advice, education and training to help them better understand and meet the needs of those with on-going mental health problems

- Maximising opportunities for effective partnership working across agencies to provide effective support for vulnerable adults, including sharing of information where appropriate and patient consent is given (N.B. not including confidential or individual data)

- Continuing to monitor the flexibility and choice of accommodation and social support that is available for citizens with on-going needs

- Ensuring that services are provided in a way that enhances choice and control for the user, whilst also meeting the needs of the local population

- Continuing to review placement of patients in residential mental health care settings to ensure that their needs are met in the best way possible whilst maximising best use of NHS rehabilitation services

- Helping those with mental health problems find help and support for issues such as housing, financial advice and support into work.

Priority 5*: Improving wellbeing and physical health of those with mental health problems*

– By ensuring good physical care for people with mental health problems. This includes physical health promotion and ill health prevention strategies, particularly in relation to heart disease and smoking.

The factors that affect poor mental health can also contribute to poor physical health. These can include social factors, such as homelessness, domestic abuse, deprivation and unemployment, stressful life events, and health related behaviours, such as smoking, alcohol or substance abuse.

People with mental health problems have poor physical health outcomes and research shows that they die far younger (15-20 years younger for people with schizophrenia)[85,86]. Many of these early deaths are from preventable causes related to unhealthy lifestyle behaviours particularly smoking.

In 2006 a formal investigation by the Disability Rights Commission, Equal Treatment: Closing the Gap[87] identified obesity, high blood pressure, smoking, heart disease, respiratory disease, diabetes and stroke as being more prevalent in people with mental health problems and also identified higher rates of bowel cancer in people with schizophrenia. Standard treatments and screening were offered less to these groups.

For people with long term physical conditions, the Kings Fund identified that “people with long term physical conditions and mental health problems disproportionately live in deprived areas and this interaction makes a significant contribution to generating and maintaining inequalities”[31].

We can have a positive impact on this by:

- ***Adopting a ‘Parity of Esteem’ approach*** which aims to keep mental and physical aspects of health linked, and gives each equal priority. Services and health workers have traditionally focussed on one aspect or the other, which can lead to gaps in addressing health needs.

- ***Reducing the gap in health inequalities for those with mental health problems*** is a current focus, it is also important to retain the goal of holistic care for all. As well as improving treatment of physical health needs, all health services need to ensure mental health problems are detected early and addressed promptly for their service users. This is particularly relevant for those with long term conditions, but is also applicable to people who require treatment for acute health needs, for example following heart attack or trauma.

- ***Improving mental health*** – we need to reduce the number of people with long term health conditions and other physical illnesses from developing mental health problems and support them to play their part managing and improving their health using self-care programmes.

Our vision for 3 years from now

To improve the physical health of people with mental health problems and to support people with long term physical conditions to effectively manage their mental health.

Some of the suggested key actions to achieve:

- Increase understanding and awareness of the factors that influence the poor physical health outcomes for people with mental health problems

- Improving physical health – by making sure that people with mental health problems have access to health improvement services, such as stop smoking support, organised sports or exercise programmes and a range of social activities e.g. through youth services for children and young people. It also includes driving up the number of people with mental health problems that take part in national screening programmes, such as cervical and bowel cancer screening tests and immunisation programmes including HPV and seasonal influenza

- Ensure health services identify physical health problems in people with mental health problems and that appropriate treatment is accessible

- Keep the 'parity of esteem' approach central to the commissioning of all health services to ensure both mental and physical health aspects are taken into account.

8. MONITORING OUTCOMES

The overall aim of this strategy is to improve the mental health and wellbeing of the population of Nottinghamshire by effectively preventing mental health conditions and ensuring appropriate access and delivery of mental health and social care services.

Measuring mental health outcomes is complex due the level, types and complexity of mental health problems. Also, mental health prevalence data has its limitations as mental health problems can go under diagnosed or under reported. Also, mortality data, such as suicide data lacks timeliness and does not capture the prevalence of mental illness, nor the disability it causes.

Therefore, in order to monitor this strategy's progress and outcomes we will be looking at a number of key indicators. These indicators are found and incorporated into:

- The three national outcomes frameworks: the Public Health Outcomes Framework, the NHS Outcomes Framework and the Adult Social Care Outcomes Framework. Each of these include specific indicators to monitor a range of mental health outcomes, **Appendix 1**
- The Department of Health (DH), No Health without Mental Health dashboard (December,2013)[88] brings together a number of indicators for a wide range of sources to reflect progress against the national mental health strategy. These indicators are outlined that in **Appendix 2.** Nationally, data and benchmarking against these indicators is in the process of being developed
- The Nottinghamshire Health and Wellbeing strategy – 2014-2016

The priorities of this strategy are also linked with other local strategies and drivers, outlined in **Appendix 3.**

9. TAKING THE NOTTINGHAMSHIRE MENTAL HEALTH STRATEGY FORWARD

Leadership

To realise the aims of the Nottinghamshire Mental Health Strategy and in order to see real improvement in Nottinghamshire we need Mental Health leaders and champions at all levels across the health, social care and voluntary sectors.

Improving mental health is '***everyone's business'***, but clear leadership needs to be demonstrated by partnership organisations, including those in the third sector.

Those of particular note are:

- Councillors and officers in Nottinghamshire County Council (the Council has already committed to prioritise mental health by signing up to the ***Mental Health Challenge***[89]). The Mental Health Challenge is a new concept where local councils through a mental health leadership role help in the promotion of good mental health in their communities and to ensure people with mental health conditions have better, more fulfilling lives. Member champions for mental health can also help to raise awareness about mental health in Nottinghamshire.

- ***Senior leaders,*** including commissioners and mental health clinical leads, from NHS Nottingham West, Nottingham North and East, Mansfield and Ashfield, Newark and Sherwood, Rushcliffe and Bassetlaw Clinical Commissioning Groups and Nottinghamshire County Council Adult and Children's Social Care.

- ***Service providers*** including Nottinghamshire Healthcare NHS Trust, Sherwood Forest Hospital Trust, Doncaster and Bassetlaw Hospital Trust, Nottingham University Hospitals, Nottinghamshire and Bassetlaw Health Partnerships, Nottinghamshire County Council and the voluntary sector.

There is a need to agree a clear way forward to ensure the strategy is implemented, including the development and delivery of detailed action plans for each of the five strategic priorities. Further strategic work will include ensuring that children's, adults and older peoples mental health work is monitored fully and is linked with agreed suitable targets for assessing progress.

Governance

The strategy is owned by the Nottinghamshire Health and Wellbeing Board and steered by the Mental Health leads. Implementation and progress of this strategy will be monitored by the Nottinghamshire Health and Wellbeing Implementation Group (HWIG).

The Nottinghamshire CAMHS, Adult and Older People's Mental Health Strategy Integrated Commissioning groups comprising of key stakeholders will be responsible for overseeing the implementation of this strategy and the quarterly progress reporting to the HWIG.

The overarching leadership for each of the five priorities will be developed and consist of the most appropriate mental health leaders and champions.

Action Plans

A detailed action plan will be developed following this consultation on this strategy. Working groups will be set up to achieve each of the five priorities in this strategy.

