worcestershire county council

# EARLY HELP NEEDS ASSESSMENT

# 2018

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## 1. Executive summary

In this needs assessment the use of the term early help includes prevention and early intervention across the lower levels of need. Effective prevention and early intervention works to prevent problems occurring, or to tackle them head-on when they do, before problems get worse. It also helps to foster a whole set of personal strengths and skills that prepare a child for adult life. This EHNA is a refresh follow up to the 2015 EHNA. This report addresses needs and outcomes of children, young people and families, and considers these in light of the latest published evidence of what works and current provision in relation to prevention and early intervention.

The need for prevention and early intervention appears to be increasing in terms of population size, complexity and vulnerability. The population of children and young people (CYP) continue to increase and the proportion resident in more deprived localities has risen. It has been estimated that 36% of CYP in the county are potentially vulnerable. Almost 5% were in receipt of statutory help and protection, indicating a further 31% would benefit from prevention and early intervention. The percentage of school pupils with special educational needs is above national average (15.2%). While local prevalence statistics have not identified an increase, there is a widely held view among professionals that more children are experiencing mental health problems such as anxiety, depression and conduct disorders. It is estimated that one in eight (12.8%) CYP have had a diagnosable mental health disorder and of those 5.8% have a conduct disorder.

Worcestershire continues to have a number of poorer outcomes for CYP than would be expected, particularly in early years and across educational outcomes. Many outcomes for CYP have improved since the previous EHNA, however these improvements have not been as great or as fast as nationally. In particular inequalities in outcomes for disadvantaged or vulnerable CYP continue to persist. Outcomes at the start of life in pregnancy and birth have not improved with higher rates of maternal obesity, smoking in pregnancy, premature births and low birth weight babies in Worcestershire which are poorest in more disadvantaged localities of the county.

Early years outcomes have improved but significant gaps between groups of children remain. School readiness, taken from Early Years Foundation Stage Profile (EYFSP) results, is lower than England and the gap for disadvantaged children wider than nationally. There is concern about numbers of children starting school with poor speech, language and communication skills with unacceptable differences evident in some areas of the county. Some educational outcomes are poorer than nationally and the gap for disadvantaged groups wider. The percentage achieving expected levels at Key stage 2 have increased but remain significantly below England and the gap widened further for disadvantaged children. Latest Key stage 4 results were above England; however results for disadvantaged and children eligible for free school meals were significantly lower. The analysis demonstrates that inequalities evident before children start school appear to widen during the school years.

Most health outcomes have improved, however the rate of decayed, missing or filled teeth in five year olds is high amongst disadvantaged children particularly in Worcester City. 22% of young children aged 4 to 5 are overweight or obese which rises to 34% by age 10 to 11 and this has not improved over several years.

A review of the published research and evidence of what works to improve outcomes for CYP since the previous EHNA, strengthens the case for prevention and early intervention. There continues to be strong academic and economic evaluation for investing in prevention and early intervention, to give every child the best start in life, ensure that emerging problems do not escalate, and to narrow inequalities. The full range of evidence based practice, approaches, programmes, interventions, services and potential service models for prevention and early intervention for children, young people and families range have been reviewed and compared to current practice and provision.

The early intervention service offer is not well integrated in Worcestershire as has been demonstrated to work elsewhere. Some services work well together and have been working more closely but generally the system remains fragmented resulting in missed opportunity to identify early signs of need and coordinate the right support as early as possible. There appears to be both gaps and potential duplications in the service offer. There is variation in availability of provision, coordination of pathways and support and adherence to the evidence base. Since the previous EHNA activity data reflects an increase in more complex and specialist provision of need or later intervention (Level 3/4) and a reduction in prevention and earlier intervention activity (Level 1/2), although this is difficult to accurately quantify.

This refreshed EHNA presents comprehensive data, analysis, and evidence review about prevention, early intervention or early help in Worcestershire. It discusses current provision, outcomes, and national evidence about what works. This review has led to the following high level principles which should guide the strategic direction of early help in Worcestershire:

- Strong investment is needed in prevention and early intervention so as to prevent problems from happening and, if they do happen, making sure they are dealt with as soon as possible;
- Priority and capacity should be given to shift to an upstream proactive preventive approach across the system
- All CYP should receive a core, universal, service which is evidence based and will provide strong prevention support as well as identifying risk or problems
- Some CYP should receive more support, which is systematically targeted on those who need it most;
- All services should be shaped around the needs of the child and wider family, and underpinned by strong evidence of what works;
- Narrowing inequalities in outcome between different groups of children should be a focus of all work
- A community-centred approach to build community capacity and resilience should underpin the system

In terms of early priorities for services, the needs assessment has concluded the following are recommended:

- Embed pregnancy prevention and pregnancy planning into existing services particularly those targeted at or working with disadvantaged women.
- Ensure a focus on healthy pregnancies and decrease the smoking in pregnancy rate
- Enhance support in pregnancy and early infancy for parenting preparation, wider social support and early help
- Implement the full 4-5-6 Healthy Child Programme including recommended universal reviews to enable screening and identification of CYP and families at risk or in need and development of the 12 high impact areas
- Integrate or align prevention and early intervention services as far as is practicable across health, education and care. This includes integration of services, assessments, pathways and workforce to ensure seamless provision to families.
- Further develop place-based and community-centred activities building on community assets and strengths, incorporating children's or family centres with variety of co-located provision
- Continue to build community capacity and further develop peer support and volunteering to provide advice, information, support and activities around parenting and health and wellbeing in communities

- Develop a comprehensive menu of evidence based parenting support across the system at universal, targeted indicated, targeted selected and specialist.
- Support practitioners to identify parental conflict and relationship problems and to provide evidence based support.
- Support and develop health promoting and whole school/whole setting approaches to emotional health & wellbeing and physical health.
- Incorporate whole family assessments and support as a way of working, including the wider social determinants of need.
- Prioritise school readiness and communication and language development. Develop prevention and early interventions to improve home learning environments, early education and speech, language and communication.
- Review the emotional health & wellbeing pathway and service offer including the development of pathways for conduct disorder.
- Ensure improving diet and physical activity in all domains of children's lives is a priority.
- Review the Early Help Strategy and ensure early help at Level 2 of need is embedded and scaled up
- Ensure services and educational settings implement trauma informed approaches and resilience building.
- Ensure evidence based practice, interventions and programmes are adopted across the early help system including monitoring and evaluation.

## **2.** Introduction

This Early Help Needs Assessment (EHNA) forms part of the Worcestershire Joint Strategic Needs Assessment (JSNA) which aims to analyse the current and future health and wellbeing needs of the local population to inform the commissioning of health, wellbeing and social care services. This EHNA is a refresh follow up to the 2015 EHNA. This EHNA has been undertaken to review and inform the commissioning of prevention, early intervention and early help services going forward. It describes the needs of children and young people 0-19 years and the current service provision for prevention and early intervention where possible, focussed on Levels 1 and 2 of need. It also seeks to assess the evidence base and where appropriate identify effective interventions, services and support based on the best local, national and international data available.

### 2.1. Aim and objectives

The aim of this report is to consider and review progress with regard to prevention and early intervention since the previous 2015 EHNA. Specific objectives are:

- To update and forecast the population profile of children aged 0-19 and their families in Worcestershire.
- To update and forecast the needs of 0-19s and their families for prevention and early intervention.
- To identify, review and compare outcomes for 0-19s and their families.
- To provide a review of the evidence base regarding prevention and early intervention approaches, interventions and services
- To consider current service provision and support in relation to prevention and early intervention.
- To provide recommendations for prevention and early intervention.

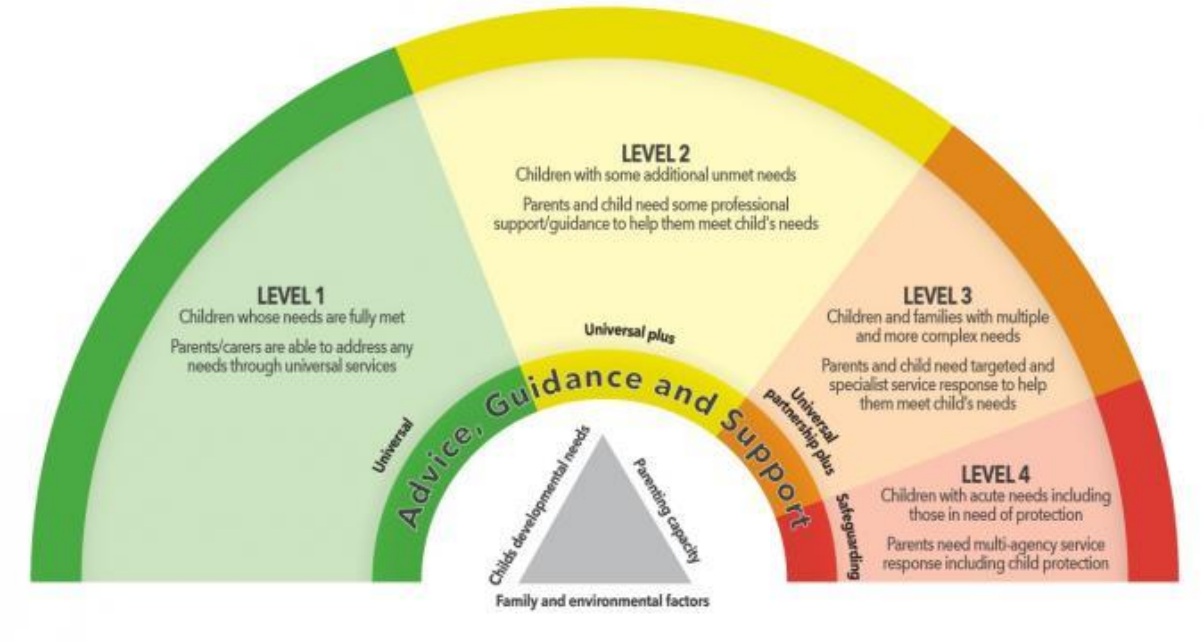
### 2.2. Methods

A mixed methods approach was used in order to capture the range of current and future needs of 0-19 year olds. Quantitative data collection included epidemiological information on the population profile, incidence and prevalence as well as current service provision. An evidence review was also performed in order to assess evidence based interventions and support.

## **3.** Prevention & Early Intervention Background

In this needs assessment the use of the term early help includes prevention and early intervention at the Level 1 and 2 of need that aim to take action as soon as an issue arises in order to prevent further escalation and reduce or avoid the need for specialised services. Prevention and early intervention can be graphically represented using the continuum of need model (Figure 1). An early help/early intervention strategy should start with an assessment of needs followed by an analysis of sufficiency of service, evidence based interventions and advice and information.

Figure 1: The continuum of need




## 4. 2015 EHNA

The previous 2015 EHNA aimed to inform the design and commissioning of early help support and provision for 0-19s and the local Early Help Strategy. The 2015 EHNA identified:

- Poorer outcomes than expected for children and young people (CYP) and persistent inequalities between those CYP from advantaged and disadvantaged communities
- Evidence of rising demand for specialist health and social care services
- Increasing need for prevention and early intervention with greatest need in areas of deprivation
- Variation in early help provision, some activities lacked an evidence base and impact not measured
- Less than half of disadvantaged CYP were accessing Children's Centres, and a third of Children's Centres were located in non-deprived areas
- Unclear if commissioned Early Help services were reducing demand or improving outcomes
- "Early Help" provision appeared to be no longer owned by agencies other than WCC
- Services, agencies and workforce providing prevention and early intervention were not joined up
- Universal services were not undertaking family or multiagency assessments
- The Healthy Child Programme (HCP) in Worcestershire had not been fully implemented and was not integrated with wider workforce or agencies
- The local Troubled Families Programme was showing promising results
- There was good evidence that effective prevention & early intervention can improve outcomes, reduce demand and save resources

The 2015 EHNA recommendations were:

- Redesign 0-19 prevention and early help using a progressive universalism approach with greater resources targeted at those at risk or where problems have emerged.
- Fully implement the local HCP led by universal services supported by other services including parenting, family support and building family and community resilience
- Fully integrate the children's early help system and workforce across agencies and across health, education and social care to ensure consistency of approach.
- Ensure key health & social risk assessments/reviews are undertaken across the population
- Review and ensure all thresholds and pathways between universal, targeted and specialist services including the multiagency assessment process are clear
- Review, identify and commission only evidence based preventive and early intervention provision and interventions consistently across the county and in accordance with NICE guidance.
- Ensure a renewed focus in early years provision on maternal mental health, attachment, nutrition and exercise, language & communication, high quality early years education and childcare to improve school readiness.
- Review provision for supporting parenting, promoting resilience and good emotional health & well-being.
- Develop a new workforce approach, to drive a shift in culture: enabling frontline professionals to understand their role, work in a more integrated way in support of the 'whole family' and with other services to collectively empower parents
- Children's Centres to focus on disadvantaged areas making use of a "virtual" service in more advantaged areas.
- Review and implement effective digital advice and information services.

## 5. Background and National policy context

What happens to young children from before they are born through to when they start at school, and particularly before the age of three, has a huge impact on the rest of their lives. Some inequalities they may be born into might affect (and afflict) them throughout their lives – unless something effective is done to avoid that. What happens in pregnancy and early childhood lays the foundations of human development, physically, emotionally and intellectually. The impact of these early years can be life-long on many aspects of health and wellbeing, educational attainment and economic status. Providing the right support to families during the first few years of a child's life underpins the principle of "giving every child the best start in life" in order to reduce health inequalities across the life course. The benefits of positive interventions during the early years of childhood, including before birth, are realised both in the short term and over the entire life course.

The support provided in the early years needs to be sustained for school aged children and young people. This period of the life course can bring with it many changes and challenges and an element of risk taking behaviour which helps young people to try new things and form a sense of their own identity as they move toward the independence of adulthood. The universal, preventive and targeted support received across the 0-19 age range is crucial to providing effective support, improving outcomes and reducing inequalities.

The 'Marmot review' [1] identified persistent, socioeconomic class-related differences in a wide range of health outcomes, from low birth weight to life expectancy. Drawing on a number of sources for evidence, it set out how a child's experiences during the early years lay down a foundation for the whole of their life. The 'Marmot review' strongly advocated greater priority on ensuring expenditure early in the developmental lifecycle (children below the age of five); that it is invested in interventions that are known to be effective; and that it should be focused proportionately across the social gradient to ensure effective support to parents from pregnancy to the child's transition to primary school – including quality early education and childcare.

Since the previous EHNA there has been a variety of further research and policy supporting the Marmot findings and guiding the provision of prevention and early intervention. The 'Social Mobility Commission's 2016 State of the Nation' report highlighted the correlation between socioeconomic status and cognitive outcomes at ages three and five, breastfeeding, postnatal depression, birthweight, home learning environment and mother-child relationships[2]. To tackle this, the government have developed a national plan for dealing with social mobility through education. The plan has 5 core ambitions: 4 which span across each life phase - the early years, school, post-16 education, and careers - and a fifth overarching ambition focussing on delivering better educational and career outcomes more evenly across the whole country[3]. In early years to close the word and development gaps, especially in early language and literacy skills and with more professional support for early years professionals. In school years to close the attainment gap and raise standards by better support for teachers. In post 16 education to create high-quality post-16 choices for all by investing in technical education. In careers by improving access for young people from lower income backgrounds to networks of advice, information and experiences of work.

The evidence base that it is better and cheaper to prevent problems before they arise, in short, that prevention is better than cure, has continued to develop. The Early Intervention Foundation (EIF) estimate in England and Wales we are spending nearly £17 billion each year on late intervention addressing problems that affect children and young people such as mental health problems, unemployment and youth crime[4]. Most of this late intervention spend is spent by Local Authorities, NHS and Department for Work & Pension. In Worcestershire this spend has been estimated as £148 million per year. The Wave Trust/Department for Education identified returns from £2.42 to £11.44 for each £1 invested in prevention; the highest predicted return was from an early years

[1] Fair Society, Healthy Lives (The Marmot Review), 2010 www.instituteofhealthequity.org/projects/fairsociety-healthy-lives-the-marmot-review
[2] Social Mobility Commission: State of the Nation report, 2016
[3] Unlocking Talent, Fulfilling Potential – A Plan for Improving Social Mobility through Education, 2017, DfE
[4] Spending on Late Intervention: How we can do better for less, Early Intervention Foundation, 2015 (updated 2016)

preventative strategy with a particular focus on preparation for parenthood[5]. A Public Health England (PHE) report identified that for every £1 invested in quality early care and education saves up to £13 in future costs, and targeted parenting programmes to prevent conduct disorders pay back £8 over six years for every £1 invested[6].

Helping women to improve their health and reduce risks prior to pregnancy will ensure healthier pregnancies, improved births and help babies have the best start in life. In 2016 NHS England's Maternity Transformation Programme[7] was set up to deliver the ambition set out in 'Better Births'[8]. The programme seeks to achieve safer, more personalised, kinder, professional, and more family-friendly maternity services. Delivering the vision 'to give every child the best start in life' requires closer working between professions such as health visiting services and maternity services and taking a 'whole system approach' to change. To support this approach, forty-four Local Maternity Systems (LMS) were set up in 2017 to deliver local transformation including a Herefordshire and Worcestershire LMS.

"Prevention is better than Cure" policy paper (2018), provides a prevention vision[9]. The vision identifies a place based approach and emphasises everyone working in the health and social care system has a role to play. The paper identifies action is required before and during pregnancy, through childbirth, and throughout childhood. The 2017 "Transforming children and young people's mental health provision" green paper focused on earlier intervention and prevention to improve mental health support for children and young people especially in and linked to schools and colleges[10]. The proposals will be implemented by the end of 2022/23. In addition, health education will become a compulsory part of the national curriculum for the first time, with all schools teaching it by September 2020. All schools will teach children about the benefits of a healthier lifestyle, what determines their physical health and how to build mental resilience and wellbeing – including how to stay safe on and offline and the importance of healthy relationships.

The Department for Education have revised statutory guidance on inter-agency working to safeguard children in England to implement the changes from the Social Work and Children Act 2017[11]. The guidance refers to early intervention as "early help" and outlines the kinds of support that this term describes:

*In addition to high quality support in universal services, specific local early help services will typically include family and parenting programmes, assistance with health issues, including mental health, responses to emerging thematic concerns in extra-familial contexts, and help for emerging problems*

[5] Conception to age 2 – the age of opportunity, Wave Trust/DfE, 2013 www.wavetrust.org/our work/publications/reports/conception-age-2-age-opportunity
[6] Improving school readiness: creating a better start for London, PHE, 2015 www.gov.uk/government/publications/ improving-school-readiness-creating-a-betterstart-for-london
[7] www.england.nhs.uk/mat-transformation/saving-babies/
[8] www.england.nhs.uk/wp-content/uploads/2016/02/nationalmaternity-review-report.pdf
[9] Prevention is better than cure: our vision to help you live well for longer, 2018, Department of Health and Social Care
[10] Transforming children and young people's mental health provision: a green paper, Department of Health and Social Care, Department for Education, 2017
[11] Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children, July 2018, DfE

*relating to domestic abuse, drug or alcohol misuse by an adult or a child. Services may also focus on improving family functioning and building the family's own capability to solve problems.*

This description hints at the variety of early intervention programmes to be developed but does not specify what. The guidance states that "early help is more effective in promoting the welfare of children than reacting later", and instructs local authorities to have measures in place to:

- identify those families who would benefit from early help;
- determine what form of early help they would benefit from; and
- provide evidence-based early help as appropriate

Working Together 2018 strengthens the section on assessing need and providing help. The guidance highlights that "Early help means providing support as soon as a problem emerges, at any point in a child's life, from the foundation years through to the teenage years. Early help can also prevent further problems arising".

The new guidance refers to practitioners rather than professionals and expands the examples of who a lead practitioner could be. "A lead practitioner should provide support to the child and family, act as an advocate on their behalf, co-ordinate the delivery of support services and should undertake the early help assessment. A GP, family support worker, school nurse, teacher, health visitor and/or special educational needs co-ordinator could undertake the lead practitioner role. Decisions about who should be the lead practitioner should be taken on a case-by-case basis and should be informed by the child and their family". There is emphasis on early help interventions being evidence based, comprehensive and effective. The early help on offer should draw upon any local assessment of need, including the Joint Strategic Needs Assessment, and the latest evidence of the effectiveness of early help and early intervention programmes.

The national Troubled Families Programme entered its second phase in 2015. The programme will work with up to 400,000 additional families by 2020 with annual reporting until 2022. The second phase is targeting additional problems, including domestic violence, health, drug abuse, mental health and children at risk. The first annual report (April 2017) identified that the programme was driving service transformation in local authorities; changing structures and processes, strengthening partnership working and promoting 'whole-family' working[12]. The second annual report (2018) identified that the Troubled Families programme appears to have reduced demand for costly children's services compared to what would have happened if programme interventions had not taken place."[13]

Since 2013 upper tier local authorities have been responsible for the delivery of the Healthy Child Programme (HCP) for 5-19 year olds and the commissioning of school nursing. From October 2015, local authorities were also given the responsibility for the HCP for 0-5 year olds and the commissioning of Health Visiting services incorporating universal to targeted programmes, and targeted intensive home visiting programme for first-time teenage parents. The HCP comprises

[12] Supporting disadvantaged families Troubled Families Programme 2015 – 2020: progress so far, DCLG, April 2017

[13] Supporting disadvantaged families: annual report of the Troubled Families Programme 2017 to 2018, MHCLG, March 2018, pp13-15

screening tests, immunisations, developmental reviews, and information and guidance to support parenting and healthy choices. It has two strands—one for pregnancy through to age 4[14], and one for children aged 5–18[15]. The programme uses a 'progressive universalism' model, with all families receiving basic elements of the programme and additional services being provided to those with specific needs and risks. A key component of the 0–5 years strand is a series of health and development reviews for each family, conducted at set periods. The five 'health visitor reviews' to all families became mandated. The transfer of responsibility for children's public health to local authorities in 2015 created an opportunity to improve the co-ordination, or move to full integration, of the services provided for young children and their families – and a number of local authority areas have taken this opportunity.

In late 2018, the EIF reviewed the current state of play for early intervention, how it works to support child development and to improve outcomes for children and young people, highlighted barriers to implementation and identified key actions to push the agenda forward[16]. The report makes a case for investing more time, money and energy in helping children and families overcome adversity at an earlier stage, rather than waiting for issues, such as parental conflict, to reach crisis point. Whilst early intervention has the potential to reduce the growing pressures in children's social care this is in the longer term rather than in the short term. The longer term wider system benefits in supporting a child's growth and development are huge, from increased personal resilience, improved academic outcomes and earning potential to reductions in crime and increased life expectancy.

The new NHS Long Term Plan (2019) identifies action the NHS will take to strengthen its contribution to prevention and health inequalities over the next ten years[17]. One of three priority areas for improving care is around *Making sure everyone gets the best start in life.* Actions in the plan include additional and targeted support in pregnancy, taking action on childhood obesity and increasing funding for children and young people's mental health.

### 5.1 Local policy context and background

Following the 2015 EHNA, an integrated 0-19 prevention service was tendered in 2016 however the tender exercise was unsuccessful. The individual contracts in scope were reviewed, reduced, extended and varied. The Health Visiting, infant feeding and school health service contracts were integrated and redesigned into a single countywide 0-19 Public Health nursing service. The Family Nurse Partnership (FNP) intensive home visiting programme for young vulnerable mothers was redesigned to provide a mixed model of FNP and an alternative home visiting programme, Family First. Three locality contracts covering provision in Children's Centres, Community Capacity Building, Parenting and Family Support were reduced and redesigned to provide a more targeted offer (South Worcestershire, Redditch & Bromsgrove, Wyre Forest). A new emotional health & wellbeing service commenced providing universal on-line counselling (Kooth) for young people and short-term group support programmes (Reach4wellbeing) for low mood and anxiety. Oversight, continuing

[14] Healthy Child Programme. Pregnancy and the first five years of life. Department of Health, 2009
[15] Healthy Child Programme. From 5 to 19 years. Department of Health, 2009
[16] Realising the potential of early intervention, October 2018, EIF
[17] The NHS Long Term Plan. January 2019. Department of Health

improvement and integration of these services were progressed through a Starting Well Transformation Board.

In 2016 the leases of 20 Children's Centre buildings were transferred to schools and childcare providers The 12 centres not transferred continued to be used for the provision of services by the Parenting and Family Support services. The transfers were in response to funding reductions and informed by the need to increase funded nursery places. Although overall footfall has fallen all children's centres continue to deliver early childhood services and support delivery of a range of services.

Following an Ofsted Single Inspection Framework, an inadequate judgement was given for Worcestershire Children's Social Care in January 2017. The DfE subsequently appointed a Children's Commissioner for Worcestershire to lead a further review of services. The Commissioners report in September 2017 led to a further statutory direction for the Council to move those services under direction into an Alternative Delivery Model (ADM). A subsequent Service Improvement Plan and a refreshed Early Help Strategy has been implemented which has resulted in consistent and sustained improvement of children's social care services. At the same time a programme to analyse, design and implement an ADM for Children's Social Care commenced. In March 2018, the Council agreed the development of a wholly owned council company as the chosen delivery model to deliver children's social care to be called *Worcestershire Children's First*. Worcestershire Children's First will commence in shadow form from April 2019 with formal launch in October. In November 2018, it was agreed to broaden the scope of services transferred to Worcestershire Children First to include the full range of Council Children's Services including education and early help.

In March 2018, Ofsted and the Care Quality Commission (CQC) conducted a joint inspection to judge the effectiveness of the area in implementing the special educational needs and disability (SEND) reforms as set out in the Children and Families Act 2014. As a result of the findings of this inspection a Written Statement of Action (WSoA) was required. The local authority and the Clinical Commissioning Group (CCG) are jointly responsible for the written statement and improvement work.

In August 2018, the commissioned targeted family support service elements were transferred back to the Council. This has resulted in most of targeted family support at Level 3 of need integrating into one function. It has also enabled closer working with the Early Intervention Family Support service for children aged 7 to 13 years at Level 2 of need, also provided by the Council. In November 2018, cabinet agreed to include this early help function within the scope of the forthcoming ADM.

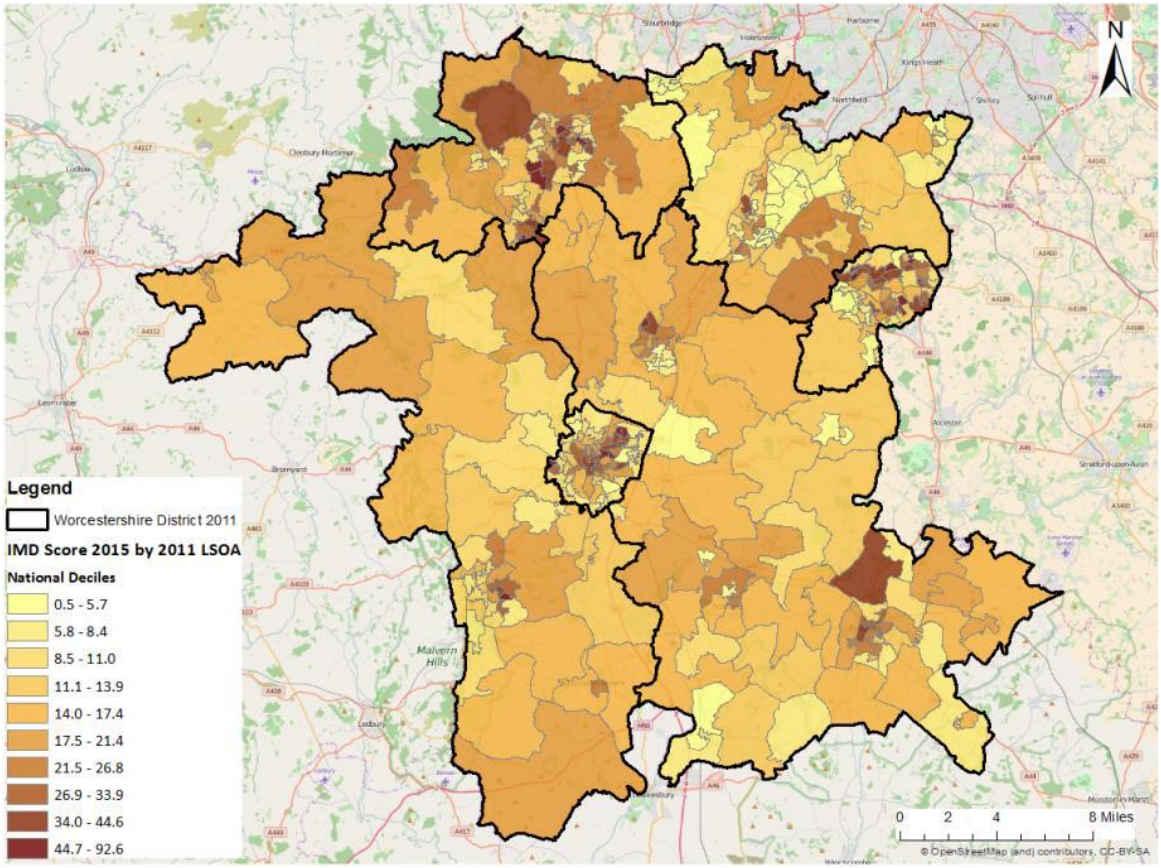
## 6. 0-19 Population and estimates of need

### 6.1. Setting the Scene

Worcestershire is a predominantly rural county with a few urban areas of more than 10,000 population including the towns of Worcester, Redditch, Bromsgrove, Malvern, Kidderminster and Evesham. Worcestershire generally has good health and wellbeing outcomes and performs better than the national average on many measures.

Worcestershire as a whole is relatively less deprived than the national average (based on the IMD score 2015) as depicted by lighter shading on the map. However, there are pockets of relative deprivation in the urban areas of Worcester, Kidderminster (Wyre Forest) and Redditch. In addition, there are some deprived rural areas, most notably in the north of Wyre Forest and in Wychavon district, to the north of Evesham.

Figure 2: Worcestershire Map - Deprivation (IMD Score 2015)



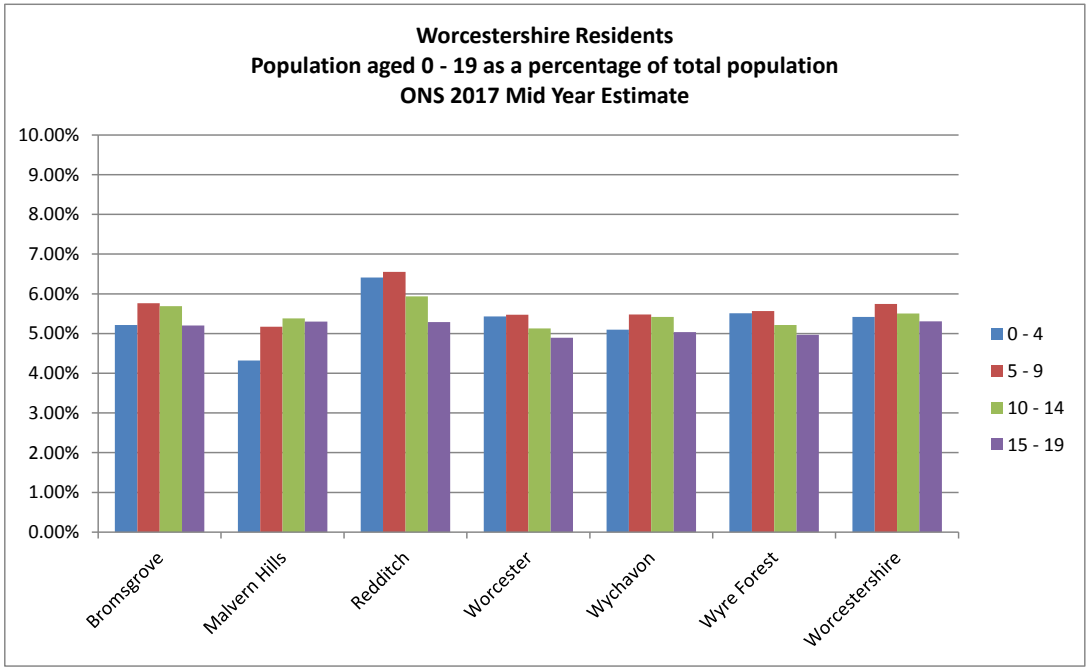

Source: GOV.UK, Index of Multiple Deprivation 2015

### 6.2. Resident Population 0-19s

At a county level the number of children and young people aged 0-19 years is estimated to be 129,300, which is 22% of the total population. This is a lower proportion than the England average of 24%. Within this the largest age group is the 5-9 years olds, representing nearly 6% of the total population and the smallest age group is the 15-19 year olds.

There is variance by District; Redditch has the largest proportion of 0-19 year olds living within its boundaries, with them accounting for 24% of the population, and Malvern having the smallest percentage (20%). Redditch has the highest proportion of 0-9 year olds who account for 13% of its population, closely followed by Wyre Forest and Worcester with 0-9s accounting for 11% of their population. However, in terms of numbers, Wychavon (as the largest district) has the highest number of 0-19 accounting for 20% of the CYP population in Worcestershire.

Figure 3: Population by age groups and District

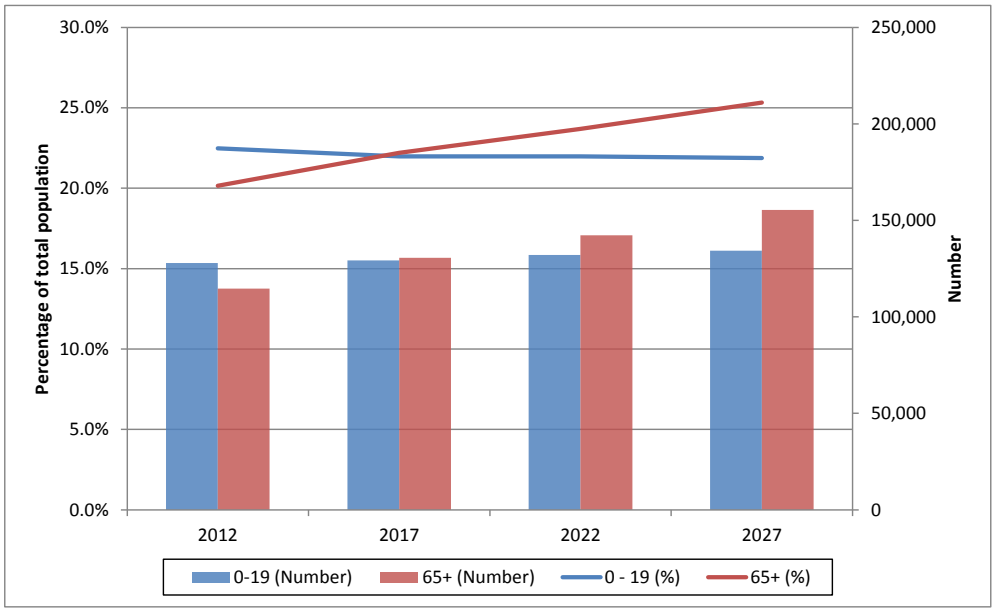



*Source: ONS population projections (2017 based)*

### 6.3. 0-19 population growth

The mid 2017 estimate was 129,289 population aged 0-19 living in Worcestershire. This is projected to increase by 3.9% over the next 10 years to 134,300 by 2027, although as a percentage of the total population living in Worcestershire it is a slight decrease. The 0-19 age population is projected to decrease as a percentage of the total population slightly over the next few years; conversely the proportion of the population aged 65+ is projected to increase quite rapidly (Figure 4).

Figure 4: Projected population change in 0-19 and 65+ age groups in Worcestershire to 2027

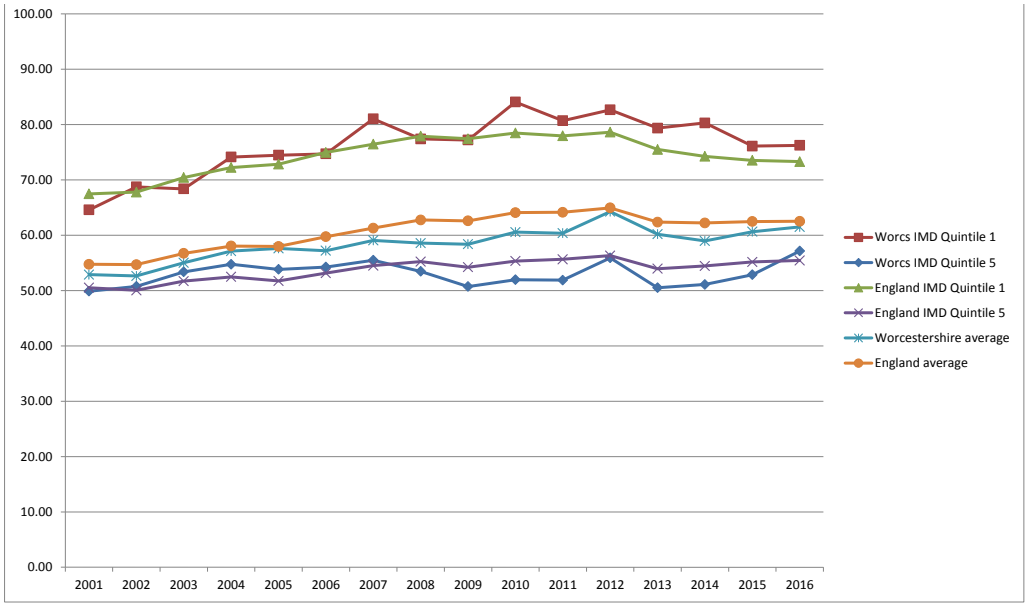



*Source: ONS population projections (2017 based)*

### 6.4. Births

Of note is the higher birth rate amongst the most deprived quintile of the population (Figure 5) in Worcestershire. Despite having a lower overall birth rate than England, in Worcestershire we have consistently had a higher birth rate in our most deprived areas. This trend indicates that although the overall population of children and young people is decreasing, the numbers from the most deprived communities in the county are increasing.

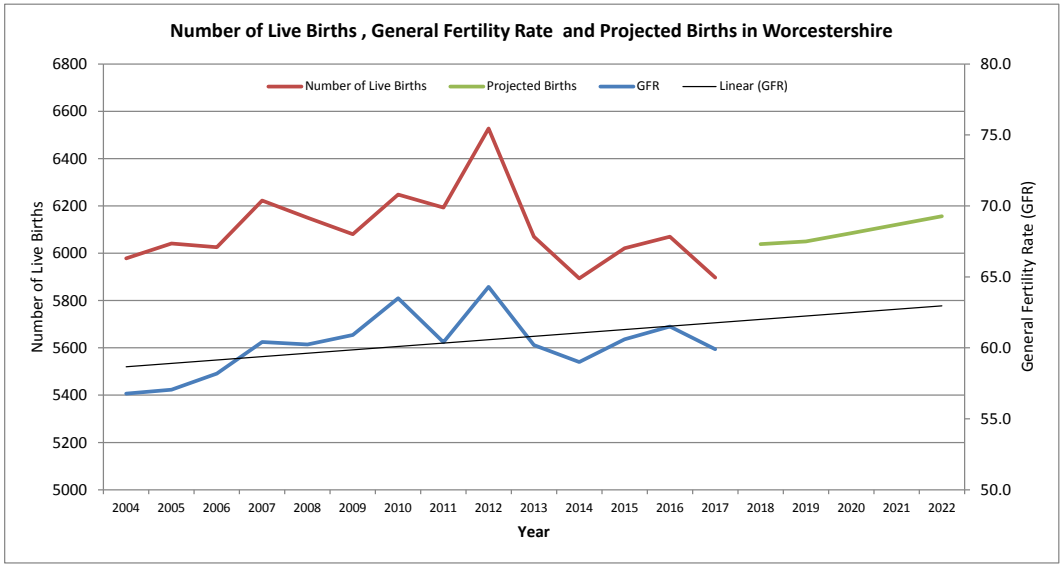
Figure 5: Live birth rate comparison by IMD quintile: Worcestershire vs. England




Source: ONS/Public Health England (bespoke analysis)

Using the General Fertility Rate over the last 14 years, we can project the number of live births forward to give us an estimated number of births over the next 5 years, as can be seen in the graph below.

Figure 6: Actual and Predicted Live births in Worcestershire 2004 – 2022




*Source: ONS/Public Health England (bespoke analysis)*

## 7. Demographic changes

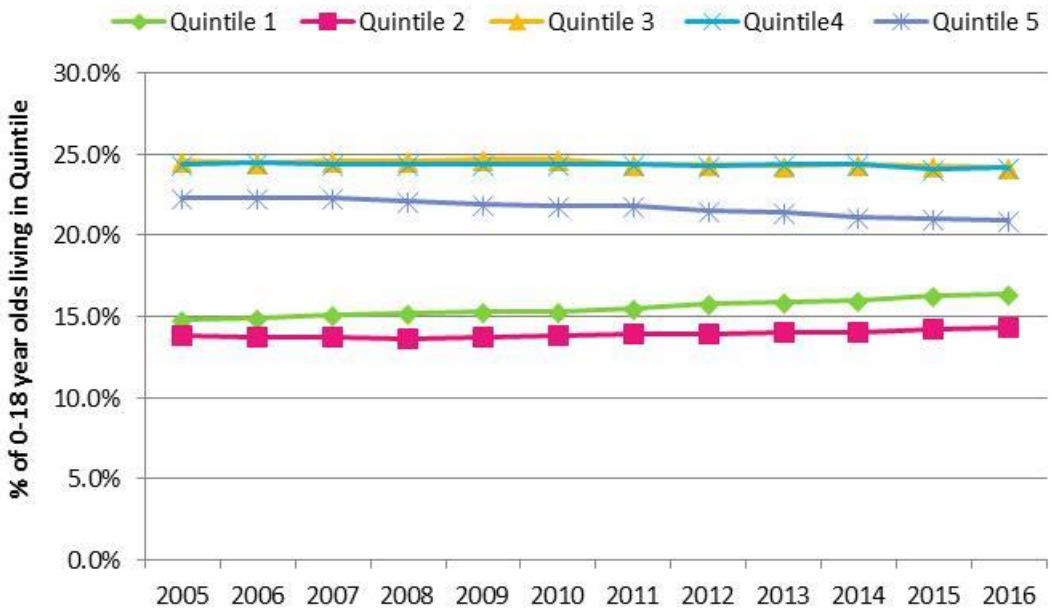
To demonstrate the demographic change in the county Table 1 provides the numbers and percentage of the under 18 population living in the 20% and 40% most deprived areas in the county. Figure 7 shows the increase in population for Quintile 1 (20% most deprived areas) and Quintile 2 (40% most deprived areas). In Quintile 5 (least deprived areas), the population of 18 and under is gradually declining.

Table 1: Numbers and % of Under 18s in 20% and 40% most deprived areas (2005-2016)

| Year | No. of Under 18s in 20% most deprived areas | % of Under 18s in 20% most deprived areas | No. of Under 18s in 40% most deprived areas | % of Under 18s in 40% most deprived areas |
|---|---|---|---|---|
| 2005 | 17605 | 14.8% | 33998 | 28.6% |
| 2006 | 17692 | 14.9% | 33970 | 28.7% |
| 2007 | 17772 | 15.1% | 33924 | 28.8% |
| 2008 | 17834 | 15.2% | 33826 | 28.9% |
| 2009 | 17739 | 15.3% | 33704 | 29.0% |
| 2010 | 17617 | 15.3% | 33546 | 29.1% |
| 2011 | 17791 | 15.5% | 33737 | 29.4% |
| 2012 | 18086 | 15.8% | 34045 | 29.7% |
| 2013 | 18311 | 15.9% | 34409 | 29.9% |
| 2014 | 18414 | 16.0% | 34578 | 30.1% |
| 2015 | 18740 | 16.3% | 35183 | 30.5% |
| 2016 | 19035 | 16.4% | 35693 | 30.8% |

*Source: ONS/Public Health England (bespoke analysis)*

Figure 7: % of Under 18 Population by Deprivation Quintile (2005-2016)




*Source: ONS/Public Health England (bespoke analysis)*

### 7.1. Ethnicity

The 2011 census data indicates that in Worcestershire 89.7% of children are White British. This is much higher than England and Wales which was 75.7% and West Midlands 72.8%.

Redditch has the lowest proportion of children who are White British (83.5%) than other local districts in Worcestershire from 93.2% in Wychavon to 90.9% in Bromsgrove. 7.4% of children under the age of 5 are Asian/Asian British, 4.6% are Mixed/Multiple ethnicity and 1.0% are Black/African/Caribbean/Black British in Redditch.

Table 2: Numbers & % of 0-19s in Worcestershire by ethnicity

| **Ethnic Group: Worcestershire** | **Numbers** | **% of children aged 0-19 years** |
|---|---|---|
| White: Total | 118391 | 92.4% |
| White: **English/Welsh/Scottish/Northern Irish/British** | 114911 | 89.7% |
| White: **Irish** | 250 | 0.2% |
| White: **Gypsy or Irish Traveller** | 443 | 0.3% |
| White: **Other White** | 2787 | 2.2% |
| Mixed/multiple ethnic group: Total | 4005 | 3.1% |
| Mixed/multiple ethnic group: **White and Black Caribbean** | 1735 | 1.4% |
| Mixed/multiple ethnic group: **White and Black African** | 385 | 0.3% |
| Mixed/multiple ethnic group: **White and Asian** | 1262 | 1.0% |
| Mixed/multiple ethnic group: **Other Mixed** | 623 | 0.5% |
| Asian/Asian British: Total | 4982 | 3.9% |
| Asian/Asian British: **Indian** | 1088 | 0.8% |
| Asian/Asian British: **Pakistani** | 2054 | 1.6% |
| Asian/Asian British: **Bangladeshi** | 604 | 0.5% |
| Asian/Asian British: **Chinese** | 594 | 0.5% |
| Asian/Asian British: **Other Asian** | 642 | 0.5% |
| Black/African/Caribbean/Black British: Total | 513 | 0.4% |
| Black/African/Caribbean/Black British: **African** | 239 | 0.2% |
| Black/African/Caribbean/Black British: **Caribbean** | 186 | 0.1% |
| Black/African/Caribbean/Black British: **Other Black** | 88 | 0.1% |
| Other ethnic group: Total | 215 | 0.2% |
| Other ethnic group: **Arab** | 49 | 0.0% |
| Other ethnic group: **Any other ethnic group** | 166 | 0.1% |
| **All aged 0-19** | **128106** | |

Source: NOMIS – Ethnicity by age and sex (2011)

## 8. Child Poverty

### 8.1. National and Worcestershire Profile: Child Poverty

There are approximately 15,370 (13.2%) children aged 20 and under who live in relative poverty (living in households where income is less than 60 per cent of median household income before housing costs). Worcestershire has a significantly lower proportion of children in low income families in comparison to England. This is true for all district areas across Worcestershire, with the exception of Wyre Forest, where the proportion is similar to the England average and there are an estimated 3,260 (16.6%) children living in low income families.

**1.01i - Children in low income families (all dependent children under 20)** 2015 Proportion - %

| Area | Count | Value | 95% Lower CI | 95% Upper CI |
|---|---|---|---|---|
| England | 1,929,285 | 16.6 | 16.6 | 16.7 |
| Worcestershire | 15,370 | 13.2 | 13.0 | 13.4 |
| Bromsgrove | 1,695 | 9.1 | 8.7 | 9.5 |
| Malvern Hills | 1,655 | 12.4 | 11.9 | 13.0 |
| Redditch | 2,935 | 15.2 | 14.7 | 15.7 |
| Worcester | 3,335 | 15.2 | 14.7 | 15.7 |
| Wychavon | 2,495 | 10.7 | 10.3 | 11.1 |
| Wyre Forest | 3,260 | 16.6 | 16.0 | 17.1 |

*Source: HM Revenue and Customs (Personal Tax Credits: Related Statistics - Child Poverty Statistics)*

Worcestershire has a significantly lower proportion of children aged 0–15 years who are living in income deprived households as a proportion of all children aged 0–15 years at 15.7%, when compared to the England average of 19.9% (2015).

**IDACI (Income Depr. - Children)** 2015 Proportion - %

| Area | Count | Value | 95% Lower CI | 95% Upper CI |
|---|---|---|---|---|
| England | 2,016,116 | 19.9 | 19.9 | 19.9 |
| Worcestershire | 15,856 | 15.7 | 15.5 | 16.0 |
| Bromsgrove | 1,652 | 10.0 | 9.6 | 10.5 |
| Malvern Hills | 1,723 | 14.0 | 13.4 | 14.7 |
| Redditch | 3,123 | 18.7 | 18.1 | 19.3 |
| Worcester | 3,383 | 18.2 | 17.6 | 18.7 |
| Wychavon | 2,627 | 13.3 | 12.8 | 13.7 |
| Wyre Forest | 3,348 | 20.0 | 19.4 | 20.6 |

*Source: Department for Communities and Local Government*

## 9. Estimate of Vulnerable Children and Young People in Worcestershire

The EHNA 2015 modelled the CYP population using the PREVIEW tool. This identified that 52% of CYP were likely to have good or very good outcomes and 48% were likely to require varying levels of preventive interventions. However, the PREVIEW tool does not indicate the type or intensity of the likely preventive intervention required.

For this refresh EHNA an estimate of vulnerable CYP for Worcestershire has been calculated using the national estimate in the Children's Commissioners Report on Vulnerability[18]. This analysed for the first time the scale of vulnerability of children in England by bringing together a range of information held by various government departments, agencies and others. This identified in England there were over half a million CYP so vulnerable the state has to step in, 670,000 children were growing up in 'high risk' family situations, 800,000 children suffering from mental health difficulties, thousands living with adults in treatment for drink or drugs and many more children under the radar, not being seen.

The Commissioners report has undertaken analysis of overall levels of vulnerability for three broad "types" of vulnerable group: Type I: Children receiving statutory support; Type II: Children with complex family needs and Type III: Children with health-related vulnerabilities and attempted to

[18] Children's Commissioner. Vulnerability Report 2018 [Internet]. 2018. Available from: https://www.childrenscommissioner.gov.uk/wp-content/uploads/2018/07/Childrens-Commissioner-Vulnerability-Report-2018-Overview-Document-1.pdf

take account of multiple vulnerabilities to estimate the overall number of children in the type as a whole. The table below sets out the specific vulnerable groups included in each of these general types of group.

Table 3: Vulnerability types and groups of vulnerable children

| Type I:<br><br>Groups of children and young people receiving statutory support | Type II:<br><br>Groups of children and young people with complex family needs | Type III:<br><br>Groups of children and young people with health-related vulnerabilities |
|---|---|---|
| • Children in care<br>• Children in secure settings<br>- Immigration detention<br>- Youth Custody<br>- Mental health secure Tier 4<br>- Secure welfare accommodation<br>• Children in Need (CIN)<br>• Children who are subject of Child Protection Plans<br>• Children with prior care experience<br>- Former Relevant Children and Qualifying children<br>- Children in Special Guardianship Orders (SGOs)<br>• Children who have been sexually abused or exploited<br>• Children who have been trafficked<br>• Children who have been victims of FGM | • Children in low-income families and materially deprived<br>• Children of prisoners<br>• Children whose parents use substances problematically<br>• Children exposed to Domestic Violence & Abuse<br>• Children with mental-ill health in the family<br>• Young carers | • Children who have SEN<br>- Children with SEN support (without statements or EHC plans)<br>- Children with SEN statements or EHC plans<br>• Children with physical ill-health<br>- Children with longstanding illness<br>- Children with a limiting longstanding illness<br>• Children with mental health (MH) difficulties<br>- Children with low-level MH conditions<br>- Children with clinically significant MH issues |

Taking account of overlaps, the Commissioners report estimated in England for the year 16/17 there were: 710,000 children receiving statutory support, 2,140,000 children with complex family needs and 2,660,000 children with health-related vulnerabilities.

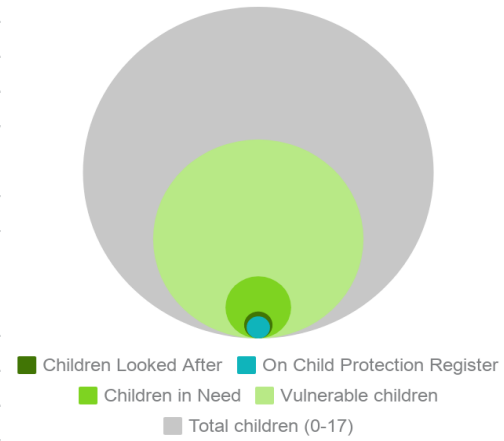
The Children's Commissioners report estimated that in total 36% of CYP under age 18 years were vulnerable in England. Using this methodology, the number of children in Worcestershire aged under 18 years who might also be classed as vulnerable has been calculated to be 41,779. The actual numbers of children looked after, subject to a child protection plan and Children in Need in 2017 are known. Figure 8 provides an estimate of the number of potentially vulnerable CYP in

Worcestershire not receiving statutory social care support or care is 36,430 or 31.4% of the population.

Figure 8: Estimated numbers of vulnerable children in Worcestershire

| | (2017) | % |
|---|---|---|
| Children Looked After* | *765* | 0.66 |
| On Child Protection Register* | *517* | 0.45 |
| Children in Need* | 4067 | 3.50 |
| Vulnerable children (Other) | 36430 | 31.40 |
| Total vulnerable | 41779 | 36.0 |
| Total children (0-17) | 116054 | |

*actual figures




*Source: Children's Commissioner Annual Report*

## 10. Children & Young People with SEND in Worcestershire

The estimated numbers of vulnerable CYP above include those CYP with Special Educational Needs and Disabilities (SEND). In the UK it is estimated there are approximately 0.9 million children aged 0-18 years who are disabled, which equates to around 7% of children overall[19]. Using this national prevalence it can be estimated there are likely to be 8,645 CYP with a disability in Worcestershire.

Neurodevelopmental conditions are the largest type of impairment in disabled children and young people and prevalence is estimated to be at around 3-4% in children overall. These include, but not limited to, Attention Deficit Hyperactivity Disorder (ADHD), speech, language and communication issues and specific and moderate learning difficulties. National estimates for specific neurodevelopmental impairment conditions or disability needs are included in the table below also giving estimated likely numbers in Worcestershire.

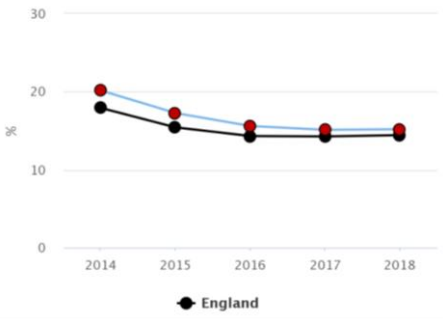
[19] Papworth Trust (2016), Disability in the United Kingdom Facts and figures,[Online], Accessed: 03/11/2017, Available from: http://www.papworthtrust.org.uk/campaigns/disability-facts-and-figures

Table 4: Percentage of children and young people with specific neurodevelopmental impairments, conditions or needs

| Impairment/Condition | Children (%) National Estimates | Worcestershire Estimates (No.) |
|---|---|---|
| Any neurodevelopmental disorder | 3.0–4.0 | 3705 - 4940 |
| ADHD | | |
| *DSM IV* | 3.0–9.0 | 3705 - 11115 |
| *ICD10* | 1.0–2.0 | 1235 - 2470 |
| Cerebral palsy | 0.2 | 247 |
| Epilepsy | 0.3 | 370 |
| Autism: | | |
| *All children* | 1 | 1235 |
| *School-aged children* | 0.9 | 1111 |
| Specific learning difficulties | 1 | 1235 |
| Moderate learning difficulties | 2 | 2470 |
| Severe learning difficulties | 0.4 | 494 |
| Profound learning difficulties | 0.1 | 123 |
| Speech, language and communication needs | 1.7 | 2099 |
| Hearing impairment | 0.2 | 247 |
| Visual impairment | 0.2 | 247 |
| Multi-sensory impairment | 0.01 | 12 |
| Physical disability | 0.4 | 494 |
| Other (unspecified) | 0.4 | 494 |

The prevalence of SEND can be identified from the annual Department for Education school census on Special Educational Needs and Disabilities and reported at Local Authority level. Worcestershire has a significantly higher proportion of school pupils with SEN in 2018, 15.2% of all school pupils had a SEN need. This has been consistently significantly higher than England from 2014 onwards.

Figure 9: Pupils with special educational needs (SEN): % of school pupils with SEN in Worcestershire




Source: Department for Education, School Census

We can project the future numbers of pupils with Special Educational Needs and Disabilities for the next 20 years by combining the numbers of children with SEND from the School Census dataset with the latest population projections from the ONS (2014 based). The projections can be interpreted as an assessment of the impact of population change on the number of children with SEND. There will in reality be a number of other influences on future numbers such as policy change, change in the health levels of the population.

SEND Projections (4-19 years): Over the period 2017 to 2037 there is forecast to be an increase of 4.1% (n.308) for males and 4.6% (n.175) for females in the numbers of SEND. The next four years may see some significant changes in the numbers of SEND pupils as a result of forecast population change. The number of boys with SEND is forecast to increase by 2.7% (n.251) between 2017 and 2021 and the number of girls may increase by 4.4% (n.149).

Early Years Projections (2-4 years): In these projections there is little change anticipated in the numbers of SEND in the five years to 2022, followed by a gradual increase over the following 15 years of approximately 10% (n.53). This contrasts with the pattern for school children in that the increase occurs between 2022 and 2037 rather than between 2017 and 2022.

There is an implicit assumption in these projections that the prevalence of SEND pupils in the population will remain constant. In reality this is unlikely to be the case, as this will be affected by changes in the general health of the population as well as changes in the extent to which disabilities in children are diagnosed.

## 11. Children in need of help and protection

Children in need of help and protection are those assessed and supported through children's social care. Children in need have safeguarding and welfare needs, and include

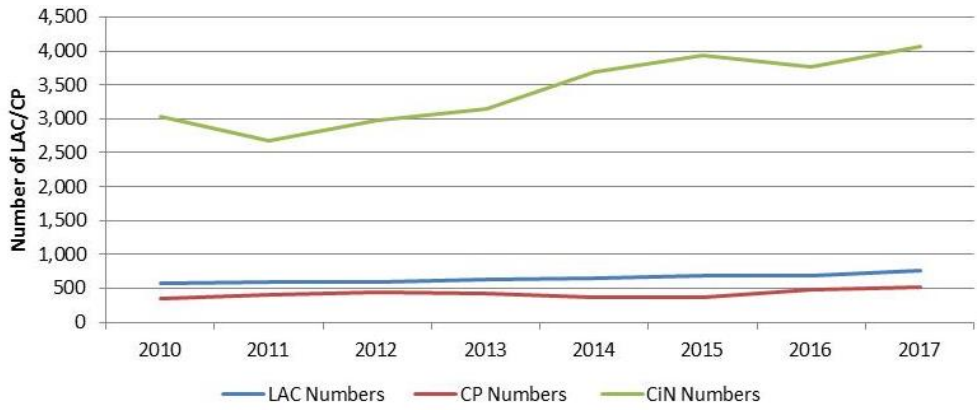
- Children on child in need plans
- Children on child protection plans
- Looked after children
- Young carers
- Disabled children

All of these children have needs identified through a children's social care assessment or because of their disability and means they are expected to require services and support in order to have the same health and development opportunities as other children. It is estimated that in any year around 6% of all children in England will be in need at some point. A recent review of children in need found that at least 1 in 10 pupils in state schools between 2016 and 2017 had been in need at some point in the previous 6 years and that pupils who had been in need at any point had worse educational outcomes than pupils who were not and that there is a lasting negative impact beyond the point of being in need[20].

[20] Children in need: preliminary longitudinal analysis, Department for Education, December 2018

The total numbers of children in need of help and protection have increased in Worcestershire over the last five years. Figure 10 highlights the increase in numbers of vulnerable children in all three categories.

Figure 10: Numbers of Children in need of help and protection 2010 to 2017

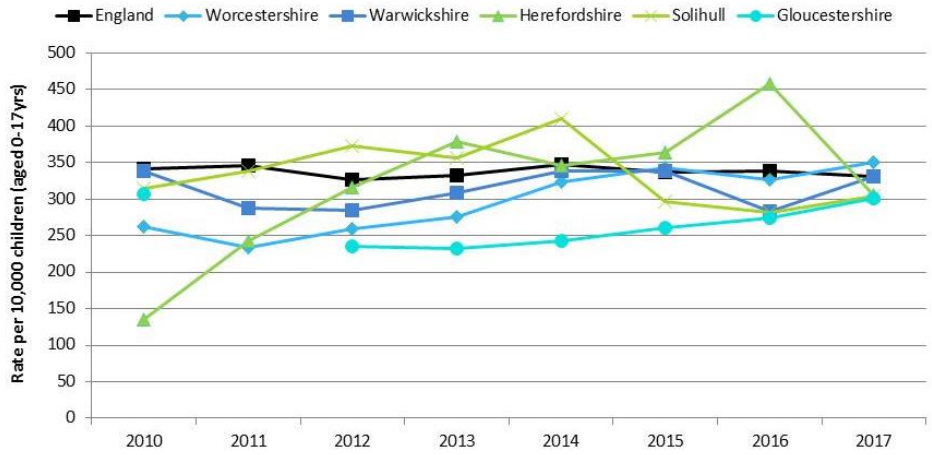



*Source: Department for Education, Characteristics of Children in Need, Children Looked after in England*.

### 11.1. Children in Need

Figure 11 shows the rate of Children in need (CIN) as at 31st March between 2010 and 2017 comparing Worcestershire to England and its statistical neighbours. Worcestershire has seen an increase over the last few years which has brought the rate of CIN to the highest of the areas compared.

