Nottinghamshire County Council

Health and Wellbeing Board (Shadow)

Wednesday, 16 January 2013 at 14:00

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

AGENDA

Notes

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

Customer Services Centre 0300 500 80 80

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

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

minutes

Nottinghamshire County Council

Meeting	HEALTH AND WELLBEING BOARD
Date	Wednesday, 7 November 2012 (commencing at 2.00pm)

membership
Persons absent are marked with `A'

COUNCILLORS

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

DISTRICT COUNCILS

Councillor Jenny Hollingsworth
Councillor Tony Roberts MBE

OFFICERS

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

CLINICAL COMMISSIONING GROUPS

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

LOCAL HEALTH WATCH

Jane Stubbings	-	Nottinghamshire County LINk

NHS COMMISSIONING BOARD

Helen Pledger	-	Local Area Team, NHS Commissioning Board

OFFICERS IN ATTENDANCE

Kate Allen	-	Public Health
Mary Corcoran	-	Public Health
Paul Davies	-	Democratic Services Officer
Chris Few	-	Chair, Nottinghamshire Safeguarding Children Board
David Hamilton	-	Service Director, Personal Care and Support (Older Adults)
Nicola Lane	-	Public Health Manager
Phil Mettam	-	Bassetlaw Clinical Commissioning Group
Eric Morton	-	Interim Chief Executive, Sherwood Forest Hospitals NHS Trust

MEMBERSHIP

The Chairman welcomed Helen Pledger, who had been appointed to the Board in place of Dr Doug Black.

MINUTES

The minutes of the last meeting held on 5 September 2012 having been previously circulated were confirmed and signed by the Chairman.

APOLOGIES FOR ABSENCE

Apologies for absence were received from Dr Kell, Dr Sheikh and David Pearson.

DECLARATIONS OF INTEREST BY MEMBERS AND OFFICERS

None.

SHERWOOD FOREST HOSPITALS NHS TRUST

Eric Morton, Interim Chief Executive, Sherwood Forest Hospitals NHS Trust gave a presentation on recent developments at the Trust. Monitor, the regulator, had found the Trust in significant breach in respect of governance and finance. Work on three specific reviews into quality, governance and finance had begun, to be completed by the end of November. He referred to the Trust's financial difficulties, and to the excellence of facilities at King's Mill Hospital. He responded to comments and questions.

- What assurances could be offered about Newark Hospital? - Mr Morton praised the facilities and staff at Newark Hospital. He believed that use of the hospital should be maximised as an integral part of the Trust. In his

view, its services could be better promoted. He saw no prospect of the hospital closing.

- How accurate were the reported costs of the Kings Mill PFI, and how had they become so great? - The costs had been reported in the press. They reflected the period of the PFI contract, and that payments would rise in line with RPI. The finance review would consider options for the PFI costs. A partnership board (including representation from CCGs and the County Council) would be established to take matters forward.

- Where were patients for King's Mill Hospital drawn from? - The pattern of referrals showed that patients from the King's Mill and Newark Hospital catchment areas sought treatment elsewhere. The Trust would look at why this was happening. Members observed that the journey times to Nottingham or Lincoln might be shorter for some patients.

- Was there room for two acute Trusts in Nottinghamshire? - The Trust would seek to treat as many local people as possible, and would speak to Nottingham University Hospitals about taking the pressure off their services. Mr Morton referred to the high quality of the accommodation at King's Mill, its low infection rates and short waiting lists.

- Some services provided by the Trust, for example screening and diagnostics, were part of the public health agenda. The Trust's outward-facing approach was welcomed.

- How would the Trust address its financial difficulties? - The Trust faced a severe challenge for the rest of 2012/13, but had the ability to borrow. The Trust would have to live within its means. While the PFI contract was an additional burden, without the contract, there would not have been the new hospital. The Trust would talk to partners about the options. Members acknowledged the quality of King's Mill Hospital.

- The Trust had not been perceived as team player in the past, and it was hoped that this would change. - The partnership board would be a useful way forward.

The Chairman concluded discussion by referring to the considerable public concern about the Trust, and observing that the Board had been somewhat reassured by the information presented.

CANCER AND NOTTINGHAMSHIRE

Mary Corcoran and Kate Allen gave a presentation which drew out key points from the report on cancer in Nottinghamshire. They explained how the three national screening programmes (for cervical, breast and bowel cancer) operated in Nottinghamshire, and how cancer services were provided locally and regionally. They responded to questions and comments.

- The district council representatives welcomed the report, but felt that there could be more targeted work with particular groups, for example ethnic minorities. There were also concerns about changes in caner networks, and making posts more generic. - There were examples of targeted work, such as targeting bowel cancer screening at groups with low take-up rates,

or cervical screening at young women. The East Midlands Cancer Network was changing as a result of the health reforms, with the NHS Commissioning Board taken on a role. However these changes were administrative in nature, and clinical inputs would be unchanged.

- It was observed that cancer rates would increase as the population lived longer, and that patients should be encouraged to present to their GP early if they had symptoms.

- Sherwood Forest Hospitals NHS Trust had been penalised for missing waiting list targets. It was suggested that GPs could warn patients that they would receive an appointment letter. Some GPs had revised their correspondence, and GPs had been asked to check that people were not invited to appointments when they knew they would be on holiday. Public Health had produced a leaflet which GPs could hand out.

- Some members were not aware of the recent cancer publicity campaigns. It was suggested that there could be links from the County Council's website, for example. - The campaigns had been targeted at particular socio-economic groups, and had improved take-up rates. The weblinks could be done.

- Why was prostate cancer not given a higher profile? - Although prostate cancer was the second most common male cancer, it was a variable disease, with uncertainty about the conclusiveness of tests. This precluded a screening programme. There was also uncertainty about how to prevent prostate cancer, and how aggressive the disease might be. Some prostate cancers are quite aggressive and the treatment options are limited, whereas some are more benign and only require minimal intervention.

- The message about links between cancer and obesity could be strengthened. For GPs, there was a lack of knowledge about weight loss services. - It was acknowledged that the message about obesity and diet could be stronger. The Obesity Strategy Group and Make Every Contact Count had a role.

- More use could be made of mobile phone applications and social media to convey public health messages.

RESOLVED 2012/022

(1) That the report be noted.

(2) That promotion of the key prevention measures for cancer be endorsed.

(3) That the promotion of the National Awareness and Early Detection Initiative locally, especially the awareness of key symptoms among local residents, be endorsed.

(4) That the use of social media in health motion be explored, with a report back to the Board on implementation.

NOTTINGHAMSHIRE CHILD AND FAMILY POVERTY STRATEGY ANNUAL PERFOMANCE UPDATE

Anthony May introduced the report, which updated the Board on the first year of the strategy, and invited the CCGs to consider how they might be more involved. The report provided statistics about child poverty in Nottinghamshire, and gave examples of progress which a number of organisations had made to fulfil the pledges they had made. The strategy was currently being refreshed, and would form part of the county's Early Intervention Strategy in future. Mr May responded to questions and comments.

- How might CCGs be involved in the strategy? It was pointed out that each CCG had a lead for children's services.

- District councils believed CCGs should be involved and that commissioning plans should recognise the needs of children. There was some concern that the strategy might lose sight of pockets of deprivation. - The County Council did have detailed data on poverty. Mr May recognised the district councils' energetic commitment to tackling child poverty.

- By defining local child poverty as a percentage of median income, there would always be children who came under the definition. Child poverty could therefore never be eradicated. - Poverty had always been defined in relative terms.

RESOLVED: 2012/023

(1) That the report and its contents be welcomed.

(2) That Clinical Commissioning Groups consider how they would like to be involved in the development of a revised Child and Family Poverty Strategy.

HEALTH AND WELLBEING BOARDS AND CHILDREN, YOUNG PEOPLE AND FAMILIES

Anthony May introduced the report which gave the national context for joint commissioning of services for children, young people and families and gave information on the Children's Trust self-assessment. He saw the Trust as moving to a more active role, and recommended that it should become the integrated commissioning group for children and young people.

During discussion, it became clear that there was a consensus that there should be closer links and better communication between the Board and bodies like the Trust. It would be useful to identify the areas where closer links would be most useful and how they might be achieved. In reply to a question about the role of CCG representatives on the Trust, Mr May stated that it would be desirable but not essential for them to be members of the Board. He saw the role as being almost a consultant to the Trust. He also explained that there were good relations with academies, which were expressing an interest in health matters.

RESOLVED 2012/024

(1) That the Board support the view that the Children's Trust should revise its focus and membership so that it becomes the lead integrated commissioning group for health and wellbeing services for children and families.

(2) That the Board support the Children's Trust to develop the next Children, Young People's and Families Plan. This new plan should reflect the Trust's revised role and the forthcoming Children and Young People's Health Outcomes Strategy, and be aligned to the Health and Wellbeing Strategy.

(3) That the Clinical Commissioning Group clinical leads consider whether it would be helpful for one or more of them to take on a lead role in the children's services agenda, working with the Corporate Director for Children, Families and Cultural Services.

EAST MIDLANDS HEALTH AND WELLBEING BOARD CHALLENGE EVENT

Guy Mansford introduced a summary of the regional event held on 25 September 2012, which had been attended by seven Board members. He highlighted the importance of members taking ownership of Board decisions, and being aware of risks but prepared to take them.

Councillor Suthers endorsed the comments in the report, and referred to a follow-up event in January. He encouraged members to return their own assessment of the Nottinghamshire Board, so that the information could help shape the workshop on 28 November.

RESOLVED 2012/025

That the report and the proposed actions be supported.

PUBLIC HEALTH TRANSITION

The report gave the current position on the work to transfer Public Health to the County Council, and on the development of the Board. Chris Kenny responded to questions and comments.

- What budget for Public Health would transfer to the County Council? - The Government would announce the Public Health grant for 2013/14 in December. It was expected to be at least £29.9m.

- This was less than the £32m mentioned previously. More precise figures could be anticipated at this stage. - There would be some proposals which would take the budget beyond £29.9m. Public Health's current spending had been identified a few weeks ago, and the budget for 2013/14 would be similar. The exact amount to be transferred would not be known until the December announcement.

- The Board should be looking at value for money in all Public Health contracts, and would be assessing the outcomes of these contracts.

- CCGs would welcome continuity in the Public Health service in 2013/14, and improved outcomes the following year.

- District councils would welcome the opportunity to participate in the programme of workshops. This would help develop collaboration. - This suggestion was welcomed, as the informal setting of the workshops would allow other stakeholders to participate.

RESOLVED: 2012/026

That the report be noted, and that stakeholders including district councils be invited to workshops where appropriate.

NOTTINGHAMSHIRE SAFEGUARDING CHILDREN BOARD ANNUAL REPORT 2011/12

Chris Few, Chair of the Nottinghamshire Safeguarding Children Board, introduced the Board's annual report for 2011/12. He highlighted the successful training programme and improved responsiveness to certain types of concern. Looking forward, the theme for 2012/13 was engagement. The Chairman observed that the Safeguarding Children Board was an important stakeholder for the Health and Wellbeing Board. Members saw bullying and early pregnancies as important issues.

There was discussion about encouraging the attendance of health professionals at child protection conferences. It was commented that GPs should provide reports for child protection conferences, and they would attend depending how useful their contribution would be; that there should be more notice of conference dates; and that it would be helpful to have a dialogue with GPs in advance of the conference. In response, Anthony May said that these were issues which the Safeguarding Children Board was considering. He pointed out that child protection timescales often left little flexibility over dates. He acknowledged that dialogue would help. Making use of new technologies was suggested.

RESOLVED: 2012/027

That the report be noted.

The meeting closed at 4.15 pm.

CHAIRMAN

Nottinghamshire County Council

Report to Health and Wellbeing Board

16 January 2013

Agenda Item: 4

REPORT OF CHIEF OPERATING OFFICER, NEWARK AND SHERWOOD AND MANSFIELD AND ASHFIELD CLINICAL COMMISSIONING GROUPS

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

Purpose of the Report

1. Following a presentation to the November 2012 Health and Wellbeing Board from the Interim Chief Executive Officer of Sherwood Forest Hospitals, the purpose of this report is to inform the Board of the work underway to ensure a sustainable health economy for Mid-Nottinghamshire. The intention is to create a "road map" for the future that sets out how Nottingham and Nottinghamshire commissioners and providers will work together to develop and integrate services, in the face of unprecedented financial pressures. The report will describe;

- The programme of work required to secure the future, including proposed outputs and associated timescales.

- The programme management approach to be adopted, and the constitution of the overseeing body – the "Mid-Nottinghamshire Integrated Care Transformation Board"

Information and Advice

Background

1. The health needs of the population of Mid-Nottinghamshire are changing and increasing due to growth, an ageing population, and changing expectations. This will increase demand for health and care services at a time of low growth in the economy for years to come, and major pressure on NHS and social care budgets. A large proportion of acute care is currently provided by Sherwood Forest NHS Foundation Trust, which has a number of fixed costs (including a PFI contract), as well as services that require a critical mass of activity to be viable under current payment arrangements.

2. Within the overall economy, Sherwood Forest Hospitals has a particularly urgent and challenging financial position that requires immediate action. The Foundation Trust has been found in significant breach of its terms of authorisation, and Monitor has intervened using its statutory powers. A new senior leadership team are dealing with the organisational implications. Commissioners and providers have agreed to work together

to jointly understand the current state trading and operating position at the Foundation Trust and to develop responsive plans for a sustainable and integrated health and social care economy. It is recognised that the longer term viability of services provided from Kings Mill and Newark Hospitals is the most significant legacy risk that Mansfield and Ashfield and Newark and Sherwood CCGs will inherit.

Establishment of the Transformation Partnership Board and Approach

3. The PCT Cluster Board, Midlands and East SHA, CCG Governing Bodies and Foundation Trust Board have all expressed the imperative for a more detailed piece of work to find solutions and to plan future service configurations. Boards and Governing Bodies have agreed that a Partnership Board should be established for Mid-Nottinghamshire that will oversee a series of projects within an overall programme of work. Governance requirements have been agreed through board level approval of terms of reference. The "Productive Nottinghamshire" collaborative has agreed an overarching vision, values and principles for local service transformation that will guide more specific decisions about service delivery and asset utilisation in the coming months and years, and the Mid-Nottinghamshire Partnership will operate within this context.

4. The Partnership Board is called the "Mid-Nottinghamshire Integrated Care Transformation Board" and has been established to oversee the progress of projects and to ensure that adequate supportive analysis is undertaken across the whole programme of work. The approach taken will be to focus on the whole Mid-Nottinghamshire "system affordability gap" and empower its clinicians to develop and deliver better models of care – irrespective of which organisation happens to incur the benefit under current rules and payment mechanisms. If care can be delivered in a way that achieves better outcomes for patients and costs the same or less money – then the leaders of the health system will support and make it happen. Examples of this might include:

- Using expertise currently residing in the acute provider to deliver care to patients not currently in the hospital
- Supporting decision making in primary care with expertise and diagnostic capabilities from the hospital
- Recognising that for patients, out of hours care is frequently most easily accessed from A&E, and structuring other out of hours provision aligned to (rather than in competition with) this
- Delivering more sub-acute care in closer-to-home settings

Key Deliverables and specific outputs of the Transformation Work

5. The initial programme of work will take 16 weeks from the beginning of January 2013, and whilst focussing on the medium to longer term in terms of required system reconfiguration, the process used will ensure that necessary 2013/14 actions can be built into contract negotiations. Key deliverables will include;

- *A model of shared clinical leadership* – with primary and acute clinicians working together in the interests of patients and freed up from organisational constraints.

- *A shared vision / blueprint for the physical health system of the future* - grounded in local understanding, owned by the organisations and capable of being delivered.
- *Analysis to demonstrate what this blueprint means for acute and out of hospital services, and the providers of those services* – including financial and quality impact at an aggregated and then individual organisation level, and how this can work in terms of organisational forms, regulatory authorisation, etc.
- *A high level road map for the health economy and individual organisations for the next 3-5 years, and a more detailed plan for the next 12 months* – built on a foundation of supporting the best services and outcomes for patients and with a local commitment to deliver.

So as to build on the working of existing clinical networks, it is proposed that clinical services are considered under the following groupings;

- Elective care
- Long term conditions
- Frail elderly
- Maternity and paediatrics
- Emergency care

6. It is also anticipated that the programme of projects will give rise to the following specific outputs.

- A description of viable options for services/specialties over the next 5-10 years in line with projected health / population needs will be provided.
- Financial, cost improvement, productivity and efficiency, and innovation measures will be quantified and projected to underpin service descriptions (based on available planning assumptions).
- Areas for statutory consultation in 2013/14 will be clearly identified.
- An engagement document will be produced, in order to begin a meaningful dialogue with stakeholders and the public. This will include options for asset utilisatiion.

Constitution of the Transformation Partnership Board

7. As outlined earlier, the Mid-Nottinghamshire Integrated Care Transformation Board has been established by the Boards / Governing Bodies of constituent providers and commissioners. It is accountable to the Boards / Governing Bodies of its membership. The scope will cover the totality of the local health system for physical healthcare (i.e. all locally commissioned services covering acute, community and primary care) as well as social care. It will not include the major parts of mental health provision, except where they overlap with physical healthcare, e.g. dementia care for physically unwell patients and liaison psychiatry.

8. Organisational sovereignty will remain, but the Board will adopt a whole system approach to debate and decision- making. The Board will ensure that all local and national levers used to drive transformation and productivity gain are considered jointly and severally (e.g. QIPP, CQUIN, CIPs). They will be impact-assessed with regard to the risks to the sustainability and viability of all providers and the differential effects/unintended consequences that may arise within the system.

9. In recognition of the programme and scope of the works, Membership of the Transformation Board will be drawn from the following;

- Board Chair (mutually agreed by members)
- Chief Executives / Chief Officers or senior representative from:
    - Commissioning CCGs
    - Sherwood Forest Hospitals NHS Foundation Trust
    - Nottinghamshire Healthcare Trust (community and mental health provider)
- Chairs (including CCG Clinical Chairs)
- Local Area Team Director
- Director of Adult Social Care and Health (representing Nottinghamshire County Council)
- Directors of Finance
- Medical Directors
- Directors of Nursing

The Board or its Chair may co-opt other members as may be required

Statutory and Policy Implications

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

RECOMMENDATION/S

It is recommended that the Health and Well Being Board:

1) **Notes** the progress underway to secure a vision for sustainable hospital and community based services in Mid-Nottinghamshire in the future.

2) **Considers** how and when further updates may be required.

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

For any enquiries about this report please contact:
Lucy Dadge
Project Director/Interim Director of Strategy
Mid-Nottinghamshire Integrated Care Transformation Board
07775 942840

Constitutional Comments

Because this report is for noting only, there are no constitutional comments.

Financial Comments

None.

Background Papers

None.

Electoral Division(s) and Member(s) Affected

All.

Nottinghamshire County Council

Report to the Health and Wellbeing Board

16 January 2013

Agenda Item: 5

REPORT OF DIRECTOR OF PUBLIC HEALTH

TACKLING DOMESTIC VIOLENCE IN NOTTINGHAMSHIRE

Purpose of the Report

1. To inform the Health and Wellbeing Board of the extent to which Domestic Violence affects the people of Nottinghamshire from a Health and Wellbeing perspective and to recommend further action.

Information and Advice

What is Domestic Violence?

2. Throughout the literature a variety of terms are used, Domestic Abuse, Intimate Partner Violence (IPV), partner abuse, physical and sexual violence and Domestic Violence. For the purpose of this paper the term 'Domestic Violence' will be used unless specifically stated. The Government defines Domestic Violence as "any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults (those aged 16 upwards) who are or have been intimate partners or family members, regardless of gender or sexuality."

Why is Domestic Violence a Public Health issue?

3. Whilst it occurs across all sections of society, men are far more likely to be the perpetrators and women the victims. Women are also more likely to experience repeated and severe forms of violence, including sexual violence and are also more likely to have sustained psychological or emotional impact or result in injury or death[1].

4. Women who experience Domestic Violence present more frequently to health services. They are admitted to hospital more often than their non-abused counterparts and are issued with more prescriptions. There is evidence of a linear relationship between severity of Domestic Violence and the use of health services[2]. Survivors of Domestic Violence can have chronic health problems including: gynaecological disorders, chronic pain, neurological symptoms, gastro-intestinal disorders, and self-reported heart disease[3]. The most prevalent effect is on mental health, including post-traumatic stress disorder, depression, anxiety, suicidal thoughts, and substance misuse[4].

5. In addition to this, approximately 75% of children living in households where Domestic Violence occurs are exposed to actual incidents[5]. These children have an increased risk of

developing acute and long term physical and emotional health problems[6]. Many will be traumatised by what they witness, whether it is the violence itself or the emotional and physical effects the behaviour has on someone in the household. It is also associated with an increased risk of abuse, deaths and serious injury for children and young people[7].

6. In addition to the physical and psychological effects there are further consequences for victims of Domestic Violence such as:

- ***Homelessness***. Research carried out by the homeless charity, Shelter; found that Domestic Violence is "the single most quoted reason for becoming homeless". The study found that 40% of all homeless women stated Domestic Violence as a contributor to their homelessness[8].

- ***Loss of income or work***. The British Crime Survey showed that more than one fifth of women (21%) who were employed and who had suffered Domestic Violence took time off work as a result of the worst incident[9].

- ***Isolation*** from friends and family. Feelings of isolation can also occur having left a violent relationship since victims might have had to move to a new area away from friends and family. Building new social networks and pursuing new work or educational opportunities whilst recovering from the effects of a violent relationship can be very hard especially where the victim has experienced mental health issues.

- ***Poverty*** and financial hardship.

At Risk Groups

7. The following have been identified by the World Health Organisation (WHO) and the National Institute of Health and Clinical Excellence (NICE) as risk factors for becoming a victim of Domestic Violence[10] [11]. It is important to note that the potential to become a victim of Domestic Violence increases where a combination of risk factors occurs for an individual.

