Nottinghamshire County Council

Health and Wellbeing Board (Shadow)

Date: Wednesday, 07 November 2012
Time: 14:00
Venue: County Hall
Address: County Hall, West Bridgford, Nottingham NG2 7QP

AGENDA

minutes

Nottinghamshire County Council

Meeting HEALTH AND WELLBEING BOARD

Date Wednesday 5th September 2012 2pm – 4.35pm

membership
Persons absent are marked with `A'

COUNCILLORS

Reg Adair
Mrs Kay Cutts
Martin Suthers OBE (Chair)
A Alan Rhodes
Stan Heptinstall MBE

DISTRICT COUNCILS

Councillor Jenny Hollingsworth
Councillor Tony Roberts MBE

OFFICERS

David Pearson	-	Corporate Director, Adult Social Care, Health and Public Protection
Anthony May	-	Corporate Director, Children, Families and Cultural Services
Dr Chris Kenny	-	Director of Public Health

CLINICAL COMMISSIONING GROUPS

Dr Steve Kell	-	Bassetlaw Clinical Commissioning Group
Dr Raian Sheikh	-	Mansfield and Ashfield Clinical Commissioning Group
Dr Mark Jefford	-	Newark & Sherwood Clinical Commissioning Group
Dr Guy Mansford	-	Nottingham West Clinical Commissioning Group
Dr Jeremy Griffiths	-	Rushcliffe Clinical Commissioning Group
Dr Tony Marsh	-	Nottingham North & East Clinical Commissioning Group

LOCAL HEALTH WATCH

Jane Stubbings (Nottinghamshire County LINk)

PCT CLUSTER

A Dr Doug Black - NHS Nottinghamshire County

OFFICERS IN ATTENDANCE

Chris Holmes - Democratic Services
Cathy Quinn - Associate Director of Public Health

MINUTES

The minutes of the last meeting held on 27th June 2012 having been previously circulated were confirmed and signed by the Chairman.

MATTERS ARISING

Exercise Referral Schemes

Concern was expressed about the uncertainty around continued funding of exercise referral schemes which were threatening the continuation of this service. Chris Kenny indicated that the question of funding was being looked at alongside all allocations for public health areas. This would ensure that the public health grant was used in the best way to improve health and wellbeing and reduce health inequalities.

APOLOGIES FOR ABSENCE

An apology for absence was received from Councillor Alan Rhodes who was on other County Council business.

DECLARATIONS OF INTEREST BY MEMBERS AND OFFICERS

None

TOBACCO CONTROL AND NOTTINGHAMSHIRE – SEPTEMBER 2012

Lindsay Price and Jo Hopkin from Public Health gave a presentation to the board on Tobacco Control and introduced the report. They emphasised that smoking remained public health enemy number one causing 81,400 premature deaths nationally each year. Almost half of all life long smokers will die prematurely, losing on average about 10 years of life. It was children who started smoking, not adults, with 90% of people starting smoking before the age of 19. Nationally, about 2 million children currently live in a household where they are exposed to cigarette smoke and many more are exposed outside the home. They stated that the local priorities were:-

- Reducing the number of young people starting to smoke.
- Motivating and supporting every smoker to quit.
- Protecting families and communities from tobacco related harm.

Localism was at the heart of the new public health system. From 2013 improving public health would be the responsibility of local authorities including tobacco control. The local authority was well positioned to impact not only on tobacco use but also the wider determinants of health. The Board locally would identify the key priorities with opportunities for all stake-holders to influence and support this agenda.

During the discussion the following points were made:-

- There was a lack of enforcement of non-smoking policies in hospitals.
- Each local authority had a different policy. They should be exemplars of good practice and develop a common policy.
- There was a need for a EU approach to the problem to prevent cheap cigarettes being available.
- Peer support for young people had been shown to be successful.
- The number of young people taking drugs was decreasing – was this the effect of the DARE programme?
- A question over radical approaches to tobacco control was proposed. The suggestion that smokers should not be employed by health and social care organisations was not supported. It was pointed out that the aim was to move to a position where smoking was not the norm.
- How aggressive was the message in schools. Did people who had COPD and cancers as a result of smoking speak to children? Many young people did not listen to people in authority e.g. doctors. Schools were now autonomous and decisions on these issues were made by Head Teachers and governing bodies although most would respond to the empowerment agenda to help young people make the right choice. There were programmes to enable young people to say no. Occasionally shock tactics worked but usually only for a short time. Social media and the youth service weren't being used to get the message over and Children centres were another mechanism. Preaching did not work and there is a need for a subtle message.

RESOLVED 2012/019

1) That the contents of the report be noted and endorsed.

2) That the roles and responsibilities for Local Authorities for commissioning to support tobacco control from 2013 be noted.

3) That approval be given to the hosting of a workshop/seminar and development of a full action plan to agree how the actions contained in the report will be delivered and monitored.

DELIVERY OF THE HEALTH AND WELLBEING STRATEGY AND THE ROLE OF INTEGRATED COMMISSIONING

David Pearson in introducing the report highlighted the importance of integrating commissioning in delivering the work of the Board.

During the discussion the following points were made:-

- Patients were not discharged in a timely way; there was often a wait for medicines, due to poor discharge planning.

- Hospital discharges was one of the work streams of Productive Notts and some progress had been made – 23 beds saved.

- The new hospital contract had financial penalties for readmissions.

- LINkS had carried out a study of feeding and nutrition and made recommendations to Hospital Trusts which had been taken up.

- The health and Wellbeing Board could receive stories about interface with services to highlight issues.

- A balance between system governance and delivering the strategy is needed to allow progress to be made.

- A report on carers issues should be brought to a future meeting.

RESOLVED 2012/020

1) That the progress being made in developing a strong supporting structure to deliver the Health and Wellbeing Strategy be noted and the process for refreshing the integrated commissioning plans to fully align with the work of the Health and Wellbeing Board be supported.

2) That the arrangements required to promote joint working and appropriate reporting mechanisms by the Health and Wellbeing Implementation Group be considered.

PRESENTATION ON CLINICAL COMMISSIONING GROUP COMMISSIONING INTENTIONS

Oliver Newbould, Chief Operating Officer Nottingham West Clinical Commissioning Group gave a presentation on behalf of the 5 Clinical Commissioning Groups of their commissioning intentions. A copy of the statement of intent of their outline commissioning intentions 2013/16 was circulated.

He indicated that the commissioning intentions were based around the joint strategic needs assessment – commissioning for local communities. They had a proactive rather than reactive approach and GP clinical leadership was at the heart of their approach. He outlined the work being done on the 5 domains of the NHS Outcomes Framework 2012/13 viz:-

- Preventing people dying prematurely.

- Enhancing quality of life for people with long term conditions.

- Helping people to recover from episodes of ill health or following injury.

- Ensuring that people have a positive experience of care.

- Treating people in a safe environment and protecting them from harm.

This meant that there would be greater focus on early intervention and treatment in the community and intensive community based rehabilitation. Standards would be universally high and there would be seamless transition between care providers. People would make positive choices about their health.

He outlined the financial background which was flat growth for the next 3 years, coupled with increases in demand, expectations, national priorities and inflation. The local NHS would need to be more productive with better services but act differently to release the following savings:-

£31 million in 2012/13,
£28.7 million in 2013/14,
£25.9 million in 2014/15.

He outlined the process for engagement and refinement and he indicated that the process would be completed by late autumn.

The approach was welcomed. It was noted that there was a need to change otherwise there would be insufficient funding. The agenda would include decommissioning some services from the providers which would be difficult. It was a prerequisite that all work together in what would be a major transformational change. The County Council had experience of this. There was a need to harness political will to get the message over to the public.

COMMISSIONING A LOCAL HEALTH WATCH FOR NOTTTINGHAMSHIRE

Consideration was given to a report on progress in commissioning a Local Healthwatch for Nottinghamshire.

Concern was expressed that the Patient Advice and Liaison Service (PALS) was going to be run from a call centre and the need for a local presence was emphasised. There was also concern over the funding of the former NHS PALS service as it was suggested that had not been as high as stated in the document.

RESOLVED 2012/021

That the contents of the report and the intended approach to commission a Local Healthwatch for Nottinghamshire be noted.

SELF ASSESSMENT OF THE HEALTH AND WELLBEING BOARD

Consideration was given to a report which described the self assessment tool published by the Local Government Association. It was noted that this was to be looked at in more detail at the next workshop. Reference was made to how Boards around the country were developing differently.

RESOLVED 2012/022

That a workshop be held on the subject and preparatory work be completed by members. Each Board member is asked to assess the statements given, using the score between 0-5 (0 = strongly disagree, 5 = strongly agree.) This will be used to produce a combined report for discussion at the workshop.

PRESENTATION ON PRODUCTIVE NOTTS

Chris Calkin, Programme Director of Productive Notts gave a presentation about Productive Notts. He explained that Productive Notts was established as a health economy alliance. This had board level commitment to work together on key projects that will best be delivered through a collaborative approach aiming to improve quality and reduce costs of services provided across the NHS/Social Care in Nottinghamshire. Being part of Productive Notts enables organisations within the health and social care economy to achieve together what they cannot achieve as individual organisations. Its membership included City and County Councils and all the Clinical Commissioning Groups and the provider trusts in Nottinghamshire.

He stated that the new financial climate required significant productivity increases to make up the funding gap. A focus on quality, innovation, productivity and prevention (QUIPP) was maintained. Demographic changes meant increase in demand for services. In Nottinghamshire the number of over 65's will increase by 37% from 2010 – 2025. The scale of the health economy challenge was outlined with £212 million out of £444 million reduction up to 2014/15 still to be identified.

It was explained that the funding for Productive Notts came from top slicing Primary Care Trust budgets and that they had a small staff. Details were outlined of what had been achieved in 2011/12.

Reference was made to the fixed nature of PFI costs and that Trusts should not be penalised for that. The need for a mature debate on these issues was emphasised.

OFSTED THEMATIC INSPECTION OF JOINT WORKING BETWEEN CHILDREN'S AND ADULT SERVICES

Anthony May updated Board members orally on the positive outcome from the OFSTED Thematic Inspection of joint working between children's and adult services on the 15th and 16th August 2012. Good joint working had been identified. The report would be published later in the year.

The meeting closed at 4.35pm.

Nottinghamshire County Council

Report to the Health & Wellbeing Board

7th November 2012

Agenda Item: 5

REPORT OF THE DIRECTOR OF PUBLIC HEALTH

CANCER AND NOTTINGHAMSHIRE

PURPOSE OF THE REPORT

1. This report provides information on cancer, including local incidence, mortality and survival. It outlines the current position in relation to cancer across Nottinghamshire, information on current policy, an overview of cancer mortality and survival and current service provision, as well as recommending further action.

INFORMATION AND ADVICE

What is cancer?

2. Cancer is a disease caused by normal cells changing so that they grow in an uncontrolled way. The uncontrolled growth usually causes a tumour to form. If not treated, the tumour can cause problems in one or more of the following ways:

   - Spreading into normal tissues nearby
   - Causing pressure on other body structures
   - Spreading to other parts of the body through the lymphatic system or bloodstream.

3. There are more than 200 different types of cancer, as there are many different types of cell in the body. Any of these cell types can grow into a primary cancer. Different types of cancer behave very differently. The type of cancer affects whether it is

   - Likely to grow quickly or slowly
   - Likely to produce hormones or other chemicals that change the way the body works
   - Likely to spread in the blood or lymph system
   - Likely to respond well to particular treatments.

4. Box 1 below lists the main type of cancers. Five sites: skin, breast, lung, large bowel (colorectal) and prostate, account for the majority of all new cancers. The majority of skin cancers, apart for a rare type called melanoma, are easily curable and are not included in most of the statistics in this report. Breast, large bowel, lung and prostate cancers account for over half (54%) of all new cancers excluding the non-melanoma skin cancers.

Box 1 Types of cancer

1. **Carcinoma** - cancer that begins in the skin or in tissues that line or cover internal organs.
2. **Sarcoma** - cancer that begins in bone, cartilage, fat, muscle, blood vessels, or other connective or supportive tissue.
3. **Leukaemia** - cancer that starts in blood-forming tissue such as the bone marrow and causes large numbers of abnormal blood cells to be produced and enter the blood.
4. **Lymphoma and myeloma** - cancers that begin in the cells of the immune system
5. **Central nervous system cancers** - cancers that begin in the tissues of the brain and spinal cord.

Why is cancer a public health issue?

5. Overall it is estimated that 1 in 3 people will develop cancer in their lifetime. Since the publication of the NHS Cancer Plan in 2000, death rates from cancer have fallen so there are more people who have survived cancer in the population. The latest analysis shows that at the end of 2006, there were over 200,000 cancer patients in the UK who were alive one year after their diagnosis. In total, there were 1.13 million cancer survivors in the UK who were alive up to 10 years from diagnosis at the end of 2006[i]. There are now an estimated 1.7 million people living with cancer in the UK. This number is increasing by over 3% per year, which suggests that by 2030 there could be over 4 million people living with cancer in the UK. These latest estimates are much higher than previous forecasts of cancer prevalence. This is mainly because incidence has been rising whilst the death rates have continued to fall. This trend is expected to continue over the coming years as a result of a number of factors, including an ageing population, earlier detection of cancer and continued improvements in treatment. However, there is still a gap between UK survival rates and the best rates in some other European countries[ii].

6. Cancer is the 3rd highest cause of premature death in Nottinghamshire accounting for 28.4% of deaths and is therefore an important local health priority[iii]. 23,861 people in the county are living with cancer. The local incidence and mortality rates are slightly above the average for England as a whole but this difference is not statistically significant.

7. The National Cancer Equality Initiative has published a summary of the available evidence[iv] regarding health inequalities and cancer. The authors noted that notwithstanding some notable exceptions e.g. breast cancer, cancer incidence is generally higher in:

    - deprived compared with affluent groups
    - older people compared with younger people
    - men compared with women.

8. The relationship with ethnicity varies according to cancer type and ethnic group. Survival is also worse in deprived communities, in older people and in men compared to women. The difference in survival is such that even among those cancers where incidence is higher among wealthier socioeconomic groups, death rates are higher among people from deprived communities

Who is at risk of developing cancer?

9. An individual's risk of developing cancer depends on many factors, including age, lifestyle and genetic make-up. A small number of infectious agents, especially certain viruses, play a key role in causing certain types of cancer. It is estimated that inherited factors cause up to 10% of all cancers. Factors such as the age at which a woman has her first child and the number of children she has affect the risk of the most common female cancers.

10. It is estimated that up to half of all cancer cases diagnosed in the UK could be avoided if people made changes to their lifestyle. These include:

    - stopping smoking
    - moderating alcohol intake
    - maintaining a healthy weight
    - having a high fibre diet
    - higher consumption of fruit and vegetables
    - lower consumption of red and processed meats
    - lower salt intake
    - lower saturated fat intake
    - reduced exposure to UV radiation.

11. More than a quarter of all deaths from cancer (including almost 90% of lung cancer deaths) are linked to tobacco smoking[v]. Estimates suggest that, in the UK, up to 12,500 new cancers each year could be avoided if alcohol consumption was reduced and 17,000 new cancers are linked to obesity[vi]. Cancer Research UK has carried out research into the potential impact of known lifestyle and environmental factors and a graphical representation of the impact on each tumour site is shown at **Appendix A**.

12. The Health and Wellbeing Board priorities underpin many of these issues. Improvements in the lifestyle factors highlighted above would have an impact on cancer incidence as they all contribute to increased risk of cancer at individual and population level.

NATIONAL AND LOCAL POLICY DRIVERS

13. *Improving Outcomes: a Strategy for Cancer* was published in January 2011 by the Department of Health[vii]. The government target is that an additional 5,000 lives should be saved from cancer each year by 2014/15. The main aims of the Cancer Strategy are to[viii]:

    a. reduce the incidence of cancers which are preventable, by lifestyle changes
    b. improve access to screening for all groups and introduce new screening programmes where there is evidence they will save lives and are recommended by the UK National Screening Committee

    c. achieve earlier diagnosis of cancer, to increase the scope for successful treatment – diagnosis of cancer at a later stage is generally agreed to be the single most important reason for the lower survival rates in England and

    d. make sure that all patients have access to the best possible treatment.

14. Increasing public awareness has been generated through coordinated campaigns via the National Awareness and Early Diagnosis Initiative (NAEDI). NAEDI has targeted initiatives

for 4 common cancers with high mortality rates: lung, large bowel, prostate and ovarian. There is also research via NAEDI into public attitudes and barriers and the public response to messages about cancer.

15. Although cancer is not a current priority in Nottinghamshire's Health and Wellbeing Strategy, three of the six Clinical Commissioning Groups in Nottinghamshire have included cancer in their priorities for the coming year. In addition, targets for cancer screening programmes and cancer waiting times are in place to ensure that more cancers are diagnosed at an earlier stage and, once diagnosed, treatment begins quickly.

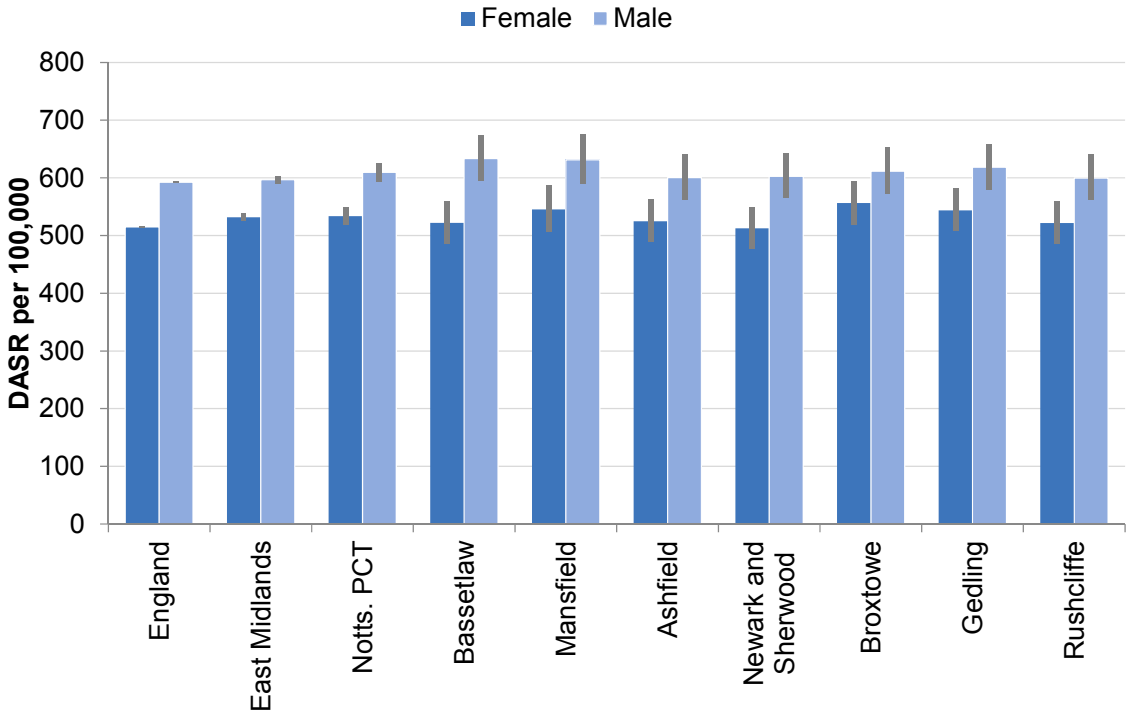
HEALTH NEED

16. As mentioned in paragraph 3 above, the UK does not compare well with the European average in respect of cancer. Incidence and mortality rates are shown across 30 countries in Europe in **Appendix B**. The UK has the 12th highest cancer incidence and the 12th highest mortality rate, both rates being above the European average. There are several countries that have lower mortality rates despite higher incidence rates, including France, Norway and Germany.

17. In Nottinghamshire County, an average of 3,571 people are diagnosed with cancer each year and 1,798 people die from the disease. Figures 1 and 2 below shows the incidence (new cases) and mortality from cancer for people aged 20 years and older between 2007 and 2009, the most recent time period for which this data is available.

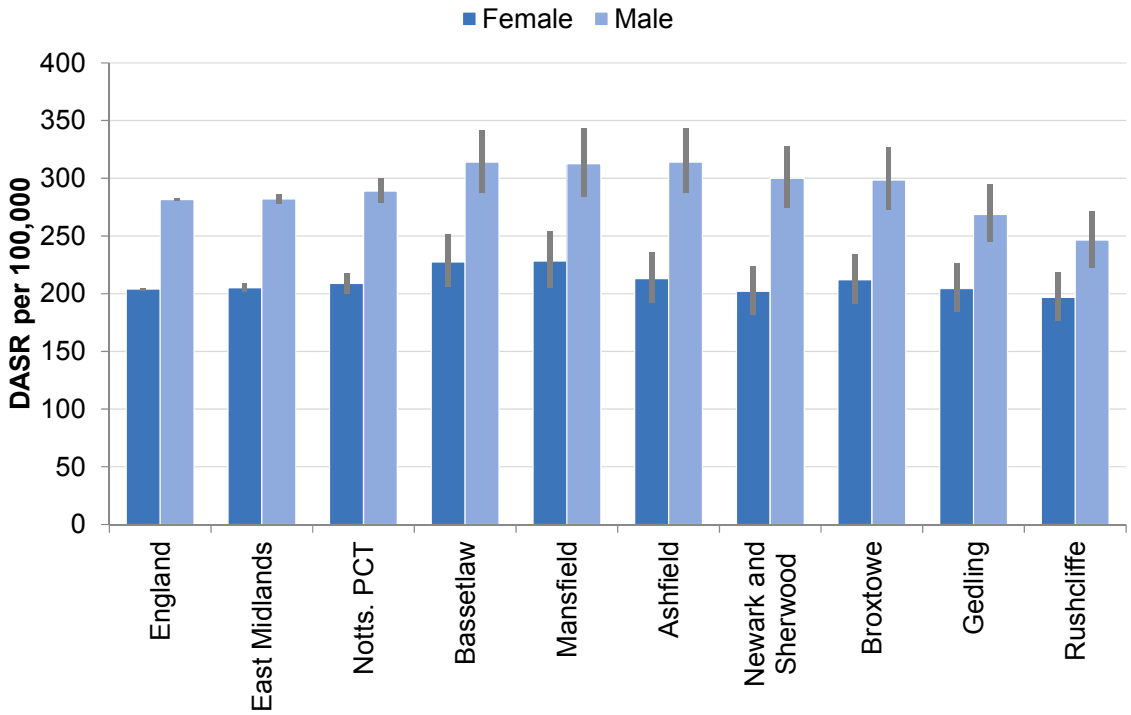
18. Both graphs indicate that Nottinghamshire has rates higher than the national average for both cancer incidence and mortality. The highest rates are in Mansfield and Ashfield and the lowest in Rushcliffe. Men have significantly worse rates for both new cases and deaths than women. Overall, more people in Mansfield die of cancer under the age of 75 years than any of the other areas in Nottinghamshire and the numbers are higher than the England average. Fewer people in Rushcliffe under the age of 75 years die of cancer than the rest of Nottinghamshire and the numbers are lower than the England average.

Figure 1 Incidence of invasive cancers for those aged 20 and over; 2007-2009; national, regional, county and district level



N.B. Data exclude non-melanoma skin cancers

Figure 2 Mortality from invasive cancers for those aged 20 and over; 2007-2009; national, regional, county and district level



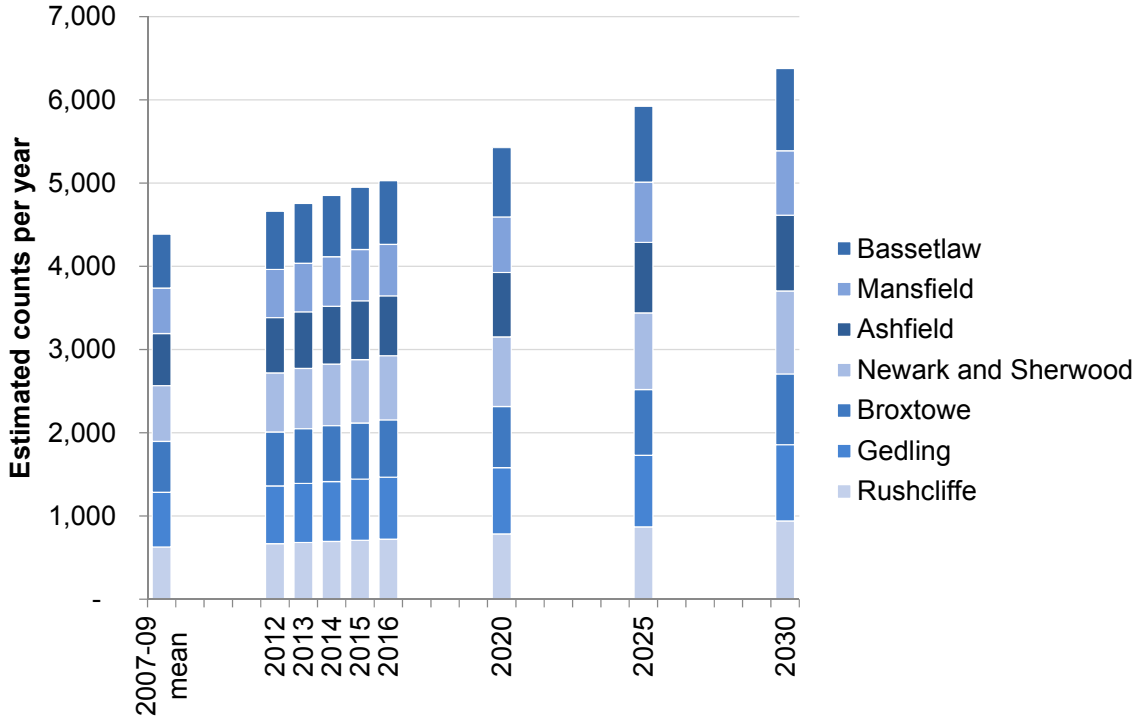
19. For men, the most common cancer in the UK is prostate cancer. For women the most common cancer is breast cancer. Lung cancer is the commonest cause of death in both men and women, accounting for 24% and 21% of deaths from cancer respectively.[ix]
20. Table 1 below shows the incidence and mortality rates of the commonest types of cancer for men and women in Nottinghamshire (2008-2010).[x] This follows the national trend.

Table 1 Incidence and mortality in 5 commonest cancers in men and women; Nottinghamshire; 2008-2010;

Tumour site	Incidence: DASR/100,000 population		Mortality: DASR/100,000 population	
	Males	Females	Males	Females
Breast	3.3	554.0	0.7	150.3
Prostate	448.3	-	131.7	-
Lung	276.3	196.3	224.7	168.7
Large bowel	270.3	209.7	104.7	85.0
Bladder	90.3	38.3	40.7	22.3
Stomach	68.0	30.7	44.3	19.0
Oesphagus	67.7	31.3	59.7	25.0
Ovary	-	84.3	-	43.0
Uterus	-	92.0	-	21.3
Pancreas	55.3	49.7	45.7	48.3

21. As discussed above, cancer incidence is rising by 1.5% per year, due to the ageing population and also the impact of the NAEDI cancer campaigns resulting in increased awareness and earlier presentation. Figure 3 below gives an indication of the estimated increase in cancer incidence by district in Nottinghamshire from 2012 to 2030.

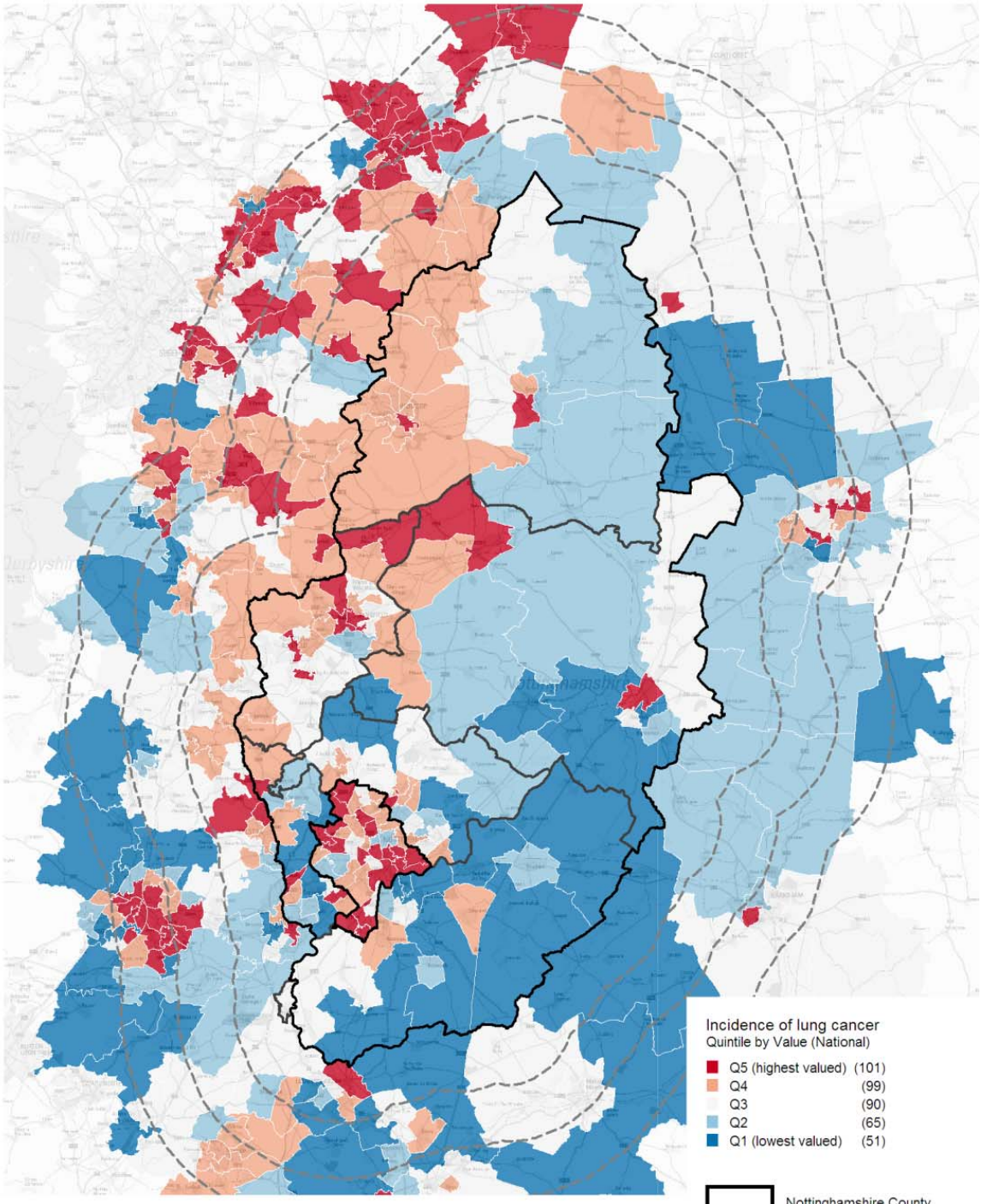
Figure 3 Estimated increase in cancer incidence in Nottinghamshire: 2012-2030



Source: PANSI/POPPI populations, NCIN (Age, Gender) incidence rates

22. The incidence of lung cancer in Nottinghamshire is higher than the England average. The higher rates occur with the highest rates of tobacco smoking prevalence, as can be seen in figure 4 below. Deaths from lung cancer are similarly distributed. Lung cancer incidence and mortality are both significantly higher in men.

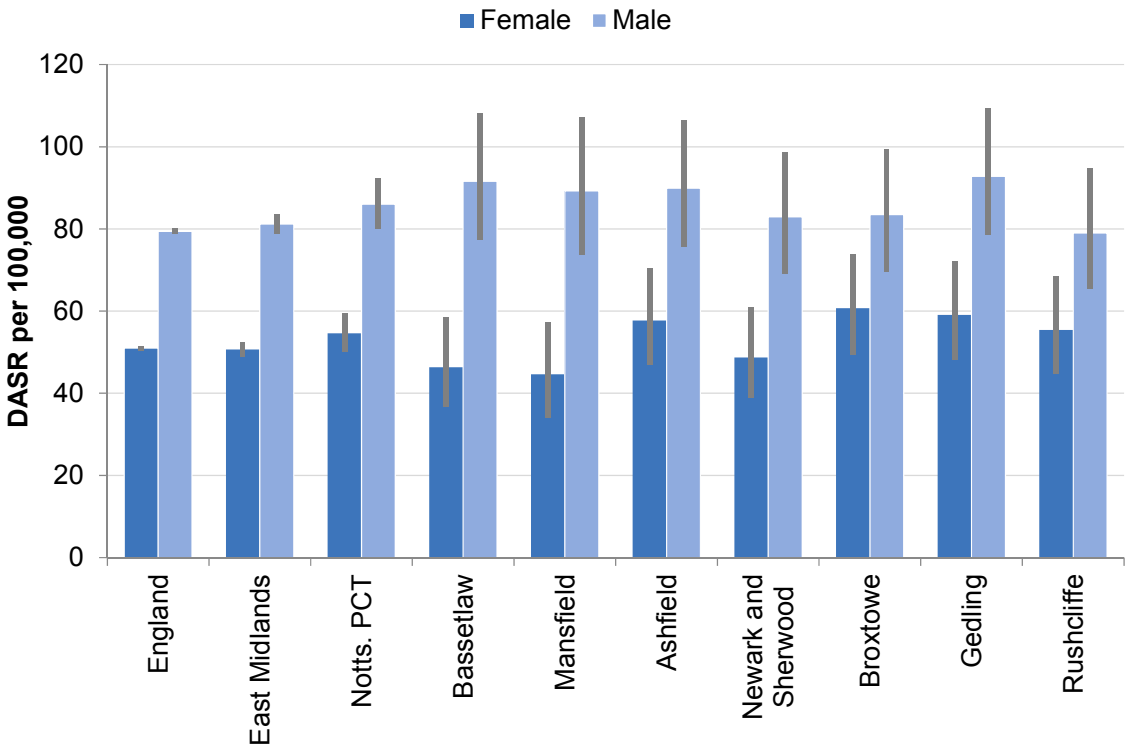
Figure 4 Incidence of lung cancer in Nottinghamshire by sub-district areas
(Lower Super Output Areas, LSOAS)



Produced by the NHS NCtPCT Public Health Intelligence Team (IB)

23. Bowel (colorectal) cancer is one of the commonest cancers in both men and women, although men have a higher incidence of the cancer than women at all ages. With the advent of the national bowel cancer screening programme in 2008, the number of people seen with early stages of the disease has increased. Figure 5 below shows the incidence of bowel cancer by district in Nottinghamshire.

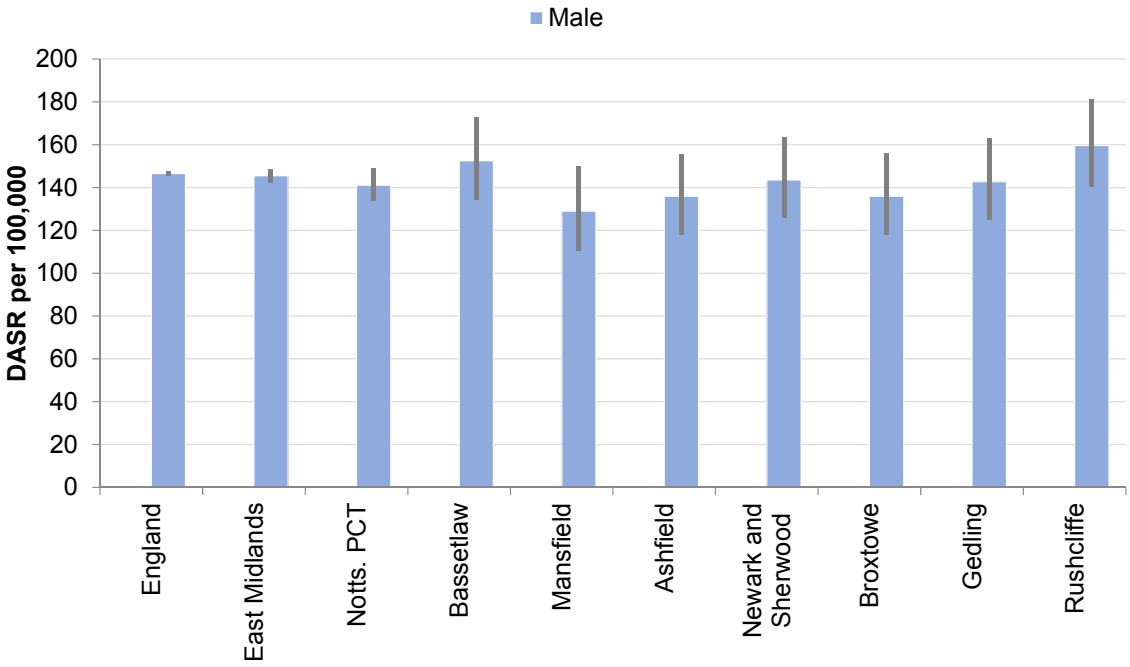
Figure 5 Incidence of colorectal cancer for those aged 20 and over; 2007-2009; national, regional, county and district level



24. The 5 year survival from prostate cancer in the UK has increased over the last three decades. There was a particular increase from 1990 onwards when testing for Prostate Specific Antigen (PSA) became available. PSA is a protein in the blood that is associated with abnormalities of the prostate, one of which may be cancer. However, the test is not very specific and two out of three men with a raised PSA level will not have any cancer cells in their prostate biopsy, while up to one in five men with prostate cancer will have a normal PSA result. Because of this, the UK National Screening Committee does not currently recommend its use for screening for prostate cancer, although many men ask for the test and it can be provided within the NHS. Use of PSA testing gives rise to a lead-time bias – this means that cancer is picked up by the screening test earlier than it would be by symptoms, which makes it look like the survival time has increased. The increased survival from prostate cancer in affluent men compared to men from lower socio-economic groups may indicate increased uptake and awareness of PSA testing, especially in private healthcare screening programmes.[xi]

25. Locally, prostate cancer incidence rates are highest in Rushcliffe and lowest in Mansfield, as shown in figure 6 below. Deaths from prostate cancer are lowest in Rushcliffe and higher in Mansfield, demonstrating the impact of deprivation highlighted in paragraph 5 above.

Figure 6 Incidence of prostate cancer for those aged 20 and over; 2007-2009; national, regional, county and district level



26. There are no significant differences between districts of Nottinghamshire in the incidence of breast cancer.

27. Many patients with cancer in one tumour site will experience spread of the disease to other organs, via the blood or lymph system. In 20% of cases, the secondary tumour (metastasis) will be in the brain and these form the commonest cause of tumours in the brain. Only 40% of brain tumours are primary tumours.

Figure 7 Trends in 1 and 5-Year Relative Survival by Site for Nottinghamshire County PCT: 1992-1996 to 2002-2006(p) Cohorts: Males

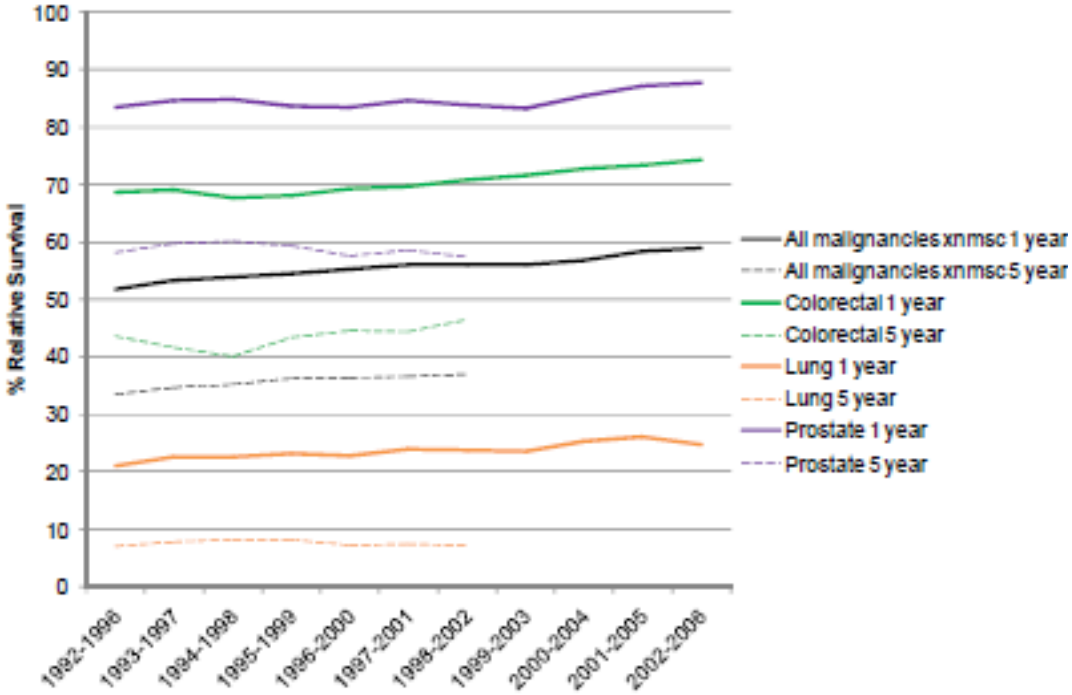
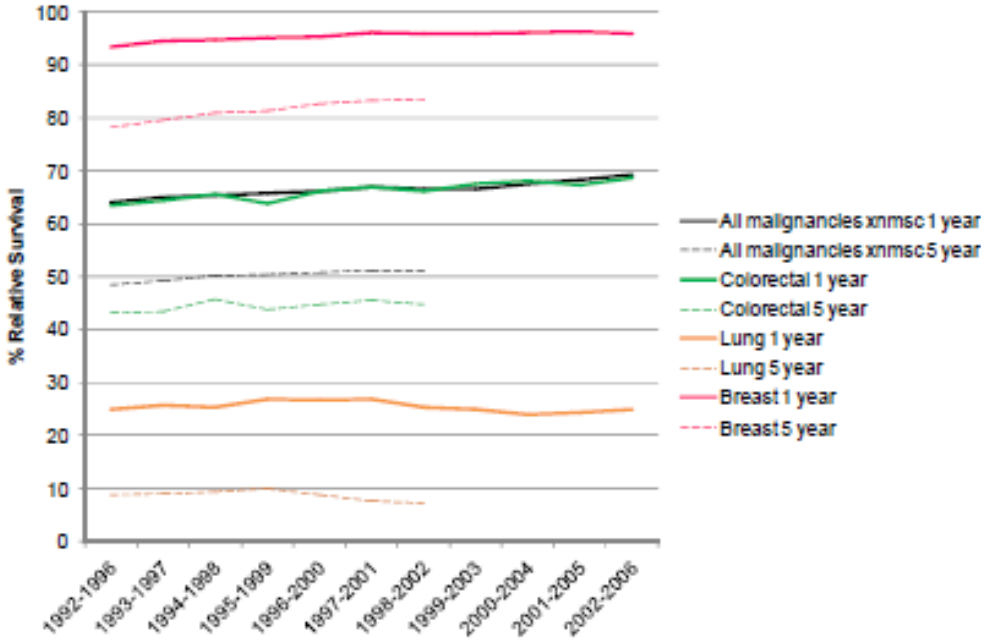


Figure 8 Trends in 1 and 5-Year Relative Survival by Site for Nottinghamshire County PCT: 1992-1996 to 2002-2006(p) Cohorts: Females

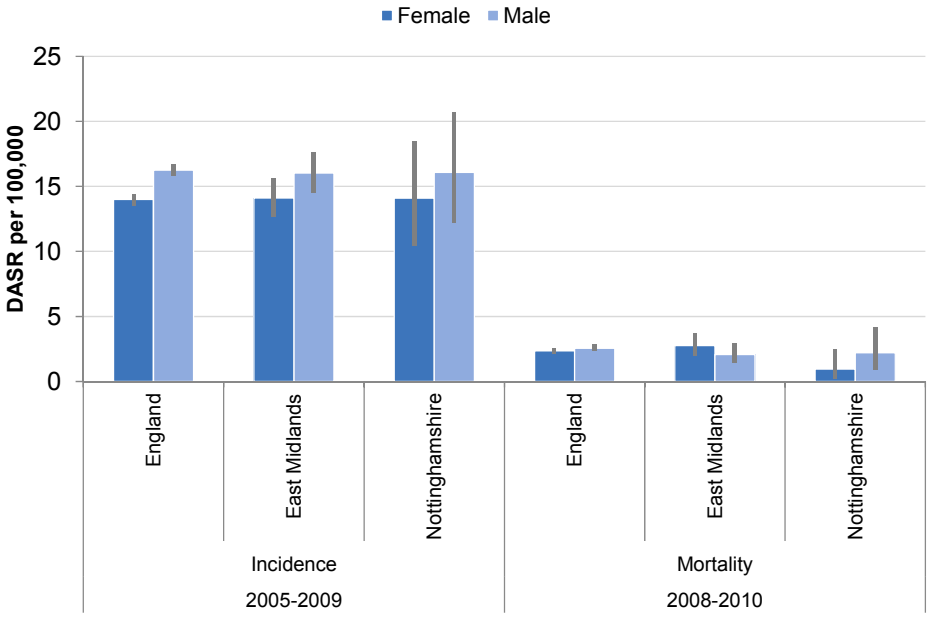


28. Nationally and locally, survival with cancer is improving gradually but five year survival for lung cancer and prostate cancer is not improving, as shown in figures 7 and 8 above. All cancers and colorectal cancer are showing the greatest improvement

Cancer in childhood

29. Figure 9 shows the rates for cancer incidence and mortality for those aged 19 and under. Nationally, cancer mortality is significantly higher in boys than girls. Because so few children are affected, it is not possible to present data at a level below that of the county as a whole and 4 years data has had to be combined.