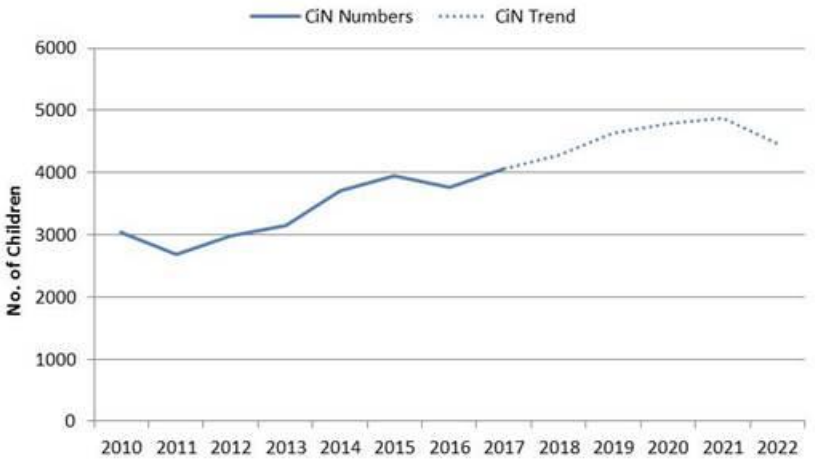
Figure 11 Children in Need compared to England and Statistical Neighbours (2010-2017)




Source: Department for Education, Characteristics of Children in Need

The numbers of CIN have increased year on year over the last five years from 3000 (3% of the CYP population) to over 4000 (3.5%). If numbers of CIN continue to increase at the same rate over the next five years, they could rise up to nearly 5000 children (over 4%).

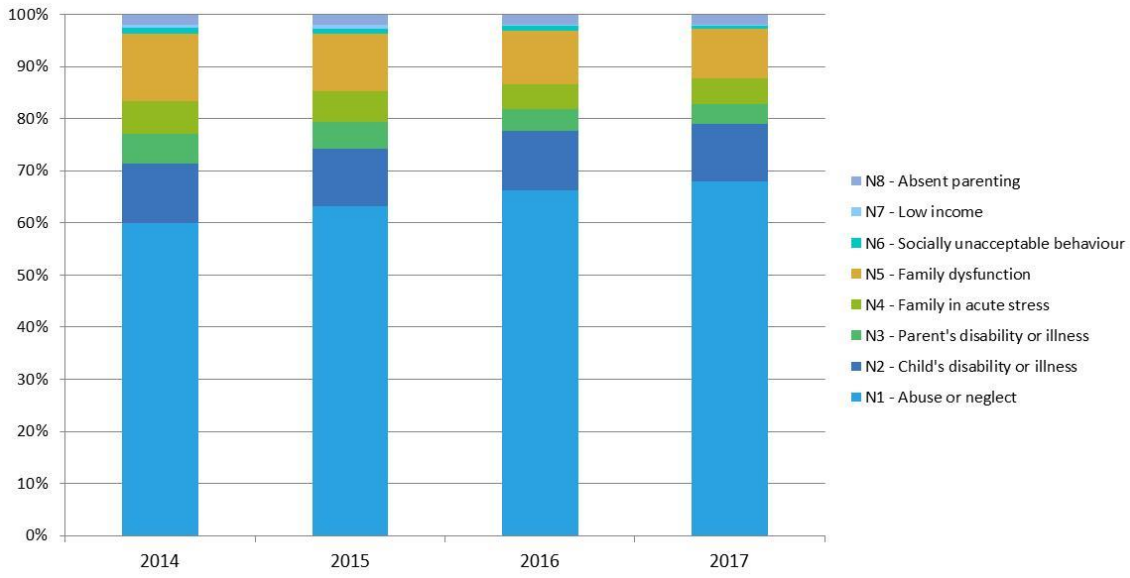
Figure 12: Children in Need Numbers with Projections to 2022




*Source: Department for Education, Characteristics of Children in Need, Children Looked after in England*.

By far the largest majority of CIN are due to concerns that the child is subject to abuse or neglect and this majority is rising year on year. 70% of children in need have abuse or neglect as the primary need identified. This is followed by 11% whose need was due to a child's disability/illness and 10% due to family dysfunction.

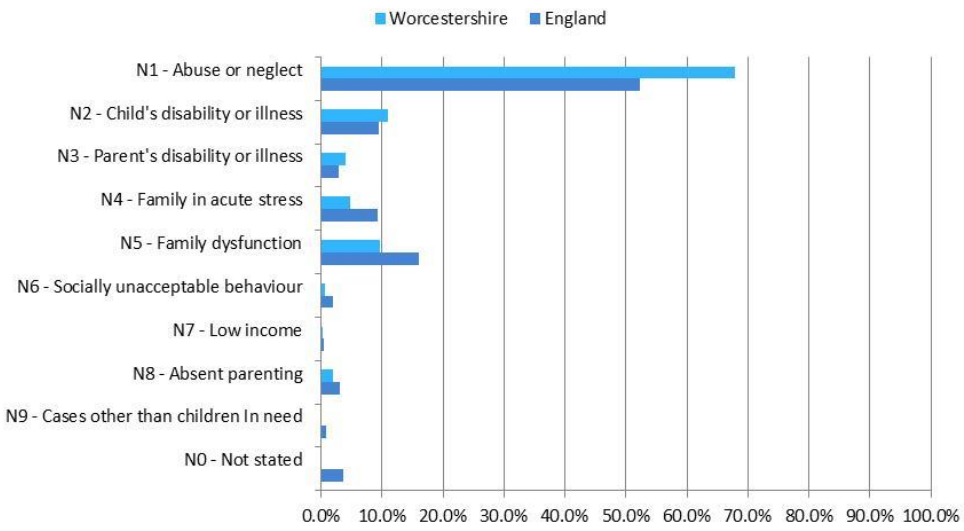
Figure 13: Primary Reason for Children in Need referral (2014 to 2017)




*Source: Department for Education, Characteristics of Children in Need*

Worcestershire has a significantly higher percentage of children whose primary need was abuse or neglect than England (68% compared to 52%). This accounts for over 2,750 of the 4,000 children flagged as CIN. The next largest category is child's disability or illness with 450 children identified in Worcestershire.

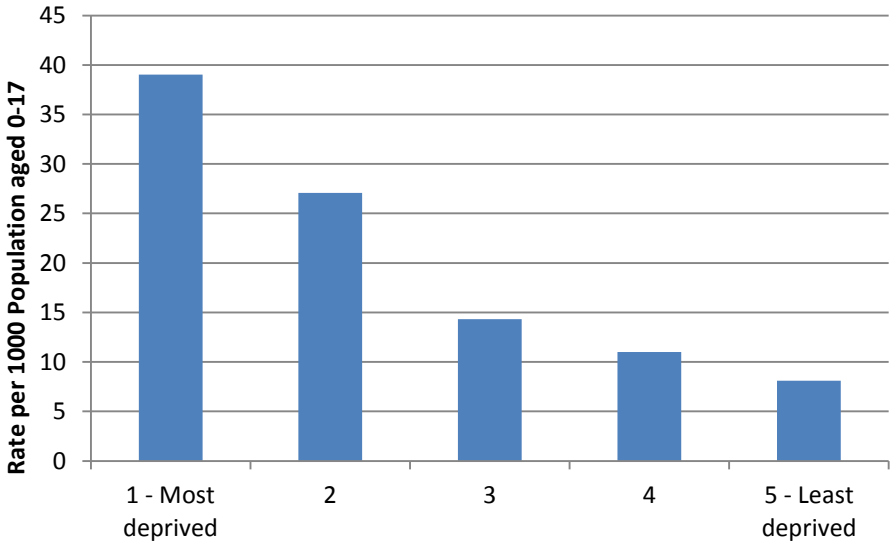
Figure 14: Primary Reason for Children in Need referral in Worcestershire compared to England (2017)




Source: Department for Education, Characteristics of Children in Need

There is a strong relationship with CIN and deprivation. The CIN rate in the most deprived quintile in Worcestershire is 5 times as high as children from the least deprived quintile.

Figure 15: Children in Need as at 31st March 2018 in Worcestershire by Deprivation Quintile

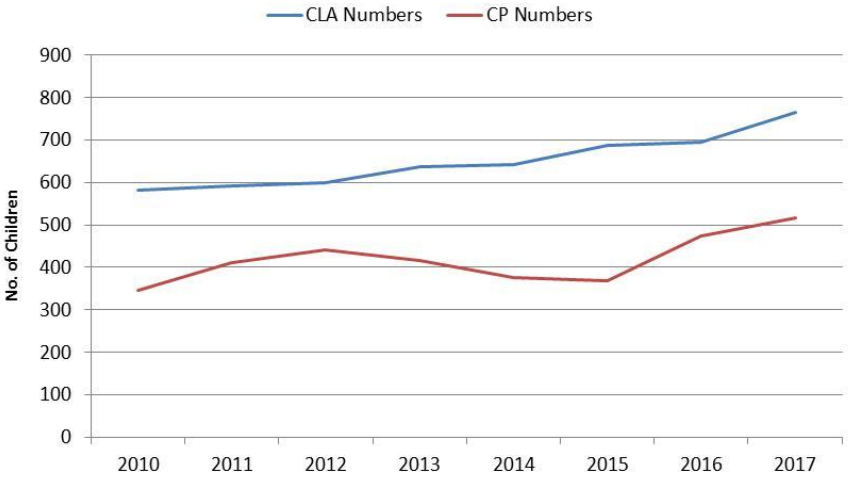



Source: Department for Education, Characteristics of Children in Need

### 11.2. Children Looked After

Figure 16 provides the numbers of Children Looked After (CLA) and numbers of children who were the subject of a child protection plan (CP) for Worcestershire from 2005 to 2017. The data are based on a snapshot of numbers at the 31st March each year. The chart shows that the number of CLAs has increased steadily year on year and the numbers of CP increased up until 2012, declined for three years but has increased again over the last couple of years.

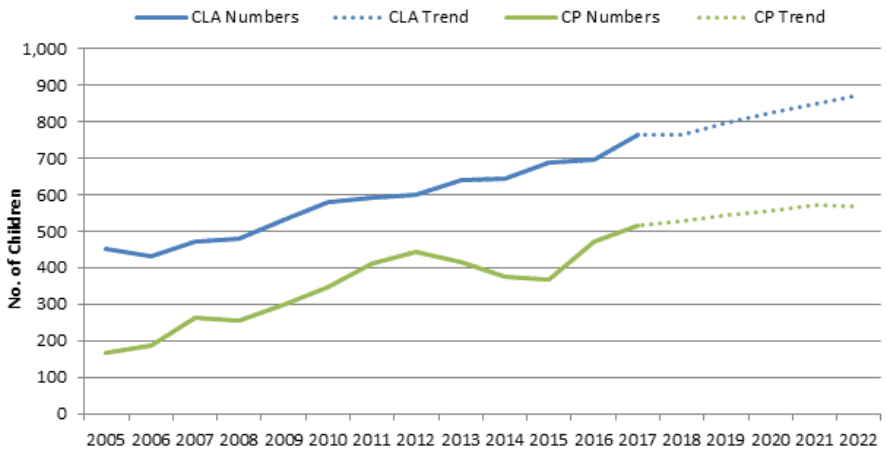
Figure 16: Total Number of CLA and CP in Worcestershire




Source: Department for Education, Characteristics of Children Looked After

The numbers of CLA have increased year on year over the last twelve years from less than 500 to almost 800 children. The numbers of CP have increased from less than 200 to over 500 during the same period. If numbers continue to increase at the same rate over the next five years, they could rise up to nearly 900 CLA and almost 600 CP by 2022.

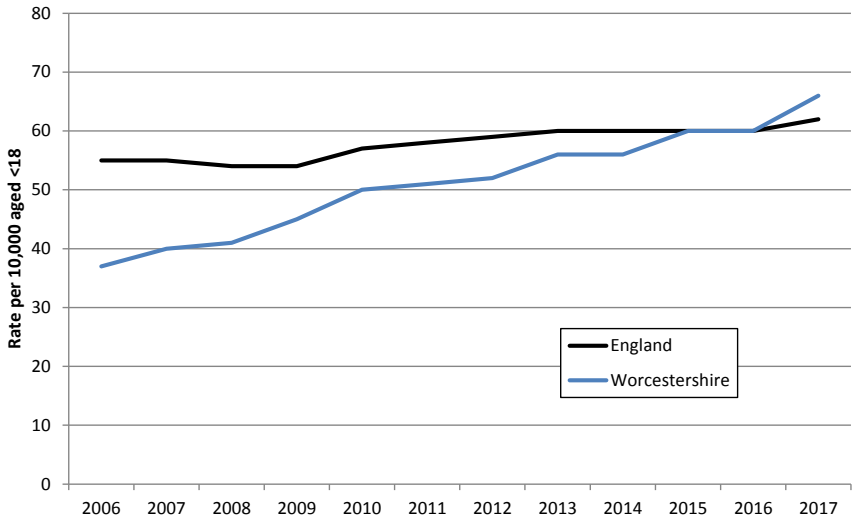
Figure 17: Trends over time for numbers of CLA and CP in Worcestershire




Source: Department for Education, Characteristics of Children Looked After

The CLA rate in Worcestershire has also increased at a faster rate than the national average. The Worcestershire rate has increased over the past decade to reach and now overtake the England rate (Figure 17).

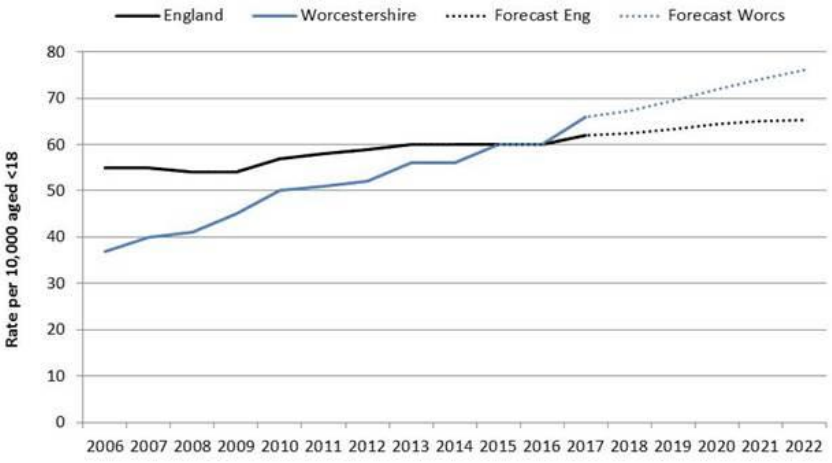
Figure 18: Children Looked After (CLA) rate per 10,000 persons aged <18




*Source: Department for Education, Characteristics of Children Looked After*

The trend graph below based on the historical increased rates suggests the Worcestershire CLA rate could continue to rise at a faster rate than England.

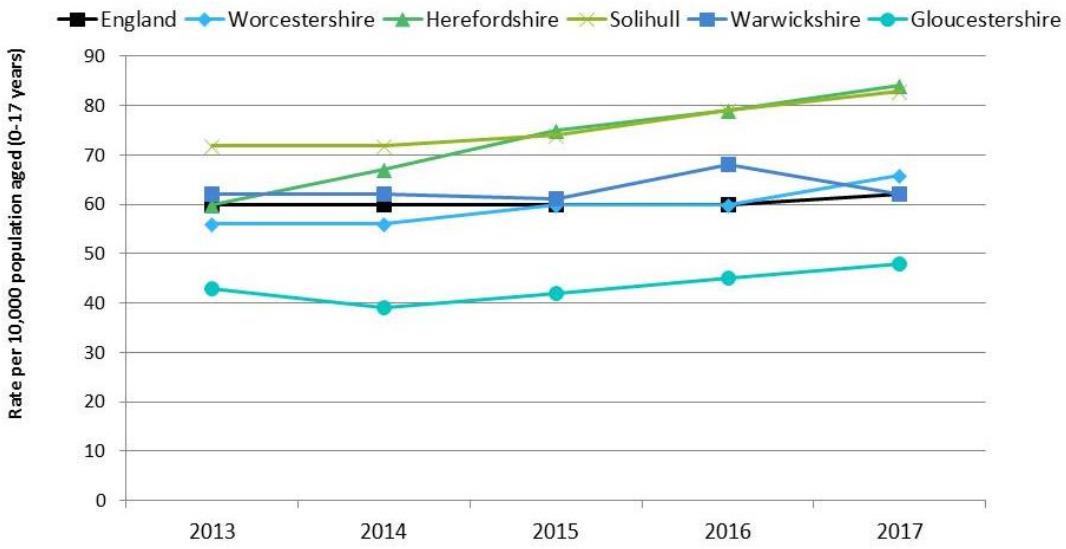
Figure 19: Children Looked After (CLA) rate per 10,000 persons aged <18 with Forecast to 2022




*Source: Department for Education, Characteristics of Children Looked After*

Although in 2017 Worcestershire had a higher rate than the England average, when compared to statistical neighbours, Worcestershire had the median value of the 5 statistical neighbouring areas with neighbouring Herefordshire and Solihull having much higher rates (Figure 20).

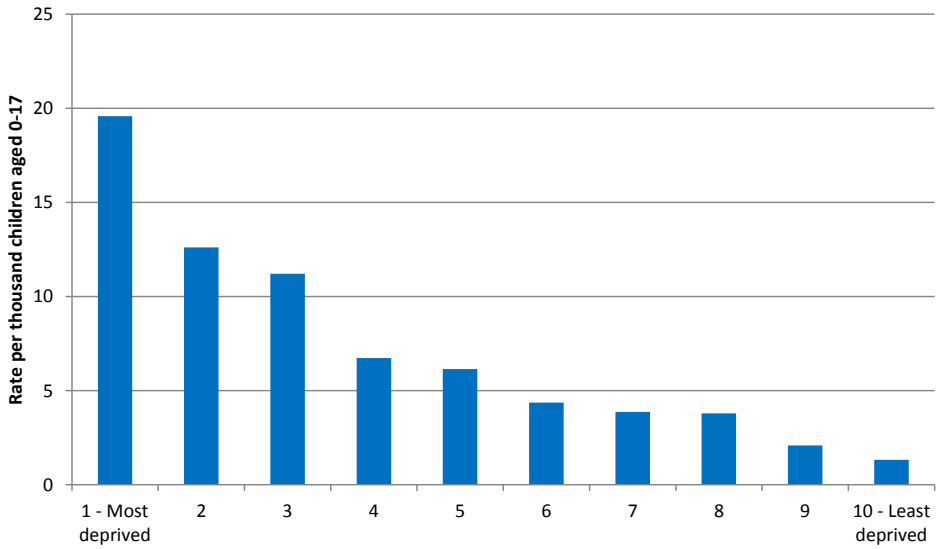
Figure 20: Children Looked After as at 31st March – Rate per 10,000 children aged <18 (2013 – 2017)




*Source: Department for Education, Characteristics of Children Looked After*

There is a strong relationship with deprivation for CLA. An analysis of an extract for children looked after as at 31st March 2018, identified that the rate per thousand population in the most deprived areas of Worcestershire is nearly 20 children per thousand compared with a rate of a little over 1 per thousand in the least deprived areas.

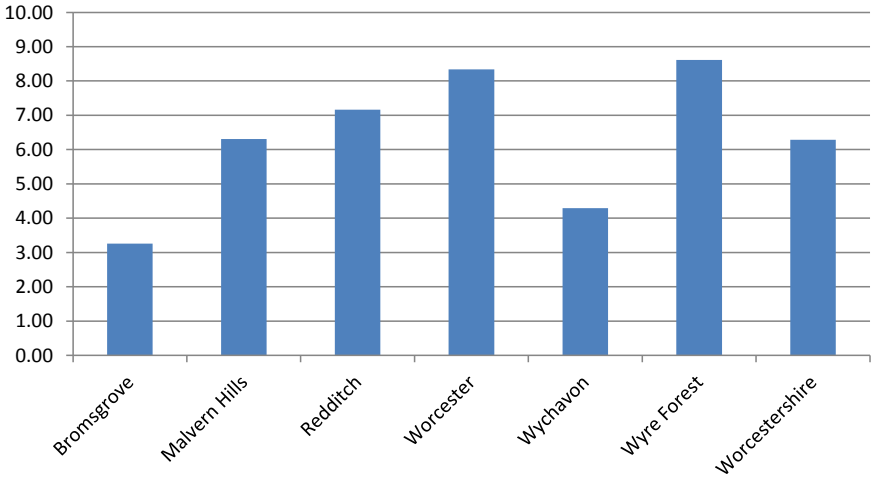
Figure 21: Children Looked After by Deprivation Decile in Worcestershire as at 31st March 2018




*Source: Department for Education, Characteristics of Children Looked After*

A further analysis of the CLA rate per thousand population using the annual snapshot data as at 31st March 2018 looked at geographical area. As expected, rates are higher in the more deprived Council District areas (Wyre Forest, Worcester City and Redditch).

Figure 22: CLA as a rate per Thousand Population aged 0-17 by Council District area in Worcestershire as at 31st March 2018

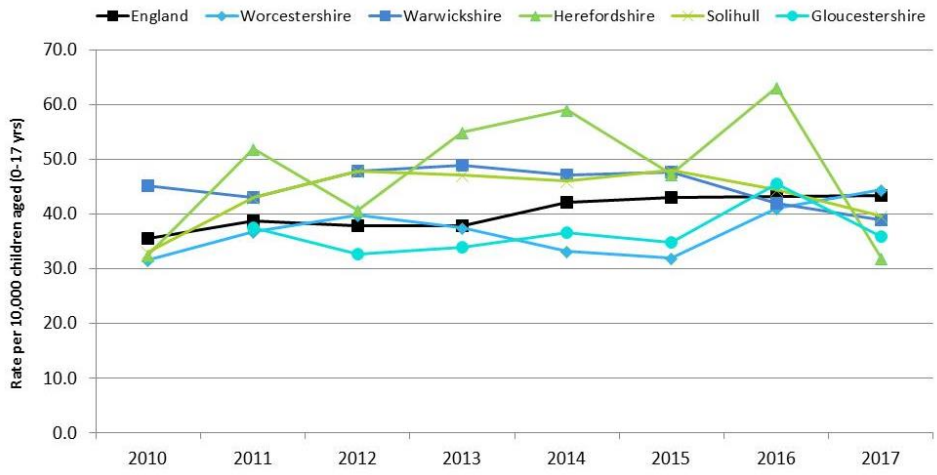



Source: Department for Education, Characteristics of Children Looked After

### 11.3. Child Protection Plans

Figure 23 shows the rate of children subject to a child protection plan as at 31st March between 2010 and 2017 comparing Worcestershire to England and its statistical neighbours. Worcestershire has seen an increase over the last two years which has brought the rate to the highest of the areas compared in 2017.

Figure 23: Children Subject to a Child Protection Plan (2010 - 2017)

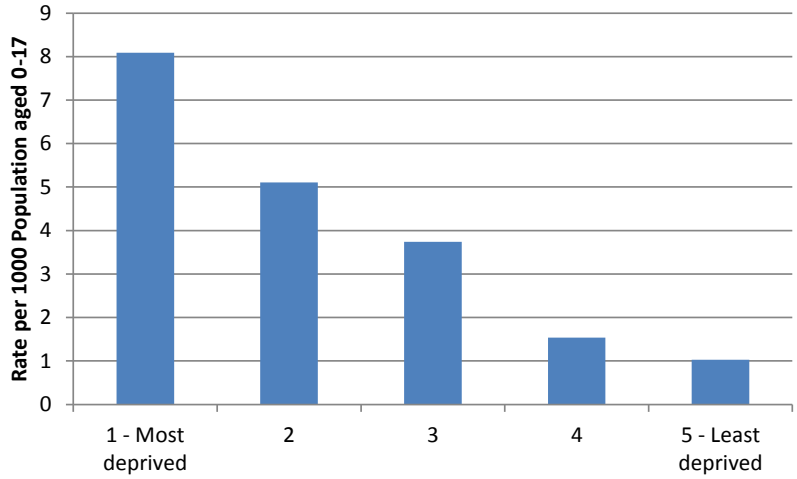



*Source: Department for Education, Characteristics of Children Looked After*

Looking at the reasons for children having a child protection plan, the largest category for children subject to a child protection plan was neglect, closely followed by emotional abuse.

An extract was analysed for children subject to a child protection plan as at 31st March 2018, to identify the rate per thousand population by deprivation quintiles. The CP rate in the most deprived areas of Worcestershire is 8 children per thousand compared with a rate of 1 per thousand in the least deprived areas.

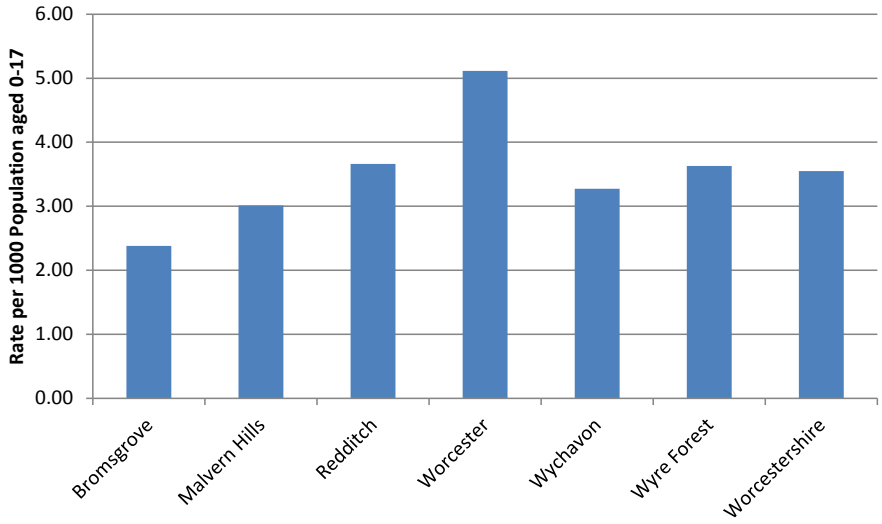
Figure 24: Children subject to a Child Protection Plan by Deprivation Quintile in Worcestershire as at 31st March 2018




Source: Department for Education, Characteristics of Children Looked After

A further analysis of the CP rate per thousand population using the annual snapshot data as at 31st March 2018 looked at geographical area. The rate is highest in Worcester City District.

Figure 25: CPP as a rate per Thousand Population aged 0-17 by Council District area in Worcestershire as at 31st March 2018




Source: Department for Education, Characteristics of Children Looked After

### 11.4. Children with Mental Health Difficulties and Poor Emotional well-being

Nationally it is estimated that 50% of those with a lifetime mental illness will experience symptoms by the age of 14, 75% of those will experience symptoms by the age of 24. There are differences by gender, boys aged 11-15 are 1.3 times more likely to have a mental illness compared to girls aged 11-15 years[22]. Around 10% of children aged 5-16 suffer from a clinically significant mental health illness and just 25% of children who need treatment, go on to receive it. In a national report, Mental Health of Children and Young People in England[21] (2017) it is estimated that in the UK:

- Around one in eight (12.8%) children and young people had a diagnosable mental health disorder.
- The prevalence for Emotional Disorders was 5.8% for children aged 5-15 years, this increased significantly for ages 17-19 where around one in four girls (22.4%) had an emotional disorder, of this proportion, around half had also self-harmed.
- Around 1 in 20 young people had self-harmed (5.5%). Rates of self-harm were over twice as high in girls in comparison to boys (7.3% compared to 3.6%). Increasing to around 1 in 5 in girls aged 17-19 (21.5%) and 1 in 10 for boys aged 17-19 (9.7%).
- Around 1 in 3 (34%) children with an emotional disorder had ever self-harmed or attempted suicide.
- Mental health disorders were found to be associated with low income, parental mental health, adverse life events, lower levels of social support and participation and less healthy family functioning.
- An association was found between daily social media use and having a mental health disorder. Those with a disorder were more likely to use social media on a daily basis and for longer periods of time, compared to those without.
- In the last year 1 in 5 children and young people aged 11 to 19 year olds had been bullied online in the past year, rates were higher in girls (25.8%) in comparison to boys (16.7%) and those young people with a mental disorder were twice as likely to have experienced this as those without a disorder.

[21] NHS Digital (2018) Mental Health of Children and Young People in England 2017, [Online], Accessed: 14/12/2018, Available from: https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2017/2017

### 11.5. Estimated Prevalence in Worcestershire for Mental Health and Behavioural Problems

Prevalence estimates for different types of mental health and behavioural problems are presented in the table below. The estimates were published by Public Health England[22] and have been applied to ONS local mid-year population estimates to identify how many individuals may be living with a particular type of condition in Worcestershire. These figures are provided to give an indication of numbers.

Based on national prevalence estimates, in Worcestershire there are estimated to be:

- 2565 Children aged 5-16 who are living with Anxiety Disorders
- 1179 Children aged 5-16 living with ADHD
- 4558 Children aged 5-16 who are living with Conduct Disorders
- 613 Children aged 5-16 who are living with Depression
- 781 Children aged 5-16 who self-harm

Table 5: National Prevalence Estimates for Common Mental Health Disorders and Estimated Number of Children in Worcestershire

| Type | National Prevalence Estimate | | | Estimated Numbers of Children in Worcestershire by Age | | |
|---|---|---|---|---|---|---|
| | 5-10 | 11-16 | 5-16 | 5-10 | 11-16 | 5-16 |
| Anxiety Disorders | 2.2 | 4.4 | - | 892 | 1673 | 2565 |
| ADHD | - | - | 1.5 | - | - | 1179 |
| Conduct Disorders | - | - | 5.8 | - | - | 4558 |
| Depression | 0.2 | 1.4 | - | 81 | 532 | 613 |
| Self Harm | 0.8 | 1.2 | - | 325 | 456 | 781 |

*Source: PHE 2017[22], ONS 2017 Mid-year population estimates*

### 11.6. Substance Misuse

A higher proportion of young people misuse drugs and alcohol than in the general population: 18% of 16-24 year olds reported using a drug in the past year. Estimates from NHS digital annual survey of over 12000 11-15 year olds in secondary school in 2017 indicated that 3% of young people were regular smokers, 10% had drunk alcohol in the past week and 10% had taken drugs in the past month. However there was a significant increase in the number of young people that had ever taken drugs at 24% which was an increase from 15% in 2014. Overall 57% of pupils said that they had smoked, drank alcohol or taken drugs on at least one occasion and the likelihood increased with age to 81% of 15 year olds. They were most likely to have taken cannabis, although prevalence use had reduced to 8% compared with 13% in 2001. 34% of black pupils had taken drugs compared with

[22] Public Health England (2016) The Mental Health of Children and Young People in England. [Online], Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575632/Mental_health_of_children_in_England.pdf , Accessed: 22/10/2018

23% of white pupils. Factors associated with drug use included smoking, truancy, exclusion and sanction from parents.

The national Drug Strategy 2017 reports on changing patterns of drug use for young people, notably an increase in use of psychoactive substances. Fewer people are entering specialist treatment. Notably, the numbers of young people using heroin requesting treatment has fallen substantially over the past 10 years. Other information from County Lines and elsewhere indicates that harmful substance misuse among young people is related to availability and access to drugs on the internet. Young people themselves may not be aware of the nature of tablets they are taking-but use them because they are offered by a friend or family members whom they trust. The chemical formulae of particular substance can change rapidly and associated harms can be linked to adulterants. The use of particular substances is frequently linked to culture which can either be associated with music or friendship networks. Evidence from County Lines describes the exploitation of vulnerable children and young people through association with criminal gang activity.

Young people's drug misuse overlaps with other vulnerabilities which can exacerbate risks of abuse and exploitation. In 2015-6, 17% of young people accessing specialist substance misuse services were not in education or training and 12% were looked after children. Most young people who have developed substance misuse problems may be reluctant to disclose it or be aware that this may be a response to other underlying stress or health issue which requires a different approach to reduce harm.

Home Office research referenced in ADEPIS[23] identifies key factors associated with increased drug taking for young people. These risk factors do not all carry equal weight and are inter-related. They cannot be regarded individually for reducing future drug use, but reducing those that are present may reduce the level of risk.

| Protective factors | Risk factors | | |
|---|---|---|---|
| | Belonging to a vulnerable group | Social and Cultural Factors | Interpersonal and Individual Risk factors |
| • Positive temperament<br>• Intellectual ability<br>• Positive and supportive family environment<br>• Social support system<br>• Caring relationship with at least one adult<br>• In education/ employment/ training | • Looked after children<br>• School non-attenders<br>• Mental health problems<br>• Drug misuse by parents<br>• Abuse within the family<br>• Homeless<br>• Young offenders<br>• Young sex workers | • High levels of neighbourhood poverty and decay<br>• High levels of neighbourhood crime<br>• Easy drug availability<br>• Widespread social acceptance of alcohol and drug use<br>• Lack of knowledge and perception of drug-related risks | • Physiological and psychological factors<br>• Family dysfunction<br>• Behavioural difficulties<br>• Academic problems<br>• Association with peers who use alcohol and drugs<br>• Early onset of tobacco smoking<br>• Early onset of alcohol and drug use |

Table 1: Risk and protective factors

[23] http://mentor-adepsis.org.uk/risk-protective-factors/

## 12. Vulnerable families with children

### 12.1. Domestic Abuse

Applying national prevalence estimates for 2016 (based on the Crime Survey for England and Wales) it is estimated that 19,336 people in Worcestershire were a victim of domestic abuse over the past 12 months.

Latest figures available for domestic abuse-related incidents and crimes recorded by the Police per 1000 population are 23.5 for the West Mercia Police Force area for 2016/17. This compares to 22.5 in England. In Worcestershire there were 4,952 reported cases of children being exposed to domestic abuse in 2017/18 (source: West Mercia Police). While police data is useful to give a local picture, It is widely recognised that domestic abuse continues to be under-reported, with many more offences committed than are reported to and recorded by the police (Domestic abuse in England and Wales: year ending March 2017, ONS)

### 12.2. Parental Substance Misuse

There are an estimated 1157 adults with an alcohol dependency who live with children in Worcestershire. A quarter of adults (25%) with an alcohol dependency are estimated to be in treatment, this is higher than the national average (21%)[24].

There are an estimated 643 adults with an opiate dependency who live with children in Worcestershire. Approximately 52% of adults with an opiate dependency are estimated to be in treatment, this is the same to the national average (52%)[24].

There are also people who have high risk alcohol use (35 units per week for women and over 50 units a week for men) or frequent drug use (more than once a month) or alcohol or drug use where there is a maladaptive pattern of use linked to impairment or distress. This is classified as non-dependent problematic patterns of drug use. Prevalence figures for non-dependent parental drug use are not currently available, but the Crime Survey for England and Wales, which is a household survey, found that around 1 in 12 (8.5%) adults aged 16 to 59 (2.8 million people) had taken a drug in the last year and many will have been parents[24].

In 2016-17, 17.2% of cases identified alcohol as a risk factor in children in need assessments this was lower than the regional (19.6%) and national average (18.0%), drug misuse episodes were identified in 14.9% of children in need assessments in Worcestershire, this was lower than the regional average (21.2%) and national average (19.7%)[24].

### 12.3. Maternal/parental mental health

In Worcestershire 70,000 adults and nearly 7,000 children are living with common mental ill-health at any time and 50 people take their own life each year. There is a high prevalence of depression in Worcestershire than nationally, with nearly 53,000 people aged over 18 on the GP Register (nearly

[24] Public Health England (2018) Parental alcohol and drug use: Understanding the problem: Parental drug and alcohol use toolkit for local authorities, [Online], Available from: https://www.gov.uk/government/publications/parental-alcohol-and-drug-use-understanding-the-problem Accessed 07/09/2018

11% of the total adult population). Despite the general prosperity in Worcestershire there are pockets of high deprivation presenting a number of risks to mental health and well-being

The physical and mental health of the mother, and the family environment during pregnancy, infancy and childhood is of fundamental importance to mental health. A parent's ability to bond with and care for their baby, their parenting style and the development of a positive relationship can predict a number of physical, social, emotional and cognitive outcomes through to adulthood[4].

While the relationship between mother and child is particularly important, the mental health of fathers and other caregivers should also be considered. Paternal and maternal depression is shown to have a negative impact on how parents interact with children[4] and can have long-term consequences if left untreated[1].

Perinatal mental health problems affect between 10 to 20% of women during pregnancy and the first year after having a baby[25]. During pregnancy and the year after birth, many women experience common mild mood changes. Some women can be affected by common mental health problems, including anxiety disorders (13%) and depression (12%)[2]. The risk of developing a severe mental health condition such as postpartum psychosis (which affects between 1 and 2 in 1000 women who have recently given birth[1]), severe depressive illness, schizophrenia and bipolar illness is low but increases after childbirth. The impact of poor mental health can be greater during this period, particularly if left untreated[5].

Table 6: Estimates of Numbers of Women in Worcestershire experiencing peri-natal mental health problems (2015-16)

| Indicator | No. | Comments |
|---|---|---|
| Postpartum psychosis | 15 | |
| Chronic SMI in perinatal period | 15 | |
| Severe depressive illness in perinatal period | 175 | |
| Mild-moderate depressive illness and anxiety in perinatal period | 575 - 860 | Upper and lower estimates |
| PTSD in perinatal period | 175 | |
| Adjustment disorders and distress in perinatal period | 860 - 1715 | Upper and lower estimates |

*Source: Public Health England, Perinatal Mental Health Toolkit*

In addition to the direct impact on families, it is estimated that perinatal mental health problems cost the NHS and social services around £1.2 billion annually. A significant proportion of this cost relates to the impact on the child.

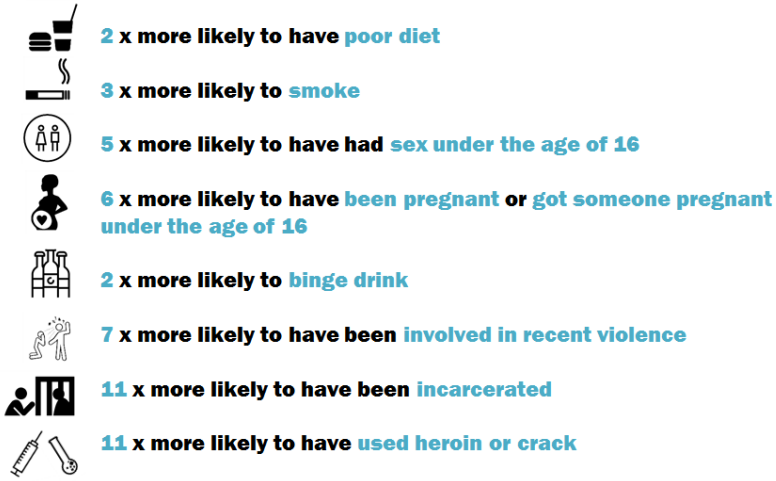
[25] GOV.UK (2018) Perinatal Mental Health [Online] Available from: https://www.gov.uk/government/publications/better-mental-health-jsna-toolkit/4-perinatal-mental-health Accessed 13/12/2018

### 12.4. Adverse Childhood Experiences (ACEs)

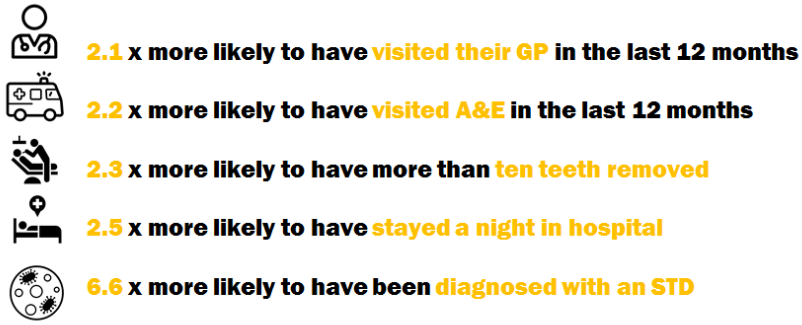
Adverse Childhood Experiences (ACEs) are stressful events occurring in childhood including; domestic violence, parental abandonment through separation or divorce, a parent with a mental health condition, being the victim of abuse (physical, sexual and/or emotional), being the victim of neglect (physical and emotional), a member of the household being in prison, growing up in a household in which there are adults experiencing alcohol and drug use problems. Adverse Childhood Experiences (ACEs) can significantly affect physical, mental and personal well-being throughout life. The study by Bellis et al (2014[7]) identified that approximately 47% of individuals reported experiencing at least one ACE. 9% of individuals reported having 4 or more ACEs.

A UK based study undertaken by Bellis et al in 2013[26] also identified that individuals with 4 or more ACEs were more likely to have a higher number of risky health behaviours and in turn have poorer health outcomes compared to those without ACEs.

Individuals with 4 or more ACEs, when compared to those with no ACEs were:




A further recent study found that ACEs also impact upon use of services – Individuals with 4 or more ACEs compared with those with no ACEs were[28]:



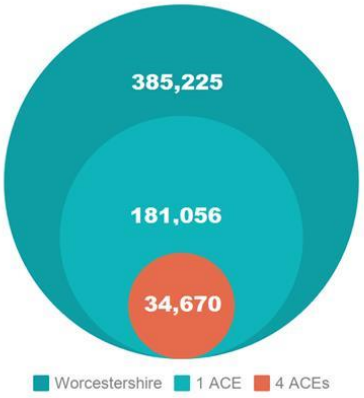

*Source: Adapted from Presentation An introduction to Adverse Childhood Experiences, Public Health England, 2018*

[26] Bellis, M., Lowey, H., Leckenby, N., Hughes, K. and Harrison, D. (2013). Adverse childhood experiences: retrospective study to determine their impact on adult health behaviours and health outcomes in a UK population. *Journal of Public Health*, 36(1), pp.81-91.

64% of Substance Misuse Service Users have 4 or more ACES[27],[28].
50% of Homeless people have 4 or more ACEs.

Hughes et al., 2017[29] identified that exposure to multiple ACEs can have an impact upon a wide range of health outcomes. The strongest correlation between multiple ACEs and onward transfer of ACEs to future generations were found in those who experienced violence, mental illness and problematic substance abuse in the family environment.
By applying these proportions to the population living in Worcestershire it can be estimated that there are around 181,056 people who have experienced at least 1 ACE and 34,670 who have experienced 4 or more ACEs during their lifetime.

Figure 26: Estimates for individuals aged 18-70 years who have experienced ACEs in Worcestershire




*Source: Bellis et al, ACES Study and ONS Mid-year Population Estimates. Bespoke Public Health Analysis.*

Research into adverse childhood experiences (ACEs) has furthered our understanding of the long-term impact of multiple risk factors within a child's home environment. ACEs include abuse or neglect, exposure to domestic violence, parental substance misuse and parental mental health problems. Studies have confirmed a strong association between the number of ACEs and the risk of mental health problems, chronic diseases, involvement in crime and other poor outcomes in later life. They also indicate that ACEs are highly prevalent: at least a quarter of the population have experienced four or more adverse experiences during childhood.

However, ACEs are not predictive at an individual level, and cannot tell us who might need early intervention or other support. An ACE score is retrospective, and because the impacts of early life adversity differ widely from person to person, it does not necessarily reflect a person's current situation, needs or risks. ACEs should not be used in isolation to determine who should receive early intervention, and an ACE score is not a substitute for careful assessment of current needs.

[27] Bellis, M., Hughes, K., Leckenby, N., Perkins, C. and Lowey, H. (2014). National household survey of adverse childhood experiences and their relationship with resilience to health-harming behaviors in England. *BMC Medicine*, 12(1).

[28] Bellis, M., Hughes, K., Hardcastle, K., Ashton, K., Ford, K., Quigg, Z. and Davies, A. (2017). The impact of adverse childhood experiences on health service use across the life course using a retrospective cohort study. *Journal of Health Services Research & Policy*, 22(3), pp.168-177.

[29] Hughes, K., Bellis, M., Hardcastle, K., Sethi, D., Butchart, A., Mikton, C., Jones, L. and Dunne, M. (2017). The effect of multiple adverse childhood experiences on health: a systematic review and meta-analysis. *The Lancet Public Health*, 2(8), pp.e356-e366.

### 12.5. Prevalence and Characteristics of Troubled Families in Worcestershire

The National Troubled Families Programme identifies and works with families to address a number of problems including: domestic abuse, physical and mental health problems, crime, worklessness and debt. All services working with children and their families are encouraged to act early and offer whole family support and engagement, to help families improve their lives and stop problems becoming worse[30]. A list of the six troubled families' domains is detailed below[31]:

1. Worklessness and Financial Exclusion – Adults out of work or at risk of financial exclusion, or young people at risk of worklessness.
2. Education and School Attendance – Children not attending school regularly.
3. Children Who Need Help – Children of all ages, who need help, identified as in need or subject to a Child Protection Plan.
4. Health – Parents or children with a range of health problems (including drug or alcohol abuse).
5. Crime and Anti-Social Behaviour – Parents or children involved in crime or antisocial behaviour.
6. Domestic Abuse – Families affected by domestic violence and abuse

The latest national report for 2017-18 stated that the Troubled Families programme was reaching families with complex needs and multiple problems. It identified the following characteristics when compared to the general population:

- Children were almost 8 times more likely to be classed as a child in need
- Adults were seven times more likely to have a caution or conviction
- Adults were five times more likely to be claiming benefits
- Children were nearly three times more likely to be persistently absent from school
- Over two fifths of troubled families had a family member with a mental health problem
- Just under a quarter of troubled families had a family member affected by an incident of domestic abuse and violence.

Of the 6 Troubled Families domains every family will have at least two of the following problems to be eligible: Worklessness and financial exclusion (including debt); Education: Truancy and poor school attendance; crime and antisocial behaviour; domestic abuse; children who need help (including Children in Need); mental and physical health issues[30]. The data presented in this section is a snapshot in time of all families who have been identified as eligible as part of the Worcestershire troubled families programme. The data is triangulated from a number of different data sources including Department for Work and Pensions, Police, Young Offenders Services and cross matched against the local Children's Case Management system Framework-i and Education system ONE by Worcestershire County Council. Data from Framework-i identifies children and young people who have been open to Social Care and/or Targeted Family Support and, through Early Help Assessment, will identify additional issues related to for example, Domestic Abuse and Health, including mental

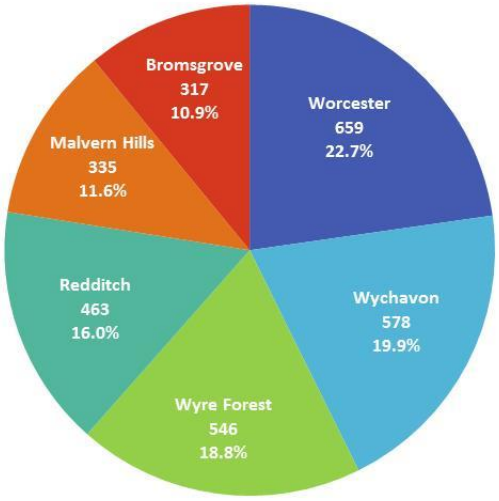
[30] Ministry of Housing, Communities and Local Government (2018), Supporting disadvantaged families Annual report of the Troubled Families Programme 2017-18, [Online], Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/694362/CCS207_CCS0318142796-1_Un_Act_Troubled_Families_AR_2017-18_Accessible__2_.pdf , Accessed: 17/08/2018

[31] Department for Communities and Local Government (2017) National evaluation of the Troubled Families Programme 2015 - 2020: family outcomes – national and local datasets: part 1, [Online], Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/605185/Family_outcomes_-_national_and_local_datasets.pdf , Accessed: 17/09/2018

health and substance misuse. As such the data contained in this section needs to be treated with caution as it a snapshot at a period in time (August 2018) and is not necessarily complete.

As at August 2018 there were a total of 2989 families in Worcestershire so far identified as eligible with 2 or more of the troubled families' domains. Figure 27 below shows the breakdown of eligible families by district area in Worcestershire. The largest number of families identified came from the Worcester City area (659) and the lowest from Bromsgrove (317). Note that this breakdown only represents the breakdown of eligible families identified for the local Troubled Families programme. The total number of families across Worcestershire is not known and therefore rates by district cannot be calculated.

Figure 27: Eligible Troubled Families identified in Worcestershire by District Area as at August 2018




*Source: Worcestershire County Council, Troubled Families Programme*

Table 7 shows the number of families who have 2 or more of the troubled families criteria identified as well as the percentage of the number of problems identified. Areas highlighted in grey show where there are a higher proportion of families meeting a number of criteria than the Worcestershire average. Bromsgrove (4.4%), Redditch (5.0%) and Wyre Forest (5.1%) all had a higher proportion of families who experienced 6 of the criteria in comparison to the Worcestershire average (4.2%).

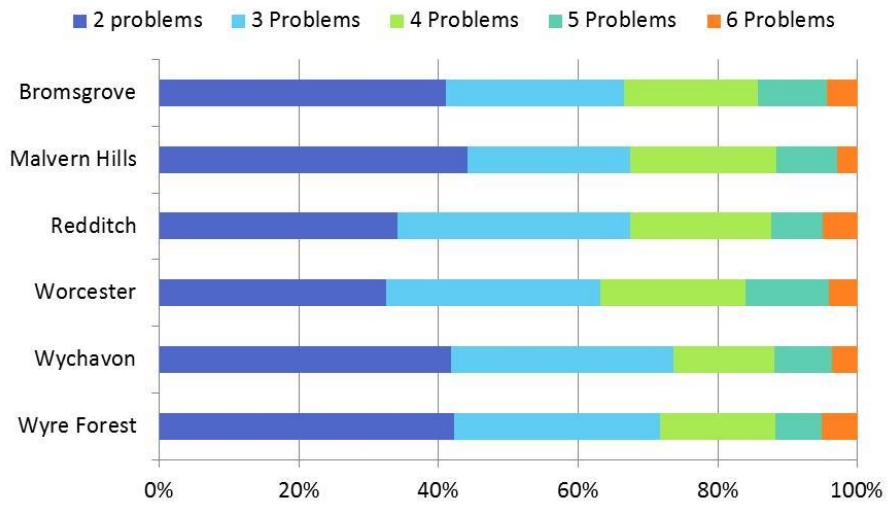
Table 7: Eligible Troubled Families in Worcestershire by District and number of criteria, as at August 2018.

| | No. of Families eligible for Troubled Families Programme | | | | | |
|---|---|---|---|---|---|---|
| **District** | **2 problems** | **3 Problems** | **4 Problems** | **5 Problems** | **6 Problems** | **Total** |
| Bromsgrove | 130 | 81 | 61 | 31 | 14 | **317** |
| % of all eligible families in area | **41.0%** | 25.6% | **19.2%** | **9.8%** | **4.4%** | |
| Malvern Hills | 148 | 78 | 70 | 29 | 10 | **335** |
| % of all eligible families in area | **44.2%** | 23.3% | **20.9%** | 8.7% | 3.0% | |
| Redditch | 158 | 154 | 94 | 34 | 23 | **463** |
| % of all eligible families in area | 34.1% | **33.3%** | **20.3%** | 7.3% | **5.0%** | |
| Worcester | 214 | 202 | 137 | 79 | 27 | **659** |
| % of all eligible families in area | 32.5% | **30.7%** | **20.8%** | **12.0%** | 4.1% | |
| Wychavon | 242 | 184 | 83 | 48 | 21 | **578** |
| % of all eligible families in area | **41.9%** | **31.8%** | 14.4% | 8.3% | 3.6% | |
| Wyre Forest | 231 | 161 | 90 | 36 | 28 | **546** |
| % of all eligible families in area | **42.3%** | 29.5% | 16.5% | 6.6% | **5.1%** | |
| **Total** | **1123** | **860** | **535** | **257** | **123** | **2898** |
| % | 38.8% | 29.7% | 18.5% | 8.9% | 4.2% | |

*Source: Worcestershire County Council, Troubled Families Programme*

Figure 28 indicates that Redditch and Worcester have a higher proportion of families who meet 3 or more criteria.

Figure 28: Eligible Troubled Families in Worcestershire by District and number of criteria as at August 2018.




*Source: Worcestershire County Council, Troubled Families Programme*

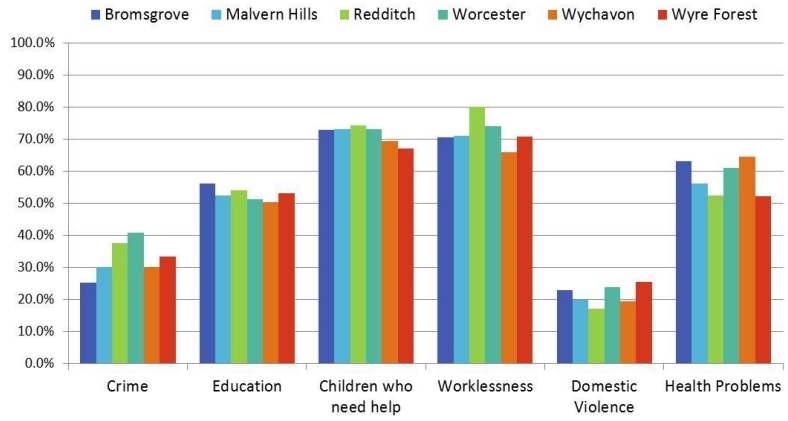
Table 8 shows that the main criteria for eligible families in Worcestershire was Worklessness (72.1%) followed closely by Children who need help (71.5%). Worklessness was highest in Redditch (80.1%), Crime was highest in Worcester (40.8%), Problems relating to education were highest in Bromsgrove (56.2%), Domestic Violence in Wyre Forest (25.6%) and health issues were highest in Wychavon (61.0%).

Table 8: % of eligible Troubled Families identified by District area and Troubled Families criteria as at August 2018

| District | Crime | Education | Children who need help | Worklessness | Domestic Violence | Health Problems |
|---|---|---|---|---|---|---|
| Bromsgrove | 25.2% | 56.2% | 72.9% | 70.7% | 23.0% | 63.1% |
| Malvern Hills | 30.1% | 52.5% | 73.1% | 71.0% | 20.0% | 56.1% |
| Redditch | 37.6% | 54.2% | 74.3% | 80.1% | 17.1% | 52.5% |
| Worcester | 40.8% | 51.4% | 73.3% | 74.1% | 24.0% | 61.0% |
| Wychavon | 30.1% | 50.5% | 69.4% | 65.9% | 19.4% | 64.7% |
| Wyre Forest | 33.3% | 53.3% | 67.2% | 70.9% | 25.6% | 52.4% |
| **Total** | **33.8%** | **52.7%** | **71.5%** | **72.1%** | **21.7%** | **58.4%** |

*Source: Worcestershire County Council, Troubled Families Programme*

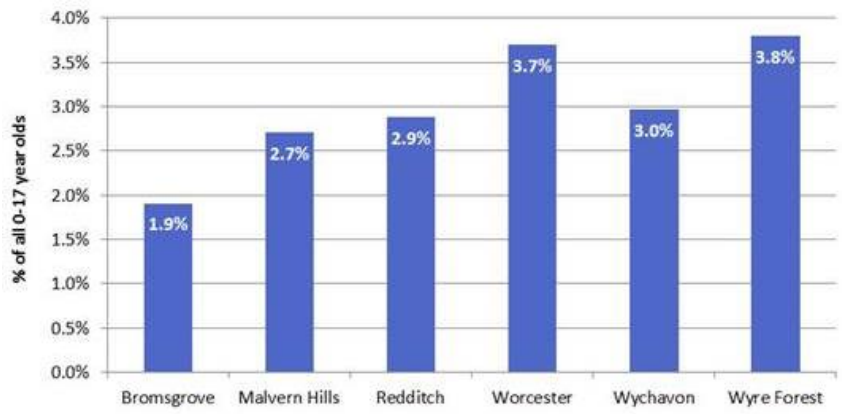
Figure 29 : % of eligible Troubled Families identified by District area and Troubled Families criteria as at August 2018




*Source: Worcestershire County Council, Troubled Families Programme*

Figure 30 identifies the proportion of 0-17 year olds identified as eligible Troubled Families by district area as at August 2018. This is based on numbers of individuals aged under 18 and not numbers of families.

Figure 30: % of Children and Young People aged 0-17 years identified as eligible for Troubled Families Programme by District Area




*Source: ONS Mid-year population estimates/Bespoke Public Health Analysis*

The first national review of the Troubled Families programme was produced in 2017. Table 9 below shows the different issues by troubled families' domain. The table shows the prevalence for families identified in Worcestershire as at August 2018, families nationally and the overall prevalence in the general population. However this data should be interpreted with caution as likely reflects the accessibility of the data sources and systems used for identification rather than actual prevalence.

The identified eligible families as at August 2018 in Worcestershire appear to have a higher prevalence, when compared to Troubled Families nationally of:

- Families with Children who need help (69.3% compared to 41.3% nationally)
- Families with at least one child who is permanently excluded from school (5.1% compared to 0.9% nationally)
- Families who have parents involved in crime (11.3% compared to 5.4% nationally)
- Families who have children involved in crime (12.8% compared to 5.1% nationally)

Identified eligible families in Worcestershire appear to have a lower prevalence, when compared to Troubled Families nationally of:

- Families in receipt of benefits (47.2% compared to 80.3% nationally)
- Families experiencing worklessness (30.8% compared to 44.6% nationally)
- Families with at least one child who has a persistent absence from school (26.1% compared to 30.6% nationally)
- Families who have a parent or child involved in Anti-social Behaviour (13.2% compared to 15.8% nationally)
- Families experiencing Domestic Violence (21% compared to 25% nationally)
- Families experiencing a health issue (56.6% compared to 72.7% nationally)

Table 9: Comparison of prevalence by type of issue between eligible Troubled Families identified in Worcestershire, Troubled Families nationally and the overall national prevalence as at August 2018[32]

| Troubled Families Domain | Family Issue | Worcestershire Troubled Families | Troubled Families (National) | National (Overall Population) |
|---|---|---|---|---|
| Worklessness & Financial Exclusion | Benefits | 47.2% | 80.3% | - |
| | Worklessness | 30.8% | 44.6% | 14.9% |
| Education and school attendance | Persistent Absence | 26.1% | 30.6% | 11.0% |
| | Permanently Excluded | 5.1% | 0.9% | 0.07% |
| Children who need help | Children who need help | 69.3% | 41.3% | 3.4% |
| Crime and anti-social behaviour | Adult Crime | 11.3% | 5.4% | 1.2% |
| | Youth Crime | 12.8% | 5.1% | 0.8% |
| | Anti-social behaviour | 13.2% | 15.8% | - |
| Domestic abuse | Domestic Violence | 21.0% | 25.0% | 6.1% |
| Health | Health issue | 56.6% | 72.7% | 21.0% |

*Source: Department for Communities and Local Government, Bespoke Public Health Analysis*

[32] Department for Communities and Local Government (2017) Supporting disadvantaged families Troubled Families Programme 2015 – 2020: progress so far; [Online], Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/611991/Supporting_disadvantaged_families.pdf , Accessed: 17/09/2018

### 12.6. Families with Dependent Children

The ONS defines a "family" as a married, civil partnered or cohabiting couple with or without children, or a lone parent with at least one child who lives at the same address.

In 2011, there were approximately 76,646 families with dependent children in Worcestershire. The majority of families with a child were married/same-sex civil partnership couples (64.9%). Lone parent families (21.6%) and co-habiting couples (13.5%) families accounted for smaller proportions.

Table 10: Proportion of all families with a dependent child aged 0-18 years by family type in Worcestershire, West Midlands and England (2011 Census data)

| | **Where youngest dependent child is aged 0-18 years** | | | | | | |
|---|---|---|---|---|---|---|---|
| | **Total No. of Families** | Married or same-sex partnership couple | | Cohabiting Couple | | Lone parent family | |
| Bromsgrove | 12510 | 8750 | 69.9% | 1452 | 11.6% | 2308 | 18.4% |
| Malvern Hills | 9129 | 6116 | 67.0% | 1229 | 13.5% | 1784 | 19.5% |
| Redditch | 12610 | 7724 | 61.3% | 1792 | 14.2% | 3094 | 24.5% |
| Worcester | 13966 | 8674 | 62.1% | 1935 | 13.9% | 3357 | 24.0% |
| Wychavon | 15224 | 10510 | 69.0% | 1922 | 12.6% | 2792 | 18.3% |
| Wyre Forest | 13207 | 8003 | 60.6% | 2021 | 15.3% | 3183 | 24.1% |
| **Worcestershire** | **76646** | **49777** | **64.9%** | **10351** | **13.5%** | **16518** | **21.6%** |
| West Midlands | 796648 | 487543 | 61.2% | 105062 | 13.2% | 204043 | 25.6% |
| England | 7360498 | 4571079 | 62.1% | 951934 | 12.9% | 1837485 | 25.0% |

Source: NOMIS – 2011 Census – DC1118EW – "Youngest dependent child in family by family type"

### 12.7. Lone parents

In Worcestershire, there were 16,518 families, with a dependent child aged between 0-18 years, which were lone parent families (21.6%) in the 2011 census which is lower than the England average. Redditch had the highest proportion of lone parent families at 24.5% and Wychavon the lowest 18.3%.

### 12.8. Concealed Families

Statistics on concealed families are used as an indicator of housing demand. A concealed family is defined as a couple or single parent family living in a multi-family household where the Family Reference Person (FRP) is not the Household Reference Person (HRP). Therefore, a concealed family can include young adults living with a partner and/or child in the same household as their parents, older couples living with an adult child and their family, and unrelated families sharing a household. Many factors contribute to why more than one family may share a household. For example, whilst financial pressure is one factor in determining the likelihood of a concealed family, other factors such as the health, age and culture of the occupants can contribute to the overall size of a household.

It is estimated that there are 939 concealed families with dependent children in Worcestershire. A higher proportion of these were from lone parent families (68.2%) and around a third were from couple families (31.8%).

