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Nottingham City Council

NOTTINGHAM CITY COUNCIL
HEALTH SCRUTINY COMMITTEE

Date: Thursday, 24 September 2015

Time: 1.30 pm

Place: LB41 - Loxley House, Station Street, Nottingham, NG2 3NG

Councillors are requested to attend the above meeting to transact the following business

Acting Corporate Director for Resources

Governance Officer: Clare Routledge **Direct Dial: 0115 8763514**

AGENDA **Pages**

1	**APOLOGIES FOR ABSENCE**	
2	**DECLARATIONS OF INTEREST**	
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PLEASE NOTE THERE WILL BE A PRE-MEETING FOR COUNCILLORS AT 1.00PM AT LOXLEY HOUSE.

IF YOU NEED ANY ADVICE ON DECLARING AN INTEREST IN ANY ITEM ON THE AGENDA, PLEASE CONTACT THE CONSTITUTIONAL SERVICES OFFICER SHOWN ABOVE, IF POSSIBLE BEFORE THE DAY OF THE MEETING

CITIZENS ATTENDING MEETINGS ARE ASKED TO ARRIVE AT LEAST 15 MINUTES BEFORE THE START OF THE MEETING TO BE ISSUED WITH VISITOR BADGES

NOTTINGHAM CITY COUNCIL

HEALTH SCRUTINY COMMITTEE

MINUTES of the meeting held at Ground Floor Committee Room - Loxley House, Station Street, Nottingham, NG2 3NG on 23 July 2015 from 13.30 - 15.39

Membership

Present	Absent
Councillor Ginny Klein (Chair)	Councillor Merlita Bryan
Councillor Anne Peach (Vice Chair)	Councillor Corall Jenkins
Councillor Jim Armstrong	
Councillor Ilyas Aziz	
Councillor Neghat Nawaz Khan	
Councillor Dave Liversidge	
Councillor Chris Tansley	

Colleagues, partners and others in attendance:

Stephanie Cook - Senior Commissioning Manager, NHS England
Martin Gawith - Healthwatch Nottingham
Lynne McNiven - Public Health
Peter Morley - Care Act Implementation Manager
Ruth Rigby - Healthwatch Nottingham
Clare Routledge - Senior Governance Officer
Linda Sellars - Director for Adult Social Care Quality and Change
Zena West - Governance Officer

16 APOLOGIES FOR ABSENCE

Councillor Merlita Bryan

17 DECLARATIONS OF INTEREST

Councillor Dave Liversidge declared an interest in item 8 on the agenda, GP Practice Merger in Sneinton, as he is a patient at one of the surgeries. Councillor Neghat Khan also declared an interest in item 8 on the agenda, as she is a patient at one of the surgeries. Neither interest was sufficient to preclude either Councillor from speaking or voting on the item.

18 MINUTES

The minutes of the meeting held on 18 June 2015 were confirmed and signed by the Chair.

19 PROGRESS IN THE IMPLEMENTATION OF THE CARE ACT 2014

Peter Morley, Care Act Implementation Manager, and Linda Sellars, Director for Adult Social Care Quality and Change, gave a presentation on the progress of the implementation of the Care Act 2014, highlighting the following points:

(a) the Act passed into law in May 2014. Part 1 final regulations and statutory guidance were published at the end of October 2014, with implementation by April 2015;

(b) an announcement was made on 17 July that the proposed cap on care costs is to be delayed until 2020;

(c) the Care Act Programme Board is in place, with programme leads in key areas – Overseeing audit of compliance with part 1 and further development work;

(d) there are new duties around wellbeing and prevention, with wellbeing principle built into training, contracts and practice. A redesign has taken place of assessment and support planning documentation, to demonstrate consideration of wellbeing and prevention approach, and frontline staff have attended mandatory cultural change workshops;

(e) work is ongoing with partners to upskill and empower frontline staff to consider whole household wellbeing issues at every contact. Frontline staff are being supported with more skills to support citizens in making positive lifestyle choices, and implementing preventative interventions;

(f) a factsheet has been developed and published on the Adult Social Care website. Information and advice services are being commissioned for a range of issues, including debt management, welfare benefits, and housing, with a multi-agency strategy for citywide information and advice currently in development. Commissioning is also underway to replace the Choose my Support directory;

(g) contacts are in place with the Care Quality Commission, and market position statements have been reviewed. A provider failure protocol is in place, with an early intervention pilot designed to identify and support struggling providers;

(h) eligibility for care is now identified using a national framework, with an audit of this due in August 2015. Carers are now being assessed in line with the requirements of the Care Act by the Carers Federation, which has resulted in the removal of carer responsibilities from 7 young carers since April 2015;

(i) workshops are being delivered to practitioners on care and support planning, and POhWER have been commissioned to deliver independent advocacy;

(j) a Local Government Association tool has determined that policies and procedures surrounding charging and financial assessment are compliant. A deferred payments policy is in place, but there has been very little citizen interest;

(k) care and support planning and personal budget procedures have been reviewed, and new forms rolled out to frontline staff. Detailed information is available to citizens regarding Direct Payments and care and support planning, with a Care and Support policy recently published. A workforce culture change programme has also been delivered, with further training to be delivered until 2016;

(l) the transition process for children (and carers) likely to have needs when they turn 18 has been checked and agreed as compliant, with a transition strategy currently in development;

(m) the Council must promote integration with the aim of joining up services. This is currently in progress through the work of the Health and Wellbeing Board and the partnership work with the Nottingham City Clinical Commissioning Group;

(n) a Safeguarding Board has been established, as has a training programme designed to embed the principle of making safeguarding personal. The Safeguarding Care Act Working Group meets to monitor safeguarding progress;

(o) current practices and process for ensuring continuity of care when moving between areas have been checked and confirmed as compliant. The Association of Directors of Adult Social Services have developed a regional cross-border carers protocol, and consideration is being given to how this can be adopted by Nottingham City Council;

(p) links have been established with HMP Nottingham, approved prison premises, and bail accommodation providers, and NHS England is providing social care assessments for prisoners. Work is underway at a regional level to understand is assumptions about prison social care were sound. HMP Nottingham is a remand prison, and it was anticipated that demand for social care would be low. However, Nottingham and other areas with remand prisons have a higher need than expected for social care provision. This may be due to the robust assessment process in place.

The following points were raised during discussion:

(q) personal budgets have been around for many years as part of the personalisation agenda. National indicators have recently been submitted, and everyone who is eligible to receive them currently is;

(r) There is a legal duty to monitor direct payments, and citizens submit invoices for checking every 3 months. A card account has recently been introduced, so that citizens won’t have to submit returns, as the account can be checked directly by Nottingham City Council to ensure that the money has been used correctly. 28 citizens are currently using the new card account;

(s) a Senior Community Care Officer and a Social Worker are dedicated to the monitoring of direct payments, and there are procedures in pace to transfer citizens from direct payments on to a commissioned service in cases of misuse;

(t) citizens who employ a personal assistant now have to offer them the option of opting into a pension. Nottingham City Council has taken the decision to support citizens with the complicated process of setting up a pension, and citizens have been notified of their obligations. Some external providers offer

direct payment citizens employment support, to ensure that they are good employers of their personal assistants;

(u) the Care Act is clear that there is a statutory responsibility to ensure that nobody under 18 is carrying out inappropriate care of an adult. All 7 young carers who had their carer responsibilities removed were under 18. Action for Young Carers, which is part of the Carers Federation, is working in partnership with Nottingham City Council;

(v) the Provider Failure Protocol will be provided to members of the Committee. It is very detailed. It is an ever-evolving document, with new information and learning added with each closure. The process is moving towards early intervention, to help struggling providers prior to closure becoming necessary and avoiding provider failure where possible;

(w) the entire 2nd part of the Act has been deferred until 2020, so there is no immediate work to do on any of the requirements of part 2. More detailed information on the implications of part 2 will be received in 2019;

(x) Healthwatch Nottingham representatives reported they are keen to use the “enter and view” function into care homes.

RESOLVED to:

(1) thank Peter Morley and Linda Sellars for the presentation;

(2) ask that details relating to young carers be provided to committee members;

(3) ask that details of the Provider Failure Protocol be provided to committee members.