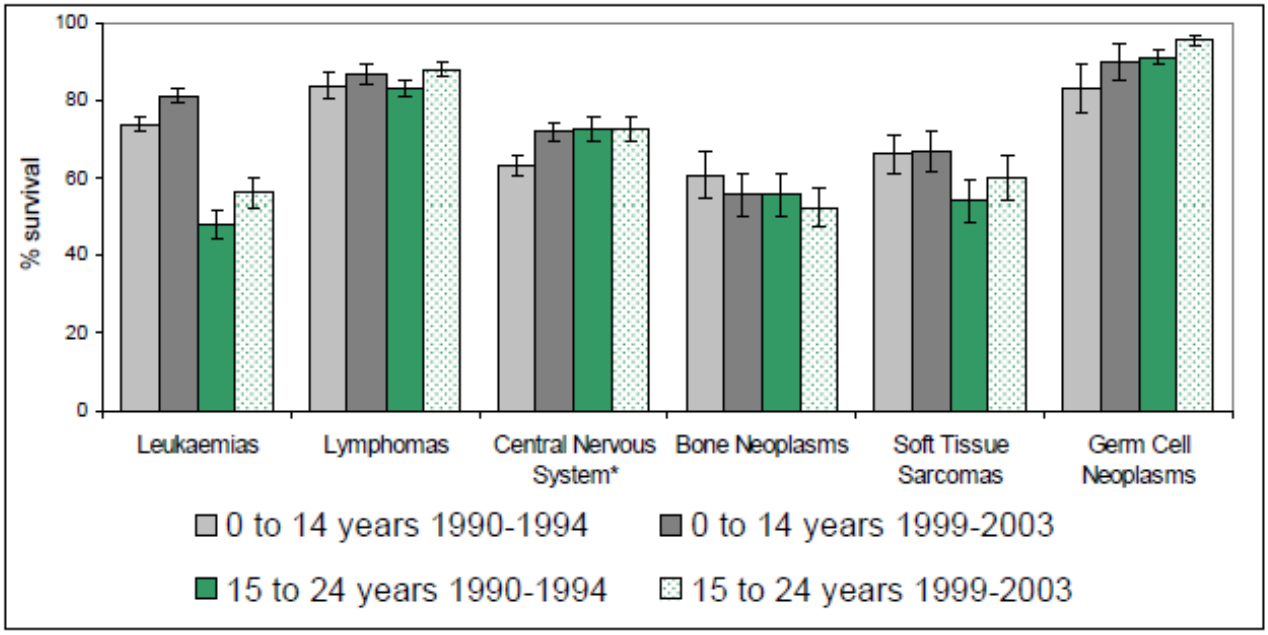
Figure 9 Incidence and mortality of all cancers for those aged under 20;
2005-2009; national, regional and county level



30. Brain tumours are the most common solid tumour in children. Leukaemia is the commonest childhood cancer overall. Of those children diagnosed with a brain tumour only 20% survive 5 years beyond diagnosis, a higher mortality rate than that of meningitis.[xii]

31. Five-year survival rates improved for most types of cancer for children and young people aged up to 24 between 1990-1994 and 1999-2003[xiii]. Survival for bone cancer decreased although this was not statistically significant in either the 0-14 or 15-24 age groups. The largest increases in survival were seen for leukaemias in both age groups. The changes in survival are shown for each of the main childhood cancers in figure 10 below.

Figure 10 5 year survival from cancer in childhood and young adulthood by main cancer group in England; 1990-1994 to 1999-200311;



*includes borderline and benign tumours. Error bars represent 95% Confidence Intervals

Expenditure on cancer:

32. It is estimated that around 5% of the NHS spend is on cancer, approximately £76 per head each year in England, costing around £4.5 billion a year in total. This would equate to approximately £45,000,000 across Nottinghamshire. It is difficult to be more precise, as the costs are spread across primary, secondary and tertiary care budgets. As well as the increase in cancer due to ageing and earlier diagnosis, new drugs and treatments for cancer are being produced, generating increased cost. Longer survival is also increasing pressure on follow up care services[xiv].

SCREENING

33. Screening is a process of identifying apparently healthy people who may be at increased risk of a disease or condition. They can then be offered information, further tests and appropriate treatment to reduce their risk and any complications arising from the disease or condition. Whilst screening has the potential to save lives and improves quality of life through early diagnosis, it is not a foolproof process and it cannot offer a guarantee of protection.

34. The Department of Health report 'Improving Outcomes: A Strategy for Cancer'[7] recognised that cancer screening was an important way to detect cancer early. Evidence suggests that when cancer is diagnosed at an early stage, survival rate is better. Over 5% of all cancers are currently diagnosed via screening. However we know that some groups and communities are not accessing this service. Factors that contribute to late detection include:

- Lack of awareness and poor knowledge of cancer symptoms
- Late presentation to GP with symptoms.

35. There are three national cancer screening programmes listed below which result in secondary prevention of cancers by detection, diagnosis and treatment:

- The NHS Breast Screening Programme
- The NHS Cervical Screening Programme
- The NHS Bowel Cancer Screening Programme.

Breast Screening Programme

36. The NHS Breast Screening Programme calls women aged 50 – 70 years for screening every three years, although there is a phased roll out currently underway to extend this from age 47 to 73. It aims to detect abnormalities which are too small to be felt by a woman herself or a doctor. A third of breast cancers are now diagnosed through screening[6]. 5-year relative survival for women with screen-detected invasive breast cancer improved significantly from 93.5 per cent in 1992/93 to 97.1 per cent in 2002/03[14]. In the UK, breast cancer mortality in middle age has been falling more steeply than in any other major European country.

37. Key points from the Nottinghamshire Annual Report are:

- Coverage at 31 March 2011 within all three Nottinghamshire PCTs exceeded the national standard of 70%. 82.7% of eligible women aged 53 to 70 in NHS Nottinghamshire County had been screened within 3 years, 75.5% of women in NHS Nottingham City and 80.5% of women in NHS Bassetlaw. Nationally 77.2% of eligible women have been screened.

- The Cancer Reform Strategy target for breast screening age extension is being rolled out at all three breast screening units, so that now women aged between 47 and 73 will all be invited every 3 years.

Cervical Screening Programme

38. Cervical screening in England is offered every three years to women aged 25 to 49 years and every five years to women aged between 50 and 64. Cervical screening takes a sample of cells from a woman's cervix for analysis and aims to detect abnormal cells which can be treated before they become cancerous. The programme aims to reduce the number of women who develop invasive cervical cancer (incidence) and the number who die from it (mortality). By regularly screening all women, conditions which might otherwise develop into invasive cancer can be indentified and treated. Early detection and treatment can prevent around 75% of cervical cancers.

39. Key points from the Nottinghamshire Annual Report are:

- Coverage in NHS Nottinghamshire County remained the highest in England with 84.3% of women aged 25-64 screened within 5 years at 31 March 2011 (85.4% at 31.3.10). 78.4% of eligible women in NHS Nottingham City had been screened at 31 March 2011 (78.9% at 31.3.10) and in NHS Bassetlaw 82.9% of women (83.9% at 31.3.10).

- Coverage in all three PCTs was comparable with or exceeded coverage in England which was 78.6% (78.9% at 31.3.10). There is a decreasing trend in coverage nationally; particularly in younger women aged 25-49.

Bowel Cancer Screening Programme

40. Bowel cancer screening is offered to men and women aged between 60 and 69 on a 3 yearly basis. Bowel cancer screening can also detect polyps. These small growths in the bowel wall are not cancers, but may develop into cancers over time. Once polyps are detected they can easily be removed thus reducing the risk of bowel cancer developing. The Bowel Cancer Screening Programme is currently being extended nationally to offer two additional rounds of screening and will soon include those up to age 73.

41. Regular bowel cancer screening has been shown to reduce the risk of dying from bowel cancer by 16 per cent.

42. Key points from the Nottinghamshire Annual Report are:

- The Nottinghamshire programme started in Bassetlaw in February 2008, Nottinghamshire County (South) from March 2008 and Nottingham City from April 2008. Screening started in Ashfield, Mansfield, Newark & Sherwood in January 2009.

- Uptake in NHS Nottinghamshire County is 60%, in NHS Nottingham City approximately 50% and 58% in NHS Bassetlaw, comparable to the national uptake of 54.8%.

43. The Annual reports for all three cancer screening programmes is attached as an Annex to this report

END OF LIFE CARE

44. The White Paper Liberating the NHS[14] states that:

> "In end-of-life care, we will move towards a national choice offer to support people's preferences about how to have a good death, and we will work with providers, including hospices, to ensure that people have the support they need"

45. In 2009/10, 28% of deaths of patients registered with NHS Nottinghamshire County GPs and 29% of deaths of patients registered with NHS Bassetlaw GPs were from cancer. The proportion of deaths due to cancer decreased with increasing age, from 37% among those aged under 65 to 15% in those aged over 85. Over half of the people died in hospital, as shown in table 11 below.

46. Many of these people have no clinical need of hospital care and most people would prefer to die in their own home or could be supported in a community setting. A higher proportion of people dying from cancer die in their own residence and a lower proportion of people die in hospital compared with respiratory disease, cardiovascular disease and other causes.

The age group most likely to die in hospital are those aged 65 to 84. Without advance recognition, planning and coordination of care during the last years of life, the majority of deaths will continue to occur in hospital.

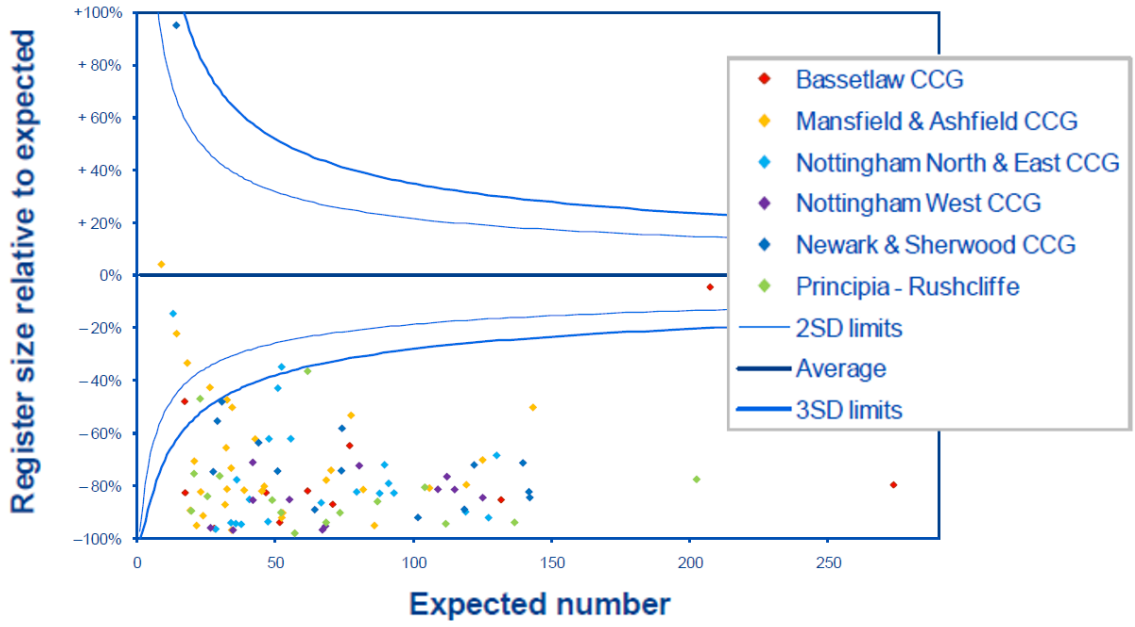
Table 11 Place of death from cancer in NHS Nottinghamshire County and NHS Bassetlaw; 2008-2010 (actual numbers)

Place of death	Nottinghamshire County	Bassetlaw
Home	547	94
Care home	279	54
Hospital	859	125
Hospice	132	61
Total	**1843**	**337**

Source: http://www.endoflifecare-intelligence.org.uk/end_of_life_care_profiles/pct_pdf_profiles.aspx

47. It is estimated that between 58% and 75% of all deaths could be anticipated, and these people should be offered the opportunity of advance care planning. In Nottinghamshire only a small proportion of people with end of life care needs are actually identified (see Figure 11 below), which limits the opportunity for advance care planning for those who may wish to make a positive choice with regard to where they are cared for and where they die. Those practices lying outside the 3 standard deviation (SD) limits on the 'funnel plot' had significantly fewer people on their palliative care registers than expected.

Figure 11 Number of people on palliative care registers in Nottinghamshire as a proportion of number expected for a typical population; March 2011



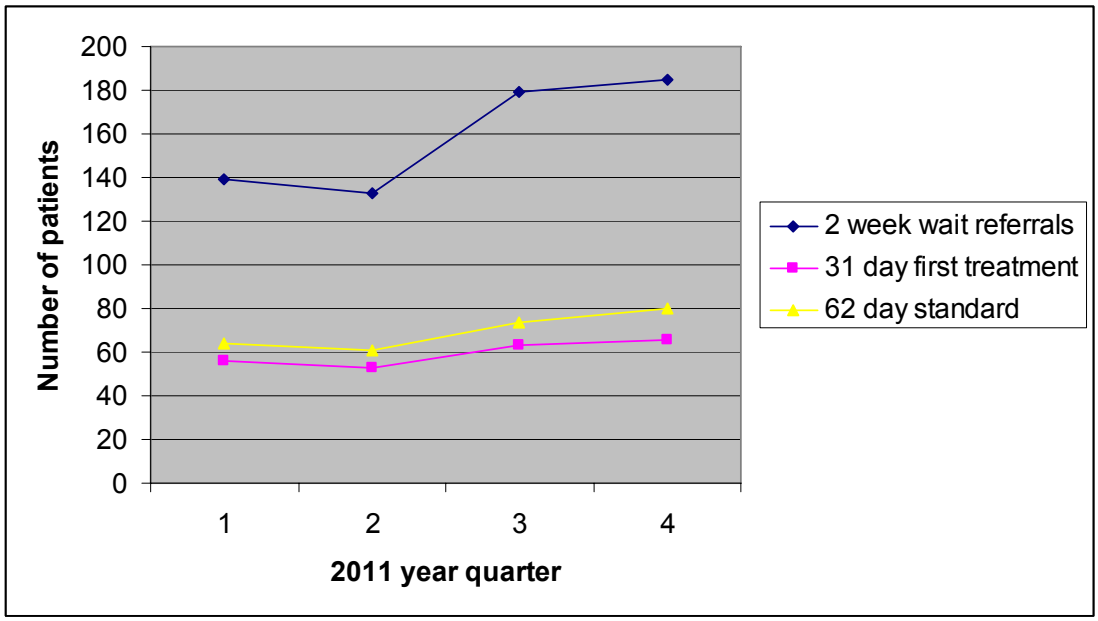
Source: Nottinghamshire County Public Health Information and Intelligence using data sources from QOF (Quality and Outcomes Framework), NHS Information Centre and PHIU Doncaster model

CURRENT COMMISSIONING INITIATIVES

48. Currently the East Midlands Cancer Network (EMCN) leads on strategic developments with regard to cancer. The EMCN is made up of oncologists in secondary care, Macmillan nurses, public health, primary care and patient representatives. The EMCN also provides guidance quality requirements for cancer services locally and supports improvements across the care pathway and training initiatives for staff. The EMCN also administers the Cancer Drugs Fund on behalf of all PCTs in the East Midlands, with a Panel dedicated to reviewing all requests and developing policies for selected drugs to minimise the delays for patients. Strategic Networks for cancer will continue under the new NHS Commissioning Board arrangements, although they are likely to be smaller and have more generic than specialised staff. Many other aspects of cancer treatment, such as radiotherapy, are currently commissioned by the East Midlands Specialised Commissioning Group. This too will be coordinated by the NHS Commissioning Board from 1 April 2013, who will also be commissioning chemotherapy on a national basis.

49. The local impact of the recent NAEDI campaigns indicate that there has been an increase in referrals for patients with suspected lung and large bowel cancer. Two campaigns related to lung cancer have been completed. The results of the first 'cough' campaign showed an increase in requests for Chest X-rays of 50% at both Sherwood Forest and Nottingham University Hospitals, and this increase has also resulted in more patients with lung cancer receiving treatment, as shown in Figure 12 below.

Figure 12 **Rates of two week wait referrals and patients going on to receive treatment in 31 and 62 days**



50. The second bowel cancer awareness campaign is still under way, but the first campaign resulted in increases in the demand for endoscopy of the lower bowel of between 30% and 90% at local providers.

51. The East Midlands Teenage and Young Adults Integrated Cancer Service will be launched later this year. This is an integrated Principal Treatment Centre between Nottingham University Hospitals and University Hospitals of Leicester, providing new specialist facilities and expert medical, nursing and psychosocial care for those between 13-24 years

diagnosed with cancer. The new facilities will be launched at Nottingham City Hospital Campus (NUH), Queens Medical Centre Campus (NUH) and Leicester Royal Infirmary (UHL). District General Hospitals across the region are working in partnership with both trusts and the EMCN, so that patients aged 19 years and above can choose to access the Principal Treatment Centre or have access to services that meet their age specific care needs more locally, dependant on the type of cancer they have.

FUTURE PLANS

52. Further action is required at all points along the cancer pathway: Primary prevention initiatives already highlighted in the Health and Wellbeing Strategy to tackle smoking, excess alcohol use and obesity all support the primary prevention of cancer, as shown in **Appendix A**.

53. Local implementation of the NAEDI programme requires ongoing work with both local residents, to increase awareness of the symptoms that may be associated with cancer, and also with GPs, to improve the uptake of 2 week wait appointments. In addition, further work needs to be done with providers to ensure that facilities are available for the increase in the number of investigations required, both as a result of the NAEDI campaigns and the increase in the number of people with most types of cancer as a result of the ageing population.

54. Further training is required for all those caring for patients with cancer to enable better recognition, planning and coordination for patients requiring end of life care, to ensure they receive this care in their preferred place.

RECOMMENDATIONS

It is recommended that the Health and Wellbeing Board:

a. Note the content of the report
b. Endorse the promotion of the key primary prevention measures for cancer
c. Endorse the promotion of the National Awareness and Early Detection Initiative locally, especially the awareness of key symptoms among local residents.

DR CHRIS KENNY
Director for Public Health

For any enquiries about this report please contact:
Dr Mary Corcoran
Public Health

Constitutional Comments (SLB 09/10/2012)

55. The Health and Wellbeing Board is the appropriate body to consider the content of this report.

Financial Comments (RWK 12/10/2012)

56. There are no additional financial implications arising from the report. The actions proposed in the reports will be met from within the existing budgets of the organisations involved. ”

Background Papers

None.

Electoral Division(s) and Member(s) Affected

All.

HWB47

Nottingham and Nottinghamshire

(City, County and Bassetlaw)

Cancer Screening Programmes

Annual Report

May 2012

Reviewing performance data from 2009-2011

Report Produced by -
Nicola Lane – Public Health Manger NHS Nottinghamshire County
Claire Probert – Senior Public Health Manager NHS Nottinghamshire County

NOTTINGHAM and NOTTINGHAMSHIRE CANCER SCREENING PROGRAMMES ANNUAL REPORT MAY 2012

Review of performance data 2009-2011

TABLE OF CONTENTS

Executive summary

NHS Nottinghamshire County commissions all National Screening Committee recommended Cancer Screening Programmes on behalf of three PCTS, NHS Nottinghamshire County, NHS Nottingham City and NHS Bassetlaw. These are:

- The NHS Cervical Screening Programme
- The NHS Breast Screening Programme
- The NHS Bowel Cancer Screening Programme

As the lead screening commissioner, NHS Nottinghamshire County is responsible for ensuring that all cancer programmes are working effectively, that new initiatives are implemented, and that key performance indicators are achieved and maintained.

The Cancer Reform Strategy[1], published in 2007, outlined future changes aimed at improving and expanding cancer screening. These recommendations included:

- ensuring that women are informed of their cervical screening result within two weeks of their test being taken
- extending the breast screening programme to nine screening rounds between the ages of 47 and 73 and implementing the use of digital mammography
- age extension of bowel cancer screening to invite men and women aged 70-73 years old

The purpose of this report is to review the performance of each cancer screening programme in Nottinghamshire. This report covers two years data, 2009/10 and 2010/11 and also describes the plans to further develop the programmes to ensure that the recommendations of the Cancer Reform Strategy are met.

Key achievements by programme

Cervical Screening Programme

- Coverage in NHS Nottinghamshire County remained the highest in England with 84.3% of women aged 25-64 screened within 5 years at 31 March 2011 (85.4% at 31.3.10). 78.4% of eligible women in NHS Nottingham City had been screened at 31 March 2011 (78.9% at 31.3.10) and in NHS Bassetlaw, the figure was 82.9% of women (83.9% at 31.3.10).

- Coverage in all three Nottinghamshire PCTs was comparable with or exceeds coverage in England which was 78.6% (78.9% at 31.3.10). There is a decreasing trend in coverage nationally, particularly in younger women aged 25-49.

Breast Screening Programme

- Coverage at 31 March 2011 within all three Nottinghamshire PCTs exceeded the national standard of 70%. 82.7% of eligible women aged 53 to 70 in NHS Nottinghamshire County had been screened within 3 years, 75.5% of women in NHS Nottingham City and 80.5% of women in NHS Bassetlaw. Nationally 77.2% of eligible women were screened as of 31 March 2011.

- Breast screening age extension is being rolled out across all three breast screening units in Nottinghamshire, in line with the Cancer Reform Strategy objective.

Bowel Cancer Screening Programme

- The Nottinghamshire programme started in Bassetlaw in February 2008, in Nottinghamshire County (South) in March 2008 and Nottingham City in April 2008. Screening began in Ashfield, Mansfield, Newark and Sherwood in January 2009.

[1] The Cancer Reform Strategy, Department of Health, December 2007

- Uptake in NHS Nottinghamshire County is around 60%, in NHS Nottingham City it is around 50% and is around 58% in NHS Bassetlaw, comparable with a national uptake of 54.8%

Local organisational structure

Locally, the Cancer Screening Programmes are overseen by multidisciplinary working groups, specific to each programme. Working group membership includes representatives from public health, provider trusts, the call and recall service, laboratories, regional quality assurance organisations, relevant PCT representatives and lay members as appropriate. The role and function of the working groups is to review programme standards against set targets and manage any developments, incidents and significant events within the relevant screening programme. Working groups support the development of appropriate protocols, develop screening pathways, problem solve local issues and oversee health promotion initiatives aimed at increasing uptake of each screening programme locally. A particular focus for all cancer screening programme working groups is to address inequalities in uptake and outcomes for specific groups within the population.

These groups are:

- **Breast Screening Liaison Group**
  Chair: Claire Probert, Senior Public Health Manager, NHS Nottinghamshire County

- **District Cervical Cytology Working Group**
  Chair: Dr Kate Allen, Consultant in Public Health/Screening Commissioner, NHS Nottinghamshire County

- **Bowel Screening Working Group**
  Chair: Claire Probert, Senior Public Health Manager, NHS Nottinghamshire County

Bassetlaw is considered within these groups. However services for diagnosis and treatment linked to the screening programmes are provided within South Yorkshire. Therefore performance of these aspects of the screening programmes are overseen by working groups in South Yorkshire.

Quality Assurance for each of the cancer screening programmes is coordinated by East Midlands Quality Assurance Reference Centre (QARC). Each QARC is active in monitoring performance, supporting developments in the programmes and coordinating regular visits to all elements of the screening programmes. Acute services for Bassetlaw come under the North East Yorkshire Humber QARC.

Data within the report

A variety of data sources has been used within the report. For the incidence and prevalence of cancer screening the UK Cancer Information Service (UKCIS) was used as a primary source of data. http://www.ncin.org.uk/cancer_information_tools/ukcis.aspx. UKCIS is a national web-based reporting tool, which spans across the NHS national network, providing the user access to cancer rates. This will enable directly standardized rates (DSR) to be calculated based on PCT population size. Data has been pooled into 3 years rolling to show general trend against the English average.

NHS CERVICAL SCREENING PROGRAMME

Background

The aim of the NHS Cervical Screening Programme (NHSCSP) is to reduce the number of women who develop invasive cervical cancer (incidence) and to reduce the number of women who die from the disease (mortality). Screening detects abnormalities within the cervix that could, if left untreated, develop into cancer.

The NHSCSP calls women for screening every 3 or 5 years depending on their age. Women aged 25 – 49 are called for screening every 3 years and women aged 50 – 64 are called every 5 years.

Call and recall for all women eligible for screening in Nottinghamshire is managed by a third party provider, NHS Shared Business Services (SBS). Services previously provided by a PCT call and recall service were centralised across the region during 2011.

Laboratory services are provided by Derby Royal Hospital NHS Trust for NHS Nottinghamshire County and NHS Nottingham City and by Sheffield Teaching Hospital NHS Foundation Trust for NHS Bassetlaw. In both cases samples are taken to the lead laboratory for screening via local transport services.

Colposcopy services have remained localised and auto-referral systems have been maintained from both the Derby and Sheffield laboratories. These systems send all reports of abnormal results requiring investigation directly to colposcopy units in order to initiate the required referral for an outpatient appointment. This link operates between the Derby laboratory and colposcopy units at Nottingham University Hospital (NUH) and Sherwood Forest Hospital Foundation Trust (SFHFT) and from the Sheffield laboratory into Doncaster and Bassetlaw Hospital.

Cervical cancer incidence and mortality

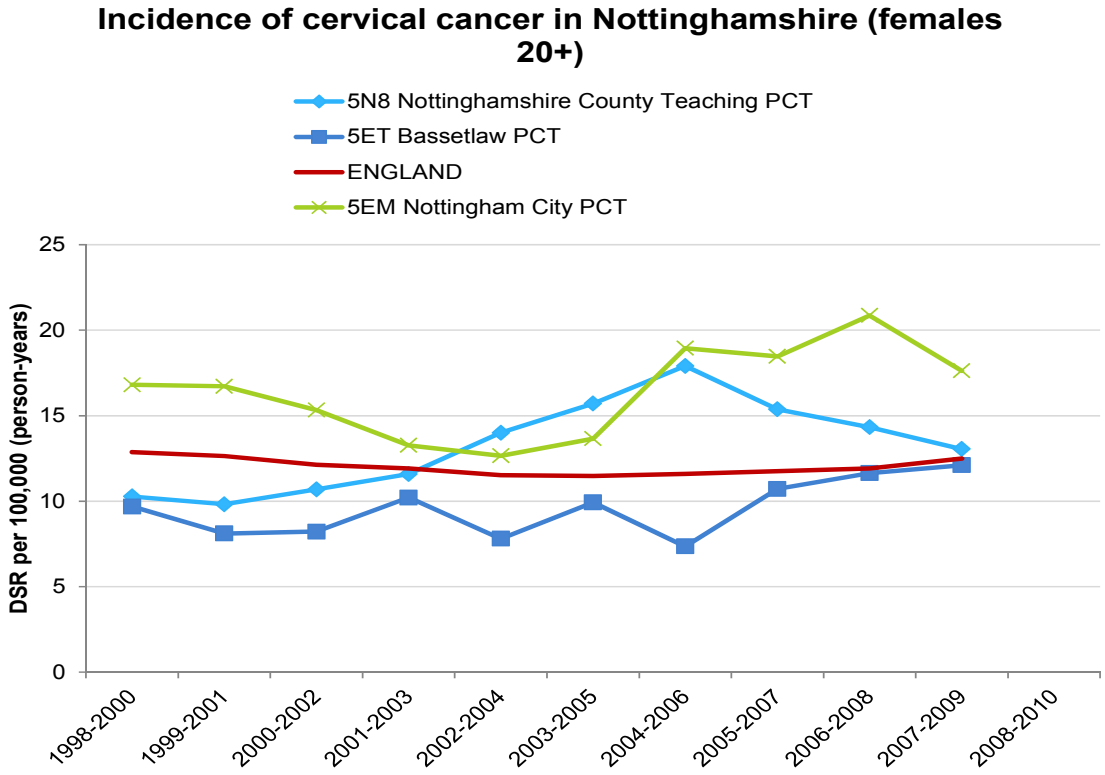


Figure 1 - Source: UK Cancer Information Service (UKCIS)

Nationally the incidence of cervical cancer remains steady. In NHS Nottinghamshire County, numbers of new cases of cervical cancer peaked during 2004-2006, followed by a gradual decline. Nottingham City had a peak in cervical cancer during 2006-2008 however recent figures shows that the number has recently declined for both City & County and are reducing back towards the national trend. NHS. NHS Bassetlaw has a lower incidence of cervical cancer than the national average however has recently moved in-line with the national average.

Figure 2 Source: UK Cancer Information Service (UKCIS)

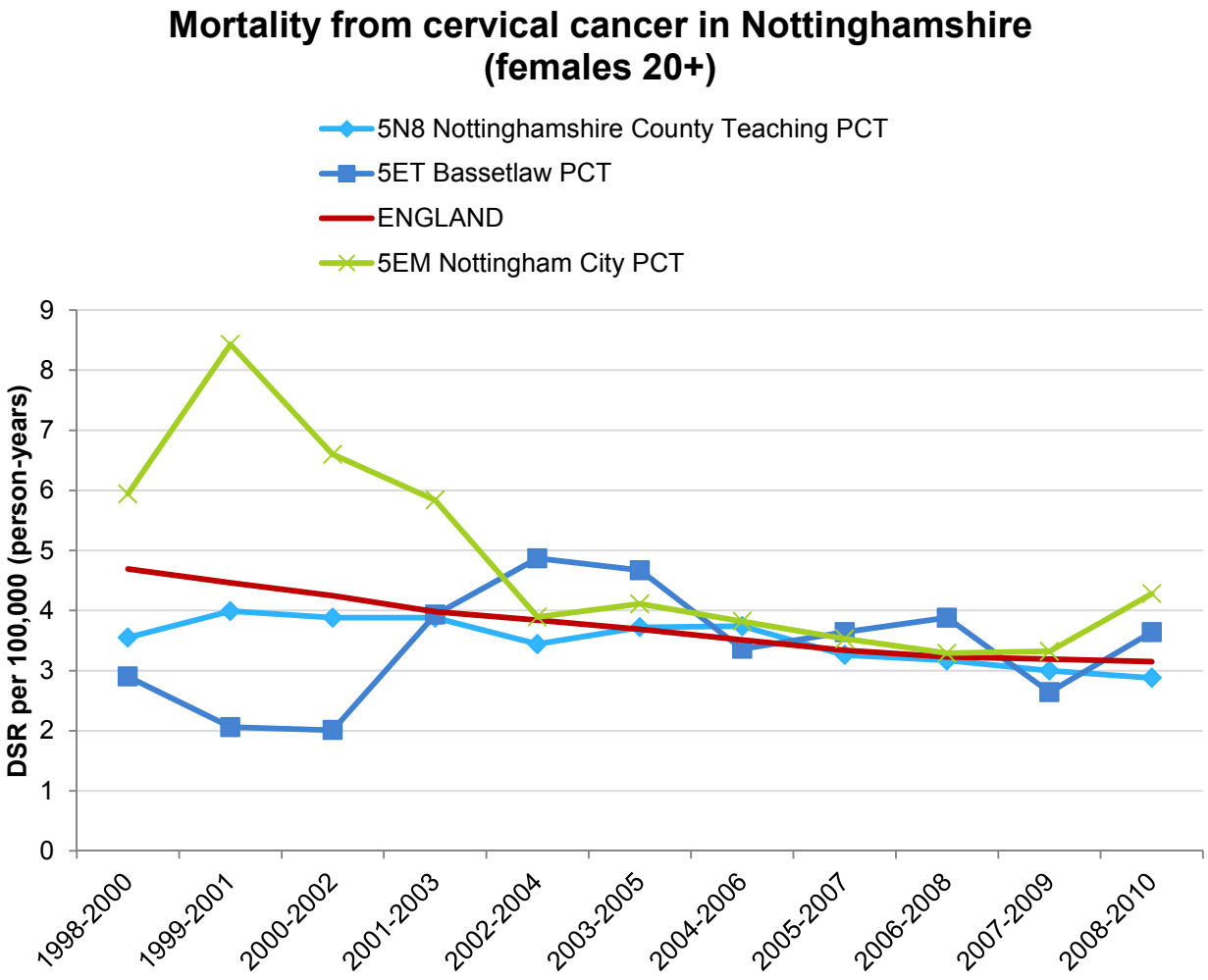


Figure 2 shows mortality from cervical cancer nationally has been on a decline. NHS Nottinghamshire County follows the national trend and is just below national average. NHS Nottingham City was significantly above national average in 1999-2001 but has since reduced mortality until recently when there has been a rise in mortality. NHS Bassetlaw has varied pattern of mortality relating to cervical cancer but has also recently seen a significant increase which has taken Bassetlaw above the national average. Numbers in Nottinghamshire County are low around 40 cases per year.

Programme Performance

Coverage

Coverage is calculated as the number of women in an age group who have had an adequate screening test within the last five years, as a percentage of the eligible population in that age group. The national target is at least 80% coverage of eligible women. Nationally, the number of eligible women who attend for cervical screening is decreasing year on year and this is reflected across Nottinghamshire also.

Jade Goody's cervical cancer diagnosis and subsequent death in March 2009 resulted in an increase in women attending for cervical screening both nationally and locally. However this has not had a sustained impact on screening coverage rates.

Coverage by age group

Data by age group shows a slight decrease in coverage in most age groups over the last three years. Coverage for younger women continues to be substantially lower, particularly in NHS Nottingham City, where coverage for those aged 25-49 decreased to 72.5% in 2010-11. It is known that coverage is

lowest in young women aged 25-29 and this is of particular concern. Table 1 and Figure 3 illustrate the trends and comparisons in coverage over recent years. For detailed age breakdown of coverage see Appendix 1.

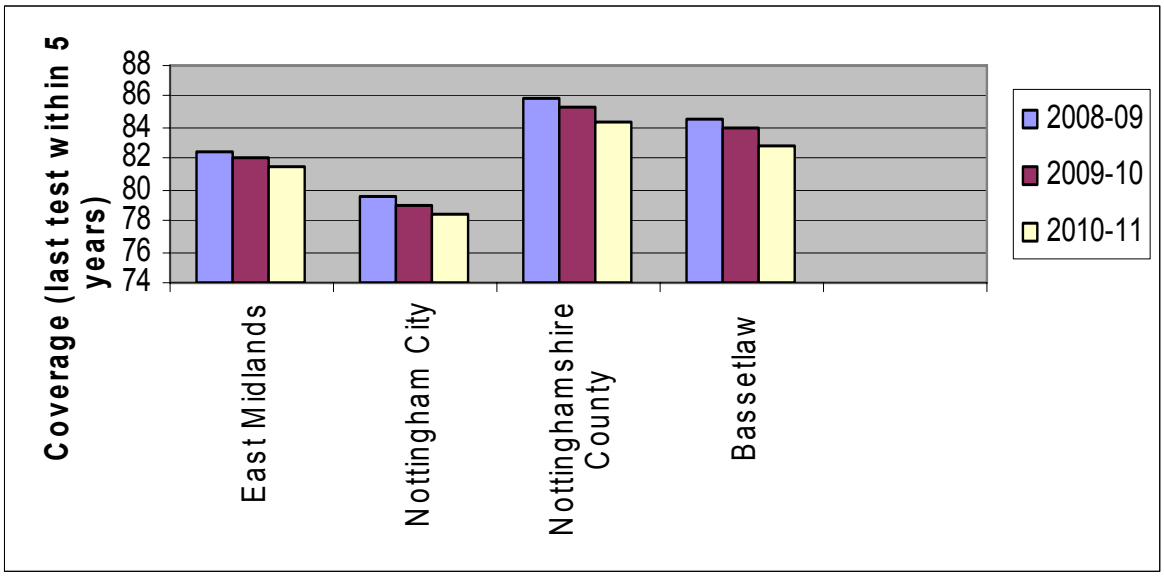
Table 1: Coverage (as % of eligible women) by age band, 2008 to 2011

		Coverage by area (%)			
Year	Age group	East Midlands	NHS Nottingham City	NHS Nottinghamshire County	NHS Bassetlaw
2008-09	25-49	76.7	73.8	81.2	79.0
	50-64	82.7	81.7	85.2	83.8
	25-64	82.4	79.6	85.8	84.5
2009-10	25-49	77.6	73.1	81.6	79.7
	50-64	81.9	81.2	84.4	82.6
	25-64	82.1	78.9	85.4	83.9
2010-11	25-49	76.9	72.5	80.4	78.7
	50-64	80.4	79.2	82.3	80.7
	25-64	81.4	78.4	84.3	82.9

Source: *KC53,*

Age 25-49 less than 3.5 years since last adequate test, age 50-64 and 25-64 less than 5 years since last adequate test

Figure 3: Percentage 5 year coverage by PCT at 31 March 2011 2008-2011 (all ages)



Source: *Cervical Screening Statistical Bulletins 2009/10 and 2010/1*

Cancer Reform Strategy – turn around times

The Cancer Reform Strategy pledged that women would receive their cervical screening results within two weeks of the date of their test by December 2010. The national standard is that 98% of women receive their result within 14 days of the date of test, known as the 14 day turn around time.

Data was previously collected for time taken from the date of screening to the *availability* of the result i.e the date the result letter was sent to the woman by the call and recall office. This is shown for Nottinghamshire PCTs in Table 2.

Table 2: Time from screening to availability of result

	Area/PCT	Number of results letters sent	% sent within 2 weeks	% sent between 2 and 4 weeks	% sent between 4 and 6 weeks	% sent over 6 weeks
2009-10	England	3,504,088	44.6	27.1	14.1	14.2
	East Midlands	280,420	50.3	24.6	10	15.0
	Bassetlaw	6,803	46.8	42.8	9.8	0.5
	Nottingham City	19.494	21.8	45.4	10.4	22.3
	Nottinghamshire	42,502	46.2	35.9	5.9	9.1
2010-11	England	3,584,418	82.8	14.6	1.8	0.8
	East Midlands	292,453	83.8	15.5	0.5	0.2
	Bassetlaw	7,110	66.3	27.7	5.5	0.5
	Nottingham City	20,726	36.7	62.1	1.1	0.1
	Nottinghamshire	47,181	56.7	42.4	0.6	0.3

Source: *Cervical Screening Statistical Bulletins 2009/10 and 2010/11*

Table 2 shows that although the PCTs were some distance from achieving the target of 14 days turn around in 2009-2010, this was inline with the national average. Laboratories were beginning to equip themselves to achieve the new target and PCTs worked with sample takers to ensure that tests were transported as soon as possible to laboratories. In 2010-2011, results had improved significantly across England and the East Midlands. However in Nottinghamshire there was still considerable improvement required to achieve national targets.

Cytology laboratory performance

Prior to 2010, samples were processed and read at three laboratories, namely Doncaster and Bassetlaw Hospital (for NHS Bassetlaw samples), Sherwood Forest Hospital (SFHFT) and Nottingham University Hospital (NUH). Following reviews in Nottinghamshire and South Yorkshire, it was agreed that cytology laboratory services should be centralised. Cytology services in South Yorkshire and Bassetlaw were all transferred to the Royal Hallamshire Hospital in April 2010. Laboratory services provided in Derbyshire and Nottinghamshire were centralised at Derby Royal Hospitals, transferring from SFHFT in February 2011 and from NUH in June 2011. Both transfers had an impact on 14 day turn around times within the laboratories. There were a number of issues which have also been identified which have impacted on the 14 day turn around times including:

- practices 'batching' samples to send to the laboratory, incurring additional delays
- ensuring transport links on to the Derby laboratory
- staffing levels at the Derby laboratory
- delays specific to the laboratory at Sheffield, incurred as a result of the HPV triage pilot process.

By March 2012, performance against the 98% standard for receipt of results was achieved in NHS Bassetlaw but not in NHS Nottingham City or NHS Nottinghamshire County. Measures have been put in place, including a review of transport arrangements, following up delays with practices and additional resource within the laboratories to improve performance to ensure achievement of the target.

The detailed performance data relating to laboratories providing cytology services to Nottinghamshire women is summarised in Appendix Table 2. Performance data is reviewed regularly by the District Cervical Cytology Cytology Working Group and the QARC, with actions taken to address concerns at an early stage.

Colposcopy Performance

Overall the performance of the colposcopy units service the women of Nottinghamshire is good and most standards have been achieved. Where national standards were not met in 2009/2010, there has been significant improvement in performance in the colposcopy units for 2010/2011. The direct referral system has helped achieve the waiting times to colposcopy.

Table 3: Colposcopy performance 2009/10

	NUH		SFHT	Doncaster and Bassetlaw Hospitals			
	City Hospital	QMC	Kings Mill, Newark	Bassetlaw DGH	Doncaster GUM	Doncaster RI	Retford Hospital
>90% women with high grade result seen ≤ 4 weeks	97	96.5	85.2	91.2	83.3	97.9	92.6
All colposcopists to see ≥ 50 new cases p.a.	Yes	Yes		Yes	Yes	Yes	Yes
100% women to be informed of biopsy result ≤ 8 weeks	99.8	96.3	93.6	100	100	99.4	97.8
DNA rate < 15%	16.8	10.1	7.1	13.2	23.7	18.2	19.4

Source: KC65 - Colposcopy Clinics: Referrals, Treatments and Outcomes

Table 4: Colposcopy performance 2010/11

	NUH		SFHT	Doncaster and Bassetlaw Hospitals			
	City Hospital	QMC	Kings Mill, Newark	Bassetlaw DGH	Doncaster GUM	Doncaster RI	Retford Hospital
>90% women with high grade result seen ≤ 4 weeks	98.0	99.6	97.9	96.7	86.6	100	95.5
All colposcopists to see ≥ 50 new cases p.a.	Yes	Yes		Yes	Yes	Yes	Yes
100% women to be informed of biopsy result ≤ 8 weeks	100	97.0	95.1	95.4	96.2	100	100
DNA rate < 15%	14.0	7.8	7.9	11.5	13.4	20.6	15.6

Source: KC65 - Colposcopy Clinics: Referrals, Treatments and Outcomes

In those units not achieving the biopsy result standard, liaison between East Midlands Quality Assurance Reference Centre (QARC) and the unit indicated that the most frequent cause relates to reduced secretarial staffing. Occasionally there may be delayed reports from the associated histopathology provider. This performance has been addressed with units by the QARC.

The areas where there have been challenges in achieving national standards are detailed below, together with developments to address these.

Waiting times: >90% women with high grade result seen ≤ 4 weeks
Failure to achieve waiting time standards has been found to relate to poor documentation of the date the first apportionment was offered or complex booking systems. All colposcopy units now operate a direct referral system, whereby positive cytology results are sent directly to colposcopy and an outpatient's appointment is generated. This has improved the availability of appointments within four weeks. In some cases staff sickness has lead to problems in the achievement of the target for appointments within four weeks.

Informing of biopsy result: 100% women to be informed of biopsy result ≤ 8 weeks
It is important that women receive the results of their biopsy promptly to minimise anxiety and to ensure timely follow up. Over half the trusts in 2010-11 fell short of the biopsy result target and this will continue to be monitored. NUH reported problems in relation to pathology and laboratory administrative staffing. These issues have now been resolved and improvements are expected. Similar issues exist in Doncaster and Bassetlaw.

Do Not Attend Rates: DNA rate < 15%
Performance data indicates high DNA rates for follow up appointments in some units. An approach recently adopted is to encourage women to attend by sending reminders one week prior to the appointment. The impact of this approach is being monitored.