### 12.9. Adults not in employment with dependent children (all ages)

In Worcestershire, there were approximately 239,717 households of which 10.9% had no adults in employment. In the West Midlands this was 16.1% and England 14.4%. Across Worcestershire there is some variation; Wyre Forest has the highest proportion (13.9%) of households with dependent children and adults not in employment, followed closely by Redditch (13.8%). Wychavon has the lowest proportion (8.4%)

Table 11: The proportion of households with dependent children (all ages) where no adults in are in employment in Worcestershire, West Midlands and England (2011 Census)

| | All households with dependent children (all ages) | Households with no adults in employment, with dependent children | |
|---|---|---|---|
| | | No. | % |
| Bromsgrove | 38290 | 763 | 6.9% |
| Malvern Hills | 32212 | 801 | 10.1% |
| Redditch | 34722 | 1498 | 13.8% |
| Worcester | 42042 | 1505 | 12.5% |
| Wychavon | 49466 | 1119 | 8.4% |
| Wyre Forest | 42985 | 1562 | 13.9% |
| **Worcestershire** | **239717** | **7248** | **10.9%** |
| West Midlands | 2294909 | 111179 | 16.1% |
| England | 22063368 | 922192 | 14.4% |

Source: 2011 Census, NOMIS – "KS106EW - Adults not in employment and dependent children"

### 6.12 Families with Dependent Children: One person in household with a long-term health problem or disability (All ages)

In Worcestershire, it is estimated that there are 66,663 (14.8%) households with dependent children have at least one person living with a long-term health problem or disability. This was lower than West Midlands (17.1%) and England (15.9%).

There is variation across Worcestershire between the districts. Redditch had the highest proportion at 16.3% and Bromsgrove the lowest at 13.9%.

Table 12: The proportion of households with dependent children (all ages) where one person has a long-term health problem or disability in Worcestershire, West Midlands and England (2011 Census)

| | All households with dependent children (all ages) | Household with one person with a long-term health problem or disability, with dependent children | |
|---|---|---|---|
| | | No. | % |
| Bromsgrove | 11105 | 1542 | 13.9% |
| Malvern Hills | 7941 | 1206 | 15.2% |
| Redditch | 10893 | 1775 | 16.3% |
| Worcester | 12081 | 1727 | 14.3% |
| Wychavon | 13382 | 1878 | 14.0% |
| Wyre Forest | 11261 | 1742 | 15.5% |
| **Worcestershire** | **66663** | **9870** | **14.8%** |
| West Midlands | 692293 | 118047 | 17.1% |
| England | 6425647 | 1019932 | 15.9% |

*Source: NOMIS 2011*

### 12.10. Family Homelessness

In 2016/17 the Worcestershire county rate of eligible homeless people 'not in priority need' was 1.0 per 1000 households (240 people) significantly higher than the England average (0.8 per 1000 households)

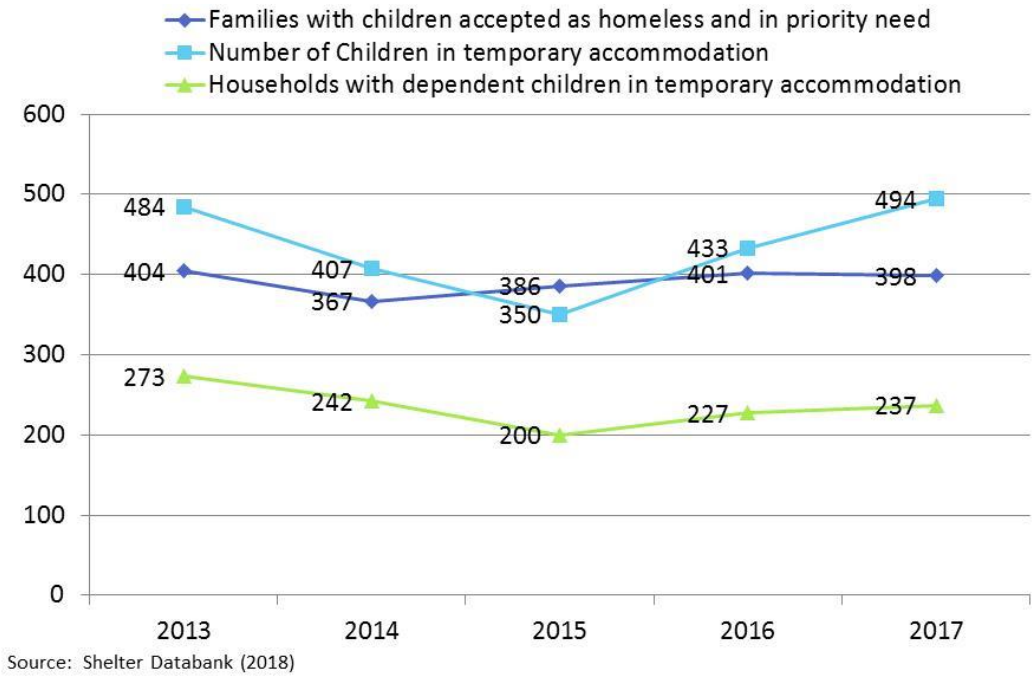
There is a significantly lower than national rate of statutory homeless households in temporary accommodation recorded in Worcestershire in 2016/17 (110 households, 0.4 per 1000 households). This is a good outcome as people living in temporary accommodation have high rates of some infections and skin conditions; and children have high rates of accidents[33].

The rate of homelessness applications in Worcestershire in 2015/16 is 4.9 per 1000 (1,198 people), this is similar to the national rate of 5.0. The family homelessness rate is similar to that nationally 1.8 per 1000 (449 households) compared to 1.9 for England. The homeless young people aged 16-24 rate in 2016/17 is 0.75 per 1000 (186 people), which is significantly higher than the national level of 0.56. It should be noted that the above figures relate primarily to applications under the homelessness legislation in force before April 2017, and will underestimate true levels of need.

Figure 31 below shows there were a total of 494 children in 2017 who were in temporary accommodation in Worcestershire. There were 237 households in Worcestershire who had dependent children and who were in temporary accommodation. In2017 there were 398 families in Worcestershire with children who are accepted as homeless and in priority need.

[33] Shelter. 2006. *Chance of a lifetime – The impact of poor housing on children's lives.* London: Shelter.

Figure 31: Family Homelessness in Worcestershire (2013-2017)



Source: Shelter Databank (2018)

### 12.11. Under 19's Living in Rural Areas

Data from the 2011 Census shows that Worcestershire has a higher proportion of 0-19 year olds who live in rural areas (23.4%) when compared to West Midlands (13.0%) and England (16.3%). There are variations across Worcestershire districts with Wychavon having the highest proportion of children aged 0-19 living in rural areas (54.4%) compared to 0.1% in Worcester District.

Table 13: The number and percentage of 0-19 year olds living in urban and rural areas in Worcestershire, West Midlands and England (2011 Census data)

| | Urban | | Rural | |
|---|---|---|---|---|
| | Number | % | Number | % |
| Bromsgrove | 17313 | 82.4% | 3710 | 17.6% |
| Malvern Hills | 8283 | 51.1% | 7923 | 48.9% |
| Redditch | 20037 | 97.3% | 550 | 2.7% |
| Worcester | 23919 | 99.9% | 32 | 0.1% |
| Wychavon | 11477 | 45.6% | 13685 | 54.4% |
| Wyre Forest | 17137 | 80.9% | 4040 | 19.1% |
| **Worcestershire** | **98166** | **76.6%** | **29940** | **23.4%** |
| West Midlands | 1211390 | 87.0% | 180541 | 13.0% |
| England | 10644588 | 83.7% | 2067687 | 16.3% |

*Source: NOMIS 2011*

## 13. Outcomes for Children and Young People in Worcestershire

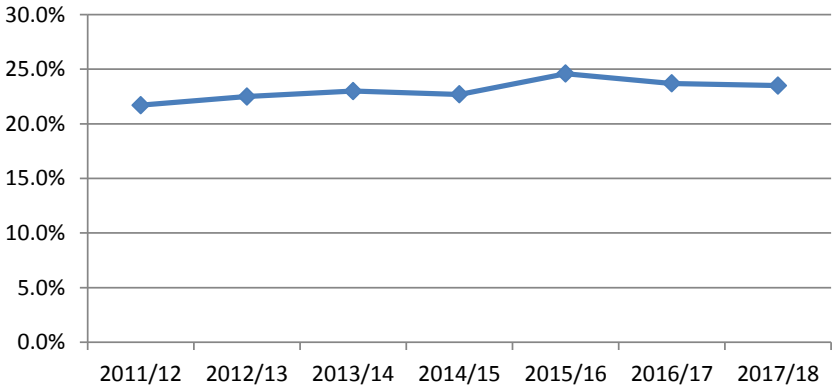
### 13.1 Pregnancy and Birth

There are around 6000 births in Worcestershire each year. It is estimated nationally that about one third of births are either unplanned or associated with feelings of ambivalence. Although pregnancies continuing to term mostly lead to positive outcomes, some unplanned pregnancies can have adverse health impacts for mother, baby and children into later in life. Helping women to improve their health and reduce risks prior to pregnancy will help to ensure that they have healthier pregnancies, and that their babies have the best start in life.

### 13.2 Maternal Obesity

Women who are overweight or obese before they conceive have an increased risk of complications during pregnancy and birth. This poses health risks for both mother and baby in both the short and the longer term. Rates of obesity are increasing among women of reproductive age and an increasing number of women who become pregnant are obese - 19% of women of reproductive age in England are obese, 3.6% are severely obese, and of these obese women 5.3% will become pregnant each year. The percentage of obese women at first maternity booking is higher in Worcestershire at around 23% than nationally (20%). The percentage of maternal obesity recorded at first maternity booking appointment in Worcestershire has risen year on year however there has been a slight reduction for the second year running in the overall percentage of pregnant women who are obese, as can be seen from Figure 32 below.

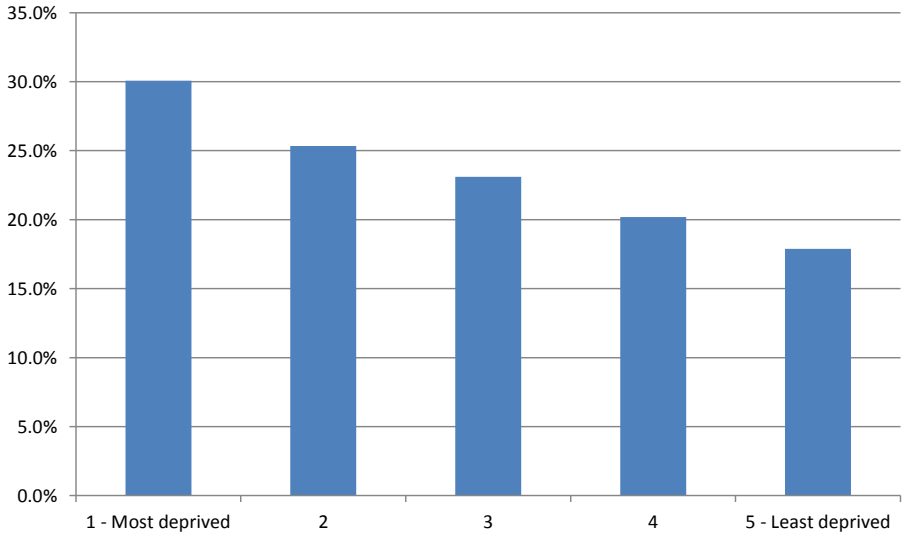
Figure 32: Percentage of women who were classified as Obese at the Maternity booking Appointment




Source: Bespoke Public Health Analysis using Local Maternity Data

The proportion of women who are overweight or obese in early pregnancy rises as the levels of area deprivation increase. In Worcestershire we have monitored the BMI Band by deprivation quintile over a number of years. The graph below shows the percentage of women who were obese at time of their booking in the most deprived areas as higher than the least deprived areas of Worcestershire.

Figure 33: Percentage of deliveries where the mother was classed as Obese at maternity booking appointment (2017/18)

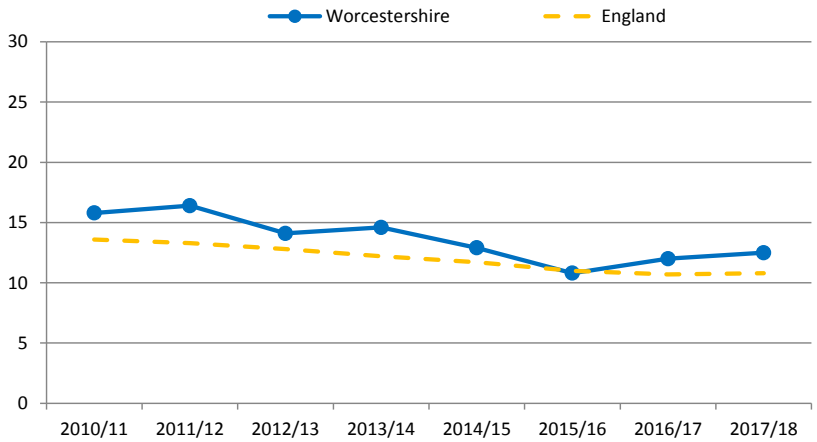



Source: Bespoke Public Health Analysis using Local Maternity Data

### 13.3 Smoking in Pregnancy

Encouraging women to stop smoking before having a baby benefits both mother and child, and may also help them stop smoking for good. Smoking in pregnancy is associated with poor foetal growth and low birthweight and with obesity in childhood. Smoking during pregnancy is also associated with higher rates of stillbirth and infant mortality. Nearly 11 per cent of women in England are still recorded as smoking at the time of delivery; however this is higher in Worcestershire. Although rates are lower than in the past, over 12% of women in Worcestershire are still recorded as smoking at the time of delivery. This translates into more than 660 infants born to smoking mothers each year. In Worcestershire, the percentage of women smoking at time of delivery has been significantly higher than the national average for much of the last 8 years. Smoking during pregnancy has many serious health implications for both the mother and unborn child and can cause premature births, miscarriages and even perinatal deaths.

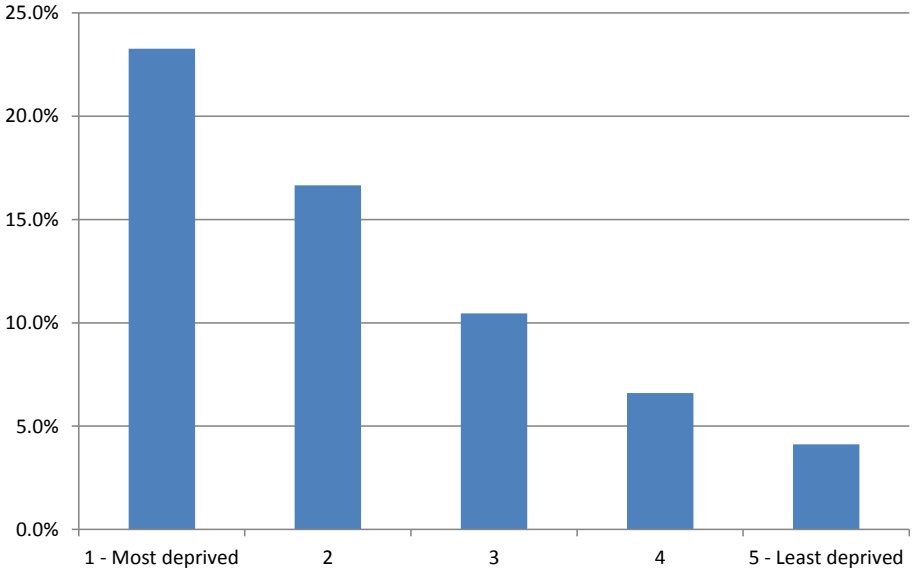
Figure 34: Percentage of women who smoke at time of delivery (2010-2018)




Source: Calculated by PHE from NHS Digital return on Smoking Status at Time of Delivery

In Worcestershire as nationally, smoking in pregnancy is strongly linked to deprivation and age, with mothers under 20 years having higher rates of smoking compared to older mothers. Figure 35 below shows the percentage of mothers who smoke in pregnancy by deprivation quintile in Worcestershire. Over 23% of mothers smoke in the most deprived quintile in Worcestershire compared with just 4% in the least deprived quintile.

Figure 35: Smoking in pregnancy by IMD quintile in Worcestershire (2017/18)

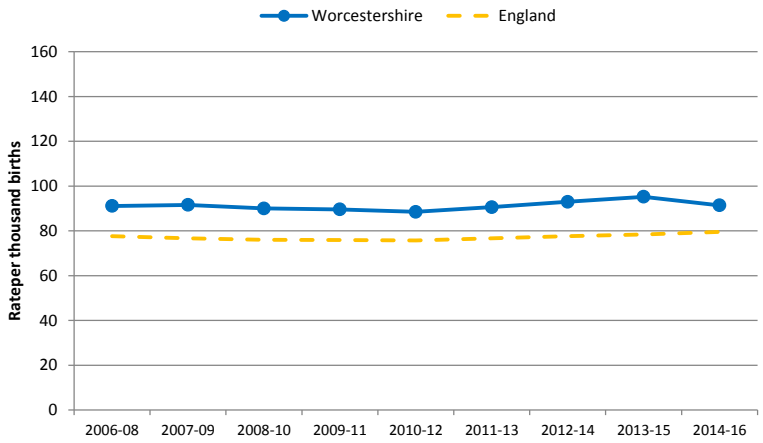



*Source: NHS Digital, Bespoke Public Health Analysis*

### 13.4 Premature Births

A premature birth is defined as gestational age less than 37 weeks. There are greater health risks and outcomes for premature births, the earlier the birth the greater the risk, however some very premature babies do very well and develop into healthy children. Worcestershire has historically had a statistically significantly higher premature birth rate than England.

Figure 36: Premature Births (less than 37 weeks gestation) as a rate of Total Births



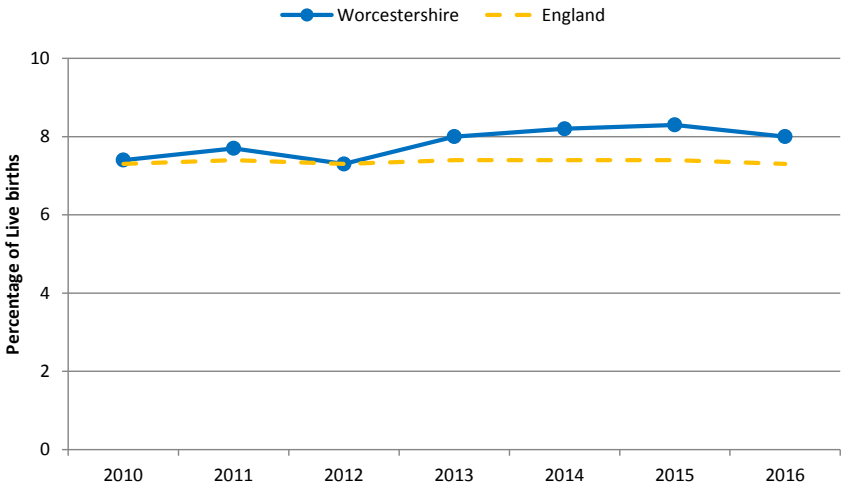

*Source: Office for National Statistics*

### 13.5 Low Birth Weight

Low birthweight at full term of pregnancy is an important public health measure as it indicates whether the baby was able to grow as expected while in the womb. Being born at low birthweight is an important marker along the trajectory of early child development, indicating an increased risk of poor health outcomes from birth onwards. Nationally 7 per cent of babies are born underweight, below 2500g (ONS).

The percentage of all births in Worcestershire with a recorded birth weight under 2500g has been significantly higher than the national average for the last four years, however this includes premature births which are likely dominating these statistics.

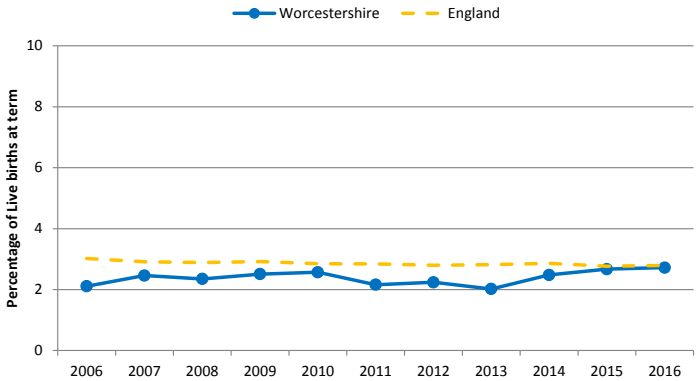
Figure 37: Low birthweight births as a percentage of all live births




*Source: Office for National Statistics*

The percentage of all live births at term (at least 37 weeks) with low birth weight has historically been below the national average for the same period as can be seen in Figure 38. However this has increased over the last two years and is now similar to the national average.

Figure 38: Percentage low birthweight at term (2006-2016)



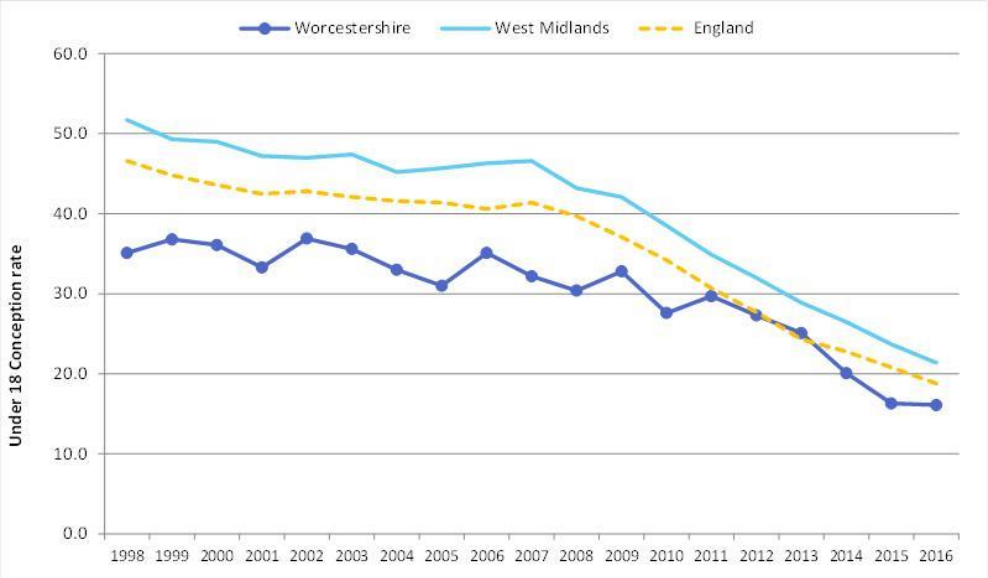

*Source: Office for National Statistics*

### 13.6 Teenage Pregnancy

Early parenthood carries a number of risks for both mother and child. The baby is more likely to have a low birth weight at term and has a higher risk of infant mortality. Due to parenting responsibilities, young mothers are less likely to complete education and may be further economically disadvantaged by a failure to enter employment. Younger mothers are also more likely to smoke during pregnancy than older mothers. Most teenage pregnancies are unplanned and around 50% end in an abortion.

The teenage conception rate nationally has more than halved over the last two decades and is currently at its lowest. The rate in Worcestershire was slower to reduce but has also significantly decreased in the last 5 years. Figure 39 compares the under 18 conception rate for Worcestershire with England and West Midlands and provides a guide as to relative performance. The rate in Worcestershire was statistically significantly lower than England until 2010. Although the rate in Worcestershire remains lower than England, as the rates get closer the chance that they are statistically significantly different will get much more unlikely.

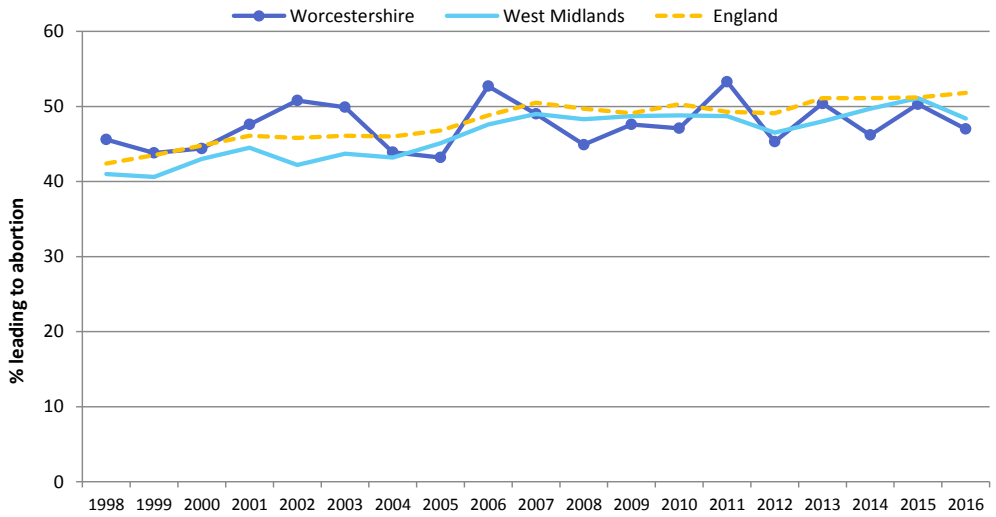
Figure 39: Under 18 Conception Rate per 1000 females aged 15 – 17 (1998 -2016)




*Source: Office for National Statistics, Conception Statistics*

Though the figures are variable from one year to another, there is generally an upward trend in the percentage of teenagers opting for an abortion as an outcome across all areas, although Worcestershire has a slightly lower percentage of mothers opting for an abortion.

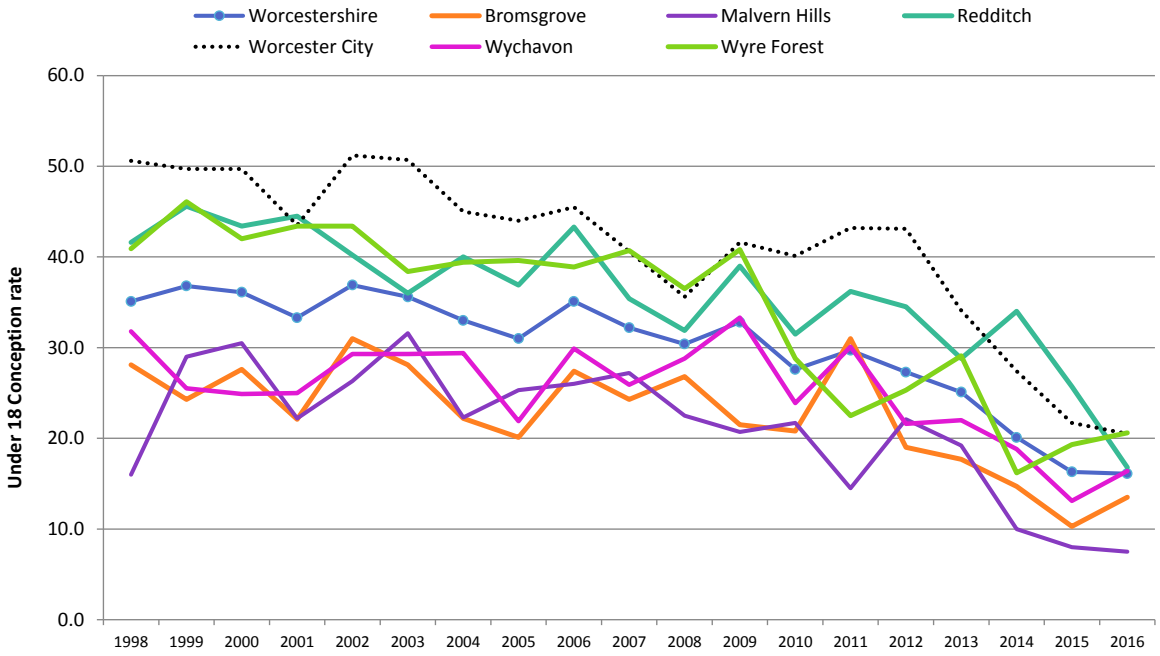
Figure 40: Outcome of Under 18 Conceptions – Percentage leading to abortion




Source: Office for National Statistics, Conception Statistics

At sub-county level there is large variance. Malvern Hills, Bromsgrove and Wychavon have the lowest teenage conception rates. Worcester City and Redditch have consistently had the highest teenage conception rates across Worcestershire. However, encouragingly, over the last few years the rate has dropped considerably. In Worcester City the rate has more than halved from 43.1 in 2012 to 20.5 in 2016.

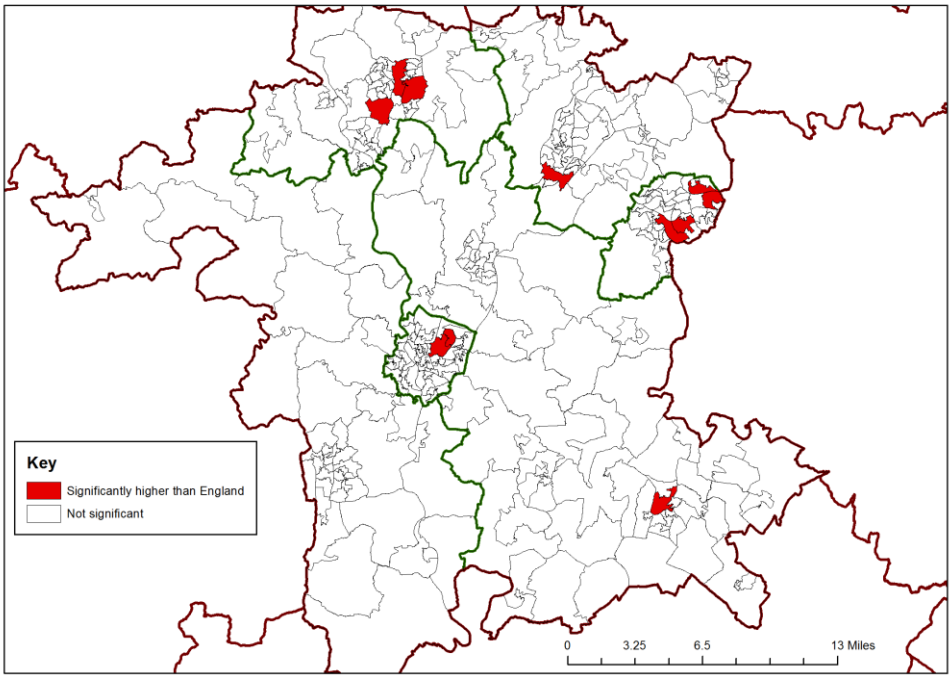
Figure 41: Under 18 Conception Rate by Council District Area




Source: Office for National Statistics, Conception Statistics

Teenage conception rates are more prevalent in areas of higher deprivation. The map in Figure 42 demonstrates this is also the case in Worcestershire and shows the Middle Super Output Areas (MSOAs) which have statistically significantly higher rates than the average in England. Between 2013-2015, there were eleven areas in Worcestershire that had statistically significantly higher rates of under 18 conceptions. All 5 of the most deprived MSOAs in Worcestershire appear in the map and all 11 MSOAs highlighted fall within the top third of deprived areas in Worcestershire based on the Index of Multiple Deprivation 2015.

Figure 42: Areas with high under 18 conception rates by Middle Super Output Area (3 Years pooled data, 2013 – 2015)



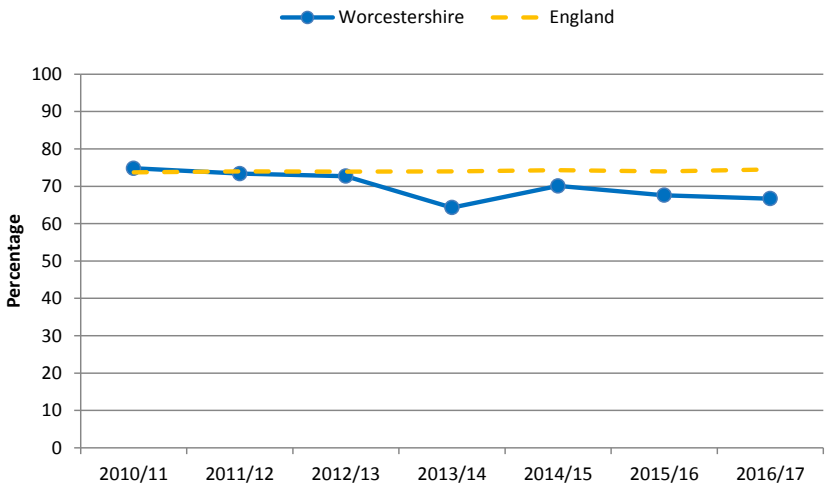



### 13.7 Breastfeeding

Breastfeeding provides the best possible nutritional start in life for a baby, protecting the baby from infection and offering important health benefits for the mother. The government's advice is that infants should be exclusively breastfed, receiving only breastmilk for the first 6 months of life.

In Worcestershire, breastfeeding initiation rates (breastfeeding within 48 hours of delivery) are significantly lower than the national average and have decreased over the last 3 years. However breastfeeding rates at 6-8 weeks have increased during the same period.

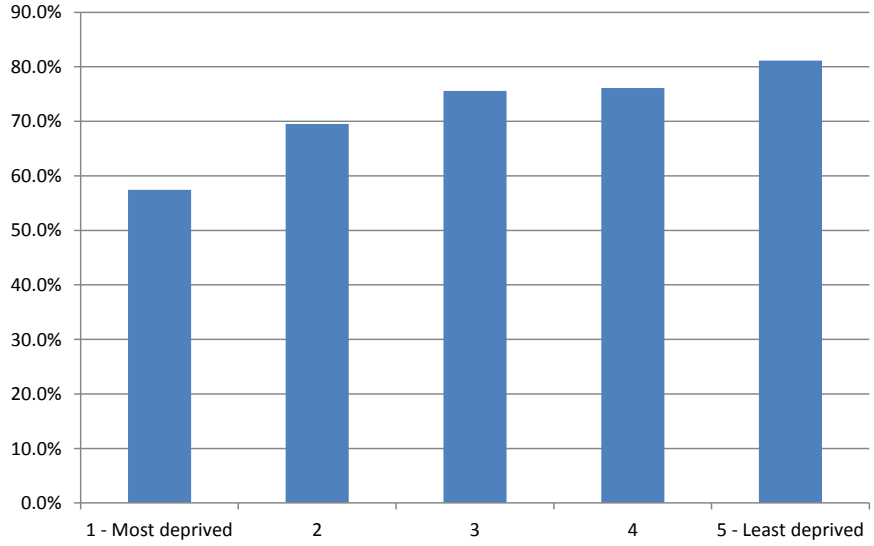
Figure 43: Breastfeeding Initiation (2010/11 - 2016/17)




Source: NHS Digital/Maternity Dataset

Breastfeeding rates are lowest amongst younger mothers, mothers of white ethnicity and those living in more deprived localities. Breastfeeding initiation in Worcestershire is lowest in Wyre Forest and Redditch Districts. Figure 44 provides the breastfeeding initiation rates by IMD quintile in 17/18 which highlights the relationship with deprivation.

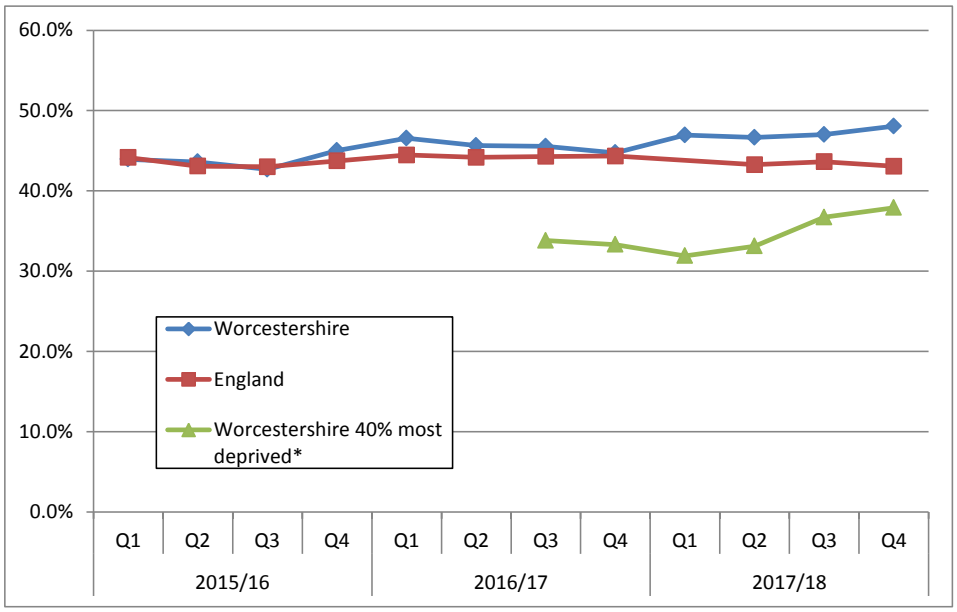
Figure 44: Breastfeeding Initiation by IMD in Worcestershire (2017/18)




Source: NHS Digital/Maternity Dataset/Bespoke Public Health Analysis

Over the last 12 months the percentage of infants still being breastfed in Worcestershire at the 6-8 week check has been consistently higher than the national average. Encouragingly, there has also been an improvement in the percentage of infants from the more deprived areas as well.

Figure 45: Percentage of all infants due a 6-8 week check that are totally or partially breastfed (2015-16 - 2017-18)




*Source: NHS Digital, Maternity Dataset/ Bespoke Public Health Analysis*

## 14. Early Years

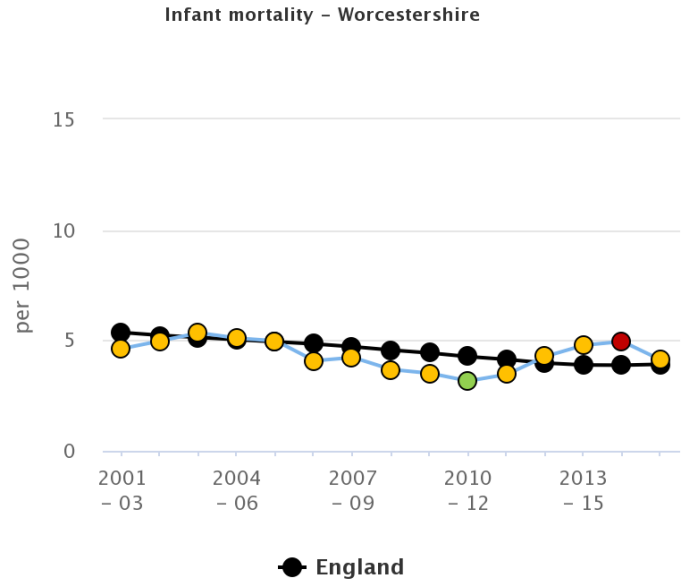
What happens during pregnancy and the first few years of life influences physical, cognitive and emotional development in childhood and may have an effect on health and wellbeing outcomes in later life.

### 14.1. Infant Mortality

Infant mortality covers all deaths within the first year of life. The majority of these are neonatal deaths which occur during the first month and the main cause is related to prematurity and preterm birth, followed closely by congenital abnormalities. Nationally and in Worcestershire, the number of infants who die is relatively small and subject to considerable variation from year to year. As a result, the data are often considered on a three-year rolling average basis.

The infant mortality rate in Worcestershire increased during the period 2012 to 2016 and became, for the first time, statistically significantly higher than the England average for the period 2014 to 2016. This was in contrast to the national decrease during the same period. However, numbers are small and caution should be used when interpreting these figures. The rate has since decreased for the period 2015 to 2017 and is now similar again to the England average.

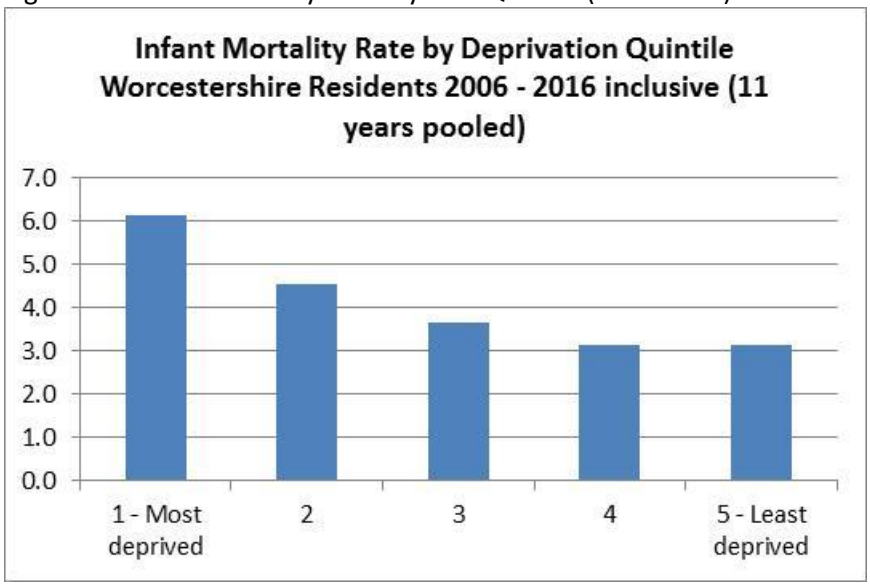
Figure 46: Infant Mortality Rate in Worcestershire (2001-3 to 2015-17)




Source: Public Health England, Public Health Outcomes Framework

Infant mortality rates are higher in deprived areas. Smoking in pregnancy and adult smoking prevalence is also higher among those living in deprived areas. The local Worcestershire data on infant mortality rates by deprivation confirms what we would expect and mirrors data at a national level. Over the last decade Infant mortality rates have been highest in the most deprived quintile and lowest in the least deprived quintile (Figure 47).

Figure 47: Infant Mortality rates by IMD Quintile (2006-2016)



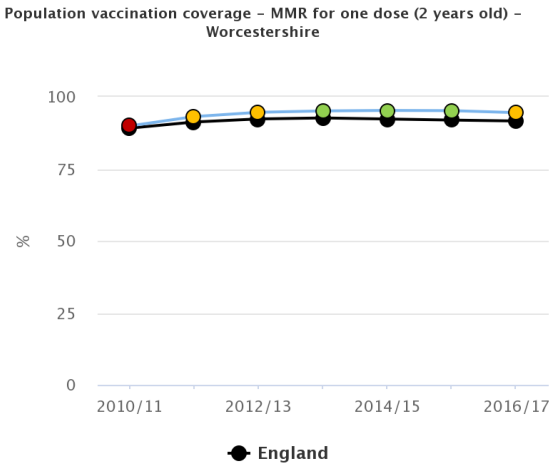

Source: Public Health England/Public Health Outcomes Framework/ Bespoke Public Health Analysis

### 14.2 Immunisation

Vaccination coverage is the best indicator of the level of protection a population will have against vaccine preventable communicable diseases. Coverage is closely correlated with levels of disease. Monitoring coverage identifies possible drops in immunity before levels of disease rise.

The overall proportion of single dose MMR at 2 years old was 94.5% for 2016-17 in Worcestershire which was similar to the England average of 91.6%.

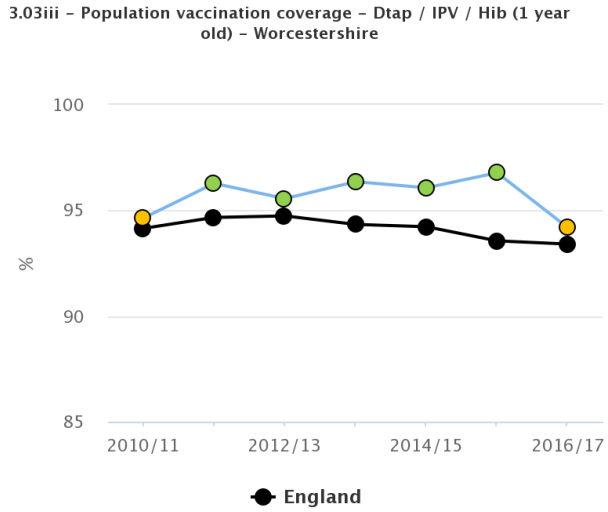
Figure 48: MMR vaccination (2 year olds) 2010-2017




*Source: Public Health England, Public Health Outcomes Framework*

The overall proportion of Dtap, IPV and Hib at 2 years old was 94.2% for 2016-17 in Worcestershire which was similar to the England average of 93.4%.

Figure 49: Dtap/IPV/Hib Vaccination (1 year olds) 2010-2017




Source: Public Health England, Public Health Outcomes Framework

### 14.3 Oral Health

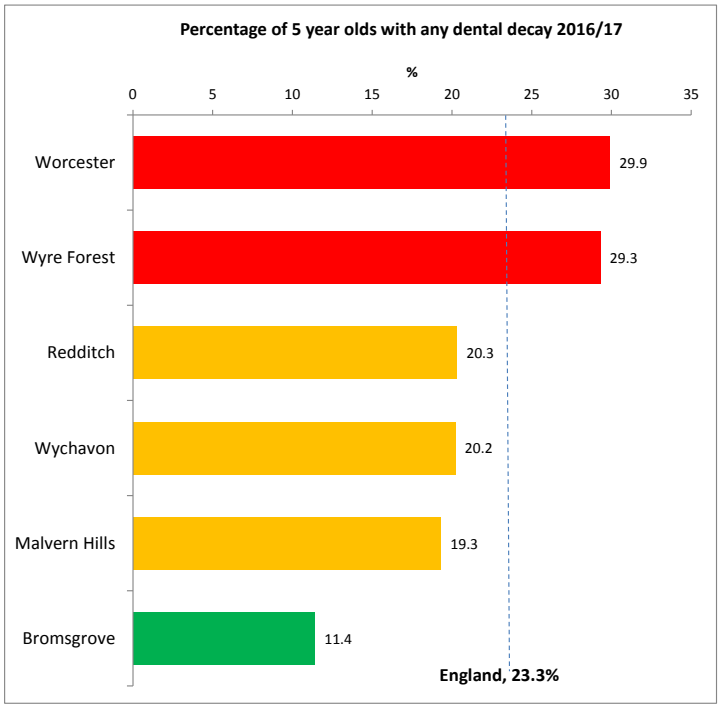
Current health advice for good oral health includes tooth brushing with fluoride toothpaste twice a day, a visit to the dentist when a child's first tooth erupts and a healthy diet with limitations on sugary snacks and drinks 23, 24. Fluoridation of water supply which is effective in improving overall dental health and reducing inequalities is also recommended as a population level intervention.

Overall dental health for 5 year olds in Worcestershire is better than the national average. In 2016/17, 21.8% of 5 year olds in Worcestershire had evidence of tooth decay. This is statistically significantly lower than the England value of 23.3%. The average number of decayed, missing or filled teeth (DMFT) was 0.62 in Worcestershire in 2016/17, significantly better than England (0.78)

However inequalities within the county have become increasingly evident in recent years. There are differences in oral health across the county by District, with Worcester City and Wyre Forest emerging as having poorer oral health for children and Bromsgrove having good oral health.

The percentage of 5 year olds with any dental decay varies by district, and the two worst areas, Worcester and Wyre Forest, have seen increases between 2014/15 – 2016/17 (from 27.3% to 29.9%, and 23.6% to 29.3% respectively).

Figure 50: Percentage of 5 year olds with any dental decay, (2016/17)




*Source: Dental Public Health Epidemiology Programme: Oral Health Survey of 5 year olds*

There is considerable variation and widening inequality by District in average numbers of decayed, missing or filled teeth (DMFT) in 5 year olds. The figure below shows that Worcester DMFT deteriorated from 0.9 in 2014/15 to 1.17 in 2016/17, while Bromsgrove DMFT improved from 0.3 to 0.25 over the same period.

Figure 51: Decayed, missing or filled teeth in five year olds, 2016/17

**dmft (decayed, missing or filled teeth) in five year olds** 2016/17 — Mean - mean dmft per child

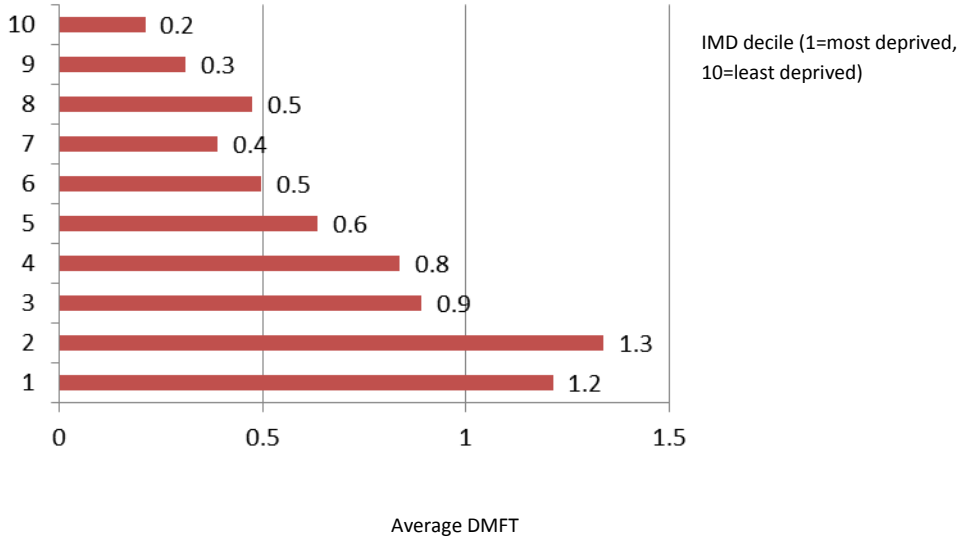
| Area | Count | Value | 95% Lower CI | 95% Upper CI |
|---|---|---|---|---|
| England | - | 0.78 | 0.77 | 0.79 |
| Worcestershire | - | - | - | - |
| Worcester | - | 1.17 | 0.99 | 1.35 |
| Wyre Forest | - | 0.82 | 0.66 | 0.98 |
| Malvern Hills | - | 0.60 | 0.44 | 0.77 |
| Redditch | - | 0.51 | 0.41 | 0.61 |
| Wychavon | - | 0.44 | 0.36 | 0.53 |
| Bromsgrove | - | 0.25 | 0.17 | 0.32 |

*Source: Dental Public Health Epidemiology Programme for England: oral health survey of five-year-old children 2017*

Source: Dental Public Health Epidemiology Programme: Oral Health Survey of 5 year olds

Part of the variation observed between districts is due to differences in deprivation levels. There is a clear relationship between child oral health and deprivation (Figure 52).

Figure 52: Average DMFT by IMD decile, Worcestershire (2014/15)




Source: Dental Public Health Epidemiology Programme: Oral Health Survey of 5 year olds

A further issue influencing variation in oral health outcomes is fluoridation of water supply: Bromsgrove, Redditch and most of Wychavon have fluoridated water supplies, while most of Wyre Forest, Malvern Hills and Worcester do not.

### 14.4 Child Obesity

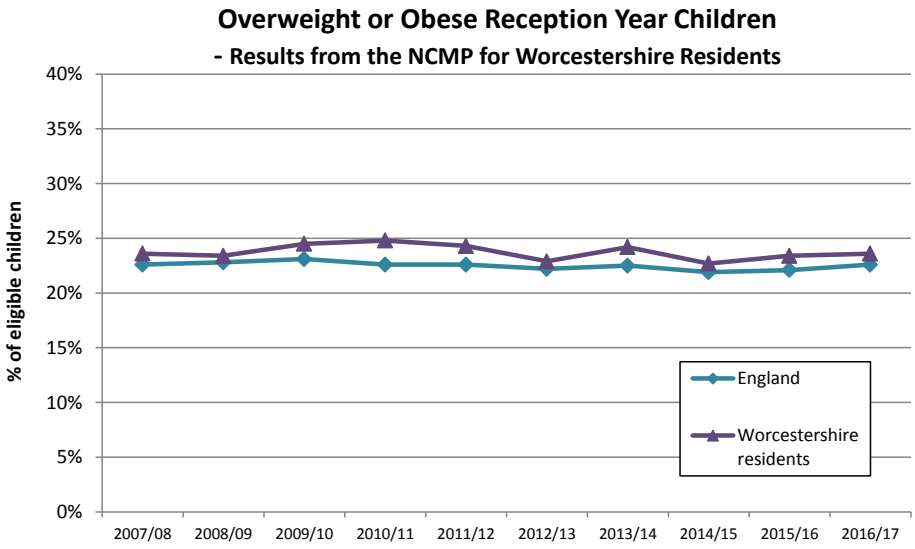
Tackling obesity is a key national public health priority and there is significant concern about the increasing levels of children who are overweight or obese. Studies have found that children who are overweight or obese have a greater probability of becoming overweight or obese in older age. There are a number of health issues related to childhood obesity including glucose intolerance, Type 2 Diabetes, exacerbation of asthma and psychological issues relating to social isolation and low self-esteem from bullying and teasing.

In the early pre-school years health visitors assess the healthy growth of infants and children. In England, the height and weight of children (Reception and Year 6) is measured in school settings (and the body mass index [BMI] calculated via the National Child Measurement Programme (NCMP). In Worcestershire this is undertaken by the school health service.

In the academic year, 2016 to 2017, nationally 22.6% of 4 and 5 year olds (Reception year children) were either overweight or obese. This level has not changed much in recent years and although the causes are complex not all children have a diet 16 or undertake physical activity at levels which reflect national recommendations[34]. Children are more likely to be obese if their mother was obese during the early stages of pregnancy[35].

In Worcestershire Reception children the percentage overweight increased slightly whereas the percentage obese decreased in 2016/17, but not enough to make much impact on the overall percentage of reception children with excess weight (overweight or obese combined). Worcestershire has consistently had a higher percentage of Reception aged children with excess weight than England, although this year the gap between them has narrowed.

Figure 53: Percentage of Reception Children with Excess Weight in Worcestershire

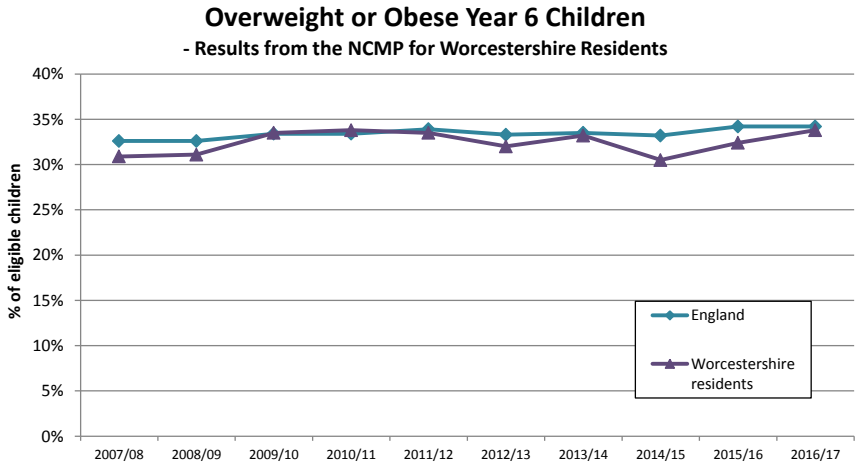



*Source: Public Health England, National Childhood Measurement Programme (NCMP)*

In the academic year 2016 to 2017, 34.2% of 10 to 11 year olds in England were overweight or obese, which was a statistically significant increase over the last 8 years. In Worcestershire we saw an increase in 2016/17 to 33.8%. Although this is still lower than the England average the gap has narrowed.

[34] Chief Medical Officer (2011) UK physical activity guidelines. Accessed 21 June 2018.
[35] Cabinet Office, Department of Health and Social Care, HM Treasury, and Prime Minister's Office (2017) Childhood obesity: a plan for action. Accessed 15 June 2018

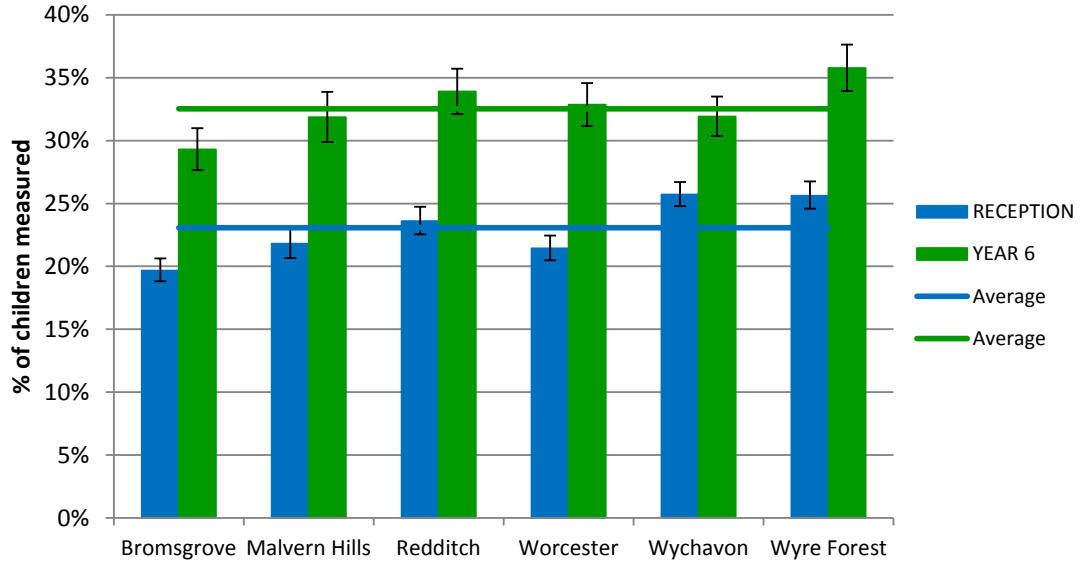
Figure 54: Percentage of Year 6 Children with Excess Weight in Worcestershire




Source: Public Health England, National Childhood Measurement Programme (NCMP)

Excess weight (overweight or obese) also varies widely between areas and districts. Like many other indicators relating to early child health, children living in more deprived areas of the county are more likely to have poor outcomes. Figure 55 provides the results by Districts and highlights higher rates of excess weight in Wyre Forest and in Redditch.

Figure 55: NCMP results: Percentage of Children who are Overweight or Obese by District (2014/15 to 2016/17)




Source: National Childhood Measurement Programme (NCMP), Bespoke Public Health Analysis

Linked data shows that children who were overweight or obese in Reception year (aged 4 and 5 years) were also more likely to be overweight or obese in Year 6 (age 10 to 11 years) and then again more likely to go on to be overweight or obese adults[36]

[36] 21.Public Health England (2017) Weight change in primary school aged children. Accessed 15 June 2018

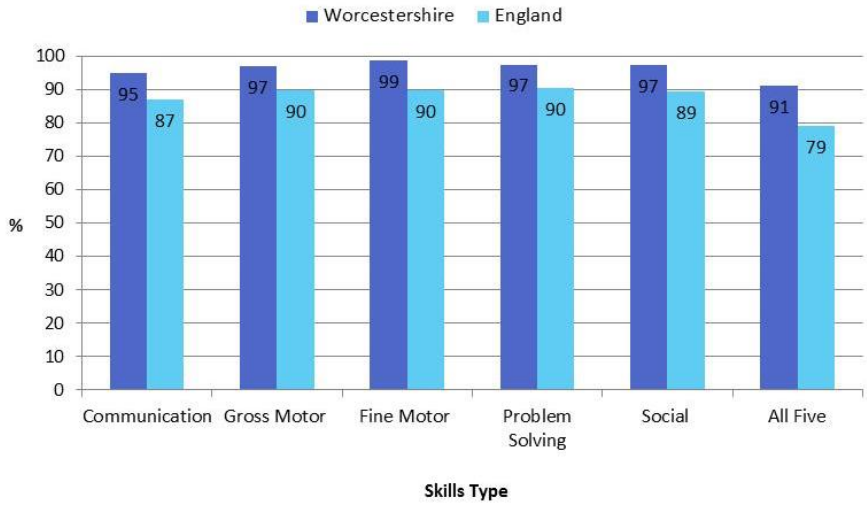
### 14.5 Child Development

The Department of Health has developed a number of measures for child development at age 2 – 2½ years[37]. The indicator will help to build a picture of child development at age 2-2½ at national and local level. The data is collected at the Healthy Child Programme (HCP) two to 2½ year review. The Ages and Stages Questionnaire-3 (ASQ-3) covers five domains of child development: communication, gross motor skills, fine motor skills, problem solving and personal-social development. Data is reported quarterly and is defined as follows: Total number of children who received a 2-2½ year review in the quarter who were at or above the expected level in selected ASQ-3 domain.

In Worcestershire, 91% of children who were offered the ASQ-3 as part of their 2-2 ½ year review, were at or above the expected level across all five domains, which was significantly higher than the England average of 79.0%. Figure 56 provides the percentage of children who were at the expected level for each of the five domains and shows that across all five areas of development, Worcestershire performs better than the England average.

Local data (Worcestershire Health and Care NHS Trust) identifies the percentage at expected level for those children living in 40% most deprived localities in Worcestershire (IMD1 & 2). This indicates some inequalities: 88% of children in deprived areas (IMD1 and IMD2) were at or above the expected level in all five domains, compared to 91 % for Worcestershire as a whole.