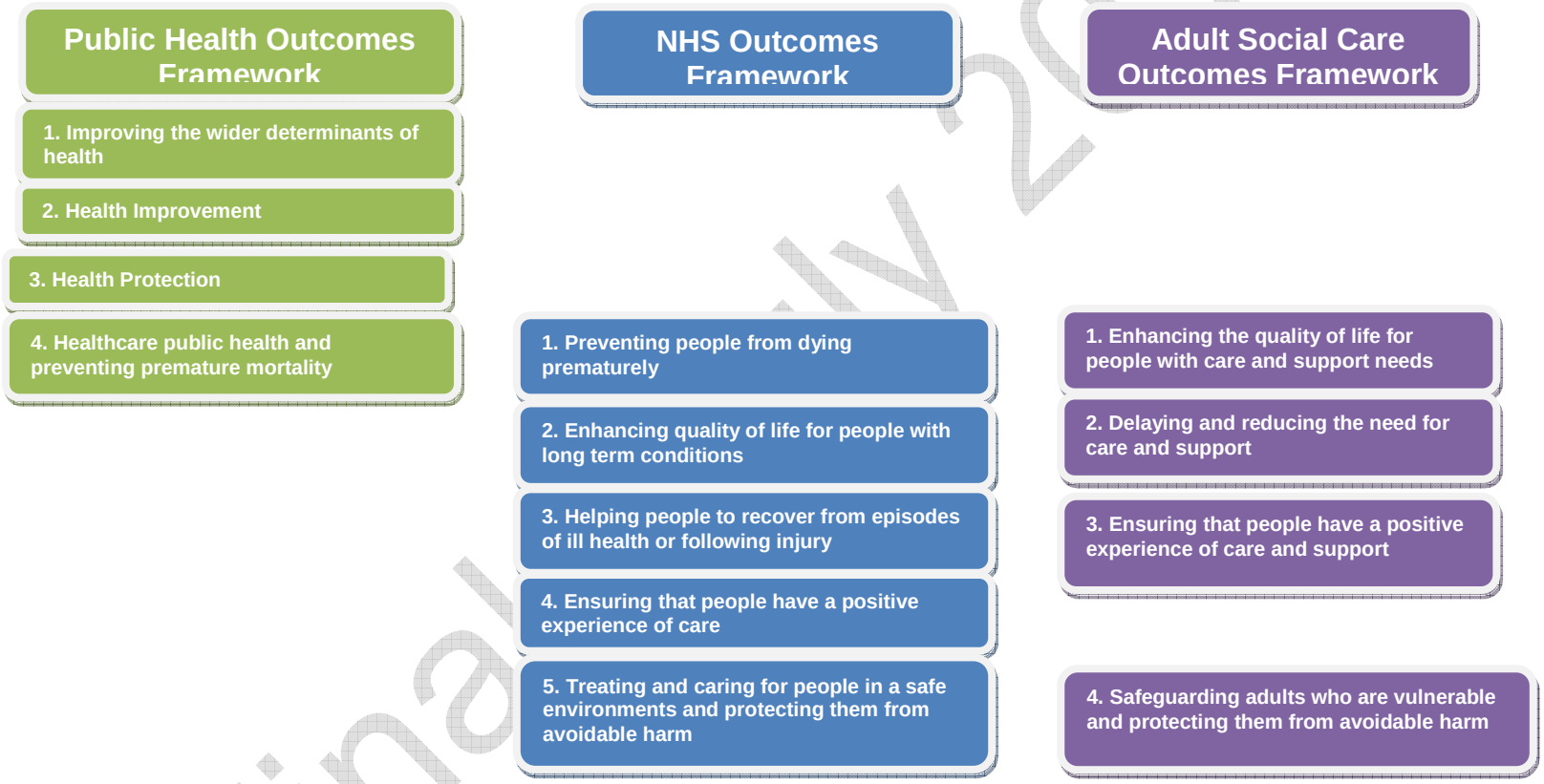
Equality impact assessment

An equality impact assessment (EIA) is an assessment to ensure that policies do not discriminate and that where possible, equality is promoted. A full equality impact assessment of this strategy will be undertaken in accordance with the Nottinghamshire County Council Equality and Diversity Policy. Further equality impact assessment will be undertaken on the action plans resulting from this strategy.

Appendices

Appendix 1: below shows the relationship of the overarching domains of all three Frameworks.

The three outcomes frameworks



Source: Improving health and care: the role of the outcomes frameworks, DH 2013

APPENDIX 2: DH MENTAL HEALTH DASHBOARD MEASURES

1. More people have better mental health	2. More people with mental health problems will recover	3. More people with mental health problems will have good physical health
Mental health and wellbeing of the whole population • Self-reported wellbeing (PHOF) • Percentage of the population with possible mental health problems (HSE) • Percentage of the population with long-term mental health problems (HSE) • Number of days lost due to common mental illness (LFS) ***Wider determinants of mental health and illness*** • Number of households accepted as being homelessness (PHOF) • Number of homeless households in temporary accommodation (PHOF) ***Low Income Households*** • Proportion of people in households with income below 60% of the median net disposable household income (HBAI) ***Illicit drug use*** • Proportion of 16–24 year-olds who are frequent drug users • Proportion of 15–64 year-olds using opiates or crack cocaine	***Care and treatment*** • Proportion of people with anxiety or depression are accessing Psychological Therapies (IAPT services) (NHS OF) • Proportion of people who complete IAPT treatment who are moving to recovery (NHS OF) ***Recovery and quality of life*** •Proportion of people with a mental illness are in employment (NHS OF, ASCOF, PHOF) •Proportion of people with a serious mental illness and of working age are in employment (NHS OF, ASCOF, PHOF) •Proportion of people with mental health problems are in stable accommodation (MHMDS) (PHOF, ASCOF) •Number of people with a mental illness have a social care quality of life (ASCOF)	***Physical health of people with serious mental illness*** Excess under 75 mortality rate in adults with serious mental illness (NHS OF) ***Physical health of people with mental health problems*** • Proportion of people with a long term physical health conditions with a long term mental health problems (GPPS) • Proportion of people with a long term mental health problems with a long term physical health conditions (GPPS) • Proportion of people with a possible mental health problem misuse alcohol (HSE) • Proportion of people with a possible mental health problem that are obese (HSE) • Proportion of people with a possible mental health problems that are current smokers(HSE)
4. More people will have a positive experience of care and support	**5. Fewer people will suffer avoidable harm**	**6. Fewer people will experience stigma and discrimination**
Detention • Number of people that are formally detained subject to the Mental Health Act (MHMDS) • Percentage of all detained patients subject to the Mental Health Act from a Black and Minority Ethnic (BME) background (MHMDS) • Number of people subject to Community Treatment Orders (CTOs) at 31st of March in each year (MHMDS) ***Satisfaction with mental health services*** • Percentage of patients with positive experiences of mental health services (NHS OF) (CMHS) • Percentage of patients with an overall satisfaction with services among people with mental health related social care needs (ASCOF)(ASCS) • Proportion of people with long term mental health problems feeling supported to manage their condition (NHS OF) (GPPS)	***Safety incidents in mental health settings*** • Safety incident reports (ONS) (per 100,000) (NHS OF) • Safety incidents involving severe harm or death (per 100,000) (ONS) (NHS OF) ***Suicide and self-harm incidents*** • Suicide rate (ONS) (per 100,000) (PHOF) • Self-harm rate (PHOF)	***Knowledge, attitudes and behaviour amongst the general public*** • Mental health related knowledge (IOP) ***Attitudes towards metal health amongst the general public*** • Attitudes towards mental illness (IOP) • Reported intended behaviour in relation to people with mental illness (IOP) ***Service users' experience of stigma and discrimination*** • Proportion of people who use secondary mental health services who have no experience of discrimination (IOP) • Proportion of people who use secondary mental health services who feel confident in challenging stigma and discrimination (IOP)
KEY:		
Link to Outcomes Frameworks ASCOF – Adult Social Care Outcomes Framework NHSOF – NHS Outcomes Framework PHOF – Public Health Outcomes Framework	**Links to other sources** • (APS) – Annual Population Survey • (CCG OI) Clinical Commissioning Group Outcomes Indicator • (CMHS) – Community Mental Health Survey • (GPPS) – GP Patient Survey • (LFS) – Labour Force Survey • (HBAI) – Households below average income survey for	• (ASCS) – Adult Social Care Survey Change • (CSEW) – Crime Survey for England and Wales • (HSE) – Health Survey for England • (IOP) – Institute of Psychiatry survey for Time to • (MHMDS) – Mental Health Minimum Dataset

Appendix 3: Local Policy Drivers

Key local documents

- **Nottinghamshire and Nottingham City Suicide Prevention Strategy 2014-2017 (draft)**
- **Nottinghamshire Joint Strategic Needs Assessment (JSNA)**
- **Nottinghamshire Health and Wellbeing Strategy 2014/16**
- **Nottinghamshire Dementia Strategy 2013**
- **Nottinghamshire Children and Young People Mental Health and Emotional Wellbeing Strategy 2014-16**
- **The Mental Health and Emotional Well-being of Children and Young People in Nottinghamshire – Health Needs Assessment 2013**
- **Public Health, NHS and Adult Social Care Outcomes Frameworks**
- **Nottinghamshire Workplace Health strategy 2014-2017 (draft)**

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Nottinghamshire County Council

Report to the Health and Wellbeing Board

3 September 2014

Agenda Item: 11

REPORT OF THE CHAIR OF THE HEALTH AND WELLBEING BOARD

CHAIR'S REPORT

Purpose of the Report

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

Information and Advice

2. Leaving Hospital Policy

The South Nottinghamshire Leaving Hospital Policy is a joint health and social care strategy to reduce the pressures on the acute hospital by ensuring that people do not stay in hospital once they have been identified as medically stable. Patients who are waiting for a placement in a care home of choice or for a care package at home will then be required to move out of hospital into alternative suitable provision until their preferred care services become available. This will enable patients to have their needs met in an appropriate community setting with increased opportunities for recovery and for regaining independence. A copy of the policy is attached as Appendix 1.

