Nottinghamshire County Council

Report to Health & Wellbeing Board

5 March 2014

Agenda Item: 7

REPORT OF THE CORPORATE DIRECTOR, CHILDREN, FAMILIES & CULTURAL SERVICES AND THE DIRECTOR OF PUBLIC HEALTH

CHILDREN AND YOUNG PEOPLE'S HEALTH AND WELLBEING: LOCAL IMPLICATIONS OF THE CHIEF MEDICAL OFFICER'S ANNUAL REPORT

Purpose of the Report

1. To consider the Chief Medical Officer's (CMO) annual report alongside a selection of current health performance indicators for children and young people and explore the implications for children's services locally.

Information and Advice

Chief Medical Officer's Annual Report

2. The focus of the CMO annual report for 2012 (published in October 2013) was children and young people, in particular whether we are giving them a good start and building their resilience. The report analyses the challenges to children's health and wellbeing and looks especially at those with neurodevelopmental disabilities, mental health problems, looked after children and young people in the youth justice system.

3. In essence the report concludes that: early interventions and preventative measures do make a difference to outcomes and also make sound economic sense; 'proportionate universalism' is the correct approach - improving the lives of all, with proportionately greater resources targeted at the more disadvantaged groups; and the importance of listening to children and young people in order to develop effective strategies and reduce their future burden of disease.

4. The CMO's key findings are as follows:

   a. England has poor outcomes for children and young people with respect to mortality, morbidity and inequality compared to other similar countries.
   b. 'Early action' is crucial and there is a need to move from reactive to proactive care.
   c. There is a need to raise the profile of children and young people's health and wellbeing with private, public and voluntary institutions and with the public itself (an annual children's week is proposed), as well as encouraging all sectors to work more closely together.
   d. Efforts to improve outcomes should be underpinned by improving the lives of all, with more resources targeted at the most disadvantaged.

e. The evidence base should be developed further around both how to nurture resilience in young people and the link between health and wellbeing and educational attainment.
f. There is a strong association between a sense of belonging in school ('connectedness') and well-being.
g. Evidence suggests that resilience and feeling connected have a positive effect in reducing risky behaviours, as too does strong communication between parents and young people.
h. A new 'health deal' to outline the compact between children and health providers will give an opportunity for organisations to show how children-focused they are.
i. The workforce must receive training on age appropriate care and develop skills to guide young people around the healthcare system, including understanding the role of school nurses.
j. Young people with a long term condition should have a named GP to coordinate their care.
k. Better data is needed around the health and wellbeing of children and young people, in particular mental health problem prevalence and neurodevelopmental disability.
l. Addressing socio-economic determinants is a primary prevention strategy that may reduce the number of children entering public care.
m. Young people in contact with the youth justice system are more likely to have multiple health problems, yet many of their needs go unrecognised and unmet.
n. Public health intervention strategies must have twin foci on early childhood and on adolescence, as both are critical periods of rapid development.

5. In addition, the CMO identifies the following challenges for the future, which will have significant implications both socially and economically over the coming decades:

a. **Child obesity** – this continues to rise steadily and is persisting most strongly among those of low socio-economic status. The CMO argues that the primary prevention of obesity should begin in infancy, with the delivery of interventions aimed at improving the eating and activity patterns of young children.
b. **Mental health** – it is increasingly clear that the foundations of good mental health are formed in childhood and adolescence, but the challenge is providing interventions in an economical manner. In addition, optimising maternal mental health during pregnancy needs to be given equal prominence to optimising maternal physical health, as it is a major influence on future child development and outcomes.
c. **Infection/immunisation** – how to ensure that messages about the advantages of vaccination reach those who need to hear them and that the health and care system responds to altered delivery needs, such as the expansion of vaccination programmes.
d. **Rare diseases** – ensuring speedier diagnosis by providing sufficient training for those working in healthcare and support with technology, both to identify disease and to assist families in navigating the system.
e. **Transition** – a core challenge in adolescence is the transition from child to adult services and, for many, moving away from home.
f. **Technology** – both harnessing the increased potential of new technologies and protecting against threats, such as data security and extra burdens on healthcare professionals.

g. **Cyber-bullying/pornography** - how to balance the potential of social media to enhance connectedness and wellbeing with the risk of exploitation of vulnerable young people.
h. **Workforce** – ensuring the workforce meets core standards and is adequately trained.
i. **Determinants of disease** – not losing sight of what is happening to inequalities, child poverty and the most vulnerable is vital in promoting health for all children.

