**NOTTINGHAM CITY COUNCIL**
**HEALTH AND WELLBEING BOARD**

**Date:** Wednesday, 30 April 2014

**Time:** 1.30 pm

**Place:** Ground Floor Committee Room - Loxley House, Station Street, Nottingham, NG2 3NG

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

**Corporate Director for Resilience**

**Governance Officer:** Noel McMenamin **Direct Dial:** 0115 8764315

**NOTTINGHAM CITY ADULT SAFEGUARDING PARTNERSHIP BOARD BUSINESS PLANS 2014-15**
Report of Independent Chair of Nottingham City Safeguarding Children Board and Adult Safeguarding Partnership Board

**8** **NHS NOTTINGHAM CITY CLINICAL COMMISSIONING GROUP (CCG) 5 YEAR PLAN 2014-2019** 77 - 90
Report of Chief Officer, NHS Nottingham City CCG

**9** **PRIMARY CARE VISION** 91 - 140
Report of Director of Primary Care Development and Service Integration

**10** **FORWARD PLAN** 141 - 148

**11** **HEALTHWATCH NOTTINGHAM UPDATE** 149 - 152
Report of Chair of Healthwatch Nottingham

**12** **STATUTORY UPDATES**

**a** **CORPORATE DIRECTOR, CHILDREN AND ADULTS**
Verbal update

COUNCILLORS, CO-OPTEES, COLLEAGUES AND OTHER PARTICIPANTS MUST DECLARE ALL DISCLOSABLE PECUNIARY INTERESTS AND / OR ANY OTHER INTERESTS RELATING TO ANY ITEMS OF BUSINESS TO BE DISCUSSED AT THE MEETING.

**b** **DIRECTOR OF PUBLIC HEALTH, NOTTINGHAMSHIRE COUNTY AND NOTTINGHAM CITY**
Verbal update

COUNCILLORS, CO-OPTEES, COLLEAGUES AND OTHER PARTICIPANTS MUST DECLARE ALL DISCLOSABLE PECUNIARY INTERESTS AND / OR ANY OTHER INTERESTS RELATING TO ANY ITEMS OF BUSINESS TO BE DISCUSSED AT THE MEETING.

**c** **CHIEF OFFICER, NHS NOTTINGHAM CITY CCG** 153 - 154

**13** **HEALTH AND WELLBEING BOARD MEETING DATES 2014-15**
To consider meeting on the following Wednesdays at 1.30pm:
2014: 25 June, 27 August, 29 October
2015: 7 January, 25 February and 29 April

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

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

CITIZENS ARE ADVISED THAT THIS MEETING MAY BE RECORDED BY MEMBERS OF THE PUBLIC. ANY RECORDING OR REPORTING ON THIS MEETING SHOULD TAKE PLACE IN ACCORDANCE WITH THE COUNCIL'S POLICY ON RECORDING AND REPORTING ON PUBLIC MEETINGS, WHICH IS AVAILABLE AT WWW.NOTTINGHAMCITY.GOV.UK. INDIVIDUALS INTENDING TO RECORD THE MEETING ARE ASKED TO NOTIFY THE GOVERNANCE OFFICER SHOWN ABOVE IN ADVANCE.

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**NOTTINGHAM CITY COUNCIL**

**HEALTH AND WELLBEING BOARD**

**M I N U T E S** of the meeting held at Loxley House on **26 FEBRUARY 2014** from 1.32 pm to 3.52 pm

**Voting members**

| | | |
|---|---|---|
| ✓ | Councillor Alex Norris (Chair) | Portfolio Holder, Adults and Health (minutes 41-44) |
| ✓ | 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 | ) |
| ✓ | Jacqui Williams (substitute for Vikki Taylor) | NHS England |
| ✓ | Dr Chris Kenny | Director, Public Health, Nottingham City / Nottinghamshire County |
| ✓ | Martin Gawith | 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**

| | | |
|---|---|---|
| Councillor Eunice Campbell | | Older Citizen's Champion |
| Alison Challenger | - | Deputy Director of Public Health |
| David Jones | - | Pensioners' Action Group |
| Sharan Jones | - | Health and Wellbeing Manager |
| Noel McMenamin | - | Constitutional Services Officer |
| Lynne McNiven | - | Public Health Consultant |
| Colin Monckton | - | Head of Commissioning and Insight |
| Linda Syston-Nibbs | - | Screening and Immunisation Lead, NHS England |

**41 APOLOGIES FOR ABSENCE**

| | | |
|---|---|---|
| Councillor Jon Collins | | (other Council business) |
| Vikki Taylor | - | NHS England |

| | | |
|---|---|---|
| Gill Moy | - | Nottingham City Homes |
| Anne Danvers | - | Nottingham Jobcentre Plus |
| Peter Homa | ) | Nottingham University Hospitals Trust |
| Danny Mortimer | ) | |
| Sarah Collis | ) | Nottingham Third Sector Forum |
| Angela Kandola | ) | |
| Elaine Yardley | (Director of Adult Provision / Health Integration, Nottingham City Council) | |

## 42 DECLARATIONS OF INTEREST

None.

## 43 MINUTES

The Board confirmed the minutes of the meeting held on 8 January 2014 as a correct record and they were signed by the Chair.

## 44 BETTER CARE FUND

Maria Principe, Director of Primary Care Development and Service Integration, NHS Nottingham City Clinical Commissioning Group (CCG), introduced a report requesting approval of the vision for and use of Better Care funds as detailed in the Better Care Plan appended to the report, as required by the NHS England Regional Team. Ms Principe made the following points:

(a) the Plan covers the boundaries of Nottingham City and comply with national conditions. These include the protection of social care services, 7-day services in health and social care, better data sharing between health and social care, joint approach to assessments and care planning and agreement on consequential impact on the acute sector;

(b) the Better Care Fund in Nottingham comes to £24.2 million and focuses on 7 elements/schemes: Independence Pathway, Co-ordinated care, Assistive Technology, Access and Navigation, Management, Carers and Disabled Facilities Grant;

(c) citizen feedback is that the health and social care system is complex, it being difficult to access appropriate support in a timely way. Citizens want to see a simplified, integrated, citizen-centred system, with a single point of access and joint outcomes;

(d) a Joint Vision has been developed which states ‘We will improve the experience of and access to health and social 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’;

(e) the aim is to focus on the whole person, not the condition, removing false divides between physical, psychological and social needs, tailoring services to need in a timely way and supporting independence;

(f) the model being adopted includes a single point of access, the NHS number as core identifier, the implementation of Care Co-ordinators, integration between NHS and local authority provision, tailored services based on population need and access to assistive technology;

(g) these changes will result in the right care being delivered in the right setting by a skilled workforce, maximising independence and minimising delays in provision.

During discussion, Board members made the following points:

(h) Ms Principe confirmed that the Matrix is based on Nottingham City capacity, and that, while Nottingham was ahead of the game in many respects, the risk identified within the Matrix about the skilled resources in place to deal with increased complexity within the community is significant;

(i) there was consensus that arrangements for the Better Care Fund were very complex and looked to deliver very ambitious outcomes, but they also offered much-needed clarity on what needed delivering. It was also difficult to predict how the roll-out of the efficiencies would affect demand;

(j) in response to a Board member's question about the need to strengthen governance arrangements, Ms Principe expressed the view that leadership through the Intregrated Programme Board would flex and evolve over time;

(k) a Board member stated that the implications for mental health service provision were very wide-ranging, and that significant training was required at an early stage for community-based staff. A Board member also stated that a large degree of the success of these changes lay with lesser-paid staff and their 'buy-in' to these changes will be needed.

**RESOLVED to approve the vision for and use of Better Care funds as detailed at appendix 1 and 2 to the report, as required by the NHS England Regional Team. Councillor Dave Liversidge abstained and asked that this be recorded.**

Councillor Alex Norris left the meeting at this point, and Dr Ian Trimble, Vice-Chair, assumed the role of Chair.

## 45 AGE-FRIENDLY NOTTINGHAM AND NOTTINGHAM'S OLDER CITIZENS' CHARTER

Councillor Eunice Campbell, Older Citizens' Champion, introduced a report highlighting actions being taken and planned to develop Nottingham as an age-friendly city, making the following points:

(a) Nottingham is a signatory to the Dublin Declaration on Age-Friendly Cities, working to enable older citizens to stay active, healthier and happier for longer, and to contribute fully to society;

(b) as part of the Age-Friendly Nottingham initiative, older citizens have come together to develop the Nottingham Older Citizens' Charter;

(c) the Charter features 12 pledges to help older citizens lead fulfilled lives. These include making engagement with older people integral to decision-making processes in Nottingham, promoting positive images of ageing, reducing loneliness and isolation, supporting housing, transport and assistive technology initiatives of benefit to older people and helping older citizens live without discrimination;

(d) a key element of the Charter is to increase dignity and choice in health and social care services, adopting the principles in the National Pensioners' Convention Dignity Code;

(e) proposed future action includes forming an Older Person's Steering Group and taking forward an action plan to help deliver on the Charter's pledges;

(f) Councillor Campbell paid tribute to David Jones of the Pensioners Action Group and Sharan Jones, Health and Wellbeing Manager, for their work in developing the Charter.

Board members expressed support for the work undertaken to date and during discussion raised the following issues and points:

(g) in response to a Board member's point, Ms Jones explained that developments in Nottingham were incorporated within the National Pensioners' Convention, but that older citizens in Nottingham wanted to have short, punchy, easily-understood Charter relating to Nottingham;

(h) a Board member expressed the view that older Nottingham citizens did not have the disposable income often assumed by younger generations;

(i) a Board member, while welcoming and supporting the work undertaken, cautioned against assuming that there was a single 'older person's view on any particular issue;

(j) Ms Jones explained that the idea of a Steering Group came from older citizens themselves, who felt that they did not have a channel into decision takers' strategic thinking.

**RESOLVED to**

**(1) support the development of Age Friendly Nottingham and consider how their organisation might be engaged in the initiative;**

**(2) support the formation of an older citizens' steering group;**

**(3) agree to receive annual reports on progress against the Age Friendly Nottingham action plan.**

## 46 TEENAGE PREGNANCY IN NOTTINGHAM – UPDATE

Lynne McNiven, Consultant in Public Health, introduced the report, making the following points:

(a) the latest data shows the current teenage pregnancy rate at 37.6 per 1000 girls aged 15-17, continuing the downward trend and putting Nottingham City in the top 30% of most improved local authorities for conception rates;

(b) termination rates remain static in Nottingham, and under-16 conception rates were improving;

(c) the Teenage Pregnancy Plan is being refreshed and developed, and will be going out to consultation shortly. As part of its development, there will be analysis of ward data to see whether there are pockets of the city not experiencing the same improvements in teenage conception rates;

(d) early intervention and primary prevention remained central to continued improvement, and the Teenage Pregnancy Taskforce, chaired by Councillor Alex Norris, helped ensure reducing teenage pregnancy remains a high priority for Nottingham.

Board members welcomed the latest positive statistics and raised the following issues and points in the discussion which followed:

(e) a Board member acknowledged the challenge of maintaining the positive 'direction of travel' where there were expenditure constraints. It was important to understand why Nottingham was doing well to inform future commissioning to know where future services might best be targeted;

(f) a Board member advised that that Family Nurse Partnership, an intensive home visiting programme working with teenage parents to improve pregnancy outcomes, was only available to first-time teenage mothers, and not for each teenage pregnancy;

(g) a Board member urged there to be a wider, more ambitious refresh, not just of the Teenage Pregnancy Plan, but of the existing model of service provision.

**RESOLVED to**

**(1) note the report, and in particular the development of the 2014/15 Teenage Pregnancy Plan;**

**(2) agree to receive further annual update reports on the work of the Teenage Pregnancy Taskforce.**

## 47 CLINICAL COMMISSIONING GROUP TWO-YEAR OPERATIONAL PLAN IN RESPONSE TO 'EVERYONE COUNTS: PLANNING FOR PATIENTS 2014/15 TO 2018/19

Dawn Smith, Chief Officer, NHS Nottingham CCG introduced a report summarising NHS England's ambitions for what CCGs and the wider commissioning system will deliver and highlighting the CCG's two-year operational plan. Ms Smith made the following points:

(a) NHS England guidance stipulates what CCGs and the wider commissioning system will deliver, and the Board is required to consider whether the CCG commissioning plan takes proper account of the Joint Health and Wellbeing Strategy;

(b) the NHS England guidance requirements focussed heavily on investment to support integrated care for older people, achieving parity of esteem for mental and physical health, delivering a programme of work to address Priority Families and delivering a shift in funding from acute to community services;

(c) the guidance is largely silent on preventing alcohol misuse, reflecting the shift in responsibility to local authorities;

(d) in addition to measures related to NHS England outcome ambitions, the CCG is required to select a local measure. Cancer mortality rates in Nottingham are higher than regional and national rates, with survivor rates significantly poorer, especially for bowel and prostate cancer. For this reason, the CCG proposes to include as its local measure improved screening rates for bowel cancer as its local measure.

The Board members noted the report and unanimously supported bowel cancer screening rates as a local priority. In the brief discussion which followed, Ms Smith confirmed that the definition of Priority Families in this context was slightly broader than that for the Priority Families initiative.

**RESOLVED to**

**(1) note the report;**

**(2) approve the CCG decision to continue the uptake of bowel screening as a local priority associated with the Quality Premium.**

## 48 HEALTH PROTECTION ARRANGEMENTS

Chris Kenny, Director of Public Health, Nottingham City and Nottinghamshire County, introduced a report explaining the new health protection duty delegated to local authorities and explaining the arrangements put in place to maintain and improve health protection for citizens. Chris Kenny made the following points:

(a) Public Health England now has the responsibility to deliver the specialist health protection response to incidents and outbreaks formerly provided by the Health Protection Agency;

(b) NHS England supports any NHS multi-agency response to an emergency as well as national screening and immunisation programmes, while NHS CCGs commission treatment services;

(c) the Director of Public Health provided a 'local leadership function' to health protection, and co-chaired the Local Health Resilience Partnership, with responsibility for both preventative measures and health emergency preparedness, resilience and response.

In the brief discussion which followed, Board members asked for several concrete examples of what the public was being protected from, and asked how the system could be tested to ensure its resilience. In response, Dr Kenny undertook to submit a more detailed report to a future meeting of the Board, once a review of the Local Health Resilience Partnership Review had been completed.

**RESOLVED to**

**(1) note the City Council's new health protection duty;**

**(2) to receive an update report to a future Board meeting, following the Local Health Resilience Partnership Review.**

## 49 INCREASING THE PROTECTION OF NOTTINGHAM CITIZENS AGAINST VACCINE-PREVENTABLE DISEASE

Linda Syson-Nibbs, Screening and Immunisation Lead, NHS England, introduced a report updating the Board on changes to commissioning arrangements for national immunisation, and on recent improvements in immunisation uptake. Ms Syson-Nibbs made the following points:

(a) commissioning arrangements for national immunisation programmes have changed, with NHS England Area Teams commissioning programmes and monitoring being carried out through the Nottinghamshire County and Nottingham City Immunisation Programme Board;

(b) four new programmes were introduced in 2013, including change to the Meningitis C programme the introduction of rotovirus and shingles vaccines and seasonal flu vaccines for all 2 and 3 year olds;

(c) there had been a high uptake of human papilloma virus (HPV) vaccination and Measles Mumps and Rubella uptake for both 2 year olds and for those aged 10 to 16 had been successful;

(d) as well as reaching targets of 95% uptake for several programmes, it was planned to roll out the seasonal flu programme to all children aged 4 and possibly up to 17 years, creating serious capacity issues for the service;

Board members praised the achievement of the programmes to date and noted the very ambitious targets for immunisation coverage going forward. The Board raised the following issues:

(e) a Board member highlighted the importance of joint commissioning to ensure that limited resources were appropriately targeted;

(f) Ms Syson-Nibbs stated that concerns about capacity to deliver of the expanded immunisation programmes were not unique to Nottingham City and Nottinghamshire County. There were also particular issues on data collection and recording where communities were less settled.

**RESOLVED to note the commissioning arrangements for national immunisation programmes and recent improvements in immunisation uptake in Nottingham.**

## 50 FORWARD PLAN

The Board welcomed the more comprehensive Forward Plan, and its alignment with the work of the Commissioning Executive Group. Dawn Smith, Chief Officer, NHS Nottingham City Clinical Commissioning Group, advised that the CCG's 5-year Commissioning Strategy will be considered at the Board's April 2014 meeting.

**RESOLVED to note the Forward Plan.**

## 51 HEALTHWATCH NOTTINGHAM - UPDATE

Martin Gawith, Healthwatch Nottingham, introduced a report updating the Board on Healthwatch Nottingham activity, making the following comments:

(a) the number of calls to Healthwatch Nottingham about dental home care for older people indicates an issue where citizens do not qualify for the Special Needs Dental Service offered by the Nottinghamshire Healthcare Trust;

(b) there is an increase in complaints about GPs, and about the GP complaints system itself. Citizens felt uncomfortable complaining to the GP practice directly, or to dial a national hotline;

(c) a significant number of calls to Healthwatch Nottingham has involved signposting local GP and dental services.

Board members made the following comments:

(d) a Board member suggested that Healthwatch Nottingham could make a complaint to NHS England about the GP complaints system being inflexible and not customer-focused;

(e) a Board member commented that there was a wider dental health issue in that there was no dentistry training in the East Midlands and that there was a lower concentration of dental services in the region.

**RESOLVED to note this update and to continue to receive regular updates.**

## 52 STATUTORY UPDATES

The Board received the following updates and requests:

### (a) Chief Officer, NHS Nottingham City CCG

### (i) South Notts Transformation Board

To help co-design and deliver a 5-year Strategy and 2-year Operational Plan for health services across South Nottinghamshire, a South Notts Transformation Board has been established. The Board is made up of the Chief Officers and Clinical Leads of the four South Nottinghamshire CCGs (Nottingham City, Nottingham West, Rushcliffe and Nottingham North and East) Social Care Leads and the main provider Chief Executives. The first briefing papers from the Board were circulated for information.

### (ii) Family and Friends Test for maternity services

NHS England published the first results of the Friends and Family Test (FFT) for NHS maternity services, and Nottingham University Hospitals Trust scored considerably higher than the England

average in all four areas tested (antenatal services, labour ward/birthing unit or home birth services, postnatal ward and postnatal community services).

**(iii) NHS Change Day**

This year's Change Day is on 3 March 2014, with a target of 500,000 pledges from staff, patients and the wider public to make the NHS better.

**(iv) Can't Make it? Then Cancel it!**

The CCG has launched an awareness campaign about the cost to the NHS of missed hospital and GP appointments.

**(b) Director of Public Health**

**(i) Tobacco/Smoking**

Following on from the recent Public Health England 'toxic blood' smoking campaign, the City Council Leader has agreed to a Full Council debate on the Nottingham City Tobacco Strategy.

**(c) Corporate Director, Children and Families**

**(i) OFSTED**

Preparations were ongoing for the forthcoming OFSTED inspection, which was expected in March 2014.

**(ii) Better Care Fund/service commissioning 0-5 years**

Colleagues and partners were making good progress on getting ready for the Better Care Fund and for taking over commissioning of early years services, both of which were coming into effect from 2015/16.

**(iii) 'Delivering Differently' bid**

Nottingham City has reached the final 25 of the Cabinet Office-sponsored Delivering Differently challenge, aimed at helping local authorities to transform services through new delivery models such as mutuals and voluntary organisations.

**RESOLVED to note the above updates**.

# HEALTH AND WELLBEING BOARD - 30th April 2014

| | | |
|---|---|---|
| **Title of paper:** | Nottingham City Health and Wellbeing Board, Healthwatch and Health Scrutiny Joint Working Agreement | |
| **Director(s)/ Corporate Director(s):** | Dr Chris Kenny, Director of Public Health Nottinghamshire County and Nottingham City | **Wards affected: All** |
| **Report author(s) and contact details:** | John Wilcox, Public Health Manager, Nottingham City Council. john.wilcox@nottinghamcity.gov.uk | |
| **Other colleagues who have provided input:** | Ruth Rigby, Managing Director, Healthwatch Nottingham.<br>Jane Garrard, Overview and Scrutiny Co-ordinator, Nottingham City Council.<br>Alison Challenger, Public Health Consultant, Nottingham City Council. | |
| **Date of consultation with Portfolio Holder(s) (if relevant)** | Nottingham City Health and Wellbeing Board Development Session 20th November 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 | ☐ |
| 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):**
The Health and Wellbeing Board and the local Healthwatch were formed as a result of the 2012 Health and Social Care Act. These bodies have specific distinct functions to that of the city council statutory function to scrutinise local health and social care services which is through the City Council Health Scrutiny Panel and the Joint City and County Health Scrutiny Committee. This written agreement will clarify how the 3 bodies relate to each other and how resources and activities can be coordinated. This will improve the ability of the bodies to plan and coordinate their activities where appropriate to improve health and social care services for citizens.

**Recommendation(s):**

| | |
|---|---|
| **1** | To endorse the working agreement between Nottingham City Health and Wellbeing Board, Healthwatch Nottingham and Health Scrutiny. |

## 1. REASONS FOR RECOMMENDATIONS

The agreement sets out the relationships between these 3 bodies and areas for potential coordination. This will improve mutual understanding of roles and functions, and reduce potential for duplication and lack of coordination between the 3 bodies. This will support the Health and Wellbeing Board's aims to improve the health and wellbeing of citizens.

## 2. BACKGROUND (INCLUDING OUTCOMES OF CONSULTATION)

### Rationale for the Agreement

Nottingham City Health and Wellbeing Board, Healthwatch Nottingham and the City Council function (which is carried out by the Health Scrutiny Panel and the Joint City and County Health Scrutiny Committee), share a common goal of improving health and social care services to benefit the health and wellbeing of citizens. All three have a role to play in reviewing and making recommendations about the way local services are planned and delivered. However, without due consideration for the complementary roles, there is potential for duplication when reviewing the health and social care system, and a lack of understanding about how the 3 bodies interact.

There was a discussion about these roles at the Nottingham City Health and Wellbeing Board Development Session on the 20th November 2013. This session set out how the 3 bodies relate to each other and potential areas for coordination. Lead officers were tasked with developing a document that describes this relationship. This is documented in the agreement being presented to the Board.

### Scope of the Agreement

The agreement sets out:

- the roles of the 3 bodies
- the legal obligations between them
- the local commitments between them
- how referrals will operate

### Benefits of having this agreement to the Health and Wellbeing Board

The agreement will help clarify and distinguish the role of the Health and Wellbeing Board from that of the health scrutiny function of the city council, and the role of Healthwatch Nottingham, which has statutory relationships with the Board and Health Scrutiny. The Health and Wellbeing Board will share its work plan with Healthwatch and Health Scrutiny. This will help reduce duplication, and also ensure that officers supporting the Board are aware of the priorities of the other 2 bodies, which are beneficial to the Board's objectives. The agreement sets out the potential for either Health Scrutiny or Healthwatch to undertake particular pieces of work (subject to available resources) that the Board has identified as a priority. This potential coordination of resources could therefore improve outcomes for citizens accessing the services being examined.

### Signing off the agreement

This Agreement will also be submitted to Healthwatch Nottingham and the Health Scrutiny Panel for agreement. If additional changes are required following this process it will be submitted to the Health and Wellbeing Board chair for approval.

## 3. OTHER OPTIONS CONSIDERED IN MAKING RECOMMENDATIONS

### Having no agreement

There is a potential for lack of local of coordination of work plans and therefore duplication of work without this agreement. Having this agreement will improve upon this situation.

### Having a detailed protocol

There was an option to develop a more detailed protocol, with more specified and formal procedures and timetables between the 3 bodies, but this was deemed to be unnecessary and did not add value to the objective of clarifying roles and improving coordination of activities and resources.

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

There are no additional financial implications from having the agreement.

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

None identified.

## 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

None.

## 8. PUBLISHED DOCUMENTS REFERRED TO IN COMPILING THIS REPORT

Health and Social Care Act 2012.
Centre for Public Scrutiny (2012). Local Healthwatch, health and wellbeing boards and health scrutiny. Roles, relationships and adding values.
Protocol between the Leicestershire Health and Wellbeing Board, the Leicestershire County Council Health Overview and Scrutiny Committee and Healthwatch Leicestershire (2013).
Health Scrutiny, Health and Wellbeing Board and Healthwatch. Draft Merton Protocol 2013.

# Nottingham City Health and Wellbeing Board, Healthwatch Nottingham and Health Scrutiny Working Agreement

**Contents**

## 1. Purpose of the Agreement

This Agreement sets out the relationship between the Nottingham City Health and Wellbeing Board, Healthwatch Nottingham and Nottingham City Council's Health Scrutiny function.

Health and Wellbeing Boards and Local Healthwatch were formed as a result of the 2012 Health and Social Care Act, which also expanded the role of Health Scrutiny. Whilst these bodies have specific distinct functions, there is potential for overlap in their work and opportunities for them to work in a complementary fashion whilst maintaining their independence.

The Agreement clarifies the key roles of the 3 bodies, their legal obligations to each other and how they will work together to improve the health and social care services for people in Nottingham.

## 2. Role of Nottingham City Health and Wellbeing Board

The Nottingham City Health and Wellbeing Board is the city's lead multi-agency partnership for improving health and wellbeing and reducing health inequalities of the citizens of Nottingham City. Functions of the Health and Wellbeing Board include:

- Supporting the development of improved and joined up health and social care services.
- Overseeing, 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.
- Developing and overseeing the implementation of the Joint Health and Wellbeing Strategy.
- Developing and overseeing the implementation of the Joint Strategic Needs Assessment and the Pharmaceutical Needs Assessment.
- Overseeing joint commissioning and joined up provision for citizens, patients, social care service users and carers, including social care, public health and NHS services with aspects of the wider local authority agenda that also impact on health and wellbeing, such as housing, education and the environment.
- Considering local commissioning plans to ensure that they are in line with the Joint Health and Wellbeing Strategy.
- Promoting public involvement in the development of the Joint Strategic Needs Assessment and the Joint Health and Wellbeing Strategy.
- Being one of the theme partnerships within the One Nottingham partnership family to lead on the Nottingham Plan to 2020 Healthy Nottingham priority.

## 3. Role of Healthwatch Nottingham

Healthwatch Nottingham will:

- Use its seat on the Health and Wellbeing Board to ensure that the views and experiences of patients, carers and other service users are taken into account when local needs assessments and strategies are prepared, such as the Joint Strategic Needs Assessment.
- Enable people to share their views and concerns about their local health and social care services and understand that their contribution will help build a picture of where services are doing well and where they can be improved.
- Give authoritative, evidence-based feedback in relation to the commissioning and delivery of local health and social care services.
- Help and support the Board to make sure that services really are designed to meet citizens' needs.
- Be inclusive and reflect the diversity of the community it serves.

## 4. Role of Health Scrutiny

Overview and scrutiny helps to provide accountability and transparency in local public services. It is an opportunity for non-executive councillors to review policies, decisions and services of the City Council and other organisations operating in Nottingham to ensure they meet the needs of the community and, where necessary, makes recommendations for improvement.

Health Scrutiny not only holds Council decision makers to account but also reviews and scrutinises commissioning and delivery across the health and social care system to ensure reduced health inequalities, access to services and the best outcomes for local people. Scrutiny can make reports and recommendations to NHS bodies and providers of NHS funded services. When a substantial change to a local health service is proposed, Health Scrutiny should be consulted and has a statutory role to ensure that the public interest has been taken into account and the proposed change is in the best interests of local health services.

There are two Health Scrutiny committees:

- Health Scrutiny Panel (for health and adult social care matters in Nottingham City)
- Nottingham City and Nottinghamshire County Joint Health Scrutiny Committee (for health matters across the Greater Nottingham area)

For the purpose of this Agreement the term 'Health Scrutiny' refers to both of these Committees.

## 5. Legal Obligations between the 3 Bodies

All three bodies have a legal basis and within their statutory functions there are specific legal obligations that exist between them.

- The Health and Wellbeing Board has a duty to involve Healthwatch. Nottingham in the preparation of the Joint Health and Wellbeing Strategy and the Joint Strategic Needs Assessment.
- The Health and Wellbeing Board has a duty to have a voting representative from Healthwatch Nottingham.
- Healthwatch Nottingham must appoint one person to represent it on the Health and Wellbeing Board.
- Healthwatch Nottingham must provide a copy of its annual report to Health Scrutiny.
- Health Scrutiny has a responsibility to review and scrutinise matters relating to the planning, provision and operation of health services in Nottingham and make reports and recommendations to relevant decision makers, including the Health and Wellbeing Board.
- Health Scrutiny must acknowledge and respond to referrals from Healthwatch Nottingham.

## 6. Local Commitments between the 3 Bodies

The Health and Wellbeing Board, Healthwatch Nottingham and Health Scrutiny will:

a) have a shared understanding of each other's roles, responsibilities and priorities
b) work in an open and constructive way
c) work in a climate of mutual respect and courtesy
d) respect each other's independence and autonomy.

Each body will produce and maintain an up-to-date work programme that is shared with each other to enable issues of mutual concern to be identified at an early stage and dealt with in a way that makes best use of respective roles, responsibilities and resources and avoids duplication. On major pieces of work requiring engagement, involvement or consultation of services users, carers and the public, the bodies will work collaboratively to agree roles and responsibilities. Where possible, the three bodies will seek to agree joint responses to consultation.

In working together recognition will be given to Healthwatch Nottingham's position as a member of the Health and Wellbeing Board; and the impact that this might have on its contribution to the work of Health Scrutiny, when that work relates to the Health and Wellbeing Board and its decisions and activities.

The successful application of the principles and commitments set out in this Agreement will depend on effective communication between the three bodies. Every effort will be made to ensure ongoing open communication and regular informal meetings will be arranged to facilitate this.

**The Health and Wellbeing Board will:**

- Share the Board and Commissioning Executive Group's work plan with Health Scrutiny and Healthwatch Nottingham.
- Update Health Scrutiny on its progress with the Joint Strategic Needs Assessment and the Joint Health and Wellbeing Strategy.
- Take account of and respond to the opinions of Healthwatch Nottingham.
- Be subject to scrutiny by the Council's Health Scrutiny Committees and provide information[1] and attend meetings as requested to assist in their scrutiny work.
- Take account of and respond to comments, reports and recommendations submitted by Health Scrutiny.
- Request Health Scrutiny (subject to available resource) to undertake a particular piece of work within its remit. (Health Scrutiny may choose not to do so).
- Request (subject to available resource) Healthwatch Nottingham to undertake a particular piece of work in order to inform the Board of public opinion and experience of services where there are particular concerns and enable the public to influence decisions. (Healthwatch Nottingham may choose not to do so).

Meetings of the Health and Wellbeing Board which includes Healthwatch Nottingham, are held in public and representatives of Health Scrutiny Panel and Joint City and County Health Scrutiny Committee will be welcome to attend.

**Healthwatch Nottingham will:**

- Share its work programme with the Health and Wellbeing Board and Health Scrutiny.
- Provide relevant public opinions/experiences about services to support the development of JSNA chapters.
- Highlight concerns about services to Health Scrutiny and, where appropriate, make referrals in line with the process set out in Section 7 of this agreement.
- As a member of the Health and Wellbeing Board, provide information and challenge from the perspective of the public, service users and carers as well as appropriate intelligence on any strategic and/or commissioning concerns.
- Work with the Health and Wellbeing Board and Health Scrutiny to provide information and comments as the public champion.
- Regularly inform Health Scrutiny of current issues and, in exceptional circumstances, request Health Scrutiny to consider whether a formal referral to the Secretary of State for Health is required.

[1]The Board and its partners will not be required to provide:

- Confidential information which relates to and identifies an individual unless the information is disclosed in a form ensuring that individuals' identities cannot be ascertained, or an individual consents to disclosure.
- Any information, the disclosure of which is prohibited by or under any enactment.
- Any information, the disclosure of which would breach commercial confidentiality.
-

- Provide Health Scrutiny with information as requested for specific topics and issues regarding patient and user experiences and access to services (subject to available resource).
- Acknowledge and respond to referrals from Health Scrutiny in line with the process set out in Section 7 of this agreement.

**Health Scrutiny will:**

- Share the Health Scrutiny Panel and Joint City and County Health Scrutiny Committee work programmes with Healthwatch Nottingham and the Health and Wellbeing Board.
- Seek views of Healthwatch Nottingham and the Health and Wellbeing Board when formulating Health Scrutiny work programmes.
- Hold the Health and Wellbeing Board to account for its work to improve the health and wellbeing of the population of Nottingham City and to reduce health inequalities, including its responsibilities in relation to the Joint Health and Wellbeing Strategy and the Joint Strategic Needs Assessment.
- Make reports and recommendations to the Health and Wellbeing Board as a result of scrutiny activity, including any concerns identified regarding the commissioning and/or delivery of local health and care services with a view to influencing future commissioning plans.
- Request Healthwatch Nottingham (subject to available resource) to submit relevant intelligence and information to support scrutiny work.
- Invite representatives of Healthwatch Nottingham to attend and, at the Chair's discretion, speak at Health Scrutiny meetings.
- Request Healthwatch Nottingham (subject to available resource) to undertake a particular piece of work in order to inform Health Scrutiny activity. In exceptional circumstances, this may include requesting that Healthwatch Nottingham use its 'Enter and View' powers where there is an issue of particular concern. (Healthwatch Nottingham may choose not to do so).
- Take account of and respond to the views and recommendations of Healthwatch Nottingham and the Health and Wellbeing Board.
- Acknowledge and respond to referrals from Healthwatch Nottingham in line with the process set out in Section 7.
- Refer relevant issues to Healthwatch Nottingham in line with the process set out in Section 7.
- Consider Healthwatch Nottingham's annual report.

Meetings of the Health Scrutiny Panel and Joint City and County Health Scrutiny Committee are held in public and representatives of Healthwatch Nottingham and the Health and Wellbeing Board will be welcome to attend.

## 7. Referrals between Healthwatch Nottingham and Health Scrutiny

### Referrals from Healthwatch Nottingham to Health Scrutiny

If, during the course of its work, Healthwatch Nottingham identifies an issue that it feels warrants exploration by Health Scrutiny it can make a referral. Referrals should

be made in writing to the lead health scrutiny councillor via the Council's Overview and Scrutiny Team. Referrals should set out:

- the nature of the referral
- the reason why the referral is being made
- any evidence about the issue
- what action it is proposed should be taken

Referrals will be acknowledged and considered at the next available meeting of the appropriate Health Scrutiny Committee. Healthwatch Nottingham will be informed of the outcome of this consideration and if the request is supported, any actions planned and progress then made in investigating the issue. If Health Scrutiny decides not to act on a referral it will provide reasons for not doing so.

