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Nottingham City Council

NOTTINGHAM CITY COUNCIL
HEALTH AND WELLBEING BOARD

Date: Wednesday, 26 February 2014

Time: 2.00pm

Place: LB31-32 - Loxley House, Station Street, Nottingham, NG2 3NG

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

Deputy Chief Executive/Corporate Director for Resources

Constitutional Services Officer: Noel McMenamin **Direct Dial:** 0115 876 4304

AGENDA **Pages**

1 APOLOGIES FOR ABSENCE

2 DECLARATIONS OF INTERESTS
If you need any advice on declaring an interest in any item on the agenda, please contact the Constitutional Services Office shown above, if possible before the day of the meeting

3 MINUTES 3 - 10
Last meeting held on 8 January 2014 (for confirmation)

4 AGE-FRIENDLY NOTTINGHAM AND NOTTINGHAM'S OLDER CITIZENS' CHARTER 11 - 16
Report of Director of Public Health

5 TEENAGE PREGNANCY IN NOTTINGHAM - UPDATE 17 - 22
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6 BETTER CARE FUND 23 - 68
Joint report of Director of Primary Care, Development and Service Integration, NHS Nottingham City Clinical Commissioning Group and Director of Quality and Commissioning, Nottingham City Council

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 AND WELLBEING BOARD

M I N U T E S of the meeting held at Loxley House on **8 JANUARY 2014** from 1.32 pm to 3.55 pm

Voting members

Councillor Alex Norris (Chair)	Portfolio Holder, Adults and Health
Dr Ian Trimble (Vice-Chair)	NHS Nottingham City CCG
Councillor Jon Collins	Leader/Portfolio Holder – Strategic Regeneration and Community Safety
Councillor Dave Liversidge	Portfolio Holder – Commissioning and Voluntary Sector
Councillor David Mellen	Portfolio Holder - Children's Services
Alison Michalska	Corporate Director, Children and Adults, Nottingham City Council
Dr Hugh Porter	)
Dawn Smith	) NHS Nottingham City CCG
Dr Arun Tangri	)
Vikki Taylor	NHS England
Dr Chris Kenny	Director, Public Health, Nottingham City / Nottinghamshire County
Adele Cresswell	Healthwatch Nottingham

Non-voting Members

Elaine Yardley	-	Director, Adult Provision / Health Integration, Nottingham City Council
Tim O'Neill	-	Director, Family Community Teams, Nottingham City Council
Gill Moy	-	Nottingham City Homes
Lyn Bacon	-	Nottingham CityCare Partnership
Peter Moyes	-	Nottingham Crime and Drugs Partnership
Michele Hampson	-	Nottingham Healthcare NHS Trust
Anne Danvers	-	Nottingham Jobcentre Plus
Angela Kandola	)	Nottingham Third Sector Forum
Sarah Collis	)	
Daniel Mortimer	-	Nottingham University Hospitals NHS Trust **(for Peter Homa)**
Steven Cooper	-	Nottinghamshire Police (City Division)

indicates present at meeting

Colleagues, partners and others in attendance

Mark Andrews	-	Head of Family Community Teams North
Marcus Bicknell	-	NHS Nottingham City CCG
Alison Challenger	-	Deputy Director of Public Health
Nicky Dawson	-	Priority Families Programme Co-ordinator
Noel McMenamin	-	Constitutional Services Officer
Colin Monckton	-	Head of Commissioning and Insight
Alison Weaver	-	Service Manager, Inclusive Education Service

30 APOLOGIES FOR ABSENCE

Councillor Jon Collins	(other Council business)
Chris Kenny	(Director of Public Health, Nottingham City and Nottinghamshire County)
Martin Gawith	(Healthwatch Nottingham)
Elaine Yardley	(Director of Adult Provision / Health Integration, Nottingham City Council)

31 DECLARATIONS OF INTEREST

Dr Trimble and Dr Tangri both declared an interest in agenda item 7 'Improving General Practice – A Call to Action' as general practitioners providing primary care services. The interest was considered insufficient to prevent them from speaking or voting on the item.

32 MINUTES

The Board confirmed the minutes of the meeting held on 30 October 2013 as a correct record and they were signed by the Chair.

33 PRIORITY FAMILIES

Mark Andrews, Head of Family Community Teams North, introduced a report updating the Board on the delivery of the Priority families programme, highlighting the following points:

(a) the Trouble Families Peer Review process was conducted in partnership with Wakefield Council, and initial findings were positive, especially relating to the ambitious scale of change to culture and ways of working being delivered;

(b) while currently on track with Payments By Results (PBR) claims, there was a potential reputation and financial risk in not meeting future PBR targets because of the ambitious pace of change;

(c) almost 1200 families have been identified and half of those have been or are being engaged. DCLG is aware that the bulk of allocations is planned for quarter 4 and rates progress to date positively, but there is a risk that it will not be possible to deliver the 360 further allocations needed to meet target;

(d) the programme has identified some short term funding gaps in support for families, and the report recommended delegating authority to the Priority Families Partnership Leadership and the relevant Portfolio Holders to make short term funding decisions to address gaps around identified need;

(e) the government requirement to match families to certain criteria could prove problematic. For example, certain groups were under represented in terms of school attendance because of the positive cultural attitude to the value of education;

(f) the Troubled Families Initiative has been extended to 2020, and will have a greater emphasis on early intervention and prevention, targeting 400,000 families nationally.

During discussion, Board members commended the Programme Team's success to date, and made several comments:

(g) a Board member requested sample case studies to help understand how priority families were being helped in practical terms under the programme;

(h) a Board member requested an equality and diversity breakdown of the families being identified and engaged under the programme.

RESOLVED to

(1) note the briefing paper with key findings from the Troubled Families peer review, with a 'next steps' report to follow receipt of the detailed peer review letter from the Local Government Association;

(2) note the progress update;

(3) agree short term funding decisions to be delegated to the Priority Families Partnership Leadership Group and the Portfolio Holder for Commissioning and the Voluntary Sector and Portfolio Holder for Children's Services, in liaison with the Health and Wellbeing Board Commissioning Executive Group where appropriate, with a full process briefing to be submitted to the Board for final approval;

(4) note the information about the nature of the extension (phase 2) to the Government Troubled Families Initiative and progress to date for phase 1 ending March 2015;

(5) request the Director of Family Community Teams to provide additional briefing information identified at (g) and (h) above.

34 SAFE FROM HARM STRATEGIC COMMISSIONING REVIEW RECOMMENDATIONS

Coiln Monckton, Head of Commissioning and Insight, introduced a report highlighting a number of recommendations relating to the conclusions of the Safe From Harm (SFH) Strategic Commissioning Review, and to the commissioning of Domestic and Sexual Violence and Abuse (DVSA) services. Mr Monckton made the following points:

(a) the review found there to be effective provision for specialist DSVA services, and recommended investment to maintain existing levels of service;

(b) there was a need to manage DVSA more effectively through earlier intervention, which resulted both in better outcomes for survivors and in more efficient use of resources;

(c) more focused work was needed on perpetrators, and the Police and Crime Commissioner was looking to commission research through the University of Nottingham;

(d) the review recommended aligning Nottingham City joint commissioning arrangements with those of Nottinghamshire County Council and NHS England where appropriate;

(e) there was little specialist provision for abuse among young people in intimate relationships and this gap could be addressed under the Child Development Strategic Commissioning Review ;

(f) the refresh of a Nottingham DVSA strategy and action plan being developed by the Crime and Drugs Partnership will help improve understanding of underlying issues facing black, minority ethnic and refugee communities, including honour based violence, forced marriage and trafficking.

During discussion, Board members raised the following issues and points:

(g) Peter Moyes, Nottingham Crime and Drugs Partnership, confirmed that a special Commissioning Group had been established to identify ways to close the £297,000 annual funding gap for current provision due to the ending of non-recurrent funding;

(h) the issue of modern-day slavery, which had increasing coverage nationally, did not form a major part of the analysis, but would be taken forward as part of the DVSA strategy refresh and action plan;

(i) several Board members made the point that the DVSA strategy refresh and action plan should ensure greater understanding of issues faced by people with learning disabilities, and the impact more widely of mental health issues on the profile of DVSA in Nottingham.

RESOLVED to

(1) note the analysis conducted as part of the Safe from Harm strategic commissioning review;

(2) support maintaining the current level of investment into the commissioning of specialist Domestic and Sexual Violence Abuse (DVSA) services, requiring all partners to continue funding the specialist services (£2,543,492) and looking to resolve the £297,000 funding gap;

(3) note that partner decision making bodies will agree recommendations regarding ongoing commissioning of current service provision;

(4) support the joint commissioning approach adopted by Nottingham City Council, NHS Nottingham City Clinical Commissioning Group, Crime and Drugs Partnership and the Police and Crime Commissioner's Office in the commissioning of all services in Nottingham, recommending aligning commissioning arrangements with Nottinghamshire County Council and NHS England where appropriate, with lead responsibility for alignment lying with the Nottingham Crime and Drugs Partnership;

(5) note that the Child Development Strategic Commissioning Review will take forward work to investigate ways of releasing resources to invest in Early Intervention measures;

(6) support the refresh of the DVSA strategy and action plan being developed by the Crime and Drugs Partnership;

35 CHILDREN AND FAMILIES BILL 2013: PROGRESS IN IMPLEMENTING THE NEW 0-25 SPECIAL EDUCATION NEEDS (SEN) SYSTEM

Alison Weaver, Service Manager, Inclusive Education Service introduced the report, making the following points:

(a) the Children and Families Bill introduces significant changes to Special Education Needs (SEN) provision, requiring a single co-ordinated assessment process, personal budgets for families and improved transition into adulthood;

(b) there are around 1,000 services users covering both mainstream and specialist education provision in Nottingham, and these numbers were increasing;

(c) work on aligning resources on the basis of current information is ongoing, and delivering the changes by September 2014 is on track. The financial implications of the changes were not yet clear. Once developed, the draft joint commissioning strategy, and proposals around joint commissioning arrangements, contracts and budget will be shared with both the Commissioning Executive Group and the Board, in line with governance arrnagements.

In the brief discussion which followed, Board members made the point that, while the report was clear on process and systems, it was unclear what the outcomes would be for children and young people. In response, Ms Weaver confirmed that positive outcomes for service users were central to the new SEN system, and that these would be made clear in the update report later in 2014. Delivering more than the Bill's statutory requirements had been the intention from the outset.

RESOLVED to

(1) note the implications of the Children and Families Bill from September 2014, and the progress to date in delivering the changes required;

(2) support the partnership approach being adopted to implement these changes through joint commissioning, delivery and funding of these services;

(3) agree to receive a further update report in June 2014, once the overall financial implications of implementing these changes were clearer.

36 IMPROVING GENERAL PRACTICE – A CALL TO ACTION

Vikki Taylor, Director of Commissioning, NHS England and Dawn Smith, Chief Officer, NHS Nottingham CCG introduced a report and gave a joint presentation on the 'Improving General Practice – A Call to Action' initiative, highlighting the following points:

(a) the Call to Action on improving general practice was launched in July 2013, setting out current issues and future challenges to the NHS. It requires CCGs to work with NHS England to engage with a range of stakeholders, including Health and Wellbeing Boards to explain these challenges and then develop a 5 year commissioning plan;

(b) the key challenges include capacity pressures, with a 50% increase in consultations, coupled with falling practice income, a shift in services from secondary to primary care, and national and localised workforce shortages;

(c) feedback from stakeholders indicated a need to empower patients to take responsibility for their health and put them in control of their care, providing real choices beyond service provision;

(d) people wanted to understand the breakdown of costs involved in treatment, and there was support for charging in certain areas, such as for not attending appointments;

(e) the time was right to build on and increase integration and provide single points of access, as well as harnessing existing technologies such as online bookings and skype to deliver more effective services;

(f) public and stakeholder engagement will inform the piloting and testing of new ways of working in general practice from January 2014 onwards; public and stakeholder engagement will inform the piloting and testing of new ways of working in general practice from January 2014 onwards;

During discussion, Board members raised the following issues:

(g) a Board member asked how learning and best practice is currently disseminated. The CCG has a programme of practice visits and the outcomes of these are shared with general practices across the City. NHS England is also looking to establish a Primary Care Shared Learning resource;

(h) several Board members agreed that demand exceeded capacity under the current service model, that new ways to manage and filter demand could lead to equally effective outcomes, and that an integrated service model was the right way to go forward;

(i) the Third Sector had a key role to play in providing long-term self-care support to ease pressure on primary care services;

(j) workforce shortages were not confined to GPs – there as a shortage of nurses in general practice as well.

RESOLVED to note the report and presentation.

37 HEALTHWATCH NOTTINGHAM - UPDATE

Adele Cresswell, Healthwatch Nottingham, updated the Board on Healthwatch Nottingham activity. In particular, work continued jointly with the Nottingham University Hospitals Trust in building a diary of patient experience. Ms Cresswell shared the experience of an elderly patient who had difficulty in getting a head wound treated around the New Year period, and she invited narratives from GPs, councillors and colleagues to help build a composite picture of the patient experience. A Board member suggested that Ms Cresswell provide her email details so that Board members could share their experiences and those of their constituents or patients.

RESOLVED to note the update.

38 FORWARD PLAN

RESOLVED to note the Forward Plan without discussion.

39 STATUTORY OFFICER UPDATES

The Board received the following updates and requests:

(a) Corporate Director for Children and Families

(i) NHS Social Care Funding 2013/14

The Health and Wellbeing Board's terms of reference require it 'to oversee, where appropriate, the use of relevant public sector resources across a wide spectrum of services and interventions to ensure outcomes from health care, social care and public health interventions'. As part of this remit, the Corporate Director, Alison Michalska, asked the Board to note that a Section 256 Partnership Agreement was in place between Nottingham City Council and NHS Nottingham City CCG covering the use of £5.548 million of NHS Social Care funding to be transferred from Health to Local Authorities in 2013/14. Ms Michalska confirmed that the Agreement had been approved through both parties' constitutional processes, and explained that NHS England had asked for evidence that the Board was content before releasing the funding. She also confirmed that the Board will have the opportunity to consider proposals in detail when considering the Better Care Fund report at its February 2014 meeting.

RESOLVED to note and support the Section 256 Partnership Agreement in place between Nottingham City Council and NHS Nottingham City CCG to cover the transfer and use of £5.548 million of NHS Social Care funding.

(ii) Point of Access Team

'Children and Families Direct', the new service acting as first point of contact for advice, guidance and referral into Children's Services had gone live and was working very well. Already there had been an increase in numbers of complex referrals.

(iii) Adoptions

The number of successfully completed adoptions in Nottingham was 55, which was higher than ever before.

(iv) North of England Education Conference

Nottingham is hosting the Conference from 15-17 January 2014, and partners are asked to consider their involvement in it – discounted rates are available for local organisations.

(v) Partnership working

Work is ongoing across the Council to address both winter pressure issues and on working up Better Care Fund proposals with partners.

(b) Director of Public Health

(i) Age-Friendly Cities

Nottingham had signed up to the Dublin Declaration on becoming an age-friendly city. Proposals for an Older Citizens Charter were out to consultation.

(ii) Smoking

Public Health England had launched a 'toxic blood' smoking campaign highlighting the hidden dangers of smoking.

(iii) Change4Life

The Change4Life smart swaps campaign had been launched, urging families to make healthier food, drink and activity choices.

(c) Chief Officer, Clinical Commissioning Group (CCG) (Dawn Smith)

(i) Everyone Counts: Planning for Patients 2014/15 to 2018/19

NHS England has published planning guidance with proposals for how to invest the NHS Budget sustainably over the next 5 years. Commissioners must develop 2-year operational and 5-year strategic plans, and NHS England expects to see better physical and mental health outcomes for citizens over a range of indicators. Further progress will be reported at the February 2014 meeting.

(ii) Better Care Fund (formerly Integration Transformation Fund)

The Better Care Fund comes into effect from 2015/16 but planning for its use must be completed before the start of the 2014/15 financial year. The NHS England 5-year planning guidance includes a template for developing agreeing and publishing a Better Care Plan, which is currently being worked up by the Contact Executive Group. The Plan will come to the February 2014 Board meeting for approval.

(iii) Challenge Fund

NHS England is inviting GP surgeries to apply for part of a £50 million Challenge Fund to pilot improvements in access to appointments. At least 9 pilots, one in each NHS region, will be established, and Nottingham City is compiling a bid for submission in February 2014.

RESOLVED to note the above updates.

40 NOTTINGHAM CITY SAFEGUARDING CHILDRENS/ADULTS BOARD ANNUAL REPORT

Paul Burnett, Independent Chair of the Nottingham City Safeguarding Children/Adults Board introduced the report, previously circulated at the Board's October 2013 meeting (minute 29(a)(viii) refers). Mr Burnett welcomed the opportunity to address the Board in person, and made the following points:

(a) there was an increase in adult referrals, especially in the over 65 age group in the care setting, and Mr Burnett believed this was down in part to a lack of understanding of the thresholds;

(b) while procedures and policies were in place, there was a need for further testing to evidence their impact, and carrying out this testing, plus evaluating the impact of financial constraints, were the key challenges in 2014;

(c) there was also an increase in child safeguarding referrals, which Mr Burnett believed was down to earlier targeted intervention identifying at-risk families;

(d) as with adults, there was an issue with understanding the thresholds to be applied and with the variable quality of data available;

(e) priorities in 2014 included rolling out the New Assessment Framework and being 'fit for OFSTED', as well as the ongoing challenge to deliver improved safeguarding at a time of significant change and continuing financial constraint.

In the brief discussion which followed, the Board and Mr Burnett made the following points:

(g) more collective working and improvements within one partner agency could lead to knock-on benefits for all partners. For example, targeted work in Leicestershire around missing children established that almost three quarters of cases involved just 11 children from 2 residential care homes, leading to substantial budget savings;

(h) there was scope for smarter commissioning of children's services, especially around early help;

(i) there was also scope for sharing information on safeguarding 'near-misses' between agencies.

RESOLVED to note the report and points arising from discussion and to thank Mr Burnett for his attendance.

HEALTH AND WELLBEING BOARD – WEDNESDAY 26 FEBRUARY 2014

Title of paper:	**Age Friendly Nottingham and Nottingham's Older Citizens' Charter**	
Director(s)/ Corporate Director(s):	**Dr Chris Kenny, Joint Director of Public Health**	**Wards affected: All**
Report author(s) and contact details:	**Sharan Jones, Health and Wellbeing Manager** sharan.jones@nottinghamcity.gov.uk	
Other colleagues who have provided input:	**Clare Routledge, Senior Health and Wellbeing Policy Officer** **Joanna Copping, Consultant in Public Health**	
Date of consultation with Portfolio Holder(s) (if relevant)	**17 December 2013**	

Relevant Council Plan Strategic Priority:	
Cutting unemployment by a quarter	☐
Cut crime and anti-social behaviour	☐
Ensure more school leavers get a job, training or further education than any other City	☐
Your neighbourhood as clean as the City Centre	☐
Help keep your energy bills down	x
Good access to public transport	x
Nottingham has a good mix of housing	x
Nottingham is a good place to do business, invest and create jobs	x
Nottingham offers a wide range of leisure activities, parks and sporting events	x
Support early intervention activities	x
Deliver effective, value for money services to our citizens	x

Summary of issues (including benefits to citizens/service users):

Nottingham has committed to develop as an age friendly city which will enable older citizens to stay active, healthier and happier for longer, thus maximising the potential of their contributions to society. As part of the Age Friendly Nottingham initiative older citizens have come together and developed the Nottingham Older Citizen's Charter. Proposed future action includes the development of an action plan by an older citizens' steering group.

Citizens have requested that the charter is ratified by the Health and Wellbeing Board and that progress against the future action plan should be reported annually to the Board.

Recommendation(s):	
1	The Board to support the development of Age Friendly Nottingham and consider how their organisations might be engaged in the initiative.
2	The Board to ratify Nottingham's Older Citizens' Charter.
3	The Board to discuss the formation of an older citizen's steering group.
4	The Board to agree that progress against the Age Friendly Nottingham action plan should be reported to them annually.

1. REASONS FOR RECOMMENDATIONS

1.1 The increasing number of older citizens is both an opportunity and a resource for Nottingham, whilst posing a challenge for wellbeing and services. By empowering older citizens to stay active, healthier and happier and increasing the recognition of the positive role that they play within society, citizens will be able to maintain a good quality of life in older age and remain independent in their own homes for longer. There is already much good work aimed at older citizens being undertaken across the city, particularly aimed at our most vulnerable adults, but there is no older persons' strategy currently in place. The Age Friendly Nottingham initiative aims to support the prevention agenda by pulling partners' contributions together and placing the needs and aspirations of older citizens at the centre of their services.

1.2 Older citizens have welcomed the concept of Age Friendly Nottingham and have been fully engaged in the creation of the Nottingham's Older Citizens' Charter. They are keen for the initiative to be taken further and have proposed the formation of a strategic older citizens' steering group which will develop and monitor progress against the Age Friendly Nottingham action plan.

1.3 Older citizens have requested that progress against the Age Friendly Nottingham action plan should be reported annually to the Health and Wellbeing Board.

2. BACKGROUND (INCLUDING OUTCOMES OF CONSULTATION)

2.1 Although Nottingham is known as a 'young' city, over 80,000 of citizens are aged 50+. Prior to 2011 the city's older population remained stable but the census (2011) indicates a surge of citizens aged 50-64 significantly higher than the England average and a 16% increase in those aged 85+.

2.2 Debates about securing optimum community environments for ageing populations emerged from a number of organisations during the 1990s. The theme of age friendly communities arose from policy initiatives launched by the World Health Organization (WHO). A precursor was the notion of 'active aging' which referred to older people's continued participation in social, economic, cultural, spiritual and civic affairs, not just the ability to be physically active or to participate in the labour market. Achieving this was seen as requiring interventions at a number of levels, including maintaining effective support within the physical and built environment.

2.3 In 2012 Nottingham City Council joined other Core Cities in signing the Dublin Declaration on Age Friendly Cities and becoming a member of the WHO affiliated UK Age Friendly Cities (AFC) Network and Councillor Eunice Campbell was appointed Nottingham's Older Citizens' Champion. This network aims to share learning through peer support; develop age friendly research and evaluation across the social determinants of health and create a collaborative voice to influence policy and practice.

2.4 The access to more data, information and expertise through the network has already benefited the city and resulted in a successful bid for £238,000 of grant funding from the Arts Council England and The Baring Foundation which will be used to improve access to the arts for older people in care settings across Nottingham.

2.5 On 1 October 2013, Nottingham held its first Older People's Festival to celebrate International Older People's Day. Almost 100 citizens participated in discussions at the Council House where they requested that a charter should be developed for the

city. Members of the Nottingham Pensioners' Action Group were particularly supportive and have encouraged active participation in the initiative.

2.6 Citizens came forward to form the task and finish group that drafted the pledges of the charter. The draft charter was circulated for consultation on 23 December 2013 and the final version now forms Appendix A of this report. The Nottingham charter commits to adopt the principles outlined in the National Pensioners' Convention Dignity Code that was launched nationally on 1 February 2014 (Appendix B).

2.7 The Big Lottery Fund has awarded £50 million for the development of the national Centre for Ageing Better which will focus on early intervention and prevention. Through the development of a more strategic approach for older citizens, Nottingham will be better placed to benefit from developments through the Centre and future funding opportunities.

3. OTHER OPTIONS CONSIDERED IN MAKING RECOMMENDATIONS

3.1 None. This is an externally funded initiative that is supported and being driven by older citizens.

4. FINANCIAL IMPLICATIONS (INCLUDING VALUE FOR MONEY/VAT)

4.1 The Age Friendly Nottingham initiative is supported through £60,000 of Communities for Health grant funding that can be used until March 2015. There will therefore be no financial impact on partner organisations.

5. RISK MANAGEMENT ISSUES (INCLUDING LEGAL IMPLICATIONS AND CRIME AND DISORDER ACT IMPLICATIONS)

5.1 None

6. EQUALITY IMPACT ASSESSMENT (EIA)

6.1 Nottingham's Older Citizens' Charter does not require an EIA but equality impact will be reviewed when the action plan is developed. Targeted action to reduce health inequalities will be informed by the Joint Strategic Needs Assessment.

7. LIST OF BACKGROUND PAPERS OTHER THAN PUBLISHED WORKS OR THOSE DISCLOSING CONFIDENTIAL OR EXEMPT INFORMATION

7.1 None

8. PUBLISHED DOCUMENTS REFERRED TO IN COMPILING THIS REPORT

8.1 Developing Age-Friendly Cities: Policy Challenges & Options
http://www.bjf.org.uk/web/documents/resources/HLINViewpoint37AgeFriendlyCities.pdf

8.2 The Dublin Declaration on Age Friendly Cities
http://www.emro.who.int/images/stories/elderly/documents/dublin20declaration.pdf

8.3 'Arts and Older People' Enquiry Visit, Nottingham City Council 25 March 2013
http://www.bjf.org.uk/web/documents/resources/Nottingham%20Enquiry%20visit%20%20final%20report.pdf

Appendix A

Nottingham's Older Citizens' Charter

In Nottingham we believe all our older citizens should have fulfilled lives – feeling valued by all sections of society, living as independently as possible and being encouraged to contribute to their local communities. By signing this Charter we aspire to develop Nottingham as a great place to grow older in. We strive to achieve this by acting in accordance with the following pledges:

1. To make engagement of older citizens integral to the decision making processes in the city.

2. To break stereotypes and promote positive images of ageing – recognising older citizens' diverse knowledge, skills and experience and how these contribute to Nottingham life.

3. To mobilise older citizens' contributions to their communities and Nottingham society – developing and promoting different opportunities for involvement.

4. To reduce loneliness and isolation - encouraging affordable, accessible and intergenerational social activities, leisure opportunities and local support networks including those with a spiritual and/or religious outlook.

5. To promote health, wellbeing and independence – supporting prevention, early intervention and integration of high quality commissioned services that have been developed in partnership with older citizens.

6. To increase dignity and choice in health and care services – adopting the principles outlined in the National Pensioners' Convention's Dignity Code.

7. To provide a variety of well maintained housing options and assistive technology which enable citizens to have choice, live independently and feel safe within their local community - considering the needs of older citizens at a neighbourhood level when planning and designing future developments.

8. To create welcoming and accessible environments that have good lighting and promote safety - developing accessible outdoor spaces, public buildings and facilities (including sufficient toilets) that are well signposted and incorporate rest areas with seating designed to meet the needs of older citizens.

9. To uphold Nottingham's reputation for having one of the best accessible transport systems in the country - ensuring that services are responsive to the needs of those with long term conditions and at risk of isolation.

10. To support the volunteering and employment of older citizens – recognising the benefits of continued occupation, education and skills development to quality of life.

11. To provide clear, consistent information to all older citizens from sources they can trust – using a variety of media, supporting the use of new technology and working in partnership to deliver key messages.

12. To ensure that all services are provided free from discrimination - recognising that elderly people are diverse and come with a range of identities eg ethnicity, sexuality, disability etc, each unique to the needs of the individual.