Current & Future Developments

Cancer Reform Strategy - automation

The Cancer Reform Strategy highlighted the intention to use 'new technologies' including automation of cytology reporting, once the research evidence supports this approach'. The Derby Cytology Laboratory has been involved in a trial of one such technology in 2009-10, looking at the accuracy of automated screening for the detection of underlying disease. The overall evaluation of the technology did not support the use of automation for primary screening. However, the results are to be evaluated to explore for the potential use of the 'no further review' category as a pre-screening tool. This would equate to 25% of samples being screened as negative with no manual screening required and this would have a significant impact on the workload of the cytology laboratories.

HPV Testing

Human Papilloma Virus (HPV) virus is common, with around 100 identified strains. Following infection with HPV, the virus is usually cleared naturally by the body. However in a small minority of cases, infection is not cleared and particular strains of the virus are known to cause cervical cancer. Following the evaluation of a pilot scheme of HPV testing of cytology samples, the National Screening Committee have recommended that HPV testing to be incorporated into the Cervical Screening Programme nationally. The new process will see HPV tests carried out on samples from women whose result is borderline or shows mild abnormality. The result of the HPV test will determine the future treatment or management required and ultimately will lead to fewer women requiring repeated, long term follow up.

Locally, HPV testing has been rolled out across NHS Bassetlaw and it is envisaged that this will occur across the rest of Nottinghamshire during 2012.

NHS BREAST SCREENING PROGRAMME

Background

The aim of the NHS Breast Screening Programme (NHSBSP) is to reduce mortality from breast cancer by detecting small changes in breast tissue at an early stage. Early detection allows more successful and less invasive treatment.

The NHSBSP offers screening to women aged 50–70 every three years. However, currently there is a trial underway offering screening to women aged 47 – 49 and 71 - 73. Women aged over 70 years and not part of the trial are able to access screening if they self refer. Women are invited to attend for screening once every three years, using a call and recall system based on the Exeter Patient Registration System. This is administered by Nottingham Breast Institute for all three Nottinghamshire PCTs.

Breast screening is provided by:

- **Nottingham University Hospitals NHS Trust (NUH):** The Nottingham Breast Institute at Nottingham City Campus, Ropewalk House (located in the city centre) and mobile provision serving rural areas and Newark

- **Sherwood Forest Hospitals NHS Foundation Trust (SFHFT):** at The Breast Unit, Kings Mill Hospital (KMH)

- **Doncaster and Bassetlaw Hospitals NHS Foundation Trust (DBT**): Bassetlaw District General Hospital (BDGH)

The initial screening process consists of two-view mammography. From this initial screen women may be recalled for further assessment. Women attending for their first screen are approximately three times more likely to be recalled for assessment than those who have been screened previously.

The screening programme is commissioned by NHS Nottinghamshire County on behalf of NHS Nottingham City and NHS Bassetlaw.

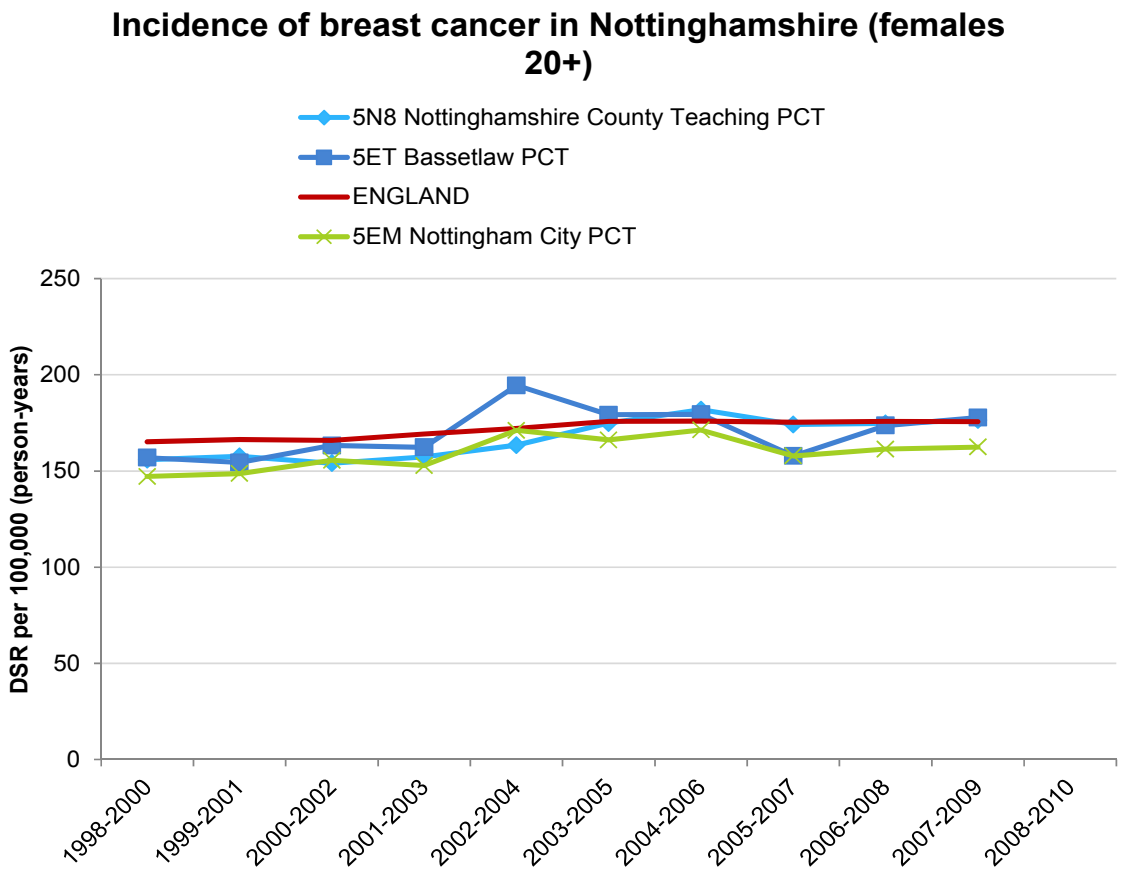
Quality standards relating to the various element of the screening programme, provided by the organisations detailed above are monitored and supported by two regional Quality Assurance Reference Centres:

- **East Midlands Quality Assurance Centre** monitors and supports NUH and SFHT breast screening units.
- **South Yorkshire and Humber Quality Assurance Centre** monitors and supports the BDGH breast unit.

There is a robust external quality assurance programme underpinning the programme on behalf of the national NHSBSP. Each PCT has an action plan in place to address any issues raised through that process. The Nottinghamshire Breast Screening Liaison Group meets biannually to oversee and performance manage the programme in conjunction with the provider units. Bassetlaw PCT links with the Doncaster steering group.

Incidence and mortality of breast cancer

Figure 4 Source: UK Cancer Information Service (UKCIS)



National data relating to breast screening shows that NHS Nottinghamshire County & NHS Bassetlaw are following the national trend with breast cancer incidence. NHS Nottingham City has a slightly lower incidence of breast cancer than the national average.

Figure 5 Mortality from Breast Cancer below has seen some small increases over time but generally has remained stable and following the national downward trend. NHS Nottinghamshire County & NHS Bassetlaw is slightly above national average.

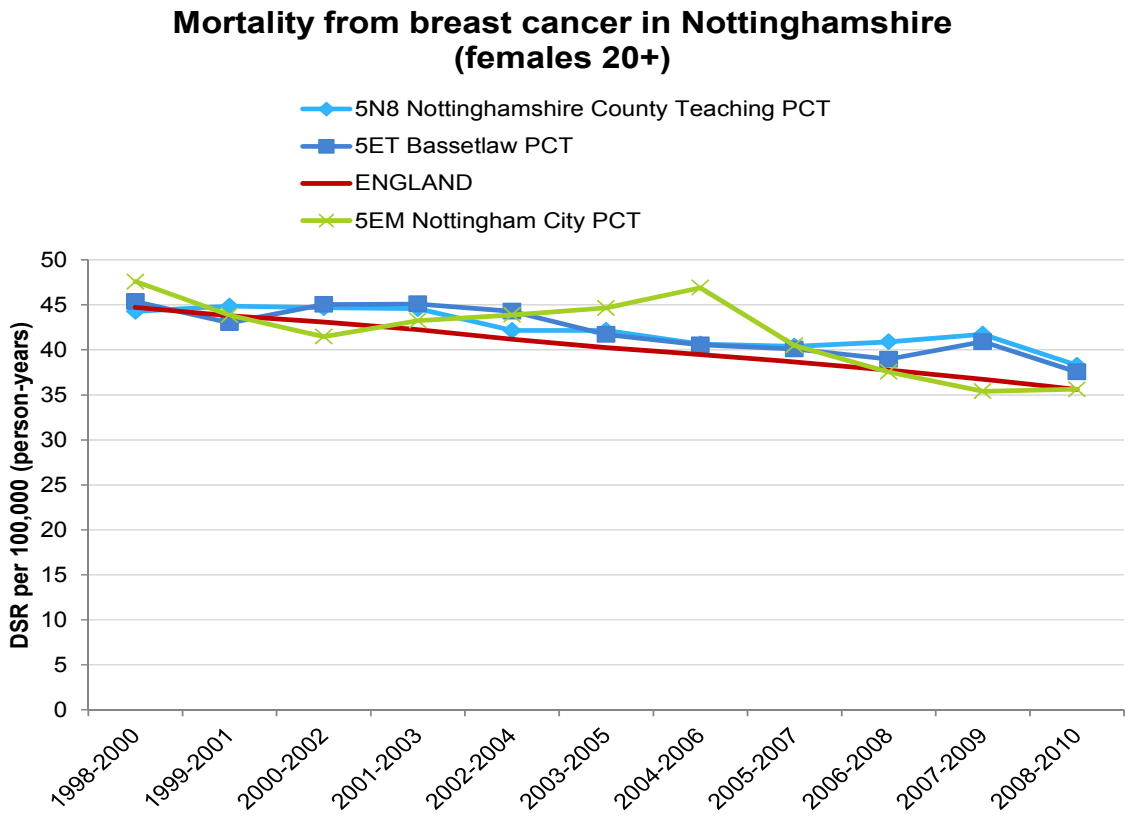


Figure 5 Source: UK Cancer Information Service (UKCIS)

Programme performance

During the reporting period 2009-11, all units continued to perform well against the minimum national standards required and in many cases exceeding performance targets set. The small cancer detection rates are particularly important in reducing mortality and both Nottinghamshire units (Nottingham Breast Unit and the Welcome Unit at Kings Mill) are performing well in this respect. Performance against Key Performance Indicators is shown Appendix 3.

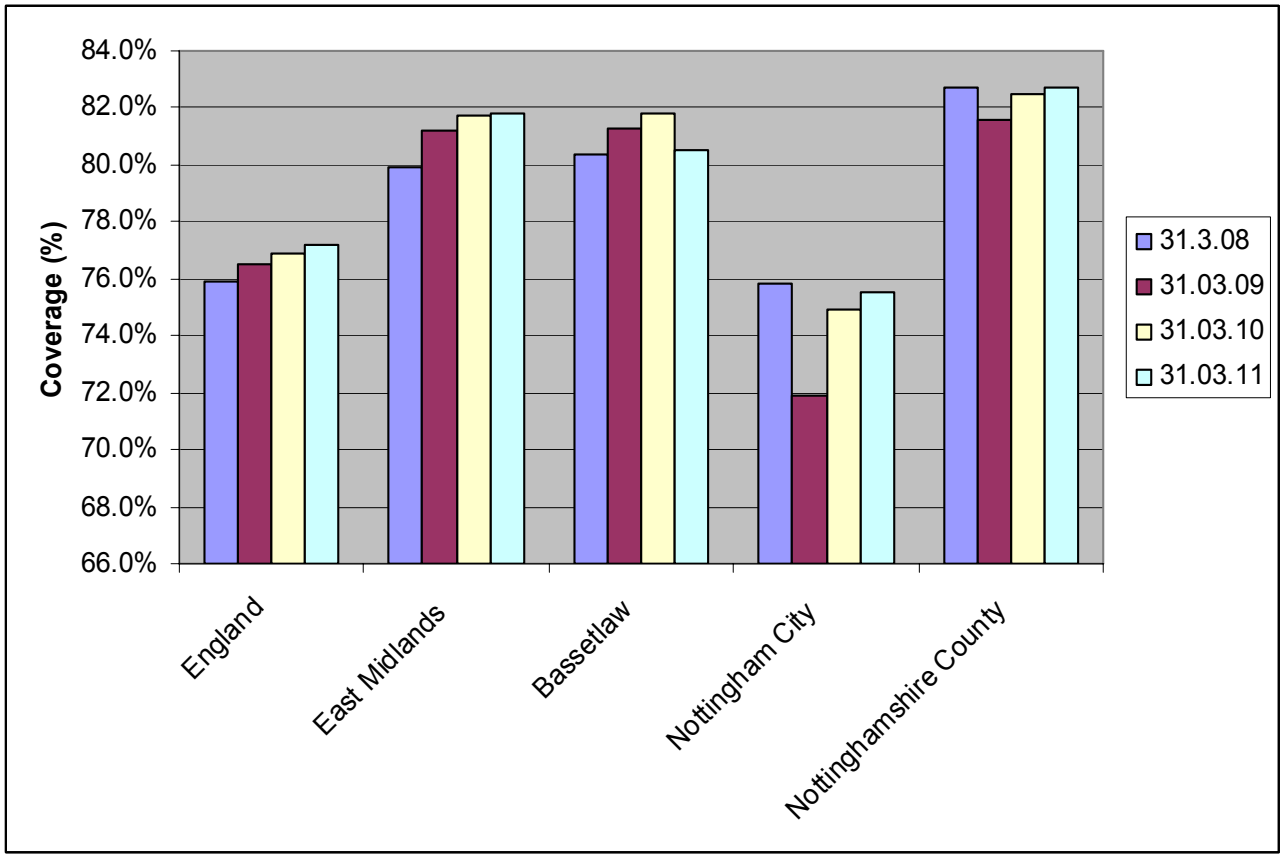
Coverage

Coverage is defined as the percentage of women resident and eligible for screening at a particular point in time who have been screened within the last 3 years and have a recorded result. As women may be called between their 50th and 53rd birthday coverage is calculated for women aged 53-70 years. The minimum national standard is 70% of eligible women should be screened. Figure 6 shows the percentage coverage for the three Nottinghamshire PCTs compared to the regional and national rate.

Coverage exceeds the national standard of 70% overall. There is some variation year to year partly as a result of slight changes in numbers screened each year of the three year screening cycle. During 2009 as a result of staff shortages there was slippage within the breast screening programme at NUH which had an impact on coverage for the 08/09 financial year.

Uptake for the prevalent first round of screening at Doncaster was slightly below the 70% target in 2010-11 (this target is based on the *screening unit* and is not for NHS Bassetlaw – see Appendix 3). A health promotion group has been established in Bassetlaw to review uptake for breast screening in the area.

Figure 6: Annual percentage coverage for breast screening for England, East Midlands, Bassetlaw, Nottingham City and Nottinghamshire County, 2008 - 2011



Source: Breast Screening Statistical Bulletins 2009/10 and 2010/11

Screening round length

Eligible women within the screening age range are invited every 3 years for breast screening. The minimum national standard is that at least 90% of women are first offered appointments within 36 months, with a target of 100%. During 2009/10 performance of the Nottingham Breast Unit fell below this and only screened 60% of women within 36 months. This was as a result of staffing shortages and uneven numbers within the 3 year screening round. A recovery plan was implemented to address the slippage and also to equalise numbers across the three year screening schedule. Data for 2010/11 indicates that performance is now above the national standard (see Appendix 3)

Benign biopsy rates

Benign biopsy rates at all three screening units exceed the minimum rate expected within the prevent screening round. This has been investigated and is not due to a failure of the assessment process but is as a result of the diagnosis of 'high risk lesions' on initial needle biopsy, which require surgical excision.

The report following the Quality Assurance (QA) visit to the Doncaster screening unit in May 2012 highlighted a low rate of biopsy as a concern. The QA report also highlighted concerns about the small cancer detection rate which fall below the minimum standard expected during 2010/11. This is being investigated and will be addressed as part of an action plan to be developed as a result of the QA report.

Screening results and screening to assessment waits

The minimum national standard is that >90% of women receive their screening test result within two weeks of undergoing screening, with a target of 100%. NUH and SFHFT Breast Screening Units achieved 96.3% and 99.6% respectively

The screening to assessment minimum national standard is for >90% of women requiring further assessment receive this assessment within 3 weeks of their screening, with a target of 100% NUH and SFHFT Breast Screening Units achieved 91.9% and 94.6% respectively.

The performance at Doncaster against the target for screening to assessment within three weeks also falls slightly below the 90% target. This is indicative however of patient choice and does not reflect the first available appointment offered.

Current and future developments

Age extension

Currently there is a trial underway, offering screening to women aged 47 – 49 and 71 – 73. The age extension trial is being implemented through a randomised programme. Practices will have either the younger or older cohort of women within the extension invited but not both. This randomisation will be rolled out over two screening rounds before fully extending to all women within the 47 to 73 age group.

Digital mammography

The Cancer Reform Strategy recommended that every breast unit should have at least one digital set of equipment for assessment. The screening units at SFHFT and Doncaster are both fully digital while at NUH has digital equipment available for assessment at Nottingham City Hospital but not elsewhere. A business case to convert other sites and the mobile units to have digital equipment is being progressed through NUH and it is hoped that the service there will be converted to be digital during 2012.

High risk screening

The Cancer Reform Strategy recommended that the surveillance of women at high risk of developing breast cancer should be transferred to become part of the national breast screening programme. Surveillance is currently undertaken at a local level, with varying standards and protocols. This recommendation was reiterated in the Improving Outcomes; A Strategy for Cancer[2] published in January 2011. It reported that the NHSBSP would manage the surveillance of women at higher risk across England, following national standards and protocols. This ensures that this group of women received a consistent and high quality service. Following successful pilots, work is underway to ensure that national standards are in place from April 2013. Discussions have been taking place on a regional basis to implement these arrangements locally. However further clarity is still required from the national programme regarding implementation.

Independent Review of the NHSBSP

In October 2011, Professor Sir Mike Richards (National Cancer Director) announced in a letter to the British Medical Journal that he would undertake a review of the evidence underpinning breast screening working with Harpal Kumar, Chief Executive of Cancer Research UK. The review is to include analysis of all relevant research including randomised control trials and observational studies relevant to breast screening. Independent advisors will carry out the review and the review report is expected in 2012. The report will be presented to the Advisory Committee on Breast Cancer

[2] Improving Outcomes: A Strategy for Cancer ,Department of Health January 2011

Screening. An update will be included in next year's annual report when the findings have been reported.

NHS BOWEL CANCER SCREENING PROGRAMME

Background

The aim of the NHS Bowel Cancer Screening Programme (NHSBCSP) is to reduce deaths from colorectal cancer. By identifying relevant changes in people before symptoms have developed, treatment can be offered at a time when it is most effective. Early detection allows more successful and less invasive treatment. Screening also enables the detection and removal of adenomatous polyps which are precursor lesions of colorectal cancer.

The NHSBCSP began in England in July 2006 and has been rolled out in stages across the county. The Nottinghamshire programme rolled out as shown:

- NHS Bassetlaw from February 2008
- NHS Nottinghamshire County (South) from March 2008
- NHS Nottingham City from April 2008
- NHS Nottingham County (North from January 2009

The Bowel Cancer Screening Eastern Regional Hub sends out invitation letters to all eligible men and women on behalf of the East Midlands and Eastern regions. A week later, individuals are sent faecal occult blood (FoBT) testing kits with a pre-paid envelope to return the completed test to the Bowel Cancer Screening Eastern Regional Hub.

Patients with a positive (abnormal) FoBT result are invited to an appointment with a specialist nurse in a screening clinic (part of the Screening Centre) to discuss their results. At the consultation, the specialist screening nurse will offer an appointment within two weeks for a colonoscopy. This is the routine investigation for the programme. The Nottinghamshire Bowel Cancer Screening Centre is based at the City Hospital Campus of NUH but operates a satellite clinic at Kings Mill Hospital, within SFHFT. People living in Bassetlaw who receive a positive test result are seen in the screening centre at Doncaster Hospital. Depending on the findings of the colonoscopy, patients will be offered screening again in two years time, entered into a surveillance programme or referred for treatment at a local hospital.

Incidence and mortality of bowl (colorectal) cancer

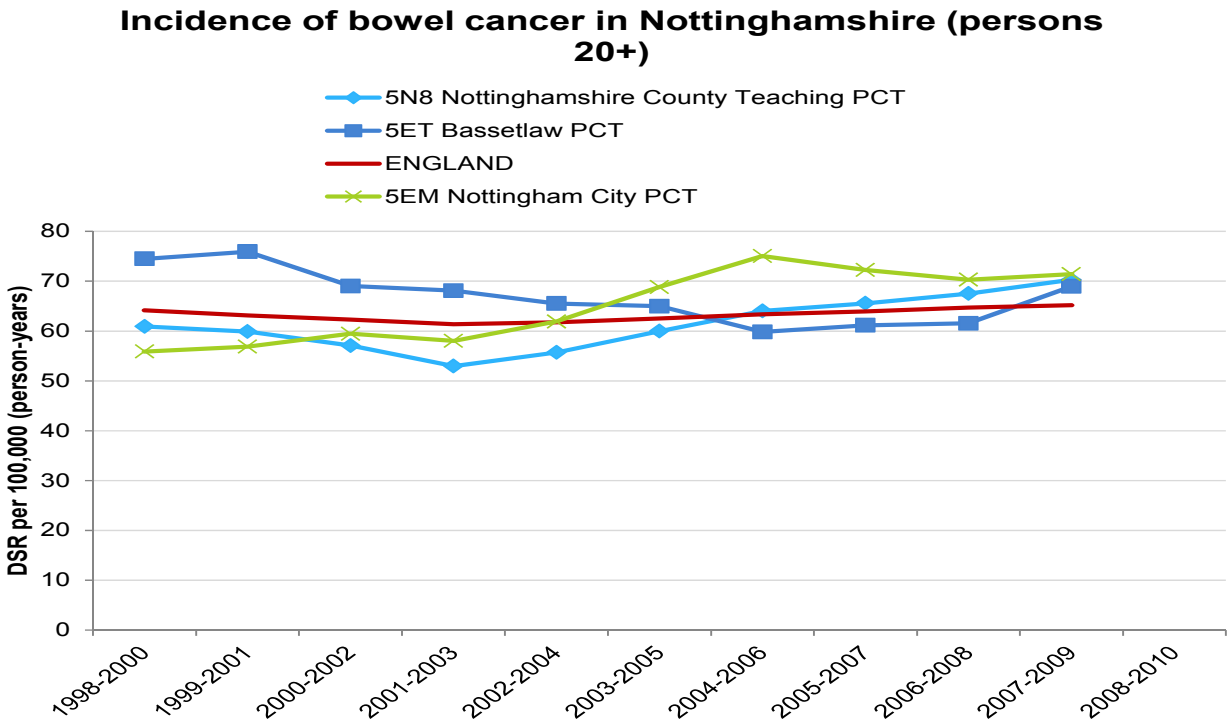


Figure 7 Source: UK Cancer Information Service (UKCIS)

Incidence of bowel cancer has been steadily on the increase in NHS Nottinghamshire County. Both NHS Nottingham City & NHS Bassetlaw have seen a drop in incidence but has recently been increasing to the national average and now all three PCT are above the national average.

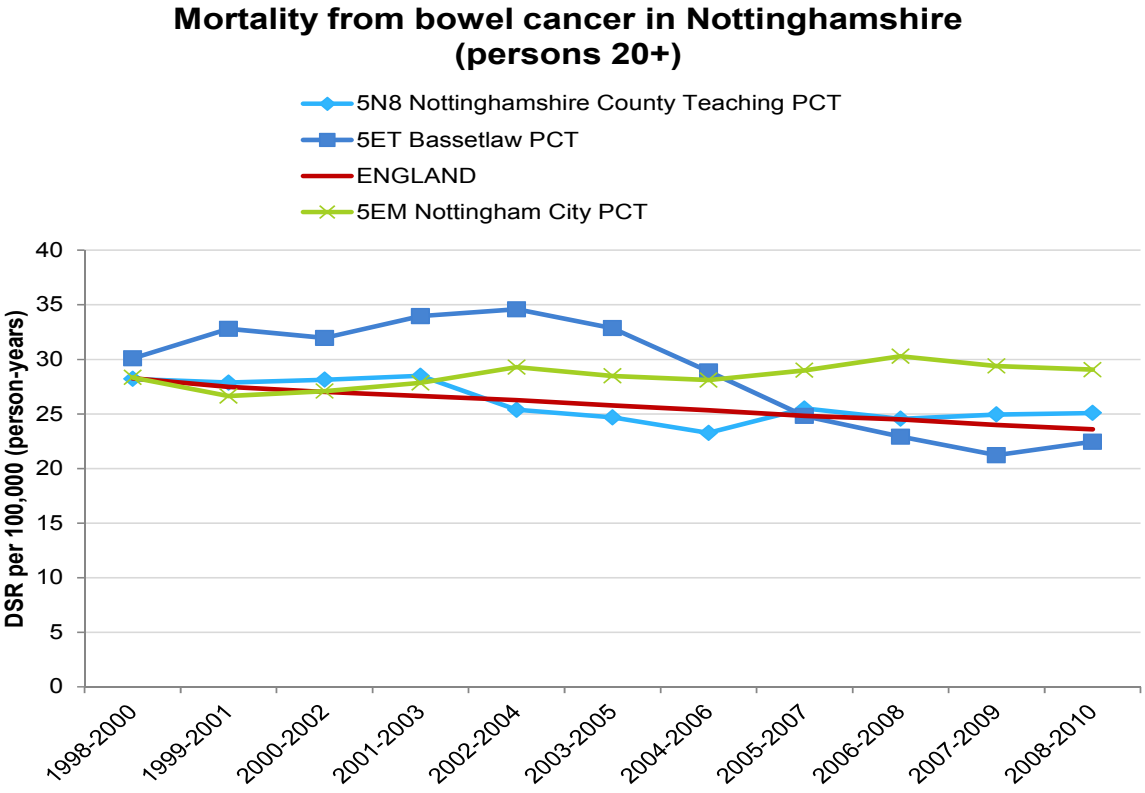


Figure 8 Source: UK Cancer Information Service (UKCIS)

Mortaility from bowel cancer nationally has been on a steady decline. NHS Nottinghamshire County is following the national trend. NHS Nottingham City is at a steady rate which is signifcantly higher than the national trend. NHS Bassetlaw was significantly higher than the national trend but is now lower.

Programme performance

In Nottinghamshire, the Bowel Cancer Screening Working Group reviews local programme performance against national targets, manages programme developments and oversees investigation and implementation of learning from incidents. Appendix 4 details performance for 2009, 2010 and 2011 for the Nottinghamshire Screening Centre and the South Yorkshire and Bassetlaw Screening Centre.

Screening Uptake

Uptake is defined as the proportion of men and women aged 60 to 69 years invited to participate in bowel cancer screening who return a completed and adequate kit. The NHSBCSP aims for an uptake rate of 60%. Uptake rates over the last four years are shown in Table 4.

Table 4: Annual % uptake of bowel cancer screening in Nottinghamshire and Nottingham City

	2008	2009	2010	2011
Nottingham City	**46.8%**	**45.4%**	**52%**	**48.8%**
Nottinghamshire County	**59.6%**	**57.7%**	**61.6%**	**60.5%**
Total Nottingham City and County	**55.3%**	**55.2%**	**59.5%**	**57.6%**

Source: Nottingham Bowel Cancer Screening Centre statistics

In Nottingham City uptake in 2011 was 48.8%, significantly lower than the desired aspiration level of 60%. Across Nottinghamshire County, uptake has been over 60% for the last two years. However, this hides the variation between the districts that make up the county.

In 2010 in order to address low uptake rates, NHS Nottingham City commissioned a local social enterprise to promote participation in the bowel screening programme specifically with local black and ethnic minority groups. A health promotion campaign was also run across the county to promote the screening programme in April 2011. While this resulted in a small increase in uptake, it did generate a large number of self referrals from people aged 70+ which had an impact on the performance of the Screening Centre at NUH.

In 2011, a health equity audit of the NHSBCSP in Nottinghamshire was completed and the information obtained will support the targeted work required to improve uptake and outcomes in groups identified as not participating in the programme. This is required to maximize the benefits of the programme, detecting bowel cancer early and reduce the related inequalities.

Current & future developments

Cancer Reform Strategy – age extension

The Cancer Reform Strategy outlined the plan for age extension of the NHSBCSP. It committed to extend the screening programme to people aged 60 – 73, introducing two further rounds of screening. Essential performance criteria for current waiting times and capacity need to be met to start age extension locally. An application has been made to implement the age extension in Nottinghamshire but to date it has not been approved because of concerns regarding waiting times within the symptomatic endoscopy service. A further bid will be submitted and the age extension will be implemented as soon as approval is given by the National Bowel Cancer Screening Programme Office.

Flexible Sigmoidoscopy

In March 2011, the UK National Screening Committee (UK NSC) recommended that a screening programme for bowel cancer using flexible sigmoidoscopy be introduced alongside the existing national bowel cancer screening programme. This decision was based on UK NSC criteria for introducing a new screening programme and from a three month public consultation. Flexible sigmoidoscopy will be provided as a one-off test, with the aim of detecting bowel polyps and cancers before any symptoms develop, using endoscopy to inspect the bowel. Clinical and cost-effectiveness modelling show that a one-off flexible sigmoidoscopy screen for bowel cancer in men and women aged 55 to 64 could reduce the incidence of colorectal cancer by 33% and mortality by 43% in those screened. [3]

In April 2011 the NHSBCSP announced that flexible sigmoidoscopy will be rolled out across England over the next few years. Men and women will be offered the one off test at age 55, in addition to the current FoBT for those aged 60 – 73 already in place. A bid has been submitted to implement the flexible sigmoidoscopy programme within Nottinghamshire during the first wave of roll out of the national initiative. The National Screening Committee has indicated that areas must first age extend before approval of flexible sigmoidoscopy bids.

[3] Once-only flexible sigmoidoscopy screening in prevention of colorectal cancer, Atkin WS et al, Lancet, May 2010

NHS Changes and Reforms

Currently the NHS Nottinghamshire PCT cluster commissions all National Screening Committee (NSC) recommended cancer screening programmes. Screening programmes are commissioned in line with patients' legal rights to nationally approved treatments and programmes as described in the NHS Constitution. Failure to commission and provide services could result in legal challenge.

From April 2013, the responsibility for commissioning of all NSC screening programmes will pass to the NHS Commissioning Board (NHSCB) using national service specifications. The local arrangements are yet to be defined but may be discharged through Public Health England (PHE).

Whilst the NHSCB will be the lead commissioner there will be an overlap of interests between NHSCB, PHE, Clinical Commissioning Groups (CCGs) and the Director of Public Health (Director of Public Health) in the Local Authority. This overlap arises from the;

- complexity of screening pathways which usually involve multiple providers including general practice.
- CCGs' interest in the quality and performance of screening programmes that are provided for their registered populations
- the eventual referral of patients from a screening pathway into a CCG commissioned diagnostic and treatment service.
- potential for screening programme developments to impact both positively and negatively on other hospital services (for example equipment purchased for a screening programme may also benefit other hospital services)
- a scrutiny role for the DPH in the local authority to assess coverage and quality of all screening programmes provided to the local population. In addition, both cervical and breast screening indicators are within the Public Health Outcomes Framework and will therefore be the part of the responsibility of local authorities.

Conclusion

Currently across Nottingham and Nottinghamshire (including Bassetlaw), there are robust structures and processes in place to ensure effective high quality cancer screening programmes for the local population. As commissioning of programmes transfers to the NHSCB, it will be important to maintain current oversight of all programmes, ensure effective performance management and support the ongoing developments within each programme.

Nicola Lane – Public Health Manger NHS Nottinghamshire County
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September 2012

Appendices

Appendix 1 –Cervical Cancer Screening Coverage Data

Coverage data NHS Bassetlaw 2009-2010

		Ceased for reasons of:					
Age Group at 31.3.11	Resident Population	Clinical (no cervix)	Age	Other reason	Eligible Population	No of women screened in last 5 years	Coverage (%) < 5 yrs since last adequate test
Under 20	12383	0	0	0	12383	13	0.1%
20 - 24	3053	1	0	0	3052	266	8.7%
25 - 29	2996	2	0	3	2994	2260	75.5%
30 - 34	2978	5	0	6	2973	2467	83.0%
35 - 39	3676	37	0	13	3639	3161	86.9%
40 - 44	4267	178	0	21	4089	3560	87.1%
45 - 49	4250	353	0	22	3897	3435	88.1%
50 - 54	3762	527	0	26	3235	2763	85.4%
55 - 59	3546	747	0	38	2799	2308	82.5%
60 - 64	3991	1078	712	172	2913	2316	79.5%
65 - 69	3093	835	1590	277	2258	1333	59.0%
70 - 74	2544	665	1353	293	1879	184	9.8%
75 - 79	2024	425	1079	417	1599	26	1.6%
80 and Over	3110	281	1184	374	2829	7	0.2%
25 - 64	29466	2927	712	301	26539	22270	83.9%
All Ages	55673	5134	5918	1662	50539	24099	47.7%

Coverage data NHS Nottingham City 2009-2010

		Ceased for reasons of:					
Age Group at 31.3.11	**Resident Population**	**Clinical (no cervix)**	**Age**	**Other reason**	**Eligible Population**	**No of women screened in last 5 years**	**Coverage (%) < 5 yrs since last adequate test**
Under 20	40804	0	0	0	40804	15	0.0%
20 - 24	24497	2	0	0	24495	521	2.1%
25 - 29	15082	9	0	8	15073	9765	64.8%
30 - 34	11462	21	0	8	11441	9075	79.3%
35 - 39	10701	118	0	13	10583	8788	83.0%
40 - 44	10548	324	0	40	10224	8745	85.5%
45 - 49	10046	708	0	68	9338	7932	84.9%
50 - 54	8346	1031	0	95	7315	6088	83.2%
55 - 59	6946	1271	0	108	5675	4614	81.3%
60 - 64	6529	1498	1104	343	5031	3928	78.1%
65 - 69	5236	1293	2540	580	3943	2136	54.2%
70 - 74	4848	1106	2622	737	3742	176	4.7%
75 - 79	4378	905	2262	1066	3473	23	0.7%
80 and Over	7147	528	2598	817	6619	15	0.2%
25 - 64	**79660**	**4980**	**1104**	**683**	**74680**	**58935**	**78.9%**
All Ages	166570	8814	11126	3883	157756	61821	39.2%

Coverage data NHS Nottinghamshire County 2009-2010

		Ceased for reasons of:					
Age Group at 31.3.11	**Resident Population**	**Clinical (no cervix)**	**Age**	**Other reason**	**Eligible Population**	**No of women screened in last 5 years**	**Coverage (%) < 5 yrs since last adequate test**
Under 20	72458	1	0	0	72457	19	0.0%
20 - 24	19013	2	0	0	19011	687	3.6%
25 - 29	19651	14	0	5	19637	14993	76.4%
30 - 34	19527	67	0	21	19460	16773	86.2%
35 - 39	22859	281	0	46	22578	19910	88.2%
40 - 44	25803	975	0	71	24828	21987	88.6%
45 - 49	25424	1923	0	116	23501	20760	88.3%
50 - 54	22124	2850	0	163	19274	16732	86.8%
55 - 59	20453	3725	0	169	16728	14112	84.4%
60 - 64	22201	5106	4078	808	17095	13961	81.7%
65 - 69	17741	4457	9082	1642	13284	7999	60.2%
70 - 74	14873	3580	8218	2076	11293	637	5.6%
75 - 79	12579	2484	6990	2687	10095	95	0.9%
80 and Over	20224	1512	7832	2634	18712	41	0.2%
25 - 64	**178042**	**14941**	**4078**	**1399**	**163101**	**139228**	**85.4%**
All Ages	334930	26977	36200	10438	307953	148706	48.3%

Coverage data NHS Bassetlaw 2010-2011

		Ceased for reasons of:					
Age Group at 31.3.11	Resident Population	Clinical (no cervix)	Age	Other reason	Eligible Population	No of women screened in last 5 years	Coverage (%) < 5 yrs since last adequate test
Under 20	12269	0	0	0	12269	6	0.0%
20 - 24	3089	1	0	0	3088	198	6.4%
25 - 29	3036	2	0	3	3034	2224	73.3%
30 - 34	2959	11	0	4	2948	2479	84.1%
35 - 39	3511	43	0	7	3468	3013	86.9%
40 - 44	4211	155	0	14	4056	3521	86.8%
45 - 49	4306	358	0	21	3948	3438	87.1%
50 - 54	3878	512	0	20	3366	2889	85.8%
55 - 59	3507	687	0	29	2820	2220	78.7%
60 - 64	4025	1078	924	302	2947	2263	76.8%
65 - 69	3230	890	1704	418	2340	1129	48.2%
70 - 74	2524	662	1406	335	1862	156	8.4%
75 - 79	2069	454	1085	441	1615	26	1.6%
80 and Over	3173	331	1302	434	2842	7	0.2%
25 - 64	29433	2846	924	400	26587	22047	82.9%
All Ages	55787	5184	6421	2028	50603	23569	46.6%

Coverage data NHS Nottingham City 2010-2011

		Ceased for reasons of:					
Age Group at 31.3.11	**Resident Population**	**Clinical (no cervix)**	**Age**	**Other reason**	**Eligible Population**	**No of women screened in last 5 years**	**Coverage (%) < 5 yrs since last adequate test**
Under 20	40213	0	0	0	40213	24	0.1%
20 - 24	25242	2	0	0	25240	391	1.5%
25 - 29	14507	8	0	5	14499	9277	64.0%
30 - 34	11713	25	0	5	11688	9287	79.5%
35 - 39	10179	89	0	14	10090	8424	83.5%
40 - 44	10353	298	0	24	10055	8557	85.1%
45 - 49	9930	668	0	64	9262	7868	84.9%
50 - 54	8439	978	0	80	7461	6198	83.1%
55 - 59	6989	1213	0	99	5776	4487	77.7%
60 - 64	6566	1466	1464	494	5100	3833	75.2%
65 - 69	5165	1301	2571	765	3864	1802	46.6%
70 - 74	4720	1095	2633	670	3625	182	5.0%
75 - 79	4283	898	2213	1064	3385	29	0.9%
80 and Over	7101	644	2815	943	6457	14	0.2%
25 - 64	**78676**	**4745**	**1464**	**785**	**73931**	**57931**	**78.4%**
All Ages	165400	8685	11696	4227	156715	60373	38.5%

Coverage data NHS Nottinghamshire County 2010-2011

		Ceased for reasons of:					
Age Group at 31.3.11	**Resident Population**	**Clinical (no cervix)**	**Age**	**Other reason**	**Eligible Population**	**No of women screened in last 5 years**	**Coverage (%) < 5 yrs since last adequate test**
Under 20	72778	1	0	0	72777	10	0.0%
20 - 24	19317	2	0	0	19315	473	2.4%
25 - 29	19852	16	0	12	19836	14567	73.4%
30 - 34	19929	61	0	19	19868	17050	85.8%
35 - 39	21890	279	0	36	21611	18972	87.8%
40 - 44	25726	929	0	57	24797	21984	88.7%
45 - 49	26063	1917	0	93	24146	21394	88.6%
50 - 54	22820	2846	0	134	19974	17345	86.8%
55 - 59	20671	3643	0	157	17028	13733	80.6%
60 - 64	22227	5016	5452	1401	17211	13565	78.8%
65 - 69	18659	4697	9904	2372	13962	6983	50.0%
70 - 74	14919	3708	8365	2141	11211	561	5.0%
75 - 79	12615	2576	6989	2734	10039	92	0.9%
80 and Over	20677	1846	8738	3012	18831	37	0.2%
25 - 64	**179178**	**14707**	**5452**	**1909**	**164471**	**138610**	**84.3%**
All Ages	338143	27537	39448	12168	310606	146766	47.3%

Appendix 2: Cytology Laboratory Performance

Parameter	*Derby*		*Nottingham City*		*Kings Mill*		*Doncaster*		*Sheffield*	
	09/10	*10/11*	*09/10*	*10/11*	*09/10*	*10/11*	*09/10*	*10/11*	*09/10*	*10/11*
Laboratory Workload	***n/a***	***75,287***	***46,889***	***49,700***	***20,251***	***18,561***	***25,719***	***n/a***	***n/a***	***89,947***
PPV * *09/10 Standard 74.2-90.3%* *10/11 Standard 77.0 -90.0%*	***n/a***	***94.2***	***88.8***	***n/a***	***94.1***	***92.5***	***87.6***	***n/a***	***n/a***	***81.7***
Low Grade (Mild/Borderline) Detection Rate *09/10 Standard 3.9 - 7.4%* *10/11 Standard 3.6 – 7.4%*	***n/a***	***4.4***	***5.8***	***5.2***	***4.2***	***3.6***	***7.1***	***n/a***	***n/a***	***3.4***
High Grade (Moderate or worse) Detection Rate *09/10 Standard 0.8 - 1.5%* *10/11 Standard 0.7 – 1.3%*	***n/a***	***0.8***	***0.9***	***1.0***	***1.0***	***0.9***	***1.3***	***n/a***	***n/a***	***1.0***
Inadequate rate	***n/a***	***1.5***	***3.5%***	***2.5***	***1.7***	***1.5***	***0.5***	***n/a***	***n/a***	***1.5***
Laboratory Turnaround Times %	***n/a***							***n/a***	***n/a***	
0-2 weeks		***99.8***	***52.5***	***69.8***	***99.9***	***100***	***71.4***			***83.9***
3-4 weeks		***0.2***	***21.5***	***29.9***	***0.1***	***0***	***28.4***			***15.3***
5-6 weeks		***0***	***8.9***	***0.2***	***0***		***0.1***			***0.7***
7-8 weeks			***6.0***	***0***	***0***		***0***			***0.1***
9-10 weeks			***10.5***	***0***	***0***		***0***			***0***
Over 10 weeks			***0.6***	***0***	***0***		***0***			***0***

* PPV – Positive Predictive Value is a measure of the laboratories ability to predict CIN[4]2 (cervical squamous intraepithelial neoplasia) or more severe abnormality from tests with a result of moderate or more severe dyskaryosis

[4] A condition in which moderately abnormal cells grow on the thin layer of tissue that covers the cervix. These abnormal cells are not malignant (cancer) but may become cancer. Also called cervical squamous intraepithelial neoplasm

Appendix 3:

Breast Cancer Screening Programme – Programme Standards 2008-2011

	Nottingham			North Nottingham			Doncaster			Min	Target
	2008/09	2009/10	2010/11	2008/09	2009/10	2010/11	2008/09	2009/10	2010/11		
Programme uptake *Percentage of women invited who attend*											
- prevalent round	74.2%	75.9%	77.5%	80.4%	77.3%	79.7%	76%	74%	**69%**		
- incident round	89.1%	88.9%	89.1%	90.4%	90.8%	91.4%	88%	89%	86%	70%	80%
- overall	76.0%	77.4%	77.4%	78.9%	78.4%	79.7%	77%	76%	74%		
Recall to Assessment *for further x-rays for review in clinic*											
- prevalent round	7.2%	6.1%	6.0%	7.1%	5.8%	6.8%	4.8%	6.8%	7.6%	<10%	<7%
- incident round	2.3%	2.2%	1.9%	2.4%	2.7%	2.3%	1.9%	2.3%	2.4%	<7%	<5%
Early recall *% women recommended for early recall after assessment*											
- overall	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.02%	0.01%	0.01%	<0.5%	≤0.25%
Benign biopsy rate *per 1000 women screened*											
- prevalent round	**3.8**	**3**	0.7	**3.8**	0.9	0.9	**1.6**	**2.4**	0.6	<1.5	<1.0
- incident round	0.2	0.6	0.2	0.6	0.5	0.7	0.3	0.4	0.3	<1.0	<0.75
Invasive cancer detection rate *per 1000 women screened*											
- prevalent round	6.4	6.7	5.4	8.6	5.7	7.0	7.0	4.8	5.4	≥2.7	≥3.6