Figure 56: Child Development Outcomes from ASQ-3 (2017/18)




*Source: Public Health England, Public Health Outcomes Framework*

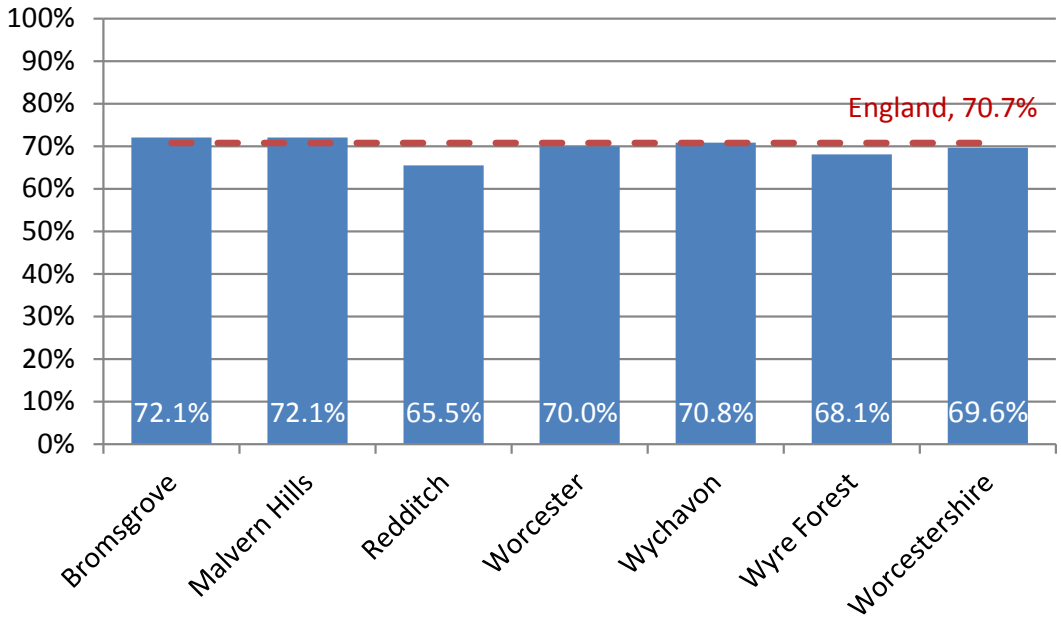
[37] Public Health England (2018) Indicator Definitions and Supporting Information, [Online], Available from: https://fingertips.phe.org.uk/child-health-early-years#page/6/gid/1938132986/pat/6/par/E12000005/ati/102/are/E10000034/iid/92543/age/241/sex/4 , Accessed: 14/05/2018

### 14.6 School Readiness: Early Years Foundation Stage (EYFS) Profile

School readiness is an important marker on the life course trajectory. Measured by applying the early years foundation stage profile (EYFSP) to children in a school setting at the end of the Reception year (age 4 to 5 years). It generates an outcome indicator based on a rounded assessment of physical, behavioural, cognitive and social development. It tells us something about outcomes from a healthy pregnancy, infancy and early childhood, which includes the effectiveness of early years' services and the opportunity for early intervention.

Children are defined as having reached a good level of development (GLD) if they achieve at least the expected level in the early learning goals in the prime areas of learning (personal, social and emotional development; physical development; and communication and language) and the early learning goals in the specific areas of mathematics and literacy. The percentage of children achieving a good level of development by end of Reception (School Readiness) in Worcestershire has increased over the last few years to 69.6% but is still a little lower than national average

Figure 57: School Readiness – Percentage of Children achieving a good level of development at the end of Reception by Council District area in Worcestershire (2016/17)




*Source: Public Health England, Public Health Outcomes Framework*

Bromsgrove and Malvern Hills have a higher proportion of children achieving a good level of development than nationally, while Worcester and Wychavon have similar proportions and Wyre Forest and Redditch have a lower proportion. Only in the case of Redditch is the difference statistically significant (worse).

In Worcestershire, achievement at the EYFS for specific and prime areas is similar to the England average, however below other statistical neighbours. For communication and language achievement, Worcestershire is significantly lower than the England average. There is increasing concern about the numbers of children starting school with poor speech, language and communication skills with unacceptable differences in outcomes in different areas of the

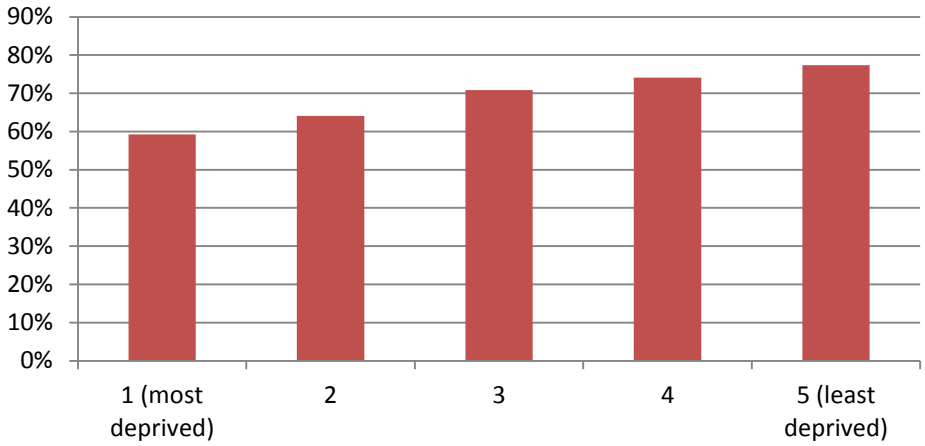
county. Language development is determined by genetic inheritance and is also very sensitive to socio-economic deprivation and the quality of input children receive from the adults around them. More than 10% of children and young people have long-term speech, language and communication needs (SLCN). This can be a barrier to communication or learning, with children from socially disadvantaged families more than twice as likely to be diagnosed with a language problem. Due to social clustering, more than 50% of children living in areas of high social deprivation may start school with SLCN.

Table 14: EYFSP attainment by each early learning goal (2016/17)

| | Specific areas | | | | Prime areas | | |
|---|---|---|---|---|---|---|---|
| | Literacy | Mathematics | Understanding the World | Expressive arts & design | Communication & Language | Physical Development | Personal, Social & Emotional Development |
| ENGLAND | 72.8 | 77.9 | 83.6 | 86.7 | 82.1 | 87.5 | 85.2 |
| **Worcestershire** | **72.3** | **77.3** | **84.5** | **87.4** | **81.2** | **87.1** | **84.5** |
| Herefordshire | 77.2 | 79.9 | 86.1 | 89.3 | 84.7 | 91.4 | 86.6 |
| Solihull | 74.8 | 79.6 | 83.3 | 84.4 | 81.8 | 86.6 | 85.1 |
| Warwickshire | 74.6 | 79.1 | 84.3 | 86.7 | 82.5 | 87.5 | 86.0 |
| Gloucestershire | 71.4 | 77.4 | 85.2 | 89.2 | 83.0 | 88.7 | 85.6 |

Child development outcomes at the end of the Reception year vary by the sex of the child, when exactly in the school year they were born (noting that some children in Reception can be almost a whole year older than some of their peers when this assessment is undertaken) and whether or not their first language is English. They also vary by deprivation.

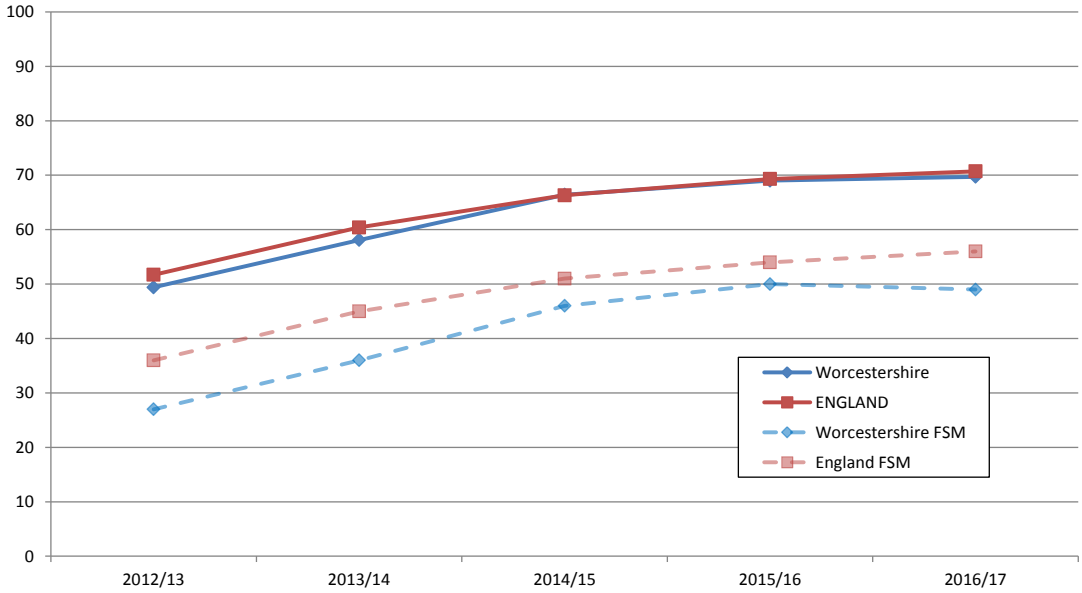
Figure 58: Early Years Foundation Stage: Percentage of Children with a good level of development by IMD (2016/17)




Source: Worcestershire County Council (children resident and attending school in Worcestershire)

There appears to be a strong relationship between the percentage of children achieving a good level of development and deprivation: in the most deprived areas (quintile 1) 59% achieve a good level of development compared to 77% in quintile 5.

Figure 59: School Readiness – Percentage of Children achieving a good level of development at the end of Reception – All pupils compared with those eligible for Free School Meals (FSM)




*Source: DfE Early Years Foundation Stage Profile Statistics, 2017 tables*

Children eligible for free school meals (FSM) is another marker of deprivation. Whilst the overall percentage of children in Worcestershire achieving a good level of development at the end of Reception is similar to England and has increased in line with the national picture. There are however, considerable differences between children who are eligible for free school meals in Worcestershire compared to these children nationally. Achievement for Worcestershire FSM children is considerably lower than the national average.

Table 15: Percentage with Good Level of Development by Free School Meal Eligibility (2016/17)

| | Pupils not eligible for FSM | %GLD for those not eligible for FSM | Pupils eligible for FSM | %GLD for those eligible for FSM | Gap (difference between FSM and non FSM) |
|---|---|---|---|---|---|
| Bromsgrove | 947 | 74.7% | 95 | 46.3% | 28.4% |
| Malvern Hills | 626 | 74.3% | 65 | 50.8% | 23.5% |
| Redditch | 940 | 67.6% | 163 | 53.4% | 14.2% |
| Worcester | 1068 | 72.8% | 164 | 51.8% | 21.0% |
| Wychavon | 1141 | 73.3% | 118 | 47.5% | 25.8% |
| Wyre Forest | 909 | 72.2% | 159 | 44.7% | 27.5% |
| Worcestershire | 5631 | 72.4% | 764 | 49.2% | 23.2% |
| England | | 73% | | 56% | 17% |

*Source: calculated from WCC school improvement data, pupils resident and attending school in Worcestershire. England data calculated from Public Health Profiles.*

Notes 1. District and county data is not official data but should be reasonably accurate. 2. Green is significantly better than England, red=significantly worse than England.

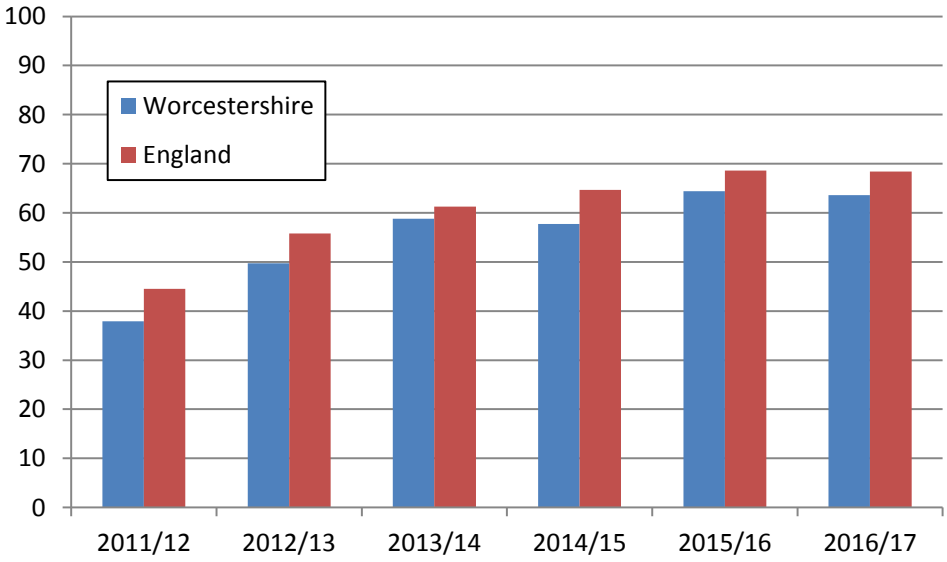
The table above compares achievement rates for children not eligible for free school meals with those who are eligible. Worcestershire has a similar rate to England for pupils not eligible for FSM but a significantly worse rate for those who are eligible for FSM. The difference according to FSM eligibility in Worcestershire is significantly greater than for England (23.2% and 17% respectively).

While Redditch has the lowest achievement rate for pupils not eligible for FSM, it has the highest rate for those who are eligible (and hence the lowest gap between the two groups). Redditch is the only Worcestershire district that has a smaller gap than England.

Wyre Forest has a significantly low rate for FSM pupils, and the second largest gap of 27.5%. Bromsgrove has the largest gap between those ineligible for and eligible for FSM (28.4%)

EYFS Phonic Element for FSM: The inequalities gap is highlighted again when looking at the phonics element of the school readiness indicator where children eligible for free school meals in Worcestershire have consistently had lower results when compared with England.

Figure 60: School Readiness: The percentage of Year 1 Pupils with free school meal status achieving the expected level in the phonics screening check



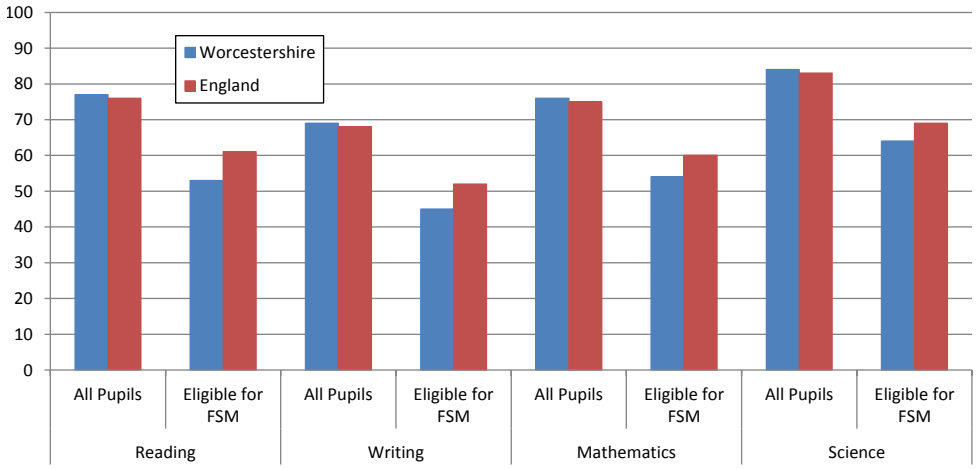

Source: Public Health England, Public Health Outcomes Framework

## 15. Educational Outcomes

### 15.1. Key Stage 1

Over the last few years the percentage of Worcestershire children achieving expected levels at Key stage 1 have risen and are similar or above the national average. However, this masks inequalities in educational outcomes at this stage. In particular Worcestershire children eligible for free school meals at Key stage 1 who, across all areas of reading, writing, maths and science, have considerably lower percentage achieving expected levels than the England averages for children eligible for free school meals.

Figure 61: Percentage of Pupils reaching the expected standards at the end of KS1 (2016/17)

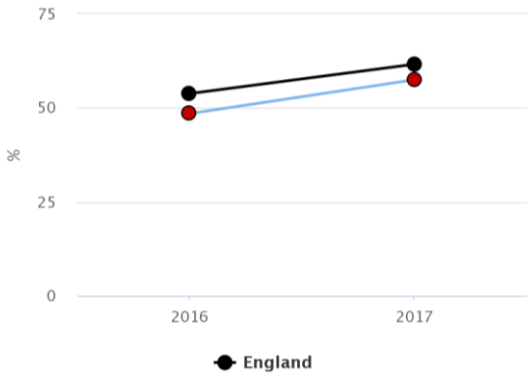



*Source: Department for Education, National curriculum assessments at Key Stage 1, SFR49/2017*

### 15.2. Key Stage 2

The percentage of pupils achieving expected levels at Key stage 2 in Worcestershire has increased over the last year but remains significantly below the national average.

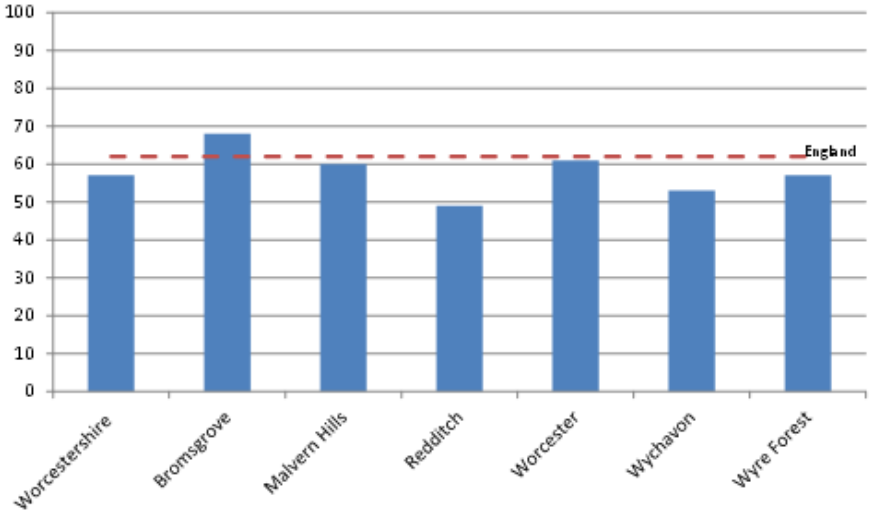
Figure 62: Key Stage 2 pupils meeting the expected standard in reading, writing and maths, Worcestershire and England (2016-2017)




*Source: Public Health England, Public Health Outcomes Framework*

All areas of Worcestershire, with the exception of Bromsgrove, had lower percentages than the national average of pupils who reached the expected standards in reading, writing and mathematics in KS2 in 2017(see Figure 63).

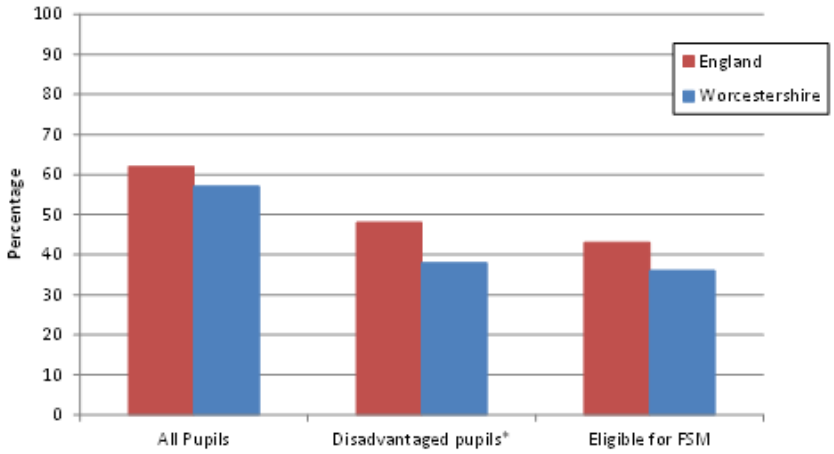
Figure 63: Key stage 2 results in reading, writing and mathematics by District (2016/17)




Source: Department for Education, National curriculum assessments at Key Stage 2, SFR69/2017

The percentages of pupils who are classed as disadvantaged* or eligible for free school meals achieving expected standards at key stage 2 are significantly lower than the national average.

Figure 64: – Key Stage 2 results in reading, writing and mathematics for disadvantaged pupils (2016/7)



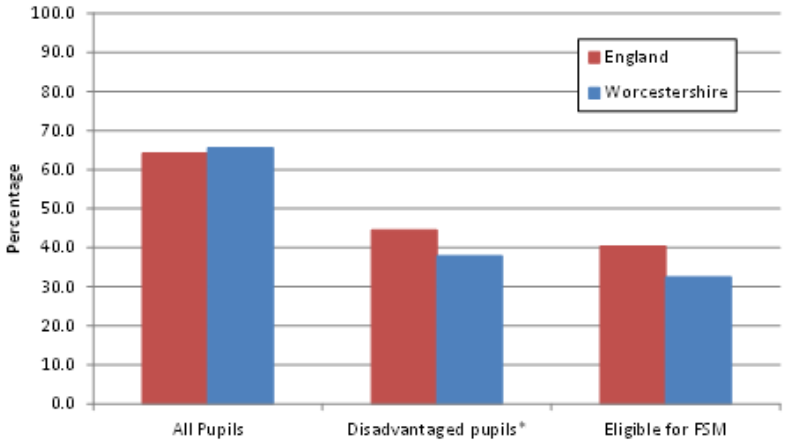

Source: Department for Education, National curriculum assessments at Key Stage 2, SFR69/2017

*Disadvantaged pupils include those eligible for FSM in the last 6 years or are looked after children for at least one day or are adopted from care

### 15.3. Key Stage 4 (GCSEs)

Across the general population in Worcestershire a higher percentage achieved a grade 4 or above in English and Mathematics GCSEs than the average across England in 2016/17. In the new grading system, pupils are graded 9 (highest) to 1 (lowest) where a grade 4 is equivalent to a 'C' in the previous scale. However, results for disadvantaged* children in Worcestershire were poorer when compared to the same cohort of children in England.

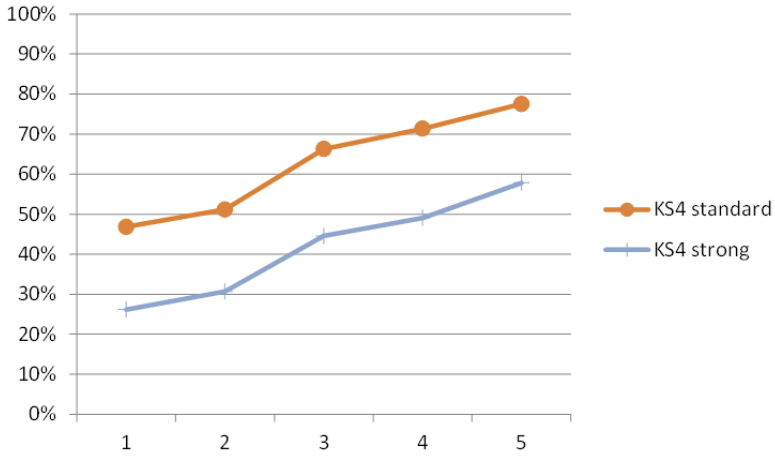
Figure 65: Key Stage 4 (GCSE) results for disadvantaged pupils (2016/17)




Source: Department for Education, National curriculum assessments at Key Stage 2, SFR69/2017

The Key stage 4 results for pupils in 2016/17 have been identified by deprivation quintile. There is a strong relationship with deprivation with poorest overall results for those pupils who live in the most deprived localities (IMD 1) rising across the social gradient. Key stage 4 results appear to be significantly lower for pupils living in the most 40% of deprived localities in Worcestershire (IMD1 and 2)

Figure 66: Educational attainment by IMD quintile in Worcestershire, KS4, (2016/17)




Source: Calculated using data supplied by School Improvement, Worcestershire County Council

### 15.4. Inequalities in Educational attainment

Inequalities before children start school are evident and these widen during the school years and whilst in education. Table 16 provides the percentage of pupils at each key stage who achieve expected levels by each deprivation quintile. The table demonstrates the inequalities in educational outcomes for children across the social gradient and how this widens during the school years. Children from more deprived localities (IMD1) perform worse at all stages than children from more affluent localities with an evident gradient at each quintile of deprivation. In addition the inequality or difference between the most and least deprived widens from EYFS (30%) to Key stage 4 (65%). The inequality or difference for those with "strong" Key stage 4 results is even wider and is more than double (121%).

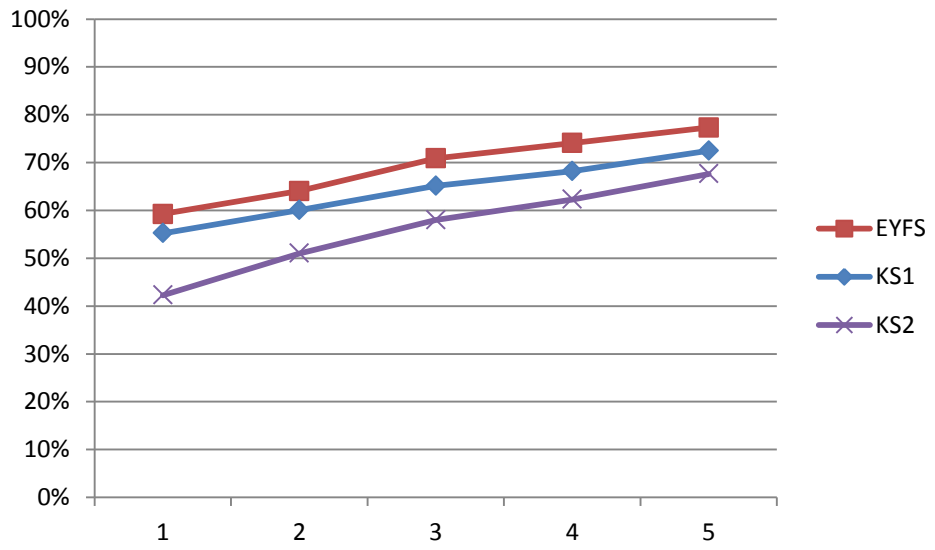
Table 16: Educational attainment by deprivation in Worcestershire, across all Key Stages 2016/17

| IMD Quintile | EYFS | KS1 | KS2 | KS4 standard | KS4 strong |
|---|---|---|---|---|---|
| 1 | 59.3% | 55.2% | 42.3% | 46.9% | 26.2% |
| 2 | 64.1% | 60.1% | 51.0% | 51.2% | 30.7% |
| 3 | 70.9% | 65.1% | 58.0% | 66.3% | 44.6% |
| 4 | 74.1% | 68.2% | 62.3% | 71.4% | 49.1% |
| 5 | 77.3% | 72.5% | 67.6% | 77.5% | 57.8% |
| % increase between IMD1: IMD 5 | 30% | 31% | 60% | 65% | 121% |

*Source: Calculated using data supplied by School Improvement, Worcestershire County Council*

Figure 67 highlights the rising levels of pupils achieving expected levels of attainment by deprivation quintile in 2016/17

Figure 67: Educational attainment by IMD quintile in Worcestershire, EYFS, KS1 and KS2 (2016/17)




*Source: Calculated using data supplied by School Improvement, Worcestershire County Council*

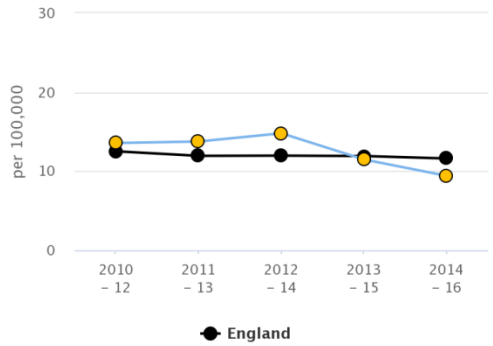
## 16. School age and Adolescent Outcomes

### 16.1. Childhood Mortality (1-17 years)

Death in childhood represents not only a tragedy for that child's family but also a loss to wider society in terms of lost years of productive life. After the age of one year, the commonest cause of death in young people is injuries. Many of these injury related deaths are potentially avoidable. The need to provide adequate support to those children and families with life-limiting or life-threatening conditions is also recognised.

The child mortality rate in Worcestershire is similar to the England rate at 9.4 per 100,000 children aged 1-17 years.

Figure 68: Child mortality rate (1-17 years) - Worcestershire

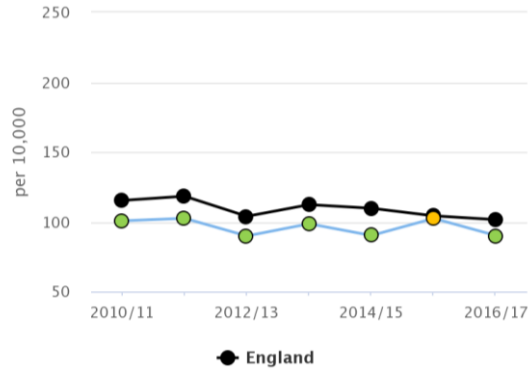



*Source: Public Health England, Public Health Outcomes Framework*

### 16.2. Unintentional Injuries and Emergency Hospital Admissions

Worcestershire has a significantly lower rate of hospital admissions caused by unintended and deliberate injuries to children for ages 0-14 when compared to the England average.

Figure 69: Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-14 years) - Worcestershire

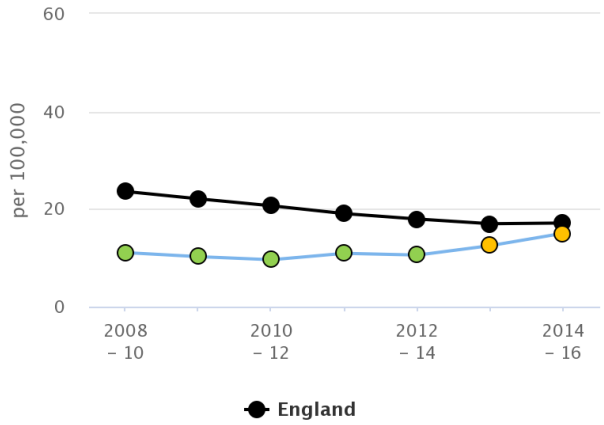



*Source: Public Health England, Public Health Outcomes Framework*

### 16.3. Road Casualties

Road traffic collisions are a major cause of deaths in children, and comprise higher proportions of accidental deaths as children get older. Parents cite vehicle speed and volume as reasons why they do not allow their children to walk or cycle, thereby reducing opportunities for physical activity. Worcestershire has a similar rate of children aged 0-15 killed and seriously injured in road traffic accidents in comparison to England.

Figure 70: Children killed and seriously injured (KSI) on England's roads - Worcestershire




*Source: Public Health England, Public Health Outcomes Framework*

### 16.4. Adolescent outcomes & risk taking behaviours

In 2014/15 the What About YOUth survey was carried out which aimed to collect robust local authority level data on a range of health behaviours amongst 15 year olds. Worcestershire results were largely positive, however, the following indicators showed slightly worse percentages than the England average. There is currently only one year's data available from 2014.

Percentage reported bullying in the past couple of months - Worcestershire has a higher percentage at 58.4% compared to the England average of 54.0%

Alcohol consumption – Worcestershire percentages were generally higher than the England average, for all 3 alcohol indicators. However, only the overall percentage who have ever had an alcoholic drink was statistically significantly higher at 70% compared to the England average of 56.3%.

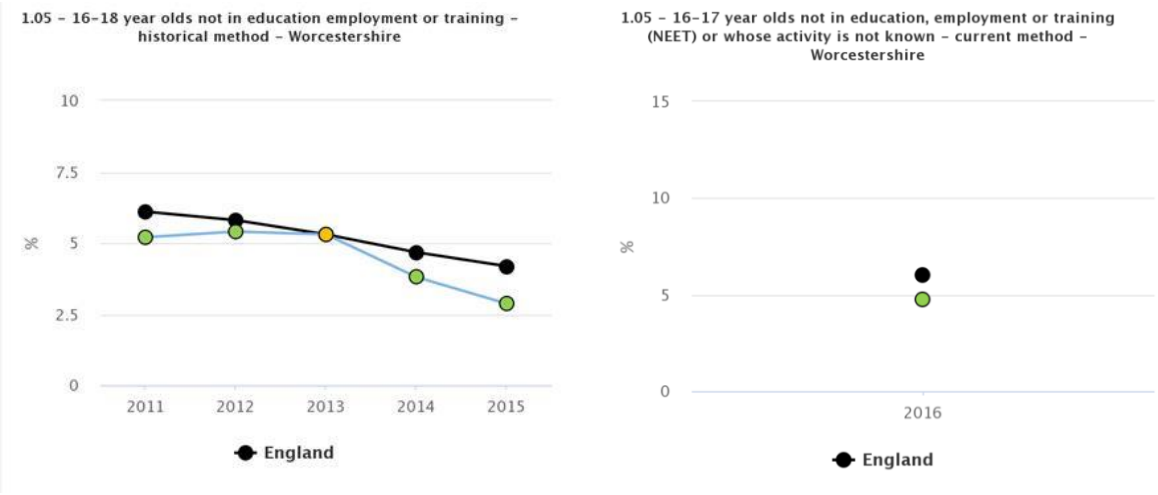
3 or more risky behaviours – Worcestershire had a higher percentage than the England average of 15 years olds who have undertaken at least 3 of the unhealthy/illegal behaviours. These behaviours included smoking, drinking, cannabis, other drugs, less than 5 portions of fruit/veg or not carried out 60 minutes physical activity in the last week.

### 16.5. Young People not in Education, Employment or Training (NEET)

Young people who are not in education, employment or training are at greater risk of a range of negative outcomes, including poor health, depression or early parenthood. The indicator is monitored to encourage services to work together to support young people, particularly the most vulnerable, to engage in education, training and work. Increasing the participation of young people in learning and employment not only makes a lasting difference to individual lives, but is also central to the Government's ambitions to improve social mobility and stimulate economic growth.

To support more young people to study and gain the skills and qualifications that lead to sustainable jobs and reduce the risk of young people becoming NEET, legislation was included in 2013 to raise the participation age as contained within the Education and Skills Act 2008. This required that from 2013 all young people remain in some form of education or training until the end of the academic year in which they turn 17[38].

Historically, Worcestershire has had a significantly lower proportion of 16-18 year olds who are not in education, employment or training (NEET) when compared to the England average, with the exception of 2013 where rates were similar to the England average. The way NEETS were calculated changed in 2016 and therefore data cannot be compared to previous years.




*Source: Public Health England, Public Health Outcomes Framework*

[38] Public Health England (2018) Indicator Definitions and Supporting Information, [Online], Accessed: 14/05/2018, Available from: https://fingertips.phe.org.uk/search/Not%20in%20Education#page/6/gid/1/pat/6/par/E12000005/ati/102/are/E10000034/iid/93203/age/174/sex/4

### 16.6. Outcomes summary since previous EHNA

A summary of all outcomes across each domain is given below and identifies and compares outcomes by domain from the 2015 EHNA to the 2018 EHNA. The summary provides a comparison with the national average and indicates whether this has improved or worsened and the direction of travel.

The summary identifies that in general although many outcomes for CYP have improved in Worcestershire since the previous EHNA, these improvements have not been as great or as fast as the national average and Worcestershire is statistically significantly worse in a number of areas.

Outcomes in pregnancy and birth appear to have worsened or at best remained static. There are a number of comparatively poorer outcomes in early years and for inequalities in outcomes in early years for more vulnerable groups. Although educational outcomes have improved they have not improved as much as nationally and now lag behind. Hospital admission rates have improved and are now better than the England average. The number of vulnerable children and young people identified in need, in care or with a child protection plan has increased however rates are now similar to the national average.

## 17. Early Help Needs Assessment – Outcomes

Getting Better | Similar | Getting Worse

| Outcome | | Measure | 2015 Needs Assessment Data Period | Worcs | Eng | 2018-19 Needs Assessment Data Period | Worcs | Eng | Comment | Comparison to England Average (Current Value) | Change Since Last EHNA |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Pregnancy and Birth | Maternal Obesity | % of women who were classified as Obese at their booking appointment | 2012-13 | 22.5 | - | 2017-18 | 23.5 | - | Rates of Maternal Obesity in Worcestershire have increased since the last needs assessment. | - | ↑ |
| | Smoking in Pregnancy | % of women who smoke at time of delivery | 2012-13 | 14.1 | 12.8 | 2017-18 | 12.5 | 10.8 | Rates of smoking in pregnancy are significantly higher than England. | | ↓ |
| | Low Birth Weight (LBW) of all babies | % of all births with low birth weight | 2013 | 8.0 | 7.4 | 2016 | 8.0 | 7.3 | Rates of LBW have remained unchanged since the last needs assessment. | | ↔ |
| | Low Birth Weight (LBW) of all term babies | % of all live births at term with low birth weight | 2013 | 2.0 | 2.82 | 2016 | 2.72 | 2.79 | There has been very little change in rates of LBW Term babies in Worcestershire. | | ↔ |
| | Under 18 Conceptions | Rate of conceptions per 1,000 females aged 15-17 | 2013 | 25.1 | 24.3 | 2016 | 16.1 | 18.8 | Rates of Teenage Conceptions have reduced since the last needs assessment. | | ↓ |
| | Breastfeeding Initiation | % of all mothers who breastfeed their babies in the first 48hrs after delivery | 2013-14 | 64.3 | 74.0 | 2016-17 | 66.7 | 74.5 | Rates have been significantly lower than England for every year since the last needs assessment | | ↓ |
| | Breastfeeding at 6-8 weeks | % of all infants due a 6-8 week check that are totally or partially breastfed | Change in Methodology | | | 2017-18 | 47.2 | 42.7 | Change in methodology in 2015-16. Comparison cannot be made. | | - |
| Early Years | Infant Mortality | Rate of deaths in infants aged under 1 year per 1,000 live births | 2011-13 | 3.5 | 4.1 | 2015-17 | 4.1 | 3.9 | Increase since last needs assessment. An in-depth analysis is currently being undertaken to establish reasons for this. | | ↔ |
| | MMR Vaccination | % of eligible children who have received one dose of MMR vaccine on or after their 1st birthday and anytime up to their 2nd birthday | 2013-14 | 95.1 | 92.7 | 2017-18 | 92.4 | 91.2 | Decreasing uptake. Rates similar to England. | | ↓ |
| | DTaP Vaccination | % of eligible children who received 3 doses of Dtap / IPV / Hib vaccine at any time by their 2nd birthday | 2013-14 | 97.5 | 96.1 | 2017-18 | 95.4 | 95.1 | Decreasing uptake. Rates higher than England. | | ↓ |
| | Children in Care - Immunisations | Rate per 10,000 population aged under 18 years | 2014 | 54.9 | 87.1 | 2017 | 29.9 | 84.6 | Rates are significantly lower than England. ? DQ Issue, significant fall in rates of uptake. | | - |
| | 5 year olds with Dental Decay (DMFT) | Percentage of children with one or more obviously decayed, missing (due to decay) and filled teeth. | 2011-12 | 20.9 | 27.9 | 2016-17 | 21.8 | 23.3 | Rates have increased since last needs assessment. They remain significantly lower than England but the gap between England and Worcestershire has closed. | | ↑ |
| | Children in Reception - Overweight/Obese | % of children aged 4-5 years classified as overweight or obese | 2012-13 | 22.9 | 22.2 | 2017-18 | 22.4 | 22.4 | Rates have decreased since last needs assessment. Based on the last 5 periods, this is decreasing and getting better. | | ↓ |
| | Children in Year 6 - Overweight/Obese | % of children aged 10-11 years classified as overweight or obese | 2012-13 | 32.0 | 33.3 | 2017-18 | 32.8 | 34.3 | Rates have increased since last needs assessment. They remain significantly lower than England. | | ↔ |
| | Child Development - 2-2.5 years | Total number of children who received a 2-2½ year review who were at or above the expected level in the in all five Ages and Stages | Indicator did not exist | | | 2017-18 | 91.0 | 83.3 | Rates who are at or above the expected level at ages 2-2.5yrs is significantly higher than England. There is no comparator for the previous Needs Assessment | | - |
| | School Readiness - All | All children achieving a good level of development at the end of reception as a percentage of all eligible children. | 2013-14 | 58.1 | 60.4 | 2017-18 | 71.2 | 71.5 | Rates have increased since last needs assessment. Rates are similar to England. | | ↑ |
| | School Readiness - FSM | All children achieving a good level of development at the end of reception as a percentage of all eligible children with Free School Meal Status | 2013-14 | 36.0 | 44.8 | 2017-18 | 50.1 | 56.6 | There has been an improvement in School Readiness for all children at the end of Reception with FSM status. However, rates remain significantly lower than the England average and the gap between children with and without free school meal status is 21.1 percentage points. Highlighting that inequalities remain. | | ↑ |
| Educational Outcomes | Meeting expected standard in the phonics screening check. at the end of KS1 - All | % of key stage 1 pupils achieving the expected standard in the phonics screening check. | 2013-14 | 74.7 | 74.2 | 2017-18 | 82.4 | 82.5 | Rates have increased since the lsat needs assessment and are similar to the England average. | | ↑ |
| | Meeting expected standard in the phonics screening check. at the end of KS1 - FSM | % of key stage 1 pupils achieving the expected standard in the phonics screening check with Free School Meal Status | 2013-14 | 58.8 | 61.3 | 2017-18 | 64.8 | 70.1 | Rates have increased since the last needs assessment. However, rates remain significantly lower than the England average and the gap between children with and without free school meal status is 17.6 percentage points, which has increased since the last needs assessment from 15.9. | | ↑ |
| | Meeting expected standards at the end of KS2 | % of key stage 2 pupils meeting the expected standard in reading, writing and maths | Indicator did not exist | | | 2017 | 57.5 | 61.6 | Rates are significantly lower than England. | | - |
| | Meeting expected standards at the end of KS4 (GCSEs) | % of key stage 4 pupils meeting the expected standard at GCSE level. | 2013-14 | 58.5 | 56.8 | 2015-16 | 60.9 | 57.8 | Rates have increased and are significantly higher than England. | | ↑ |

## Early Help Needs Assessment - Outcomes

Getting Better | Similar | Getting Worse

| Outcome | | Measure | 2015 Needs Assessment Data Period | 2015 Needs Assessment Worcs | 2015 Needs Assessment Eng | 2018-19 Needs Assessment Data Period | 2018-19 Needs Assessment Worcs | 2018-19 Needs Assessment Eng | Comment | Comparison to England Average (Current Value) | Change Since Last EHNA |
|---|---|---|---|---|---|---|---|---|---|---|---|
| School Age and Adolescent Outcomes | Children in Poverty (Under 16's) | % of children in low income families (children living in families in receipt of out of work benefits or tax credits where their reported income is < 60% | 2013 | 14.5 | 18.6 | 2015 | 13.7 | 16.8 | Rates have decreased since last needs assessment. Based on the last 5 periods, this is decreasing and getting better. | | |
| | Family Homelessness | Rate per 1,000 households. | 2013-14 | 1.9 | 1.7 | 2016-17 | 1.9 | 1.9 | There has been no significant change since the last needs assessment. Based on the last 5 periods. | | |
| | Childhood Mortality (1-17 years) | Directly standardised rate of death due to all causes, persons aged 1-17 years. | 2011-13 | 13.8 | 12.5 | 2014-16 | 9.4 | 11.6 | Rates have decreased since last needs assessment. | | |
| | Children Killed and Seriously Injured on the Roads | Crude rate of children aged 0-15 years who were killed or seriously injured in road traffic accidents per 100,000 population | 2011-13 | 11.0 | 19.0 | 2014-16 | 15.0 | 17.0 | Rates have increased since last needs assessment and are now similar to the England rate. | | |
| | First time entrants to the Youth Justice System | Rate of 10-17 year olds receiving their first reprimand, warning or conviction per 100,000 population | 2013 | 460.8 | 448.9 | 2017 | 352.3 | 292.5 | Rates have decreased since the last needs assessment, however, remain significantly higher than the England rate. | | |
| | Young People not in Education, Employment or Training (NEET) | 16-17 year olds not in education, employment or training (NEET) or whose activity is not known | 2013 | 5.3 | 5.3 | 2017 | 5.1 | 6.0 | There has bee a change in methodology since the last needs assessment therefore it is not possible to comment on trend. | | - |
| Hospital Admissions | Unintentional Injuries and Emergency Hospital Admissions (0-14yrs) | Crude rate of hospital admissions caused by unintentional and deliberate injuries in children aged under 15 years per 10,000 resident population | 2013-14 | 98.4 | 112.2 | 2017-18 | 77.7 | 96.4 | Rates have decreased since last needs assessment. Rates are significantly lower than the England rate | | |
| | Admission episodes for alcohol-specific conditions - Under 18's | Hospital admissions for alcohol-specific conditions, under 18s, crude rate per 100,000 population | 2010-11 - 12/13 | 61.8 | 48.0 | 2015-16 - 17/18 | 31.9 | 32.9 | Rates have decreased since last needs assessment. Rates are similar to the England rate | | |
| | Hospital admissions due to substance misuse (15-24 years) | Directly standardised rate of hospital admission for substance misuse, per 100,000 population aged 15-24 years. | 2010-11 - 12/13 | 68.4 | 75.2 | 2014-15 - 16-17 | 60.9 | 89.8 | Rates have decreased since last needs assessment. This is in contrast to nationally, where rates have risen since the last needs assessment. | | |
| | A&E Attendances (0-4years) | A&E attendance rate per 1,000 population aged 0-4 years. | 2013-14 | 406.1 | 525.6 | 2016-17 | 392.5 | 601.8 | Rates have decreased since last needs assessment. Rates are significantly lower than the England rate | | |
| | Hospital Admissions for Asthma | Emergency hospital admissions for asthma, crude rate per 100,000 | 2013-14 | 150.2 | 197.2 | 2016-17 | 169.3 | 258.9 | There has been no significant change since the last needs assessment. Based on the last 5 periods. | | |
| | Hospital Admissions for Mental Health Conditions | Inpatient admission rate for mental health disorders per 100,000 population aged 0-17 years. | 2013-14 | 85.2 | 87.2 | 2016-17 | 65.5 | 81.5 | There has been a reduction in the rate of admissions since the last needs assessment and it is getting better. | | |
| | Hospital Admissions for Self Harm (10-24) | Directly standardised rate of finished admission episodes for self-harm per 100,000 population aged 10-24 years. | 2013-14 | 398.9 | 415.8 | 2016-17 | 364.6 | 407.1 | There has been a decrease in admissions since the last needs assessment. | | - |
| Vulnerable Children and Young People | Children in Need (Rate per 10,000 0-17yrs) | Rate of children in need per 10,000 children aged 0-17 years | 2013 | 323.7 | 346.4 | 2017 | 330.4 | 350.4 | There has been an increase in the rate since the last needs assessment. The rate is lower than England | | |
| | Children subject to a child protection plan | Rate of children subject to a child protection plan per 10,000 children aged 0-17 years | 2013 | 33.2 | 42.1 | 2015 | 44.5 | 43.3 | There has been an increase in the rate since the last needs assessment. The rate is higher than England. | | |
| | Children in Care | Rate per 10,000 population aged under 18 years | 2013 | 55.0 | 60.0 | 2017 | 66.0 | 62.0 | There has been a increase in the rate of children in care since the last needs assessment. This is increasing and getting worse. The rate is similar to England. | | |

## 18. Published evidence about what works

Since the previous EHNA, there has been an increase in scientific knowledge and understanding of the extent to which the experiences of the very early years – from pregnancy to age three – influence, and can significantly determine a range of outcomes health, behaviours, education and social and economic wellbeing. In particular, far more is known about the development of the infant brain, and the crucial importance of the relationship with the infant's primary carer (usually the mother). We also know more about the impact of environmental factors, from exposure to toxins and adversities to opportunities (or the lack of them) to develop social, emotional and cognitive skills. It is also known that the quality of the home environment and early years education can help and improve life chances, and that whole school approaches can help develop resilience and protect emotional health and wellbeing. There is overwhelming evidence that early action to prevent or tackle problems as early as possible can both improve outcomes and result in longer term cost savings. It is then crucial to use universal services and opportunities to provide prevention and identify need as early as possible and ensure these are addressed through evidence based effective early intervention. This section of the EHNA summarises and updates the evidence base about prevention and early intervention that is effective.

### 18.1. Marmot - Giving every child the best start in life

The Marmot Review published in 2010 identified a worsening in health inequalities in England[39] and provides much of the evidence base around using prevention and early intervention to improve outcomes and reduce inequalities. The review argues that, traditionally, government policies have focused resources only on some segments of society. To improve health for all of us and to reduce unfair and unjust inequalities in health, evidence identified that action is needed across the social gradient. Central to the review is the recognition that disadvantage starts before birth and accumulates throughout life. This is reflected in the 6 policy objectives to reduce inequalities and to the highest priority being given to the first objective: Giving every child the best start in life. The review makes the following recommendations for action, which still remain relevant for Worcestershire:

1. Increase the proportion of expenditure allocated to the early years and ensure expenditure is focused progressively across the social gradient.
2. Support families to achieve progressive improvements in early years development, including:

- Giving priority to pre and postnatal interventions, such as intensive home-visiting programmes, that reduce adverse outcomes of pregnancy and infancy
- Providing paid parental leave in the first year of life with a minimum income for healthy living
- Providing routine support to families through parenting programmes, children's centres and key workers, delivered to meet social need via outreach to families

[39] Fair society, healthy lives. The Marmot Review, 2010

- Developing programmes for the transition to school

3. Provide good quality early years education and childcare proportionately across the social gradient. This provision should be:

- Combined with outreach to increase the take up by children from disadvantaged families
- Provided on the basis of evaluated models and must meet quality standards.

The second Marmot policy objective is; Enabling all children, young people and adults to maximize their capabilities and have control over their lives. The review makes the following recommendations for action for children and young people:

1. Ensure that reducing social inequalities in pupils' educational outcomes is a sustained priority
2. Prioritise reducing social inequalities in life skills, by:

    - Extending the role of schools in supporting families and communities and taking a 'whole child' approach to education
    - Consistently implementing 'full service' extended school approaches
    - Developing the school-based workforce to build their skills in working across school–home boundaries and addressing social and emotional development, physical and mental health and well-being

2. Increase access and use of quality lifelong learning opportunities across the social gradient, by:

- Providing easily accessible support and advice for 16-25 year olds on life skills, training and employment opportunities
- Providing work-based learning, including apprenticeships, for young people and those changing jobs/careers
- Increasing availability of non-vocational lifelong learning across the life course.

### 18.2. Economic case for early intervention

Spending on the early years of life should be seen as an investment which will yield returns in future. Giving children the right platform of physical and emotional health, and cognitive, social and linguistic skills from which to thrive will enhance their lives, help to avoid the human and economic costs associated with adverse childhood and adult experiences and provide a skilled, capable adult population to support a future economy[40]. In many areas of child health, small shifts in focus towards prevention would have a profound impact on children's lives while also saving money. These financial gains are major in the long term, but even in the short term they represent significant health improvements and cashable savings. There is a wide range of evidence-based

[40] Annual Report of the Chief Medical Officer 2012, Out Children Deserve Better: Prevention Pays. CMO Annual Report 2012

practice set out, for example in NICE guidance, which if properly implemented would make a real difference.

A recent EIF report makes again the case for investing more time, money and energy in helping children and families overcome adversity at an earlier stage, rather than waiting for issues, such as parental conflict, to reach crisis point. Whilst early intervention has the potential to reduce the growing pressures in children's social care this is in the longer term rather than in the short term. The longer term wider system benefits in supporting a child's growth and development are huge, from increased personal resilience, improved academic outcomes and earning potential to reductions in crime and increased life expectancy. The first recommended local action is to "Agree a clear vision that is founded on the benefits of effective early intervention to local communities and the local economy" and secondly to "Foster a culture of evidence-based decision-making and practice"[41].

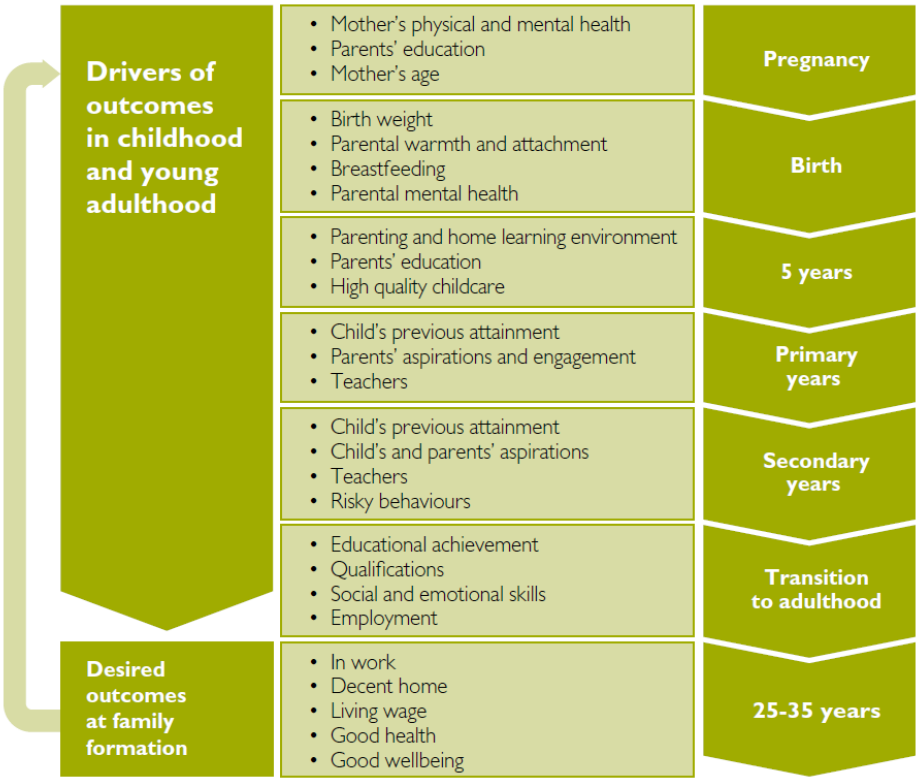
A study  to identify which of the social determinants have the most effect in putting children and young people at social, emotional and cognitive risk identified the most important factors as: lone parenthood; low income; social housing; living in areas of deprivation; young motherhood; maternal education; and health[42].  Frank Field, in his report The Foundation Years, placed these and other factors within the life course, which helps to identify when key factors come into play as depicted in Figure 64[43]. The factors which determine a child's life chances start from conception and change over the life course. The role of parents and families is a consistent factor which influences child outcomes.

[41] Realising the potential of early intervention, October 2018, EIF

[42] Baxter S, Blank L, Messina J, Fairbrother H, Goyder L, Chilcott J. Promoting the social and emotional wellbeing of vulnerable pre-school children (0-5 yrs): Systematic review level evidence. Available at www.nice.org.uk/nicemedia/live/13634/58882/58882.pdf.

[43] HM Government, The Foundation Years: preventing poor children becoming poor adults, The Report of the Independent Review on Poverty and Life Chances, Crown Copyright 2010.

Figure 71: The key drivers of life change throughout childhood




### 18.3. Identifying and tackling wider determinants

Tackling poverty and debt will improve outcomes. Child poverty is associated with a wide range of health-damaging impacts, negative educational outcomes and adverse long-term social and psychological outcomes. The poor health associated with child poverty limits children's potential and development, leading to poor health and life chances in adulthood[44]. Children from large families (3 or more children), lone-parent families, have disabled parents or are of Pakistani or Bangladeshi origin are more likely to be in poverty.

Living in substandard housing can have a profound impact on a child's physical and mental development with implications for both their immediate and future life chances[45]. The numbers of children in Worcestershire living in poor housing is not known but In 2010-11, the English Housing Survey found nationally three in ten children were living in 'bad housing' defined as overcrowded or a non-decent home, 23% lived in a non-decent home and 10% in an overcrowded home[46]. Living in substandard housing can have a profound impact on a child's physical and mental development with implications for both their immediate and future life chances[47]. The impact of poor housing can Increase the risk of severe ill health or disability by up to 25%; children who live in damp, mouldy

[44] S Wickham et al 2016: Poverty and Child Health in the UK: using evidence for action; Archives of Disease in Childhood 101:759-766

[45] Shelter (2006) Chance of a lifetime: The impact of bad housing on children's lives. Shelter - Chance of a lifetime

[46] NatCen (2013). People living in bad housing - numbers and health impacts NatCen Report 2013

[47] Shelter (2006) Chance of a lifetime: The impact of bad housing on children's lives. Shelter - Chance of a lifetime

homes are one-and-a-half to three times more prone to coughing and wheezing; Children living in damp accommodation are more likely to miss school; Poor housing may lead to emergence of problem behaviour[48]. Bad housing is more common for households living in privately rented homes compared to socially rented and owner/mortgaged. Across England, non-decent housing is most common among children living in private rented accommodation and overcrowding more common among those living in social housing. It is estimated that almost one in six families with dependent children are living in non-decent homes. Unhealthy, overcrowded and precarious housing negatively affects attendance at school, educational achievement, family relationships and in turn life chances.

The causes of poor housing, homelessness and child poverty are complex and multifactorial, however their effects on the future health and wellbeing of affected children may be mitigated by targeted early interventions on:

- Perinatal factors such as antenatal health and nutrition, and healthy behaviours
- Support for at-risk parents and families, such as Intensive Home Visiting
- Community services to support early years education and child development, including health visitors and Children's Centres activities.

### 18.4. Pre-conception and pregnancy planning

Maternal weight, smoking, alcohol/substance misuse, folic acid intake, immunisations, long-term physical and mental health conditions, previous pregnancy complications, maternal age, consanguineous relationships and domestic violence of women and men of reproductive age all influence outcomes. Good health before and during pregnancy is vital. Pre-conceptual care includes a variety of services giving universal and targeted advice on:

- full immunisation status
- vitamin D and folic acid
- reducing alcohol consumption
- giving up smoking
- contraception, family spacing and sexual health
- management of weight/long-term conditions
- mental health

Research has identified that 1 in 6 (16.2%) pregnancies experienced in the UK are unplanned. Pregnancies in young, single women are most likely to be unplanned[49]. Recent experiences of smoking, having used drugs, and depression are more common amongst women reporting unplanned pregnancies. This highlights the need to help women and their partners to modify aspects

[48] The health impacts of cold homes and fuel poverty. Marmot Review Team. May 2011. IHE 2011 Cold Homes and Fuel Poverty

[49] Wellings K et al. The prevalence of unplanned pregnancy and associated factors in Britain: findings from the third National Survey of Sexual Attitudes and Lifestyles (Natsal-3). Lancet 2013; 382: 1807–16. Wellings et al, 2013

of lifestyle that could harm their own health and wellbeing, and that of their child[50]. More services need to take a forward and holistic view to promote healthy behaviours and support early interventions to manage emerging risks across the life-course, prior to first pregnancy, and then looking ahead to the next baby and beyond. Preconception care is person-centred and holistic, requiring coordinated, collaborative commissioning, within local maternity systems, across primary care and more broadly.