- being female
- long-term illness or disability (women and men with a long-term illness or disability are almost twice as likely to experience Domestic Violence as others)
- age (women in younger age groups, in particular in those aged 16–24 years are at greatest risk)
- pregnancy (the greatest risk is for teenage mothers and during the period just after a woman has given birth[12])
- marital status (married people had the lowest risk, while those who had previously been married had the highest risk)
- alcohol consumption (alcohol use is associated with a fourfold risk of violence from a partner and is commonly present where sexual violence has occurred[13])
- drug misuse
- witnessing or being a victim of Domestic Violence as a child
- poverty, economic stress and unemployment
- frequent visitor to a nightclub[14].

What are the causes of Domestic Violence?

8. It is very difficult to identify the underlying causes of Domestic Violence as experts in the field do not agree as to what these are. As a result, there are several different, and at times overlapping, theories of causation[15] ranging from biological theories where by violent behaviour can be genetic or occur as a result of head injuries to psychopathological where behaviour is learned and shaped by early childhood experiences and social attitudes to gender and identity. Other theories examine both family and societal structures. Whichever theory is adhered to a commonly held view is that alcohol is a significant risk factor for Domestic Violence. However, a systematic review and meta-analysis[16] designed to assess the magnitude of the association between male alcohol consumption and Domestic Violence against women found the evidence for this to be of low quality. Alcohol is a situational factor that contributes to domestic and sexual violence increasing the severity rather than a primary cause[17].

Drivers for Change

9. In 2010 the coalition government launched a new cross government strategy ***'Call to End Violence against Women and Girls'***. The strategy emphasises four distinct themes:

   A. **Prevention** of violence against women and girls by challenging the attitudes and behaviours which foster it and intervening as early as possible
   B. **Provision** of adequate levels of support where violence does occur
   C. Action to **reduce the risk** to victims and ensure that perpetrators are brought to justice.
   D. **Partnership work** to obtain the best outcome for victims and their families.

10. In 2012 the first National Public Health Outcomes Framework for England was published. The framework has four domains, and the first *improving the wider determinants of health* includes Domestic Abuse. At the time of writing this report, guidance is yet to be published regarding how this will be measured. Further to this the recent Mandate[18] from the government to the NHS Commissioning Board cites the broader role of the NHS in society is to work in partnership to contribute to reducing violence, in particular by improving the way the NHS shares information about violent assaults with partners and supports victims of crime.

11. The high profile of Domestic Violence nationally is reflected in the fact that NICE is now developing guidance on how health services, social care and those they work with can identify, prevent and reduce Domestic Violence between intimate partners and this is due to be published in 2014.

12. Locally, Domestic Violence has been identified as a priority for action both for the Safer Nottinghamshire Board (SNB), the Nottinghamshire Health & Wellbeing Strategy, and for the recently elected Police and Crime Commissioner. The SNB has produced a Domestic Violence Strategic Framework (2011-13), organised around the same four key areas as the national strategy.

Picture of Domestic Violence in Nottinghamshire

13. The majority of Domestic Violence incidents or victims remain hidden, i.e. they are not disclosed to authorities. This makes it a challenge to accurately describe and analyse levels of need across Nottinghamshire. However, it is possible to estimate the numbers of victims

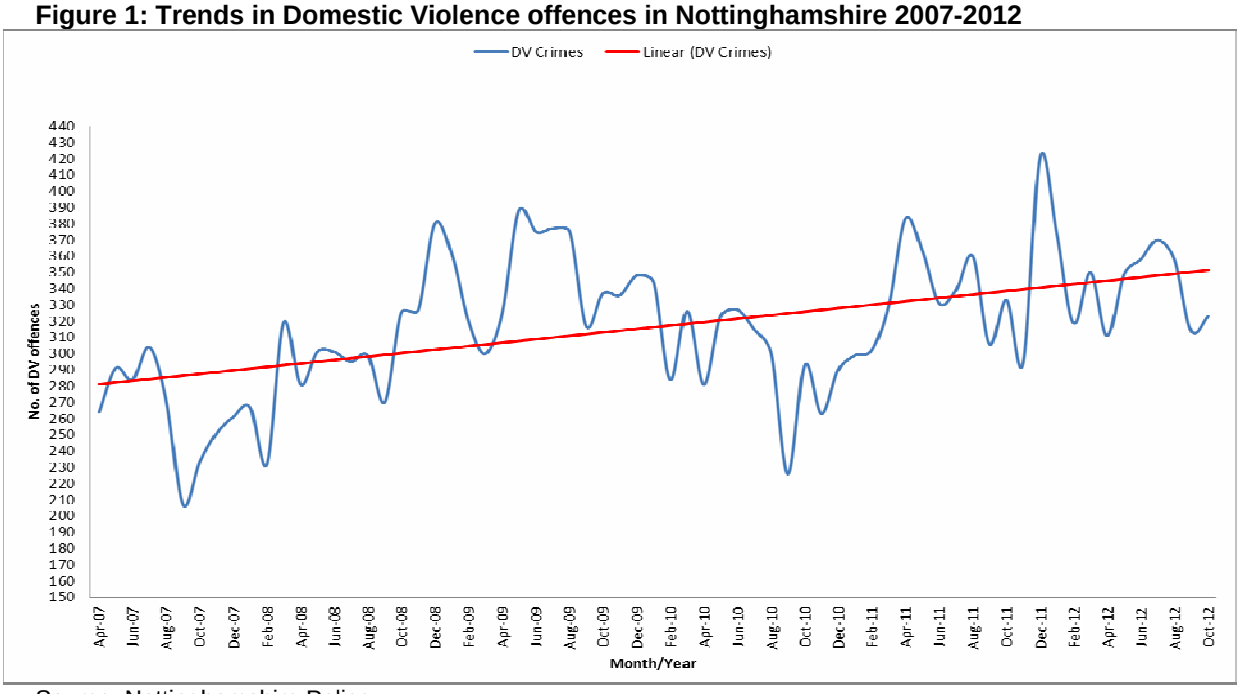
by applying the findings of the British Crime Survey 2011/12 to the Nottinghamshire population and this is shown in Table 1.

Table 1: Estimated Number of Female Victims of Domestic Violence (16-59 years of age)[19]

Period	Percentage	Numbers
Across their lifetime	29 - 32	66,410 and 73,280
In the last year	7 - 11	16,030 and 25,190

14. Nottinghamshire Police regularly provide data on reported crime. Figure 1 shows the trends in number of reported offences. This trend may be influenced by the perceived confidence of the victim in the Nottinghamshire Police Force. Indeed it could be argued that increased reporting is a reflection of growing confidence rather than growing prevalence in Violence against the Person (VAP is a performance indicator for the Police and wider Partnership). It is clear that there remains a significant gap between the estimated numbers from Table 1 and the reported numbers in Figure 1.

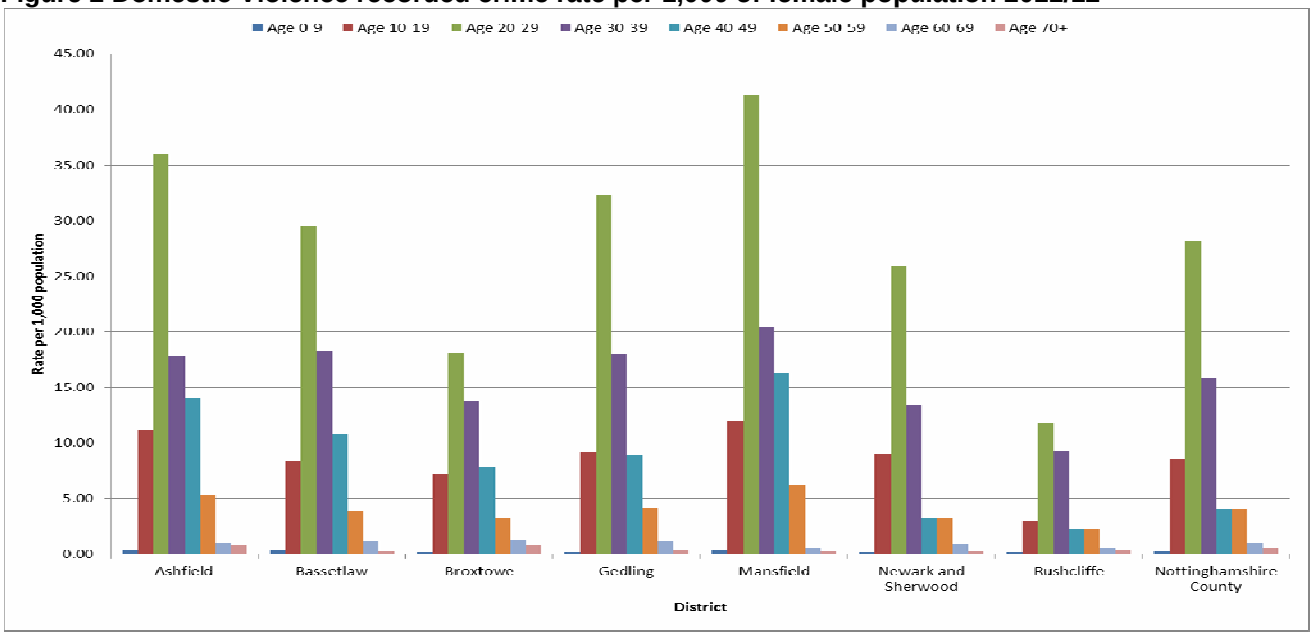
Figure 1: Trends in Domestic Violence offences in Nottinghamshire 2007-2012



Source: Nottinghamshire Police

15. Figure 2 shows the recorded crime rate is highest in the 20-29 age group and this fits with national research regarding the at risk groups. In terms of geography, Mansfield, Ashfield, Gedling and Bassetlaw Districts all exceed the County average. A profile of the victims of recorded Domestic Violence has been compiled based on Nottinghamshire Police data. Details of 3,499 of the 4,222 victims in 2011/12 are available. Of these victims 80% were female, and 16% male with the remaining 4% unknown. Of the female victims the majority (81%) were white or white European.

Figure 2 Domestic Violence recorded crime rate per 1,000 of female population 2011/12



Source: Nottinghamshire Police

16. Figure 3 (map) shows all recorded Domestic Violence crime at ward level compiled from call out locations for Nottinghamshire Police over 2011/12. The profile identifies greater numbers of Domestic Violence offences (red and orange shades) in Mansfield, Sutton in Ashfield, North Central and East, Hucknall, Eastwood, Beeston, Daybrook, Kingswell, Killisick, St. Marys Carlton, Newark town centre, Worksop, Worksop North, West and South East and Harworth. The repeat profile largely mirrors that of the pattern of offences across the county. However, it is important to note that the location of a call out will include household addresses and public premises such as streets or public houses so the repeat location profile presented here does not provide a profile of repeat victimisation. Whilst there may be an issue re how best to interpret increase in reported incidents of Domestic Violence, everyone would aspire to achieving a reduction in repeat victimisation.

17. There have been six Domestic Homicides in Nottinghamshire in the 20 months between March 2011 and November 2012.

18. In addition to presenting crime based data this paper aimed to establish what other data is available from the Health Service. However, although Domestic Violence is recorded when disclosed very little data is readily available electronically and in most services a case note audit would be required.

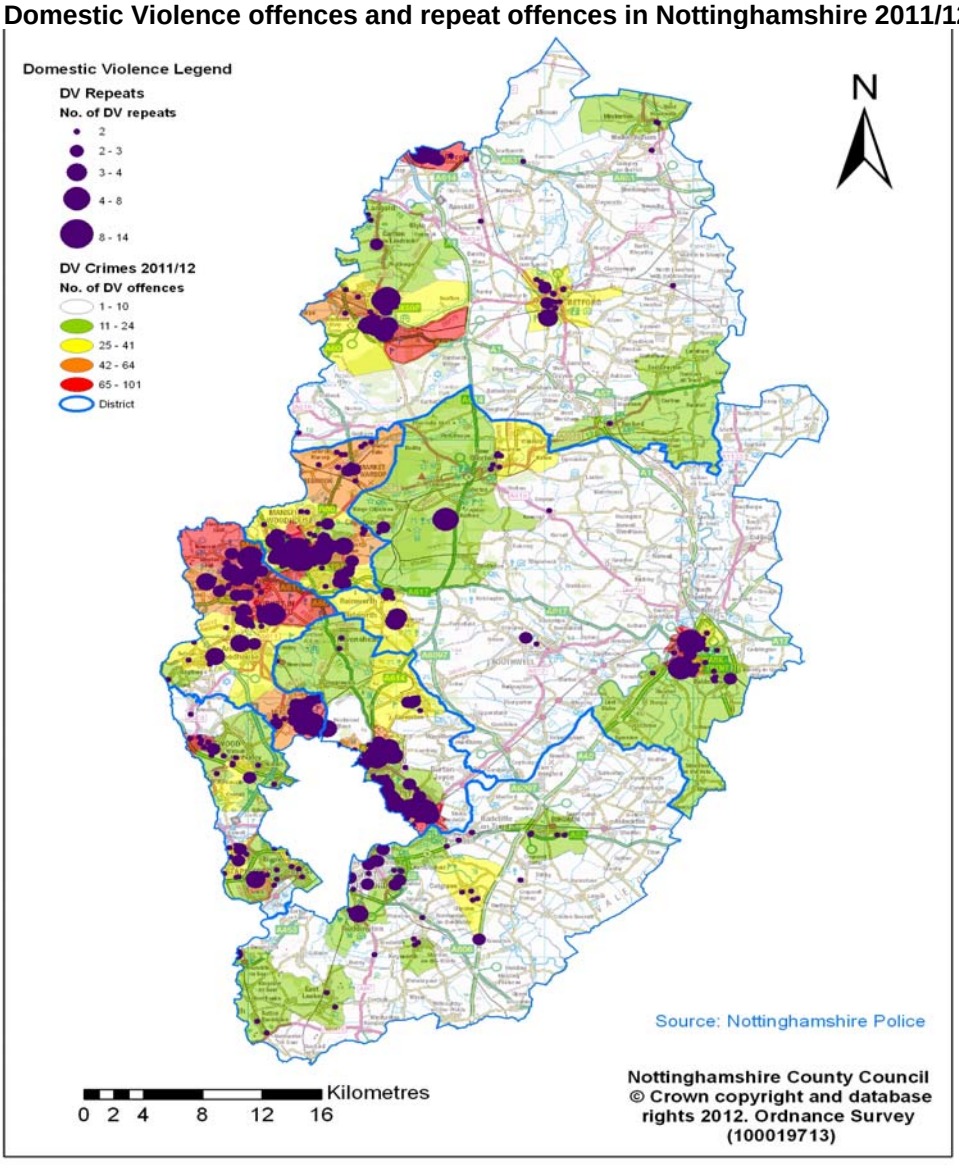
19. Many victims of Domestic Violence will attend their GP presenting with both physical and/or emotional symptoms but this data is not systematically available. Another cohort may present at A&E with trauma injuries. From November 2011 to October 2012 235 patients disclosed Domestic Violence whilst attending the A&E at Kings Mill Hospital and this information is shown in Table 2.

Table 2: SFHT A&E attendees disclosing Domestic Violence Nov 2011-Oct 2012 regardless of residency

Criteria	Number of patients
Disclosed Domestic Violence	235
Of which	
Are living with children	98 (41%)
Are pregnant	26 (11%)
Repeat attendance (previously attended for DV reasons in the last year)	50 (21%)
Registered with Nottinghamshire GP	168 (71%)
Registered with Nottinghamshire GP and referred to MARAC	57

Source: Accident and Emergency Department at Kings Mill Hospital

Figure 3 Domestic Violence offences and repeat offences in Nottinghamshire 2011/12



20. Some victims will use the emergency ambulance service. East Midlands Ambulance Service does not have a specific Domestic Violence category; instead they use an 'assault' category which covers a wide range of issues. So although EMAS will be called out to attend to victims of Domestic Violence we do not have statistics to present here.

21. All women receiving antenatal care are routinely asked about Domestic Violence by their midwife. Data from Sherwood Forest Hospital Trust (SFHT) for 2011-12 identified that 6.4% of pregnant women disclosed Domestic Violence. Despite this proactive approach the figure

falls short of the estimated numbers in Table 1. It is, therefore, a working assumption that some women still do not disclose when asked.

Table 3: Women disclosing Domestic Violence to SFHT midwifery services in 2011-12

Area	Yes	No	Total	% with DV Disclosure
Ashfield	84	1,121	1,205	6.97
Bassetlaw	0	4	4	0.00
Mansfield	79	1,337	1,416	5.58
Newark & Sherwood	123	1459	1582	7.78
North Derbyshire	3	156	159	1.89
Nottingham	1	28	29	3.45
South Derbyshire	0	65	65	0.00
(blank)	0	69	69	0.00
Total	**290**	**4,239**	**4,529**	**6.40**

Source: Midwifery Department at SFHT

22. Multi Agency Risk Assessment Conferences (MARACs) are convened fortnightly to share information on 'High Risk' cases and agree interventions to reduce the risk of harm to victims and their children. In the 12 months prior to 30th September 2012 there were 688 cases referred to MARACs in Nottinghamshire of which 88 (13%) were from Health agencies (primarily A&E, Substance Misuse and Mental Health services and Child Health Services).

23. The specialist Domestic Violence service working in the north of the County routinely asks their service users about their health and how they believe Domestic Violence has impacted on this. Of the 95 women surveyed in 2011 64% (61) disclosed having mental health issues of which 77% (47) had sought support from their GP and 62% (38) were prescribed medication. 87% (53) thought that their mental health issue was directly related to their experience of Domestic Violence. In addition to this 46% (44) of women disclosed physical health issues of which 75% (33) had sought support from their GP regarding their physical health. 99% (94) disclosed physical injury caused by assault of which 27% sought treatment from their GP and 33% via A&E.

Action being taken – Prevention

24. Schools provide a good setting for preventing the problem occurring in the first instance[20]. Directing resources at groups such as school age children can introduce new values, thinking and relationship skills that promote healthy relationships. In Nottinghamshire school based programmes such as Social and Emotional Aspects of Learning and Personal Social and Health Education contributes to children and young people's understanding of what constitutes a healthier relationship. A more targeted Domestic Violence prevention programmes called the GREAT project commissioned by the Safer Nottinghamshire Board is being implemented in schools within Partnership Plus locations (communities which experience very high levels of crime). Funded for 2 years the first year evaluation demonstrates positive outcomes and the programme appears to be an effective tool in changing knowledge, attitude and behaviour. This local evaluation is in line with emerging findings from published literature which has found that school based violence prevention programmes are effective at increasing students' knowledge, have positive effects on attitudes, increase skills and even self-reported decreases in perpetration of teen dating violence.

25. In 2009 the government consulted[21] with over 300 women. These women reported that school and community-based prevention programmes which focused on healthy

relationships and skill development would help with prevention. So in addition to school based programmes, community based programmes for adults exist. In Nottinghamshire the Freedom Programme is available to any woman who wishes to learn more about the reality of Domestic Violence.

26. Most of the action taken to reduce Domestic Violence has focused on secondary prevention, in other words action to prevent further incidents of Domestic Violence amongst those who have experienced it and or are at risk of it e.g. training staff on Domestic Violence awareness and how to ask the question. Locally there are examples across the Health Service where key personnel (e.g. accident and emergency staff) are in regular contact with women from the 'at risk' groups. All these staff receive training in Domestic Violence awareness. This is in line with the findings of a systematic review which found that 7 out of 8 studies in healthcare settings identified that structured training led to an increase in appropriate referral to other health services or support agencies. Our main community service provider, County Health Partnerships (CHP) is currently incentivised through their contract (via CQUIN) to provide training to community service staff (health visitors, schools nurses and community nurses) in Domestic Violence awareness and routine enquiry. CHP are training their staff in collaboration with Nottinghamshire Women's Aid.

27. Locally commissioned Domestic Violence service providers support children who have been affected by Domestic Violence, both on a one to one and small group basis. Staff that fulfil this role often have a dual role as a Domestic Abuse Link Worker whereby they also work within Social Care advising social workers about Domestic Violence and making contact with families to offer support.

Work in Progress – Provision

28. Nottinghamshire County Council and NHS Nottinghamshire County jointly commission two specialist Domestic Violence services to provide refuge services to women. Refuge is a critical feature of the service providing a safe place for women and children escaping Domestic Violence. Refuge offers safe 24 hour emergency accommodation for women and children escaping Domestic Violence. They have specialised staff that help and support women and children to deal with their practical needs. Evaluations of Refuge (referred to as Shelter in the literature) indicate that a stay in a Refuge can reduce the frequency and intensity of new violence[22], increase victims feeling of being safe[23] and that after two weeks of living in a Refuge women were less depressed and more hopeful[24].

29. Advocacy usually accompanies Refuge use but is also available to victims without them leaving their own home (in Nottinghamshire this is via outreach, floating support, supported accommodation and drop-in sessions). Advocacy involves the provision of advice, safety planning, support, information and liaison between victims and institutions and organisations to negotiate access to and the use of community resources (such as police, health, criminal justice, housing and legal services). Evidence from peer review journals concluded that intensive advocacy (12 hours or more duration) can help reduce physical abuse one to two years after the intervention and that brief advocacy (less than 12 hours duration) increased the use of safety behaviours both up to and beyond one year after the intervention.

30. In Nottinghamshire there is a confidential 24 hour 7 days a week telephone helpline for those affected by Domestic Violence. It offers advice, information and support on issues such as housing, child protection, immigration, welfare rights and health issues. This helpline also offers advice to professionals who may be supporting women and children experiencing

Domestic Violence. An evaluation[24] demonstrates victims gain important information and access increased levels of support through their use of Domestic Violence helpline services.

31. Counselling services are available from the specialist Domestic Violence services to anyone who may be finding it difficult to cope with their emotions and anyone who may be experiencing abuse, anxiety, fear, helplessness, shame, sadness, guilt, blame, grief and emotional loss. Victims of Domestic Violence who receive counselling can gain important information about Domestic Violence, increase their levels of support, perceive improvement in their decision making ability and experience increased self-efficacy and improved coping skills. In addition a review[25] by Barts and The London Queen Mary's School of Medicine and Dentistry recommends psychological interventions for women who have left the abusive relationship for improvement of depression and self-esteem.