We will always listen to your views and tell you about the progress we are making. In return we ask that you get involved and help us fulfil the pledges in the Charter.

Dignity Code

The purpose of this Dignity Code is to uphold the rights and maintain the personal dignity of older people, within the context of ensuring the health, safety and wellbeing of those who are increasingly less able to care for themselves or to properly conduct their affairs.

This Code recognises that certain practices and actions are unacceptable to older people, such as:

- Being abusive or disrespectful in any way, ignoring people or assuming they cannot do things for themselves
- Treating older people as objects or speaking about them in their presence as if they were not there
- Not respecting the need for privacy
- Not informing older people of what is happening in a way that they can understand
- Changing the older person's environment without their permission
- Intervening or performing care without consent
- Using unnecessary medication or restraints
- Failing to take care of an older person's personal appearance
- Not allowing older people to speak for themselves, either directly or through the use of a friend, relative or advocate
- Refusing treatment on the grounds of age

This Code therefore calls for:

- Respect for individuals to make up their own minds, and for their personal wishes as expressed in 'living wills', for implementation when they can no longer express themselves clearly
- Respect for an individual's habits, values, particular cultural and religious background and any needs, linguistic or otherwise
- The use of formal spoken terms of address, unless invited to do otherwise
- Comfort, consideration, inclusion, participation, stimulation and a sense of purpose in all aspects of care
- Care to be adapted to the needs of the individual
- Support for the individual to maintain their hygiene and personal appearance
- Respect for people's homes, living space and privacy
- Concerns to be dealt with thoroughly and the right to complain without fear of retribution
- The provision of advocacy services where appropriate

NPC
Walkden House, 10 Melton Street, London NW1 2EJ
www.npcuk.org

NPC
NATIONAL PENSIONERS CONVENTION

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Health and Wellbeing Board 26 February 2014

Title of paper:	**Teenage Pregnancy in Nottingham – an update**	
Director(s)/ Corporate Director(s):	**Dr Chris Kenny, Director of Public Health**	**Wards affected: All**
Report author(s) and contact details:	**Lynne McNiven, Consultant in Public Health** **Tel: 0115 8765429** **Email: lynne.mcniven@nottinghamcity.gov.uk** **Marie Cann-Livingstone, Early Intervention and Teenage Pregnancy Specialist** **Tel: 0115 8763511** **Email: marie.cann-livingstone@nottinghamcity.gov.uk**	
Other colleagues who have provided input:		
Date of consultation with Portfolio Holder(s) (if relevant)	**13.02.2014 Councillor Alex Norris**	

Relevant Council Plan Strategic Priority:	
Cutting unemployment by a quarter	☐
Cut crime and anti-social behaviour	☐
Ensure more school leavers get a job, training or further education than any other City	x
Your neighbourhood as clean as the City Centre	☐
Help keep your energy bills down	☐
Good access to public transport	☐
Nottingham has a good mix of housing	☐
Nottingham is a good place to do business, invest and create jobs	☐
Nottingham offers a wide range of leisure activities, parks and sporting events	☐
Support early intervention activities	x
Deliver effective, value for money services to our citizens	x

Summary of issues (including benefits to citizens/service users):

Teenage pregnancy is a complex and serious social problem. Having children at a young age can adversely influence the health and wellbeing of young women, severely limit education and career prospects and result in negative health outcomes for their children, who are significantly more likely to become teenage parents themselves. In Nottingham reducing rates of unplanned teenage pregnancy and supporting teenage parents is delivered through a partnership approach conveying the message that reducing teenage conceptions is 'everyone's business'. Early Intervention and Primary Prevention is central to our approach to support parents to make positive decisions and ensure the best possible start in life for their children.

Nationally, the under-18s conception rate is at its lowest level since 1969, however, this still equates to approximately 30 000 conceptions (15 to 17 years of age) per year of which three quarters are unplanned and half end in abortion. The data for Nottingham for Quarter 3 2012 indicates that the rolling quarterly rate of 42.6 per 1000 girls aged 15-17 remained the same as the previous rolling figure reported in Quarter 2 2012.

In Nottingham during the 12 months from the baseline in October 1998 to September 1999 there were 362 pregnancies, indicating a decrease of 43.1% when compared to the September 2012 data (206 conceptions) This puts Nottingham City in the top 30% of most improved local authorities with regard to the number of conceptions.

Reducing rates of unplanned teenage pregnancy and supporting teenage parents is carried out through a partnership approach conveying the message that reducing teenage conceptions is 'everyone's businesses'. Early Intervention and Primary Prevention is central to our approach to support parents to make positive decisions ensuring the best possible start in life for their children.

Recommendation(s):	
1	**Members of the Health and Wellbeing Board are asked to note the content of the report.**
2	**Members of the Health and Wellbeing Board are asked to note the development of the 2014/15 Teenage Pregnancy Plan and comment on the draft plan when circulated in March 2014.**
3	**Members of Health and Wellbeing Board are asked to agree to receive an annual update from the Teenage Pregnancy Taskforce.**

1. REASONS FOR RECOMMENDATIONS

Teenage pregnancy remains a key driver for poor health and social outcomes. Despite the continued reduction in teenage pregnancy rates in Nottingham, there is no room for complacency and all organisations / partners must continue to work together to ensure a cohesive strategic approach to achieve our 2020 target. The development of a refreshed Teenage Pregnancy Action Plan 2014/15 for Nottingham is central to ensuring that we achieve a sustained reduction of the rates year on year.

2. BACKGROUND (INCLUDING OUTCOMES OF CONSULTATION)

Teenage pregnancy is a complex and serious social problem. Having children at a young age can influence the health and wellbeing of young women, severely limit education and career prospects and result in negative health outcomes for their children, who are significantly more likely to become teenage parents themselves. There are also strong associations between high under-18 conception rates and; low educational attainment, low aspirations, poor attendance at school, alcohol use, regretted sex or forced sex, being in public care, being the daughter of a teenage mother, having mental health problems, having been sexually abused or involved in crime.

For teenage conceptions that end in a birth the outcomes are often poorer for mother and child and can include:

- Of those not in employment, education or training at age 16-18, 15% are teenage mothers or pregnant teenagers.
- Teenage parents are 20% more likely to have no qualifications by age 30.
- Teenage mothers are 22% more likely to be living in poverty at age 30 and much less likely to be employed or living with a partner.
- Children of teenage mothers have a 63% increased risk of being born into poverty and are more likely to have accidents and behavioural problems.
- Teenage mothers have three times the rate of postnatal depression and a higher risk of poor mental health for up to three years after the birth.
- The infant mortality rate of babies born to teenagers is 60% higher than those born to older parents.
- Teenage mothers are three times more likely to smoke through their pregnancy and 50% less likely to breastfeed – both of which have negative health consequences.

Lowering teenage pregnancy rates is, therefore, a key driver for reducing health inequalities and social exclusion. Achieving any reduction in the current rates requires high level strategic understanding and commitment from all agencies to secure a coordinated

approach. Public Health will continue to influence and lobby a wide range of partners at a strategic level to ensure that the reduction of teenage pregnancy rates remains high on everyone's agenda.

National and local statistics

Nationally, the under-18s conception rate is at its lowest level since 1969, however, this still equates to approximately 30 000 conceptions (15 to 17 years of age) per year of which three quarters are unplanned and half end in abortion. The latest provisional teenage pregnancy data is for Quarter 3 (July to September) 2012, during this quarter the under-18 conception rate for England was 28.4 conceptions per 1000 girls aged 15-17 compared to 32.0 as at Quarter 3 2011; representing a decrease of 11.3% and continues the overall downward trend observed since 1998.

The data for Nottingham for Quarter 3 2012 indicates that the rolling quarterly rate of 42.6 per 1000 girls aged 15-17 remained the same as the previous rolling figure reported in Quarter 2 2012. However, the current rate is better than Quarter 3 2011 (50.4 per 1000 girls) and Quarter 3 1999 (73.4 per 1000 girls) demonstrating reductions of 15.5% and 42% respectively.

Teenage pregnancy numbers

There were 206 conceptions for the year ended September 2012 compared to 242 for the same period the previous year, a 14.9% reduction. During the 12 months from the baseline in October 1998 to September 1999 there were 362 pregnancies, representing a decrease of 43.1% when compared to the September 2012 data (206 conceptions). This puts Nottingham City in the top 30% of most improved local authorities with regard to the number of conceptions. The England average is 32% better than the 1999 baseline of 39 643 conceptions compared to the current 26 819. This continued improvement in Nottingham has improved its national ranking which has now dropped to 13th highest teenage pregnancy rate in the country. Middlesbrough currently has the highest rate at 52.1 and Barnet the lowest at 13.9; the England average is 28.4. Of the 11 statistical neighbours, Nottingham has the fourth highest teenage conception rate compared to the third highest for Quarter 3 2011.

The national and local strategic drivers

Although the overall number of teenage conceptions has reduced significantly, reductions in the number of school age conceptions have not been so dramatic. Therefore, there is commitment within the Teenage Pregnancy Plan to identify and intervene early to support the most vulnerable children and young people who are at risk of becoming teenage parents eg looked after children and those with poor attendance and attainment at school (particularly girls not achieving sufficient progress during school years 7 to 9).

Nationally, the focus on teenage pregnancy began in 1999 with the previous government's national 'Teenage Pregnancy Strategy' which had the ambitious target of reducing teenage pregnancy rates 50% by 2010. Although this target was not achieved, reducing unplanned teenage pregnancy continues to be a high priority and we continue to keep the momentum going in terms of advice, prevention and promotion. By 2020, the Nottingham Plan objective is to halve the rate of under 18 conceptions from the 1998 baseline of 74.7 to 37.4. Although this remains a constant challenge, the City is still showing significant year on year progress and is ahead of the 2013/14 incremental target of 52.6 per 1000 population.

Reducing the under 18s conception rate is included in the *Public Health Outcomes Framework* and is one of the key priorities in the *Framework for Sexual Health Improvement* published in March 2013.

The overarching aim in Nottingham is to enable teenagers to make genuine, informed decisions about their lives in order to achieve a long-term reduction in the number of unplanned teenage pregnancies and improve outcomes for teenage parents and their children. The Teenage Pregnancy Plan 2014 - 2015 is currently under development. The previous plans were delivered through a strong partnership commitment and governance structure with the targets underpinned by the Nottingham Plan to 2020, the Council Plan and the Children and Young People's Plan.

Nottingham's high level Teenage Pregnancy Taskforce, founded by Graham Allen MP and now chaired by Councillor Alex Norris, ensures that reducing unplanned teenage pregnancy and supporting teenage parents, remains a high priority in the City. Nottingham's teenage pregnancy agenda is firmly rooted within all of our Early Intervention work.

Services in Nottingham

Work to tackle teenage pregnancy is delivered through both universal services for children, young people and families as well as targeted support to those most at risk.

Reducing rates of unplanned teenage pregnancy and supporting teenage parents is carried out through a partnership approach conveying the message that reducing teenage conceptions is 'everyone's businesses'. Early Intervention and Primary Prevention is central to our approach to support parents to make positive decisions and ensure the best possible start in life for their children.

We have a local commitment to 'You're Welcome' standards and many of our City services work towards this accreditation to ensure that their services are young-people friendly.

Nottingham services for Primary Prevention include:

- Nottingham City's Outreach Contraception and Sexual Health Services (CASH) for young people deliver accessible and integrated sexual health services within the community focusing on those aged 13-25 and at risk of poor sexual health. CASH services are available in a multitude of locations eg schools, health centres, colleges, children's centres etc and offer advice and support on the full range of contraceptive services, providing condoms through the C-Card scheme, emergency contraception and making referrals as appropriate. Between April 2011 and March 2012 CASH recorded 7680 attendances by young people.
- General Practitioners provide information and contraception eg Long Acting Reversible Contraception (LARC).
- Pharmacies across Nottingham provide a range of services including emergency contraception and pregnancy testing.
- The 'Public Health Nursing for school-aged children and young people' service is central to supporting the reduction in teenage pregnancies by providing information and practical support through the delivery of 'Clinic in a Box'.
- The delivery of Sexual and Relationship Education (SRE) continues to be encouraged in all schools as an evidence based approach to improving young people's level of information, understanding and reducing pregnancy rates.
- Family and Community Teams support activities for children, young people and families and are based in Children's Centres.

The teams have staff trained to deliver sexual health, contraceptive and positive relationships advice as well as support to young people and adults aged 13-25.

- Universal and targeted youth provision carries out project work to raise aspirations and promote positive relationships.

Nottingham services for Early Intervention include:

- The Family Nurse Partnership is a licensed, intensive home visiting programme working with teenage parents to improve pregnancy outcomes, child health and development as well as aspirations for parents and their baby.
  The Family Nurse visits from early pregnancy until the child is two years old developing relationships with the mother, father and family to support and educate on parenting and any issues that concern the young woman.
- The Teenage Pregnancy Midwifery service is available to support all pregnant under-18s (and for under-19s with additional needs). The majority of these young women will have a Family Nurse Partnership nurse and access the generic maternity service too.
- The generic Midwifery and Health Visiting services support all young parents.
- The Beckhampton Centre is a learning centre for school age pregnant girls and school aged mothers who have made a decision to keep their babies. The Centre provides continuity of education for the period a student is unable to attend mainstream school and supports the girl in her role as a young mother providing onsite nursery care for the babies. The teenage pregnancy midwifery service and health visitor service are attached to the Centre and provide weekly antenatal and postnatal sessions.
- The Education Officer for Teenage Pregnancy co-ordinates and monitors the participation and attainment of all pregnant teenagers and school-age parents, assisting them to overcome barriers to accessing education and prevent social exclusion.

Development of the new Teenage Pregnancy Plan 2014-15

On 8 November 2013, a Teenage Pregnancy Network event was held to develop the Teenage Pregnancy Plan 2013-14 and the new teenage pregnancy pathway. 60 people attended the event and contributed to the development of the plan and the pathway. The full draft plan will be emailed out for consultation during March 2014.

Conclusion

The continual reduction of teenage pregnancy rates is not easy to achieve and the evidence clearly shows that any one organisation on its own will not have sufficient impact to guarantee a year-on-year reduction. The examples of current services and strategic drivers within this paper illustrate that plans and actions should be developed and delivered in partnership in order to improve outcomes for all young people.

Commissioning decisions

None

Commissioning intentions

None

3. OTHER OPTIONS CONSIDERED IN MAKING RECOMMENDATIONS

None

4. FINANCIAL IMPLICATIONS (INCLUDING VALUE FOR MONEY/VAT)

None

5. RISK MANAGEMENT ISSUES (INCLUDING LEGAL IMPLICATIONS AND CRIME AND DISORDER ACT IMPLICATIONS)

None

6. EQUALITY IMPACT ASSESSMENT

Has the equality impact been assessed?

Not needed (report does not contain proposals or financial decisions)	**X**
No	☐
Yes – Equality Impact Assessment attached	☐

Due regard should be given to the equality implications identified in the EIA.

7. LIST OF BACKGROUND PAPERS OTHER THAN PUBLISHED WORKS OR THOSE DISCLOSING CONFIDENTIAL OR EXEMPT INFORMATION

8. PUBLISHED DOCUMENTS REFERRED TO IN COMPILING THIS REPORT

A link to the previous Nottingham City Council Teenage Pregnancy Plan 2011-12 can be found at http://nottinghamcity.gov.uk/index.aspx?articleid=1328

A Framework for Sexual Health Improvement in England *Department of Health* 15 March 2013 https://www.gov.uk/government/publications/a-framework-for-sexual-health-improvement-in-england

Tackling teenage pregnancy: Local government's new public health role *Local Government Association* March 2013 http://www.local.gov.uk/web/guest/publications//journal_content/56/10171/3964823/PUBLICATION-TEMPLATE

Public Health Outcomes Framework for England 2013-16 *Department of Health* January 2012 https://www.gov.uk/government/publications/healthy-lives-healthy-people-improving-outcomes-and-supporting-transparency

Chief Medical Officer Annual Report 2012, Our Children Deserve Better, Prevention Pays https://www.gov.uk/government/organisations/department-of-health

Guidance on registering births at children's centres http://www.foundationyears.org.uk/2013/09/registering-births-at-childrens-centres/

HEALTH AND WELLBEING BOARD – FEBRUARY 2014

Title of paper:	**Better Care Fund**	
Director(s)/ Corporate Director(s):	Maria Principe, Director of Primary Care Development and Service Integration, NHS Nottingham City Clinical Commissioning Group Candida Brudenell, Director of Quality and Commissioning, Nottingham City Council	**Wards affected:**
Report author(s) and contact details:	Maria Principe, Director of Primary Care Development and Service Integration – 0115 8839421,maria.principe@nottinghamcity.nhs.uk Candida Brudenell, Director of Quality and Commissioning, 0115 8763609, candida.brudenell@nottinghamcity.gov.uk	
Other colleagues who have provided input:	Jo Williams, Integrated Care Programme Manager – 0115 8839566, jo.williams@nottinghamcity.nhs.uk Antony Dixon, Strategic Commissioning Manager – 0115 8763491 antony.dixon@nottinghamcity.gov.uk	
Date of consultation with Portfolio Holder(s) (if relevant)	**Cllr Norris – 13th February**	

Relevant Council Plan Strategic Priority:	
Cutting unemployment by a quarter	☐
Cut crime and anti-social behaviour	☐
Ensure more school leavers get a job, training or further education than any other City	☐
Your neighbourhood as clean as the City Centre	☐
Help keep your energy bills down	☐
Good access to public transport	☐
Nottingham has a good mix of housing	☐
Nottingham is a good place to do business, invest and create jobs	☐
Nottingham offers a wide range of leisure activities, parks and sporting events	☐
Support early intervention activities	☒
Deliver effective, value for money services to our citizens	√

Summary of issues (including benefits to citizens/service users):

This paper provides Board with context in relation to the establishment of the Better Care Fund as an enabler to deliver the integration agenda at scale and pace. It sets out national guidance and performance expectations in relation to the Fund and associated sign-off and governance requirements.

Recommendation(s):

1	Board approves the vision for and use of Better Care funds as detailed in the Better Care Plan template (appendix 1 and 2) as required by the NHS England Regional Team.

1. REASONS FOR RECOMMENDATIONS

1.1 The Fund provides for £3.8 billion worth of funding nationally in 2015/16 to be spent locally on health and care to drive closer integration and improve outcomes for patients and service users and carers. In 2014/15, in addition to the £900m transfer already planned from the NHS to adult social care, a further £200m will transfer to enable localities to prepare for the Better Care Fund in 2015/16. For 2014/15 there are no additional conditions attached to the £900m transfer already announced, but NHS England will only pay out the additional £200m to councils that have jointly agreed and signed off two-year plans for the Better Care Fund (BCF).

1.2 The requirements for the use of the funds transferred from the NHS to local authorities in 2014/15 remain consistent with the guidance from the Department of Health (DH) to NHS England on 19 December 2012 on the funding transfer from NHS to social care in 2013/14. In line with the following conditions:

- *"The funding must be used to support adult social care services in each local authority, which also has a health benefit. However, beyond this broad condition we want to provide flexibility for local areas to determine how this investment in social care services is best used.*
- *A condition of the transfer is that the local authority agrees with its local health partners how the funding is best used within social care, and the outcomes expected from this investment. Health and Wellbeing boards will be the natural place for discussions between NHS England, clinical commissioning groups and councils on how the funding should be spent, as part of their wider discussions on the use of their total health and care resources.*
- *In line with our responsibilities under the Health and Social Care Act, an additional condition of the transfer is that councils and clinical commissioning groups have regard to the Joint Strategic Needs Assessment for their local population, and existing commissioning plans for both health and social care, in how the funding is used.*
- *A further condition of the transfer is that local authorities councils and clinical commissioning groups demonstrate how the funding transfer will make a positive difference to social care services, and outcomes for service users, compared to service plans in the absence of the funding transfer"*

1.3 It is a stipulation of the fund that Councils should use the additional £200m (1.292m for Nottingham City) to prepare for the implementation of pooled budgets in April 2015 and to make early progress against the national conditions and the performance measures set out in the locally agreed plan. This is important, since some of the performance-related money is linked to performance in 2014/15.

1.4 Appendix 1 and 2 details the Nottingham BCF in the template format that is required by NHS England. This document is required to be formally signed off by the Health and Well-being Board

1.5 The additive elements of the Nottingham BCF are as follows:

- Care Coordination Service to support the Care Deliver Groups
- Expansion of Health and Care Point
- Support 7 day working across primary care
- Development of the Telehealth programme
- Mental Health In-reach Discharge Coordinators

2. BACKGROUND (INCLUDING OUTCOMES OF CONSULTATION)

2.1 Over the past four years, funding from the Department of Health has been passed, via local NHS commissioners (previously the Primary Care Trust, now, following NHS Reform, a combination of the Clinical Commissioning Group and NHS England Area Team). Funding streams have included: additional support funding for social care; improving and sustaining performance on access (primarily to hospital services); and reablement support. Each funding stream has typically come with guidance about use of the funding, which has informed the development of local agreements between the NHS and Local Authority about use of the funding. These agreements are termed "Section 256" Agreements as they are made under the terms of Section 256 of the National Health Service Act 2006.

Following NHS Reform, a proportion of the funding for 2013/14 is covered by a Section 256 Agreement between the Clinical Commissioning Group (CCG) and Council. In the June 2013 spending round covering 2015/16 a national £3.8 billion "Integration Transformation Fund" was announced. This fund, established by the Department of Health, is to be held by local authorities and will include funding previously transferred by local NHS commissioners to the Council under Section 256 Agreements.

Guidance on developing plans for the Better Care Fund (formerly the Integration Transformation Fund) were published by both NHS England and the Department of Communities and Local Government on 20th December 2013 along with local allocations of the first full year of the fund in 2015/16.

2.2 **What is the Better Care Fund?**

The Better Care Fund (previously referred to as the Integration Transformation Fund) was announced in June as part of the 2013 Spending Round. It provides an opportunity to transform local services so that people are provided with better integrated care and support. It encompasses a substantial level of funding to help local areas manage pressures and improve long term sustainability. The Fund will be an important enabler to take the integration agenda forward at scale and pace, acting as a significant catalyst for change.

The Fund will support the aim of providing people with the right care, in the right place, at the right time, including through a significant expansion of care in community settings. This will build on the work Clinical Commissioning Groups (CCGs) and councils are already doing.

2.3 **Nottingham City's approach to implementing the Better Care Fund Principles**

A sub group made up of CCG and LA members has been meeting on a weekly basis to agree principles that will ensure a consistent and transparent approach to the allocation of the better care funds. It was agreed that the overarching principles of the BCF should:

- Support the priorities in the Joint Health and Wellbeing Strategy as well as align with the CCG Plan, NHS England operational plan and others;
- Acknowledge the extent of integrated commissioning and service delivery already in place, and where applicable use the Fund to formalise what is already in place;
- Acknowledge that the Fund does not represent "new" money flowing into the local health and social care system;
- Utilise the Integrated Programme Board for operational systems and processes to ensure engagement and consistent feed through.

- Utilise The Health and Wellbeing Commissioning Executive Group to strategically oversee performance and outcomes of the fund.

- Work towards achieving the national metrics to:-
  - Reduce Length of Stay
  - Improve Delayed Transfers of Care
  - Reduce emergency admissions
  - Remain at home after 90 days after re-ablement

2.4 **National Conditions**

The Spending Round established six national conditions for access to the Fund:

-

National Condition	Definition
Plans to be jointly agreed.	The Better Care Fund Plan, covering a minimum of the pooled fund specified in the Spending Round, and potentially extending to the totality of the health and care spend in the Health and Wellbeing Board area, should be signed off by the Health and Well Being Board itself, and by the constituent Councils and Clinical Commissioning Groups.
Protection for social care services (not spending).	Local areas must include an explanation of how local adult social care services will be protected within their plans.
As part of agreed local plans, 7-day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends.	Local areas are asked to confirm how their plans will provide 7-day services to support patients being discharged and prevent unnecessary admissions at weekends.
Better data sharing between health and social care, based on the NHS number.	Local areas should confirm that they are using the NHS Number as the primary identifier for health and care services, and if they are not, when they plan to.
Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional.	Local areas should identify which proportion of their population will be receiving case management and a lead accountable professional, and which proportions will be receiving self-management help - following the principles of person-centred care planning. Dementia services will be a particularly important priority for better integrated health and social care services, supported by accountable professionals.

3. OTHER OPTIONS CONSIDERED IN MAKING RECOMMENDATIONS

3.1 In developing the Nottingham Better Care Fund commissioners had regard to the national guidance and expectations issued by NHS England and the agreed outcomes contained within the Nottingham Health and Wellbeing Strategy and the Integrated Care Programme. These criteria were used to inform how the additive elements of the Fund should be allocated recognising that the Fund is predominantly comprised of existing allocated funding. Despite the 'new' element of the Fund

comprising only 5% the commissioners will deliver efficiencies to enable the additive elements of the Nottingham BCF to total 18% of available funding.

4. FINANCIAL IMPLICATIONS (INCLUDING VALUE FOR MONEY/VAT)

4.1 **Better Care Fund - Nottingham City**
The Nottingham City Better Care Fund allocation is comprised as follows:

2014/15 – £9.8m	**2015/16 - £23.2m**
In 2015/16 the Fund will be created from:	
£23.2m of Health and Local Authority Funding £9.8m based on existing funding in 2014/15 that is allocated across the health and wider care system. This comprises of: • £800k Carers Break funding • £1.9m CCG reablement funding • £7.1m existing transfer from health to adult social care. The 23.2m will comprise of: • £9.8m existing funding allocation for 2014/15 • £11.6m additional health funding • £1.8m Disabled Facilities & Social Care Capital Grant	

4.2 The specific elements of the Nottingham Better Care Fund for 2015/16 are as follows:

Schemes:	**Investments**
Independence Pathway	10,060,093
Coordinated Care	8,118,690
Assistive Technology	1,145,000
Access & Navigation	1,815,852
Management	160,000
Carers	1,041,857
Disabled Facilities and Social Care Grant	1,863,000
TOTAL INVESTMENT	**24,204,492**

*Further negotiation required to meet 23.2m targeted expenditure, however this is expected to be delivered in 2015/16 once the budgets are integrated and duplication and excess can be identified.

5. RISK MANAGEMENT ISSUES (INCLUDING LEGAL IMPLICATIONS AND CRIME AND DISORDER ACT IMPLICATIONS)

5.1 **Performance Related Pay**

The Spending Round indicated that £1bn of the £3.8bn would be linked to achieving outcomes. For Nottingham City this equates to approximately £6m. Ministers have agreed the basis on which this payment-for- performance element of the Fund will operate.

Half of the £1bn will be released in April 2015. £250m of this will depend on progress against four of the six national conditions and the other £250m will relate to performance against a number of national and locally determined metrics during 2014/15. The remainder (£500m) will be released in October 2015 and will relate to further progress against the national and locally determined metrics.