Local Needs and Outcomes

6. Evidence from Public Health England[1] (PHE) confirms that health outcomes for children and young people vary considerably across Nottinghamshire, mostly in line with deprivation. Although deprivation locally is lower than the national average, around 24,500 children (aged 0-16 years) still live in poverty. Child poverty is concentrated in the north and west of the County, with Ashfield and Mansfield suffering higher levels than those nationally.

7. The links between deprivation and poor health outcomes are well-documented and evidenced in Nottinghamshire by a difference in life expectancy (9.0 years lower for men and 7.6 years lower for women in the most deprived areas than in the least deprived). Educational attainment, also influenced at least in part by deprivation, is connected to this since health obviously plays a major role in allowing children and young people to meet their academic potential.

8. Most recent data suggests that obesity in primary school age children across the County is generally in line with, or lower than, national levels, with Gedling and Rushcliffe displaying the lowest levels. In Year 6, 17.5% of children are classified as obese, compared to the national figure of 18.9%. The proposed new system model for obesity prevention and weight management services to be commissioned in Nottinghamshire[2] should support sustained behaviour change and improved outcomes in the coming years. In terms of tooth decay in children aged five years, Nottinghamshire has the lowest levels in the East Midlands and all districts are in line with or lower than the national average.

9. The number of women smoking in pregnancy is significantly higher than the national average across both the former Nottinghamshire Primary Care Trust (PCT) and Bassetlaw PCT areas, while numbers starting breastfeeding are significantly lower[3]. In comparison with local authority statistical neighbours, Nottinghamshire comes ninth out of eleven in terms of smoking in pregnancy and sixth out of eleven for breastfeeding (where first is best). However, virtually all statistical neighbours also under-perform compared to the national average for these two indicators. The County's percentage of term babies with a low birth weight is in line with the percentage nationally, but levels are much higher in the more deprived areas of the County, and there is a clear correlation between smoking at time of delivery and low birth weight.

[1] Evidence in this section is taken from the PHE Health Profiles 2013 (www.healthprofiles.info) and the PHE Health Outcomes Framework data tool (http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000043/pat/6/ati/102/page/0/par/E12000004/are/E10000024).
[2] Report to Children's Trust Board on 5 December 2013 (http://www.nottinghamshire.gov.uk/caring/childrenstrust/about-the-childrens-trust/childrenstrustboard/?entryid217=363549&p=1)
[3] PHE data for breastfeeding and smoking in pregnancy is only available by former PCT areas, not by local authority district. Other evidence, such as data from clinical commissioning groups, suggests that breastfeeding and smoking in pregnancy performance varies considerably across the County, generally relating to deprivation.

10. While teenage pregnancy has declined in recent years locally, rates in Ashfield and Mansfield are significantly higher than the national average, whereas rates in Broxtowe and Rushcliffe are significantly lower. Overall, Nottinghamshire levels of chlamydia diagnosis in the 15-24 years age range are also significantly lower than the national average, but rates in Ashfield, Bassetlaw, Gedling and Mansfield are significantly higher.

11. The rate of under-18s admitted to hospital due to alcohol-specific conditions is lower than the regional and national average. The conurbation areas of Broxtowe, Gedling and Rushcliffe have the lowest levels and, in comparison with statistical neighbours, the County's admission rate is also low. In addition, admissions caused by unintentional and deliberate injuries (aged 0-14 years) are lower than England and much of the region, with levels significantly lower than those nationally in all districts except Bassetlaw, which is similar to the England average.

12. Infant deaths under one year of age are generally in line with national and regional levels and Nottinghamshire is average among its statistical neighbours. However, the number of (all-age) road injuries and deaths is significantly higher than that nationally and above all but two statistical neighbours. Bassetlaw, Newark & Sherwood and Rushcliffe exhibit the highest rates. As children and young people are passengers, pedestrians and cyclists, this is a safeguarding issue which requires careful monitoring.

Local Delivery

13. The CMO's annual report is an endorsement of the direction of travel of the Children's Trust and the County Council's Children, Families and Cultural Services (CFCS) Department. The key themes of early intervention, proportionate universalism and participation of children and young people are reflected in the overall approach of the partnership locally and the purpose, principles and outcomes of the CFCS Department.

