Children Young People and Families

Needs Assessment

Spring 2018

Executive Summary

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Context:

The Children Young People and Families Needs Assessment provides an opportunity to review the current state of health and wider wellbeing of the children, young people and families in Gloucestershire, and through this make evidence informed recommendations to drive positive change.

HNA Structure

To gain as complete a picture as possible, we have looked at the needs of children, young people and families from a number of perspectives. The first section is a detailed analysis of population indicators that provide a snapshot of the health, wellbeing, lifestyle, education and development of our children young people and families. Where possible, we have considered indicators at a more granular level than Gloucestershire wide. This ensures that we do not overlook issues being experienced by subgroups of people, and don't "average out" serious inequalities that should be addressed. In some cases we have also highlighted issues on the basis of worsening trends, or issues where the absolute numbers, or the seriousness of the individual situation, flags the issue as a topic of concern that will need to be addressed to drive population health and wellbeing improvement.

In the second section, we take a more detailed look at what we know about specific groups of children, young people and families whom the evidence tells us are likely to need extra support. This includes children in poverty, those with SEN, disabilities or chronic health conditions, and those for whom we know things have already gone wrong such as children in care, those in contact with the criminal justice system, or those experiencing/at risk of CSE.

The third section considers the wider Gloucestershire environment that our children, young people and families are growing up in. We know from the work around wider determinants of health that such factors have a real impact on health and wellbeing. This section considers the natural environment, the built environment and the wider economic environment locally and its impact on children young people and families

In line with current work going on at the Health and Wellbeing Board level, the whole needs assessment takes an ACES informed perspective and there is a specific section looking at this. The evidence base around the enormous and wide ranging impact of Adverse Childhood Experiences (ACES) is growing exponentially, and the ACES paradigm has been adopted both nationally and internationally. We know that experiencing adversity in childhood can have a significant impact on an individual's future, but also that developing resilience can help mitigate such impacts. In this needs assessment we present a synopsis of current knowledge and evidence in this area, as well as a picture of what we know about local prevalence of adverse experiences and where and how we are using an ACES informed approach locally.

Making use of the evidence:

The challenge

In each section we have considered the evidence around what works to optimise positive outcomes in that area. While not every area has strong evidence available, overall there is a wealth of research findings. However, as with many overarching reviews of this size, breadth and complexity, the volume of competing information and level of detail brings its own problems; with so many competing options it can be hard to know what to prioritise and how to fit everything together. Again, the evidence does help us; we know that complex issues tend to require a co-ordinated system wide approach to be maximally effective. However, once again, the theory can be hard to breakdown into a tangible action plan; there is a leap that needs to be taken to translate the knowledge and theory reflected in the analysis into actual policy and practice, and from there into positive change.

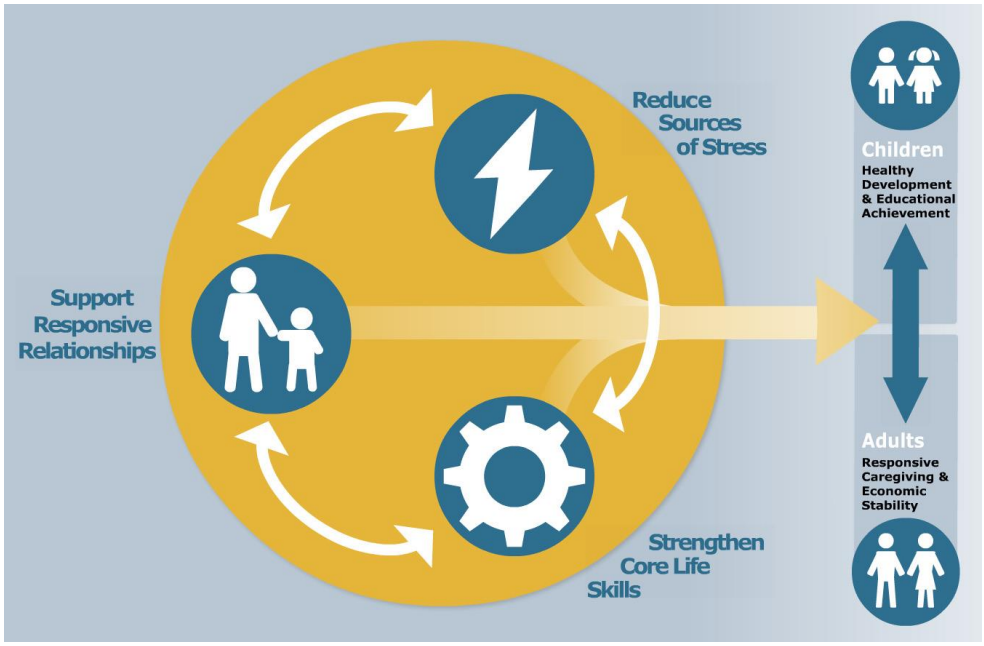
A proposed way forward:

The Centre on the Developing Child at Harvard University have recently published a theoretical model to specifically address this problem, and have developed a framework designed to help translate science and evidence into effective policy and practice. The model is derived from the evidence around ACES and around promoting resilience, and considers the child in the family and wider community context. The model proposes three principles to improve outcomes for children, young people, and families. These principles can be applied at every level from policy proposals to individual practice, and across multiple sectors from health, education, and children's services to transport and planning. The model can therefore be used as a simple, practical tool to drive unified, system wide change that improves outcomes for all children, young people and families.

The three principles are:

- Reduce sources of (toxic) stress
- Support Responsive Relationships
- Strengthen Core Life Skills

The model can be graphically represented as below:



Source: **Center on the Developing Child at Harvard University (2017). Three Principles to Improve Outcomes for Children and Families. https://developingchild.harvard.edu/resources/three-early-childhood-development-principles-improve-child-family-outcomes/**

Priorities identified in the Children, Young people and Families Needs Assessment

- Provide support to children, young people and families to ensure children grow up in safe, non-toxic environments
- Promote an ACE (Adverse Childhood Experience) informed approach to working with children and families
- Promote systems to improve children and young people mental health and wellbeing
- Reduce levels of emergency health service use by strengthening upstream processes and educating families around their use
- Ensure all CYP receive immunisations at the appropriate time and achieve immunisation rates that promote herd immunity (>95%)
- Promote good oral health in all children and focus on reducing the inequality in oral health outcomes
- Minimise the harmful use of drugs, alcohol and tobacco in children and young people
- Use a whole systems approach to encourage physical activity, healthy eating and reduce obesogenic environments

- Support families to ensure a child's first 1,001 days (conception to age 2)are the best they can be
- Support school, childcare settings and families to work together to provide high quality environments that promote, growth , learning and improve school readiness for ALL children particularly those in receipt of free school meals
- Support schools to develop approaches including restorative practice to reduce school exclusion rates
- Close the educational attainment gap between those on free school meals and those who are not
- Reduce levels of child poverty in Gloucestershire and buffer our children from its negative impacts
- Improve outcomes for children with Special Educational Needs and/or Disabilities
- Ensure that the most vulnerable are protected and work upstream with early help services to safely reduce the numbers of children in care
- Ensure maintain a focus on effectively reducing the exploitation risks to Children and Young People
- Work to reduce rates of youth offending to continue to drive down numbers of first time entrants and reoffending rates
- Increase the voice, participation and influence of children and young people

Emerging themes:

There is some evidence that we are becoming a county of two parts with some children having the best of times and others the worst of times. Some children are excelling, but we do not seem to be supporting enough people who are born into early adversity to break free of the cycle.

We appear to be letting the most vulnerable children down. There is a negative spiral emerging for some children – they experience early adversity, are not supported to develop resilience, adopt health harming behaviours and attain a poor level of educational achievement. Overall they experience a reduced quality, and indeed length, of life. For Gloucestershire as a whole, the economic impact of this is large both in direct financial costs to the county and in lost productivity.

However, at the same time, many children, young people and families are thriving and are able to take advantage of the good things on offer in Gloucestershire. However, the wider Gloucestershire environment may not be configured to capitalise on this. Gloucestershire does not have the world class higher education opportunities other areas have and, as a result young people leave to find these opportunities. There is no clear alternative offering to either retain or entice young people

into the area. Entry level housing affordability is worse than that seen nationally making settling in the county difficult. Access to quality jobs in some areas is also lacking. In combination this leads to a forced net migration of young people away from the county. When combined with the growing number of older people in the population this presents a serious issue for the county as a whole

Recommendations for Action:

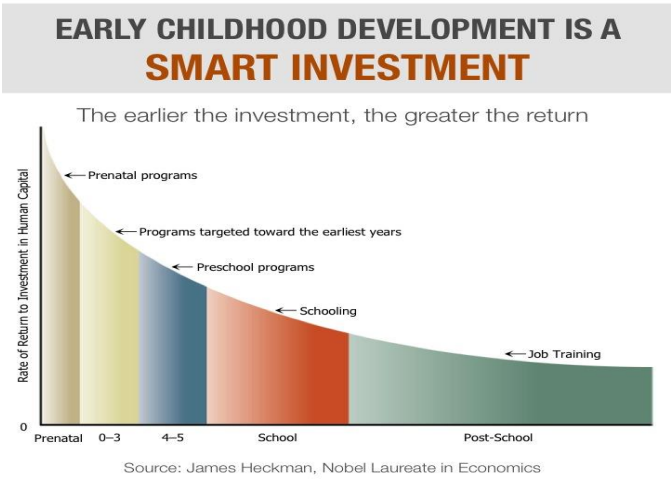
1. **Adopt the Harvard three principles to improve outcomes for children** – This model is simple, easy to apply and can be rolled out across the whole local authority (cf Leeds example of being a "Child Friendly City". Success of strategy attributed to broad adoption of simple to understand principles that people could buy into and apply).

2. **Embed prevention and early intervention principles into practice** – It is important to ensure this becomes practice not simply rhetoric. The economic argument for early intervention is compelling (Heckman Curve[1]), and the evidence for individual intervention efficacy all support the benefits of early intervention. For children and young people this means working as early as preconception .

3. **Prioritise identifying and supporting the most vulnerable early on** – There are children who are currently suffering real harm and meeting their needs must be a priority. The increasing numbers of children entering care is unsustainable and by looking at the prevalence of ACES in a child's experience we can potentially identify the cohort of children on the edge of care who need timely intervention

4. **In combination with the targeted approach outlined above strengthen the universal offer** to all children, young people and families to ensure whole population shifts in favour of reduced stressors and increased skills and relationship effectiveness. (Rose Hypothesis[2]). Local communities can play an large role in this

[1] https://heckmanequation.org/resource/the-heckman-curve/



[2] Rose sought to change the paradigm of risk factor modification by treating the whole population rather than high-risk individuals exclusively. According to Rose , "a large number of people at small risk may give rise to more cases than a small number of people at high risk".

5. **Empower schools and childcare settings to be the place based setting at the centre of interventions.** The evidence supports the critical role schools and good early years childcare can have in improving outcomes for children. The impact goes beyond the provision of education and life skills and extends into being a source of supportive relationships and a location that can reduce life stressors. It should be noted that currently many schools lack both the capacity and resources to fulfil this role and would require support to do so.

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Methodology

Methodology

The traditional model of epidemiological, corporate and comparative healthcare needs assessment has been developed by Stevens and Rafferty[3]. This health needs assessment draws on all three approaches and broadly follows their best practice model.

Epidemiological need looks at the severity and size of the health problem. Corporate need looks at the perceptions of the service providers, commissioners and users while comparative need looks at the data in comparison to other localities/sub groups and national targets[4].

Epidemiological approach:

This section gathered existing data from a range of sources that provided information on the prevalence and distribution of factors pertinent to children, young people and families locally. We looked both at the prevalence of risk and protective factors for health and wellbeing, specific outcomes for children locally as well as distribution of wider social determinants of health for this group.

In addition, current services were identified, and mapped against the areas they serve.

Comparative approach:

This component involved analysis of available data and comparing performance against relevant benchmarks. Benchmarks included national averages as well as within locality comparators to identify differences between specific subgroups where possible. Where possible, the findings were compared against expressed need (demand).

A further comparison was made by considering the current situation against current best practice as identified through evidence reviews. The evidence reviews looked at what public health interventions are supported by evidence of effectiveness, considered what national guidelines and expert bodies recommend. In some cases we were also able to consider what interventions have been shown to have a positive economic impact.

Corporate approach:

Due to time constraints this section mainly relied on expert interviews and discussions and on qualitative review data gathered over the last 12 to 18 months for other projects. Thus it is not comprehensive but still provides useful information and perspectives to add to the

[3] Stevens A. Rafferty J. Health Care Needs Assessment: The Epidemiologically Based Needs Assessment Reviews, Vol. 1. Oxford: Radcliffe Medical Press

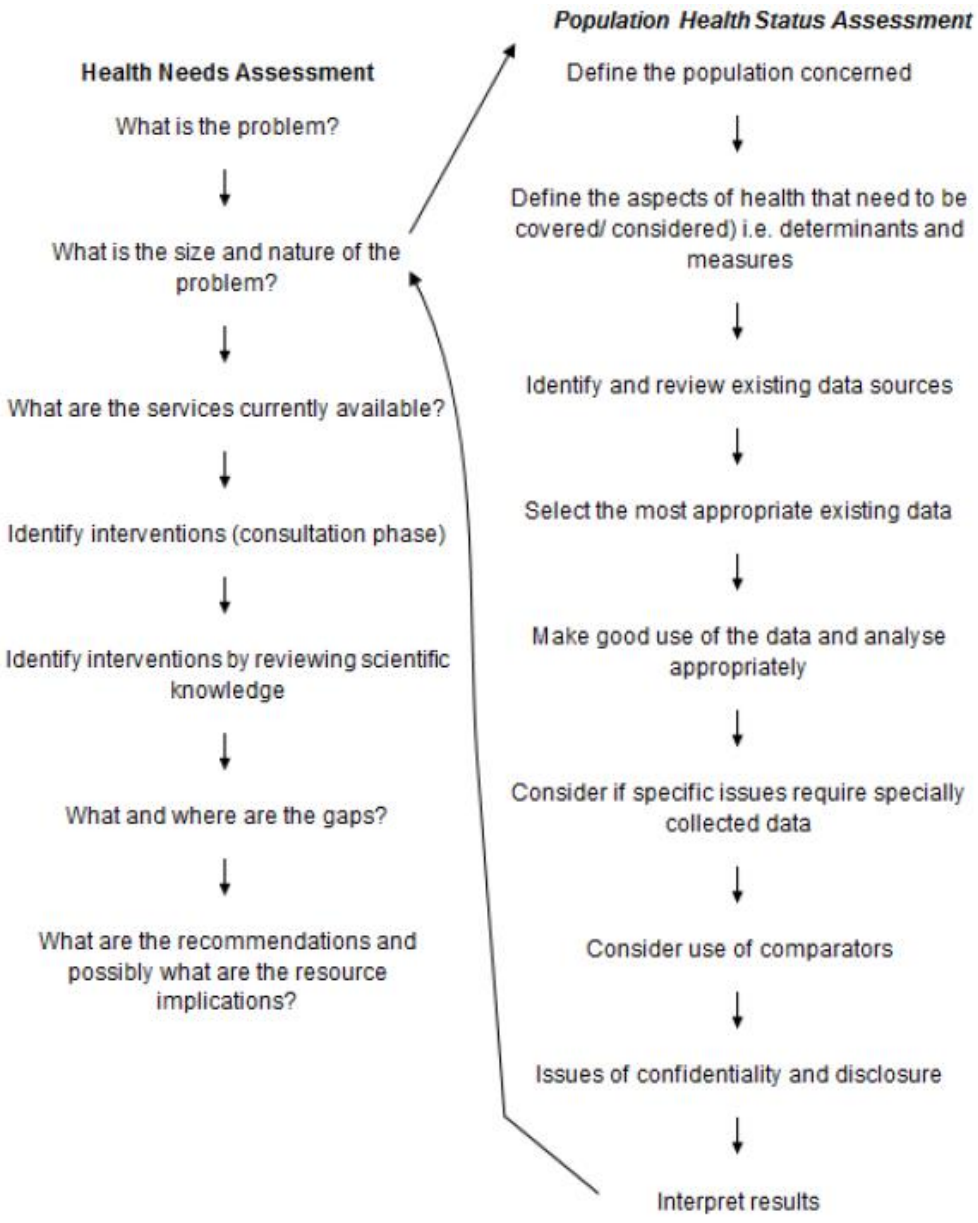
[4] Hooper J, Longworth P. Health needs assessment workbook. Health Development Agency. January 2002

other data gathered and ensure a more rounded picture is formed that includes service users, providers and the wider population.

Following review and analysis of all data gathered, strengths and weaknesses in each area were identified and recommendations were made based on the needs assessment's findings.

The figure below gives a visual overview of the process used to drive the production of this mental health and wellbeing needs assessment.

Flow chart to summarise the process steps in carrying out the Children, Families and Young people Needs Assessment for Gloucestershire



Limitations of the data

The health and wellbeing of children, young people and families is a broad and complex area and the data are often incomplete and variable in quality and timeliness. This is in part due to the complexity of the service provision for children young people and families and, in some cases also because of confidentiality and data sharing arrangements. We have attempted to bring together multiple sources of data, with valuable local data helping to create a more comprehensive picture of what life is like for children, young people and families in Gloucestershire. However, as identified throughout the document, the data available for analysis is frequently imperfect.

Demographics

Demographics

General population

Knowing both the population size and demography of an area, and understanding how it is changing, are both important factors for any organisation operating in that area. This is particularly the case for those delivering services to the population both now and into the future. You can find further information and links in the Population theme of Inform Gloucestershire.[5]

Overview:

Situated in the South West of England, Gloucestershire has one upper tier and six lower tier councils, with an estimated population of 623,100 people. The main urban centres are Gloucester and Cheltenham, where 39% of the population live.

The district of Gloucester has the largest population in the county and the Forest of Dean the smallest. From 2015 to 2016, Tewkesbury had the fastest rate of growth in the county (2.0%) whilst Cotswold, Cheltenham and Stroud had the lowest rates (0.7%, 0.6% and 0.6% respectively). Tewkesbury's and Cheltenham's growth rates were both higher than their rates for 2014/15, whilst Stroud's growth had slowed compared with 2014/15; the Forest of Dean, Cotswold and Gloucester all had similar rates of growth to those in 2014/15.

Table 1: Gloucestershire and Districts Mid-Year Population Estimates, 2016

	Population 2016	Population 2015	Change 2015 to 2016	% Change 2015 to 2016	% Change 2014 to 2015
Gloucestershire	**623,129**	**617,162**	**5,967**	**1.0%**	**1.0%**
Cheltenham	117,530	116,781	749	0.6%	0.2%
Cotswold	85,756	85,162	594	0.7%	0.6%
Forest of Dean	85,385	84,544	841	1.0%	1.0%
Gloucester	128,488	127,158	1,330	1.0%	1.2%
Stroud	117,381	116,627	754	0.6%	1.3%
Tewkesbury	88,589	86,890	1,699	2.0%	1.3%
South West	5,515,953	5,471,180	44,773	**0.8%**	**0.9%**
England and Wales	58,381,217	57,885,413	495,804	**0.9%**	**0.8%**

[5] https://inform.gloucestershire.gov.uk

Age Structure:

The working age population (aged 20-64) made up 56.6% of the population in Gloucestershire in 2016. This was slightly higher than the figure for the South West, but lower than that for England and Wales. The proportion of people aged 65 or over (20.8%) was lower than that for the South West but higher than that for England and Wales. The proportion of children and young people aged 0-19 (22.6%) was slightly higher than that for the South West but lower than that for England and Wales.

Table 2: Age structure of the Gloucestershire population, Mid-2016

	Number of people 2016	% of population 2016		
		Gloucestershire %	South West %	England and Wales %
0-19	140,666	22.6	22.2	23.7
20-64	352,840	56.6	56.2	58.3
65 or over	129,623	20.8	21.6	18.0

Table 3 shows that from 2015 to 2016, population growth in Gloucestershire was fastest in the 65+ age group, which increased by 2.2%; this was faster than the rates for this age group in the South West and England and Wales (1.9% and 1.8% respectively).

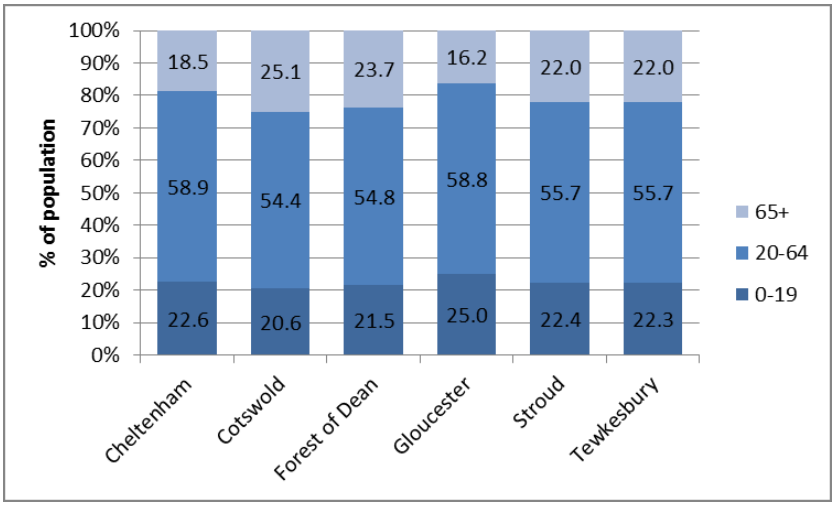
The rate of growth in the children and young people (0-19) population in Gloucestershire (1.1%) was also higher than the rates for the South West and England and Wales (0.6% and 0.7% respectively) whilst the growth in the working age (20-64) population of 0.5% was comparable with that for the South West and England and Wales.

Table 3: Population changes for 2015/2016 with regional and national comparators

	% change in population 2015-2016		
	Gloucestershire %	South West %	England and Wales %
0-19	1.1	0.6	0.7
20-64	0.5	0.5	0.6
65 or over	2.2	1.9	1.8

The age structure of the population in the six Gloucestershire districts in 2016 is shown in Figure 1 below:

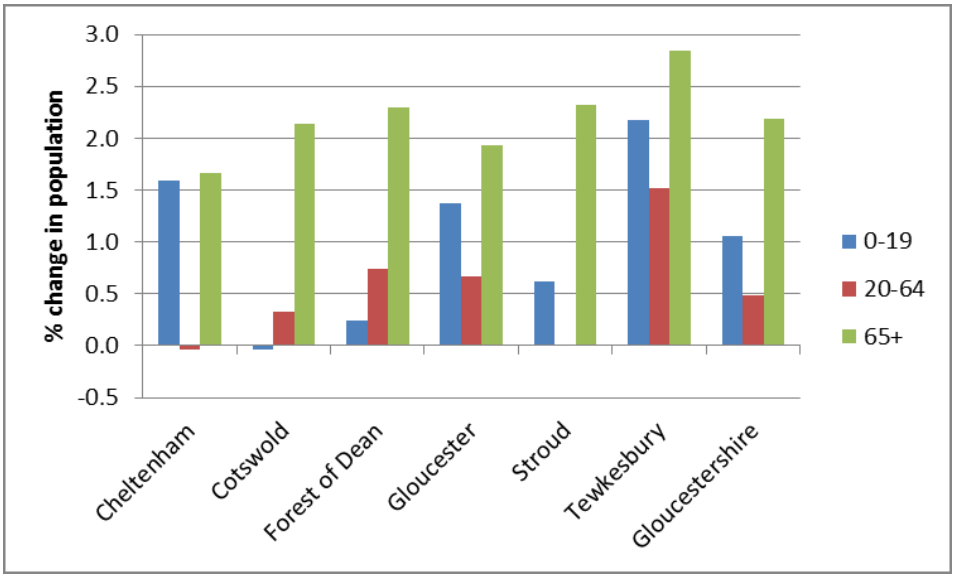
Figure 1: Age structure in the Gloucestershire Districts Mid-2016



- Gloucester had the highest proportion of 0-19 year olds (25.0%) and Cotswold the lowest proportion (20.6%).
- Cheltenham and Gloucester had the highest proportion of 20-64 year olds (58.9% and 58.8% respectively) and Forest of Dean and Cotswold the lowest (54.8% and 54.4% respectively).
- Cotswold has the highest proportion of people aged 65 or over (25.1%) and Cheltenham and Gloucester the lowest (18.5% and 16.2% respectively).

In terms of population growth Tewkesbury , Cheltenham and Gloucester saw the highest growth in children aged 0-19. Cotswold saw a decline in its population of 0-19 tear olds. Population growth rates by age band are illustrated in figure 2 below. The older population (65+) is the fastest growing age band in all regions.

Figure 2: Population change in the Gloucestershire Districts by broad age group, 2015 to 2016



Projections

Assuming current population trends continue, ONS projections suggest that the population in Gloucestershire will rise by 46,300 between 2014 and 2024, rising from 611,300 to 657,600. This increase of 7.6% of the 2014 population is equivalent to an average annual increase of 0.8% per annum. Between 2024 and 2039, the population is projected to rise to 714,000, an increase of 8.6% of the 2024 population. Over the full 25 year period of the ONS projections, the Gloucestershire population is projected to increase by 16.8%, with an annual average growth rate of 0.7%. These projections are slightly higher than those for England and Wales. The same projections suggest that 8.1% of the growth during the 25 year period will be accounted for by natural growth (births minus deaths) and 72.4% by internal migration (the net number of people moving into the county from within the UK). International migration is projected to contribute to the remaining 19.5% of growth.

Within the county, Tewkesbury and Gloucester are projected to have the largest percentage increases in population over the next 25 years (24.5% and 19.9% respectively) whilst the Forest of Dean is projected to have the smallest increase (10.9%).

Projected population changes in Gloucestershire by district 2014 to 2039

	Number of people[2]			Projected population growth (%)	
	2014	2024	2039	2014 to 2024	2024 to 2039
Gloucestershire	**611,300**	**657,600**	**714,000**	**7.6**	**8.6**
Cheltenham	116,500	123,800	133,800	6.3	8.1
Cotswold	84,600	89,800	96,400	6.1	7.3
Forest of Dean	83,700	87,600	92,800	4.7	5.9
Gloucester	125,600	137,200	150,600	9.2	9.8
Stroud	115,100	123,200	133,600	7.0	8.4
Tewkesbury	85,800	96,000	106,800	11.9	11.3
England & Wales				**7.3**	**8.1**

Projected changes in age structure

The dominating feature of the projections is the sharp increase in population in the age group 65 or over, which is projected to increase from 123,800 in 2014 to 206,300 in 2039 (an increase of 66.6%). This increase is sharper than the national trend for England and Wales and means that by 2039 the proportion of people in Gloucestershire who are aged 65 or over will have risen from 20.3% of the population to 28.9%. The population of children and young people (those aged 0-19) is projected to rise by 11.0% over the twenty-five year period which is in line with the trend for England and Wales. By comparison, the working age population (those aged 20-64) is projected to rise by only 1.4% over the same period. This increase is lower than the national trend for this group and means that by 2039 the working population in Gloucestershire will have fallen from 57.1% of the population to 49.6% of the population.

Projected population change by age group, 2014 to 2039

	Number of people in Gloucestershire			% increase 2014-2024		% increase 2024 to 2039	
	2014	2024	2039	Gloucestershire	England & Wales	Gloucestershire	England & Wales
All Ages	611,300	657,600	714,000	7.6	7.3	8.6	8.1
0-19	138,200	148,200	153,400	7.2	7.4	3.5	2.6
20-64	349,300	355,700	354,300	1.8	3.3	-0.4	2.1
65+	123,800	153,800	206,300	24.2	20.2	34.1	31.7

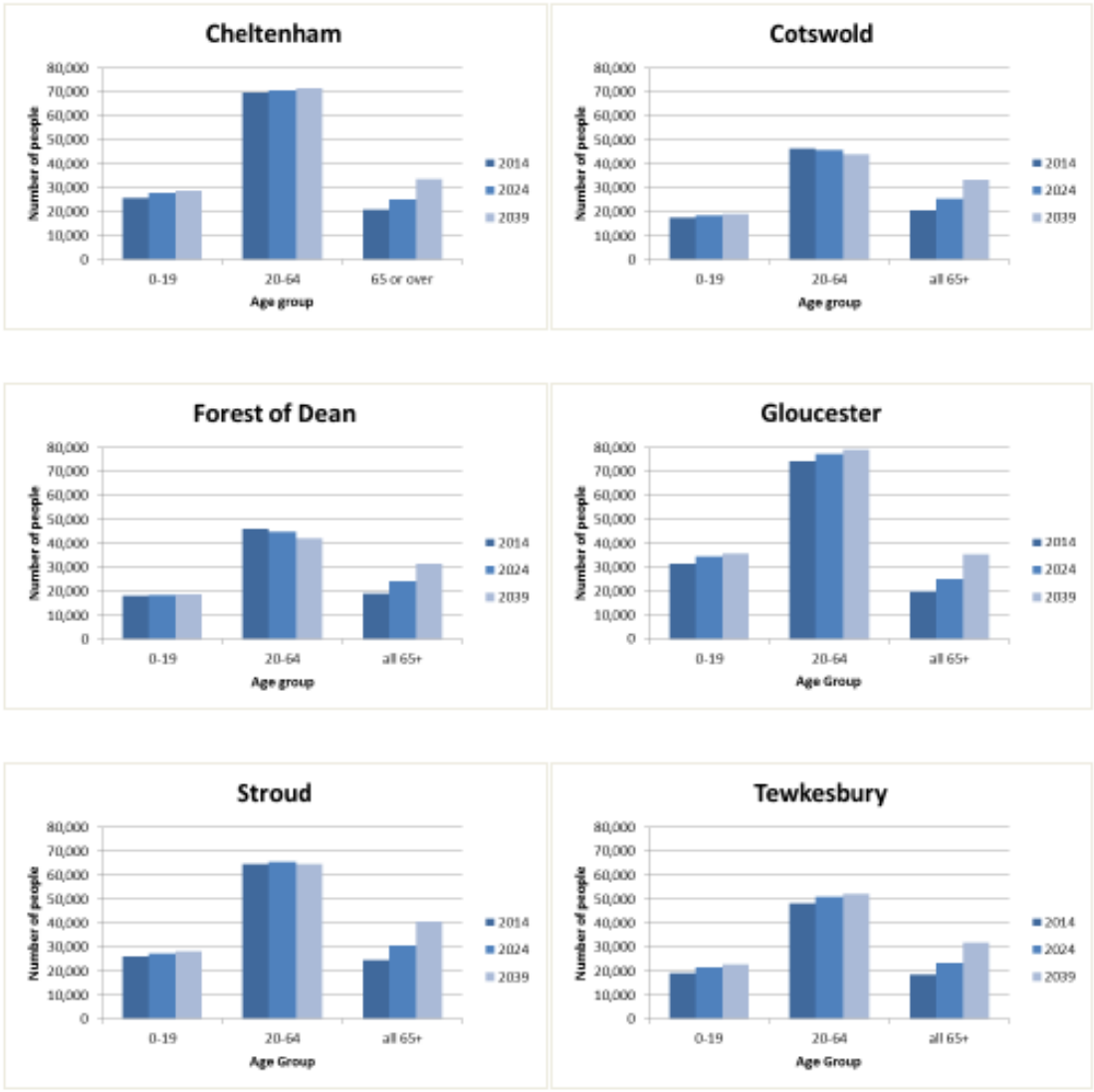
Age Structure of Gloucestershire population 2014 to 2039 (%)

	Percentage of population					
	2014		2024		2039	
	Gloucestershire %	England & Wales %	Gloucestershire %	England & Wales %	Gloucestershire %	England & Wales %
0-19	22.6	23.7	22.5	23.7	21.5	22.6
20-64	57.1	58.6	54.1	56.4	49.6	53.3
65+	20.3	17.7	23.4	19.8	28.9	24.1

Projected population changes in the Gloucestershire districts by age group, 2014 to 2039

	Projected % increase (2014 to 2039)					
Age	Cheltenham	Cotswold	Forest of Dean	Gloucester	Stroud	Tewkesbury
0-19	10.8	7.9	3.8	14.1	8.5	20.0
20-64	2.7	-4.7	-8.2	6.7	0.2	8.3
65+	60.6	61.2	64.6	77.9	66.5	70.4
All ages	14.8	13.9	10.9	19.9	16.1	24.5

Projected number of people in the Gloucestershire districts by age group, 2014 to 2039



Deprivation

The population pyramids on the next two pages show the population broken down by socio economic quintile by locality and age band first by head of population, and then by population proportion. Quintile 1 is considered the most deprived and quintile 5 the least deprived.

The first set of pyramids shows the different socio economic profiles of the different localities in Gloucestershire split by number of residents. Looking at the charts shows that the different localities have significantly different compositions.

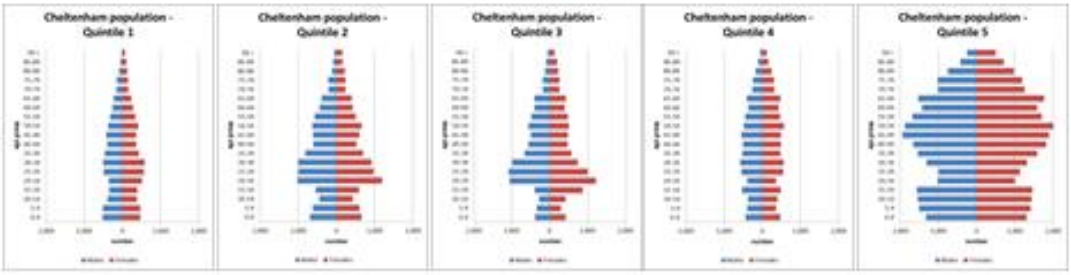
Cheltenham has a high number of residents who are in quintile 5 (the most well off) and within quintile 5 the majority of the Cheltenham population is over 50 with a relative lack of young working age residents. However, within quintile 2 and 3 there is a relative over representation of younger working age adults.

In contrast, Gloucester has a population which is much more evenly split between the socio economic quintiles and is generally younger then the Cheltenham population.

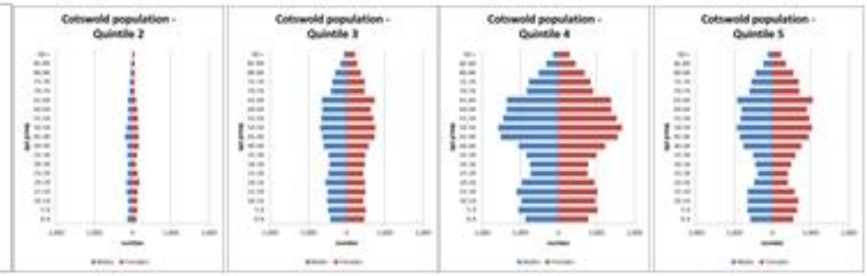
Forest of Dean has a distinct population pattern with the majority of residents being in quintile 3 and very few in either the highest or lowest socio economic quintile.

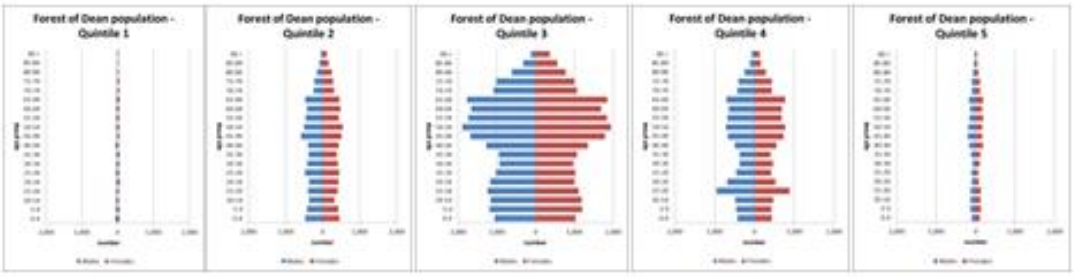
In the second set of pyramids (by population proportion) the average, Gloucestershire wide population proportion is shown by the wavy line. From these charts it is possible to see that the young working age population is disproportionately clustered in quintile 3and 4 in Gloucester, Cheltenham, Cotswold and Forest of Dean.

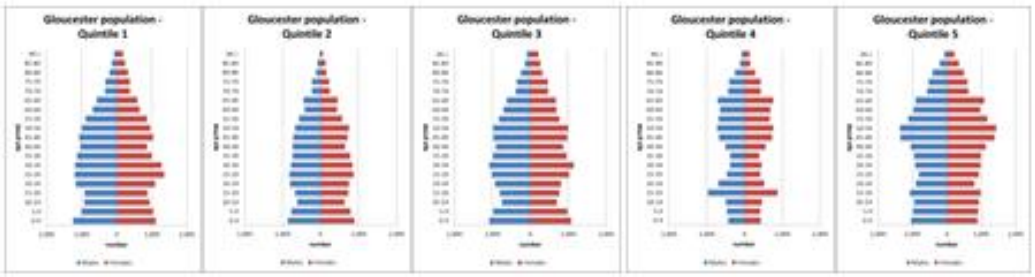
Population number by national IMD quintile



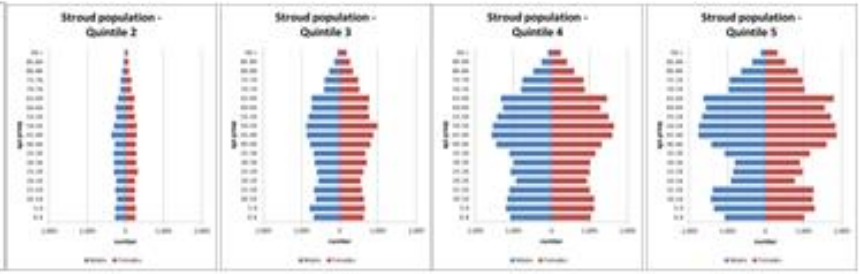
No areas in Cotswold are categorised as national IMD quintile 1

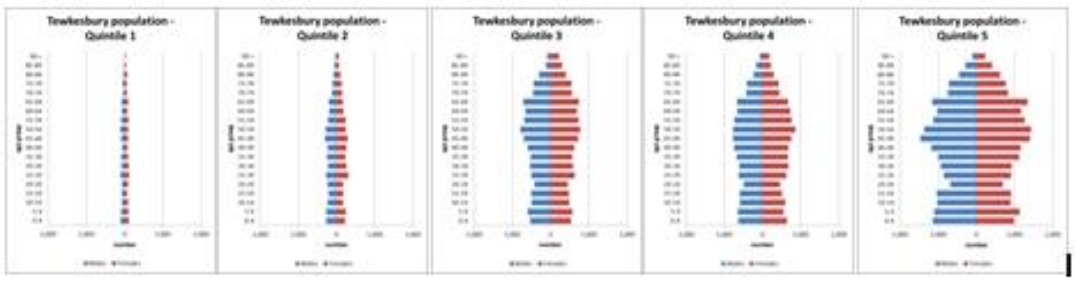




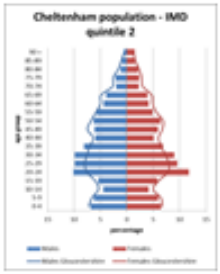


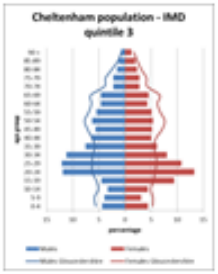
No areas in Stroud are categorised as national IMD quintile 1

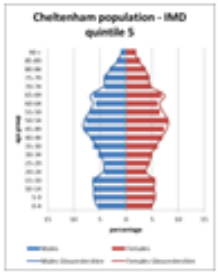




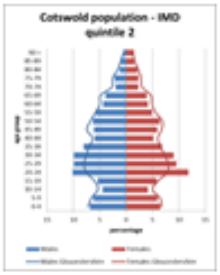
Population proportion by national IMD quintile

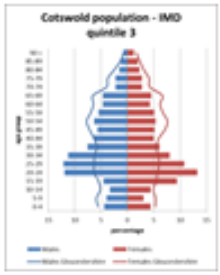


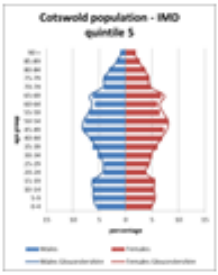


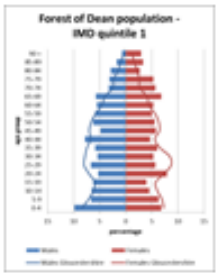


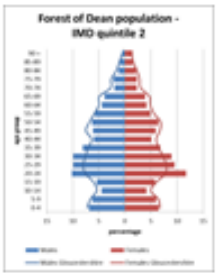
No areas in Cotswold are categorised as national IMD quintile 1

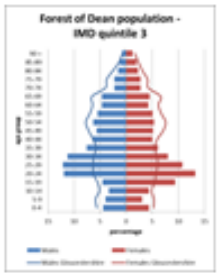


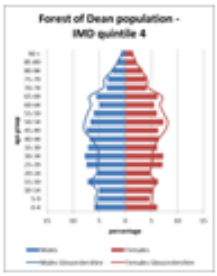


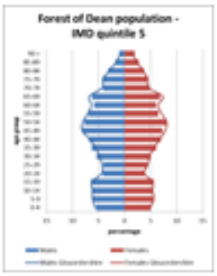


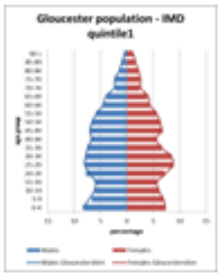


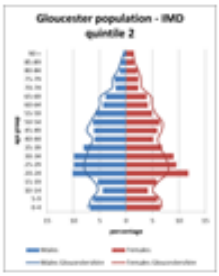


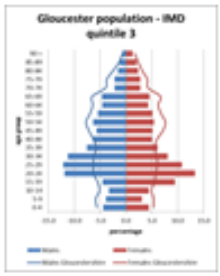


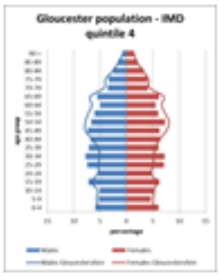




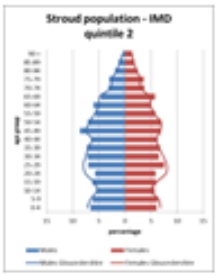


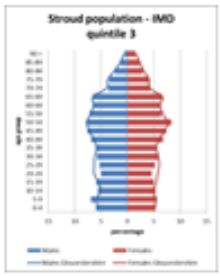


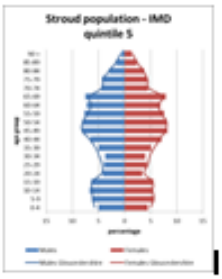




No areas in Stroud are categorised as national IMD quintile 1







Ethnicity

With regards to ethnic groups, the 2011 Census found that 91.6% of Gloucestershire residents were White British, 2.1% were Asian/Asian British, 1.5% were from a Mixed Ethnic group, 0.9% were Black/Black British, 0.6% were White Irish, 0.1% were of Gypsy or Irish Traveller origin, and 3.9% were in an 'other White' category. Overall, 4.6% of the population were from Black and Minority Ethnic (BME) backgrounds; this figure increased to 8.4% when the Irish, Gypsy or Irish Traveller and 'other White' categories were included. Around 36% of the people who were not White British were born in the UK.

There is a wide variation at district level in the proportion of the population who are not White British. At the time of the 2011 Census, Gloucester and Cheltenham had the highest proportions at 15.4% and 11.7% respectively, whilst the Forest of Dean had the lowest proportion at 3.3%. Some 22% of the Gloucestershire Asian/Asian British population lived in Barton and Tredworth ward in Gloucester, and 42% of people who were of Gypsy/Irish Traveller origin lived in Tewkesbury district. People from other BME backgrounds and other White backgrounds were more geographically dispersed.

In relation to language, the 2011 Census found that 3.3% of the population in Gloucestershire who were aged 3 or over did not speak English as their main language. Amongst this group, Polish was the most common main language, followed by Gujarati and then a Chinese language. Some 82% of the people, whose main language was not English, could speak English well or very well. Older people were less likely than younger people to be proficient in English; 29% of people aged 50 and over who did not speak English as a main language were not proficient compared with 17% of people aged under 50 who did not have English as a main language[25].

Focus on Children, Young, People and Families

The composition of the children and young people population is slightly different to the population as a whole and is changing relatively rapidly.

According to the 2011 census 7.6% of 0-19 year olds were from a Black or Minority Ethnic Group. This compares to 4.6 % in the wider Gloucestershire population and 21.1% in the wider Uk population.

The children and young people segment of the population of Gloucestershire is becoming increasingly diverse. In 2011 around 10,300 0-19 year olds were from a Black or Minority Ethnic Group (7.6%). This has increased since 2001 when 6,300 people or 4.6% of 0-19 year olds were from a Black or Minority Ethnic Group. The number of 0-19 year olds classed as "white other" which includes migrants from Europe, has also increased from 1,725 people or 1.3% of 0-19 year olds in 2001 to 3,600 people or 2.6% of 0-19 year olds in 2011.

Although the 0-19 year old population fell between 2002 and 2012, the latest population projections suggest this trend will be reversed over the next ten years. Gloucestershire's 0-19 year old population is projected to increase by almost 10,000 people or 7.2% to about 146,700 in 2021.

Conception, Pregnancy and Infancy

Conception, Pregnancy and Infancy

The First 1,000 Days are accepted to be the most significant in a child's development. Many agree that care given during the first 1,000 days has more influence on a child's future than any other time in their life. As a result, getting the best start is essential.

A) Healthy pregnancy

Introduction

Healthy children start with healthy parents. Opportunities to secure a child's best start in life begin in pregnancy, and in some cases even before conception. Several modifiable risk factors, such as smoking, drinking, diet and physical activity can affect the pregnancy and may lead to pre-term (less than 37 weeks) delivery, low birth weight, stillbirth, and pregnancy complications. Maintaining a healthy weight, taking dietary supplements like iron and folic acid , not smoking or drinking alcohol, and seeking early support from a healthcare provider, are known to reduce the risk of poor outcomes during pregnancy and birth, and even to be associated with better maternal and child outcomes in later life. This section considers health and wellbeing issues around conception, pregnancy and early infancy

Policy Context

NHS England has published a resource pack containing a framework to support Clinical Commissioning Groups (CCGs) regarding the commissioning of maternity services[6]. The framework focuses on obstetric and midwifery care across the antenatal, intrapartum and immediate postnatal periods and encourages CCGs to think in a holistic way about women's health, maternity services and early years. Emphasis is laid on pre-conceptual care, perinatal mental health, the rising birth rate, the complexity and acuity of pregnancy and integration with the early years' agenda. NICE have also published a guideline on what good antenatal care for uncomplicated pregnancies looks like.[7]

C-section rates in England continue to rise. More than 1 in 4 (26.2%) of women will have a caesarean rather than a vaginal delivery with C-Sections categorised as elective (planned) or emergency. NICE guidance [*Caesarean section, CG132]*[8] is clear on when women should be offered a C-section with the aim of trying to halt the increasing rate of C-sections as women who have a C-section will often spend longer in hospital, start breastfeeding later and may suffer post-surgical complications.

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[6] NHS. *Commissioning Maternity Services - A Resource Pack to support Clinical Commissioning Groups*. 2012; Available from: https://www.england.nhs.uk/wp-content/uploads/2012/07/comm-maternity-services.pdf.

[7] NICE, *Antenatal care for uncomplicated pregnancies - CG62*, NICE, Editor. 2008.

[8] NICE, *Caesarean section, NICE guidelines [CG132].* 2011.

The *National Maternity Review Report: Better Births*[9] is a review, which focuses on improving outcomes of maternity services in England. It sets out wide-ranging proposals to not only make care safer but to empower women and give them more control over the decisions that involve them. Their vision is to ensure that women can access support which is centred around their individual needs and circumstances, delivered by teams which are well led and in cultures which promote innovation and continuous learning.

Gloucestershire has a Better Births Gloucestershire programme which driving the Better Births principles forward. Emphasis is based on driving the following evidence based outcomes forward

- How the safety of maternity care will be improved so that by 2020/21 all services:
  - Have reduced rates of stillbirth, neonatal death, maternal death and brain injury during birth by 20% and are on track to make a 50% reduction by 2030.
  - Are investigating and learning from incidents, and are sharing this learning through their Local Maternity Systems and with others.
  - Are fully engaged in the development and implementation of the NHS Improvement Maternity and Neonatal Health Safety Collaborative.
- How choice in and personalisation of maternity services will be improved so that:
  - All pregnant women have a personalised care plan.
  - All women are able to make choices about their maternity care, during pregnancy, birth and postnatally.
  - Most women receive continuity of the person caring for them during pregnancy, birth and postnatally.
  - More women are able to give birth in midwifery settings (at home and in midwifery units).

Epidemiological Data Review

PHE Fingertips data overview:

PHE fingertips provides a pregnancy and childbirth dataset summary overview. This is shown below.

[9] NHS. *Better Births - Improving outcomes of maternity services in England: A Five Year Forward View for maternity care*. 2016; Available from: https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf

Compared with benchmark Better Similar Worse Not Compared

Benchmark Value
Worst 25th Percentile 75th Percentile Best

Indicator	Period	Glouc'shire			Region	England	England		
		Recent Trend	Count	Value	Value	Value	Worst	Range	Best
Percentage of deliveries to mothers from Black and Minority Ethnic (BME) groups	2015/16	–	506	7.8%	8.9%	23.3%	1.9%		70.1%
General fertility rate	2015	→	6,697	61.8	60.0	62.5	43.7		84.8
Under 18 conceptions	2015	↓	162	15.2	16.8	20.8	43.8		5.7
Under 18s conceptions leading to abortion (%)	2015	↑	86	53.1%	54.1%	51.2%	28.9%		82.4%
Teenage mothers	2016/17	↓	34	0.5%	0.6%	0.8%	2.1%		0.0%
Smoking status at time of delivery (current method)	2016/17	↓	302	8.6%*	11.3%	10.7%	28.1%		2.3%
Caesarean section %	2015/16	–	1,634	25.3%	24.3%	26.3%	38.1%		18.5%
Multiple births	2015	→	113	17.1	15.9	16.0	7.7		29.2
Low birth weight of term babies	2016	↓	135	2.2%	2.5%	2.8%	5.2%		1.3%
Low birth weight of all babies	2015	↑	453	6.8%	6.8%	7.4%	11.5%		4.5%
Very low birth weight of all babies	2015	→	79	1.19%	1.49%	1.26%	3.23%		0.32%
Stillbirth rate	2014 - 16	–	76	3.8	3.7	4.5	7.7		2.3
Admissions of babies under 14 days	2015/16	–	325	50.3	74.0	66.3	208.3		24.3

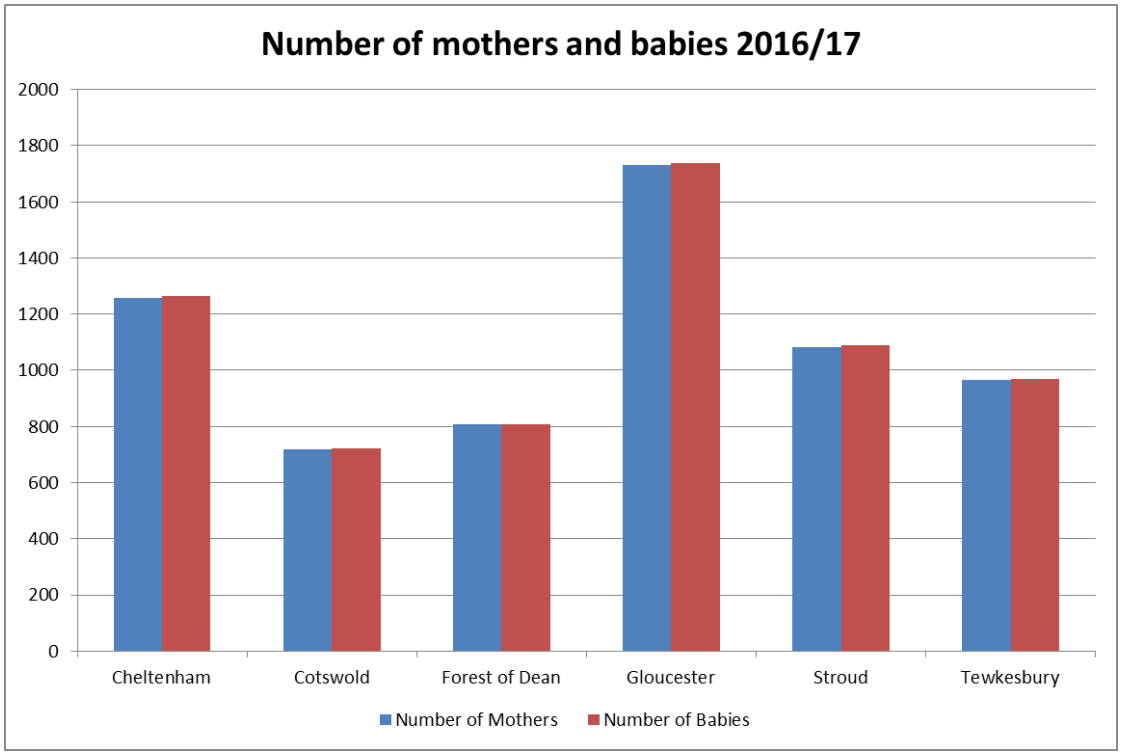
(NB There is a recognised data quality issue reported for the smoking at time of birth indicator so this is not a reliable statistic in this data set)

This shows that all Gloucestershire generally performs well compared to the national average in pregnancy data. One area of concern highlighted by this data is the upward trend in low birth weight babies. Comparing this indicator to the low birth weight of term babies indicator (green arrow denoting positive trend) it appears that the issue lies around increased low birthweight premature babies. This is a vulnerable group at risk of going on to have health and wellbeing issues. Addressing it will require addressing the factors that lead to premature birth.

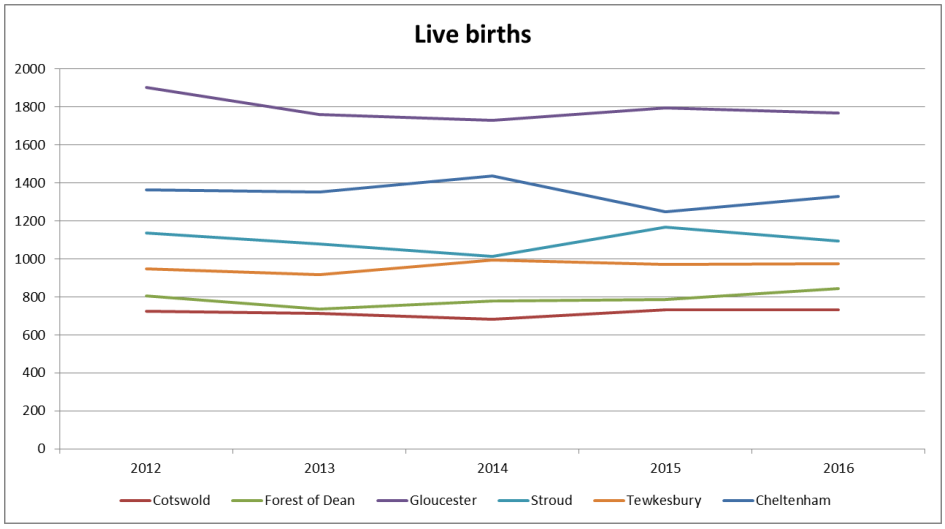
Local Data:

The number of live births in Gloucestershire has been rising since 2013. On average, over the previous 5 years, there have been around 6,700 live births per year in Gloucestershire. In statistical terms this translates in to a General fertility rate (Birth rate per 1,000 females aged 15 to 44 years) for Gloucestershire of 61.8 which is statistically in line with the England rate of 62.5.

In 2016/17 6563 mothers gave birth to 6593 babies in Gloucestershire. The chart below shows the births split by district of residence of the mother. Gloucester district had the highest number of births having around 500 more than the second highest district Cheltenham..

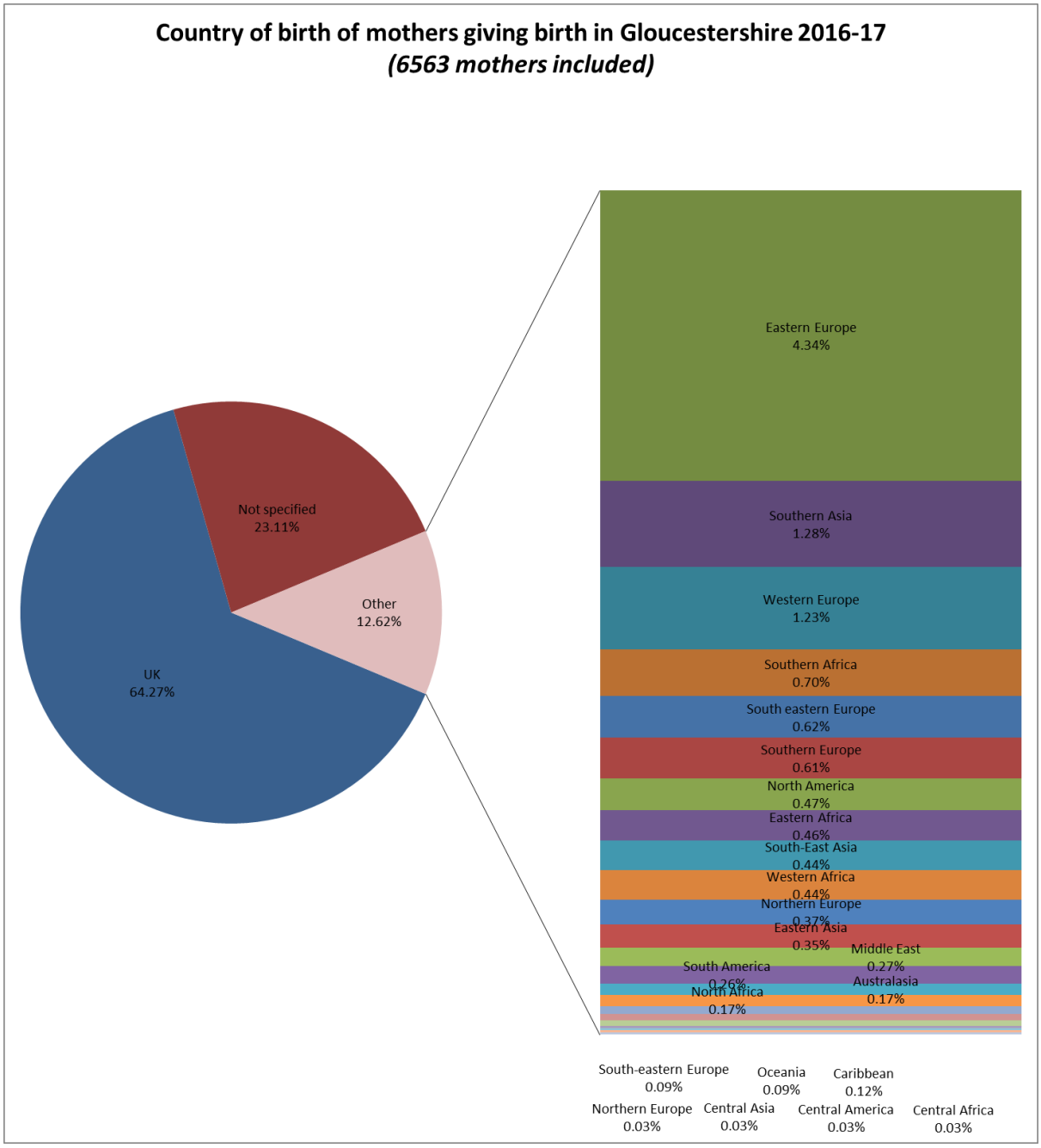


The geographic trend data for number of births in Gloucestershire are shown in the diagram below.

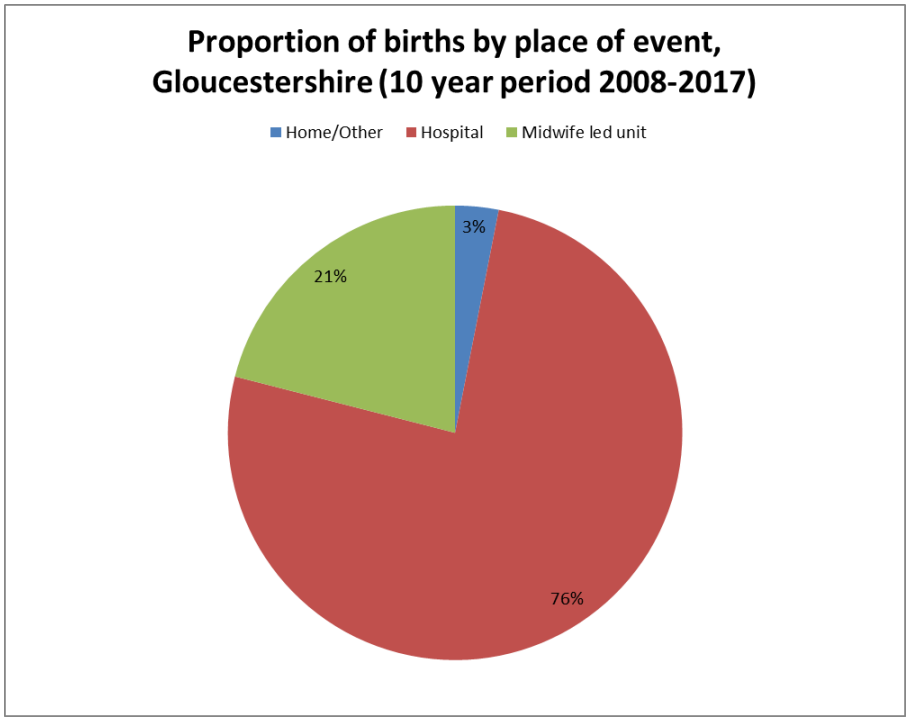


This shows that the highest number of birth has consistently been in Gloucester and the lowest in Cotswold. Over the last five years the numbers of live births has dropped slightly in Cheltenham, Gloucester and Stroud, the numbers of births has risen slightly in Forest of Dean and Tewkesbury and has remained similar in Cotswold.

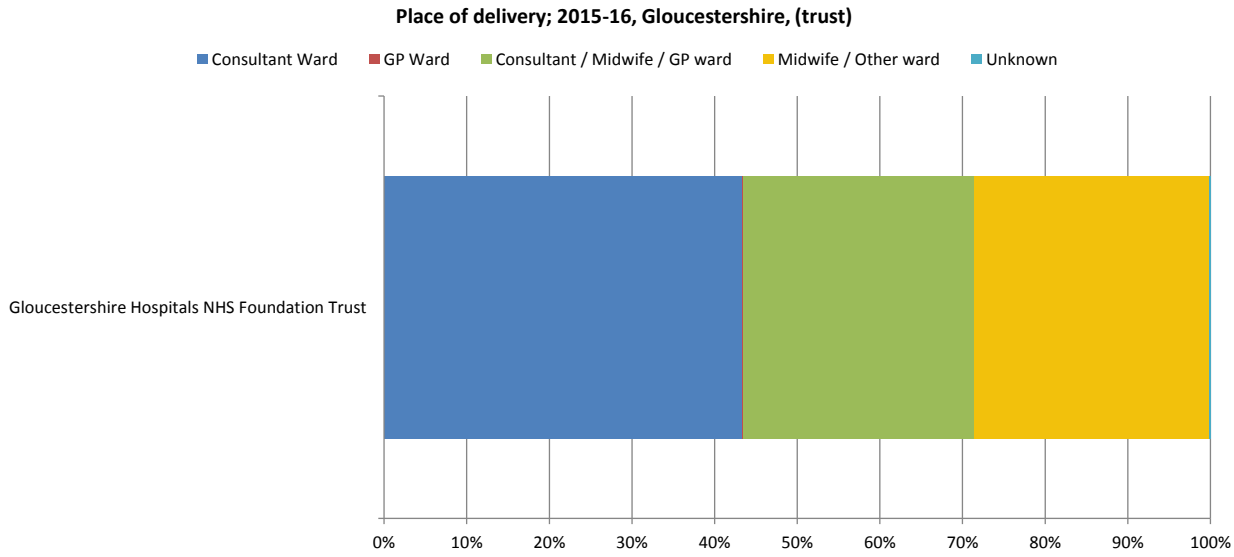
The majority of mothers giving birth in Gloucestershire are born in the UK . The largest identified minority is Eastern European mothers. The full county of origin maternal data for last year is summarised in the diagram below.



Over the last 10 years, the majority of mothers have had hospital births, although roughly one in five give birth in a midwife led unit.

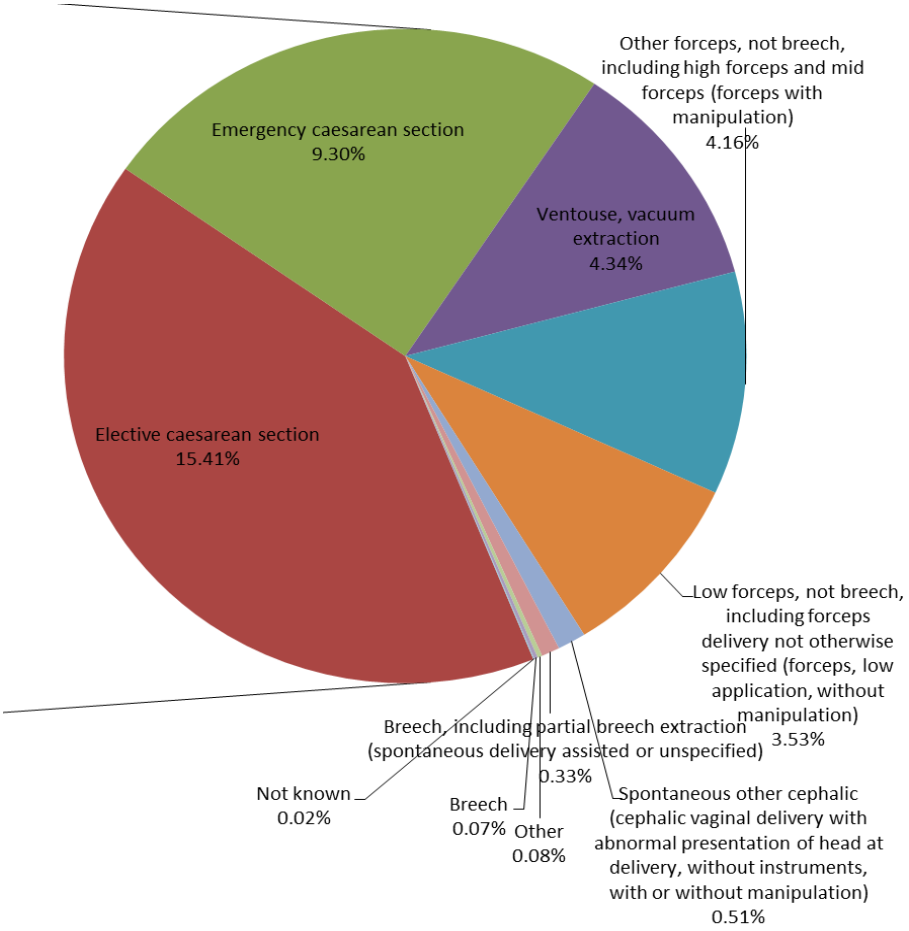


Looking at a one year snapshot around 30% of women gave birth under midwife led care either ina birth unit or at home. This is higher than other areas in the South West .



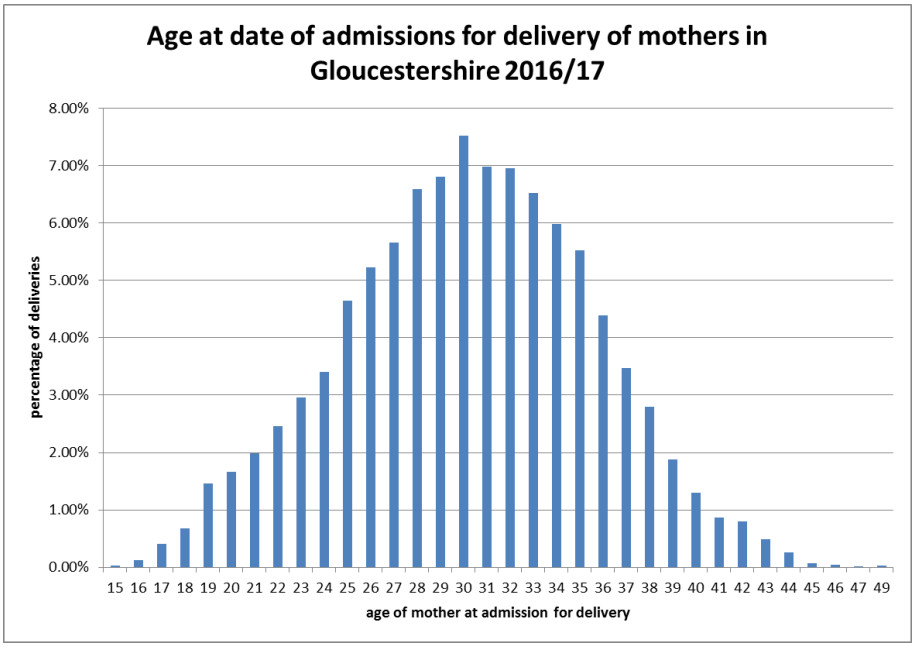
Source data: NHS Digital, 2015/16 Link: http://www.content.digital.nhs.uk/catalogue/PUB22384

62% of births locally are spontaneous vaginal deliveries. The breakdown of the remaining 38% of births is summarised below.

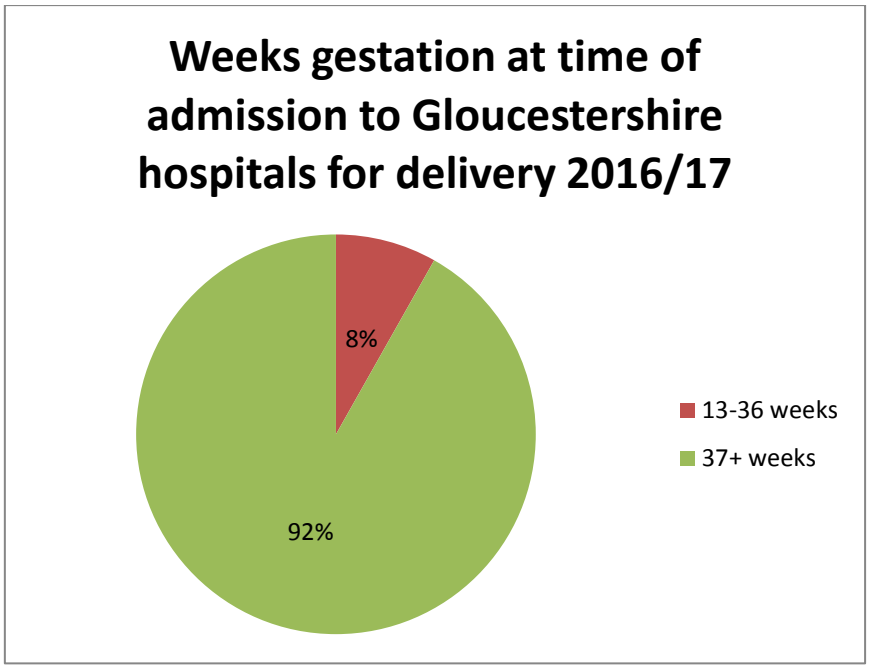


The elective C-section rate of 15.4% is above the national average of around 13% suggesting there is scope for improving this.

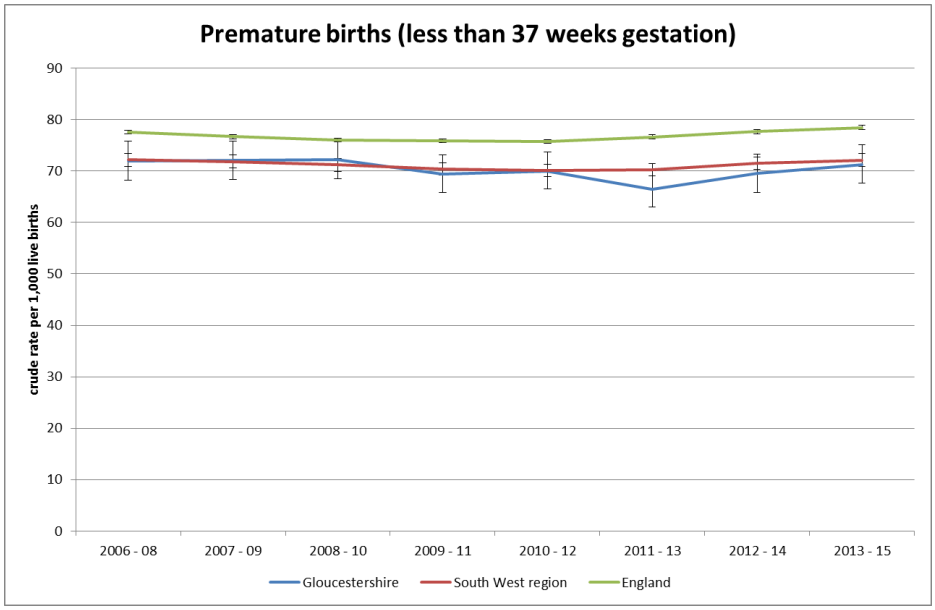
The median age of giving birth for women in Gloucestershire is 29 years with a range from 15 to 49 years old



The majority of women are being admitted to hospital at term but around one in twelve is admitted early.



Pre term birth is often associated with low birth weight and, as discussed in the previous section, premature birth can be associated with poorer outcomes and so it is important to monitor this.



Source: PHE fingertips

As can be seen in the above chart, Gloucestershire has a crude rate of premature births that is in line with the regional South West average and better than the national rate. As well as immediate problems, in the very long-term, a baby with a low birth weight has a greater risk of being overweight or obese in adulthood, and of developing diabetes, high blood pressure and heart disease.

Qualitative Data Review

In May 2017, a 'Whose Shoes' Maternity Engagement event was held. It was attended by around 50 people including mothers and babies, midwives, medical staff and health visitors. The attendees worked through a range of scenarios in an informal way which encouraged open, honest discussions. This feedback along with the results of the 2015 Care Quality Commission (CQC) survey give an initial focus for developing a plan to improve experiences of intra and postnatal care. A graphic artist recorded the themes that arose from the engagement process and they are summarised in the diagram below. It includes both what users liked and what they felt needed improvement.

Following focus group work with women in Stroud and Cheltenham, a Maternity Voices Gloucestershire website was developed to provide easy access to the range of information available to women and their families about lifestyle choices during pregnancy, antenatal, maternity and postnatal care. Access to consistent, clear information was identified by women as being important to enable them to make informed choices about their care.

The website is intended to act as a conduit for engagement with women and their families to ensure their voice is integral in further developing maternity services. Women attending the focus groups were keen to develop this approach as a means of two-way engagement and communication.

Healthwatch Gloucestershire provided feedback from women and their families from the Polish community, about their experiences of maternity services. This identified some broader issues around communication and shared understanding of cultures and the range of NHS services available.

Feedback from women highlighted the following main areas:

- Additional postnatal support, particularly around the postnatal ward, feeding support, handover from midwifery to health visiting and mental health support.
- Further culturally appropriate support for Gloucestershire's diverse communities.
- Continuity of care is important to women, who stated they would prefer to have a small number of care givers.
- The involvement of partners throughout the whole of the maternity pathway.
- Accessibility of groups and classes.
- Improving women's experience on the main Delivery Suite at Gloucestershire Royal, particularly during busy times.
- The need for consistent messages from health professionals and clarity of their roles.

Local Service Provision

Maternity services in Gloucestershire are provided by Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT).

Hospital Birth Services:

The maternity service offers a full range of choice of place of birth, including an alongside birth unit, freestanding birth unit, home birth and an obstetric unit. The Gloucester Women's Centre based at Gloucester Royal Hospital has an Obstetric Unit and a purpose built Alongside Midwifery-led Unit. The obstetric led services include outpatients, day assessment, triage, delivery suite and a mixed antenatal and postnatal maternity inpatient ward.

Midwifery Led Birth Services

n addition to the Women's Centre at the hospital there are two Free-standing Midwifery-led Units one on the site of the Cheltenham General Hospital and one adjacent to the Stroud General Hospital; Stroud Maternity Unit. An annual report of the Birth Centres demonstrates good outcomes for women choosing this option for birth. Benchmarked against the South West Maternity dashboard and nationally, Gloucestershire is one of the highest providers of births in midwifery led facilities

The Mums Up and Mobile (M.U.M.) project supports increased choice during labour and birth for women with more complex care needs. The project equips midwives working on the Delivery suite with the tools and strategies to enable physiological birth. The MUM project has increased midwives' confidence in supporting women to have a safe, physiological birth regardless of complexity improving women's birth experience in a complex care environment.

Community Midwives

Community midwives are grouped within three geographical localities; West (Gloucester and the Forest of Dean), East (Cheltenham and North Cotswolds) and South (Stroud and Cirencester). In each locality community midwives are in teams of between 10 and 20 midwives based in a number of venues around the county e.g. Birth Centre, Children and Family Centre, Community Hospital. Most community antenatal clinics are held in GP practices with a small number being held in Children and Family Centres or local Birth Centre. A small number of women are seen at home if they are unable to attend a more structured clinic. The two Free-standing Midwifery Units provide antenatal and postnatal clinics and parent education sessions.

Midwifery Advice Line

A Midwifery Advice Line is part of the South West Ambulance Service. This service provides consistent advice to women and frees up midwives in the triage unit in the Obstetric Unit to provide direct clinical care for women without interruption. The advice line also supports joint working with the urgent care system preventing some ambulance call outs and conveyances.

Specialist Midwifery Services

There are specialist midwives for vulnerable women including teenagers, those with mental health concerns, substance misuse problems, bereaved parents as well as to to support safeguarding and infant feeding. In addition to the specialist support for vulnerable women the midwifery partnership team is provided in areas of deprivation in Gloucester and Cheltenham. This service aims to improve access to midwifery care and achieve better health and parenting outcomes for vulnerable women and their families. All midwives within the partnership team are trained in motivational interview techniques and some have additional training to provide support to stop smoking.

Neonatal Services

GHNHSFT Neonatal Unit has been classified as a Local Neonatal Unit (Level 2 equivalent). It is the largest Unit in the region. The unit has 32 cots; of which, 12 are ITU/HDU, 16 are special care and 4 are based in a bay with beds for mums to stay with their baby. It is a fully staffed unit and in 2017 achieved 70% ratio of nursing staff having the neonatal training qualification (a national standard). There are between 550-600 admissions per year.

Health Visiting Services

Gloucestershire Care Services provides health visiting services for women, babies and families across Gloucestershire. Midwifery and Health Visiting Leads meet regularly with an aim of improving the provision of seamless care and reducing conflicting advice and information.

Perinatal Mental Health

The maternity service is working closely with 2gether NHS Trust to develop a specialist perinatal mental health service which will be integrated with maternity/health visiting services. It is expected this service will be fully operational early 2018.

Healthy Pregnancy Service

Gloucestershire's Healthy Lifestyles Service has recently been commissioned by the local authority to develop a targeted maternity and early year's programme which will begin January 2018. The service will work with current services and stakeholders to develop a targeted programme of healthy

lifestyles support for women with highest needs during pregnancy and the two years following birth. This will include, where applicable:

During pregnancy:

- Support to stop smoking for women and their partners
- Information and support to avoid excess weight gain during pregnancy (targeting women who are obese)
- General health advice for pregnancy on diet (including Healthy Start scheme), nutrition and food safety, alcohol, physical activity and emotional wellbeing.

After delivery:

- Infant feeding including encouragement to breastfeed and access Healthy Start
- Weight reduction / return to healthy weight (for mothers)
- Healthy lifestyles information and support to reduce the risk of obesity among the children of obese mothers.

Evidence around What Works

Much of the evidence around what works has been incorporated into NICE maternity care guidelines and NHS England publications such as "*Better Births*" or "*Commissioning Maternity Services - A Resource Pack to support Clinical Commissioning Groups*."

Emphasis is laid on:

- high quality and timely pre-conceptual care,
- perinatal mental health,
- identifying complexity in pregnancy and
- integration with the early years' agenda.

Overall, good birth outcomes are associated with support that is focussed on the individual needs and circumstances, care teams that are well managed and focussed on continuous improvement.

Discussion, Gap Identification and Recommendations

Strengths:

- Generally good pregnancy and outcome statistics when compared nationally
- A substantial amount of work has been undertaken to engage with service users and respond to their views

Areas of Concern

- Increasing trend for low birth weight babies being observed
- The absolute numbers of women smoking in pregnancy and having elective C sections is high
- Up to date data collection has been hampered by recent issues in the data collection system
- Service users report a desire for culturally flexible services that can deliver the right things for every mother at the right time in a way the individual can relate to. This is a high aspiration and as service pathways become more complex and the birthing population becomes more diverse this will be challenging to deliver.

B) Smoking in pregnancy

Introduction

Smoking in pregnancy has well known detrimental effects on the growth and development of the baby and health of the mother. These include complications during labour and an increased risk of miscarriage, premature birth, stillbirth, low birth-weight and sudden unexpected death in infancy. In addition, children whose mothers smoke in pregnancy are more likely to smoke in later life, reinforcing existing inequalities and cycles of disadvantage.

Smoking in pregnancy occurs in all socio-economic groups. However, rates are higher amongst the poorest, meaning the disadvantages of being born to a mother who smokes are likely to disproportionately impact the less well off. Nationally women in routine and manual jobs are almost five times more likely to smoke during pregnancy than those in managerial and professional roles[10].

Younger mothers are also more likely to smoke during pregnancy; teenage mothers are five times more likely to smoke throughout pregnancy than women who are aged 35 or older[11]. They are also less likely to quit before or during pregnancy.

Protecting babies from tobacco smoke is one of the best things that can be done to give babies a healthy start in life. Stopping smoking has immediate and long term benefits on both mother and child.

Policy Context

The Department of Health's Tobacco control Plan for England 2017- *Towards a Smokefree Generation*[12] intends to improve life chances for all children by tackling inequality associated with smoking in pregnancy. It aims to reduce the prevalence of smoking in pregnancy from 10.7% to 6% or less by the end of 2022.

In November 2014, Secretary of State for Health announced a new ambition to reduce the rate of stillbirths by 50 per cent in England by 2030. The Saving Babies' Lives Care Bundle is part of a drive to halve the rate of still births from 4.7 per thousand to 2.3 per thousand by 2030 with a 20 per cent reduction by 2020. Saving Babies' Lives brings four elements of care together, the first of which is reducing smoking in pregnancy.

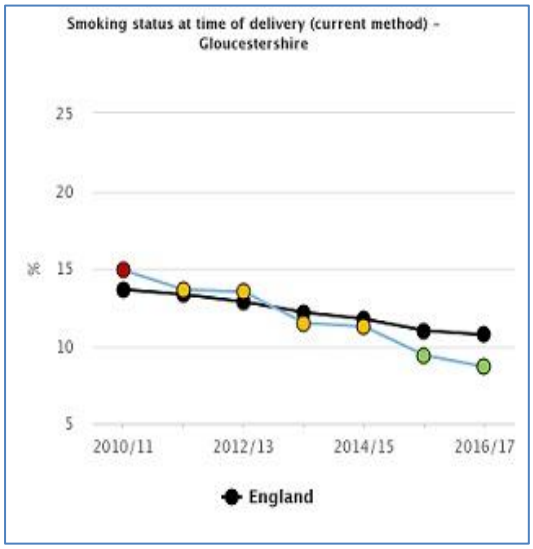
NHS England will work to reduce smoking in pregnancy through Carbon monoxide (CO) testing of all pregnant women at antenatal booking appointment and referral, as appropriate, to a stop smoking service/specialist through the Saving Babies' Lives Care Bundle[13]. This is in line with evidence based

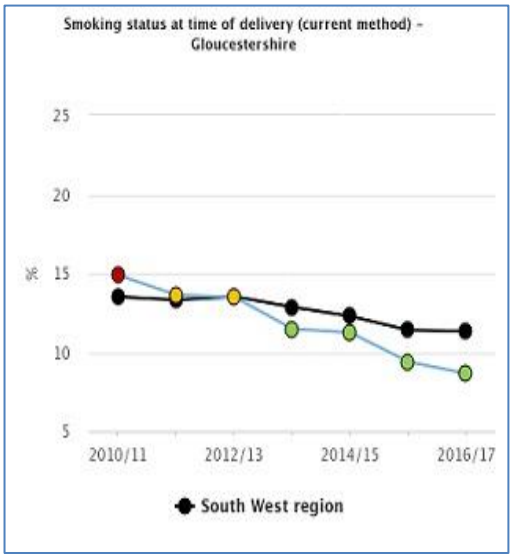
[10] NICE (PH26)
[11] ibid
[12] Tobacco Control Plan
[13] Saving Babies Lives Care Bundle

guidance from NICE- *Smoking: Stopping in pregnancy and after childbirth* Public Health Guideline (PH26)[14]

Epidemiological Data Review

A can be seen in the charts below, the number of women who smoke when pregnant has steadily declined over the years. Fewer women smoke in pregnancy in Gloucestershire (8.6%) on the whole than in England (10.5%) and the South West region (11.1%).





Source: PHE fingertips data

Although the proportion of pregnant women smoking has reduced from nearly 15% in 2010/11, and is lower than the England average of 10.6%, it still means that almost 1 in every 10 babies born in Gloucestershire will be at higher risk of premature birth, low birth weight, still birth and sudden unexpected death in infancy. This is around 600 babies.

As stated in the introduction to this section the 2022 national target is that less than 6% of women are still smoking that the time of their child's birth. Assuming the birth rate stays constant, to reach this target an extra 174 women would need to quit.

In 2016/17, 126 pregnant smokers in Gloucestershire made a quit attempt and 66 (52%) of the women successfully quit at 4 weeks. This suggests that getting the additional 174 pregnant smokers to quit that will be needed to reach the 6% national 2022 target may not be a trivial undertaking.

However, it should be noted that the overall population rates for smoking are also declining and this may positively impact reaching the target as if the trend continues fewer women will be smoking overall and thus also in pregnancy.

[14] NICE (2010) PH 26 (updated 2017)

Comparator and Qualitative Data Review

Feedback received from pregnant women who have used the Healthy Lifestyles Service to stop smoking is very positive.

- 98% think the service is of good or very good quality,
- 83% are either fairly or very confident that they will continue to stop smoking and
- 100% of pregnant women were likely or very likely to recommend the service to others.

Local Service Provision

Stop smoking support for pregnant women in Gloucestershire is currently funded by the local authority and delivered by the Healthy Lifestyles Service. Pregnant smokers have been identified as a priority group to receive stop smoking support.

The Midwifery Service follows NICE guidelines (PH 26)[15] and operates an 'opt out' referral policy whereby all pregnant women who smoke are referred to the stop smoking service unless they decline this offer of support. In addition the maternity service:

- Provides information about local stop smoking support to fathers and other household members who smoke.
- Works with the local stop smoking provider to support pregnant women to access their service.

As part of the Better Births Prevention Plan a target has been set to reduce the prevalence of smoking in pregnancy to 6.0% in line with the national ambition in the Tobacco Control Plan (2017). To support this, all midwives have carbon monoxide monitors which can identify pregnant women who smoke or are exposed to second hand smoke. Midwives make direct referrals where appropriate to the Healthy Lifestyles Service who will then support the women to stop smoking. Midwives in some of the most deprived areas of the county have undertaken Motivational Interviewing and Smoking Cessation training and take women through a quit attempt themselves, offering them additional support. Women who continue to smoke throughout their pregnancy are offered two extra scans to monitor the growth and development of their babies.

Gloucestershire's Healthy Lifestyles Service have developed a targeted maternity and early year's programme which began delivery in 2018. The service works with current services and stakeholders to develop a programme of healthy lifestyles support for women with the highest needs during pregnancy and the two years following birth. This support will include support to stop smoking for women and their partners.

The Healthy Lifestyles Service also provides 'Making Every Contact Count' training including bespoke sessions for Community Midwives. The training covers the role of the midwife in behavioural change, barriers and enablers particularly with regard to smoking, alcohol consumption and obesity.

[15] https://www.nice.org.uk/Guidance/pH26

The Smoking Cessation in Pregnancy and after Childbirth Guideline has been reviewed and outlines the roles and responsibilities of those that are involved in the stop smoking pathway for pregnant women. The Guideline includes the referral mechanism for women accessing the stop smoking service.

Evidence around What Works

Nice guidelines (PH26), recommends:

- Early identification of pregnant women who smoke and referral to services which evidence based interventions
- Contacting and supporting women who have been referred
- Use of Nicotine Replacement Therapy (NRT) or other pharmacological support
- Ensuring stop smoking services meet the needs of disadvantaged pregnant smokers
- Ensuring appropriate levels of training for midwives and all those supporting women through pregnancy
- Provision of advice and support to partners and others in the household who smoke

Discussion, Gaps and Recommendations

Strengths in this area:

- Reduction in rates of smoking in pregnancy, performance better than national average
- Combination of universal and targeted support

Areas of Concern

- Target reduction is challenging and at current rates of reduction may be hard to meet. The newly configured services will need to show effectiveness from early on.
- Smoking in pregnancy is a significant health inequality affecting the poorest most frequently

Recommendations

Given smoking in pregnancy's major role in impacting the future health of the child, ensure focus remains on providing high quality smoking cessation services for pregnant women in order to meet the targets set

C) Screening in Pregnancy /New-born Period

Introduction

NHS England offers an antenatal screening programme to all pregnant women in England. It is a programme whereby the woman is offered a range of tests, including blood tests and ultrasound baby scans designed to help make the pregnancy safer, check and assess the development and wellbeing of the mother and her baby, and to screen for specific conditions. Screening takes places for infectious diseases (including hepatitis B, HIV and syphilis), inherited conditions (sickle cell, thalassemia and other haemoglobin disorders, Down's syndrome, Edward's syndrome and Patau's syndrome) and foetal abnormalities (12 weeks and 18-21-week scan). Women are educated about the purpose of all the tests so that they can make an informed decision about whether to have them or not. Nevertheless, all are strongly encouraged to ensure that both mother and baby are as healthy and safe as can be.

