NOTTINGHAM CITY COUNCIL

HEALTH AND WELLBEING BOARD

MINUTES of the meeting held at on 29 October 2014 from 13.30 - 15.45

Membership
Voting Members

Present

Councillor Alex Norris (Chair)	Portfolio Holder for Adults, Commissioning and Health
Dr Ian Trimble (Vice Chair)	NHS Nottingham City Clinical Commissioning Group
Martin Gawith	Healthwatch Nottingham
Councillor Nicola Heaton	Portfolio Holder for Community Services
Chris Kenny	Director of Public Health
Alison Michalska	Director of Adult Social Services/ Director of Children's Social Services
Dr Hugh Porter	NHS Nottingham City Clinical Commissioning Group
Dr Arun Tangri	NHS Nottingham City Clinical Commissioning Group
Vikki Taylor	NHS England

Absent

Councillor Sally Longford	Nottingham City Councillor
Councillor David Mellen	Portfolio Holder for Children's Services
Dawn Smith	Chief Operating Officer, NHS Nottingham City Clinical Commissioning Group

Non-Voting Members

Present

Gill Moy	Nottingham City Homes
Christine Oliver (for Peter Moyes)	Crime and Drugs Partnership

Absent

Lyn Bacon	Nottingham CityCare Partnership
Steven Cooper	Nottinghamshire Police
Michele Hampson	Nottinghamshire Healthcare NHS Trust
Peter Homa	Nottingham University Hospitals NHS Trust

Colleagues, partners and others in attendance:

Phyllis Brackenbury	-	Nottingham CityCare Partnership
Candida Brudenell	-	Nottingham City Council
Laura Catchpole	-	Nottingham City Council
Alison Challenger	-	Nottingham City Council
Stephanie Cook	-	NHS England
Antony Dixon	-	Nottingham City Council
Jane Garrard	-	Nottingham City Council
Marie Halford	-	Nottingham City Council
Dawn Jenkin	-	Nottinghamshire County Council

Helen Jones	-	Nottingham City Council
Mirth Parker	-	Nottingham City Council
Ruth Rigby	-	Healthwatch Nottingham
Richard Taylor	-	Nottingham City Council
Dot Veitch	-	Nottingham City Council
Chris Wallbanks	-	Nottingham City Council
Joanne Williams	-	NHS Nottingham City Clinical Commissioning Group

24 APOLOGIES FOR ABSENCE

Peter Homa, Nottingham University Hospitals NHS Trust
Peter Moyes, Crime and Drugs Partnership
Dawn Smith, Nottingham City Clinical Commissioning Group

25 DECLARATIONS OF INTERESTS

None

26 MINUTES

Subject to amending the wording of Minute 17 'Nottingham Plan 2013-14 (Year 4): Healthy Nottingham Targets Performance' para (f) to better reflect achievements in people completing drug treatment programmes, the Board confirmed the minutes of the meeting held on 27 August 2014 as an accurate record and they were signed by the Chair.

27 MEMBERSHIP

The Board noted that Councillor Heaton, Portfolio Holder for Community Services, and Councillor Longford, City Councillor, had been appointed to the Board, replacing Councillor Collins, Leader of the Council, and Councillor Liversidge, Portfolio Holder for Community Safety, Housing and Voluntary Sector.

28 BETTER CARE FUND

Councillor Norris advised the Board that colleagues were awaiting confirmation of approval of the City's Better Care Fund plan, and that this news would be circulated to Board members when available. He thanked colleagues for their hard work in developing the plan.

Joanne Williams, Programme Manager for Adult Integrated Care, Nottingham City Clinical Commissioning Group, introduced the report updating on the revised Better Care Fund (BCF) plan. She highlighted the following points:

a) An original version of the BCF plan came to the Board in February 2014. Since then national guidance had been revised and, in accordance with this revised guidance, the plan was re-submitted in September 2014, having been signed off at Executive level.
b) Significant changes since the original BCF submission in April 2014 were:
   i. Total emergency admissions had replaced the original metric of avoidable emergency admissions;

ii. Of the £1.9bn additional NHS contribution to the BCF, £1bn would remain within the BCF but now be either commissioned by the NHS on out-of-hospital services or linked to a reduction in total emergency admissions (as in Nottingham). This replaced the 'pay for performance' fund; and
iii. The need to clarify the level of protection of social care from the £1.9bn NHS additional contribution to the BCF, including identification of contribution to implementation of the Care Act.

c) The plan was re-submitted in September 2014 within required timescales and the assurance process was currently underway.
d) Work had commenced on how to implement the BCF plan, including possible development of a joint decision making process for managing the pooled budget and mechanisms for monitoring performance and finance.

