Nottinghamshire County Council

Health and Wellbeing Board

Wednesday, 06 November 2019 at 14:00

County Hall, **West Bridgford, Nottingham, NG2 7QP**

AGENDA

1	Minutes of the last meeting held on 4 September 2019	3 - 10
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3	Declarations of Interests by Members and Officers:- (see note below) (a) Disclosable Pecuniary Interests (b) Private Interests (pecuniary and non-pecuniary)	
4	Chair's Report	11 - 24
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6	Approval of the Joint Strategic Needs Assessment Chapter - Health and Homelessness	37 - 148
7	Approval of the Joint Strategic Needs Assessment Chapter - Early Years and School Readiness	149 - 244
8	Retrospective Approval of the 2019-2020 Better Care Fund (BCF) Planning Template Submission	245 - 284
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Notes

(1) Councillors are advised to contact their Research Officer for details of any Group Meetings which are planned for this meeting.

(2) Members of the public wishing to inspect "Background Papers" referred to in the reports on the agenda or Schedule 12A of the Local Government Act should contact:-

Customer Services Centre 0300 500 80 80

(3) Persons making a declaration of interest should have regard to the Code of Conduct and the Council's Procedure Rules. Those declaring must indicate the nature of their interest and the reasons for the declaration.

Councillors or Officers requiring clarification on whether to make a declaration of interest are invited to contact Martin Gately (Tel. 0115 977 2826) or a colleague in Democratic Services prior to the meeting.

(4) Councillors are reminded that Committee and Sub-Committee papers, with the exception of those which contain Exempt or Confidential Information, may be recycled.

(5) This agenda and its associated reports are available to view online via an online calendar - http://www.nottinghamshire.gov.uk/dms/Meetings.aspx

Nottinghamshire County Council

minutes

Meeting	HEALTH AND WELLBEING BOARD
Date	Wednesday, 4 September 2019 (commencing at 2.00 pm)

Membership
Persons absent are marked with an 'A'

COUNTY COUNCILLORS

Steve Vickers (Chair)
Joyce Bosnjak
Glynn Gilfoyle
Francis Purdue-Horan
Martin Wright

DISTRICT COUNCILLORS

	David Walters	-	Ashfield District Council
	Susan Shaw	-	Bassetlaw District Council
	Colin Tideswell	-	Broxtowe Borough Council
	Henry Wheeler	-	Gedling Borough Council
	Debbie Mason	-	Rushcliffe Borough Council
	Neill Mison	-	Newark and Sherwood District Council
A	Amanda Fisher	-	Mansfield District Council

OFFICERS

Melanie Brooks	-	Corporate Director, Adult Social Care and Health
Colin Pettigrew	-	Corporate Director, Children and Families Services
Jonathan Gribbin	-	Director of Public Health

CLINICAL COMMISSIONING GROUPS

A	Dr Nicole Atkinson	-	Nottingham West Clinical Commissioning Group

A	Dr Thilan Bartholomeuz	-	Newark and Sherwood Clinical Commissioning Group
	Andrea Brown	-	Nottingham and Nottinghamshire CCG
	Nicole Chavaudra		Bassetlaw Clinical Commissioning Group
A	Idris Griffiths	-	Bassetlaw Clinical Commissioning Group
	Dr Jeremy Griffiths	-	Rushcliffe Clinical Commissioning Group (Vice-Chair)
A	Dr James Hopkinson	-	Nottingham North and East Clinical Commissioning Group
A	Dr Gavin Lunn	-	Mansfield and Ashfield Clinical Commissioning Group

LOCAL HEALTHWATCH

A Sarah Collis - Healthwatch Nottingham & Nottinghamshire

NOTTINGHAMSHIRE POLICE AND CRIME COMMISSIONER

Kevin Dennis

OTHER COUNCILLORS IN ATTENDANCE

Councillor John Wilmott - Ashfield District Council
Councillor Hannah Land - Broxtowe District Council
Councillor Lynne Schuller – Bassetlaw District Council

OFFICERS IN ATTENDANCE

Kerrie Adams	-	Public Health
Helena Cripps	-	Public Health
Amanda Fletcher	-	Public Health
Nicola Lane	-	Public Health
Edward Shaw	-	Public Health
Sarah Quilty	-	Public Health
Martin Gately	-	Democratic Services

OTHER ATTENDEES

David Wakelin	-	Gedling Borough Council
Dave Banks	-	Rushcliffe Borough Council

MINUTES

The minutes of the last meeting held on 5 June 2019 having been previously circulated were confirmed and signed by the Chairman.

APOLOGIES FOR ABSENCE

Apologies for absence had been received from Sarah Collis, Healthwatch, Councillor Amanda Fisher, Mansfield District Council and Idris Griffiths, Bassetlaw CCG.

DECLARATIONS OF INTEREST BY BOARD MEMBERS AND OFFICERS

None.

CHAIRS' REPORT

David Wakelin made a presentation regarding the recently established Nottinghamshire Violence Reduction Unit (VRU). The VRU Board is chaired by the Police and Crime Commissioner and key contributions are made to it by Colin Pettigrew and Jonathan Gribbin. Viewing the issue of violence reduction through a public health lens assists in gaining a deeper understanding of the root cause of why violence occurs e.g. Adverse Childhood Experiences.

Work is taking place with schools and also to utilise youth workers in custody suites in order to utilise that moment of opportunity. There is evidence that considerable progress is being made.

In response to a question from Dr Griffiths on what success would look like, Mr Wakelin indicated that reduced attendances at Accident & Emergency Departments for knife-related injuries as well a reduction in the statistics for GBH and attempted murder.

In response to further questions from Councillor Gilfoyle regarding resourcing, Mr Wakelin explained that there would be funding for next year.

Mr Dave Banks of Rushcliffe Borough Council provided details to the Board of the Safer Nottinghamshire Board's work to counter scams and fraud against the vulnerable and elderly. This is an issue affecting every district and every street and can result in mental health issues and even suicide. Victims can be targeted many times, and loneliness only serves to make the elderly more vulnerable.

An operational action plan is being developed, and it was highlighted that fraud is the most commonly experienced crime, as well as being grossly underreported.

Councillor Vickers commented that there was a need to upskill the population and make them more aware of the activities of scammers, as well linking this to what's happening in the banking industry.

RESOLVED: 2019/023

That:

1) The contents of the report be noted, and any actions required by the Board in relation to the issues raised be considered.

HEALTH AND WELLBEING BOARD ACTIONS TO REDUCE THE HARM CAUSED BY DRINKING ALCOHOL AT HARMFUL LEVELS

Amanda Fletcher and Sarah Quilty, Public Health, introduced the report, the purpose of which was to confirm the actions agreed by the Health and Wellbeing Board to reduce alcohol related harm in Nottinghamshire through the delivery of the Nottingham and Nottinghamshire Integrated Care System (ICS) Alcohol Harm Reduction Plan and Bassetlaw Integrated Care Provider (ICP) approaches, with a key focus on identifying how Alcohol Identification and Brief Advice (IBA) can be embedded in frontline services and for employee health and wellbeing approaches.

Councillor Bosnjak commented that there was a need to have a better understanding of why people use alcohol as a coping mechanism, e.g. problems at work – as well as to replace it with a different coping mechanism. Ms Quilty explained that IBA identified the need and once referred to treatment the success rate was high.

In response to a question from Councillor Mason, Ms Quilty indicated that further training could be delivered where required.

In response to a comment from Councillor Shaw regarding engaging in partnership working in order to avoid duplication, Ms Fletcher stated that a tailored action plan was being developed.

Dr Griffiths applauded the IBA initiative but registered some concern if a large number of people were to be taken out of the system in order to be trained. He also referred to the change in how alcohol is consumed by young people with people now heading into the City Centre in the same state they used to come out due to pre-loading.

RESOLVED: 2019/024

That:

The Health and Wellbeing Board and individual partners consider and approve the following local actions which demonstrate leadership and commitment to reducing alcohol-related harm in Nottinghamshire and are consistent with the Nottingham and Nottinghamshire ICS alcohol harm reduction plan and Bassetlaw ICP approaches:

Support and advocate for organisational cultural change regarding Alcohol

1. Health and Wellbeing Board members act as “Alcohol Champions” within their own organisations - being the named link person, actively promoting the topic of alcohol

harm reduction and ensuring local actions (taken from the Alcohol Harm Reduction Plan) are delivered by the relevant officer within their organisation.

2. Health and Wellbeing Board members acknowledge their already agreed commitment in supporting the workplace health agenda by ensuring alcohol harm reduction is explicitly covered in their organisations existing employee health and wellbeing plans/activities.

Roll out Alcohol IBA training within organisations

3. Health and Wellbeing Board members engage with senior level colleagues in their organisations to identify their frontline services who could be trained in Alcohol IBA by CGL and then support CGL to make those links with key personnel, including with Human Resources leads for employee health and wellbeing.
4. Once CGL IBA training dates are in place, Health and Wellbeing Board members will champion and promote the training sessions to increase the number of staff trained in Alcohol IBA within their organisation.

Continuous improvement of Alcohol IBA training

5. Health and Wellbeing Board members commit to reporting back on the effective delivery of Alcohol IBA within their organisation, by giving future progress updates to the Health and Wellbeing Board on how Alcohol IBA training is being implemented within their frontline services and for employee health and wellbeing.

Wider system working to deliver on the Alcohol Harm Reduction Plan

6. Health and Wellbeing Board members note that public health colleagues intend to undertake a stakeholder mapping exercise to ensure appropriate partner organisation representatives are in place across the various working groups that deliver on the alcohol agenda (for example across the Healthy and Sustainable Places Co-ordination Group, the Nottinghamshire Alcohol Pathways Groups and the Nottingham and Nottinghamshire ICS Human Resources and Organisational Development Collaborative). The results of the stakeholder mapping, and in particular any gaps in representation which need to be addressed, will be shared with the Health and Wellbeing Board members once completed.

7. The Healthy & Sustainable Places Co-ordination Group will co-produce and drive forward wider local alcohol harm reduction actions (for example alcohol licensing) which were not the focus of the workshop

2019/20 FIRST QUARTER BETTER CARE FUND PERFORMANCE AND PROGRAMME UPDATE

Paul Johnson, Service Director, Strategic Commissioning, Adult Access and Safeguarding presented the report, the purpose of which was to set out the progress to date against Nottinghamshire Better Care Fund performance targets, and to update the Board on the 2019/20 BCF planning timetable as well as the work to develop a more collaborative approach to the use of the Disabled Facilities Grant (DFG). Mr Johnson said that further to a previous request from the Board, the report now contained more depth and context.

Councillor Bosnjak queried what the figures were in terms of readmission, and what the real impact was on people's lives. Mr Johnson explained that BCF 3 looked at readmission and that 83% of people remain at home.

Councillor Shaw cited the example of some people not being aware of the Rapid Response Team and some people being transferred home without the offer of support from this team. Mr Johnson indicated that the team was now working very closely with other teams, but this sort of information was of assistance in further developing services.

RESOLVED: 2019/025

That:

1) The 2019/20 BCF performance targets, set in line with national and local organisational requirements be approved.

2) The process whereby the 2019/20 BCF Plan will be submitted to NHS England by 27th September 2019, pending subsequent approval by the Board on 6th November 2019.

APPROVAL OF THE JSNA CHAPTER – 1001 DAYS, CONCEPTION TO AGE 2

Jonathan Gribbin, Director of Public Health, Kerrie Adams, Senior Public Health Commissioning Manager and Helena Cripps, Public Health Commissioning Manager introduced the report, the purpose of which was to request the Board's approval of the JSNA Chapter – 1001Days, Conception to Age 2.

Mr Gribbin indicated that the JSNA Chapters were developed with partners, and that the NHS has a statutory duty to have regard of them when commissioning services. In addition, Ms Cripps explained that the chapter considers both maternal health and early child development, and will replace the current JSNA chapter on pregnancy.

Councillor Wheeler emphasised the importance of alcohol reduction and cessation, and the impact of foetal alcohol syndrome. Ms Adams explained that while alcohol is not specifically mentioned in the chapter, there would be engagement with maternity services.

RESOLVED: 2019/026

That**:**

1. The new 1001 Days Joint Strategic Needs Assessment (JSNA) Chapter be approved.

WORK PROGRAMME

The December meeting would now be formal meeting of the Board rather than a workshop.

The Chairman thanked Nicola Lane for her work supporting the Health and Wellbeing Board since 2010.

RESOLVED 2019/0027

That:

1) the report be noted.

The meeting closed at 15:34

CHAIR

Nottinghamshire County Council

Report to the Health & Wellbeing Board

6 November 2019

Agenda Item:4

REPORT OF THE CHAIR OF THE HEALTH & WELLBEING BOARD

CHAIR'S REPORT

Purpose of the Report

1. An update by Councillor Steve Vickers on local and national issues for consideration by Board members to determine implications for Board matters.

Information

2. **Nottingham & Nottinghamshire Suicide Prevention Strategy and Action Plan 2019-23**
Suicide has a devastating and long-lasting impact on individuals, families, communities and society. In Nottinghamshire, 168 deaths by suicide occurred over the three year period of 2015-17. Suicide is complex, with many causes and risk factors. However, it is possible to prevent suicides by identifying risks, addressing them and acting to reduce the impact on those it affects.

The Government recommends that all local areas develop suicide prevention strategies to consider these risks in a local context. Nottinghamshire County and Nottingham City's current strategies end this year and a new joint strategy and action plan have been developed for 2019-23.

A public consultation on the strategy took place in July / August. Feedback informing the final strategy and plan were approved by the Nottingham & Nottinghamshire Suicide Prevention Steering Group on 8 October 2019.

Delivery of the action plan will be overseen by the steering group to ensure the priority areas of the strategy are addressed across Nottinghamshire. These include:

- Identifying and addressing at-risk groups
- Use of local data
- Bereavement support
- Staff training
- Working with the media.

3. **Action on dementia**
A new action plan to increase awareness and improve the lives of people living with dementia in Nottinghamshire has been approved by the Adult Social Care & Public Health Committee. This is a refresh of a previous Dementia Declaration action plan and has been developed collaboratively by colleagues from Public Health, Social Care and Community Friendly Nottinghamshire teams.

Aims of the plan include:

- Making Nottinghamshire County Council a Dementia Friendly organisation and supporting partners and communities to become Dementia Friendly
- Promoting healthy lifestyle choices that help people live well with dementia or delay the onset of the condition, and ensure more tailored support for carers
- Providing training and encouraging the take-up of assistive technology for people living with dementia
- Engaging with people living with dementia by asking them what works well and what changes they would like to see
- Identifying, promoting and delivering quality standards and best practice in services used by people with dementia.

A press release is available online.

4. **Nottinghamshire Health & Care Portal (NHCP)**

Since the end of August, Nottinghamshire County Council employees in frontline adult social care roles can now access health information for service users within Mid and South Nottinghamshire. This has helped many colleagues gather information quicker and make better decisions on care. Overall usage and feedback will be monitored over the coming months.

Nottinghamshire County Council's social care data will also be available via the portal by the end of the year. This will help inform health staff if there is involvement from social care and enable access to contact some providers directly. Health staff across organisations are keen to have this information to speed up decision making and prevent unnecessary referrals or queries to social care colleagues.

5. **2019-20 Flu Campaign**

Flu can be a serious illness, particularly for older people or those with other health conditions. Nottinghamshire County Council is working with partners to increase the uptake of the flu vaccination amongst frontline staff and vulnerable residents.

Health and social care workers care for some of the most vulnerable people within communities, so it is important they help protect themselves, and those receiving care, against flu. Plans are in place to align Nottinghamshire County Council with NHS partners in increasing the number of health and social care workers receiving a free vaccination. On-site clinics are being offered to staff at the main County Council sites so they can have their flu jab whilst at work, in addition to supplementary clinics in a number of care settings. There have also been 'myth-busting' sessions to help frontline staff understand the potential impact of flu on service users.

Arrangements are in place with partner organisations to support the uptake of the flu vaccination. Resources have been sent to a variety of settings such as schools, children's centres and care homes, to promote uptake amongst at-risk groups.

For more information, please contact Nicola Lane (email: nicola.lane@nottscc.gov.uk).

6. **Delivering Health & Social Care Tasks policy**

The *Delivering Health and Social Care Tasks* policy replaces the *Responsibilities for Care in the Home* policy which was written in 2010. It describes the responsibilities of community nursing

services and domiciliary services in delivering health and social care tasks in an individual's own home. The policy will be supported by robust protocols and procedures, a learning and development programme, competency assessments and clinical oversight delivered in partnership with health organisations.

It aims to have a positive impact on health and social care workers by helping to embed the changes and ensure that staff are trained and competent to deliver the new low-level medication and healthcare tasks. Implementation of the policies will ensure the right support is provided at the right time in the most cost effective way. It is anticipated the policy will result in cost efficiencies through better use of resources.

7. **Review of the START Assisting with Medication Policy**

The Assisting with Medication policy has been updated as a result of a recent review. This is aimed at Short Term Assessment & Re-ablement Team (START) re-ablement support workers that are operating in the homes of service users.

Nottinghamshire County Council staff are now able to offer support to service users with new tasks. The policy will be supported with robust protocols and procedures, learning and development, competency assessments and oversight by appropriate healthcare professionals. Furthermore, the amendments will bring Nottinghamshire in line with support which is offered in neighbouring authorities.

There are several benefits to this review, including:

- More efficient and effective medication management for service users with support from health colleagues
- Greater consistency and continuity for staff and those in receipt of the service
- Upskilling of staff
- A reduction in the number of delayed discharges from the acute trusts
- Provision of a more cost effective way in which to manage medication as part of a larger support offer.

8. **Bassetlaw Transport Summit**

In September 2019, partners from bus and rail companies, Nottinghamshire County Council, the NHS, and community transport organisations convened for a transport summit. This aimed to identify how Bassetlaw could get better connected, reduce isolation and optimise opportunities for more effective use of collective transport resources.

Outcomes from the event included exploration of bus services between hospital sites in Bassetlaw and Doncaster, how transport could be more inclusive for people with additional needs, and making better use of voluntary sector opportunities. A report is available online.

9. **Inclusive Employment in Bassetlaw**

An Inclusive Employment event took place in Bassetlaw on 18 October 2019. This was sponsored by Cerealto (a large employer in Worksop) and provided businesses with insights from Bassetlaw District Council, the NHS, Department for Work & Pensions, Building Better Opportunities, and Working Win, about how inclusive employment practices can support recruitment and retention and result in better wellbeing for the workforce.

Employment can be good for health and wellbeing, particularly for groups where there may be barriers to work, such as care leavers, ex-offenders and those with long term health conditions or

Special Educational Needs. The event was successful in connecting employers with sources of support in Bassetlaw. A report is available onine.

10. **Gedling Borough Council Spatial Planning & Health Workshop**

There is a wealth of evidence that well-designed homes and communities can make a significant contribution to improving the health and wellbeing of residents. In recognition of this, Nottinghamshire County Council (i.e. Public Health, Planning Policy, and Development Management) are working with district and borough councils across a range of disciplines (i.e. Planning Policy, Development Management, Community Relations, Housing, Economic Growth, and Public Protection) to support work in this area.

A recent workshop took place at Gedling Borough Council on 10 September 2019, including a variety of local authority services and Clinical Commissioning Groups. A round table approach was used to discuss healthy place-making using the principles within the Nottinghamshire Spatial Planning & Health Framework and Nottinghamshire Rapid Health Impact Assessment Checklist. The workshop also covered case studies presented by Active Derbyshire & Nottinghamshire, Rushcliffe Borough Council, NHS Rushcliffe Clinical Commissioning Group and the Nottingham & Nottinghamshire Estates team.

A number of practical and positive actions have been identified to support improvements for the health and wellbeing of residents in Gedling.

Given the success of the events, further workshops are being made available to other district and borough councils in Nottinghamshire. For more information, please contact Jenny Charles Jones (email: jenny.charles-jones@nottscc.gov.uk) or Nina Wilson (email: nina.wilson@nottscc.gov.uk).

PROGRESS FROM PREVIOUS MEETINGS

11. The Healthy & Sustainable Places Coordination Group met on 17 September 2019. This included the following items:
    - A presentation on 'Our approach to Neighbourhoods' from Newark & Sherwood District Council, on behalf of the Mid Nottinghamshire Integrated Care Provider
    - A report on physical activity
    - A report on the food environment
    - Presentations on the structure and governance of Integrated Care Systems, Integrated Care Providers and Primary Care Networks
    - The future work programme and development of a delivery framework.

PAPERS TO OTHER LOCAL COMMITTEES

12. **Adult Social Care & Public Health Alignment to Two Integrated Care System Architecture for Bassetlaw, Mid Notts & South Notts**
    Report to Adult Social Care & Public Health Committee
    9 September 2019

13. **Nottinghamshire County Council Refreshed Dementia Declaration Action Plan 2019-2022**
    Report to Adult Social Care & Public Health Committee
    9 September 2019

14. **Childhood Obesity Trailblazer**
    Report to Adult Social Care & Public Health Committee
    9 September 2019

15. **Public Health Intelligence Support to the Integrated Care System**
    Report to Adult Social Care & Public Health Committee
    9 September 2019

16. **Progress of Partnership Strategy for Nottinghamshire Looked After Children and Care Leavers (2018-21)**
    Report to Children & Young People's Committee
    16 September 2019

17. **Safer Nottinghamshire Board Update**
    Report to Policy Committee
    18 September 2019

INTEGRATED CARE SYSTEMS AND INTEGRATED CARE PROVIDERS

18. **Bassetlaw Integrated Care Partnership bulletin**
    October 2019

19. **Nottingham & Nottinghamshire Integrated Care System board papers**
    October 2019

A GOOD START IN LIFE

20. **Children's oral health**
The Faculty of Dental Surgery at the Royal College of Surgeons of England has issued a position statement on children's oral health. This statement updates the position on children's oral health in light of developments since 2015, and sets out a series of recommendations that describe how the government can build upon what has already been achieved. It focuses on three key areas central to eliminating child tooth decay: prevention, access, and education.

21. **Preventing offending and re-offending by children**
Public Health England has published information on collaborative approaches to preventing offending and re-offending by children. This resource outlines how health, education, social care, criminal justice, voluntary sector services and others can work together to stop children and young people offending.

22. **Serious youth violence**
A report from the Home Affairs Committee describes the rise in serious youth violence as a social emergency and argues that young people have been failed by an inadequate response to the rise in knife related offences. It finds that the government's 'public health' approach to violence is not reflected on the ground and calls for this issue to be addressed through much more concerted government action at a national and local level.

23. **Tackling family homelessness**

The Children's Commissioner has published *Bleak houses: Tackling the crisis of family homelessness in England*. This report focusses on children who are living in homeless families and those children who are at risk of becoming homeless. It summarises visits to children and families living in temporary accommodation and some of the frontline professionals working with them. It also analyses new data in order to identify the scale of the problem. See also: Children's Commissioner press release.

24. **Childhood obesity**
The Royal Society for Public Health has published *Routing out childhood obesity*. This report outlines recommendations for transforming the street environment, particularly around schools, with the ambition that all children should have access to a healthy route home.

25. **The Good Childhood Report 2019**
This report from The Children's Society finds that young people's happiness is at its lowest since 2009, due to issues around boys' appearance, friendships and school as potential driving factors.

26. **A manifesto for children**
The Children's Commissioner has published *A Manifesto for Children*. This calls on Britain's political parties to include a six-point plan in their election manifestos to transform the life chances for disadvantaged children and to help children to thrive. The key themes are: supporting stronger families, providing decent places for children to live, helping children to have healthy minds, keeping children active, providing Special Educational Needs & Disability support for those who need it, and creating safer streets and play areas.

27. **Mental health and the journey to parenthood**
Healthwatch has published a document on mental health and the journey to parenthood. This report shares what parents have said about their experiences of mental health problems during and after pregnancy, and calls on services to give people more opportunities to talk about their mental wellbeing. See also: Healthwatch news item.

HEALTHY & SUSTAINABLE PLACES

28. **Attitudes towards emergency care**
The National Centre for Social Research has published the results from the British Social Attitudes Survey relating to attitudes towards emergency care. These results consider whether people share concerns of policy-makers about over-use of emergency services and whether public attitudes and perceptions suggest strategies put forward to tackle this issue might be successful. They reveal significant differences in perspectives by a range of socio-demographic factors, such as area deprivation, age, young children in the household and gender. See also: NIHR press release and the BSA survey press release.

29. **NHS Health Checks Review**
The Department of Health & Social Care has announced there will be an evidence-based review of the NHS Health Check service. The review will explore new predictive checks which take age, risk factors and lifestyle into account. It will examine how to improve the system with a focus on offering personalised interventions. The review will also explore a special check-up for people approaching retirement age, increasing the range of advice the checks can offer, ways to increase the uptake of health checks, and the digitisation of health checks where appropriate.

30. **Patient experience**

QualityWatch has published its latest indicator update which examines how patient experience of NHS and social care services has changed over time. It uses data from national patient surveys to compare the experience of different NHS and social care services. Overall, access to GP services has worsened, experience of inpatient services has improved, and satisfaction with adult social care services has remained stable. In general, people report their experiences of children and young people's services and maternity services more positively than their experiences of emergency departments and community mental health services.

31. **Public health, prevention and health improvement**

The Local Government Association (LGA) has published *Public health, prevention and health improvement*. This prospectus outlines the programme of sector-led improvement support available through the LGA and partners, and the early support arrangements for local authorities with performance challenges in public health. It also signposts to other support and resources.

32. **Tackling loneliness**

The House of Commons has published a briefing paper on *Tackling loneliness*. This paper examines the Government's Loneliness Strategy published in October 2018 and outlines current progress. It also looks at research into the causes and impact of loneliness, and possible interventions.

33. **Going the extra step: A compendium of best practice in dementia care**

The Housing Learning & Improvement Network have published a case study report. This provides examples of extra care schemes and other housing-related community services which support people with dementia to develop meaningful relationships, thereby reducing social isolation and loneliness.

34. **Towards equality for mental health**

The Mental Health Policy Group has published *Towards equality for mental health: developing a cross-government approach*. This report considers the steps that may be required if the ambition of 'parity of esteem' for mental health is to be achieved in England.

35. **Mental health implementation plan**

The Healthcare Financial Management Association has published a summary of the NHS mental health implementation plan from 2019-24.

36. **Mental health care for young people and young adults**

The Healthcare Quality Improvement Partnership has published information on mental healthcare in young people and adults. This review focusses on mental healthcare provided to young people from the perspective of the overlap between physical and mental healthcare, the quality of physical and mental healthcare provided, and how patients with mental health conditions use healthcare services. The aim of this study was to identify areas of care that can be improved for all patients aged between 11-25 years.

37. **Saturated fats and health**

The Scientific Advisory Committee on Nutrition has published a report on saturated fats and health. This considers the relationship between saturated fats, health outcomes and risk factors for non-communicable diseases in the general UK population. See also: Consultation responses on the draft report and PHE press release.

38. **Preventing Sexually Transmitted Infections**

Public Health England has published *Health Matters: preventing Sexually Transmitted Infections (STIs)*. This edition of focuses on the prevention of five common STIs: gonorrhoea, chlamydia, syphilis, genital herpes, and genital warts. It also covers the public health challenge of antimicrobial-resistant STIs, and the commissioning and improvement of sexual health services.

39. **Sexual and reproductive health commissioning**
The Local Government Association has published *Collaboration and cooperation: sexual and reproductive health commissioning*. This report summarises how local authorities can endeavour to create a responsive and proactive sexual health service through the creation of strong commissioning networks and expert groups.

40. **Homes for older people**
Homes for Later Living have published an analysis of the fiscal and wellbeing benefits of building more homes for later living. This report explores the wellbeing benefits and significant fiscal savings that homes for later living could provide. See also: press release.

41. **Identifying the health care system benefits of housing with care**
The Housing Learning & Improvement Network and Southampton City Council have published the results of a study that highlights the healthcare system benefits of housing with care. The study identified benefits including improvements to the residents' quality of life, reductions in the use of health services and associated resources, and significant cost-benefits for the health system. Although the research focuses on Southampton, the findings will be of interest to planners and commissioners of services across the country.

42. **Physical activity guidelines**
The Department of Health & Social Care has published a report from UK Chief Medical Officers on the amount and type of physical activity people should be doing to improve their health. This draws upon global evidence to present guidelines for different age groups, covering the volume, duration, frequency and type of physical activity required across the life course to achieve health benefits. The guidelines are designed to aid health professionals and others to provide individuals and communities with information on the type and amount of physical activity that they should undertake to improve their health. See also: DHSC press release and DHSC physical activity infographics.

43. **Cardiovascular disease prevention**
Public Health England and the Association of Directors of Public Health have published a summary of an effective Cardiovascular Disease prevention programme. It synthesises existing evidence, examples of best practice, practitioners' experiences, and consensus expert opinions.

44. **Creating healthy lives**
The Health Foundation has published: *Creating healthy lives: a whole-government approach to long-term investment in the nation's health*. This paper suggests five significant changes needed to improve health across the whole of government. See also: Health Foundation press release.

45. **Health inequalities in older populations in coastal and rural areas**
Public Health England has published a report on the health inequalities experienced by older populations in coastal and rural areas, with a summary of key considerations to reduce

inequalities and promote healthy ageing in these areas. It comprises a literature review supplemented with case studies.

HEALTHIER DECISION MAKING

46. **Smoking, drinking and drug use among young people in England in 2018**
NHS Digital have published a report on a biennial survey of secondary school pupils in England in the school years 7-11 (mostly aged 11-15), focussing on smoking, drinking and drug use. It covers a range of topics including prevalence, habits, attitudes, and for the first time in 2018, wellbeing.

47. **Minimum Unit Pricing for alcohol in Scotland – evidence of success**
In 2018, Scotland become the first country in the world to introduce a national Minimum Unit Pricing (MUP) policy on alcohol, setting a limit of 50p per unit below which alcohol cannot be sold. A recent research study, published in the British Medical Journal, shows evidence the policy is affecting drinking trends positively.

The study examined the impact of the MUP policy on the amount of alcohol purchased, and the cost, in the 34 weeks immediately after implementation. The findings show each adult bought 9.5g less alcohol per week, a reduction of 7.6%.

These observed reductions are more than double what was initially estimated, highlighting that the health benefits of such a policy could be considerably greater than originally thought.

48. **Alcohol consumption in Europe**
The World Health Organisation has published a status report on alcohol consumption, harm and policy responses in 30 European countries, including the United Kingdom. The report summarises changes in alcohol consumption and alcohol-related harm between 2010-16. See also: WHO press release.

49. **Sugar reduction: progress between 2015-18**
This report includes a detailed assessment of progress by the food industry between 2015-18, towards meeting the 20% reduction ambition by 2020 for the sugar reduction programme.

There was an overall 2.9% reduction in sugar (sales weighted average sugar per 100g) since 2015 in the in-home / retailer-manufacturer sector. Some categories have shown greater progress (i.e. yogurts / fromage frais, and breakfast cereals, have reduced sugar by 10.3% and 8.5% respectively).

There was a 4.9% reduction (simple average sugar per 100g) since 2017 in the out-of-home sector.

The report also covers progress made on sugary drinks covered by the Soft Drinks Industry Levy, introduced in April 2018. The average sugar content of the drinks covered by the levy decreased by 28.8% between 2015-18.

50. **Gambling related harm reduction**
The Association of Directors of Public Health Yorkshire and Humber Problem Gambling Working Group has published a public health framework for gambling harm related reduction. This

framework summarises a variety of possible interventions aimed at reducing gambling related harm.

WORKING TOGETHER TO IMPROVE HEALTH & CARE SERVICES

51. **Public Health England strategy**

Public Health England have published a 2020-25 strategy. This document outlines how Public Health England will work to protect and improve the public's health, and reduce health inequalities, over the next five years. It includes the following 10 strategic priorities:

- Smoke-free society: take steps towards creating a smoke-free society by 2030
- Healthier diets, healthier weight: help make the healthy choice the easy choice to improve diets and reduce rates of childhood obesity
- Creating cleaner air: develop and share advice on how best to reduce air pollution levels and people's exposure to polluted air
- Better mental health: promote good mental health and contribute to the prevention of mental illness
- Best start in life: work to improve the health of babies, children and their families to enable a happy healthy childhood and provide the foundations of good health into adult life
- Effective responses to major incidents: enhance the ability to respond to major incidents (including pandemic influenza) by strengthening the health protection system
- Reduced risk from antimicrobial resistance: work to help contain, control and mitigate the risk of antimicrobial resistance
- Predictive prevention: utilise technology to develop targeted advice and interventions and support personalised public health and care at scale
- Enhanced data and surveillance capabilities: improve data capability and strengthen approach to disease surveillance using new tools and techniques
- New national science campus: transition to a new national science campus with state-of-the-art facilities at Harlow.

52. **Public Health England infectious diseases strategy**

Public Health England have published a 2020-25 strategy for combatting infectious diseases. It includes the following 10 strategic priorities:

- Optimise vaccine provision and reduce vaccine preventable diseases in England
- Be a world leader in tackling Antimicrobial Resistance (AMR)
- Capitalise on emerging technologies to enhance data and infectious disease surveillance capability
- Eliminate Hepatitis B and C, Tuberculosis and HIV, and halt the rise in sexually transmitted infections in our population
- Strengthen the response to major incidents and emergencies, including pandemic influenza
- Build evidence to address infectious diseases linked with health inequalities
- Embed Whole Genome Sequencing (WGS) in Public Health England labs and optimise the use of WGS-based information
- Integrate and strengthen England's Health Protection System
- Strengthen Global Health activities to protect health in the UK and globally
- Define the value generated by delivering the infectious diseases strategy.

53. **Achieving integrated care**

The Social Care Institute for Excellence and the Local Government Association have published *Achieving integrated care: 15 best practice actions*. This practical resource supports local

systems in fulfilling their ambition of integration. The fifteen actions prioritised in this resource draw on evidence about what works from international research, emerging best practices and engagement with stakeholders and partners.

54. **'People' not 'beds'**
Recent changes have been agreed to the use of language across health and social care in relation to Delayed Transfers of Care (DTOC). The purpose of this plan is to drive change so that organisations refer to (and report on) people delayed within hospitals, rather than the beds they occupy. Through doing so, it is hoped to highlight the harmful impact that can result from prolonged hospital stays and delayed discharges (such as deconditioning).

55. **Improving identification of people with a learning disability**
The NHS Long Term Plan commits to improve health care for people with a learning disability. To assist practices to ensure they have an accurate and complete register of patients with a learning disability, NHS England and NHS Improvement have published *Improving identification of people with a learning disability: guidance for general practice*. Practices have been asked to ensure that eligible patients are offered a flu vaccination and flagged for an annual health check.

56. **Healthy New Towns**
NHS England and NHS Improvement have published a series of documents examining the Healthy New Towns programme. This worked with 10 demonstrator sites across England to explore how the development of new places could create healthier and connected communities with integrated and high-quality services.

57. **The value of community services**
The Healthcare Financial Management Association has published *The value of community services: helping people stay happy, healthy and independent*. This briefing is the second of a series looking at how services delivered in the community add value to both the patient and the wider health & care economy. This report focuses on the role that community services play in preventing illness or reducing exacerbations.

GENERAL

58. **Health Profile for England 2019**
Public Health England have published the 2019 edition of the Health Profile for England, providing a comprehensive snapshot of the nation's health. Recent decades have seen overall improvements to many aspects of early-years health, including a decrease in teenage conceptions, smoking in pregnancy, the proportion of babies with low birthweights and infant deaths. However, over the last few years some of these improvements have started to slow down, with no improvement seen in infant mortality rates or the proportion of low birthweight babies. Tooth decay, the biggest cause of hospital admissions for children aged 6-10 years, also remains a serious problem despite being largely preventable. See also: PHE Blog.

59. **Spending Round 2019**
HM Treasury has published Spending Round 2019. This sets out the government's spending plans for 2020-21.

60. **Spending Round analysis**

The King's Fund has published *Five numbers to sum up the Spending Round for health and social care*. This examines the key numbers mentioned in the Spending Round and the implications they have for health and social care.

61. **Updated EU exit operational guidance**
The Department of Health & Social Care has published updated operational guidance for healthcare providers and commissioners on how to manage the risks of a no-deal EU exit.

62. **Protecting the supply of medicines if there is a no-deal EU exit**
Information for patients on the NHS website has recently been updated and explains the government's approach to ensure that medicines continue to be available if there is a no-deal EU exit. Frequently asked questions on the NHS England website, which support discussions between healthcare professionals and patients about medicines and medical products, have also been updated.

63. **Service user experience**
Healthwatch has published *What people have told us about health and social care*. This outlines the feedback Healthwatch has received from users of health and social care services between April and June 2019. It also summarises how Healthwatch England is using this information to shape health and social care policy and practice. See also: Healthwatch news release.

64. **Creating a learning culture in social care**
Healthwatch has published *Creating a learning culture in social care*. This summarises findings from a desk-based audit of local authority annual complaints reports. It encourages local authorities to handle complaints with openness and transparency, treating complaints reports as an opportunity to tell a powerful story of learning and improvement.

65. **Health inequalities: place-based approaches to reduce inequalities**
Public Health England, the Association of Directors of Public Health, and the Local Government Association, have developed guidance on place-based approaches to reduce health inequalities. This aims to support co-ordinated action between local government, the NHS, and the voluntary and community sectors.

CONSULTATIONS

66. **Survey for the National Rehabilitation Centre**
The Clinical Commissioning Groups across Nottingham and Nottinghamshire are launching a four-week phase of public engagement on proposals to develop a National Rehabilitation Centre (NRC).

The proposals aim to improve the health and wellbeing of people across Nottingham and Nottinghamshire, by improving access to high quality rehabilitative care and helping patients improve skills and functioning for daily living that have been lost or impaired due to sickness, injury or disability.

The NRC is being developed on the Stanford Hall Rehabilitation Estate, situated in Nottinghamshire. The site also hosts the Defence Medical Rehabilitation Centre, which provides rehabilitation services to military personnel. There has been an ambition to treat NHS patients and military personnel at the Stanford Hall Rehabilitation Estate from its inception, with a recognition that this benefits both the defence medical services and the NHS.

The NRC will provide services that cover the East Midlands Major Trauma Network, which means patients from across the region will be treated at the facility. It is intended the NRC will be a regional clinical unit and national centre of excellence, national training & education centre, and research & innovation hub.

A programme of patient engagement is being undertaken by Clinical Commissioning Groups over the coming weeks. This will involve talking to patients, carers and families who may be affected by the development of the NRC. The engagement programme will build on conversations that have taken place already with patients. It is supported by Healthwatch and the Clinical Commissioning Group patient committees.

A public survey has been created which is available to complete online. The survey will remain open until 1 November 2019.

Clinical Commissioning Group and the NRC Programme Board will consider the feedback from patients alongside any clinical and financial considerations when developing final options and proposals. Final proposals may form a formal public consultation in the future.

Other Options Considered

67. Not applicable.

Reason/s for Recommendation/s

68. To identify potential opportunities to improve health and wellbeing in Nottinghamshire.

Statutory and Policy Implications

69. This report has been compiled after consideration of implications in respect of crime and disorder, data protection and information governance, finance, human resources, human rights, the NHS Constitution (public health services), the public sector equality duty, safeguarding of children and adults at risk, service users, smarter working, sustainability and the environment and and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

Financial Implications

70. There are no financial implications arising from this report.

RECOMMENDATION/S

1) To consider whether there are any actions required by the Health & Wellbeing Board in relation to the issues raised.

Councillor Steve Vickers
Chairman of Health & Wellbeing Board

For any enquiries about this report please contact:

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Constitutional Comments (LW 23/10/2019)

71. Health and Wellbeing Board is the appropriate body to consider the content of the report.

Financial Comments (DG 23/10/2019)

72. There are no specific financial implications arising directly from this report.

Background Papers and Published Documents

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.

- None

Electoral Division(s) and Member(s) Affected

- All

Nottinghamshire County Council

Report to the Health & Wellbeing Board

6 November 2019

Agenda Item:5

REPORT OF THE DIRECTOR OF PUBLIC HEALTH

ANTIMICROBIAL RESISTANCE

Purpose of the Report

1. The purpose of this report is to:

   - Raise awareness of the issues associated with antimicrobial resistance
   - Highlight national and local action that has taken place to help address antimicrobial resistance
   - Identify how Health & Wellbeing Board members can support the antimicrobial resistance agenda.

Information

Why is antimicrobial resistance a concern?

2. Antimicrobial resistance (AMR) poses a significant threat to the entire population and demands a local, national and global response beyond the confines of the medical community. AMR arises when the micro-organisms that cause infection evolve to survive exposure to a medicine that would normally kill them or stop their growth. The term antimicrobial includes antibiotic, antiprotozoal[1], antiviral and antifungal medicines. Resistance is a natural biological phenomenon but is increased and accelerated by various factors such as unnecessary use or misuse of antimicrobial medicines, poor infection control practices and global spread through trade and travel. This is a particular concern with antibiotics.

3. Before the advent of antimicrobials, even a simple cut had the potential to kill if it became infected. Antimicrobials make it possible to carry out routine surgery, make childbirth safer and protect cancer patients whilst their immune systems are weakened by chemotherapy. Without effective antimicrobial treatments, simple infections will once again kill people and cancer treatment or surgery will have to be weighed against the possibility of death through infection. The rise and spread of AMR is creating a new generation of 'superbugs' that cannot be treated with existing medicines.

[1] Antiprotozoal drugs are a class of medication used to treat infections caused by protozoa, which are single cell organisms either free-living or parasitic.

4. Inappropriate and over-use of antimicrobials is the main cause of AMR. According to a 2018 House of Commons Report[2], antimicrobial use is rising across the world, with global consumption of antibiotics increasing by nearly 40% between 2000 and 2010, which is in turn accelerating the rate at which resistance is developing. In the UK, it is estimated that 20% of prescriptions are inappropriate[2] and there is also an increasing expectation from patients to receive antibiotics. Antimicrobial use in animals is also of concern, where antibiotics have in the past been added routinely to animal feed or given to a whole herd when only one or two animals have been infected.

5. Professor Dame Sally Davis, former Chief Medical Officer, described AMR as a 'catastrophic threat' and stated that if action is not taken, 'modern medicine will be lost'. Similarly, the World Health Organisation states: 'There is no time to wait. Unless the world acts urgently, antimicrobial resistance will have disastrous impact within a generation'[3]. The estimate of global mortality from AMR across the world by 2050 is ten million people per year, which would represent a greater death toll than cancer and diabetes combined[4]. Those at most risk of resistant infections are care home residents, people who are immuno-compromised, and those who travel to specific countries or have multiple health care contacts or courses of antibiotics.

6. An increase in AMR places a greater burden on both health and social care services. The estimated cost to the NHS of treating drug-resistant infections with more expensive alternatives is £180 million per year. However, there are not always alternative treatments available, particularly given the fact that no new classes of antibiotics have been developed for over thirty years. No reliable estimates have yet been modelled for the financial impact on adult social care caused by AMR, but the burden is undoubtedly considerable and upfront investment in the prevention of infection occurring in the first place is crucial.

7. A recent review[5] of the impact of five types of antibiotic resistant bacteria in Europe has identified significant increases in the burden associated with resistant infections. This is measured in the number of cases, attributable deaths and disability-adjusted life-years[6] (DALYs), which includes the increased need for long term health and social care. There was an overall increase in the burden between 2007 and 2015, with the largest impact in the countries with the higher rates of multi-resistant infections and in the under-1 and over-65 year old age groups (see Figures 1 and 2 overleaf).

[2] https://publications.parliament.uk/pa/cm201719/cmselect/cmhealth/962/962.pdf
[3] https://www.who.int/antimicrobial-resistance/interagency-coordination-group/IACG_final_report_EN.pdf?ua=1
[4] https://publications.parliament.uk/pa/cm201719/cmselect/cmhealth/962/962.pdf
[5] https://www.thelancet.com/journals/laninf/article/PIIS1473-3099(18)30605-4/fulltext
[6] One DALY can be thought of as one lost year of "healthy" life. The sum of these DALYs across the population, or the burden of disease, can be thought of as a measurement of the gap between current health status and an ideal health situation where the entire population lives to an advanced age, free of disease and disability.

Figure 1 Model estimates of the burden of infections with antibiotic-resistant bacteria of public health importance in DALYs, EU and European Economic Area, 2015

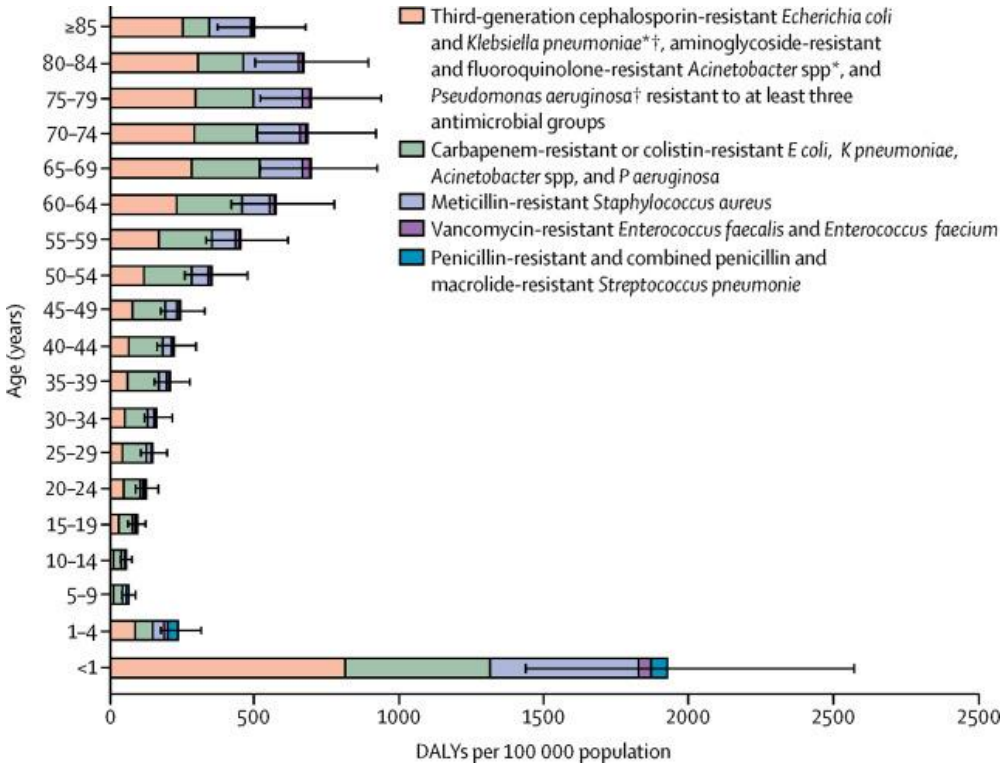
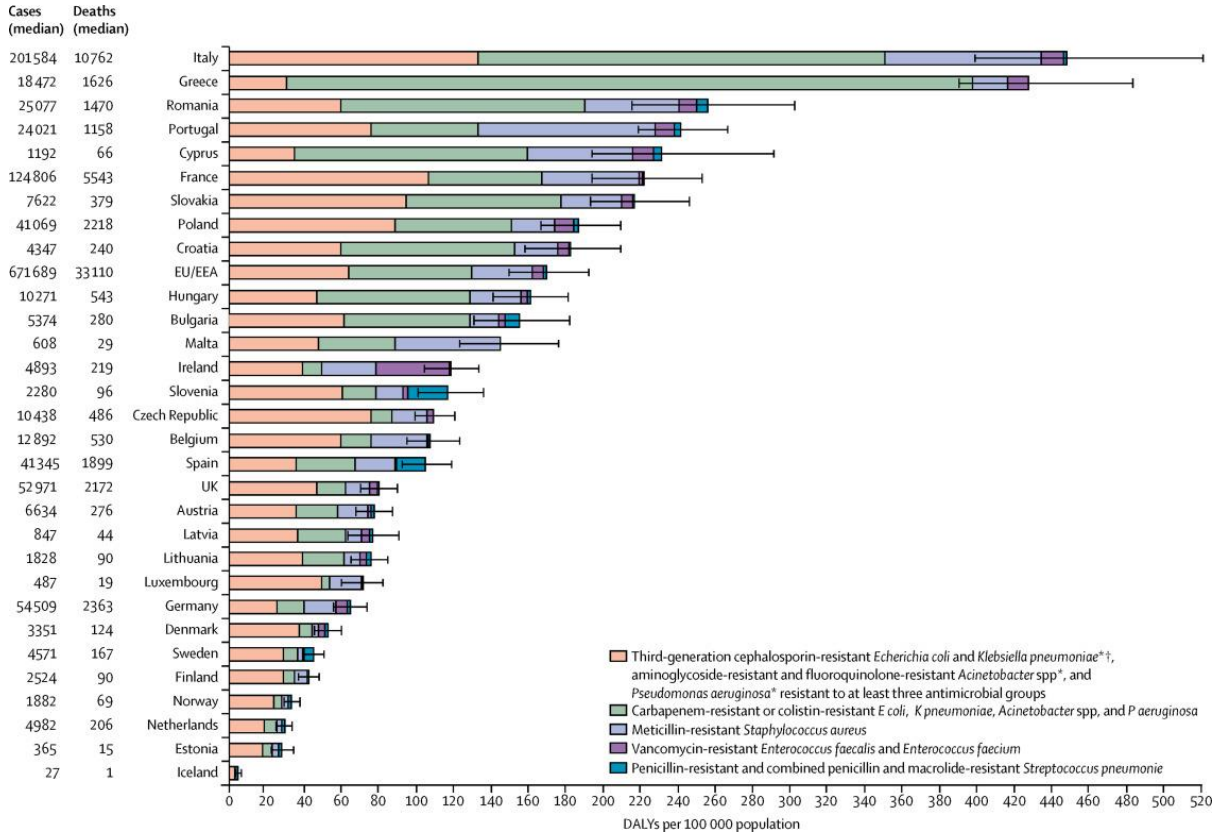


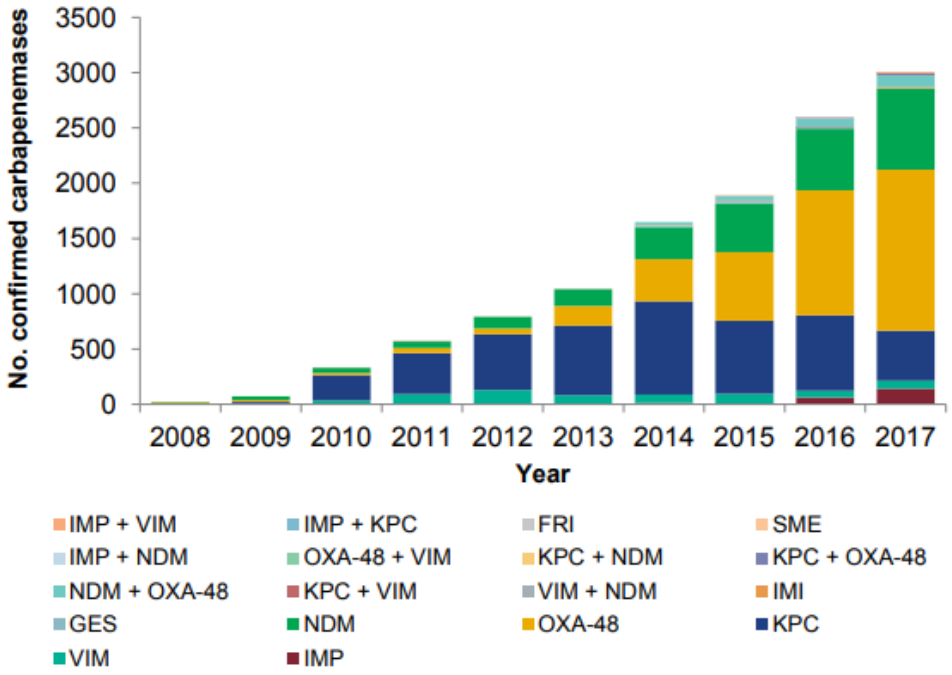
Figure 2 Burden of infections with antibiotic-resistant bacteria in DALYs, EU and European Economic Area, 2015



Local issues

8. In Nottinghamshire, there has been a significant decrease in infections caused by resistant *S. aureus* strains (MRSA), but in some areas there have been an increasing number of cases colonised[7] or infected with multi-resistant Gram-negative organisms[8], including carbapenemase producing enterobacteriaceae (CPE)[9]. Initially all cases had acquired CPE in healthcare settings abroad, but in the last few years we have also experienced cases in Nottinghamshire and the East Midlands which have not had this risk factor and, worryingly, numbers have significantly increased in other areas in England with multiple different mechanisms of resistance (Figure 3).

Figure 3 Number of confirmed CPE isolates referred to PHE's AMR Healthcare Acquired Infection Reference Unit, 2008-17(England[10]) (*Note: the three letter acronyms below indicate the names of the different identified carbepanemasae enzymes*)



[7] Colonisation describes the growth of bacteria on body sites exposed to the environment (such as the skin, mouth, intestines or airway), without causing any infection.

[8] Gram-negative bacteria are classified by the colour that they turn after a chemical process called Gram staining is used on them. Gram-negative bacteria counter-stain red and Gram-positive bacteria keep the original purple stain due to differences in their cell walls.

[9] Enterobacteriaceae are bacteria that can live in the gut of humans and animals. Most of the time they are harmless and there are no signs or symptoms because a person's immune system keeps them in check. If they get into other parts of the body (such as the urine or the bloodstream), they can cause an infection that needs treatment. Patients who have a weakened immune system may be more at risk of developing infection. Enterobacteriaceae which have become resistant to carbapenems are 'carbapenem resistant enterobacteriaceae' (CRE), and those that have become so by producing a carbapenemase enzyme are 'carbapenemase producing enterobacteriaceae' (CPE). CPE infections can be very difficult to treat because they are often resistant to multiple classes of antibiotics.

[10] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/759975/ESPAUR_2018_report.pdf

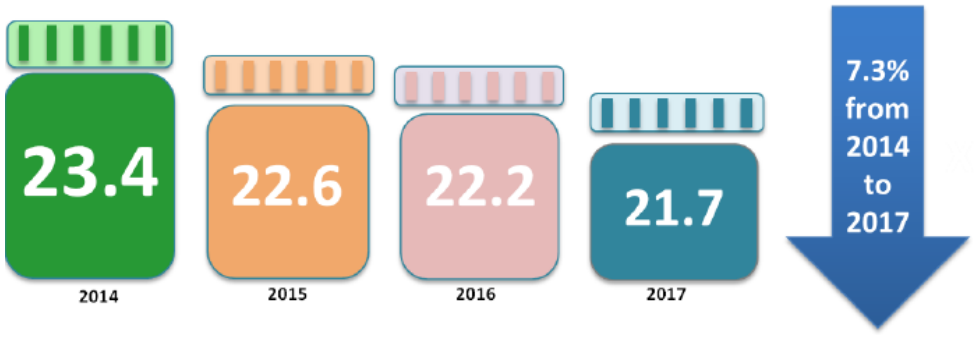
How is AMR being addressed nationally?

9. The Government initially launched its five year UK strategy to tackle AMR in 2013 and earlier this year a renewed action plan was published, Tackling Antimicrobial Resistance (2019-2024)[11], alongside the UK's 20-year Vision for Antimicrobial Resistance[12]. The action plan is also supported in the NHS Long Term Plan (2019) and focuses on three key ways of tackling AMR:
    - Reducing the need for, and unintentional exposure to, antimicrobials
    - Optimising the use of antimicrobials
    - Investing in innovation, supply and access.

10. Along with global efforts to tackle AMR, the UK has identified six key areas for action:
    - Improving infection prevention and control (IPC) practices in animals and humans
    - Optimising prescribing practice
    - Improving professional education, training and public engagement
    - Developing new drugs, treatments and diagnostics
    - Improving access to, and use of, surveillance data
    - Identifying and prioritising AMR research needs.

11. Over the last five years there have been a range of approaches to improving IPC practices in humans (e.g. regulations, audits of practice, and training and vaccination of healthcare workers). There has also been significant progress in reducing IPC in animals and voluntary targets have been set. Various initiatives have been put in place to optimise prescribing and, as a result, there has been a significant reduction in antibiotic consumption since 2014 as outlined in Figure 4. The reduction in antibiotic consumption has also been mirrored in the animal health sector, where the amount of antibiotics sold for UK food-producing animals has reduced by 40% (Figure 5).

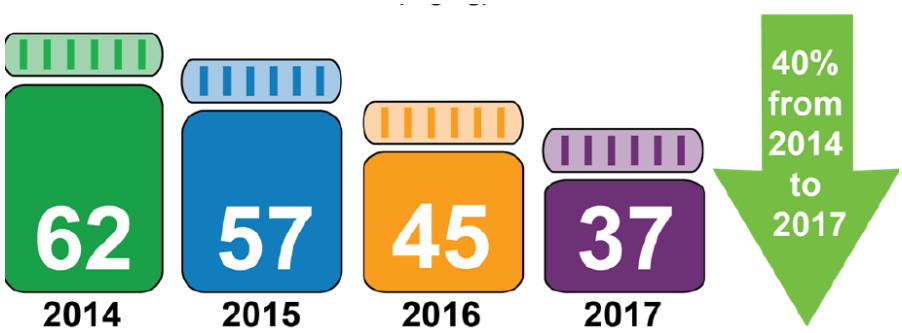
Figure 4 Amount of antibiotics consumed in the UK (defined daily doses per 1000 inhabitants per day)



[11] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/784894/UK_AMR_5_year_national_action_plan.pdf

[12] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/773065/uk-20-year-vision-for-antimicrobial-resistance.pdf

Figure 5 Amount of antibiotics sold for use in UK food-producing animals (milligrams of active ingredient per kilogram of bodyweight, mg/kg)



How is AMR being addressed locally?

12. In response to the national 2013 five-year AMR strategy, the Nottinghamshire Antimicrobial Stewardship (AMS) Group was formed in 2015. The group has expanded over time and now has cross-sector representation working to agree and deliver a common message. It is unique in that it has veterinary, dentistry, private, acute, community, public health (Public Health England and local authority), GP and lay representation. The group does not have identified resource to drive the AMS agenda, but relies on organisational membership to contribute to deliverables.

13. The original aim of the AMS Group was to identify what work was already being delivered across Nottinghamshire in each of the areas of the national strategy and how to address any gaps. An AMS work plan was produced as a result of this and has been refined over the subsequent years and in response to the most recent Government publications.

14. In line with the identified actions in the national strategy, the AMS group prioritised working on: a) improving professional education, training and public engagement; and b) improving local antibiotic guidance and prescribing, for example documentation of allergy status and improving the diagnosis and management of urinary tract infections (UTIs). It has also addressed other areas, such as prevention of infections (especially in care homes) and improving the diagnosis of infection.

15. Key achievements for the group to date include:
    - Cross-organisation working to develop and agree local communication campaigns, such as the highly successful '1,2,3 Healthy Wee' hydration poster.
    - Winning a national Antibiotic Guardian award in 2017.
    - Raising local concerns about online prescribing at a national level.
    - Being the first area to successfully introduce the national change in treatment of UTIs and seeing a resultant decrease in trimethoprim (antibiotic) resistant E. coli UTIs.
    - Supporting the promotion of world antibiotic awareness weeks with cross-organisational agreed messages, including a Nottinghamshire antibiotic amnesty to safely dispose of unused antibiotics (which was given a prime-time slot on the local BBC news) and a local AMR message under the national 'keep antibiotics working campaign', which successfully reached over 200,000 people using social media.
    - Sharing of hospital initiatives, including the use of specialty consultant antimicrobial champions to help support appropriate prescribing.

- Running a successful multi-agency communications and training campaign, supported by Nottinghamshire County Council, which was undertaken to inform residents about overuse or misuse of antibiotics and to encourage a reduction in demand.

16. To improve prescribing within GP practices, clinical commissioning groups (CCGs) have been required to work to national Quality Premium (QP) antibiotic targets. The QP scheme is about rewarding CCGs for improvements in the quality of the services they commission. The scheme also incentivises CCGs to improve patient health outcomes, tackle inequalities and improve access to services. The antibiotic targets aim to reduce total antibiotic prescribing and encourage narrow spectrum antibiotic prescribing[13].

17. The CCGs review their QP targets on a monthly basis. The first target is the number of antibiotic items (prescriptions) prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR-PUs), which monitors the volume of prescribing. The target has recently been updated, changing from being equal to or below the England mean of 1.161 to now being equal to or below 0.965. Figure 6 shows that there are currently three CCGs achieving this target (Nottingham North & East, Nottingham West and Rushcliffe), and the direction of travel for all CCGs is positive (Figure 7 overleaf).

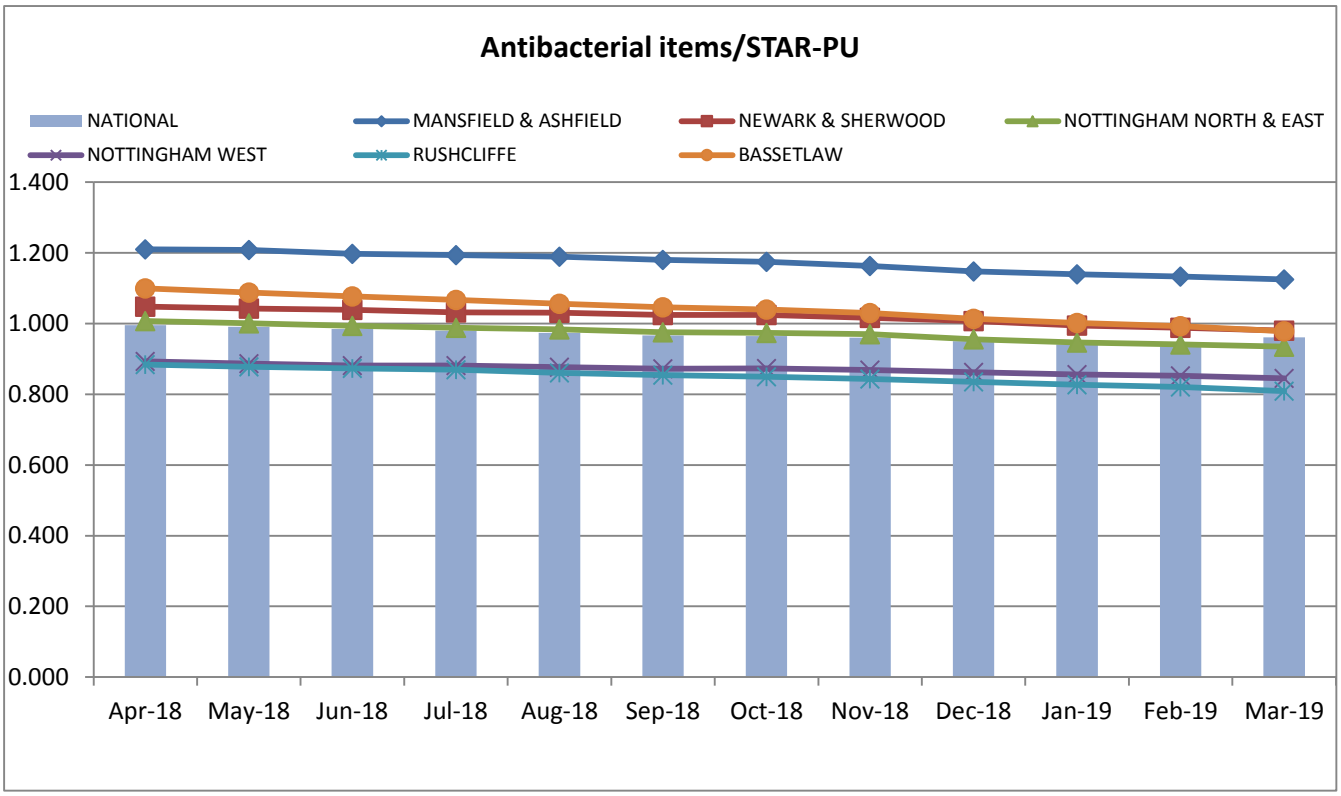
Figure 6 Antibiotic prescribing volumes in Nottinghamshire, 2018/19

Commissioner (CCG)	Antibacterial items/STAR-PU (new target <0.965) (April 2018 – March 2019, 12-month rolling average)
Bassetlaw	0.978
Mansfield & Ashfield	1.125
Newark & Sherwood	0.98
Nottingham North & East	0.935
Nottingham West	0.845
Rushcliffe	0.809

18. The second target looks at the proportion of prescriptions where the antibiotic prescribed is either co-amoxiclav, cephalosporin or a quinolone. The aim is to reduce the prescribing of these antibiotics, as they are broad spectrum antibiotics. Although powerful, broad-spectrum antibiotics[14] pose specific risks, particularly the disruption of native, normal bacteria and the development of antimicrobial resistance. Narrow spectrum antibiotics are active against a selected group of bacterial types and are used for the specific infection when the causative organism is known. They will not kill as many of the normal microorganisms in the body as the broad-spectrum antibiotics.

[13] In the case of narrow-spectrum antibiotics, the range of bacteria that are targeted by the medication is small. These antibiotics are designed only to treat a specific type of bacteria.
[14] Broad spectrum antibiotics are formulated to destroy a large number of different types of bacteria. They are effective against a wide range of infections caused by a variety of bacteria. They are designed to attack several strains and species of bacteria.

Figure 7 Antibiotic prescribing volumes in Nottinghamshire, 2018-19



19. The national target is for the proportion of broad-spectrum antibiotic prescriptions to be below 10% of antibiotic prescriptions written. The results in Figure 8 show that all local CCGs are currently achieving this target.

Figure 8 Broad-spectrum antibiotic prescribing volumes in Nottinghamshire, 2018-19

Commissioner (CCG)	Proportion of co-amoxiclav, cephalosporin & quinolone items (April 2018 – March 2019, 12-month rolling average)
Bassetlaw	4.83%
Mansfield & Ashfield	7.66%
Newark & Sherwood	8.36%
Nottingham North & East	8.94%
Nottingham West	7.25%
Rushcliffe	8.11%

20. To support practices to achieve their targets, antibiotic prescribing is included in each practice's annual CCG prescribing visit. These visits highlight to prescribers the requirement to adhere to Nottinghamshire-wide Area Prescribing Committee antimicrobial guidance and to promote the national targets. Prescribers are also signposted to the use of local and national resources, which include patient leaflets, audit toolkits, posters and videos for use in patient waiting areas. In addition, each prescriber is encouraged to become an Antibiotic Guardian to promote messages about antibiotic resistance.

What are the local issues and how might they be addressed?

21. Good progress has been made so far locally, but there are further challenges that the Antimicrobial Stewardship (AMS) Group is looking to address:
    - There is evidence to suggest there is a higher demand for, and reliance on, antibiotics in some cultural groups. The AMS Group plans to review public awareness materials and adapt the message to different age and cultural groups, particularly under-served populations, such as the homeless, Gypsy, Roma & Travellers and those where English is not the first language. The AMS Group would welcome support from Health & Wellbeing Board partners to engage with and promote messages to key groups.
    - Documentation of antibiotic allergy status, particularly penicillin, is an issue. The Group is working with the NUH allergy service to improve the diagnosis and communication in relation to this.
    - Whilst it remains an aspiration, none of the Nottinghamshire hospital trusts currently have an e-prescribing system, which makes real time feedback, intervention of antimicrobial prescribing issues and promotion of guidelines more difficult.
    - The introduction of point of care/near patient diagnostic tests to improve the diagnosis of infection in the community (including in care homes) and reduce unnecessary antibiotic use has been difficult to introduce locally and there is no funding stream to support their introduction.
    - There is potential for community pharmacies to play a more active role in promoting antimicrobial stewardship to the public and the group aims to look into this, ensuring appropriate training is available.
    - Although training around infection prevention and control has taken place with care home and domiciliary care workers, there is an ongoing need for the development of multi-agency training strategies due to the turnover of workers in this area.

Other Options Considered

22. No other options were considered.

Reason/s for Recommendation/s

23. The Health & Wellbeing Board is well-placed to exert a positive influence upon agencies across the health and social care economy and, in turn, upon members of the public who use their services.

Statutory and Policy Implications

24. This report has been compiled after consideration of implications in respect of crime and disorder, data protection and information governance finance, human resources, human rights, the NHS Constitution (public health services), the public sector equality duty, safeguarding of children and adults at risk, service users, smarter working, sustainability and the environment and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

Financial Implications

25. There are no direct financial implications arising from this report. However, the long-term financial implications to the health and social care sector of inaction in relation to AMR are considerable.

RECOMMENDATIONS

The stewardship of antimicrobials is a health protection issue that affects the whole population and requires multi-agency ownership. Members of the Health & Wellbeing Board are asked to consider:

1) Promoting awareness of antimicrobial resistance and infection prevention with their employees and service users, using resources from the Antimicrobial Stewardship Group.

2) Providing advice and support to the Antimicrobial Stewardship Group with the delivery of antimicrobial resistance and infection prevention messages across Health & Wellbeing Board partners and their networks, specifically to under-served populations such as the homeless, Gypsy, Roma & Travellers and those where English is not the first language.

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Chair of the Nottinghamshire Antimicrobial Stewardship Group

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NHS Newark & Sherwood Clinical Commissioning Group
Greater Nottingham Clinical Commissioning Partnership

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Constitutional Comments (LW 23/10/19)

26. Health and Wellbeing Board is the appropriate body to consider the content of the report.

Financial Comments (DG 23/10/2019)

27. There are no specific financial implications arising directly from this report.

Background Papers and Published Documents
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.

- NHS Long Term Plan (https://www.england.nhs.uk/long-term-plan/)
- Tackling Antimicrobial Resistance (2019-24) (https://www.gov.uk/government/publications/uk-5-year-action-plan-for-antimicrobial-resistance-2019-to-2024)
- UK 20-Year Vision for Antimicrobial Resistance (https://www.gov.uk/government/publications/uk-20-year-vision-for-antimicrobial-resistance)
- House of Commons Report on Antimicrobial Resistance (2018) (https://www.gov.uk/government/publications/uk-20-year-vision-for-antimicrobial-resistance)
- World Health Organisation: Securing the Future from Drug Resistant Infections (2019) (https://www.who.int/antimicrobial-resistance/interagency-coordination-group/IACG_final_report_EN.pdf?ua=1)
- Public Health England: English Surveillance Programme for Antimicrobial Utilisation and Resistance (2018) (https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/759975/ESPAUR_2018_report.pdf)

Electoral Division(s) and Member(s) Affected

- All

Nottinghamshire County Council

Report to the Health & Wellbeing Board

6 November 2019

Agenda Item:6

REPORT OF THE DIRECTOR OF PUBLIC HEALTH

APPROVAL OF JSNA CHAPTER: HEALTH & HOMELESSNESS

Purpose of the Report

1. To request that the Health & Wellbeing Board approve the Health & Homelessness Joint Strategic Needs Assessment (JSNA) chapter.

2. This report contains an executive summary of the chapter. The Board will be approving the full chapter which is available as an appendix to this report and for review at Nottinghamshire Insight.

Information

3. Shelter defines homelessness as not having a home. You are homeless if you have nowhere to stay and are living on the streets, but you can be homeless even if you have a roof over your head. You count as homeless if you are:
    - staying with friends or family
    - staying in a hostel, night shelter or B&B
    - squatting (because you have no legal right to stay)
    - at risk of violence or abuse in your home
    - living in poor conditions that affect your health
    - living apart from your family because you don't have a place to live together.

4. Homelessness is an issue of concern across the country and Nottinghamshire is not exempt from this picture. Homelessness is a far wider problem than the aspect that is most visible to the public – rough sleeping, which is considered the tip of the iceberg.

5. The causes of homelessness and who is most at risk of homelessness and rough sleeping is complex and warrants action to both address those that are at risk of and who are currently homeless as well as attention to how we can prevent homelessness in the future. This can only be done by agencies from across the public sector working together in a more systematic and joined up way over an extended period.

6. People who are homeless experience worse health outcomes than the general population. Consequently, the focus of this JSNA chapter is on the physical and mental health needs of the homeless population as well as identifying who is at greatest risk of

becoming homeless, the causes of homelessness and evidence of what works to prevent homelessness and respond to homelessness when it arises.

7. This JSNA chapter was endorsed by the Homeless Executive Steering Group with additional feedback provided by local organisations that formed the JSNA steering group or contributed towards the local views section. Whilst this JSNA chapter does not replace any previous version it does provide a more up-to-date narrative on the health and wellbeing of those who are homeless than the 'Assessment of the impact of housing on health and wellbeing' (2013) JSNA chapter and builds on the 'Assessment of the Health Needs of Single Homeless People in Nottinghamshire' (2013).

Unmet needs and service gaps

8. Housing and health need in Nottinghamshire must be set in the context that levels of statutory homelessness and rough sleeping remain low in the County and well below the England average. However, rough sleeping numbers have shown a steady increase since 2010, with variation across districts and boroughs, and higher rates occurring in Mansfield and Bassetlaw. This gives an indication of a rising level of unmet health, social, welfare or housing need.

Housing supply and welfare

9. This JSNA has highlighted a number of factors that are known to affect availability of affordable and appropriate housing, in particular for the most vulnerable populations at risk of homelessness due to complex needs and debt arrears. Specific issues highlighted within this JSNA include:
    - Lack of affordable housing
    - Housing benefit set at rates lower than landlords can obtain in rent on the open market
    - Private landlords unwilling to consider housing people in receipt of benefits
    - Private rental barriers to housing people aged under 35 years
    - Need for support in tenancy to prevent eviction
    - Housing options to support people with experience of homelessness and existing rent arrears
    - Recent trend in increased use of bed and breakfast accommodation in some areas within Nottinghamshire.

10. Whilst approaches to address housing supply in these cases are critically important to securing positive outcomes and reducing homelessness, these are covered within the Homelessness Strategies produced by local housing authorities. Therefore, the recommendations of this JSNA will focus on the non-housing risk factors leading to homelessness and how these wider needs can be met.

11. It is clearly acknowledged that neither housing approaches nor wider health and social care support can be truly effective in isolation to prevent homelessness. These needs are interconnected and therefore implementing effective solutions requires dedicated and strongly aligned partnership working.

Primary prevention approaches

12. The role of upstream primary prevention initiatives is not yet fully understood or embedded within strategic approaches, either nationally or locally.

13. This is likely driven by, amongst other factors:
    - The need to focus limited local resources on addressing the most acute and immediate needs of those at risk of homelessness
    - The diffuse and system wide nature of risk factors leading to homelessness.

14. It is recognised that a range of local provision which commissioners currently invest in has the potential to significantly contribute to the prevention of poor outcomes through homelessness. These include, but are not limited to:
    - Debt, tenancy sustainment and welfare advice
    - Veteran support strategies
    - Housing adaptations secured through disabled facilities grant
    - Substance misuse services
    - Domestic abuse and sexual violence support services
    - Family mediation
    - Coping and resilience approaches in school settings
    - Improving Access to Psychological Therapies (IAPT), talking therapies, social prescribing and befriending initiatives
    - Employment support
    - Ex-offender support strategies.

15. It is difficult and possibly counter productive to identify unmet need in any single preventative approach, in particular as evidence points to the fact that those at risk of homelessness are far from a homogenous cohort and benefit from personalised approaches taking into account a range of support needs.

