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.