RESOLVED to approve the revised Better Care Fund plan for 2014/15 and 2015/16

29 INTEGRATED CARE FOR ADULTS UPDATE

Joanne Williams, Programme Manager for Adult Integrated Care, Nottingham City Clinical Commissioning Group, introduced the report updating on the Integrated Care Programme for Adults and the progress against relevant actions within the Joint Health and Wellbeing Strategy. She highlighted the following points:

a) The Better Care Fund plan is based on the Adult Integrated Care Programme.
b) The aim of the Programme is to enable people to live longer, be healthier and have a better quality of life through removing barriers to provide more joined up services and co-ordinated care, with the citizen at the centre of provision.
c) The first phase of implementation of the Programme focused on the structural work necessary to better co-ordinate care. There are now 8 Care Delivery Groups in operation; intermediate care services, crisis response and local authority reablement and emergency home care services have been reconfigured and processes aligned to support the independence pathway; and the use of assistive technology has been expanded. This work has been successful but services are still a long way from being fully integrated. In particular, the need for cultural change to facilitate the move away from silo working has been highlighted.
d) The Programme is now in phase 2 of implementation. Work in this phase will include:
   i. A review of specialist services
   ii. Choose to admit/ transfer, to change the relationship with secondary care
   iii. Seven day working
   iv. Development of joint assessment and care planning approaches
   v. Further expanding the use of assistive technology
   vi. Further developing links with the community and voluntary sector.
e) Progress against all relevant actions within the Joint Health and Wellbeing Strategy is currently on track and where appropriate the Programme is linking with other areas of work e.g. implementation of the Care Act.

During discussion the following points were made:

f) Current ways of commissioning to support integration aren't working as well as they could and this is being reviewed.
g) A project plan and timescales for IT integration are in place as part of the Better Care Fund plan. Work is linked to the Connecting Nottinghamshire programme.
h) The Five Year Forward View recently published by NHS England's Chief Executive Simon Stevens shows that NHS England is keen for local innovation to flourish.

RESOLVED

1) to note the progress of the Adult Integrated Care Programme; and
2) to note the progress against the Joint Health and Wellbeing Strategy actions related to the Adult Integrated Care Programme.

30 HEALTH VISITOR IMPLEMENTATION PLAN AND TRANSFER OF COMMISSIONING RESPONSIBILITIES TO NOTTINGHAM CITY COUNCIL

Stephanie Cook, NHS England Area Team, and Phyllis Brackenbury, Nottingham CityCare Partnership, introduced a report updating on work to increase the number of health visitors in the City; and informing the Board that Nottingham City Council will take on responsibility for commissioning children's public health services 0-5 years with effect from 1 October 2015 and outlining the work taking place to transfer these responsibilities. They gave a presentation which highlighted the following points:

a) In Nottingham the health visiting service and Family Nurse Partnership is provided by Nottingham CityCare Partnership.
b) Following the national Call to Action in February 2011, the Government set out a commitment to deliver a larger re-energised health visiting service. The Prime Minister made a commitment to increase the size of the health visiting workforce. For Nottingham this meant an increase from 69.4 Whole Time Equivalent (WTE) in 2010 to a target of 154.7 WTE to be reached by March 2015. This target represented the third largest increase in the country.
c) It has been challenging to achieve this target for a number of reasons including:
    i. The limited capacity of the provider to train students with such a low WTE starting point;
    ii. The need to revise training methodologies to support the increased number of students;
    iii. Ensuring sufficient numbers of planned places for students;
    iv. Ensuring the retention of students within the City post qualification;
    v. Limited numbers of suitably qualified and experienced nurses and midwives to complete further degree level training; and
    vi. The loss of existing experienced health visitors to retirement or other disciplines.
d) By the end of August 2014 there were 92.9 WTE in post. September 2014 students plus external recruitment will see an increase of 9.36 WTE, and a

further 3 WTE are expected to join the workforce in October 2014. There will be further recruitment from students in January 2015 and it is anticipated that there will be oversupply from neighbouring areas that can potentially join the workforce in Nottingham.