Effective communication is central to the success of managing choice on hospital discharge and is being supported by the whole health and social care community. Regular communication across health and social care services in the form of leaflets, posters and verbal communication will reinforce the message that once patients are clinically ready for discharge they will not be able to continue to occupy an inpatient bed. If they require further care, they will be moved to an alternative community setting where their care needs can most appropriately be met. A communication strategy will be initiated by all partner agencies to reduce the potential for misunderstanding or failure to adhere to this policy and to ensure it is implemented effectively and fairly.

For further information contact: Caroline Baria, Service Director email: caroline.baria@nottscc.gov.uk or tel: 0115 97 74892.

3. Encompass

The Encompass Nottinghamshire initiative is being launched from September 2014 to inform schools of domestic abuse incidents involving children (aged 4-18).

Encompass Nottinghamshire creates a process to embed routine, intelligent and timely information sharing between the council, police and schools regarding domestic violence.

The Encompass model informs schools of medium and high risk domestic violence incidents (involving children) which have been reported to the police by the next working day. The information is communicated from the Multi Agency Safeguarding Hub (MASH) to the 'Key Adult' in the school, usually the designated Safeguarding Lead. This includes domestic violence incidents that children are involved in or witness, and households in which children live but are not present at the time of the incident. This model enables schools to have more accurate information on the factors impacting on a child's life so that they are more aware of the family situation and understand its impact.

This initiative is also being extended to pre-school aged children (0-4) through the Early Help Unit. The initiative is being trialled in Newark, Sherwood and Rushcliffe from September 2014. Briefings on the process and support pathways are being held in schools and Children's centres in these districts in September . An evaluation will follow with further rollout in 2015.

For further information contact: Amy Newbery email: amy.newbery@nottscc.gov.uk tel: 0115 9773372 or 07843551506

4. Mental Health Challenge

The Mental Health Challenge is a national initiative recognising the key role of local government in improving mental health in their communities.

Local Councils, through a mental health leadership role, help in the promotion of good mental health in their communities and help to ensure that people with mental health conditions have better, more fulfilling lives.

Nottinghamshire County Council has signed up to the Challenge with Councillor Bosnjak acting as the lead mental health champion locally. Councillors and Officers are being sought to act as mental health champions to help raise awareness of mental health in Nottinghamshire.

For further information contact: Susan March, Senior Public Health Manager email susan.march@nottscc.gov.uk or tel: 01623 433216.

5. Stakeholder Network Event – relationship with the voluntary and community sector

The latest stakeholder network event was held on 9 June 2014 and focussed on the relationship between the Health and Wellbeing Board and the voluntary and community sector. It was attended by around 90 people.

Feedback from the event included:

- The voluntary and community sector are very keen to be involved with and support the Board to improve Health and Wellbeing in Nottinghamshire, including delivery of the Strategy and in development of the Joint Strategic Needs Assessment (JSNA).
- The Stakeholder Network is a key opportunity for direct involvement with the Board
- Communication needs to be improved to ensure that all stakeholders are aware of the work of the Board and how to get involved. Plain language and accessibility are key.

- There has been work in some Clinical Commissioning Group (CCG) areas to develop a directory of services to help professionals and the public and this should be extended across the county.

A summary of the event is attached as Appendix 2.

For further information contact Nicola Lane, Public Health Manager email: nicola.lane@nottscc.gov.uk or tel: 0115 977 2130

6. Winterbourne Project update

The Department of Health (DH) report 'Transforming Care: A National Response to Winterbourne View Hospital' was published in December 2012. Work has been ongoing in Nottinghamshire to deliver actions required locally and nationally to drive up the quality of support provided to people with learning disabilities (and particularly to those identified as having challenging behaviour) and regular updates on progress have been made to the Health and Wellbeing Board.

The current position in Nottinghamshire is as follows:

In April/May 2013, 28 people were assessed as being ready to leave hospital by June 2014.

So far, 18 people have moved out, including 1 person whom we did not think would be ready to move but recovered better quickly.

- 4 of these people have moved to a new residential service where they will live until their supported living is built – expected to be October 2014.
- 8 people have moved directly into supported living services.
- 6 people have moved into residential care.

11 people who were expected to be ready to move have not done so. This is due to:

- 3 people not being given Ministry of Justice permission to leave yet.
- 6 people who have not recovered as quickly as expected and are still having treatment.
- 1 person did move out but then went straight back to hospital because he did not want to leave. Work is continuing with him to help him move again.
- 1 person's placement did not work out as they visited the service for an overnight stay before moving in and did not get on with the other people living there. Other options for this person are being considered.

Work is continuing with all of the people still in hospital to make sure the right accommodation and support is ready for them when they do leave. This is an ongoing programme with up to another 30 people likely to be ready to leave hospital in the next 2 years.

A strategy to address the needs of people who challenge services, to reduce hospital admissions and reduce the length of stay should admission be required has been written (copy attached as Appendix 3 for information). This strategy is intended to be a working document which will be reviewed and updated regularly with an action plan being produced each year to target specific areas. The Winterbourne Project Board continues to meet and the project manager post runs to March 2015, and may be extended, to ensure that the momentum for this work is continued.

For further information contact: Cath Cameron-Jones Commissioning Manager, email: cath.cameron-jones@nottscc.gov.uk or tel: 0115 9773135

7. Health and Wellbeing Board Peer Challenge

An expression of interest for the Health and Wellbeing Board Peer Challenge was discussed at the July 2014 Board meeting. It was subsequently submitted and has been successful. Caroline Bodset has been assigned as peer challenge manager to the Nottinghamshire Board.

An introductory meeting to plan the review will be held with key members of the Board and Council in October and the full review is due to take place between 3rd and 6th February 2015.

Health and Wellbeing Board members are asked to hold these dates in their diary for participation in the review. Further information will be circulated following the scoping meeting.

For further information contact: Cathy Quinn, Public Health email: cathy.quinn@nottscc.gov.uk tel: 0115 9772882.

8. NHS Premises

The Board had previously raised concerns regarding the standard of NHS premises locally. These concerns were raised by the Chair and Vice Chair in a letter to the Regional Director of NHS Property Services.

A response to this letter has now been received providing assurance that these concerns will be investigated and addressed. The letter and response are attached as Appendix 4 and 5.

For further information contact Nicola Lane, Public Health Manager email: nicola.lane@nottscc.gov.uk or tel: 0115 977 2130.

Statutory and Policy Implications

9. This report has been compiled after consideration of implications in respect of crime and disorder, finance, human resources, human rights, the NHS Constitution (Public Health only), the public sector equality duty, safeguarding of children and vulnerable adults, service users, sustainability and the environment and ways of working and where such implications

are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

RECOMMENDATION/S

1) That the report be noted.

Councillor Joyce Bosnjak
Chairman of Health and Wellbeing Board

For any enquiries about this report please contact:

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

Constitutional Comments

10. This report is for noting only.

Financial Comments

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

Background Papers and Published Documents

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

- None

Electoral Division(s) and Member(s) Affected

- All

APPENDIX 1

SOUTH NOTTINGHAMSHIRE HEALTH AND SOCIAL CARE COMMUNITY

LEAVING HOSPITAL DIRECTIVE POLICY & GUIDANCE

1. BACKGROUND

Most people return home after a period of acute care, some after a period of intermediate care. Increasingly, in line with the policy of supporting independent living, those who are immediately unable to return to their previous place of residence are offered more appropriate extra care housing or other provision.

The South Nottinghamshire health and social care community is working together to develop a model of 'transfer to assess'. The objective of this is to ensure that patients who are having a supported transfer of care from the hospital move within 24 hours of being medically safe for transfer to a suitable environment for them to receive further assessment of their long term needs.