- incident round	6.1	6.2	6.1	6.0	6.4	5.9	5.0	4.7	4.8	≥3.1	≥4.2
Small cancer detection rate *Cancers <15mm per 1000 women screened*											
- prevalent round	4.1	3.5	2.4	4.8	2.8	3.5	3.7	2.4	**1.2**	≥1.5	≥2.0
- incident round	4.2	4	4.4	3.7	4.3	3.6	2.4	3.2	3.3	≥1.7	≥2.5
Standardised detection ratio *takes account of age of women screened*											
- prevalent round	1.54	1.75	1.43	2.38	1.53	1.77	2.16	1.25	1.66		
- incident round	1.49	1.46	1.41	1.42	1.54	1.38	1.27	1.20	1.22	≥0.85	≥1.0
- overall	1.50	1.51	1.42	1.55	1.54	1.44	1.40	1.21	1.29		
Preoperative diagnosis rate *% of cancers diagnosed cytologically or histologically without surgery*											
- overall	94.5%	98.0%	95.9%	94.4%	100.0%	92.6%	100%	97%	97%	≥80%	≥90%
DCIS detection rate *cancers which are in situ carcinoma per 1000 women*											
- prevalent round	1.50	1.00	**0.00**	2.90	0.90	0.90	1.1	1.2	0.6	≥0.4	NA
- incident round	1.50	1.10	1.30	2.00	1.10	1.30	0.5	0.8	0.8	≥0.5	NA
Round length *% women offered appointment within 36 months of previous screen*											
- overall	91.5%	**60.6%**	99.1%	96.7%	97.9%	95.4%	**89.90%**	99.64%	99.07%	≥90%	100%
% women offered appointment within 38 months of previous screen											
- overall	99.2%	99.4%	99.3%	99.3%	99.6%	99.4%	97.80%	99.69%	99.70%		
Screening to results											
% women sent result within 2 weeks - overall	98.6%	98.6%	97.3%	99.2%	99.1%	98.8%	99.36%	99.27%	99.10%	≥90%	100%

Screening to assessment *% women who attend assessment clinic within 3 weeks of mamogram*	97.5%	98.4%	92.6%	99.7%	98.6%	94.2%	96.31*%	**89.10%**	**89.80%**	≥90%	100%

Appendix 4 – Bowel Cancer Screening Programme Performance

Nottinghamshire NHS BCSP PROGRAMME PERFORMANCE- 2009						
Quality Standard	**National Target**	**National Standard**	**Jan-Mar 10**	**Apr-June 10**	**July-Sept 10**	**Oct-Dec 10**
Colonoscopies Performed			119	106	171	205
Completion rate to caecum, terminal ileum or anastamosis	≥97%	≥ 90%	100%	94.26%	96.47%	96.04%
Average wait (in days) from +ve FOBt to SSP clinic	≥14 Days		7.3	8.2	10.53	11.02
Average wait (in days) from SSP clinic to colonoscopy	≥ 14 Days		5.19	7.95	13.25	18.76
Average wait (in days) from colonoscopy to SSP result clinic	≥ 21days		10.27	13.86	17.85	16.5
Adenoma detection rate	≥ 40%	≥ 35%	41.7%	44.7%	41.64%	41.61%
Cancer detection rate	11%		8.97%	14.83%	7.26%	7.69%
Polyp retrieval rate	≥95%	≥ 90%	87.47%	84.82%	92.93%	92.11%
Number of initial invites			12341	13442	13393	13982
Number of kits returned			8317	7832	7921	7878
Positivity			1.63%	2.48%	3.05%	2.58%
Uptake - FOBt			56.28%	55.14%	55.08%	54.28%
Uptake colonoscopy	88%	85%	91.2%	90.37%	86.79%	84.86%
Adverse events						
Post polypectomy bleeds			1	2	3	2
Perforations						

Nottinghamshire NHS BCSP PROGRAMME PERFORMANCE- 2010

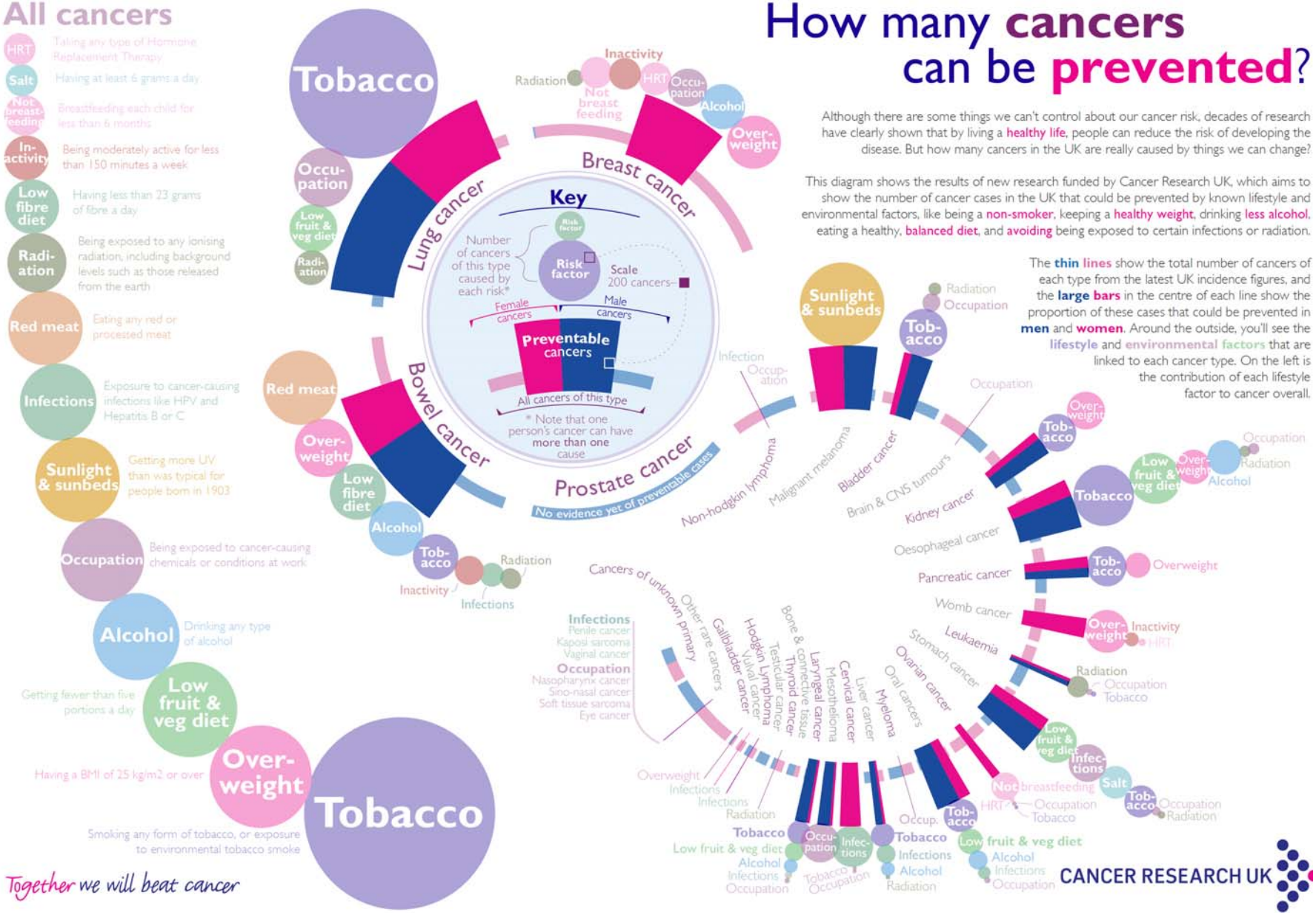
Quality Standard	National Target	National Standard	Jan-Mar 10	Apr-June 10	July-Sept 10	Oct-Dec 10
Colonoscopies Performed			245	182	234	195
Completion rate to caecum, terminal ileum or anastamosis	≥97%	≥ 90%	96.5%	96.84%	98.55%	96.12%
Average wait (in days) from +ve FOBt to SSP clinic	≥14 Days		8.53	8.44	8.88	7.57
Average wait (in days) from SSP clinic to colonoscopy	≥ 14 Days		14.48	8.19	6.67	8.8
Average wait (in days) from colonoscopy to SSP result clinic	≥ 21days		15.48	14.62	12.91	12.88
Adenoma detection rate	≥ 40%	≥ 35%	46.42%	39.43%	34.57%	54.74%
Cancer detection rate	11%		8.97%	14.83%	7.26%	7.69%
Polyp retrieval rate	≥95%	≥ 90%	86.28%	87.71%	92.39%	93.49%
Number of initial invites			12162	13526	13510	12628
Number of kits returned			8958	8738	8884	7865
Positivity			2.34%	2.4%	2.57%	2.85%
Uptake - FOBt			56.04%	64.42%	60.13%	57.2%
Uptake - Colonoscopy	88%	85%	91.2%	90.37%	86.79%	84.86%
Adverse events						
Post polypectomy bleeds			3	0	3	5
Perforations			1			

Nottinghamshire NHS BCSP PROGRAMME PERFORMANCE- 2011

Quality Standard	National Target	National Standard	Jan-Mar 11	Apr-June 11	July-Sept 11	Oct-Dec 11
Colonoscopies Performed			223	210	236	207
Completion rate to caecum, terminal ileum or anastamosis	≥97%	≥ 90%	96.63%	96.87%	98.42%	96%
Average wait (in days) from +ve FOBt to SSP clinic	≥14 Days		8.95	10.27	7.44	9.03
Average wait (in days) from SSP clinic to colonoscopy	≥ 14 Days		6.87	9.56	8.46	12.84
Average wait (in days) from colonoscopy to SSP result clinic	≥ 21days		11.33	13.89	12.63	15.36
Adenoma detection rate	≥ 40%	≥ 35%	40.10%	49.27%	40.37%	47.61%
Cancer detection rate	11%		10.3%	9.04%	5.08%	8.69%
Polyp retrieval rate	≥95%	≥ 90%	83.33%	94.26%	95.38%	97.69%
Number of initial invites			13095	12455	13140	13325
Number of kits returned			9580	9504	8075	7233
Positivity			2.22%	2.54%	2.32%	2.64%
Uptake - FOBt			62.4%	61.15%	52%	55.58%
Uptake - Colonoscopy	88%	85%	88.39%	86.26%	83.81%	88.66%
Adverse events						
Post polypectomy bleeds			1	0	1	2
Perforations						

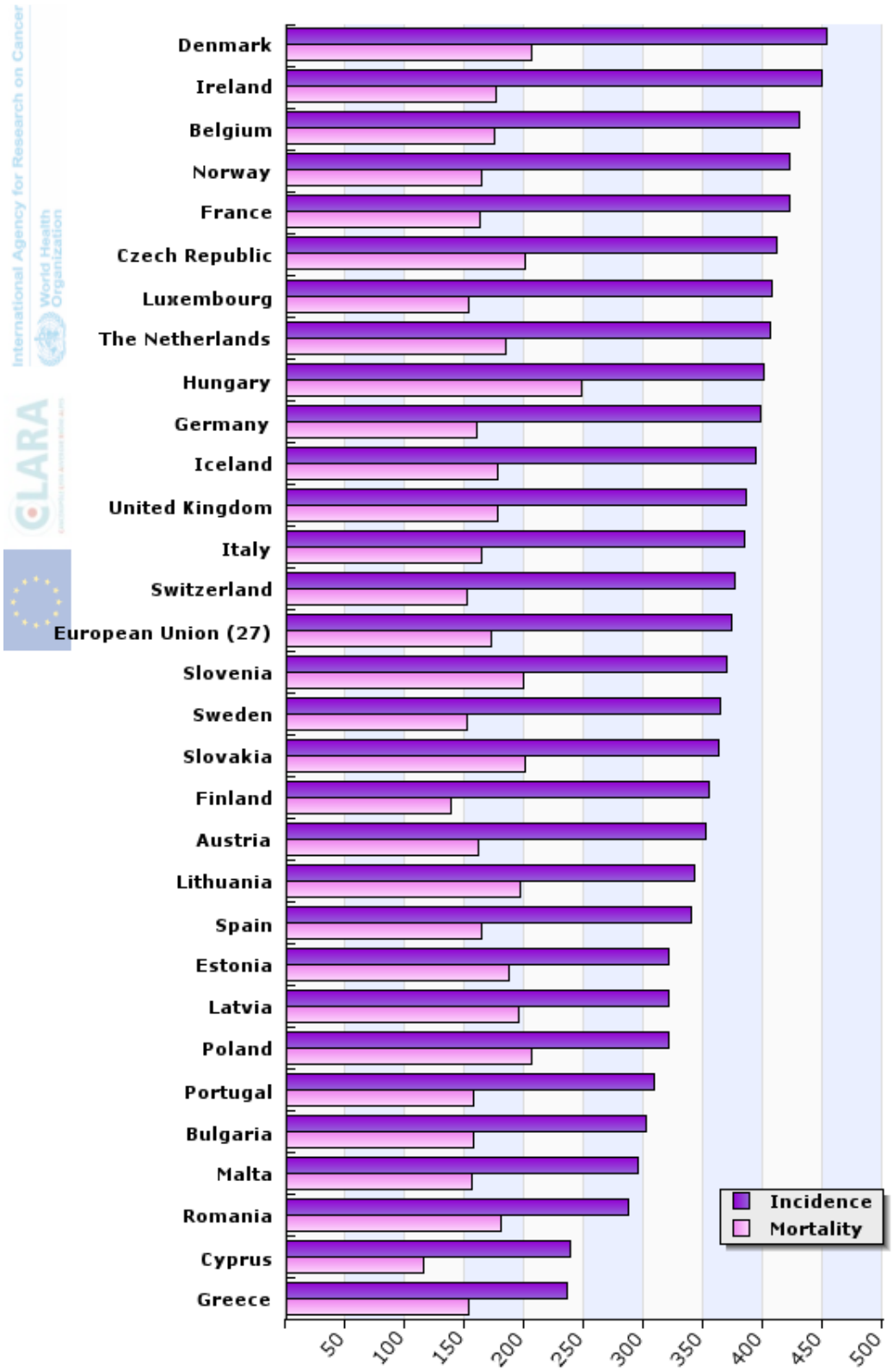
South Yorkshire and Bassetlaw NHS BCSP PROGRAMME PERFORMANCE- 2008-2011

Quality Standard	April – Dec 08	Jan – Dec 09	Jan – Dec 10	Jan – Dec 11
Colonoscopies Performed	634	866	957	1423
Completion rate to caecum, terminal ileum or anastamosis	601	813	918	1341
Average wait (in days) from +ve FOBt to SSP clinic	99.63%	100%	99.07%	98.25%
Average wait (in days) from SSP clinic to colonoscopy	94.23%	63.46%	97.11%	97.53%
Adenoma detection rate	51.02%	55.09%	45.25%	45.92%
Cancers detected	84	104	91	121
Polyp retrieval rate	95.27%	94.18%	92.46%	94.29%
Number of initial invites	96864	81323	97344	120925
Number of kits returned	51667	51275	64781	71803
Positivity	1.76%	1.72%	1.67%	2.08%
Uptake	55.18%	56.35%	62.18%	53.54%
Adverse incidents	19	13	10	15


All cancers
HRT
Taking any type of Hormone Replacement Therapy
Salt
Having at least 6 grams a day
Not breast-feeding
Breastfeeding each child for less than 6 months
In-activity
Being moderately active for less than 150 minutes a week
Low fibre diet
Having less than 23 grams of fibre a day
Radi-ation
Being exposed to any ionising radiation, including background levels such as those released from the earth
Red meat
Eating any red or processed meat
Infections
Exposure to cancer-causing infections like HPV and Hepatitis B or C
Sunlight & sunbeds
Getting more UV than was typical for people born in 1903
Occupation
Being exposed to cancer-causing chemicals or conditions at work
Alcohol
Drinking any type of alcohol
Low fruit & veg diet
Getting fewer than five portions a day
Over-weight
Having a BMI of 25 kg/m2 or over
Tobacco
Smoking any form of tobacco, or exposure to environmental tobacco smoke
Together we will beat cancer
How many cancers can be prevented?
Although there are some things we can't control about our cancer risk, decades of research have clearly shown that by living a healthy life, people can reduce the risk of developing the disease. But how many cancers in the UK are really caused by things we can change?
This diagram shows the results of new research funded by Cancer Research UK, which aims to show the number of cancer cases in the UK that could be prevented by known lifestyle and environmental factors, like being a non-smoker, keeping a healthy weight, drinking less alcohol, eating a healthy, balanced diet, and avoiding being exposed to certain infections or radiation.
The thin lines show the total number of cancers of each type from the latest UK incidence figures, and the large bars in the centre of each line show the proportion of these cases that could be prevented in men and women. Around the outside, you'll see the lifestyle and environmental factors that are linked to each cancer type. On the left is the contribution of each lifestyle factor to cancer overall.
Key
Risk factor
Number of cancers of this type caused by each risk*
Scale 200 cancers
Female cancers
Male cancers
Preventable cancers
All cancers of this type
* Note that one person's cancer can have more than one cause
Lung cancer
Breast cancer
Bowel cancer
Prostate cancer
No evidence yet of preventable cases
Tobacco
Occu-pation
Low fruit & veg diet
Radi-ation
Inactivity
Radiation
Not breast feeding
HRT
Occu-pation
Alcohol
Over-weight
Red meat
Over-weight
Low fibre diet
Alcohol
Tob-acco
Radiation
Inactivity
Infections
Sunlight & sunbeds
Radiation
Occupation
Tob-acco
Infection
Occup-ation
Non-hodgkin lymphoma
Malignant melanoma
Bladder cancer
Brain & CNS tumours
Kidney cancer
Oesophageal cancer
Pancreatic cancer
Womb cancer
Leukaemia
Stomach cancer
Ovarian cancer
Oral cancers
Myeloma
Cervical cancer
Liver cancer
Mesothelioma
Laryngeal cancer
Thyroid cancer
Bone & connective tissue
Testicular cancer
Hodgkin Lymphoma
Vulval cancer
Gallbladder cancer
Other rare cancers
Cancers of unknown primary
Occupation
Tob-acco
Over-weight
Tobacco
Low fruit & veg diet
Alcohol
Occupation
Tob-acco
Overweight
Over-weight
Inactivity
HRT
Radiation
Occupation
Tobacco
Low fruit & veg diet
Infec-tions
Salt
Not breastfeeding
HRT
Occupation
Tobacco
Tob-acco
Occupation
Radiation
Low fruit & veg diet
Alcohol
Infections
Occupation
Occup.
Tob-acco
Tobacco
Infections
Alcohol
Radiation
Tobacco
Occu-pation
Infec-tions
Tobacco
Occupation
Tobacco
Low fruit & veg diet
Alcohol
Infections
Occupation
Infections
Penile cancer
Kaposi sarcoma
Vaginal cancer
Occupation
Nasopharynx cancer
Sino-nasal cancer
Soft tissue sarcoma
Eye cancer
Overweight
Infections
Infections
Radiation
CANCER RESEARCH UK

APPENDIX B

Estimates of cancer incidence and mortality in Europe in 2008; male and female combined



Estimated incidence and mortality from All sites but non-melanoma skin cancer in both sexes, 200 Age Standardised Rate (European) per 100,000

Source: J. Ferlay, D.M. Parkin, E. Steliarova-Foucher. Estimates of cancer incidence and mortality in Europe in 2008. Eur J Cancer 2010;46(4):765–81.

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[x] Data from Ian – cancer registry I think – will confirm

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[xiii] National Cancer Intelligence Network: Survival of Children, Teenagers and Young Adults with Cancer in England; 2011.Cancer in England; 2011.

[xiv] Cancer Research (2012) NCRI Session: The cost of cancer care http://scienceblog.cancerresearchuk.org/2008/10/21/ncri-session-the-cost-of-cancer-care/

HWB47

Nottinghamshire County Council

Report to Health and Wellbeing Board

7 November 2012

Agenda Item: 6

REPORT OF THE CORPORATE DIRECTOR FOR CHILDREN, FAMILIES AND CULTURAL SERVICES

NOTTINGHAMSHIRE CHILD AND FAMILY POVERTY STRATEGY ANNUAL PERFORMANCE UPDATE

Purpose of the Report

1. This report provides the Health and Wellbeing Board with an annual update of the implementation of Nottinghamshire's first Child and Family Poverty Strategy, published in October 2011.

2. This report also considers the refresh of Nottinghamshire's Child and Family Poverty Strategy and asks Clinical Commissioning Groups to consider how they may like to engage in Child Poverty activity.

Information and Advice

3. Poverty can have a profound impact on children and their families, and the rest of society. It often sets in motion a deepening spiral of social exclusion, creating problems in education, employment, mental and physical health and social interaction. This has been compounded by the economic downturn which is seeing child poverty levels increase nationally and locally.

4. A recent study of GPs identified that 76% of GPs believed the economic downturn has had a negative impact on patient health in the last four years[1]. The same study identified that alcohol abuse and mental health conditions have increased which can have a damaging consequence for children living in these households.

5. Poverty can have a profound impact on health and wellbeing outcomes as the following suggests[2]:

   - Children in poor families are 10 times more likely to die suddenly in infancy
   - Children in poor families are twice as likely to die at birth or in infancy, a gap that has widened in recent years
   - Babies in the 20% most deprived areas have a lower average birth weight which produces health risks through adulthood
   - Children living in poverty have worse health than their peers; continuous health improvement among those in higher incomes is widening health inequalities.

[1] Insight Research Group (2012) *The Austerity Britain Report – the impact of the recession on the UK's health, according to GP's* http://www.insightrg.com/downloads/austerity-britain-key-findings-august-2012.pdf

[2] Spence, Nick (2009) *Health Consequences of Poverty for Children,* End Child Poverty

6. Furthermore the Millennium Cohort Study[3], which has been tracking 18,000 children born in 2000, has found that poorer children are more likely to suffer from limiting chronic illness in the following ways:

- 1 in 6 chance of developing asthma compared to 1 in 16 for the richer group
- increased risk of ear infections and tooth decay
- more likely to have an asthma episode that requires admission to hospital
- more prone to sudden illness e.g. acute infections e.g. pneumonia and respiratory illness

7. The Millennium Cohort Study also identified that children born into poverty have significantly lower cognitive behaviour test scores at ages 3, 5 and 7, and that continually living in poverty in their early years has a cumulative negative impact on their cognitive development.

8. Long term influences on childhood poverty on lifetime health are clear, for example adults who had a low birth weight (i.e. less than 2.5kg at birth) are:

- 25% more likely to die from heart disease.
- 4 times more likely to have Type 2 Diabetes which is linked to poverty
- 33 year olds who were disadvantaged aged 7-11 are 50% more likely to report a limiting illness.

The Child Poverty Act 2010

9. 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 proposed to take to reduce and mitigate the effects of child poverty in their area.

10. The Nottinghamshire Child and Family Poverty Strategy *'Building Aspiration: working together to tackle child and family poverty in Nottinghamshire[4]'* was developed by asking partners to make organisational pledges to tackle poverty. Organisations were asked to shape their pledges based on a series of recommendations made in the local child poverty needs assessment[5].

11. The Nottinghamshire Child and Family Poverty Strategy is reviewed annually by the Nottinghamshire Child Poverty Reference Group which comprises each statutory partner including District Councils, PCTs (including Public Health), Police, Probation and Jobcentre Plus. Clinical Commissioning Groups are not currently represented on the Child Poverty Group however and they may want to consider how they want to be engaged in this work.

[3] Dickerson A, Popli G (2012) *Persistent poverty and children's cognitive development: Evidence from the UK Millennium Cohort Study*. Centre for Longitudinal Studies http://www.cls.ioe.ac.uk/page.aspx?&sitesectionid=851&sitesectiontitle=Welcome+to+the+Millennium+Cohort+Study

[4] Nottinghamshire County Council (2011) *Building Aspiration: working together to tackle child and family poverty in Nottinghamshire* http://cms.nottinghamshire.gov.uk/childandfamilypovertystrategy0911.pdf

[5] Nottinghamshire County Council (2011) *Nottinghamshire Child Poverty Needs Assessment* http://cms.nottinghamshire.gov.uk/home/learningandlivingwork/childrenstrust/childpoverty/childpovertyservicemapping.htm

12. Alongside the annual review of pledges made within the Strategy, progress is also assessed by examining the proportion of children living in child poverty in Nottinghamshire. Reducing child poverty to 10% by 2020 is a national target; however Nottinghamshire is keen to compare progress alongside national data, statistical neighbours, and across Districts.

Child Poverty Data

13. The local child poverty measure is defined as the proportion of children living in families in receipt of out of work (means-tested) benefits or in receipt of tax credits where their reported income is less than 60% of median income. The data is analysed and provided by the Department for Work and Pensions (DWP).

14. The local child poverty measure is published annually. The latest data for 2010 was published on 28 September 2012. Data for 2011 will be available in Autumn 2013.

Local progress in reducing levels of child poverty

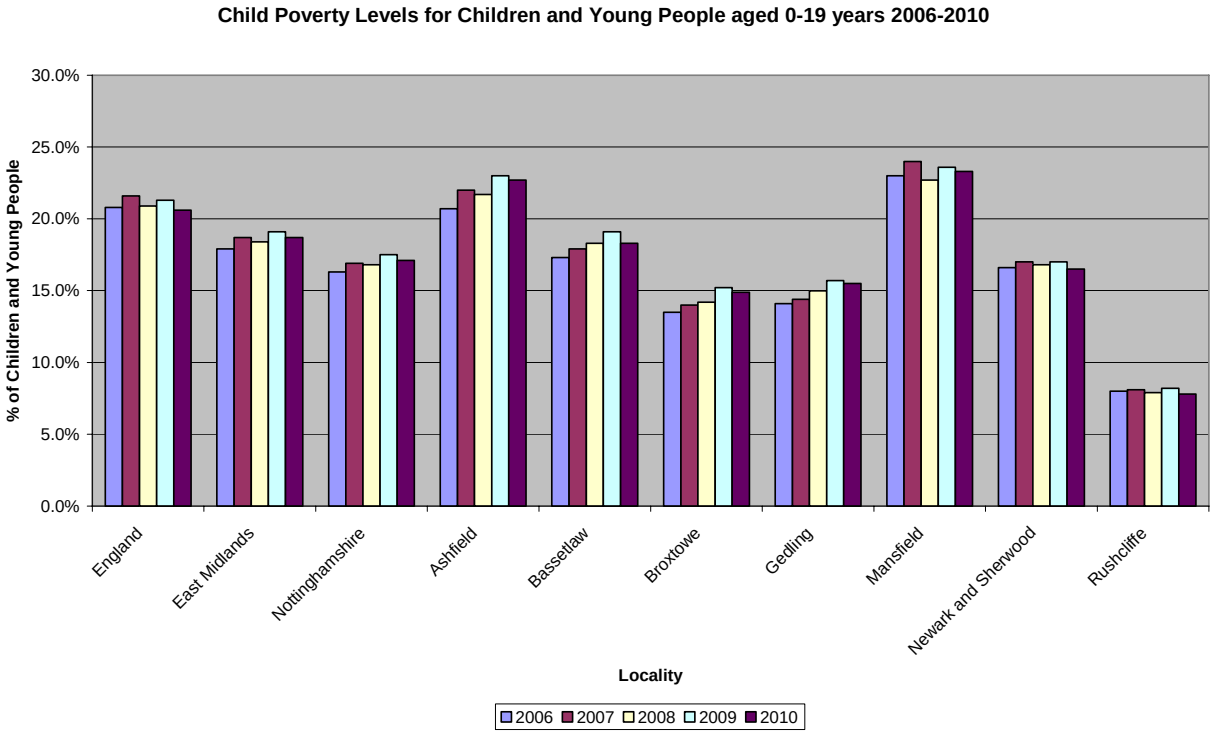
15. In 2010 across Nottinghamshire 27,950 children and young people aged 0-19 were identified as living in poverty, which equates to 17.1% of the 0-19 population.

Figure 1: 2010 Child Poverty Data by Local Authority

	Number of Children in families in receipt of Child Tax Credit (<60% median income) or Income Support/Job Seekers Allowance		**2010 % of Children in "Poverty"**	
	Under 16	**All Children 0-19 yrs**	**Under 16**	**All Children 0-19 yrs**
England	2,066,320	2,367,335	21.1%	20.6%
East Midlands	159,005	181,245	19.3%	18.7%
Nottinghamshire	24,480	27,950	17.8%	17.1%
Ashfield	5,275	5,905	23.7%	22.7%
Bassetlaw	3,760	4,340	18.8%	18.3%
Broxtowe	2,685	3,115	15.4%	14.9%
Gedling	3,105	3,565	16.0%	15.5%
Mansfield	4,540	5,200	24.1%	23.3%
Newark & Sherwood	3,555	4,025	17.3%	16.5%
Rushcliffe	1,565	1,800	8.1%	7.8%

16. 2010 child poverty data identifies that in England 20.6% of children were living in poverty, which shows a small decrease compared to the 2006 baseline year, as can be seen in Figure 2 overleaf. The 2010 data also indicates that there are fewer children in poverty in Nottinghamshire compared to England and the East Midlands.

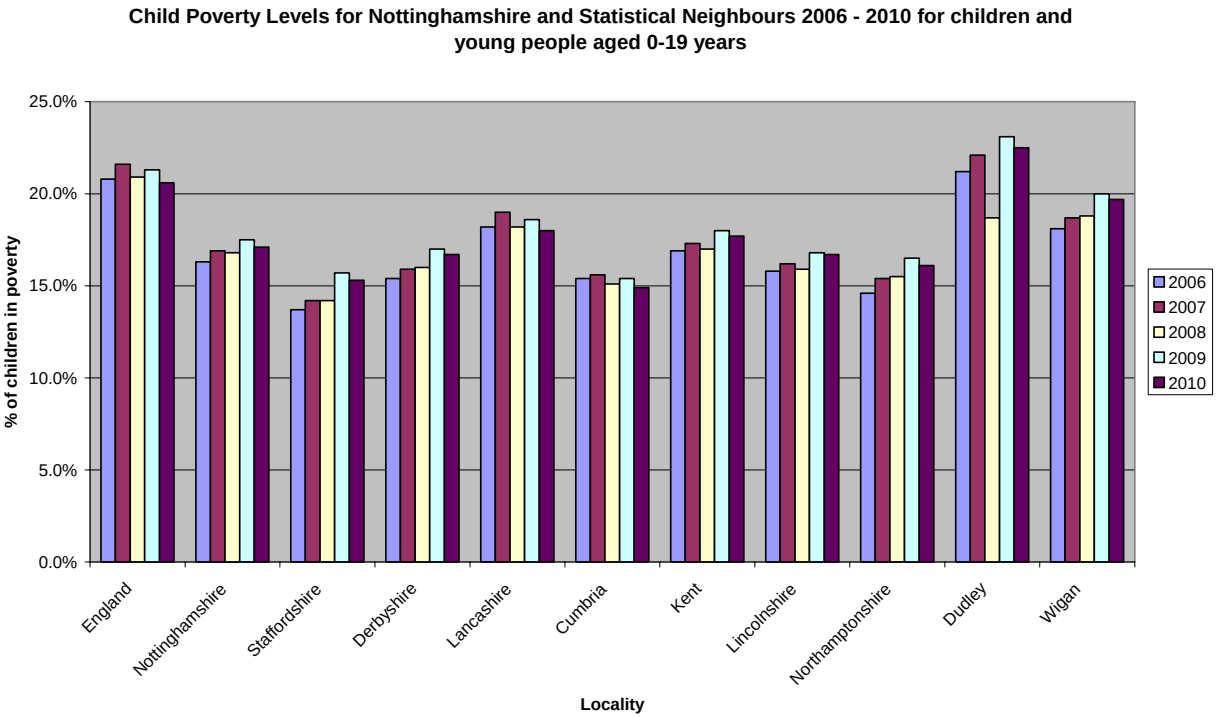
Figure 2: 2006-2010 Child Poverty Data - comparisons by Nottinghamshire Localities



Comparisons with statistical neighbours

17. 2010 data identified that child poverty levels have increased for all of Nottinghamshire's statistical neighbours since the baseline year with the exception of Cumbria; Nottinghamshire's increase in child poverty levels is therefore comparable with progress in similar local authority areas for 2010.

Figure 3: 2006 - 2010 Child Poverty Data comparisons by Statistical Neighbour



Ward level child poverty levels

18. 2010 child poverty levels have also increased in the majority of wards in Nottinghamshire since the 2006 baseline year.

19. A hotspot ward is identified as a locality where over 16.7% of children live in poverty, as defined by government's indicator of relative poverty. In 2008 59 wards within Nottinghamshire were identified as hot spots, by 2010 there were 63 wards. Figure 4 below identifies those wards in Nottinghamshire where over 30% of children lived in poverty in 2010.

Figure 4: Nottinghamshire wards with over 30% levels of child poverty (2010)

	2010 **Wards with over 30% of children living in poverty**
Ashfield	Kirkby in Ashfield East – 36.4%
Bassetlaw	Worksop South East – 37.4%
Gedling	Killisick – 38.7%
Mansfield	Cumberlands – 30.7%
	Pleasley Hill – 32.5%
	Ravensdale – 47.2%
Newark & Sherwood	Boughton – 31.9%
	Devon – 35.0%

Poverty Projections

20. Child poverty figures are predicted to rise over the next few years. The Institute of Fiscal Studies[6] has predicted that relative child poverty will stand at 24% by the financial year 2020/21 – significantly more than the target of 10% set out in the Child Poverty Act 2010.

21. The Institute of Fiscal Studies has also predicted that the median income of families in the UK is predicted to fall by 7% between 2009/10 and 2012/13. This would equate to the largest three-year fall in income for 35 years.

Child Poverty Strategy Performance

22. Nottinghamshire's Child and Family Poverty Strategy was designed with partners who agreed to submit pledges to state what their organisation was going to do to alleviate the impact of poverty on children and families, how they planned to improve outcomes for the poorest children and families; and how they could help lift children out of poverty. A list of these pledges is attached as **Appendix 1**.

23. There were 84 pledges covering activity by 18 different organisations, two of which are District Strategic Partnerships. All organisational pledges include at least one measurable milestone to help us assess progress and performance. There are 169 milestones in total.

[6] Brewer M, Browne J, Joyce R (2011) 'Child and working-age poverty from 2010 to 2020'; Institute of Fiscal Studies

Child Poverty Pledges

24. Progress against each of the pledges can be assessed by measuring activity against a number of milestones listed under each pledge.

25. Of the 84 pledges made the following progress has been made:

		No. of pledges
	Behind or not happening – work has not started when scheduled or has started but activity is not meeting or unlikely to meet its milestones	**2**
	Happening but behind schedule – work has started but activity is not meeting milestones, but us expected to by the deadline if adjustments are made	**9**
	On schedule – work has started and is meeting milestones	**42**
	Completed – work has been successfully completed to deadline	**19**
	No judgement possible	**2**
	No information received	**10**

26. Of the 169 milestones measured:

		No. of milestones
	Behind or not happening – work has not started when scheduled or has started but activity is not meeting or unlikely to meet its milestones	**4**
	Happening but behind schedule – work has started but activity is not meeting milestones, but us expected to by the deadline if adjustments are made	**14**
	On schedule – work has started and is meeting milestones	**89**
	Completed – work has been successfully completed to deadline	**33**
	No judgement possible	**5**
	No information received	**24**

Examples of Progress against Key Pledges

27. Since the launch of the Strategy, Nottinghamshire County Council and Clinical Commissioning Groups (CCGs) have pooled funding for the development of a Nottinghamshire Family Nurse Partnership**.** The work is highlighted within a pledge from **Public Health** who have co-ordinated the work. The Family Nurse Partnership is an intensive evidence based preventive programme for vulnerable, first time young parents that begins in early pregnancy and ends when the child reaches two years old. The programme goals are to improve antenatal health, child health and development and parents' economic self-sufficiency. The Family Nurse Partnership programme is known to improve the following outcomes:

- improvements in antenatal health
- reductions in children's injuries, neglect and abuse

- improved parenting practices and behaviour
- fewer subsequent pregnancies and greater intervals between births
- improved early language development, school readiness and academic achievement
- increased maternal employment and reduced welfare use
- increases in fathers' involvement.

28. **Nottinghamshire Police** pledged to reduce levels of crime and anti-social behaviour in target wards across Nottinghamshire. Annual data indicated reductions in anti-social behaviour (ASB) across all districts, and although adverse weather may have made a contribution, the introduction of Operation Animism in some areas provided a highly visible response to calls and planned ASB patrols have had an impact.

29. The Closing the Gap strategy led by **Nottinghamshire County Council** was launched in 2012 in line with their pledge to reduce the achievement gap between pupils on Free School Meals (FSM) and their peers each year. A number of achievement gaps are measured at ages 11, 16 and 19. Achievement gaps at all ages in Nottinghamshire are wider than national achievement, however at age 16 Nottinghamshire saw a greater reduction than that achieved at national level. At age 19 the gap has remained broadly static since 2008 although FSM attainment has seen a steady, year on year increase.

30. **Jobcentre Plus** pledged to deliver a welfare system which recognised work as the primary route out of poverty. To achieve this pledge Jobcentre Plus (JCP) services have been delivered from Children's Centres where staff have promoted opportunities to parents to increase their interest in improving work related skills and essential skills such as literacy, numeracy and IT. In addition, JCP staff have provided information to parents on the range of JCP services, and they have promoted opportunities for parents to become volunteer helpers which has enabled Jobcentre Plus to provide references based on contact with the centre. JCP also provides advice on access to childcare for parents while they are working or attending education or training sessions.

31. The **Adult Community Learning Service** within **Nottinghamshire County Council** has been successful in engaging families from key target groups including those without a Level 2 qualification in literacy and/or numeracy. Furthermore, 82% of learners on Family Learning courses came from the 250 most disadvantaged Super Output Areas[7] (62% from the 150 most disadvantaged Super Output Areas). 91% of those on Family Learning Courses reported being more confident to learn and 93% reported feeling more confident to support their child's learning. 75% of those on Family Learning courses reported receiving information and guidance about further learning opportunities.

32. The **Newark and Sherwood Local Strategic Partnership Board** has commissioned a Family Intervention Worker with a focus on debt advice. The post commenced in July 2012. The worker supports high risk and vulnerable families in the district, targeting in particular families experiencing debt problems and long term unemployment. In addition a Vulnerable Families summit was held jointly with Newark and Sherwood CCG in June 2012, which has resulted in a new service being commissioned from October 2012.

[7] Super Output Areas (SOAs) are a geography designed to improve the reporting of small area statistics. SOAs have been created by the Office for National Statistics (ONS) for collecting, aggregating and reporting statistics. They have been automatically generated to be as consistent in population size as possible, and the minimum population is 1000 and the mean is 1500 residents.

33. The newly merged **Ashfield and Mansfield Employment and Skills Group** worked closely with a new supermarket development in Kirkby in Ashfield to help employ 300 local individuals, and 'retail gateway' training was provided for approximately 40 local, long-term-unemployed individuals. All of these were interviewed and around half were offered employment

34. There are examples of activity that is behind schedule or no longer happening, often stemming from financial pressures and budget restrictions.

35. There are also examples of activity that it is no longer possible to measure because of adjustments in information sharing and national data collection changes.

36. An overview of progress indicates that there is a greater targeting of resources, services and interventions to those most in need. Target groups for the Strategy are well known and were evidenced in the child poverty needs assessment.

Refreshing the Nottinghamshire Child and Family Poverty Strategy

37. The Strategy is currently being refreshed and amended to ensure that all activity is current and progress can be assessed. It is likely that the Child and Family Poverty Strategy will be developed as part of Nottinghamshire's revised Early Intervention Strategy, which aims to ensure that children, young people and their families will receive the most appropriate support to meet their needs at the earliest opportunity, in order to ensure better outcomes and the cost effective delivery of services.

38. CCGs may want to consider if they want to be involved in the forthcoming work to refresh the Nottinghamshire Child and Family Poverty Strategy as they were not established when the Strategy was first developed.

Other Options Considered

39. None.

Reason/s for Recommendation/s

40. Child poverty affects the most vulnerable children and young people across Nottinghamshire. These groups are also most at risk of poor health and well being outcomes, so work to tackle child poverty is strongly associated with work to tackle a range of inequalities including health.

Statutory and Policy Implications

41. 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

That:

1) The Health and Wellbeing Board notes the content of this report.

2) Clinical Commissioning Groups consider if and how they would like to be involved in the development of a revised Child and Family Poverty Strategy as they are currently not represented through the Nottinghamshire Child Poverty Reference Group.

Anthony May
Corporate Director, Children, Families and Cultural Services

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Constitutional Comments (LM 15/10/12)
42. The recommendations in this report fall within the remit of the Health and Wellbeing Board.

Financial Comments (NDR 17/10/12)
43. There are no financial implications arising directly from this report.

Background Papers

Building Aspiration: Working together to tackle child and family poverty in Nottinghamshire – report to County Council (22/9/11)

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

Electoral Division(s) and Member(s) Affected
All.

C0092

APPENDIX 1

Organisational Pledges forming the basis of Nottinghamshire's Child and Family Poverty Strategy

** indicates statutory partner*

Nottinghamshire County Council*

- We will work with the Local Enterprise Partnership to deliver business growth and inward investment
- We will better equip young people to enter the workplace.
- We will close the achievement gap between pupils eligible for free school meals and their peers achieving the expected level at Key Stages 2, 4 and 5.
- We will deliver effective family and parenting support services to ensure that the needs of families are met appropriately and at the earliest opportunity.
- We will adopt and ensure a whole family approach to service delivery.
- We will deliver an Early Intervention and Prevention Strategy for Nottinghamshire to ensure that the needs of children, young people & families are met appropriately and at the earliest opportunity.
- We will improve outcomes for young Carers across Nottinghamshire.
- We will continue to target family learning, adult education and parenting courses to parents and carers from target groups.
- We will maintain a quality library and information service for children and young people, and will develop and run activities which encourage a love of reading and learning in children and young people though under fives programme of events and offer to schools.
- We will build the aspirations of children and families
- We will work to protect and support the most vulnerable children and young people in Nottinghamshire, who are also more likely to be affected by poverty.
- We will contribute to increasing the skills of disabled people and parents.
- We will increase the take up of free school meals.
- We will assess poverty factors in relation to all young people who have offended or who are at risk of offending and facilitate appropriate interventions.

Ashfield District Council*

- We will reduce crime and Anti-Social Behaviour in hotspot areas identified in our Strategic Assessment.
- We will improve the aspirations of young people in Ashfield.
- We will work with partners to ensure that local people have access to employment opportunities.
- We will provide financial support to Ashfield Citizens Advice Bureau in 2011/12.
- We will support physical activity and wellbeing within Ashfield.

Bassetlaw District Council*

- We will work collaboratively with the voluntary and community sector to provide advice, information and training on financial inclusion focusing on basic current accounts, income maximisation, saving and responsible borrowing and financial literacy.
- We will maintain a programme of economic development activity to encourage new employment opportunities and retain existing jobs within the district
- We will promote access to housing and council tax benefits, paying entitlement under a 48 hour guarantee
- We will support vulnerable households (including those with young children) to achieve affordable warmth
- We will prevent homelessness by providing a range of housing advice and support
- We will increase the amount of affordable housing in the district
- We will maintain a network of access points to assist residents in rural areas to access Council and other service providers and sources of information and support
- We will work in partnership with clubs and other organisations to provide sport and physical activity opportunities in safe and welcoming environments.

Broxtowe Borough Council*

- We will provide opportunities for children, young people and parents to increase skills and employability.
- We will improve access to services and provide support for children, young people, parents and carers.
- We will develop and deliver community health promotion activities to improve health and increase community cohesion.
- We will support the increased take up of free and reduced cost home insulation including the WarmZone project using benefits data to target efforts.
- We will reduce crime and anti social behaviour in Broxtowe.
- We will increase use of Nottingham Credit Union to promote financial inclusion.
- We will maximise benefit take up of families in poverty and support them to claim relevant Council Tax discounts.

Gedling Borough Council *

- We will continue to process homeless applications efficiently and timely.
- We will prevent homelessness by providing a range of housing advice and support.
- We will ensure the provision of appropriate temporary accommodation for homeless families.
- We will continue to support the Citizens' Advice Bureau at existing level.
- We will lead the development of a multi-agency intervention initiative.

Mansfield District Council *

- We will provide more opportunities for employment and apprenticeships for local residents.
- We will coordinate inter-agency activity to raise family incomes by reducing worklessness and raising skill levels.
- We will work with the Local Enterprise Partnership and Sherwood Growth Zone to deliver business growth and inward investment.
- We will provide access to affordable and safe leisure activities for children and families.
- Work with schools to encourage children to respect their local environment.
- We will provide information, advice and support to families experiencing financial and housing difficulties with efficient appropriate responses.
- We will improve the energy efficiency and quality of homes in Mansfield.
- The Community Safety team will ensure that child poverty data informs The Community safety planning and the implementation of local actions in respect of Alcohol and Drugs, Anti Social Behaviour (ASB) and Domestic Abuse in the priority geographic area.