The (national) performance payment arrangements are summarised in the table below:

When:	Payment for performance amount	Paid for:
April 2015	£250m	• Progress against four of the national conditions: • protection for adult social care services • providing 7-day services to support patients being discharged and prevent unnecessary admissions at weekends • agreement on the consequential impact of changes in the acute sector; • ensuring that where funding is used for integrated packages of care there will be an accountable lead professional
	£250m	Progress against the local metric and two of the national metrics: • delayed transfers of care; • avoidable emergency admissions; and
When:	**Payment for performance amount**	**Paid for:**
October 2015	£500m	Further progress against all of the national and local metrics.

5.2 **Nottingham City Better Care Fund metrics**

The following table details the performance aspirations for Nottingham against each of the agreed national metrics. These targets have been developed based on guidance issued by NHS England and are subject to approval by the Regional Team

NHS Outcomes Framework	
Metrics	**How we will measure this**
• 4% increase of people feeling supported to manage their (long term)condition	• Non-elective admissions aged 65+ per 1,000 pop 65+ • Non-elective bed days aged 65+ per head of

• 13% Reduction in admissions to residential and care homes; • 6% increase in the effectiveness of reablement; • 5% Reduction in delayed transfers of care; • 10% Reduction in avoidable emergency admissions • Patient Experience metric (TBA).	1,000 pop 65+ • Non-elective re-admission rate within 30 days • Non-elective re-admission rate within 90 days • Excess winter deaths for over 65s • No of delayed transfer of care days aged 18+ per 100,000 pop • Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation • Proportion of people aged 65+ discharged direct to residential care • Outcome of short-term support to maximise independence for new and existing clients (STS002a/b) • Permanent admissions to residential / nursing care aged 65+ per 100,000 pop 65+ • Count of clients receiving long-term services (LTS001a)

5.3 To ensure that the performance expectations are delivered a performance dashboard will be created and monitored via the Health and Wellbeing Commissioning Executive Group (HWBCEG). A joint programme Manager post will have the responsibility for ensuring the necessary performance and outcomes are delivering against the agreed metrics, with the HWBCEG providing oversight and guidance, feeding into the Health and Wellbeing Board through quarterly reports.

5.4 **Timescales:** the following needs to be adhered to in order to meet NHS England deadlines for submission of plans and release of additional 14/15 allocation.

- February 14th: Submit 1st draft to Area Team
- February 26th 2014: Sign off by Health and Wellbeing Board
- March 12th 2014: Nottingham City Council Executive Board Commissioners Sign off
- 4th April 2014: Submit plans

6. EQUALITY IMPACT ASSESSMENT

Yes – Equality Impact Assessment attached – Appendix 3

Due regard should be given to the equality implications identified in the EIA.

7. LIST OF BACKGROUND PAPERS OTHER THAN PUBLISHED WORKS OR THOSE DISCLOSING CONFIDENTIAL OR EXEMPT INFORMATION

None

8. PUBLISHED DOCUMENTS REFERRED TO IN COMPILING THIS REPORT

The link to 'Everyone Counts: Planning for Patients 2014/15 to 2018/19' document is below:

http://www.england.nhs.uk/wp-content/uploads/2013/12/5yr-strat-plann-guid-wa.pdf

Better Care Fund planning template – Part 1

Please note, there are two parts to the template. Part 2 is in Excel and contains metrics and finance. Both parts must be completed as part of your Better Care Fund Submission.

Plans are to be submitted to the relevant NHS England Area Team and Local government representative, as well as copied to: NHSCB.financialperformance@nhs.net

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Nottingham City**
Clinical Commissioning Groups	**NHS Nottingham City**
Boundary Differences	**Boundary is coterminous with the City Council**
Date agreed at Health and Well-Being Board:	**26th February 2014**
Date submitted:	**14th February 2014**
Minimum required value of ITF pooled budget: 2014/15	**£10.01**
2015/16	**£24.0**
Total agreed value of pooled budget: 2014/15	**£24.0**
2015/16	**£24.0**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	
By	Dawn Smith
Position	Chief Operating Officer
Date	

Signed on behalf of the Council	
By	Alison Michalska
Position	Corporate Director of Children and Adult Services
Date	

Signed on behalf of the Health and Wellbeing Board	
By Chair of Health and Wellbeing Board	Councillor Alex Norris
Date	

c) Service provider engagement

Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it.

BCF funds now form part of the Integrated Care Programme which has senior sponsorship from Ian Curryer Chief Executive Nottingham City Council, and Dawn Smith, Chief Operating Officer NHS Nottingham City CCG. To ensure operational compliance health and social care providers are involved with this programme via the following groups:-

- The Health and Wellbeing Board
- Health and Wellbeing Commissioning Executive Group (CEG)
- Weekly Better Care Funding sub groups
- The Strategy and Implementation Group for Nottinghamshire South (SIGNS)
- The Urgent Care Board
- The Collaborative Commissioning Congress
- The Integrated Care Programme Board

The Integrated Care Programme aligns with the national agenda for integrating health and social care in which Nottingham City stakeholders and citizens have come together to develop a local vision and programme structure, overseen by a joint board comprising of executive leads from both provider and commissioning organisations under the scrutiny and oversight of the Health and Wellbeing board.

d) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it.

During the analysis phase of the Programme detailed engagement with citizens and carers took place to understand the issues, concerns and strengths of the current health and social care system. This information was used to shape the integrated care model which is now being implemented with on-going newsletters and documentation keeping stakeholders updated with progress.

An engagement plan to ensure that citizens are involved in decision making throughout implementation of the programme is now in place with discussions underway with 'Healthwatch' Re: mechanisms to support the on-going planning processes.

Discussions have been held with HWB3 – the VCS engagement mechanism of the Health & Well-being Board – in relation to the objectives of the Nottingham BCF, the additive elements and how the VCS can be better involved in the Integrated Care programme moving forward

e) Related documentation

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	Synopsis and links
Integrated Care Programme Plan	**Detailed Programme plan describing the new model of integrated care and the projects established to deliver the vision.**
Health and Wellbeing Strategy	**Priority 2 describes Integrated Care and how the Health and Wellbeing Board will monitor outcomes of the planned changes to the health and social care system**
BCF Reconciliation Plan	**Provides detailed breakdown of projects.**

2) VISION AND SCHEMES

a) Vision for health and care services

Please describe the vision for health and social care services for this community for 2018/19.

- What changes will have been delivered in the pattern and configuration of services over the next five years?
- What difference will this make to patient and service user outcomes?

Our Vision is to improve the experience of and access to health and social care services for citizens. More citizens will report that their quality of life has improved as a result of integrated health and care services. The number of citizens remaining independent in the community, including after hospital admission will increase with improved and seamless transfers of care.

To deliver this vision we will undertake an extensive system wide Programme of change that will see local services reshaped to deliver joined up care. The emphasis will be on a more generic model of care across the health and social community rather than single-disease specific care pathways. In approaching care in this way we are able to ensure patients are managed in the community more effectively and efficiently, reducing emergency admissions, re-admissions and supporting the discharge pathway.

The changes will involve the following:-

- Agree the configuration of Care Delivery Groups which incorporates groups of GP practices.
- Reconfigure community services to establish neighborhood care teams that work within the care delivery groups.
- Reconfigure primary care services to share clinical and back office functions
- Reconfigure social care assessment to support the Care Delivery Groups.
- Reconfigure intermediate care services, crisis response and LA reablement and emergency home care services to support independence pathways.
- Align specialist LTC support services to support Care Delivery Groups as appropriate
- Support general practice to provide an early intervention and proactive approach to the management of people with LTCs (including the frail elderly)
- Increase operational delivery to 7 days a week
- Utilize assistive and information Technology

Our vision is shaped by, and continues to be shaped by our citizens and our staff. As an integrated programme of work our citizens will find that:-

- Access to services will be less complex through single points of access and use of web based information allowing self-access
- People will only tell their story once as assessment functions are joined up and information is shared across health and social care
- Citizens will have greater choice and control over their lives and greater support in self care.
- People will have greater self-awareness of how to improve their own health and wellbeing through prevention and healthy lifestyles

- Local communities and individuals will be healthier, live longer and more independently. They will be supported to live with risk and will be less reliant on statutory services
- Hospitals and long term care will be last resorts and only when there is an absolute need that cannot be met outside of these environments
- Organisations will be joined up and will work together to share resources and learning

b) Aims and objectives

Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- What are the aims and objectives of your integrated system?
- How will you measure these aims and objectives?
- What measures of health gain will you apply to your population?

The long term aim of Nottingham City CCG and Nottingham City Council is that through integrated strategies citizens will see a transformed health and social care system. This will be achieved by:

- removing false divides between physical, psychological and social needs
- focussing on the whole person not the condition
- supporting citizens to thrive, creating independence not dependence;
- being tailored to overall need - hospital will be a place of choice, not a default; and
- not incuring delays, people will be in the best place to meet their needs

These aims will be delivered by the following objectives:-

- Develop community health services with social care support linked to groups of GP practices working in geographically proximate areas
- The right care delivered at the right time through Primary care, community services and social care working together in localities; accessing secondary care appropriately.
- Coordinated care through services being delivered by multi-disciplinary teams holding regular MDT meetings.
- Ensure that there is a single person responsible for coordinating the care of citizens with complex needs
- Early identification and intervention of on-going health and social care needs building on risk stratification, risk registers and data held by relevant agencies
- A proactive approach to identify citizens at risk of needing an increased level of care to ensure appropriate support is in place before a crisis situation occurs.
- Restructure and skill up our workforce so that health and social care services work better together to deliver the right care at the right time
- Personalised care planning with access to appropriate specialist support in the community.
- Support to ensure that citizens are empowered to manage their own condition/s
- Support citizens maintain their independence and manage their own care through the creation of effective networks with community, housing and health support services

- Improved transition of care between hospital and community setting.

A performance dashboard will be created and monitored via the Health and Wellbeing Commissioning Executive Group (HWBCEG). The HWBCEG will monitor the following indicators

- Non-elective admissions aged 65+ per 1,000 pop 65+
- Non-elective bed days aged 65+ per head of 1,000 pop 65+
- Non-elective re-admission rate within 30 days
- Non-elective re-admission rate within 90 days
- Excess winter deaths for over 65s
- No of delayed transfer of care days aged 18+ per 100,000 pop
- Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation
- Proportion of people aged 65+ discharged direct to residential care
- Outcome of short-term support to maximise independence for new and existing clients (STS002a/b)
- Permanent admissions to residential / nursing care aged 65+ per 100,000 pop 65+
- Count of clients receiving long-term services (LTS001a)

The following health gains will be seen across the City:-

- Citizens will report that their quality of life has improved as a result of integrated health and social care services
- Reduction of re-admissions <90 days
- Reduction in Length of Stay for General Medical conditions (Frail elderly, LTC)
- Reduction in avoidable emergency admissions
- Increase of earlier diagnosis of dementia
- An increase of older citizens remaining independent after hospital admission
- An increase in citizens who are satisfied with their care and support

c) Description of planned changes

Please provide an overview of the schemes and changes covered by your joint work programme, including:

- The key success factors including an outline of processes, end points and time frames for delivery
- How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

This plan fits with the wider approach to improving health and wellbeing in the city and is a key enabler of the Nottingham Plan (Local Authority strategy for wellbeing) and the Clinical Commissioning Groups 3 year commissioning strategy. The key objective of the Better Care Fund proposal is to improve citizens' experience of care through the delivery of more integrated primary, secondary health and social care services.

Integrating care presents significant transitional and operational challenges. In order to realise our overarching benefit of an Integrated Nottinghamshire, there will be a number

of key success factors:

Strong and Deliberative Engagement - Engagement with all our stakeholders is key to making sure that there is a strong sense of ownership of the change. We will have dedicated groups in place to facilitate this, including our Citizens' Panels and engagement workstreams. We will commission an independent communications team that will work with all parties to ensure engagement and communication is carried out effectively for all stakeholders.

Clinical and Organisational Leadership - Leadership is the single biggest contributory factor to the success or failure of a complex change programme. We will ensure our clinicians and leaders are involved. This programme of change will be led by the Health and Wellbeing Board to ensure the integrity of the programme and drive benefits for citizens.

Programme Management - We understand the necessity of rigorous programme management and will ensure this is identified via the ITF plans so we can assure ourselves on the delivery of our plans, management and escalation of our risks and evaluation of our outcomes.

An Integrated Delivery Team - Our delivery teams will include representation from major stakeholder groups, programme management, design, clinical leadership, information, estates and workforce transformation.

Innovative Finance and Contracting - We are considering how to use contracting mechanisms to promote provider collaboration to ensure optimum outcomes for citizens that are also good value for money. We aim to explore new commissioning models such as Capitated and Outcome-Based Incentivised Contracts (COBIC).

Timely access to Data and Systems - All of the interventions proposed require technology enablement. Our organisations are committed to working on sharing data and providing single records for health and social care through Connected Nottinghamshire.

Workforce and Culture - We are committed to delivering a workforce that meets the needs of patients through innovation, inclusiveness and engagement. Strategic direction is provided by the East Midlands Local Education and Training Board (LETB) and Training Council (LETC). Our culture is also one that is hungry for change. Our staff and our citizens see the value of what we are doing and are proud to be a part of such an important transformation.

The delivery of this project will be carried out in the following 3 phases:

Phase One:-
By end January 2014

Workforce

- The following teams will be reconfigured to support the eight Care Delivery Groups:
  - Community Matrons
  - Community Nursing and rehabilitation including support staff
  - Social care assessment (named link)

- The **care coordinator role** will be established an operational from 8am – 8pm, Monday – Friday.
- Champion roles will be established to support teams implementing new ways of working.
- Workforce engagement plan will be in place

Contractual requirements

- Service specification for the care coordinator service will be agreed.
- Service specification for neighbourhood teams will be agreed.
- Agreement re: approach to the 'alignment' of the services supporting the independence pathway model.

Operational processes

Minimum requirements for Operational processes will be in place for the following:

- MDT team meetings (NB this is supported through the risk stratification DES)
- Access to services in scope of the programme including the care coordinator
- Secondary care interface 'choose to admit' and 'transfer to assess'

Access and navigation

- Proposal to simplify access to services and navigation around the health and social care system will be agreed and a detailed implantation plan in place.

IT and estates

- Information sharing agreements across health and social care will be in place**.**
- Relevant health and social care staff will have access to SystmOne and Care First.
- 8 bases for care delivery coordinators will be confirmed.

Secondary Care interface

- Services will be redesigned to support 'choose to admit' and 'transfer to assess'.

By April 2014

Workforce

- The following services will be aligned to support the independence pathway model:

Reablement pathway	Urgent Response Pathway
Intermediate care at home mainstream (CityCare)	Crisis Response service (CityCare)
Intermediate care at home mental health (CityCare)	Nottingham Emergency Homecare Service NEHCS (NCC)
Intake service (NCC)	Through The Night service (NCC)

Contractual requirements

- Assistive technology: A new telehealth service will have been procured and be operational. Telecare expansion to targeted groups will be in place.
- Service specifications to support independence pathway will be agreed.
- The joint venture will be explored as a mechanism to support the independence

pathway model.
- Agreement re: FAQs eligibility and independence pathway processes.

Operational processes
Minimum requirements for Operational processes will be in place for the following with local implementation developed in the CDGs:
  - Case management
  - Key worker role
- Agreement re: criteria for reablement and community beds to support signposting to appropriate pathway.
- Implementation of the self care pathway to support early intervention.
- Agreement re: how social care assessment process will support the independence pathways.
- Plans for the implementation of comprehensive geriatric assessment will be developed.

Access and navigation
- Nottingham Health and care Point will be integrated to support access to integrated services.

IT and estates
- Shared platform for information sharing to be implemented by 'Connecting Nottinghamshire'

Secondary Care interface
- All referrals from the hospital care coordination team will be transferring patients with a description of care needs, appropriate support will be sourced by the community care coordinators.

Phase Two:-

From April 2014
Workforce
- CDG teams will be supported with additional staff to up skill in Long Term Condition management
- Review of specialist services and integration into neighbourhood teams as appropriate
- Review of social care assessment in pathways including the development of trusted assessors.
- Development of shared roles / holistic worker.
- Reconfigure independence pathway teams to support CDGs as appropriate.

Contractual requirements
- Implementation of joint venture to support independence pathway if agreed.

Operational processes
- Formalise processes to support links to housing and the community and voluntary sector, including workforce opportunities.
- The integrated AT service will be established.
- Support for primary care to work in natural communities.

Access and navigation

- Further development to ensure coordinated support with services out of scope of the programme, for example mental health services.

IT and Estates

- Services supporting CDGs will be collocated where possible.

Phase Three:-

- Continued transfer of specialist support as appropriate into CDGs.
- Continued roll out of IT to support integrated care.
- Continued development of holistic worker role
- Continued development of primary care role in CDGs
- Explore the roll out of integration to other service areas, e.g. mental health services.

Complexity - The model incorporates different levels of complexity to ensure a targeted approach and an appropriate response as citizens move between levels requiring different types of support.

- Complex needs requiring an intensive case management approach, citizens at high risk of unplanned hospital admission.
- Complex LTC and/or care needs deterioration can be managed by a low intensity case management/ monitoring approach, moderate risk of hospital admission.
- Complex LTC (1 or multiple), require enhance support from GP as well as supported self-care.

Secondary Care interface • All referrals from the hospital care coordination team will be transferring patients with a description of care needs; appropriate support will be sourced by the community care coordinators.

d) Implications for the acute sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

The biggest risk to the savings not being realised, is a failure of the integrated care programme to achieve a sufficient magnitude of reduction in demand for acute care. If the required demand reductions are not achieved, then one of 3 situations is likely to occur

- Acute services will not be able to be reduced; There will consequently be a financial shortfall where these were anticipated to be delivering the NHS savings
- Acute services that had already been reduced to achieve the required savings will require putting back in at short notice to deal with the unplanned level of demand. History suggests that having to rapidly put in additional/temporary services is more

costly and provides lower quality than if they were planned.
- Acute services that had already been reduced are unable to be increased to cope with the unplanned demand (either due to inability to recruit necessary staff, or lack of funding in the system to fund the increase in services), resulting in impacts on quality and experience to patients, increased risk of harm, non-achievement of access targets/service standards, and a significant risk to organisational reputations.

The integrated programme aims to mitigate the risks of additional activity in the acute setting by:-

- Enabling, promoting and developing care into the community. This will involve increasing capacity in provision and workforce and working with the local authority to identify gaps and analysis in current provision.
- Prevent additional acute activity by targeting and managing conditions prior to escalation in a holistic way, thus reducing avoidable admissions and ED attendances.
- The plans will be underpinned by data obtained from the Utilisation Review of un-scheduled medical in-patient admissions at NUH, in-patient admissions to Lings Bar Hospital and the Intermediate Care Utilisation Review of bed based and home based services. The 2010 review identified the following reason for admission reviews not meeting the criteria for admission were:
- (one third) External factors e.g. availabilty of Nursing Home Care, community provision, assessment
- (Two-thirds) Internal Trust factors e.g. waits for clinical assessment.
- Appropriately 28.4% did not have a continued need for an acute stay. In most cases, the failure to pass admitted patients from acute to a more appropriate level of care was due to external processes such as capacity constraints in existing services or incomplete discharge planning. Those patients who did not meet the continued stay criteria could have been managed at a lower level of acute care or Home Care or at home with a returning out patient appointment.

Further analysis through the SIGNS group in 2013 concluded that 2,596 patients could have been discharged earlier freeing up 14,090 bed days, over one year. These patients required a range of services in the community including therapy and assessment, 24 hour intensive nursing/therapy assessment, complex sub acute nursing and therapy, nursing and therapy needs which could be managed in the home or low level Reablement services.

The integrated Programme work will see an impact in the acute sector from November 2014

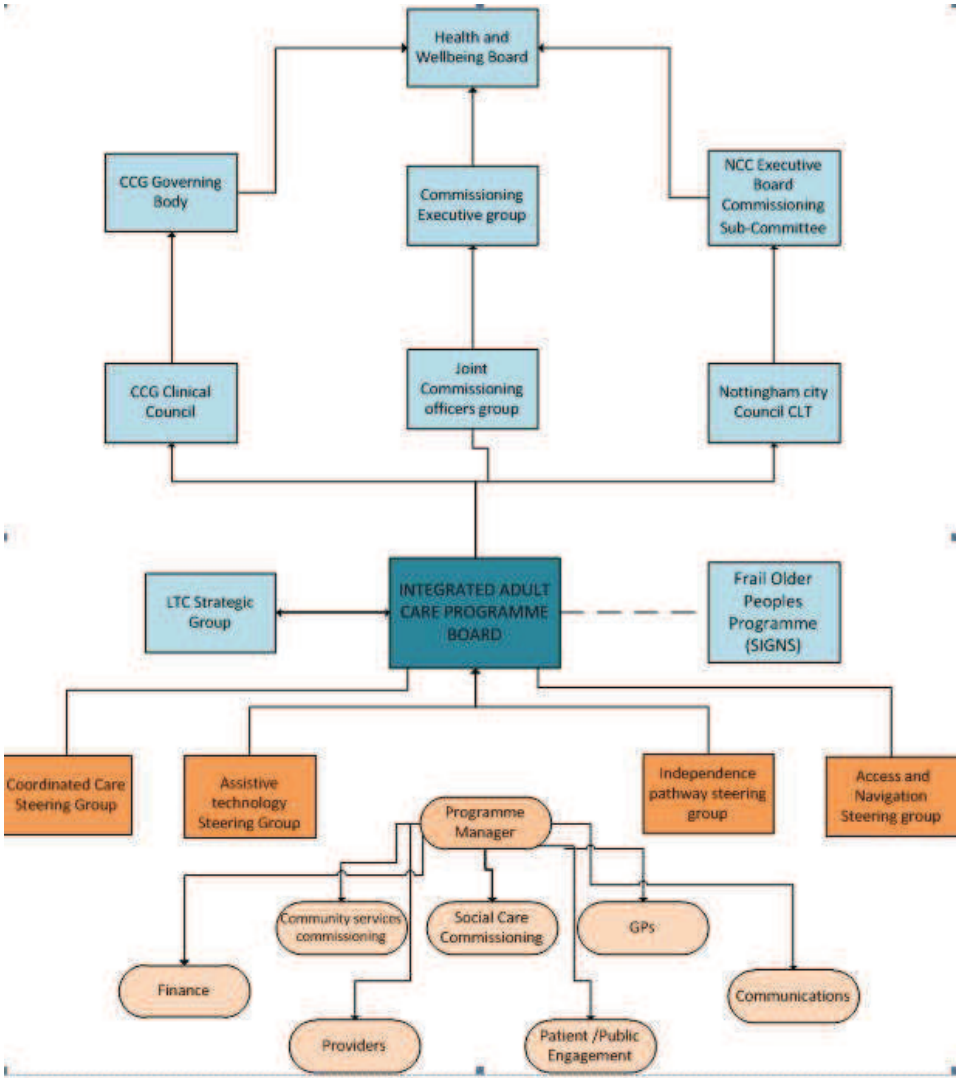
e) Governance

Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

The Commissioning Executive Group (a commissioning sub group of the Health and Wellbeing Board) will hold this transformation to account under the Integrated Care Programme in which clinicians, providers and the Local Authority are key members. Through monthly meetings the HWBCEG will regularly evaluate programme delivery and

financial benefits realisation, ensuring that there are high levels of satisfaction with services through patient, carer and staff feedback, via a performance dashboard of integrated care metrics. An Annual Report will be presented to the Health and Wellbeing Board and subsequent Governing bodies each year. (please see governance map below).

The operational management of the Integrated Transfer Funds will be the responsibility of the ITF programme Manager. This will be incorporated within the ITF plan, and will be a shared position between health and the local authority.



NATIONAL CONDITIONS

a) Protecting social care services

Please outline your agreed local definition of protecting adult social care services

The core commissioning Stakeholders can confirm that the eligibility criteria for accessing adult social care will remain the same. In Nottingham City the eligibility threshold is High Moderate.

In addition to maintaining the current eligibility criteria the local definition of protection for social care services includes the following:

- Ensuring that we can respond to demographic pressures/increasing levels of need in particular; dementia, long-term conditions and younger adults with complex care needs
- Promoting innovation in social care and integration with Health in line with transformation plans to improve social care outcomes and realise savings and efficiencies in both health and social care budgets
- Future proofing – capacity for Care Bill implementation
- Maintaining (not compromising) existing social care model – essential core services, enhancing personalisation, focus on support for carers, promoting enablement, building community capacity

Please explain how local social care services will be protected within your plans

Schemes identified in the plan support the model of integrated care currently being implemented and will therefore support delivery of objectives.

b) 7 day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends

Nottingham City sees 7 day working as a critical component for its planning assumptions to support hospital discharge and avoid admissions to both hospital and care homes.

A crisis coordination team has already been commissioned to support discharge over 7 days with a number of seven day services already in place, such as Rapid Response Teams and Intermediate Care Teams, new services are outlined in the BCF plan that will require further development to ensure that services are in place to meet the identified needs of patients through established working groups while working within the strategic direction of the Adult Integrated agenda.

All relevant providers have been informed of plans to further expand 7 day working

through the 2014/15 contract negotiations.

c) Data sharing

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

The core commissioning Stakeholders can confirm that they are not using the NHS Number as the primary identifier across all health and care services

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

NHS Nottingham City and Nottingham City Local Health Authority are signed up to the Productive Notts IT Programme. A recent IT summit has been held in which all key provider organisations within Nottinghamshire have signed up to IT principles. These principles include shared information and data and the use of the NHS Number as the primary identifier. A rollout of shared data (including single use of the NHS Number) is now planned for summer 2014.

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK)

The stakeholders are committed to sourcing systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practise and in particular requirements set out in Caldicott 2.

Nottingham City is a member of the newly formed Record Sharing Group. This group comprising of clinical, and governance/ Caulidcott leads works together as a health and social care community to develop and implement system-wide best-practice information policies that support the sharing of citizen information. This group works within best practice guidance to ensure the appropriate level of information is available to support the delivery of this programme, safely, securely and in line with legal requirements.

d) Joint assessment and accountable lead professional

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to

risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

Multi-disciplinary teams comprising of both health and social care staff will be working with primary care to identify patients at high risk using the Devon risk stratification tool. Joint decisions re: management of patients will be made at multi-disciplinary meetings. Plans to identify a key worker (lead professional) supported by a joint assessment and care management process are currently underway and will be implemented in April 2014.