20 UPDATE ON THE PROGRESS ON THE TRANSFER OF THE HEALTH VISITORS AND FAMILY NURSE PARTNERSHIP COMMISSIONING RESPONSIBILITIES FROM NHS ENGLAND TO NOTTINGHAM CITY COUNCIL - 1ST OCTOBER 2015

Lynne McNiven, Consultant in Public Health, and Stephanie Cook, Senior Commissioning Manager NHS England, presented a report on the progress of the transfer of Health Visitor and Family Nurse Partnership Commissioning Responsibilities from NHS England to Nottingham City Council on 1 October 2015, highlighting the following points:

(a) as of 31 March 2015 there were 126 full time equivalent Health Visitors in post. This is more than doubled the original starting number, and is an immense achievement. The target is 154 Health Visitors, so it is in everyone’s interest to get as close to that number as possible;

(b) service specifications have been agreed nationally. The funding allocation has been agreed in year, from October 2015 to 31 March 2016. Nottingham City

Council is still awaiting clarification from the Department of Health and Local Government Association on the funding formula and allocation for 16/17;

(c) historically health visitors and family nurse practitioners have been commissioned on a registered basis but nationally this will be changing to resident population. Whilst this may sound simple, it is complicated when working with vulnerable families. Nottingham City Council have raised concerns over last 9-10 months, and high level guidance and principles are expected on the matter;

(d) there is a lot of work to do to ensure data (i.e. new-born blood spot, vaccines etc.) is not jeopardised and tightened up before April;

(e) communication plans are in place to ensure colleagues and the public are informed that there is a change in contracts ownership, not the actual services;

(f) vitamin D supplement provision is part of the universal service offered to women and this policy is expected to continue;

(g) the public health team have developed profiles for 0-5 years olds, based on children's centres geographies. The profiles give health and social outcomes for all 0-5 year olds across city, enabling services to be targeted on evidence base;

(h) The exchange of contract has been signed and approved by NHS England. The West Midlands are a couple of months ahead in the process, which is useful for learning about any issues that may arise with the process.

The following points were raised during discussion:

(i) there is currently a health visitor staffing shortfall, but there are no penalties in place for missing the targets. Funding and support has been made available to providers for them to continue to recruit. There is some over-supply in other areas, so public health has been connecting people in different areas to enable appointments. Primary Care Trusts didn't previously view health visitors as a key area for investment. It takes 12 months to train a health visitor and they must be qualified nurses prior to entering the training, so increases in staffing levels take time;

(j) the Department of Health set the health visitor target of 154 in 2011 and this target has not yet been reviewed, but Nottingham City Council will review it at a later date. The staffing shortfall is being managed at the moment, but most nurses are over 50, which will bring more issues when they reach retirement age. Citycare health visitors are mostly keeping to their key performance indicators for service provision, achieving about 90% of targets;

(k) health visitors have a crucial role in working more closely with diverse communities in the city. The public health remit for training health visitors is based around equity of access and evidence base. Although the workload of health visitors is huge it is important that health visitors use the skill mix of support staff around them;

(l) the health visitor service is the only universal service that has the privilege to see every child born and identify early vulnerabilities. It is the bedrock of prevention and early intervention;

(m) Small Steps, Big Changes will potentially come under public health with 2016/17 funding being ring fenced into the public health budget but the amount has not yet been confirmed. The funding formula was sent out for comment in February 2015, and extensive comments were sent back, but there has been no update since then. There is a mandate regarding health visitors is in place, and an expectation of continuation of funding for at least the 18 month settling in period;

(n) health visitors within Citycare receive very robust training, intensive 1-2-1 support, and supervision. The mentorship relationship is maintained throughout a new Health Visitors 1st year in post;

(o) the service was congratulated and the importance of promoting the public health agenda for long term gains was reiterated.

RESOLVED to thank Lynne McNiven and Stephanie Cook for the update on the transfer of Health Visitor and Family Nurse Partnership Commissioning Responsibilities.

21 UPDATE ON THE IMPLEMENTATION OF NOTTINGHAM'S NEW NEEDS-LED SCHOOL NURSING SERVICE

Lynne McNiven, Consultant in Public Health, presented an update to the committee on the implementation of Nottingham's new needs-led school nursing service, highlighting the following points:

(a) school nursing is incredibly important, and is often the only independent access that children and young people have to health and social care. Nurses work with young people to ensure physical and emotional health, and health and education outcomes are often very strongly connected;

(b) the new needs led model commenced in September 2014. Previously there was a bit of a scattergun approach, with nurses working in isolation. Most senior nurses worked exclusively in secondary schools, when there was just as big a need in primary schools. Public Health has worked with providers to develop teams for school nursing, 33 whole time equivalents across the city. There is a skill mix, from band 6 right down to nursery nurses. The teams now work with groups of schools organised within Clinical Commissioning Groups delivery areas, trying to integrate and mix school nursing with education and Clinical Commissioning Groups. There is a coordinated effort to deliver service;

(c) existing data has been examined, and developed into a profile which anyone can use. The data is currently being refreshed. It is very important to examine the data and target services according to need. Readiness for school is an important time in a child's life. If a child has an identified physical health need,

the transfer goes quite well. However, if a child is just missing targets, that information often doesn't get passed on to the school nurse or early year's teachers;

(d) traditionally there has been a school entrance questionnaire. This has been changed to be much more holistic, much more useful to schools, and much more useful to school nurses;

(e) (e) there are 3 health improvement facilitators in post. These are non-clinical staff, with experience in health promotion. They support campaigns and get information back to families. Their specialities are sexual health relationships, healthy weight, and the rest of the agenda (mainly mental and emotional health and wellbeing);

(f) Public Health is working with schools and the Healthy Schools team to try to build capacity within schools. 3 stakeholder events have been held over the last 18 months. The stakeholder events have focussed on sex and relationship education, child sexual exploitation and female genital mutilation;

(g) historically, vaccinations and immunisations have been provided by the school nursing team, and commissioned by NHS England. There is now a dedicated vaccinations and immunisations team for schools starting in September 2015, which will free up additional school nursing time to address other health issues;

(h) the school health agenda is growing. There are still high levels of teenage pregnancy, emotional and wellbeing issues and ongoing problems with healthy weight.

The following points were raised during discussion:

(i) whilst there has been some opposition to sex education by parents, with some choosing to have their children opt-out, all sex and relationship education in the city is completely age appropriate. If children and young people are not taught what is normal, they won't know what's abnormal (i.e. abuse, exploitation, female genital mutilation) and will potentially be susceptible. Some populations may attempt to label sex and relationship education as a cultural issue, but there are options for overcoming these barriers, including mother and daughter sessions, gender separated sessions, and involving parents to let them know what valuable life skills are being taught;

(j) the cost of the school nurses programme is £1.6 million;

(k) a full review of the service and stakeholders was held 18 months ago, which highlighted problems with the school nursing service from both sides, including:
- visibility of school nurses as some schools did not know they even had a school nurse;
- issues with lack of facilities for school nurses - no private room, no parking, no Wi-Fi
- issues with inappropriate facilities – storage rooms being used as nurse consultation rooms;

stakeholder meetings have been useful for addressing these issues. Public Health can work with the schools on quality assurance and sharing good practice;

(l) a personalised health plan is being introduced for all children and young people. At reception age aa health questionnaire is completed, which picks out areas of work and key points As there are 47,000 5 – 16 year olds in the city Resources are not available to maintain plans for those children who do not have identified needs, except in the case of looked after children, where there is a legal requirement. Children are monitored as they come into primary and secondary school, and school nurses work closely with schools to pick up any developing issues or needs;

(m) each nurse covers around 4 schools, with Monday to Friday coverage. Providers are expected to be flexible to meet demand and visits can be carried out of school term if required. The guide to school nursing in Nottingham did not appear to show contact points for nurses in Radford and Park, this will investigated and reported back to the Committee;

(n) school nurses do not carry out blood tests for children as it is good practice for phlebotomists to do this. GP practices with phlebotomists are now open more frequently in the evenings, so children who require regular blood tests may not necessarily have to be taken out of school for them to be done;

(o) school nursing profiles are available on Nottingham Insight.

RESOLVED to:

(1) thank Lynne McNiven for the update on the school nurses programme;

(2) further scrutinise uptake of advertised services;

(3) request further information on school nursing contact points in Radford and Park.