**Referrals from Health Scrutiny to Healthwatch Nottingham**

If, during the course of its work, Health Scrutiny identifies an issue that it feels warrants exploration by Healthwatch Nottingham it can make a referral. Referrals should be made in writing to the Healthwatch Nottingham Managing Director. Referrals should set out:

- the nature of the referral
- the reason why the referral is being made
- any evidence about the issue
- what action it is proposed should be taken

Referrals will be acknowledged and considered. Health Scrutiny will be informed of the outcome of this consideration and if the request is supported, any actions planned and progress then made in investigating the issue. If Healthwatch Nottingham decides not to act on a referral it will provide reasons for not doing so.

# HEALTH AND WELLBEING BOARD - 30 April 2014

| | | |
|---|---|---|
| **Title of paper:** | **Nottingham Plan Refresh 2013-14 – Healthy Nottingham targets** | |
| **Director(s)/ Corporate Director(s):** | Nigel Cooke, Director of One Nottingham | **Wards affected:** All |
| **Report author(s) and contact details:** | Liz Jones, Interim Head of Corporate Policy<br>0115 8763367 liz.jones@nottinghamcity.gov.uk<br>Laura Catchpole, Corporate Policy Team<br>0115 87 64964 laura.catchpole@nottinghamcity.gov.uk | |
| **Other colleagues who have provided input:** | John Wilcox, Public Health Manager<br>0115 87 65110 John.wilcox@nottinghamcity.gov.uk | |
| **Date of consultation with Portfolio Holder(s) (if relevant)** | 26 February 2014 (at previous Health and Wellbeing Board) | |

| **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 report presents the recommended proposals to refresh the Nottingham Plan to 2020, specifically regarding the 6 Healthy Nottingham targets for which the Health and Wellbeing board is the accountable partnership.

Given the significant political and economic changes since the plan's launch, the One Nottingham Board and the leadership of Nottingham City Council asked for a refresh of the Nottingham Plan, to ensure the right areas of work are prioritised, that partnership resources targeted efficiently and the best measures are used to ensure it is delivering effectively for Nottingham citizens.

Overall consensus is that the current focus of the targets continues to articulate the right outcomes for Nottingham citizens and its partners, but the details and measures needed some refinement.

This refresh is not a full revision of the Plan.

| **Recommendation(s):** | |
|---|---|
| **1** | To approve the final recommendations, as show in section 1.3 and detailed in Appendix 1, following discussion at the Health and Wellbeing Board meeting in February, and to note the final position for all the other targets in the Nottingham Plan out in Appendix 2. |
| **2** | To note the Health and Wellbeing Board's role in relation to the Healthy Nottingham ambitions in the Nottingham Plan, including responsibility for receiving an annual picture of performance and ensuring delivery is on track. |

## 1. REASONS FOR RECOMMENDATIONS

1.1 The refresh ensures that going forward the targets are appropriate, credible, robust and measurable, whilst maintaining ambition and possible areas which would benefit from dedicated partnership focus.

1.2 The revisions have been developed by Nottingham Plan lead officers in discussion with the One Nottingham Board, One Nottingham family of partnerships and the Leadership of Nottingham City Council including Portfolio Holders.

1.3 Summary of key proposals for the Healthy Nottingham targets:

There was consensus about a need to maintain alignment with the Health and Wellbeing Strategy and consider the Public Health Outcomes Framework (PHOF), as advised by the Lead Officer. The PHOF is a national framework enabling comparison between authorities and therefore it is likely that Nottingham will be assessed and compared on these outcomes.

- 2 targets unchanged: **Smoking** (target 1) - The PHOF indicator reports adult smoking prevalence estimated through the national integrated household survey. This survey has a smaller sample size and different methodology to the Citizen's Survey which has been used to collect smoking status since 2006. It was decided to continue to collect data through the Citizen Survey as there are a number of years' trend data, and a larger sample size enabling the annual data to be analysed at the local area level. **Health inequality** (target 3) – the current target was considered appropriate.

- 2 targets with amended wording: **Physical activity** (target 4) has been amended to align with the adult physical activity recommendation for health, and the corresponding PHOF indicator, moving from '3 x 30 minutes of moderate physical activity per week' to '150 minutes of moderate physical activity per week'. This is measured through the national Active People Survey. The target has been revised to 56% in line with the new data. **Mental wellbeing** (target 6) has been amended to take account of both the proportion of adults in the city with poor mental wellbeing, and a comparison of the city's mean mental wellbeing score to the England mean score. This is measured through the Citizen's Survey.

- 2 targets with adjusted targets: **Adult overweight and obesity** (excess weight) (target 2) – measurement has been changed to use the new PHOF indicator which uses data collected through the new national Active People Survey data. The target has been revised to 58% in line with this new data. The **alcohol** target (target 5) will continue to measure alcohol-related hospital admissions. The target will be reset in line with the PHOF when the data is published.

## 2. BACKGROUND (INCLUDING OUTCOMES OF CONSULTATION)

2.1 The Nottingham Plan to 2020 is the city's Sustainable Community Strategy, setting out a 10 year plan to bring the city half way to achieving the 2030 vision for Nottingham.

The Plan was developed from the extensive I'maginiNG consultation and engagement programme, which involved residents from across the city, community groups, businesses, voluntary and faith groups and public agencies across Nottingham. The Plan had a robust

evidence base (the State of Nottingham) and all One Nottingham partners and partnerships were involved, including Nottingham City Council.

All One Nottingham partners remain committed to delivering the targets and ambitions in the Plan and the One Nottingham Board has overall responsibility for delivering the Plan, although responsibility for detailed delivery is delegated to the relevant board or partnership.

The One Nottingham Board and the City Council consider performance on the Nottingham Plan on an annual basis, through the development of an annual report. Targets which are not at expected position are considered by a joint One Nottingham and Scrutiny Performance Panel.

The context in which the Nottingham Plan is delivered has changed significantly since its development. Since 2009 there has been:

- A coalition Government with a rapidly evolving policy landscape
- Significant budget pressures and reduced capacity across partnerships
- Significant reductions in the national and regional capacity of the civil service

The Health and Wellbeing Board considered and approved these recommendations at the February Board meeting and the One Nottingham Board signed off the overall refreshed targets in March.

## 3. OTHER OPTIONS CONSIDERED IN MAKING RECOMMENDATIONS

3.1 Other options were considered from a full scale revision of the plan to a minimal refresh of poorly performing targets. The refresh that has been undertaken was a halfway point between these extremes, ensuring a review of all targets and a focus on key priorities, without the need for new consultation and research that a full revision would require or a light touch which may not have adequately focussed on priorities.

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

4.1 There are no financial implications arising from the refresh targets. Lead Officers recommended proposals can continue to be delivered within existing service plans.

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

5.1 Risk is managed through the departmental risk register and Partnership Governance Framework.

## 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

7.1 None

## 8. PUBLISHED DOCUMENTS REFERRED TO IN COMPILING THIS REPORT

8.1 Nottingham Plan to 2020

**Appendix 1**

| Current Target | Proposed | ON Board/ NCC Leadership feedback | Approved by Portfolio Holder/ and Partnership |
|---|---|---|---|
| **World Class Nottingham** | | | |
| **WCN1** To recover and continue growth in Nottingham GVA (per capita) of 3.8% per year | **Achieve and maintain Nottingham City GVA per capita to at least 30% above the England average.** | Content with this proposal | Proposals discussed with Portfolio Holder (confirmed 22.1.14) |
| **WCN2:** 20,000 new jobs created in the science and technology sectors (to 75,100 jobs) | **By 2020 Nottingham will have a greater proportion of its population working in the Knowledge Economy than any other Core City.** | Content with this proposal | |
| **WCN3: 5% growth in the visitor economy year on year** | No change. Retain target. | Content with this proposal | |
| **WCN4:** Host at least 12 internationally significant cultural and sporting events per year | **Host a minimum 4 internationally significant and 4 regional/city events per year** | Content with this proposal | Proposals discussed with Portfolio Holder and Cultural Strategic Partnership & Nottm Major Sports Event Group (confirmed 6.1.14) |
| **WCN5:** Continue the increase in new business starts by 10% per year | **Increase the rate of new business VAT registration to match that of the East Midlands.** | Content with this proposal | Proposals discussed with Cllr MacDonald (confirmed by PDB 22.1.14) |
| **Neighbourhood Nottingham** | | | |
| **NN1: Raise resident satisfaction with their neighbourhood (across the city) to 80%** | No change. Retain target. | Content with this proposal | *Proposals to be discussed with Portfolio Holder* |
| **NN2:** Raise resident satisfaction with their neighbourhood to no less than 5% below the city average in every neighbourhood | **Raise the residential satisfaction within each of the locality areas to no less than 5% below the city average**. | Content with this proposal | |

| Current Target | Proposed | ON Board/ Leadership Group feedback | Approved by Portfolio Holder/ and Partnership |
|---|---|---|---|
| **NN3:** 11,500 net new homes from 2008-2020 | **9,900 net new homes from 2008-2020** | Initial concern about the reduction & implied lack of ambition – now content with this proposal | Narrative improved to clearly present the case for revised target and how it realigns with the core strategy<br><br>Proposal presented & agreed at Housing Strategic Partnership – Portfolio Holder present 4.2.14 |
| **NN4: Increase family housing stock outside of the city centre (as defined in the Nottingham Local Plan) to at least 33% of all housing stock** | No change. Retain target. | Content with this proposal | *Proposals to be discussed with Portfolio Holder* |
| **NN5: Increase the percentage of people who believe that people from different backgrounds get on well together in their local area to 80%** | No change. Retain target. | Content with this proposal | |
| **NN6:** Increase the percentage of people who feel they can influence decisions in their locality to 40% | **Increase the percentage of people who feel they can influence decisions in their locality to 55%** | Content with this proposal | |
| **NN7: Increase the use of public transport by 2 million trips to 58 million trips per year by 2020** | No change. Retain target. | Content with this proposal | *Proposal to be discussed with Portfolio Holder on 10.3.14* |
| **NN8:** Eradicate fuel poverty by 2016 | **By 2020 Nottingham will have reduced fuel poverty below that of any other Core City** | Content with this proposal | Proposals discussed with Portfolio Holder (confirmed 14.2.14)<br><br>Proposal presented & agreed at Housing Strategic Partnership – Portfolio Holder present 4.2.14 |

| Current Target | Proposed | ON Board/ Leadership Group feedback | Approved by Portfolio Holder/ and Partnership |
|---|---|---|---|
| **Family Nottingham** | | | |
| **FN1:** Raise the percentage of children developing well across all areas of the early years foundation stage so that Nottingham is in the top 25% of local authorities | **Each year, all of our eligible 2 year olds (as specified by the Department for Education), access free nursery provision (15hrs per week)** | A previous proposal considered having a basket of measures, however this was rejected and a simple target was preferred. | Original proposals forwarded to Cllr Mellen (CM 3.2.14) *– further discussion to follow as FN1 developed*<br>*Proposals to be shared with Nottingham Children's Partnership 19.3.14* |
| **FN2: Child obesity will be reduced to 18%** | No change. Retain target | Content with this proposal | |
| **FN3: The number of first-time entrants each year into the criminal justice system aged 10-17 will be halved** | No change. Retain target | Content with this proposal | |
| **FN4: The teenage pregnancy rate will be halved** | No change. Retain target | Content with this proposal | |
| **FN5:** Raise the percentage of pupils achieving 5 or more A*-C GCSEs including English and Maths so that Nottingham is in the top 20% of the most improved local authorities | **The percentage of pupils achieving 5 or more A*-C GCSEs including English and Maths is above the average of all Core cities** | Content with this proposal | |
| **FN6: Reduce the percentage of pupils leaving school with no qualifications to 0%** | No change. Retain target | Content with this proposal | |
| **Working Nottingham** | | | |
| **WN1:** Increase the city's employment rate to 75% | **Increase the city's employment rate to 70%** | Content with this proposal | Proposals discussed with Portfolio Holder (confirmed 22.1.14) |
| **WN2:** Raise the proportion of adults with at least Level 2 qualifications to 90% | **Raise the proportion of adults with at least Level 2 qualifications to 80%** | Content with this proposal | |
| **WN3: Move the city of Nottingham up out of the 10% most deprived authorities in England, i.e. out of the bottom 35** | No change. Retain target | Content with this proposal | |

| Current Target | Proposed | ON Board/ Leadership Group feedback | Approved by Portfolio Holder/ and Partnership |
|---|---|---|---|
| **WN4: Ensure that no neighbourhood is in the most deprived 5% nationally** | No change. Retain target | Content with this proposal | Proposals discussed with Portfolio Holder (confirmed 22.1.14) |
| **WN5: The proportion of children living in poverty will be halved** | No change. Retain target, but address accountability. | Content with this proposal | |
| **Safer Nottingham** | | | |
| **SN1:** Reduce 'all crime' to the average for Nottingham's family of similar Community Safety Partnerships and the Core Cities | **Reduce 'all crime' by 6% by 2014-15.** | The CDP are currently working on targets from 2016 to 2020. | Proposals discussed with Portfolio Holder (confirmed 17.2.14)<br>Raised at Crime & Drugs Partnership 26.2.14 |
| **SN2:** Reduce core ASB calls to the Police by 39% (over a 2006/07 baseline) by March 2014 | **Reduce core ASB calls to the Police by 50% (over a 2006/07 baseline) by March 2015.** | | |
| **SN3:** Increase the number of people successfully completing treatment from 14.28% (2010/11 baseline) to 20.5% by March 2014 | **Increase the number of people successfully completing treatment from 14.28% (2010/11 baseline) to 15% by March 2015.** | | |
| **SN4: Reduce the total proven reoffending rate for all adult and juvenile offenders to the 2009 national average (26.6%) by March 2014** | Not possible to develop new target at this time.<br>Retain target. | Content with this proposal | |
| **Healthy Nottingham** | | | |
| **HN1: Reduce smoking prevalence to 20%, which is below the national average** | No change. Retain target. | Content with this proposal | Proposals discussed at the Health & Wellbeing Board, Portfolio Holder present 26.2.14 |
| **HN2:** Reduce the proportion of overweight and obese adults to the 2000 average levels for England (60%) | Retain target, but use Public Health Outcomes Framework (PHOF) measure – national comparator. Baseline and targets to be reset to 58%.<br>**Reduce the proportion of overweight and obese adults to 58%** | Content with this proposal | |

| Current Target | Proposed | ON Board/ Leadership Group feedback | Approved by Portfolio Holder/ and Partnership |
|---|---|---|---|
| **HN3:** Increase levels of physical activity to 32% of adults participating in 3 x 30 minutes moderate physical activity per week | Use PHOF measure – national comparator. Baseline and targets to be reset:<br>**Increase the proportion of adults achieving 150 minutes of physical activity per week to 56%** | No appropriate local targets could be identified after further investigation.<br>Content with this proposal | Proposals discussed at the Health & Wellbeing Board, Portfolio Holder present 26.2.14 |
| **HN4: Reduce the health inequality gap between Nottingham city and England by 70% by 2020. Defined as mortality rate from all circulatory diseases at ages under 75** | No change. Retain target. | | |
| **HN5: Reduce alcohol related hospital admissions to 1,400 per 100,000 population** | Retain target, but use new PHOF measure (due for release in late March). Baseline and targets to be reset. | Content with this proposal | |
| **HN6:** Improve mental health and wellbeing across the city (defined by reducing the proportion of people with poor mental health by 10%) | **Reduce the proportion of people with poor mental health by 10% and maintain the city wellbeing level in line with England as a whole** | Revised wording aligns with Health and Wellbeing strategy and incorporates PHOF measure –<br>Content with this proposal | |
| **Green Nottingham** | | | |
| **GN1: Reduce the city's carbon emissions by 26% of 2005 levels** | No change. Retain target. | Content with this proposal | Proposals discussed with Portfolio Holder (confirmed 14.2.14)<br>Proposals raised at Green Theme Partnership 26.2.14 |
| **GN2: Increase the reuse, recycling and composting of household waste to 50%** | No change. Retain target. | Considered for deletion, but ON Board & Leadership preference for it to be retained. | |
| **GN3: 20% of energy used in the city will be produced within the Greater Nottingham area from renewable or low/zero carbon sources** | No change. Retain target. | Content with this proposal | |

**Nottingham Health and Wellbeing Board - 30th April 2014**

| | | |
|---|---|---|
| **Title of paper:** | Parity of esteem – valuing mental health equally with physical health | |
| **Director(s)/ Corporate Director(s):** | Dr Chris Kenny, Director of Public Health, Nottingham City/Nottinghamshire County Councils | **Wards affected:** |
| **Report author(s) and contact details:** | Dr Michelle Hampson, Honorary Consultant Psychiatrist, Nottinghamshire Healthcare NHS Trust<br>Dr Joanna Copping, Consultant in Public Health Medicine, Nottingham City Council<br>Joanna.copping@nottinghamcity.gov.uk | |
| **Other colleagues who have provided input:** | Dr Marcus Bicknell, GP executive Mental Health Lead, Nottingham City CCG | |
| **Date of consultation with Portfolio Holder(s) (if relevant)** | April 2014 | |

| **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):**

In our society mental health does not receive the same attention as physical health. People with mental health problems frequently experience stigma and discrimination, not only in the wider community but also from services.

A recent report from the Royal College of Psychiatrists, Whole-person Care: from rhetoric to reality, (2013) highlighted the significant inequalities that exist between mental and physical health and outlined key areas for action. This paper summarises these priority areas and makes recommendations for further work required in Nottingham to achieve parity between mental and physical health. In addition, this paper updates the Health and Wellbeing Board on the progress of the Nottingham Mental Health Strategy.

**Recommendation(s):**

| | |
|---|---|
| **1** | The board is asked to endorse the parity of esteem approach to ensure equal status for mental and physical health |
| **2** | That all organisations represented on the board, nominate a mental health lead to champion the parity of esteem approach and work collectively to steer the implementation of the forthcoming Nottingham Mental Health Strategy |
| **3** | That a development session is scheduled to consider the Board's role in supporting the mental health strategy and parity of esteem |

## 1. REASONS FOR RECOMMENDATIONS

1) The aim of the Nottingham City Health and Wellbeing Board is to improve health and specifically reduce inequalities for Nottingham City residents. Significant inequalities currently exist between mental and physical health. Adopting the parity of esteem approach is essential in order to tackle this inequality.

2) Collective, co-ordinated action by the Health and Wellbeing Board will be required to drive significant improvements in mental health in Nottingham. Nominating champions from each organisation will give the mental health agenda the high level collaboration and steer required to push this agenda forward.

## 2. BACKGROUND (INCLUDING OUTCOMES OF CONSULTATION)

Parity of esteem is the principle by which mental health must be given equal priority to physical health and it was enshrined in law by the Health and Social Care Act 2012.

Mental health problems are the largest source of disability in the United Kingdom- almost one in four British adults and one in ten children experience a diagnosable mental health problem at any given time. However, despite the availability of effective, evidence-based interventions, unlike physical conditions, only a quarter of those with mental illness receive treatment.

Among people under 65, nearly half of all ill health is mental illness, and mental illness tends to be more debilitating than most chronic physical conditions. One in three avoidable deaths is linked to mental illness. People with severe mental illness on average die 15-20 years younger than people without mental illness and people with long term conditions are two to three times more likely to suffer from depression, which often remains undiagnosed and untreated. Mental health disorders (including dementia and substance misuse) account for 23% of the overall burden of disease, but national spending on mental health services is only 13% of total NHS expenditure.

In 2013 the Royal College of Psychiatrists published a report, *Whole-person Care: from rhetoric to reality,* to highlight these significant inequalities that exist between mental and physical health. The report outlined key areas for action for health and social care providers and wider partners. The attached paper, Parity of esteem- valuing mental health equally with physical health: the implications for policy and service development in Nottingham, summarises these priority areas and makes recommendations for further work required in Nottingham to achieve true parity between mental and physical health.

The draft Nottingham Mental Health Strategy, *Wellness in Mind,* has adopted this parity of esteem approach as an overarching theme. It has recently been out for extensive consultation and is now awaiting the inclusion of children's mental health, further to the completion of the children's mental health needs assessment. It will be launched later this year as an all ages, life course mental health strategy. Mental health is already one of four priorities within the Nottingham City Joint Health and Wellbeing Strategy and Health and Wellbeing Board members are now asked to nominate a mental health lead for each represented organisation to champion the parity of esteem agenda and to steer the implementation of the Nottingham Mental Health Strategy.

## 3. OTHER OPTIONS CONSIDERED IN MAKING RECOMMENDATIONS

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

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

## 6. EQUALITY IMPACT ASSESSMENT

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

## 8. PUBLISHED DOCUMENTS REFERRED TO IN COMPILING THIS REPORT

Whole-person Care: from rhetoric to reality (achieving parity between mental and physical health) Royal College of Psychiatrists (2013)

Nottingham City Joint Health and Wellbeing Strategy 2013-2106

## Parity of esteem – valuing mental health equally with physical health: the implications for policy and service development in Nottingham.

The term "parity of esteem" was introduced in the cross-government national mental health strategy, "*No health without mental health*" (2011) and is now reflected in a number of national documents on health service development including the NHS Mandate. The Health and Social Care Act specifically refers to the Secretary of State's duty in relation to both physical and mental health, with regard to service improvement, prevention, diagnosis and treatment, and states that both should be treated equally. Norman Lamb, minister of state for care and support has made clear the government's intention to ensure that the policy is translated into action.

As summarised in the 2012 London School of Economics report, "*How mental illness loses out in the NHS"*, the level of inequality in the way the NHS treats mental illness compared to physical health conditions is considerable. Among people under 65, nearly half of all ill health is mental illness and mental illness is generally more debilitating than chronic physical conditions, and yet only a quarter of those with mental illness are in treatment, compared with the vast majority of those with physical conditions.

This paper relates this national parity of esteem agenda to services in Nottingham and is based on the Royal College of Psychiatrists' report "*Whole-person care: from rhetoric to reality*", commissioned by the Department of Health (2013). This report focused on the domains of the NHS Outcomes Framework, whilst recognising that parity should apply to the public health and social care outcomes framework too.

This focus is timely given the cuts to health and social care budgets, as more holistic care from assessments to intervention should result in more effective and efficient healthcare. Furthermore, improvements to mental health and wellbeing should bring economic benefits to individuals, workplaces and the wider community. The longer term goal of truly integrated care can only be successfully achieved if the mental health component is adequately addressed and so this work is a vital first step towards achieving that objective.

### What is parity of esteem?

A "parity approach" ensures that holistic care is provided across health and social care and that all publicly funded services give equal value to mental and physical health problems.

The report identifies the implications of giving equal status as follows:

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

The report goes on to identify the key features of a parity approach as:

- It applies to all ages, from pre-birth onwards and includes those most at risk of mental and physical health problems.
- There should be equal access to care; comparable waiting times, equitable treatment, based on need with equivalent choice and quality
- Holistic care that views the mind and body as integrated, with education across health, social care and the wider population to reflect this.
- Investment in prevention of mental health problems and mental wellbeing in proportion to need.
- Investment in mental health research in proportion to need

- Investment of clinical, managerial time and funding in proportion to the prevalence and scale of the problem.
- Expectation that the care and outcomes will improve as in other areas of healthcare
- Respect and dignity for those with mental health problems

From the above the following points were identified as aspirations for commissioners:

1. The parity approach will be adopted for all health and social care provision from pre-birth and throughout the life course.
2. Commissioners will understand that physical and mental health is inextricably linked, and that it is not possible to treat or support one without affecting the other.
3. Commissioners will give the same priority to addressing and preventing mental health problems as they do to addressing and preventing physical health problems.
4. Generic health and social care policy, planning and services will integrate mental health and wellbeing from the outset.
5. Service providers will be expected to have and to fulfil aspirations for the recovery of people with mental health problems in the same way as for people with physical health conditions.
6. People who present with a physical health problem will receive assessment to identify potential mental health problems, and appropriate intervention to prevent escalation of any existing mental health problem.
7. Mental health problems will be recognised as a risk factor in physical illness and vice versa.
8. Continuity of care will be a guiding principle for the commissioning and provision of both mental and physical healthcare.
9. Public mental health and well-being will be an integral part of both national and local public health services, programmes and campaigns.
10. Mental health research will receive funding that reflects the prevalence of mental health problems and their cost to society.

People with mental health problems should then:

1. Receive timely and appropriate treatment, as is expected for physical health conditions
2. Have parity of life expectancy and similar rates of physical illness compared with those without mental health problems
3. Receive the same quality of physical healthcare as those without a mental health problem
4. Express the same levels of satisfaction with health and social care services as people with physical health conditions. This includes experiencing the same levels of dignity and respect from health and social care staff
5. Be offered appropriate intervention and support to address the factors affecting their much higher rates of health risk behaviour (e.g. smoking)
6. Receive social care on the same basis as people with physical health problems – according to the impact of the condition on the quality of their day-to-day life and the risk of a deterioration in health without such support from health or social care
7. Be given the same level of choice and control over their care, including discussions about choice of treatment and access to personal budgets. Where necessary, advocacy will be provided to enable this to happen.

## Parity of Esteem in Nottingham

This paper reviews the key recommendations in the Royal College of Psychiatry report in relation to services in Nottingham and recommends the action required to make parity of esteem a reality in this city. In line with national guidance, the recommendations have been grouped together under the headings of leadership, stigma and discrimination, parity of

outcomes, parity of care and treatment, comorbidity, public health, overall funding and research.

In Nottingham we have an excellent foundation to build upon; Nottingham has a national reputation for work relating to early intervention. The Health and Wellbeing Strategy includes mental health as one of its four key priorities. The Clinical Commissioning Group has likewise prioritised mental health as one of its key themes. We have a draft Nottingham Mental Health Strategy, *Wellness in Mind* due to be formally agreed and launched by the Health and Wellbeing Board this year.

## 1) Leadership

Leadership is needed to show commitment to whole person care and the recognition of the importance of lifelong coordinated care across health and social services. This will help to begin the process of cultural change within each organisation. To this end the report recommends:

- That local authorities should have a lead councillor for mental health to ensure adequate attention in commissioning and service delivery to mental as well as physical health and the social factors affecting both.
- All providers of physical health care should have a board member leading on mental health issues for their patient population and
- Mental health providers should have a board member leading on the physical health issues of their patients with mental health problems.

Nottingham is unusual in having providers attending the Health and Wellbeing Board (HWB), which facilitates an integrated approach between commissioning and public health, health and social care delivery. The chair of the Nottingham Health and Wellbeing Board (the portfolio holder for health) has already agreed to be the lead champion for mental health for Nottingham City and has signed up to 'The Mental Health Challenge' joining a national network of such leads. The Clinical Commissioning Group (CCG) has a mental health clinical lead and the local authority has a public health consultant lead for mental health and wellbeing and a public health consultant lead for children (including children's mental health). Nottingham University Hospitals has agreed in principle to a mental health lead and Nottinghamshire Healthcare NHS Trust is currently exploring having a physical health lead at board level.

***Proposed actions for Nottingham:***

a. To develop the role of mental health leads in all major healthcare providers (including City Care) and other key organisations represented on the Health and Wellbeing Board.
b. For the nominated mental health leads to work collaboratively to steer the mental health agenda, including the delivery of the forthcoming mental health strategy.
c. For the roles of the lead officer and councillor for mental health in Nottingham City Council to include raising awareness across all local authority services ( whether commissioned or directly provided) of the potential to improve mental health and to promote mental health awareness across the community.
d. For the HWB to consider parity of esteem in all aspects of its work and in particular work to tackle inequalities in physical and mental health and mental health discrimination.
e. For the HWB to receive an annual report on progress as part of the mental health strategy.

## 2) Tackling stigma and discrimination.

Time to Change, a national Government funded body, set up to end mental health discrimination, notes that discrimination, misunderstanding and stigma remain, and that mental health professionals are not exempt from this. Derogatory comments are not

infrequently made both of those with mental health problems and the professionals caring for them.

Nottinghamshire Healthcare NHS Trust has signed the Time to Change pledge to end mental health discrimination and is working on improved awareness and support for those with mental health problems in the workforce.

There is a local pilot of a national project involving faith communities across Nottinghamshire, Nottinghamshire Healthcare NHS Trust, Time to Change and the Royal College of Psychiatrists to improve mental health awareness in faith communities

***Proposed actions for Nottingham:***

a. Lead commissioning and provider organisations in Nottingham should review their equality and diversity policies to ensure that:
- Polices address mental health discrimination
- Staff are encouraged to challenge and report inappropriate behaviour
- Training is made available to support the policy
- Promote equality of opportunity for people living with long term mental health problems including the requirement to make 'reasonable adjustments' to the way services are delivered.

b. For Nottingham City Council and health providers to review and where necessary, improve mental health awareness and support for staff in their organisations and to disseminate the benefits of this approach to local employers.
c. For all organisations on the HWB to promote mental health awareness across the local community.

## 3) Parity of outcomes: preventing premature mortality.

Those with severe mental illness can on average expect to live 15-20 years less than their counterparts. This appears to be due to a number of factors including poor lifestyles, side effects from medications and less physical healthcare interventions.

Much of the premature mortality is due to cardiovascular disease, often attributable to smoking. 42% of tobacco is consumed by those with mental health disorders in this country. Both the mental and physical health issues of those with severe mental illness can limit the likelihood of them accessing smoking cessation support. Nottingham's aim to reduce smoking can only be achieved by including a specific focus on those with mental health problems.

Nottingham has developed a form across primary and secondary care to review the physical health status of those with mental health problems (the "phys form"), which has received national interest. This assessment and review tool is to be used across primary and secondary care.

***Proposed actions for Nottingham:***

a. Ensure that the Nottingham Tobacco Control Strategy further improves the accessibility of smoking cessation support and services to those with mental health problems.
b. Ensure the effective use of the phys form for physical health needs assessment in secondary care.
c. Develop the use of the phys form so that it includes a focus on outcomes. This would specifically include monitoring to ensure reduction in cigarettes smoked, effective treatment of cardiovascular disease and diabetes.
d. Undertake a Health Equity Audit of key health improvement services for those with severe mental illness
e. Ensure that in primary care those with mental health problems have the same access to physical health care monitoring, promotion and interventions.

## 4) Parity of care and treatment

Equality should be expected across physical and mental health services in relation to access to NICE recommended treatments including psychological therapies. The most recent national morbidity survey showed that only 24% of those with a common mental health disorder and 65% of those with a psychotic disorder received treatment in the past year. Comparable figures in high-income countries are over 90% for diabetes and hypertension, over 70% for heart disease and over 50% for asthma. NICE guidance CG91 recommends that services treating people with long term physical health problems routinely assess for common mental health problems.

Access should be equivalent for those with physical and mental health problems, including crisis care. Commonly those with mental illness and their carers express uncertainty as to how to access crisis care. There should be adequate service provision including the provision of approved mental health professionals (AMHPs) to ensure prompt assessment of those detained under section 136 of the Mental Health Act out of hours (the assessment should commence within 3 hours).

Parity should extend to cover the ambulance provision for those with acute mental health problems. In particular, the ambulance contract should specify a response time within 30 mins for those detained under s136 of the Mental Health Act, in line with national guidance.

***Proposed actions for Nottingham:***

a. The CCG to review waiting times across secondary healthcare services to ensure parity based on need.
b. To act of the findings of the forthcoming review of Improving Access to Psychological Therapies (IAPT) services to ensure all receive the appropriate level of evidence based interventions, as they would in physical healthcare, across the lifespan.
c. The CCG to identify mental health issues where NICE recommended treatments are not routinely commissioned (such as post traumatic stress disorder) and to work to address this.
d. Ensure that local reviews of crisis care consider equality of access for those with mental health problems, within and out of hours. .
e. Review the provision of AMHPs by the local authority to ensure adequate staffing to comply with national commissioning guidance.
f. Review of ambulance contract to ensure that national commissioning guidance is followed.
g. Ensure that the police have suitable training for their role in providing support for those with mental health problems including training from those with lived experience of mental health problems. This training should be for those working in custody suites as well as in the community.
h. Raise awareness of NICE guidance CG91 with Commissioners and providers of physical health care.

## 5) Parity of integrated care: addressing co and multi-morbidity of mental and physical health conditions.

All political parties recognise the need for more integrated care and this includes social care. The care of those who have both physical and mental health conditions is more costly than if they had one or other condition. Thus integrated care is more likely to result in cost savings.

Nottingham has a limited mental health liaison service for adults, compared with other equivalent cities. This service covers the Emergency Department and the wards of Nottingham University Hospitals. The service for older adults has been recently expanded and there are also workers focussing specifically on substance misuse

***Proposed actions for Nottingham:***

a. Ensure that all assessments, whether undertaken by healthcare staff of the acute or mental health trust or social care assessments cover mental, physical and social care needs and the care plan addresses all the problems identified.
b. To review staffing of liaison services. To consider cost effectiveness of a community based component of the service e.g. for those with medically unexplained symptoms.
c. For the HWB to work towards greater integrated care, embracing parity within it. This should include information transfer between clinicians to avoid duplication of assessments.
d. Ensure that the future CCG strategy includes co-morbidity in each work stream.

## 6) Parity and public health.

A parity approach should be evident in the work programme of public health in relation to health promotion and public health commissioned services. The mental health aspect of those and drug and alcohol use should be considered. Access to physical health interventions should be targeted at those with mental health problems according to need, and adjustments made to ensure equity of access.

The Nottingham Health and Wellbeing Strategy has a strong focus on mental health and specifically prioritises early intervention in mental health. The specific issues covered under this heading are the assessment of and parenting intervention for children with behavioural problems and improving the mental health of those in work and supporting those with mental health problems to find work.

The new mental health strategy for Nottingham is currently being finalised and parity of esteem is an overarching priority, providing a backdrop for the whole document.

***Proposed actions for Nottingham:***

a. Ensure parity of funding between physical and mental health within public health in line with the rates of disability
b. All public health polices and reports should consider both physical and mental health
c. Ensure that public health funded services such as Healthy Change seek to maximise mental health promotion
d. To develop an integrated approach across all Health and Wellbeing Board members for health promotion and wellbeing.

## 7) Parity across the life course.

All recommendations above cover the whole population. Specific issues for young people include ensuring that all those working with them have sufficient understanding of mental wellbeing, including signs of abuse and neglect and know how to respond. Schools should implement the NICE public health guidance on mental health promotion in schools. Early intervention in mental health problems is highly cost-effective. One in 10 children will have mental health difficulties and parity should apply to the resources allocated to the mental and physical problems of childhood. Antenatal and post natal classes should include the mental wellbeing of both the infant and parents.

It is important that within services for adults access should not be determined solely by age thresholds, rather patients should be offered the service that can best meet their needs.

In Nottingham two of the four priorities of the Nottingham Health and Wellbeing Board Strategy relate to integrated care for the older age group and increased support for priority families. A third focuses on early intervention in mental health includes early intervention for children with behavioural problems.