e) There has been national investment to deliver an increased number of health visitors but there has been no further investment in the Family Nurse Partnership.

f) The Healthy Child Programme operates at 4 levels of service provision. Consultation with families about provision found that families liked the service but they did not receive sufficient support when dealing with specific issues. This resulted in changes to the service including targeting of resources to the most deprived areas; health visitors trained to deliver minor ailment clinics; developing the GP core offer. These changes have received national and local recognition.

g) A key challenge for the Healthy Child Programme is workforce retention.

h) Discussions are underway locally between NHS England and Nottingham City Council and nationally between the Local Government Association and the Department of Health to ensure a smooth transition of responsibilities and funding for children's 0-5 years public health commissioning on 1 October 2015.

During discussion the following comments were made:

i) There was support from members of the Board for the important work of the health visiting service and recognition of the impact that it has on the lives of children and their families.

j) It is important to not just focus on meeting the numerical target for increasing the size of the health visiting workforce but also to make sure that it is a good quality service meeting local need.

k) There is a lot of work taking place within the City Council to ensure a smooth transfer of responsibilities for children's 0-5 years public health commissioning. It forms part of longer term goals for early intervention and health and wellbeing integration.

l) Funding for 0-5 years public health commissioning has not been formally identified yet. However there is a clear expectation that the investment to increase the health visiting workforce should be maintained and that there should be no risk to the increased workforce size.

m) There were no blockages to achievement of the target for increasing numbers of health visitors that other partners on the Board were responsible for and needed to address.

RESOLVED

1) to note the progress with the Health Visitor Implementation Programme through increased numbers of health visitors, service transformation and implementation of the Healthy Child Programme; and

2) to note the transfer of commissioning responsibilities for children's public health services 0-5 years with effect from 1 October 2015 and the roles and responsibilities and implications to Nottingham City

Council for future service provision in accordance with the mandation instructions.

31 0-25 SPECIAL EDUCATION NEEDS AND DISABILITIES REFORMS (SECTION 3 OF CHILDREN AND FAMILIES ACT 2014)

Mirth Parker, Head of Inclusion and Disability, and Marie Halford, Disability Service Manager, Nottingham City Council introduced a report updating on progress in responding to reforms in Special Educational Needs and Disability (SEND) contained within the Children and Families Act 2014. They also gave a presentation on demographic demand analysis of children and young people with SEND. They highlighted the following information:

a) The Children and Families Act covers a range of changes to improve services for vulnerable children including those with special educational needs and/ or disabilities.
b) Nottingham is not a pathfinder authority but many of the outcomes achieved so far in the City are comparable to the pathfinder authorities who commenced implementation at an earlier stage.
c) The minimum requirements with a deadline of September 2014 have all been met. This included the launch of a Local Offer website providing guidance and information as well as a directory of services; a multi-agency personal budgets offer giving children and families more choice in the services that best support their needs; and the introduction of a multi-agency key worker service to provide children and their families with a single point of contact.
d) Phase 2 of implementation requires more significant reform. It will be linked to work taking place to implement the Care Act to ensure a joined-up approach across children and adults and make best use of resources and governance arrangements.
e) There are a number of demographic challenges to be met in implementing phase 2. For example, locally there is a higher rate of SEN than nationally and a rising population of disabled young people.
f) Many of the changes require integrated IT solutions, which currently do not exist.

During discussion the following points were made:

g) There is now a more transparent process for parents to understand whether a Statement is needed or not, and personal budgets enable them to buy the services that they believe best meets their child's needs. This process is robust.
h) Nottingham is a low Statementing authority but this is supported by mainstream support.
i) Costs of implementation have so far been met through transitional grants. Demographic challenges suggest future demand pressures but the longer term costs pressures aren't yet known, for example there is no national evidence about the likely take up of children's personal budgets.