14. The re-modelling of Children's Social Care and the Early Help offer, including the establishment of the Multi-Agency Safeguarding Hub (MASH) and the Early Help Unit, have laid foundations for further improving the outcomes of vulnerable children and young people. This has been augmented by an enhanced children's centre core offer and new arrangements for a single Education, Health and Social Care Plan for children with special educational needs. The new local operating model in children's services will aid integration to improve a range of outcomes.

15. A number of key components describe the direction of travel for children's services and align with the some of the key CMO findings:

    a. Easier access to services by streamlining the "front door" for children's services, building on work to align the MASH and the Early Help Unit.
    b. Better triage and assessment of need through developments such as the MASH, Early Help Unit and the arrangements for Education, Health and Care Plans.
    c. Joining up services locally through integrated, multi-disciplinary, co-located teams based in the three geographical localities (Mansfield and Ashfield; Newark & Sherwood and Bassetlaw; Rushcliffe, Gedling and Broxtowe).
    d. Focused support on children and families with the greatest need and those geographical areas where services are needed most.

e. Helping children and families as early as possible, to deliver better outcomes for them.
f. Delivering a refreshed children's workforce development strategy to ensure staff keep pace with changes to services.

16. The CMO's challenges for the future broadly encompass much of the Children's Trust's work. Priorities for action in the previous Children, Young People and Families (CYPF) Plan (2011-14) that directly related to these challenges included emotional wellbeing, safeguarding, disability and child poverty. Obesity levels were also monitored under the Plan's performance framework, alongside a suite of other relevant indicators. The new CYPF Plan (2014-16) goes 'live' shortly, subject to approval by Policy Committee on 5 March 2014, and the Children's Trust Board has also considered how best to ensure the CMO's challenges remain effectively addressed over the coming years. There are a number of areas in the Health and Wellbeing Strategy that take a life course approach (for example tobacco, obesity, sexual health and substance use) which include a children's element. These are tackled across the whole age spectrum and therefore are not specifically detailed in the CYPF Plan.

17. Positive trends in educational results over the last few years, based on successful partnerships with schools, and work to narrow the gaps in attainment should gradually increase 'school connectedness' and boost resilience among children and young people. However, there is still much to be done to obtain better data for disability and mental health locally, and workforce development around the provision of age-appropriate care is an issue which needs careful monitoring in commissioned services. Influencing wider socio-economic determinants of health is also becoming increasingly difficult at a time of rising demand for services and reductions in budgets. The recent establishment of the dedicated Integrated Commissioning Hub (ICH) for children's health services will enable public agencies to work more closely together to streamline complex health-related commissioning activities and effectively evaluate the impact on outcomes.

Local Implications

18. The findings of the CMO's report present a backdrop against which the Health and Wellbeing Board can examine its effectiveness in improving outcomes for children and young people's health and wellbeing and test its preparedness for future risks. They provide a benchmark for the Board to measure itself against and assess whether it is 'on the right track' as it finalises its new Strategy for 2014-17. Eight implications are outlined in the table below, alongside what has been done locally and what still needs to be done.

Implication of CMO Report	Local Response	Next Steps
1. Regulators to review annually the extent to which they evaluate the contribution of statutory partners, local safeguarding boards and health and wellbeing boards to the health and protection needs of children and young people.	• The Health & Wellbeing Board holds all partners to account for their contributions to the Health and Wellbeing Strategy.	• Await national guidance from regulators such as the Care Quality Commission (CQC) and Ofsted.

Implication of CMO Report	Local Response	Next Steps
2. PHE should work with local authorities and schools to build on current efforts to increase participation in physical activity and promote innovative solutions that lead to improved access to existing sports facilities.	• The commissioning of weight management services will include an element for children and young people. • Ideas are currently being consulted upon with stakeholders, including young people. Consultation includes questions regarding physical activity. • A new service will be in place from April 2015.	• Ensure ICH representatives are active members of local obesity commissioning panels to champion the needs and views of children, young people and families. • Await national PHE guidance for local authorities and schools.
3. PHE should work with local government to identify how the health needs of families are met through Troubled Families Programme.	• The Nottinghamshire Supporting Families Programme offers a holistic support package. • Further work may be required to specifically identify and respond to health needs.	• Await national guidance.
4. Local authorities to examine if they are enacting the Healthy Child Programme in full and are prepared for the change in commissioning that is due shortly.	• A paper focusing on the Healthy Child Programme was presented at the January 2014 Health and Wellbeing Board. • The ICH is working with both NHS England area teams to aid the transition of health visiting and Family Nurse Partnership (FNP) to the Local Authority in October 2015.	• Determine the commissioning plan for school nursing. • ICH to continue to work with both NHS England area teams.
5. An annual National Children's Week should be held to provide a focal point for highlighting to stakeholders and the public current work to improve health and wellbeing.	• The ICH and Public Health disseminate all key national health and wellbeing campaigns e.g. Change4Life. • The ICH has a communications plan which includes support for national campaigns such as Sexual Health Awareness Week.	• Await information about a National Children's Week. • The ICH and Public Health will continue to work with communications teams to support national campaigns and communication regarding local activity.