### 18.5. Teenage Pregnancy and Young Parents

Although teenage pregnancy rates have fallen to their lowest levels since records began continuing to prevent or support teenage pregnancies is still a high priority because outcomes are worse for children of teenage mothers. A response to this requires input of a variety of effective interventions:

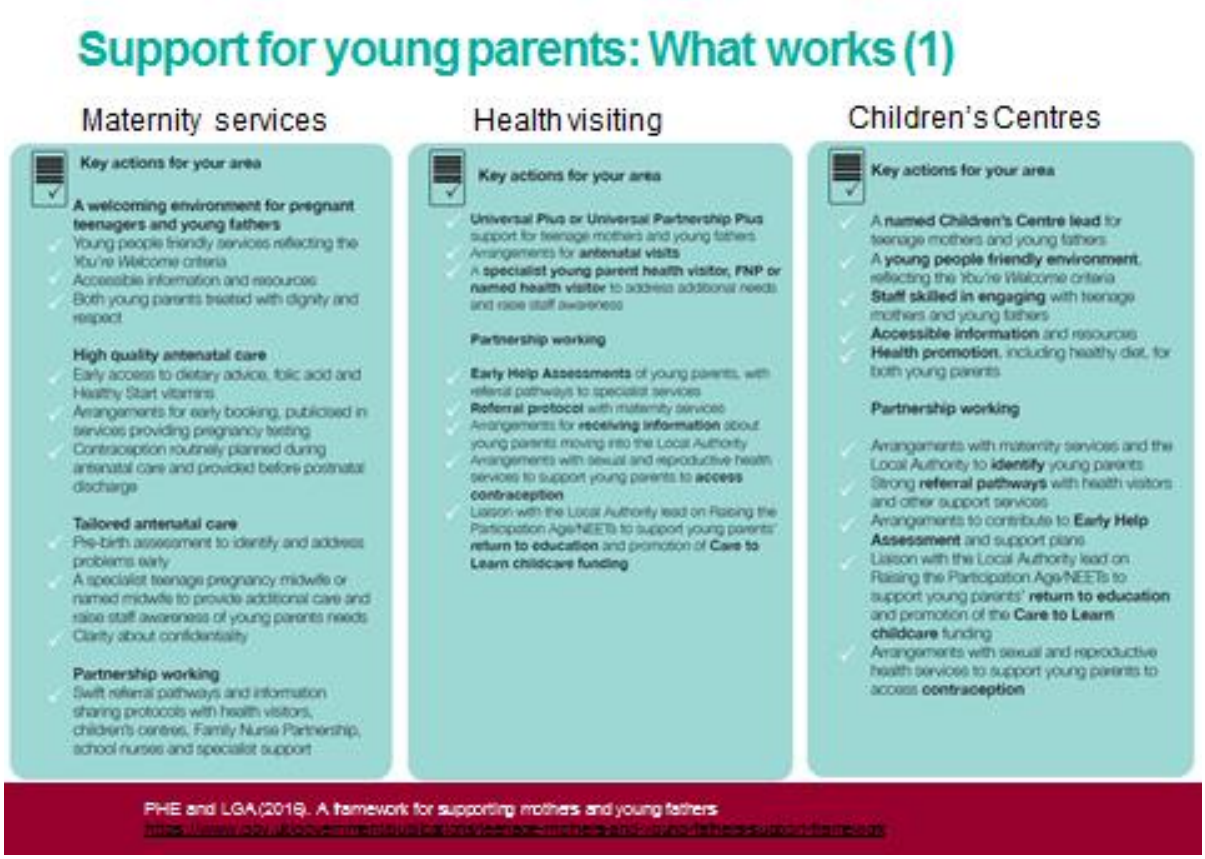
- Good quality sex and relationships education in schools
- Training on relationships and sexual health for health and non-health professionals
- Support for parents to discuss relationships and sexual health
- Youth friendly contraception and sexual health services and condom schemes
- Access to contraception in youth related non-health settings
- Targeted prevention for young people at risk
- Early intervention and coordinated support for young parents including prevention of further unplanned pregnancies
- Consistent messages to young people, parents and practitioners

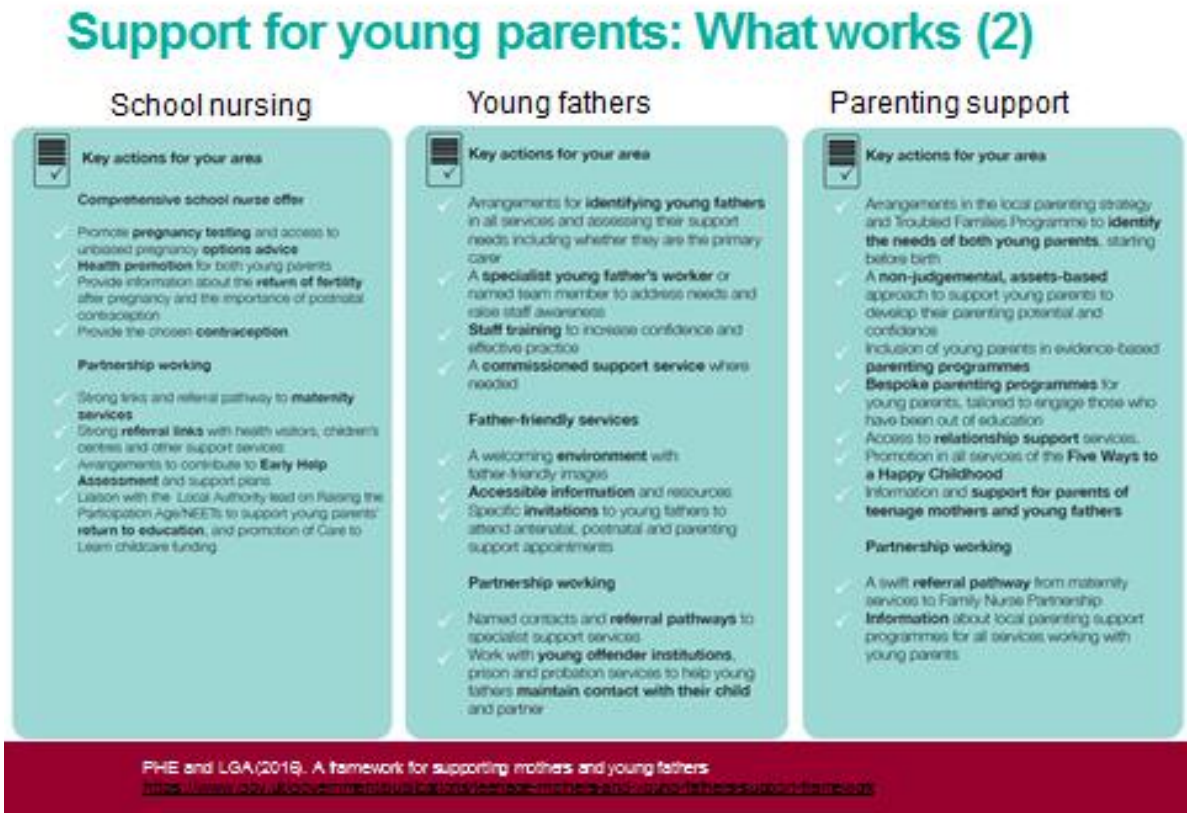
Early help for young parents contributes to preventions by:

- Reducing the risk factors associated with teenage pregnancy by helping teenage mothers, young fathers and their children fulfil their potential
- Supporting young parents to prevent subsequent unplanned pregnancies

[50] Public Health England, May 2016. Health Matters: giving every child the best start in life. https://www.gov.uk/government/publications/health-matters-giving-every-child-the-best-start-in-lif

Figure 72: Evidence based interventions by service to support young parents






### 18.6. Healthy pregnancy and birth

Antenatal development is a natural, but complex process. Mothers can support this process by eating nutritious food, maintaining a healthy weight and abstaining from nicotine, alcohol and drugs. Mothers can also support their unborn child's development by avoiding high levels of stress. The primary aim of most antenatal interventions is to therefore help mothers take care of themselves and prepare for the transition to parenthood.

The physical health of mothers can affect the development of the foetus and is important in preventing a child being born prematurely and/or with a low birth weight. Important aspects include general health, nutrition, exercise and exposure of the foetus to toxins (eg tobacco, alcohol and other drugs)[51]. It is important that women have early access to antenatal care for a full health and social risk assessment. The antenatal booking appointment delivered by midwives (between 8-12 weeks) and the antenatal health promoting visit delivered by health visitors (between 32-36 weeks) needs to be used to identify risks and needs and to help individuals plan for a fit pregnancy and motherhood by offering advice, support and interventions on for example smoking cessation, healthy weight, early identification of poor mental health or early help and support in relation to social risk factors.

[51] The Science Within: What Matters for Child Outcomes in the Early Years, The Social Research Unit at Dartington

Smoking in pregnancy increases the risks of complications in pregnancy and of the child developing a number of conditions later on in life. Smoking is the main modifiable risk factor in pregnancy; rates vary across the county but are strongly related to age and deprivation. NICE have developed evidence based guidelines that recommend[52]:

- All midwives are trained to the same standards as stop smoking advisers.
- All pregnant women are CO screened at the booking appointment and this is recorded to identify smokers and/or those at risk from CO exposure
- There is an 'opt-out' referral pathway for all pregnant women who smoke to a local stop smoking adviser
- There are robust data systems in place

The guidelines recommend that the stop smoking specialist advisers should:

- Provide cognitive behaviour therapy / motivational interviewing
- Provide structured self-help and support from NHS Stop Smoking Services
- Recommend use of NRT and other pharmacological support (mixed evidence of effectiveness)
- Provide clear advice about the danger that other people's tobacco smoke poses to the pregnant women and to the baby before and after birth
- Recommend not smoking around the pregnant woman, mother and baby.

### 18.7. Family Nurse Partnership

The Family Nurse Partnership (FNP) is an intensive home visiting programme delivered by specially trained nurses to first-time young mothers (up to the age of 24, with most clients aged 19 and under). It begins during the mother's pregnancy and then continues until the child's second birthday. Disappointing findings from a recently completed UK trial create challenges in understanding its evidence within the UK context.

However, it is important to note that the FNP programme was not developed only to improve child birth outcomes. While the programme does include maternity care and advice, the programme also focuses on the quality of mother and child interaction during the child's first two years. From this perspective, the relative advantage of FNP within the UK context may be more evident in the years following the child's birth. So while the trial's initial findings are clearly disappointing, it is likely that many of the programmes benefits have yet to be observed.

On the basis of information about resource requirements submitted by the provider, EIF has assigned FNP a cost rating of 5, meaning that it is a high cost programme to implement[53]. Factors contributing to this rating include the fact that is it provided to mothers on a one-to-one bases over

[52] NICE guidelines PH26 (2010): Smoking: Stopping in pregnancy and after childbirth
[53] Early Intervention Foundation (2016): Foundations for Life, what works to support parent and child interaction in the early years

a period of two and a half years (involving approximately 64 sessions lasting one hour each) by highly trained (QCF Level 6) and supervised nurses and health visitors. While these costs are high, the impacts observed on key outcomes in previous trials (including a significantly reduced risk of child maltreatment, significantly reduced behavioural problems in adolescence and a decreased risk of accidental death in early adulthood) suggest a potential 6% return on investment. It is important to consider, however, that these cost calculations are not based on the birth outcomes measured in the UK trial, but on longer-term benefits observed in mothers and children in the US studies.

Although FNP is considered the "gold standard" there is good evidence that intensive home visiting interventions generally can be effective across a range of outcomes.

### 18.8. Perinatal Mental Health

One of the strongest predictors of wellbeing in early years is the mental health and wellbeing of the mother or caregiver[54]. During pregnancy and in the first year after birth, mothers can be affected by a range of mental disorders. Collectively, these issues are termed perinatal mental disorders. Mental illness in pregnancy and the first year after birth is experienced by up to 20 per cent of women in the UK. If left untreated it can impact on the quality of parenting and mother-infant bond, and adversely affect a child's cognitive, emotional and behavioural development. Examples of these illnesses include antenatal and postnatal depression, anxiety, obsessive compulsive disorder, post-traumatic stress disorder (PTSD) and postpartum psychosis.

Some women are at higher risk of experiencing perinatal mental health problems. Risk factors include:

- history of abuse in childhood
- previous history of mental illness
- teenage mothers
- maternal obesity
- traumatic birth
- history of stillbirth or miscarriage
- relationship difficulties

Health Professionals should be alert to the increased risk associated with these risk factors . To increase identification of perinatal mental illness, all midwives and health visitors should incorporate NICE Guidance [QS115] Antenatal and Postnatal mental health into their practice by asking the following Whooley depression identification questions as part of a general discussion about mental health and wellbeing[55]:

[54] MBRACE-UK. Confidential enquiry into Maternal Deaths 2015
[55] PHE 2016, Early years High Impact Area 2: Maternal mental health

During the past month have you often been bothered by:

- Feeling down, depressed or hopeless?
- Having little interest or pleasure in doing things?

Anxiety can be identified using the GAD-2:

- During the past month have you been:
- Feeling nervous, anxious, or on edge?
- Unable to stop or control worrying?

In addition evidence based guidelines recommend:

- All those involved in the care of pregnant or postpartum women should have training in the normal emotional changes associated with pregnancy and the postpartum period, the maternity context, psychological distress, perinatal disorders and early parent-child relationship issues.
- All women with serious psychiatric disorder should have access to specialist advice before becoming pregnant. This should cover the possible impact of pregnancy and childbirth on their condition, and of their condition and its treatment on the outcome of the pregnancy.
- All women should be asked about previous mental health problems at early pregnancy assessment. Those who have had a serious mental illness should be referred to a psychiatrist (preferably a perinatal psychiatrist) for proactive management during pregnancy.
- All women should be regularly asked about their current mental health during pregnancy and the postpartum period and if they have problems whether they would like help.
- All women requiring admission to a psychiatric unit in late pregnancy or the postpartum period should be admitted together with their infant to a specialised mother and baby unit unless there are specific reasons not to do so.
- Women with perinatal conditions who require the care of secondary mental health services should receive specialised perinatal community care.
- Women should have access to psychological and psychosocial treatments including prompt treatment by IAPT and other providers of psychosocial treatments such as listening visits and cognitive counselling by health visitors.
- Managed (strategic) clinical networks should be set up and commissioned covering populations of patient flow of approximately four to five million (delivered population 50,000) to advise commissioners, assist in the development of strategic plans and commissioning frameworks, advise provider organisations, assist with workforce development and training, develop integrated care pathways and develop and maintain a network of involved clinicians and other stakeholders including patient organisations56.

The strength of evidence underpinning various treatments for harmful levels of drug and alcohol use during pregnancy is weak. Commonly used treatments found not to be effective in the general population include brief interventions providing advice to adults engaging in harmful drinking or

[56] Joint Commissioning Panel for Mental Health (2012). Guidance for commissioners of perinatal mental health services

drug use. However, the efficacy of these interventions during pregnancy has not been explicitly tested.

There is good evidence to suggest that methadone treatment programmes improve birth outcomes among children born to mothers with a heroin addiction. Recent studies have also found that buprenorphine is a safe alternative to methadone for managing opioid addictions during pregnancy.

Pregnancy is a period of particular risk for intimate partner violence (IPV), occurring in approximately one-sixth of all pregnancies. IPV substantially increases mothers' experiences of stress and trauma, resulting in increased levels of cortisol in the womb which may contribute to a variety of adverse childbirth outcomes, including maternal and infant death.

There is now good evidence to support the use of a variety of screening practices for the identification of IPV during the perinatal period. FNP remains an evidence-based option for reducing IPV among first-time teenage mothers. Psychosocial support integrated into routine antenatal care has evidence of reducing revictimisation rates among women reporting IPV during their pregnancies. This support provides mothers with information about partner behaviours considered to be abusive, as well as strategies for developing a safety plan.

### 18.9. Early Years

A child's brain doubles in size in the first year and by age three it will have reached 80 per cent of its adult volume. Cognitive skills (memory, problem solving and reasoning) develop more in the early years than at any other time throughout life and there is good evidence to show that if children fall behind in early cognitive development, they are more likely to fall further behind at subsequent educational stages. The early years are also important for the development of non-cognitive skills such as application, self-regulation and empathy – which are emotional and social capabilities that enable children to make and sustain positive relationships and succeed both at school and in later life[57].

Human babies are born very immature, so are highly dependent on their care-givers and a supportive physical and emotional environment. 'Positive stress' can help children develop

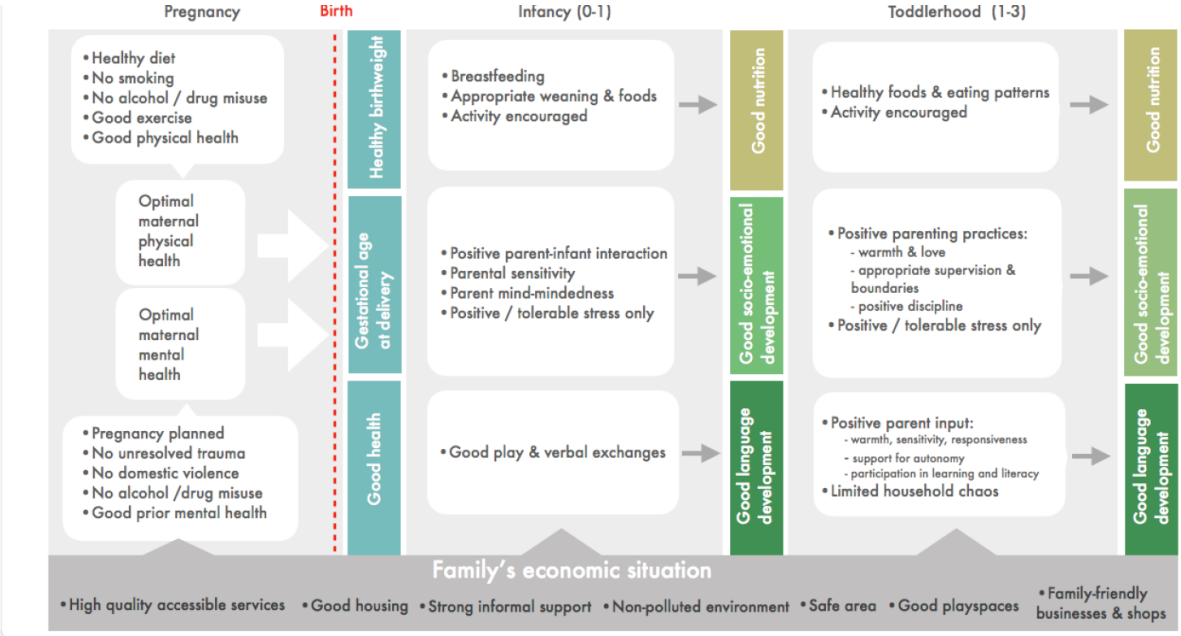
healthy stress response systems; 'toxic stress' leads to changed brain architecture and reduced thresholds for stress, with potentially harmful consequences. Household chaos can affect children's language ability at 36 months, which can have a long-term impact on cognitive development and the child's ability to interact positively with peers[58].

The emotional bond between parent and child is known as attachment. Children's social and emotional skills are formed in large part by their attachment with their parents[59]. Attachment security is associated with better learning outcomes; play which involves verbal exchanges is important for later verbal interaction, and engagement and verbal stimulation with toddlers

[57] Fair Society, Healthy Lives Marmot Review, 2010
[58] The Science Within, Social Research Unit at Dartington
[59] An Equal Start: Improving outcomes in Children's Centres, The Evidence Review. London: UCL Institute of Health Equity 2012

contribute to language development. Good parent–child relationships help build children's self-esteem and confidence and reduce the risk of children adopting unhealthy lifestyles[60]. Taking these points together sets out a vision for what a better start for children looks like as depicted below.

Figure 73: A better start for children[61]




To achieve this start for all children a variety of prevention activity and early interventions will be required. A significant review of high quality evidence [62] identified the following characteristics of effective early years interventions:

- Programmes that are targeted at populations who are most likely to benefit from the interventions are likely to yield the greatest benefits.
- Quality of service provision is important, particularly for childcare.
- Programmes that involve parents, the community and direct interaction with the child appear to have the greatest success.
- Practitioners should be accessible, approachable and responsive; as well as culturally sensitive.
- Intensive, behavioural-based programmes appear to have good results.
- Universal services, particularly those linked to health services, are non-stigmatising and can be used to identify at-risk individuals and refer them to more specialised services.
- Home visiting programmes have been identified as a potentially successful intervention, particularly for young, first-time mothers.

[60] Healthy Lives, Healthy People: Our strategy for public health in England. London: HM Government 2010
[61] Social Research Unit, Dartington, Better Evidence for A Better Start
[62] Mayor of London (2011). Early years interventions to address health inequalities in London

- Parenting education and support programmes can be effective, but some have had limited success with disadvantaged families.
- High quality childcare and early education programmes have been identified as potentially successful early years intervention for children from disadvantaged backgrounds.
- Robust evaluation is necessary to assess what is effective.

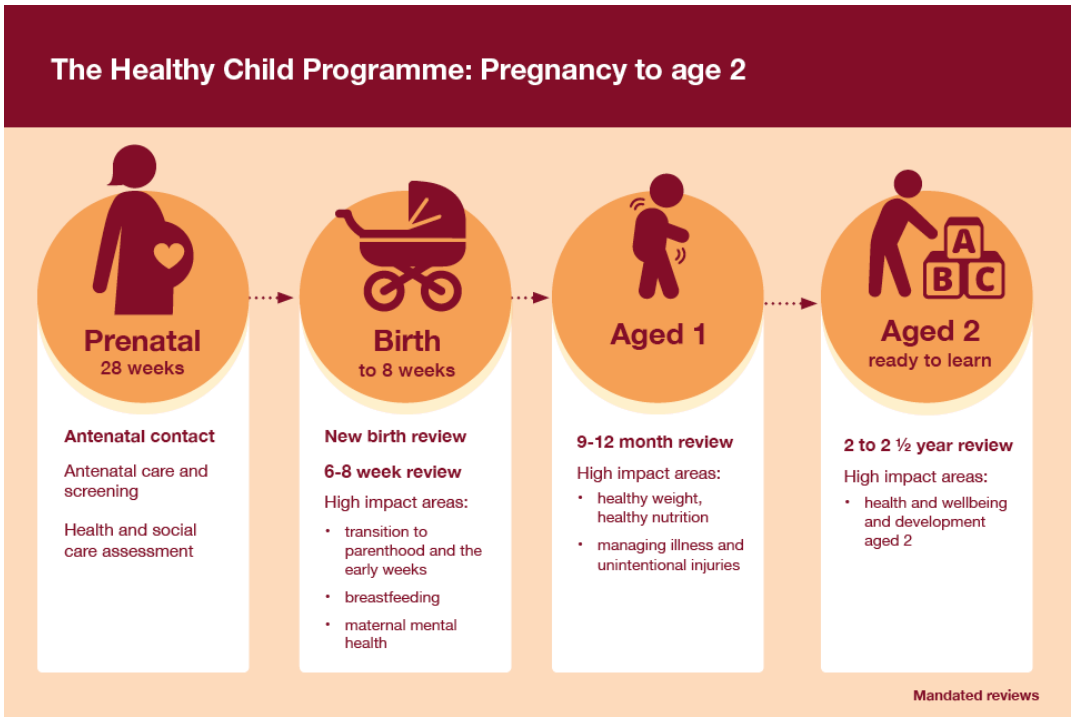
On the balance of all the evidence, the following programmes were suggested as being likely to be effective if implemented or extended further in the UK:

- Pre-natal and post-natal care programmes such as Nurse Family Partnerships (Intensive Home Visiting).
- Pre-school programmes such as the Perry Preschool Programme.
- Follow-on programmes should supplement these interventions during primary and secondary school.

The Healthy Child Programme 0-5 years [63] sets out the schedule for public health services for children and families covering care from 28 weeks of pregnancy through to age 5. It brings together the evidence on delivering good health, wellbeing and resilience for every child and is a universal progressive service with additional services for families needing extra support. The 0-5 HCP is a universal programme delivered by health visitors. It includes extra levels of help and support to those families that need it (see service model below). All families are offered the core elements of the programme which includes five mandated health and development reviews (antenatal health promoting visit, new baby review, 6-8 week assessment, one year review and two – two and half year review), screening, immunisations, social and emotional development support for parenting and health promotion activities.

[63] Healthy Child Programme. Pregnancy and the first five years of life. Department of Health, 2009

Figure 74: The Healthy Child Programme 0-5




Managing the transition to parenthood is an early years high impact area for the Healthy Child Programme. Interventions that aim to support this process typically include activities which give parents information about the childbirth experience, promote breastfeeding and provide strategies for managing the weeks following childbirth.

The extent to which childbirth preparation classes improve birth-related outcomes (reduced pain, fewer birth complications) remains unknown, as few programmes have been rigorously evaluated. However, there is good evidence showing that the Family Foundations programme reduces parental stress and child attachment-related behaviours when offered to couples expecting their first child[64].

In terms of Breastfeeding - There is now good evidence showing that breast milk protects infants from a wide variety of infectious diseases and reduces the risk of breast and ovarian cancer in mothers. There is also good evidence to suggest that the likelihood of these benefits increases with the duration and exclusivity of breastfeeding. Individual breastfeeding advice, provided to mothers over the phone and in person in the weeks before and after childbirth has the best evidence of increasing breastfeeding initiation and duration rates.

Unicef have modelled the cost effectiveness of increasing breastfeeding rates in the UK and demonstrated the return on investment for additional interventions[65]. Public Health England

[64] https://www.eif.org.uk/download.php?file=files/pdf/what-works-to-enhance-effectiveness-healthy-child-summary.pdf
[65] UNICEF UK (2012) Preventing disease and saving resources: the potential contribution of increasing breastfeeding rates in the UK

identified what works in terms of increasing breastfeeding at the population level[66]. They have identified an evidence based 4 part approach:

Figure 75: Breastfeeding – What Works?


Early Language - The rate at which children develop language is sensitive to the amount of input they receive from the adults around them; however, the quality of linguistic input that children receive is likely to be more important than the quantity. Language skills are then shaped and nurtured by the child's 'home learning environment' (HLE), which includes the physical characteristics of the home, but also the quality of the implicit and explicit learning support they receive from the caregivers[67].

Recently published reports by the Early Intervention Foundation and Education Endowment Foundation highlight the strong association between early language delay, deprivation and inequalities: Between 5% and 8% of all children have early language difficulties; however children from low income households are two times more likely to experience these difficulties. In areas of higher deprivation, up to 50% of children may start school with delayed speech, language and communication skills. There is good evidence that intensive home visiting interventions support children's language development in the early years.

Babies are born ready to communicate; midwifery, health visiting and Early Years services are well placed to promote parental attunement during pregnancy and the first few years of life to support

[66] Public Health England 2016: https://www.gov.uk/government/case-studies/providing-support-and-guidance-on-breastfeeding
[67] Melhuish, E. C. (2010). Impact of the home learning environment on child cognitive development: secondary analysis of data from" Growing Up in Scotland"

parents to recognise and respond to their baby's individual cues and gestures which provide the foundation for future language. The Healthy Child Programme highlights that the preschool years represent a prime opportunity to promote the language and communication of all children and identify those children who are not developing as expected and require targeted and specialist intervention to improve their outcomes. NICE quality standard CG recommends screening for speech language and communication difficulties at the 2.5 year mandatory check.

A recent DfE policy paper summarises the evidence regarding the influence of the Home Learning Environment (HLE) on child outcomes and proposes a whole system and behaviour change approach. It identifies and recommends a "Chat, Play, Read" behaviour change model to help parents create a positive HLE, and which will be simple and easy to communicate through a range of channels and nudges. Chat, Play, Read can also rally and support those professionals, volunteers and communities working with families every day[68].

### 18.10.Parenting Interventions

Positive, warm parenting with firm boundaries and routines supports social and emotional development and reduces behavioural problems. There is evidence that a range of parenting programmes designed for families with children of a particular age are effective.

Parenting interventions could reduce inequalities in health across the social gradient if they result in better living conditions for families, higher maternal wellbeing, good parenting actions or improved outcomes for children. To reduce health inequalities, commissioning of parenting programmes should be part of a wider local system of measures to support parents. Good financial and emotional resources make it easier for parents to take good parenting actions.

A good transition from home or nursery into school is important particularly for children living in more difficult circumstances, those with special needs, or for whom English is not a first language

Good home to school transition programmes have been linked to better outcomes particularly for at-risk groups which means they have a role to play in reducing inequalities in outcomes.

Parenting programmes: What works? The Early Intervention Foundation assessed 75 early intervention programmes aimed at improving child outcomes through positive parent-child interactions in the early years[69]:

The report found that although the overall evidence base for programmes available in the UK is not yet mature, there is a range of well evidenced and promising interventions that, if carefully commissioned to ensure they fit with local need and context, are likely to be effective in tackling problems identified in the early years

[68] Improving the home learning environment : A behaviour change approach. DfE, November 2018
[69] Early Intervention Foundation (2016). Foundations for life: What works to support parent child interaction in the early years

Overall the evidence is strongest for programmes that target based on early signals of risk, such as child behaviour problems, insecure attachment, delayed development of speech and lack of maternal sensitivity.

The review focussed on 3 key areas of child development and found 17 programmes that are well evidenced and a further 18 have preliminary evidence of impact. 35 programmes were identified that cannot yet be considered evidence based in terms of having rigorous evidence of impact, but were based on good science and robust implementation processes and could become the high quality, evidence based interventions of the future (NL2). Five programmes were rated by the EIF review as having had "no effect". Programmes with the highest level of evidence (4 or 4+) are identified below.

The review did conclude however, that if commissioned, targeted and implemented carefully, many of these 75 programmes have the potential to enhance development and tackle problems identified in the early years and, for example, improve children's behaviour and achievement at school, or prevent mental health problems when they are older.

Attachment - Programmes that help enhance attachment demonstrated substantial reductions in important risks for vulnerable children. Although relatively high cost, involving frequent contact with vulnerable families for a period of a year or longer they, were also relatively high impact. The review found 5 programmes (18%) with good evidence (Level 3 and 4 Evidence) of improving children's attachment security or attachment related behaviours and 6 programmes with preliminary evidence that they may be effective (Level 2). Highest level of evidence was identified for Family Nurse Partnership (4+) and Family Foundations (4).

Behaviour - best evidence involves families with a noncompliant child aged 2 or older. When well targeted these programmes can keep problems from becoming worse and improve the parent/child relationship. There is less evidence for the effectiveness of programmes that aim to prevent problems emerging in the first place. These programmes tend to be relatively low cost, often based on group activity and of relatively short duration. The review found 10 programmes (37%) with good evidence in improving children's behaviour (Level 3 and 4 Evidence) and 5 programmes with preliminary evidence that they may be effective (Level 2) . Highest level of evidence found for Incredible Years preschool (4+)

Early cognitive and language development - the length and intensity of the intervention contribute strongly to the size and duration of its impacts. The review found 2 programmes (10%) with good evidence of improving cognitive development (Level 3 and 4 evidence) and 7 programmes with preliminary evidence that they may be effective (Level 2).

Table 17: Evidence-based programmes to support parent child interaction

| | |
|---|---|
| Programmes that help enhance attachment | • FNP (4+)<br>• Family Foundations (4)<br>• Child–Parent psychotherapy (3+)<br>• Infant-parent psychotherapy (3+)<br>• Child First (3)<br>• Nobody Slips Through the Net (2+) |

| | |
|---|---|
| | • Toddler-Parent Psychotherapy (2+)<br>• Play and Learning Strategies (PALS) (2+)<br>• Watch, Wait, Wonder (2+)<br>• Circle of Security (group) (2)<br>• Mellow Toddler (formerly Mellow Parenting) (2) |
| Interventions that help parents manage children's behaviour | • The Incredible Years Preschool BASIC (4+)<br>• The Family Check-Up (FCU) for Children (3+)<br>• Triple P Discussion Groups (3+)<br>• Triple P Group (3+)<br>• The New Forest Parenting Programme (3+)<br>• ParentCorps (3+)<br>• Triple P Standard (3)<br>• Empowering Parenting and Empowering Communities (EPEC) (3)<br>• Dare to be you (2+)<br>• Parents Plus Early Years (2+)<br>• Solihull Approach Parenting Group (2)<br>• Families and Schools Together (FAST) Preschool (2)<br>• Helping the Noncompliant Child (3)<br>• Hitkashrut (3)<br>• Incredible Years Toddler (2+) |
| Interventions that support children's early cognitive and language development | • Raising Early Achievement in Literacy (REAL) (3)<br>• Let's Play in Tandem programme (3)<br>• Parents as First Teachers (PAFT) (2+)<br>• Getting Ready (2+)<br>• Missing Home Instruction Program for Preschool Youngsters (HIPPY) (2+)<br>• Learning Together Programme – Foundation PEEP: 3s Level (2+)<br>• Learning Together Programme – Foundation PEEP: 4s Level (2+)<br>• Lidcombe Program (2+)<br>• Reach out and Read (ROR) (2+) |
| Found not to be effective in at least one rigorously conducted study (NE) | • Maternal Early Childhood Sustained Home-visiting (MECSH)<br>• Social Baby Approach<br>• Family Links Nurturing Programme<br>• Toddlers without tears<br>• Let's Learn Language |

Key:

- Level 4 recognises programmes with evidence of a long-term positive impact through multiple high-quality evaluations.
- Level 3 recognises programmes with evidence of a short-term positive impact from at least one high-quality evaluation.

- Level 2 recognises programmes with preliminary evidence of improving a child outcome, but where an assumption of causal impact cannot be drawn.
- NE (No effect) Found not to be effective in at least one rigorously conducted and did not provide significant benefits for children.

*It should be noted that "Parents 1st Community Parent Volunteer Peer Support Programme" was rated as NL2 (not level 2) indicating that this cannot yet be considered evidence based in terms of having rigorous evidence of impact, but is based on good science.

There is strong evidence that conflict between parents – whether together or separated – can have a significant negative impact on children's mental health and long-term life-chances. Not all conflict is damaging, but where this is frequent, intense and poorly resolved it can harm children's outcomes.

The government's Improving Lives strategy introduced a new focus on tackling the impact of parental conflict on children, with the aim that this will become mainstream, alongside support for parenting. As part of this work, the Department for Work and Pensions (DWP) is leading a national Reducing Parental Conflict Programme to embed evidence-based support to tackle parental conflict in local areas.

There is evidence that inter-parental relationships are crucial to children's outcomes and development. Despite this, the evidence about interventions and what works to improve parental relationships is still at an early stage. The majority of interventions which have robust evidence come from outside the UK, and many lack of evidence of how they improve child (rather than parent or couple) outcomes. There are, however, a growing number of interventions that have shown that they can be effective in improving relationship quality and child outcomes. However The UK evidence of effective programmes to address inter-parental conflict with a view to improving child outcomes is still at an early stage. Supporting practitioners to identify relationship problems early and refer families to the right interventions is essential in tackling parental conflict.

### 18.11. School Readiness

School readiness is a measure of how prepared a child is to succeed in school cognitively, socially and emotionally. The good level of development (GLD) is used to assess school readiness. Children are defined as having reached a GLD at the end of the Early Years Foundation Stage if they achieved at least the expected level in the early learning goals in the prime areas of learning (personal, social and emotional development, physical development and communication and language) and in the specific areas of mathematics and literacy. There is a wealth of evidence showing that for children these skills are fundamental to their future educational, health and life outcomes. Investing in school readiness and providing early intervention is cost effective and provides a return on investment.

## Why invest in school readiness?

Failing to invest sufficiently in quality early care and education short changes taxpayers because the return on investment is greater than many other economic development options

In the UK every **£1** invested in quality early care and education saves taxpayers up to **£13** in future costs

For every **£1** spent on early years education in the UK, **£7** has to be spent to have the same impact in adolescence

The benefits associated with the introduction of the literacy hour in the UK outstrip the costs by a ratio of between **27:1** and **70:1**

Targeted parenting programmes to prevent conduct disorders pay back **£8** over six years for every **£1** invested with savings to the NHS, education and criminal justice system

Several factors have been shown to increase school readiness. The interaction between some of them may also result in a synergistic effect in improving outcomes for children and some can compensate for others. Several of the factors are also especially effective for children from disadvantaged backgrounds.

- Good maternal mental health: This reduces the chances of children having behavioural and emotional issues, is associated with better birth outcomes and serves as a protective factor in family breakdown.
- Parenting support programmes: Positive parenting styles enhance a child's emotional wellbeing, brain development and capacity to learn. Parenting support programmes have been shown to positively impact on parental mental health, especially those during the antenatal period, which also has an effect on children's behaviour and emotions.
- Integrated health, education & social care services in early years: to support good child development, prioritise identification of need and provision of holistic prevention and early intervention to better support parents and children
- Learning activities, including speaking to your baby and reading with your child: These impact educational achievement as well as socioemotional development. The Home Learning Environment has a greater impact on a child's social and emotional development than certain parental factors such as income and occupation. This means that a good learning environment in the home can counteract the effects of disadvantage.
- High-quality early education: This impact on children's numeracy and literacy can compensate for the home learning environment and is especially effective for disadvantaged pupils.
- Enhancing physical activity: Physical activity for young children is an important component of early brain development and learning. Communication skills depend on well-developed physical skills.

### 18.12. Home to school transition

When children start school, a good transition from the home or nursery environment to school is important, particularly for children living in more difficult circumstances, those with special needs, or for whom English is not a first language. Good home to school transition programmes have been linked to better outcomes, particularly for at risk groups, which means that they have a role to play in reducing inequalities in outcomes. Practices to support a child's start at school like open days, familiarisation lessons and visits, are linked with children making a better adjustment to the school environment and having improved social and emotional skills. Support for parents through the transition period can also be helpful in reducing anxiety and social isolation.

Good transition practices have been identified [70] as follows:

- Focus on the whole child - for example, ask children about family, likes and dislikes and show an interest in more than knowledge of the alphabet
- Implement a variety of practices - use of several practices (e.g. open days, information sessions, one to one support) is particularly beneficial for children who have the greatest risk of a making a poor transition.
- Provide targeted support for at-risk groups such as looked-after children and those from disadvantaged backgrounds
- Be flexible and responsive to local needs for example, by being flexible on times, providing appropriate translation services and creches.
- Ensure strong leadership and high-quality delivery – this includes strong leadership from the LA and full engagement from senior management within schools.
- Share information and proactively seek it – for example record sharing, pre-school and school linking schemes, teachers familiarising themselves with previous curriculums in pre-school and getting transition information from parents and other services in contact with the child
- Hold induction and orientation meetings for when the child starts school.
- Adopt shortened school days at the beginning of the school year
- Continue some of the activities and routines from EYFS at Key Stage 1
- Ensure good communication between all parties

### 18.13.Oral Health

Good oral health is integral to a child's general health and wellbeing. Oral health affects how children grow, enjoy life, look, speak, chew, taste food and socialise, as well as their feelings of social wellbeing. Poor oral health and associated pain and disease can lead to difficulties in eating, sleeping, concentrating and socialising, thereby affecting health-related quality of life with individual, family and societal consequences (school absence, time off work and financial impacts to

[70] PHE and UCL Institute of Health Equity – Local action on health inequalities: good quality parenting programmes and the home to school transition

the individual and society). Tooth decay is the most common oral disease affecting children and young people in England, yet it is largely preventable. While children's oral health has improved over the past 20 years, almost a quarter (24.7%) of five year olds in England have tooth decay having on average 3 or 4 teeth affected.

Oral health is an integral part of overall health; when children are not healthy, this affects their ability to learn, thrive, and develop. Good oral health can contribute to school readiness. Often dental treatment for young children (such as extractions of decayed teeth) may only be done under general anaesthetic, which is both distressing for the families concerned and carries a financial burden. Tooth decay accounts for high numbers of child general anaesthetics and for children aged between five and nine years across England it is the most common reason for hospital admission.

What works for improving oral health has been identified[71] as:

- Supporting consistent evidence informed oral health information
- Oral health training for the wider professional workforce (e.g. health, education)
- Integration of oral health into targeted home visits by health/social care workers
- Community-based preventive services
- Targeted community-based fluoride varnish programmes
- Targeted provision of toothbrushes and tooth paste (i.e. Postal or through health visitors)
- Supportive environments
- Supervised tooth brushing in targeted childhood settings
- Healthy food and drink policies in childhood settings
- Fluoridation of public water supplies
- Community action
- Targeted peer (lay) support groups/peer oral health workers
- Healthy public policy
- Influencing local and national government policies

### 18.14. Healthy Weight and physical activity

Obesity harms children and young people. It causes health harms such as high cholesterol, high blood pressure, pre-diabetes, bone and joint problems and breathing difficulties. It contributes to school absence and can impact their emotional and behavioural outcomes as a consequence of stigmatisation, bullying or low self-esteem. Overweight/Obese children are more likely to be overweight adults and increase their lifetime risk of ill health and premature mortality. Research demonstrates tackling obesity is a good return on investment and can create savings across society.

[71] PHE (2014) Local authorities improving oral health: commissioning better oral health for children and young people: an evidence-informed toolkit for local author

Preschool children should aim for 3 hours of activity each day achieved through play and activities. Evidence shows the following works to tackle obesity[72]:

- Multi-component and holistic approach that aims simultaneously to improve diet and physical activity in multiple domains of children's lives.
- The following have been identified as effective components of interventions:
- Decreasing pre-schoolers' screen time
- Decreasing consumption of high fat/calorie drinks/foods
- Increasing physical exercise
- Increasing sleep
- Modifying parental attitudes to feeding
- Promoting authoritative parenting
- Involving whole families (parents and children) in interventions that promote both healthier diet and more exercise

To increase physical activity in under 5s the following evidence based actions have been identified:

- Active play is important in tackling inactivate lifestyles. For children under 5, active play is the predominant source of physical activity and is essential to children's growing bodies and developing physical literacy.
- Free play provides opportunities for children to role play and practice decision making skills to support future risk taking behaviours. Play can also support children to develop relationships with their parents and peers.
- Evidence shows play initiatives lead to improvements in children's health and wellbeing, and are linked to a range of other cognitive and social developmental benefits. Free play is also more accessible for children from lower socio-economic groups who have less access to structured sport/exercise[73].
- While the evidence is strongest in schools, it is reasonable to expect that they will also be seen in childcare settings. Childcare settings and Schools can support active play by establishing an environment that provides a variety of opportunities for children to play both indoors and out. This includes a variety of equipment and challenges to support both free and structured play.

There are a range of NICE guidelines and quality statements that support the identification, assessment, prevention and treatment of obesity in children and young people that should be supported at scale.

### 18.15. Healthy Child Programme

The Healthy Child Programme 0–19 is an evidence-based framework for the delivery of public health services to families with a child between conception and age 19. This is a universal prevention and

[72] PHE (2015): Rapid Review to update evidence for the Healthy Child Programme 0-5
[73] UK Physical Activity Guidelines (2011)

early intervention programme and aims to ensure that every child gets the good start they need to lay the foundations of a healthy life.

An effective universal service is central to the success of the Healthy Child Programme; Marmot's review of health inequalities concluded that, "Focusing solely on the most disadvantaged will not reduce health inequalities sufficiently. To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. Marmot (2010)"

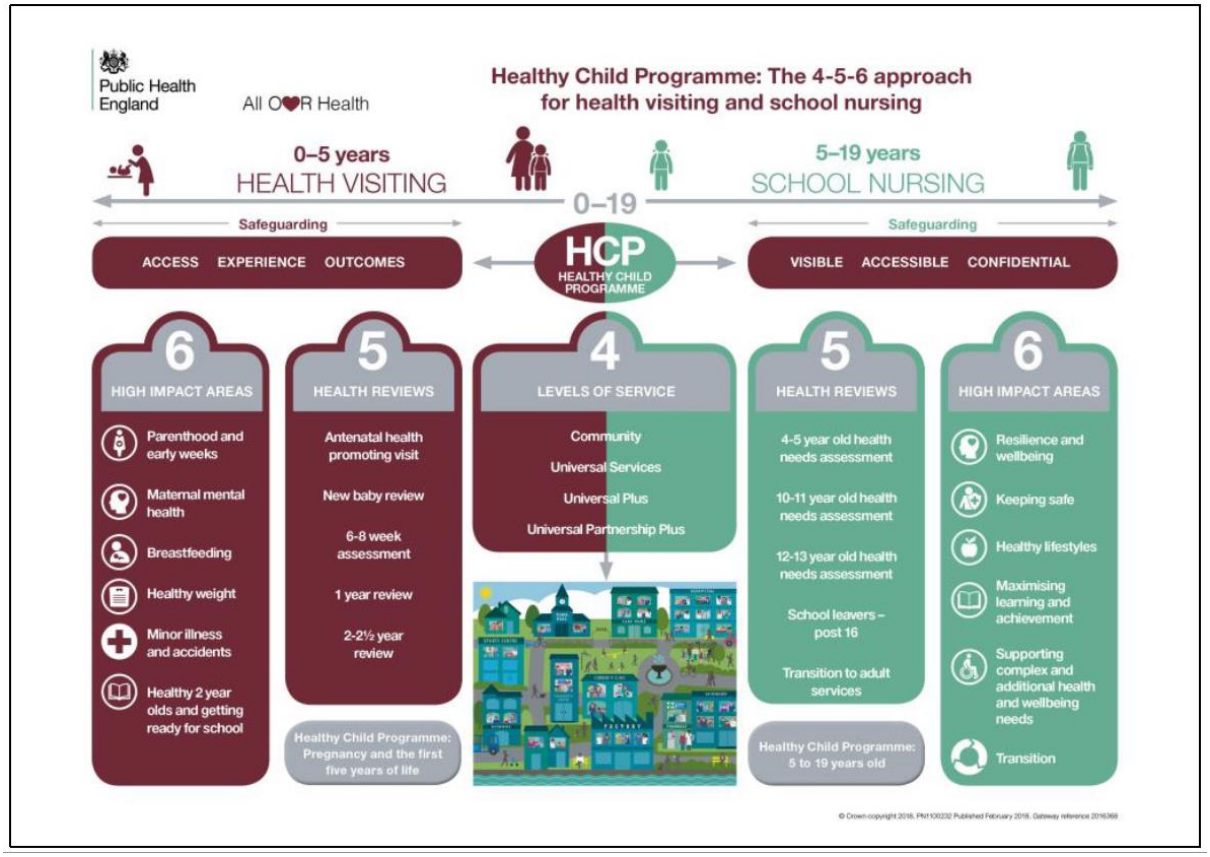
The HCP comprises child health promotion, child health surveillance, screening, immunisations, child development reviews, prevention and early intervention to improve outcomes for children and reduce inequalities. The 0-5 element of the Healthy Child Programme is led by health visiting services and the 5-19 element is led by school nursing services, providing place-based services and working in partnership with education and other providers. These professional teams provide the vast majority of Healthy Child Programme services. The universal reach of the Healthy Child Programme provides an invaluable opportunity from early in a child's life to identify families that are in need of additional support and children who are at risk of poor outcomes.

The Healthy Child Programme provides a framework to support collaborative work and more integrated delivery. The Programme (0-19) aims to:

- help parents develop and sustain a strong bond with children
- support parents in keeping children healthy and safe and reaching their full potential
- protect children from serious disease, through screening and immunisation
- reduce childhood obesity by promoting healthy eating and physical activity
- identify health and wellbeing issues early, so support and early interventions can be provided in a timely manner
- focus on the health needs of children and young people ensuring they are school ready
- make sure children are prepared for and supported in all child care, early years and education settings and especially are supported to be 'ready for to learn at two and ready for school by five'

In addition 6 high impact areas for early years and 6 high impact areas for school aged years have been developed to maximise and focus the health visiting and school nursing impact and revised to link to current policy drivers and recent evidence. The high impact areas are part of the 4-5-6 model shown in Figure 76. The 4-5-6 model provides an evidence-based framework on which health visitors and school nurses, as leaders of the Healthy Child Programme, can maximise their contribution.

Figure 76: The 4-5-6 model for health visiting and school nursing




The 12 high impact areas do not describe the entirety of the role and of the health visiting and school nursing services. There is still a requirement to deliver all elements of the Healthy Child Programme within the service model: Community, Universal, Universal Plus and Universal Partnership Plus, and support is tailored to individual and community needs. The high impact areas provide an opportunity to consider areas which provide the biggest impact in improving outcomes for children, young people and families, using the universal reviews and key contact points to improve individual, community and population health.

There are a number of core principles that are common in each of the high impact areas:

- health visitors and school nurses have an important role as leaders of the Healthy Child Programme, which should form part of multi-professional care pathways and integration of services for maternity and healthy pregnancy and for children aged 0-5 and 5-19 years
- universal services are essential for primary prevention, early identification of need and early intervention - universal services lead to early support and harm reduction
- early intervention evidence-based programmes should be used to meet needs and to ensure that changing needs are identified in a timely way
- all areas are/should be focussing on improving health outcomes and reducing inequalities at individual, family and community level
- outcome measures need to align between health and education/other early years and school age providers and there should be shared outcomes across the health and social care system

- safeguarding is a thread through all of the high impact areas ranging from identification of risk and need, to early help and targeted work, through to safeguarding and formal child protection
- health needs will be identified in partnership with parents, children and young people using an approach that builds on their strengths as well as identifying any difficulties. Clinical judgement will be used alongside formal screening and assessment tools
- engagement with the whole family is an important component of the Healthy Child Programme
- public health, health promotion and health prevention issues are discussed during every contact
- early years, education, voluntary organisations, social services, peer supporters, GPs and primary care teams, oral health and secondary care providers all have an important contribution to make towards improving of child health outcomes
- partnership, integration, communication and multi-agency working are key to improving outcomes

When HCP 0–5 was first introduced in 2009 it was based on the best available evidence summarised in the fourth edition of Health for All Children[74] and supplemented with guidance from NICE. However there have been two recent rapid reviews which have updated and enhanced the HCP[75,76] and an EIF review of the effectiveness of the HCP[77] which supported the effectiveness of the HCP as a delivery mechanism for identifying need and for midwives, health visitors and school nurses in providing some of the targeted indicated early interventions directly.

Promotion of Good Mental Health & Wellbeing and Mental Health Support

Rates of cyberbullying and self harm in adolescents have increased. It is estimated that 10% of children aged 5 to 16 will suffer from a significant mental health illness and that 50% of those with a lifetime mental illness experienced symptoms before they were 14. Promoting emotional health & wellbeing and preventing poor mental health is high priority and cost saving.

Health visitors and school nurses are well placed to play a key role in promoting emotional wellbeing and positive mental health of children, young people and their families. They have a specific contribution to make in identifying issues, using protective screening and providing effective support. The different levels of intervention across the 4 tiers of health visiting and school nursing service model are outlined in 'Promoting emotional wellbeing and positive mental health of children and young people'[78]

[74] Hall, D. M., & Elliman, D. (2006). Health for all children: revised fourth edition. Oxford University Press
[75] Rapid Review to Update Evidence for the Healthy Child Programme 0–5. London: Public Health England.
[76] Rapid review on safeguarding to inform the healthy child programme 5 -19, Public Health England 2018
[77] What works to enhance the effectiveness of the Healthy Child Programme: An evidence update. EIF 2018
[78] Department of Health and PHE (2014). Promoting emotional wellbeing and positive mental health of children and young people

The Children's Society and New Economics Foundation have adapted the Five Ways to Wellbeing to become more appropriate for use with children and young people[79]. The five steps provide the framework for Health Visitors and School Nurses working with children, young people and families, as well as an organisational tool to effect cultural change.

- Connect… Enable young people to spend time with friends and family.
- Be active… Urge young people to exercise regularly, either on their own or in a team.
- Take notice… Encourage awareness of environment and feelings.
- Keep learning… Keep young people's world as large as possible, encouraging their natural curiosity.
- Creativity and play… Encourage children's imagination and creativity as they grow.

What works in schools to promote good mental health & wellbeing:

- Support from senior leadership team is essential
- Physical, social and emotional environment in which staff and students spend a high proportion of every week day has been shown to affect their health wellbeing as well as impacting on attainment
- School-based programmes of social and emotional learning have the potential to help young people acquire the skills they need to make good academic progress as well as benefit pupil health and wellbeing
- Involving students in decisions that impact on them can benefit by helping them to feel part of school and wider community and to have some control over their lives
- It is important for staff to access training to increase their knowledge and to equip them to be able to identify mental health difficulties in their students
- There are variety of tools that education settings can use as basis for understanding and planning a response to pupils' emotional health and wellbeing needs
- Schools have role in providing targeted support and specialist provision for pupils with particular needs

The Early Intervention Foundation has summarised the range of interventions that promote social and emotional skills in schools[80]. Promoting social and emotional development involves teaching and modelling social and emotional skills, providing opportunities for students to practice these skills and giving them the opportunity to apply these skills in various situations. The range of approaches for promoting social and emotional skills in schools can be divided into; Universal classroom-based interventions, Whole-school interventions and Targeted interventions. A further EIF review [81]systematically examined evidence on the effectiveness of school and out-of-school interventions

[79] The Children's Society (2014). Ways to well-being Research report
[80] Introduction to social and emotional learning in schools [Internet]. Early Intervention Foundation. Early Intervention Foundation; 2018
[81] Clarke AM, Morreale S, Field C-A, Hussein Y, Barry MM. What works in enhancing social and

implemented in the UK that are aimed at enhancing children and young people's social and emotional skills. The review identified the following approach:

Adopt whole school thinking

- Use a 'whole school approach', which ensures that all parts of the school organisation work coherently together
- Start with a positive and universal focus on well-being
- Develop a supportive school and classroom climate and ethos
- Identify and intervene early
- Take a long-term approach
- Promote the well-being of staff and tackle staff stress

Engage the whole community

- Promote pupil voice and peer learning
- Involve parents, carers and families

Prioritise professional learning and staff development

- Understand risk and resilience to actively respond to problems and difficulties
- Help all students with predictable change and transitions

Implement targeted programmes and interventions (including curriculum)

- Use a range of leaders for specific programmes (such as psychologists)
- Teach social and emotional skills (self-efficacy, emotional literacy, motivation and problem solving, social skills)

Develop supportive policy

- Provide clear boundaries and robust policies

Connect appropriately with approaches to behaviour management

- Understand the causes of behaviour

Implement targeted responses and identify specialist pathways

- Provide clear pathways of help and referral
- Provide more intense work on skills work for those with difficulties

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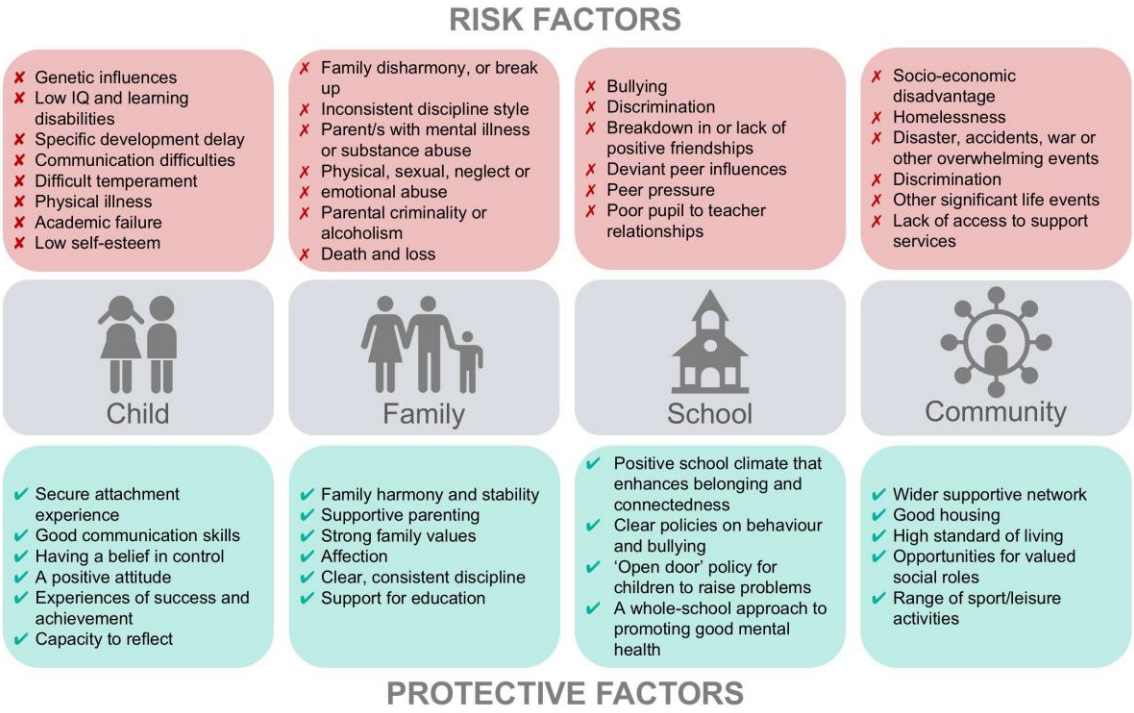
emotional skills development during childhood and adolescence? A review of the evidence on the effectiveness of school-based and out-of-school programmes in the UK

A report by the Mental Health Policy Commission[82] sets out the evidence base around the factors that can impact on young people's mental health. It identified a need to achieve "mentally friendly

Education" and recommended the implementation of whole-school Social and Emotional Learning programmes that are universal but can offer additional support for more vulnerable children and whole-school approaches for addressing harmful behaviour, particularly bullying, substance abuse, and reducing exclusions.

There are a variety of risk factors and protective factors that can negatively or positively impact on a child or young person's mental health[83].

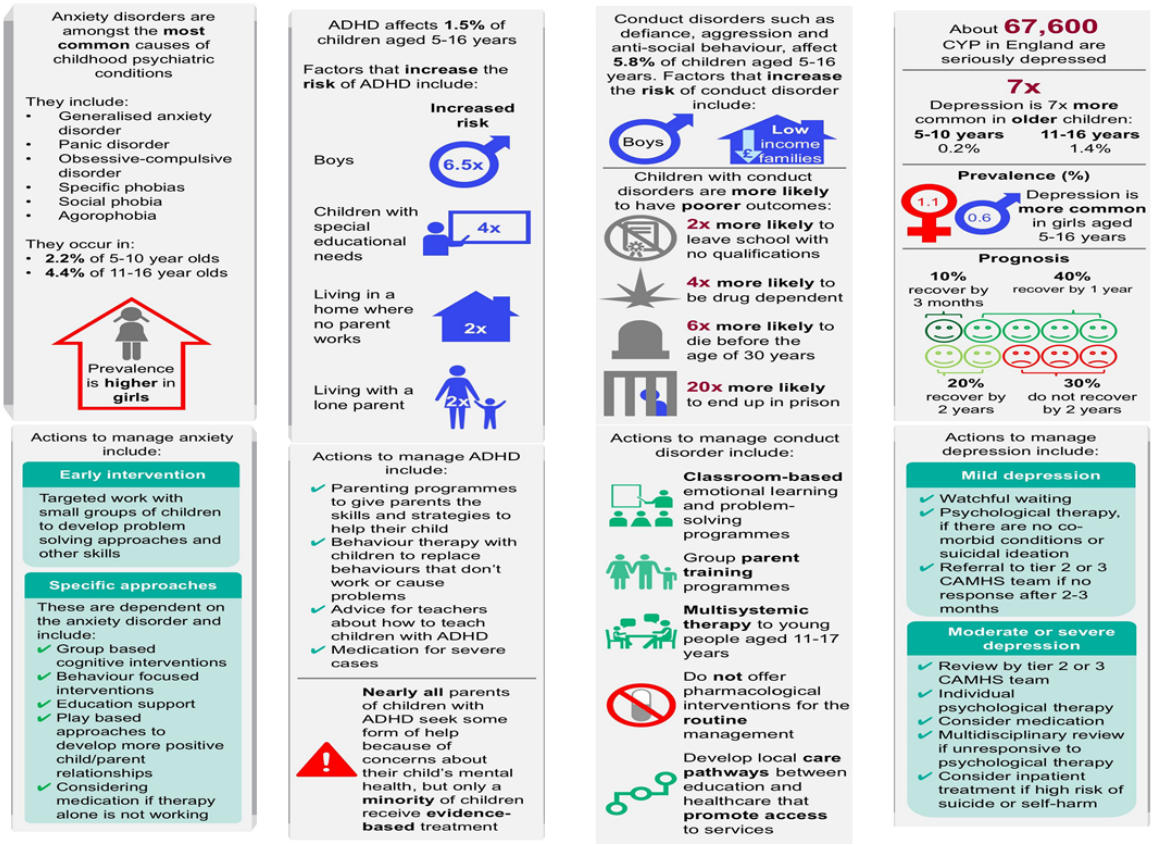
Figure 77: Risk and protective factors for CYP's mental health




There is good evidence that investing in prevention and early intervention in CYP mental health avoids young people falling into crisis and avoids expensive and longer term interventions into adulthood[84].

[82] Mental Health Policy Commission. INVESTING IN A RESILIENT GENERATION Keys to a Mentally Prosperous Nation Executive Summary and Call to Action. 2018.
[83]https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575632/Mental_health_of_children_in_England.pdf
[84]https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575632/Mental_health_of_children_in_England.pdf

Figure 78: Summary of what works to improve mental health in CYP by condition




More specifically in respect of conduct disorders a clinical knowledge summary by NICE in 2018 summarised the management of suspected conduct disorders in children aged from 36 months to 18 years of age[85]. This recommends a referral to Child and Adolescent Mental Health Services (CAMHS) for a CYP with suspected conduct disorder if they have a coexisting mental health problem (for example depression, or post-traumatic stress disorder), a neurodevelopmental condition (in particular ADHD or autism), a learning disability or difficulty or substance misuse in young people.

For children who do not have a complicating factor refer directly for a psychosocial intervention depending on the age of the CYP:

- Parent training programmes — usually offered where the child is aged 3 to 11 years (Incredible Years).
- Foster carer or guardian training — usually offered where the child is aged between 3 and 11 years.
- Child focused programmes — usually offered where the child is aged between 9 and 14 years (CBT based).

[85] https://cks.nice.org.uk/conduct-disorders-in-children-and-young-people#!scenario

- Multimodal interventions — usually offered to young people aged between 11 and 17 years (Multi Systemic Therapy).

### 18.16. Schools – Whole school approach and PHSE

Robust evidence shows that interventions taking a "whole school approach" have a positive impact in relation to a range of health and wellbeing outcomes including: body mass index (BMI), physical activity, physical fitness, fruit and vegetable intake, tobacco use, and being bullied[86]. Whole-school approaches have been associated with improvements in children's diets and their food choices.

A whole school approach is one that goes beyond the learning and teaching in the classroom to pervade all aspects of the life of a school including:

- culture, ethos and environment: the health and wellbeing of students and staff is promoted through the 'hidden' or 'informal' curriculum, including leadership practice, the school's values and attitudes, together with the social and physical environment
- learning and teaching: using the curriculum to develop pupils' knowledge, attitudes and skills about health and wellbeing
- partnerships with families and the community: proactive engagement with families, outside agencies, and the wider community to promote consistent support for children and young people's health and wellbeing
- 'Healthy schools' or 'health promoting schools' approaches are used by some schools to help translate the whole-school approach into practice and to enhance health and educational outcomes of their pupils.

The National Institute for Health and Care Excellence (NICE) has produced guidance documents about improving children and young people's health and wellbeing, and a number of these include recommendations for schools.

Although PSHE is a non-statutory subject, the great majority of schools choose to teach it because it makes a major contribution to their statutory responsibilities to promote children and young people's personal and economic well-being; offer sex and relationships education; prepare pupils for adult life and provide a broad and balanced curriculum. An Ofsted review of PSHE found that the quality of PSHE education is not yet good enough in a sizeable proportion of schools in England[87].

Evidence for the impact of PSHE on pupil's life chances is outlined by the PSHE Association[88]:

- When pupils receive lessons on healthy relationships, their first sexual activity occurs later and they are more likely to report abuse and exploitation. Experts see PSHE education as the best way to promote the safe use of technology and address online abuse.
- Educating pupils about their health reduces risk-taking behaviours such as drug or alcohol addiction and improves diet and exercise levels, in turn boosting long-term life chances.

[86] PHE (2014): The link between pupil health and wellbeing and attainment – a briefing for head teachers, governors and staff in education settings

[87] Ofsted, 2013. Not yet good enough: personal, social, health and economic education in schools. Personal, social and health education in English schools in

[88] PSHE Association, September 2016. A curriculum for life: the case for statutory PSHE education

- There is growing evidence that, when delivered well, PSHE education can promote positive outcomes relating to emotional health while reducing stigma and helping pupils learn where to go if they have mental health concerns. This all helps to boost pupils' life chances, but there are risks related to lessons about mental health delivered by untrained teachers.
- The non-academic skills and attributes acquired through PSHE education – often termed 'character' – have a positive impact on academic performance and life chances as well as being key to boosting the employability of school-leavers and improving social mobility.
- There is strong evidence to suggest that the focus of PSHE education on health, wellbeing and key skills has the potential to significantly aid academic attainment.