16. The opportunity across existing primary prevention approaches is for commissioners and providers to recognise that housing plays a critical role in health and wellbeing outcomes, and the services they provide have additional benefits of reducing future risk of homelessness. Strong joint working across services alongside improved awareness and skills in considering the housing needs of clients has the potential to maximise health outcomes for clients with complex needs within existing resource. The ‘duty to refer’ introduced in the Homelessness Reduction Act provides an opportunity to engage a wider frontline workforce on the impact of housing on health and identify needs earlier.

Early Intervention and support

17. Consultation with local stakeholders showed a perception that support where available was not well known about, nor readily accessible. There was also a perception that support was not offered early enough and did not cover the broad range of the needs experienced by service users. Whilst the introduction of the Homelessness Reduction Act may address the need for earlier identification and support to some extent, consideration needs to be given to how support offers can be made more visible and accessible. In particular, for individuals who experience complex needs or chaotic lifestyles consideration needs to be given to targeted or tailored outreach approaches which reduce the barriers to engaging with services for support, in order to reduce the risk of exclusion and worsening health inequalities.

18. Services and commissioners may also need to consider how the profile of available support can be raised in frontline settings, to facilitate a ‘no wrong front door’ approach to support at the point of care.

Governance and leadership

19. The wide range of services which have a role in supporting better health outcomes for those at risk of homelessness means that strong governance and leadership is needed at strategic level, to drive, support and hold to account effective delivery across a partnership. Stakeholders have described current partnership arrangements as operational rather than strategic, which may limit effectiveness to drive system change such as strategic commissioning of care pathway approaches. The Rough Sleeping Strategy suggests the introduction of Homelessness Reduction Boards which would take on the role of leading system change.

Healthcare

20. Users of homeless services locally have reported particular barriers to accessing healthcare appointments and mental health services. This can be considered in the context that national evidence shows individuals who are rough sleeping or in temporary accommodation are high users of healthcare. The combination of difficulties accessing care, with high levels of health need (mental and physical) leads to high volume service use for potentially preventable conditions. In order to better meet the healthcare needs of this population, flexible, innovative and targeted approaches are needed which specifically address the barriers presented by having no fixed abode, no access to transport, multiple health needs and in some cases chaotic lifestyles. Some examples of such innovative practice have been piloted in primary and secondary care settings in Nottinghamshire but are not as yet commissioned in line with population need in an integrated approach. Given the relatively small numbers of individuals who present with high levels of complex need or in crisis (as compared to the population as a whole), a targeted approach, delivered in settings most accessible to homeless individuals, with high levels of support and case management, is most likely to be effective in meeting need. Effectiveness is likely to be enhanced by delivery alongside providers with existing trusted relationships in homeless communities.

21. This JSNA highlights that substance misuse, musculoskeletal (MSK), dental and respiratory problems are likely to be the most prevalent physical health needs, along with a broad range of presenting common and severe mental health conditions. In addition, homeless populations face inequalities in access to screening programmes for both communicable and non-communicable conditions. Inclusion health standards highlight that providing equitable care in this population requires opportunistic approaches to offer screening and treatment.

Integrated commissioning and care pathways

22. Both service users and commissioners have reflected that commissioned support appears fragmented, potentially duplicative, and in some cases with lack of clarity as to thresholds and eligibility criteria. Where service users present with multiple or complex needs this can result in multiple assessments, referrals and delays in care, which in a worst-case scenario leads to disengagement by the service user and difficulty in supporting recovery within temporary accommodation settings. One strategy to support service users in navigating care is the use of a case worker, however it is unclear whether case worker capacity is sufficient to meet existing needs, and fragmented care pathways will also impact on the effectiveness of case workers themselves.

23. The service gaps particularly noted include management of support for those with mental health and/or social care needs, although interactions between all services are perceived as challenging.

24. Therefore, there is a critical need for commissioners (together with providers) to work jointly in creating effective care pathways which will deliver better value for individual services through more efficient processes, and better outcomes for service users through co-ordinated person-centred approaches.

25. The evidence base suggests that care-pathways designed around critical time intervention, identifying high risk groups at specific points, such as discharge from prison or other institutions, can offer an effective risk stratified approach. Examples of such approaches are currently being trialled as part of the Rapid Rehousing Pathway, providing navigators for prisons, hospitals and mental health. To maximise the opportunities for effectiveness in these pilots, specific partner commitment is needed for:
    - Robust evaluation and sharing of learning across the local system
    - Development of integrated care pathways which address wider health and social needs in addition to housing provision
    - Development of sustainable financial investment to embed effective practice emerging from the pilot.

Knowledge gaps

26. This JSNA has relied on a combination of local views, local commissioned research and national data to develop a picture of health needs for those at risk of homelessness. There is very little reliable local data available to allow robust assessment of the scale of homelessness and the range of local health need.

27. This is a gap mirrored at national level and highlighted in the Rough Sleeping Strategy. Further work is needed for commissioners and providers to routinely collate and share information locally on the risk factors and health, housing and social care needs of those accessing services, as a starting point for estimating true population health need. It is expected that the new Homelessness Case Level Information Collection (H-CLIC) data collection will provide some useful data to better quantify need in those owed a support duty.

Recommendations for consideration by commissioners

28. A number of recommendations have emerged to establish and or strengthen strategic arrangements, improve carepathways and plan for more collaborative commissioning in order to prevent homelessness and improve health outcomes across Nottinghamshire.

Recommendation		Lead(s)
Strategic Leadership, Governance and Partnership Working		
1.	Establish formal governance arrangements in line with Ministry of Housing, Communities and Local Government (MHCLG) proposals for a **Homelessness Reduction Board**, to provide leadership and accountability for improving health and homelessness outcomes, including delivery of JSNA recommendations.	Housing Authorities, Commissioners of Supported Housing
2.	Establish a coordinated or integrated strategic commissioning forum to address gaps in provision and enable effective care pathways across housing, social care, mental health and primary and secondary healthcare.	Housing Authorities, Supported Housing Commissioners, Clinical Commissioning Groups, Adult and Children's Social Care
3.	Identify opportunities through the Homelessness Strategies of Nottinghamshire Housing Authorities to support prevention and early identification of homelessness by partners across the system, including best use of duty to refer.	Housing Authorities
4.	Consider the recommendation of the Rough Sleeping Strategy that strategic leadership is provided through a dedicated Homelessness lead on the Health and Wellbeing Board.	Health and Wellbeing Board
Integrated Commissioning and Care Pathways		
5.	Develop and implement a commissioned care pathway for critical time intervention with specific high-risk groups: ex-offenders, mental health needs, veterans, substance misuse.	Strategic Commissioning Forum
6.	Identify opportunities to align funding to evidence based primary prevention of homelessness, including through family mediation, debt advice, healthy lifestyles, tenancy sustainment initiatives, and education/support in at risk groups.	Homelessness Reduction Board
7.	Develop the healthcare offer across primary, secondary and community care to meet the specific health needs of those with no fixed abode or in temporary accommodation, in line with inclusion health standards.	CCG, Healthcare providers
8.	Identify opportunities to strengthen effectiveness of Street Outreach and Rapid Rehousing Pathway initiatives through system wide engagement, pathway development and advocacy for longer term funding settlements.	Homelessness Reduction Board

Recommendation		Lead(s)
9.	Identify and implement strategies for opportunistic screening and treatment for communicable diseases including blood borne viruses and tuberculosis, in settings most accessible to at risk homeless populations.	Public Health England (PHE), Health Protection Strategic Group, CCG
Implementation - Service Models, evaluation and data collation		
10.	Embed evidence based psychological approaches to managing and recovering from complex trauma into front line delivery of service, including Psychologically Informed Environments and trauma informed services (ReACH).	Service Providers
11.	Develop robust and shared methods for data collation and evaluation for existing services, to improve local knowledge of risk factors and health needs for those at risk of homelessness.	Strategic Commissioning Forum
12.	Develop a strategic assessment of the Housing First model, as an option for securing long term health and social gains for individuals with complex and enduring needs, including substance misuse.	Strategic Commissioning Forum
13.	Develop shared protocols across service provision to improve accessibility and visibility of early identification and support options.	Service Providers

Other Options Considered

29. Not applicable.

Reason/s for Recommendation/s

30. As stated earlier in this report the causes of homelessness and who is most at risk of homelessness and rough sleeping is complex and warrants action to both address those that are at risk of and who are currently homeless as well as attention to how we can prevent homelessness in the future. This can only be done by agencies from across the public sector working together in a more systematic and joined up way over an extended period.

Statutory and Policy Implications

31. This report has been compiled after consideration of implications in respect of crime and disorder, data protection and information governance, finance, human resources, human rights, the NHS Constitution (public health services), the public sector equality duty, safeguarding of children and adults at risk, service users, smarter working, sustainability and the environment and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

Financial Implications

32. There are none arising from this report although the findings and recommendations will inform local commissioning decisions.

RECOMMENDATION

1) That the Health & Wellbeing Board approves the Health & Homelessness Joint Strategic Needs Assessment chapter.

Jonathan Gribbin
Director of Public Health

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Constitutional Comments (LW 22/10/2019)

Financial Comments (DG 23/10/19)

34. There are no specific financial implications arising from this report.

Background Papers and Published Documents

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.

- Nottinghamshire Health and Wellbeing Board: Joint Health and Wellbeing Strategy 2018-2022

Electoral Division(s) and Member(s) Affected

- 'All'

Nottinghamshire Health & Wellbeing Board

Topic information	
Topic title	Health and Homelessness JSNA
Topic owner	Homeless Executive Steering Group
Topic author(s)	John Sheil, Public Health and Commissioning Manager Susan March and Nick Romilly Senior Public Health Commissioning Manager Dawn Jenkin Consultant in Public Health
Topic quality reviewed	September 2019
Topic endorsed by	Homeless Executive Steering Group
Topic approved by	Pending approval from the Health and Wellbeing Board
Current version	
Replaces version	N/A
Linked JSNA topics	An assessment of the impact of housing on health and wellbeing (2013), An assessment of the Health Needs of Single Homeless People in Nottinghamshire (2013), Older Adults Mental Health (2017) Suicide prevention (2016) Substance misuse: Young people and adults (2018) Youth offenders (2014) Child Poverty (2016) Mental health (adults and older people) (2017), Viral Hepatitis (2017) Domestic Abuse (2019) Sexual Abuse (2014) Winter Warmth and Excess Winter Deaths (2014)

Executive summary

Introduction

Shelter defines homelessness as not having a home[1]. You are homeless if you have nowhere to stay and are living on the streets, but you can be homeless even if you have a roof over your head. You count as homeless if you are:

- staying with friends or family
- staying in a hostel, night shelter or B&B
- squatting (because you have no legal right to stay)
- at risk of violence or abuse in your home
- living in poor conditions that affect your health
- living apart from your family because you don't have a place to live together

Homelessness is an issue of concern across the country and Nottinghamshire is not exempt from this picture. Homelessness is a far wider a problem than the aspect that is most visible to the public – rough sleeping which is considered the tip of the iceberg[2].

The causes of homelessness and who is most at risk of homelessness and rough sleeping is complex and warrants action to both address those that are at risk of and who are currently homeless as well as attention to how we can prevent homelessness in the future. This can only be done by agencies from across the public sector working together in a more systematic and joined up way over an extended period.

People who are homeless experience worse health outcomes than the general population. Consequently, the focus of this JSNA chapter is on the physical and mental health needs of the homeless population as well as identifying who is at greatest risk of becoming homeless, the causes of homelessness and evidence of what works to prevent homelessness and respond to homelessness when it arises.

This JSNA chapter was endorsed by the Homeless Executive Steering Group with additional feedback provided by local organisations that formed the JSNA steering group or contributed towards the local views section. Whilst this JSNA chapter does not replace any previous version it does provide a more up to date narrative on the health and wellbeing of those who are homeless than the A*ssessment of the impact of housing on health and wellbeing (2013)* JSNA chapter and builds on the 2013 *assessment of the Health Needs of Single Homeless People in Nottinghamshire.*

Unmet needs and service gaps

Housing and health need in Nottinghamshire must be set in the context that levels of statutory homelessness and rough sleeping remain low in the County and well below the England average. However, rough sleeping numbers have shown a steady increase since 2010, with variation across districts and boroughs, and higher rates occurring in Mansfield and Bassetlaw. This gives an indication of a rising level of unmet health, social, welfare or housing need.

Housing supply and welfare

This JSNA has highlighted a number of factors that are known to affect availability of affordable and appropriate housing, in particular for the most vulnerable populations at risk of homelessness due to complex needs and debt arrears. Specific issues highlighted within this JSNA include

- Lack of affordable housing
- Housing benefit set at rates lower than landlord can obtain in rent on the open market
- Private landlords unwilling to consider housing people in receipt of benefits
- Private rental barriers to housing people aged under 35 years
- Need for support in tenancy to prevent eviction
- Housing options to support people with experience of homelessness and existing rent arrears
- Recent trend in increased use of bed and breakfast accommodation in some areas within Nottinghamshire

Whilst approaches to address housing supply in these cases are critically important to securing positive outcomes and reducing homelessness, these are rightly covered within the Homelessness Strategies produced by local Housing Authorities. Therefore, the recommendations of this JSNA will focus on the non-housing risk factors leading to homelessness and how these wider needs can be met.

It is clearly acknowledged that neither housing approaches nor wider health and social care support can be truly effective in isolation to prevent homelessness. These needs are interconnected and therefore implementing effective solutions requires dedicated and strongly aligned partnership working.

Primary prevention approaches

The role of upstream primary prevention initiatives is not yet fully understood or embedded within strategic approaches, either nationally or locally. This is likely driven by, amongst other factors:

- The need to focus limited local resources on addressing the most acute and immediate needs of those at risk of homelessness
- The diffuse and system wide nature of risk factors leading to homelessness

It is recognised that a range of local provision which commissioners currently invest in has the potential to significantly contribute to the prevention of poor outcomes through homelessness. These include, but are not limited to:

- Debt, tenancy sustainment and welfare advice
- Veteran support strategies
- Housing adaptations secured through disabled facilities grant
- Substance misuse services
- Domestic abuse and sexual violence support services
- Family mediation
- Coping and resilience approaches in school settings
- Improving Access to Psychological Therapies (IAPT), talking therapies, social prescribing and befriending initiatives
- Employment support
- Ex-offender support strategies

It is difficult and possibly counter productive to identify unmet need in any single preventative approach, in particular as evidence points to the fact that those at risk of homelessness are far from a homogenous cohort and benefit from personalised approaches taking into account a range of support needs.

The opportunity across existing primary prevention approaches is for commissioners and providers to recognise that housing plays a critical role in health and wellbeing outcomes, and the services they provide have additional benefits of reducing future risk of homelessness. Strong joint working across services alongside improved awareness and skills in considering the housing needs of clients has the potential to maximise health outcomes for clients with complex needs within existing resource. The “duty to refer” introduced in the Homelessness Reduction Act provides an opportunity to engage a wider frontline workforce on the impact of housing on health and identify needs earlier.

Early Intervention and support

Consultation with local stakeholders showed a perception that support where available was not well known about, nor readily accessible. There was also a perception that support was not offered early enough and did not cover the broad range of the needs experienced by service users. Whilst the introduction of the Homelessness Reduction Act may address the need for earlier identification and support to some extent, consideration needs to be given to how support offers can be made more visible and accessible. In particular, for individuals who experience complex needs or chaotic lifestyles consideration needs to be given to targeted or tailored outreach approaches which reduce the barriers to engaging with services for support, in order to reduce the risk of exclusion and worsening health inequalities.

Services and commissioners may also need to consider how the profile of available support can be raised in frontline settings, to facilitate a “no wrong front door” approach to support at the point of care.

Governance and leadership

The wide range of services which have a role in supporting better health outcomes for those at risk of homelessness means that strong governance and leadership is needed at strategic level, to drive, support and hold to account effective delivery across a partnership. Stakeholders have described current partnership arrangements as operational rather than strategic, which may limit effectiveness to drive system change such as strategic commissioning of care pathway approaches. The Rough Sleeping Strategy suggests the introduction of Homelessness Reduction Boards which would take on the role of leading system change.

Healthcare

Users of homeless services locally have reported particular barriers to accessing healthcare appointments and mental health services. This can be considered in the context that national evidence shows individuals who are rough sleeping or in temporary accommodation are high users of healthcare. The combination of difficulties accessing care, with high levels of health need (mental and physical) leads to high volume service use for potentially preventable conditions. In order to better meet the healthcare needs of this population, flexible, innovative and targeted approaches are needed which specifically address the barriers presented by having no fixed abode, no access to transport, multiple health needs and in some cases chaotic lifestyles. Some examples of such innovative practice have been piloted in primary and secondary care settings in Nottinghamshire but are not as yet commissioned in line with population need in an integrated approach. Given the relatively small numbers of individuals who present with high levels of complex need or in crisis (as compared to the population as a whole), a targeted approach, delivered in settings most accessible to homeless individuals, with high levels of support and case management, is most likely to be effective in meeting need. Effectiveness is likely to be enhanced by delivery alongside providers with existing trusted relationships in homeless communities.

This JSNA highlights that substance misuse, musculoskeletal (MSK), dental and respiratory problems are likely to be the most prevalent physical health needs, along with a broad range of presenting common and severe mental health conditions. In addition, homeless populations face inequalities in access to screening programmes for both communicable and non-communicable conditions. Inclusion health standards highlight that providing equitable care in this population requires opportunistic approaches to offer screening and treatment.

Integrated commissioning and care pathways

Both service users and commissioners have reflected that commissioned support appears fragmented, potentially duplicative, and in some cases with lack of clarity as to thresholds and eligibility criteria. Where service users present with multiple or complex needs this can result in multiple assessments, referrals and delays in care, which in a worst-case scenario leads to disengagement by the service user and difficulty in supporting recovery within temporary accommodation settings. One strategy to support service users in navigating care is the use of a case worker, however it is unclear whether case worker capacity is sufficient to meet existing needs, and fragmented care pathways will also impact on the effectiveness of case workers themselves.

The service gaps particularly noted include management of support for those with mental health and/or social care needs, although interactions between all services are perceived as challenging.

Therefore, there is a critical need for commissioners (together with providers) to work jointly in creating effective care pathways which will deliver better value for individual services

through more efficient processes, and better outcomes for service users through joined up person centred approaches.

The evidence base suggests that care-pathways designed around critical time intervention, identifying high risk groups at specific points, such as discharge from prison or other institution can offer an effective risk stratified approach. Examples of such approaches are currently being trialled as part of the Rapid Rehousing Pathway, providing navigators for prisons, hospitals and mental health services. To maximise the opportunities for effectiveness in these pilots, specific partner commitment is needed for:

- Robust evaluation and sharing of learning across the local system
- Development of integrated care pathways which address wider health and social needs in addition to housing provision
- Development of sustainable financial investment to embed effective practice emerging from the pilot

Knowledge gaps

This JSNA has relied on a combination of local views, local commissioned research and national data to develop a picture of health needs for those at risk of homelessness. There is very little reliable local data available to allow robust assessment of the scale of homelessness and the range of local health need.

This is a gap mirrored at national level and highlighted in the Rough Sleeping Strategy. Further work is needed for commissioners and providers to routinely collate and share information locally on the risk factors and health, housing and social care needs of those accessing services, as a starting point for estimating true population health need. It is expected that the new Homelessness Case Level Information Collection (H-CLIC) data will provide some useful data to better quantify need in those owed a support duty.

Recommendations for consideration by commissioners

	Recommendation	Lead(s)
Strategic Leadership, Governance and Partnership Working		
1.	Establish formal governance arrangements in line with Ministry of Housing, Communities and Local Government (MHCLG) proposals for a **Homelessness Reduction Board**, to provide leadership and accountability for improving health and homelessness outcomes, including delivery of JSNA recommendations.	Housing Authorities, Commissioners of Supported Housing
2.	Establish a coordinated or integrated strategic commissioning forum to address gaps in provision and enable effective care pathways across housing, social care, mental health and primary and secondary healthcare.	Housing Authorities, Supported Housing Commissioners, Clinical Commissioning Group (CCG), Adult and Children's Social Care
3.	Identify opportunities through the Homelessness Strategies of Nottinghamshire Housing Authorities to support prevention and early identification of	Housing Authorities

	homelessness by partners across the system, including best use of duty to refer.	
4.	Consider the recommendation of the Rough Sleeping Strategy that strategic leadership is provided through a dedicated Homelessness lead on the Health and Wellbeing Board.	Health and Wellbeing Board
Integrated Commissioning and Care Pathways		
5.	Develop and implement a commissioned care pathway for critical time intervention with specific high-risk groups: ex-offenders, mental health needs, veterans, substance misuse.	Strategic Commissioning Forum
6.	Identify opportunities to align funding to evidence based primary prevention of homelessness, including through family mediation, debt advice, healthy lifestyles, tenancy sustainment initiatives, and education/support in at risk groups.	Homelessness Reduction Board
7.	Develop the healthcare offer across primary, secondary and community care to meet the specific health needs of those with no fixed abode or in temporary accommodation, in line with inclusion health standards.	CCG, Health Care Providers
8.	Identify opportunities to strengthen effectiveness of Street Outreach and Rapid Rehousing Pathway initiatives through system wide engagement, pathway development and advocacy for longer term funding settlements.	Homelessness Reduction Board
9.	Identify and implement strategies for opportunistic screening and treatment for communicable diseases including blood borne viruses and tuberculosis, in settings most accessible to at risk homeless populations.	Public Health England (PHE), Health Protection Strategic Group, CCG
Implementation - Service Models, evaluation and data collation		
10.	Embed evidence based psychological approaches to managing and recovering from complex trauma into front line delivery of service, including Psychologically Informed Environments and trauma informed services (ReACH)	Service Providers
11.	Develop robust and shared methods for data collation and evaluation for existing services, to improve local knowledge of risk factors and health needs for those at risk of homelessness	Strategic Commissioning Forum
12.	Develop a strategic assessment of the Housing First model, as an option for securing long term health and social gains for individuals with complex and enduring needs, including substance misuse.	Strategic Commissioning Forum
13.	Develop shared protocols across service provision to improve accessibility and visibility of early identification and support options.	Service Providers

Nottinghamshire Health & Wellbeing Board

Full JSNA report

What do we know?

Overview

Homelessness is an issue of concern across the country and Nottinghamshire is not exempt from this picture. Homelessness is a far wider a problem than the aspect that is most visible to the public – rough sleeping which is considered the tip of the iceberg[2].

The causes of homelessness and who is most at risk of homelessness and rough sleeping is complex and warrants action to both address those that are at risk of and who are currently homeless as well prevention of homelessness in the future. This can only be done by agencies from across the public sector working together in a more systematic and joined up way over an extended period.

As things currently stand the national picture is concerning with homeless charities such as Shelter reporting increasing numbers of homeless people in 2018.

"According to Shelter there were 320,000 people recorded as homeless in Britain in 2018. That is 13,000, or four per cent, more than the previous year and means that 36 new people become homeless every day. Many people are in precarious situations known as "hidden homeless" which can involve moving in and out of hostels and emergency shelters, or sofa surfing, and so beyond the reach of most forms of support. On 30th June 2018 the number of households in temporary accommodation was 82,310, up five per cent from 78,540 on 30th June 2017, and up 71 per cent on the low of 48,010 on 31 December 2010. Meanwhile the number of families in Bed & Breakfast (B&B) style accommodation has more than tripled in the same time period. This has drastic effects on already vulnerable people and it is also extremely costly. Local authorities (LA's) in England spent £1.39billion on homelessness services in 2017-18. This is the cost of a reactive approach to acute social problems. That money would be far better spent on preventative services that stop people becoming homeless in the first place[1]". There are significant knock on costs. The estimated average cost to the public purse, across a range of service areas, of a single homeless person rough sleeping for twelve months ranges between £20,128 and £34,500.[2,3]

Consequently, some national measures have been introduced over the last year or two including the introduction of new legislation through the Homelessness Reduction Act (2017), the development of a national Rough Sleeping Strategy (2018) and the availability of national (often short-term) funding streams.

The purpose of this JSNA is to establish a coherent picture in terms of the health needs of those who are homeless and to identify those who are at increased risk of homelessness as well as what we can do about this locally. Owing to an absence of published research that establishes a sufficiently robust evidence base to support specific ways forward this JSNA relies on a mixture of opinions from leading organisations in the sector such as Crisis, Homeless Link and Shelter, that have published guidance and best practice. Further to this data presented is at times, based on national estimates or local counts for national data set returns which are still deemed experimental* rather than more robust known prevalence rates that are reliable and applicable to our local homeless population.

* Considered experimental and not official statistics until more than 12 months of LA data is collected and data quality is assured more information available here

i. Defining Homelessness

Shelter defines homelessness as not having a home[1]. You are homeless if you have nowhere to stay and are living on the streets, but you can be homeless even if you have a roof over your head. You count as homeless if you are:

- staying with friends or family
- staying in a hostel, night shelter or B&B
- squatting (because you have no legal right to stay)
- at risk of violence or abuse in your home
- living in poor conditions that affect your health
- living apart from your family because you don't have a place to live together

Homelessness is often the consequence of multiple factors. It describes a range of circumstances from living on the streets to residing in insecure housing. Crisis UK uses the terms 'core homelessness' and 'wider homelessness' which relate to the severity of the housing situation.

'Core homelessness' refers to households who are considered homeless at any point in time due to experiencing the most acute forms of homelessness or living in short-term or unsuitable accommodation.

'Wider homelessness' refers to those at risk of homelessness or who have already experienced it and are in accommodation which is on a temporary basis (Table 1).

Table 1: Definitions of Core and Wider Homelessness

Core Homelessness
Rough Sleeping
Sleeping in tents, cars, public transport
Squatting (unlicensed, insecure
Unsuitable non-residential accommodation e.g. 'beds in sheds/
Hostel residents
Users of night/winter shelters
Unsuitable temporary accommodation (which includes bed and breakfast basis/wanting to move, in crowded conditions (this does not include students)
Wider Homelessness
Staying with friends/relatives because unable to find own accommodation (longer term)
Eviction/under notice to quit (and unable to afford rent/deposit)
Asked to leave by parents/relatives
Intermediate accommodation and receiving support
In other temporary accommodation (e.g. conventional social housing, private sector leasing)
Discharge from prison, hospital and other state institution without permanent housing

Source: Bramley, G. (2017)[4]

ii. Homelessness Legal Framework

Local Housing Authorities in England have a duty to secure accommodation for unintentionally homeless households who fall into a 'priority need' category under Part 7 of the Housing Act 1996 (amended). People in priority need include care leavers, those with dependent children, pregnant women, disabled, fleeing domestic abuse etc[5]. The Act also requires that Local Housing Authorities must have an allocation scheme for determining priorities between applicants for housing which sets out the procedure to be followed when allocating housing. There is no duty to secure accommodation for all homeless people.

The Homelessness Reduction Act (2017)[6] came into force in April 2018 and introduced a new requirement (which supplemented the requirements of the 1996 Act) that local authorities work to prevent and relieve homelessness for all eligible homeless applicants. The Act extends the length of time a household can be considered at threat of homelessness from 28 to 56 days. Local authorities will be required to take action to support the household in finding alternative accommodation at the beginning of the notice period, rather than the end.

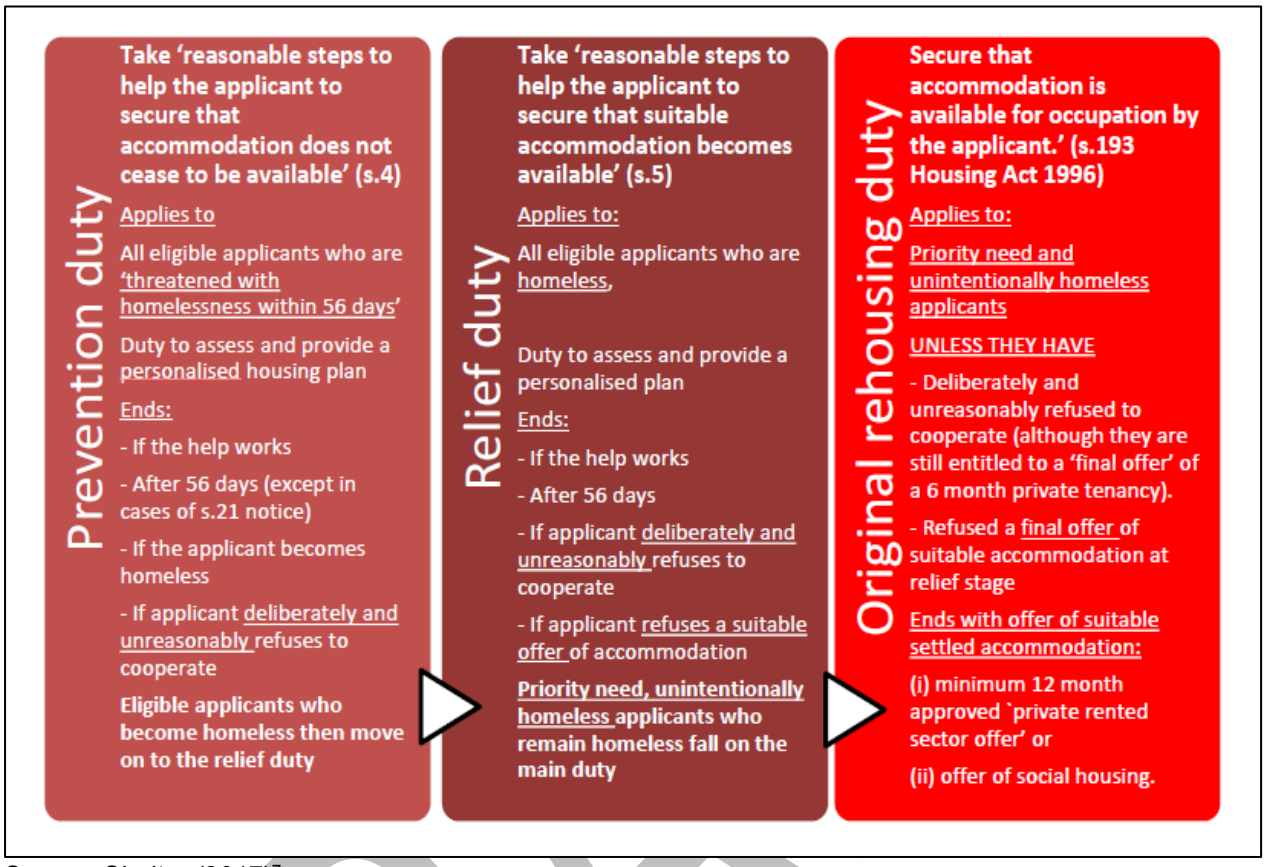
Additionally, with effect from October 2018, the Act requires specified public authorities to refer service users who they think may be homeless or threatened with homelessness to LA housing teams. The specified public authorities can be found here and include:

- prisons
- young offender institutions
- secure training centres
- secure colleges
- youth offending teams
- probation services (including community rehabilitation companies)
- Jobcentres in England
- social service authorities (both adult and children's)
- emergency departments
- urgent treatment centres
- hospitals in their function of providing inpatient care
- Secretary of State for defence in relation to members of the regular armed forces

The Homelessness Act 2002, requires all housing authorities to have in place a homelessness strategy based on a review of all forms of homelessness in their district. The strategy must be renewed at least every 5 years. Further information and guidance on homelessness legislation can be found here.

At the end of 2018, the Government published the national Rough Sleeping Strategy which set out ways to help people who are sleeping rough now and to put in place the structures to halve rough sleeping by 2022 and end it by 2027. Within this, there is a requirement for Local Housing Authorities to refresh their homelessness strategies and re-badge as homelessness and rough sleeping strategies by winter 2019.

Figure 1: Summary of changes introduced by the Homelessness Reduction Act

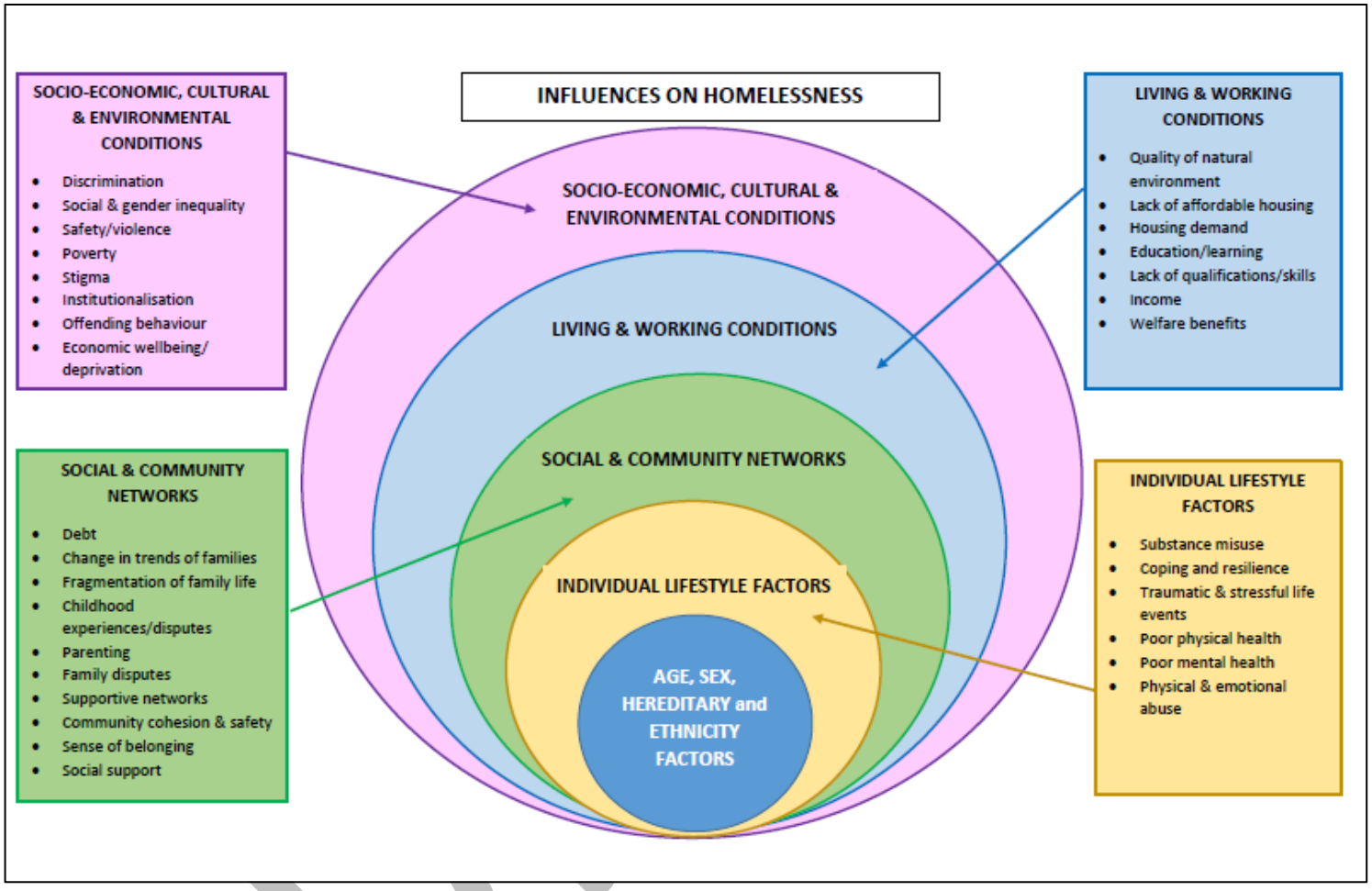


Source: Shelter (2017)[7]

1) Who is at risk and why?

The determinants or influences on a person's risk of homelessness is multifactorial and complex and can range from the individual's lifestyle factors, social and community networks, socio-economic environments and living and work conditions, as shown in Figure 2.

Figure 2: Influencing factors on homelessness



Source: Adapted from Social Determinants of Health; Dahlgren and Whitehead (1991)

1.1) The root causes of homelessness

The factors or causes of homelessness are typically described as either structural or individual, as listed in Figure 3. These causes, and their relationship, vary across the life course.

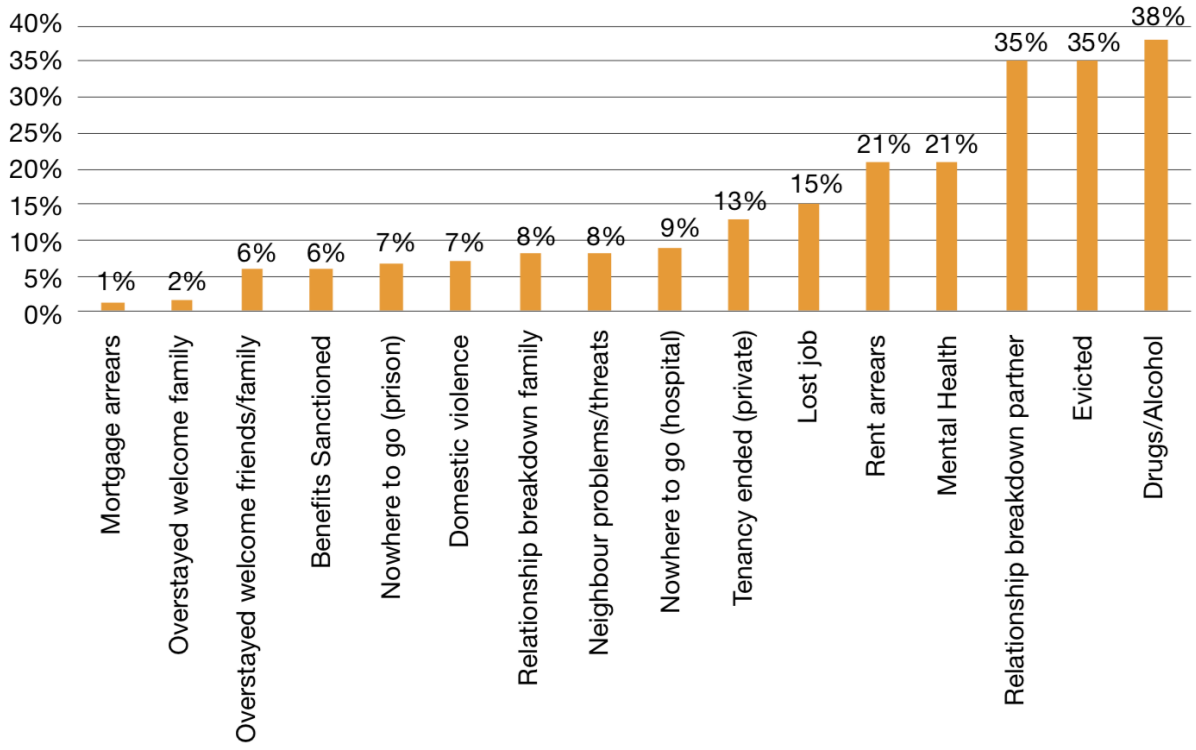
Figure 3: Causes of Homelessness

Structural factors	Individual
Housing demand (linked to demographic trends)	Family disputes / Childhood disputes
Lack of affordable housing (Eviction / Re-processions)	Veterans
Poverty	Physical and emotional abuse
Unemployment / welfare benefits	Poor physical health and mental health problems
Ethnicity	Institutionalism / Offending behaviour (Care, prison, armed forces
Changing trends in family formation and fragmentation	Drug and Alcohol misuse
	Lack of qualifications and skills
	Social networks
	Debt

Source: Harding, Irving and Whowell (2011)[8]

Figure 4 highlights some of the main underlying causes of single people becoming homeless. This research highlights underlying individual factors (more than one may apply) where as local and national level data identifies loss of tenancy and or eviction as two of the main presenting factors. This research highlights some of the reasons behind this where health (e.g. mental health) and health related behaviours (e.g. drug and alcohol use) are substantial factors.

Figure 4: Reported causes of single homelessness (individual factors)



Source: Pleace and Culhane (2016)[2]

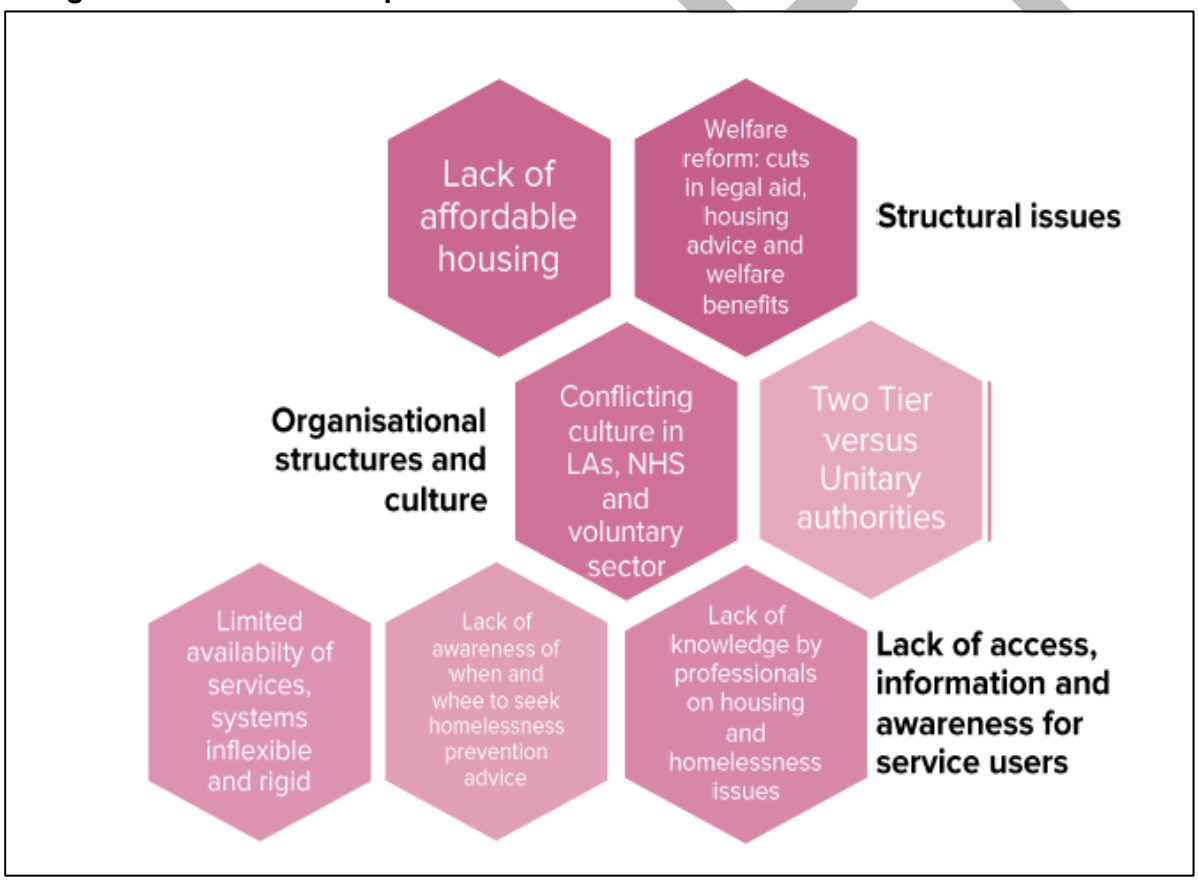
Several factors are driving the recent rise in homelessness in England, affecting both the vulnerability of individuals and families to homelessness and the wider societal conditions that give rise to homelessness. These factors are multi-faceted and include:

- **Individual circumstances - health, social and behavioural risk factors** which are the focus of this report including complex and overlapping needs, substance misuse, mental ill health, offending behaviour and certain groups such as veterans, care leavers and or those being released from prison and offenders. Socioeconomic factors, such as; relationship breakdown, unemployment, rising relative poverty and problematic debt.

- **Wider forces -** the **supply** of affordable housing and changes to the **welfare system.**

- **Complex interplay** -Structural and individual factors are often interrelated (Figure 5); individual issues can arise from structural disadvantages such as poverty or lack of education and/or poor quality housing that can lead to worsening of health conditions, such as; respiratory conditions. While personal factors, such as family and social relationships, can also be put under pressure by structural forces such as poverty[9].

Figure 5: Interrelationship of the Structural causes of Homelessness



Source: Homeless Link (2015) Preventing homelessness to improve health and wellbeing[9]

1.2) Health, social and behavioural risk factors

In May 2019, the Ministry of Housing, Communities and Local Government (MHCLG) published The Homelessness Case Level Information Collection (H-CLIC) data from 1st of April 2018 to 31st of December 2018 for the monitoring the Homelessness Reduction Act 2017[10]. Currently, this is considered as test data but in the longer term should provide a better understanding of the issues and factors with regard to homelessness. This data has been utilised to compile an estimate of homelessness in Nottinghamshire in section 2.

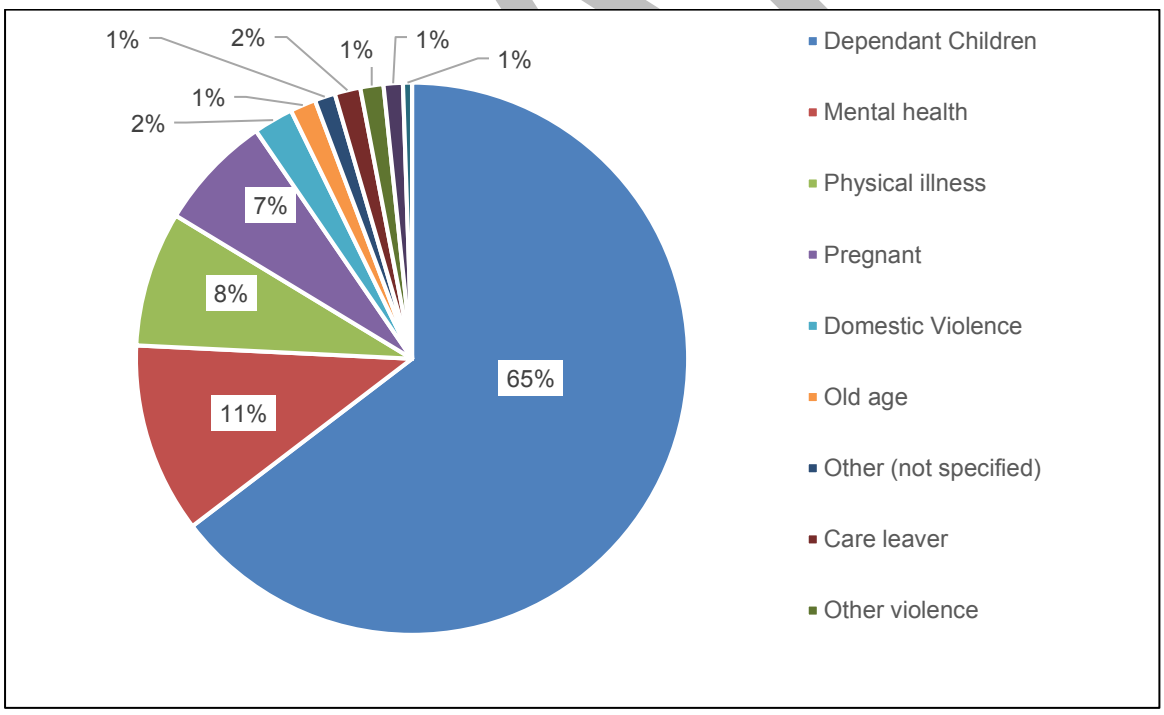
Characteristics of Homeless Vulnerable Households

Figure 6 shows the national profile for recordings of priority need taken from statutory homeless application statistics and gives an indication of the characteristics that make a household more vulnerable.

People who present as priority needs are often those with dependent children/ pregnancy, accounting for three quarters of all homeless applications nationally. However, it is possible that despite this being recorded as the priority need category there is another reason for their homelessness (for example domestic abuse).

Ill health as a factor in terms of vulnerability to homelessness is the second and third highest categories with mental health and physical illness occurring in approximately one fifth of priority need applications nationally.

Figure 6: % Priority need of applicants – January to March 2018



Source: P1E returns

Homelessness and Gender

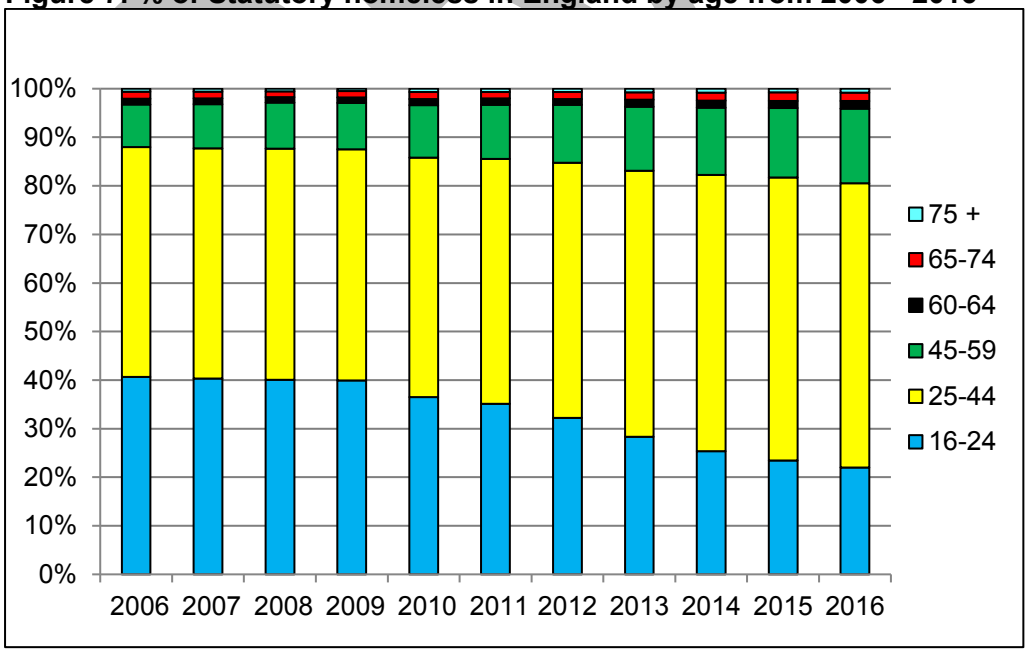
Of those identified as lone parents that presented to homeless services in England in 2016/17 (Q3) 92% were accepted as statutory homeless. This represents the largest household group at 47% of total homeless acceptances in that period. Women are also susceptible to homelessness if their housing situation changes due to pregnancy (particularly young women who are no longer able to live with their parents).

The number of women who become homeless is also often underestimated as there is thought to be a prevalence of hidden homelessness amongst women who will seek accommodation options with family and friends to avoid rough sleeping[11]. By contrast, government statistics from 2018[12] show 84% of rough sleepers are male and the majority of single homeless people accessing accommodation and support are male[13].

Statutory Homelessness and age

Figure 7 shows the national picture of statutory homelessness by age. With the highest proportion of statutory homeless being in the 25-44 age range. Since 2010, the proportion of young people between the ages of 16-24 years has steadily decreased. However, this could be an underrepresentation of the true number of homeless young people because of the level of hidden homelessness amongst this cohort. For instance, research by Homeless Link into young people and homelessness based on surveys with local authorities, service providers and interviews with young people found that most homeless young people were staying temporarily at the homes of friends, family members or acquaintances (e.g. sofa surfing) prior to accessing support[14]. These figures do not show the numbers of children amongst homeless families. The Children's Commissioner for England reports that there are124,000 children living in temporary accommodation in England in 2018 an increase of 80% from 2010[15]. This report highlights that the term "temporary" is misleading as for some families this is for extended periods of time which from a child's perspective does not feel temporary. Additionally, the report identifies that official statistics are likely to underestimate the actual numbers due to the hidden nature of homelessness that goes unreported to authorities where children and families are staying with friends or sofa surfing.

Figure 7: % of Statutory homeless in England by age from 2006 - 2016



Source: Ministry of Housing, Communities and Local Government (HCLG) (2016)

Domestic abuse

Domestic violence and abuse is also a common reason for people becoming homeless and the majority of survivors are women. Metropolitan Police statistics show that male violence against women made up 85% of reported domestic violence incidents[16]. Research by St Mungo's shows a complexity in homeless women's support needs because of the prevalence of violence and abuse they have experienced[17].

The national Homelessness code of guidance for local authorities[18] states that women can be at increased risk of homelessness if they are escaping honour based violence, including forced marriage and female genital mutilation. Both men and women are at risk of homelessness if they have been involved or associated with gang violence or a victim of modern slavery or trafficking.

Homelessness and Sexual/Gender identity

According to a 2014 report from the Albert Kennedy Trust[19], 77% of young Lesbian Gay Bi-sexual Transgender (LBGT) homeless people believed their sexual / gender identity was a causal factor in rejection from home. Shelter reported in 2007 that "there is very little information and research on the housing needs of lesbian and gay older people". A decade later this still seems to be the case.

Homelessness and Ethnicity

The national rough sleeping count in Autumn 2018 estimated that 4,667 people slept rough on a single night in England. Of these 64% were UK nationals, compared to 71% in 2017. 22% were EU nationals from outside the UK, compared to 16% in 2017. 3% were non-EU nationals, compared to 4% in 2017[12]. Further to this there are uncertainties in terms of eligibility for housing in relation to the Britain's pending withdrawal from the European Union.

1.3) The supply of affordable housing and changes to the welfare system

It is widely recognised that there is an undersupply of good quality, affordable housing in most areas of the country. This is due to a number of factors including a shortage in the delivery of new housing of all tenures; an expansion of Right to Buy and a shortage of available properties in the Private Rented Sector to house people in housing need. The House of Commons Communities & Local Government Committee report into Homelessness (2016)[20] concluded that the increase in homelessness is due to the affordability and availability of housing.

Estimates have put the number of new homes needed in England at between 240,000 and 340,000 per year. In 2017/18, the total housing stock in England increased by around 222,000 homes (a gap of over 100,000 homes per year)[21]. However, the Institute for Public Policy Research (IPPR) stresses that it is not just the number built but also the balance of tenures and affordability which need to be thought through for an effective housing strategy[22].

MHCLG data[23] shows that the delivery of affordable housing has generally reduced over the past 10 years. In 2011/12, 58,327 homes were developed in England, of which 38,823 were Affordable or Social rented. This compares to 32,618 in 2015/16; 42,198 in 2016/17 and 47,124 in 2017/18. The pressures of supply not keeping pace with demand has contributed to increased house prices and increased rental values and therefore increased pressures on the availability of affordable housing and the gap between average earnings and average house prices continuing to widen.

According to the Office of National Statistics[24] in 2002, the East Midlands Median Gross annual wage was £19,513. This increased to £27,606 in 2018 (an increase of 42%). Over the same period, the average property value in the East Midlands has increased from £110,306 to £177,656 (an increase of 60%)[25].

The increase in house prices is also reflected in rent levels in the Private Rented Sector. During the financial year 2018/19, the average (median) rent for a 2 bedroom property in Nottinghamshire as recorded by the Valuation Office Agency[26] was £500 per calendar month (this varies across the County as £475 in Ashfield, Bassetlaw and Mansfield to £650 in Rushcliffe).

Housing Benefit rates are calculated by reference to a claimants eligible rent. In brief, this is calculated based on a Local Housing Allowance rate which is fixed 30th percentile point for rents in each size category of dwelling in the local area (known as the Broad Rental Market Area (BRMA), as based on market rents paid by tenants who are not receiving housing benefit. This means that in higher value areas within the BRMA, Housing Benefit will tend to not cover the rent that a landlord would be able to obtain in the open market.

Social Housing and Right to Buy

The tenure profile of housing in England has changed over time. As at 31st March 2018, there were an estimated 24.2 million dwellings in England[27]. Of these, 15.3 million were owner occupied; 4.0 million were affordable rented dwellings i.e. rented from Councils or Registered Providers and 4.08 million were rented from private landlords or were linked to a job with the remainder being classified as 'other public sector dwellings'.

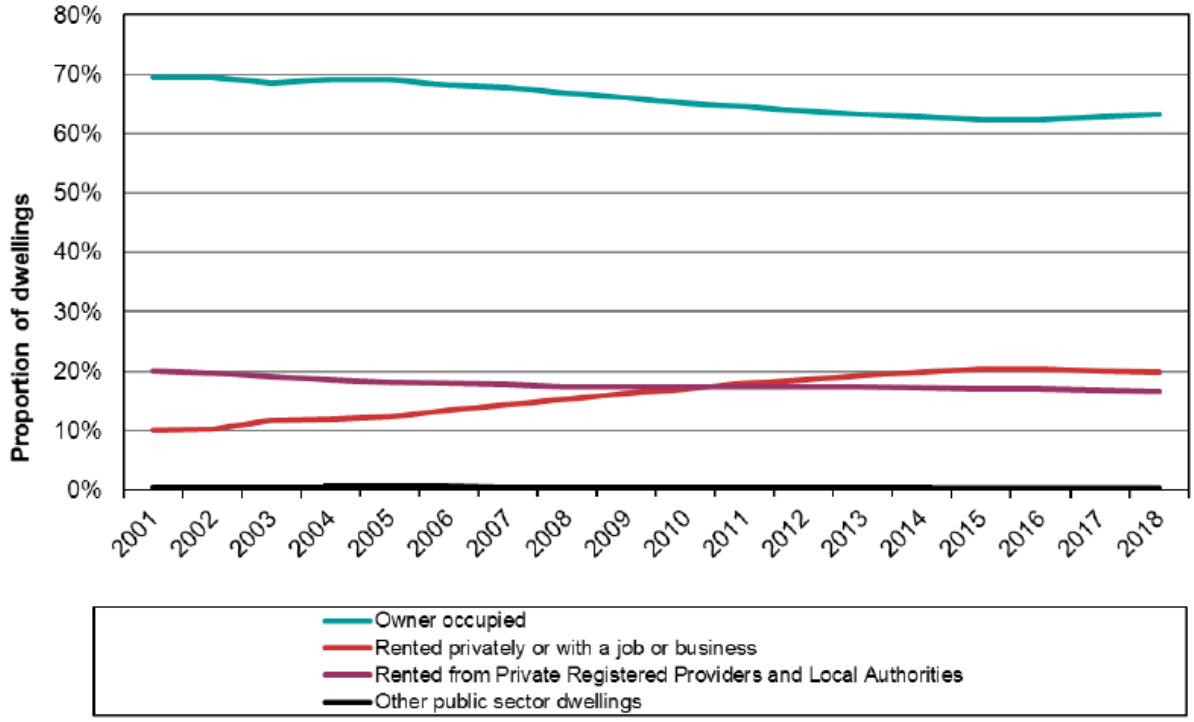
Over the last near to 20 years the shift in tenure has seen a reduction in the % of owner occupier and renting from council and an increase in % private rents (Table 2).

Table 2: Change in housing tenure in England by type 2002 - 2018

Tenure	%		
	2002	2018	Direction
Owner Occupied	70%	63%	↓
Council Rented or Registered providers	19.7%	16.7%	↓
Private Rental Sector	10.3%	19.9%	↑

Figure 8 shows that in 2001 only 10% of the population lived in the private rental sector but by 2014 this proportion had risen to 20% of total households and has remained at this level since[27]. This substantial shift from social to private renting means that there is significantly less opportunity to shape the housing market to meet housing need with many private landlords being unwilling to consider housing people who are in receipt of benefits.

Figure 8: Proportion of dwellings in England by tenure from 2001 to 2018



Source: ONS Housing Statistical release MHCLG dwelling stock estimates [27]

The changes in tenure are due to a number of factors with the reduction in social housing being primarily due to the popularity of the Right to Buy Scheme which has seen nearly two million homes have been bought in England under the scheme. In Nottinghamshire (County) alone, this equated to over 30,000 homes[28]. In the same period local authorities nationally built only 350,450 homes with borrowing restrictions imposed, alongside a requirement to spend resources on modernising existing stock.

Housing and Planning

It is reported that successive Governments have not built sufficient homes to meet the growing need[29]. Recent government housing policy has been outlined in the Housing and Planning Act 2016[30] and Housing White Paper 2017[31], both of which are heavily focussed on planning and building for home ownership at the expense of affordable rental dwellings, which is not directly helping to prevent the risk of homelessness for low income households. This approach has limited impact on assisting people who are most in housing need.

Where recent legislation does relate to social housing and the Private Rented Sector (PRS) it introduces measures that will potentially further limit access to affordable housing. For example, the move to end lifetime tenancies builds in the notion that people should only live in social housing when in need and when circumstances change they should move out and make room for the next household in need. This brings with it implications around stability and security of tenure and balance in communities and neighbourhoods.

Impact of Welfare Reform

Since 2010, there have been significant changes to the UK's benefits system. The changes are intended to reduce benefit dependency; to incentivise work for those who are able to work and to make the system more affordable for Government. This includes the introduction of Universal Credit; reductions in the annual increase in benefits and tax credits to a maximum of 1% per year and changes to Housing Benefit levels as well as a host of other measures,

many of which removed the eligibility of claimants who previously received relatively small awards. Additionally, a number of reforms were intended specifically to introduce more stringent entitlements to benefits for claimants.

Several of the reforms have been recently introduced or are still being rolled out, therefore, it is still early stages for a full assessment of the cumulative impacts of benefit changes to be undertaken. However, Homelessness Monitor 2019 identifies, "There is considerable concern amongst local authority respondents of the ongoing expected impact of welfare reform on homelessness in their area. The full roll out of universal credit is the subject of greatest concern with nearly two thirds of LAs anticipating a "significant" homelessness increase as a result. Aside from anxieties on universal credit, most LAs anticipated that homelessness would "significantly" increase due to the freeze in Local Housing Authority rates (53%) and other working age benefits (51%), with almost as many LAs (47%) reporting likewise for the lowered benefit cap"[32].

1.4) Homelessness and Health and Wellbeing

Homelessness and Mortality

Homeless people are more likely to die young, with an average age of death of 47 years old, compared to 77 years for the general population. It is important to note that this is not life expectancy; it is the average age of death of those who die on the streets or while resident in homeless accommodation. Standardised mortality ratios for excluded groups, including homeless people are around 10 times that of the general population[33].

Homeless people aged 16-24 years are at least twice as likely to die as their housed contemporaries; for 25-34 year olds the ratio increases to four to five times, and at ages 35-44, to five to six times. Even though the ratio falls back as the population reaches middle age, homeless 45-54 year olds are still three to four times more likely to die than the general population, and 55-64 year olds one and a half to nearly three times[33].

Drug and alcohol abuse are common causes of death amongst the homeless population, accounting for just over a third of all deaths. Homeless people have seven to nine times the chance of dying from alcohol-related diseases and 20 times the chance of dying from drugs compared to the general population[34]. When homeless people die, they do not commonly die as a result of exposure or other direct effects of homelessness they die of treatable and or often preventable diseases[35].

Homelessness and physical and mental health

There is a paucity of evidence on the health of homeless people nationally. However, what exists tends to be focused on rough sleepers and single homeless people. This section looks at national evidence on a range of health conditions which affect homeless people and where applicable is compared to the general population.

There is consistent evidence that this group experiences worse mental and physical health than the general population[36,37]. This is described throughout much of the literature as 'a tri-morbidity of physical illness, mental health problems and substance misuse'[366].

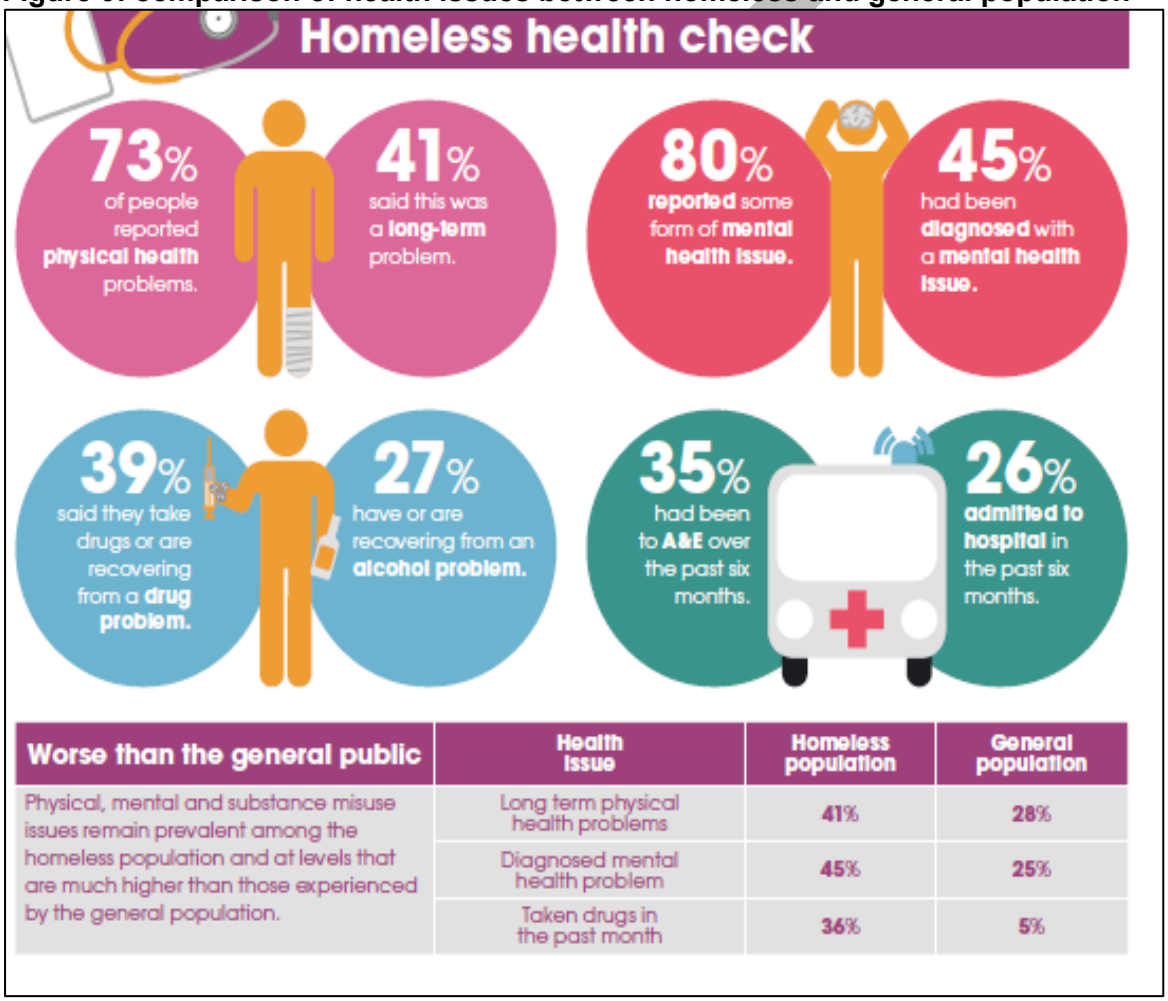
- Poorer health amongst this group compared to the general population is compounded by the inverse care law: those in greatest need have most difficulty accessing healthcare[38].
- Common physical health and mental health problems are described throughout the literature as disproportionately affecting people who are homeless, and that homelessness may be both a cause and a symptom of ill health is described[39].

- Rough sleepers report the worst physical health compared to single homeless or hidden homeless groups[38].
- Rough sleepers were also statistically more likely to report alcohol and/or drug use compared to single homeless or hidden homeless groups. No difference was found for smoking prevalence[38].

Physical Health

Homeless Link (2014)[40] reports that "available comparable data shows that almost all long-term physical health problems are more prevalent in the homeless population than in the general population" with 41% of the homeless population experiencing long term physical health problems compared to 28% of the general population (Figure 9).

Figure 9: comparison of health issues between homeless and general population



Worse than the general public	Health issue	Homeless population	General population
Physical, mental and substance misuse issues remain prevalent among the homeless population and at levels that are much higher than those experienced by the general population.	Long term physical health problems	41%	28%
	Diagnosed mental health problem	45%	25%
	Taken drugs in the past month	36%	5%

Source: Homeless Link (2014)

Mental Health

Homelessness and poor mental health often go hand in hand. Having a mental health problem can create the circumstances which can cause a person to become homeless in the first place. Yet poor housing or homelessness can also increase the chances of developing a mental health problem or exacerbate an existing condition. In turn, this can make it even harder for that person to recover – to develop good mental health, to secure stable housing, to find and maintain a job, to stay physically healthy and to maintain relationships.

Single homeless people are much more likely to have mental health problems compared to the general population. In 2015, 32% of single homeless people reported a mental health problem, and depression rates are over 10 times higher in the homeless population. Other psychological issues such as complex trauma, substance misuse and social exclusion are also common[41].

The prevalence of serious mental illness (including major depression, schizophrenia and bipolar disorder) is reported as 25–30% in the street homeless population and those living in direct-access hostels. Homelessness is also associated with higher rates of personality disorder, self-harm and attempted suicide[42].

For accessing accommodation, the initial assessment of 'priority need' is not made by a mental health professional. Some local authorities commission private companies to assess mental health status and these assessments are usually made on the basis of written evidence submitted by the local authority, rather than a personal assessment[43]. Other local authorities ask for a letter from the GP.

Adverse Childhood Experiences (ACEs)

ACEs can be categorised into three direct and six indirect experiences that have a negative impact on a child and includes; verbal abuse, physical abuse, sexual abuse, parental separation, domestic violence, mental illness, alcohol abuse, drug use and incarceration. ACEs can significantly affect physical, mental and personal well-being throughout life.

An increase in ACEs has been found to result in an increase in negative health and well-being outcomes. This includes; risky behaviours such as smoking, alcohol and drug use or sexual risk taking, and also an increased risk of different types of diseases such as depression, liver disease and ischaemic heart disease. It is estimated that approximately 50% of homeless people have four or more Adverse Childhood Experiences (ACEs)[44, 45].

Communicable Diseases

A high prevalence of communicable diseases such as tuberculosis (TB), hepatitis and bacterial infections such as streptococcal and staphylococcal infections can be found among those living on the streets or in hostels.

The national enhanced TB surveillance system (ETS), data is collected on the presence or absence of four social risk factors (SRFs) known to increase the risk of TB. SRFs include, current alcohol misuse that would impact on the patient's ability to take treatment, current or history of drug misuse, homelessness and/or imprisonment. The number of cases of tuberculosis in the UK peaked in 2011 and subsequently the number of people notified with TB has fallen by nearly 40% to 5,102 in 2017. However, this reduction has not occurred consistently across all population groups. For example, since 2013 there has been a slight increase in the proportion of TB cases amongst homelessness people rising to 4.7% (217/4,584) in 2017[46].

People who are street homeless are at higher risk of developing Group A Streptococcal (GAS) infections. Group A Streptococcus can cause a range of disease from non-invasive manifestations such as pharyngitis, impetigo and scarlet fever to life threatening invasive disease such as necrotising fasciitis or Group A Streptococcal septicaemia.

There are particular challenges in screening and treating this group for TB, hepatitis and bacterial infections. Unstable housing, homelessness and lack of recourse to public funds can make it more difficult for patients to complete the lengthy TB treatment regimens required for

cure, thereby increasing the risk of transmission and poor treatment outcomes. Non-completion of treatment can contribute to drug resistance, relapse and onward transmission of the disease. TB cases can also occur in individuals who face particular challenges in accessing affordable, suitable and stable homes, such as people with close links to high incidence countries who may be ineligible for social security; people with a history of imprisonment; people who misuse drugs and alcohol[47]. Poor access to health services may make treatment of bacterial infections such as Group A Streptococcus challenging and treatment adherence may also be difficult when living on the streets.

In terms of infectivity and access to health services it is important to note that whilst TB treatment is free in the UK, those with no recourse to public funds (e.g. undocumented migrants or refused asylum seekers) will not normally have access to welfare payments, local authority/housing association accommodation or social care services. Public Health England report that these issues can influence a person's ability to successfully complete treatment and may also increase the public health risk they pose to others due to prolonged periods of infectivity.

Blood borne virus screening rates in the homeless population are unknown as other SRFs apart from injecting drug use are not routinely recorded at a national or local level. As a result, homeless people may not receive preventive vaccines against hepatitis B or be identified for potentially curative treatment against hepatitis C.

Cancer Screening

Cancer prevalence, risks and uptake of cancer screening remains understudied in the homeless population[48]. However, access to screening can be largely dependent on a person being registered with a GP[49] and population groups without a postal address may also face challenges in accessing health services, including screening, as they have no address to which information about appointments can be sent[50].

A study conducted in Toronto, Canada, explored the perceptions of women living in homeless shelters and women with severe mental health challenges about the factors influencing their decision-making processes regarding breast and cervical cancer screening. The study recommended that to improve uptake of cancer screening for women with complex needs, appropriately designed intervention programmes for marginalised women are required, as well as sensitivity training for health care providers. Tailored and effective health promotion strategies leading to life-long cancer screening behaviours among marginalized women may improve clinical outcomes[51].

Long-term Conditions

As the demographic profile of those who are homeless has shifted towards older age, the incidence of chronic diseases and age-related conditions, such as cognitive impairment and functional decline, has increased. Additionally, homeless individuals aged 50 years and older have higher rates of age-related conditions (functional impairments, cognitive impairments, falls, and urinary incontinence) than a general population comparison that is 20 years older[52].

Oral Health

Healthy Mouths is a research study into the oral health of people experiencing street homelessness, which was conducted by Groundswell and was led by Peer Researchers[53]. The study engaged 262 people who are currently homeless in London, utilising focus groups and one-to one interviews and also engaged over 50 professionals working in this area. The Healthy Mouths study reveals that homeless people suffer extremely poor oral health compared to the general population.

The oral health of participants was very poor and significantly worse than the general population.

- 90% have had issues with their mouth since becoming homeless. Particularly common were bleeding gums (56%), holes in teeth (46%) and dental abscesses (26%).
- Many participants had experienced considerable dental pain. 60% had experienced pain from their mouths since they had been homeless. 30% were currently experiencing dental pain.
- 70% reported having lost teeth since they had been homeless and 7% had no teeth at all. 35% had teeth removed by a medical professional, 17% lost teeth following acts of violence and 15% of participants pulled out their own teeth.

The report identified some key factors underlying poor oral health in homeless people

- High levels of sugar consumption
- High rates of drug and alcohol misuse and smoking tobacco
- Rates of cleaning teeth were significantly lower than the advised minimum levels
- Rates of attendance and "sign up" at dentists were far lower than in the general population.

Alcohol and drugs were commonly used in an attempt to manage oral health issues. 27% of participants have used alcohol to help them deal with dental pain and 28% have used drugs. This may be contributing to continued drug and alcohol misuse[40].

Substance Misuse, Smoking and Alcohol

Homeless people are at increased risk of a wide range of health problems related to substance misuse: this can be both a cause and consequence of homelessness.

National and local research indicates high prevalence of usage of illegal and prescribed drugs, and of tobacco and alcohol.

According to the national Homeless Link Health Audit[54]:

- 27% of homeless people reported that they have or are recovering from an alcohol problem.
- Data on the regularity and amount homeless people drink implies that these needs may be more common. 39% of homeless men and 25% of women who took part in the audit drink twice or more a week, and around two-thirds of homeless men and women drink more than the recommended amount each time they drink.
- By comparison, one-third of the general public drink more than recommended amount on at least one day each week. Males appear to be more likely to drink more frequently than females.
- The audit also identified a higher prevalence of smoking, 77% in the homeless population compared to 20% in the general population, of whom fewer wanted to quit smoking (41% of homeless smokers compared to 63% of the general population).

Nutrition

A review of research studies of street homeless people's diet found a recurrent theme of high levels of saturated fat, low fruit and vegetable intake and numerous micronutrient deficiencies, thus highlighting the presence of malnutrition. In summary: "For the homeless individual even the basic survival requirements of food can be limited, resulting in a daily struggle both physically and mentally" [55].