3) RISKS

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers

Risk	Risk rating	Mitigating Actions
Acute provider already has significant Cost reduction targets which could impact on quality and delivery if not managed prior to money being removed.	High	Ensure a proposal is discussed around phased activity and finance, to ensure core services are not significantly affected
Increase in ED and admissions capacity	High	Ongoing monitoring of activity with close links to community provision to scale up and down as required
Insufficient skilled resources to manage increased complexity within the community	High	Collaboration with community providers to ensure training and development programmes are in place to manage influx and increase of skills needed.
Implementation of NHS Number	High	Working collaboratively with productive IT to develop Data sharing protocols and systems requirements
Existing contract not fit for purpose to meet shared responsibility	High	Work with stakeholders to understand implications and scope opportunity of developing shared responsibility.
Impact on workforce in regards to remit, responsibility and job description	Medium	Work with HR to ensure staff are engaged with during the process and undertake a training needs analysis.
Insufficient internal resource to streamline discharge of care from acute to community	Medium	Work with NUH to monitor performance of discharge to transfer to assess workgroups.
Confusing access and navigation points	Medium	Collate and migrate existing access points to streamline and remove fragmentation.
Sign up and cultural changes required to enable whole scale change from all partners, including changes to ways of working is not achieved within the timescale	High	On-going leadership from the Integrated Programme Board Early engagement of partners with work programmes agreed in partnership at a senior level

		Planned change management approach for all organisations involved to engage and communicate these changes to the front line
There is a risk that as performance related funding is reliant on outcomes these may not be evidenced in the short to medium term	High	On-going monitoring of outcomes at a senior level through the Integrated Programme Board and Commissioning Executive Group with a robust approach to performance management On-going monitoring and evaluation of programmes to ensure that services/projects within the programmes are fit for purpose and meeting expected outcomes within timescales Services to be procured on an outcomes basis with funding linked to outcomes therefore a shared risk between commissioners and providers
Future changes to national policy in respect of Urgent and Emergency Care (primary care, A&E and OOH) and changes to the primary care contract may impact on delivery of the plan	High	Maintain and sustain strong links and communication channels with Area Team, NHS England
There is a risk that implementation of the changes will impact on the financial stability of providers	High	On-going leadership from the Integrated Programme Board Early engagement of partners with work programmes agreed in partnership at a senior level through Commissioning Executive group Ensure individual projects and overall programme subject to robust analysis and modelling to ensure any financial impact on providers is clear
There is a risk that staff moving from existing services to care delivery groups will destabilise existing services leading to overall loss of performance	High	Reduce scale of services and / or phase delivery to accommodate extended recruitment timescales Use of agency staff to bridge gaps

		Early discussions with regional workforce development teams to facilitate long term recruitment and development planning
Access to Risk profiling Data. Legalities around access.	High	Work collaboratively with information governance team to identify impact, risk and outcomes in a bid to produce a legally appropriate response.
Monitoring data for Delayed transfer of care may not be as accurate as required due to process of 'calling off' section 5 requests to local authority.	High	Working with NUH and LA to ensure accurate process is in place in regards to use of Section 2 and 5.
There is a risk that there is public resistance to the proposed changes and that population behaviour change will not materialise	Medium	Plan to be supported by the on-going development and implementation of a communication and engagement strategy
There is a risk that implementation of the changes will result in an increase in admissions to care homes	Medium	On-going leadership from the Commissioning Executive Group to monitor Bed availably in care home Intermediate Care / Assessment Beds to be used flexibly when necessary
There is a risk that social care funding challenges result in a reduction of available care packages to support long term care resulting in a shift in cost of long term care to	High	Ensure individual projects and overall programme are subject to robust analysis and modelling to ensure that the impact of funding cuts is identified and included
There is a risk that implementation of the changes will impact on the financial stability of providers		Early engagement of partners Via Integrated Programme Board. Ensure individual projects and overall programme subject to robust analysis and modelling to ensure any financial
There is a risk that as performance related funding is reliant on outcomes these may	High	On-going monitoring of outcomes at a senior level through the CEG with a robust approach to

not be evidenced in the short to medium term		performance management On-going monitoring and evaluation of programmes to ensure that services/projects within the programmes are fit for purpose and meeting expected outcomes within timescales Services to be procured on an outcomes basis with funding linked to outcomes therefore a shared risk between commissioners and providers
There is a risk that if the existing contractual arrangements with Nottingham University Hospitals NHS Trust remain unchanged this will have a negative impact on delivery of the plan	High	Early engagement of partners with work programmes agreed in partnership at a senior level
There is a risk that the sign up and cultural changes required to enable whole scale change from all partner organisations, including changes to ways of working is not achieved	Medium	Early engagement of partners with work programmes agreed in partnership at a senior level Planned change management approach for all organisations involved to communicate these changes to the front line

Association

England

Outcomes and metrics

For each metric other than patient experience, please provide details of the expected outcomes and benefits of the scheme and how these will be measured.

The following outcomes and benefits will be seen across the City :-
• Citizens will report that their quality of life has improved as a result of integrated health and social care services
• Reduction of re-admissions <90 days, citizen stating that they feel more supported in the community
• Reduction in Length of Stay for General Medical conditions (Frail elderly, LTC), patients are seen in the most appropriate location.
• Reduction in avoidable emergency admissions
• Increase of earlier diagnosis of dementia to ensure patients receive timely treatment
• An increase of older citizens remaining independent after hospital admission
• An increase in citizens who are satisfied with their care and support

The following performance measures will be put in place and monitored via the Health and Wellbeing Commissioning Executive Group:-
• Non-elective admissions aged 65+ per 1,000 pop 65+
• Non-elective bed days aged 65+ per head of 1,000 pop 65+
• Non-elective re-admission rate within 30 days
• Non-elective re-admission rate within 90 days
• Excess winter deaths for over 65s
• No of delayed transfer of care days aged 18+ per 100,000 pop
• Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation
• Proportion of people aged 65+ discharged direct to residential care
• Outcome of short-term support to maximise independence for new and existing clients (STS002a/b)
• Permanent admissions to residential / nursing care aged 65+ per 100,000 pop 65+
• Count of clients receiving long-term services (LTS001a)

For the patient experience metric, either existing or newly developed local metrics or a national metric (currently under development) can be used for October 2015 payment. Please see the technical guidance for further detail. If you are using a local metric please provide details of the expected outcomes and benefits and how these will be measured, and include the relevant details in the table below

For each metric, please provide details of the assurance process underpinning the agreement of the performance plans

A performance dashboard will be created and monitored via the Health and Wellbeing Commissioning Executive Group (HWBCEG). A joint programme Manager post will have the responsibility for ensuring the necessary performance and outcomes are delivering against the agreed metrics, with the HWBCEG providing oversight and guidance, feeding into the Health and Wellbeing Board through quarterly reports.

If planning is being undertaken at multiple HWB level please include details of which HWBs this covers and submit a separate version of the metric template both for each HWB and for the multiple-HWB combined

Metrics		Current Baseline (as at….)	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Metric Value*		N/A	
	Numerator			
	Denominator			
		(April 2012 - March 2013)		(April 2014 - March 2015)
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Metric Value*		N/A	
	Numerator			
	Denominator			
		(April 2012 - March 2013)		(April 2014 - March 2015)
Delayed transfers of care from hospital per 100,000 population (average per month)	*Metric Value*	10.2	9.9	9.5
	Numerator	27	6.1	5.2
	Denominator	245725	245,	245,
		Apr 12-Sept 13	**(April - December 2014)**	**(January - June 2015)**
Avoidable emergency admissions (composite measure)	*Metric Value*	3.34	2.12	2.09
	Numerator	601	561	521
	Denominator	209,735	308,	308,
		Apr 12-Aug 13	**(April - September 2014)**	**(October 2014 - March 2015)**
Patient / service user experience [for local measure, please list actual measure to be used. This does not need to be completed if the national metric (under development) is to be used]		*(insert time period)*	N/A	*(insert time period)*
Health related quality of life for people with long-term conditions. Weighted EQ-5DTM scores for all responses from people identified as having a long-term condition.	*Metric Value*	69.8	71.5	73.3
	Numerator			
	Denominator			
		(April 2012 - March 2013)	**(April - September 2014)**	**(October 2014 - March 2015)**

Draft Plan
Better Care Fund

Maria Principe

Director Primary Care and Service Integration, NHS Nottingham City Clinical Commissioning Group

Candida Brudenell

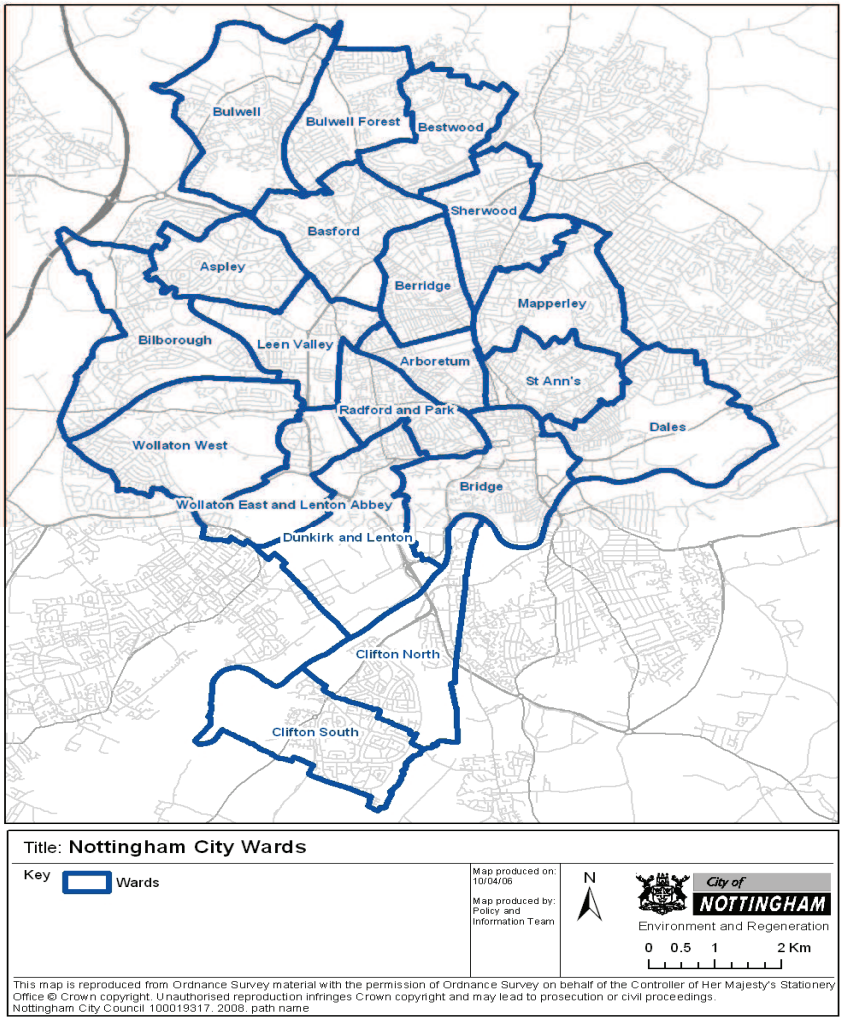
Director Childrens and Adult Service Nottingham City Council

NHS Nottingham City Clinical Commissioning Group

Nottingham City Council

Coverage

This plan covers the boundaries of Nottingham City



NHS Nottingham City Clinical Commissioning Group

Nottingham City Council

National Conditions

- Protection for social care services (not spending)
- 7-day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends
- Better data sharing between health and social care, based on the NHS number
- Joint approach to assessments and care planning and accountable professional
- Agreement on the consequential impact of changes in the acute sector

NHS Nottingham City Clinical Commissioning Group

Nottingham City Council

Nottingham BCF

- NOT new funding
- Additive funding element equates to 5%
- BCF Focus delivering:
  - Integrated Adult Care Programme
  - Chose to Admit
  - Transfer to Assess

NHS Nottingham City Clinical Commissioning Group

Nottingham City Council

Better Care Fund Elements

Schemes:	Investments
Independence Pathway	10,060,093
Coordinated Care	8,118,690
Assistive Technology	1,145,000
Access & Navigation	1,815,852
Management	160,000
Carers	1,041,857
Disabled Facilities Grant	1,863,000
TOTAL INVESTMENT	24,204,492

Nottingham City Council

Citizen Feedback

- The health and social care system is complex; it is difficult to access appropriate support in a timely way.
- Stakeholder engagement events demonstrated a strong shared ambition for the future which includes the following characteristics
  - Simplifying the system
  - Taking an holistic approach
  - Citizen centred / seamless
  - Shared information
  - Services integrated across health and social care
  - Single point of access
  - Joint outcomes

Joint Vision

"We will improve the experience of and access to health and social care services for citizens. More citizens will report that their quality of life has improved as a result of integrated health and care services. The number of citizens remaining independent after hospital admission will increase with improved and seamless transfers of care"

NHS Nottingham City Clinical Commissioning Group

Nottingham City Council

Aim

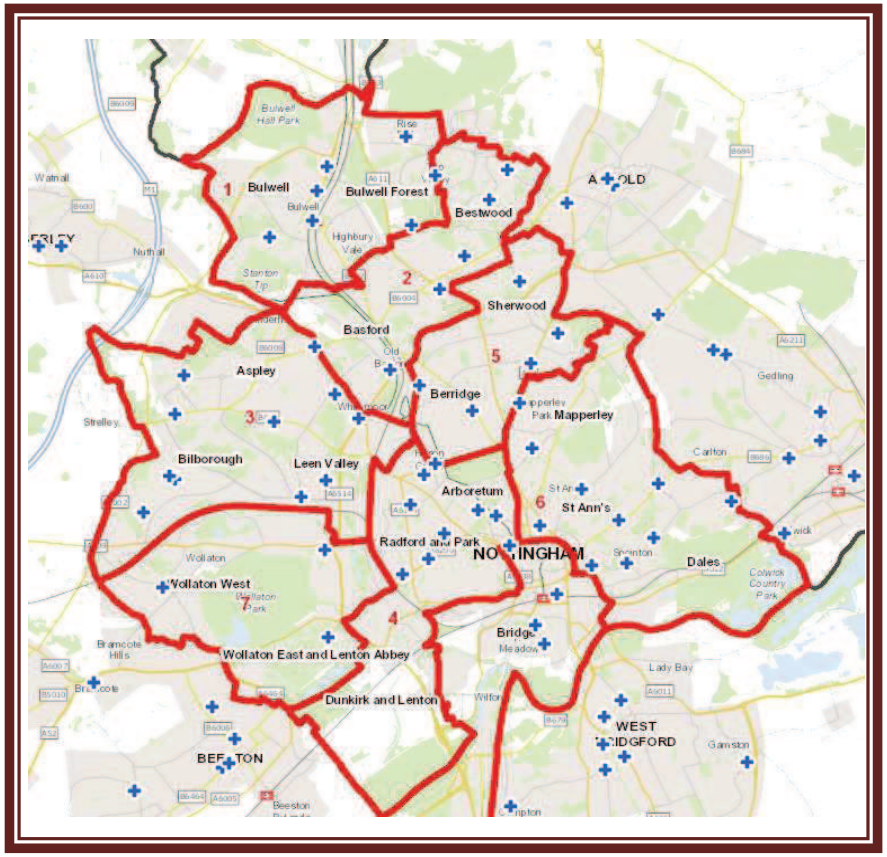
- Remove false divides between physical, psychological and social needs
- Focus on the whole person not the condition
- Support citizens to thrive, creating independence not dependence;
- Services tailored to need - hospital will be a place of choice, not a default; and
- Not incur delays, people will be in the best place to meet their needs

NHS Nottingham City Clinical Commissioning Group

Nottingham City Council

Characteristics of Model

- Single Point of Access
- NHS Number as core patient identifiable link
- Implementation of Care Co-ordinators
- Shared community workforce
- Integration with LA
- Tailored services based on population need with equitable access across all Care Delivery Groups CDGs
- MDT management of patient care
- Access to assistive technology



NHS Nottingham City Clinical Commissioning Group

Objective

- Develop community health services with social care support linked to groups of GP practices working in geographically proximate areas
- Coordinate care through services being delivered by multi-disciplinary teams holding regular MDT meetings.
- Ensure that there is a single person responsible for coordinating the care of citizens with complex needs with access to appropriate specialist support in the community
- Early identification and intervention of on-going health and social care needs building on risk stratification, risk registers and data held by relevant agencies
- Restructure and skill up our workforce so that health and social care services work better together to deliver the right care at the right time
- Support to ensure that citizens are empowered to manage their own condition/s through the creation of effective networks with community, housing and health support services
- Improved transition of care between hospital and community setting.

NHS Nottingham City Clinical Commissioning Group

Nottingham City Council

What programmes will deliver this?

Access & Navigation

Independence Pathway, Staff

Independence Pathway Urgent response

Carers

Independence Pathway/ Community Beds

Coordinated Care

For Ada's sake its time for us to work together better.

Independence Pathway Reablement

Assistive Technology

Capital/DFG

NHS Nottingham City Clinical Commissioning Group

Nottingham City Council

What programmes will deliver this?

Risk profiling

Independence Pathway, Self Care

Independence Pathway Urgent response

7 day access

Independence Pathway/ Community Beds

Care Delivery Groups/Neighbourhood teams

For Ada's sake its time for us to work together better.

Independence Pathway Reablement

Single Point of Access/ Care Co-ordination

Shared data and IT

NHS Nottingham City Clinical Commissioning Group

Nottingham City Council

Nottingham BCF Additive Elements

- Care Coordination Service
- Expansion Health & Care Point
- Tele-health Programme
- MH In reach Discharge Coordinators
- 7 Day Working
- => 18% of total Fund

NHS Nottingham City Clinical Commissioning Group

Nottingham City Council

What will these Programmes deliver?

- Citizens will report that their quality of life has improved as a result of integrated health and social care services
- The health community will see a reduction of re-admissions <90 days
- The acute sector will see a reduction in Length of Stay for General Medical conditions (Frail elderly, LTC)
- The health community will see a reduction in avoidable emergency admissions
- The community will benefit through earlier diagnosis of dementia
- Increased number of patients will remaining independent after hospital admission

What will this mean for Ada?

Right care delivered at the right time in the right place

24/7 Care delivered through MDT,

Workforce skilled to manage her condition at home

One point of contact to co-ordinate her care

Personalised care planning with access to specialist services

Earlier identification and intervention

For Ada's sake its time for us to work together better.

Support to enable her to manage her own condition

Seamless transition of care between providers

Support to enable her to maintain her independence

NHS Nottingham City Clinical Commissioning Group

Nottingham City Council

Appendix 3 Equality Impact Assessment Form

Name and brief description of proposal / policy / service being assessed

Better Care Fund

The Better Care Fund (BCF) (previously referred to as the Integration Transformation Fund) was announced in June as part of the 2013 Spending Round. It provides an opportunity to transform local services so that people are provided with better integrated care and support. It encompasses a substantial level of funding to help local areas manage pressures and improve long term sustainability. The Fund will be an important enabler to take the integration agenda forward at scale and pace, acting as a significant catalyst for change. The Health & Wellbeing Board will be responsible for determining utilisation of the Fund

The Fund will support the aim of providing people with the right care, in the right place, at the right time, including through a significant expansion of care in community settings. This will build on the work Clinical Commissioning Groups (CCGs) and Councils are already doing. It should be noted that only 5% of the funding available through the BCF is new funding – the remainder is an pooling of existing funding streams including:

- Section 256 funding transfer from Health to Social Care
- Reablement Funding
- Carers Breaks Funding
- Disabled Facilities Grant
- Social Care Capital Funding
- Transfer from Acute Health budget

Up to 25% of the BCF budget will be performance related and released on attainment of aspirational targets against the following metrics:

- Residential and Nursing Care Admissions
- Delayed Transfers of Care
- Emergency Hospital Admissions
- More Effective Reablement Services
- Patient & Service User Experience
- Local Measure (to be determined)

The additive elements of the Nottingham BCF plan amounts 18% of the total funding available and will be utilised to develop the following:

- Care Coordination Service to support the Care Deliver Groups
- Expansion of Health and Care Point
- Support 7 Day working across primary care
- Development of the Tele-health programme
- Mental Health In-reach Discharge Coordinators

Information used to analyse the effects on equality

A variety of qualitative and quantitative data has been used to inform this EIA. This includes:

- Statutory Health and Social Care data returns
- JSNA in relation to older people and those with long-term conditions.
- Integrated Adult Care engagement events with Health and Social Care professionals
- Specific engagement with Patient Participation mechanisms and recipients of social care services

Appendix 3 Equality Impact Assessment Form

	Could particularly benefit (X)	**May adversely impact (X)**	How different groups could be affected: Summary of impacts	Details of actions to reduce negative or increase positive impact (or why action not possible)
People from different ethnic groups			The objective of the Integrated Adult Care programme is to streamline and integrate Health and Social Care service delivery models and systems, positively transforming citizen experience of how their needs are met. The development of an integrated care pathway will be of benefit to all those with long-term conditions (including older people with complex needs) will be based on, and responsive to, the aspirations of the citizen and predicated on early intervention, prevention, maximising independence and optimising citizen choice and control. Citizens contacting Health and Care Point will benefit from an integrated and expanded service. This will mean that they are more likely to be routed to the appropriate function to meet their needs (enablement, reablement, crisis) and in a shorter timeframe. The care coordination service will result in a more streamlined service for the frail elderly and those with long-term conditions. The aim of a care coordinator is to complete administration tasks to release clinicians to focus on direct patient contact and support. The role of the care coordinator will be to:- • Navigate and coordinate services to meet individual's needs across the CDG. • Act as a point of contact for professionals, citizens and carers. • Monitor service capacity to assist the CDG to manage demand. • Complete relevant referral documentation and chase referrals as required. • Gather information to support assessment and intervention. • Order and follow up equipment orders. All citizens will benefit from 7 day access to primary care services. BCF funding is concerned with ensuring that there are routes into community health and social care provision and assessment over the weekend. This will in turn facilitate discharge from hospital.	Performance against BCF performance objectives will be monitored across Health and Social Care and reported to the Health & Well-being Board on a bi-annual basis and to the Health & Well-being Board Commissioning Executive Group on a quarterly basis. A particular focus of this will be the value of the additive elements in meeting overall BCF and Integrated Adult Care objectives An evaluation framewrok has been commissioned as part of the Integrated Adult Care programme. A key focus of evaluation will be qualitative data from citizens and health and social care professionals as to the ongoing benefits accrued as a result of the programme. Regular evaluation reports will be provided. to the Integrated Adult Care Programme Board and modifications will be made to the programme as approipriate.
Men, women (including maternity/pregnancy impact), transgender people				
Disabled people or carers	x			
People from different faith groups				
Lesbian, gay or bisexual people				
Older or younger people	x			
Other – please specify				

			People with a long-term condition will benefit from the roll-out of Telehealth. By 2018 200 patients will be able to have their vital signs monitored remotely in a home rather than hospital environment. This will facilitate prevention and enable nurses to focus resources on those with critical care needs The expansion of the Mental Health In-reach Discharge service will benefit those with acute mental health needs by reducing the amount of time taken to facilitate discharge from a hospital to community setting	

Outcome(s) of equality impact assessment:
No major change needed ☒ Adjust the policy/proposal ☐ Adverse impact but continue ☐ Stop and remove the policy/proposal ☐

Arrangements for future monitoring of equality impact of this proposal / policy / service:
Health and Well-being Board Commissioning Executive Group – quarterly monitoring reports

Approved by (manager signature): Antony Dixon – Strategic Commissioning Manager	Date sent to equality team for publishing: Send document or link to equalityanddiversityteam@nottinghamcity.gov.uk

HEALTH AND WELLBEING BOARD – FEBRUARY 26th 2014

Title of paper:	**The CCGs two-year operational plan in response to *Everyone Counts: Planning for Patients 2014/15 to 2018/19***	
Director(s)/ Corporate Director(s):	**Dawn Smith Chief Officer NHS Nottingham City CCG**	**Wards affected: all**
Report author(s) and contact details:	**Dawn Smith, Chief Officer, NHS Nottingham City CCG Email: Dawn.Smith@nottinghamcity.nhs.uk**	
Other colleagues who have provided input:	**Louise Bainbridge, CCG Chief Finance Officer Ray Davey, CCG Deputy Finance Officer**	
Date of consultation with Portfolio Holder(s) (if relevant)		

Relevant Council Plan Strategic Priority:	
Cutting unemployment by a quarter	☐
Cut crime and anti-social behaviour	☐
Ensure more school leavers get a job, training or further education than any other City	☐
Your neighbourhood as clean as the City Centre	☐
Help keep your energy bills down	☐
Good access to public transport	☐
Nottingham has a good mix of housing	☐
Nottingham is a good place to do business, invest and create jobs	☐
Nottingham offers a wide range of leisure activities, parks and sporting events	☐
Support early intervention activities	☒
Deliver effective, value for money services to our citizens	☒

Summary of issues (including benefits to citizens/service users):

On December 20th 2013, NHS England published planning guidance, which set out its proposals for how the NHS budget is invested in order to secure sustainable models of care over the next five years. The CCG has a statutory duty to take account of this guidance when preparing its commissioning plan for the forthcoming financial year and to present the plan to the Health and Wellbeing Board.

This paper provides a summary of NHS England's ambitions for what CCGs and the wider commissioning system will deliver and also presents a summary of the CCG's draft plan.

Recommendation(s):

1	The Health and Wellbeing Board is asked to note the planning guidance produced by NHS England and comment on the CCGs draft plan in relation to whether it sufficiently supports the Joint Health and Wellbeing Strategy.
2	The Health and Wellbeing Board is asked to approve the decision of the CCG to continue the uptake of bowel screening as a local priority associated with the Quality Premium.

1. REASONS FOR RECOMMENDATIONS

1.1 The Health and Wellbeing Board is required in consider whether the CCG's commissioning plan for the coming financial year takes proper account of the Joint Health and Wellbeing Strategy.

1.2 Cancer accounts for around one in four deaths in Nottingham, and half of all such deaths are from lung, bowel, breast and prostate cancers. Cancer is the joint largest contributor to our life expectancy gap for women, and the second largest for men. Cancer is more common in areas with higher levels of deprivation, and is the second highest cause of death in BME groups. Overall, cancer mortality rates in Nottingham are higher than regional and national rates, and the number of new cancers for men is higher than the rest of the East Midlands. Nottingham City has significantly poorer survival rates for cancer, with one-year survival rates for breast, bowel and prostate cancer in the bottom 20 per cent for England. This is thought to be largely as a result of patients leaving it longer before seeing a health professional, meaning that their cancer is more advanced when diagnosed.

2. BACKGROUND (INCLUDING OUTCOMES OF CONSULTATION)

2.1 A summary of NHS England's ambitions for what CCGs and the wider commissioning system will deliver is presented in Appendix 1. In relation to the priorities set out in the Joint Health and Wellbeing Strategy, the guidance requires the following:

2.1.1 Preventing Alcohol Misuse

The guidance is largely silent with respect to any requirements on the CCG to address alcohol misuse specifically. This is largely a reflection of the responsibility for this agenda shifting to the Local Authority. However, the CCG's commissioning and financial plans for 2014/15 enable it to continue with its strategic ambitions to improve cancer prevention and reduce emergency admissions to hospital by supporting public health to tackle alcohol misuse.

2.1.2 Integrated Care: Supporting Older People

This is a particular focus of NHS England's guidance, which places a requirement on the CCG to:

- Invest approximately £50 per over 75 year-old on improving quality of care for older people through support for the "accountable-GP" role
- Take steps to reduce spend on acute hospital services to support the establishment of the Better Care Fund in 2015/16 (see separate paper/presentation)

The CCGs plans allow for both of these requirements to be fulfilled and also enables early establishment of the Better Care Fund in shadow form from 2014/15.