Newborn screening is offered to babies, to identify those at high risk of a specific condition for whom early treatment may be offered to improve their health outcomes, prevent severe disability and/or mortality.

In the UK, this constitutes a hearing test within the first 3 months of life and a blood spot test taken when the baby is 5 days old (usually by a community midwife) to identify conditions such as sickle cell, cystic fibrosis, congenital hypothyroidism and inherited metabolic diseases.

Policy Context

The Healthcare Commission assesses the performance of NHS organisations in meeting core and developmental standards set by the Department of Health which includes implementation of clinical guidelines around antenatal screening[16]. NICE has also published a number of tools and resources (costing templates, costing reports, slide sets) to facilitate putting the guidance into practice.

Together with achieving the national target of 100% of newborns screened, the latest PHE guidelines stress;

(1) the importance of NBS screening in preventing severe disability and death,
(2) steps to take if parents decline screening (plus new template letters),
(3) why good quality samples are vital for accurate screening results,
(4) how to complete the blood spot card and collect good quality spots first time and
(5) what to do in different situations (i.e. baby who needs a repeat). [17]

The UK National Screening Committee (UK NSC) advises on screening policy and supports the UK-wide implementation of screening programmes. Together with the Screening Quality Assurance Service, a significant component of this support is tailored towards providing information, education

[16] NICE, *Antenatal care for uncomplicated pregnancies - CG62*, NICE, Editor. 2008
[17] PHE, *PHE screening: Newborn blood spot screening: new guidelines, leaflets and data published*. 2016.

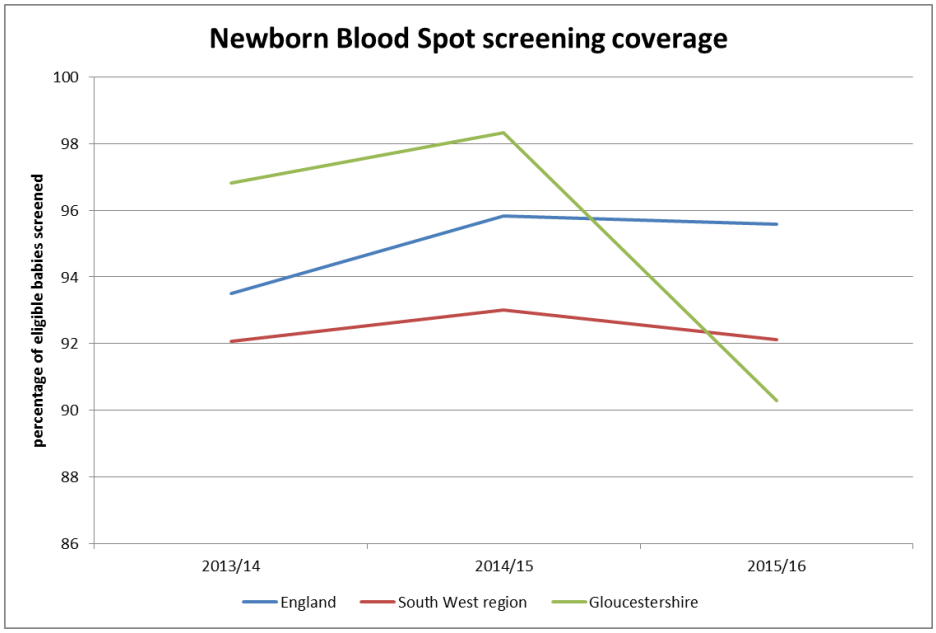
and training for multidisciplinary staff delivering, commissioning and performance-managing screening[18].

Epidemiological Data Review

The table below gives an overall summary of how four of the key strands of screening in pregnancy are performing. Syphilis screening coverage has improved over the last 5 years, HIV and Hep B screening coverage has stayed level and Sickle and Thalassaemia screening coverage rates have fallen from almost 100% coverage to 94%.

Screening in pregnancy - percentage coverage (eligible females)					
	2016-17	2015-16	2014-15	2013-14	2012-13
Syphilis	98.4	98.8	98	87	90
Hep B	98.4	98.9	98	87	98
HIV	98.6	98.6	98.2	99.5	98.2
SCT	93.7	99.9	99.8	100	99.9

New born blood spot screening coverage:

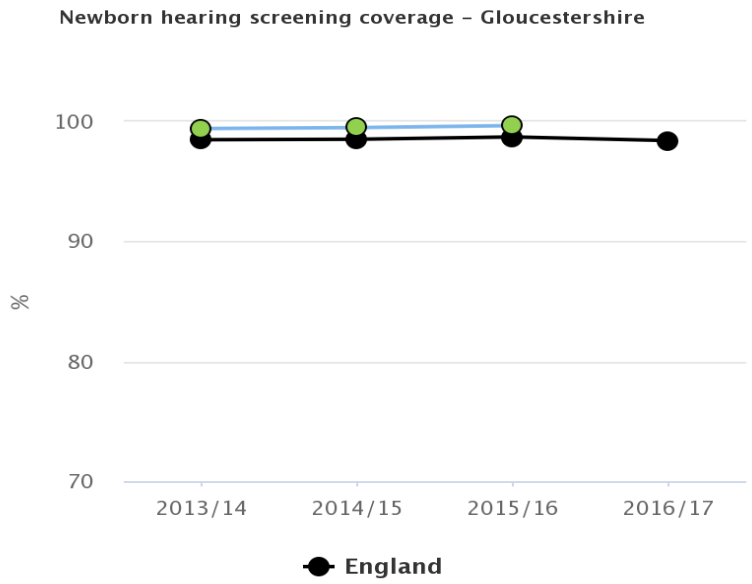


As can be seen above there has been a significant decline in the proportion of Gloucestershire babies receiving new born blood spot screens. As a result, the new born blood spot screening coverage is significantly lower in Gloucestershire than the England average.

[18] NHSE, *NHS public health functions agreement 2016-17: Service specification no.19 - NHS Newborn Blood Spot Screening Programme.* 2016.

New born Hearing Screening coverage

Gloucestershire level data is available for new born hearing screening coverage up to 2016 and the data is shown below. Gloucestershire has consistently performed above the UK average in this indicator.



Other screening data has been hard to find at the local level as it is no longer recorded on fingertips and local data collection system issues have affected availability. However, regional level data is available and detailed below. It should be noted that, while this is the best available information, as the new born blood spot graph above illustrates, we may not perform in line with the regional average.

Table to show regional Antenatal HIV screening coverage:

Period	South West	England
2013/14	99.2	98.9
2014/15	98.9*	98.9*
2015/16	99.2	99.1
2016/17	99.4	99.5

Table to show regional Sickle cell and Thalassaemia screening coverage:

Period	South West	England
2013/14	99.4	98.9
2014/15	99.4*	98.9*
2015/16	99.4	99.1
2016/17	99.0	99.3

In both antenatal HIV and sickle/Thalassaemia screening, while South West coverage rates are high, they are statistically worse than the rest of the UK.

Data around antenatal ultra sound and gestational diabetes screening have not been available for review.

Local Service Provision

Gloucestershire Hospitals' NHS Foundation Trust (GHNHSFT) provides the county's maternity services, with the exception of the very small number of women who opt for care by independent midwives. Services are located within Gloucestershire Royal Hospital, Cheltenham General Hospital and Stroud Maternity Unit covering the community localities of Tewkesbury, Cheltenham, Gloucester, Cirencester, the Cotswolds, Stroud and the Forest of Dean.

There are six NHS antenatal and new born screening programmes in line with NHS Screening Programme requirements. These are:

Antenatal screening:

- Sickle Cell and Thalassaemia
- Fetal Anomaly Screening Programme (Down's, Edward's and Patau's syndrome & fetal anomaly ultrasound)
- Infectious Diseases (Hepatitis B, HIV, Syphilis, Rubella)

Newborn screening:

- Newborn Blood Spot (Phenylketonuria, Medium Chain Acyl CoA Dehydrogenase Deficiency (MCADD), Cystic Fibrosis, Congenital Hypothyroidism, Sickle Cell)
- Newborn and Infant Physical Examination
- Newborn Hearing Screening programme

Maternity Services delivered through the NHS Trust generally deliver the antenatal screening programme. All women in early pregnancy booked by Gloucestershire Hospitals' NHS Foundation Trust receive the NHS Screening Programme's standardised parent information booklet for antenatal and newborn screening 'Screening tests for you and your baby'. Women presenting later receive the booklet but may not be eligible for all tests. 'Your Ultrasound scans' leaflet is also provided and on identification of a high-risk/abnormal result from a screening or scan other booklets and information are provided along with counselling and discussion of ongoing pathways.

At the time of writing, the newborn hearing screening programme is provided by Gloucestershire Care Services NHS Trust staff within the community. Hearing services staff from GHNHSFT perform screenings on the neonatal unit at Gloucestershire Royal Hospital. New born hearing screening will transfer to Gloucestershire Hospitals NHS Foundation Trust in summer 2018.

Gloucestershire Care Services NHS Trust are also responsible for the community screening aspects on the Child Health system liaising with the GHNHSFT team to ensure follow up of infants for whom there was no newborn bloodspot screening after 17 days (unless baby was very preterm).

Evidence around What Works

NICE have performed a full evidence review to underpin their guidelines. This can be found at https://www.nice.org.uk/Guidance/CG62/Evidence . Their findings around what works in antenatal screening are summarised below.

Screening for haematological conditions:

- Screening for sickle cell diseases and thalassaemias should be offered to all women as early as possible in pregnancy (ideally by 10 weeks). The type of screening depends upon the prevalence and can be carried out in either primary or secondary care.

Screening for foetal anomalies:

- Participation in regional congenital anomaly registers and/or UK National Screening Committee-approved audit systems is strongly recommended to facilitate the audit of detection rates.
- The 'combined test' (nuchal translucency, beta-human chorionic gonadotrophin, pregnancy-associated plasma protein-A) should be offered to screen for Down's syndrome between 11 weeks 0 days and 13 weeks 6 days. For women who book later in pregnancy the most clinically and cost-effective serum screening test (triple or quadruple test) should be offered between 15 weeks 0 days and 20 weeks 0 days

Screening for clinical conditions

- Screening for gestational diabetes using risk factors is recommended in a healthy population. At the booking appointment, the following risk factors for gestational diabetes should be determined:
    - body mass index above 30 kg/m2
    - previous macrosomic baby weighing 4.5 kg or above
    - previous gestational diabetes (refer to diabetes in pregnancy NICE guideline CG63)
    - family history of diabetes (first-degree relative with diabetes)
    - family origin with a high prevalence of diabetes

Discussion, Gap Identification and Recommendations

Strengths in this area:

- Strong evidence base and clear guidelines available
- Historically high levels of coverage rates showing that excellent is attainable

Weaknesses in this area:

- Data availability has been patchy. Without adequate data it is difficult to fully evaluate the situation and to identify in a timely manner areas where performance is declining
- Evidence of declining coverage rates in new born blood spot screening and sickle cell and thalassaemia testing. Delays to diagnosing these conditions can have significant life changing and life limiting implications for the affected children and families

Recommendations

Continue to monitor local level indicators and ensure that coverage does not drop below targets.

D) Breastfeeding

Introduction

Breast milk provides the ideal nutrition for infants in the early stages, offering them the best start in life. It has many well established benefits (both in the short term and the longer term) to both infants and their mothers. It promotes health and prevents disease[19] and also helps contribute to reducing health inequalities.

Any period of breast feeding provides benefits to both the baby and mother. Babies that are breastfed have less chance of getting infections, of becoming obese and therefore of developing type 2 diabetes and other illnesses when they get older. Mothers who breastfeed also receive health benefits, these include a lower risk of breast and ovarian cancer, and osteoporosis. Evidence-based reports demonstrate breastfeeding supports close and loving relationships, improves mental health and can reduce the rate of post natal depression.

Supporting women to start and continue breastfeeding provides a rapid return on investment with fewer hospital admissions as a result of the protection that breastfeeding provides. Babies who are breastfed have lower risk of gastrointestinal illness, ear and chest infections in their first year of life, and a reduced risk of obesity and diabetes in later life.

There is a clear link between a woman's infant feeding choice and both her age and level of deprivation; the UK Infant Feeding Survey 2010[20] shows that mothers who are more likely to start breastfeeding are over 30 years old, have achieved higher levels of educational achievement and are living in the least deprived areas.

Policy Context

Improving breastfeeding rates is a key national driver in child health and is highlighted in numerous government policy documents. In England, the Department of Health (DoH) adopts the World Health Organisation (WHO) guidance recommending exclusive breastfeeding for the first six months of an infant's life.

The Public Health Outcomes framework 2016 prioritises breastfeeding initiation and breastfeeding prevalence at 6-8 weeks as indicators of health improvement; requiring local authorities to prioritise breastfeeding support locally and to increase rates of breastfeeding initiation and prevalence[21].

The NHS Outcomes Framework 2016/17[22]. Supporting breastfeeding will help to reduce neonatal mortality (one of the framework indicators) and implementing Baby Friendly Initiative will help to improve women's experience of maternity care.

[19] NHS choices
[20] HSCIC 2012 Infant Feeding Survey 2010
[21] PHOF https://fingertips.phe.org.uk/search/breastfeeding
[22] NHS Outcome Framework

The Chief Medical Officer report (2013) - Our children deserve better: Recommends increasing involvement with WHO and UNICEF's Baby Friendly Initiative, as a minimum standard, to support breastfeeding.

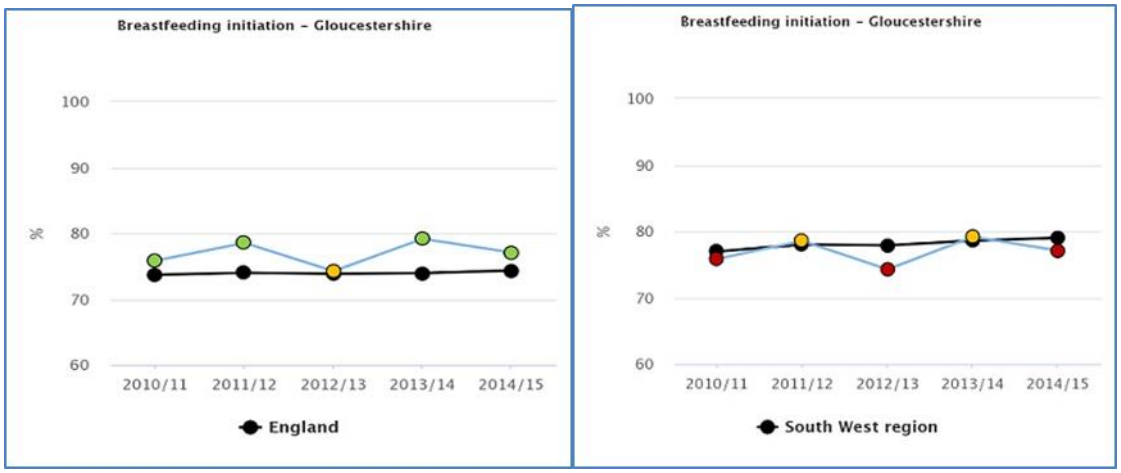
The Healthy Child Programme (2009): The English policy framework 'Giving all children a healthy start in life', is underpinned by the Healthy child programme which recommends the Baby Friendly Initiative as a minimum standard to support breastfeeding and reduce obesity.

Epidemiological Data Review

At the national level, 69% of mothers were exclusively breastfeeding at birth in 2010. At one week, less than half of all mothers (46%) were exclusively breastfeeding, while this had fallen to around a quarter (23%) by six weeks. By six months, levels of exclusive breastfeeding had decreased to one per cent, indicating that only one in a hundred mothers were following the UK health departments' recommendation that babies should be exclusively breastfed until around the age of six months (*UK Infant Feeding Survey 2010*). This survey is no longer carried out so in-depth national data is now harder to find.

Breastfeeding Initiation in Gloucestershire

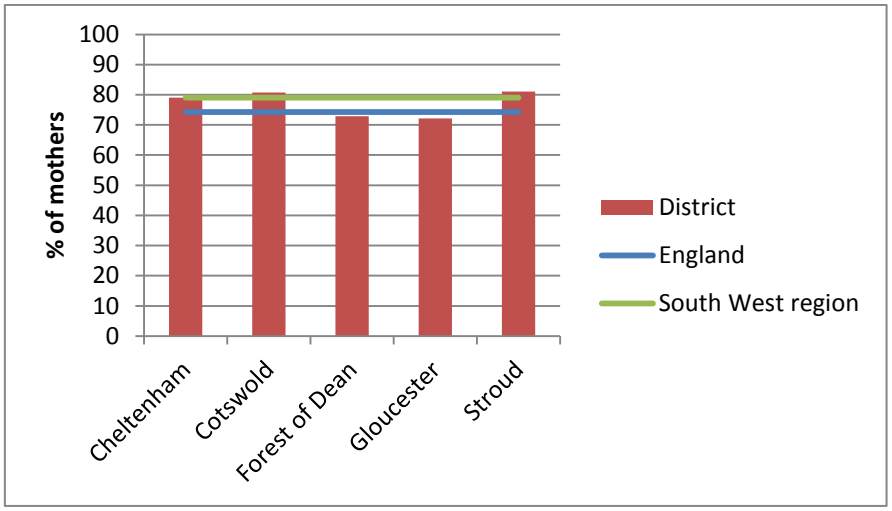
In 2015/16, 77% of new mothers in Gloucestershire initiated breastfeeding. This is significantly better than the national average but less good than the regional average. The time trends for this indicator and for Gloucestershire compared to national and regional performance are shown below. Red circles denote a statistically worse performance, green a statistically better performance and orange a performance in line with the comparator.



The rates of breastfeeding initiation vary throughout Gloucestershire and while county wide performance is better than the national average there are localities that perform worse than the national average.

The figure below shows the percentage of new mothers in the different Gloucestershire districts who gave their babies' breast milk in the first 48 hours after delivery. Whilst initiating breastfeeding results in Cheltenham, Cotswold and Stroud are significantly better than the national average, initiating breastfeeding in Gloucester and the Forest of Dean (the most deprived districts) is lower than the national average.

Chart showing Breastfeeding Initiation rates across Gloucestershire



Source: PHE-Breastfeeding initiation 2014/15. Data for Tewkesbury not published for data quality reasons

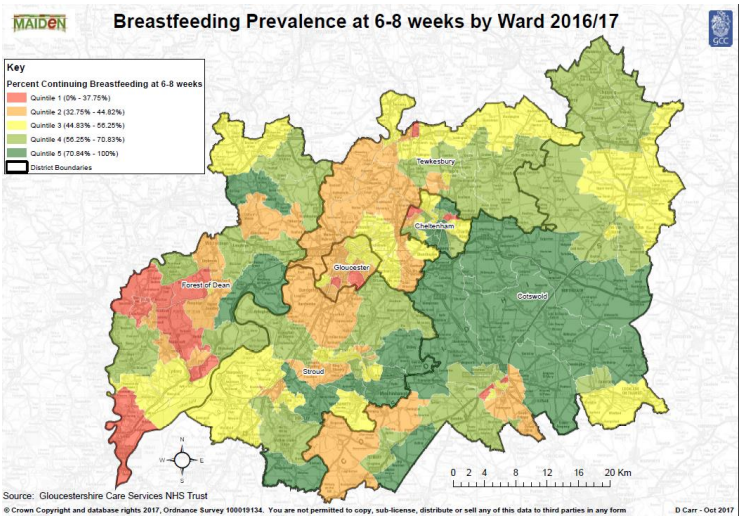
At 6-8 weeks after birth, only half (49.2%) of new mothers were breastfeeding in Gloucestershire. The 6-8 week breastfeeding prevalence figures are based on the number of infants recorded by CCGs as exclusively[23] or partially breastfeeding, as a percentage of all infants due a 6-8 week check. The data show that there is a significant drop off in breast feeding rates by 6-8 weeks. Asa result less than half of Gloucestershire's babies and mothers are enjoying the health and wellbeing benefits of breastfeeding at 6-8 weeks.

In terms of ethnicity, local data on breastfeeding is not available but nationally white mothers are less likely to breast feed meaning their children are more likely to miss out on the protective factors associated with breast feeding.

There are variations in the 6-8 week prevalence between the districts as shown in the map below. Again the areas of highest deprivation tend to also be the areas with lowest breastfeeding rates meaning that those who already experience many other life challenges fail to benefit from breast feedings protective effects.

[23] Exclusive breastfeeding: is defined as giving the baby no other food or drink except breast milk (but the baby can receive vitamin drops and medicine syrups)

Breastfeeding Prevalence at 6-8weeks after Birth



Qualitative Data Review

Qualitative data providing insights into how mothers and service users feel about breast feeding support has been gathered for the Public Health Nursing and the Health Visitor survey.

Both surveys identified breast feeding as an important issue, and 14% of respondents identified infant feeding and weaning to be the single most important topic to learn about in Baby Hubs.

Feedback identified that a number of mothers felt that the current support and information available was not enough and needs improving.

Comments included:

- *"I had significant breastfeeding issues with my youngest. She was tongue tied and it was cut three times, but re-attached. Baby gained well, but I got a lot of damage. My HV wanted to help and was emotionally supportive, but didn't have the training to do so. All she could suggest was formula feeding. My eldest had weight gain due to breastfeeding issues too. I suspect in retrospect she has had ongoing tongue tie issues. Again my HV was supportive, but unable to help. From my own experience and conversations with other mums, I assume this is an issue of training. Until or if this can be resolved, it would be useful for HV to refer on to GBSN groups in Cheltenham. GBSN seem to be the only real bf support locally. Whilst a volunteer group cannot meet all needs, it's the best we've got. - I don't recall any of my HV recommending the groups though."*

- *"[They need] more training so if I ask for advice they can actually give it, instead of me knowing more information than they can provide.*

- *"Breastfeeding support needs building on. The most helpful advice I received was from la Leche over the phone. In retrospect I know now that I suffered with post-natal anxiety but was quite high functioning"*

- *"I found breastfeeding quite hard so decided to switch one feed to formula as my mental health was suffering. My baby is allergic to cow's milk protein so needed specific formula.I felt*

I could have been supported better in my decision and assisted more in how to go about this.

Local Service Provision

Breastfeeding is recognised as providing a cost effective approach to optimising short and long-term physical and mental health of mother and baby especially if sustained exclusively for the first six months of life.

Breastfeeding is a significant key influence on a child's health status and later life chances. By ensuring they have the best start in life and is crucial to reducing health inequalities across the life course. There are many initiatives delivered through both statutory and voluntary agencies which support the delivery of breastfeeding in the county:

Gloucester Royal NHS Trust- UNICEF Baby Friendly Initiative

Gloucestershire Hospitals were awarded the Level 3 UNICEF Baby Friendly Initiative accreditation in 2017. The initiative is a global programme which provides a practical and effective way for health services to improve the care given to all mothers and babies by contributing to standardisation advice given to women both pre and post-natally to enable successful breastfeeding. From 2018 they are hoping to achieve accreditation of the neonatal ward.

Breastfeeding Peer Support Service

Gloucestershire County Council commissions the breastfeeding peer support service, currently delivered by the Breastfeeding Network. The service aims to provide proactive, intensive, early, skilled non clinical peer support to mothers who wish to breastfeed. The peer supporters do not replace health care professionals but work alongside them to proactively offer support to new mothers soon after birth and help to prevent any problems and barriers that lead to mothers stopping breastfeeding earlier than they wished.

Breastfeeding Peer Support operates in Cheltenham, Gloucester, Cirencester, Stroud, Dursley, Churchdown and Tewkesbury. Since being recommissioned in 2017 a new refocused approach has been taken to target more deprived areas across the county.

Gloucestershire Breastfeeding Supporters Network (GBSN) is a registered charity which runs seven breastfeeding support groups in Cheltenham, Gloucester, Cirencester, Stroud, Dursley, Churchdown and Tewkesbury. Both providers are members of GIFSP (Gloucestershire Infant Feeding Partnership).

Public Health Nursing (Level 3 UNICEF Baby Friendly Initiative accredited)

Promotion and provision of support for breastfeeding for all families is part of the universal offer from Gloucestershire's Public Health Nursing (Health Visiting service) commissioned by Gloucestershire County Council.

As of April 2018, Gloucestershire Care Services NHS Trust Health Visiting Services have been re-accredited as UNICEF UK Baby Friendly demonstrating continued high quality care for babies, their mothers and families.

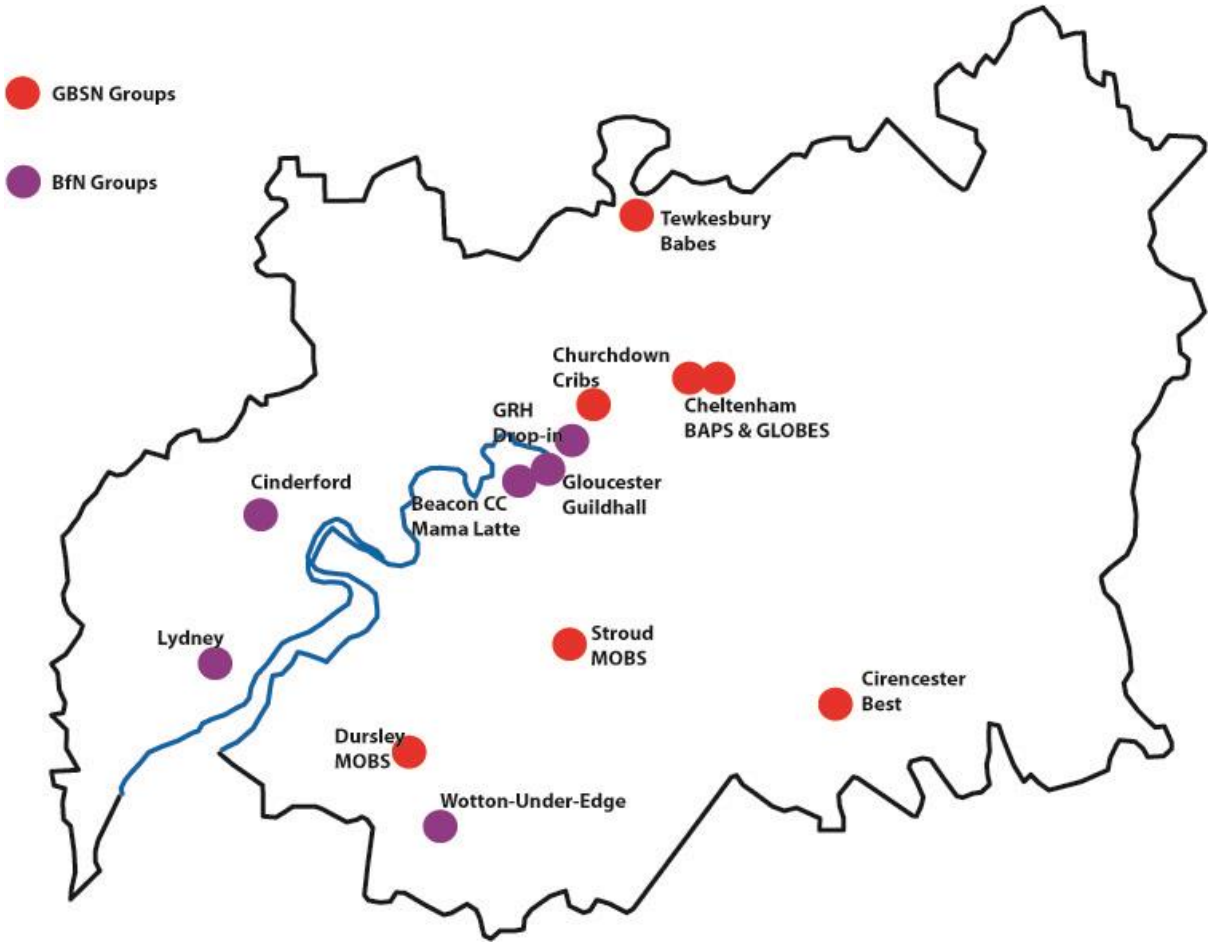
Family Support Services

Breastfeeding is an outcome in the specification for targeted family support services requiring them to promote and support breastfeeding alongside other work with vulnerable families.

Gloucestershire Infant Feeding Strategic Partnership

The partnership meets four times a year and aims to increase collaboration, to share best practice, and to ensure breastfeeding and safe infant feeding support is delivered effectively and consistently across the county aiming to increase the prevalence of breastfeeding initiation and continuation.

The diagram below provides a map of local breast peer support groups in Gloucestershire.



Evidence around What Works

The 2005 NICE summary paper *"Breastfeeding for Longer - -What works?"* identifies key practices or policies which were found to be effective and beneficial for enhancing the duration (not initiation) of breastfeeding. This practices/polices are outlined below:

Postnatal hospital stay

- Skilled breastfeeding support, peer or professional, proactively offered to women who want to breastfeed
- Preventing the provision of discharge packs containing formula feeding information and samples

- Unrestricted feeding from birth onwards
- Unrestricted mother–baby contact from birth onwards
- Unrestricted skin-to-skin contact from birth onwards
- Avoiding supplementary fluids for babies unless medically indicated
- Regular breast drainage/continued breastfeeding for mastitis
- Antibiotics for infective mastitis.

Postnatal care in the community

- Skilled breastfeeding support, peer or professional, proactively offered to women who want to breastfeed.

Ongoing care in the community

- skilled breastfeeding support, peer or professional

Discussion, Gaps and Recommendations

Strengths in this area:

- Current performance is better than the national average with over three quarters of women initiating breastfeeding

Areas of Concern

- Based on service user feedback the demand for skilled and knowledgeable support does not appear to be being met in all cases
- Better awareness of and access to the services on offer is need

Recommendations

Breastfeeding is a key early intervention that brings long term health benefits to both mother and child. Thus the reach and effectiveness of the breast feeding support service needs to be increased. Evidence supports a proportionate universalism approach to help reduce the health inequalities associated with variable breast feeding rates.

E) Immunisations

Introduction

According to the World Health Organization, the two public health interventions that have had the greatest impact on world health are clean water and vaccines. In the UK, responsibility for the vaccine programmes are jointly held by the Department of Health, Public Health England and NHS England with schedule changes issued by the Joint Committee on Vaccines and Immunisation.

There have been numerous changes to the routine childhood immunization schedule over the past decade with more recent variations including introduction of the Meningococcal B (MenB) and Rotavirus vaccines in infants under 1 years of age, Influenza (i.e. "Flu") vaccine in children between 2 – 8 years of age, Human Papilloma Virus (HPV) vaccine in females between 12 – 13 years of age and the removal of the Meningococcal C (MenC) vaccine given at 3 months of age. The changes to the school vaccination schedule reflect an appraisal of the knowledge and evidence bases regarding vaccinations within the context of epidemiology of disease in eh UK.

A summary of the current immunization schedule is given on the next page.

All pre-school immunisations will be discussed in this section with HPV (human papilloma virus being discussed under young people. There is also a winter 'flu vaccination programme in place. Fr 2016/17 this was a school based programme.

A fuller discussion of the issues around this subject can be found in the Health Protection Needs Assessment.

Policy Context

The WHO recommended immunisation rate against vaccine-preventable diseases is at least 95%.This is to ensure herd immunity (where there are enough individuals who are immune to stop the spread of disease through the population and confer protection on those who can not be immunised).

The Department of Health set the national immunisation policy and this is commissioned through NHS England.

Nationally, immunisations for children are a key Public Health Outcomes Framework objective with a comprehensive surveillance programme known as Cover of Vaccination Evaluated Rapidly (COVER) set up nationally to review vaccination coverage in the UK.

Inequality in vaccination uptake is a national policy focus with NICE guidelines on reducing differences in uptake in under 19s (PH21, 2009)[24] recommending;

- improving access to immunisation services,
- providing parents and young people with tailored information and support,
- checking children and young people's immunisation status during health appointments and when they join nurseries, playgroups, schools and further education colleges, and offering them vaccinations and

[24] https://www.nice.org.uk/guidance/ph21/resources/immunisations-reducing-differences-in-uptake-in-under-19s-pdf-1996231968709

- ensuring babies born to hepatitis B-positive mothers are given all recommended doses of the vaccine on time, a blood test to check for infection and, where appropriate, hepatitis B immunoglobulin

The routine immunisation schedule from Autumn 2017

Age due	Diseases protected against	Vaccine given and trade name		Usual site
Eight weeks old	Diphtheria, tetanus, pertussis (whooping cough), polio, *Haemophilus influenzae* type b (Hib) and hepatitis B	DTaP/IPV/Hib/HepB	Infanrix hexa	Thigh
	Pneumococcal (13 serotypes)	Pneumococcal conjugate vaccine (PCV)	Prevenar 13	Thigh
	Meningococcal group B (MenB)	MenB	Bexsero	Left thigh
	Rotavirus gastroenteritis	Rotavirus	Rotarix	By mouth
Twelve weeks old	Diphtheria, tetanus, pertussis, polio, Hib and hepatitis B	DTaP/IPV/Hib/HepB	Infanrix hexa	Thigh
	Rotavirus	Rotavirus	Rotarix	By mouth
Sixteen weeks old	Diphtheria, tetanus, pertussis, polio, Hib and hepatitis B	DTaP/IPV/Hib/HepB	Infanrix hexa	Thigh
	Pneumococcal (13 serotypes)	PCV	Prevenar 13	Thigh
	MenB	MenB	Bexsero	Left thigh
One year old (on or after the child's first birthday)	Hib and MenC	Hib/MenC	Menitorix	Upper arm/thigh
	Pneumococcal	PCV	Prevenar 13	Upper arm/thigh
	Measles, mumps and rubella (German measles)	MMR	MMR VaxPRO[2] or Priorix	Upper arm/thigh
	MenB	MenB booster	Bexsero	Left thigh
Two to eight years old[1] (including children in reception class and school years 1-4)	Influenza (each year from September)	Live attenuated influenza vaccine LAIV[3]	Fluenz Tetra[2]	Both nostrils
Three years four months old or soon after	Diphtheria, tetanus, pertussis and polio	DTaP/IPV	Infanrix IPV or Repevax	Upper arm
	Measles, mumps and rubella	MMR (check first dose given)	MMR VaxPRO[2] or Priorix	Upper arm
Girls aged 12 to 13 years	Cervical cancer caused by human papillomavirus (HPV) types 16 and 18 (and genital warts caused by types 6 and 11)	HPV (two doses 6-24 months apart)	Gardasil	Upper arm
Fourteen years old (school year 9)	Tetanus, diphtheria and polio	Td/IPV (check MMR status)	Revaxis	Upper arm
	Meningococcal groups A, C, W and Y disease	MenACWY	Nimenrix or Menveo	Upper arm
65 years old	Pneumococcal (23 serotypes)	Pneumococcal Polysaccharide Vaccine (PPV)	Pneumococcal Polysaccharide Vaccine	Upper arm
65 years of age and older	Influenza (each year from September)	Inactivated influenza vaccine	Multiple	Upper arm
70 years old	Shingles	Shingles	Zostavax[2]	Upper arm

1. Age on 31 August 2017.
2. Contains porcine gelatine.
3. If LAIV (live attenuated influenza vaccine) is contraindicated and child is in a clinical risk group, use inactivated flu vaccine.

All vaccines can be ordered from www.immform.dh.gov.uk free of charge except influenza for adults and pneumococcal polysaccharide vaccine.

immunisation
The safest way to protect children and adults

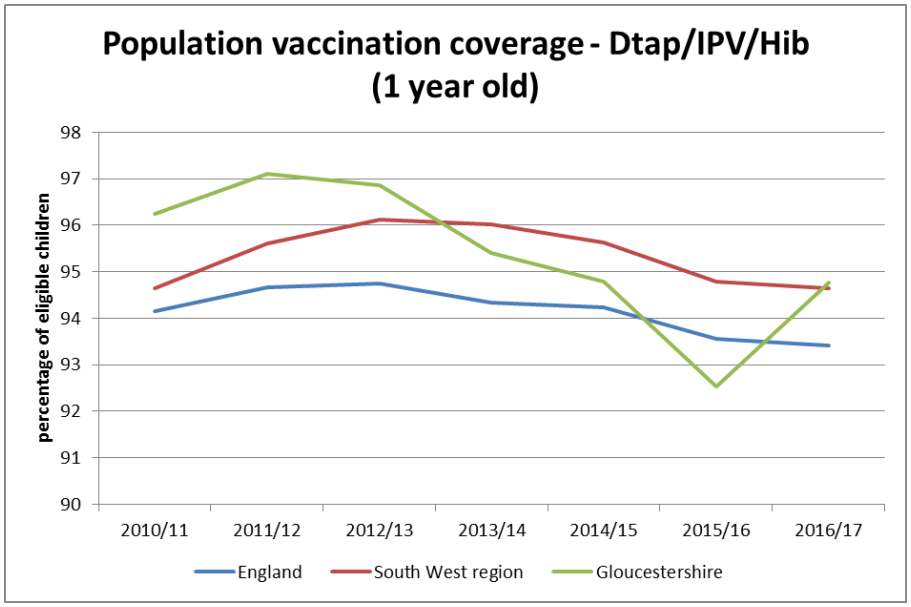
NHS

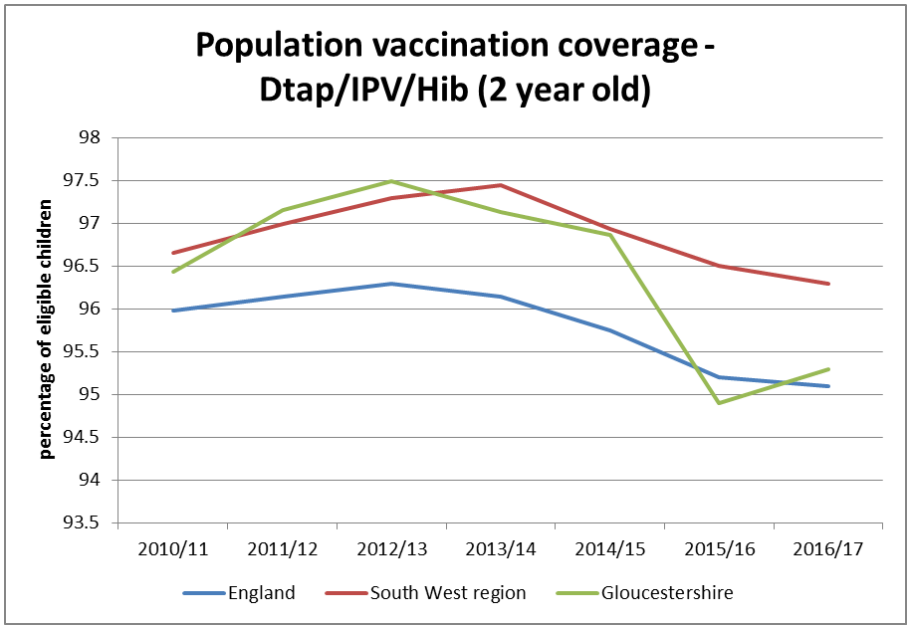
Epidemiological Data Review

Immunisation uptake rates and trends for a number of childhood vaccinations are given below.

Dtap/IPV/Hib

The 5-in-1 vaccine was used in the UK for many years. In late September 2017 the UK replaced it with a 6 in 1 vaccine for all babies born on or after 1st August 2017. This vaccine gives protection against diphtheria, tetanus, whooping cough (pertussis), polio and Hib disease (*Haemophilus influenzae* type b). Before vaccines existed, these diseases used to kill thousands of children in the UK every year The 6-in-1 vaccine also gives protection against hepatitis B, a cause of serious liver disease. Data for the 5in 1 vaccine is given here as this is the best currently available data.





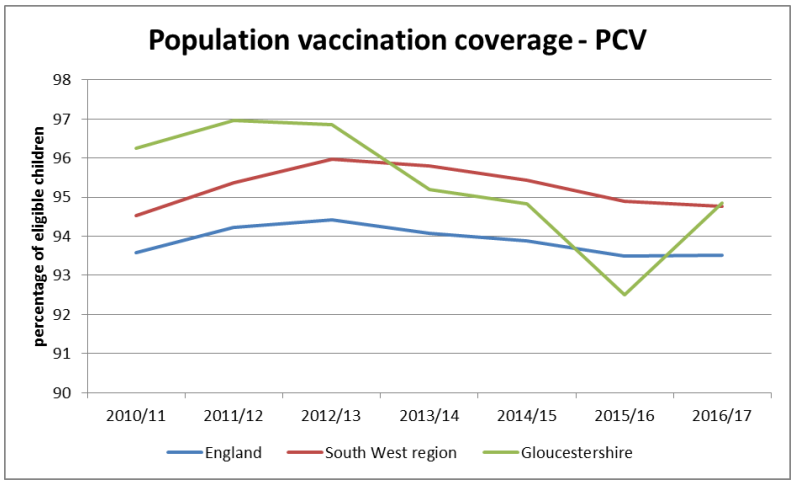
While national and regionally there has been a drop off in vaccination coverage since 2012-/13, the rate of decline in Gloucestershire has been steeper and in 2015/16 Gloucestershire dipped

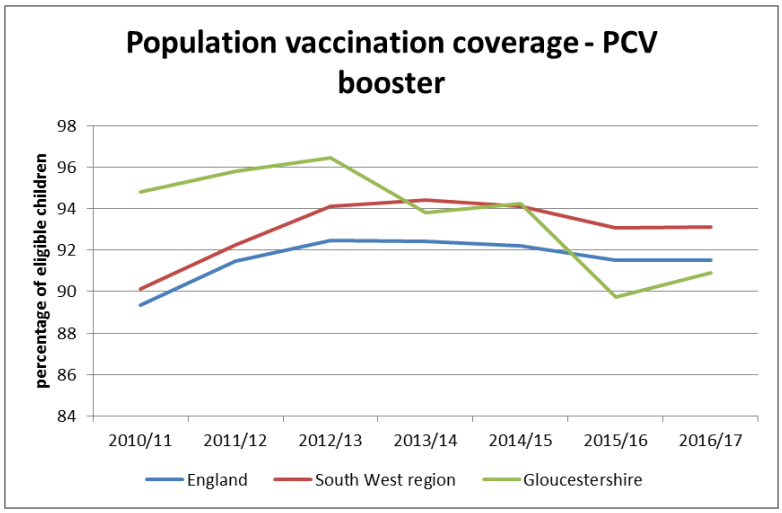
below the WHO recommended 95% coverage rate for both 1 and 2 year olds. There has been a recent increase in coverage for 2016/17. This uptick has not been seen in either the regional nor national comparators and may be die to a catch up programme run locally to try to increase vaccine coverage rates.

Pneumococcal Conjugate Vaccine

The PCV used in the UK gives protection against 13 types of pneumococcal bacteria that all cause pneumococcal disease. There are over 90 different types of pneumococcal bacteria, and they cause a range of problems including ear infections and pneumonia (serious chest infections). Pneumococcal disease can also cause life-threatening conditions such as meningitis and septicaemia (blood poisoning). Vaccines have been produced to protect against the types that cause the most disease. In the UK the PCV is given to all babies at 2, 4 and 12-13 months of age.

A declining rate of coverage is seen for both the PCV vaccination given at 8 weeks and the booster vaccination given at 12 months. Gloucestershire had declined more steeply than its national or regional comparators and fell below the herd immunity threshold in 2015/16. In 2016/17 an increase in coverage levels was seen brining Gloucestershire back in line with its comparators at 8 weeks but still lower for booster uptake.

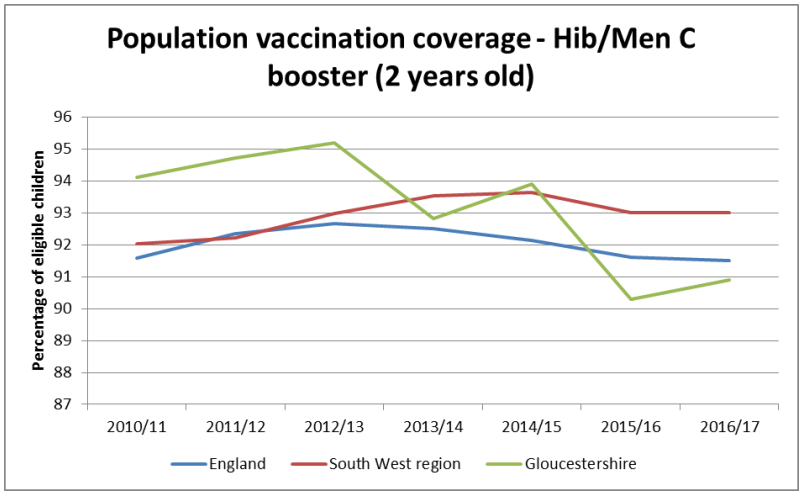


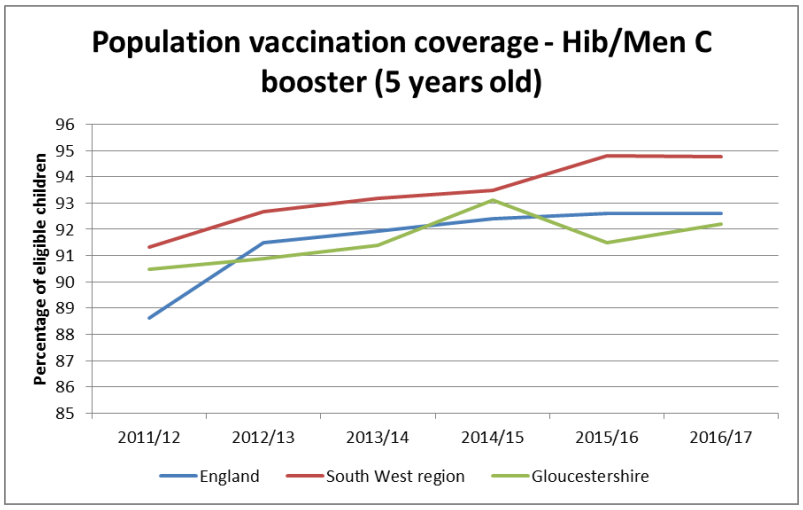


Hib/Meningitis C

The Hib/MenC vaccine used in the UK boosts protection against against Hib disease, and protects against meningococcal disease caused by type C *Neisseria meningitidis* bacteria.. *Haemophilus influenzae* type b (Hib) is a bacterium which can cause a range of very serious diseases, particularly in children under the age of 5. There are very few cases of Hib disease in older children and adults. 60% of cases of Hib disease result in meningitis, often with septicaemia (severe blood poisoning). 15% of cases result in epiglottitis (inflammation of the epiglottis). In the UK this vaccinations is given at 12-13 months

As with many other vaccines discussed in this section a pattern of declining coverage was seen in 2 year olds until 2016/17 when coverage started to increase again. It still remains below national and regional comparators and below the threshold for herd immunity. In five year olds there is a minimal increase in booster coverage above and beyond the levels seen at 2 years old. Despite recent upward trends Gloucestershire remains below the regional average.

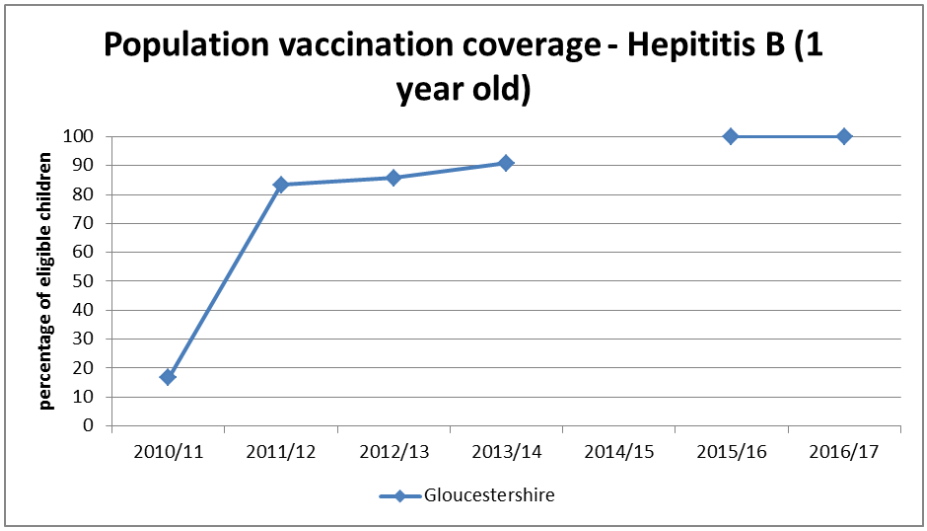




Hepatitis B

The hepatitis B virus is a major cause of serious, life-threatening liver disease, including liver cancer and cirrhosis (scarring of the liver caused by long-term liver damage).

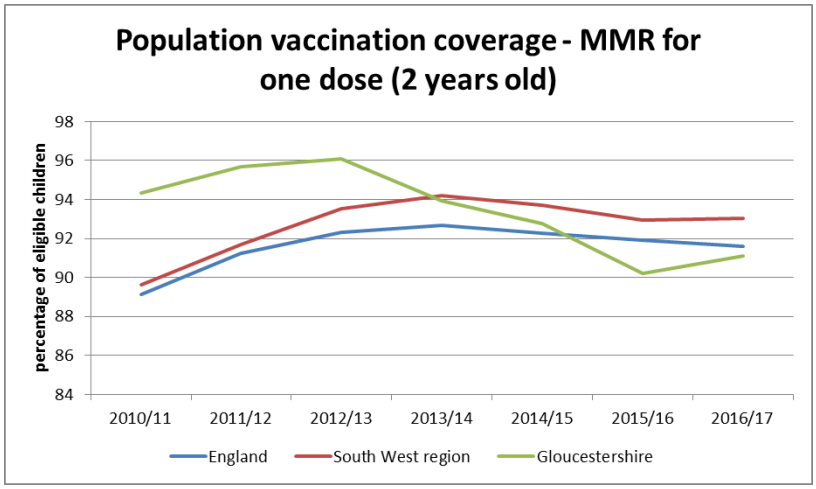
Hep B is now a routine vaccination as of autumn 2017. Historically it was only given to those with an identified risk. While there was a gap in data recording in 2014/15 it is encouraging to note that in the last two years of available data Gloucestershire had vaccinated 100% of children within the first 12 months of their life.

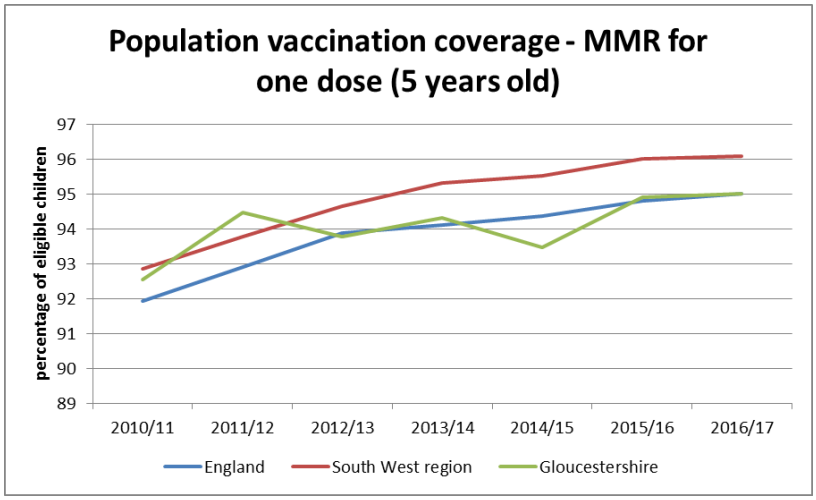


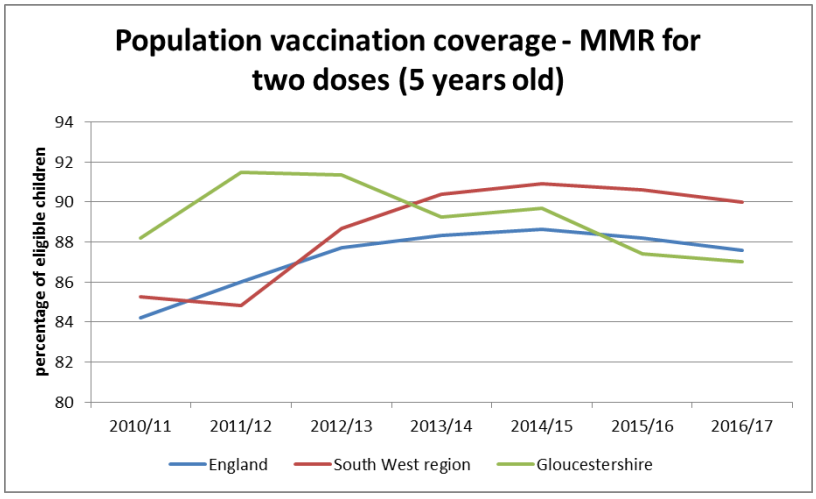
Measles Mumps and Rubella (MMR)

The MMR vaccination is designed to protect against measles, mumps and rubella. These infections can have life changing consequences. One dose of the vaccine confers some immunity but two doses are needed for full immunity.

As with a number of the vaccinations already discussed, MMR one dose coverage at 2 years was falling and was below comparator levels. Encouragingly there has been a recent increase in uptake and Gloucestershire is coming back in line with the national average (although still below regional peers). At 5 years old the around 94% of the population has had one MMR dose. However, for full protection 2 doses are needed and, while the recent decline in coverage rates has slowed, at around 87% uptake is still below the level needed for herd immunity.







In contrast, the two dose uptake at 5 years old lies around 87%. This is far below the level needed for herd immunity. In recent months there have been a number of local measles outbreaks and a number of children have been hospitalised. This causes a negative impact on the individual both in terms of health and days lost from school, the family in terms of stress and absence from work and the wider community in terms of considerable impact on the health service and health protection

system and lost productivity. In a recent local measles outbreak a significant proportion of cases were admitted to intensive care.

'Flu Vaccination Programme

Influenza (flu) is a very common, highly infectious disease caused by a virus. It can be very dangerous, causing serious complications and death, especially for people in risk groups. In rare cases flu can kill people who are otherwise healthy. In the UK an average of 600 people a year die from complications of flu, but in some years this can rise to over 10,000 people. Flu leads to hundreds of thousands of GP visits and tens of thousands of hospital stays a year.

The flu virus is very variable and changes over time. Each year there are different strains around, and a new vaccine has to be prepared to deal with them. Vaccination from previous years is not likely to protect people against current strains of flu.

There are three basic types of flu: A, B and C. Type A is the most dangerous; it is the one that can cause serious disease and also triggers worldwide pandemics. Type C causes mild disease. Type B can make you feel very ill, but it has never led to a worldwide pandemic.

In 2017/18 the flu campaign was for the first time delivered in school settings to all children in reception to year 4. Over 62% of children had received a vaccination by the end of January 2018. Children outside of this cohort with additional medical needs (that meant they were more at risk of developing flu) were also offered a vaccination and a further 184 vaccinations were delivered to this population.

In the UK, pregnant women are eligible to receive a free flu vaccination. Compared to the general population, pregnant women are more likely to be hospitalised and require admission to an intensive care unit due to influenza virus infection. For pregnant women who are hospitalised following flu, increased rates of preterm birth and fetal/neonatal death are reported. In 2016/17 47% of pregnant women received the seasonal flu vaccination which is below the target of 55%.

Qualitative Data Review

The word cloud below collates recent feedback from children, young people and parents in receipt of immunisation services. As can be seen from the largest words the feedback suggests that the service is well regarded by users.

It seems that the service is generally well regarded so issues with vaccine uptake may relate to more upstream issues.

Local Service Provision

Pre-school immunisations are promoted across health services but delivered by Primary Care and scheduled by the Child Health Information Service . As of 2016/17 the school 'flu programme is delivered in schools.

The BCG immunisation programme for protection against Tuberculosis is hosted by Gloucestershire Care Services (GCS) who receive referrals for any child or young person who is registered with a GP in Gloucestershire that meets the' at risk' criteria. These vaccinations are delivered in a clinic setting by the GCS Immunisation team. The team is supported by a tuberculosis nurse specialist for children over 6 years who require additional Manteaux testing.

School aged immunisations (see schedule earlier) are also delivered by the GCS Immunisation team. These are predominately school-based programmes. However, community clinics and home visits where required are also provided and the team work closely with other partnership services to support children with additional needs or home schooling to ensure all children and young people are offered the opportunity for immunisation.

In 2017/18 the flu campaign was for the first time delivered in school settings to all children in reception to year 4. Over 62% of children had received a vaccination by the end of January 2018. Children outside of this cohort with additional medical needs (that meant they were more at risk of developing flu) were also offered a vaccination and a further 184 vaccinations were delivered to this population.

Evidence around What Works

NICE has performed an extensive evidence review to inform their recommendations around increasing vaccination uptake. The recommendations can be summarised as follows:

- Ensure there is an identified healthcare professional in every GP practice who is responsible – and provides leadership – for the local childhood immunisation programme.
- Ensure all staff involved in immunisation services have access to the Green book. Also ensure updates to the childhood immunisation programme and schedule are monitored and services adapted appropriately.
- Ensure there is an identified person responsible for coordinating the local hepatitis B vaccination programme for babies at risk of hepatitis B infection.
- Develop and implement a clear process for the local infant hepatitis B vaccination programme.
- Ensure antenatal, postnatal, neonatal, paediatric, primary care and community support teams communicate effectively and share information so that the children and families affected can be contacted and followed up.
- Improve access to immunisation services. This could be achieved by extending clinic times, ensuring children and young people are seen promptly and by making sure clinics are child- and family-friendly.
- Ensure enough immunisation appointments are available so that all local children and young people can receive the recommended vaccinations on time.
- Send tailored invitations for immunisation. When a child or young person does not attend appointments, send tailored reminders and recall invitations and follow them up by telephone or text message.
- Provide parents and young people with tailored information, advice and support to ensure they know about the recommended routine childhood vaccinations and the benefits and risks. This should include details on the infections they prevent. Information should be provided in different formats, for example, for those whose first language is not English.
- Ensure parents and young people have an opportunity to discuss any concerns they might have about immunisation. This could either be in person or by telephone and could involve a GP, community paediatrician, health visitor, school nurse or practice nurse.
- Ensure young people fully understand what is involved in immunisation so that those who are aged under 16, but considered sufficiently capable, can give their consent to vaccinations, as advised in the 'Green book'.
- Ensure young people and their parents know how to access immunisation services.
- Consider home visits to discuss immunisation with parents who have not responded to reminders, recall invitations or appointments. Offer to give their children vaccinations there and then (or arrange a convenient time in the future). Such visits could include groups that may not use primary care services, for example, travellers or asylum seekers.
- Check the immunisation status of children and young people at every appropriate opportunity. Checks should take place during appointments in primary care (for example, as part of a child health review), hospital in- or outpatient and accident and emergency departments, walk-in centres or minor injuries units. Use the personal child health record (PCHR, also known as the 'Red book') as appropriate. If any vaccinations are outstanding:

    - discuss them with the parent and, where appropriate, the young person. Where they have expressed concerns about immunisation and this is documented, these appointments should be used as an opportunity to have a further discussion
    - offer vaccinations by trained staff before they leave the premises, if appropriate. In such cases, notify the child or young person's GP, health visitor or local child health information department so that records can be updated
    - and, if immediate vaccination is not possible, refer them to services where they can receive any outstanding immunisations.
- Ensure health professionals who deliver vaccinations have received training that complies with the 'National minimum standard for immunisation training
- Ensure staff are appropriately trained to document vaccinations accurately in the correct records
- Raise awareness of the National immunization schedule
- Encourage a campaign warning mothers of the dangers of opting out of or not adhering strictly to the National immunization programme.
- The Healthy Child team, led by a health visitor working with other practitioners, should check the immunisation record (including the personal child health record) of each child aged up to 5 years. They should carry out this check when the child joins a day nursery, nursery school, playgroup, BSiL children's centre or when they start primary school. The check should be carried out in conjunction with childcare or education staff and the parents.
- School nursing teams, working with GP practices and schools, should check the vaccination status of children and young people when they transfer to a new school or college. They should also advise young people and their parents about the vaccinations recommended at secondary school age.
- If children and young people are not up-to-date with their vaccinations, school nursing teams, in conjunction with nurseries and schools, should explain to parents why immunisation is important. Information should be provided in an appropriate format (for example, as part of a question and answer session). School nursing teams should offer vaccinations to help them catch up, or refer them to other immunisation services.
- Head teachers, school governors and managers of children's services should work with parents to encourage schools to become venues for vaccinating local children. This would form part of the extended school role.

Discussion, Gap Identification and Recommendations

Strengths in this area:

- Strong delivery of Hep B vaccine to eligible children (100% coverage)
- MMR catch up programme showing some signs of effectiveness
- Postitive service user feedback

Areas of Concern

- The recent downward trend in vaccination coverage for MMR and DtaP/IPV particularly is an area of deep concern especially as coverage has dropped below the WHO targets of 95%. While there has been a recent upturn in coverage trends the levels remain lower than optimal.
- Recent outbreak of measles in the UK which is affecting Gloucestershire due to low MMR uptake

Recommendations

Continue to push for improvements in vaccination coverage by using a universal offer and targeted programmes where appropriate. Early indicators are that this approach is bearing fruit.

Support the new local SCRIMMS inequalities post to identify local inequalities in vaccination delivery and implement recommendations that come out of this work.

Early Years and Primary School

Early Years and Primary School

"The best possible health underpins a child's or young person's ability to flourish, stay safe and achieve as they grow up. Good health and emotional wellbeing are associated with improved attendance and attainment at school, which in turn lead to improved employment opportunities"
Healthy Child Programme 2009

A) Emergency Admissions, Accidents and Acute Illness

Introduction

This section covers the related issues of A&E attendances (either for accidents or acute illness), and also the emergency admissions to hospital that arise from an A&E visit if the patient is not discharged home following treatment.

A&E attendance is usually for acute illness or accidental injury. Nearly a quarter of all those attending Accident and Emergency (A&E) are aged under 16, and the number of attendances and emergency admissions is rising for this age group[25][26]. Reasons for A&E attendance can be complex, and are often led by the parent's perception of the child's condition.

Perceptions about illness severity and misconceptions about being unable to access a GP quickly are identified as the biggest reasons for avoidable attendances[27] [28]As a result, children who are acutely unwell with non-emergency problems often seek unplanned care for conditions which could be easily treated in primary care[29].These conditions include feverish illness, diarrhoea, vomiting, rash and abdominal pain. Between 2000 and 2011, NHS hospital admission data for children aged less than 15 years noted that more than half of short-stay admissions were for potentially avoidable infectious and chronic conditions[30].

As well as illness, accidents can also be a reason for attending A&E. Attendances in children aged under five years are commonly caused by accidental injuries and, hospital admissions among under-5s following an accidental injury, have been rising by five per cent per annum[31]. Accidental injuries

[25] Gill, P.J., et al., *Increase in emergency admissions to hospital for children aged under 15 in England, 1999–2010: national database analysis.* Archives of disease in childhood, 2013: p. archdischild-2012-302383.
[26] Clements, K., *Opening the door to better healthcare: ensuring general practice is working for children and young people.* London: National Children's Bureau, 2013.
[27]Prince, M. and C. Worth, *A study of 'inappropriate'attendances to a paediatric accident and emergency department.* Journal of Public Health, 1992. **14**(2): p. 177-182
[28] Williams, A., P. O'Rourke, and S. Keogh, *Making choices: why parents present to the emergency department for non-urgent care.* Archives of disease in childhood, 2009. **94**(10): p. 817-820.
[29] Dale, J., et al., *Primary care in the accident and emergency department: I. Prospective identification of patients.* Bmj, 1995. **311**(7002): p. 423-426.
[30] Cecil, E., et al., *Impact of UK Primary Care Policy Reforms on Short-Stay Unplanned Hospital Admissions for Children With Primary Care–Sensitive Conditions.* The Annals of Family Medicine, 2015. **13**(3): p. 214-220.
[31] RoSPA (2013) Delivering Accident Prevention at a local level in the new Public Health System

are a major cause of death and disability among children under five years in England. These injuries (majority of which are preventable) tend to happen in and around the home.

Childhood accidents and injuries are linked to several factors including: child development, the physical environment in the home, knowledge and behaviour of parents and other carers (including literacy), overcrowding or homelessness, availability of safety equipment; and new consumer products in the home. Children from poorer backgrounds are more likely to die as a result of an unintentional injury than children from better off families[32].

High A&E attendance and high rates of emergency admissions put a burden on the health system. Approximately 35% of all admissions in the NHS in England are classified as emergency admissions, costing approximately £11 billion a year. Admitting a patient to hospital as an emergency case is costly and frequently preventable, yet the number of emergency admissions to hospital has been rising for some time. From a public health point of view, emergency admissions data gives an indication of wider determinants of poor health, linked to areas such as housing and transport[33]. Falls account for the majority of non-fatal accidents while the highest numbers of deaths are due to fire[34].

The available data, policy documents and discussion of the issues in this section will cover the full age spectrum of this report (0-25). This is to aid coherence and avoid duplication over multiple sections.

Policy Context

Emergency Attendance and Admissions:
The *Urgent and Emergency Care Review* concluded that with rising demand and greater costs, the urgent and emergency care system is requiring ever increasing resources annually, and that the currently fragmented services are confusing to patients who may find it difficult to access appropriate care when they need it. As in childhood obesity, they advocate the adoption of a whole-system approach to commissioning more accessible, integrated and consistent urgent and emergency care services to meet patient's unscheduled care needs [35].

Accidental Injury:
Action to reduce unintentional injury is aligned with the overall vision for the public health system as set out in the Public Health Outcomes Framework, contributing to the two high level outcomes of – Increased healthy life expectancy, and reduced differences in life expectancy and healthy life expectancy between communities.

Unintentional injury to children is a major public health concern causing a significant cost to health, social care and education. NHS Evidence has published a summary of selected new evidence

[32] Department of Health (2012), Annual Report of the Chief Medical Officer. Our children deserve better: Prevention pays
[33] PHE fingertips
[34] RoSPA
[35] NHSEngland, *Transforming urgent and emergency care services in England - Urgent and Emergency Care Review - End of Phase 1 Report*. 2013

regarding strategies to prevent unintentional injuries among children and young people under 25[36]. NICE has issued three PH guidance documents on unintentional injuries;

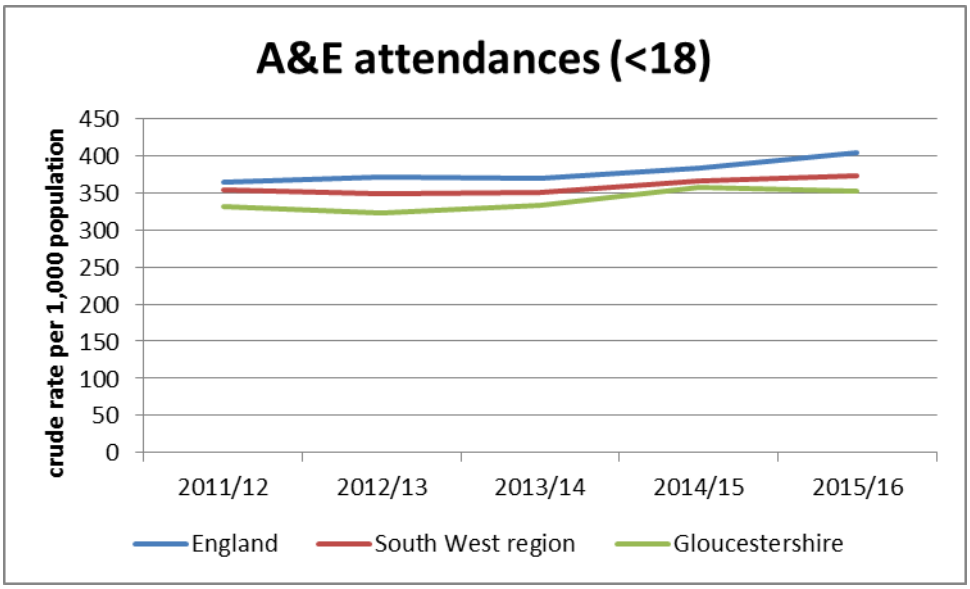
- Unintentional injuries on the road: interventions for under 15s [PH31],
- Unintentional injuries in the home: interventions for under 15s PH30 and
- Unintentional injuries: prevention strategies for under 15s [PH29]

Epidemiological Data Review

Emergency Attendances and Admissions

A&E attendance data

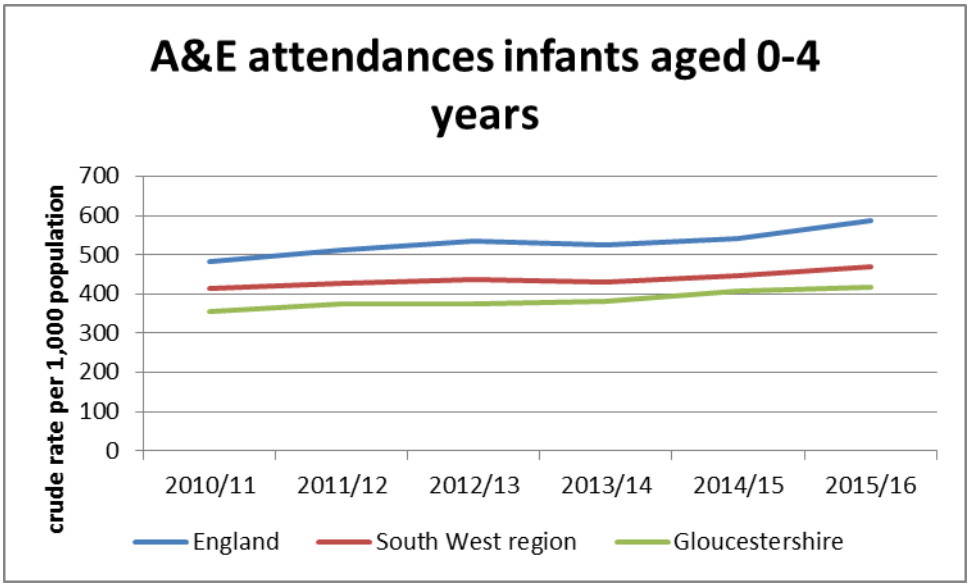
A&E attendances for young people in Gloucestershire remain lower than those for the regional peers and lower than the England average. Trend data shows that the trend in Gloucestershire is worsening, suggesting that rates of attendance are increasing faster than nationally although there is some evidence of a recent plateau.



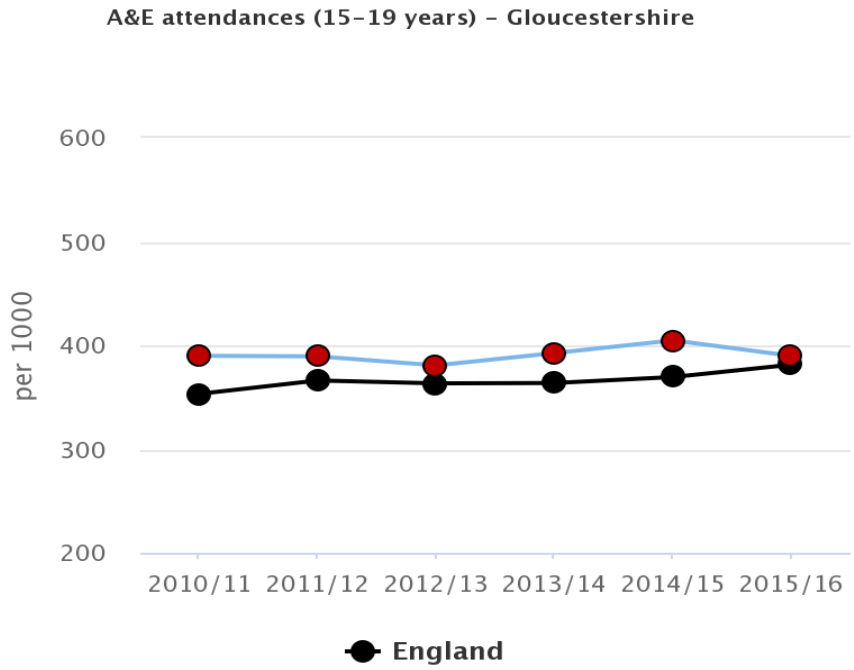
While the overall picture is positive, looking at attendance data for different age groups shows a varied pattern with some age groups performing well and others significantly less well.

[36] NHSEvidence, Strategies to prevent unintentional injuries among children and young people aged under 15. 2013.

In line with the rest of the UK, A & E attendances in children aged 0-4 years in Gloucestershire have seen a steady increase in rate over the past 5 years. Overall however, the latest data show that Gloucestershire still performs statistically better than the national average. This is illustrated below



At the other end of the age spectrum, in 15-19 year olds the rates of A&E attendances are significantly higher than the national average. This higher rate has been a consistent feature over the last 5 years. This is shown in the graph below.



This high attendance rates in older teenagers is concerning. The driving factor behind this is not known but could be investigated further as this is likely to be a key demographic to target to reduce overall emergency attendance. This age group may be choosing to attend without consulting their parents and the high attendance rates might indicate a lack of familiarity with how the health system works.

Emergency hospital admissions

Generally, an A&E attendance can result in discharge home following treatment or an emergency admission to hospital. In Gloucestershire, children may also be referred to the Paediatric Assessment Unit (PAU). All attendances at eh PAU are coded as admissions. Not all areas follow this practice and this makes it harder to benchmark performance against other units some of whom are using different coding practices.

As for A&E attendances, the rate of emergency admissions in 0-19 year olds as a whole in Gloucestershire is significantly lower than the national average. However, the comparative performance across age groups is variable with emergency admissions in the 1-4 age group being statisatically worse than the national average, emergency admission rates in 15-19 year olds are in line with the national average and those for 5-14 year olds are better than the national average. The data is summarised in the spine chart below.

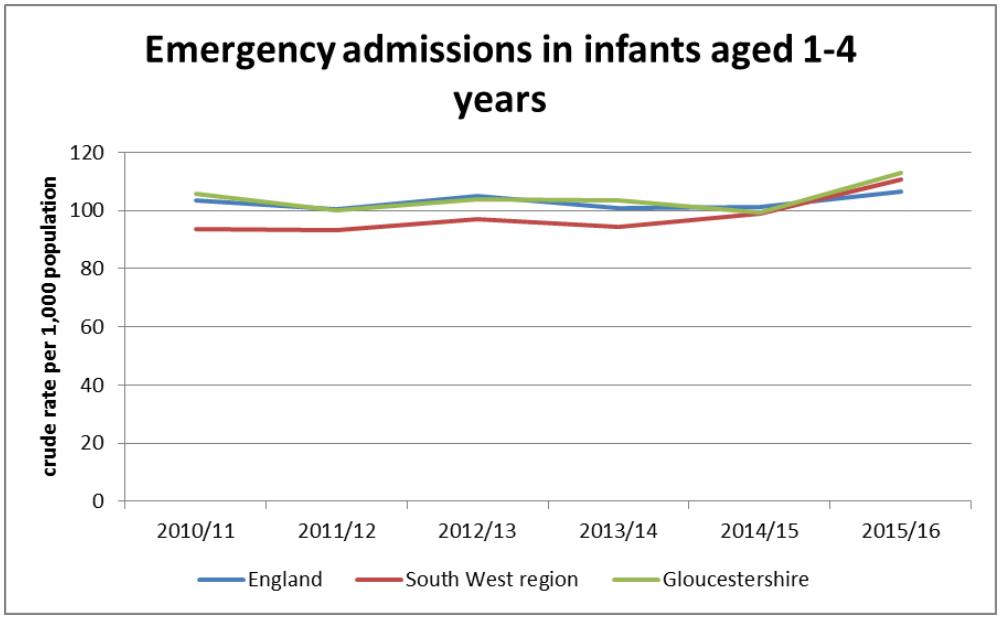
Export table as image

Benchmark Value

Worst/Lowest 25th Percentile 75th Percentile Best/Highest

Indicator	Period	Glouc'shire		Region	England	England		
		Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Emergency admissions (aged 1-4)	2015/16	3,186	113.1	110.6	106.5	202.1		39.0
Emergency admissions (rate per 1000 population) 5-9	2015/16	1,358	38.7	40.0	41.1	80.5		17.5
Emergency admissions (rate per 1000 population) 10-14	2015/16	1,187	35.9	38.1	39.1	75.4		20.4
Emergency admissions 15-19	2015/16	1,861	51.4	56.0	53.7	93.9		28.1
Emergency admissions 15-17	2015/16	1,076	49.3	54.2	49.7	85.6		22.3
Emergency admissions under 18 years	2014/15	8,518	68.8	69.6*	73.3	131.9		38.1
Emergency admissions 0-19	2015/16	9,987	71.7	74.2	73.8	139.4		33.8

Looking at the trend data shows that the worse rate of emergency admissions in 1-4 year olds is a recent development. While the rate of emergency admissions in this age group in England has remained relatively static over the last 5 years, the rate has had an upward trend locally (and in the south west) since 2013/14. Some of this may be due to coding PAU attendance as an admission. Internal data suggests that the majority of PAU admissions are less than 4 hours suggesting minor issues that in other areas would not be coded as an admission.



When compared with statistical neighbours[37], as opposed to geographic neighbours this comparatively raised rate of admissions is also seen.

Emergency Admissions (rate per 1,000 populations) aged 0-4

Area	Value	Lower CI	Upper CI
England	155.0	154.6	155.4
Gloucestershire	160.5	156.3	164.8
Wiltshire	131.5	127.4	135.8
Bath and North East Som...	174.3	166.0	182.9
West Sussex	132.8	129.6	136.1
Dorset	172.6	166.8	178.6
Cambridgeshire	137.9	134.2	141.6
Devon	179.0	174.8	183.2
Shropshire	184.8	178.0	191.8
Hampshire	126.5	124.0	129.1
South Gloucestershire	101.4	96.6	106.4
Worcestershire	153.9	149.6	158.3

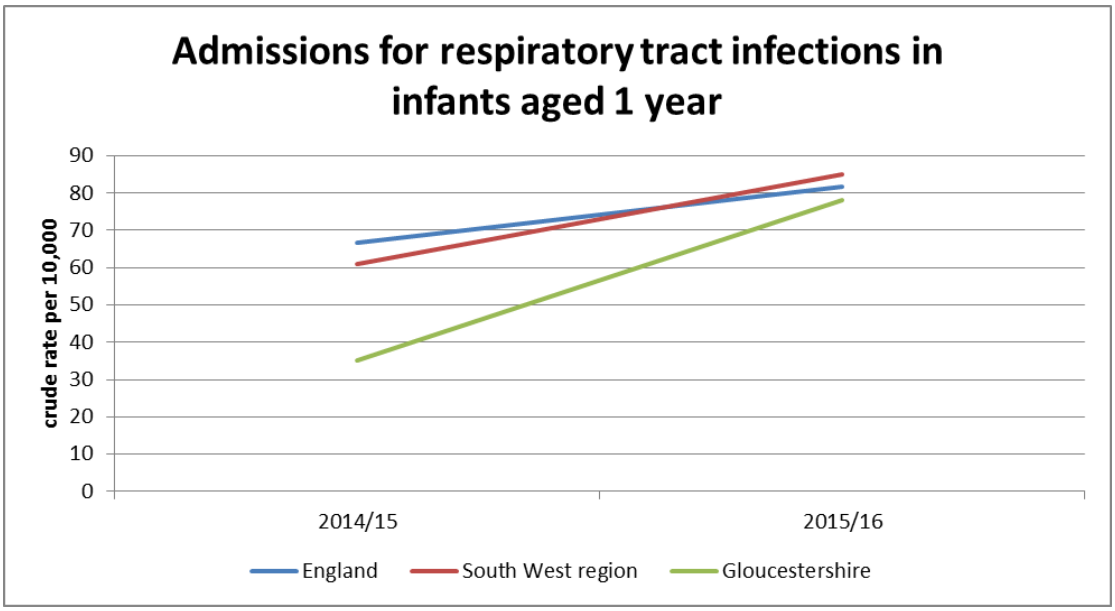
Compared with benchmark Better Similar Worse

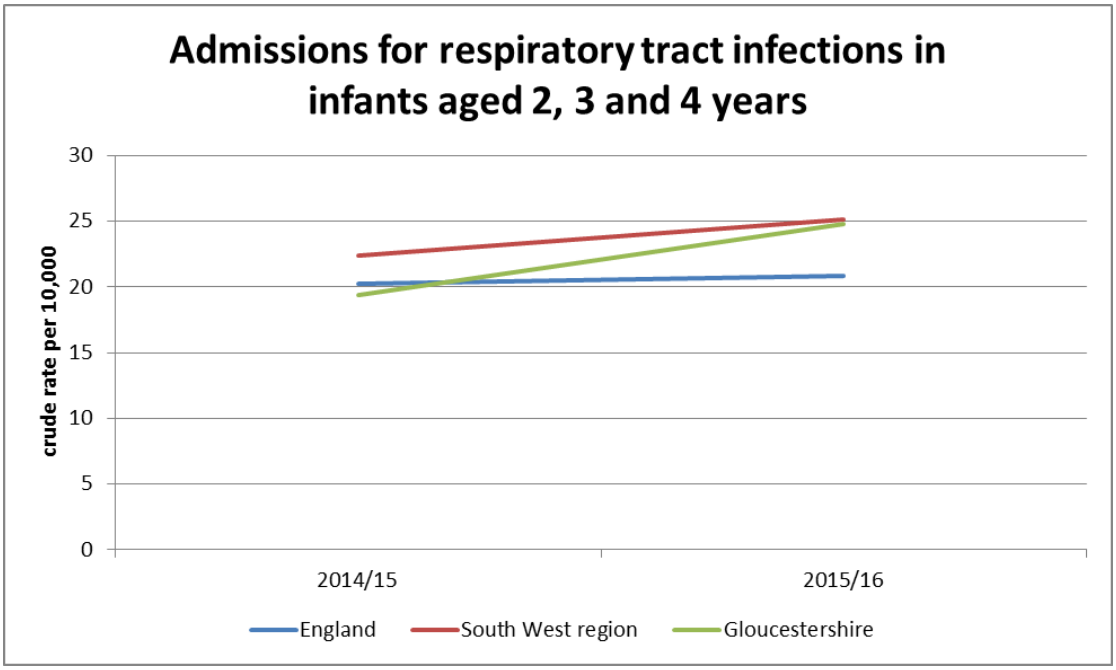
The reason for this higher rate of emergency admissions is not clear. It is significant because, admitting a patient to hospital as an emergency case is costly and frequently preventable. From a public health point of view, emergency admissions data also gives an indication of wider determinants of poor health, linked to areas such as housing and transport.

[37] CSSNBT- Children Services Statistical Neighbours Benchmarking Tool

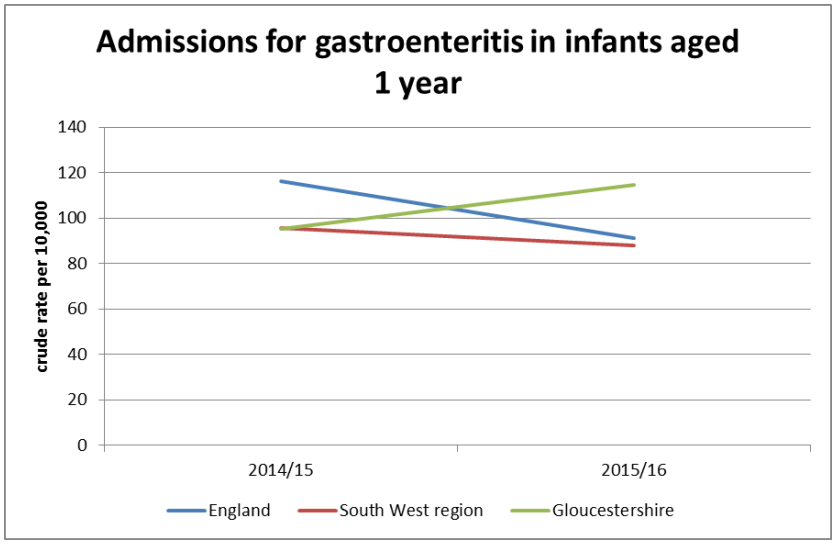
Over one quarter of emergency hospital admissions in children aged under 5 years in 2014/15 were for respiratory infections. Factors such as smoking in the home and damp housing are known to increase the risk and severity of respiratory infections in young children.

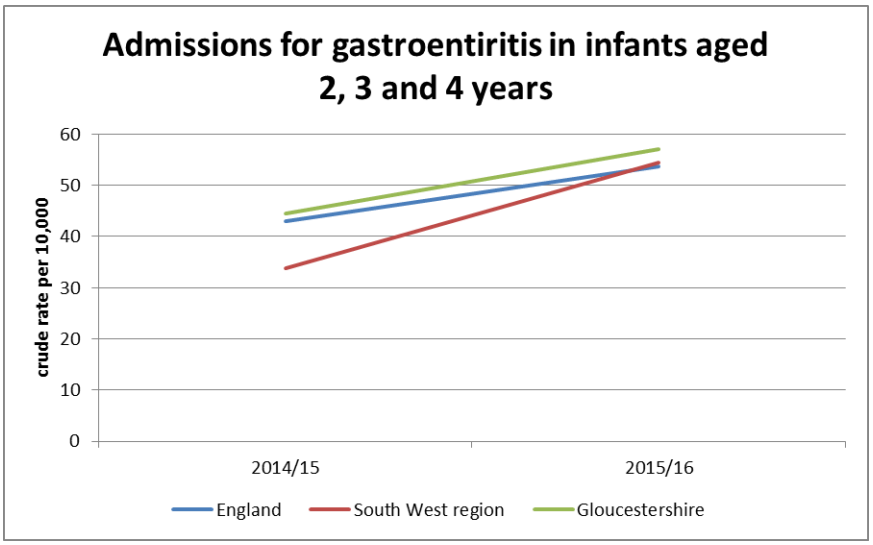
Gloucestershire has seen a rate of emergency respiratory admissions in this age group that is growing faster than the national average. This increase has been particularly marked in the less than 1 year olds as is shown in the two graphs below.





Another common reason for emergency admission to hospital in the0-4s is gastroenteritis. Similar to the pattern observed in respiratory illness in this age group the rates of admission in Gloucestershire have been increasing. In the less than one year olds the crude rate of admissions is rising while in comparator groups it is falling. This contrary trend and poor is an area of concern.





Both the respiratory and gastroenteritis admission data are downstream indicator of success in treatment outside hospital for types of childhood illness that have limited morbidity or need for hospital-based care.

From this data it appears Gloucestershire may need to improve pre hospital options. Treatment and prevention options for these illnesses include encouraging breast feeding, better diet, hygiene, and management of infections; better support for young parents in the care of their children and in the management of illnesses in the home; providing support as well as facilitating access to health advice and therapy through NHS Choices or NHS 111; and enhanced primary care services. The weak performance in these indicators locally suggests that more work is needed in this arena.

Hospital admissions for accidental (non intentional) and non-accidental injuries in children

Alongside illness, injuries accidental or otherwise, are another leading cause of hospitalisation and represent a major cause of premature mortality for children and young people. They are also a source of long-term health issues, including mental health related to experience(s)[38]. Non accidental injuries in older children/young people will be considered in the young people's section on self harm.

Gloucestershire fares better than most of its statistical neighbours when comparing hospital admissions for accidental and non-accidental injuries in children under 5.

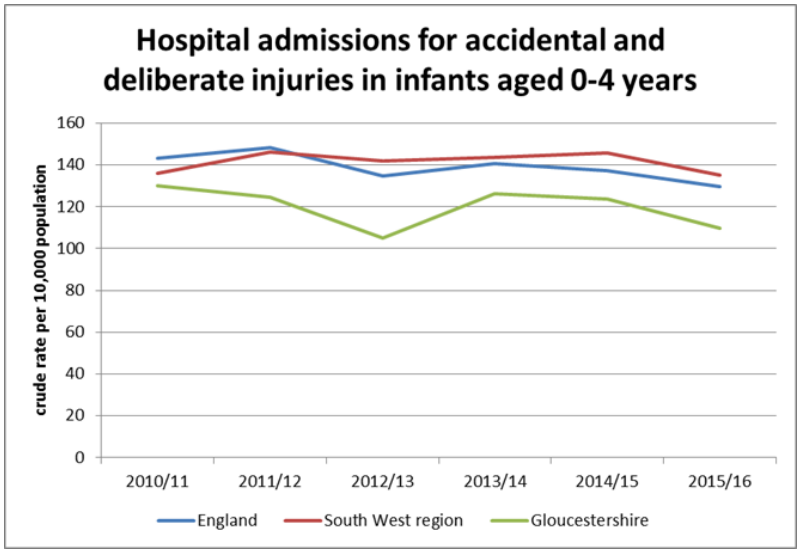
Hospital admissions for accidental and deliberate injuries in children (aged 0-4) 2015/16

Area	Value	Lower CI	Upper CI
England	129.6	128.4	130.8
Gloucestershire	109.8	99.1	121.4
Wiltshire	124.7	112.0	138.4
Bath and North East Som...	159.0	134.8	186.4
West Sussex	133.8	123.6	144.5
Dorset	149.8	133.1	168.1
Cambridgeshire	105.2	95.2	116.0
Devon	123.1	112.2	134.6
Shropshire	156.6	137.3	177.9
Hampshire	117.8	110.3	125.7
South Gloucestershire	108.8	93.4	126.0
Worcestershire	138.2	125.6	151.7

Source: Hospital Episode Statistics (HES)Statistics (ONS) - Mid Year Population Estimates

Compared with benchmark Better Similar Worse

When compared with the south west region and the rest of England it can be seen that this better than average performance has been maintained over time.