Use of Health Services

Research carried out in 2010 identified total cost of hospital use by homeless people was estimated to be four times that of the general population with inpatients costs increasing to eight times higher amongst homeless people[56].

According to the national Homeless Link Health Audit[54]:

- 90% of surveyed homeless people said they are either permanently or temporarily registered with a GP. 21% of homeless people said they had used opticians in the last six months. 32% had visited a dentist.
- On average there were 1.18 hospital admissions per year for homeless people compared with 0.28 per year for the general public. This reflects previous research which found that homeless people usually stay in hospital for longer than the general public, mainly because of their more acute health issues.
- Single homeless people are five times more likely to use Accident & Emergency Services than the general public and 3.2 times more likely to have hospital admissions with longer lengths of stay[57].
- Poor health can be exacerbated by limited access to appropriate health services and limited integration between services. The poor outcomes homeless people often experience from the health service mean that health conditions are not always treated effectively and can in turn lead to worse conditions developing.

Homelessness and Inclusion Health standards

Bodies that represent the main medical specialities (e.g. Royal College of GPs, the British Medical Association) have endorsed homeless and inclusion health standards to better address the needs of homelessness people[58]. The standards incorporate the findings of the evidence of what works in inclusion health[59] which recommends implementing policies that address the upstream causes of exclusion such as poverty and ACEs whilst accentuating some key principles to inclusive health services:

- build trust and relationships through continuity by clinician/team
- access to include walk in provision, in-reach to hostel, street outreach
- integrated, multi-disciplinary, collaborative care
- person centred care
- involvement of those with lived experience in planning and delivery of care
- recovery focused
- where specialist services are provided they should act as a catalyst to improving care throughout local health system
- work closely with public health functions to address serious communicable diseases
- link hospital to community through integrated care / hospital in-reach
- treat those who have no recourse to public funds

2) Size of the issue locally

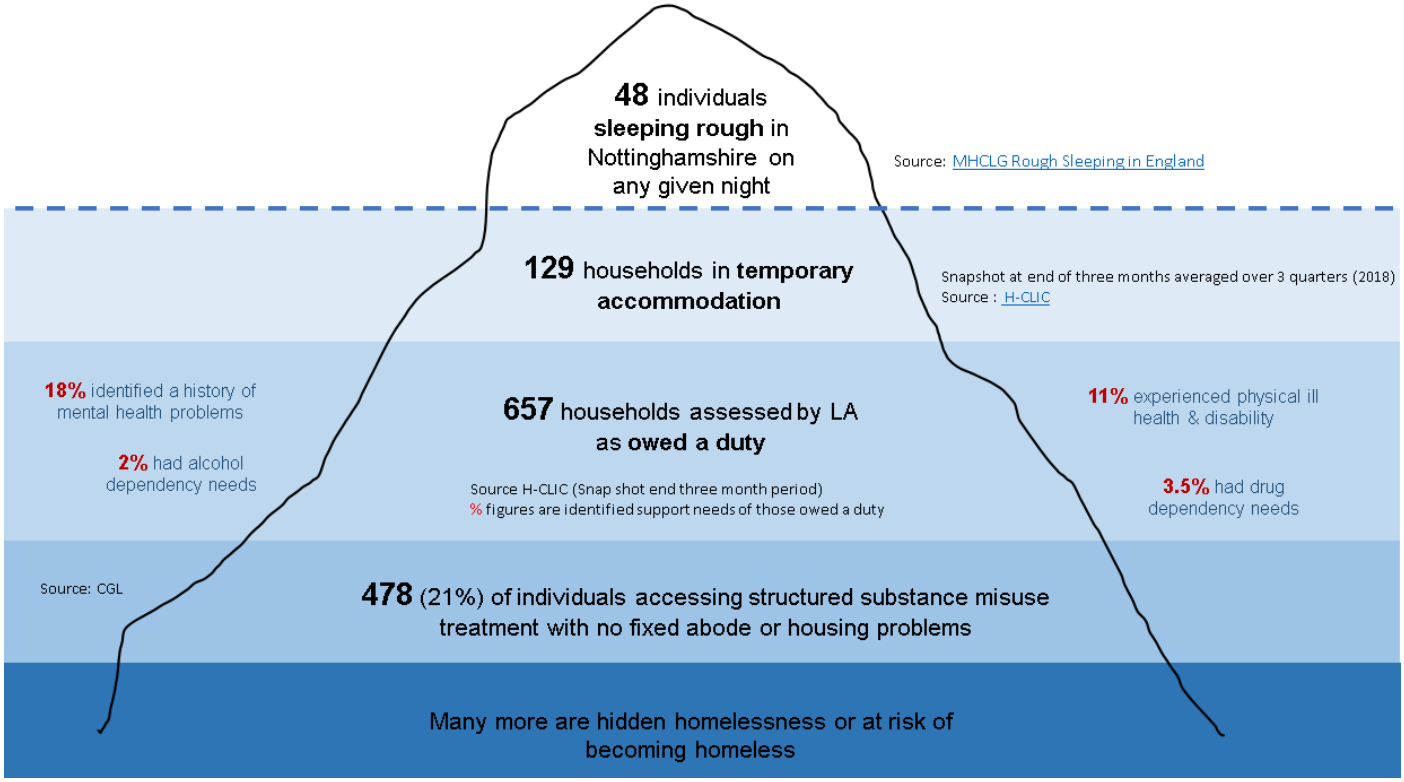
A substantial number of metrics are routinely recorded and reported by local authorities to central government (for example households accepted as being homeless and in priority need, eligible homeless not in priority need, households in temporary accommodation etc).

Only two of these measures are presented in the Wider Determinants of Health section of the Public Health Outcomes Framework†. Whilst this is an important data source that enables comparison with other Local Authorities and the national and regional rate, it does not quite express the presenting issue in a way that enables a shared understanding across our local partnership of organisations that collectively need to work together to reverse the current situation.

2.1) Estimate of the numbers of homeless people in Nottinghamshire

An estimate of the homelessness need in Nottinghamshire has been compiled using some key data points

Figure 10: Estimate of homeless population in Nottinghamshire at any one point in time



Adapted from Shelter https://twitter.com/shelter/status/1092147212069556225

† PHOF 1.15i Statutory Homelessness and PHOF 1.15ii Statutory Homelessness

Rough Sleeping

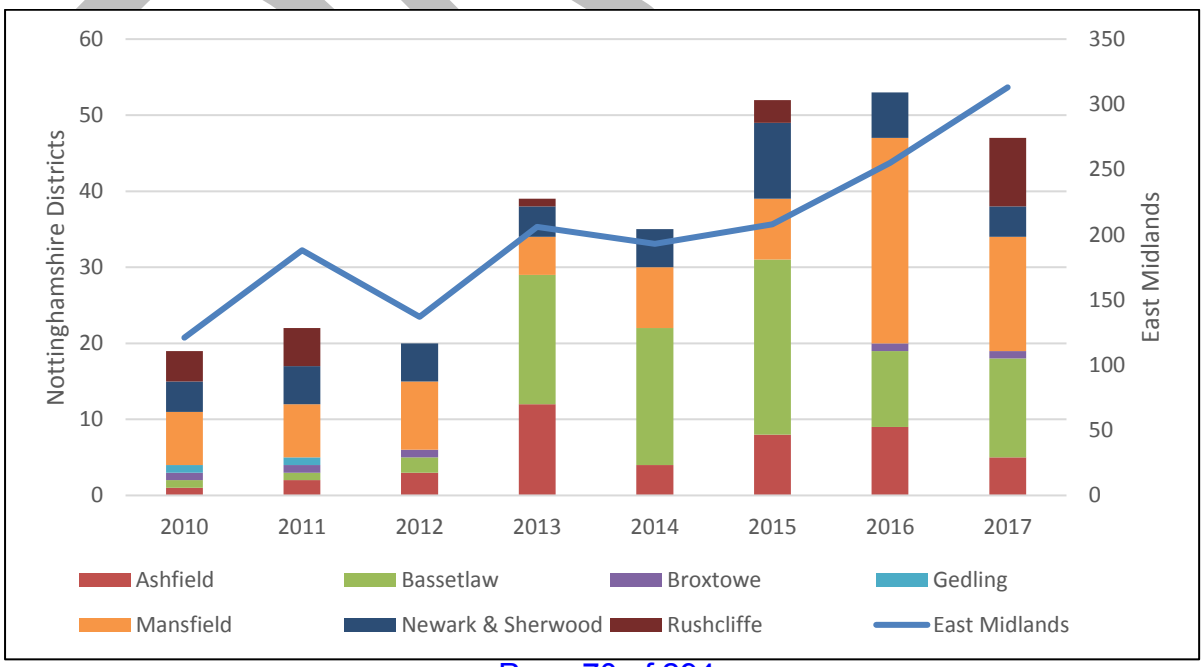
Formal rough sleeper counts take place annually on one night of each year between 1st October and 30th November. The count is to provide Government with an estimate of the number of rough sleepers in an area. Accurately counting or estimating the number of people sleeping rough within a local authority is inherently difficult given the hidden nature of rough sleeping. There are a range of factors that can impact on the number of people seen or thought to be sleeping rough on any given night. This includes the weather, where people choose to sleep, the date and time chosen, and the availability of alternatives such as night shelters[12].

In line with an East Midlands trend, there has been a steady rise in the number of rough sleepers across Nottinghamshire since 2010.The 2018 rough sleeper count tells us that it is estimated that 48 individuals sleep rough on any given night across Nottinghamshire, 90% of whom are male and aged over 26. This figure is similar to the previous year. However, rough sleeping is not distributed evenly across the county with Bassetlaw (16) and Mansfield (17) having the highest estimate and the southern boroughs the lowest number of rough sleepers in Nottinghamshire.

Additionally, rough sleeping is the most visible form of homelessness that tends to be experienced by single people with a wide range of health issues. In the year from April 2018 to March 2019 the Street Outreach Team encountered a total of 336 individuals sleeping rough across the County. The vast majority (more than 90%) of these had significant support or care needs relating to their mental and/ or physical health, alcohol, drug or New Psychoactive Substance (NPS) misuse. A significant proportion (more than 70%) of rough sleepers experienced multiple or complex needs.

Figure 10a shows the number of rough sleepers by each Nottinghamshire District from 2010 to 2017. In line with the East Midlands trend, since 2010 there was a steady rise in the number of rough sleepers across all Nottinghamshire Districts with Bassetlaw and Mansfield having the highest number.

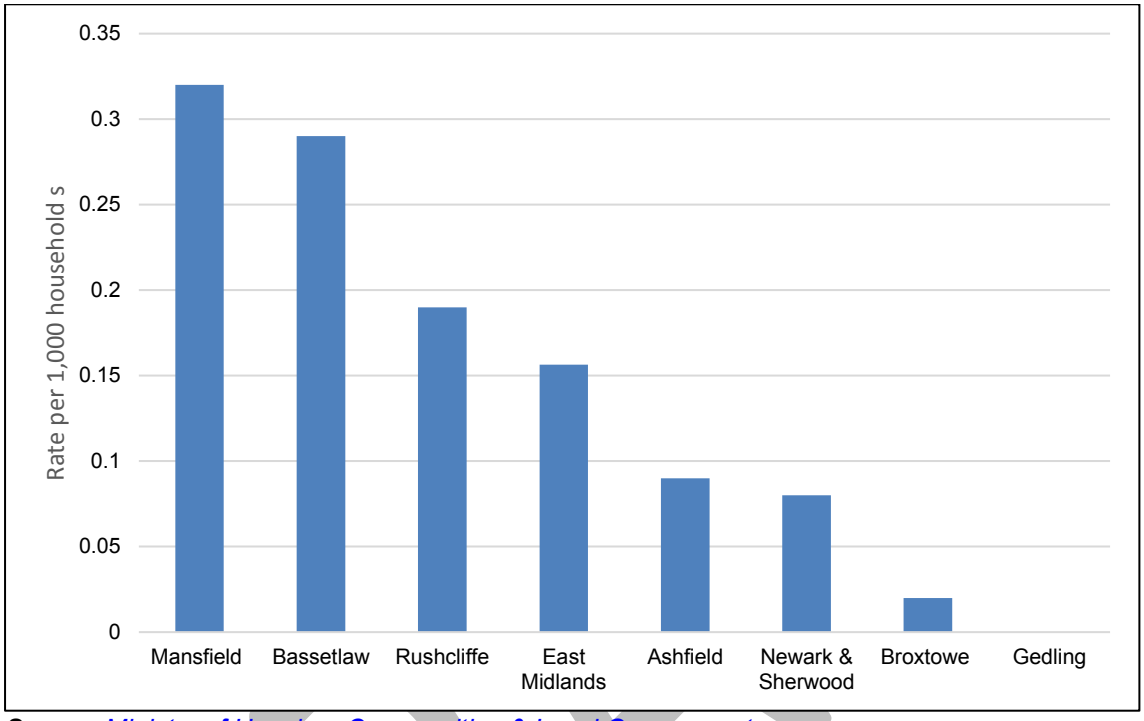
Figure 10a: Number of Rough Sleepers by Nottinghamshire Districts from 2010 to 2017



Source: Ministry of Housing, Communities & Local Government

Figure 10b, shows the rate per 1,000 household of rough sleepers for each Nottinghamshire District. In 2017, Mansfield, Bassetlaw and Rushcliffe were higher than the East Midlands rate of 0.15 per 1,000 household.

Figure 10b: Rate per 1,000 household of rough sleepers by each Nottinghamshire District compared to the East Midlands Region in 2017



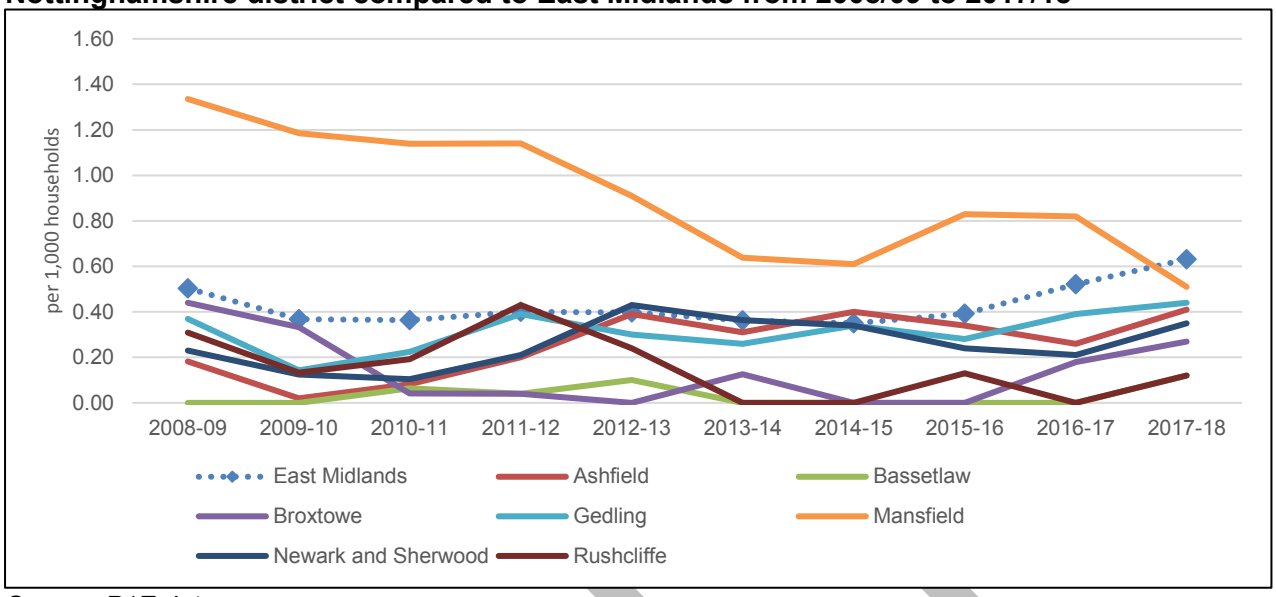
Source: Ministry of Housing, Communities & Local Government

Temporary Accommodation

Temporary accommodation includes Bed and Breakfast (B&B) accommodation; hostels; use of Local Authority and Housing Association accommodation on a temporary basis; private sector leased accommodation as well as other types including through the private rented sector. Data on households in temporary accommodation is based on a snapshot at the end of each quarter and could potentially under-represent the numbers experiencing homelessness during the reported period. Data reported to MHCLG on households in temporary accommodation are currently deemed experimental statistics.

Based on the three reported periods in 2018 Nottinghamshire had on average 129 households per quarter placed in temporary accommodation (112 in Apr-June; 134 in July-Sept and 141 in Oct-Dec 2018). Greater numbers of households placed in temporary accommodation existed in Mansfield, Ashfield, Newark and Sherwood and Gedling with fewer households in Bassetlaw, Broxtowe and Rushcliffe. However, trends in the rates of households in temporary accommodation over time show that the majority of Nottinghamshire districts experience a lower rate than that of the East Midlands with Mansfield district showing the greatest decline in rate over the ten-year period 2008/09 to 2017/18.

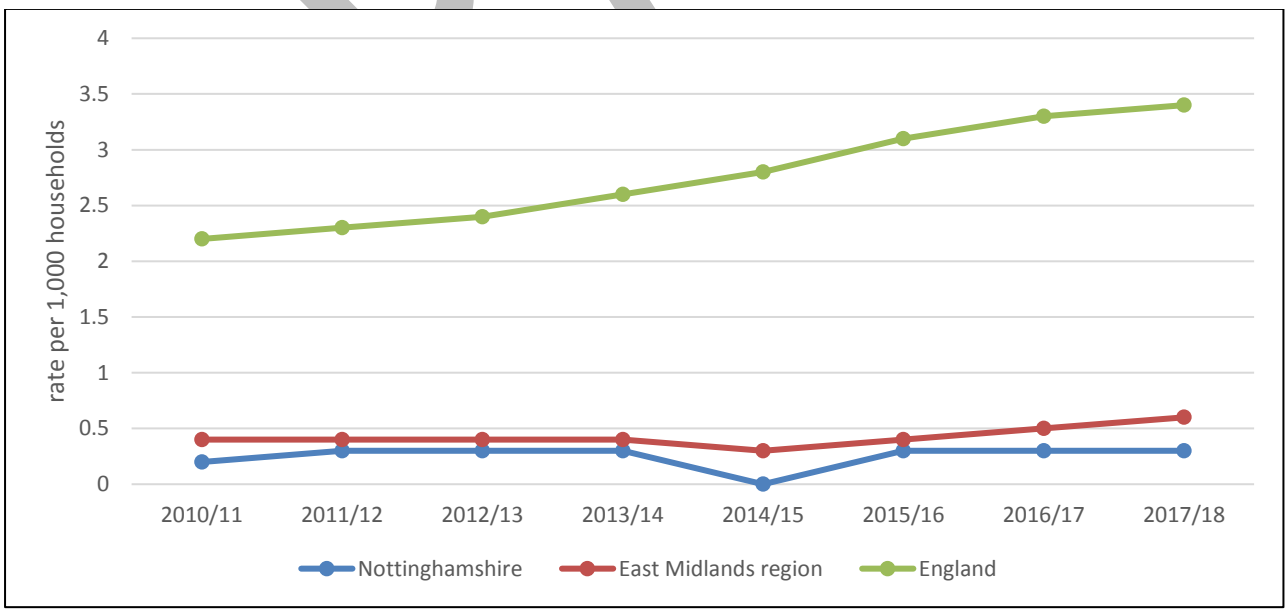
Figure 11: Rate per 1,000 household in temporary accommodation by each Nottinghamshire district compared to East Midlands from 2008/09 to 2017/18



Source: P1E data

The Nottinghamshire rate per 1,000 households in temporary accommodation has remained relatively unchanged at 0.2 per 1,000 households in 2010/11 to 0.3 per 1,000 households in 2017/18. This equates to 80 households in 2010/11 to 110 household in 2017/18. Nottinghamshire is consistently lower when compared to England and the East Midlands region.

Figure 12: Nottinghamshire rate per 1,000 household compared to England- Statutory Homelessness – households in temporary accommodation 2010/11 to 2017/18



Source: Ministry of Housing, Communities & Local Government

Total households assessed by Local Authority as owed a duty
Since the introduction of the Homelessness Reduction Act 2017, data is reported to MHCLG on initial assessments. However, this data is still relatively new and thereby considered as experimental statistics. This data provides an indication of the number of households owed a duty by the LA as a result of the initial assessment.

This is utilised in two ways in this section on our estimate of the size of the issue locally.

This data return can tell us, of the number of households assessed how many households are owed a duty - whether this be support to prevent them becoming homeless (prevention duty) or action to address their homeless situation (relief duty) or whether following assessment the household is not threatened with homelessness within 56 days (no duty owed).

Secondly of those owed a duty by their LA, information is documented on their physical health, mental health and drug and alcohol support needs. Thereby helping us build a picture of the potential health needs we can seek to address sooner thereby avoiding health conditions deteriorating alongside a potential homelessness situation arising.

In Nottinghamshire in 2018 on average 730 households were assessed over a three month period of whom 657 households were owed a duty by their local authority. Of these 657 households 121 (18%) identified a history of mental health needs, 74 (11%) experienced physical ill health and disability, 23 (3.5%) experienced drug and 14 (2%) alcohol dependency needs. It is acknowledged that whilst each health status is self-reported and not validated at the point of assessment this data alongside the health profile presented in section 2 provides us with some useful information about the health need of homeless people in Nottinghamshire.

Further to this, one specific cohort of vulnerable people we do know the housing status of is those who are in structured substance misuse treatment. Of the 2,265 people accessing structure substance misuse treatment in December 2018 in Nottinghamshire, 478 (21%) disclosed having no fixed abode or housing problems at one point in time (December 2018).

2.2) Health needs of the homeless in Nottinghamshire

Nottinghamshire Homelessness Health Check

There is very little health data collected on the Nottinghamshire homeless population, mainly due to housing status not being routinely recorded in healthcare. Therefore, to calculate the local crude rate of physical and mental health problems in the homeless population, the national health status estimates[60] of the homeless population were applied to the local Nottinghamshire population accepted as being homeless and in priority need. The prevalence of the following estimates relating to health and wellbeing are based on a Nottinghamshire figure of 628 homeless people (MCHLG 2017-18 numbers accepted as being homeless and in priority need). However, this cohort is not exactly the same as those who form the sample in the Homeless Link's Health Audit Data which was users of homeless services. Thereby this data may overestimate the health needs of all Nottinghamshire homeless people.

Smoking, Drugs and Alcohol Use

Table 3 below gives the crude estimates of the smoking status, drug and alcohol use across the Nottinghamshire homeless population.

- The estimated number of smokers is significantly higher than the general population, 78% compared to the general population, 14.9%.

- Approximately, 84% are consuming alcohol higher than the recommended guidelines with 35% drinking heavily, 10+ units on a typical drinking day.
- Cannabis use is the most common drug of choice, 62%. However, it is likely that a number are combining alcohol consumption with poly drug use.

Table 3: Crude Estimates - Number/% of the Nottinghamshire accepted as being homeless and in priority need population - smoking, drug and alcohol use status

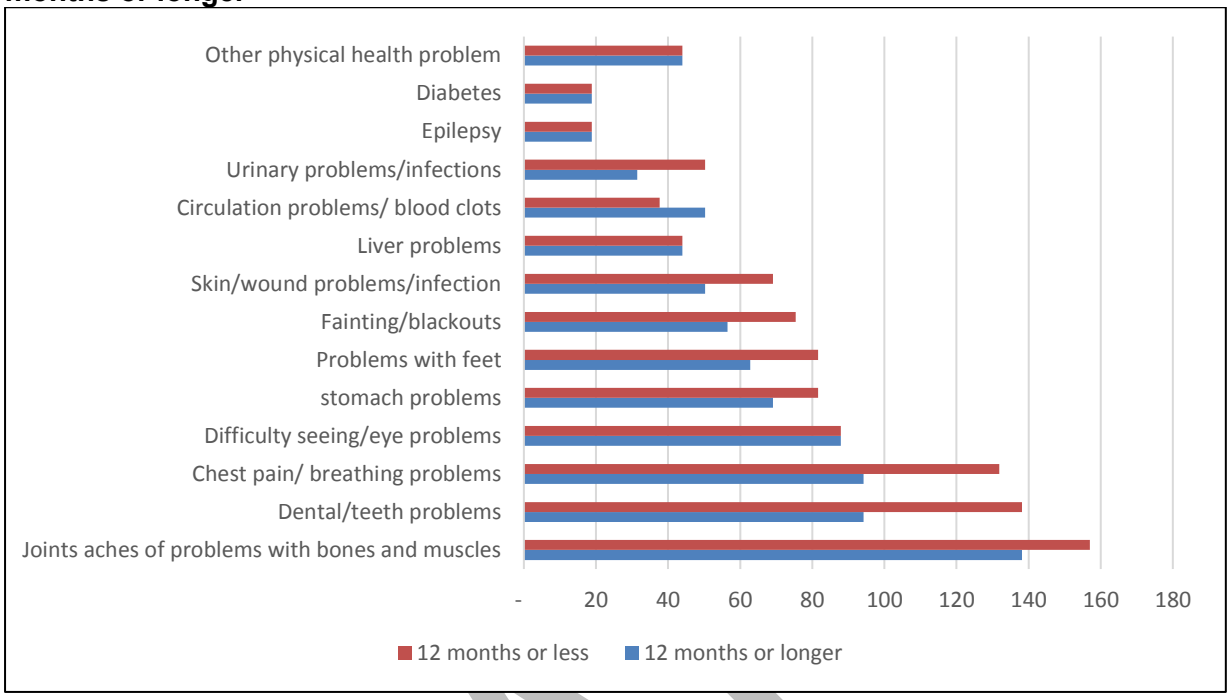
Unhealthy lifestyle behaviour	Use and Frequency	Number	%
Smoking Status			
Currently smoke	Yes	489	*78*
Would like to stop smoking?	Yes	251	*40*
Has been offered advice or help to stop smoking?	Yes, and took this up	94	*15*
	Yes, but did not take this up	333	*53*
Alcohol Use			
Drinking frequency	Every day	94	*15*
	4-6 times per week	31	*5*
	2-3 times per week	88	*14*
	2-4 times per month	94	*16*
	Monthly or less	151	*24*
	Never	157	*25*
Average units consumed on a typical drinking day	1-2 units	100	*16*
	3-4 units	132	*21*
	5-6 units	107	*17*
	7-9 units	75	*12*
	10+ units	220	*35*
Drug Use			
Used heroin in the last month	Yes	188	*30*
Used crack/cocaine in the last month	Yes	170	*27*
Used cannabis/week in the last month	Yes	389	*62*
Used amphetamines/speed in the last month	Yes	113	*18*
Used benzodiazepines in the last month	Yes	119	*19*
Used prescription drugs in the last month	Yes	188	*30*
Used methadone	Yes	195	*31*

Source: Homeless Link (2014) ***Drug use for some individuals includes poly drug + alcohol use**

Physical Health Problems

It is estimated that muscular skeletal problems, followed by dental and chest pain / respiratory problems are the greatest physical health problems amongst the Nottinghamshire homeless population, as shown in figure 13.

Figure 13: Crude Number Estimates of Nottinghamshire accepted as being homeless and in priority need population – reported physical health conditions - previous12 months or longer

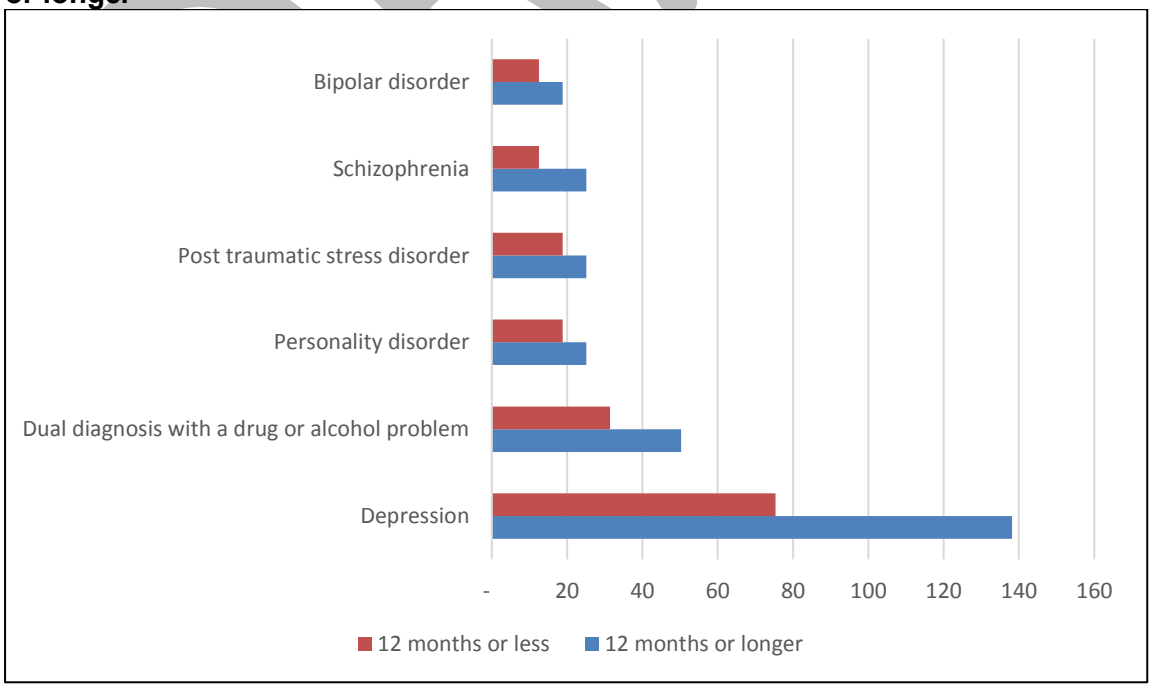


Source: Homeless Link Health Needs Audit

Mental Health Problems

For mental health problems, as shown in figure 14, long term depression rates the highest followed by mental health problems with co-existing substance misuse problems.

Figure 14: Crude Number Estimates of Nottinghamshire accepted as being homeless and in priority need population – reported mental health problems - previous12 months or longer

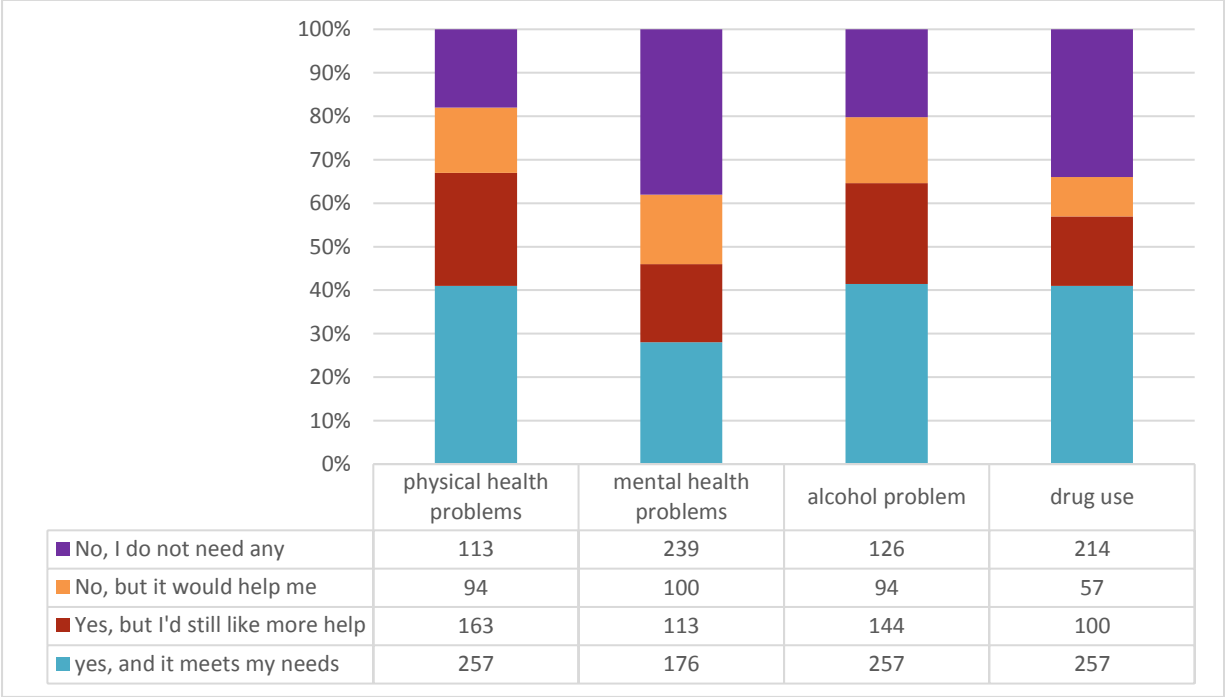


Source: Homeless Link Health Needs Audit

Access to Health Interventions and Treatment

Improving access to health services and access to ongoing treatment is wanted across physical and mental health as well as substance misuse services, as shown in figure 15.

Figure 15: Crude Number Estimates of Nottinghamshire accepted as being homeless and in priority need population – access to health interventions and treatment



	physical health problems	mental health problems	alcohol problem	drug use
No, I do not need any	113	239	126	214
No, but it would help me	94	100	94	57
Yes, but I'd still like more help	163	113	144	100
yes, and it meets my needs	257	176	257	257

Source: Homeless Link Health Audit

In terms of types of healthcare used in the past 6 months General Practice is the most frequently used followed by visits to A&E as shown in table 4.

Table 4: Crude estimates – Number/% of healthcare usage

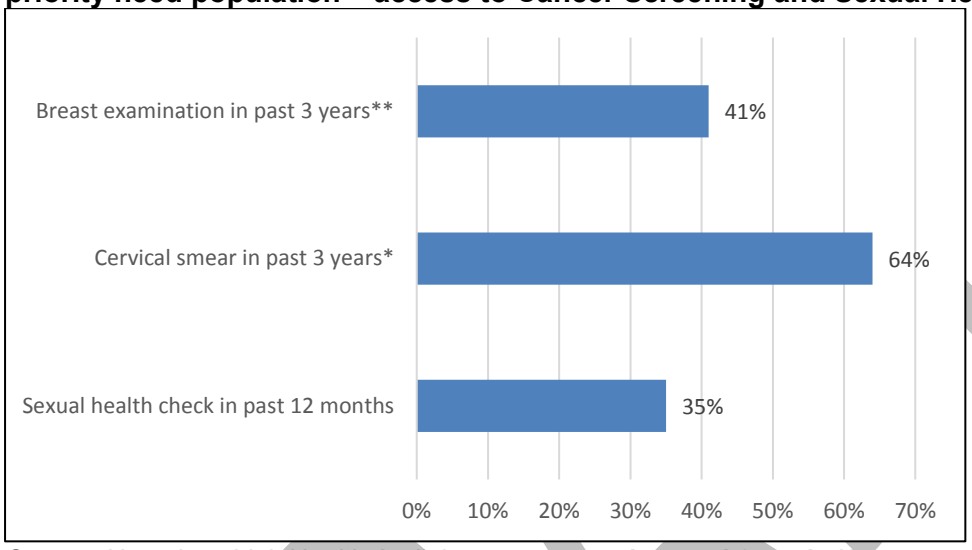
Type of healthcare usage	Over 5 times		3-5 times		1-2 times		Yes	
	Number	%	Number	%	Number	%	Number	%
Used a GP in the past 6 months	188	*30*	126	*20*	201	*32*		
Used a dentist in the past 6 months	13	*2*	25	*4*	182	*29*		
Used an ambulance in the past 6 months	13	*2*	19	*3*	132	*21*		
Visited A&E in the past 6 months	31	*5*	38	*6*	170	*27*		
Admitted into hospital in the past 6 months	13	*2*	19	*3*	132	*21*		
Hospital staff ensured suitable discharge							446	*71*

Source: Homeless Link Health Audit

Access to Sexual health, breast and cervical cancer screening

As shown in Figure 16, the estimated uptake of breast and cervical cancer screening in the homeless population of Nottinghamshire is lower when compared to the general population, 71.1% and 75.2%, respectively. The rate of uptake in the general population in accessing sexual health checks is not quantifiable due to the confidential nature of sexual health service provision. Therefore, the estimate of homeless people accessing sexual health services cannot be compared against the general population.

Figure 16: Crude Estimates – % of Nottinghamshire accepted as being homeless and in priority need population – access to Cancer Screening and Sexual Health checks



Source: Homeless Link Health Audit *** women over the aged 25 only **women over the age 45 only**

Friary Drop in General Practitioner Sessions

The Friary Drop in service holds two General Practitioner (GP) sessions per week. On average, approximately 5 clients attend the session. The gender ratio of clients attending the GP session is 2:1 male with the majority in the age range between 20 to 40 years. However, clients accessing the service have been as old as 60-70 years.

The presenting health problems range from sore throats, coughs through to pneumonia, unexplained lumps and concern about a cancer diagnosis. Occasionally, sepsis or a Deep Vein Thrombosis (DVT), Pulmonary Embolus has been detected. Mental health problems, may present in crisis and need emergency access to mental health crisis care.

The pathway to access the GP is self-referral and the clinic does not hold an appointment system to support ease of access. However, appointments can be arranged if a client is brought to the clinic by their key worker.

Approximately 50% of clients are registered with a GP but many are unable to access health care for reasons such as; moved away from the area or do not have phone credit to make or receive appointments or have difficulty in navigating the system. When clients are not registered with a GP, the Friary Drop in GP will encourage a client to register with their local GP.

Occasionally, referrals are made directly to acute and secondary care hospitals but is dependent on the level of urgency and risk.

Nottinghamshire Health & Wellbeing Board

3) Targets and performance

There are three national outcomes frameworks (listed below)

I. Public Health Outcomes Framework (PHOF)
II. NHS Outcomes Framework (NHSOF)
III. Adult Social Care Outcomes Framework (ASCOF)

Public Health England has produced a comprehensive guidance document entitled Homelessness: Applying all our Health[76]. This document outlines the links between homelessness and health and lists the relevant health outcome measurements as outlined below in Table 5.

There are 2 specific indicators in the Public Health Outcomes Framework (PHOF) which relate to statutory homelessness.

- Eligible homeless people not in priority need (1.15i)
- Households in temporary accommodation (1.15ii)

Table 5: National Outcomes Framework specific indicators relating to Health and Homelessness

Indicator	PHOF	NHSOF	ASCOF
Wider Determinants of Health			
Social readiness	√		
Pupil absence (1.03)	√		
Proportion of adults in contact with secondary mental health services who live in stable and appropriate accommodation	√		√
Domestic abuse (1.11)	√		
First time offenders and re-offending levels (1.13)	√		
Health Improvement			
Self-reported wellbeing	√		
Smoking prevalence in adults (2.14)	√		
Successful treatment of drug treatment – opiate users (2.15i)	√		
Successful treatment of drug treatment – non-opiate users (2.15ii)	√		
Successful treatment of alcohol treatment (2.15iii)	√		
Cancer screening coverage – breast cancer (2.20i)	√		
Cancer screening coverage – cervical cancer (2.20ii)	√		
Cumulative % of the eligible population aged 40 to 74 offered an NHS health check (2.22iii)	√		
Cumulative % of the eligible population aged 40 to 74 offered an NHS health check who received an HNS health check (2.22iv)	√		
Cumulative % of the eligible population aged 40 to 74 who received an NHS health check (2.22v)	√		
Health related quality of life for people with mental illness	√	√	√
Employment for people with mental illness		√	
Employment for those who are in contact with secondary mental health services		√	
Total health gain as assessed by patients accessing psychological therapies		√	
Recovery in quality of life for patients with mental illness		√	
Excess under 75 mortality rate in adults with serious mental illness	√	√	
Excess under 75 mortality rate in adults with common mental illness	√	√	
Patient experience of community mental health services		√	
Health protection			
Population vaccination coverage – Flu (at risk individuals) (3.03xv)	√		

People presenting with HIV at late stage of infection (3.04)	√		
Incidence of TB (3.05ii)	√		
Treatment completion for TB (3.05i)	√		
Healthcare and premature mortality			
Mortality rate from causes considered preventable (persons) (4.03)	√		
Mortality from communicable diseases (4.08)		√	
Emergency readmissions within 30 days discharge from hospital (4.11)		√	√
Excess winter deaths (4.15)	√	√	√

4) Current activity, service provision and assets

Many assets are in place in order to respond to homelessness within Nottinghamshire however the amount of provision of such services is not necessarily sufficient or equitable across the county.

In addition to statutory services such as local authority housing departments our local assets include provision of:

- Advice services such as debt, welfare, legal and housing advice
- Accommodation in terms of supply of places to live – local authority housing, registered social landlords, private rents
- Accommodation based support services e.g. support in hostels, support in tenancy, floating support
- Emergency accommodation for young people in a housing crisis and refuge accommodation for those fleeing domestic abuse
- Support with specific groups of people Care Leavers, Younger People, mothers with babies, mental health, disabilities, autism
- Clinical services both primary, secondary, mental healthcare and substance misuse services
  Outreach services to those who are currently experiencing rough sleeping
- Prevention, education and training providers, advice to prevent homelessness

Appendix 2 provides a breakdown of the Health and Homelessness prevention, early intervention and treatment and recovery activity service provision, commissioned services and assets within Nottinghamshire. The majority of activity and provision targets those people who are already homeless rather than focusing on preventing homelessness from arising in the first place.

Primary and secondary healthcare

General practice provides primary care services to registered patients, patients can be registered temporarily however transient and homeless individuals may find it difficult to register with some GP practices[61] [62]. One approach to address this is via a GP locally enhanced service (LES). There are currently 4 practices (3 in Nottingham City) and 1 in Mid Notts that adopt this approach locally. The CCG is the commissioner of this enhanced provision aimed at meeting the needs of homeless patients.

In Mid Notts Sherwood Forest Hospital NHS Trust provide a Street Health outreach provision working in partnership with a faith based organisation in central Mansfield. Services are being brought together in a community setting where homeless and rough sleeping people regularly attend to access hot meals, support and other services. The GP providing the LES, a mental

health worker from Nottinghamshire Healthcare NHS Trust and a substance misuse worker from Change Grow Live (CGL) is also contributing to a multidisciplinary team approach in this setting.

Nottinghamshire Local Offer for Care Leavers

Nottinghamshire County Council and the seven district councils in Nottinghamshire are the legal 'corporate parents' for care leavers and must provide a certain range of services and support by law, up to the age of 25 years. In preventing homelessness in care leavers, setting up a home support is offered and includes;

- Help with finding somewhere to live and supporting to manage tenancy and bills.
- Help to stay with foster families until 21, if wanted or for those18, and wish to stay with their foster family until the end of the summer term to finish school or college courses
- For care leavers with children of their own, accommodation is provided
- Help to find housing in an emergency
- Do not pay Council Tax until 25 years of age
- Are classified as a high priority on district council housing waiting lists

Street Outreach Team

In 2016, a joint proposal to Government by Nottinghamshire District Councils and Nottingham City enabled Framework Housing to develop a Street Outreach Service. The Framework County Street Outreach Team works across Nottinghamshire and exists to support those that are rough sleeping in the community. Teams go out in the early hours responding to referrals and directly engaging with individuals living on the street.

The service has three main functions;

- To engage with and support rough sleepers
- To quantify the extent of street homelessness in any area
- To work in partnership with other agencies such as the Local Authority.

The support offered by the Street Outreach Team is dependent on the need of the individual and may involve (but is not limited) to the following;

- Find safe and secure accommodation
- Find appropriate treatment for underlying substance, alcohol and mental health issues
- Secure access to medical help
- Re-engage with estranged family members
- Support to return to home region or home country where they can link in with existing support networks
- Claim whatever benefits they may be entitled to

The teams actively look for new and existing rough sleepers in known 'hot-spots' around the County. Further details of the Street Outreach team delivery and activity can be found in Appendix 3.

Friary

The Friary homelessness drop-in centre provides a range of services for people who are homeless or vulnerably housed with the purpose to empower people to rebuild their lives by offering practical services, advice and emotional support.

Data from The Friary homeless day centre (Oct-Dec 2018) shows that there were 327 individuals accessed the service. Of which, 145, 44% were deemed to be statutorily homeless. Appendix 4 gives a further overview of the Friary Drop in client demographic profile, current housing status, activity and delivery.

Framework Housing Association

Framework Housing Association is a charitable organisation delivering housing, health, employment, support and care across Nottinghamshire and offers services to people with a diverse range of needs from supporting people who are homeless, preventing others from losing their homes and help them sustain their own tenancies.

Framework Supported Accommodation Service is commissioned by Nottinghamshire County Council. The service provides intensive support in short-term hostel accommodation (up to 18 weeks) for single homeless people in immediate housing need, and less intensive support in Move-On accommodation (typically for 6 months and up to 12 months or more) for those whose history and/ or support needs makes it especially difficult for them to access mainstream social or private sector tenancies. The service aims to assist service users to achieve a range of outcomes including self-care, living skills, managing money, motivation, taking responsibility for themselves, managing their accommodation/ tenancy, reducing offending and meaningful use of time.

In the twelve months to March 2019 the Supported Accommodation Service (both hostel and move on comprising 238 units in all) was used by 413 separate individuals. The profile of this user group was similar to that of the rough sleeping population, a high percentage having significant and frequently complex support and care needs.

In the final quarter of 2018/19, a total of 39 new referrals were accepted into the short-term hostel element of the service (comprising 63 of the 238 units) and 31 people exited it in a planned way. Over the same period, 29 people accessed the move-on element with the same number (29) exiting it in a planned way. Among the barriers to leaving both the hostel and the move-on elements, and similar services provided by other specialist organisations, are the lack of availability of social housing and the expensive/ poor quality nature of private sector housing. This is exacerbated by the reluctance of landlords to grant tenancies to people with a history of rent arrears, offending or anti-social behaviour and the absence of provision for ongoing floating support.

Substance Misuse

Nottinghamshire County Council commission Change Grow Live (CGL) service to support people with substance misuse issues. Latest data from CGL shows that at December 2018, there were 2,265 service users in structured treatment and that 21% (478) disclosed to having No Fixed Abode (NFA) or having housing problems which further demonstrates the significant links between housing issues and substance misuse. Housing problems included those with acute housing problems; being in unsuitable housing or being in 'housing risk'.

Table 6 show the number and % by district for CGL clients reported being either NFA or having housing problems. Mansfield followed by Bassetlaw had the highest number experiencing NFA or housing problems, 35% and 23%, respectively. With opiate use being the highest substance of use for this cohort, 84% (table 7).

Table 6: Number/% of CGL clients with No Fixed Abode (NFA) or a Housing Problem – December 2018

Locality	Reported NFA/Housing Problem at assessment	% of total clients reporting housing problems (rounded)
Mansfield	166	35%
Bassetlaw	111	23%
Ashfield	80	17%
Newark and Sherwood	49	10%
Broxtowe	37	8%
Gedling	25	5%
Rushcliffe	10	2%
Grand Total	**478**	**100%**

Source: CGL performance data

Table 7: Number/% of CGL clients with No Fixed Abode (NFA) or a Housing Problem by type of substance misuse– December 2018

Drug Category	Reported NFA/Housing Problem at assessment	% of total clients (rounded)
Opiate	400	84%
Alcohol	43	9%
Non-Opiate	16	3%
Non-Opiate and Alcohol	19	4%
Grand Total	**478**	**100%**

Source: CGL performance data

5) Evidence of what works

Homelessness Prevention

Tackling homelessness at the crisis stage is estimated to cost between £20,128 and £34,500[2,3] per person per year. Whilst investing in homeless prevention can substantially reduce costs in direct service provision and provide further benefits of reduction in expenditure across the wider system, in areas such as health and policing[3].

The prevention of homelessness was a stated priority under the Coalition Government and in 2012 the Ministerial Working Group on Homelessness published Making Every Contact Count: A joint approach to preventing homelessness[63]. This report brought together the Government's commitments to:

- Tackle troubled childhoods and adolescence, including promoting innovative approaches to youth homelessness;
- Improve health, including improving outcomes for homeless people with dual substance misuse, and mental health needs; and helping improve hospital discharge practices;
- Reduce involvement in crime;
- Improve skills; employment; and financial advice;
- Pioneer social funding for homelessness – through a Social Impact Bond for rough sleepers and support to local commissioners to turn social investment propositions into a reality.

Preventative action can be split into three levels – in relation to health and healthcare and the prevention of disease this is routinely referred to as primary, secondary and tertiary where:

Primary prevention is to do with preventing or minimising the risk of a problem arising in the first place
Secondary prevention targets action towards individuals or groups who are at high risk of the problem, and
Tertiary prevention is intervening once there is a problem to stop it progressing further or getting worse.

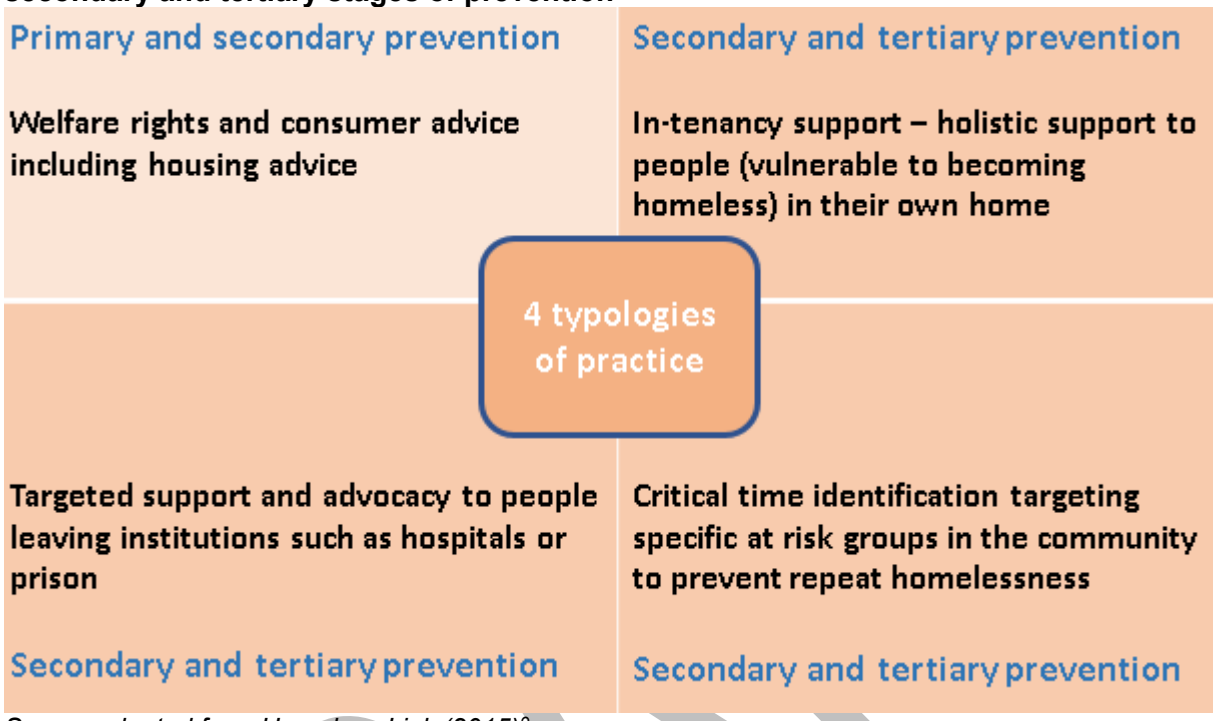
It is acknowledged that the evidence of the effectiveness and cost effectiveness of homeless prevention that takes place in relation to health and wellbeing is currently limited. Evidence in this field relates to the more acute end of homelessness namely secondary and tertiary prevention. However, there is learning based on evaluation of pilot and small-scale projects that can be used to inform preventative action in relation to homelessness[9].

Homeless Link's 2015 review of evidence into preventing homelessness to improve health and wellbeing[9] highlights prevention activity identified in the homeless sector where:

- Primary homelessness prevention involves action to avoid households becoming homeless such as action where there is a perceived threat e.g. eviction date and structural intervention such as increasing supply of affordable homes
- Secondary homelessness prevention includes action to prevent future homelessness from occurring for specific targeted groups such as young people or care leavers and
- Tertiary homelessness prevention includes interventions such as rapid rehousing that minimise repeat homelessness for those that have already experience homelessness.

In relation to current actions taken in response to homelessness and how these can fit within a preventative approach four typologies emerge from the 2015 review of evidence.

Figure 17: How current approaches to addressing homelessness fit within primary, secondary and tertiary stages of prevention



Source adapted from Homeless Link (2015)[9]

Critical time identification targets those in the community that have already experienced homelessness and whose current circumstance mean that even when accommodation is resolved are more likely to become homeless again.

Research[64, 65] identifies four phases of engagement to support individuals and families to develop sustainable strategies to live securely:

1. **Identify high risk groups** (e.g. prison discharge, mental illness, army veterans)
2. **Transition phase**: intensive support and advocacy from case worker to establish practical approaches (e.g. furniture, bill payments, moving in)
3. **Try-out phase**: case manager adopts a more hands-off approach but can step back in to support the individual as required. Ensures that mainstream services (e.g. doctors appointments, counselling sessions) are accessed
4. **Transfer phase**: a planned end to the support, involving individual reflection and recognition of the ongoing support available through universal services.

Emerging evidence from evaluations [63, 66, 67, 68] into homeless prevention identify some tangible steps which can be taken to reduce the risk of homelessness include:

- Provision of expert 'enhanced' housing advice, aimed at helping households to gain access to, or to retain private or social rented tenancies and providing information around entitlements and service access. This works best when delivered as a link worker/ case manager package to encourage advocacy and co-ordination. Advice

work often includes liaison with private landlords and may also have an 'outreach' dimension targeted at vulnerable groups.

- Rent deposit schemes, or other schemes to increase access to private rented tenancies.
- Family mediation. This tends to focus on preventing youth homelessness, with attempts made to reconcile parents and young people in order to prevent eviction from the family home. It can also involve facilitating young people's access to family support to assist them with independent living.
- Domestic abuse support. This includes a range of interventions such as 'sanctuary schemes' (security measures to enable victims to remain in their own homes after the exclusion of an abusive partner), supporting planned moves, crisis intervention services and resettlement support.
- Tenancy sustainment support, to help vulnerable tenants to retain their tenancies. These services often provide 'floating' support to people living in mainstream accommodation but are very diverse with respect to the intensity and duration of support they offer and the client groups targeted. Typically, help is provided with claiming benefits, budgeting, furnishing accommodation, accessing health and other services, in addition to seeking 'purposeful activity'.
- Intensive, time critical case management, for example prison-based homelessness interventions, and at other critical transition points e.g. leaving care, the armed forces, or hospital
- Sustained, person-centred, multi component support, for example long-term mentoring of individuals with chaotic lives (e.g. the Nightsafe[69] programme in Blackburn which involved one to one mentoring and coaching for young people to stay positively engaged and to overcome barriers to living safely and securely)
- Housing vouchers and subsidies (for example, medium-term subsidies for veterans and families in crisis has been shown to help homeless people to develop competencies to sustain their tenancy;
- Co-production of joint action plans. Plans should involve an element of choice and also be realistic.
- Fast, flexible access to financial support. Not just limited to use for rent, bills or deposits, but available to provide creative solutions

The prevention of homelessness can be undertaken by a wide range of services and sectors beyond housing, and interventions often target the factors which can put people's housing at risk – e.g. debt problems, poor mental health.

Early intervention in the context of homelessness

A number of studies highlight the risk of becoming homeless in the future is increased significantly if there are particular experiences in early childhood. It follows that, one key way to prevent or reduce such outcomes would be to identify and intervene at the earliest opportunity. Preventing childhood adversity and/or finding ways of mitigating against the negative outcomes associated with such experiences is crucial[70].

Similarly, Shelton et al[71] believe that young people at the greatest risk of becoming homeless should be identified early through schools, paediatric services, social services and other similar types of contact points with children and families. Also, they recommend that prevention efforts should also be directed towards other factors that appear to predispose young people to homelessness such as a diagnosis of depression and receiving psychiatric care in the past 5 years (mid to late teens).

Fitzpatrick et al[72] advise that preventative interventions should focus on earlier signs of distress wherever possible. For example, with schools, drug and alcohol services, and the criminal justice service who are likely to come into contact with those vulnerable to homelessness well before housing and homelessness agencies do.

For early intervention to prevent homelessness an inclusive integrated strategic and commissioning of services commitment and approaches is required to improve the health and wellbeing of local vulnerable communities to reduce health inequalities for all ages. Local authorities, clinical commissioning groups (CCGs), Health and Wellbeing Boards, Healthwatch, representatives of local voluntary and community sector organisations and communities themselves need to consider the health and social care and housing needs in disadvantaged areas or vulnerable groups who experience health inequalities. This applies to those who find it difficult to access services and those with complex and multiple needs, such as; gypsies, Travellers and Roma; the homeless and rough sleepers; sex workers; and vulnerable migrants[73].

Integrated working and system wide approaches

Johnsen et al[74] found that enforcement to combat street drinking and begging could result in positive outcomes for those who are homeless if there are also strong integrated working practices in place. This integration leads to less opportunities for vulnerable people to fall through the gaps between services and professionals and enables strong and coherent pathways for people.

One of the key examples of where integrated working and a system wide approach is vital is at the points in time when a person is leaving some form of institutionalised care be that a hospital, prison or mental health facility. The point of discharge from an institution is a particularly challenging time for any individual, but again having strong integrated pathways of care and support would reduce the impact of such experiences in relation to homelessness.

The Mental Health Needs of Nottingham's homeless population: an exploratory research study[75] undertaken by Sheffield Hallam University in 2018 highlights approaches that work effectively with people with complex needs including:

- ***Improving access*** through; interagency working, innovative referrals, e.g. without the need for GP referral, anonymous referrals, 'out of hours' or extended provision, direct access, co-location, empathetic and non-judgemental approach, outreach and in-reach
- ***Interagency working*** (assessment, referral, ongoing support), including: common assessments, co-location, information sharing, partnership networks and agreements
- ***Key working principles***, including: service navigators, or case co-coordinator, long-term support, follow-on or aftercare support, or onward referral, intensive support.

Further to this the report highlights good practice that includes – common single assessment, direct access services, peer support, dedicated mental health worker input, intensive support, key working, working in partnership, co-creation of services and strength based models.

Public Health England Homelessness: applying all our health

The PHE Homelessness: applying all our health guidance[76] outlines that for most people who are at risk of, or experiencing, homelessness and rough sleeping there isn't a single intervention that can tackle this on its own, at population, or at an individual level.

The guidance goes on to describe the action required to support better-integrated health and social care, and to help people to access and navigate the range of physical and mental health and substance misuse services they require in order to sustain stable accommodation.

Health and care professionals play an important role, working alongside other professionals to:

- Identify the risk of homelessness among people who have poor health, and prevent this
- Minimise the impact on health from homelessness among people who are already experiencing it
- Enable improved health outcomes for people experiencing homelessness so that their poor health is not a barrier to moving on to a home of their own.

The guidance recommends that there needs to be clear local action, partnership working (across the local authority, clinical commissioning group and other local organisations) and understanding and alignment of commissioning decisions to prevent and respond to homelessness across the life course. This can include:

- Reducing the risk of homelessness to children and young people to strengthen their life chances
- Enabling working-age adults to enjoy social, economic and cultural participation in society
- Breaking the cycle of homelessness or unstable housing by addressing mental health problems, or drug and alcohol use, or experience of the criminal justice system

This requires strong local leadership and prioritisation to identify unmet need, funding and actions to address gaps in provision

NICE guidelines

While there are no specific guidelines on homelessness, other guidelines do recognise the relationship between homelessness and specific health conditions, such as TB, alcohol and drug misuse and mental health problems.

Further evidence of what works is detailed in Appendix 6 and mapped against Health and Homeless promotion and prevention, Homeless early identification and Homeless treatment and recovery.

Homeless Treatment and Recovery Interventions

There are a range of interventions discussed in the literature linked to homelessness and rough sleeping.

Key interventions include:

- ***No Second Night Out*** [77, 78] – offers a 24 hour helpline and website so that members of the public can report and refer rough sleepers. An outreach worker dispatched to contact the person as quickly as possible, rapid assessment and helped to access a place of safety
- ***Housing First*** [79],[80],[81] – offers stable, affordable housing alongside ongoing, intensive person-centred support to enable people to keep their housing and avoid returning to homelessness. It operates in a harm reduction framework and is designed to provide open-ended support to long-term and recurrently homeless people who have high support needs, including severe mental illness, poor physical health, long-term limiting illness, physical disabilities and learning difficulties compared to the general

population. Clients do not have to be abstinent from drugs or alcohol to access services and getting housing or remaining in housing is not conditional on accepting support or treatment.

- ***Psychologically Informed Environments (PIE)*** [82] enables clients to make changes in their lives. Usually this approach would enable changes in behaviour such as reduce drug or alcohol use and/or change in emotions such as being less fearful. However, the report notes that people who are homeless or insecurely housed are among those most in need of psychologically informed help, but are also among those least able to access mainstream psychological therapy services. An explicitly psychological framework can legitimise and inform the different approaches staff can adopt providing additional insight into how people may behave. Training all staff within an agreed framework or combination of frameworks will help them work more effectively with clients with complex trauma.
- ***Personalised Services*** [83] - Homeless Link carried out a review of services, which aim to deliver personalised responses to rough sleeping and entrenched homelessness. They examined how 5 projects working with long-term rough sleepers and people with complex needs who had often been sleeping rough were using personalised approaches to support people sleeping on the streets. This approach whilst small in scale reported positive outcomes including increased self-confidence, taking responsibility, feeling better about themselves, reduce substance use and sustaining tenancy arrangements, increased hope. Personalised approaches were deemed to be most effective where workers were given time and flexibility to support clients as they require, with no imposed time limits for support and hold small case loads of clients.

6) What is on the horizon?

Tackling Homelessness Together national consultation

In February 2019, MHCLG published a consultation[84] on local structures relating to homelessness. The consultation sought views on how the Government could improve partnership arrangements and local accountability for the delivery of homelessness services in relation to:

- Existing accountability arrangements
- Homelessness Reduction Boards (HRB)
- Other ways of achieving effective partnership working.

The consultation asked for comments around the role, membership and geographical focus of the HRBs and suggested that the role of the HRB may include:

- Setting the strategic vision for reducing homelessness in the locality and monitoring progress in achieving it
- Using data, evidence, and user and lived experience to identify the homelessness challenges in the area, including those that may apply to particular groups of people, and priority actions
- Evaluating the effectiveness of service provision and interventions
- Mapping homelessness services and the delivery chain in the locality, redesigning them where appropriate to improve effectiveness and outcomes
- Identifying and co-ordinating across all partners the effective use of funding for homelessness services and interventions

- Promoting and facilitating the joint-commissioning of homelessness services and interventions.

Nottinghamshire submitted a joint consultation response and at time of publication of this JSNA is awaiting the government's response to the full consultation.

Nottinghamshire Homelessness Executive Steering Group - in line with the above consultation partners have taken steps to establish a countywide homeless strategic group. The group comprises of Public Health, Adult Social Care; CCGs; Children and Young Peoples Services and City and District Councils. However, it is proposed that the group should have a wider remit and, subject to the outcomes of the national consultation, could form the basis of the Homelessness Reduction Board.

Rough Sleeping Initiative

Funding that ceased for Homeless Street Outreach in April 2019 coincided with securing additional monies from MHCLG under the Rough Sleeping Initiative. This 2 year funding alongside some local investment from Public Health and district councils provides additional capacity to address rough sleeping and in particular to provide substance misuse and mental health support along with access to emergency accommodation. Further consideration will need to be given to what happens beyond the short term two year funding allocation from government.

Rapid Rehousing Pathway

The Rapid Rehousing Pathway was launched as part of the Rough Sleeping Strategy in August 2018. The pathway brings together 4 policy elements (Somewhere Safe to Stay, Supported Lettings, Navigators and Local Lettings Agencies) that will help rough sleepers, and those at risk of rough sleeping, access the support and settled housing they need to leave the streets for good. Nottinghamshire was successful in securing funding for 2019/20 and has begun this work. Further consideration will need to be given to what happens beyond the short term two year funding allocation.

A brief overview of planned implementation includes:

Call before you serve	An independent service provided by Decent and Safe Homes (DASH) which aims to engage with and support landlords if they are considering action to repossess a property to try to find solutions to sustain tenancies, or if it is not possible to work with that landlord to see if they would let their property to someone referred by the local council.
Social lettings	A private lettings agent has been commissioned to work with other private landlords to encourage them to let their properties to council referred people, by offering a range of support services and incentives, such as • Tenancy Liaison, and tenant identification • Access to the call before you service scheme – available to all landlords • Tenancy management This service will provide general needs housing for the local authorities.
Homeless Navigators	The navigators will have a small case load and a budget of £500 per person to help with rehousing costs, and their purpose is to engage with

	the most challenging cases, often requiring a multi discipline / service approach. To assist with our objective of delivering a more preventative as opposed to reactionary service, the 6 navigator posts will be located at the main sources of rough sleeping within the city and county Prison Navigators - two workers covering Nottingham and Ranby prisons one for the city one for the county. Hospital Navigators - two workers covering the hospitals one for the city one for the county. Mental health Navigators - two workers focussed on mental health, one based at Kingsmill hospital the other working with the moving forward team.
Supported lettings	The YMCA and The Friary have so far identified 8 units with a further 4 to follow These properties will assist with the rehousing of those applicants with additional needs Derventio Housing are undertaking similar work in mid Nottinghamshire
Landlord liaison officers	These posts will work with landlords to access additional affordable homes and provide support to tenants who may be experiencing difficulties with their landlord. 4 posts across the county as follows: - 1 Bassetlaw - 1 Mansfield - 1 Broxtowe, Gedling, Rushcliffe - 1 Ashfield and Newark

Nottinghamshire Supported Housing Strategy

The Nottinghamshire county-wide Supported Housing Strategy has been formulated to establish a strategic framework for meeting the needs of the most vulnerable people in Nottinghamshire through the appropriate and efficient use of housing, well-being and linked social care resources. Its purpose is to promote collaboration amongst partners, achieve a better outcomes for individuals and a rationalise and streamline the approach to service provision. It provides a cohesive response to the national and local policy agendas.

The strategy recognises that housing is a key contributor to health and wellbeing and that an integrated approach should be at the heart of policy development and operational implementation. Partnership working supports the strategy in promoting an effective interface between housing and social care services.

The current document is a hybrid which forms the basis for the further development of a finalised strategy on the one hand and on the other provides a strategic and practical framework for how the partners should work together going forward.

The partners to the strategy are the seven district councils within Nottinghamshire each of who have a homelessness and rough sleeping strategy or a homeless prevention strategy: Ashfield District Council, Bassetlaw District Council, Broxtowe Borough Council, Gedling Borough Council, Newark and Sherwood District Council, Mansfield District Council, Rushcliffe Borough Council as well as Nottinghamshire County Council.

Universal Credit in Nottinghamshire

Crisis reports widespread anxieties about the likely homelessness impacts of future welfare reforms already programmed to take effect over the next two years. They state nearly two thirds of local authorities anticipate a "significant" increase in homelessness as a result of the full roll-out of Universal Credit, with a further 25 per cent expected some level of increase[32].

At the end of 2018, the whole of Nottinghamshire became a full digital area meaning that most new claims from working age people for any type of benefit will be for Universal Credit. The government plans to start transferring people who are still on existing benefits or tax credits onto Universal Credit from July 2019 and expect to complete this process by March 2023.

Domestic Abuse Consultation

In January 2019, HM Government published the Transforming the Response to Domestic Abuse Consultation Response and Draft Bill[85] and identifies nine measures that require primary legislation to be implemented. The measure relating to Homelessness Prevention is where a local authority, for reasons connected with domestic abuse, grants a new secure tenancy to a social tenant who had or has a secure lifetime or assured tenancy (other than an assured shorthold tenancy), this must be a secure lifetime tenancy. The Domestic Abuse Bill will establish a commissioner, expected to play a key role in ensuring councils deliver support for victims and funding is expected to support this. Following the prorogation of parliament in September 2019 this bill has been cancelled but the government has indicated that a new domestic abuse bill will be developed[86].

Homelessness projections

It is difficult to make homeless projections in part due to the range of social and economic factors that influence rates of homelessness and in part because the likely impact of the Homelessness Reduction Act is not yet fully understood. Homelessness data from Wales suggests that following legislative changes in 2014 a 43% increase in approaches from households who were homeless or threatened with homelessness. The HCLIC data we use in this chapter is currently deemed experimental however this will become more established providing a clearer picture moving forward.

7) Local Views

Throughout the development of the JSNA, views have been sought from stakeholders, professionals and service users on homelessness need with regard to health, social and economic need and homeless prevention and recovery services in the County. This included;

- Establishment of a JSNA steering group which has included input from a wide range of partners including District/ Borough Councils; CCGs; Adult Social Care; County Children and Young Peoples Services, Public Health England and Public Health
- An on-line stakeholder survey
- Local exploratory research into mental health needs of Nottingham's homeless population
- Homelessness service user interviews
- Linking in with a commissioned pieces of work undertaken by Homelessness Link regarding the housing and support needs of under 35 year olds in the County (with a focus on the Ashfield, Broxtowe, Gedling and Rushcliffe areas) and the development of the mid-Nottinghamshire Homelessness Strategy (Ashfield, Mansfield, Newark and Sherwood).

Exploratory Research into the Mental Health Needs of the Nottingham population

The Mental Health Needs of Nottingham's homeless population: an exploratory research study[60] highlights the many difficulties and challenges encountered by homeless people and professionals in meeting the mental health and associated needs of homeless people with mental ill health summarised in the report as;

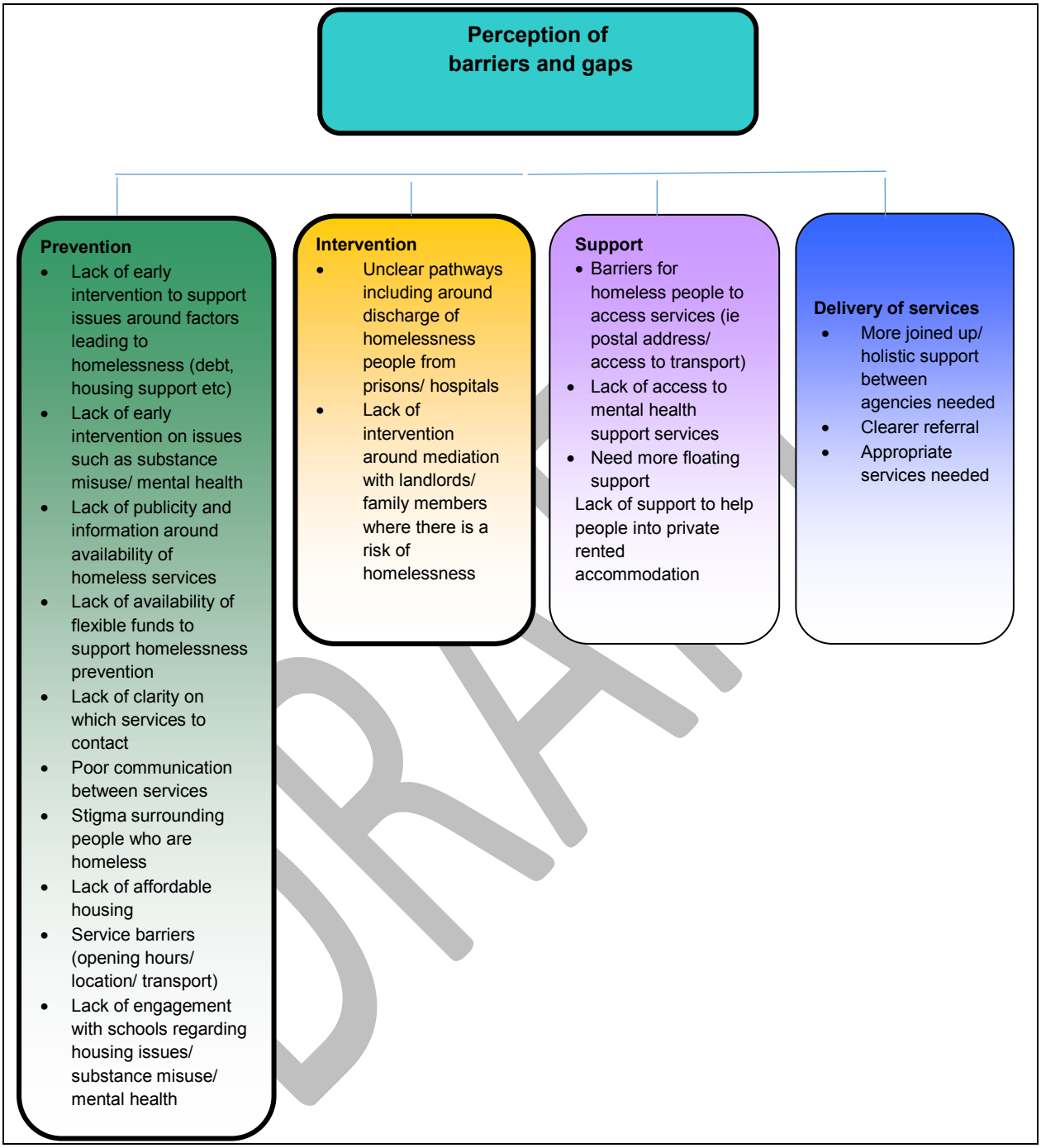
- **Accessibility**: many of the key barriers identified in this study related to accessing services, rather than problematic experiences with service provision or professionals.
- **Continuity of care**: including intensity and length of support.
- **Limited services working with people with complex needs**: this is a 'complex needs' population group, and service developments designed to better meet their needs will have to be informed by this fact.

Stakeholder Survey

An online survey undertaken in January/February 2019. The survey was emailed to key stakeholder partners including Framework; The Friary; Notts YMCA; Emmaus Trust; Broxtowe Youth Homelessness; Women's Aid; NCHA; Equation; Brighter Futures; DASH; Lighthouse Homes; District Councils; CCGs; County Adult Social Care; County Children and Young Peoples Services; Substance Misuse Services; Nottinghamshire Police. In total, 18 individual responses were received.

A summary of the findings from the stakeholder survey is detailed below in Figure 18. Full results from the stakeholder survey are detailed in Appendix 7.

Figure 18: Stakeholder Survey Health and homelessness perceptions of barriers and gaps in homelessness prevention, early identification, support and delivery of services



Private Landlords Forum

In October 2018, two private landlords' forums were undertaken to gain their views on housing people on benefits, in particular younger people (under 35s). A total of 80 private landlords from South Nottinghamshire and Nottinghamshire Private Landlords Forums took part.

Table 8 below summarises the forum responses.