2.1.3 Improving Mental Health

Achieving parity of esteem, (making sure that the CCG is just as focused on improving mental health, as well as physical health. Ensuring that patients with mental health problems don't suffer inequalities, either because of the mental health problem itself or because they then don't get good care for their physical health) is a strong theme in the

guidance. This continues to be a strategic objective of the CCG; its commissioning plan allows it to develop Improving Access to Psychological Therapies, increased community support and improving physical health. Investment will also continue for a scheme to support people with mental health conditions to return to work.

2.1.4 Priority Families

The CCG will continue its programme of work as set out in its three year strategy to improve care pathways for children and young adults. This includes working in partnership with the City Council to implement the family support pathway to identify children and families most at risk of poor outcomes in health, education, and social care.

2.2 Financial allocations

Details with respect to the CCG's investment schedule and shifts in planned expenditure from acute to community are shown in appendix 2.

From 2014/15 all Clinical Commissioning Groups will receive their program allocations based on the new NHS England funding formula. The funding formula aims to balance the three main factors in healthcare needs - population growth; deprivation and the impact of an aging population. For Nottingham City Clinical Commissioning Group the formula shows that the CCG is currently overfunded against its target allocation by 2.11%, so under the agreed pace of change policy it will receive the minimum 2.14% uplift (£8.2m) in 2014/15 and 1.7% (£6.7m) in 2015/16.

The allocation for CCG running costs in 2014/15 remains at the same level nationally; however, individual CCG allocations have not yet been notified. From 2015/16 the running cost allocation will reduce by 10%.

2.2.1 Financial Planning Assumptions 2014/15

CCGs should plan to:

- Deliver a minimum 1% surplus
- Hold a minimum 0.5% contingency
- Set aside 2.5% of funding for non-recurrent expenditure, 1% of which should be focussed on local transformation and preparation for the introduction of the Better Care Fund

2.2.2 Financial Planning Assumptions 2015/16

CCGs should plan to:

- Deliver a minimum 1% surplus
- Hold a minimum 0.5% contingency
- Set aside 1% of funding for non-recurrent expenditure
- Create the Better Care Fund in line with notified amounts.

2.3 Quality Premium

The Quality Premium rewards CCGs for improvements in the quality of the services that they commission and for associated improvements in health outcomes and reducing inequalities. There are seven measures relating to NHS England's outcome ambitions (see appendix 1) and the CCG is required to select a local measure. The Health and

Wellbeing Board is asked to support the proposal for the CCG to include improved screening rates for bowel cancer as its local measure.

3. OTHER OPTIONS CONSIDERED IN MAKING RECOMMENDATIONS

4. FINANCIAL IMPLICATIONS (INCLUDING VALUE FOR MONEY/VAT)

See appendix 2

5. RISK MANAGEMENT ISSUES (INCLUDING LEGAL IMPLICATIONS AND CRIME AND DISORDER ACT IMPLICATIONS)

This is addressed through the CCGs risk framework and relates to the requirement to shift spend from the acute sector and to achieve large scale efficiencies in order to deliver the required level of investment in its priority areas.

6. EQUALITY IMPACT ASSESSMENT

Has the equality impact been assessed?

Not needed (report does not contain proposals or financial decisions)	☐
No	☐
Yes – Equality Impact Assessment attached	☐

Due regard should be given to the equality implications identified in the EIA.

7. LIST OF BACKGROUND PAPERS OTHER THAN PUBLISHED WORKS OR THOSE DISCLOSING CONFIDENTIAL OR EXEMPT INFORMATION

8. PUBLISHED DOCUMENTS REFERRED TO IN COMPILING THIS REPORT

NHS Nottingham City CCG Commissioning Strategy 2013-16
http://www.nottinghamcity.nhs.uk/images/stories/docs/About_us/Publications/Strategy_web.pdf

Everyone Counts: Planning for Patients 2014/15 to 2018/19
http://www.england.nhs.uk/wp-content/uploads/2013/12/5yr-strat-plann-guid-wa.pdf

Appendix 1: Summary of *Everyone Counts: Planning for Patients 2014/15 to 2018/19*

1.1 Five outcome domains and ten measurable ambitions

The guidance reiterates that NHS England wants to see better outcomes in five domains

1. Preventing people from dying prematurely
2. Obtaining the best quality of life for people with long-term conditions, including those with mental illness
3. Ensuring that patients recover quickly and successfully from episodes of ill-health or following injury
4. Ensuring that patients have a great experience of all their care
5. Keeping patients safe and protecting them from avoidable harm whilst they receive care

The critical indicators of success against which progress will be tracked are as follows:

1. Securing additional years of life for the people of England with treatable mental and physical health conditions.
2. Improving the health related quality of life of people with one or more long-term condition, including mental health conditions.
3. Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital.
4. Increasing the proportion of older people living independently at home following discharge from hospital.
5. Increasing the number of people with mental and physical health conditions having a positive experience of hospital care.
6. Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community.
7. Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care.

In addition to these seven measures that fall within the five outcome domains, NHS England has set out a further three measures where they expect to see rapid improvements:

8. Improving health, which must have just as much focus as treating illness
9. Reducing health inequalities.
10. Parity of esteem, making sure that we are just as focused on improving mental as physical health and that patients with mental health problems don't suffer inequalities.

1.2 Direction of Service Development

In response to the Call to Action NHS England has identified that the health care system in England will have to have the following six characteristics if it is to be sustainable and continue to deliver high quality care:

1. ***A new approach to ensuring that citizens are fully engaged in service design and change and that patients are empowered in their own care***

- Extending the Friends and Family Test to community and mental health services and GP Practices by December 2014 and to the rest of NHS services by the end of March 2015

- *Roll-out of personal health budgets to all patients who may benefit, with a right to a Personal Health Budget for NHS Continuing Healthcare patients from October 2014*
- *Expanding the range of patient reported outcome measurements*
- *All patients with a long-term condition to have a personalised care plan available electronically and linked to their GP health record so that they don't have to repeat their details at every new contact*
- *Greater use of telehealth and telecare*
- *Ensuring that by the end of March 2015, data from 90% of GP practices is linked to hospital data*
- *Universal use of the NHS number as the prime identifier with CCGs to asked to secure immediate improvement from providers who do not comply; GP practices must use this in all clinical correspondence from April this year and to transfer patient records electronically*

2. Wider primary care provided at scale

- *Enabling primary care to play a much stronger role with provision of more proactive services, particularly for the frail elderly and those with complex needs, enabled by an integrated system of community-based services*
- *NHS England to work with CCGs to support general practice to work at greater scale and in closer collaboration with other health and care organisations, supported by innovative forms of commissioning and contracting*

3. A modern model of integrated care

- *CCGs will be expected to support practices to transform the care of over 75 year olds and to commission additional services that practices have identified will support an "accountable" GP role. This should include allocating approximately £5 per head of population/£50 per over 75 year old for this purpose*
- *CCGs must demonstrate how individual practices can have the influence that they need over the commissioning of community services, especially end of life care and district nursing to enable them to deliver the accountable GP role in an integrated way*
- *The 2014/15 General Medical Service contract will support this agenda through ensuring that*
    - *all over 75 year olds have an accountable GP who is responsible for overseeing their care*
    - *proactive care management for those with complex needs under the supervision of a named GP, underpinned by more systematic risk profiling*
    - *giving GPs more specific responsibilities for helping monitor the quality of out-of-hours provision and supporting more integrated working with out-of-hours services*
- *It is anticipated that all integrated models will feature a senior clinician working within a team taking full responsibility for people with multiple long-term conditions along with co-ordination of care including lifestyle support, social care, general practice and co-management of hospital episodes*
- *CCGs must include in their plans the actions they will take in 2014/15 to ensure that this programme of work is affordable. Irrespective of whether*

CCGs have released this money, funding will be diverted from their allocations in 2015/16 to create what is referred to as the "Better Care Fund"

4. ***Access to the highest quality urgent and emergency care***

- *NHS England and CCGs to produce a new service specification for 111*
- *Continued requirement for Urgent Care Working Groups to oversee system-wide urgent care resilience planning*
- *Urgent Care Working Groups will be expected to be the vehicle by which investment plans are agreed in relation to the use of funds released as a result of the application of the marginal rate tariff for emergency activity above an agreed baseline*

5. ***A step change in the productivity of elective care***

- *The guidance highlights the need to maximise productivity gains in acute trusts in-line with international comparisons that suggests that more patients can be treated at the same or lower cost*

6. ***Specialised services concentrated in centres of excellence***

- *NHS England anticipates that it will concentrate expertise in 15-30 sites in order to improve quality and ensure that standards are applied consistently.*

The guidance acknowledges that setting out these six characteristics does not mean that there is an expectation that services will be delivered in the same way everywhere; it is for local communities to determine the delivery vehicle that best suits local geographies and capabilities.

1.3 Maintaining the focus on essentials

NHS England has set out four essential elements that will apply to all of the above characteristics in every health community:-

1. ***Quality***

- All commissioners are required to put quality at the centre of what they do with the CQC making definitive judgments on quality in providers.
- There are three "non-negotiables" which relate to delivering expectations set out in *The Francis Report*; *transforming care: A national response to Winterbourne View Hospital* and the *Bewick review into patient safety*
- Continued zero tolerance of MRSA and an ongoing focus on reducing *Clostridium difficile*
- Commissioners required to take prompt action if providers are judged by the CQC as "requiring improvement" or "inadequate" and to inform the CQC if they become aware of a quality or risk issue in a provider
- Commissioners are required to respond more proactively to patient complaints and to develop a strong relationship with their local Healthwatch
- Plans should address how measurable improvements will be made in patient experience and that there is continued investment in generating feedback
- CCGs should ensure that local areas of action in the "Compassion in Practice" implementation plan for the 6Cs[1] strategy for nursing, midwifery and care giving are reflected in the services that they commission.
- Attention should be given to staff satisfaction surveys and the staff Friends and Family Test as an indicator of quality

[1] care, compassion, competence, communication, courage and commitment

- An action plan for delivering the Seven Day Services Forum Standards for urgent and emergency care should be reflected in local contracts for 2014/15 and consideration given to a local CQUIN for the standard relating to time taken for a consultant assessment
- Demonstrating how safeguarding duties will be discharged must be reflected in local plans

2. Access to services

- Improving outcomes for patients by ensuring that services are available for people when they need them and in a way which is convenient for them and fits with their daily lives; tailored services for disadvantaged and minority groups is considered key to this
- All plans must address how access will generally be improved but specifically detail how constitutional standards will be delivered

3. Driving change through innovation

- Commissioners should actively understand where research is taking place within their contracted providers and support this activity wherever possible, as well as seeking out other research opportunities

4. Value for money

- Commissioners must demonstrate a systematic approach to securing value for money

Appendix 2: Investment Schedule
Table 1

Investment funds available over the 5 year planning period.

Investments:	2014/15 £m	2015/16 £m	2016/17 £m	2017/18 £m	2018/19 £m
Recurrent	6.2	9.5	3.0	3.1	3.1
Non Recurrent:					
Transformation Fund	3.9	4.0	4.1	4.1	4.2
Local Investments	7.4	4.7	1.8	1.1	1.0
Total Non Recurrent	11.3	8.7	5.9	5.2	5.2
Total Investments	**17.5**	**18.2**	**8.9**	**8.3**	**8.3**

Table2

Efficiency challenge over the five year period:

Efficiency Requirement	2014/15 £m	2015/16 £m	2016/17 £m	2017/18 £m	2018/19 £m
QIPP Challenge	6.0	6.6	5.0	5.5	6.4

Chart 1: Acute to Community split of Planned Spend at 2014/15

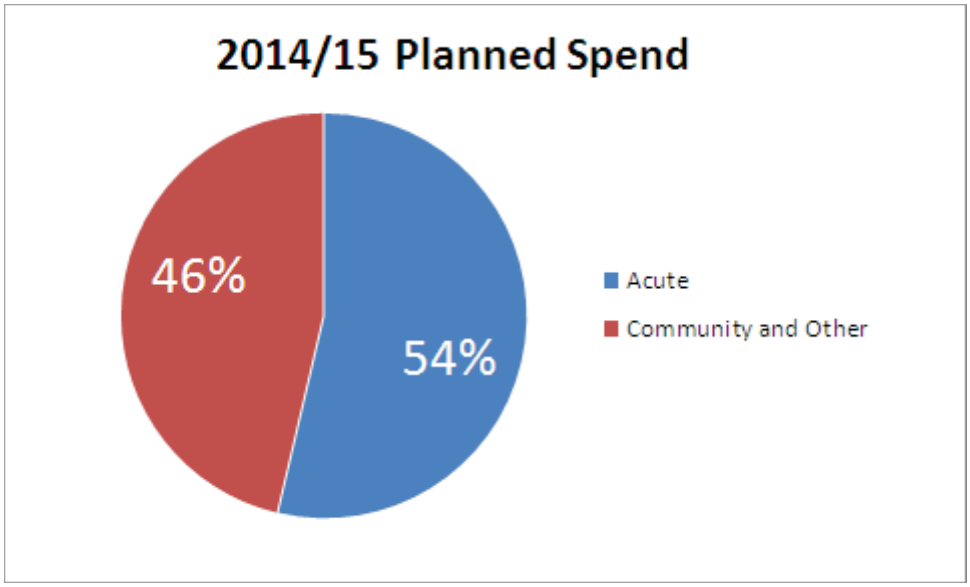


Chart 2: Acute to Community split of Planned Spend at 2018/19 to show movement from Acute to Community

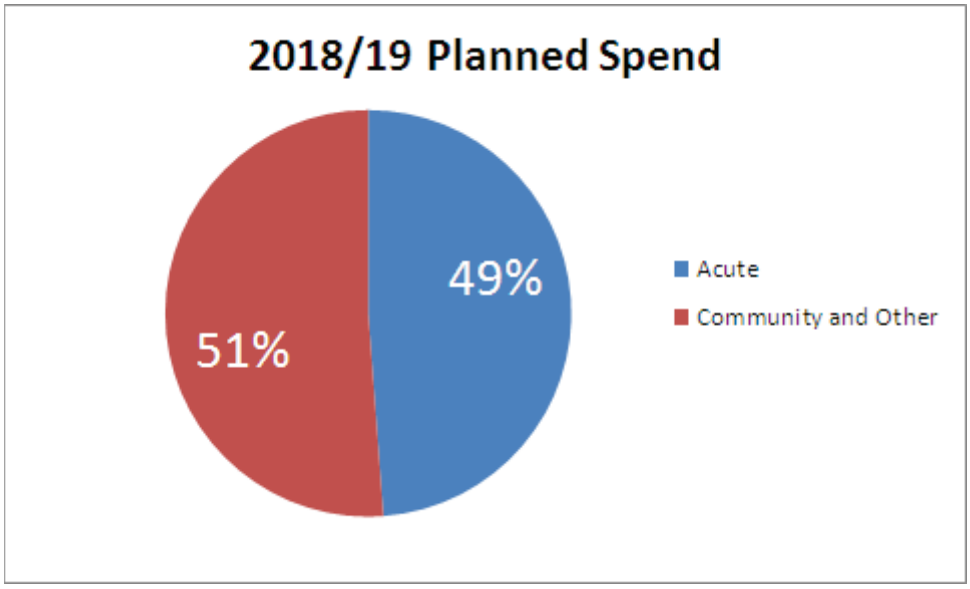
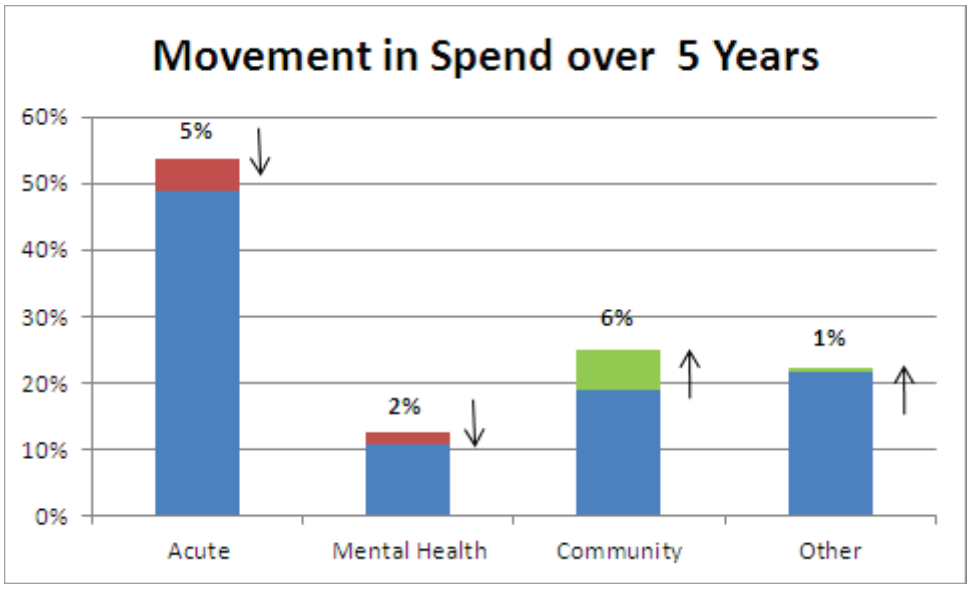


Chart 3: Movement in spend to show Acute, Mental Health, Community and Other



Health and Wellbeing Board February 2014

Title of paper:	**Arrangements for health protection**	
Director(s)/ Corporate Director(s):	**Chris Kenny** **Director of Public Health**	**Wards affected: ALL**
Report author(s) and contact details:	**Jonathan Gribbin** **Consultant in Public Health** **jonathan.gribbin@nottscc.gov.uk**	
Other colleagues who have provided input:	**Dr Vanessa MacGregor** **Public Health England**	
Date of consultation with Portfolio Holder(s) (if relevant)	**n/a**	

Relevant Council Plan Strategic Priority:	
Cutting unemployment by a quarter	☐
Cut crime and anti-social behaviour	☐
Ensure more school leavers get a job, training or further education than any other City	☐
Your neighbourhood as clean as the City Centre	☐
Help keep your energy bills down	☐
Good access to public transport	☐
Nottingham has a good mix of housing	☐
Nottingham is a good place to do business, invest and create jobs	☐
Nottingham offers a wide range of leisure activities, parks and sporting events	☐
Support early intervention activities	☐
Deliver effective, value for money services to our citizens	☐

Summary of issues (including benefits to citizens/service users):

- As part of the changes introduced through the Health and Social Care Act 2012, local authorities assumed a health protection duty, delegated to them by the Secretary of State for Health
- Local authorities' new health protection duty is to provide information and advice to relevant organisations so as to ensure all parties discharge their roles effectively for the protection of the local population
- Guidance envisages that it is the director of public health (DPH) who is responsible for the local authority's contribution to health protection, and that this is primarily a leadership not a managerial function which depends on the capacity of the DPH and his team to influence other parts of the system
- The DPH for Nottingham City has established arrangements to secure assurance that health protection outcomes for the population are maintained and improved

Recommendation(s):	
1	To note the new health protection duty of the local authority in the reformed health system
2	To be assured about the arrangements of the Director of Public Health to secure assurance about outcomes for residents.

1. REASONS FOR RECOMMENDATIONS

The Health and Social Care Act 2012 introduced significant change to arrangements for health protection, including a new duty for local authorities.

2. BACKGROUND (INCLUDING OUTCOMES OF CONSULTATION)

1. Health protection is the domain of public health action which seeks to prevent or reduce the harm caused by communicable diseases, and to minimise the health impact of environmental hazards such as chemicals and radiation, and extreme weather events.

Health protection duty arising from recent reforms

2. On April 1st 2013, local authorities assumed a health protection duty, delegated to them by the Secretary of State for Health who has the overarching duty to protect the health of the population. (This was enacted under regulation 8 of the Local Authority Regulations 2013, made under section 6C of the National Health Service Act 2006, as inserted by section 18 of the Health and Social Care Act 2012.)

3. The same reforms also established a range of new organisations, some of which have specific health protection responsibilities. For example,

    a. Public Health England (PHE) brings together a wide range of public health functions and now has the responsibility to deliver the specialist health protection response to incidents and outbreaks which was formerly provided by the Health Protection Agency
    b. The Area Team of NHS England provides the co-chair and managerial support for the Local Health Resilience Partnership which, along with preparedness, coordinates any NHS multi-agency response to an emergency
    c. NHS England also hosts the Public Health England team with responsibility for implementation of national screening and immunisation programmes in Nottinghamshire
    d. NHS Clinical Commissioning Groups commission treatment services which comprise an important component of strategies to control communicable disease.

4. Local authorities' new health protection duty is to provide information and advice to relevant organisations so as to ensure all parties discharge their roles effectively for the protection of the local population[1].

5. Guidance envisages that it is the director of public health (DPH) who is responsible for the local authority's contribution to health protection, and that the role is "not a managerial, but a local leadership function" which depends on the capacity of the DPH and their team "to identify any issues and advise appropriately".

6. The scope of this leadership role extends to arrangements for the **preventative** aspects of health protection (e.g. national screening and immunisation programmes commissioned by NHS England[2], and the implementation of other local strategies for the control of communicable diseases by NHS and other organisations) and for **health**

[1] Protecting the health of the local population: the new health protection duty of local authorities. DH, PHE, LGA. May 2013.

[2] National programmes for screening and immunisation are set out in Immunisation & Screening National Delivery Framework & Local Operating Model. PHE, NHS England. May 2013.

emergency preparedness, resilience and response[3] (for which the DPH is co-chair of the Local Health Resilience Partnership). The role also encompasses alerting and advising relevant commissioning organisations about arrangements required to address needs related to **treatment** services for some communicable diseases (e.g. treatment services for TB and for hepatitis).

7. This leadership role of the DPH mainly relates to functions for which responsibility for commissioning or coordinating lies with other organisations in the system. In addition to this, the local authority itself has a direct health protection commissioning responsibility for sexual health services, health checks, and for community infection prevention and control.

Arrangements for providing assurance on health protection to the Health & Wellbeing Board

8. The DPH chairs the Nottinghamshire County and Nottingham City Health Protection Strategy Group, whose remit is to seek assurance regarding outcomes and arrangements relating to health protection for people in Nottinghamshire County and Nottingham City. Membership of the group includes a range of other partners, who commission or provide elements of the overall health protection system in Nottinghamshire including: environmental health colleagues from local authorities, NHS clinical commissioning groups, NHS England Derbyshire & Nottinghamshire team, and Public Health England.

Developing the preventative aspects of the local health protection system

9. Nottinghamshire City Council has commenced a review of arrangements for Community Infection Prevention and Control in order to ensure that it has affordable arrangements in place for addressing the future needs of the local population. Progress on this will be monitored by the Health Protection Strategy Group.

10. The Screening and Immunisation Team hosted by NHS England's Area Team leads the local implementation of national immunisation programmes in Nottinghamshire City including the introduction of a rotavirus vaccine (to protect babies against gastroenteritis), a shingles vaccine (to protect older people against herpes zoster), seasonal flu vaccine for two and three year olds, and changes to the Meningitis C programme which will align its delivery to the teenage Td/IPV vaccine. Future changes to the national programmes will also include introduction of a seasonal flu vaccine for adolescents. The same team is also responsible for effective local implementation of national screening programmes. Assurance related to outcomes and arrangements for these programmes is secured through the membership of public health colleagues in the local programme boards and through the Screening and Immunisation Team's membership of the Nottinghamshire County and Nottingham City Health Protection Strategy Group.

Developing the response aspects of the local health protection system

11. Planning and preparation for emergencies requiring a multi-agency health response is coordinated by the Local Health Resilience Partnership (LHRP), which shares the same footprint as the Local Resilience Forum (LRF). The LHRP is co-chaired by the local authority director of public health and the director of the NHS England Area Team with

[3] Health Emergency preparedness, resilience and response refers to the functions and duties of organisations within the health system, which are coordinated by the Local Heath Resilience Partnership.

responsibility for leading on emergency planning, through whom links to the LRF are maintained. Current priorities for the LHRP include: development of robust major incident plans, monitoring and planning for hazards identified as "high" and "very high" risks, agreement of mutual aid arrangements. Assurance related to arrangements for health emergency planning will be reported to the Health and Wellbeing Board via the Health Protection Strategy group.

12. Incidents and outbreaks which are of smaller scale may not require a full multi-agency response. Nevertheless, some further work is required to refine local arrangements to ensure that colleagues in the local Public Health England team have ready access to the resources and points of contact to make a timely response to a suspected outbreak. Assurance related to arrangements for this will be secured through the Health Protection Strategy group.

Developing treatment aspects of the local health protection system

13. NHS Clinical Commissioning Groups fund the provision of treatment services for communicable diseases. Public Health Nottinghamshire County & Nottingham City ensure that local NHS commissioners receive appropriate advice about gaps in provision and evidence about what works, to ensure that health protection related needs are addressed effectively. Current work includes better arrangements for identifying people with Hepatitis C virus, and public health advice to TB Stakeholder groups.

Health protection in the Public Health Outcomes Framework

14. Public Health England has published the Public Health Outcomes Framework which describes measurable outcomes associated with the vision to improve and protect the health and wellbeing of the population, and improve the health of the poorest fastest[4]. One of four domains within the framework relates to health protection and contains 27 indicators. Many of these relate to immunisations. Each outcome is based on the most recent available information and is refreshed periodically. As the outcome framework is updated, the health protection indicators will be monitored by the Health Protection Strategy group.

3. OTHER OPTIONS CONSIDERED IN MAKING RECOMMENDATIONS

None.

4. FINANCIAL IMPLICATIONS (INCLUDING VALUE FOR MONEY/VAT)

The duties of the local authority for health protection are funded through the public health grant. The duties of other organisations on which the system relies for health protection (e.g. Public Health England, NHS England) are funded independently of the local authority.

5. RISK MANAGEMENT ISSUES (INCLUDING LEGAL IMPLICATIONS AND CRIME AND DISORDER ACT IMPLICATIONS)

[4] Background documents about the Public Health Outcomes Framework are available at https://www.gov.uk/government/publications/healthy-lives-healthy-people-improving-outcomes-and-supporting-transparency

6. EQUALITY IMPACT ASSESSMENT

Has the equality impact been assessed?