[38] NICE (2012) Local Government Briefing-NICE guidance and Public health outcomes

Road Traffic injuries

Road traffic injuries are an avoidable cause of accidents. The PHE Fingertips spine chart below considers the contribution that road traffic accidents make to childhood mortality and serious injury. Road traffic accidents are considered a potentially modifiable factor in death or serious injury and thus are an area where interventions could have an impact. They also account for a sizeable proportion of child death or serious injuries (56 in 2014-2016). As can be seen below, Gloucestershire remains in line with the national average and is not significantly different.

Spine chart to show Gloucestershire performance in child mortality and rates of children killed or seriously injured on roads.

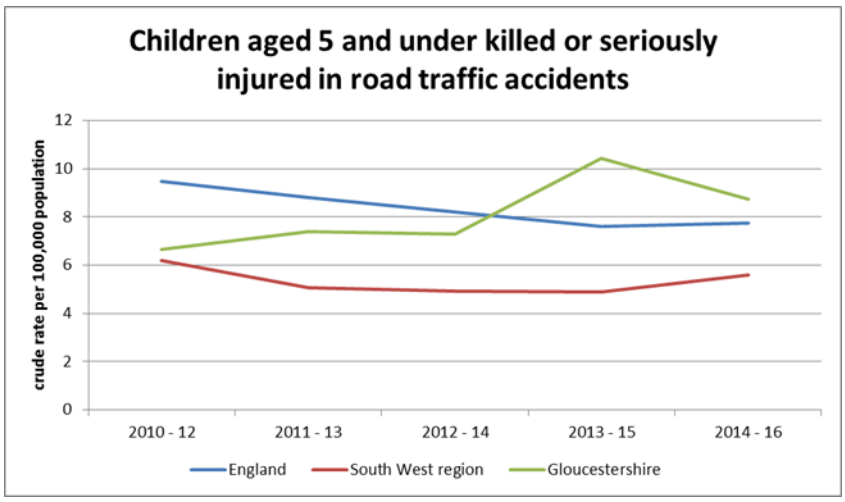
Compared with benchmark Better Similar Worse Not Compared

Benchmark Value

Worst 25th Percentile 75th Percentile Best

Indicator	Period	Glouc'shire			Region	England	England		
		Recent Trend	Count	Value	Value	Value	Worst	Range	Best
Child mortality rate	2013 - 15	–	47	13.1	10.5	11.9	20.7		6.5
Children aged 6-10 killed or seriously injured in road traffic accidents	2014 - 16	–	9	8.7	11.1	14.8	64.7		0.0
Children aged 11-15 killed or seriously injured in road traffic accidents	2014 - 16	–	36	35.8	26.1	32.6	84.9		0.0
Children killed and seriously injured (KSI) on England's roads	2014 - 16	–	56	16.9	13.5	17.1	46.8		1.3

As can be seen in the graph below Gloucestershire rates are higher then national and regional comparators. Due to small numbers the confidence intervals around these figures are large and it should be noted that the observed difference is not statistically significant.



Local Service Provision

Gloucestershire has two accident and emergency departments, one in Gloucester Royal and one in Cheltenham General. In addition there are 8 minor injury and illness units as detailed below:

Minor Injury and Illness Unit locations	
Cirencester Hospital	8am – 11pm
Dilke Memorial Hospital	8am – 11pm
Lydney and District Hospital	8am – 11pm
North Cotswolds Hospital	8am – 8pm
Stroud General Hospital	8am – 11pm
Tewkesbury Hospital	8am – 8pm
Vale Community Hospital	8am – 8pm

To help guide people to the type of care they need and avoid unnecessary A&E visits Gloucestershire CCG run the Advice ASAP App service which provides advice on where to seek care.

Evidence around What Works

A combination of a number of factors are known to prevent accidents[39], some of these are:

Environmental :

Improvement in planning and design-results in safer homes and leisure areas, also adaptations such as fireguards and safety gates help to make the home environment safer.

Households at greater risks of unintentional injuries could also be prioritised (based on surveys, needs assessments and existing datasets) for home safety assessments and the supply and installation of home safety equipment[40]

Education:

Increasing the awareness of the risk of accidents in a variety of settings and providing information on ways of minimising these risks.

Staff working with children under five years are ideally placed to help reduce deaths and hospital attendances and admissions. There are opportunities to integrate safety advice within all contacts with parents. Equipping parents with an understanding of how a baby and young child will develop

[39] PHE 2014 Reducing unintentional injuries in and around the home among children under five years

[40] ibid

can help them to stay 'one step ahead' – anticipating future risks, for example one-to-one meetings with parents and during 'stay and play' in early year settings

Strengthen early years practitioners' knowledge and skills by specialist training is also key as the most effective home safety interventions are delivered by health care and social care professionals who have had specific training on injury prevention [41]

Empowerment:
Local consultation and community involvement can generate a strong sense of commitment and ownership. Accident prevention initiatives, which have been influenced by the community, are more likely to reflect local need and therefore encourage greater commitment.

Enforcement:
Legislation which relates to child safety- These regulations ensure that the purchased products meet a reasonable level of safety performance and that new dwellings meet an acceptable level of safety.

Discussion, Gaps and Recommendations

Strengths in this area:

- Gloucestershire is well provided for with 2 A&Es and 8 minor illness and injury units
- Performance is in line with or better than nationally on the majority of emergency attendance and admissions data

Areas of Concern

- Higher than national rates of A&E attendances in 15-19 year olds. This has not seen improvement in the last 5 years.
- High rates of emergency admissions in 0-4 year olds with worsening performance in Gloucestershire while national admissions data is seeing an improving trend
- High rates of road traffic accidents. These are often preventable causes of injury.

Recommendations

Review education opportunities around accessing medical care appropriately.

Improve performance in upstream factors that contribute to high rates of respiratory and gastro enteritis hospital admissions in0-4 year olds (See sections on smoking, breast feeding, child poverty)

[41] NICE (PH30)
Organisations such as the Royal Society for Prevention of Accidents (RoSPA) offer specialist training

B) Healthy Weight

Introduction

Obesity isn't just a Gloucestershire problem – it's a global one with the UK having the highest rate of child obesity in Europe. In England, a quarter of 2-10 year olds and one third of 11-15 year olds are overweight or obese[42] and, 2.9% of girls and 3.9% of boys in the UK have severe obesity[43].

Obesity is a complex issue influenced directly by what we eat and drink as well as our activity levels. Our ability to eat healthily and be active is influenced by over 100 factors or "wider determinants" of individual and family eating and physical activity habits. These factors are inter-related, operating together as a highly complex system. They include; mental health and wellbeing and the food and physical activity environments in which people live, work and play. A 'whole systems approach', which involved multiple interventions at different levels, is recommended to address obesity at population level. However, to date no country in the world has managed to successfully apply such an approach to reducing obesity levels.

Estimates suggest that without clear action, 6 out of ten UK children will be obese or overweight by 2050 and thus at risk of developing a range of serious physical and psychological health conditions.

However, obesity is preventable. . Evidence shows that habits acquired in early life influence later risk of obesity and that many risk factors for developing obesity originate during childhood[44], if these are unhealthy habits this can continue to the development of obesity through generations of families.

To aid continuity, and because of the interconnectedness of obesity risk factors and approaches throughout the life course, this section will consider obesity throughout childhood as opposed to splitting it into different sections for early years, childhood and youth. .

Definitions

What do we mean by the term healthy weight and obesity?

The term 'healthy weight' means that an individual's body weight is appropriate for their height and is not a risk to their health. Above the healthy weight range there are increasingly adverse effects. . Obesity is defined as a significant excess of body fat, which occurs gradually over time when energy intake from food and drink is greater than energy used through the body's metabolism and physical activity.

Measuring healthy weight, overweight and obesity

The recommended measure of overweight and obesity is body mass index (BMI). This is a ratio of height to weight; it does not directly measure body fat. In children BMI is adjusted for a child's age and gender against reference charts to give a 'BMI percentile' (or centile). This compares the child's BMI to other children of the same age and gender. For example, if a boy is eight years old and his

42 Public Health England (2014) Child Weight Data Factsheet
43 Ells, et al (2015)
44 Public Health England (2014) Child Weight Data Factsheet

BMI falls at the 60th percentile, that means that 40% of eight-year old boys have a higher BMI and 60% have a lower BMI than that child. Children with a BMI centile in the overweight and obese range are more likely to become overweight or obese adults. The UK BMI centile classifications for children's BMI are given below:

Table to show BMI centile classifications for children

Classification	**BMI Centile**
Underweight	<2nd centile
Healthy weight	2nd centile – 84.9th centile
Overweight	85th centile – 94.5th centile
Obese	≥95th centile

NOTE: The thresholds given in the table above are those conventionally used for population monitoring and are not the same as those used in a clinical setting, where overweight is defined as a BMI greater than or equal to the 91st but below the 98th centile and obese is defined as a BMI greater than or equal to the 98th centile.

Obesity is preventable and reversible–it's not an illness that appears suddenly; it's something that develops slowly over time. Maintaining a healthy weight is affected by a complex set of factors acting across many areas of our lives and there is no one single influence that dominates. Factors include societal factors, psychology, environment, biology (including genetics), food production and consumption and socioeconomics. Weight is affected by habits and beliefs, which in turn affect people's behaviour about healthy eating and activity. Culturally, 'unhealthy' food and activity behaviours have become the norm in modern Britain. This means that we struggle to identify ourselves as an unhealthy weight or to understand that our weight has any health consequences.

Causes of Obesity

At an individual level the main causes of obesity are poor diet and sedentary lifestyles. What we choose to eat and drink plays a significant role in causing obesity. The human body is efficient at storing energy from food as fat and has an evolutional desire for high-energy foods. Whilst this helped hunter gatherers to survive during times of famine, in today's modern societies there is an abundance of cheap, energy dense convenience foods and drinks. Economic factors can influence an individual's ability to choose a healthydiet or access opportunities to be active. There are also links

between our mental health and wellbeing; low mood, social isolation and people not feeling in control of the food and activity choices they make

The environment in which people live has become increasingly 'obesogenic' over recent decades, meaning that it promotes weight gain and discourages weight loss. Environmental factors affecting weight include the design of local neighbourhoods in terms of: whether they encourage and enable people to walk and cycle rather than drive, the accessibility of shops and public services and the availability of affordable good quality food and leisure and activity opportunities. (For more information see section on the built environment).

It is clear that children need to be supported within the context of their families to make and sustain behaviour change, as they have limited control over their own food and activity choice. This is particularly important in the early years where the likelihood of developing obesity is largely determined by the age of five. Interventions can be effective as early as preconception, where maternal health has a significant impact on foetal development and the health of the child later in life. Habits are laid down early and there is evidence that 80% of obese 10 to 14 year olds will become obese adults, increasing their risk of chronic disease, particularly if one of their parents is also obese. Intervening to prevent childhood obesity has a positive impact not just on the child but is also carried through into adulthood.

Who is most at risk

Whilst the prevalence of obesity is increasing in all communities, some sectors of the population are at greater risk.. They include:

- Children
- Individuals from particular Black Minority (BME) groups
- People living on a low income
- Women during and after pregnancy
- People with a mental health condition
- People with disabilities

Children aged 2–15 who have a long term limiting illness or disability are 35% more likely to be obese or overweight. For children with learning disabilities obesity is a particular issue, it is estimated that 24% of children with learning disabilities are obese.

Obesity and Inequalities

In line with the national picture, the distribution of childhood obesity within the county is associated with deprivation with children living in the most deprived neighborhoods being twice as likely to be obese than those living in the least deprived. These differences in levels of obesity are likely to lead to significant differences in adult health outcomes and life expectancy. Evidence suggests that the difference between the least and most deprived continues to widen; in other words the inequality is worsening.

Cost of obesity

Human cost:
Obesity in children can lead to the development of a range of serious physical and psychological health conditions including hypertension, early markers of cardiovascular disease, insulin resistance (leading to type 2 diabetes), bone and joint problems and a 40-50% increased risk of asthma as well as increased risk of obesity in adulthood. Without intervention obese children are likely to develop significant co-morbidities as young adults[45]. In addition to these health risks, children who are obese have lower levels of physical fitness, suffer from discrimination, school absence, low self-esteem and lower quality of life.

Financial Cost
The total cost of overweight and obesity to NHS Gloucestershire in 2010 was estimated by NICE at £149.1 million. The majority of these costs are incurred treating the consequences of obesity among adults.

Policy Context

National Context

National Childhood Obesity: A Plan for Action (2016) sets out the Government's approach for reducing childhood obesity over the next decade. The plan aims to significantly reduce England's rate of childhood obesity within the next ten years.

The Healthy Child Programme (2009): The English policy framework 'Giving all children a healthy start in life', is underpinned by the Healthy child programme which recommends the Baby Friendly Initiative as a minimum standard to support breastfeeding and reduce obesity.

Local Context

The Gloucestershire Health and Wellbeing Strategy highlighted obesity as a priority area (Glos 2012) and a 'healthy weight delivery plan' is in place setting out local priorities for action from 2016-19.

In addition, the five year Sustainability and Transformation Plan (STP) for Gloucestershire has identified obesity as a priority area. It reiterates the need to work in partnership to deliver whole system approach to prevention through empowering individuals and enabling active communities.

Gloucestershire is one of four local authority areas working with Leeds Beckett University on a national programme to co-develop a whole system approach to addressing obesity. The aim is to co-create a roadmap that all local authorities will be able to use to help implement whole systems approaches based on what works for local authorities, drawing on national and international evidence, learning and practice.

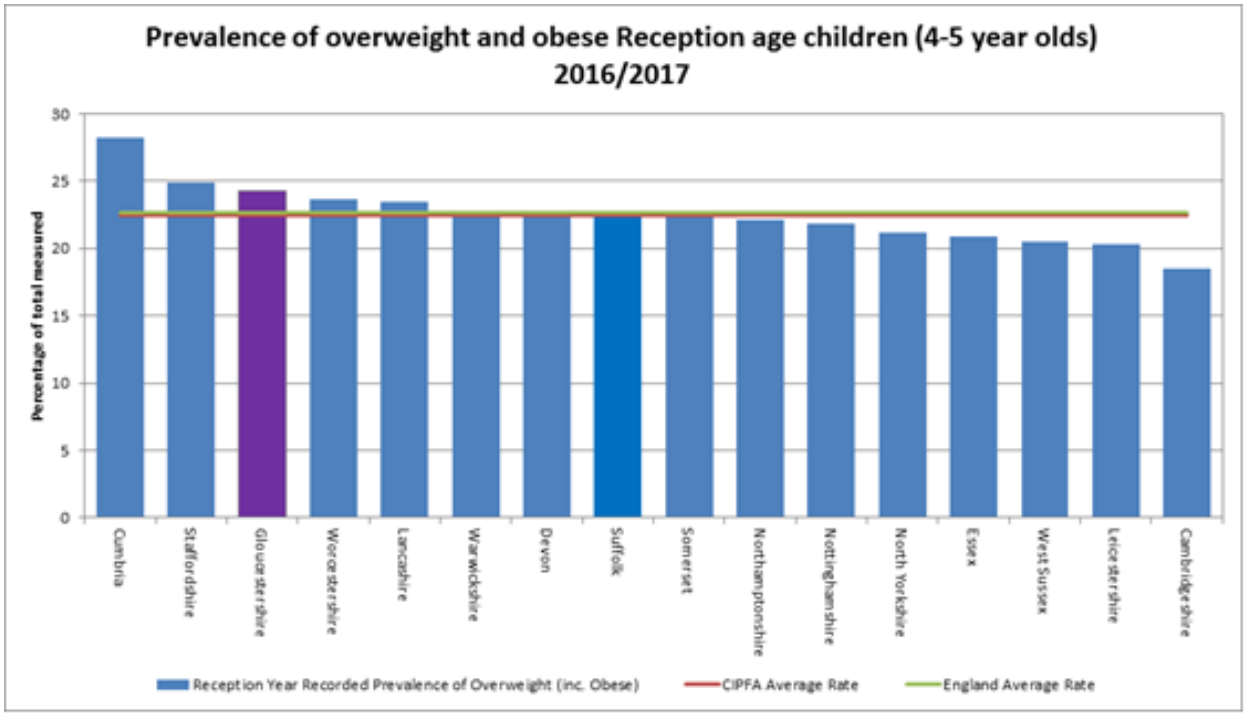
The healthy weight delivery plan includes action to prevent obesity alongside proposals to ensure that effective weight management support is in place for those who area already obese.

[45] Public Health England (2015) Making the case for tackling obesity – why invest?

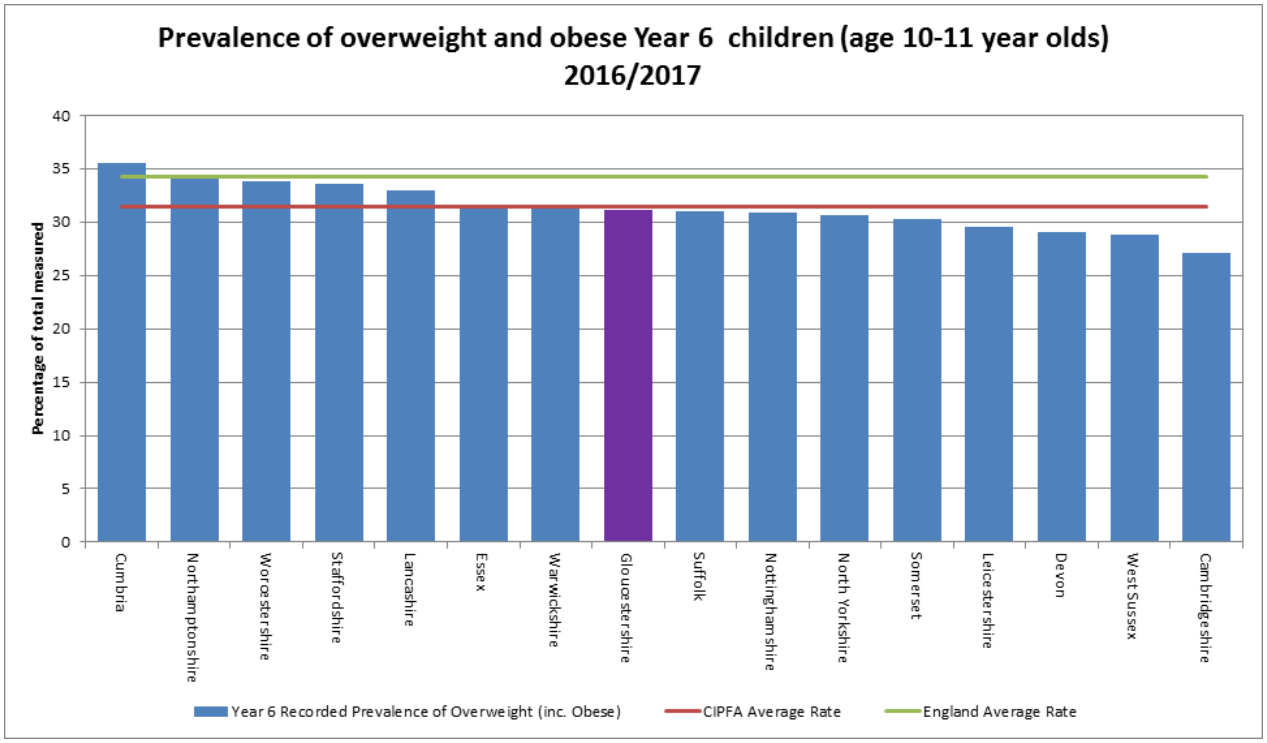
Epidemiological Data Review

The National Child Measurement Programme (NCMP) is a robust data source used to inform the planning and delivery of services for children nationally and locally. In Gloucestershire the program has been running since 2008 and annually measuries the height and weight of reception age children (4-5 year olds) and year six children (10-11 year olds)to assess their weight status.

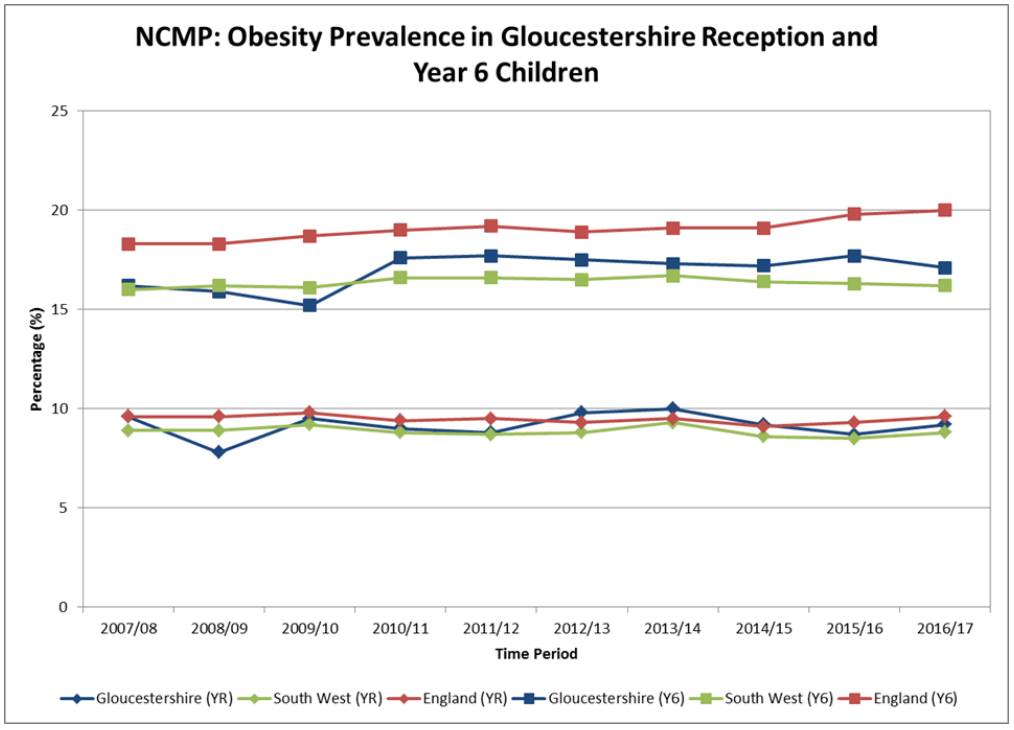
The chart below shows how Gloucestershire compares to its statistical neighbours in terms of prevalence of overweight and obesity combined for reception age children in 2016/17. Gloucestershire is the third worst performer and the prevalence is above both the statistical neighbour and national average.



The same data is shown below but this time for year 6 (10-11 year olds). In this age group Gloucestershire is in line with its statistical neighbours.



The chart below shows the trends in prevalence of obesity for reception year and year six children since the beginning of the NCMP. This makes clear the progression of obesity with a greater proportion of 11 year olds being obese than reception year children.

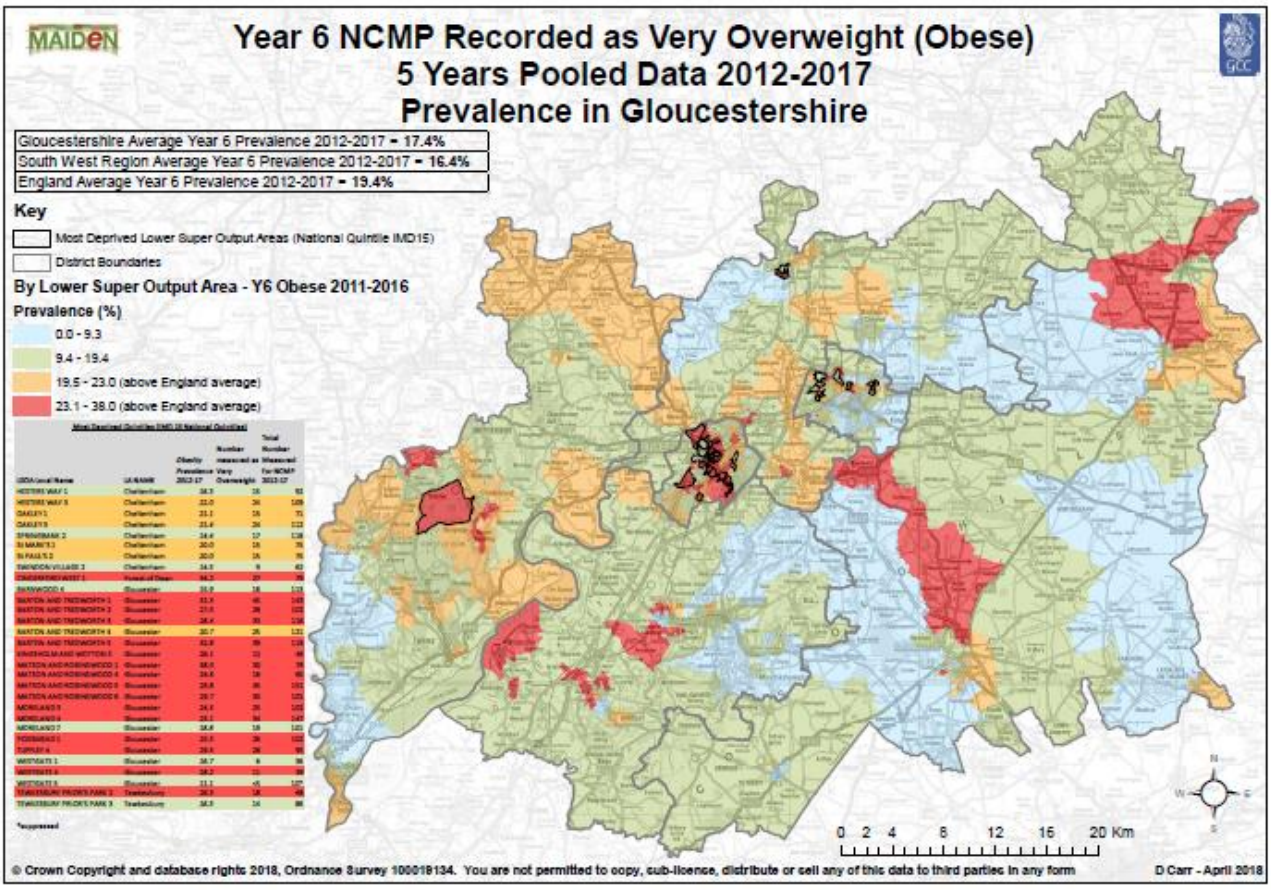


At age 4-5, there are just over 600 Reception Year children classified as obese in Gloucestershire. Obesity prevalence in Reception Year children in 2016/17 was 9.2% in Gloucestershire which is

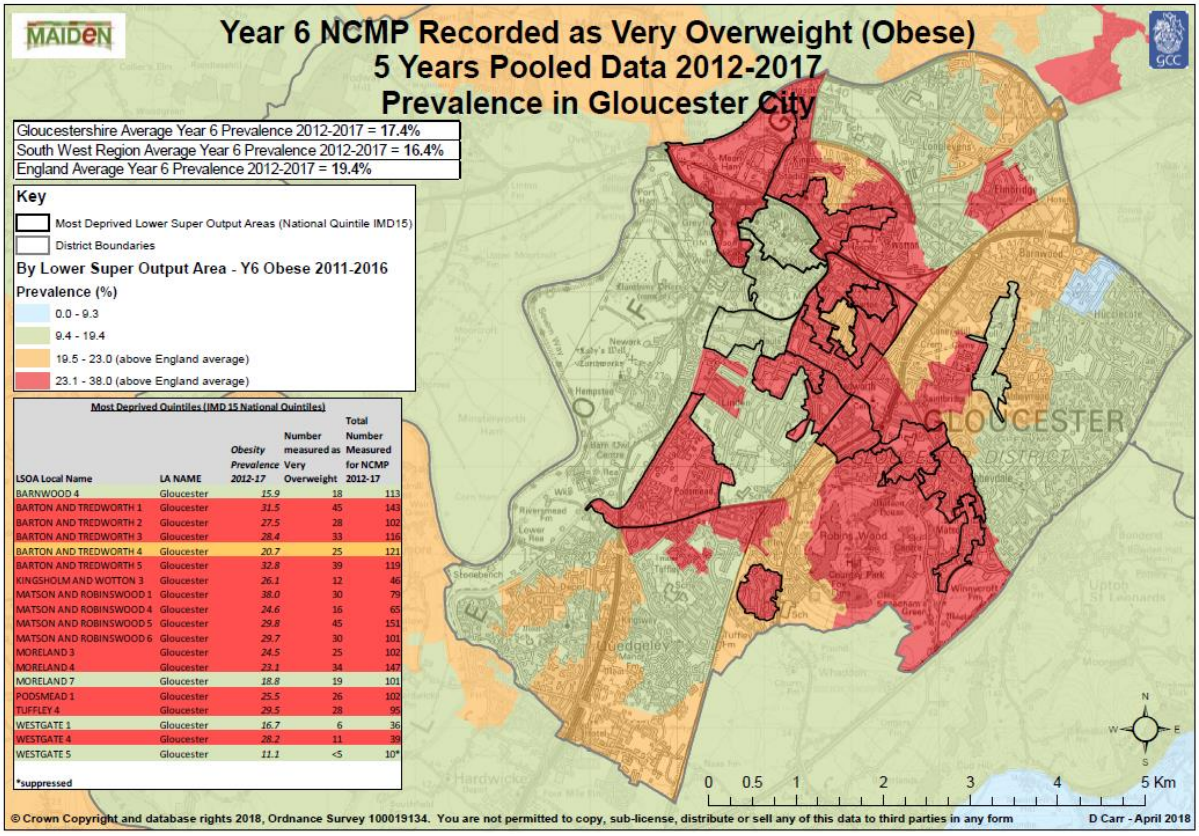
equal to the pooled average prevalence for each year in Gloucestershire since 2007/08 – 9.2%. This means that improvements in obesity levels have not been seen in the last decade despite action on obesity.

At age 11, there are just over 1000 Year Six children classified as obese in Gloucestershire. This is 400 more than at age 4 to 5. This equates to a prevalence rate of 17.1% which is slightly higher than the pooled average rate over the last 10 years at 16.9%. Since 2010/11, prevalence rates of obesity in Year Six children in Gloucestershire have been consistently significantly below the national prevalence rates but tend to be slightly above the regional rates.

Obesity is not evenly distributed across the county; there are pockets of obesity that tend to correlate with the more deprived neighbourhoods such as Gloucester and the Forest of Dean. This is illustrated for year six (children aged 10-11 years) below.



The distribution of obesity within Gloucester is illustrated at Lower Super Output Area level below.



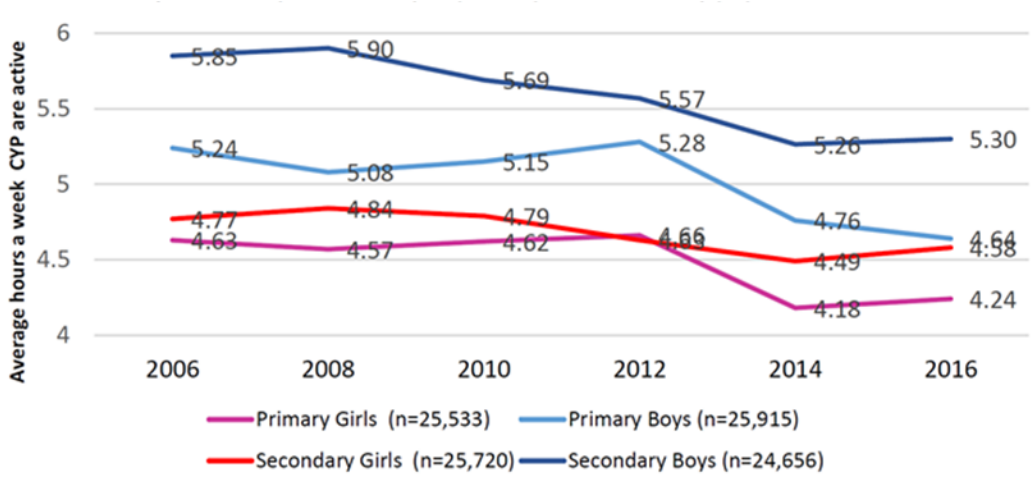
The areas in black are the most deprived areas and, while the correlation is not perfect it can bee seen that there is an association between areas of increased obesity and areas of increased deprivation..

Risk Factors

There are a number of risk factors associated with becoming overweight and obese. The Online Pupil Survey has been a rich source of data on risk factors as reported by the children themselves.

Physical Activity:

Physical activity of primary and secondary pupils over time

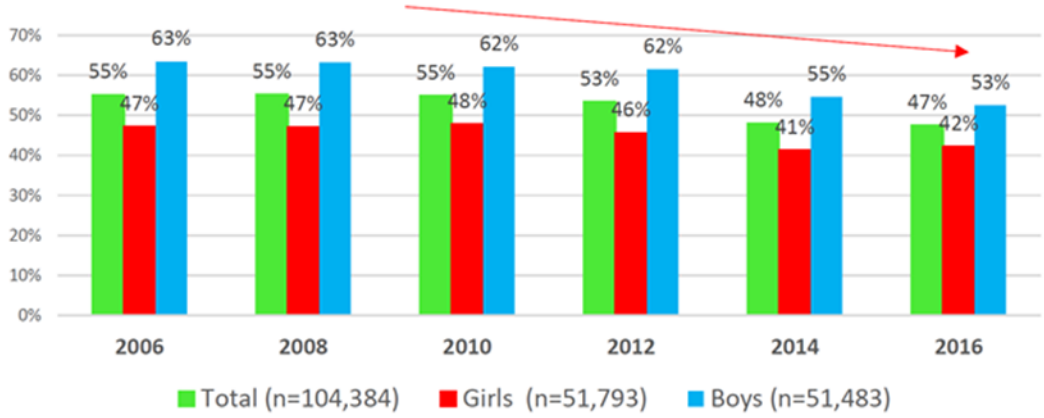


Source: Online Pupil Survey 2016: www.ghll.org.uk/online-pupil-survey

Figure X above shows that elf reported physical activity levels have declined in all groups over time. The steepest declines were seen in boys and girls in primary school between 2012 and 2014. This decline plateaued between 2014 and 2016 though further years data are needed to determine whether this apparent levelling off has been sustained. .

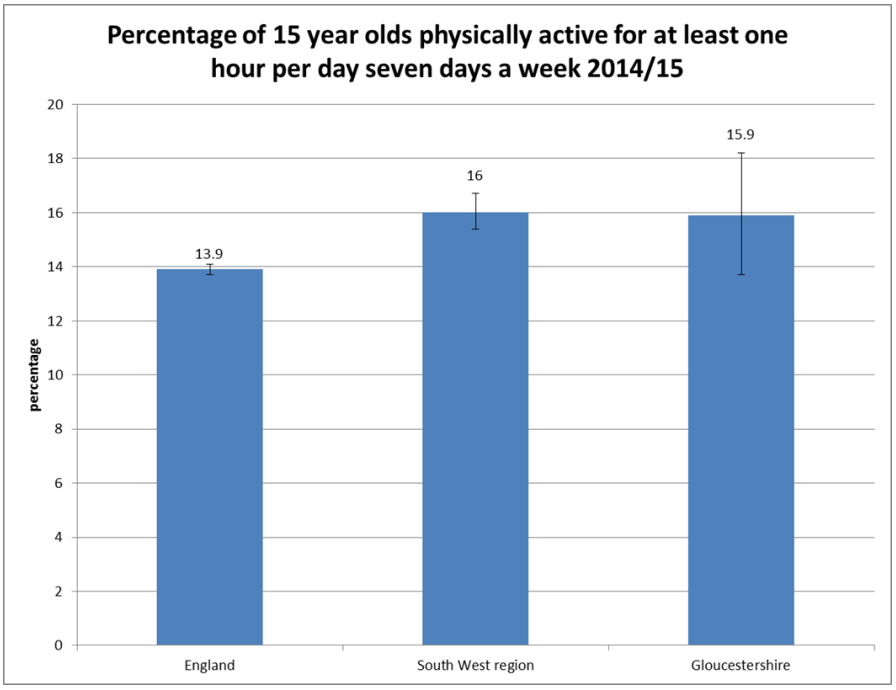
Another way of looking at the data is to look at the proportion of children who are physically active for more than 6 hours a week. This shows a similar decline but it also clearly shows the gap in physical activity levels between boys and girls with girls being less active at all times sampled.

Figure 25: Physical activity in primary & secondary phase pupils, % of children and young people who are physically active for 6 or more hours a week

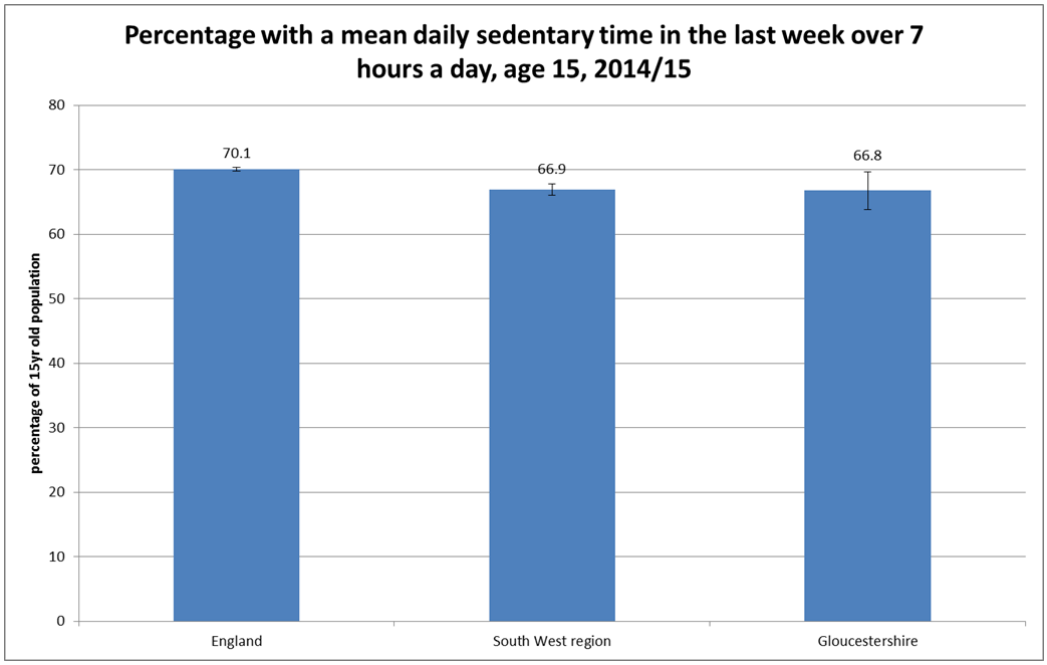


Source: Online Pupil Survey 2016: www.ghll.org.uk/online-pupil-survey

The WAYS survey allows an insight into reported physical activity at age 15 and allows the data to be compared to national and regional levels. This shows that activity levels in Gloucestershire are slightly above the national average, but not significantly so.

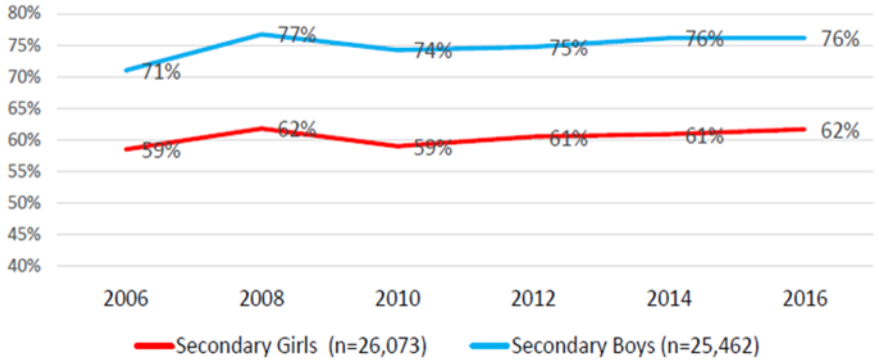


There is an increasing body of evidence that shows the amount of sedentary time may have a negative impact on health over and above simply not being active. The chart below shows that in Gloucestershire over two thirds of 15 year olds spend over 7 waking hours a day being sedentary.



Dietary Habits

Healthy eating patterns are important to maintaining a healthy weight. Eating breakfast is an important healthy eating habit. The chart below shows the proportion of secondary school boys and girls who regularly eat breakfast.

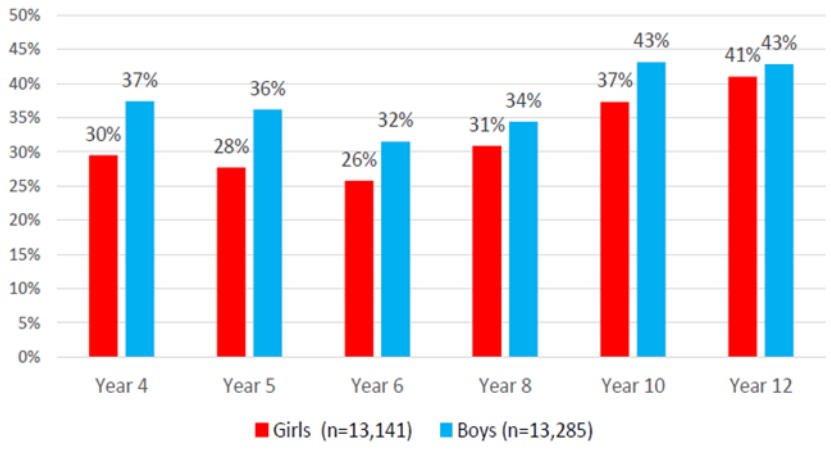


Source: Online Pupil Survey 2016: www.ghll.org.uk/online-pupil-survey

Almost 4 in 10 secondary school age girls regularly skip breakfast.

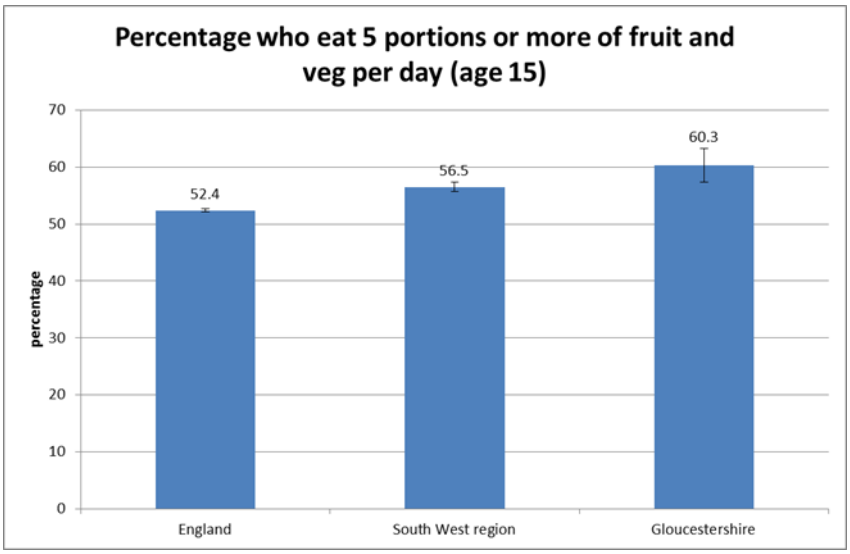
Unhealthy snacking can lead to excess weight gain . The proportion of secondary school boys and girls reporting eating three or more unhealthy snacks a day is shown below. For both boys and girls unhealthy snacking habits increase from year six onwards. Boys are more likely to eat 3 or more unhealthy snacks a day at all age groups. The biggest gender gap is observed in the primary years with 6-8% more boys reporting three or more unhealthy snacks a day. By year 12 the gender gap has closed due to girls having caught up with the boys.

Figure 19: Unhealthy snack consumption; % of pupils who eat 3 or more unhealthy snacks a day illustrating the gender gap



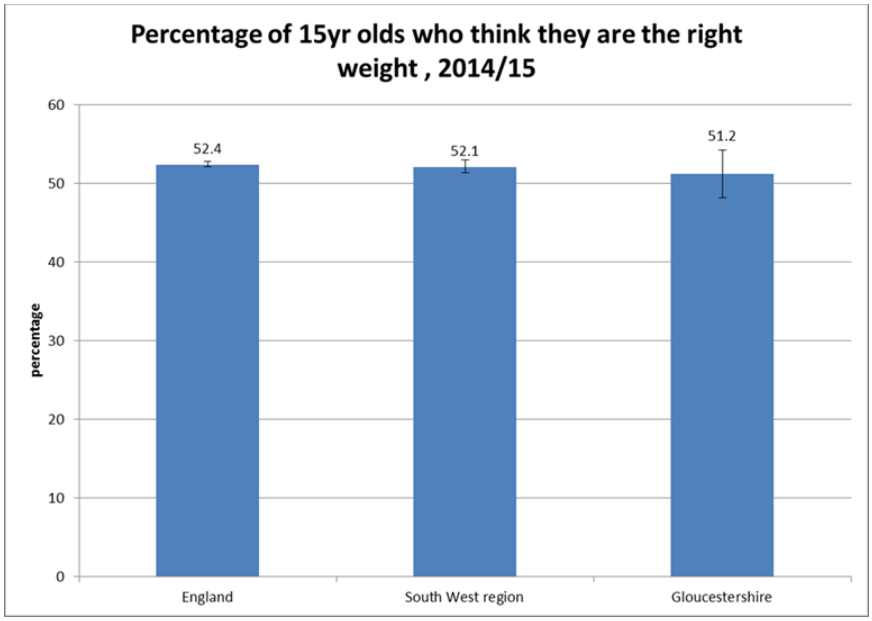
Source: Online Pupil Survey 2016: www.ghll.org.uk/online-pupil-survey

Eating 5 or more portions of fruit and vegetables a day is associated with better health and weight control. How Gloucestershire performs on this indicator is shown below.



The percentage of 15 year olds who report eating '5-a-day' (60.3%) is significantly higher in Gloucestershire than England (52.4%). However, this still means that 4 in 10 fifteenyear olds are not managing to achieve this goal.

As well as physical health implications, being an unhealthy weight can have mental and emotional health implications. It is therefore of concern that only around half the 15 year olds in the county think they are the 'right weight'. This figure is in line with both the regional and national average.



The finding could be interpreted as meaning that our young people feel in need of support to reach, maintain and recognise the weight which is healthy for them.

Qualitative Data Review

In order to gain local views on future provision of lifestyles information and support for adults , a formal consultation was undertaken between December 2015 and March 2016. There was general public and service user support for the following design principles for healthy lifestyles services:

- More emphasis on helping individuals and communities to help themselves – supporting 'self-care'
- More emphasis on primary prevention e.g. helping people to avoid becoming overweight or obese in the first place
- Focusing on the first 1001 days of life i.e. offering healthy weight information and support from conception to the second birthday (for mother, baby and the wider family)
- Lifestyles support should be targeted towards those with greatest capacity to benefit (i.e. those whose health outcomes are likely to be poor)
- Lifestyles information and support should be embedded across front-line services where possible.

In 2014 NHS Gloucestershire CCG consulted widely with members of the public in Gloucestershire on *Joining Up Your Care*, the Five Year Strategic Plan for the Gloucestershire Health and Care Community. The key themes emerging from this engagement exercise, which can also be applied to the work on the obesity agenda, are as follows:

- Having the right information and knowledge to ensure people are supported to manage their conditions and to live healthier lives; including information about all of the services available (both statutory and non-statutory).
- Empowerment was a key message; the importance of self-management, particularly for people with one or more long term condition and the need for patients and their families/carers to be involved in care plans and decision making.
- Stakeholders acknowledged the role of the wider health community and the need for a joined up timely approach across the system, supporting partnership working both with and complementary to health and social care services. This includes making the best use of the voluntary sector and community pharmacists.
- It was understood that a 'one size fits all' approach was not appropriate, with a consideration of the differing needs our population i.e. urban v rural. The importance of our local population as individuals was clear, this included understating the need for parity of esteem and the importance of the role of carers in providing joined up care that meets the needs of individual patients.

More specific qualitative feedback on weight management programmes for children was obtained as part of a pilot family based group intervention delivered in Cheltenham. This explored some of the barriers to engaging participants and families in such interventions.

Parents participating in the programme gave positive feedback and found the peer support the group provided useful with one father saying;

> *"It is good that we can go along and I can speak to other parents who are trying to change things, also my child can make friends with other kids the same who may not be fantastic at football and feel really bad, but they can play on the same level."*
> -.

However, a grandmother of a child who was recommended for the intervention had concerns about the child's perception of the group:

> "*The thing is, he doesn't look fat … hmm … obese, so if we go and he thinks, 'do I look like the others?' then that wouldn't be nice, don't you think?"*
> *- grandparent of a child who did not attend the intervention.*

Even this small amount of qualitative data illustrates some of the difficulties, sensitivities and conflicting views people have around weight management programmes and how tailoring them to appeal to the majority might be challenging.

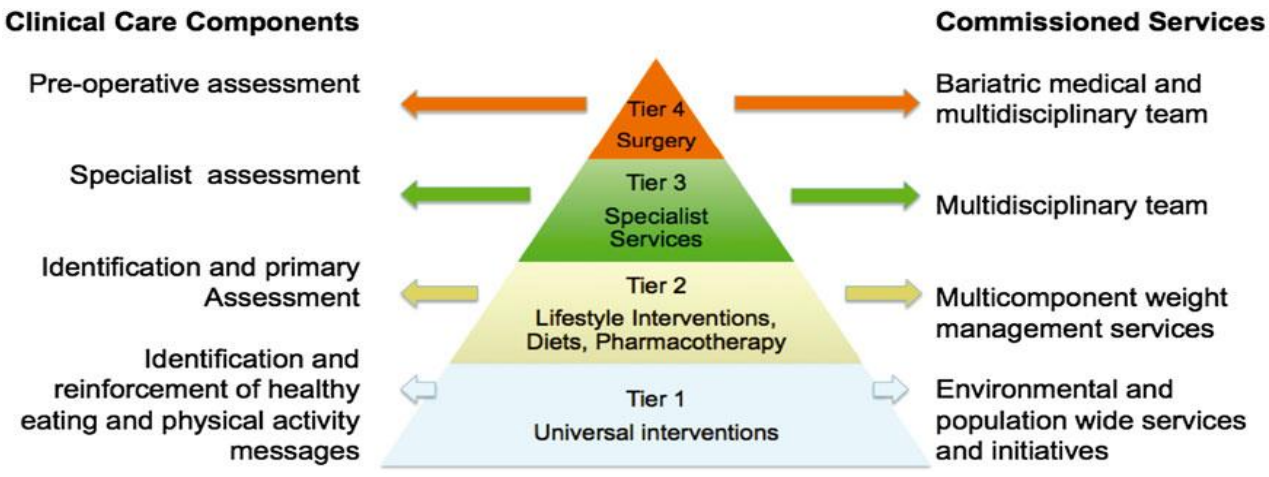
Evidence around What Works

Addressing obesity across the life course will necessitate the establishment of new social norms around eating and physical activity and, given the complex interplay of determinants, most experts agree that a 'whole system approach' is needed.

Reducing childhood obesity at a population level requires a combination of preventive action to address the social, familial, environmental and behavioural determinants, alongside effective weight management interventions for individuals who are overweight and obese. This will require a joined up approach from communities and organisations.

For obese children NICE recommends a joined up obesity pathway, linking with the NCMP and including interventions across a number of levels or "tiers" of care (see figure below). Tier 1 interventions are aimed at preventing unhealthy weight, and tier 3 interventions at supporting those with greater needs. Tier 4 covers bariatric surgery, which is generally not recommended in children or young people, except in exceptional circumstances. Tier 4 interventions for children also include residential summer camps.

Tiers of Care for Childhood Obesity Interventions



The National Institute for Health and Care Excellence (NICE)[46] recommends multicomponent interventions aiming to reduce a person's energy intake and to help them to be more physically active by changing their behaviour. The aim of weight management programmes for children and young people may focus on either weight maintenance or weight loss depending on the person's age and stage of growth.

Evaluations of existing tier 2 weight management services for children and young people show that they can have small but significant positive effects on anthropometric measures, such as BMI and waist circumference; behavioural and lifestyle measures, such as improvements in eating habits in the home and reductions in unhealthy food and sedentary behaviour; and psychological measures, such as self-esteem and body-esteem. The evidence suggests that these positive effects can be sustained for over 2 years, but families may need on-going support to achieve long-term change.

Local Service Provision

Within Gloucestershire there are a number of services and early prevention interventions being undertaken to support healthy lifestyles and contribute to obesity prevention.

In Gloucestershire there is a countywide Healthy Weight Programme and delivery plan, which includes action to prevent and treat obesity. Gloucestershire County Council is also working with Leeds Beckett University on a national programme to develop an effective 'whole systems approach' to obesity prevention and the learning from this programme will inform future development of the local delivery plan. While there is a range of weight management services for obese adults there is currently no systematic provision for the assessment, referral and treatment of obesity among children in Gloucestershire. At the time of writing commissioners are awaiting a decision on investment into children's weight management services.

Further examples of current provision in Gloucestershire is summarised below.

Tier 1: Environmental and population wide interventions and services

Food environment – a multi-agency action plan to improve the food environment is currently being developed as part of the 'whole systems obesity' programme. This will explore the key barriers and enablers to accessing and eating a healthy diet and involve communities in the development of actions to address local uses.
Physical activity – Gloucestershire Moves is a multiagency plan to support inactive people to become more physically active. This programme, being led by Active Gloucestershire, will be implemented from 2018.

[46] NICE (2014) Obesity: identification, assessment and management. Available at: https://www.nice.org.uk/guidance/cg189/resources/obesity-identification-assessment-and-management-35109821097925

Other example of tier 1 interventions include:

Health Visiting teams currently provide universal promotion of breastfeeding and introduction of weaning at 6 months. Healthy eating and exercise is a standard benchmark for all universal contacts, so it is discussed with the family at the antenatal contact, new birth visit, 6-8 week review, 12 month contact and 2 year review.

School Nursing teams use the NCMP to identify those children who are overweight or obese. A letter is sent to these families explaining the measurements and the potential impact on health. The family is asked to contact the service and if agreed, the School Nurse will work with the family on areas identified through a lifestyles assessment. However uptake of this service by parents is low.

Gloucestershire Healthy Living and Learning (GHLL) support schools to review their community need with regard to health and wellbeing. They provide an accreditation when the school can demonstrate that it has provided two interventions that have had a positive impact on the health of its pupils. Many schools are implementing activities and strategies associated with healthy eating and improved physical activity.

Facts4Life is a service that is commissioned by Gloucestershire CCG that focuses on changing attitudes in school children by moving the focus of control from medical experts to individuals. The aim is help children and their families take greater responsibility for their health.

Active Gloucestershire has been commissioned by Gloucestershire CCG to offer all schools training to implement the "**daily mile**" initiative. The Daily Mile is an evidence-based initiative which requires primary school aged children to run, walk, hop, skip, jump or jog a mile each day for 15 minutes. The initiative is non-competitive, free and fully inclusive and encompasses a number of physical, mental and social benefits for children. The initiative is part of the Active Gloucestershire's Active Schools programme and is supported by Gloucestershire CCG Sustainability and Transformation partnership Project, Gloucestershire County Council Public Health, Hartpury College and a number of other partners. Up until August 2017, 10,000 pupils from 55 primary schools in the county had taken part in the Daily Mile.

Tier 2 : Multicomponent weight management services for obese children and young people

Community weight management support for children and families has previously been piloted in various areas within the county, but no universal or targeted services currently exist. An outline business case for the provision on tier 2 services has been developed and a decision is awaited around funding. Meanwhile, the children's countywide dietetics service (provided by GHNHSFT) will accept referral from health professionals for children and young people who have excess weight. They receive an estimated 480 referrals per year for dietary assessment and advice. The service acknowledges that they are unable to offer the level of intervention necessary for effective weight loss.

Tier 3: Multidisciplinary team support for severly obese children

There are no dedicated tier 3 weight management services in Gloucestershire; An outline business case for the provision on tier 3 services has been developed and a decision is awaited around funding. Meanwhile, a limited number of Children with complex needs are referred to the Care of Childhood Obesity (CoCo) in provided by University Hospitals Bristol NHS Foundation Trust (UHBNHSFT). This provides a multidisciplinary assessment and care over a period of 12-18 months at Bristol Royal Hospital for Children.

Tier 4: Bariatric surgery or residential summer camps

There is currently no tier 4 provision available in Gloucestershire, however, NHS England are currently tendering for tier 4 provision nationally. Discussion, Gap Identification and Recommendations

The growing body of research and evidence on this topic suggests that this is a very significant public health issue with huge implications for population health, but an issue where no single intervention will work to solve the issue.

Discussion, Gaps and Recommendations

Strengths in this area:

- The level of data coverage on who and where the problems are occurring allows the issues to be identified clearly and also will provide a way of assessing the overall impact of interventions
- Ongoing work with Leeds Beckett University places Gloucestershire at the forefront of developing a system wide approach to obesity in a local authority context.

Areas for Improvement

- Gloucestershire is a relatively wealthy county and yet is performing worse than the regional average.
- There remain stark inequalities around childhood obesity with the worse off being most badly impacted.
- Interventions to date have not had a significant impact on overall levels of overweight and obesity.

Recommendations

- Use the findings from the Leeds Beckett pilot project to inform future practice.
- Implement a comprehensive integrated healthy weight pathway for children and families. This should a range of age appropriate interventions at tiers 2 and 3
- Build capacity within universal and targeted children's services to reinforce healthy eating and physical activity messages and to identify obesity and deliver brief interventions
- Develop self-care resources for children and families, and young people, to enable then to maintain a healthier weight

- Strengthen weight management support for obese pregnant women including post-natal support for those at greatest risk

C) Teeth and Gums

Introduction

Poor oral health can have a major impact on a child's physical health and their quality of life. Poor oral health and tooth decay in early childhood can lead to a series of health problems, including::

- pain;
- infections;
- altered sleep and eating patterns;
- school absence; and
- need for dental extraction (with the potential for subsequent dental problems later in life).

Tooth decay is almost entirely preventable. However, despite this, it remains a significant public health issue, particularly for deprived populations where children are less likely to have good oral hygiene practices and more likely to have high sugar diets; these risks are often coupled with poorer access to dental care. Health inequalities are an issue in oral health; 5-year-olds living in the most deprived areas of England, Northern Ireland and Wales were at least three times more likely to experience severe tooth decay than their peers living in the most affluent areas.

Tooth decay occurs when mouth bacteria produce acids which soften the outer covering (enamel) of the tooth. Research suggests that development of these bacteria may be compensated in part by good oral hygiene practices and diet. Sugar is an important factor in the development of tooth decay, as it can fuel the acid formation by oral bacteria.

Oral health problems include gum (periodontal) disease, tooth decay (dental caries), tooth loss and oral cancers (NICE guidance PH 55, Oct 2014). Dental treatment is a significant cost, with the NHS in England spending £3.4 billion per year on dental care (with an estimated additional £2.3 billion on private dental care)[47].

Despite significant investment in childhood education programmes, the percentage of children with decayed, missing or filled teeth (DMFT), a marker of child dental health, remains high with 28% of five-year-old children across England having observable decay.

Whilst the Public Health Outcomes Framework oral health indicator specifically looks at 5-year olds, it should be noted that good oral health is important for children and young people of all ages (and indeed adults although they are beyond the scope of this document).

Policy Context

Tooth decay in 5 year old children is included as a key indicator in the Public Health Outcomes Framework as an important indicator of population health. In addition, the NHS Outcomes Framework includes indicators related to patients' experiences of and access to NHS dental services. The Children and Young People's Health Outcomes Forum report published in 2012, and its 2014

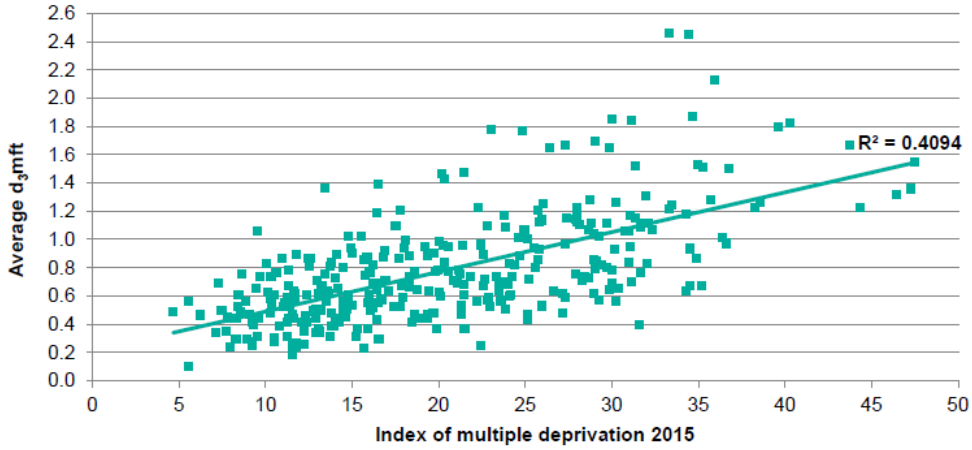
[47] PHE, *Local authorities improving oral health: commissioning better oral health for children and young people*. 2014.

annual report recommended improved integration and greater action to reduce regional variation in child dental health outcomes.

Epidemiological Data Review

Nationally, the tooth decay level in children is closely correlated with deprivation.[48] National data is available on the correlation between deprivation and poor oral health and the findings are shown below. The R^2 value of 0.409suggests that around 41% of all dental decay in five year olds can be attributed to the effects of living in deprivation.

Correlation between number of dentinally decayed, missing (due to decay) and filled teeth ($d_3$mft) among five-year-old children and Index of Multiple Deprivation (IMD 2015) score. Lower-tier local authorities in England, 2015.



Public Health England provides collated data on oral health by locality and the data available is given in the spine chart below. The data is not collected regularly and so some of the "most recent" information is already almost a decade out of date. It is however the best available information. As illustrated below Gloucestershire is broadly in line with the national averages, except in the proportion of three year old free from decay where Gloucestershire performs worse than nationally.

[48] PHE http://www.nwph.net/dentalhealth/14_15_5yearold/14_15_16/DPHEP%20for%20England%20OH%20Survey%205yr%202015%20Report%20FINAL%20Gateway%20approved.pdf

Summary of PHE Fingertips data on Oral Health In Gloucestershire

Compared with benchmark: Better, Similar, Worse | Lower, Similar, Higher, Not Compared

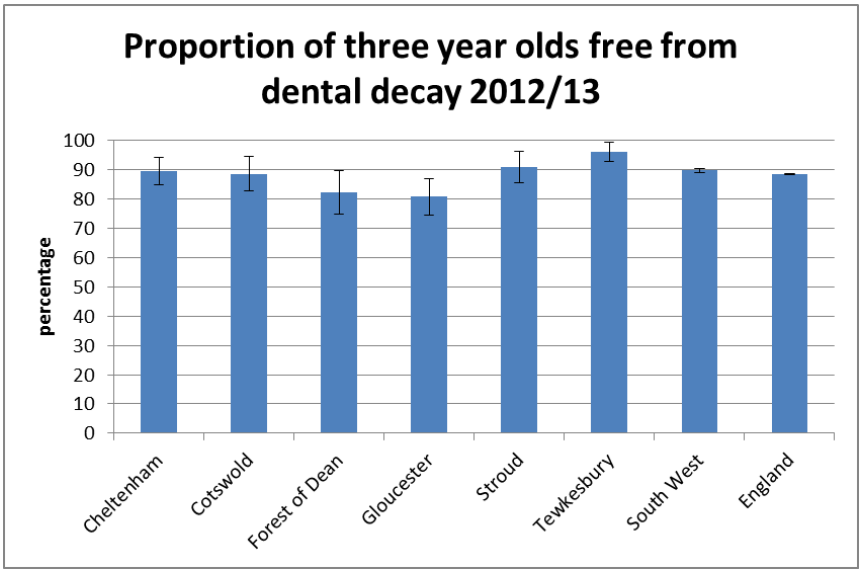
Benchmark Value: Worst/Lowest | 25th Percentile | 75th Percentile | Best/Highest

Indicator	Period	Gloucester			Region	England	England		
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
4.02 - Proportion of five year old children free from dental decay	2014/15	–	186	80.3%	78.5%	75.2%	43.9%		91.8%
dmft (decayed, missing or filled teeth) in five year olds	2014/15	–	-	0.78	-	0.84	2.46		0.10
Incisor caries prevalence in three year olds	2012/13	–	3	1.8%	3.0%	3.9%	16.1%		0.0%
Proportion of three year olds free from dental decay	2012/13	–	141	80.7%	89.7%	88.4%	66.0%		100%
dmft in three year olds	2012/13	–	-	0.62	0.31	0.36	1.17		0.00
Proportion of twelve year olds free from dental decay	2008/09	–	133	70.5%	-	66.4%	43.4%		87.7%
DMFT in twelve year olds	2008/09	–	-	0.65	-	0.74	1.61		0.20

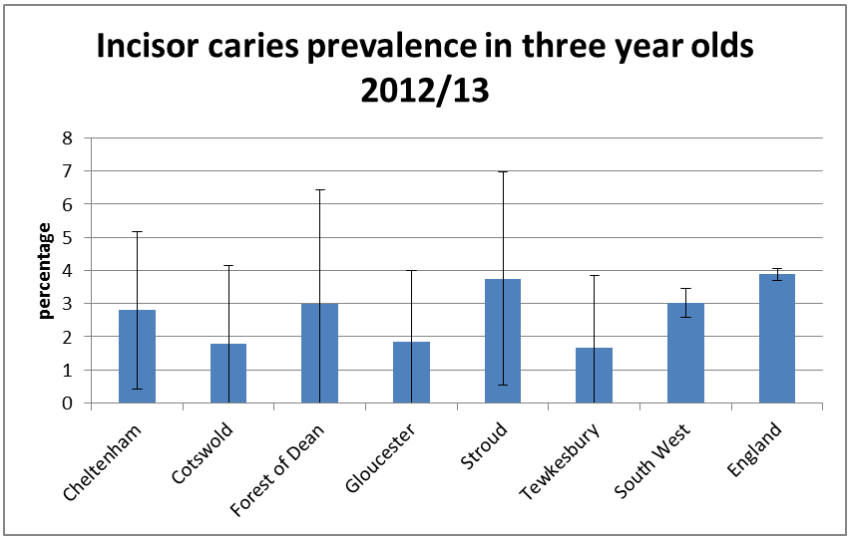
Greater detail on some of these indicators is given below.

Data on three year olds:

The spine chart above shows that Gloucestershire performs worse than the national average in terms of the number of three year olds free from decay. The chart below shows the proportion of three year olds by locality that are free from any dental decay.

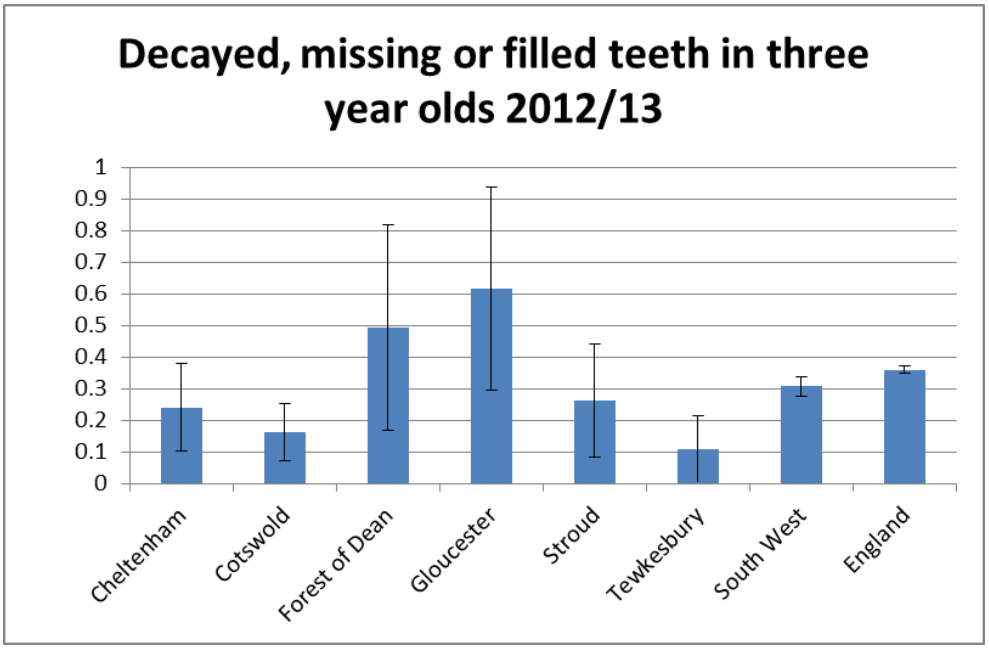


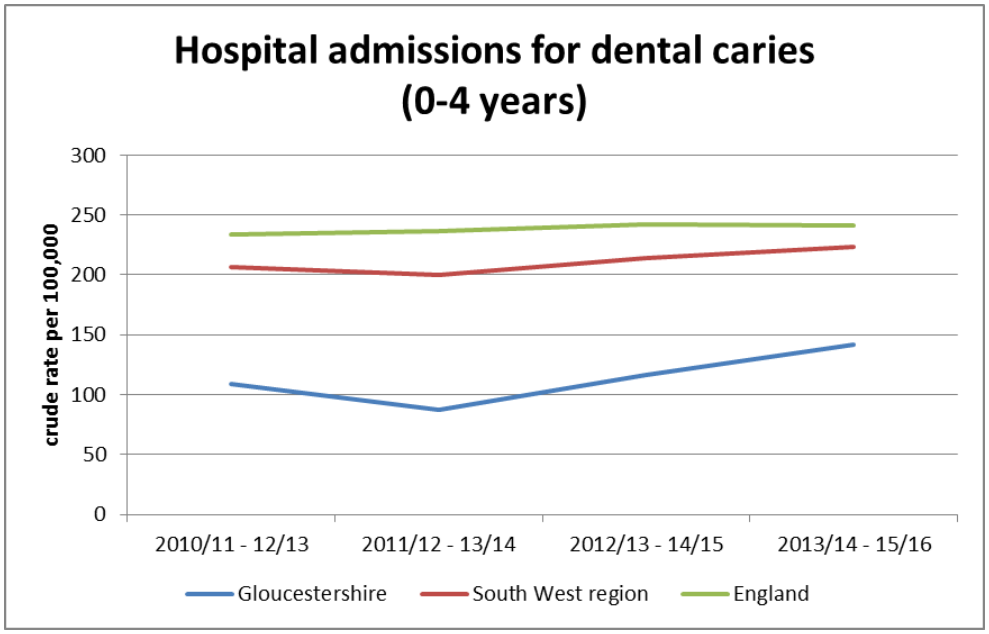
Due to the small sample sizes the confidence intervals are quite wide meaning inter locality differences may not be statistically significant. It is interesting to note that for this indicator locally the highest areas of decay are not the most deprived.



Incisor caries are often found in toddlers with poor snacking and oral health practices. Again small sample numbers create large confidence intervals and so differences of the inter-locality findings are not statistically significant.

The chart below shows the average number of decayed missing or filled teeth for three year old children. It should be noted that this is the average over the entire population of three year olds rather than just those who have dental disease. Thus, at the individual level there are three year old with multiple decayed, missing or filled teeth and a large number with no dental decay. This average indicator does not give a feel for the high levels of decay seen in a small number of individuals Locally, the Forest of Dean and Gloucester have the highest average numbers of decayed teeth per child.



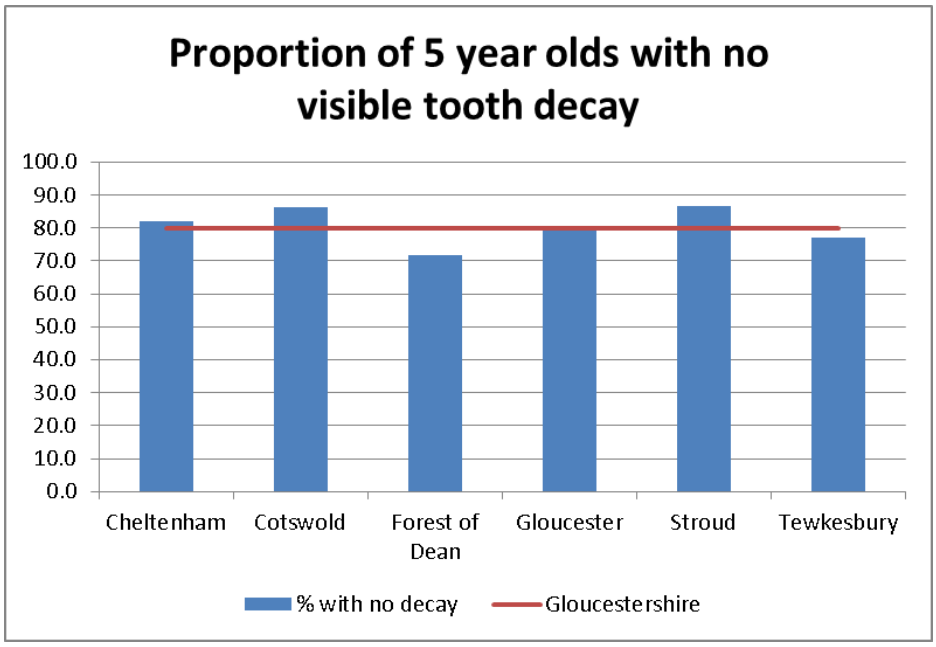


In this age group hospital admissions for dental caries are usually for removal of teeth under general anaesthetic. While Gloucestershire generally performs better than the regional or national average the upward trend in this indicator is concerning. Events of this nature are avoidable, have a significant impact on the individual and on the wider community and are costly to the health system.

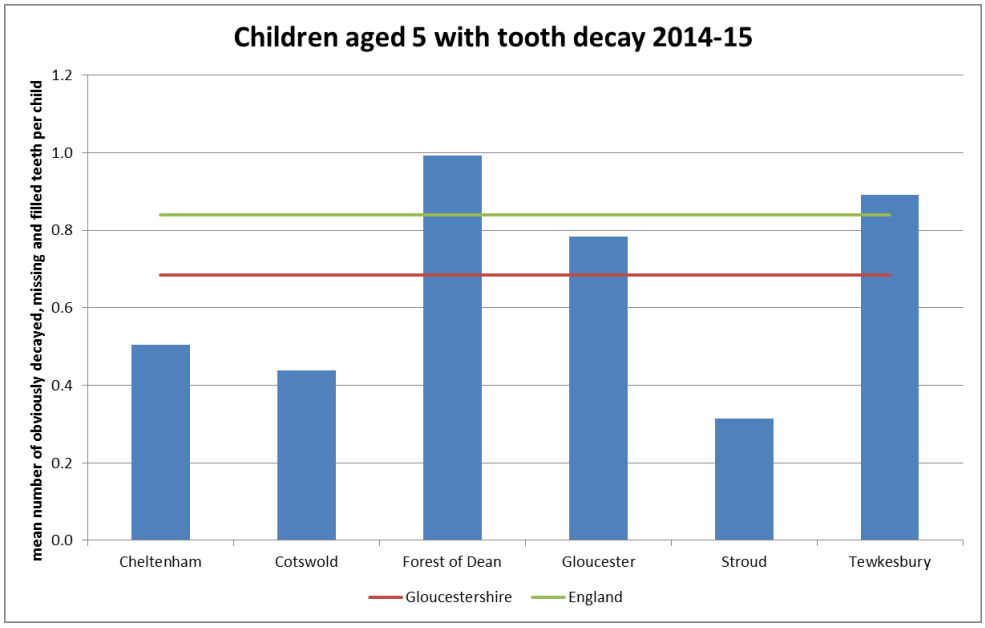
It could be considered that even one child aged 0-4 having tooth decay (an easily preventable condition) so bad that it requires tooth extraction under general anaesthetic (a procedure with serious potential side effects) is unacceptable.

Data for 5 year olds

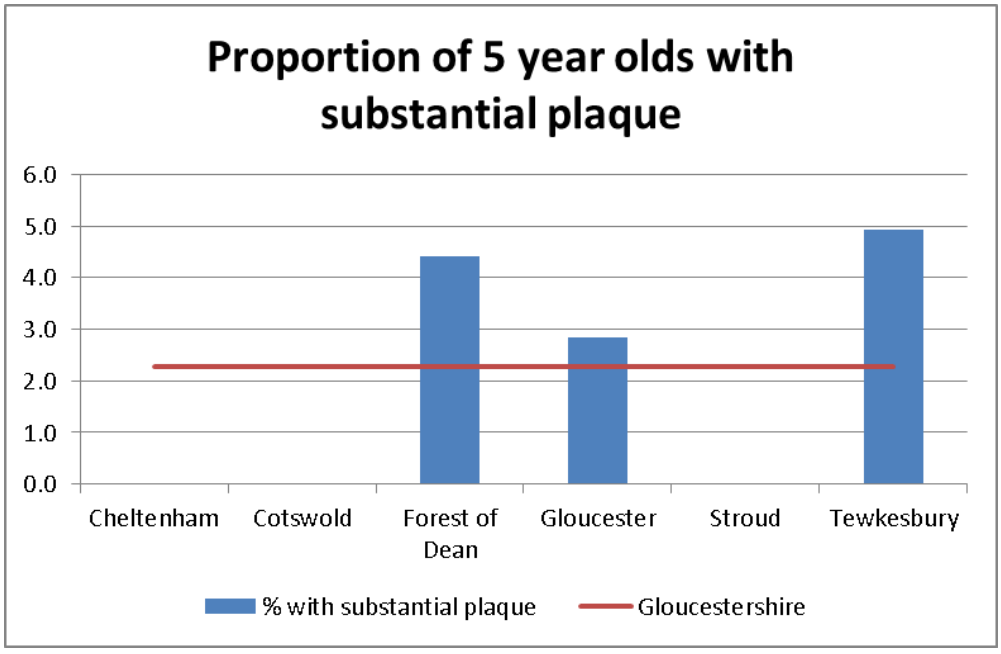
Locality data is available for the proportion of five year olds with no visible tooth decay. Gloucester, Forest of Dean and Tewksbury are the worst performers.



Looking at the statistic the other way around(ie the number of children who do have decay) unsurprisingly the pattern is maintained. Forest and Tewksbury perform worse than the national average. In the Forest of Dean the number of decayed missing of filled teeth in 5 year olds is so high that on average there is one for every five year old. Given that only 30% of five year olds have any tooth decay this means that for those who do there are on average 3 decayed teeth per five year old.



Plaque build up is an indicator of poor brushing and can be a precursor to dental disease. As shown in the chart below the patterns of substantial plaque deposits mirror those of tooth decay (although data quality is poor with missing data in some areas)



Poor oral health shares common risk factors with many other conditions that affect child health, most notable obesity. Interestingly, the three worst performing districts for levels of excess weight in reception age children are the same three worst performing districts for tooth decay in 5 year olds, potentially showing the link between poor diet and snacking habits in contributing to both obesity and tooth decay.

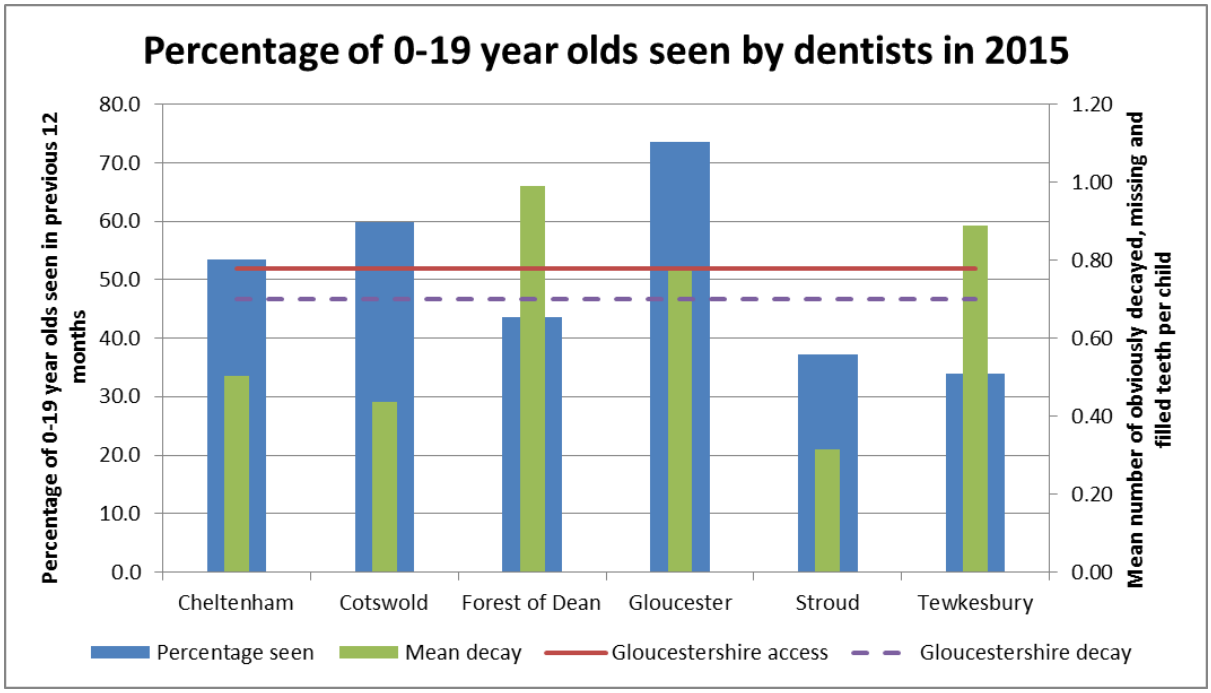
District	IMD rank (1 worst)	Tooth decay rank YR	Excess weight rank YR
Cheltenham	3	4	6
Cotswold	5	5	5
Forest of Dean	2	1	1
Gloucester	1	3	3
Stroud	6	6	4
Tewkesbury	4	2	2

While a number of factors contribute to good dental health visiting a dentist is often seen as one of the key actions required to maintain good oral health. National data shows that 80 per cent of one and two-year-olds in England did not visit an NHS dentist last year. The figure was 60 per cent for children aged one to four, according to data from NHS Digital.[49]

The chart overleaf shows the percentage of children who have seen an NHS dentist plotted along with levels of decay. In Tewkesbury and Stroud only 1 in 3 children were seen by a dentist in the previous 12 months. Tewkesbury had the second highest level of decay; Stroud however had low levels of decay in children despite there being fewer recorded NHS dentist visits. In Gloucester the highest percentage of children had been seen by NHS dentists (74%) of all the districts, but levels of decay were above the Gloucestershire average.

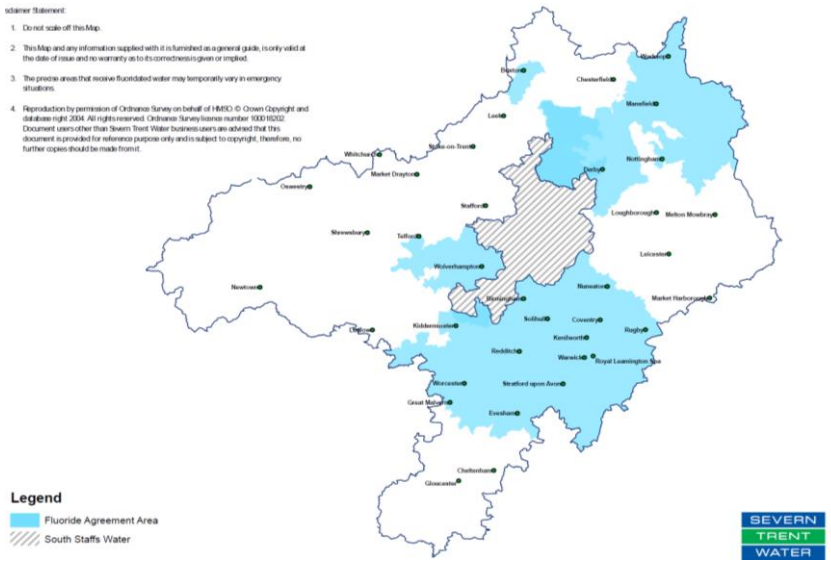
The imperfect correlation between dental visits and levels of decay is probably multifactorial. One issue is that the data only record NHS dental visits and use of private dentists is not uncommon. In addition some families only attend the dentist once problems have emerged and so the opportunity for prevention work is lost.

[49] Daily Mail http://www.dailymail.co.uk/news/article-4582888/Four-five-toddlers-not-taken-dentist.html#ixzz4jViolsKq



A potential protective factor for tooth decay is fluoride. Fluoride occurs naturally at low levels in most 'raw' water In some areas water companies have been asked by the local CCG to add fluoride to improve dental health. Fluoride is not currently added to water supplies in Gloucestershire (neither by Thames Water nor Severn Trent Water). Fluoride levels of around 1mg/l are considered to be a safe level that has a positive impact on tooth decay. Fluoride levels in Thames Water areas (Cotswold in Gloucestershire) has a natural concentration of 0.1-0.4mg/l. Severn Trent Water does add fluoride in other areas it serves in the Midlands (see map below) but none is currently added in Gloucestershire.

Map to show Fluoride agreement areas for Severn Trent Water



Local Service Provision

An urgent dental service is delivered from the Dental Access Centre Southgate Moorings, Gloucester. The service can be accessed by calling NHS 111

In addition there are a number of NHS dentists https://www.gloucestershireccg.nhs.uk/your-services/dentists/

Evidence around What Works

The Royal College of Paediatrics and Child Health have put forward a number of evidence backed recommendations. These are summarised below:

- Promoting improved oral health in children requires action at a national, local and individual level, and should be evidence-based and standardised.
- Families need to be equipped from birth with the knowledge to enable good oral hygiene and encouraged to maintain regular brushing.
- All children should receive their first check up as soon as their first teeth come through and by their first birthday (Dental Check by One), and this should be recorded in their Personal Child Health Record.
- Paediatricians should include oral health in assessment of children's all-round health.
- Reduction in consumption of high-sugar foods, particularly drinks, is key; national actions to reduce sugar in children's food should be accompanied by education of children and parents in reducing and replacing high-sugar foods and drinks.
- Children need timely access to both primary and specialist dental care to reduce the likelihood of serious complications following early tooth decay.

Fluoridation of public water supplies also requires consideration as an effective public health measure which has been shown to also reduce health inequalities

Discussion, Gaps and Recommendations

Strengths in this area:

- Gloucestershire, as a relatively affluent county performs broadly in line with England in terms of most oral health indicators for children

Areas of Concern

- High rates of hospital admissions for extractions. This represents a significant but potentially entirely avoidable cause of suffering for a child that has wider community and health care cost implications.

Recommendations

Focus on producing a comprehensive oral health strategy that

- Tackles social determinants and common risk factors
- Integrates action on oral health with other health improvement work
- Protects some oral health specific commissioning

D) Childcare and Early Education

Introduction

Providing children with good quality education and care in their earliest years can help them succeed at school and later in life. This contributes to creating a society where opportunities are equal regardless of background.

Affordable and easily accessible childcare is crucial for families by helping to create more opportunities for parents who wish, or need, to work and raise children at the same time. A number of funded early years childcare entitlements are available to parents; the 15 hour entitlement for the most disadvantaged two year olds (Achieving 2 Year Olds offer), the 15 hour entitlement for parents of all three and four year olds (the universal offer) and since September 2017, the 30 hours entitlement (the extended offer) for eligible working parents of three and four year olds. The entitlements provide funded childcare for 38 weeks a year (term time) or this can be stretched over 52 weeks by reducing the number of hours taken each week until a child goes to school.

Evidence shows that pre-school has a positive and long term impact on children's attainment, progress and social-behavioural development. At age five, children who have attended high quality childcare for two to three years are nearly eight months ahead in their literacy development than children who have not attended pre-school. At a range of time points, disadvantaged children gain from high quality pre-school. It reduces the risk of anti-social behaviour and leads to improved attainment. It is particularly important for children who have a less stimulating home learning environment or who are from families where parents have poor or no qualifications[50].

In addition to pre-school, parents' education and the support they are able to give their children at home is also important. To help parents in supporting their children, all children receive universal services e.g. services provided by community midwives, health visitors, school nurses, voluntary and community groups etc. However, some children will need extra support in order to be healthy, safe and to achieve their potential.

In Gloucestershire, a targeted family support service operates from sixteen Children and Families Centres based in the areas of greatest deprivation. These provide an outreach and home visiting service across the county. Early help and extra support is provided to vulnerable families, children and young people as soon as problems emerge to avoid them becoming serious and entrenched. This integrated approach includes professionals working together co-ordinating support, sharing information and adopting a holistic approach to identification, assessment and planning. The targeted family support service provides support at all stages of a child's life; pre-birth, during pregnancy, childhood and adolescence.

The universal and targeted services provided in and around Children and Families Centres are part of Early Help provision for children and families in Gloucestershire. This provides community support to vulnerable children and families to promote their wellbeing and prevent problems getting worse.

[50] Effective pre-school, primary and secondary education project (EPPSE 3-16+), DfE, Research Brief, 2015

Early Years Foundation Stage Profile

Performance in the early years is measured using the Early Years Foundation Stage Profile (EYFSP. This is a teacher assessment of children's development at the end of the EYFS (the end of the academic year in which the child turns five). It should support a smooth transition to Key Stage 1 (KS1) by informing the professional dialogue between EYFS and KS1 teachers. This information should help Year 1 teachers plan an effective, responsive and appropriate curriculum that will meet the needs of all children. The Profile is also designed to inform parents or carers about their child's development against the early learning goals.