22 HEALTHWATCH NOTTINGHAM ANNUAL REPORT 2014/15

Martin Gawith and Ruth Rigby from Healthwatch Nottingham, gave a presentation on its annual report for 2014/15 and future plans for Healthwatch Nottingham, highlighting the following points:

(a) Healthwatch Nottingham is a local consumer champion for health and social care and has matured over the last year. It represents the voice of Nottingham citizens, gathers the experiences of service users, and uses this information to provide a fuller picture of people’s experiences for commissioners, providers, and regulatory bodies;

(b) 845 separate experiences were gathered to inform service and system development, with around half of those from “seldom heard” individuals. The Healthwatch website has been redeveloped to make engagement easier, and pop-up “Talk to Us” information points were developed. The information

gathered was fed back to every care home and GP practice, and is continuously rolled out;

(c) targeted work has taken place to ensure the views of various groups have been accounted for, including:
- older people;
- people in care homes;
- people with mental health issues;
- younger people;
- asylum seekers and refugees;
- recovering alcohol or drug users;
- carers;
- citizens from minority ethnic groups;
- LGBT (lesbian, gay, bisexual and transgender) citizens;

(d) Healthwatch Nottingham also has the power to see how health services are working, to enter and view services and collect the views of service users, carers and staff, and to observe service delivery. This is not an inspection; it is instead an opportunity for lay people to engage with service users and their families. This methodology was used to assess Nottingham City Council's implementation of the Care Act, and development for 2015/16 includes care homes and learning disabilities;

(e) Healthwatch Nottingham raised concerns with Nottingham City Council regrading information issued prior to the implementation of the Care Act, and enabled citizens to be part of the procurement process of the urgent care centre services developments; as well as contributing to the Joint Strategic Needs Assessment and quality surveillance groups. Healthwatch Nottingham delivers recommendations to various partners and meetings, including:
- Health and Wellbeing Board;
- Nottingham City Council regarding Care Act implementation;
- Clinical Commissioning Groups;

(f) Healthwatch Nottingham aims to put people at the heart of service improvement, by feeding information to commissioners, providers and regulators. They also aim to involve people in strategy development and commissioning, such as South Notts Transformation, Urgent Care Centre procurement, and upskilling volunteers to work in other areas;

(g) In 2015/16, ongoing priorities include care homes, young people and mental health, ME (myalgic encephalomyelitisthe – chronic fatigue syndrome), and the impact of the Immigration Act 2014. A local profile with the public, information systems, and involvement of local people in decision making will all continue to be developed. Other areas to be looked at sustainably include engagement work, increased use of mystery shoppers, and using research evidence and insight.

The following points were raised during discussion:

(h) Healthwatch Nottingham currently receives £160,000 in funding each year from Nottingham City Council up to March 2016, and are required to report how it is spent. £130,000 is spent on staffing, leaving a very small amount to

feed into the service, and for other costs such as publicity. It is not a large organisation, but they use resources efficiently and provide a good service with what little they have. There is a target of 40 volunteers, and there are currently 38, with volunteer recruitment ongoing. Some core funding is necessary to maintain the independence of the service;

(i) providers are able to add the Healthwatch Nottingham feedback widget to their website for citizens to provide feedback more easily. The new website went live in November 2014 and some aspects are still being rolled out. Information and feedback is also fed in from other areas, such as Patients Opinion, and NHS Choices. Healthwatch Nottingham focuses on those who perhaps won't comment elsewhere, for example because they don't have internet access. They collate all information gathered from all arenas into a standard format. There is a dedicated researcher post within the team for 2 days per week;

(j) some training sessions, such as safeguarding, have to be run regularly. Specific training on mystery shopping will be launched shortly. There is a relatively small pot of volunteers to call from, and they are not necessarily representative of the whole population of the City, so Healthwatch Nottingham are keen to get a wider demographic of volunteers.

RESOLVED to thank Martin and Ruth for the update on Healthwatch Nottingham's activities.

23 GP PRACTICE MERGER IN SNEINTON

RESOLVED to note the information provided in the report.

24 HEALTH SCRUTINY COMMITTEE 2015/16 WORK PROGRAMME

Clare Routledge, Senior Governance Officer, presented a report on the work programme for the Health Scrutiny Committee for 2015/16. The following points were raised during discussion of the item:

(a) the work programme reflects previous discussions. The September 2015 meeting will consider sex and relationship education in schools and a strategic response to reducing health inequality in the city;

(b) Councillors Neghat Khan, Chris Tansley, Ilyas Aziz, Corall Jenkins and Ginny Klein agreed to be members of the study group. Councillor Jim Armstrong also expressed an interest, but will not be available for November.

RESOLVED to note the work programme for the Health Scrutiny Committee for 2015/16.

HEALTH SCRUTINY COMMITTEE
24 SEPTEMBER 2015
STRATEGIC RESPONSE TO REDUCING HEALTH INEQUALITIES IN THE CITY
REPORT OF HEAD OF DEMOCRATIC SERVICES

1. Purpose

1.1 Nottingham city faces significant health inequalities. The Public Health team within Nottingham City Council are continually working with colleagues and partners via a community wide approach to improve the health outcomes of citizens.

2. Action required

2.1 The Committee is asked to scrutinise the local strategic approach to tackling health inequalities with the city and recommend ways to ensure Nottingham City Council is responding as robustly as possible to improving the health of the local population.

3. Background information

3.1 Major issues facing the city include smoking, mental health and obesity.

3.2 The Interim Director of Public Health will outline how Nottingham City Council is working to address the health inequalities within the city. Health inequalities are being reduced through an asset based approach and by engaging communities.

3.3 The report will also consider the health profiling data available, distinguish between equity and equality and what future collective actions are required to improve the health inequalities.

4. List of attached information

4.1 Interim Director of Public Health Strategic response to reducing health inequalities in the city report .

5. Background papers, other than published works or those disclosing exempt or confidential information

5.1 None.

6. Published documents referred to in compiling this report

6.1 Joint Strategic Needs Assessment.
http://jsna.nottinghamcity.gov.uk/insight/Strategic-Framework/Nottingham-JSNA.aspx

7. Wards affected

7.1 All

8. Contact information

8.1 Clare Routledge, Health Scrutiny Project Lead
Tel: 0115 8763514
Email: clare.routledge@nottinghamcity.gov.uk

HEALTH SCRUTINY COMMITTEE

24 SEPTEMBER 2015

STRATEGIC RESPONSE TO REDUCING HEALTH INEQUALITIES IN THE CITY

1. Purpose

1.1 Nottingham City faces significant health inequalities. The Public Health team, within Nottingham City Council, are continually working with colleagues and partners via a community wide approach to improve the health outcomes of residents.

2. Action required

2.1 The Committee is asked to scrutinise the local strategic approach to tackling health inequalities within the city and recommend ways to ensure Nottingham City Council is responding as robustly as possible to improving the health of the local population. The Interim Director of Public Health will outline how Nottingham City Council is working to address the health inequalities within the city. Activity to reduce health inequalities uses an asset based approach which engages communities.
The report will also consider the health profiling data available; distinguish between equity and equality and identify what future collective actions are required to reduce health inequalities.

3. Background information: Health and Wellbeing in Nottingham

3.1 Health inequalities can be defined as differences in health status or in the distribution of health determinants between different population groups (World Health Organisation). Some health inequalities are attributable to susceptibility to disease or health behaviours, whilst others are attributable to the external environment and are mainly outside the control of the individuals concerned. As such health inequalities can be described as, avoidable, unjust and unfair.

3.2 Diverse factors can impact on health inequality including age, gender, ethnicity, where individuals live and work and family and community relationships. Existing physical and mental health conditions can also influence health inequality. For example people with diabetes are two to three times more likely to have depression than the general population (The Kings Fund).

3.3 The most obvious health inequality is differences in life expectancy. Across England, people living in deprived neighbourhoods die earlier than those living in more affluent areas and spend more of their lives living with disability.

3.4 In Nottingham, life expectancy over the last 10 years has continued to increase with males living an additional 4 years and females an extra 3.1 years[1]. This increase over the last 10 years is greater than the England average and thus the inequalities gap is closing[2]. Nonetheless, as Figure 1 highlights, there is still a significant difference in life expectancy in Nottingham compared to England average.

Figure 1: Life expectancy in Nottingham City

3.5 There is a clear and persisting link between deprivation and social circumstances on the one hand, and life expectancy and mortality on the other. Nottingham's comparatively low life expectancy is directly related to its high levels of deprivation. Reducing inequalities in socio-economic circumstances and opportunity, particularly education and income, will reduce mortality and increase life expectancy in more deprived areas.

3.6 Within the city, distribution of deprivation contributes to inequalities in life expectancy between wards. Nonetheless, the gap, particularly in relation to males, continues to reduce.