Where a place is not available in the individual's preferred residential or nursing care home or there is a wait whilst packages that will support the citizen from returning home are put in place, remaining in an acute hospital setting is undesirable both for the patient and for other patients trying to access care within that hospital. There are particular risks of increasing dependency and acquiring infections. In addition the acute care provision is needed for those with acute care needs.

This policy is needed to support the timely, effective transfer of care of medically fit patients, ready for discharge from an NHS inpatient setting who need to move into a care home. It is to be used in conjunction with the Hospital Discharge Policy and is for use by all staff with responsibility for arranging the transfer of care for patients. It is based on direction given by the Department of Health in the document, 'Discharge from Hospital: Pathway, process and practice (2003) and 'NHS Responsibility for meeting Continuing Health Care Needs' (HSG (95)5)

2. AIM AND OBJECTIVES

The aim of this policy is to reduce the length of time a patient waits in an acute hospital bed whilst waiting to be transferred to a care home of choice. In particular the policy aims to

a) Be patient centred, aiming to improve the welfare of the patient and minimise frustration and distress.
b) prevent the development of expectation that a person may stay in the hospital indefinitely
c) offer guidance to staff who have responsibility in arranging the transfer of care from hospital of those patients who need to move to a care home
d) ensure that there is a clear escalation process in place for when patients remain in hospital longer than is clinically required
e) ensure NUH inpatient beds will be used appropriately and efficiently for those who require that service.

3. PATIENT GROUP

The policy needs to apply to patients who meet the following criteria:

1. The patients' needs cannot be adequately provided for in their usual place of residence

2. The agreed initial assessment shows that the patient can be discharged from hospital, requires a nursing home or residential care home (and this placement will be funded by either a patient, Adult Social Services or the NHS) or requires care at home, but is waiting for the package to be ready
3. The patient has identified a preferred home, or is having difficulty in identifying one.
4. The patient is unwilling to be discharged until a preferred placement is available
5. An interim, or alternative long term placement exists which meets the patients assessed needs.

4. UNDERLYING PRINCIPLES / STANDARDS

- All patients should be treated fairly and without discrimination
- Patients, relatives and carers should be fully involved from the beginning in the discharge planning process which should be initiated when the patient is admitted to hospital. This adheres to the Hospital Discharge Policy.
- If the patient is unable to contribute to the assessment the wishes and views of their relatives and carers must be sought.
- The patient, their relatives, carers or advocate should be informed at the outset of planning that while every effort will be made to transfer the patient to the home of choice, if the home has no vacancy an interim arrangement will need to be made.
- Patients would only be expected to make one move before entering the care home of their choice
- If the patient is awaiting a care home, the patients name will remain on the list for their preferred choice whilst they are discharged to an alternative or interim location.

5. MANAGING CHOICE

5.1 Communication to patients

Communication is central to the policy for managing choice on hospital discharge. This policy should be supported by the whole health and social care community – ensuring regular communication across the system (through posters, leaflets etc.) to reinforce the message that once patients are clinically ready for transfer they cannot continue to occupy an inpatient bed.

Interactions with patients and or representatives will need to acknowledge and offer support with any concerns, whilst reinforcing the message that everyone will work towards the patients discharge from hospital. At the time of admission, all patients must understand that once they are clinically ready for transfer of care they cannot continue to occupy the inpatient bed. See Appendix 1 and 2. All patients must understand that they will be supported by a social worker and given relevant information to help them choose an interim placement (where a choice is available) until a vacancy becomes available in the home of their choice.

5.2 Support for patients who lack capacity to make decisions

If the patient has been assessed as lacking capacity to make decisions around their transfer of care and is unable to contribute to the assessment, a best interests decision must be made. Under the Mental Capacity Act, s4(7), the decision maker has a duty to take into account the views of significant others where it is practical and appropriate to do so (see paragraph 5.49 of Mental Capacity Act Code of Practice (p84) for who should be consulted when working out someone's best interests).

It is essential that staff determine at admission whether the patient has, an Advance Decision to Refuse Treatment (ADRT), statement of wishes and feelings, a Lasting Power of Attorney for Health and Welfare or Property and Affairs or is under a Safeguarding protection plan and the contact details of those persons who manage any of these instruments.

In circumstances where a patient lacks capacity and has no 'significant other' able to contribute to a Best Interests decision, then an Independent Mental Capacity Advocate (IMCA) must be appointed if the decision for transfer of care necessitates a change in the venue of care from that pertaining at admission and is likely to be effective for a period longer that 28 days (Mental Capacity Act 2005; MCA Code of Practice, Chapter 10).

5.3 Escalation process

When the Multi-disciplinary team is certain the key principles have been met, that the patient's eligibility for Continuing Healthcare has not altered and that the patient or their relative/carer/advocate on the patients behalf refuses to leave hospital to an address other than the care home of choice then the following escalation process must begin.

- Responsible Consultant to meet with patient, family and MDT to advise that the patient no longer requires an Acute Care NHS bed and that an alternative arrangement must be made.

The following points should be confirmed:

- The patient no longer requires the services of an acute hospital and that the MDT decision is to transfer their care
- The inadvisability of remaining in hospital for the patient (i.e. that the acute hospital environment is no longer of benefit)
- Ensure that all necessary information and support is available to the patient and all involved in the selection of appropriate venues of further care.
- Confirm with the Social Worker or advocate that an appropriate placement which is able to meet the persons care needs is available within the area.
- Explain to the patient and carers that a further period of up to seven days from the date of the meeting is available in which to find an appropriate venue for further care.

If, after a further 5 days there are no indications that transfer of care is imminent, the Ward Manager should inform the responsible provider Head of Service.

- The Head of Service should convene the Final Review Meeting and invite the patient, family or advocate attending in order to mandate and action the transfer of care plans. This should be confirmed in writing and posted by recorded first class delivery.
- This meeting should take place within 2 working days of the expiry of the extended period (maximum 2 weeks from completion of assessments).
- The Hospital Adult Services Team Manager (if Social Services are involved) should be invited to attend. It is recommended that a 'minute taker' be appointed.
- If it becomes apparent at this meeting the patient/relative/advocate, do not intend finding a placement immediately, it should be advised that the Trust may instigate legal proceedings to ensure that the patient is transferred to an appropriate placement.
- The details of this meeting must be sent to all attendees including the responsible Consultant, relative/carer/advocate, Trust Legal team, Executive Directors

If there is no agreement to a placement within this meeting, then a meeting should be convened to discuss, assess risk and plan the patients transfer to a care facility which meets their assessed need, where necessary taking legal action to ensure this happens.

Attendees should include Head of Service, Director of Operations, General Manager or Clinical Lead, Adult Services Team Manager and NUH Legal Services Officer.

6. MEETING THE COSTS

For self- funding patients who are waiting for a care home of choice, they will not be required to pay for an interim placement for a maximum of 2 weeks.

Where the cost of interim accommodation is higher than the usual cost paid by Social Services due to a shortage of care homes, market conditions or other commissioning difficulties the person and/or third parties should not be asked to pay more towards their accommodation than s/he would normally be expected to contribute.

7. MONITORING AND REVIEW

This policy will be monitored by an on-going programme of weekly audit of the delayed discharges reported by the ward staff as being delayed due to ‘awaiting placement in care home’ or ‘patient or family choice’ by the Care Co-ordination team manager.

Nottinghamshire Health and Wellbeing Board Stakeholder Network
9 June 2014

This event was held at the Summit Centre, Kirkby in Ashfield and was attended by around 100 people from across the voluntary and community sector as well as Clinical Commissioning Groups (CCG), the County and borough/district councils, Nottinghamshire Police and healthcare providers.

Councillor Joyce Bosnjak opened the event and gave an overview of the Health and Wellbeing Board and gave an overview of the Board and its progress to date. She stressed that integration was a key priority for the Board and that the voluntary and community sector were vital to achieving that.

Chris Kenny, Director of Public Health and Kristina McCormick gave an overview of the **Joint Strategic Needs Assessment (JSNA)** which identifies the health needs in Nottinghamshire and is a core responsibility of the Health and Wellbeing Board. Cathy Quinn then launched the **Health and Wellbeing Strategy** for Nottinghamshire which the Board has agreed to address those needs identified by the JSNA.

Val Gardiner and Penny Spice gave an overview of current partnership arrangements supporting carers in Nottinghamshire.