A new EYFSP was introduced in September 2017. The revised profile has a stronger emphasis on the three prime areas which are most essential for children's healthy development: communication and language; physical development; and personal, social and emotional development. There are 7 areas of learning covering 17 early learning goals (ELGs). A child is scored 1 for emerging, 2 for expected, and 3 for exceeded. Therefore the minimum score is 17 points and the maximum possible score is 51 points. The areas covered are detailed below:

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

The data can be collated into a key global score known as the GLD – Good level of Development. Children achieving a Good Level of Development are those achieving at least the expected level within the following areas of learning: communication and language; physical development; and personal, social and emotional development; literacy; and mathematics. In addition, the data is analysed in sub groups to allow levels of inequality to be assessed.

The Gender Gap looks at the difference between the percentages of girls compared to boys who achieve a good level of development. The Free School Meals Gap looks at the difference between the good level of development percentage of for those who do not receive free school meals compared to those who do receive free school meals. They are both ways of monitoring inequalities.

Policy Context

The Childcare Act 2006 places duties on local authorities to improve outcomes for young children and reduce the inequalities between them; to secure sufficient childcare to enable parents to work; and to provide information to parents about childcare and a wide range of services that may benefit them.

The Childcare Act 2016 places a duty on local authorities from September 2017 to secure sufficient places for the 30 Hours extended entitlement (an additional 15 hours a week on top of the universal entitlement) over 38 weeks of the year for qualifying children.

The Sure Start Children's Centres Statutory Guidance 2013 for local authorities, commissioners of local health services and Job Centre Plus emphasises that integrated services should be provided locally, close to where families live and for Children Centre services to act as community hub either through coordinating the delivery of services from local authority owned buildings, or from community venues.

The local authority views Children Centre services as an integral part of how it carries out its statutory duties set out in the Childcare Acts 2006 and 2016 and Working Together to Safeguard Children 2015. The core purpose of Children Centre services is to improve outcomes for young children and their families and reduce inequalities between families in greatest need and their peers (Statutory Guidance and section 2 Childcare Act 2006).

Government policy includes improvements to qualifications for the early years workforce, the introduction of early years educator qualifications, Teach First and working alongside Ofsted to reform the inspection system and challenge weak providers to improve more quickly.

Epidemiological Data Review

School Readiness - Data on Early Years Foundation Stage Attainment

Good early years provision and strong parental engagement and support both contribute to children having a good level of development and been deemed school ready when assessed against the Early years Foundation Stage profile framework

The following analysis is an overview of the 2016-17 academic year results, which is the most recently available data.

Early Years Foundation Stage Profile Results Headlines 2016-2017, National and Gloucestershire

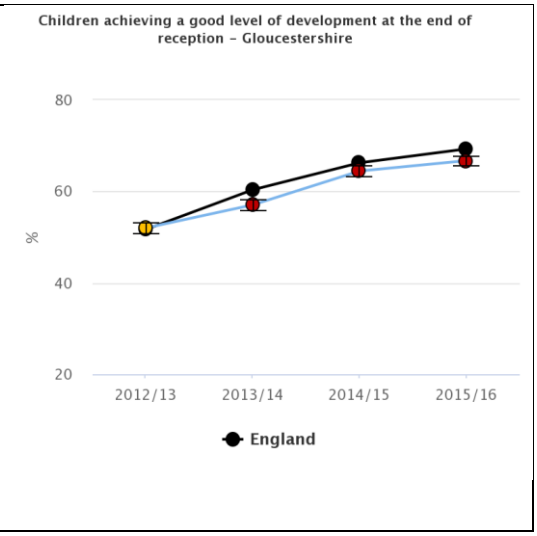
National		Gloucestershire	
71%	The proportion of children achieving a good level of development. This is up 2% from 69% last year.	**68%**	The proportion of children achieving a good level of development. This is up 1% from 67% last year.
34.5	The average EYFPS point score for 2017. This remains the same at 34.5 points in 2016.	**35.1**	The average EYFPS point score for 2017. A decrease of 0.1 points from 35.2 points in 2016.
69%	The proportion of children achieving at least the expected level in all 17 early learning goals.	**67%**	The proportion of children achieving at least the expected level in all 17 early learning goals.
14	The gender gap between the percentage of girls and boys achieving a good level of development - 78% of girls achieved a good level of development compared to 64% of boys.	**13**	The gender gap between the percentage of girls and boys achieving a good level of development - 75% of girls achieved a good level of development compared to 62% of boys.
31.7	The percentage gap between lowest 20% and the rest. An increase of 0.3% from 31.4 in 2017.	**30.4**	The percentage gap between lowest 20% and the rest. A decrease of 0.5% from 30.9 in 2016.

When GLD attainment is compared to the national and South West region it becomes clear that as a county Gloucestershire is significantly underperforming in terms of children achieving a good level of development by the end of reception. This is illustrated in the chart below:

Chart to show Gloucestershire's relative performance in Good Level of Development attainment at the end of reception

Area	Value	Lower CI	Upper CI
England	69.3	69.2	69.4
South West region	69.5	69.2	69.9
Isles of Scilly	*	-	-
Plymouth	64.0	62.3	65.7
Bristol	66.3	65.1	67.6
Gloucestershire	66.7	65.6	67.8
Cornwall	67.2	66.1	68.4
Somerset	68.7	67.5	69.9
Swindon	68.8	67.1	70.4
Bath and North East Som...	68.9	66.8	70.9
Dorset	70.1	68.6	71.4
Torbay	70.6	68.2	72.9
Wiltshire	70.8	69.6	72.0
Bournemouth	72.0	70.0	73.9
Devon	72.2	71.2	73.1
Poole	72.4	70.2	74.5
North Somerset	74.2	72.4	75.8
South Gloucestershire	76.3	74.8	77.6

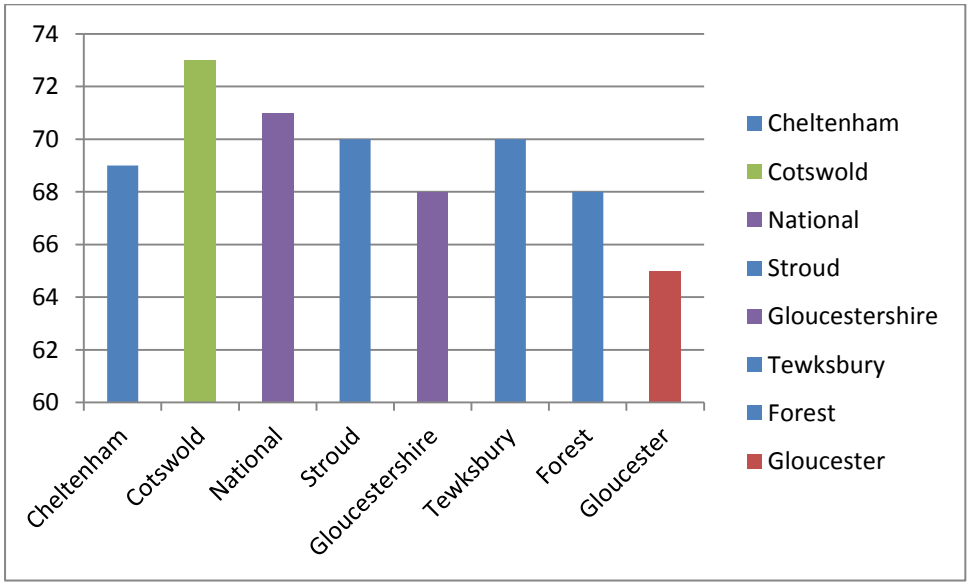
Source: Department for Education (DfE), EYFS Profile: EYFS Profile statistical series



This poor relative performance is of concern because falling behind, even at this early stage, can dramatically impact on a child's future attainment and life chances.

The proportion of those who achieve a good level of development by district is given below. Cotswold performs well above the national and county averages, Stroud and Tewkesbury perform better than the county average but slightly less than the national average. Gloucester is the worst performing district falling well below the national and county wide level of attainment.

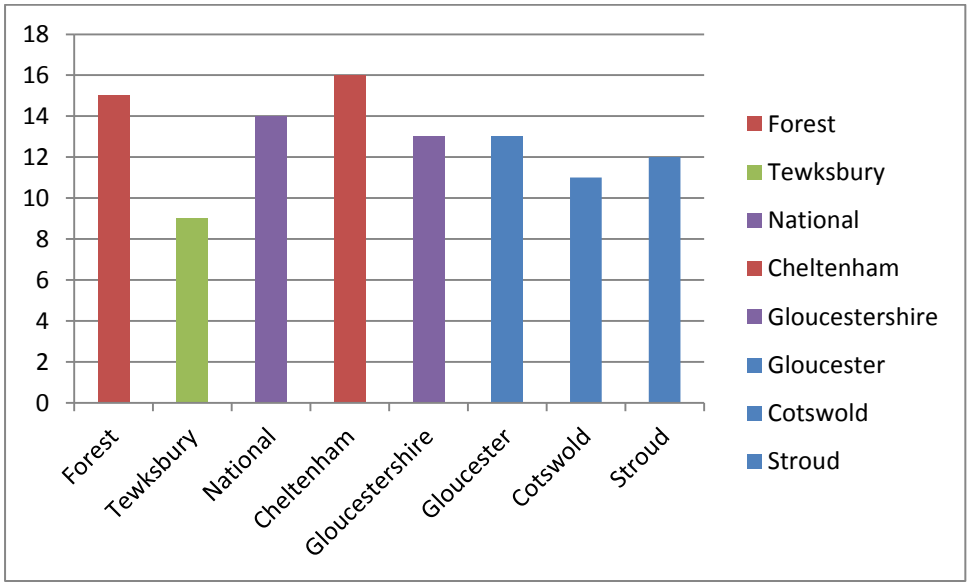
Graph showing GLD attainment by district with regional and national comparators.



Source Early Years Foundation Stage Profile data 2017: Reviewing the outcomes in each Gloucestershire Locality

The Gender Gap looks at the difference between the percentages of girls compared to boys who achieve a good level of development. The largest gender gap is seen in Cheltenham; in this region the proportion of boys achieving a good level of development is 16 percentage points lower than the girls, closely followed by the Forest of Dean where boys' attainment is 15 percentage points lower than the girls. The best performing district is Tewkesbury where the difference between girls and boys is 9%.

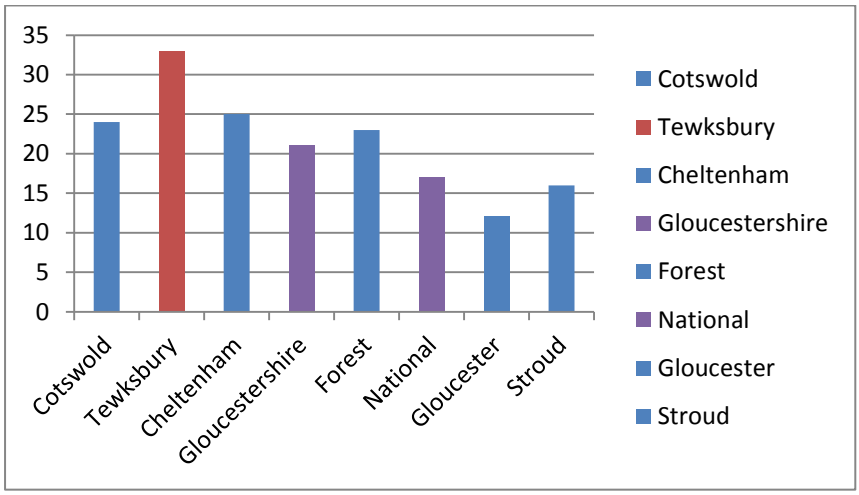
Graph showing GLD attainment Gender Gap by district with regional and national comparators



Source Early Years Foundation Stage Profile data 2017: Reviewing the outcomes in each Gloucestershire Locality

The attainment gap between those in receipt of free school meals and those who are not can be used as an indicator of social deprivation attainment inequality. Tewkesbury has a Free School Meal attainment gap of 33 percentage points; almost twice the national average.

Graph showing GLD attainment Free School Meal Gap by district with regional and national comparators



Source Early Years Foundation Stage Profile data 2017: Reviewing the outcomes in each Gloucestershire Locality

The Joseph Rowntree Foundation recently published analysis of school readiness data in terms of those achieving a good level of development by the end of reception[51]. It is of concern that, after Bath and North East Somerset, Gloucestershire ranked second worst out of 150 local authorities in the whole country terms of poorer children achieving a good level of development. In their analysis the foundation found a pattern of poor children in areas with generally low child poverty doing worse than their counterparts in authorities with higher overall levels of child poverty, suggesting that poorer children in wealthy areas are being disproportionately let down.

Data on Childcare in Gloucestershire

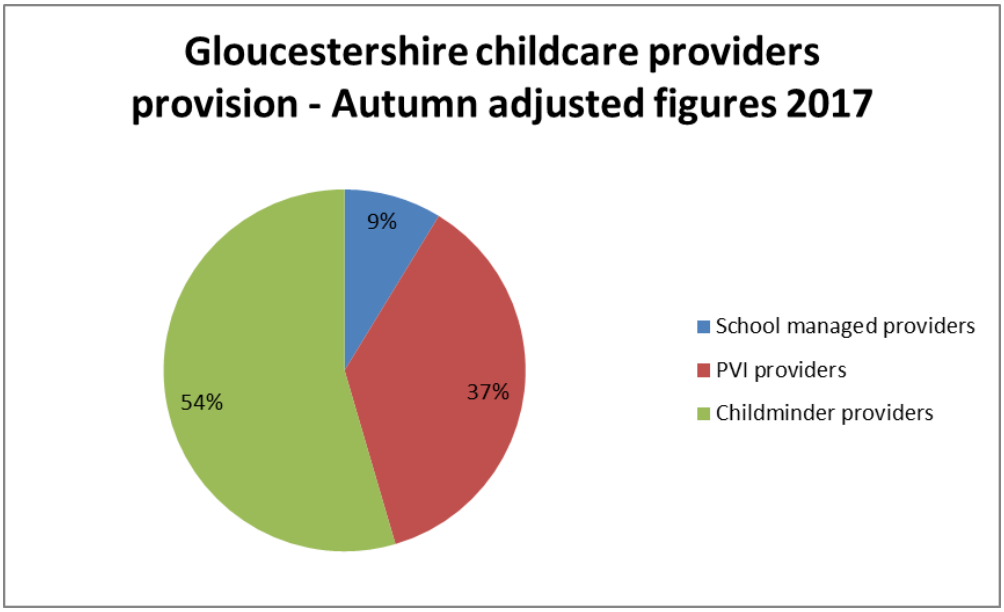
When thinking about data around early years childcare it is important to make a conscious distinction between whether one is considering provision in terms of childcare places, or in terms of childcare providers. Each provider can offer multiple childcare places. Looking at each indicator provides different information.

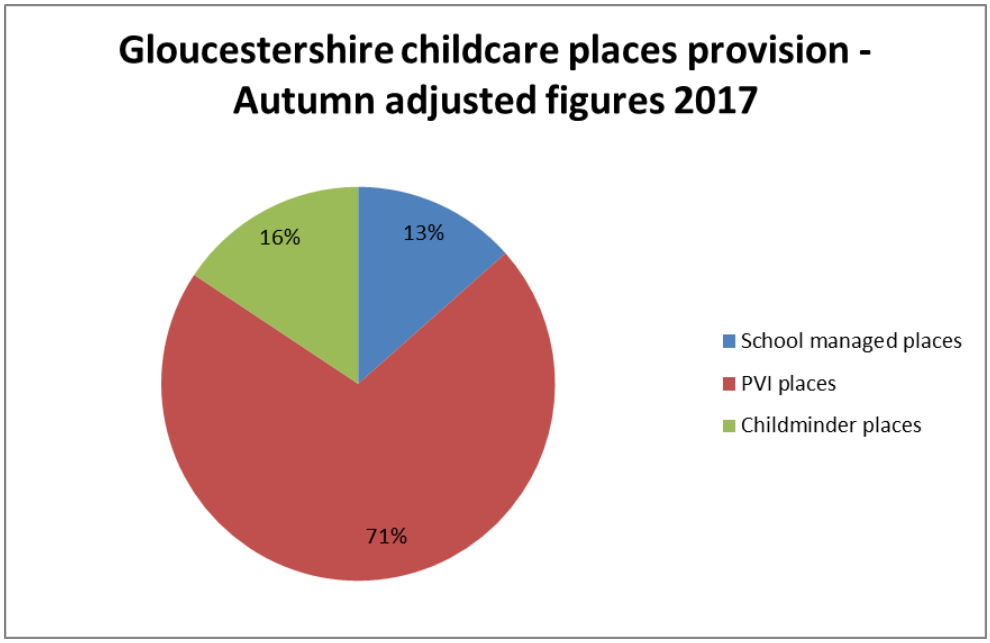
Type of childcare provision

While numerically, over half of childcare providers in Gloucestershire are childminders, this only represents 16% of funded early years childcare places; the majority of funded childcare places are in larger settings. Just over a third of providers are Private, Voluntary and Independent (PVI) providers and they provide over two thirds of places. The proportion of providers that are school managed is similar to the proportion of places offered by school managed providers.

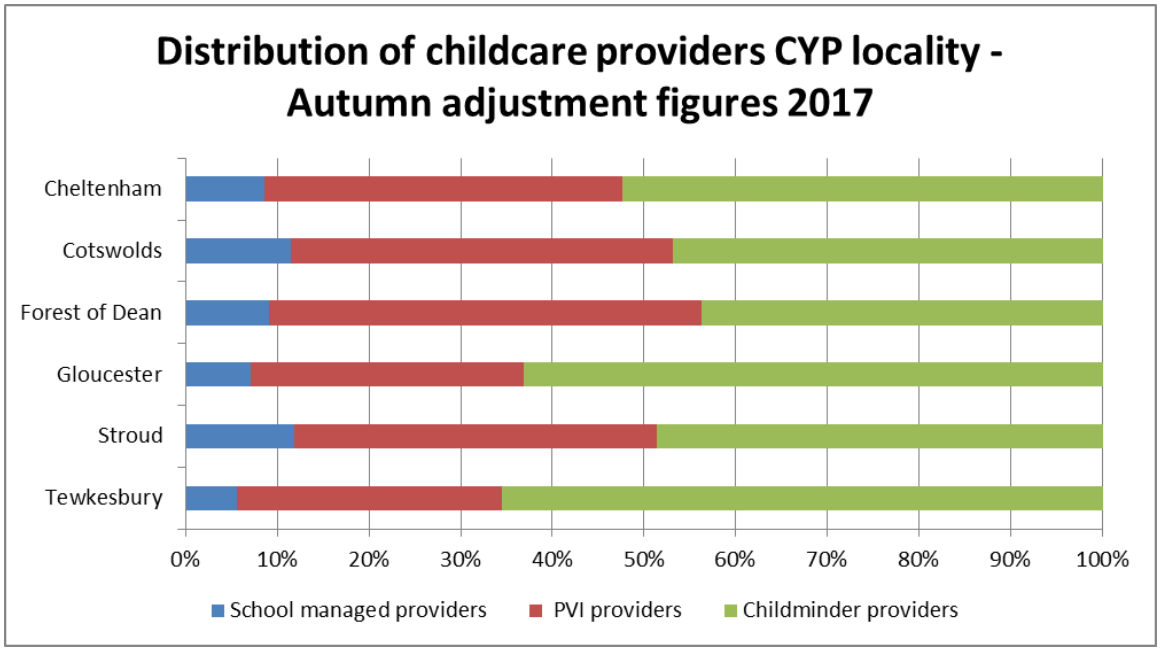
The charts below show the split of childcare provision in terms of provider characteristics and in terms of childcare place characteristics.

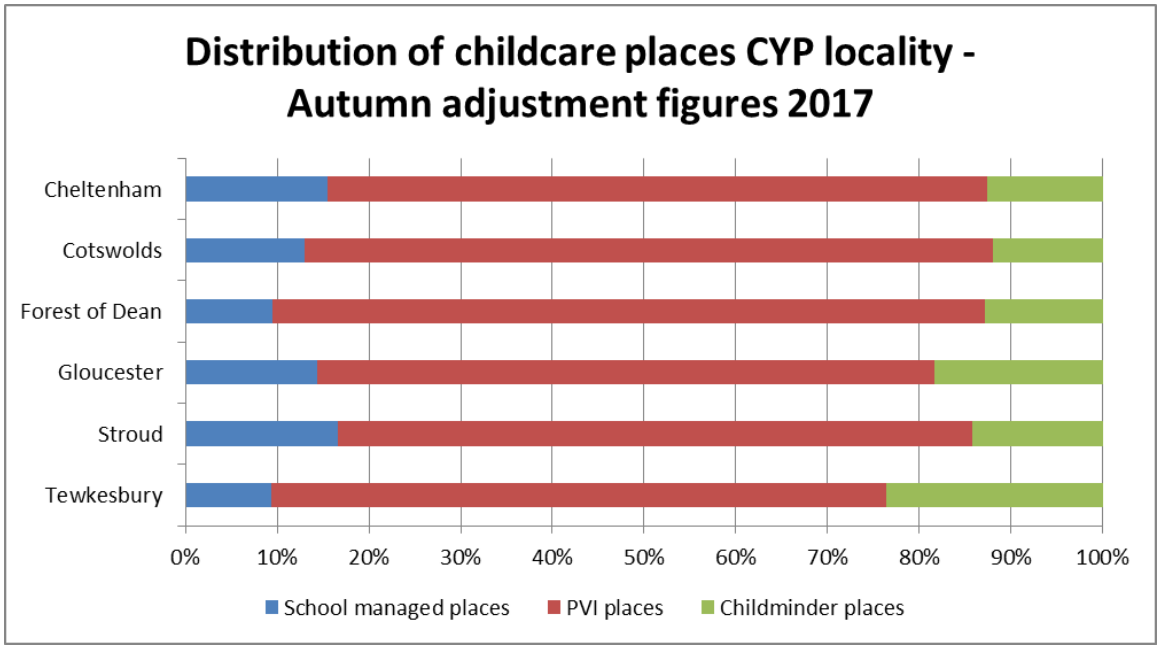
[51] https://www.jrf.org.uk/press/%E2%80%98life-chances-postcode-lottery%E2%80%99-analysis-shows-parts-country-where-children-fall-behind-age-5v



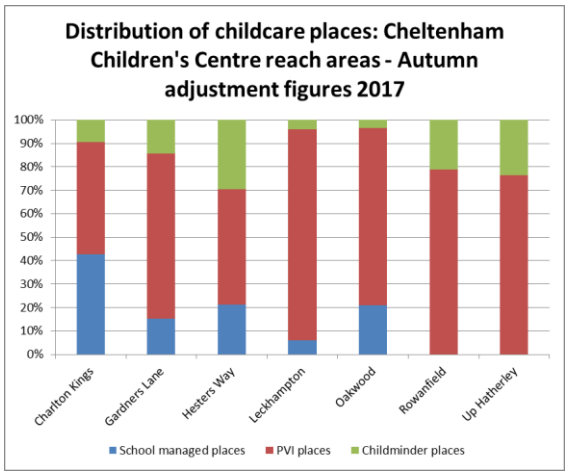


The distribution of childcare providers differs across Gloucestershire localities. The more rural localities generally have a lower proportion of childminder provision (Cotswolds, Forest of Dean and Stroud) than the urban localities (Cheltenham, Gloucester and Tewkesbury). The proportion of PVI providers is generally higher in the rural localities than the urban localities. In Stroud and Cotswold localities, over 10% of providers are school managed.





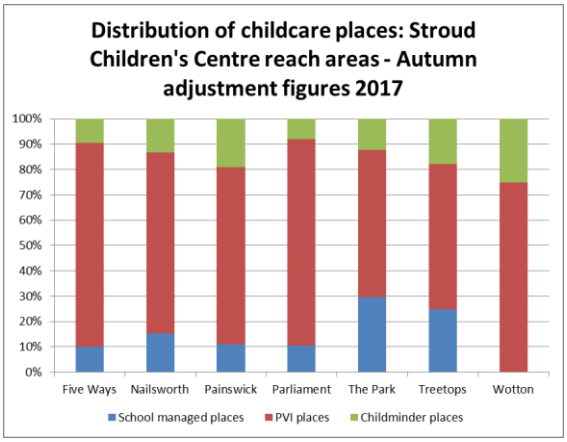
Local level data is collected by children's centre localities. In terms of children's centre areas, there are wide variations in distribution of childcare places and this is shown below.



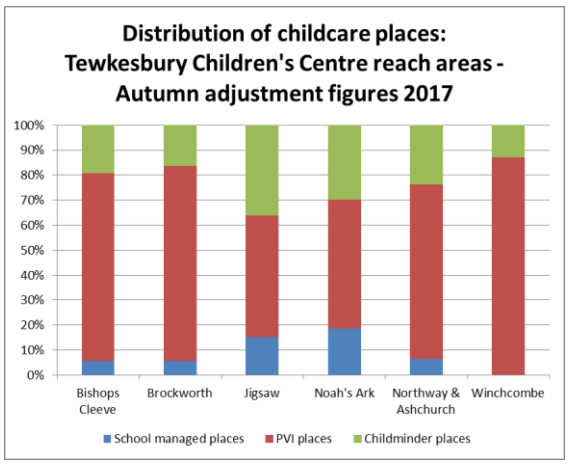
In Cheltenham locality, Charlton Kings has the highest proportion of places at school managed settings (42.7%) in both Cheltenham and Gloucestershire overall. Leckhampton has the lowest proportion (6.2%).

Leckhampton has the highest proportion of PVI places (89.8%) across the locality. The proportion of places at

child-minders is highest in Hesters Way area (29.4%), which is also one of the most deprived areas.



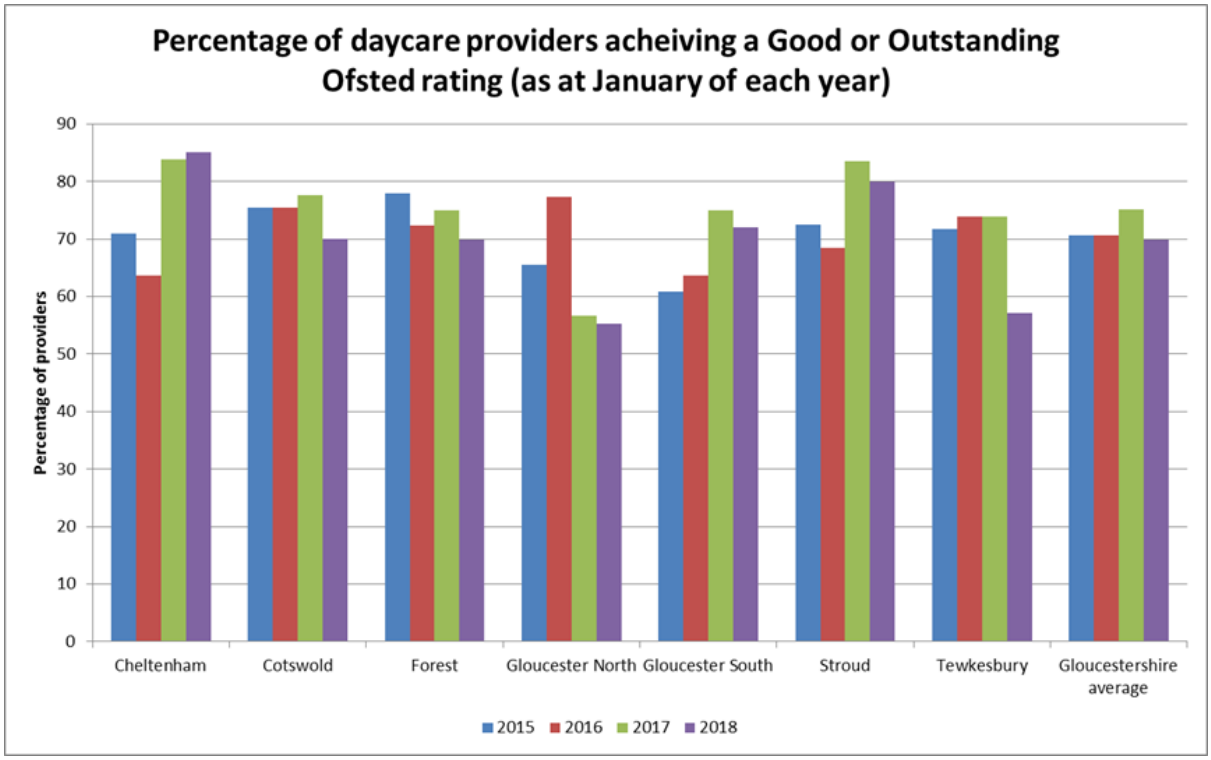
In Stroud locality, The Park and Treetops areas have around a quarter of places in school managed settings (29.7% and 24.8%). Five Ways and Parliament areas have the highest proportions of places in PVI settings (80.6% and 81.5%). A quarter of places in Wotton area are with child-minders.



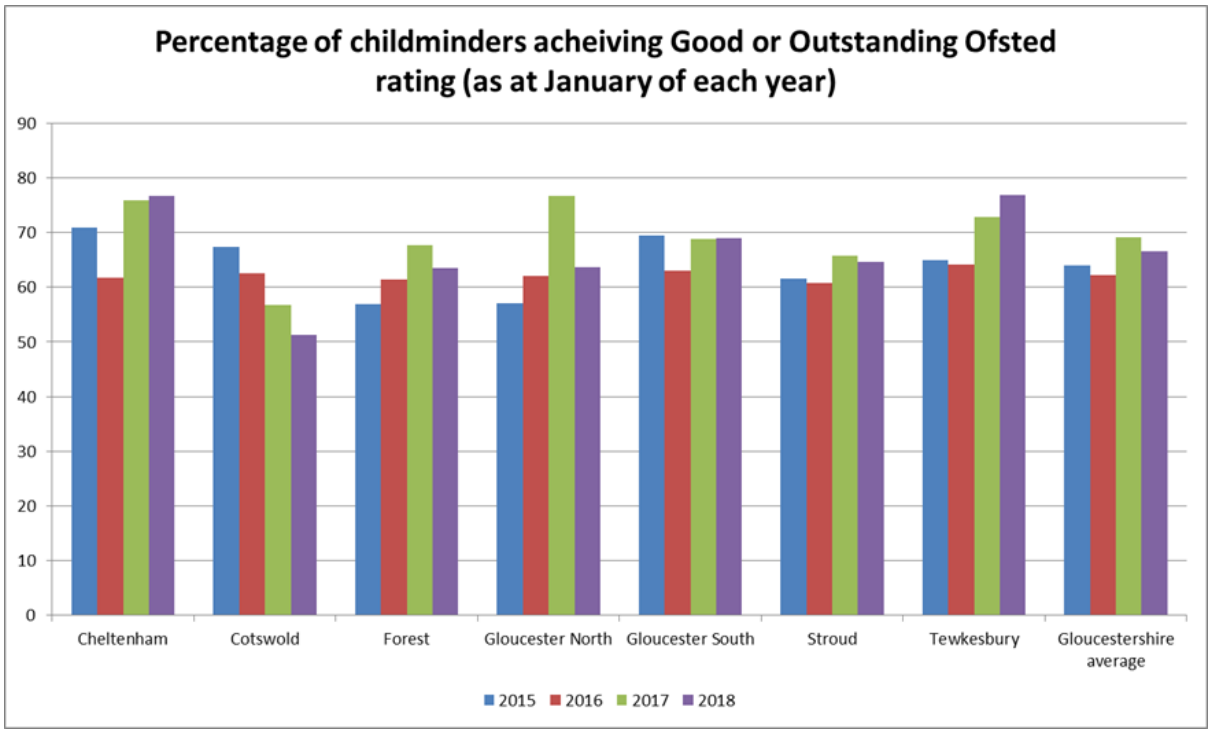
In **Tewkesbury locality**, Noah's Ark area has the highest proportion of school managed places (18.6%). Winchcombe area has the highest proportion of places in PVI settings (87.1%). Over a third of places in Jigsaw area are at child-minders (36.2%) (the highest proportion in the county).

Quality of childcare provision - Provider Ofsted ratings

Since 2015, Gloucestershire has had quite a stable record of 70% of daycare providers achieving good or outstanding Ofsted rating although this has been lower in Gloucester North for the last two years (55% 2018, 57% 2017) and Tewkesbury district for the last year (57%). The percentage of childminders achieving the same rating is slightly lower in the county (67%) with Cotswold showing a decline in outstanding or good childminders since 2015.



Source: Ofsted inspection results by locality 2015-18, Early Years Team



Source: Ofsted inspection results by locality 2015-18, Early Years Team

Childminders are generally less likely to be ranked good or outstanding than other day care providers. This may have implications for considering how to boost early years achievement.

Child attendance at high quality providers

Figures from the Government's Local Authority Interactive Tool (LAIT) show that 97% of 3 & 4 year old children claiming funding in Gloucestershire attended a provider that was rated good or outstanding in 2017. This means that providers with the lower Ofsted ratings are providing care to children younger than 3 years old.

Achieving 2 Year Olds (A2YO) – 15 hours funded early years childcare for eligible 2 year olds

Funded early years childcare is offered to vulnerable 2 year olds, including children from low-income families and looked after children. Children may be entitled to the funding if they meet one of the following criteria:

- The child has an Education Health & Care Plan (EHCP) or a current statement of special educational needs, or a SEND My Plan +.
- The child is in receipt of Disability Living Allowance.
- The child is in the care of the Local Authority, they have left care through special guardianship order, child arrangement order or an adoption order.

Potentially eligible children are identified by analysis of Department for Work and Pensions income data. Local authorities have a duty to contact parents and encourage take up of an A2YO place.

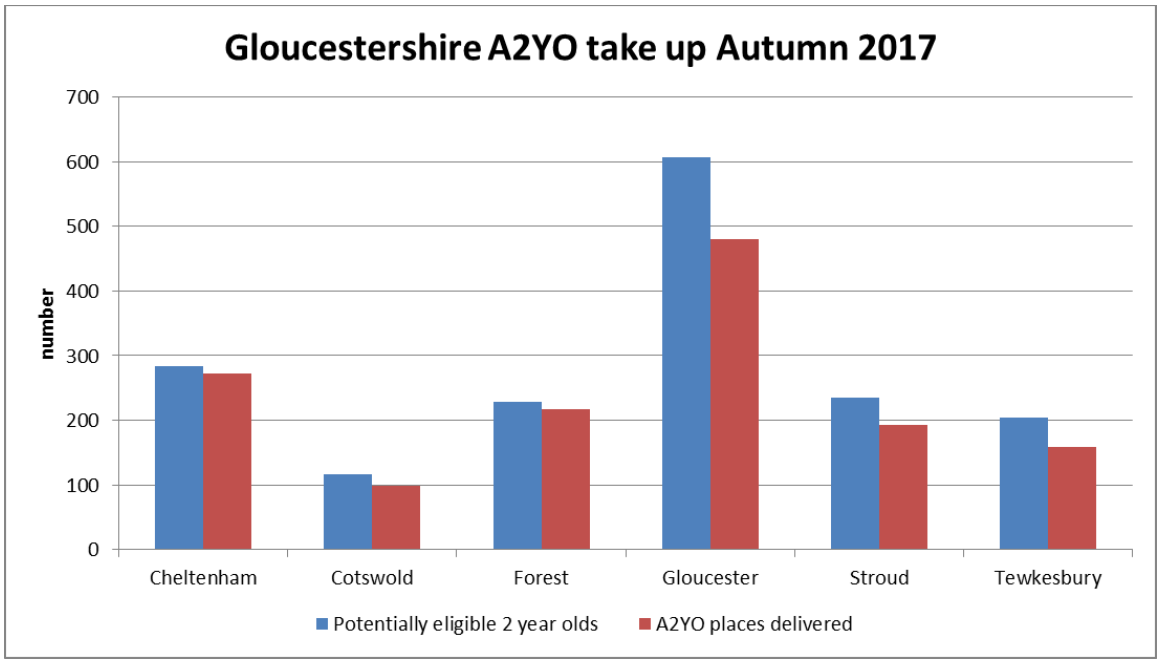
Research suggests it is difficult for children with special needs and disabilities to access good quality appropriate childcare[52] and that 25% of these children don't access any of their free entitlement of early education. This low uptake represents a source of concern because getting a good early years foundation can help boost resilience to other challenges later in life.

Across Gloucestershire approximately 84.6% of eligible 2 year old children took up a A2YO place in Autumn 2017. Take up was highest in Cheltenham locality (95.8%) and lowest in Tewkesbury locality (77.5%).

[52]Levelling the playing field – equal access to childcare for disabled children https://contact.org.uk/media/907126/levelling_the_playing_field_-_equal_access_to_childcare_for_disabled_children.pdf

A2YO take-up Autumn Term 2017			
	Potentially eligible 2 year olds	A2YO places delivered	% take up
Cheltenham	284	272	95.8
Cotswold	116	98	84.5
Forest	228	217	95.2
Gloucester	607	480	79.1
Stroud	235	192	81.7
Tewkesbury	204	158	77.5
Grand Total	1674	1417	84.6

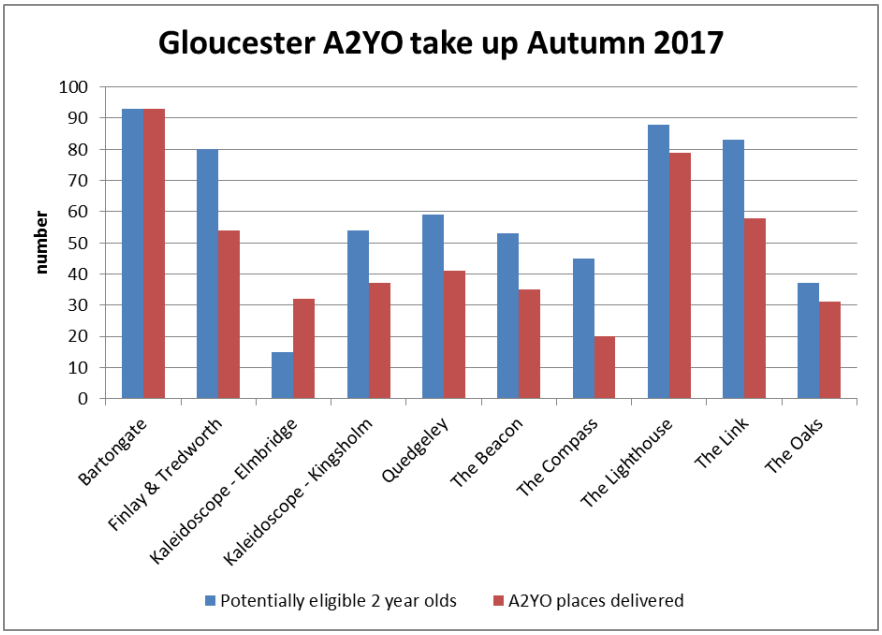
This analysis presented above identified regional variation in uptake of A2YO places with Cheltenham and Forest having high uptakes and Gloucester and Tewksbury the lowest uptake levels. In terms of absolute numbers of children missing out on free early learning places, Gloucester has the greatest number of children through a combination of a large eligible population and a low overall uptake. This is illustrated below.



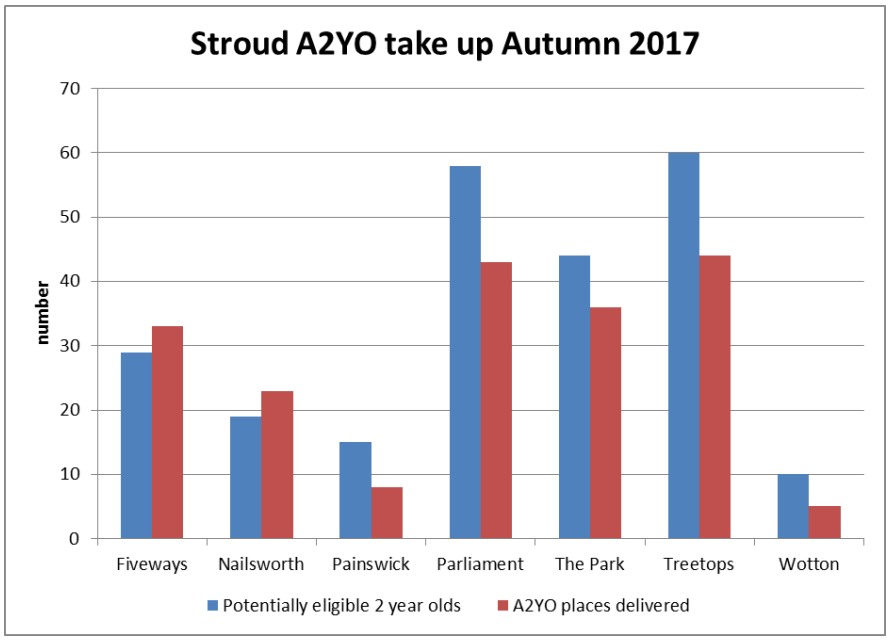
Analysis by children centre locality presents a mixed picture in terms of uptake.

In Gloucester Kaleidoscope – Elmbridge area had the highest take up (213.3%) and The Compass area had the lowest (44.4%).

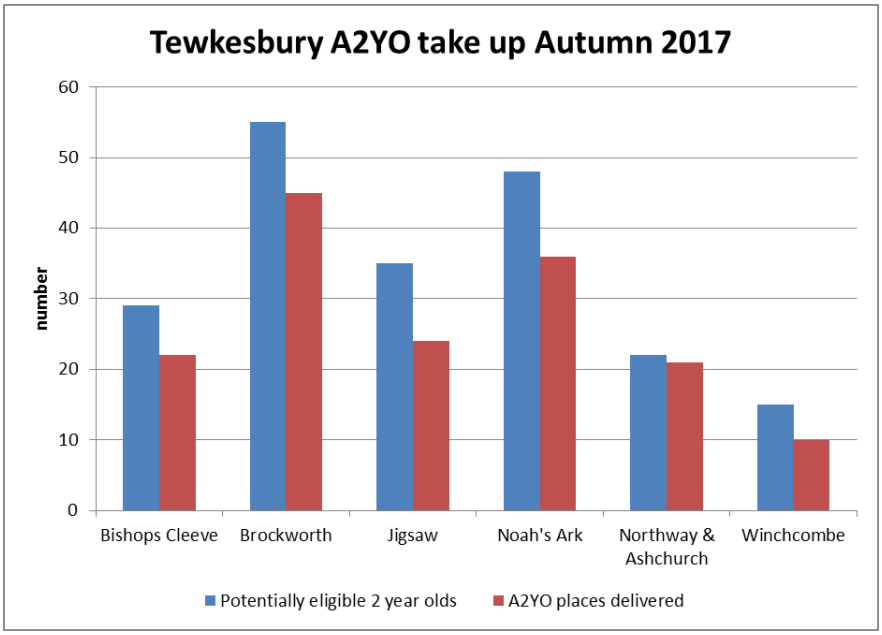
It should be noted that uptake rates of over 100% are possible in these charts due to a recognised 20% estimate variance in calculating the denominator and/or children from outside the area attending a setting and/or high numbers of children attending who are eligible through non-financial reasons (such as health visitor referral).



In Stroud, Nailsworth area had the highest take up (121.1%) and Wotton had the lowest (50%), numbers of eligible children were low in this area.



In Tewkesbury Northway & Ashchurch area had the highest take up (95.5%) and Winchcombe had the lowest (66.7%).



Generally, in most localities, the number of settings offering A2YO funded places is proportional to the number of potentially eligible children. However in Tewkesbury this is not the case.

Tewkesbury has a lower number of places than might be expected based on the number of eligible children. It also has a low rate of uptake which is the opposite of what might be expected based on the proportionate relative scarcity of places when compared to other locations. It is possible that the places available are not well matched to the areas of need meaning accessibility is preventing parents taking up places.

Universal entitlement– 15 hours funded early years childcare for all 3 & 4 year olds

The local authority has a statutory duty to ensure there is sufficient and accessible high quality early years and childcare provision. The childcare sufficiency strategy assessment is the way through which this is assessed and assured. The Gloucestershire Childcare Sufficiency Assessment is therefore one of the key sources of data for understanding the characteristics of the universal childcare offer locally and this data is used through out this section.

The Childcare Sufficiency Assessment brings together a range of information to enable the local authority to assess the sufficiency and quality of childcare provision and support the local market to meet demand. The 2017 Childcare Sufficiency Assessment examined the provision of all childcare offers (the A2YO 15 hour funded childcare offer for the most disadvantaged 2 year olds as well as the universal 15 hour funded childcare for all 3 and 4 year olds) as at Spring term 2017 and assessed providers' intention to deliver and the potential parental demand for the extended entitlement (30 Hours) from September 2017. The key findings are summarised below.

(In the tables below high uptake is flagged red as it suggests limited capacity in the system)

Gloucester City

Gloucester Children's Centre reach area	Total No of 0-5 yr old providers	Total No of 0-5 yr old places	40% of 2 yr olds eligible for early years funding @ 31.8.16	Take up of 2 yr old places (Spring 2017)	% of takeup of eligible places	No of 3 & 4 yr olds	Take up of 3 & 4 yr old Universal Places (15 hours) Spring 2017	% of takeup from 3 & 4 year old population	No of providers intending to offer Extended Entitlement (30 hours)	% of all providers intending to offer Extended Entitlement	Take up of 2, 3 & 4 yr old places	% of takeup of 2, 3 & 4 yr old places	RAG rating
Bartongate	15	295	117	92	79%	368	254	69%	6	40%	-51	117%	
Finlay & Tredworth	16	211	68	42	62%	331	103	31%	10	63%	66	69%	
Kingsholm -Elmbridge	30	481	23	41	178%	327	326	100%	21	70%	114	76%	
Kingsholm - Kingsholm	16	391	56	44	79%	283	293	104%	9	56%	54	86%	
Quedgeley	28	346	66	43	65%	540	360	67%	15	54%	-57	116%	
The Beacon	18	264	65	50	77%	437	210	48%	11	61%	4	98%	
The Compass	34	464	43	49	114%	465	302	65%	16	47%	113	76%	
The Lighthouse	23	532	86	79	92%	472	314	67%	15	65%	139	74%	
The Link	26	340	84	41	49%	464	258	56%	15	58%	41	88%	
The Oaks	19	231	42	28	67%	253	176	70%	12	63%	27	88%	

- The % of setting rated good or outstanding by Ofsted is 87% across the Gloucester City area although the quality of provision is lower in Bartongate, The Beacon, The Compass, The Link and The Oaks.
- 58% of settings plan to offer the extended entitlement, more providers in Kingsholm – Elmbridge (70%) and The Lighthouse (65%) plan to offer 30 hours than other parts of the Gloucester City district.
- Take up of places for 2, 3 & 4 year olds is strong with higher take up for 2 year old places in Kingsholm – Elmbridge, The Compass and The Lighthouse.

Cheltenham

Cheltenham Children's Centre reach area	Total No of 0-5 yr old providers	Total No of 0-5 yr old places	40% of 2 yr olds eligible for early years funding @ 31.8.16	Take up of 2 yr old places (Spring 2017)	% of takeup of eligible places	No of 3 & 4 yr olds	Take up of 3 & 4 yr old Universal Places (15 hours) Spring 2017	% of takeup from 3 & 4 year old population	No of providers intending to offer Extended Entitlement (30 hours)	% of all providers intending to offer Extended Entitlement	Take up of 2, 3 & 4 yr old places	% of takeup of 2, 3 & 4 yr old places	RAG rating
Charlton Kings	22	316	9	7	78%	269	241	90%	9	41%	68	78%	
Gardners Lane	42	719	89	81	91%	521	464	89%	20	48%	174	76%	
Hesters Way	23	278	104	95	91%	467	209	45%	12	52%	-26	109%	
Leckhampton	23	520	21	30	143%	425	314	74%	15	65%	176	66%	
Oakwood	33	311	65	56	86%	512	394	77%	10	30%	-139	145%	
Rowanfield	13	170	54	28	52%	242	643	266%	8	62%	-501	395%	
Up Hatherley	41	422	27	20	74%	402	319	79%	17	41%	83	80%	

- The % of EY providers who are rated good or outstanding by Ofsted is 87% across the Cheltenham locality although the quality of provision is lower in Charlton Kings, Gardners Lane, Leckhampton and Rowanfield areas.
- Less than 50% of settings (48%) plan to offer the extended entitlement.
- Take up of 2, 3 & 4 year old places is high with higher take up for 2 year old places in Gardners Lane, Hesters Way and Leckhampton and higher take up for 3 & 4 year old places in Charlton Kings and Rowanfield.

Tewkesbury

Tewkesbury Children's Centre reach area	Total No of 0-5 yr old providers	Total No of 0-5 yr old places	40% of 2 yr olds eligible for early years funding @ 31.8.16	Take up of 2 yr old places	% of takeup of eligible places	No of 3 & 4 yr olds	Take up of 3 & 4 yr old Universal Places (15 hours) Spring 2017	% of takeup from 3 & 4 year old population	No of providers intending to offer Extended Entitlement (30 hours)	% of all providers intending to offer Extended Entitlement	Take up of 2, 3 & 4 yr old places	% of takeup of 2, 3 & 4 yr old places	RAG rating
Bishops Cleeve	38	501	49	42	86%	466	288	62%	20	53%	171	66%	
Brockworth	25	402	48	37	77%	391	256	65%	12	48%	109	73%	
Jigsaw	31	350	33	38	115%	406	255	63%	17	55%	57	84%	
Noah's Ark	36	384	37	24	65%	406	238	59%	19	53%	122	68%	
Northway & Ashchurch	19	250	26	16	62%	166	127	77%	14	74%	107	57%	
Winchcombe	11	182	12	4	33%	162	99	61%	4	36%	79	57%	

- The % of setting rated good or outstanding by Ofsted is 84% across the Tewkesbury area although the quality of provision is lower in Brockworth, Northway and Ashchurch and Bishops Cleeve.
- 54% of settings plan to offer the extended entitlement, notably more providers in Northway and Ashchurch plan to offer 30 hours (74%) than other parts of the Tewkesbury district.
- Take up of places for 2, 3 & 4 year olds is generally good with higher take up for 2 year old places in Bishops Cleeve and Jigsaw.
- Sufficiency of places for 2, 3 & 4 year olds is strong in Northway and Ashchurch and Winchcombe.

Stroud

Stroud Children's Centre reach area	Total No of 0-5 yr old providers	Total No of 0-5 yr old places	40% of 2 yr olds eligible for early years funding @ 31.8.16	Take up of 2 yr old places	% of takeup of eligible places	No of 3 & 4 yr olds	Take up of 3 & 4 yr old Universal Places (15 hours) Spring 2017	% of takeup from 3 & 4 year old population	No of providers intending to offer Extended Entitlement (30 hours)	% of all providers intending to offer Extended Entitlement	Take up of 2, 3 & 4 yr old places	% of takeup of 2, 3 & 4 yr old places	RAG rating
Fiveways	20	287	21	26	124%	274	171	62%	7	35%	90	69%	
Nailsworth	23	342	26	20	77%	283	192	68%	12	52%	130	62%	
Painswick	33	311	20	16	80%	287	196	68%	13	39%	99	68%	
Parliament	25	421	65	42	65%	394	253	64%	14	56%	126	70%	
The Park	32	461	44	50	114%	394	289	73%	12	38%	122	74%	
Treetops	41	528	65	50	77%	529	331	63%	20	49%	147	72%	
Wotton	17	191	7	8	114%	195	138	71%	7	41%	45	76%	

- The % of EY providers who are rated good or outstanding by Ofsted is 87% across the Stroud locality although the quality of provision is lower in Painswick and Wotton areas.
- Less than 50% of settings (44%) plan to offer the extended entitlement.
- Take up of 2, 3 & 4 year old places is reasonable with higher take up for 2 year old places in Fiveways, The Park and Wotton.
- Sufficiency of places for 2, 3 & 4 year olds is good. There is an above average demand for 2 year old places.

Forest of Dean

Forest of Dean Children's Centre reach area	Total No of 0-5 yr old providers	Total No of 0-5 yr old places	40% of 2 yr olds eligible for early years funding @ 31.8.16	Take up of 2 yr old places	% of takeup of eligible places	No of 3 & 4 yr olds	Take up of 3 & 4 yr old Universal Places (15 hours) Spring 2017	% of takeup from 3 & 4 year old population	No of providers intending to offer Extended Entitlement (30 hours)	% of all providers intending to offer Extended Entitlement	Take up of 2, 3 & 4 yr old places	% of takeup of 2, 3 & 4 yr old places	RAG rating
Hilltop	29	395	69	44	64%	360	251	70%	19	66%	100	75%	
River	49	673	96	82	85%	620	453	73%	24	49%	138	79%	
The Family Tree - Branches	38	488	36	26	72%	344	275	80%	16	42%	187	62%	
The Family Tree - Leaves	27	353	57	58	102%	335	233	70%	11	41%	62	82%	
The Family Tree - Twigs	13	240	22	25	114%	175	258	147%	9	69%	-43	118%	

- The % of EY providers who are rated good or outstanding by Ofsted is 87% across the Forest of Dean locality although the quality of provision is lower in Hilltop and Leaves.
- 53% of settings plan to offer the extended entitlement.
- Take up of places for 2, 3 & 4 year olds is good with Twigs having notably higher than average take up for 2 and 3 & 4 year olds.
- Sufficiency of childcare places for 2, 3 & 4 year olds is good apart from Twigs and 2 year old places in Leaves.

Cotswold

Cotswolds Children's Centre reach area	Total No of 0-5 yr old providers	Total No of 0-5 yr old places	40% of 2 yr olds eligible for early years funding @ 31.8.16	Take up of 2 yr old places	% of takeup of eligible places	No of 3 & 4 yr olds	Take up of 3 & 4 yr old Universal Places (15 hours) Spring 2017	% of takeup from 3 & 4 year old population	No of providers intending to offer Extended Entitlement (30 hours)	% of all providers intending to offer Extended Entitlement	Take up of 2, 3 & 4 yr old places	% of takeup of 2, 3 & 4 yr old places	RAG rating
Springboard - Cirencester	46	686	54	50	93%	646	643	100%	25	54%	-7	101%	
Springboard - Northleach & Fairford	30	369	23	15	65%	402	292	73%	11	37%	62	83%	
Springboard - Stow	29	572	12	19	158%	423	275	65%	17	59%	278	51%	
Springboard - Tetbury	14	280	37	29	78%	207	152	73%	6	43%	99	65%	

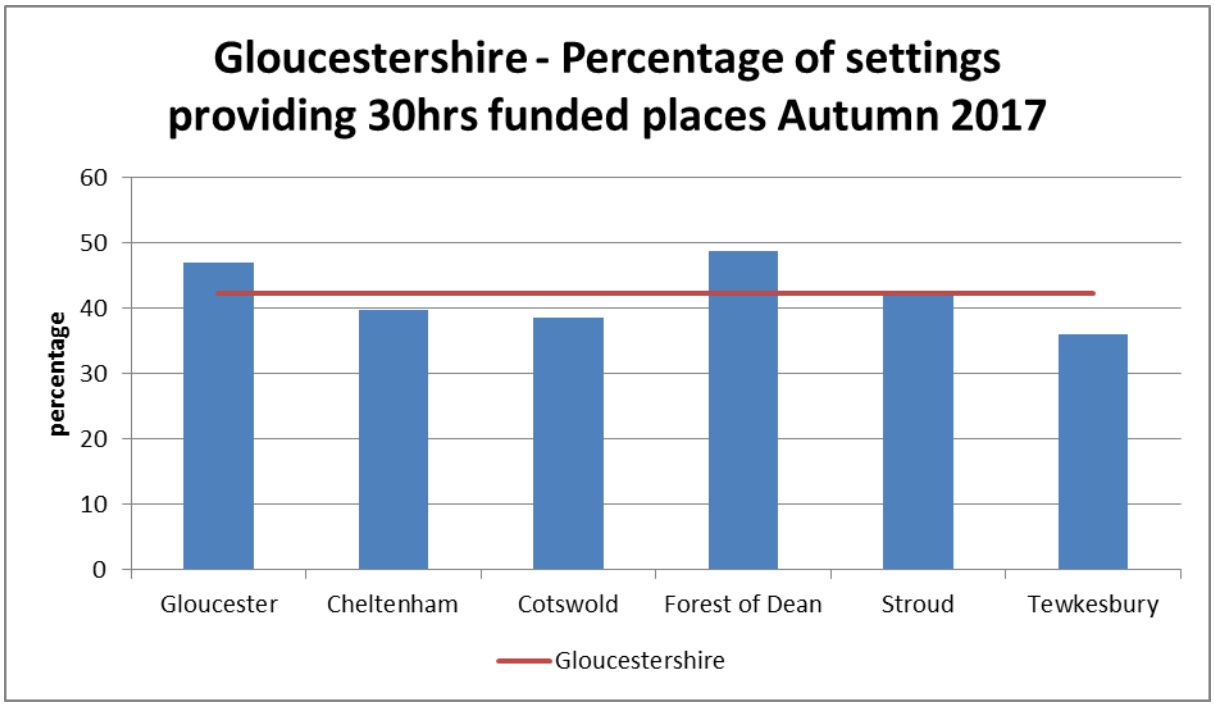
- The % of setting rated good or outstanding by Ofsted is 92% across the Cotswolds area although the quality of provision is lower in Northleach & Fairford and Tetbury.
- 48% of settings plan to offer the extended entitlement.
- Take up of places for 2, 3 & 4 year olds is good (75%) with higher take up for 2,3 & 4 year old places in Cirencester but lower take up in Stow.

30 Hours early years funded childcare (extended entitlement)

Since 1st September 2017, eligible working parents can access an additional 15 hours of funded early years childcare, an extension of their 15 hours universal entitlement. Called the 30 Hours childcare offer or extended entitlement, it is available to working parents of 3 and 4 year olds who work a minimum of 16 hours a week on National Minimum Wage or Living Wage. Both parents have to be working or the sole parent working in a lone parent family. The extended entitlement can either be taken term time or stretched over the full year. It is not mandatory for providers to offer 30 Hours to parents but the local authority encourages and works with childcare settings to do so. Parents are able to access the extended entitlement by using multiple providers.

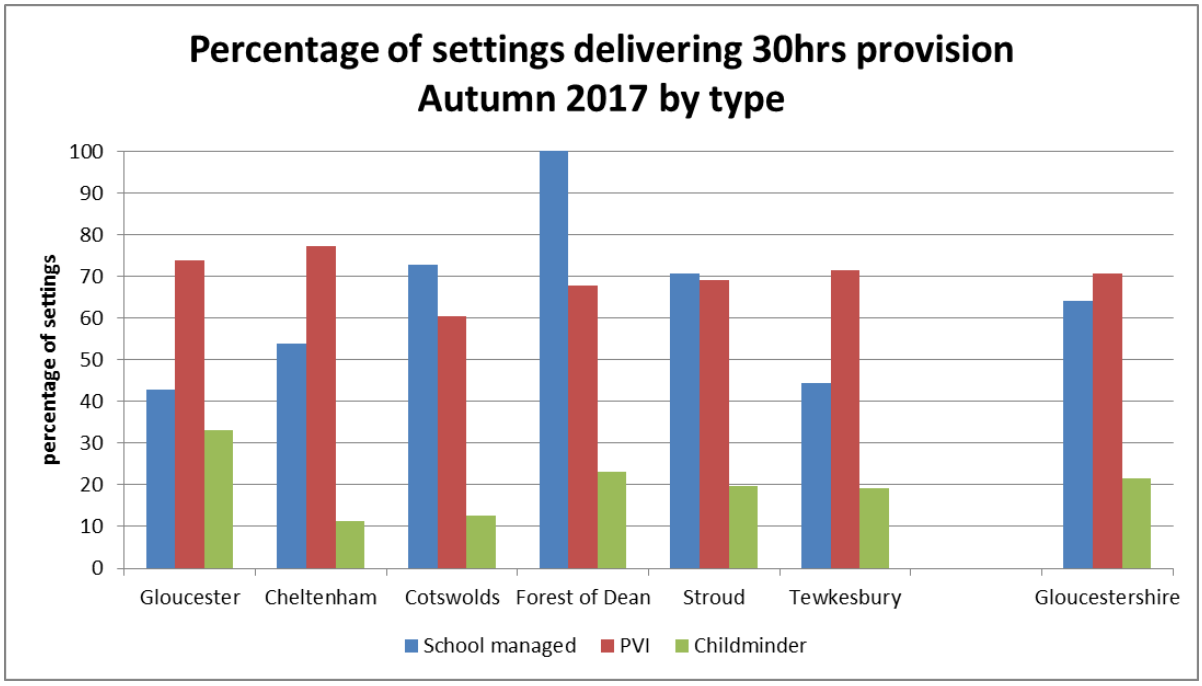
Analysis of the Autumn 2017 (the first term of 30 Hours delivery) showed that across Gloucestershire 42% of providers delivered the extended entitlment. However there was slight

variation in the localities. Tewkesbury had the lowest percentage of providers delivering 30 Hours provision. Locality levels are illustrated below.



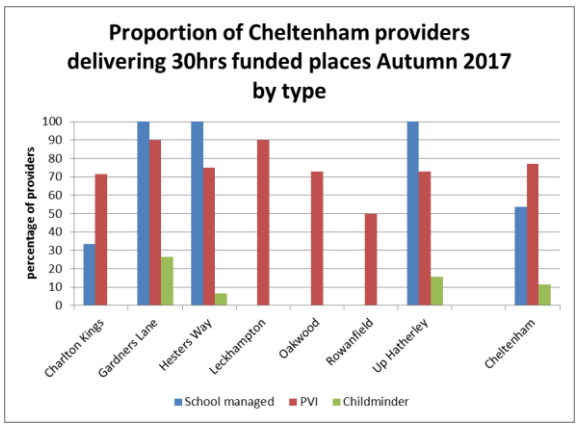
There is also variation by provider type. Around 70% of PVI providers across Gloucestershire have delivered 30 Hours provision, 64% of school managed providers have delivered the free 30 hours but only 21% of childminders did.

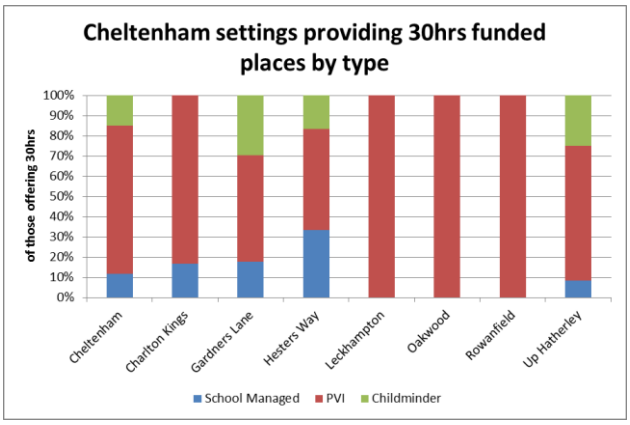
In the localities; Gloucester has the lowest proportion of school managed providers delivering 30 Hours (42%) in contrast all school managed providers delivered 30 Hours in Forest of Dean; Cotswolds had the lowest proportion of PVI providers offering 30 Hours (60%), Cheltenham had the highest (78%); Cheltenham had the lowest proportion of childminders offering 30 Hours (11%) and Gloucester had the highest (32%). This information is summarised in the chart below.



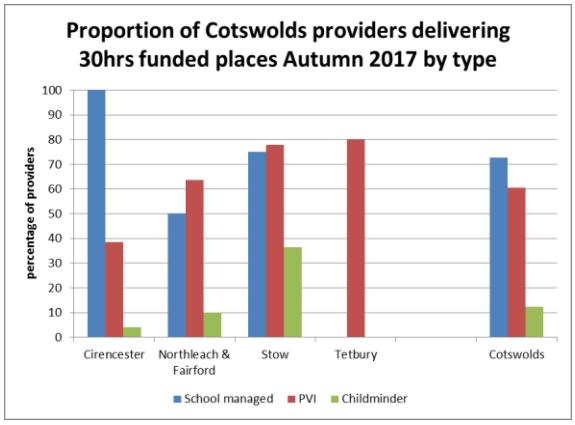
The data can also be analysed at the locality level and this is shown in the sections below.

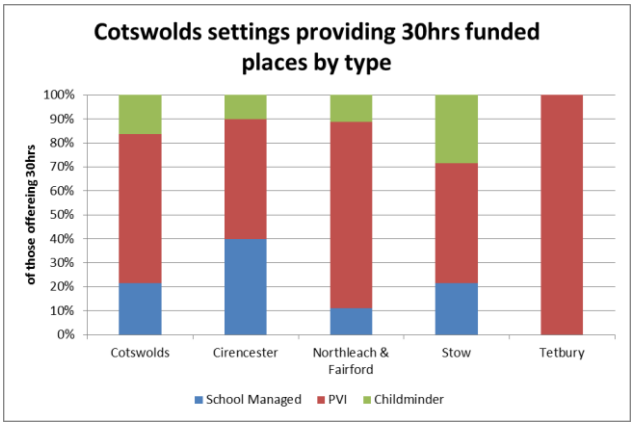
In Cheltenham locality around three quarters of PVI providers are delivering 30 Hours, but the number of school managed providers (52%) and childminders (12%) delivering 30 Hours is lower than the Gloucestershire averages. In most areas a high proportion of PVI providers offered 30hrs (Rowanfield was the lowest with 50%). In 3 children's centre reach areas (Leckhampton, Oakwood and Rowanfield) the only providers offering 30 Hours are PVI settings. In Cheltenham, around 74% of 30 Hour places are delivered by PVI providers but the percentage of places at school managed providers (11%) and childminders (15%) are lower than the Gloucestershire averages.





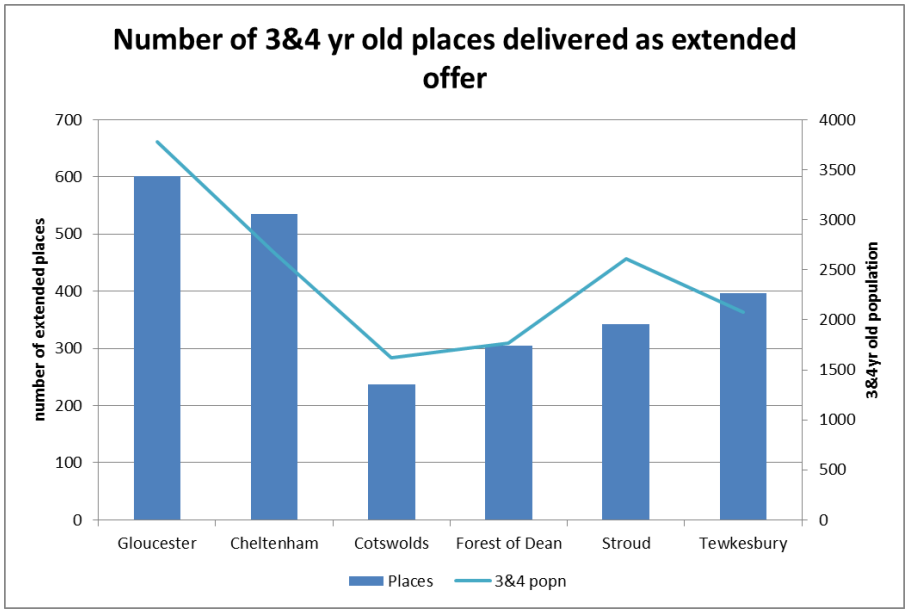
In Cotswolds locality around 70% of school managed providers are delivering 30 Hours, 60% of PVI providers but only 13% of childminders are. In Cotswolds, the percentage of 30 Hour places being delivered by PVI providers is comparable to Gloucestershire but there is a higher percentage of school managed places (21%) but lower percentage of places at childminders (17%).





In Cirencester, all school managed providers are delivering 30 Hours; the proportion delivering 30 Hours was also high in the other areas, except Tetbury. A high proportion of childminders in Stow area are delivering 30 Hours.

In autumn 2017, 2417 childcare places for 3&4 year olds were delivered as the 30 Hours offer.



	Extended 30hrs placements				
Locality	**Places**	**School managed**	**PVI**	**Childminder**	**3&4 popn**
Gloucester	601	41	487	73	3776
Cheltenham	535	71	442	22	2670
Cotswolds	237	33	196	8	1625
Forest of Dean	305	43	236	26	1769
Stroud	343	60	262	21	2609
Tewkesbury	396	30	344	22	2075
Gloucestershire	**2417**	**278**	**1967**	**172**	**14524**

The number of 30 Hours places across the localities varies in relation to population. Generally those areas with larger populations of 3 & 4 year olds have more 30 Hour places being delivered.

Qualitative Data Review

During the last couple of years, the local authority has engaged with parents, families and children to understand their thoughts and views on proposals for reshaping services for families with young children and potential demand for the new extended childcare entitlement (30 Hours).

Key findings from these consultation activities were:

- 87% supported the proposal for an integrated family support service for families and children aged 0-11 years
- Of those parents who thought they were eligible for the 30 hours and had children aged 3 or 4:
  - 61% thought they would take up the full 30 hours
  - 70% said they would wish to use childcare all year round rather than term time only
  - 37% said they would use more than one provider to access 30 hours childcare
- The majority of those consulted believed the proposed locations of the 16 children and family hubs would have no impact or a positive impact on their families
- 76% of parents with 3 and 4 year old children were accessing some extra paid formal childcare in addition to their universal childcare and 41% said they used some informal childcare. These figures suggest a strong need for additional funded childcare for 3 & year old children
- 71% agreed that existing children's centre childcare facilities should be expanded to deliver the extended entitlement of 30 hours for working parents of 3 & 4 year olds. However many parents believed that government proposals to increase funded hours to 30 a week was too much for very young children
- 44% were happy with the quality of the childcare provider(s) they were able to access meaning 56% were not
- 42% of responses cited a lack of suitable childcare as a personal barrier to training or working
- 77% thought that the proposed targeted family support service would have a positive impact on the early identification and support for children with special needs and disabilities
- There was variable agreement for the location of the 30 children's centre buildings and development of these to become a network of universal services for families. In Gloucester North locality this was high at 82% but in Stroud, agreement was much lower at 45%.

Local Service Provision

Children's Centres

The local authority commissions the provision of an Early Help service that delivers a targeted family support service for children pre- birth to 11 and their families in Gloucestershire. The service is delivered from 16 Children and Families Centres based in the areas of greatest deprivation and provides an outreach and home visiting service across the county.

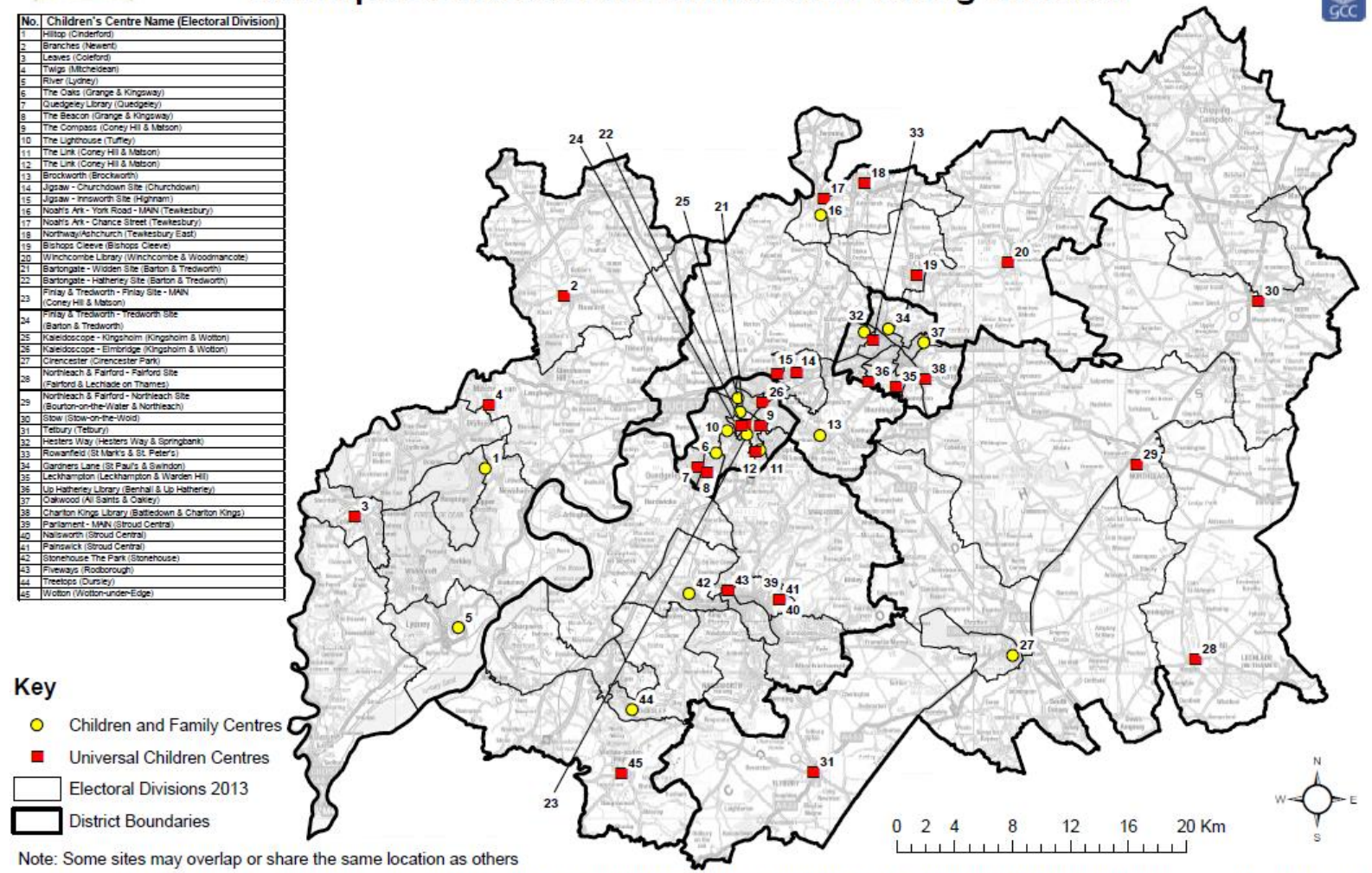
Barnardos delivers the targeted family support service for Gloucester City (6 Children and Family Centres), Stroud (2 Children and Family Centres) and Forest of Dean (2 Children and Family Centres). Gardners Lane and Oakwood Foundation (GLOW) delivers the targeted family support service for Cheltenham (3 Children and Family Centres) and Tewkesbury (2 Children and Family Centres). The

local authority provides the targeted family support service for Cotswold (1 Children and Family Centre).

A network of 29 satellite children's centres provide early education, childcare and universal services for families including hosting informal community activities and office bases for professionals who work with families. Universal services for families are provided by partner organisations, the voluntary and community sector and volunteers from these satellite centres.

Reshaped Services for Families with Young Children

No.	Children's Centre Name (Electoral Division)
1	Hilltop (Cinderford)
2	Branches (Newent)
3	Leaves (Coleford)
4	Twigs (Mitcheldean)
5	River (Lydney)
6	The Oaks (Grange & Kingsway)
7	Quedgeley Library (Quedgeley)
8	The Beacon (Grange & Kingsway)
9	The Compass (Coney Hill & Matson)
10	The Lighthouse (Tuffley)
11	The Link (Coney Hill & Matson)
12	The Link (Coney Hill & Matson)
13	Brockworth (Brockworth)
14	Jigsaw - Churchdown Site (Churchdown)
15	Jigsaw - Innsworth Site (Highnam)
16	Noah's Ark - York Road - MAIN (Tewkesbury)
17	Noah's Ark - Chance Street (Tewkesbury)
18	Northway/Ashchurch (Tewkesbury East)
19	Bishops Cleeve (Bishops Cleeve)
20	Winchcombe Library (Winchcombe & Woodmancote)
21	Bartongate - Wilden Site (Barton & Tredworth)
22	Bartongate - Hatherley Site (Barton & Tredworth)
23	Finlay & Tredworth - Finlay Site - MAIN (Coney Hill & Matson)
24	Finlay & Tredworth - Tredworth Site (Barton & Tredworth)
25	Kaleidoscope - Kingsholm (Kingsholm & Wotton)
26	Kaleidoscope - Elmbridge (Kingsholm & Wotton)
27	Cirencester (Cirencester Park)
28	Northleach & Fairford - Fairford Site (Fairford & Lechlade on Thames)
29	Northleach & Fairford - Northleach Site (Bourton-on-the-Water & Northleach)
30	Stow (Stow-on-the-Wold)
31	Tetbury (Tetbury)
32	Hesters Way (Hesters Way & Springbank)
33	Rowanfield (St Mark's & St. Peter's)
34	Gardners Lane (St Paul's & Swindon)
35	Leckhampton (Leckhampton & Warden Hill)
36	Up Hatherley Library (Benhall & Up Hatherley)
37	Oakwood (All Saints & Oakley)
38	Charlton Kings Library (Battledown & Charlton Kings)
39	Parliament - MAIN (Stroud Central)
40	Nailsworth (Stroud Central)
41	Painswick (Stroud Central)
42	Stonehouse The Park (Stonehouse)
43	Fivelways (Rodborough)
44	Treetops (Dursley)
45	Wotton (Wotton-under-Edge)



Note: Some sites may overlap or share the same location as others

G Browne - May 2016

Children and Family Centres offer:

- targeted work with children and their families aged pre-birth-11 years
- 1:1 home base support with a range of interventions delivered by a highly skilled team of experienced Family Support Workers
- Working with families from Level 2 - Early Help to Child Protection (Levels of Intervention)
- Working with the Whole Family Approach and ensuring the voice of child captured.

Examples of group work provided by Children and Family Centres are:

- Parenting programmes e.g. Solihull, Triple P, Webster Stratton
- Best Start programme
- Domestic abuse programmes e.g. Freedom, You me and Mum
- Targeted Family Time Group
- Provide support to 'walkins' through the door.

Examples of services delivered by partners from the Children and Family Centres:

- Baby hubs
- Co-location of health visitors.
- Midwife drop in
- Breastfeeding support groups
- Childminder support groups
- Postnatal support
- Autism support group
- Universal family support groups
- Parent Led groups
- Adult Education courses
- Case conference and Family meetings
- Counselling services

The targeted family support service delivers tailored support, intervention and services to a range of target groups identified by national guidance as being vulnerable to poor outcomes and include lone parents, teenage mothers and pregnant teenagers, children from low income backgrounds, children living with domestic abuse, adult mental health issues and substance abuse, children showing early signs of abuse/neglect, children 'in need' or with a child protection plan or who are in the care of the local authority, children with additional needs, children with disabilities etc.

The reshaped services for families of young children have been operational since 1st April 2017. It is too early to fully evidence the impact of the targeted family support service in improving outcomes for children and families. Work is in progress to develop the reporting capability of the information/case management system to support effective monitoring and evaluation of the service.

Early Education and Childcare provision

In Gloucestershire, early education and childcare services are provided by over 850 pre schools (school managed), independents (school managed), day nurseries, playgroups, childminders, out of school clubs, holiday schemes and home carers. Unlike many other local authorities, Gloucestershire does not have any Local Authority maintained nurseries.

Childcare providers are supported by local authority's Early Years staff who provide business support, training, quality improvement support in advance of and post inspection, targeted

intervention etc to ensure provision of sustainable, high quality and accessible childcare services to children and parents.

The Family Information Service offers a wide range of information to support families, children and young people from 0 – 19 years old (25 for young people with additional needs). This includes a telephone and email enquiry service and online directory providing information on finding and choosing childcare, funding support for children with special educational needs, helping parents with childcare entitlement queries, family support, benefits, funding, etc.

	New CMs	**Closed CMs**	**New Daycare**	**Closed Daycare**	**New CM places**	**Closed CM places**	**New Daycare places**	**Closed Daycare places**
April – Mar 2015	58	89	59	55	260	428	1129	613
2015 Net Turnover	-31		4		-168		516	
2015 provider/ place net change	Loss of 27 providers				Increase of 348 places			
April – Mar 2016	51	80	67	68	242	383	761	555
2016 Net Turnover	-29		-1		-141		206	
2016 provider/ place net change	Loss of 30 providers				Increase of 65 places			
April – Dec 2017	41	71	72	62	221	385	725	692
2017 Net Turnover	-30		10		-164		33	
2017 provider/ place net change	Loss of 20 providers				Loss of 131 places			
2015 – 2017 net change	**Loss of 77 providers**				**Increase of 282 places**			

Over the last 2.5 years there has been a net loss of 77 providers but an increase of 282 childcare places across Gloucestershire. Gloucestershire is currently working with new and current early years providers in areas where sufficiency is not matched to places e.g. in securing funds to offer a limited number of small grants to enable providers to make small-scale adaptions to buildings to increase provision of 30 Hour funded childcare places.

Gloucestershire libraries support the Bookstart Scheme which is a national bookgifting programme. Bookstart gifts free books to all children in England and Wales at two key ages before school (Baby Packs before a child's first birthday and Treasure Packs for 3 and 4 year old children) to help families read together every day and support school readiness.
www.gloucestershire.gov.uk/libraries/activities-and-services-in-libraries/bookstart/

Evidence around What Works

PHE[53] and NICE[54] specify a number of recommendations to improve the delivery of effective early education and childcare. These include:

Policy

- Ensure arrangements are in place for integrated commissioning of universal and targeted services for children aged under 5. This includes services offered by general practice, maternity, health visiting, school nursing and all early years' providers.
- Ensure all vulnerable children can benefit from high quality childcare outside the home on a part- or full-time basis and can take up their entitlement to early childhood education, where appropriate.

Community Level Actions

- Health and early years' practitioners should work with community and voluntary organisations to help vulnerable parents who may find it difficult to use health and early years' services. The difficulties may be due to their social circumstances, language, culture or lifestyle.
- Managers and providers of early education and childcare services should ensure all vulnerable children can benefit from high quality services which aim to enhance their social and emotional wellbeing and build their capacity to learn. Services should:
    - promote the development of positive, interactive relationships between staff and children
    - ensure individual staff get to know, and develop an understanding of, children's needs (continuity of care is particularly important for younger children)
    - focus on social and emotional, as well as educational, development

Ofsted's[55] research of good practice in preparing disadvantaged and vulnerable children for school by successful early years providers in deprived areas found:

- Where providers had developed close partnerships they were more likely to have developed a localised mutual understanding of what was expected in terms of children's readiness at the time of transfer.
- Evidence of good practice in engaging parents and carers was seen mainly but not exclusively through children's centres. They were particularly effective in working with other agencies to engage vulnerable parents and target support where it was most needed.
- Ofsted found examples of very good practice where providers in disadvantaged areas worked closely with parents and carers through the transition period. These providers were increasing parental understanding of what was expected in terms of school readiness and were providing parents with information and guidance on how best to get their child ready.
- In the settings visited, a significant majority of children experienced learning and developmental delays. They were working below a typical level of development on arrival. Providers reported three common areas of developmental delay in children's social and emotional development, physical development and communication.

[53] PHE, *Health matters: giving every child the best start in life*. 2016.
[54] NICE, *Social and emotional wellbeing: early years*. 2012
[55] Ofsted: Are you Ready? Good practice in school readiness 2014

- Half of all settings made reference to specific programmes of support and appropriate interventions that were a significant factor in helping children to develop their speaking, listening and communication skills. This process was very well overseen. In many settings it was led and managed by speech and language therapists, enabling children to acquire new skills rapidly and gaps to be closed.
- The positive impact made on children's communication development when every member of staff spoke clearly and understood the importance of promoting opportunities for children to speak in sentences and initiate questions, and of engaging in children's imaginative role-play scenarios.
- All school headteachers working with children in disadvantaged areas saw the benefit of providing discrete adult-directed teaching sessions, often to small groups of children. The settings visited were effective in improving the achievement of disadvantaged children.
- Schools were using Pupil Premium funding to ensure the early identification and specialist support for children from their starting points. In one example of excellent practice, schools and a children's centre were working in partnership to ensure gains made by disadvantaged children in early years settings were not set back over the summer holidays.
- Quickly completing an accurate assessment of a child's starting point or baseline was common to all successful settings visited. It is of particular importance in areas of deprivation, where children often arrive with learning and development delays. In order to catch up, children require high-quality provision and individualised support on arrival in a new setting. Where settings reached out to work in partnership with providers from across private, voluntary and independent early years settings, the better the accuracy of baseline assessments.
- Underpinning the success in helping children make rapid progress in developing areas of weakness, the very best settings knew their locality well and had identified common areas of weakness in children's starting points. Accordingly, they completed additional baseline assessments that provided a more detailed identification of children's knowledge and skills. Settings made effective use of a range of standardised assessments of a child's hearing vocabulary (receptive), phonological awareness and expressive language.

Discussion, Gap Identification and Recommendations

Strengths in this area:

- Stable record of majority of daycare providers achieving good or outstanding Ofsted ratings
- Strong take-up of Achieving 2 year old places especially in Cheltenham and Forest of Dean and 3&4 year old universal childcare, particularly in Cheltenham and Gloucester localities
- Combination of universal and targeted support offered to children and families in all localities
- The majority of families and parents are either in agreement with or favourable to the location of the 16 children and family hubs.

Areas of Concern

- Lower number of childminder places available in rural areas – particularly Cotswold, Forest of Dean and Stroud

- Lower number of PVI providers in urban areas –particularly Tewkesbury and Gloucester
- Proportion of daycare providers achieving good or outstanding Ofsted ratings in Gloucester North locality and Tewkesbury is lower than the county average
- Proportion of childminders achieving good or outstanding Ofsted ratings is lower than daycare providers in Gloucestershire and is notably lower in Cotswold
- In the first term of provision, less than half of childcare providers are delivering the extended entitlement (30 Hours). Only 21% of childminders are providing additional hours
- The proportion of children achieving either a good or the expected level of development in their EYFS profile is 2-3% lower than the national average. Gloucester district is the worst performing locality in Gloucestershire of children achieving a good level of development when compared against county and national levels
- Cheltenham has the largest gender gap when comparing the good levels of development attained by boys and girls
- Gloucestershire is ranked the second worst local authority for poorer children achieving a good level of development. Tewkesbury and Cheltenham have the largest attainment gaps between those in receipt of free school meals and those who are not
- Over the last 2.5 years, Gloucestershire has lost more childcare providers than it has had open.

Recommendations

Promote availability and take-up of high quality early childcare by raising partner/professional awareness of access to Achieving 2 year old places with a health visitor referral and to parents on Universal Credit (who may have been missed off Department for Work and Pension lists issued to local authorities[56]).

Investigate the lower than average uptake of 2 year old places in Tewkesbury and Gloucester. Determine whether availability of places is matched to need and if accessibility of places is preventing uptake.

Improve the quality of childcare provision in childminders by working with the market to share best practice, encourage peer support and to work in partnership to improve standards of practice.

Assess the uptake of children with SEND accessing high quality childcare and identify ways to increase uptake to reduce inequality of building a good early years foundation that builds resilience to cope with other challenges later in life.

Increase provision of 30 Hours delivery especially in Tewkesbury, Cotswold and Cheltenham and by childminders to enable working parents and those wanting to return to work access to affordable and high quality childcare.

[56] https://www.cypnow.co.uk/cyp/news/2004765/glitch-left-thousands-of-families-at-risk-of-missing-out-on-free-childcare?utm_content=&utm_campaign=190118_DailyNews&utm_source=Children%20%26%20Young%20People%20Now&utm_medium=adestra_email&utm_term=https%3A%2F%2Fwww.cypnow.co.uk%2Fcyp%2Fnews%2F2004765%2Fglitch-left-thousands-of-families-at-risk-of-missing-out-on-free-childcare

Develop the reporting capability of the information/case management system to provide management reports on progress of the targeted family support service against service performance measures and indicators and its impact on improving outcomes for young children and families.

Continue to support improvement and sustainability of the childcare market by promoting and facilitating peer support and partnership working, providing support with business modelling, providing financial assistance where possible for small-scale premises adaptions, advising on levels of childcare demand etc.

School Age and Young People

School Age and Young People

"Adolescence is a critical time for health. The first signs of many serious long term conditions emerge at this age. It is also a time when sexual activity starts, many risk-taking behaviours begin and when life-long health behaviours are set in place" Association for Young Peoples Health

A) Mental Health and Emotional Wellbeing

Introduction

The World Health Organisation[57] defines mental health as:

> "*a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.*"

As the above definition makes clear, mental health is more than simply the absence of disease and there is now an increasing emphasis on positive mental health and wellbeing. However, much of the traditional focus has been on managing ill health, and much of the readily available data reflects this focus. Mental ill health is a broad term which encompasses a wide spectrum of difficulties ranging from everyday stress and worry through to severe depression or acute psychosis. The spectrum spans conditions managed mainly by primary care and community organisations, to conditions that are almost exclusively managed by highly specialist referral centres.

There is a clearly stated aim that there should be parity of esteem between mental and physical health conditions. While there is progress, there is still much to be achieved in this arena with stigma persisting and children still being negatively affected. Although over 14 years ago, a 2004 survey found that nearly 10% of children aged 5-16 in this country have a clinically diagnosable mental health condition, but only a minority receive any form of effective intervention. This is damaging and costly, not only in terms of immediate distress to the children and families concerned but also because untreated childhood mental health problems have a strong tendency to persist into later life, often with a wide range of adverse consequences, including extra costs for individuals, taxpayers and society.