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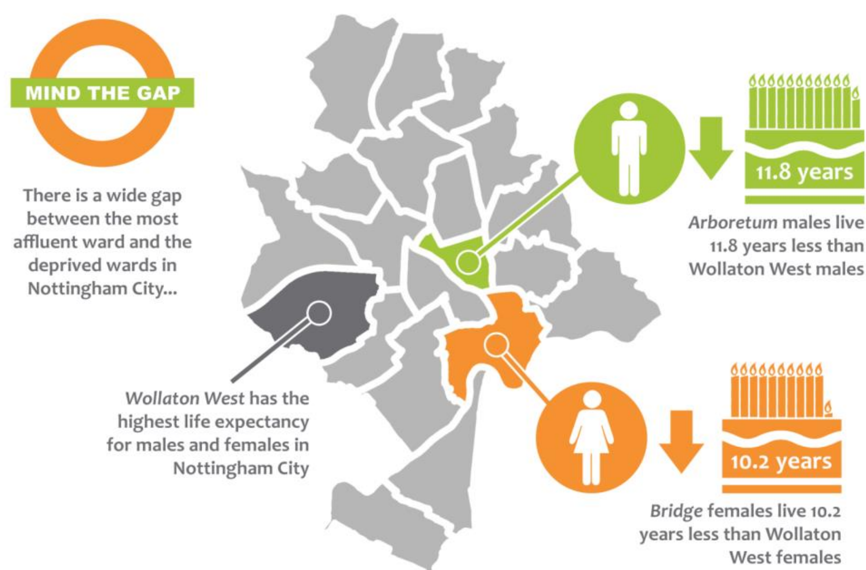
[1]Life expectancy is the number of years that a person can expect to live on average in a given population and is a commonly used summary measure of population level health. Source: ONS 2011-13 data extracted from Public Health Outcomes Framework tool compared to 2001-03

[2] Over the same period male life expectancy increased 3.2 years for males and females 2.4 years across England as a whole

Figure 2: Differences in life expectancy in Nottingham City



3.7 Assessment of life expectancy across Nottingham, comparing the most deprived areas to the least, by Lower Super Output Area (LSOA), shows that the gap has reduced by 2.8 years for males and 0.5 years for females over the last nine years[3]. Historically, men have experienced greater inequalities within the city but this has improved significantly. Thus the difference in life expectancy, based on LSOAs, between the most and least deprived areas is 8 years for males and females.

3.8 Historically, there have always been differences in life expectancy by socioeconomic group. Reasons for this include affluent groups having better living conditions, nutrition and access to healthcare than more economically deprived groups. These differences persist today. The Marmot review[4] described a comprehensive picture of unfair distribution of health and length of life in England, with a finely graded relationship between the socioeconomic characteristics of the area in which people live and life expectancy.

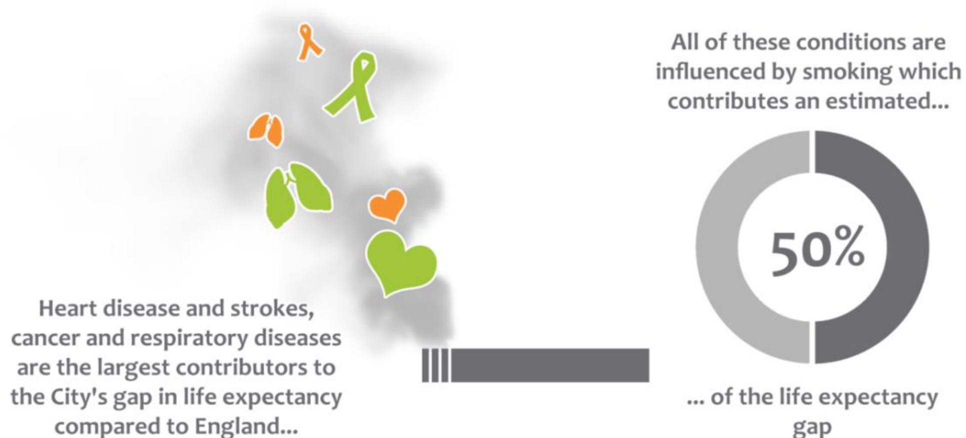
3.9 The largest contributors to the gap in life expectancy in Nottingham, compared to the England average, are circulatory disease (heart disease and strokes), cancer and respiratory diseases[5] which account for 60% of the gap. Furthermore, all of these conditions are influenced by smoking, which contributes to an estimated 50% of the life expectancy gap.

[3] Slope index of inequality in life expectancy at birth within English local authorities measures the range in years of life expectancy across the social gradient (based on deprivation at Local Super Output Level) within the city, from most to least deprived. Source: ONS 2011-13 data extracted from Public Health Outcomes Framework tool. Data not available for 2001-03

[4] UCL (2010), Fair Society Health Lives: The Marmot Review

[5] Largely related to Chronic Obstructive Pulmonary Disease

Figure 3: Contributors to the differences in life expectancy

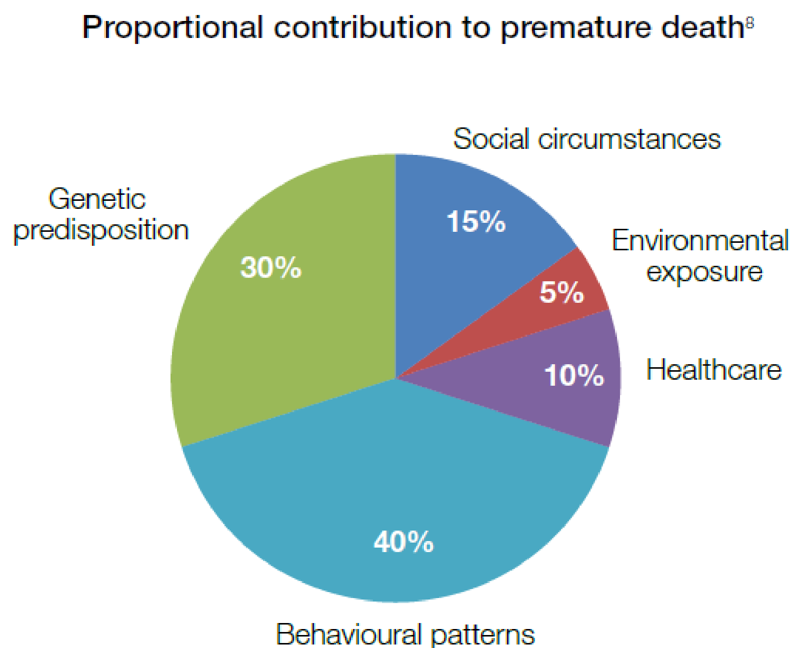


3.10 Smoking, harmful use of alcohol, physical inactivity and poor diet are key lifestyle factors which contribute to the 'big killers'. These have been identified and their contribution to 'disability adjusted life years[6]' calculated for the UK, in the global burden of disease study (Lancet, 2013). Additionally, the proportional contribution of behavioural, or 'lifestyle', factors, compared to genetic predisposition, social circumstances, environmental exposure or healthcare are shown in figure 1, below. Thus, lifestyle factors make up the greatest proportion explaining 40% of premature deaths. However, that is not the whole story with wider determinants, including social circumstances and environmental exposure, also accounting for 20%.

3.11 Interventions to increase life expectancy and reduce health inequality should recognise the difference between equity and equality. Using smoking cessation services as an example, equality is offering a service to all residents of Nottingham city. Equity is tailoring those services to promote access by those with greatest need, including offering more smoking cessation sessions in areas of deprivation and/or providing resources in different languages and formats.

[6] WHO definition of DALY: One DALY can be thought of as one lost year of "healthy" life. The sum of these DALYs across the population, or the burden of disease, can be thought of as a measurement of the gap between current health status and an ideal health situation where the entire population lives to an advanced age, free of disease and disability

Figure 4: Proportional contribution to premature death. Source: McGinnis et al, in PHE (2014)[7]



4. A Life Course Approach to Reducing Health Inequalities

A range of evidence-based interventions are implemented to tackle inequalities across the city. The following highlights some of the current work using the Marmot framework.

4.1 Give every child the best start in life

4.1.1 Health inequalities and children's susceptibility

Health inequalities are responsible for considerable levels of reduced length and quality of life in the United Kingdom. Children are amongst the most vulnerable sections of society. As such, they are greatly affected by the outcomes of any social and economic deterioration surrounding them. These inequalities mean poorer health, reduced quality of life and an overall shorter life expectancy for many. Children are susceptible throughout their life course; from before birth and all the way through their crucial developmental, preschool and school years.

4.1.2 Importance of early life and development

There is mounting evidence that shows the benefits and cost effectiveness of focusing on the development and health of infants and children. The vital importance of early life, both in its own right and for promoting future life chances is evident. Children's early physical and emotional development will eventually help determine educational and social progress, employment prospects and physical, social and

[7] PHE (2014) From evidence into action: opportunities to protect and improve the nation's health.

mental health outcomes. The best possible health underpins a child's or young person's ability to flourish, stay safe and achieve as they grow up; and lifestyles and habits established during childhood, influence a person's health throughout their life. The need to ensure all children within Nottingham get the support they need to obtain the best start in life is clear.

More than a quarter of the population of Nottingham is under the age of twenty. There are an estimated 20,000 infants aged 0-4 years and 57,200 children and young people aged 5-19 years resident in the City. The number of births has risen considerably in recent years and is likely to continue to do so. The projected population (age 0-19 years) in 2020 is 78,500. In 2011, 30.3% of births were to mothers born outside of the UK, more than double the percentage in 2001 (14.5%). 44% of school children are from a black or minority ethnic group.