Work in Progress - Reducing the risk

32. Currently there is insufficient evidence for or against the implementation of screening for Domestic Violence in all healthcare settings[26] [27] when the primary outcome goal is to prevent Domestic Violence morbidity and mortality. However, when considering secondary outcome goals such as increasing case findings (identifying those who are being abused), improving health status, decreasing subsequent abuse and utilisation of community resources such as referral to Domestic Violence services (so as to access refuge, advocacy, safety planning etc where there is evidence of benefit) then a greater case for screening arises. Some parts of the health service in Nottinghamshire (e.g. midwifery, health visitors and drug and alcohol teams) routinely screen for Domestic Violence.

33. Accident and Emergency departments at Sherwood Forest Hospitals Foundation Trust (SFHT) and Nottingham University Hospitals Trust (NUHT) currently adopt clinical enquiry where by staff ask everyone where there is clinical indication that Domestic Violence may be taking place. Both of these A&E departments have a lead Domestic Violence nurse who co-ordinates training, advises staff, oversees risk assessment and referral of patients who disclose Domestic Violence. Now that both these lead nurses are well established they are frequently called upon to support other departments within the hospital. A development at NUHT over the next year will be the appointment of a second specialist Domestic Violence post funded for up to three years by the NUHT Charitable Trust to extend the advice and training beyond A&E to other departments and to provide input into the County MARAC process.

34. Following disclosure of Domestic Violence a risk assessment is undertaken and all those who are deemed high risk are referred to the Multi Agency Risk Assessment Conference (MARAC). A 2011 review[28] of existing literature on the effectiveness of MARACs found emerging evidence that MARACs have the potential to improve victim safety and reduce re-victimisation and therefore may be a highly cost-effective measure. The three areas perceived as core to MARACs effectiveness are - enhanced information sharing; appropriate agency representation; and the role of the Independent Domestic Violence Advocate (IDVA) in representing and engaging the victim in the process. Factors which were seen as supporting effective practice included having: strong partnership links (including a commitment from agencies to tackle Domestic Violence in general); strong leadership (through the MARAC chair); good co-ordination (through a MARAC co-ordinator); and the availability of training and induction to the MARAC process.

35. Independent Domestic Violence Advocates (IDVAs) are specialist case workers who focus on working with victims who have been assessed as high risk i.e. those at most risk of harm

and or homicide. IDVAs work in partnership with other agencies to promote safety, provide emotional and practical support and reduce further risk. In 2009 the first large scale multi-site evaluation[29] of the IDVA services across England and Wales reported that of the 2,500 women studied over a 2 year period domestic abuse stopped completely in over two thirds of cases where there was intensive support from an IDVA and for those where abuse continued levels were considerably reduced. The report recommends that the number of IDVAs needs to double to achieve national coverage and that the cost of providing an IDVA to a high risk victim per successful outcome is cost effective.

Partnership working

36. The prevention and reduction of Domestic Violence in Nottinghamshire relies heavily on the successful engagement of a range of stakeholders both statutory and voluntary including engagement with the victims of Domestic Violence. A review conducted by an external consultant on behalf of the Home Office scored the SNB Domestic Violence Partnership arrangements as 'good'.

37. The new Nottinghamshire Multi-Agency Safeguarding Hub (MASH) is designed to improve and accelerate information sharing between agencies. It will involve collaboration between Police, the Local Authority, Probation and the NHS to respond to safeguarding enquiries from professionals or the public which relate to children and vulnerable adults. Information on previous Domestic Violence and related risk assessments will be some of the information that can be shared by partners within the MASH to inform safety planning and signposting to support services. It is anticipated that safeguarding interventions will be implemented more quickly and effectively as a result of the MASH process.

Current Gaps or Challenges

38. Currently NICE are compiling guidance on preventative approaches to reducing Domestic Violence which is due in 2014. However, pending its recommendations there are some current noticeable gaps in service provision in Nottinghamshire which commissioners should seek to address.

39. Despite Domestic Violence being such a sizable public health issue Ramsay et al[25] identifies that there is a lack of evidence based treatment approaches in primary care. Evidence[30] from Domestic Violence service users is that the response they have received from primary care clinicians is inconsistent. Yet primary care can be victims first or only point of contact with professionals[31]. GP practices and Clinical Commissioning Groups are not currently engaged in the Multi Agency Risk Assessment Conferences (MARACs). General Practice does not routinely refer patients to MARAC or have a systematic way of exchanging information and actions on patients who have been party to MARAC unless children are involved (where information exchange is managed by County Health Partnership staff).

40. Following the publication of a UK based randomised controlled trial[3] in 2011 a new approach called Identification and Referral to Improve Safety (IRIS) is being adopted within Primary Care in some parts of the England. The programme includes practice based training sessions, a prompt within the medical records to ask about abuse and a referral pathway to a named Domestic Violence advocate who also delivers the training and provides further consultancy to practices. The primary outcome was recorded referral of patients to the Domestic Violence advocacy service. The results show that 12 months after the intervention training 21 times as many victims of domestic abuse had been referred in the intervention practices than in the control group. This provides evidence that the intervention improves

the response of clinicians to women experiencing Domestic Violence. The IRIS approach is currently being implemented in Nottingham City but not in Nottinghamshire.

41. Emerging themes from the six DHRs to date identify gaps in how Domestic Violence is being addressed in Nottinghamshire. These include:

- Gaps in staff Domestic Violence awareness leading to the need to revise or revisit their training programmes
- Information sharing has not been effective both within and between agencies leading to failure to see the whole picture and complexity of a case. In particular linkage between criminal justice agencies and health service providers has been poor in some instances
- Risk Assessment and referral procedures have not always been followed correctly or recorded adequately.

42. Despite attempts to more systematically identify and risk assess victims of Domestic Violence at A&E departments across Nottinghamshire inconsistencies remain in whether this information is communicated back to the victim's GP. A letter to the GP will describe the presenting reason e.g. 'head injury' but rarely gives a fuller explanation e.g. physical assault by partner.

43. Owing to the increase in reporting of domestic violence and the potential for this to increase further, there is a need to ensure that there is sufficient capacity within both MARACs and the Independent Domestic Violence Advocates (IDVAs) service to meet needs.

44. There is limited provision for those identified at 'medium risk' of Domestic Violence.

45. Primary prevention programmes in schools (the GREAT Project) has been targeted to Partnership Plus areas as priority in 2011 and 2012. This means that there is currently an absence of prevention programmes in areas where domestic violence will be prevalent yet under reported (hidden need). The funding for the GREAT Project is short term.

Statutory and Policy Implications

46. 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.

Recommendations

It is recommended that the Health and Wellbeing Board:

1) note the content of this report

2) approve that the Domestic Violence Strategy group develops a plan of action to address the challenges identified above and presents a follow up report to the Health & wellbeing Implementation Group in 3 months time.

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Constitutional Comments (SG 11/12/2012)

47. The Board is the appropriate body to consider the issues set out in this report.

Financial Comments (NDR 07/01/2013)

48. There are no financial implications arising directly from the report

Background Papers

None.

Electoral Division(s) and Member(s) Affected

All.

HWB50

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Nottinghamshire County Council

Report to the Health and Wellbeing Board

16th January 2013

Agenda Item: 6

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

EXPENDITURE OF CARERS FUNDING ALLOCATION - PROPOSED PLANS - NOTTINGHAMSHIRE CLINICAL COMMISSIONING GROUPS (CCGS)

Purpose of the Report

1. To notify the Health and Wellbeing Board of the availability of an additional £1.5million recurrent funding from Health to be spent on support for Carers across Nottinghamshire County.

2. To share with the Board outline proposals for use of the funding; and

3. To set out the appropriate Governance arrangements to ensure appropriate use of monies and monitoring of the impact on outcomes for Carers and the people they care for.

Information and Advice

4. Nottinghamshire County Council currently spends £4.4m on care and support for Carers and the people they care for. The services currently available for Carers range from one-off personal budgets (of up to £200.00), Day services and short breaks, crisis prevention schemes and the use of Assistive Technology.

5. NHS Nottinghamshire County received, as part of its financial settlement in 2012/13, a hypothecated sum for carers. This amounts to £1.5 million and, until this point, this amount has been held as a central reserve by the Primary Care Trust.

6. Current health expenditure on carers is principally through the funding of carers breaks – Health pay for the member of staff to administer breaks as part of the continuing health care scheme and circa £300,000 is spent each year on Carer's breaks. There are other funds, much smaller, available in individual Clinical Commissioning Group (CCG) schemes in addition to this amount.

7. Health services are continually being scrutinised to test the level of expenditure on carers, with regular questions through Freedom Of Information (FOIs) requests and other channels. Given the recent emphasis on support for carers, it is important and timely to recognise the contribution that carers make in enabling the 'cared for' person to remain at home and out of more costly hospital or other health-related care or long term residential care.

8. This paper proposes plans for the use of this funding (an additional £1.5 million) on carers this year and recurrently.

What approach should we take?

9. It is important that this additional funding is utilised to secure maximum impact on improving outcomes for both Carers and the people they are caring for. In planning for this, account should be taken of the following:

    - There is already an existing agreed joint carers strategy between Health and Nottinghamshire County Council.(see **Appendix 1**)
    - There is a clear connection between investment in carer services to prevent breakdown of care for the 'cared for' person, who might be at risk of admission to hospital or residential care. This is of particular concern over the winter period, when unplanned admissions to hospital increase.
    - Due to the aging population, as well as the increase in the incidence of dementia, there is a need to consider services that are specific to the needs of those who are carers of people with dementia.
    - There are agreed and clear governance arrangements for Joint Commissioning with Nottinghamshire County Council and the CCGs.

Funding proposals

10. The following proposals are suggested for the use of an additional £1.5million on a recurrent basis:

    - Immediate increase in funding carers breaks. This budget (held by Health) is under pressure and, now we have generated interest and awareness amongst carers, we need to provide funding for the anticipated increase in demand for this service. **The proposal is to double the current investment (an additional £300k) on a recurrent basis.**

    - Health contribute a very small amount to the overall carers spend (about £300k). The carers strategy and action plan has been widely consulted on with carers and other stakeholder groups. **The proposal is to transfer one million from Health to the Local Authority in 2012/13 and then year on year.** The Carers Implementation Group, which has CCG representation, will develop a prioritised list of recurrent and non-recurrent schemes for use of this investment for approval by the CCG Accountable Officers and the Cares lead for the County Council. **The proposal is that the existing integrated Commissioning Group for Older People, which also has CCG representation, will oversee the use of the funding and account to the CCGs and the County Council for its appropriate use**. The transfer agreement will enshrine these as the appropriate governance arrangements for oversight of this funding.

      The Carers Implementation Group will seek to prioritise 'winter' schemes, such as targeted support for carers of frail elderly and those with dementia. (Around 60% of the referrals for Carers Breaks are for Carers looking after those living with

Dementia or other memory related conditions). Many of the carers are elderly or have a Long Term Conditions themselves.

- **The proposal is to allocate the remaining funding (£200k) on a capitation basis to CCGs.** This will facilitate the development and uptake of a Local Enhanced Service (LES) for GP practices to provide early identification of carers and signposting into support services that currently exist. Many carers do not consider or see themselves as carers. They see looking after the person 'cared for' as just something they have to or want to do. The introduction of a LES and practice register with a commitment to health checks for carers would incentivise the involvement of a wide range of professionals in becoming aware of carer issues and risks. This would mean that an additional 2000 carers could be identified and the associated risks managed. The approximate funding split across the 5 CCGs is shown below:

Mansfield & Ashfield	**Newark & Sherwood**	**Nottingham North & East**	**Nottingham West**	**Rushcliffe**
30.27% (£60,000)	18.67% (£37,000)	21.66% (£45,000)	13.63% (£27,000)	15.77% (£32,000)

Other Considerations

11. Nottinghamshire County Council has, in the past, found it difficult to engage with the Primary Care Trust and more recently the CCGs to progress the issues related to the carers agenda as there is no identified lead for Carers across Health.

12. Given the growing focus on this area and the requirement to have robust governance arrangements for the use of joint funding, the CCGs are recommended to appoint a **carers lead** and ask that this responsibility is recognised in the revised memorandum of understanding between the CCGs. Whilst there is not a requirement to have an additional post, the governance arrangements need to ensure that all CCGs are appraised of Carers developments and proposals regarding future expenditure of this recurrent funding.

Recommendations already agreed by CCGs

13. Support the recommendations for allocation of the £1.5m funding set out in this paper:

    a. £1.0m be transferred to the County Council on a recurrent basis
    b. £0.3m be added to the budget for the provision of Carers breaks administered by the CCGs
    c. £0.2m be allocated to the 5 CCGS for use on Carers initiatives.

14. Agree that the existing governance arrangements will be sufficient to oversee the use of the joint funding on an on-going basis and that these should be set out in the section 256 agreement. However, request, on a one-off basis, the Accountable Officers to 'sign off' the plan when it has been produced by the Carers Implementation Group.

15. Ask the finance team (Health) to enact the necessary funding transfer.

16. To further improve governance, agree the nomination of a Carers Lead in one of the CCGs on behalf of all and tie this in to a revised memorandum of understanding.

17. Agree to the identification of a Carers lead for CCGs.

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) Note and support the recommendations for proposed expenditure of the additional £1.5m funding.

2) Receive a further report in April 2013 updating on the Carers Strategy and how the additional funding will be used across Health and Social Care.

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

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Constitutional Comments (SG 07/01/2013)

19. The Board is the appropriate body to consider the issues set out in this report.

Financial Comments (NDR 07/01/2013)

20. The financial implications are set out in the report.

Background Papers

None.

Electoral Division(s) and Member(s) Affected

All.

HWB57

Improving Lives – Nottinghamshire Joint Commissioning Strategy
Strategic care area: Carer Support

CARERS' STRATEGY AND ACTION PLAN 2012- 2013

1. Introduction

This Joint Commissioning Strategy is the over-arching strategy agreed by Nottinghamshire County Council, NHS Nottinghamshire County and NHS Bassetlaw in relation to carer support. It has been developed in partnership with carers, NHS and voluntary / community sector colleagues.

The strategy and action plan is overseen by the Nottinghamshire Carers' Implementation Group, which in turn is overseen by the Older Peoples' Integrated Commissioning Group and ultimately the Health and Well Being Board.

The action plan will be developed and up-dated on a quarterly basis following scrutiny by the Carers' Implementation Group. Other relevant strategies will be taken into account in terms of developing actions/activity, for example the Nottinghamshire Healthcare NHS Trust Carer Strategy.

2. Purpose and Context

Many people, mainly women, are now balancing work, childcare and caring for an ageing parent. Increasing numbers of older people often care for their partner while providing childcare for grandchildren and parents of children with complex health needs, knowing that they will be 'lifetime' carers. Furthermore, the positive shift to independent living and care at home, away from institutional care, will continue to require a greater contribution from carers.

The challenges posed by an ageing society and the concurrent increase in the number of carers are relevant to both the NHS and to Local Authorities, and also the voluntary and community sector. It is therefore essential that the needs and services required by carers are considered jointly. The key principles underpinning the work include:

- Involving and engaging carers in decisions that affect them as individuals and decisions made by policy makers about the way public money is spent
- Putting carers at the heart of service delivery and decisions, rather than expecting carers to fit around the needs of a service
- Enabling carers to take more control and exercise more choice in the services they access
- Outcomes which improve the quality of life of carers

83,000 carers identified themselves in the 2001 census, with approximately 26,000 of those classed as providing 20 hours or more of regular and substantial care. Nottinghamshire has a higher proportion of carers in the population than the England average. Ashfield has the largest number of people providing unpaid care, and Mansfield has the highest proportion of carers in the population. Most carers in Nottinghamshire were aged between 35 and 59.

3. Context and drivers

3.1 'Carers at the heart of 21st Century Families and Communities', Department of Health, 2008

The key aims of the national carers' strategy by 2018 are:

- Carers will be respected as expert care partners and will have access to the integrated and personalised services they need to support them in their caring role
- Carers will be able to have a life of their own alongside their caring role
- Carers will be supported so that they are not forced into financial hardship by their caring role
- Carers will be supported to stay mentally and physically well and treated with dignity

Children and young people will be protected from inappropriate caring and have the support they need to learn, develop and thrive, to enjoy positive childhoods and to achieve against all the 'Every Child Matters' outcomes

3.2 "Our NHS care objectives: a draft mandate to the NHS Commissioning Board", Department of Health, 2012

This highlights carers, focusing on early identification of carers, positive experience of care, working collaboratively, enhancing quality of life for carers of people with long term conditions, improved co-ordination, opportunities, information and support to take an active role in decisions about care and treatment, etc.

3.3 "Caring for Our Future: reforming care and support", White Paper, 2012 Outcomes

The vision outlined in this paper is one that promotes people's independence and wellbeing by enabling them to prevent or postpone the need for care and support; clearly the role of carers is crucial in achieving this.

3.4 "In Sickness and in Health". A survey of 3,400 carers, www.carersweek.org, 2012

This survey emphasises the plight of carers:

- 83% said caring had a negative impact on their physical health and 87% on their mental health
- 39% had put off medical treatment because of their caring
- 37% of carers aged 18 to 64 had to cease working because of their caring responsibilities

3.5 "Transparency in outcomes: a framework for quality in adult social care", Department of Health, 2012

The outcomes listed below are all related to carers, demonstrating the importance of the carer voice and experience in the delivery of health and social care.

Domain	Outcome	Measure
1. Enhancing quality of life for people with social care and support needs	Carers can balance their caring roles and maintain their desired quality of life	Carer reported quality of life (from Carers' Survey due October 2012)

2. Delaying and reducing the need for care and support	Earlier diagnosis, intervention and reablement mean that people and their carers are less dependent on intensive services	The proportion of older people (65 plus) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services
3. Ensuring that people have a positive experience of care and support	Outcome: People who use social care and their carers are satisfied with their experience of care and support services	Overall satisfaction of carers with social services (from Carers' Survey due October 2012)
	Carers feel that they are respected as equal partners throughout the care process	The proportion of carers who report that they have been included or consulted in discussions about the person they care for (from Carers' Survey due October 2012)
	People know what choices are available to them locally, what they are entitled to, and who to contact when they need help	The proportion of …carers who find it easy to find information about services (from Carers' Survey due October 2012)

4. NHS Operating Framework

The NHS Operating Framework for 2012 identifies action required by Local Authorities and Primary Care Trusts in relation to carers.

	NHS Nottinghamshire County	NHS Bassetlaw	Nottinghamshire County Council
Plans are explicitly agreed and signed off by PCTs and Local Authority	√ This Carers' Strategy is agreed and signed off	√ This Carers' Strategy is agreed and signed off	√ This Carers' Strategy is agreed and signed off
Identify the financial contribution made to support carers by both Local Authorities and PCT clusters	£300,000 for 2012- 2013	£310,000 for 2012 - 2013	£4,403,548 for 2012 - 2013
Specify how much of the total is being spent on carers' breaks	100%	Difficult to determine as spend on breaks is based on services provided to a service user which give a carer a break. However, to date no request for a break has been turned down.	65% or £2874,304 (this is based on services provided to a service user which give a carer a break)
Identify an indicative number of breaks	Approximately 400	Difficult to determine as breaks are not separately identified	Difficult to determine as breaks are not separately identified
Published on PCT clusters' website	√ Will be published on NHS website by 30.9.12	√ Will be published on Bassetlaw PCT website by 30.9.12	√ Will be published on NCC website by 30.9.12

Carers					
Strategic Outcomes sought: • More carers identified • More carers assessed and offered support • More young carers identified • Improved quality of life for carers • More carers accessing assistive technology • More carers offered Personal Budgets • More carers offered a break from caring			**Key Risks:** a) Low numbers of young carers identified b) Agreeing priorities within the strategy or commissioning plan across the partnership c) Inadequate engagement of carers		
Actions required/milestones	**Target/measure**	**Timescale**	**Lead (post/ organisation)**	**Resources**	
				Delivery capacity	**Activity/ Service**
Ensure joint carers plans are in place, including carers breaks	Identify the financial contribution made to support carers by both Local Authorities and PCT clusters, specifying how much of the total is being spent on carers' breaks (from NHS Operating Framework, 2012)	30 September 2012	• NHS Nottinghamshire County & Bassetlaw Primary Care Trusts (PCT) & Nottinghamshire County Council (NCC) • Nottinghamshire County Council (NCC) commissioning team		
	Identify an indicative number of breaks that should be available within the funding and publish all this information on websites by 30 September 2012 (from NHS Operating Framework, 2012)	30 September 2012	• NHS Nottinghamshire County & Bassetlaw PCT & NCC • NCC commissioning team		

Improve support to carers	Ensure carers of people living with dementia can benefit from psychological therapies	March 2013	• NHS Nottinghamshire County & Bassetlaw PCT & NCC • NCC commissioning team		
	Assess the level of support available to carers of people with early onset dementia and provide recommendations for service development	March 2013	• NCC commissioning team • NHS Nottinghamshire County & Bassetlaw PCT		
	Increase the number of Direct Payments offered to eligible carers	March 2013	• NCC commissioning team		
	Organise a focus group to ensure suitable advice, information and support available for carers from Black and Minority Ethnic (BME) communities. Involve voluntary sector providers (Carers' Federation, Rushcliffe CVS, Self Help Notts etc) in this work Make use of learning from demonstrator site	December 2013	• NCC commissioning team		
	Evaluate schemes identifying and supporting carers in hospital settings: a) Lings Bar Hospital b) Carers' Federation and NUH scoping a project	Up-date December 2012	• NHS Rushcliffe Clinical Commissioning Group • Nottingham University Hospitals Trust • Carers' Federation		

	Increase number of carers using assistive technology to 79 (10% increase from 2011-12)	March 2013	• NCC Mark Douglas		
	Carer training: a) Carers' Federation to run training courses ('Caring with Confidence') across the county b) Increase awareness of and recruitment to 'Looking After Me' course c) Work with Job Centre Plus to raise awareness of 'Work Preparation Support Programme' for carers, in relevant settings	March 2013	• Carers' Federation • Nottinghamshire County Health Partnerships • NCC commissioning team • Job Centre Plus		
	Carry out awareness raising sessions with organisations supporting carers of people misusing substances/alcohol to increase up-take of support available (e.g. carer assessments/personal budgets\)	March 2013	• NCC commissioning team		
	Explore expansion of crisis prevention scheme remit to include enhanced support for carers when the caring role is at risk of breakdown (link with 'Living at Home' initiative and 'Care and Support' centres)	March 2013	• NCC commissioning team		

Identify and support young carers	Project established to support young carers and provide appropriate care for disabled parents (and disabled siblings) Aims: • To diminish the amount of caring undertaken by young children/adolescents • To meet the needs of young carers • To increase awareness of issues for young carers (Nottinghamshire Young Carers' Strategy:)	March 2013	• NCC Sue Foster / commissioning team		
Identify carers within all settings e.g. health, community settings	Increase number of carers identified and assessed	March 2013	• NCC commissioning team • NHS Nottinghamshire County Clinical Commissioning Groups • Nottinghamshire Healthcare Trust		
	Develop or support multi agency forums in each district , aiming to identify carers and to involve them in planning Ensure that groups representing BME carers are included	March 2013	• NHS Nottinghamshire County Clinical Commissioning Groups • Nottinghamshire County Council		

Improve information for carers	Carer information to be available in all GP surgeries and hospitals	December 2012	• NHS Nottinghamshire County Clinical Commissioning Groups • NCC commissioning team		
	Roll out of First Contact Scheme incorporating a carer question and provision of information (factsheet) to all identified carers	March 2013	• NCC commissioning team		
	Adult Access Team carer worker to ensure that all carers contacting the department have access to good quality and timely information/signposting	Model fully operational by March 2013	• NCC Adult Access Team and commissioning team		
	Improve information for parent carers	March 2013	• NCC commissioning team • Children's' services		

APPENDIX

Integrated Commissioning principles and processes

During development of the Health and Wellbeing Strategy, partners agreed on underpinning principles and processes. In developing the Health and Wellbeing Strategy a set of criteria was agreed to enable comparison and prioritisation:

- Whether the service addresses unmet local need
- The benefit that can be produced from a change in service. Whether it will extend life, improve quality of life or close the gap in health inequalities
- The level of certainty that the change will deliver real improvements, using evidence from where it has been used before.
- Whether improvements can be measured
- If the cost is reasonable compared to the level of benefit produced
- Whether benefits will be seen in a practical timeframe
- Whether there is potential to improve efficiency or quality through joint working
- Whether the community supports the proposed change.