The most common mental health conditions affecting children and young people are conduct disorder (e.g. severe behavioural problems), anxiety, depression and attention deficit hyperactivity disorder (ADHD).

The following discussion does not comprehensively cover all aspects of children and young people's mental health; this is covered in the Mental Health Needs Assessment available on the Inform

[57] World Health Organisation. Mental Health: a state of well-being, http://www.who.int/features/factfiles/mental_health/en/

Gloucestershire website https://inform.gloucestershire.gov.uk/viewpage.aspx?c=page&page=Health-NeedsAssessments308044211C This section looks mainly at mental wellbeing and the issues around self harm which are reported at higher rates in Gloucestershire than nationally.

Policy Context

The *Future in Mind* government report, launched in 2015 and produced by the Children and Young People's Mental Health and Wellbeing Taskforce, made 5 key recommendations;

- Promoting resilience, prevention and early intervention,
- Improving access to effective support – a system without tiers,
- Care for the most vulnerable,
- Accountability and transparency
- Developing the workforce[161]
- In addition, the Government's 2011 Mental Health strategy, *No Health without Mental Health*, pledged to provide early support for mental health problems [58]with the then Deputy Prime Minister's 2014 strategy, *Closing the Gap: priorities for essential change in mental health*, including actions such as improving access to psychological therapies for children and young people[59].

Local Context

A full Children's and Young People Mental Health Needs Assessment was carried out in August 2015 and can be found at: https://inform.gloucestershire.gov.uk/viewpage.aspx?c=page&page=ChildrenandYoungPeople

This needs assessment informed the development of the Gloucestershire Future in Mind transformation plan for children and young people's emotional health and wellbeing, which was published by local partners in October 2015 and updated annually.

This review will look at updated indicators around general wellbeing, aggregate indicators of mental ill health and consider self harm in more detail as this is an area where rates of admission to hospital are high in children and young people locally.

[58] Government, No health without mental health: A cross-government mental health outcomes strategy for people of all ages. 2011

[59] DoH, *Closing the Gap: Priorities for essential change in mental health* 2014

Epidemiological Data Review

Data in this section is split into three sections: data on hospital admissions for mental ill health, data around mental wellbeing and then data around the specific issue of self harm in young people as this has been highlighted as an area of concern given the Gloucestershire performs worse than nationally in terms of hospital admissions.

Public Health England Fingertips Data

Public Health England collates a number of mental health indicators that focus more on ill health. The summary table for Gloucestershire benchmarked nationally is given below:

Mental Health Indicators for Children and Young People

Compared with benchmark Better Similar Worse Lower Similar Higher Not Compared

Benchmark Value

Worst/Lowest 25th Percentile 75th Percentile Best/Highest

Indicator	Period	Glouc'shire			Region	England	England		
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Estimated prevalence of mental health disorders in children and young people: % population aged 5-16	2015	–	7,138	8.7%*	8.9%*	9.2%*	7.0%		11.0%
Estimated prevalence of emotional disorders: % population aged 5-16	2015	–	2,787	3.4%*	3.4%*	3.6%*	2.8%		4.2%
Estimated prevalence of conduct disorders: % population aged 5-16	2015	–	4,242	5.1%*	5.3%*	5.6%*	4.0%		6.9%
Estimated prevalence of hyperkinetic disorders: % population aged 5-16	2015	–	1,121	1.4%*	1.4%*	1.5%*	1.1%		1.9%
Prevalence of potential eating disorders among young people: estimated number aged 16 - 24	2013	–	8,335	8,335*	-	*	-	-	-
Prevalence of ADHD among young people: estimated number aged 16 - 24	2013	–	8,825	8,825*	-	*	-	-	-
Cause for concern - Looked after children where there is cause for concern: % of looked after children	2015/16	–	95	40.9	43.3	37.8	55.6		20.5
Hospital admissions as a result of self harm: DSR per 100,000 population aged 10-24	2015/16	–	611	580.8	597.8	430.5	102.5		1,444.7
Hospital admissions as a result of self harm: Crude rates per 100,000 (10-14 yrs)	2015/16	↑	82	248.1	302.0*	225.1	38.9		839.3
Hospital admissions as a result of self harm: Crude rates per 100,000 (15-19 yrs)	2015/16	↑	321	886.1	915.0*	648.8	157.3		1,899.9
Hospital admissions as a result of self harm: Crude rates per 100,000 (20-24 yrs)	2015/16	→	208	606.0	578.2*	410.3	53.2		1,582.3
Pupils with social, emotional and mental health needs (Primary school age)	2016	–	945	2.06%	2.70%	2.08%	0.97%		4.01%
Pupils with social, emotional and mental health needs (Secondary school age)	2016	–	577	1.53%	2.55%	2.36%	0.92%		5.51%
Pupils with social, emotional and mental health needs (School age)	2016	–	1,653	1.95%	2.78%	2.34%	0.97%		4.63%

Source: PHE Fingertips[60]

[60] https://fingertips.phe.org.uk/profile-group/child-health/profile/cypmh/data#page/1/gid/1938133090/pat/6/par/E12000009/ati/102/are/E10000013/iid/91141/age/246/sex/4

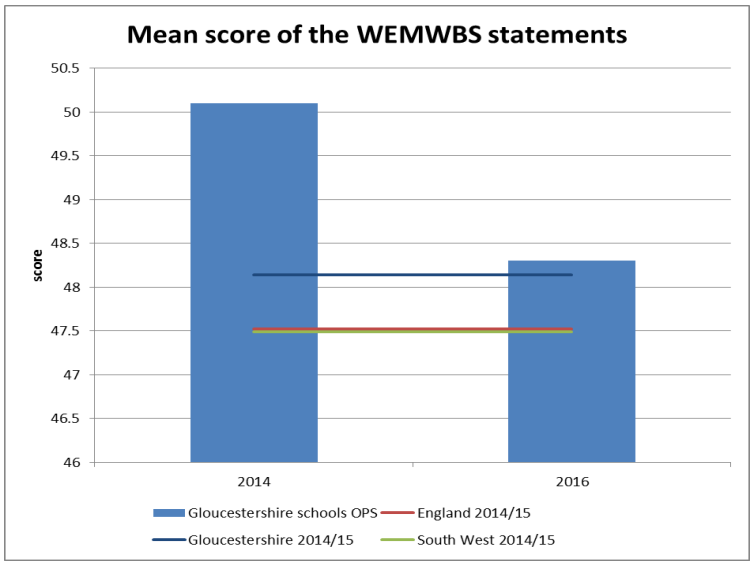
The data collated by PHE is a mixture of estimates and data from hospital admissions and school reported data. From the table above, the data around hospital admissions as a result of self harm show a recent upward trend indicator in the 10-14 and 15-19 age groups and are also higher than national averages. The self harm data is reviewed in more detail in the section on self harm.

Mental Wellbeing

Mental ill health is one end of the mental health spectrum and mental wellbeing is the other end. Mental wellbeing is important as it plays a large part in personal resilience to adversities. A large number of factors contribute to mental wellbeing and an individual's wellbeing is a dynamic state, which can change over time.

The Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) is one way of measuring aggregate mental wellbeing. WEMWBS is formed of 14 statements covering a range of feelings and attitudes towards life. Participants are asked to rate how often they felt like each of the 14 statements on a scale ranging from 'None of the time' to 'All of the time'. Responses are scored from 1 to 5. Each participant is given a single score based on their responses to the 14 statements which ranges from 14 – 70 (a sum of their scores to the individual statements). A higher score denotes greater emotional wellbeing.

The WEMWBS scale was used in a survey of 15 year olds across the country: What About YOUth (WAY) survey 2014/15. Children in the secondary phase in Gloucestershire were also asked to complete the WEMWBS survey as part of the OPS. To ensure data comparability only answers from those in Y10 (aged 14-15 years) have been used in the chart below.

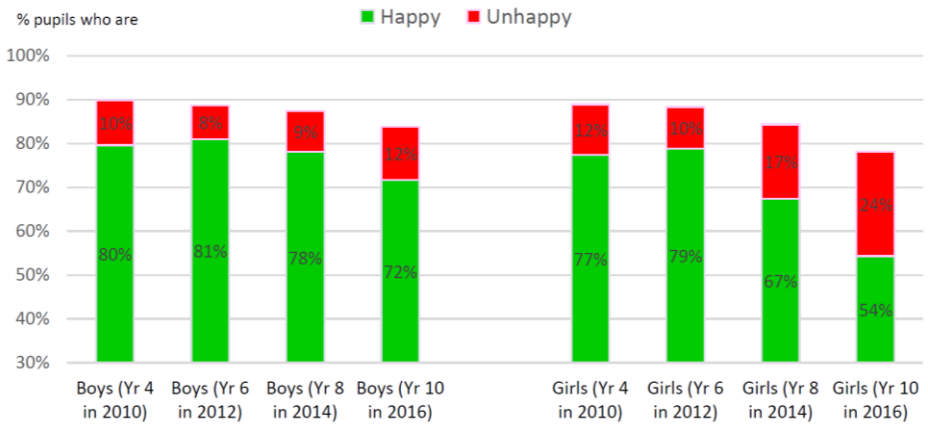


Source: https://fingertips.phe.org.uk

The Online Pupil Survey comparator data suggests that mental wellbeing has decreased between the Y10 cohort surveyed in 2014 and the Y10 cohort surveyed in 2016.The chart suggests that 15 year old children in Gloucestershire do still record slightly better mental wellbeing than those in the South West and England (although not significantly so).

The results of the Online Pupil Survey allow us to track self-reported happiness (a construct related to wellbeing) over a longer period. The graph below has been built from the OPS data to try to follow the same year group of pupils (a cohort of about 4,500 young people) tracked from 2010, when they were in year 4 (aged 8-9), to 2016 when they were in year 10 (aged 14-15). Technically this can not be guaranteed to be the exact same children as some will move in and out of the cohort each year, but it is the best possible approximation that can be built from the data. The decrease in reported happiness is seen in both boys and girls but the decline in happiness is much greater for girls between year 4 and year 10. The corresponding increase in unhappiness (as opposed to neutral feelings) is even more marked with a doubling in the number of girls reporting being unhappy in Year 10 compared to Year 4.

Figure 43: What % of our young people are happy? Genders compared following the cohort who were in Year 4 in 2010 and in Year 10 for the 2016 OPS.



Hospital Admissions for Mental Health Illness in Children and Young People

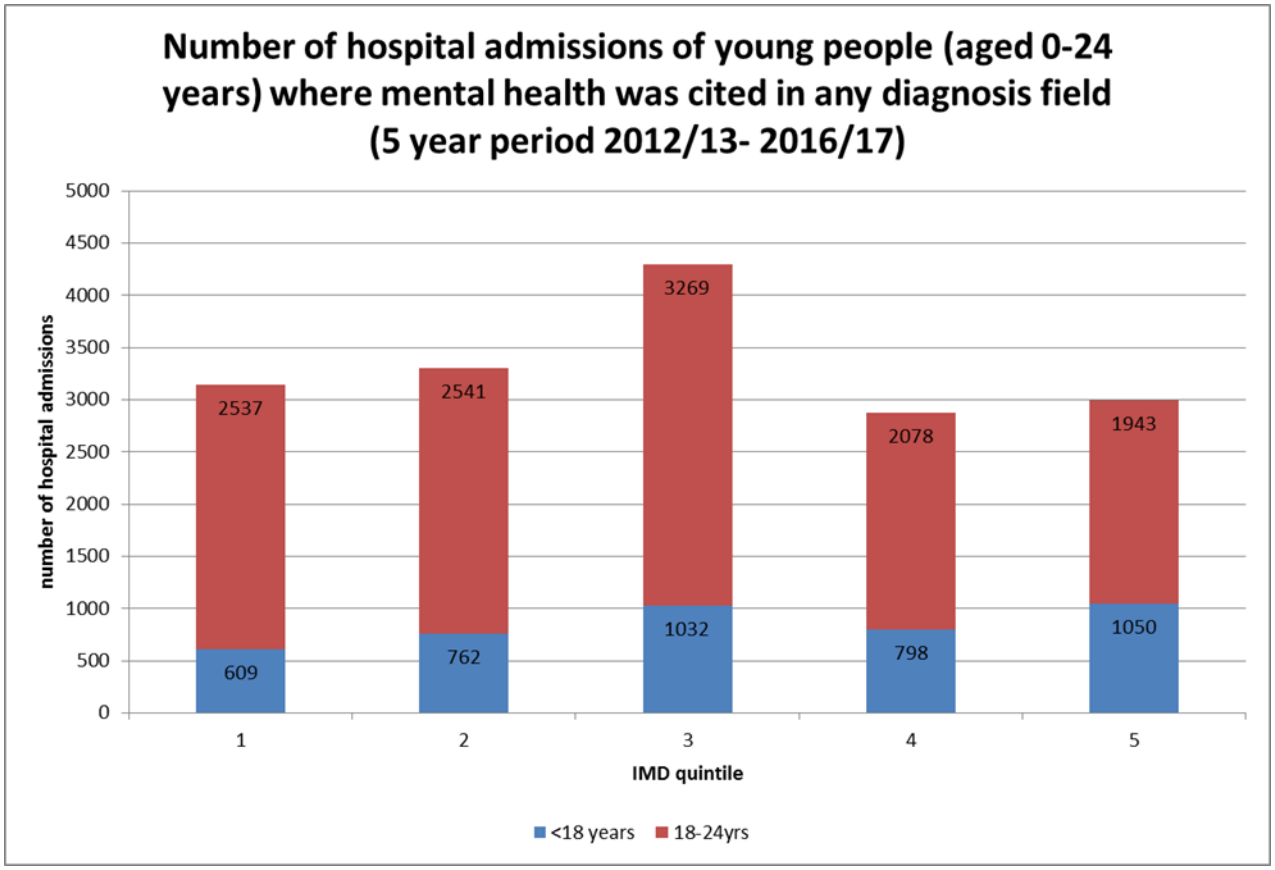
In the most extreme cases mental ill health can result in the need for hospitalisation. The data table below shows the trends for hospital admissions by locality of home address and then at the county level but distinguishing between where mental health was the primary diagnosis (i.e. main reason for admission) and where is was a contributing factor but not the primary reason for admission.

Admissions to Gloucestershire hospitals where there was a mental health diagnosis						
Age Group	**District**	**2012/13**	**2013/14**	**2014/15**	**2015/16**	**2016/17**
<18	Cheltenham	110	142	165	185	149
	Cotswold	58	55	75	86	86
	Forest of Dean	74	139	120	141	218
	Gloucester	193	259	262	193	232
	Stroud	128	131	146	151	159
	Tewkesbury	64	107	133	128	162
18-24	Cheltenham	500	534	492	429	405
	Cotswold	205	229	200	217	238
	Forest of Dean	340	286	349	273	274
	Gloucester	856	751	739	803	721
	Stroud	400	407	386	417	362
	Tewkesbury	300	330	377	300	248
Grand Total		**3228**	**3370**	**3444**	**3323**	**3254**

Admissions to Gloucestershire hospitals where there was a mental health diagnosis						
	Age Group	**2012/13**	**2013/14**	**2014/15**	**2015/16**	**2016/17**
MH Diagnosis as Primary Diagnosis	<18	70	57	84	92	83
	18-24	82	120	118	155	129
	TOTAL	*152*	*177*	*202*	*247*	*212*
MH Diagnosis quoted in any diagnosis field	<18	557	776	817	792	923
	18-24	2519	2417	2425	2284	2119
	TOTAL	*3076*	*3193*	*3242*	*3076*	*3042*
	Total years admissions	**3228**	**3370**	**3444**	**3323**	**3254**

Overall, the number of admissions for children and young people that have a mental health component has remained roughly stable. However, admissions where mental health is the primary diagnosis have grown by approximately a third over the period suggesting an increase in the prevalence of diagnosed serious mental health disorders in our young people. This may represent a real increase in disorders or an increase in awareness, access to support and diagnosis.

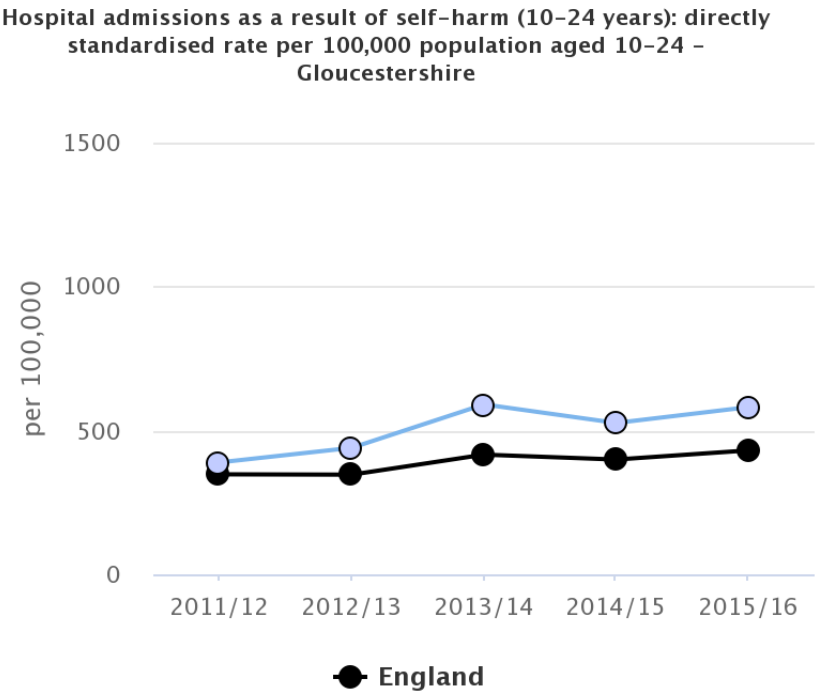
Looking at the mental health admissions data by socio-economic grouping shows that this affects all walks of life. The highest number of admissions overall and in 18-24 year olds is seen in quintile three. For children under 18 the highest number of admissions is in quintile 5 (the most well off). Whether the higher number of admissions reflects a higher prevalence in this quintile or reflects parents better able to navigate the health system is not clear from this data.



Self Harm in Children and Young People

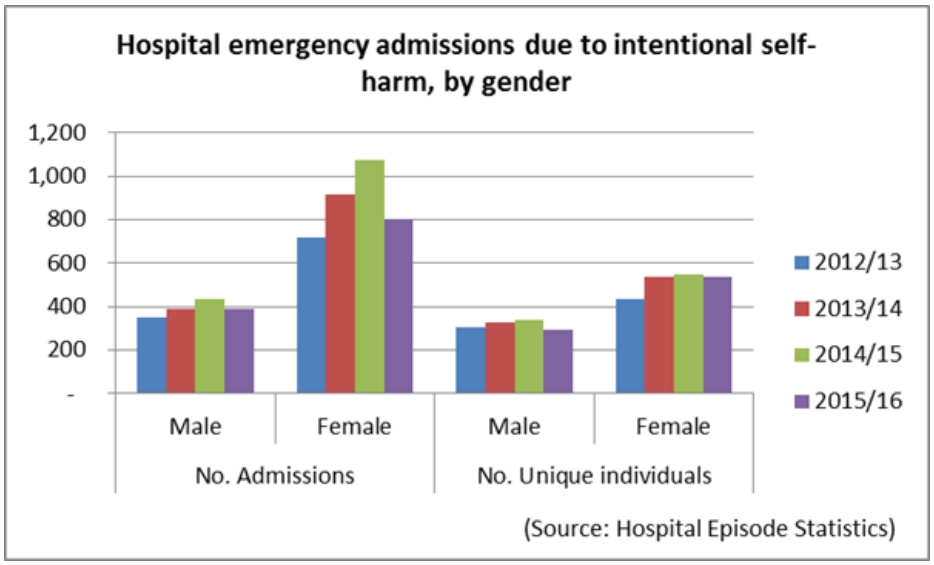
Self harm is one way in which some children and young people try to manage the sometimes overwhelming feelings of distress and unhappiness they feel. The majority of people who self harm do not present in hospital. The most up to date study published in the Lancet (which used OPS data) found that the rate ratio of hospital self-harm to community self-harm in 12-14 year olds is: 1:28 for males and 1:18 for females and in 15-17 year olds is 1:7 for males and 1:7 for females. The local protocol is that any child or young person who comes to A&E with self harm is admitted overnight for review with the child and adolescent mental health team.

The chart below shows the amalgamated picture for self harm hospital admission for young people age 10-24. Gloucestershire has a higher rate of hospital admissions for self-harm by young people aged 10-24 (580.8 per 100,000) than England (430.5 per 100,000). This corresponds to 611 admissions in 2015/16. The Gloucestershire rate is similar to the South West rate.



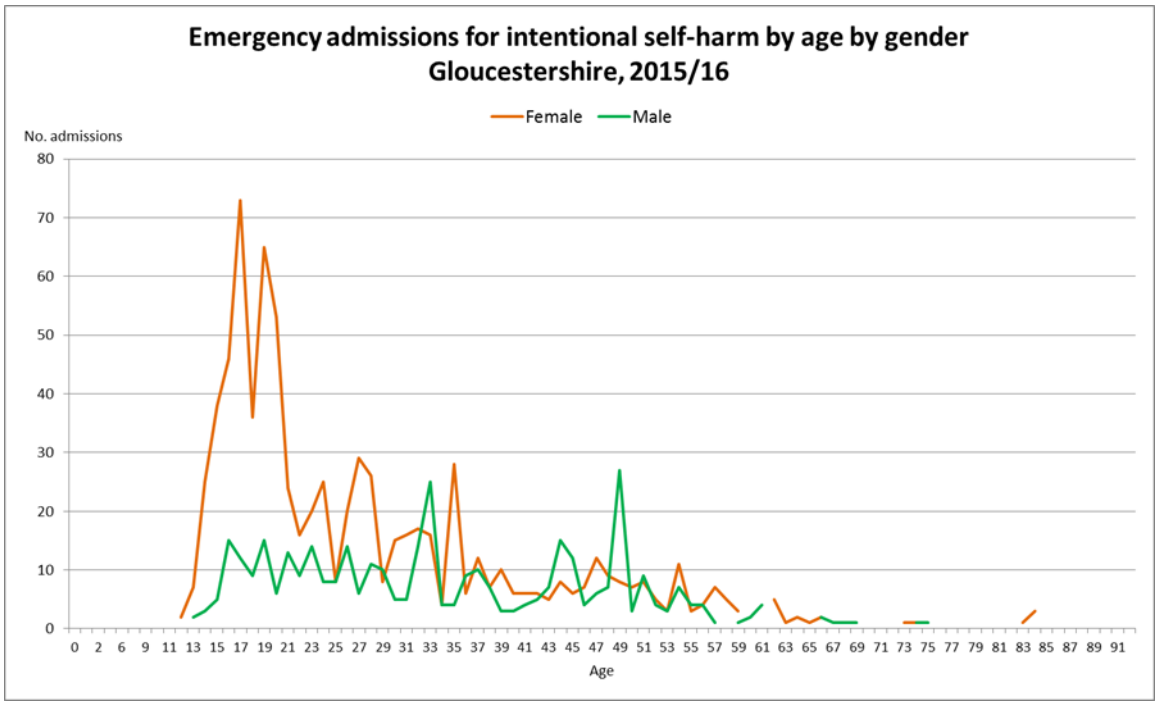
Source: PHE Fingertips

The burdens of self harm are not distributed equally between the sexes; young women are more likely to self harm and to self harm more frequently than young men. Women and girls account for around 60% of unique individuals admitted to hospital but they account for around 70% of all admissions due to their higher rate of repeat admissions. This is illustrated below.

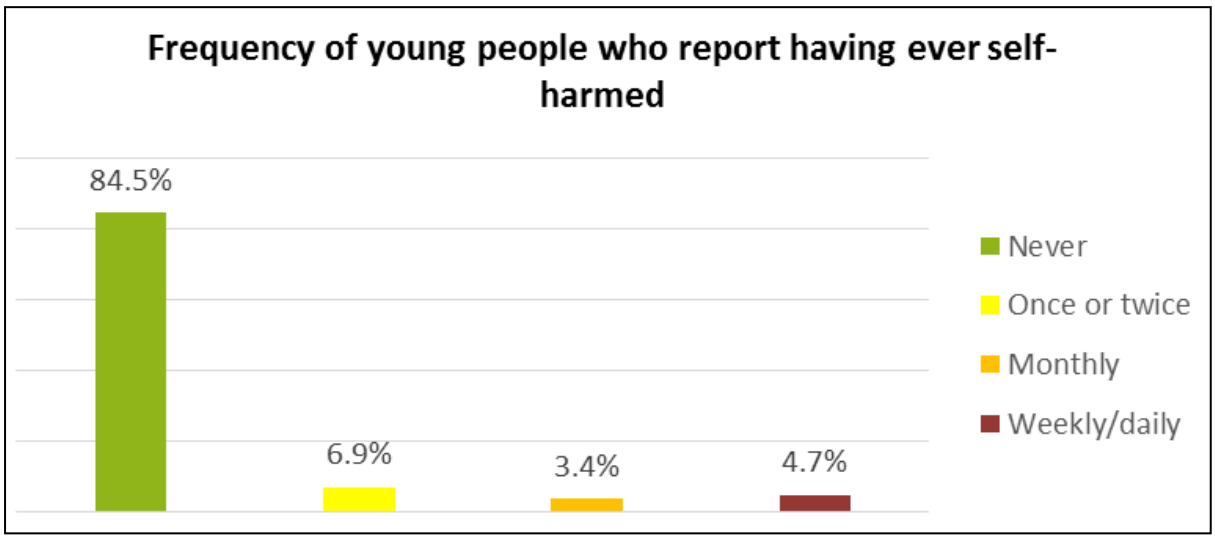


As can be seen in the graph below, children and young people account for the highest numbers of emergency admissions for self harm within the population as a whole. Under 20s make up just over half of all admissions. Children are being admitted from as young as 11 (small numbers), and the admission peaks are between age 15 and 21. There are marked disparities between male and

female patterns; the female peaks are at 17 and 19 with the male peaks coming later. Self harm is happening across all deprivation quintiles.

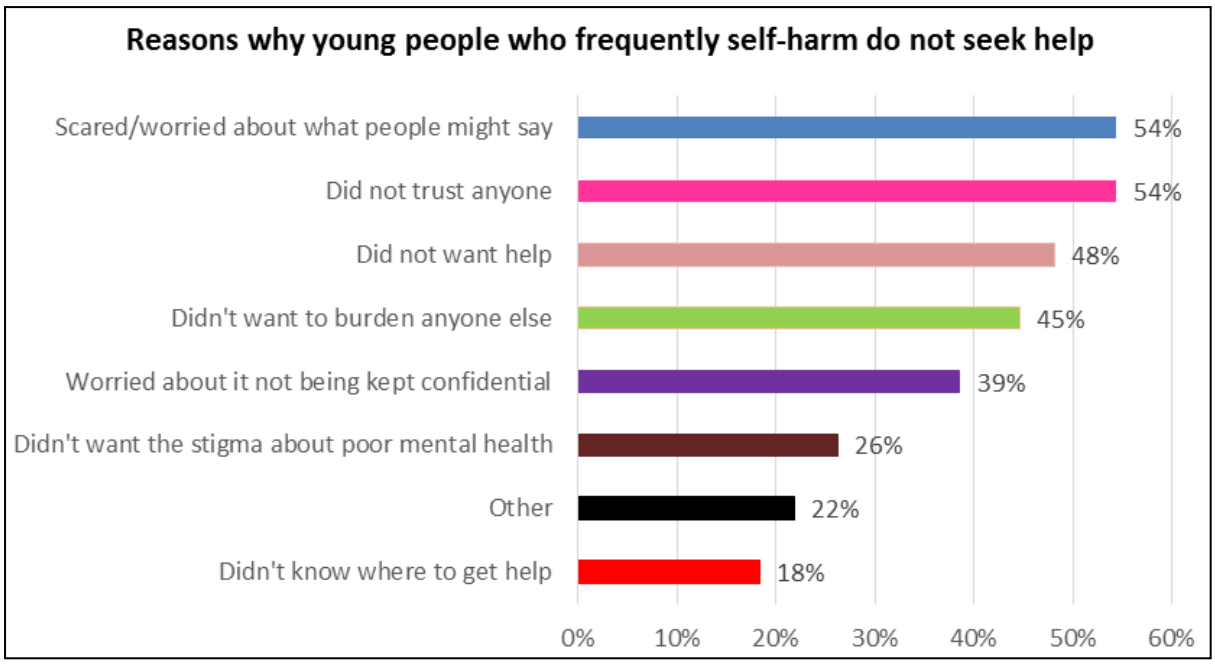


In the online pupil survey data around 15% of young people reported experience of self harming and almost 5% of pupils reported self harming daily or weekly. This data is represented below.



Source: Online Pupil Survey 2016

The difference between the number of admissions and the numbers reporting self harming illustrates a trend seen nationally; only a minority of people who self harm will do so seriously enough to require admission to hospital. Those who self-harm may not seek any medical or pastoral help. The reasons reported locally for not seeking help are given below:



Source: Online Pupil Survey 2016

This data suggests that over half of those who self harm would like help but for various reasons feel unable to access it. This suggests that there is a need to continue tackling stigma, myth busting and generally raising awareness.

Comparator and Qualitative Data Review

As part of the recent review of local pathways for people who self-harm, a number of semi-structured interviews were conducted to establish what stakeholders felt was going well and what could be improved around support for children and young people who self harm. A summary of the findings is given below:

What is going well	What could be improved
Suite of resources for schools, including training and lesson plans	Challenging perceptions/stigma, improving understanding of self-harm
Future in Mind: schools pilot, MH champions award, TIC+	Skilling up the wider workforce to assess risk
Pathways between GHT and school nursing	Improved (awareness of) pathways, particularly in primary care & MIUs
Self-harm helpline – confidential, non-judgemental	More timely psychiatric assessment of young people in A&E
Third sector support, e.g. the Cavern	Better support for parents and carers, advice on how they can help
Future in Mind: schools pilot, MH champions award, TIC+	Consideration of appropriate support for men and boys and those in extreme emotional distress but without a mental illness
Pathways between GHT and school nursing	Better joining up of physical and mental health treatment – wider view?
2g: Dialectical Behaviour Therapy (DBT) groups for young people and adults who self-harm; ED	A greater emphasis on recovery and staying well

Liaison Team (within available hours for young people); CYPS professionals helpline; 'Staying Alive' app	

Work is underway to develop a strategic plan for improving local pathways under the following headings:

- Prevention and early intervention
- Access to support in community, primary and secondary care
- Quality of treatment and care
- Recovery and staying well.

Progress against this plan will be reported to the Gloucestershire Mental Health & Wellbeing Partnership Board and will also link to the implementation of Gloucestershire's Future in Mind transformation plan for children and young people's emotional health and wellbeing.

Local Service Provision

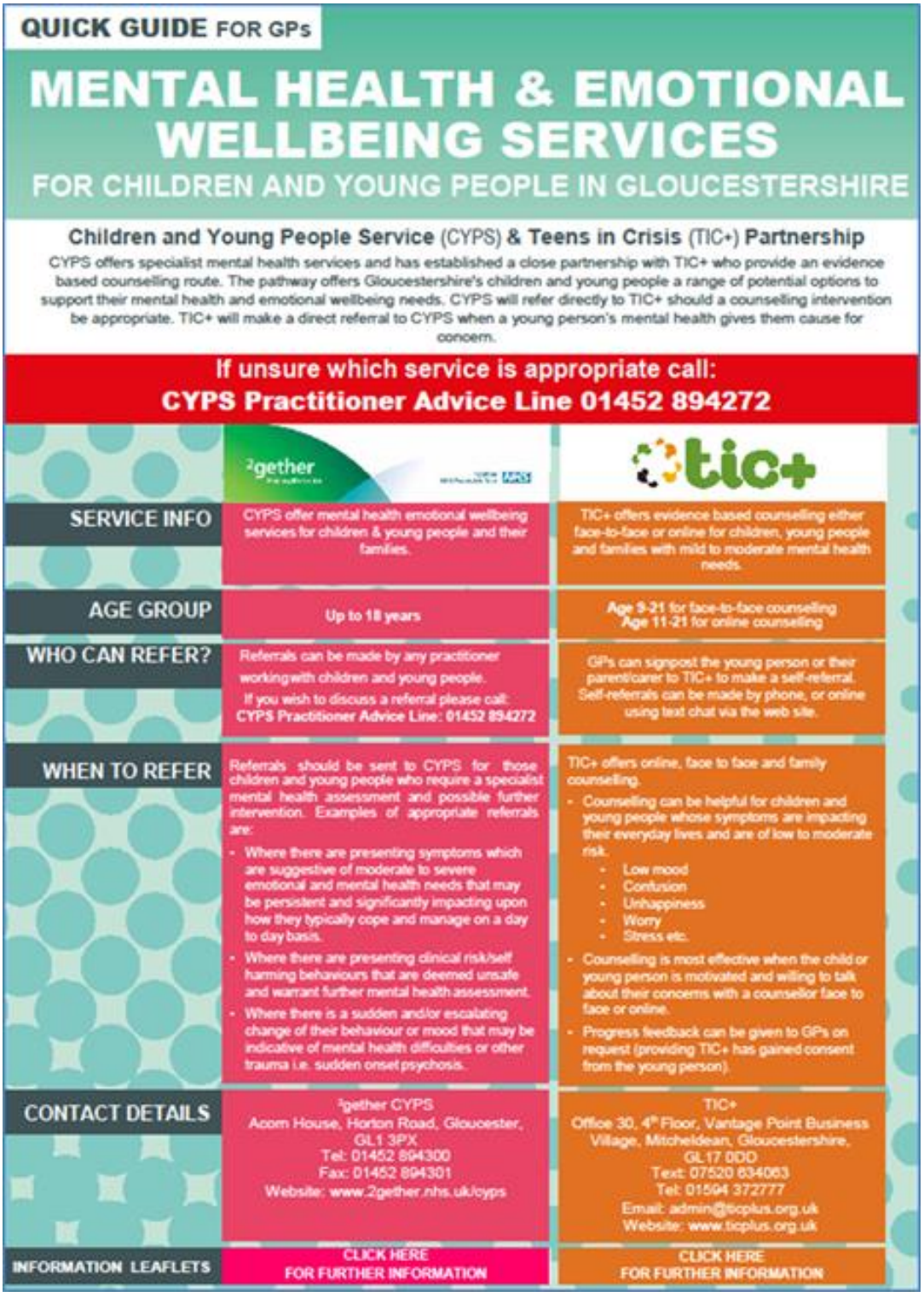
General Mental Health Service Provision

Gloucestershire's Child & Adolescent Mental Health Service (CAMHS) is provided by 2gether NHS Foundation Trust and, on the basis of feedback from children and young people is known locally as the Children & Young People Service (CYPS).

Broadly, the 2Gether CYPS consists of the following teams:

- Primary Mental Health Workers
- Practitioner Advice Line
- Parenting Programme Team
- Infant Mental Health Service
- The Level 3 Service Team (mod/severe issues or complex cases)
- CYP Learning Disabilities team
- Eating Disorder Service
- Inpatient Services
- The Maxwell Suite – place of safety for section 136 detentions
- Gloucestershire Recovery in Psychosis Team
- Vulnerable children - including infant mental health, youth support and children in care

In addition the voluntary sector organisation, TIC+ is commissioned to provide support for children and young people who do not reach the threshold for CYPS through online and face to face counselling services. The service characteristics are summarised below.



Children and Young People Interventions and Services for addressing Self Harm

A) Gloucestershire Healthy Living and Learning – Beyond Fed Up

- Resource aimed at Key Stage 3 and 4
- Focused on self-harm and suicide prevention: promoting emotional resilience, supporting friends and coping with difficult emotions
- Accompanied by guidance on self-harm for school staff:

- What is self-harm? Forms of self-harm
- Facts and figures
- Reasons for self-harming
- Risk and resilience factors
- Ways to help a young person
- Alternative coping strategies

B) Gloucestershire Self-Harm Helpline provided by Rethink– including online advice and coping strategies

C) Well established Suicide Prevention Partnership as part of MH&WB Partnership

Gloucestershire libraries have a 'shelf help' scheme, a range of books and titles chosen by young people and medical practitioners that can provide young people with support and advice on mental health conditions, such as depression, anxiety and stress.
www.gloucestershire.gov.uk/libraries/activities-and-services-in-libraries/health-and-well-being/

Evidence around What Works

There is a large amount of literature around what works in mental health. In terms of the type of evidence of what works, there is little in the way of randomised controlled trials and some of what is regarded as good evidence in this paradigm of public health is policy initiative supported by case study.

Public health interventions can be grouped into life course interventions and those that are place based. For each type of intervention there tend to be a number of recommended universal interventions and a number of targeted interventions that are aimed at those who are most high risk. The Faculty of Public Health and the Mental Health Foundation have produced a report called "Better Mental health for All"[61] that reviews potential public health interventions and approaches to improve mental health at different stages of the life course and in different settings. This section summarises the findings from this report.

Children and Young People Interventions

Universal approaches:

- The English Healthy Child Programme (2009) covers five to nineteen year olds and sets out the recommended framework of universal and progressive services for children and young people in order to promote optimal health and wellbeing.
- NICE advises supporting schools to adopt a comprehensive 'whole school' approach to promoting the mental wellbeing of children and young people
- Anti-bullying programmes are a top prevention investment. Evidence based bullying prevention programmes should be present in settings in which children and young people learn, live and spend their leisure time.

Targeted Approaches:

Poverty, discrimination, long-term health issues or factors such as living in care, having parents with mental health problems or drug and alcohol abuse all place children at higher risk of mental health problems. The following approaches are recommended:

- The NICE quality standards for looked after children featured the central recommendation that looked after children should have sufficient involvement in decisions to do with their

[61] Better mental health for All: A public health approach to mental health improvement (2016) London: Faculty of Public health and Mental Health Foundation

care. It was also emphasised that it was vital these children had access to nurturing relationships that foster attachment.

- Interventions to reduce drop-out and exclusion rates, and to focus on raising the educational standards of the most vulnerable children and young people should be rolled out.
- Develop targeted wellness services towards clusters of children identified as being at high risk of multiple poor behaviours, rather than providing single issue services only.
- The Early Intervention in Psychosis (EIP) model is an effective intervention that should be implemented at a local area level.
- A prevention intervention aimed at children at risk of eating disorders is Cognitive Dissonance Activities. This initiative engages young people in conversation on body image.
- The Increasing Access to Psychological Therapies (IAPT) programme has recently been extended to children, including those aged five and under. An IAPT programme aimed primarily at the practitioners who support parenting is also being planned.

Place based interventions

A public health approach to creating mentally healthy places requires targeting outwards from the home and institutional settings where people live, to education and working settings, to the community, then the physical environment, and finally to the overarching socio-economic conditions. It also requires committed and proactive engagement with community members. NICE published updated guidelines on community engagement to improve health and wellbeing and reduce health inequalities in 2016. Key to this approach is ensuring all frontline staff can act as mental health ambassadors and to do this training and resource development will be required.

Home

Many of the interventions listed above as family interventions could also be considered home interventions. The approaches that follow are targeted to those at risk of or recovering from a mental health problem.

Targeted Approaches:

- Psychologically Informed Environment (PIE) is a promising approach, which centres services' physical and social environments based on service users' emotional and psychological needs. PIEs have been piloted in housing, homelessness, social care and criminal justice settings in England.
- Provide mental health literacy training to frontline housing and advice workers to make contact count in helping individuals and families to secure and sustain appropriate accommodation, manage debt and maximise their incomes.
- Develop partnership working with a broad range of stakeholders to co-produce an integrated housing, health and social care pathway.
- Work in partnership with government departments, public bodies and other agencies to provide specialist housing support for vulnerable people with mental health problems.
- Advocate for the use of NHS land to make more supported housing available for vulnerable people with mental health problems.

Educational settings

The evidence base for school based interventions is perhaps the most extensive of the place based approaches. Long-term benefits include improved academic performance with a positive benefit on future prospects.

- Implement preschool programmes for children who are at risk in order to promote school readiness, and communication, social and emotional skills.
- The 'whole school' approach to prevention and promotion has been shown to be effective at building resilience in young people. This comprises of systematic changes (for example changes to ethos, anti-bullying policies and programmes to support teacher wellbeing), universal interventions for all pupils (for example curriculum based social education), and

outreach programmes for parents and the wider community. Whole school approaches are best combined with targeted support (providing timely school-based input for those with risk factors such as behavioural problems).

- Whole college and university based approaches within future education, informed by the work of the English Healthy Universities Network and the World Health Organization's Health Promoting Universities Programme should be implemented.
- Ensure there is leadership for and commitment to supporting mental health within educational settings by providing training and support for teachers and head teachers in relation to mental health literacy, including protecting and improving their own mental health
- Highly effective parenting support programmes like FAST, mentioned above, can also be run through schools.

Workplace settings (more applicable to the 18-24 cohort of young people)

Effective workplace interventions should address the physical, environmental and psychosocial factors influencing mental health including workload, job control, role clarity and bullying, using a whole workplace approach. This integrated approach combines universal, selective and indicated preventative strategies, and pulls together core business missions, human resources (HR) strategy and corporate social responsibility programmes.

Universal approaches:

- Work in partnership with local businesses leaders and employers to embed a whole workplace approach to protect and improve mental health at the individual, collective and organisational level, supporting them to:
    - Adopt the PHE Healthy Workplace Charter
    - Embed mental health in all organisational policies and procedures
    - Deliver line management training to create mentally healthy environments, as detailed in NICE guidance
- Share and use the British Heart Foundation advice on how employers can promote healthy eating using interventions to inform and educate, provide a supportive environment and actively promote healthy choices.

Targeted Approaches:

- Support workplaces to provide stress management support for employees experiencing distress.
- Increase access to talking therapies for those who are experiencing common mental health problems.
- Support local employers to engage with evidence based supported employment programmes such as Individual Placement and Support (IPS) and Access to Work in order to enable people to join the workforce.
- Use the recommendations made by CIPD around managing actual or potential problems due to alcohol or substance misuse to support employers.

Built environment and neighbourhood

- Public Health England published a briefing on community centred approaches which can inform their inclusion in local public service planning and delivery.
- The English Mental Health Task Force Report proposed the development of mentally healthy communities including through the use of social movement approaches. The Mental Health Foundation have created a 'Whole Community' approach that aims to embed mental health improvement action within all settings, systems and policies where there are opportunities to make every contact count. In applying a wider approach to measuring change, this can address the social determinants and inequalities alongside measures of mental health problems and wellbeing.

- Create and protect green spaces within neighbourhoods in order to generate better physical and mental health outcomes for individuals and communities.

Discussion, Gap Identification and Recommendations

Strengths in this area:

- 15 year olds generally report better mental health and wellbeing than their peers regionally or nationally
- The nationally collated summary indicators around mental ill health are broadly in line with or better than national averages
- The school based suite of mental wellbeing resources has been generally well received
- Significant local energy around addressing mental wellbeing in our youth

Areas of Concern

- Self harm rates and admissions to hospital in our young people are high and show a rising trend over the last five years. Over half of all admissions to hospital for self-harm were of individuals under 20, with peak ages of 15-21
- Reported mental ill health is worse in girls and young women than in boys and young men; this is reflected in self reported wellbeing and in admissions to hospital
- Reported teenage mental wellbeing is showing a decline over time both at the population levels and also at the individual level.
- People report needing self-harm services and interventions that focus more on recovery and staying well, are easier to access(particularly in primary care), are more joined up and support parents and carers better.

Recommendations

Focus on implementing Gloucestershire's Future in Mind transformation plan for children and young people's emotional health and wellbeing and the strategic action plan for improving pathways and services for people who self-harm.

B) Sexual Health and Relationships

Introduction

Sexual relationships have become commonplace in adolescence. A national study found that 31% of 16-24 year olds first had sexual intercourse before the age of 16 years.[62] If young people are not using appropriate contraception these sexual encounters can result in unplanned pregnancy and/or sexually transmitted infections (STIs). While for some young women having a child when young can represent a positive turning point in their lives, research evidence, particularly from longitudinal studies, shows that teenage pregnancy is associated with poorer outcomes for both young parents and their children.

Nationally, with the exception of HIV, young people aged 15 to 24 years continue to experience the highest rate of STIs, accounting for 55% of gonorrhoea, 52% of genital warts and 42% of genital herpes diagnosed in Genitourinary Medicine (GUM) and integrated GUM/Sexual and Reproductive Health services (SRH) in 2014[63].. Untreated, STIs can have long-term consequences such as ectopic pregnancy and infertility.

Good sex and relationships education, combined with access to contraception and frequent testing is effective in avoiding the unwanted consequences of sex; but also ensuring that young people have the skills and knowledge to be able to look after their sexual health, understand about healthy sexual relationships and feel more assured in their choices and rights in relation to sex.

Policy Context

The Framework for Sexual Health Improvement in England (2013) outlines the Government's commitment to improving the population's sexual health and wellbeing[64]. Specific to young people, it aims to improve their knowledge and resilience through provision of good quality Sexual and Reproductive Education(SRE) at home, school and in the community, accessible and confidential advice and support about wellbeing, sex, relationships, increasing awareness and understanding of consensual sex and abusive relationships, and building confidence and emotional resilience to understand the benefits of loving, healthy relationships and delaying onset of sex.

In addition, it aims to improve young people's sexual health outcomes through; targeted prevention, provision of accessible Sexual and Reproductive Health services, comprehensively meeting sexual health needs regardless of sexuality, raising awareness of risks of unprotected sex, benefits of stable relationships, issues around consent, and supporting responsible and informed decision-making. Guidance for commissioners in local government , CCGs and NHSE is provided by

[62] Mercer et al (2013) Changes in sexual attitudes and lifestyles in Britain through the life course and over time: findings from the National Surveys of Sexual Attitudes and Lifestyles (Natsal), The Lancet, Vol. 382
[63] Government, *Infection Report.* 2016.
[64] DoH, *A Framework for Sexual Health Improvement in England* 2013.

PHE's "Making it work" document , which outlines and describes the principles underpinning the commissioning responsibilities across these levels for sexual health , reproductive health and HIV.[65]

Commissioning Responsibilities:

Sexual health services are commissioned at a local level to meet the needs of the local population, including provision of information, advice and support on a range of issues, such as sexually transmitted infections (STIs), contraception, relationships and unplanned pregnancy.

Local authorities are mandated to commission comprehensive open access sexual health services.

Local authorities' commission:

- comprehensive sexual health services including most contraceptive services and all prescribing costs, but excluding GP additionally-provided contraception
- sexually transmitted infections (STI) testing and treatment, chlamydia screening and HIV testing
- specialist services, including young people's sexual health, teenage pregnancy services, outreach, HIV prevention, sexual health promotion, services in schools, college and pharmacies

- the Specialist Sexual Health Service to provide STI testing and treatment; contraceptive services and specialist psychosexual services.
- General practice to provide Long Acting Reversible Contraception (LARC) and sexual health clinics.
- Pharmacies to provide Emergency Hormonal Contraception (EHC) free to under 25s
- Targeted prevention services aimed at preventing poor sexual health, including condom distribution to under 25s and community HIV testing; and
- Support for people living with HIV and their Carers.

Some specialised sexual health services are directly commissioned by clinical commissioning groups (CCGs), and at the national level by NHS England.

CCGs commission:

- most abortion services, sterilization, and vasectomy
- non-sexual-health elements of psychosexual health services
- gynaecology including any use of contraception for non-contraceptive purposes

NHS England commissions:

- contraception provided as an additional service under the GP contract

[65] PHE. *Making it work. A guide to whole system commissioning for sexual health, reproductive health and HIV*. 2015; Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/408357/Making_it_work_revised_March_2015.pdf.

• HIV treatment and care (including drug costs for PEPSE)
• promotion of opportunistic testing and treatment for STIs and patient-requested testing by GPs
• sexual health elements of prison health services
• sexual assault referral centres
• cervical screening
• specialist fetal medicine services

Epidemiological Data Review

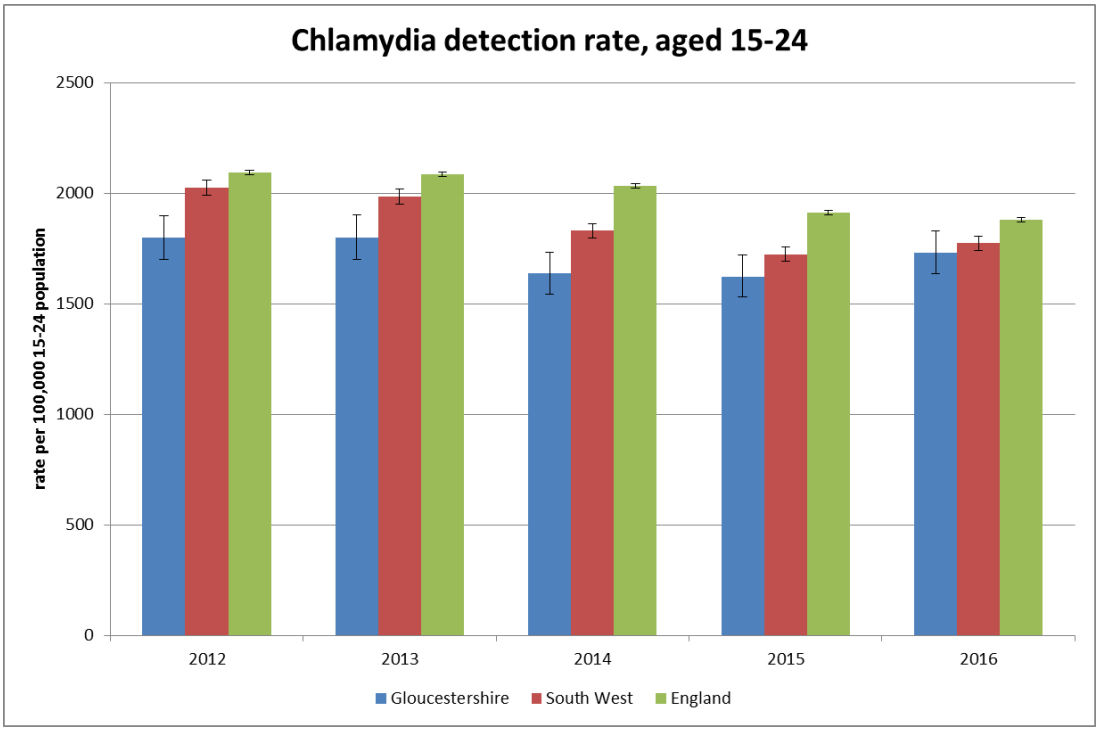
While the trend is improving, as can be seen in the graph below, Gloucestershire does not perform well compared to national and regional peers when looking at the rate of STI testing per 100,000 of the population. It is interesting to note that all the best performing regional areas are large urban populations compared to Gloucestershire's more rural make up. This suggest that there may be structural features that have a significant influence on STI testing and make it more challenging for rural areas.

STI testing rate (exc chlamydia aged <25) / 100,000 2016 — Crude rate - per 100,000

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	↑	5,899,843	16,722	16,708	16,735
South West region	↑	450,387	13,229	13,190	13,268
Plymouth	↑	35,578	20,597	20,384	20,813
Bristol	↑	61,762	19,882	19,726	20,040
Bournemouth	↑	24,072	18,507	18,274	18,742
Swindon	↑	21,100	14,791	14,592	14,992
Torbay	↑	11,344	14,488	14,223	14,757
Devon	↑	65,841	14,136	14,029	14,245
North Somerset	↑	16,641	13,255	13,054	13,458
Cornwall	↑	42,971	12,994	12,872	13,118
Gloucestershire	↑	46,136	11,911	11,802	12,020
Poole	→	10,891	11,752	11,532	11,975
Bath and North East Somer...	↑	13,439	11,089	10,902	11,278
Dorset	↑	25,018	10,399	10,270	10,529
South Gloucestershire	↑	17,162	9,740	9,595	9,887
Somerset	↑	30,525	9,303	9,199	9,408
Wiltshire	↑	27,829	9,256	9,147	9,365
Isles of Scilly	→	78	5,532	4,373	6,904

Source: Public Health England

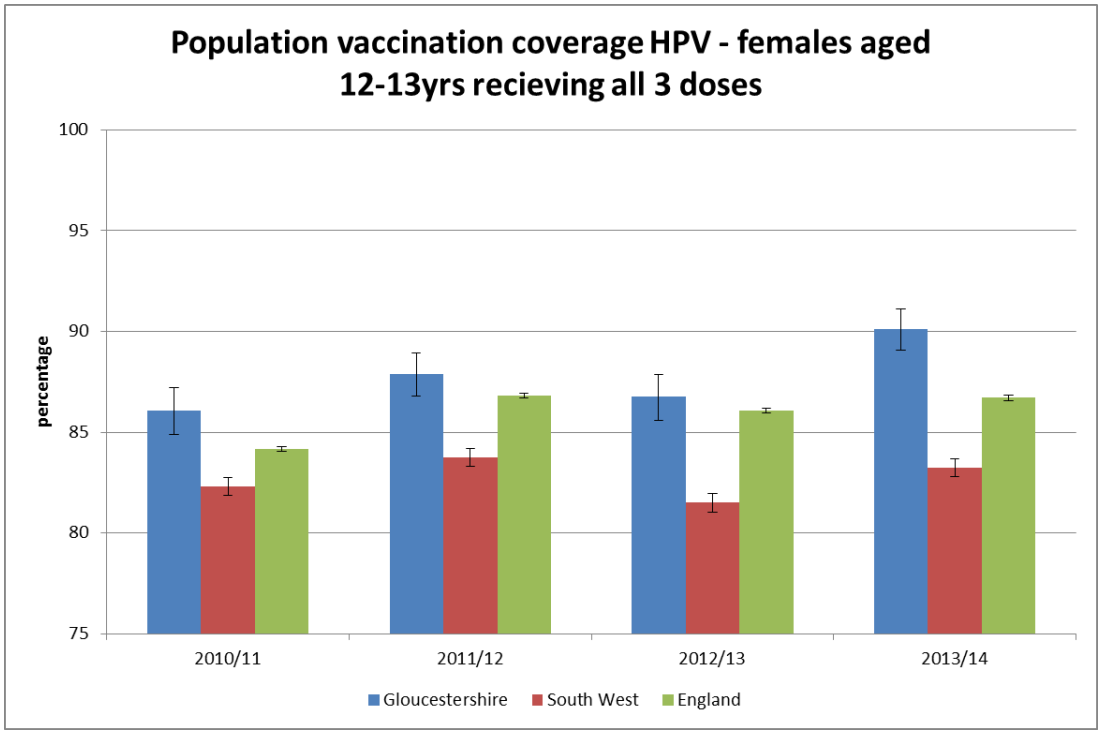
Chlamydia is the most commonly diagnosed bacterial sexually transmitted infection in England, with rates substantially higher in young adults than any other age group. The Chlamydia detection rate in Gloucestershire has been significantly lower than the England rate throughout the period 2012-2016. It is unclear whether this lower rate of detection reflects lower infection rates or whether it reflects undetected infections due to lower levels of testing. Traditionally this indicator is interpreted as the latter, suggesting Gloucestershire is underperforming.



Source PHE Fingertips

Human Papilloma Virus (HPV) is the name for a group of viruses that infect skin and most membranes. Around 40 types of HPV infection can affect the genital area. Infection with some types of HPV infection can cause genital warts and/or changes to cells in the cervix which can lead to cervical cancer. Since autumn 2008 a national vaccination programme for HPV has been in place for girls aged 12/13. Locally the programme is delivered mainly through secondary schools. The latest available data only runs to 2013/14. At this point Gloucestershire had attained a 90% vaccination rate which was higher than the national or regional average.

It should be noted that vaccination does not negate the need for cervical screening in women aged 26-64.



Source: PHE Fingertips

As well as infections the other concern around sexual activity in young people is unplanned pregnancy.

There has been a downward trend in under 18 conceptions in the county, and overall Gloucestershire's under 18 conception rate is good at 15.2 per 1,000 compared to a national rate of 20.8 per 1,000. Performance against regional comparators is shown below.

Under 18s conception rate / 1,000 (PHOF indicator 2.04) 2015 — Crude rate - per 1000

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	↓	19,080	20.8	20.5	21.1
South West region	↓	1,518	16.8	16.0	17.7
Plymouth	↓	97	23.9	19.4	29.1
Torbay	↓	50	22.9	17.0	30.2
Poole	↓	51	20.6	15.3	27.0
Bournemouth	↓	52	20.3	15.2	26.7
Swindon	↓	77	20.2	15.9	25.2
Devon	↓	223	18.3	16.0	20.9
Cornwall	↓	161	17.6*	15.0	20.6
Bristol	↓	113	17.3	14.2	20.8
Somerset	↓	165	17.1	14.6	20.0
Dorset	↓	109	15.3	12.5	18.4
Gloucestershire	↓	162	15.2	12.9	17.7
North Somerset	↓	49	14.2	10.5	18.8
Wiltshire	↓	125	14.0	11.6	16.7
Bath and North East Somer...	↓	34	11.4	7.9	16.0
South Gloucestershire	↓	50	11.0	8.1	14.5
Isles of Scilly	–	-	*	-	-

Source: Office for National Statistics (ONS)

One of the possible reasons for the lower than national under 18 conception rates may be the comparatively high uptake of long Acting Reversible Contraception (LARC). Gloucestershire has the highest rate of LARC use in under 25s in the region at 36.2% compared to a national average of 20.6%.

Under 25s choose LARC excluding injections at SRH Services (%) 2016 — Proportion - %

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	87,377	20.6	20.4	20.7
South West region	–	9,891	27.5	27.0	27.9
Gloucestershire	–	1,594	36.2	34.8	37.6
Wiltshire	–	485	33.1	30.7	35.5
Poole	–	156	32.6	28.5	36.9
Dorset	–	669	32.5	30.5	34.6
Cornwall	–	1,112	30.8	29.3	32.3
Torbay	–	369	28.8	26.4	31.4
Plymouth	–	615	28.6	26.7	30.6
Devon	–	1,766	28.6	27.5	29.7
Somerset	–	565	27.2	25.3	29.1
South Gloucestershire	–	331	24.2	22.0	26.5
Bristol	–	1,168	24.1	22.9	25.4
Swindon	–	358	21.5	19.6	23.5
Bournemouth	–	283	20.6	18.5	22.8
North Somerset	–	245	16.1	14.3	18.0
Bath and North East Somer...	–	175	11.7	10.1	13.4
Isles of Scilly	–	0	0.0	0.0	49.0

Source: NHS Digital

Gloucestershire also performs well when compared to its regional peer group in terms of low rates of repeat abortions in under 25s. Gloucestershire has the second lowest proportion as can be seen in the graph below.

Under 25s repeat abortions (%) 2016 — Proportion - %

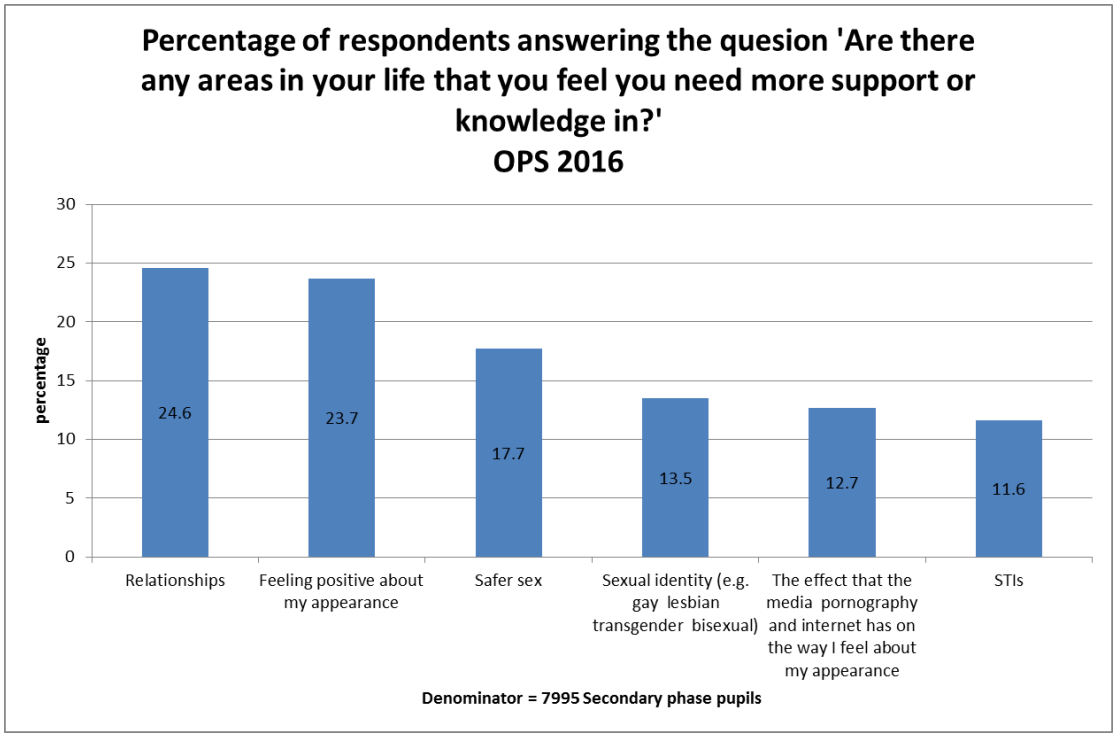
Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	→	18,949	26.7	26.3	27.0
South West region	→	1,367	23.4	22.3	24.5
Swindon	→	91	31.6	26.5	37.2
Torbay	→	70	29.9	24.4	36.1
Poole	→	46	27.7	21.5	35.0
Bournemouth	→	81	26.0	21.4	31.1
Dorset	→	91	25.6	21.4	30.4
Wiltshire	→	108	24.5	20.8	28.8
Bristol	→	151	24.3	21.1	27.8
Cornwall	→	131	23.1*	19.8	26.7
Bath and North East Somer...	→	44	22.4	17.2	28.8
South Gloucestershire	→	64	22.1	17.7	27.3
Somerset	→	121	21.8	18.5	25.4
Plymouth	→	89	20.8	17.2	24.9
North Somerset	→	36	20.3	15.1	26.9
Gloucestershire	→	112	20.2	17.1	23.8
Devon	→	132	19.9	17.0	23.1
Isles of Scilly	–	-	*	-	-

Source: Department of Health

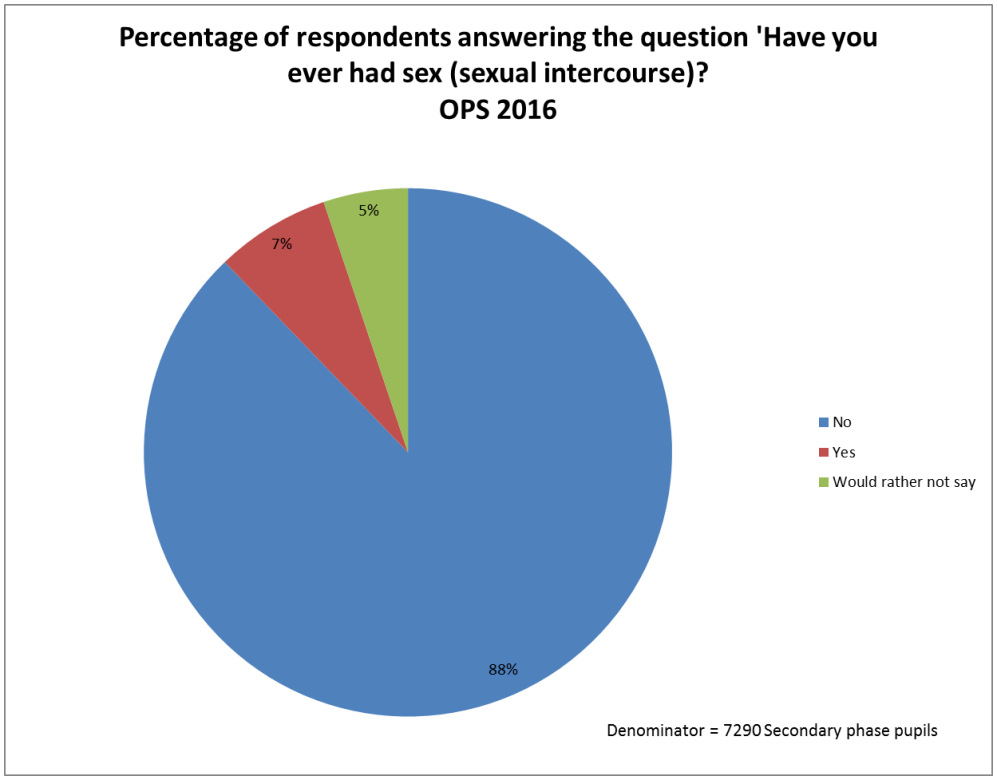
The PHE data presented above tends to focus more on sexual health hard outcomes (and often those relating to ill health or negative outcomes). The Online Pupil Survey can provide some more insight into the experiences, beliefs, insights and understanding that underpins these results. Sex and Relationships questions are only asked to secondary phase pupils (Y8 and Y10). The denominator for each result differs depending on previous answers and so has been included on

each chart for clarity. It is also important to note this is a voluntary survey and pupils can opt out of answering any questions or may not answer 100% accurately for each question.

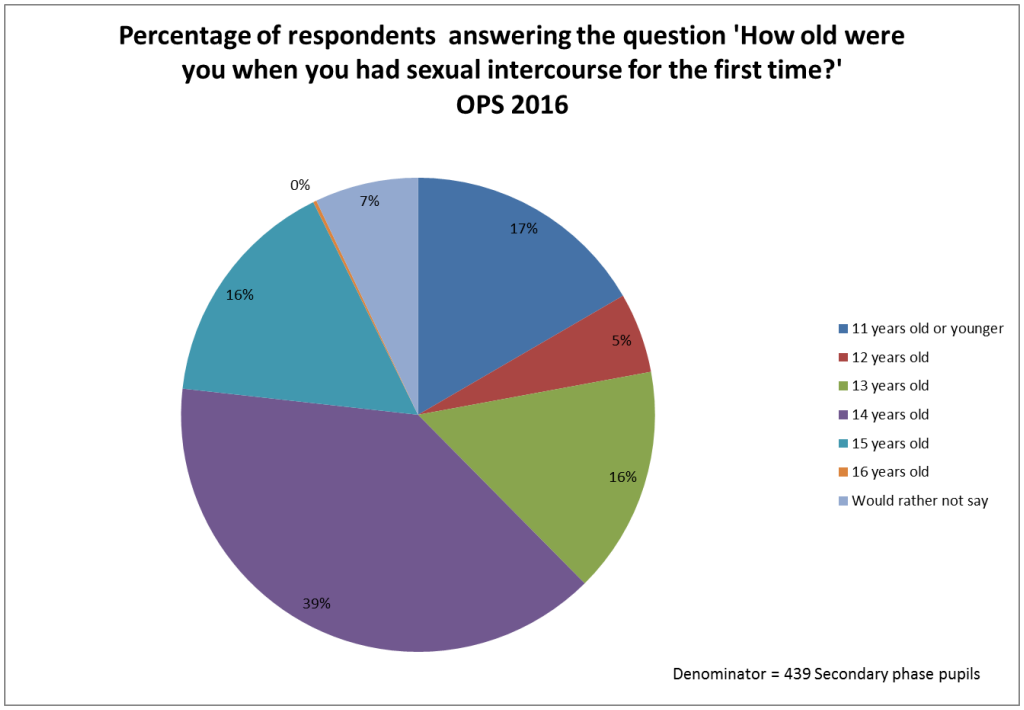
In contrast to much of the nationally comparable data around young people's sexual and relationship health, the pupils surveyed were generally keener to learn about relationships and their own body image/sexual identity than imply focussing on sexually transmitted infections. This is illustrated below.



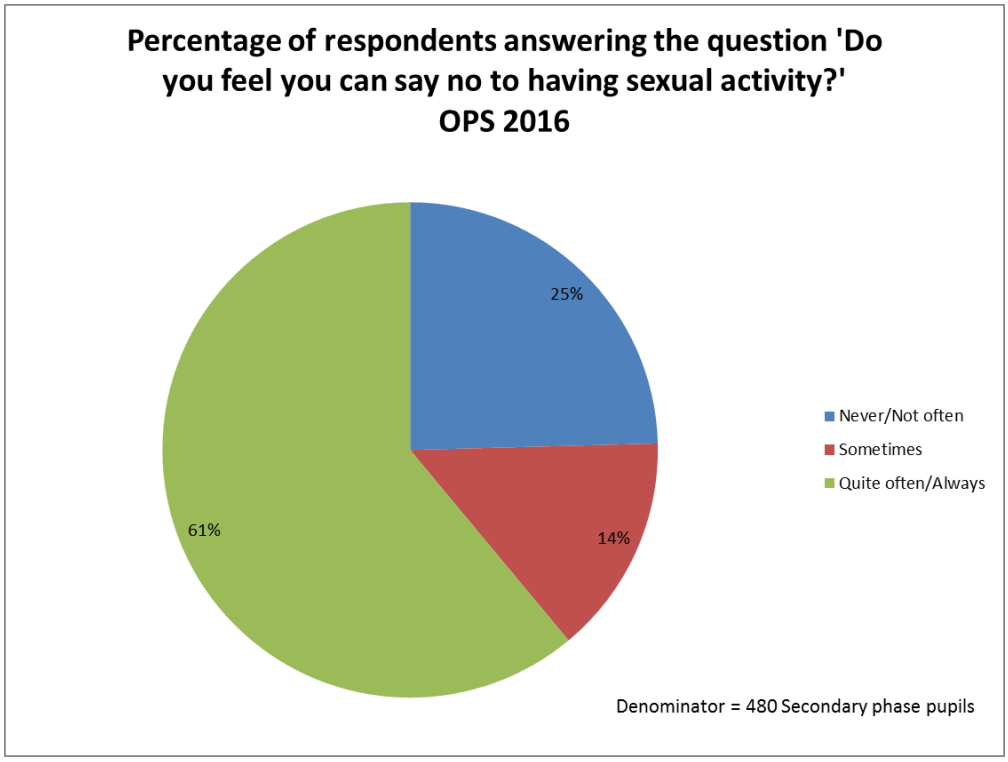
This focus of interest might relate to the fact that the majority of those surveyed (88%) are not actually sexually active.



Of the 439 pupils who reported having had sex the age at which they first had sex is given below. It should be noted that 22% of these children were 12 years or younger i.e. at an age where they could not legally give consent to sex. This represents almost 100 children who are effectively reporting having been raped.

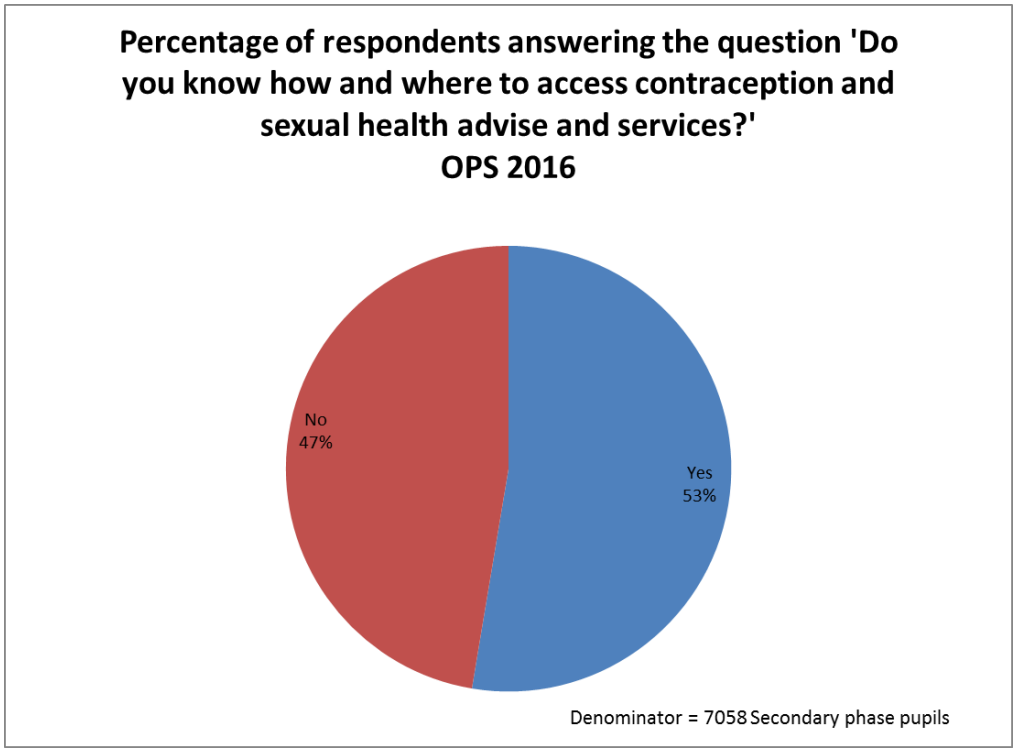


The majority of children do report feeling able to say not to sex if they do not want it, but this still leaves around a quarter who feel unable to say no.

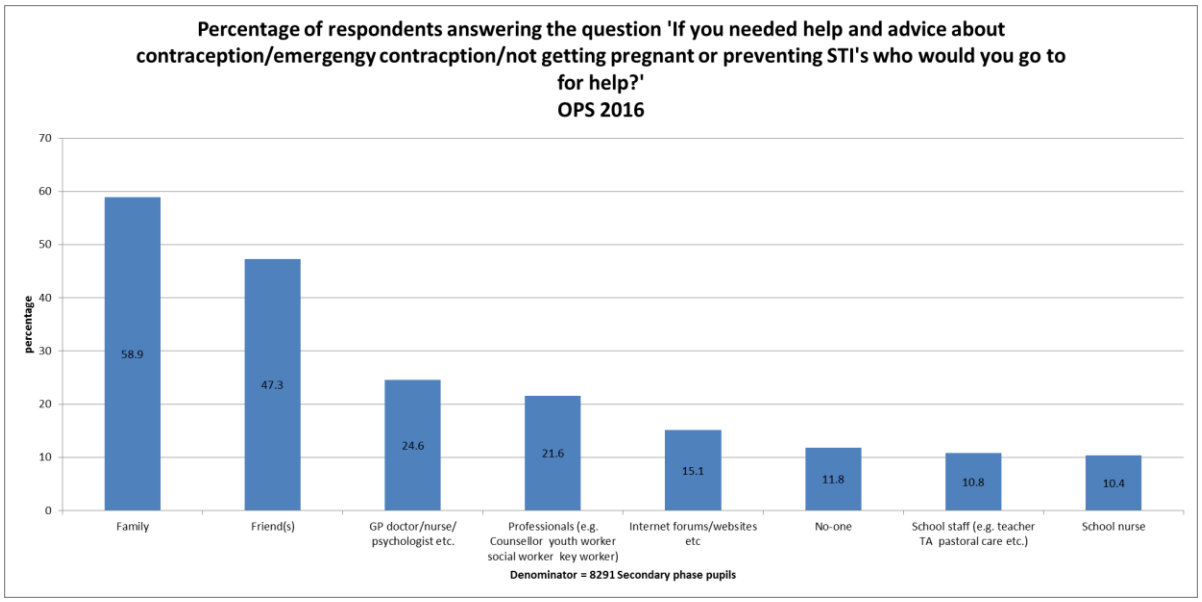


The majority of young people having sex are also reporting using contraception with just over half reporting use of condoms (which protect from both pregnancy and sexually transmitted infections).

However, when the whole cohort is taken into consideration it is worth noting that almost half so not know where to access contraception and sexual health advice and services suggesting that more could be done to plug this gap.



Most children and young people report that they would turn to friends and family for such information rather than a professional/official source.



Local Service Provision

Relationships and Sex Education (RSE)

Relationship and sex education is often delivered as part of the Personal Social and Health Education (PSHE) curriculum inschools. From September 2019, Relationships and Sex Education (RSE) will become statutory in all secondary schools; and 'relationships education' will become statutory in primary schools. . Gloucestershire Healthy Living and Learning have produced a resource pack to support teachers in delivering RSE in both primary and secondary schools in Gloucestershire.

Sexual health services

Young people can access sexual health and contraceptive services provided by the Specialist Sexual Health service and within primary care across the county. Service providers attend safeguarding training and are required to assess the Fraser competency of children under the age of 16 years.

Emergency Hormonal Contraception is available free of change to women under the age of 25 years in the majority of pharmacies in Gloucestershire.

Over 16s are also able to order postal STI testing kits online via the Specialist Sexual Health Service.

Gloucestershire C-Card scheme

The C-Card scheme provides free condoms to young people under the age of 25 years. Young people receive sexual health advice and information when registering with the scheme and are able to access condoms from distribution sites across the county, including pharmacies, colleges and youth services.

The prevention service

In 2018/19, the County Council is commissioning a new service focused on preventing poor sexual health, with a particular focus on young people. The service will include a mix of health behaviour change, health education and health promotion interventions aimed at providing young people with the skills and knowledge to make positive decisions about their sexual health and relationships. It will include work with partner agencies to increase the reach of the service.

Hope House website

The Hope House website managed by the Specialist Sexual Health service provides information on Sexually Transmitted Infections (STIs), contraception, emergency contraception, pregnancy advice, HIV and chlamydia screening and advice on sexual assault and rape. It tells people where they can go to access Sexual Health Clinics in Gloucestershire and explains what to expect when visiting one of these clinics.

www.hopehouse.nhs.uk

Respect Yourself website

The 'Respect Yourself' website is designed to engage with young people, aged 13 to 25, in Gloucestershire around issues relating to relationships and sex while providing information on a range of sexual health services available throughout Gloucestershire.

www.respectyourself.info/gloucestershire

Gloucestershire Youth Support Team

The Gloucestershire Youth Support Team can offer support to young people aged 10-19 (or up to 25 for young people with a special educational need or disability) around relationships and sexual health. The service provides information and advice, support for young parents and parents-to-be and support around Child Sexual Exploitation and domestic abuse.

Evidence around What Works

Reducing Sexually Transmitted Infections:

Both NICE and PHE have issued a number of guidelines around what works in reducing levels of STIs. In general these can be summarised as below:

Policy Level

- Improve accessibility of sexual health services through well located and more effectively signposted clinics , providing confidential advice, and support
- Aim to deliver a collaborative regional commissioning model for sexual health services; enabling robust clinical governance, safeguarding and quality assurance when commissioning GUM services; all of which lead to an improved patient experience and sexual health outcomes.
- Identify individuals at high risk of STIs using their sexual history.
- Provide the patient and their partners with infection-specific information, including advice about possible re-infection. For chlamydia infection, also consider providing a home sampling kit.

Community Level

- Prevention programmes which engage young people and which focus on safer sex practices
- Coordination and delivery of robust Sex and Relationship Education in schools and the community, either through regionally or nationally commissioned programmes; with focus on sex and relationships education targeted at vulnerable young people, aided by signposting of sexual health services online (SHINE) and through social media. Ultimately, these should help build healthy relationships and delay the onset of sex
- If necessary, refer patients to a specialist, who may be given the responsibility of partner notification.

Reducing Unwanted Pregnancy

Policy Level

- Needs and attitudes of men and women aged 19-24 years shift constantly. Service providers and commissioners need to consider and understand those shifting needs and attitudes toward primary methods of contraception and continue to build them into provision
- Tailor services considerate of the impact of culture on health seeking behaviour
- Continue to extend patient group directives (PGDs) and local arrangements to improve access to Emergency ormonal Contraception (EHC)
- Raise awareness of emergency contraception (EC) methods and where they can be accessed, among young people and health professionals; with an increased focus on long-acting reversible contraception (LARC) for emergency conception.
- Provision of on-going support for children and young people who have been abused to delay on-set of sex, and to reduce instances of teenage pregnancy, and patterns of unhealthy and unsafe sexual behaviours.

Community Level

- Raise awareness of EC methods and where they can be accessed, among young people and health professionals
- Raise awareness of all contraceptive methods and improve young people's access to them.
- Improve young people's access to and uptake of contraceptive services; through increased and effective signposting of services; more and better located clinics; including use of alerts and reminders to contraceptive users when next course of contraception is due.

- Increase uptake and provision of contraception, including long-acting reversible contraceptives, at abortion services to reduce repeat abortions.

Discussion, Gap Identification and Recommendations

Strengths in this area:

- Low rates of teenage pregnancy, low rates of repeat abortion in under 25s and high rates of long acting contraception (LARC) use in under 25s suggest that young people's ability to make informed choices around contraception is high

- Almost all GPs in the county are commissioned to provide LARC; and almost all pharmacies are commissioned to provide EHC free to under 25s. This ensures a good level of coverage and availability of these services countywide.

- The introduction of online ordering of postal STI testing kits for over 16s should help increase the accessibility of testing for young people.

- The commissioning of the prevention service will mean a renewed focus on promoting positive sexual health behaviours among young people. Similarly, the introduction of statutory RSE in schools provides an opportunity to strengthen relationship and sex education in education settings.

Areas of Concern

- Rates of STI testing generally and of chlamydia in particular are lower than the national average suggesting that people are not testing and looking after their sexual health as well as they might be.

Recommendations

Monitor how the implementation of the new contracts for local provision of sexual health services is working and monitor for performance against outcome targets and service user perceptions about the services provided.

C) Lifestyle and Risky Behaviours (smoking, alcohol and drugs)

Introduction

Adolescence is a common start point for tobacco, alcohol and substance abuse. Reasons for initiating these risky behaviours include; desire for new experiences, use as a coping strategy or peer pressure. Factors such as domestic abuse or violence, mental illness and parental drug or alcohol use can also influence substance abuse in young people. A young person's substance misuse can be a sign and/or a symptom of other risks.

Each year, it is estimated that around 207,000 children in the UK begin smoking with the 2011 General Lifestyle Survey of adult smokers revealing that nearly 40 per cent had begun smoking regularly before the age of 16 years. An estimated 1third to half of children who try smoking are likely to become regular smokers within two to three years (defined as smoking at least once per week. Smoking-related diseases (e.g. Lung cancer, heart disease) are dose-dependent, meaning that those who smoke from childhood have a longer lifetime exposure to the associated toxins and are therefore at greater risk of developing such diseases.

In addition, children have a greater susceptibility to second hand smoke/passive smoking, with an increased risk of chest infections such as bronchitis and pneumonia, asthma attacks, and middle-ear infections. Since smoke-free legislation was introduced in 2007, the primary source of exposure to tobacco smoke for young children is parental smoking.

Policy Context

Smoking

The Government's 2011 publication, *Healthy Lives, Healthy People: a tobacco control plan for England*, sets out a strategy for tackling tobacco in England with commitments to examine evidence in support of plain packaging for tobacco products, and to end display of tobacco products in shops by 2015. It also outlines clear goals to reduce smoking prevalence among adults from 21% to 18.5%, reduce rate of smoking among 15 year olds from 15% to 12%, and reduce smoking in pregnancy from 14% to 11%[66] In addition, a ban on smoking in vehicles when a child or children are present, came into force on 1 October 2015. These policies are now well embedded.

Drugs and Alcohol

The PHE Young people –substance misuse commissioning support pack 2018-19: principles and indicators outlines key principles and useful prompts to consider when commissioning universal and targeted drug, alcohol and tobacco prevention interventions, and specialist interventions for young people already experiencing harms[67].

In addition, the Department for Education and the Association of Chief Police Officers (2013) *Drug Advice for Schools*, recommends that schools have a written drugs policy, pupils should have early

[66] Government, *Healthy Lives, Healthy People: A Tobacco Control Plan for England*. 2011.
[67] PHE, *Young people –substance misuse commissioning support pack 2018-19: principles and indicator, planning comprehensive interventions for young people.*

access to support via schools and other local services and that a dedicated senior school staff member liaises with the local police and support services[68]

Epidemiological Data Review

Overall Picture

There are two main sources of data available on the overall picture of health behaviours in children in Gloucestershire. The first is the PHE fingertips tool that collates information from the National WAYS survey of 15 year olds carried out nationally in 2014/15. This data source allows benchmarking of the Gloucestershire performance against national data to give an idea of how we compare nationally. In addition, the Online Pupil Survey data is a more comprehensive source of data on local children's self reported behaviours and allows some trends over time to be observed. It does not however allow for comparison against other areas.

As a result we will consider both data sources in the following section as they give insights into different aspects of young people's behaviours.

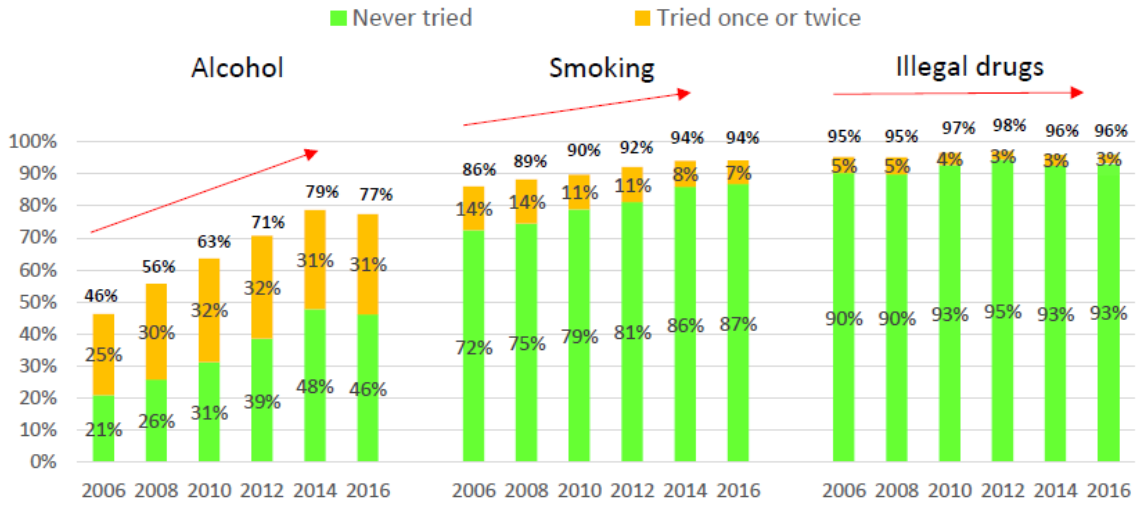
Indicator	Period	Glouc'shire			Region	England	England		
		Recent Trend	Count	Value	Value	Value	Worst	Range	Best
Percentage reporting general health as excellent	2014/15	–	-	34.7%	30.6%	29.5%	24.1%		37.7%
Percentage with a long-term illness, disability or medical condition diagnosed by a doctor	2014/15	–	-	14.6%	14.5%	14.1%	18.6%		9.2%
Percentage with 3 or more risky behaviours	2014/15	–	-	17.0%	17.8%	15.9%	23.8%		3.2%
Percentage who eat 5 portions or more of fruit and veg per day	2014/15	–	-	60.3%	56.5%	52.4%	39.9%		67.6%
Percentage with a mean daily sedentary time in the last week over 7 hours per day	2014/15	–	-	66.8%	66.9%	70.1%	81.0%		58.7%
Percentage physically active for at least one hour per day seven days a week	2014/15	–	-	15.9%	16.0%	13.9%	8.3%		18.8%
Percentage of current smokers	2014/15	–	-	8.9%	9.8%	8.2%	14.9%		3.4%
Percentage of regular smokers	2014/15	–	-	5.0%	6.3%	5.5%	11.1%		1.3%
Percentage of occasional smokers	2014/15	–	-	4.0%	3.5%	2.7%	7.6%		0.6%
Percentage who have tried e-cigarettes	2014/15	–	-	18.5%	19.2%	18.4%	33.9%		7.2%
Percentage who have tried other tobacco products	2014/15	–	-	16.7%	15.0%	15.2%	28.8%		5.5%
Percentage who have ever had an alcoholic drink	2014/15	–	-	68.3%	71.8%	62.4%	77.6%		14.6%
Percentage of regular drinkers	2014/15	–	-	8.3%	7.4%	6.2%	12.3%		1.0%
Percentage who have been drunk in the last 4 weeks	2014/15	–	-	15.9%	17.5%	14.6%	27.0%		2.6%
Percentage who have ever tried cannabis	2014/15	–	-	12.8%	13.3%	10.7%	24.2%		4.9%
Percentage who have taken cannabis in the last month	2014/15	–	-	6.2%	5.9%	4.6%	14.4%		1.6%
Percentage who have taken drugs (excluding cannabis) in the last month	2014/15	–	-	1.2%	1.4%	0.9%	4.2%		0.1%
Percentage who think they're the right size	2014/15	–	-	51.2%	52.1%	52.4%	46.5%		57.1%
Mean score of the 14 WEMWBS statements	2014/15	–	-	48.1	47.5	47.6	45.4		48.9
Percentage reporting low life satisfaction	2014/15	–	-	13.4%	13.4%	13.7%	19.1%		9.5%
Percentage who were bullied in the past couple of months	2014/15	–	-	57.1%	57.6%	55.0%	63.1%		42.6%
Percentage who had bullied others in the past couple of months	2014/15	–	-	9.2%	10.6%	10.1%	14.1%		5.5%

[68] Government, *Support for children and young people*. 2016.

The above spine chart gives the PHE Fingertips snap shot of health behaviours in 15 year olds. Red dots indicate a statistically significantly worse performance than the national average. It is of concern that Gloucestershire is flagged red in terms of occasional smokers, those who have tried drinking by age 15, regular drinkers, and those who have ever tried or have used cannabis in the last month. This suggests that in terms of smoking, cannabis use and alcohol use more of our 15 year olds are engaging in health damaging behaviours across the board than is seen nationally. This may go on to have long term health and social implications for the individuals and the wider community.