Not needed (report does not contain proposals or financial decisions) ✓

7. LIST OF BACKGROUND PAPERS OTHER THAN PUBLISHED WORKS OR THOSE DISCLOSING CONFIDENTIAL OR EXEMPT INFORMATION

None

8. PUBLISHED DOCUMENTS REFERRED TO IN COMPILING THIS REPORT

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HEALTH AND WELLBEING BOARD 2014

Title of paper:	**Increasing protection of Nottingham City residents against vaccine preventable disease**	
Director(s)/ Corporate Director(s):	Chris Kenny Director of Public Health	**Wards affected:** **ALL**
Report author(s) and contact details:	**Linda Syson-Nibbs & Caroline Jordan** **NHS England Screening & immunisation team for Derbyshire & Nottinghamshire** **Contact via jonathan.gribbin@nottscc.gov.uk**	
Other colleagues who have provided input:	**Jonathan Gribbin** **Consultant in Public Health**	
Date of consultation with Portfolio Holder(s) (if relevant)		

Relevant Council Plan Strategic Priority:	
Cutting unemployment by a quarter	☐
Cut crime and anti-social behaviour	☐
Ensure more school leavers get a job, training or further education than any other City	☐
Your neighbourhood as clean as the City Centre	☐
Help keep your energy bills down	☐
Good access to public transport	☐
Nottingham has a good mix of housing	☐
Nottingham is a good place to do business, invest and create jobs	☐
Nottingham offers a wide range of leisure activities, parks and sporting events	☐
Support early intervention activities	X
Deliver effective, value for money services to our citizens	X

Summary of issues (including benefits to citizens/service users):

- As part of the changes introduced through the Health and Social Care Act 2012, commissioning arrangements for the delivery of national immunisation programmes have changed
- Protection for people in Nottingham City against vaccine-preventable disease has been extended by the recent MMR catch up programme, ongoing efforts to address unmet need in the population, and by the successful introduction of four new national programmes

Recommendation(s):

1	Note for assurance the commissioning arrangements for national immunisation programmes and recent improvements in immunisation uptake in Nottingham City

1. REASONS FOR RECOMMENDATIONS

1.1 As part of the changes introduced through the Health and Social Care Act 2012, commissioning arrangements for the delivery of national immunisation programmes have changed.

1.2 Ongoing efforts to address unmet need have resulted in an extension to protection against vaccine-preventable disease.

2. BACKGROUND (INCLUDING OUTCOMES OF CONSULTATION)

Please see the attached summary paper and accompanying appendix which contains supporting detail.

3. OTHER OPTIONS CONSIDERED IN MAKING RECOMMENDATIONS

None

4. FINANCIAL IMPLICATIONS (INCLUDING VALUE FOR MONEY/VAT)

None - national immunisation programmes are commissioned through NHS England.

5. RISK MANAGEMENT ISSUES (INCLUDING LEGAL IMPLICATIONS AND CRIME AND DISORDER ACT IMPLICATIONS)

None

6. EQUALITY IMPACT ASSESSMENT

Has the equality impact been assessed?

Not needed (report does not contain proposals or financial decisions)	✓
No	☐
Yes – Equality Impact Assessment attached	☐

Due regard should be given to the equality implications identified in the EIA.

7. LIST OF BACKGROUND PAPERS OTHER THAN PUBLISHED WORKS OR THOSE DISCLOSING CONFIDENTIAL OR EXEMPT INFORMATION

8. PUBLISHED DOCUMENTS REFERRED TO IN COMPILING THIS REPORT

Public Health England

NHS England

Increasing the protection of people in Nottingham City against vaccine-preventable disease

The Health & Wellbeing Board is requested to:-

1. Note for assurance the commissioning arrangements for national immunisation programmes and recent improvements in immunisation uptake in Nottingham City

Background

After the provision of clean drinking water, immunisationprogrammes are one of the most cost effective health protection interventions and a cornerstone of public health practice. High immunisation rates arekey to preventing the spread of infectious disease, complications and possible early death among individuals.

Immunisation programmes aim to protect the population health through both individual and herd immunity (also known as community immunity).Herd immunity is achieved when a sufficient proportion of the target population are immunised to suppress the spread disease to non-immune or unimmunised individuals. For most infectious diseases in the national programmes, official estimates are that an uptake of 95% of the population is required to ensure herd immunity. This constitutes a target level for the population[1].

High immunisation uptake rates support good school attendance and educational attainment, reduced inequalities, and healthy independent living in later years.

Commissioning arrangements and responsibilities

Under Section 7a of the National Health Service Act 2006 and the Health and Social Care Act 2012, NHS England are responsible for the commissioning of national immunisation programmes. This responsibility is transacted locally though NHS England Area Teams. Each Area Team has an 'embedded' Public Health EnglandScreening and Immunisation Team to provide public heath expertise and support to the commissioning process.

Immunisation programmes are commissioned against sixteen nationally determined services specifications (https://www.gov.uk/government/publications/public-health-commissioning-in-the-nhs-2014-to-2015 to ensure consistency of service provision across England.

The AreaTeam commission immunisation services from a range of providers including primary care, school nursing and health visiting services as well as acute hospitals providers.

[1] When there is sufficient immunity to slow down the spread of a disease in a population, this is referred to as community immunity (sometimes called 'herd immunity'). It is critical to note that although this results in slowing down the spread of the disease within the overall group, it does not provide protection to the small number of unimmunised individuals who may still come into contact with someone who is infected. These individuals still need to be immunised to be protected; without this, they remain at risk.

The quality and performance of these programmes are monitored through the Nottinghamshire County and Nottingham City Immunisation Programme Board. Assurance is provided to the Director of Public Health through the Nottinghamshire County & Nottingham City Health Protection Strategy Group.

Appendix A is a detailed report of the commissioned immunisation programmes and associated uptake in Nottingham City and Nottinghamshire County for key immunisation programmes.

On an annual basis, local rates of uptake for many of these are included in the health protection section of the Public Health Outcomes Framework and the local Nottingham plan.

Addressing health inequalities

Improving individual and community uptake of vaccination can only be achieved through collaborative working between service providers and community groups, supported by active cooperation of organisational leaders (e.g. employers, Head Teachers) to provide settings in which to deliver the programmes.Some population groups such as looked after young people, may require additional support and different approaches to enable them to take up the offer of vaccinations. This approach is endorsed through guidance from the National Institute for Health and Care Excellence (NICE). For example the Nottingham CityCare Specialist Practitioner for Immunisations health visitor coordinates and provides an individualised service provision to vulnerable groups through an agreed working protocol with general practices. This collaborative working has contributed to the programme successes.

Immunisation achievements

Appendix A details programme specific performance but of specially note is

- The successful introduction of four new national immunisation programme during 2013
- The high uptake of human papilloma virus(HPV) vaccinationin the city that reached the national target andexceeded Nottinghamshire County for the 2012/13 cohort
- The success of the measles, mumps and rubella (MMR) outbreak mitigation plan that resulted in increased uptake of MMR vaccination in children and young people aged 10–16 years. There have been no reported cases of measles in Nottingham City since May 2013
- Across Nottingham City, the uptake of MMR vaccination amongst children aged 2 years has reached 93% uptake (see Appendix A), which is an improvement of about 20 percentage points compared to 2007-08.

Immunisation Challenges

Appendix A shows that whilst improvements are being observed the City remains below 95% uptake for a number of programmes as detailed in Table 1 below.

Table 1 Recorded uptake in Nottingham City for selection of childhood immunisations as at 2013-14 Quarter 2.

Immunisation programmes in Nottingham City	**Recorded %uptake for the eligible population at cut-off date**
Age 1 Diptheria, tetanus, pertussis, polio and haemophillus influenza B vaccine	92.7%
Age 2 Measles, mumps and rubella (MMR) primary	93.0%
Age 5 years Measles, mumps and rubella (MMR) second	85.8%
Age 5 Diptheria, tetanus pertussis and polio (pre-school booster)	87.0%

Further developments and challenges

Communities and populations are ever changing and the challenge to commissioners and service providers is to adapt and improve the way we deliver series to maintain and improve immunisation uptake rates. The Immunisation Programme Board has an annual work plan to deliver planned developments for 2014/15 including:

- Audit of vaccine preventable hospital admissions
- Review of commissioning models for teenage vaccination programmes
- Continued support for Looked After Children and traveller communities though specialised community services
- Expansion of the seasonal flu programme to all children aged four years and, dependent on national guidance, up to age 17 years

Regarding the children's seasonal flu expansion, at the time of writing, the details of how this programme extension will be rolled out are yet to be determined nationally.However, there is an expectation that immunisation should be offered through school based programmes.

The Screening and Immunisation Team have started initial discussions regarding this with Local Authority Public Health School Nursing commissioners, primary care including and the Local Medical Committeeand School Nursing providers to discuss potential future delivery models. The views of Local Authority education leads and Head Teachers including Academy Head Teachers will be an essential part of this too, as will be their support in implementing any new arrangements.

Linda Syson-Nibbs
Screening and Immunisation Lead
31.1.14

Caroline Jordan
Screening and Immunisation Manager

Public Health England

NHS England

NHS ENGLAND AREA TEAM DERBYSHIRE AND NOTTINGHAMSHIRE

IMMUNISATIONS PROGRAMMES UPDATE TO NOTTINGHAM CITY AND NOTTINGHAMSHIRE HEALTH PROTECTION STRATEGY GROUP AND HEALTH AND WELLBEING BOARDS

JANUARY 2014

Introduction

This paper updates the Nottingham City and Nottinghamshire County Health Protection Strategy Group and Health and Wellbeing Boards on immunisation uptake in Nottingham City and Nottinghamshire County including progress on the introduction of new national immunisation programmes during 2013 and a progress report on the measles, mumps and rubella (MMR) catch up programme for 10-16 year olds.

New national immunisation programmes

A number of new immunisation programmes were introduced during 2013. These include:-

- Change in the Meningitis C programme
- Introduction of rotavirus vaccine
- Introduction of shingles vaccine
- Introduction of seasonal flu vaccination to all two and three year olds

In response to these new programmes, the Screening and Immunisation Team planned and delivered a number of new immunisation workshops for primary care and other clinicians during June 2013. Eight were held across Nottingham City and Nottinghamshire.

Change in the Meningitis C programme

Summary

- The removal of the second dose of MenC at age 16 weeks from the routine schedule for infants from 1 June 2013
- Introduction of an adolescent MenC booster dose at around age 14 years (school year 10) for the academic year 2013-14
- The adolescent MenC booster dose, together with the adolescent tetanus, diphtheria and polio (Td/IPV) vaccine, should be given routinely at age 13-14 years; it is intended that, over time, there will be a planned, coordinated, country-wide approach to enable areas to move towards giving these vaccines between the ages of 13-14 years (School Year 9); the national letter suggests that this should be delivered through a schools immunisation programme;

NB. Td/IPV vaccine is administered solely by primary care in Derbyshire County. This vaccine is funded in primary care through the General Medical Services (GMS) Global Sum or Personal Medical Services (PMS).

Primary care ceased administering the second dose of MenC at age 16 weeks from 1 June 2013. With regard to the requirement to administer both the MenC and Td/IPV vaccines at the same time, discussions are continuing with both Nottingham City

Council and Nottinghamshire County Council public health school nursing commissioners, Nottinghamshire Healthcare Trust Health Partnership and Nottingham CityCare School Nursing Services and primary care, including Nottinghamshire Local Medical Committee (LMC), to clarify the current status of the models and contracts for the delivering the current Td/IPV vaccine programme and how this might be considered for not only MenC vaccine, but consideration of other and future teenage vaccines – see later.

For Td/IPV vaccine in Nottingham City, there has been a mixed delivery model i.e. by primary care and school nursing services. In Nottinghamshire County, Nottinghamshire Healthcare Trust Health Partnership Health Partnership School Nursing deliver this. In addition to the county based school nursing service, primary care can also administer this vaccine in response to individual patient requests or children that are not in school.

Rotavirus vaccine
This oral live vaccine was introduced from July 2013 to the childhood immunisation schedule to protect babies against rotavirus gastroenteritis. It comprises two doses given at ages two and three months administered four weeks apart along with other primary vaccines. It is delivered by primary care. The first complete measurement of the uptake on this new vaccine for children aged one year will be available in the 2014-15 Cover of Vaccination Evaluated Rapidly (COVER) Quarter 1 data at the end of August 2014.

Shingles vaccine
This vaccine is being introduced from September 2013 for people aged 70 years (routine cohort) and 79 years (catch-up cohort) to protect against herpes zoster. It is being delivered by primary care. The first complete measurement of the uptake of this new vaccine for the routine and catch up cohorts will be through an Annual Shingles Survey in August 2014. This will entail a manual and automated collection from all GP practices. The first eleven months of the uptake from September 2013 for uptake in 2013/14 will be through a sentinel collection so only GP practices who are with a GP IT Supplier that have the capability to extract data automatically will participate in this survey.

Many GP practices were hoping to give this vaccine at the same time as the seasonal flu vaccination. However, most practices have been unable to do this due to national vaccine supply shortages. The current position is that capped numbers of vaccine are available to order per week by each practice.

The uptake on IMMFORM of the vaccine up to 30.11.13 in each Clinical Commissioning Group area (CCG) and for the whole Area Team for GP Sentinel practices is shown below in Table 1

Table 1

Clinical Commissioning Group (CCG)	Uptake age 70 years 30.11.13	Uptake age 79 years 30.11.13
Nottingham City	42.0%	36.4%
Newark and Sherwood	43.7%	47.9%
Nottingham North & East	43.7%	48.2%
Nottingham West	53.8%	49.7%
Mansfield and Ashfield	44.5%	45.1%
Rushcliffe	38.8%	37.2%
Derbyshire & Nottinghamshire	44.8%	44.5%

Seasonal flu vaccination to all two and three year olds
This is an extension of the existing seasonal flu immunisation programme. It is a phased introduction over the next three years of Fluenz which is a live nasal vaccine to include all children aged two to 17 years inclusive. During the 2013-14 season, as part of the national plan, the Area Team has commissioned the vaccination of all two and three year olds through primary care.

In addition to the programme for two and three year olds, there are six pilots for children aged four to ten years are being carried out across England. Most of these pilots are testing school based models but one is also piloting a community pharmacy based approach to inform the future roll out of the programme. The nearest pilot area is in the Leicestershire and Lincolnshire Area Team with whom the Screening and Immunisation Team have close links.

NHS England and Public Health England now wish to implement an accelerated rollout of this immunisation programme to all children up to age 17 years (Year 12) during the 2014-15 season to maximise the protection to the wider population from the spread of any flu virus. It is expected that this programme will be commissioned from primary care for children aged 4 years (in addition to the two and three year olds).

A national workshop in December 2013 was attended by the two of the Screening and Immunisation Team members to explore the different options for this accelerated roll out to school age children. The challenges around this are managing the scale of this to approximately 188,229 - 55,031 children in Nottingham City and 133,198 children in Nottinghamshire County within a short time i.e. before implementation from September 2014. The Screening and Immunisation Team are aware of the reviews of the school nursing service by public health departments in both local authorities in their role as leading the commissioning of school nursing. NB. In Derbyshire, no immunisations are given by school nurses – all are given by primary care e.g. HPV vaccination and school leaving booster vaccinations.

As part of the on-going planning for this the Screening and Immunisation Lead and Manager have already had initial discussions in November about this programme with both Local Authority Public Health School Nursing commissioners. The team are also starting to scope and explore through completion of a national template in January what might be reasonably and practically considered. The opportunity to discuss this further at both the Nottingham City and Nottinghamshire Health Protection Strategy Group and Health and Wellbeing Boards is welcomed.

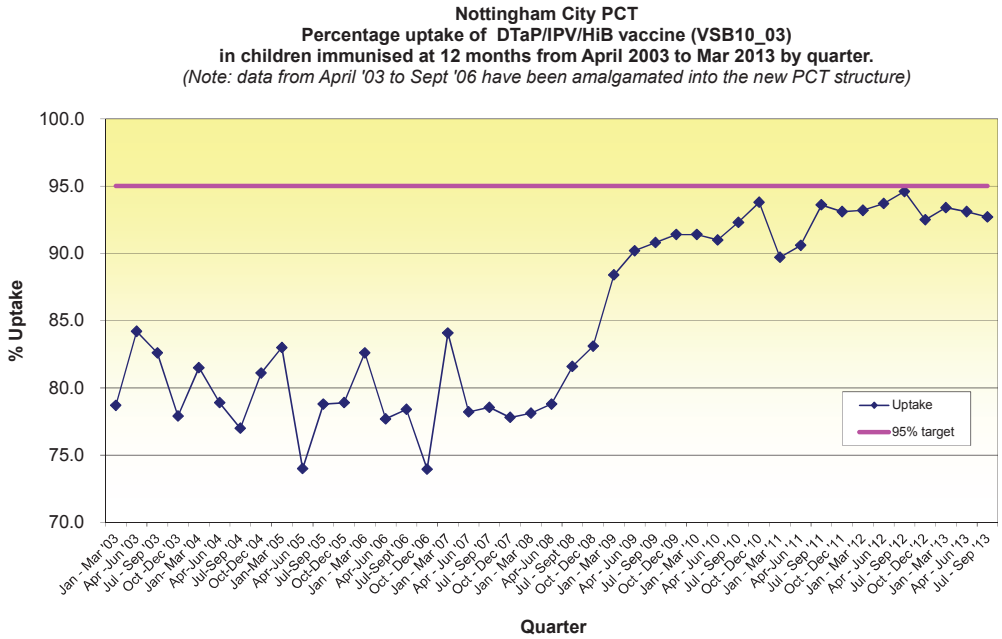
Implications for the future of adolescent immunisation programmes

The introduction the teenage MenC vaccine aligned to the teenage Td/IPV vaccine programme, along with the future introduction of seasonal flu vaccine to all children aged up to 17 years in addition to the existing Human Papilloma Virus (HPV) vaccine to girls aged 12-13 years (Year 8) raises a number of questions about the future delivery models for all these vaccines to adolescents. It is therefore timely that there is a strategic review of this. The Screening and Immunisation Team have started initial discussions regarding this with Local Authority Public Health School Nursing commissioners, primary care including and Local Medical Committees and School Nursing providers to discuss potential future delivery models. The views of Local authority education leads and Academy Head Teachers will be an essential part of this too.

Childhood Immunisation uptake in Nottingham City

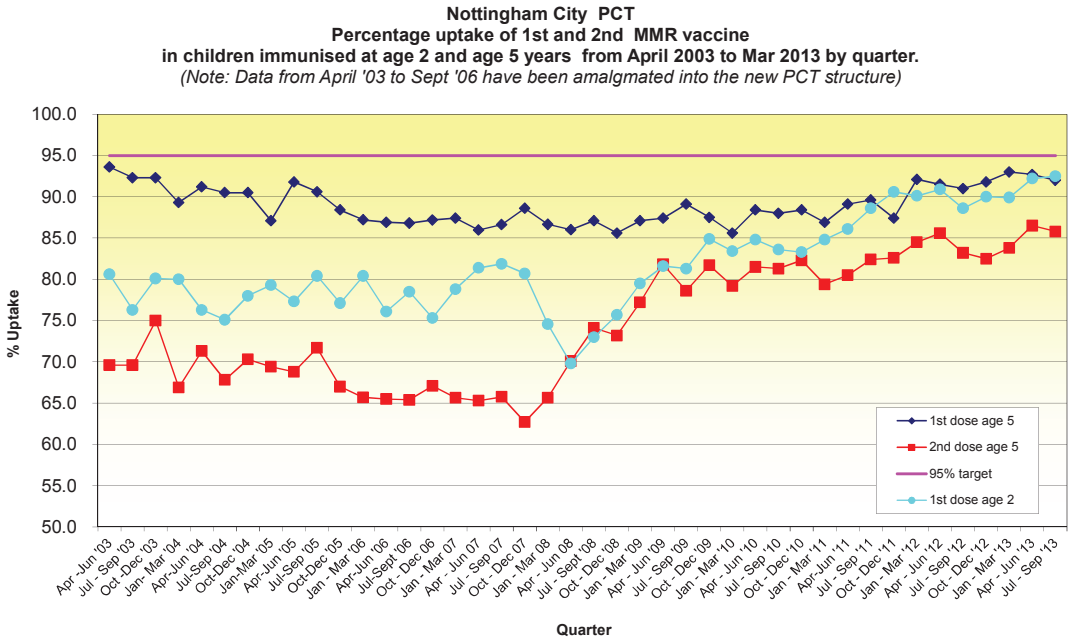
The uptake of the childhood immunisation programme in Nottingham City continues to improve year on year towards the 95% herd immunity target. The uptake for the key tracer immunisations measured at ages one, two and five
Years up to 2013-14 Quarter 2 are shown below.

Graph 1
Age 1 Diptheria, tetanus, pertussis, polio and haemophillus influenza B vaccine



- 2013-14 Quarter 2 – 92.7% - down slightly by 0.4%

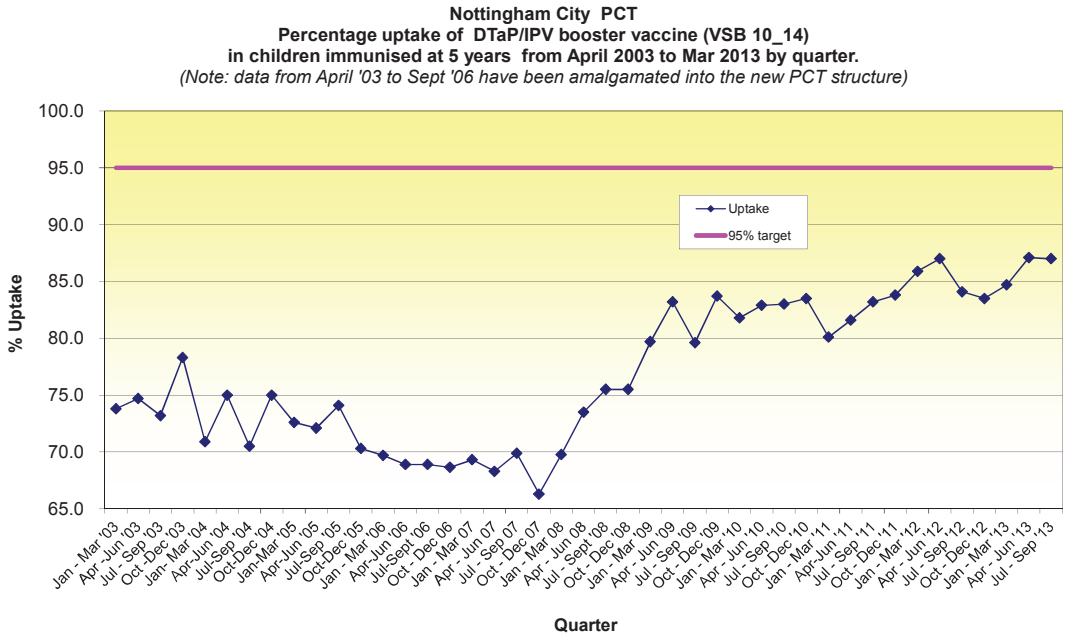
Graph 2
Age 2 and 5 years Measles, mumps and rubella (MMR) primary and secondary



2013-14 Quarter 2

- Primary MMR age 2 years – 93.0% - highest ever level – up 0.8% from Quarter 1
- Second MMR age 5 years – 85.8% - down slightly by 0.7%

Graph 3
Age 5 Diptheria, tetanus pertussis and polio (pre school booster)



- 2013-14 Quarter 2 – 87.0% - maintaining performance from Quarter 1

This improvement in performance is following targeted actions over the last four years to support practices through a number of actions. These include:-

- Practice leadership, data cleansing, improved recording and reporting and call and recall processes
- Practice and Nottingham CityCare Child Records Department support to cleanse data
- Promotion of good practice in immunisation programmes also championed by Nottingham City Clinical Commissioning Group (CCG)
- Increase in supportive work from Nottingham CityCare health visiting service
- Supportive information, advice and visits to underperforming practices by the Area Team
- Circulation of self-audit tool to practices

There has been close cooperative work with Nottingham City Clinical Commissioning Group (CCG) through their lead GP for children and families, CCG visits to practices including immunisations and frequent communication in the CCG newsletter 'Connect'. More recently, following the Quarter 1 performance, the positive improvement across the CCG was highlighted in the newsletter including in at least one practice whose patients comprise a highly mobile population.

NHS Nottingham City Public Heath (previously) and now the Area Team, Nottingham City CCG and Nottingham CityCare have also worked together in the development of

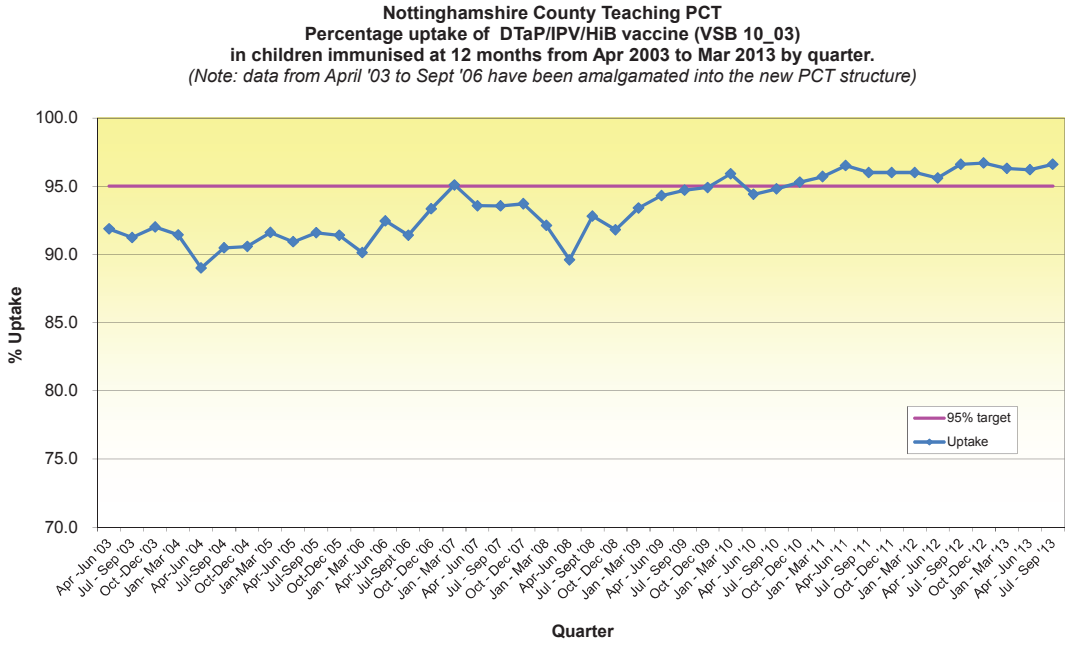
a protocol between primary care and the health visiting teams to support the referral of un/under immunised vulnerable hard to reach children to the health visiting team for home immunisation and to encourage attendance at primary care for future immunisations. The impact of this is currently being evaluated.