4.1.3 **Deprivation and the wider determinants of child health**

Deprivation strongly influences children's health outcomes throughout all aspects of their development. Poor maternal health and lifestyle choices, premature labour, low birth weight and social / physical developmental problems are strongly associated with higher levels of poverty and worse health outcomes. Successful early emotional, physical and social developments are essential to enhance a child's future ability to form positive relationships, improve their educational attainment and achieve good health. Research shows, if children fall behind in these aspects of development during their first year they will continue to do so throughout the rest of their preschool and school education.

Nottingham's level of child poverty is worse than the England average with almost 19,000 (35.2%) children aged less than 16 years living in poverty. Nottingham's children fare worse on a range of wider determinants of health than children in England as a whole.

Deprivation also negatively impacts on a child's health through: their parent's age, level of education, whether they are unemployed and in good health, the environment they live in, housing quality, choice of nursery/schools, opportunities for social interaction and the quality of services accessed such as transport, leisure, libraries, shops, health and social care.

4.1.4 **Early childhood and education**

The foundations of a healthy and fulfilled adult life are laid in childhood and adolescence. For example, up to 79 per cent of obese adolescents remain obese in adulthood, and adolescents who binge drink are 50 per cent more likely to be dependent on alcohol or misusing other substances when they reach the age of 30. Failure to meet the health needs of children and young people would be costly in the long term; in both health and economic terms.

Health is crucially linked with education. Good health and emotional wellbeing are associated with improved attendance and attainment at school, which in turn lead to improved employment opportunities. An evidence-based approach using prevention and early intervention would reduce costs to society and to health, education and

wider children's services in the long term. The Healthy Child Programme (HCP) sets out the good practice framework for prevention and early intervention services for children and young people to promote optimal health and wellbeing.

4.1.5 **Reducing Health inequalities**

Reducing health inequalities and improving health and social outcomes for children are not easy to address. The evidence clearly shows that any one agency on its own will not have sufficient impact to guarantee a reduction in the gap currently observed between populations. The examples of current services and strategies within this paper specifically focusing on reducing inequalities illustrate that actions need to be executed in partnership with all agencies involved in the wider causes and outcomes of child health inequalities.

This requires a high level strategic understanding and commitment from everyone to secure a coordinated approach. Public Health will continue to support services and strategies by persuading and influencing a wide range of partner agencies to make certain the reduction in child health inequalities is high on everyone's agenda.

'*Reducing health inequalities, improving health and social outcomes for children and young people in Nottingham City is everyone's business.'*

5. Create Fair Employment and Good Work for All

"The social conditions in which people live and work can help create or destroy their health. Lack of income, inappropriate housing, unsafe workplaces and lack of access to health care systems are some of the social determinants of health leading to inequalities"(WHO, 2004)

5.1 Being in employment is associated with better health whilst being unemployed contributes to poor health. There are strong links between unemployment and poorer physical and mental health resulting in an increased use of medication, health and care services including higher hospital admission rates.

5.2 The nature of employment can reinforce or minimise health inequalities. 'Good jobs', that is jobs that pay fairly, offer opportunities for development, policies that enable work/life balance and a range of support services, including occupational health, are more likely to have 'healthy' employees who are able to stay in work even if they experience ill-health.

5.3 The local Fit for Work programme aims to support 1100 people, over 3 years, to remain in work or begin working. The programme has been particularly successful in supporting citizens who experience mental ill-health to return to work following sickness absence. Supporting citizens who are long-term claimants of Employment Support Allowance (ESA) to return to work has been more challenging but the numbers of citizens finding employment is on the increase.

5.4 Employers have a valuable role to play in promoting good physical and mental health including stress management. A survey of the support for employees offered by the organisations represented on the Health and Wellbeing board has been undertaken with the aim of encouraging all organisations to develop as exemplar employers with specific regard to mental health.

6. Create and Develop Healthy and Sustainable Places and Communities

Nottingham City has an excellent reputation for innovative sustainable development and health through the work of the Nottingham Health Action Team and respective action groups.

6.1 'Food' - The Food Health and Environment action group developed the Food Initiatives Group, and commissioned the Nottingham Food Health and Environment Strategy with a small grants fund to target scarce resources at supporting people on low income, in Nottingham's communities, to procure and consume healthy sustainable food at low cost and supported Nottingham University Hospitals Trust in achieving Gold Food for Life status.

The Food for Life Partnership has been commissioned to support a whole school approach to food. This is improving access to healthy and nutritious foods in 40 schools, in areas of disadvantage in Nottingham, which is helping to transform the food culture and tackle diet inequalities across the population.

6.2 'Transport' - The Transport and Health Initiatives Group developed the Ridewise "cycling with confidence" service which provides the Cycling for Health Service[8].

6.3 'Warmth' - The Affordable Warmth Action Group developed the Healthy Housing Referral Service[9] and supported the eradication of fuel poverty by developing systems for reducing housing running costs and increasing personal finance for fuel payments.

Energy efficiency measures and renewable energy installation are targeted towards the homes of vulnerable people.

6.4 'Air quality' - Improving local air quality and reducing our impact on climate change by reducing carbon equivalent emissions across the partnership.

6.5 Contributing to a reduction in avoidable injuries, accidents and falls and improving security in the homes of vulnerable people.

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[8] http://www.ridewise.org.uk/ride/index.php

[9] http://www.nottenergy.com/projects/domestic/greater_nottingham_healthy_housing_service/.

7. Strengthen the role and impact of ill-health prevention

7.1 The city council commissions a range of services to enable adults to access behaviour change support to reduce lifestyle risk factors for long term conditions such as cardiovascular disease and cancer. These services include the New Leaf Stop Smoking Service and the Healthy Change Lifestyle Referral hub which supports citizens to set goals to improve their health and supports their referral into other physical activity, healthy eating, weight management and other commissioned services and opportunities using a client centred tailored approach.

7.2 Each of the public health commissioned services has a service specification which sets out the requirements of the services. The aim is that these services are accessed by citizens who are most at risk of dying early from long term conditions or who have a higher prevalence of the given risk factor, e.g. smoking, thus the principle of proportionate universalism is reflected in the service specification[10].

This is achieved through the inclusion of targeted, service level targets. For example not just the proportion of smokers who quit smoking but additional proportional 'smoking quitter' targets for 'at risk groups' such as people with mental health problems, pregnant women and people from routine and manual groups.

8. **Next Steps**

8.1 Use data and information, including the JSNA, to inform commissioning that reduces health inequality. For example, data suggests that citizens living in more deprived areas of Nottingham city are less likely to access sexual health services. This understanding has informed the new, integrated sexual health service specification for 2016 onwards.

8.2 Work in partnership with the CCG to commission services that reduce health inequality through effective targeting of service provision to those with greatest need. For example, recently commissioned mental health training targets frontline staff working with the most disadvantaged who are more likely to experience mental ill-health.

8.3 Monitor and evaluate service use to inform local action to reduce health inequality. For example, a planned health equity audit of breast cancer screening will aim to identify variation in uptake of screening.

8.4 Support citizens who may be adversely affected by budget cuts mitigating, where possible, widening health inequality[11].

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[10] The Marmot Review identifies that *"Focusing solely on the most disadvantaged will not reduce health inequalities sufficiently. To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. We call this proportionate universalism."*

[11] Colin Monkton's work on mitigating the combined impacts of budget cuts

8.5 Ensure health inequalities are specifically considered in the refresh of the Health and Wellbeing strategy.

9. List of attached information

None

10. Background papers, other than published works or those disclosing exempt or confidential information

None

11. Published documents referred to in compiling this report

- Department of Health (2015) The Healthy Child Programme. https://www.gov.uk/government/publications/healthy-child-programme-pregnancy-and-the-first-5-years-of-life
- Fair Society Health Lives: The Marmot Review (2010)
- Global Burden of Diseases, Injuries, and Risk Factors Study (2013). The Lancet http://www.thelancet.com/global-burden-of-disease
- Nottingham City Joint Strategic Needs Assessmenthttp://jsna.nottinghamcity.gov.uk/insight/Strategic-Framework/Nottingham-JSNA.aspx
- Public Health England (2014). From evidence into action: opportunities to protect and improve the nation's health. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/366852/PHE_Priorities.pdf
- The King's Fund (2012) Long-term conditions and mental health: the cost of comorbidities http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/long-term-conditions-mental-health-cost-comorbidities-naylor-feb12.pdf
- World Health Organisation (2015) Glossary of Terms http://www.who.int/hia/about/glos/en/index1.html

- World Health Organisation (2004) Commission on the Social Determinants of Health http://www.who.int/social_determinants/resources/csdh_brochure.pdf

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HEALTH SCRUTINY COMMITTEE
24 SEPTEMBER 2015
SEX AND RELATIONSHIPS EDUCATION (SRE)
REPORT OF HEAD OF DEMOCRATIC SERVICES

1. Purpose

1.1 To receive an update on current legislation, good practice and evidence base regarding sex and relationships education (SRE).