Interestingly there is a slightly different picture emerging from the Online Pupil Survey data. This shows an increasing proportion of year 8 and 10 pupils having never tried alcohol, smoking or drugs. It should be noted that the fingertips tool only covers a 15yr old cohort (year 10), whereas the OPS data presented captures responses from a larger cohort, years 8-10 (12-15) and whilst there is an overlap, they are not directly comparable; therefore due to this and methodological differences we would not expect to see closely corresponding trends.

Alcohol is the substance years 8 and 10 report as being most likely to use with less than half having "never tried" it compared to 87% having never tried smoking and 93% having never tried illegal drugs. From the other side of the issue, 23% of years 8 and 10 report drinking alcohol regularly compared to only 6% reporting smoking regularly and only 4% report using illegal drugs regularly.

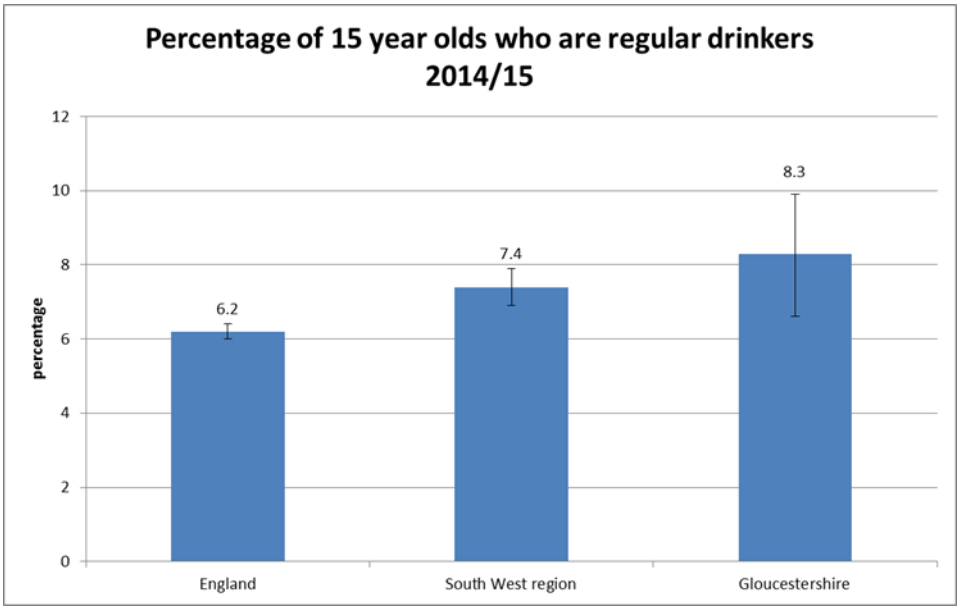


Source: Online Pupil Survey

Alcohol

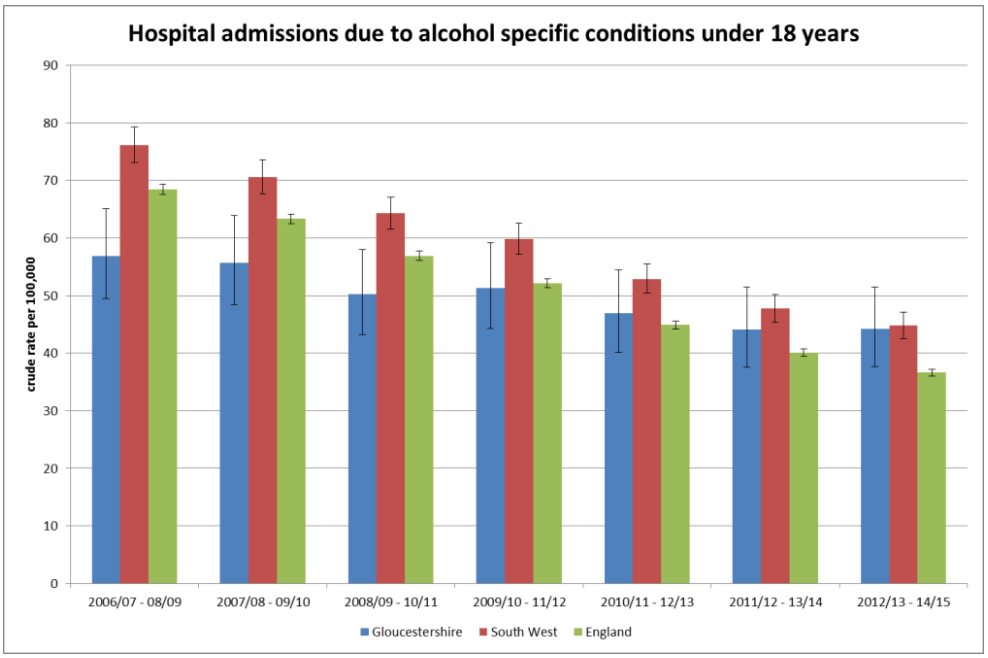
Taking both data sets together suggest that alcohol may be the most problematic and health damaging behaviour for our young people. On the positive side, a seen above, in the online pupil survey almost half of pupils reported never having tried alcohol. However, of those who reported having used alcohol in the online pupil survey, almost 1 in 4 years 8 and 10 (age 13-15 year olds) reported regular alcohol use. The PHE fingertips data suggests that more young people are regular

drinkers in Gloucestershire than nationally. The graph below shows that significantly more 15 year olds were regular drinkers in Gloucestershire (8.3%) than the England average (6.2%).



Source PHE fingertips data

In addition to greater proportions of young people drinking regularly in Gloucestershire, there is some indication that those who are drinking regularly are doing so to the point it is causing themselves problems. In the latest available figures (shown below), Gloucestershire has a statistically significant higher rate of admissions for alcohol related conditions in those under 18 than the England average.

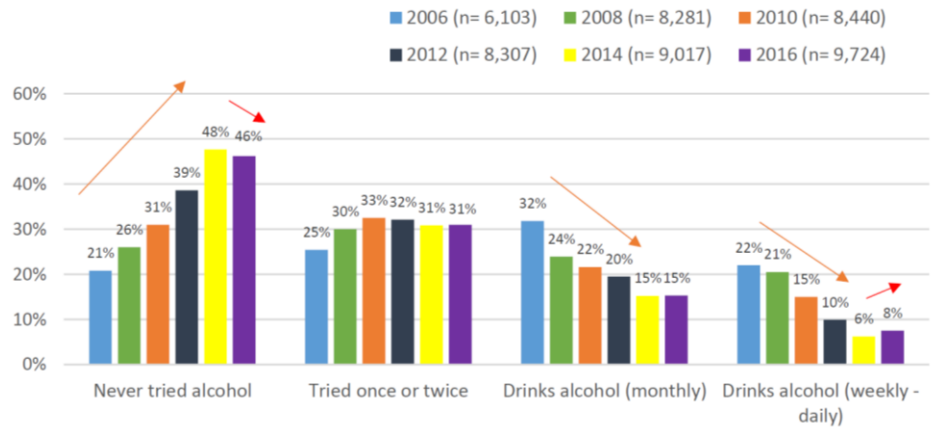


Source: https://fingertips.phe.org.uk

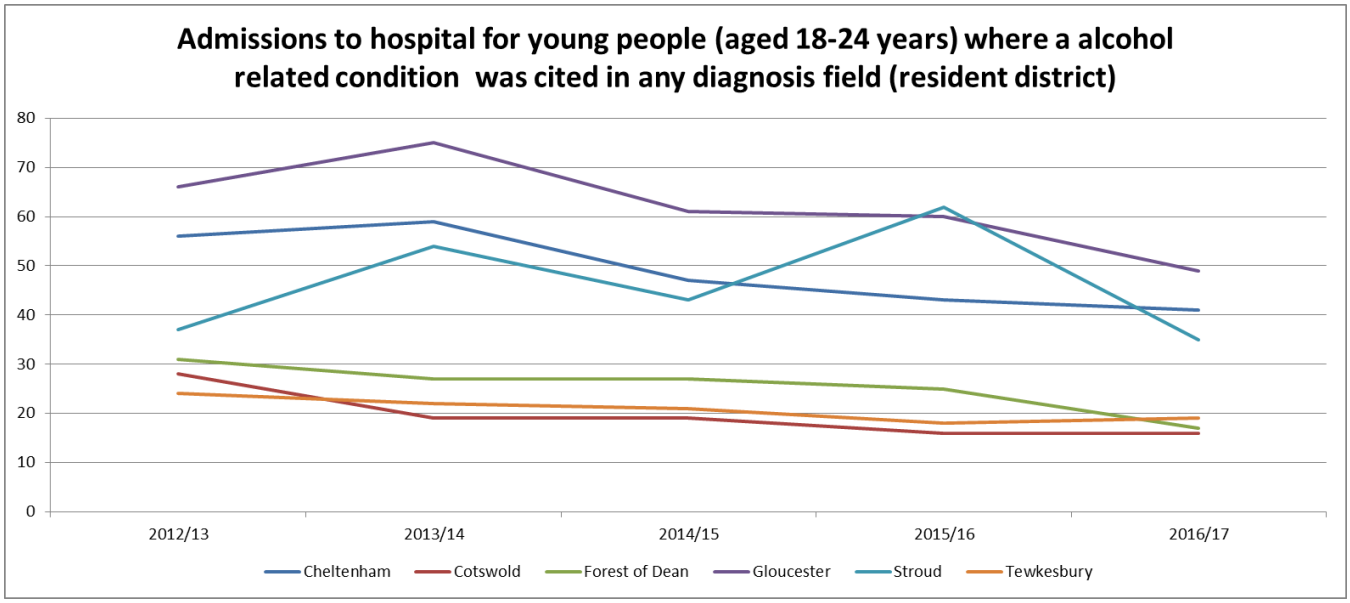
Looking at the time series analysis above suggests that 10 years ago Gloucestershire had a statistically significantly lower rate of hospital admissions due to alcohol specific conditions in children under 18 but that this has now reversed. While the rate of alcohol admissions in under 18s in Gloucestershire has reduced, it has done so more slowly than in the rest of the country meaning there is now a statistically significant higher rate of admissions in Gloucestershire than the England rate.

The recent rise in those in year 8 and 10 drinking alcohol weekly seen in the online pupil survey (illustrated below) may be an area of further concern as is the slight up tick in admissions seen when comparing the last 2 years of available data. Some caution should be applied when interpreting this information. This is an apparent increase but given the way the admission rate is calculated we cannot be certain that this is a genuine increase.

Figure 33: Alcohol consumption changes in mainstream secondary (year groups 8 & 10 only) over time (n=59,978)

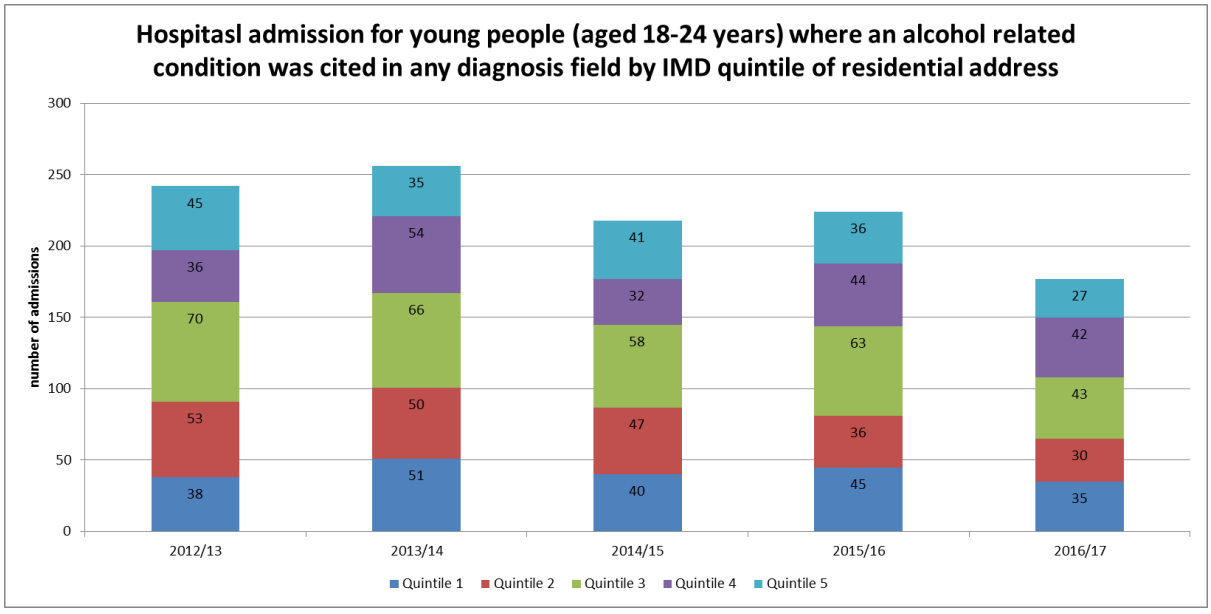


The children and young people being admitted to hospital are mainly coming from Gloucester, Cheltenham and Stroud (which represent the largest population groups)



In 2016/17 the Lower Super Output Area with the highest number of admissions for alcohol related conditions (in any diagnosis field) for young people (aged 18-24 years) was Westgate area.

Numerically, the highest number of admissions are in quintile three although admissions are distributed right across the socio economic spectrum. The data by year and by area are shown below.



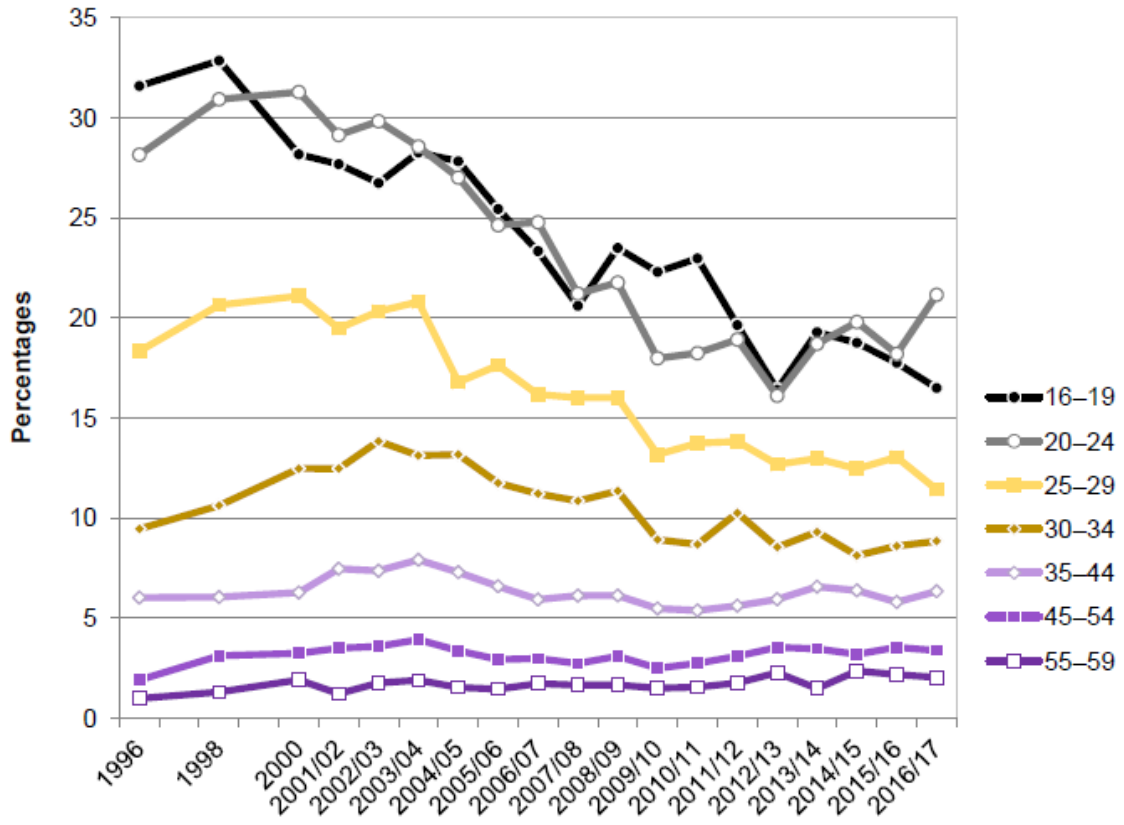
In summary, in terms of alcohol use in children and young people it is a picture of two parts. While the numbers of children and young people who do not drink are increasing, at the same time there seems to be a significant and growing minority who are regularly using alcohol and are causing themselves harm resulting in hospital admissions due to their alcohol use patterns. The activities of this sizeable minority are causing Gloucestershire to perform worse than the national average in this area and the trends are worsening.

Drugs

The 2016-17 Crime Survey for England and Wales (CSEW) found that in England and Wales, as in previous years, younger people were more likely to take drugs than older people. During 2016-17, the level of any drug use in the last year was highest among 16 to 19 year olds (16.5%) and 20 to 24 year olds (21.2%). People living in urban areas reported higher levels of drug use than those living in rural areas. Around 1 in 11 (8.8%) people living in urban areas had used any drug in the last year, compared with 1 in 15 (6.7%) of those living in rural areas.

Although drug use is highest among the youngest age groups, use has been declining over time and consistently so for the last 3 years for the 16-19 age group. The 20-24 age group has seen a recent upturn in use from 2015-16.

Figure 3.1: Proportion of 16 to 59 year olds using any drug in the last year by age group, 1996 to 2016/17 CSEW



Drug Misuse: Findings from the 2016/17 Crime Survey for England and Wales, Statistical Bulletin 11/17, July 17

Heroin (opiate) and crack cocaine use are associated with the highest harm and potential for drug dependence, and most likely to bring people into contact with treatment services. Official local prevalence estimates for the use of these substances are produced by Liverpool John Moores University.

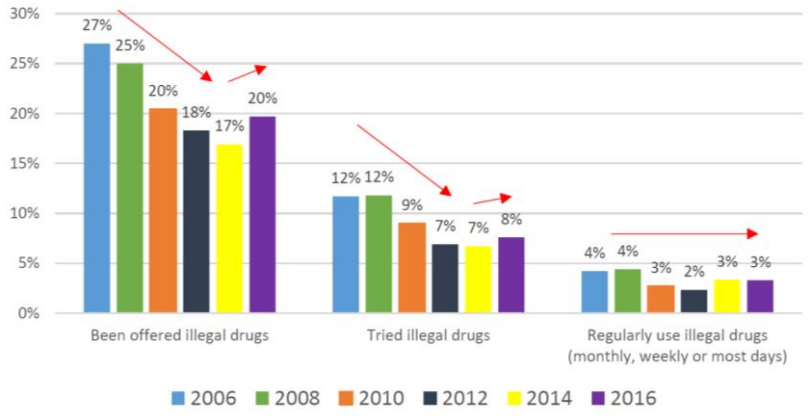
Prevalence of opiate use and/or crack cocaine use aged 15-24 for 2014-15 as the following for Gloucestershire:

	15-24 years of age		
	Gloucestershire Prevalence Estimate for 2014-15		
	Mid point estimate	Lower bound 95% Confidence Interval	Upper bound 95% Confidence Interval
Opiate & crack	352	109	578
Opiate only	186	82	453

These estimates suggest that there should be approximately 186 (95% CI 82-453) opiate users aged 15 to 24 years of age residing in the county. Local treatment system data[69] for young people and adults show that approximately 50 people within this age group received treatment for opiate use in 2016-17. Given the wide confidence interval, this indicates that there are fewer individuals using these substances than the estimates suggest and that the true number will likely be closer to the lower bound of the confidence interval than to the mid point.

Only 3% of Gloucestershire's pupils in Years 8 and 10 report using illegal drugs regularly (monthly, weekly or on most days). Since the last survey there has been a slight increase in those reporting being offered drugs although this proportion remains lower than the 2006-2010 rates.

Figure 40: Illegal drug behaviour in secondary pupils over time

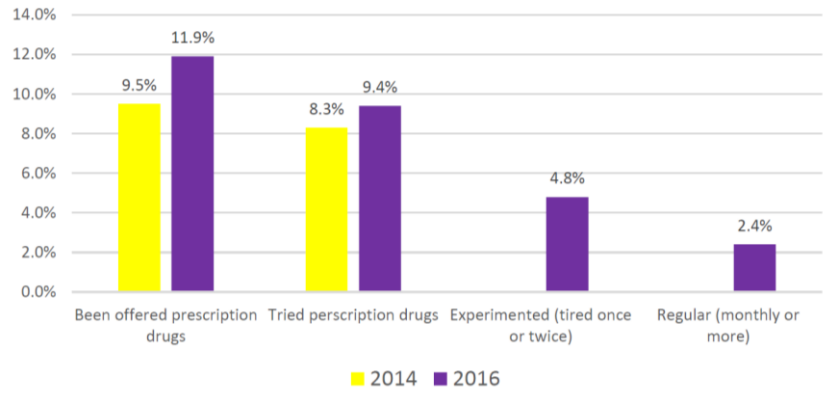


Source Online Pupil Survey

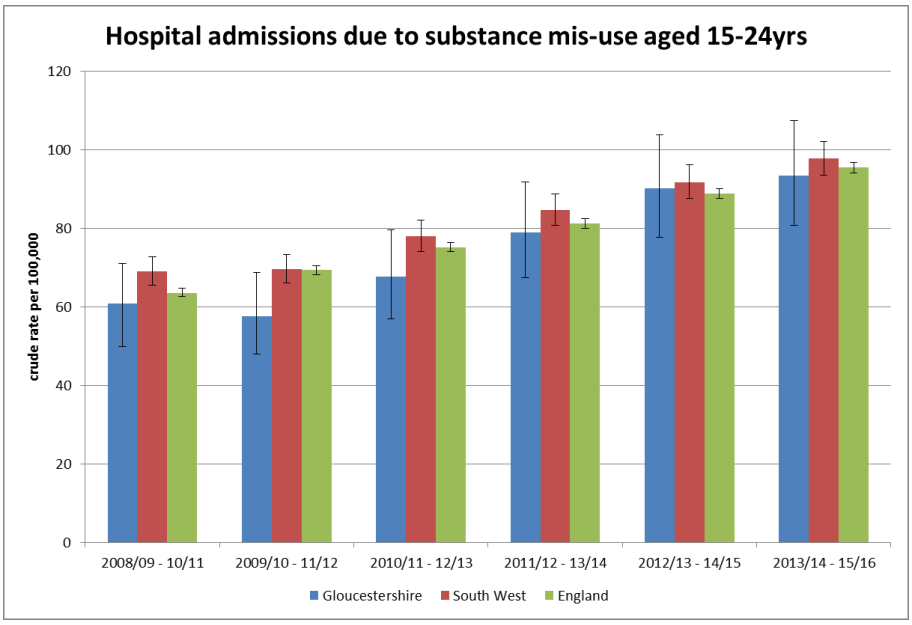
Since 2014 a question has been asked around use of prescription drugs for non prescribed purposes. The reported results suggest this behaviour is increasing locally with more young people reporting being offered them, trying them and using them regularly.

[69] *Public Health England; National Drug Treatment Monitoring System – Adult Partnership Activity Report Quarter 4, 2016-17 and Young People Quarterly Activity Report, Quarter 4 2016-17.*

Figure 41: Taking prescription drugs that are not your own - behaviour in secondary pupils over time



In line with national trends there has been an increase in the rate of young people aged 15-24 being admitted to hospital for issues related to substance misuse (this includes drugs and alcohol).



Source PHE fingertips data

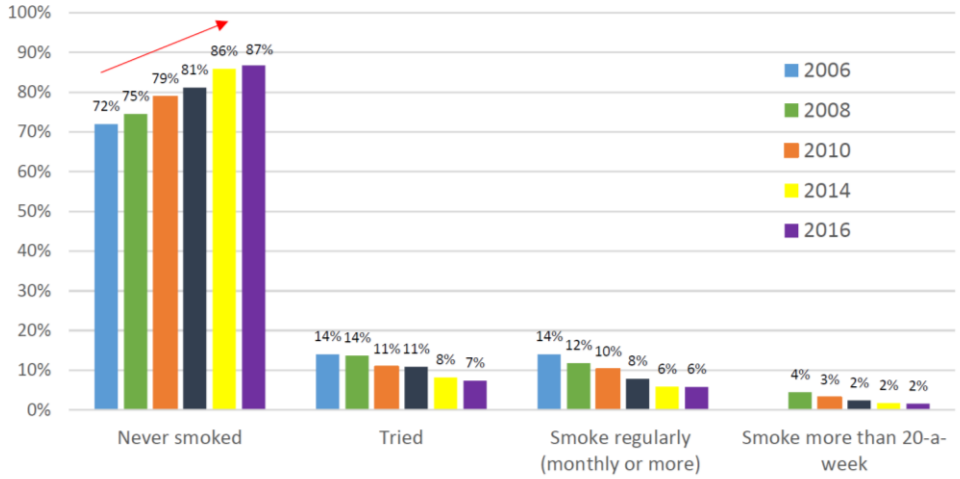
Analysis of the time series data shows the Gloucestershire rate of admissions due to substance mis-use in 15-24 year olds has increased in line with regional and national trends since 2008/09 and is not significantly different to either the South West or England rates. Despite being inline with national trends this increase is still of concern as it represents a number of young people participating in a very harmful behaviour.

Smoking

The increase in year 8 and 10 pupils who report never smoking is encouraging and is currently 87%. An additional 7% of pupils report having tried smoking but not continuing it regularly. However,

despite the encouraging data for the majority, there are still 2% of pupils who report smoking more than a pack a week and 6% who smoke regularly (defined as at least once a week).

Figure 36: Secondary pupils smoking (tobacco habits)



Source: OPS Online Pupil Survey 2016: www.ghll.org.uk/online-pupil-survey

Local Service Provision

Education and prevention work covering all types of substance misuse (smoking, vaping, alcohol, prescription drugs, and illegal drugs) is a key part of the Personal Health and Social Education (PHSE) curriculum for primary and secondary schools and colleges. Public Health commissions Gloucestershire Healthy Living and Learning (GHLL) to provide leading teachers and local resources for PHSE delivery in schools by teachers, health professionals, and other agencies.

Drug and Alcohol Services for Young People

Gloucestershire County Council commissions drug and alcohol treatment for young people under the age of 18 through its youth support contract with Prospects.

The Gloucestershire Safeguarding Children Board (GSCB) hosts guidance for the children and young people's workforce, coordinates training on hidden harm and young people's substance misuse screening tools, and acts as a referral hub for substance misuse concerns. The combination of provision of training, tools and hub facilitates access to the appropriate service.

There have been 66 young person screening tool referrals to the GSCB hub in the 14 months up to January 2018. Of these 47 were male and 19 were female and the majority were in the 16-17 age group. The main reason for referral was concerns about cannabis and alcohol.

Lower level cases are signposted to interventions by community partners Infobuzz and EMotivate, who are then commissioned by schools to work with individuals or groups. A tailored workbook intervention on substance misuse issues can often lead to better school engagement overall.

Higher level cases go to the Young People's Substance Misuse Treatment Service, part of Youth Support, where psychosocial interventions are delivered by a multi-professional health team

following NICE clinical guidance. Youth Support works with young people who are the most at risk of not making a successful transition into adulthood, including young offenders and young people arrested for drugs offences. About 50 young people are on substance misuse treatment caseloads, with three out of four of those leaving treatment having both reduced their primary drug use by more than half and renewed their engagement in education or training. Service satisfaction levels are consistently over 90%.

Stop Smoking Support for Young People

Gloucestershire Healthy Lifestyle Service

The Gloucestershire Healthy Lifestyles Service provides up to 12 weeks of free support to young smokers. This support includes 1:1 coaching and support via telephone, email, and text. In line with NICE guidance Nicotine Replacement Therapy (NRT) is only available for people aged 12 years and over, however the Service will provide behavioural support to people of any age. The Service can be accessed either via a self referral or through a referral from a health care professional.

Peer Support Programme for Young People

The Healthy Lifestyles Service is developing an evidence-based prevention and early intervention peer support programme for schools. The programme will support the prevention of smoking, alcohol and substance use by young people. It will be delivered to groups of young people aged between 8 and 14 in schools and will target the major social and psychological factors that promote the initiation of substance misuse and other risky behaviours.

In the first three quarters of financial year 2017/18, 12 young people under 18 accessed services.

Evidence around What Works

Drug and Alcohol Services:

NICE and PHE provide numerous guidance on reducing alcohol consumption and substance misuse amongst children and young people[70] These recommendations include:

Policy level:

- Develop and implement a strategy to reduce substance misuse among vulnerable and disadvantaged people aged under 25, as part of a local area agreement. This strategy should be:
    - based on a local profile of the target population developed in conjunction with the regional public health observatory. The profile should include their age, factors that make them vulnerable and other locally agreed characteristics
    - supported by a local service model that defines the role of local agencies and practitioners, the referral criteria and referral pathways.

[70] NICE, *Substance misuse interventions for vulnerable under 25s*. 2007, Drug misuse prevention: targeted interventions, NICE guideline [NG64], Feb 2017 https://www.nice.org.uk/guidance/ng64/chapter/Recommendations, Alcohol use disorders: prevention, Public Health guideline [PH24], June 2017 https://www.nice.org.uk/guidance/ph24

- Use existing screening and assessment tools to identify vulnerable and disadvantaged children and young people aged under 25 who are misusing – or who are at risk of misusing – substances. These tools include the Common Assessment Framework and those available from the National Treatment Agency.
- Work with parents or carers, education welfare services, children's trusts, child and adolescent mental health services, school drug advisers or other specialists to:
    - provide support (schools may provide direct support)
    - refer the children and young people, as appropriate, to other services (such as social care, housing or employment), based on a mutually agreed plan. The plan should take account of the child or young person's needs and include review arrangements.
- Offer a family-based programme of structured support over 2 or more years, drawn up with the parents or carers of the child or young person and led by staff competent in this area. The programme should:
    - include at least three brief motivational interviews each year aimed at the parents/carers
    - assess family interaction
    - offer parental skills training
    - encourage parents to monitor their children's behaviour and academic performance
    - include feedback
    - continue even if the child or young person moves schools.
- Offer more intensive support (for example, family therapy) to families who need it.

<u>Community Level</u>

- Consideration should be given to offering the children group-based behavioural therapy over 1 to 2 years, before and during the transition to secondary school. Sessions should take place once or twice a month and last about an hour. Each session should:
    - focus on coping mechanisms such as distraction and relaxation techniques
    - help develop the child's organisational, study and problem-solving skills
    - involve goal setting.
- Consideration should be given to offering the parents or carers group-based training in parental skills. This should take place monthly, over the same period (as described above for the children). The sessions should:
    - focus on stress management, communication skills and how to help develop the child's social-cognitive and problem-solving skills
    - advise on how to set targets for behaviour and establish age-related rules and expectations for their children.

Smoking

A substantial amount of national guidance on supporting young persons to stop smoking is published by NICE[71]. A summary of these recommendations include:

Policy level

- Determine the characteristics of the local population of people who smoke or use other forms of tobacco. Determine the prevalence of all forms of tobacco use locally.
- Ensure NHS Stop Smoking Services target minority ethnic and socioeconomically disadvantaged communities in the local population; in line with how they currently prioritise the under 25 population.
- Set realistic performance targets for both the number of people using the service and the proportion who successfully quit smoking. These targets should reflect the demographics of the local population. Services should:
    - aim for a success rate of at least 35% at 4 weeks, validated by carbon monoxide monitoring. This figure should be based on all those who start treatment, with success defined as not having smoked in the third and fourth week after the quit date. Success should be validated by a CO monitor reading of less than 10 ppm at the 4-week point. This does not imply that treatment should stop at 4 weeks.
    - Audit performance data routinely and independently and publically publish quit rates by each provider. Audits should also be carried out on exceptional results – 4-week quit rates lower than 35% or above 70% – to determine the reasons for unusual performance, and to help identify best practice and ensure it is being followed.
    - Establish links between contraceptive services, fertility clinics and ante- and postnatal services. These links should ensure health professionals use the many opportunities available to them (at various stages of the woman's life) to offer smoking advice Offer behavioural counselling, group therapy, pharmacotherapy or a combination of treatments that have been proven to be effective (see the list at the start of this section).
    - Ensure clients receive behavioural support from a person who has had training and supervision that complies with the 'Standard for training in smoking cessation treatments' or its updates.
    - Provide tailored advice, counselling and support, particularly to clients from minority ethnic and disadvantaged groups. Provide services in the language chosen by clients, wherever possible.
- Ensure the local NHS Stop Smoking Service aims to treat ethnic groups in proportion to their representation in the local population of tobacco users

Community level

Build and maintain relationships with partners, thereby improving compliance with tobacco legislation such as stopping underage sales, promoting smoke-free laws, enforcing ban on smoking in a vehicle when a child or children are present, reducing the availability of illicit tobacco.

[71] NICE, Stop smoking services. 2013; Government, Smoking: supporting people to stop [QS43]. 2013; Government, Smoking and tobacco. 2016.

Discussion, Gap Identification and Recommendations

Strengths in this area:

- Increasing numbers of children and young people who have never engaged in smoking, alcohol or drug taking behaviours

Areas of Concern

- Regular and harmful drinking rates in young people appears to be increasing and we are a poor performer nationally in terms of admissions to hospital for alcohol related issues in young people

- Slight increases in the number of children being offered and trying drugs even though regular use rates remain low.

Recommendations

Ensure services are configured to meet the changing needs of our young people and are accessible and effective.

Focus on teenage drinking to investigate causes of high rates of regular use in some of our children and young people. Consider taking a wider, trauma/ACEs informed approach to working with these children given that alcohol use can be associated with other co-occurring issues.

Children with Chronic Health Conditions

Children with Chronic Health Conditions

Introduction

In previous sections we have looked at a number of health indicators that mainly look at health related episodes in a child's life (eg birth, a vaccination or an episode of acute illness) . However, there is a cohort of children that are born with or develop significant long term conditions in childhood and these children and their families have to live with and manage these conditions throughout childhood and for the rest of their lives. . These conditions include illnesses such as asthma, epilepsy and insulin dependent diabetes. Such conditions, especially if poorly managed, can have a negative impact on school attendance, quality of life and can go on to have significant, negative health implications in adulthood. In extreme cases these conditions can result in death.

Analysis of childhood performance indicators for these chronic conditions can give insights into how well healthcare services are meeting the needs of these children. Poor performance will have health implications for the children both now and in the future, psychological implications for the children both now and in the future and can go on to have significant financial impacts on health services. The three conditions mentioned above are often used as proxy indicators for all long term health conditions in children (and will be here) , but there are obviously other conditions that children and young people live with that have similar impacts.

The 2012 Annual Report of the Chief Medical Officer[72] identified that outcomes for children and young people in England are poorer than they could or should be. International evidence demonstrates that better is possible, with England an extreme outlier in asthma mortality in the under 14s, with almost 25 times higher mortality than the best performing country studied in a recent review[73].

Even within England, there are large, and unacceptable, variations in outcomes. The 2015 Atlas of Variation in Healthcare[74] noted that in diabetes management nationally there was a 60.6 fold variation between the best and worst performing locations in the number of patients aged 0-24 whose blood sugar levels were maintained below the target threshold. Similarly, in emergency asthma admissions there is a 10.6 fold variation in the admission rates between the best and worst performing CCGS.

[72] Government, *Annual Report of the Chief Medical Officer 2012 - Our Children Deserve Better: Prevention Pays*. 2012.
[73] Wolfe, I., et al., *Health services for children in western Europe.* Lancet, 2013. **381**(9873): p. 1224-34.
[74] https://fingertips.phe.org.uk/profile/atlas-of-variation

One of the key things to note, and an aspect which is highlighted int eh Royal College of paediatricians and Child helath report is that many of the upstream factors important for prevention such as stopping maternal smoking, safe and healthy housing and good levels of education around the conditions are common to may other issues that impact children in childhood. A prevention focussed common risk factors approach could reap multiple dividends.

Policy Context

NHS England and CCGs have a responsibility for enhancing the quality of life for people with long term conditions that include reducing avoidable emergency admissions, improving the quality of life for children with long term conditions, as well as reducing pressures on local hospitals. All of these aspects feature in the NHS Outcomes Framework.

Each of the conditions mentioned in this section is also the focus of individual NICE guidance.

Epidemiological Data Review

Overall, Gloucestershire's children generally enjoy good health with self reported excellent health being the highest in the region.

Percentage of Children reporting general health as excellent

Area	Value	Lower CI	Upper CI
England	29.5	29.2	29.8
South West region	30.6	29.8	31.5
Gloucestershire	34.7	31.8	37.6
Dorset	33.2	30.3	36.0
South Gloucestershire	32.0	29.2	34.7
North Somerset	31.4	28.6	34.1
Devon	31.1	28.4	33.8
Cornwall	31.0*	28.2	33.8
Bath and North East Som...	30.0	27.3	32.7
Wiltshire	29.8	27.1	32.5
Swindon	29.0	26.3	31.6
Bournemouth	29.0	26.3	31.8
Torbay	28.9	26.0	31.8
Somerset	28.7	26.1	31.2
Poole	28.6	26.0	31.2
Plymouth	28.1	25.4	30.8
Bristol	27.6	24.7	30.5
Isles of Scilly	*	-	-

Source: What About YOUth (WAY) survey, 2014/15

In terms of doctor diagnosed levels of ill health relating to long term conditions Gloucestershire performs in line with national and regional averages with around 15% of children in the county being diagnosed with a long term condition. This equates to around 21,000 children.

Percentage of children with long term chronic condition as diagnosed and recorded by a doctor

Area	Value	Lower CI	Upper CI
England	14.1	13.8	14.3
South West region	14.5	13.8	15.1
Plymouth	16.1	13.9	18.3
Torbay	16.0	13.6	18.4
Poole	15.9	13.7	18.1
Bath and North East Som...	15.4	13.2	17.6
North Somerset	15.3	13.1	17.5
Gloucestershire	14.6	12.4	16.7
Devon	14.6	12.4	16.7
South Gloucestershire	14.6	12.5	16.7
Cornwall	14.5*	12.3	16.7
Bournemouth	14.5	12.4	16.7
Somerset	14.4	12.3	16.4
Dorset	14.4	12.2	16.6
Wiltshire	13.6	11.6	15.7
Bristol	13.5	11.2	15.7
Swindon	12.0	10.1	13.9
Isles of Scilly	*	-	-

Source: What About YOUth (WAY) survey, 2014/15

Asthma

Asthma is a significant long term condition of childhood both for the individual and families concerned, but also as an indicator condition for the broader state of child health and health system function.

It is a common illness nationally - The prevalence of asthma in the UK is among the highest in the world. It is estimated that 1.1 million children in the UK are currently receiving treatment for asthma. The number of reported asthma deaths in the UK is also amongst the highest in Europe.

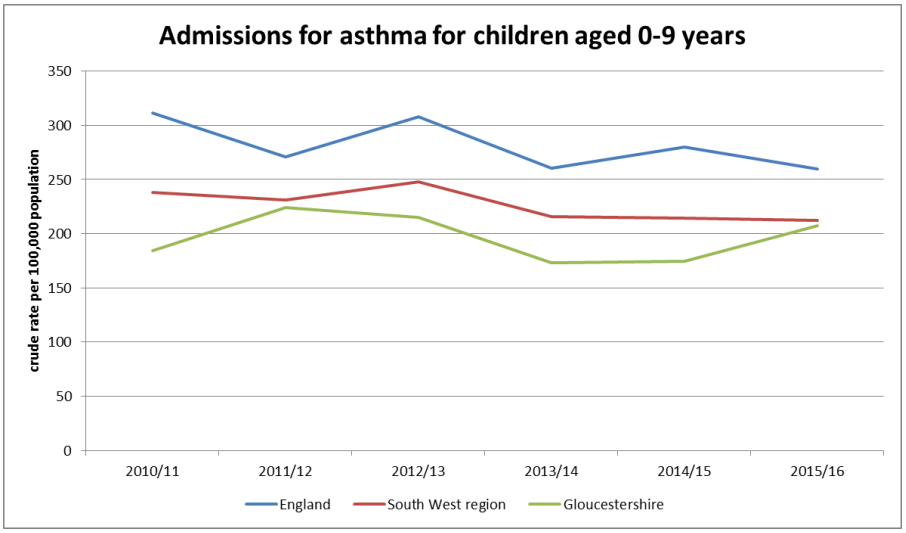
Asthma has serious consequences that are often avoidable with early intervention, prevention and correct management - the National Review of Asthma Deaths (NRAD) found that the overall standard of care for children was inadequate in 46% of the deaths reviewed and that there were potentially avoidable factors related to patients and their families in 65% deaths. In addition, it is estimated that up to 70% of emergency admissions for asthma (adults and children) may be preventable.

As can be seen below, Gloucestershire generally performs better than or in line with the national average in terms of asthma admissions. However, it should be noted that the trend around this indicator appears to be worsening with a recent up tick in admissions shown by the red upward arrow in the spine chart and illustrated in the time trend charts below.

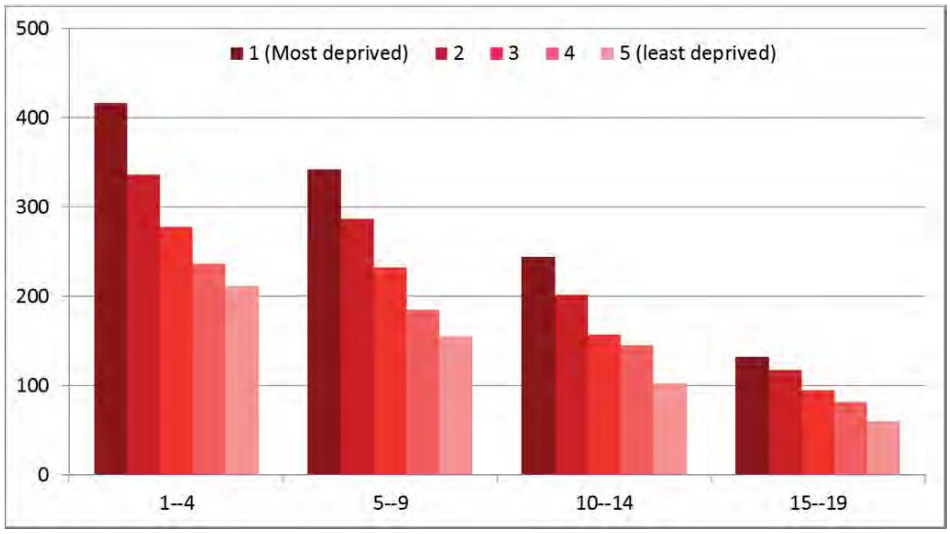
Compared with benchmark ● Better ● Similar ● Worse ○ Not Compared

Benchmark Value
Worst | 25th Percentile | 75th Percentile | Best

Indicator	Period	Glouc'shire			Region England	England	England		
		Recent Trend	Count	Value	Value	Value	Worst	Range	Best
Hospital admissions for asthma (under 19 years)	2015/16	→	211	159.5	168.0	202.4	591.6		84.3
Admissions for asthma for children aged 0 to 9	2015/16	→	145	207.4	212.1	259.8	805.1		91.8
Admissions for asthma for young people aged 10 to 18	2015/16	↑	66	105.8	117.0	132.0	342.4		49.0

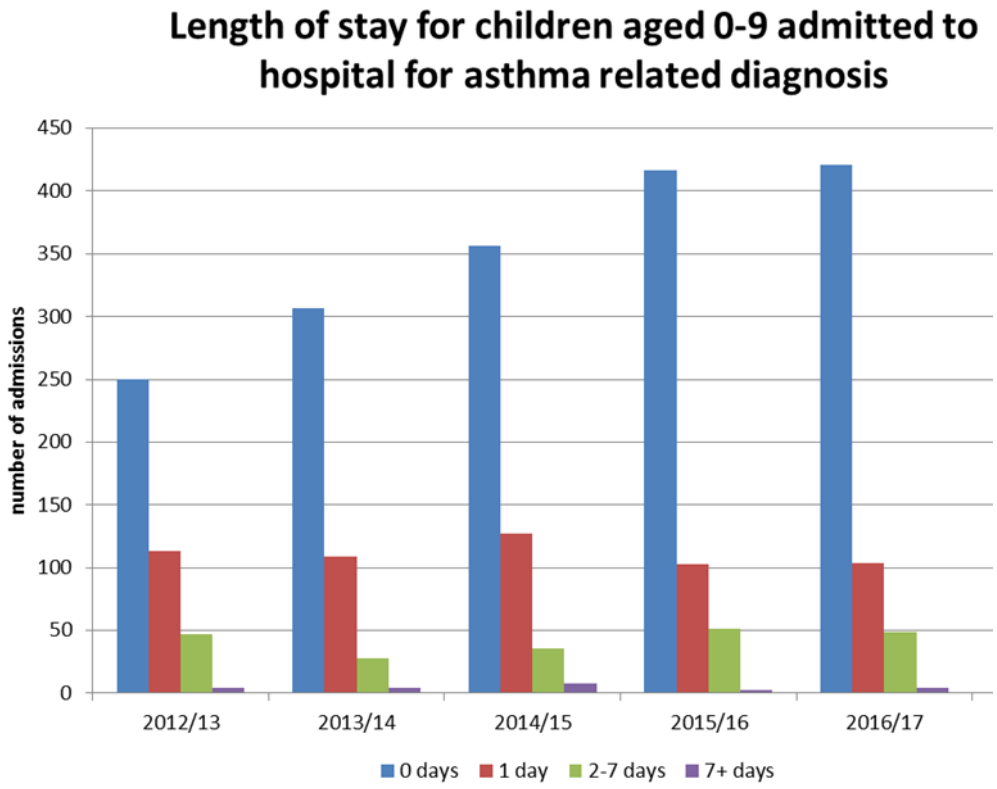


A rising rate of emergency admissions is of concern as most emergency admissions are preventable with high-quality management (including the use of asthma plans) and early intervention to address deterioration in asthma control. Thus rising rates suggest deterioration in upstream factors and prevention system failures. It is also of concern because emergency admissions tend to show a social gradient with the highest proportion of admissions being for the least well off. Local data on this are unavailable but national trends are shown in the chart below.



Source: State of Child Health Report 2017

In terms of length of stay a large number of admissions are very short term and this number has been rising in recent years.



Diabetes

Like asthma, Type 1 diabetes is a common condition of childhood, with an estimated 31,500 children in the UK under the age of 19 living with the illness. The UK is currently sixth highest in the world for number of new cases of Type 1 diabetes, with 28.2 per 100,000 being diagnosed each year. Early diagnosis is essential as when diabetes remains unidentified diabetic ketoacidosis can develop which is a potentially life-threatening condition where there is a lack of insulin preventing the body from using glucose for fuel.

The twin goals of managing Type 1 diabetes are maintaining good control of blood glucose while maintaining a good quality of life for children and young people. Diabetes can lead to high or low blood glucose issues and psychological problems during childhood. There are also serious long-term complications related to poor diabetes control during childhood and adolescence, including retinopathy, renal dysfunction and other microvascular complications, as well as later macrovascular complications including heart disease and stroke and higher risk of death.

If well managed, hospital admissions should be avoidable, thus rates of hospital admissions for diabetes can given an indication of how well the diabetes management and early intervention pathways are working. Rates of hospital admissions for children and young people in Gloucestershire are given in the spine chart below.

Compared with benchmark Better Similar Worse Not Compared

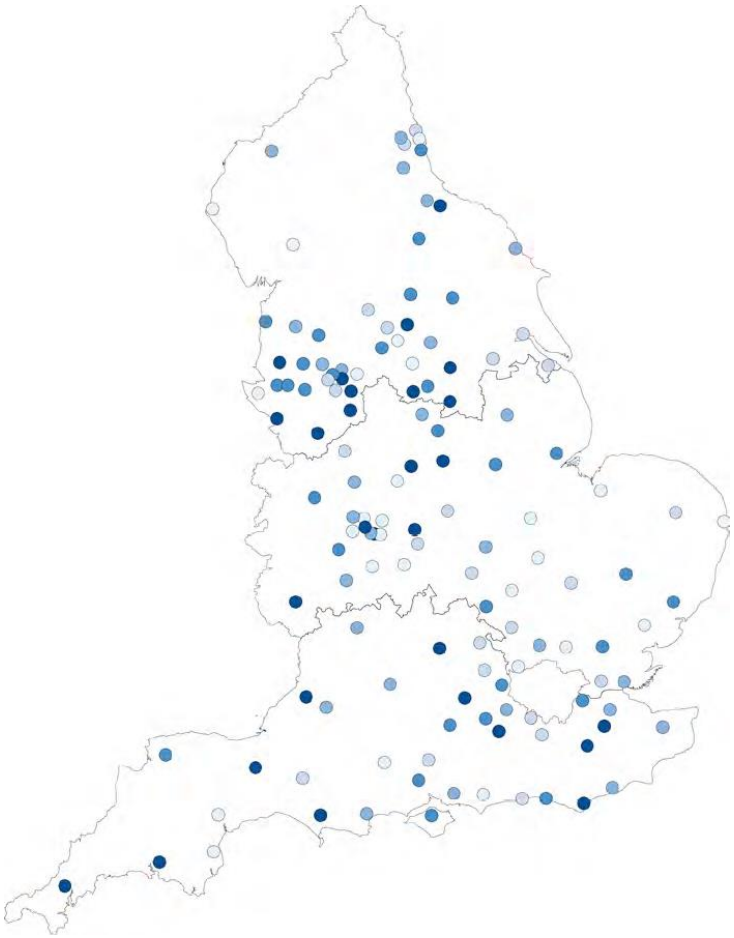
Benchmark Value
Worst 25th Percentile 75th Percentile Best

Indicator	Period	Glouc'shire			Region	England	England		
		Recent Trend	Count	Value	Value	Value	Worst	Range	Best
Admissions for diabetes for children and young people aged under 19 years	2015/16	➡	65	49.1	57.1	55.4	115.9		22.3
Admissions for diabetes 0-9	2015/16	➡	20	28.6	29.1	29.8	80.3		10.4
Admissions for diabetes for children aged 10 to 18	2015/16	➡	45	72.2	89.4	86.8	-	*Insufficient number of values for a spine chart*	-

The rates of admission for diabetes are in line with national rates and showing a stable trend.

In terms aof maintaing good glucose control Gllucestershire is performing in the mid range nationally. This could represent an area for improvement as getting more children to maintain their HbA1c levels below the target 58mm is impotant for long term health (see map below).

Percentage of children and young people aged 0–24 years with diabetes in the National Paediatric Diabetes Audit (NPDA) whose median HbA1c measurement was less than 58 mmol/mol (7.5%) by paediatric diabetes unit



(Darker dot means higher proportion of children)

Source 2015 Atlas of variation

Epilepsy

Epilepsy is the most common significant neurological disorder in children under the age of 19: more than one in 220 have epilepsy (approximately 63,400). Although some types of epilepsy last for a limited period of time, for most children it will be a life-long condition. Whilst deaths from epilepsy are rare, there were 44 registered deaths of children aged zero to 17 where epilepsy was the underlying cause in England and Wales in 2014. Many children and young people and their families report poor experiences of care and management, and that their epilepsy has a major impact on school attendance, educational attainment, mental health and life chances.

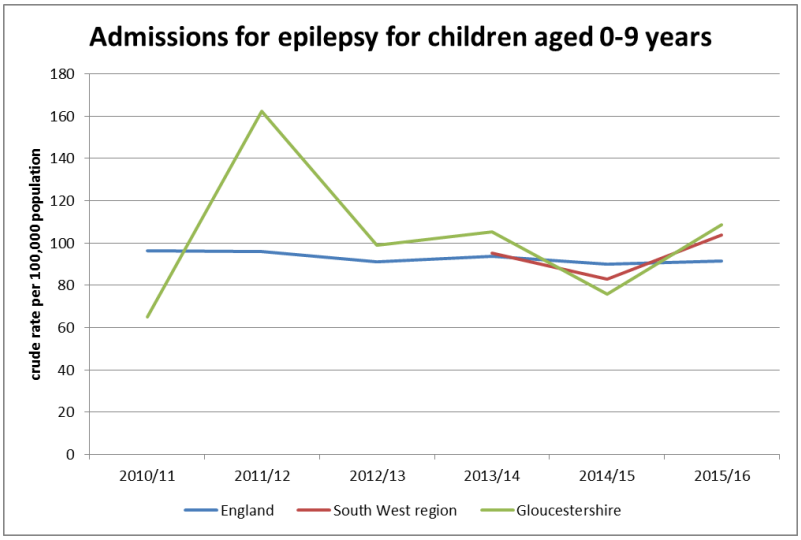
It is recognised that a comprehensive measure of epilepsy outcomes would include a range of indicators, including deaths (especially potentially avoidable deaths and SUDEP deaths), school attendance, educational and mental health outcomes, and wider quality of life measures. However, unplanned admission rates act as a proxy for seizure control and quality of local acute pathways impact on quality of life, and are available at the local level. They therefore offer the best current available single indicator of epilepsy clinical outcomes for this purpose and are used nationally.

Compared with benchmark Better Similar Worse Not Compared

Benchmark Value: Worst | 25th Percentile | 75th Percentile | Best

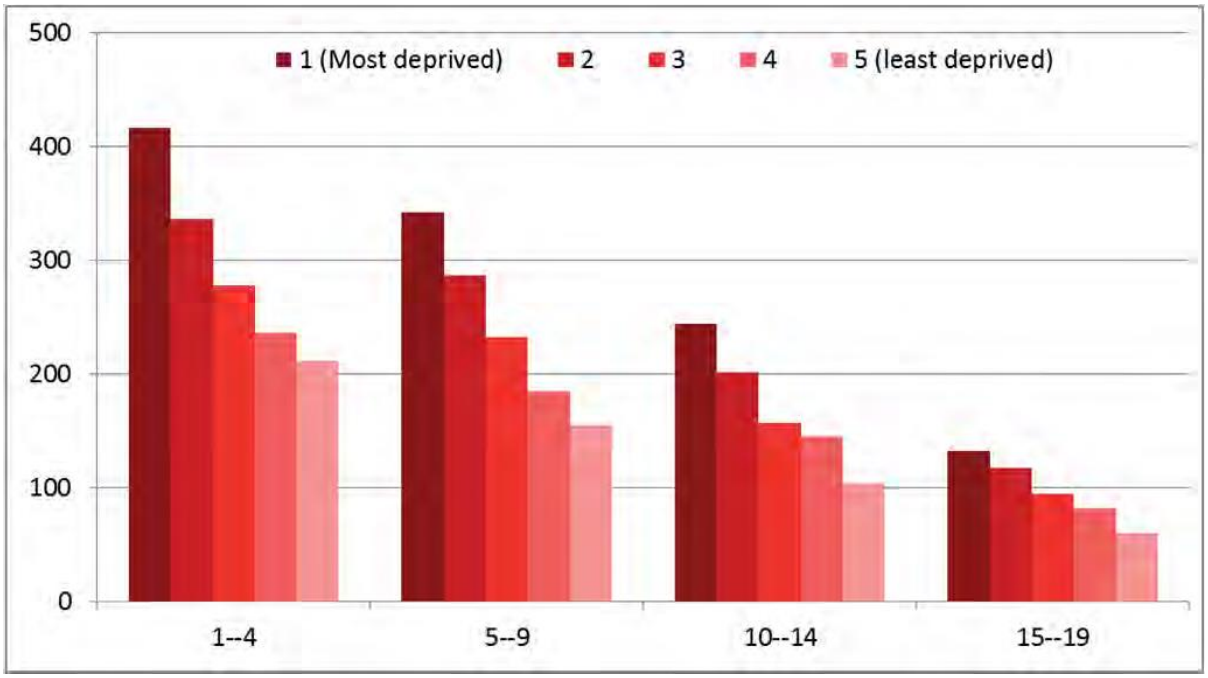
Indicator	Period	Glouc'shire			Region England	England	England		
		Recent Trend	Count	Value	Value	Value	Worst	Range	Best
Admissions for epilepsy for children and young people aged under 19 years	2015/16	→	133	100.6	79.5	76.6	183.4		20.4
Admissions for epilepsy for children aged 0 to 9	2015/16	↓	76	108.7	103.9	91.5	281.0		32.0
Admissions for epilepsy for young people aged 10 to 18	2015/16	→	57	91.4	51.4	58.2	236.3		19.1

Gloucestershire is performing significantly worse for epilepsy hospital admission in 0-19 year olds when compared to the national rate. This higher rate is driven by a worse performance for 10-18 year olds rather than for the younger age group. The chart below shows that there has been a large reduction in admission rate for this younger age group that has not been seen in the older cohort.



Higher than average rates of admissions are likely to suggest a significant health inequality as, as for a many conditions, admissions for epilepsy are highest in the most deprived quintile. Local data is not available on this but the national picture is shown below.

Admissions for epilepsy by age group and social grouping



Source: State of Child Health Report 2017

Local Service Provision

Gloucestershire NHS Foundation Trust has specialist outpatient clinics in respiratory medicine, diabetes and epilepsy. They are multidisciplinary teams with consultant led clinical expertise and are designed to support children and their families so children can live as normal a life as possible. Planned transitions to the adult team are offered with children being prepared from age 11-14 and transitioned between 16 and 18 depending on individual needs and circumstances.

Evidence around What Works

Asthma – RCPCH recommendations

Prevention -

Efforts to address the impacts of asthma should start with prevention. Actions should be focussed on

- supporting pregnancy women to stop smoking and reduce exposure to second hand smoke generally
- encouraging breast feeding
- reducing the impact of environmental smoke, and pollution and the impact of poor housing

Whole pathway approach - Ensure full implementation of guidance (NICE and SIGN)

Tailor treatment to the individual – all children with asthma should be provided with a personal asthma action plan and have a structured review by a healthcare professional with specialist training in asthma, at least annually

Improve education around and awareness of asthma triggers
Poor recognition of risk factors which can trigger an asthma attack is an important avoidable factor for children.

- There needs to be better education to enable children and their families to understand what triggers their symptoms and support to help them avoid these triggers and self- manage their condition.
- There is also a substantial role for schools to play to deliver their responsibilities to support children with long-term conditions such as asthma. These responsibilities are statutory in some countries

Diabetes - RCPCH recommendations

- Strengthen research into the underlying causes of diabetes and ways to manage it effectively.
- Collect comparable data across the UK to give a UK-wide overview of diabetes care and management which can be used to share best practice and drive improvement in areas of poor performance.
- Ensure joined-up care which meets the wider needs of children with diabetes, including appropriate transition to adult diabetes services.
- Ensure full implementation of updated NICE guidance for HbA1c levels across the UK, along with the recommendations from the NPDA regarding care management.
- Improve diabetes education for children, young people, families and healthcare and educational professionals to decrease stigma and discrimination.

Epilepsy - RCPCH recommendations

- Strengthen research into the underlying causes of epilepsy and ways to prevent it.
- Develop new methods of collecting and sharing data to facilitate delivery of more integrated, person-centred care.
- Ensure joined-up care which meets the wider needs of children with epilepsy, including timely access to mental health services.
- Ensure full implementation of NICE and SIGN guidelines across the UK and the recommendations from the Epilepsy12 programme.
- Increase use of the epilepsy passport or similar patient-held care plans.
- Improve epilepsy education for children, young people, families and healthcare andeducational professionals to decrease stigma and discrimination

Discussion, Gap Identification and Recommendations

Strengths in this area:

- Performance in childhood asthma and diabetes are broadly in line with national performance

Areas of Concern

- Poor performance in epilepsy related indicators particularly in older children and young people

Recommendations

Many of the upstream factors that impact on these long term conditions are the same as for other issues children encounter. Embed prevention of these common rsik factors into a whole system approach to improved child health strategies locally.

Childhood Mortality

Childhood Mortality

Overview

Not all pregnancies end with a live, healthy baby and not all children live to become adults. Deaths at such a young age take a high toll on the families involved and in terms of overall years of life lost to society. The majority of all childhood deaths occur in those under one, and the causes of death change during the course of childhood. Overall, there is a strong association between deprivation and the risk of death throughout childhood. While death in childhood is rare, statistically families in deprived areas are more likely to experience the death of a child.

Childhood Mortality: Definitions and National Trends

Stillbirths and Infant Mortality (0-1 years)

Infant mortality rates have declined markedly in the UK over the last 40 years, but progress has slowed in the last 20 years particularly in comparison to other European nations.

Still birth rates and infant mortality rates are an important indicator of maternal and child health and the infant mortality ratio is a commonly used basic indicator of overall population health and the overall quality of healthcare services.

The definitions used can be confusing as there can be subtle differences between users. In this document, and in line with UK agreed standards, a stillbirth is defined as a baby born without signs of life after 24 completed weeks of pregnancy. Infant mortality can be split into neonatal mortality (deaths 0-27 days post birth) and post-neonatal mortality (28-365 days post birth). Rates are given per 1,000 live births. Stillbirths are not included in the infant mortality indicator.

Neonatal mortality accounts for between 70% and 80% of infant deaths. The great majority of neonatal deaths are due to perinatal causes, particularly preterm birth, and are strongly related to maternal health. The remainder of infant deaths are post-neonatal, due to a broad range of causes, including sudden infant death syndrome (SIDS). Stillbirths account for half of all deaths during the perinatal period (the period surrounding birth, from about 24 weeks of pregnancy up to either seven or 28 days of age). Social inequalities play a role in almost all the leading causes of infant death. [75]

Child Mortality (1-17 years)

Mortality rates in this age group have decreased in the UK over the last 40 years although this decline has slowed in the last two decades and reductions in adolescent mortality in particular have not matched reductions in other wealthy countries. In 1-9 year olds the leading causes of death are cancer, injuries and poisonings, congenital conditions and neurological and developmental disorders. In 10-17 year olds the most common causes of death are injuries, violence and suicide, followed by cancer, substance misuse and nervous system and developmental disorders

[75] Royal College of Paediatrics and Child Health (RCPCH). () *State of Child Health Report 2017* [Online]. Available from: http://www.thehealthwell.info/node/1062390 [Accessed: 30th November 2017].

Child Mortality is measured as a child mortality rate which gives a directly standardised rate of death due to all causes in 1-17 year olds. The rate is given per 100,000 population.

Policy Context

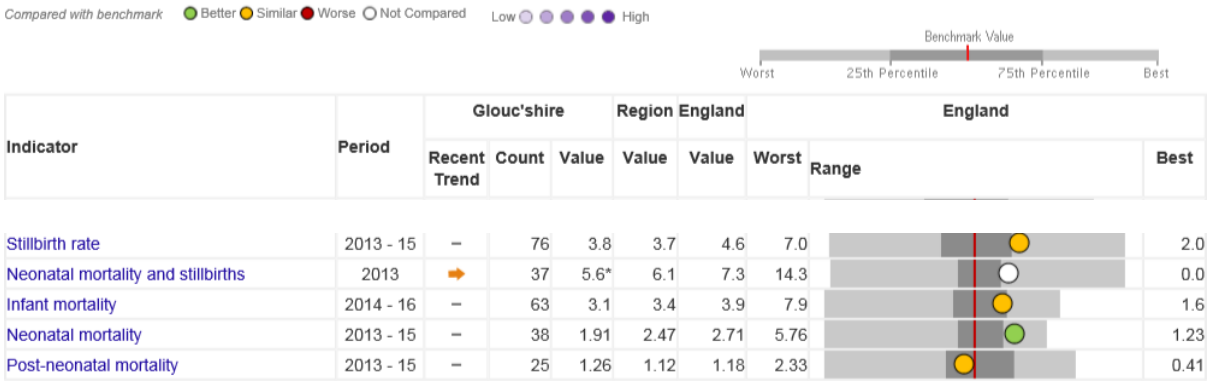
Reducing infant deaths and stillbirths is a priority for the NHS and the government and forms part of the NHS and Public Health Outcomes Framework. There is a range of specific policies, national guidance and programmes relevant including the National Service Framework "*Healthy Child Programme: Pregnancy and the first five years of life*" amongst others.

Epidemiological Data Review

National Data Sources –PHE Fingertips Data

The Public Health England Child and Maternal Health Fingertips data tool pulls together information from a number of sources to provide nationally comparable data. It collates and analyses a wide range of publically available data. Each indicator comes with a detailed description of its methodology of calculation and more information can be found at https://fingertips.phe.org.uk/profile-group/child-health

The chart below looks at child mortality indicators for the first year of life and benchmarks them against national performance.



Indicator	Period	Glouc'shire			Region	England	England		
		Recent Trend	Count	Value	Value	Value	Worst	Range	Best
Stillbirth rate	2013 - 15	–	76	3.8	3.7	4.6	7.0		2.0
Neonatal mortality and stillbirths	2013	➡	37	5.6*	6.1	7.3	14.3		0.0
Infant mortality	2014 - 16	–	63	3.1	3.4	3.9	7.9		1.6
Neonatal mortality	2013 - 15	–	38	1.91	2.47	2.71	5.76		1.23
Post-neonatal mortality	2013 - 15	–	25	1.26	1.12	1.18	2.33		0.41

Gloucestershire is broadly in line with national performance in terms of early child death except for neonatal mortality where Gloucestershire performs significantly better than the national average.

Local Data Sources – Child Death Overview Panel (CDOP)

The "Gloucestershire Child Death Overview Panel Annual Report for Child Death Reviews Gloucestershire Safeguarding Children Board 1st April 2016 – 31st March 2017" report looks at the circumstances around Gloucestershire child deaths (in this context from birth to 18th birthday). It provides a range of data around child deaths locally.

Numbers of child deaths notified by year 2012 to 2017 in Gloucestershire

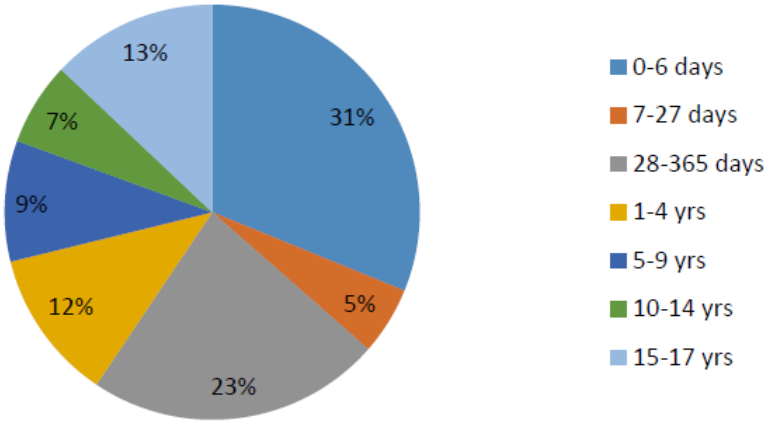
		Number of child deaths notified				
	2012-13	2013-2014	2014-2015	2015-2016	2016-17	**TOTAL**
Gloucestershire	44	26	46	19	36	171

Source: CDOP 2017

Age at death:

Using five year data, the greatest proportion of notifications (36%) were received for babies dying in the neonatal period (under one month of age), especially in the first week after birth (31%). This figure increases to 59% when all deaths under one year are included. This is similar to 64% observed nationally.

Gloucestershire Child Death Notifications by Age: 2012-2017



Source: CDOP

Ethnicity:

The 2011 Census showed Gloucestershire's residents to be 91.6% White British, 3.1% White Other, 2.2% Asian, 0.9% Black, 1.5% Mixed and 0.2% Other. In line with this population profile, the majority of deaths for Gloucestershire are children of White British ethnic origin. However, l ooking at the pie chart below suggests there may be over-representation of children from Mixed Ethnic groups (6% deaths vs 1.5% population) and also White Other groups (6% deaths vs 3.1% population).

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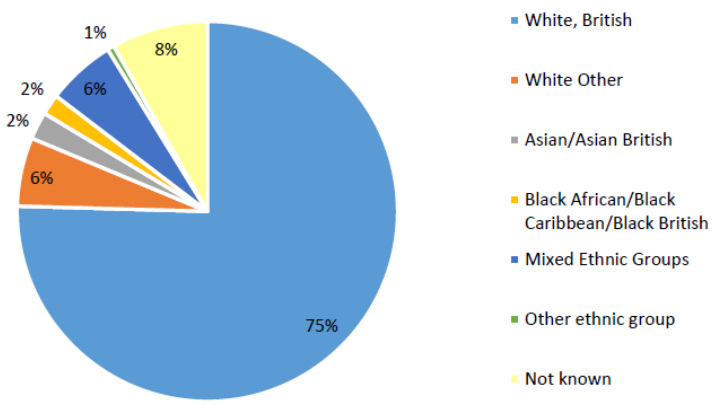
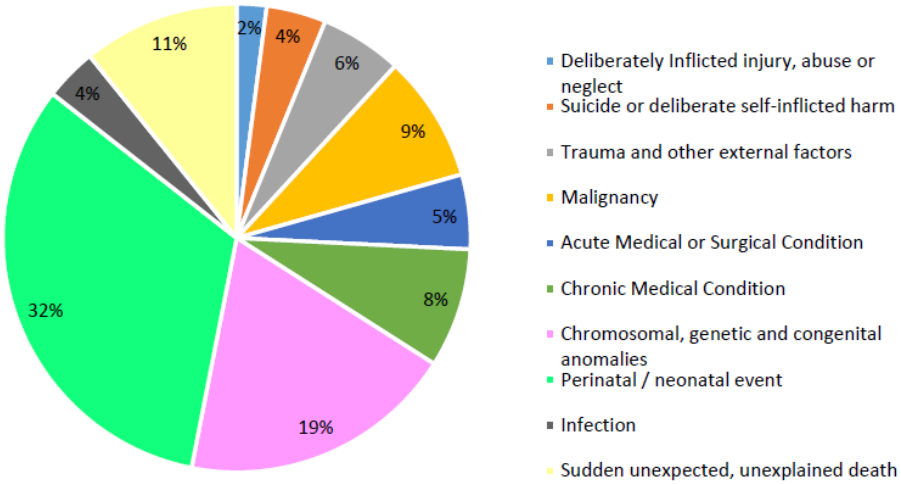
Pie Chart Showing Gloucestershire Child Death Notifications by Ethnicity: 2012-2017



Source: CDOP

As part of the Child Death Review process, each death reviewed by the panel is categorised by the most likely cause of death based on a set of pre-defined categories. The categorisation of deaths for cases reviewed by the panel over the five year period is shown in below. This shows that the most common cause of death is a perinatal / neonatal event (32%) followed by chromosomal, genetic and congenital anomalies (19%). All other categories are much less common.

Pie chart Showing Cause of Child Death in Gloucestershire by Cause:2012-2017



Source CDOP

It is important to note that in the majority of deaths reviewed no modifiable factors were identified.

However modifiable factors were identified in 26% of cases reviewed by the panel in 2016/17. Nationally this figure remains at around 24%. This means that while around three quarters of child deaths have no modifiable factors and can not be avoided, around one quarter are potentially amenable to intervention.

Evidence around What Works

The Royal College of Paediatrics and Child Health in its report *The State of Child Health*, *2017*[76] has identified a number of evidence based areas for intervention in children's mortality.

The Royal College advises :

- **Reducing poverty and inequalities and promoting social health**
  Nationally, childhood death continues to be strongly associated with poverty and deprivation and so steps to reduce this will continue to drive reductions in child death. Deaths during infancy are strongly associated with preterm birth, fetal growth restriction and congenital abnormalities, which disproportionately affect the most disadvantaged families in society. This means efforts to reduce child poverty remain crucial to improving infant survival. Other protective factors, such as social protection policies (for example, benefits, child care, and housing) and economically redistributive policies, could be implemented to improve and maximise infant survival[2]. (see section on child poverty for more information)
- **Improving maternal health and education**
  Maximising the health and wellbeing of women before conception and during pregnancy is central to efforts to reduce the infant mortality rate. Reducing smoking rates in pregnant women, optimising maternal nutrition before and during pregnancy, and reducing maternal obesity are all important in achieving this. (See sections on smoking in pregnancy and maternal health for more information)
- **Infant feeding and care interventions such as promoting breast feeding, safe sleeping positions**
  Breastfeeding is a protective factor for infant survival, particularly for infants born preterm; therefore it is vital that women are supported to breastfeed. Promoting safe sleeping positions is key to prevention of SIDS. Maternal mental health is an important risk factor for poor child health outcomes. Universal midwifery and health visiting services are one of the key ways in which new mothers receive education and support in managing their new baby, including supporting breastfeeding and safe sleeping positions. (See section on breast feeding for more information)
- **Support for young mothers**
  Each of the above issues is particularly important for young and first-time parents. Increased efforts to reduce unplanned pregnancy during adolescence and providing additional support for younger mothers antenatally and postnatally are likely to contribute to reducing infant mortality. Providing high-quality, evidence-based sex, relationships and reproductive health education in schools is a key part of improving outcomes.

[76] Royal College of Paediatrics and Child Health (RCPCH). () *State of Child Health Report 2017* [Online]. Available from: http://www.thehealthwell.info/node/1062390 [Accessed: 30th November 2017].

- **Reduce road traffic accidents**
  These are a leading cause of death in older children. Schemes such as graduated licensing schemes and 20mph speed limits in built up areas are know to be effective.
- **Greater focus on research and its application**
  Greater focus on research and its application to practice is an essential prerequisite for improving outcomes from before birth, through the first year of life. For example, tremendous progress has been made in reducing SIDS through public health research translated into changes in practice and health education campaigns. They also emphasise the importance of ensuring that policy strategies to improve maternal and child health are joined up.

Discussion, Gaps and Recommendations

Strengths in this area:

- Low neonatal mortality compared to nationally
- Universal and targeted services in place for midwifery, health visiting, breast feeding and specialist pregnancy stop smoking services
- CDOP programme in case

Areas of Concern:

- A quarter of child deaths locally have modifiable factors
- There appears to be an over representation of Black and minority ethinic groups in the reported child deaths – this represents a health inequality

Recommendations

Continue to gather and examine local data around child deaths and ensure action is taken around identified modifiable factors in deaths locally.

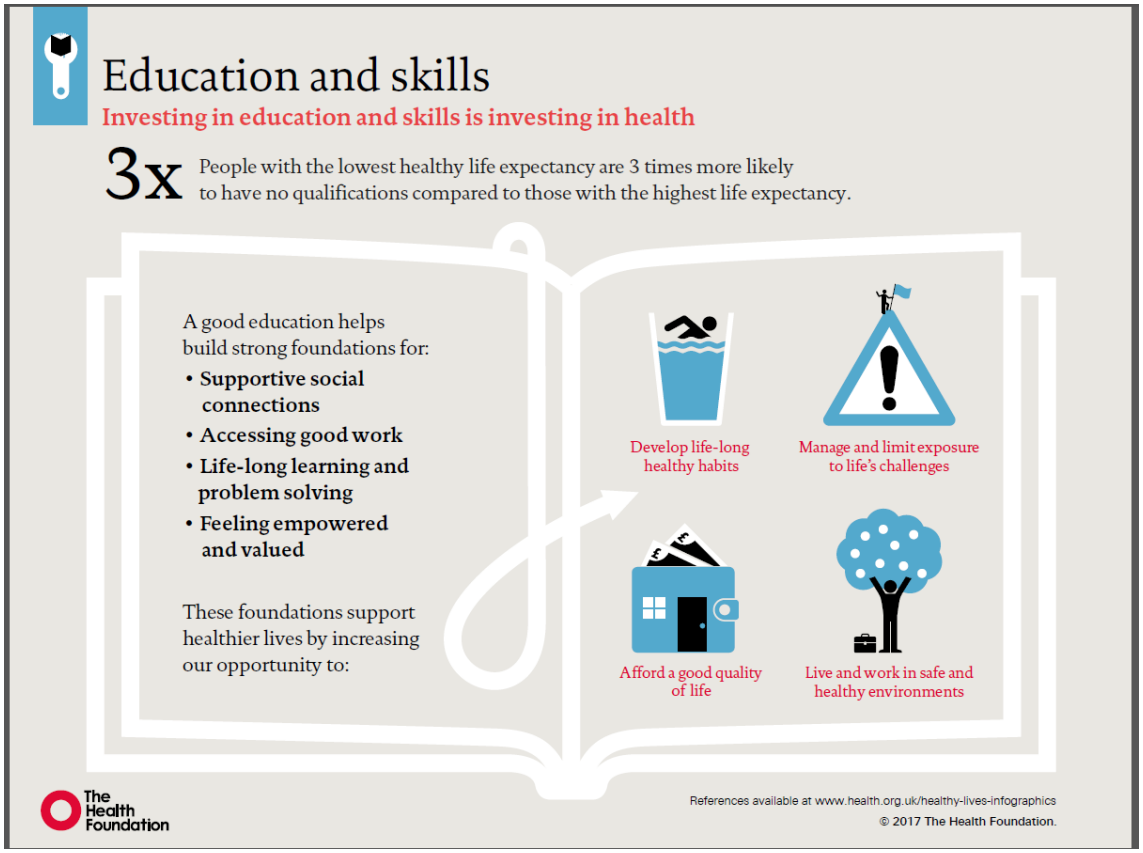
It should be noted that, in line with an number of other topics discussed in this report, there are a number of common risk factors identified and prevention measures that can be taken to improve reduce child mortality (breastfeeding, reduction in child poverty, maternal education). Focussing on these common risk factors will ensure maximal impact across a number of sectors.

Education

Education

Introduction

Educational excellence is the linchpin of a successful economy and society. Children in our schools today will be the adults who shape our tomorrow. It is therefore vital that we focus our energies on inspiring and motivating children whilst they receive a high quality education.



Education provision across the county is made up of:

- Over 850 early years settings – the highest private, voluntary and independent sector of any local authority area in England
- 246 primary schools – of which 37 are stand alone academies, and 5 sponsored and one primary free school
- 39 secondary schools – of which 27 are stand alone academies and 7 are sponsored
- 12 special schools – 3 of which are sponsored academies
- 4 colleges
- 5 alternative provision schools of which one is a free school and one is the Hospital Education Service
- 25 independent mainstream schools and 4 independent special schools

There are currently 10 Multi Academy Trusts in the county.

Diversity can be a major strength in a school system, but with it comes the risk of a lack of coherence and loss of accountability.

Whilst the introduction of the National Funding Formula was a welcome principle, and indeed actively campaigned for by Gloucestershire, the reality for the county is less comforting. As things currently stand, there will be a 0.6% increase in funding across the county, but the actual impact on individual schools varies hugely – with small rural primary schools gaining (some by over 23%) and larger schools, including the majority of secondary schools, losing. Further financial pressure will be applied by the freezing of the high needs allocation (discussed more under Children with Special Educational needs and Disabilities)

Policy Context

The government's aim is for all schools to become academies with Multi Academy Trusts (MATs) as the preferred vehicle - but how we get to that position, and on what timescale, is less clear.

High quality leadership is imperative for the successful academisation of the country's educational system. Where schools are weak or failing, it is crucial for those schools to attract strong sponsors; this has not generally been the case to date.

In the meantime the council has a range of statutory responsibilities for more than 200 maintained schools. A report is due imminently on the role of the local authority, but it is clear that even if all schools are in the academy sector, local authorities will continue to be a key part of the local education scene, retaining core responsibilities such as admissions and place planning and promoting good outcomes for children and young people with additional needs.

In 2017 the headline accountability measures for secondary school attainment changed and so are no longer directly comparable with older recorded data. The 2017 headline accountability measures for secondary schools are: Attainment 8, Progress 8, attainment in English and mathematics at grades 5 or above, English Baccalaureate (EBacc) entry and achievement (including a grade 5 or above in English and mathematics), and destinations of pupils after key stage 4.

Epidemiological Data Review

Summary of Educational Attainment in Gloucestershire

Educational outcomes for most children and young people locally are good. Children in Gloucestershire generally perform in line with or above national averages on the majority of measures at all key stages. Attainment is generally good overall and Gloucestershire regularly ranks highly when compared with its statistical neighbours. However, this success masks some areas of relative weakness particularly for more disadvantaged children.

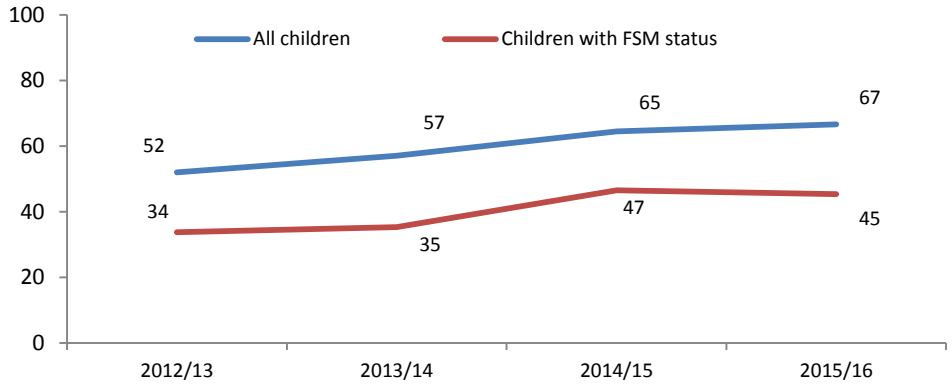
In this analysis disadvantaged pupils are defined as pupils who have ever been in receipt of free school meals or who are Looked-after children (LAC) defined in the Children Act 1989 as one who is

in the care of, or are provided with accommodation by an English local authority or children who have ceased to be looked after by a local authority in England and Wales because of adoption, a special guardianship order, a child arrangements order or a residence order. The Free School Meals (FSM) cohorts are pupils who currently are entitled to and receive free school meals. It should be noted that not all children entitled to free school meals claim them.

Early Years - School readiness:

Children need to develop a range of skills and abilities from their parents and early learning environments to ensure they are prepared for learning. A 'school ready' child is able to speak, listen and understand basic instructions. They have developed some early social skills through playing with their friends, and they have mastered practical skills like dressing themselves, using cutlery and being able to go to the toilet. This is important because achieving a good level of development at the end of reception is a strong indicator of future educational attainment and life chances.

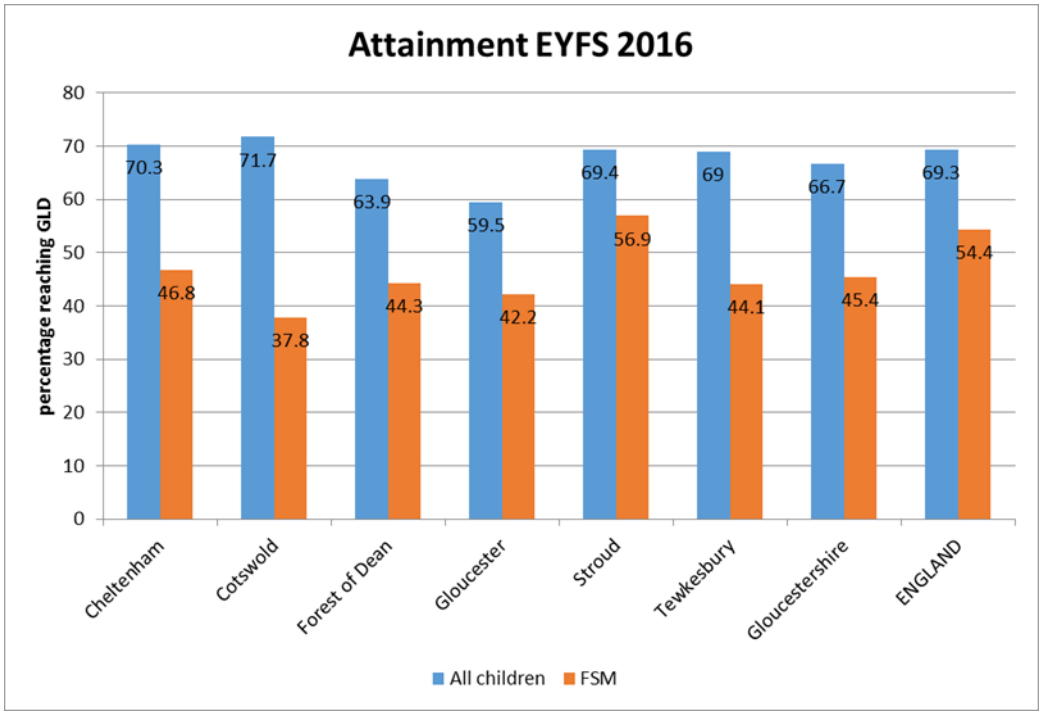
The changing percentage of children achieving a good level of development as assessed in the EYFS is shown below. This has been increasing year on year which is positive but it is of concern that the attainment gap for those receiving free school meals is widening.



As can be seen in the table below, Gloucestershire is performing worse than nationally in this indicator.

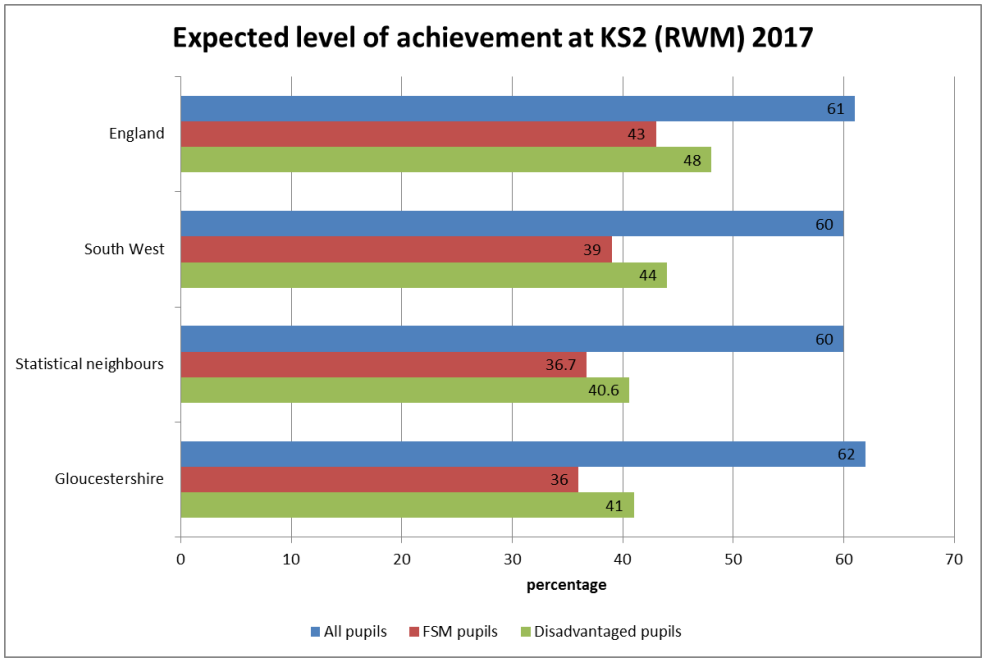
Children achieving a good level of development at the end of reception (2016)	Gloucestershire % (number)	England
all children (not including those eligible for Free School Meal)	67% (4447)	69%
children eligible for a free school meal	45% (364)	54%

The performance by locality is given below. The percentage of children eligible for FSM reaching a GLD is below the national average in all districts except Stroud where it was above the England level.



Key Stage 2

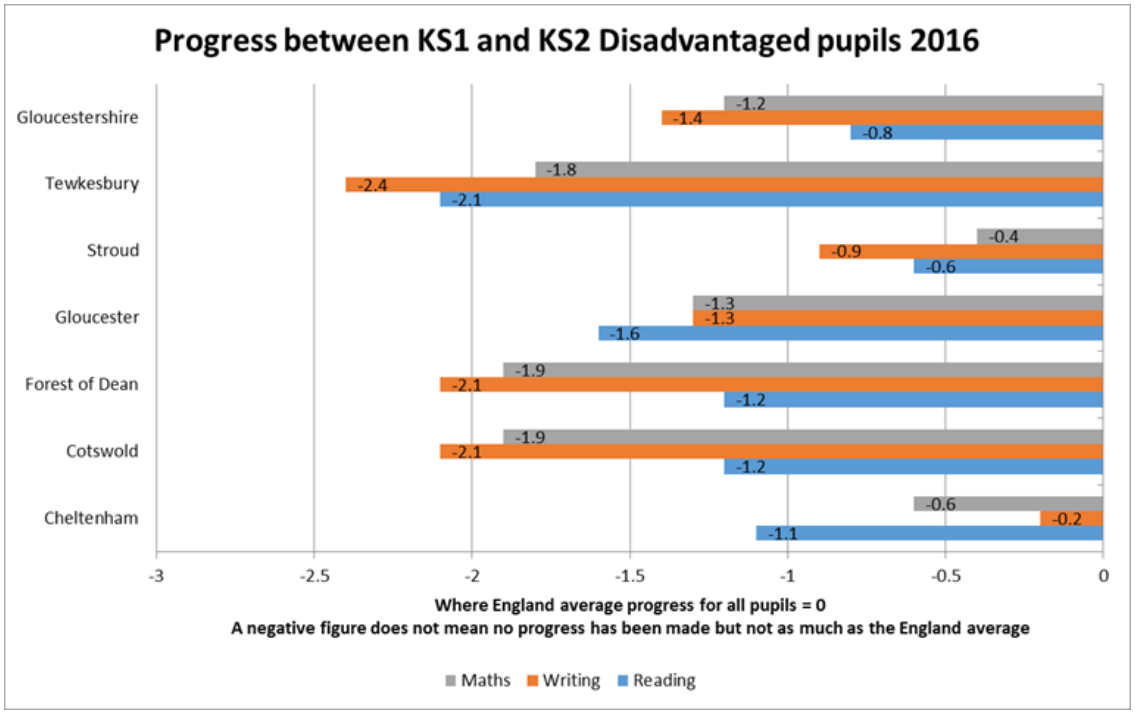
Performance in Key Stage 2 is summarised in the chart below:



Overall Gloucestershire performs highly with better achievement rates than seen nationally and when compared to our statistical peer group. However, when looking at disadvantaged pupils or those receiving free school meals we perform significantly worse than nationally and slightly worse

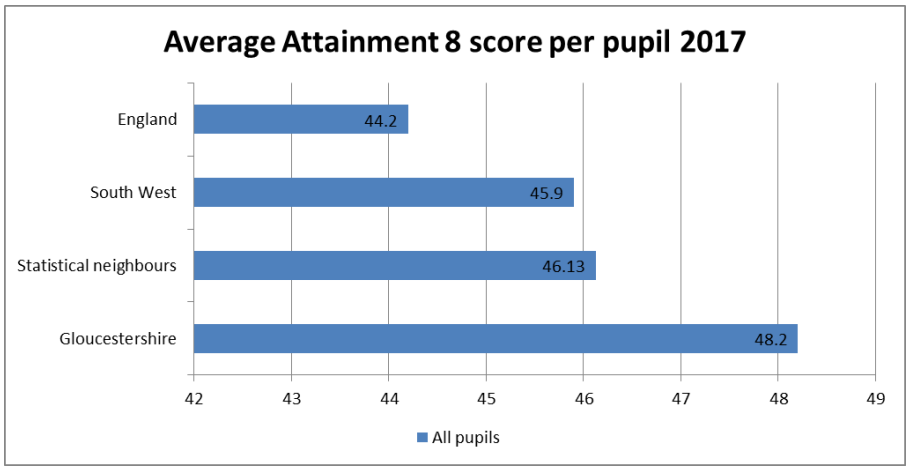
than our regional or statistical peer group. This means that our good overall results are being powered by a cohort of children that does exceptionally well, but that the most disadvantaged pupils are significantly underperforming and are not thriving in our schools.