RESOLVED

1) **to note the progress and achievements that have been made under the Special Educational Needs and Disability reforms outlined in Section 3 of the Children and Families Act 2014**;
2) **to note the demographic demand challenges facing these services supporting children and young people with disabilities and special educational needs**;
3) **to note the future recommendations to progress the Special Educational Needs and Disability reforms; and**
4) **to support the ongoing commitment to these reforms through strong partnership working, in particular the ongoing work within Adult Social Care to meet the requirements identified in the Care Act due to come into force in April 2015.**

32 CARE ACT 2014: IMPLICATIONS

Helen Jones, Director of Adult Social Care, and Laura Catchpole, Policy Officer, Nottingham City Council introduced a report and gave a presentation on the key implications of the Care Act 2014 for Nottingham City Council and its partners. They highlighted the following information:

a) The Care Act 2014 requires greater integration and co-operation between health, care and support and the wider determinants of health such as housing. Some of the provisions of the Act reinforce current initiatives and ways of working, while others have a more significant transformational impact.
b) The final guidance on implementation of the Care Act has only just been issued and is still being considered.
c) Key implications of the Act include:
    i. Need to identify gaps in the provision of information and advice, and where appropriate redesign or commission new services;
    ii. Likely increase in assessments for care accounts;
    iii. Likely increase in carers assessments, and the need to meet their eligible needs;
    iv. Increased administrative burden arising from a citizen's ability to defer payments;
    v. Increased administrative and financial burdens arising from the cap on care costs. The implications for working age citizens is not yet known;
    vi. Need to refresh care and support plans and direct payment policies;
    vii. Need to consider how best to deliver care assessments in secure settings; and
    viii. Need to check some current ways of working for compliance.
d) Duties under the Care Act will increase adult social care costs considerably with potentially high set up costs for IT systems, increased number of assessments, increased administrative burdens and workforce skills and training.
e) Corporate risks have been identified.

During discussion the following points were made:

f) Implementation is being overseen by a local authority programme board and other organisations are being engaged through specific work streams. If an organisation has an issue or concern, these can be raised through the Commissioning Executive Group which is reviewing progress in implementation.
g) It would be useful for the Board to have a better understanding of the citizen perspective in future updates on implementation.
h) It is important to continue focusing on public health preventative work e.g. reducing tobacco use and cutting obesity to minimise future demand pressures.
i) Some early modelling of future cost of care gaps has taken place but currently it is not possible to know how many people will come forward. The Association of Directors of Adult Social Services has stated that there is sufficient funding within 2015/16 funding settlements to cover costs; but there are significant concerns about 2016/17 and beyond.
j) The NHS England Area Team has links with prisons and can provide support on the work stream looking at the implications for those in secure settings.

The Chair suggested that it would be useful to have regular updates on implementation of the Care Act at future meetings of the Board.

RESOLVED

1) that partners understand the implications of the Care Act 2014 for their organisations and the contribution they can make to implementation of the Act;
2) to request that the Commissioning Executive Group monitor progress towards the implementation of the Care Act 2014 at their monthly meetings; and
3) to receive regular updates on progress towards implementation of the Care Act 2014 at future meetings of the Board.

33 AIR QUALITY AND HEALTH: DELIVERING LONGER, HEALTHIER LIVES IN NOTTINGHAM CITY

Richard Taylor, Nottingham City Council, and Dawn Jenkin, Nottinghamshire County Council introduced a report and gave a presentation on the links between air quality and health, and actions being taken to improve air quality. They highlighted the following information:

a) Approximately 70% of air pollution in urban areas is linked to traffic emissions.
b) Air quality pollutants have changed over recent decades and air quality is now largely an invisible issue because many of the pollutants are gases or very small particles.
c) There is a strong evidence base that air quality is a significant determinant of health. This makes it a public health problem, with good evidence that

air pollution causes or contributes to disease processes which lead to premature deaths.

d) Local authorities have a statutory responsibility to improve air quality, and gather data on air pollution. If levels exceed certain thresholds then further more detailed assessment has to be carried out. Where necessary Air Quality Management Areas have to be established and Air Quality Action Plans developed.

e) Air pollution in the City also impacts on the wider conurbation. Local authorities in the City and County are working together, with other partners, to reduce emissions to improve air quality.

f) The Nottinghamshire Environmental Protection Working Group is about to review the local Air Quality Improvement Strategy.