Several events were also held to develop the principles, process and 2012-13 Integrated Commissioning priorities:

Principles

Partners within integrated commissioning will:

- ensure services are shaped by those who will use them**,** by actively engaging local communities and partners, (including children, adults and carers), in the co-design, development, commissioning, delivery and evaluation of local care and support options
- ensure proactive safeguarding of children and adults, especially the most vulnerable in our county
- support a shift to early intervention and prevention, seeking where possible to maintain and improve health and thereby reduce demand for more intensive services
- consider decommissioning services that are no longer appropriate for future purpose, as well as refocusing and commissioning new services
- encourage innovation in delivering services and developing providers
- be transparent, sharing information as appropriate
- seek to promote independence and develop more personalised options, supporting and enabling people to have choice and control over their care and support
- make a shift to provide more care closer to home where this offers value for money

Process of implementing integrated commissioning priorities – planning how we will do it and making it happen:

- Service models and interventions chosen should be based on evidence of evaluation or research into their effectiveness. When new innovations are trialled, they should be subject to robust evaluation.
- Consideration will be given to the use of flexibilities under section 75 of the NHS Act 2006, (pooled budgets, lead commissioning and integrated provision) where it can be shown that using these adds value, over and above what other methods could.
- Partners will agree a joint investment plan that will identify respective contributions, how any anticipated savings will be spilt and how financial risks, e.g. new cost pressures, will be managed and shared. This may require include work that avoids future escalating costs e.g. by reducing levels of demand, as well as active disinvestment.
- Commissioners will establish systems of measuring jointly agreed outcomes to inform their investment decisions e.g. do fewer people fall as a result of engaging with a falls service?
- Risks will be understood, monitored and managed both as individual organisations, as well as for the partnership
- Initiatives will be supported by strong senior leadership, appropriate governance arrangements and capacity to deliver.
- Methods will be agreed to jointly stimulate providers, as appropriate. This will include pro-active engagement with providers on service models to address/avoid perverse incentives
- Consideration will be given to undertaking lead or joint procurement arrangements where benefits can be established

Nottinghamshire County Council

Report to Health and Wellbeing Board

16th January 2013

Agenda Item: 7

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

HEALTH AND WELLBEING IMPLEMENTATION GROUP REPORT

Purpose of the Report

1. This report provides a summary of progress made by the Health and Wellbeing Implementation Group. It describes achievements around governance, review of the Joint Strategic Needs Assessment and progress made by a range of integrated commissioning groups.

Information and Advice

2. Following approval of the Terms of Reference by the Board, the Health and Wellbeing Implementation Group was established in May 2012.

3. The Health and Wellbeing Implementation Group is responsible for managing the work programme on behalf of the Health and Wellbeing Board, assisting the Board to fulfil its statutory duties. It ensures the delivery of the Health and Wellbeing Strategy through monitoring and holding integrated commissioning groups to account for delivering against their commissioning action plans.

Key Achievements

4. Key achievements of the Health and Wellbeing Implementation Group, including the work of its associated supporting structure between May and December 2012 cover strategic, governance and delivery aspects. Further details of these achievements are included in **Appendix One**.

Delivery

5. One of the main roles of the Implementation Group is to ensure delivery of the Health and Wellbeing Strategy by the range of integrated commissioning groups. Examples of key successes involving Adult and Older People have been included in **Appendix Two**.

6. Since presenting a report on Dementia to the Health and Wellbeing Board in September 2011, £1.5M has been secured as a direct result of raising

the profile of dementia and identifying the level of unmet need. The funding has been invested in Mental Health Intermediate Care Services and Dementia Memory Assessment Services (with social care support). In addition, dedicated social workers have been identified to support the intermediate care services. All services will be up and running by April 2013.

7. Reports have been received from most integrated commissioning groups, describing review of systems, processes and membership to align them to the Health and Wellbeing Board. This work has gone alongside continued delivery of key priority areas. The Children's Trust Executive has reviewed its accountability mechanism to form a direct link between the integrated commissioning groups for Teenage Pregnancy, Child and Adolescent Mental Health Services (CAMHS), Children and and Young Peoples Disability and Special Educational Needs, and the Health and Wellbeing Board. **Appendix Three** includes a summary of key achievement during this time.

8. **Appendix Four** includes a recent report from the Tobacco Control integrated commissioning group, which identified key commissioning priorities and early benefits being realised.

9. Each group has been asked to identify up to three key actions which have been prioritised for early progress. Achievement of these will be monitored and reported at future meetings.

10. A reporting framework is being established to bring consistency to the reporting schedule. This includes review of key successes under the new system and risks along with identification of the three key actions to allow prioritisation within the Health and Wellbeing Strategy.

Strategy and Governance

11. As the Health and Wellbeing Implementation Group is in the early stages of establishment, there has been significant investment in setting strategy and robust governance arrangements to build a platform for future delivery. Key successes include:

    a. Establishment of the Health and Wellbeing Implementation Group with nominated membership and work programme.
    b. Review and approval of detailed supporting structures to support the work of the Health and Wellbeing Board, including the review of joint commissioning arrangements to form the new integrated commissioning structure.
    c. Review of the Joint Strategic Needs Assessment and development of an ongoing programme of work.
    d. Development of a reporting mechanism to review progress of the integrated commissioning groups in the delivery of the Health and Wellbeing Strategy.

e. Development of a Local Outcomes Framework to support the delivery of the Health and Wellbeing Strategy.
f. Development of a communication and engagement plan for the Board.
g. Planning of the next Stakeholder network, due to take place in January 2013.
h. Oversight of the Public Health transition process and establishment of local HealthWatch.

Future Programme

12. The Health and Wellbeing Implementation Group will prioritise the following actions over the next 3 months.

a. Implementation of the Communications and Engagement Plan following approval.
b. Organisation of the next Health and Wellbeing Board Stakeholder event.
c. Further development of Operating Principles for the Health and Wellbeing Board.
d. Proposal for a development plan for Health and Wellbeing Board based on findings of the recently completed self assessment.
e. Development of reporting arrangements for the Health and Wellbeing Board supporting structure.
f. Development of a Local Outcomes Framework to monitor the delivery of the Health and Wellbeing Strategy.
g. Development of plan to initiate a continual refresh for JSNA and Health and Wellbeing Strategy.

Statutory and Policy Implications

13. 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) The Health and Wellbeing Board is asked to note the content of the report describing progress being made to support the work of the Board and delivery of the Health and Wellbeing Strategy.

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

For any enquiries about this report please contact:
Cathy Quinn, Associate Director of Public Health

Constitutional Comments

14. Because this report is for noting only, no constitutional comments are required.

Financial Comments (NRD 07/01/2013)

15. There are no financial implications arising directly from the report.

Background Papers

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

a. Health and Wellbeing Board report - Structures to Support the Work of the Health and Wellbeing Board 11 January 2012.

b. Public Health Transition Self-assessment 10 October 2012.

c. Public Health Business Plan 2012-13 December 2011.

Electoral Division(s) and Member(s) Affected

All.

HWB51

Appendix One

Nottinghamshire County Council

Summary Report from the Health and Wellbeing Implementation Group

December 2012

The following report described the key achievements of the Health and Wellbeing Implementation Group and its associated supporting structure.

The Health and Wellbeing Implementation Group provides the executive oversight to the Board by directing the work of the groups within the supporting structure. These include a range of integrated commissioning groups covering areas such as older people, mental health, children and young people and obesity along with other areas.

The Health and Wellbeing Implementation Group was established in May 2012 and meets every other month to performance monitor activity and manage the work programme.

Health and Wellbeing Board Governance
The Supporting structure to the Health and wellbeing Board (HWB) is now in place, which provides a good governance system to manage the work of the HWB.

Communication and Engagement Plan
A communication and engagement plan has been written and will be presented at the January HWB.

Stakeholder Network
A second stakeholder network is being organised for early January 2013. The event will concentrate on the link between housing and health, using case studies and sharing of good practice. The event is being lead jointly across the Public Health, County and District Councils.

JSNA, Strategy and Outcomes Group
The JSNA, Strategy and Outcomes Group has a coordinating function bringing together the outputs of the integrated commissioning groups. Its main role is to maintain a work programme to continually refresh and develop the JSNA and Health and Wellbeing Strategy (HWS). This work is supported by the development of a Local Outcomes Framework to monitor delivery of the strategy, and implementation of a communication and engagement plan to ensure the JSNA and HWS is developed around local views.

- **JSNA and Health and Wellbeing Strategy**

The Groups has produced a work programme for the review of the JSNA content format and accessibility. This is being lead through a working group to produce a comprehensive library of information that is easily navigated. To

support this work a standard template is being piloted to bring consistency to the content and format of the JSNBA chapters.

A Draft Local Outcomes Framework has been produced and consulted on within the integrated commissioning groups. This includes a core set of outcome measures from the various nationally outcomes frameworks. Work is now taking place to produce a baseline and targets for consideration and approval by the health and Wellbeing Board in March 2013.

Review of the health and Wellbeing Strategy has commenced with the identification of three key priorities from each integrated commissioning group. Consultation is due to commence in January on the scope format and content of the next strategy.

HealthWatch
The commissioning of Local HealthWatch is being led through Policy Planning and Corporate Services and includes Public Health, NHS and LINks involvement. Following a detailed tender exercise the applicants did not meet the required service specification; therefore the contract could not be awarded. In January, the Policy committee is due to consider whether to establish HealthWatch as a social enterprise supported by the County Council. If approved, the Council will establish Local HealthWatch through an implementer and adverts for HealthWatch Board chair and members will be issued to ensure Local HealthWatch is established by April 2013.

Public Health Transition
A dedicated Project Board has been established to manage the remaining 4 months of transition. This provides in depth support to areas of transition that require detailed action. The project is sponsored through David Pearson and Chris Kenny and managed through Cathy Quinn, Associate Director of Public Health.

There are currently 62 members (56.3 FTE) of the Public Health Department. Five members of staff are currently employed by NHS Bassetlaw; the remainder are employed by NHS Nottinghamshire County. Nottinghamshire County staff are already co-located within County Hall and Meadow House.

It has been agreed nationally that a transfer scheme will govern the legal transfer of Public Health staff from the NHS to Local Authorities. This Transfer scheme is being developed nationally to set the terms of all PCT staff transfers across the Country. Therefore many issues are being considered nationally, including employment terms and conditions at transfer and pensions. The HR working group is maintaining oversight of these issues to ensure they are resolved effectively prior to transfer

There are no significant risks identified for the transition that are not being addressed. Detailed work is being taken forward to address the smooth and effective transfer of contracts, staff and PH functions by 31 March 2013.

A self assessment was submitted on 10th October 12 describing the status of the current transition arrangements.

Public Health Grant
Confirmation on the Public Health Grant for 2013-14 is still outstanding but is now expected in January, following further discussion on the allocation formula. As Nottinghamshire County is not an outlier, it is not expected that the shadow grant will be significantly different to the actual allocation.

A confirm and challenge session took place on 8th October with senior Public Health managers to discuss priorities for funding over the next 1-2 years. Each policy lead presented their case, and members of the department challenged the information based on prioritisation criteria agreed by the Health and Wellbeing Board. Proposals will be presented to the Corporate Leadership Team, Health and Wellbeing Board and Public Health subcommittee (once established) to agree the Public Health Grant allocations and business plan.

A report is due to be presented to the January Health and Wellbeing Board following consultation with the Corporate Leadership Team (CLT). The paper outlines the preparatory work that is taking place to ensure the Council agrees the PH grant by April 2013.

Public Health Business Plan
The Public Health Department continue to make progress against their annual business plan. Regular reporting of activity is collated through departmental checkpoint reports. These illustrate the broad scope of Public Health work and how it contributes to delivery of the Public Health and Health and Wellbeing agenda.

Public Health Governance
A Public Health Governance Framework is being considered nationally by the UK Association of Directors of Public Health (DPH) and internally by CLT. In line with this process, a Public Health subcommittee is being established to provide a formal mechanism within the council to approve Public Health strategy and action. There will be a dual role with the Health and Wellbeing Board, as much of the Public Health agenda falls within their remit. The policy committee has approved the establishment of the Public Health subcommittee, which will hold its first meeting in February.

Further information is available from: Cathy Quinn, Associate Director of Public Health

Appendix Two

Joint Commissioning:
Examples from Nottinghamshire County Council's work with partners

1. **Mental Health Support Services**
2. **Care, Support and Enablement for Younger Adults**
3. **Mental Health Supported Living – alternatives to residential rehabilitation and secure units**
4. **Partnership Homes, Learning Disability Residential Care**
5. **Integrated Community Equipment Service (ICES)**
6. **Mental Health Intermediate Care Services for Older People (MHICS)**
7. **Urgent Community Support Service (UCCS) Rushcliffe**
8. **A2A (Access to Advocacy, Specialist Advice and Representation)**
9. **Dementia Intensive Care Unit (DICU)**
10. **Social Care Support to Memory Assessment Services (MAS)**
11. **Short term Assessment, Recuperation and Reablement beds (STARR service)**
12. **Independent Sector Partnership and Workforce Development**
13. **Support to Carers**
14. **Services to Improve Hospital Discharge Arrangements**
15. **Community Equipment and Occupational Therapy Services**
16. **Assistive Technology**
17. **Medicines Management**

1. Mental Health Support Services

Background

Born out of the need to deliver 47% savings against the Supporting People budget for services for people with mental health needs, a service redesign commenced that sought to:

- Deliver the required savings
- Limit the impact on service users by achieving lower hourly rates and greater efficiency with contracts
- Integrate a range of budgets to deliver economies of scale
- Deliver closer working with Community Mental Health Teams (CMHTs) to improve the customer experience
- Involve service users in the design of services

The Commissioning Process

A project board was established that would oversee the development of the service specification and take the service to tender stage. The board included a representative from the CMHT Managers and a representative from the district /borough Strategic Housing Managers.

A piece of work was undertaken involving around 30 service users and their current service providers following the 'Working Together for Change' (WTfC) process. This looks at the individual experiences of service users to determine priorities for change. The process, which has been promoted by the DoH linked to the personalisation agenda, uses individual outcomes focused reviews to provide powerful insights into what is working and not working in people's lives, as well as their aspirations for the future. The information gathered was clustered and prioritised during a workshop event involving service users, providers and commissioners in one prioritisation exercise. Those priorities informed the development of the new service specification.

A separate consultation event was also held with a range of third sector mental health providers regarding the proposed structure for the new service.

The Service

The new services combine several elements of service into one package:

Core support: makes up the majority of the service, supporting people around issues of housing, benefits, debt, employment, training, volunteering, health management and improvement, community engagement and social networks. The focus will be on delivering recovery focussed support, building service users' own networks of support that last beyond the withdrawal of formal support. The contract is more flexible than previous arrangements, allowing the provider to use support resources to best effect. The contract also requires the provider to support people in a range of ways to improve efficiency e.g. through group activities, peer support networks and drop-in surgeries.

Crisis Link: working within Crisis Resolution and Home Treatment teams, this element of service primarily aims to intervene, particularly with regard to housing/debt related crises, in order to help avoid of hospital admissions.

Inclusion and Opportunity Work: an element of funding has been identified within the contract to challenge stigma and barriers to opportunity, and then engage with communities and business to open up opportunities for people with mental health difficulties. This has been linked to, and requires steering group representation in respect of, the co-production model of services being developed across the county.

Carer Support: the service will support carers by engaging with service users who are not in contact with services and therefore very dependant on their carers.

Outcomes

The redesign of and tender for new mental health support services will deliver a number of benefits:

- 47% (or £1.5m) savings
- Other smaller savings, linked to other ASCHandPP savings targets (Service Level Agreements and Carers Service) will be delivered.
- The winning provider, Framework Housing Association, has given a commitment that, when the service commences on 1st October 2012, no service users currently in receipt of a support service will lose that service.
- Over the course of the first year of the contract a target has been set for number of people receiving services to increase by 31%
- Referrals will be managed by CMHTs with much stronger links between CMHT referral co-ordinators and Gateway workers within the provider organisation, allowing the development of more effective prioritisation by teams, better consideration how this support service sits alongside reablement services that are still in development, and quick response (1-3 days) times for urgent cases.
- Outcomes for service users will be monitored in range of areas including: access to accommodation and moving through supported accommodation to independence; participation in employment/education/training/voluntary work; developing social networks; improved general health and mental health; and the provider will also be required to measure whether service users feel that they have ‘a bright future and some goals’ (which came from service users participating in the WTfC process).

Areas of innovation

- Involving service users in service design through WTfC
- Closer working between CMHTs and the contracted support service
- Broad set of outcomes monitoring that reflect service user priorities and focus on achieving sustainable independence

2. Younger Adults – Care, Support and Enablement Tender – supported living and outreach services for adults with learning disabilities, Asperger's, mental health issues and physical disabilities.

Background

In 2010/11 a tender process was undertaken to re-establish an Approved List for the above services. The existing list was for care and support for people with learning disabilities only and consisted of 21 providers who had bid in at a fixed price per hour which they would offer services at throughout the course of the contract. Prices ranged from £12.98 to £16.21 per hour. The lower cost providers had not, by the end of the contract taken on much work as they had not managed to build up a critical mass of hours to enable them to be cost effective as each new package of support may be offered in batches of 1 or small groups.
Contracts were due to be renewed and as the strategic direction was to increase supported living (as an alternative to residential care) we needed to ensure new packages of support were as cost effective as possible.

The commissioning process

The department employed a two stage tender process in order to establish who amongst the bidding companies (more than 50 of them) would be offered a place on this list.

The first stage incorporated general legal, financial and contract compliance checks as well as ensuring the provider was equipped to meet minimum standards relating to the service specification. Successful candidates were then invited to tender by completing a series of statements relating to their ability to deliver the service in response to questions posed.

The final list was limited to 15 providers rather than as previously where all who met the criteria were accepted to encourage economies of scale to be developed over the period of the contract and asked for indicative rates below £14 per hour. Future work would require a further competitive process in which price was still a factor but service users were also involved in choosing their own support provider from the approved list. The provider could bid for this work at any hourly rate below £14 an hour.

Pricing was not part of the evaluation other than to ensure providers understood that there was a maximum price payable of £14 for any work undertaken.

Carers and service users were fully involved in the tender. A group of 3 carers who had family members in supported living designed and marked a specific question. There was also a service user question which 'We Can Do It' a service user run organisation was commissioned to develop and mark. They had full control over the process, and the only input from staff was to ensure that the question and marking criteria were appropriate for the overall tender process

Once the approved list had been developed, individual packages of support, or small groups where people wanted to live together, are commissioned via an expression of interest from any approved provider submitting a price (lowest 3 invited to next stage)

and then being interviewed with service user input at whatever level the individual chooses. This gives the service user and/or their carer, where appropriate, a real choice of their provider.

The market and what we did to test this

Market intelligence from many years of working with supported living providers, including regular provider forums to engage with the sector meant that we were aware that there was already a robust market in the area of learning disability, many of whom also had experience with other service user groups. Supporting People service providers were also approached to ensure a range of providers to cover the different service user types. The open advert encouraged providers operating in other areas to consider Nottinghamshire also.
Regarding price, we know we had some providers who were able to offer lower prices in other areas of the county but had struggled in Nottinghamshire because there were too many competing providers meaning they could not develop economies of scale. Benchmarking work undertake with other authorities also lead us to believe that some of the existing suppliers were able to deliver services at lower prices.

What were the outcomes and benefits?