The chart below shows by locality progress made by disadvantaged children between Key stage 1 and 2 in reading writing and maths. All areas show worse than average performance in all sectors. Tewksbury, Cotswold and Forest of Dean perform worst and Stroud and Cheltenham least badly. Writing seems to be the weakest performing indicator in most areas.



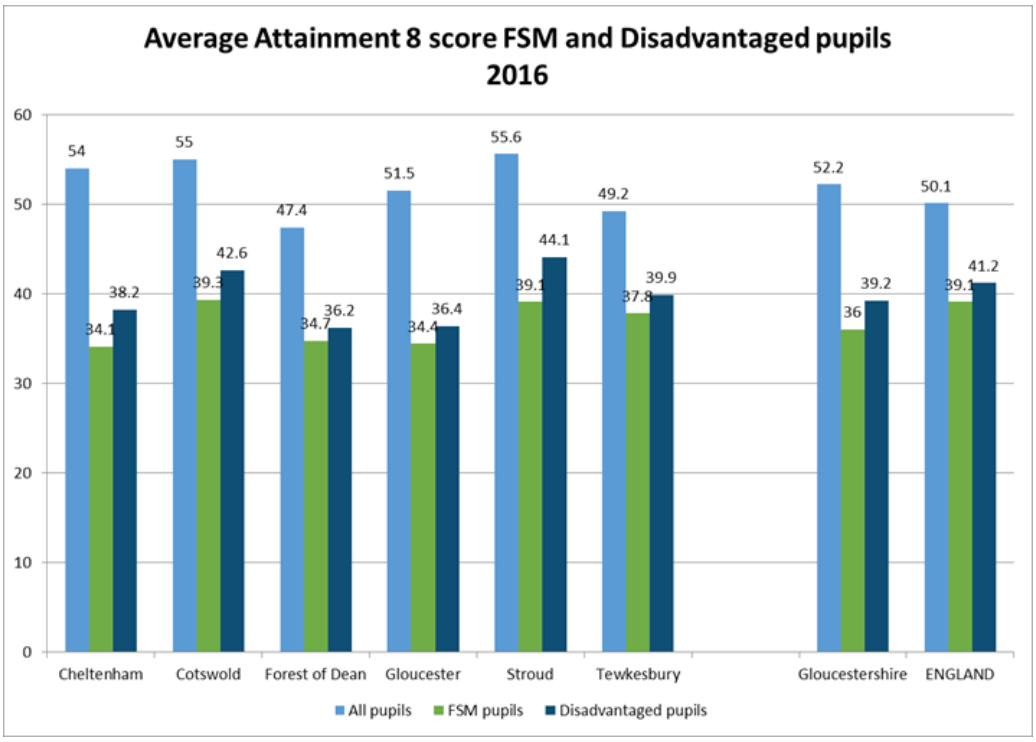
Attainment 8

The attainment 8 score measures attainment at Key Stage 4 (GCSEs)



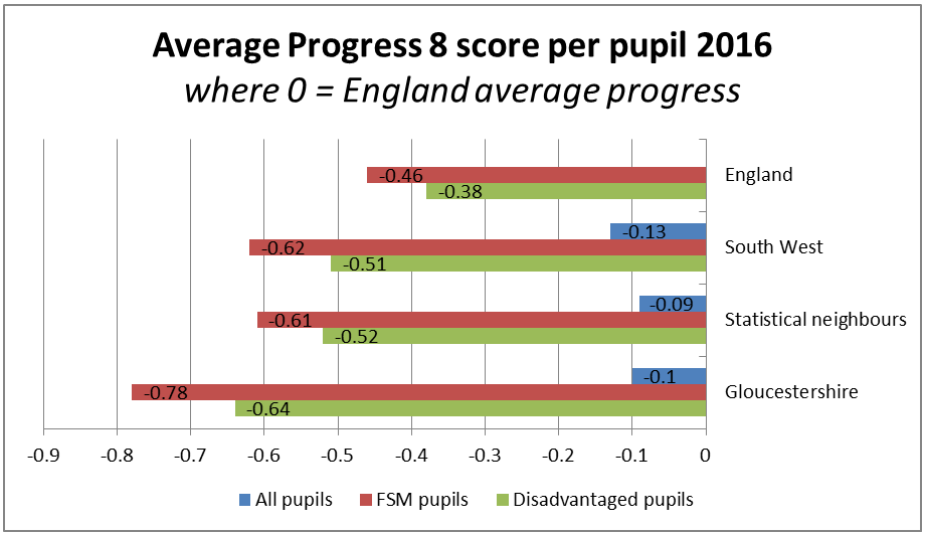
Level of attainment at KS4 for all pupils in Gloucestershire is higher than its statistical neighbours and regional and national averages.

However, as seen at other levels, disadvantaged children have a lower score both nationally and locally. Across the districts disadvantaged children in Forest of Dean and Gloucester had a significantly lower score. Disadvantaged children in Cotswold and Stroud gained on average better Attainment 8 scores than the England average for disadvantaged children.



Progress 8

Progress 8 measures the progress between KS2 and KS4. A score above zero means pupils made more progress, on average, than pupils across England who got similar results at the end of key stage 2. A score below zero means pupils made less progress, on average, than pupils across England who got similar results at the end of key stage 2. It should be noted that a negative progress score does not mean pupils made no progress, or the school has failed, rather it means pupils in the school simply made less progress than other pupils across England with similar results at the end of key stage 2.

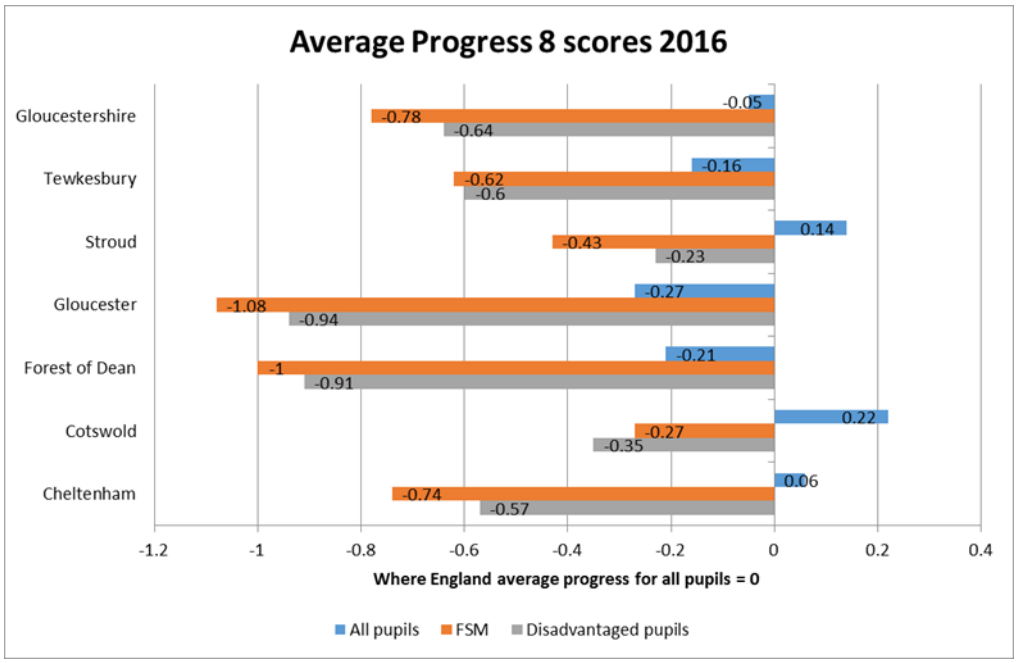


NB in the above chart the higher the negative number the less good performance is compared to the national average.

In Gloucestershire pupils are making slightly less progress than the England average but are in line with the South West and Statistical neighbours. Children eligible for FSM and disadvantaged children in Gloucestershire make less progress than in its statistical neighbours, the South West or the England average.

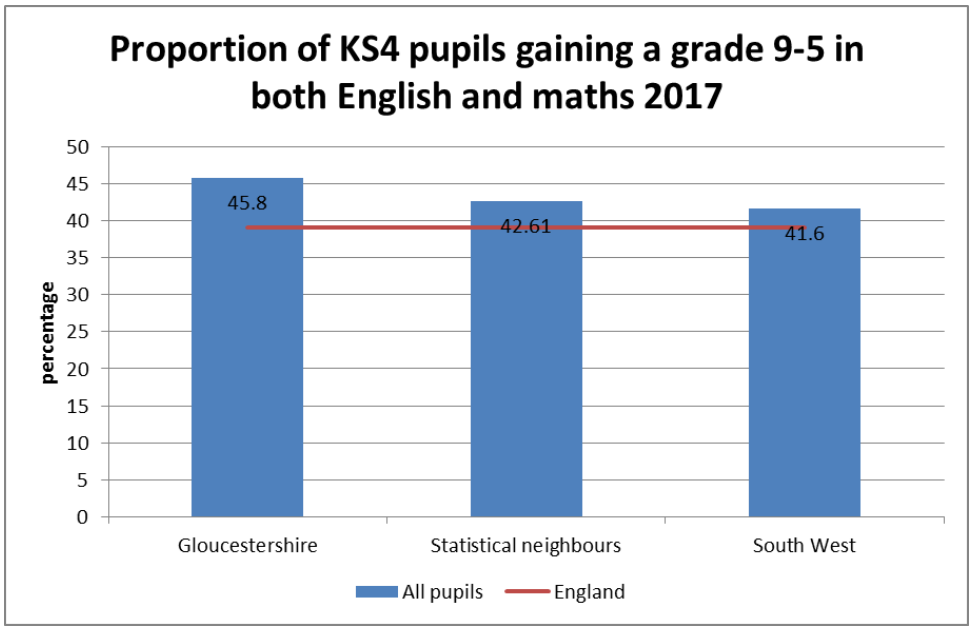
In combination, the two section above show that not only are disadvantaged children underperforming their peer group in absolute terms, but these groups of less advantaged children are also not making as much progress as their peers suggesting that their potential is not being fulfilled.

This data can be further examined by locality.



Across the districts pupils in Cheltenham, Cotswold and Stroud make slightly more progress than the national average. However pupils eligible for FSM and Disadvantaged pupils make less progress especially in Gloucester and Forest of Dean; FSM and Disadvantaged pupils in both areas make around a grade less progress than nationally.

KS4 Pupil's attainment in English and Maths



A higher proportion of pupils in Gloucestershire gained a grade 9-5 (good pass) in both English and Maths (note: English can be either English literature **or** English language and does not mean the student took both subjects or has a grade 9-5 in both). This data is not available broken down by FSM and disadvantaged pupils.

However, the 2016 data is available, and is summarised in the table below. The pattern of above average overall performance with some groups significantly underperforming is repeated.

Indicator	Gloucs	England	Comparable LAs
% pupils achieving A*C in English and Maths	66.4	59.3	65.3
% boys achieving A*-C in English and Maths	63.4	59.4	62.1
% Girls achieving A*-C in English and Maths	69.6	67.3	69.2
% pupils eligible for FSM achieving A*-C in English and Maths	34.9	39.2	35.3
% other pupils achieving A*-C in English and Maths	69.1	67.0	68.1

A higher proportion of pupils (66.4%) achieved A*-C in English and Maths compared to nationally (63.3%) and Gloucestershire ranked 4th amongst statistical neighbours for this measure.

Less encouragingly, boys consistently underperformed girls and there was a large attainment gap at GCSE between the proportion on free school meals who achieved A*-C in English and Maths and the proportion of those not on free school meals that achieved the same grades.

Accessing FE

In 2016 90% of KS5 pupils in Gloucestershire either stayed in Education or entered employment, inline with the England (89%) and South West (89%) averages. This is broken down as;

- 7% going onto apprenticeships, in line with the England average (7%),
- 11% going onto a Further Education college (FE), below the England average of 13%,
- 21% went to Top Third Higher Education Institutions (HEI) above the England average of 18%,
- 16% went onto Russell Group Universities above the England average of 12%.

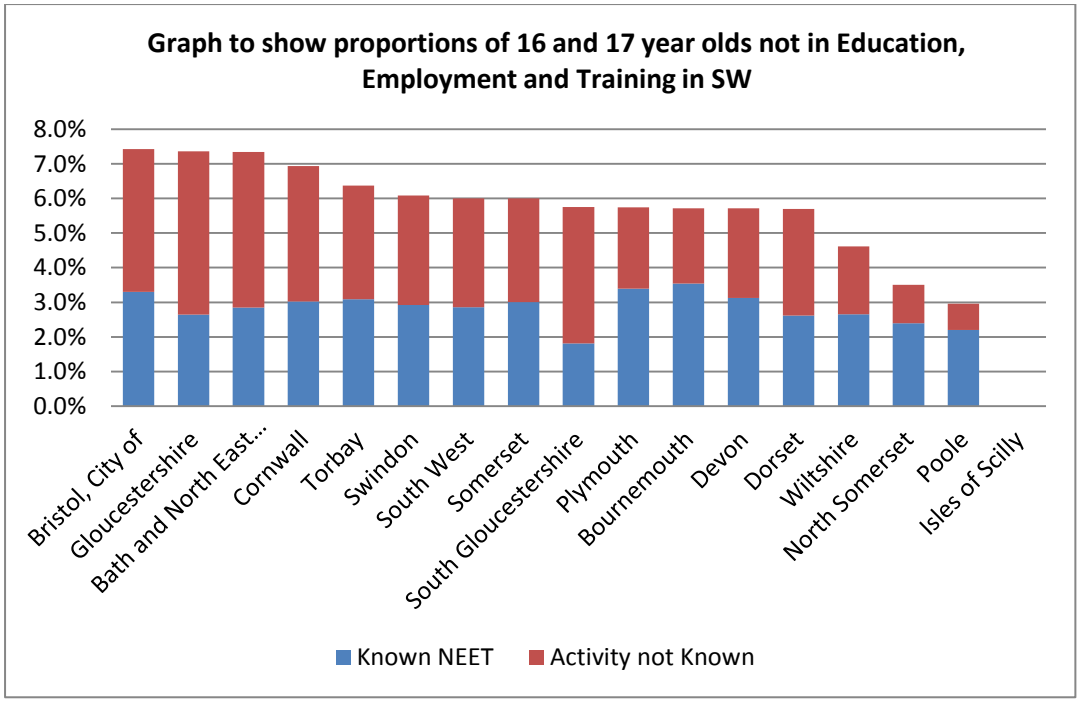
Gloucestershire is again showing a pattern of over representation at the highest levels of academic achievement but not at the lower end. From this data alone it is not possible to know if the lower levels of entrance to further education colleges and average levels of apprenticeships are driven by over representation at other levels or under attainment of those who might want to take up these opportunities.

NEETs - Those Not in Education, Employment or Training

The government provides the framework and funding to increase participation and reduce the proportion of young people not in education, employment or training (NEET), however, responsibility and accountability for delivery lies with local authorities (LAs). Under Section 68 of the Education and Skills Act 2008 LAs have a duty to encourage, enable or assist young people's participation in education or training. Statutory guidance that underpins this duty directs LAs to collect information to identify young people who are not participating, or who are at risk of not doing so, and to target their resources on those who need them most.

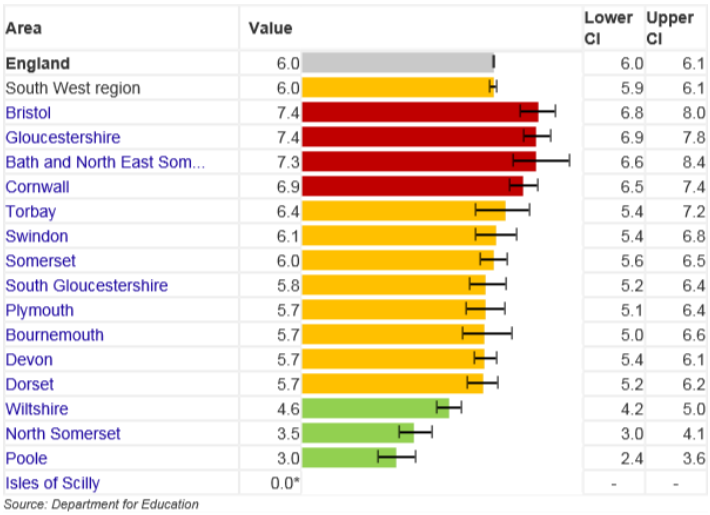
Historically, LA responsibilities for tracking extended from ages 15 to 19, and to 20-25 year olds with a statement of educational need or disability (SEND). However, LAs are now only required to track and submit information about young people up to the end of the academic year in which they have their 18th birthday ie academic age 16 and 17-year-olds.

The results for Gloucestershire show that we have a relatively high proportion of 16 and 17 year olds not in education, employment and training or whose activities are unknown. As can be seen in the graph below, after Bristol, Gloucestershire is the worst performing local authority in the region. Traditionally NEETS have been considered a vulnerable group who are at risk of not going on to thrive in adulthood.



Source: Dept for Education data

16-17 year olds not in education, employment or training (NEET) or whose activity is not known – current method 2016



Area	Value	Lower CI	Upper CI
England	6.0	6.0	6.1
South West region	6.0	5.9	6.1
Bristol	7.4	6.8	8.0
Gloucestershire	7.4	6.9	7.8
Bath and North East Som...	7.3	6.6	8.4
Cornwall	6.9	6.5	7.4
Torbay	6.4	5.4	7.2
Swindon	6.1	5.4	6.8
Somerset	6.0	5.6	6.5
South Gloucestershire	5.8	5.2	6.4
Plymouth	5.7	5.1	6.4
Bournemouth	5.7	5.0	6.6
Devon	5.7	5.4	6.1
Dorset	5.7	5.2	6.2
Wiltshire	4.6	4.2	5.0
North Somerset	3.5	3.0	4.1
Poole	3.0	2.4	3.6
Isles of Scilly	0.0*	-	-

Source: Department for Education

Source: PHE fingertips

Exclusions

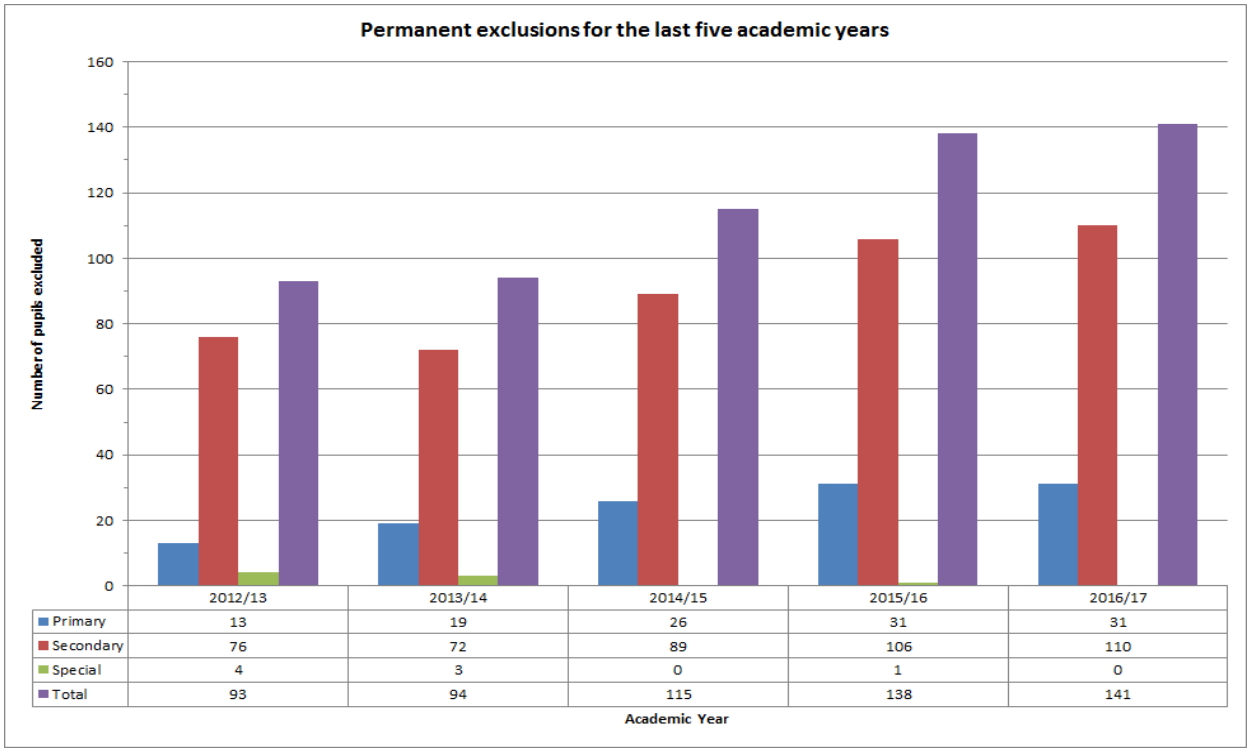
Exclusion from school potentially sets a child on a path to poorer qualifications, poorer job prospects and smaller life time earnings.

There are two types of exclusion from school:

- Permanent exclusion (or 'expulsion')is removal from a school roll
- Fixed-term exclusion (or 'suspension') is exclusion for a set number of days, not totalling more than 45 days in a school year

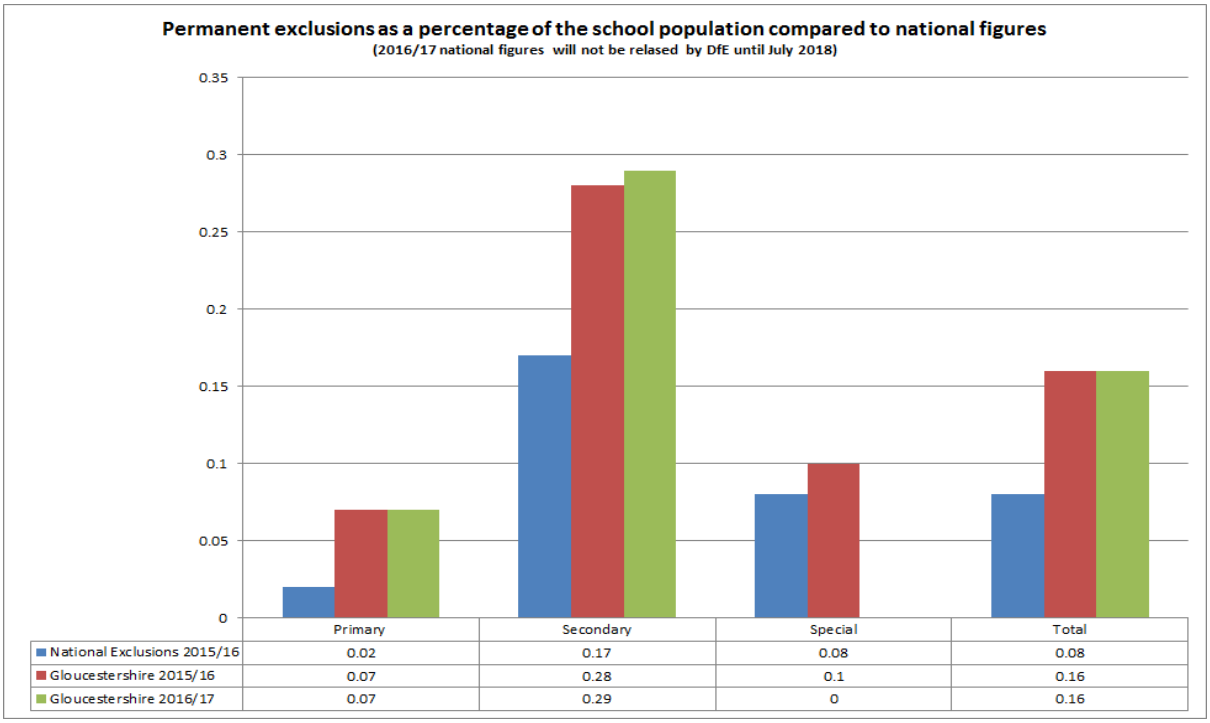
In 2015/16, Gloucestershire was the highest permanent excluding Local Authority in comparison with its statistical neighbours to the national average. In 2015/16, (2016/17 DfE figures not available until July 2018) Gloucestershire permanently excluded 0.16% of its school population compared to the national average of 0.08%. Gloucestershire's interim figure for 2016/17 is 0.16%. Nationally, in 2015/16, Gloucestershire was the joint 16th highest excluding authority in England (out of 152 authorities).

The level of permanent exclusions has risen by 45% in the last 5 years (from 18 to 31 primary exclusions and 76 to 110 secondary). 7,763 days of education were lost in the last year due to fixed term exclusions – with the highest increase being for persistent disruptive behaviour and verbal abuse or threatening behaviour towards adults.



	2012/13	2013/14	2014/15	2015/16	2016/17
Primary	13	19	26	31	31
Secondary	76	72	89	106	110
Special	4	3	0	1	0
Total	93	94	115	138	141

Source: GCC Exclusions report 2016/17



Source: GCC Exclusions report 2016/17

The story behind these rising exclusion figures is a complex one and there are no discernible patterns within the data. It is clear, however, that national policy has encouraged less tolerance in the system. Structural changes have led to less partnership working between schools and other providers and with the LA. There is also a reported increase in children and young people with complex and challenging behaviour.

Exclusions and Special Educational Needs and Disabilities

The percentage of SEND permanent exclusions against total exclusions has increased by 9% compared to 2015/16. In 2016/17 there were 73 (52%) SEND permanent exclusions compared to 59 (43%) in 2015/16.

In 2016/17 52% of permanently excluded pupils (73 pupils) were on the SEND code of practice. 9% of permanent exclusions (12 pupils) had a statement/EHC Plan.

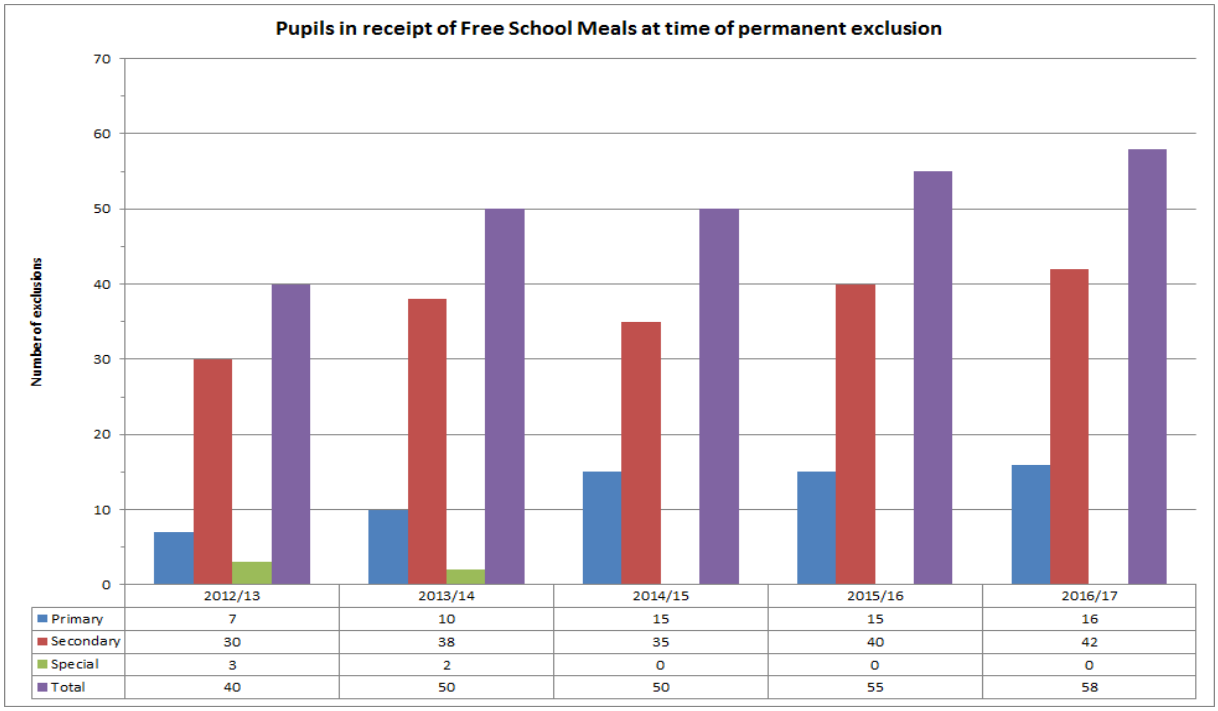
Permanent Exclusions	Terms 1-6					
	2015/16			2016/17		
	PRI	SEC	SP	PRI	SEC	SP
SEND Support	13	30	0	21	39	0
EHCP	12	3	1	6	7	0
No SEND	6	73	0	4	64	0
TOTAL	**31**	**106**	**1**	**31**	**110**	**0**
TOTAL SEND	**25**	**33**	**1**	**27**	**46**	**0**

Source: GCC Exclusions report 2016/17

This compares to the national picture where 49% were SEND in 2015/16 and 5.5% had statements/EHC Plans.

Exclusions and Free School Meals

In 2016/17 58 pupils (41% of all excluded pupils) were in receipt of free school meals when they were permanently excluded. In comparison, 55 FSM pupils (40%) were excluded in 2015/16. 51% of primary school pupils excluded in 2016/17 were in receipt of free school meals.

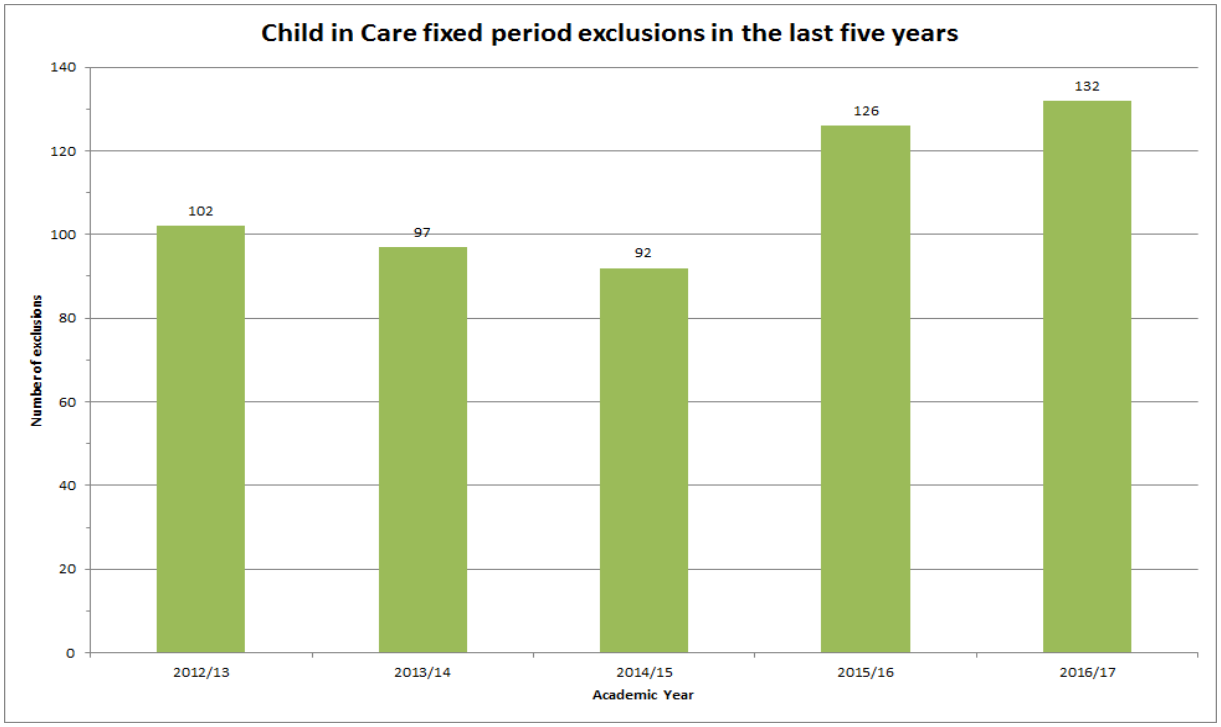


	2012/13	2013/14	2014/15	2015/16	2016/17
Primary	7	10	15	15	16
Secondary	30	38	35	40	42
Special	3	2	0	0	0
Total	40	50	50	55	58

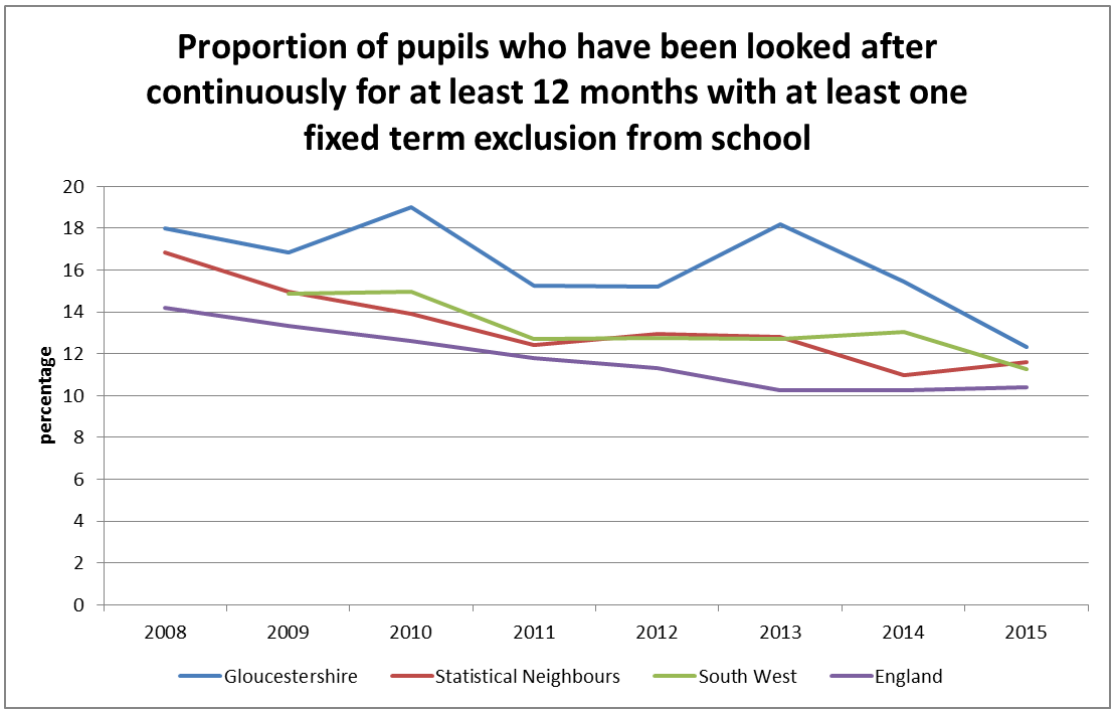
Children in Care and Exclusions

There were 12 pupils in care permanently excluded in 2016/17. They all had their exclusions overturned by the head teacher in favour of using the Children In Care Transfer Protocol.

53 pupils in care were excluded for a fixed period in 2016/17 (3% of all pupils receiving fixed period exclusions); this is an increase of 29% (12 pupils) on 2015/16. These pupils had a total of 132 separate exclusions (4% of all fixed period exclusions); this is an increase of 5% (six exclusions) on 2015/16. A total of 304 school days were lost (4% of total days lost) through fixed period exclusions, an increase of 10.4% (29 days) on 2015/16.



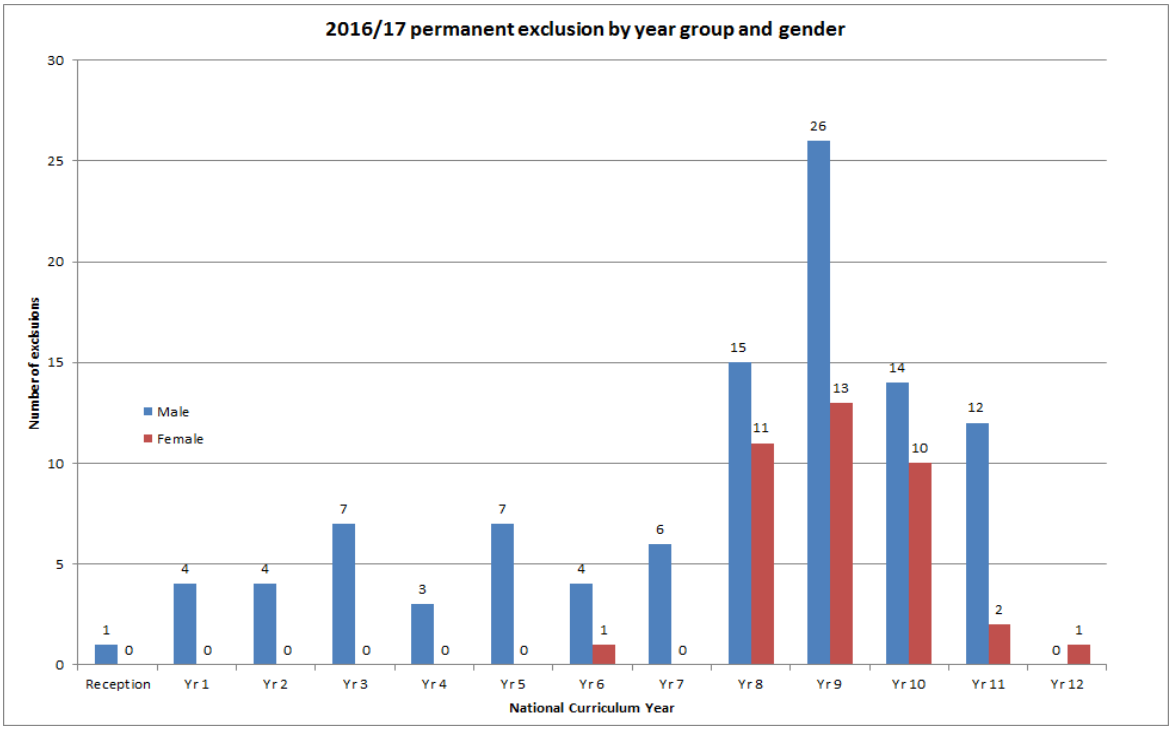
It is interesting to note that while the absolute numbers of CIC with fixed term exclusions is increasing the relative proportion has been falling. This is shown in the graph below.



Exclusions by Age, Gender and Ethnicity

In terms of looking at exclusions by gender, male exclusions have decreased by 5% (five pupils) from 108 in 2015/16 to 103 in 2016/17. Female exclusions have increased by 27% (eight pupils) from 30

in 2015/16 to 38 in 2016/17. Male exclusions account for 73% of total permanent exclusions, a decrease of 5% on 2015/16. In the primary phase, male exclusions account for 97% of all primary exclusions.



Source: GCC Exclusions report 2016/17

When considered in terms of ethnicity, white English pupils being excluded, as a percentage of all exclusions, have gradually decreased from 83% in 2012/13 to 72% in 2016/17. Pupils with a black background[77] have had their permanent exclusions increase from 3% (one pupil) in 2012/13 to 6% (eight pupils) in 2016/17. Nationally, in 2015/16, 8% of pupils with a black background have been permanently excluded.

Local Service Provision

Education provision across the county is made up of:

- Over 850 early years settings – the highest private, voluntary and independent sector of any local authority area in England
- 246 primary schools – of which 37 are stand alone academies, and 5 sponsored and one primary free school
- 39 secondary schools – of which 27 are stand alone academies and 7 are sponsored
- 12 special schools – 3 of which are sponsored academies
- 4 colleges

[77] DFE category of ethnic group **Black** (Any Other Black Background, Black Caribbean and Black African). White and Black African and White and Black Caribbean are categorised as **Mixed**.

- 5 alternative provision schools of which one is a free school and one is the Hospital Education Service
- 25 independent mainstream schools and 4 independent special schools.

There are currently 10 Multi Academy Trusts in the county.

The selective grammar schools in Gloucestershire are currently increasing their pupil numbers and are generally over subscribed as are a number of the higher rated secondary schools locally.

Evidence around What Works

Locally, Gloucester County Council's Education team are carrying out an in-depth review of education locally and this will contain more detailed and specific information.

More generally, both NICE and the department for Education have issued a number of guidance documents for improving education and these cover interventions at the policy, local and neighbourhood level.

Policy level

At this level the recommendations are that working across partnerships and pooling resources to support schools tends to be most effective.

Pupils from poorer homes tend to perform worse than their wealthier peers, whichever secondary school they are in. This suggests pupil-level interventions to narrow the gap at each school are also essential.

Around half of the achievement gap is already present by the time children enter secondary school. This suggests the early years and primary schools have a pivotal role to play and that intensive catch-up programmes at the start of secondary school should be widely used.

Community level

Local authorities should:

- provide sufficient training for governing bodies so that they can be effective in appointing head teachers and managing their performance;
- work with School Improvement Partners to analyse, monitor and better understand school performance;
- provide speedy extra support (and funding if necessary) to all identified vulnerable schools and monitor their progress closely; and
- be prepared to use their statutory powers to enforce changes in vulnerable schools that will not cooperate in accepting support.
- in conjunction with Ofsted, assess the potential of a poorly performing school to recover quickly. Where this is unlikely, they should take fast and effective action to replace the leadership team or close the school;

- support the school in addressing issues such as falling rolls and the relatively large numbers of vulnerable pupils that these schools often have, who may require relatively intensive support.

School level

Schools should:

- put teaching at the heart of the school's self-evaluation: including, for example, a commitment to regular curriculum reviews and assessment of teaching quality;
- build effective leadership teams that provide collective leadership and responsibility, based on mutual trust and the high expectations of all staff and pupils that they will fulfil their potential; and
- seek external support for school improvement, particularly from their local authority services and neighbouring schools.

Exclusions

As part of the local authority's work to use and embed Restorative practice in its children's services, restorative pilots in two schools have led to significant reductions in pupil exclusions and improvements in pupil attendance and behaviour. In Tewkesbury Secondary School, there have been no permanent exclusions to-date in the current academic year (2017-18) where there were 3 in the previous year. There has also been a 29% reduction in same day detentions from 2016 to 2017. In Moat Primary School between 2015 and 2016 there was an 84% reduction in fixed term exclusions since the introduction of restorative practice within the school. Work is progressing to expand the offer of supporting Gloucestershire schools in adopting restorative practice in their teaching, curriculum and behaviour management in two secondary schools and four primary schools.

The Children's Charity Barnardos released a report into school exclusions[78] which looks in depth at the issues, its effects and what other approaches could be used. Each of the four approaches considered early intervention approaches targeted at those known to be at risk. The approaches involved a partnership approach between schools colleges, the local authority and the third sector.

The alternatives reviewed were

1.The Shropshire Project works with the local authority across this large, mainly rural county to support young people aged five to 18 who have family and other difficulties that distract them from learning and affect their behaviour. This service aims to support young people together with their families, so that they can benefit from their education.

2.Leeds Reach works in partnership with secondary schools, Barnardo's and other agencies to deliver an alternative, inclusive learning programme for one term for young people who, for varying reasons, have found it difficult to remain in mainstream school. The service aims to support these young people during their return to school the following term.

[78] http://www.barnardos.org.uk/not_present_and_not_correct.pdf

3.Palmersville Training offers between one and three days a week of a vocational learning option for young people in North Tyneside. The service aims to help those alienated by the academic nature of schoolwork to gain qualifications, see the relevance of learning and become more motivated to focus on their studies.

4.The Late Intervention Service (LIS) works with the most troubled and troubling group of young people in deprived parts of a former industrial region. Many were unable to cope with mainstream school and had experiences which made it hard for them to trust other people. The service aims to help them take part in positive activities and to develop good relationships, breaking the cycle of harmful experiences.

Discussion, Gap Identification and Recommendations

Strengths in this area:

- Some children are performing exceptionally well and driving good levels of countywide academic attainment when compared to the national picture and peers

Areas of Concern:

- Disadvantaged children are significantly underperforming on every indicator and the attainment gaps are much larger than seen elsewhere in the country
- Exclusion levels are some of the highest in the country and disadvantaged and vulnerable children are over represented in the exclusion cohort
- Significant social inequalities are seen to prevail in educational attainment and the evidence suggests that these will be carried into adulthood

Recommendations

Gloucestershire needs to work towards an education environment where **all** children thrive and fulfil their potential regardless of the background they were born into. There are significant attainment inequalities in the current system.

Continue to develop and share the positive impact of adopting restorative practice into school teaching, curriculum and behaviour management to build stronger teacher:student relationships, improve connectedness and a sense of belonging within schooling communities that has also been proved to reduce high rates of student exclusions.

Focus and resources need to be applied to narrowing the attainment gap between disadvantaged children and their peers.

Focus and resources need to be applied to reducing the rates of exclusion and finding ways to reduce the long term impacts that exclusion have on children and young people and in their adulthood.

Children in Contact with Criminal Justice System

Children in Contact with Criminal Justice System

Introduction

Young people can be both victims and perpetrators of crime and being on either side of the issue can be detrimental to the child's life chances in the future.

Young people are increasingly becoming victims of crime although, encouragingly, fewer and fewer young people are youth offending – in Q3 2017 0.25% of the Gloucestershire youth population were in contact with the criminal justice system. Young offenders often have health, education and/or social care needs, which, if not addressed early, can lead to a lifetime of declining health, worsening offending behaviour and increasing costs to both the taxpayer and victims of these crimes. Institute of Public Policy and Research (IPPR) research estimates the annual financial cost of a young person in the criminal justice system to be over £40,000.

Whilst reforms to health and social care in England, and the emphasis on localism, provide a chance to improve joint working between youth justice and healthcare services, there remains a need to provide education and training to enable young offenders to return to school, college or find employment.

Nationally a number of groups are over represented in the youth justice system. These include, Black, Muslim and White working class boys and young men as well as children who are or have been in care. In addition it is common to find that the children and young people in the system have mental health issues, learning difficulties and other health problems that impact their lives. In custody the picture is even more extreme with over 40% of children and young people coming from black, Asian and minority ethnic (BAME) backgrounds, a large proportion having previously been in care (38% in Young Offender Institutions, 52% in Secure Training Centres), and more than a third having a diagnosed mental health disorder. Many of the children in the criminal justice system come from dysfunctional and chaotic families where drug and alcohol misuse, physical and emotional abuse and offending is common. Often they are also victims of crimes themselves although this can be overlooked.

Although criminal and antisocial behaviour can not be excused simply on the basis of a child's background, it is clear systemic failures are failing to disrupt a negative cycle for a number of children and that their experiences to date have an influence on their behaviours. Locally, a brief police audit of children in the Aston project found a higher proportion of participating children had 4 or more adverse childhood experiences (se next section for more information) than in the general population. .

Policy Context

The youth justice system (YJS) was also set up under the Crime and Disorder Act 1998 with the aim to prevent young people offending or re-offending. The age of criminal responsibility in England is 10 years and the YJS covers children from 10 to under 18. The formal system starts once a child in this age bracket commits an offence and receives a reprimand/warning or is charged to appear in court.

Youth offending teams (YOTs) work with children and young people who are offending or who are at risk of offending. Youth offending teams must include representatives from the police, probation, health, education and children's services and continue to have an ongoing responsibility for children and young people sentenced or remanded to custody.

More broadly, Community Safety Partnerships (CSPs) were established as statutory bodies under Sections 5-7 of the Crime and Disorder Act 1998. They include representatives from the police, the local authority, and the fire, health and probation services, the 'responsible authorities'. The responsible authorities work together to develop and implement strategies to protect local communities from crime and to help people feel safe. They also deal with issues including antisocial behaviour, drug or alcohol misuse and re-offending and work with others who have a pivotal role, including community groups and registered local landlords.

There are six local CSPs in Gloucestershire, Cheltenham, Cotswold, Forest of Dean, Gloucester, Stroud, Tewkesbury, and a regional partnership, Safer Gloucestershire, which provides overall leadership and a Gloucestershire-wide vision for community safety.

Safer Gloucestershire have recently commissioned a Community Safety Strategic Needs Assessment setting out areas of strategic focus and more detail on the safety of people in Gloucestershire can be found there.

Epidemiological Data Review

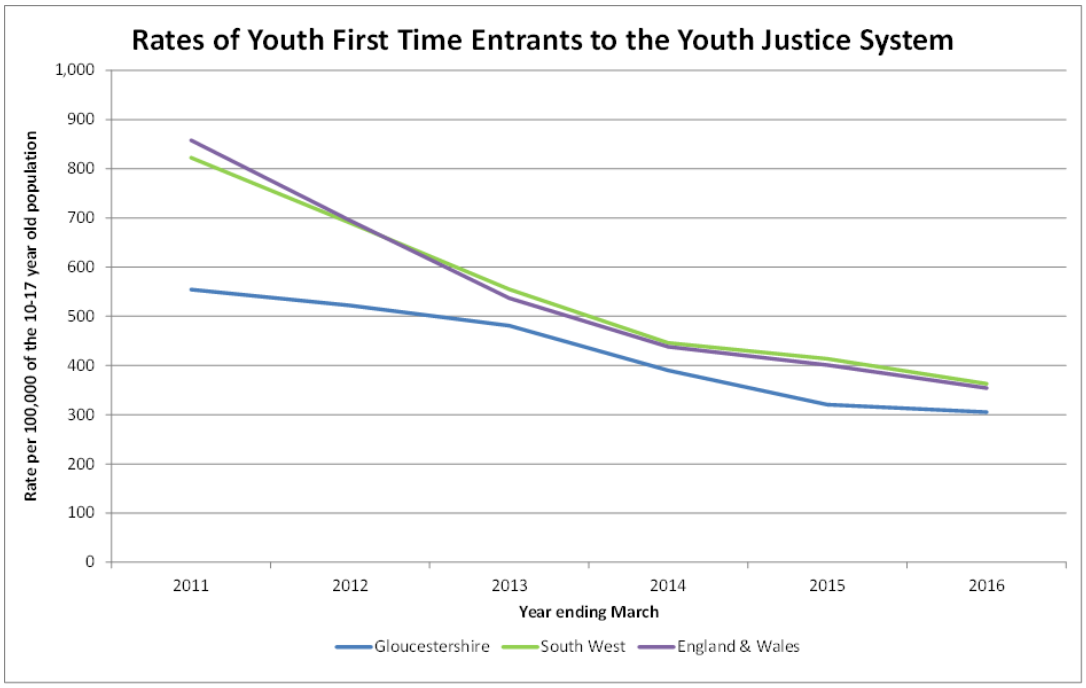
Statistically, younger people in Gloucestershire are more likely to become a victim of crime. In Gloucestershire, people aged between 20 and 24 experience the highest rate of recorded crime compared to other age groups. It should be noted that all crime data is susceptible to shifts in recording/reporting behaviours.

Age of Victims	All Crime Victims 2015/16 Glo'shire	All Crime Victims 2016/17 Glo'shire	Victims per thousand 16/17 based on ONS population mid 2015
Under 16	1182	1495	13.6
16-19	1416	1473	50.3
20-24	2388	2342	68.2
25-39	6413	6669	63.2
40-54	5981	5937	44.5
55-64	2330	2377	30.6
65-74	1513	1403	20.3
75+	956	822	14.2
Unknown	656	693	-
ALL	**22835**	**23211**	37.6

Recorded victims of crime by age 2016/17. Source: Gloucestershire Constabulary

The Youth Justice System (YJS) in England and Wales works to prevent offending and reoffending by young people aged 10-17. The system is different to the adult system and is structured to address the needs of young people. The YJS is far smaller in terms of volume of people than the adult system.[79]

Rates of youth First Time Entrants to the Youth Justice System



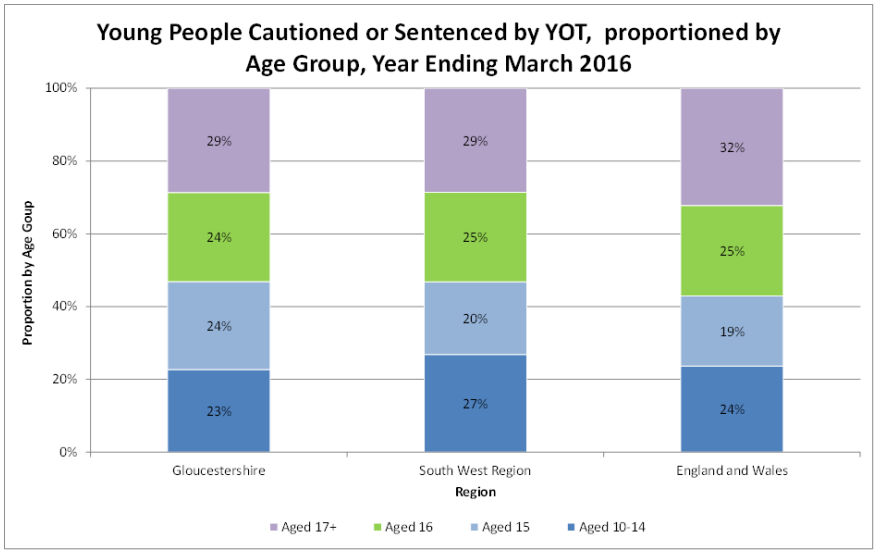
Source: Ministry of Justice

Over the last five years, there have been reductions in the number and rate of young people cautioned or convicted for the first time (First Time Entrants, FTEs) across Gloucestershire, the South West region, and England and Wales. The number of young people aged 10-17 entering the youth justice systemas first time entrants has been declining nationally since 2007 when it was over 110,000 to under 20,000 in 2015/16.

In terms of absolute numbers, Gloucestershire saw 168 FTEs in 2016. This equates to a rate of 306 per 100,000 population which is below the South West rate of 341 per 100,000 and the England rate of 334 per 100,000. . The rates of FTEs in Gloucestershire have remained consistently lower than those in both the South West and England and Wales over the last five years. However, the gap between Gloucestershire's rates and the regional and national rates narrowed in 2013 and have remained at a similar level ever since.

[79] Ministry of Justice, *Youth Justice Statistics 2015/16 England and Wales*, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/585897/youth-justice-statistics-2015-2016.pdf

Young people cautioned or sentenced by Youth Offending Teams by age group, year ending March 2016



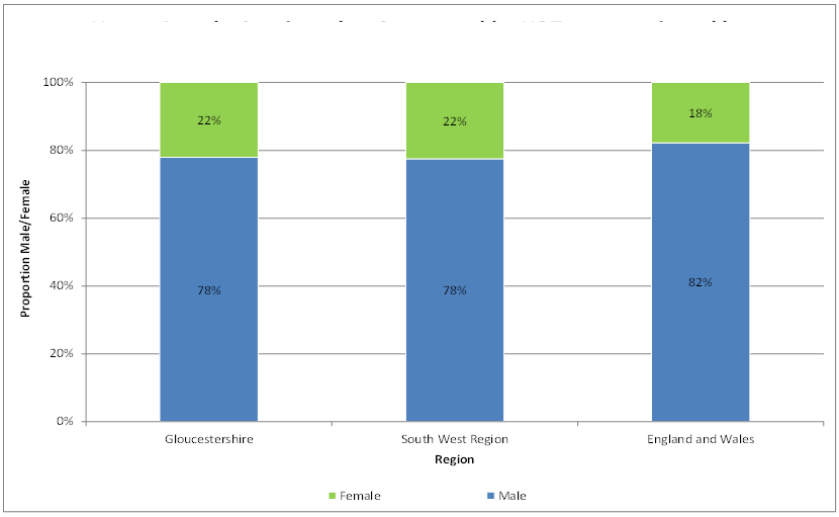
Source: Ministry of Justice

Young people who were cautioned or sentenced in 2016 were most commonly in the 17+ age group (throughout Gloucestershire, the South West, and England and Wales).

In Gloucestershire, 82 (29%) young people who were cautioned or sentenced were in the 17+ age group; the remaining 71% were split fairly evenly across the other age groups, with slightly fewer in the 10-14 age group (65 young people; 23%).

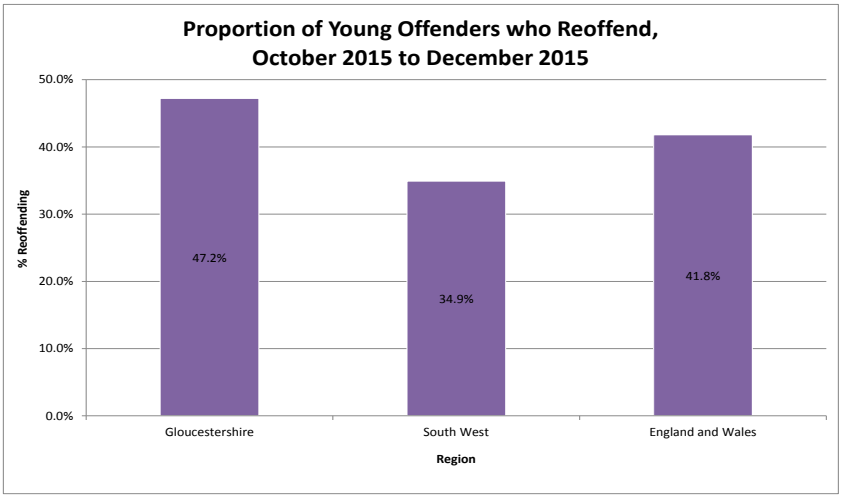
The gender split of young people who were cautioned or sentenced in 2016 was the same in Gloucestershire as in the South West region, with 78% male and 22% female. England and Wales had a higher proportion of males who were cautioned or sentenced, than locally, with 82% male and 18% female.

Young people cautioned or sentenced, proportioned by gender, year ending March 2016



Source: Ministry of Justice.

Proportion of young offenders who reoffend, Oct 2015 - Dec 2015.[80]



Source: Ministry of Justice.

The most recent Government proven reoffending figures (for the quarter October 2015 to December 2015) suggest that the reoffending rate of young offenders in Gloucestershire was higher than those in the South West, and across England and Wales. During this period, 47.2% of young offenders reoffended, compared to 34.9% in the South West, and 41.8% in England and Wales.

There were 72 young people in Gloucestershire who received a caution, a non-custodial conviction at court or who were released from custody in the period October 2015 to December 2015. This was the number of young people in the cohort used to calculate reoffending statistics. Of this cohort, 34 committed a proven re-offence within the one year follow-up period.

There was an average of 3.91 reoffences per reoffender in Gloucestershire during this period – higher than the South West and England and Wales rates of 3.85 and 3.88 respectively.

Local Service Provision

Every local authority, acting in co-operation with partner agencies, has a statutory duty to establish one or more youth offending teams for their area under section 39(1) of the 1998 Crime and Disorder Act and Gloucestershire is no exception to this.

The Youth Offending Team (YOT) in Gloucestershire is a multi-agency team comprising staff from Youth Support (Prospects) Probation[81], the Children and Young People Service of the 2gether Trust (aka CAMHS) , other health profesionals (such as physical health nurses, substance misuse nurses and speech and language therapists) and the Police. In line with its statutory obligations, the Youth offending Team

- co-ordinate the provision of youth justice services for all those in the authority's area who need them,

[80] https://www.gov.uk/government/statistics/proven-reoffending-statistics-october-2015-to-december-2015
[81] Since 2014 this is divided into the National Probabtion Service for high tariff offenders and a regional Community Rehabilitation Company for others.

- carry out the functions assigned in the local authority's youth justice plan;
- contribute to the local authority's duty to take reasonable steps to encourage children and young peoplenot to commit offences.

Youth Justice Liaison & Diversion (L&D) Team

Since 2013, Gloucestershire's Youth Justice Liaison and Diversion has intervened early to improve health assessments and outcomes for children and young people in contact, or at risk of contact, with the youth justice system. Diversion can be action to avoid a young person coming into the youth justice system in the first place (diversion away from the system) or action to improve what happens if they do come in (diversion within the system).

Children First Project

Launched in January 2018, this is a restorative intervention that aims to divert children and young people away from the formal criminal justice system wherever possible and reduce unnecessary criminalisation particularly of vulnerable groups e.g. children in care, learning difficulties, mental health problems. It encourages children and young people to take responsibility for their own actions and promote reintegration into their communities. It aims to ensure children and young people are offered the right support in order to prevent further offending at the earliest opportunity

Ultimately the hope is to make restorative interventions the norm and default disposal for children and young people who offend and by doing this focus on the child and the victim and keep them at the heart of the process.

Aston Project

Established in Cheltenham in 2011, this project for 9-17 year olds aims to reduce crime and anti-social behaviour amongst young people through an ethos of positive engagement and intervention. Police and local partners support young people to make the right choices towards becoming law-abiding, productive members of adult society.

Evidence around What Works

In 2016 The Ministry of Justice commissioned "What Works in Managing Young People who Offend? A Summary of the International Evidence"[82]. The following outlines the findings from this report.

Key elements of effective programmes to reduce reoffending

The evidence showed that successful interventions in reducing youth reoffending considered the factors set out below.

- The individual's risk of reoffending**:** assessing the likelihood of further offending and importantly, matching services to that level of risk with a focus on those people who are assessed as having a higher risk.

[82] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/498493/what-works-in-managing-young-people-who-offend.pdf

- The needs of the individual: focusing attention on those attributes that are predictive of reoffending and targeting them in rehabilitation and service provision.
- An individual's ability to respond to an intervention: maximising the young person's ability to learn from a rehabilitative programme by tailoring approaches to their learning styles, motivation, abilities and strengths.
- The type of programme: therapeutic programmes tend to be more effective than those that are primarily focused on punitive and control approaches. Therapeutic approaches include:
    - skills building (e.g. Cognitive Behavioural Therapy; social skills);
    - restorative (e.g. restitution; victim-offender mediation);
    - counselling (e.g. for individuals, groups and families) and mentoring in some contexts.
- The use of multiple services: addressing a range of offending related risks and needs rather than a single factor. Case management and service brokerage can also be important.
- Programme implementation: quality and amount of service provided and fidelity to programme design.
- The wider offending context**:** considering family, peers and community issues.

Community, Custody and Resettlement

- When applying risk based or other approaches to inform rehabilitation planning, it should be borne in mind that some young people will desist from crime without any intervention. There is also evidence to suggest that drawing young people who commit low level offences into the formal youth justice system may increase their offending. Therefore, diversionary approaches, including restorative justice, which direct these individuals away from the formal justice system may be appropriate for some young people.
- Within the community, effective programmes can be characterised by strong inter-agency partnerships that are well managed, with appropriate strategic leadership. Partnership protocols need to be embedded into routine practice. The best international evidence shows that family based therapeutic interventions that draw on the community and also consider wider offender needs can be effective and deliver a positive net return on investment. That said, the family can itself be a setting of trauma, abuse and exploitation and this may be particularly relevant for those young people who come to the attention of youth offending teams. This, therefore, needs to be considered as part of intervention planning for young people who offend.
- Community based interventions tend to be more effective than custody. Some young people will, however, always need to be sentenced to custody and these young people are likely to be those in most need of intensive intervention. Where appropriate, consideration should be given to moving young people to well trained foster carers. Good quality supervision in custody also requires planning for release and resettlement to be an integral part of the sentence, and for young people's needs to be assessed in terms of transition back to the community. Brokers or advocates who will help guide young people through this transition and be available whenever needed are worth considering.
- Prison visitation programmes aimed at young people at risk of offending were not found to reduce offending behaviour; conversely, they may increase the likelihood of committing crime.

Military style 'boot camps' run as alternative to custody were also found not to reduce reoffending.

- No one style of talking with or to young people is going to resonate either with all staff or all those in their care. However, there is some consensus that effective communication is characterised by mutual understanding, respect, and fairness. Motivational interviewing and other techniques that allow a young person to confront the consequences of his or her actions can be useful when deployed in conjunction with other support and individual therapies.
- Finally, in all settings young people need to be encouraged to develop agency, autonomy, and respect for others as well as themselves. This requires commitment from staff as well as the young people themselves. Care should be taken to make sure that young people understand how they arrived at their position, and how to move forward.

Discussion, Gap Identification and Recommendations

Strengths in this area:

- Gloucestershire has seen a reduction in the number of children in the criminal justice system.
- A number of innovative interventions are being rolled out to reduce numbers of first time entrants and reduce reoffending e.g. Children First and the Aston Project

Areas of Concern

- Higher proportion of reoffending compared to both south west and nationally.
- Scope for further reductions in numbers of first time entrants into the youth justice system

Recommendations

Focus on continuing to drive down numbers of first time entrants into the system and on reducing reoffending rates (which are higher than the national average). Early intervention is likely to be the key to this.

Adverse Childhood Experiences

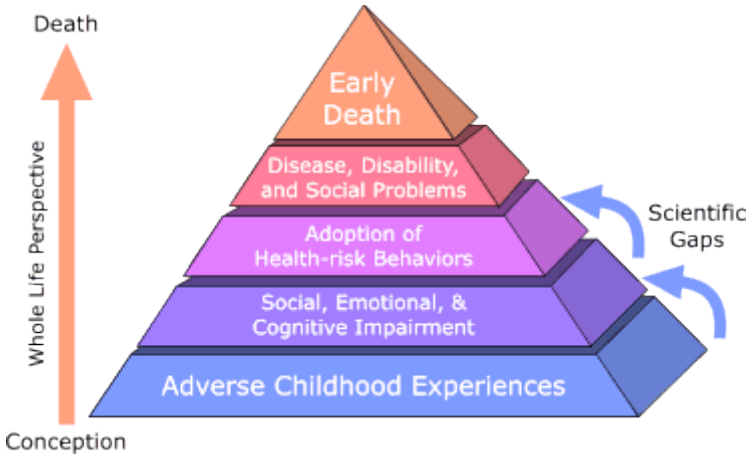
Adverse Childhood Experiences

Introduction

What happens in childhood matters; positive experiences can promote lifelong wellbeing and resilience, while negative experiences can have a long term detrimental impact. The family context a child is born into and their ongoing family life experiences matter not just in the moment ,but carry on into the future for that individual, as well as out into the wider society, and often on into the next generation.

The impact of adverse Childhood Experiences (ACEs) are an increasing concern internationally and there is a growing body of evidence that our experiences during childhood can affect health throughout the life course. Evidence shows that children who experience stressful and poor quality childhoods are more likely to adopt health-harming behaviours during adolescence which can themselves lead to mental health illnesses and diseases such as cancer, heart disease and diabetes later in life. This chain of events is illustrated in the model below.

The ACEs Pyramid - a model to represent the potential life-long impacts of ACEs



Source: *Source: The Center for Disease Control and Prevention, " The ACE pyramid", 2014.* *https://web.archive.org/web/20160116162134/http://www.cdc.gov/violenceprevention/acestudy/pyramid.html*

Adverse Childhood Experiences are not just a concern for health. Experiencing ACEs means individuals are more likely to perform poorly in school, more likely to be involved in crime and ultimately less likely to be a productive member of society.

People who experience ACEs as children often end up trying to raise their own children in households where ACEs are more common. Such a cycle of childhood adversity can lock successive generations of families into poor health and anti-social behaviour for generations. Equally however, preventing ACEs in a single generation or reducing their impacts can benefit not only those children

but also future generations. As a result, understanding more about local adverse childhood experiences and using this to design interventions to tackle them represents a potentially very powerful tool to prevent ill health and promote future population health and productivity.

ACES and the Evidence Around Their Impacts

There is now a robust evidence base linking adverse childhood experiences (ACEs) to severe negative health and social outcomes across the life course, including the leading causes of illness and death in the UK. This evidence came initially from large population studies in the US[83], and has been replicated in studies in many different countries all over the world, including England[84] and Wales[85]. Adverse Childhood Experiences (ACEs) are traumatic events occurring before the age of 18. Different studies have used slightly different ACES although there is a common core. The majority of international studies have considered between nine and eleven ACEs; some which relate directly to the child and the majority of which relate to the parents / household. These are detailed in the Infographic below:

Infographic to show commonly considered ACES

Source: Public Health England

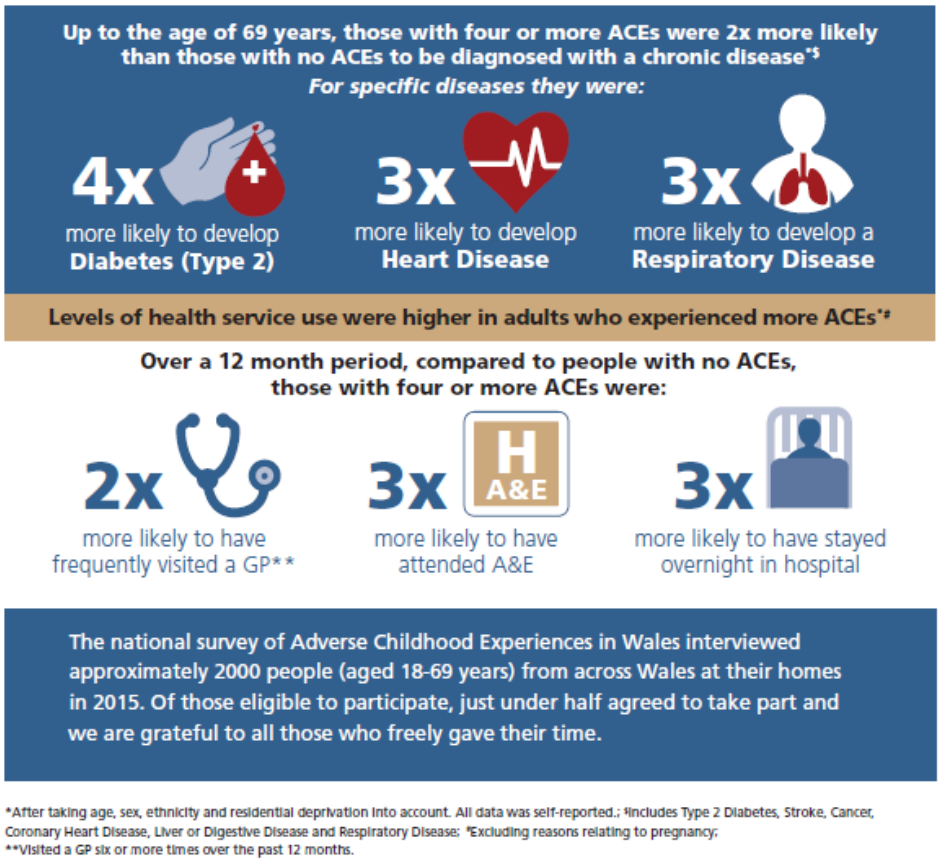
ACEs are strongly associated with the development of long term conditions as well as a substantial increase in the use of health and care resources. There have been a number of international studies on ACEs prevalence including a large Welsh study. The results of the Welsh studies are used here as they are likely to be fairly transferable to out population. In the Welsh ACEs study, participants up to the age of 69 years with four or more ACEs were at least twice as likely as those with none to be diagnosed with long term conditions or experience an episode of ill health, including: Type 2

[83] Felitti, V.J., Anda, R.F., Nordenberg, D., Williamson, D.F., Spitz, A.M., Edwards, V., Koss, M.P. & Marks, J.S. (1998) Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study, *American Journal of Preventive Medicine*, 14(4): 245-258

[84] Bellis, M.A., Hughes, K., Leckenby, N., Perkins, C. & Lowey, H. (2014) National household survey of adverse childhood experiences and their relationship with resilience to health-harming behaviors in England, *BMC Medicine*, 12: 72

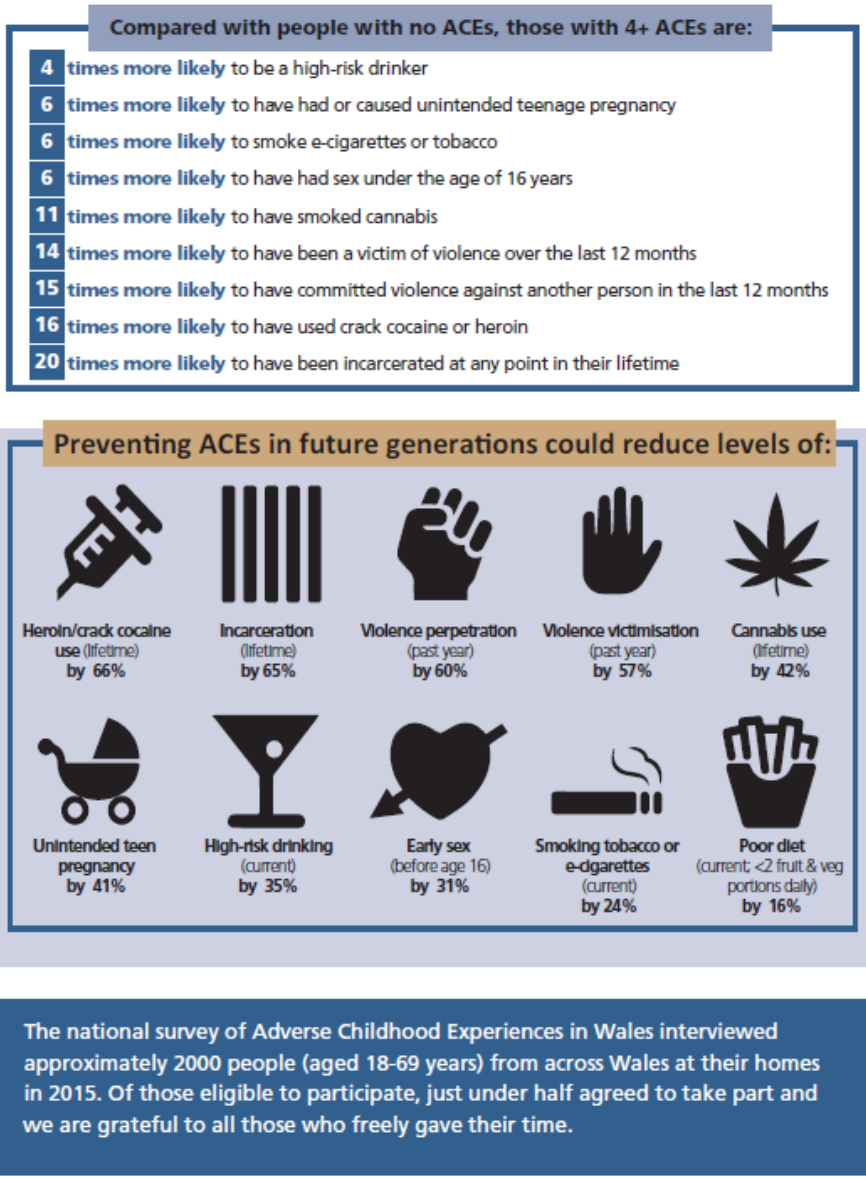
[85] Bellis, M.A., Ashton, K., Hughes, K., Ford, K., Bishop, J. & Paranjothy, S. (2015) *Adverse Childhood Experiences and their impact on health-harming behaviours in the Welsh adult population*, Centre for Public Health, Liverpool John Moores University, Liverpool

diabetes, stroke, cancer, coronary heart disease, liver or digestive disease and respiratory diseases. The results of the Welsh ACES study[86] are summarised in the diagram below.



In addition to increased risk of disease outcomes ACES are also associated with an increased risk of a number of health harming behaviours (which may be the route through which the effects on disease are mediated). The associations with increased risk of societal and health harming behaviours that were found in the Welsh ACES studies are summarised below:

[86] Bellis, M.A., Ashton, K., Hughes, K., Ford, K., Bishop, J. & Paranjothy, S. (2015) *Adverse Childhood Experiences and their impact on health-harming behaviours in the Welsh adult population*, Centre for Public Health, Liverpool John Moores University, Liverpool



Where ACEs occur in family settings, there is a high risk of intergenerational transmission, contributing to a cycle of disadvantage and health inequity. The World Health Organisation has described the impact of ACEs as a global crisis, driving both current and future high levels of demand and poor outcomes across the health, education, care and criminal justice sectors[87].

Prevalence

National Data

National studies of the prevalence and impact of ACEs have been conducted in England and Wales, supported by a number of smaller regional studies. Around 50% of the UK population experience at

[87] World Health Organisation (2009) *Addressing Adverse Childhood Experiences to Improve Public Health: Expert Consultation, 4-5 May 2009*,

least one ACE, with around 12% experiencing four or more ACEs[88] . A dose-response relationship exists where the more types of abuse and adversity a person experiences, the higher the risk of harmful health and social outcomes later in life; individuals experiencing four or more ACEs are at highest risk of poor health and social outcomes, dying on average 20 years younger than individuals with no ACEs[89].

While Gloucestershire is often considered as a population with better health outcomes than average, distinct pockets of deprivation and poor health prevail across the county. It is likely that the prevalence of ACEs in Gloucestershire is similar the UK figures above.

Applying the national prevalence of 12 % experiencing 4 or more ACES, would mean that in Gloucestershire's population of 140,666 children there would be expected to be 16,800 children at risk of multiple adverse outcomes resulting from their childhood trauma.

Individual ACE prevalence

To date the discussion has centred around the experience and outcomes relating to multiple ACEs. To aid progress on how to address ACEs and prevent their occurrence, it is first helpful to consider the individual experiences. Accurate and reliable data is hard to come by and this should be kept in mind when considering the sections below. This year, for the first time the Online Pupil Survey has included a question asking sixth form pupils to self score in terms of the number of ACEs they have experienced.

Bellis et al [90] carried out a study to estimate the prevalence of several adverse childhood experiences in England. The prevalence estimates, along with any triangulating local data are given below

- **Verbal Abuse**

Nationally[79] it is estimated that 18% of the population experienced verbal abuse in childhood. When applied to Gloucestershire's population of 140,666 children this would given an estimate of 25,300 children whose lives are negatively impacted by experience of verbal abuse.

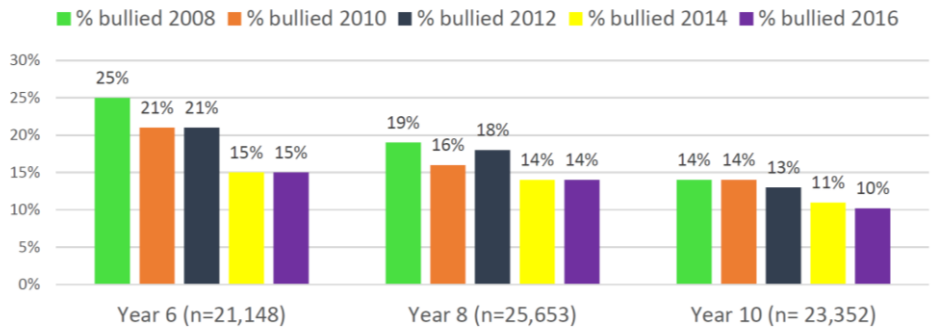
Verbal abuse does not have to occur in the home it can occur at school or other places. The online pupil survey provides some local data on bullying levels at different ages and over time. Encouragingly this shows a decreasing trend with time and with increasing age of the child. For 2016, around 15% of 11 year old reported being bullied. The majority of this was recorded as verbal bullying

[88] Bellis, M.A., Hughes, K., Leckenby, N., Perkins, C. & Lowey, H. (2014) National household survey of adverse childhood experiences and their relationship with resilience to health-harming behaviors in England, *BMC Medicine*, 12: 72

[89] Felitti, V.J., Anda, R.F., Nordenberg, D., Williamson, D.F., Spitz, A.M., Edwards, V., Koss, M.P. & Marks, J.S. (1998) Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study, *American Journal of Preventive Medicine*, 14(4): 245-258

[90] Bellis, M.A., Hughes, K., Leckenby, N., Perkins, C. & Lowey, H. (2014) National household survey of adverse childhood experiences and their relationship with resilience to health-harming behaviors in England, *BMC Medicine*, 12: 72

Figure 7: The % of pupils bullied frequently in the past year (monthly, weekly or most days)



Bullying rates are falling in all age groups. In children in years 6 and 8, around 15% report regular bullying in the most recent data.

- **Physical Abuse**

Nationally[79] it is estimated that 15% of the population experienced physical abuse in childhood. When applied to Gloucestershire's population of 140,666 children this would given an estimate of 21,100 children whose lives are negatively impacted by experience of physical abuse.

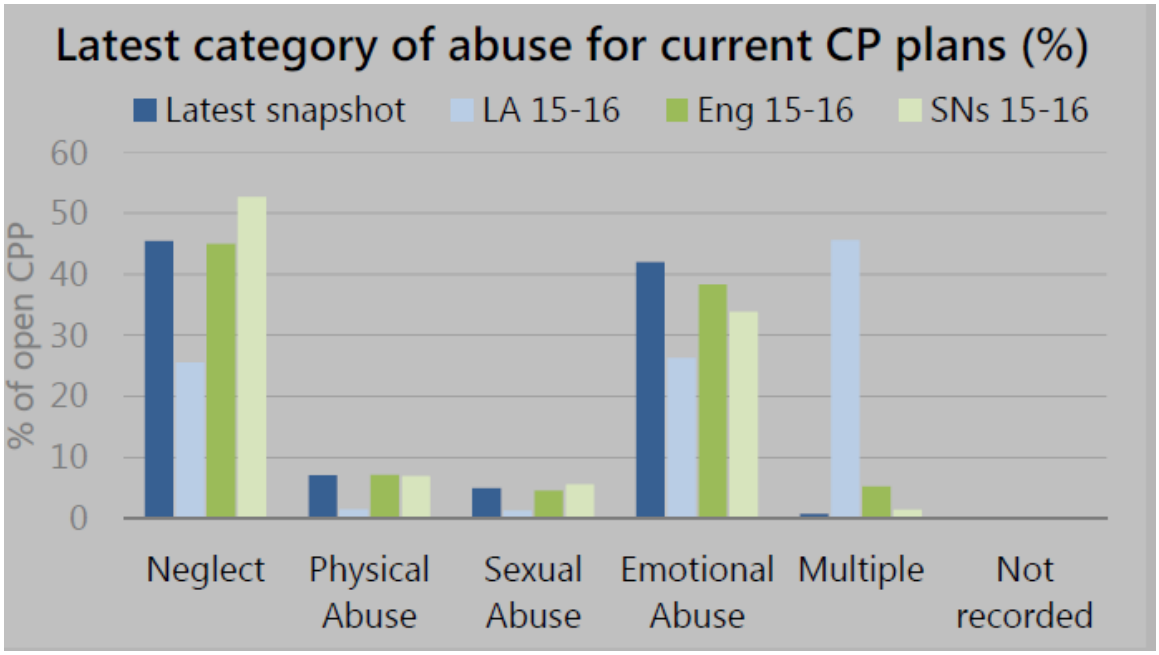
In a 2016 Office of National Statistics survey based on the results of the Crime Survey For England and Wales 7% of respondents reported experiencing physical abuse in childhood. This is roughly half that reported in the ACESs study.

- **Sexual Abuse**

Nationally[79] it is estimated that 6% of the population experienced sexual abuse in childhood. When applied to Gloucestershire's population of 140,666 children this would given an estimate of 8,400 children whose lives are negatively impacted by experience of sexual abuse.

The NSPCC estimate that 1 in 20 children (5%) will experience sexual abuse. This is broadly inline with the ACEs study estimate. The NSPCC also estimate that a third of children never tell anyone about sexual abuse, so these estimates may be lower than the actual numbers.

Overall information on abuse and neglect levels are also available from child protection plan data. The prevalence figures in the population of children on child protection plans will obviously be higher than that observed in the national population but It is helpful to compare the relative frequency of the different types of abuse and also to look at the difference in numbers between those in the system and the population estimates. The CHAT (Children's analysis tool) data set provides this data. The December 2017 snap shot data is given below. At this point in time there were 570 children on child protection plans



Interestingly this data shows that historically, the majority of children they were recorded as experiencing multiple forms of abuse. However, in the latest snapshot this has been shifted to recording high proportions of neglect and emotional abuse. The rates of physical abuse recorded are well below what might be expected based on population prevalence.

- **Parental Separation**

Nationally[79] it is estimated that 24% of the population experienced parental separation/divorce in childhood. When applied to Gloucestershire's population of 140,666children this would given an estimate of 33,800 children whose lives are negatively impacted by experience of parental separation.

Nationally divorce rates have been decreasing over the past decade. Divorce rates in 2016 were over 20% lower than the recent peak in divorce rate in 2003 and 2004[91] suggesting that the prevalence of children experiencing trauma from divorcing parents may be decreasing.

- **Domestic Abuse**

Nationally it is estimated that 13% of the population have lived with domestic abuse in childhood. When applied to Gloucestershire's population of 140,666 children this would given an estimate of 18,300children whose lives are negatively impacted by experience of domestic abuse.

In the 2016 Online Pupil Survey, 13% of year 12 students reported having witnessed or experienced domestic abuse with 7% of these reporting this was a frequent occurrence. This is broadly in line with the ACEs findings nationally. .

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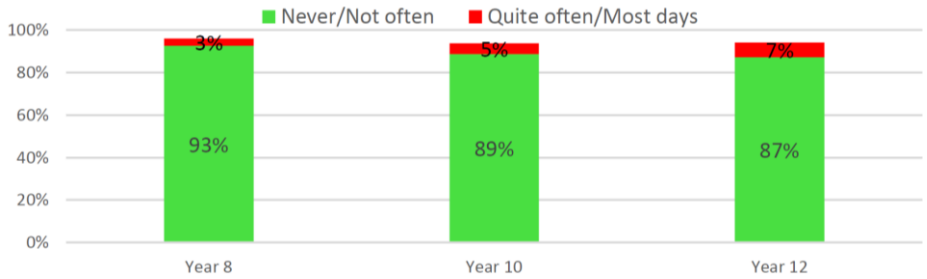
https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/divorce/bulletins/divorcesinenglandandwales/2016

Fig: 2 Have young people or anyone in their immediate family ever been a victim of domestic abuse



Locally, data is collected on the number of children in the care of domestic abuse service users. The number of children for 2016/17 is given in the table below.

Age	Female	Male	Total	%
0 - 5 yrs	919	895	1814	32.5%
6 - 10 yrs	910	833	1743	31.3%
11 - 15	595	540	1135	20.4%
16-18	198	245	443	7.9%
18+	175	135	310	5.6%
Unknown	51	81	132	2.4%
Total	**2848**	**2729**	**5577**	

The majority of affected children are aged 5 years or under (32.5%), followed by those aged 6-10 (31.3%). This is not unexpected given that domestic abuse often starts or escalates in pregnancy or the early childhood years. Comparing the total figure of 5,577 children who are known to be living with domestic abuse in Gloucestershire to the estimated prevalence of 18,300 suggests that around two thirds remain under the radar.

Domestic abuse cases referred to multi agency assessment conferences (MARAC) are often those considered most severe or highest risk. In 2016/17, 772 children were associated with MARAC referred cases.

- **Mental Illness**

Nationally it is estimated that 12% of the population experienced living in a household affected by mental illness in childhood. When applied to Gloucestershire's population of 140,666 children this would given an estimate of 16,800 children whose lives are negatively impacted by experiences of living with parents with mental illness.

Local data on children with one or more parent with a mental illness is limited. However, local social care data can provide part of the picture. The following information is a snapshot of data from Gloucestershire County Council's social care database, showing cases where parental mental health is a concerning factor.

As at 31st March 2017, 1318 or 35% of children in open social care cases (3,767) had parental mental health recorded as a concerning factor.

The table below shows the number of children in open social care cases where parental mental health is a concerning factor, 31st March 2017 snapshot cohort.

Children in open cases where parental mental health is a concerning factor, by district (as at 31st March 2017)			
	Number of children	% of total children where parental mental health is a concerning factor	% of total open cases that have parental mental health as a concerning factor
Cheltenham	234	17.75%	35.73%
Cotswold	121	9.18%	48.21%
Forest of Dean	135	10.24%	33.33%
Gloucester	451	34.22%	32.45%
Stroud	197	14.95%	31.07%
Tewkesbury	180	13.66%	41.67%
Total	**1318**	100%	34.99%

This data is likely to underestimate the total number of children affected as it only record those known to social care.

- Alcohol Abuse

Nationally it is estimated that 10% of the population grew up in a household impacted by alcohol abuse. When applied to Gloucestershire's population of 140,666 children this would given an estimate of 14,100 children whose lives are negatively impacted by experience of living with parents who abuse alcohol.

As at 31st March 2017, 601 or 16% of children in open social care cases (3,767) had parental alcohol abuse recorded as a concerning factor.

The table below shows the number of children in open social care cases where parental alcohol abuse is a concerning factor, 31st March 2017 snapshot cohort.