During discussion the following comments were made:

g) There is a need to make information about air pollution meaningful for citizens in order to communicate the public health messages effectively.

h) There are cost implications of large-scale communication campaigns but there could be scope to co-ordinate this with other public health messages, for example reducing sedentary lifestyles, or work with the third sector to communicate messages to particular groups.

i) Nottingham's focus on developing public transport supports work to reduce air pollution from traffic.

j) Data about air pollution could be cross-referenced with information held about citizens with respiratory problems.

RESOLVED

1) to note the public health significance of good air quality and that the adverse health impact on residents of long term exposure to air pollution can be modified through realistic and practical steps; and

2) that partners exercise patronage of the work of the Nottinghamshire Environmental Protection Working Group, to ensure that they are able to secure the engagement of all relevant parties to review the Nottinghamshire Air Quality Improvement Strategy.

34 CHILDREN'S PARTNERSHIP BOARD UPDATE

Chris Wallbanks, Nottingham City Council, presented the report on behalf of Councillor David Mellen (Chair of the Children's Partnership) highlighting the following points:

a) The Children's Partnership oversees services for children, young people and families in the City. It is the key Children's Trust mechanism to support partners to work together to deliver a joined up vision.

b) In terms of the Safeguarding priority of the Children and Young People's Plan (CYPP), there has been an increase in demand in areas such as child protection enquiries and numbers of children in care. The recent OFSTED inspection of 'services for children in need of help and protection, children looked after and care leavers' concluded that Nottingham children remain

safe but the Council and Safeguarding Children Board received a judgement of 'Requires Improvement'. The recommendations of the inspection will be reflected in the refreshed CYPP.

c) In terms of the Healthy Living priority of the CYPP, the school nursing service has been reviewed and a new model implemented from September 2014; child obesity continues to be a priority issue; oral health promotion services are due to be re-commissioned in 2015; and although there has been good progress challenges remain in terms of teenage pregnancy.

d) In terms of the Reducing Substance Misuse priority of the CYPP, actions have included continuation of the DrugAware programme; development of a clearer signposting pathway; and a review of the young people's substance misuse system. Findings from this review will be incorporated into the refreshed CYPP.

e) In terms of the Raising Educational Attainment and Improving Attendance priorities of the CYPP, work is taking place to support secondary schools, particularly following recent OFSTED inspections that judged a number of the secondary schools as 'Inadequate'. Further development of the Schools Challenge Board continues to take place. There has been a high profile campaign to improve school attendance but issues remain and action plans have been refreshed.

f) Overall there have been a number of successes in delivery of the CYPP, including a reduction in the teenage pregnancy rate, a fall in youth crime, improvements in educational attainment and a fall in NEET 'Not Knowns'.

g) A number of challenges remain, including increased demand for social care and safeguarding services, increased demand for children in care services, partner 'buy-in' to the Common Assessment Framework (CAF) process, and educational attainment remains relatively low. These challenges will be reflected in the refreshed CYPP.

h) It is intended that consultation on refreshing the CYPP will be carried out in January and February 2015, with final sign off by the Children's Partnership Board in March 2015.

During discussion the following comments were made:

i) It is likely that the refreshed CYPP will continue with the same priority areas but it needs updating to reflect new legislation and the need for revised indicators.

j) Schools are making progress in improving attainment but not as quickly as other areas. Progress has also been made in improving attendance but again performance remains low compared with other areas. Schools are constantly being challenged to do better and the recent series of OFSTED inspections gave a renewed focus for this. There are issues for schools in terms of financial investment and recruitment challenges.

k) Despite early intervention activity and higher levels of adoption there are still approximately 580 children in care. This number has remained relatively stable over time even though the child population has increased. Those children now in care tend to have more complex problems and/or are older children – typically these are the more expensive cases to deal with and this is a real pressure on the system.

RESOLVED

1) **to note the activity within the Children's Partnership;**
2) **to note the progress against the Children and Young People's Plan priorities; and**
3) **to support the development of a new Children and Young People's Plan for 2015.**

35 FORWARD PLAN

The Board considered its Forward Plan. It was noted that under a previous agenda item the Board had requested regular updates on implementation of the Care Act.