The flexible pricing approach has led to the mean hourly daytime rate bid for new packages to fall from £15.33 in the first year of the previous agreement (Sept 08 - Sep 09), to £13.46 for the current agreement (Apr 11 – Apr 12).

Areas of innovation

Flexible pricing model allows providers to bid competitively and flexibly with regard to the specifics of each individual package of support. This results not only in the achievement of Best Value for each commissioned service, but also that providers can tailor the costings according to the specific requirements of each person, creating a bespoke service that will meet the desired outcomes and also ensure the long-term viability of support in situations where issues such as rurality or specialist requirements have previously caused difficulties.

People using the service their and carers made a vital contribution to the tender, enhancing the person-centeredness of the process and helping to ensure both the quality and value-for-money of the final approved list.

3. Mental Health Supported Living – alternatives to residential rehabilitation and secure units (work in progress)

Background

In younger adult mental health services there are currently a number of rehabilitation hospitals in Nottinghamshire. There were 7 open units and one locked, all run by the NHS. They accommodate people with the highest needs with serious, long-term mental illness.

Working with health partners we have identified that many people stay in these hospitals much longer than they require because there is little appropriate step-down

accommodation and support available. Many people, even at quite young ages, when they do eventually leave the rehabilitation units, go to residential care rather than services which would seek to promote their independence. Both these delayed discharges and moves to residential care mean these people have poor outcomes and are very expensive options. A recent review has indicated that approximately 40 people are ready to leave the open units and a further 12 from the locked unit.

The commissioning process/market testing

NCC commissioners have been working improve care pathways for these very vulnerable people with the primary aim of setting up a range of new 24 hour supported living projects around the county.
A big issue with providing the right care and support is getting the right housing. Therefore we have set up a pilot with providers from our Care, Support and Enablement framework who are also able to provide housing to develop supported living for people leaving rehabilitation hospitals. This pilot was to test the demand for such accommodation and market test the development of new supported living arrangements.
This is an interim arrangement which will be reviewed following the completion of a tender for approved housing providers which is nearly finished and is likely to give us 3 housing providers who will develop bespoke housing options for the continued development of supported housing across all younger adult groups.

What were the outcomes and benefits?

The first unit for 4 people has opened in Worksop and is already full. We are using the success of this project so far to work with providers to develop more projects in all parts of the county. The cost of a rehabilitation hospital bed is £2100 a week and at present the average cost of supported living in Worksop is £473 per week. For those with the highest needs there are likely to be clear financial benefits from supported living over residential care. Upon discharge in the past service users have often gone to residential care at an average cost of £1996 a week.

There are clear positive outcomes for service users. Instead of remaining in NHS units we are giving them the opportunity to move on to well supported, good quality accommodation that will promote their independence, social inclusion and improve their incomes dramatically whilst ensuring we keep them safe. There are also clear financial savings to NCC and the NHS because supported living is cheaper in the long-term than the cost of hospital beds or residential care (as people's independence improves so their need for support can fall).

Areas of innovation

NCC worked with local Clinical Commissioning Groups (CCGs) to assess the rehabilitation services and proposed that the council could deliver improved pathways out of hospital that would enable hospital units to be freed up to work with more appropriate people with higher needs. Working as a partnership NCC asked for and received a transfer of £900k to provide additional staffing resource to develop new supported living arrangements and enable the individuals to move. This work has been highly innovative in working with health partners to jointly assess and deliver improved care pathways, service models and outcomes, with partnership agreements about funding that support both agencies and avoid ‘cost shunting’.
Without taking a proactive approach to the risk this posed to ASCHandPP, based on clear intelligence around potential needs and the strategic direction for people to have more community based support, the future costs are likely to have been much

higher. Undertaking this joint commissioning has strengthened links with health as they are also seeing the benefits in terms of savings.

4. PARTNERSHIP HOMES, LEARNING DISABILITY RESIDENTIAL CARE – 2011/12

The service and reasons for change

The joint re-commissioning covered eight existing residential care homes for people with learning disabilities (mainly complex needs), previously managed by the NHS Trust and last re-tendered by Nottinghamshire PCT and Nottinghamshire County Council in 2006. Total running costs in 2009/10 from NCC and Notts PCT was £5.79m for the 89 bed spaces. Due to a shared strategic objective to increase use of more supported living options that promote independence rather than use residential care as a first choice for younger adults, it was recognised that it would become increasingly difficult to fill voids and therefore the homes would become more expensive per individual. It was also identified that in some cases individuals would benefit from supported living or a change in who they lived with. Service user mixes had evolved over time and people did not always get on with the people they lived with.

Therefore, as part of the 2011/12 contract, providers were asked to review the current situation of all service users and remodel services to ensure on-going sustainability to meet the needs of existing and future service users. Commissioning moved from semi block arrangements, to individual unit costs, shifting the responsibility for managing viability back to the provider.

The process

A consultation event was undertaken with all family carers and their views fed into the service specification alongside those of frontline staff and health colleagues. A group of 5 carers were then involved in setting and marking the questions for providers, along side front line, commissioning and procurement staff. Service users were all asked if they wished to take part but only one person expressed an interest in doing so. He has been engaged in the new provider induction and will be undertaking some peer mentoring. The tenders were marked on a 50/50 split between quality and price.

An open, two stage tender was undertaken, with a capped price based on the existing staffing levels, including any individual 1:1 hours which were being delivered. In order to deliver efficiencies as part of the re-modelling, the cap was set at £300,000 per annum below the 09/12 spend assuming all 89 bed spaces were filled.

The two stage tender established provider's experience in delivery not only residential care but also supported living and their experience of change management and staff TUPE as well as ensuring standard legal, financial and contractual requirements could be met

The market and what we did to test this

There is quite a developed local market for both residential care and supported living but as we wished to ensure the new provider would seek to remodel some of the

existing provision we did some soft market testing by meeting with six of our larger providers to talk to them about what we need to achieve, how this type of re-provision had been managed in other areas and what the best approach would be. Rather than being prescriptive, it was decided to allow the successful provider to take the lead of the re-provision, with the final approval of plans by the Council.

What were the outcomes and benefits?

The successful provider offered actual savings of a further £788,000 over the four year period (i.e. maximum contract price was £22m and bid came in at £21,212,000 inclusive of inflation expectations.)

The contract was let in July 2012 and the provider is currently working to develop plans for remodelling talking to housing providers and working closely with social care staff to undertake reviews and person centred assessments and having regular meetings with family carers.

Staff transferring over have been pleased with the result of the tender. Four of the homes were previously under contract with NCC direct services and no objections were raised by the Unions regarding the final choice of provider.

Areas of innovation

Soft market testing enabled conversations with providers upfront to ensure that the expertise required was available. This also enabled us to hear how similar projects had been undertaken in other areas which gave confidence in the feasibility and style of the tender.

This was a complex tender due to TUPE issues relating not only to Local Government Pension scheme but also to NHS pensions. In order to protect the council from potential shortfall costs the tender asked the prospective providers to state whether they were going to offer a comparable pension or apply to become associate members of the LGPS and/or NHSPS. Actuary information was given to providers and Government Actuary department was engaged to negotiate around the NHS pensions. Any shortfall in pension was to be built into the bid price by the provider ensuring that there could not be unexpected additional costs.

5. Integrated Community Equipment Service (ICES)

Nottinghamshire County Council is the lead commissioner for an integrated community equipment service partnership for adults and children. The arrangements are made under a section 75 agreement of the 2006 National Health Service Act and include Nottingham City Council, NHS Nottingham City, NHS Nottinghamshire County and NHS Bassetlaw. The partnership selected and awarded the current provider a three year contract which started on April 2011 at a value of £5,360.123 per annum, with the option of extension for a further two years.

Community equipment and the ability to have it put in place quickly, is a vital component for partners to achieve their shared priority objective of supporting more people in their own homes and facilitating timely and safe discharges from hospital. As more people are supported at home with increasingly complex needs, the demand for more costly packages of equipment is steadily rising.

The commissioning process

The current contract replaced two separate contracts for the North and South of the County. Partners agreed to merge into one contract to provide greater consistency of approach, performance and policy on equipment, deliver efficiency savings from the provider through scaling up the service, as well as internal administrative processes of the partnership. A joint specification was designed alongside a Partnership Agreement which agreed each partner's contribution to the budget and mechanisms for managing risk

The market and what we did to test this.

ICES has been a mandatory requirement since April 2004 and there are a number of key service providers already established across the country. A Project Officer was appointed to oversee the process, and carry out a benchmarking exercise of existing services. In particular, to analyse the two existing services, enabling the Partners to make key decisions on how the service should be run going forward.
The OJEU tender process advertised and invited expressions of interest, using the then available Department of Health Resource Hub. Interested parties were offered the opportunity to visit the Nottinghamshire service and were able to ask questions and request further information.

Outcomes and areas of innovation

- Improved co-ordination of the service and consistency of policy regarding both the use of equipment and who it is provided to
- The design of the new combined contract delivered £300,000 efficiency savings for Nottinghamshire County Council (children and adults)
- More equipment being delivered quickly and also returned for re-use
- Staff in multi-agency teams assessing for equipment is resulting in less duplication of assessment
- Less delays due to agreeing whether health or social care is responsible for providing the equipment
- Demand is rising for the equipment, placing increased pressures on this budget. The Partnership is well placed to agree a shared approach to address this and ensure a consistent approach to appropriate prescribing, value for money and demand forecasting into the future.

6. Mental Health Intermediate Care Services for Older People (MHICS)

The service

The service is for older people with mental health problems and/or dementia. It is a time limited intensive service which is provided in the community through district multi-disciplinary teams.

The first team started in Rushcliffe in September 2008, followed by Newark and Sherwood in 2010 and Broxtowe in 2011. Plans are in place for further roll-out of the service across the county to include Bassetlaw, Gedling and Mansfield and Ashfield by the end of 2012-13

The focus of the teams' work is;

- to provide rapid assessment to people in the community at risk of losing their independence and to provide support to avoid unnecessary admission to hospital or care
- to work with individuals and their families to facilitate timely and safe discharge from acute and specialist mental health beds
- to support people in residential care who wish to return to the community.

Specific targets are to;

- reduce the numbers of avoidable hospital admissions
- reduce length of stays in hospital
- prevent avoidable admissions to urgent short term care
- reduce inappropriate admissions to long term care by
- increase numbers returning to their own homes
- improve the quality of life/wellbeing for both the patient and carer

Trigger points for referrals include;

- breakdown in informal carer arrangements
- concerns re mental health and possibility of admission under the mental health act
- significant self neglect
- persistent refusal to accept or to engage with services.

The teams work closely with mainstream intermediate care services and mental health services for older people. MHICS will often signpost and support people to access more appropriate services where a referral to their service is inappropriate.

The teams also work with people who may not have had a formal diagnosis and refer to and receive referrals from the memory assessment clinics. Assistive technology is utilised through, for example, the installation of smoke and care alarms and the "Just Checking" system.

Commissioning process

The service was the result of joint work following the announced closure of some long stay inpatient provision. Extensive work was undertaken to identify the potential impact of the reduction of inpatient beds on social care and primary care, this involved NCC, Nottingham City Council, Notts Health Care Trust, Nottingham University Hospital, Notts County PCT and the relevant GP commissioning groups. The result of this work was the development of a number of alternative services to mitigate against the anticipated increase in demand for social care and primary health care services; these were funded primarily by reinvestment from the closure of the inpatient facilities. The services were focused on prevention and crisis avoidance.

There was also a formal consultation process with services users, carers and the general public plus further involvement events around the implementation of the National Dementia Strategy.

The market and what we did to test this.

Work was undertaken with a range of stakeholders; population forecasting and modelling tools were used to predict the likely increase in demand for services.

Pilot projects were initiated to test different services and ongoing evaluation and monitoring has been undertaken.

The outcomes and benefits

In the areas where the MHICS teams have been operational there has been a reduction in length of stay on the mental health older peoples' wards, a reduction in admission to long term care and a impact on the number of admissions under the Mental Health Act.

Recent reports show that 75% of people discharged from the MHICS teams in July-September 2011 were still at home 90 days after discharge and 67% after 180 days.

In addition, the teams have facilitated discharges from specialist mental health beds into residential care homes in cases where such a move had been previously considered impossible. They have also enabled the discharge of people from residential care back into the community through intensive short term support.

Areas of innovation

- The teams are mainly located in primary care centres, this has facilitated closer working with primary care staff. The Community matrons and district nurses are located in the same building and close working relationships have been established.

- The teams use NCC Framework as well as the NHCT electronic recording system; this facilitates the sharing of information and provides one system for the collection of data and performance reporting.

- The open referral system means that the teams are more accessible to families and informal carers as well as professionals and service providers.

- They develop trust with individuals and carers who have been resistant to support and, therefore, reduce the risk of admission to hospital or residential care.

- The team works with domiciliary home care providers to increase their skills in supporting people with challenging behaviour.

7. Urgent Community Support Service (UCCS) Rushcliffe

The service

The Urgent Community Support Service is the result of joint commissioning by one of the CCGs, Principia Rushcliffe and Notts County Council. It is currently provided by East Midlands Crossroads.

The service is a crisis avoidance/response service providing both health and social care through a team of generic workers. This aims to support service users to remain at home and avoid an unnecessary hospital or urgent short term care admission.

Service objectives:

- Provides an Urgent Community Support Service offering immediate support, to triage and stabilise service, therefore avoiding unnecessary admission to hospital, urgent or residential care
- Provide support and care for a maximum of 5 working days while alternative services are co-ordinated
- Work closely with all other partner agencies involved in the patients' care to provide consistent and responsive care pathways
- Data collection and analysis of the interventions or support that enables people to stay at home and avoid hospital admission. Including an evaluation of the contribution that the Urgent Community Support Service makes to admission avoidance and to evaluate the role of the Community Ward Support Worker.

Commissioning process

The service was a partnership development between Principia Rushcliffe, Community Health Partnership (CHP) and Nottinghamshire County Council. Officers from all the partners worked together to identify the problem, design a solution, write the specification, commission and procure the service, implement and then monitor.

Service users were consulted through the CCGs Patient Participation Group.

The market and what we did to test this

There was inadequate rapid response capacity across health and social care services in Rushcliffe which was causing problems in terms of preventing people from being admitted to and discharged from hospital. There was a general perception that there was a gap in service provision which had been created by both a lack of capacity and the division of responsibilities between organisations, with existing services covering health or social care needs, but not both.

This gap was seen to be detrimental to service users as they either had a number of different workers coming into their home or a delay or gap in their care when services were not co-ordinated. It was believed that this has often led to either emergency admission into hospital or short term residential care or a delayed hospital discharge. From an organisational perspective the current division of services did not make the most effective use of resources (i.e. staff time and skills) and is not in the interest of the patient. The idea of a generic social care and health worker was put forward as a potential solution to some of the difficulties identified and a pilot project was initiated and funded by both the CCG and NCC.

The project ran for 12 months during which time close monitoring and evaluation was undertaken and at the end of the 12 months it had shown that it had been successful in diverting people from hospital or urgent short term care admission and so continued funding was sought from the Reablement funds.

The outcomes and benefits

The service enabled service users to remain at home rather than be admitted in to hospital care, urgent care or residential care unnecessarily.

Benefits include:

- Quickly triage and stabilised service users health conditions and social issues
- Integrated service user care delivered by a community multi disciplinary team
- Service users able to stay in their own home
- Case management and enhanced communication of care to both service user and carer
- Improved service user satisfaction and opinion

The table below shows, the source of referral, the outcome in relation to whether an admission to hospital has been saved or not and where savings have been made the value.

Areas of innovation

The service is based on a shared commitment to provide early intervention to people

Source	No	Yes Care Home	Yes Hospital	Grand Total	Savings (02/03/2011-30/06/2012)
Adult Social Care and Health	6	1	27	34	**£67,500**
Community Matron	16	2	28	46	**£70,000**
GP	14		27	41	**£67,500**
Other	1		8	9	**£20,000**
Senior District Nurse	13	1	52	66	**£130,000**
Senior Therapist	2		21	23	**£52,500**
Grand Total	**52**	**4**	**163**	**219**	**£407,500**

in their own homes to avoid further deterioration or crisis. The service forms part of the integrated care model developed locally; service users are admitted onto the 'virtual ward' whilst in receipt of the service.

The staff have the appropriate skills to be able to provide basic health and social care. Timely support avoids delays resulting from a lack of clarity regarding which service should provide specific input.

8. A2A (Access to Advocacy, Specialist Advice and Representation)

The service and reasons for change

All health and social care agencies across Nottinghamshire County and City Council worked with providers to develop a new information, advice and advocacy model. The new contract from April 2012 now incorporates a range of services, including both statutory and specialist advocacy, delivered by one organisation with a single point of access, making a more cost effective service that is easier for citizens to access.

Under the previous arrangements NCC contracted directly with advocates (eight organisations) under "Block" annual payments with little control over activity or cost(s). This expired at the end of March 2011, however the Council extended the

arrangements for a further 12 months to allow the cross county working group to review and agree its needs going forward. As part of the extension, in the short term existing Advocate rates were renegotiated and delivered a reduction of £96k (14%) against the 11/12 budget (£700k). The renegotiation also allowed engagement and key messages to be provided to the market on future needs.

Whilst historical data concerning activity and performance was sparse, views across the City, County Health and PCT's and from the provider forums confirmed that in relation to the delivery of Specialist Advocacy, approximately 60%-70% of activity related to Information, Advice, Signposting or Supported Signposting, with actual face to face Advocacy only being circa 30%. This raised the concerns of "burning" expensive advocate rates for a service that should be cheaper to deliver.

Performance quality varied greatly across the advocates, providers and also geographically. There were no incentives for advocates to "move on" or resolve cases promptly and no outcomes based measurements. The partnership agreed there was a need to instigate a change to the whole of the advocacy delivery and arrangement(s) with a move to a focus on outcomes and outputs, but also around effective performance and cost management.

The commissioning process

A new model was developed jointly through forums with all partners and providers. Service users would have one point of contact across the County of Nottinghamshire via an A2A (Access to Advocacy) service designed to meet the needs of any service user via a triage process. Managed by the agent, this includes any and all requirements for advice, information signposting and supported signposting at the point of contact. Access to Specialist Advocacy is only targeted at those with the direct need, the most vulnerable in society and the advocates are associates of the Agent.

The market and what we did to test this.

The local provider base ranged from large national organisations to small independent (one person) providers. A series of forums were held for providers to input into the development of the operating model, the market engaging strategy, specification(s) and how an outcomes based arrangement through the agency Model could be delivered. This included the move away from "block payments" without any link to outcomes and outputs

Outcomes and areas of innovation

The approach was nominated for the 2011/12 CIPS Supply Management Awards, Best Public Procurement Project

For the first time intervention levels have been clearly defined for advocacy provisions (Statutory and SA) into "Brief/Standard/Complex and Exceptional" with agreed average hours per intervention that can be then performance managed

across the whole delivery. There had been no visibility over activity under previous arrangements.

The model, tender, specification, scope and approach creates future proofing, in that other associated and similar community services can simple be added to the A2A service.

The contract and arrangement is outcomes based, the structure of the contract and the whole basis of payment is linked to outcomes and outputs performance management around service delivery and the management of associates.

The contract will deliver over its 3 year initial term savings of £340k against a total baseline spend of £2.4m or £800k P/A.

Further examples of specific joint developments to be progressed and are part funded in 2012 -13 through NHS Support to Social Care funding

9. Dementia Intensive Care Unit (DICU)

A new in-patient service for people with dementia and complex needs is being developed at Highbury Hospital by Nottinghamshire Healthcare Trust. This will be a county-wide service which will offer a short-term, intensive and specialist support to people who have very difficult to manage behaviour. It is likely that many of the people using this service will require assessments for NHS Continuing Healthcare for their ongoing services. This may create additional work for the social care teams who will be required to partake in multi-disciplinary team meetings and detailed care planning. Additional social care support for this service is requested to cover the additional work which is likely to arise from this specialist unit.

10. Social Care Support to Memory Assessment Services (MAS)

Early diagnosis of dementia is one of the key aims of the National Dementia Strategy and locally both Primary Care Trusts have committed additional funding to extend the provision of Memory Assessment Services currently provided by the Alzheimer's Society across the county. In the 2011-12 NHS Operating Framework the Department of Health stipulated that funding should be made available to local authorities to provide social care support to the memory assessment services; the local allocations were £124,000 from County Primary Care Trust and £20,000 from Bassetlaw. Although this allocation was only made available last year the Department of Health expects that local authorities should make a similar allowance from the NHS Support to Social Care funding to maintain this service. Part year funding is required for 2012-13.

11. Short term Assessment, Recuperation and Reablement beds (STARR service)

The Short term Assessment, Recuperation and Reablement Service (STARR) covers the Assessment Beds and other bed based services which support timely hospital discharges and provide an opportunity for recuperation. This includes beds which have been used for people being discharged from hospital who are unable to return home as they have upper or lower limb fractures otherwise known as non-weight bearing fractures. The service which has been used to support people with upper or

lower limb fractures has primarily been in Bassetlaw, Newark and Sherwood. In order to maintain this service and to extend it into other parts of the county funding is required for physiotherapy support.

The assessment bed service provides an alternative environment for recuperation, assessment and reablement for older people who are medically fit and no longer need to remain in hospital, but at the time of discharge are unable to return home and so are at risk of being admitted into long-term residential care. Over the period of the pilot which ran from October 2011 - March 2012 the assessment beds proved to be so successful in some areas that an additional eight beds were established in two of the remaining Nottinghamshire County Council care homes. The pilot project demonstrated that approximately 40% of service users who access the assessment beds service return home rather than moving into a long-term residential placement. Of the other 60% of people some are readmitted to hospital, some move into long term care, some transfer to residential intermediate care or short term care and a few die. For the 40% returning home this is a good outcome, both for the service user and the County Council as it enhances peoples' quality of life, maximises independence and reduces the number of people in long term care. In order to maintain and expand these services continued funding is required.