Table 8: Private Landlords forum common themes on housing people under 35 years

Discussion	Common Themes
Issues with renting to people under 35	Main barriers were around property condition, such as; **Behaviour:** - Lack of respect for the property and potential damaging to the dwelling; - Behaviour including anti-social behaviour and causing a disturbance **Tenancy:** - High rate of tenancy abandonment - High rate of eviction - Tenancy turnaround (18-25) - Greater risk of tenancies failing due to rent arrears (18-25) - Property left in poor condition - Rent paid in advance **Knowledge:** - Maturity – less rental history and references to assess - Lack of knowledge and support on how to maintain a property - More likely to change location meaning higher turnover; **Financial:** - Being more likely to end up in arrears and not pay rent; - Lack of guarantor - Selective licencing increases costs for the landlord **Property:** - Affordability
Easier to rent to young people under 35 (and in particular to those on low income/ benefits)	- Some landlords suggested that nothing would persuade them to rent to younger people - Some stated that incentives such as rent deposits, rent guarantees or rent in advance may provide an appropriate incentive **Support:** - Access to key contacts and a 'dedicated support person' within councils - Helpful to deal with issues such as rent arrears, disturbance complaints, vacancies between tenancies and anti-social behaviour - Helpful to explore faster eviction processes for tenants that were causing very significant issues - Incentives should include rental guarantees; compensation if tenants cause significant physical damage to properties - A mediation service - Additional support where complex needs are evident - Education, training and employment - More work opportunities and removal of 0% contracts. - Employment support services/training - Pre-Tenancy training/Tenancy support - More engagement from this group with RSL/Community Group

Friary Drop In service user engagement

To gain a service user perspective on current homeless services and gaps, in-depth service user one to one interviews were conducted at the Friary Drop In. A total of three service users agreed to a one to one interview. All three of the service users were sleeping rough at the time of the interview.

Prior to becoming homeless, all participants experienced significant ***homelessness risk factors*** such as;

- Feeling unsafe in current tenancy and/or hostel accommodation due to verbal and physical abuse from neighbours
- Loss of employment due to mental health problems and alcohol use
- Loss of tenancy due to the 28 days' notice period
- No accommodation on release from prison

A number of ***health and support needs*** were identified and includes;

- Complex mental health problems
- Substance misuse
- Long term physical conditions

All of the participants expressed the difficulty in ***accessing health services*** when homeless. For reasons such as;

- Travel to health appointments when physical disabled and not eligible for a bus pass due to being homeless
- Walking long distances to health care appointments worsening the physical long term condition
- Not having a mailing address or mobile phone do not receive notification of health care appointments so miss health care appointments

Under 35 study

In 2018, Ashfield District Council, Broxtowe Borough Council, Gedling Borough Council and Rushcliffe Borough Council commissioned Homeless Link to carry out a study of housing options and choices for low-income single person households for people under 35. This came about in response to Government proposals to extend Housing Benefit Local Housing Allowance limits to social housing for people in this age group. The study is available at: www.ashfield.gov.uk/media/5729/housing-options-for-under-35s-final.pdf.

The study recognises the need to ensure an effective and joined up approach to preventing and relieving homelessness.

Key recommendations broadly fell into 2 themes of increasing supply and improving partnership working to maximise the contribution each agency/sector can make.

Further detail of the under 35 study can be found in appendix 3.

What does this tell us?

8) Unmet needs and service gaps

Housing and health need in Nottinghamshire must be set in the context that levels of statutory homelessness and rough sleeping remain low in the County and well below the England average. However rough sleeping numbers have shown a steady increase since 2010, with variation across districts and boroughs, and higher rates occurring in Mansfield and Bassetlaw. This gives an indication of a rising level of unmet health, social, welfare or housing need.

Housing supply and welfare

This JSNA has highlighted a number of factors that are known to affect availability of affordable and appropriate housing, in particular for the most vulnerable populations at risk of homelessness due to complex needs and debt arrears. Specific issues highlighted within this JSNA include

- Lack of affordable housing
- Housing benefit set at rates lower than landlord can obtain in rent on the open market
- Private landlords unwilling to consider housing people in receipt of benefits

- Private rental barriers to housing people aged under 35 years
- Need for support in tenancy to prevent eviction
- Housing options to support people with experience of homelessness and existing rent arrears
- Recent trend in increased use of bed and breakfast accommodation in some areas within Nottinghamshire

Whilst approaches to address housing supply in these cases are critically important to securing positive outcomes and reducing homelessness, these are rightly covered within the Homelessness Strategies produced by local Housing Authorities. Therefore, the recommendations of this JSNA will focus on the non-housing risk factors leading to homelessness and how these wider needs can be met.

It is clearly acknowledged that neither housing approaches nor wider health and social care support can be truly effective in isolation to prevent homelessness. These needs are interconnected and therefore implementing effective solutions requires dedicated and strongly aligned partnership working.

Primary prevention approaches

The role of upstream primary prevention initiatives is not yet fully understood or embedded within strategic approaches, either nationally or locally. This is likely driven by, amongst other factors:

- The need to focus limited local resources on addressing the most acute and immediate needs of those at risk of homelessness.
- The diffuse and system wide nature of risk factors leading to homelessness.

It is recognised that a range of local provision which commissioners currently invest in has the potential to significantly contribute to the prevention of poor outcomes through homelessness.

These include, but are not limited to:

- Debt, tenancy sustainment and welfare advice
- Veteran support strategies
- Housing adaptations secured through disabled facilities grant
- Substance misuse services
- Domestic abuse and sexual violence support services
- Family mediation
- Coping and resilience approaches in school settings
- Improving Access to Psychological Therapies (IAPT), talking therapies, social prescribing and befriending initiatives
- Employment support
- Ex-offender support strategies

It is difficult and possibly counter productive to identify unmet need in any single preventative approach, in particular as evidence points to the fact that those at risk of homelessness are far from a homogenous cohort and benefit from personalised approaches taking into account a range of support needs.

The opportunity across existing primary prevention approaches is for commissioners and providers to recognise that housing plays a critical role in health and wellbeing outcomes, and the services they provide have additional benefits of reducing future risk of homelessness. Strong joint working across services alongside improved awareness and skills in considering the housing needs of clients has the potential to maximise health outcomes for clients with

complex needs within existing resource. The "duty to refer" introduced in the Homelessness Reduction Act provides an opportunity to engage a wider frontline workforce on the impact of housing on health and identify needs earlier.

Early Intervention and support

Consultation with local stakeholders showed a perception that support where available was not well known about, nor readily accessible. There was also a perception that support was not offered early enough and did not cover the broad range of the needs experienced by service users. Whilst the introduction of the Homelessness Reduction Act may address the need for earlier identification and support to some extent, consideration needs to be given to how support offers can be made more visible and accessible. In particular, for individuals who experience complex needs or chaotic lifestyles consideration needs to be given to targeted or tailored outreach approaches which reduce the barriers to engaging with services for support, in order to reduce the risk of exclusion and worsening health inequalities.

Services and commissioners may also need to consider how the profile of available support can be raised in frontline settings, to facilitate a "no wrong front door" approach to support at the point of care.

Governance and leadership

The wide range of services which have a role in supporting better health outcomes for those at risk of homelessness means that strong governance and leadership is needed at strategic level, to drive, support and hold to account effective delivery across a partnership. Stakeholders have described current partnership arrangements as operational rather than strategic, which may limit effectiveness to drive system change such as strategic commissioning of care pathway approaches. The Rough Sleeping Strategy suggests the introduction of Homelessness Reduction Boards which would take on the role of leading system change.

Healthcare

Users of homeless services locally have reported particular barriers to accessing healthcare appointments and mental health services. This can be considered in the context that national evidence shows individuals who are rough sleeping or in temporary accommodation are high users of healthcare. The combination of difficulties accessing care, with high levels of health need (mental and physical) leads to high volume service use for potentially preventable conditions. In order to better meet the healthcare needs of this population, flexible, innovative and targeted approaches are needed which specifically address the barriers presented by having no fixed abode, no access to transport, multiple health needs and in some cases chaotic lifestyles. Some examples of such innovative practice have been piloted in primary and secondary care settings in Nottinghamshire but are not as yet commissioned in line with population need in an integrated approach. Given the relatively small numbers of individuals who present with high levels of complex need or in crisis (as compared to the population as a whole), a targeted approach, delivered in settings most accessible to homeless individuals, with high levels of support and case management, is most likely to be effective in meeting need. Effectiveness is likely to be enhanced by delivery alongside providers with existing trusted relationships in homeless communities. This JSNA highlights that substance misuse, musculoskeletal, dental and respiratory problems are likely to be the most prevalent physical health needs, along with a broad range of presenting common and severe mental health conditions.

In addition, homeless populations face inequalities in access to screening programmes for both communicable and non-communicable conditions. Inclusion health standards highlight that providing equitable care in this population requires opportunistic approaches to offer screening and treatment.

Integrated commissioning and care pathways

Both service users and commissioners have reflected that commissioned support appears fragmented, potentially duplicative, and in some cases with lack of clarity as to thresholds and eligibility criteria. Where service users present with multiple or complex needs this can result in multiple assessments, referrals and delays in care, which in a worst-case scenario leads to disengagement by the service user and difficulty in supporting recovery within temporary accommodation settings. One strategy to support service users in navigating care is the use of a case worker, however it is unclear whether case worker capacity is sufficient to meet existing needs, and fragmented care pathways will also impact on the effectiveness of case workers themselves.

The service gaps particularly noted include management of support for those with mental health and/or social care needs, although interactions between all services are perceived as challenging.

Therefore, there is a critical need for commissioners (together with providers) to work jointly in creating effective care pathways which will deliver better value for individual services through more efficient processes, and better outcomes for service users through joined up person centred approaches.

The evidence base suggests that care-pathways designed around critical time intervention, identifying high risk groups at specific points, such as discharge from prison or other institution can offer an effective risk stratified approach. Examples of such approaches are currently being trialled as part of the Rapid Rehousing Pathway, providing navigators for prisons, hospitals and mental health. To maximise the opportunities for effectiveness in these pilots, specific partner commitment is needed for:

- Robust evaluation and sharing of learning across the local system.
- Development of integrated care pathways which address wider health and social needs in addition to housing provision.
- Development of sustainable financial investment to embed effective practice emerging from the pilot.

9) Knowledge gaps

This JSNA has relied on a combination of local views, local commissioned research and national data to develop a picture of health needs for those at risk of homelessness. There is very little reliable local data available to allow robust assessment of the scale of homelessness and the range of local health need. In addition to this there is currently insufficient information available to inform commissioning in relation to the needs of certain groups known to be at greater risk of being homeless e.g. veterans, offenders and people being released from prison.

This is a gap mirrored at national level and highlighted in the Rough Sleeping Strategy. Further work is needed for commissioners and providers to routinely collate and share information locally on the risk factors and health, housing and social care needs of those accessing services, as a starting point for estimating true population health need. It is expected that the new H-CLIC data collection will provide some useful data to better quantify need in those owed a support duty.

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What should we do next?

10) Recommendations for consideration by commissioners

	Recommendation	Lead(s)
Strategic Leadership, Governance and Partnership Working		
1.	Establish formal governance arrangements in line with Ministry of Housing, Communities and Local Government (MHCLG) proposals for a **Homelessness Reduction Board**, to provide leadership and accountability for improving health and homelessness outcomes, including delivery of JSNA recommendations.	Housing Authorities, Commissioners of Supported Housing
2.	Establish a coordinated or integrated strategic commissioning forum to address gaps in provision and enable effective care pathways across housing, social care, mental health and primary and secondary healthcare.	Housing Authorities, Supported Housing Commissioners, Clinical Commissioning Groups (CCG), Adult and Children's Social Care
3.	Identify opportunities through the Homelessness Strategies of Nottinghamshire Housing Authorities to support prevention and early identification of homelessness by partners across the system, including best use of duty to refer.	Housing Authorities
4.	Consider the recommendation of the Rough Sleeping Strategy that strategic leadership is provided through a dedicated Homelessness lead on the Health and Wellbeing Board.	Health and Wellbeing Board
Integrated Commissioning and Care Pathways		
5.	Develop and implement a commissioned care pathway for critical time intervention with specific high-risk groups: ex-offenders, mental health needs, veterans, substance misuse.	Strategic Commissioning Forum
6.	Identify opportunities to align funding to evidence based primary prevention of homelessness, including through family mediation, debt advice, healthy lifestyles, tenancy sustainment initiatives, and education/support in at risk groups.	Homelessness Reduction Board
7.	Develop the healthcare offer across primary, secondary and community care to meet the specific health needs of those with no fixed abode or in temporary accommodation, in line with inclusion health standards.	Clinical Commissioning Groups (CCG), Health Care Providers
8.	Identify opportunities to strengthen effectiveness of Street Outreach and Rapid Rehousing Pathway initiatives through system wide engagement, pathway development and advocacy for longer term funding settlements.	Homelessness Reduction Board
9.	Identify and implement strategies for opportunistic screening and treatment for communicable diseases	Public Health England, Health

	including blood borne viruses and tuberculosis, in settings most accessible to at risk homeless populations.	Protection Strategic Group, CCG
Implementation - Service Models, evaluation and data collation		
10.	Embed evidence based psychological approaches to managing and recovering from complex trauma into front line delivery of service, including Psychologically Informed Environments and trauma informed services (ReACH)	Service Providers
11.	Develop robust and shared methods for data collation and evaluation for existing services, to improve local knowledge of risk factors and health needs for those at risk of homelessness	Strategic Commissioning Forum
12.	Develop a strategic assessment of the Housing First model, as an option for securing long term health and social gains for individuals with complex and enduring needs, including substance misuse.	Strategic Commissioning Forum
13.	Develop shared protocols across service provision to improve accessibility and visibility of early identification and support options.	Service Providers

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Appendices:

Appendix 1: Number of eligible homeless in Nottinghamshire from 2013/14 to 2017/18

District	Year	Eligible, intentionally homeless and in priority need	Eligible, homeless but not in priority need	Eligible, but not homeless	Total decisions
Ashfield	2013-14	10	0	34	133
	2014-15	13	11	36	146
	2015-16	14	10	21	138
	2016-17	21	9	33	163
	2017-18	14	6	20	163
Bassetlaw	2013-14	11	39	81	172
	2014-15	30	53	101	275
	2015-16	22	66	84	237
	2016-17	20	32	51	191
	2017-18	16	10	49	152
Broxtowe	2013-14	8	8	10	36
	2014-15	5	9	10	34
	2015-16	0	0	7	24
	2016-17	0	0	7	28
	2017-18	10	8	13	46
Gedling	2013-14	0	0	16	74
	2014-15	0	0	14	91
	2015-16	0	0	30	114
	2016-17	0	0	19	124
	2017-18	0	0	20	128
Mansfield	2013-14	33	21	95	299
	2014-15	26	18	87	268
	2015-16	15	15	75	219
	2016-17	19	14	79	281
	2017-18	24	5	51	269
Newark & Sherwood	2013-14	6	0	8	145
	2014-15	0	0	10	139
	2015-16	0	0	18	128
	2016-17	15	0	0	131
	2017-18	22	0	0	124
Rushcliffe	2013-14	5	0	9	28
	2014-15	0	0	16	33
	2015-16	0	0	7	32
	2016-17	0	0	5	30
	2017-18	0	0	0	36

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Appendix 2: Nottinghamshire Health and Homelessness current activity, service provision and assets

1. Healthy housing														
Homeless Risk Factor/ client group	**Name of service/ asset**	**Description**	**District coverage**							**Commissioner/ funder**	**Service**	**Asset**
			Bassetlaw	Newark & Sherwood	Mansfield	Ashfield	Broxtowe	Gedling	Rushcliffe			
Young people	Broxtowe Youth Homelessness	Provide educational programme in schools and some pre-tenancy training and support					√		√	Lottery funded, some funding from Broxtowe BC and other sources	√	
	Bassetlaw Floating Support Service (Framework Housing Association)	Provides flexible housing related support for people who live in their own home or tenancy. We work to prevent homelessness, promote independence and ensure that the people we support can sustain their homes. We offer an individual support plan around: benefits, homelessness prevention, attending court, rent arrears, money management, debts, training and help with social inclusion.	✓									

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2. Homelessness prevention													
Homeless Risk Factor/ client group	**Name of service/ asset**	**Description**	**District coverage**							**Commissioner/ funder**	**Service**	**Asset**
			Bassetlaw	Newark & Sherwood	Mansfield	Ashfield	Broxtowe	Gedling	Rushcliffe			
All	The Ark	Housing, benefits advice						√		?	√	
Young people	Centre Place	Debt and homelessness advice to young people who are LGBT		√						Charitable trusts, Big Lottery	√	
Individuals with aspergers/ autism/ learning difficulties	Brighter Futures	Floating support for individuals with Asperger's/autism/learning difficulties			√					Commissioned	√	
All needing legal housing advice	Direct Help and Advice (DHA)	Wednesday afternoon sessions at Civic Centre for advice on housing and homelessness issues						√		Legal Advice Agency	√	
Homeless prevention	Citizens Advice Broxtowe	Specialist housing worker giving independent advice and debt advice service					√			Grant aid funded and funded through Broxtowe BC	√	

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Homelessness prevention	Citizen's Advice Newark and Sherwood	**Debt advice service**		√						NSDC and NS Homes	√	
Homelessness prevention	DASH – Call Before You Serve	Early intervention project to prevent landlords serving eviction notices (being developed)					√	√		District Council funded	√	
3. Treatment, recovery and rehabilitation												
Homeless Risk Factor/ client group	**Name of service/ asset**	**Description**	**District coverage**							**Commissioner/ funder**	**Service**	**Asset**
			Bassetlaw	Newark & Sherwood	Mansfield	Ashfield	Broxtowe	Gedling	Rushcliffe			
Domestic abuse (women)	Newark Women's Aid	Refuge accommodation for women and their families fleeing domestic abuse		√						Independent with HB to cover rent and support	√	√
Domestic abuse (women)	Nottinghamshire Women's Aid	Floating Support for women suffering Domestic Abuse		√	√	√				Commissioned service	√	
Domestic abuse (men)	Equation	Support for men fleeing threat of domestic violence	√	√	√	√	√	√	√			

Domestic Abuse (women)	Midland Women's Aid	Refuge accommodation for women fleeing domestic abuse.					√			An independent service with HB entitlement to cover rent and support	√	√
Domestic Abuse (women)	Women's Aid Integrated Service (WAIS)	Floating support for women experiencing DV					√	√	√	Commissioned service	√	
Domestic Abuse (women)	Broxtowe Women's Project	Floating support for women experiencing domestic abuse					√			Lottery funded	√	
Single people not in priority need	Framework Supported housing accommodation	Provider Framework Housing Association – Russell House/The Old Dairy – Supported housing for single homeless 10-12 bed spaces in Newark town centre.		√						County Public Health	√	√
Substance misuse	Framework Support housing accommodation	Pelham Mews – Newark Delivered for single residents with drug or alcohol issues		√						County Public Health	√	√
Rough sleepers	Framework – street outreach	Outreach service for Rough Sleepers	√	√	√	√	√	√	√	Government funded through bid to March 2019	√	

Aged 18+ with medium to low support needs	Framework – Elizabeth House supported accommodation	Supported housing for clients 18+ with medium to low support needs. 21 bed space accommodation (provision is shared between southern districts)					√	√	√	Commissioned service with HB to cover rent and support element	√	√
Unknown	Hope into Action	Supported housing						√		?		V
Homeless	HOPE	Direct Access hostel, 14 beds. Support plans, debt advice, legal advice, signposting to mental health, drug and alcohol. Average 100 per year	√							Self-Funding via Housing Benefit		
Young families	Bond Street Arnold	Young family accommodation						√		??		V
Rough Sleepers	Emmanuel House	Drop in service for street homeless people						√	√	??	√	√
Rough sleepers	The Friary	Advice for people facing homelessness, benefit advice, food bank	√	√	√	√	√	√	√		√	√
Single Homeless People	Derventio Housing Trust	Supported accommodation for single homeless in PRS leased properties.					√			Funded through HB to cover rent and support.	√	√

Males aged 18+ with medium to low support needs	Canaan Trust	Supported accommodation for males aged 18+ medium to low support needs 10 bed spaces					√			Independent service funded through the Trust	√	√
Singles and mother and baby provision	NCHA – Branching Out	Supported housing for young people aged 16 – 21. Service is for singles and mother and baby provision. Core service in Newark town centre + dispersed throughout district. https://www.ncha.org.uk/home		√						Commissioned with HB to cover rent and support	√	√
Young people (16-21)	NCHA (in partnership with New Roots) – Branching Out	Support to 79 young people aged 16-21, with an additional 2 emergency beds for young people in a housing crisis. There are 'core' services located in Newark, Retford and Worksop which are staffed 24 hours a day, and 'cluster' properties throughout Newark and Sherwood and Bassetlaw where young people receive visiting support (funded to July 2020 with the option to extend by total of 24 months)	√	√						Nottinghamshire County Council Commissioning and Placements Group	√	√
Young people (16-21)	Framework – Transitions North	Service provides support to 91 young people aged 16-21, with an additional 3 emergency beds for young people in a housing crisis. There are 'core' services located in Ashfield and Mansfield which are staffed 24 hours a day, and 'cluster' properties throughout both districts where young people receive visiting support.			√	√				Nottinghamshire County Council Commissioning and Placements Group	√	√

Young people (16-21)	Framework – Transitions South	Service provides support to 50 young people aged 16-21, with an additional 2 emergency beds for young people in a housing crisis. There is a 'core' service which is staffed 24 hours a day in Rushcliffe, and 'cluster' properties throughout Gedling, Rushcliffe and Broxtowe where young people receive visiting support.					√	√	√	Nottinghamshire County Council Commissioning and Placements Group	√	
Mental health	Framework and NCHA– Moving Forward	Mental Health Floating and accommodation based Support Also includes crisis link workers based on MH wards whose aim is to prevent people losing their home if being admitted to a MH ward and facilitate discharge in relation to any housing issues. http://www.frameworkha.org/framework_near_me/221_moving_forward_steps_to_independence	√	√	√	√	√	√	√	Commissioned by NCC ASCH	√	
Rough Sleepers	Framework – complex needs worker	1:2:1 support for entrenched rough sleepers http://www.frameworkha.org/		√						Community Safety Partnership	√	
Homeless	Sherwood Street Centre	Hostel 18+			√							
People facing homelessness	The Friary, Musters Road, W Bridgford	Advice for people facing homelessness, benefit advice, food bank						√	√			

Young people aged 16/17	High Needs DPS	23 LAC aged 16/17 with individual placement agreements with a range of providers. There are approximately 25 providers on the DPS to support young people unable to manage in the 16+ supported accommodation services. Contract duration is dependent on the provisions of the IPA	√	√	√	√	√	√	√	Nottinghamshire County Council Commissioning and Placements Group	√	√
Singles and mother and baby provision	Emmaus Trust	Supported housing for young people aged 16 – 25. Service is for singles and mother and baby provision. Approximately 35 bed spaces in Newark town centre https://www.emmaus.org.uk/		√						Independent service with HB to cover rent and support	√	√
Homeless	YMCA Shakespeare Street, Nottingham	Hostel (16-25 occasionally 35) Can self refer			√	√						
Homeless	YMCA	Hostel (16-25 occasionally 35) Can self refer	√					√				
Rough sleepers	Newark Churches Together – Impact	Drop in service for rough sleepers providing meals, washing facilities, clean clothing and a mentor service		√						Churches/ donations	√	

Homeless	Beacon Project	Day service – food, clothes, showers			√					More detail	√	
Homeless	Lighthouse	Hostel for males 18+			√	√				More detail		
Individuals with aspergers/ autism/ MH issues facing homelessness	Chatsworth House Framework	24 units in Sutton in Ashfield aimed at preventing people from becoming homeless and developing independent living skills.				√	√	√	√	NCC ASCH		

Appendix 3: Under 35 study

Increasing the availability of single person accommodation for people under 35 with low incomes with measures including improving access to advice, assistance and mediation; working with social landlords to seek to remove the perceived barriers to accessing housing, including rent in advance, historic anti-social behaviour and minor rent arrears etc; seeking to effectively use discretionary housing payments, rent deposit support etc to improve access to accommodation; work with landlords to support them accommodation people in housing need; consider using a housing first approach to respond to homelessness and complex needs; piloting house sharing models; consideration of utilisation of ex sheltered housing to young persons accommodation; procuring accommodation and bringing empty properties back into use.

Improving prevention/tenancy sustainment

With measures including commissioning support for people to sustain their accommodation through advice, assistance and remediation; further developing floating support to prevent loss of accommodation, support for moving into a new property and support for moving on from supported housing. Additionally, the report recommends more pre-tenancy training and financial literacy to ensure young people are better able to sustain their tenancy.

Increase the amount and range of supported options

Recommendations include commissioning accommodation based supported housing for people with additional needs; Commissioning a Housing First approach for those people who have the most complex needs; commissioning refuge accommodation; enabling access to extra support from Adult Social Care to support agencies in working with people who are close to thresholds; exploring Social Impact Bonds models (SIBS) for 18-24 year olds not in employment, education or training; working with partners to explore supported lodgings with well-trained and well-supported hosts in the social and the private sector

Improve move-on rates from supported housing

Standardising the placement of people ready to move on into band 2 housing registers across all areas; developing a move-on plan protocol to inform what type of accommodation is needed.

Advice and Information on housing and homelessness

Promoting information and advice about housing and homelessness; promoting access to floating support; maximising social media such as Twitter and Facebook.

Improve skills, training and employability of young people

Creating better linkages to develop training programmes and apprenticeships and exploring LEP funding to support training and development initiatives.

Build on existing partnerships and develop new ones

To further develop joint working between Districts and County Council teams and other partners (including mental health; drug and alcohol services etc) and to ensure effective shared understanding of key data relating to homelessness to plan effective joint measures; work with partners such as Jobcentres and faith groups; Ensuring that young people are actively involved in designing services that affect them.

Appendix 4: Street Outreach Team

From October to December 2018, a total of 2,231 individual interviews were conducted. Figure 3A gives a breakdown of the nature of support interventions offered. Welfare (refers to practical assistance given in the form of food parcels, clothing & toiletries) support intervention rated the highest, 60%.
There are 4 ways that individuals can self-refer or agencies can refer to us;

1. BY PHONE – Our 0800 number is free from any landline or mobile and is answered 24 hours a day, 7 days a week
2. BY EMAIL –sotnottinghamshire@frameworkha.org
3. BY STREETLINK – The National Rough Sleeping Referral mechanism www.streetlink.org.uk Can be downloaded on a phone or tablet as an app.
4. BY TEXT – No credit required and can text 80800 starting the message with SOT and we will respond

Table A below give a breakdown of all referrals from April 2017- March 2018 by District and the number of Street Outreach interventions delivered. Mansfield District had the highest number of Street Outreach interventions delivered, followed by Ashfield. However, as with all outreach services, a referral does not always mean someone is rough sleeping.

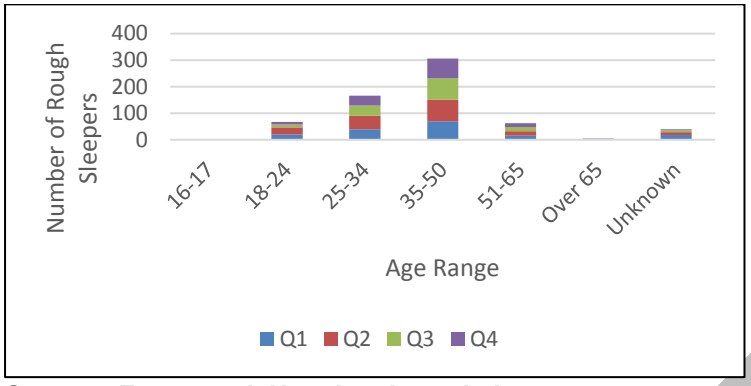
Table A: Number of Street Outreach interventions delivered by Nottinghamshire District – April 2017 – March 2018

Interventions	District							
	Ashfield	Bassetlaw	Broxtowe	Gedling	Mansfield	Newark & Sherwood	Rushcliffe	Total
People helped off the streets	27	32	1	8	62	11	24	**165**
Individual rough sleepers supported	50	56	10	11	122	24	49	**322**
Outreaches completed in area	82	65	38	37	100	39	66	**427**

Source: Framework Housing Association

Figure A shows the number of Street Outreach contacts by age range for each quarter in 2017/18. The highest proportion were aged between 35 to 50 years followed by 25 to 34 years.

Figure A: Number of individuals worked with the Street Outreach Team during 2017/18, by age range



Source: Framework Housing Association

Appendix 5: Friary Homelessness Drop In – Activity and Delivery

Table A1 shows the demographic breakdown for those attending the Friary between October and December in 2018. The district breakdown shows where people are of no fixed abode this refers to the area which they have the greatest connection. Of the 327 individuals accessing the service, majority of clients were from Nottingham City, 70.0% followed by Rushcliffe, 23%. With the majority in the18 to 49 years age range, 72% and predominantly male, 75%, and 69% White British. With majority, aged between 18 to 49 years, 72%, male, 75% and White British, 69%.

Table A1: Demographics of Friary Drop In clients

District of greatest connection	Number	%
City	241	*70.0*
Rushcliffe	79	*23.0*
Broxtowe	7	*2.0*
Mansfield	0	*0.0*
Ashfield	0	*0.0*
Newark and Sherwood	0	*0.0*
Bassetlaw	0	*0.0*
Age Range	**Number**	**%**
17 years and under	<5	*1.0*
18 to 49 years	235	*72.0*
50 to 59 years	42	*13.0*
60 to 64 years	20	*6.0*
65+ years	10	*3.0*
Not stated	16	*5.0*
Gender	**Number**	**%**
Male	258	*75.0*
Female	87	*25.0*
Ethnic Background	**Number**	**%**
White British	238	*69.0*
White other	64	*19.0*
Black British	28	*8.0*
Black other	5	*1.0*
Asian (incl Chinese)	<5	*1.0*
Not stated	8	*2.0*

Figure A1 below shows that the majority of the Friary drop in clients where living in private rental accommodation followed by temporary accommodation, 37% and 20%, respectively. 9% were rough sleeping.

Figure A1: Number/% of Accommodation Status of Clients attending the Friary Drop in Service – October – December 2018.

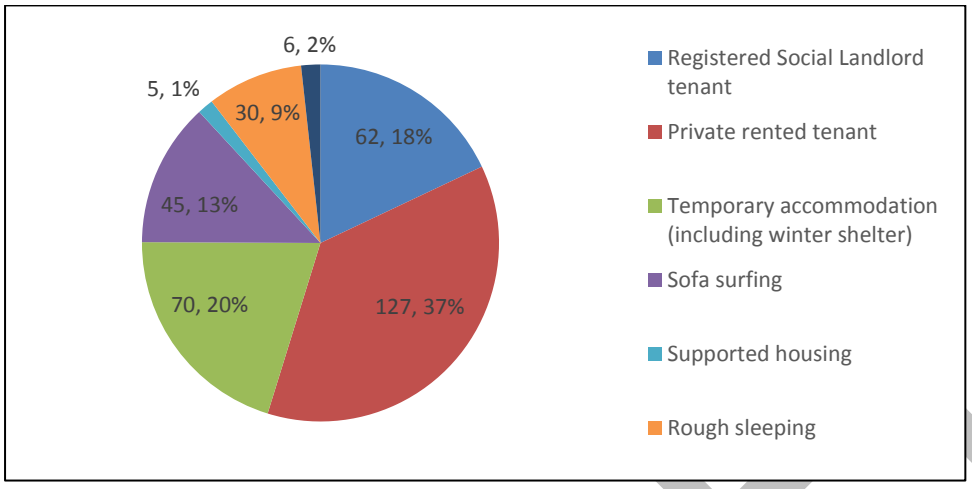
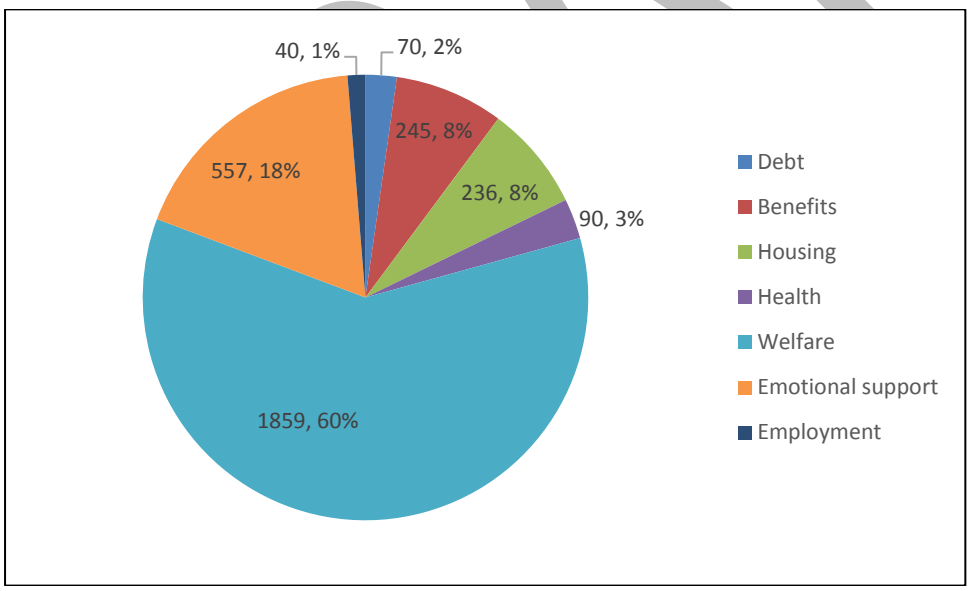


Figure B1: Number/% of support intervention offered to Clients attending the Friary Drop in Service – October – December 2018.



In table B1 below, shows the breakdown of facilities offered, with the highest being free meals followed by access to a shower and laundry facilities.

Table B1: Number of facilities offered to Clients attending the Friary Drop in Service – October – December 2018.

Free meals	620
Shower	581

Laundry	517
IT suite	336
GP consultations	104
Nurse joint with GP	48
Chiropodist	15
Optician	14

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Appendix 6: Evidence of what works - mapped against Health and Homeless promotion, Homeless prevention and treatment, recovery and rehabilitation.

Evidence of what works	Health of the Homeless Promotion and Prevention	Homelessness Prevention	Homelessness Early Identification	Homelessness Recovery and rehabilitation
National Policies and Guidance				
Homeless Reduction Act Homeless Reduction Act (HRA) (2017) extends the length of time a household can be considered at threat of homelessness from 28 to 56 days. Local authorities will be required to take action to support the household in finding alternative accommodation at the beginning of the notice period, rather than the end. The HRA brings a number of new duties to the local authority as follows: • Duty to assess - and develop personalised housing plans • Duty to prevent – to help stop a household from losing their accommodation • Duty to relieve – to help a household transition straight from one accommodation to another • Duty to refer – duty on other public sector bodies to identify people at risk of homelessness and refer them for assessment and support	x	x	x	x
Rough Sleeper Strategy Rough Sleeper Strategy (2018) is a wide ranging document which lays out the government's plans to help people who are sleeping rough now and to put in place the structures to end rough sleeping by halving rough sleeping by 2022 and ending it by 2027. Specifically, the Strategy makes funding available to tackle rough sleeping and homelessness more broadly.	x	x	x	x
PHE Homelessness: applying all our health Public Health England (PHE) Homelessness: applying all our health (2016) guidance provides examples to help healthcare professionals: • identify and advocate to prevent the risk of homelessness among people who have poor • health minimise the impact on health from homelessness among people who are already experiencing it enable improved health outcomes for people experiencing homelessness so that their poor health is not a barrier to moving on to a home of their own	x	x	x	x
Local Homelessness Strategies				
Local Housing Authorities (LHAs) are required to undertake an assessment of homelessness needs and provision and publish a homelessness strategy at least every 5 years. In the case of Nottinghamshire, the Local Housing Authorities are the seven District and Brough Councils.				
Bassetlaw Homeless Prevention Strategy (2017-2022): https://www.bassetlaw.gov.uk/media/2883/homeless-prevention-strategy-delivery-plan.pdf			x	x

At local level the Bassetlaw Homeless Prevention Strategy links to the new Council Plan, (2017 to 2020), and focuses on the ambition: Enhancing Home and Place, under the following priorities; • Support the delivery of a wide variety of homes across all sectors, (town & rural areas). • Work with the private rented sector to improve the quality of homes. • Use our full range of powers to protect local people and the place they live. • Support the health & wellbeing of local people through early intervention and initiatives.				
South Nottinghamshire (Broxtowe, Gedling, Rushcliffe) Homeless Strategy (2017 -2021) https://www.rushcliffe.gov.uk/media/1rushcliffe/media/documents/pdf/housing/homelessness/south%20nottinghamshire%20homelessness%20strategy%202017-2021-dr22086.pdf The strategy sets the framework for improving access to housing. Supporting vulnerable people and minimising rough sleeping continue to be our priorities, together with a greater emphasis on developing clear pathways and effective preventive interventions. Since publication in 2013, there has been significant progress through the implementation of South Nottinghamshire's first homelessness strategy through stronger partnership working between the three councils and our partners. The strategy was based on the following main strategic objectives: • No one should have to sleep rough in South Nottinghamshire • All local authorities will work with partners to reduce the number of homeless applications they need to consider year on year • All councils will minimise the use of Bed & Breakfast accommodation for homeless households, with the long term aim of ending it altogether • Knowing that there is insufficient social housing to meet demand, all potentially homeless clients will get the help they need to access private rented housing • All young people in South Nottinghamshire should learn about homelessness, realistic housing options, domestic abuse and healthy relationships in school • All client groups with special needs will have clear and up to date referral pathways so that it is clear which agency is responsible for providing services to them at what time.		x	x	x
Mid Nottinghamshire are currently working with Homelessness Link to develop a homelessness strategy				
Public Health Guidance				
Older people and alcohol misuse: helping people stay in their homes Guidance (2016) Guidance on how to prevent and reduce harmful drinking in older people	x	x	x	x
Hidden needs: identifying key vulnerable groups in data collections: vulnerable migrants, gypsies and travellers, homeless people, and sex workers (2014) This report, from the Data and Research Working Group of the National Inclusion Health Board (NIHB):	x		x	

• identifies where to find good data and the gaps in information and data where the burdens of ill health and untimely death are greatest for vulnerable groups (vulnerable migrants, gypsies and travellers, homeless people, and sex workers) • is for data providers, healthcare professionals, commissioners and others working to improve the health of the vulnerable groups The report concludes that: • it is impossible to obtain a comprehensive picture of the vulnerable groups' health • the health needs of some of the most vulnerable people in society continue to be invisible to health commissioners and the wider health system planners • the health needs of the vulnerable groups sometimes place heavy and unpredictable demands on the health service, which may result in multiple avoidable visits to hospital • the data gaps prevent effective monitoring of health care use and seriously undermine local efforts by NHS and local government to understand and prioritise the local needs of the vulnerable groups				
Commissioning inclusive health services: practical steps (n.d) While there are many vulnerable groups, the Inclusion Health programme has identified as an initial priority those with the poorest health, where information on their needs and successful interventions is relatively weak, and crucially where there has been much less focus in JSNAs. These are the focus of this guide: Gypsies, Travellers and Roma; the homeless and rough sleepers; sex workers; and vulnerable migrants. This guide includes a section for each of these groups describing their health needs and barriers they face to accessing services; and with practical advice for developing inclusive JSNAs and JHWSs.	**x**			**x**
Tackling tuberculosis in under-served populations (2019) Outline the roles of those involved alongside the TB clinical teams in meeting the needs of under-served populations. These chapters cover the roles and responsibilities of local government, TB Control Boards, CCGs and the third sector. With 'models of care' that can be used to meet the needs of under-served populations with TB.	**x**			
Tuberculosis (TB) and homelessness This leaflet advises people who work in the homelessness sector how to recognise TB and help clients access NHS treatment.	**x**			
NICE quality standards				
Quality standard for drug use disorders (QS23) (2012) This quality standard covers assessment and treatment of drug use disorders in adults (aged 18 and over). It includes treating the misuse of opioids, cannabis, stimulants and other drugs in all settings, including inpatient and specialist residential and community-based treatment settings, and prison services. It describes high-quality care in priority areas for improvement.	**x**			x

NICE Clinical Pathway for Hepatitis B and C testing (2017) This guidance gives and overview on Hepatitis B and C testing pathways, policy and commissioning on hepatitis B and C testing, increasing the uptake of hepatitis B and C testing and hepatitis B vaccination	**x**			
NICE Transition between inpatient hospital settings and community or care home settings for adults with social care needs NG27 (2015) This guideline covers the transition between inpatient hospital settings and community or care homes for adults with social care needs. It aims to improve people's experience of admission to, and discharge from, hospital by better coordination of health and social care services.	**x**			**x**
NICE clinical Pathways				
NICE Oral health: local authorities and partners QS141 (2014) This guideline covers improving oral health by developing and implementing a strategy that meets the needs of people in the local community. It aims to promote and protect people's oral health by improving their diet and oral hygiene, and by encouraging them to visit the dentist regularly	**x**			
Tuberculosis (NICE guidelines NG33) This guideline covers preventing, identifying and managing latent and active tuberculosis (TB) in children, young people and adults. It aims to improve ways of finding people who have TB in the community and recommends that everyone under 65 with latent TB should be treated. It describes how TB services should be organised, including the role of the TB control board.	**x**			
Borderline personality disorder: treatment and management (CG78) (2009) This guideline covers recognising and managing borderline personality disorder. It aims to help people with borderline personality disorder to manage feelings of distress, anxiety, worthlessness and anger, and to maintain stable and close relationships with others	**x**			
Antisocial behaviour and conduct disorders in children and young people: recognition, intervention and management (CG158)(2017) This guideline covers recognising and managing antisocial behaviour and conduct disorders in children and young people aged under 19. It aims to improve care by identifying children and young people who are at risk and when interventions can prevent conduct disorders from developing. The guideline also makes recommendations on communication, to help professionals build relationships with children and young people and involve them in their own care.	**x**	x		
Alcohol-use disorders: Diagnosis and clinical management of alcohol-related physical complications (CG100) (2017) This guideline covers care for adults and young people (aged 10 years and older) with physical health problems that are completely or partly caused by an alcohol-use disorder. It aims to improve the health of people with alcohol-use disorders by providing recommendations on managing acute alcohol withdrawal and treating alcohol-related conditions	x	x		**x**
Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence (CG115) (2011)This guideline covers identifying, assessing and managing alcohol-use disorders (harmful drinking and alcohol dependence) in adults and young people aged 10–17 years. It aims to reduce harms (such as liver disease, heart problems, depression and anxiety) from alcohol by improving assessment and setting goals for reducing alcohol consumption.	**x**	x		x
Drug misuse – psychosocial interventions (CG51) (2007) This guideline covers using psychosocial interventions to treat adults and young people over 16 who have a problem with or are dependent on opioids, stimulants or cannabis. It aims to reduce illicit drug use and improve people's physical and mental health, relationships and employment.	**x**	x		x

Severe mental illness and substance misuse (dual diagnosis) (2016) This guideline covers how to improve services for people aged 14 and above who have been diagnosed as having coexisting severe mental illness and substance misuse. The aim is to provide a range of coordinated services that address people's wider health and social care needs, as well as other issues such as employment and housing.				x
Evidence Reviews				
Preventing homelessness to improve health and wellbeing Research and analysis (2015) A rapid evidence review into interventions that are effective in responding to health and wellbeing needs, in households at risk of homelessness.	x	x		
PHE Homeless adults with complex needs: evidence review (2018) gives an overview of the homeless situation across England with insights into the current evidence base to support action to prevent and reduce homelessness. This review is aimed at local authorities and other stakeholders who are developing strategies and interventions to prevent homelessness and support adults with complex needs. It advises a system-wide, integrated approach to dealing with homelessness and identifies some tools and guidance which may be of use to local authorities in developing their work in this area.	**x**	**x**	**x**	**x**
Strategies and Policies				
Tuberculosis (TB): collaborative strategy for England Policy paper (2015) Public Health England (PHE) and NHS England's strategy for dealing with tuberculosis (TB) from 2015 to 2020.	x			
Reports and Resources				
Health and wellbeing: a guide to community-centred approaches Research and analysis (2015) This guide outlines a 'family of approaches' for evidence-based community-centred approaches to health and wellbeing. Peer-based interventions approaches aim to recruit and train people on the basis of sharing the same or similar characteristics as the target community, often with the aim of reducing communication barriers, improving support mechanisms and social connections. In the UK peer methods have been applied across a range of health issues, for example; people experiencing homelessness[87] Although all peer approaches aim to tap into the social influence of people who share similar experiences or characteristics, peer education focuses on teaching and communication of health information, values and behaviours between individuals, peer mentoring involves one-to-one relationships that model and support positive behaviour and peer support involves providing positive social support and helping buffer against stressors There is a clear link between peer support roles and mutual aid interventions that aim to encourage self-help and create supportive networks[88].	x			x
Making every contact count: A joint approach to preventing homelessness Making Every Contact Count is the government's strategy for reducing homelessness through joint working and preventative measures. It sets out ten recommendations to local authorities9: 1. Adopt a corporate commitment to prevent homelessness which has buy in across all local authority services 2. Actively work in partnership with voluntary sector and other local partners to address support, education, employment and training needs 3. Offer a Housing Options prevention service, including written advice, to all clients 4. Adopt a *No Second Night Out* model or an effective local alternative	x			x

5. Have housing pathways agreed or in development with each key partner and client group that includes appropriate accommodation and support 6. Develop a suitable private rented sector offer for all client groups, including advice and support to both clients and landlords 7. Actively engage in preventing mortgage repossessions including through the Mortgage Rescue Scheme 8. Have a homelessness strategy which sets out a proactive approach to preventing homelessness and is reviewed annually so that it is responsive to emerging needs 9. Not place any young person aged 16 or 17 in Bed and Breakfast accommodation 10. Not place any families in Bed and Breakfast accommodation unless in an emergency and then for no longer than 6 weeks[89]				
Homeless health needs: audit toolkit Research and analysis (2015) The Homeless Health Needs Audit offers a practical way to improve the health of people who are homeless in your local area.	x			
Planning Guidance				
Gypsy and Traveller health: accommodation and living environment Independent report (2016) National Inclusion Health Board (NIHB) report: effect of insecure housing and poor living conditions on health of Gypsies and Travellers.	x	x		

Appendix 7: Stakeholder Survey

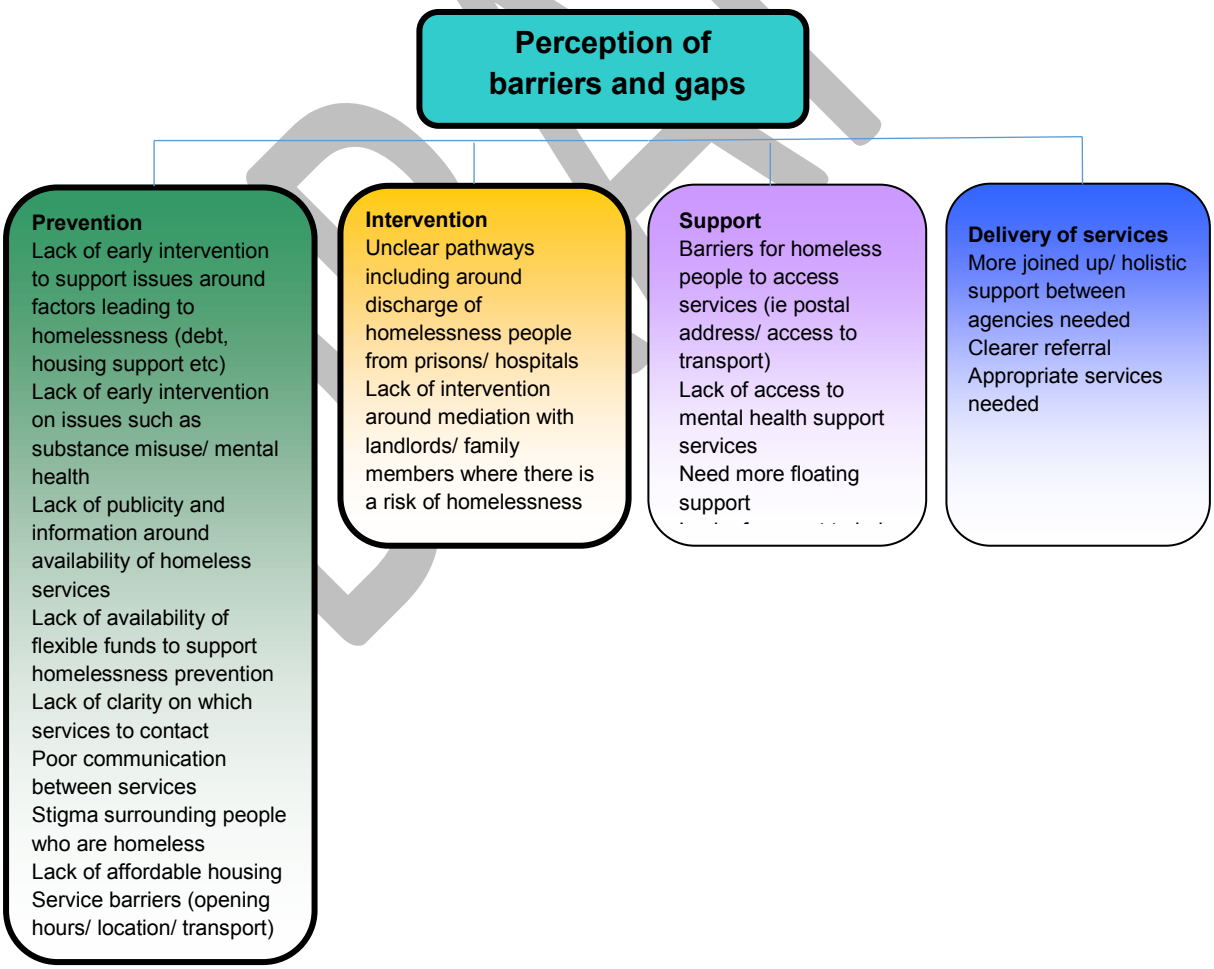
Views of professionals and service users.

Throughout the development of the JSNA, views have been sought from professionals and service users with regard to Health and Homelessness health, social and economic needs and homeless prevention and recovery services in the County.

This has included:

- Establishment of a JSNA steering group which has included input from a wide range of partners including District/ Borough Councils; CCGs; Adult Social Care; County Children and Young Peoples Services and Public Health
- An on-line stakeholder survey
- Homelessness service user interviews
- Linking in with a commissioned pieces of work undertaken by Homelessness Link regarding the housing and support needs of under 35 year olds in the County (with a focus on the Ashfield, Broxtowe, Gedling and Rushcliffe areas) and the development of the mid-Nottinghamshire Homelessness Strategy (Ashfield, Mansfield, Newark and Sherwood).

Summary of findings



Nottinghamshire Health & Wellbeing Board

Views of professionals

1. Methodology and responses

An online survey was opened on 18th January 2019 and ran until 1st February 2019. The survey was emailed to key stakeholder partners including Framework; The Friary; Notts YMCA; Emmaus Trust; Broxtowe Youth Homelessness; Womens Aid; NCHA; Equation; Brighter Futures; DASH; Lighthouse Homes; District Councils; CCGs; County Adult Social Care; County Children and Young Peoples Services; CGL; Police and others.

In total, 18 responses were received from a range of partner organisations.

Respondents **area of work** by top tier local authority and district (respondents could give more than 1 response)

District	N =
Ashfield	6
Bassetlaw	6
Broxtowe	3
Gedling	4
Mansfield	4
Newark & Sherwood	3
Rushcliffe	2
All of the Nottinghamshire area	2
Not answered	1
Prefer not to say	0
Total	31

Table xx shows the organisations and professional groups represented by the respondents. This provided a good mix of commissioners and service providers.

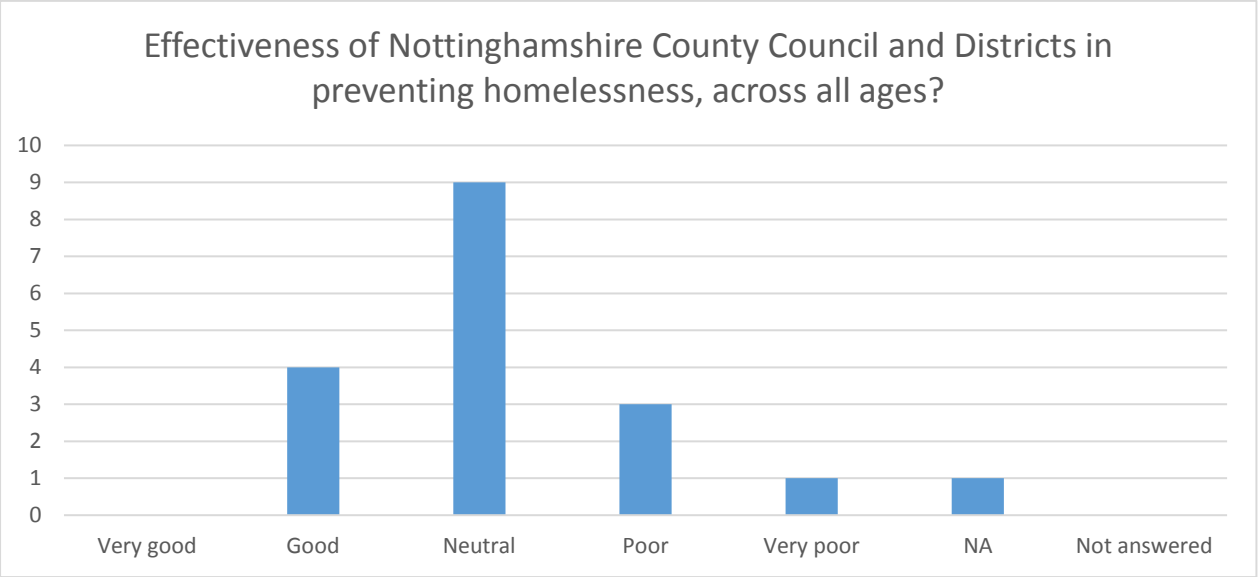
Survey respondents by organisations and professional group represented

Organisation	N =	Professional Group/s
CCG	3	Administrator Deputy Chief Nurse Head of Adult Nursing
Local Authority	5	Senior Community Engagement Officer Housing and Welfare Support Manager Housing Manager Housing Strategy Lead Homelessness Engagement and Development Officer
Service provider	9	Project Manager Head of Service Centre Co-ordinator Manager Manager Deputy Manager Site Manager Services Director
Missing	1	

Total	**18**	

General views

i) **Stakeholders were asked to rate the effectiveness of Nottinghamshire County Council and partners in preventing homelessness, across all ages. In total, 18 responded, as follows.**



ii) Stakeholders were asked to comment on what effective awareness, support and interventions (if any) are needed to be put in place to prevent homelessness, across all ages. Recurring points included:

- Earlier intervention before people become homeless
- More of a joined up approach across agencies
- A more holistic approach to support people to make sense of benefit changes
- More support for care leavers
- Better embedding of systems to identify and support people who are homeless clearer/ earlier referral mechanisms
- To seek to remove the barriers that are in place for homeless people to access services
- Support and training for tenants to be able to sustain tenancies and more help/ education for landlords to access support
- More publicity by Local Authorities as to what support is available, including cold weather shelters
- Health checks for the homeless
- Case studies to understand how people become homeless
- Consider Housing First model
- Better interventions around Mental Health and Substance Misuse at an earlier stage before crisis point
- Longer tenancies
- Improved floating support
- Improved advice for younger people around housing and preparing for living independently
- That no-one is discharged homeless from an institution
- Greater involvement of those with lived experience to help design clearer homelessness pathways and more collaborative working between partners

- Supporting people who are under-occupying to move to smaller accommodation to free up accommodation
- Ensuring smaller organisations have opportunities to bid for contracts
- Improved substance misuse awareness programmes
- Flexible resources which can be deployed rapidly to support early interventions to support people at risk of homelessness through low level interventions (simple referral is key)

iii) **Stakeholders were asked to comment on what could be done differently at an early stage to support people who are currently at risk of homelessness. Recurring points included:**

- For agencies to intervene at an earlier stage before crisis point ie sorting rent arrears; educating on preventing repeat homelessness; signposting for specialist support; providing more face to face advice
- Sharing referrals between all support agencies and improving sharing of information
- Support the VCS in supporting people at risk of homelessness
- Improve availability of information in other sources than just the internet – perhaps a free phone number?
- Proactively working with landlords to sustain tenancies and avoid evictions
- Improved support for mediation with family members where this can avoid someone becoming homeless
- Offering free legal advice to tenants regarding their rights
- Better understanding homelessness pathways and what opportunities there are to prevent homelessness earlier
- Better partnership working between agencies to prevent and tackle homelessness
- Flexibility of funding to support rapid homelessness prevention (including ie flexible funding for tenants to pay off arrears, where appropriate)

iv) Stakeholders were asked whether, when working with homeless people, they asked them about their health needs.

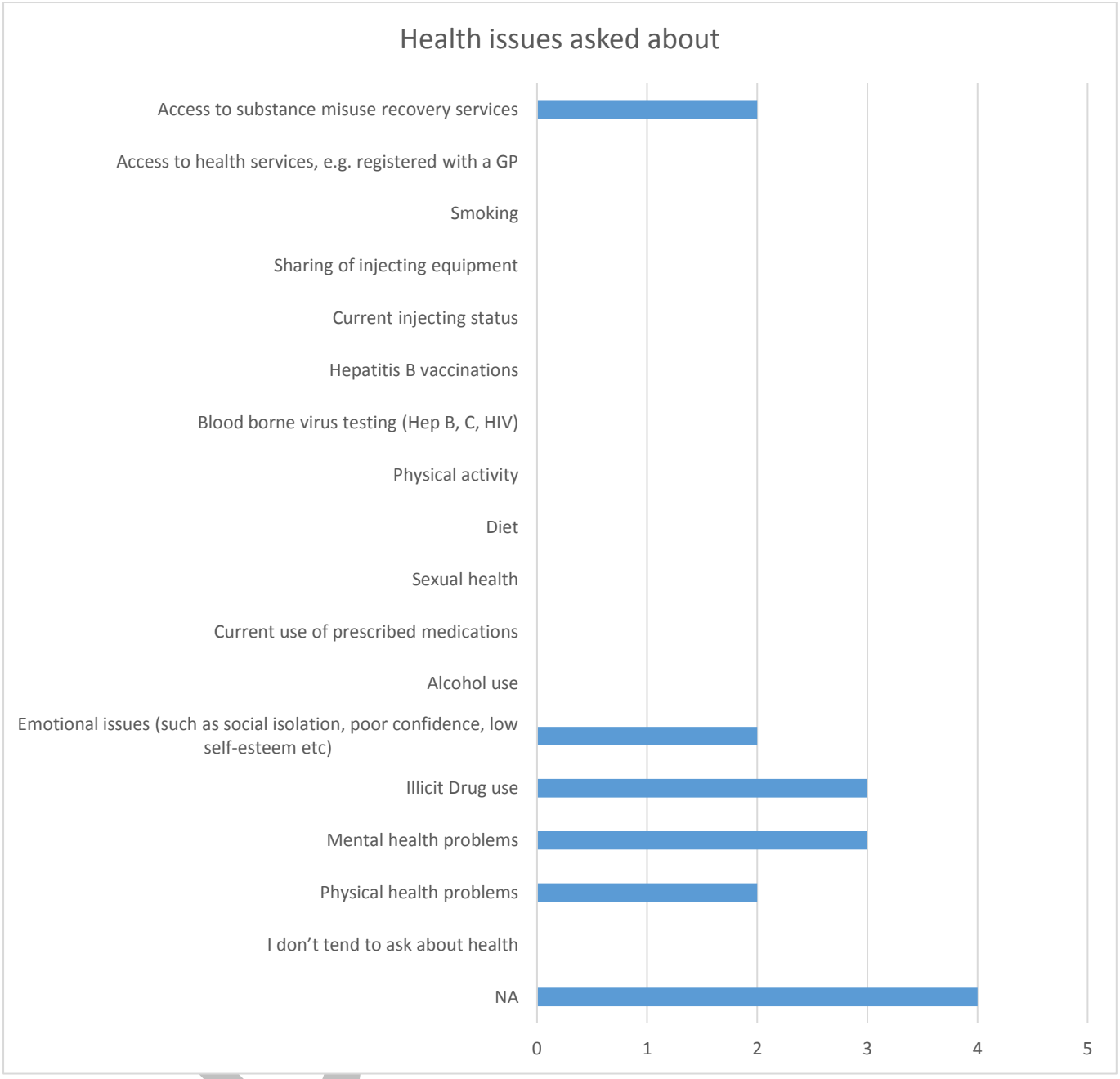
In total, 18 stakeholders responded to this question as follows:

Response	Number of responses
Yes, always	12
Yes, sometimes	1
Never	0
NA	5
Not answered	0

v) Stakeholders were asked which health needs they ask homeless people.

A total of 16 stakeholders responded to this question but stakeholders were asked to tick all that apply.

Stakeholders stated that the main health issues they ask about relate to substance misuse (2 cases); emotional issues (2 cases); drug usage (3 cases); mental health issues (3 cases) and physical health issues (2 cases)



vi) Stakeholders also had the option of stating any further questions that they asked.

<u>Some respondent noted that they were only able to select one choice and wished to select more than one</u>

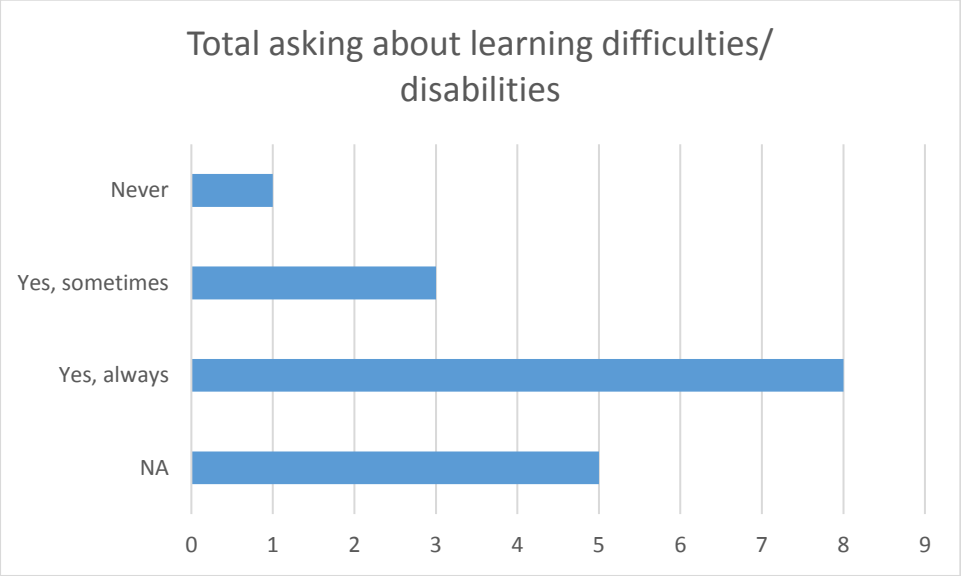
Responses included:

- Biggest issue is seeking and getting mental health support
- All of the above is explored when we assess an individual regardless of homelessness status, we would support the individual with a majority of the above issues. However, we have noted that most people do not wish to wish their substance use when they are homeless.

- Tend to ask people whom I meet in the community about their general wellbeing and give them a chance to open up or to establish if they want help or assistance

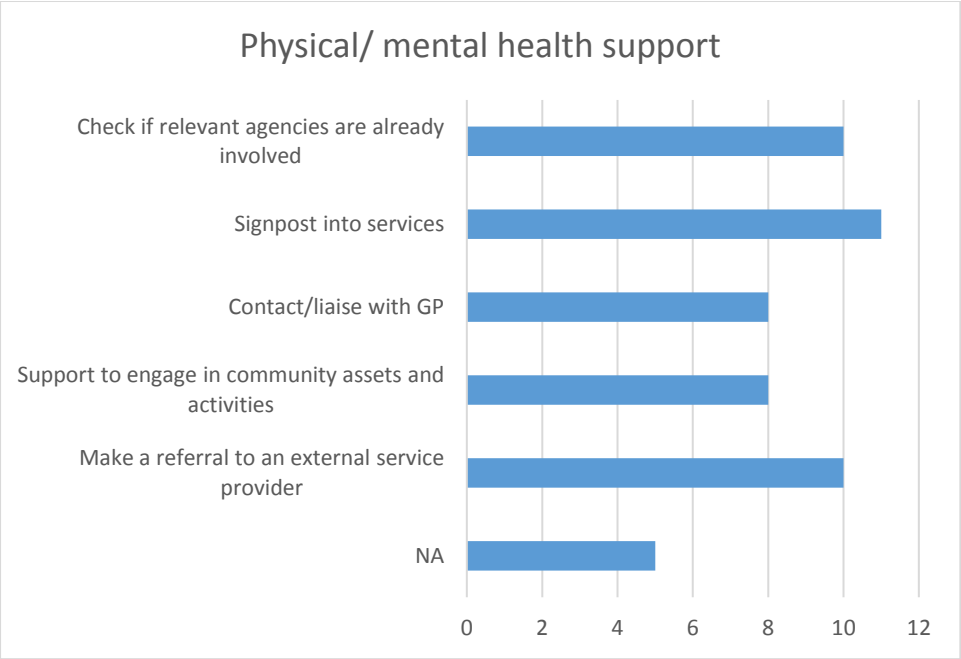
vii) **Stakeholders were asked whether they ask any questions regarding learning difficulties or learning disabilities during the initial assessment or at any other contact with the client**

A total of 17 stakeholders responded to this question.



viii) **Stakeholders were asked whether during initial assessment or at any other stage of assessment and follow-up interventions or treatment, what do you usually do if you suspect a client has a specific physical or mental health condition which may require additional support. Stakeholders could tick all that apply.**

A total of 52 stakeholder responses were included to this question.

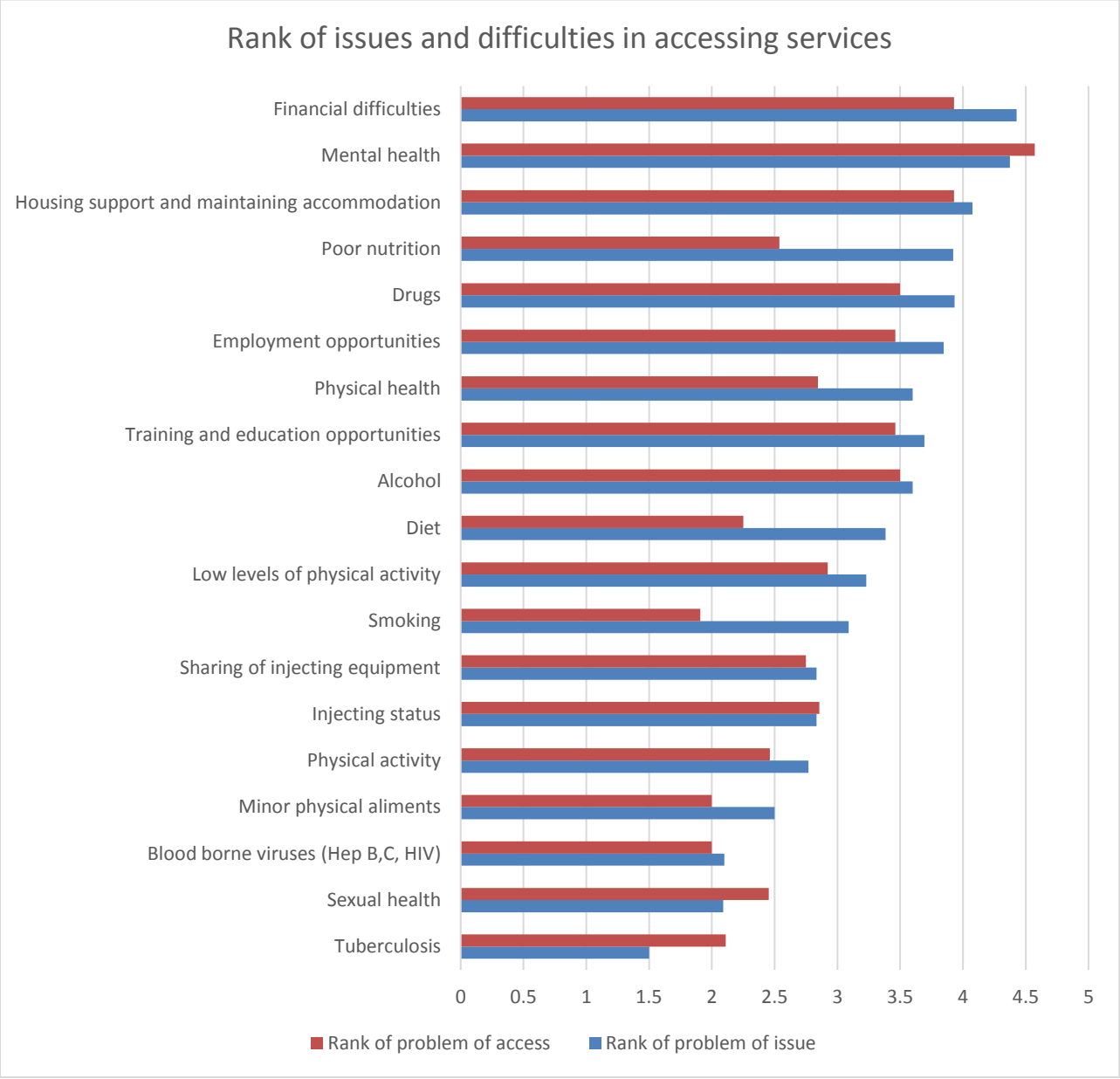


ix) **Stakeholders were asked to rate on a scale of 1-5, (with 1 being the least health/ social problem and 5 being the greatest health/ social problem) their perception of health / social problems for those clients who are homeless. Respondents were also asked to rate on the same scale the difficulties in referring clients to health and social care type services. Chart XXX shows the averages of those responding.**

With regard to the perception of health/ social problems and difficulties of access, the following were ranked as an average of 3 or higher as either an issue or difficulties in accessing services.

Issue	Ranking of issue	Ranking of difficulties in accessing services
Financial difficulties	4.43	3.93
Mental health	4.38	4.57
Housing support and maintaining accommodation	4.08	3.93
Poor nutrition	3.92	2.54
Drugs	3.93	3.50
Employment opportunities	3.85	3.46
Physical health	3.60	2.85
Training and education opportunities	3.69	3.46
Alcohol	3.60	3.50
Diet	3.38	2.25
Physical activity	3.23	2.92
Smoking	3.09	1.91

Issues around financial difficulties; mental health and housing support and maintaining accommodation were seen as the most significant issues and also the issues were it was perceived that services were most difficult to access. Notably, mental health services are seen as the most difficult to access for homeless clients. Of the 14 respondents to this question, 10 scored as 5 and a further three scored as 4.



x) Stakeholders were also asked whether there were any other key health or social issues that had not been listed. Two stakeholders responded to this question by responding:

Loneliness; family & friendship support; feeling a part of a community – belonging; getting back into 'mainstream' living; stigma; feeling isolated in society and no longer

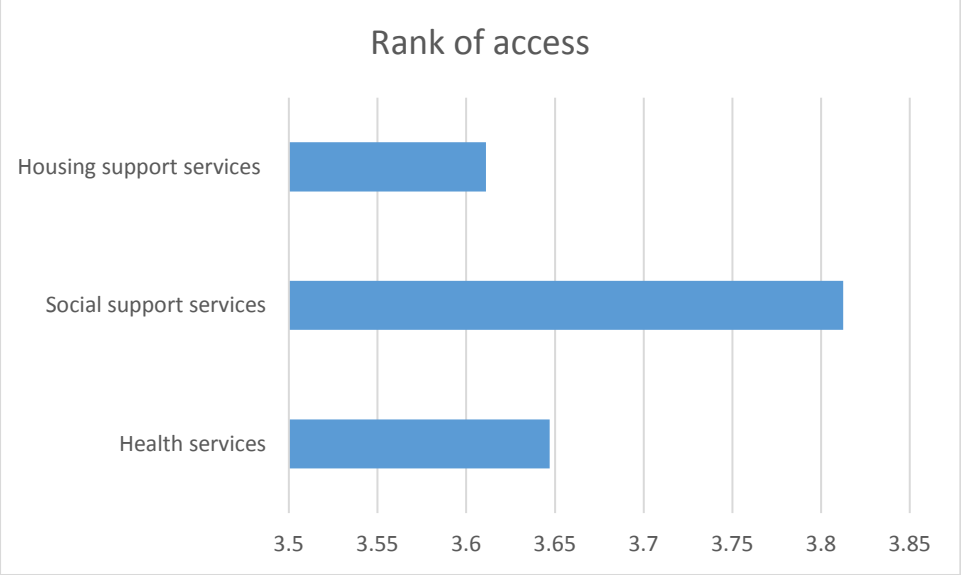
part of things that so many of us take for granted, family, friends, feeling safe, feeling valued, feeling loved, receiving unconditional support even when we make mistakes.

xi) Stakeholders were also asked whether there were any other key health or social access issues that had not been listed, stakeholders stated. Two stakeholders responded to this question by responding:

- I know working for a drug and alcohol team in a previous role a number of the caseload were homeless or no fixed abode. It is difficult to keep patient's engaged and willing to attend appointments and although they do receive incredible support from workers it is on an individual basis for them to recognise their need to change to make things better for themselves which can take time.
- The reason I have scored all 5 is that if someone is homeless how do you send them an appointment, how do they travel to and from appointments, do they still have a NI number etc.

xii) Stakeholders were asked to rate on a scale of 1-5, (with 1 being the least health/ social problem and 5 being the greatest health/ social problem) their perception of health / social problems for those clients who are homeless.

Whilst housing support; social support and health services all gave an average score over 3.6, social support services were seen as the most difficult to access. Of the 16 responses relating to social support, 12 rated access difficulties as a 4 or 5.



xiii) **Stakeholders were asked what, in their opinion, are the reasons for the difficulties for homeless people to access health, social and other support services**

Recurrent responses included:

- Lack of ID to join GP practices, especially street homeless and young people. No address.

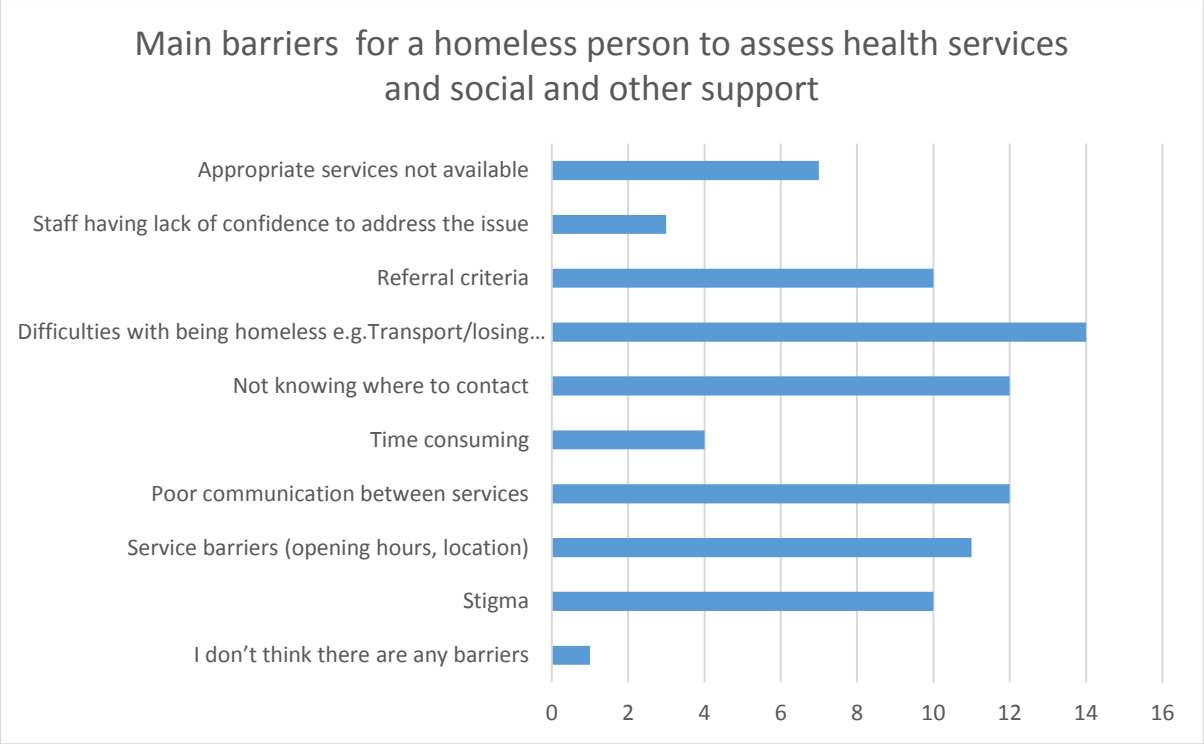
Bar is set to high for social care and does not take into account how difficult it can be to engage when you are homeless without basic facilities.