2. Action required

2.1 The Committee is asked to use the information provided to scrutinise the delivery of SRE in Nottingham schools.

3. Background information

3.1 There needs to be a whole school approach to SRE with age appropriate content delivered at each stage of the child's school life as part of a comprehensive Personal Social and Health Education (PHSE) programme in partnership with parents/carers.

3.2 The report will outline the national legislation and describe the current provision for children and young people in Nottingham as well as what is being done to improve this.

3.3 The report will examine the evidence base for effective SRE and how this contributes to public health priorities including teenage conceptions, sexually transmitted diseases, child sexual exploitation, female genital mutilation, homophobia and examining the link between emotional well – being and academic achievement.

3.4 Local data will be provided.

3.5 The Health Scrutiny Committee will also be informed of how Nottingham City Council and its partners are supporting schools to improve SRE provision, which include the SRE Charter, PSHE continuing professional development, Healthy Schools, School Nursing, Health Improvement Facilitators and stakeholder events.

4. List of attached information

4.1 SRE Report, September 2015.

5. Background papers, other than published works or those disclosing exempt or confidential information

5.1 None.

6. Published documents referred to in compiling this report

6.1 None.

7. Wards affected

All

8. Contact information

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Health Scrutiny Committee report

Information for Health Scrutiny Committee: Update on current legislation, good practice and evidence base around Sex and Relationships Education (SRE), describe current provision for children and young people in Nottingham and detail what is being done to improve this.	
Date of meeting:	24th September 2015
Report author:	Lynne McNiven, Consultant in Public Health, Nottingham City Council Catherine Kirk, SRE Consultant, Nottingham City Council Claire Trott, PSHE Officer, Nottingham City Council
Responsible Director:	Alison Challenger, Director of Public Health (Interim)
Portfolio Holder:	Cllr Sam Webster

Purpose

Update on current legislation, good practice and evidence base around Sex and Relationships Education (SRE), describe current provision for children and young people in Nottingham and detail what is being done to improve this.

What is SRE?

Sex and Relationships Education is lifelong-learning about the emotional, social and physical aspects of growing up, relationships, sex, human sexuality and sexual health. A comprehensive, age appropriate SRE programme through primary and secondary school gives children and young people the skills for building positive and healthy relationships and staying safe, as well as factual information about the body, reproduction, sex and sexual health and online safety. Effective SRE is inclusive of all children and young people, reflecting different families and relationships, exploring faith and cultural perspectives and meeting the needs of more vulnerable children such as those with disabilities or from abroad.

It is recommended that SRE is delivered as part of a broader Personal Social and Health Education (PSHE) programme in each year of a child's education. A whole school approach is vital to ensure SRE provision meets the needs of all pupils; this involves consulting with all key stakeholders when planning policy and curriculum. SRE should be delivered in partnership with parents/carers to ensure that the school content is followed up in the home setting.

SRE legislation

Where SRE is provided there is a statutory duty for the school to have 'due regard' to the government's Sex and Relationship Education Guidance (DfEE 2000). All maintained schools must have an up-to-date policy on SRE which is available for inspection and to parents/carers. It is not compulsory for Academies to have an SRE policy but it is advisable.

All schools have a duty to promote pupil well-being (Education and Inspection Act 2006) and should make provision for PSHE that meets the needs of their pupils. It is compulsory for maintained secondary schools to provide education to pupils on HIV and AIDS and other sexually transmitted infections. There are also statutory elements of sex education within national curriculum science programmes of study at key stages 1 to 3 (see below). Parents have the right to withdraw their child/ren from SRE that is delivered outside of National Curriculum Science (Education Act 2006/Learning and Skills Act 2000).

National Curriculum Science:

Year group	Learning objectives
Year 2	• Notice that animals, including humans, have offspring which grow into adults
Year 5	• Describe the changes as humans develop to old age.
Key Stage 3	• Reproduction in humans (as an example of a mammal), including the structure and function of the male and female reproductive systems, menstrual cycle (without details of hormones), gametes, fertilisation, gestation and birth, to include the effect of maternal lifestyle on the foetus through the placenta
Key Stage 4	• Communicable diseases including sexually transmitted infections in humans (including HIV/AIDs) • Hormones in human reproduction, hormonal and non-hormonal methods of contraception • Sex determination in humans

The Equality Act 2010 places a legal duty on schools to promote equality. They must also combat bullying (Education Act 2006), including homophobic, sexist, sexual and transphobic bullying. Statutory guidance on safeguarding children and young people highlights the importance of effective PSHE and SRE in giving pupils the skills and knowledge to manage risks and stay safe (DfE 2015).

The new Ofsted Framework 2015 places more focus on the effectiveness of schools to promote spiritual, moral, social and cultural development and safeguarding among pupils. Where these areas are found lacking it is likely to negatively impact on the judgements for leadership and management, personal development and welfare and overall effectiveness. Aspects of SRE as part of the broader PSHE curriculum will contribute to a school's evidence in addressing key safeguarding concerns such as Child Sexual Exploitation, Female Genital Mutilation and unplanned teenage conceptions.

What does the evidence show?
Evidence suggests that young people who have had good SRE are more likely to choose to have first sex later (Kirby 2007, UNESCO 2009, NICE 2010) and more likely to use condoms and contraception when they first have sex (Kirby 2007). This is contrary to the view that SRE will encourage young people to have sex earlier in fact it gives protective factors.

The third British National Survey of Sexual Attitudes and Lifestyles (Natsal-3) carried out in 2010-12 found that those people who mainly learned about sex from school lessons were less likely to have had sexual intercourse before age 16, unsafe sex in the past year, and to have ever been diagnosed with a sexually transmitted infection (STI), compared with those who mainly learned from other sources (Macdowall, W. et al 2015).

In their recent report on PSHE, 'Not yet good enough', Ofsted found that SRE required improvement in over a third of schools leaving some young people unprepared for the physical and emotional changes of puberty and relationships in adult life. The lack of appropriate SRE may also make children and young people more vulnerable to exploitation and inappropriate sexual behaviours as they have not been taught the appropriate language or developed the confidence to know what is right and wrong and where to go for help. Ofsted also highlighted the correlation between the grades that schools in the survey were awarded for overall effectiveness in their last section 5 inspection and their grade for PSHE education. The majority of the schools graded outstanding in their last section 5 inspection were also graded outstanding for PSHE education (Ofsted 2013).

It is vital that children and young people learn about safe and healthy relationships and how to get help if they are worried. A recent review into child abuse prevention programmes found that school based prevention programmes were effective in increasing participant's skills in protective behaviours and knowledge of sexual abuse prevention concepts. There were also greater odds of a child disclosing their abuse than a child who had not been through a programme. Common elements of these programmes included teaching of safety rules, body ownership, private part of the body, distinguishing types of touches and types of secrets, and who to tell. (Walsh, K et al). These are all elements that would be included within a comprehensive SRE programme.

The Nottingham context
We know that the situation in Nottingham reflects the national context outlined in recent Ofsted reports. SRE provision varies from school to school and whilst there are pockets of good practice emerging there are also schools where the quantity and quality of SRE needs improvement. In some primary schools puberty education is still only delivered in year 5 or 6 despite anecdotal evidence that some children in these schools are starting puberty in year 4. At secondary level some schools only deliver SRE on specialist one-off health days rather than as part of a broader PSHE programme. Many

teachers lack the confidence and skills to deliver SRE effectively as this is rarely covered adequately in their initial teacher training.

Early indications from local health and well-being data also appear to support national findings from Ofsted. Although the sample size is small the emerging data gives an interesting picture. In a sample of 296 9 to 11 year olds only 5% said they **had not** learnt anything at school about relationships/friendships, with the majority of children reporting that what they had learnt was definitely useful. However a third of the 9-11 year olds in the sample **had not** learnt anything in school about changes to the body. This supports Ofsted's national data that the physical aspects of SRE are less well covered in primary schools. 21% of the sample said that they would **definitely not** feel comfortable talking to parents/carers about puberty, growing up and relationships. This highlights the importance of signposting children to sources of support and also the need to engage parents and support them to have discussions around these issues.

The emerging local health and well-being survey data for 11 to 15 year olds (sample size of 433) shows that SRE is generally received positively. However, nearly a quarter definitely want more information. There was a mixed response when young people were asked if it is easy to get advice on sexual health and relationships in school. The most common response was the 33% who said **'maybe'**, with 38% responding **definitely or mostly** and 29% responding **not really or definitely not**. This may reflect differing provision and raises questions around how to ensure that advice on sexual health and relationships in schools is consistently and easily available to all pupils. When asked where they would prefer to get advice and information the most popular answer was 'parents/carers' although there was a mixed response as to how comfortable they would feel doing this with 40% **responding not really or definitely not**. This emphasises the importance of working with and supporting parents and carers.