### 18.17. ACEs

Childhood experiences, both positive and negative, have a tremendous impact on future violence victimisation and perpetration, and lifelong health and opportunity. The UK ACE studies have provided a wealth of information identifying the harmful impacts of childhood adversity on local populations. Findings were consistent with those of ACE studies carried out elsewhere, showing that almost half of adult residents experienced at least one ACE before the age of 18 years and almost one in ten experienced four or more. As adults, these individuals are more likely to engage in harmful behaviours and are at greater risk of poor physical and mental health, chronic disease and premature mortality. Findings also show that over one in ten residents with 4+ ACEs had/caused an unintended pregnancy under 18 years. Such unplanned pregnancies have shown in turn to increase the risk of ACEs against resulting children and these taken together indicate how individuals affected by ACEs are at increased risk of exposing their own children to ACEs.

These findings are of interest/relevance to a wide range of local stakeholders, from health and social care to the criminal justice system, education, employment and other government and non-government agencies. The strength of the ACE approach is in highlighting the linkages between a wide range of outcomes and risk factors; it should not be considered an isolated 'project', rather part of a whole system approach to help understand and improve health and wellbeing. ACEs are not predictive at an individual level either, and cannot tell us who might need early intervention or other support. An ACE score is retrospective, and because the impacts of early life adversity differ widely from person to person, it does not necessarily reflect a person's current situation, needs or risks. ACEs should not be used in isolation to determine who should receive early intervention, and an ACE score is not a substitute for careful assessment of current needs.

The evidence around ACEs reinforces the case for investment in prevention and early intervention to prevent ACEs occurring; through promoting early attachment, supporting parents, building resilience in schools; and evidence based early interventions to tackle adversities when identified. There is also good evidence to develop and implement adversity and trauma informed models of care and provision in schools and services.

There is now broad consensus that child abuse, neglect and other adversity in childhood is rarely due to a single cause. Rather, childhood adversity is more frequently determined by multiple risk factors existing at the level of the child, family, community and society. The multifaceted nature of these risk factors indicates that single intervention strategies are likely to be inadequate for addressing complex family needs. Instead, comprehensive prevention 'systems' combining different types of

support will be necessary. Table 17 provides an overview of activities targeting the early years (for families with a child aged 5 or younger) identified by EIF as having good evidence of preventing or improving the negative outcomes associated with the ACE categories in particular. While this list is by no means exhaustive, it is representative of the kinds of activities that have been shown to work[89].

Table 18: Prevention and intervention activities found to have good evidence of preventing or reducing negative outcomes associated with ACEs in the early years (EIF).

| **Adverse childhood experience** | **Prevention** (available to all families) | **Targeted-selective intervention** (preventative interventions made available to families on the basis of demographic risks) | **Targeted-indicated intervention** (interventions made available to families on the basis of pre-identified adversities) | **Edge of care** (interventions made available to families when child maltreatment has been confirmed) |
|---|---|---|---|---|
| Physical abuse | | Family Nurse Partnership (FNP) | Child First<br>Infant Parent Psychotherapy (IPP)<br>Child Parent Psychotherapy (CPP)<br>Incredible Years Preschool<br>Parent-Child Interaction Therapy<br>Triple-P Pathways | Treatment Foster Care Oregon-UK (TFCO-UK) |
| Emotional abuse | | FNP | Child First<br>IPP/CPP<br>Incredible Years Preschool | TFCO-UK |
| Sexual abuse | No interventions identified | | | |
| Physical neglect | | FNP | Child First<br>IPP/CPP | TFCO-UK |
| Emotional neglect | | FNP | Child First<br>IPP/CPP | Multisystemic Therapy for Child Abuse and Neglect (MST-CAN)<br>TFCO-UK |
| Intimate partner violence | | FNP | Intimate partner violence counselling integrated into routine antenatal care | |
| Parental substance misuse | No interventions identified | | | |
| Parental mental health problems | Maternal mental health screening during pregnancy and through early childhood. | | Pharmaceutical interventions<br>CBT and other forms of psychotherapy | |
| Parental separation or divorce | Family Foundations | | New Beginnings | |
| Parental incarceration and household crimes | No interventions identified | | | |

[89] Written evidence submitted by EIF (EYI0061) for House of Commons Evidence-based early-years intervention inquiry, Nov 2018

Parental Substance Misuse – The EIF review did not identify any high grade evidence for specific interventions in their study above. However there is good practice and promising emerging evidence regarding identification and early intervention of parental substance misuse. The recently published Drug Strategy in 2017 highlighted particular issues for young people and their parents misusing drugs and alcohol. Parental substance misuse is one of the main factors that can impact on a range of vulnerabilities in developing children and young people. Parental substance misuse dependency can impact on parent's caring roles and can also mean that in some situations children take on inappropriate caring roles for parents. Problem parental alcohol and drug use is a common factor in serious case reviews. In a DfE analysis of these reviews between 2011-2014, drug use (either parent or child related) or alcohol use was assessed as a factor in over a third of reviews, with at least one of these present in 47% of cases.

The recommendation in the recent safeguarding guidance 2018 is for all social care, health and support organisations to come together in a whole family approach to assessment and triage referral[90].

This guidance promotes the need for joint protocols and more joint working at the "early help" end of safeguarding and that this should be preventive, rather than reactive. The guidance includes:

- Joint training for substance misuse staff
- Joint training for staff carrying out joint assessments and care planning
- Locating substance misuse and social care staff in same buildings
- Embedding substance misuse workers in social care teams
- Embedding social care workers in substance misuse teams

The work of early help professionals and public health nurses is key to ensuring appropriate screening and early intervention with the aim of preventing further harm later in life. This should include:

- Screening for problematic alcohol and drug use in parents who attend their services
- Assessing impact their current use has on children
- Assessing risks to their children if alcohol or drug use escalates
- Providing help and support at an early stage
- Single point of contact and clear information sharing and decision making for referrals

Newcastle University are currently finalising a rapid evidence review to highlight the harm of parents' non-dependent use of drugs and alcohol on their children and evaluated interventions to reduce harm[91]. The review identified an evidence gap regarding the the effectiveness of interventions for parents misusing but not dependent on alcohol and drugs. The University are testing and evaluating the PAReNTS study (Promoting Alcohol Reduction in Non-Treatment Seeking parents). They are examining the feasibility and acceptability of alcohol screening (using the AUDIT-C

[90] https://www.gov.uk/government/publications/safeguarding-children-affected-by-parental-alcohol-and-drug-use
[91] http://fuseopenscienceblog.blogspot.co.uk/2017/12/not-addicted-but-still-having-impact.html .

questionnaire) and brief interventions with parents involved in early help and statutory children's social care services.

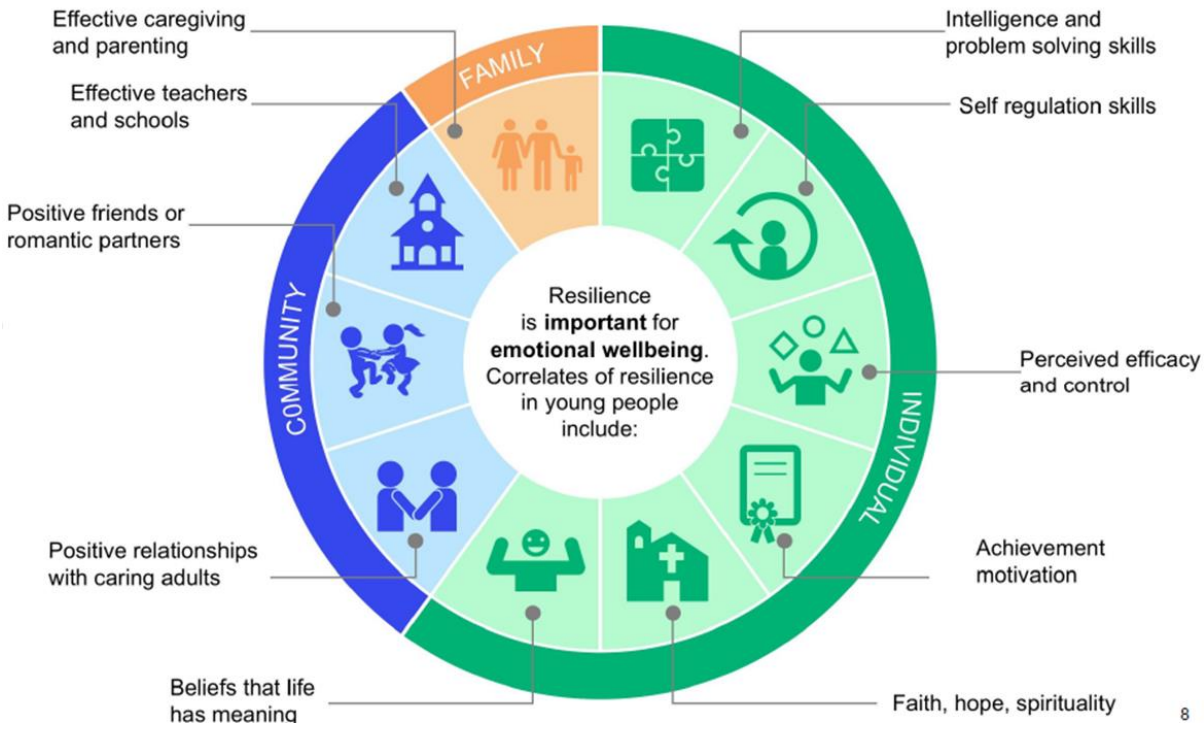
### 18.18. Resilience

Resilience is described as the capacity to 'bounce back' from adverse experiences, and succeed despite adversity. Adversity can be defined as a lack of positive circumstances or opportunities, partly brought about by physical, mental or social losses or deprivation.

Resilience and adversity are distributed unequally across the population and are related to broader socio-economic inequalities which have common causes – the inequalities in power, money and resources that shape the conditions in which people live and their opportunities, experiences and relationships.

Those who face the most adversity are least likely to have the resources necessary to build resilience. This 'double burden' means that inequalities in resilience are likely to contribute to health inequalities. The Marmot Review recognised the important role of schools in building resilience and recommended as a policy objective that schools, families and communities work in partnerships to reduce the gradient in health, wellbeing and resilience of children and young people. Research on resilience has emphasised the importance of a combined universal and targeted approach[92]. PHE have identified factors for building resilience amongst young people[93]

Figure 79: Building resilience (the ability to cope with adversity and adapt to change)




[92] PHE and UCL Institute of Health Equity (2014): Local action on health inequalities: Building children and young people's resilience in schools

[93] PHE (2016): The mental health of children and young people in England

The following identifies what works for building resilience:

- Individual: Improving achievements - high risk children who enjoy primary school are more likely to have improvements in social and behavioural wellbeing than those who did not enjoy it. Supporting transitions (home to school, between schools, and from secondary school to further education or work) – sharing information and working across organisation boundaries is particularly important to understand the background and circumstances of children. Promoting healthy behaviours – schools can impact on behaviours, decreasing the likelihood of young people taking up smoking, drinking, taking drugs, eating unhealthily or not exercising.
- Interpersonal: parents and carers – effective parenting and good parent-child relationships are likely to have significant effect on resilience. Teachers and other staff – teachers' support and guidance of pupils is key for children's development and in helping them to build resilience. Support from school staff is particularly beneficial for those from backgrounds of poverty or who are facing multiple adversities.
- School and community level: whole school approaches – Ten elements include: leadership, management, and managing change, policy development, curriculum planning and resources, including working with outside agencies, learning and teaching, school culture and environment, given children and young people a voice, provision of support services for children and young people, staff professional development needs, health and welfare, partnerships with parents/carers and local communities, assessing, recording and reporting children and young people's development. School as community hub – schools can provide a hub for local services and agencies that have relevance for wellbeing of children, families and communities.
- Resilience forms part of the social and emotional aspects of learning (SEAL) programme, implemented as a national strategy in 2005, which is define as "a comprehensive, whole-school approach to promoting the social and emotional skills that underpin effective learning, positive behaviour, regular attendance, staff effectiveness and the emotional health and wellbeing of all who learn and work in schools". It was implemented in 90% of primary schools and 70% of secondary schools in the UK. Although funding for the programme was withdrawn by the coalition government, many local areas continue to use the materials and run the programme locally.

### 18.19. Substance Misuse

Alcohol consumption and substance misuse comprise a set of risk-taking behaviours, which cluster together, with shared risk factors (such as social deprivation) and shared consequences for ill health[94]. In addition young people who misuse alcohol or drugs may be more likely to engage in risk taking (such as unprotected sex) and criminal behaviour.

Although the prevalence of both behaviours is decreasing in children and young people they remain an important concern, as they have the biggest impact on those with the most vulnerabilities. About 80% of lifetime alcohol or cannabis use is initiated <20 years, with the proportions initiating other illicit drugs in adolescence closer to 50%. Once initiated, these behaviours track strongly into adult

[94] Annual Report of the Chief Medical Officer 2012, Out Children Deserve Better

life, highlighting the importance of intervention in adolescence to prevent health burden[95]. The focus for all activity with young drug or alcohol misusers should be preventing the escalation of use and harm, including stopping young people from becoming drug or alcohol dependent adults. Drug and alcohol interventions need to respond incrementally to the risks in terms of drug use, vulnerability and particularly age. Young people with substance misuse problems have a range of vulnerabilities which must be addressed by collaborative work across local health, social care, family services, housing, youth justice, education and employment services[96].

Intervening early works and is cost saving. The evidence for prevention of alcohol harm suggests improving awareness of alcohol harm amongst young people and delay age of first usage. For drug prevention it is around building resilience among young people and to promote drug free environments.

Implications for Early Help - Screening, assessment and preventive interventions to reduce drug and alcohol use should be delivered using a whole family approach at an early stage to be effective. In addition, there needs to be a multi-agency response for identification and intervention from all agencies that comes into contact with a young person. This can include police, sexual health services, Early Help services, children's services, youth service and schools meeting a young person in the context of wider problems. A lifelong protective influence can be linked to instilling healthy habits and behaviours at an early age. School staff and public health nurses are in a unique position to be able to deliver effective prevention, early intervention and triage for onward referral for specialist help for young people.

Evidence suggests that individual, knowledge only approaches are ineffective alone, unless linked to a more comprehensive prevention Programme. In 2017, PHE funded an expansion of the Alcohol and Drugs Education Programme (ADEPIS) and Mentor UK resources for schools and community prevention services[97]. This is the leading resource digital platform for teachers, and professionals, providing information, evidence based interventions and tools for alcohol and drug education for young people. It builds on building young people's knowledge, skills and resilience to make better choices, rather than the well-meaning "hard hitting" approach which can be counter-productive. Effective responses by schools to enable young people to develop specific protective factors include:

- Developing supportive and safe relationships
- Insisting on regular school attendance
- Providing pupils to cope with academic and social demands of school
- Allowing strong and supportive social networks
- Encouraging good social skills
- Developing self-knowledge and self esteem
- Building good knowledge of legal and illegal drugs, effects and risks

[95] Health and Social Care Information Centre (2012) Smoking, drinking and drug use among young people in England in 2011

[96] Home Office (2010) Drug Strategy 2010: Reducing demand, restricting supply, building recovery: supporting people to live a drug-free life

[97] http://mentor-adepsis.org.uk/risk-protective-factors/

- Building good knowledge of general health and ensuring good mental health

It is estimated that approximately 207,000 children aged 11-15 start smoking each year in the UK, and 13% of 15 year olds in England reported being regular or occasional smokers in 2014. Many factors contribute to an increased likelihood of young people starting to smoke.

Evidence suggests that a strong anti-smoking ethos in schools, the family and the wider community is important in preventing smoking uptake. The majority of smokers start while in their teenage years with very few new smokers beginning after the age of 20.

School-based programmes have been found to have some effect in reducing smoking uptake but not if they are just based on educational approaches. Promoting a non-smoking community and reducing access to tobacco in those under the age of 18 are key to youth prevention.

Educational content implemented in learning environments ensures that young people understand the short and long-term health, and the economic and societal consequences of tobacco use. This can be achieved within the school curriculum. Targeted peer mentoring programmes are implemented in areas of greater need.

### 18.20. Young Carers

According to the 2011 Census nearly a quarter of a million people aged 19 and under in England and Wales were caring for parents, siblings and others. Young carers have significantly lower educational attainment at GCSE level, the equivalent of nine grades lower overall then their peers. Young carers may remain hidden due to the fear of being identified, not realizing they are a young carer or through professionals not acknowledging their role and therefore failing to identify and support them[98].

According to one survey, fewer than one in five (19%) parents of young carers helping within the household reported that their child had received an assessment of the child's needs by the local authority. Nearly two thirds (64%) were receiving no support, whether formal or informal. Of those receiving help, the most common source was a young carers' project, followed by their school or college[99].

What works in helping Young Carers?

- Young Carers in Schools is a free England-wide initiative that provides resources for schools to help them identify and support young carers. This includes guidance, webinars and good practice awards. It is delivered by the Carers Trust and The Children's Society and funded by The Queens Trust and the Big Lottery Fund (https://youngcarersinschools.com/)
- The School Nurse Programme advocates a pathway designed to support integrated working between the school nursing service, other public health nurses and partners. It is set within

[98] The Children's Society (2013) Hidden from view: The experiences of young carers in England
[99] DH (2017). The lives of young carers in England. Omnibus survey report. Research report

the context of the school nursing model, Healthy Child Programme and the Compassion in Practice strategy[100]

- The NHS England publication "An integrated approach to identifying and assessing Carer health and wellbeing" advocates a "whole-family approach" to assessment and support, for example in addressing the inter-related needs of young carers and their families. It promotes an integrated approach through agencies working together, such as adult social care services, NHS commissioners and providers, and third sector organisations[101].
- The publication 'Commissioning for Carers: Principles and resources to support effective commissioning for adult and young carers', intends to help Clinical Commissioning Groups (CCGs) better identify and support carers to stay well. It focuses on key actions that are most likely to achieve the best outcomes from the evidence and case studies that have been received[102].

### 18.21. Young People and Early Intervention

Although in recent years we have seen reductions in the proportions of young people aged 10-24 who drink, smoke, use drugs and get pregnant, there are still a large number of young people who are at risk, have poor outcomes and the consequences can last a lifetime. PHE have developed a useful evidence based framework to address the health and wellbeing needs of school children and young people[103]. The Framework has been developed as a resource to help local areas support young people to be healthy and to improve outcomes for young people. It sets out at a high level a way of thinking about young people's health, taking an asset-based approach, and focusing on wellbeing and resilience.

Evidence tells us that treating different, specific health issues separately will not tackle the overall wellbeing of this generation of young people[104]. Young people's mental and physical health are intertwined, and at the heart of health and wellbeing are their relationships with others. Young people think about their health holistically. They want an integrated, youth friendly approach that recognises their particular needs, makes them feel supported, emphasises the positives and helps them to cope. Building on the research of what works for this age group, the framework identified six core principles that cut across health topics to develop holistic approaches to meet needs. These build on concepts of resilience and are presented in a way that commissioners and service providers can use.

[100] DOH (2014) School Nurse Programme: Supporting implementation of the new service offer: Supporting the health and wellbeing of young carers

[101] NHSE (2016). An integrated approach to identifying and assessing Carer health and wellbeing. NHS England/Patient Experience Team

[102] NHSE (2014) NHS England's Commissioning for Carers: Principles and resources to support effective commissioning for adult and young carers. NHS England

[103] PHE and AYPH (2014): Improving young people's health and wellbeing: A framework for public health

[104] Age band 10-24 based on the UNICEF definition of 'young people' and the recommendation from the Chief Medical Officer (2013) Prevention pays: Our children deserve better. London: Department of Health

Figure 80: Framework for addressing health & wellbeing of young people


Statutory Guidance for Local Authorities on Services and Activities to Improve Young People's Well-being was issued by the Secretary of State for Education under Section 507B of the Education and Inspections Act 2006. It relates to local authorities' duty to secure services and activities for young people aged 13 to 19, and those with learning difficulties to age 24, to improve their well-being, as defined in Subsection 13. Within the rationale and scope of the duty it describes the local authorities' duty *to secure, so far is reasonably practicable, equality of access for all young people to the positive, preventative and early help they need to improve their well-being*. This includes youth work and other services and activities. The Government does not prescribe which services or activities LAs should fund or deliver, but LAs should *determine the mix of open access, targeted, preventative and specialist provision needed to meet local needs, and how to integrate all services around young people.* Local Authorities are responsible for securing, as far as is reasonably practicable, *a local offer that is sufficient to meet local needs and improve young people's well-being and personal and social development – having regard to the general principles of the UNCRC.*

The LGA have recently published a vision for youth services based on best practice. This identifies six principles for effective youth services[105].

[105] Bright Futures: our vision for youth services, LGA, 2018

- Youth-led - Provision is structured around the needs of young people locally, offering both universal, open-access provision wherever possible, with targeted support for those considered more at-risk, disadvantaged or with higher need.
- Inclusivity, equality and diversity - The local youth offer helps to improve social mobility for young people from all backgrounds by offering support to develop the skills, knowledge and networks they need to access and take advantage of opportunities
- Respect - They are actively encouraged to participate in their communities and to enjoy opportunities in their local area without fear of judgement or negative stereotyping
- Quality, safety and well-being - Good quality services are provided by staff with appropriate safeguarding training, linked to a wider network of support. Ideally this includes professionally qualified youth workers with the skills, expertise and competencies to support safe, quality services with appropriate levels and types of intervention.
- Empowerment - Services empower young people to progress and engage in employment, education and training, and to take an active role in their local communities
- Positivity - Services are strengths-based and focus on developing the skills and attributes of young people, rather than attempting to 'fix a problem'

Targeted Youth Support (TYS) is an initiative aimed at vulnerable young people and involves ensuring that agencies work together to meet young people's needs. The initiative's rationale is that a collaborative, „joined-up" approach is needed because young people may have complex and multiple needs which cannot be met by mainstream or specialist services in isolation.

Spending time not in employment, education or training (NEET) has been shown to have detrimental effect on physical and mental health. This effect is greater when time spent NEET is at younger age or lasts for longer. The link between time spent NEET and poor health is partly due to an increased likelihood of unemployment, low wages, or low quality work later on in life, Being NEET can also have an impact on unhealthy behaviours and involvement in crime. These negative health effects do not occur equally across the population, as the chance of being NEET is affected by area deprivation, socio-economic position, parental factors (such as employment, education, or attitudes), growing up in care, prior academic achievement and school experiences. Being NEET therefore occurs disproportionately among those already experiencing other sources of disadvantages[106].

The Institute of Health Equity identified what works to reduce the proportion of young people NEET:

- Act early: strategies implemented before the age of 16 that are designed to prevent young people from becoming NEET are likely to be the most effective way of reducing local NEET levels.
- Tackle barriers and obstacles: when trying to help young people to move back into education, training or work, it is important to consider the wide range of barriers that they may face, and to help them overcome these.
- Work across organisational and geographical boundaries: successful strategies have involved collaboration and cooperation of different agencies and sectors, as well as some cross-area coordination and information sharing.

[106] PHE and UCL Institute of Health Equity (September 2014): Local action on health inequalities: Reducing the number of young people not in employment, education or training (NEET)

- Work with local employers: getting people into work is unlikely to be successful unless local employers are involved and have a role from early on in the process.
- Track people and monitor progress: to reduce the number of people NEET, information is important: about who is NEET, but also about why they are, their history, and the agencies they are engaged with. Effective monitoring and evaluation of programmes is also essential.
- Base interventions on features of other successful programmes: there are some common features of programmes delivered or commissioned by local authorities that have worked well. This includes the content of courses, ensuring that they are accredited, not like school, and are developed and implemented in partnership with young people. There is also evidence to support using financial incentives, flexible and personalised programmes, small group sizes, one-to-one support, and helping young people to manage transitions.

## 19. Service Models

### 19.1. Integrated services

The transfer of responsibility for children's public health to local authorities in 2015 created an opportunity to dramatically improve the co-ordination, or move to full integration, of the services provided for young children and their families – and many local authority areas have used this opportunity. The greater coherence of a more holistic approach to families benefits all, but beyond the core of maternity, health visiting and early years services, the involvement of services including social care, primary health care, adult mental health, housing, police, and local voluntary services offers the prospect of making far more effective provision for families with more complex needs.

The EIF reviewed integrated systems and promising practice and provided advice for local areas. In this report the term 'integration' was used to mean bringing together and merging different systems, primarily across health and LAs, to create coherent family services. They identified that currently, the way services are organised for families with young children can be too fragmented, resulting in missed opportunities to identify early signs of need and then coordinate support. Better integration can mean better public services for families who do not have to repeat their story to different professionals and get the help they need more swiftly. Unnecessary and wasteful duplication can also be avoided. They identified from qualitative studies on integration a number of positive effects including enhanced communication between services leading to better cooperation and implementation. Integrated services were more responsive with greater accessibility and user engagement. Integration also reduces duplication and is more cost-effective. There was some evidence that integration improved outcomes for children in terms of increased cognitive development, better physical health and behaviour and improvements in parenting and family relations. The report found a strong consensus that integration improves outcomes for children and families although there was a lack of quantitative evidence on the difference that integration can make to outcomes.

> "*Young children and their families have regular contact with a number of different services such as midwifery, health visiting, childcare and early education provision… Service coordination or integration is likely to improve families' experiences, enable those needing*

*support to be identified more quickly and increase the likelihood of families receiving the help they might need…"*

The EIF report looks in some detail at the main aspects of integration, and draws out a number of key considerations. There are different degrees of integration, from better co-ordination of services around the individual, collaboration between different teams or organisations, to large scale commissioning for a population. The key considerations identified were.

- Effective local leadership is key to develop a shared vision
- Joint commissioning to establish common systems, processes and evidence based services and programmes
- Listen to families and communities to understand what things concern them
- Streamline structures and processes.
- Integrated assessments
- Integrated pathways
- Integrated teams
- Information sharing
- Integrated workforce and workforce development
- Children's Centres as part of wider holistic family services

It is important to translate the shared vision into shared systems and processes. Increasing consistency in the systems and processes used by different sections of the workforce (across health, children's services and education) can help co-ordinate services; use of a common assessment process is especially beneficial, and joint training and information sharing can greatly increase practitioners' shared language and understanding of each other's roles. Team structures that best support integrated working vary widely, reflecting local circumstances, but locality-based teams (virtual or co-located in the same premises, such as a children's centre) is a common model – with some areas developing a 'Single Point of Access' for professionals to make referrals or seek advice.

A number of areas have moved to more integrated provision across health, social care and education particularly in early years. The most ambitious model, particularly in terms of its scale is the Greater Manchester's Early Years delivery model (EYDM) for early years services. A Greater Manchester (GM) 'Start Well' strategy is now in place and embedded across the ten GM local authority areas.

The model started with completion of a comprehensive business case. The business case highlighted that 40 per cent of GM children starting school (in 2012) were considered not to be school ready, and described the overall objective as, to make best use of resources to improve outcomes for all children in their early years and close the gap in performance for the Early Years Foundation Stage Profile between all children and the bottom 20 per cent. It outlined a set of related and measurable short, medium and long-term outcomes and sub-outcomes, all contributing to the overall aim of children being ready to learn and it set out the following clear chain of causal and correlative events:

- a child's experience in its early years, particularly in terms of secure attachment and the home learning environment, has a significant impact on parent-child relationships which is linked to whether that child is 'school ready'
- attainment at Early Years Foundation Stage Profile (EYFSP) is an indicator of attainment at Key Stage 1
- attainment at Key Stage 2 is a reliable indicator of attainment at Key Stage 3 and onwards to GCSE level
- attainment at aged 16 is a reliable indicator of likely future educational achievement, levels of economic activity and income, and chronic health conditions in later life.

It estimated the total spend on early years services across the ten GM local authority areas as almost £300 million, with an additional 'cost of failure' estimated at more than £320 million for a range of interventions and services required to respond to needs which could have been prevented by early identification and intervention. It makes a strong argument that the current pattern of service provision, and public sector spending, does not align with the critical period of development between late pregnancy and two years of age, and should be re-focused. Work done with parents and service users identified three other key causes which contribute to the failure of the current model:

- a generalised failure of frontline staff to engage in partnership with parents, and to be perceived as meeting their needs
- a lack of integration between services and of information sharing, communication and integrated care planning around a shared assessment of need
- a failure to tackle – or support parents, families and communities in tackling – the wider determinants of health, wellbeing and attainment which mitigate against good outcomes.

A key objective of the Greater Manchester Early Years Delivery Model (EYDM) was to improve parents' and service users' experience, whilst improving the outcomes for their children. The EYDM builds on existing policy and guidelines, and implements recommendations for better outcomes from a series of independent expert reports. It is designed to 'both ensure that best practice is implemented fully and at scale across GM, and also break new ground with the focus on best evidence, prevention and early intervention within an integrated system that takes a "whole family" approach.' It is acknowledged that, while there will be significant short-term gain, the principal impact of savings will be realised up to 10 years after the early years period, and the organisations that stand to benefit most are not those that traditionally fund the services – but Manchester's devolution arrangements provide an opportunity to address this.

The EYDM is comprised of four key components:

- effective universal services
- an 8-stage assessment pathway
- a range of multi-agency pathways
- a suite of evidence based assessment tools and targeted interventions.

GM intends to ensure that children are ready to start school by prioritising prevention and early intervention to address health, education and social inequalities. This will be achieved by a commitment to:

- utilising the strength of universal and targeted services to deliver prevention and early intervention.
- a coherent approach: strengthening Early Years partnerships and reducing duplication.
- co-production of a 'place-based' and integrated approach to commissioning and service delivery.
- helping children, families and communities to secure outcomes themselves
- breaking cycles of poverty, inequality and poor outcomes in the early years.
- improving the quality of and access to early education.
- putting quality at the heart of service delivery

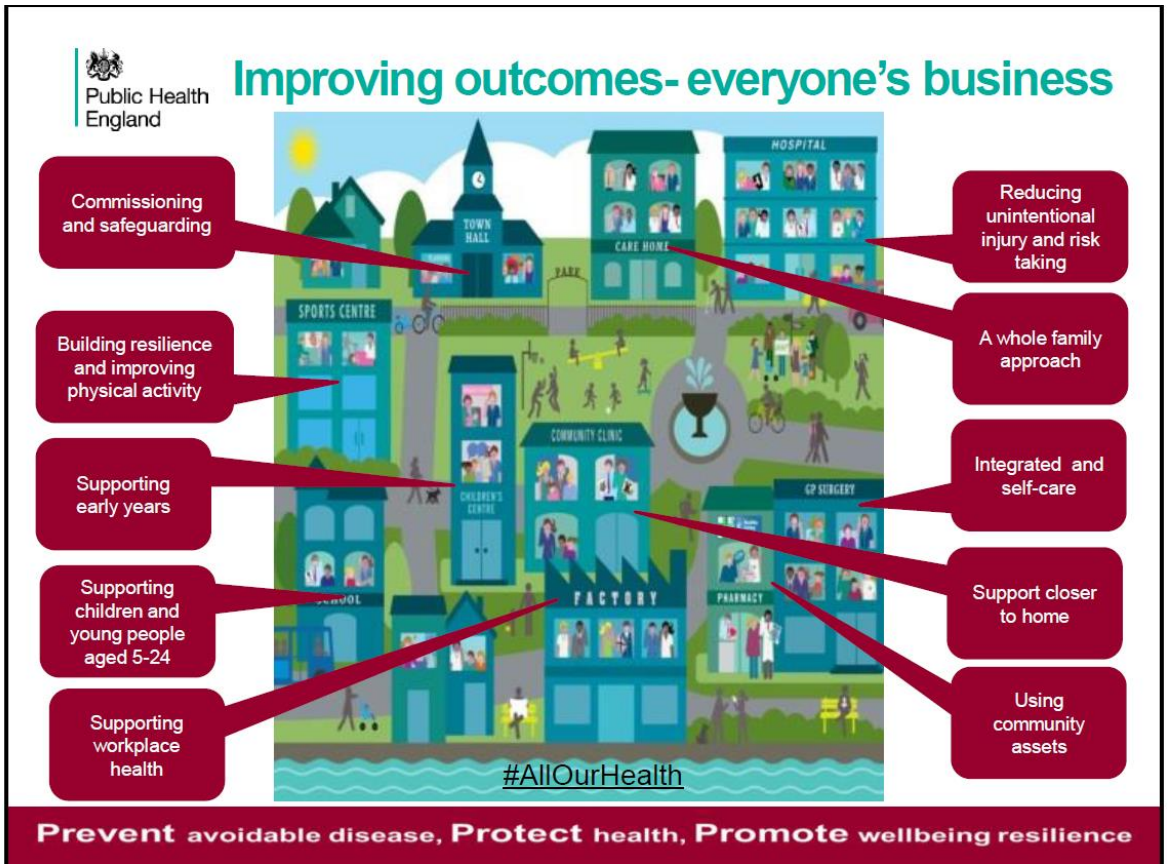
The EYDM is now being incrementally implemented across all localities in GM having recently been included in the GM Population Health Plan 2017-2021

### 19.2. Place-based and Community Centred Approaches

The HCP high impact areas are intended to use a place-based approach. Building on the relationship, reach and opportunities healthcare professionals have to influence and impact on the population's health and well-being, the high impact areas focus on interventions at the individual and family level, at the community level and the population level using a place-based approach. The place-based approach offers opportunities to impact on the whole community and aims to address issues that exist at the community level, such as poor housing, social isolation, poor or fragmented services, or duplication or gaps in service provision. Health visitors and school nurses, as leaders of the Healthy Child Programme, are well placed to support families and communities to engage in this approach. They are essential to the leadership and delivery of integrated services for individuals, communities and population to provide RightCare that maximises place-based systems of care.

A place-based, or community-centred, approach aims to develop local solutions that draw on all the assets and resources of an area, integrating services and building resilience in communities so that people can take control of their health and wellbeing, and have more influence on the factors that underpin good health. This is illustrated in Figure 81, which uses the "All Our Health" townscape to demonstrate how improving outcomes is everyone's business, working across both traditional and non-traditional settings such as the workplace, green spaces and community centres.

Figure 81: Community and place-based approach to health and wellbeing




There is good evidence that community engagement improves health and wellbeing. A recent review suggested that community engagement interventions are: *'effective in improving health behaviours, health consequences, participant self-efficacy and perceived social support for disadvantaged groups'*[107]. The review identified that collaborations and partnerships as well as peer and lay roles are effective approaches to involving communities in local health and wellbeing initiatives. The review also concluded that community engagement activities lead to more than just traditional improvements in health and behaviour. For example, they also improve people's social support, wellbeing, knowledge and self-belief.

A recent report by PHE and NHS England on community-centred approaches for health and wellbeing describes the effectiveness of community-centred approaches, including community capacity building and volunteering, and which can potentially offer a significant return on investment[108]. The report identified a family of approaches to enable community assets to thrive and for services to work effectively alongside. Community centred approaches are about mobilising assets within communities, promoting equity and increasing people's control over their health and lives. The four strands of the approach are:

- strengthening communities – where approaches involve building on community capacities to take action together on health and the social determinants of health

[107] Community engagement to reduce inequalities in health: a systematic review, meta-analysis and economic analysis O'Mara-Eves et al. 2013
[108] A guide to community-centred approaches for health and wellbeing. Public Health England. 2015

- volunteer and peer roles – where approaches focus on enhancing individuals' capabilities to provide advice, information and support or organise activities around health and wellbeing in their or other communities
- collaborations and partnerships – where approaches involve communities and local services working together at any stage of planning cycle, from identifying needs through to implementation and evaluation
- access to community resources – where approaches connect people to community resources, practical help, group activities and volunteering opportunities to meet health needs and increase social participation.

#### 19.2.1. Children's Centres

Following on from the Sure Start initiative of 1998, Children's Centres were launched in 2002 with the aim of giving disadvantaged children the "best possible start in life." Children's centres provide or co-ordinate a variety of early years services (such as education, childcare, health services, social services and information, advice and training), based around a broadly-defined 'core purpose' to improve child and family outcomes and reduce inequalities in child development, parenting, health and life chances[109]. The original policy intention was to deliver provision in the most 30% disadvantaged areas. A national evaluation of Sure Start found in 2012 that Sure Start local programmes had beneficial effects on family functioning and maternal wellbeing, but not on child outcomes at age seven[110]. By 2013, national guidance on the 'core purpose' of children's centres shifted focus to targeting 'high need' families, rather than open access to universal services.

The DfE commissioned a large evaluation of Children's Centres in 2015 from Oxford University[111]. This found a number of significant but relatively small positive effects in outcomes for child, mother, and families and confirmed that engagement with children's centres can promote better outcomes especially in terms of family functioning measures. The evaluation also provided evidence about children's centre characteristics and processes that promote better child, mother and family outcomes. Offering a greater number of named programmes for families predicted better outcomes. Centres that were maintaining or increasing services rather than experiencing cuts and restructuring had better outcomes for mothers and family. Multi-agency working (mixed leadership, partner-agency resourcing) appears to be beneficial for some child outcomes and some family outcomes. The impact analyses concluded that children's centres can promote better outcomes, especially for family functioning linked to parenting; but these positive effects are not as strong as some of the adverse effects of background disadvantage. Thus the provision of services by children's centres has the potential to ameliorate the effects of disadvantage but results suggest that on their own children's centres cannot be expected to overcome the adverse effects of being part of a disadvantaged family living in a disadvantaged neighbourhood.

The number of centres has since fallen nationally. The Sutton Trust estimated that at least 14% of children's centres closed between August 2009 and October 2017, with closures concentrated in

[109] Department for Education, 'Sure Start children's centres statutory guidance' (2013),
[110] Department for Education, 'The impact of Sure Start Local Programmes on seven year olds and their families' (2012)
[111] https://www.gov.uk/government/publications/childrens-centres-their-impact-on-children-and-families

certain areas but equally distributed between more and less-deprived communities[112]. It also reported that the children's centres that remained open offered fewer services and had shorter opening times. Reduced services were reported by 55% of local authorities. Financial pressures came top in 84% of local authorities as a principal driver of change but Change of focus' came a close second (80%). This was not just a move towards greater targeting of individual high need families and away from open access. It was also a way of integrating children's centres into a wider package of 'early help' as part of local teams with a much wider age range (0-19), with more than 40% of authorities extending the age range to include school age children. The suspension of Ofsted inspections and the lack of any national guidance since 2013 on the purpose of children's centres were seen in the survey as reducing the importance of children's centres. The effect was to reduce the strength of children's centres in local authority priorities. Substantial further changes in the pipeline were expected by 34% of local authorities: more emphasis on referred families (47%), increased age range (40%), reorganising centres in clusters (29%), and further centre closures (19%), with further consultations or reviews to come.

The Government first announced that it would review children's centres in 2015, with a proposed consultation on the future children's centres and suspended Ofsted inspections. This suspension was reconfirmed January 2018 (registered early years provision within children's centres continues to be inspected as part of the Common Inspection Framework). The consultation on the future for children's centres has still not been launched.

### 19.3. Troubled Families

The Troubled Families Programme has run since 2012, with a second phase starting in 2015. Under the programme, local authorities are asked to identify and support families with multiple problems (at least two of six defined problems, including domestic abuse, physical or mental health problems and having children in need), and can claim funding if the family achieves "significant and sustained progress" against all identified problems or if an adult in the family moves into continuous employment. The Early Intervention Foundation has described the programme as "an important vehicle for reaching vulnerable families who may be at risk of exposing children to adverse experiences".

The EIF have used the existing evidence held by them to identify 23 parenting interventions which have evidence of improving child and parent outcomes in vulnerable families The EIF report on commissioning parenting and family support for Troubled Families identified the following Key points[113]:

- Parents within the Troubled Families programme are frequently confronting multiple problems that are likely to affect their inter-parental relationship and their ability to parent effectively.
- Investment in evidence-based parenting support which addresses these problems is likely to support the outcomes aimed for by the Troubled Families programme.

[112] https://www.suttontrust.com/research-paper/sure-start-childrens-centres-england/
[113] Commissioning parenting and family support for troubled families. Early Intervention Foundation 2017 Oct

- When implemented properly, these interventions also have the potential for providing value for money and some instances, reduce local authority costs.
- Evidence of what works is not the only factor that should be considered when selecting interventions. Commissioners must also determine the extent the intervention will provide added value over their current provision and consider the capacity of their local systems to deliver it.

Table 19: Evidence Based Parenting Interventions by Troubled Families Criteria

| | |
|---|---|
| Parents involved in crime/antisocial behaviour | No specific programmes identified |
| Children involved in crime/antisocial behaviour | Functional Family Therapy: Family therapy when a young person is involved with offending<br>MST: Family therapy when a young person is involved with offending<br>MST-CAN: Family therapy where there is a reported case of child abuse<br>MST-PSB: Family therapy for families with a young person who has committed a sexual offence<br>TFCO-UK Adolescence: A young person in care where there is a possibility of reunification with parents |
| Children who have not been attending school regularly | Helping the Non-compliant child: Children with an identified behavioural problem<br>Incredible-Years School Age Basic: Children with an identified behavioural problem<br>Triple P Standard: Children with an identified behavioural problem<br>Triple P Group: Children with an identified behavioural problem |
| Children of all ages who are identified as in need or are subject to a Child Protection Plan | Programmes listed above<br>Child First: Parents experiencing multiple adversities living in disadvantaged communities<br>Infant-Parent Psychotherapy: Mothers at risk of a mental health problem or child maltreatment<br>Toddler-Infant Psychotherapy: Mothers at risk of a mental health problem or child maltreatment<br>Child-Parent Psychotherapy: Mothers at risk of a mental health problem or child maltreatment<br>Triple P Pathways: Children who have been physically abused<br>TF-CBT: Children who have been sexually abused<br>TFCO-UK Adolescence: A young person in care where there is a possibility of reunification with parents |
| Adults out of work or at risk of financial exclusion and young people at risk of worklessness | No specific programmes identified |
| Families affected by domestic violence and abuse | Child First: Parents experiencing multiple adversities living in disadvantaged communities<br>Infant-Parent Psychotherapy: Mothers at risk of a mental health problem or child maltreatment<br>Toddler-Infant Psychotherapy: Mothers at risk of a mental health problem or child maltreatment<br>Child-Parent Psychotherapy: Mothers at risk of a mental health problem or child maltreatment |
| Parents identified with mental health problem<br>*The programmes listed have* | Child First: Parents experiencing multiple adversities living in disadvantaged communities<br>Infant-Parent Psychotherapy: Mothers at risk of a mental health |

| | |
|---|---|
| *evidence of being effective with families where maternal depression was identified as an issue. None of the interventions here have evidence of working with families where one or both parents have difficulties with drug or alcohol misuse.* | problem or child maltreatment<br>Toddler-Infant Psychotherapy: Mothers at risk of a mental health problem or child maltreatment<br>Child-Parent Psychotherapy: Mothers at risk of a mental health problem or child maltreatment |

All the interventions listed in Table 19 are intended to be offered at the targeted-indicated or specialist level by practitioners with experience within a helping profession. It is likely that many of the programmes targeting children's behaviour (such as Incredible Years or Triple P) could be coordinated as part of the package of support offered to Troubled Families programme participants.

Specialist interventions must be delivered by suitably qualified and supervised family key workers. These programmes include Multi-Systemic Therapy (MST) or Treatment Foster Care Oregon-UK (TFCO-UK) which provide more comprehensive – or 'wrap-around' – support for families where there are serious problems with a child's behaviour (such as criminal misconduct) or reported incidents of physical or emotional abuse. However, it is important that the family key workers who deliver these programmes are suitably qualified, trained and supervised within the recommendations of the MST or TFCO-UK models. Further information on how practitioners should be recruited, trained and supervised in relation to these programmes is provided by the TFCO-UK and MST national units.

## 20. Current prevention & early intervention services

### 20.1. Maternity Services

There are around 6000 births each year in Worcestershire; almost 90% of these are delivered by maternity services at Worcestershire Acute Hospitals NHS Trust (WAHT). It is important that women access maternity services as early as possible to receive antenatal care and to enable a full health and social risk assessment to identify any additional needs. On average 90% of women are accessing WHAT for their first "booking" before 13 weeks gestation which is better than national average (82%).

Pregnant women with complex social factors may have additional needs. The percentage of women at booking presenting for antenatal care with any complex social factor during 2017 was recorded as 8% which is lower than the national average of 10% for the same period. In line with NICE guideline pregnant women with complex social factors are those with pregnancies complicated by one or more of the following[114]: alcohol or drug misuse, recent migrant or asylum seeker status, difficulty reading or speaking English, aged under 20, domestic abuse. WAHT have specialist midwives who provide additional support to very vulnerable pregnant women including where there is existing Children's social care involvement. The specialist midwives provide supervision and support to the community midwifery teams when dealing with vulnerable women. WHAT reports an increasing

[114] CG110: Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors, NICE, 2010

number of referrals to specialist midwives and estimates 20-25% of pregnant women have vulnerabilities.

Following the booking interview with pregnant woman maternity services complete a Midwife-Health Visitor Communication Form, highlighting any risks, needs or vulnerability which is forwarded to the Health Visiting service. Specialist midwives forward notifications of those vulnerable young pregnant women eligible for the Intensive Home Visiting programme to the Health Visiting Service.

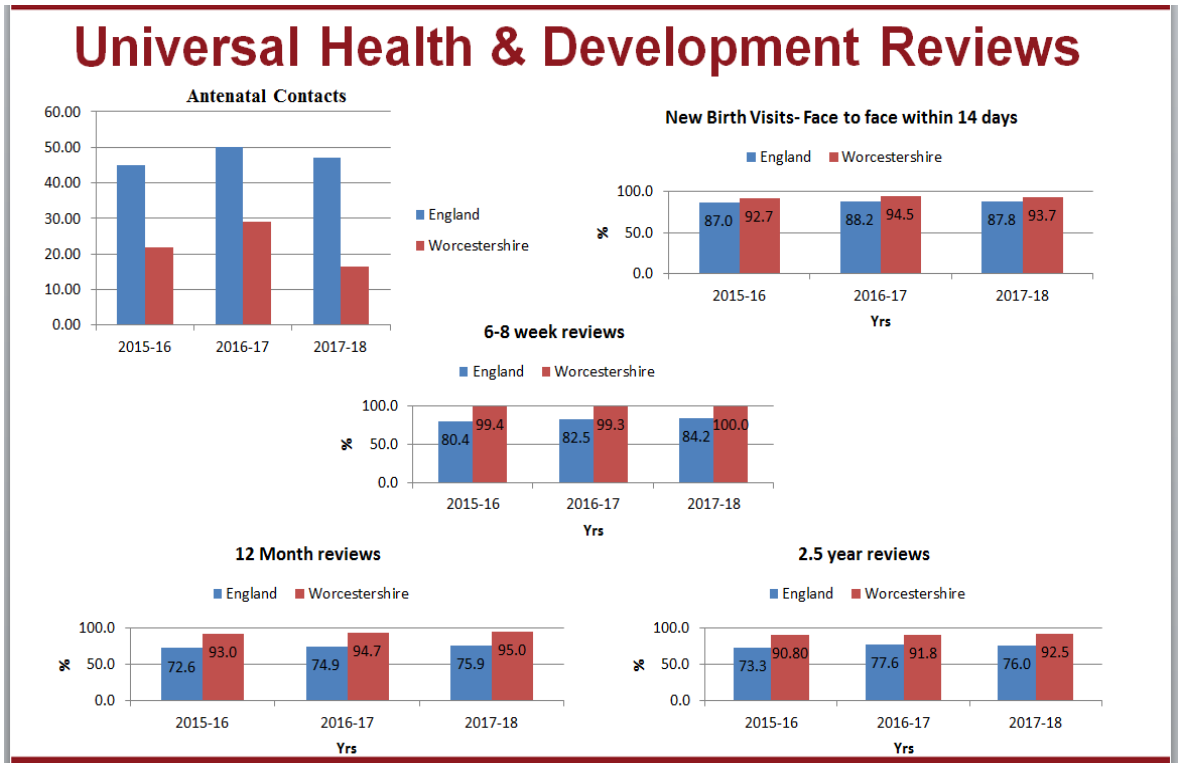
### 20.2. Public Health Nursing

The 0-19 Public Health Nursing Services in Worcestershire operates as one integrated service comprising Health Visitors, Nursery Nurses, breastfeeding support workers, Health Care Assistants and School Nurses, provided by Worcestershire Health and Care NHS Trust (WHCT). The service leads the HCP 0-19, provides universal mandatory health and development reviews, infant feeding support, additional health and wellbeing support and interventions (universal plus), a targeted intensive home visiting service for vulnerable young mothers and contributes to safeguarding and complex multiagency assessments and packages of care (universal partnership plus). Drop in access to advice and support is available for babies/parents via baby clinics located in targeted localities and for children and young people in all High Schools.

The service was remodelled towards the end of 2016 in light of budget reductions and a new specification. The full national 4-5-6 evidence based HCP model is not in place.

- 4 levels of service: The service does not lead or deliver activity at the community level of the model. The service provides universal, universal plus and universal partnership plus.
- 5 Health Reviews: The service provides the 5 pre-school mandatory reviews (ante-natal, new birth, 6-8 weeks, 12 months and 2.5 years). However, the antenatal review is targeted rather than universal. The service does not provide universal health needs assessments during the school years but provides assessments for CYP that present or are referred as well as annual health assessments for LAC.
- 6 High Impact Areas: The service provides much of recommended activities in early years but less of the recommended impact activities in school aged years. The service has well developed pathways of care within the service, within and between other specialist and community health services and responds well to identified health needs of children. The service undertakes less activity with other agencies and services with regard to wider wellbeing, social or family needs. Multiagency activities or pathways relating to each high impact area at the individual, community or population level are not in place.

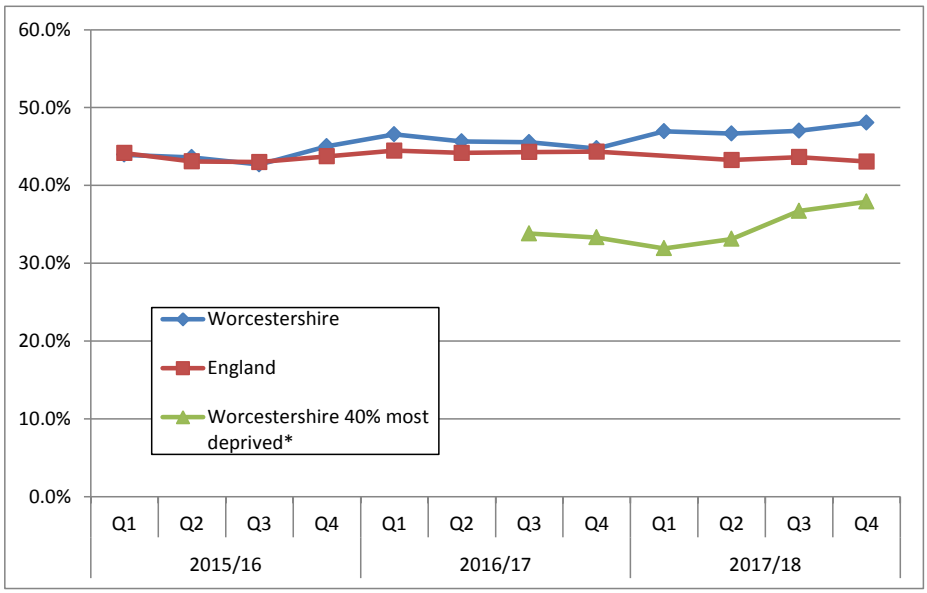
Figure 82: Mandatory Universal Health & Development Reviews




The mandatory universal pre-school development reviews provide the opportunity for all children and families to receive advice and support (prevention) and to identify those at risk or with additional needs (early intervention). The percentage of universal reviews completed for 4 of the 5 pre-school mandatory checks are significantly higher than the national average and reporting by exception achieves full coverage. This provides assurance that all children in the county have received evidence based early support, those at risk or with additional need identified and appropriate early or specialist intervention given. The proportion of antenatal reviews completed is significantly less than the national average. Last year 2017/18, 16-17% of pregnant women received an antenatal review from a Health Visitor, although women are also seen ante-natally by maternity services. Antenatal contacts are delivered only for more vulnerable women as identified by the midwifery/health visitor communication.

The service provides comprehensive evidence based infant feeding support. All breastfeeding women are contacted within 48 hours after delivery of their baby and offered breastfeeding peer support either face to face or over the phone for up to 6 weeks. Face to face support is targeted in more deprived areas. At the 6 to 8 week development review the breastfeeding status of all new mothers is recorded. Breastfeeding rates at 6 to 8 weeks have increased over the last 3 years and are currently higher than national average. Breastfeeding rates at 6 to 8 weeks have also increased amongst women living in 40% most deprived quintiles (IMD1 and IMD2).

Figure 83: Percentage of all infants due a 6-8 week check that are totally or partially breastfed




*Source: Worcestershire Public Health Nursing Service*

Numbers of young children on caseload being supported for each element of the HCP; universal, Universal Plus (UP), Universal Partnership Plus (UPP) as at November 2017 and October 2018 are given in Table 20. This indicates that 5% to 6% of under 5s receive additional universal plus support and around 3 to 3.5% receive support as part of safeguarding or multiagency complex care activity. These figures include numbers of universal children on HV caseloads up to age 2 ½ but numbers of UP and UPP children up to age 5.

Table 20: Health Visitor Caseloads by HCP service element

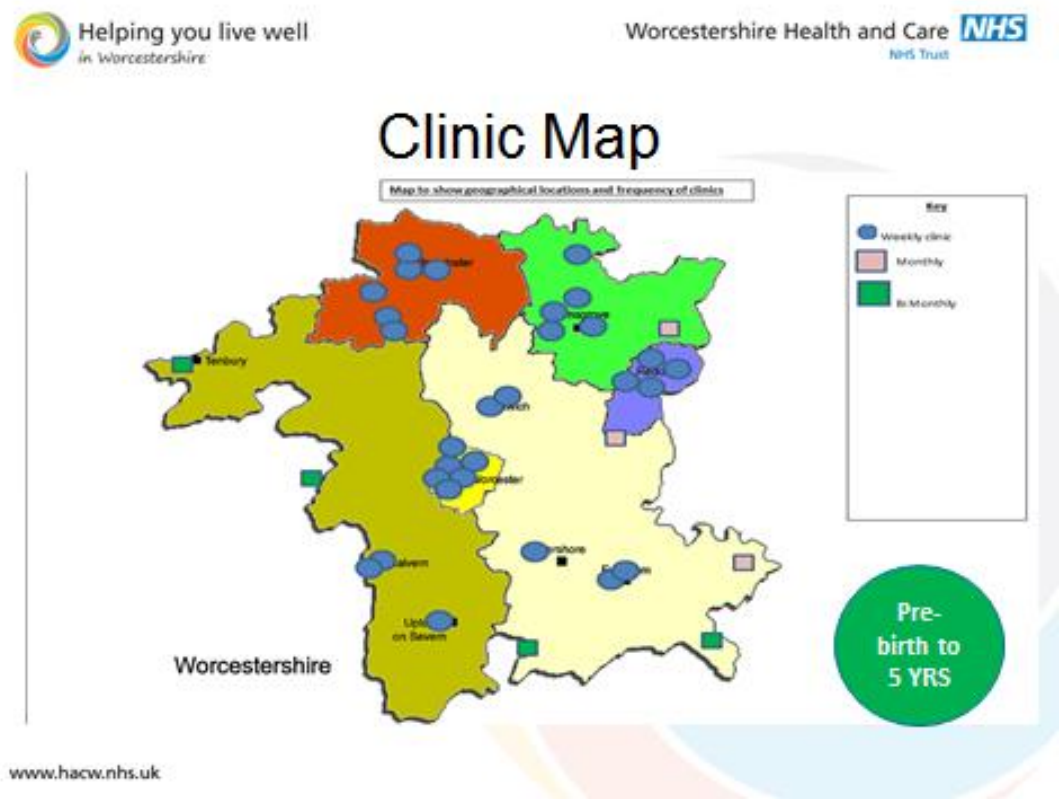
| Team | Number of children | | | | As a % of total | | |
|---|---|---|---|---|---|---|---|
| Worcestershire | Universal | UP | UPP | Totals | Universal | UP | UPP |
| HV caseloads (0-5s) As at Nov 2017 | 15499 | 869 | 609 | 16977 | 91.3 | 5.1 | 3.6 |
| HV caseloads (0-5s) As at Oct 2018 | 14135 | 970 | 467 | 15572 | 90.8 | 6.2 | 3.0 |

Source: Worcestershire Public Health Nursing Service

Drop in child health or baby clinics are provided in targeted urban areas and rural areas with transport difficulties.

Figure **84** provides a map indicating location and frequency of clinics.

Figure 84: Baby Clinics in Worcestershire




Numbers of school aged CYP seen by the school health service by each HCP service element is given in Table 21. The School Health Service is not delivering Universal activities or activities at the whole school, community or population level. Delivery at the Universal Plus level includes High school drop-ins or Time4U sessions and health assessments; Universal Partnership Plus includes safeguarding activities and LAC health assessments (77%). A significant increase in safeguarding activities has occurred over the last 2 years which is impacting on capacity for prevention and early intervention activity.

Table 21: School Health Nursing activity as at November 2017

| Team | Number of children | | | | As a % of total | | |
|---|---|---|---|---|---|---|---|
| Worcestershire | Universal | UP | UPP | Totals | Universal | UP | UPP |
| School Health Nurses | 0 | 342 | 1147 | 1489 | 0.0 | 5.1 | 77.0 |

Source: Worcestershire Public Health Nursing Service

Numbers of CYP and numbers of contacts over the last 3 years by HCP service element for preschool and school age children years is given in Table 22. This indicates that over the two year period October 2016 to September 2018 for under 5s, 36% of contacts were universal, 51% were for UP activity and 13% were for UPP activity. For UP there were on average 2.2 contacts per child and for UPP 4.9 contacts per child. Over the 2 years, the proportion of universal and UPP appears to have

risen and UP reduced. For school aged children, the Table indicates an annual increase in numbers of UP and UPP activity over the 3 year period.

Table 22: Public Health Nursing Contacts (2016-2018)

| | 0-5 Years | | | | | 5 – 19 Years | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Oct 16 - March 17* | April 17 - March 18 | April 18- Sept 18* | **Total Oct 16-Sept 18** | | April 15- March 16 | April 16- March 17 ** | April 17 - March 18 | April 18- Sept 18* | **Total Oct 16-Sept 18** |
| **Number of Contacts** | | | | | | | | | | |
| Universal | 11445 | 22448 | 10283 | 44176 | | | | - | | |
| Universal Plus | 22980 | 28934 | 11797 | 63711 | | 7861 | 10245 | 13027 | 6110 | 19137 |
| Universal Partnership Plus | 3549 | 8449 | 3549 | 15547 | | 4678 | 3199 | 3445 | 3487 | 6932 |
| Total Contacts | 37974 | 59831 | 25629 | 123434 | | 12539 | 13444 | 16472 | 9597 | 26069 |
| **Number of Patients** | | | | | | | | | | |
| Universal | 8860 | 16122 | 8480 | 33462 | | | | - | | |
| Universal Plus | 10240 | 13083 | 5892 | 29215 | | 2461 | 5461 | 6731 | 3316 | 10047 |
| Universal Partnership Plus | 949 | 1377 | 845 | 3171 | | 2791 | 2279 | 1237 | 1244 | 2481 |
| Total Contacts | 20049 | 30582 | 15217 | 65848 | | 5252 | 7740 | 7968 | 4560 | 12528 |
| | | | | | | | | | | |
| **Average No of Contacts** | | | | | | | | | | |
| Universal | 1.29 | 1.39 | 1.21 | 1.32 | | | | | | |
| Universal Plus | 2.24 | 2.21 | 2.00 | 2.18 | | 3.19 | 1.88 | 1.94 | 1.84 | 1.90 |
| Universal Partnership Plus | 3.74 | 6.14 | 4.20 | 4.90 | | 1.68 | 1.40 | 2.78 | 2.80 | 2.79 |
| | | | | | | | | | | |
| **% of patients** | | | | | | | | | | |
| Universal | 44.19% | 52.72% | 55.73% | 50.82% | | | | | | |
| Universal Plus | 51.07% | 42.78% | 38.72% | 44.37% | | 58.21% | 70.56% | 84.48% | 72.72% | 80.20% |
| Universal Partnership Plus | 4.73% | 4.50% | 5.55% | 4.82% | | 41.79% | 29.44% | 15.52% | 27.28% | 19.80% |
| | | | | | | | | | | |
| **% of contacts** | | | | | | | | | | |
| Universal | 30.14% | 37.52% | 40.12% | 35.79% | | | | | | |
| Universal Plus | 60.52% | 48.36% | 46.03% | 51.62% | | 62.69% | 76.20% | 79.09% | 63.67% | 73.41% |
| Universal Partnership Plus | 9.35% | 14.12% | 13.85% | 12.60% | | 37.31% | 23.80% | 20.91% | 36.33% | 26.59% |

Source: WHCT (Carenotes) * only 6 months ** Electronic Patient Record System changes during period

### 20.3. Intensive Home Visiting

The Worcestershire Family Nurse Partnership programme commenced in 2015. The service provided intensive support from a Family Nurse during pregnancy and through infancy up to aged 2.5 years for 100 mothers. Following the findings of the national RCT, the service moved to a mixed model offering Family Nurse Partnership (FNP) places and Family First (FF) places (at a lower intensity) for 190 young vulnerable mothers. From December 2018 the Intensive Home Visiting service provides only the FF model for up to 240 mothers.

The Intensive Home Visiting Service is a programme for identified young and first time mothers with specific vulnerabilities requiring additional help and support to achieve improved outcomes for their babies and families. Clients on the programme will receive a minimum of 15 structured visits over the two and a half year delivery period. Mothers are identified and enrolled in pregnancy. The visiting structure of the programme is set out in three stages; pregnancy (5 visits), infancy (7 visits)

and toddlerhood (at least 3 visits). Public Health nurses have been trained to provide specific tools and practice required for the programme.