***Proposed actions for Nottingham:***

a. Ensure that the mental health strategy for Nottingham adopts a life course approach.
b. Advocate that schools implement NICE guidance around mental wellbeing.
c. Review the interface between young people's services and adult mental health services to ensure that there is seamless transition of care where appropriate.
d. Review how services and funding will be realigned to reflect the needs of an increasing older population.
e. Consider long term financial gain of investing in child mental health in the forthcoming children's mental health needs assessment.

## 8) Parity and funding.

There should be evidence that funding is proportionate to the identified need across mental and physical health. This should apply across all ages and take into account the growing population with dementia.

***Proposed action for Nottingham:***

a. For CCG and Nottingham City Council to demonstrate parity with regard to funding in relation to need across physical and mental health.
b. Consider greater funding of interventions in young people to reduce long term mental health conditions in adulthood.

## 9) Parity and research.

Whilst this is a national issue to ensure that research funding is related to clinical need, locally we can work together to promote more inter-agency research. This could include evaluation of interventions in relation to the Nottingham Health and Wellbeing Strategy, the Nottingham Mental Health Strategy or specific parity of esteem issues such as smoking and mental health.

***Proposed developments for Nottingham:***

a. For the Health and Wellbeing Board, Clinical Commissioning Group and health providers to work with our partner institutions to encourage research that will promote integrated care and parity of esteem.

**Dr Michelle Hampson**: Honorary Consultant Psychiatrist, Nottinghamshire Healthcare NHS Trust
**Dr Joanna Copping**: Consultant in Public Health Medicine, Nottingham City Council
**Dr Marcus Bicknell**: General Practitioner Executive & Mental health lead, Nottingham City Clinical Commissioning Group

**HEALTH AND WELL-BEING BOARD April 2014**

| | | |
|---|---|---|
| **Title of paper:** | **NCSCB AND NCASPB BUSINESS PLANS 2014/15** | |
| **Director(s)/ Corporate Director(s):** | Corporate Director for Children and Adult Services | **Wards affected: All** |
| **Report author(s) and contact details:** | Paul Burnett, Independent Chair of the Nottingham City Safeguarding Children Board and Adult Safeguarding Partnership Board | |
| **Other colleagues who have provided input:** | | |
| **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):**
The Safeguarding Boards key purposes are to secure effective safeguarding arrangements for the citizens of Nottingham and to secure effective co-ordination between all agencies responsible for safeguarding.

| **Recommendation(s):** | |
|---|---|
| **1** | To consider any further additions or amendments to the Business Plan for consideration for consideration by the Safeguarding Boards. |
| **2** | To agree the Business Plans |
| **3** | To identify any issues arising from the Business Plans that will be built into the Strategic Commissioning Plan formulated by the Health and Well-Being Board. |
| **4** | |

## 1. REASONS FOR RECOMMENDATIONS

1.1 It has been agreed that the Health and Well-Being Board will be a partnership board that contributes to the development of the Safeguarding Boards Business Plan as part of the annual consultative process. In addition, it has been agreed that the Health and Well-Being Board will consider how the key objectives in the

Safeguarding Boards Business Plan will be built into their own Strategic Commissioning Plans

## 2. BACKGROUND (INCLUDING OUTCOMES OF CONSULTATION)

2.1 It is a statutory requirement that the Nottingham City Safeguarding Children Board produce an annual Business Plan setting out its key objectives and priorities for action for each financial year. Whilst it is not a statutory responsibility to produce a Business Plan for the Safeguarding Adult Board it has been agreed that this should be produced in Nottingham City as a matter of good practice. This is the second time that the Business Plans have been combined into one document to reflect the alignment between the two boards that was put in place in 2012/13.

2.2 The key priorities for the Business Plan 2014/15 were agreed at the annual Development Day held by the Boards in January 2014. The formulation of this Business Plan has been undertaken with the engagement of members of both Boards and other stakeholders. It aims to articulate the key improvement objectives that will underpin our work in the period 2014-15 and, most importantly, to set out the actions that will be taken to address these priorities. In addition we have this year incorporated into the Plan the quality assurance and performance management indicators that will be used to evaluate the impact of our work under each priority objective.

2.3 The increased emphasis performance indicators and specific actions is also intended to ensure that we are more explicit about the outputs, outcomes and impact that the Boards intends to achieve. This we believe will strengthen our ability better to quality assure, performance monitor and risk manage the work of the Boards and their impact on safeguarding service delivery and on safeguarding outcomes for children, young people and adults.

2.4 The priorities in this Business Plan have been identified against a range of national and local drivers including:

- National policy drives to strengthen safeguarding arrangements and the roles of LSCBs and SABs – including revisions to Working Together, a move to statutory status for safeguarding adults boards, the outcomes of the Winterbourne View review;
- Recommendations from regulatory inspections including the inspection undertaken by Ofsted in March 2014;
- The outcomes of Serious Case Reviews and Serious Incident Learning Processes (SILPs) – emerging from both national and local reports;
- Evaluations of the impact of previous Business Plans and analysis of need in Nottingham City;
- Priorities for action emerging from Quality Assurance and Performance Management arrangements operated by both Boards;
- Responses to the views of stakeholders including the outcomes of engagement activities with children and young people;
- Best practice reports issued by Ofsted, ADCS and ADASS;
- The JSNA for Nottingham City.

2.5 The key priorities identified for the Business Plan 2014-15 are:

Priority 1: To be assured that 'Safeguarding is Everyone's Responsibility'

Priority 2a: To be assured that children and young people are safe across the child's journey

Priority 2b: To be assured that adults in need of safeguarding are safe

Priority 2C: To be assured that safeguarding services are effectively coordinated across children and adult services – applying the 'Think Family' concept

Priority 3: To be assured of the quality of care for any child not living with a parent or someone with parental responsibility

Priority 4: To be assured that our Learning and Improvement Framework is raising service quality and outcomes for children, young people and adults

Priority 5: To be assured that the workforce is fit for purpose

2.6 The Business Plan for 2014/15 is attached as appendix 1 to this report and sets out both the quality assurance and performance management indicators that will be applied to assess impact against each of the priorities and the actions that will be undertaken to support the achievement of these impacts and outcomes.

2.7 The draft Business Plan was considered by the Executive of the Health and Well-Being Board at its meeting on 4th March 2014. Comments made at that meeting have been incorporated into the draft of the Business Plan now attached.

## 3. OTHER OPTIONS CONSIDERED IN MAKING RECOMMENDATIONS

3.1 There are no other options presented.

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

4.1 Both the NCSCB and NCASPB are funded through a budget to which all statutory partners contribute through a formula agreed by the Board. These contributions have been agreed and there are no financial implications specifically for the Health and Well-Being Board.

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

5.1 The NCSCB and NCASPB operate their own risk registers that are monitored by both the Quality Assurance Sub-Group and the Operational Management Group.

## 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

7.1 The Business Plan is attached as Appendix 1.

## 8. PUBLISHED DOCUMENTS REFERRED TO IN COMPILING THIS REPORT

8.1 The NCSCB Business Plan is required by Working Together 2013 published by the Department for Education

**NOTTINGHAM CITY NCSCB AND NCASPB**

**Business Plan Priorities 2014/15**

**Priority 1:** To be assured that 'Safeguarding is Everyone's Responsibility'

**Priority 2a**: To be assured that children and young people are safe

**Priority 2b**: To be assured that adults in need of safeguarding are safe

**Priority 2c:** To be assured that services are effectively coordinated

**Priority 3**: To be assured that our Learning and Improvement Framework secures a workforce fit for purpose and is raising service quality and safeguarding outcomes for children, young people and adults

**CROSS CUTTING**

- Safeguarding services are co-ordinated
- The voices of children and adults are heard
- The voices of staff are heard
- Sub-regional and regional co-ordination will be maximised – specifically to assist partners who work across local authority boundaries
- Effective communication will underpin all Board activity

**Priority 1: To be assured that 'Safeguarding is Everyone's Responsibility'**

The focus of this priority is on partnership and individual agency effectiveness in safeguarding delivery and developing and embedding outcomes focus across the partnerships.

Outcomes sought in 2014/15.

**1.1** Ensure Boards' and partner agency compliance with Working Together 2013 (WT13) and the Care Bill.

**1.2** Ensure full agency compliance in Section 11 and SAF Audit processes.

**1.3** Ensure that the Board, OMG and Subgroups:

a. have appropriate and regular attendance rates,

b. have capacity to deliver Business Plan expectations,

**1.4** The Board drives partnerships and partner agencies to own, prioritise, resource, improve and positively impact on safeguarding.

**1.5** The Board receives management information to evidence, scrutinise and challenge performance so that it knows the safeguarding strengths and weaknesses of agencies, both individually and collectively, and the safeguarding outcomes for service users.

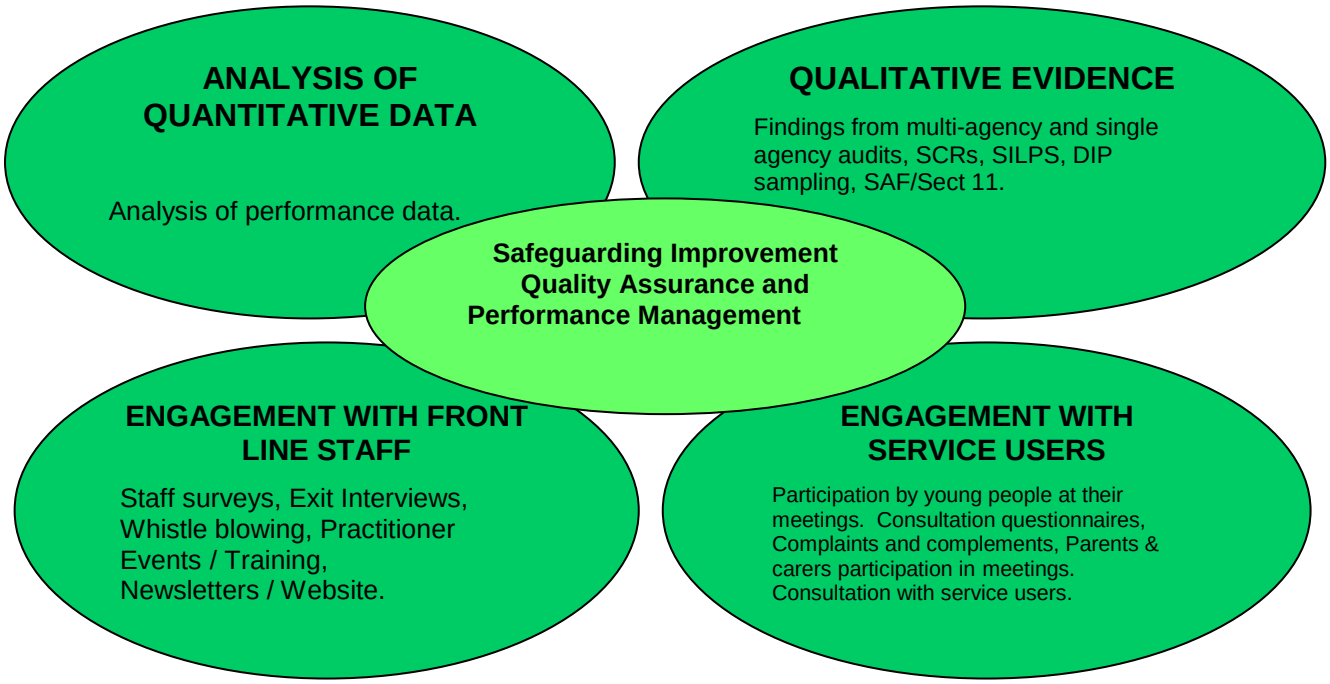
**1.6** Secures the effective implementation of new practice guidance issued in 2014.

**1.7** Formulate and implement the Information Sharing Protocol.

**1.8** Safeguarding roles and responsibilities and outcomes are explicit in the commissioning, contracting, monitoring and review of services.

**1.9** The 'voice' of children, young people, adults and practitioners is heard and acted on across all priorities.

**We will evidence our performance on the above as follows:**


ANALYSIS OF QUANTITATIVE DATA
Analysis of performance data.
QUALITATIVE EVIDENCE
Findings from multi-agency and single agency audits, SCRs, SILPS, DIP sampling, SAF/Sect 11.
Safeguarding Improvement Quality Assurance and Performance Management
ENGAGEMENT WITH FRONT LINE STAFF
Staff surveys, Exit Interviews, Whistle blowing, Practitioner Events / Training, Newsletters / Website.
ENGAGEMENT WITH SERVICE USERS
Participation by young people at their meetings. Consultation questionnaires, Complaints and complements, Parents & carers participation in meetings. Consultation with service users.

**Priority 2a: To be assured that children and young people are safe across the child's journey including the transition to adult services.**

**2a.1** The Local Authority Assessment Protocol is effectively implemented and secures impact.

**2a.2** Thresholds for safeguarding children are clear, understood and consistently applied across the Partnership.

**2a.3** That children receive the help and support they need at the earliest possible stage.

**2a.4** That all children requiring protection and/or care have had the benefit of early help and intervention.

**2a.5** That children subject to child protection plans and those in need have high quality multi agency support that reduces risks.

**2a.6** Children at high risk/vulnerable are being identified and risks managed to secure positive outcomes. The groups that we have prioritised for 2014/15 are: CSE; Missing; Domestic Violence/Abuse; Self-Harm.

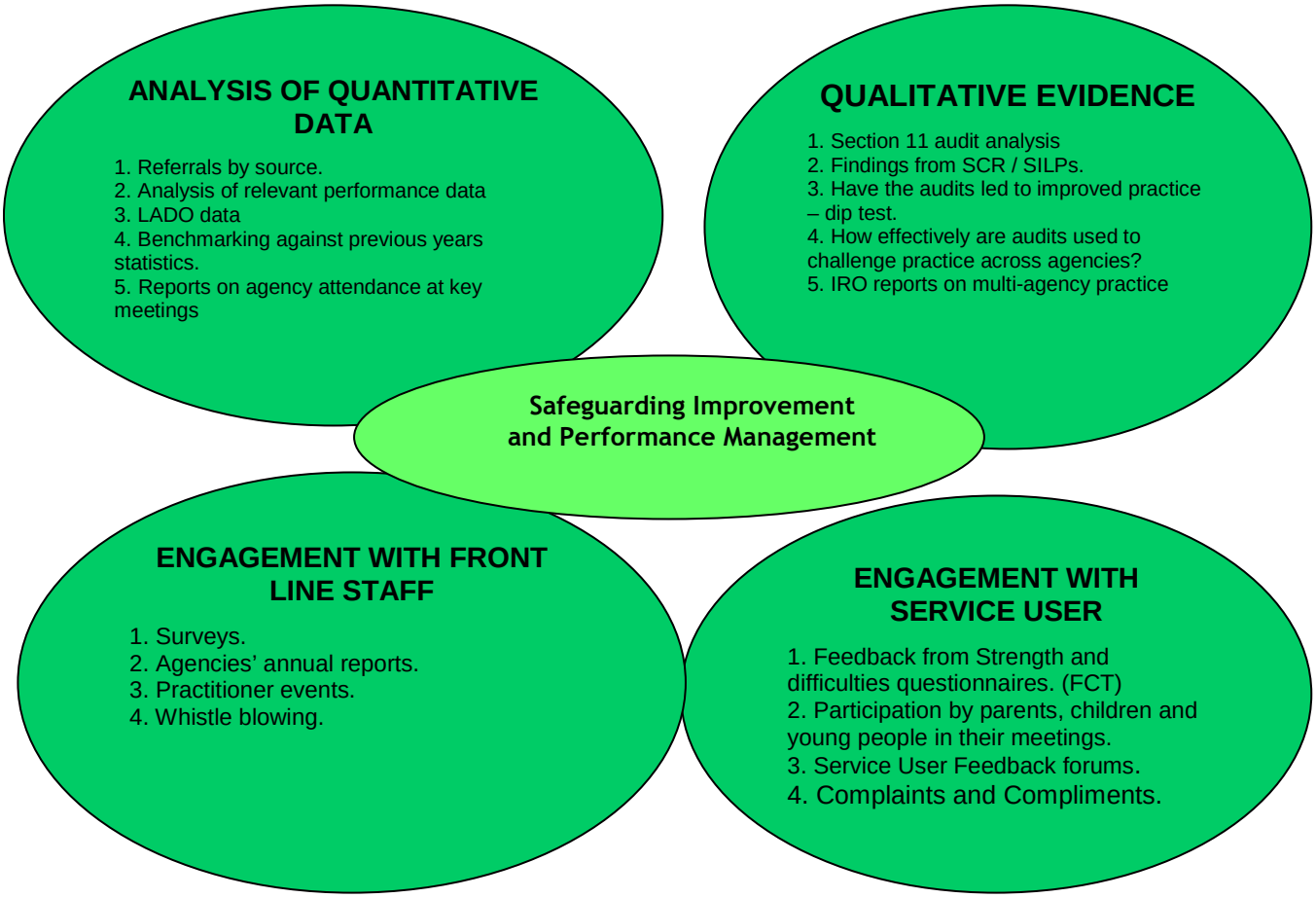
**2a.7** Effective transitions from children to adult services where appropriate.

**2a.8** Children/young people who are privately fostered are identified and supported.

**2a.9** The workforce has capacity to deliver effective safeguarding.

**2a.10** Adults who are assessed as posing risk to children and young people in need of safeguarding are effectively managed through MAPPA and MARAC and that risk to others is mitigated.

**Safeguarding Improvement**
**Quality Assurance and Performance Management**



**Priority 2b – To be assured that adults in need of safeguarding are safe**

**2b.1** Vulnerable adults are receiving the support they need at the earliest possible stage and any safeguarding concerns are appropriately identified and referred.

**2b.2** Thresholds for safeguarding adults are clear, understood and consistently applied.

**2b.3** Quality and impact of single agency provision to adults in need of safeguarding.

**2b.4** Quality and impact of multi-agency provision to adults in need of safeguarding.

**2b.5** Improved outcomes are evident in areas previously identified as risk. The groups that we have prioritised for 2014/15 are:

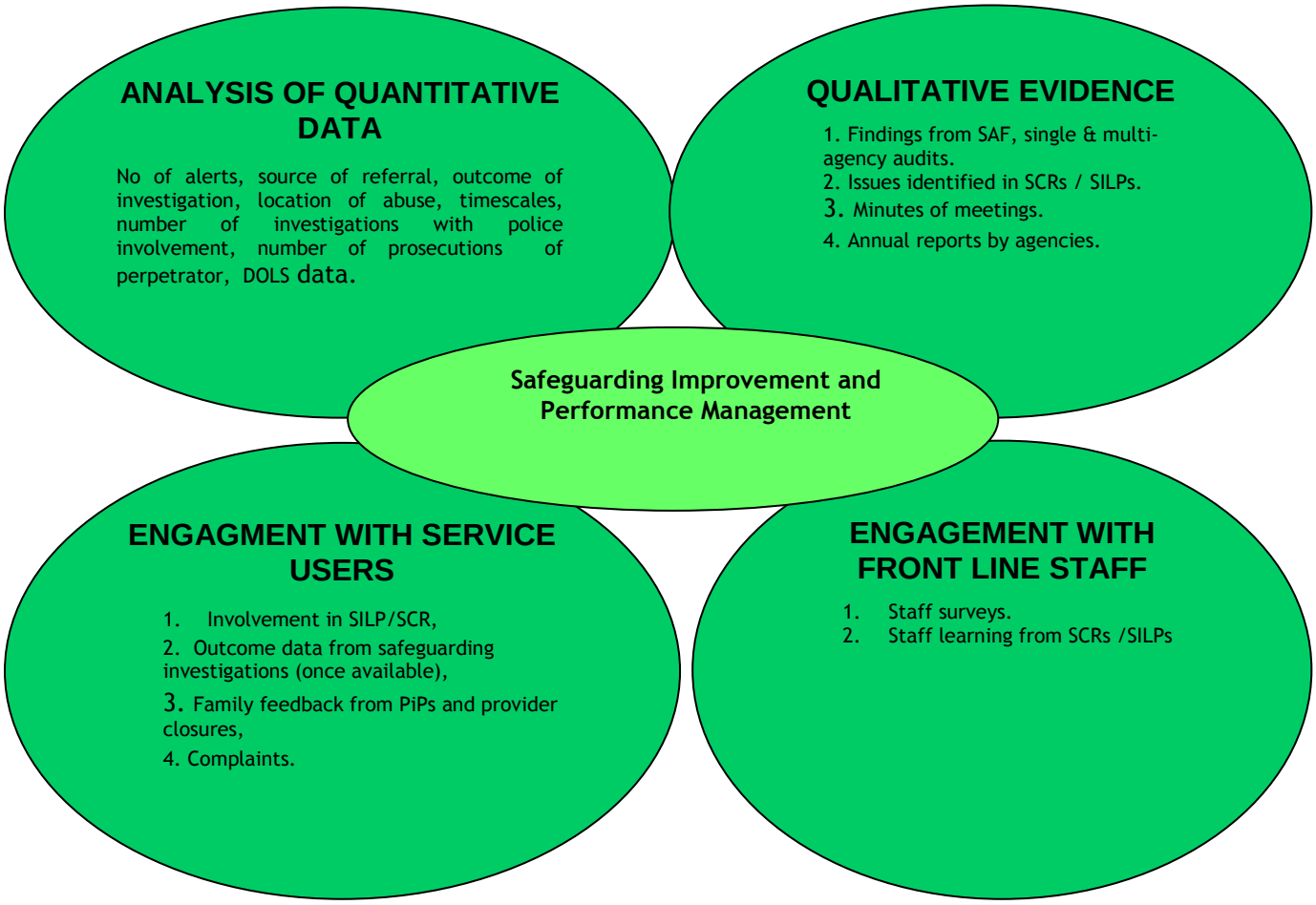
c. those receiving self-directed support and personal health budgets & those adults living with or receiving services from registered providers;

d. those affected by MCA/DoLS

e. those experiencing domestic abuse;

**2b.7** The workforce has capacity to deliver effective safeguarding.

**Safeguarding Improvement and Performance Management**

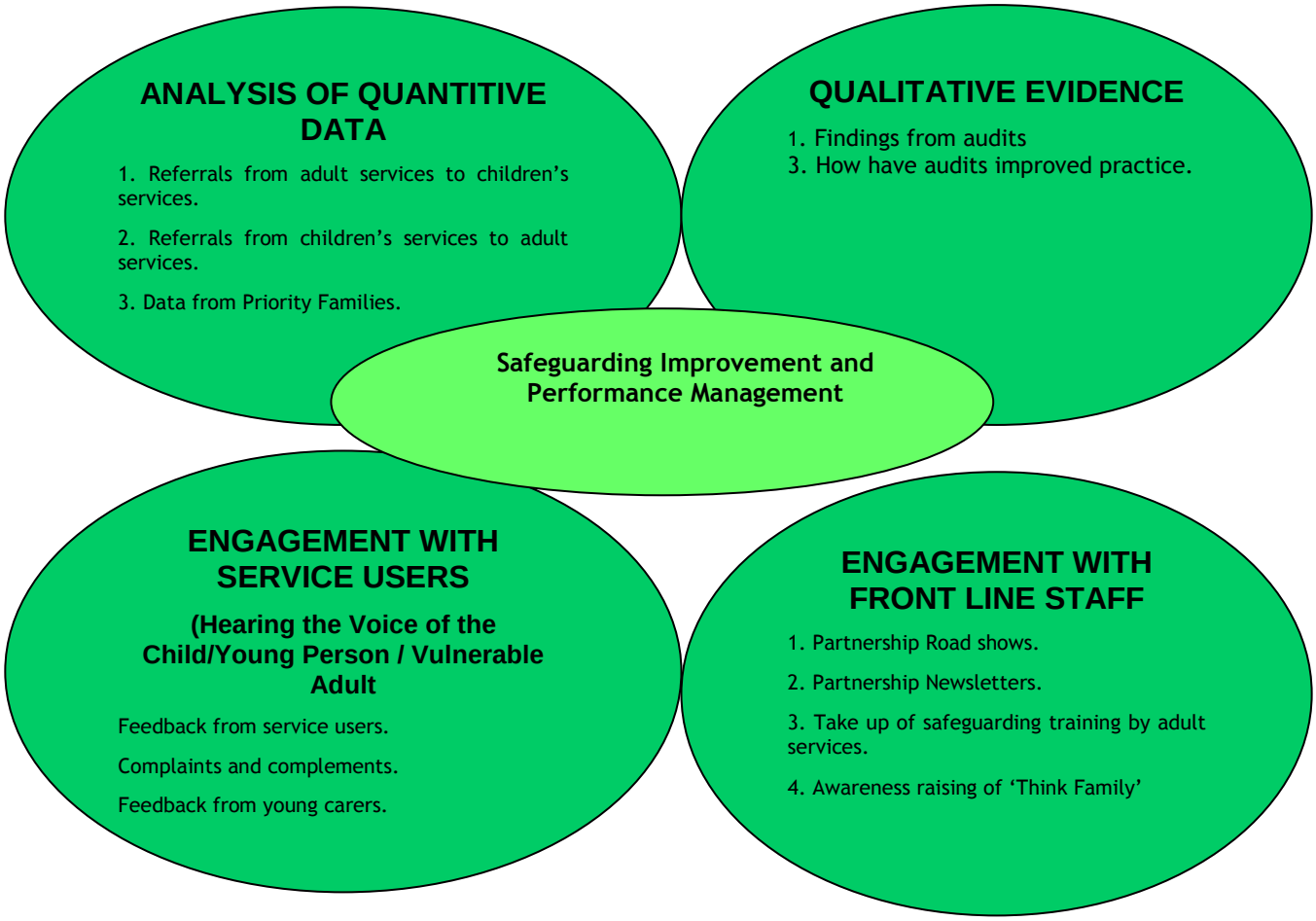


**Priority 2c – To be assured that safeguarding services are effectively coordinated across children and adult services – applying the 'Think Family' concept**

**2c.1** Adult services to consistently consider the safeguarding of children in households where they are working with an adult and make referrals for support and intervention where necessary.

**2c.2** Children's services to consistently consider the safeguarding of adults in households where they are working with children and make referrals for support and intervention where necessary.

**2c.3** Services that work with "whole" families are effectively coordinated (e.g. Priority Families) and secure added value in ensuring and co-ordinating effective safeguarding.



**Priority 3: To be assured that our Learning and Improvement Framework secures a workforce fit for purpose and is raising service quality and safeguarding outcomes for children, young people and adults.**

**How we learn, improve and test competency**

**3.1** Ensure learning from national, regional and local SCRs and other review/audit processes is incorporated into the practice of partner agencies and the partnership as a whole.

**3.2** Ensure the effectiveness of CDOP and lessons from child deaths are understood and consistently acted upon.

**3.3** Review safeguarding procedures and practice guidance to ensure they are 'fit for purpose' and reflect current learning and best practice.

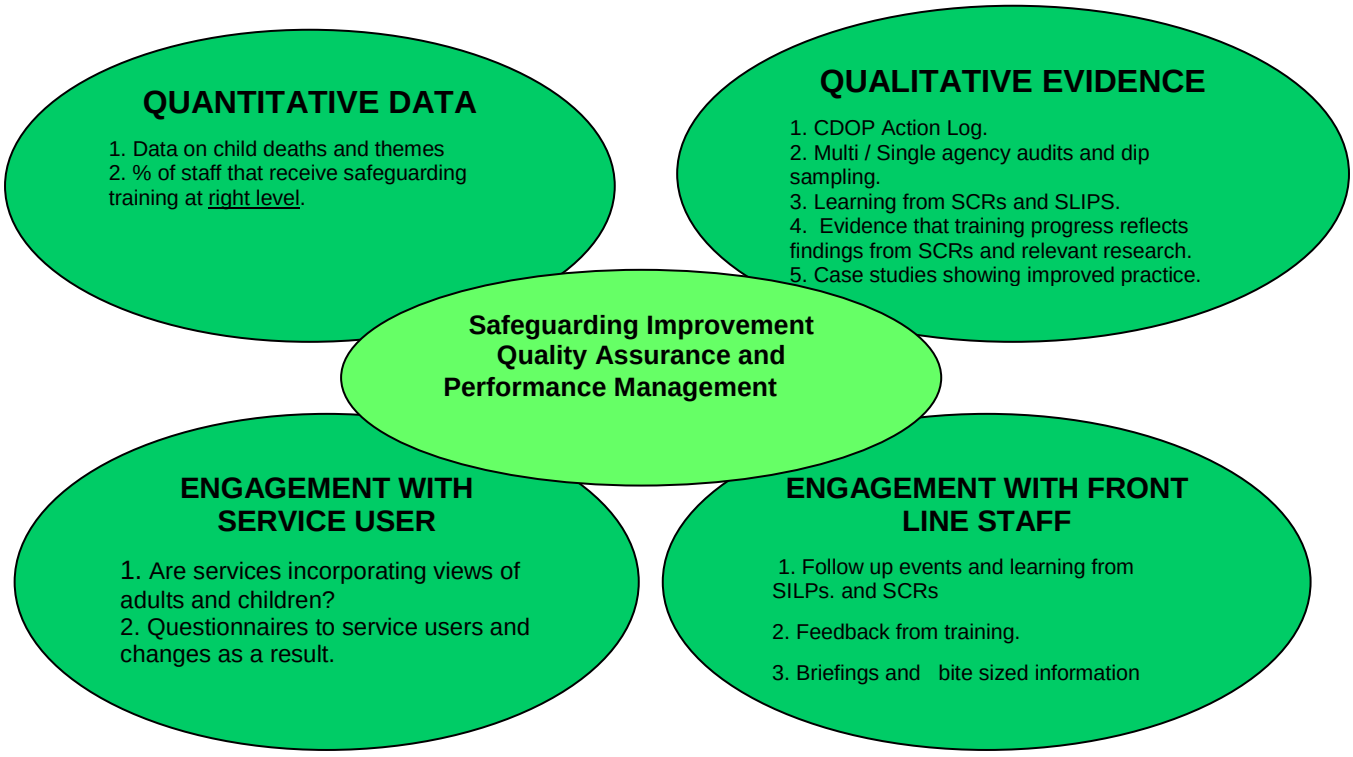
**3.4** Ensure the communication and engagement strategy is fit for purpose in order to secure awareness of safeguarding issues and the responsibilities of the Boards' partner agencies and the wider community in safeguarding.

**3.5** Establish a learning and improvement framework for adults.

**3.6** Monitor and evaluate the effectiveness of training and development in terms of the impact on the quality of safeguarding practice and outcomes for service users.