Immunisation uptake in Nottinghamshire County 2013-14 Quarter 2

Clinical Commissioning Group (CCG)	Age 1 Diptheria, tetanus, pertussis, polio and haemophillus influenza B vaccine	Age 2 Measles, mumps and rubella (MMR) primary and secondary	Age 5 years Measles, mumps and rubella (MMR) second	Age 5 Diptheria, tetanus pertussis and polio (pre-school booster)
Newark and Sherwood	96.6%	92.5%	92.1%	92.7%
Nottingham North & East	95.7%	94.4%	88.7%	89.7%
Nottingham West	96.6%	94.9%	93.0%	92.1%
Mansfield and Ashfield	96.5%	95.4%	91.9%	90.4%
Rushcliffe	97.7%	96.9%	96.5%	96.3%
All Nottinghamshire	96.5%	94.7%	91.8%	91.4%
Nottingham City	92.7%	93.0%	85.8%	87.0%

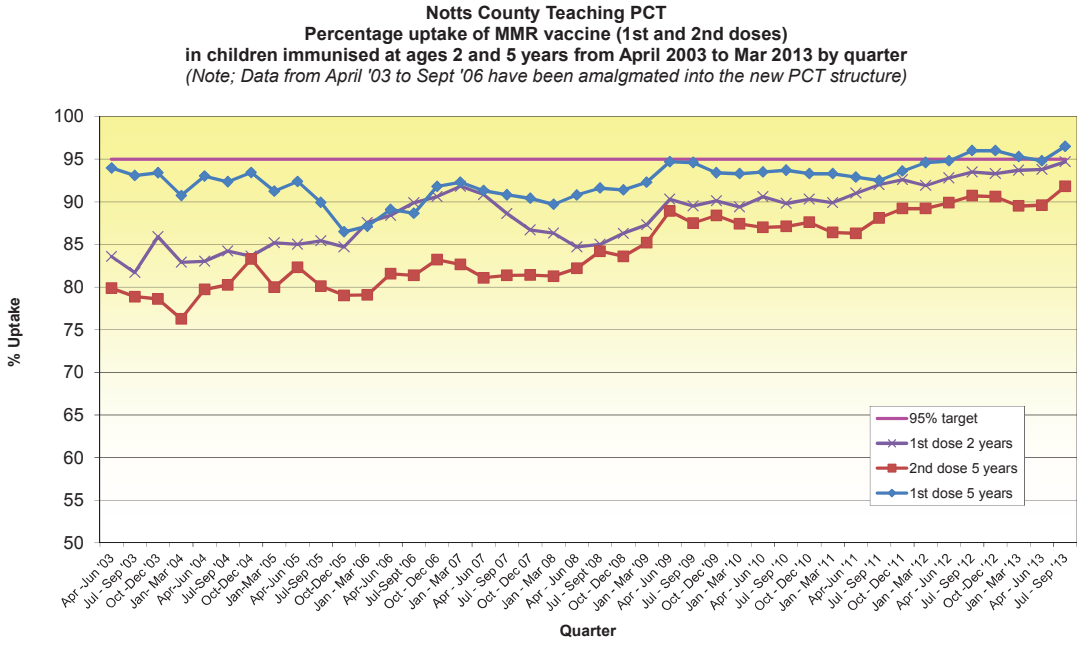
The uptake of the childhood immunisation programme in Nottinghamshire County remains high and above the 95% herd immunity target for most vaccine measure points. The uptake for the key tracer immunisations measured at ages one, two and five years up 2013-14 Quarter 2 are shown below along with the latest Quarter 2 COVER data performance.

Graph 4
Age 1 Diptheria, tetanus, pertussis, polio and haemophillus influenza B vaccine



- 2013-14 Quarter 2 – 96.5% - up 0.3% from Quarter 1

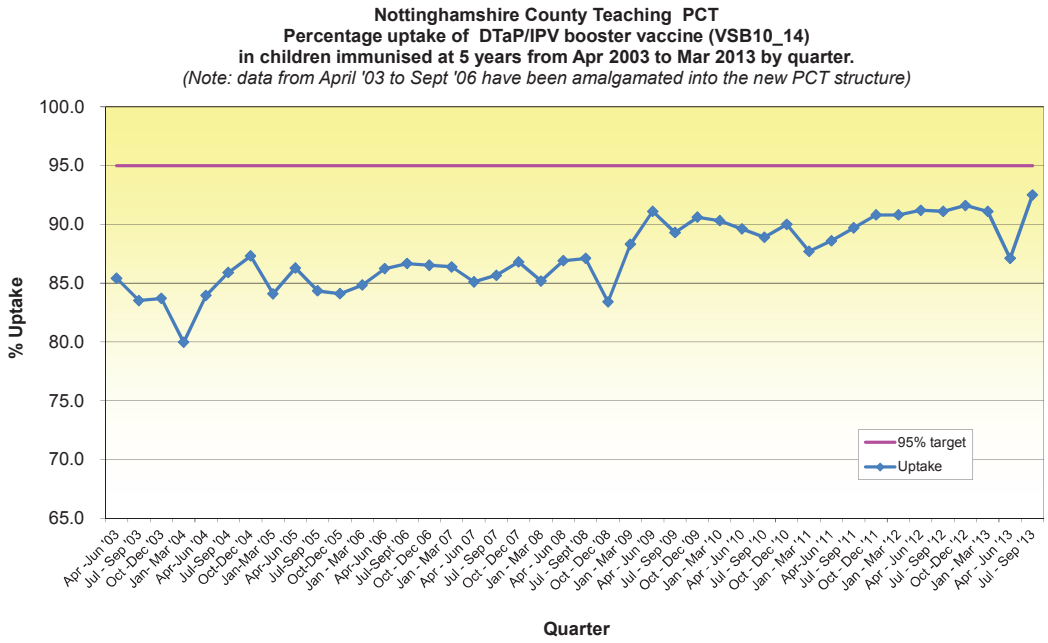
Graph 5
Age 2 and 5 years Measles, mumps and rubella (MMR) primary and secondary



2013-14 Quarter 2 –

- Primary MMR age 2 years – 94.7% - highest ever level – 0.3% short of herd immunity target
- Second MMR age 5 years – 91.8% - highest ever level

Graph 6
Age 5 Diptheria, tetanus pertussis and polio (pre school booster)



- 2013-14 Quarter 2 – 91.4% - up by 4.3% from Quarter 1 and just short of highest ever at 91.6% in 2012-13 Quarter 3

Work is underway to maintain the performance and supportive actions through liaising with the Clinical Commissioning Groups and through the Area Team giving supportive information and circulation of self-audit tool. Mansfield and Ashfield CCG have been particularly supported data cleansing and identified a Locality Development Manager to champion and support practices. Practices have also benefited from an extensive visiting programme previously undertaken by the Primary Care Trust.

For both authorities, the Screening and Immunisation Team are also working closely with their Public Health Area Team colleagues who commission health visiting services to ensure the future inclusion in service specifications for their role in not only promoting immunisation, but in cases of need, immunising vulnerable unimmunised children.

Human Papilloma Virus (HPV) vaccine
This national programme is administered routinely to all girls in Year 8 age 12-13 years by the School Nursing Services in Nottingham CityCare and Nottinghamshire Healthcare Trust Health Partnership. This programmes run from September to August i.e. by academic year. This vaccine requires three doses to be administered over six months. The annual figures for year 2012-13 are due soon. Indications are that uptake for all three doses is close to the 90% target in Nottingham City and Nottinghamshire County. The uptake for 2011-12 is shown below.

Table 2
HPV Year 8 uptake 2012- 2013 *(2011- 2012)*

	Dose 1	Dose 2	Dose 3
NHS Nottingham City	91.3% (91.4%)	90.8% (91.1%)	90.0% (89.6%)
NHS Nottinghamshire County	91.8% (93.2%)	90.3% (91.5%)	86.3% (89.8%)

The achievement of the 90.0% target in Nottingham City for the first time for dose three of this vaccine is very positive and notable due to the assertive follow-up approach by Nottingham CityCare School Nursing service and on-going monitoring of cohort numbers of by the Child Health Records Department. The drop in performance in Nottinghamshire is being investigated by the Trust at a locality level. The Area Team are also establishing contract and performance meetings with both providers.

Seasonal influenza vaccine
The 2013-14 seasonal influenza vaccine programme runs from September to January. The first national letter published in June outlined the requirements and priority groups for this year's programme covering all people aged over 65 years, people in clinical at risk groups aged 6 months to under 65 years and all pregnant women. The target uptake is 75% for all of these groups.

See page 3 for update on children's seasonal flu campaign developments. The expected target uptake is 75% as outlined in the national service specification although this is not stated in the national letter about this programme.

There is also a health and social care workers flu vaccination programme for frontline staff. Planning and implementation of this programme is led through a county-wide implementation group.

Uptake for primary care in the 2013-14 season up to 31.12.13 from bulk upload NB. final data for 31.12.13 due mid-January

Nottingham City - for 57/62 practices	
Age 65yrs	70.8%
Age 6mths-<65yrs in a clinical at risk group	46.5%
All pregnant women	33.0%
Pregnant women at risk	49.6%
Pregnant women not at risk	31.6%
2 years NOT in a clinical at risk group	37.6%
2 years and in a clinical at risk group	51.6%
All age 2 years	37.9%
3 years NOT in a clinical at risk group	31.5%
3 years and in a clinical at risk group	45.8%
All age 3 years	32.0%

Rushcliffe CCG for 14/15 practices

Age 65yrs	78.4%
Age 6mths-<65yrs in a clinical at risk group	51.6%
All pregnant women	46.0%
Pregnant women at risk	65.8%
Pregnant women not at risk	44.3%
2 years NOT in a clinical at risk group	47.9%
2 years and in a clinical at risk group	53.3%
All age 2 years	48.0%
3 years NOT in a clinical at risk group	45.8%
3 years and in a clinical at risk group	69.2%
All age 3 years	46.7%

Nottingham West CCG for 12/12 practices	
Age 65yrs	75.6%
Age 6mths-<65yrs in a clinical at risk group	55.2%
All pregnant women	45.3%
Pregnant women at risk	70.0%
Pregnant women not at risk	43.1%
2 years NOT in a clinical at risk group	53.7%
2 years and in a clinical at risk group	54.2%
All age 2 years	53.8%
3 years NOT in a clinical at risk group	51.3%
3 years and in a clinical at risk group	59.1%
All age 3 years	51.6%

Nottingham North and East CCG for 21/21 practices	
Age 65yrs	72.5%
Age 6mths-<65yrs in a clinical at risk group	48.8%
All pregnant women	42.9%
Pregnant women at risk	60.2%
Pregnant women not at risk	41.4%
2 years NOT in a clinical at risk group	45.0%
2 years and in a clinical at risk group	72.7%
All age 2 years	45.7%
3 years NOT in a clinical at risk group	41.7%
3 years and in a clinical at risk group	54.7%
All age 3 years	42.3%

Newark and Sherwood CCG for 15/15 practices	
Age 65yrs	76.5%
Age 6mths-<65yrs in a clinical at risk group	47.5%
All pregnant women	47.2%
Pregnant women at risk	59.2%
Pregnant women not at risk	46.2%
2 years NOT in a clinical at risk group	45.9%
2 years and in a clinical at risk group	52.9%
All age 2 years	46.1%
3 years NOT in a clinical at risk group	45.2%
3 years and in a clinical at risk group	70.0%
All age 3 years	46.0%

Mansfield and Ashfield CCG for 31/31 practices

Age 65yrs	74.2
Age 6mths-<65yrs in a clinical at risk group	49.2
All pregnant women	44.3
Pregnant women at risk	56.5
Pregnant women not at risk	43.2
2 years NOT in a clinical at risk group	46.0
2 years and in a clinical at risk group	60.9
All age 2 years	46.4
3 years NOT in a clinical at risk group	43.5
3 years and in a clinical at risk group	57.4
All age 3 years	43.9

Healthcare workers flu vaccination uptake to 30.11.13

Organisation	**Uptake**
NUH	60.5%
SFHT	64.6%
Nottinghamshire Healthcare Trust	34.3%
Area Team including Nottingham CityCare	48.6%

Progress report on the measles, mumps and rubella (MMR) catch up programme for 10-16 year olds

The Area Team MMR catch up programme for 10-16 year olds continues to be implemented through primary care in both local authorities and supported by Nottingham CityCare in Nottingham City. The target is for 95.0% of 10-16 year olds to have at least one dose of MMR.

At the time of the catchup programme the most recent data (August 2012 annual IMMFORM survey) showed that uptake in this age group is:-

- Nottinghamshire County – 96.7%
- Nottingham City – 89.5% (a more recent interim update recorded an uptake of 90.7% as at 23.12.13)

The biggest challenge is in demonstrating improving uptake in Nottingham City is related to the accuracy of the data. All practices, supported by Nottingham CityCare Child Records Department, have undertaken a data cleansing exercise.

Nationally, Public Health England and NHS England required all Area Teams to produce MMR Phase 2 actions plans for mid September. The priority for Phase 2 plans is around the introduction of school based programmes based on local need. It has been agreed that Nottingham City is the local priority area for consideration.

Nottingham CityCare Child Health Records Department has supported the identification of the three city schools and the GP practices that have most (n. 362) of the school children registered with them with the highest numbers of children with no MMR vaccination. These are:-

- Djanogly City Academy (highest)
- Nottingham Academy (second highest)
- The Nottingham Emmanuel School (third highest).

This targeted Phase 2 vaccination plan by Nottingham CityCare school nurses has been funded through the Area Team and is currently being completed in these three

secondary schools in addition to the existing primary care and health visiting protocol. The final report on is due from Nottingham CityCare on 17.1.14. Initial information shows that consents were gained from 20% of those invited which compares favourably with a Phase 1 plan elsewhere in the country that had a 12% return. The conversion of these to being vaccinated will be in the final report. Early indications showing that there has been a 20% return of consent forms with approximately 15% of the total invited being vaccinated or subsequently confirmed as already vaccinated.

This is in addition to the on-going primary care programme and supportive work done with Nottingham CityCare utilising the already agreed Primary Care/Health Visiting protocol to follow- up un/under immunised children. This work is being led by the Specialist Health Visitor for Immunisations. This is continuing to demonstrate the intense challenge for practices and Nottingham CityCare to follow up a complex mobile population who often are no longer living in the city, yet remain on both the practice lists and CHIS. The mobility of this population runs ahead of accurate national population data used by the CHIS in order to calculate accurate cohort lists.

It is encouraging too that there have been no confirmed cases of measles locally since May 2013.

Vaccine Patient Group Directions (PGDs)
Legislation establishing PGDs was introduced in 2000 and the Health Care Service (HSC 2000/026) provided additional guidance. A PGD must be signed by a doctor and a pharmacist, both of whom should have been involved in developing the direction. Vaccine PGDs provide a legal framework to allow registered nurses to administer a vaccine to a pre-defined group of patients, without them having to see a prescriber. PGDs are widely used in primary care to facilitate the administration of immunisations.

There are two historical and existing different processes in Derbyshire and Nottinghamshire to develop vaccine PGDs. The Nottinghamshire based model has been developed through a long established health communitywide group for primary care and other Trusts whereas PGDs in Derbyshire have been developed by Southern Derbyshire CCG Medicines Management Team (MMT) for primary care only. Other Derbyshire providers access these and authorise them for their own use within their own organisations.

Following the publication of national National Institute for Health and Clinical Excellence (NICE) and two national letters in 2013, the Screening and Immunisation Team are reviewing the current processes for the development and authorisation of vaccine PGDs through a multiagency stakeholder group. A number of options were discussed. A recommendation is to be taken through to the Area Team and Clinical Commissioning Groups to develop an Area Team-wide steering group comprising the Screening and Immunisation Team and CCG Medicines Management Team. NB. there is no named pharmacist within the Area Team. There are a number of pros and cons around this. Pros include that it gives one process within the governance of the local Area Team, shares pharmacy MMT capacity required across 10 CCGs, supports CCGs' role in supporting the quality of primary care and involves the experienced local PHE Centre Consultant involvement to sign off the clinical content of PGD. Cons include that it relies on MMT capacity and expertise from CCGs, that there is minimal dedicated administrative support available in the Area Team to support the efficient significant administration of process for approximately 15 vaccines.

It should also be noted that feedback to NHS England and Public Health England (PHE) national leaders from NHS England/PHE Screening and Immunisation Leads (SILs) and CCG and Trust pharmacists has urged PHE and NHS England to develop one clinically signed off PGD per vaccine which is then issued to Area Teams to authorise locally.

Immunisation Training

Training on immunisations and vaccinations is central to the provision of a safe immunisation service. There are national minimum standards for immunisation training and an accompanying core curriculum that were published by the Health Protection Agency in June 2005.

Public Health England nationally will be reviewing immunisation and vaccination training. The NHS England and Public Health England 'Immunisation and Screening National Delivery Framework and Local Operating Model' May 2013 states that Area Teams have a role in system management in monitoring quality standards for training. It also states that Area Teams are responsible for seeking assurance from GP Practices and providers that staff undertaking immunisation and screening meet national quality standards. NB. the Area Team does not commission or provide immunisation training courses. Employers have a responsibility to ensure that their staff are adequately trained as well as all practitioners being are responsible for their own competency through keeping their knowledge and skills up-to-date.

Locally the Screening and Immunisation Team are undertaking a local review across the Area Team. In Nottingham City, Nottingham Citycare contract with an independent clinical trainer to provide immunisation training to in-house staff as well as charging primary care for places which is mostly taken by Nottingham City practices. It is also offered to Nottinghamshire practices but due to being often oversubscribed and. There is no dedicated Nottinghamshire based provider of immunisation training to primary care. In Derbyshire, training is offered to primary care by Derbyshire Community Health Services (DCHS). It is the view of the Area Team that it is timely to undertake this review as the continuing provision of the current training cannot be assured.

Other issues will also need consideration including:-

- What expert capacity and expertise is there within local health communities to deliver training?
- What is the 'market' for providing training?
- How are courses accredited?
- How is competency assessed?
- Accountability - are employers and staff clear about their accountability for staff competence if they are providing an immunisation service?
- What do the primary care employers and staff need and want?
- How is immunisation training funded and contracted?
- Interim updates - how are staff updated about new immunisation programmes that are introduced in between formal update sessions?

The Area Team therefore wish to facilitate discussions with Clinical Commissioning Groups (CCGs) and other stakeholders regarding the future provision.

Conclusion

This paper summarises the latest position against the national immunisation service specifications. It demonstrates the breadth of the programme and the work that has

been undertaken in primary care, providers and the Area Team along with local authority colleagues.

Recommendation
The group are asked to note and comment on the content of this report.

Caroline Jordan
Screening and Immunisation Manager

Iolanda Shaker
Screening and Immunisation Coordinator

January 2014

HEALTH & WELLBEING BOARD COMMISSIONING EXECUTIVE GROUP FORWARD PLAN 2014-5

	Report Title	Form	Steering Group/Other Consultation	Officer Presenting	Report into HWBB
	4th MARCH 2014				
	Looking After Each Other (Building Community Capacity)	Report		Kevin Banfield	No
	JSNA Update	Report		Louise Noon	No
	Priority Families Update	Report		Nikki Dawson	No
	Community Services Specification Plan	Report		Lucy Davidson	No
	BLF Opportunity Nottingham (Complex Needs)	Presentation		Antony Dixon/Andrew Redfern	No
	NCSB/NCASPB Draft Business Plans	Report		Paul Burnett	Yes 30/04/14
	BCF Monthly Update	Verbal		Maria Principe	No

HEALTH & WELLBEING BOARD COMMISSIONING EXECUTIVE GROUP FORWARD PLAN 2014-5

	Report Title	Form	Steering Group/Other Consultation	Officer Presenting	Report into HWBB
	1st April 2014				
	HWB Strategy update Alcohol priority and Substance Misuse update	Report		Barbara Brady	Yes 30/04/14
	Primary Care Plan	Report		Maria Principe	Yes 30/04/14
	Critical Care Long Term Capital Development at QMC.	Report			Yes 30/04/14
	CCG 5 Year Commissioning Plan Update	Report		Maria Principe	Yes 25/06/14
	Mental Health Strategy (Sign Off)	Report		Mandy Clarkson	Yes 30/04/14
	Avoidable Injuries Strategy (Sign Off)	Report		Lynne McNiven	Yes 30/04/14
	Emotional, Mental Health and Wellbeing Pathway	Report		Deborah Hooton	No
	BCF Monthly Update	Verbal		Maria Principe	No

HEALTH & WELLBEING BOARD COMMISSIONING EXECUTIVE GROUP FORWARD PLAN 2014-5

	Report Title	Form	Steering Group/Other Consultation	Officer Presenting	Report into HWBB
	6th MAY 2014				
	Children & Families Bill Implementation Update	Report	SEN Steering Group	Tim O Neil	No
	Autism Strategy (sign off)	Report	LD JCG	Charlotte Reading/Sharon Bramwell	No
	Early Intervention Performance Update & Assistive Technology Focus	Report		Katy Ball	No
	Mental Health Pathway Annual report	Report	MHUR Board	Lucy Davidson/Antony Dixon	No
	Care Homes Annual Report (Strategic Review)	Report	Residential Care Review Steering Group	Steve Oakley/Sally Seely	No
	Better Care Fund – Performance Dashboard	Report		Maria Principe	No
	Health Watch Annual Report	Report		Sarah Collis	No

HEALTH & WELLBEING BOARD COMMISSIONING EXECUTIVE GROUP FORWARD PLAN 2014-5

	Report Title	Form	Steering Group/Other Consultation	Officer Presenting	Report into HWBB
4th JUNE 2014					
	HWB Strategy – 12 Month Report	Report		John Wilcox	Yes 25th June 2014
	HWB Strategy Integrated Adult Care Theme Update	Report	Integrated Adult Care Programme Board	Maria Principe	Yes 25th June 2014
	JSNA Update Report	Report		Louise Noon	Yes 25th June 2014
	NHS Health Checks Commissioning Report	Report		Alison Challenger	Yes 25th June 2014
	BCF Monthly Update	Verbal		Maria Principe	No
	Carers Annual Report	Report		Clare Gilbert	No

HEALTH & WELLBEING BOARD COMMISSIONING EXECUTIVE GROUP FORWARD PLAN 2014-5

	Report Title	Form	Steering Group/Other Consultation	Officer Presenting	Report into HWBB
	2nd JULY 2014				
	Children & Families Bill Implementation Update	Report	SEN Steering Group	Tim O Neil	No
	BCF Monthly Update	Verbal		Maria Principe	No
	Opportunity Nottingham (BLF Complex Needs) Update	Report		Andrew Redfern	No
	Dementia Annual Report	Report		Lucy Davidson/Antony Dixon	No

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HEALTH AND WELLBEING FORWARD PLAN 2014/2015.

All future submissions for the FWD plan should be made at the earliest stage through Dot Veitch: dot.veitch@nottinghamcity.gov.uk

30th APRIL 2014				
Public Health topic: Director of Public Health	Combined paper : Substance misuse, contracts update, plus HWS Alcohol Theme update.	Barbara Brady County Council Public Health Barbara.brady@nottscc.gov.uk	Report	01.04.14
Health and Wellbeing Strategy (HWS), Nottingham Plan, and other Key Strategies: Nottingham Plan Programme Group HWS Accountable Board members	Nottingham Plan Healthy Nottingham Refresh report Mental Health strategy: agree and sign off the strategy	Liz Jones, Chief Execs. Liz.jones@nottinghamcity.gov.uk Jo Copping, City Public Health.* Joanna.copping@nottinghamcity.gov.uk	Report	N/R 01.04.14
Commissioning and JSNA: Nottingham City Council Clinical Commissioning Group, NHS Commissioning Board Commissioning Executive Group	CCG Primary Care Plan	Maria Principe, CCG Maria.Principe@nottinghamcity.nhs.uk	Report	01.04.14
Other relevant reports (safeguarding and social determinants of health): Safeguarding Boards Provider organisations and council services relating to the social determinants of health	*Critical Care Long Term Capital Development at QMC:* Protocol for Joint working between Health and Wellbeing Board, Health Scrutiny and Health Watch. Consultation on NCSCB / NCASPB Draft Business Plans	*BuddhikaSamarasinghe, Board Member, Peter Homa* John Wilcox, City Public Health. John.Wilcox@nottinghamcity.gov.uk Paul Burnett; independent chair of NSCB pr.burnett@btopenworld.com	*tbc*	01.04.14 N/A 4.03.14
Standing items	Corporate Director of Children and Families Director of Public Health Health watch Clinical Commissioning Group	Alison Michalska Alison.maiclska@nottinghamcity.gov.uk Chris Kenny chris.kenny@nottscc.gov.uk Martin Gawaith martin.gawaith@healthwatchnottingham.co.uk Dawn Smith Dawn.Smith@nottinghamcity.nhs.uk		

JUNE 2014				
Public Health topic: Director of Public Health	Cancer update	Mary Corcoran, County Council Public Health Mary.Corcoran@nottscc.gov.uk		tbc
Health and Wellbeing Strategy (HWS), Nottingham Plan, and other Key Strategies: Nottingham Plan Programme Group HWS Accountable Board members	HWS Overall 12 month report. HWS Integrating Older Peoples Health and Social Care Theme update Avoidable injuries strategy (sign off).	John Wilcox, City Public Health. John.Wilcox@nottinghamcity.gov.uk Antony Dixon, Quality and Commissioning. Antony.Dixon@nottinghamcity.gov.uk Sarah Quilty and Lynne McNiven, City Public Health. Sarah.quilty@nottinghamcity.gov.uk. Lynne.mcniven@nottinghamcity.gov.uk		04.06.14 04.06.14 01.04.14
Commissioning and JSNA: Nottingham City Council Clinical Commissioning Group, NHS Commissioning Board Commissioning Executive Group	JSNA update report. NHS Health Checks Commissioning Report.	Jo Copping, City Public Health Joanna.copping@nottinghamcity.gov.uk Helen Scott, County Council Public Health Helen.scott@nottscc.gov.uk		04.06.14 04.06.14
Other relevant reports (safeguarding and social determinants of health): Safeguarding Boards Provider organisations and council services relating to the social determinants of health				
Standing items	Corporate Director of Children and Families Director of Public Health Health watch Clinical Commissioning Group	Alison Michalska Alison.maiclska@nottinghamcity.gov.uk Chris Kenny chris.kenny@nottscc.gov.uk Martin Gawaith martin.gawaith@healthwatchnottingham.co.uk Dawn Smith Dawn.Smith@nottinghamcity.nhs.uk		

AUGUST 2014				
Public Health topic: Director of Public Health	Sustainable Development and Health	Helen Ross, City Public Health. Helen.ross@nottinghamcity.gov.uk Lynne McNiven Lynne.mcniven@nottinghamcity.gov.uk John Tomlinson, County Public Health John.tomlinson@nottscc.gov.uk		
Health and Wellbeing Strategy (HWS), Nottingham Plan, and other Key Strategies: Nottingham Plan Programme Group HWS Accountable Board members	HWS Mental Health Theme update Nottingham Plan Annual Report	Jo Copping Joanna.copping@nottinghamcity.gov.uk Lynne McNiven, City Public Health. Lynne.mcniven@nottinghamcity.gov.uk Liz Jones, Chief Execs. Liz.jones@nottinghamcity.gov.uk		tbc tbc
Commissioning and JSNA: Nottingham City Council Clinical Commissioning Group, NHS Commissioning Board Commissioning Executive Group				
Other relevant reports (safeguarding and social determinants of health): Safeguarding Boards Provider organisations and council services relating to the social determinants of health				
Standing items	Corporate Director of Children and Families Director of Public Health Health watch Clinical Commissioning Group	Alison Michalska Alison.maiclska@nottinghamcity.gov.uk Chris Kenny chris.kenny@nottscc.gov.uk Martin Gawaith martin.gawaith@healthwatchnottingham.co.uk Dawn Smith Dawn.Smith@nottinghamcity.nhs.uk		