Implication of CMO Report	Local Response	Next Steps
6. There is a renewed call for professionals to think about the whole family, not just the child, and the CMO has asked professional bodies to develop tools to support this.	• The County Council's Corporate Leadership Team approved a Think Family position statement in October 2013. • An Ofsted thematic inspection in May 2013 identified a number of recommendations and a Think Family Group was established to implement these.	• Ensure that the Health and Wellbeing Board can demonstrate an effective Think Family approach. • Await national tools for local use.
7. There is a need to prioritise pre- and post-natal interventions that reduce adverse outcomes in pregnancy and infancy (e.g. relating to smoking, breastfeeding and mental health). The CMO notes that this would require investment in research and expansion of services for pregnancy and the early years.	• Completion and implementation of the maternity services reviews at Nottingham University Hospital Trust, Sherwood Forest Hospitals Foundation Trust and Doncaster & Bassetlaw Hospitals Foundation Trust.	• Nottinghamshire County Council commissions children centres, so performance management information that is gathered could be used in the Joint Strategic Needs Assessment (JSNA) to inform priorities and commissioning plans. • Continue to work closely with NHS England to embed the FNP and support the transition of FNP and health visiting commissioning to the Local Authority from October 2015.
8. A discrete adolescent public health strategy is proposed, which would be horizontal across substance use, sexual health, mental health and long-term conditions.	• Nottinghamshire currently has separate strategies and plans for young people's substance use, teenage pregnancy, child/adolescent mental health and disability. • In addition there are life course strategies for obesity, smoking and sexual health.	• The Health and Wellbeing Board may wish to consider the development of a local adolescent public health strategy to pull together all key areas of work for this age group.

19. It seems likely that Ofsted, CQC and other inspectorates will seek to strengthen their evaluation processes relating to the health and protection needs of children and young people in due course. The renewed call for a 'Think Family' approach will no doubt be developed further as professional bodies are encouraged to promote and practise it, and more joined-up working between PHE and local authorities across a range of

programmes will present an opportunity to create more innovative ways to improve health and wellbeing outcomes further.

Other Options Considered

20. The report is presented for consideration and discussion by the Board. No other options have been considered.

Reason for Recommendations

21. To ensure that this major national policy document is taken into account in the Health and Wellbeing Board's strategic planning.

Statutory and Policy Implications

22. This report has been compiled after consideration of implications in respect of crime and disorder, finance, human resources, human rights, the public sector equality duty, safeguarding of children and vulnerable adults, service users, sustainability and the environment and ways of working and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

RECOMMENDATIONS

That the Board:

1) considers the findings and implications of the CMO's annual report (paragraphs 4 & 18) in relation to local efforts to improve health and wellbeing outcomes for children, young people and families.

2) discusses the challenges for the future that the CMO highlights (paragraph 5) and how these will be addressed through the new Health and Wellbeing Strategy and the wider work of the Health and Wellbeing Board.

Anthony May
Corporate Director, Children, Families and Cultural Services

Chris Kenny
Director of Public Health

For any enquiries about this report please contact:

Geoff Hamilton
Performance, Participation & Needs Assessment Manager
T: 0115 9772646
E: geoff.hamilton@nottscc.gov.uk

Constitutional Comments (LM 13/02/14)

23. The contents of the report fall within the remit of the Health and Wellbeing Board.

Financial Comments (KLA 11/02/14)

24. It is assumed that the actions proposed can be resourced from within existing budgets, therefore there are no financial implications arising directly from the report.

Background Papers and Published Documents

Annual Report of the Chief Medical Officer 2012, Department of Health
https://www.gov.uk/government/publications/chief-medical-officers-annual-report-2012-our-children-deserve-better-prevention-pays

Public Health England Health Profile 2013 (Extract) – by district and by statistical neighbour

Except for previously published documents, which will be available elsewhere, the documents listed here will be available for inspection in accordance with Section 100D of the Local Government Act 1972.

Electoral Divisions and Members Affected

All.

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