**3.7** Workforce is safely recruited.

**3.8** Allegations made against people who work with children and adults are dealt with effectively.



**ACTION PLANS**

**PRIORITY 1: To be assured that safeguarding is everyone's responsibility**

| No. | CAB | What do we want to achieve? | How are we going to do it? | Who will lead? | How will we know we have achieved our goal? | When are we going to achieve this? | Comment on Progress | RAG rating |
|---|---|---|---|---|---|---|---|---|
| **1.1** | **B** | Boards' and partner agency compliance with Working Together 2013 (WT13) and the Care Bill | Ensure that Board is compliant with Working Together 2013 and any new relevant guidance.<br><br>Monitor the impact of the updated Governance Document within the Board, Operational Management Group (OMG), Sub Groups. | **Service Manager, Board and Partnerships** | Robust challenge, evidence of impact gathered, fit for purpose attendance at meetings. | June 2014<br>Ongoing | | |
| **1.1** | **B** | " " | Revise Section 11 framework to reflect WT2013 and improve agency safeguarding processes and outputs. | **LSCB Service Manager**<br>**QA Sub-Group** | Section 11 Audit revised | May 2014 | | |
| **1.1** | **B** | " " | <u>Care Bill</u><br>Task and Finish Group created to determine what action is required to secure compliance when the Bill is passed. | **Care Bill Task and Finish Group** | Actions identified by the Task and Delivery Group have been achieved. | Insert | | |
| 1.2 | B | Ensure full agency compliance in Section 11 and SAF Audit processes | All agencies to undertake Section 11 / SAF audit for 2014<br><br>Compare outcomes of audits 2012 to audit 2014 to evaluate change and improvement. | **QA Sub Group**<br><br>**Service Manager and officers** | All agencies have completed Section 11 / SAF<br><br>Findings reported to Board. | 1st July 2014<br><br>30th Sept 2014 | | |

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| 1.3 | B | Ensure that the Board, OMG and Subgroups have appropriate and regular attendance rates | Maintain register of attendance and present quarterly analysis of attendance to OMG/Board. | **Board Officers/Service Manager** | Full attendance at appropriate level. | Ongoing Monitoring / Reporting | | |
| 1.3a | B | Have capacity to deliver Business Plan expectations. | Ensure appropriate representation and participation of agencies at subgroups and OMG. | **LSCB Service manager and Subgroup Chairs** | Sub groups complete work plans. | insert | | |
| 1.4 | B | The Board drives partnerships and partner agencies to own, prioritise, resource, improve and positively impact on safeguarding | Constructive challenge on areas for development and under performance | **Board OMG and Sub-groups** | Evidence of challenge in minutes of meetings<br><br>Specific changes relating to the challenges made. | Ongoing through the year. | | |
| 1.5 | B | The Board receives management information to evidence, scrutinise and challenge performance so that it knows the safeguarding strengths and weaknesses of agencies, both individually and collectively, and the safeguarding outcomes for service | Analysis of performance data and findings from single and multi-agency audit to be reported to Board to get a picture of safeguarding practice on a quarterly – including:<br>• Bench marking with statistical neighbours where available.<br>• Trend Data<br>• Early emerging themes arising from SCRs / SILPs. | **Board Service Manager and Officers supported by Chairs of QA and Serious Case Review Sub group chairs and agency leads** | Analytical report to Board. | | | |

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| | | users. | | | | | | |
| 1.5 | B | " " | This information is scrutinised and challenged by the OMG and Board. | **OMG & Board** | Scrutiny and challenge is evidenced in minutes.<br><br>Impact of such is evidenced in minutes.<br><br>Board has full picture of quality of safeguarding practice across agencies | Ongoing through the year. | | |
| 1.6 | C | Secure the effective implementation of new practice guidance issued in 2014. | Ensure that new Practice Guidance is used and utilised through feedback from staff at all levels.<br>Practice guidance to inform audit programme of single and multi-agency audits.<br>Evidence of impact gathered through audit. | **Board service manager / Officers.**<br>**OMG / Board** | Report to Board on progress and findings of audit. | Quarterly feedback to Board. | | |
| 1.7 | B | Formulate and implement the Information Sharing Protocol. | Task and Finish Group to progress and ensure fitness for purpose of information sharing protocol. | **Independent Chair led by Task and Finish Group** | Information is shared effectively for multi-agency audits and review processes.<br><br>Evidenced in audits. | | | |
| 1.8 | B | Safeguarding roles and responsibilities and outcomes are | Expectations regarding safeguarding to be included in all commissioning and contracting arrangements. | **Board Manager to inform Commissioning** | Dip sampling of contracts and commissioning | Ongoing throughout the year. | | |

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| | | explicit in the commissioning, contracting, monitoring and review of services across agencies. | | **Departments**<br><br>**QA subgroup / Board Officer.** | processes.<br><br>Dip sampling of contracts by commissioning and findings reported to QA subgroup. | | | |
| 1.9 | B | The 'voice' of children, young people and adults is heard and acted on | Evidence based Feedback from Social care and Partner agencies.<br><br>Feedback from Participation Offers across agencies received. | **Board Partner Agencies**<br><br>**QA Sub Group** | Report received from agencies assuring that the voices of service users are heard and acted on. | Received quarterly. | | |
| 1.9 | C | | Analysis CAF questionnaires | **Lead of Family & Community Team** | Report to Board analysing CAF questionnaires | Received quarterly. | | |
| 1.9 | B | | Feedback from Complaints Officers across all agencies. | **Complaints departments in partner agencies/ OMG** | Improved practice as a result of themes arsing from complaints made by children and adults reported to OMG | Received quarterly. | | |

**ACTION PLANS**

**Priority 2a: To be assured that children and young people are safe across the child's journey**

| No. | CAB | What do we want to achieve? | How are we going to do it? | Who will lead? | How will we know we have achieved our goal? | When are we going to achieve this? | Progress Review | RAG rating |
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| **2a.1** | **C** | Local authority Assessment Protocol is effectively implemented and secures impact | Reports from social care and other agencies that show the assessment protocol is now in place. | **Head of Social Care** | Findings from single agency audits to show that the assessment protocol has been implemented. | **Quarterly throughout the year** | | |
| **2a.1** | **C** | " " | Report of analysis of re-referrals. | **Head of Social Care** | Decrease in re-referrals. | **Bi annual report to Board.** | | |
| **2a.2** | **C** | Thresholds for safeguarding children are clear, understood and consistently applied across the Partnership | Review of Family Support Strategy and Pathway, publication and implementation.<br><br>Feedback from individual agencies.<br><br>Feedback from escalations. | **Quality & Commissioning**<br><br>**Head of Social Care**<br><br>**Head of Social Care.** | Children, including children in need, receive support at the right level and this is evidenced in single and multi-agency audits. | | | |
| **2a2** | **C** | " " | All training materials is up-to-date and reflects the new thresholds. | **Training subgroup** | Training materials fit for purpose and available | **Bi annual checks.** | | |
| **2a.3** | **C** | That children receive the help and support they need at the earliest possible stage | Receive bi monthly analysis reports to OMG of early help data. | **QA subgroup/ Children's partnership Board**<br>**Head of Family & Community** | Data and audit will show that early help was put in place. | | | |

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| | | | Findings and action plans from SCRs & SILPs | **SCR Sub group** | Report on findings | | | |
| **2a.4** | **C** | That all children requiring protection and/or care have had the benefit of early help and intervention. | Undertake themed and single agency audits. | " " | Findings from audits will show that children in need of protection were identified early or that early help prevented concerns escalating. | | | |
| **2a.4** | **C** | " " | Findings and action plans from SCRs & SILPs | **SCR Subgroup** | Report on findings | | | |
| **2a.5** | **B** | That children subject to child protection plans and those in need have high quality multi-agency support that reduces risks. | Monitor multi-agency engagement and quality of practice through multi-agency audits. | **QA subgroup** | Reduction in the numbers of re-registrations. | | | |
| **2a.5** | **C** | " " | Findings and action plans from SCRs & SILPs | **SCR Subgroup** | Report on findings | | | |
| **2a.5** | **B** | " " | Ensure single agency audits focus on safeguarding and are reported to the Board. | **QA subgroup** | Report on findings. | | | |
| **2a.5** | **B** | | IRO report to Board on a six monthly basis. | **Principal Manager –** | IRO report to Board in quality of multi-agency | | | |

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| | | " " | | **Children's Quality Assurance** | practice. | | | |
| **2a.6** | **C** | Children at high risk/vulnerable are being identified and risks managed to secure positive outcomes. The groups that we have prioritised for 2014/15 are: CSE; Missing; Domestic Violence/Abuse; Self-Harm; | Reports of evidence of impact from subgroups. | **CSE Subgroup**<br><br>**Missing Subgroup**<br><br>**DV subgroup** | Findings from reports and audits show that children affected by these issues are identified and risks are appropriately managed. | | | |
| **2a.7** | **C** | Effective transition from children's to adults services where appropriate. | Assess the impact of actions taken following relevant SCRs through audit. | **QA subgroup**<br><br>**Cross Authority Transition**<br><br>**LSCB Service Manager / Board Officer** | Findings from assessment reported to the Board. | | | |
| **2a.7** | **B** | " " | Ensure that learning from local and national SCRs are disseminated. | **SCR Sub group** | Evidence of dissemination.<br>Evidence of impact of learning. | **Dip testing for specific learning issues.** | | |
| **2a.7** | **C** | " " | Request report on transitions from children's services where they meet the thresholds for adults services. | **Lead for CAMHS/ Lead for Disabled Children** | Evidence of how effective transitions are with action plans for identified barriers. | **Analysis in requested reports bi annually.** | | |
| **2a.8** | **C** | Children/young people who are privately fostered are identified | Receive six monthly report from social care, examining the number | **Service manager (Private** | Received report<br><br>Increase in number of | **Analysis of findings / Action** | | |

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| | | and supported. | of children who are privately fostered. | **fostering)** | privately fostered children identified. | **planning bi annually.** | | |
| **2a.8** | **C** | " " | Test professionals understanding of private fostering. | **Service manager (Private fostering)** | Report findings | **Bi annually.** | | |
| **2a.9** | | The workforce has effective capacity to deliver effective safeguarding. | Be assured that agencies have sufficient capacity to undertake safeguarding practice effectively.<br><br>Report on any capacity issues identified in SCRs and SILPs. | **Board Partner agencies/ Board Service manager**<br><br>**SCR Sub group** | Six monthly report to Board if any issue regarding capacity impacts on safeguarding work.<br><br>Reports received and subsequent actions tracked. | **Bi annually.** | | |
| **2a.10** | **B** | Adults who are assessed as posing risk to children and young people in need of safeguarding are effectively managed through MAPPA and MARAC and that risk to others is mitigated | Board to consider the outcome from the CARDA assessment of MARAC. | **MARAC/ Board** | Report received and any actions put in place to address identified shortfalls. | | | |
| | | " " | Report from MARAC on engagement by professionals in the MARAC process | **MARAC/ Board** | Report received and any actions put in place to address identified shortfalls. | | | |
| | | " " | Board to consider report on effectiveness of MAPPA | **Lead for MAPPA / Board** | Report received and any actions put in place to address identified shortfalls. | | | |

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| | | “ “ | Report from MAPPA on engagement by professionals in the MAPPA process. | **Lead for MAPPA / Board** | Report received and any actions put in place to address identified shortfalls. | | | |

**ACTION / SUB GROUP WORK PLANS**

**Priority 2b - To be assured that adults in need of safeguarding are safe**

| No. | CAB | What do we want to achieve? | How are we going to do it? | Who will lead? | How are we going to know that we have achieved? this | When are we going to achieve this? | Progress Review | RAG rating |
|---|---|---|---|---|---|---|---|---|
| **2b.1** | **A** | Vulnerable adults are receiving the support they need at the earliest possible stage and any safeguarding concerns are appropriately identified and referred. | Examine support through single and multi-agency audits. | **QA subgroup** | Data and audit will show appropriate support and intervention was put in place. | **Monitoring over 12 month period through dip testing.** | **Bi annually.** | |
| **2b.2** | **A** | Thresholds for safeguarding adults are clear, understood and consistently applied across the partnership. | Threshold training in place with good take up across agencies. | **Training subgroup** | Report from subgroup on attendance. | | | |
| **2b.2a** | **A** | " " | Targeted agency attendance at training. | **Training subgroup** | Updated report. | | | |
| **2b.2b** | **A** | " " | Analysis of source of referrals. | **Head of Adult Social Care / LSCB Board Manager.**<br><br>**QA subgroup** | Report to the Board to be assured that practitioners, providers and any other referrers are aware of referral processes. | **Bi annual reporting.** | | |
| **2b.2c** | **A** | " " | Single agencies to report to Board on monitoring of their own safeguarding referrals. | **Board Partner agencies/ QA subgroup** | Data provided by partner agencies with analysis. | **Bi annual reporting.** | | |

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| | **A** | " " | Implement a programme of single agency themed audits to ensure thresholds are being applied. | **QA subgroup** | Findings from audits to show that thresholds are being consistently and appropriately applied. | **Bi annual reporting.** | | |
| **2b.3** | **A** | Quality and impact of multi-agency and single agency provision to adults in need of safeguarding | Ensure multi agency and single agency audits are completed and results reported to NCASPB. | **QA subgroup** | Findings from audits<br><br>Action plans to address areas of improvement | **Bi annual reporting.** | | |
| | | " " | Review the data on adult safeguarding to capture relevant information. | **Director of Adult Social**<br>**QA subgroup** | Report on analysis of data presented. | | | |
| | | " " | Analyse the data on adult safeguarding | **Head of Adult Services /LSCB Board Manager** | Report on analysis of data presented. | | | |
| **2.4** | **A** | Quality and impact of single agency provision to adults in need of safeguarding. | Initiate SCRs and SILPs as required, ensuring criteria is met. | **SCR subgroup** | Quarterly report to Board on activity and findings. | | | |
| **2.4a** | | " " | Learning from reviews to be disseminated appropriately. | **QA subgroup** | Quarterly report to Board on activity and findings. | | | |
| **2.4b** | | " " | Recommendations to be implemented and impact evaluated. | **QA subgroup** | Quarterly report to Board on activity and findings. | | | |
| | | " " | Multi-agency audit of a Provider investigation | **QA subgroup** | Quarterly report to Board on activity and findings. | | | |
| **2.5** | **A** | Improved outcomes are | Single agencies to audit | **QA subgroup** | | | | |

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| | | evident in areas previously identified as risk. The groups that we have prioritised for 2014/15 are: | that safeguarding is embedded in policy, contracts and quality monitoring process and provide assurance to the Board. | | | | | |
| **2.5a** | **A** | **a.** those receiving self-directed support and personal health budgets & those adults living with or receiving services from registered providers | Ensure that recommendations and actions from SCRs and SILPs to be implemented effectively, | **SCR subgroup/QA Subgroup** | Findings from multi-agency and single agency audits and dip-testing. | | | |
| **2.5** | | b. those affected by MCA/DoLS | Agencies to provide evidence from single agency audits that MCA is considered in safeguarding interventions and applied and recorded appropriately. | **MCA/DoIs subgroup** | Findings from audit reported. | | | |
| **2.5** | | " " | Analysis of data, highlighting areas of concern and implementing remedial action as required. Completion of the national and statutory return for DoIs data. | **MCA/DoIs subgroup** | Action plans to address identified issues.<br><br>Quarterly report to Board. | | | |
| **2.5** | | " " | To be assured through audit that applications made for DOLs are appropriate. | **MCA/DoIs subgroup** | Report on findings and action plan to address identified issues. | | | |

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| | | “ “ | Co ordinate and respond to training needs identified to feed into training sub group. | **MCA/DoIs subgroup / Training subgroup** | Appropriate training in place and taken up. | | | |
| **2.5** | | “ “ | Review of MCA policy and procedure. | **Director of Adult Social Care / MCA / DoIs subgroup.** | Reviewed policy and procedure. | | | |
| **2.5** | | | Analysis of data, highlighting areas of concern and implementing remedial action as required. Completion of the national and statutory return for DoIs data.<br>To be assured through audit that applications made for DOLs are appropriate | **MCA/DoIs subgroup** | | | | |
| **2.5** | | | Coordinate and respond to training needs identified to feed into training subgroup. | **MCA/DoIs subgroup/** | | | | |

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| | | | Review of MCA policy and procedure. | **Director of Adult Social Care/ MCA/DoIs subgroup** | | | | |
| **2.5** | | Improved outcomes are evident in areas previously identified as risk. The groups that we have prioritised for 2014/15 are:<br><br>**c.** those experiencing domestic abuse; | Board to consider the outcome from the CARDA assessment of MARAC. | **MARAC/ Board** | Report received and any actions put in place to address identified shortfalls. | | | |
| **2.5** | | " " | Report from MARAC on engagement by professionals in the MARAC process. | | | | | |
| **2.5** | | " " | Be assured through audits that Vulnerable adults are appropriately screened using the DASH risk assessment tool. | **DV subgroup** | Report findings of audit | | | |
| **2.6** | **A** | The workforce has capacity to deliver effective safeguarding | Be assured that agencies have sufficient capacity to undertake safeguarding practice effectively. | **Board Partner agencies/ Board Service manager** | Six monthly report to Board if any issue regarding capacity impacts on safeguarding work.<br><br>Reports received and subsequent actions | | | |

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| | | | | | tracked. | | | |

**ACTION / SUB GROUP WORK PLANS**
**Priority 2C – To be assured that safeguarding services are effectively coordinated across children and adult services – applying the 'Think Family' concept**

| No. | CAB | What do we want to achieve? | How are we going to do it? | Who will lead? | How will we know we have achieved our goal? | When are we going to achieve this? | Progress Review | RAG rating |
|---|---|---|---|---|---|---|---|---|
| **2c.1** | **B** | Adult services to consistently consider the safeguarding of children in households where they are working with an adult and make referrals for support and intervention where necessary. | Review services against recommendations from the Ofsted thematic inspection on joint working between adult and children's services 'What about the children' | **Chair and Board service manager** | Report to Board on extent to which recommendations are met | | | |
| | | | Seek feedback from young carers about their experience | **Report from relevant manager** | Young carers will report positively/ action plan developed on areas for improvement | | | |
| | | | Examine referrals by source | **QA group/ Head of QA** | Evidence of increasing number of referrals from adult services over the year. | | | |
| | | | Audit adult cases to ensure the needs of children are considered | **QA group/ Head of QA** | Findings from audits with action plans for areas for improvement | | | |
| | | | Ensure adult services are trained in recognising safeguarding issues for children | **Training sub-group** | Improved take up of training by adult services (need to set baseline and target- improve from what to what) | | | |

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| | | | Report on any relevant findings from SCRs and SILPs in relation to child - adult interface. | **SCR sub group** | Report to Board. | | | |
| **2c.2** | **B** | Children's services to consistently consider the safeguarding of adults in households where they are working with children and make referrals for support and intervention where necessary. | Ascertain numbers of referrals from children's services to adult services. | **Head of Adults Social Care / LSCB Manager** | Consider numbers and information received and report to the Board. | | | |
| | | " " | Audit children's cases to ensure the needs of adults are considered | **QA group/ Head of Safeguarding and QA** | Findings from audits with action plans for areas for improvement | | | |
| **2c.3** | **B** | Services that work with "whole" families are effectively coordinated (e.g. Priority Families) and secure added value in ensuring and co-ordinating effective | Report from Priority Families on their impact for children and adults<br><br>Agencies are required to implement think family. | ??? | Receive report, discuss findings and any action plan for areas for improvement | | | |

**ACTION / SUB GROUP WORK PLANS**

**Priority 3: To be assured that our Learning and Improvement Framework secures a workforce fit for purpose and is raising service quality and safeguarding outcomes for children, young people and adults**

| No. | CAB | What do we want to achieve? | How are we going to do it? | Who will lead? | How will we know we have achieved our goal? | When are we going to achieve this? | Progress Review | RAG rating |
|---|---|---|---|---|---|---|---|---|
| **3.1** | **B** | Ensure learning from national, regional and local SCRs and other review/audit processes is incorporated into the practice of partner agencies and the partnership as a whole. | Effective dissemination of learning within Board and Partner agencies | **QA Sub Group / Training Sub Group** | Report from the sub group on how learning has been disseminated. | | | |
| **3.1a** | **B** | " " | Board and Partner agencies to measure impact through multi-agency and single agency case file audits. | **QA Subgroup** | Practice is informed by the learning and tested through audit, and findings reported to Board.<br><br>Evidence collated and shared at OMB/Board. | | | |
| **3.2** | **C** | Ensure the effectiveness of CDOP and that lessons from child deaths are understood and consistently acted upon | Themes and issues on the work from CDOP are identified and disseminated.<br><br>Board and Partner agencies to measure impact through multi-agency and single agency case file audits | **CDOP** | Specific campaigns will increase public awareness of specific risks to children resulting in these specific risks reducing for children<br><br>Audits will show that practice has changed or improved. | | | |

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| **3.3** | **B** | Review safeguarding procedures and practice guidance to ensure they are 'fit for purpose' and reflect current learning and best practice. | Annual review and update of procedures. | **Head of Safeguarding/ Board Service manager** | Report to Board identifies changes and the expected impact on practice of these. The Board ratifies updated procedures and practice guidance. | | | |
| **3.4** | **B** | Implement the communication and engagement strategy to secure awareness of safeguarding issues and the responsibilities of the Boards' partner agencies and the wider community in safeguarding<br><br>**Discuss with Paul** | Set up a communication and engagement task and finish group to ensure the implementation of the comms and engagement strategy.<br><br>Create and disseminate a Board newsletter on a quarterly basis to raise the profile of the work of the Board<br>Is this best use of time? What impact do we expect this to have?<br>**Discuss with Paul** | **Board service manager**<br><br>**Comms and Engagement task and finish group** | | | | |
| **3.5** | | Establish a learning and improvement framework for adults. | | **Training subgroup** | Report on % of staff across agencies that have received safeguarding training at the right level. | | | |
| **3.6** | | Monitor and evaluate the effectiveness of training and development in terms of the | Assess extent of access to safeguarding training | **Training subgroup** | | | | |

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| | | impact on the quality of safeguarding practice and outcomes for service users. Ensure feedback loops are established following each training sessions. | and take up across agencies. | | | | | |
| **3.6a** | | " " | Seek examples of how practice has improved | **Training subgroup** | Identify examples of improved practice following training. | | | |
| **3.6b** | | " " | " " | **Training subgroup** | Case file audits should show improved practice that links back to specific training. | | | |
| **3.7** | **B** | Workforce is safely recruited. | Sample HR files across agencies. | **QA subgroup** | Report to Board on any issues with action plans to address. | | | |
| **3.8** | | Allegations made against people who work with children and vulnerable adults are dealt with effectively. | Board receives bi-monthly analysis reports of number of allegations and themes and issues raised. | **OMG** | Report received with recommendations and action to be taken. | | | |
| **3.8a** | **C** | " " | " " | **OMG** | Increase in LADO referrals | | | |

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# HEALTH AND WELLBEING BOARD – 2014

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| **Title of paper:** | **The CCGs five-year operational plan in response to *Everyone Counts: Planning for Patients 2014/15 to 2018/19*** | |
| **Director(s)/ Corporate Director(s):** | **Dawn Smith<br>Chief Officer<br>Nottingham City CCG** | **Wards affected: all** |
| **Report author(s) and contact details:** | **Dawn Smith** | |
| **Other colleagues who have provided input:** | **Jane Laughton, Transformation Associate, South Notts Transformation Board** | |
| **Date of consultation with Portfolio Holder(s) (if relevant)** | **Via Contract Executive Group** | |

| **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 guidance included a requirement for NHS commissioners to work together to co-design a five year strategy that sets out a clear plan on how commissioners, local authorities and NHS providers will work together to deliver services over the next five years within financial constraints.

Agreement has already been reached that in producing this plan, Nottingham City CCG will work with other CCGs in the South of Nottinghamshire (Nottingham North and East CCG; Nottingham West CCG and Rushcliffe CCG). To take the work forward a South Notts Transformation Board has been established with representation from key partners in health and social care.

The five year plan must be submitted by June 20th 2014. This presentation provides an update on the development of the plan to date.

**Recommendation(s):**

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| **1** | The Health and Wellbeing Board is asked to note the development of the plan and confirm that it approves the direction of travel |
| **2** | The Health and Wellbeing Board is asked to support a proposal to allow members of the Commissioning Executive Group to take the lead role in signing off the final version of the plan prior to submission on June 20th 2014 |

## 1. REASONS FOR RECOMMENDATIONS

**1.1** The Health and Wellbeing Board has a key role to play in ensuring that the CCGs five year plan is aligned with its own plans and it is required to contribute to the plans development. This engagement has taken place in a number of ways with some individuals from the Health and Wellbeing Board represented on the South Notts Transformation Board and involved in development workshops and other engagement events. Early drafts of the plan have also been considered by the Commissioning Executive Group.

## 2. BACKGROUND (INCLUDING OUTCOMES OF CONSULTATION)

The plan builds on the 'Call to Action' engagement

## 3. OTHER OPTIONS CONSIDERED IN MAKING RECOMMENDATIONS

See attached presentation

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

See attached presentation

## 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 maintain and improve existing NHS services

## 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

Chief Officer updates to the Health & Wellbeing Board (October 2013; January 2014 and February 2014)

## 8. PUBLISHED DOCUMENTS REFERRED TO IN COMPILING THIS REPORT

*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

# CCG Five Year Plans 2014 - 19

## Update to Nottingham City Commissioning Executive Group

***1 April 2014***

***Dr Ian Trimble***



Nottinghamshire County Council

Nottingham City Council

NHS

# NHS England Draft Planning Guidance – Dec 2013

| | |
|---|---|
| **National picture** | **Commitment to transforming outcomes for patients**<br>**Forecast of financial gap of £30 billion by 2020/21** |
| **Mandate to commissioners** | **Set local ambitions for improved outcomes**<br>**Plan transformation of services over five years**<br>**Two year detailed operational plan** |

# What does this mean in practice?

- CCGs form 'Units of Planning' (UoP)
  - South Nottinghamshire UoP: Nottingham City, Rushcliffe, Nottingham North and East, Nottingham West CCGs
- 'Units of Planning' work with providers and partners (including Local Authorities) to design and deliver a five year strategy
- Engagement with patients and the public underpins this process through *A Call to Action*
- Tight national timescales:
  - Draft strategy by 4 April (initial draft submitted 14 Feb)
  - Final strategy by 20 June 2014

**Together we need to think very differently about how we plan, commission, deliver and use services**



Nottinghamshire County Council
Nottingham City Council
NHS

# Citizen engagement - *A Call to Action*

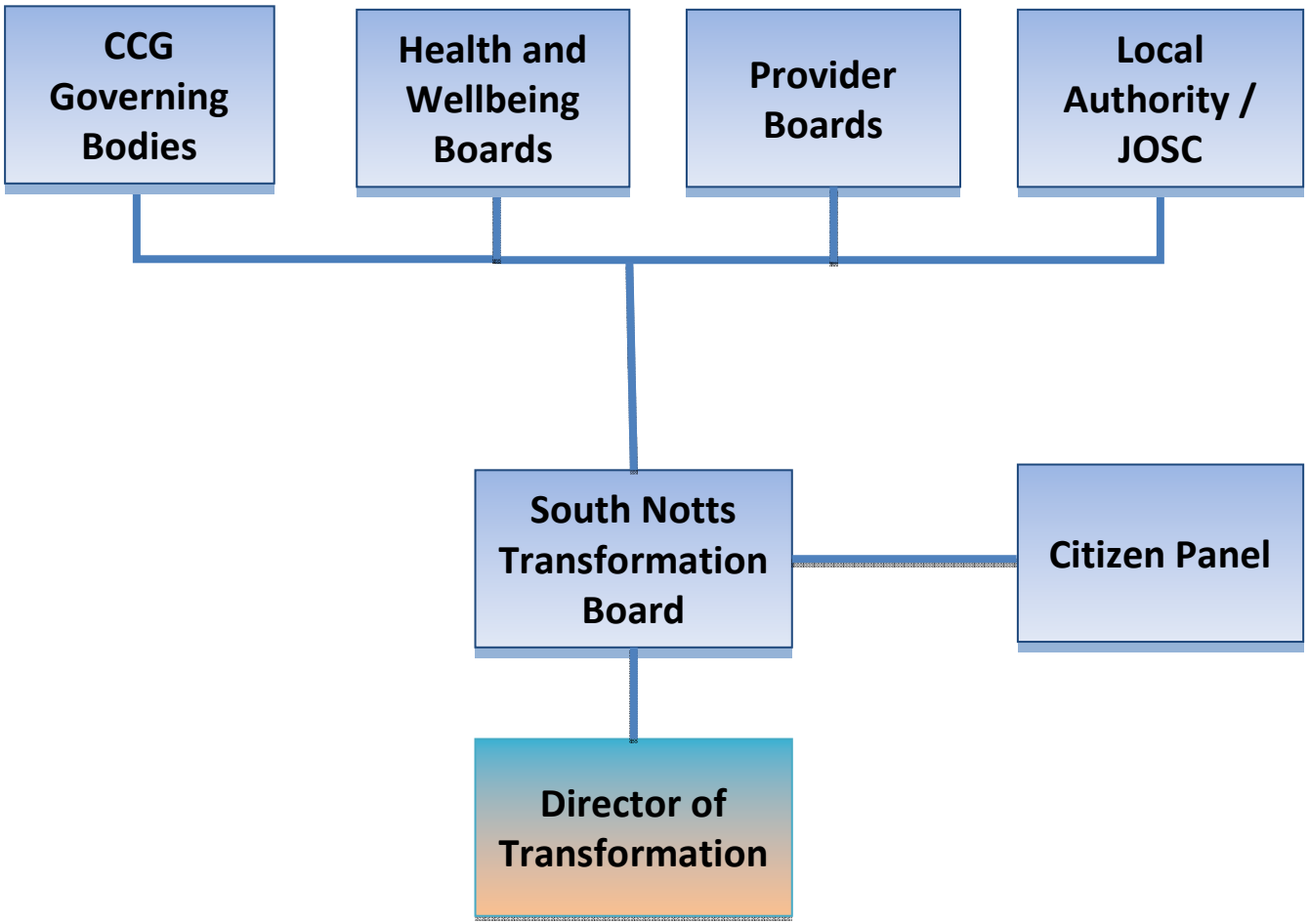



Nottinghamshire County Council
Nottingham City Council
NHS

# National requirements for submission

| | Sections of five year plan following NHS England template |
|---|---|
| 1 | Five year 'plan on a page' |
| 2 | System vision and statement on vision for integration |
| 3 | Improving quality and outcomes |
| 4 | Sustainability |
| 5 | Transformational interventions |
| 6 | Governance overview |
| 7 | Values and principles |

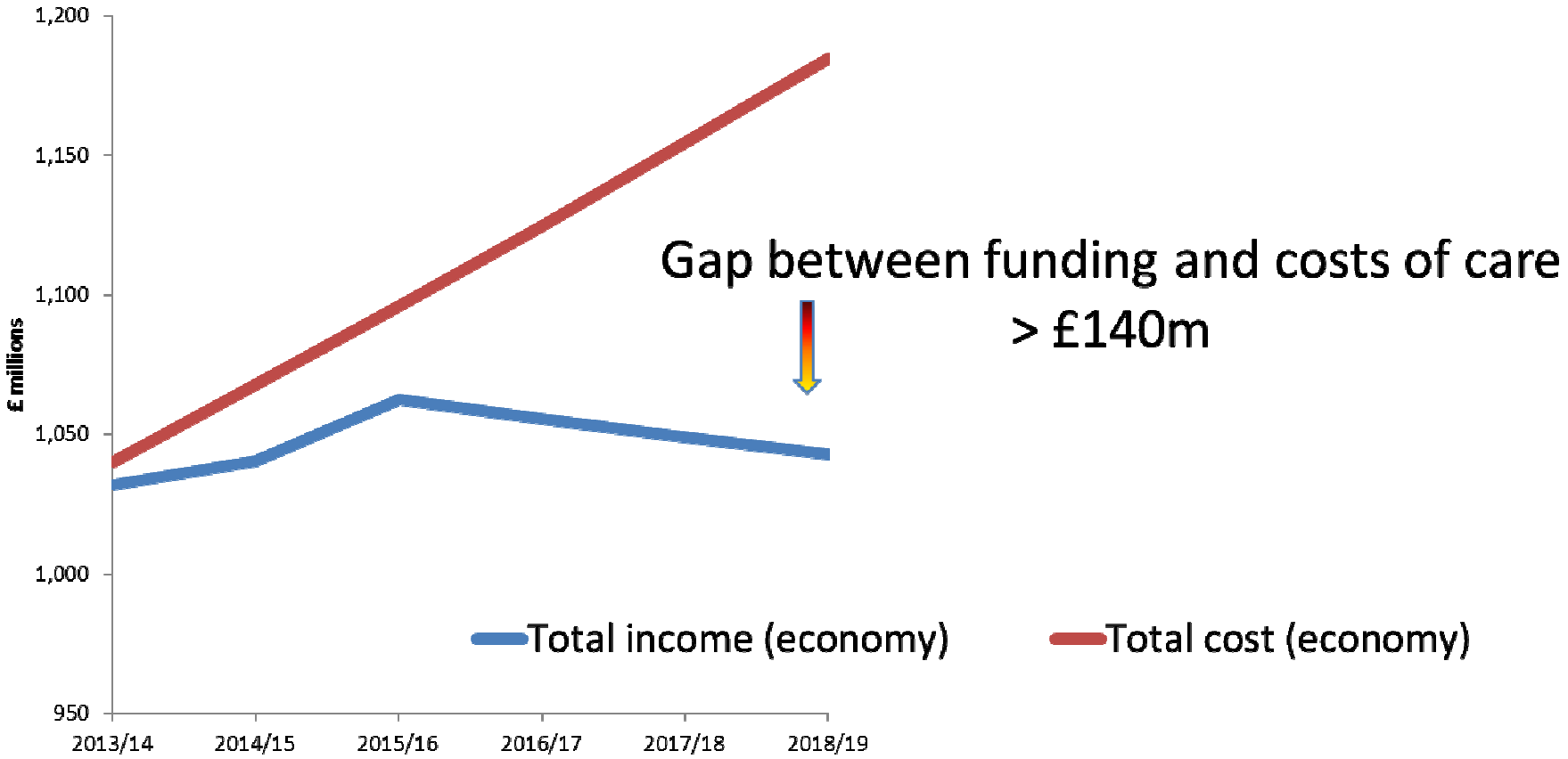
# Governance


CCG Governing Bodies
Health and Wellbeing Boards
Provider Boards
Local Authority / JOSC
South Notts Transformation Board
Citizen Panel
Director of Transformation

# Organisations involved

| | |
|---|---|
| Nottingham City CCG | County Health Partnerships |
| Nottingham North and East CCG | Nottingham CityCare Partnership |
| Nottingham West CCG | Circle Partnership |
| Rushcliffe CCG | EMAS |
| Nottingham University Hospital Trust | Nottingham City Council |
| Nottinghamshire Healthcare Trust | Nottinghamshire County Council |

# South Nottinghamshire funding gap
# Health and Social Care






Nottinghamshire County Council
Nottingham City Council
NHS

# Highlights from five year strategy 'Plan on a Page'

**Five Year Strategic Vision:** ***Supporting independence, personalisation and empowerment through the provision of compassionate and seamless integrated health and social care.***

**System Objectives:**

***1.Increase the proportion of people living independently at home***

***2.Reduce time spent unavoidably in hospital through more and better integrated care***

***3.Improve the health related quality of life of those with LTCs including mental health conditions***

***4.Secure additional years of life for people with treatable mental and physical health conditions (Parity of Esteem)***

***5.Engage with the local population to change patient behaviour, promote public health messages and to ensure efficient use of healthcare resources***

***6.Support quality of services – safe and avoidable harm and clinical effectiveness***

***7.Deliver services which optimise patient experience; reflect best practice and deliver the NHS Constitution***

## Outcome ambitions

5 domains, 7 outcome measures.

Improve the health of our population, reduce health inequalities and create equity for users across different forms of health and care services .

## Delivering transformational service models

- *New approach to ensuring that citizens are fully included in all aspects of service design and change and that patients are fully empowered in their own care*
- *Wider primary care, provided at scale*
- *A modern model of integrated care*
- *Access to the highest quality urgent and emergency care*
- *A step-change in the productivity of elective care*
- *Specialised services concentrated in centres of excellence*

***Our vision : Supporting independence, personalisation and empowerment through the provision of compassionate and seamless integrated health and social care.***

### *Access*

- *Convenient for everyone*
- *NHS Constitution*
- *Key clinical data sharing*

### *Quality*

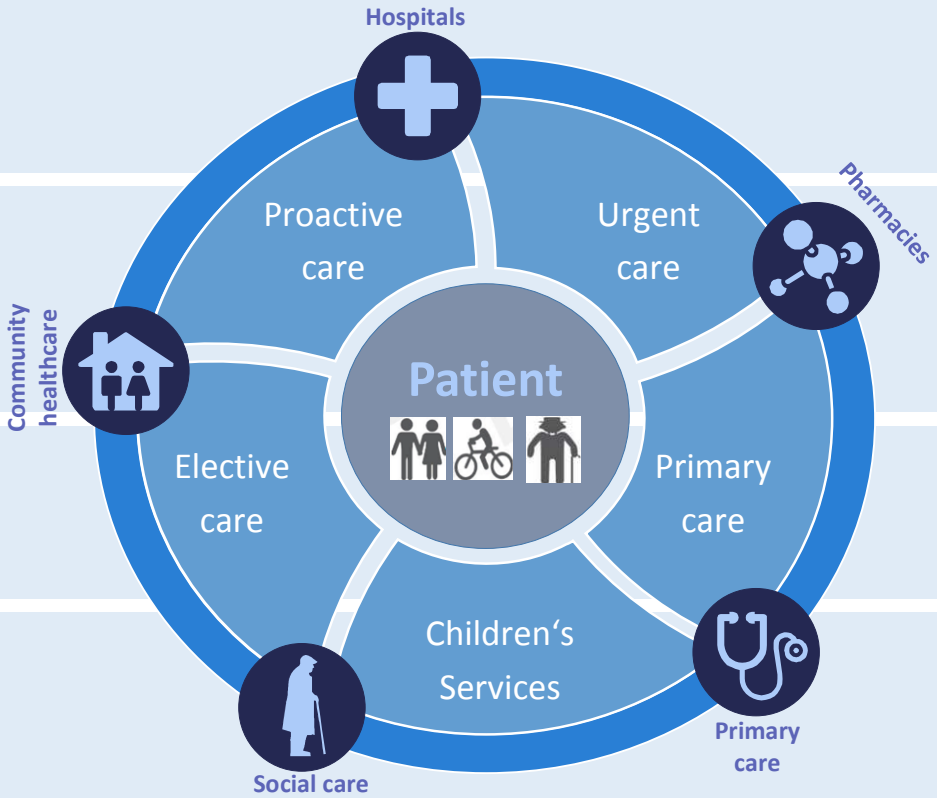
- *Recent reports on quality failings (e.g. Francis, Berwick)*
- *Patient safety*
- *Compassion in practice*
- *Staff satisfaction*
- *Seven day working*
- *Safeguarding*

### *Innovation*

- *Supporting our staff to innovate*
- *Research*
- *Ensuring implementation at scale*

### *Value*

- *Value for money*
- *Effectiveness*
- *Efficiency*
- *Procurement*



# South Nottinghamshire Transformation

## This is the accepted direction:

- Put people in charge of their own health through education and self-management as part of care
- Integrated working between health and social care
- Reduce reliance on the acute sector
- Reduce proportion of community care delivered in community beds
- Increase home based care
- Enhance primary care

# Timeline

| | |
|---|---|
| 6 & 13 March | Multi-professional/cross organisational events held |
| 26 March | Transformation Board approve DRAFT Five Year Strategic Plan |
| 4 April | Submission of DRAFT Five-Year Strategic Plan to NHS England |
| April to June | Refine analysis / comprehensive citizen engagement |
| 20 June | Submission of FINAL Five-Year Strategic Plan to NHS England |
| → | Implementation / delivery |

**HEALTH AND WELLBEING BOARD APRIL 2014**

| | | |
|---|---|---|
| **Title of paper:** | **Primary Care Vision** | |
| **Director(s)/ Corporate Director(s):** | Maria Principe | **Wards affected:** |
| **Report author(s) and contact details:** | **Maria Principe, Director of Primary Care Development and Service Integration** | |
| **Other colleagues who have provided input:** | **As per stakeholders listed within document** | |
| **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):**

**Improved access to primary care**
**Standardised access to primary care services**
**Support to self-refer**

**Attached are an executive summary, presentation and the full plan.**

**Recommendation(s):**

| | |
|---|---|
| **1** | The strategic vision is built on a compelling case for change with a clear set of reasons for improvement in order to deliver high quality and equitable primary care services that improve patient outcomes. The Commissioning Executive Group is asked to comment on the vision |

## 1. REASONS FOR RECOMMENDATIONS

As per strategy.