- Homeless people are negatively stereotyped
- Referrals can be delayed
- There is a lack of information as to what support may be available
- In our experience they find if difficult to have a routine which means attending pre arranged appointments is unlikely in most cases without reminders. We have to capture people when they are with us or give them the tools to allow communication such as giving them a cheap phone, we have tried this and it has led to better communication.
- Own pride, possibly needing an advocate to help with the situation, fear of the unexpected, not wanting to be helped, fear of being judged
- The one number. This is truly the most awful decision ever made by the council and has led to the deterioration of health of Nottinghamshire residents. Failure to access service. Quadrupled council work time due to failure for an enquiry to be dealt with first time by the right member of the team. This antiquated and most expensive method of dealing with the public is appalling. Speak to professor John Seddon or read one of his books on the call centre chaos.
- Chaotic lifestyles, transport, high thresholds, lack of services, waiting lists, contact (no phone), postcode lottery
- I do not think they are always aware of what support they can get and where from. Some are difficult to engage with and don't easily accept or look for help.
- It depends where they are in Bassetlaw, as previously mentioned I think Worksop may have more opportunities for homeless people to go to than Retford, maybe because the population needs there are different. They may also not be aware of how or who to contact. Transport is a major issue.
- The reason I have scored all 5 is that if someone is homeless how do you send them an appointment, how do they travel to and from appointments, do they still have a NI number etc. Perceptions of those working in these areas towards the homeless person.
- Officiousness of organisations
- They need support and need to feel comfortable, if unsupported the homeless client gets anxious and frustrated and often walks out. The processes need to be client friendly and more support given
- With the complex lives that rough sleepers have, they need someone to advocate for them to remind them of appointments and speak for them if they can't communicate.
- Thresholds and access arrangements to mental health and social care assessment and services are serving as barriers to homeless people. Long waits, location of appointments, referral protocols are problematic for those with insecure accommodation. Particular issues are present for those with multiple needs where services may determine that their presentation should primarily be seen as an issue for another agency

xiv) Stakeholders were asked what they felt were the main barriers for a homeless person to access health services and social and other support. Stakeholders could tick all that apply.

A total of 84 responses were included.

The main barriers were identified as difficulties with being homeless e.g. Transport/losing appointment times etc (14 responses); not knowing where to contact (12 responses) and poor communication between services (12 responses).



xv) Stakeholders were asked to state one thing that they would change to help address the needs of a homeless person

- To make homeless people feel valued
- safe and secure accommodation, temporary or social
- A service which is proactive in working with individuals who are at risk of homelessness and looking at prevention.
- That we break down the barriers of being able to approach homeless people bearing in mind one's own safety whilst doing so and how we may help.
- The one number
- Services attitudes - there are going to be missed appointments, being late, not being in the area, etc. Need to consider alternative waiting list and not put to bottom due to things outside their control
- More temporary accommodation and affordable accommodation. Better links with Private Rented sector
- Posters in town centres particularly around the cold weather time promoting shelters. Posters also advertising where help can be sought.
- Local communities awareness raising and action to support those homeless people in their areas in new ways.

- Secure Housing
- Join up services
- Don't just talk the talk, be genuine and sincere and make them feel valuable.
- More funding to third sector to allow more support at grass roots level
- More floating support to address the complex needs that rough sleepers have with access to bonds and rent in advance, housing first model.
- More Hostels that were equipped with the Counsellors, Talking Therapists and Staff Team that were equipped to meet the needs of those that use addictions to hide from Trauma and
- Services that are better co-ordinated and that communicate and work collaboratively towards sustained positive outcomes for the individual.

xvi) Stakeholders were asked if they had any further comments

- I believe that in order to assist homeless people you need to understand that they no longer think like we do on a daily basis, they say that it takes 6 weeks to mentally adapt to living rough and it takes longer to adapt back. We need to have a little bit more patience and understanding, all people make mistakes but if you are homeless or have chaotic needs the consequences always seem to be more severe
- support services work with accommodation providers
when finding private rent, how can they find money to pay for admin fees to letting agents ??
- To treat a homeless person with respect, providing help where possible. Having the knowledge of how to help someone and refer them wherever they need to go to obtain help required
- A multi-agency preventative strategy would help however the voice of the homeless person should be at the centre.
- Building more houses is not the answer. Services need to join up to ensure communication is synced.
- We need funding aimed at local organisations
- School visits from those that have gone though recovery and know the pit falls of experimental drug taking.
- A range of services need to be in place that are welcoming and can intervene appropriately wherever the individual presents and at whatever stage their homelessness situation has reached - early and at risk or late and in immediate crisis.

Views of service users

Focus group methods

One to one service user interviews were undertaken by Susan March (Senior Public Health Commissioning Manager) and John Sheil (Public Health Commissioning Manager) at the Friary Homelessness Drop-In Centre on 17th December 2018. Additional views were considered through engagement undertaken by Homelessness Link work in development of the Under 35s Housing and Support Study and Mid Nottinghamshire Homelessness Strategy.

Three in-depth service user interviews were conducted and staff were also interviewed. The aim of the sessions were to gain a service user perspective on current homeless services and gaps in provision from the service user perspective. At the time of the interviews, all three of the service users were sleeping rough.

All service users were advised that the feedback from the interviews would be anonymous and that no identifiable information would be used.

Whilst a framework of questions was available and partially used, service users were given significant opportunity to discuss their experiences in a free-flowing manner.

Key messages

There were a number of key issues and barriers around homelessness expressed by the participants and also the staff at the Friary. In particular, the following issues were identified:

- Suggestion of a lack of support where residents are being bullied in shared accommodation or in private accommodation which can lead to homelessness
- Suggestion that housing providers evict residents too easily if there are issues, such as arrears; disruptive behaviour or substance misuse
- In discussing their backgrounds, all participants spoke of significant issues regarding both mental and physical ill health
- One interviewee spoke of the importance of dogs to homeless people, that they are an important companion to people who may lack other friendships. One participant advised that he would not give up his dog even if that meant continuing to sleep on the streets. It was felt important that opportunities to maximise provision of support to enable homelessness people to remain with their dogs are maximised
- There was a suggestion from all participants that different services do not communicate well between themselves on support plans and do not fully consider input from the service user
- Participants expressed that caseworkers have limited time to support individuals due to large caseloads and that case workers need to work more closely with service users around how to appointments ie are letters always the best method?
- Suggestion that waiting lists to access support (in particular, mental health support) are too long
- Issue that if someone has no fixed abode, they may be disadvantaged in accessing services ie free bus passes.
- There was a suggestion that there was a lack of provision for people with complex needs
- Participants expressed frustration with delays they had experienced in accessing benefits

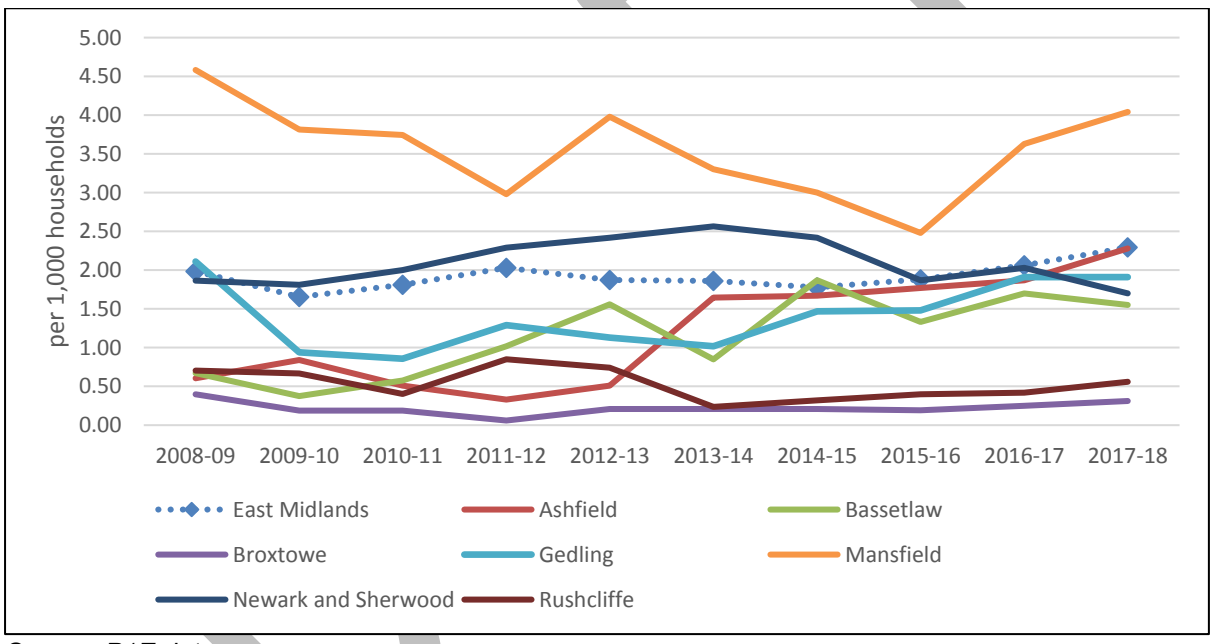
Appendix

Further information to accompany section 2. Size of the issue locally

Nottinghamshire Risk of Homeless Presentations

Nottinghamshire (All Districts) Homeless Eligibility
Figure i below shows the rate per 1,000 households accepted as homeless in priority need by Nottinghamshire districts, with Mansfield District since 2008/09 to 2017/18 consistently having the highest rate of household accepted as homeless in priority need followed by Newark and Sherwood and Ashfield districts.

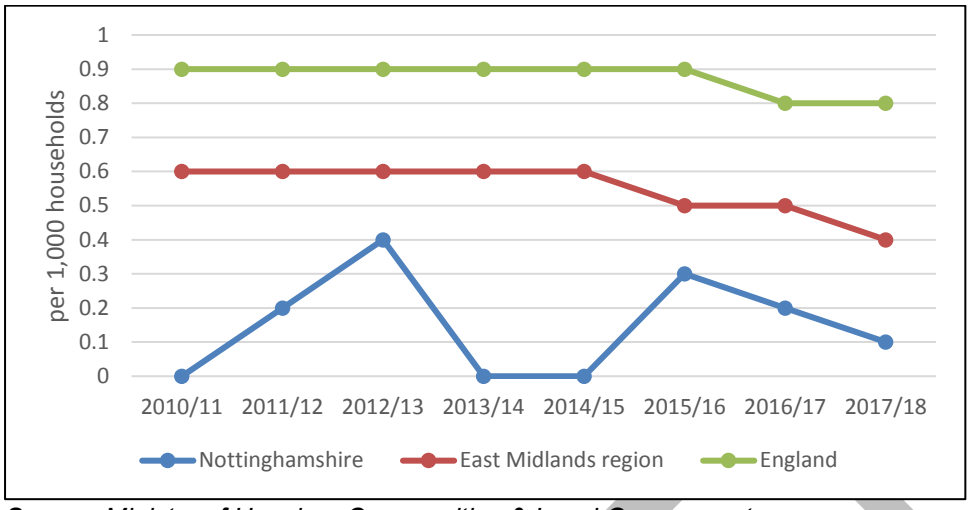
Figure i: Nottinghamshire by districts accepted as being homeless in priority need, compared with East Midlands, standardised rate per 1,000 households from 2008/09 to 2017/18



Source: P1E data

Nottinghamshire Statutory Homelessness – eligible homeless not in priority need
The Public Health Outcomes Framework (PHOF) Statutory Homeless indicator 1.15i demonstrates the number of household that have presented to local authorities but have been deemed not to be in priority need. As shown in figure ii below, in 2011/12 the Nottinghamshire rate per 1,000 household was highest at 0.4 per 1,000 households. There has been a decrease in the rate per 1,000 household in Nottinghamshire for eligible homeless not in priority need to 0.1 per 1,000 households in 2017/18. This equates to 145 households in 2011/12 to 45 households in 2017/18. In 2010/11, 2013/14 or 2014/15 the rate was zero, this could be due to missing data. Consistently, Nottinghamshire is lower than England and the East Midlands region.

Figure ii: 1.15i – Nottinghamshire rate per 1,000 household compared to England - Statutory Homelessness – eligible homeless not in priority need – 2010/11 to 2017/18

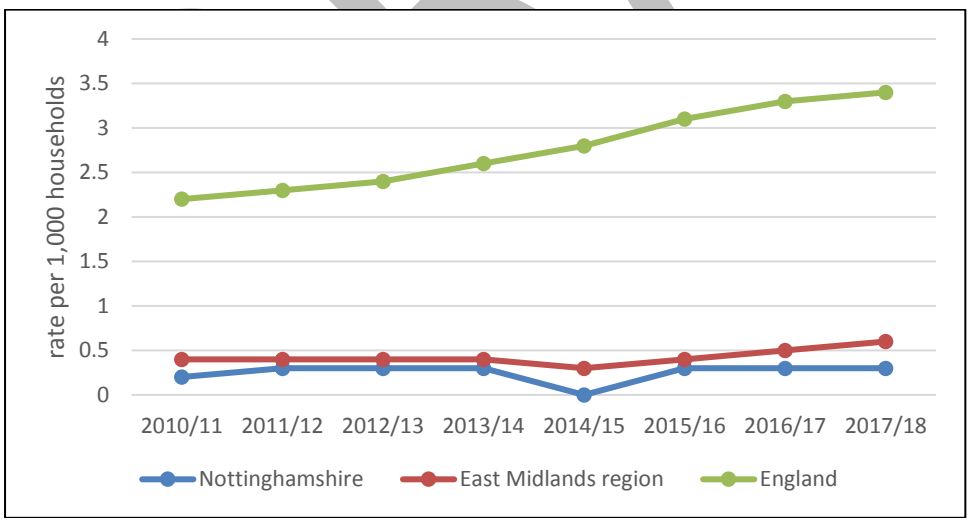


Source: Ministry of Housing, Communities & Local Government

Nottinghamshire Statutory homelessness - households in temporary accommodation

Figure iii below indicates for Nottinghamshire the rate per 1,000 households in temporary accommodation has remained relatively unchanged at 0.2 per 1,000 households in 2010/11 to 0.3 per 1,000 households in 2017/18. This equates to 80 households in 2010/11 to 110 household in 2017/18. Once again Nottinghamshire is consistently lower when compared to England and the East Midlands region.

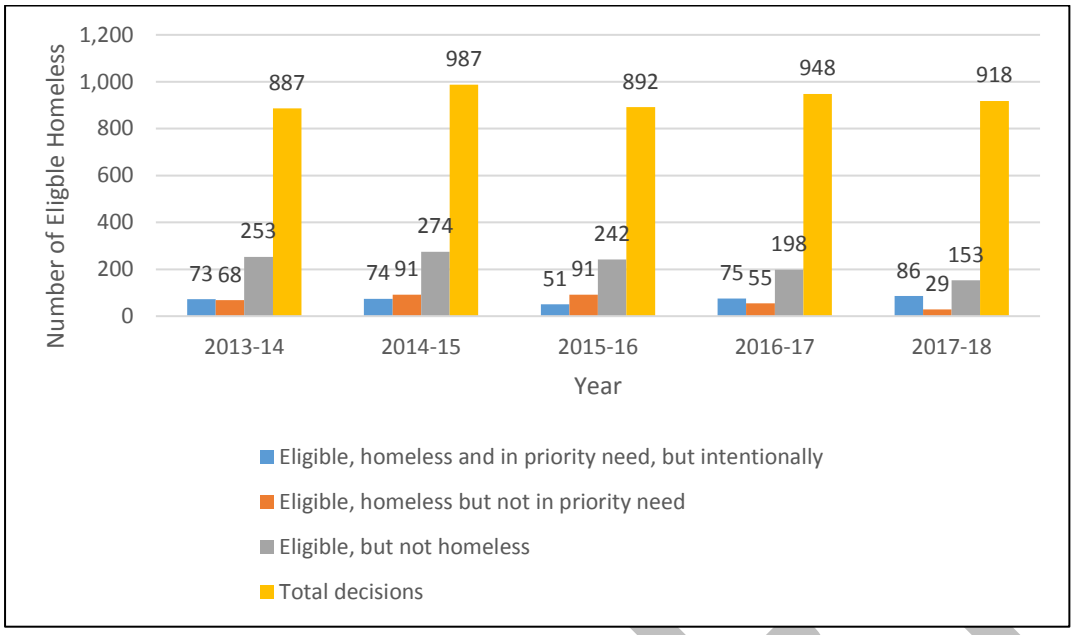
Figure iii: 1.5ii – Nottinghamshire rate per 1,000 household compared to England- Statutory Homelessness – households in temporary accommodation 2010/11 to 2017/18



Source: Ministry of Housing, Communities & Local Government

During 2017/18, there were a total of 918 homelessness decisions across all Nottinghamshire district and borough councils. Of these, 650 were accepted as being homeless and in priority need whilst the remaining were eligible but not homeless (153); Eligible, homeless but not in priority need (29) or Eligible, homeless and in priority need, but intentionally (86) Since 2008/09, this figure has stayed generally stable, as shown below in Figure iv.

Figure iv: Number of eligible homelessness decisions– Nottinghamshire County – 2013/14 to 2017/18



Source: P1E data

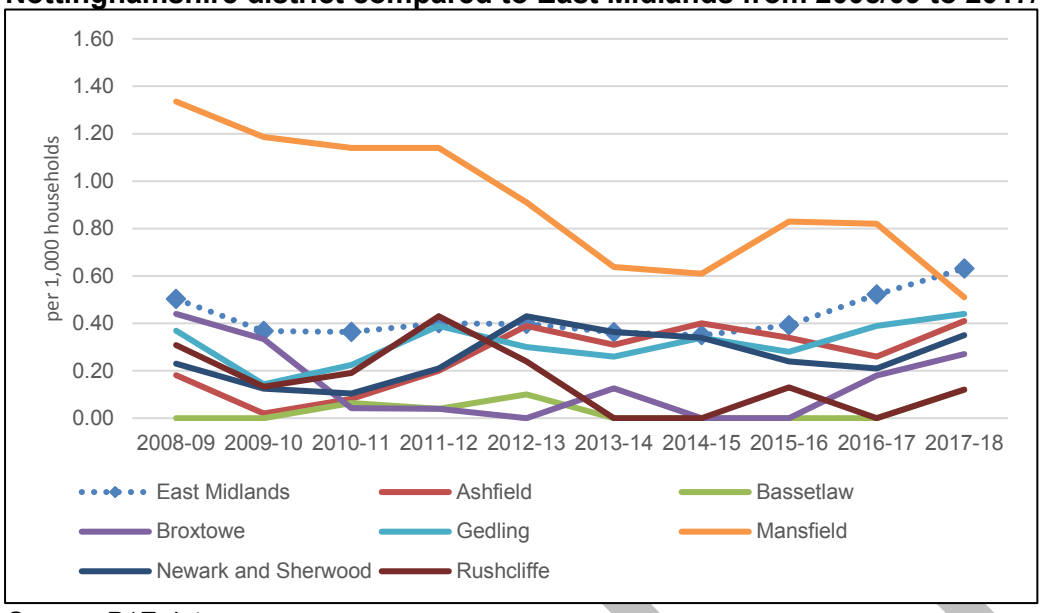
A further breakdown by district is shown Appendix 1 highlighting the total decisions made from 2013/14 to 2017/18. The two areas with the highest number who are intentionally homeless and in priority need are Mansfield and Newark & Sherwood Districts. With lowest number in Rushcliffe and Gedling Districts. In 2017/18 shows a wide variation between districts, with the highest number of decisions made in Mansfield District (269) compared to the lowest in Rushcliffe District (36).

Temporary Accommodation

Temporary accommodation includes Bed and Breakfast (B&B) accommodation; hostels; use of Local Authority and Housing Association accommodation on a temporary basis; private sector leased accommodation as well as other types including through the private rented sector. Local Authorities are required by government to ensure that families in B&B accommodation are for no more than six weeks[90].

Figure v shows the rate per 1,000 households in temporary accommodation for each Nottinghamshire District from 2008/09 to 2017/18. Mansfield District has shown a steady decline with the remaining Districts have remained unchanged. In 2017/18, all Nottinghamshire Districts rate per 1,000 household in temporary accommodation was slightly lower than the East Midlands rate of 0.63 per 1,000 household.

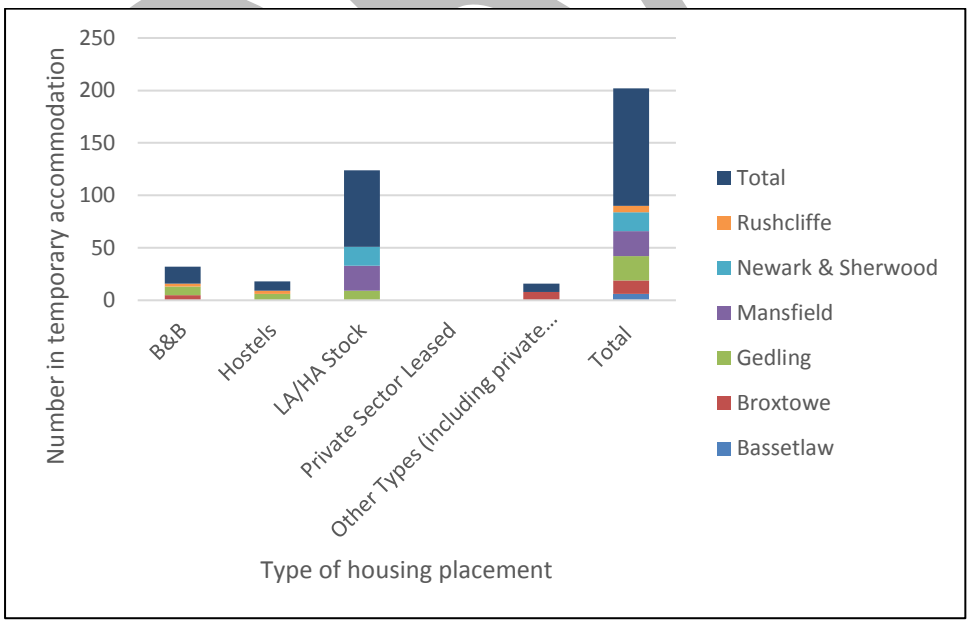
Figure v: Rate per 1,000 household in temporary accommodation by each Nottinghamshire district compared to East Midlands from 2008/09 to 2017/18



Source: P1E data

With regard to Government returns, data is based on a snapshot of people in temporary accommodation at the end of each quarter and could potentially lead to under-representing the numbers in temporary accommodation. The numbers placed into temporary accommodation for each Nottinghamshire District are shown in figure vi below. In 2017/18 Local Authority and Housing Association – Housing stock has the highest rate of temporary accommodations usage (73) with Mansfield District having the highest usage (24).

Figure vi: Number and type of temporary accommodation placement for all Nottinghamshire Districts in 2017/18



Source: P1E data

Bed and breakfast

Bed and Breakfast (B&B) accommodation is used by District and Borough Councils where there are limited other options as it is recognised that B& B is the least suitable form of accommodation for most households and should be used as a last resort[91]. District and Borough Councils recognise the negative impacts of the use of B&B accommodation and therefore seek to minimise usage.

As shown in Table A below, in 2017/18, across all Nottinghamshire Districts there were 191 B&B accommodation used with the highest proportion, 63% allocated to single people. Gedling followed by Broxtowe had the highest usage of B&B accommodation, 63 and 52, respectively with Newark and Sherwood had no B&B accommodation usage. A total of £219,680 was spent on B&B accommodation across Nottinghamshire.

Table A: Bed and Breakfast Accommodation allocation and spend by each Nottinghamshire District in 2017/18

District/ Borough	Total Number of B&B placements	Cost
	Number	£
Gedling	63 (31 to single people)	82,000
Rushcliffe	23 (17 to single people)	68,500
Bassetlaw	36 (20 to single people)	38,400
Broxtowe	52 (42 to single people)	23,380
Ashfield	17 (10 to single people)	7,400
Newark and Sherwood	0	0
Mansfield	0	0
TOTAL	191 (of which 120 to single people)	£219,680

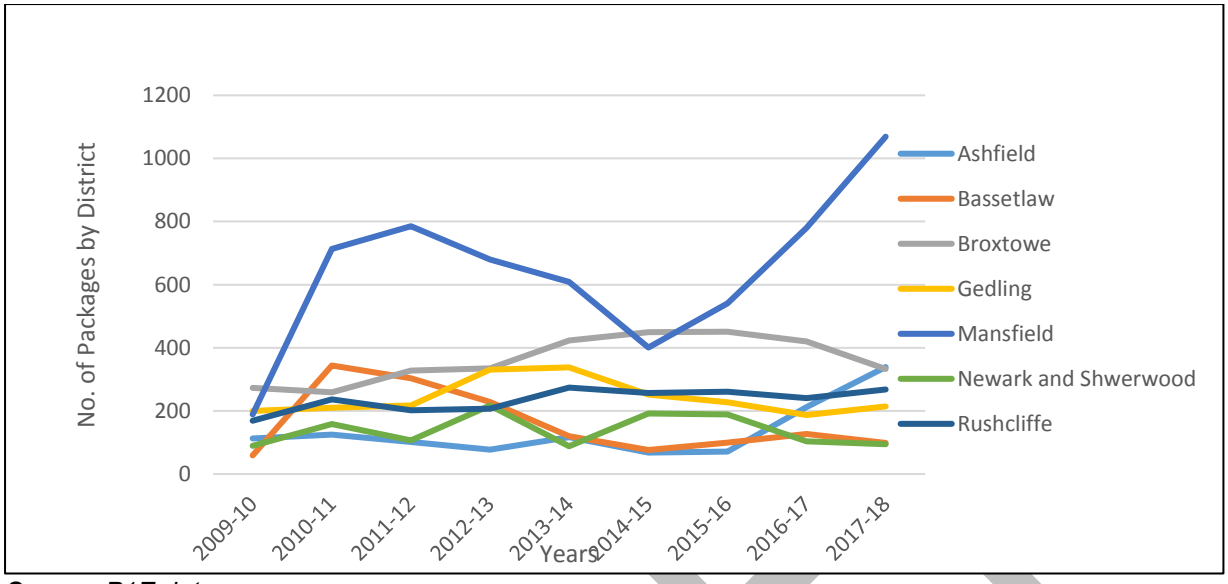
Source: P1E data

Homelessness Relief Packages

Homeless relief packages are offered by local housing authority at the point when homelessness prevention is not possible and the person/family are at certain risk of becoming homeless. A relief 'package' includes measures such as finding alternative accommodation; paying a deposit to secure alternative accommodation or acting as guarantor. It should noted that there where changes as highlighted in 1.2 section of this JSNA that the HRA (2017) has changed the way relief packages are applied.

Figure vii shows that across all Nottinghamshire Districts, Mansfield consistently have offered the highest number of Homeless Prevention Relief Packages from 2009/10 to 2017/18. This could be due to the number of presentations for homelessness prevention support but also due to Mansfield District having well-resourced homelessness prevention support packages and/or a different homeless relief criteria.

Figure vii: Number of Homelessness Prevention Relief Packages by District, from 2009 to 2018



Source: P1E data

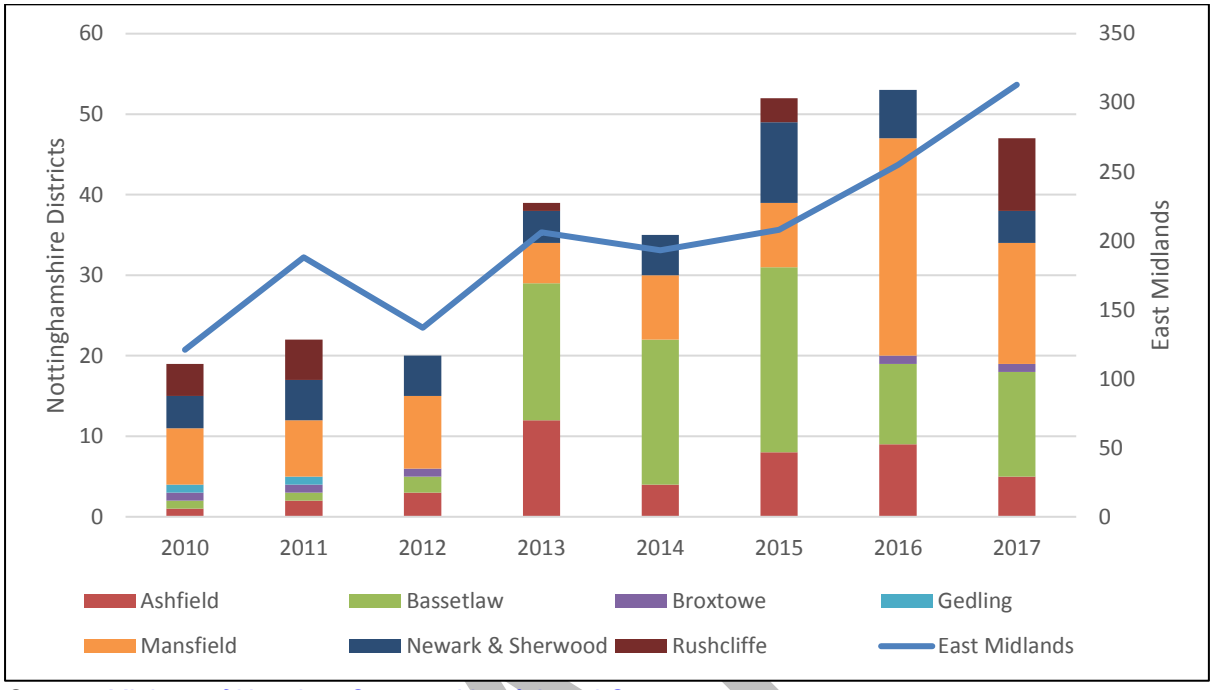
Rough Sleepers

Rough sleeping is normally considered to be the most extreme and visible form of homelessness. The impacts of rough sleeping on mental and physical health are very significant and wide ranging, as outlined in Section 3.

Formal rough sleeper counts take place annually on one night of each year between 1st October and 30th November. This is to provide an estimate to be submitted to Government of the number of rough sleepers in an area. There are a number of caveats to this including that it is generally seen that the count under-estimates the number of rough sleepers in an area due to the extent of ability to search for rough sleepers and also that the count is only over one night. However, it does provide a useful basis for measuring trends in rough sleeping and areas of high prevalence.

Figure viii below shows the number of rough sleepers by each Nottinghamshire District from 2010 to 2017. In line with East Midlands trend, since 2010 there was a steady rise in the number of rough sleepers across all Nottinghamshire Districts with Bassetlaw and Mansfield have the highest number. In 2017, the number of rough sleepers declined slightly across all districts with a total of 47 people rough sleeping with Mansfield and Bassetlaw Districts remaining the highest for the number of people rough sleeping, 25 and 13, respectively.

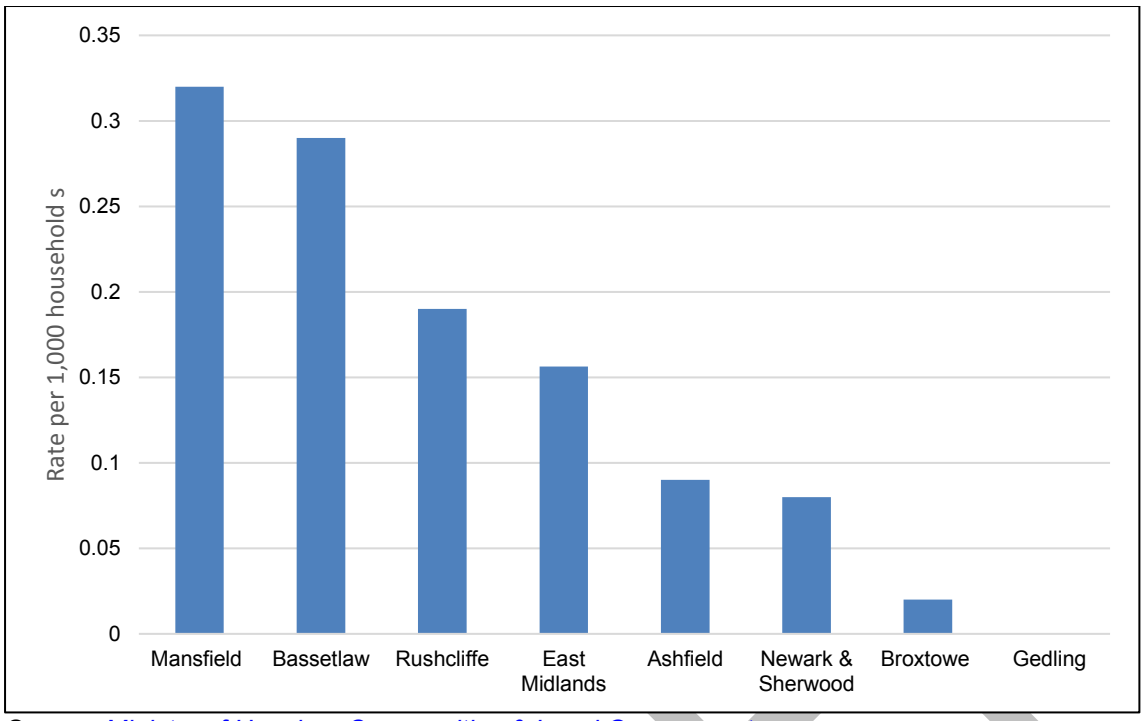
Figure viii: Number of Rough Sleepers by each Nottinghamshire District from 2010 to 2017



Source: Ministry of Housing, Communities & Local Government

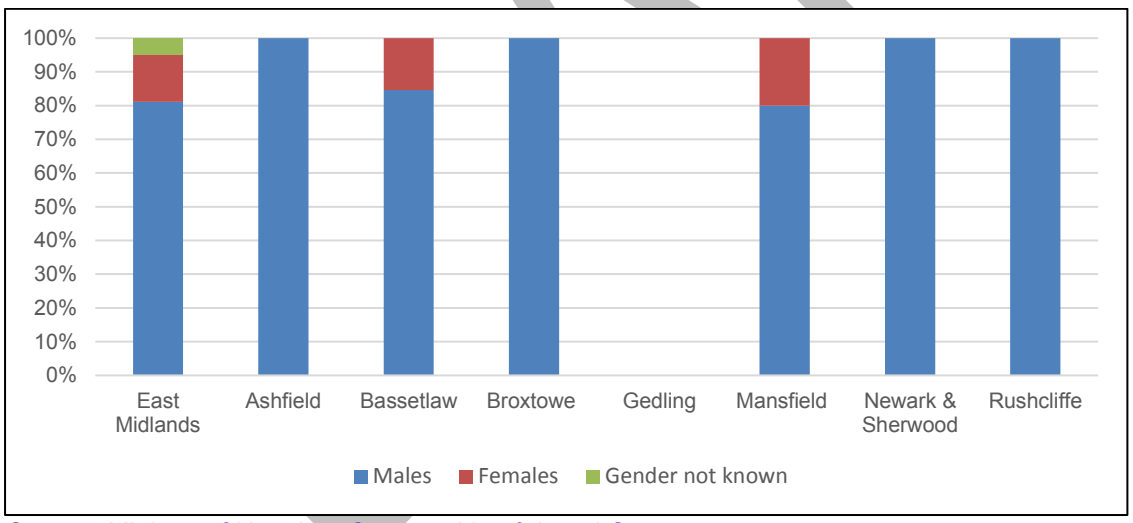
Figure ix, shows the rate per 1,000 household of rough sleepers for each Nottinghamshire District. In 2017, Mansfield, Bassetlaw and Rushcliffe were higher than the East Midlands rate of 0.15 per 1,000 household. As shown in figure X, the proportion of males rough sleeping was significantly higher compared to females, 84% and 16%, respectively.

Figure ix: Rate per 1,000 household of rough sleepers by each Nottinghamshire District compared to the East Midlands Region in 2017



Source: Ministry of Housing, Communities & Local Government

Figure X: Gender of Rough Sleepers by each Nottinghamshire District in 2017



Source: Ministry of Housing, Communities & Local Government

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Nottinghamshire County Council

Report to the Health & Wellbeing Board

6 November 2019

Agenda Item:7

REPORT OF THE CORPORATE DIRECTOR FOR CHILDREN & FAMILIES

APPROVAL OF JSNA CHAPTER: EARLY YEARS & SCHOOL READINESS

Purpose of the Report

1. To request that the Health & Wellbeing Board approve the new Early Years & School Readiness Joint Strategic Needs Assessment (JSNA) chapter.

2. This report contains an executive summary of the chapter. The Board will be approving the full chapter which is available as an appendix to this report and for review at Nottinghamshire Insight.

Information

3. Ensuring children are able to get the best from education is vital; not enough children are starting school with the range of skills they need to succeed. Educational attainment is one of the main markers for wellbeing through the life course and so it is important that no child is left behind at the beginning of their school life.

4. Research shows that access to high quality early learning experiences, together with a positive learning environment at home, is a vital combination to ensure that children have reached a good level of development at the start of compulsory school age. School readiness is a strong indicator of how prepared a child is to succeed in school cognitively, socially and emotionally.

5. This Joint Strategic Needs Assessment (JSNA) chapter focuses on school readiness which is measured by the level of development of a child when they reach Foundation Stage at school.

6. In 2018, there was a small increase in the percentage of children who achieved a good level of development both nationally and locally. However, in 2018, 69.7% of Nottinghamshire pupils achieved a good level of development, compared to 71.5% across England. Nottinghamshire also performs poorly in comparison with statistically similar local authorities. Progress in Nottinghamshire is slow and despite improvements in many other outcome measures; addressing school readiness remains a challenge and therefore a local priority.

7. Children from low income households do less well than their peers. In 2018, only 49.9% of children eligible for free school meals in Nottinghamshire achieved a good level of

development. *"Early years education for children below the age of four has a positive impact on the life chances of disadvantaged children, yet disadvantaged children spend significantly less time in pre-school than children from more affluent backgrounds"* (House of Commons Education Committee 2019). Around 25% are unable to communicate effectively, control their own feelings and impulses or make sense of the world around them to ensure they are ready to learn. Furthermore, many have reduced opportunities for home learning and parental engagement (Ofsted 2016).

8. The chapter provides information about current performance, local services and interventions, as well as a comprehensive review of research and evidence of what works to improve children's development.

Unmet needs and service gaps

9. Unmet needs and service gaps are explored fully in the JSNA chapter. Gaps and opportunities have been identified in relation to several areas:

   - Interventions to improve school readiness should start much earlier during the antenatal period so greater engagement of maternity services is required.
   - School readiness targets have often been the responsibly of the Children & Families department. However, evidence suggests that a partnership approach is required, taking into consideration a holistic whole family approach focusing on a range of interdependent outcomes as evidenced in this JSNA chapter.
   - Funding for children accessing early years provision who have Special Educational Needs & Disabilities, and especially those with complex medical needs, is insufficient. Funding from the Early Years Inclusion Fund and Disability Access Fund only provide minimal costs to contribute towards staffing, equipment and training. A longer-term solution is required in order to prevent children with complex needs being turned away from early years provision.
   - There are localities across Nottinghamshire where there are sufficiency challenges in terms of childcare. This is especially the case for parents who require childcare to fit around their working patterns. There are also localities where there is sufficient high-quality childcare. However, parents choose not to take up their funded childcare entitlements for a range of reasons.

Recommendations for Consideration by Commissioners

10. A number of recommendations have emerged following a review of local service provision, performance, research and evidence. The JSNA has provided opportunities to review activities which will help inform the new Best Start Plan, as well as the transfer of the Children's Centre Service to the council in June 2020.

Priority	Recommendations	Suggested Lead
To ensure Children get the Best Start	• Develop a Best Start Strategy/Plan and a strategic partnership group to consider wider factors which contribute to school readiness from preconception to the age of 4. • Target resources to engage families earlier during the antenatal period and not wait for children to access early years provision.	Early Childhood Services, Nottinghamshire County Council (NCC). Public Health, NCC
Children achieve a Good Level of Development	• Raising the quality of early year's providers to ensure that all childcare settings are 'good' or 'outstanding' to enable poorer children to gain the best start in life. • Promotion, delivery and commission of evidence based interventions only. • Implement and review the findings of the Best Start early years tracker tool to help early years providers to assess the developmental needs of children and enable commissioners to track progress and assess impact of services and interventions. • Explore increasing the moderation of assessments carried out by schools during the Early Years Foundation Stage as they do not reflect the progress children are making at age 2 - 2½.	Early Childhood Services, NCC.
Children most at risk of poor educational outcomes have a good level of development and the attainment gap is narrowed	• Narrow the attainment gap for children eligible for Free School Meals and their peers, ensuring that progress is on par with statistical neighbours (measured by the Early Years Foundation Stage Profile). • Target wards across Nottinghamshire with higher proportions of children living in Poverty and low IDACI[1] scores. • Additional work is required to engage low income families prior to the age of three and low income families not accessing early education or childcare. • Increase the take up of funded early education for 2 year olds eligible for Free School Meals. • Work with early years providers to ensure there are sufficient high quality and sustainable places available in low income areas. • Target Children's Centre resources to target groups most at risk of poor attainment and development. • Undertake tracking of outcomes for children with SEND who have claimed supplementary funding (Disability Access Fund and Early Years Inclusion Fund). • Review specific needs of migrant families and refugees with young children. Information is required to help engage these groups to access early years and childcare provision.	Early Childhood Services, NCC
Highly Skilled Early Years Workforce	• Provide and evaluate high quality training and workforce development support to early years professionals across Nottinghamshire. • Links with Higher Education and Further Education organisations should be strengthened to improve promotion of accredited qualifications including teaching.	Early Childhood Services, NCC

[1] IDACI – Income Deprivation Affecting Children Index

Priority	Recommendations	Suggested Lead
Improve outcomes for Looked After Children and those known to Social Care	• Ensure early years is embedded in the work of the Virtual School to enable young children in Local Authority Care to succeed; and commissioners are able to assess the impact of additional Pupil Premium funding allocated to this group. • Ensure early years strategic leads work closely with the Virtual School to ensure that social workers, kinship and foster carers are aware of the importance of the quality of early years education. • Provide training and support to early years settings to enable them to be prepared for working with high-risk and potentially high-need groups, such as looked after children. • Undertake early years foundation stage data tracking and analysis for Children in Need and those on Child Protection Plans following the introduction of the Deprivation Fund.	Early Childhood Services, NCC
Parents are engaged in their child's learning	• Continue the Home Talk intervention or similar evidence based intervention to address and improve speech, language communication needs (SLCN) by working with parent and child in their own home. • Promotion of the national Home Learning campaign 'Hungry Little Minds' (launched July 2019) • Consider the commissioning/delivery of a Home Learning resource co-produced with parents. • Ensure that home learning is promoted through all local online and social media opportunities. • Evaluate existing home learning interventions and launch the new home learning pathway.	Early Childhood Services, NCC
Parents are effectively supported to improve their wellbeing, parenting skills, and understand their child's development needs.	• Review the latest evidence base to identify which parenting programmes and family support interventions are most effective and evidence value for money, for delivery by the Children's Centre Service from 2020. • Continued evaluation of outcomes for parents and carers who have participated in a variety of evidence based programmes delivered by Children's Centre Services. Topics will include boundaries and behaviour, sleep routines, parental conflict etc. • Continued delivery and evaluation of 1-2-1 family support delivered by the Children's Centre Service, focusing on family routines, parental wellbeing, keeping children safe, emotional needs of children and home learning.	Early Childhood Services, NCC
Children's Centre Services are responsive to need and improve outcomes	• Review the impact of Children's Centre interventions and ensure that interventions are evidence based and evaluated. • Greater engagement of children most at risk of developmental delay and their families. • Greater focus on engaging families from the antenatal period until children reach the age of 3. • Ensure the Children's Centre Service once under the management of the Local Authority maintains strong links with Healthy Family Teams and Maternity Services.	Early Childhood Services, NCC

Priority	Recommendations	Suggested Lead
Improve outcomes for White British Boys	• Improve outcomes for White British boys by ensuring that the opportunities we are providing for boys in the Early Years Foundation Stage fully engage and support them in developing positive dispositions to learning. • Increase take up of childcare and early education opportunities for White British Boys as early as possible. • Provision of Forest School approaches should include a thorough evaluation on the impact for White British Boys, anecdotal information on the impact is insufficient and yet practitioners regularly share information about the successful engagement of boys in Forest School work.	Early Childhood Services, NCC
Improve communication and language skills	• Implement the recommendations highlighted from the Speech Language and Communication Needs (SLCN) Maturity Matrix assessment tool which include: o Greater engagement with maternity services and specialist Speech and Language Therapy (SLT) services. o Greater ownership by Clinical Commissioning Groups o Improve Speech Language and Communication Needs pathways to specialist SLT services. • Maintain effective speech and language support through the evaluated Home Talk programme (or similar), which identifies and supports children with early speech and language delay. • Active promotion of the new national Hungry Little Minds home learning campaign which includes a focus on SLCN.	Early Childhood Services, NCC & Public Health, NCC
Improve the emotional wellbeing and resilience of children	• Promote tools to foster emotional well-being from the earliest stages of life, enhancing resilience and the importance of relationships to help build solid foundations for overall health and well-being. • Implement the REAcH programme to ensure that parents have their needs addressed and the intergenerational cycle of disadvantage is broken through the Children's Centre Service and Healthy Family Teams.	Public Health, NCC
Improve outcomes for Children with SEND	• The significant increase in the number of young claimants of Disability Living Allowance will require a focus on this population to review access and take-up to inform plans to ensure sufficiency of appropriate provision. • Commissioners should work across County Council departments to help share findings from SEND[2] assessments for children under the age of five; sharing key findings and learning which in turn will inform commissioning decisions and service planning. This will need to include the children that do not meet the thresholds for specialist support. • Review the use of the Early Years Inclusion Fund and the Disability Access Fund to ensure that children are effectively supported as part of their transition to school. • Greater promotion of childcare provision to families with children with SEND and increased promotion of funding supplements to early years settings.	Early Childhood Services, NCC

[2] SEND – Special Educational Needs and Disabilities

Priority	Recommendations	Suggested Lead
Developmental Delays are identified and supported early	• Embed and review the findings of the 2-year integrated review and the impact for children accessing early years settings; and compare progress against statistical neighbours.	Public Health, NCC
Improve outcomes for children with English as an Additional Language (EAL)	• Explore the specific childcare and health needs of families with English as an Additional Language (including refugees and asylum seekers). • Encourage schools and health services to report both ethnic origin and English as an additional language using ONS codes to enable improved monitoring and analysis.	Early Childhood Services, NCC
Ensure sufficient high-quality childcare provision is available	Nottinghamshire needs to have robust data about both supply and demand for childcare, it is recommended the local authority evaluates progress of new data collection and monitoring procedures to ensure it supports their market management role and sufficiency duties. *Refer to the Nottinghamshire Childcare Sufficiency Assessment.*	Early Childhood Services, NCC
Reduce financial barriers preventing access to childcare	Work should be undertaken with key stakeholders to ensure partners and staff are aware of what support for the costs of childcare is available, and how the free entitlement can be used, and disseminate that information to their client groups. *Refer to the Nottinghamshire Childcare Sufficiency Assessment.*	Early Childhood Services, NCC
Offer flexible childcare provision and provide additional childcare during school holidays and increased wrap around care	• Explore flexible delivery models as a matter of urgency; and consider how these models of working can be applied across different types of provision for all age ranges of children. • The Childcare Sufficiency Assessment identified demand for provision in school holidays and an unmet for after school and before school provision. Work should be undertaken with key stakeholders to identify options for additional childcare and wrap around provision, ensuring all available provision is recognised and promoted through the local authority's information duty, delivered by the Families Information Service. *Refer to the Nottinghamshire Childcare Sufficiency Assessment.*	Early Childhood Services, NCC
Ensure Teenage Parents are effectively engaged and supported	• Improve uptake of Care to Learn Grant for teenage parents • Gain a better understanding of which services teenage parents access and gain a better understanding of the local barriers for young people in accessing the Children's Centre Service and childcare.	Public Health and Early Childhood Services, NCC

Priority	Recommendations	Suggested Lead
Consider ceasing the commissioning /delivery of some interventions with no evidence base	Review the interventions provided locally that do not have a clear evidence base, or evaluation and performance does not evidence impact. Commissioners and service providers should not prioritise these interventions where budgets are restricted. This could include baby massage which parents enjoy. However, it must also be acknowledged that evidence of effectiveness is not a replacement for ongoing evaluation. The fact that an intervention has evidence from a rigorous evaluation conducted at one time and place does not mean that it will be effective again. The evidence described in this chapter is therefore not a replacement for good monitoring and evaluation systems as interventions are set up and delivered.	Public Health and Early Childhood Services, NCC
Provision of behavioural sleep training	Continue to provide behavioural sleep training through the Children's Centre Service and provide information through Healthy Family Teams during the antenatal and postnatal stage.	Public Health and Early Childhood Services, NCC
Increase the use of social media and web-based resources	Consider increasing and improving information and support available for parents and expectant parents including activities to promote positive home learning environments and parenting support such as 'Triple P Online'.	Early Childhood Services, NCC

11. It is proposed that the Best Start Group should oversee the implementation of all recommendations, working in close partnership with commissioners and providers of educational, health and wellbeing services for preschool children and their families.

Other Options Considered

12. Not applicable.

Reasons for Recommendation

13. The JSNA chapter has provided an opportunity to consolidate information regarding service provision and local performance data against the latest evidence of what works. It is now understood that some interventions are provided because parents enjoy them rather than there being any evidence to suggest that outcomes have improved for those families. The JSNA chapter therefore provides detailed recommendations of what should change and what activities should continue.

14. Historically, work to improve children's development has resulted in intensive work with organisations providing childcare; however, we know that disadvantaged children are less likely to access childcare and that interventions need to start much earlier. The JSNA chapter helps to reprioritise activity provided by the council and other key stakeholders.

15. The aim to give every child a good start in life is a key priority in the Nottinghamshire Health & Wellbeing Strategy; and the aim to ensure families prosper and achieve their potential is a priority within Nottinghamshire County Council's Strategic Plan.

Statutory and Policy Implications

16. This report has been compiled after consideration of implications in respect of crime and disorder, data protection and information governance, finance, human resources, human rights, the NHS Constitution (public health services), the public sector equality duty, safeguarding of children and adults at risk, service users, smarter working, sustainability and the environment and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

Financial Implications

17. There are none arising from this report although the findings and recommendations will inform local commissioning decisions.

RECOMMENDATION

1) That the Health & Wellbeing Board approve the new Early Years & School Readiness Joint Strategic Needs Assessment chapter.

Colin Pettigrew
Corporate Director: Children & Families

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Constitutional Comments (LW 23/10/2019)
18. Health and Wellbeing Board is the appropriate body to consider the content of the report.

Financial Comments (DG 23/10/2019)
19. There are no specific financial implications arising from this report.

Background Papers and Published Documents
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.

- Nottinghamshire Health and Wellbeing Board: Joint Health and Wellbeing Strategy 2018-2022
- Early Years Improvement Plan Children and Young People's Committee Report 2019
- Nottinghamshire Childcare Sufficiency Assessment.

Electoral Division(s) and Member(s) Affected
- 'All'

Topic information	
Topic title	Early Years and School Readiness
Topic owner	Healthy Child and Early Childhood Integrated Commissioning Group
Topic author(s)	Irene Kakoullis
Topic quality reviewed	August 2019
Topic endorsed by	Healthy Child and Early Childhood Integrated Commissioning Group (5.9.19)
Topic approved by	*Pending approval by the Health and Wellbeing Board*
Current version	Version 11
Replaces version	New chapter
Linked JSNA topics	Maternity and Early Years (2014), 1,001 Days: from conception to age 2 (2019), Avoidable Injuries in Children and Young People (2019), Diet and Nutrition (2015), Excess Weight in children, young people and adults (2016), Child Poverty (2016), Teenage Pregnancy (2017), Children and Young People (2013), Emotional and Mental Health of Children and Young People (2014), Domestic Abuse (2019), Breastfeeding and Healthy Start (2014).

Executive summary

Introduction

How we treat young children shapes their lives – and ultimately our society (Wave Trust, 2013). If we get the early years right, we pave the way for a lifetime of achievement. If we get them wrong, we miss a unique opportunity to shape a child's future. Despite early education being better than it has ever been, it is still not benefiting our poorest children compared to their peers (Ofsted 2016).

There is a clear economic case for investing in the early years of children's lives, with economic analysis demonstrating that returns are much higher when interventions are targeted early in the life of disadvantaged children (Heckman 2008). Investing in quality early care and education has been shown to have a greater return on investment than many other economic development options. For every £1 invested in quality early care and education, taxpayers save up to £13 in future costs; in addition, for every £1 spent on early years education, £7 would need to be spent to have the same impact in adolescence (Early Intervention Foundation 2018a).

Furthermore, securing a successful start for our youngest children, and particularly those from disadvantaged backgrounds, is crucial. It can mean the difference between gaining

seven Bs at GCSE compared with seven Cs and is estimated to be worth £27,000 more in an individual's salary over the course of their career. Attending any pre-school, compared to none, predicted higher total GCSE scores, higher grades in GCSE English and maths, and the likelihood of achieving 5 or more GCSEs at grade A*- C. The more months students had spent in pre-school, the greater the impact on total GCSE scores and grades in English and maths (DfE 2016).

Ensuring children are able to get the best from education is vital; not enough children are starting school with the range of skills they need to succeed. Educational attainment is one of the main markers for wellbeing through the life course and so it is important that no child is left behind at the beginning of their school life.

Research shows that access to high quality early learning experiences, together with a positive learning environment at home, is a vital combination to ensure that children have reached a good level of development at the start of compulsory school age. School readiness is a strong indicator of how prepared a child is to succeed in school cognitively, socially and emotionally.

This chapter focuses on school readiness which is measured by the level of development of a child when they reach Foundation Stage at school. This chapter is supported by the Nottinghamshire Childcare Sufficiency Assessment which is repeated annually and is available here Nottinghamshire Childcare Sufficiency Assessment.

Unmet Needs and Service Gaps

- There are localities across Nottinghamshire where there are sufficiency challenges in terms of childcare. There is a need to ensure that good or outstanding provision is located where there are higher numbers of under 5's and where numbers are projected to increase following new housing developments. Local schools and the local early years sector will be encouraged to develop provision in these areas in the absence of capital funding to develop new early years properties.
- Parents require childcare to meet their irregular working patterns and school holidays, further work is required to meet this demand and unmet need as evidenced in the Nottinghamshire Childcare Sufficiency Assessment 2018
- Children Centre services have previously had a key role in engaging fathers, however in recent years, the needs of fathers have received a lower profile than the needs of mothers. It is currently unclear what the current needs and views of fathers are in relation to outcomes for young children.
- Not all children under the age of 5 are eligible for funded childcare. This means that many parents have to pay for childcare to enable them to gain or return to employment or not access employment until their child can access funded childcare. This is especially pertinent for children with Special Educational Needs and Disabilities (SEND) who are not entitled to additional top up funding to ensure they receive the intensive support they need; this can result in children being turned away from early years settings that do not have the ability to meet their needs.
- Early Years settings working with children who have complex medical needs require additional support from specialist services. Practitioners have told the Local Authority that they are unable to pay to cover costs to access training and assessments provided by specialist health services. Greater engagement with specialist health services is required to help address this service need.

- Funding for children accessing early years provision who have SEND and especially those with complex medical needs, is insufficient. Funding from the Early Years Inclusion Fund and Disability Access Fund only provide minimal costs to contribute towards staffing, equipment and training; however the Inclusion Fund has recently been used to help early years settings access additional support to help address the needs of children with complex health issues. A longer term solution is required in order to prevent children with complex needs being turned away from early years provision.
- Interventions to improve school readiness should start much earlier during the antenatal period so greater engagement of maternity services is required.
- School Readiness targets have often been the responsibility of the Early Years Attainment Group which has focused heavily on attainment and children already accessing early years provision. Evidence suggests that a wider partnership approach is required, taking into consideration a holistic whole family approach focusing on a range of interdependent outcomes as evidenced in this JSNA chapter.

Recommendations for Consideration by Commissioners

Priority	Recommendations	Suggested Lead
To ensure Children get the Best Start	• Develop a Best Start Strategy/Plan and a strategic partnership group to consider wider factors which contribute to school readiness from preconception to the age of 4. • Target resources to engage families earlier during the antenatal period and not wait for children to access early years provision.	Early Childhood Services, Nottinghamshire County Council (NCC). Public Health, NCC
Children achieve a Good Level of Development	• Raising the quality of early year's providers to ensure that all childcare settings are 'good' or 'outstanding' to enable poorer children to gain the best start in life. • Promotion, delivery and commission of evidence based interventions only. • Implement and review the findings of the Best Start early years tracker tool to help early years providers to assess the developmental needs of children and enable commissioners to track progress and assess impact of services and interventions. • Explore increasing the moderation of assessments carried out by schools during the Early Years Foundation Stage as they do not reflect the progress children are making at age 2 - 2½.	Early Childhood Services, NCC.
Children most at risk of poor educational outcomes have a good level of development and the attainment gap is narrowed	• Narrow the attainment gap for children eligible for Free School Meals and their peers, ensuring that progress is on par with statistical neighbours (measured by the Early Years Foundation Stage Profile). • Target wards across Nottinghamshire with higher proportions of children living in Poverty and low IDACI scores. • Additional work is required to engage low income families prior to the age of three and low income families not accessing early education or childcare.	Early Childhood Services, NCC

	• Increase the take up of funded early education for 2 year olds eligible for Free School Meals. • Work with early years providers to ensure there are sufficient high quality and sustainable places available in low income areas. • Target Children's Centre resources to target groups most at risk of poor attainment and development. • Undertake tracking of outcomes for children with SEND who have claimed supplementary funding (Disability Access Fund and Early Years Inclusion Fund). • Review specific needs of migrant families and refugees with young children. Information is required to help engage these groups to access early years and childcare provision.	
Highly Skilled Early Years Workforce	• Provide and evaluate high quality training and workforce development support to early years professionals across Nottinghamshire. • Links with Higher Education and Further Education organisations should be strengthened to improve promotion of accredited qualifications including teaching.	Early Childhood Services, NCC
Improve outcomes for Looked After Children and those known to Social Care	• Ensure early years is embedded in the work of the Virtual School to enable young children in Local Authority Care to succeed; and commissioners are able to assess the impact of additional Pupil Premium funding allocated to this group. • Ensure early years strategic leads work closely with the Virtual School to ensure that social workers, kinship and foster carers are aware of the importance of the quality of early years education. • Provide training and support to early years settings to enable them to be prepared for working with high-risk and potentially high-need groups, such as looked after children. • Undertake early years foundation stage data tracking and analysis for Children in Need and those on Child Protection Plans following the revision of the Deprivation Fund.	Early Childhood Services, NCC
Parents are engaged in their child's learning	• Continue the Home Talk intervention or similar evidence based intervention to address and improve speech, language communication needs by working with parent and child in their own home. • Promotion of the national Home Learning campaign 'Hungry Little Minds' (launched July 2019) • Consider the commissioning/delivery of a Home Learning resource co-produced with parents. • Ensure that home learning is promoted through all local online and social media opportunities. • Evaluate existing home learning interventions and launch the new home learning pathway.	Early Childhood Services, NCC
Parents are effectively supported to improve their wellbeing, parenting	• Review the latest evidence base to identify which parenting programmes and family support interventions are most effective and evidence value for money, for delivery by the Children's Centre Service from 2020. • Continued evaluation of outcomes for parents and carers who have participated in a variety of evidence based programmes	Early Childhood Services, NCC

skills, and understand their child's development needs.	delivered by Children's Centre Services. Topics will include boundaries and behaviour, sleep routines, parental conflict etc. • Continued delivery and evaluation of 1-2-1 family support delivered by the Children's Centre Service, focusing on family routines, parental wellbeing, keeping children safe, emotional needs of children and home learning.	
Children's Centre Services are responsive to need and improve outcomes	• Review the impact of Children's Centre interventions and ensure that interventions are evidence based and evaluated. • Greater engagement of children most at risk of developmental delay and their families. • Greater focus on engaging families from the antenatal period until children reach the age of 3. • Ensure the Children's Centre Service once under the management of the Local Authority maintains strong links with Healthy Family Teams and Maternity Services.	Early Childhood Services, NCC
Improve outcomes for White British Boys	• Improve outcomes for White British boys by ensuring that the opportunities we are providing for boys in the Early Years Foundation Stage fully engage and support them in developing positive dispositions to learning. • Increase take up of childcare and early education opportunities for White British Boys as early as possible. • Provision of Forest School approaches should include a thorough evaluation on the impact for White British Boys, anecdotal information on the impact is insufficient and yet practitioners regularly share information about the successful engagement of boys in Forest School work.	Early Childhood Services, NCC

Improve communication and language skills	• Implement the recommendations highlighted from the Speech Language and Communication Needs Maturity Matrix assessment tool which include:
	  ○ Greater engagement with maternity services and specialist SLT services
	  ○ Greater ownership by CCGs
	  ○ Improve SLCN pathways to specialist SLT services.
	• Maintain effective speech and language support through the evaluated Home Talk programme (or similar), which identifies and supports children with early speech and language delay.
	• Active promotion of the new national Hungry Little Minds home learning campaign which includes a focus on SLCN.
		Early Childhood Services, NCC & Public Health, NCC

Improve the emotional wellbeing and resilience of children	• Promote tools to foster emotional well-being from the earliest stages of life, enhancing resilience and the importance of relationships to help build solid foundations for overall health and well-being. • Implement the REAcH programme to ensure that parents have their needs addressed and the intergenerational cycle of disadvantage is broken through the Children's Centre Service and Healthy Family Teams.	Public Health, NCC
Improve outcomes for Children with SEND	• The significant increase in the number of young claimants of Disability Living Allowance will require a focus on this population to review access and take-up to inform plans to ensure sufficiency of appropriate provision.	Early Childhood Services, NCC

	• Commissioners should work across County Council departments to help share findings from SEND assessments for children under the age of five; sharing key findings and learning which in turn will inform commissioning decisions and service planning. This will need to include the children that do not meet the thresholds for specialist support. • Review the use of the Early Years Inclusion Fund and the Disability Access Fund to ensure that children are effectively supported as part of their transition to school. • Greater promotion of childcare provision to families with children with SEND and increased promotion of funding supplements to early years settings.	
Developmental Delays are identified and supported early	• Embed and review the findings of the 2-year integrated review and the impact for children accessing early years settings; and compare progress against statistical neighbours.	Public Health, NCC
Improve outcomes for children with English as an Additional Language (EAL)	• Explore the specific childcare and health needs of families with English as an Additional Language (including refugees and asylum seekers). • Encourage schools and health services to report both ethnic origin and English as an additional language using ONS codes to enable improved monitoring and analysis.	Early Childhood Services, NCC
Ensure sufficient high-quality childcare provision is available	Nottinghamshire needs to have robust data about both supply and demand for childcare, it is recommended the local authority evaluates progress of new data collection and monitoring procedures to ensure it supports their market management role and sufficiency duties. *Refer to the Nottinghamshire Childcare Sufficiency Assessment.*	Early Childhood Services, NCC
Reduce financial barriers preventing access to childcare	Work should be undertaken with key stakeholders to ensure partners and staff are aware of what support for the costs of childcare is available, and how the free entitlement can be used, and disseminate that information to their client groups. *Refer to the Nottinghamshire Childcare Sufficiency Assessment.*	Early Childhood Services, NCC
Offer flexible childcare provision and provide additional childcare during school holidays and increased wrap around care	• Explore flexible delivery models as a matter of urgency; and consider how these models of working can be applied across different types of provision for all age ranges of children. • The Childcare Sufficiency Assessment identified demand for provision in school holidays and an unmet for after school and before school provision. Work should be undertaken with key stakeholders to identify options for additional childcare and wrap around provision, ensuring all available provision is recognised and promoted through the local authority's information duty, delivered by the Families Information Service. *Refer to the Nottinghamshire Childcare Sufficiency Assessment.*	Early Childhood Services, NCC

Ensure Teenage Parents are effectively engaged and supported	• Improve uptake of Care to Learn Grant for teenage parents • Gain a better understanding of which services teenage parents access and gain a better understanding of the local barriers for young people in accessing the Children's Centre Service and childcare. • Continue to commission evidence based early intervention services for teenage parents such as the Family Nurse Partnership Programme	Public Health and Early Childhood Services, NCC
Consider ceasing the commissioning /delivery of some interventions with no evidence base	Review the interventions provided locally that do not have a clear evidence base, or evaluation and performance do not evidence impact. Commissioners and service providers should not prioritise these interventions where budgets are restricted. This could include baby massage which parents enjoy. However, it must also be acknowledged that evidence of effectiveness is not a replacement for ongoing evaluation: The fact that an intervention has evidence from a rigorous evaluation conducted at one time and place does not mean that it will be effective again. The evidence described in this chapter is therefore not a replacement for good monitoring and evaluation systems as interventions are set up and delivered.	Public Health and Early Childhood Services, NCC
Provision of behavioural sleep training	Continue to provide behavioural sleep training through the Children's Centre Service and provide information through Healthy Family Teams during the antenatal and postnatal stage.	Public Health and Early Childhood Services, NCC
Increase the use of social media and web-based resources	Consider increasing and improving information and support available for parents and expectant parents including activities to promote positive home learning environments and parenting support such as 'Triple P Online'.	Early Childhood Services, NCC

Full JSNA report

What do we know?

1. Who is at risk and why?

We know there are children and families who are more likely to experience a range of poor outcomes during pregnancy and the first 5 years of life. As the early years are critical in building child development it is paramount that we understand who we need to target and why. Many children and families face a number of poor outcomes and risk factors which are often interlinked so a family in poverty may be destined for poor educational outcomes as well as poor health and well-being outcomes. This table provides only a summary of some of the risks and outcomes facing families and young children.

Levels of school readiness links to educational attainment, which impacts on life chances; it has been shown to impact on health, future earnings, involvement in crime, and even death as can be evidenced in the table below.

Target Group	Increased Risk of the following Poor Outcomes
Families living in poverty (in work and out of work poverty) have a range of poor outcomes	• Nearly 50% of children from disadvantaged backgrounds have not secured the essential skills and understanding expected for their age by the time they finish Reception Year. Around 25% are unable to communicate effectively, control their own feelings and impulses of make sense of the world around them to ensure they are ready to learn. Many have reduced opportunities for home learning and parental engagement (Ofsted 2016). • Children from more deprived backgrounds are more likely to experience speech and language delay, with 23% of five-year olds eligible for free school meals not meeting the expected levels in speech, language and communication at the end of Reception, compared to 13% of those not eligible for free school meals (Department for Education 2018). • "Early years education for children below the age of four has a positive impact on the life chances of disadvantaged children, yet disadvantaged children spend significantly less time in pre-school than children from more affluent backgrounds" (House of Commons Education Committee 2019). • Children from low income households are less likely to achieve developmental milestones compared to their peers (Department for Education 2018) • *"In the most deprived localities, rates of tooth decay (indicative of a poor diet) are twice as high, children are twice as likely to be obese, and the chance of attending a good or better early years setting is less likely than in more affluent areas"* (Ofsted 2016)
Children and families known to Social Care and those Looked After	• Children in the care system do poorly in education and have a poorer level of development than that their peers at Foundation stage. Attendance at Early Years provision by newly placed LAC children is low as children stay at home to develop attachments with carers (Nottinghamshire County Council 2018a).

	• Children in care starting school are 'well-behind' their peers and this achievement gap only widens as they get older (Mathers et al 2016). • High-quality early education vastly improves outcomes for disadvantaged children, however, take-up of the free early education places for two, three and four-year-olds is at least 14 percent lower among children in care (Mathers et al 2016). • LAC are already at risk of 'much poorer outcomes' they are put at an additional disadvantage when they start school if they have not had good quality early years education (Mathers et al 2016) • High-quality early education vastly improves outcomes for disadvantaged children, research has shown that take-up of the free early education places for two, three and four year olds is at least 14 percent lower among children in care (Mathers et al 2016).
Children with SEND	• Those identified as having a special educational need (SEN) are one of the groups who are least likely to achieve a good level of development (Department for Education 2018).
Teenage Mothers and their Children	Teenage mothers are: • Three times more likely to experience postnatal depression • Three times more likely to be Looked After. • Less likely to access services that are perceived as judgemental and not 'Young people friendly'. • Most likely to have disengaged from formal education, usually with poor school attendance and low aspirations. Babies of teenage mothers are: • More likely to have delayed child development • More likely to have poor educational attainment (Department of Health 2008)
Children with English as an Additional Language (EAL)	• Access to services can be problematic • Services are not always equipped to support children and families with EAL • Children with English as an additional language do less well academically at all Key Stages. • Although many children from EAL backgrounds who have poor outcomes at the end of the Foundation Stage go on to become among the highest achieving children, there are also many who do not catch up. • "The children learning EAL who are most vulnerable to poor outcomes at the end of the Foundation Stage and beyond are usually those with the least experience of being in an Early Years or Foundation Stage setting. Some of these children will be newly arrived to England, but many more will have remained at home because – for whatever reason, either through choice or lack of appropriate and accessible information – parents have not taken up the offer of free education for three- and four-year-old children before statutory school age". (DCSF 2007).
Some Black and Minority Ethnic Groups	• Some BME groups are less likely to achieve a good level of development than their peers; there are wide variances when looking at individual ethnicities (Department for Education 2018).
White British Boys	• White British Boys have a lower level of development than all girls and boys from BME groups. This is especially profound amongst white British boys who are eligible for Free School Meals. This is evidenced in both local and national data (Department for Education 2018).

	• For decades, this group has been underachieving, and for decades this phenomenon has been researched, yet no consensus has been reached as to why they continue to underachieve (Terrelonge 2018).
Children with language delay	• Language difficulties predict problems in literacy and reading comprehension, but they may be indicative of problems in children's behaviour and mental health as well. Once children enter school, language skills remain a strong predictor of their academic success. Evidence also shows that children with poor vocabulary skills at age 5 are more likely to have reading difficulties as an adult, more likely to have mental health problems, and more likely to be unemployed. • Most children develop typically, including those who grow up in disadvantage. However, there is strong evidence to suggest that the achievement gap is underpinned by income-related gaps in children's language and communication skills, which are already detectable during the second year of life. Early intervention has an important role to play in supporting children who are showing early signs of atypical development. (Children's Commissioner 2019, Local Government Association 2019) Difficulties in early language development can lead to: • Educational disadvantage resulting in reduced school readiness and poor academic achievement. • emotional and behavioural difficulties such as increased risk of ADHD and anxiety disorders in adolescence • risky behaviours, for example more than 70% of young people in the youth offenders system have a communication disability • issues with criminal justice: 50% of the UK prison population have language difficulties, compared to 17% of the general population • economic disadvantage, shown by 12% average lower earnings among those with inadequate literacy skills, who are also twice as likely to be unemployed at age 34 • a threefold increased risk of mental health problems in adulthood (Public Health England 2019)
Children and parents affected by Adverse Childhood Experiences (ACEs)	• Adverse Childhood Experiences (ACEs) refer to some of the most intensive and frequently occurring sources of stress that children may suffer early in life. ACEs range from experiences that directly harm a child, such as physical, verbal or sexual abuse, and physical or emotional neglect, to those that affect the environments in which children grow up, such as parental separation, domestic violence, mental illness, alcohol abuse, drug use or imprisonment. ACES have lasting, measurable consequences later in life, we therefore need to foster emotional well-being from the earliest stages of life, enhancing resilience and the importance of relationships to help build solid foundations for overall health and well-being. • Parent's emotional health and wellbeing plays an important part in the care, support and education of children; 1 in 3 adult mental health conditions relate directly to their own Adverse Childhood Experiences (ACES). • Toxic stress caused by ACES adversely affects the structure and functioning of a child's developing brain and affects short-and long-term health, leading to autoimmune diseases, as well as heart disease, breast cancer, lung cancer and a range of mental health problems.

	• There is a strong and proportionate (dose-response) relationship between ACES and the risk of developing poor physical health, mental health and social outcomes. • ACEs are associated with a large proportion of absenteeism from work, costs in health care, emergency response, mental health and criminal justice involvement. (Bellis MA et al 2014, Hughes K et al 2016, Young Minds 2018)
Gypsy, Roma and Traveller (GRT) Families	• An area may be unknown to the family; parents have no local knowledge of services and arrive to a new area without a support network. • There is a reluctance to access services. • Many families experience rural isolation. • Lack of permanent accommodation makes it impractical to access services and for those services to track progress or provide follow up. • Without a permanent address, families cannot access early years funding for eligible children. • GRT children are less likely to achieve a good level of development. (Department for Education 2018).
Summer born children	• Children born in the summer months have a poor level of development compared to those born earlier in the year. • The time of year a child is born is the highest predictor for poorer early years foundation stage results as they have received fewer educational opportunities than their peers and assessments are carried out in the summer term each year.
Children with speech, language and communication needs	• The UK prevalence rate for early language difficulties is between 5%–8% for all children, and over 20% for those growing up in low-income families. Tackling this gap in early language acquisition is complex and requires a system-wide approach across maternity and the early years (Children's Commissioner 2019). • The latest national Early Years Foundation Stage Profile results show that 18% of five-year olds, are not reaching the expected development levels in communication (DfE 2018a). About 4% of all primary school children, who are on the SEN register because of identified speech, language and communication needs (DfE 2018a), although other studies have shown that there are likely to be even more children than this who are having difficulties (Norbury 2016).
Mothers experiencing Post Natal Depression	• Postnatal depression (PND) has a profound impact on maternal health and wellbeing, and both short-term and long-term implications for the developing child and wider family. Treatment is, therefore, a major public health concern. • Like other episodes of depression, depression after childbirth affects the woman's feelings about herself and her interpersonal relationships, and notably the mother-baby relationship, the couple relationship and relationships with older children and the wider family (Lee et al 2007). • Not responding appropriately to a baby's needs may lead to prolonged increase of cortisol, a stress hormone, which may affect how babies tolerate stress later in life (Gerhardt 2004). • Maternal mental health problems are consistently linked to higher levels of cortisol in the womb and an increased risk of poor birth outcomes. Mothers experience mental health problems at rates comparable to general female population, ranging from 15 to 25% (Early Intervention Foundation 2018a).