### 20.4. Children's Centres and Building Community Capacity

There are three providers commissioned to build community capacity since December 2016, known as the Parenting and Community Development Service; Action4Children (South Worcestershire), Barnardo's (Wyre Forest) and Redditch Borough Council (Redditch & Bromsgrove). This activity is undertaken through 4 work strands:

- Improving access to activities for families, including mapping of community assets
- Development of Community Parenting Programmes
- Development of Peer Support, Volunteering and Mentoring
- Provision of information and advice to families

The first strand of their work was to map activities and identify locality need. The service develops, promotes and provides parenting support, CYP or family based activities through children's centres and other community venues. Much of this work is delivered through children's centres.

There are currently 32 Children's Centres in Worcestershire. Leases for 10 buildings are held by the Parenting and Community Development service. All of the Children's Centre buildings continue to provide early childhood services and continue to focus on the provision of early years' services and the targeting of services to those most in need of support. There are also early childhood services being provided in other community venues such as libraries, community centres and health clinics.

Since 2016, the centres run by schools and childcare providers have not been required to record or measure activity data so it is not possible to identify or compare usage with previous data. Footfall (the number of individual visits to a centre) has continued to be recorded by those 10 centres run by the Parenting and Community Development Service. Table 23 identifies footfall in these centres in 2016, prior to changes and funding reductions, and 2017 and indicates a 45% reduction. The footfall reflects all visits to the centres including health clinics and other activities provided by other agencies. However, during this period the providers were commissioned to provide more targeted and outreach support and so a reduction would be expected.

Table 23: Children's Centres Footfall by District

| | 2016 | | 2017 | |
|---|---|---|---|---|
| **Children's Centres** | **Children** | **Carers** | **Children** | **Carers** |
| Pear Tree (Bromsgrove) | 2204 | 2225 | 2939 | 4087 |
| Holly Trees (Redditch) | 2803 | 5723 | 2882 | 5231 |
| Brookside & Half Crown Wood (Wyre Forest) | 6753 | 10335 | 3308 | 7267 |
| Tudor Way, Saffron, Buttercup (Worcester) | 11058 | 17167 | 4440 | 13563 |
| WANDS & Blossom Vale (Wychavon) | 7105 | 7533 | 2192 | 3211 |
| Sunshine (Malvern) | 2388 | 4604 | 1873 | 4696 |
| **TOTAL** | **32311** | **47587** | **17634** (45% reduction) | **38055** (20% reduction) |

The optimisation of all Children's Centres buildings through which early childhood services are made available and activities are provided has continued to be a priority. Early childhood services are defined as

- early years provision (early education and childcare);
- social services functions of the local authority relating to young children, parents and prospective parents;
- health services relating to young children, parents and prospective parents;
- training and employment services to assist parents or prospective parents;
- information and advice services for parents and prospective parents.

A variety of early childhood services are provided through all children's centres buildings in Worcestershire. All centres deliver early childhood services and most provide health services (midwifery, health visitor clinics and speech & language clinics). Some centres host social services functions, some host and provide targeted support sessions (parenting, family support) and some provide universal activities such as stay and play and breastfeeding support.

The Parenting and Community Development Service are commissioned to deliver a range of services using the children's centres they lease as well as promoting, developing and facilitating access to activities in all children's centres and other community buildings. They utilise their buildings for a wide range of provision such as targeted parenting support, parenting groups, family learning, health services, targeted family support, ante-natal education sessions, baby groups, stay and play, breastfeeding support, holiday clubs, before/after school clubs, lunch clubs, Mums groups, CYP groups and SEN parent groups in addition to provision of education or childcare.

The service has developed a new community parenting programme which evidence suggests if properly run, with good training and supervision of volunteers, are popular with parents and can increase confidence, social networks and engagement. Highly trained volunteers can run parenting programmes successfully. A programme has been developed based on the Parents 1st programme [115]. The Parents 1st Community Parent Volunteer Peer Support Programme has been used in other areas as an early prevention peer support initiative starting in pregnancy that provides a continuum of focused home visiting from a trained volunteer during the transition to parenthood within defined

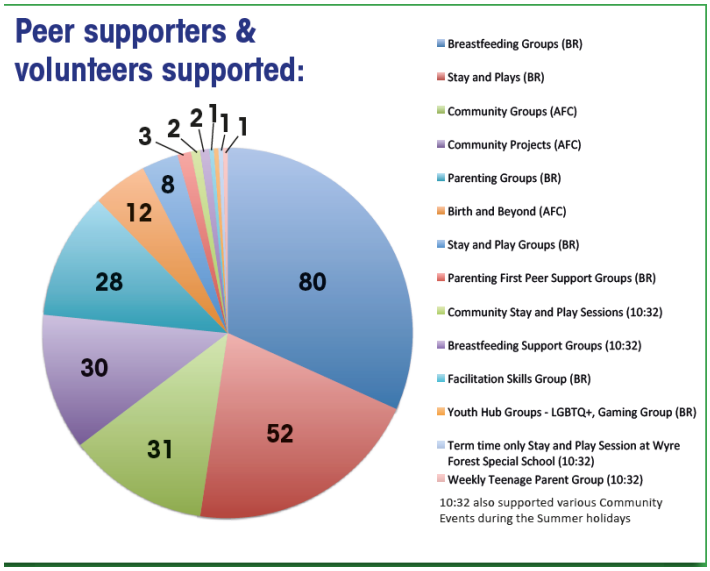
[115] https://www.parents1st.org.uk/

disadvantaged areas. It has been shown to improve confidence and wellbeing in parents and the volunteers gain satisfaction from 'giving' to their community.

In Worcestershire peer support volunteers have been recruited to support parenting practitioners in delivering parenting courses to families. The peer supporters are important intermediaries who carry out a role midway between that of a professional and a friend and help to build the strength and skills of parents living in less advantaged communities. The peer supporters have been trained and developed as the third practitioner in the groups, in the longer term the aim is to further train the peer supporters to becoming competent in delivering the courses. To date, 3 cohorts have been recruited to and peer supporters have commenced placements. In the twelve month period 17/18 the peer supporters have given support to 110 sessions, contributing 209 hours to the service.

The third strand of the service is the development of other volunteering and peer support. The community capacity service has recruited 77 volunteers during 17/18 providing 3863 volunteer hours in total. Volunteers have been recruited to support breastfeeding, parenting, stay & play groups, groups for teenagers and young people, community groups and to support antenatal education sessions. Figure 85 below highlights the variety and numbers of groups and activities supported.

Figure 85: Peer supports and volunteer activity 17/18




The volunteering experience has enabled a number of the volunteers to develop and improve their own life experiences or chances. During the period 15 went on to Further Education, 7 into employment, 3 into further volunteering opportunities.

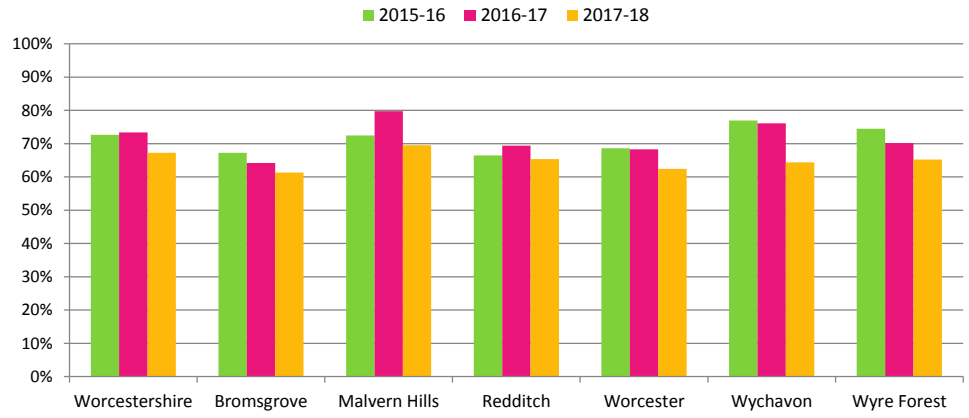
The final service strand is to provide advice, guidance and assistance for parents in finding and accessing childcare or nursery provision (Family Information Service).

### 20.5. Early Education

There is strong evidence that access to and uptake of high quality childcare and early education can improve child development and future educational outcomes. As in rest of England, all 3 and 4 year olds in Worcestershire can access 15 hours (Universal Hours) of free early education or childcare. Some more disadvantaged 2 year olds are also eligible for 15 hours free childcare if the household is in receipt of certain benefits or if the child has a special educational need and/or disability. In September 2017, there was an extension of the number of hours of free childcare available for certain eligible children aged 3 and 4 from 15 hours to 30 hours (Extended Hours)[116].

Across Worcestershire overall, the proportion of eligible children aged 2 accessing universal hours decreased from 73% in 2015-16 to 67% in 2017-18. There is some concern that this may be a result of the introduction of the new 30 hours, which is resulting in more 3 and 4 year olds taking up more hours at providers. This will be monitored over time to see whether this continues to be the case. This pattern is reflected across all district areas in Worcestershire. In 2017-18, the highest uptake of universal hours was in Malvern Hills at 70% and the lowest uptake was in Bromsgrove at 61%.

Figure 86: Eligible 2 year old uptake of early education and childcare (2015-16 – 2017-18)

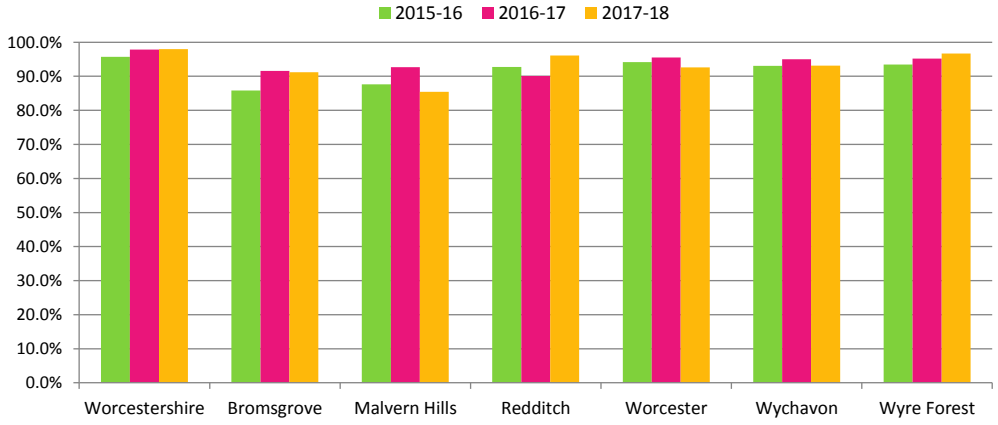



*Source: Worcestershire County Council, Children's Services*

Across Worcestershire, the proportion of eligible children aged 3 accessing universal hours has increased from 95.7% in 2015-2016 to 98.0% in 2017-18. In 2017-18, the highest uptake of universal hours was in the Wyre Forest district at 97% and the lowest uptake was in Malvern Hills district at 85%.

1. [116] **GOV.UK (2018) Help paying for childcare, [Online], Available from: https://www.gov.uk/help-with-childcare-costs/free-childcare-and-education-for-2-to-4-year-olds , Accessed: 23/08/2018**

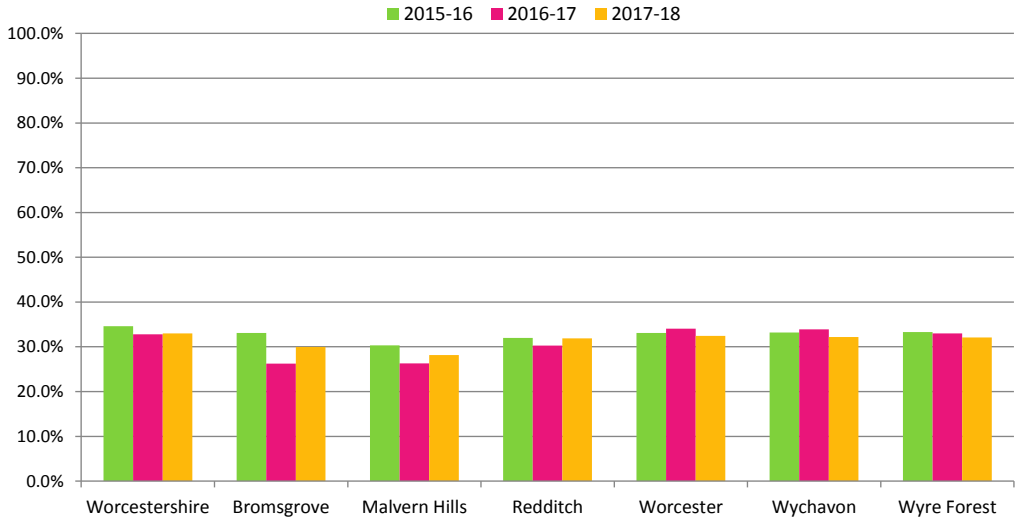
Figure 87: Eligible 3 year olds uptake of early education and childcare (2015-16 – 2017-18)




Source: Worcestershire County Council, Children's Services

Take up of Universal Hours is lower in 4 year olds when compared to 3 year olds because the majority are in school by this age. Across Worcestershire the proportion of eligible children aged 4 accessing universal hours has decreased slightly from 34.8% in 2015-16 to 33.4% 2017-18. This is also reflected across the district areas. Uptake rates were similar across districts in 2017-18. Rates are highest in Worcester district at 33.0% and lowest in Malvern Hills at 28.3%.

Figure 80 – Eligible 4 year olds uptake of early education and childcare (2015-16 – 2017-18)

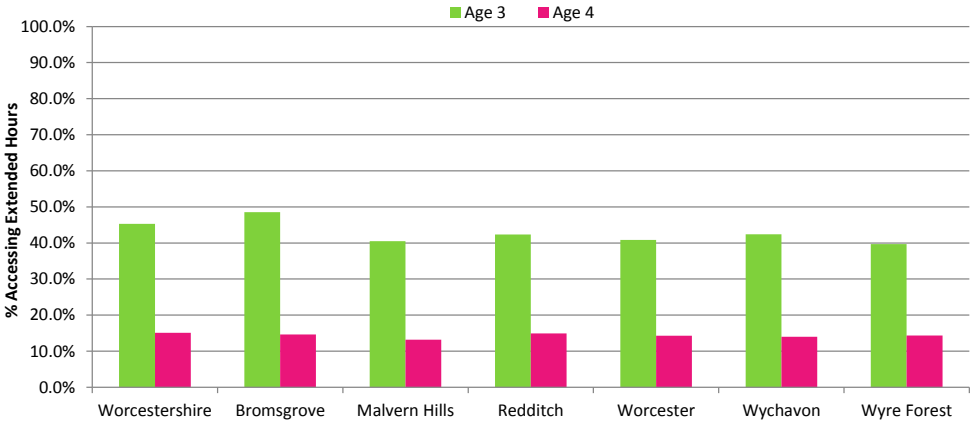



*Source: Worcestershire County Council, Children's Services*

Figure 88 below shows the proportion of children accessing extended hours by age and district in 2017-18. This is the first year that extended hours have been available. For children aged 3 the overall uptake in Worcestershire was 45%. Only a proportion of families are eligible for 30 hours free childcare. It is estimated that at the most 60-70% of families in Worcestershire will be eligible. It is anticipated that the uptake will be higher next year because this is the first year of the programme.

However, it should be noted that this is a significant proportion of eligible families. The highest rate of uptake in Bromsgrove at 49% and the lowest rate was Wyre Forest at 40%. For children aged 4 the overall uptake of extended hours free childcare was 15.3% across Worcestershire. In the district areas, the highest rate of uptake was in Bromsgrove at 15% and the lowest rate of uptake was in Malvern Hills at 13%.

Figure 88: Proportion of children accessing extended hours (2017-18)




*Source: Worcestershire County Council, Children's Services*

There are 575 Early Years Settings in Worcestershire. Childminders make up the highest proportion of early years provision across the county with 337 (58.6%) across the county. There are 134 day nurseries (23.3%), 98 pre-school play groups (17%) and 6 Wrap around Care providers (1.0%).

Nationally, 95% of providers on the Early Years Register were rated as Outstanding or Good on their most recent inspection[117]. In Worcestershire, a total of 485 providers were inspected and overall, 96.7% of early years providers in Worcestershire were rated as Outstanding, Good or Met (n.469) at their most recent inspection. Wychavon (92.0%) and Malvern Hills (93.8%) all had a lower proportion of early years settings with a rating of this kind. In Worcestershire, 28.7% of providers were rated as Outstanding, which was higher than the national average of 19%.

A very small number of providers (n.16) received a rating of satisfactory, requires improvement, inadequate or not met and these accounted for just 3.3% of all providers, who were inspected in Worcestershire. At the time of writing, there were 90 providers across Worcester, which had not yet been inspected (15.7%, n.90).

[117] OFSTED (2018) The Annual Report of Her Majesty's Chief Inspector of Education, Children's Services and Skills 2017/18, [Online], Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/761606/29523_Ofsted_Annual_Report_2017-18_041218.pdf , Accessed: 07/03/2019

Table 24: Ofsted ratings at most recent inspection for Early Years Settings by District (2017-18)

| OFSTED Rating | Bromsgrove | Malvern Hills | Redditch | Worcester City | Wychavon | Wyre Forest | Total Worcestershire | Overall Effectiveness of those inspected (Worcestershire) |
|---|---|---|---|---|---|---|---|---|
| Outstanding | 33 | 15 | 14 | 28 | 18 | 31 | 139 | 28.7% |
| Good | 59 | 29 | 47 | 57 | 72 | 47 | 311 | 64.1% |
| Met | 3 | 1 | 2 | 5 | 2 | 6 | 19 | 3.9% |
| Satisfactory | - | - | - | - | 1 | - | 1 | 0.2% |
| Requires Improvement | - | 3 | 2 | - | 5 | 1 | 11 | 2.3% |
| Inadequate | - | - | - | - | - | 1 | 1 | 0.2% |
| Not Met (with actions) | - | - | - | 1 | 2 | - | 3 | 0.6% |
| Not inspected | 16 | 2 | 8 | 23 | 23 | 18 | 90 | - |
| **Total** | **111** | **50** | **73** | **114** | **123** | **104** | **575** | |
| **Total - of those inspected** | **95** | **48** | **65** | **91** | **100** | **86** | **485** | |
| Outstanding/Good/Met (No.) | 95 | 45 | 63 | 90 | 92 | 84 | 469 | |
| Outstanding/Good/Met (%) | 100.0% | 93.8% | 96.9% | 98.9% | 92.0% | 97.7% | 96.7% | |

### 20.6. Parenting

A variety of parenting support and interventions are in place provided by a range of services and practitioners. All pregnant women receive antenatal care from maternity services. All parents/families receive mandatory reviews from the Health Visiting service to support their parenting. There are universal free on-line "Solihull Approach" parenting courses for antenatal, postnatal and 0-18 years. Intensive parenting support is provided to new at risk vulnerable young mothers through the Intensive Home Visiting Service until their child is aged 2.5 years. A variety of parenting groups and activities are available usually in children's centres. A variety of group parenting programmes are held provided by the Parenting and Community Development service. The Early Intervention Family Support Service (EIFS) who work closely with schools provide individual and group parenting support. Targeted Family Support provides more intensive parenting and family support. Children's Social Care provide more specialist and intensive parenting interventions for those children in need of help and protection. This section focusses on parenting support and programmes provided at the Level 1 and Level 2 of need since the last EHNA.

### 20.7. On-line Solihull Approach programme

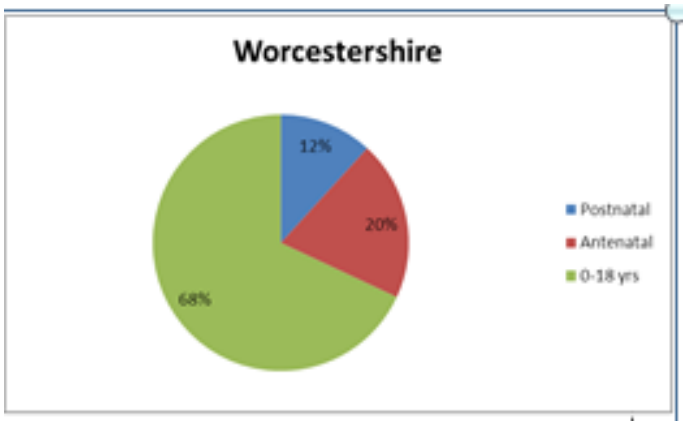
A multi-user licence has been funded to enable all parents, grandparents and carers to access free on-line parent programmes for the 3 year period 2017-2020. There are three evidence based Solihull Approach programmes:

- Understanding pregnancy, labour, birth and your baby - antenatal

- Understanding your baby – postnatal
- Understanding your child – (6 months to 18 years)

The programmes are promoted by maternity services, Public Health Nursing services, libraries and through the WCC YLYC website. The parenting and community development providers also use the courses to provide individual support with some parents and promote the courses to augment their face to face group programmes. On-line access commenced in August 2017 and by December 2018 there have been 568 registrations with three quarters undertaking the course. The most popular course is for older children Understanding Your Child. (68%)

Figure 89: On-line Solihull Approach parenting courses Aug 2017-December 2018




### 20.8. Antenatal Education and Preparing for Birth

Antenatal education and preparation for birth & beyond in Worcestershire has historically varied and has not been universal. In 2017 a collaborative approach to provide the evidence based programme "Birth & Beyond" commenced. The training and 4 week programme was led, developed and coordinated by the Public Health Nursing service in conjunction with a national expert. The 4 week Birth & Beyond Worcestershire programmes have been delivered in partnership by Midwifery, Public Health Nursing and Parenting and Community Development providers. The programmes are based in Worcester, Kidderminster and Redditch (targeted universal). The programmes have evaluated well. The 4-week antenatal class explores getting to know your baby, changes for you/your partner, giving birth and meeting baby, parents' health and wellbeing and feeding, bathing and practical care.

#### 20.8.1. Parenting Providers

The Parenting and Community Development Providers are commissioned to provide parenting support groups and activities and to provide evidence based group parenting programmes. The programmes are delivered through children's centres, community buildings and sometimes within the family home. The three providers offer similar activities and programmes but there are differences by locality. Some of the programmes provided have better evidence of effectiveness than others. Table 25 identifies all providers offer Solihull Approach groups and Incredible Years. Triple P is used in Redditch & Bromsgrove (R&B) and South Worcestershire (SW) but not Wyre Forest

(WF). PEEP, the only programme focussed on cognitive and language development is available in R&B and WF but not SW. Family Links which does not have evidence of effectiveness is being provided in R&B and SW. Henry which does have a good evidence base for sustained changes in family lifestyle is only provided in WF.

Table 25: Parenting programmes by locality

| Programme | Preschool | 0-19 | Teenage | Focus of Outcome | Evidence rating |
|---|---|---|---|---|---|
| Redditch & Bromsgrove | PEEP | | | Cognitive & language | NL2 (Baby, 1s & 2s) 2+ (3s & 4s) |
| | Triple P Discussion Group | | | Behaviour | 3+ |
| | | Understanding Your Child (Solihull Approach) Groups | | Behaviour | 2 |
| | | Incredible Years | | Behaviour | 4+ (Preschool) |
| | | Family Links | | Behaviour | NE |
| | | Triple P Group (2-10 yrs) | | Behaviour | 3+ |
| | | | Teen Triple P | Behaviour | 3 |
| | | | Talking Teens | | Not rated |
| South Worcestershire | Triple P Discussion Group | | | Behaviour | 3+ |
| | | Understanding Your Child (Solihull Approach) Groups | | Behaviour | 2 |
| | | Incredible Years | | Behaviour | 4+ (Preschool) |
| | | Family Links | | Behaviour | NE |
| | | Triple P Group (2-10 Yrs) | | Behaviour | 3+ |
| | | | Teen Triple P | Behaviour | 3 |
| | | | PPAP Parents Plus Adolescents Programme | Behaviour | 2+ |
| Wyre Forest | PEEP | | | Cognitive & language | NL2 (Baby, 1s & 2s) 2+ (3s & 4s |
| | HENRY | | | Diet & physical activity | |
| | | Understanding Your Child (Solihull Approach) Groups | | Behaviour | 2 |
| | | Incredible Years | | Behaviour | 4+ (Preschool) |
| | | | Understanding your teen (Solihull Approach) | | Not rated |
| | | Understanding your child with special needs (Solihull | | | Not rated |

| | | | | | |
|---|---|---|---|---|---|
| | | Approach) | | | |

Activity data for short parenting courses or workshops less than 4 weeks in duration is recorded via the E-Start system and parenting programmes over 4 weeks duration recorded via FWi and so there are likely to be duplication of cases on both systems. The parenting activity can be stand alone or part of a package of support which has made it difficult to extract meaningful data for this needs assessment.

Table 26 shows parenting activity recorded in E-Start (activities less than 4 weeks duration) between November 2016 and October 2018. This suggests 1392 parents accessed short duration parenting activities. There were more activities in Redditch (n.500, 35.9%), Wyre Forest (n.376, 27.0%) and Bromsgrove (n.281, 20.2%). This reflects the differences in availability, duration and type of activities provided in different areas. The most common short course/activities were:

- Triple P Discussion Group (n.373, 26.8%): These are short, small sessions run by a trained Triple P provider. Each session brings together about 10-12 parents who are experiencing the same parenting issue. They are given tips and suggestions for dealing their child's problem behaviour. Parents will be given a take-home work book with simple exercises and information to help them try out the new strategies at home.
- PEEP (n.336,24.1%): This is a learning programme aimed at families with children to value and build on the home learning environment and relationships with their children, by making the most of everyday learning opportunities – listening, talking, playing, singing and sharing books and stories together.

Table 26: Numbers of parents accessing short parenting courses/activities (less than 4 weeks) by type and district (November 2016 to October 2018)

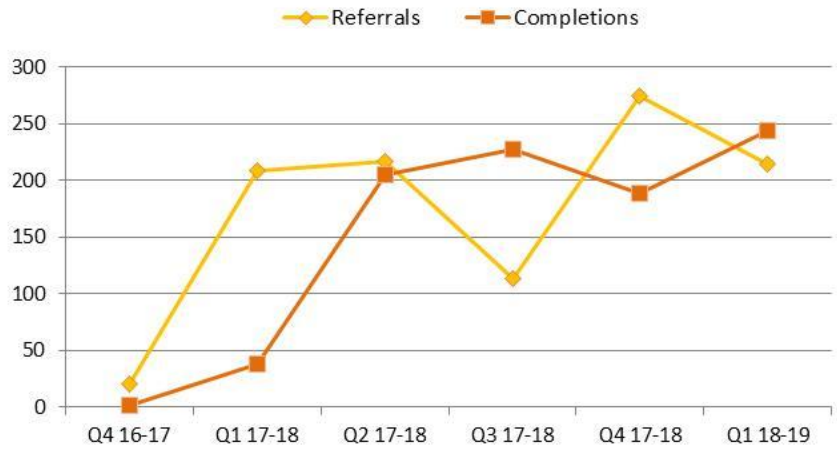
| Name of Course | Bromsgrove | Malvern | Redditch | Worcester | Wychavon | Wyre Forest | Total | % |
|---|---|---|---|---|---|---|---|---|
| PPP Discussion group | 119 | 10 | 188 | 41 | 15 | | **373** | 26.8% |
| PEEP | 75 | | 129 | | | 132 | **336** | 24.1% |
| Understanding your Child | 31 | | 82 | | | 56 | **169** | 12.1% |
| Family Links | 15 | 34 | 52 | 27 | 13 | | **141** | 10.1% |
| Talking Teens | 41 | | 49 | | | | **90** | 6.5% |
| HENRY | | | | | | 74 | **74** | 5.3% |
| Understanding your Baby | | | | | | 56 | **56** | 4.0% |
| Understanding your Teen | | | | | | 43 | **43** | 3.1% |
| PPAP | | | | 31 | | | **31** | 2.2% |
| Incredible Years | | 3 | | 26 | | | **29** | 2.1% |
| Solihull Approach | | 18 | | 7 | | | **25** | 1.8% |
| Parents with Prospects | | | | 1 | 8 | 3 | **12** | 0.9% |
| Parenting Workshop | | | | | | 12 | **12** | 0.9% |
| Protective Behaviours | | | | 1 | | | **1** | 0.1% |
| **Total** | **281** | **65** | **500** | **134** | **36** | **376** | **1392** | |
| % | 20.2% | 4.7% | 35.9% | 9.6% | 2.6% | 27.0% | | |

Source: Worcestershire County Council, Children's Services

Parenting programme support over 4 weeks duration provided between November 2016 and June 2018 was extracted from Framework-I system. During this period, there were a total of 1047 referrals for parenting programmes. There were 904 episodes where a programme of parenting support was completed during this time period. This data includes parenting programmes provided

by all providers (Parenting and Community Development Providers, EIFS and Targeted Family Support). Figure 90 demonstrates the development and increase in parenting programmes over the last 2 years.

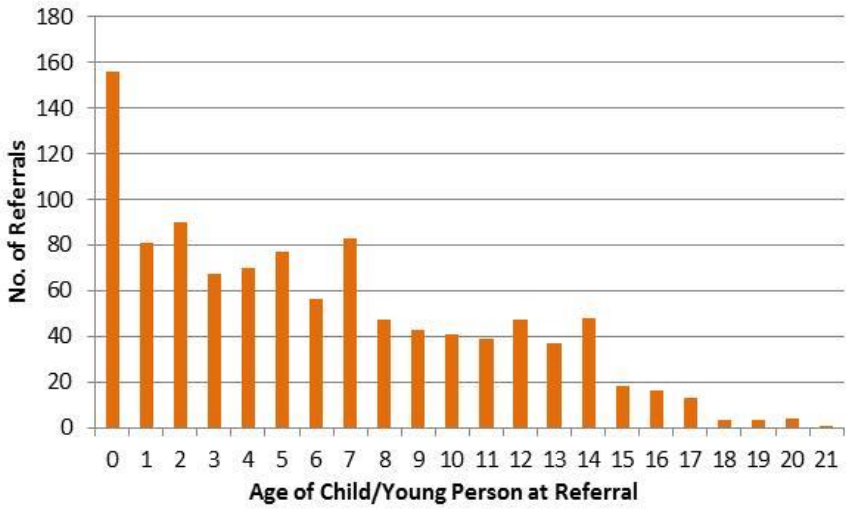
Figure 90: Number of Referrals and Completions to a Parenting Programme (Nov'16 – Jun'18)




Source: Worcestershire County Council, Children's Services

Figure 91 identifies referrals for parenting programmes by age group. The majority of referrals were for families with children aged 0-4 (n. 464, 44.3%) and 5-9 years old (n.306, 29.2) and accounted for 73.5% of all referrals into the service.

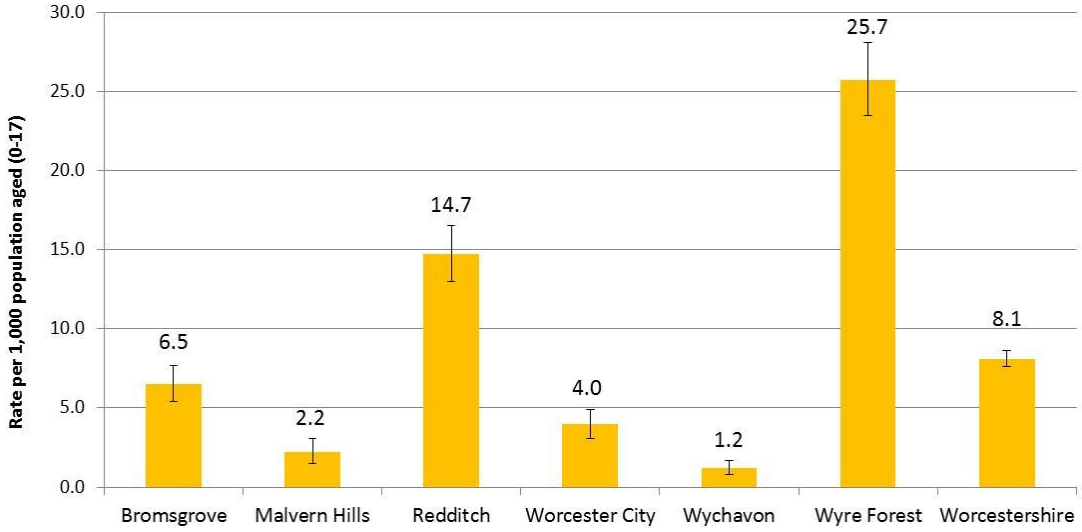
Figure 91: Number of referrals to parenting programmes by age of CYP at referral (Nov'16 – Jun'18)




*Source: Worcestershire County Council, Children's Services*

Further analyses identified that 50.6% (n.530) of referrals for parenting programmes were from the 40% most deprived Super Output Areas (SOAs) across Worcestershire. Referral rates for parenting programmes vary by District, however this likely represents the variation in the development, range and length of programmes provided in each District. Figure 92 below identifies that the highest rates of referrals are for families from the Wyre Forest (23.3 per 1,000 population) and Redditch (13.5 per 1,000 population).

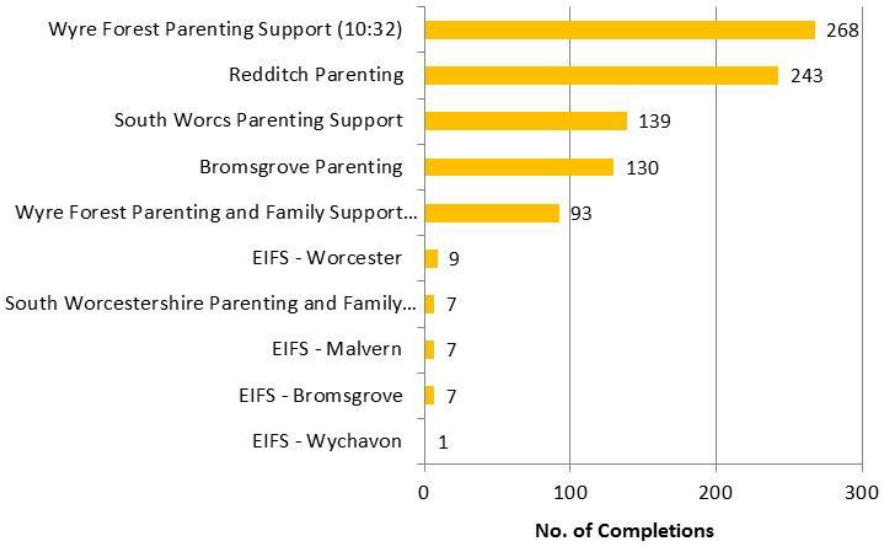
Figure 92: Rate of Referrals by District per 1,000 population aged 0-17 years (Nov'16 – Jun'18)




*Source: WCC, Children's Services/ Office for National Statistics Mid-year Population estimates.*

Completions of parenting programmes have been analysed by Provider. Figure 93 shows the breakdown by Provider. Again this is likely to reflect the variation in the development, access and length of programmes in each locality as well as indicating need.

Figure 93: Parenting Programme completions by Provider (Nov'16 – Jun'18)




*Source: Worcestershire County Council, Children's Services*

Table 27 provides the completed parenting programmes by programme. The data highlights that most parents were referred to:

- Understanding your child - Solihull Approach (n.249, 27.4%) is a ten week programme focusing on improving positive relationships between parents and children.
- PEEP (n.191, 21.1%) is a 10-12 week learning programme aimed at families with children to value and build on the home learning environment and relationships with their children, by making the most of everyday learning opportunities – listening, talking, playing, singing and sharing books and stories together
- Family Links (n.104, 11.5%) is ten week nurture based programme that builds on the skills that parents already have and introduces lots of ways to improve family relationships and manage the behaviour of children of all ages. However this programme has been found not to be effective according to academic research.

Table 27: Parenting programme completions by Programme Type (Nov'16 – Jun'18)

| Type of Programme | Total | % |
|---|---|---|
| Understanding your Child | 248 | 27.4% |
| PEEP | 191 | 21.1% |
| Family Links | 104 | 11.5% |
| Triple P 2-10 | 103 | 11.4% |
| Unknown | 75 | 8.3% |
| Henry | 59 | 6.5% |
| Triple P Teen | 57 | 6.3% |
| Parenting workshop | 31 | 3.4% |
| Family learning | 16 | 1.8% |
| The Solihul Approch | 14 | 1.5% |
| Other | 6 | 0.7% |
| **Total** | **904** | |

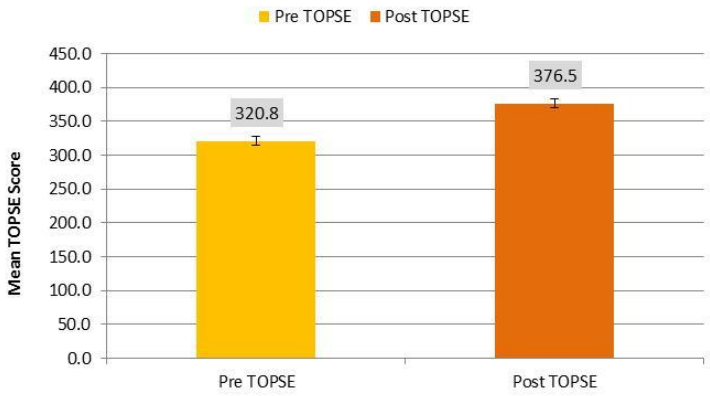
*Source: Worcestershire County Council, Children's Services*

The parenting providers have introduced the use of the TOPSE tool during the period of this data analyses. TOPSE has been developed as a tool to measure parenting self-efficacy and is used both in the UK and in many other countries to evaluate a range of parenting programmes and interventions. TOPSE consists of 48 self-efficacy statements that address six domains of parenting; emotion and affection, play and enjoyment, empathy and understanding, control, discipline and boundary setting, pressures of parenting, self-acceptance, and learning and knowledge. There are six self-efficacy statements for each domain and parents indicate how much they agree with each statement by responding to a Likert scale from 0-10 where 0 equates to completely disagree and 10 equates to completely agree[118].

Parents complete the TOPSE booklet on the first session of a parenting programme and again on the final session to determine any change in self-efficacy scores. Between November 2016 to June 2018, 498 parents enrolled onto a programme, completed a TOPSE questionnaire at the start and end of the programme. Figure 94 below shows that there was a statistically significant increase in overall mean TOPSE score from 320.8 (CI: 314.4-327.1) to 376.5 (CI: 369.7 – 383.2, P <0.0001). This demonstrates that following the programmes, overall, the scores in self efficacy and belief in their parenting capabilities had increased.

[118] TOPSE (2009) What is TOPSE?, [Online], Available from: http://www.topse.org.uk/site/index.php?option=com_content&view=article&id=131&Itemid=163, Accessed: 10/08/2018

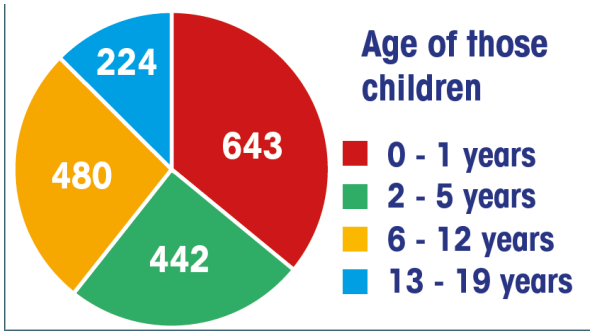
Figure 94: Overall TOPSE scores at start and completion of parenting programmes (Nov'16 – Jun'18)




*Source: Worcestershire County Council, Children's Services/Bespoke Public Health Analysis*

Data provided by the Parenting and Community Development Providers for the year 2017 to 2018 identified they delivered 175 parenting programmes, 1479 parents attended the programmes which impacted on 1789 of their children. Figure 95 highlights the numbers and age range of children impacted.

Figure 95: Children of parents who attended programmes (2017-2018)




20.9. Early Help Assessments

The Early Help Assessment (EHA) is a tool to assist any professional who is working with children, young people and families. It should be used where there are emerging welfare or well-being concerns. The EHA gives a framework to consider whilst working with a child or family and is a whole family assessment.

The number of EHAs completed and recorded via Frameworki between April 2015 and March 2018 were examined for this EHNA. During that period there were a total of 6933 EHAs. 95.9% (n.6646) of EHAs were for children and young people resident in Worcestershire, a small percentage (1.5%, n.102) were for children and young people resident in neighbouring counties. There were a number of records where postcode was not available (2.7%, n.185).

There have been a number of service changes since the previous 2015 EHNA. During 2016 the previous commissioned early help providers received reduced funding and a new service specification and the internal WCC early help services (EIFS and targeted family support) were adjusted. A new Early Help Strategy was implemented including when an EHA would be completed. Figure 96 demonstrates that since 2016 the number of EHAs completed have reduced as would be expected in light of changes above.

Figure 96: Numbers of Early Help Assessments (Apr'15 to Mar'18)


*Source: Worcestershire County Council, Children's Services*

To better identify the impact of the 2016 changes, within this analysis this is referred to as the Pre and Post periods. Table 28 below shows the completed Early Help Assessments by provider or service as identified on FWi. Although some of the services appear to have been included more than once but with a different name, the table demonstrates that most EHAs pre 2016 were completed by an Early Help Provider (56.6%, n.2651) and Early Intervention Family Support (20.9%, n.976). Post 2016, EHAs have been completed by Early Intervention Family Support (24.2%, n.545) and Family Support services.

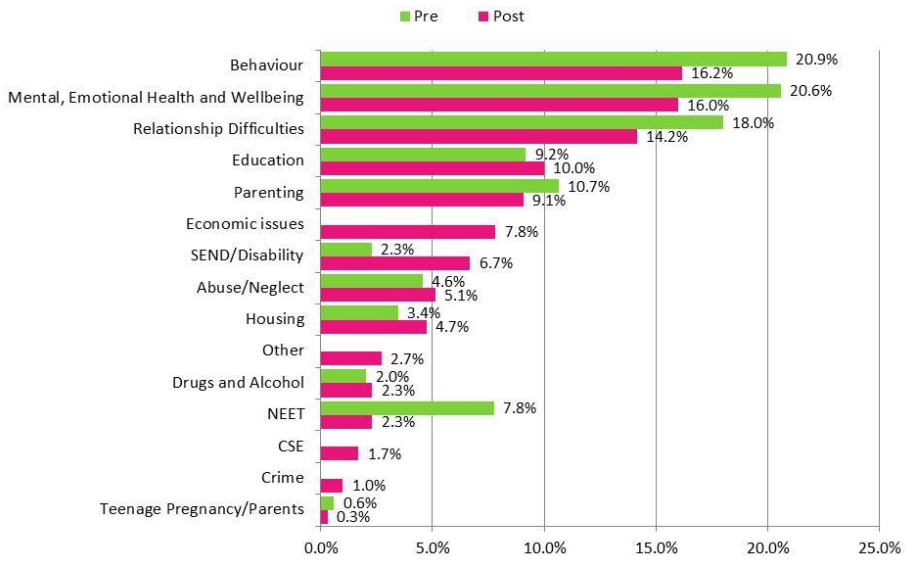
Table 28: Early Help Assessments by Provider (Apr'15 to Mar'18)

| | No. | | | % | |
|---|---|---|---|---|---|
| **Provider** | **Pre** | **Post** | **Total** | **Pre** | **Post** |
| Early Intervention Family Support | 976 | 545 | 1521 | 20.9% | 24.2% |
| Action for Children SW | 6 | 359 | 365 | 0.1% | 15.9% |
| Early Help Provider | 2651 | 325 | 2976 | 56.6% | 14.4% |
| Stronger Families | 205 | 285 | 490 | 4.4% | 12.6% |
| Parenting and Family Support | 38 | 210 | 248 | 0.8% | 9.3% |
| Wyre and Hagley Project | 183 | 179 | 362 | 3.9% | 7.9% |
| 10:32 Wyre Forest | 118 | 137 | 255 | 2.5% | 6.1% |
| Connecting Families | 3 | 121 | 124 | 0.1% | 5.4% |
| Targeted Family Support | | 52 | 52 | 0.0% | 2.3% |
| Unknown | 6 | 17 | 23 | 0.1% | 0.8% |
| MHEH | 243 | 11 | 254 | 5.2% | 0.5% |
| Social Care | 8 | 6 | 14 | 0.2% | 0.3% |
| Evesham Area Team | 69 | 5 | 74 | 1.5% | 0.2% |
| CAMHS | 2 | 1 | 3 | 0.0% | 0.0% |
| Redditch and Bromsgrove Team | 48 | | 48 | 1.0% | - |
| Nursery/School/Post 16 | 38 | | 38 | 0.8% | - |
| Pershore Area Team | 27 | | 27 | 0.6% | - |
| Bromsgrove Team | 21 | | 21 | 0.4% | - |
| Integrated Working | 18 | | 18 | 0.4% | - |
| Droitwich Area Team | 15 | | 15 | 0.3% | - |
| Homestart | 4 | | 4 | 0.1% | - |
| NHS | 1 | | 1 | 0.0% | - |
| **Total** | **4680** | **2253** | **6933** | | |

*Source: Worcestershire County Council, Children's Services*

Figure 97 shows prior to September 2016 there were a smaller number of categories of reasons for EHA completion, with behavioural issues being cited in 20.9% as well as issues relating to Mental, Emotional Health and Wellbeing at 20.6%. Post 2016, there has been a greater range of reasons given in EHAs. The most common being behavioural issues (16.2%), Mental, Emotional Health and Wellbeing (16.0%) and Relationship difficulties (14.2%).

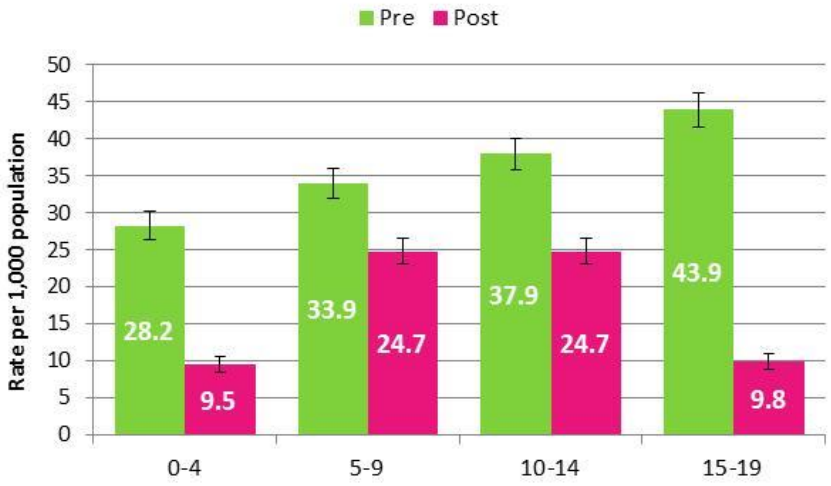
Figure 97: Reasons given in Early Help Assessments (Apr'15 to Mar'18)




*Source: Worcestershire County Council, Children's Services*

Pre 2016 the highest proportion of EHAs undertaken were for the 15-19 year old age group. Post 2016 the highest rates of EHAs undertaken by age group are in the 5-9 year old age group and 10-14 year old age group which were both at 24.7 per 1,000 population. There is a significant reduction undertaken for 15 to 19 year olds, however this may reflect that activity in relation to NEET prevention does not now require completion of an EHA unless a wider family assessment or early help plan is required.

Figure 98: Early Help Assessment Completion Rates by Age Group (Pre/Post)




*Source: Worcestershire County Council, Children's Services*

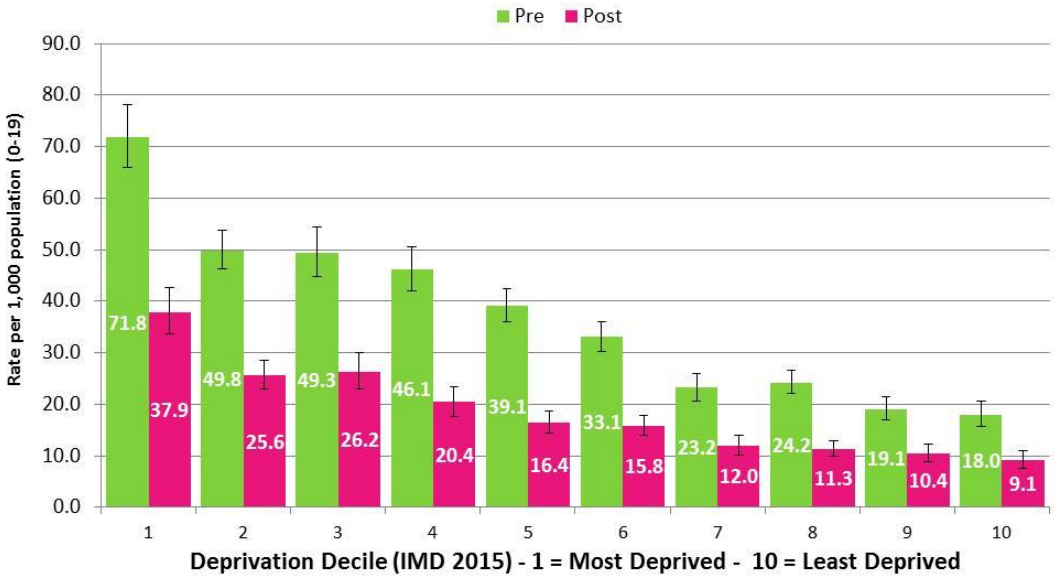
Figure 99 identifies a change by locality for EHA completions. Pre 2016 the highest rate of EHAs were undertaken in Wyre Forest at 44.8 per 1,000 population and Wychavon at 43.4 per 1,000 population. Post 2016 the highest rates of EHAs are from Worcester at 21.7 per 1,000 population followed by Wyre Forest at 19.6 per 1,000 population.

Figure 99: Rate of EHAs completed by District per 1,000 population aged 0-19 (Pre/Post)


*Source: WCC, Children's Services/Office for National Statistics Mid-year Population Estimates*

Figure 100 shows the rate of EHAs by deprivation decile per 1,000 population for children resident in Worcestershire. In both pre and post periods, there was a significantly higher rate of EHAs completed for those from the most deprived decile in comparison to the least deprived decile.

Figure 100: Early Help Assessment completion rate by Deprivation Decile per 1,000 population aged 0-19 years resident in Worcestershire (Pre/Post)




*Source: Worcestershire County Council, Children's Services/Bespoke Public Health Analysis*

### 20.10. Early Intervention Family Support (EIFS) and Wyre Forest and Hagley Project

The Early Intervention Family Support (EIFS) service is provided by WCC across the county except Wyre Forest and provides early intervention support for schools and CYP aged 7 to 13 years mainly at the Level 2 of need. EIFS provides additional support to schools to improve issues around low level emotional wellbeing and mental health, attendance that is impacted by issues at home and inclusion. Referrals to EIFS are from Primary, First and Middle schools only. The service works with Primary, Middle and Special Schools (including their nurseries) to provide support and guidance for children and their families when needs are first identified at an early stage. The EIFS team have workers based in different schools across the county, including special schools, to work directly with pupils and families. All workers receive management oversight through regular support and supervision.

EIFS offers additional advice, guidance and expertise for the school in addition to its own pastoral provision. Support for children and families can be used to:

- improve home to school links and strengthen relationships between families and schools to include promoting inclusion of children and reducing exclusions
- improve attendance where it is impacted by issues at home, such as housing issues, financial difficulties, family relationship breakdown, parental ill health etc

- improve attendance where there are issues around low level emotional well-being and mental health

The Wyre Forest and Hagley Project (WHP) provide early intervention family support at the Level 2 of need for CYP of primary school age in Wyre Forest District. The service is provided by the ContinU Trust. WHP Home School Link Workers help parents and carers to get the right kind of help, when they need it – for their child, for themselves or for the family as a whole. The aim is to help make things better at school and/or at home so the child can make the most of each school day. Families either approach the service directly for help (69%), or a request is made by the child's primary school for support (31%).

### 20.11. Targeted Family Support

The targeted family support service is predominantly delivered at Level 3 of the Levels of Need Guidance. All targeted family support is provided by WCC. Targeted Family Support (TFS) works in partnership with families who are experiencing complex issues that require a multi-agency approach and plan of intervention. Level 3 represents children with complex or escalating needs that can only be met by a coordinated multi-agency plan which sets out the outcomes to be achieved and the role of each partner agency and the family in meeting these objectives. TFS workers will with the consent of the family complete an Early Help Assessment and plan in partnership with children young people and their families. The type of support and intervention that a Family Support Worker can offer would be aligned to the child and their family's needs as identified in the early help assessment and is likely to involve other agencies who can also work with the family through the difficulties and help to create the changes needed.

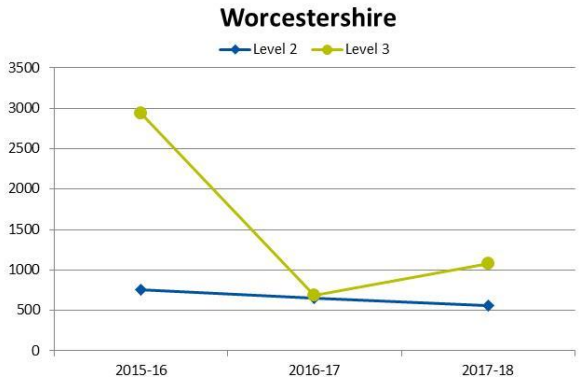
TFS teams are based in each district within the county and work in partnership with social care, district councils, health providers, police, schools, fire service, third sector organisations, as well as other organisations. TFS provides whole family interventions as part of the local Troubled Families programme. Since August 2018 all targeted support services are delivered by Worcestershire County Council.

TFS workers develop a consistent key working response in the family home or other appropriate setting. The service:

- Allocates a named worker who is responsible for delivering intensive family support.
- Undertakes an assessment with the whole family to create and design a plan which empowers the family to help themselves moving forward
- Deliver practical evidence-based interventions to meet the specific family needs
- Fulfils a co-ordinating role to complement and maximise the potential of existing services to support families who are in need of additional support
- Records all assessments and interventions on the Framework-i recording system
- Promotes and encourages multi agency support of the family and delivery of the plan
- Ensures an effective closure strategy with signposting and linkages made to more universal provision where possible

The number of closed early help cases completed by both EIFS and WHP (Level 2) and TFS (L3) provided from December 2016 to November 2018 are given in Figure 101. This indicates a slight decrease in Level 2 cases over the 3 years and an increase in Level 3 during the last year.

Figure 101: Closed early help cases for EIFS & WHP (L2) and Targeted Family Support (L3): Dec to Nov 2015 to 2018.

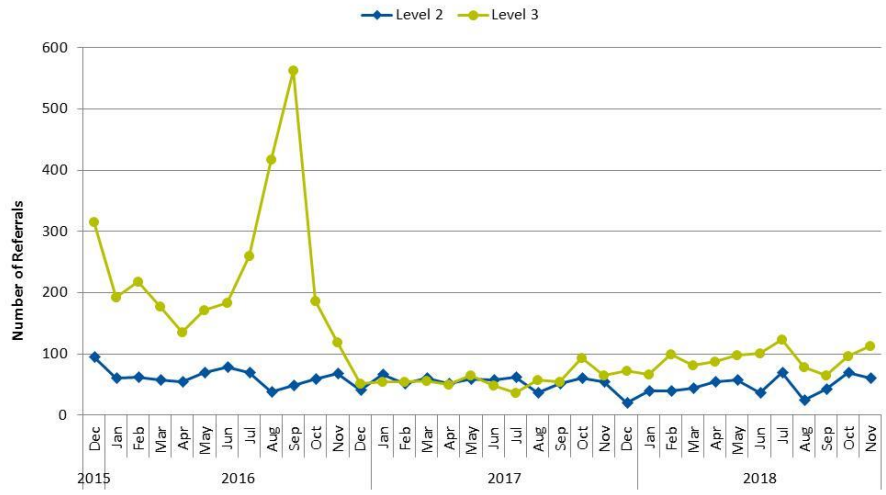



| Service Tier | 2015-16 | 2016-17 | 2017-18 | Total |
|---|---|---|---|---|
| Level 2 | 760 | 652 | 557 | 1969 |
| Level 3 | 2941 | 685 | 1083 | 4709 |
| Unknown | 20 | 5 | 0 | 25 |
| **Total** | **3721** | **1342** | **1640** | **6703** |

*Source: Worcestershire County Council, Children's Services*

Figure 102 shows closed cases by month. In the most recent year there has been almost 50 referrals per month to Level 2 targeted early help (EIFS and WHP) and almost 100 to Level 3 (TFS). The median number of weeks of provision was 18 weeks for Level 2 and 25 weeks for Level 3.

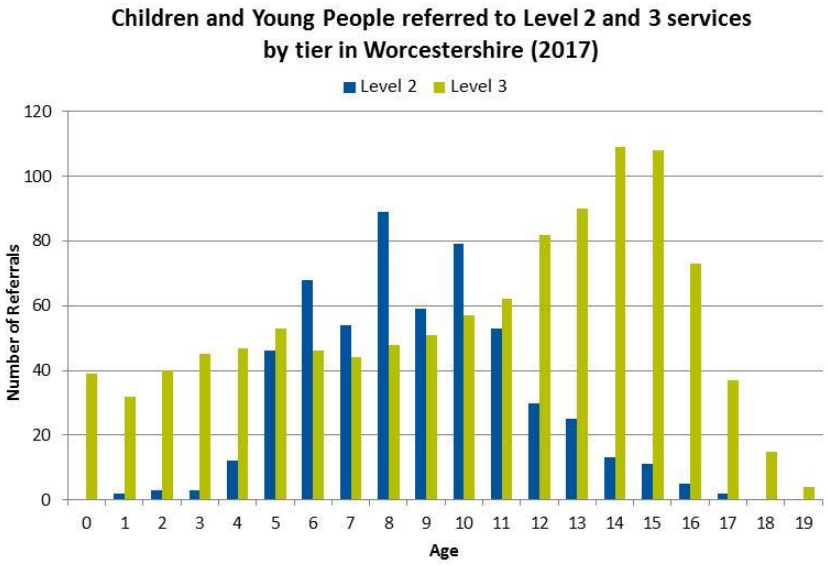
Figure 102: Closed early help cases for EIFS & WHP (L2) and Targeted Family Support (L3): Dec to Nov 2015 to 2018 by month




*Source: Worcestershire County Council, Children's Services*

Most cases were for children aged 6 to 11 for Level 2 support and adolescents for Level 3 support (Figure 103)

Figure 103: Closed early help cases for EIFS & WHP (L2) and Targeted Family Support (L3): Dec to Nov 2015 to 2018 by age




*Source: Worcestershire County Council, Children's Services*

The most Level 2 cases were completed in Wychavon over the 3 year period. The most Level 3 cases were completed in Wyre Forest.

In Worcestershire, the rate for level 2 early help cases over the 3 year period was 5.3 per 1,000 population. Rates were significantly higher in Malvern Hills at 7.8 per 1,000 population. Rates were significantly lower in Redditch at 2.4 per 1,000 population. This may reflect variation in need, access or provision.

The rate for level 3 early help cases was 12.8 per 1,000 population in Worcestershire. Rates were significantly higher in Worcester City (16.9 per 1,000 population) and Wyre Forest (20.5 per 1,000 population). Redditch, Malvern Hills and Bromsgrove all had a significantly lower rate of closed early help cases at level 3 support when compared to the Worcestershire average.

Figure 104: Closed early help cases for EIFS & WHP (L2) and Targeted Family Support (L3): Dec to Nov 2015 to 2018 by District, rate per 1,000 population aged 0-18 (2015-2018).


Source: Worcestershire County Council, Children's Services/ Bespoke Public Health Analysis

### 20.12. Emotional Health and Wellbeing and Mental Health Services

A universal online counselling and emotional well-being platform is available for all children and young people, called Kooth accessible through mobile, tablet and desktop and free at the point of use[119]. The service is free, anonymous and provided by qualified counsellors.

The Reach4Wellbeing Service, promotes and supports emotional wellbeing for children and young people aged 5-19 years old. The service offers short-term group support programmes for those experiencing emotional difficulties, specifically anxiety, low mood and self-harm. The group programmes are based on the evidence based programme Coping Cat. The Coping Cat program is a CBT manual-based and comprehensive treatment program for children from 7 to 13 years old with separation anxiety disorder, social anxiety disorder, generalized anxiety disorder, and/or related anxiety disorders[120].

The Consultation, Advice, Support and Training Service (CAST) provided by WHCT, works directly with professionals who are working with young people experiencing or at risk of experiencing mental health difficulties including; School Nurses, Teachers, GPs, Health Visitors, Social workers and Family support workers. The service can be specifically tailored to suit the professional seeking the service. The service is not a face to face intervention for Children and Young People[121].

The Children's and Adolescent Mental Health Service (CAMHS) is a multi-agency specialist team including psychiatrists, psychologists, psychotherapists, nurses and social workers providing county wide services. The service specialises in delivering assessment, support, therapeutic intervention and treatment for children and young people with both emerging and complex and enduring mental health difficulties. The Community Eating Disorder Service is a specialist service, providing treatment for children and young people aged 8 to 17 ½. The service works across the CAMHS Worcestershire bases, with an eating disorder lead clinician in Worcester, Redditch and Wyre Forest.

The Kooth on-line counselling, Reach4Wellbeing, CAST and Community Eating Disorder services have all developed since the 2015 EHNA as part of the CYP Mental Health and Emotional Wellbeing Transformation Plan and been operational since early 2017. The data presented below relates to the period 1st December 2015 to 31st July 2018 and includes analyses referred to as pre and post implementation of the new service elements.