RESOLVED to amend the Forward Plan to include regular updates on implementation of the Care Act at future meetings of the Board.

36 HEALTHWATCH NOTTINGHAM UPDATE

Martin Gawith, Chair of Healthwatch Nottingham, introduced a report outlining the current activity and findings of Healthwatch Nottingham since the last report to the Board in August, and plans for future work. He highlighted the following points:

a) Healthwatch Nottingham is developing a new website.
b) Members of the Board have been invited to attend the launch of the new informatics system to understand more about the information Healthwatch holds.
c) The Talk to Us points have been successful in gathering views and raising the profile of Healthwatch.
d) Healthwatch Nottingham intends to develop better links with local councillors as a way of understanding local, community issues and local people's concerns.
e) Healthwatch Nottingham is trying to address a current gap in getting regular contact from the public in relation to social care issues.
f) Current priority areas for Healthwatch Nottingham are care home quality, access to GP services and mental health services for young people.
g) Healthwatch England recently published a report looking at the health and social care complaints system. Healthwatch Nottingham will raise the issues outlined in the report with local health and social care commissioners and providers.

RESOLVED to note the update.

37 STATUTORY UPDATES

The Board received the following updates:

a) Corporate Director for Children and Adults, Nottingham City Council

Alison Michalska, Corporate Director for Children and Adults, gave the following update:

a) There have been a number of changes to the Children and Families structure including in the following areas: Vulnerable Children and Families Directorate, children's social care and education;
b) The Council is working with the Police, Nottinghamshire County Council and other partners on investigations into historic abuse in children's homes. The Police and Crime Commissioner has called for an independent review to look at how the Police and local authorities have worked together, and the Council is involved in scoping this.
c) Following the publication of the report examining the incidence of child sexual exploitation in Rotherham, the Council is reviewing the recommendations to ensure that everything possible is done to avoid this happening in Nottingham. Through the Safeguarding Children's Board, the Council is working with partners across the City on this.
d) The Care Quality Commission has confirmed that the Shared Lives Service is fully compliant with its requirements.
e) The Priority Families Programme won an Association for Public Service Excellence (APSE) award for its work helping some of the City's most challenging families into work and training.
f) The number of adoptions secured for children in care this year has significantly increased compared with the previous year.

b) Director of Public Health, Nottingham City and Nottinghamshire County Councils

Chris Kenny, Director of Public Health, gave the following update:

a) The current risk of having any Ebola cases in the UK is low, but work is taking place at a national level in relation to managing risks, and ensuring preparedness for any Ebola cases that do occur. The UK has good infection control mechanisms and is fully prepared to deal with any incidents.
b) In September Full Council had a debate about the importance of reducing tobacco use and addressing illicit and counterfeit tobacco trade. Council agreed to endorse the Local Government Declaration on Tobacco Control. Tobacco use will be considered at the Health and Wellbeing Board Development Session in November.

c) Chief Officer, NHS Nottingham City Clinical Commissioning Group

Dr Hugh Porter, Nottingham City Clinical Commissioning Group, gave the following update on behalf of Dawn Smith, Chief Operating Officer, Nottingham City Clinical Commissioning Group:

a) NHS England's Chief Executive Simon Stevens recently launched the Five Year Forward View for the NHS. It sets out why change is needed, what that change might look like and how it can be achieved. It is a permissive document regarding the establishment of new models of care.
b) The Clinical Commissioning Group had its quarterly assurance meeting with the NHS England Area Team. It was 'assured' against all six domain headings but the significant pressures around consistent failure to meet the four hour Accident and Emergency standard were highlighted and

contributed to domain one (Are patients receiving clinically commissioned, high quality services?) being 'assured with support'.

c) NHS England is restructuring its Area Teams and as a result Nottingham will be part of a Derbyshire, Nottinghamshire, Shropshire and Staffordshire Area Team. It is expected that the changes will be complete by 31 March 2015.

d) The Crisis Concordat has been launched setting out how public services should work together to respond to people who are in mental health crisis. An action plan needs to be agreed and submitted nationally by the end of November 2014.

RESOLVED to note the updates.