Mansfield Strategic Partnership (MASP)

- We will incorporate child poverty priorities within the Sustainable Community Strategy for Mansfield.
- We will focus inter-agency collaboration around the Work Programme on areas of highest Child Poverty need.

Newark and Sherwood District Council*

- We will work with partners to ensure that local people have access to employment opportunities.
- We will work with partners to encourage all homes in the district to be safe, warm and of a decent standard.
- We will seek to reduce the rate of homelessness by providing a range of housing advice and support.
- We will continue to provide access to affordable leisure and cultural activities.
- We will review local support available to vulnerable families, the impact these services have and identify opportunities for improvement.
- We will collaborate with and assist a range of voluntary and community organisations that provide support and services to residents vulnerable to child poverty.
- We will maximise benefit take up of families in poverty and turnaround applications quickly and accurately.

Rushcliffe Borough Council *

- We will prevent homelessness by effective multi agency intervention to reduce the number of homeless 16/17 year olds.
- We will educate young people about the reality of becoming homeless.
- The Cultural Services Department will prioritise officer support and external funding opportunities to areas that have been identified as suffering from child poverty and a deficiency of equipped play provision as identified by the Childs play Strategy “Playing for Life in Rushcliffe” 2007-2012.

Rushcliffe Strategic Partnership

- The Rushcliffe Community Partnership - Health Issues Group will ensure that child poverty data informs the health planning and the implementation of local actions in respect of obesity, alcohol & smoking.
- The Community Safety team will ensure that child poverty data informs community safety planning and the implementation of local actions in respect of alcohol and drugs, anti social behaviour (ASB) and domestic abuse in the priority geographic area. (This is a shared priority for Rushcliffe District Council).
- The Rushcliffe Children and Young People’s partnership will ensure that child poverty data informs the group and services are targeted to these areas. The Group will adopt Child Poverty as a priority and develop actions to tackle this in areas that are over the 10 % target.

Jobcentre Plus *

- We will deliver a welfare system which recognises work as the primary route out of poverty and reduces the number of children in workless households.
- We will continue partnership arrangements with Children’s Trust partners to tackle child poverty by improving access to Jobcentre Plus support for parents who are furthest removed from the labour market.
- We will participate in child poverty pilot activity and other activities designed to better engage parents in improving their employment prospects.
- We will gather and share information about those parents looking for work and the extent to which accessing appropriate childcare is a barrier to entering work and training leading to work.

Nottinghamshire Police*

- We will reduce levels of crime and anti-social behaviour in target wards across Nottinghamshire.
- We will identify higher risk young offenders at reprimand stage and refer to multi-agency teams through the Youth Offending Service for assessment and intervention.
- We will support truancy and persistent absence initiatives and raise awareness of the importance of truancy reduction as being vital to the reduction of crime and victimisation.
- We will ensure onward referral to appropriate interventions where young people are at risk due to alcohol or substance misuse, missing from home or vulnerable to radicalisation.

- We will support the delivery of diversionary activities for young people to reduce local crime and antisocial behaviour and to signpost children and young people to them, e.g. Princes Trust, 'Kickz' 999 challenge.
- We will ensure robust and effective partnership arrangements are in place for targeted offender management.

Nottinghamshire Probation Trust *

- As the organisation which coordinates the Reducing Reoffending Delivery Group, we will work with partner organisations to strengthen families, to help reduce the risk of reoffending; maintain Multi Agency Risk Assessment Conferences to protect and support victims of domestic abuse; and better support young adults who offend in their transition from childhood to adulthood. Additionally, to support positive family links to help substance misusing offenders abandon substance misuse.

NHS Bassetlaw *

- We will commission services which protect and support children and young people affected by domestic violence.
- We will commission services which provide support to adults suffering from anxiety and depression.

NHS Nottinghamshire County* / Public Health

- We will reduce health inequalities between families across Nottinghamshire by reducing the gap in life expectancy, infant mortality, low birth weight and teenage conception rates between the most deprived and least deprived localities.
- We will improve outcomes for vulnerable young families by developing the Health Visitor implementation plan and commissioning the Family Nurse Partnership.
- We will provide services and support for children and young people and their families where substance misuse is an issue and provide specialist training to the wider workforce on identifying hidden harm issues.

Nottingham and Nottinghamshire Futures (Connexions)

- We will work with schools, colleges and training providers to achieve an increase annually in the proportion of year 11 and 13 leavers entering Learning or work.
- We will support 3,000 adults from Nottinghamshire who are unemployed to progress in learning or work

Citizens Advice Bureau

- We will provide the advice families need for the problems they face and improve the policies and practices that affect families lives.
- We will provide data and outcome measurements focused on improving the financial stability of families.
- We will seek funding to increase the financial capability of people building on expertise gained in delivering a successful project in Nottinghamshire.

Home-Start

- We will offer specific support to families in Nottinghamshire to maximise their income and manage their money effectively to avoid debt.

Nottinghamshire County Council

Building Aspiration: Working Together to Tackle Child and Family Poverty in Nottinghamshire

September 2011




Developed by the Tackling Child Poverty Reference Group

Contents

The full needs assessment and further information is available at:
www.nottinghamshire.gov.uk/childpoverty

1. Introduction

Nottinghamshire County Council and its partners have created a vision to support the Nottinghamshire Child Poverty Strategy. All partners have signed up to the following vision.

Nottinghamshire's vision: Our ambition is for Nottinghamshire to be a place where children grow up free from deprivation and disadvantage, and birth and social background do not hold people back from achieving their potential.

Nottinghamshire's strategic objective: We will work together to reduce levels of child poverty and to mitigate the effects of child poverty on children, young people and families, as well as on future generations. We will establish a downward trend in levels of child poverty and our progress will compare well to our statistical neighbours

What is Child Poverty?

A child is said to be living in poverty when they live in a family/environment that lacks the resources to enable the child to participate in the activities and have the living conditions and amenities that are 'ordinary'.

Nationally, Government aims to reduce child poverty to 10% or less by 2020. Government uses the definition of 'relative poverty' to measure progress in reducing the number of children living in poverty. The proportion of children in relative poverty is calculated as follows:

$$\frac{\text{Number of children in families in receipt of either out of work benefits or tax credits where their reported income is less than 60\% median income}}{\text{Total number of children in the area}}$$

This forms the nationally defined target for child poverty, which measures the proportion of children living in families in receipt of out of work (means-tested) benefits or in receipt of tax credits, where their reported income is less than 60% of median equivalised[1] household income[2]. Nationally (excluding London) in 2009/10 a couple with two children would be identified as living in child poverty if their income before housing costs is less than £379 per week; and a single parent with two children would be identified if their income is less than £297 per week.

The child poverty target measures whether the poorest families are keeping pace with the growth of incomes in the economy as a whole. Low income is the most commonly used measure of poverty, as it provides a broad indication of the living standards of families and includes families experiencing poverty whilst also in employment.

Why tackling child poverty is important to Nottinghamshire

Poverty can have a profound impact on the child, their family, and the rest of society. It often sets in motion a deepening spiral of social exclusion, creating problems in education, employment, mental and physical health and social interaction. We understand that tackling child poverty will improve the life chances of children and their parents now and in years to come. Tackling child poverty is not just about children and is a deep rooted issue affecting many of our communities.

It is important to note that whilst children in out of work families are more likely to be in relative poverty than those where at least one parent is in work, nationally about half of children in relative poverty are in families where a parent works. Tackling child poverty is therefore not just about families reliant on the benefits system. In Nottinghamshire however, more than two thirds of all children living in poverty are reliant on welfare benefits.

Levels of child poverty in Nottinghamshire are slightly below the national (20.9%) and regional (18.4%) estimates. There are currently 16.8% of children (under the age of 20) living in poverty in the county. This equates to 27,080 children, of which 23,990 (17.4%) are under the age of 16[3] Since 2007, there has been a 0.1% reduction in the number of children living in poverty.

Across districts there is some variation in the percentage of children living in poverty. In 2008, there were 21.7% of children in poverty in Ashfield, 18.3% in Bassetlaw, 14.2% in Broxtowe, 15.0% in Gedling, 22.7% in Mansfield, 16.8% in Newark and Sherwood and 7.9% in Rushcliffe. All Districts have a greater proportion of under 16's who live in poverty[4]. All districts including Rushcliffe have wards with over 10% of children living in poverty[5].

2. How the strategy was developed

The strategy has been developed in partnership and aims to ensure that work to tackle poverty is embedded into the core business of Nottinghamshire County Council and its partners. We asked Nottinghamshire County Council and its partners to adapt and align their existing priorities to tackle child poverty and provide evidence of its impact.

The Child and Family Poverty Strategy has dependencies on other key strategies and plans across Nottinghamshire including the Nottinghamshire County Council Strategic Plan, the Youth Crime Action Plan, the Children, Young People and Families Plan to name but a few.

The Nottinghamshire Child Poverty Strategy was developed by the Child Poverty Reference Group using findings from a comprehensive needs assessment[6], which included a service mapping exercise and literature review containing evidence of what works to reduce child poverty and what mitigates against the effects associated with it. A key recommendation of the needs assessment included the need to use evidence based practice to ensure the interventions we prioritise will have greatest impact.

However there remain gaps in our knowledge because data is not available, for example the numbers of families affected by debt, or homelessness. We will be developing a separate action plan to address some of the gaps identified in the needs assessment.

The findings from the needs assessment generated a series of recommendations which have been disseminated widely to inform the actions included in this strategy. All partner organisations were asked to consider the recommendations which included evidence of what works, to inform a series of organisational pledges. These pledges are the basis of our child poverty strategy.

The building blocks of a child poverty needs assessment

The national Child Poverty Strategy focuses on four 'Building Blocks of Child Poverty', underpinned by attention to at risk groups and what interventions are available. These provide a powerful framework for the engagement of all key partners in progressing the development of a local strategy and needs assessment.

Figure 1: Building Blocks of the Child Poverty Strategy

Place and delivery: focuses on housing, transport, crime and communities. Localism and the 'big society' approach are driving the agenda, and services are being encouraged to establish a clearer picture of their role and the impact of their regional and area-based activities on decreasing child poverty.

Employment and skills: covers worklessness, promoting parental employment by addressing barriers to work, lack of skills and labour market experience, lack of childcare and flexible working arrangements. It also looks at 'in-work' poverty.

Family and life chances: recognises that there are significant barriers to some disadvantaged children and young people achieving positive health, educational and future employment outcomes. The aim is to remove these barriers through interventions at key stages and help reduce inter-generational poverty. The approach is to investigate which policies show evidence of having a positive impact on children living in poverty and then identify what further action is needed to improve these outcomes.

Financial support: explores the potential for benefits to have a positive impact on child poverty, by increasing take up by vulnerable groups and improving work incentives for workless households. The building block also explores financial inclusion, debt and capability to help some of the most vulnerable engage with the benefit system and other forms of support, in conjunction with voluntary and community sector organisations.

3. What we will do to tackle child poverty in Nottinghamshire

The Nottinghamshire Child Poverty strategy has been developed during a time of national and local financial challenge; in the light of the growing cost of living, it is likely that levels of child poverty will increase over the next few years before we start to see a downward trend. "The Institute for Fiscal Studies has predicted that by 2013 both relative and low income poverty and absolute low income poverty will have started rising again. In part this will be due to social security and welfare benefit cuts"[7]. It is critical therefore to ensure that our poorest children and families are targeted so that we can, in partnership, mitigate against the effects of poverty, intervene earlier to prevent outcomes from worsening and build resilience across families and communities. Families and children experiencing severe or persistent poverty will ultimately be our key target groups.

What we are aiming to achieve

We understand that responsibility for children lies with parents and carers, and throughout this strategy we want to ensure that wherever possible parents and carers take the lead role in improving the life chances of their children. However we have positive aspirations for our communities and aim to ensure that Nottinghamshire has high levels of economic prosperity, with increasing employment opportunities and a viable economy. We are also striving for improved skills and education for children and their parents to enable them to access employment opportunities that pay. We aim to reduce the number of families reliant on welfare benefits and help them to have the confidence and skills to access opportunities that will break intergenerational cycles of poverty and deprivation. Even though we face challenging financial times we have opportunities to promote and deliver a better future for Nottinghamshire.

Nottinghamshire County Council and its partners will focus on the following priority areas in the implementation of the Child and Family Poverty Strategy. We will:

- Target localities of Nottinghamshire with greater levels of poverty to ensure outcomes in these areas are improved and children and families thrive in safe, cohesive communities and neighbourhoods.
- Increase educational attainment, employment and skills amongst children, young people and parents in Nottinghamshire; reduce dependency on welfare benefits and ensure work pays.
- Raise aspirations and improve the life chances for children and families so that poverty in childhood does not translate into poor experiences and outcomes.
- Support families to acquire the skills and knowledge to access responsive financial support services, money management, and debt crisis support.
- Support families with complex problems compounded by poverty and disadvantage.

Our overall approach

Our child poverty needs assessment highlighted ten top recommended priorities which will underpin our strategy, and which will be evidenced in the pledges which form the basis of the Strategy.

Nottinghamshire's top 10 Recommendations to tackle Child Poverty:

1. **Embed child poverty activity** into core delivery of services across Nottinghamshire.
2. Services should work with families using a **whole family approach**, dealing with families in a holistic way to assess needs and ensure children and their parents/ carers receive appropriate services and interventions to lift themselves out of poverty.
3. Services and interventions should use a **targeted approach** to work with children, families and communities in greatest need. There are steps that can be taken to carry out further outreach to engage the most disaffected children and families.
4. **Use early intervention approaches** to break the cycle of disadvantage; early years settings also have a substantial role to play in improving outcomes for children and families.
5. **Integrate service provision** to enable easier access and enable holistic support packages for those who need them most.
6. **Increase educational attainment**, skills and employment amongst young people and parents across Nottinghamshire. In particular ensure that young people and unemployed parents are equipped for employment.
7. Engage the **private sector and Local Enterprise Partnership** in plans to tackle child poverty.
8. Commissioners and managers should ensure they utilise **evidence based practice** when developing interventions which impact on child poverty; and **performance management and evaluation** systems must be strengthened in order to measure impact and share learning.

9. Improve the awareness and skills of professionals and volunteers working in universal and targeted services. It is advisable that child poverty is fully considered by **workforce development** leads across agencies to ensure training, support and information needs are further identified and addressed.

10. **Further assess need** by addressing the data challenges highlighted in the Child Poverty Needs Assessment, this will help shape local interventions to ensure the needs of those most at risk are identified and met.

All statutory partners have been asked to provide pledges and wider partners have also been encouraged to submit information. It is important to note however that work in Nottinghamshire which aims to reduce child poverty or mitigate against its effects is much broader than the pledges listed below. We have a wide range of interventions and organisations working in Nottinghamshire that all contribute to the shared aim to tackle child poverty and improve outcomes for the poorest in our communities.

Organisational Pledges

** indicates statutory partner*

Nottinghamshire County Council*

- We will work with the Local Enterprise Partnership to deliver business growth and inward investment.
- We will better equip young people to enter the workplace.
- We will close the achievement gap between pupils eligible for free school meals and their peers achieving the expected level at Key Stages 2, 4 and 5.
- We will deliver effective family and parenting support services to ensure that the needs of families are met appropriately and at the earliest opportunity.
- We will adopt and ensure a whole family approach to service delivery.
- We will deliver an Early Intervention and Prevention Strategy for Nottinghamshire to ensure that the needs of children, young people & families are met appropriately and at the earliest opportunity.
- We will improve outcomes for young carers across Nottinghamshire.
- We will continue to target family learning, adult education and parenting courses to parents and carers from target groups.
- We will maintain a quality library and information service for children and young people, and will develop and run activities which encourage a love of reading and learning in children and young people through under fives programme of events and offer to schools.
- We will build the aspirations of children and families.
- We will work to protect and support the most vulnerable children and young people in Nottinghamshire, who are also more likely to be affected by poverty.
- We will contribute to increasing the skills of disabled people and parents.
- We will increase the take up of free school meals.
- We will assess poverty factors in relation to all young people who have offended or who are at risk of offending and facilitate appropriate interventions.

Ashfield District Council*

- We will reduce crime and Anti-Social Behaviour in hotspot areas identified in our Strategic Assessment.
- We will improve the aspirations of young people in Ashfield.
- We will work with partners to ensure that local people have access to employment opportunities.
- We will provide financial support to Ashfield Citizens Advice Bureau in 2011/12.
- We will support physical activity and wellbeing within Ashfield.

Bassetlaw District Council*

- We will work collaboratively with the voluntary and community sector to provide advice, information and training on financial inclusion focusing on basic current accounts, income maximisation, saving and responsible borrowing and financial literacy.
- We will maintain a programme of economic development activity to encourage new employment opportunities and retain existing jobs within the district.
- We will promote access to housing and council tax benefits, paying entitlement under a 48 hour guarantee.
- We will support vulnerable households (including those with young children) to achieve affordable warmth.
- We will prevent homelessness by providing a range of housing advice and support.
- We will increase the amount of affordable housing in the district.
- We will maintain a network of access points to assist residents in rural areas to access Council and other service providers and sources of information and support.
- We will work in partnership with clubs and other organisations to provide sport and physical activity opportunities in safe and welcoming environments.

Broxtowe Borough Council*

- We will provide opportunities for children, young people and parents to increase skills and employability.
- We will improve access to services and provide support for children, young people, parents and carers.
- We will develop and deliver community health promotion activities to improve health and increase community cohesion.
- We will support the increased take up of free and reduced cost home insulation including the WarmZone project using benefits data to target efforts.
- We will reduce crime and anti social behaviour in Broxtowe.
- We will increase use of Nottingham Credit Union to promote financial inclusion.
- We will maximise benefit take up of families in poverty and support them to claim relevant Council Tax discounts.

Gedling Borough Council *

- We will continue to process homeless applications efficiently and timely
- We will prevent homelessness by providing a range of housing advice and support
- We will ensure the provision of appropriate temporary accommodation for homeless families
- We will continue to support Citizens' Advice Bureau at existing level
- We will lead the development of a multi-agency intervention initiative.

Mansfield District Council *

- We will provide more opportunities for employment and apprenticeships for local residents.
- We will coordinate inter-agency activity to raise family incomes by reducing worklessness and raising skill levels.
- We will work with the Local Enterprise Partnership and Sherwood Growth Zone to deliver business growth and inward investment.
- We will provide access to affordable and safe leisure activities for children and families.
- Work with schools to encourage children to respect their local environment.
- We will provide information, advice and support to families experiencing financial and housing difficulties with efficient appropriate responses.
- We will improve the energy efficiency and quality of homes in Mansfield.
- The Community Safety team will ensure that child poverty data informs The Community safety planning and the implementation of local actions in respect of Alcohol and Drugs, Anti Social Behaviour (ASB) and Domestic Abuse in the priority geographic area.

Mansfield Strategic Partnership (MASP)

- To incorporate child poverty priorities within the Sustainable Community Strategy for Mansfield.
- To focus inter-agency collaboration around the Work Programme on areas of highest Child Poverty need.

Newark and Sherwood District Council*

- We will work with partners to ensure that local people have access to employment opportunities.
- We will work with partners to encourage all homes in the district to be safe, warm and of a decent standard.
- We will seek to reduce the rate of homelessness by providing a range of housing advice and support.
- We will continue to provide access to affordable leisure and cultural activities.
- We will review local support available to vulnerable families, the impact these services have and identify opportunities for improvement.
- We will collaborate with and assist a range of voluntary and community organisations that provide support and services to residents vulnerable to child poverty.
- We will maximise benefit take up of families in poverty and turnaround applications quickly and accurately.

Rushcliffe Borough Council *

- We will prevent homelessness by effective multi agency intervention to reduce the number of homeless 16/17 year olds.
- We will educate young people about the reality of becoming homeless.
- The Cultural Services Department will prioritise officer support and external funding opportunities to areas that have been identified as suffering from child poverty and a deficiency of equipped play provision as identified by the Childs play Strategy "Playing for Life in Rushcliffe" 2007-2012.
- Rushcliffe Borough Council revenues and benefits service is committed to working with Nottinghamshire County Council on highlighting issues related around benefit take up and would be keen to explore data sharing opportunities.

Rushcliffe Strategic Partnership

- The Rushcliffe Community Partnership - Health Issues Group will ensure that child poverty data informs the health planning and the implementation of local actions in respect of obesity, alcohol & smoking.

- The Rushcliffe Community Safety team will ensure that child poverty data informs the community safety planning and the implementation of local actions in respect of alcohol and drugs, anti social behaviour (ASB) and Domestic Abuse in the priority geographic area. (This is a shared priority for Rushcliffe District Council).
- The Rushcliffe Children and Young People's partnership will ensure that child poverty data informs the group and services are targeted to these areas. The Group will adopt Child Poverty as a priority and develop actions to tackle this in areas that are over the 10 % target.

Jobcentre Plus*

- We will deliver a welfare system which recognises work as the primary route out of poverty and reduces the number of children in workless households.
- We will continue partnership arrangements with Children's Trust partners to tackle child poverty by improving access to Jobcentre Plus support for parents who are furthest removed from the labour market.
- We will participate in child poverty pilot activity and other activities designed to better engage parents in improving their employment prospects.
- We will gather and share information about those parents looking for work and the extent to which accessing appropriate childcare is a barrier to entering work and training leading to work.

Nottinghamshire Police*

- We will reduce levels of crime and anti-social behaviour in target wards across Nottinghamshire.
- We will identify higher risk young offenders at reprimand stage and refer to multi-agency teams through the Youth Offending Service for assessment and intervention.
- We will support truancy and persistent absence initiatives and raise awareness of the importance of truancy reduction as being vital to the reduction of crime and victimisation.
- We will ensure onward referral to appropriate interventions where young people are at risk due to alcohol or substance misuse, missing from home or vulnerable to radicalisation.
- We will support the delivery of diversionary activities for young people to reduce local crime and antisocial behaviour and to signpost children and young people to them, e.g. Princes Trust, 'Kickz' 999 challenge.
- We will ensure robust and effective partnership arrangements are in place for targeted offender management.

Nottinghamshire Probation Trust*

- As the organisation which coordinates the Reducing Reoffending Delivery Group, we will work with partner organisations to strengthen families, to help reduce the risk of reoffending; maintain Multi Agency Risk Assessment Conferences to protect and support victims of domestic abuse; and better support young adults who offend in their transition from childhood to adulthood. Additionally, to support positive family links to help drug misusing offenders abandon drugs misuse.

NHS Bassetlaw*

- We will commission services which protect and support children and young people affected by domestic violence.
- We will commission services which provide support to adults suffering from anxiety and depression.

NHS Nottinghamshire County*/Public Health

- We will reduce health inequalities between families across Nottinghamshire by reducing the gap in life expectancy, infant mortality, low birth weight and teenage conception rates between the most deprived and least deprived localities.
- We will improve outcomes for vulnerable young families by developing the health visitor implementation plan and commissioning the Family Nurse Partnership.
- We will provide services and support for children and young people and their families where substance misuse is an issue and provide specialist training to the wider workforce on identifying hidden harm issues.

Nottingham and Nottinghamshire Futures (Connexions)

- We will work with schools, colleges and training providers to achieve an increase annually in the proportion of year 11 and 13 leavers entering Learning or work. We will support 3,000 adults from Nottinghamshire who are unemployed to progress in learning or work.
- We will support 3,000 adults from Nottinghamshire who are unemployed to progress in learning or work.

Citizens Advice Bureau

- We will provide the advice families need for the problems they face and improve the policies and practices that affect families lives.
- We will provide data and outcome measurements focused on improving the financial stability of families.
- We will seek funding to increase the financial capability of people building on expertise gained in delivering a successful project in Nottinghamshire.

Home-Start

- We will offer specific support to families in Nottinghamshire to maximise their income and manage their money effectively to avoid debt.

Detailed pledges are included in Appendix One of the strategy which is published separately at **www.nottinghamshire.gov.uk/childpoverty**

How we will know when we have made a difference?

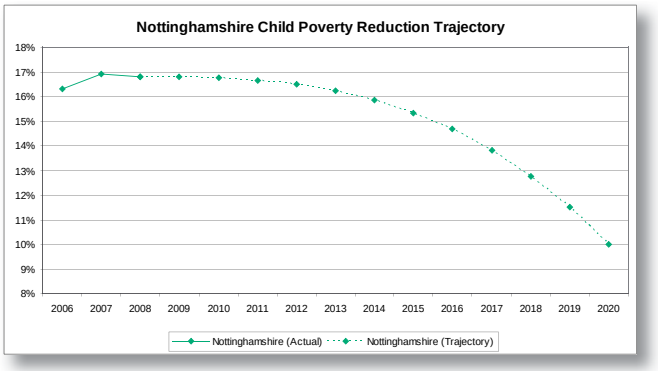
Nottinghamshire County Council as the lead organisation for the co-ordination of the Strategy, will be responsible for implementing an annual review and liaising with organisational leads to assess progress against the local pledges as well as the national child poverty target.

The annual review of the Child Poverty Strategy will be shared with the Child Poverty Reference Group who will measure progress against the national child poverty target and assess progress alongside statistical neighbours. The group will also be responsible for refreshing the Strategy and pledges to ensure activity is effective and continues to meet identified and emerging needs.

There is an expectation that the pledges included in the Strategy will be performance managed through existing organisational performance reports and therefore embedded into the core business of all statutory partners. There is an expectation that all partners contributing to the strategy will endeavour to progress their performance management to improve information about the impact of interventions as recommended in the Child Poverty Needs Assessment.

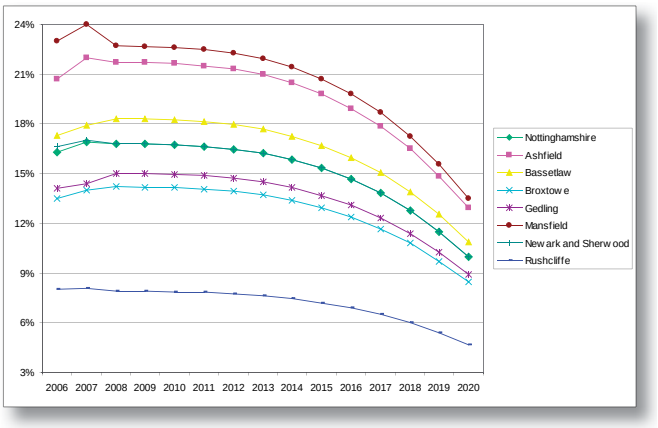
Nottinghamshire is keen to set a trajectory to help demonstrate progress. We will use this trajectory as an illustrator of child poverty levels for Nottinghamshire and the seven districts. It is important to acknowledge that child poverty levels are influenced by a great number of determinants not within the control of local organisations e.g. changes to the welfare system.

Figure 1: Nottinghamshire Child Poverty trajectory to achieve 10% reduction by 2020



The following graph has set trajectories for each of the seven district Local Authority areas within Nottinghamshire. All districts with the exception of Rushcliffe have over 10% of children living in poverty, and for some districts reducing poverty levels to below 10% will be unachievable within the current economic climate. The graph therefore uses a weighted average to apportion the reduction required for each district to ensure that the aggregate of these equals the Nottinghamshire target of 10%. Consequently each district has a variable target, however when aggregated, it would equate to 10% of children being in poverty in Nottinghamshire in 2020.

Figure 2: Child Poverty trajectories for Nottinghamshire's Seven Districts



NB: The trajectory for Newark and Sherwood mirrors the trajectory set for Nottinghamshire.

Information updates and progress reports will be published on the Nottinghamshire County Council website: **www.nottinghamshire.gov.uk/childpoverty**

4. Next Steps

The Nottinghamshire Child Poverty Strategy will be reviewed on an annual basis by the Child Poverty Reference Group which is led by Nottinghamshire County Council with representation from all statutory partners.

The Child Poverty Needs Assessment will be refreshed alongside the Joint Strategic Needs Assessment with input from the Child Poverty Reference Group.

Child Poverty will also be included in Nottinghamshire and District Sustainable Community Strategies to further embed the work into plans to ensure economic prosperity for Nottinghamshire.

We will engage children and families experiencing poverty in order to evaluate progress and ensure that the Strategy is effective in meeting the needs of the poorest families in Nottinghamshire.

We will work with workforce development leads across the partnership to ensure the training and development needs of Nottinghamshire's workforce are identified and addressed in order to enable practitioners to take an active approach to identification and support for children and families in poverty.

We will implement the child poverty communications plan to raise awareness and increase engagement in the delivery of the strategy.

References

1 Equivalisation - income data is adjusted to take into account variations in both the size and composition of the household. This process reflects the notion that a family of several people needs a higher income than a single person in order for both households to enjoy a comparable standard of living. Equivalisation is needed in order to make sensible income comparisons between households.

2 Measuring Child Poverty, Department for Work and Pensions, December 2003

3 HMSO NI 116 data http://www.hmrc.gov.uk/stats/personal-tax-credits/child_poverty.htm

4 HMSO NI 116 data http://www.hmrc.gov.uk/stats/personal-tax-credits/child_poverty.htm

5 HMSO NI 116 data http://www.hmrc.gov.uk/stats/personal-tax-credits/child_poverty.htm

6 Nottinghamshire Child Poverty Needs Assessment 2011 can be accessed at www.nottinghamshire.gov.uk/childpoverty

7 End Child Poverty (March 2011) 'Child Poverty Map of the UK' Child Poverty Action Group

Nottinghamshire County Council

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The full Nottinghamshire Child Poverty Needs Assessment can be accessed at:
www.nottinghamshire.gov.uk/childpoverty

Nottinghamshire County Council

Report to Health and Wellbeing Board

7 November 2012

Agenda Item: 7

REPORT OF THE CORPORATE DIRECTOR FOR CHILDREN, FAMILIES AND CULTURAL SERVICES

HEALTH AND WELLBEING BOARDS AND CHILDREN, YOUNG PEOPLE AND FAMILIES

Purpose of the Report

1. The purpose of this report is to:

   - set out the national context for the joint commissioning of health and wellbeing services for children, young people and families

   - report back to the Board the main issues arising from the self-assessment undertaken by the Children's Trust. This was completed using the key success factors and key challenges for Health and Wellbeing Boards that arose from the work of the Health and Wellbeing Board National Learning Set for children and young people

   - make a recommendation to the Board that Nottinghamshire's Children's Trust becomes the integrated commissioning group for health and wellbeing services for children and families.

Information and Advice

2. With the advent of the NHS reforms, there is an opportunity to ensure that each part of the system for children, young people and families is working together to improve the health outcomes of our local population.

The Children and Young People's Health Outcomes Forum

3. The Secretary of State for Health is currently considering the recommendations of the Children and Young People's Health Outcomes Forum. The Forum produced a report that will form the basis of the Health Outcomes Strategy to be published later this year.

4. Some of the key issues identified within the report are:

   - Directors of Public Health and their local clinical commissioning groups (CCGs) should work together with maternity and child health services to identify and meet the needs of their local population

   - Directors of Children's Services should be responsible for overseeing the overall quality and delivery of health and wellbeing for looked after children

- the National Health Service Commissioning Board (NHS CB) must ensure that there is a nationally designated, strategic managed network for children and young people. This should include maternity and neo-natal care. The network should incorporate:

    - all children and young people's services within the Specialised Services Definition Set
    - all parts of relevant pathways, from specialist centres through district general hospitals to community service provision and primary care. The NHS CB must ensure explicit links between the specialist elements of the pathway commissioned by them, and those areas of the pathway commissioned by CCG.

- clinical commissioning groups need to develop local networks and partnerships with providers to address and deliver the sustainable provision of local acute, surgical, mental health and community children's services and to ensure care closer to home and no gaps in provision. There is a view that General Practice does not always meet the needs of children and young people

- the NHS CB, with clinical commissioning groups should address service configuration to meet the needs of children and young people on a sustainable, safe and high quality basis

- local commissioners, including clinical commissioning groups and local authorities, should identify a senior clinical lead for children and young people

- the Department of Health (DH) and the NHS CB should publish a full accountability framework for safeguarding children in the wider health system as soon as possible

- as part of the new multi-agency inspections, the Care Quality Commission should consider how all parts of the health system, including relevant adult services, contribute to effective local safeguarding. This should include a focus on measuring the effectiveness of early help/early intervention

- the use of the NHS Number as the unique identifier bringing together health, education, social care and criminal justice records for children and young people

- social care staff and others dealing with looked after children should have responsibility for ensuring they are registered with a GP and that the GP is kept informed of the details of their care

- clinical commissioning groups and local authorities should specifically recognise care leavers in early adulthood (18-25), as well as looked after children, in their commissioning, including a requirement that children in care health teams include a focus on this group

- the National Curriculum Review currently taking place should include the promotion of health and wellbeing within the 'statutory aims' of the revised national curriculum.

Responsibilities Transferring to Local Authorities

5. Alongside the publication of the new Strategy for Children and Young People, the responsibility for a number of Primary Care Trust commissioning functions focusing on children and young people will be transferring to the Local Authority (Public Health). On behalf of the Health and Wellbeing Board, the Children's Trust has an important role in ensuring that these services are shaped and reviewed jointly to improve outcomes for children and young people. The services and programmes of interest to the Children's Trust include:

   - School Nursing (Healthy Child Programme 5-18yrs) – transferring to Public Health in April 2013
   - Healthy Schools Programme (Healthy Child Programme 5-18yrs) – April 2013
   - Health Visiting (Healthy Child Programme 0-5yrs) – April 2015 *(to be commissioned by the NHS Commissioning Board from April 2013)*
   - Family Nurse Partnership – April 2015 *(to be commissioned by the NHS Commissioning Board from April 2013.)*

6. There will be additional public health functions coming to the LA that have a broader life-course perspective but will still impact on children and young people. These include work to tackle obesity (including the National Child Measurement Programme and nutrition services), alcohol and drug misuse services, and sexual health services. It is equally important that the Health and Wellbeing Board and Children's Trust work together to ensure effective commissioning of these services, particularly as they cover the life-course.

The Self Assessment Completed by the Children's Trust

7. These changes in the national system afford an opportunity to align our governance and joint commissioning activity so we are clear about what our children, young people and families need, and how we are going to work together to secure high quality provision to meet these needs.

8. On behalf of the Health and Wellbeing Board, the Children's Trust has undertaken a self-evaluation against the key issues arising from the work of the National Learning Set. The self evaluation was carried out in August 2012 with final discussion at the Children's Trust in September 2012. A copy of the full assessment is attached at **Appendix 1**, along with a copy of the poster published by the Learning Set, which sets out the key strategic questions and challenges for Health and Wellbeing Boards in their work related to children and young people. The main issues arising from the self assessment include the following:

   - the focus and membership of the Children's Trust should be revised to ensure that it more effectively champions health and wellbeing issues for children, young people and families, and plays a more fundamental role in the work of the Health and Wellbeing Board

   - this revised focus would enable stronger leadership of a cycle of integrated commissioning for children's services

- specifically, this should include a more formal confirm and challenge role for the Trust in respect of the Integrated Commissioning Groups that report to it, holding groups and chairs to account for activity and progress

- in order to achieve this, the Trust should ensure that its membership includes the principal commissioners for heath services (Public Health, the NHS Commissioning Board and local Clinical Commissioning Groups)

- there needs to be particular drive to engage with the new Clinical Commissioning Groups, both strategically and locally. There are a range of perceived benefits to this approach, including stronger needs assessment and commissioning arrangements, and a better understanding at local level about the way in which the system for children's services operates and how General Practitioners can engage with it. There may be some merit in one or more of the clinical leads who are Board members taking a lead role in the work of the Children's Trust, working with the Corporate Director

- the Children's Trust should review the arrangements across the partnership for the participation of children, young people and families in the commissioning of services. There is room for improvement in these arrangements and some incentive in the new system for the use of ready made tools such as the NHS 'You're Welcome' initiative

- the Trust should review and strengthen the Children's chapter of the Joint Strategic Needs Assessment (JSNA) so that it includes evidence of what works to improve health outcomes for children and families

- this revised chapter of the JSNA should be the platform for a new Children, Young People and Families Plan which sets out key priorities for the future, commissioning plans and develops the notion of a "core offer" of health interventions for children, young people and families across Nottinghamshire.

Reason/s for Recommendation/s

9. There is a statutory requirement to have a local partnership overseeing the integration of services for children and young people. With the advent of the Health and Wellbeing Board and the NHS reforms, it is natural development of Nottinghamshire's Children's Trust to focus on the effective commissioning of provision for the health and wellbeing of children and young people.

Statutory and Policy Implications

10. 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.

Implications for Service Users

11. The Children's Trust oversees services for more than 180,000 children and young people. In doing so, it has a range of systems and processes to ensure that services reflect the needs of the local population and are managed in a compliant and safe way. The Trust also has strong links with the Nottinghamshire Safeguarding Children Board and is part of the wider governance structure of the Health and Wellbeing Board.

RECOMMENDATION/S

That:

1) the Health and Wellbeing Board supports the view that the Children's Trust should revise its focus and membership so that it becomes the lead integrated commissioning group for health and wellbeing services for children and families

2) the Health and Wellbeing Board supports the Children's Trust to develop the next Children, Young People and Families plan. This new plan should reflects the Trust's revised role, the forthcoming Children and Young People's Health Outcomes Strategy, and be aligned to the Health and Wellbeing Strategy

3) the Clinical Commissioning Group clinical leads consider whether it would be helpful for one or more of them to take a lead role in the children's services agenda, working with the Corporate Director for Children, Families and Cultural Services.

Anthony May
Corporate Director for Children, Families and Cultural Services

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Constitutional Comments (SG 24/10/12)

12. The Health and Wellbeing Board is the appropriate body to consider the issues set out in this Report.

Financial Comments (NDR 23/10/12)

13. There are no financial implications arising directly from this report

Background Papers

None.

Electoral Division(s) and Member(s) Affected

All.

C0112

APPENDIX ONE

Health and Wellbeing Boards and Children, Young people and Families

The following assessment aims to consider how well children, young people and families (CYPF) issues are championed through the Health and Wellbeing Board (HWBB) and their supporting governance structure. This document aims to secure a baseline of current activity within Nottinghamshire and the links to the HWBB through the Children's Trust Executive (CTE); it aims to identify next steps in order to succeed in achieving the goals listed below.

The assessment template was developed using the national resources developed by the National Learning Set focusing on Health and Wellbeing Boards and CYPF, chaired by Anthony May. The vision of which is as follows:

Vision: That Health and Wellbeing Boards make an effective contribution to improving health and wellbeing outcomes for children and young people.

Goal	Rating	Comments	Next Steps
1. A local partnership dedicated to CYPF is established and links to the HWBB.	**AMBER**	The CTE is an established sub group of the Shadow HWBB. The Chair of the CTE is a member of the HWBB. The CTE is considered the lead integrated commissioning group leading on CYPF on behalf of the HWBB. Clinical Commissioning Groups (CCG) are represented on the CTE and its integrated commissioning groups. A number of NHS Providers are members of the CTE - this would not appropriate for an integrated commissioning group.	Amend the CTE terms of reference to acknowledge the links with the HWBB and its integrated commissioning groups. Review the terms of reference and membership for the CTE to ensure the group is the lead Integrated Commissioning Group for Children, Young People and Families.
2. Commissioning of NHS services for CYPF sits alongside commissioning of all services for CYP (the concept of holistic commissioning).	**AMBER**	There are a number of areas that are jointly commissioned and planned namely disability and SEN services, CAMHS, and teenage pregnancy including the Family Nurse Partnership. There are also examples where joint work has led to holistic commissioning such as health needs of Looked After Children and those in Young Offender	Commissioning plans of all key partners (including CCG) should be shared and discussed through the Children's Trust to ensure links are made and partners are aware of what services are commissioned and decommissioned. The CTE should have a confirm and

Goal	Rating	Comments	Next Steps
		Institutions; as well and CYPF living in poverty. Priorities of all partner agencies have been identified, shared and formed into the Children, Young People and Families Plan 2012-14. There are however gaps where services are commissioned in silos e.g. speech and language therapy resulting in some duplication and confusion of roles. Nottingham North East CCG is the lead for children and young people and is establishing a Children's Services Commissioning Group bringing together all CCG and Public Health. This will be a useful group to help progress holistic commissioning. In addition sharing and agreeing on commissioning intentions can be even more challenging where the boundaries/governance of partners are not is a lack of coterminous. This will be particularly challenging where Bassetlaw CCG reports to South Yorkshire and Humber NHS commissioning Board.	challenge role in relation to commissioning e.g. ensuring that commissioning intentions are based on evidence of what works, that activity is value for money, the views of CYPF inform plans etc. There needs to be an improved method for cascading relevant information to the CTE from the HWBB and vice a versa e.g. CCG commissioning intentions. NHS and LA service specifications should be routinely shared with the CTE to ensure appropriate links are made. Ensure the newly established Children's Services Commissioning Group engages all relevant commissioning leads and invites additional leads to share and confirm commissioning plans as appropriate. Support to ensure all CCG which cross boundaries into other areas are fully engaged in local governance and reporting arrangements.
3. The HWBB prioritises interventions for CYP which are proven to work.	**AMBER**	The HWBB delegates commissioning activity impacting on CYPF to the Children's Trust Executive as their lead joint commissioning sub group for CYPF. The HWBB and CTE support the use of a clear evidence base to support commissioning decisions. The Family Nurse Partnership is currently being developed in Nottinghamshire and most CCG and NCC are pooling funds to progress this evidence based programme.	Despite the Children's Trust being seen as the lead commissioning group for children on behalf of the Health and Wellbeing Board, further work is required to ensure that CCG understand this role and strong links are made with the new Children's Services Commissioning Group and the Children's Trust. The JSNA does not include an evidence

Goal	Rating	Comments	Next Steps
		Commissioners are encouraged to focus on the evidence base of what works where this is available although the evidence base is still patchy. The SEND Pathfinder the 'One project' aims to help build the evidence base of what works and the Nottinghamshire Pathfinder will report its findings to the CTE, NWBB and nationally.	base to support commissioning plans so where capacity is available more in depth pieces of work are carried out e.g. Disability and SEN, CAMHS. Commissioning plans are informed by an assessment of local need, and this needs assessment should also include a summary of evidence based practice i.e. what interventions have been proven to be most effective. The CTE needs to consistently and effectively confirm and challenge commissioning plans to ensure that they are based on the evidence where it is available.
4. Commissioning of services is informed by the views of CYPF.	**AMBER**	There is ad hoc consultation with CYPF to inform commissioning decisions following budget pressures and reduced capacity. There have been a number of examples of positive engagement of CYPF throughout the commissioning cycle for areas such as substance use, teenage pregnancy, CAMHS, SEND Pathfinder etc; however this is currently less consistent.	Ensure consistent engagement of CYPF throughout the commissioning cycle to help inform commissioning decisions and assessing need. The CTE should provide support and challenge to ensure that CYPF have been engaged before commissioning decisions are made and confirmed.
5. The HWBB ensures a focus on early intervention within an overall understanding of a 'lifecourse' approach to provision.	**AMBER**	The Chair of the Children's Trust (and DCS) sits on the HWBB to champion early intervention and the lifecourse approach to provision. Early intervention is referenced in the HWB Strategy as an appropriate focus to minimise increases in need / the deterioration of health and wellbeing. The HWBB has already received presentations focusing on children, young people and older	Further work is required to embed early intervention and lifecourse approaches across all partners including CCG.

Goal	Rating	Comments	Next Steps
		people. Some public health topics on the HWBB agenda have focussed on the lifecourse approach i.e. obesity (July 2012) and smoking (September 2012).	
6. The HWBB links effectively with the Children's Trust, NSCB, and CCG to ensure cohesive governance and leadership across the Children's agenda.	**AMBER/GREEN**	Governance arrangements have been developed with clear links with the HWBB, CTE and NSCB. CCG are represented at each of these groups. There is currently ad hoc reporting to and from the CTE and NSCB to the HWBB.	A paper is due to be presented to the September HWBB to confirm governance arrangements for the CTE, NSCB. A reporting system should be developed and maintained to ensure information is cascaded from the HWBB to the CTE and NSCB as appropriate. The CTE forward plan should reflect the HWBB Forward plan.
7. The HWBB has an agreed process to ensure children's issues receive sufficient focus.	**AMBER**	The HWBB received a presentation on CYP health in July 2011, and the forward plan includes an item on vulnerable CYP in February 2013. There is no regular item regarding CYP on the HWBB agenda. There is no regular item on the Children's Trust Executive regarding feedback from the HWBB.	The HWBB Forward plan should be consistently shared with the CTE to ensure key issues are set on the forward plan as required. The Children's Trust should consider a standing item on their agenda to receive feedback from the HWBB.
8. The HWBB has contributed to defining the early help offer as recommended by Professor Munro.	**AMBER**	This has not been addressed at the HWBB, however as the CTE is the thematic sub group of the HWBB it has addressed a number of the recommendations of Munro and early intervention is a key priority for the CTE. An early intervention strategy has been developed by the CTE.	Further work is required to embed early help and intervention at HWBB level. The HWBB Forward Plan could be influenced to include a session on early intervention.
9. The HWBB is making appropriate use of local mechanisms to listen to the views of CYPF.	**AMBER**	Healthwatch is due to be commissioned and Children's Health leads have supported the development of the Service Specification to ensure the successful provider uses the existing local	The existing networks to enable effective consultation with CYPF should be promoted and actively used e.g. Youth MPs.