The Group then split to discuss how the Health and Wellbeing Board and the voluntary and community sector (VCS) could work together in the future. Points raised included:

- The VCS are very keen to be involved and to support the Board to improve Health and Wellbeing in Nottinghamshire.
- There were numerous opportunities to get involved and to influence health and wellbeing policy in Nottinghamshire. The Stakeholder Network being a key opportunity to speak to Board members directly.
- The VCS could have a direct involvement in the JSNA process and had a lot of information which could feed into that.
- A joined up approach would help – 'coordinated listening' from the Board, CCGS, the County Council and Healthwatch and coordinated consultations so that people were only asked for information once.
- Organisations needed to feel that they were being listened to and that action was being taken as a result of their views.
- The VCS could get messages out from the Health and Wellbeing Board into local communities.
- Communications from the Board could be improved including developing the website, utilising networking groups, ebulletins and using social media.
- A variety of methods of engagement were necessary as 'one size doesn't fit all' and plain language and accessibility were key.
- It would help to map local VCS services to form a directory to help professionals and the public. There were good examples of how this had been achieved for individual Clinical Commissioning Groups and it was agreed that this should be shared across other areas.

- The voluntary and community sector is a large part of the local health and wellbeing system but many organisations work in isolation and there needs to be some coordination across the sector using existing networks like NAVO and the Community and Voluntary Services (CVS's) where possible.

- The scope and capability of the third sector isn't well understood and commissioners need to consider their work when scoping services.

- Some of the smaller organisations found it difficult to be heard and had limited capacity for development but could also support the work of the Board.

- There are existing networks which would be used for communications and engagement including NAVO and the CVS's across the county – these networks should be used wherever possible to circulate information and involve VCS organisations.

- Since the changes within health and social care it was difficult to know who was responsible for what.

- The Health and Wellbeing Strategy was the cornerstone which would bind everyone together and the Delivery Plan would under pin that and identify leads for each priority action.

Next steps

A report will be presented to the Health and Wellbeing Board at the meeting to be held on 3 September 2014 and will include feedback from this event.

The next Stakeholder Network event will take place on Monday 10 November 2014 and will focus on Homelessness.

There would be an annual Stakeholder Network event for the voluntary and community sector and the Health and Wellbeing Board.

Useful links

Nottinghamshire Insight – Joint Strategic Needs Assessment
http://jsna.nottinghamcity.gov.uk/insight/Strategic-Framework/Nottinghamshire-JSNA.aspx

Nottinghamshire Health & Wellbeing Strategy 2014-17
http://www.nottinghamshire.gov.uk/caring/yourhealth/developing-health-services/health-and-wellbeing-board/strategy/

Presentations from the event on 9 June 2014
http://www.nottinghamshire.gov.uk/caring/yourhealth/developing-health-services/health-and-wellbeing-board/stakeholdernetwork/?entryid282=410962

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

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

Commissioning in Nottinghamshire to meet the needs of people with behaviours which challenge services

Introduction

This strategy is a local document, written in response to the Department of Health's Winterbourne Concordat and sets out the key aims and objectives for working across health and social care to deliver services in the community to people with a learning disability or autism who have challenging behaviour and/or mental health issues. It also maps current provision and makes recommendations for further work to improve current services and identify gaps in service. Each year the strategy will be reviewed to ensure it reflects the needs identified within Nottinghamshire and an annual action plan will be drawn up to prioritise and address the areas outlined in the strategy.

1) Background

Valuing People 2001 was based on the core principles of rights, independence, choice and inclusion. The 2009 update, Valuing People now, reiterated this should be for all people with a learning disability, including those with profound and multiple disabilities or those who challenge services.

Mansell Report 2007 – Championed the development of local services to meet the needs of people with challenging behaviours to avoid out of area placements being made.

Winterbourne 2012 - The report following the Panorama exposure of the appalling treatment of individuals in one learning disability secure hospital gave a clear instruction that people should not be left in secure hospitals because there were no other services for them and that areas needed to develop appropriate local community services.

Ordinary life – this is a principle which has been around since the 1980's and influenced Valuing People. These values have been restated in the United Nations Convention on the Rights of Persons with Disabilities (ratified by the U.K. in 2009), especially Article 19 Living Independently and Being Included in the Community.

'State Parties….recognize the equal right of all persons with disabilities to live in the community, with choices equal to others, and shall take effective and appropriate measures to facilitate full enjoyment by persons with disabilities of this right and their full inclusion and participation in the community'

The convention identifies three building blocks to advance this principle

- Self- determination: 'I can say what matters to me and how I want to live'.
- Personalised support: 'I get the assistance I need to live as I want'.

- Inclusion: ‘I’m included in my community and benefit from its services’.

2) Purpose

The purpose of this strategy is to identify the needs, current provision and changes which need to be made to ensure Nottinghamshire can support people with learning disabilities and/or autism with behaviours which challenge services, within the local community.

3) Outcomes

- More people with learning disability being supported to live at home
- Fewer people developing behaviour that challenge and those who do being kept safe in their communities
- Fewer people being admitted to secure hospitals
- Any hospital stays kept as short as possible.
- Any hospital stays being as close to the individual’s home and support networks as possible

4) Principles

- We will work in partnership with individuals and their families to develop person centred solutions

- We will work in partnership across health and social care commissioners to develop local, community based housing and support solutions with appropriate clinical and care management support.

- We will work in partnership with clinicians, care mangers and providers to ensure expertise is shared

- We will ensure appropriate risk assessments are undertaken and strategies put in place to manage risk, whilst promoting a culture of positive risk taking.

- We will develop cost effective services which promote individuals independence.

- We will develop a ‘no blame’ culture – so we can learn from mistakes and share good practice going forward. We will develop an evidence base by tracking the support of individuals, what has worked and not worked. This involves developing an outcomes framework and a costing analysis.

- We will ensure a shared commitment to achieving outcomes based on “ordinary life‟ principles

5) What is Challenging Behaviour?

The Challenging Behaviour Foundation have adopted Emerson's definition of challenging behaviour

"Culturally abnormal behaviour(s) of such an intensity, frequency or duration that the physical safety of the person or others is likely to be placed in serious jeopardy, or behaviour which is likely to seriously limit use of, or result in the person being denied access to, ordinary community facilities."(1)

The term "challenging behaviour" has been used to refer to the "difficult" or "problem" behaviours which may be shown by children or adults with a learning disability including:

- Aggression (e.g. hitting)
- Self-injury (e.g. head banging)
- Destruction (e.g. throwing objects)
- Other behaviours (e.g. running away)

Challenging behaviour can occur for a number of reasons and is likely to be a response from a person who is unable to make themselves heard in any other way. This can be due to factors such as mental ill health or physical or emotional pain, coupled with communication difficulties. This can be exacerbated or even caused by things such as poor support, lack of understanding from carers/support staff, over or under stimulating environments, physical illness and pain.

Poor support can mean individuals develop challenging behaviour. Getting the right support in the right environment is therefore key to reducing challenging behaviour and ensuring a better quality of life for the individuals.

6) What does 'good' look like?

In practice a local service would include

- a range of small-scale housing, work, education and other day placements into which markedly different levels of staff support could be provided on the basis of individual need at a particular time
- sufficiently skilled workforce to reduce the probability of challenging behaviour emerging or worsening throughout the service, and to provide a pool of sufficient skill to help services work through difficult periods
- skilled professional advice from a full range of specialists, working in a coordinated and genuinely multi-disciplinary way, and backed-up by good access to generic services (including mental health services)
- services providing a range of meaningful therapeutic activities to enable individuals to establish fulfilled lives and contribute to preventing challenging behaviours.
- management commitment to and focus on service quality and the staff training and support to achieve this.

7) Prevalence and people known to health and social care

As the definition of 'challenging behaviour' is not exact and can apply to individuals in some settings but not in others, due to the changes in their environment or the way their behavior is managed, it is difficult to pin down the exact number of people with a learning disability who challenge services. However, national Projecting Adult Needs and Service Information (PANSI) estimates that approximately 15,000 people aged 18-64 living in the UK with a learning disability have challenging behavior.

Applying these prevalence rates to Nottinghamshire PANSI estimate there are about 218 individuals with challenging behavior currently living in the county. This is not a group of people which are specifically identified and data collated on within either children's or adult's social care, but rather individuals are known to services.

