NOTTINGHAM CITY COUNCIL

HEALTH AND WELLBEING BOARD

MINUTES of the meeting held at Room LB 31/32 - Loxley House, Station Street, Nottingham, NG2 3NG on 27 November 2019 from 1:38pm to 3:56pm

Membership

Voting Members

Present	Absent
Councillor Eunice Campbell-Clark (Chair)	Samantha Travis
Dr Hugh Porter (Vice Chair)	
Councillor Cheryl Barnard (items 52-59)	
Dr Marcus Bicknell	
Alison Challenger	
Sarah Collis	
Sarah Fleming	
Catherine Underwood	
Councillor Adele Williams (items 47-52)	

Non-Voting Members

Present	Absent
Leslie McDonald	Lyn Bacon
Tim Guyler (Substitute of Alison Wynne)	Ian Curryer
Tracey Macdonald (Substitute for Viki Dyer)	Viki Dyer
	Julie Hankin
CI Alan Pearson (Substitute for Superintendent Matthew Healey)	Superintendent Matthew Healey
	Richard Holland
	Craig Parkin
	Jane Todd
	Andy Winter
	Alison Wynne

Colleagues, partners and others in attendance:

Rachael Harding	-	Homelessness Strategy Manager, Nottingham City Council
Aleks Jackowska	-	Jigsaw Youth Club
Adrian Mann	-	Governance Officer, Nottingham City Council
Kimberley Pike	-	Rough Sleeping Co-ordinator, Nottingham City Council
Amanda Robinson	-	Integrated Care System Program Manager, NHS Nottingham City Clinical Commissioning Group
Richard Taylor	-	Environmental Health and Safer Places Manager, Nottingham City Council
Michelle Tilling	-	Nottingham City Locality Director, Greater Nottingham Clinical Commissioning Partnership
Eleanor Youdell	-	Café Sobar

47 CHANGES TO MEMBERSHIP

The Board noted that Councillor Leslie Ayoola has stood down from the Board, that Sarah Fleming has replaced Andrea Brown as a representative of the Greater Nottingham Clinical Commissioning Partnership, and that Viki Dyer has replaced Tim Brown as the representative of the Department for Work and Pensions.

48 APOLOGIES FOR ABSENCE

Lyn Bacon
Ian Curryer
Viki Dyer
Superintendent Matthew Healey
Craig Parkin
Jane Todd
Andy Winter
Alison Wynne

49 DECLARATIONS OF INTERESTS

None.

50 MINUTES

The Board confirmed the minutes of the meeting held on 25 September 2019 as a correct record and they were signed by the Chair.

51 POPULATION HEALTH MANAGEMENT

Amanda Robinson, Integrated Care System Program Manager at NHS Nottingham City CCG, gave a presentation on Population Health Management, its methodology, the challenges in delivery and the next steps. The following points were discussed:

(a) as part of the Integrated Care System (ICS), Population Health Management (PHM) is an approach to improving the health and care of the entire population through the integration of health and social care. Its aim is to improve the physical and mental health and wellbeing of people while reducing health inequalities. This includes action to reduce the occurrence of ill health, including addressing the wider determinants of health, and requires working with communities and partner agencies;

(b) PHM improves population health by data-driven planning and the delivery of care to achieve the best possible outcomes. It includes population segmentation, stratification and impact modelling to identify local ‘at risk’ groups, to design and target services in a consistent and equal way to prevent ill health and to improve care and support for people with ongoing health conditions. In preventing ill health, detailed consideration needs to be given on the effects on populations of the environment, work opportunities, money, housing, education and skills, diet, transportation and community;

(c) to succeed, PHM will develop the required basic infrastructure, including digitalised health and care records, integrated data and the associated information governance processes. This will enable the gathering, analysis and interpretation of data in a timely way to understand populations, to enable the planning of proactive services to prevent illness, reduce the risk of hospitalisation and address inequalities;

(d) the previous, stratified approach to PHM was limited in that it only had an impact on a small percentage of the population; it focused on those where complex care needs had been identified already; it did not develop proactive or sustained healthcare; it had limited or no data usage for Mental Health, Social Care and the Voluntary Sector; there was no review of spend against outcomes; and there was no consideration of social and economic factors;

(e) the system was reviewed against the national PHM maturity matrix. This identified regional variation in patient and citizen outcomes, the use of resources, the risk stratification approach and funding. Incompatible systems for data and information exchange were identified, with low levels of monitoring, governance or auditing of systems. There was a limited focus on prevention, with services focussing on the reactive management of health and care, rather than proactive health and self-care;