## 2. BACKGROUND (INCLUDING OUTCOMES OF CONSULTATION)

As per strategy.

## 3. OTHER OPTIONS CONSIDERED IN MAKING RECOMMENDATIONS

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

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

N/A

## 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

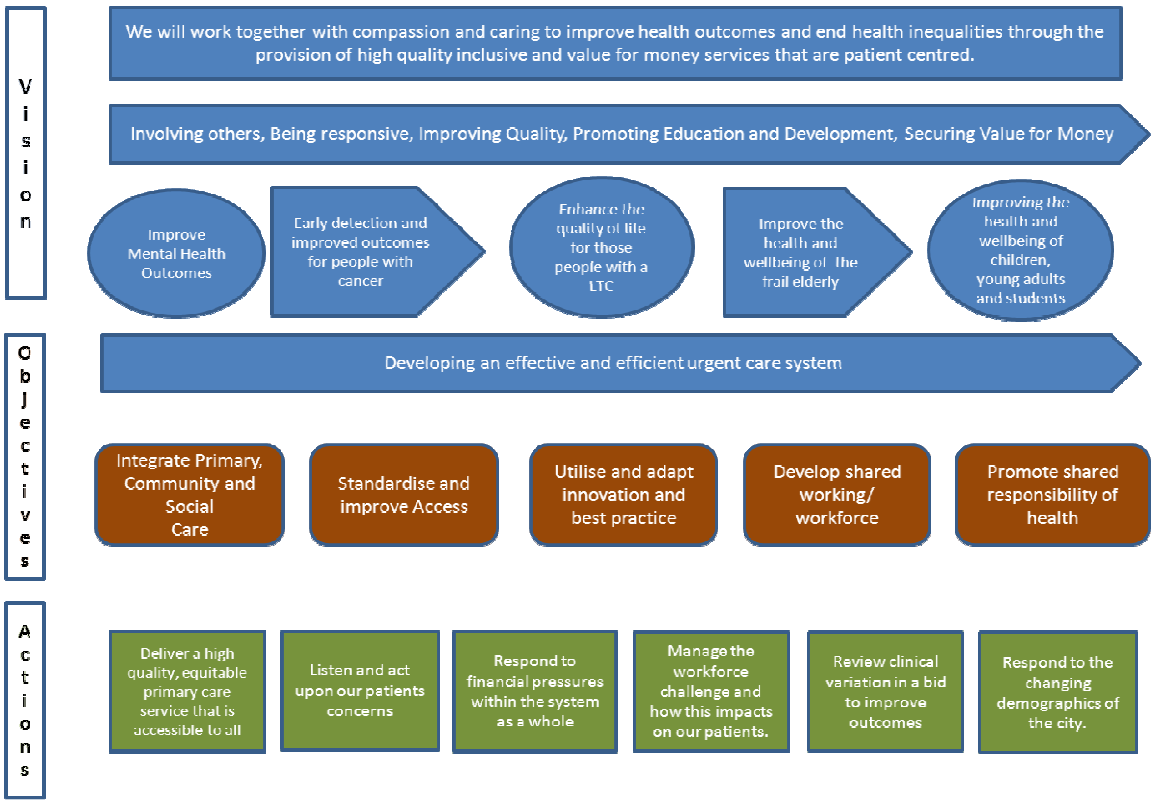
## 8. PUBLISHED DOCUMENTS REFERRED TO IN COMPILING THIS REPORT

# Primary Care Vision

## Introduction

This aim of this paper is to articulate and to introduce to the Commissioning Executive Group the Clinical Commissioning Groups future vision (see appendix 1) for primary care, specifically General Practice which is built on five essential objectives identified within the plan on a page in diagram 1. The key objectives for primary care for 2014-2015 are to:-

- Integrate Primary Community and social care
- Standardise and improve access
- Utilise and adapt innovative technology and best practice
- Develop shared workforce/working
- Promote shared responsibility of health




It is recognised that this vision cannot stand alone; therefore it should be implemented within the context of the CCGs Adult Integrated Care vision, Urgent Care Plan, Operating Framework, Patient Involvement and Challenge Fund requirements and IT framework.

## Background

In 2013/14 the NHS in England spent more than £11 billion on primary care services. Primary care has long been identified as a particularly important determinant of access, quality improvement and equity[1].

Primary Care is at the heart of the NHS accounting for around 90 per cent of all patient contact and is the gateway to secondary care, and is both the start and the end point of most

[1] Future Challenges for Primary Care, Kings Fund, 2013

patient journeys.A strong and effective primary care is acknowledged to be a critical component of a high-performing health care system. This is based on the principle that high quality primary care improves health outcomes and helps contain health care costs.

NottinghamCity has a very diverse population with different needs who require a wide range of services from primary care providers. There is also a significant amount of variation in the provision both in size and quality of service provision. Our clusters are seeing a higher than expected use of costly hospital services. Some of the services have potential to be more appropriately provided in a primary care setting. Better primary care provision will contribute to addressing the life expectancy across the city.

Primary care is key to delivering a cost-effective health care system for our population. Primary care is the first point of contact for more than 90% of our patients and service-users in accessing care. Primary Healthcare teams play a crucial role in chronic disease management, health promotion, diagnostics and early intervention, and treatment information management.

Through clinical commissioning, GPshave a shared financial responsibility hold for many local NHS services however this also puts them in a potential position of conflict as local independent providers. In developing our primary care objectives, we recognised this conflict and looked at what primary care should look like from the eyes of our patients. In doing this, we are able to transparently develop a vision and objectives strategy that meets the needs of our patient population.

**Drivers for Change**

NHS Nottingham City Clinical Commissioning Group (CCG) has achieved much over the last few years and has developed a robust working partnership with our member practices, challenges in workforce combined with increasing demand from older and frail patients living with complex and multiple long term conditions and other vulnerable groups such as those with mental health problems, and the deprivation that exists within the city has resulted in the CCG reviewing its primary care provision with a view of developing a vision that focuses on quality improvement.

The drivers for the attached primary care vision are:-

Improve the quality of primary care - General practice is seen as the bedrock of the health care system. Patient surveys highlight high levels of trust in GPs and an overall level of satisfaction with the services received in general practice. The primary care performance dashboard and Quality Performance indicators identifies areas of excellence in the provision of primary medical services, but we also have other areas where the quality falls below expected standards, these are monitored through Quality Outcomes Framework and local and national performance dashboards. Nottingham City CCG has increased its focus on quality improvement in recent years, with greater availability and sharing of data and information through e-healthscope, and peer review of practicesvia the practice visit programme. Nottingham also aims to make greater use of evidence-based clinical guidelines and decision-support aids through the procurement and development of a bespoke pathways database. However for future success it is It is key that practices are supported and encouraged to seek out and address variable performance and see these reviews as the 'norm' in improving primary health care provision.

Reduce health inequalities - In overall terms the City's residents are less healthy than elsewhere in the country. Life expectancy in Nottingham for men is 75 years, compared with 78 for Greater Nottingham and for England, and for women 80 years compared with 82 for Greater Nottingham and Englandhttp://www.nottinghaminsight.org.uk/insight/jsna/jsna-

executive-summary.aspx - _ftn5. The gap in life expectancy between Nottingham and England has been widening since the early 1990s.http://www.nottinghaminsight.org.uk/insight/jsna/jsna-executive-summary.aspx -_ftn6Within the City there are high levels of health inequalities – life expectancy varies by ten years between the most and least deprived wards of St Ann's and Woollaton West. 15 of the 20 wards have significantly lower life expectancy than the regional average. The most significant disease contributors to our lower than average life expectancy are premature deaths caused by cardiovascular disease (CVD), respiratory diseases and cancers.

Improve the inequity in primary care provision - The GP contract and previous approach to Local Enhanced Services has resulted in fragmentation of service provision. This has resulted in inequity of provision for basic services such as Treatment Room and ECG. In meeting this inequity and improving access and choice specific primary care services will need to be opened up to more providers, improving access to treatment and offering patients greater choice.

Mitigate local and national workforce challenges - The Centre for Workforce Intelligence, the national workforce planning body in England, is forecasting an oversupply of hospital doctors and an undersupply of GPs. Therefore across NottinghamCity the demand for health and social care workers is growing, but the number of workers is not. The resolution to these challenges cannot develop locally, however in the interim, the vision must identify an approach that will bridge the gap until education and training leads are able to identify a national direction and solution. "Most of the professionals who will be working in the NHS in ten years' time are working in the NHS today. Any workforce redesign needs to focus more on re-training or re-assigning/re-purposing the current workforce, so that they have the skills needed to deliver new models of care"(Kings Fund, 2013)

Integrating Care- The current workforce is trained and developed to work in a model centred around single episodes of treatment in hospital. It is now more evident that those patients placing the greatest demand on services, both now and in the future, are older people with multi-morbidities (both mental and physical), who need integrated, long-term health and social care treatment, complimenting the adult integrated care programme. The vision must recognise this shift change and work within the remit of integrating care.

Develop a modern NHS - It is anticipated that new information technology systems will enable different ways of working, including enhanced roles for patients, ultimately changing how the workforce operates. Technology within the vision will need to enable patients to have more control over the management of their health, supporting them to thrive outside of a hospital setting.

Meet the Quality Innovation Productivity and Prevention (QIPP) Challenge **-** QIPP is a large-scale programme developed by the Department of Health to drive forward quality improvements in NHS care. QIPP represents a broad, policy agenda rather than a single, definable policy. There are a number of national workstreams within QIPP designed to support the NHS to improve care and lower costs. These range from improving commissioning (or purchasing) of care for patients with long-term conditions, to improving how organisations are run, staffed and supplied. Nottingham City's QIPP plan for 2014/15 assumes an increasing level of shift of care from acute services into community and primarycare service, therefore it is essential to ensure that the primary care vision enables the local community to respond to this strategic shift change.

**Vision Development**
The following steps have been taken to develop this vision:

1. Engage with patient and public forums to understand what a quality primary care service looks like.
2. Engage with clinicians to understand clinical approach to quality improvements
3. Undertake an analysis of current quality, variation, capacity, capability and assess against desired levels

1. <u>Engage with patient and public forums to understand what a quality primary care service looks like</u>

Nottingham City has gained insight into the views of patients and the public. In September 2013 the CCG began to ask patients and stakeholders how best to develop primary care services. Questions were developed via the People's Council in which patients designed the questions to ask other patients. This was then developed into an online survey to gain further feedback, together with paper surveys and questionnaires sent to GP Practices and forums such as help the aged, asylum seeker groups and other voluntary organisation. The following engagement has taken place:-

- Attendance and discussion at Patient Council.
- Production and distribution of online surveys
- Production and distribution of paper survey distributed to practices
- Utilisation of social media, including Twitter and Facebook
- Online survey sent to key stakeholder groups
- Feedback from patient representatives at cluster groups.

In engaging with our patient and citizen population we have identified that:-

- Patients expect the NHS to utilize modern technology
- More development to adopt GP telephone triage where appropriate to streamline access
- Consistent approach to access to remove inequity for city based population
- Expectation that the NHS is sharing information and data to improve care
- Practice receptionist role developed to signpost patients to most appropriate service (not act as a gatekeeper to the GP).
- Saturday access is viewed positively
- Limited interest in Sunday access

2. <u>Engage with clinicians to understand clinical approach to quality improvements</u>

This vision has its origins in an intensive period of dialogue with Primary Carepractitioners. With the support of CCG Clinical and non Clinical Executives – we have:-

- Attended cluster board meetings, to obtain local dialogue on key concerns regarding current challenges and future needs
- Linked through our education lead to national forum and discussions on the wider remit in relation to workforce and development
- Fed back and sought guidance from Bi-annual meetings
- Presented findings and recommendations via the CCGs clinical Council meeting
- Engaged with the local Area Team and shared the vision with key commissioning leads to raise awareness of its conception

In engaging with our members we have identified that:-

- The current shift in work is having a significant impact on primary care, however concerns are raised as practitioners are seeing a shift in work but not in resources
- Financial management / competition / contract changes - The majority of practices are inexperienced in bidding and competing for business, which could have a detrimental effect on primary care provision
- Communication overload from all sectors
- Workforce retention, retiring GPs, shortage of primary care clinicians is having an impact on provision
- Variations in service delivery/community services is impacting on equity of provision
- Managing patient expectations.

3. Undertake an analysis of current quality, variation, capacity, capability and assess against desired levels

The CCG has a statutory duty to assist the NHS Commissioning Board in continually improving the quality of local primary medical care services and ensuring that the commissioning finances of the CCG are managed. Within the Inter Practice Agreement the Primary Care Development and integration team have been delegated the responsibility of working supportively with member practices to implement any required quality improvements. These are identified via the Primary Care Performance and Quality Group (PCPQG), in which primary care performance is viewed by utilising local and national dashboards. These dashboards enable the CCG to understand how general practice is performing on delivering the CCGs strategic indicators as well as indicators identified via the national primary care framework.Where practices are identified as an outlier the PCPQG triangulates activity and performance data alongside practice visit feedback and patient comments and where required carries out a deep dive review. This triangulation of information enables the CCG to identify variation, capability and capacity issues noting where quality can be improved and best practice communicated. Findings to date have identified:-

- Practice are having to close their list due to increases in demand
- Patients are opting to travel for a preferred GP
- Variation and approach to clinical pathways is impacting on activity
- Clinicians not using commissioned pathways as they are unaware of them
- Choose and book has created a divide in communication between GP and consultant
- Variation in approach to access
- GPs feel the route to ask for advice and guidance has been removed

During this engagement process a theme emerged that demonstrated the need for a more integrated way of working, enabling practices who wish to do so to support one another, working geographically within care delivery groups to enable the population of the City to have access to similar range and quality of services. This theme has been merged into the vision.

**Summary**

Primary care, and in particular care delivered by general practice has been a cornerstone of the NHS since its inception. Its delivery model has evolved through the years but potentially faces its greatest challenge. These challenges within primary care are of significant scale, complexity and risk to have a real impact on Primary Care provision, therefore the aim of the attached vision is to develop sustainable changes by supporting and enabling change to internal systems such as access, workforce and outcomes.

Whilst GP services are commissioned by NHS England, it is imperative that Clinical Commissioning Groups support and encourage the development of primary care services as our GP members play an important role in influencing this vision, and implementation will only succeed with the clinical ownership of GPs working in conjunction with health partners.

**Recommendation**
Our strategic vision is built on a compelling case for change with a clear set of reasons for improvement in order to deliver high quality and equitable primary care services that improve patient outcomes. The Governing body is asked to comment on the vision

NHS
Nottingham City
Clinical Commissioning Group

Working together for a healthier Nottingham

# A primary care plan for Nottingham City

**Dr Hugh Porter**
**Chair, Nottingham City CCG**

**Maria Principe, Director Primary Care Development and Service Integration**
**NHS Nottingham City CCG**

**March 2014**

## 1. Executive Summary

This is a first draft of NHS Nottingham City Clinical Commissioning Group's (CCG) future vision for primary care, and specifically General Practice. This document is a result of extensive engagement with primary and community front line clinicians, our patients and our public. It is a document that will need to flex and change to meet the needs of our diverse population It takes into account national policy and guidance on how primary care should be developed alongside patient views and surveys on the needs and preferences of our local population. This document aims to present a primary care plan on how primary care services might be developed in Nottingham City and is a first step and builds on our engagement with clinicians, colleagues and partners. We know the links to other primary care contractors and healthcare commissioners will be essential in delivering a comprehensive service and we will build on this vision to with all stakeholders to ensure it is fully inclusive'. This primary care plans is built on five essential objectives (as seen on the plan on a page):

- Integrate Primary Community and social care
- Standardise and improve access
- Utilise and adapt innovative technology and best practice
- Develop shared workforce/working
- Promote shared responsibility of health

1. <u>The reasons for change are:</u>

- We need to improve the health and wellbeing of the citizens of Nottingham City and reduce health inequalities
- We want to deliver a high quality health service that is accessible and places care and compassion at its heart
- We need to be in a position to manage the changing patient demographics of Nottingham City that are placing greater demand on local health and social services
- We need to respond to significant financial pressures in health and social care
- We must respond to our patients concerns regarding access and choice.
- We must pre-empt the workforce challenges in general practice to mitigate the impact on our patients.

2. <u>Where are we now?</u>

- We have a vibrant and dynamic CCG and our membership understands its role as commissioner of health services
- The CCG has formalised its strategy for the next. 3 years and needs effective General Practice (GP) services to help deliver this
- Across our four clusters of GP Practices we have examples of excellence in primary health care delivery; however, we also have significant variance in terms of patient experience, clinical quality of care, and varied provision of services between practices
- The CCG and membership understand that whilst not directly commissioning GP services ( this is done by NHS England) it has a key role in supporting NHS England to improve the quality of primary care, and has been leading this agenda locally for sometime
- The current pressures on primary are increasing because of recent changes and this makes transforming primary care both imperative but also even more challenging
- We have a history of financial stability, but the current challenges are unprecedented and we can only meet this challenge by delivering this transformational change.

3. How will we deliver this

- In collaboration with NHS England we will deliver our primary care objectives, ensuring fairness, equity and transparency in the decisions we make - especially given potential conflicts on interest of GPs as both commissioners and providers
- We aim to improve the productivity and sustainability of all health services with a strategic shift of activity from hospitals to the community by providing care closer to people's homes, ensuring people do not spend any longer in hospital than they need to and preventing the need for hospital admission wherever possible. This will mean fewer people will need to attend the Emergency Department (ED) and have unplanned admissions to hospital
- We will improve communication across NHS and social care providers by integrating services to reduce duplication and errors and make care more holistic
- We will promote the right culture that places the patient at the heart of everything we do, and which encourages innovation and transformation

4. What are the benefits of this vision for Primary care?

The Primary Care vision offers general practices, the opportunity to work more closely and collaboratively, by doing so they improve efficiencies and capacities to:

- Improve access and quality through shared resources and support
- Strengthen the capacity of primary care to enable care to be seen closer to home
- Share corporate and financial services such as shared tendering, Human Resources, accounts and other back office functionality
- Share clinical support or general mentor support to enable increase resources and shared care.
- Improve local service integration across practices and other providers
- Improve quality and safety of services
- Develop training and education capacity
- Reduce un-necessary hospital admissions.
- Maximise income to be reinvested into patient care
-

5. What are the benefits of the Primary Care vision for patients and families?

The Primary Care Vision will improve quality and inefficiencies for the patients and families by:

- Having improved and sustainable access to primary care services
- Providing a more holistic approach to meeting individual patient needs, rather than the patient being seen by a multitude of separate independent health and social care workers, they will be seen by a member of the neighbourhood team who will coordinate appropriate input from other team members
- Ensuring better continuity of care for patients is improved through the multi-disciplinary team meetings as more team members will be familiar with the patient
- Providing links for patients and carers to other agencies within the community
- The introduction of the multi-disciplinary approach which will allow patients with Long term conditions (LTC) to be better managed in the community and potentially reduce unnecessary hospital admissions or facilitate earlier discharge
- Reducing the likelihood of clinical management errors/misunderstanding
- Improved and equitable access to care.

## 2. Context

Nottingham City has a very diverse population with different needs who require a wide range of services from primary care providers. There is also a significant amount of variation in the provision both in size and quality of service provision. Our clusters are seeing a higher than expected use of costly hospital services. Some of the services have potential to be more appropriately provided in a primary care setting. Better primary care provision will contribute to addressing the life expectancy across the city.

Primary care is key to delivering a cost-effective health care system for our population. Primary care is the first point of contact for more than 90% of our patients and service-users in accessing care. Primary Healthcare teams play a crucial role in chronic disease management, health promotion, diagnostics and early intervention, and treatment information management.

Through clinical commissioning, GPs have a shared financial responsibility hold for many local NHS services however this also puts them in a potential position of conflict as local independent providers. In developing our primary care objectives, we recognised this conflict and looked at what primary care should look like from the eyes of our patients (see patient vision later in the document). In doing this, we are able to transparently develop a vision and objectives strategy that meets the needs of our patient population.

We have, through Practice Based Commissioning (PBC) and the early years of clinical commissioning, seen good examples of quality and innovation across Nottingham City. The hard work and dedication of staff across general practice has delivered real improvements for patients. However, we still have variation in the clinical quality of general practice provision with differential health outcomes for residents across the City.

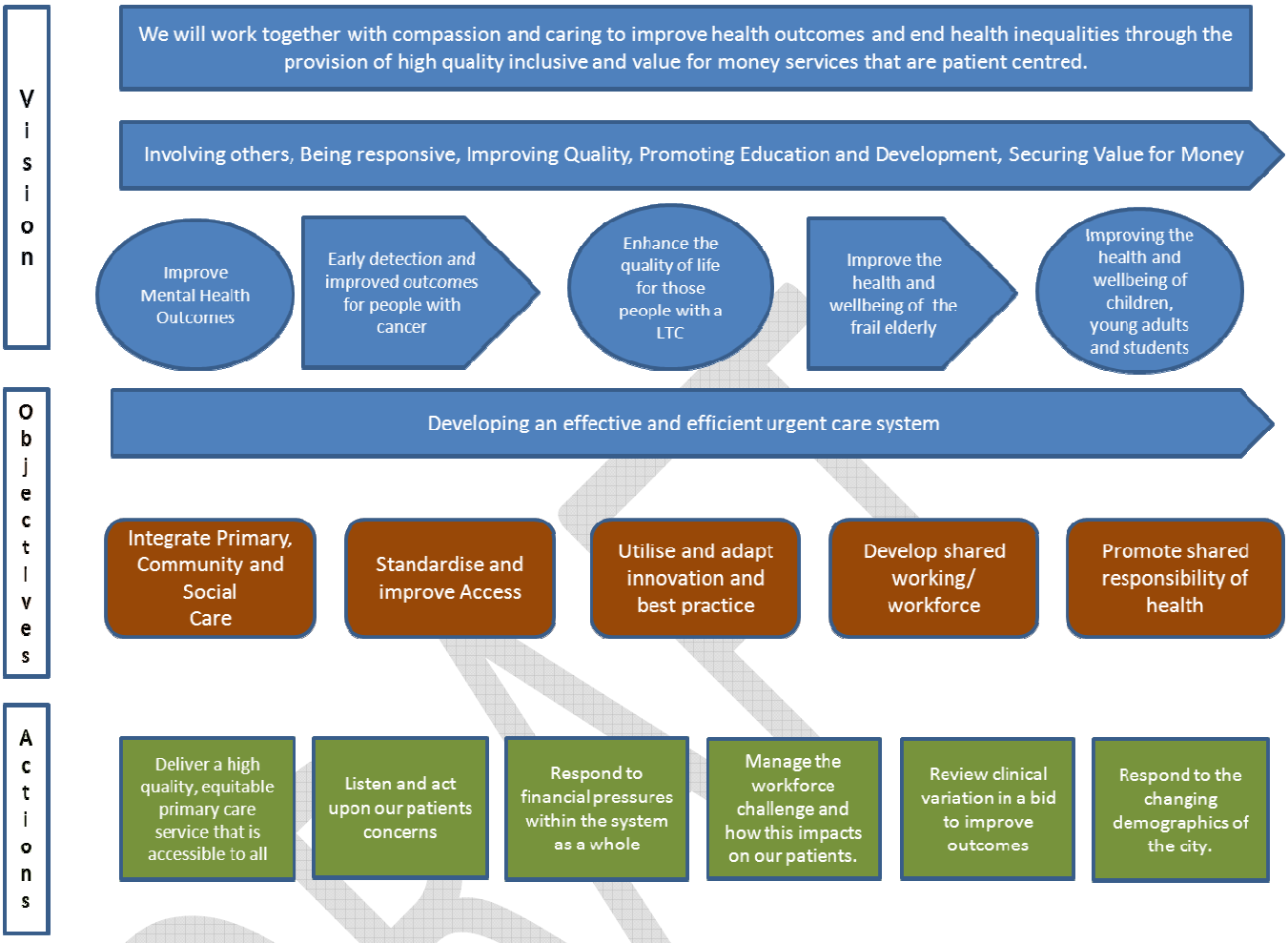
Our case for change focuses on the following factors:

- Rapidly changing population
- High levels of health and wellbeing need
- Variations in access to primary care medical services
- Variations in clinical quality and patient health outcomes
- Variations in the premises from which primary health care is delivered
- A changing workforce profile and changing skills set needed for new models of care
- A shift towards moving follow-up and care into the community.

The NHS has to reduce the cost of health care and improve the efficiency of service providers and the health outcomes for local populations. GPs have taken a central role in health care planning and primary care will be commissioned by the NHS England. The intention of this plan is to identify the areas of change and improvement required to transform primary care services to meet the standards that our patients expect. Our aim is to offers general practices, the opportunity to work more closely and collaboratively. In working in an integrated way health and social care services are able to improve efficiency, add capacity and deliver quality through a strengthened and shared workforce, underpinned by training, support and mentorship that are tailored to the populations need with the aim of delivering care closer to home. This redesign will improve and extend access to primary and community services while reducing hospital admissions and length of stay.

## 3. What is the Primary Vision?

*(plan on a page)*



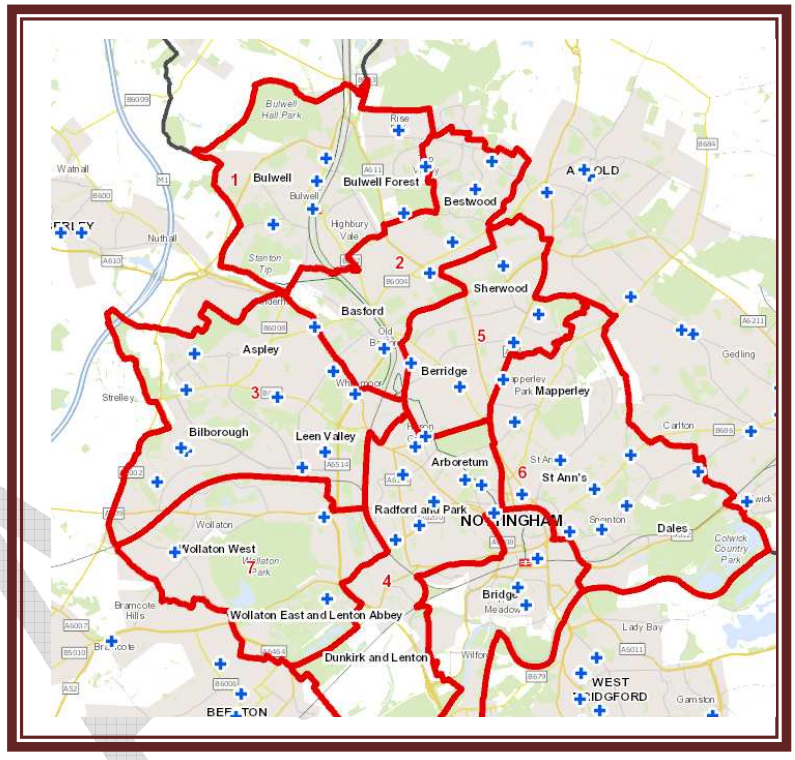

Currently all Nottingham City GP Practices are aligned via commissioning clusters. These clusters enable 'like minded' GPs to come together to commission services for their population. These commissioning structures have been extremely successful for Nottingham City, and will remain. Therefore in order to improve quality within Primary Care we will focus on the following objectives:-

1. Integrate Primary Community and social care
2. Develop shared workforce/working
3. Standardise and improve access
4. Utilise and adapt innovative technology and best practice
5. Promote shared responsibility of health
6. Utilise resources and funds available within the Challenge Fund

## 4. How will we deliver the Primary Vision?

### 4.1. Integrate Primary Community and social care

There is a strong national driver to improve services through better integration. Integrated care is seen as being essential to meeting the needs of an ageing population, transform the way that care is provided for people with long term conditions and enable people with complex needs to live healthy, fulfilling independent lives.

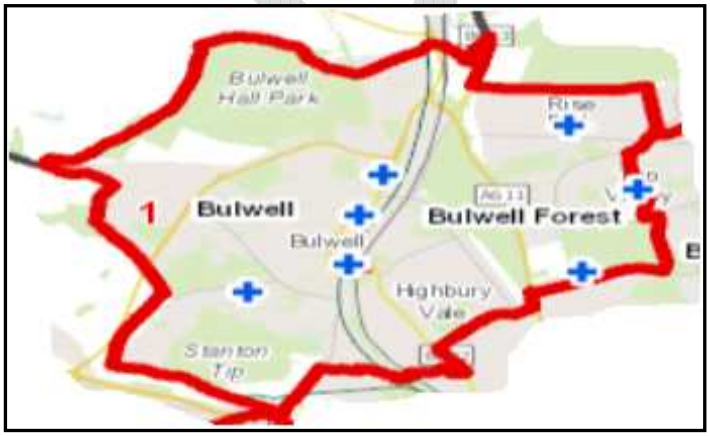



Nottingham City's Adult Integrated Care Programme was established in July 2012. A partnership between NHS Nottingham City CCG and Nottingham City Council has been created in order to develop an integrated health and social care system that focusses on patients with long term conditions as well as the frail elderly. The intention of the programme is to design a system of care that is less fragmented and in turn improve patient outcomes and help drive efficiencies across health and social care.

Nottingham City CCG will as part of its integrated care project, align practices and wrapping community provision within each care delivery group. These care delivery groups will enable providers to utilise and share resources for patients within a similar demographic area. Working with the Local Authority we have been able to mirror social care provision, moving towards all teams becoming integrated and tailored to a particular demographic need, whilst working together to utilise and share a limited workforce.

### 4.2. Develop shared workforce/working

Traditionally, workforce planning has been about ensuring that we are able to maintain the supply of nurses, doctors, and AHPs to meet demand. However, changing population demographics, service delivery imperatives and future workforce profiles and the subsequent change in the needs of patients, means the need to support appropriate care models for role flexibility becomes ever greater. It will be important for the CCG to modernise and further develop its models of delivery and community nursing services and allied health profession services by reconfiguring the existing workforce and introducing a new mix of skills and competencies to meet these challenges. Feedback from GP practices, community providers and local authority provision has highlighted that all providers are facing a number of similar challenges. These challenges such as; variations in provision, limitations and



reduction in the workforce, reduction in funds and an increase in demand has resulted in Nottingham City changing the way services are currently delivering care.

GP Alliances/Federations - Once aligned within a care delivery group, It is anticipated that some GP practices will collaborate in a federation/GP community. These alliances (dependent on form and function) will be underpinned by robust and strong governance arrangements. All alliances will retain the benefits of the local GP practice but strengthen the capacity of the practice by having access to a shared workforce, enabling patients to have greater and improved access to primary care services. In an environment where resources and funds are becoming limited, federations will enable practices to make efficiency savings/economies of scale in back office functions, developing training and education capacity and deliver provision on behalf of its locality. These federations or alliances will also have the opportunity of sharing or employing a clinical workforce on behalf of its locality.

**Neighbourhood Teams** - Neighbourhood Teams will be populated on the needs of that locality based on identified need and requirements from the joint strategic needs assessment and primary care feedback. Core teams will consist of Community matrons, community nurses, occupational therapists, physiotherapists, social workers, and support workers. The teams will be tailored and wrapped around the Care delivery group, accessed via a Care co-ordinator, who's responsibility and remit will be to guide patients and primary care through a complex system, ensuring patients and clinicians are seen once by an integrated service, rather than multiple times from multiple organisations.


4.3 Standardise and improve access

Access to primary medical services is a key consideration in improving the delivery of services and ensuring patients are at the heart of how these are designed and provided. The national survey results as part of the Better Together patient experience programme give a picture of patients' perception of access. It will be crucial to use these results to focus actions and give priority to helping all Primary Care contractors improve access for patients. A recent patient survey of over 700 patients within Nottingham City highlighted that access for GP appointments should be at one day of an urgent appointment, and 3 days for a routine appointment. With the aim of improving access and quality in Nottingham city practices we will work with GP surgeries to deliver the following standards:-

- *GP Triage* - Where willing, we will encourage practices to review their booking systems and appointment allocation. Due to the increased numbers of appointments needed and the reduction in workforce, the CCG will encourage practices to review the system in which clinical appointment triage is carried out prior to an appointment being offered. This system tried and tested in other areas, enables those patients who are more needy to have quicker access to a primary care clinician, by capacity being freed up by utilising a telephone and virtual triage approach.

- *Standard access* - Practices will demonstrate 95% achievement of the urgent access standards. These being that patients are seen within the same day of their condition being diagnosed as urgent by an appropriate clinician. Practices will demonstrate an average of 90% achievement of the routine access standards. These being that patients are seen within 3 days of request for a routine GP appointment.

- *Online Booking* - Promote and advertise online access to appointments. Within the GP contract practices must ensure electronic access to appointments is available. The CCG will support practices to ensure a consistent approach to the marketing and management of these appointments is given to its patient population. This will include more technical support to ensure mobile phone appointment bookings, reminders and cancellations are also utilised.