Currently there are nearly 100 people from Nottinghamshire living in residential care out of county of which 20 are considered to have challenging behavior. 7 of those 20 are on the autistic spectrum, with or without a learning disability. While there are various reasons for people being placed out of county, including people moving to be nearer family, 6 people with challenging behavior were primarily placed out of area because there was no suitable service in Nottinghamshire with two more staying out of area following a school placement.

As at the end of March 2014 there were 58 people with a learning disability and/or Autism for whom Nottinghamshire has commissioning responsibility in in-patient setting as a result of mental ill health and/or challenging behaviour. Some of these individuals have been in hospital for ten years plus because they were considered too challenging to return to the community, some of whom were placed out of county and away from their families as children. However, where people are not in hospital for assessment or treatment, it is no longer considered acceptable that they should live in hospital.

As part of the Winterbourne work, all those in secure hospitals including ATU were reviewed in early 2013 and 28 people were identified as able to leave hospital within the next 12-18 months. However 7 people have since been reclassified due to them being on section 37/41 (home office restriction) or to deterioration in their mental health status. Therefore 21 people will have moved out by June 2014. Some of those have already moved out and work is on-going to secure appropriate supported living or residential accommodation for the remainder.

8) Future demand

There is, according to PANSI, expected to be a very small increase in numbers of people with challenging behavior over the next 15 years (approximately 3.7% or 8 people) however, local information on children coming through transitions, together with a lower mortality rate would suggest that this number may increase slightly more by about 2 people a year.

Nottinghamshire is also a net importer of people with social care and health needs due to the high levels of residential care and supported living services available. Responsible commissioner rules for health this confirm that as soon as someone registers with a GP in Nottinghamshire, funding responsibility passes to Nottinghamshire/Bassetlaw CCGs. For social care it is about ordinary residence so Nottinghamshire does not become responsible for people living in registered care unless they have previously been put on a section 3 (other than for safeguarding concerns) whilst living in Nottinghamshire. This means social care would then become responsible for their aftercare funding wherever they choose to live in future. There have been seven cases identified in the last year where Nottinghamshire will become responsible funders upon discharge from hospital.

There were 5 new admissions to locked rehab or secure hospitals in 2013/14. Some of these individuals were in community services or residential care already, others lived with family carers.

In Nottinghamshire we are aiming to ensure that people only go to secure hospital if they need treatment or rehabilitation which cannot be delivered in the community. Once treatment has finished then people should be supported to leave hospital and to complete their rehabilitation within a community setting.

Therefore over the next 2 years (2014-2016) we are likely to need services in Nottinghamshire for about 20 more people with challenging behaviours and then on-going 3-5 new places a year although many individuals who have been within services prior to any hospital admission will need more robust placements to allow them to be maintained within the community and prevent future admissions.

9) Prevention

Within the context of challenging behaviour, prevention falls into two categories, the prevention of the challenging behaviour in the first place and where this is not possible, the management of people within the community in a manner as to minimise the impact on the individual, people they live with and/or are supported by and members of the public and so reduce the incidents of hospital admission.9.1 Prevention of challenging behaviour

The right environment and the right support can go a long way towards minimising challenging behaviour.

A multidisciplinary approach to supporting people with challenging behaviours is essential with health clinicians, care managers families and support providers working to support each other as well as the individual.

Staff who are skilled in communication and least restrictive approaches, operate in a person centred way and understand and work to positive behavioural support strategies are key.

Properties which allow people space, somewhere they can be on their own if they need to and often with a good outdoor area will help.

9.2 Prevention of hospital admission

Developing services so that community health resource is available to offer timely therapeutic interventions and medication to a person in their own home rather than admitting them to hospital.

Ensuring appropriate housing so that the impact of challenging behaviour on others is reduced.

Ensuring high quality, well trained staff who are appropriately supported to manage behaviours that challenge

Providing flexible services to meet the different needs of individuals.

While it is the aim to reduce the number of people admitted to hospital, there are times when it is appropriate to do so – the Royal College of Psychiatrists (2) state

"Treatment for 'challenging behaviour' does not necessarily require an in-patient setting. Indeed, the therapeutic approach to it has been well described and emphasises the use of the least restrictive community resource wherever possible (Royal College of Psychiatrists et al, 2007). In-patient admissions are required only if the risk posed by the behaviour is of such a degree that it cannot safely be managed in the community. Persistent challenging behaviour, which poses a level of risk that is unmanageable in a community setting, may be the manifestation of some other underlying mental health difficulty that requires careful assessment and treatment in the safe setting of an in-patient resource. Equally, there may be many people with a learning disability who require an in-patient admission for further assessment, diagnosis and treatment of mental disorders that do not necessarily present with challenging behaviour. Indeed, admission to a specialist unit can sometimes be appropriate and beneficial early on in the care pathway, rather than as a last resort. Suffice to say that the purpose of admitting a person with a learning disability to a specialist in-patient setting is not merely because that person has 'challenging behaviour'."

9.3 Triggers

There are a multitude of potential causes for people with challenging behaviour which are likely to include social/environmental, biological and psychological factors which interact together. The severity of the learning disability is not usually a factor but the presence of Autism or mental health conditions with a learning disability is more common. Communication difficulties significantly increase the likelihood of challenging behaviour as do factors relating to deprivation, neglect and abuse.

10) Funding

What do we have now?

Currently funding for people with behaviours which challenge is in a variety of different health and social care budgets.

The Clinical Commissioning Groups fund individuals in hospital settings, whilst secure services are commissioned and funded by NHS England Specialised Commissioning.

When individuals return to the community it is usually under a section 117 order which means that they cannot be charged for their support or care. Funding is then provided by social Care from the Community Care Social Budget (CCSB) or through a form of Continuing Healthcare (CHC) called section 117 funding depending on the assessed needs of the individual.

Where there has been no section 3, i.e. either a voluntary admission to hospital or where challenging behaviour has been managed within the community, then funding can be from either CCSB or CHC or a mixture of the two depending on the outcome of a Decision Support Tool which looks at the levels of health and social care need.

A pooled budget is being developed between health and social care to meet the needs of people when in hospital and when they are discharged into the community under a section 117.

What are the difficulties?

Funding tied up in contracts.

- Clinical Commissioning Groups block fund Nottinghamshire NHS Trust to provide Treatment and Assessment and locked rehabilitation services within Nottinghamshire. This funding therefore cannot follow the patient.
- NHS England also have a block funding arrangement which means funding from people in secure hospitals cannot be released back to Nottinghamshire Delays in agreeing who should be funding – uncertainty as to the future funding levels

Different commissioning leads depending on where the funding is coming from can mean a lack of cohesion in market development.

Quality monitoring and care co-ordination of patients that are 100% funded by health (through Continuing Care arrangements) in the community. Quality monitoring of patients that are either fully or partially funded by the LA is carried out by the Local Authority but this is withdrawn if the person is funded solely by Health. There are currently no robust arrangements in place to ensure monitoring takes place for these patients although they are likely to be more complex.

What do we need to do about it?

Reduce out of area placements for locked rehab services and utilising the NHS Trust block contracts effectively.

Raise issues regionally and nationally about the difficulties of the block funding from NHS England

Develop the pooled budget arrangements between health and social care

Shared understanding of what we are trying to achieve in the market regarding quality, price and choice as laid out in the principles section of this strategy.

Work proactively with providers, users and carers to set goals around promoting independence and positive risk taking but accept this could be a long term outcome and initial packages may be high cost.

Work with providers to develop flexible packages of care so that needs that vary over time can be catered for without delay.

11) Transitions

What do we have now?

Education, Health and Care Hub – Where there are indications of significant need young people are referred to the Hub to see if they are eligible for an Education, Health and Care plan (EHC). This will look at needs up until the age of 25 and enable commissioners to more accurately identify what services will be required in the future and plan for a smoother transition across all statutory services.

Information detailing the local offer will play a key role in providing alternative or complimentary support to statutory services.

Transitions team – this team is based in Adult's Social Care and engages with young people aged 14+ who are likely to be eligible for adult social care services. Primarily this is young people with learning disabilities or physical disabilities. The transitions worker get involved in the young persons' review and helps to plan for services post eighteen.

Concerning Behaviours pathway – this pathway, devised in partnership by Health, Social Care, Education and parent carers in Nottinghamshire aims to ensure that young people under the age of 18 who's behaviour causes concern, either due to them challenging services or displaying other behaviours which may indicate a developmental disorder or mental health issue are recognised and assisted early on. In some case this may lead to a referral for diagnosis for Autism or Attention Deficit Hyperactivity Disorder, in other cases it may be low level parenting interventions or support groups.