(f) as a result, a six-step plan has been produced to develop a new system for PHM. The ICS has created twelve priority outcomes to address and improve population health, with three major ambitions with defined outcomes, which can be addressed and measured at the levels of the ICS, the Integrated Care Partnership (ICP) and the Primary Care Network (PCN);

(g) within the new system, the population is split into segments by different care requirements. People's needs will rarely remain static and movement between segments will be explored through regression analysis techniques, to enable the system to identify whether specific characteristics can act as a warning of increasing risk. This enables the system to target where a response is needed and move the required resources. The segments are stratified to define the levels of risk, to help to identify who within each segment is at the greatest risk, and respond to the population's health and care needs. This approach has been trailed for diabetes in the first instance, to target measures at preventing people without diabetes from developing it, and to respond to the particular needs of people with pre-diabetes, diabetes and high needs diabetes. The next two areas of focus will be frailty and mental health;

(h) identifying people with the same characteristics across the care system enables ICPs and PCNs to see true variation and deliver more focussed and targeted support. By looking at the clinical characteristics of citizens and what services they are engaging with in what areas, it is possible to gain a clear image of the population needs in certain places – including when people may not be able to access needed services that are available, due to life circumstances such as working patterns. Conversations are underway on where particular services should be commissioned, and what services can be put in place in a targeted way to prevent the worsening of certain health issues. For people with complex care needs, it is intended to move away from individual 'pathways' relating to a specific

condition and instead focus on the 'journey' of an individual through life, when their needs are different at different points in their life;

(i) the new PHM system has implementation phases over the next two, five and ten years, with the ICPs assessing what services are needed for their populations, going forwards. Each segment of people will have a data pack created that identifies the population, areas of concentration, proposed services and a baseline, and ICPs will be able to choose from interventions based on the intervention needs of their particular populations. The interventions available will be from a range of services, including medical, social care and the voluntary sector. The ICP will establish who will carry out the interventions and generate the workflows to identify care gaps, to enable effective capacity planning. An update will be provided by the ICP in early 2020, once the segment data packs are available;

(j) to support care delivery and the effective collection and sharing of data at the local level, it will be vital to increase funding to the voluntary sector. Discussions are underway with partners to find means of developing the skills and knowledge in the voluntary sector in support of PHM. It is very important that services are developed in partnerships with the communities to which they will be delivered and their voluntary sector organisations, to ensure that their voices are heard.

The Board noted the presentation. It felt that, going forward, it would be vital for it to understand and engage with the ICS on this new system for PHM, to ensure good care delivery for citizens at the neighbourhood level, and to take proactive steps in supporting citizens in avoiding ill health.

52 NOTTINGHAM AND NOTTINGHAMSHIRE AIR QUALITY STRATEGY 2019-2028

Richard Taylor, Environmental Health and Safer Places Manager, presented a report on the revised Nottingham and Nottinghamshire Air Quality Strategy, which provides information to citizens, businesses and partners on how to reduce emissions and exposure, and to improve air quality and citizen health. The following points were discussed:

(a) the 2008 Air Quality Strategy has been revised and the updated 2019-28 document has been completed, reflecting the rapid changes in the area that have taken place since 2015. An accessible, electronic version of the Strategy is now published on a dedicated website, to communicate the information on managing air quality as widely and effectively as possible, using the visual information graphics created by the Environment Agency. The website is designed to explain why bad air quality is a significant issue for public health, why the problem needs to be dealt with, how it will be addressed, and what the major objectives of the Strategy are for the future. Minor updates to the website material will be carried out on a rolling basis, and the Strategy will be reviewed in full after five years;

(b) although Local Authorities can introduce air quality management zones, it is not always possible for a given Council to control all of the issues arising within its area, as air pollution can travel from other parts of the country. However, Councils need to work closely with citizens, businesses and partners to reduce local

pollution to improve public health. Full guidance is available on the website on how people can help with this in their daily lives and travel, and how businesses can reduce their energy usage;

(c) Nottingham and Nottinghamshire Councils have a wide range of individual plans lying behind the overarching Strategy, to achieve its delivery by bringing improvements in specific areas. Councils should report on the measures in place and their progress in addressing the improvement of air quality on a yearly basis, to contribute to the annual status report to the Department for the Environment, Food and Rural Affairs. A full report on what has been achieved against the Strategy is carried out every five years.

The Board felt that the new Strategy is very positive, and that its members should both raise awareness about it and adopt and implement it in their organisations. It noted that an Air Quality Improvement group is hosted periodically by Nottingham City Council and that members are encouraged to send a representative to attend. Partner organisations are also encouraged to continue to contribute to the annual air quality report. It recommended that, as part of the Strategy, the full electrification of trains, buses and taxis in Nottingham, Nottinghamshire and the wider Midlands area is taken very seriously.