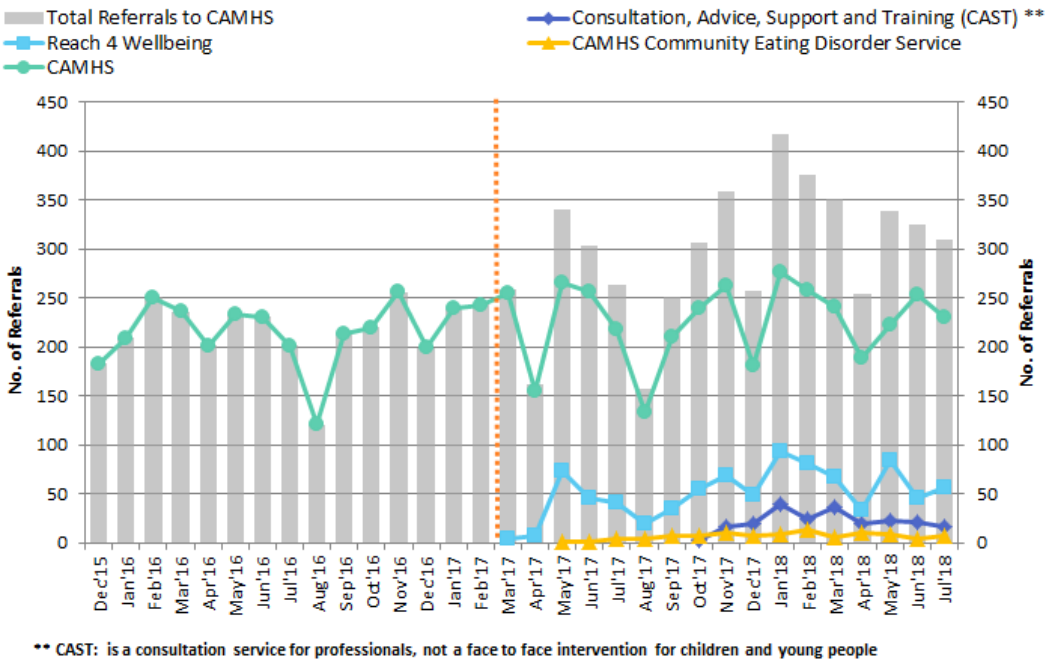
Between December 2015 and July 2018 there were a total of 8275 referrals to all Mental Health and Emotional Wellbeing Services overall. 7088 (85.7%) referrals were made to CAMHS, 862 (10.4%) to Reach 4 Wellbeing, and a further 105 (1.3%) referrals were made to Community Eating Disorder Service. 5.7% (n.470) referrals were for children known to be Looked After Children (LAC). A total of 220 (2.7%) requests for support for Consultation, Advice, Support and Training (CAST) were also made. Figure 105 highlights the total of all referrals and referrals for each service element by month.

[119] https://kooth.com/

[120] Kendall, P.C. and Hedtke, K.A. (2006) Cognitive-Behavioural Therapy for Anxious Children: Therapist Manual (Third Edition). Ardmore: Workbook Publishing

[121] NHS Worcestershire Health and Care NHS Trust (2018) CAST, [Online], Available from: https://www.hacw.nhs.uk/our-services/childrens-community-health-services/camhs/cast/ , Accessed: 21st December 2018.

Figure 105: Referrals to all Mental Health & Emotional Wellbeing Services in Worcestershire by month (Dec'15-Jul18)

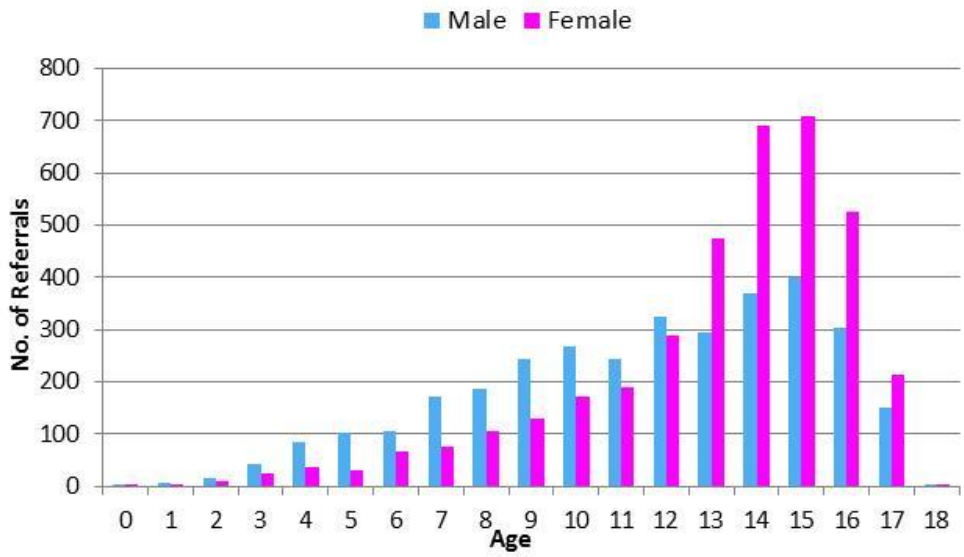



*Source: Worcestershire Health and Care Trust*

Although it is early days, Figure 105 suggests that referrals to CAMHs specialist service remains at similar levels as prior to the introduction of the new lower level of need early intervention services. This may reflect increasing need or previously unmet need. However it is unlikely that an impact will be seen so soon on levels of CAMHs referrals

Between December 2015 and July 2018 there were 7088 referrals to CAMHS, which accounted for the largest proportion of referrals to all services overall (85.7%). There are a slightly higher proportion of girls referred to CAMHS at 53.0% (n.3759) when compared with boys 47.0% (n.3328). There is a marked distribution in age, Figure 106 shows that boys are referred to CAMHS at an earlier age in comparison to girls. Around three quarters of boys are referred to CAMHS between the ages of 0-14 (74.1%) compared to girls (61.4%). Whereas more girls aged 15 to 18 (38.6%) are referred than boys (25.9%).

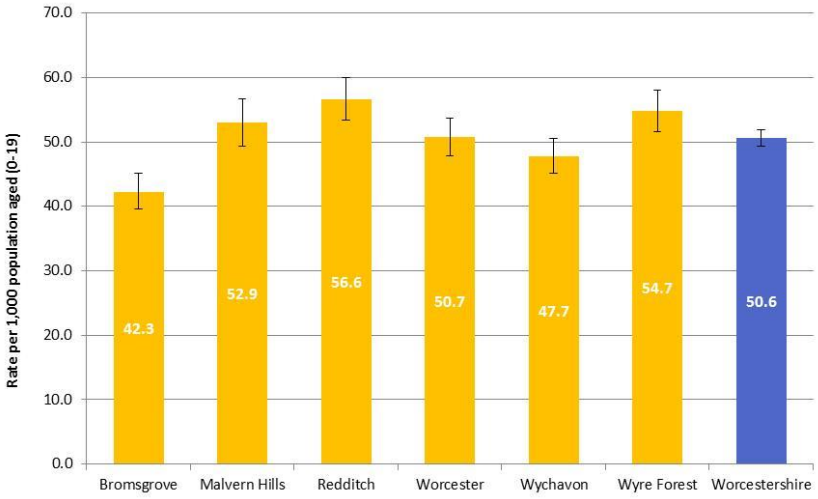
Figure 106: Referrals to CAMHS by age and gender Worcestershire (Dec'15-Jul'18)




*Source: Worcestershire Health and Care Trust*

There were 7088 referrals received by the CAMHS service for children resident in Worcestershire, 198 children were referred from neighbouring counties and there were a further 349 records where area of residence could not be identified. There was a similar rate of referrals to CAMHS across most district areas in Worcestershire when compared to the Worcestershire rate (50.6 per 1,000 population). Rates of referrals to CAMHS were significantly lower for Bromsgrove at 42.3 per 1,000 population aged 0-19 when compared to the Worcestershire rate.

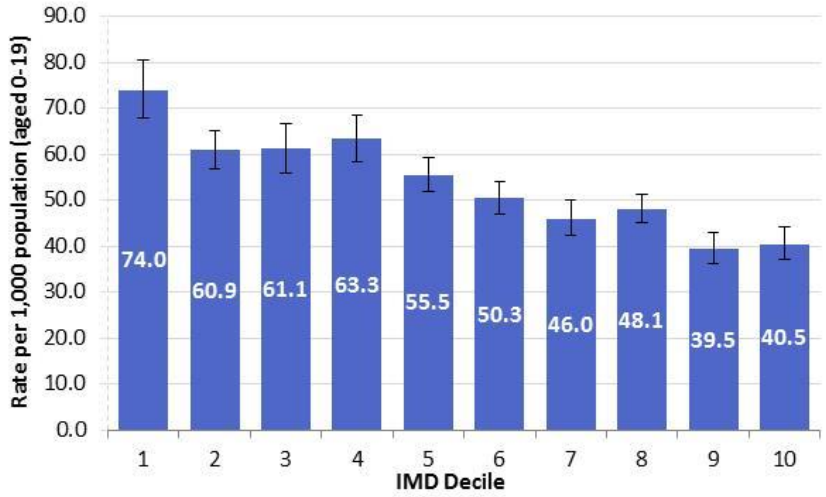
Figure 107: Rate of referrals to CAMHS by District per 1,000 population aged 0-18




*Source: Worcestershire Health and Care Trust/Bespoke Public Health Analysis*

There is a clear difference between the rate of referrals from children and young people in the most deprived (Decile 1) to the least deprived (Decile 10). There were a significantly higher rate of referrals for children and young people living in the most deprived areas (74.0 per 1,000 population aged 0-19 years) compared to the least deprived areas (40.5 per 1,000 population aged 0-19 years).

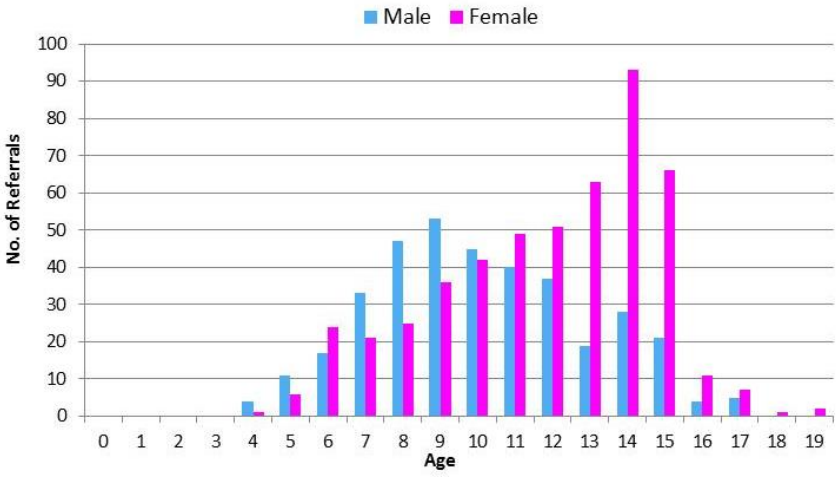
Figure 108: Rate of CAMHS Referrals by Deprivation Decile per 1,000 population aged 0-18 years resident in Worcestershire




*Source: Worcestershire Health and Care Trust/Bespoke Public Health Analysis*

There were 862 referrals to the Reach4Wellbeing service in Worcestershire between March 2017 and July 2018. More girls were referred to the service (n.498), compared to boys (n.364). There is a difference between the ages at which boys and girls are referred to Reach 4 Wellbeing. Figure 109 shows that boys are referred at a younger age in comparison to girls. Between the ages of 0-9, just under half of all boys are referred into the service (45.3%) compared to just over a fifth of girls (22.7%). At ages 10-19, 54.7% of boys were referred to the service, compared to 77.3% of girls.

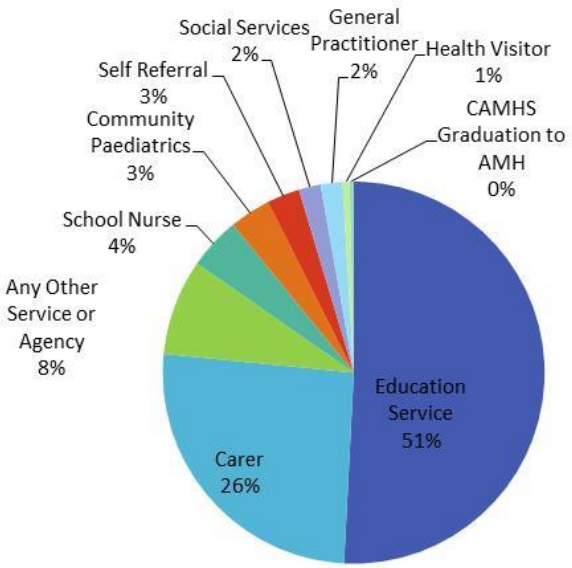
Figure 109: Referrals to Reach 4 Wellbeing by age and gender Worcestershire (Mar'17-Jul'18)




*Source: Worcestershire Health and Care Trust*

Approximately half of all referrals to Reach4Wellbeing were from schools/education (51%, n.438) with a further 26% (n.222) of referrals from Carers. A smaller proportion of referrals came from other agencies such as school nursing (4%, n.38), Community paediatrics (3%, n.30), Social Services (2%, n.16), GP (2%, n.16) and Health Visitor (1%, n.5). A small number of individuals self-referred (3%, n.24)

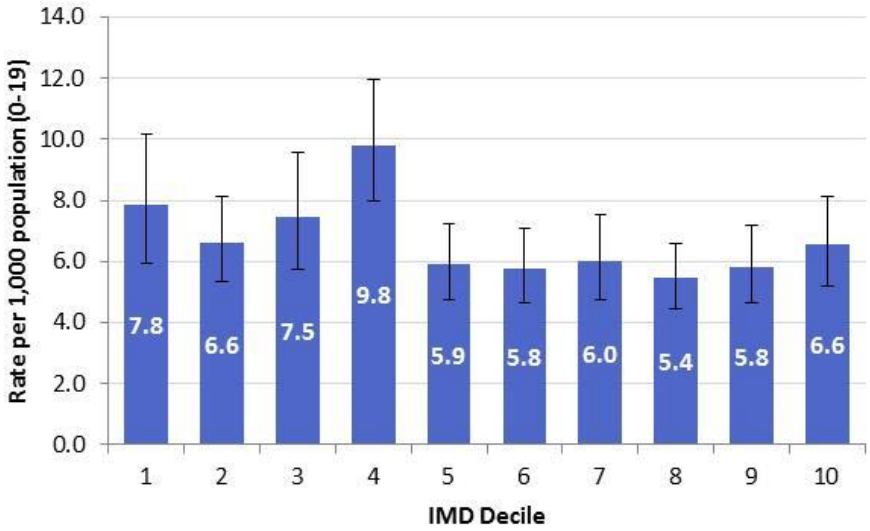
Figure 110: Referrals to Reach4Wellbeing by Referrer (Mar 17 to Jul 18)




*Source: Worcestershire Health and Care Trust*

Interestingly Figure 111 shows, there was no significant difference between referrals from the most deprived and least deprived deprivation decile as would be expected from prevalence data.

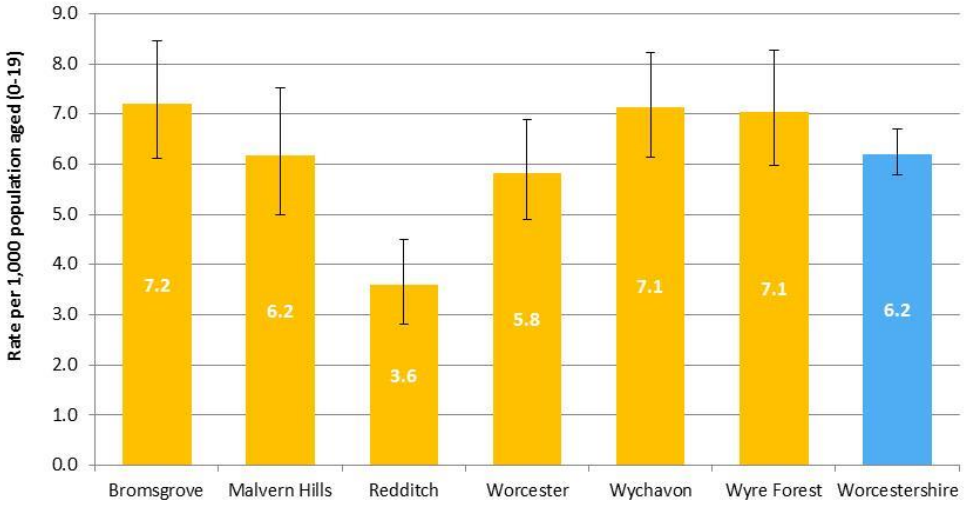
Figure 111: Reach4Wellbeing Referral rates by Deprivation Decile (Mar 17 to Jul 18)




*Source: Worcestershire Health and Care Trust/Bespoke Public Health Analysis*

There was a significantly lower rate of referrals from Redditch to the Reach4Wellbeing service. However the service works closely with and through schools and this may indicate that the service had not yet worked with some of the schools in Redditch by July 2018.

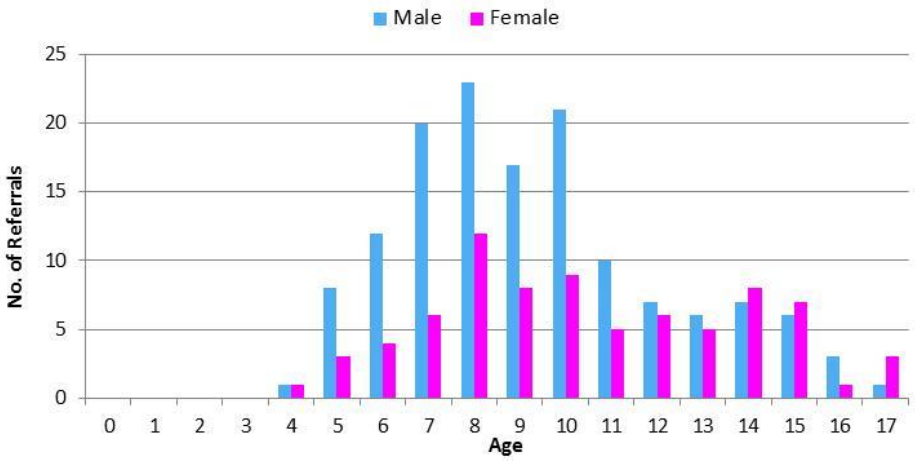
Figure 112: Referral rates to Reach4Wellbeing by District (Mar 17 to July 18)




*Source: Worcestershire Health and Care Trust/Bespoke Public Health Analysis*

There were a total of 220 referrals to the CAST service between October 2017 and July 2018. Around two-thirds of referrals to CAST were regarding boys (64.5%, n.142) compared to girls (35.5%, n.78). Similar to other mental health services for children and young people, activity for boys were at a younger age, in comparison to girls. At ages 15-19, a higher proportion of girls were referred to the service compared to boys.

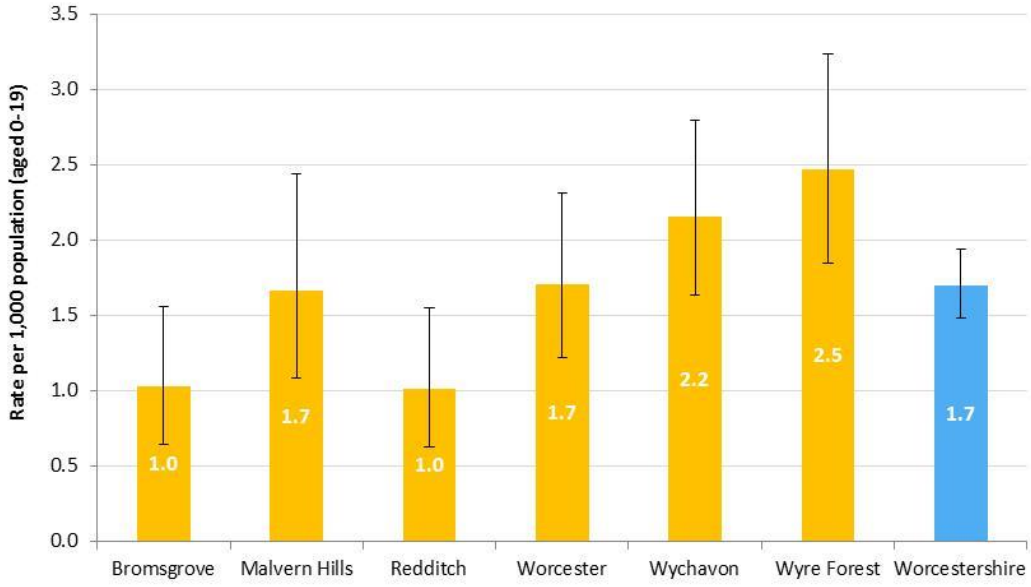
Figure 113: Referrals to CAST by age and gender Worcestershire (Oct 17-Jul 18)




*Source: Worcestershire Health and Care Trust*

The highest referrals were from Wyre Forest (2.5 per 1,000 population) and the lowest rate of referrals were from Redditch (1.0 per 1,000 population).

Figure 114: CAST Referral rates by District per 1,000 population (Oct 17 to Jul 18)




*Source: Worcestershire Health and Care Trust/Bespoke Public Health Analysis*

### 20.13. Speech, Language and Communication Services

Early language is recognised as a primary indicator of child wellbeing due to the link between language and other social, emotional and learning outcomes. Without support, children and young people with speech, language and communication need risk underachievement, mental health problems and poor life chances. There has been a steady increase in referrals to the speech and language therapy service in Worcestershire for children aged 0-14 (Figure 115).

Figure 115: Speech and Language Therapy Referrals for children aged 0-14

| Year | Referrals |
|---|---|
| 2010/11 | 1937 |
| 2011/12 | 2142 |
| 2012/13 | 2106 |
| 2013/14 | |
| 2014/15 | |
| 2015/16 | |
| 2016/17 | 2457 |
| 2017/18 | 2531 |

*Source: Worcestershire Health and Care Trust*

The highest numbers of referrals each year are for the 0-4 year age group and are approximately 70% per annum (Figure 116).

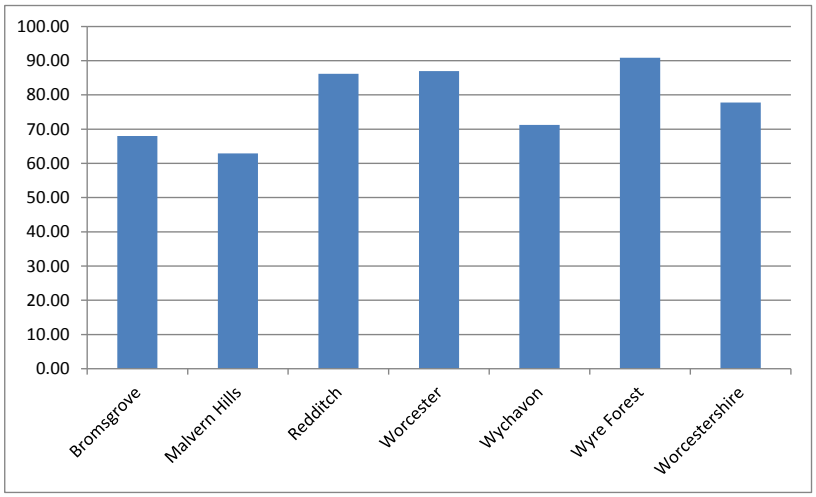
Figure 116: Speech and Language Therapy Referrals for children aged 0-14 (2016-2018)

| Age Group | 2016/17 | 2017/18 |
|---|---|---|
| 0 - 4 | 1685 | 1762 |
| 5 - 9 | 559 | 509 |
| 10 - 14 | 213 | 260 |
| Grand Total | 2457 | 2531 |

Source: Worcestershire Health and Care Trust

Figure 117 below shows that the highest referral rates for the last two years combined, are in Wyre Forest, Redditch and Worcester City.

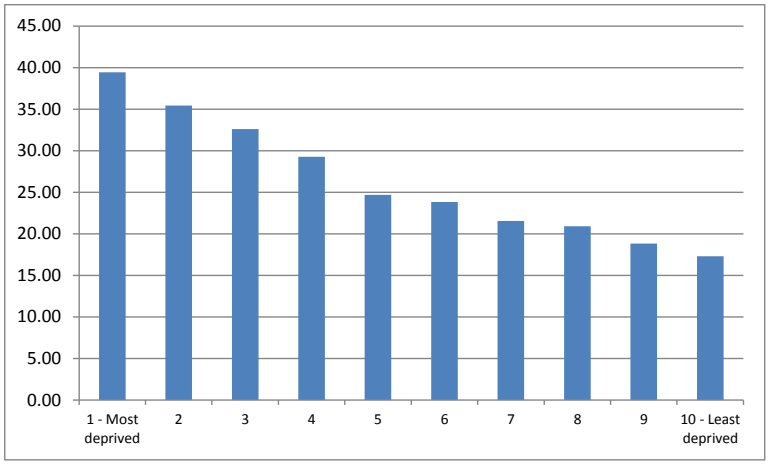
Figure 117: Referral Rate per thousand children aged 0-14 by council District of Residence in Worcestershire (2016/17 and 2017/18 combined)




*Source: Worcestershire Health and Care Trust/Bespoke Public Health Analysis*

Figure 118 below shows the speech and language therapy referral rates for the last two years combined split by national IMD decile. It clearly shows that the referral rate increases with deprivation.

Figure 118: Speech & Language Therapy referral rates by IMD Decile




*Source: Worcestershire Health and Care Trust/Bespoke Public Health Analysis*

### 20.14. Positive Activities

Positive Activities focus on providing young people with 'things to do and places to go'. The County Council has a duty, set out in statutory guidance, to secure a local offer that is sufficient to meet local needs and improve young people's well-being and personal and social development[122]. Positive Activities are those that are undertaken by young people aged 13-19 years (or up to 24 years for those with physical or learning disabilities) which have a positive impact on their personal development, health, social, educational and economic well-being. Provision usually takes place in the evenings, at weekends and during holiday periods. Good quality provision is structured, organised and supported by appropriately trained and supportive adults. Activities include sports, leisure and educational activities such as music, youth clubs, active participation, real empowerment, arts. These are used as tools to enable informal learning about healthy and safe lifestyles and to help build personal confidence and resilience.

Positive activities in Worcestershire are commissioned from a wide range of providers across 17 contracts of varying sizes. Positive activities providers are in regular contact with around 4000 different individual young people. Most providers have built on the Council funding provided for core work by developing additional projects and securing funding from other sources, thus broadening the scope of the local youth offer and encouraging and supporting the sustainability of the voluntary youth sector. In addition, they provide events that attract larger numbers and street based work with young people from whom it is not practicable to consistently collect personal information. The date analysed from activity returns showed between the years 2016 to 2018, that a total of 6,910 young people accessed commissioned Positive Activities across Worcestershire.

Table 29: Numbers of young people attending positive activities by Financial Year and District

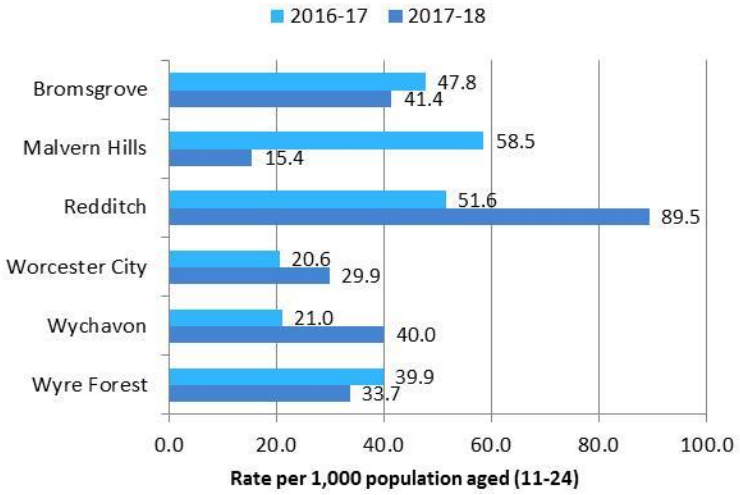
No of Individuals

| District | 2016-17 | 2017-18 | Total |
|---|---|---|---|
| Bromsgrove | 670 | 581 | 1251 |
| Malvern Hills | 629 | 166 | 795 |
| Redditch | 667 | 1157 | 1824 |
| Worcester City | 394 | 573 | 967 |
| Wychavon | 360 | 686 | 1046 |
| Wyre Forest | 557 | 470 | 1027 |
| **Total** | **3277** | **3633** | **6910** |

Attendance rates have been highest in Redditch, Malvern and Bromsgrove Districts.

[122] Worcestershire County Council (2014) Comments from Children and Young People Overview and Scrutiny Panel – Positive Activities for Young People, [Online], Available from: http://worcestershire.moderngov.co.uk/documents/s6509/item%207%20appendix%202%20positive%20activities.pdf Accessed: 28/11/2018

Figure 119: Positive Activities attendance rates by District (2016-2018)




*Source: WCC/Bespoke Public Health Analysis*

Between 2016-17 and 2017-18, just over half of individuals accessing Positive Activities were male (n.3636, 52.8%), over a third were female (n.2785, 40.3%) a further 479 individuals had an unknown gender. The highest proportion of individuals by age group were in the 13-19 year old age group and accounted for around two thirds of individuals attending positive activities (n.4284, 62.0%). The average number of attendances by age group varies. The average number of attendances at a positive activities session was 8. There was no significant difference by gender.

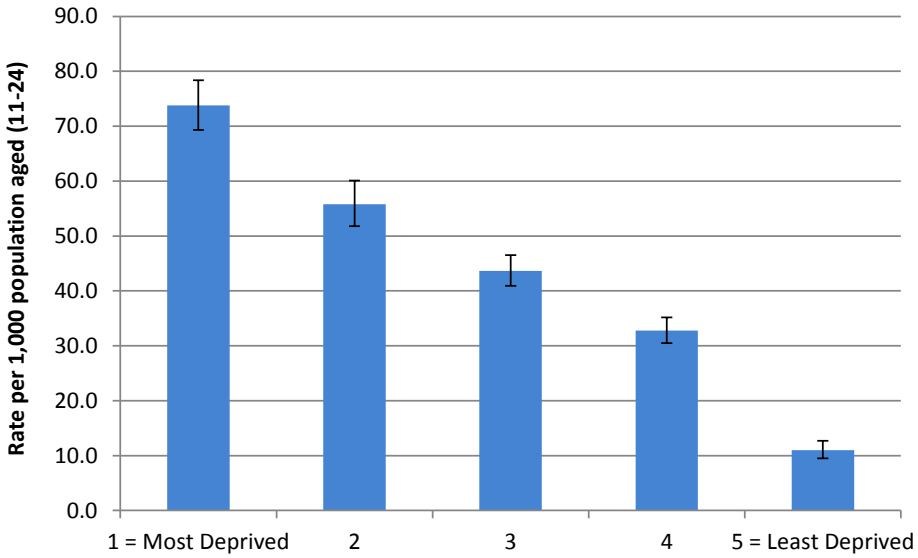
Table 30: Attendances and average number of attendances by age group (2016-17 to 2017-18)

| Age Group | No. of Individuals | Average no. of attendances |
|---|---|---|
| Under 11 | 102 | 3 |
| 11-12 | 1407 | 7 |
| 13-19 | 4284 | 8 |
| 20-24 | 175 | 11 |
| Over 24 | 5 | 6 |
| Over 25 | 15 | 6 |
| Unknown | 922 | 5 |
| **Total** | **6910** | **8** |

*Source: WCC/Bespoke Public Health Analysis*

There was a higher rate of young people attending positive activities from the most deprived deprivation quintile when compared to the least deprived quintile.

Figure 120: Attendances at Positive Activities by deprivation quintile (rate per 1,000 population aged 11-24)




Source: WCC/Bespoke Public Health Analysis

Positive Activities providers now use the nationally recognised Outcomes Star measurement tools to provide a new focus on outcomes and to enable more analysis of the difference being made for individual young people. This is still being embedded across all providers and for all activity however early indications suggest improvements were made for almost 300 young people where a pre and post outcome star was completed.

## 21. Conclusions

### 21.1. Need

The need for prevention and early intervention continues to be increasing. The numbers of births and the CYP population aged 0-19 years have increased and are projected to increase by a further 3.9% over the next 10 years. Births are increasing at a faster rate in more deprived localities likely to lead to a rise in mothers and babies with risks factors. Over the last decade demographic movement appears to have occurred resulting in an increase proportion of CYP resident in more deprived areas.

Applying national methodology indicates 41,779 (36%) of CYP could be potentially vulnerable in the county. Deducting the numbers of CYP known to be in receipt of statutory help and protection, leaves a further 36,430 (31.4%) potentially vulnerable CYP who could benefit from prevention and early intervention.

The numbers above include CYP with Special Educational Needs and Disabilities (SEND). 15.2% of all school pupils had an SEN need in 2018, higher than the national average. We have estimated that numbers of CYP with SEND are also likely to increase by 5% over the next 10-20 years.

Children in need of help and protection as assessed and supported through children's social care have increased over the last five years and at a faster rate than nationally. Rates of CIN, CLA and CP

are now above the England average and higher than many statistical neighbours. Over the last 5 years CIN have increased from around 3000 (3%) to 4000 (3.5%). Worcestershire has a higher percentage of CIN whose primary need is abuse or neglect (68%) than nationally (52%) where there is a very strong relationship with deprivation. Over the last decade numbers of CLA have increased from 500 to almost 800 and CP from 200 to 500.

The physical and mental health of the mother, during pregnancy, infancy and childhood is of fundamental importance to the future mental health of the child. Perinatal mental health problems can affect between 10 to 20% of women during pregnancy and the first year. It is estimated that 1800 to 3000 women in Worcestershire will suffer from perinatal mental health issues each year.

While local prevalence statistics have not identified an increase, there is a widely held view among professionals and academics that more and more children are experiencing mental health problems such as anxiety, depression and conduct disorders. It is estimated nationally that one in eight (12.8%) CYP have had a diagnosable mental health disorder. Using national prevalence, it is estimated in Worcestershire for children aged 5-16 there are likely to be:

- 2565 with Anxiety Disorders
- 1179 with ADHD
- 4558 with Conduct Disorders
- 613 with Depression
- 781 who self-harm

The disorder with greatest numbers is conduct disorder (5.8%) for which there is currently no defined pathway, assessment or service offer in Worcestershire (unless there is a coexisting mental health condition).

CYP can be negatively impacted by their home environment and parental characteristics. Last year Police reported cases of 5000 children being exposed to domestic abuse, however national data suggests there were likely to be over 19,000 victims of domestic abuse over the past 12 months in the county – although not all may involve CYP. There are an estimated 1157 adults with an alcohol dependency and 643 adults with an opiate dependency who live with children in Worcestershire. However it is estimated that 21% of adults regularly drink above recommended levels and 8.5% of adults had taken a drug last year. 70,000 adults are living with common mental ill-health at any time in Worcestershire, however it is not known how many of these will be parents or if their children are supported.

Research into adverse childhood experiences (ACEs) has furthered our understanding of the long-term impact of multiple risk factors within a child's home environment. Studies confirm a strong association between the number of ACEs in childhood with poor outcomes throughout life as well as increased risk of onward transfer of ACEs to the next generation. It is estimated there are around 34,670 (9%) adults who may have experienced 4 or more ACEs during their lifetime in Worcestershire.

As at August 2018, 3000 families (approx. 3%) were identified "eligible" under the national "Troubled Families" programme in Worcestershire. This number includes families who had met the programme

criteria and had received support; therefore the true number of eligible families is likely to be much higher than this.

### 21.2. Outcomes

Worcestershire continues to have a number of poorer outcomes for CYP than would be expected given the demographics of the county, particularly in the early years and across educational outcomes. Many outcomes for CYP have improved since the previous EHNA, however these improvements have not been as great or as fast as nationally and Worcestershire is statistically significantly worse in a number of areas. Inequalities in outcomes for disadvantaged or vulnerable CYP continue to persist.

Outcomes in pregnancy and birth appear to have worsened or remained static. Worcestershire has higher rates of maternal obesity which can cause complications in pregnancy and birth, higher rates of smoking in pregnancy, higher rates of premature births and low birth weight babies and lower rates of breastfeeding initiation than the national average. In particular all of these outcomes are poorest in more disadvantaged localities of the county.

Outcomes in the early years have improved a little overall but there remains a significant gap between groups of children. In particular school readiness, defined as achieving a good level of development in the Early Years Foundation Stage Profile (EYFSP), has improved but remains lower than England and is lowest in Redditch and Wyre Forest Districts. The inequality or gap in school readiness remains wider in Worcestershire than nationally, at 59% in deprived localities compared to 77% in least deprived and 49.2% for those eligible for free school meals compared to 56% for England.

There is increasing concern about the "word gap" and the numbers of children starting school with poor speech, language and communication skills with unacceptable differences in outcomes in different areas of the county. Worcestershire is significantly lower than England and statistical neighbours for the proportion of children achieving the expected levels on the communication and language area of the EYFSP. Inequalities of communication and language levels are evident as demonstrated by the significantly low percentage of Year 1 pupils with free school meal status achieving the expected level in the phonics screening check compared to all children and the national average.

Some educational outcomes are poorer than the rest of England and the inequality or gap for disadvantaged groups of children wider. Key stage 1 results for all pupils have increased and are now above England, but less than England for FSM children. The percentage of pupils achieving expected levels at Key stage 2 have increased but remain significantly below the national average and the gap has widened further for disadvantaged children. Latest Key stage 4 results for all pupils were above England; however results for disadvantaged and FSM children were significantly below England.

The data suggests that inequalities evident before children start school appear to widen during the school years in Worcestershire. Disadvantaged children from more deprived localities perform worse at all Key Stages than children from more affluent localities. The inequality or difference between the most and least deprived widens from EYFS (30% difference) in Reception to Key stage 4

(65% difference) at Year 11. The inequality or difference for those with "strong" Key stage 4 results is even wider and is more than double (121%).

The rate of decayed, missing or filled teeth in five year olds is highest amongst disadvantaged children particularly in Worcester City which is of concern. 22% of young children aged 4 to 5 are overweight or obese which rises to 34% by age 10 to 11 and this has not improved.

### 21.3. Conclusions from evidence of what works

To improve outcomes and reduce inequalities in Worcestershire, the recommendations from the Marmot review, that action is needed across the social gradient but focussed progressively in accordance with need (2010), remain valid for Worcestershire. To reduce inequalities in the early development of physical and emotional health, and cognitive, linguistic, and social skills we need increased investment and activity in early years, focused according to need. We need to ensure high quality maternity services, parenting programmes, childcare and early years education and that they are delivered to meet need proportionately across the social gradient. We must ensure that reducing social inequalities in pupils' educational outcomes becomes a sustained priority. Schools, families and communities need to work in partnership to reduce the inequalities in health, well-being and resilience of children and young people.

Since the previous EHNA, science and research has continued to identify the importance of the early years in shaping outcomes for CYP. In particular the importance of the bond and emotional relationship with the primary care giver, the impact of adversities and poor external environments and the importance of the quality of the home environment and early education. There is overwhelming evidence that early action to prevent or tackle problems as early as possible can both improve outcomes and result in longer term cost savings. It is then crucial to use universal services to provide prevention and identify need as early as possible and ensure these needs are addressed through evidence based effective early interventions.

The evidence review highlights the importance of tackling the wider determinants of poor outcomes for CYP and families such as housing, poverty, unemployment and education. All prevention and early intervention activity should take a holistic and whole family approach and seek to impact the wider root causes of a child's or families circumstances.

Research shows up to a fifth of pregnancies are unplanned and mothers rarely modify their lifestyle behaviours in preparation for pregnancy. More agencies/services across the system need to take action on pre-conception and pregnancy planning before and in between births as this can significantly impact on children's subsequent outcomes. Young parents can have poorer outcomes so although teenage pregnancy rates have reduced action is still required to prevent or support pregnancy amongst young people through; good quality sex and relationships education, youth friendly contraception, sexual health services and condom schemes, access to contraception in youth related non-health settings, targeted prevention for those young people at risk, early intervention and support for young parents including prevention of further unplanned pregnancies.

Early access to high quality antenatal care supports healthier pregnancies and births and prepares for parenthood. It is important that all women have early access to antenatal care for a full health and social risk assessment. The antenatal booking delivered by midwives and the antenatal health

promoting visit delivered by health visitors must be used to identify all risks and needs and to help individuals plan for optimum pregnancy and motherhood. By giving advice, support and interventions on for example smoking cessation, healthy weight, early identification of poor mental health or early help and support in relation to social risk factors. There remains good evidence regarding the effectiveness of Intensive Home Visiting starting early in the antenatal period to improve outcomes for disadvantaged young mothers.

One of the strongest predictors of good outcomes in early years is the mental health and wellbeing of the mother or caregiver. During pregnancy and in the first year after birth, up to 20% of mothers can be affected by a range of mental disorders. NICE guidance should be followed and audited regarding screening, identification and treatment of mental health, substance misuse and domestic violence in pregnancy and infancy.

To ensure a best start in early years a variety of prevention activity and early interventions is required. Evidence suggests the following programmes are likely to be effective for disadvantaged or targeted families when implemented or extended at scale:

- Pre-natal and post-natal care programmes such as Nurse Family Partnerships (Intensive Home Visiting).
- Pre-school programmes to improve school readiness, educational achievement, behaviours and mental health and wellbeing. Such programmes as the Perry Preschool Programme, Incredible Years Preschool, Home Instruction for Parents of Preschool Youngsters (HIPPY), PATHS Preschool, Let's Play in Tandem, Learning Together (PEEP)
- Follow-on programmes should supplement these interventions during primary and secondary school.

The Healthy Child Programme (HCP) is an evidence-based universal prevention and early intervention programme and aims to ensure that every child gets the good start they need to lay the foundations of a healthy life. The HCP comprises child health promotion, child health surveillance, screening, immunisations, child development reviews, prevention and early intervention to improve outcomes and reduce inequalities. The 0-5 element of the HCP should be led by health visiting and the 5-19 element by school nursing, providing place-based services and working in partnership with education and other providers. The HCP provides the opportunity to identify families that are in need of additional support and children who are at risk of poor outcomes through the universal development reviews and health assessments across the 0-19 age range. There have been two recent rapid reviews which have updated and enhanced the HCP since the previous EHNA. A recent EIF review has further endorsed the HCP as an effective delivery mechanism for identifying need and for midwives, health visitors and school nurses in providing some of the targeted indicated early interventions directly. Effective universal services (midwives, health visiting, school nursing) are central to the success of the HCP.

Language skills in early years are of concern in Worcestershire. Language skills are shaped and nurtured by the child's 'home learning environment' which includes the quality of the implicit and explicit learning support they receive from caregivers and from early education. In areas of higher deprivation, up to 50% of children may start school with delayed speech, language and communication skills. Intensive home visiting interventions support children's language development in the early years. There is also strong evidence regarding the importance of the

quality of childcare and early education settings in relation to language. A recent DfE policy paper recommends a "Chat, Play, Read" behaviour change model for use by parents, early year's settings, professionals, communities and through social marketing techniques.

Positive, warm parenting with firm boundaries and routines supports social and emotional development and reduces behavioural problems. There is evidence that a range of parenting programmes designed for families with children of a particular age can be effective. The evidence is strongest for programmes that target based on early signals of risk, such as child behaviour problems, insecure attachment, delayed development of speech and lack of maternal sensitivity. There are a number of programmes that have evaluated as effective. It is however vital that whatever parenting programmes are chosen they are commissioned, targeted and implemented carefully retaining fidelity to the model.

The parenting programmes with the highest evidence of effectiveness are: Family Nurse Partnership, Family Foundations and Incredible Years. Family Links Nurturing Programme however, is identified as having no effect, which has been in place in Worcestershire for some time. It is important that parenting programmes are delivered by practitioners with experience within a helping profession and are fully trained and supervised in relation to the programmes. Some families, however will still need a more specialist parenting programme, depending on the presenting need, such as Multisystemic Therapy (MST) or Family Functioning therapy and these should be delivered by specialists. It is important that the right parenting programme is provided for the presenting need(s) of the family.

The evidence review has identified that parental conflict can have a significant negative impact on children's mental health and long-term life-chances. Support to address this has been identified as a gap in Worcestershire. The evidence about which interventions and what works to improve parental relationships is still at an early stage however all practitioners should be supported to identify relationship problems early and refer families to the right interventions as they become available.

School readiness particularly in disadvantaged communities needs to be a priority for Worcestershire. Several factors have been shown to increase school readiness; Good maternal mental health, Parenting support programmes, Integrated health, education & social care services in early years, Learning activities, including speaking to your baby and reading with your child, High-quality early education and Enhancing physical activity for young children.

Professionals and agencies have identified that promoting emotional health & wellbeing and preventing poor mental health is high priority for Worcestershire. Health visitors and school nurses are well placed to play a key role in promoting emotional wellbeing and positive mental health of children, young people and their families. They have a specific contribution to make in identifying issues, using protective screening and providing effective support. The Five Ways to Wellbeing for use with children and young people provides a framework, as well as an organisational tool to effect cultural change.

Schools can contribute a large role in promoting good mental health & wellbeing through the physical, social and emotional environment of the school. Schools can implement programmes of social and emotional learning, such as SEAL, train their staff to increase knowledge and equip them to identify mental health difficulties, use tools to understand and plan a response to pupils'

emotional and wellbeing needs and provide targeted support and specialist provision for their pupils with particular needs. Schools should aim to provide "mentally friendly education" involving the implementation of whole-school Social and Emotional Learning programmes that are universal but can offer additional support for more vulnerable children, and whole-school approaches for addressing harmful behaviour, particularly bullying, substance abuse, and reducing exclusions.

Additional or targeted support for CYP identified with anxiety should receive group based problem solving approaches or group based cognitive interventions. Psychological therapy is recommended for depression. In respect of conduct disorders, estimated to affect the largest number of CYP and a gap identified in Worcestershire, a referral to CAMHS is recommended if there is a coexisting mental health problem; if not direct referral for a psychosocial intervention is required depending on the age group as follows:

- Parent training programmes —aged 3 to 11 years (Incredible Years).
- Foster carer or guardian training —aged between 3 and 11 years.
- Child focused programmes —aged between 9 and 14 years (CBT based).
- Multimodal interventions —aged between 11 and 17 years (MST).

The evidence review also shows that taking a “whole school approach” has a positive impact in relation to a range of other health and wellbeing outcomes too including: body mass index (BMI), physical activity, physical fitness, fruit and vegetable intake, tobacco use, and being bullied. There is also further evidence on the effectiveness of ensuring and providing high quality PHSE in schools.

There is renewed interest in ACEs in Worcestershire, whilst it is important to promote awareness, the strength of the ACE approach is in highlighting the linkages between a wide range of outcomes and risk factors; it should not be considered an isolated ‘project’, rather part of a whole system approach to help understand and improve health and wellbeing. ACEs are not predictive at an individual level either, and cannot tell us who might need early intervention or other support, an ACE score is not a substitute for careful assessment of current needs. The evidence around ACEs however, reinforces the case for investment in prevention and early intervention to prevent ACEs occurring; through promoting early attachment, supporting parents, building resilience in schools; and providing the right early evidence based interventions to tackle the specific adversities when identified. There is also good evidence to develop and implement adversity and trauma informed models of care and provision in our schools and services. A comprehensive prevention ‘system’ combining different types of support and interventions will be necessary to tackle child adversities. To tackle adversity and improve wellbeing a strengthening of resilience is required amongst CYP, families, schools and communities. Research on resilience emphasises the importance of a combined universal and targeted approach.

A third of CYP are overweight or obese and there is concern that there is not enough activity tackling child obesity in Worcestershire. The evidence identifies a multi-component and holistic approach that aims to improve diet and physical activity in multiple domains of children’s lives works best. The following have been identified as effective components; Decreasing pre-schoolers' screen time, Decreasing consumption of high fat/calorie drinks/foods, Increasing physical exercise, Increasing sleep, Modifying parental attitudes to feeding, Promoting authoritative parenting and Involving

whole families (parents and children) in interventions that promote both healthier diet and more exercise.

There are a range of NICE guidelines and quality statements that support the identification, assessment, prevention and treatment of obesity in children and young people that should be implemented by prevention and early intervention services.

The evidence tells us that treating different, specific health issues separately will not tackle the overall wellbeing of young people. Young people's mental and physical health is intertwined, as are their relationships with others. Young people think about their health holistically. They want an integrated, youth friendly approach. Effective youth services or prevention and early intervention for young people should be:

- Youth-led - offering both universal, open-access provision wherever possible, with targeted support for those considered more at-risk, disadvantaged or with higher need.
- Good quality provided by staff with appropriate training, linked to a wider network of support.
- Empower young people to progress and engage in employment, education and training, and to take an active role in their local communities
- Strengths-based and focus on developing the skills and attributes of young people, rather than attempting to 'fix a problem'.

There is robust evidence that integrated service models across health, social care and education can be very effective particularly for early years and by using a place-based approach. There are different degrees of integration however the key ingredients for success appear to be around use of integrated assessments, pathways, teams, workforce, information sharing and using Children's Centres as part of wider holistic family services.

A place-based approach to support and provision offers opportunities to impact on the whole community and aims to address issues that exist at the community level, such as poor housing, social isolation, poor or fragmented services, or duplication or gaps in service provision. A place-based, or community-centred, approach aims to develop local solutions that draw on all the assets and resources of an area. Integrating services and building capacity and resilience in communities is shown to be effective and potentially offers a significant return on investment. The four strands of the approach are:

- strengthening communities
- volunteer and peer roles
- collaborations and partnerships
- access to community resources.

Children's Centres should be utilised as an asset to build community capacity and develop place based approaches. Evaluations have shown that Children's Centres can promote better outcomes if they offer a number of named programmes for families, maintain or increase services and include

multi-agency working and resourcing. This should not be as a stand-alone offer but as part of wider community centred and capacity building development. There is an opportunity to further develop local centres into wider family centres and as part of holistic maternity and community hubs.

There are effective parenting interventions that improve child and parent outcomes for more vulnerable or troubled families. Programmes targeting children's behaviour such as Incredible Years or Triple P, which are used in Worcestershire, can be coordinated as part of the package of support offered to local Troubled Families. However for some families more specialist interventions are required which must be delivered by suitably qualified and supervised family key workers. These programmes include Multi-Systemic Therapy (MST) or Treatment Foster Care Oregon-UK (TFCO-UK) which provide more comprehensive – or 'wrap-around' – support for families where there are serious problems with a child's behaviour (such as criminal misconduct) or reported incidents of physical or emotional abuse. It is important that the family key workers who deliver these programmes are suitably qualified, trained and supervised within the recommendations of the MST or TFCO-UK models.

### 21.4. Current Services

Local maternity services undertake a full health and social care assessment at booking offering the first opportunity to identify potential risks or needs early. Specialist midwives support more vulnerable women. Referrals are made to specialist services as per NICE guidance; however opportunities to enhance the identification, assessment and provision of non-clinical early support for some women at Level 2 and 3 of need should be prioritised. One stop maternity hubs are being developed; this gives an opportunity for further integration and co-location with other CYP prevention and early intervention activities and agencies.

The Public Health Nursing Service comprises integrated teams of Healthy Visiting, Infant Feeding, Intensive Home Visiting and School Health. The service does not fully provide the national 4-5-6 evidence based recommended HCP model. The service offer does not include activity at the community or population level of need, the recommended universal health reviews for school age children, coordinate or lead activities for the high impact areas and does not proactively support whole school approaches or healthy settings activity. The service responds well to identified health needs of children but undertakes less activity in relation to wider wellbeing or social needs of CYP and families. Demand and activity data indicates the service has experienced increased activity at the universal partnership or Level 3/4 of need and less on prevention or early intervention (universal plus or Level 2) since the previous EHNA, particularly for school age children. The service works well at multiagency safeguarding or higher level of need however there is less activity working with or coordinating support with other agencies at the Level 2 of need.

The service provides comprehensive breastfeeding peer support which appears to have contributed to an increase in breastfeeding rates at 6 to 8 weeks. The service provides evidence based intensive home visiting however at present, this is only commissioned for a defined small number of mothers (up to 240 per 18 months, around 2-3% of population). High uptake of universal mandatory pre-school health reviews are achieved ensuring full coverage of prevention activity and enabling screening and identification of risks/needs of all children up to age 2.5 years. Beyond age 2.5 years, only children in receipt of UP and UPP interventions continue to receive support unless referred into the service by another agency.

Activity data for the school aged service element highlights 77% of capacity is at UPP, safeguarding activity, and this has been increasing, and 33% at UP, mainly drop ins (Time4Us). The service lacks capacity to provide universal school entry or adolescent health assessments thus there is no further universal opportunity to identify developing risks/needs for children beyond age 2.5 years. The service lacks capacity to support schools with wider prevention work in schools or in the community or to proactively support the health promoting and whole school approach agenda. The service is providing an increasing number of LAC annual Health Assessments delivered by specialist looked after nurses.

The Building Community Capacity Service is providing some of the "community" level of the HCP model, however not in coordination with the universal service who have access to all families. The community capacity service hosts and provides large numbers of activities and services from ten Children's Centres across the county. In addition the service promotes and facilitates access to activities and support in other children's centres and community assets across the county. It has not been possible to compare activities, uptake or footfall with previous EHNA findings as activity in or through Children's Centres are no longer recorded in a comparative way. However a wide and varied programme across the county appears to be in place.

There is a variety of parenting support being provided across the county. The antenatal 4 week Birth & Beyond programme is available in targeted locations, which has evaluated well. It is not clear what other antenatal education is available across the county. The universal Solihull Approach on-line parenting programmes are available for all age groups. These are being taken up on-line as well as being utilised through one to one or group sessions by the Parenting providers. The providers have developed and introduced a community parent volunteer peer support programme across the county to support parenting groups and parenting programme activity.

There are a variety of parenting programmes being run in different localities and different age groups but the offer is not consistent. There are parenting support activities less than 4 weeks duration and a similar number attending for longer manualised parenting programme activity. Most activity is for parents of younger children, in particular Triple P Discussion groups, Understanding your Child and PEEP. Most of the programmes used have an evidence base, however it is not clear if the programmes are delivered with fidelity to the model in terms of age, duration, length or content. Both Incredible Years and Triple P are offered which have been shown to be most effective. Family Links is provided which has been shown to have no evidence of effect. Around 1500 parents received a parenting intervention last year and almost three quarters were for parents with preschool children. This is positive but it is not possible to determine from the data available how parents were identified, attrition or completion rates or if the right parents received the right programmes.

It is not clear what parenting support is provided by which service. Some parenting support is provided proactively, some is provided to troubled families and families receiving targeted family support, and to some families in receipt of or previous receipt of social care (step down). Other services also provide parenting support, such as Intensive Home Visiting, Early Intervention Family Support Workers (EIFS), Targeted Family Support Key workers and social workers and therapists. A comprehensive menu of evidence based parenting support at the Universal, Targeted and Specialist level should be identified and agreed across the system.

There is a variety of provision that supports CYP emotional health and wellbeing, however this does not appear to be fully joined up resulting in potential duplication and/or gaps. Schools have an evidence based toolkit resource to guide them regarding both universal and targeted support but there is no capacity/support to assist schools to implement or embed this resource. Whole school approach activity and targeted support for CYP provided varies by school; school nursing triage and provide some lower level support to presenting CYP, EIFS provide some group work with CYP in schools and offer parenting support for CYP referrals aged 5 to 13 years, Reach4wellbeing provide group support for anxiety and low mood and CAMHS provides specialist support for CYP with a diagnosed mental illness. The identification, pathway and provision for conduct disorder in Worcestershire is not clear.

The "word gap" between young children and the language and communication outcomes in early years requires improvement in Worcestershire. Numbers of referrals to speech & language therapy have increased over the last 5 years. The Worcestershire SLCN pathway was developed in 2011 using the "Balanced System" and refreshed in 2015, however a number of changes particularly in early years have occurred since. Separate services and pathways are now commissioned and monitored by CCGs and WCC Education services rather than a population or systems approach. A review would be beneficial to incorporate the evidence identified in this EHNA and to ensure consistent and effective universal services with clear pathways to targeted and specialist support .

There is a variety of provision at the Level 2 of need for CYP aged 0-19 years but this appears not to be well integrated or coordinated. The EIFS service and Wyre Forest and Hagley Project (WHP) provide early intervention family support at the Level 2 of need for individual CYP aged 7 to 13 years and work closely with schools to support around attendance, inclusion and low level emotional wellbeing issues. The school nursing service and Reach4Wellbeing also provide support in schools that address some of these issues and both services and schools would benefit from a more joined up approach.

The current early help family support offer provided by WCC provides services for families who meet level two and three of the levels of need guidance and there is an identified need that requires a service from a Family Support Worker. The number of closed early help cases from these services December 2015 to November 2018 indicates a small decrease in Level 2 cases over the 3 years and an increase in Level 3 during the last year. The rate for Level 3 cases which require more intensive and prolonged support is more than double for Level 2 cases – this is counter intuitive and suggests early help is being accessed later than optimal. The rates vary by District, but it is not clear if this reflects need or capacity.

The current prevention and early intervention service offer or service model is not integrated in Worcestershire as has been demonstrated to work elsewhere. Some services work well together and have been working more closely but generally services remain fragmented resulting in missed opportunity to both identify early signs of need and to better coordinate the right support as early as possible. Health, care and education need to work better together ensuring services and programmes avoid duplication and provide a ‘seamless’ experience for children and families. This will enable gaps or capacity issues in provision to be better identified and addressed.

Since the previous EHNA there has been increased activity and focus on more complex and specialist provision of need and later intervention (Level 3/4), particularly in light of recent Ofsted and CQC inspections and the rise in children in need of statutory help and protection. During this period there appears to have been a reduction in prevention and universal (Level 1) activity and earlier intervention activity (universal plus or Level 2), although this is difficult to accurately quantify. Early intervention provided is generally delivered by single agencies or commissioned services resulting in a lack of coordination of lower level early help (Level 2) and the inability to tackle or support the family with wider social determinants of their health, wellbeing and attainment.

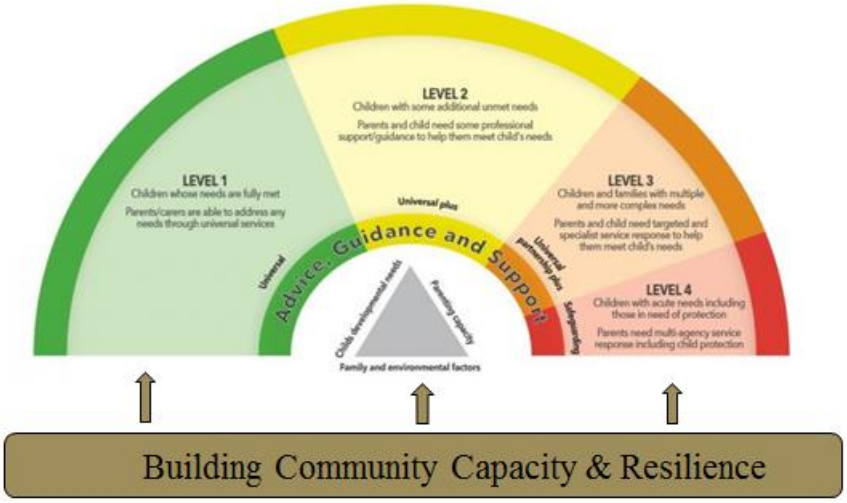
## 22. Recommendations

This refreshed EHNA presents comprehensive data, analysis, and evidence review about prevention, early intervention or early help in Worcestershire. It discusses current provision, outcomes, and national evidence about what works. This review has led to the following high level principles which should guide the strategic direction of early help in Worcestershire:

- Strong investment is needed in prevention and early intervention so as to prevent problems from happening and, if they do happen, making sure they are dealt with as soon as possible;
- Priority and capacity should be given to shift to an upstream proactive preventive approach across the system
- All CYP should receive a core, universal, service which is evidence based and will provide strong prevention support as well as identifying risk or problems
- Some CYP should receive more support, which is systematically targeted on those who need it most;
- All services should be shaped around the needs of the child and wider family, and underpinned by strong evidence of what works;
- Narrowing inequalities in outcome between different groups of children should be a focus of all work
- A community-centred approach to build community capacity and resilience should underpin the system

This can be shown diagrammatically below:

# Prevention & Early Intervention




In terms of early priorities for services, the following are recommended:

- Embed pregnancy prevention and pregnancy planning into existing services particularly those targeted at or working with disadvantaged women.
- Ensure a focus on healthy pregnancies and decreasing the smoking in pregnancy rate
- Enhance support in pregnancy and early infancy to parenting preparation, wider social support and early help
- Implement the full HCP 4-5-6 model including recommended universal reviews to enable screening and identification of CYP and families at risk or in need and development of the 12 high impact areas
- Integrate or align prevention and early intervention services as far as is practicable across health, education and care. This includes integration of services, assessments, pathways and workforce to ensure seamless provision to families.
- Further develop place-based and community-centred activities building on community assets and strengths, incorporating children's or family centres with variety of co-located provision
- Build community capacity and further develop peer support and volunteering to provide advice, information, support and activities around parenting and health and wellbeing in communities
- Develop a comprehensive menu of evidence based parenting support across the system at universal, targeted indicated, targeted selected and specialist.
- Support practitioners to identify parental conflict and relationship problems and to provide evidence based support.
- Support and develop health promoting and whole school/whole setting approaches to emotional health & wellbeing and physical health.

- Incorporate whole family assessments and support as a way of working, including the wider social determinants of need.
- Prioritise school readiness and communication and language development. Develop prevention and early interventions to improve home learning environments, early education and speech, language and communication.
- Review the emotional health & wellbeing pathway and service offer including the development of pathways for conduct disorder.
- Ensure improving diet and physical activity in all domains of children's lives is a priority.
- Review the Early Help Strategy and ensure early help at Level 2 of need is embedded and scaled up
- Ensure services and educational settings implement trauma informed approaches and resilience building.
- Ensure evidence based practice, interventions and programmes are adopted across the early help system including monitoring and evaluation.