What are the difficulties?

The Concerning Behaviours pathway and the EHC hub are in early stages so it is not yet know what the impact will be on ensuring a smooth transition for people moving from childhood to adulthood.

The transition service works well for individuals who are clearly going to have needs around learning or physical disability eligible for adult services however, as the service is social care only, there is not the same level of planning for health transition and as eligibility criteria for continuing health care changes between adults and children's services this can lead to delays in agreeing services.

Existing transition services are not meeting the needs of people with less clearly defined needs, e.g. low level learning disabilities, mental health issues or high functioning autism which can lead to an unclear transition or people being referred to adult services at a later date where prevention work may have avoided this.

Where children are placed out of area, this can also impact on the transition planning as it is more difficult to get to know people and service users and carers often want to stay with the provider they know, making it challenging to bring people back locally.

<u>What do we need to do about it?</u>

1) Monitor the impact and effectiveness of the behaviours which concern pathway and the commissioning hub in preventing individuals needing higher levels of health or social care services or hospital admission.

2) Ensure the pathway is used for early identification of individuals who may not meet adult social care criteria due to the low level of their learning disability but have other factors which may make them at risk of future hospital admission e.g. a combination of one or more of the following factors:

- mental health issues
- offending behaviour
- inappropriate sexual behaviour
- having suffered abuse or neglect
- autism (including asperger's)
- having emotional difficulties

3) Map pathway of all service users known to have challenging behaviour to see if they were known in children's services and if they had a transition to adult services to identify if there is a need for more targeted prevention work.

4) Identify gaps in service to meet the needs of these individuals pre and post 18.

5) Ensure better joined up transitions processes through health, social care and education, considering further the potential use of integrated teams and pooled budgets.

6) Work closely with children's to help prevent out of area placements, wherever possible but ensuring there is a pathway for the person to return to Nottinghamshire.

12) Accommodation

What do we have now?

A range of residential places and supported living options throughout Nottinghamshire.

Capital funding to part fund up to 60 supported living properties, some of which will be for people with challenging behaviour.

A pilot 6 bed step down property, currently residential care with supported living staff working alongside the residential staff to provide continuity of care when people move onto supported living.

What are the difficulties?

Ensuring appropriate accommodation alongside appropriate support for people with challenging behaviour needing residential care

Insufficient good quality housing in self-contained properties offering the ability to deliver cost effective support.

Insufficient supported living properties available when required – new developments can take 1-2 years to complete.

What do we need to do about it?

Continue to work with housing partners to develop a range of appropriate accommodation for people with challenging behaviour throughout Nottinghamshire

Introduce a basic training, skills and knowledge requirement for residential care providers who state they can work with people with challenging behaviour

Review the effectiveness of the step down facility during the two year pilot and consider whether this type of facility could also be used as a 'step up' to avoid hospital admission and whether there is a need for more units.

13) Support Provider development

What do we have now?

A number of providers in both the supported living and residential sectors who are able to work with people with challenging behaviour.

The development of Supported Living Plus where a premium rate is paid to providers – this is intended to be used to recruit more experienced staff and provide higher levels of management and behavioural support.

What are the difficulties?

Residential care – inconsistent quality with appropriate properties and skilled staff not always coinciding. Providers who state they can work with people with challenging behaviour but no real test of this.

Supported Living Plus – some difficulties in marrying service user choice and control with the management of behaviours which challenge.

Limited provision for people with dual diagnosis or high level forensic history.

Lack of expertise/appropriate placements for people with autism within supported living settings.

Deprivation of Liberty Safeguards and the time and cost of taking these cases through the court of protection for supported living.

Some providers are not engaging with NHS Trust staff around emergency and clinical support well.

What do we need to do about it?

Agreed minimum training standards for all staff working in services with people with challenging behaviour.

Closer analysis of what works and what does not work and sharing of good practice.

Stronger partnership working between clinical staff, social care staff and providers.

Joint training/workshop events between clinical staff, providers and social care, carers and users to ensure shared understanding of ‘ordinary life’ principles within the context of challenging behaviour.

Ensure the on-going development of a range of providers who can offer different accommodation to this service user group

Include the requirement for providers to work with people with challenging behaviours including those with dual diagnosis and/or forensic histories in Care Support and Enablement tender with clear specification.

14) Carer support

What do we have now?

While services primarily for the service user, even where this also benefits the carer, are offered following an assessment of need and an allocation of resources. This is then given to the individual as a personal budget which can either be managed by the Council or given as a Direct payment for the service user and their carer to purchase services directly.

Carer assessments are undertaken to look at needs of the carer which may result in a small personal budget for the carer. However, respite services, considered to be primarily related to the needs of the carer, even if the service user also benefits, are not currently part of the personal budget and allocation is a little ad hoc.

There is also an NHS carers break fund which can be used to purchase a residential care break or homecare, eligibility for this also depends on a local authority carers assessment.

A new process is being developed to link the carers needs to the service user's needs to come up with an allocation of funding for short breaks. This will then be included in the personal budget and will be able to be taken as a Direct Payment so carers and service users can spend the money on alternative goods or services to meet their outcomes.

Services available which could offer a break/support to carers of people with behaviours which challenge

- Outreach and Homecare services who can work with people in their own homes, and therefore also provide a break to the carer.
- NHS day services providing additional support for people who challenge services or have specific health needs, they can also offer support to carers in how to manage behaviours when the person is at home.
- Two providers offering autism specialist day services
- 4 in-house respite services, one NHS day service
- Two other providers currently offering respite services to people who can be challenging.
- Community Assessment and Treatment Team – can offer support by working alongside carers to manage behaviours.
- Carer support groups – a range of groups with and without health or social care input around the county.

What are the difficulties?

Some people who may not be eligible for social care services and therefore carer is unlikely to have had an assessment – if the needs of the individual escalate it may reach crisis before either health or social care are involved.

People may struggle to access carer support groups if they are not receiving respite services.

Reduction in in-house and NHS respite services planned

What do we need to do about it?

Through mapping of pathways of people being sectioned, analyse the levels of health or social care support going in and at what stage leading up to the section and try and identify high risk or trigger points for carers earlier.

Ensure allocation of in-house services responds to the needs of people with the most challenging behaviours and that alternatives are also developed.

15) Health Community resource

What do we have now? –

2 Community Assessment and Treatment teams (CAAT) covering North and South of the county.

Psychiatry

Psychology

Speech and Language Therapy (SALT)

Occupational Therapy

Nursing

Physiotherapy

Specialist Epilepsy nurse

What are the difficulties?

Challenges for the current workforce to meet the increases in demand

Identifying likely increase in need for all clinical support as part of the on-going prevention agenda as well as those coming back to the community from hospital

Support providers with in-house services joint working with NHS community resources meaning lack of clarity between support providers and clinical staff as to roles and responsibilities

Lack of resource within mental health services around autism (Asperger's) – much of the resource above is within learning disability services and therefore people with autism but no learning disability do not have access.

What do we need to do about it?

Work with current provider to demonstrate the level of need and how this can best be commissioned for.

Share knowledge from learning disability services relating to Autism

Develop SALT, Psychology and occupational therapy resource for people with Asperger's.

Work with providers and clinical staff to provide clarity of roles and responsibilities and to develop clear guidance around when providers should be liaising with NHS clinical staff – this may vary by provider depending on their in-house arrangements.

Analyse the potential costs and benefits of developing the role of the CAAT team to enable 24/7 response and ability to do more work alongside providers – stepping in to cover shifts where mental health or behaviours are deteriorating.

16) Social Care Community Resource

7 Community Learning Disability team – one in each district.

1 County Wide Asperger's Team

1 County Wide Transitions Team

4 Community Mental Health Teams

1 Transformation Team

What are the difficulties?

Challenges for the current workforce to meet the increases in demand

What do we need to do about it?

On-going strategic planning to deliver more joined up working between health, social care and providers

Better discharge planning and needs mapping to ensure pressure points are identified early.

A project manager post has been agreed until March 2015 to co-ordinate work around the strategy and ensure appropriate service provision going forward.

17) Advocacy

What do we have now?

For people living within Nottinghamshire they have access to the jointly commissioned advocacy provider who offer both IMCA and general advocacy.

For people placed out of area Independent Advocacy is a service requirement within the service provider's contract.