RESOLVED to endorse the Nottingham and Nottinghamshire Air Quality Strategy 2019-28.

53 ROUGH SLEEPING AND WINTER PREPAREDNESS

Racheal Harding, Homelessness Strategy Manager, and Kimberley Pike, Rough Sleeping Co-ordinator, presented a report on homelessness in Nottingham and the steps in place to prepare for homelessness during the winter. The following points were discussed:

(a) the number of rough sleepers found during the monthly snapshot count on an average night has decreased over the past few months, following an all-time high of 55 in August 2019. The November 2019 count figure of 30 is also lower than the 34 recorded in November 2018, the 43 recorded in November 2017 and the 35 recorded in November 2016. This positive reduction is a result of the system of additional services and approaches that the Council and its partners have developed and introduced following successful bids for additional Government funding from 2018;

(b) in 2019/20, the Council was successful in obtaining £1.2million in grants from the Ministry for Housing, Communities and Local Government (MHCLG) to introduce additional provision for rough sleepers and deliver a strategic approach of prevention, identification, engagement, assessment, support, shelter and sustained housing. The enhanced provision includes a year-round night shelter and sit-up service, a complex needs hostel, move-on accommodation and new staffing, including a coordinator, resettlement workers, private rented sector lettings workers, community navigators and tenancy support workers;

(c) work is underway with Housing Aid to help people enter the private rented sector, and ‘housing first’ properties have been acquired to ensure accommodation for

rough sleepers, within which further support can then be provided. Housing Aid also helps in linking to the records of people who became homeless in other Local Authority areas and then move into the city. Funding has been secured for specialist navigators working across both the City and County who focus on entrenched rough sleepers who are at risk of returning to street homelessness following discharge from acute and mental health hospitals (or release from prison), to help to ensure continuity of care;

(d) however, although there is a reduction in the monthly snapshot count of rough sleepers on an average night, the actual number of individual rough sleepers on the streets is increasing. The number of different individuals seen rough sleeping in Nottingham in 2019 to date has increased by 16% against the figure for the same period in 2018, with approximately seventeen new rough sleepers entering the city per month. These people tend to have slept rough in other areas before coming into the city centre and have struggled with homelessness over a long period. The locations where rough sleepers are reported are mapped and new reports are checked within 24 hours. Known rough sleepers are not removed from the active list until a housing outcome has been achieved;

(e) the reduction in monthly counts alongside the increase in individuals found rough sleeping suggests that the Council's ability to identify and respond to rough sleepers with accommodation and housing-related support is strong. However, there are still significant pressures that cause people to become homeless, and these are increasing. Homelessness is not simply a housing issue. The loss of accommodation can be a symptom or consequence of another support need that is not being met. Rough sleepers may refuse housing options, and those that accept shelter may be at risk of losing it quickly if their additional support needs are not addressed. These support needs can include mental health conditions, dealing with the impact of trauma (including childhood trauma), substance misuse, physical health, conditions, illnesses, injuries and offending behaviours;

(f) in trying to prevent the reasons for homelessness, people with a high level of financial vulnerability – particularly when they are at risk of losing access to benefits – need support in engaging with social services and living independently, and this support should be provided as early as possible. Services must be accessible, with checks in place to ensure that people at risk of homelessness due to health reasons attend their medical appointments and receive support in their accommodation, which may also need to have specialist provision. Wherever possible, people at risk of homelessness should be found stable accommodation and provided with required services within that accommodation;

(g) the Nottingham Cold Weather Plan for this year is in place. The Council has been successfully awarded £90,000 from the MHCLG Cold Weather Fund to introduce emergency and short-term additional bed spaces in new and existing projects to reduce reliance on bed and breakfast provision, which does not help rough sleepers to gain access to other services that they need. The funds will also enable more evening outreach workers and a move-on coordinator to help people move through the system. The funding will pilot a scheme for a limited number of nights in community nursing beds for rough sleepers who require further rehabilitation, care or support following discharge from hospital;

(h) the outreach team is working had to ensure that there is 'no first night out' for people at risk of homelessness, and it will be possible for people calling in regarding rough sleepers to be put through to an officer on the street. The voluntary sit-up service delivered through a partnership between the Nottinghamshire Fire and Rescue Service and the British Red Cross will be expanded to two sites, to provide emergency shelter for low-needs rough sleepers when the Severe Weather Emergency Protocol is activated. Discussions are also progressing with the Arches project to deliver a third sit-up service when the temperatures reach freezing. The YMCA is also providing single unit facilities for both complex and lower-needs provision, and there have been offers of support from faith groups;