October 2014				
Public Health topic: Director of Public Health	Sexual Health & HIV	Alison Challenger, City Public Health. alison.challenger@nottinghamcity.gov.uk		
Health and Wellbeing Strategy (HWS), Nottingham Plan, and other Key Strategies: Nottingham Plan Programme Group HWS Accountable Board members	HWS Overall 18 month Report	John Wilcox, City Public Health. John.Wilcox@nottinghamcity.gov.uk		tbc
Commissioning and JSNA: Nottingham City Council Clinical Commissioning Group, NHS Commissioning Board Commissioning Executive Group	Better Care fund. Nottingham CityCare Partnership update on Health Visiting (commissioning transferring to Local Authority from NHS England in 2015	Antony Dixon, Quality and Commissioning. Anthony.dixon@nottinghamcity.gov.uk Lyn Bacon, Nottingham CityCare Partnership. lyn.bacon@nottinghamcitycare.nhs.uk		tbc tbc
Other relevant reports (safeguarding and social determinants of health): Safeguarding Boards Provider organisations and council services relating to the social determinants of health				
Standing items	Corporate Director of Children and Families Director of Public Health Health watch Clinical Commissioning Group	Alison Michalska Alison.maiclska@nottinghamcity.gov.uk Chris Kenny chris.kenny@nottscc.gov.uk Martin Gawaith martin.gawaith@healthwatchnottingham.co.uk Dawn Smith Dawn.Smith@nottinghamcity.nhs.uk		

January 2015				
Public Health topic: Director of Public Health				
Health and Wellbeing Strategy (HWS), Nottingham Plan, and other Key Strategies: Nottingham Plan Programme Group HWS Accountable Board members	HWS Priority Families Theme update.	Nicky Dawson, Family and Community teams Nicky.dawson@nottinghamcity.gov.uk		tbc
Commissioning and JSNA: Nottingham City Council Clinical Commissioning Group, NHS Commissioning Board Commissioning Executive Group	Pharmaceutical Needs Assessment Sign Of.	Jo Copping, City Public Health Joanna.copping@nottinghamcity.gov.uk		tbc
Other relevant reports (safeguarding and social determinants of health): Safeguarding Boards Provider organisations and council services relating to the social determinants of health	Safeguarding Annual Report	Paul Burnett; independent chair of NSCB pr.burnett@btopenworld.com		tbc
Standing items	Corporate Director of Children and Families Director of Public Health Health watch Clinical Commissioning Group	Alison Michalska Alison.maiclska@nottinghamcity.gov.uk Chris Kenny chris.kenny@nottscc.gov.uk Martin Gawaith martin.gawaith@healthwatchnottingham.co.uk Dawn Smith Dawn.Smith@nottinghamcity.nhs.uk		

Feb 2015				
Public Health topic: Director of Public Health				
Health and Wellbeing Strategy (HWS), Nottingham Plan, and other Key Strategies: Nottingham Plan Programme Group HWS Accountable Board members	HWS Alcohol Theme update.	Barbara Brady, County Public Health Barbara.brady@nottscc.gov.uk		tbc
Commissioning and JSNA: Nottingham City Council Clinical Commissioning Group, NHS Commissioning Board Commissioning Executive Group				
Other relevant reports (safeguarding and social determinants of health): Safeguarding Boards Provider organisations and council services relating to the social determinants of health				
Standing items	Corporate Director of Children and Families Director of Public Health Health watch Clinical Commissioning Group	Alison Michalska Alison.maiclska@nottinghamcity.gov.uk Chris Kenny chris.kenny@nottscc.gov.uk Martin Gawaith martin.gawaith@healthwatchnottingham.co.uk Dawn Smith Dawn.Smith@nottinghamcity.nhs.uk		

April 2015				
Public Health topic: Director of Public Health				
Health and Wellbeing Strategy (HWS), Nottingham Plan, and other Key Strategies: Nottingham Plan Programme Group HWS Accountable Board members				
Commissioning and JSNA: Nottingham City Council Clinical Commissioning Group, NHS Commissioning Board Commissioning Executive Group	Better Care Fund.	Antony Dixon, Quality and Commissioning. Antony.dixon@nottinghamcity.gov.uk		tbc
Other relevant reports (safeguarding and social determinants of health): Safeguarding Boards Provider organisations and council services relating to the social determinants of health				
Standing items	Corporate Director of Children and Families Director of Public Health Health watch Clinical Commissioning Group	Alison Michalska Alison.maiclska@nottinghamcity.gov.uk Chris Kenny chris.kenny@nottscc.gov.uk Martin Gawaith martin.gawaith@healthwatchnottingham.co.uk Dawn Smith Dawn.Smith@nottinghamcity.nhs.uk		

Notes on the new format:

Column 2: report title and content will in the future have a brief 1 sentence summary. This will enable board members to identify items which are of specific interest to them and may require prior work or contact to support the item. I will ask report authors to give me this when submitting an item for the forward plan.

Column 3: contains the contact details. This will enable board members to contact the report writer for key areas on which they may wish to consult their members prior to the meeting.

Column 5. This will be a cross reference against the CEG forward plan.

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Chief Officer Update

NHS England has provided clear instruction to NHS commissioners and providers that they must work together to co-design and deliver a five year strategy and a two year operational plan. These must clearly identify how we, as a local health community, plan to transform health services across South Notts to deliver care within the shared resource we have. The four South Notts CCGs (Nottingham City, Rushcliffe, Nottingham West and Nottingham North and East) have already come together to take proactive steps towards creating a shared strategy and have begun a process of patient engagement. NHS commissioners are leading this process but to identify effective strategic and operational solutions the voice of our patients and citizens, providers, partners and key stakeholders must be heard, acted upon and included in our plans.

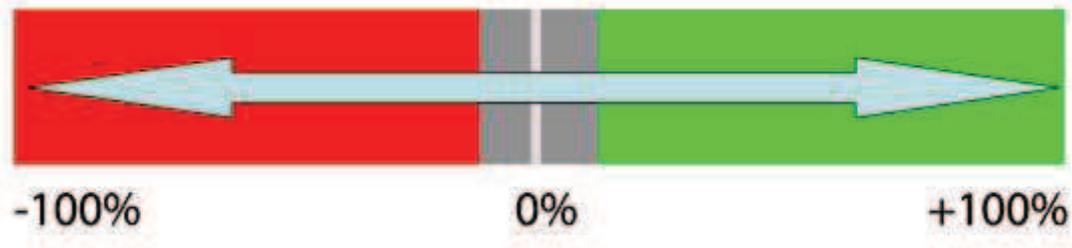
A South Notts Transformation Board has been created to guide the development of the South Notts Transformation Plan. The Board has representation from key partners at the very highest level - CCG Chief Officers and Clinical Leads, Social Care Leads and the main provider Chief Executives.

The Board will produce regular briefings and briefing 1 and briefing 2 are attached for information.

First results of Friends and Family Test for maternity services published

NHS England has published the first results of the Friends and Family Test (FFT) for NHS-funded maternity services across England alongside the latest FFT results for A&E and Inpatient departments.The maternity data consists of feedback from pregnant women and mothers of new-born babies through responses to four questions at three stages during their pregnancy. They are asked whether they would recommend maternity services to their friends and family based on their own experience of care.

The scores are calculated by analysing responses and categorising them intopromoters, detractors and neutral responses. The proportion of responsesthat are promoters and the proportion that are detractors are calculated andthe proportion of detractors is then subtracted from the proportion ofpromoters to provide an overall ‘net promoter’ score (NPS). NPS is a single number that ranges from -100% to +100



Nottingham University Hospitals NHS Trust scored above the England average in all four areas as follows:

- antenatal services +73 (England average +63)
- the labour ward/ birthing unit or home birth services +84 (England average +75)
- the postnatal ward +74 (England average +66)
- postnatal community services +77 (England average +74)

Make a difference - NHS Change Day

NHS Change Day was started last year by a group of young doctors with the aim of getting as many people as possible who work in the NHS to pledge to do one thing to make the NHS better – all on the same day. This year it's taking place on 3 March 2014.

Pledges can be big or small, personal or professional but all have the common goal of improving care, attitudes or experiences for patients and staff. Last year 189,000 people took part and the target for 2014 is 500,000 pledges.

Anyone can get involved, including patients and members of the public. If you'd like to make a pledge for 3 March visit http://changeday.nhs.uk/pledge.

Can't make it? Then cancel it!

Nottingham City CCG has launched a new campaign to raise awareness of the cost to the NHS of missed hospital and doctor's appointments.Every year more than 140,000 hospital and doctor's appointments are missed in Nottingham City, totalling more than £5.5 million.

The campaign has a simple message: 'If you can't make it, cancel it.' If people cancel their appointments with as much notice as possible then these appointments can be offered to other patients.The campaign will be seen on buses, bus stops and telephone boxes across the City. Posters have also been sent out to GP surgeries, pharmacies, libraries and community centres.

Dawn Smith
February 2014

South Notts Transformation Plan

Why do we need a South Notts Transformation Plan?

The NHS is at a critical point in its history. We have a rapidly ageing population which is putting increasing demands on our health and social care services. We know that older people can have multiple, often complex mental and physical long-term conditions, which are costly to manage. We know that the NHS will have very limited resources going forward and that Social Care departments will have to significantly reduce spend. The rising expectations of our patients and citizens are going to become harder and harder to meet.

If we are to continue to provide safe and effective care for our patients and citizens we need to change dramatically across all services to meet the enormous future challenges, some of which are already beginning to impact locally and nationally. We need to work together collaboratively across CCGs, all providers (NHS, private and voluntary sector) and social care to redesign systems and streamline services. We need to value and empower our clinical staff to work together to lead change. We need to commission services in a way that maximises how we use our collective resource, focuses on improving patient and citizen outcomes and shares risk equitably between organisations.

NHS England has provided clear instruction to NHS commissioners and providers that they must work together to co-design and deliver a five year strategy and a two year operational plan. These must clearly identify how we, as a local health community, plan to transform health services across South Notts to deliver care within the shared resource we have.

The four South Notts Clinical Commissioning Groups (Nottingham City, Rushcliffe, Nottingham West and Nottingham North and East) have already come together to take proactive steps towards creating a shared strategy and have begun a process of patient engagement. NHS commissioners are leading this process but to identify effective strategic and operational solutions the voice of our patients and citizens, providers, partners and key stakeholders must be heard, acted upon and included in our plans.

How will this be overseen and managed?

This is a significant piece of work with a challenging timeframe attached. The draft strategy and two year operational plan need to be approved by Boards by the end of March 2014 and submitted by 4th April 2014. There is no time to waste in engaging all our stakeholders in this conversation and garnering their opinion on how the NHS will deliver in the future.

A South Notts Transformation Board has been created to guide the development of the South Notts Transformation Plan and has so far met once. The Board has representation from key partners at the very highest level - CCG Chief Officers and Clinical Leads, Social Care Leads and the main provider Chief Executives.

There are close links to the development of plans for the Better Care Fund (formally known as the Integrated Transformational Fund) that are being led by Nottinghamshire County Council and 2 Nottingham City Council Health and Wellbeing Boards. These links will be managed by the South Notts Transformation Board.

The Executive Lead for the South Notts Transformation Plan is Sam Walters, Chief Officer at Nottingham North and East CCG, and she will be supported by Jane Laughton, Associate Programme Director.

PwC has won a tender to provide analytical and modelling support, review and advise on decision-making and governance processes and lead on writing the strategy and plan. The

main contacts in PwC are Joanne Devlin (project lead), Alex Brogan (programme support) and Nick Jones (analysis). They will be working with us until March 2014. Each organisation will be asked to nominate a management lead and contact names for analysis and finance. Partners are requested to respond to any queries from PwC promptly so that we can meet the demanding timescale that we have been set.

How does this link to current transformational programmes?

Although PwC will lead on writing the strategy and plan, the content will be determined and owned by all partners in South Notts. The intention is to build on existing clinically-led transformational programmes and strategies, for example the Frail Older People Programme and CCG- based integrated care programmes, rather than create new ones. However, it is unlikely that these will be sufficient to deliver sufficient impact, so new areas of focus are likely to emerge.

There are a significant number of programme and project leads working on transformational change across organisations in South Notts. The South Notts Transformation Board has agreed in principle to refocus the remit of these leads to support this work, acknowledging the significant insights, skills and experience that these staff will bring to our current and future plans for system-wide transformational change.

What next?

In January and February 2014 we will:

- quantify the scale of the financial challenge across health and social care in South Notts and Nottingham City and identify our collective financial gap
- assess the potential impact of our current transformational change programmes to fill the gap
- consider whether and how quickly we can scale up our ambition around integrated care and the frail older people programme

For further information please contact;

Sam Walters: Sam.walters@nottinghamnortheastccg.nhs.uk

or

Jane Laughton: Jane.laughton@nottinghamcity.nhs.uk

South Notts Transformation Plan

What is the South Notts Transformation Plan and what will it deliver?

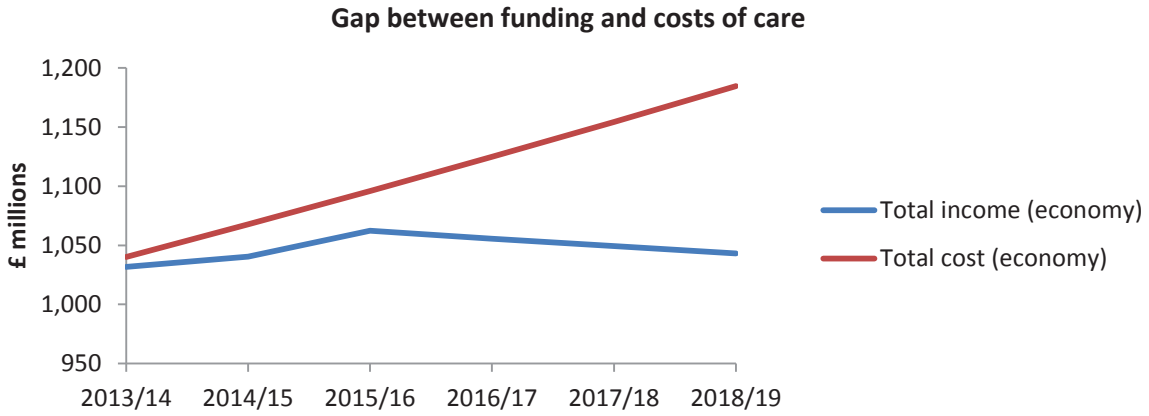
A rapidly ageing population will put increasing demands on our health and social care services. The rising expectations of our patients and citizens are going to become harder and harder to meet. NHS commissioners and providers are working together to identify how we, as a local health community, can transform health services across South Notts to deliver care within the shared resource we have.

We have started by talking to patients and the public as part of the national *Call to Action* programme. This culminated in a large event with 120 members of the public attending an event on January 29th where we described challenges ahead, conducted a real time voting exercise and held structured discussions. This process will continue over the coming months. The South Notts Transformation Board is overseeing the development of this plan and includes representatives from local health and social care organisations and a lay Chair and Vice Chair.

What is the scale of the financial challenge?

The total spend on health and social care by the four CCGs and two Local Authorities in South Notts is around £1,032bn. This excludes spend on GP contracts and specialised services. In future, NHS funding is expected to remain constant in real terms, but social care budgets are expected to come under significant pressure. In addition the costs of delivering care will increase as a result of population growth and ageing, and as a result of medical inflation.

If services continue to be delivered as they are now, current estimates are that by 2017/18 there will be gap of around £100m between available funding and the actual costs of delivering care across health and social care in South Notts.



CCGs have been working on this problem for some time, and the potential benefits from delivering integrated care through current schemes is currently estimated to be between £5 and £11m. This still leaves a gap of around £90m.

How will we fill the gap?

The task of the South Notts Transformation Board is to develop a five year plan on how commissioners, local authorities and providers will work together to deliver services within these financial constraints. We are already engaging with patients and the public. We now need to talk to staff across all organisations to get their views.

Two events are being held to take forward this discussion with staff across health and social care on 6 and 13 March. Each organisation will be asked to nominate a small number of staff to attend to represent their colleagues and organisations, but all staff are invited to share their views by discussing them within their organisations in advance of the events.

We will be considering how we can improve the way in which we deliver care and support people to look after themselves by:

- taking a more holistic approach to keeping people well
- thinking as a system rather than as individual organisations
- enabling funding to follow the patient rather than being constrained by current payment systems
- reshaping how and where we deliver care including a review of the role of the hospital, primary care and community-based services (health and social care)

If you would like to provide input ahead of these events please contact the South Notts Transformation lead for your organisation (listed on the next page)

For further information please contact

Sam Walters: Sam.walters@nottinghamnortheastccg.nhs.uk

Jane Laughton: Jane.laughton@nottinghamcity.nhs.uk

Organisational Leads on the South Notts Transformation Board

Name	*Role*	*Organisation*	*E-mail*
Dawn Smith Hugh Porter	Chief Operating Officer Clinical Lead	Nottingham City CCG	Dawn.Smith@nottinghamcity.nhs.uk hugh.porter@gp-c84023.nhs.uk
Sam Walters Paul Oliver	Chief Operating Officer Clinical Lead	Nottingham North & East CCG	sam.walters@nottinghamnortheastccg.nhs.uk Paul.Oliver@nottinghamnortheastccg.nhs.uk
Oliver Newbould Guy Mansford	Chief Operating Officer Clinical Lead	Nottingham West CCG	Oliver.Newbould@nottinghamwestccg.nhs.uk Guy.Mansford@nottspct.nhs.uk
Vicky Bailey Stephen Shortt	Chief Operating Officer Clinical Lead	Rushcliffe CCG	Vicky.Bailey@rushcliffeccg.nhs.uk stephen.shortt@gp-c84005.nhs.uk
Peter Homa/ Tim Guyler	Chief Executive Better for You Programme Director	Nottingham University Hospitals NHS Trust	peter.homa@nuh.nhs.uk Tim.Guyler@nuh.nhs.uk
Paul Smeeton	Chief Operating Officer, County Health Partnerships	County Health Partnerships Nottinghamshire Healthcare NHS Trust	Paul.Smeeton@nottshc.nhs.uk
Lyn Bacon	Chief Executive	Nottingham CityCare Partnership	Lyn.Bacon@nottinghamcitycare.nhs.uk
Sue Noyes	Interim Chief Executive	East Midlands Ambulance Service	Sue.Noyes@emas.nhs.uk
Caroline Baria	Service Director	Nottingham County Council	caroline.baria@nottscc.gov.uk
Alison Michalska Helen Jones	Corporate Director of Children & Families Director for Adult Assessment	Nottingham City Council	Alison.michalska@nottinghamcity.gov.uk helen.jones@nottinghamcity.gov.uk
Rachael Magnani	General Manager, Nottingham Treatment Centre	Circle Partnership	rachael.magnani@circlepartnership.co.uk

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Health and Wellbeing Board 26th February 2014

Title of paper:	**Healthwatch Nottingham Update – February 2014**	
Director(s)/ Corporate Director(s):	**Martin Gawith, Chair - Healthwatch Nottingham**	**Wards affected: All**
Report author(s) and contact details:	**Ruth Rigby, Managing Director – Healthwatch Nottingham** **0115 859 9528**	
Other colleagues who have provided input:	**Shaniek Parks, Communication and Information Officer**	
Date of consultation with Portfolio Holder(s) (if relevant)		

Relevant Council Plan Strategic Priority:	
Cutting unemployment by a quarter	☐
Cut crime and anti-social behaviour	☐
Ensure more school leavers get a job, training or further education than any other City	☐
Your neighbourhood as clean as the City Centre	☐
Help keep your energy bills down	☐
Good access to public transport	☐
Nottingham has a good mix of housing	☐
Nottingham is a good place to do business, invest and create jobs	☐
Nottingham offers a wide range of leisure activities, parks and sporting events	☐
Support early intervention activities	☐
Deliver effective, value for money services to our citizens	☒

Summary of issues (including benefits to citizens/service users):

Information report outlining the current activity, findings and future work of Healthwatch Nottingham.

Recommendation(s):

1	The content of the report is noted and the work of Healthwatch Nottingham is supported.
2	The Board continues to receive reports outlining evidence and insight gathered by Healthwatch Nottingham and the outcomes from any specific work at its future meetings.

1. REASONS FOR RECOMMENDATIONS

1.1 Healthwatch Nottingham is the independent consumer champion for health and social care in the city. In partnership with the Care Quality Commission, it exists to give citizens and communities a stronger voice to influence and challenge how health and social care services are commissioned and provided, including through reporting of its activity and findings to the Health and Wellbeing Board.

1.2 This report outlines activity, evidence and insight gathered in since the last report to the Board in October 2013 and outlines current work priorities.

2. BACKGROUND (INCLUDING OUTCOMES OF CONSULTATION)

2.1 **Evidence & Insight:**

The following summarises calls to the Healthwatch Nottingham Information Line only. Mechanisms are currently under development to enable the reporting of more qualitative information gathered through engagement activities which will provide a broader picture of consumer/citizen issues. Copies of the full reports are available from the Healthwatch Nottingham website.

Quarter 2

Trends:

- 20% of total callers requested information on dental home care for older people. This is indicative of a real concern about contractual changes in the NHS and people needing to access private dental care services if they do not qualify for the Special Needs Dental Service offered by the Nottinghamshire Healthcare Trust.
- A high percentage of calls related to information requests to find a GP or dentist in their area
- Rise in calls about children services, both health and social care related issues.
- Increase in complaints about GP's. Callers expressed frustration about the behaviour of GPs and lack of knowledge about where to take the complaint. Some did not feel comfortable making complaints to the GP practice and were hesitant about making complaints nationally via the NHS England Customer Care Centre.
- There has been a decrease in the number of callers following up on PALS complaints in comparison to the first quarter.

Learning Curve:

We experienced a decrease in the number of calls in the second quarter. However, we received quality based narratives on concerns about the local hospitals, GP's and child services. In response, we have strengthened internal processes to ensure immediate referrals of quality concerns and alerting of safeguarding concerns through appropriate reporting routes. We are also building our network of protocols

around information sharing to ensure we can feed information into reviews by statutory bodies while protecting caller identity.

The types of enquiries also changed, we had fewer calls regarding complaints about the NHS, more information requests about NHS services, dental home services and enquiries making GP complaints.

Quarter 3

Trends:

- Increase in general information requests. Previously, information requests were mainly about finding the nearest dentist or GP while this quarter they covered a range of health and social care issues.
- Complaints about GPs remained of importance to callers.
- There were no calls following up on previously made PALS complaints as had been the case in previous quarters.
- Access to dental services for older people remains an important issue.
- Increase in calls requesting advice. Often people requested direct advice on what to do; many felt that they were being given choices of health/care provider but had no basis on which to choose and argued that without a basis from which to make a decision, they would prefer not having a choice at all. Issues on which people sought advice included information about the best nursing homes for their relatives.

Learning Curve:

Enquiries this quarter included complaints about the inconvenience of an added step via the CCG, to access to optical care, podiatry services and orthodontic services. There was also an increase in information requests about social care issues, access to specialist doctors and linking private to public healthcare options. In response, we have strengthened our relationships with health and social care providers to ensure we understand any process/pathway changes. This information helps to ensure our directory of information is constantly updated and able to deal with the enquiries we receive.

2.2 **Engagement:**

As one of the risks Healthwatch Nottingham faces is that of duplicating other engagement and consultation activity, much of the engagement activity to date has involved attending and listening at events established by commissioners and providers. Hence Healthwatch Nottingham attended and recorded discussions at the recent Call to Action events held by the CCG and the very recent ‘Shape the Future of the Health Services event held at Nottingham Forest FC.

Additionally we continue to link with other organisations, particularly within the third sector, providing closer access to specific communities including those who may not be linked in with other engagement routes.

2.3 **Healthwatch Board Priorities**

Care Homes

At its first meeting, the Healthwatch Nottingham Board identified Care Homes as an area for specific attention. This followed the short notice closure of the St Andrews Lodge Nursing Home and subsequent comments by CQC that the quality of local care homes was poorer than in other areas. Healthwatch Nottingham is now working through a programme of activity designed to:

- Ascertain views regarding tenants' rights for care home residents.
- Raise awareness of local Healthwatch in care homes.
- Contribute to work, led by the city council and CCG, to improve care home quality.
- Promote Dignity in Care.
- Support the Nottingham Older Citizens' Charter, and
- Contribute to learning from the closure of St Andrews Lodge

A future report to this meeting will provide the outcomes from this work.

Diaries Project

A programme of work, led by the Healthwatch Nottingham Board, is currently being developed, requesting that individuals keep diaries of their experiences and what they hear about health and social care services. Linked to the findings of the Francis report, it is intended that this work stream will help identify themes in relation to people's experiences of the system, which can then form the basis of more focussed attention.

To date, diaries have been kept by Healthwatch Nottingham Board members but it is intended to roll this out across a range of other stakeholders in the forthcoming months.

2.4 **Profile raising:**

As a relatively new entity, much of Healthwatch Nottingham's activity remains focussed on developing awareness of the local Healthwatch 'brand', linking with key stakeholders including, most importantly, ensuring all Nottingham citizens understand what Healthwatch is and how to contact us.

To this end, developing relationships with health and social care providers and commissioners remains vital, as does strengthening links with the voluntary and community sector – through HWB3 and with direct work with specific organisations.

In addition to this, we are currently looking at how we can better support our members to contribute to our work, including through volunteering opportunities. We are looking to recruit to specific volunteering roles – through establishing Healthwatch Champions and by utilising volunteers on our information line, to broaden our community reach.

Perhaps one of the best networks we have linked into in recent months has been the local press. We are now regularly contacted by local TV channels, radio and

newspapers for comment on local stories about health and social care matters – including NUH car parking charges, maggots in a GP practice, the £100m health/care budget challenge - in addition to the Healthwatch Nottingham Chair's regular Nottingham Post column. We provide input into local news stories most weeks. This is a great way to undertake and publicise our role as consumer champions but also, through our links with the statutory sector, we can also help minimise the sharing of inaccurate information and scaremongering.

3. OTHER OPTIONS CONSIDERED IN MAKING RECOMMENDATIONS

None.

4. FINANCIAL IMPLICATIONS (INCLUDING VALUE FOR MONEY/VAT)

None specifically.

5. RISK MANAGEMENT ISSUES (INCLUDING LEGAL IMPLICATIONS AND CRIME AND DISORDER ACT IMPLICATIONS)

None specifically.

6. EQUALITY IMPACT ASSESSMENT

Has the equality impact been assessed?

Not needed (report does not contain proposals or financial decisions) Y☐

No ☐

Yes – Equality Impact Assessment attached ☐

Due regard should be given to the equality implications identified in the EIA.

7. LIST OF BACKGROUND PAPERS OTHER THAN PUBLISHED WORKS OR THOSE DISCLOSING CONFIDENTIAL OR EXEMPT INFORMATION

None.

8. PUBLISHED DOCUMENTS REFERRED TO IN COMPILING THIS REPORT

Healthwatch Nottingham Information Line Quarterly Report (July- September 2013)
Healthwatch Nottingham Information Line Quarterly Report (October- December 2013)

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