Goal	Rating	Comments	Next Steps
		mechanisms for engagement and listening to CYPF. There are a range of mechanisms for children and young people to influence the planning and provision of services but there is a lack of focus on bringing these together at either the Children's Trust or the HWBB. There are useful vehicles in existence to engage children and young people in their local health services (such as the You're Welcome initiative) but there is no strategic view about their use in Nottinghamshire.	The performance management of the Healthwatch contract should ensure that CYPF issues are championed consistently at quarterly contract review meetings. The CTE should ensure that the views of children influence its planning better and advise the HWB about the use of initiatives such as You're Welcome.
10. The HWB Strategy analyses and prioritises the health needs of CYPF and describes success.	**AMBER**	The HWB strategy for 2012/13 will be further shaped for 2013 and beyond following the refresh of the children's chapter of the JSNA in 2012/13. The strategy itself only highlights a number of headline areas and refers to the JSNA for in depth analysis. The HWB Strategy does not include detail re success criteria however each of the CYP priorities have in depth performance arrangements and action plans.	More work is required to inform the commissioning priorities of the HWB Strategy for 2013/14 and beyond and ensure that health needs are being identified and addressed. The CYP chapter of the JSNA is due to be refreshed in 2012/13. The HWB supports the development of a new Children, Young People and Families Plan to incorporate its lead role in the commissioning of effective services for health and wellbeing.
11. The views of frontline staff and clinicians have been factored into the HWBB's planning.	**AMBER**	The HWB Strategy was sent out for consultation however further work is required to engage frontline staff and clinicians and secure feedback as responses were low.	Consider wider consultation for the next refresh of the HWB Strategy. The Children's Trust Executive is due to formalise reporting arrangements from the CYP Health Network which engages clinicians. This group will be central for future consultation. The CTE could play an important role in developing an integrated workforce

Goal	Rating	Comments	Next Steps
			strategy for the children's workforce and advising the HWB in this respect.
12. The HWBB has an agree method of engaging with schools.	**GREEN**	The Corporate Director for Children, Families and Cultural Services is a member of the HWBB and enables the engagement of schools through regular communication with Headteachers and Governors as and when required.	More could be done to ensure that schools are up to date with the NHS reforms and the work of the HWB. The Corporate Director will present these issues at the next termly meetings of head teachers.
13. The HWBB has a clear plan to maximise the use of public assets (children centres, schools, youth services, health centres etc) to improve the health outcomes for CYPF.	**AMBER**	There is currently ad hoc planning e.g. Children Centres have a health core offer, school nursing and health visiting services will refresh their core offer in 2012/13 in line with national guidance. The new Youth Centre in Mansfield is still waiting for NHS commissioners to enable the delivery of a Contraception and Sexual Health Outreach service on site. There is no systematic understanding of all of the key public assets available through all partners of the CTE or HWBB.	Broader countywide plans are required to pull together information regarding all key public assets to aid planning and delivery of services and interventions which aim to improve health outcomes for CYPF. Further work is required to establish a core offer of health interventions for CYPF at a range of sites. This work should be a key focus of the CTE in the future, particularly making sure that CCG are aware of what provision is available and how to access it. The new Pathway to Provision can play an important role in this and it is imperative that the details of this get to GP.
14. The HWBB is satisfied that the Common Assessment Framework (CAF) is sufficiently embedded in the local partnership.	**AMBER**	The HWBB delegates this function to the Children's Trust.	Further work is required to promote the CAF across all partners of the CTE. Children's Trust Protected Learning Time events are being planned for each CCG to focus on CYPF issues, and this may include the need to embed CAFs.

Goal	Rating	Comments	Next Steps
			CAF development is at the heart of the new Pathway to Provision and it is important that GP understand the CAF and how it is used. The CTE should lead on this.

Recommendations for the Children's Trust Executive

- Further develop this assessment through debate and discussion to secure an accurate picture of current working practice.
- Consider the suggested next steps and agree which actions to progress to improve current arrangements for the Health and Wellbeing Board to improve outcomes for children, young people and families.

Health and wellbeing boards and children, young people and families

Key success factors

- A local partnership dedicated to children and young people (linked into the governance of health and wellbeing boards) is essential.
- Commissioning of NHS services for children and young people must sit alongside commissioning of all services for children (the concept of holistic commissioning).
- Health and wellbeing boards should prioritise interventions for children and young people which are proven to work.
- Commissioning of services should be informed by the views of children, young people, parents and families.
- Health and wellbeing boards should ensure a focus on early intervention, within an overall understanding of a 'lifecourse' approach to provision.

Key strategic questions and challenges for boards

- Does the health and wellbeing board link effectively with the local children's trust, safeguarding board and clinical commissioning groups (CCGs) to ensure cohesive governance and leadership across the children's agenda?
- Does the health and wellbeing board have an agreed process to ensure children's issues receive sufficient focus?
- Has the health and wellbeing board contributed to defining the early help offer, as recommended by Professor Munro?
- Is the health and wellbeing board making appropriate use of local mechanisms to listen to the views of children, young people and families?
- Does the local health and wellbeing strategy analyse and prioritise the health needs of children and describe success?
- Have the views of frontline staff and clinicians been factored into the board's planning?
- Has the health and wellbeing board got an agreed method of engaging with schools?
- Has the health and wellbeing board got a clear plan to maximise the use of public assets (children's centres, schools, youth services, health centres, etc.) to improve health outcomes for children?
- Is the health and wellbeing board satisfied that the common assessment framework is sufficiently embedded in the local partnership?

This poster was produced in June 2012 by the health and wellbeing board learning set for children and young people. It represents their key learning and does not necessarily showcase best practice but aims to provide health and wellbeing members with an accessible and helpful resource. This learning set was led by Anthony May, Corporate Director for Children and Families and Cultural Services for Nottinghamshire County Council, anthony.may@nottscc.gov.uk.

For further information, or to comment on this poster, please email hwb@nhsconfed.org.

INF30701

Vision

That health and wellbeing boards make an effective contribution to improving health and wellbeing outcomes for children and young people.

Supported by

Department of Health

Local Government Association

NHS CONFEDERATION

NHS Institute for Innovation and Improvement

Further resources

- The Department of Health Children and Young People's Health Outcomes Strategy (due to be published in July 2012)
- A plethora of Local Government Association resources, collated by the LGA: www.local.gov.uk/childrens-health
- Local authority child health profiles (published by the Child and Maternal Heath Observatory – ChiMat): www.chimat.org.uk/profiles
- The NHS Atlas of Variation in Healthcare for Children and Young People: www.chimat.org.uk/variation
- NHS Confederation review of policy documents on children and young people's health and wellbeing: www.nhsconfed.org/hwb
- Assured Safeguarding – GP and Health Leader Edition (safeguarding advice for GP and health leaders developed by the East Midlands group of Directors of Children's Services): www.jriep.com
- Commissioning Child Health and Wellbeing Services (information and guidance framework developed by the East of England Strategic Network for Child Health and Wellbeing Commissioning Champions) – EOE Info and guidance framework
- National Institute for Health Research (for health-related research materials): www.nihr.ac.uk
- A guide for commissioners of children's and young people's and maternal health and wellbeing services NHS North West: www.northwest.nhs.uk/childhealth

The spectrum of children's health needs

Taken from the project scope of the Department of Health Children and Young People's Health Outcomes Forum

- Health promotion, prevention and improvement
- Primary care
- Children with poor mental health
- Urgent care for children with acute illness
- Children with long-term conditions
- Children with complex health needs
- Children with disabilities
- Looked after children
- Palliative care
- Ensuring the use of medicines for children optimises health outcomes
- The health sector's contribution to safeguarding children
- The health sector's contribution to support for troubled families

Nottinghamshire County Council

Report to the Health and Wellbeing Board

7th November 2012

Agenda Item: 8

REPORT OF THE CLINICAL LEAD FOR NHS NOTTINGHAM WEST CLINICAL COMMISSSIONING GROUP

EAST MIDLANDS HEALTH & WELLBEING BOARD CHALLENGE EVENT

Purpose of the Report

1. The report provides information on the recent Health & Wellbeing Board Challenge Event, which took place with nominated members of each Health & Wellbeing Board across the East Midlands region. It summarises format, content and discussions on the day and proposes actions to be taken following the event.

Information and Advice

2. A Health & Wellbeing Board Challenge Event was arranged jointly by the Local Government Association, NHS Midlands and East and the Department of Health. The aim of the event was to explore challenges and understand the inherent complexities and conflicts within roles and between agencies on Health & Wellbeing Boards. It was also designed to allow time to identify development needs for Boards and translate these into actions.

3. Seven Members of the Nottinghamshire Health & Wellbeing Board were nominated from the membership to attend the event on 25 September 2012. The selection aimed to include members with a good range of different backgrounds.
   Attendees included:

   - Deputy Leader of Nottinghamshire County Council and Chair of the Health & Wellbeing Board (HWB)
   - Corporate Director of Adult Social Care, Health & Public Protection
   - Corporate Director of Children, Families and Cultural Services
   - Clinical Lead for NHS Nottingham West Clinical Commissioning Group (CCG)
   - GP Member Lead for HWB in NHS Rushcliffe Clinical Commissioning Group (CCG)
   - Councillor representative for Newark & Sherwood District Council
   - LINks representative

   In addition, the event was also attended by the Associate Director of Public Health in her role as the Health & Wellbeing Board coordinator.

4. The simulation event took the form of introductory presentations followed by group sessions discussing a range of case studies that were pertinent to the work of Health & Wellbeing

Boards. Group discussions were centred on each Board, although opportunity was given to share ideas between Boards at various stages through the day. Impartial observers were sited in each group to capture observations and facilitate the discussion if necessary.

5. There were two compulsory case studies or scenarios provided to the group, and a further seven optional areas, where each Board could choose to discuss items relevant to their locality. The case studies discussed were:

   - **Reconfiguration of hospital services:** this scenario was particularly pertinent to the Nottinghamshire Board as it included the consolidation of hospital emergency departments to better meet the needs of the local population.

   - **Improving Primary Care and Out of Hours Services:** this scenario involved theoretical concerns over the quality of primary care out of hours services, focusing on how improvements in primary care services can reduce unnecessary attendance and admissions to hospital.

   - **Service User and Public Engagement**: this exercise involved time to formulate a plan for effective communications and engagement for the Health & Wellbeing Board.

6. A wide ranging discussion took place between members of the Board allowing for an honest and open exchange of ideas. A summary of issues for the Board to consider are:

   - It was noted that the HWB would need to maintain a strategic approach, with defined aims and objectives. These should not only tackle major health issues that might take many years, but smaller issues with potentially quicker wins, in order to build experience and confidence in collaborating on change and transformation.

   - Discussion time is essential to explore different knowledge bases and gain a common understanding of the issue in question. There is also a need to expose issues that can be difficult to raise and it was noted that all members needed to be actively engaged in discussions. It was felt vital that where an issue had been fully discussed and signed up to by HWB members, that from there on, all members had a duty to support other organisations in achieving these goals.

   - The Board needs access to evidence on what works, to assist discussions around potential solutions. This will allow informed decisions to be made using a good understanding of the issues in the context of the overall evidence as well as individual experiences.

   - Comment was also made that clarity around decisions making roles across partners on the HWB was essential. For example, the HWB would not be decision makers in relation to reconfiguration of hospital services, but would be involved centrally in discussions and supporting the change when agreed.

   - As the system leader, it was felt important that the HWB provided a formal position statement on issues in a timely way, especially where there was high media coverage. However, it was noted that the Board needed to consider information from all sides before it reached any conclusions.

- Clarity around the role of the HWB and scrutiny is required to prevent systems duplicating discussions or working against each other. It was felt that providing proper process was adhered to, with a discussion at HWB and a joint position arrived at, that there would then be less potential for the scrutiny process to unduly disrupt implementation.

- Consideration needed to be given around engaging all senior political and managerial leaders so the view of the HWB was the same as the collective view of individual partner organisations. CCG's were happy to support other member organisations with difficult implementations once agreed, but expected the same support in return.

- Comment was made that the Board needed to consider its appetite for risk. It was felt that this would depend on trust, understanding of the issues and careful communication and engagement to capture conflicting views. It was recognised that without risk, the present system would not transform sufficiently quickly but that risk was particularly difficult to handle for those engaged in a political process.

- The importance of engagement was a common theme, and comment was made to map and make use of the communication and engagement work that already took place across the system, but was currently not joined up.

- Engagement with a wider set of stakeholder will allow for a better understanding across the system and consideration of potential issues and solutions. The HWB needed to strengthen its process for engaging wider stakeholders so that views could be heard and considered early.

- The HWB needed to consider how it could support getting the public on board with difficult decisions. The HWB needed to be seen as authoritative, with a collective interest for the local population. The public needed to trust that decisions are made on the best evidence and have been considered fully to agree the best workable option for local people. This is especially difficult in a tight financial climate, where the best workable option may not be viewed by the public as a good outcome in the short term. Therefore decisions may need to be sold on their merits, whilst being open on the constraints being managed.

- The exercise of creating a communication and engagement plan allowed further time to design a plan around the existing communication plan and current engagement activity. It also allowed the design to be tested by members of other HWB's when it was presented to other delegates. It was noticeable that the Nottinghamshire plans were well in advance of almost all other regional HWB's.

- In summary, the HWB members felt that the Board needed to consider difficult transformation, there should be a common understanding of roles and responsibilities and there was a need to actively communicate and engage to ensure the Board maintained a collective view on behalf of the County.

7. All attendees commented that the event was extremely useful as it allowed time to extend debate on difficult issues that are likely to be discussed at HWB meetings. There was good discussion over development needs for the HWB and comments were captured in a draft development plan.

8. There will be formal feedback from the event organisers including comments from the observers and draft development plans. However some summary actions identified include:

   - Share the learning from this event with other Board members.
   - Develop Operating Principles for the Health & Wellbeing Board
   - Develop a new communication and engagement plan for the Health & Wellbeing Board. NB: This will be led through the JSNA, Strategy and Outcomes Group and will be presented at a future HWB meeting for approval.
   - Review the development plan and add to this to address development needs of the HWB.
   - Use real tasks to address development needs. For example, consider use of site visits to areas of good practice to explore potential solutions to local problems.

9. The Next HWB workshop is planned for 28th November 2012. This has been identified to take forward discussions around the HWB self assessment. As this work links with the work identified through the challenge event, it is proposed that the session be broadened to cover learning from this event. This would also mean that the proposed cancer action planning discussion take place in a different setting.

Statutory and Policy Implications

10. 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) The Health & Wellbeing Board are asked to note the content of the report and support the proposed actions to be taken following the event.

DR GUY MANSFORD
Clinical Lead NHS Nottingham West CCG

For any enquiries about this report please contact:
Cathy Quinn, Associate Director of Public Health
Cathy.quinn@nottspct.nhs.uk

Background Papers

None.

Electoral Division(s) and Member(s) Affected

All. HWB49

Nottinghamshire County Council

Report to the Health and Wellbeing Board

7th November 2012

Agenda Item: 9

REPORT OF THE DIRECTOR OF PUBLIC HEALTH

REPORT ON PUBLIC HEALTH TRANSITION

Purpose of the Report

1. The report provides information on progress around Public Health Transition including the recent self assessment assurance report to the Local Government Association. It also describes the work being taken forward to develop the work programme underpinning the work of the Health & Wellbeing Board.

Information and Advice

Public Health Transition

2. A project plan was initially developed in March last year to manage the transition of Public Health from NHS Nottinghamshire County and Bassetlaw to Nottinghamshire County Council. This plan has been regularly reviewed and maintained to keep the work on track according to national timescales and performance milestones.

3. There are 62 members (56.3 Full Time Equivalent) of the Public Health Department due to transfer to the Council on 1 April 2013. Five members of staff are currently employed by NHS Bassetlaw; the remainder are employed by NHS Nottinghamshire County. Nottinghamshire County staff are already co-located within County Hall and Meadow House.

4. A self assessment was submitted on 10 October 2012 to the Lead Chief Executive for the region on behalf of the Local Government Association. This described the status of the current transition arrangements.

5. There are no significant risks identified within the transition plan that are not being addressed. Detailed work is being taken forward to ensure the smooth and effective transfer of contracts, staff and Public Health functions by 31 March 2013. Further information is available from the Associate Director of Public Health.

6. A dedicated Project Board is being established to manage the remaining five months of transition to give in depth support to areas of transition that require detailed action. The project is sponsored through David Pearson and Chris Kenny and managed through Cathy Quinn, Associate Director of Public Health.

Public Health Grant

7. Confirmation on the Public Health Grant for 2013-14 is still outstanding but is expected in December, following further discussion on the allocation formula. As Nottinghamshire County is not an outlier, it is not expected that the shadow grant will be significantly different to the actual allocation.

8. As part of the preparatory work, a report has been developed to describe the current expenditure across Public Health, including a summary of how this is spent within each policy area. This report is being used to prepare a discussion paper on future funding priorities within the Public Health Grant. Further information is available from the Associate Director of Public Health.

9. A confirm and challenge session took place on 8 October 2012 with senior Public Health managers to discuss priorities for funding over the next 1-2 years. Each policy lead presented their case, and members of the department challenged the information based on prioritisation criteria agreed by the Health & Wellbeing Board.

10. Proposals will be presented to the Corporate Leadership Team and Health & Wellbeing Implementation Group during November based on the information known to date. Once the Public Health Grant for 2013-14 has been confirmed, the final proposals will be presented to the Public Health Sub-Committee (once established) and Health & Wellbeing Board for ratification in January 2013. This will agree the Public Health Grant allocations and be used to develop the Public Health business plan for 2013-14.

Public Health Business Plan

11. The Public Health Department continue to make progress against their annual plan. Regular reporting of activity is collated through departmental checkpoint reports. These describe all the work of the department and illustrate the broad scope of Public Health work and how it contributes to delivery of the Public Health and Health & Wellbeing agenda. Further information is available from the Associate Director of Public Health.

Health & Wellbeing Board

12. The establishment of the Health & Wellbeing Board is also included in the Public Health Transition & Business Plan due to the connection with the Health & Social Care Act 2012. The Associate Director of Public Health provides leadership to the work programme, ensuring coordination of Board development, governance arrangements and Board business.

13. The Board meeting agendas and workshops continue as described in the forward programme (**Appendix One**) covering a range of health and wellbeing issues. Information on past agendas is also included in the forward programme. Members of the Board are asked to consider the programme and feedback any items for inclusion in the future programme.

14. The supporting structure to the Health & Wellbeing Board is now in place, which provides a good governance system to manage the work of the Board. Key developments are

described below and further information on the governance arrangement is available through the Associate Director of Public Health.

14.1. **Health & Wellbeing Implementation Group**:
The Health & Wellbeing Implementation Group provides the executive oversight to the Board by directing the work of the groups within the supporting structure. These include a range of integrated commissioning groups covering areas such as older people, mental health, children & young people & obesity along with other areas.

The Health & Wellbeing Implementation Group was established in May 2012 and meets every other month to performance monitor activity and manage the work programme.

14.2. **JSNA, Strategy & Outcomes Group**
The JSNA, Strategy & Outcomes Group has a coordinating function bringing together the outputs of the integrated commissioning groups. Its main role is to maintain a work programme to continually refresh and develop the JSNA and Health & Wellbeing Strategy (HWS).

Two of the three chapters of the JSNA were refreshed and formally approved by the Council and Primary Care Trusts in July 2012. The update of the Children & Young People's chapter has now commenced.

This work is supported by the development of a Local Outcomes Framework to monitor delivery of the strategy, and implementation of a communication and engagement plan to ensure the JSNA and HWS are developed around local views.

Health & Wellbeing Stakeholder Network

15. A second stakeholder network is being organised for November/December 2012. The Implementation Group felt it important to consider a wider determinant of health. Therefore the event will concentrate on the link between housing and health, using case studies and sharing of good practice. Further information will be circulated in due course.

Development of the Health & Wellbeing Board

16. The Health & Wellbeing Board has now hosted four workshops covering, development of the Health & Wellbeing Strategy, long-term neurological conditions and stroke, obesity and joint work with Productive Notts. Actions have been identified to consolidate commissioning plans or work programmes as relevant and these are being taken forward via the appropriate supporting group.

17. The Health & Wellbeing Board is due to discuss the recent self assessment at the next workshop on 28 November 2012 and identify development needs as part of discussions.

18. Seven Health & Wellbeing Board members also took part in the recent regional challenge event. A report is going to the next Board and the learning from the event is being considered as part of this forthcoming workshop.

19. Planned Work for November 2012 – January 2013 include the following areas:

- Development of Operating Principles for the Health & Wellbeing Board
- Completion of the HWB Self Assessment during the November Health & Wellbeing Board workshop
- Agree development plan for Health & Wellbeing Board based on findings of self assessment
- Development of reporting arrangements for the Health & Wellbeing Board supporting structure
- Development of a Local Outcomes Framework to monitor the delivery of the Health & Wellbeing Strategy
- Development of a Communications & Engagement Plan
- Development of plan to initiate a continual refresh for JSNA and Health & Wellbeing Strategy

HealthWatch

20. The establishment of HealthWatch is also set out in the Health & Social Care Act 2012. Within Nottinghamshire Council Council, the process of commissioning a Local HealthWatch is led through Policy, Planning & Corporate Services and includes Public Health, NHS and LINks involvement. A project plan manages the delivery of work against tight timescales.

21. The service specification for Local HealthWatch has been developed following consultation with key stakeholders and market sounding events have been held to provide information to potential providers of the service from April 2013. The contract is currently out to tender, which closes on 29th November 2012. Evaluation panels are scheduled to take place the first week in December to assess the applications.

Statutory and Policy Implications

22. 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) The Health & Wellbeing Board are asked to note the content of the report and feedback any items for including in the forward programme for the Board.

DR CHRIS KENNY
Director of Public Health

For any enquiries about this report please contact:
Cathy Quinn, Associate Director of Public Health
Cathy.quinn@nottspct.nhs.uk

Constitutional Comments

As the report is for noting, no constitutional comments are required.

Financial Comments

Background Papers

Public Health Self Assessment 10 October 2012

Public Health Checkpoint report April – July 2012

Supporting Structure for the Health & Wellbeing Board and delivery of the Health & Wellbeing Strategy September 2012

Electoral Division(s) and Member(s) Affected

All.

HWB49

Health and Wellbeing Board & Workshop Forward Plan

	Health & Wellbeing Board (HWB)	HWB Workshop (closed sessions)
7 November 2012	**Cancer incorporating the Cancer Screening Annual Report** (Bowel/Cervical/Breast) – (Mary Corcoran / Kate Allen) **Audit of Children's Services** (Anthony May) **Child Poverty Strategy -** 12 month update (Derek Higton / Irene Kakoulis) **Safeguarding Children Board Annual Report** (Anthony May) **Report from HWB Challenge Event** (Guy Mansford) **Briefing on Sherwood Forest Hospitals FT** (Helen Pledger / Eric Morton)	
28 November 2012		Self Assessment of HWB / HWB Challenge Event TBC *NB: Cancer action planning to be considered via cancer network with SC and CYP input*
16 January 2013	**Domestic Violence** – (Barbara Brady) John Robinson / Police & Crime Commissioner to attend **Public Health Grant** **District Council role in Health & Wellbeing** (TBC) **Health & Wellbeing Implementation Group report** **Communications & Engagement Strategy TBC** **Collaborative Working with Productive Notts** **Role of Police & Crime Commissioner TBC**	

Updated: 18 September 2012

6 February 2013		**Sexual Health -** Action Planning
6 March 2013	**Sexual Health** - (Penny Spring) **Vulnerable Children** (Anthony May / Kate Allen) **Children's Disability Needs Assessment** (TBC)	
27 March 2013		**Vulnerable Children -** Action Planning
17 April 2013	**Health Protection Arrangements** (Jonathan Gribbin) **Housing & Homelessness** (Barbara Brady) **Campaign to End Loneliness** (Mary Corcoran)	

Proposed Future Items (& suggested date)

Public Meeting	**Workshop**
• Safeguarding – dependent on timing of annual report • PH annual report – NB: This will overlap with individual agenda items • Acute Trust Contracts • Community / Mental Health Trust Contracts • Workplace Health • Learning Disabilities • End of Life • Role of Police & Crime Commissioner (Jan 13?) • Role of NHS CB • Self Harm / Suicides	• SHA review outcomes – scrutiny of QOF data / Quality of Primary Care services (May/July) • QIPP

Health and Wellbeing Board - Deadlines for Papers

Date of Board Meeting	Deadline for submission of reports	Pre-agenda paper circulation	Pre-agenda meeting	Release of final papers
7 November 2012	1 October 2012	w/c 15 October 2012	w/c 22 October 2012	Tues 29 October 2012
16 January 2013	3 December 2012	w/c 24 December 2012	w/c 31 December 2012	Tues 7 January 2013
6 March 2013	21 January 2013	w/c 11 February 2013	w/c 18tFebruary 2013	Tues 25 February 2013
17 April 2013	4 March 2013	w/c 25 March 2013	w/c 1 April 2013	Tues 8 April 2013

Meetings are held between 2pm to 4pm in the Council Chamber at County Hall

Papers are published on the NCC website via the council diary 8 days before the meeting:
http://www.nottinghamshire.gov.uk/home/your_council/councillorsandtheirrole/councildiary-view.htm

Updated: 18 September 2012

Previous Agendas

2012-13

	Key topic	Governance	Other papers
2 May 2012 *John Wilderspin to attend*	Long Term (Neurological) Conditions National Service Framework & Stroke To focus on working age adults	Terms of Reference for HWB Implementation Group	• Endorsement of HWS • Presentation of JSNA
27 June 2012	Obesity	Adult Social Care, Health & Public Protection and Children, Families & Cultural Services CCG Authorisation	• Endorsement of JSNA
5 Sept 2012	Tobacco	HWS & JSNA work programme update & delivery inc. Integrated Commissioning Self Assessment of HWB function	• CCG Commissioning Intentions • HealthWatch – update on progress • Productive Notts

2011-12

	Key topic	Governance	Other papers
4 May 2011	Strategic Approach to Life Expectancy and All Age Cause Mortality	Membership Roles & Activities of the Board	• Scope of Health & Wellbeing Strategy • Joint Commissioning in Nottinghamshire • The Role of Nottinghamshire Children's Trust
6 July 2011	Child and Adolescent health behaviour	QIPP	• Government Response to Listening Exercise • JSNA • Outline Plan Health & Wellbeing Strategy (HWS) • Re-ablement
7 Septembr 2011	Dementia		• Outcomes frameworks • Healthy Lives, Healthy People: Update and Way Forward • Child poverty
9 November 2011	Substance Misuse	Joint commissioning – structures & scope	• Health & Wellbeing Strategy (HWS) update • Clinical Commissioning Group (CCG) Authorisation

11 January 2012	Health Protection Inc. infection control, vaccination & immunisation	CCG Commissioning Plans x 3 North CCGs – Bassetlaw, Mansfield & Ashfield, Newark & Sherwood Governance Arrangements	• HWS update • JSNA Update
7 March 2012	Mental Health	CCG Commissioning Plans x 3 South CCGs – Nottingham North & East, Nottingham West and Principia Rushcliffe Public Health Outcomes Framework	• HealthWatch • Verbal Update on HWS & JSNA • Troubled families initiative

Nottinghamshire County Council

Report to Health and Wellbeing Board

7 November 2012

Agenda Item: 10

REPORT OF THE GROUP MANAGER, SAFEGUARDING AND INDEPENDENT REVIEW

NOTTINGHAMSHIRE SAFEGUARDING CHILDREN BOARD ANNUAL REPORT 2011/12

Purpose of the Report

1. To inform Members of the content of the Nottinghamshire Safeguarding Children Board's Annual Report 2011/12, which is attached as an **Appendix**.

Information and Advice

2. The current national statutory guidance 'Working Together to Safeguard Children 2010' notes the requirement for Safeguarding Children Boards to produce and publish an annual report on the effectiveness of safeguarding in the local area. This report should provide an assessment of the effectiveness of local arrangements to safeguard and promote the welfare of children. It should recognise achievements and the progress that has been made in the local authority area as well as providing a realistic assessment of the challenges that still remain.

3. The Working Together guidance is currently being revised and a draft document has been circulated for consultation. The revised draft document reinforces the expectations of Safeguarding Children Boards to publish an Annual Report and make this available to the Chief Executive and Leader of the Council, the local Police and Crime Commissioner, and the Chair of the Health and Wellbeing Board.

4. The Nottinghamshire Safeguarding Children Board (NSCB) Annual Report outlines the context, both national and local, which has driven the work of the Board during the year. It outlines the key priority areas addressed by the Board including the work of the Child Death Overview Panel and the management of the serious case review which was initiated and completed during the year,

5. The Report identifies the organisational structure that supports the work of the Board together with the relevant areas of responsibility. A key area for the Board is the coordination and provision of multi-agency safeguarding training. The nature of the training provision was revised during the year to reach a wider audience of staff from across the range of agencies, both statutory and voluntary, involved in safeguarding and protecting children. Feedback from those attending NSCB training events continues to be very positive. The number of learners registered with the NSCB e-learning module 'Awareness of Child Abuse and Neglect' increased as did the numbers of those completing this course.

6. Work undertaken to strengthen the effectiveness of the response to child sexual exploitation, missing children, anti-bullying and managing allegations against those who work with children is also covered in the Report.

7. During 2011/12 all NSCB agencies again completed self-assessments to measure their compliance against key safeguarding standards. Overall compliance with the standards was high; where there was a need to improve performance individual agencies identified appropriate actions. There will be a progress report on these areas to the NSCB meeting in January 2013.

8. The NSCB has continued to strengthen its arrangements for providing scrutiny of safeguarding arrangements and this has included taking on the responsibility for the ongoing monitoring of key areas previously addressed through the Safeguarding Improvement Programme.

9. The Report shows the NSCB's multi-agency financial arrangements and contains some detailed performance information covering 2011/12.

10. Finally, the Report sets out the Board's priorities for 2012/13 and highlights the main contextual influences which will impact on safeguarding arrangements over the next period of time.

Other Options Considered

11. As this is a report for noting, it is not necessary to consider other options.

Reason/s for Recommendation/s

12. The report is for noting only.

Statutory and Policy Implications

13. 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 report be noted.

Pam Rosseter
Group Manager, Safeguarding and Independent Review

For any enquiries about this report please contact:

Steve Baumber
NSCB Development Manager
T: 0115 977 3935
E: steve.baumber@nottscc.gov.uk

Constitutional Comments

14. As this report is for noting only, no Constitutional Comments are required.

Financial Comments (NDR 16/10/12)

15. There are no financial implications arising directly from this report.

Background Papers

None.

Electoral Division(s) and Member(s) Affected

All.

C0096

Nottinghamshire
SAFEGUARDING
CHILDREN Board

Annual Report 2011/12

Contents

Foreword from the Chair

Welcome to the 2011/12 Nottinghamshire Safeguarding Children Board Annual Report.

This year has seen a number of substantial, but as yet incomplete, national developments in the environment within which the Board and its partner agencies work.

In May 2011 Professor Eileen Munro published the final report of her Review of Child Protection, followed in July of that year by the Government response which accepted most of her recommendations. This heralded new and less prescriptive ways of working, particularly within Children's Social Care services, and an increased focus on early intervention to address the needs of children before statutory child protection measures become necessary. Where the implications of this were clear the Board has already taken action, for example by ensuring greater engagement with early intervention services. Work to make these reforms real and the challenges that this presents to services are however ongoing. Consultation on new statutory guidance within which agencies operate to safeguard children has recently commenced and the Board is ensuring that the interests of children and young people in Nottinghamshire are robustly represented, as well as planning for the new ways of working encapsulated in the draft guidance.

The ongoing reforms of the NHS have also continued and in Nottinghamshire many of the key organisational changes, such as the transfer of public health functions to the Local Authority, creation of Clinical Commissioning Groups and introduction of a Health and Wellbeing Board, have already taken place, at least in shadow form ahead of the new organisations assuming their full responsibilities. As a Board we recognise that arrangements to keep children safe can be particularly vulnerable in periods of transition. We have therefore been, and will continue to be, vigilant in this regard as the changes move towards completion in 2013.

As a backdrop to these developments all partner agencies have faced continued financial and resource pressures, challenging them to increasingly target their services where they can most effectively provide better outcomes for children and young people.

In this context the achievements of all agencies and professionals, working within the Safeguarding Improvement Programme put in place as a result of the March 2010 Ofsted Inspection, are particularly commendable. This was recognised by the Under Secretary of State for Children who in November 2011, following a Peer Review and a positive further Ofsted inspection of safeguarding arrangements, lifted the Improvement Notice with immediate effect. We are not however complacent about this. Further work is ongoing and I would like to highlight in particular a major development in collaboration between partner agencies, the creation of a Multi Agency Safeguarding Hub which is on course to go live in November 2012.

This report provides an overview of the Board's work during 2011/12 and progress against the key priority areas identified in our business plan for that year. It also looks forward to the key challenges that we face in 2012/13 as we enter the second year of our delivery strategy, the theme of which is improving engagement; with young

people, with the more difficult to reach sections of the community, with front line professionals and with the new and developing partnership structures. Our ambition is to ensure that arrangements to safeguard the young people of Nottinghamshire are outstanding. By working together and engaging all of our community I am confident that we can achieve this.

Finally, I would like to thank all members of the Board and its sub-groups as well as its staff for their commitment and valued contribution over the last year. Without this the achievements outlined in this report would not have been possible.

Chris Few
NSCB Independent Chair

NSCB Governance, Accountability & Connectivity

The Nottinghamshire Safeguarding Children Board (NSCB) was established in accordance with the Children Act 2004 and operates in line with statutory guidance, '*Working Together to Safeguard Children 2010*'.

The role of the NSCB is to:

- Coordinate local work to safeguard and promote the welfare of children, and
- Ensure the effectiveness of that work

It seeks to achieve this through:

- Developing **policies and procedures** for safeguarding and promoting the welfare of children
- **Communicating and raising awareness** with regard to the need to safeguard and promote the welfare of children
- **Monitoring the effectiveness** of what is done to safeguard and promote the welfare of children and offering advice with regard to making improvements
- Delivering and quality assuring **training**
- Undertaking **serious case reviews**
- Developing procedures to ensure a coordinated response to **unexpected child deaths** and collecting and analysing **information about all child deaths.**

The NSCB is chaired by an Independent Chair appointed specifically to carry out the role. Membership of the Board includes representatives from the local authority and the statutory organisations required to cooperate with the establishment and operation of the Board. The Board is strengthened by the inclusion of a voluntary sector representative and designated safeguarding professionals from the health community. A full list of Board members is included as Appendix 1 to this report. The NSCB have welcomed the contribution of a lay member and in particular their involvement in the DN11 serious case review. Unfortunately neither of the appointed lay members is able to currently take an active role and we are in the process of recruiting.

Activities that fall under the responsibilities of the Board are funded through contributions from partner agencies as outlined in Appendix 2. The work of the NSCB is guided and progressed through Board meetings and a number of sub-groups that have specific areas of responsibility. An organisational chart shown at (Fig. 1) outlines the structure and demonstrates the relationship between the NSCB and its constituent bodies.

The **NSCB Executive** has delegated authority to deal with much of the day to day business of the NSCB including; setting the budget, agreeing practice guidance and scrutinising the work of the sub-groups. It is chaired by the Assistant Director for Social Care, Nottinghamshire Healthcare NHS Trust, and its membership comprises of the Chairs of the NSCB sub-groups along with senior decision makers from organisations represented on the Board.

The following sub-groups support the NSCB in fulfilling its statutory obligations:

- **Performance and Quality** sub-group – leading quality assurance activities, impact evaluation and multi agency audits
- **Training** sub-group – coordinating the provision of multi-agency safeguarding training and evaluating of the scope and quality of single agency and multi-agency training provision
- **Child Death Overview Panel** – responsible for overseeing the immediate response to unexpected child deaths and for reviewing all child deaths
- **Standing Serious Case Review** sub-group – considering cases and making recommendations on whether to instigate a serious case review or other form of review, monitoring progress against serious case review action plans

In addition, task and finish groups are formed as required to progress specific pieces of work. Further information about the work of these sub-groups and the two task and finish groups currently in place is detailed later within this report.

A cross authority group meets to coordinate the work of the Nottinghamshire and Nottingham City Safeguarding Children Boards. It is acknowledged that issues do arise for partner agencies that work across both local authority areas and this group seeks to minimise any negative effect wherever possible, avoid duplication of effort and share good practice. The commitment to use joint safeguarding procedures continues and the NSCB work programme for 2012-13 includes the development of an interactive online version of the procedures to improve accessibility for professionals. Learning from case reviews is shared between the Boards and where appropriate work is jointly carried out, for example the cross authority task and finish groups and Section 11 audits referred to later.

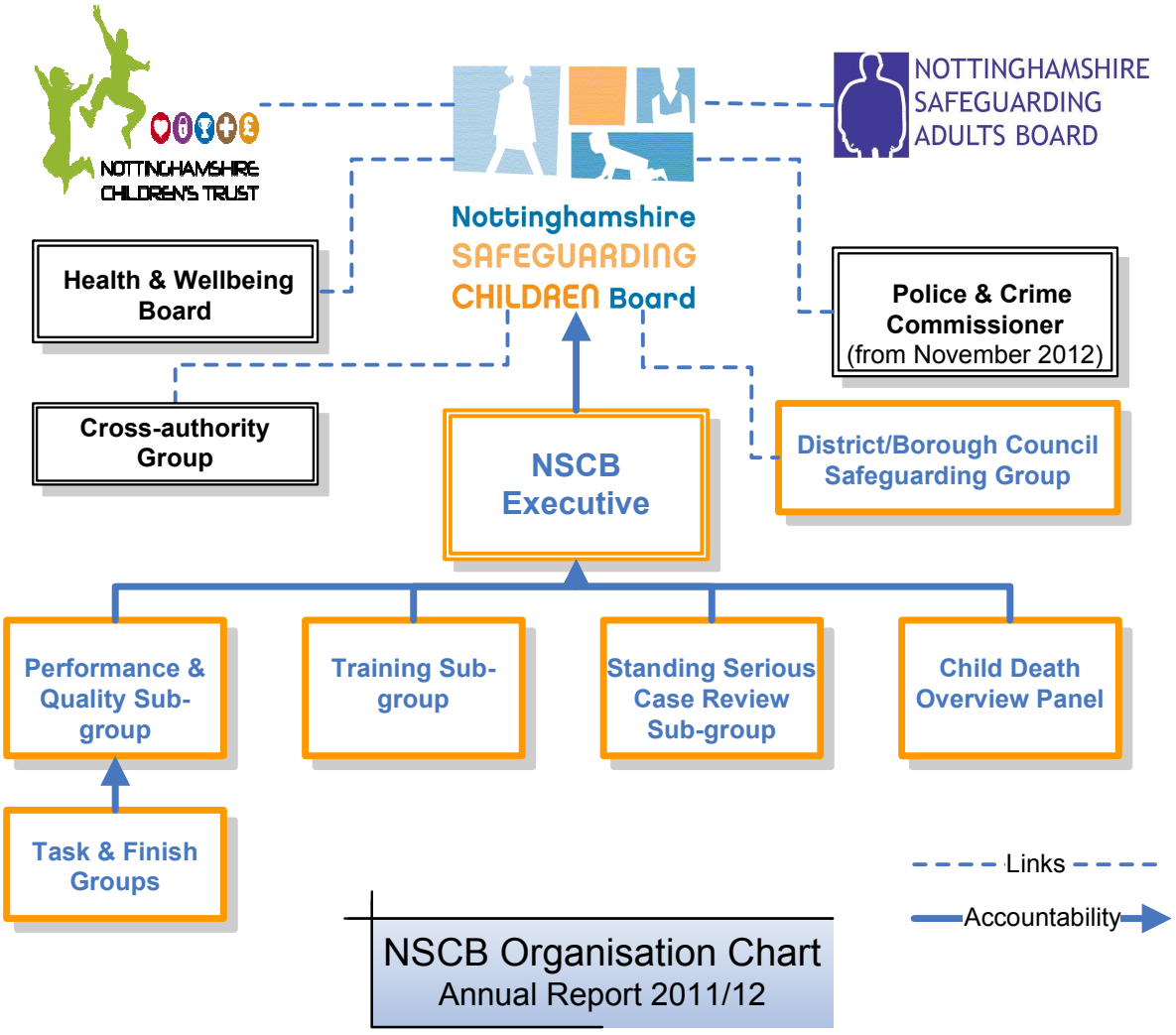
District and Borough Council Safeguarding leads continue to meet on a quarterly basis providing an invaluable opportunity to develop consistent safeguarding practice and share learning. One member of the group attends the NSCB and the NSCB Business Manager attends the District and Borough Council Safeguarding Group meeting to ensure connectivity.

The NSCB continues to ensure that the necessary links with public protection work are maintained. A member of the NSCB sits on the Strategic Management Board of the Multi Agency Public Protection Arrangements (MAPPA) and the MAPPA Policy and Strategy Officer has provided a briefing to the NSCB on the key public protection issues for Nottinghamshire.

The NSCB Manager has continued to link in with the Young People's Board attending as required. The NSCB publishes newsletters to provide updates for practitioners on key developments in safeguarding. Communications and engagement with professionals that contribute to safeguarding work and children and young persons will be strengthened further during 2012-13 as part of the work described later in this report.

The publication of this Annual Report and its presentation to the Committee of Nottinghamshire County Council, together with other strategic Partnership Boards

contribute to the accountability of the Board. Furthermore the publication of serious case review reports enables safeguarding activities connected with the most serious incidents to be open to scrutiny and facilitates the wider learning from such reviews.



NSCB Organisation Chart
Annual Report 2011/12

NSCB Standing Sub-groups

Performance & Quality Sub-group

The Performance and Quality (PQ) sub-group leads, on behalf of the Board, detailed work to evaluate the effectiveness of local inter-agency practice. It is accountable to the NSCB and provides quarterly reports to the Executive.

The sub-group meets quarterly and is chaired by Nottinghamshire County Council, Children, Families and Cultural Services Group Manager – Safeguarding and Independent Review. The Vice Chair is from the NSPCC. The sub-group includes representatives from Nottinghamshire County Council, Police, Probation and the Health communities.

Over the past year the PQ sub-group has monitored the following areas of safeguarding through the provision of regular reports and attendance at sub-group meetings by lead officers:

- Private Fostering
- Allegations against people who work with children
- Missing children
- Child protection conferences

The group has also maintained oversight of the work of two task and finish groups and developments in the multi-agency audit programme; further details are included later within this report.

The PQ sub-group has overseen the development of the Impact Evaluation Framework (IEF) and has monitored the impact of implementing recommendations from a previous serious case review. The group also led work to improve participation in child protection conferences by agencies. This work is ongoing and includes strengthening reporting processes and working with agencies to understand and address barriers to their participation. The group continues to meet on a quarterly basis and will shortly be considering the impact of implementing recommendations from the DN11 serious case review which was completed in December 2011. Further work will also be undertaken to respond to guidance recently published for consultation by the Department for Education which sets out a new approach for learning and improvement.

Multi- Agency Audit Group

A multi-agency audit group has been established chaired by the Vice Chair of the PQ sub-group. An audit programme was developed by the group and two audits have been completed.

The joint working with adult services audit was devised to explore the extent to which 'Think Family' principles inform work with families where there are vulnerable adults and children. The audit found examples of good practice with some joint work however; it was not always as integrated as it could have been. Recommendations from the audit promote the 'Think Family' agenda and support the strengthening of

links between the Nottinghamshire Safeguarding Adults Board and the NSCB. The findings from the audit been communicated in an NSCB newsletter.