A recent audit of SRE provision in Nottingham secondary schools found that all of the sample schools were delivering SRE to pupils including content around consent, parenting and contraception. Only one school incorporated education around pornography into their curriculum and there was no coverage of forced marriage or FGM in any of the schools in the sample. The amount of time dedicated to SRE varied from school to school with the main delivery being undertaken by tutors with limited training. Two out of the five schools assessed progress in SRE enabling them to ensure that the SRE delivered was achieving it's aims. This highlights the lack of consistency and the lack of equity for Nottingham children in receiving quality SRE.

At a recent stakeholder networking event for teachers and school nurses (June 2015) the need for support with key areas of PSHE/SRE was highlighted. Schools identified particular support needs around FGM, domestic violence and internet safety.

Effective SRE, and access to high quality contraceptive and sexual health services, have been key to the reduction in teenage pregnancy rates in Nottingham and across England as a whole. The latest annual figures for 2013 put Nottingham's teenage conception rate at 37.5 per 1000; a reduction of almost 50% since the baseline year of 1998. There is no room for complacency though, as Nottingham was ranked seventh worst of 146 local authorities and has a significantly higher rate than the 2013 England average of 24.3.

What are we currently doing to improve SRE in Nottingham City Schools?

Nottingham City Council currently offers SRE support to schools through the SRE Consultant post within the PSHE Advisory Service. The post-holder works with schools to improve and develop SRE policy, an effective needs-led SRE curriculum, staff training, consultation and work with parents. Central training events are also held on relevant SRE issues.

Over the coming term we are introducing the Nottingham City Council SRE Charter a means of schools auditing their current SRE provision and making improvements with specialist support. There are three levels of engagement with the charter: 1) Commitment to ensure effective SRE for children/young people within their setting; 2) Working towards effective SRE with support; 3) Providing effective SRE and committed to ongoing evaluation.

The PSHE Advisory Service continues to offer the national PSHE Continuing Professional Development Accreditation programme for teachers. This programme enables staff to achieve recognition of their PSHE skills through the University of Roehampton alongside making real improvements to the PSHE provision within their schools. Members of the PSHE Advisory Service provide guidance to both primary and secondary schools as part of their healthy schools work. Training and support is also offered on other issues such as online safety. Where beneficial the service works in partnership with, and support, other providers to ensure high quality practice for example in relation to relationships abuse. An external provider checklist has also been produced to help guide schools to good practice in this area. Schools are also encouraged to take a whole school approach to their SRE developments by working towards gaining or renewing Healthy Schools status and addressing targeted areas through the Health Improvement Model (HIM) 53% of schools have reviewed and updated their SRE work in school when completing the whole school review to renew or gain status during the last 2/3 years.

Stakeholder events continue to be held to explore the needs of schools and how we can work together to improve SRE, PSHE and the general health and well-being of children and young people in our schools.

Schools nurses are a valuable resource for schools and are commissioned to support schools with delivery of SRE where appropriate. School nurses can provide a useful enhancement to a school's SRE programme. They are

supported by a Health Improvement Co-ordinator who ensures appropriate training.

What will help us to achieve a comprehensive SRE provision for every child in Nottingham?

- Continue to showcase and celebrate SRE good practice in schools
- Raise awareness of the importance of effective PSHE and SRE in safeguarding children and young people
- Identify and share good practice in working with parents/carers
- Encourage schools to work together to provide an equitable provision for all Nottingham children
- Encourage schools to sign up to the SRE Charter

References

Kirby, D (2007) **Emerging Answers 2007: Research Findings on Programs to Reduce Teen Pregnancy and Sexually Transmitted Diseases**. Washington, DC: National Campaign to Prevent Teen and Unplanned Pregnancy.

UNESCO (2009) **International guidelines on sexuality education; an evidence informed approach to effective sex, relationships and HIV/STI education**. Paris: UNESCO. http://unesdoc.unesco.org/images/0018/001832/183281e.pdf

NICE (2010) **Public Health draft guidance; School, college and community-based personal, social, health and economic education focusing on sex and relationships and alcohol education**. http://www.nice.org.uk/guidance/indevelopment/gid-phg0

Ofsted (2013) **Not yet good enough; personal, social, health and economic education in schools**. http://www.ofsted.gov.uk/resources/not-yet-good-enough-personalsocial-health-and-economic-education-schools

Macdowall, W et al (2015) **Associations between source of information about sex and sexual health outcomes in Britain: findings from the third National Survey of Sexual Attitudes and Lifestyles** (Natsal-3), BMJ Open; 5:e007837 doi:10.1136/bmjopen-2015-007837

DfE (2015) **Keeping children safe in education: statutory guidance for schools and colleges**, Government

DfEE (2000) **Sex and Relationship Education Guidance**, Government

Walsh, K et al. (2015) **School based Education programmes for the prevention of child sexual abuse**, Cochrane Development Psychosocial and Learning Problems Group

HEALTH SCRUTINY COMMITTEE
24 SEPTEMBER 2015
END OF LIFE SERVICES/PALLIATIVE CARE STUDY GROUP
REPORT OF HEAD OF DEMOCRATIC SERVICES

1. Purpose

1.1 To consider the focus of the study group and its work programme over the coming months.

2. Action required

2.1 The Committee is asked to approve the focus of the study and receive monthly updates on the progress of the work.

3. Background information

3.1 Members of the Health Scrutiny Committee have agreed to participate in in a study group considering end of life services/palliative care services in Nottingham. The study group has agreed that it will focus on adult services.

3.2 The study group are keen to ensure that end of life services are delivered across Nottingham City to a quality standard to meet the needs of patients, their families and carers, including in relation to cultural and faith needs.

3.3 Study group members will meet with providers of services (both NHS and the voluntary sector), as well as patients, carers and family members and commissioners of services. Focus groups may also be held to ensure services are meeting the needs of new and emerging communities living within Nottingham city.

3.4 A report outlining the findings and recommendations will be presented to the Health Scrutiny Committee at its December meeting.

4. List of attached information

4.1 End of life/palliative care services scoping document.

5. Background papers, other than published works or those disclosing exempt or confidential information

5.1 None.

6. Published documents referred to in compiling this report

6.1 None.

7. Wards affected

7.1 All

8. Contact information

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Scoping end of life services / palliative care – study group

Initial discussions with members on 12 August 2015 will determine the scope of the study group.

Membership	**Officer Support**
Councillor Ginny Klein	Clare Routledge
Councillor Ilyas Aziz	
Councillor Corall Jenkins	
Councillor Neghat Khan	
Councillor Chris Tansley	
Councillor Jim Armstrong (participating until late October)	

Scheduling of dates:
Study group members are asked to agree future meeting dates on 12 August. The study group will conclude by early November 2015, in order that a report with findings can be presented to the December 2015 Health Scrutiny Committee.

What is the broad remit set for the study group?

1. **The study group will focus on adult specific services.**

2. **To address the question – 'Are end of life/ palliative care services delivered across Nottingham City to a quality standard to meet the needs of patients, their families and carers, including in relation to cultural and faith needs?';**

3. **To make recommendations on service improvements at the conclusion of the study group;**

What is the specific focus for the study group?

- To hold discussions with NHS organisations responsible for the provision of primary, community and secondary end of life/palliative care to understand the current services in place, needs of patients and families, identify gaps in provision and areas for improvement.

- To seek views from carers and families regarding their experience of end of life/palliative care services across the city.

- To hold discussions with voluntary sector organisations responsible for the provision of end of life services/palliative care to understand funding streams, current services in place, needs of patients and families, identify gaps and areas for improvement.

- To hold discussions with NHS commissioners of primary, community and secondary care services of end of life /palliative care services to

understand the national drivers and influence and funding of the services within Nottingham city.

- To write a report outlining findings and recommendations for approval by the Health Scrutiny Committee in December 2015.

Scheduled meetings:

17th September 2015, 10 am – 12 pm @ Loxley House
Discussion with Citycare on the provision of primary and community services.

23rd September 2015, 10 am – 12 pm visit to Haywood House, at City Campus NUH
Tour of services available and meeting with staff, patients, family and carers.

1st October 2015 1 pm – 4 pm @ Loxley House
Discussion with Nottingham City Clinical Commissioning Group on the commissioning of end of life/palliative care services

To arrange a visit to Nottinghamshire Hospice
Tour of services available and meeting with staff, patients, family and carers.

HEALTH SCRUTINY COMMITTEE
24 SEPTEMBER 2015
CLEANLINESS OF NOTTINGHAM UNIVERSITY HOSPITALS
REPORT OF HEAD OF DEMOCRATIC SERVICES

1. Purpose

This report informs members of concerns raised over the summer regarding the cleanliness of Nottingham University Hospitals (NUH) sites. The Nottingham Keep our NHS Public (KONP) group have protested on the NUH sites regarding cleanliness concerns.