12. Independent Sector Partnership and Workforce Development

Nottinghamshire County Council's Workforce Development and Planning Team are working on a project with the Nottinghamshire Partnership for Social Care Workforce Development (NPSCWD), which is currently hosted this authority, to develop the NPSCWD into a new independent organisation. This new NPSCWD will be an overarching workforce development organisation which will deliver a holistic approach to workforce planning and development. It will enable care providers to identify their own workforce development needs, share resources and work together to embed excellent working practices. It will include representatives from all areas of the care sector; residential and domiciliary services, voluntary carers and organisations and personal assistants. NCC is requested to fund and host a strategic manager and a training co-ordinator to facilitate the development of this new organisation, training for managers and delivery of a dementia programme to the workforce. This proposal is for a two year period up to 31st October 2014.

A temporary End of Life and Dementia Workforce Development Officer post has been funded for the past 3 years by Strategic Health Authority to work with independent sector providers to improve the quality of services for people with dementia and at the end of life. However, this funding will cease on 31st March 2013 so the current temporary 0.7 fte (26 hours) Workforce Development Officer, post will be funded from the NHS funding for social care monies until 31st March 2014.

13. Support to Carers

Nottinghamshire County Council already provides a number of carer specific services but sometimes identifying carers and ensuring access to services is problematic. It is important therefore that the Adult Access Team at the Customer Service Centre (CSC) is fully equipped to identify and support carers so a temporary Carers Triage Worker post has been created to work within the existing Adult Access Team for 12 months. This post is to be part funded through carers' specific funds and part from the NHS funding for social care money.

14. Services to improve hospital discharge arrangements

Hospitals across the county are experiencing an unprecedented and sustained increase in demand for services. All the hospital trusts across the county are embarking on transformational projects to try new ways of working with the aim of improving patients' services whilst reducing the demand for inpatient care. The increasing demand and the drive to transform services is in turn placing additional pressures on the County Council for social care services specifically for; advice and signposting, weekend access, winter pressures, rapid response to home care services and services for younger people with physical disabilities. The extension of existing temporary posts and the other initiatives already in place to support this has been agreed.

15. Community Equipment and Occupational Therapy Services

With the increase in the numbers of people remaining in their own homes there has been a corresponding rise in the demand for occupational therapy assessments and community equipment to support people to remain safe and independent in the community. Additional funding has been agreed to resource these.

A need has been identified for specialist occupational therapist assessments for seating and complex pieces of equipment and a 1 fte temporary Occupational Therapy post has been established for 12 months to work across health and social care to undertake these types of assessments whilst further work is undertaken to resolve this long-term.

16. Assistive Technology

Assistive technology plays an important part in supporting people to remain as independent as possible in their own homes. The County Council and health partners are keen to expand the range of assistive technology services available to people across the county and particularly those offering Telecare and Telehealth. National studies have shown that where local authorities and the NHS have invested in Telecare and Telehealth services the outcomes both for service users and statutory services have been very positive. In line with commissioning priorities to expand the range of assistive technology services available further investment has been agreed.

17. Medicines Management

Nottinghamshire County Council currently commissions a small amount specialist part-time support from a pharmacist advisor to ensure that Nottinghamshire County Council's policies and guidance on medicines management are up to date and in-line with clinical standards and practice. The County Council will maintain this support and has agreed resources for a further year.

Appendix Three

Report to Health and Wellbeing Implementation Group on the Children's Trust and Supporting Structure – September 2012.

1. The Nottinghamshire Children's Trust is a well established partnership which aims to improve outcomes for children, young people and families in Nottinghamshire. It is the lead integrated commissioning group for children, young people and families

2. The ambition of the Children Trust states *"We want Nottinghamshire to be a place where children are safe, healthy and happy, where everyone enjoys a good quality of life and where everyone can achieve their potential"*

3. The Children's Trust is soon to be reviewed in line with the Health and Wellbeing Board governance and structures. It is likely that the membership will change to ensure that the group retains a strategic integrated commissioning focus.

4. **Needs Assessment** - The Children's Trust is responsible for producing and updating the children's chapters of the JSNA which were last updated in 2010. From September 2012, key sections of the JSNA will be refreshed to confirm existing or inform new priorities for the Children's Trust.

5. **Priorities** – The Trust has developed a Children, Young People and Families Plan for 2011-2014. The plan is the foundation of shared planning to continue improving how we work together. It summarises priorities and the main activities that we will undertake to improve the lives of children and young people.

6. The key themes of the Children, young people and families plan highlight where the Trust wants to see continual improvements to improve outcomes for children and young people.
    - Child protection
    - Education and attainment
    - Health and Wellbeing
    - Participation

7. Priorities for action are to:
    - Continue to improve our early intervention services to ensure that children, young people and families in the greatest need receive appropriate support
    - Sustain and build on improvements made in safeguarding
    - Improve the effectiveness of services for disabled children
    - Implement the Child and Family Poverty Strategy for Nottinghamshire
    - Reduce achievement gap at all key stages
    - Raise achievement at age 16-19 and promote the employment of young people aged 18- 24
    - Improve children and young people's emotional wellbeing

8. Priorities are refreshed on a regular basis and it is likely that the priorities listed will change from 2013/14 to reflect any new emerging findings from the Children's chapter of the JSNA.

9. **Performance** - The Children, Young People and Families plan is performance managed every 6 months by Nottinghamshire County Council and reviewed annually. Performance

reports are shared every 6 months with the Children's Trust Executive who in turn report to the Health and Wellbeing Board. A sample performance template is available on request.

Integrated Commissioning Groups that Report into the Children's Trust

Child and Adolescent Mental Health Service (CAMHS) Integrated Commissioning Group (ICG)

10. The CAMHS ICG is a well established group which includes commissioners from PCTs, the LA and CCGs.

11. Improving emotional health and wellbeing for children and young people is one of the priorities of the Children, Young People and Families Plan 2011-14 and the Health and Wellbeing Strategy 2012-13.

12. The CAMHS ICG has an integrated commissioning plan that spans 2011-14. Its priorities include:
    - Children and young people have improved emotional health and well being.
    - There will be improved identification of the needs for children and young people in relation to their emotional health and wellbeing.
    - There will be improved commissioning of specialist emotional health and well being services for children and young people

    Each priority includes a number of milestones for example:
    - Development of a CAMHS focused Health Needs Assessment during 2012-13, which details needs of vulnerable groups.
    - Develop clear pathway for planning and commissioning CAMHS complex care packages that span Health, Education and Children's Social Care by March 2013

13. A CAMHS Needs Assessment has been commissioned by the group and this will be completed by April 2013.

Disability and SEN Integrated Commissioning Group

14. The Integrated Commissioning Group for Children with Disabilities and Special Needs' is a strategic level decision making group that commits to decisions being enacted. Nottinghamshire County Council, NHS Nottinghamshire County, NHS Bassetlaw and CCGs are the lead commissioners in Nottinghamshire for this group so are the key members.

15. Improving integrated services for children and young people with disabilities is one of the priorities of the Children, Young People and Families Plan 2011-14 and the Health and Wellbeing Strategy 2012-13.

16. The group has developed an in depth needs assessment which has informed their integrated commissioning plan which spans 2012-14. Its priorities include:
    - Children and young people with disabilities will have equitable access to a range of appropriate services and interventions

- Children, young people and families will be enabled to access specialist equipment with greater ease
- We will improve outcomes for children, young people and their families by working together to use multi-agency single assessment processes, which ensure the holistic needs of children are met through a single multi-agency plan
- Children, young people and families will be supported effectively during key transition stages
- Children, young people and families will have clearer access to Occupational Therapy to meet their needs.
- Children and young people with Special Educational Needs will have improved educational attainment
- Young people are effectively supported in Post 16 placements
- Children and young people with Complex Health and /or Palliative Care needs are assessed and supported appropriately
- Children, young people and families will have equitable access to short breaks
- Children and families will have access to good quality up to date Information, Advice and Guidance
- Looked After children and young people will, where possible, be placed closer to home

17. The group does have a large role with a large number of priorities; and there are a number of challenges in relation to this huge agenda, further work will be required to strengthen partnership further and ensure the work is sustainable.

Teenage Pregnancy Integrated Commissioning Group

18. There has been a teenage pregnancy partnership in existence in Nottinghamshire since 2000. The vision of the Teenage Pregnancy ICG is to ensure that Nottinghamshire is a place where children are safe, healthy and happy, where everyone enjoys a good quality of life and where everyone can achieve their potential. In particular we want young people to have healthy relationships, good sexual health and have good outcomes for young parents and their children.

19. Teenage Pregnancy is currently neither a priority within the Children, Young People and Families Plan 2011-14 nor the Health and Wellbeing Strategy 2012-13.

20. The group has a Teenage Pregnancy Integrated Commissioning Plan for 2012-2014. Its priorities include:

- Prevention of teenage conception and poor sexual health through contraception and sexual health service provision;
- Children and Young People have access to information and education about sexual health and relationships;
- Workforce Development;
- Improve outcomes for teenage parents and their children.

21. The Teenage Pregnancy ICG is working to strengthen working links with the Sexual Health Commissioning Group, in order to establish young people's outreach Contraception and Sexual Health provision in areas of greatest need.

Targeted Youth Support Board

22. The Targeted Youth Support Board is a statutory Board that drives the Youth Justice agenda across Nottinghamshire, having a lead statutory duty to oversee the work of the Youth Offending Service. The Board currently has responsibility for commissioning substance use services for children and young people, as well as commissioning services for children affected by parental substance use. However the main focus on the Board has not been the integrated commissioning agenda.

23. Substance use is not currently a priority within the Children Young People and Families Plan 2011-14 but is a priority within the Health and Wellbeing Strategy 2012/13.

Child Poverty Reference Group

24. The Child Poverty Reference Group has been in existence since December 2010. The group was established in line with new statutory requirements as set out in the Child Poverty Act 2010. The group has wide membership from a range of named statutory partners including Nottinghamshire County Council, all District Councils, the Police, Probation, and Jobcentre Plus.

25. Tackling Child Poverty is one of the priorities of the Children, Young People and Families Plan 2011-14 and a key priority for Nottinghamshire County Council.

26. A Child Poverty Needs Assessment was completed in 2011 and this informed the Nottinghamshire Child and Family Poverty Strategy 2011. The strategy is a ten year strategy that is refreshed each year following annual performance management. The first performance report for the strategy is due to be presented to the Children's Trust in October and the Health and Wellbeing Board in November 2012.

27. The strategy was developed by asking all partner organisations to make a number of measurable pledges in line with the needs assessment priorities which included:

- Target localities of Nottinghamshire with greater levels of poverty to ensure outcomes in these areas are improved and children and families thrive in safe, cohesive communities and neighbourhoods.
- Increase educational attainment, employment and skills amongst children, young people and parents in Nottinghamshire; reduce dependency on welfare benefits and ensure work pays.
- Raise aspirations and improve the life chances for children and families so that poverty in childhood does not translate into poor experiences and outcomes.
- Support families to acquire the skills and knowledge to access responsive financial support services, money management, and debt crisis support.
- Support families with complex problems compounded by poverty and disadvantage.

Troubled Families Group

28. The Troubled Families Group oversees the development and implementation of the national Troubled Families initiative across Nottinghamshire. The group is not an integrated commissioning group but does jointly plan activity across the partners represented.

29. The Troubled Families group is chaired by David Wakelyn from Gedling Borough Council, and includes representatives from all District Councils, Nottinghamshire County Council and the Police.

30. The Troubled Families activity has been laid out in a project plan which is available on request.

31. The Troubled Families agenda is neither a priority in the Children, Young People and Families Plan nor the Health and Wellbeing Strategy.

Appendix Four

Tobacco Control

1 A Paper was taken to the Health and Wellbeing Board and agreement was gained on the recommendations.

2 A Strategic Tobacco Alliance Group (STAG) workshop has taken place with the key partners discussing delivery of the recommendations agreed by the Health and Wellbeing Board.

3 The STAG workshop agreed the key priorities and actions as described below.

4 The 3 priority areas and associated actions are;

Motivating and supporting every smoker to quit and reducing health inequalities
- Tailored and targeted stop smoking services to meet the needs of local population
- Intelligence gathering around illicit and illegal tobacco
- Harm reduction use for certain cohorts of smokers

Reducing the number of children and young people starting to smoke
- Appropriate brief intervention training to frontline health, social and voluntary sector staff
- Social marketing around challenging and changing social norms to denormalise smoking

Protecting Families and communities from tobacco related harm
- Social marketing and the use of local media around secondhand smoke
- Delivering the secondhand smoke messages to children and families effectively.

5 Next Steps

- An Action Plan is being developed supporting the priorities identified at the workshop.
- This Action Plan with key performance indicators and timelines will be taken to the next meeting of the STAG in two months.
- The Tobacco Control Strategy will be updated in line with the identified local priorities.

6 Benefits

- STAG roles and purpose of the group agreed in line with the HWB and HWIG.
- All members of the STAG have been offered free places on the Tobacco Control module at Nottingham University in February 2013.
- The Tobacco Control Team have presented to the Broxtowe Health Partnership who will now be looking at how to take forward local initiatives in line with the agreed priorities of the STAG. Options to present in other districts are being investigated.

- Access has been given to the Nottinghamshire Neighbourhood Alert to help provide intelligence re illegal and illicit tobacco.

- Relationships have been established between partner organisations outside of the strategic group.

- Access has been agreed for the Tobacco Team to The Health Improvement Network (THIN) database at the University to start to try and monitor local smoking prevalence data.

Nottinghamshire Health & Wellbeing Implementation Group

Terms of Reference

Version:	1.1	Date:	3 August 2012

1 Purpose and Objectives

Following royal asset, from April 2013, the Health & Social Care Act will present the Health & Wellbeing Board (HWB) with a duty to encourage integrated working between decision makers and service providers in health and social care to improve the health and wellbeing of the local population its serves. The Health and Wellbeing Implementation Group (HWIG) will be the executive group to manage the work programme on behalf of the Health and Wellbeing Board, assisting the Board to fulfil its statutory duties.

The Health and Wellbeing Implementation Group will undertake this role through delivery of the following objectives:

- To maintain an overview of the supporting structures and work programme underpinning the HWB, encouraging coordinated action by all partners to deliver improvements in health and wellbeing.
- To encourage integration across health and local government to achieve additional benefits to commissioning and delivery of health and social care, e.g. improved outcomes or efficiency.
- To ensure national, regional and local policy developments are incorporated into the local work of the Health and Wellbeing Board.
- To oversee the local implementation of the Health & Social Care Act, including Public Health transition and the establishment of HealthWatch.
- To facilitate shared responsibility and leadership in improving health and wellbeing within Nottinghamshire.
- To ensure effective communications and engagement across Nottinghamshire to maintain a common purpose
- To act as a source of advice for Health and Wellbeing issues within Nottinghamshire.

2 Accountability

- The Nottinghamshire Health and Wellbeing Implementation Group will report to the shadow Health & Wellbeing Board.

- The executive sponsors for Health and Wellbeing are:
  - David Pearson, the Corporate Director, Adult Social Care, Health and Public Protection
  - Dr Chris Kenny, Director of Public Health

- The sponsors will be responsible for the delivery of work relating to the Health & Wellbeing Board programme.

3 Core Membership

- Corporate Director, Adult Social Care, Health and Public Protection
- Corporate Director, Children, Families and Cultural Services
- Director of Public Health
- Chief Executive Officers from two District Councils in Nottinghamshire
- Chief Executive, NHS Nottingham & NHS Nottinghamshire County
- Chief Operating Officers from two Clinical Commissioning Groups (CCG) within Nottinghamshire
- Clinical Leads from two Clinical Commissioning Groups (CCG) within Nottinghamshire
- Assistant Chief Constable, Nottinghamshire Police
- Chair of the Nottinghamshire Safeguarding Children Board
- Chair of the Nottinghamshire Safeguarding Adult Board
- Chief Probation Officer or deputy
- Partnership Manager, Nottinghamshire Fire & Rescue
- Associate Director of Public Health.

Additional representatives may be co-opted to the group as required according to the agenda items under discussion, e.g. Joint Commissioning Group Manager, Lead for HealthWatch

4 Responsibilities

The Objectives of the Health and Wellbeing Implementation Group will be achieved through delivery of the following responsibilities:

- To coordinate the overall work programme for the Health & Wellbeing Board.
- To oversee the development and maintenance of the Joint Strategic Needs Assessment and Health and Wellbeing Strategy.
- To act as a link between the HWB and groups underpinning the work of the HWB, such as the strategic commissioning groups, CCGs, District Local Strategic Partnerships (LSPS; or equivalent), safeguarding boards, Children's Trust Executive and the Children's Trust encouraging joint commissioning and action to improve health and wellbeing.
- To review local commissioning plans to ensure alignment with the Health & Wellbeing Strategy, and integrated commissioning takes place across partner organisations.
- To review the implications of changes in national, regional and local policy on local implementation of the Health and Social Care Act, commissioning local action as required.
- To oversee the delivery of the Public Health transition plan.
- To oversee the delivery of the project plan relating to the establishment of HealthWatch and Complaints Advocacy.
- To maintain a communication and engagement network with stakeholders to allow a two way flow of information relating the health & wellbeing.
- To consider implications relating to CCG authorisation and development.

5 Frequency Meetings

- Meetings will be held Bi-monthly – 12 months meetings will be organised in advance and scheduled to correspond with the Health and Wellbeing Board submission dates where possible.

- The group may meet more frequently as required according to the work programme.

6 Ways of Working

- The group will be quorate if there is a minimum of 5 members or nominated deputies, present.
- The group will be chaired by the Corporate Director, Adult Social Care, Health and Public Protection
- Administration will be provided from Nottinghamshire County Council.
- Agenda items will be submitted to the office at least 8 working days before each meeting.
- Papers for each meeting will be sent to members at least 5 working days prior to each meeting.
- Each member will be expected to participate in actions, be responsible for the flow of information into the group and feedback actions and decisions to their own organisations.
- Confidentiality must be maintained where items are explicitly itemised as such e.g. draft structures.

7 Reporting Procedures

- The Nottinghamshire Health & Wellbeing Implementation Group will report to the shadow Health & Wellbeing Board.

8 Review Arrangements

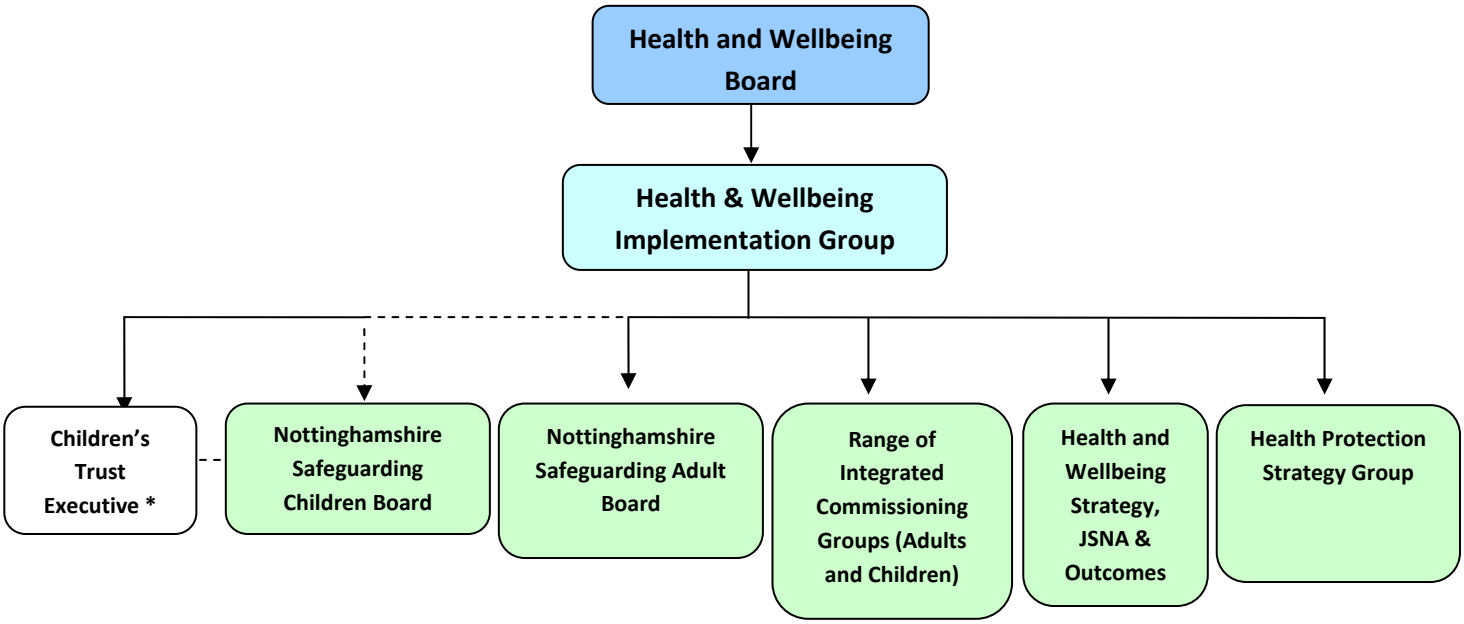
- The terms of reference and membership will be reviewed annually.

9 Governance Structure of the Health & Wellbeing Board

- The illustration overleaf describes the governance structure of the Health & Wellbeing Board. Further information is available through the Associate Director of Public Health.

Health & Wellbeing Board

Supporting Structures



* As a Statutory Board, the Children's Safeguarding Board has independent accountability arrangements

Public and Provider Engagement linked to each Commissioning Group, including Voluntary & Independent Sector
Provider & Stakeholder Network established to promote wider engagement
Engagement with local strategy and delivery groups e.g. District LSPs will be maintained through the strategic commissioning groups

Nottinghamshire County Council

Report to the Health and Wellbeing Board

16 January 2013

Agenda Item: 8

REPORT OF GEDLING BOROUGH COUNCIL REPRESENTATIVE ON THE HEALTH AND WELLBEING IMPLEMENTATION GROUP

THE ROLE OF DISTRICT COUNCILS IN IMPROVING HEALTH AND WELLBEING

Purpose of the Report

1. This report seeks to raise awareness of the contributions being made by District Councils and their partners at a local level, to addressing the goals of the Health and Wellbeing Board.