- *7 Day Working* - Working in partnership with NHS England, the CCG will look to commission a service in which each care delivery group will make a number of routine appointments available on a Saturday and/or Sunday. Access to these appointments are co-ordinated by the care delivery group and based on need (i.e. those patients unable to attend the practice during a weekday). These weekend clinics supported by the necessary admin functions and Practice Nurse will aim to be delivered within the same building as neighbourhood teams, enabling access and links with community provision whilst managing and maintaining estate costs. The patient survey recognised that while these appointments were necessary, it was accepted that accessing appointments at weekends would result in the patient losing the ability to choose which GP they prefer to see. The extended hours GP will be responsible for liaising with the practice regarding treatment and outcomes in a similar style to that provided by the Out of Hours service (Nottingham Emergency Medical Services).

- *Training for frontline staff* - The medical receptionist is a central function to the GP practice. Over the years the perception gained by patients is that the receptionist is the 'gate keeper' to the GPs time. This has been substantiated within a local survey carried out by Nottingham City CCG. In order to progress with improving access to primary care we feel it is necessary to dispel this common misrepresentation. With intensive training, development and supported by a marketing strategy our aims is to ensure all receptionists and frontline staff within practices attend an intensive training course in which they will be developed into healthcare guides. Receptionists will be trained on how the healthcare system works, the importance they plan within this role and how they can steer, guide and support patients through a complex, confusing and sometimes frustrating situation. This training package will be bespoke to Nottingham City, with all practices sending their receptionists to at least 1 out of the 4 available courses.

- *Home Visiting Services* - The Home Visiting Service will support GP practices by providing a rapid access service for acute care at home, thus reducing the need to access urgent hospital care. The service aims to streamline emergency admissions and attendance by better managed access, utilise existing commissioned services and achieve better patient satisfaction. The Home Visiting Service will be available between 9:00 am and 1.00 pm Monday to Friday. The clinicians who make the visits are all local therefore familiar with local services and care pathways and aim to visit the patients within 60 minutes with a basic clinical history provided by the patients GP. This will include: Direct access telephone number for practice with named contact in case of queries, presenting complaint, relevant history and repeat medication list. Where a GP attendance is required the GP will have the technology and facilities to carry out a full appraisal within the patients home (mobile technology), including electronic access to notes and the documentation of vital information.

- *Enhanced Services* - The CCG will review and realign Local Enhanced Services (now known as Primary Care Contracts). The CCG will aim to ensure that they are fit for purpose and commissioned in a transparent, simple way as possible. We will do this through continued engagement with all interested parties so that by Spring 2014 we will be in a position to ensure all patients have more local access and choice to primary care services such as wound care and phlebotomy.

- *Pathways website* - Agreed care pathways assist both healthcare staff and patients understand and achieve the best approaches for care which is safe, person centred and clinically and cost effective. It is recognised that the combination of targeted action within Primary Care, and both informing and empowering the individual with a condition, will improve their sense of wellbeing and avoid repeated admission to hospital. In the first instance, we will focus on pathways where the behaviour of Primary Care has the greatest impact on Secondary Care and on the health service as a whole. However we will also work with key stakeholders to ensure that boundaries, and organisations do not fragment the information to needed by our patient population.

- *Responsiveness contract* - The CCG will develop a one year "Responsiveness contract" that will incentivise practices to adopt and migrate to the change programmes listed within this document. The incentive payment will be underpinned with key requirements that will enable practices to use the funds for back-fill, engagement and training in order to make the leap to a new way of working. While it is recognised that the change proposed within the document will benefit patients, the pace of change will be dependent on practices ability to adopt.

### 4.4 Utilise and adapt innovative technology and best practice

Nottingham City CCG recognises that the GP clinical system is a strategic component within healthcare. The quality of clinical data held within GP systems has never been more important both internally to support the clinical and business processes within GP practices, and externally to support the delivery of care in the wider context. Advances in technology such as skype, online bookings, electronic prescribing, shared data and tele-health, tele-care and tele-medicine are ever more important in managing the health of our population. The success of this vision, is dependent on a robust and sustainable IT infrastructure, therefore it is essential that this vision is read alongside the CCGs Information Technology plan 2013/2016 and the Adult Integrated Care Assistive Technology strategy.

### 4.5 Promote shared responsibility of health

It is essential that patients feel empowered to manage their own health and social care needs and have the necessary information at hand to do this. We will ensure that where possible, and safe to do so, we will commission and encourage direct access services to support our patients to directly refer for routing car such as physiotherapy and podiatry services. We will also ensure that all practices contain information on how patients are able to direct themselves to and around the complexities within health and social care with support from the practice receptionist (see practice receptionist training). The CCG is working with the local Authority to ensure a collaborative approach to self care. Each practice will have a self referral information that will guide patients on how to:-

- Find information on their condition
- Access self help treatments and services
- Order equipment
- Find people with a similar condition to talk to
- Make lifestyle changes eg: losing weight, being more active or stopping smoking
- Get help for carers
- Create their own care plans

## 5. What will this mean to our patients?

Taking into account national policy and guidance on how primary care should be developed, we need to be aspirational and ambitious in our future planning and delivery of primary care services. Therefore, building on the national document *The Patients' Voice* and more recently using information obtained from *"A Call to Action"* and "*Improving primary care – a call to action" as well as* the Royal College of General Practitioners *"General Practice 2022* we will use the information we know about our population and the national direction of travel, to steer a vision for primary care in Nottingham City:

Our buildings

In 2016 all our practices are Care Quality Commission (CQC) registered, with their premises being fit for purpose irrespective of the age and type of building. We have a mix of new and old, large and small buildings; but they are all clean, bright, and tidy and will display only current relevant information about our services.

Primary care buildings are supported by NHS England and we will work with our practices and NHS England to ensure that our buildings are accessible for all, including the disabled, and will conform to all health and safety and infection control requirements, ensuring a safe and clean environment. There will be a comfortable waiting area and all of our practices are child friendly, understanding the needs of both parents and children, at what may be a stressful time.

Accessing the practice

On arrival, the practice reception staff will be welcoming and patients will be able to check-in confidentially, either face to face, or electronically. New patients will be introduced to the "primary care information pack" that will guide patients through the things that will be useful including:

- How to get a personal health profile
- Self-care and lifestyle advice
- Exercise and diet on prescription
- Housing, benefits, employment, healthy foods and cookery advice
- Specialist advice on drugs and alcohol abuse
- Specialist advice and support for sexual health services.
- Details of how to access all services.

The primary care information pack will view patients as a member of the local health community and will provide them with public health information about disease patterns, likelihood and symptoms. We know the expected patterns of ill-health in a community and can advise patients on healthy living, prevention and early diagnosis. Health promotion and illness prevention is as much a part of our service as care and treatment.

For routine (non-emergency) issues, patients will have access to their practice via phone or in person weekdays between 8am and 6.30pm with appointment available at the weekend and evenings for those individuals or are unable to access weekday appointments. Maximum waits for routine appointments will be 3 days however we recognise that clinical need will determine how quickly a patient requires an appointments. Service provision will be communicated via NHS Choices and the practices own website. Occasionally, a practice may close for a half-day staff training session, but they will have arranged for an out of hours care provider to cover any patient needs.

On the day that a patient makes an appointment the reception staff will courteously and professionally try to direct the patient to the most appropriate clinician. This may include offering

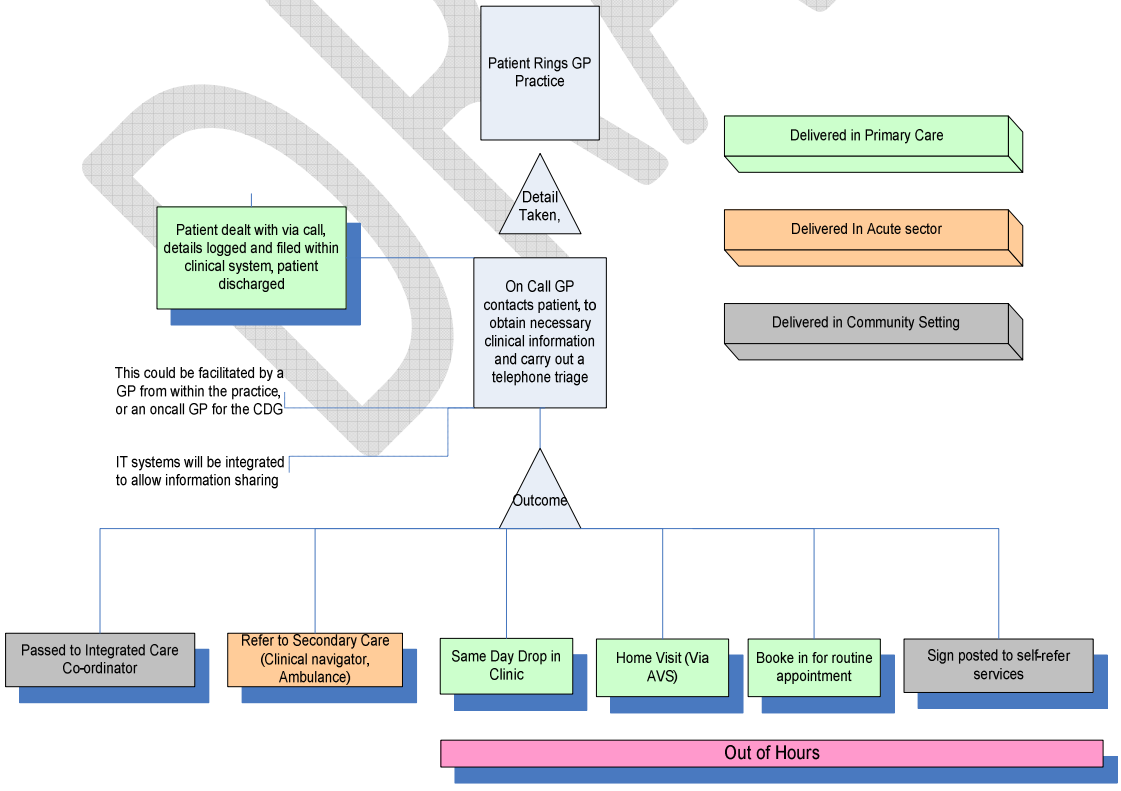
the patient a face to face, telephone, Skype or email consultation. This is not a triage process; merely trying to quickly guide the patient to the most appropriate team enabling the patient to be seen quicker and again flexing the capacity of our integrated teams. If continuity of care is important the practice will respect this, and where practical and safe to do so offer an appointment with the clinician of your choice.

GPs will be able to offer patients a consultation locally, often with a specialist community-based service, or will arrange a hospital appointment. Our coordinated care pathways will mean that GPs, the community services and the hospital consultants can communicate electronically to share information and agree on the best course of action to meet patients' particular needs. All clinicians will actively involve patients and their carers' in decisions about their care and treatment. Our GPs will only ever do what they know they can do safely in their own practice, and sometimes it will be necessary to refer a patient for further diagnostic tests and/or treatment.

<u>What if a patient needs urgent access?</u>

The practice will have set up a responsive urgent system which will include discussion with a clinician who will triage the patient's symptoms and discuss the most appropriate route for the patient. If an appointment is needed whether in the practice or at home, the 'on call' Primary care team will ensure that the patient is seen and treated the same day within the most appropriate setting. This may look like a drop-in urgent care clinic. If a home visit is required, the 'on call' service will liaise with the home visiting service and arrange for an experienced clinician to visit the patient in their home. During this urgent need the practice cannot guarantee that the patient will be seen by their own GP, however the practice will ensure that the patient is seen in a timely manner, with the visiting clinician having full access to the patients clinical records.

<u>What Does Access into Primary Care look like for our Patients?</u>



How will these networks communicate with one another?

Communication between practices will mostly be electronic as most practices use the same computer system, but those few who have a different system can still communicate with each other across the IT network. With a patients' permission practices will also be able to communicate directly with other community-based clinicians and hospitals to ensure effective transfer of relevant patient information across organisational boundaries.

In line with national policy, patients will be able to log on to the same system to check their own health summary care record at any time. If a patient doesn't have a computer or smart phone available they will be able to use the surgery patient computer to check their records, make future appointments or re-order medication.

How will long term conditions be managed in primary care?

Our aim is to free up the GP time to enable them to focus more on managing those patients with a Long Term Condition (LTC). The GP will work with the patient to ensure a proactive approach to the management of the patient's condition, particularly as long-term conditions such as chronic obstructive pulmonary disease (COPD) and diabetes will require monitoring and treatment over a long period of time. Consistency and support is key, therefore the GP will aim to diagnose a condition early to enable treatment to start as soon as possible and ensure that care is available seven days a week.

When a patient is first diagnosed with a long-term condition practices will:

- Provide them with full educational information about their condition soon after diagnosis
- Introduce the patient to the relevant nursing team who will lead much of their long-term conditions management
- Advise patients of additional support services. These will often be patient groups or charities that are expert in the management a patient's condition but may include those available through pharmacies.
- Agree a package of care based on need. This will include a written Care Plan with mutually agreed goals and periodic and annual reviews.
- Agree with the patient what supported self-care they can do for themselves and when to seek the help of their healthcare team.

We want patients to become confident in managing their own condition as much as possible. If a patient has a complex condition, or set of conditions, we will ensure they are appointed with a named care co-ordinator, to work with them and the rest of the team. They will then help patients to implement their Care Plan; we will ensure they have one integrated plan, not many disconnected ones.

What if a patient needs an operation?

We will do as much as we can to avoid unnecessary hospital admissions, including giving patients access to information to enable them to make an informed decision about whether or not an operation is the right procedure for them, and which provider and specialist to see. If however, following a consultation with the GP, a patient decides that an operation is necessary, their GP will:

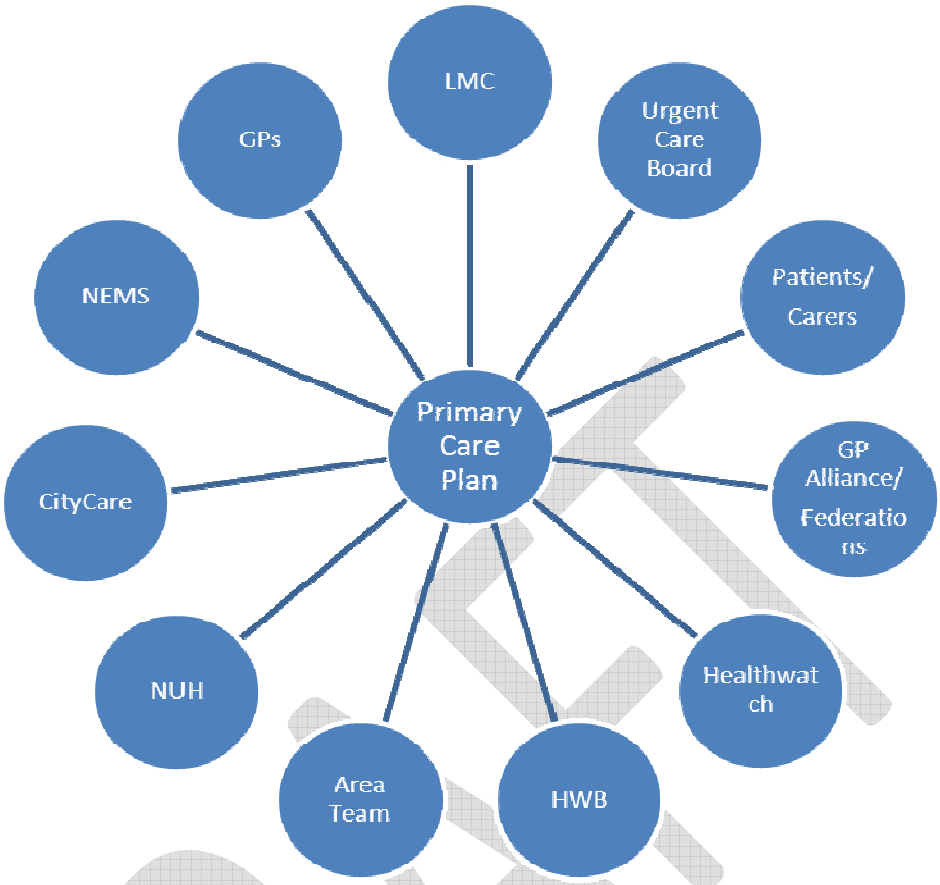
- Offer a choice of hospital and consultant
- Use the Choose and Book system to refer the patient to the appropriate specialty
- Have access to information to confirm that the hospital makes all parties aware of the discharge arrangements and discharge plan details

- Support a patients rehabilitation and convalescence at home or in a community setting
- Work with the hospital to arrange any follow up consultations with the most appropriate clinician, who may be the GP, the hospital consultant or another specialist clinician. These maybe face to face but equally where appropriate may involve telephone or email reviews.

How will primary care keep up to date with latest practices and innovation?

We will ensure we are fully linked with the latest developments within NICE and other health organisations. Our clusters will encourage innovation in which primary, community and secondary care providers will develop localised pathways that meet the needs of its population while taking into consideration innovation. We will support training and learning through our Protected Learning Times (PLT), and the Academic Health Science Network (AHSN) and wherever possible continue to support research within our practices, in a bid to further develop knowledge and outcomes that will benefit the wider population.

## 2. Stakeholder Engagement




It is important that our stakeholders are included within this plan. As an integral part of the primary care infrastructure we want them as enablers of this vision to have a clear understanding for our case for change. Excellent communication and engagement will ensure our stakeholders are able to deliver our primary care plan and also enable them to be clear about how their roles contribute to us achieving this our innovative change in direction.

The main aim of communication and engagement within this plan is to communicate our vision and deliver our priorities. We have identified the following communication and engagement vision statements which will help us to do this:

- Ensure stakeholders are fully engaged and are able to feed into the development process
- Proactively build continuous, meaningful engagement with the public and patients to shape services and improve health.
- To ensure that everybody who wants to influence the planning, development, review and improvement of services has the opportunity to do so.

## 3. Key Performance Indicators (still under development – PH are advising we look at four main areas and these then are sub categories, the four areas would be LTC/Complex; Frail elderly; Prevalence; Risk factors

*specific KPIs to be agreed locally

| Key Performance Indicator | Measure/Indicator |
|---|---|
| 1. Satisfied patients | a. Evaluation of the pilot using qualitative and quantitative design utilising patient participation groups – using quality of life measures adapted from PROMs |
| | b. Number of complaints received about the service each month |
| | c. Number of incidents |
| | d. Proportion of patient reporting easier, on-line registration |
| | e. Number of patients requiring referral back to the GP following redirection to alternative service |
| | f. Number of patients offered a choice of primary care services within AQP process |
| | g. Number of patient accessing electronic prescriptions and online booking of appointments |
| | h. GP survey to measure satisfaction to include experience of the practice offer, attitudes, cleanliness and CQC registration |
| 2. Motivated positive staff | a. Staff questionnaire – to include experience and level of skill |
| | b. Training and development |
| | c. Number of WTE staff working in the service |
| | d. GP and practice staff evaluation |
| | e. Proportion of time GP and practice staff for multi-disciplinary working with the wider health and social care team across all sectors including children's and adults public health services |
| 3. Outcomes | a. Proportion of patients with long term conditions/complex needs which are case managed increase from baseline |
| | b. Proportion of patients with end of life needs actively case managed from baseline |
| | c. Proportion of residential and nursing home patients case managed increase from baseline |
| | d. Proportion of readmissions within 30 days |
| | e. Proportion of expedited discharges |
| | f. Proportion of patient entering long term care |
| | g. Proportion of patients living at home |
| | h. Proportion of health checks completed |
| | i. Patient not accessing the services but with inequalities or life style issues identified and actively managed |
| | j. Proportion of patients on long term sickness notifications |
| | k. Number of emergency department attendances/non-elective admissions and mental health admissions |
| | l. Length of stay in hospital |
| | m. Proportion of use of ambulance and transport services |

| | |
|---|---|
| 4. Financial management | a) Cost effectiveness (avoidance, reduction and savings) due to the pilot |

## 4. Enablers to deliver the vision

To deliver the CCGs vision, we will need key partners and stakeholders to be fully informed, engaged and supportive of this vision. This will include developing a sustainable highly motivated workforce, estate capacity to meet the needs of care closer to home while ensuring equity of funding.

In terms of specific requirements the following actions will be undertaken:

| Vision/Outcome | Delivery Mechanism | Resource |
|---|---|---|
| Distribution of primary care welcome packs to all new patients, informing of all services and care available from a health and social care setting and how to access it | Health care info and map, PH info, How to use ED, how to access the practice, who to call in an emergency. Opening and closing hours | Practice, CCG, LA, LAT, NUH, CityCare, NHT, NCVS |
| Improved and convenient options of making, cancelling or re-arranging an appointment | Improved IT and technology such as practice apps, appointments, email addresses and text reminders | Practice, NHIS, Practice, CCG |
| Improved information, communication and support to enable and encourage self-care/management | Practice/patient computer, practice App, practice email address, E-prescribing, National Summary Health record, expert patient, remote monitoring | Practice, NHSCB, CCG, independent, carers groups |
| Technology and infrastructure available and ready to support integrated and aligned working arrangements. | Integrated systems<br>Shared access to appointment bookings and records | Practice, NHSHIS, LA, CCG |
| Develop a culture that is patient focussed. Ensure those who work in primary care are appropriately skilled, supported, educated and informed to deliver optimum care in their role | Practice visits, peer support, mentoring, pathway launches and development, personal development plans, appraisals, 1-2-1s, customer service courses, revalidation, PLTs | CCG, AT, LETB, independent courses, recruitment |
| Clear and Non Jargon communication from your clinician when an operation is required, including support to enable patients to decide the appropriate treatment for them | Expert patient programme | CCG, LETB, patient |
| Supported discharges with a full and co-ordinated care plan between primary, secondary and community care with access to a specialist within the community | Follow up and discharge activity plans. | Practice, NUH, CityCare, CCG, patient |
| Ensure choice is offered, supporting patients to choose the most convenient date, location, provider and consultant for his/her condition | Choose and Book, NHS Choices, CAS | CCG, Choice Website, National Choose and Book Team. |
| Develop a culture where innovation is used to develop new and improved services for patient population, using national guidance and local patient input | Under-spends, innovation funds, national funds, non- recurrent sums, feedback forms. | Practice, CCG, LAT, national institute for innovation, patient AHSN, Public Health |
| Ensure patients have the opportunity within the practice to make recommendations for commissioning improvement or raise concerns regarding existing | Practice participation group, feedback forms, genera patient feedback email address, text, twitter, patient council, patient representative on cluster board, | |

| | | |
|---|---|---|
| clinical care | pathway redesign input | |
| Safe clean and fit for purpose premises that are easily accessible to all patients, located in areas of need | CQC registration, Primary Care accommodation review, patient feedback | PropCo, CCG LAT, LMC |
| Development of natural GP communities working within federations to enable practices to partner up to deliver all or part of clinical services supported by a central back office function | Primary Care alliance, federations, Natural GP Communities | Practice, CCG, LAT, LMC |
| Practices working within natural communities to meet the demands of 7 day working, ensuring practices and services are more geographically accessible | Primary Care alliances, contracts, home visiting service, natural GP communities | Practice, CCG, LAT, LMC |
| Commission and support GP First, enabling urgent access to be screened and dealt with according to need by an appropriate professional | Primary care alliances, contracts. | Practice, CCG, LAT, LMC |
| Out of hours provision offering equitable and consistent clinical care | 111, GP out of hours, Clinical Navigator, crisis team | CCG, eHealthscope, LETB, LAT, Institute for innovation, NVQ |
| Ensure each Care Delivery Group has access to, and clear guidance on how to access the home visiting service, 7 days a week. | Primary Care alliance, CCG commissioning. | Practice, CCG, LAT, LMC |
| Strategic workforce review and plan ensuring consistency and care in future years | Workforce strategy review, horizon scanning | Practice, CCG, LETB, LAT |
| Integration across primary and community care, within health and social care | Integrated workplan | Practice, CCG, LETB, LAT |
| Greater access to primary care provision through shared resources and teams | AQP, LA, community contracts, GP Federations, Alliances | Practice, CCG, LA, NHSCB, CityCare, patient |
| Reduced variation in primary care through ongoing monitoring and support | QIC, primary care steering group, practice visits programme, QoF, practice quality reports, eHealthscope | Practice, CCG, LAT, LMC patient |

## 5. How will we know if we are doing a good job?

We will know we are doing a good job when we have the right people being cared for in the most appropriate setting demonstrated by progress against trajectories. Feedback and ensuring consistent high quality is paramount. The following will assist us in gauging our success:-

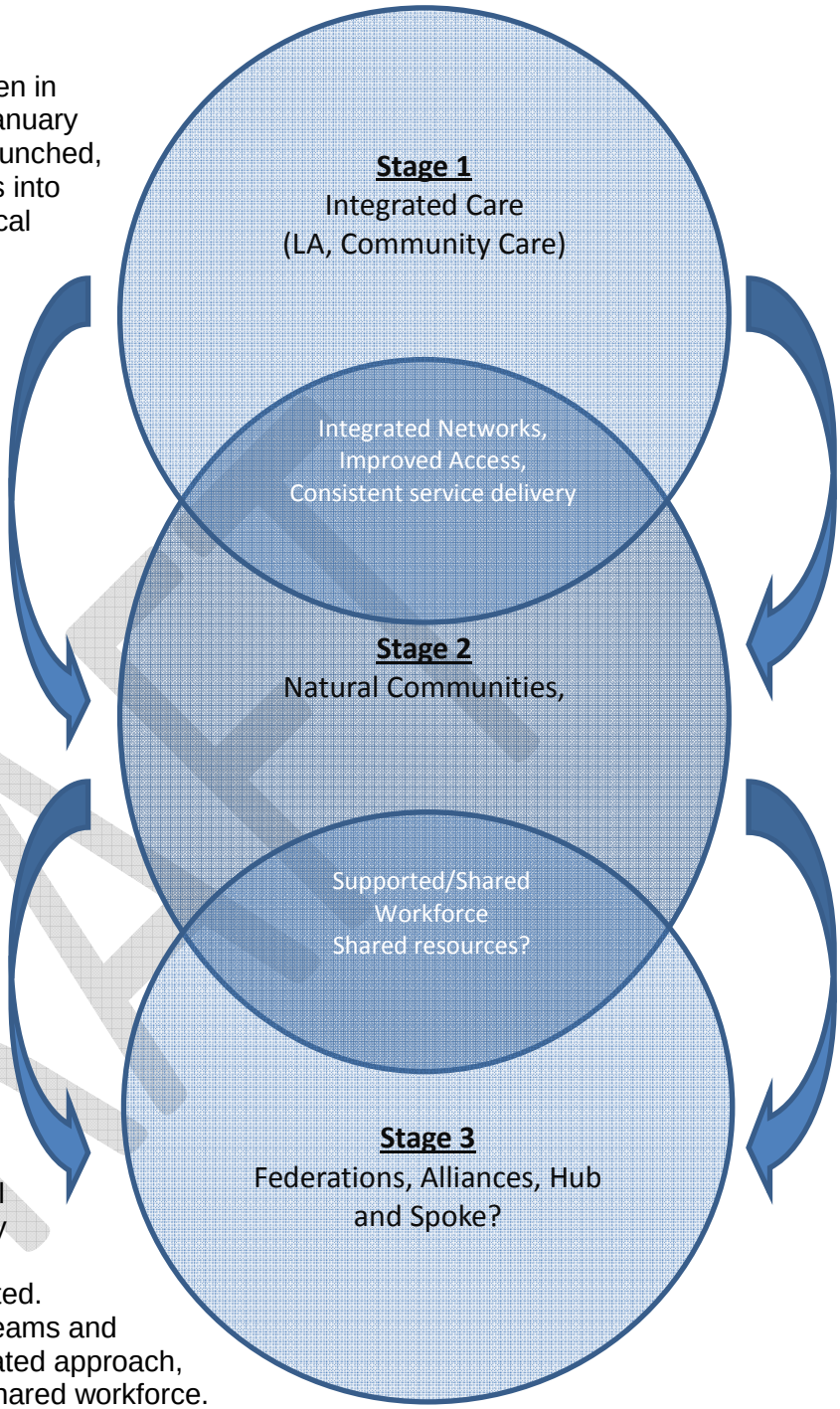
- We will work with NHS England to monitor the quality of primary care through their web based tool, alongside our local system called eHealthScope benchmarking performance against all practices within Nottingham City to ensure our service is at a consistent level and a standard.
- We will participate in an annual peer-to-peer review, with practices agreeing and implementing specific actions that will improve and enhance the quality of service to patients. This data and actions will be compared year on year to ensure that primary care services are improving, and service delivery is meeting the needs of our patients.
- Our practices will actively seek and welcome feedback from patients on their experience of services including the use of the friends and family test.
- The practice and CCG will monitor complaints as an opportunity to improve services and the practice will acknowledge a patients complaint within 48 hours and keep them advised of progress.
- We will undertake regular patient surveys and the results and will publish this information. This will augmented by mystery shopper assessments from which practices will be required to develop action plans to address any areas where potential improvements have been identified.
- We will routinely assess our services against the needs of our diverse population to ensure that they offer equality to the rich diversity of City residents.
- We will engage in more formal public involvement through local networks and independent consumer organisations that will have the statutory right of entry to visit the premises of service providers and to report their findings.

## 6. When will this change happen?

**Stage 1** - January 2014 - April 2014
The Integrated care programme has been in operation for a number of months. In January 2014, the care delivery groups will be launched, bringing together services and providers into network locations that are aligned to Local Authority provision. During this time a project manager will facilitate bringing the practices together to meet the neighbourhood teams.

**Stage 2** – From April 2014 to March 2018, GPs will be supported to develop natural GP communities to enable them to share their resources. As part of these 'natural communities" practices will come together and identify a common purpose in which working in partnership would benefit them. This may include integrating/supporting back office functions, sharing clinical support or general mentor support. During this phase, the practices will be introduced to GP first, and the home visiting service.

**Stage 3** – From January 2014 - March 2018 the "natural GP communities" will formalise their alliance through a robust arrangement that enables them to work as a community network of GPs enabling their patients to have greater access to a shared clinical team that will be responsible for delivering high quality care in a time when resources and funds are limited. During this phase, the neighbourhood teams and providers will begin to work in an integrated approach, including multi-disciplinary teams and shared workforce.



## 7. Evaluation

We will work with NHS England who have commissioned the Collaboration for Leadership in Applied Health Research and Care (CLAHRC) to evaluate our plan to ensure the outcomes and KPIs are either met, or lessons learned are shared. This evaluation will enable the CCG to determine the true outcome of this innovative approach to primary care redesign.

## 2. Appendix 1 - Case for Change

Setting the scene of Primary Care in Nottingham City

Nottingham City Clinical Commissioning Group has 62 practices, with a combined patient population of 340,000. The patient list within the practices varies from 1600 to 36000 dependent on the practice size and location.

Three types of contracts have been available to commission primary medical services:

- General medical services (GMS)
- Personal medical services (PMS) – which includes specialist PMS (SPMS)
- Alternative provider medical services (APMS)

Currently (2013) Nottingham City commissions primary care medical services from 62 independent contractors (down from 63 in 2012). The contracts used vary to meet the needs of our residents, however, all primary medical services contractors (GPs) are required to provide patients with the same essential services. They can opt out of providing additional services, which a few do.

Workforce

The primary care workforce is changing. Retiring GPs, single-handed practices, partnerships dissolving and a national shortage of clinicians will only add to the future challenges within Nottingham City. Our practices are already experiencing difficulties in employing and retaining GP, nurses and workforce to meet the increasing demands on these services. We will proactively identify existing and potential gaps in provision and workforce via direct links with the practice, LMC and Area Teams. These communication links will enable us to triangulate our data, working with stakeholders to plan local and national mitigation plans.

Primary care access arrangements

Primary care access arrangements are referred to in relation to core and extended hours. The GMS Contract defines core hours as the period beginning at 8am and ending at 6.30pm on any day from Monday to Friday, except Good Friday, Christmas Day or bank holidays. The contract states that the contractor must provide essential services (see appendix 1), at such times, within core hours, as are appropriate to meet the reasonable needs of its patients, and to have in place arrangements for patients to access such services.

Practices implement local access arrangements to meet the needs of their patients and their practice. Practices operate systems for walk-in access, same day and pre-booked appointments. Responsibility for triage varies from practice to practice, and between GPs and nurses. Nottingham City has a wide variation in patient access five days a week, with a proportion of practices closing for business one afternoon per week. For practices that are closed one afternoon a week, access to their core services is not available to practice patients but they are able to access urgent care via an out-of-hours provider.

Patient health outcomes

Cancer mortality varies considerably across the City including deaths attributable from tobacco smoking; deaths from cardiovascular disease are higher than expected and we have significant ward-level life expectancy variation between the City and our neighbours.

Nottingham City Joint Strategic Needs Assessment (JSNA)

Nottingham City's population increased over the past five years, mainly through migration (recently from Eastern Europe) and an increase in university students, supported by a big increase in house building. The number of births has risen considerably and is likely to continue to rise over the next five years. The proportion of children is lower than average, although much less so for under-fives often because parents and children tend to leave the City before starting school. The City therefore gains young adults due to migration while losing all other age groups.

Nottingham City has a very young population with a high proportion (30%) of people aged 18 to 29, due largely, but not entirely, to the presence of the two universities. Students account for approximately one in nine of the population, however the percentages in other age-groups are commensurately lower than average, with the proportion aged 40 to 69 being particularly low. The trends in the age structure of the City do not follow national trends. In the short to medium term, the City is unlikely to follow the national trend of increasing numbers of people over retirement age.

Analysis shows a higher than average proportion of 'Twilight Subsistence' households in the City. These are characterised as households with older people living in social housing with high care needs and limited access to transportation. One third of City residents aged 60 plus claim Pension Credit, an entitlement intended to raise their income to a minimum level, compared to just over one fifth in Greater Nottingham and England. As depicted in fig 1. Nottingham ranks 13th out of the 354 local authority districts in England for deprivation. The high level of deprivation affects an extensive part of the city, with 56 of the 176 Super Output Areas being within the 10% most deprived in the country, and 106 in the 20% most deprived.