All service users moving from hospital into the community have had advocacy support available to them.

What are the difficulties?

We have no specific evidence to identify whether the services are appropriately meeting the needs of people with challenging behaviours as monitoring information does not specifically identify this service user group.

What do we need to do about it?

Undertake a review of the advocacy which is available and has been provided to people in hospital and people with challenging behaviours living into the community to ensure the provision is appropriately meeting needs.

18) Workforce development (health, social care and providers) – training re challenging behaviours, ASC and dual diagnosis.

What do we have now?

Training is undertaken by each organisation according to the needs identified.

What are the difficulties?

Different organisations may take different approaches to managing behaviour which challenges, particularly around the use of restraint. This can lead to inconsistent behavioural support which is confusing to the service user.

No measure to ensure that there is a consistent approach to training

Knowledge of Autism within the mental health sector is low.

What do we need to do about it?

The current tender for care, support and enablement services includes a minimum training requirement for people working with service users who challenge and those with learning disabilities and/or Autism. This needs to be rolled out to care homes and existing support providers.

Following an audit of current training approaches within health and social care, develop a joint training plan, incorporating shared training to ensure similar approaches are undertaken.

Develop higher level expertise around ASC within mental health services

19) ATU and secure hospitals

What do we have now?

18 bed ATU

One 8 bed Male only locked rehab service run by the NHS Trust

A number of private locked rehab services for males and females

One high secure hospital.

Current use of additional out of area locked rehab and secure provision

What are the difficulties?

People are still being sent out of area to locked rehab or secure hospitals.

Too many people are still being admitted to hospital because they cannot stay where they are due to the impact of their behaviour on others.

People who have stayed in hospital too long i.e. when they are no longer being treated.

is not usual practise for patients to be funded in hospital through Continuing Care but this does sometimes happen, particularly in Bassetlaw. There are no consistent quality monitoring arrangements in place for these patients.

What do we need to do about it?

Ensure sufficient high quality locked rehab and low secure in Notts to meet demand

Work with providers and neighbouring authorities to try and ensure we all place as close to home as possible.

Develop step up/down provision both registered and supported living as an alternative to hospital where the issue is about not being able to remain where they are rather than them specifically needing hospital services.

Ensure a regular review of every person in hospital is carried out by health and social care in partnership with the individual and family members and the provider to enable good discharge planning.

Develop standard process for discharge planning to ensure all requirements are appropriately considered and available when required.

Conclusion

There is a range of service available to meet the needs of people in Nottinghamshire who may challenge services.

Partners in Nottinghamshire are committed to working together to ensure the continued delivery of person centred approaches to housing and support to ensure we are up to the challenge of increasing the number of people who may challenge services living within the community and reducing the need for, or length of time spent in, secure hospital settings.

This is a living document and will be updated annually to reflect progress, new developments and take into account new information.

An action plan will be developed each year to address some of the key issues identified in the strategy which will be widely consulted on.

Bibliography

(1)Emerson, 1995, cited in Emerson, E (2001, 2nd edition): Challenging Behaviour: Analysis and intervention in people with learning disabilities. Cambridge University Press

(2) People with learning disability and mental health, behavioural or forensic problems:
the role of in-patient services Faculty Report FR/ID/03
July 2013 Royal College of Psychiatrists'
Faculty of Psychiatry of Intellectual Disability

This matter is being dealt with by:
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Reference: JB/SK
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Nottinghamshire County Council

Martin Royal
Regional Director Midlands and East
NHS Property Services Ltd
2-4 Victoria House
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CB21 5XB

1st July 2014

Dear Martin

We are writing to you on behalf of the Nottinghamshire Health & Wellbeing Board following concerns raised by the Board regarding health service premises in Nottinghamshire.

The Board has received regular reports from NHS England around the Primary Care Strategy for England and have been impressed with ambition within the plans and the potential improvements in the services for our local population.

The Board are concerned however that the standard of the premises locally is not consistent with the aspirations within the Strategy. Members expressed concerns around bureaucracy in adapting premises to accommodate changes to services, the efficiency of use of the buildings and the safety of primary care premises.

I am aware of the recent Premises Assurance Model but understand that this does not apply to GP premises.

I would be grateful if you could provide me some assurance of plans to review and improve primary care premises in Nottinghamshire in order that I may in turn reassure the Health and Wellbeing Board.

Yours sincerely

Councillor Joyce Bosnjak
Chair

Dr Stephen Kell
Vice- Chair

Nottinghamshire Health and Wellbeing Board, Nottinghamshire County Council

15 July 2014

Our Ref: MR03
Your Ref: JB/SK

NHS Property Services

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Tel: 01223 597576

Councillor Joyce Bosnjak
Dr Stephen Kell
Nottinghamshire County Council
County Hall
West Bridgford
Nottingham
NG2 7QP

Dear Councillor Bosnjak/Dr Kell,

Thank you for your letter dated 1st July 2014.

I am sorry to hear of your concerns regarding the standard of the premises in your area and the difficulties you have encountered adapting these buildings to accommodate changes to services. NHS Property services Ltd is committed to providing appropriate accommodation for both patients and tenants, and working with both local authorities and commissioners to review and improve primary care facilities is key to making this happen.

I have contacted representatives from the local CCG to discuss the concerns you have raised and clarify the details in order to be able to confirm our plans in this regard and provide you with the assurance you need.

I hope to arrange to meet with you later this month to discuss how our plans can assist in meeting the local Primary Care Strategy.

Yours sincerely,

Martin Royal
Regional Director Midlands and East

Nottinghamshire County Council

Report to Health and Wellbeing Board

3 September 2014

Agenda Item: 12

REPORT OF CORPORATE DIRECTOR, POLICY, PLANNING AND CORPORATE SERVICES

WORK PROGRAMME

Purpose of the Report

1. To consider the Board's work programme for 2014/15.

Information and Advice

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

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

Other Options Considered

4. None.

Reason/s for Recommendation/s

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

Statutory and Policy Implications

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

RECOMMENDATION/S

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

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

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

Constitutional Comments (HD)

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

Financial Comments (PS)

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

Background Papers

None.

Electoral Division(s) and Member(s) Affected

All

	Health & Wellbeing Board (HWB)	HWB Workshop (closed sessions)
1 October 2014	**Better Care Fund report** (Paul Oliver) **Health Inequalities** (Chris Kenny) **Child & Adolescent Mental Health report** (Kate Allen) **Annual Immunisation report** (NHS England) **Annual Screening report** (NHS England) **Community Infection Prevention & Control** (Jonathan Gribbin) ***Health Scrutiny and the Health & Wellbeing Board*** *(TBC)* **Chairs report:** • **Mental Health Concordat** (Karen Glynn/Sue Batty) • **Progress report on workplace health** (TBC) • **Children's' Disability/Children's Charter** (Anthony May/Sue Gill/Sarah Everest) • **Peer Challenge on Dementia** (Gill Oliver) TBC	
5 November 2014		Care Act TBC
3 December 2014	**Excess Winter Deaths** (Mary Corcoran) **Director of Public Health Annual Report** (Chris Kenny) **Breast Feeding** (Kate Allen)	

	Health & Wellbeing Strategy report (Anthony May/ Cathy Quinn) ***Public Health Committee Annual Summary*** *(TBC)*	
7 January 2015		Budget Consultation and the Health & Wellbeing Board TBC
4 February 2015	**Dental Public Health & Fluoridation** (Kate Allen) **Approval of the Pharmaceutical Needs Assessment** (Cathy Quinn) **Health & Wellbeing Strategy report** (Anthony May/ Cathy Quinn) **Health & Wellbeing Implementation Group report** (Anthony May/ Cathy Quinn) **Better Care Fund report** (Jon Wilson) **Chairs Report:** • **Report on Pharmacy Applications** • **Progress report on Mental Health Challenge** (Barbara Brady / Cllr Bosnjak)	
4 March 2015		Health Inequalities TBC
1 April 2015	***Follow up report on Healthy Child Programme and Public Health Nursing for Children and Young People*** *(Kate Allen) TBC* **Annual report on Winterbourne Review** (Jon Wilson) **Health & Wellbeing Strategy report** (Anthony May/ Cathy Quinn)	

	Better Care Fund report (Jon Wilson)	
May 2015	***No Meeting due to elections***	
3 June 2015	**Health & Wellbeing Strategy report** (Anthony May/ Cathy Quinn)	