Information and Advice

2. The schedule to this report summaries the range of initiatives being undertaken by District Councils and their partners at a local level to support the Health and Wellbeing goals.

3. As can be seen, these initiatives span the full range of "goals" that have been agreed by the Health and Wellbeing Board. The role of District Councils in improving health can be traced back to their origins when they were involved in tackling bad housing, poor water supplies, inadequate drainage and contaminated food.

4. District Councils work in partnership with many public sector and other service providers to deliver services that improve health outcomes. In recent years, District Councils have worked closely with their local Primary Care Trusts and new relationships have already been forged with Clinical Commissioning Groups.

5. Some form of local health partnership can now be found in every District Council area. The majority of these partnerships have emerged out of district based Local Strategic Partnerships and have a strong track record of co-delivery of local initiatives.

RECOMMENDATION/S

The Health and Wellbeing Board is asked to:-

(i) note the contributions made by District Councils to address health and wellbeing goals.

COUNCILLOR JENNY HOLLINGSWORTH
Gedling Borough Council

For any enquiries about this report please contact:

John Robinson
Chief Executive, Gedling Borough Council

Ruth Marlow
Managing Director Mansfield District Council

NOTTINGHAMSHIRE DISTRICT COUNCIL CONTRIBUTIONS TO HEALTH AND WELLBEING

Ref.	Health and Wellbeing Board "Goals"	District Council Activity to Support Goals
1.	**Reduce rates of smoking**	• Work with New Leaf – workplace promotions, help lines • Workplace Health Awards for businesses • Enforcement of smoke free legislation
2.	**Achieve downward trend in levels of excess weight**	• G.P. Referral Scheme • Workplace Healthy Eating (Eatwell) • Community outreach work - holiday activity programmes - activity programmes for older people - community allotment service - community nutrition services
3.	**Prevent and reduce substance misuse**	• Confiscating alcohol from under 18's when drinking in public spaces • Raising awareness of 'Direct Access' clinics and needle exchange facilities • Working in partnership to raise awareness of substance misuse issues • Enforcement of Licensing conditions • Workplace training on alcohol misuse
4.	**Improve services for children and young people with physical disabilities**	• Administration of disabled facilities grants • Development of initiatives to enable people with physical disabilities to get involved in as many activities as possible, to include specific targeted sessions for the physically disabled • 'Wheelchair' Basket Ball • 'Want to Play' sessions • Inclusive gyms • Swimming lessons/clubs
5.	**Improve children and young people's emotional wellbeing**	• Working to ensure mechanisms are in place to provide support and guidance on a variety of issues from debt crisis to involvement in activities within the community, e.g. nutrition advice for homeless • Access to affordable leisure • Theatre programmes in disadvantaged areas
6.	**Improve the quality of life for individuals with physical or sensory impairment or disability, increasing their opportunity to**	• Continually working to encourage the involvement of physically or sensory impaired and disabled individuals in community groups, especially when grant funding has been awarded. • Tele-care Service

	contribute to and take part in wider society and community	• Equality Policy is working to address inequalities
7.	**Reduce inequalities leading to and arising from mental health**	• Ensure relevant programmes of activities are in place for persons suffering from mental health issues and to actively help engage them to join in • Work in liaison with Kings Mill Hospital, Millbrook Unit
8.	**Improve the quality of life and quality of care for older people, ensuring appropriate access to services closer to home to improve health and wellbeing and maintain independence**	• Support and services for older people - alarms service - Tele-care and Tele-health - handyman's services • Review aids and adaptations as necessary • Disabled facilities grants
9.	**Improve participation and attainment in learning up to age eighteen and reduce the achievement gap between vulnerable groups and their peers**	• Work in partnership to assist in providing help and support with education, employment and training issues • Apprenticeship Schemes • Work Experience • Summer Jobs Shop
10.	**Increase the use of early intervention techniques to improve community engagement, reduce domestic violence and prevent children and young people offending through reducing substance misuse**	• Identification of programmes and support mechanisms to assist in the reduction of domestic violence, substance misuse, training, education, etc. • Parenting Support Officers • Temporary Accommodation and Support Services
11.	**Prevent crime and offending, including violent and serious acquisitive crimes and reducing substance misuse by adults**	• Continue effective partnership working with the Police - C.C.T.V. Services - Neighbourhood Warden Service
12.	**Increase the confidence and satisfaction of local communities through reducing anti-social**	• Work in partnership with various agencies to help provide social activities and address issues arising from anti-social behaviour • Neighbourhood Warden Services

	behaviour, victim support and ensuring an effective response to community safety issues	• C.C.T.V. Services • Noise Nuisance Enforcement Services
13.	**Create sustainable communities and environments that promote and enable healthy living and wealthy lifestyles**	• Maintain Environmental Health and Licensing legislation • Encourage healthy eating and a healthy living environment

Nottinghamshire County Council

Report to the Health and Wellbeing Board

16 January 2013

Agenda Item: 9

REPORT OF THE DEPUTY LEADER OF NOTTINGHAMSHIRE COUNTY COUNCIL

AMBITION AND OPERATING PRINCIPLES FOR THE HEALTH AND WELLBEING BOARD

Purpose of the Report

1. This report provides a summary of discussions from the recent workshop held on 28 November 2012. It proposes an ambition statement and operating principles for the Board.

Information and Advice

2. Health & Wellbeing Board members participated in a workshop to consider the Local Government Association self assessment tool and discuss the role and operating principles for the Board going forward.

3. Discussions were far reaching, but were around the following themes. A full report of discussions is available on request:

   a. The Board should maintain a strategic approach to issues and be confident in setting future strategy.
   b. The Board should lead system change to find a financially sustainable solution to delivering health and wellbeing services that meet local needs.
   c. Discussions need to be supported by accurate, comprehensive information and evidence.
   d. The Board should concentrate its role around what it can do over and above the role of individual organisations.
   e. The Board needed to invest in engaging communities to help shape the debate on future priorities.
   f. The Board has a major influencing role across the system as it could maintain a holistic view across all partners.
   g. The Board should lead by example and guide the change to commissioning by outcomes. Success will build credibility with partners and the public.
   h. The Board should be greater than the sum of its individual members.
   i. The Board should lead the integrated approach, using public health as a focus for change.
   j. The Board provides opportunity to harness political power to deliver the Health & Wellbeing Strategy.

4. The Board members discussed the importance of an ambition statement to communicate what the Health & Wellbeing Board aspired to. **Appendix One** includes a draft statement and supporting principles. The Board is asked to consider this information and adapt or approve the statement.

5. The Board discussed the development of operating principles to govern member responsibilities and codes of conduct. It was noted that there were a number of similar standards available. Therefore the Board members agreed to be governed by the Nottinghamshire County Council Councillors Code of Conduct (see **Appendix Two**) and the Seven Principles of Public Life developed by the Nolan Committee. New regulations for Health & Wellbeing Boards are due to be published in January, which will govern how the Board will operate and therefore replace the Code of Conduct.

6. The self assessment was completed by 10 members before the workshop. The collated information was discussed at the Board, but members felt that views from all members should be obtained and the information re-analysed to get a representative picture. A request for outstanding responses has been undertaken and a follow up report will be circulated and or presented at a future workshop.

7. Several actions were identified from the workshop. These included gaining a better understanding each others role; further work on mapping roles and accountability across partners; clarity around scrutiny; communications and review of the self assessment responses. In addition, an example of early leadership in tobacco control was raised, and it was suggested that all partners be asked to make a pledge about what they would do to support this important health and wellbeing area. All actions will be incorporated into the forward programme for the Board.

Statutory and Policy Implications

8. 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) The Health & Wellbeing Board is asked to consider and agree the Ambition statement and supporting principles.

COUNCILLOR MARTIN SUTHERS
Deputy Leader of Nottinghamshire County Council

For any enquiries about this report please contact:
Cathy Quinn, Associate Director of Public Health

Constitutional Comments (SG 21/12/2012)

9. The Board is the appropriate body to consider the issues set out in this report.

Financial Comments (NDR 07/01/2013)

10. There are no financial implications arising directly from the report.

Background Papers

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

Seven Principles of Public Life. Available at:

http://www.public-standards.org.uk/Library/Seven_principles.doc

Electoral Division(s) and Member(s) Affected

All.

HWB53

Appendix One

Ambition

The Health & Wellbeing Board will advocate for improvement in Health & Wellbeing for the population of Nottinghamshire.

Health & Wellbeing Strategy includes the following Ambition:

Our aim is that the people of Nottinghamshire have longer, healthier and happier lives.

Through better joined up working across health, social care and wider communities, we want to make a real difference in improving health and wellbeing opportunities for all.

Supporting Principles

The Board will operate in an open and transparent manner.

Each Board member will work together to build a common understanding of Health & Wellbeing priorities, and what needs to be done to make improvements.

Each Board member will use their position and influence to advocate for the Health & Wellbeing Strategy.

The Board will focus on what can be done differently and collectively to improve outcomes, reduce waste and avoid duplication.

The Board will promote the need for financial sustainability and prioritise action to achieve extra benefit that could not be realised by individual partners.

Information and views will be actively sought so that the Boards plans take account of what is important to local people.

The HWB will advocate for community involvement, so that decisions are shared and based on all information available, taking account of risks and constraints.

The Boards strategy will use the best evidence of what works and make sure we measure success through recognised health and wellbeing outcomes.

The Board will keep a broad oversight of health and wellbeing issues so that the needs of all people, especially the vulnerable, are considered.

Appendix Two

COUNCILLOR CODE OF CONDUCT

INTRODUCTION

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

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

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

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

UNDERLYING PRINCIPLES

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

GENERAL CONDUCT

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

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

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

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

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

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

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

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

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

REGISTERING AND DECLARING PECUNIARY AND NON-PECUNIARY INTERESTS

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

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

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

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

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

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

SENSITIVE INTEREST

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

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

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

ANNEX

DISCLOSABLE PECUNIARY INTERESTS

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

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

Nottinghamshire County Council

Report to the Health and Wellbeing Board

16th January 2013

Agenda Item: 10

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

COMMUNICATIONS AND ENGAGEMENT PLAN

Purpose of the Report

1. To propose a plan for communication and engagement for the Health and Wellbeing Board, the JSNA and Health and Wellbeing Strategy.

Information and Advice

2. Communication and engagement with partners and users of services is a fundamental part of the work of the Health and Wellbeing Board.

3. 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. There is a requirement to consider community views within the Joint Strategic Needs Assessment.

4. Communication and engagement is also fundamental to the work of other directorates within the County Council. Formal consultations are currently coordinated though a central database.

5. There is currently no coordination with the engagement activity of other key partners such as CCGs and district and borough councils although there may be an overlap in areas of interest and potential audiences.

6. There are a number of communications and engagement plans within Nottinghamshire County Council, which include overarching plans such as the Children's Trust Participation Strategy or specific plans designed around individual projects.

7. The impact of any communication and engagement activity would be increased if linked to national campaigns such as Stop Smoking day or National Falls Week

8. A draft Communication and Engagement Plan is attached as Appendix 1.

9. The plan recommends:

- Early time-limited work to raise the profile of the Health and Wellbeing Board (HWB) and the Joint Strategic Needs Assessment and Health and Wellbeing Strategy across all stakeholders within Nottinghamshire.
- Awareness raising of the role of the Board and the work plan within the County Council to coordinate activity across the directorates.
- Identifying existing networks for consultation and engagement that can be used to spread the message around the HWB, and developing a database to allow sharing of information on networks and activities.
- in mapping the networks for consultation, links should also be established to ensure that feedback is provided and integrated into commissioning and development of services.
- feedback should be established to the Health and Wellbeing Boards through the Integrated Commissioning Groups and coordinated by the Health and Wellbeing Implementation Group.

10. Activity should also be aligned with the ongoing refresh of the JSNA and the consultation and engagement required to support that process. A programme of activity for the development of the JSNA is available and could also be used to coordinate with partners.

11. A coordinated approach across the County Council and Health and Wellbeing Board partners would ensure that consultation and engagement work was focussed to support the overall priorities of the Health and Wellbeing Board, duplication could be avoided and 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.

12. Each communication and engagement opportunity should be maximise, so that the role of the Health and Wellbeing Board is communicated as part of any exercise.

13. A refresh of the web-site for the Health and Wellbeing Board would provide and opportunity to initiate this work – to provide more details of the Board and its members, the work programme and to provide some more accessible materials summarising the Board and its role, the JSNA and Health and Wellbeing Strategy.

14. Initial input in awareness raising would present an opportunity for a short term project. This could be covered by one of the National Management Trainee Scheme placements.

15. Ongoing communications and engagement work could be incorporated into the work plan of the communications staff.

Other Options Considered

16. Resource is currently being considered to support communication activity for Public Health and could encompass a role for the Health and Wellbeing Board. However this would be limited and would not allow for the initial awareness raising and development activity described above.

Reason/s for Recommendation/s

17. The Health and Wellbeing Board has a duty to consult and engage with stakeholders and the local population in developing priorities and services.

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 Plan proposed as **Appendix 1**.

2. That the Board support the proposal for a national management trainee or similar project worker to provide short-term dedicated support to undertake this work and to provide a presence on behalf of the Board at local events.

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

4. That the Board supports the Communications and Engagement Plan is initiated by a refresh of the Health and Wellbeing Board website to include more detail about the Board and its members, their remit and work programme.

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

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

Constitutional Comments (SG 07/01/2013)

19. The Board is the appropriate body to consider the issues set out in this report.

Financial Comments (NDR 07/01/2013)

20. There are no financial implications arising directly from the report.

Background Papers

None.

Electoral Division(s) and Member(s) Affected

All.

HWB56

APPENDIX 1

Nottinghamshire County Council

Nottinghamshire Health & Wellbeing Board

Communications & Engagement Plan

Background

The Health and Social Care Act was passed in March 2012. The main changes within the Act are:

- The abolition of Primary Care Trusts and Strategic Health Authorities
- The formation of Clinical Commissioning Groups (CCGs) responsible to a new NHS Commissioning Board.
- All hospital trusts to become foundation trusts.
- The creation of Public Health England (PHE)
- The creation of local Health and Wellbeing Boards
- The appointment of a Director of Public Health in upper tier local authorities (including joint appointments where appropriate.)
- The transfer of the public health workforce & responsibilities between the NHS to local authority
- The creation of a ring fenced public health budget for local authority.

The majority of these changes will become effective from April 2013.

Local
The Shadow Nottinghamshire Health and Wellbeing Board was established in May 2011 and is comprised of 18 members:

- 5 county councillors
- 2 representatives of the district/borough councils
- The Director of Adult Social Care, Health and Public Protection
- The Director of Children, Families & Cultural Services
- The Director of Public Health
- Representatives of each of the 6 Nottinghamshire CCGs
- A representative of Healthwatch (currently LINks)
- A representative of the NHS Commissioning Board (currently PLT Cluster Board rep)

The aim of the board is to provide leadership to improve the health and wellbeing of Nottinghamshire and to develop a strategy to deliver this through close co-operation between the health service, local government and providers of services.

The legislation requires the Health and Wellbeing Board to produce a Joint Strategic Needs Assessment and a Health and Wellbeing Strategy which local commissioners have a duty to consider when making commissioning decisions.

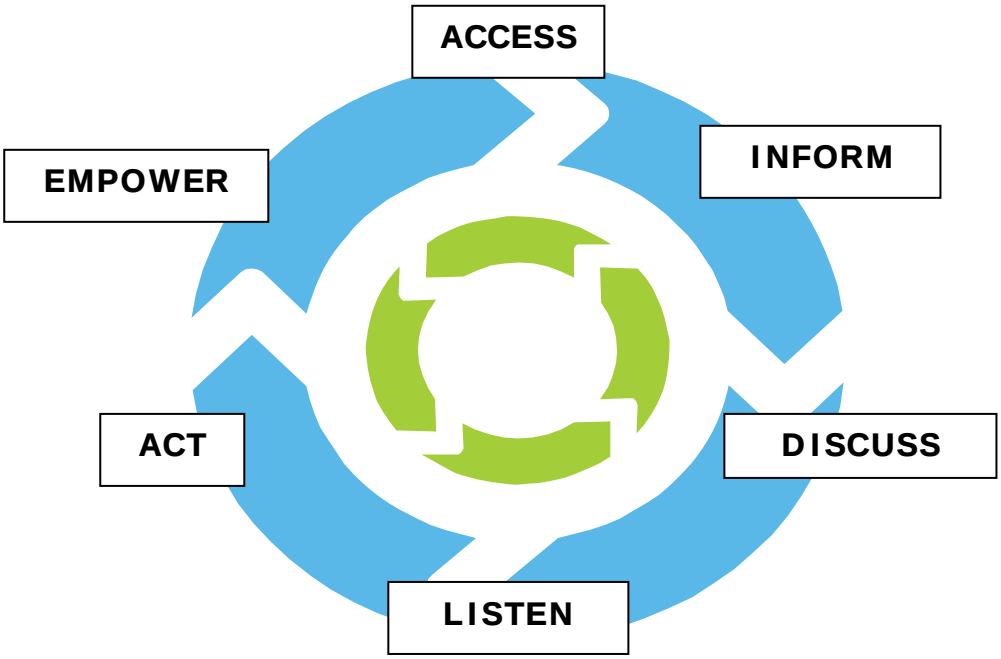
Aim of the Plan

To raise awareness of the Health and Wellbeing Board and its role in the new system of health and social care.

To raise awareness of the work of the Health and Wellbeing Board, including the JSNA and the Health & Wellbeing Strategy and how they may be influenced.

Approach

The Plan promotes a joined up and continuous process for communication and engagement. This is described using the following illustration:



ACCESS:	Making sure all interested people are given the opportunity to get involved
INFORM:	Providing information to help an informed debate
DISCUSS:	Promoting active discussions to gain all viewpoints
LISTEN:	Being open to all contributions
ACT:	Being prepared to act on all comments and providing feedback on what has changed as a result
EMPOWER:	Building capacity in communities to continue the consultation and engagement cycle and take a lead in promoting health and wellbeing.

Principles

All communication relating to the JSNA, HWS and public health should refer back to their contribution to the work of the Health and Wellbeing Board and the overall principles of the Board, wherever possible. Exceptions will be made where this would confuse the key message being communicated.

Communications should be accessible to as many people as possible. It is recognised that with a large and diverse population that methods of communication will be developed to engage with as many stakeholders as possible, in a variety of formats.

Wherever possible existing networks will be utilised including membership of NCC citizens panel, CCG Take a Healthy Interest forums, LINks network, HWB stakeholder network, provider networks and other local groups.

Communication should be consistent with the engagement strategies of other directorates within NCC e.g. Children's Trust Participation Strategy,.

Communication should also be coordinated. There is a great deal of overlap with the work of the Health and Wellbeing Board and the work within the council in Adult Social Care and in Children and Families and this could be coordinated under the umbrella of the Health and Wellbeing Board to ensure that all consultation supports the overall aims and work plan of the HWB and that it is not duplicated.

Coordination could extend to other key partner organisations such as CCGs and district/borough councils and aligned with relevant national campaigns such as National No Smoking Day or Falls Awareness Week.

This plan provides a foundation for raising awareness of the Health and Wellbeing Board and its role in improving the health and wellbeing of the population of Nottinghamshire. In developing the work of the board more targeted plans will be developed which are specific to individual pieces of work by JSNA chapter.

Target audiences

This document looks at those stakeholders with an interest in generic health and wellbeing. The audience may change depending on the focus of the work to be undertaken, for example in reviewing different sections of the JSNA.

Stakeholders have been grouped into 4 general groups:

Commissioners:	those people who buy and shape services
Customers:	those people who directly use the services or support those who do so
Collaborators & providers:	those who provide a service or who has an impact on services provided
Commentators:	those people or organisations who are not directly involved in using, buying, providing or shaping service but whose opinion may influence the opinion of others

Commissioners	
CCGs	Public health
Nottinghamshire County Council	NHS Commissioning Board/PHE

Customers	
Local population	Carers
Service users	Seldom heard groups
Neighbouring populations	PPGs?

Collaborators & providers	
Fire	Police
Probation service	Ambulance
District/borough councils	CCGs
Voluntary and community sector	Healthwatch
Scrutiny and policy committees	Clinical networks
Clinical senates	Care Quality Commission
NHS provider trusts	Private providers
Community groups	Integrated commissioning groups
User groups (including carers)	Housing associations
Parish councils	Neighbourhood groups
Recreational groups (e.g. WI)	Local businesses
Safeguarding Board	PPGs
Schools	

Commentators	
Media – local & national	MPs
District/borough CEs	County Councillors
District councillors	Other local authorities
Department of Health	NCC staff
Pressure groups/bloggers	Social media
Youth MPs	

Key messages

- The Nottinghamshire Health and Wellbeing Board is the key vehicle to improve the health and wellbeing of the population of Nottinghamshire by ensuring that partners across health and social care work together.

- The Health and Wellbeing Board is responsible for identifying the health needs of Nottinghamshire through the production of a Joint Strategic Needs Assessment (JSNA) and developing a Health and Wellbeing Strategy to address those needs.

- The Nottinghamshire Health and Wellbeing Board is committed to communicating and engaging in as many ways as possible through a range of communication vehicles, encouraging people to have their say on local plans.

Communications

Internal communications

- PCT Team Talk
- NCC Team Talk
- CCG newsletters
- NCC intranet site
- District/borough council intranet sites
- Updates to HWIG & HWB

External communications

- Presence on PCT and NCC web sites
- CCG websites
- NCC County News
- Stakeholder network briefings
- LINks newsletters
- CCG/PPI newsletters
- Local media
- District/borough council web sites & newsletters
- Social media

Evaluation

Evaluation should be undertaken based on generic awareness raising and also by individual theme and its specific audience.

An evaluation plan will be developed and will include the following methods of evaluation to assess awareness of the HWB, JSNA and HWS.