**Figure 1**

| Mosaic Group | Mosaic Tile | Nottingham Population | % population by Mosaic group | Nottingham:England Population Index | Index of Multiple Deprivation | Long-term illness | Smoker or buys tobacco products | Heavy smokers | Bad diet | Drink alcohol daily | Heavy/ medium beer drinking |
|---|---|---|---|---|---|---|---|---|---|---|---|
| A | Career professionals living in sought after locations | 9,122 | 3.3 | 30 | 41 | 59 | 80 | 38 | 68 | 174 | 58 |
| B | Younger families living in newer homes | 13,672 | 4.9 | 43 | 75 | 71 | 92 | 70 | 102 | 83 | 100 |
| C | Older families living in suburbia | 15,071 | 5.4 | 31 | 70 | 77 | 91 | 57 | 78 | 106 | 62 |
| D | Close-knit, inner city and manufacturing town communities | 40,878 | 14.7 | 86 | 134 | 104 | 109 | 109 | 108 | 88 | 160 |
| E | Educated, young, single people living in areas of transient populations | 52,787 | 19.0 | 272 | 123 | 79 | 99 | 92 | 80 | 97 | 130 |
| F | People living in social housing with uncertain employment in deprived areas | 45,182 | 16.2 | 347 | 182 | 185 | 113 | 195 | 138 | 59 | 143 |
| G | Low income families living in estate based social housing | 53,980 | 19.4 | 297 | 181 | 153 | 125 | 203 | 155 | 68 | 173 |
| H | Upwardly mobile families living in homes bought from social landlords | 29,560 | 10.6 | 99 | 144 | 124 | 116 | 151 | 126 | 73 | 118 |
| I | Older people living in social housing with high care needs | 10,072 | 3.6 | 139 | 144 | 136 | 106 | 42 | 89 | 85 | 72 |
| J | Independent older people with relatively active lifestyles | 8,084 | 2.9 | 42 | 87 | 83 | 91 | 93 | 73 | 146 | 77 |

1. Mosaic uses an index, where 100 is the England average, enabling us to benchmark our population groups and their atributes against other areas with a similar demography.
2. 1 in 3 residents are from Groups F and G, which have the highest index for deprivation and long-term illness.
3. Groups F and G are also the heaviest smokers, have the worst diets and are the heaviest drinkers.

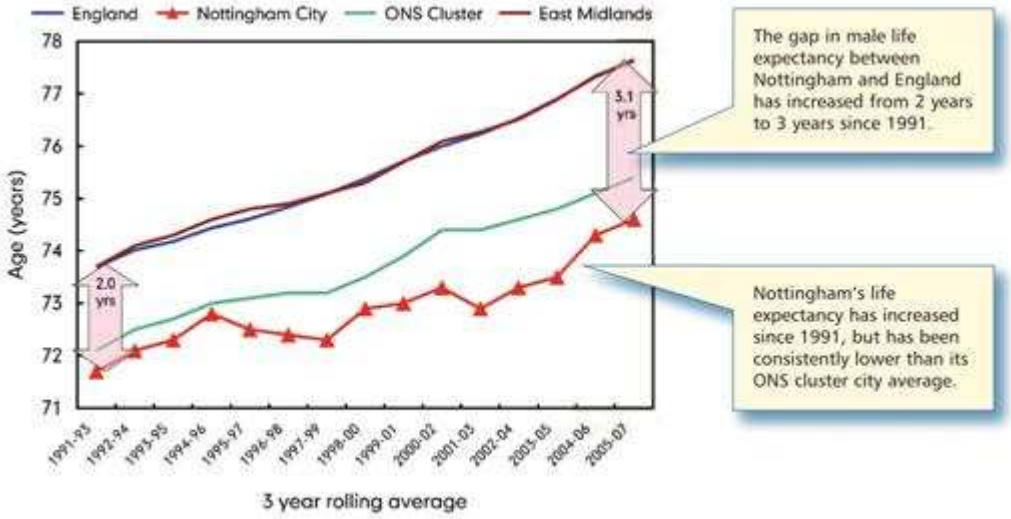
Older peoples' health is generally much worse than that of other groups; nearly half have a limiting long-term illness or disability. Two thirds of clients receiving adult social care support are older people. Most of these require help because of a physical disability (including sensory impairment) or frailty, and one in ten needs support due to mental health problems. The City has

a very high rate of avoidable injury in over 64 year olds. 70% of these injuries are due to falls, which can directly lead to disability or death for older people.

Teenage pregnancy is high in the City compared with the rest of the country at 49.5 conceptions per 1000 girls aged 15-17, compared with 30.7 nationally. Some wards in the City have a rate higher than twice the national average. This overall high rate for the City remains static despite implementation of interventions that have been effective elsewhere. 20% of year 6 age children are classed as obese, and are likely to grow into obese adults at risk of heart disease, stroke and type 2 diabetes.

Nottingham's high levels of deprivation, high level of unemployment, low educational attainment and unhealthy lifestyles (high smoking, poor diet, and low physical activity) are all interrelated determinants of its poor health outcomes and high level of health inequality.

**Figure 2**




In overall terms the City's residents are less healthy than elsewhere in the country. Life expectancy in Nottingham for men is 75 years, compared with 78 for Greater Nottingham and for England, and for women 80 years compared with 82 for Greater Nottingham and England . The gap in life expectancy between Nottingham and England has been widening since the early 1990s (Figure 2). Within the City there are high levels of health inequalities – life expectancy varies by ten years between the most and least deprived wards of St Ann's and Wollaton West. 15 of the 20 wards have significantly lower life expectancy than the regional average. The most significant disease contributors to our lower than average life expectancy are premature deaths caused by cardiovascular disease (CVD), respiratory diseases and cancers.

<u>Clinical variations</u>

Nottingham City has areas of excellence in the provision of primary medical services, but we also have other areas where the quality falls below expected standards, these are monitored through Quality Outcomes Framework or other national performance dashboards. There are many examples where we know that if primary care providers improved their range of services and clinical quality performance, this would have a positive impact on a range of health issues for the residents of Nottingham City.

Variation in quality and outcomes framework performance

The quality and outcomes framework (QOF) is a national annual incentive scheme for general practices which rewards them for improving the quality of their clinical services and the way they are provided. Practices are rewarded for their performance in a number of areas, but in particular for improvements they make in the management of patients with long term conditions.

As this is a national scheme, we can compare the performance of practices in Nottingham City against each other as well as against the performance of others in England. Data from QOF is an important measure of the performance of GP practices and CCGs in how well, for example, long-term conditions are managed. It is possible to compare the recorded prevalence of the long-term conditions in the registered population with the expected prevalence. This can indicate unmet health need in the population. QOF allows practices to exception-report (exclude) specific patients from data collected to calculate achievement scores.

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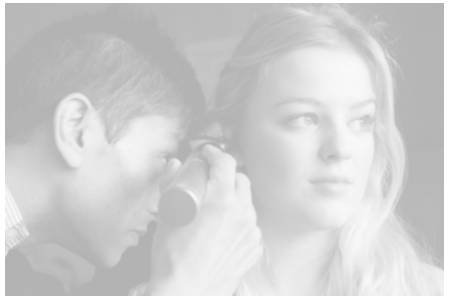

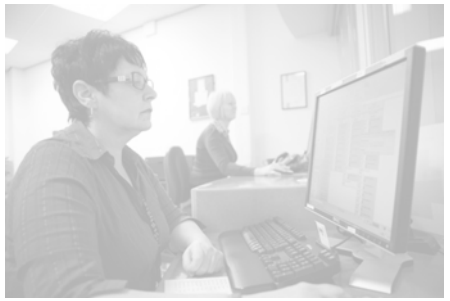

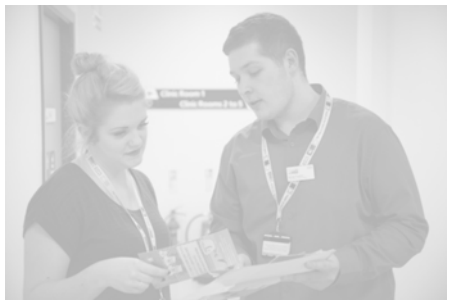

# Primary Care Plan


## Maria Principe

*Director of Primary Care Development and Service Integration*


*February 2014*

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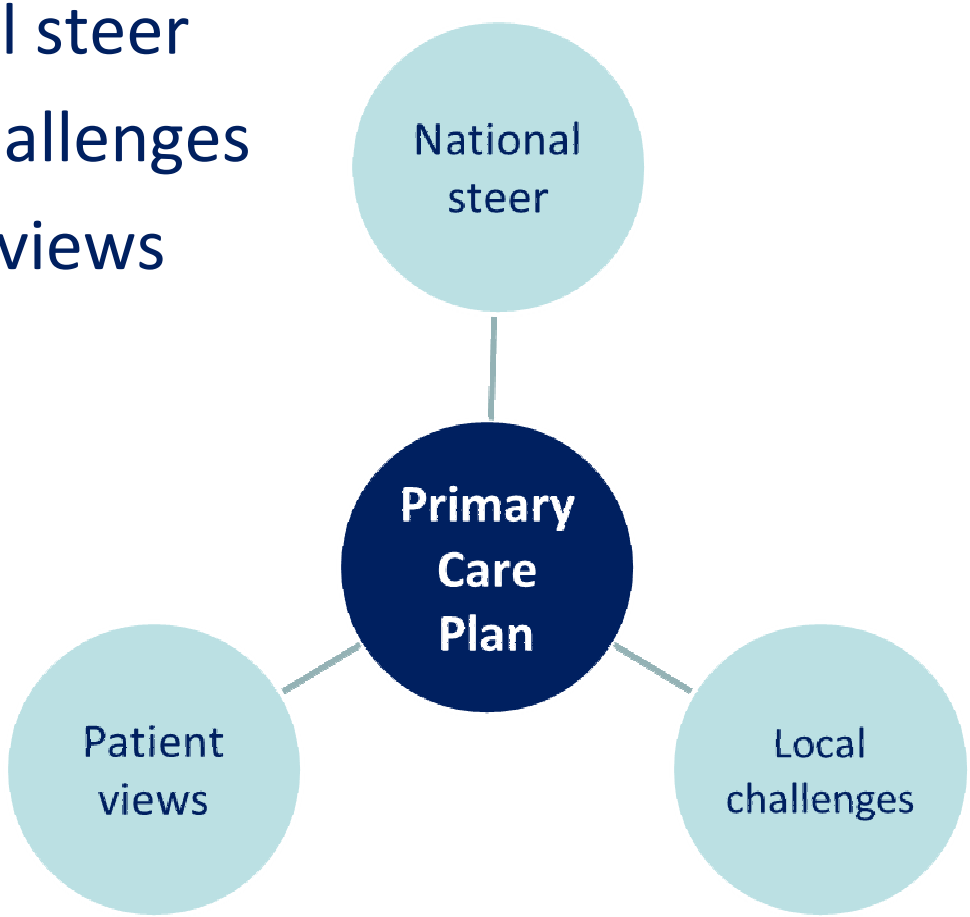
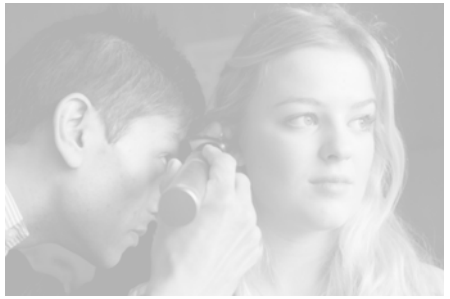
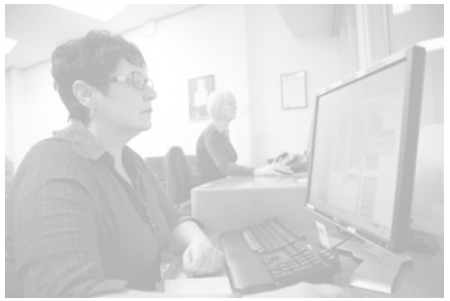
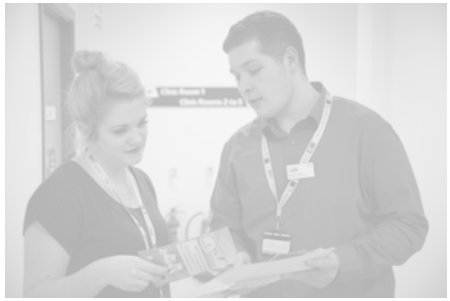
# Our approach

- National steer
- Local challenges
- Patient views







# National steer

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- Access 8am-8pm, Weekend working
- Flexible access including email, Skype and phone consultations for those who might prefer it to face-to-face, when it is safe to do so
- Easier, on-line registration and choice of practice
- Joining-up of urgent care and out-of-hours care to ensure rapid walk-in access to care
- Greater flexibility about how people access general practice, for instance with the option to visit a number of GP surgery sites in their area
- Better access to 'telecare' to help people stay comfortable at home, as well as to healthy living apps


- Improving outcomes
- Strategic and operational plans
- Allocation for CCGs
- The tariff
- Integrated Transfer Funds
- Developing integrated plans
- Working together
- Competition
- Local innovation
- Intermediate actions

- Named GP for over 75s
- Quality monitoring for out –of-hours (GPs who have opted out)
- Care plans
- Use of NHS number
- Online appointment booking
- Patients to order repeat prescriptions online
- Extended hours - extended with flexibilities to allow practices to work together to provide the most appropriate service for their patients
- Avoiding unplanned admissions enhanced service (case management, timely telephone access, shared information and data, GP2GP, discharge review, unplanned admissions review)

# Local challenges

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- Transient and aging population
- Variations in access to primary care medical services
- Variations in clinical quality and patient health outcomes
- Variations in service delivery (LESs, access etc)
- Variations in the quality and size premises from which primary health care is delivered

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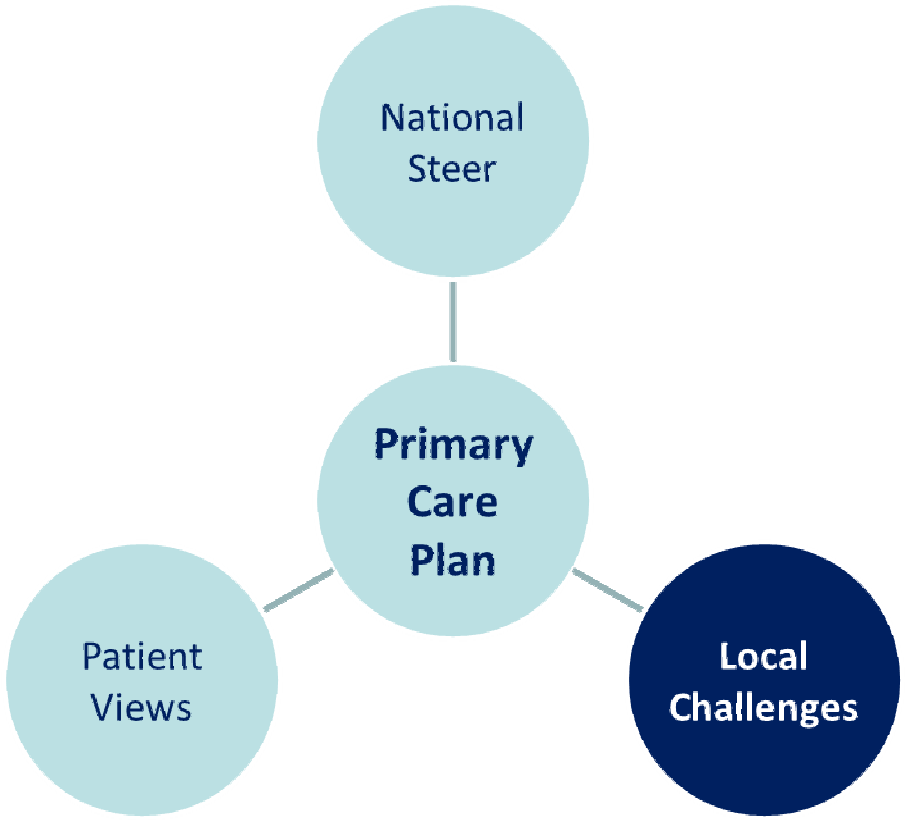
- Workforce concerns - shift in work but not in resources or funds
- Financial management / competition / contract changes
- Communication overload
- Workforce retention, retiring GPs, shortage of primary care clinicians
- Variations in service delivery/community services
- Managing patient expectations



# Patient Views 600 surveys returned

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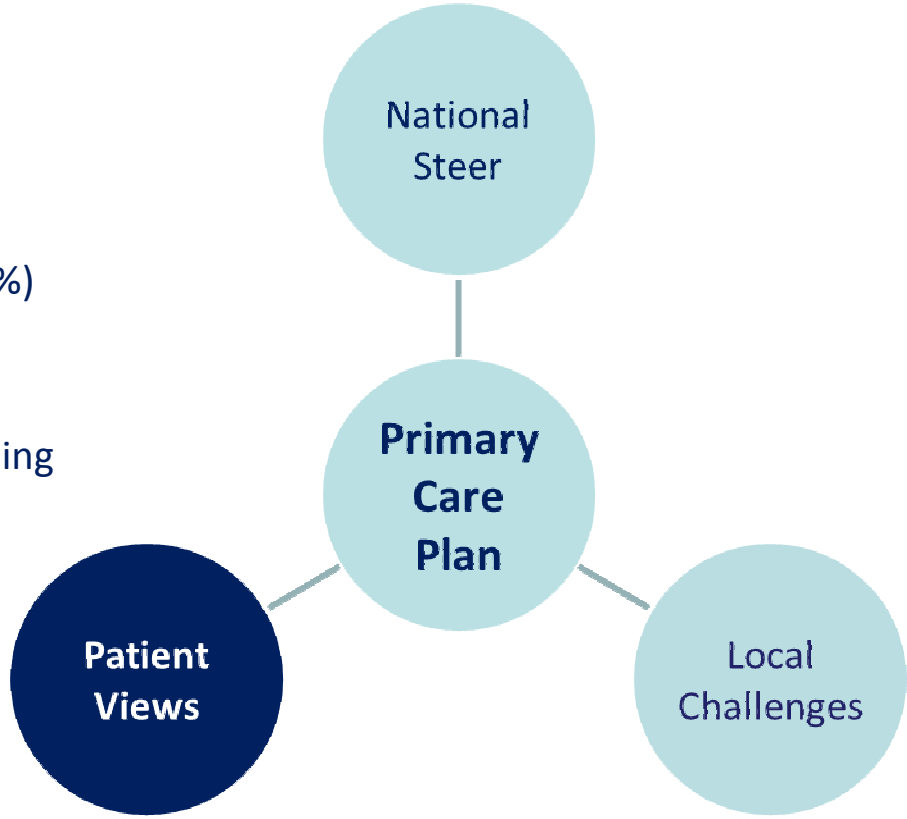
## Access

- Large support for GP telephone contact (312 - 65.7%)
- Happy for receptionist to signpost to nurse (under guidance)
- Consistency of approach of access (324 - 74%)
    - Urgent appointments same day (259 - 59.3%)
    - Routine appointment up to 3 days (147 - 33.6%)
    - Routine appointment bookings 2 weeks in advance (110 - 25%)
    - Sit and wait drop-in clinics (rather than attending ED)
- Saturday opening (339 - 77.6%)
- Sunday opening (110 - 25.2%)

## General feedback

- Flexibility of named GP, when urgent/same day
- Consistency required for LTC on-going treatment
- appointment required. (49%), (29.7% yes if LTC related)
- Would like to see more use of technology
- All NHS resources should have Shared technology/data



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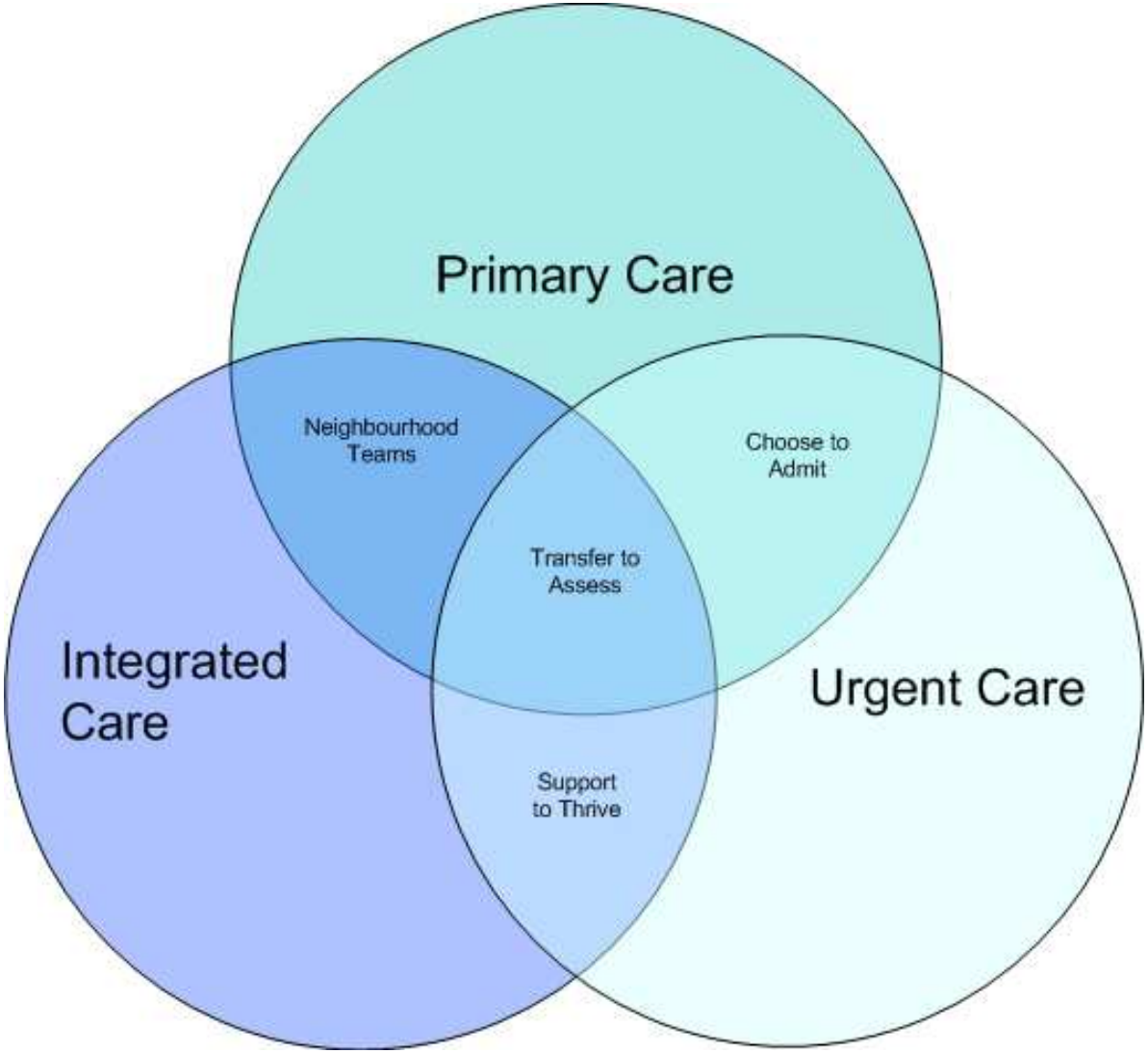
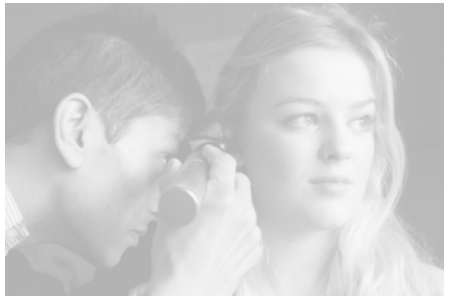
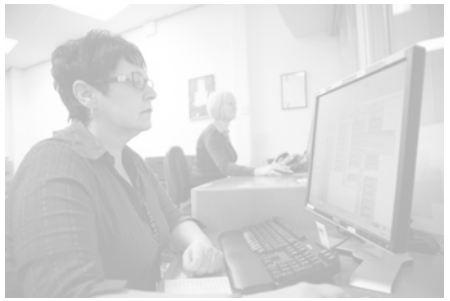
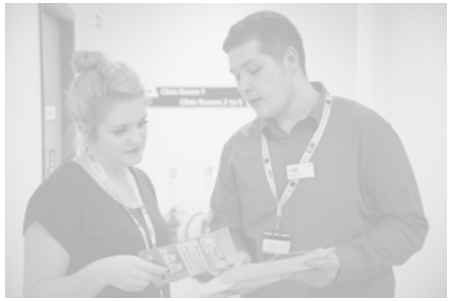
# Relationships to Consider







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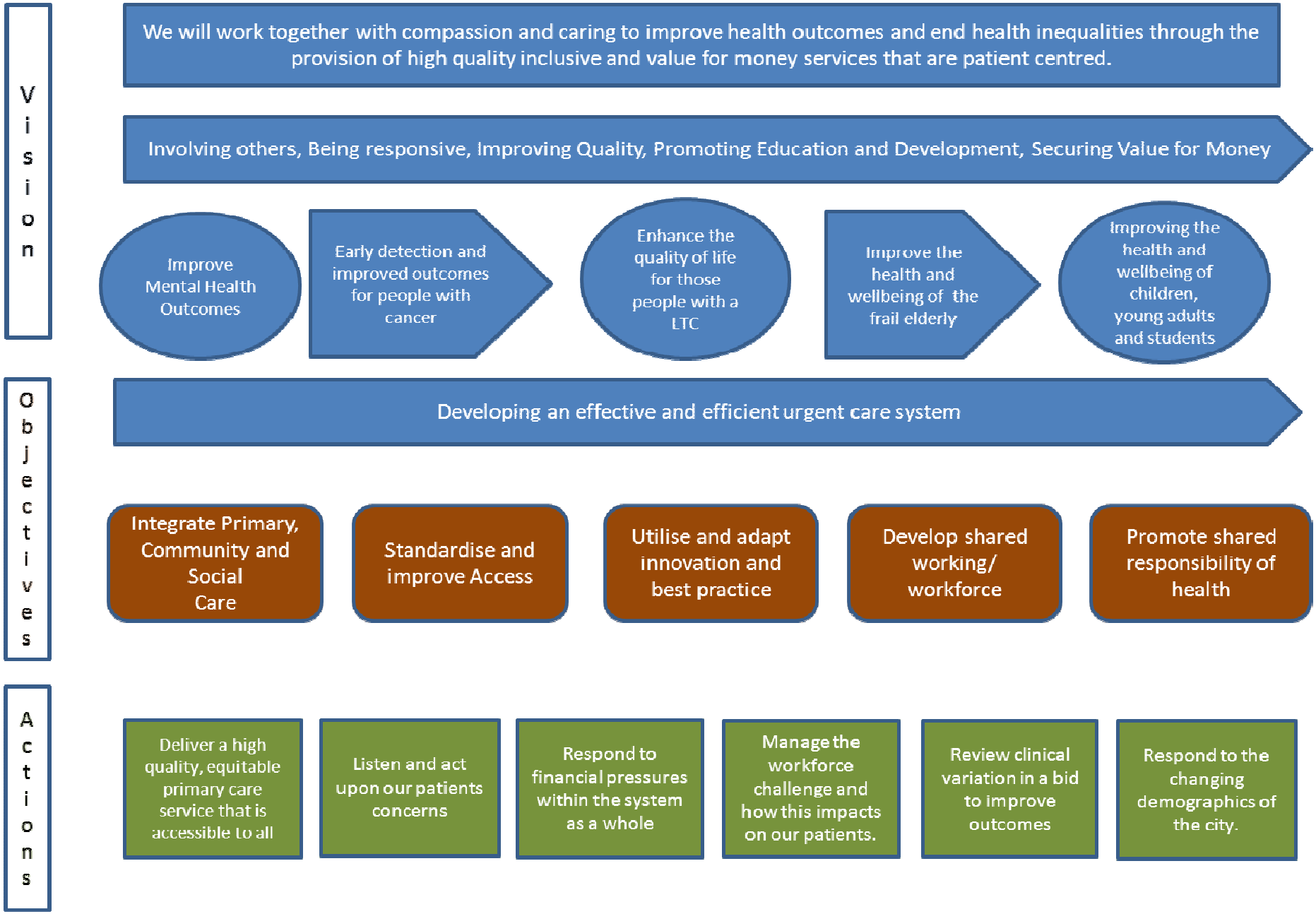
# Primary Care Vision
# Plan on a Page


Vision
We will work together with compassion and caring to improve health outcomes and end health inequalities through the provision of high quality inclusive and value for money services that are patient centred.
Involving others, Being responsive, Improving Quality, Promoting Education and Development, Securing Value for Money
Improve Mental Health Outcomes
Early detection and improved outcomes for people with cancer
Enhance the quality of life for those people with a LTC
Improve the health and wellbeing of the frail elderly
Improving the health and wellbeing of children, young adults and students
Objectives
Developing an effective and efficient urgent care system
Integrate Primary, Community and Social Care
Standardise and improve Access
Utilise and adapt innovation and best practice
Develop shared working/ workforce
Promote shared responsibility of health
Actions
Deliver a high quality, equitable primary care service that is accessible to all
Listen and act upon our patients concerns
Respond to financial pressures within the system as a whole
Manage the workforce challenge and how this impacts on our patients.
Review clinical variation in a bid to improve outcomes
Respond to the changing demographics of the city.

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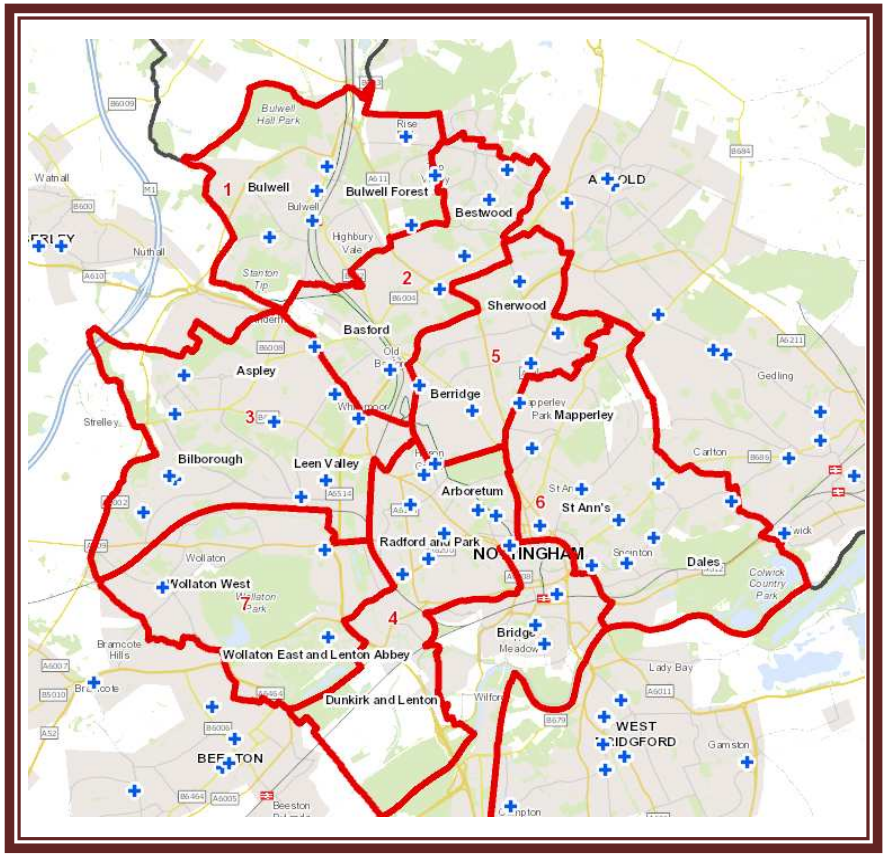
# How will the vision be achieved?

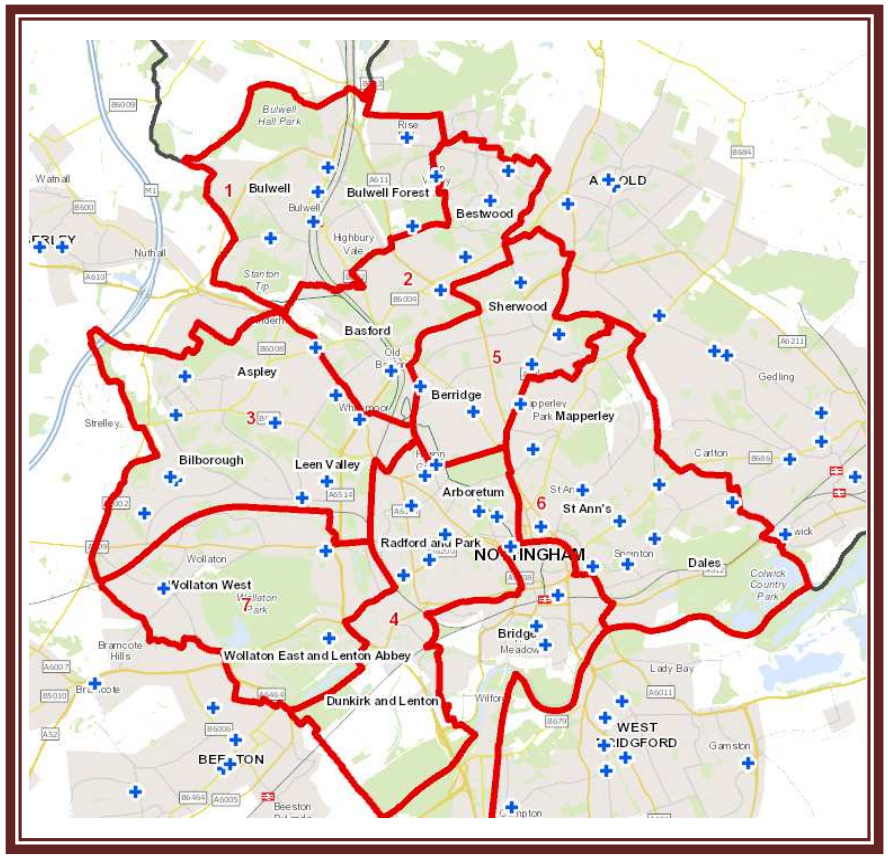
# Integrate Care

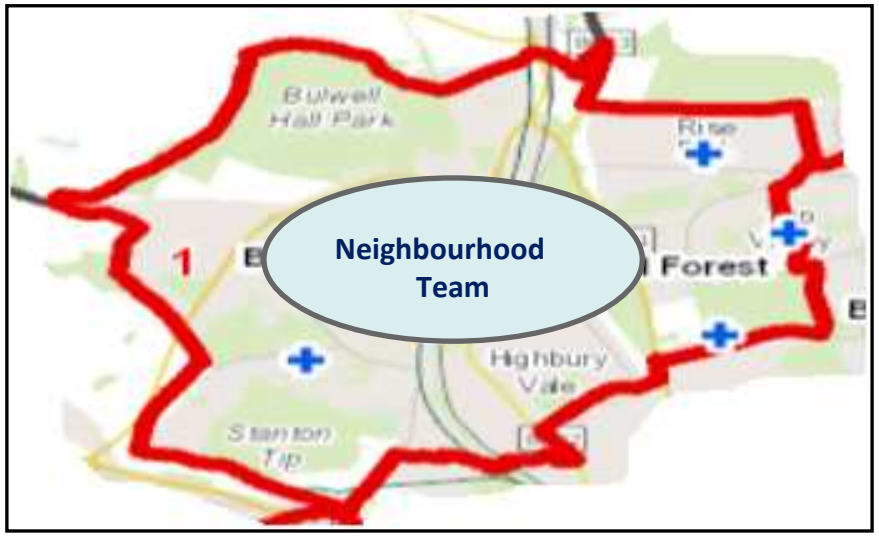
- Alignment of GPs within care delivery groups with LA including neighbourhood teams
- Implementation of Care Co-ordinators to underpin and support CDGs.
- Implementation of management MDT management of patient care
- Promotions of shared working and workforce to alleviate current local and national pressures.