Women affected by Domestic Violence and Abuse	• Pregnancy is a period of particular risk for intimate partner violence (IPV), occurring in approximately one-sixth of all pregnancies. IPV substantially increases mothers' experiences of stress and trauma, resulting in increased levels of cortisol in the womb which may contribute to a variety of adverse childbirth outcomes, including maternal and infant death (Early Intervention Foundation 2018a).
Children with poor sleep routines	• Sleep difficulties during infancy have been linked to a wide range of child problems, including behavioural difficulties and an increased risk of child physical illness. Parents also report higher levels of stress and depression when their infants are not able to sleep through the night (Early Intervention Foundation 2018a).

2. Size of the issue locally

Improving educational attainment and outcomes for children requires services and interventions for families with children under the age of 5. Assessing population estimates and population predictions assists commissioners in assessing current and future demands and requirements, including ensuring there is sufficiency high quality childcare across Nottinghamshire.

2.1 Population of Under Fives in Nottinghamshire

In April 2019, it was estimated that Nottinghamshire had a population under the age of 5 of approximately 45,000. Detailed population estimates are available in from the Office of National Statistics which is available using this link Population estimates.

Figure 1: Nottinghamshire Mid-Year Population estimates for children under the age of 5

Name	All ages	0	1	2	3	4
Nottinghamshire	823,126	8,216	8,991	9,071	9,247	9,363
Ashfield	127,151	1,332	1,534	1,496	1,500	1,576
Bassetlaw	116,839	1,141	1,318	1,300	1,301	1,301
Broxtowe	113,272	1,094	1,174	1,170	1,203	1,198
Gedling	117,786	1,184	1,206	1,275	1,291	1,267
Mansfield	108,841	1,209	1,341	1,309	1,350	1,360
Newark and Sherwood	121,566	1,169	1,261	1,294	1,343	1,321
Rushcliffe	117,671	1,087	1,157	1,227	1,259	1,340

Source: ONS Mid-Year Estimates 2019

2.2 Children's Development at age 2 – 2 ½ years

All children receive a series of mandatory checks as stated in the Healthy Child Programme and led by Health Visitors (in Nottinghamshire this is provided through Healthy Family Teams). A nationally recognised Ages and Stages Questionnaire (ASQ) is used to assess

developmental milestones. Where there are areas of concern, Healthy Family Teams work with the parent and early years setting (if a child is accessing childcare) to develop the check into an integrated review to address concerns.

In Nottinghamshire in 2017/18, 91.1% of 2 – 2 ½ year olds who received an integrated review comparing favourably across statistical neighbours and national take up which stands at 90.2%. Outcomes for children identified by these mandatory checks is collected locally and submitted to central government for further analysis. The data from these checks is able to tell us the skills of children regarding communication, gross motor skills, and problem solving and personal-social skills. The challenge regarding this data however is that not all local authority areas have submitted their results as this is a new requirement, this makes it harder to compare our progress with statistical neighbours; we can however assess our progress against national data.

	England	Nottinghamshire
Percentage of children at or above expected level of development in all five areas of development at 2-2½ years	83.3%	86.2%
Percentage of children at or above expected level of development in communication skills at 2-2½ years	83.3%	90.5%
Percentage of children at or above expected level of development in gross motor skills at 2-2½ years	91.5%	94.9%
Percentage of children at or above expected level of development in problem solving skills at 2-2½ years	91.9%	97.7%
Percentage of children at or above expected level of development in personal-social solving skills at 2-2½ years	91.3%	96.2%

Source: PHE's interim reporting of health visiting metrics (June 2019)

These findings indicate that children in Nottinghamshire perform better than national figures; this however is not reflected in the Early Years Foundation Stage Profile where Nottinghamshire's results are worse than national and statistical neighbour averages. Further work may be required to moderate the assessments carried out in schools at Foundation Stage.

2.3 Early Education and School Readiness

Research shows that access to high quality early learning experiences, together with a positive learning environment at home, is a vital combination to ensure that children have reached a good level of development at the start of compulsory school age.

School readiness is a strong indicator of how prepared a child is to succeed in school cognitively, socially and emotionally. To assess how 'school ready' a child is, we use a measure called the good level of development (GLD). A child with a GLD at the Early Years Foundation Stage (from birth to five years old) will have reached the expected level in all the prime areas of learning. Evidence shows that those who do not reach a GLD by age five, will go on to struggle with key skills such as communication, language, literacy and mathematics (Kokodiols 2015).

Levels of school readiness links to educational attainment, which impacts on life chances; it has been shown to impact on health, future earnings, involvement in crime, and even death.

The Early Years Foundation Stage (EYFS) sets standards for the learning, development and care of children from birth to 5 years old. All schools and Ofsted-registered early years providers must follow the EYFS, including childminders, preschools, nurseries and school reception classes.

The EYFS framework supports an integrated approach to early learning and care. It gives all professionals a set of common principles and commitments to deliver quality early education and childcare experiences to all children

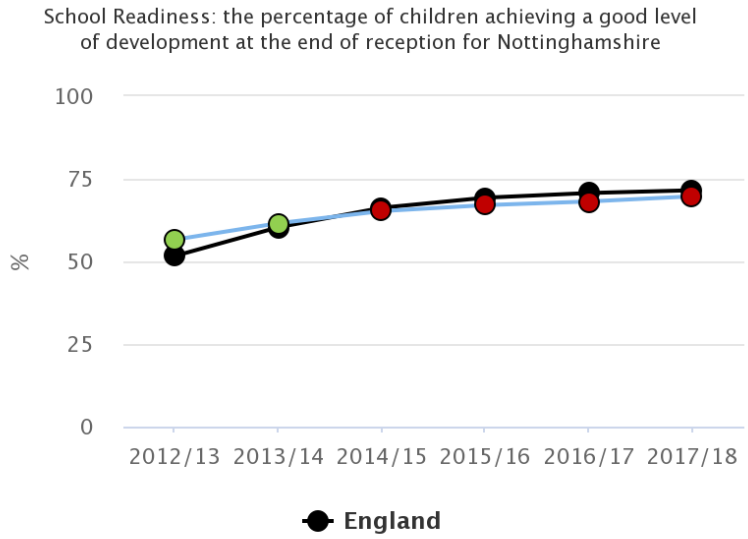
The Early Years Foundation Stage Profile (EYFSP) is a teacher assessment of children's development at the end of the EYFS (typically aged 5). There are seven areas of learning which cover 17 early learning goals:

Communication and Language	1. Listening and attention 2. Understanding 3. Speaking
Physical Development	4. Moving and handling 5. Health and self-care
Personal, Social and Emotional Development	6. Self-confidence and self-awareness 7. Managing feelings and behaviour 8. Making relationships
Literacy	9. Reading 10. Writing
Mathematics	11. Numbers 12. Shape, space and measures
Understanding the World	13. People and communities 14. The world 15. Technology
Expressive Arts and Design	16. Exploring and using media and materials 17. Being imaginative

A child receives a score for each 17 areas of either 1 (for emerging), 2 (expected) or 3 (exceeding). A child is deemed to have reached a good level of development if they achieve at least the expected level (a score of 2 or 3) within communication and language; physical development; personal, social and emotional development; literacy; and mathematics.

In 2018, there was a small increase in the percentage of children who achieved a Good Level of Development both nationally and locally. However, in 2018, 69.7% of Nottinghamshire pupils achieved a good level of development, compared to 71.5% across England. Progress in Nottinghamshire is slow and despite improvements in many other outcome measures; addressing school readiness is therefore a local priority.

Figure 2: School Readiness trends in Nottinghamshire and England 2012-2018



Data source: Early Years Foundation Stage Results 2018 (PHE 2019)

Figure 3: Early Years Foundation Stage Profile results for Nottinghamshire and Statistical Neighbours 2018

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI Lower CI	95% Upper CI Upper CI
England	↑	-	466,668	71.5	71.4	71.6
Fourth less deprived decile (IMD2015)	–	-	6,582	69.7	68.8	70.6
Nottinghamshire	↑	-	6,582	69.7	68.8	70.6
Staffordshire	↑	1	7,146	75.0	74.1	75.8
Derbyshire	↑	2	5,911	70.8	69.8	71.8
Lancashire	↑	3	9,796	69.5	68.7	70.3
Warwickshire	↑	4	4,720	72.3	71.2	73.4
Lincolnshire	↑	5	5,440	69.1	68.1	70.1
Worcestershire	↑	6	4,605	71.2	70.1	72.3
Northamptonshire	↑	7	6,792	71.3	70.3	72.2
Gloucestershire	↑	8	4,743	69.2	68.1	70.2
Suffolk	↑	9	5,735	71.5	70.5	72.4
Essex	↑	10	12,570	73.8	73.1	74.4
Norfolk	↑	11	6,700	71.6	70.6	72.5
Leicestershire	↑	12	5,534	70.8	69.8	71.8
Cumbria	↑	13	3,535	70.0	68.7	71.3
Somerset	↑	14	4,134	71.8	70.6	73.0
Kent	↑	15	13,614	75.1	74.5	75.8

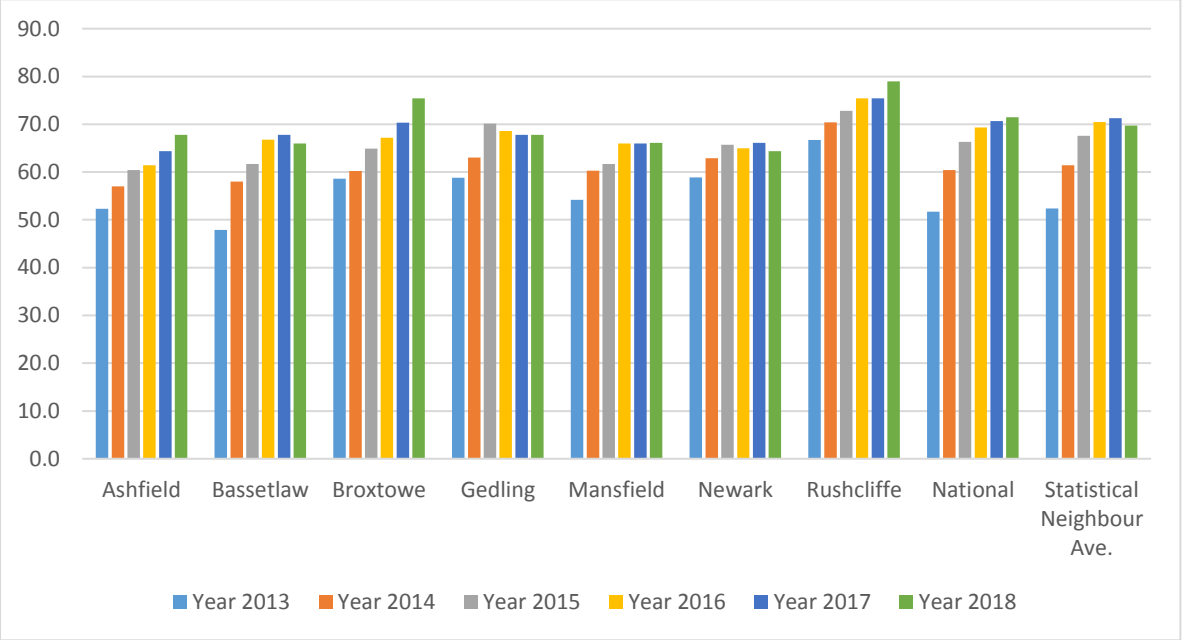
Data source: Early Years Foundation Stage Results 2018 (PHE 2019)

Data for statistical neighbours shows that Nottinghamshire needs to do more to ensure children have a good level of development and learn from areas such as Staffordshire, Essex, and Kent.

2.3.1 District Progress

Progress to improve children's development has been increasing steadily since 2013, however there are some local variations which often reflect the socioeconomic status of an area. Rushcliffe and Broxtowe are the only districts that performs better than the national average.

Figure 4: % Children Achieving a Good Level of Development – district progress 2013-2018



Data Source: Nottinghamshire County Council Early Years Foundation Stage results 2018

Figure 5: % of children achieving a Good Level of Development - District progress 2017 – 2018 with national comparisons

District	Pupils	% GLD	Change from 2017	GLD Gap between national
Bassetlaw	1,267	67.3	-0.5	-4.2
Broxtowe	1,312	70.3	0.0	-1.2
Mansfield	1,317	67.2	1.2	-4.3
Nottinghamshire	**9,432**	**69.7**	**1.5**	**-1.8**
Ashfield	1,532	66.3	1.9	-5.2
Newark	1,310	68.2	2.1	-3.3
Gedling	1,337	70.0	2.2	-1.5
Rushcliffe	1,357	79.0	3.6	7.5
National	**--**	**71.5**	**0.8**	**0.0**

Good level of development by school district and percentage point increases from 2017. Districts ordered by 'Change from 2017' and shading is based on national increases from 2017, Gap shading is based on district / national gap.

Data Source: Nottinghamshire County Council Early Years Foundation Stage results 2018

Ashfield continues to have the widest gap against national progress, however this has reduced from 7.9 percentage points in 2016, 6.3 in 2017 and 5.2 this year. Rushcliffe, Gedling and Newark and Sherwood Districts have seen the greatest improvement since 2017.

2.3.2 Early Education for Children in Low Income Households

"Early years education for children below the age of four has a positive impact on the life chances of disadvantaged children, yet disadvantaged children spend significantly less time in pre-school than children from more affluent backgrounds" (House of Commons Education Committee 2019).

It is recognised nationally that children from lower socio-economic groups tend to do worse than their peers from higher-earning families, and this data demonstrate that this inequality is evident in Nottinghamshire.

When examining 2018 data for children who are eligible for Free School Meals (FSM), it is clear that children from low income households do less well than their peers. In 2018, 49.9% of children eligible for FSM in Nottinghamshire achieved a good level of development.

When comparing Nottinghamshire's progress against statistical and regional neighbouring authorities, it is evident that most local authorities are seeing similar results with the exception of Kent where 60% of children eligible for FSM achieved a good level of development. However only Leicestershire and Gloucestershire have poorer results than Nottinghamshire.

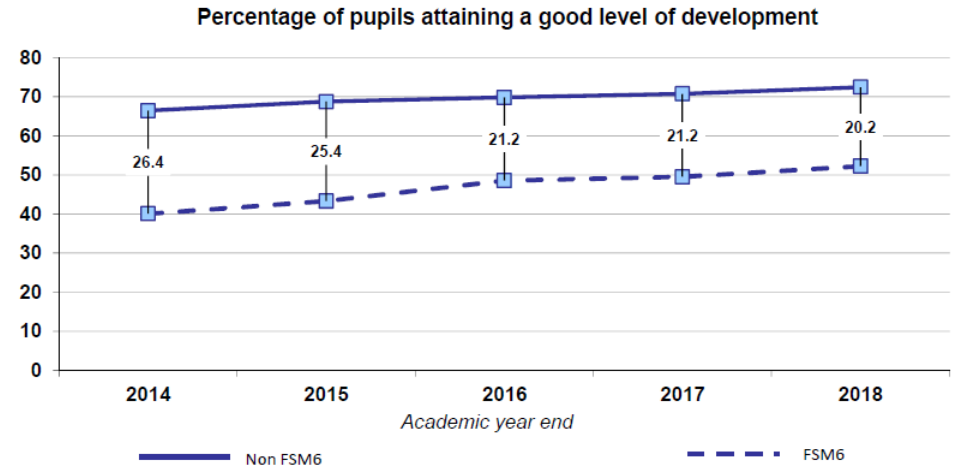
Figure 6: School readiness: good level of development at age 5 with free school meal status – Statistical Neighbour Comparisons, 2018

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI Lower CI	95% Upper CI Upper CI
England	↑	-	49,312	56.6	56.2	56.9
Staffordshire	↑	1	488	58.3	54.9	61.6
Derbyshire	↑	2	611	51.3	48.5	54.1
Lancashire	↑	3	968	53.6	51.3	55.9
Warwickshire	↑	4	315	55.0	50.9	59.0
Lincolnshire	→	5	624	52.4	49.6	55.3
Worcestershire	↑	6	370	50.1	46.5	53.7
Northamptonshire	↑	7	421	56.1	52.5	59.6
Gloucestershire	↑	8	303	48.9	45.0	52.9
Suffolk	↑	9	484	57.2	53.9	60.5
Essex	↑	10	1,041	56.0	53.8	58.3
Norfolk	↑	11	703	57.5	54.7	60.2
Leicestershire	↑	12	265	48.4	44.2	52.5
Cumbria	↑	13	284	53.4	49.1	57.6
Somerset	↑	14	500	57.5	54.2	60.7
Kent	↑	15	1,239	60.0	57.9	62.1
Nottinghamshire	↑	-	547	49.9	47.0	52.9

Data source: Early Years Foundation Stage Results 2018 (PHE 2019)

The attainment gap for children eligible for Free School Meals continues to be significantly wider than England and statistical neighbours. The graph below shows that the attainment gap is gradually reducing, albeit slowly.

Figure 7: Children eligible for Free School Meals and their peers achieving a Good Level of Development -Attainment Gap in Nottinghamshire 2014-2018



Data Source: Nottinghamshire County Council Early Years Foundation Stage results 2018

The links with poverty and attainment are well evidenced and can be demonstrated across Nottinghamshire, where localities with larger numbers of children living in poverty also have smaller numbers of children who achieve a good level of development at the end of Foundation year. A map is included in Appendix One of this report.

Analysis by school district shows results are varied. Gedling was the only district to witness a fall in results since 2017; with 67.8% of pupils achieving a good level of development, a fall of 0.8 percentage points from 2017 (68.6% in 16/17). The previous year, Gedling witnessed a fall of 1.5 points from 2016 (70.1% in 2015). Mansfield and Rushcliffe remained static since 2017 at 66.0% and 75.4% respectively. Broxtowe and Ashfield witnessed increase of 3.1 (to 70.3%) and 3.0 (to 64.4%) respectively.

Although Bassetlaw and Newark districts witnessed an increase in the percentage of pupils achieving a good level of development from 2016 outcomes, those increases were less than witnessed nationally (1.4 percentage point increase). Only Ashfield and Broxtowe witnessed greater increases. It is unclear why some districts have performed better than others and what interventions may have impacted on results.

Rushcliffe is the only district where outcomes are better than the national average although this gap has reduced since last year when the district was 6.1 percentage points above national, now 4.7. However, as the cohort of children eligible for Free School Meals is smaller in Rushcliffe than other districts, this change could be attributed to outcomes for a very small number of children.

Ashfield continues to have the widest gap from 2016 but this has reduced from 7.9 percentage points to 6.3 this year.

Figure 8: Children gaining a Good Level of Development by District and FSM eligibility 2018

	All pupils		FSM Eligible		Not FSM Eligible	
District	**Pupils**	**% GLD**	**Pupils**	**% GLD**	**Pupils**	**% GLD**
Ashfield	1,533	66.3	257	52.1	1,273	69.2
Bassetlaw	1,267	67.3	155	43.9	1,110	70.7
Broxtowe	1,312	70.3	127	47.2	1,184	72.8
Gedling	1,337	70	118	55.1	1,219	71.5
Mansfield	1,317	67.2	226	50	1,091	70.8
Newark	1,310	68.2	146	49.3	1,164	70.5
Rushcliffe	1,357	79	71	49.3	1,286	80.6
Nottinghamshire	9,433	69.7	1,100	49.7	8,327	72.4

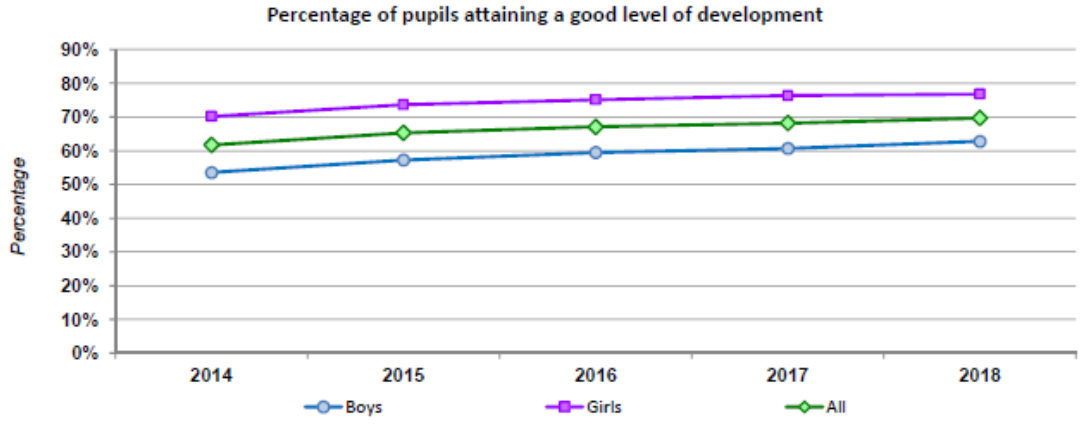
Data Source: Nottinghamshire County Council Early Years Foundation Stage results 2018

2.3.3 Groups most at risk of Poor Educational Outcomes

2018 EYFS results highlight key groups less likely to achieve a good level of development. Results reflect national data with the same groups consistently being identified as 'at risk'.

Boys - Boys perform less well than girls and this picture is reflected nationally and in Nottinghamshire. In 2018, 76.8% of girls achieved a good level of development compared to 62.8% for boys. Analysis of the Early Years Foundation score by gender identifies a 14% point gap between boys and girls. This gap has narrowed from 15.6% in 2017 and progress for boys has improved by 2.1% in 2017/18.

Figure 9: Percentage trend of children in Nottinghamshire attaining a good level of development by Gender (2014-2018)



Data Source: Nottinghamshire County Council Early Years Foundation Stage results 2018

When this data is broken down by term of birth, the gap between the genders for summer born pupils show a 16.0 percentage point gap which is a narrowing from 17.3 last year. Although narrowed this is the widest gap between the genders and term of birth. Autumn

and spring born pupils have a slightly narrower gender gap at 11.7 and 13.9 percentage points respectively.

Summer born – in 2018, 80% of all children across Nottinghamshire born in the autumn term achieved a good level of development compared to 59% of children born in the summer term.

Summer Born Boys - The lowest consistently performing group across the early years foundation stage are boys born in the summer term. Summer born boys perform less well with 51.1% achieving a good level of development compared to 71.2% for autumn born boys. Autumn born girls was the highest performing group at 85.9%. All groups witnessed an increase from 2017 outcomes.

In 2018 in Nottinghamshire, 51.1% of summer born boys achieved a GLD compared with autumn born girls who achieved the highest results with 85.9% achieving a GLD. The gap between the genders for summer born pupils shows a 17.3 percentage point gap between boys and girls. This picture is reflected nationally.

It must be noted however, that the progress for summer born boys is positive, having increased from 49.3% to 51.1% since 2017.

Figure 10: Children's Development in Nottinghamshire by Gender and Term of Birth (2018)

Gender	Term of Birth	2017		2018		Increase from 2017
		Pupils	% GLD	Pupils	% GLD	
Boys	Autumn	1,709	71.2	1,656	74.2	3.0
	Spring	1,658	61.6	1,545	62.8	1.2
	Summer	1,713	49.3	1,594	51.1	1.8
	All Boys	**5,080**	**60.7**	**4,795**	**62.8**	**2.1**
Girls	Autumn	1,626	85.5	1,654	85.9	0.4
	Spring	1,550	76.1	1,461	76.7	0.6
	Summer	1,482	66.6	1,522	67.1	0.5
	All Girls	**4,658**	**76.3**	**4,637**	**76.8**	**0.5**
All Pupils	Autumn	3,335	78.2	3,310	80.0	1.8
	Spring	3,208	68.6	3,006	69.5	0.9
	Summer	3,195	57.3	3,116	59.0	1.7
	All Pupils	**9,738**	**68.2**	**9,432**	**69.7**	**1.5**

2018 GLD shading based on 2018 national GLD figure of 71.5%, difference shading based on pupil group increases between 2017-18.

Data Source: Nottinghamshire County Council Early Years Foundation Stage results 2018

Summer Born White British Boys eligible for FSM - Analysis for White British free school meal eligible boys by term of birth shows a marginal increase from 2017. Outcomes remain low at 40.4% achieving this threshold of a good level of development. When broken down by term of birth the White British FSM eligible boys cohort achieve broadly 30 percentage points lower than the equivalent cohort who are not eligible for free school meals. The gap also widens the younger the pupils are (e.g. the gap for summer born pupils is 32.8 percentage points while the gap for autumn born pupils is 23.6).

Figure 11: 2018 Early Years Foundation Stage results – White British Boys eligible for Free School Meals by term of birth.

*White British boys who **are** eligible for free school meals:*

Term of Birth	2017		2018		Increase from 2017
	Pupils	% GLD	Pupils	% GLD	
Autumn	158	51.9	189	54.5	2.6
Spring	161	37.3	167	40.7	3.4
Summer	167	30.5	156	23.1	-7.4
Group Total	**486**	**39.7**	**512**	**40.4**	**0.7**
All Pupils	**9,738**	**68.2**	**9,432**	**69.7**	**1.5**

2018 GLD shading based on 2018 national GLD figure of 71.5%,
difference shading based on pupil group increases between 2017-18.

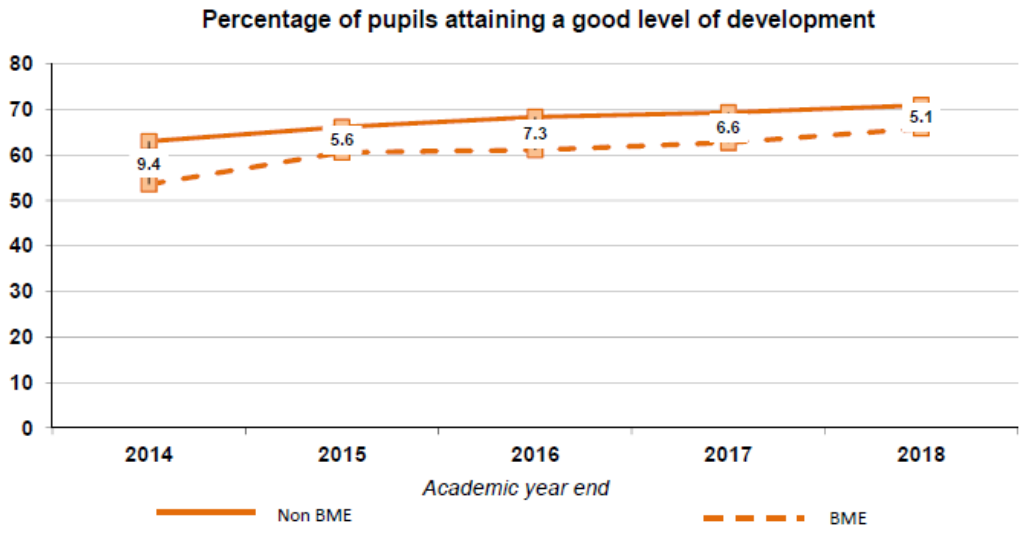
Data Source: Nottinghamshire County Council Early Years Foundation Stage results 2018

Ethnicity – 65.9% of Children in Nottinghamshire from BME groups achieved a good level of development compared to 70.9% for non BME groups, and the attainment gap is narrowing.

Ethnic groups show a wide spread in the percentage of pupils achieving a good level of development and there are wide variances when looking at individual ethnicities. White and Asian pupils have the highest attainment at 84.5% achieving this threshold compared with 25.0% for Traveller of Irish Heritage after removal of groups with small cohort numbers. A difference of 59.5 percentage points between the highest and lowest group.

Caution needs to be used when interpreting individual pupil ethnic groups as the number of pupils can be low for certain groups.

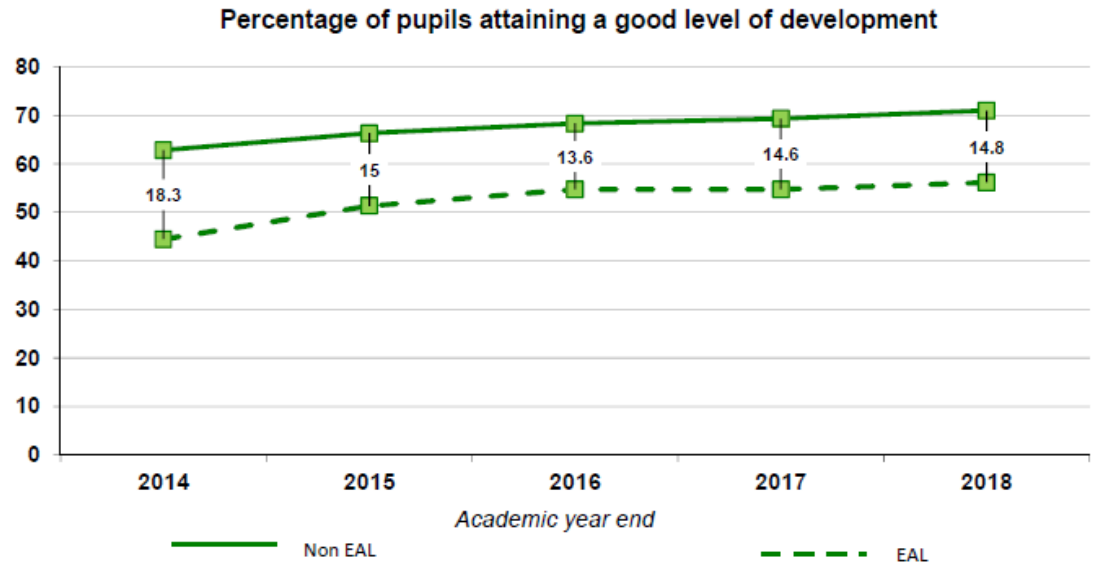
Figure 12: Percentage of pupils attaining a good level of development by ethnicity in Nottinghamshire (2018)



Data Source: Nottinghamshire County Council Early Years Foundation Stage results 2018

English as an Additional Language – in 2018, 56.2% of children with English as an Additional Language (EAL) achieved a good level of development, compared with 71% of non EAL children.

Figure 13: Children achieving a good level of development by first language in Nottinghamshire (2018)

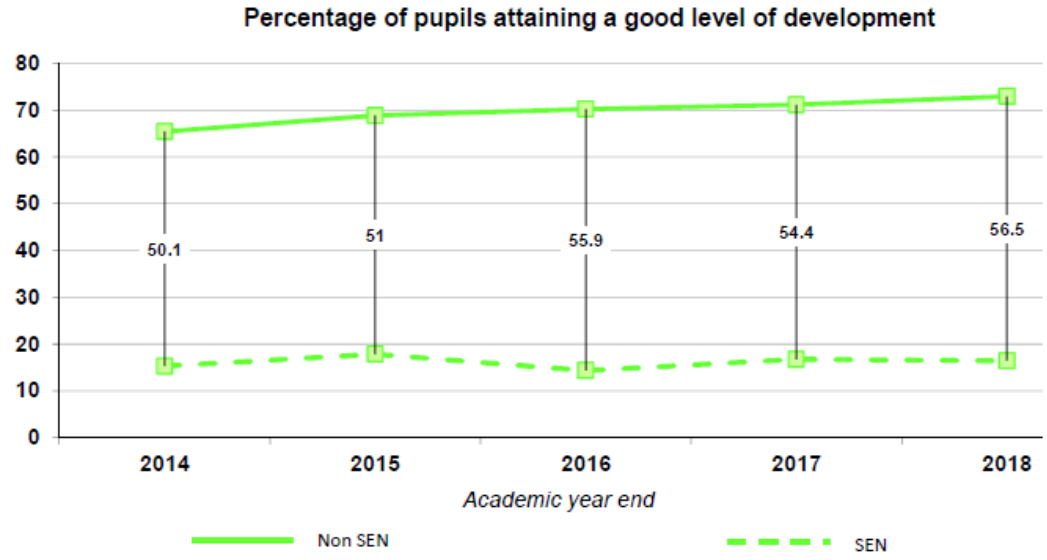


Data Source: Nottinghamshire County Council Early Years Foundation Stage results 2018

Analysis by language shows a wide spread in pupils achieving a good level of development. Although the number of pupils in certain language groups is low, the highest achieving group in 2018 was French (87.5%) and the lowest was Turkish (11.1%) after removal of groups with small cohort numbers. Polish speaking children will continue to be a priority due to the large cohort size; in 2018, 58% of polish speaking children achieved a good level of development.

Early Education and Special Educational Needs and Disability - Those identified as having a diagnosed special educational need (SEN) are less likely to achieve a good level of development compared to those with no known SEN. In 2018 in Nottinghamshire, 16.4% of SEN children achieved a good level of development compared to 72.9% for their peers; this is also reflected nationally.

Figure 14: Children achieving a good level of development by Special Educational Need status in Nottinghamshire 2018



Data Source: Nottinghamshire County Council Early Years Foundation Stage results 2018

Early Education and Looked After Children - Looked After Children are less likely to achieve a good level of development compared to their peers. The average score for Looked After Children in Nottinghamshire is 18.2 points compared to 69.7 points achieved by all children in Nottinghamshire; however numbers are relatively small and cohorts do change regularly, so trend data is problematic.

Figure 15: The percentage of Children Looked After achieving a good level of development in Nottinghamshire 2014-2018

Academic year end	Pupils	% achieving a good level of development	% achieving at least expected level across all ELGs	Average total point score
2014	20	35.0	30.0	30.0
2015	17	41.2	41.2	30.5
2016	18	33.3	33.3	27.9
2017	13	46.2	46.2	30.8
2018	11	18.2	18.2	23.5

Data Source: SSDA 903 return (LAC 12 months or more) matched to EYFSP results

NB: Nottinghamshire LAC (regardless of the school they attend) who have been in care for 12 months or more as at 31st March of the stated year.

Looked After Children are eligible for Early Years LAC Pupil Premium funding. This funding is used to top up the hourly rate that an early years provider receives for a child. From September 2017, early years providers who work with LAC are asked to track their progress using the new Better Start software. This will enable greater analysis of progress.

2.4 Speech Language and Communication Needs

The Children's Commissioner published the We Need to Talk Report in June 2019. The report focuses on access to speech and language therapy and the funding made available by local commissioners for SLT services. The report states that *"Thousands of children in England struggle with speech, language and communication, and these difficulties can have severe long terms effects on their education, their emotional well-being and their employment prospects. Eleven percent of two-year olds who receive their development checks are already identified as being below the expected level of communication".*

Nationally in 2018, 72.4% of children achieved at least the expected level of development across all the early learning goals within the Communication & Language and Literacy areas of learning, up from 71.8% in 2017 and 56.9% in 2013. In Nottinghamshire, 82.6% of all children achieved their expected levels or above in learning goals which comprise communication and language in the EYFS in 2018, which we suspect evidences the impact of the local Speech Language and Communication Needs (SLCN) interventions provided by the Children's Centre Service.

Children from more deprived backgrounds are more likely to experience SLCN problems, with 23% of five-year olds eligible for free school meals not meeting the expected levels in speech, language and communication at the end of Reception, compared to 13% of those not eligible for free school meals across England (EYFS 2018). Progress in Nottinghamshire however is better than national progress, although it is still evident that children eligible for Free School Meals are less likely to achieve outcomes in comparison to their peers with 64.8% of children eligible for FSM achieved expected goals compared to 84.9% for their peers (EYFS 2018).

Figure 16: Percentage of children achieving expected or above in all learning goals which comprise communication and language in the EYFSP by free school meal eligibility in Nottinghamshire (EYFS 2018).

	Not eligible for FSM		Eligible for FSM		FSM / Non-FSM GAP	All pupils	
Year	Pupils	% expected+ in all C&L goals	Pupils	% expected+ in all C&L goals		Pupils	% expected+ in all C&L goals
2013	7,581	79.2	1,508	60.4	**18.8**	9,089	76.1
2014	7,595	81.6	1,469	61.4	**20.2**	9,064	78.3
2015	8,288	82.6	1,118	60.2	**22.4**	9,406	79.9
2016	8,525	82.2	1,108	65.8	**16.4**	9,634	80.3
2017	8,695	83.1	1,038	65.6	**17.5**	9,738	81.2
2018	8,329	84.9	1,100	64.8	**20.1**	9,432	82.6

2.5 Special Education Needs and Disability (SEND)

In Nottinghamshire, a child or young person is considered to have SEN or a disability if they need extra help for a range of needs in the four areas of SEND described in the SEND code of practice: 0 to 25 years (2014):

- Communicating and interacting
- Cognition and learning
- Social, emotional and mental health difficulties
- Sensory and/or physical needs

Information about the prevalence of special education needs and disability (SEND) in Nottinghamshire will be included in the SEND JSNA chapter currently in development.

Children and young people with SEND have learning difficulties or disabilities that make it harder for them to learn than most children and young people of the same age; this is reflected in all key stages including the Early Years Foundation Stage. This is evidenced in Nottinghamshire where 16.4% of children with SEN achieve a good level of development compared 72.9% of children with no known SEN (Nottinghamshire County Council 2018a).

2.6 Teenage Pregnancies

Teenage conception rates are declining nationally and in Nottinghamshire as can be evidenced in the JSNA chapter on teenage pregnancy. Since the national Teenage Pregnancy Strategy was launched in 1998, the conception rate has declined by 61.8% across England and 64.7% in Nottinghamshire. However, the health, education and economic outcomes of teenage parents and their children remain disproportionately poor and, as numbers have declined, many have increasingly complex needs. For a minority, this makes parenting very challenging. Almost 60 per cent of mothers involved in serious case reviews were under 21 when they had their first child (LGA and PHE 2019).

Further detail is available in the Teenage Pregnancy JSNA chapter.

2.7 Perinatal Mental Health

Up to 20% of women develop mental health problems in pregnancy or in the first year after childbirth. Maternal mental health conditions can range from low mood and depression to psychosis and can impact on a child's development.

Further information is included in the 'Maternity and early years (2014) ' and 'mental health (adults & older people 2017)' JSNA chapters and in the recent chapter focusing on the first 1,001 Days (2019).

3. Targets and Performance

There are a number of national and local strategies that set local priorities and targets for implementation.

3.1 National Strategies and Policy:

- **Childcare Act 2016** - makes provision about free childcare for young children of working parents and the requirement to publish information about childcare and related matters by local authorities in England. Childcare Act 2016
- **Statutory framework for the early years foundation stage (2018)** sets standards for the learning, development and care of children from birth to 5 years old. All schools and Ofsted-registered early years providers must follow the EYFS, including childminders, preschools, nurseries and school reception classes. Statutory Framework for the Early Years Foundation Stage 2018
- **A Framework for supporting teenage mothers and young fathers (2016)** highlights the poor outcomes and risk factors for teenage parents and their children. The frameworks provides a useful tool to ensure that needs are identified and met through an integrated approach with local services. A Framework for supporting teenage mothers and young fathers
- **Healthy Child Programme: Pregnancy and the first 5 years of life (2015)**: Pregnancy and the first five years of life (DH/DCSF, 2009) and Healthy Child Programme rapid review to update evidence (PHE, 2015) provides a framework to support collaborative work and more integrated delivery.
  The Programme (0-19) aims to:
  - help parents develop and sustain a strong bond with children
  - encourage care that keeps children healthy and safe
  - protect children from serious disease, through screening and immunisation
  - reduce childhood obesity by promoting healthy eating and physical activity
  - identify health issues early, so support can be provided in a timely manner
  - make sure children are prepared for and supported in all child care, early years and education settings and especially are supported to be 'ready for to learn at two and ready for school by five'

  Healthy Child Programme: Pregnancy and the first 5 years of life (2015)
- **The Child Poverty Act 2010** placed new statutory duties upon top tier local authorities and their named partners to prepare a joint child poverty strategy which set out the measures that the Local Authority and each partner propose to take to reduce and mitigate the effects of child poverty in their area. The government has since amended the Child Poverty Act 2010, replacing the income targets with a duty to report on Life Chances, contained in the Welfare Reform and Work Act 2016.

3.2 Local Strategies

Nottinghamshire Health and Well Being Strategy – 2018-2022 sets out the ambitions and priorities for the Health and Wellbeing Board with the overall vision to improve the health and wellbeing of people in Nottinghamshire. The strategy is available at Health and Wellbeing Strategy 2018-2022.

Nottinghamshire Early Years Improvement Plan 2018-20 aims to improve a range of outcomes for children under the age of five. Ensuring children are ready for school is a key priority, including the active targeting of groups most at risk of lower educational attainment. The action plan can be accessed from Early Years Improvement Plan 2016-18.

The plan includes a number of priorities which will be measured by the Early Years Foundation Stage Profile.

- Increase the number of children achieving a good level of development at the foundation stage, and by reducing the attainment gap to ensure the most vulnerable children are ready for school (children eligible for Free School Meals, children with SEND, BME groups, children with English as an additional language, white boys and summer born children).
- Increase the number of 'good/ outstanding' Early Year's providers to ensure childcare is of high quality and able to improve educational outcomes.
- Ensure eligible 2, 3 and 4 year olds access their free early education and childcare entitlements.
- Implementation of a new Home Learning Pathway and tool.
- Targeted work with White British Boys and Polish Communities in Ashfield.

Nottinghamshire Childcare Sufficiency Assessment – aims to assess the level of childcare provision in an area to ensure, there is sufficient high-quality childcare for children and families. Publishing the Childcare Sufficiency Assessment is a statutory duty for all top tier Local Authorities. The 2018 assessment can be accessed from here Nottinghamshire Childcare Sufficiency Assessment.

Nottinghamshire Strategy for Improving Educational Opportunities for All - aims to ensure that the full range of Nottinghamshire County Council services and partners work coherently with learning providers and businesses to maximise the impact of available resources in further raising the attainment and increasing the progression of all, including the most vulnerable groups of learners. Current priorities include the need to close the attainment gap of children under the age of 5 that are entitled to free school meals and their peers. Improving Educational Opportunities for All

Nottinghamshire Child Poverty Strategy and action plan aims to reduce inequalities between families across Nottinghamshire by reducing the gap in health, education and socioeconomic outcomes. The strategy can be accessed here Nottinghamshire Child Poverty Strategy.

Nottinghamshire Looked After Children and Care Leavers strategy 2018-21 aims to improve outcomes for children in Local Authority Care and Care Leavers. This includes improving health and educational outcomes for all ages. Nottinghamshire Looked After Children and Care Leavers Strategy

Nottinghamshire Language for Life Strategy – aims to work collaboratively to give all children the chance to develop their language and communication skills, so that they can achieve their best educationally and can contribute positively to their community Nottinghamshire Language for Life Strategy.

3.3 Nottinghamshire Better Start Tracking Tool

As children's development is not measured until the end of the Foundation Stage in school, Nottinghamshire has been unable to measure progress for children prior to starting school. A new countywide tracking system was introduced in 2018/19 whereby early years settings can input and share data to track progress of preschool children. All early years providers who receive supplementary funding are required to use Better Start to track the progress of the most vulnerable children. As the tool becomes embedded into daily practice, increasing numbers of early years providers are adopting the tool to measure the progress of all children. The tool will help partners to target interventions and measure progress prior to the EYFS.

From the returns received so far, initial indications are that children eligible for the Early Years Pupil Premium, for example, are making progress over the academic year. In autumn 2018, 59% of the results collated were showing 'on target' or 'ahead' progress. By spring 2019, this figure has risen to 75% 'on target' or 'ahead'. Further work is planned to widen the rate of returns from providers and to moderate the results to aid more in depth analysis.

3.4 National indicators

There are a number of Public Health Outcome Framework indicators relating to early years. These were developed by NHS England and the National Child and Maternal Health Intelligence Network as key indicators of public health outcomes relating to early years (children aged 0-5 years), and include:

Indicator	Nottinghamshire	England	Stat Neighbours Average	Year
School Readiness: the percentage of children achieving a good level of development at the end of reception	69.7%	71.5%	75.1%	2018
School Readiness: the percentage of children with free school meal status achieving a good level of development at the end of reception	56.6%	56.6%	57.6%	2018

Further discussion on public health data is included in relevant JSNA chapters.

4. Current Activity, Service Provision and Assets

NHS, Local Authority and the voluntary sector work together to support and care for families and children 0-5 years. These partners provide some specialist services to support mothers and children with complex social needs and work together to provide early access to services using an early intervention approach in the main.

4.1 Childcare and Early Education

Local Authorities are required by the Childcare Act 2016 to secure sufficient, flexible, high quality early education places for eligible two year olds, and all three and four year olds, offering 570 hours a year over 38 weeks a year.

The need for flexible and affordable childcare is necessary to support those parents ready to enter the labour market and local authorities are also required, where practicable, to ensure sufficient childcare places for working parents, or parents who are studying or training.

Evidence shows that children will benefit most from an early learning experience, in terms of their social, physical, emotional, communication and language development, if it is of a Good standard at least, as defined by Ofsted. Government proposes that only those settings with such ratings should be used for two-year olds wherever possible.

Sufficiency levels - The Childcare Sufficiency Assessment 2018 confirms that the county continues to benefit from a wide range of registered early years and childcare provision.

More information about childcare sufficiency in Nottinghamshire is available in the annual Childcare Sufficiency Assessment Nottinghamshire Childcare Sufficiency Assessment 2018

4.2 NCC Early Childhood Services

The Council's Early Childhood Service delivers a range of activities to improve the development of children and improve outcomes of families. The service also fulfils the statutory duties placed on Nottinghamshire County Council for childcare. The following tasks are delivered by the service:

- Childcare Sufficiency Assessments to create more childcare places where they are needed.
- Quality and improvement support for providers of childcare and early education including providing training and support packages.
- Promotion and assessment of free childcare schemes to help improve attainment levels and support parents into employment.
- Implementation of a range of projects as part of a wider programme to support Early Years initiatives and fulfil statutory duties.
- Improving the attainment levels for our most disadvantaged and vulnerable children through tracking, targeting and intensive support.
- Commissioning Children's Centre services who provide help for children with speech, language and communication needs, parenting support, evidence based parenting programmes, perinatal support etc.
- Commissioning the Nottinghamshire Families Information Service where parents can get information about a range of topics, local services and local childcare provision.
- Campaigns and support to increase parental engagement and home learning.
- support packages and training to the early years sector,
- Leading on key strategies for school readiness and home learning.

4.3 Early Childhood Services Training and Development Opportunities (TADO) Service

Evidence shows a strong correlation between children's development and a skilled early years workforce. Nottinghamshire County Council Early Childhood Services provide a

comprehensive offer of training and support to all early years settings across Nottinghamshire through the TADO.

The national CEEDA Early Years Sector Skills Survey 2018 highlights:

- Over four fifths of providers (88%) have arranged off the job training for their staff in the last 12 months and 75% have arranged on the job training. These rates are higher than for employers generally (48% and 53% respectively), reflecting the statutory requirements on the sector.
- Sector spend on training provision in the last 12 months ranged from nil to £10,800 with an average setting spend of £600 (excluding staff cover and expenses). Forecast spend for next 12 months averages £525 per setting. These modest budgets can limit staff development in areas beyond statutory requirements.
- One in two settings report skills gaps in their existing workforce (55%), compared to 13% employers across all sectors an estimated 35,600 early years staff (11%), have skills gaps, compared to 4% across all sectors. Providers will skills gaps say they are having a negative impact on staff workloads (55%) and making it harder to maintain quality standards.
- The average staff turnover rate in the early years sector is 15%; over one in ten providers have rates of 26% of higher. One in four employers losing staff said pay was a factor in one of more cases (26%).
- Demand for training is highest for level 3 provision. Safeguarding (46%), identifying and supporting children with Social Emotional Behavioural Difficulties (45%), observation, assessment and planning (45%), understanding and managing children's behaviour (45%) and the theory and practice of supporting children's learning (41%) were the most common needs which is also reflected in Nottinghamshire.
- Cost is the biggest barrier to training (56%), followed by challenges releasing staff (41%) and course timing (34%).

4.4 NCC Schools and Families Specialist Services (SFSS)

SFSS is a team within the council formed of teachers and teaching assistants with additional qualifications and experience in working with children and young people with a range of special educational needs aged from 0—19. The service comprises of 4 specialist teams: Early Years, Autism, Cognition & Learning and Sensory.

SFSS work in homes, early years settings and schools offering advice, information and support to children and young people with complex special educational needs and to their families and the staff who work with them.

The Early Years Team works with children with a range of complex special educational needs and disabilities from birth to the end of key Stage 1. (Approximately 7 years of age). The team comprises of specialists for children with complex learning needs, communication and interaction needs/autism and for hearing impaired and visually impaired children.

The service provides:

- Support for the delivery of high quality inclusive early years provision in schools, Private Voluntary and Independent (PVI) early years sector and Children's Centre Services

- Regular home teaching for children before they attend School
- Support and advice to parents and carers
- Transition planning
- Awareness raising of issues relating to disabled children and their families
- Advice and training to staff in schools and early years settings

Referrals to the Early Years SFSS team for the period 1st September 2017 - 31st March 2018 show that 192 children were referred to the service. The greatest proportion of referrals are from schools (22%), followed by Paediatricians (21%), parents (19%), PVI setting (19%), Speech and Language Therapists (8%), Health (8%). No referrals were received from Children's Centre services or Children's Social Care.

4.5 Children's Centre Services

Children Centre Services in Nottinghamshire are commissioning to achieve the following outcomes

- Children achieve a good level of development and are ready for school with children most at risk of developmental delay effectively supported to close the attainment gap.
- Parents are job ready with increased aspirations for themselves and their children.
- Children and parents have improved emotional health and wellbeing.
- The needs of children and their families are identified early and the risk of harm is prevented.

The service contributes to the following objectives:

- Children and families have access to high quality early years provision.
- Children achieve age appropriate language, comprehension and communication skills.
- Children achieve age appropriate personal, social and emotional development milestones.
- Children achieve age appropriate physical development.
- Parents have secure attachments to children. They build strong relationships to help their baby feel secure and loved.
- Good parental health behaviour positively influences children's well –being and development.
- Parents provide a good home learning environment for children to support their development.
- Parents keep their children safe.
- Parents develop skills and confidence needed for employment.

The service targets the following groups:

- Low income families with identified needs
- Children of teenage parents /teenage parents : non FNP (under 20)
- Families identified as having mild/moderate mental health issues
- Children with English as an additional language
- 2,3 and 4 year olds not accessing their minimum childcare entitlement
- Unemployed/single parents
- Unemployed parents living in rural areas
- Children under 5 with speech, language and communication delay

- BME groups where there is a need.
- Parents of children with SEND who do not meet thresholds for specialist services
- Children known to Social Care

2018-2019 Activity:

- 98% of all under 5s were registered with their local Children's Centre.
- 47% of all under 5's received a Children's Centre service.
- Almost two out of three children aged 0-3 received a service.
- 3,184 children or expectant parents have been referred for 1-1 family support. Work was successfully completed with 1,306 children and parents in the same time period.
- 884 (98%) parents who completed evaluation forms reported improved knowledge and confidence in how to play and interact with their child to support their learning, language and development.
- 837 (94%) parents who completed evaluation forms report making changes at home to provide a better learning and play environment to help support their child's development.
- 1,278 (87%) parents who completed evaluation forms report their child is talking and understanding more and listening better which will help their learning in the future.
- 496 (87%) of speech language and communication goals were achieved by children on the speech and language team caseload.
- 1,302 (93%) children accessing Home Talk achieved their goals (Home Talk is a home learning speech and language intervention).
- 878 (93%) parents who accessed the service report they feel closer to their child/family and have built stronger relationships with them as a result of CC intervention.
- 153 (53%) mothers who have accessed the Footsteps programme report improvements in their emotional wellbeing following involvement with a Footsteps volunteer (perinatal peer support), when a case closes.
- 92% (280) Children's Centre volunteers reported greater skills and confidence which supports them to gain a qualification.
- 749 (98%) parents who had issues around their well- being progressed to be able to manage their well-being.
- 328 (69%) families who were not work ready progressed to being ready and able to work.
- 712 (93%) families in which there were issues around boundaries and behaviour progressed to having appropriate boundaries in place.
- 685 (97%) families in which there were issues around their child's learning progressed to being able to support their child's learning

An in-depth impact report showing the performance and activity of Children's Centre services in 2018/19 is available to download from here Children's Centre Impact Report. This web link also includes case studies containing stories, comments and quotes from service users.

4.5.1 Children's Centre Speech and Language Therapy

Nottinghamshire County Council commissions a Speech and Language Therapy (SLT) service for under 5s as part of the Children Centre Service. SLT encompasses a wide range of approaches that meet the needs of a diverse group of children who have Speech, Language and Communication Needs (SLCN).

The Nottinghamshire core offer of the Children's Centre Speech and Language Team (under 5s) aims to:

- Identify Speech, Language and Communication Needs and intervene early.
- Improve parental confidence and effectiveness in supporting their child's language needs.
- Provide language enrichment through developing community capacity.

The SLT service provides:

- Support with local campaigns and resource development.
- Language Leads networks (champions identified through the EY Sector).
- Home Talk
- Early Years setting (including school foundation units) and volunteer training, advice and support around children with emerging needs.
- Family Learning sessions for focused children and families e.g. video interaction and group session combinations
- SLT informal advice to parents and professionals.
- Elklan Talk with the under 5's parent programme.
- Home visiting
- Close integrated working with the wider children's centre, health and social care teams
- Liaison with specialist services division specialist SLT
- Transition packages and referrals to specialist SLT that facilitate support by settings and families

The **Home Talk** intervention provided by the SLT team within the CC service has been evaluated (McDonald et al 2019) and has shown that:

- Families who are experiencing high levels of social disadvantage are reached and supported.
- Most of the children's language skills develop at an accelerated rate and catch up with age expectations by 3 years of age.
- Fewer children have language skills which would put them among the lowest 20% of children for their age.
- Parents/carers who have high levels of parenting stress are helped to access other appropriate child and family services.

Key stakeholders have completed a new Early Intervention Foundation Maturity Matrix which focused on Speech Language and Communication Needs (SLCN). The matrix is a self-assessment tool to help measure how advanced a local area is in creating a local system to help children in their early years to thrive and to guide planning to make this local system more effective. The exercise has identified that further work is required to help lead change and drive forward improvements, recommendations include the need to better engage maternity services and specialist SLT services, as well as progressing pooled budgets.

4.5.2 Children's Centre Sleep Tight programme

The CC Service also provides the Sleep Tight Programme which is based on evidence that improving sleep routines reduce stress, symptoms of depression (EIF 2018). Sleep Tight is a behavioural sleep programme, focused on child sleep problems and family wellbeing, delivered by Family Support Workers (FSWs) in Nottinghamshire's Children's Centres.

A research study was undertaken with Nottingham University, to explore the impact of the programme; this was published in the Journal of Health Visiting (Turner et al 2016) and is detailed in the 'Evidence of What Works' section of this JSNA chapter.

4.5.3 Children's Centre Evidence Based Parenting Programmes

The CC service also delivers a range of evidence based parenting programmes facilitated by trained skilled professionals. Programmes include '123 Magic', 'Theraplay', 'Preparation for Parenthood and Beyond', 'Solihull Approach', 'Incredible Years', and 'Empowering Parents-Empowering Communities' (EPEC). They also jointly deliver courses for parents affected by domestic violence and abuse with both Women's Aid services available in Nottinghamshire.

4.5.4 Children's Centre School Readiness Interventions

The CC service also provides the Forest School approach as well as other interventions facilitated by trained early years practitioners. Programmes include locally developed courses and interventions including the new 'Let's Play' programme, 'Little Talkers', 'Now I am 2' and 'Talking Walks'.

4.6 Healthy Families Programme

Across Nottinghamshire, as part of the Healthy Families Programme service, 20 Healthy Family Teams based in localities deliver the national health visiting framework:

- 4 levels of service, based on need
- 5 universal health reviews for all children
- 6 high impact areas, where health visitors have the greatest impact on child and family health and wellbeing

The Healthy Families Programme is provided by Nottinghamshire Healthcare NHS Foundation Trust and brings together care provided by Specialist Public Health Practitioners (Health Visitors and School Nurses) and their teams to support all children, young people and families in Nottinghamshire. All families receive:

- Antenatal visit, usually after 28 weeks of pregnancy
- New baby review, usually when baby is 10-14 days
- Review when baby is 6-8 weeks old
- Developmental review at 1 year
- Developmental review at 2 to 2.5 years

Healthy Family Teams also deliver first level support and advice on health issues such as maternal mental health, breastfeeding, formula feeding, minor ailments, eating, parenting issues, behaviour and continence. Healthy Family teams refer or signpost to other services who will be able to provide ongoing help.

Healthy Family Teams also have an opportunity to Make Every Contact Count, promoting the importance of healthy lifestyles and the value of health as a foundation for future wellbeing, for example healthy eating, physical activity, accident prevention, improving parents' confidence in managing minor illnesses, sun safety, oral health; promotion of smoke-free homes and cars; responsive parenting, behaviour management, including sleep, and the promotion of development, play and a language-rich home learning environment[8].

4.6.1 Development Reviews

Healthy Family teams deliver the 1 year and 2 to 2.5 year health and development review to assess a child's progress with the aim of optimising child development and emotional wellbeing, reducing health inequalities and promoting school readiness. The Ages and Stages Questionnaire ASQ-3 TM is used, which covers the development of gross and fine motor, communication, problem solving and personal-social skills.

The 2 year reviews are integrated with the Early Years Foundation Stage assessment, delivered by a child's early year's settings, aiming to:

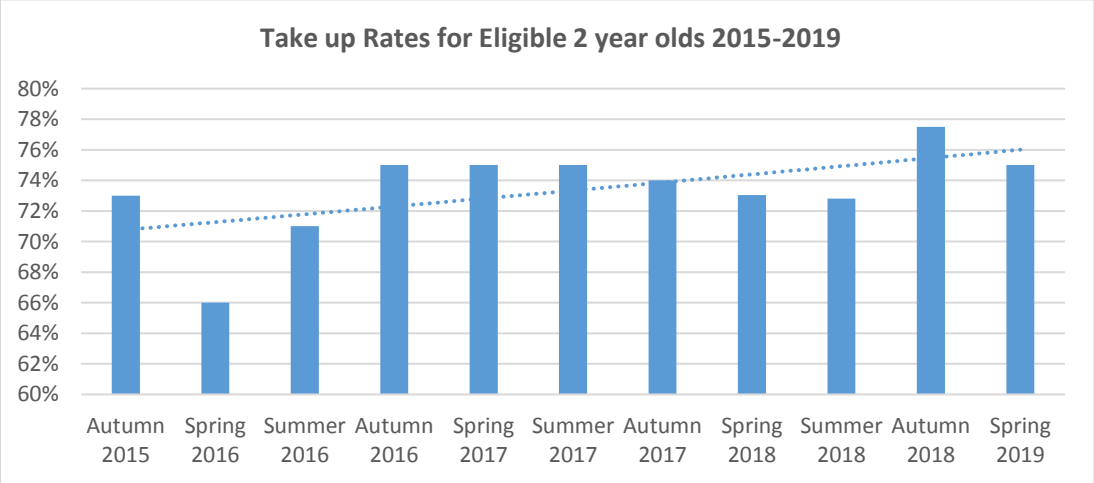
- identify the child's progress, strengths and needs in order to promote positive outcomes in health and wellbeing, learning and behaviour and school readiness
- facilitate appropriate early intervention and support for children and their families where developmental delay or additional needs are identified
- generate information which can be used to plan services and contribute to the reduction of inequalities in children's outcomes.

4.7 Funded Childcare Initiatives

4.7.1 Free Early Education for eligible 2 year olds

Government introduced the free entitlement to early education for the 20% most disadvantaged two year olds from September 2013. The anticipated number of eligible children in Nottinghamshire was 1,910. 76% of eligible children accessed a place during the first full year of operation. From September 2014 the programme was increased to include the 40% most disadvantaged children.

Figure 17: Nottinghamshire take up rates for eligible 2-year olds accessing their free childcare entitlement (2015-2019)



Data Source: Nottinghamshire Council Headcount Spring 2019

The graph shows that there has been a gradual improvement in the numbers of eligible 2 year olds from low income families accessing their 15 hours a week free early education. 75.34% (2,004 of 2,660 children), have taken up their place in spring 2019, compared to 73.04% (2,166 of 2,897children) in spring 2018.

However there are seasonal variations and take up rates remain fairly static at 75% most years. Further work is taking place with statistical neighbours to explore how to better improve take up rates; in addition targeted marketing in low income areas is imminent with additional targeting led by the Children's Centre Service.

4.7.2 Universal Childcare for eligible 3 and 4 year olds

All 3 and 4 year olds are entitled to 15 hours of free early education 38 weeks of the year. Take-up rates have been consistently high across the county with on average 95% of all 3 year olds and 97% of all 4 year taking up their place.

4.7.3 Extended Funded Childcare for 3 and 4 year olds

The Childcare Act 2016 placed new duties on local authorities to ensure there is sufficient childcare provision for working parents of 3 and 4 year olds. Since September 2017, children of working parents are now eligible for 30 hours of funded childcare each week (1,140 hours over the year). This is an increase on the current entitlement of 15 hours per week. Eligibility criteria includes households where one (if lone parent) or both parents are working earning the equivalent of 16 hours a week on national minimum wage and less that £100k each.

Government expectation is that the additional places will be delivered flexibly across the year to better meet the needs of working parents, whilst improving access for children with SEND. The additional investment is intended to help with childcare costs for those already in work and to incentivise those parents working part-time to increase their hours, and to encourage those who aren't to consider entering the labour market

Parental awareness of the extended entitlement has continued to increase since its launch in September 2017. This has been reflected in the increase in numbers taking up their entitlement. Figures for spring term 2019, show that 5,786 children have taken up their extended childcare entitlement compared to 3,634 children in autumn term 2018.

4.7.4 Early Years Pupil Premium

- The Early Years Pupil Premium was introduced in 2015 to support early years providers to close the attainment gap between the most disadvantaged children and their peers. The fund provides supplementary funding for 3 and 4 year olds who receive their 15 hours childcare entitlement and are from identified low income groups.
- Take of up the Early Years Pupil Premium (EYPP) funding in Nottinghamshire is 100%, however it is unclear how early years settings are using this to improve outcomes for the most vulnerable children so this will be addressed in audits and additional guidance.
- Looked After Children are automatically entitled to this fund.

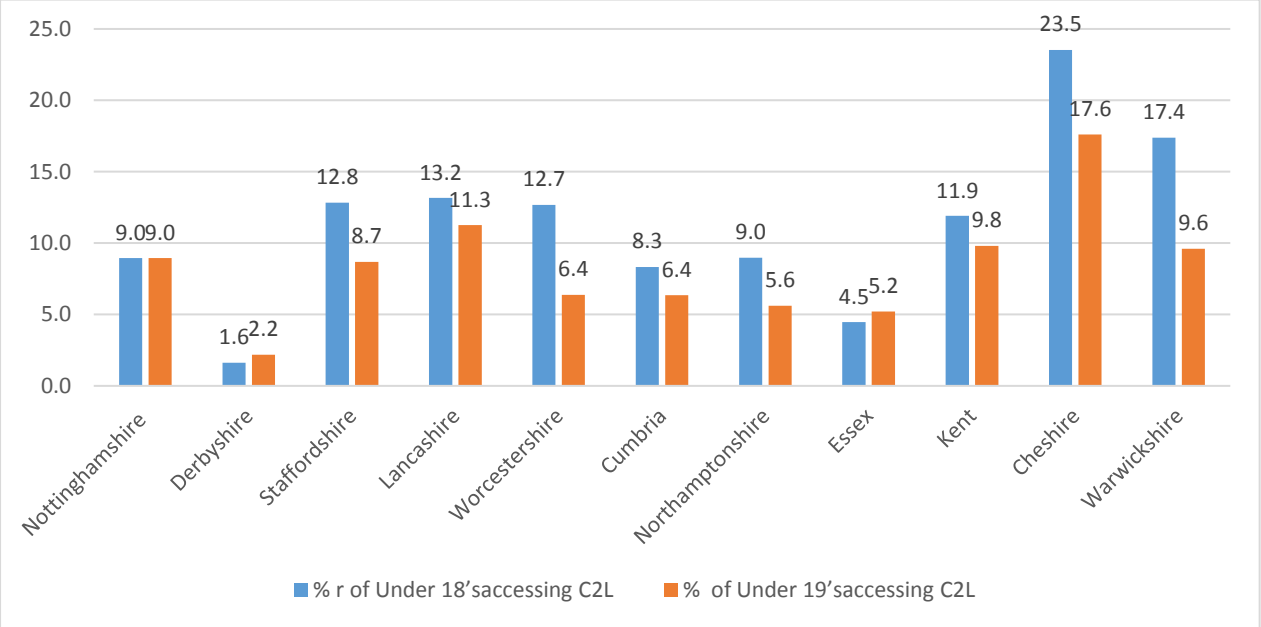
4.7.5 Early Years Deprivation Supplement

The 2016 Childcare Act required local authorities to administer new deprivation funding using the Early Years funding block of the devolved schools grant. There is flexibility in the use of this fund and as the Early Years Pupil Premium is already in place for children eligible for free school meals, the fund in Nottinghamshire is used to support early years providers to effectively support children known to social care. This fund enables early years providers to attend meetings and prepare the paperwork required.

4.7.6 Care to Learn Childcare Grant

Care to Learn is a childcare grant for all teenage parents under the age of 20 (including fathers and under 16's), to enable them to access education or training. The grant pays for all childcare costs, including travel costs for teenage parents. Only young parents in education or training can access the grant Care to Learn - GOV.UK.

Figure 18: Percentage of all teenage mums under the age of 18 and 19 accessing the Care to Learn Grant compared to statistical neighbours (snapshot June 2016)



Data Source: DfE 2017

Take up rates in Nottinghamshire are low compared to statistical neighbours. The graph above shows the % uptake of all teenage parents under the age of 18 and 19. The data used however is a snapshot and changes depending on the time of year and when education and training provision is available.

It is unclear what the barriers are for young parents and this could be linked to disengagement from education, lack of accessible and appropriate education or training provision, lack of childcare provision on or near a place of education or training e.g. an FE college; a misconception about what the grant is for and who is eligible, and/or a lack of proactive promotion. It is important to note that young people who do conceive at a young age are more likely to have disengaged from school, left school with no qualification and for

16-19 year olds are more likely to be NEET (Not in Training or Education); although local NEET data for teenage parents is no longer available as there is no longer a duty to collect and analyse this data. Young mothers are also more likely to be dependent on their parents and living at home which prevents their eligibility for the Care to Learn grant (LGA and PHE 2019).

This data will no longer be available nationally, so it is important that Nottinghamshire continues to promote this childcare funding as previous take up has been poor.

4.7.7 Early Years Support for Children with SEND

All early education and childcare providers have access to inclusion support from Early Years Specialist Teachers who facilitate Area SENCO networks linked to family school SENCOs; and to various training opportunities available to advice and guide providers on the development of inclusive early learning environments and practice.

Early Childhood Services administer the Early Years Inclusion Fund and Disability Access Fund which helps early years settings be inclusive and meet the additional needs of children with SEND.

Nottinghamshire County Council also offers support to providers to access specialist support for a child with SEND, such as Specialist Family School Service, Community Nursing Team, Speech and Language Therapist service, Occupational Therapist, etc.

A. Disability Access Fund (DAF)

The Disability Access Fund (DAF) is funding for early years providers to support children with disabilities or special educational needs. The fund aids access to early years places by supporting providers in making reasonable adjustments to their settings. The fund was launched in 2017 and is available to all 3 and 4 year olds who claim Disability Living Allowance. Take up in Nottinghamshire and many other Local Authorities is low.

All 3 and 4 year olds are eligible for the DAF if they are attending an early years PVI setting that provides funded places, and meet the following criteria:

- The child is in receipt of Disability Living Allowance
- The child receives funded early education and childcare.

Each child is eligible for £615 per year which is paid to the early years setting to meet the needs of the child. If a child accesses childcare in more than one setting, a parent is asked to decide which setting receives the DAF.

B. Early Years Inclusion Fund

The 2016 Childcare Act required local authorities to create a new Inclusion Fund using a mixture of funding sources to enable 3 and 4 year olds eligible for funded childcare who have SEND access to childcare. This fund is only allocated to PVI settings as schools are able to access High Needs Funding instead.

In Nottinghamshire, the Inclusion Fund is funded by Nottinghamshire County Council and through the Dedicated Schools Grant. The fund is used to pay for additional staffing, training, assessments and specialist equipment. Using council funding has meant that the Inclusion Fund can also be extended to 2 year olds eligible for 15 hours of free childcare per week as well as children with physical disabilities.

Applications can be submitted for a 2, 3 or 4 year old child with SEND who is accessing their funded entitlement and meet the High Level Needs descriptors outlined in funding guidance. The Inclusion Fund panel who allocate funding also consider applications to meet the needs of children with physical disabilities. All applications for inclusion funding are considered by a panel who meet each month.

Figure 19: Nottinghamshire take up of the Early Years Inclusion Fund by age 2018/29

Age Funded	Total Number of children
2	13
3	69
4	106
5+	7
Total	195

Data Source: Nottinghamshire County Council 2019

The Local Authority now jointly commissions the British Red Cross to manage an Integrated Children's Equipment Store (ICELS). Since September 2018, early years funding from the council and the Early Years Inclusion Fund has been used temporarily to pay for equipment costs through ICELS. Only children eligible for funded early education or childcare are entitled to access this equipment.

The Early Years Inclusion Fund has also been used to provide funding to 40 early years professionals to access training on Manual Handling and Creating an Autism Friendly setting.

4.8 Families Information Service

The Families Information Service provides accurate up to date information for parents, young people and children about a range of services and support including childcare provision and services for children with special educational needs and/or disabilities.

The Families Information Service provides;

- Detailed information about registered childcare provision in Nottinghamshire.
- Information that may be of benefit to parents in their parenting role; this includes education, employment, health, leisure and parenting.
- Information is made available to families through the Notts Help Yourself Website, Facebook and through telephone advice via Nottinghamshire County Council's Customer Service Centre.
- A social media presence via Facebook
- Information that is accessible to people who might otherwise have difficulty in accessing the services they need. In practice, this includes ensuring information is available to disadvantaged groups by working with services engaging disadvantaged families.
- Information for existing early years and childcare providers, and for those wishing to become a new provider.
- Information, advice and support directly to children, young people and parents on matters relating to special educational needs and disability via the Local Offer.

In 2017-18, the service delivered

- 96,639 visits per month to Notts Help Yourself Website, at quarter 4 2017-2018.
- Reach for FIS Facebook of 19,607, at quarter 4 2017-2018.

- At quarter 4 2017-2018 there were a total of 628 'likes', with 62 new 'likes' in the quarter.
- Supported and processed 663 childcare providers to update their details during the year 2017-2018.

4.9 Bookstart

Bookstart is a national programme that encourages all parents and carers to enjoy books with their children from as early an age as possible. The programme is available in Nottinghamshire and is provided by Inspire, the County's Library and Information Service.

Bookstart aims to give free packs of books to every baby in the UK, to inspire and create a love of reading that will give children a flying start in life. In Nottinghamshire, Inspire works together with health professionals and early years settings such as nurseries, pre-schools and Children's Centres to make sure every child receives their book packs.

All children are eligible to receive the following two free book packs 'Bookstart Baby Pack' and the 'Bookstart Treasure Gift'.

Bookstart also provides packs for children who need extra support to develop a love of books and reading. The packs contain advice and guidance for parents and carers to support their child's additional needs.

- Booktouch packs are for children between the ages of 0 to 4 years who are blind or partially sighted.
- Bookshine packs are available for children between the ages of 0 – 4 years who are deaf or hearing impaired.
- Bookstart Star pack is aimed at children aged three to five who have a condition or disability that impacts on or delays the development of their fine motor skills and includes books and resources to help families enjoy reading together every day.

More information is available at Bookstart Packs | Inspire - Culture, Learning, Libraries

4.10 Quality of Childcare Provision

In March 2019, there were 557 PVI providers and 261 schools who provide funded childcare to eligible 2, 3 and 4 year olds.

a) PVI – Outstanding 91 (16%) – Good 389 (70%) – R.I. 14 (3%) – Inadequate 7 (1%) – Met 14 (3%) – Not Yet Inspected 42 (9%)
b) Schools – Outstanding 31 (12%) – Good 168 (64%) – R.I. 11 (4%) -Inadequate 1 (1%) – Not Yet Inspected 50 (27%)

In March 2019, of all the settings that had been inspected by Ofsted, 83% of early years settings in Nottinghamshire are were assessed as 'Outstanding' or 'Good' by Ofsted; this compares to 86% in 2018, however 106 new settings have been established and yet to be inspected.

In March 2019, 14 (3%) of settings were judged as 'requires improvement' and only 7 settings (1%) were judged as 'inadequate'.

The Early Years Quality and Attainment team actively targets their support to those providers that: 'require improvement'; are newly registered; have failed their Ofsted registration. They also target settings where there are safeguarding concerns; or where

support is needed to care for children with SEND as well as settings that have larger proportions of 2 year olds from low income families.

5. Evidence of what works

"Effective teaching and effective parenting are absolutely vital in terms of how young children are going to develop through their lives. When it is at its best, it really does have a strong impact on helping children from more disadvantaged backgrounds to achieve more" (Professor Dominic Wyse 2019).

A strong Home Learning Environment	The home learning environment includes the physical characteristics of the home and also the quality of the implicit and explicit learning support received by children from caregivers. The quality of the home learning environment has been recognised to be the most significant factor in terms of outcomes at age five. The range and quality of activities which parents undertake with pre-school children is more strongly associated with children's social and intellectual development as compared with either parental education or occupation. In order for children to progress, parents need to engage them in activities which 'engage and stretch' the child's mind. Parental support and the home learning environment have a major effect on children's life chances. It is particularly important for children's oracy and language development which, although not the only important skill to be developed, is vital for children's life chances (DfE 2018). Parents engaging in learning activities such as speaking to their baby and reading with their child are shown to have a great impact on levels of communication. A child's communication environment is a more dominant predictor of early language than their social background; so this really is an important part of successful early development (Goff et al 2012). Short interventions with parents can influence parenting practices, personal beliefs and affective relationships with children. Research suggests that through a UK-based intervention, it is possible to improve levels of parental involvement and broaden the quality of the home learning environment (Goff et al 2012). There is some evidence to show the specific interventions that could be used within a home environment, however these are limited, with some programmes included on the Early Intervention Foundation website. The absence of evidence about interventions to support parents and families in creating and maintaining an effective learning environment in the home is regarded as a major concern by the Local Government Association (2019).
Educational Attainment	All research used in this chapter that focuses on school readiness states that starting early education at an early age had a direct impact on the attainment of children. Judged by the evidence identified in a report by the Centre for Research in Early Childhood (Bertram et al 2014), the core characteristics and delivery features of programmes that have successfully boosted the learning and development of disadvantaged children can be grouped into four types:

	i. Programmes that provide support to parents during pregnancy and early childhood; ii. Early health programmes for children 0-5 years iii. Programmes that combine parent support, health and early education and care for children 0-2 years; iv. Early education and care programmes for children 0-2 years; v. Early education programmes for children 3-4 years The Literature Review set out below three areas of early years policy and practice which the evidence shows would benefit from further development, listing fruitful actions in each area. i. System Developments ii. Structural Developments iii. Process Developments
Effective Parenting	Early support from parents and carers enables young children to acquire the social and emotional skills, knowledge and attitudes necessary for school and later life. The role of parenting is central in promoting child development. There is a direct link between the nature of parental care and an increased risk of emotional and behavioural problems across child development (Craig 2004). Parenting support combined with high quality early education, will contribute to a child's early learning and ability, and put them on the road to being school ready. Evidence based parenting programmes are a source of support for all parents and carers and offer an opportunity to share parenting experiences, develop a greater understanding of child development, build positive relationships and learn skills to deal with challenging behaviour. The Early Intervention Foundation provides guidance on the impact and cost benefit analysis of parenting programmes and a number of programmes are listed in Appendix 2.
Addressing Speech, Language and Communication Needs	The early years are a critical time for all children to develop strong cognitive, social and emotional foundations. Early language acquisition impacts on all aspects of young children's development. It contributes to their ability to manage emotions and communicate feelings, to establish and maintain relationships, to think symbolically, and to learn to read and write. As speech and language is both an essential building block for a range of cognitive and social and emotional skills, and predictive of a range of later-life issues. This means it is an excellent way of assessing typical development in the early years – a primary indicator of child wellbeing and social mobility. Studies show that, during the early years, language is best supported through developmentally appropriate parent–child conversations that respond to the child's interests. So, in infancy this means child-directed speech involving household items and toys. For toddlers, quantity is crucial, particularly in terms of new vocabulary. In the third year, children benefit from more diverse and grammatically complex language, and beyond that the opportunity to use structured narratives in conversations (EIF 2018).