2. Action required

2.1 Committee members are asked to note the concerns of the Keep our NHS Public group and the responses from NUH Trust and decide if further information is to be provided to the Committee at a future meeting.

3. Background information

3.1 In March 2014, Carillion was named as the preferred provider to run Nottingham University Hospitals estates and facilities services.

3.2 Members the Nottingham (KONP) protested the NUH Trust Board meeting on 27 August 2015 to raise concerns regarding cleanliness and again at the QMC campus on 16th September 2015. The KONP group campaign against privatisation.

3.3 NUH has publicly acknowledged deterioration in cleaning standards in some areas and has been in discussion with Carillion about the requirement to quickly ensure delivery of standards described in the contract. Cleaning staff numbers have increased and supervision and monitoring strengthened.

3.4 The Chairperson and Chief Executive of NUH will be meeting with representatives of KONP on 25th September 2015 to discuss and address their concerns and standards of cleanliness.

3.5 Patients, relatives and staff are encouraged to raise any concerns including cleanliness to ward teams or via 24/7 helpline so that concerns can be rapidly addressed.

3.6 Regular updates regarding cleanliness are discussed at NUH Board meetings and in written and verbal reports to other public bodies including the Joint City and County Health Scrutiny Committee.

4. List of attached information

4.1 Report to follow.

5. Background papers, other than published works or those disclosing exempt or confidential information

5.1 None.

6. Published documents referred to in compiling this report

6.1 None.

7. Wards affected

7.1 All

8. Contact information

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HEALTH SCRUTINY COMMITTEE
24 SEPTEMBER 2015
WORK PROGRAMME 2015/16
REPORT OF HEAD OF DEMOCRATIC SERVICES

1. Purpose

1.1 To consider the Committee's work programme for 2015/16 based on areas of work identified by the Committee at previous meetings and any further suggestions raised at this meeting.

2. Action required

2.1 The Committee is asked to note the work that is currently planned for municipal year 2015/16 and make amendments to this programme if considered appropriate.

2.2 Committee members may wish to consider the composition of the proposed Study Group considering End of Life Services, which has been scheduled to take place during the autumn period.

3. Background information

3.1 The Health Scrutiny Committee is responsible for carrying out the overview and scrutiny role and responsibilities for health and social care matters and for exercising the Council's statutory role in scrutinising health services for the City.

3.2 The Committee is responsible for determining its own work programme to fulfil its terms of reference. The work programme is attached at Appendix 1.

3.3 The work programme is intended to be flexible so that issues which arise as the year progresses can be considered appropriately. This is likely to include consultations from health service providers about substantial variations and developments in health services that the Committee has statutory responsibilities in relation to.

3.4 Where there are a number of potential items that could be scrutinised in a given year, consideration of what represents the highest priority or area of risk will assist with work programme planning. Changes and/or additions to the work programme will need to take account of the resources available to the Committee.

3.5 Councillors are reminded of their statutory responsibilities as follows:

While a ‘substantial variation or development’ of health services are not defined in Regulations, a key feature is that there is a major change to services experienced by patients and future patients. Proposals may range from changes that affect a small group of people within a small geographical area to major reconfigurations of specialist services involving significant numbers of patients across a wide area.

This Committee has statutory responsibilities in relation to substantial variations and developments in health services set out in legislation and associated regulations and guidance. These are to consider the following matters in relation to any substantial variations or developments that impact upon those in receipt of services:

(a) Whether, as a statutory body, the relevant Overview and Scrutiny Committee has been properly consulted within the consultation process;

(b) Whether, in developing the proposals for service changes, the health body concerned has taken into account the public interest through appropriate patient and public involvement and consultation;

(c) Whether a proposal for changes is in the interests of the local health service.

Councillors should bear these matters in mind when considering proposals.

3.6 Nottingham City and Nottinghamshire County Councils have established a Joint Health Scrutiny Committee which is responsible for scrutinising decisions made by NHS organisations, together with reviewing other health issues that impact on services accessed by both City and County residents.

4. List of attached information

4.1 The following information can be found in the appendix to this report:

Appendix 1 – Health Scrutiny Committee 2015/16 Work Programme

5. Background papers, other than published works or those disclosing exempt or confidential information

None

6. Published documents referred to in compiling this report

None

7. Wards affected

All

8. Contact information

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APPENDIX 1

Health Scrutiny Committee 2015/16 Work Programme

27 May 2015	• **Flu Immunisation** To consider the progress of the children's flu immunisation programme, targeting of flu immunisations to children and adults, the relationship between flu in adults and flu in children; and the benefits and potential disadvantages of vaccination in children. (NHS England/Public Health England/ NCC) • **Nottingham CityCare Partnership Quality Account 2014/15** To consider the draft Quality Account 2014/15 and decide if the Committee wishes to submit a comment for inclusion in the Account (Nottingham CityCare Partnership) • **Extended work programme planning session** To agree a draft work programme for 2015/16 and agenda items for June and July meetings
18 June 2015	• **Ada's Story** 2 short dvd's providing an understanding of the integrated care programme model within the city (Nottingham City Clinical Commissioning Group) • **Consideration of the 2015/16 Work Programme**
23 July 2015	• **Progress in the implementation of the Care Act** To receive a second report on the implementation of the Care Act within the city (Nottingham City Council) • **Healthwatch Nottingham** To receive and give consideration to the Annual Report of Healthwatch Nottingham

	(Healthwatch Nottingham) • **Progress in transition of children's public health commissioning for 0-5 year olds to Nottingham City Council** To receive a progress report on the transition arrangements prior to the September 2015 transfer (Nottingham City Council/NHS England) • **Review of school nursing services** To gain a greater understanding of issues being considered within the review of school nursing services (Nottingham City Council) • **Proposed GP mergers in Sneinton** To receive details of the proposed merger of two local practices in Nottingham (NHS England) • **Consideration of the 2015/16 Work Programme**
24 September 2015	• **Sex and relationships education in schools** To receive a report on sex and relationship issues experienced by young people in schools (Nottingham City Council) • **Strategic response to reducing Health Inequalities in the City** To receive a report on health inequalities reduction activities within the City (items of focus will include life expectancy, obesity, smoking cessation, mental health) (Nottingham City Council) • **End of Life Services/Palliative Care Health Scrutiny Committee Study Group Scope** To agree the scope of the study group (Nottingham City Council) • **Nottingham University Hospitals Cleanliness issues** To receive a report in relation to the cleanliness of NUH (NUH) • **Consideration of the Work Programme 2015/16**

22 October 2015	• **Implementation of the Better Care Fund** To receive a report on implementation and impact of the Better Care Fund (Nottingham City Clinical Commissioning Group) • **Telecare/Telehealth** To have a greater understanding of the working relationship between the two components (Nottingham City Clinical Commissioning Group/Nottingham City Council) • **Integrated Care Programme** To receive an update on delivery timescales and service user/staff survey results (Nottingham City Clinical Commissioning Group) • **Consideration of the Work Programme 2015/16**
19 November 2015	• **Quality of GP practices within Nottingham City** To consider the quality of GP provision in the City (Nottingham City Clinical Commissioning Group) • **Review of residential care homes quality bandings/ quality dashboard** (Nottingham City Council) • **Consideration of the Work Programme 2015/16**
17 December 2015	• **Dementia Services within Nottingham City** (Nottingham City Clinical Commissioning Group/Nottingham City Council/Nottingham CityCare Partnership) • **Consideration of the Work Programme 2015/16**

21 January 2016	• **Consideration of the draft 2015/16 Nottingham City Care Partnership draft Quality Account** (Nottingham CityCare Partnership) • **Consideration of the Work Programme 2015/16**
18 February 2016	• **Consideration of the Work Programme 2015/16**
17 March 2016	• **Consideration of the Work Programme 2015/16**
21 April 2016	• **Urgent Care Services Centre Progress** (Nottingham City Clinical Commissioning Group/Nottingham CityCare Partnership) • **Consideration of the Work Programme 2015/16**

Briefing note updates to be provided to the Health Scrutiny Committee:

- Update on bowel cancer screening uptake
- Update on NHS Health Check Programme performance

Proposed visits by the Health Scrutiny Committee:

- Nottingham CityCare Partnership Clinics within Boots, Victoria Centre (Autumn 2015)
- Urgent Care Centre (Spring 2016).

Health Scrutiny Committee Study Group:

- Review of End of Life Services (Autumn 2015, 4 members of HSC to be involved in the scoping and reviewing activities)
- Service user experience of care at home services (spring 2016, 4 members of HSC to be involved in the scoping and reviewing activities)

Items to be scheduled for 2016/17:

- Nottingham CityCare Partnership Quality Account 2015/16 (May 2016)
- Flu Immunisation

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