# Innovative use of IT and Technology

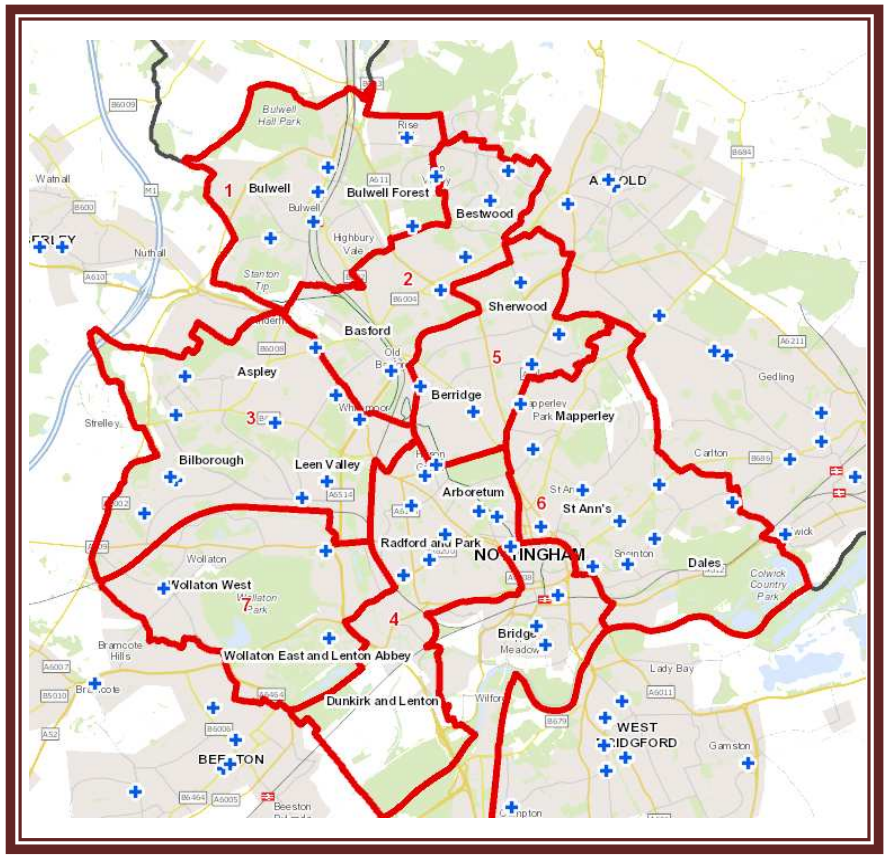
- Commissioning of Interoperability gateways to support and enable Information sharing between organisations
- Promotion of NHS number between health and LA
- Continued promotion of Innovative systems such as Electronic Prescriptions, Sunquest ICE, online patient records
- Promote Mobile working
- Remote visual Consultations
- Assistive Technology / Innovative Technology
  - Online Booking
  - Skype
  - Telehealth
  - Telemedicine

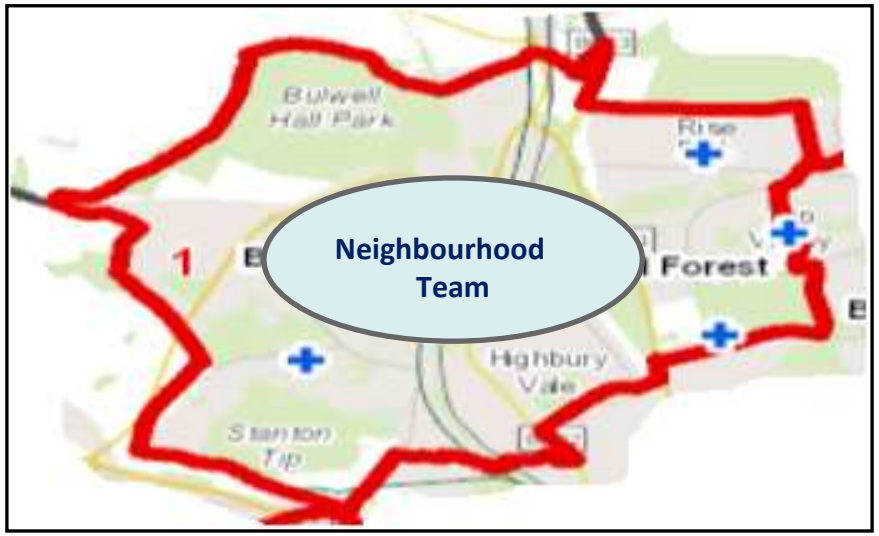


# Standardize access and improve quality

- Standardise approach / aspirations
  - Standardise access (1 day urgent, 3 day routine)
  - GP First/triage system
  - First line physio
  - Sit and wait ‘drop in’
  - Promotion of self referral services
  - Utilisation of AQP for generals services to ensure equitable access and quality
- Development of Pathways website
- Development of 7 day working at CDG level**
- Acute (Home) Visiting Service
- Assistive Technology / Innovative Technology
  - Online Booking
  - Skype
  - Telehealth/Telemedicine

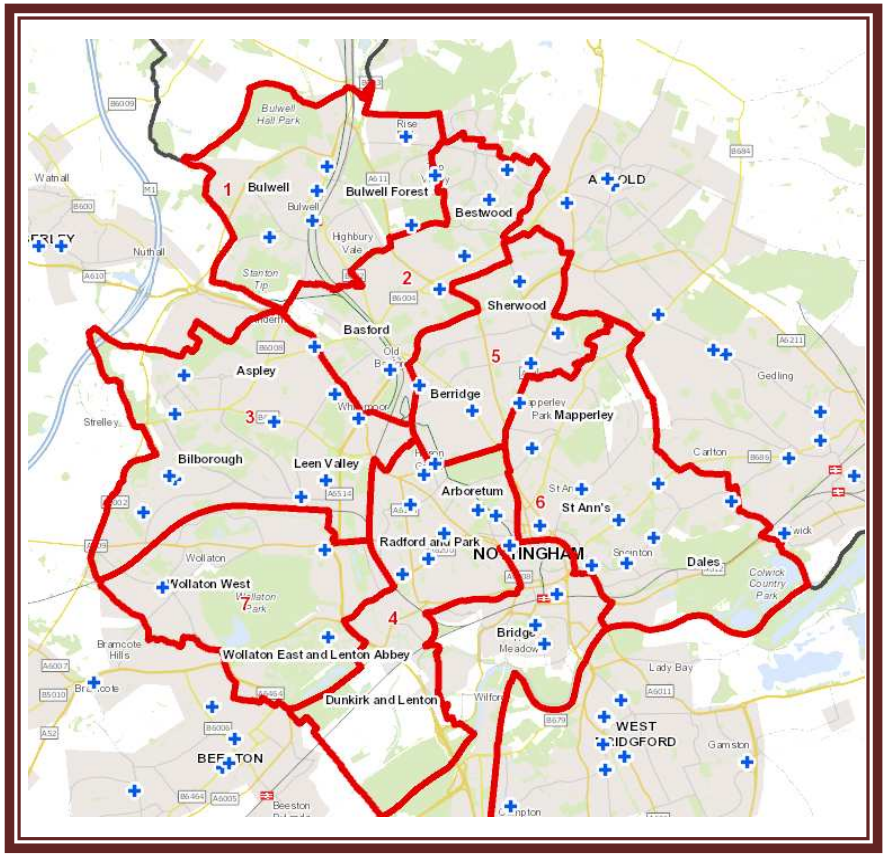


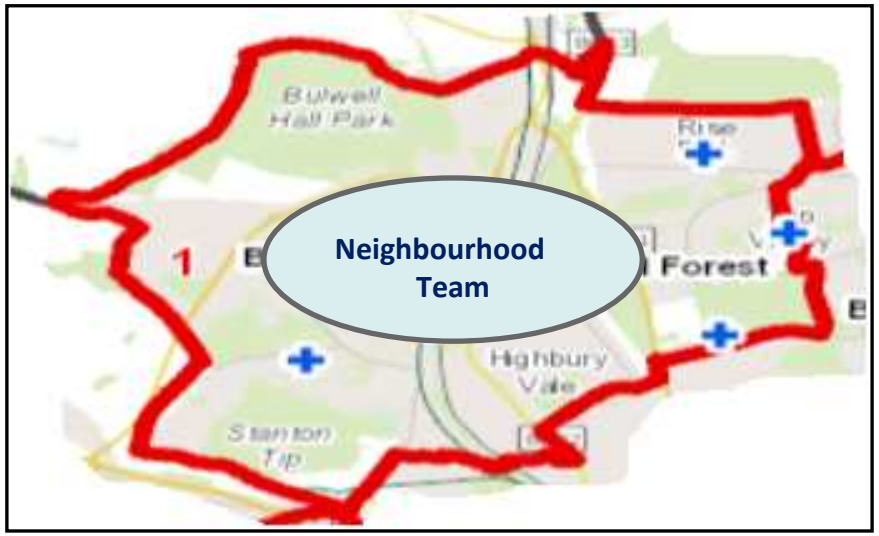



# Shared working/learning

- Pilot of GP communities/Federations and alliances
- Working with LMC to develop primary care infrastructure

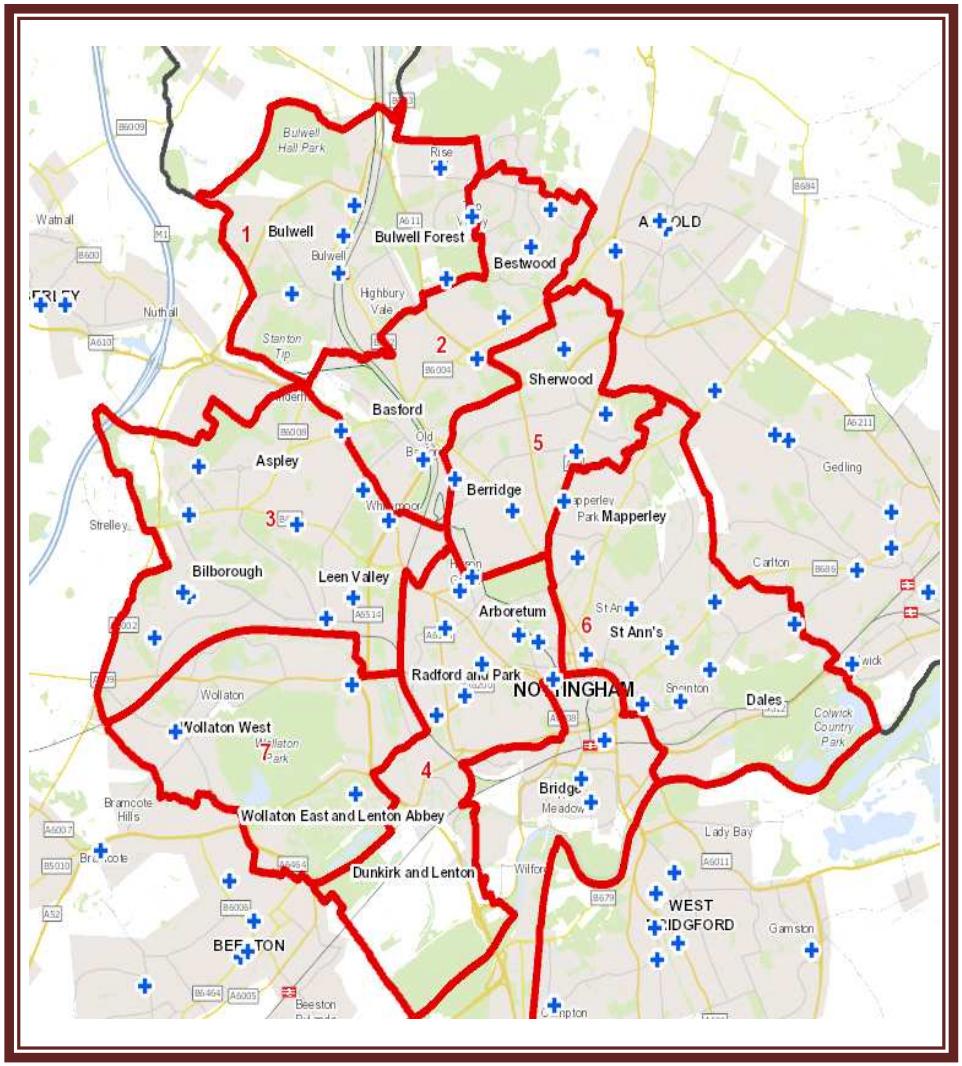
- Practice Visit programme
- Protected Learning Times
- Practice Manager development/forums
- Reception training
- Practice Nurse development/forums
- Responsiveness contract



# Promote shared responsibility

- Communicate responsibility of managing resources in health, (cancelling appointments, using right services, using ED).
- Commission self referral services, physiotherapy, podiatry, pain management, IAPT
- Create self help advice and support within each practice



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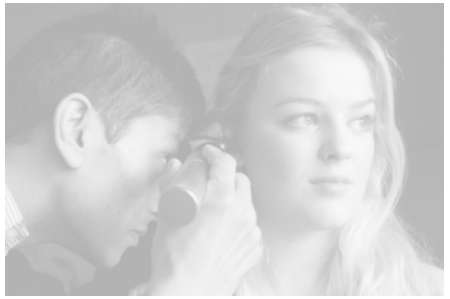
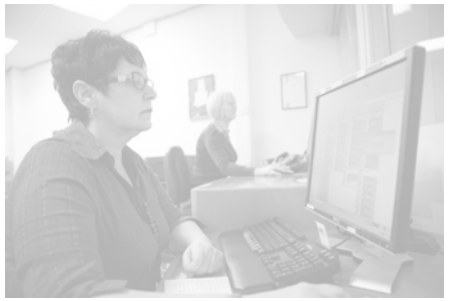
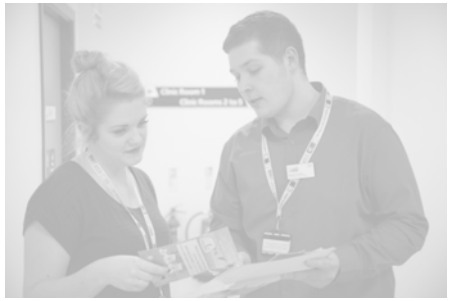
# How will this be funded?







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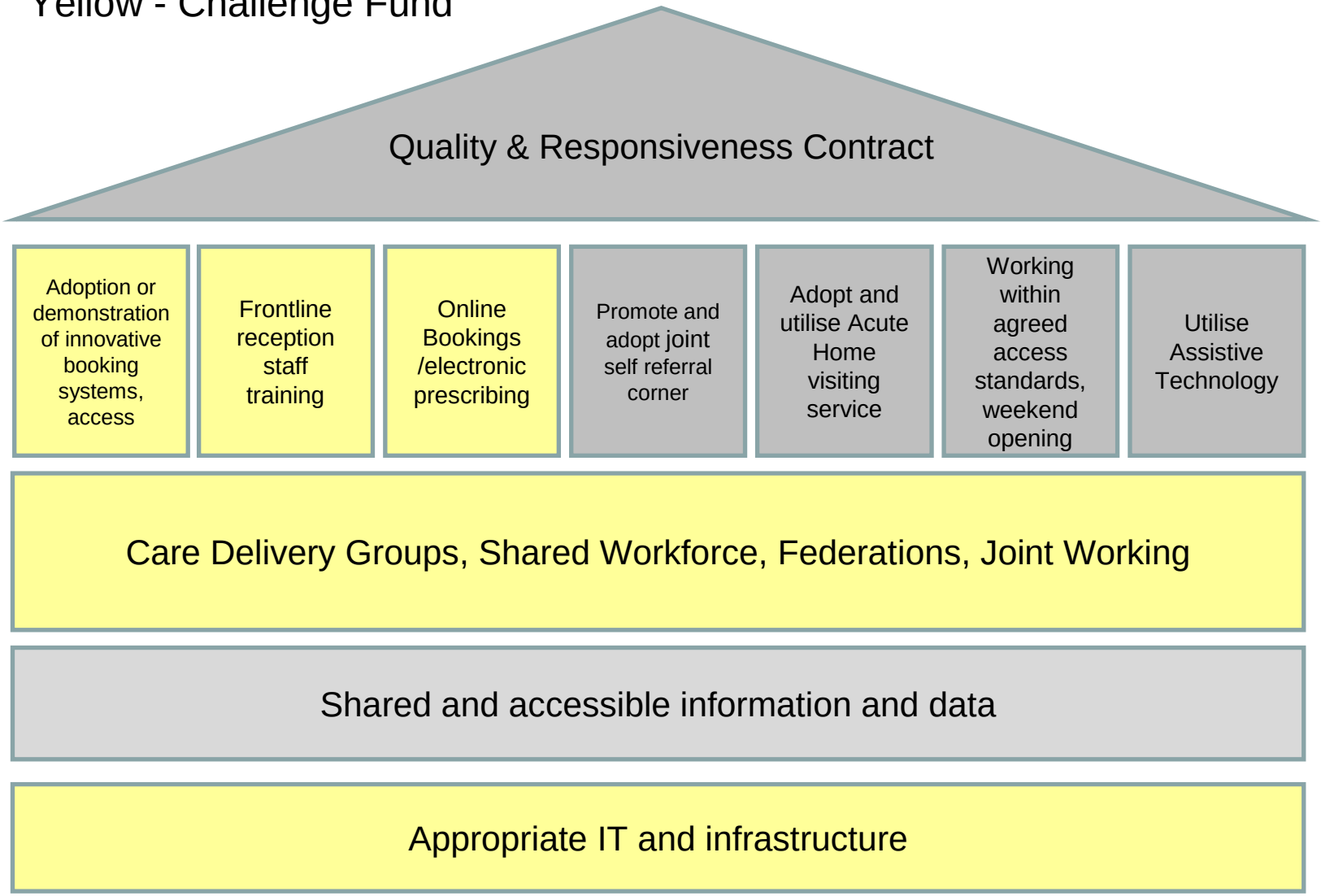
Grey - Non recurrent CCG
Yellow - Challenge Fund



# What will success look like?

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**Improved Primary Care access**

•Uptake, usability, satisfaction

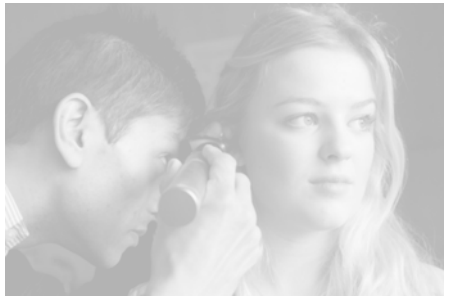
**Improved patient outcomes**

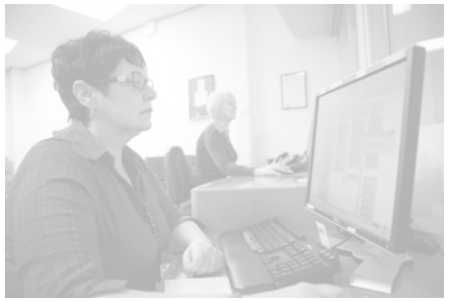
•Focus on self-care, clinical communities, and equitable care

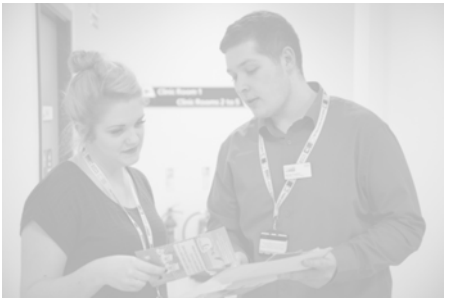
**Improved cost-effectiveness**

•Earlier presentation, unnecessary interventions avoided

•Assist GP productivity, net savings on unnecessary interventions







**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**

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|---|---|---|---|---|
| **30th APRIL 2014** | | | | |
| **Public Health topic:** Director of Public Health | | | | |
| **Health and Wellbeing Strategy (HWS), Nottingham Plan, and other Key Strategies:** Nottingham Plan Programme Group<br>HWS Accountable Board members | Nottingham Plan Healthy Nottingham Refresh report<br><br>Mental Health strategy: agree and sign off the strategy | Liz Jones, Chief Execs.<br>Liz.jones@nottinghamcity.gov.uk<br><br>Jo Copping, City Public Health.<br>Joanna.copping@nottinghamcity.gov.uk | Report<br><br>tbc | N/R<br><br>01.04.14 |
| **Commissioning and JSNA:**<br>Nottingham City Council<br>Clinical Commissioning Group, NHS Commissioning Board Commissioning Executive Group | CCG Primary Care Plan<br><br>CCG 5 year Commissioning Plan | Maria Principe, CCG<br>Maria.Principe@nottinghamcity.nhs.uk<br><br>Maria Principe, CCG<br>Maria.Principe@nottinghamcity.nhs.uk | Report<br><br>Report | 01.04.14<br><br>01.04.14 |
| **Other relevant reports (safeguarding and social determinants of health):**<br>Safeguarding Boards<br>Provider organisations and council services relating to the social determinants of health | *Critical Care Long Term Capital Development at QMC:*<br><br>Protocol for Joint working between Health and Wellbeing Board, Health Scrutiny and Health Watch.<br><br>Consultation on NCSCB / NCASPB Draft Business Plans<br><br>*Priority Families* | *BuddhikaSamarasinghe, Board Member, Peter Homa*<br><br>John Wilcox, City Public Health.<br>John.Wilcox@nottinghamcity.gov.uk<br><br>Paul Burnett; independent chair of NSCB<br>pr.burnett@btopenworld.com<br><br>*Mark Andrews, Family Community Teams* | *Information distribution only.*<br>Report<br><br>Report<br><br>*Information distribution only.* | 01.04.14<br><br>N/R<br><br>4.03.14<br><br>01/04/14 |
| **Standing items** | Corporate Director of Children and Families<br>Director of Public Health<br><br>Healthwatch Nottingham<br><br>Clinical Commissioning Group | Alison Michalska<br>Alison.maiclska@nottinghamcity.gov.uk<br>Chris Kenny<br>chris.kenny@nottscc.gov.uk<br>Martin Gawith<br>martin.gawith@healthwatchnottingham.co.uk<br>Dawn Smith<br>Dawn.Smith@nottinghamcity.nhs.uk | Verbal update/report | |

| JUNE 2014 | | | | |
|---|---|---|---|---|
| **Public Health topic:** Director of Public Health | Cancer update | Mary Corcoran, County Council Public Health<br>Mary.Corcoran@nottscc.gov.uk | | tbc |
| **Health and Wellbeing Strategy (HWS), Nottingham Plan, and other Key Strategies:** Nottingham Plan Programme Group<br>HWS Accountable Board members | HWS Overall 12 month report.<br><br>HWS Integrating Older Peoples Health and Social Care Theme update<br><br>Avoidable injuries strategy (sign off). | John Wilcox, City Public Health.<br>John.Wilcox@nottinghamcity.gov.uk<br>Antony Dixon, Quality and Commissioning.<br>Antony.Dixon@nottinghamcity.gov.uk<br><br>Sarah Quilty and Lynne McNiven, City Public Health.<br>Sarah.quilty@nottinghamcity.gov.uk.<br>Lynne.mcniven@nottinghamcity.gov.uk | | 04.06.14<br><br>04.06.14<br><br>01.04.14 |
| **Commissioning and JSNA:**<br>Nottingham City Council<br>Clinical Commissioning Group, NHS Commissioning Board Commissioning Executive Group | JSNA update report.<br><br>NHS Health Checks Commissioning Report. | Jo Copping, City Public Health<br>Joanna.copping@nottinghamcity.gov.uk<br>Helen Scott, County Council Public Health<br>Helen.scott@nottscc.gov.uk | | 04.06.14<br><br>04.06.14 |
| **Other relevant reports (safeguarding and social determinants of health):**<br>Safeguarding Boards<br>Provider organisations and council services relating to the social determinants of health | Priority Families<br><br>CDP Future commissioning tbc | Mark Andrews, NCC<br>Mark.andrews@nottinghamcity.gov.uk<br><br>Peter Moyes<br>peter.moyes@nottinghamcity.gov.uk<br>Lucy Putland<br>Lucy.putland@nottinghamcity.gov.uk | Report<br><br>Paper for information only tbc | 06.05.14<br><br>04.06.14 |
| **Standing items** | Corporate Director of Children and Families<br>Director of Public Health<br><br>Healthwatch Nottingham<br><br>Clinical Commissioning Group | Alison Michalska<br>Alison.maiclska@nottinghamcity.gov.uk<br>Chris Kenny<br>chris.kenny@nottscc.gov.uk<br>Martin Gawith<br>martin.gawith@healthwatchnottingham.co.uk<br>Dawn Smith<br>Dawn.Smith@nottinghamcity.nhs.uk | Verbal update/report | |

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

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

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

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

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



**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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**HEALTH & WELLBEING BOARD 30 APRIL 2014**

| | | |
|---|---|---|
| **Title of paper:** | **Healthwatch Nottingham Update – April 2014** | |
| **Director(s)/ Corporate Director(s):** | n/a<br>Martin Gawith, Chair – Healthwatch Nottingham | **Wards affected:**<br><br>All |
| **Report author(s) and contact details:** | **Ruth Rigby, Managing Director – Healthwatch Nottingham**<br>**0115 859 9528** | |
| **Other colleagues who have provided input:** | | |
| **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

This report outlines Healthwatch activity since the last report to the Board in February 2014. It also outlines developing work areas and plans.

## 2. BACKGROUND (INCLUDING OUTCOMES OF CONSULTATION)

### Evidence and Insight

2.1 An analysis of the full year's calls to the Healthwatch Nottingham Information Line will be provided to the next meeting along with plans to promote this service as a way of gathering the public's views of health and care services.

2.2 The team's Evidence & Insight Manager, whose post is shared with Healthwatch Nottinghamshire, commenced work last month. Working with local academic institutions, it is intended that the post holder will lead the organisation's research programme. Work to develop information sharing arrangements with all major local commissioners and providers remains ongoing and the Evidence & Insight Manager is currently undertaking a data audit to ensure best and appropriate use of the information gathered from the Nottingham community. A specific piece of work currently underway is the analysis of GP practices' patient participation arrangements and action plans. Findings from this exercise may usefully feed into both the implementation of the CCG's Primary Care Plan for Nottingham City and the consultation on the Urgent Care Centres.

2.3 Joint work with the Joint Health Scrutiny Committee has assisted both the Committee and Healthwatch Nottingham in the development of input into the Quality Accounts of major local NHS-commissioned providers.

2.4 Healthwatch Nottingham has provided significant input into the CQC inspection of Nottingham University Hospitals NHS Trust, the Quality Summit that preceded the publication of its Inspection and a recent piece of work initiated by the Trust: "Are we living our Values?"

2.5 Healthwatch England outlined eight consumer rights identified in its Annual Report. Based on information received through early engagement and consultation work, Healthwatch Nottingham responded to consultation on these rights. Further consultation is now being undertaken by Healthwatch England in relation to a set of responsibilities. Healthwatch Nottingham also intends to feed the views of Nottingham citizens into this process.

### Engagement

2.6 Development of Healthwatch Nottingham's engagement capacity remains a key area of work. This will rely on the use of volunteers. A programme of volunteer recruitment is underway to extend the organisation's engagement capacity through the use of local Healthwatch Champions. Additionally, the city council's Citizen's Panel recruitment process is also offering people the opportunity to get involved with the work of Healthwatch Nottingham. Work continues with the CCG to develop their plans for Nottingham City Voices.

2.7 Healthwatch Nottingham, in conjunction with Healthwatch Nottinghamshire, is currently observing and supporting the development of engagement arrangements for the Transformation work programme across the health and social care communities in South Nottinghamshire. Additionally, we are currently working with the CCG to ensure consultation around the Urgent Care Centres engages those whose voices are seldom heard and captures the views of the range of people who use current Walk In Centre provision, to improve access to primary care for those who need it.

2.8 Recent involvement in the HWB3 development day sought to improve engagement of vulnerable citizens through access to the network of voluntary sector services that often support them. Healthwatch Nottingham staff have also attended recent consultation events regarding BME Mental Health and the Vulnerable Adults Plan.

**Board Priorities and campaigns**

2.9 The Healthwatch Nottingham Board is continuing to prioritise care homes in its work, particularly in the light of the planned closure of a care home in the county, near the city border. A report on work undertaken and outcomes will be provided to a future meeting.

2.10 Work to develop a strategic plan to cover the Board's next two years is underway. As this needs to be linked, at least in part, to the commissioning and procurement plans of local commissioning organisations, a recent invitation to the Commissioning Executive Group is very welcome. Alongside this, the Board is also developing the first Healthwatch Nottingham Annual Report.

2.11 A Media Log has now been developed to capture the increasing media activity undertaken by Healthwatch Nottingham. A Communication strategy is currently under development.

2.12 Recent reactive media input has included TV coverage in relation to a high profile court case regarding an issue at NUH, care data EMAS. Planned media activity incudes joint work with the Local Pharmacy Committee and Healthwatch Nottinghamshire regarding the Electronic Prescription Service, given some high pressure marketing by a small number of pharmacies.

## 3. OTHER OPTIONS CONSIDERED IN MAKING RECOMMENDATIONS

None specifically.

## 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 specifically.

## 8. PUBLISHED DOCUMENTS REFERRED TO IN COMPILING THIS REPORT

None specifically.

**Chief Officer Update**

**1. New NHS Chief Executive**

Simon Stevens came into post as Chief Executive of NHS England on 1 April 2013 following the retirement of Sir David Nicholson.

Mr Stevens joined the NHS Graduate Training Scheme in 1988 and has held a number of frontline NHS management roles, running hospitals, health authorities and community services. From 1997 to 2004 he was the Health Secretary's Policy Adviser at the Department of Health, and the Prime Minister's Health Adviser at 10 Downing Street. He is a trustee of the Nuffield Trust in London, and a director of the Commonwealth Fund of New York. He has also been a trustee of the King's Fund and chair of the World Economic Forum's Advisory Board on Sustainable Health Systems.

In his first speech as Chief Executive, Mr Stevens outlined some of the areas where he believes there is now a broad policy and political consensus for action, including raising standards of care for older people and better joint working between health and social care.

**2. Quarter Three Assurance**

The CCG held their quarter three assurance checkpoint meeting with the Area Team on 6 March 2.14. The CCG was 'assured' against all six of the domain headings, and whilst Nottingham City CCG remained assured overall, the status for one assurance domain had been changed to 'assured with support'. This was in relation to domain one (*Are patients receiving clinically commissioned, high quality service?)*and is due to the following reasons:

- Consistent failure of delivery of a key target – 4 hour A&E standard
- Management of the urgent care system as a health community.

The Area Team had given its commitment to working with CCGs in the City and South Nottinghamshire to develop an overall package of mutually agreed support with the intention of ensuring the CCG has a successful quarter four assurance checkpoint outcome.

**3. Challenge Fund awards**

Nottinghamshire and Derbyshire have been given £5.25 million to improve access to care for more than a million patients in their area as part of the £50m Challenge Fund. The Prime Minister announced the Challenge Fund in October last year to improve access to primary care and practices were invited to submit 'expressions of interest' in December which were considered by Area Teams and a national assessment panel. Following more than 250 expressions of interest, 20 GP collaborations were announced as chosen pilot sites on 14 April 2014 and have been awarded investment of between £400k and £5m to run pilots for a year. Four pilot schemes have been approved across the Midlands and East of England region.

Surgeries across Nottinghamshire and Derbyshire will trial a number of initiatives to make services more flexible and accessible under the banner *Transforming General Practice*. This will include offering extended hours and weekend opening, new ways to access consultations by phone, email and Skype, and using telecare to help people to better manage their conditions at home.

**4. Engagement on proposal for new Urgent Care Centre**

NHS Nottingham City Clinical Commissioning group is encouraging patients, carers and the wider public to find out more about proposals for a new NHS Urgent Care Centre and have their say on where it should be located and the services it should offer.

Nottingham currently has two Walk-in Centres and a Nurse Access Point and the contracts for these services come to a natural end on 31 March next year (2015). Previous feedback from patients, doctors and health professionals led to the development of a proposal for a new Urgent Care Centre located in the City which could replace existing Walk-in facilities and provide an extended range of services. The proposal would see the pooling of existing resources to provide a new facility that could include diagnostics such as x-ray facilities. The proposal has so far seen support from the CCG's Clinical Council, the Nottinghamshire Clinical Senate and the Nottingham City Council's Health Overview and Scrutiny Committee.

An event for clinicians to develop and comment on the proposals was held on 23 April 2014 and four drop-in engagement sessions for patients were held during April in St Ann's, Bulwell, Clifton and Hyson Green. A larger patient engagement event is being held 30 April 2014 from 6.00pm to 8.30pm at The Park Inn, Mansfield Road, Nottingham. Patients can also access the online survey *Developing an Urgent Care Centre* at www.nottinghamcityvoices.org.

**5. Duncan Selbie Visit to Nottingham**

The Chief Executive of Public Health England, Duncan Selbie, visited Public Health teams at Nottingham City and Nottinghamshire County Councils on 31 March 2013 to see how the joint Public Health system across the City and Countyhas been integrated into the Local Authorities, discuss local priorities and see some of the innovative projects taking place to reduce health inequalities including the Change Makers programme of peer support. As well as meeting with the Public Health Senior Leadership Team he also talked to Local Authority Senior Elected Members, Chief Executives, CCG accountable officers and clinical leads about reliance on hospital based care being neither necessary nor sustainable and how effective joint working between local authorities and the NHS will be the only way to squeeze best value out of combined local authority and NHS spending power.

**6. South Nottinghamshire Transformation**

The 'unit of planning' for South Nottinghamshire (City, Rushcliffe, Nottingham West and Nottingham North and East CCGs) submitted its draft strategy to NHS England on 4 April 2014, focusing on how services could be transformed over the next five years to address an estimated health and social care funding gap of £150 million. Further financial modelling, development and engagement with citizens to inform the final version of the strategy will take place between now and submission in June. A Director of Transformation is currently being recruited to lead the programme with interviews taking place on 13 May. A Citizen Advisory Group (CAG) comprising patient and service-user representatives has been established to act as a 'critical friend' to the programme, advising on proposals for service redesign, plans for engaging with citizens and the development of external communications to support transformation.

**Dawn Smith**
**April 2014**