(i) the two main housing challenges are to ensure that there is adequate emergency shelter for rough sleepers who have multiple and complex needs that are assessed as too high to be addressed solely through housing-related support, and that there are move-on options for rough sleepers with multiple and complex needs who need specialist long-term supported accommodation placements. Neither of these two housing solutions can be facilitated or delivered without strategic, financial and operational input from the health, social care and criminal justice sectors. The prevention of rough sleeping requires a system-wide, cross sector approach with a commitment to provide adequate investment and the flexible delivery of services that support people with multiple and complex needs. Particular work is being carried out with the NHS on how and when homeless people are discharged from hospital, and how the right care services can be put in place for them.

The Board noted the report. It felt that the work being carried out to reduce homelessness and support rough sleepers is very positive. It requested that, to help partners support this work, detailed information is forwarded to Board members on what partners can do so that they can circulate it more widely, including detail of the volunteering opportunities and the donations that can be made to participating support charities.

54 PRIMARY CARE NETWORKS UPDATE

Michelle Tilling, Nottingham City Locality Director at the Greater Nottingham Clinical Commissioning Partnership, gave a presentation on the work of the Nottingham City Primary Care Networks. The following points were discussed:

(a) there are three levels under the new care system reorientation:

(i) an Integrated Care System (ICS) covers a population area of around 1 million people and is responsible for system strategy and planning, developing accountability arrangements across the system, implementing strategic change and transformation at scale, and managing performance and funding;

(ii) within the overall ICS, the Integrated Care Partnerships (ICPs) cover population areas of around 150,000 to 500,000 people and are responsible for the integration of hospital, council and primary care teams and services, and developing new provider models for anticipatory care;

(iii) at the neighbourhood level, Primary Care Networks (PCNs) cover population areas of around 30,000 to 50,000 people and are responsible for strengthening PCN practices and other out-of-hospital services, and establishing proactive and integrated models for a defined population;

(b) a new Nottingham City ICP is being established as a distinct place, with a Nottingham City Clinical Commissioning Group (CCG). The ICP will work with a wide range of partners to provide support at a neighbourhood level through a wider collaboration across health, social care, community groups and other agencies. The ICP launch event for the workforce was held on 7 November. It had 39 stalls and around 500 staff attended from 67 organisations, to see how all of these partners can link together in providing care;

(c) the areas of the eight PCNs within the ICP follow the ward boundaries in most cases. The PCNs are able to tailor care provision to the specific needs of their communities, and close consideration is being giving to how to supply effective provision in neighbourhoods with high student populations. PCNs have started as GP Practices collaborating together (delivered through the new 2019 GP contract) and will mature to include community health care, mental health, social care and the voluntary sector;

(d) Clinical Directors and Deputy Clinical Directors have been appointed to the PCNs and an induction programme is underway. Many of these are new to this area of work and the post holders cover a wide range of skills and clinical experience, with the intention of growing new leadership. Additional funding is available to support the establishment of PCNs, including £1.76 per head of population for practice-based funding to support participation in a PCN, and £1.50 per head of population for PCN-based funding to support administration of PCNs. New funding is available to support an Accountable Clinical Director for each PCN, who must be a practising clinician within the particular PCN. Further funding is also available for Social Prescribing Link Workers, Clinical Pharmacists, Physiotherapists, Physicians and Associates Paramedics;

(e) the PCN Maturity Matrix outlines the components that underpin the successful development of a PCN. It is a progression model that evolves from the initial establishment of a PCN to the delivery of integrated care and population health across four stages, from Foundation to Step 3. The sections of these steps are leadership, planning and partnerships, the use of data and population health management, integrating care, managing resources, and working in partnership with people and communities;

(f) PCNs do need to engage closely with partners at a very local level, including community partner groups, and involve them in supporting local care. It is particularly important that Black, Asian and minority Ethnic groups are included, and that their voice is heard within the new structure. A Citizens' Council will be established to support local input into decision-making and engage with the voluntary sector. The CCG's engagement team is working to establish what this Council will look like at the PCN level;

(g) of the seven National Network Services, Structured Medications Reviews and Optimisation, Enhanced Health in Care Homes, Anticipatory Care, Supporting

Early Cancer Diagnosis, and Personalised Care (as part of the NHS Comprehensive Model) will begin from April 2020. Cardio Vascular Disease (Prevention and Diagnosis) and Tackling Neighbourhood Inequalities will start from April 2021. The particular local PCN requirements will need to be identified and fed into the national specifications;