	The content of parent–child conversations really counts. Conversations about objects and living things help children to understand how the world works, which in turn supports their analogical reasoning capabilities as they grow older. Conversations about the thoughts, feelings and desires of others increases their empathy and understanding of others' perspectives. Parent–child 'number talk' has been found to support children's early counting capabilities. Early counting skills, in turn, strongly predict children's mathematical achievement in later primary and secondary school. The Royal College of Speech and Language Therapists (RCSLT) has commissioned a return on investment report which shows that for every £1 spent on specialist therapy for children with Developmental Language Disorder, £1.46 is generated in savings. Similarly Stoke Speaks Out (a universal approach not dissimilar to aspects of Nottinghamshire Language for Life) showed that every £1 invested could generate £4.26 in savings due to prevention of later difficulties arising from SLCN. Speech, language and communication needs can occur on their own without any other developmental needs, or be part of another condition such as general learning difficulties, autism spectrum disorders or attention deficit hyperactivity disorder. For many children, difficulties will resolve naturally when they experience good communication-rich environments. Others will need a little extra support. However, some may need longer term speech and language therapy support.
Children's Centre Services (Formerly known as Sure Start Children's Centres)	Since Children's Centres were first launched in 1999, there has been a wealth of national research into both the impact and the reach of Children's Centre services. Nationally, the two main longitudinal research projects were the National Evaluation of Sure Start NESS Research and Evaluation of Children's Centres England ECCE research. They both report a positive impact overall on engaging families with Children's Centres, this in turn helps children to have the best start in life resulting in short term and long term improved outcomes. Both research studies demonstrated that: a) parents evidenced an improved knowledge of child development, lower levels of dysfunction and improved parenting skills b) developmental concerns were predicted earlier on (mean age 14 months) as a direct result of engagement with a Children's Centre c) the greater the family is disadvantaged the increased likelihood that they will engage with services for a longer period (5 months), suggesting families are aware of the support they need and they are actively seeking this out d) parents who accessed a Children's Centre service improved their parenting skills and provided an improved home learning environment e) children had better social development with higher levels of independence and self-regulation f) There were higher immunisation rates, fewer reported accidental injuries and the families engaged more with other family services.

	Both studies identified that improving household economic status did not improve substantially. When this is considered alongside the findings of local research it is clear that financial stability is a key target area to consider when moving forwards. Participants who took part in local consultation highlighted the need for greater support to prepare parents for employment and this appears to be a consistent theme throughout national and local reviews and research. The NESS research study identified that improving health outcomes did not improve significantly. It is anticipated that health outcomes will be improved through integrated service delivery arrangements with Healthy Families Teams who are also currently provided through the Nottinghamshire Healthcare Foundation Trust. Recent research from Hall et al (2019) found that the use of Children's Centres in the UK is associated with fewer preschool behavioural disorders, which the authors suggest, can be attributed to intermediate changes to the quality of home learning environments. However this research stated that establishing the effectiveness of Children's Centre Services is difficult because each local area has changed service models in recent years, with many now 'shifting from a standalone model of working where one Centre serves one neighbourhood to a hub and spoke model of working in which services are shared across multiple centres located across multiple neighbourhoods (Sylva et al 2015, Hall et al 2019). The Institute for Fiscal Studies has published The health effects of Sure Start. This report looks at the overall impacts on health of the Sure Start programme. Findings include Sure Start significantly reduced hospitalisations among children by the time they finish primary school; it benefits children living in disadvantaged areas most; there is no evidence that it impacted on child obesity at age 5 or maternal mental health; and a simple cost–benefit analysis shows that the benefits from hospitalisations are able to offset approximately 6% of the programme costs. The Institute of Fiscal Studies also found that while the poorest 30% of areas saw the probability of any hospitalisation fall by 11% at age 10 and 19% at age 11, those in more affluent neighbourhoods saw smaller benefits, and those in the richest 30% of neighbourhoods saw practically no impact at all. The bigger benefits in the poorest neighbourhoods could come about because disadvantaged children are more able to benefit from Sure Start, because the types of services Sure Start offers in poorer areas are more helpful, or because children in disadvantaged areas were more likely to attend a centre. They concluded that one way to deliver more value for money would be to focus on providing services to the disadvantaged areas, which are more likely to benefit from them, and to consider which types of services and models of provision could most effectively help this group.
Early Intervention: Conception to Age 2: First 1001 Days	Early intervention with children before they reach the age of 2, can significantly prepare children for school and improve academic success in the long term. *'Children's development in the early years sets them on a positive trajectory. Children's development at just 22 months is linked to their qualifications at 26 years'* (Feinstein 2003). This suggests that we must prioritise the earlier identification of need and provision of evidence-based support for families in the first 1,001 days.

	The Manifesto | 1001 critical days was informed by the report developed by the Wave Trust Conception to age 2 - the age of opportunity | WAVE Trust which supports earlier intervention. The key areas within this are: • Breastfeeding and nutrition • Immunisation • Parenting and parent child relationship • Attachment • Speech and language development • Maternal mental health The impact of poor parental mental health, domestic abuse, substance misuse, parents not in education, employment of training, and poverty on children's development are also highlighted.
Mental Health Screening during antenatal stages	Several recent systematic reviews have confirmed that universal screening for mental health problems during pregnancy is associated with reduced symptoms of depression and anxiety in expectant mothers. In particular, studies show that universal mental health screening reduces symptoms of depression in mothers who are not clinically depressed in the absence of any further provision, as well as in clinically depressed mothers when leading to additional effective treatment (EIF 2018).
Healthy Child Programme	The Healthy Child Programme (HCP) is the key universal public health service for improving the health and wellbeing of children through health and development reviews, health promotion, parenting support, screening and immunisation programmes. A rapid review of evidence was completed in 2015 (Axford et al 2015) and is referenced in the JSNA chapter 1,001 Days.
Parents with good health and wellbeing outcomes	Parents and carer givers lay the foundations for emotional regulation, communication, and problem solving as well as strengthening their self-esteem. Young children thrive in environments that are predictable and responsive to their needs. Children can struggle, however, where environments are neglectful, unpredictable or overwhelming (Asmussen et al 2016). It is important therefore that the health and wellbeing of parents and carers is considered when looking to improve a range of outcomes for young children.
Family Nurse Partnership (FNP)	FNP is a two-and-a-half-year home visiting programme offered to first-time single mothers. It has good evidence from studies conducted in the United States of improving attachment security amongst infants who are at risk of child maltreatment. It should be noted, however, that these benefits have not been replicated in a recent UK Randomised Control Trial (Public Health England 2016). FNP remains an evidence-based option for reducing intimate partner violence among first-time teenage mothers (Early Intervention Foundation 2018a).
Quality of Teaching and a Skilled Early	Evidence shows that high-quality early education boosts children's outcomes and narrows the attainment gap, regardless of a child's background. Therefore, it is vital that addressing barriers to social mobility begins at birth.

Years Workforce	*"The quality of teaching in the early years is just as important to outcomes as it is in other stages of education. Quality is key to early years provision that have the biggest impact on children's life chances. Pre-schools should have low staffing ratios and well-trained professionals"* (House of Commons Education Committee 2019). The majority of evidence suggests that well qualified staff are likely to have a greater positive impact on children than those who are less qualified. *'Our study shows that having well-trained and qualified staff increases the quality of education and care in a child's early years*" (Melhuish & Gardiner 2019). This 2019 research indicated that attending early childhood education and care (ECEC) can promote longer-term positive life outcomes, which is more likely when the ECEC is of higher quality. The study of 600 ECEC group settings for 3–4 year olds, staff qualifications were predictive of quality at private (for profit) settings. For voluntary (not for profit) settings, which were more homogenous in staff qualifications, having a staff training plan and a better staff to child ratio were found to be significant predictors of quality. However, state funded nursery classes/schools, which tend to have less favorable staff to child ratios than private and voluntary settings, also tended to have higher process quality ratings, where the presence of more highly qualified staff apparently allowed quality to be maintained with a larger number of children per staff member. Better staff-to-child ratios were found to be a sign of quality (Melhuish & Gardiner 2019)
Access to high quality Early Childhood Education and Care (ECEC)	Research indicates that attending ECEC promotes school readiness and contributes to later school attainment and positive life outcomes into adolescence (Sylva et al 2008, Melhuish et al 2017). As well as affecting cognitive and educational outcomes, there is clear evidence that ECEC experience can have long-term consequences for socio-emotional development (Melhuish and Gardiner 2019).
Targeting children living in poverty	Children from socially and economically disadvantaged backgrounds can be given a better start via two channels: partnership working and a solution-focused approach to improving school readiness. Interventions can contribute to a better start by facilitating secure attachments with the primary caregiver and through parents learning to model responsive parenting.
Building Attachment	Attachment security refers to the positive expectations young children develop about themselves and others. Attachment security develops as a result of positive and predictable interactions with the caregiver occurring on a regular basis during the child's first year. A secure attachment during infancy is significantly associated with positive social and emotional development throughout the life-course, whereas an insecure attachment increases the risk of later mental health problems (EIF 2018).
Universal Service Provision	*"Strategies which are likely to make a difference to these children and improve outcomes include family support, high-quality early education and care programmes in the preschool years, and early detection of emerging problems and risk factors.*

	The evidence suggests that these services and programmes are best delivered within a framework of progressive universalism—a universal basket of services for all children and families, with additional support commensurate with additional needs. This provides the best opportunity for early identification and appropriate intervention for emerging developmental problems and family issues that impact on children's development. *While there are a number of challenges that need to be addressed and overcome, such an approach is an important investment that will yield measurable educational, social and economic benefits over the long term"* (Oberklaid et al 2013).
Promoting Early Education in schools for disadvantaged boys	Disadvantaged boys given extra early years schooling show the greatest academic improvement and carry the benefits through school, so engaging boys in early education will reduce the attainment gap and improve cognitive and non-cognitive skills. Cornelissen & Dustmann in 2019 found that providing an additional term (four months) of early schooling for disadvantaged boys increased their test scores in language and numeracy at age five by up to 20%; their personal, social and emotional development at the same age improved by 8%, and their language and numeracy skills at age seven by around 10%. However, for boys from high socio-economic backgrounds, the results for many of these effects were close to zero (Cornelissen & Dustmann 2019). Most Early Years Practitioners provide Forest School approach in particular to engage boys who seem to benefit from trying new activities when they are involved in the planning so that their interests and strengths are valued. There is however no concrete evidence of the impact of Forest Schools for boys as no research has been published on this subject yet.
Forest School Initiatives	The Forest School initiative came to the UK primarily from Scandinavia, where early years education conducted in the outdoors is a widely accepted practice. Forest School is a form of outdoor education that is particularly associated with early years education (children from the age of 3 to the age of 8) wherein young children spend time in forest or woodland settings. A qualified forest school leader devises a program of learning that is based on the children's interests and that allows the children to build on skills from week to week, at their own pace. O'Brien and Murray (2007) found 7 key themes of the positive impact on children: • Increased self-esteem and self-confidence • Improved social skills • The development of language and communication skills • Improved physical motor skills • Improved motivation and concentration • Increased knowledge and understanding *'Forest School can enrich children's educational experiences in both the short and long term, nurturing positive attitudes towards educational institutions, hands-on learning, and creativity'* (Pilmott-Wilson & Coates 2019). Psychological research has shown that children's senses are stimulated by nature and that these experiences form children's relation to natural areas

	and are often remembered into adult life (Kaplan and Kaplan, 1989; Ward Thompson et al. 2002). Forest School provides an opportunity for regular and critical observation of the ways that children take advantage of given freedoms (within a controlled setting) to express themselves physically and verbally. Long-term contact with Forest School involving regular and frequent sessions is important in allowing children the time and opportunity to learn and develop confidence at their own pace. The more relaxed and freer atmosphere provides a contrast to the classroom environment that suits some children who learn more easily from practical hands on involvement, such as kinaesthetic learners (Gardner, 1983; Dillon et al, 2005).
Addressing Adverse Childhood Experiences	There are no simple solutions to preventing Adverse Childhood Experiences (ACEs). It is unlikely that any single intervention will be sufficient. Vulnerable parents often require access to a range of interventions, including intensive support able to address multiple issues. • Addressing adversity for high-risk cases requires long-term, individualised support: This is likely to be expensive and there is little evidence to suggest that less-intensive forms of parenting advice (for example, delivered through the web, TV or books) are sufficient for vulnerable families struggling with complex problems. • Evidence-based programmes are not an easy fix: They are only likely to deliver results if delivered carefully according to the programme requirements and if effort is made to ensure they are integrated with wider local service arrangements. • Effective intervention requires a suitably qualified workforce: A lack of suitably trained practitioners can be a barrier to delivering effective interventions. There is also some evidence that under skilled and under supervised practitioners can make things worse for vulnerable families and even, in some cases, cause harm. Early Intervention Foundation (2017)
Building Resilience	Mental health problems can start in early years, even if they don't present any symptoms. The environment children grow up in and their ability to handle the pressures and stresses of growing up – i.e. resilience – all play an important part in preventing problems developing as they grow up. Building resilience in children and raising awareness with parents is required to reduce the effects of trauma and ACEs and improve overall outcomes. Research (Hill et al 2007) has shown that parental factors can promote resilience in children, in other words, general coping capacities that usually enable them to do well in life: • warmth, responsiveness and stimulation • providing adequate and consistent role models • harmony between parents • spending time with children • promoting constructive use of leisure • consistent guidance • structure and rules during adolescence.

	Such parenting not only helps children to develop intrinsic resilient capacities, it also directly mediates coping responses to many adversities, such as poverty, ill health, bereavement or community violence (Hill et al 2007). Parenting programmes should therefore improve the resilience of children and ultimately impact on a range of outcomes.
Improve sleep routines	There is good evidence to support the use of behaviour sleep training and advice with parents who are having sleep difficulties with an infant who is four months or older. Parents acting on this advice report significant reductions in the time required for their infant to fall asleep, fewer night wakings and increases in the amount of time infants sleep. Parents also report less stress and fewer symptoms of depression once infants sleep through the night. Studies also find that these practices do not increase the likelihood of any adverse consequences, including reductions in breastfeeding and attachment security or increases in SIDS-related deaths (EIF 2018).
Physical Activity	Pellegrini and Smith (1998) argue that play not only confers benefits in terms of fitness but also that physically activity play serves a developmental function. They say that rhythmic play in babies and very young children may improve motor control. Exercise play helps improve strength and endurance, and provides cognitive benefits. Physical Activity is regarded as beneficial for social, psychological reasons and also because it instils good habits for adulthood (Booth, 2001; Corbin et al, 1994). Livingstone (2003) agrees that the benefits for children's mental well-being and self-esteem are proven.

Evidence Based Interventions

There are a range of evidence based interventions that can be used to improve the attainment of preschool children. Many require a license and there is a cost of services to use the resources. Commissioners should consider best value when selecting which programmes to use.

Examples of Evidence Based School Readiness Interventions are included in the EIF Guidebook, including how effective each intervention is and implementation requirements. The Guidebook does not have any direct interventions regarding school readiness per se, but programmes do state if there is are positive outcomes in relation to school readiness and educational attainment and family support; the Early Intervention Foundation has published additional research focusing on school readiness interventions.

A review of evidence based programmes and interventions is included in Appendix 2 of this chapter.

6. What is on the horizon?

6.1 Children Centre Service Model

NCC commissions an external body to deliver Children Centre services; this contract has been in place since June 2013 and ends on the 31st May 2020. The Children's Centre service delivery model changed in September 2018 to refocus activity on target groups only. The service is no longer providing universal access provision and subsequently is no longer

required to register all children. Instead, the service has been required to work with families where there are worries or concerns, including children in low income families and where neither parent is employed. Universal service provision is now led by parent volunteers who are trained and supported to be 'job ready'.

From June 2020, the service will be managed by Nottinghamshire County Council and smooth transition arrangements will be required. This will provide an opportunity to review current activity and interventions to ensure that evidence based interventions are delivered that also evidence value for money and prevent children from entering the care system. It will however be important to retain some universal provision and the continued role of parent volunteers will be critical in order to sustain a universal service offer, whilst prioritising resources to families most in need.

6.2 Nottinghamshire Best Start Plan

In 2020, Nottinghamshire will launch a new Best Start Plan in order to ensure children have the best start. The strategy will consider all of the evidence that improves outcomes for children under the age of 5 and their families. This broader approach will include a focus on the following outcomes:

- Prospective parents are well prepared
- Children and parents have good antenatal outcomes
- Children and parents have good attachment and bonding
- Parental engagement and participation
- Children are ready for nursery
- Children are ready for school
- Parents are job ready
- Mothers and babies have improved health outcomes
- Parents experiencing emotional health and wellbeing challenges are identified early and supported.
- Children and parents are supported with early language, speech and communication
- The most vulnerable families will be identified early and well supported by a skilled workforce.

6.3 Early Years Professional Development Fund

The Department for Education recently announced that Nottinghamshire County Council has been successful in securing a grant worth £391,800 for the new Early Years Professional Development Fund which will span two years. The grant will provide high quality professional development for practitioners in pre-reception nursery settings.

The intention of the Professional Development Fund is to identify and train champions from across the local early years sector with support provided by a national delivery partner and the Local Authority. Champions are required to cascade their learning through a 'train-the-trainer' model to other practitioners working in pre-reception PVI and school-based settings, through local partnerships across England, convened and administered by selected local authorities. The training will equip the champions with a strong understanding of effective pedagogy and practice to improve pre-reception children's early language, literacy and numeracy, focused on implementing an evidence-based approach to help improved

outcomes for disadvantaged children. Work is now taking place to recruit early years practitioners as champions.

Local Authorities are required to:

- facilitate the establishment of three early years Continuing Professional Development (CPD) Partnerships, each comprising of 10-15 early years settings by identifying and recruiting settings in the areas of greatest need
- work with Partnerships to identify and nominate suitably skilled and experienced practitioners as champions
- work with the Partnerships to agree a delivery plan to ensure the cascade of CPD activity by the CPD Champions can be delivered locally over the lifetime of the programme
- organise and provide the venues to cascade activity, including refreshments, travel and any other logistics required to ensure successful delivery of the cascaded CPD activity to Partnerships
- manage and monitor the budget for staff cover for practitioners to leave their settings to participate in CPD, including reimbursing travel costs
- engage in national and local evaluation
- facilitate links between partnerships and other relevant local services as relevant, e.g. Health Visitors, specialist speech and language services
- support dissemination of learning / sharing of practice more widely across other pre-reception/reception settings in the LA area.

6.4 The New Ofsted Inspection Framework 2019

The new Ofsted Framework has changes to some early years elements of the Ofsted Framework including whereby 'Quality of Education' is now a new judgement area; also progress in relation to personal development will now be separated from 'Behaviour and Attitudes'. Ofsted has published separate handbooks for early years, schools, further education and colleges.

The new framework proposes a rebalance, so instead of taking exam results and test data at face value, Ofsted will look at whether a nursery, school or college's results have been achieved via broad and rich learning.

The Professional Association for Childcare and Early Years (PACEY) chief executive Liz Bayram said, *'PACEY, like many others in the sector, is supportive of the new Education Inspection Framework (EIF), and its renewed focus on quality of education. We hope its reduced focus on outcomes and data will give early years practitioners more time to do what they do best – give children the best start in life – by reducing unnecessary paperwork.' (Nursery World 15.5.19).*

Despite support for key elements of the new Framework, concerns have been raised about the lack of capacity for practitioners to prepare themselves for the new Framework which will be rolled out in September 2019. This capacity issue is one affecting the sector and local authority teams who support the sector to prepare for and learn from Ofsted inspections.

6.5 NASEN Accredited Training

NASEN; the National Association of Special Educational Needs is a national charity who have been commissioned by the DfE to facilitate accredited training for SENCOs in early years settings. Nottinghamshire has been successful in securing NASEN to deliver one of their programmes locally funded by DfE. Local funding is being used to commission a further programme for local early years practitioners. The training will support practitioners in identifying and meeting the needs of children with emerging and diagnosed SEND needs.

Training started in May 2019 and evaluation will be shared with additional analysis of developmental outcomes for children with SEND locally.

6.6 National DfE Hungry Little Minds (Home Learning) Campaign

The Department for Education in England launched Hungry Little Minds on the 1st July 2019. This is a three-year campaign that aims to help parents understand that they have a big impact on their child's learning and that reading, playing and chatting with them is a simple thing they can do to help them develop. The campaign will tackle the barriers some parents face in supporting their child's learning at home, including time, confidence and ideas of things to do.

The campaign includes social media and online adverts, and a website where parents can access tips and activities and search for activities in their area using a new postcode finder service.

Education Secretary Damien Hinds said as part of the launch "*Every parent wants to give their child the best start in life but not everyone has family support at hand and there is no manual telling us how to do everything right. Part of making sure our children have the opportunity to take advantage of all the joys of childhood and growing up is supporting them to develop the language and communication skills they need to express themselves. Sadly, too many children are starting school without these – and all too often, if there's a gap at the very start of school, it tends to persist, and grow. The only way we are going to solve this is through a relentless focus on improving early communication".*

Local activity to promote the campaign is being planned over the 3 year period of the campaign. This will be supported by local home learning activities and promotion via the Families Information Service Children's Centre Service.

7. Local Views

7.1 Local Views about Childcare and Early Education

Every year Nottinghamshire County Council carries out a Childcare Sufficiency Assessment. The 2016 assessment engaged 533 parents to help understand unmet need. Based on comments made by parents completing the survey, and echoed in qualitative feedback, concern about the availability and flexibility of current childcare provision to meet needs is a primary issue.

- Participants reported that the costs, opening hours and flexibility of childcare provision were the most commonly identified barriers. This includes the lack of provision during school holidays and opening times not suited their work patterns e.g. shift workers.
- Survey respondents also identify a lack of availability and choice and there are high levels of informal childcare use (family and friends). Qualitative feedback and comments made by survey respondents indicate that for at least some of these parents use of

family and friends is a necessity, not a choice, as a result of the cost of childcare or a lack of provision either generally or at times when it is needed.

Looking ahead, the greatest demand for pre-school children over the next 12 months is for all year round provision. Atypical hours childcare (defined in the survey as childcare to fit in with shifts i.e. before 8am and after 6pm) was needed by 22% of parents with a pre-school aged child. For school-aged children, responses indicated high demand for after school provision and strong demand for before school provision. Responses also indicate a need for flexible and stretched provision (e.g. outside a 'normal' working day of 9/9.30am and 5/5.30pm) and for all year round provision.

7.2 Local Views about Extended Funded Childcare Entitlement (30 Hours)

As an early implementer authority for the 30 hours of free childcare, Nottinghamshire conducted a survey to assess demand for the new offer to commence in September 2017. With around 1300 responses, the key findings were;

a) Parents are keen to take up the offer of extra free hours.
b) Parents would prefer to take the full 30 hours with one provider, with whom they already have an established relationship.
c) The additional free hours will make a significant positive difference to family finances.
d) Parents need some help to make sense of the financial assistance available to them.

Though the response rate was high, the majority of responders were from higher-income families. This fits with the programme being targeted at working parents each earning between the equivalent of 16 hours per week at national minimum wage and up to £100k.

7.3 Local views about Children's Centre Services

In 2017/18, Nottingham Trent University was commissioned to carry out focus groups with local service users to help understand the benefits of the service and what changes, if any, would be required to service delivery. The groups included mothers, fathers, young parents, and parent volunteers. The report is available to download here A review of Children's Centre Services 2018.

Key findings identified that:

a) parents and carers would like to be more involved in running services and volunteering
b) additional outreach work with hard to reach groups is required to engage vulnerable families
c) there is a need to increase engagement with organisations which support parents into work e.g. JobCentre Plus
d) parents want the service to continue its strong links with healthcare professionals
e) Children's Centre properties are not used to their capacity and service users would like to see more services operating in the buildings.

What does this tell us?

8. Unmet Needs and Service Gaps

- There are localities across Nottinghamshire where there are sufficiency challenges in terms of childcare. There is a need to ensure that good or outstanding provision is located where there are higher numbers of under 5's and where numbers are projected to increase following new housing developments. Local schools and the local early years sector will be encouraged to develop provision in these areas in the absence of capital funding to develop new early years properties.
- Parents require childcare to meet their working patterns and school holidays, further work is required to meet this demand and unmet need as evidenced in the Nottinghamshire Childcare Sufficiency Assessment.
- Interventions to improve school readiness should start much earlier during the antenatal period so greater engagement of maternity services is required.
- Not all children under the age of 5 are eligible for funded childcare. This means that many parents have to pay for childcare to enable them to gain or return to employment or not access employment until their child can access funded childcare. This is especially pertinent for children with SEND who are not entitled to additional top up funding to ensure they receive the intensive support they need; this can result in children being turned away from early years settings who do not have the ability to meet their needs.
- School Readiness targets have often been the responsibly of the Children and Families Department, however evidence suggests that a partnership approach is required, taking into consideration a holistic whole family approach focusing on a range of interdependent outcomes as evidenced in this JSNA chapter.
- Funding for children accessing early years provision who have SEND and especially those with complex medical needs, is insufficient. Funding from the Early Years Inclusion Fund and Disability Access Fund only provide minimal costs to contribute towards staffing, equipment and training. A longer-term solution is required in order to prevent children with complex needs being turned away from early years provision.
- Local Authorities have a statutory duty to allocate funding to PVI settings for the funded hours that a child is entitled to. This has created a challenge for parents who pay for additional hours in a childcare setting. For example, a 3-year-old who accesses 15 hours of funded childcare will be entitled to this funding supplement (often used to provide one to one support); however, this additional support is not available for the remainder of the week.
- The Disability Access Fund is only available for 3 and 4 year olds who claim Disability Living Allowance (DLA), however not all children who claim DLA access childcare provision. We also understand from the sector that some parents do not accept that their child may have an emerging need and refuse to seek medical advice from a GP or Paediatrician. These challenges have resulted in PVI settings not receiving funds to support the complex needs of a child. This resulted in an underspend of the Disability Access Fund whilst other funding streams were stretched.
- Early Years settings working with children who have complex medical needs require additional support from specialist services. Since September 2017, changes to NHS commissioning of specialist clinical services has meant that PVI settings are now

charged for medical training to support children who have clinical needs such as feeding, mobility and medication. In some cases, PVI settings have been unable to pay for these new charges which has resulted in some children being unable to access provision or they have been signposted to school early years settings who can access this training for free. Further work is taking place with CCG commissioners to explore solutions to enable PVI settings to access training to effectively support children with profound medical needs.

- The Local Authority now jointly commissions the British Red Cross to manage an Integrated Children's Equipment Store (ICELS). Since September 2018, early years funding from the council and the Early Years Inclusion Fund has been used temporarily to pay for equipment costs through ICELS. Only children eligible for funded early education or childcare are entitled to access this equipment, leaving a gap for children under the age of 3 who are not entitled to funded childcare.

9. Knowledge Gaps

Developing this JSNA chapter has highlighted a number of knowledge gaps that require some additional exploration.

- Further information is required from parents in localities where there is sufficient childcare provision but a reluctance for families to access the free childcare that they are entitled to.
- The number of teenage parents not in education, training and employment and the barriers that these young people face in accessing support and interventions including free childcare.
- The specific needs of Gypsy, Roma and Traveller Groups accessing early childhood services and childcare.
- The specific needs and views of refugees and asylum seekers with young children. Information is required to help engage these groups to access both universal and targeted services.
- The needs of families with young children where one or more parents has a disability.
- There is very little data regarding the specific local needs of families with young children living in insecure housing, emergency accommodation and those identified as homeless. This is not currently included in the Housing JSNA chapter.
- The needs of foster carers in relation to childcare and home learning are required to help prepare Looked After Children for school.
- Analysis of the early years foundation score results for Children in Need and those on Child Protection Plans has never been addressed. It is currently unclear how their experiences impact on their attainment at the Foundation stage.
- At present, data recording does not always highlight if parents and young children have English as an Additional Language (EAL). This is particularly the case within health services. Without this data, we are unable to understand the issues the families have when accessing services; and what their specific needs are re health, employment and early years. School attainment data categories are wider, however

it seems that some schools either use larger categories such as 'other than English' or 'believed other than English'.

- Local data on the number of young children affected by disability and complex health needs is limited and it is anticipated that this will be addressed in the new JSNA chapter focusing on children with Special Educational Needs and Disabilities.
- Knowledge of specific home learning interventions which will lead to improve outcomes is only available for a small number of programmes. There is a requirement to build in independent evaluation to local home learning initiatives, funding permitted.

What should we do next?

The recommendations and data gaps will be explored by the Healthy Child and Early Childhood Integrated Commissioning Group and the new Best Start Partnership Group which will be launched in 2020. Both groups will use the findings of the JSNA to influence its work programme.

Recommendations in terms of early years will be incorporated into a new Best Start Plan, bringing together interventions to improve the health, well-being and educational outcomes for children and families from preconception to age 5. The Best Start Plan will be the county's overall plan for families with preschool children which will bring together health plans and the Early Years Improvement Plan which currently focuses on attainment in the main. By extending the remit, it is anticipated that work to improve school readiness and attainment will start as early as possible.

Recommendations will also be used to influence the future commissioning and delivery of services for children under the age of 5 and their families including the Children's Centre Service.

10. Recommendations for Consideration by Commissioners

Priority	Recommendations	Suggested Lead
To ensure Children get the Best Start	• Develop a Best Start Strategy/Plan and a strategic partnership group to consider wider factors which contribute to school readiness from preconception to the age of 4. • Target resources to engage families earlier during the antenatal period and not wait for children to access early years provision.	Early Childhood Services, Nottinghamshire County Council (NCC). Public Health, NCC
Children achieve a Good Level of Development	• Raising the quality of early year's providers to ensure that all childcare settings are 'good' or 'outstanding' to enable poorer children to gain the best start in life. • Promotion, delivery and commission of evidence-based interventions only. • Implement and review the findings of the Best Start early years tracker tool to help early years providers to assess the developmental needs of children and enable commissioners to track progress and assess impact of services and interventions.	Early Childhood Services, NCC.

	• Explore increasing the moderation of assessments carried out by schools during the Early Years Foundation Stage as they do not reflect the progress children are making at age 2 - 2½.	
Children most at risk of poor educational outcomes have a good level of development and the attainment gap is narrowed	• Narrow the attainment gap for children eligible for Free School Meals and their peers, ensuring that progress is on par with statistical neighbours (measured by the Early Years Foundation Stage Profile). • Target wards across Nottinghamshire with higher proportions of children living in Poverty and low IDACI scores. • Additional work is required to engage low income families prior to the age of three and low-income families not accessing early education or childcare. • Increase the take up of funded early education for 2-year olds eligible for Free School Meals. • Work with early years providers to ensure there are sufficient high quality and sustainable places available in low income areas. • Target Children's Centre resources to target groups most at risk of poor attainment and development. • Undertake tracking of outcomes for children with SEND who have claimed supplementary funding (Disability Access Fund and Early Years Inclusion Fund). • Review specific needs of migrant families and refugees with young children. Information is required to help engage these groups to access early years and childcare provision.	Early Childhood Services, NCC
Highly Skilled Early Years Workforce	• Provide and evaluate high quality training and workforce development support to early years professionals across Nottinghamshire. • Links with Higher Education and Further Education organisations should be strengthened to improve promotion of accredited qualifications including teaching.	Early Childhood Services, NCC
Improve outcomes for Looked After Children and those known to Social Care	• Ensure early years is embedded in the work of the Virtual School to enable young children in Local Authority Care to succeed; and commissioners are able to assess the impact of additional Pupil Premium funding allocated to this group. • Ensure early years strategic leads work closely with the Virtual School to ensure that social workers, kinship and foster carers are aware of the importance of the quality of early years education. • Provide training and support to early years settings to enable them to be prepared for working with high-risk and potentially high-need groups, such as looked after children. • Undertake early years foundation stage data tracking and analysis for Children in Need and those on Child Protection Plans following the revision of the Deprivation Fund.	Early Childhood Services, NCC
Parents are engaged in their child's learning	• Continue the Home Talk intervention or similar evidence-based intervention to address and improve speech, language communication needs by working with parent and child in their own home.	Early Childhood Services, NCC

	• Promotion of the national Home Learning campaign 'Hungry Little Minds' (launched July 2019) • Consider the commissioning/delivery of a Home Learning resource co-produced with parents. • Ensure that home learning is promoted through all local online and social media opportunities. • Evaluate existing home learning interventions and launch the new home learning pathway.	
Parents are effectively supported to improve their wellbeing, parenting skills, and understand their child's development needs.	• Review the latest evidence base to identify which parenting programmes and family support interventions are most effective and evidence value for money, for delivery by the Children's Centre Service from 2020. • Continued evaluation of outcomes for parents and carers who have participated in a variety of evidence based programmes delivered by Children's Centre Services. Topics will include boundaries and behaviour, sleep routines, parental conflict etc. • Continued delivery and evaluation of 1-2-1 family support delivered by the Children's Centre Service, focusing on family routines, parental wellbeing, keeping children safe, emotional needs of children and home learning.	Early Childhood Services, NCC
Children's Centre Services are responsive to need and improve outcomes	• Review the impact of Children's Centre interventions and ensure that interventions are evidence based and evaluated. • Greater engagement of children most at risk of developmental delay and their families. • Greater focus on engaging families from the antenatal period until children reach the age of 3. • Ensure the Children's Centre Service once under the management of the Local Authority maintains strong links with Healthy Family Teams and Maternity Services.	Early Childhood Services, NCC
Improve outcomes for White British Boys	• Improve outcomes for White British boys by ensuring that the opportunities we are providing for boys in the Early Years Foundation Stage fully engage and support them in developing positive dispositions to learning. • Increase take up of childcare and early education opportunities for White British Boys as early as possible. • Provision of Forest School approaches should include a thorough evaluation on the impact for White British Boys, anecdotal information on the impact is insufficient and yet practitioners regularly share information about the successful engagement of boys in Forest School work.	Early Childhood Services, NCC

Improve communication and language skills	• Implement the recommendations highlighted from the Speech Language and Communication Needs Maturity Matrix assessment tool which include:
	  ○ Greater engagement with maternity services and specialist SLT services
	  ○ Greater ownership by CCGs
	  ○ Improve SLCN pathways to specialist SLT services.
	• Maintain effective speech and language support through the evaluated Home Talk programme (or similar), which
		Early Childhood Services, NCC & Public Health, NCC

	identifies and supports children with early speech and language delay. • Active promotion of the new national Hungry Little Minds home learning campaign which includes a focus on SLCN.	
Improve the emotional wellbeing and resilience of children	• Promote tools to foster emotional well-being from the earliest stages of life, enhancing resilience and the importance of relationships to help build solid foundations for overall health and well-being. • Implement the REAcH programme to ensure that parents have their needs addressed and the intergenerational cycle of disadvantage is broken through the Children's Centre Service and Healthy Family Teams.	Public Health, NCC
Improve outcomes for Children with SEND	• The significant increase in the number of young claimants of Disability Living Allowance will require a focus on this population to review access and take-up to inform plans to ensure sufficiency of appropriate provision. • Commissioners should work across County Council departments to help share findings from SEND assessments for children under the age of five; sharing key findings and learning which in turn will inform commissioning decisions and service planning. This will need to include the children that do not meet the thresholds for specialist support. • Review the use of the Early Years Inclusion Fund and the Disability Access Fund to ensure that children are effectively supported as part of their transition to school. • Greater promotion of childcare provision to families with children with SEND and increased promotion of funding supplements to early years settings.	Early Childhood Services, NCC
Developmental Delays are identified and supported early	• Embed and review the findings of the 2-year integrated review and the impact for children accessing early years settings; and compare progress against statistical neighbours.	Public Health, NCC
Improve outcomes for children with English as an Additional Language (EAL)	• Explore the specific childcare and health needs of families with English as an Additional Language (including refugees and asylum seekers). • Encourage schools and health services to report both ethnic origin and English as an additional language using ONS codes to enable improved monitoring and analysis.	Early Childhood Services, NCC
Ensure sufficient high-quality childcare provision is available	Nottinghamshire needs to have robust data about both supply and demand for childcare, it is recommended the local authority evaluates progress of new data collection and monitoring procedures to ensure it supports their market management role and sufficiency duties. *Refer to the Nottinghamshire Childcare Sufficiency Assessment.*	Early Childhood Services, NCC
Reduce financial barriers	Work should be undertaken with key stakeholders to ensure partners and staff are aware of what support for the costs of	Early Childhood Services, NCC

preventing access to childcare	childcare is available, and how the free entitlement can be used, and disseminate that information to their client groups. *Refer to the Nottinghamshire Childcare Sufficiency Assessment.*	
Offer flexible childcare provision and provide additional childcare during school holidays and increased wrap around care	• Explore flexible delivery models as a matter of urgency; and consider how these models of working can be applied across different types of provision for all age ranges of children. • The Childcare Sufficiency Assessment identified demand for provision in school holidays and an unmet for after school and before school provision. Work should be undertaken with key stakeholders to identify options for additional childcare and wrap around provision, ensuring all available provision is recognised and promoted through the local authority's information duty, delivered by the Families Information Service. *Refer to the Nottinghamshire Childcare Sufficiency Assessment.*	Early Childhood Services, NCC
Ensure teenage parents are effectively engaged and supported	• Improve uptake of Care to Learn Grant for teenage parents • Gain a better understanding of which services teenage parents' access and gain a better understanding of the local barriers for young people in accessing the Children's Centre Service and childcare.	Public Health and Early Childhood Services, NCC
Consider ceasing the commissioning /delivery of some interventions with no evidence base	Review the interventions provided locally that do not have a clear evidence base, or evaluation and performance does do not evidence impact. Commissioners and service providers should not prioritise these interventions where budgets are restricted. This could include baby massage which parents enjoy. However, it must also be acknowledged that evidence of effectiveness is not a replacement for ongoing evaluation: The fact that an intervention has evidence from a rigorous evaluation conducted at one time and place does not mean that it will be effective again. The evidence described in this chapter is therefore not a replacement for good monitoring and evaluation systems as interventions are set up and delivered.	Public Health and Early Childhood Services, NCC
Provision of behavioural sleep training	Continue to provide behavioural sleep training through the Children's Centre Service and provide information through Healthy Family Teams during the antenatal and postnatal stage.	Public Health and Early Childhood Services, NCC
Increase the use of social media and web-based resources	Consider increasing and improving information and support available for parents and expectant parents including activities to promote positive home learning environments and parenting support such as 'Triple P Online'.	Early Childhood Services, NCC

Key contacts
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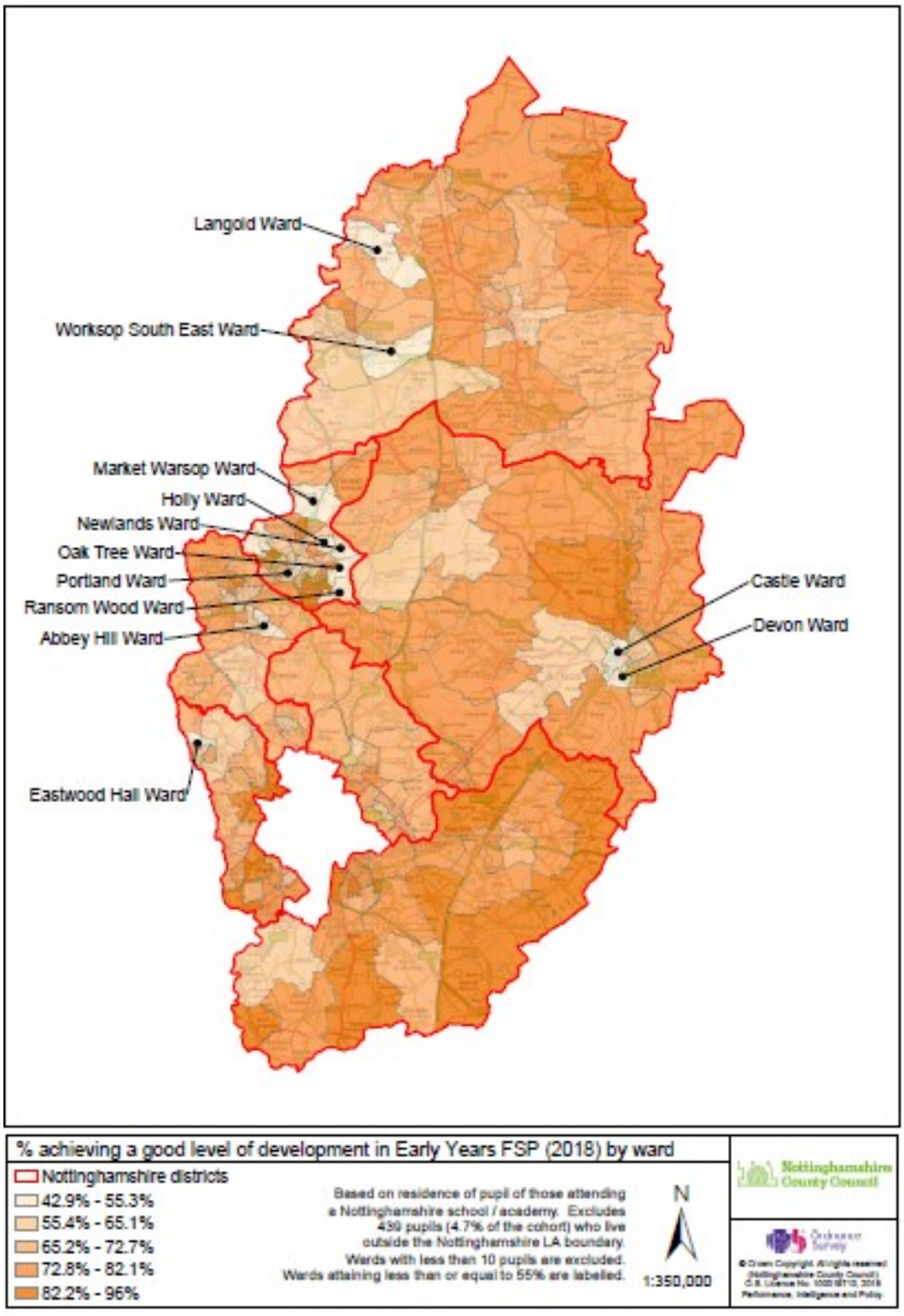
Appendix 1: Early Years Foundation Stage Profile by ward 2018



Appendix 2: Evidence Based Interventions to improve children's development

Preparation for Birth and Beyond

This 4 week antenatal parenting programme is aimed at women and birthing partners from 28 weeks gestation. The University of Warwick (Schrader McMillan et al. 2009) undertook a review of the research that has so far been carried out into the effectiveness of antenatal education. While this remains an under-researched area, and while the evidence on what works is limited, the review highlighted the following:

- Antenatal education has a role to play in improving knowledge of and preparation for parenthood.
- Participation in antenatal preparation courses is associated with higher satisfaction with the birth experience.
- Antenatal preparation courses can lead mothers and fathers to adopt a range of healthy behaviours that affect pregnancy, birth and early parenthood (as well as their own health), such as eating more healthily, cutting down or stopping smoking and taking more exercise.
- Group-based antenatal programmes that include topics on couple relationships, co-parenting, gender issues and father involvement, parenting skills, bonding and attachment, and problem-solving skills are associated with improved maternal well-being and with an increase in the confidence and satisfaction of both parents with the couple and the mother–infant/ father–infant relationships.
- Group-based programmes have high levels of consumer satisfaction, partly because they offer parents the opportunity to develop supportive social networks with their peers.
- As part of antenatal preparation for parenthood courses, group-based social support can be effective in supporting women with low-level symptoms of depression and anxiety.
- There is also some good evidence that focused and participative antenatal education can help to manage and reduce maternal anxiety and depression during pregnancy and early childhood, leading to improved coping, greater partner support and a better birth experience.
- Interactive antenatal group work on breastfeeding – covering such issues as positioning, attachment and the prevention of nipple trauma, and involving breastfeeding peer supporters as volunteers – is effective in supporting the initiation and continuation of breastfeeding.

More information is available at
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/215386/dh_134728.pdf

Baby Massage

Infant massage has some evidence of improving physical outcomes in low-birthweight babies, as well as decreasing parental stress and increasing sensitivity. It is important to note, however, that these benefits have not been replicated when offered universally to mothers with healthy, normal-weight infants (EIF 2018).

Interventions based on baby massage focus directly on parents and have had beneficial results in both parents (Underdown 2009). The first Randomised Control Trial to test the efficacy of baby massage (five x75minutes sessions) in the treatment of Post Natal Depression found significantly lower depression scores in the baby massage group and overall improved quality mother-baby relationships compared with controls (Onozawa et al

2001). These preliminary findings are promising, though the study reported high dropout rate and did not measure long-term outcomes.

Massage gives parents the opportunity for positive touch which helps with bonding and attachment and building those early relationships. Massage also encourages early communication from parents towards their babies through using nursery rhymes during massage. Baby massage is something parents do 'with' their babies, not 'to' their babies which encourages parental awareness of their baby's responses and needs. Baby massage is a powerful form of communication that can strengthen the emotional bond between parent and child.

However, it has also been reported that the evidence to date suggests that while the practice of infant massage is popular and is likely not to be harmful, there is no conclusive evidence to suggest that it provides lasting benefits for low or high risk mothers and their infants, including mothers who are feeling depressed. *"If the activity is safe, relatively inexpensive and commissioned primarily because local families want and enjoy it — than there is likely no harm in making it available to parents and children, or for communities to commission it for themselves. However, if the activity is being offered to improve outcomes that it has little evidence of achieving – then commissioners should think twice about why and for whom they are commissioning it, particularly when resources are very tight"* (Asmussen 2015).

Incredible Years Toddler

The Incredible Years (IY) Toddler programme is for parents (typically living in disadvantaged communities) with a child between the ages of two and three. Parents attend 14 weekly group sessions where they learn strategies for responding sensitively to their child and discouraging unwanted behaviour. Two facilitators lead parents in weekly two-hour group discussions of mediated video vignettes, problem-solving exercises and structured practice activities addressing parents' personal goals.

According to the best available evidence for this programme's impact, it can improve children's behaviour. https://guidebook.eif.org.uk/programme/incredible-years-toddler

Incredible Years Preschool

The Incredible Years (IY) Preschool basic programme is for parents with concerns about the behaviour of a child between the ages of three and six.

Parents attend 18 to 20 weekly group sessions where they learn strategies for interacting positively with their child and discouraging unwanted behaviour. Two facilitators lead parents in weekly two-hour group discussions of mediated video vignettes, problem-solving exercises and structured practice activities addressing parents' personal goals.

The Advanced add-on to Incredible Years Preschool includes a component that seeks to improve children's outcomes by improving the quality of interparental relationships.

- The Incredible Years model assumes that some parenting behaviours inadvertently encourage unwanted child behaviour.
- Parents will learn more effective strategies for dealing with unwanted child behaviour when they have opportunities to practise and perceive themselves as effective in using them.
- Effective parenting strategies help the child learn how to better manage his or her emotions and behaviour.
- In the longer term, the child will get along better with others and there will be a reduced likelihood of antisocial or criminal behaviour.

Incredible Years Preschool has evidence of a long-term positive impact on child outcomes through multiple rigorous evaluations. The programme has been found to improve a range of outcomes. https://guidebook.eif.org.uk/programme/incredible-years-preschool#about-the-evidence

One study found that the programme improved children's behaviour, reduced symptoms of depression, reduced levels of stress, reduced critical parenting and increased positive parenting (Hutchings et al 2007).

Two further studies identified that the programme improved reading, improved behaviour on all measures, less defiant behaviour, reduced inappropriate commands and warmer expressed emotion (Scott et al 2001; Scott et al 2014).

A further study identified that the programme improved behaviour on all measures, increased sense of competence, increased positive parenting strategies and decreased negative parenting strategies (Gardner et al 2006).

Triple P (Positive Parenting Programme)

Triple P aims to enhance parental knowledge and resourcefulness, promoting nurturing, low conflict environments for children, and promoting children's social, emotional and intellectual competencies through positive parenting practices. The framework is developmentally sensitive and offers flexible delivery (Sanders et al 2000).

Level 4 Standard Triple P is for parents, with a child aged 0 to 12 years, who have concerns about their child's behaviour. Parents attend 10 one-to-one weekly sessions with an individual therapist lasting approximately one hour. The sessions are provided by a practitioner trained and accredited in Triple P. Practitioners also receive ongoing supervision. Parents learn 17 different strategies for supporting their children's competencies and discouraging unwanted child behaviour through role play, homework exercises and discussions involving video-taped examples of effective parenting.

This programme has been found to improve all outcomes in relation to improved behaviour for children (Sanders et al 2000, Bor et al 2002, Sanders et al 2007). https://guidebook.eif.org.uk/programme/triple-p-standard-level-4

Triple P Online is a web-based parenting intervention. The programme can be used as an early intervention strategy or as a more intensive programme for parents with children up to 12 years with significant social, emotional or behavioural problems.

Parents are given access to a website which enables them to work through modules sequentially. It is the equivalent of Level 4 Standard Triple P, which is the face-to-face version of the programme. The online programme is designed to reach parents who prefer to complete a parenting programme online because, for example, they are they are too busy, hesitant or unable to access a programme in-person. A practitioner can provide support alongside the self-directed online programme. It includes 8 modules which focus on positive parenting principles and supporting parents to integrate and generalise parenting strategies through parenting plans.

According to the best available evidence this programme has been found to improve children's behaviour and difficulties including emotional health, hyperactivity/inattention, restlessness/impulsivity, conduct, social functioning, defiance /aggression (Early Intervention Foundation https://guidebook.eif.org.uk/programme/triple-p-online#about-the-evidence).

Enhanced Triple P (Level 5) provides adjunctive interventions (alongside a Level 4 Triple P programme) to address family factors that may impact upon and complicate the task of parenting, such as parental mood and partner conflict.

The programme aims to achieve positive outcomes for both parents and children. With regards to parents, Enhanced Triple P aims to: increase parents' competence in managing common behaviour problems and developmental issues; reduce parents' use of coercive and punitive methods of disciplining children; improve parents' personal coping skills and reduce stress; improve parents' communication about parenting issues and help parents support one another in their parenting role; and develop parents' independent problem-solving skills.

According to the best available evidence this programme has been found to improve children's behaviour (Early Intervention Foundation https://guidebook.eif.org.uk/public/files/pdfs/programmes-triple-p-enhanced.pdf)

The Solihull Approach Parenting Group

The UK-based Solihull Approach focuses on developing the skills of community health workers to support the parent-baby relationship. The main aim is to promote a collaborative relationship between practitioners and parents to encourage parents to develop sensitive and attuned parenting.

Solihull Approach is a 10 week parenting group for parents with children from universal to complex needs and aged 0-18 years. It is based on the Solihull Approach model of containment, reciprocity and behaviour management and uses social learning theory in the design of the parenting programme. It is delivered by two trained professionals from a wide range of professions and agencies through joint working and following a resource manual for parents with children.

Bateson et al evaluated the approach in 2008. Data was analysed on 72 pre and post measurements using three questionnaires. The Becks Anxiety Inventory for Adults (BAI), the Strengths and Difficulties Questionnaire and Child Behaviour Checklist. Results showed attendance of the Solihull Approach Parenting Group was associated with decreased externalising child behaviour (i.e. aggression, defiance) over the age of two years and a decrease in parental anxiety. In addition there was a relationship between parental anxiety and the changes in child internalising behaviour. The 22% drop out rate of parents attending the Solihull Approach Parenting Groups compares favourably with the national average of 40 per cent.

Solihull Approach course for foster carers: understanding your foster child's behaviour - Many young people in care have experienced trauma. The emotional and behavioural issues that often ensue, along with foster carers' varying levels of confidence and skills, are cited as the main reasons for placement disruption. Placement breakdown can represent a further trauma for young people and is also highly costly for local authorities. The need for interventions to develop foster carers' competence and confidence in understanding and managing foster children's behaviour is therefore significant. The Solihull Approach (SA) promotes the parent and child relationship by emphasising the need for emotional containment and a reciprocal relationship so as to form a framework for thinking about, understanding and effectively managing behaviour. The 'Solihull Approach course for foster carers: understanding your foster child's behaviour' is a 12-week programme tailored to the demands of this task (Madigan et al 2017).

In the reported study 83 participants completed evaluation forms. A thematic analysis of their replies revealed that the most important things learned were: taking a step back; understanding the effects of trauma; reciprocity; communication and play; containment (of my child); understanding my child; and the ability to offload when full up. The course helped participants to better understand their foster child by clarifying the nature of the relationship and their role, understanding the impact of the child's early experiences and appreciating that she or he is not to blame. Participants took from the course: increased understanding; being part of the group; staying calm and thinking before they act; feeling more confident; and looking after themselves and seeking containment. Pre- and post-Child Behaviour Checklist questionnaires were collected from 34 carers with children in the six to 18 age group and 13 looking after children aged one-and-a-half to five years. The identified qualitative themes suggest that the aims of the training are being met. There was a strong overall sense that foster carers found the course helpful and informative, suggesting that it could represent a valuable intervention for promoting placement security (Madigan et al 2017).

Despite some positive evidence, the Early Intervention Foundation found that the Solihull Approach has preliminary evidence of preventing crime, violence and antisocial behaviour, but they could not be confident that the programme caused the improvement. However evidence lacks rigour as a RCT has not been carried out. The Solihull Approach (Understanding Your Child's Behaviour) | EIF Guidebook

123 Magic

1-2-3 Magic is a behavioural management programme for parents and other carers of young children aged 2-12, including teachers and family support workers. This group-based parenting programme explores parent-child relationships and child behaviour including sibling rivalry, conflict and tantrums. The sessions also promote self-preservation, reminding parents that taking care of themselves and their needs are important too.

This programme also supports families with children who have a diagnosis or are undergoing assessment with a consultant paediatrician for Autistic Spectrum Disorder (ASD) which includes Attention Deficit Hyperactivity Disorder (ADHD) Attention Deficit Disorder (ADD) or higher functioning autism or a learning disability.

There is a plethora of evidence from across the world for the successful outcomes of this specific parenting programme. Many institutions have conducted their own audits to evaluate outcomes and there have also been randomised controlled trials published.

A study that randomised parents to control group or brief psychosocial intervention group using the video '1-2-3 Magic' to reduce parent-child conflict found a reduction in child problem behaviour in the intervention group (Bradley et al 20013).

Bloomfield and Kendall (2010) evaluated the effectiveness of '123 Magic' by measuring whether parenting self-efficacy increases after attending a programme. 74 parents took part in the study over 16 '123 Magic' parenting programmes. Parents completed the TOPSE evaluation tool as a pre- and post-course measure of parenting self-efficacy. Scores increased at the end of the parenting programmes for all scales, which suggests that '123 Magic' is an effective parenting programme to increase parenting self-efficacy over the period of the programme. This increase in self-efficacy is important in itself as studies have shown that parents who are more confident in their ability to parent are more likely to be competent to nurture and develop their children into healthy and confident young adults (Jones et al 2005).

Theraplay

Theraplay is a child and family therapy for building and enhancing attachment, self-esteem and trust in others. It is based on the natural patterns of playful, healthy interaction between parent and child and is personal, physical, and fun. Theraplay interactions focus on four essential qualities found in parent-child relationships: Structure, Engagement, Nurture, and Challenge. Theraplay sessions aim to create an active, emotional connection between the child and parent or caregiver, resulting in a changed view of the self as worthy and lovable and of relationships as positive and rewarding.

Research suggests that Theraplay has clinical validity and is an effective intervention for children. Morgan (1989) found that after receiving Theraplay, two thirds of the study's subjects had increased in measures of self-esteem, self-control and self-confidence, as evaluated by parents, teachers, observers and the therapist. Munns et al, (1997) demonstrated decreased aggression for children receiving Theraplay. Zanetti et al (2000) used Theraplay activities to reduce children's negative behaviours. Siu (2009) identified that Theraplay was effective in showing positive improvements for children who are at risk of internalising problems. Siu also found that Theraplay can also enhance mother-child relationships, as it gives more opportunities for interaction through fun and playful activities.

Tucker et al 2017) evaluated 'Sunshine Circles' which is a teacher-led group process using social-relationship principles from Theraplay. This study, conducted across 6 preschool sites in the Midwestern United States, was the first to examine empirical outcomes against a control group for this program. Students in these teacher-led, play-based groups improved significantly compared with controls in social-emotional skills, behavioral regulation, problem-solving, and fine motor control. Specific improvements occurred in domains of managing feelings, cooperation, accepting limits, peer interactions and friendships, and solving social problems. Furthermore, structured teacher observation measurements yielded data indicating improvement in teacher classroom performance. Interviews with teachers confirmed that the intervention subjectively increased classroom cohesion, improved teacher–student relationships, and improved overall classroom behaviour.

EPEC – Empowering Parents, Empowering Communities Parenting Programme

Empowering Parents, Empowering Communities (EPEC) is for disadvantaged families experiencing behavioural difficulties with a child between the ages of 0-16.

Parents attend eight weekly two-hour sessions facilitated by pairs of trained and supervised peer facilitators. During these sessions, parents learn strategies for improving the quality of their interactions with their child, reducing negative child behaviour and increasing their efficacy and confidence in parenting. The sessions involve group discussions, demonstrations, and role play and homework assignments.

It is a community-based program training local parents to run parenting groups (in pairs) through early years and parenting focused services. Parent facilitators trained to work in the EPEC program are supported and supervised by a specially trained practitioner within a local community organisation.

EPEC offers the following parenting programmes:

- Being a Parent, for parents of children age 2-11 years.
- Baby and Us, for parents of babies aged 0-1 year.

- Living with Teenagers, for parent of adolescents aged 12-16 years.

There are also a range of specialist EPEC programmes for parents with children with Attention Deficit Hyperactivity Disorder, for parents with children with Autism Spectrum Disorder, and for families living in homeless accommodation.

EPEC has been rigorously evaluated in research trials and routine practice. These show that EPEC improves children's social, emotional and behavioural development, parenting, parents' wellbeing, confidence and resilience. For example, a randomised control trial *(Day et al., 2012a)* shows that EPEC results in significantly better outcomes for:

- Child behaviour problems
- Positive parenting behaviour
- Parenting concerns
- Parents' improved understanding, confidence and skills in parenting

Research also found positive outcomes for parent facilitators Over 90% of parents completing EPEC rate group leader competence, knowledge and motivational skills very highly (Day et al., 2012a; Day et al, 2017), and it significantly increases their parenting knowledge and facilitation skills (Day et al., 2012a).

EPEC has been independently rated by the Early Intervention Foundation in the UK and the Australian Institute of Family Studies as an effective, low cost parenting programme. The Early Intervention Foundation reviewed research from the RCT carried out by Day et al (2012) and identified that the programme improved child behaviour and improved parenting. The Foundation recommend this programme because it is low cost, its rigorous evidence base and high retention rate for parents. Additional research is available both from the UK and Australia.

Developed and tested by the UK Centre for Parent and Child Support, EPEC encompasses the best of current theoretical and practical knowledge and provides an alternative model to practitioner-led parenting interventions. The basic course for all parents with children aged 2-12 is "Being a Parent", with 8 x 2.5 hour sessions delivered according to a structured manual which employs attachment, social learning, structural, relational and cognitive behavioural theory. Childcare is provided for children up to age 5. After completing the basic course, parents who are interested (about one fifth in recent trials) can continue to become parent facilitators through a ten day course.

A UK randomised control trial found that EPEC significantly reduced children's behavioural problems, and improved the competencies of parents in a population that was considered to be disengaged from services. This trial and other UK research has shown peer-led parenting training groups have a much higher retention rate than conventional parenting group formats for disengaged parents.

Nottinghamshire Children's Centre Sleep Tight programme

Sleep Tight is a behavioural sleep programme, focused on child sleep problems and family wellbeing, delivered by Family Support Workers (FSWs) in Nottinghamshire's Children's Centres. A research study was undertaken with Nottingham University, to explore the impact of the programme; this was published in the Journal of Health Visiting (Turner et al 2016) and is detailed in the 'Evidence of What Works' section of this |JSNA chapter. A service evaluation of 40 families with a child aged 0–12 years was completed. A before and after within-subjects design was used and outcomes assessed using the Sleep Disturbance Index (Quine, 1991). Evidence of a statistical effect was found for settling, night waking, sleeping in parents' bed, and parents up at night. On average, children had 2.5 hours more

sleep per night after the intervention. Parents reported changes in family life and child's daytime behaviour. The findings support the use of Sleep Tight as an effective, time-limited behavioural sleep programme.

Best Start at Home

Below are two examples cited from within the Early Intervention Foundation's Literature Review 'Best Start at Home' which demonstrate effective evidence-based UK interventions designed to improve and encourage school readiness, from conception to age 5 years.

https://www.eif.org.uk/report/the-best-start-at-home.

PALS (Playing and Learning Strategies)

PALS is based on responsiveness, that is, responsive parenting will in turn encourage children to communicate their needs and to engage in learning activities. PALS is a universal home-visiting intervention that promotes responsive parenting in order to support children's social-emotional, cognitive and language development. Home visits are a 1.5hrs once a week, for a period of three months (a total of 10 visits). Providers demonstrated developmentally appropriate activities to parents and educational videos are also used to encourage reflection and planning. The intervention is aimed at families with low socio-economic background and/or where other risks are present.

There are two versions of PALS. PALS I is for parents of children aged 6-8months and PALS II is for parents with children aged 24-28 months. PALS I and PALS II have been evaluated via RCT's. (Landry et al., 2006, 2008).

PALS I had a significant positive effect on contingent responsiveness, levels of warm sensitivity, verbal scaffolding, labelling of objects, levels of labelling actions, infant use of words and infant social cooperation. PALS II had a significant effect on parent verbal encouragement, infant's cooperation, social engagement, infant's use of words and vocabulary. The results suggest that there is a causal link between responsiveness and infant development. That is, overall PALS attendance significantly increases and encourages maternal warmth, with responsiveness leading to greater growth in infants' social, emotional communication and cognitive competence, when compared to a control group. The best available evidence for this programme relates to implementation through Home visiting. https://guidebook.eif.org.uk/public/files/pdfs/programmes-play-and-learning-strategies.pdf

Reach Out and Read

Reach Out and Read is an intervention aimed at low income families with children aged 6 months to 5 years old. The intervention is delivered during children's check-ups. The intervention encourages parents to read with their child for 10 minutes a day, by giving them a signed prescription to do so. Parents are modelled how to appropriately read with their child and aims to give each child 10 books for home use, before they begin school.

Randomised controlled trials (High et al, 2000 and Jones et al, 2000) and quasi-experiments (Sharif et al., 2002; High et al, 1998; Sanders, et al., 2000; Mendelsohn et al., 2001) have revealed that Reach Out and Read positively impacts aspects of children's language/ communication (including receptive and expressive vocabulary) and/or parent literacy behaviours with their child (including home literacy orientation and parent-child reading).

Early Talk Boost

Early Talk Boost (ETB) is an intervention for children with delayed language. It is a targeted programme for children between the ages of 3 and 4. It is delivered in children's centres or other early years settings by early years practitioners, and aims to improve children's core language skills, as well as academic attainment and social/emotional difficulties in the longer term.

Children taking part in the programme have all been identified by early years practitioners as having delayed language (developing in the same way as typically developing children, though slower). The children do not have an identified special educational need. This may include children with English as an additional language.

Early Talk Boost group sessions are designed to replace or complement circle or group times. The child-focused component of Early Talk Boost is delivered in three sessions (up to 15–20 minutes each) per week for nine weeks, by one early years practitioner to groups of children. There is also a home-based component, for each child, which involves using the Early Talk Boost story books at least once a week for up to 20 minutes. Finally, there is also a parent component for each parent or carer, which is delivered in a one-off workshop lasting one hour.

The Early Intervention Foundation reviewed the evidence for Early Talk Boost and Early identified preliminary evidence of improving auditory language skills and improved expressive language outcomes, but they could not be confident that the programme caused the improvement. Early Talk Boost's most rigorous evidence comes from an RCT which was conducted in the UK. This study identified statistically significant positive impact on a number of child outcomes (Reeves et al 2018).

https://guidebook.eif.org.uk/programme/early-talk-boost#about-the-programme

Bookstart

Bookstart Plus is a good example of a book-sharing initiative. It is an intervention for families with children aged two years to improve children's language and communication skills, and encourage positive parent-child interactions. On a standard visit, trained Health Visitors provide a pack of books and associated reading materials in a bag. To encourage parents to share books, stories and rhymes with their two-year-old child, they discuss and demonstrate the pack.

There are many evaluations of Bookstart, the majority of which are qualitative or focus on outcomes such as parental awareness, parental attitudes, and library membership, increased reading with children, increased book ownership. A study of Bookstart Plus with 462 families in Northern Ireland is typical in the sense that it did not measure the impact on child outcomes, but it is unusual in its use of an RCT design, showing an improvement in parents' attitudes to reading and books.

There are also three (retrospective) QED studies of Bookstart (Regular) with quantitative outcomes (Wade and Moore, 1998, 2000; Collins et al., 2005), although only the first of these tested the statistical significance of difference between intervention and comparison groups. It found that Bookstart children significantly outscored the comparison group at 5 and 7 years of age on teacher assessments of English, Maths and Science scores, and also on a range of SATS test elements, including a reading task, reading comprehension, writing,

spelling and maths test. Meanwhile, an RCT of Let's Read in Australia involving 552 families from relatively disadvantaged communities, 324 of whom received the intervention, found no evidence of effectiveness in terms of vocabulary and limited evidence of effectiveness for phonological awareness (Goldfeld et al., 2011).

Bookstart Corner

Bookstart Corner is a programme to improve children's language and communication skills by encouraging parents and children to read together. It is designed for children aged 12-24 months from socially disadvantaged backgrounds. Families attend four group-based sessions in the local children's centre where parents are offered intensive support to read with their children for pleasure and with confidence. They are given specifically-developed resources such as a rhyme sheet, some picture books with information sheets, a DVD for parents about sharing stories, a puppet, pad and crayons. The intervention is run by Booktrust, who provide specially trained practitioners.

A non-controlled pre-post evaluation (Demack et al., 2013) with 65 pre-post responses from parents and practitioners was conducted in England. Significant gains were noted for parental encouragement/interaction, parent confidence and enjoyment, child engagement and enjoyment, and child interest. In addition, parent and practitioner responses indicated that subsequent to the Bookstart Corner sessions, parents were more likely to participate in local services such as the library, the Children's Centre (for boys) and the Bookstart Bear Club and rhyme/story time at either a Children's Centre or library. The intervention offers preliminary evidence that it can increase parental engagement.

More information is available at https://www.booktrust.org.uk

Kaleidoscope Play and Learn,

Parents and caregivers (including grandparents, aunts, uncles, older brothers and sisters, good family friends) are taught about child development, skills that children need when they start school, and activities that they can do at home to support child's learning (including pre-literacy development) and turn everyday activities into learning opportunities. The programme also seeks to build supportive social networks. The programme is delivered in community settings (e.g. children's centre, school) to groups of 12-15 families who meet weekly for 90 minutes over the course of a year.

Kaleidoscope Play and Learn, there is formative evidence only from a pre-post evaluation involving 61 caregiver-child pairs from 20 centres. The results were mixed but the study found an improvement in aspects of child social- emotional and preliterate development, and a marginally significant increase in caregiver-child interaction (Organizational Research Services 2012).

The Parents Early Education Partnership (PEEP)

PEEP is a UK developed universal group-based intervention aimed at promoting children's learning. It primarily works with parents who have children up to the age of 5, living in disadvantaged areas. The intervention focuses upon age appropriate activities and practices that enhance children's self-esteem, attitudes to learning and their physical and cognitive (language, literacy and numeracy) development.

Evangelou and Sylva (2003) compared 156 families in Oxford who received PEEP for 3-4 year olds, with 86 families (with similar characteristics) who no access to the intervention. Participants who participated in the intervention were significantly more likely to progress in

verbal comprehension, vocabulary, concepts about print, early number concepts and self-esteem relating to cognitive and physical competence.

Similarly, Evangelou et al, (2005) compared 301 families who received PEEP and 303 families who did not receive PEEP. The results revealed that between the ages of 2 and 4, PEEP attendees progressed significantly greater on measures of vocabulary, phonological awareness of rhyme, phonological awareness of alliteration and understanding about books and print. Likewise Between the ages of two and five years they made greater progress in vocabulary, total phonological awareness, letter identification, and understanding about books and print, which are indicative of future literacy success.

Results from these RCTs also suggests that PEEP not only has a positive effect on children but parent also. Parents who attended PEEP significantly changed their view on the importance of parent-child-interaction. Similarly, PEEP parents also scored significantly higher in the quality of their care-giving environment.

EasyPeasy

EasyPeasy is a universal programme for families with children aged between 2 and 5 years old. It is delivered via home visits and in children's centres or primary schools for a 20 week period. The programme aims to improve mental health and wellbeing, school achievement and physical health. Easy Peasy is partially delivered digitally via videos and text messages, which provide activities, tips and advice for parents in bitesize chunks of information. To accompany the videos there is an online forum which practitioners can use to share information and advice directly with parents. There are a total of 65 games which relate to a specific domain.

EasyPeasy's most rigorous evidence comes from two Randomised Controlled Trials which were conducted in the UK. One study identified statistically significant positive impacts on a number of child and parent outcomes stating that the programme had a statistically significant positive impact on a number of child and parent outcomes, including child cognitive self-regulation and behaviour, and improved parenting self-efficacy; however the conclusions drawn from the trail are limited because of the small sample size and attrition (Jelley, F et al 2016). The second study identified that there is statistically significant positive impact on a number of child and parent outcomes, including child self-regulation and behaviour and parental self-efficacy. The conclusions that can be drawn from this study are limited by methodological issues pertaining to clustering not being taken into account in the analysis (Sylva et al 2018).

The evidence base has been reviewed by the Early Intervention Foundation and is available to download from their website. https://guidebook.eif.org.uk/programme/easypeasy. Further information about the programme is available at https://www.easypeasyapp.com/

Let's Play in Tandem

Let's Play in Tandem is a school-readiness programme aimed at parents and their children aged 3 years old, from socio-economically deprived areas. The aim of this intervention is to improve school readiness for children based on their cognitive development and cognitive self-regulation.

The programme is run for a period of 12 months and usually delivered via children's centres, however a worker will also visit the family home each week for a period of 90-120 minutes. Three activities are provided to develop early reading and numeracy skills, and to promote

vocabulary and general knowledge – activities are designed to promote positive verbal parent-child interaction to allow parents to prompt, instruct and encourage their children.

Let's Play in Tandem has been found to be significantly effective in the UK, as children were found to be significantly better on knowledge, pre-reading and numeracy skills, when compared to a control group (Ford et al, 2009). The effects of the intervention were present four months after the intervention took place, as children who attended this intervention were significantly better on scores of listening and communication, responding to stimuli, writing, mathematics, personal and social skills, and inhibitory control, when compared to a control group.

Making it REAL (Raising Early Achievement in Literacy)

Making it REAL is an intervention aimed at 2 – 5 year olds, to improve their literacy skills as a family. Making it REAL is an evidence-based intervention based on the ORIM framework, that is: Opportunities for literacy, Recognition of children's literacy development, Interaction around literacy and Models of literacy users. Making it REAL works with parents to support their children's home learning environment, access to books and early writing and oral skills/development. Making it REAL, via the NCB Early Childhood Unit, train and support local authorities and their professionals (via support packages and Hub events), so they can effectively work with parent to support the home learning environment to ultimately improve children's literacy development (during home-visits).

Rix, Lea and Graham, (2016) have evaluated the Making it REAL (Year 3) intervention on the interventions effectiveness of producing positive outcomes for both parents and children. Data was collected from service users, service providers and a plethora of stakeholders, via both quantitative and qualitative methods. Overall, the findings suggests that Making it REAL had a positive impact on both parents and children. More specifically, the evaluation found when comparing rates of book sharing, at the start and end of the intervention, that the frequency of book sharing between parents/carers and children was significantly increased. Similarly, there was a significantly positive impact in the frequency with which children engaged with environmental print and mark making, and song singing and rhymes. Children's language and communication skills improved as a result of this intervention. Furthermore, Making it REAL was also found that parents were more confident and knowledgeable in how to best support their children's literacy development. It is also important to note that this intervention is highly influential as the participants in this research were inclusive of children with SEND and EAL.

Making it REAL year 1 and year 2 evaluations also found similarly positive results regarding the impact and effectiveness of the intervention, in producing positive outcomes for parents and children (Graham et al 2014 and Lea et al 2015).

Parental Engagement Network (PEN) Home Learning Project

The PEN Home Learning Project is for children in nursery or reception and is designed to work with parents, particularly from disadvantaged backgrounds, to help them support their child's learning and to build positive relationships with other parents and teachers. The PEN Home learning project provides workshops and activities for families which help support early literacy and language skills. Videos are also provided to parents which demonstrate positive parenting techniques to encourage learning.

This intervention has been evaluated using a RCT, which demonstrates the effectiveness of the PEN Home Learning Project in producing positive outcomes for parents and therefore

their children (Jelley & Sylva, 2017).18 schools, with a combined total of 167 families were involved in the research. The intervention was delivered in schools by trained professionals and consisted of 2 – 4 workshops per school term. Workshops also provided activities and a 'play club bag' which could be used at home to help improve their child's achievement in the foundation stage curriculum. The RCT found that compared to those who did not attend the PEN Home Learning Project, intervention attendees scored significantly better on measures of Home Learning Environment. That is, compared to a control group, parents who attended the intervention demonstrated a greater supportive home environment, as a result of attending the PEN Home Learning Project.

ParentChild+

Twice weekly home visits (a total of 92, half-an-hour visits), were used to model positive-parent interactions with the aim of improving the home learning environment also. This intervention was found to positively enhance school achievement by improving cognitive ability, child language/literacy skills and the socio-emotional competence of children.

Madden et al, (1984) have performed a randomised controlled trial to evidence the impact of ParentChild+. The study involved 55 families with children between 21 and 33 months old, where families were receiving housing benefits. ParentChild+ was found to significantly improve children's cognitive ability and intelligence.

https://guidebook.eif.org.uk/programme/parentchildplus

ELKLAN Talking Matters Programme

Talking Matters is a training programme aimed at staff who work with pre-school children in early years settings. Talking Matters aims to facilitate knowledge of and skills in supporting children's speech, language and communication and therefore improve outcomes in children's speech, language and communication. The training is delivered to either Key Communication Practitioners (KCPs) or Lead Communication Practitioners (LCPs). KCPs and LCPs cascade their training to all the staff they work with in a setting and therefore aim to develop the knowledge and skills of a wider range of staff across early years settings.