- Annual surveys through NCC's existing mechanisms i.e. annual residents survey, citizens' panel and County News
- Annual survey through stakeholder network
- On-line survey via NCC website
- Attendance at events
- Evaluation from events
- Stakeholder satisfaction with the JSNA & HWS.
- Number of responses received during consultations
- Responses representative of local population & including equality groups, key stakeholders & seldom heard groups.
- Number of internet hits for web pages.
- Other channel measures (e.g. media coverage).

Feedback

Methods of feedback should be integral to all of the communications and engagement work undertaken.

Coordination and collation of responses should be undertaken through the Health and Wellbeing Implementation Groups via integrated commissioning groups.

Where relevant topic specific feedback should be collated across the integrated commissioning groups to allow a holistic approach to be developed e.g. obesity would involve input across children, young people and adults.

Sustainability

Through a coordinated approach, the plan will keep track of networks and contributors, identifying community champions to promote health & wellbeing messages. It aims to harness the knowledge, skills and capacity of individuals to embed communication and engagement into everyday life and work, forming locally empowered communities.

Activity Plan

Stakeholders	Objective	Method	When	Where	Who	Cost? £ Y or N
Local population of Nottinghamshire	Consultation to seek views on the structure, format & accessibility of the JSNA.	Internet (web pages) Online survey Media Social media	March/April	Internet	HWB plus digital team	
Local population of Nottinghamshire	To consult with the public and stakeholders in Nottinghamshire on a draft version of a health and wellbeing strategy to gain broad spectrum agreement for the strategic priorities for the health and wellbeing board and strategic plan, to inform the final version of the strategy.	Internet (web pages) Face to face: Meeting Written: Survey Online: Survey Media Social media	February/March 2012	Internet	HWB plus digital team	
Various	HWB workshop discussion on HWS identifying priorities for action.	Face to face meeting	February 2012	CH	HWB	
Various	Papers presented on HWS & JSNA for comment.	Face to face	May 2012	CH	HWIG	N
Various	Papers presented on HWS & JSNA for comment.	Face to face	May 2012	CH	HWB & others	N
Local population of Nottinghamshire	To raise awareness of the JSNA and proposed development plan for review and encourage engagement in the process.	Publish the work plan for the JSNA process to identify the specific topic areas & intended plan for engagement.	Publish work plan on NCC website by December 2012	Internet		
	To develop a template for topic leads to define engagement activity for each topic area.	Written material	December 2012	NCC intranet	JSO Group	
Population	To raise awareness of the HWB and its work	Article in County News	January 2013	Publications	HWIG	
Population	To raise awareness of the HWB and its work	Refresh of HWB web pages • Profile of members • Work plan	January 2013	Internet	HWIG	

Population	Availability of accessible documents	Development of summary/easy read documents for HWB, JSNA & HWS	To be confirmed when project manager in place			
Population	To raise awareness of the HWB & its work & specific areas of interest for each meeting.	Internet Media Social media PCT/NCC staff briefings Local events	January – March 2013	Internet Event locations CH/PCT	PH Comms NCC CCG PPI leads?	
NCC/HWB	Appoint short term project support.	Recruitment / secondment / Trainee placement	January 2013	CH	HWIG	
NCC/partners	Map / Review stakeholders and communication and engagement mechanism to identify overlaps and gaps	Face to face meetings Emails Discussion with NCC engagement lead	To be confirmed when project manager in place			
NCC/partners	Establish links for current/planned engagement work to coordinate activity	Face to face meetings Emails Discussion with NCC engagement lead	To be confirmed when project manager in place			

Nottinghamshire County Council

Report to the Health and Wellbeing Board

16th January 2013

Agenda Item: 11

REPORT OF THE DIRECTOR OF PUBLIC HEALTH

PUBLIC HEALTH GRANT AND BUDGET PLANNING UPDATE REPORT

Purpose of the Report

1. To inform the Members of the Health and Wellbeing Board of the current funding arrangements within Public Health (2012/13) and the ongoing work to prepare for the Public Health Grant allocation from 2013/14.

Information and Advice

Context

2. As from April 2013 Public Health functions will be funded through three principal routes:

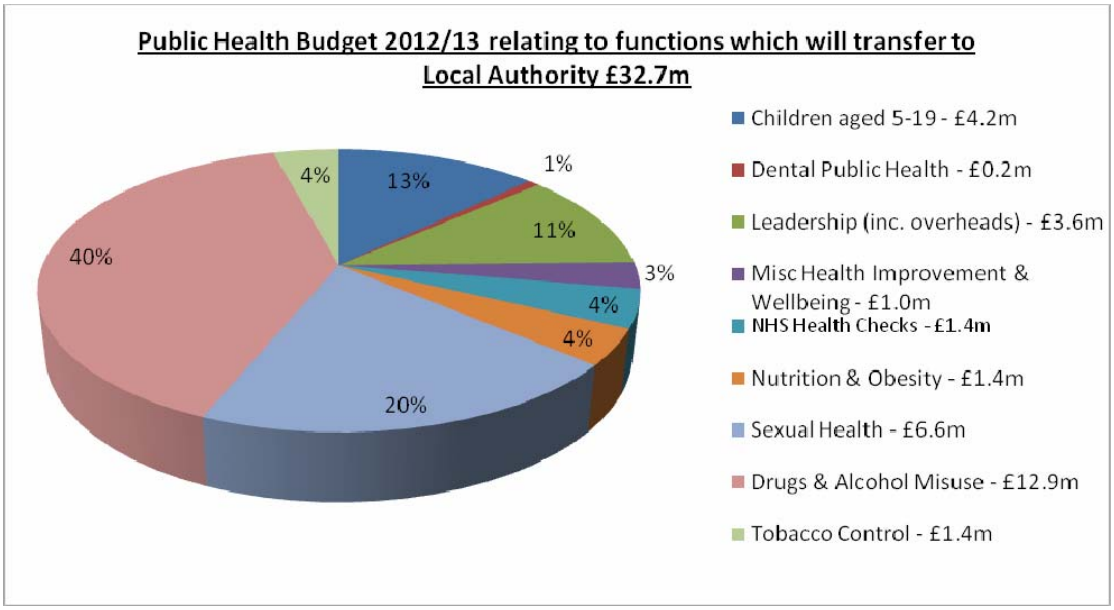
   - Ring-fenced grants to upper tier and unitary local authorities.
   - Through the NHS Commissioning Board.
   - Public Health England commissioning or providing services itself.

Public Health Budget 2012/13

3. The Public Health Budgets for 2012/13 across NHS Bassetlaw and NHS Nottinghamshire County total £67.4m. Approximately £32.7m (48.5%) of this budget relates to functions which will fall within the Local Authority's remit. **Table 1** below illustrates how the £32.7m is currently allocated across the public health policy areas.

4. A list of Public Health functions transferring to Local Authority along with summary of the services commissioned for each of the policy areas are included for information in **Appendix One.**

Table 1



Public Health Grant

5. The Public Health Grant for 2013/14 was expected to be announced by the 21st December 2012, but has now been delayed until January. A number of baseline returns have been submitted to the Department of Health by NHS Bassetlaw and NHS Nottinghamshire County which suggest that the Public Health grant could range from £29.9m to £33.7m. The indicative allocation released in February 2012 was £29.9m and this is the figure we have used for planning purposes. We have also assumed that the Public Health Grant will be ring fenced in 2013/14.

Public Health Budget Planning

6. Detailed work has been undertaken within Public Health, in conjunction with Nottinghamshire County Council's (NCC) Procurement and Legal team to establish current budgetary commitments and contractual obligations.

7. There is also a Public Health Contract Transition team which has been established to oversee the transfer of contracts to Nottinghamshire County Council in April 2013. A Steering Group has been established with procurement and contract membership from the NHS and from both City and County Councils. This team is led by the Associate Director of Public Health with the NCC Procurement Team Manager and reports to the Public Health and NCC senior and corporate management teams.

8. The Director of Public Health held a Confirm and Challenge Session on the 8th October at which each Public Health Consultant put forward proposals for their lead policy areas outlining their future commissioning intentions, budget required and desired outcomes. **Appendix Two** summarises the requested budget by policy area and identifies how much of the budget is pre-committed and how much was additionally requested recurrently and non-recurrently. Appendix Two highlights that the total recurrent funding requested exceeds the indicative grant figure by approximately £2.9m.

Budget Proposal

9. The budget required to meet our present contractual commitments is £29.9m. This would give us a break even position, which would be our preferred approach for a safe and effective transfer during 2013/14.

10. In addition to the Public Health Grant the Public Health Directorate will have access to some non recurrent monies which will be held in a Council reserve. Currently this is estimated at £1.5m. A financial plan is currently being developed against this reserve along with some general principles for what and how it should be accessed e.g. transition implementation and set up costs, cost pressures and financial risks.

11. There are some financial risks – some which are currently excluded from the latest baseline working exercise. These include GP prescribing costs associated with Public Health services which are commissioned from Primary Care Contractors and some areas where there may be an issue with how the budget/plan is set, for example, NHS Contract over performance. Work is ongoing to calculate and score each risk and put mitigation plans in place where appropriate.

12. The **preferred option 1** is to fund all current pre-commitments only and use the non recurrent monies to meet in year cost pressures and financial risks.

Other Options Considered

13. Dependent on the final Public Health grant allocation, the following other options will be explored in order to maintain a break even position regarding 2013/14 budgets:

- **Option 2 –** Set each policy area a budget based on the current pre-committed value £29.9m and develop a £600k cost improvement programme across the Public Health function (which equates to a reduction in current commitments of approximately 2%). The £600k could be used to establish a risk reserve and an innovation fund to which the PH team could access or bid for within agreed financial governance arrangements.

- **Option 3 –** Top slice 10% from each policy area to keep the efficiency targets the same across the directorate. This would release approximately £2.9m which would fund a risk reserve and also create a development fund to which the PH team could access via submission of a business case, which would be assessed by pre-defined criterion.

- **Option 4 –** Top slice 5% from specific PH functions which would release £1.5m which would fund a risk reserve and create a development fund to which the PH team could access via submission of a business case, which would be assessed by pre-defined criterion. The £1.5m could be used to fund services part year effect in 2013/14 whilst notice is being served on some existing services.

14. Further assessment and prioritisation will be undertaken as required once the Public Health allocation for 2013/14 is known. This will form a follow up report to the Health & Wellbeing Board in March 2013.

Statutory and Policy Implications

15. 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

The Health & Wellbeing Board are asked to:

1) Note the 2012/13 Public Health Budgets in place and the services that the budget is used to commission, to address the health needs across Nottinghamshire County.

2) Receive information on the planning work undertaken to date

3) note the preferred option to setting budgets for 2013/14, which is **Option 1** – Fund all current pre-commitments only and use the non-recurrent monies to meet in year cost pressures and financial risks.

DR CHRIS KENNY
Director of Public Health

For any enquiries about this report please contact:
Cathy Quinn, Associate Director of Public Health

Constitutional Comments (SG 21/12/2012)

16. The Board is the appropriate body to consider the issues set out in this report.

Financial Comments (NDR 07/01/2013)

17. The financial implications are set out in the report.

Background Papers

None.

Electoral Division(s) and Member(s) Affected

All.

HWB 52

APPENDIX 1

The following list describes the Public Health responsibilities which will be transferring with Public Health to Local Authority on 1 April 2013. This includes five mandated functions, which are highlighted in **Bold**:

- **the National Child Measurement Programme**
- **NHS Health Check assessments**
- **comprehensive sexual health services (including testing and treatment for sexually transmitted infections, contraception outside of the GP contract and sexual health promotion and disease prevention)**
- **the local authority role in dealing with health protection incidents, outbreaks and emergencies**
- **Public Health advice to NHS commissioners**
- tobacco control and smoking cessation services
- alcohol and drug misuse services
- PH services for children and young people aged 5-19 (including Healthy Child Programme 5-19) and longer term all children and young people PH services
- interventions to tackle obesity such as community lifestyle and weight management services
- locally-led nutrition initiatives
- increasing levels of physical activity in the local population
- public mental health services
- dental public health services (prevention/health promotion elements only)
- accidental injury prevention
- population level interventions to reduce and prevent birth defects
- behavioural and lifestyle campaigns to prevent cancer and long-term conditions
- local initiatives on workplace health
- supporting, reviewing and challenging delivery of key public health funded and NHS delivered services such as immunisation and screening programmes
- local initiatives to reduce excess deaths as a result of seasonal mortality
- PH aspects of promotion of community safety, violence prevention and response
- PH aspects of local initiatives to tackle social exclusion
- Local initiatives that reduce PH impacts of environmental risks.

Public Health services currently commissioned

The table below summarises, for each of the policy areas, the needs of the local population and the services currently commissioned.

Reasons for investing in these services	Services commissioned
Public Health Leadership	
	This heading includes pay and non pay costs associated with the Public Health leadership team, administrative support, commissioning support and information analysts, including overheads and supporting functions.
Drugs and Alcohol Misuse	
It is estimated that there are 4,700 opiate and/or crack users in Nottinghamshire, 120,000 high risk drinkers and approximately 21,000 dependent drinkers. Whilst the prevalence of Opiate and/or Crack User's in treatment remains higher than any other illicit substance users, over the last 5 years, we are seeing greater increases in those reporting the use of cannabis, amphetamines and legal highs. The links between alcohol and violent crime are evident, with both victims and perpetrators identifying problems with alcohol. Once effectively engaged in drug treatment the outcomes are positive for opiate users. Reductions are seen in drug use and injecting, with reports in improvements in employment and housing, however there are reported increases in alcohol use. A quarter of those in drug treatment also report problems with alcohol use.	A range of services a commissioned to treat dependency on drugs and alcohol across the County using a number of different funding streams (Adult Pooled Treatment budget, Drug Intervention Programme as well as PCT mainstream healthcare monies). The budget currently commissions community drug and alcohol misuse treatment services as well as the successful identification of drug misusing offenders, a comprehensive and standard assessment of their treatment and other support needs; and effective, consistent case management to help break the cycle of drugs and offending**.**
Sexual Health Services	
Many sexually transmitted infections (STI's) have long term effects on health and there has been an increase in risky sexual behaviour, with continued ignorance about the possible consequences. Preventative services not only promote well-being but positively impact upon cost to the NHS. It is suggested that the prevention of unplanned pregnancy by the NHS contraception services saves the NHS over £2.5 billion a year. The highest burden of sexually related ill-health is borne by women, gay men, teenagers and young adults and more deprived communities.	The current model commissioned sits across numerous providers and in a variety of settings i.e. hospitals, health centres, schools and colleges, providing different elements of the care pathway. The services provide specialist sexual health and contraception services that contribute to the following outcomes: • Prevention, detection and treatment of sexual ill health; • Provide effective contraceptives services; • Plan and prevent unwanted pregnancy; • Reduce the transmission of STIs and HIV • Reduce the prevalence of undiagnosed STIs and HIV • Improve the Health of people living with STIs • Reduce the stigma attached to STIs and HIV Promoting good sexual health; • Increase access of sexual health services in the community; • Provide effective Sexual Relationship Education into schools (Mansfield &

	Ashfield) that encourage young people to delay Sexual relationships, understand sexuality, and actively manage their contraceptive requirements.
Tobacco Control	
Smoking is the primary reason for the gap in health life-expectancy between rich and poor. It is also the single greatest cause of preventable deaths in England – killing approx 1,300 people across the county per year. Each year in Nottinghamshire it is estimated that smoking costs society £204.4m (£40m NHS spend).	Smoking cessation services are currently commissioned to support the Tobacco agenda. These are commissioned from three providers (including a specialist provider, GP's and Pharmacists), targeting areas of the highest deprivation, to meet an NHS four week quitter target.
Obesity	
Obesity is a major public health problem. Unhealthy diets combined with physical inactivity have contributed to an increase in obesity with almost a quarter of adults and almost a sixth of children under the age of 11 are deemed obese. Obesity threatens the health and wellbeing of individuals and will place a national financial burden in terms of health and social care costs, on employers through lost productivity and on families because of the increasing burden of long term chronic disability.	A range of services are currently commissioned as follows: 1. The National Childhood Measurement Programme involves the annual weighing and measuring of all eligible children in reception (aged 4-5) and year 6 (aged 10-11). This service provides surveillance data on weight status of children to provide parents/carers with feedback on their child's weight status and information about where to access support and advice. 2. Prevention and weight management interventions include the community nutrition service, exercise referral schemes and 12 week management courses.
Dental Public Health & Fluoridation	
Levels of dental caries in five year olds are lower than the national average in all areas except Broxtowe and Gedling. The levels of dental decay in the three areas with water fluoridation are significantly lower than the national average, despite high levels of deprivation in those areas. Poor oral health may be associated with low weight and failure to thrive in very young children. Poor oral hygiene in adults is linked to periodontal disease which is associated with heart disease.	Three services are currently commissioned as follows: 1. Oral health promotion service provides a range of promotion services across the County. This work includes the Incredible Mouths initiative which promotes good dietary habits, good oral hygiene and regular dental attendance. 2. The Dental epidemiology study provides surveillance data on the health of children's teeth. 3. Water fluoridation in Ashfield, Bassetlaw and Mansfield.
Children aged 5-19	
There is a close association between health and academic attainment, with academic attainment influencing and being influenced by, health status. There is clear evidence that poor health can inhibit learning. Particular issues can be prevalent in schools where there are high proportions of pupils eligible for free school meals. Areas highlighted include: Childhood Obesity Teenage conception	Two services are currently commissioned as follows: 1. The Healthy Schools programme. This team are responsible for improving health for children and young people in schools, children's centres by working with services to achieve and maintain a healthy school standard or healthy early years standard. Healthy schools advisors support schools, children's centres and provider staff to deliver the wider public health agenda, providing information, guidance and expertise on encouraging

Substance misuse Smoking prevalence Emotional health and wellbeing Immunisation rates Safeguarding issues	healthy lifestyles. Schools select priority health topics such as emotional health or healthy eating to focus on depending on the needs in their setting. 2. The School Nursing service leads the implementation of the Healthy Child Programme for 5-19 year olds. This includes provision of health promotion, advice, signposting to other services, direct clinical treatments, education, safeguarding support and service co-ordination. The service focuses on improving health outcomes, particularly for targeted groups, including those disengaged from school. The service is provided to approximately 136,000 children and young people across the patch.
NHS Health Checks	
NHS Operating Framework 2012 -13 whereby a target of 20% coverage of the eligible population to have had an offer of a NHS Health Check. To demonstrate improved uptake rates up to 75%. The NHS Nottinghamshire County Health Check programme was introduced in 2010 to provide adults aged 40 to 74 with no previous history of cardiovascular disease (CVD) with a health check once every five years aiming to identify those at highest risk of heart disease, stroke, type 2 diabetes or kidney disease. The programme is now being fully rolled out. Ultimately, all eligible people should be invited for a health check within five years of the introduction of the scheme.	The service is commissioned via a Local Enhanced Service agreement with GP practices. A payment is made per NHS Health Check to identify eligible patients, send out invitations, undertake the Health Check, provide lifestyle advice and appropriate management e.g. referral to intervention services e.g. NHS Smoking Cessation services. An additional remuneration is paid for each patient placed on a CVD high risk register and managed according to national guidance including NICE CG 67 Lipid modification, NICE CG 34 Hypertension, NICE CG 43 Obesity, as part of an annual review. This payment is fixed for 3 years only and will cease in 2012/13.
Miscellaneous Health Improvement and Wellbeing	
	A range of services are commissioned which fall under this heading, including Domestic Violence services, services to tackle public mental health, homelessness, fuel poverty and social exclusion.

Appendix 2

Public Health - Confirm & Challenge financial proposal summary 2013/14

Programme Area	2013/14 Budgets Requested at Confirm & Challenge			
	Pre-committed £	Additional requested £	Total Recurrent £	Non Recurrent requested £
Public Health Directorate Pay	3,249,500	-	3,249,500	-
Directorate Non Pay	150,000	-	150,000	-
Mandated Functions:				
Public Health advice to NHS Commissioners (cost is absorbed within Directorate Pay)	-	-	-	-
Dealing with Health protection incidents & emergencies	-	2,500	2,500	-
Comprehensive sexual health services	6,046,124	507,376	6,553,500	-
National Child Measurement Programme (inc in School Nursing Contract)	-	-	-	-
NHS Health Checks (Assessment & Lifestyle interventions)	889,221	459,452	1,348,673	32,000
Non Mandated Functions:				
Obesity, Nutrition and Exercise	906,616	593,384	1,500,000	500,000
Tobacco control	1,910,294	747,776	2,658,070	-
Alcohol and Drug Misuse services	11,678,204	-	11,678,204	-
Local initiatives on workplace health	-	227,000	227,000	-
Dental public health & Fluoridation	235,000	-	235,000	-
Public mental health services	-	107,900	107,900	-
Public health services for children and young people aged 5-19, including healthy schools	4,199,886	-	4,199,886	-
Accidental injury prevention, including falls prevention	-	5,000	5,000	-
Population level interventions to reduce and prevent birth defects	33,000	-	33,000	-
Behavioural and lifestyle campaigns to prevent cancer and long-term conditions	59,650	15,000	74,650	-
Local initiatives to reduce excess deaths as a result of seasonal mortality	15,000	-	15,000	-
Public health aspects of promotion of community safety, violence prevention and response	141,875	152,895	294,770	
Public aspects of local initiatives to tackle social exclusion	28,439	5,000	33,439	36,000
Local initiatives to reduce public health impacts of environmental risks	-	-	-	-
Multifactorial services	389,215	-	389,215	-
Shared functions included for consideration:				
Infection prevention and control services	-	1,000	1,000	
Totals (£)	**29,932,024**	**2,824,283**	**32,756,307**	**568,000**

Summary

	£	£
Public Health Indicative Grant	**29,900,000**	-
Forecast NR resources held under s256	-	**1,150,000** *
Total recurrent funding requested	**32,756,307**	
Total non recurrent funding requested		**568,000**
Budget shortfall	**- 2,856,307**	**582,000**

** includes forecast values to be transacted in November 12 in addition to the balance from 2011/12 (excludes substance misuse monies transferred under s256 arrangements).*