(h) the new ICP and PCNs represent an opportunity to think broadly and work at a neighbourhood level to deliver care to populations with City Council officers, Community Protection and local Area Committees. This will include development, Mental Health Trust and City Care alignment, with links to the Voluntary Sector, Area Policing and Public Health. There will be complex persons panel that will work to a multi-agency approach, with escalation points on the patient pathway;

(i) the Department for Work and Pensions is in a strong position to work with the ICP, and has information and resources to share that should be beneficial to collaboration. The Police are also glad to work in partnership with the ICP, to develop the operation of neighbourhood policing within PCN areas to support vulnerable people.

The Board noted the presentation. It felt that the new ICP and PCN system has the potential to be very positive for the provision of care in local communities, and that all elements of the care services need to work together in partnership closely.

RESOLVED to request that the scoping detail relating to the creation of the Citizen's Council is shared with Board members, with information on how feedback will be returned to consultees on how the input that they have provided will be used in decision-making.

55 INTEGRATED CARE PARTNERSHIP UPDATE

Dr Hugh Porter, GP Lead at the Greater Nottingham Clinical Commissioning Partnership, gave a verbal update on the work of the Nottingham City Integrated Care Partnership (ICP). The following points were discussed:

(a) the Integrated Care Partnership (ICP) held a launch event on Thursday 7 November 2019. The event was run as a drop-in session for the workforce from all the ICP partner organisations. An invitation was sent to all staff across the ICP, and to all partner organisations to have a stall at the event where they could showcase their services and discuss how they would work as part of the ICP. At least 67 different organisations were represented from across the city, from all the health and care sectors, and there were 39 stalls in total from a wide range of partners;

(b) it is estimated that there were at least 500 people attending the event throughout the day, and up to 90 flu jabs were delivered to the staff attending from all organisations. A number of alcohol brief interventions took place at the event, as well as some full interventions, and health checks were carried out for a number of people, included taking their height and weight to calculate their BMI, as well as taking their blood pressure and providing results to take to their GP if necessary;

(c) the ICP is working on different ways to meet citizens' health needs and its particular priorities are social prescribing (currently, there are 11 social prescribers, aligned with Primary Care Networks to support specific populations), reducing smoking and improving end of life care. Work is also being carried out on immunisation, addressing homelessness, improving home care and supporting mental health – particularly with children;

(d) the Nottingham and Nottinghamshire Integrated Care System submitted a response to the NHS long-term plan on 15 November and the next step for the ICP is to provide its response, and to start delivering programmes relating to its priorities.

The Board noted the update.

56 THE MICHAEL VARNAM AWARDS 2019

Eleanor Youdell, of Café Sobar, and Aleks Jackowska, of the Jigsaw Youth Club, gave presentations on the their work that had been recognised as the Group and Individual winners of the Michael Varnam Awards 2019. The following points were discussed:

(a) Café Sobar is a social enterprise responding to the support needs of the recovery community in relation to social and emotional isolation and a lack of work opportunities. It provides a city-centre social hub and work experience scheme for the recovery community as an independent and alcohol-free café venue, which has now been open for five years. It works with treatment and recovery services, with Double Impact as a partner provider, and hosts a large number of support meetings. The café serves both the recovery community, in enabling peer support, and the wider public – using this opportunity to promote information on general good health. It is open for live performance, art exhibitions and social events, giving it a broad appeal to a wide range of community groups;

(b) the Jigsaw Youth Club is for young people over the age of 10 years who have Asperger's Condition. There is no upper age limit for members. It began in 1998 and took its current form from 2008, with a focus on developing practical and social skills to help people with Asperger's Condition advance in life, improve their social welfare and increase their quality of life. Sports activities and the opportunity for gardening at an allotment are also available, and the club promotes healthy eating. The Club has no regular external funding and relies completely on volunteer staff. Beyond attendance contributions from the members of the Club, it seeks grant sources whenever possible.

The Board thanked Eleanor Youdell and Aleks Jackowska for their presentations, and for the very hard work that they are carrying out for communities, as recognised by their Michael Varnam Awards.

57 BOARD MEMBER UPDATES

The Board noted the written updates of Nottingham City Council's Corporate Director for People (Children and Adults) and Director for Public Health.

58 FORWARD PLAN

The Board noted that the current Forward Plan is under review and that, if members have any comments or suggestions regarding the Plan, these should be forwarded to Nottingham City Council's Director for Public Health.

59 CITIZENS' QUESTIONS

The Board noted that there were no questions from citizens.