An independent evaluation of the Talking Matters programme was carried out in 2017 and involved 400 trained practitioners. The overall aim of the evaluation was to determine the impact of the Talking Matters programme on the receptive and expressive language abilities of young pre-school children. Evaluation shows that children in early years settings who received the programme made more progress in their receptive and expressive language abilities when compared to children in settings who did not receive the programme. Settings receiving the KCP programme made more progress than those receiving the LCP programme. Although the progress in language abilities is modest, they are identifiable when compared to a control group. Statistical analysis showed that although the progress in the KCP and LCP groups was not significant for receptive and expressive language, it was significant for the total language raw score. When the KCP and LCP groups were combined, the progress in this combined intervention group approached statistical significance for receptive and expressive language whereas it did not in the control group. On the total language raw score, the increase in the combined intervention group was significant whereas it was not in the control group (Clegg & Rohde 2017).

The independent evaluation shows that the Talking Matters programme does make a positive impact on the receptive and expressive language abilities of young children across a range of early years settings. The findings indicate that the KCP model of delivery may be

more effective than the LCP model of delivery. The Talking Matters programme makes a statistically significant impact on practitioners' knowledge of and confidence in supporting children's speech, language and communication (Clegg & Rohde 2017).

Home Talk

The Children's Centre Service in Nottinghamshire provides the Home Talk programme which aims to improve speech, language and communication. This was developed by Speech and Language Therapists within the service and is delivered by trained 'Home Talk' workers who provide support to parents and children in their own homes through 6 hour long home visits across 6 to 10 weeks. The programme targets children aged 2- 2½.

In 2017, the service carried out evaluation (McDonald et al 2017) to review the impact of Nottinghamshire's Home Talk programme and found the following

- Home Talk leads to accelerated language development for many children in the targeted group of 2 year olds with moderate to severe expressive language delay who do not meet criteria for local SLT services;
- For some children, Home Talk leads to early identification of wider speech, language and communication needs (SLCNs) which had not previously been identified;
- Home Talk leads to early referral for further specialist Speech and Language Therapy support for those who need it and who otherwise may not have been identified and supported until they enter education;
- Home Talk successfully reaches children from Sure Start Children's Centre focused areas who, as a group, are at higher risk of not accessing early SLT services, and are therefore at long-term risk of persistent SLCNs and low school readiness;
- A small number of children had made accelerated progress with spoken language skills after being referred to Home Talk and before starting to take part in the service. Home Talk was adapted for this group to focus on ways to expand children's use of short sentences to help them reach their potential;
- We saw no short-term impact on the spoken language skills of children with wider and more severe SLCNs, who are not the target group for this service. Home Talk was adapted for this group of children to focus on realistic short-term therapy goals to teach parents new strategies and skills. The service was successful in achieving these goals for parents, and referring children on to the appropriate specialist SLT service.

This evaluation used multiple baseline assessments (twice before they started Home Talk and again after they finished the programme. 24 families consented to take part, 23 completed the first baseline assessment and 17 completed the second baseline assessment. Three families declined Home Talk after the second baseline assessment as they felt it was no longer needed, and one postponed starting the service due to illness, so were not included in this study. The findings should be used with caution as there was no control group, numbers were small and the evaluation was not independent.

Strengthening Families, Strengthening Communities (SFSC)

Strengthening Families, Strengthening Communities (SFSC) is an inclusive evidence-based parenting programme, designed to promote protective factors which are associated with good parenting and better outcomes for children. SFSC is a universal group-based

programme, and there are usually 8-12 parents in the group. The programme is delivered by two trained facilitators. The programme lasts for 13 weeks and include weekly sessions lasting 3 hours.

The SFSC model is designed to support parents to understand how children and young peoples' behaviour is impacted by age, developmental stage, health and emotional well-being; to be aware of the range of strategies that they can utilise and understand how and when to use them; to build better relationships with their children; put appropriate boundaries in place; and support their children to avoid or decrease risk taking behaviour.

The Race Equality Foundation who developed the programme commissioned a number of reports to evidence impact, however no independent RCT has taken place as yet. Wilding and Mark 2009 used pre and post questionnaires with 897 parents identified that the course increased in family activities and discussions; increased the use of positive discipline and communication strategies; a decrease in the use of negative discipline and communication strategies; an increase in the participants competence; and an increase in the children's competence. The findings however did not clarify if there were differences for parents with preschool children and parents of older children.

Karlsen (2013) looked at a sample of 1,843 parents and highlighted the diversity of the parents who completed the SFSC course. They included low income families, fathers, lone parents and Black Minority Ethnic Groups.

Lynsday et al (2008) found that there were substantial improvements in parenting behaviour, parental mental well-being and reported behaviour of the child about whom the parent had most concern for displaying or being at risk of anti-social behaviour. Significant improvements were found for parenting skills and mental well-being following participation with moderate to large effect sizes. Reported child behaviour also improved: conduct problems and SDQ total difficulties both reduced, although average effect sizes across programmes were lower than for the parenting measures. Other aspects of child behaviour, for example emotional symptoms and hyperactivity, showed less improvement, as expected, since these are not the main target of the programmes.

The most recent evaluation for SFSC was carried out by Professor Yvonne Kelly (2018), and looked at the impact of SFSC on health and care outcomes for children and young people at risk of experiencing violence. Evaluation identified significant impact on child and adult mental wellbeing, including a significant change in parental sleep.

Appendix 3:

Glossary

ACES	Adverse Childhood Experiences
ADHD	Attention Deficit Hyperactivity Disorder
BME	Black Minority Ethnic Groups
CC	Children's Centre
DAF	Disability Access Fund
DfE	Department for Education
DH	Department for Health
NCC	Nottinghamshire County Council
ECS	Early Childhood Services
EIF	Early Intervention Foundation
EY	Early Years
EYFS	Early Years Foundation Stage
EYFSP	Early Years Foundation Stage Profile
EYPP	Early Years Pupil Premium
FIS	Families Information Service
FSM	Free School Meals
ICELS	Integrated Children's Equipment Store
IDACI	Income Deprivation Affecting Children Index
LA	Local Authority
ONS	Office of National Statistics
PHE	Public Health England
PVI	Private Voluntary and Independent
RCSLT	Royal College of Speech and Language Therapists
RCT	Randomised Control Trial
SENCO	Special Educational Needs Co-ordinator
SEND	Special Educational Needs and Disabilities
SIDS	Sudden Infant Death Syndrome
TOPSE	Tool to Measure Parenting Self-Efficacy

Nottinghamshire County Council

Report to the Health & Wellbeing Board

6 November 2019

Agenda Item:8

REPORT OF THE CORPORATE DIRECTOR FOR ADULT SOCIAL CARE & HEALTH

RETROSPECTIVE APPROVAL OF THE 2019-20 BETTER CARE FUND (BCF) PLANNING TEMPLATE SUBMISSION

Purpose of the Report

1. In accordance with the approved recommendations within the Better Care Fund Report to the Board on 4 September 2019, this report requests that the Health & Wellbeing Board:

    - Approve the Nottinghamshire 2019-20 Better Care Fund planning template that was submitted to NHS England on 27 September 2019.

Information

2. The national 2019-20 Better Care Fund planning template was delayed during the recent period of government transition and was not available to be approved by the Health & Wellbeing Board prior to the required submission date of 27 September 2019 to NHS England.

3. On 4 September 2019, the Health & Wellbeing Board approved a process of retrospective approval for the planning submission.

4. Led by Paul Johnson (Service Director: Strategic Commissioning & Integration), all local Better Care Fund partners contributed to the completion of the 2019-20 planning template. The completed plan was agreed by all partners prior to submission, namely:
    - Councillor Steve Vickers (Chair of the Health & Wellbeing Board)
    - Melanie Brooks (Corporate Director: Adult Social Care & Health)
    - Amanda Sullivan (Nottingham & Nottinghamshire CCGs Accountable Officer)
    - Idris Griffiths (Bassetlaw CCG Accountable Officer)

5. Subsequently the Nottinghamshire Plan was approved by the Regional Assurance Panel on 8 October 2019 and passed to the national team for final approval.

6. The Nottinghamshire 2019-20 Better Care Fund planning template submission is shown in full at Appendix 1.

Other options considered

7. None.

Reasons for Recommendation

8. To ensure the Health & Wellbeing Board has oversight of the Better Care Fund and can discharge its national obligations.

Statutory and Policy Implications

9. This report has been compiled after consideration of implications in respect of crime and disorder, finance, human resources, human rights, the NHS Constitution (Public Health only), 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.

Financial Implications

10. The 2019-20 Better Care Fund pooled budget has been agreed as £92,221,595 after inflation and is summarized in Appendix 1.

Human Resources Implications

11. There are no Human Resources implications contained within the content of this report.

Legal Implications

12. The Care Act facilitates the establishment of the Better Care Fund by providing a mechanism to make the sharing of NHS funding with local authorities mandatory. The wider powers to use Health Act flexibilities to pool funds, share information and staff are unaffected.

RECOMMENDATION

That the Health & Wellbeing Board:

1) Approve the Nottinghamshire 2019-20 Better Care Fund planning template that was submitted to NHS England on 27 September 2019.

Melanie Brooks
Corporate Director: Adult Social Care & Health

For any enquiries about this report please contact:
Paul Brandreth
Better Care Fund Programme Coordinator
Email: paul.brandreth@nottscc.gov.uk
Telephone: 0115 977 3856

Constitutional Comments (LW 22/10/2019)

13. Health and Wellbeing Board is the appropriate body to consider the content of the report.

Financial Comments (DG 22/10/2019)

14. The 2019-20 Better Care Fund pooled budget has been agreed as £92,221,595 after inflation and is summarized in Appendix 1.

Background Papers and Published Documents

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.

- 2018-19 Progress Update and Approval for the Use of the BCF Care Act Allocation (Recurrent and Reserve), the Improved BCF, and the Winter Pressures Grant 2019-20 – report to Health & Wellbeing Board on 6 March 2019
- 2019-20 Better Care Fund Policy Framework, Department of Health & Social Care, 10 April 2019
- Quarterly reporting from Local Authorities to the Department of Health & Social Care in relation to the Better Care Fund, Quarter 4 Return – 18 April 2019
- 2018-19 Better Care Fund Performance – report to Health & Wellbeing Board on 5 June 2019
- Better Care Fund Planning Requirements for 2019-20, Department of Health & Social Care, Ministry of Housing, Communities & Local Government, and NHS England, 18 July 2019
- 2019-20 First Quarter Better Care Fund Performance and Programme Update – report to Health & Wellbeing Board on 4 September 2019

Electoral Division(s) and Member(s) Affected

- All.

APPENDIX 1

Better Care Fund 2019/20 Template

Department of Health & Social Care

Ministry of Housing, Communities & Local Government

NHS

2. Cover

Version 1.2

Health and Wellbeing Board:	Nottinghamshire
Completed by:	Paul Brandreth
E-mail:	paul.brandreth@nottscc.gov.uk
Contact number:	0115 97 73856 or 07384 236 169
Who signed off the report on behalf of the Health and Wellbeing Board:	Melanie Brooks

Will the HWB sign-off the plan after the submission date?	Yes
If yes, please indicate the date when the HWB meeting is scheduled:	06/11/2019

	Role:	Professional Title (where applicable)	First-name:	Surname:
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Councillor	Steve	Vickers
	Clinical Commissioning Group Accountable Officer (Lead)		Amanda	Sullivan
	Additional Clinical Commissioning Group(s) Accountable Officers		Idris	Griffiths
	Local Authority Chief Executive		Anthony	May
	Local Authority Director of Adult Social Services (or equivalent)		Melanie	Brooks
	Better Care Fund Lead Official		Melanie	Brooks
	LA Section 151 Officer		Nigel	Stevenson
Please add further area contacts that you would wish to be included in official correspondence -->				

**Only those identified will be addressed in official correspondence (such as approval letters). Please ensure all individuals are satisfied with the information entered above as this is exactly how they will appear in correspondence.*

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercaresupport@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'

Complete

	Complete:
2. Cover	Yes
4. Strategic Narrative	Yes
5. Income	Yes
6. Expenditure	Yes
7. HICM	Yes
8. Metrics	Yes
9. Planning Requirements	Yes

[<< Link to the Guidance sheet]

Checklist

2. Cover

^^ Link back to top

	Cell Reference	Checker
Health & Wellbeing Board	D13	Yes
Completed by:	D15	Yes
E-mail:	D17	Yes
Contact number:	D19	Yes
Who signed off the report on behalf of the Health and Wellbeing Board:	D21	Yes
Will the HWB sign-off the plan after the submission date?	D23	Yes
If yes, please indicate the date when the HWB meeting is scheduled:	D24	Yes
Area Assurance Contact Details - Role:	C27 : C36	Yes
Area Assurance Contact Details - First name:	F27 : F36	Yes
Area Assurance Contact Details - Surname:	G27 : G36	Yes
Area Assurance Contact Details - E-mail:	H27 : H36	Yes

Sheet Complete	Yes

4. Strategic Narrative

^^ Link back to top

Cell Reference	Checker

A) Person-centred outcomes:	B20	Yes
B) (i) Your approach to integrated services at HWB level (and neighbourhood where applicable):	B31	Yes
B) (ii) Your approach to integration with wider services (e.g. Housing):	B37	Yes
C) System level alignment:	B44	Yes

Sheet Complete	Yes

5. Income

^^ Link back to top

	Cell Reference	Checker
Are any additional LA Contributions being made in 2019/20?	C39	Yes
Additional Local Authority	B42 : B44	Yes
Additional LA Contribution	C42 : C44	Yes
Additional LA Contribution Narrative	D42 : D44	Yes
Are any additional CCG Contributions being made in 2019/20?	C59	Yes
Additional CCGs	B62 : B71	Yes
Additional CCG Contribution	C62 : C71	Yes
Additional CCG Contribution Narrative	D62 : D71	Yes

Sheet Complete	Yes

6. Expenditure

^^ Link back to top

	Cell Reference	Checker
Scheme ID:	B22 : B271	Yes
Scheme Name:	C22 : C271	Yes
Brief Description of Scheme:	D22 : D271	Yes
Scheme Type:	E22 : E271	Yes
Sub Types:	F22 : F271	Yes
Specify if scheme type is Other:	G22 : G271	Yes
Planned Output:	H22 : H271	Yes
Planned Output Unit Estimate:	I22 : I271	Yes
Impact: Non-Elective Admissions:	J22 : J271	Yes
Impact: Delayed Transfers of Care:	K22 : K271	Yes
Impact: Residential Admissions:	L22 : L271	Yes

Impact: Reablement:	M22 : M271	Yes
Area of Spend:	N22 : N271	Yes
Specify if area of spend is Other:	O22 : O271	Yes
Commissioner:	P22 : P271	Yes
Joint Commissioner %:	Q22 : Q271	Yes
Provider:	S22 : S271	Yes
Source of Funding:	T22 : T271	Yes
Expenditure:	U22 : U271	Yes
New/Existing Scheme:	V22 : V271	Yes

Sheet Complete	Yes

7. HICM

^^ Link back to top

	Cell Reference	Checker
Priorities for embedding elements of the HCIM for Managing Transfers of Care locally:	B11	Yes
Chg 1) Early discharge planning - Current Level:	D15	Yes
Chg 2) Systems to monitor patient flow - Current Level:	D16	Yes
Chg 3) Multi-disciplinary/Multi-agency discharge teams - Current Level:	D17	Yes
Chg 4) Home first / discharge to assess - Current Level:	D18	Yes
Chg 5) Seven-day service - Current Level:	D19	Yes
Chg 6) Trusted assessors - Current Level:	D20	Yes
Chg 7) Focus on choice - Current Level:	D21	Yes
Chg 8) Enhancing health in care homes - Current Level:	D22	Yes
Chg 1) Early discharge planning - Planned Level:	E15	Yes
Chg 2) Systems to monitor patient flow - Planned Level:	E16	Yes
Chg 3) Multi-disciplinary/Multi-agency discharge teams - Planned Level:	E17	Yes
Chg 4) Home first / discharge to assess - Planned Level:	E18	Yes
Chg 5) Seven-day service - Planned Level:	E19	Yes
Chg 6) Trusted assessors - Planned Level:	E20	Yes
Chg 7) Focus on choice - Planned Level:	E21	Yes
Chg 8) Enhancing health in care homes - Planned Level:	E22	Yes
Chg 1) Early discharge planning - Reasons:	F15	Yes
Chg 2) Systems to monitor patient flow - Reasons:	F16	Yes

Chg 3) Multi-disciplinary/Multi-agency discharge teams - Reasons:	F17	Yes
Chg 4) Home first / discharge to assess - Reasons:	F18	Yes
Chg 5) Seven-day service - Reasons:	F19	Yes
Chg 6) Trusted assessors - Reasons:	F20	Yes
Chg 7) Focus on choice - Reasons:	F21	Yes
Chg 8) Enhancing health in care homes - Reasons:	F22	Yes

Sheet Complete	Yes

8. Metrics

^^ Link back to top

	Cell Reference	Checker
Non-Elective Admissions: Overview Narrative:	E10	Yes
Delayed Transfers of Care: Overview Narrative:	E17	Yes
Residential Admissions Numerator:	F27	Yes
Residential Admissions: Overview Narrative:	G26	Yes
Reablement Numerator:	F39	Yes
Reablement Denominator:	F40	Yes
Reablement: Overview Narrative:	G38	Yes

Sheet Complete	Yes

9. Planning Requirements

^^ Link back to top

	Cell Reference	Checker
PR1: NC1: Jointly agreed plan - Plan to Meet	F8	Yes
PR2: NC1: Jointly agreed plan - Plan to Meet	F9	Yes
PR3: NC1: Jointly agreed plan - Plan to Meet	F10	Yes
PR4: NC2: Social Care Maintenance - Plan to Meet	F11	Yes
PR5: NC3: NHS commissioned Out of Hospital Services - Plan to Meet	F12	Yes
PR6: NC4: Implementation of the HICM for Managing Transfers of Care - Plan to Meet	F13	Yes
PR7: Agreed expenditure plan for all elements of the BCF - Plan to Meet	F14	Yes
PR8: Agreed expenditure plan for all elements of the BCF - Plan to Meet	F15	Yes
PR9: Metrics - Plan to Meet	F16	Yes
PR1: NC1: Jointly agreed plan - Actions in place if not	H8	Yes

PR2: NC1: Jointly agreed plan - Actions in place if not	H9	Yes
PR3: NC1: Jointly agreed plan - Actions in place if not	H10	Yes
PR4: NC2: Social Care Maintenance - Actions in place if not	H11	Yes
PR5: NC3: NHS commissioned Out of Hospital Services - Actions in place if not	H12	Yes
PR6: NC4: Implementation of the HICM for Managing Transfers of Care - Actions in place if not	H13	Yes
PR7: Agreed expenditure plan for all elements of the BCF - Actions in place if not	H14	Yes
PR8: Agreed expenditure plan for all elements of the BCF - Actions in place if not	H15	Yes
PR9: Metrics - Actions in place if not	H16	Yes
PR1: NC1: Jointly agreed plan - Timeframe if not met	I8	Yes
PR2: NC1: Jointly agreed plan - Timeframe if not met	I9	Yes
PR3: NC1: Jointly agreed plan - Timeframe if not met	I10	Yes
PR4: NC2: Social Care Maintenance - Timeframe if not met	I11	Yes
PR5: NC3: NHS commissioned Out of Hospital Services - Timeframe if not met	I12	Yes
PR6: NC4: Implementation of the HICM for Managing Transfers of Care - Timeframe if not met	I13	Yes
PR7: Agreed expenditure plan for all elements of the BCF - Timeframe if not met	I14	Yes
PR8: Agreed expenditure plan for all elements of the BCF - Timeframe if not met	I15	Yes
PR9: Metrics - Timeframe if not met	I16	Yes

Sheet Complete	Yes

Better Care Fund 2019/20 Template

3. Summary

Selected Health and Wellbeing Board: Nottinghamshire

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£6,950,696	£6,950,696	£0
Minimum CCG Contribution	£55,259,670	£55,259,670	£0
iBCF	£26,484,159	£26,484,159	£0
Winter Pressures Grant	£3,527,070	£3,527,070	£0
Additional LA Contribution	£0	£0	£0
Additional CCG Contribution	£0	£0	£0
Total	£92,221,595	£92,221,595	£0

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum CCG allocation

Minimum required spend	£15,703,231
Planned spend	£31,629,156

Adult Social Care services spend from the minimum CCG allocations

Minimum required spend	£21,452,018
Planned spend	£21,452,018

Scheme Types

Assistive Technologies and Equipment	£20,000
Care Act Implementation Related Duties	£2,168,668
Carers Services	£1,809,777
Community Based Schemes	£12,869,371
DFG Related Schemes	£6,950,696
Enablers for Integration	£0
HICM for Managing Transfer of Care	£1,068,319
Home Care or Domiciliary Care	£0
Housing Related Schemes	£0
Integrated Care Planning and Navigation	£17,833,000
Intermediate Care Services	£750,125
Personalised Budgeting and Commissioning	£0
Personalised Care at Home	£0
Prevention / Early Intervention	£0
Residential Placements	£0
Other	£48,751,639
Total	£92,221,595

HICM >>

		Planned level of maturity for 2019/2020
Chg 1	**Early discharge planning**	Established

Chg 2	**Systems to monitor patient flow**	Established
Chg 3	**Multi-disciplinary/Multi-agency discharge teams**	Established
Chg 4	**Home first / discharge to assess**	Established
Chg 5	**Seven-day service**	Established
Chg 6	**Trusted assessors**	Established
Chg 7	**Focus on choice**	Established
Chg 8	**Enhancing health in care homes**	Established

Metrics >>

Non-Elective Admissions
Delayed Transfer of Care

Go to Better Care Exchange >>

Residential Admissions

		19/20 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	554.7701288

Reablement

19/20 Plan

Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	0.829568789

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	**PR1**	Yes
	PR2	Yes
	PR3	Yes
NC2: Social Care Maintenance	**PR4**	Yes
NC3: NHS commissioned Out of Hospital Services	**PR5**	Yes
NC4: Implementation of the High Impact Change Model for Managing Transfers of Care	**PR6**	Yes
Agreed expenditure plan for all elements of the BCF	**PR7**	Yes
	PR8	Yes
Metrics	**PR9**	Yes

Better Care Fund 2019/20 Template

4. Strategic Narrative

Selected Health and Wellbeing Board:	Nottinghamshire

Please outline your approach towards integration of health & social care:

When providing your responses to the below sections, please highlight any learning from the previous planning round (2017-2019) and cover any priorities for reducing health inequalities under the Equality Act 2010.

Please note that there are 4 responses required below, for questions: A), B(i), B(ii) and C)

Link to B) (i)
Link to B) (ii)
Link to C)

A) Person-centred outcomes Your approach to integrating care around the person, this may include (but is not limited to):	
- Prevention and self-care - Promoting choice and independence	
Remaining Word Limit:	609

The Nottingham and Nottinghamshire Integrated Care System is one of the national 'accelerator' sites. It covers six CCGs, and a unitary and two-tier local government structure with a city council, and a county council with seven district councils. There are also two well established Health and Wellbeing Boards – city and county. Across Nottinghamshire there are 3 planning systems; Integrated Care System (ICS), Integrated Care Partnership (ICP) and organisational level. ICS Leadership of the Universal Personalised Care programme is driving a collaborative approach across health, social care, district/borough Council and voluntary sector to commit to integrated teamwork and person-centred care, which underpins a shared commitment to Home First approaches, Services supporting discharge are planned jointly and multi-disciplinary assessments are undertaken outside of hospital. Helping people to help themselves; helping people when they need it and resolving issues at the earliest point; maximising peoples independence are all key attributes.

Targeting resources to help avoid admissions or minimise the length of stay respects the wishes of citizens to receive care and support as close to home as possible. The relentless focus on delayed transfer of care is supported by collaborative operational and strategic approaches.

A therapy led approach is adopted; Social care Occupational Therapy staff are working with hospital OT staff sharing knowledge to reduce length of stay. Sustaining people within their homes is supported by the supply of aids and adaptations, assistive technology and where necessary adaptations to housing funded by a Disabled Facilities Grant.

Led by the Health & Wellbeing boards and guided by the production of Joint Strategic Needs Assessments, there is a shared understanding at system level of the wider determinants of health. Constructive conversations are held with all partners to maximise the resources to address inequalities. Deprivation is a strong driver of illness and poor levels of health and it is recognised that across the ICS deprivation varies dramatically, increasingly place-based approach is being deployed to address inequalities and to maximise the strengths and assets of the community. Primary Care Networks (PCNs) and the Integrated Care Partnership (ICP) are a new driving force for integration of care. A social prescribing and community connectivity group on an ICP & HWB footprint has been developed to drive the objectives of the ICS strategy. The group's focus is on the following key elements of the promotion of self-care and independence:

- Community development – development of locally accessible forums for community leaders and local citizens/'patients' to meet with public service providers and local businesses, sports, cultural, spiritual and retailers on a regular basis to build more confident, capable and inclusive communities
- Community asset mapping – directory of local resources and build on these existing assets so that individuals can be signposted /supported to access appropriate activities, groups, facilities to achieve their goals within their own localities.
- Social prescribing/Link Worker implementation – development and support for the introduction of the Primary Care Networks (PCNs) Link Worker workforce and integration with existing social prescribing services.

Social prescribing approaches, utilising link workers will be supported and supplemented by the various services commissioned by the local authorities. Better community connectiveness for people facing isolation is a priority. Providing the right provision without recourse to formal assessments requires a shared and aligned approach. The use of digital apps is being explored to offer greater choice for managing ones needs. This will help reduce demand for limited resources, including A &E attendance. Collaboration is also evident with a revised carers strategy and the development of a newly commissioned carers hub.

The number of Personal Health Budgets has increased to over 1,800. Completion of each of these adds to the shared skill base of health and social care staff identifying "what matters" to people and devising self-directed care plans. Front line staff are piloting joined up assessments and the learning from the Integrated Care Teams and Integrated Accelerator Pilot is being rolled out. Discussions are underway to enable staff in the Newark and Sherwood District to hot-desk in shared venues in Newark and Ollerton, in order to increase opportunities for information sharing and advice. Further roll out of integrated approaches beyond older adults' services is planned with the Physical Disabilities team covering Mansfield and Ashfield. This will explore how best to engage with the Integrated Care Team and the monthly GP multi-disciplinary meetings for citizens with complex health and social care needs.

Frontline staff have also been equipped with person centred tools to help them have healthy conversations with people. A guide to make the most of conversations has been drafted and will be used by the multi-disciplinary teams. The final version will be made widely available within Notts Help Yourself (the website for citizens support and advice).

Within the ICS systems there is a commitment to engagement and co-production. Experts with lived experience are bringing their knowledge in a wide variety of planning and operational situations. They have developed a key element of the quality audit process for homebased care and are actively involved with its implementation. Within the Bassetlaw ICP the commitment to embracing a wide and inclusive partnership is exemplified by the local CVS chairing the Board. The Bassetlaw Place Plan is well embedded and is based on supporting people to self-manage their care to the maximum of their ability, and that of their carers.

B) HWB level

(i) Your approach to integrated services at HWB level (and neighbourhood where applicable), this may include (but is not limited to):	
- Joint commissioning arrangements - Alignment with primary care services (including PCNs (Primary Care Networks)) - Alignment of services and the approach to partnership with the VCS (Voluntary and Community Sector)	^^ Li
Remaining Word Limit:	203

Nottinghamshire has three Integrated Care Partnerships (ICP).; South County, Mid-Nottinghamshire and Bassetlaw ICP. All three ICPs will bring together health and care providers and local commissioners to work together to improve services for their population, and to make sure that they are sustainable.

The commitment to a consistent population health management approach will build on the existing Primary Care Networks, made up of GP practices and community teams. They will identify care gaps and utilise evidence-based interventions. The next phase will involve joint prioritisation of resources, to avoid the duplication of commissioned services. This will also enable the proportionate targeting of resources to reduce health inequalities where this is evidenced based.

A system-wide care navigation model to access urgent clinical assessment to avoid hospitalisation will be developed, using the learning from the 'Call for Care' provision used in Bassetlaw will be supplemented by learning from another part of the system namely the utilisation of social care and health data and predictive analytics in use in mid-Notts.

A joint strategic commissioning programme is underway to develop alternative services that have an evidence base for reducing the use of residential care. This includes Housing with Care, Short-term assessment and reablement apartments and Assistive Technology.

Since the publication of Nottinghamshire's BCF Plan for 2017/19, the lessons learnt include:

- A review of current services in 2018/19 identified an over-reliance on a large community bed base to provide Intermediate Care and Reablement. The development of a new integrated service across health and social care which will rationalise the current 7 pathways into Intermediate Care and Reablement support services, to 3 core integrated pathways, thus improving patient/service user outcomes.

- The development of the Integrated Discharge Team (IDT) and an integrated MDT approach to discharge planning has consistently reduced DTOC levels. The monitoring of DTOCs now forms part of a system escalation processes. In order to embed the change and continue to reduce DTOCS, we are reviewing the IDT, with the aim of implementing a fully funded 7-day service in 2019/20.

- The OT and community sector workers in the First Point of Contact Team, and the closer working relationships between the Care Co-ordination Centre and Integrated Rapid Response Service, shows that integration and alignment has clear benefits to customers/patients and to staff who become more knowledgeable of the wider health and social offer.

- Optimising the opportunities for ICT interoperability to improve patient experience across the whole system. We are now at the vanguard of this nationally, supported by the County Council using BCF, in harmony with Connected Nottinghamshire.

Increasingly there is an appetite to align market management and market development activity. Joint audits using the skill set of healthcare and social care staff are routinely undertaken. Training for care home staff is delivered by one of the NHS providers ensuring a minimum of 85% are trained on the seven key warning signs that leads to patient deterioration.

The joint commissioning partnership, Integrated Community Equipment Loans service, (ICELs) provides a highly effective and timely response to discharge patients. The service is available 7 days per week and often provides same day provision to expedite the speediest return home. The partnership harnesses the expertise of the British Red Cross as the delivery agent. Other services have been commissioned to provide 7-day rapid response, including night time support.

Advocacy is commissioned jointly and delivers the statutory requirements for health and social care, there are opportunities to maximise the use of advocacy to ensure people in marginalised groups are supported and able to access health and social care with equity.

(ii) Your approach to integration with wider services (e.g. Housing), this should include:	
- Your approach to using the DFG to support the housing needs of people with disabilities or care needs. This should include any arrangements for strategic planning for the use of adaptations and technologies to support independent living in line with the (Regulatory Reform Order 2002)	^^ Li
Remaining Word Limit:	483

There is a renewed commitment from all statutory partners to maximise the use of the DFG and the use of technology enabled care. Chief Executive Officers of the District Councils and the Corporate Director of Adult Social Care have met and agreed principles for the transformation of the DFG.

A review of the current process was commissioned from consultants ARK and a detailed action plan is being developed. The challenges of aligning the policies and procurement practice across 7 Districts will be tackled, with the shared objective of maximising the independence of citizens. This will extend to the provision of Assistive Technology.

Every partner recognises that Assistive Technology will be a major enabler for delivering more choice and control for citizens, with less interventions. This approach will be supported by a key strategic partner, Connected Nottinghamshire. They are tasked with delivering transformation across the health and care system, including collaboration with IT and digital solutions. Their work provides more effective and efficient services.

Nottinghamshire County Council has developed a Housing Strategy for younger adults and a Strategy for Housing with Care, previously referred to as "Extra care". These strategies are based on detailed needs analysis and have been created in close collaboration with partners and by co-production.

For working age adults with care needs the emphasis is to only provide housing with support (commissioned by the Council) where it is really needed and to try and maximise peoples' abilities to live in general needs housing. A review of all existing supported living is underway and at each property the potential use of Assistive Technology is considered.

For Older adults the approach is to develop a range of housing options, some of which are commissioned as Housing with Care. Projects are coming on stream, with more planned. Technology is of course maximised and embedded in all new schemes.

C) System level alignment, for example this may include (but is not limited to):	
- How the BCF plan and other plans align to the wider integration landscape, such as STP/ICS plans - A brief description of joint governance arrangements for the BCF plan	^^ Li
Remaining Word Limit:	930

In Nottinghamshire there are two Integrated Care Systems that cover the same footprint as the local authority. Nottinghamshire ICs and South Yorkshire and Bassetlaw ICS.

The ICSs are the vehicles for delivering integration across primary and specialist care, physical and mental health and social care. The systems provide strong local leadership and seek to implement population health management approaches, whilst tackling the systemic challenges that face health and social care. There are three Integrated Care Partnerships accountable to the ICSs. (The Nottinghamshire ICS has an additional ICP coterminous with Nottingham City). It makes for a complex set of relationships, especially for agencies and partners that have cross cutting relationships e.g. EMAS, Nottingham University Hospital.

The strength of the Nottinghamshire Health and Well Being Board (HWB) is that it is uniquely aligned to the boundaries of the County Council and all the Districts and Boroughs. As a statutory body it has governance at member and Chief Executive Officer level. The HMB provides oversight and scrutiny for all planning and expenditure with respect to the BCF. It is chaired by a lead member from the County Council with a GP as deputy chair. The population health approach is supported by the substantial input from Public Health.

The BCF steering group, which reports to the HWB is constituted from all the statutory partners and develops the detailed planning and programme management. There exists a strong commitment from all partners to ensure the BCF conditions are met and that quality is professionally evaluated.

The principles and purpose of the BCF are complementary to the priorities across the ICSs. Activity to: reduce length of stay in hospital; to promote preventative and reabling services; to support the care providers and ensure sustainability of provision; promote personalised care; use of digital, ICT and assistive technology are all examples of completely aligned objectives.

The HWB receives and signs off JSNAs and this year they also approved the Market Position Statement. All relevant key strategies are presented to partners such as the Housing with Care, Housing with Support, Digital, Autism Strategy. The Board and the BCF steering group are therefore able to oversee implementation plans that impact on processes such as patient flows, discharge planning, use of DFGs, long term care admission. Individual schemes and changes to services will undertake Equality Impact Assessments to understand any potential positive or negative impact on people from protected characteristics groups and also to assess the potential impact on health inequalities. All partners have a stake in aligned these pathways for citizens. By sharing commissioning activity the challenges presented by delayed transfers of care, lack of supply in the market, workforce deficits can be tackled more successfully, with better outcomes. An area that we are continuing to develop and learn about, across the whole system, is interoperability. We are constantly striving to be best in class in delivering integrated systems that have tangible benefits for citizens for example in reduce length of stay in hospital and better experience of assessment processes. We are equipping every GP, every Social Worker and all relevant hospital staff with the means to share records and improve interventions. This is advancing to Predictive Analytics, whereby automated notices for possible support can be generated based on algorithms and risk stratification. This approach is completely consistent with the ambitions of the ICSs.

Better Care Fund 2019/20 Template

5. Income

Selected Health and Wellbeing Board: Nottinghamshire

Local Authority Contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
Nottinghamshire	£6,950,696
DFG breakerdown for two-tier areas only (where applicable)	
Ashfield	£922,788
Bassetlaw	£1,167,487
Broxtowe	£867,198
Gedling	£1,048,082
Mansfield	£1,256,409
Newark and Sherwood	£1,021,695
Rushcliffe	£667,037
Total Minimum LA Contribution (exc iBCF)	**£6,950,696**

iBCF Contribution	Contribution
Nottinghamshire	£26,484,159
Total iBCF Contribution	**£26,484,159**

Winter Pressures Grant	Contribution
Nottinghamshire	£3,527,070
Total Winter Pressures Grant Contribution	**£3,527,070**

Are any additional LA Contributions being made in 2019/20? If yes, please detail below	No

Local Authority Additional Contribution	Contribution	Comments - please use this box clarify any specific uses or sources of funding
Total Additional Local Authority Contribution	**£0**	

CCG Minimum Contribution	Contribution
NHS Mansfield and Ashfield CCG	£13,850,112
NHS Nottingham North and East CCG	£9,991,378
NHS Newark and Sherwood CCG	£8,844,060
NHS Bassetlaw CCG	£8,180,652
NHS Rushcliffe CCG	£7,717,620
NHS Nottingham West CCG	£6,675,848
Total Minimum CCG Contribution	**£55,259,670**

Are any additional CCG Contributions being made in 2019/20? If yes, please detail below	No

Additional CCG Contribution	Contribution	Comments - please use this box clarify any specific uses or sources of funding
Total Addition CCG Contribution	**£0**	
Total CCG Contribution	**£55,259,670**	

	2019/20
Total BCF Pooled Budget	**£92,221,595**

Funding Contributions Comments Optional for any useful detail e.g. Carry over

Better Care Fund 2019/20 Template

6. Expenditure

Selected Health and Wellbeing Board: Nottinghamshire

<< Link to summary sheet

Running Balances	Income	Expenditure	Balance
DFG	£6,950,696	£6,950,696	£0
Minimum CCG Contribution	£55,259,670	£55,259,670	£0
iBCF	£26,484,159	£26,484,159	£0
Winter Pressures Grant	£3,527,070	£3,527,070	£0
Additional LA Contribution	£0	£0	£0
Additional CCG Contribution	£0	£0	£0
Total	£92,221,595	£92,221,595	**£0**

Required Spend	Minimum Required Spend	Planned Spend	Under Spend
NHS Commissioned Out of Hospital spend from the minimum CCG allocation	£15,703,231	£31,629,156	£0
Adult Social Care services spend from the minimum CCG allocations	£21,452,018	£21,452,018	£0

Link to Scheme Type description

						Planned Outputs		Metric Impact				Expenditure								
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Planned Output Unit	Planned Output Estimate	NEA	DTOC	RES	REA	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Expenditure (£)	New/ Existing Scheme
1	A. Seven Day Working	Seven Day working	Intermediate Care Services	Reablement/Rehabilitation Services		Hours of Care	50,000.0	Low	Low	High	High	Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£750,125	Existing
2	B. Delayed Transfers of Care	Reablement services	Community Based Schemes					Low	High	Medium	Medium	Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£5,734,809	Existing
3	C. Reducing non-elective admissions	Community Based Schemes	Other		Geriatrician input pre & post discharge			High	High	Medium	Medium	Acute		CCG			NHS Acute Provider	Minimum CCG Contribution	£108,045	Existing
3	C. Reducing non-elective admissions	Community Based Schemes	Community Based Schemes					High	Medium	Medium	Medium	Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£1,806,499	Existing
3	C. Reducing non-elective admissions	Community Based Schemes	Community Based Schemes					High	Medium	Medium	Medium	Community Health		CCG			CCG	Minimum CCG Contribution	£972,399	Existing
3	C. Reducing non-elective admissions	Community Based Schemes	Other		Pysychological medicine scheme			High	Low	Low	Low	Mental Health		CCG			CCG	Minimum CCG Contribution	£162,066	Existing
3	C. Reducing non-elective admissions	Community Based Schemes	Community Based Schemes					High	Medium	Medium	Medium	Other	Charity /Voluntary Sector	CCG			CCG	Minimum CCG Contribution	£1,502,897	Existing
3	C. Reducing non-elective admissions	Community Based Schemes	Community Based Schemes					High	Low	Low	Medium	Primary Care		CCG			CCG	Minimum CCG Contribution	£2,745,407	Existing
4	D. Support to social care	Personalised Care at Home	Carers Services	Respite Services				Medium	Medium	Medium	Medium	Other	Carers	CCG			CCG	Minimum CCG Contribution	£273,605	Existing
5	E. Enabling	Other	Other		Enabling			Low	Low	Low	Low	Other	Enabling	CCG			CCG	Minimum CCG Contribution	£434,107	Existing
6	F. Proactive care (community based)	Integrated care teams	Integrated Care Planning and Navigation	Care Planning, Assessment and Review				High	Medium	Not applicable	Not applicable	Community Health		CCG			CCG	Minimum CCG Contribution	£10,938,445	Existing
6	F. Proactive care (community based)	Integrated care teams	Integrated Care Planning and Navigation	Care Planning, Assessment and Review				Medium	Not applicable	Not applicable	Not applicable	Community Health		CCG			CCG	Minimum CCG Contribution	£857,566	Existing
6	F. Proactive care (community based)	Integrated care teams	Integrated Care Planning and Navigation	Care Planning, Assessment and Review				Low	Not applicable	Not applicable	Not applicable	Community Health		CCG			CCG	Minimum CCG Contribution	£122,956	Existing
6	F. Proactive care (hospital based)	Integrated care teams	Integrated Care Planning and Navigation	Care Planning, Assessment and Review				Medium	High	Not applicable	Not applicable	Acute		CCG			CCG	Minimum CCG Contribution	£2,010,556	Existing

7	G. Patient and carer support	Personalised support/ care at home	Community Based Schemes					Low	Not applicable	Not applicable	Not applicable	Community Health		CCG			CCG	Minimum CCG Contribution	£77,360	Existing
7	G. Patient and carer support	Personalised support/ care at home	Carers Services	Respite Services				Medium	Not applicable	Not applicable	Not applicable	Primary Care		CCG			CCG	Minimum CCG Contribution	£180,356	Existing
8	H. Better Together Implementation	Other	Other		Assistive Technology			Medium	Not applicable	Not applicable	Not applicable	Other	Enabling	CCG			CCG	Minimum CCG Contribution	£87,658	Existing
9	I. 7 day access to services	7 day working	HICM for Managing Transfer of Care	Chg 5. Seven-Day Services				Medium	Medium	Medium	Low	Community Health		CCG			CCG	Minimum CCG Contribution	£1,068,319	Existing
10	J. Mental Health Liaison	Integrated care teams	Integrated Care Planning and Navigation	Care Planning, Assessment and Review				High	Low	Low	Low	Mental Health		CCG			CCG	Minimum CCG Contribution	£466,430	Existing
11	K. Discharge / Assessment incl. Intermediate	Integrated care teams	Integrated Care Planning and Navigation	Care Planning, Assessment and Review				Medium	High	Not applicable	Not applicable	Community Health		CCG			CCG	Minimum CCG Contribution	£2,906,603	Existing
11	K. Discharge / Assessment incl. Intermediate	Integrated care teams	Integrated Care Planning and Navigation	Care Planning, Assessment and Review				Medium	High	Not applicable	Not applicable	Mental Health		CCG			CCG	Minimum CCG Contribution	£470,549	Existing
11	K. Discharge / Assessment incl. Intermediate	Integrated care teams	Integrated Care Planning and Navigation	Care Planning, Assessment and Review				Medium	High	Not applicable	Not applicable	Acute		CCG			CCG	Minimum CCG Contribution	£59,895	Existing
12	L. Respite services	Support for carers	Carers Services	Carer Advice and Support				Low	Low	Medium	Medium	Community Health		CCG			CCG	Minimum CCG Contribution	£21,000	Existing
13	M. Improving Care Home quality	Improving healthcare services to care homes	Community Based Schemes					Medium	Medium	Medium	Medium	Other	Care Homes	CCG			CCG	Minimum CCG Contribution	£30,000	Existing
14	N. Telehealth	Assistive Technologies	Assistive Technologies and Equipment	Telecare				Low	Not applicable	Medium	Medium	Community Health		CCG			CCG	Minimum CCG Contribution	£20,000	Existing
15	O. Support for carers	Support for carers	Carers Services	Carer Advice and Support				Low	Low	Medium	Medium	Social Care		LA			Local Authority	Minimum CCG Contribution	£864,816	Existing
15	O. Support for carers	Support for carers	Carers Services	Respite Services				Low	Low	Medium	Medium	Social Care		LA			Local Authority	Minimum CCG Contribution	£470,000	Existing
16	P. Protecting social care	Protecting social care	Other		Protecting social care			Medium	High	High	High	Social Care		LA			Local Authority	Minimum CCG Contribution	£17,948,534	Existing
17	Q. Disabled Facilities Grant	DFG Related Schemes	DFG Related Schemes	Other	Housing			Medium	Medium	Medium	Medium	Other	Housing	LA			Local Authority	DFG	£6,950,696	Existing
18	R. Enabling Care Act statutory responsibilities	Enabling Care Act statutory responsibilities and	Care Act Implementation Related Duties	Other	Enabling Care Act statutory responsibilities			Medium	High	High	High	Social Care		LA			Local Authority	Minimum CCG Contribution	£2,168,668	Existing
19	S. Improved Better Care Fund	Improved Better Care Fund	Other		Improved Better Care Fund			Medium	High	High	High	Social Care		LA			Local Authority	iBCF	£26,484,159	Existing
20	T. Winter Pressure	Winter Pressure	Other		Winter Pressure			Medium	High	High	High	Social Care		LA			Local Authority	Winter Pressures Grant	£3,527,070	Existing

Better Care Fund 2019/20 Template

7. High Impact Change Model

Selected Health and Wellbeing Board:	Nottinghamshire

Explain your priorities for embedding elements of the High Impact Change Model for Managing Transfers of Care locally, including:

- Current performance issues to be addressed
- The changes that you are looking to embed further - including any changes in the context of commitments to reablement and Enhanced Health in Care Homes in the NHS Long-Term Plan
- Anticipated improvements from this work

COUNTYWIDE

The ICS have set up a demand & capacity workstream to bring together operational and ICT colleagues to design ways to share information about capacity and flow. Each system's Surge & Escalation plan details triggers for identifying increased demand and bottlenecks together with actions at each OPEL level. Social care has produced a demand and capacity function which has allowed the system to have sight of available resource.

The NECS Care Home Bed Tracker has been rolled out countywide; this provides new insight about car home bed availability to save time in planning discharges.

SOUTH

Maintaining system flow across Greater Nottingham from the acute Trust into community services continues to be a challenge. As a result, health and social care partners are committed to streamlining the urgent and emergency care hospital discharge planning to support system resilience. As a local health and social care system, it is recognised that the development of a 'Home First' approach to care will support the delivery of high-quality patient care for the population. Local Health and Social Care partners over the last two years have been committed to develop the model of an Integrated Discharge Function (IDF). The IDF is a system wide integrated function that is community led with an overarching aim to ensure that all individuals are timely and effectively discharged or transferred from acute, health and social care settings to improve outcomes for individuals and support efficient flow through the Greater Nottingham services. The principle is patients are proactively managed from the time of admission to discharge to ensure patients do not wait, and their discharge is planned, timely and seamlessly managed between and across all providers. System partners have reviewed the progress made to date and have developed a system transformation plan to tackle key system issues utilising BCF schemes which includes but not limited to:

Leadership:

- Single function incorporating front door, back door, and community hub(s)
- Single leadership/accountability for function regardless of staff employment

• Sustainability plan (permanent workforce)
• Investment in staff development (rotational training)

Process:
• One IDT process across all wards, early decision making, reduction of handoffs including to community, Lean work progressing. Streamline partner processes
• Front door pathway re-mapped to link with acute frailty pathways
• Re-design of community support services such as rehabilitation beds, rehabilitation at home and home care

Performance:
• Rethink development of KPI's including access and time stamping of each part of the process
• System ownership operational group reporting to Home first via Highlight report & performance vigour

As result of this work we have updated our current maturity position for change 1, 3 & 4 with an aspiration of these change areas maturing to established by March 2020.

MID NOTTS

The Home First Integrated Discharge (HFID) work stream has experienced delays in full implementation, so whilst early phases have gone live the project in its entirety and has not. A Head of HFID post has been recruited to create a senior operational lead with responsibility to drive through service improvements and cultural change. There is evidence that patients are not being referred to Social Care early enough, and that there are continuing instances of inappropriate discharge notices – to improve this and other discharge processes embedded at SFHFT a revised Discharge Policy has been approved and is being rolled out across Sherwood Forest Health Trust (SFHT).

The ICS have set up a capacity and flow workstream to bring together operational and ICT colleagues to design ways to share data and intelligence about capacity and flow. Internal bed modelling work has taken place at SFHT to provide a seasonal bed model requirement. The system's Surge & Escalation plan details triggers for identifying increased demand and bottlenecks together with actions for all system partners at each OPEL level. This plan forms part of the mid-Notts system-wide Winter Plan which has been signed off by A&E Delivery Board and has been received by both the ICP and ICS Boards. Social care has produced a demand and capacity function which has allowed the system to have sight of available resource.

Social Care are attending the SFHT discharge hub and the Home First Response Service is in place. The NECS Care Home Bed Tracker which is being embedded at SFHFT and the Trusted Assessor post which is being considered as part of the Intensive Rapid Response Service (IRRS) work stream, will also provide additional insight and support to existing collaborative working nature of the Mid-Notts system.

There continues to be no appetite within local Social Care functions for the utilisation of a single trusted assessment form, or for health to assess on behalf of Social Care, but partners continue to review opportunities to streamline working processes. Some health organisations assess on behalf of other health

organisations e.g. IDAT for CFC and vice versa. On this basis Mid Notts is unlikely to be in a position to commit to achieving Mature or Exemplary. However, it is acknowledged that revised guidance around the HICM criteria will soon be available and this position will be re-considered if the expectations of the indicator change.

Patient Choice is a strong focus within the SFHT discharge policy and operationally, joint conversations take place between Health and Social Care teams when interim care is offered. The recent DToC guidance change to the Social Care categorisation of declined interim placements where homecare provision is not available, will ensure that the relevant organisation is enabled to impact upon these delays. Funding has been agreed to appoint a second Age UK Advocacy worker, who will increase the capacity for patients to have independent support when needed to take discharge actions. Care Home admissions continue to be low as per the target for mid-Nottinghamshire. A sustained portfolio of health services supports this cohort of providers, including the Acute Home Visiting Service, Significant Seven and 111. The 111 service will go live with offering the Call for Care Non-injury Falls Pathway to patients - previously this has only been available to EMAS, which will reduce unwarranted urgent care system activity and offer greater support to care homes. SFHT are part of the Frailty network and a work stream is in place to strategically address frailty from A&E throughout patient flow areas and to amalgamate all projects which will impact on frailty e.g. Clinical Navigators using e-Healthscope in General Practice to identify patients with severe, moderate and rising risks of frailty. Notts Healthcare Trust Proactive Care Homes & NEMs colleagues have undertaken RESPECT training and processes. Bi-monthly meetings between the EoL Head of Service and the CCG Care Homes Lead take place to ensure alignment of work programmes.

The mid-Nottinghamshire A&E Delivery Board has a workplan for 19/20 which incorporates the board's priorities for delivery. The EHCH framework is an indicator within the plan, along with the combined action plan to reduce LoS and DToCs.

BASSETLAW

Bassetlaw health and social care partners are committed to streamlining the urgent and emergency care hospital discharge planning to support system resilience. As a local health and social care system, the development of a 'Home First' approach to care supports the delivery of high quality, patient care for the population. This is recognised in the establishment of a new Bassetlaw task and finish group to review the current Home first pathways to ensure and develop the optimum approach to best serve the local population. There is already an embedded trusted assessor model in place with the hospital Integrated Discharge team but there are plans to extend this approach to the front end of the hospital within the Emergency Department to ensure efficient triage for individuals enabling the right service at the right time in the right place. The principle is patients are proactively managed from the time of initial triage through to admission and on to discharge to ensure patients do not wait, and their discharge is planned, timely and seamlessly managed between and across all providers. System processes are reviewed via 'System Perfect' weeks which enable robust reviews of hospital pathways from admission to discharge, where action plans are formed with all partners to resolve any highlighted key barriers to the patient journey.

- Redesign of Intermediate Care services linked to hospital discharge with a wrap round service providing patients with the right service at the right time in the right place via assessment apartments, home rehabilitation and community rehabilitation beds.

- Redesign of Emergency Department front door hospital services, developing a trusted assessor concept which would include a Frailty assessment linked to joined up Home first approach; to reduce hospital admissions, providing more efficient signposting to alternative services enabling people who present

at the emergency department to self-support.

- Further development of the Interoperability project to increase information sharing between hospital staff from the wards to the integrated discharge team, aiding efficiency in a patient's journey to timely hospital discharge.

		Please enter current position of maturity	Please enter the maturity level planned to be reached by March 2020	If the planned maturity level for 2019/20 is below established, please state reasons behind that?
Chg 1	**Early discharge planning**	Plans in place	Established	
Chg 2	**Systems to monitor patient flow**	Established	Established	
Chg 3	**Multi-disciplinary/Multi-agency discharge teams**	Plans in place	Established	
Chg 4	**Home first / discharge to assess**	Plans in place	Established	
Chg 5	**Seven-day service**	Established	Established	
Chg 6	**Trusted assessors**	Established	Established	
Chg 7	**Focus on choice**	Established	Established	
Chg 8	**Enhancing health in care homes**	Established	Established	

Better Care Fund 2019/20 Template

8. Metrics

Selected Health and Wellbeing Board: Nottinghamshire

8.1 Non-Elective Admissions

	19/20 Plan	Overview Narrative
Total number of specific acute non-elective spells per 100,000 population	**Collection of the NEA metric plans via this template is not required** as the BCF NEA metric plans are based on the NEA CCG Operating plans submitted via SDCS.	SOUTH When constructing the CCG operating plan, Nottingham University Hospitals declared some significant coding and counting changes which resulted in the Trust adding 15,000 additional zero length of stay non-elective spells to reflect the impact of the pathway changes at the A&E front door. These planned substantial increases in activity have yet to materialize and further work is planned to attain a better understanding of whether the lower numbers are due to lower demand, higher achievement against Quality, Innovation, Productivity and Prevention (QIPP) plans, or a lower level of coding and counting changes. Several projects and schemes are in place to assist with admission avoidance. These include care co-ordination which aims to deliver the foundations of a consistent approach to Population Health Management across the Greater Nottingham footprint. This project will build on the existing Primary Care Networks made up of groups of GP practices and community teams to embed a consistent care co-ordination approach to admission avoidance to identify care gaps and utilize evidence-based interventions. Schemes in place include: • Ensuring Network Navigators are fully focused on the identification of potential end-of-life patients as part of the GP Multi-Disciplinary Teams, and • Increasing levels of training for care home staff on the seven key early warning signs that lead to patient deterioration. Ensuring a minimum of 85% are trained in each targeted care home in a shorter timeframe.

		• A scheme focusing on high intensity users is also underway; the aim is to target patients who are frequent attenders to urgent care services. This will focus on three main categories of patients – frailty, long-term conditions, and mental health/alcohol – and will encompass social prescribing, care gap analysis as well as health coaching in some locality areas. MID-NOTTS Work is taking place across both mid-Notts and the Integrated Care System (ICS) to reduce activity at the front door, via the Drivers of Demand work stream, for example via the East Midlands Ambulance Service (EMAS) non-conveyance group, the Proactive Care Homes Service, High Intensity User Service and the Acute Home Visiting service. A focus on frailty continues in 2019/20 and Commissioning Leads are working closely with GP practices to ensure appropriate patients are identified and have care plans in place to reduce the risk of admission to hospital. Conversations are taking place with wider system partners to understand the holistic system response to frailty, for example via NEMS and EMAS. The End of Life service is now live and providing an alternative pathway for ambulance crews. The new IRRS (Integrated Rapid Response Service) will be mobilised in October 2019 and this will target both a reduction in ED attendance and a reduction in non-elective admissions. The mid-Notts CCGs review levels of high activity at individual practice level and manage with practices as appropriate. QIPP schemes are monitored closely and additional schemes are developed where possible. This has included extending the current chronic obstructive pulmonary disease (COPD) scheme to include further groups of patients and a scheme which will proactively manage those at risk of deterioration in care homes ('Significant7'). The mid Notts CCGs are working with ICS colleagues to commission an integrated urgent care pathway in 2019/20 which will include an integrated out of hours and clinical assessment service (CAS). This will ensure that more 111 calls receive clinical assessment, reducing the number of Emergency Department (ED) and ambulance dispositions.

		The A&E Delivery Board has agreed a work plan for 2019/20 which includes the national urgent and emergency care (UEC) deliverables as well as local priorities to manage demand. A seasonal plan has been developed, acknowledging the pressure on system providers all year and learning has been assimilated into this plan from last summer and winter periods. BASSETLAW: The CCG has invested considerably for this year's emergency / unplanned activity both in the hospital and to introduce the Call for Care model for Bassetlaw and to utilize health and social care data/predictive analytics tools already used in Mid and South Nottinghamshire. The CCG will continue to work with all partners to try and minimize the increase in activity.

8.2 Delayed Transfers of Care

	19/20 Plan	Overview Narrative
Delayed Transfers of Care per day (daily delays) from hospital (aged 18+)	39.0	BCF funded hospital-based Social Workers, Integrated Care Teams, integrated patient/service user information systems, Home First and reablement services (START) have all made a positive contribution to reducing or eliminating delays for social care reasons, which are now consistently close to zero and comfortably below target. A&E Delivery Boards have a lead role in managing DToCs for health reasons and Greater Notts are reporting that performance is in line with the NHS target of delays below 3.5% of monthly occupied bed days – which is at odds with the BCF indicator, where DToCs for health reasons are consistently above target. An ongoing issue with monitoring of DToCs is the conflicting method of calculating DToCs between NHSE/I and BCF. The Winter Pressures Grant has been targeted at services at the interface between health and social care and will increase the system's resilience through the seasonal period of increased demand. Areas of deployment include: - Additional OT capacity within reablement services

		- Additional roles within reablement services to help develop service user's independence - Additional SW and CCO capacity within community mental health teams to support earlier discharge planning - Increased numbers of commissioned Home First packages of care to enable timely discharge SOUTH The integrated discharge team at NUH is being re-developed into an integrated discharge function to increase capacity, activity, productivity and flow. This will be completed by winter 2019/20. MID-NOTTS There is now a Sherwood Forest Hospital Trust (SFHT) owned combined Length of Stay (LoS) & DToC action plan in place. This is part of the Accident and Emergency Delivery Board (A&EDB) workplan and the Board has signed-off the plan and will be monitoring progress from now onwards. • The Divisional General Manager for Medicine at SFHT, the Head of Nursing for Medicine and a lead Consultant undertake a Long Stay review of patients every week – this meeting also looks at DToCs and they are now shifting their focus from patients with a stay over 21+ days to 14+ days. • A system review of the SFHT discharge policy has been undertaken with a focus on Home First and addressing some of the blocks previously in place such as issuing 'Letter 1' on day 1 of a family looking for care homes instead of issuing on day 7. • SFHT and CCG colleagues DToC review meetings are in place. • The DToC & LoS action plan is made up of several internal and system-wide improvement work streams which will contribute to the overall improvements. • SFHFT colleagues have identified a new 7-day discharges work stream which will increase discharges during weekend periods, resulting in marginal gains for DToC reductions. • CCG colleagues have met with Notts CC and have undertaken a sit visit to the Notts county-wide equipment provider. Conversations are now taking place to identify how learnings from this visit can be embedded into operational process improvements within HFID. • Revised OPEL escalation triggers for SFHT now

		include DToC levels. . This will ensure that DToCs are aligned to business as usual processes and flow and ensure focus on blockages. • A new senior Home First lead has been appointed to drive the workstream and a dashboard of Key Performance Indicators (which include DToCs) has been created. • Transformation funding has now been received which will provide a discharge route out of the acute trust for non-weight bearing (NWB) patients, who currently contribute to DToC levels in mid-Notts. The remainder of the funding will go towards expediting the start dates of process improvement work streams for example, IRRS which will contribute to DToC rates by offering alternatives to admission. BASSETLAW Bassetlaw Hospital's share of the total DToC position has decreased significantly over the past year. The Integrated Discharge Team will continue to work with County Council colleagues and community care providers to ensure delays are kept to a minimum, and the Bassetlaw Call for Care service went live on the 29th July. Call for Care is the urgent care navigation service commissioned to deliver a two-hour response for people in Bassetlaw to prevent an avoidable hospital admission or support timely discharge from the Emergency Department.

8.3 Residential Admissions

		18/19 Plan	19/20 Plan	Comments
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	558	555	Admissions into long-term care are avoided where possible through peer review and approval of placements by Team Managers/Group Managers to ensure that all alternative options to promote the person's independence have been explored. A Strategic Commissioning Programme is underway to develop alternative services that have an evidence base for reducing the use of residential care. This includes Housing with Care, Short Term Assessment and Reablement Apartments and Assistive Technology.
	Numerator	950	960	
	Denominator	170,230	173,045	

8.4 Reablement

		18/19 Plan	19/20 Plan	Comments
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	85.0%	83.0%	Last year's performance averaged at 80% so meeting this refreshed target will be challenging but should be achievable; actions put in place have already delivered significant improvement. Performance varies by the type of service and complexity of needs of the people using it: the START re-ablement team that supports people in their own homes achieved 89% last year, with accommodation based short term re-ablement for people with more complex needs having lower outcomes.
	Numerator	340	404	
	Denominator	400	487	

Better Care Fund 2019/20 Template

9. Confirmation of Planning Requirements

Selected Health and Wellbeing Board: Nottinghamshire

Theme	Code	Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR)	Please confirm whether your BCF plan meets the Planning Requirement?
NC1: Jointly agreed plan	PR1	**A jointly developed and agreed plan that all parties sign up to**	**Has a plan; jointly developed and agreed between CCG(s) and LA; been submitted?** Has the HWB approved the plan/delegated approval pending its next meeting? Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan? Do the governance arrangements described support collaboration and integrated care? Where the strategic narrative section of the plan has been agreed across more than one HWB, have individual income, expenditure, metric and HICM sections of the plan been submitted for each HWB concerned?	Yes
	PR2	**A clear narrative for the integration of health and social care**	**Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that covers:** - Person centred care, including approaches to delivering joint assessments, promoting choice, independence and personalised care? - A clear approach at HWB level for integrating services that supports the overall approach to integrated care and confirmation that the approach supports delivery at the interface between health and social care? - A description of how the local BCF plan and other integration plans e.g. STP/ICSs align? - Is there a description of how the plan will contribute to reducing health inequalities (as per section 4 of the Health and Social Care Act) and to reduce inequalities for people with protected characteristics under the Equality Act 2010? This should include confirmation that equality impacts of the local BCF plan have been considered, a description of local priorities related to health inequality and equality that the BCF plan will contribute to addressing. Has the plan summarised any changes from the previous planning period? And noted (where appropriate) any lessons learnt?	Yes

	PR3	**A strategic, joined up plan for DFG spending**	**Is there confirmation that use of DFG has been agreed with housing authorities?** Does the narrative set out a strategic approach to using housing support, including use of DFG funding that supports independence at home. In two tier areas, has: - Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory Disabled Facilities Grants? or - The funding been passed in its entirety to district councils?	Yes
NC2: Social Care Maintenance	**PR4**	**A demonstration of how the area will maintain the level of spending on social care services from the CCG minimum contribution to the fund in line with the uplift in the overall contribution**	Does the total spend from the CCG minimum contribution on social care match or exceed the minimum required contribution (auto-validated on the planning template)?	Yes
NC3: NHS commissioned Out of Hospital Services	**PR5**	**Has the area committed to spend at equal to or above the minimum allocation for NHS commissioned out of hospital services from the CCG minimum BCF contribution?**	Does the total spend from the CCG minimum contribution on non-acute, NHS commissioned care exceed the minimum ringfence (auto-validated on the planning template)?	Yes
NC4: Implementation of the High Impact Change Model for Managing Transfers of Care	**PR6**	**Is there a plan for implementing the High Impact Change Model for managing transfers of care?**	**Does the BCF plan demonstrate a continued plan in place for implementing the High Impact Change Model for Managing Transfers of Care?** Has the area confirmed the current level of implementation and the planned level at March 2020 for all eight changes? Is there an accompanying overall narrative setting out the priorities and approach for ongoing implementation of the HICM? Does the level of ambition set out for implementing the HICM changes correspond to performance challenges in the system? If the current level of implementation is below established for any of the HICM changes, has the plan included a clear explanation and set of actions towards establishing the change as soon as possible in 2019-20?	Yes
Agreed expenditure plan for all elements of the BCF	**PR7**	**Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?**	Have the planned schemes been assigned to the metrics they are aiming to make an impact on?Expenditure plans for each element of the BCF pool match the funding inputs? (auto-validated)Is there confirmation that the use of grant funding is in line with the relevant grant conditions? (tick-box)Is there an agreed plan for use of the Winter Pressures grant that sets out how the money will be used to address expected demand pressures on the Health system over Winter?**Has funding for the following from the CCG contribution been identified for the area?**- Implementation of Care Act duties?- Funding dedicated to carer-specific support?- Reablement?	Yes
	PR8	**Indication of outputs for specified scheme types**	Has the area set out the outputs corresponding to the planned scheme types (Note that this is only for where any of the specified set of scheme types requiring outputs are planned)? (auto-validated)	Yes

Metrics	**PR9**	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	Is there a clear narrative for each metric describing the approach locally to meeting the ambition set for that metric? Is there a proportionate range of scheme types and spend included in the expenditure section of the plan to support delivery of the metric ambitions for each of the metrics? Do the narrative plans for each metric set out clear and ambitious approaches to delivering improvements? **Have stretching metrics been agreed locally for:** - Metric 2: Long term admission to residential and nursing care homes - Metric 3: Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement	Yes

Nottinghamshire County Council

Report to the Health & Wellbeing Board

6 November 2019

Agenda Item:9

REPORT OF THE MONITORING OFFICER

OUTSIDE BODIES

Purpose of the Report

1. To consider the various outside bodies which are relevant to the remit of the Health & Wellbeing Board and whether any specific updates are currently required.

Information

Background

2. At its meeting of 22 May 2019, Policy Committee agreed the findings of the Governance and Ethics Committee cross party working group review of the Council's Outside Bodies Register. One of the issues which the working group considered was how best to enable a flow of information between the Council and the various outside bodies.

3. The review's findings in that respect were as follows:-

Information on the work of outside bodies

As part of the review, further thought was given as to how information can be fed back to the Council about the work of each of the outside bodies. It is felt that the best means of doing this would be for information to be brought to the most appropriate Council Committee for the outside body in question.

In light of the fact that Committee agendas are already very full, it is proposed that such reporting should be by specific request of the Committee, with such requests made largely on a 'by exception' basis, for example where concerns have been expressed or where there is a particular issue which is relevant to a Committee's current focus. Such requests for information can be raised by Members through work programme discussions. The relevant outside body's Council representative would be expected to provide the information when requested with sufficient notice, working in conjunction with the outside body as appropriate.

If a committee has concerns about a specific outside body and the Council's ongoing involvement, these concerns will be referred to Policy Committee as appropriate.

4. In line with this agreed approach, Members are advised that the following bodies are relevant to the remit of this Committee:-

Organisation	Appointees
Nottinghamshire Healthcare NHS Foundation Trust	Cllr Steve Vickers
Sherwood Forest Hospitals NHS Foundation Trust	Cllr Steve Vickers

5. With reference to the recommended 'by exception' reporting approach described above, Members' views are sought as to whether there are any outside bodies for which they require an update currently (if there are any highlighted then the Council's nominees will be requested to provide the information to a future meeting of the Committee).

6. It is the role of Policy Committee to confirm the latest version of the outside bodies list and to seek approval or endorsement of any changes that have occurred in the reporting period. If additional bodies need to be added to the Register, this work can be undertaken ahead of the next six monthly update to Policy Committee.

Other Options Considered

7. None. Policy Committee agreed the working group's recommendation that each Committee be informed of their relevant outside bodies and proposed approach for feeding back updates.

Reason/s for Recommendation/s

8. To enable relevant information to be shared with the Committee as appropriate.

Statutory and Policy Implications

9. This report has been compiled after consideration of implications in respect of crime and disorder, data protection and information governance, finance, human resources, human rights, the NHS Constitution (public health services), the public sector equality duty, safeguarding of children and adults at risk, service users, smarter working, sustainability and the environment and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

Financial Implications

10. There are no direct financial implications arising from this report.

RECOMMENDATIONS

That the Health & Wellbeing Board:

1) Considers the list of outside bodies that are relevant to the remit of the Health & Wellbeing Board and the agreed approach for requesting updates in the future.

2) Decides whether there are any bodies for which an update is required currently.

Marjorie Toward
Monitoring Officer

For any enquiries about this report please contact:
Keith Ford
Team Manager: Democratic Services
Telephone: 0115 977 2590
Email: keith.ford@nottscc.gov.uk

Constitutional Comments (LW 22/10/2019)

11. Health and Wellbeing Board is the appropriate body to consider the content of the report.

Financial Comments (DG 23/10/19)

12. There are no specific financial implications arising directly from the report.

Background Papers and Published Documents

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.

- Responses to Questionnaires from Outside Bodies and Council representatives;
- Report of working group - Review of Outside Bodies - Governance and Ethics Committee - 1 May 2019
- Report to Policy Committee - Review of Outside Bodies - Report to Policy Committee - 22 May 2019

Electoral Division(s) and Member(s) Affected

- All

Nottinghamshire County Council

Report to Health and Wellbeing Board

6 November 2019

Agenda Item: 10

REPORT OF THE SERVICE DIRECTOR, CUSTOMERS GOVERNANCE AND EMPLOYEES

WORK PROGRAMME

Purpose of the Report

1. To consider the Board's work programme for 2019/20.

Information

2. The County Council requires each committee, including the Health and Wellbeing Board to maintain a work programme. The work programme will assist the management of the committee's agenda, the scheduling of the Board's business and forward planning. The work programme will be updated and reviewed at each pre-agenda meeting and Board meeting. Any member of the Board is able to suggest items for possible inclusion.

3. The attached work programme has been drafted in consultation with the Chair and Vice-Chair, and includes items which can be anticipated at the present time. Other items will be added to the programme as they are identified.

Other Options Considered

4. None.

Reason/s for Recommendation/s

5. To assist the Board in preparing its work programme.

Statutory and Policy Implications

6. This report has been compiled after consideration of implications in respect of finance, equal opportunities, human resources, crime and disorder, human rights, the safeguarding of children, sustainability and the environment and those using the service and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

RECOMMENDATION/S

1) That the Board's work programme be noted, and consideration be given to any changes which the Board wishes to make.

Marjorie Toward
Service Director – Customers, Governance and Employees

For any enquiries about this report please contact: Martin Gately, x 72826

Constitutional Comments (HD)

1. The Board has authority to consider the matters set out in this report by virtue of its terms of reference.

Financial Comments (NS)

2. There are no direct financial implications arising from the contents of this report. Any future reports to the Board will contain relevant financial information and comments.

Background Papers

None.

Electoral Division(s) and Member(s) Affected

All

Work programme: 2019-20

Report title	Description	Lead officer	Report author(s)
WORKSHOP: Wednesday 2 October 2019 (2pm)			
Plans to deliver the NHS long term plan in Nottinghamshire	Development of the local Integrated Care System plans to deliver the NHS long term plan		Alex Ball / Helen Stevens
WORKSHOP: Friday 18 October 2019 (12.30pm)			
Employment & Health: Improving Lives in Nottinghamshire	To identify opportunities to improve both health and prosperity through work		Dawn Jenkin / Catherine O'Byrne / Sonja Smith
MEETING: Wednesday 6 November 2019 (2pm)			
Approval of Joint Strategic Needs Assessment chapter: Health & homelessness		Jonathan Gribbin	Nick Romilly
Approval of Joint Strategic Needs Assessment chapter: Early years & school readiness		Colin Pettigrew	Irene Kakoullis
Health protection: Anti Microbial Resistance	Setting out current issues around Anti Microbial Resistance and identification of support / actions for Health & Wellbeing Board members	Jonathan Gribbin	Geoff Hamilton
Approval of the Better Care Fund planning template submission (2019-20)		Melanie Brooks	Paul Johnson / Paul Brandreth
Outside Bodies		Marjorie Toward	Keith Ford
Chair's report		Councillor Steve Vickers	Edward Shaw
MEETING: Wednesday 4 December 2019 (2pm)			

Report title	Description	Lead officer	Report author(s)
Joint Strategic Needs Assessment progress and development in Nottinghamshire	Update on progress in delivering and developing the Joint Strategic Needs Assessment	Jonathan Gribbin	Amanda Fletcher / Lucy Hawkin
Employment & Health: Improving Lives in Nottinghamshire (feedback from workshop)	To agree actions from the workshop on Friday 18 October 2019	Councillor Steve Vickers	Dawn Jenkin / Catherine O'Byrne / Sonja Smith
Plans to deliver the NHS long term plan in Nottinghamshire (feedback from workshop)	To agree actions from the workshop on Wednesday 2 October 2019	Jonathan Gribbin / Idris Griffiths	Alex Ball / Helen Stevens
Chair's report	To include updates on: • Integrated Wellbeing Service • Substance misuse	Councillor Steve Vickers	Edward Shaw
MEETING: Wednesday 8 January 2020 (2pm)			
Health protection update: Screening	Update on the local screening programme and opportunities for the Health & Wellbeing Board to support, promote and improve uptake	Jonathan Gribbin	Geoff Hamilton
Approval of Joint Strategic Needs Assessment chapter: Oral health		Jonathan Gribbin	Louise Lester / Kay Massingham
Approval of Joint Strategic Needs Assessment chapter: Tobacco		Jonathan Gribbin	Catherine Pritchard / Lindsay Price
'Healthier decision making' ambition: Update	Update on progress in implementing health in all policies approach	Jonathan Gribbin	Edward Shaw
Approval of Supplementary Statement for Pharmaceutical Needs Assessment (2018-22)	Supplementary statement to confirm amendments to the Pharmaceutical Needs Assessment for quarter 1 and quarter 2 of 2019-20 (for approval of publication by the Health & Wellbeing Board)	Jonathan Gribbin	Lucy Hawkin
Better Care Fund progress update		Melanie Brooks	Paul Johnson / Paul Brandreth

Report title	Description	Lead officer	Report author(s)
Chair's report		Councillor Steve Vickers	Edward Shaw
WORKSHOP: Wednesday 5 February 2020 (2pm)			
'A good start in life' ambition: School readiness	Joint workshop with the Children & Families Alliance	Colin Pettigrew	Irene Kakoullis / Kerrie Adams
MEETING: Wednesday 4 March 2020 (2pm)			
Annual report from the Director of Public Health		Jonathan Gribbin	William Brealy
Approval of Joint Strategic Needs Assessment chapter: Children & Young Peoples' Emotional and Mental Health		Jonathan Gribbin	Andrew Turvey / Rachel Clark
'Healthy & sustainable places' ambition: Autism Spectrum Disorder	Agreement of partnership actions arising from the recent refresh of the Joint Strategic Needs Assessment chapter for autism	Councillor Steve Vickers	Anna Oliver / Gill Vasilevskis
Nottinghamshire Tobacco Declaration	Update on implementation of the Nottinghamshire Tobacco Declaration across all Health & Wellbeing Board partner organisations	Councillor Steve Vickers	Catherine Pritchard / Lindsay Price
Improved Better Care Fund plan (2020-21)	Update on progress and approval for the use of the Better Care Fund Care Act allocation and the Improved Better Care Fund	Melanie Brooks	Paul Johnson / Paul Brandreth
Annual report from the Healthy & Sustainable Places Coordination Group		Jonathan Gribbin	Dawn Jenkin / Edward Shaw
Chair's report		Councillor Steve Vickers	Edward Shaw
WORKSHOP: Wednesday 1 April 2020 (2pm)			

Report title	Description	Lead officer	Report author(s)
MEETING: Wednesday 6 May 2020 (2pm)			
‘A good start in life’ ambition: Breastfeeding	Review of progress in implementing breastfeeding friendly places and actions to increase availability in future	Colin Pettigrew	Kerrie Adams / Tina Bhundia
Public Health Outcomes Framework		Jonathan Gribbin	William Brealy / David Gilding
WORKSHOP: Wednesday 3 June 2020 (2pm)			
MEETING: Wednesday 1 July 2020 (2pm)			