The second audit focussed on the effectiveness of interagency working when dealing with concerns relating to unborn babies and their families. The audit methodology adopted was very qualitative, looking in detail at a small number of cases. Overall the audit reported positively on the cases examined, and supported the view that practice continues to improve in this area, although there were some inconsistencies identified. The Multi-Agency Audit Group also reflected on the qualitative audit model used and took the view that it allowed a critically challenging and discursive approach to audit work. The audit also provided an opportunity for some learning however the question was raised as to how transferable the findings were when a small sample is used. The group recommended that the good practice and areas for improvement identified could be further interrogated through an additional audit that focussed on those areas.

The Multi-Agency Audit Group has recently met and is in the process of agreeing the multi-agency audit activity for 2012-13. This will take account of corresponding work within Nottingham City and the impact on those agencies involved and will identify the most appropriate audit methodology to provide the necessary quality assurance and learning.

Training Sub-group

The NSCB provides multi-agency safeguarding children training for colleagues who work with children, young people, adults and families in order to improve outcomes for children. Although the provision of inter-agency training is not a core requirement for Local Safeguarding Children Boards, the provision of such training through a pool of trainers from a range of agencies has proved to be an effective way to ensure professionals are equipped to deal with safeguarding issues. The NSCB also has a responsibility to evaluate the scope and effectiveness of single agency and multi-agency training to ensure it is meeting local need. This work is directed and monitored through the Training sub-group.

As part of this requirement we have;

- Implemented a quality assurance policy for single and multi-agency training which currently focuses on the provision of Introduction to Safeguarding Children training in conjunction with colleagues from the Nottingham City Safeguarding Children Board (NCSCB)
- Introduced an electronic method for collecting and collating NSCB post course evaluations
- Revised our multi-agency training provision to reach a wider audience using themed based events

As well as offering a core suite of training events (Introduction to Safeguarding Children, Working Together to Safeguard Children and What's New in Safeguarding Children) a number of additional events were developed as part of a move to reach a broader multi-agency audience. These events were; Confronting Neglect and Emotional Abuse, Working with Complex Cases, Safeguarding Vulnerable Young

People and The Management of Safeguarding Children. Feedback from those attending NSCB training events continues to be very positive.

96.7% of those who completed our post course evaluation indicated that their overall opinion of the event attended was that it was either, satisfactory, good or very good.

"Splendid session, presented very well from an entirely different angle that fit all practitioners/professionals in the room. One of the best sessions I've been on in a long time" - from a delegate who attended The Management of Safeguarding Children course

A total of 1600 training places over the year were planned although the actual number of places used was 1251. The number of training place used in the previous year was 1646. There are a number of reasons why there is such a reduction in the number of training places used in 2011 – 2012. Firstly; two courses were cancelled (Introduction to Safeguarding Children and Working Together to Safeguard Children) due to low occupancy. Also a large scale event for 150 was delivered in April 2012 instead of March and therefore falls outside of the 2011/12 training year. 133 places were lost to short notice cancellations and non-attendance at training events and work is underway to reduce this figure in the future. Line Managers are contacted about a member of staff's non attendance at an event and a charge for £40.00 is pursued. Details of agency non attendance are also reported to the Training sub-group representatives to follow up.

A number of agencies and organisations provide services across Nottinghamshire and Nottingham City and therefore can access training provision from both Boards.

The number of learners registered for the e-learning Awareness of Child Abuse and Neglect module has increased from 5250 to 7169 with completions rising from 2914 to 4121.

"Audio as well as visual was useful. Very easy to use, short sections held my attention"
- feedback from a learner completing the e-learning module in Nottinghamshire

Work for 2012-13 involves the planning and delivery of multi-agency training which will involves the reviewing and updating of content and the design of new events as well as further development and implementation of the quality assurance policy. A key part of this will the consideration of evidencing the role that multi-agency training plays in improving outcomes for children.

Number of training places used by agencies in 2011-2012

Agency / Organisation	Core events	Thematic events	Seminar	Total	Total for 2010-2011
Army	1	0	0	1	-
Borough / District Councils	3	2	0	5	39
Cafcass	1	1	0	2	23
Children's Centres	99	70	11	180	-
Connexions (now known as Nottingham and Nottinghamshire Futures)	9	5	2	16	18
County GP Consortia	2	0	0	2	-
East Midlands Ambulance Service	7	6	2	15	2
Nottingham University Hospital Trust	0	5	1	6	8
Nottinghamshire County Council: -Adult Social Care, Health and Public Protection -Children, Families and Cultural Services -Learning and Organisational Development	 4 199 2	 1 146 4	 0 78 0	 5 423 6	 10 402 -
Nottinghamshire Fire and Rescue	2	0	0	2	5
Nottinghamshire Health Care Trust (NHCT): -Mental health services -Bassetlaw Community Health -County Health Partnership	 16 10 90	 12 4 32	 3 4 17	 31 18 139	 42 79 129
Nottinghamshire Police	25	10	0	35	30
Nottinghamshire Probation Trust	12	5	0	17	32
Other	1	5	0	6	7
Private	9	1	0	10	22
Schools and Colleges	154	43	2	199	268
Sherwood Forest Hospital Trust	24	18	1	43	63
Voluntary/Charity	52	28	11	91	105
Total	**722**	**398**	**132**	**1251**	**1646**

N.B. Please note that the total columns for the comparative years 2010 - 2011 and 2011 - 2012 display information which has been recorded under different requirements for each year, therefore for some organisations/agencies it cannot provide a direct comparison. (For example; the recording of staff attending training from Children's Centres has been recorded as a service area in 2011-2012 however, in the previous year this information was recorded under which organisation had responsibility for the particular Children's Centre the applicant worked at).

Standing Serious Case Review sub-group

Serious case reviews are undertaken when a child dies and abuse or neglect is suspected or in some circumstances when a child is seriously harmed as a result of abuse and there are concerns about the way agencies have worked together. The purpose behind instigating a serious case review is to establish what lessons can be learned about the way local professionals and organisations work individually and together to safeguard children. A key part of the serious case review is to identify what needs to change in order to improve safeguarding in the future and to agree actions and timescales in which to bring that about.

The decision as to whether a serious case review should be instigated lies with the NSCB Independent Chair. To support the Chair in making that decision the Standing Serious Case Review (SSCR) sub-group gathers and analyses information about potential cases. There are alternative options to a serious case review including, for example, single agency reviews of practice and this year a new model for 'Learning Reviews' has been introduced. Account also needs to be taken of reviews held under other arrangements, such as Domestic Homicide Reviews, so as to avoid duplication and to ensure the most appropriate review is undertaken.

The SSCR sub-group is made up of senior representatives from health, police and children's social care and the commitment of those agencies to the work of this sub-group has been strong throughout the year. The Head of Service for the Children and Family Court Advisory and Support Service (CAFCASS) now chairs this sub-group.

Activity, Achievements and Future Developments

The SSCR sub-group met on nine occasions during the reporting year and considered the circumstances of eight cases. The following table provides a breakdown of the decisions reached with regard to those cases:

Decision regarding type or review/action required	Number of cases
Serious case review to be instigated	2
Domestic Homicide Review appropriate	2
Single agency review (non NSCB member) required	1
Single agency review (NSCB member) required	1
No further action required	2

One serious case review was completed and submitted to Ofsted during this time. The evaluation of the review by Ofsted concluded the following:-

- That the NSCB had a robust process in place to conduct the review,
- Individual management reviews prepared by agencies were comprehensive

- The review had been completed to a very high standard with the quality of analysis throughout described as exceptionally high.
- A high level of effective learning had been enabled with robust recommendations and actions.

The Overview Report and Executive Summary for this review have been published and can be found on the NSCB webpage www.nottinghamshire.gov.uk/nscb

A further serious case review commenced in April 2012 and is in progress with a target for completion of November 2012.

An alternative multi-agency review model referred to as a 'Learning Review' has been developed with the objective of providing a means of learning quickly and effectively from cases that may not meet the criteria for a serious case review. One Learning Review has been undertaken to date and feedback from participants has been very positive. The review was facilitated by the Designated Safeguarding Nurse for NHS Nottinghamshire County, who had no prior connection to the case, and involved drawing together the professionals involved in the management of the case and taking them through a reflective learning cycle. The primary strength of this review was that it enabled participants to take away their own individual learning, however a small number of very specific recommendations were made to ensure that the potential risk of physical harm to babies who had been assessed as being at risk of emotional abuse were more widely appreciated.

The SSCR sub-group also engaged with a private health provider following the commission of a serious sexual assault on a child by a patient on unescorted leave from their establishment. The circumstances leading up to the offence were reviewed independently by NHS commissioners and the SSCR sub-group contributed to the action plan developed in response and received an update on the progress being made. The SSCR sub-group also linked in with the Multi Agency Public Protection Arrangements (MAPPA) Strategic Management Board which is leading on the development of communication pathways with secure mental health unit providers.

The SSCR sub-group monitors progress by partner agencies towards the completion of serious case review action plans by partner agencies and provides independent challenge and scrutiny to ensure that recommendations are appropriately responded to. A revised system to assist the sub-group with this task has been successfully introduced. The system supports the identification of actions that are at risk of not being completed within the agreed timescales and allows the sub-group to agree any mitigating action that may be required as well as identifying actions that are considered to have been completed by the agency and require sign off.

The sub-group will continue to carry out its functions throughout 2012-13 and will be seeking develop a simple referral process that takes account of all review options available. It will further improve the Learning Review model in light of experience and respond to changes in statutory guidance which are currently being consulted upon by the Department for Education.

Child Death Overview Panel

Arrangements are in place to ensure that whenever a child dies unexpectedly the immediate response of agencies is coordinated effectively. Subsequently all child deaths, whether they were expected or unexpected, are reviewed by, a multi-disciplinary panel known as the Child Death Overview Panel (CDOP)

The purpose of the CDOP is to ensure that through a process of multidisciplinary review of child deaths, the Nottinghamshire Safeguarding Children Board will better understand how and why children in our local authority areas die and incorporate any lessons learned into strategic planning.

The child death review includes:

- An evaluation of the information about the child's death,
- An assessment of the preventability of the death through the identification or otherwise of modifiable factors
- Consideration of any issues relating to the effectiveness of the review
- Identification of lessons to be learnt and/or recommendations as appropriate

The CDOP has a permanent core membership drawn from key organisations and additional representatives are co-opted when individual cases require particular expertise. Information that may identify the child is removed prior to the case being discussed by the panel.

Activities, Achievements and Future Developments

Summary of Nottinghamshire Child Death Review Process activities 2011-2012	
Number of NSCB CDOP meetings	9
Number of joint review meetings with Nottingham City CDOP	2
Number of child deaths were notified to NSCB between April 2011 to March 2012	44
Number of child deaths where the review of the child's death has been completed by NSCB CDOP.	40
Of the deaths where the review was completed, the number the panel assessed as having modifiable factors	12
Of the deaths where the review was completed, the number the panel assessed as not having modifiable factors	28
Of the deaths where the review was completed, the number identified as unexpected.	14
Of the deaths where the review was completed, the number identified as expected.	26
Number of cases pending completion in 2012/2013	18

The information within the previous table evidences that the Nottinghamshire CDOP continues to meet on a regular basis and is reviewing cases in a timely manner. A key aspect of the review is the professional assessment of whether future deaths are preventable, that is to say are there factors which could be modified through local or national interventions to reduce the risk of future deaths, the panel then considers what actions are necessary. Over the past year the panel identified 12 cases where it considered there to be modifiable factors, it has also ensured that corresponding actions have been completed in a timely manner. The modifiable factors included safer sleeping arrangements for babies, the risk of premature birth linked to high maternal Body Mass Index (BMI) and the risk of smoking. Since its inception, the panel has reviewed a number of fatalities involving older teenagers who have been involved in collisions whilst crossing the road. Similarities between the cases such as being distracted whilst crossing the road, crossing at a pedestrian crossing point but failing to observe the signals and in the case of cyclists not wearing helmets have been identified and the panel is currently exploring ways that road safety messages to young people can effectively be delivered.

There are strong cross authority links between the Nottinghamshire CDOP and Nottingham City CDOP with joint meetings taking place twice a year and recently members of the two CDOPs collaborated to organise and hold an East Midlands Regional Child Death Summit. The event was planned following representatives from Nottingham University Hospitals Trust identifying the potential to share learning across the region. The summit was well supported and enabled CDOPs from across the East Midlands to explain what was working well in their area and raise issues for wider discussion. It is hoped that further regional events will be held in the future.

The past year has seen a number of developments to the work of the CDOP. Membership of the panel has been strengthened through permanent representation from Children's Social Care and a route to enable contributions from education services when appropriate has been agreed, links to the Coroner's Office have also been improved. The panel has sought to ensure that any recommendations it makes are specific and achievable and an improved system for monitoring the completion of actions has been introduced. Multi-agency rapid response training has been provided and revised procedures have been produced and published as part of the inter-agency safeguarding procedures. Public health colleague's expertise has been utilised to provide further in-depth analysis of the data gathered through the review process and it is planned to use this information to inform the work of the panel and identify themes on which to focus resources.

Looking to 2012-13, a number of areas have been identified for action. The panel will develop a communication pathway to feedback relevant information to parents and carers once a review has been completed. Similarly the process for linking back to the professionals involved in the immediate response to an unexpected death will be strengthened. Work to improve the consistency of communication between the Registrars and the CDOP will continue.

Monitoring the effectiveness of local work to safeguard and promote the welfare of children

The NSCB prioritises particular areas of work that have a high profile some of which are specific requirements under *Working Together to Safeguard Children 2010*.

Child Sexual Exploitation (CSE)

The issue of CSE is a significant area of concern nationally. It is a changing phenomenon, with social media for example having an impact on patterns of exploitation and different models of how adults exploit children emerging.

Nottinghamshire has undertaken a significant amount of work on CSE over many years including updated inter-agency practice guidance (November 2011). There have been regular multi-agency training events for professionals working with young people. Multi-agency strategy meetings are also an established way of discussing young people about whom there are concerns. There is however room for improvement in the way we strategically approach CSE.

One of the main drivers for change is new Government guidance, in particular the Department for Education *'Tackling Child Sexual Exploitation – Action Plan'* (December 2011). In addition there is a body of academic research and reports, for example from the Child Exploitation Online Protection Centre (CEOP), which coupled with the practical advice from other police forces and local authorities, can be used to inform work in this area.

A cross-authority task and finish group was established towards the end of this reporting year to take forward the issue of child sexual exploitation in a robust and multi-agency way. The group is chaired by a Nottinghamshire Police Inspector, initial scoping work has been completed and a multi-agency strategy and local action plan have been drafted. Options on responding to the key strategic priorities, including the delivery of a coordinated response to CSE through the possible creation of a co-located multi-agency team, are being developed. Nationally CSE is also an issue which is increasingly being linked to children who go missing and also to intra-country trafficking and efforts are being made to ensure a much more joined up approach to all of these safeguarding issues.

Developing Excellence in Complex Abuse Cases (Emotional abuse / sexual abuse / self harm / risk of suicide)

The second cross authority task and finish group was established as a result of a Nottingham City serious case review. Links have also been made with learning from Nottinghamshire cases. The group focuses on multi-agency professional practice in working with emotional abuse, sexual abuse, self-harm and risk of suicide. Initial scoping has been completed which has identified potential work-streams to develop practice. These include: gathering and analysing data to develop understanding of the nature and size of these issues across Nottinghamshire, reviewing existing inter-agency practice guidance to identify where these could be strengthened and developing tools to assist practitioners.

Anti-bullying

Bullying is one of the top concerns that parents have about their children's safety and well being. It is also a top concern for children and young people themselves. The Anti-bullying co-ordinator within Nottinghamshire County Council's Children, Families and Cultural Services, is responsible for promoting anti-bullying work. A multi agency group, the Anti-bullying Steering Group, has developed the County's anti-bullying strategy and plan and monitors progress in the delivery of that plan.

The three strategic priorities identified by the group are:

1. Continuing to support schools in Nottinghamshire on the national agenda to improve behaviour and safety in schools, and create a positive climate for learning
2. Working with the wider community to ensure consistency in anti-bullying work across the county for all children and their families, especially vulnerable groups.
3. Enabling more families in Nottinghamshire to develop strategies and have access to support to keep themselves safe in the digital world.

Although the main focus of the work has been in schools supporting their anti-bullying work, over the last two years the scope of the work has expanded to support children and their families in other aspects of their lives and in their communities.

The Anti-bullying coordinator has been supporting and developing work in children's homes and with adoptive families, and in sports clubs and working with other groups in the community such as the fire service and the police,

A major focus of anti-bullying work continues to be around keeping children and young people safe in the digital world. It is important that this is started at a very early age to allow young people to develop the skills and competencies to deal with the challenges of keeping themselves safe.

Missing Children

The NSCB has responsibility for ensuring that there are robust interagency procedures in place for dealing with children missing from home and care in line with the statutory guidance on children who run away and go missing from home or care (2009). It carries out this function through regular reporting to the PQ sub-group referred to earlier.

The Nottinghamshire Missing Children Steering Group is a multi-agency group that provides the strategic lead for the coordination of inter-agency work in relation to children who go missing in Nottinghamshire.

The response to children who go missing has been significantly enhanced over the last year (Since January 2011). The establishment of the new Nottinghamshire Runaways Missing service (Provided by the Charity Catch 22 based within Targeted Support Services) is a very welcome resource and will be an excellent opportunity to provide early help and support for those children who do not have a social worker.

Those children who have a social worker continue to be supported within a strengthened system.

An important element of working with missing children is the need for a return interview or a multi-agency meeting to explore the reasons why the young person goes missing and what has happened to them and thus enabling what support may be needed to prevent or reduce the risk of this happening again. The Children Missing Officer monitors and tracks whether or not the return interview has been completed. This work is assisted by strong partnerships with Nottinghamshire Police.

During 2011-12 there were 1518 notifications of missing episodes which related to 863 young people with an even gender split. Some young people went missing only once, some went for significantly more. Children went missing from home in 78% of the cases and from care in 22%. In total 417 return interviews were completed which represented 42% of appropriate cases which was an improvement on the previous year's performance. This figure is expected to continue to improve during the coming year.

	Qtr 1	%	Qtr 2	%	Qtr 3	%	Qtr 4	%	Year	
Missing Episodes	395		430		347		346		1518	
Total Individuals	269		289		238		241		864	
Female	140	52%	142	49%	111	47%	129	54%	437	51%
Male	129	48%	147	51%	127	53%	112	46%	427	49%

The main themes emerging for the reasons given for going missing indicate alcohol and substance misuse as a predominant factor (23%), Child sexual exploitation (CSE) (12%) and involvement with those who pose risk (8%), domestic issues 14% and no reason specified 18%. Our approach to tackling the risks associated with missing children is in line with recent national initiatives, the links between young people going missing and CSE have been recognised within the work of the CSE task and finish group. The particular vulnerability of looked after children (LAC) has also been acknowledged.

Two training events were put on during the year, to both the fostering service and the private residential and fostering sector to raise awareness of missing and CSE issues. Further cross-authority training is planned for the coming year.

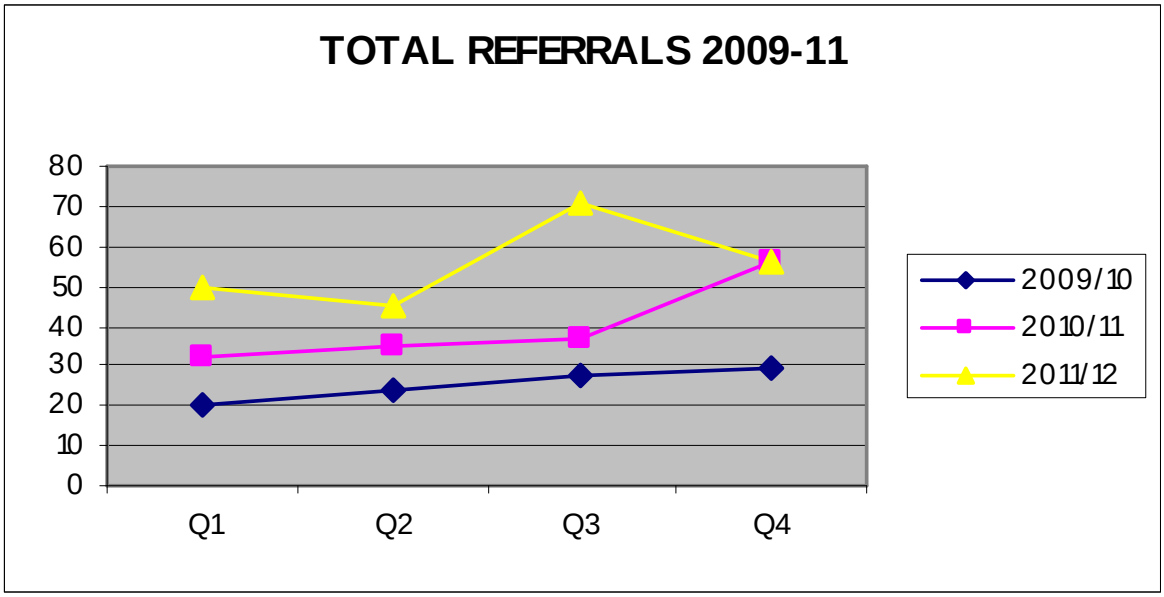
Managing allegations against those who work with children

The NSCB has responsibility for ensuring that there are robust interagency procedures in place for dealing with allegations against people who work with children and for monitoring and evaluating the effectiveness of those procedures. *Working Together to Safeguard Children 2010* requires that all allegations are investigated and dealt with in a 'timely manner'. This applies to matters that go beyond the 'significant harm' threshold and applies where the allegation or concern may indicate that the person is unsuitable to work with children in their present position or in any capacity. This applies to those in paid employment and equally to

volunteers, fosters carer's etc. The Local Authority Designated Officer (LADO) is responsible for the management and oversight of these cases.

During the Ofsted Inspection in October 2011 there was very positive feedback about the operational arrangements for managing allegations. Ofsted did recommend that more effort is made to make those organisations that work with children, but who may be 'hard to reach,' more aware of the need to work to these procedures. The Ofsted Inspectors also asked that the Local Authority Designated Officer (LADO) exercises a challenge function to ensure that all agencies work to the procedures effectively.

In line with national trends 2011/12 has been a busy year for referrals, up to 222 for the year plus a similar number where advice was requested (200) but didn't meet the threshold for a referral. This is thought to be as a result of greater awareness of the issues concerned and the role of the LADO.



A number of multi-agency strategy meetings were also held where professionals discussed the concerns raised (86).

Concerns about staff come from a wide range of organisations from formal to informal, the education sector is the largest (32.3%) with early years next (17%) but this is thought to reflect a high level of understanding about the need to refer and the large numbers of people employed.

The type of referral received is more often about practice issues and a question mark about someone's suitability to work with children than about significant abuse.

Referral by issue						
	Physical	**Sexual**	**Neglect**	**Emotional**	**Conduct**	**Total**
2009/10	52	52	2	4	12	122
2010/11	72	37	7	14	29	159
2011/12	82	39	5	12	84	222

We are working to improve our data on the outcome of cases. The majority of cases investigated are not founded or substantiated although some clearly are found to be substantiated and in those cases members of staff may be dismissed. They may also be referred to their professional body for consideration of being barred from working in a professional capacity i.e. from teaching or to the Independent Safeguarding Authority for consideration of being barred from working with children in any capacity.

Outcomes for closures during 2011/12	
Employment	
Dismissal	11
Resigned	5
Sanction	8
Suspension	25
Disciplinary	58

The response to managing allegations is robust and increasingly systematic and process driven with strong professional judgment, which will, by consequence, strengthen procedures and practice. Inevitably there are challenges and room for improvement but over the last year foundations have been strengthened.

Private Fostering Arrangements

A child or young person may be considered to be in a private fostering arrangement when they are being looked after by a person, other than a close relative, for a period of 28 days or more. In such circumstances children or young people may be more vulnerable therefore legislation, statutory guidance and minimum standards set out the responsibilities of parents, private foster carers and the local authority with regard to private fostering arrangements.

The NSCB PQ sub-group, in their role of providing scrutiny and challenge, receive regular reports on private fostering. The sub-group has prompted enquiries to ensure the arrangements for providing training to schools are continuing satisfactorily and to verify awareness of private fostering within Youth Justice Services. Information about private fostering continues to be incorporated into a number of multi-agency training events coordinated by the NSCB.

The sub-group has also been kept informed of a range of initiatives, led by the local authority, to ensure the safety and welfare of children who are privately fostered.

The Advanced Social Work Practitioner Team has completed a programme of social worker team briefings regarding private fostering. The briefings aimed to improve awareness and understanding of private fostering and local policies and procedures. In addition work is ongoing to simplify and improve the workflow for private fostering on Framework-i (Children's Social Care IT system). This coupled with supporting guidance being developed should help improve practice and recording.

A new management information reporting process is being introduced to improve the capability to monitor working practices and improve data quality. The reports will help to ensure that tasks such as visiting children who are being privately fostered

are carried out within the required time period and allow anomalies in recording to be addressed at an earlier stage.

During 2012-13 the NSCB will extend the type and range of communications with partner agencies to improve awareness of private fostering with the objective of increasing the notification of private fostering arrangements. The Framework Development Team will continue their work on streamlining the workflow for private fostering and this will be tested with a number of practitioners prior to implementation. The use of management information reports to improve data quality and identify practice issues will continue with the aim of utilising the reports to monitor compliance with the regulations on a more frequent basis.

Children in custody and in secure children's units

Working Together to Safeguard Children 2010 requires Local Safeguarding Children Boards to put in place arrangements for scrutinising the use of restraint in any secure children's unit within their area. Nottinghamshire has one secure unit, Clayfields House, and the Unit Manager has attended the NSCB Executive to provide details on key areas of practice and policy including: the steps being taken to minimise the use of restraint, methods deployed to de-escalate situations, safety holds and restraint techniques and incidents of injury to children or staff that may cause concern. Executive members were able to satisfy themselves that the necessary safeguards are in place to manage the use of restraint. In addition a member of the NSCB has visited Clayfields House and further visits are planned in the future.

The NSCB has subsequently reported to the Youth Justice Board in line with national requirements.

In December 2011 a report entitled "Who's looking out for the children? : A joint inspection of Appropriate Adult provision and children in detention after charge" was published by HMI Constabulary with HMI Prisons, HMI Probation, the Care Quality Commission, the Healthcare Inspectorate Wales and the Care and Social Services Inspectorate Wales. The report makes twelve recommendations, and the NSCB received a briefing prepared by Targeted Support and Youth Justice and Nottinghamshire Police outlining the local position in relation to those recommendations and implications for local partners. As part of the briefing an improvement plan was presented to the Board and agreed and progress against that plan will be monitored during 2012-13.

Agency Self Evaluation

All NSCB partner agencies undertake a range of self assessment work to ensure that they monitor, and continually improve, their safeguarding arrangements. Issues impacting on agency performance are a standing item on the Board agenda.

In addition to the ongoing cycle of reporting, each year NSCB partner agencies complete a self assessment, referred to as the Section 11 Audit, to examine whether they are meeting the requirements placed on them by the Children Act 2004. The 2011/12 Section 11 Audit utilised a revised version of the 'Markers of Good Practice 2', a template developed by NHS East Midlands and required agencies to assess their compliance with a series of standards under the following categories: -

- Leadership and Organisational Accountability
- Serious case reviews
- Safer Working Practices
- Training
- Supervision
- Policies and Procedures
- Whole Family/Think Family Approach
- Voice of Children
- Environment, and
- LSCB Indicators

The 2011/12 Section 11 Audit returns have been analysed and reported on to the NSCB Executive. All NSCB partner agencies completed the self assessment with the exception of the voluntary sector. A separate approach is being introduced for the voluntary sector in recognition of the varied nature and scale of such organisations. Compliance with the standards included within the self assessment was high.

A number of agencies reported partial compliance against some of the standards and identified the following developmental work to address the issues;

- strengthening child protection supervision arrangements
- auditing and improving the monitoring of safeguarding training take up
- strengthening their implementation of NSCB/NCSCB Domestic Abuse practice guidance
- improving training and awareness raising regarding honour based violence and forced marriage
- improving training and raise awareness of a whole family approach

Updates on progress with this developmental work will be reported to the Board in January 2013.

At each Board meeting agencies are invited to report any issues that effect safeguarding performance. As a result Board members have worked together to address concerns over the use of part of the CAF documentation as a referral form and devised a specific referral form in it's place to simplify the process for providing written confirmation about referrals to Children's Social Care. A report on budgetary constraints within the local authority and health services and the impact this was having on the voluntary sector has been presented to the Board and it was agreed to monitor the situation and review the issue when the full impact of reduced funding was understood. East Midlands Ambulance Service (EMAS) also reported that following a reassessment against the Care Qualities Commission standards they were now compliant in relation to safeguarding practices.

NSCB Effectiveness

The previous sections within this report include commentary on the progress made by the NSCB sub-groups against their own work plans. This section now outlines the progress made against the overarching NSCB Business Plan 2011-12. A self assessment tool, developed within the region, has also been used to measure the NSCB against key effectiveness factors (see table below).

Progress Against Key Priority Areas

Priority Area - Effective scrutiny of local safeguarding performance

Following a productive peer review, re-inspection by Ofsted in October 2011 and lifting of the Improvement Notice in November 2011 the Safeguarding Improvement Programme (SIP) was disestablished during the reporting year and the NSCB took over its responsibilities in relation to the four work streams:

- Operations
- Performance
- Workforce
- Partnerships

The Board has considered reports on progress with uncompleted elements of the SIP at each meeting – along with thematic reports on all elements of the SIP to ensure that progress has been maintained.

The Ofsted inspection in October 2011 was a follow up inspection to evaluate the progress and contribution made by relevant services in the local area since the previous inspections towards ensuring that children and young people are properly safeguarded. The overall effectiveness of safeguarding services in Nottinghamshire was graded as adequate. The inspection identified the following seven areas for improvement:

1. the quality of assessments in particular the analysis of risk
2. reducing inappropriate referrals to children's social care
3. reducing the number of children subject to safeguarding plans and looked after plans
4. improving the strategic lead and challenge functions of the Local Authority Designated Officer
5. improving manager's awareness of the range of commissioned services available
6. increasing the use of the CAF
7. providing a comprehensive management development programme for all first line managers.

These issues have been incorporated into the NSCB monitoring programme along with recommendations made by the Department for Education on lifting the improvement notice.

The Impact Evaluation Framework is now being used to provide a structure to identify effectiveness and impact of work activities of the NSCB, including the work of the

Child Death Overview Panel, the impact of serious case reviews, and the impact of inter-agency training. Work-plans developed by the sub-groups are guided by the NSCB Business Plan priority areas and the IEF.

The development of a multi-agency audit function was an important action under this priority area and details of the achievements in this regard are included within the PQ sub-group section of this report. The provision of a revised self assessment tool for the section 11 audits and arrangements to consider the findings are described under the agency evaluation section.

The NSCB has maintained an oversight, through regular updates, of the re-structuring taking place within a number of agencies to ensure that the impact on safeguarding children is actively considered. The NSCB manager and members of the Board have proactively engaged with those responsible for the development of Clinical Commissioning Groups to ensure that arrangements for safeguarding are included within their plans for example by ensuring that the current robust framework of Designated and Named safeguarding professionals is maintained and that safeguarding children is effectively built into the governance and commissioning systems of the new bodies.

The NSCB has contributed to the development of the Children and Young People's Plan by the Nottinghamshire Children's Trust. Under the plan, the Early Intervention and Prevention Strategy has been implemented and its effectiveness is currently being measured by three safeguarding indicators. These have shown that the rate of children requiring statutory child protection interventions has improved since last year, the number of contacts made to Children's Social Care are reducing and a higher proportion of referrals are appropriately going on to initial assessment. The levels of first time entrants into the youth justice system have also shown an encouraging decline over time. The NSCB recognises the importance attached to early intervention and the expectation is that the Board will lead on the future scrutiny of this area of work. The NSCB has also been pleased to welcome the Group Manager for Early Years and Early Intervention as a member of the Board.

During 2011/12 the Youth Offending Service underwent a Criminal Justice Joint Inspection and a full report on the outcome of that inspection will be presented to the Board in due course. A summary update has already been provided indicating that safeguarding was assessed as 'minimum need for improvement' which is the equivalent of outstanding and overall it had been a positive inspection for the service.

Priority Area – Improve connectivity with other partnership bodies

As part of the promotion of a strategic 'think family' approach, links between the NSCB and the Nottinghamshire Adult Safeguarding Board have been strengthened through regular meetings between the Independent Chairs of the respective Boards, Group Managers and Board officers. Learning has been shared around review methodologies and a joint multi-agency audit was conducted details of which are included earlier within this report.

The Chair of the NSCB attends meetings of the Children's Trust Executive which meets every 6 weeks, and has contributed to key developments including Joint Commissioning of services for disabled children and the Looked After Children

Strategy. There is information exchange by virtue of sharing minutes of respective meetings. The NSCB Independent Chair is also a member of the newly instituted Health and Wellbeing Implementation Group, responsible for developing and implementing the county Health and Wellbeing Strategy.

Details of cross authority work between the NSCB and the Nottingham City Safeguarding Children Board are evidenced throughout this report. The coordination of activities between the two Boards is described within the governance and accountability section.

Priority Area – Improve the response to children who have been, or at risk of being, harmed

A number of actions under this priority area have been carried forward into the 2012/13 business plan, in particular the revisions to the sexual abuse practice guidance which falls under the remit the cross authority task and finish group 'Developing Excellence in Complex Abuse Cases'. Revised practice guidance to support practitioners dealing with potential neglect cases has been published, complemented by the delivery of multi-agency training on the subject. Further detail on the work carried out under this priority area is included within the training section. The NSCB has also contributed to the revision of the Pathways to Provision document which provides guidance to practitioners on thresholds for levels of services.

Regular updates have been received on the Transformation Programme that is underway in Children's Social Care services which seeks to build on the improvements in services achieved through the Safeguarding Improvement Programme by introducing a new operating model. A key element of the programme is the introduction of a Multi Agency Safeguarding Hub (MASH) and members of the NSCB have been directly involved in the work streams that are driving the development of the MASH. Further detail on this work is available in the 'Looking Forward' section of this report.

NSCB Self Assessment

Effectiveness Indicator	2010/11	2011/12	Commentary
Clear lines of accountability for the Chair and Board.	GREEN	GREEN	**The NSCB has a clear governance structure. This was reviewed in 20010/11 and a new constitution was adopted**
Clear management structures for the Chair and the Board.	GREEN	GREEN	**This is addressed through the constitution**
Skilled Chair with authority who is able to keep partnership focused on core tasks	GREEN	GREEN	**The Board is chaired by an Independent Chair with an extensive background in safeguarding**
LSCB have clearly defined aims and objectives that are strategic in their focus on safeguarding.	GREEN	GREEN	**The Board has a clear, agreed business plan which is explicitly cross referenced with the Children, Young People and Families plan**
There is good planning and reviewing of progress.	GREEN	GREEN	**A 3 year business plan has been agreed and is reviewed and updated regularly. NSCB sub-groups similarly develop, review and update their work plans and take account of strategic priorities. An Impact Evaluation Framework has also been introduced**
There is a clear vision amongst Board members about purpose of the LSCB.	AMBER	GREEN	**The NSCB Vision and long term mission was reviewed in July 2011**
The LSCB is supported by a Business Manager and appropriate level of staff and resource to help it function effectively.	GREEN	GREEN	**A financial strategy was agreed that allows activity to be delivered within the annual income of the Board**
The Board has a good level of seniority amongst its membership – the right people are present who can act on the behalf of their agency.	GREEN	GREEN	**The Board is comprised of senior managers from all key local agencies. Membership is regularly reviewed and has recently been strengthened by the addition of the Group Manager for Early Years**
Attendance and participation in the Board and sub-groups are stable and active.	GREEN	GREEN	**Attendance continues to be good**
Clear conduits exist between the LSCB and professional practice.	GREEN	GREEN	**Operational staff are strongly represented within the NSCB sub-structure. Audit, case review activity and practice guidance development directly involves operational staff. An NSCB newsletter Is published which provides updates on key safeguarding developments**
Members of the Board understand their roles and responsibilities in the LSCB and act upon them.	GREEN	GREEN	**The roles and responsibilities are specified within the constitution, Impact Evaluation Framework and sub-group terms of reference**

Effectiveness Indicator	2010/11	2011/12	Commentary
Open communication both between and within agencies that facilitates coordinated response. Frontline professionals have a clear understanding of roles and responsibilities in terms of safeguarding.	**AMBER**	**AMBER**	**This area is recognised as one that is in constant need of attention. Joint inter-agency safeguarding procedures are in use which coupled with the pathway to provision provide a common understanding of terminology, thresholds and appropriate responses. A training programme involving updates on current safeguarding issues is established**
A representative from adult safeguarding services to sit on the NSCB. A member of the NSCB to sit on the adult safeguarding board.	**GREEN**	**GREEN**	**The Board has a member from the Adult Social Care, Health and Public Protection Department of Nottinghamshire County Council. This individual is also a member of the Adult Safeguarding Board.** **There are periodic meetings between the chair of the Adult Board and the Independent Chair of the NSCB**

Looking Forward

Major revisions to the child protection statutory guidance

The Government accepted Professor Eileen Munro's recommendation within her final report into the review of child protection and agreed that a major revision of the child protection statutory guidance is needed. Professor Munro believes that the current guidance, *Working Together to Safeguard Children 2010,* has led to a culture of compliance and dependency which has stifled individual professional judgement and local innovation. Three new documents have recently been published for consultation with the intention that they will provide a much shorter and precise set of guidance. The NSCB has contributed to the consultation process and will be considering the implications of the new proposals and the opportunities to drive improvements locally with partner agencies. The NSCB will ensure that professionals are properly supported and that transitional arrangements to maintain safeguarding standards are in place as practice moves to the model envisaged by Professor Munro.

Implementing new ways of working

A new operating model for Children's Social Care is being developed under the direction of the Transformation Programme. Central to the new approach will be the introduction of a Multi-Agency Safeguarding Hub (MASH) which is planned for implementation in late 2012. The MASH will act as the first point of contact, receiving safeguarding concerns or enquiries and collating information from different agencies to build up a holistic picture of the circumstances of the case. The agencies involved will be able to share information on a case quickly and make a swift decision on the most appropriate action needed. Better co-ordination between agencies will also lead to an improved service for children, adults and their families. The NSCB has received regular briefings on the progress being made towards the implementation of the MASH and will have a key role in developing ways to monitor the effectiveness of the new arrangements and the impact they are having on the outcomes for children and families.

Addressing the new organisational structures

Clinical Commissioning Groups (CCGs) are now operating shadowing primary care trusts during a transition period before assuming full responsibilities for commissioning health services. From April 2013 CCGs are due to come into statutory form and will be undergoing authorisation processes during 2012 which the local authority and partner agencies, through the Health and Wellbeing Board, will play an important role. The authorising process includes a specific facet to ensure that arrangements for safeguarding children are in place. The NSCB will need to make sure that new communication pathways continue to be developed and that safeguarding children remains a priority. In particular the NSCB will need to engage with the NHS National Commissioning Board, the commissioner for General Practice Primary Care, Health Visitors and School Nurses.

The Police Reform and Social Responsibility Act 2011 will lead to a Policing and Crime Commissioner (PCC) being elected in November 2012. One of the first responsibilities of the PCC will be to introduce a Policing and Crime Plan and the

NSCB needs to ensure that it addresses the safeguarding needs of children and young people, including the commissioning of services, such as those relating to domestic violence that can have a major impact on children's outcomes.

NSCB Business Plan 2012-13

The NSCB is working to a three year delivery strategy; the theme for year 2 is improving engagement. However some work from the previous year's business plan has necessarily been carried forward, for example the strengthening of links with other partnerships in the evolving partnership environment and actions to improve the response to children who suffer sexual abuse.

The Business Plan for 2012-13 identifies three priority areas for action

- *Improving Engagement and Communication*
- *Effective scrutiny of local safeguarding performance*
- *Improve the response to children who have been, or are at risk of, being harmed*

The NSCB will develop and implement a strategy for focussing on the contribution of children and young people to the work of the Board. It will also revise and update the current engagement strategy and develop new and improved routes of communication. The latter work extends across all stakeholders but will specifically reference hard to reach groups. The implementation of the 'peer challenge' process agreed in 2011 was delayed due to competing demands however a revised process will be considered as part of the business plan for 2012-13.

The structure for disseminating inter-agency guidance and procedures will be revised. A learning strategy will be developed to replace the current training strategy and it will include learning from multi-agency audit work, serious case reviews and other forms of review. This will take account of revisions to *Working Together to Safeguard Children 2010* and the new Ofsted Inspection Framework.

The key activities under the priority area of improving the response to children who have been, or are at risk of being harmed, fall under the work plans of the two cross authority task and finish groups: *Developing Excellence in Complex Abuse Cases and Child Sexual Exploitation*.

Work will continue to build on and develop further the scrutiny role of the NSCB. The Impact Evaluation Framework will be reviewed in light of revisions to *Working Together to Safeguard Children 2010.* Cross authority working will be strengthened by improving connectivity between the respective sub-groups and links between the NSCB and other partnership arrangements will be further developed.

Appendix 1

NOTTINGHAMSHIRE SAFEGUARDING CHILDREN BOARD MEMBERSHIP

(At time of publication)

Chris Few	Independent Chair
Julie Gardner	Vice Chair - Associate Director of Social Care, Nottinghamshire Healthcare NHS Trust

NCC Representatives:

Anthony May	Corporate Director, Children, Families & Cultural Services, Nottinghamshire
Steve Edwards	Service Director for Children's Social Care, Children, Families & Cultural Services
Pam Rosseter	Group Manager, Safeguarding and Independent Review
Justine Gibling	Group Manager, Early Years and Early Intervention
Laurence Jones	Group Manager, Targeted Support & Youth Justice Service
Caroline Baria	Service Director Joint Commissioning, Quality & Business Change, Adult Social Care & Health & Public Protection

Health Community Representatives:

Cathy Burke	Designated Nurse Safeguarding Children, NHS Bassetlaw
Denise Nightingale	Head of Service Improvement, NHS Bassetlaw
Deborah Oughtibridge	Deputy Director of Nursing & Quality, Doncaster & Bassetlaw Hospitals NHS Foundation Trust
Elaine Moss	Director of Quality and Governance, Newark and Sherwood Clinical Commissioning Group
Val Simnett	Designated Nurse Safeguarding Children, NHS Nottinghamshire County
Dr Emma Fillmore	Designated Dr for Safeguarding (South), Nottingham University Hospitals NHS Trust
Cheryl Crocker	Director of Quality, Governance and Patient Safety, Nottingham North and East Clinical Commissioning Group
Dr Doug Black	Medical Director (GP Link), NHS Nottinghamshire County

Dr Stephen Fowlie	Medical Director, Nottingham University Hospital NHS Trust
Wendy Hazard	Clinical Quality Manager, Nottinghamshire Div. HQ, East Midlands Ambulance Service
Susan Bowler	Executive Director of Nursing & Quality, Sherwood Forest Hospital NHS Foundation Trust

Other Agency Representatives:

Mark Taylor	Director, Nottinghamshire Probation Trust
Supt Helen Chamberlain	Head of Public Protection for Nottinghamshire Police
Neville Hall	Head of Service, A11 Central & South East, CAFCASS
Joh Bryant	Head of Housing, Broxtowe Borough Council (Chair of District Councils Safeguarding Group)
Sue Fenton	Manager, Home Start Nottingham (Voluntary Sector Representative)
Paul Betts	Executive Head Teacher, Yeoman Park School

Advisors to the Board:

Sarah Wells	NSCB Training Coordinator
Vacant Post	NSCB Development Manager
Steve Baumber	NSCB Business Manager

Participant Observer:

Councillor Philip Owen	Chairman of the Children and Young People's Committee

Appendix 2

NSCB Financial Arrangements

NSCB Contributions 2011/12	
Nottinghamshire County Council Children, Families and Cultural Services Department (NCC CFCS)	163,597[1]
NHS Nottinghamshire County	95,189[2]
Nottinghamshire Police	17,612
Nottinghamshire Probation Service	1,958
Children & Families Courts Advisory Services	550
East Midlands Strategic Health Authority	1,000
NHS Bassetlaw	23,000
Schools Forum	7,000
Total	**309,906**
Serious case review contributions from NCC CFCS, Police, NHS Nottinghamshire, NHS Bassetlaw,	**32,000**
Income from training – private providers/non attendance	**1,590**
Overall Total	**343,496**

[1] Includes £30,785 part funding for NSCB Manager post

[2] Includes £30,785 part funding for NSCB Manager post

NSCB Expenditure 2011/12	
Safeguarding CIMT	92,669
NSCB administration	31,853
NSCB training	82,770
NSCB serious case reviews	21,643
Board Manager/Independent Chair/Lay member expenses	82,831
Total	**311,766**

Planning for 2012-13

It has been agreed by the NSCB Executive that agency contributions for 2012-13 will remain the same as 2011-12. It is also proposed that the funding for the NSCB Manager post continues as currently with half funding between Nottinghamshire County Council and county health commissioners.

As the above tables show if expenditure continues during 2012-13 at a similar level the contributions will adequately cover expenditure.

The NSCB now has a contingency totalling approximately £70,000 which is held to cover unforeseen expenditure, including greater than usual numbers of serious case reviews. A further amount of £46,618 has been received from central Government to support Professor Munro's proposed model of working and this will be used to assist with the implementation of the revised *Working Together to Safeguard Children* guidance.

Nottinghamshire SAFEGUARDING CHILDREN Board

Performance Information 2011-2012

This report to the Nottinghamshire Safeguarding Children Board focuses on the key annual performance results for 2011/12. The first section of the report brings together a wide range of data to show outcomes for children and young people in Nottinghamshire against the National Indicators Set. It is based on data published in the Local Area Interactive Tool (LAIT) supplemented with updated and additional information from numerous sources including the DFE, DoH, Ofsted and NCC Performance Review.

The following information is presented in the data tables for each NI:

- details whether good performance is characterised by higher/lower values
- outcomes since 2006/07 (although not all NIs have historic data back to 2006/07)
- where available a 2011/12 target
- details of the most recently published statistical neighbour data (a list of neighbours is provided at the end of the report)
- details of the most recently published national data (this may not correspond directly to the most recent local data due to the time lag in publishing national datasets)
- an arrow indicating whether the trend is upwards, downwards or stable. The colour of the arrow indicates whether performance is positive (Green), negative (Red) or has remained stable (Orange).

The second section of this report provides analysis of child protection information, the data is provisional. Finalised data will be available in November 2012 when the results from the Children in Need census are due to be published.

Please note: The provisional 2011/12 data used for social care indicators is the most up-to-date information available and may not match previous reports.

National Indicator Table Key.
L - Indicator is included within the LAA
C - Indicator is included within the Children and Young People's Plan
S - Indicator is one of the 10 statutory targets for education and early years
(p) - provisional data
(q) – Most recent quarterly data
* For a number of NI's good performance is not simply measured by a higher lower value, but may require performance to be within a certain range albeit generally higher/lower, refer to NI definitions for further guidance
n/a – Data is currently not available for inclusion in the particular cell
** Refers to Initial Assessments completed within 7 working days

CONTENTS

NI	Description	Good	07/08	08/09	09/10	10/ 11	11/ 12	Target 11/12	Stat Neigh	Nat Avg	Year Trend
	Be Healthy										
NI 52a	Uptake of Primary school lunches (%) - **C**	Higher	**37.8**	**38.2**	**40.3**	**41.6**	**n/a**	**n/a**	**40.6**	**44.1**	⇧
NI 52b	Uptake of Secondary school lunches (%) - **C**	Higher	**30.4**	**26.6**	**28.6**	**31.2**	**n/a**	**n/a**	**39.0**	**37.6**	⇧
NI 55	Obesity among primary school age children in Reception Year (%) - **LC**	Lower	**9.9**	**9.1**	**8.7**	**8.1**	**n/a**	**8.49**	**9.8**	**9.8**	⇩
NI 112	Reduce the under 18 conception rate (per 1000 girls) - **LC**	Lower	**39.9**	**34.6**	**32.9**	**n/a**	**n/a**	**26.4**	**36.0**	**35.4**	⇩
	Stay Safe										
NI 59	Initial assessments for children's social care completed within timescale (%)	Higher	**79.3**	**65.0**	**63.1**	**65.6**	**79.8 (p)**	**75.0**	**74.1**	**77.2**	⇧
NI 60	Core assessments for children's social care that were carried out within 35 working days of their commencement (%)	Higher	**78.5**	**60.3**	**47.5**	**63.2**	**73.7 (p)**	**75.0**	**73.1**	**75.0**	⇧
NI 61	Looked after children adopted during the year who were placed for adoption within 12 months of the agency deciding that the child should be placed for adoption (%)	Higher	**51.5**	**53.1**	**61.3**	**45**	**71 (p)**	**75.0**	**75.0**	**74.0**	⇧
NI 62	Stability of placements of looked after children: number of placements (%)	Lower	**8.8**	**7.1**	**7.2**	**6.3**	**6.6 (p)**	**5.0**	**9.5**	**10.7**	⇧
NI 63	Stability of placements of looked after children: length of placement (%)	Higher*	**67.1**	**69.4**	**72.6**	**71.6**	**75.1 (p)**	**72.0**	**68.0**	**68.6**	⇧
NI 64	Child protection plans lasting 2 years or more (%) - **C**	Lower*	**7.2**	**10.7**	**6.5**	**5.6**	**5.9 (p)**	**8.0**	**6.4**	**6.0**	⇧
NI 65	Children becoming the subject of a Child Protection Plan for a second or subsequent time (%) - **C**	Lower*	**16.4**	**15.2**	**15.7**	**13.8**	**15.5 (p)**	**13.0**	**13.4**	**13.3**	⇧
NI 66	Looked after children cases which were reviewed within required timescales (%)	Higher	**91.6**	**96.5**	**88.7**	**85.5**	**89.4 (p)**	**100**	**90.1**	**90.5**	⇧
NI 67	Child protection cases which were reviewed within required timescales (%)	Higher	**100**	**99.3**	**92.5**	**98.1**	**99.1 (p)**	**100.0**	**97.3**	**97.1**	⇧
NI 68	Referrals to children's social care going on to initial assessment (%)	Median*	**68.9**	**56.5**	**53.1**	**77.2**	**89.4 (p)**	**n/a**	**72.6**	**71.5**	**n/a**
NI 111	Reduce the number of first time entrants to youth justice system aged 10-17 - **LC**	Lower	**1610**	**1270**	**1320**	**1028**	**643**	**Not set**	**1403**	**1472**	⇩
	Make a Positive Contribution										
NI 19	Rate of proven re-offending by young offenders (%)	Lower	**33.6**	**30.4**	**29.5**	**30.4**	**n/a**	**n/a**	**n/a**	**37.4**	⇧
	Additional Indicators										
	Number of Children who are subject of a Child Protection Plan	Median	**421**	**444**	**626**	**759**	**729**		**n/a**	**n/a**	
	Allegations against individuals working with children	Lower	**n/a**	**89**	**111**	**159**	**222**		**n/a**	**n/a**	
	Children privately fostered		**12**	**14**	**n/a**	**14**	**8**		**n/a**	**n/a**	
	Unaccompanied Asylum Seeking Children		**20**	**30**	**35**	**23**	**18**		**n/a**	**n/a**	
	Initial assessments started where domestic violence is a feature		**n/a**	**n/a**	**1628**	**1839**	**1721**		**n/a**	**n/a**	
	Missing children (from home and looked after) NB. Calendar Year	Lower	**n/a**	**827**	**1012**	**996**	**1518**		**n/a**	**n/a**	

National Indicators Commentary

- **NI 59 Initial assessments for children's social care carried out within timescale (%)**
  Performance over the year has been sustained consistently above the target level. Action plans put in place as part of the Safeguarding Improvement Programme have led to improvements in both the timeliness and quality of assessments, supported by mandatory training for staff. Independent reviews of practice quality via targeted auditing have evidenced a marked improvement in both the quality and timeliness of initial assessments.

- **NI 60 Core assessments for children's social care that were carried out within 35 working days of their commencement (%)**
  Monthly performance has recovered above the target level during quarter 4 in February and March, following a dip in performance in January 2012. Monthly performance can be variable and continued focus in this area is therefore being applied via the Quality Management Framework and through independent audits to ensure performance levels are consistently maintained.

- **NI 64 Child protection plans lasting 2 years or more (%)**
  Of the children whose child protection plan ceased during the last quarter of the year (total 226), 8% had lasted for more than 2 years. The cumulative figure for the year however was 5.9% which was below the target figure and represents good performance. Child Protection Coordinators continue to give a particular focus to those children who have been subject to a child protection plan for 18 months or more

- **NI 65 Children becoming the subject of Child Protection Plan for a second or subsequent time (%)**
  Performance against this indicator improved during the last quarter of the year to below the target figure (positive). Over the year 876 children had become subject to a child protection plan, of which 136 were subject to a plan for a second or subsequent time. This equates to 15.5% which is above the target figure for the year. Children who fall within this category often live in families where neglect or domestic violence is a feature. It remains an expectation that operational service managers have oversight of those cases where children re-enter the child protection process

- **NI 67 Child protection cases which were reviewed within required timescales (%)**
  At the end of March, there were 541 children with child protection plans of 3 months or more duration. Of these, 5 children had had a review out of timescale during the year. This receives consistent managerial oversight. The end of year performance of 99.1% shows an improved performance over the end of year figure for last year (98.1%).

- **NI 68 Referrals to children's social care going on to initial assessment (%)** Focussed effort from CSC to apply the thresholds as set out in the Pathway to Provision Guidance means that a higher proportion of referrals appropriately go on to initial assessment. Targets have not been set in this area pending the outcome of the Munro review nationally, and the impact of the transformation programme locally.

- **NI 111 Reduce the number of first time entrants to youth justice system aged 10-17**

  The actual number of first time entrants to the criminal justice system was 71. This equates to 97 FTEs per 100,000 of the 10-17 population. This is much lower than previous years and is the lowest actual number to date. It shows a continued decline in the number of young people entering the criminal justice system for the first time. For the same period last year there were 196 FTEs, which equated to 267 per 100,000. When comparing year to date figures there has been a significant decrease in FTE from 834 per 100,000 population to 471 per 100,000. RAG rating: Green

- **NI 19 Rate of proven re-offending by young offenders (%)**

  Whist marginally less of the cohort have offended this year, compared to the same period last year, in terms of re-offences per 100 offenders, there has been a slight increase in comparison to previous years. When broken down by district the quarter 2 six month data shows that Ashfield has a significantly lower rate of re-offences per 100 offenders than other districts. Whilst Broxtowe and Mansfield have the lowest percentage of offenders within the cohort re-offending, they have a fairly high rate of re-offences. RAG rating: Green

Child Protection Analysis

Please note the 2011/12 information provided in this section is provisional, finalised data will be available in November 2012 when the results from the Children in Need census are due to be published by the DfE.

Referrals

	2007/08	2008/09	2009/10	2010/11	2011/12
Total number of referrals of children who have been the subject of referral (including re-referral) during the year	6971	8464	9736	9298	7230
Number of these children whose referral occurred within 12 months of previous referral	2067	2645	3901	2550	2102
Percentage of referrals occurring within 12 months of previous referral	30%	31%	40%	27%	29%

- The volume of referrals has decreased by 22% from last year.

Initial Assessments

	2007/08**	2008/09**	2009/10**	2010/11	2011/12
Initial Assessments completed within timescale	3808	3106	2856	4709	5600
Other initial assessments completed	993	1675	2317	2466	1420
Total number of initial assessments during year	4801	4781	5173	7175	7020
Percentage of initial assessments completed within timescale	79%	65%	55%	66%	80%

- The volume of initial assessments has increased by 96% from 2009/10
- The proportion of initial assessments completed within timescale has increased from 66% to 80%.

Core Assessments

	2007/08	2008/09	2009/10	2010/11	2011/12
Completed within 35 working days of initial assessment	1175	560	430	1049	1879
Other core assessments completed	321	369	476	610	671
Total number of core assessments during year	1496	929	906	1659	2550
Percentage of core assessments completed within 35 working days of referral	79%	60%	47%	66%	74%

- The volume of core assessments has increased by 79%
- The proportion of core assessments completed within the 35 working days timescale has increased from 66% to 74%.

Section 47 enquiries and initial child protection conferences

	2007/08	2008/09	2009/10[1]	2010/11	2011/12
Number of children who were the subject of S.47 enquiries initiated during the year	812	891	1172	1906	2408
Number of children who were the subject of ICPCs held during the year	531	537	647	1030	1025
Number of children whose ICPCs were held within 15 working days of the initiation of the S47 enquiries which led to the conference	460	459	618	881	955
Percentage ICPCs held within 15 working days of the initiation of the S47 enquiries which led to the conference	87%	85%	96%	86%	93%

- The volume of Section 47 Enquiries initiated during the year has gone up by 26% from the previous year.
- The number of children subject to Initial Child Protection Conferences has remained stable from last year.
- The proportion of ICPCs held within 15 working days of the initiation of the S47 enquiries which led to the conference has increased from 86% to 93%.

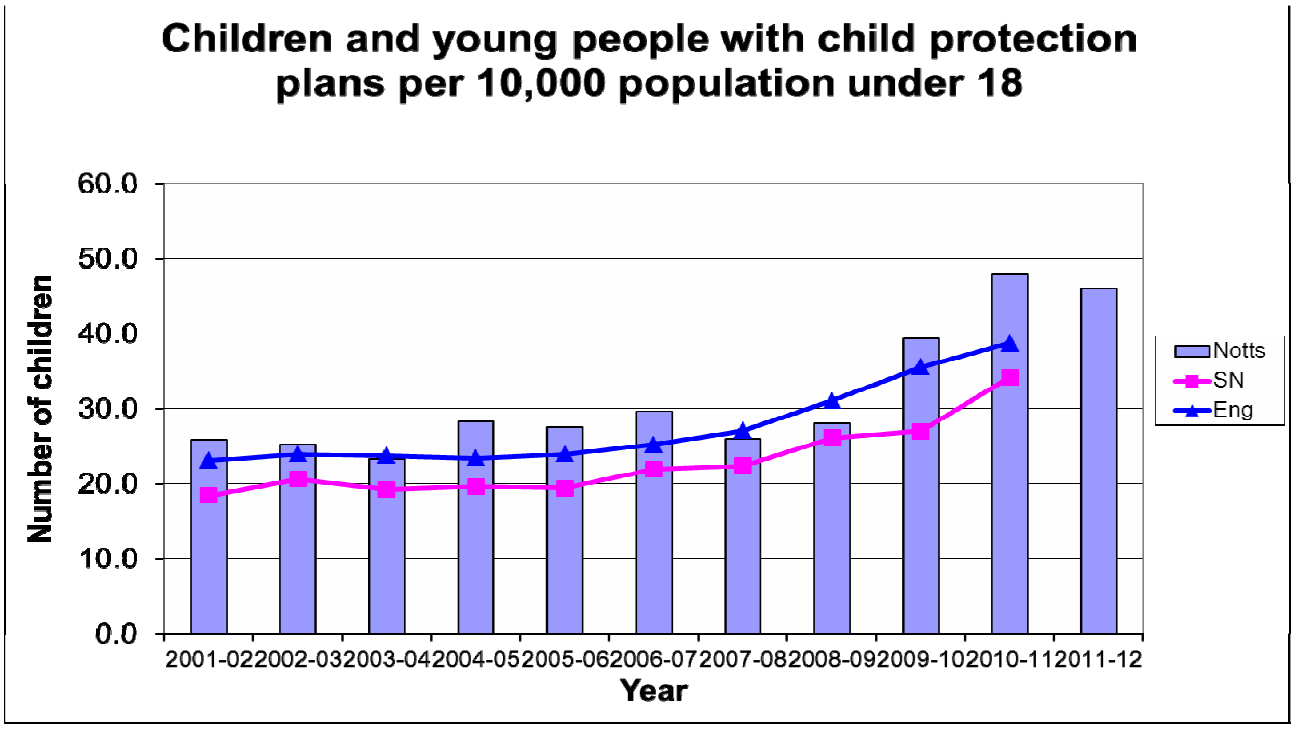
Children and Young People subject of a Child Protection Plan

District and Locality Analysis

District	31/03/2008	31/03/2009	31/03/2010	31/03/2011	31/03/2012	% Change
Ashfield	58	73	118	151	126	-16.6%
Mansfield	75	83	143	141	134	-5.0%
MAN/ASHFIELD	**133**	**156**	**261**	**292**	**260**	**-11.0%**
Bassetlaw	77	67	89	131	145	+10.7%
Newark	101	78	100	86	118	+37.2%
NEW/BASS	**178**	**145**	**189**	**217**	**263**	**+21.2%**
Broxtowe	31	55	59	82	64	-22.0%
Gedling	42	44	69	91	73	-19.8%
Rushcliffe	18	31	34	49	53	+8.2%
BGR	**91**	**130**	**162**	**222**	**190**	**+14.4%**
Others	19	13	15	29	16	-44.8%
TOTAL	**421**	**444**	**627**	**760**	**729**	**-4.1%**

[1] As reported in NSCB Annual report 2009/10

National Comparison



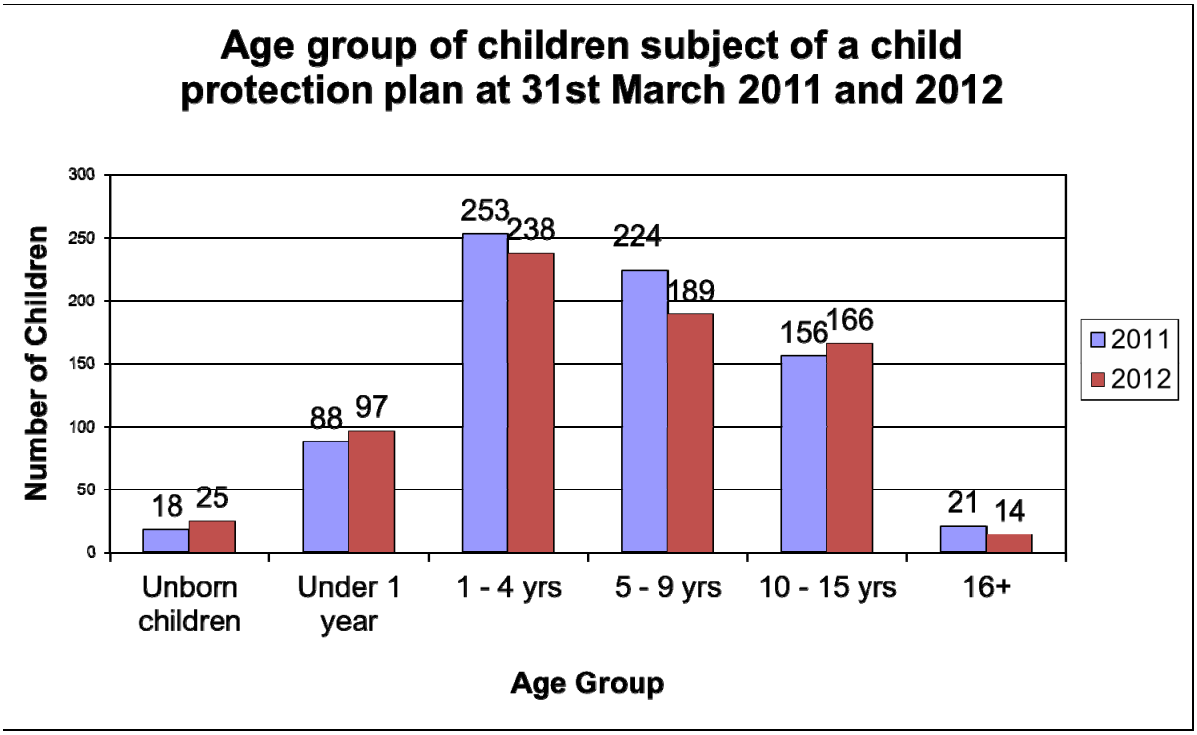
The rate of children subject of a child protection plan aged 0-18 per 10,000 population has slightly fallen from last year.

Age and Gender of Children Subject of a Child Protection Plan

Gender	31/03/2010		31/03/2011		31/03/2012	
	n	%	n	%	n	%
Male	315	50.2	396	52.1	354	48.6%
Female	301	48.0	360	47.4	357	49.0%
Unborn/Gender n/k	11	1.8	4	0.5	18	2.5%
TOTAL	**627**	**100.0%**	**760**	**100.0%**	**729**	**100.0%**

Age	31/03/2010		31/03/2011		31/03/2012	
	n	%	n	%	n	%
Unborn children	4	0.6	18	2.4	25	3.4
Aged under 1 year	88	14.0	88	11.6	97	13.3
Aged 1-4 years	229	36.5	253	33.3	238	32.6
Aged 5-9 years	182	29.0	224	29.5	189	25.9
Aged 10-15 years	115	18.3	156	20.5	166	22.8
16 and over	9	1.4	21	2.8	14	1.9
TOTAL	**627**	**100**	**760**	**100**	**729**	**100**

- There are slightly more female children subject of a child protection plan than male, this was the reverse last year when there were more male.
- The largest single age group is in the 1-4 year range, followed by 5-9 year range.



Ethnic Origin of Children Subject of a Child Protection Plan

Ethnicity	31/03/2009		31/03/2010		31/03/2011		31/03/2012	
	n	%	n	%	n	%	n	%
White British	379	85.4%	543	86.6%	676	88.9%	600	82.3%
White Irish	0	0.0%	0	0.0%	1	0.1%	4	0.5%
Any other white background	1	0.2%	5	0.8%	4	0.5%	5	0.7%
Polish or other Eastern Europe	n/a	n/a	2	0.3%	0	0.0%	7	1.0%
Gypsy/Roma	n/a	n/a	10	1.6%	0	0.0%	0	0.0%
White and Black Caribbean	15	3.4%	26	4.2%	25	3.3%	30	4.1%
White and Black African	0	0.0%	2	0.3%	1	0.1%	2	0.3%
White and Asian	8	1.8%	6	1.0%	7	0.9%	7	1.0%
Any other mixed background	5	1.1%	15	2.4%	12	1.6%	14	1.9%
Indian	5	1.1%	0	0.0%	1	0.1%	2	0.3%
Pakistani	0	0.0%	0	0.0%	4	0.5%	4	0.5%
Bangladeshi	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Any other Asian background	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Caribbean	0	0.0%	0	0.0%	0	0.0%	0	0.0%
African	0	0.0%	2	0.3%	2	0.3%	0	0.0%
Any other black background	1	0.2%	0	0.0%	0	0.0%	1	0.1%
Chinese	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Any other ethnic group	2	0.5%	3	0.5%	3	0.4%	3	0.4%
Not known/unborn	28	6.3%	13	2.1%	24	3.2%	50	6.9%
Total	444	100.0%	627	100.0%	760	100.0%	729	100.0%

- The proportion of children subject of a child protection plan from BME backgrounds has increased from 7.2% in 2011 to 9.6% this year.
- The largest single group is those children who are recorded in the mixed white and black Caribbean ethnic origin group category.

Child Protection Category for Children Subject of a Child Protection Plan as at 31st March 2012

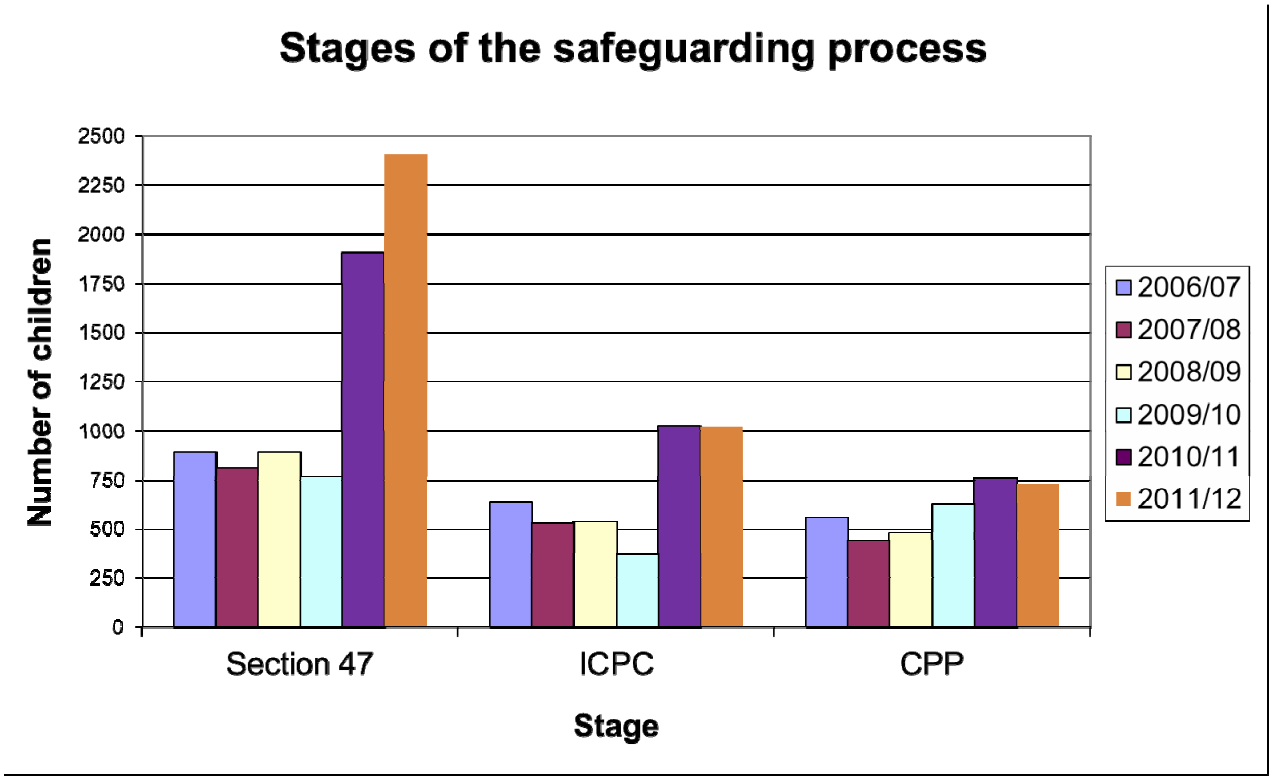
Child Protection Category	n	%
Emotional	117	16.1
Neglect	213	29.3
Physical	46	6.3
Sexual	52	7.1
Multiple:		
Emotional, Neglect	54	7.4
Emotional, Neglect, Physical	22	3.0
Emotional, Neglect, Physical, Sexual	5	0.7
Emotional, Neglect, Sexual	4	0.5
Emotional, Physical	147	20.2
Emotional, Physical, Sexual	1	0.1
Emotional, Sexual	5	0.7
Neglect, Physical	40	5.5
Neglect, Physical, Sexual	4	0.5
Neglect, Sexual	12	1.6
Physical, Sexual	6	0.8
No Category recorded		

- The child protection category with the highest percentage is Neglect with 29.3%.

Stages of the Safeguarding Process

	2007/08	2008/09	2009/10[2]	2010/11	2011/12
Number of children who were the subject of S.47 enquiries initiated during the year	812	891	1172	1906	2408
Number of children who were the subject of ICPCs held during the year	531	537	647	1030	1025
Number of children whose ICPCs were held within 15 working days of the initiation of the S47 enquiries which led to the conference	460	459	618	881	955
Percentage ICPCs held within 15 working days of the initiation of the S47 enquiries which led to the conference	87%	85%	96%	86%	93%

The bar chart below shows increased levels of activity at the Section 47 stage and a stabilisation of the numbers that go on to the Initial Child Protection Conference and child protection plan stages. A smaller proportion of Section 47 cases are leading on to ICPCs which tends to suggest that the threshold between the two stages is being more closely monitored.



[2] As reported in NSCB Annual report 2009/10

Attendance by Agencies at ICPC's between 1st April 2011 and 31st March 2012

Agencies:	Invited	Attended	Sent Report	Sent Apologies	Participated	% Attended	% Participated
Parent/ stepparent/ partner of parent	1020	813	5	113	815	79.7	79.9
Friends/supporter	65	63		1	63	96.9	96.9
Other Family Member	285	270	3	10	270	94.7	94.7
Other Household Member	17	17		0	17	100.0	100.0
CYPS - Responsible service manager	2	1		0	1	50.0	50.0
CYPS - Responsible social worker	574	502	471	62	547	87.5	95.3
CYPS - Responsible team manager	245	142	7	100	144	58.0	58.8
CYPS - EDT	2	2		0	2	100.0	100.0
CYPS - Educational psychologist	7	4	2	3	6	57.1	85.7
CYPS - Educational Welfare Officer	41	21	13	17	27	51.2	65.9
CYPS - Other social worker	212	188	20	21	191	88.7	90.1
CYPS - Other team manager	39	34	1	5	34	87.2	87.2
CYPS - Residential worker	2	2		0	2	100.0	100.0
CYPS - Student social worker	35	34	2	1	34	97.1	97.1
CYPS - Targeted family support services	226	168	72	44	182	74.3	80.5
CYPS - Trainee social worker	25	25	8	0	25	100.0	100.0
CYPS - Youth Offending Service	16	10	11	5	13	62.5	81.3
CYPS - Youth Services	2	2	1	0	2	100.0	100.0
CYPS - Other staff	72	58	15	8	61	80.6	84.7
Foster carer	11	9	1	2	9	81.8	81.8
School	505	367	269	100	411	72.7	81.4
Police - CAIU	140	64	36	56	76	45.7	54.3
Police - Divisional	146	67	33	59	90	45.9	61.6
Police - Domestic Abuse Unit	25	6	9	14	13	24.0	52.0
Probation	112	62	65	45	87	55.4	77.7
Legal Services	48	45		1	45	93.8	93.8
Voluntary organisation	8	5	4	2	7	62.5	87.5
Health (County) - Consultant paediatrician	67	12	32	42	34	17.9	50.7
Health (County) - GP	369	15	120	269	128	4.1	34.7
Health (County) - Health visitor	332	272	200	54	306	81.9	92.2
Health (County) - Mental health worker	53	23	21	22	33	43.4	62.3
Health (County) - Midwife	149	96	64	47	114	64.4	76.5
Health (County) - School nurse	250	179	155	64	223	71.6	89.2
Health (County) - Substance misuse worker	74	42	44	28	61	56.8	82.4
Health (Bassetlaw) - Consultant paediatrician	18	1	8	10	9	5.6	50.0
Health (Bassetlaw) - GP	103	6	40	68	43	5.8	41.7
Health (Bassetlaw) - Health Visitor	87	79	59	7	83	90.8	95.4
Health (Bassetlaw) - Mental health worker	9	5	3	3	6	55.6	66.7
Health (Bassetlaw) - Midwife	39	24	20	12	28	61.5	71.8
Health (Bassetlaw) - School nurse	75	60	48	13	68	80.0	90.7
Health (Bassetlaw) - Substance misuse worker	22	9	11	11	14	40.9	63.6
Other involved professional	603	364	182	180	428	60.4	71.0
OLA - Social Care	28	18	12	8	21	64.3	75.0
OLA - School	9	9	7	0	9	100.0	100.0
OLA - GP	5	1	1	3	2	20.0	40.0
OLA - Health visitor	6	5	2	1	5	83.3	83.3
OLA - Midwife	5	2		3	2	40.0	40.0
OLA - Police	5	3	1	2	3	60.0	60.0
OLA - Other involved professional	75	50	19	23	54	66.7	72.0
OLA - Voluntary organisation	1	1	1	0	1	100.0	100.0
Total	**6266**	**4257**	**2098**	**1539**	**4849**	**67.9**	**77.4**

N.B. For an agency to be considered as having participated in an ICPC they must have either attended or sent a report or both.

Attendance by Agencies at RCPC's between 1st April 2011 and 31st March 2012

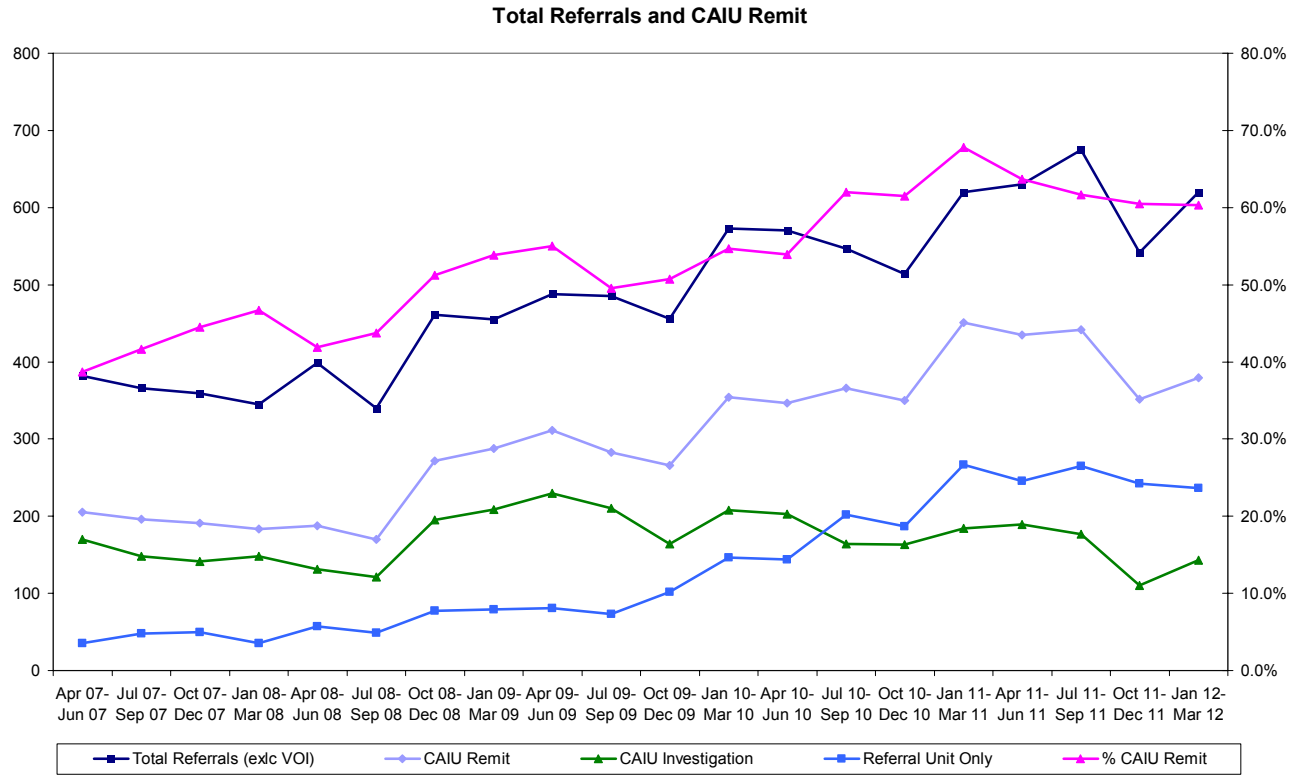
Agencies:	Invited	Attended	Sent Report	Sent Apologies	Participated	% Attended	% Participated
Parent/ stepparent/ partner of parent	2083	1468	3	329	1468	70.5	70.5
Friends/supporter	91	82	1	4	82	90.1	90.1
Other Family Member	507	420		55	420	82.8	82.8
Other Household Member	18	14		4	14	77.8	77.8
CYPS - Responsible service manager	6	6	1	0	6	100.0	100.0
CYPS - Responsible social worker	1160	983	994	141	1094	84.7	94.3
CYPS - Responsible team manager	302	79	6	217	82	26.2	27.2
CYPS - EDT	1	1		0	1	100.0	100.0
CYPS - Educational psychologist	18	7	1	6	7	38.9	38.9
CYPS - Educational Welfare Officer	77	59	26	14	62	76.6	80.5
CYPS - Other social worker	225	189	23	26	194	84.0	86.2
CYPS - Other team manager	7	4		3	4	57.1	57.1
CYPS - Residential worker	4	4	2	0	4	100.0	100.0
CYPS - Student social worker	46	44	3	1	45	95.7	97.8
CYPS - Targeted family support services	566	392	258	144	452	69.3	79.9
CYPS - Trainee social worker	37	32	12	5	33	86.5	89.2
CYPS - Youth Offending Service	14	11	8	2	13	78.6	92.9
CYPS - Youth Services	4	3	2	1	3	75.0	75.0
CYPS - Other staff	166	110	45	43	119	66.3	71.7
Foster carer	43	33	3	8	34	76.7	79.1
School	1190	923	638	202	1000	77.6	84.0
Police - CAIU	35	9	6	20	14	25.7	40.0
Police - Divisional	108	54	5	34	56	50.0	51.9
Police - Domestic Abuse Unit	21	7	4	9	8	33.3	38.1
Probation	211	117	108	76	143	55.5	67.8
Legal Services	110	102		1	102	92.7	92.7
Voluntary organisation	38	29	15	8	32	76.3	84.2
Health (County) - Consultant paediatrician	107	9	21	50	29	8.4	27.1
Health (County) - GP	761	18	132	494	145	2.4	19.1
Health (County) - Health visitor	692	586	520	96	661	84.7	95.5
Health (County) - Mental health worker	69	25	12	27	27	36.2	39.1
Health (County) - Midwife	102	60	33	34	68	58.8	66.7
Health (County) - School nurse	599	464	384	121	527	77.5	88.0
Health (County) - Substance misuse worker	112	66	60	41	84	58.9	75.0
Health (Bassetlaw) - Consultant paediatrician	42	3	4	12	7	7.1	16.7
Health (Bassetlaw) - GP	236	4	70	150	72	1.7	30.5
Health (Bassetlaw) - Health Visitor	192	164	155	26	184	85.4	95.8
Health (Bassetlaw) - Mental health worker	16	5	2	9	6	31.3	37.5
Health (Bassetlaw) - Midwife	18	10	8	6	12	55.6	66.7
Health (Bassetlaw) - School nurse	186	146	142	32	173	78.5	93.0
Health (Bassetlaw) - Substance misuse worker	58	33	23	19	43	56.9	74.1
Other involved professional	1293	764	362	362	864	59.1	66.8
OLA - Social Care	13	7	2	2	7	53.8	53.8
OLA - School	21	20	10	1	21	95.2	100.0
OLA - Foster carer	5	3		2	3	60.0	60.0
OLA - GP	12			7		0.0	0.0
OLA - Health visitor	9	5	4	2	7	55.6	77.8
OLA - Midwife	2			2		0.0	0.0
OLA - Police	1	1		0	1	100.0	100.0
OLA - Other involved professional	125	82	38	37	87	65.6	69.6
Total	**11759**	**7657**	**4146**	**2885**	**8520**	**65.1**	**72.5**

N.B. For an agency to be considered as having participated in an RCPC they must have either attended or sent a report or both.

Public Protection – Child Abuse

Current Picture & Emerging Threats

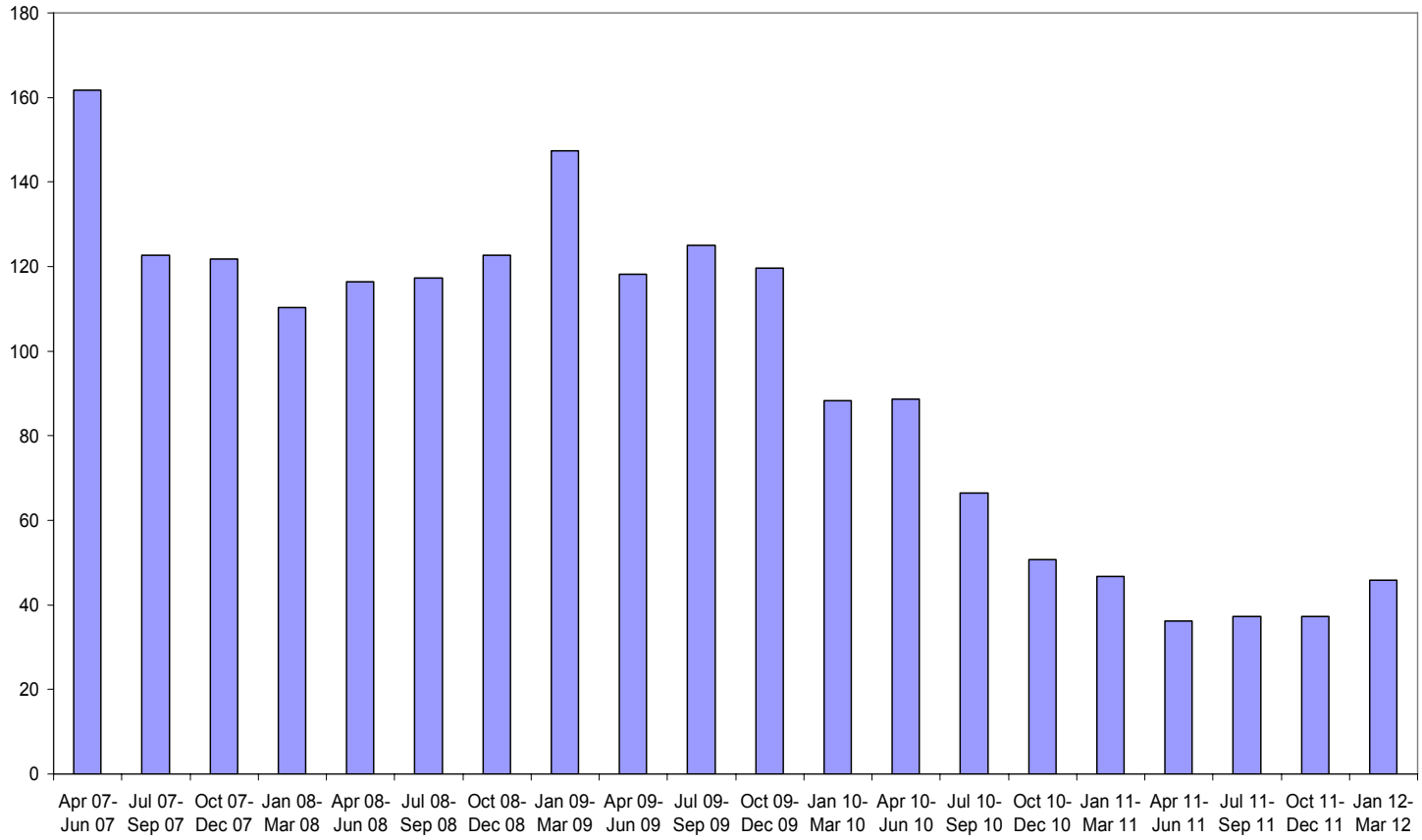
	2009 - Q1	2009 - Q2	2009 - Q3	2009 - Q4	2010 - Q1	2010 - Q2	2010 - Q3	2010 - Q4	2011 - Q1	2011 - Q2	2011 - Q3	2011 - Q4	2012 - Q1
Referalls through Referral unit	535	565	571	524	647	644	590	569	665	683	717	582	628
Video Interview Only	80	77	86	68	74	74	43	55	45	53	42	40	8
Total Referrals (exlc VOI)	455	488	485	456	573	570	547	514	620	630	675	542	620
CAIU Remit	288	311	283	266	354	347	366	350	451	435	442	352	379
% CAIU Remit	53.8%	55.0%	49.6%	50.8%	54.7%	53.9%	62.0%	61.5%	67.8%	63.7%	61.6%	60.5%	60.4%
CAIU Investigation	209	230	210	164	208	203	164	163	184	189	177	110	143
Referral Unit Only	79	81	73	102	146	144	202	187	267	246	265	242	236



The number of referrals in the CAIU remit has increased over time but has seen a downward trend since the beginning of 2011; this trend appears to be levelling off however. Quarter 1 volume in 2012 is lower than in 2011, however quarter 1 in 2011 is the highest quarter in recent years and with a recent downward trend since then a lower CAIU remit is to be expected. The percentage within the CAIU remit remains above 60% in the last 7 quarters with the number of referrals in the CAIU remit in line with performance in total referrals for qtr 1 2012.

	Average Number of Days from Referral Receipt to Completion Date												
	Jan 09-Mar 09	Apr 09-Jun 09	Jul 09-Sep 09	Oct 09-Dec 09	Jan 10-Mar 10	Apr 10-Jun 10	Jul 10-Sep 10	Oct 10-Dec 10	Jan 11-Mar 11	Apr 11-Jun 11	Jul 11-Sep 11	Oct 11-Dec 11	Jan 12-Mar 12
Average Days to Completion	147.44	118.23	124.93	119.67	88.21	88.6	66.4	50.62	46.66	36.19	37.21	37.28	45.79

CAIU Referrals Average Days to Finalisation



The above bar chart reflects the progression of efficiency of the CAIU (even with the increase in referrals) resulting from continuous attempts to drive improvement. However, the figures in the above chart are affected by (i) Recent referrals may still be completed in the future which will increase the average time to finalisation and (ii) Older referrals may be re-opened for administrative purposes. When they are re-completed, the original completion date is over-written which skews the time to completion and increases the average time to finalisation.

ANNEX A

Statistical Nearest Neighbours (SN)

Nottinghamshire
Derbyshire
Staffordshire
Lancashire
Cumbria
Northamptonshire
Swindon
Kent
Dudley
Wigan
Lincolnshire

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