Children in open cases where parental alcohol abuse is a concerning factor, by district (as at 31st March 2017)			
	Number of children	% of total children where alcohol abuse health is a concerning factor	% of total open cases that have parental alcohol abuse as a concerning factor
Cheltenham	82	13.64%	12.52%
Cotswold	66	10.98%	26.29%
Forest of Dean	54	8.99%	13.33%
Gloucester	221	36.77%	15.90%
Stroud	110	18.30%	17.35%
Tewkesbury	68	11.31%	15.74%
Total	**601**	100%	15.95%

This data is likely to underestimate the total number of children affected as it only record those known to social care.

- Drug Abuse

Nationally it is estimated that 4% of the population grew up in a household impacted by drug abuse. When applied to Gloucestershire's population of 140,666 children this would given an estimate of 5,600 children whose lives are negatively impacted by experience of living with parents who abuse drugs.

As at 31st March 2017, 712 or 19% of children in open social care cases (3,767) had parental drug abuse recorded as a concerning factor.

The table below shows the number of children in open social care cases where parental drug abuse is a concerning factor, 31st March 2017 snapshot cohort.

Children in open cases where parental drug abuse is a concerning factor, by district (as at 31st March 2017)			
	Number of children	% of total children where drug abuse health is a concerning factor	% of total open cases that have parental drug abuse as a concerning factor
Cheltenham	143	20.08%	21.83%
Cotswold	50	7.02%	19.92%
Forest of Dean	67	9.41%	16.54%
Gloucester	258	36.24%	18.56%
Stroud	111	15.59%	17.51%
Tewkesbury	83	11.66%	19.21%
Total	**712**	100%	18.90%

This data is likely to underestimate the total number of children affected as it only record those known to social care.

- **Incarceration**

Nationally it is estimated that 4% of the population grew up in a household impacted by parental incarceration. When applied to Gloucestershire's population of 140,666 children this would given an estimate of 5,600 children whose lives are negatively impacted by experience of living with parents who are incarcerated.

More information on how living in a family with an imprisoned family member impacts children can be found below.
https://www.jrf.org.uk/report/poverty-and-disadvantage-among-prisoners-families

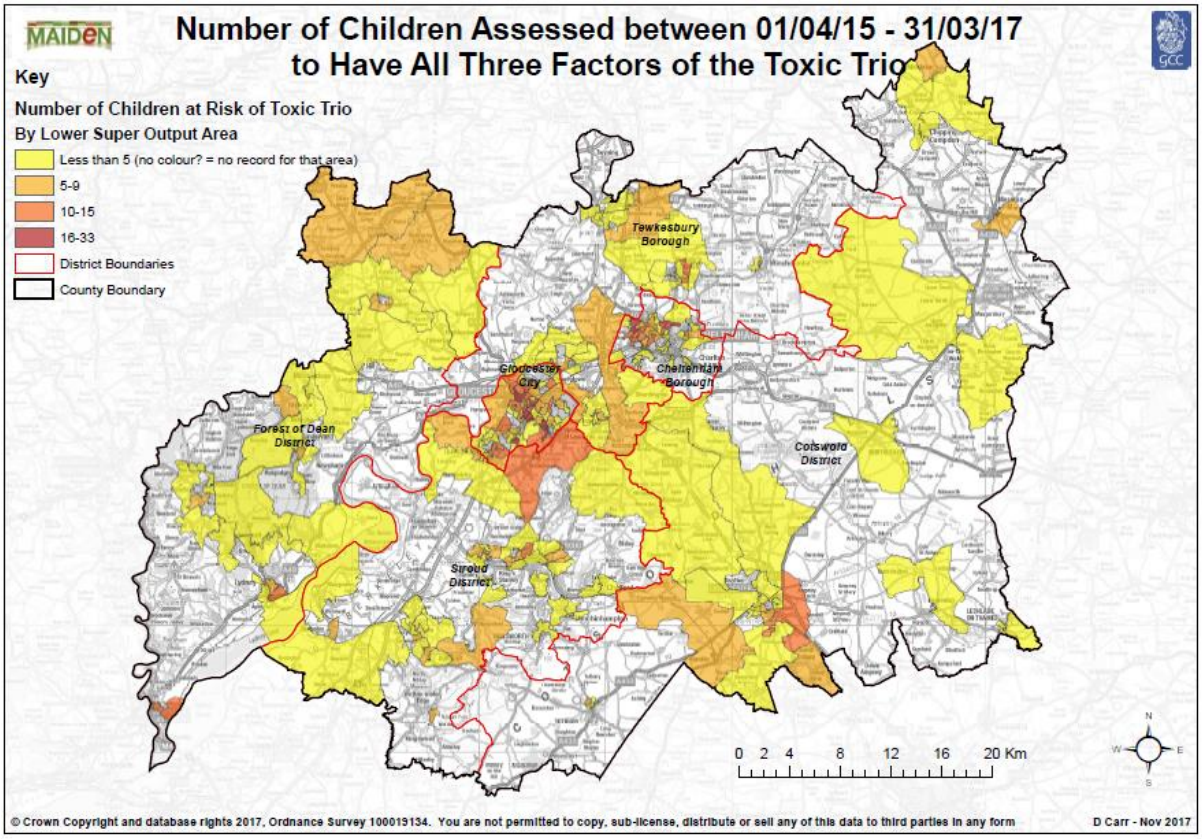
Toxic trio proxy

Many of the adversities children experience are not single isolated issues; instead the adversities often cluster. The classic example of this is the so called "toxic trio" of domestic abuse, poor mental health and substance abuse. Some local research has been carried out into this clustering of these Adverse Childhood Experiences and it can be considered as a proxy for a high incidence of coexisting ACEs that is likely to make the child high risk for poor outcomes.

The table below uses data from the Children Social Care database where an initial assessment has taken place. The count represents every child where a concern flag has been raised for all three Toxic Trio issues; some children may be counted in both years. In 2016/17, 40% of children lived in Gloucester City and 20% lived in Cheltenham.

District	2015/16	2016/17
Cheltenham	102	121
Cotswold	32	63
Forest of Dean	67	45
Gloucester	259	253
Stroud	75	74
Tewkesbury	33	63
Unknown	31	19
Total Recorded by GCC	**599**	**638**

The geographic distribution of these multiple risk factors can be estimated by using the last two years of full data, with duplicate child records removed, to show the total number of children in each Lower Super Output area at high risk due to the combination of all three elements of the Toxic Trio present in their home. This gives the following mapping



ACEs in young people known to police In Gloucestershire

A further data source that can give some information on local ACEs is the Gloucestershire police audit of ACES prevalence in high risk children they are working with. An initial audit of the prevalence of ACEs has been conducted by Gloucestershire Police in a small cohort (42) of high risk young people engaged in the Great Expectations and Aston Projects. This found that:

- 69% of the cohort had experienced 4 or more ACEs;
- 29% of the cohort had experienced 8 or more ACEs; and
- the average number of ACEs experienced across the cohort was 5.3.

This audit was conducted on the basis of what professionals knew already rather than directly asking the young people, and so in reality it is likely that there are young people who experienced more, undisclosed, ACEs. Given the nature of the cohort it is not surprising that the proportion who have experienced multiple ACES is higher than projected background population prevalence. The findings do lend support the notion that those with high experience of ACEs may go on to have issues in future life.

Evidence Around what Works

Adverse childhood experiences do not define people; they are simply a tool to understand the potential risks an individual or population may face. It is possible to intervene to 'interrupt the cycle of adversity'. This is well set out in this video from the US (the 'ACEs primer').
http://kpjrfilms.co/resilience/bonus-content/

While individuals that suffer ACEs have an increased risk of poor outcomes as adults, many individuals who experience ACEs do not encounter these effects. An individual's ability to avoid harmful behavioural and psychological changes in response to chronic stress is known as resilience. Having a strong relationship with a trusted adult throughout childhood has been found to reduce the long-term negative impacts of childhood adversity.[92]

Research shows that the key to addressing the impacts of ACEs is early identification; with evidence suggesting that people rarely disclose issues of childhood adversity or trauma voluntarily. It is estimated that if not asked directly by professionals, it can take individuals nine to sixteen years to disclose a history of adversity[93]

The importance of building 'routine enquiry' into childhood adversity in order to facilitate early intervention has been highlighted in a number of national policy documents. Both the *Future in Mind* report [94]and the *Tackling child sexual exploitation* report (HM Government, 2015) [95]included specific

[92] Ford, K., Butler, N., Hughes, K., Quigg, Z. & Bellis, M.A. (2016) *Adverse Childhood Experiences (ACEs) in Hertfordshire, Luton and Northamptonshire*, Centre for Public Health, Liverpool John Moores University, Liverpool
[93] Read, J., McGregor, K., Coggan, C. and Thomas, D.R. (2006). Mental health services and sexual abuse: the need for staff training. *Journal of trauma & dissociation*, *7*(1), pp.33-50.
[94] NHS England (2015) *Future in mind: Promoting, protecting and improving our children and young people's mental health and wellbeing*, Department of Health, London
[95] HM Government (2015) *Tackling Child Sexual Exploitation*, HM Government, London

recommendations calling for the development of routine enquiry by health and social care services for childhood adversity.

Based on the evidence that routine enquiry about ACEs can improve outcomes, a number of models have been developed to support public and voluntary services to adopt routine enquiry. An example developed in the UK is the 'REACh' model, developed by Lancashire Care NHS Foundation Trust as a training programme designed to offer a practical framework for organisations and services to develop and adopt routine ACE enquiry. The 'REACh' model has been rolled out across the health and care system in Lancashire including health visiting, substance misuse, domestic abuse, children's services, early help and mental health services. Qualitative evaluations of the model have shown that:

- Professionals, when adequately trained and supported, are confident in holding difficult conversations around ACEs, and feel the approach is valuable and can deliver improved outcomes.
- Routine enquiry does not appear to increase demand on services, but instead allow individuals already accessing support to have their needs more effectively met (Real Life Research, 2015).[96]

The Centre on the Developing Child at Harvard have recently published a model to specifically address the problem of how to apply the ever increasing findings about the impact of ACES and translate this evidence into a model for practice. They have developed a framework designed to help translate the theory, science and evidence into effective policy and practice.

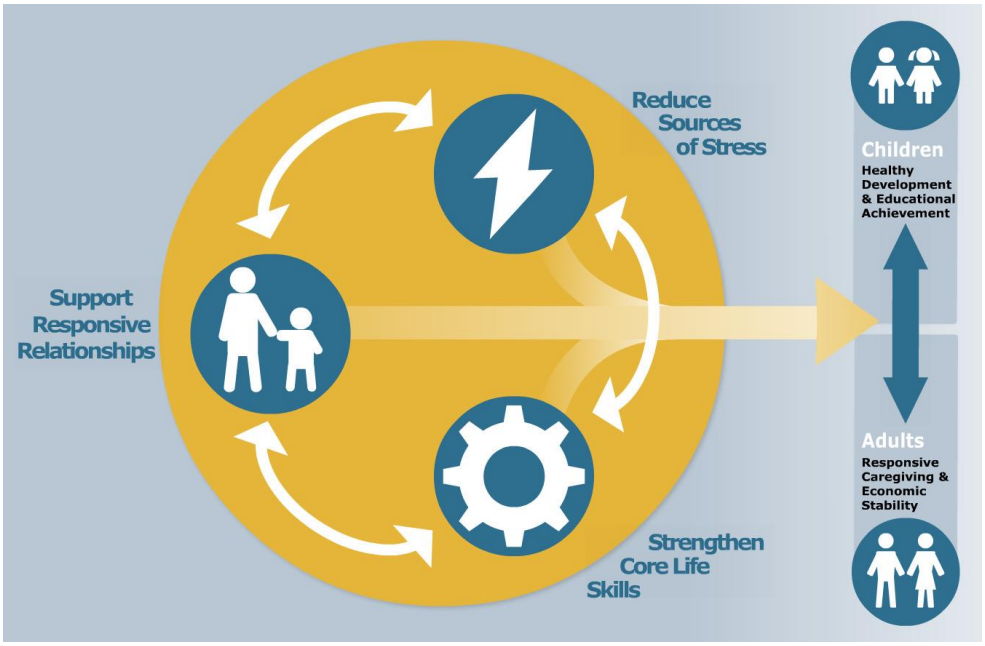
The model is derived from the evidence around ACES and around promoting resilience and considers the child in the family and wider community context. The model proposes three principles to improve outcomes for children, young people, and families. These principles can be applied at every level from policy proposals to individual practice, and across multiple sectors from health, education, and children's services to transport and planning. The model can therefore be used as a simple, practical tool to drive unified, system wide change that improves outcomes for all children, young people and families.

The three principles are:

- Reduce sources of (toxic) stress
- Support Responsive Relationships
- Strengthen Core Life Skills

The model is pictorially represented below:

[96] Real Life Research (2015). An Evaluation of REACh: Routine enquiry into adversity in childhood



Source: **Center on the Developing Child at Harvard University (2017). Three Principles to Improve Outcomes for Children and Families. http://www.developingchild.harvard.edu**

This is a new theoretical model and is in the process of being evaluated. It can be used to provide a tangible and logical framework within which actions to tackle ACEs can be structured.

Recommendations and Ongoing Work

The ACES agenda is a rapidly evolving area of activity in Gloucestershire. A multi organisation ACES panel has been convened as a subgroup of the Health and Wellbeing Board and a Gloucestershire wide ACEs strategy is in development. This will look to raise awareness of ACEs and to embed action on tackling them into families, communities and organisations across the county.

Child Poverty

Child Poverty

What is the issue?

Whilst some children thrive despite the poverty they grow up in, for many children growing up in poverty can result in a poor quality childhood with lower levels of health, wellbeing and educational attainment. Children who grow up in poverty all too often become the parents of the next generation of children living in poverty. In addition to the often considerable personal and social impacts there is also an economic impact estimated to be around £29m a year from lost productivity income and costs of providing services[97].

Parents raising children in poverty often do an extraordinary job, raising children in very difficult and challenging circumstances. Financial difficulties can have a significant impact on parents, which in turn can affect the development and physical, mental and social health and wellbeing of the children. Childhood poverty can restrict educational achievement and disrupt a child's transition to an independent adult life. Growing up in poverty can mean being left out and left behind, wearing different clothes and not being able to go on school trips or outings that other families would take for granted, and growing up acutely aware of what poverty means. Long-term, child poverty leads to worsening educational attainment, increased morbidity from physical and mental health conditions (including maternal depression) and worsening healthy life expectancy.

Measuring Poverty

Measuring poverty is not a straightforward issue as poverty can be defined in a number of ways. Absolute poverty is defined as the lack of one or more basic human needs (i.e. food, water, clothing, housing and sanitation). In contrast, relative poverty is compared against a standard set for a specific area, with people deemed to be in relative poverty if they can't keep up with a society's standard of living.

The current official measure of child poverty as defined by Her Majesties Revenue & Customs (HMRC) defines child poverty as *'the proportion of children in families in receipt of out of work (means-tested) benefits, or in receipt of tax credits where their reported income is less than 60% of median income.* 'The HMRC definition tends to look at income before housing costs while The Joseph Rowntree Foundation, a well respected UK based social policy think tank, in their recent report "UK Poverty 2017, Analysis of Poverty Trends and Figures"[98] define child poverty as when a family has an income of less than 60% of median income *for their family type, after housing costs* as their preferred indicator of poverty. Using this measure the poverty thresholds for different types of family are:

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98 https://www.jrf.org.uk/report/uk-poverty-2017 Accessed on 4 Dec 2017.

Family Type	£ per week, equivalised, 2015/16 prices
Couple with no children	248
Single with no children	144
Couple with two children aged 5 and 14	401
Single with two children aged 5 and 14	297

Source Joseph Rowntree Foundation. https://www.jrf.org.uk/report/uk-poverty-2017

In many supranational, academic and third sector organisations involved in the field of child poverty taken to mean when a family does not have the resources "to obtain the types of diet, participate in the activities and have the living conditions and amenities which are customary, or are at least widely encouraged and approved, in societies in which they belong"[99]

National Issues and Trends in Child Poverty

Causes of Child Poverty

Like may complex issues, child poverty is caused by a blend of structural issues relating to macro-economic, political, social as well as individual factors[100]. Research suggests that societal belief around the cause of child poverty often focus on individual level factors such as parental substance misuse. In reality such factors may only account for as 3% of total child poverty.

- Macro-economic factors contributing to child poverty include:
  the structure of the labour market, the housing market, low pay, irregular hours and insecure employment

- Political factors contributing to child poverty:
  social welfare policies

- Social and individual factors contributing to child poverty:
  Gender, lone parenthood, disability, age, ethnicity, parental capacity and lifestyle choices

There are particular groups of children who are especially vulnerable if their situation interacts with the experience of poverty, for example; disabled children/children of disabled parents; children in care; children leaving care; children with a parent in prison; children who are carers; asylum seeker/refugee children; and traveller/gypsy children. Not only are these groups more at risk of poverty, the experience of poverty for them is often more severe, and the support required will be greater.

National Trends in Child Poverty[101]

Nationally, there have been significant improvements in child poverty levels over the last few decades with 800,000 children lifted out of poverty since 1998. In 2011/12 the child poverty rate fell to 27%, its lowest in recent times, but has started to rise again, reaching 30% in 2015/16. As

[99] *Poverty in the United Kingdom: a survey of household resources and standards of living*. Harmondsworth, Penguin.
[100] What Works Scotland Evidence Review**:** Tackling child poverty: Actions to prevent and mitigate child poverty at the local level Available from http://whatworksscotland.ac.uk/wp-content/uploads/2017/08/WWSActionsToPreventAndMitigateChildPovertyAtLocalLevel.pdf
[101] The Joseph Rowntree Foundation report "UK Poverty 2017" https://www.jrf.org.uk/report/uk-poverty-2017 Accessed on 4 Dec 2017.

described above, lone parent families or those with 3 or more children are particularly at risk of experiencing child poverty.

- 46% of lone parent families in 2015/16 lived in poverty. This is a rise from a low of 41% in 2010/11
- 39% of families with 3 or more children lived in poverty in 2015/16 (arise from and low of 32% in 2012/13). By comparison around 27% of families with 1 or 2 children live in poverty. In April 2017 a 2 child limit on benefits and tax credits was introduced which may further impact this disparity.

The rise in employment rates is no longer leading to decreases in child poverty as there has been an increase in recent in-work child poverty rates. These rates are closely linked to the number of adults in work in the family and their hours of work. As might be expected, families with a single earner or with only part-time workers experience much higher poverty rates.

- 67% of children living in poverty live in a household where at least one parent works[102]
- In lone-parent families where the parent is working full time, poverty has risen from 13% in 1996/97 to 28% in 2015/16.
- Between 1996/97 and 2010, the child poverty rate in lone-parent families working part time halved from 46% to 23%. It has since risen back to reach 36% in 2015/16.

Risk Factors for Child Poverty

The key points detailed below demonstrate how certain lifestyle and situational factors can increase the risk that a child will live in poverty, and should be considered at a local level where possible in any strategy to tackle child poverty:

Lone parents - children of lone parents are at greater risk of living in poverty than children in two parent families.

Large families - children in larger families are at far greater risk of poverty than children from families with fewer children.

Children with disabilities - disabled children are more likely than their nondisabled peers to live in poverty as a result of lower incomes (because parents need to look after disabled children and so cannot work) and the impact of disability-related additional costs (an impact which is not captured by official figures).

Children with disabled parents - children with disabled parents face a significantly higher risk of living in poverty than those of non-disabled parents. The main reason for this is that disabled parents are much less likely to be in paid work, and also suffer the impact of additional disability related costs which sap family budgets.

Children who are carers – Not only are children who are carers more likely to live in poverty (mainly due to the person they are for having a reduced earning capacity) but their additional responsibilities can compound the effect.

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Children who have teenage parents – National data shows that children of teenage mothers have a 63% increased risk of being born into poverty compared to babies born to mothers in their twenties.

Children growing up in social housing - children living in households that live in social housing (either local authority or housing associations) face a high risk of being poor. 49% of children in local authority accommodation are poor before housing costs (rising to 58% after housing costs). Poor children in social housing are also a large proportion of all poor children. Though the numbers in private rented accommodation are smaller, these children also face an increased risk of poverty.

Black and minority ethnic children - children living in households headed by someone from an ethic minority are more likely to be living in a poor household. This is particularly the case for those households headed by someone of Pakistani or Bangladeshi origin, where well over half the children are living in poverty.

Asylum seekers - there is no robust quantitative data on asylum seekers. However the parents in this group are prohibited from working and are only entitled to safety net support at a lower level than the usual income support.

Traveller and gypsy children - there is a lack of robust quantitative data on Gypsy and Traveller families, including data around poverty. However, both practice knowledge and other studies show that some have few financial resources.

Children with a parent in prison – it is recognised that these children are more likely to be living in poverty.

Children leaving care - young people leaving care are likely to face multiple disadvantages including poverty. Those entering care are also much more likely to have experienced poverty. This is a consequence of their pre-care, in-care, leaving care and after-care 'life course' experiences.

Sometimes these factors combine and there are key family characteristics which create barriers to some families working their way out of poverty. The five key factors are parents who are long-term workless, parents with low qualifications, lone parents, having three or more children to care for, and experiencing ill health.

Policy Context

The previous government launched a Child Poverty Strategy 2014-17 with a goal to end child poverty by 2020, a target set in legislation by the Child Poverty Act 2010[103]. The Welfare Reform and Work Act 2016 has recently come into effects and this has superseded much of the Child Poverty Act 2010. The headline focus of both acts can be summarised as

(1) supporting families into work and increasing earnings and by creating more jobs and tackling low pay and

[103] Townsend, P. (1979). *Poverty in the United Kingdom: a survey of household resources and standards of living*. Harmondsworth, Penguin.

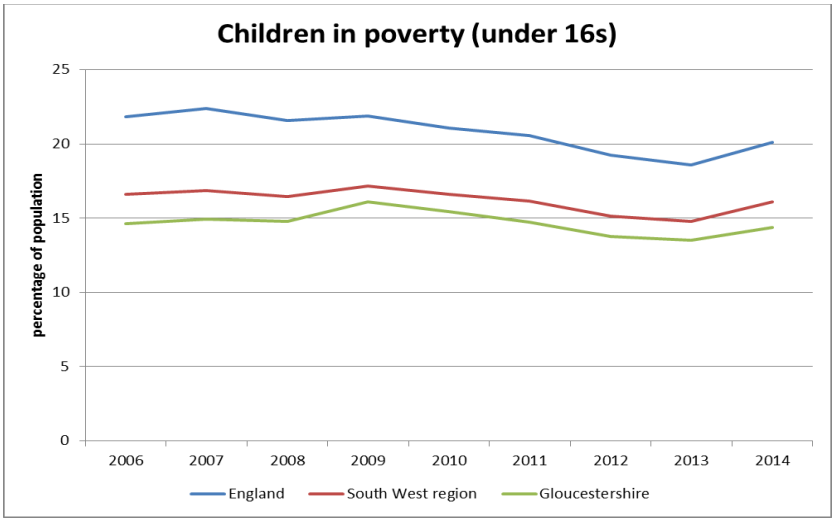
(2)preventing poor children becoming poor adults by supporting educational attainment, support for education to get people into better paid jobs together with efforts made to "make work pay" (e.g. Childcare subsidies and free school meals for all school children),

However, the newer Welfare Reform and Work Act 2016 focuses more heavily on "Making Work Pay" than its predecessor. Financial benefits to families with more than two children have been cut, and the duty on local authorities to have a strategy around or work collaboratively to reduce child poverty has been removed. Instead the focus has shifted to looking at child poverty through the prism of "workless families" with action targeted to reducing this. There is a concern that this will mean that the 67% of children currently classed as living in poverty who live in working households will be forgotten[104].

Epidemiological Data Review

Child poverty

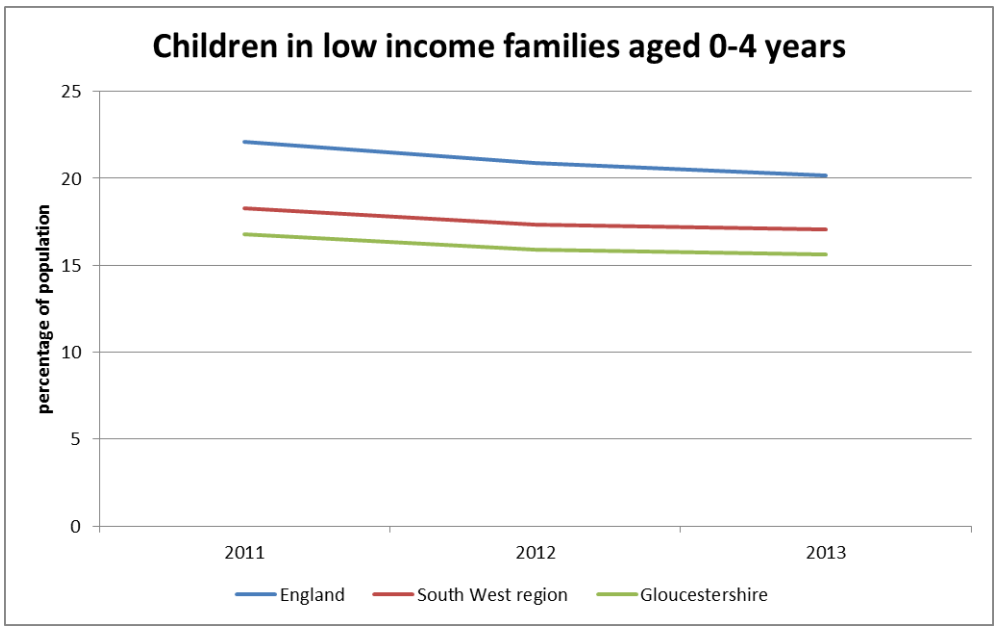
Child poverty can include households with below average income, households in material deprivation, households in persistent poverty and households with absolute low income. Each of these is defined differently. ONS uses the HBAI (Households Below Average Income) as it's main source for Child poverty figures this defined as the "Percentage of children in low income families (in receipt of out of work benefits or tax credits where their reported income is <60% of the median income)". The graph below shows this indicator for Gloucestershire and regional and national comparators. Gloucestershire has lower levels of child poverty than are seen regionally or nationally. There has been a recent rise in the proportion of children living in poverty and, given the impact this can have on children this increase in poverty is an area of significant concern for the overall wellbeing of children in our population.



The evidence around life course effects shows us that very young children are often disproportionately impacted and so the chart below allows us to see the proportion of young

[104] https://www.childrenssociety.org.uk/sites/default/files/Welfare%20Reform%20and%20Work%20Bill%20-%20Second%20Reading%2C%20House%20of%20Commons.pdf

children living in low income families. As in under 16s Gloucestershire is outperforming its peer group but over 15% of young children are still living in poverty locally. This proportion is higher than that for all children.



2018 January release (using DWP data from July-September 2017)

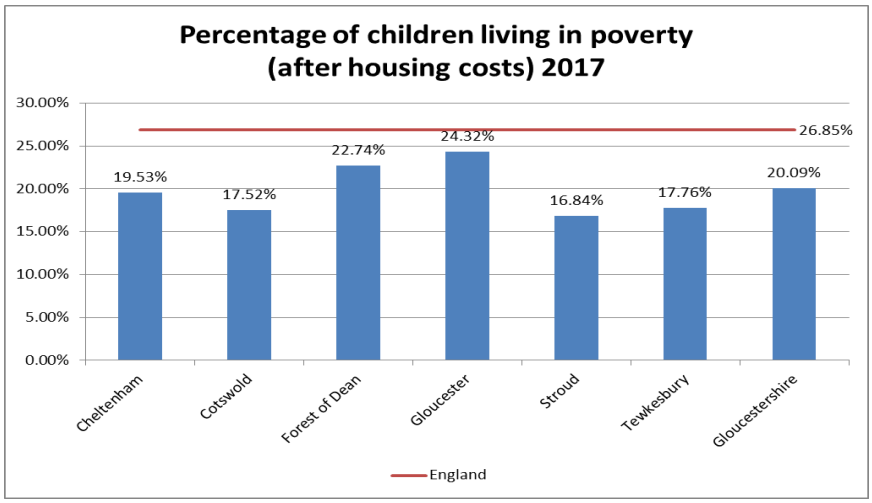
Child poverty is not evenly distributed across the county, rather it is clustered in certain areas. 18 wards in Gloucestershire have a percentage of children living in poverty above the England estimate of 26.85% after housing costs. (The England estimate has risen by 8 percentage points since the last release using DWP data from October to December 2015.)

In total approximately 24,658 children (aged 0-16) are living in poverty in Gloucestershire (after housing costs). 7,812 children in Gloucestershire are living in areas where the proportion of children living in poverty is higher than the England average. These areas are also more likely to have higher rates of other social factors that are associated with poverty (such as unemployment and crime).

Percentage of children living in poverty (after housing costs) - wards over the England average of 26.85%		
Local Authority and wards*	**Number of children**	**%**
Barton and Tredworth	1,454	43.28%
St Paul's	284	34.38%
Oakley	515	34.13%
Coleford Central	202	32.92%
Lydney East	408	32.48%
Matson and Robinswood	880	32.28%
Springbank	520	31.25%
Moreland	887	31.06%
Littledean and Ruspidge	236	30.46%
Tewkesbury Prior's Park	258	29.02%
Hesters Way	544	28.77%
Westgate	372	28.17%
Upton St Leonards	179	28.04%
Newland and St Briavels	168	27.93%
Cirencester Chesterton	214	27.57%
Bream	181	27.04%
Coleford East	334	27.04%
Podsmead	176	26.86%

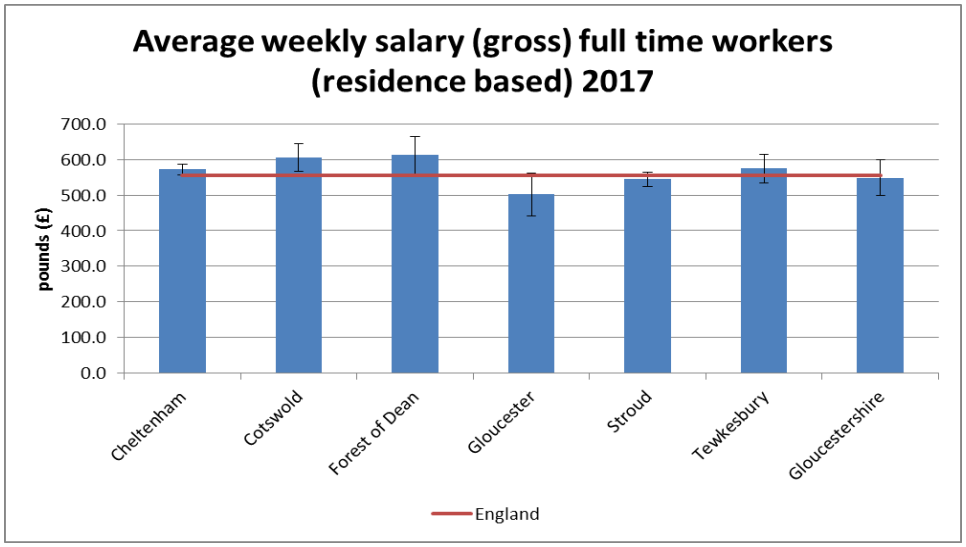
Another way of looking at whether households are living in poverty is by looking at relative income after housing costs. This adjusts for the variable cost of housing in different areas. The Centre for Research in Social Policy makes these annual estimates for the End Child Poverty Coalition of the number of children in poverty in each ward, local authority and parliamentary constituency in the UK. This local data is calculated by classifying children (aged under 16) as in poverty if they live in families in receipt of out of work benefits or in receipt of in-work tax credits where their reported family income is less than 60 per cent of median income (reported for August 2014 by HMRC). Figures are then updated, taking into account Labour Force Survey data on the number of children in non-working households (reported for the third quarter of 2017). Child Benefit data are used to count the total number of children in each area. These estimates are not accurate counts of how many children are in poverty in each area. Rather, they use the best local data available to give an indication of where child poverty is particularly high, and therefore where there needs to be the strongest efforts to tackle it.

This locality level data is shown for Gloucestershire below.

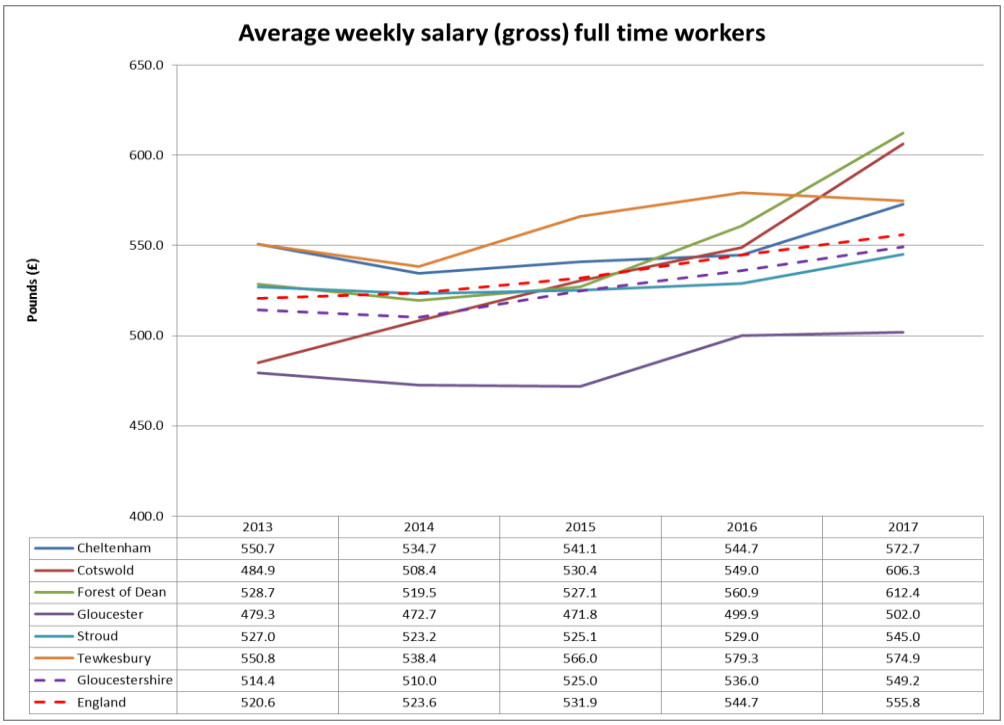


By this methodology, Gloucester, Forest of Dean and Cheltenham are identified as the worst performing areas with almost a quarter of children in Gloucester are living in poverty.

Child poverty calculations of all types are based on average weekly income. The information on average salaries by area of residence is given below and is compared to average national salaries



Interestingly average salaries are reported as highest in the Forest of Dean despite this being an area of high poverty. This suggests that a number of residents receive very high salries and that that skews the average data. Trend data on average salaries shows that the fastest increases by locality have been for the Forest fo Dean and Cotswold. Stroud by contrast has seen fairly flat salaries and Tewksbury has seen a decrease in average salary.



	2013	2014	2015	2016	2017
Cheltenham	550.7	534.7	541.1	544.7	572.7
Cotswold	484.9	508.4	530.4	549.0	606.3
Forest of Dean	528.7	519.5	527.1	560.9	612.4
Gloucester	479.3	472.7	471.8	499.9	502.0
Stroud	527.0	523.2	525.1	529.0	545.0
Tewkesbury	550.8	538.4	566.0	579.3	574.9
Gloucestershire	514.4	510.0	525.0	536.0	549.2
England	520.6	523.6	531.9	544.7	555.8

Children in Receipt of Free School Meals

As explored in the education section, children in receipt of free school meals (FSM) is often used as a proxy for disadvantaged children or children living in poverty. The table below shows the distribution of FSM eligibility and take up by type of school. Overall it shows that around 10% of children are eligible for free school meals which is a smaller proportion than either of the other methods for estimating children in poverty explored in this section. In addition it can be seen that a significant proportion of eligible children do not take up the FSM offer. This is particularly marked in secondary school where only 16% of eligible children took up the offer. This may be to do with the considerable stigma children feel is associated with poverty and FSM as a marked of this. The table also highlights that families with children with special needs are much more likely to experience poverty.

January 2017 Census

School Meals Analysis (FSM & UIFSM) - Summary of All Schools

Phase	Total NOR	Not Eligible for Free School Meals (Includes FSM Ever 6)	Eligible for Free School Meals (FSM)	Free Meals Taken on Census Day	Eligible for Univeral Infant Free School Meal (UIFSM)	Universal Infant School Dinners Taken on Census Day	Eligible for UIFSM & FSM	FSM Ever 6 (Pupil Premium)	Percent Eligible for FSM of NOR (%)
Primary	46652	41330	5322	3459	20701	14172	2365	111	11.41
Secondary	37855	34887	2968	472	0	0	0	56	7.84
Special	1080	712	368	263	151	127	46	2	34.07
Total	**85587**	**76929**	**8658**	**4194**	**20852**	**14299**	**2411**	**169**	**10.12**

Families with 3 or more children.

Recent changes to the benefits system mean that families with three or more children will be disproportionately impacted. Currently there are 7,420 children in Gloucestershire who are in families in receipt of Child Tax credit or IS/JSA equivalent where there are 3 or more children and 3,485 children are in families that have 4 or more children. (Oct-Dec 2015 estimates). This suggests that there is a large number of individual children whose exposure to the negative impacts of living in poverty is likely to get worse in the short term at least. The wards most likely to be impacted, ie those where these children are living are shown below:

Table showing wards in Gloucestershire with over 100 children in families in receipt of Child Tax credit or IS/JSA equivalent – with 3 or more children

Ward	Children in families in receipt of Child Tax Credit or IS/JSA equivalent - with 3 or more children
Barton and Tredworth	500
Matson and Robinswood	330
Moreland	295
Barnwood	285
Quedgeley Fieldcourt	255
Hesters Way	240
Springbank	240
Oakley	225
Tuffley	190
St Mark's	175
St Paul's	155
St Peter's	145
Brockworth	145
Kingsholm and Wotton	135
Lydney East	115
Westgate	105
Coombe Hill	105
Stonehouse	100
Cainscross	100

Citizens Advice Bureau Contacts

The Citizens Advice Bureau (CAB) is a national organisation that provides advice on a number of issues including debt and poverty management. Contacts with CAB services thus provide another indicator of need, in this case need felt by individuals themselves.

An estimated 17,000 people sought advice from CAB across. Where stated around a third of these consultations were due to financial difficulties, except in Gloucester where 43% were seen for financial reasons.

Evidence around What Works

Due to time constraints, this section has been complied using a review of reviews methodology. A number of reviews consider what causes child poverty but there are fewer that look at how to alleviate it. The main reviews used were "Tackling child poverty: Actions to prevent and mitigate child poverty at the local level" a September 2017 evidence review done by What Works Scotland and the Joseph Rowntree Foundation 2016 report, "UK Poverty: causes, costs and solutions"

The reviews consider both prevention and mitigation. Prevention looks at ways to stop child poverty from occurring in the first place and mitigation looks at reducing the impact of child poverty when it

occurs. The distinction between the two is significant, and both are important in comprehensively tackling the issue.

What makes an effective approach to reducing child poverty?

The "Tackling Child Poverty" review has collated a number of strategic steps Local Authorities and community facing partners can take to begin poverty mitigation and prevention[105]. These are:

- Ensure everyone across the entire partnership system feels ownership over the approach to child poverty.
- Involve local people living in poverty in discussions and planning (coproduction).
- Keep awareness raising and stigma reduction at the core of services.
- Implement evidence-based practice.
- Provide ongoing education and training of system-wide partnership members and relevant staff.

Evidence around Income Maximisation

Income maximisation can have both a preventative and a mitigating effect. As a poverty reduction strategy there is evidence it affect children and families pre, during and post pregnancy and there is good evidence "having more money directly improves the development and level of achievement of children"[106]. Maximising income involves ensuring high quality paid employment, ensuring benefits people are entitled to are received, ensuring good quality financial advice and support is available to all who need it and reducing the poverty premium (where low-income households pay more for the same goods or services due to payment methods available to them). Supporting income maximisation can often be achieved by bringing together existing services in more efficient and accessible ways.

Employment: Many reviewers are agreed that secure, well paid employment is the best route out of poverty and also confers other advantages to individuals, families and society. However, the fact that two thirds of children living in poverty live in a home where at least on parent works demonstrates that simply being in work is not enough. Findings suggest that in work poverty is caused by insecurity of the labour market, the role of temporary work and zero hours contracts, the growth of poorer quality work and a reduction of in-work benefits.

The Joseph Rowntree Foundation has collated the following evidence backed actions that local authorities can provide leadership in to improve high quality improvement

- Review local economic development policy for the role it plays in creating and supporting good quality family-friendly employment in relation to paying the living wage, writing into procurement contracts that the living wage is to be paid and no zero hours contracts are to be used, encouraging employers to provide secure and regular hours.
- Discourage the use of zero hours contracts. Local Authorities can discourage their use, especially in relation to procurement, and could also influence local employers and lobby central government for action.

[105] What Works Scotland Evidence Review**:** Tackling child poverty: Actions to prevent and mitigate child poverty at the local level Available from http://whatworksscotland.ac.uk/wp-content/uploads/2017/08/WWSActionsToPreventAndMitigateChildPovertyAtLocalLevel.pdf

[106] Cooper, K., K. Stewart F. (2013). *Does money affect children's outcomes? A systematic review*. Joseph Rowntree Foundation.

• Provide stronger support services to improve skills, opportunities and prospects.
• Ensure transport links from where people in poverty live, e.g. particular social housing estates, to where the majority of training and employment are.
• Provide free travel cards for those moving into work.
• Boost digital skills and use public libraries to facilitate access to the Internet.
• Have a central hub, or one stop shop, that brings together skills, training, employment support, employer events, linking this to money advice and information hubs incorporating things like transport and childcare so that these go hand in hand and are not seen as separate activities.

Increased uptake of benefit entitlements: Being eligible for but not taking up tax credit and benefit entitlement is detrimental to the financial wellbeing of a family and greatly increases their financial vulnerability. A significant number of people living in low income working families with children who are entitled to certain benefits do not claim them. For example, UK Government statistics for 2013-14 show that only two thirds of those who were eligible for Working Tax Credits actually claimed their entitlement. The reasons for not claiming benefits are often complex and driven by individual circumstances. However, lack of awareness and not feeling able to navigate the claims system are often cited. As a result, local authorities can beneficially ensure that their benefit systems are simple and efficient and easily accessible .In addition they can provide support to help local residents understand and navigate national systems (see below).

Money Advice: As discussed above, an effective means of maximising income is to facilitate access to financial advice and support. There is evidence that advice and support can be made "more accessible when embedded in services that people in poverty already use, for example, GP surgeries, employment support providers, services provided by social landlords or community organisations"[107]. Alternatively, there is evidence that well sign posted centrally located services with a high level of public trust and efficacy can also be effective. An example of this is the West Lothian Advice shop which provides advice on energy, money, debt, housing and benefits, and also runs a 'Money Week' which hosts events on family networking, employment with local employers, food shopping and volunteering. Another interesting model that has evidence of effectiveness is the NHS "Healthier Wealthier Children Project"[108] which takes a prevention rather than mitigation approach and used the early years workforce to facilitate bringing advice and information into the homes of those *at risk of* poverty. As well as evidence of poverty reduction and other benefits to families the project has conservatively achieved a financial benefit to cost ratio of around 5:1.

Overall the Rowntree Foundation concludes there is evidence to recommend that local authorities

- audit existing provision of monetary advice services,
- identify areas and groups with the greatest needs,
- collectively develop a plan for local advice and support,
- ensure maximum use of existing national provision of advice and support through websites and helplines to avoid duplication,
- marshal other local resources – such as the NHS and housing associations – to deliver the plan,

[107] Joseph Rowntree Foundation (2016) *UK Poverty: causes, costs and solutions*, JRF: York
[108] http://www.nhsggc.org.uk/your-health/campaigns/healthier-wealthier-children/

- commission services to fill gaps,
- monitor local provision.

Reducing the Poverty Premium: The poverty premium is where low-income households pay more for the same goods and services than others do because of the payment methods available to them. The poverty premium can add as much as £1000 per annum or approximately 10% of annual income to a low-income household. Services that create a poverty premium include those such as gas and electricity where direct debit payments may not be available to low income families who have previously missed a payment or where lack of internet access and skills may make searching for better utility provider options difficult.

Evidence backed actions to reduce poverty premiums include:

- Providing help in switching utility providers and accessing energy-efficiency programmes.
- Providing help in accessing insurance companies that offer insurance to social housing tenants.
- Local Authorities and housing providers entering markets, for example purchasing energy from the wholesale market or partner suppliers to become energy providers, or developing local electricity generation capacity
- Creating or working with local credit unions to encourage savings and to allow access to cheaper borrowing
- Working with businesses to encourage them to provide a no-interest loans scheme similar to the Good Shepherd Microfinance scheme in Australia for low-income families. The Good Shepherd Microfinance scheme works in partnership with charities, communities and government to offer no-interest loans to low-income households in receipt of certain benefits who are excluded from mainstream credit .
- Providing advice services and support to access debt reduction services where families are already in debt, especially as a result of high interest credit.

Evidence Around Education

Education is critical to mitigating the effects of poverty and in preventing poverty from passing down the generations. However, education often brings with it costs that are not immediately evident to educators, but are keenly felt by those living with poverty. The cost of schooling can have a negative effect on children and young people's ability to engage as full members of the school community. Both children and parents can develop strategies to avoid extra school associated costs such as trips. However, children's participation in school and out-of-school activities and trips is beneficial to their learning and to their social and cultural development meaning that avoiding them and missing out is damaging. Good parental engagement in schooling has been shown to be vital to children's educational outcomes and so building school/parental relationships is important.

As a result of these findings, the main issues identified around child poverty interventions targeted at education involve poverty proofing the school day, getting the balance between universal and targeted interventions right and promoting parental engagement with school.

Evidence back recommendations include:

• Publicise free school meals to encourage take up. Evidence demonstrates this provides both financial and nutritional benefit to children and currently around 300,000 pupils in the UK do not take up their free school meal entitlement. .

• Ensure privacy for pupils on free school meals in order to minimise stigma.

• Make taking school meals the usual mode of eating at lunchtime.

• Accept supermarket uniforms rather than branded school uniforms, which are also used to generate funds for the school. If schools wish to have branded uniforms, consider the sale of sew on badges for jumpers.

• Reduce fundraising/charitable giving that can highlight poorer pupils' lack of income, e.g. money for book clubs, wear your own clothes day.

• Encourage schools to consider an end of year activity that is of minimal cost to parents, rather than school proms which can be expensive for parents.

• There appears to be no clear cut answer on targeting vs universalism. If considering targeting then using an appropriate targeting system is essential. Evidence for some specific interventions is available. For example, implement breakfast and holiday clubs on a sliding scale of fees that are available to all pupils, but free to those on the lowest incomes.

• Provide teachers with high quality continuing professional development on the nature, causes and consequences of poverty.

• Undertake initiatives to build relationships with the poorest parents so that they are comfortable to be in the school environment. This could have positive effects by building trust so that income maximisation initiatives can be implemented through the school as well as having a positive impact on parents' social capital and children's participation and success in education

Evidence Around Provision of Childcare

The provision of childcare is important to enable parents, especially women, to work. High quality childcare is also good for children's development having a positive influence now and in their future life. In the UK there is a complex array of preschool childcare providers and types of provision; some of these are private, some public and others are in the voluntary sector.

The Joseph Rowntree Foundation identifies three main problems with the current childcare provision in the UK. The first is that families in areas of high unemployment predominantly have access only to the free childcare provision proved by the public sector. This is usually in school nurseries which have shorter days and a lack of flexibility in the hours provided, although it is generally of higher quality than private and voluntary sector nurseries. The second problem identified is that, excluding the public sector school-based provision, the quality of childcare is not sufficient to support child development. The third is that state support for childcare costs is poorly targeted, poor value for money and does not provide support for up-front costs. In England, only 43% of local authorities were found to have sufficient childcare in 2015 for parents who worked fulltime.

The Joseph Rowntree Foundation also find that in order to balance work and caring commitments many women opt for employment that is far below their skill level. Not only does this have a negative effect on these women's current and future earnings, it also takes up vital jobs that people with lower levels of skills and qualifications could usefully do. They note that 'enabling more women to stay in work after having children could reduce poverty in the short, medium and long term, with potential effects on women's incomes in later life'. When affordable, accessible childcare was introduced in Québec it reduced poverty by 50% in 10 years, and resulted in an increase in workforce participation, number of hours worked and annual earnings, and fewer women were on benefits.

As a result of such findings, the What Works" Report suggests that local authorities and their partners facilitate provision of childcare to support parental full time employment. This could be done using a tapered fee model keeping fees below 10% of a families disposable income and ensuring those in the severest poverty pay nothing. Models could include innovative childcare co operatives and social approaches with parent led community initiatives responsive to local pressures.

Evidence Around Supporting Lone Parents

Lone parents are usually female (86% in the UK and 91% in Scotland) and are more strongly affected by the inequalities that affect women more generally, e.g. gender pay gap. Lone mothers are more likely to have low-quality insecure employment, which has detrimental impacts on children. . If lone parents are to be able to work their way out of poverty then adequate childcare is crucial. Research shows that it is not lone motherhood itself that is associated with poorer child outcomes but the poverty, deprivation and lack of social support structures they experience. Stigma against lone parents can exacerbate the effects of poverty.

Local authorities and their partners can support lone parents by

- Effectively addressing their deeper levels of poverty and material deprivation.
- Supporting lone parents into stable employment that enables them to earn a decent wage at a time that is right for them and their children.
- Communicating to central government when policies are punitive or result in precarious employment.
- Reducing and removing the barriers to employment by improving the affordability and availability of childcare, holiday care and specialised care for disabled children; by increasing maternal skills and confidence, increasing maternal education and vocational training and helping with the costs of childcare.
- Supporting projects that build lone parents' social capital, social relationships, social support and social engagement.
- Ensuring adequate support for mental health difficulties.

Discussion, Gap Identification and Recommendations

Strengths in this area:

- Gloucestershire is a comparatively affluent county with below average levels of child poverty overall.

Areas of Concern

- Levels of child poverty are rising locally after several years of decline
- There is some evidence to suggest that children who live in poverty in otherwise affluent areas are actually more disadvantaged than those who are poor in generally poorer areas. This means that Gloucestershire's poor children may be more impacted than the average

Recommendations

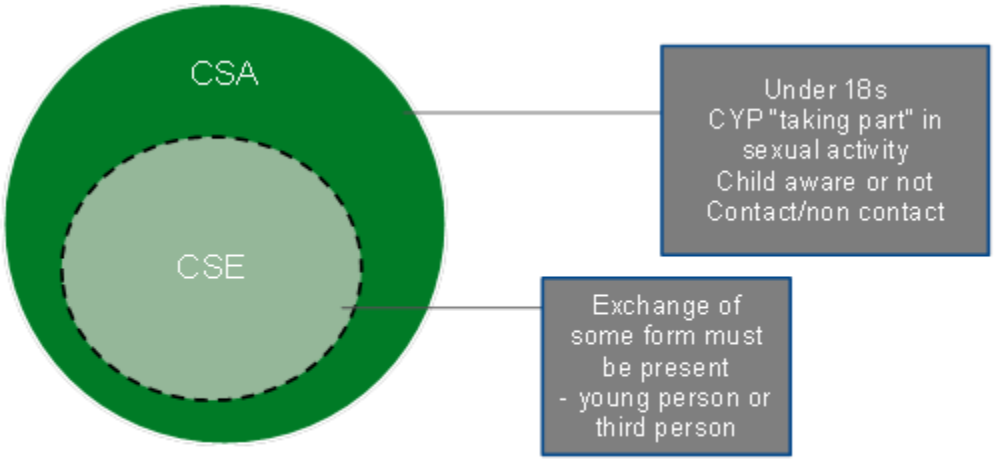
Ensure that as a county we do not lose focus on the over 20,000 children living in poverty in Gloucestershire and put prevention and mitigation strategies in place to break the association between growing up in poverty and worse health, wellbeing and social outcomes.

Child Sexual Exploitation

Child Sexual Exploitation

Introduction

The last few years have seen rapidly increasing awareness of the issue of child sexual exploitation (CSE) across the UK. However, confusion remains as to what CSE actually is, the different forms in which it can manifest and who it affects. As the diagram below illustrates at the most basic level, CSE is a form of child sexual abuse.



(Beckett 2016)

Source: https://www.gov.uk/government/publications/child-sexual-exploitation-prevention-and-intervention

As illustrated in the diagram above, the key factor that distinguishes CSE from other forms of child sexual abuse within the current policy framework is the presence of some form of exchange - the fact that the child (and/or someone else) receives 'something' in return for the sexual activity.

There are a number of definitions in place and that provide a useful overview of the scope of CSE. The Department of Education 2017 statutory definition explains:

> *"Child sexual exploitation is a form of child sexual abuse. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact; it can also occur through the use of technology."* (Department for Education 2017)

The London Child Sexual Exploitation Operating Protocol 2nd Edition March 2015 considers CSE as follows:

- *Sexual exploitation of children and young people under 18 involves exploitative situations, contexts and relationships where the young person (or third persons/s) receive 'something' (e.g. food, accommodation, drugs, alcohol, cigarettes, affection, gifts, money) as a result of them performing, and/or another or others performing on them sexual activities;*

- *Child sexual exploitation (CSE) can occur through the use of technology without the child's immediate recognition; for example being persuaded to post images on the internet/mobile phones without immediate payment or gain;*

- *Violence, coercion and intimidation are common. Involvement in exploitative relationships is characterised by the child's or young person's limited availability of choice as a result of their social, economic or emotional vulnerability;*

- *A common feature of CSE is that the child or young person does not recognise the coercive nature of the relationship and does not see themselves as victims of exploitation. Because of the vulnerabilities of care leavers and the need to address the issue of CSE holistically, this strategy also addresses our role, in liaison with other agencies, to tackle exploitation of vulnerable young adults up to the age of 25.*

CSE can take many forms including:

- Sexually exploitative relationships with an individual (in which the child believes he/she is in a consensual sexual relationship and the abuse is only by that individual)
- Third-party facilitated exploitation (in which an individual or group facilitates the involvement of others in abuse, often benefitting financially from this role);
- Paying for the sexual services of a child (language as per Sexual Offences Act 2003; includes sexual activity in return for any pre-agreed financial advantage);
- The party house model (in which young people are typically introduced to a party scene, provided with drugs or alcohol and then expected/forced to engage in sexual activity as a consequence of this);
- Online abuse in the virtual environment;
- Trafficking for sexual exploitation (this can be into, or within, the UK).
- Part of involvement with gang activity

CSE is often hidden from sight, difficult to identify, and harder still to stop. It preys upon the most vulnerable in society and perpetrators mostly evade prosecution. Sexual abuse may involve physical contact, or include non-contact activities, such as involving children in the production of sexual images forcing children to look at sexual images or watch sexual activities, encouraging children to behave in sexually inappropriate ways or grooming a child in preparation for abuse (including via the internet). According to the Child Exploitation and Online Protection Centre (CEOP), a significant

number of CSE offences include deceiving children into producing indecent images of themselves and engaging in sexual chat online or sexual activity over a webcam.

Children and young people at risk of harm online may not have previous vulnerabilities that are often associated with being victims of sexual abuse and exploitation. This means that they are less likely to be identified as they might not be previously known to authorities. This also means the currently accepted indictors of possible sexual exploitation, such as going missing or school absence, may not be displayed.

Children and young people often do not see the dangers of sharing intimate images of themselves to strangers. The internet creates a false feeling of security and diminishes inhibitions that would exist offline. Children and young people are particularly vulnerable due to the anonymous nature of the internet which allows perpetrators to adopt false personas and build trust online conversations.

Any child or young person under the age of 18 years – including those aged 16 or 17 who can legally consent to sex - can be a victim of these or other manifestations of CSE. Whilst younger children can also experience CSE, this form of abuse is most frequently documented amongst those of a post-primary age, with the average age at which concerns are first identified being 12-15 years of age.

Although most identified cases of CSE relate to young females, research repeatedly shows that young males are also abused in this manner, with their abuse even less likely to be identified than that of females. Similarly, both males and females can perpetrate CSE, individually or as part of an organised or informal network of abusers.

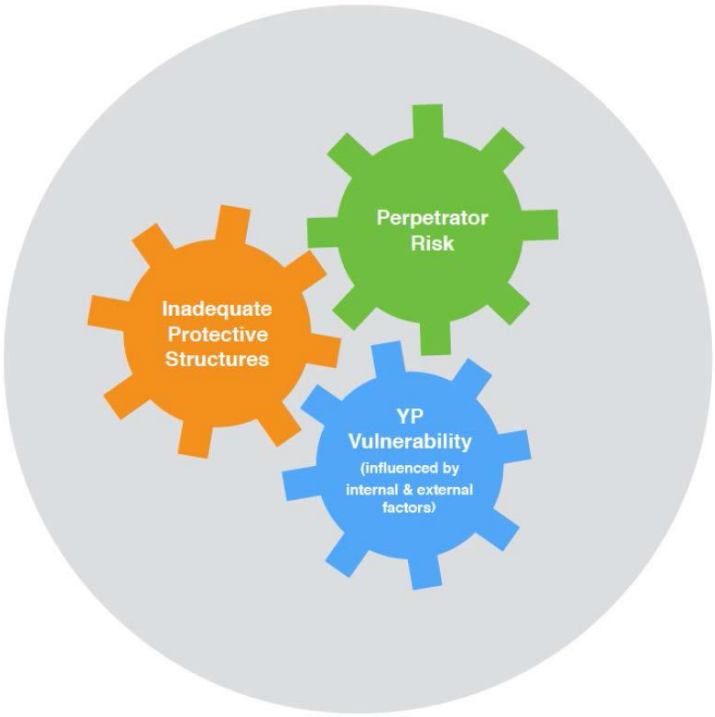
Research demonstrates that CSE exists across every ethnic grouping, both in terms of those perpetrating and those experiencing the abuse.

Although CSE can affect any child, there are a number of recognised factors (including adverse childhood experiences) that can heighten vulnerability to this form of abuse. Examples of these include:

- Prior (sexual) abuse;
- Chaotic or dysfunctional family background;
- Being in (residential) care;
- Substance misuse;
- Going missing;
- Social isolation and/or low self-esteem;
- Absence of a safe environment to explore sexuality; and
- Disability

Such vulnerability factors are not an explanation for, nor pre-determinant of CSE. There is usually a complex interplay of factors including perpetrator risk, inadequate protective factors and young person vulnerability. This is illustrated in the diagram below which fits well with the local strategy of "Prevent, Protect and Pursue". :

Diagram showing interconnected conditions for CSE



Source: Beckett et al, https://www.gov.uk/government/publications/child-sexual-exploitation-prevention-and-intervention

Potential impact of CSE

Research indicates that the health and wellbeing impacts of CSE can be profound and long lasting. CSE can result in a range of physical, sexual and mental health difficulties including Sexually Transmitted Infections (STIs) and gynaecological problems, drug or alcohol problems, depression, post-traumatic stress disorder, self-harm or suicidal ideation. Research also illustrates links between CSE and higher rates of youth offending, risk of forced marriage, involvement in adult sex work and poor educational prospects, amongst other things, all of which hold negative impacts for young people's wellbeing in both the short and longer terms. Risk of re-victimisation is also a very real concern where appropriate interventions are missing.

The effects of CSE can extend beyond the individual, with damaging consequences for a family's cohesion, health, social life and economic stability and, depending on the nature and reach of the abuse, potentially destabilising impacts on a community.

Policy Context

In June 2009, the government published its guidance on *Safeguarding Children and Young People from Sexual Exploitation (Supplementary Guidance to Working together to Safeguard Children).* This was an opportunity for Local Safeguarding Children Boards (LSCBs) to review their approach; to

consider their policies; and to develop their procedures. It was also a signal to many areas yet to address CSE that they should begin to do so.

Subsequent reports from the Office of the Children's Commissioner have confirmed that too little was being done to address CSE, despite a number of high profile cases across the country. These reports confirmed that CSE is more widespread than was previously thought and that the perpetrators were far from being exclusive to any one community, race or religion and that the victims come from an equally diverse range of backgrounds.

More significantly, the Children's Commissioner report: "*If only someone had listened*" November 2013, found that despite the high-profile attention CSE cases had been having, there were still practitioners in key roles who often did not acknowledge its existence; did not recognise the powerlessness of the young victims; and did not respond to the support needs of identified victims. Serious gaps were found in the knowledge, practice and services required to tackle this problem.

Similar findings were identified in the 2014 Rotherham Independent Inquiry, but additionally, a culture of denial was found to be reinforced by a lack of accountability and governance at the highest level across agencies.

In November 2014 Ofsted published its thematic inspection of eight local authorities' effectiveness in relation to CSE: 'The sexual exploitation of children: it couldn't happen here, could it? This inspection report found that local authorities and their partners were still not meeting their full responsibilities to prevent CSE in their area, nor were they adequately protecting victims or pursuing and prosecuting the perpetrators. Where local arrangements were in place, they did not link up with other local strategic plans. Few areas were adequately evaluating what they were doing and much more work needed to take place in raising awareness and engaging local communities.

The Casey Report of February 2015 alerted us to the potential for sustained organisational denial in recognising the extent of the problem. The Governments publication 'Tackling Child Sexual Exploitation' March 2015 states:

> '*We must eradicate the culture of denial that allows organisations and individuals to avoid the issue, blame others, or distract themselves with endless planning rather than making sure they actually make a difference. Changing culture requires strong leadership, clear accountability, engagement with victims and staff, and unequivocal feedback on what is working well and what is not across the whole local area".*

Local context:

Child sexual exploitation is a key priority for Gloucestershire's Safeguarding Children's Board (GSCB). The 2018-21 strategy sets out the commitment of the GSCB to do everything possible to prevent abuse and support victims of this abuse.

The Local Safeguarding Board (LSCB) has a significant role in strengthening the strategic framework around the key areas of exploitation together with there being 'ownership' at the highest level. The overarching Strategy in Gloucestershire is led by the GSCB. The GSCB strategy includes collaboration with Gloucestershire Safeguarding Adults Board in recognition of the risks extending to and overlapping with vulnerable adults. (see point on transitions in local service section)

The new strategy 2018 – 21 builds on the cross agency work already taking place within Gloucestershire and sets out how all agencies will work together to ensure the most effective and

coordinated response to these issues over the next three years. As discussed in the introduction, the issues around sexual exploitation are often difficult to detect and, as a result it is recognised no single agency can tackle this problem alone. It is clear that the collaboration of all partners is required to ensure that exploitation of children is eradicated. Multi-agency working is further strengthened by the Gloucestershire MASH (Multi-Agency Safeguarding Hub) and MACE (Multi-Agency Child Exploitation Meeting)

Epidemiological Data Review

Prevalence

It is difficult to find reliable data regarding the prevalence of CSE. However the National Society of Prevention of Cruelty to Children (NSPCC) estimates the numbers to be 5-16% of children under 16yrs[109]. Applying these prevalence rates to the local population of 10-16 year olds would mean roughly between 2,000 and 6,000 children affected in Gloucestershire.

It is recognised that there is significant under reporting of the issue which is felt to be due to issues of shame, perceived or actual threats to the young person or their family, or due to the young person's failure to recognise that they are being exploited. The average age of victims of CSE is 15 but there is a growing cohort of younger children identified (10 -14 years) and a cohort that continue to be vulnerable into adulthood. .

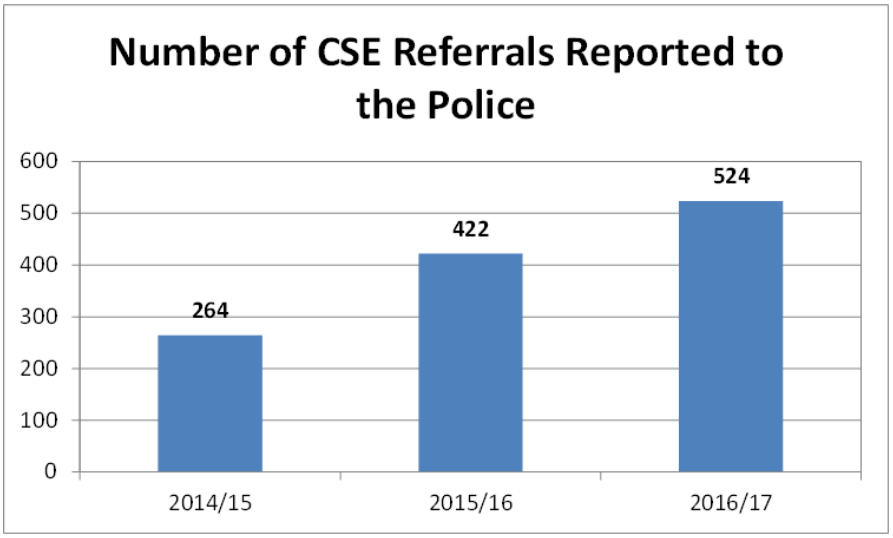
Gloucestershire Data:

During 2016/17, the number of CSE referrals into the police was 524., compared to 422 referrals in 2015/16. This increase is in line with the national trend and should be regarded as positive in the sense that work to raise awareness and identify more children at risk has had an impact.[110]

Between 1st April 2017- 31st March 2018 the number of completed CSE screening tools sent to the Gloucestershire CSE multi agency team was 341.

[109] (Cawson, P et al (2000) Child Maltreatment in the United Kingdom: A Study of Child Abuse and Neglect. NSPCC) https://www.nspcc.org.uk/globalassets/documents/research-reports/childmaltreatment- uk-executive-summary.pdf

[110] Gloucestershire Safeguarding Children Board, *Annual Report 2016/17 and Business Plan 2017/18*, p. 29, http://www.gscb.org.uk/media/16609/gscb-annual-report-2016-17-10-final-040717.pdf



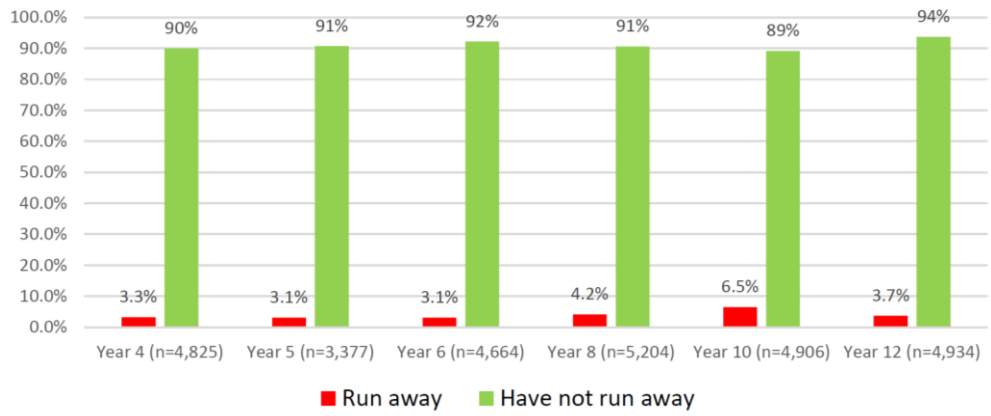
Source: Gloucestershire Constabulary

Data on Missing Children

Children and young people who go missing can be at risk of CSE. Children and young people go missing for a variety of reasons. There may have been a misunderstanding about what time they were due back or they may have been the victim of a serious crime. The job of the authorities is to record and investigate missing person reports in order to work to prevent children and young people from being harmed and/or exploited.

There tends to be limited data available on missing child incidences. The online pupil survey gives some data on children and young people running away in the last 6 months. This suggests it is an issue that affects a small minority of children with a peak incidence in year 10 (approx. 14-15 years old). Children may run away multiple times.

Figure 14: children and young people who have runaway from home in the past 6 months



Of the children who went missing in Gloucestershire 2016[111] the following statistics have been gathered

- There are on average 4 missing episodes every day
- 58% of the cohort only go missing once
- 28% have attendance levels at school of less than 90%
- 33% are thought to be at risk of CSE

Local Service Provision

Multi Agency CSE Team

To help tackle this issue in Gloucestershire, the CSE Team has been established. This is a multi-agency team including representatives from Children's Social Care, the Police, Youth Support and a voluntary sector provider. The team provides a coordinated response to concerns about children and young people who are at risk of CSE and supports young people and their families be they at risk of and/or victims of CSE. This team also provides strategic leadership across the agenda.

The role of the Multi-Agency Strategy Meetings

These meetings are key to ensuring there is a robust and multi-agency process for discussing all children and young people where there are concerns about CSE, missing children and/or being trafficked. The meetings include professionals who are working with individual victims or young people at risk and are key to ensuring concerns are reviewed and referred to the MACE Panel as appropriate.

The Role of MACE Panel (Multi-Agency Child Exploitation Panel)

The MACE Panel is a monthly meeting co-chaired by the MACE Police Lead and the Head of Service with Sexual Exploitation Lead for CSE in Gloucestershire. Its main purpose is to develop and maintain a detailed overview of the profile of CSE in Gloucestershire. Cases are not usually be discussed at the MACE Panel unless they have previously been referred into MASH and discussed at a multi-agency strategy meeting. This ensures that any risk to the child has been managed in a timely and appropriate manner as well as enabling the MACE Panel to maintain a strategic overview of CSE.

The Gloucestershire CSE group operates under the following priority areas. This is a summary of some key aspects and greater detail is available in the CSE strategy and associated action plan.

Awareness Raising:

- Annual CSE conference and Missing awareness day
- Chelsea's' Choice programme delivered in schools to raise awareness and educate children. This is in collaboration with the Gloucestershie Healthy Living and Lifestyles team in schools
- Staff training to raise awareness in frontline staff

[111] Gloucestershire Community Safety Strategic Needs Assessment, December 2017

- Business engagement work. Recent successes have included awareness training for taxi drivers

Early Identification and Protection

- Clear inter agency pathways for referrals is in place
- Multi agency meetings to ensure co-ordinated multiagency response for those at highest risk
- CSE transitions group to ensure continuity for young people transitioning to adult services

Brining Perpetrators to Justice

- An intelligence informed approach that maintains close links between police and other agencies

Intervention and Support

- Focus on ensuring young people and their families have appropriate support available to them throughout the disclosure process and beyond.
- Embed CSE commissioning into core children's services to influence positive outcomes

Strong governance

- Clear governance frameworks are in place and essential data collection and sharing protocols have ben developed.

Evidence around What Works

In 2017, Public Health England published a literature review identifying the latest research about effective interventions to prevent child sexual exploitation[112].

The research literature indicates that an effective response to CSE is one that:

- Is collaborative and multi-agency, with clear roles and responsibilities and clear lines of communication and accountability within this;
- Takes learning from the national context but is locally informed and based on an up-to-date understanding of the local profile;
- Is contextual, both in terms of locating CSE within a wider context of risk and harm and moving beyond a case by case response;
- Straddles both the preventative and responsive agendas; and
- Focuses on both victims and perpetrators.

The response can be considered under the interconnected themes of Prevention, Protection and Prosecution and disruption of perpetrator activity.

Prevention:

[112] https://www.gov.uk/government/publications/child-sexual-exploitation-prevention-and-intervention

Work with Children and Young people

Research has demonstrated a need for universal education programmes with children and young people to address their documented lack of/misunderstanding around CSE. It also demonstrates the need to educate around the closely related concepts of consent, healthy and unhealthy relationships, pornography and the unacceptability of (sexual) violence and abuse and an apparent gap between children's and young people's conceptual understanding of sexual harm and the ability to identify this in their own lives. There is no evidence to support a single way of delivering prevention activities but there is evidence around the following principles:

- Education and awareness raising being seen as an on-going process rather than a discrete deliverable
- Educative work commencing in an age-appropriate manner with primary aged children, given the increasingly young age at which children are now being referred for concerns around CSE
- Locating discussions of CSE with reference to wider constructs of gender, power and sexuality and challenging harmful social norms in relation to these
- Exploring links with related issues such as drug or alcohol misuse or going missing
- Using educative opportunities to minimise likelihood of perpetration as well as victimisation
- Adopting a strengths-based approach that considers resilience alongside risk
- Ensuring that messaging is of relevance to, and accessible for, all children and young people, irrespective of their individual biographies
- Ensuring children and young people outside of mainstream education also receive appropriate education
- Recognising the importance of a safe environment when delivering these messages (and recognising that the school environment, or community environment, may itself be a site of risk)
- Educating parents/carers and wider communities about the importance of preventative work with children and young people;
- Ensuring accurate and consistent messaging across different methods, audiences and settings
- Exploring the use of resources made by young people for young people
- Messages being delivered by 'credible individuals' who are confident discussing these issues and gently challenging unhelpful perceptions
- Provision of accessible and appropriate support mechanisms should issues of concern be identified by children and young people, their friends or family, or those working with them

The above educational work should be supplemented with targeted preventative work with groups known to be at heightened risk. There should also be a focus on enhancing resilience in children.

Work with parents and Carers

There is a limited evidence base around working with carers and parents but what does exist indicates the critical role this group can have and their need for greater understanding of the risks of CSE and a greater confidence in supporting their children and young people around those risks. Principles of practice that the evidence supports include:

- Working in partnership with parents/carers (and other families members as relevant);
- Recognising the value of a strengths-based approach;

- Helping parents/carers to create and maintain open lines of communication with their children and young people;
- The provision of accessible resources that complement those provided to children and young people; and
- The ability to respond flexibly to different needs and circumstances.

Work with Professionals

The evidence demonstrates some common themes around missed opportunities to identify CSE amongst professionals with safeguarding responsibilities. These are

- The presence of victim-blaming and harm-minimising conceptualisations of abuse amongst adolescents;
- Inadequate levels of professional curiosity;
- Insufficient challenge of harmful stereotypes around gender, ethnicity, victimisation and perpetration;
- Difficulties in reconciling practice tensions between confidentiality commitments, clinical needs and the identification and reporting of safeguarding concerns

In the context of the above as areas for redress the existing evidence offers some core principles that all professionals should embed in practice. These include:

- Clarity as to their safeguarding responsibilities and local reporting routes in relation to this
- Knowledge of local inter-agency working practices, and clarity around distinct roles and responsibilities and information sharing within this
- Recognition that all under 18s are entitled to protection and support from the state and understanding that our statutory duty to safeguard does not depend on a young person's desire to be safeguarded
- Recognition of the need to proactively assess risk and exercise 'professional curiosity', together with the provision of skills of how to do this in practice
- Moving beyond stereotypes to recognise the different forms that CSE can take, the different people who can perpetrate this and the fact that any child or young person can be affected by this
- Recognising the potential overlap between 'victim' and 'perpetrator' within peer on peer abuse
- Understanding of the interconnected nature of vulnerability, resilience and risk
- Recognition of the complex ways in which a young person's capacity to make choices and their understanding of consent can be abused
- Understanding of the impact of trauma on behaviour and presentation
- Understanding of the many different forms that 'disclosure' can take, and an understanding of disclosure as a process rather than a discrete event
- Recognition of the power of professional reactions to facilitate or close down access to support and protection
- Practical skills in facilitating conversations with children and young people and creating safe spaces for disclosure or identification of risk
- Ensuring access to support is not dependent on a disclosure

- Setting a positive example through a zero tolerance approach to any form of sexual harassment, bullying or abuse.

The evidence also highlights the impact that working on such issues can have on professionals. The research emphasises the need for appropriate support and supervision of professionals to ensure they are able to perform well and are not negatively impacted by working in such a challenging arena.

Work with Wider Communities

In terms of identification and reporting of risk, research is increasingly illustrating the critical preventative role that can be played by individuals outside of the child or young person's immediate circles of influence. This includes, for example, individuals working in the service industries or individuals living near party houses or other hotspots for abuse such as takeaways, shopping centres, parks and red light districts. Recent years have seen an increased focus on community awareness-raising but these efforts vary considerably and often lack strategic co-ordination.

Lack of awareness and misconceptions about CSE amongst the general public can leave children and young people at considerable risk. It can also result in those who experience abuse being blamed. So too can a culture of denial, resulting from community taboos or a fear of damaging community reputation.

Though still in its infancy, research into community awareness-raising around CSE suggests that the following considerations may begin to construct a helpful scaffolding for such initiatives:

- Agencies working in partnership with community members and groups to identify joint solutions to the problem;
- Recognising that communities are not homogeneous entities and ensuring that 'community representatives' reflect the full range of interests within a community;
- Developing a range of resources and providing a range of engagement options to meet the different needs of different members of the community;
- Ensuring local relevance, rather than just 'importing' programmes from elsewhere and making sure community messaging is relevant to local manifestations of the problem; and
- Providing appropriate and accessible sources of further support and contact.

Protection

Protection incorporates both targeted early intervention work with "high risk" cases and also recovery and integration work for those who have been exposed to abuse. While this could in some ways be considered preventative in terms of minimising risk and preventing further abuse in the future, it is quite distinct from the primary preventative intervention in the previous section.

The evidence base demonstrates the importance of early identification of risk and the implementation of early intervention measures to manage this risk, enhance protective structures and reconstruct safety. This should include targeted protective work with:

- Individuals who are known to have significant or multiple vulnerabilities that would heighten their risk of CSE (a previously sexually abused child whose peers or siblings are being sexually exploited, for example)
- Those who are exhibiting indicators of potential exploitation or grooming (going missing, unexplained money and STI's for example).

The evidence base also demonstrates a need for recovery and reintegration work with those who have already been abused through CSE. This can require restoration of psychological and relational safety alongside the more obvious concern of physical safety. This requires a long term investment, and for some the support may need to continue into adulthood requiring a smooth transition between child and adult services.

Prosecution and Disruption of Perpetrator Activity

The disruption and prosecution of offenders can contribute to the protection of children and young people and to the prevention of further abuse. The evidence suggests that public heath and partners can contribute to this in a number of ways

- Changing public attitudes around CSE to increase recognition and reporting
- Delivering systems that identify and support the needs of children and young people engaging with the criminal justice system as victims or witnesses.
- Promoting systems of partnership working and evidence sharing amongst different professions. Greater clarity and confidence around information sharing is likely to be required before this potential contribution to disruption and prosecution can be fully realised.

Discussion, Gap Identification and Recommendations

Strengths in this area:

- Gloucestershire has an established, dedicated CSE team to work as a multi agency group to address the issue of CSE
- Good partnerships have improved understanding of and response to targeted areas of concern.
- The CSE local strategy incorporates many of the aspects identified in good practice evidence reviews

Areas of Concern

- Understanding of the extent of the issue locally is still in the early phases
- Understanding of the complexities across a range of exploitations beyond sexual and how they impact upon vulnerable young people is still in its early phases.

Recommendations

Continue to grow local understanding of the area and embed the principles of prevent, protect and pursue to ensure the risks posed by CSE are mitigated for all children in Gloucestershire .

Children in Contact with Children's Services

Children in Contact with Children's Services

Introduction

Most children are able to lead happy and healthy lives without the need for specialist or targeted services. However, others have needs which go beyond the scope of universal services and require specialist support. These children are those that will need children social services input. The level of input can range from light touch services contact to going into care. This section will present an overview of this range of service levels and look at some of the data behind them. It will look at statistics around Children in Need (CIN), Children who are subject to a Child Protection Plan (CPP) and Children in Care (CiC) also referred to in the literature around this topic as Children looked after or Looked After Children (LAC).

Definitions:

The definitions around Children in Need, Child Protection Plans and Children in Care/Looked after Children are intuitive to many who work in the area, but can be confusing to those who are not routinely exposed to them. For clarity the following definitions will be used in this section.

A **child in need (CIN)** is defined as a child who is unlikely to achieve or maintain a reasonable level of health or development, or whose health and development is likely to be significantly or further impaired, without the provision of services[113]. This group includes children with disabilities as well as those who may have social issues that affect their wellbeing. Early identification of these children is vital with interventions implemented promptly to ensure good health, education and social care outcomes.

A child can become subject to a **child protection plan (CPP)** after a child protection conference is triggered. This could be for a wide range of issues but is likely to have a safeguarding component to it. At the child protection conference the child (where appropriate), family members and health, care, education and other professionals and practitioners involved in a child's future safety, health and development draw up a plan to keep the child safe, improve things for the family and identify support that is needed. Support is offered to ensure the plan is followed.

A **child in care (CiC)** is defined as a child cared for by a local authority if a court has granted a care order to place a child in care, or a council's children's services department has cared for the child for more than 24 hours. CiC are monitored closer than other children because of the higher probability of them having poor outcomes in education, physical and mental health[114]. These outcomes further deteriorate if they experience multiple relocations.

[113] Government, *Children's Act 1989*. 1989.
[114] PHE, *Public Health Outcomes Framework - Overarching Indicators*. 2016.

Where possible issues in a child's life should be identified and addressed early to prevent escalation and the need for more intensive services at a later date. The early help framework has been established to facilitate this and is discussed in more detail later in this section.

Research confirms late entrants into care are more likely to have multiple placements; be in high cost residential placements; be more at risk from going missing from placement and have poorer outcomes from children who came into care at an earlier age or who avoided coming into care at all.[115][116]

Policy Context

National:

The Children Act 1989 set out duties to local authorities, courts, parents, and other agencies to ensure children are safeguarded and their welfare is promoted. It centres on the argument that children are best cared for within their own families but also makes provisions for instances when parents and families do not co-operate with statutory bodies.

The Children and Social Work Act 2017 is being implemented and duties come into force from April 2018. These include changes to the legislation for looked-after and previously-looked after children, and care leavers, introducing:

- corporate parenting principles to which local authorities must have regard when exercising their functions in relation to looked after children and care leavers up to the age of 25
- extended eligibility for support from a personal advisor to all care leavers up to 25
- a requirement to consult on and publish a local offer for all care leavers.

In *Every Child Matters*, a Government Green Paper informed by the findings of the inquiry into the death of Victoria Climbie. The government at the time contended that "We need to ensure that we properly protect children at risk within a framework of universal services which support every child to develop their full potential and which aim to prevent negative outcomes."

The Children Act 2004 amended the Children Act 1989 largely in consequence of the Victoria Climbie inquiry. The Act promotes co-ordination between multiple official entities to improve the overall wellbeing of children. It brings all local government functions of children's welfare and education under the statutory authority of local Directors of Children's Services.

The Governments 'Working together to safeguard children 2015: A guide to inter-agency working to safeguard and promote the welfare of children' guidance sets out the legislative requirements and expectations on individual services to safeguard and promote the welfare of children and a clear framework for Local Safeguarding Children Boards (LSCBs) to monitor the effectiveness of local services. The guidance is to help leaders, managers, professionals and providers understand what they need to do, and what they can expect of one another, to safeguard children. It focuses on core legal requirements, making it clear what individuals and organisations should do to keep children safe.

The NICE quality standard, *Looked-after children and young people [QS31]* details the recommended service specification to ensure the health and wellbeing of LAC from birth to 18 years and care

[115] DfE, *Fostering and Adoption: Placement stability and permanence*. 2014.
[116] Boddy, J., *Understanding Permanence for Looked After Children: a review of research for the Care Inquiry.* 2017.

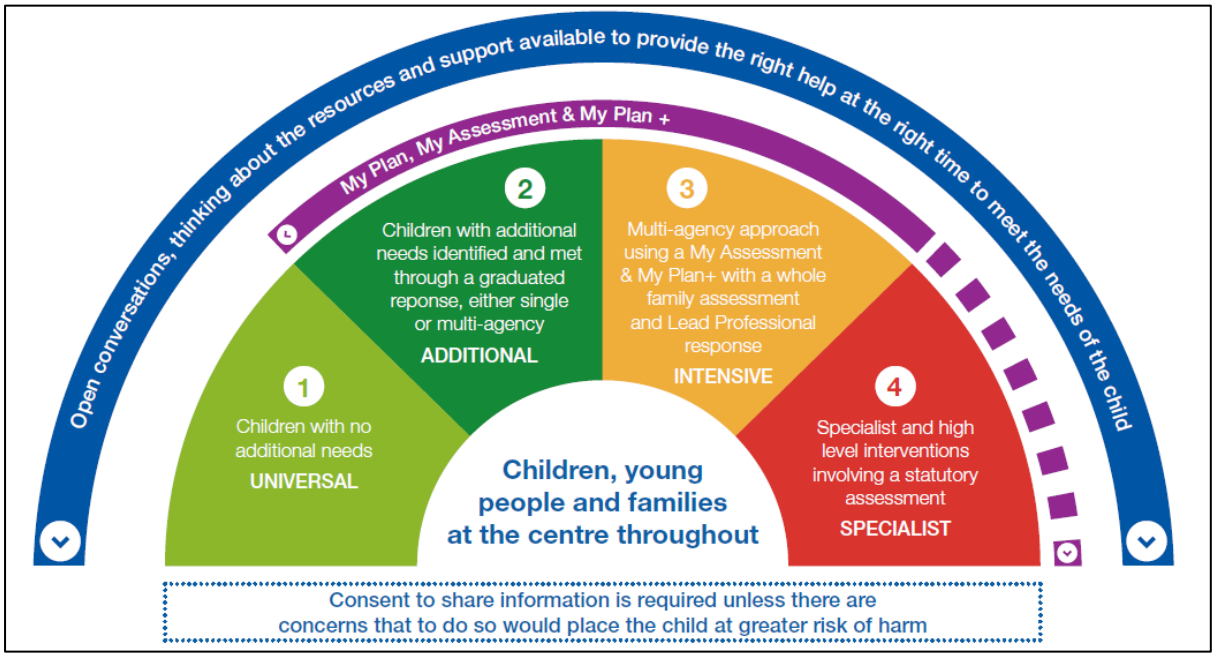
leavers (including young people planning to leave care or under leaving care provisions) across all settings and services irrespective of where they live.

A Government programme of work is in progress to improve understanding of the educational experiences and outcomes of all children with additional needs, and those who live in challenging circumstances including a review of outcomes for children in need.

Local Context:

The Jan 2018 document "Gloucestershire's Levels of Intervention Guidance – Working Together to Provide Early Help, Targeted and Specialist Support for Children and Families in Gloucestershire" provides detailed information on the local policy for working with children and families in Gloucestershire and outlines the "Windscreen" approach to considering need and the continuum of services available to meet need. The importance of early help is recognised when working with children and young people; to take action as early as possible to avoid issues escalating and becoming entrenched and children being damaged from delayed intervention. The latest version of the Windscreen can be found at www.gscb.org.uk/i-work-with-children-young-people-and-parents/guidance-for-working-with-children-and-young-people/ and the diagram (as at Jan 2018) is depicted below.

The Windscreen – A diagram to demonstrate the Continuum of Need



The diagram locally identifies four levels of need, Universal, Additional, Intensive and Specialist. Services for children with additional and intensive needs are sometimes known as targeted services, such as additional help with learning in school, behaviour support, and extra support to parents in early years or targeted help to support young people through youth services.

Specialist services are where the needs are so great that statutory and/or specialist intervention is required to keep a child or young person safe or to ensure their continued development. Examples of specialist services are Children's Social Care or the Youth Offending Service. The local guidance

provides a way of working together to ensure public money and resources are used effectively to bring about positive change for children and families in Gloucestershire.

The Windscreen, Levels of Intervention guidance and supplementary guidance for professionals working with children and young people within Gloucestershire can be found on the Gloucestershire Safeguarding Children Board website(www.gscb.org.uk).

Epidemiological Data Review

Work is in progress to provide a summary overview of statistics around Children in Need, Children who are on a Child Protection Plan and Children in Care. This will be called the ChAT (Children's Services Analysis Tool) and should be referred to as an up to date picture of activity in children's services.

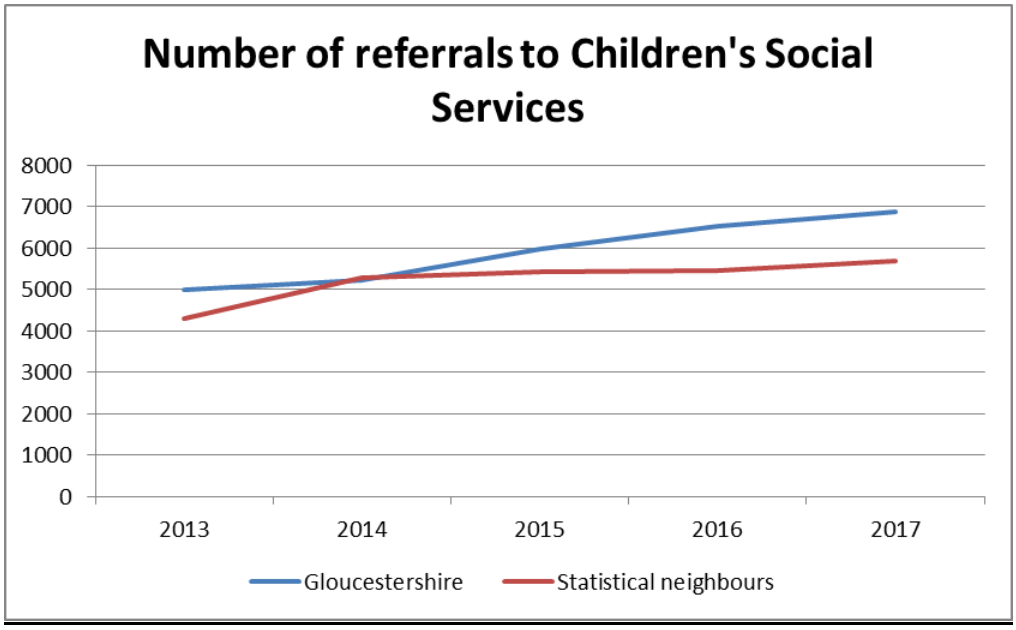
This document makes use of the currently available, nationally comparable data. Annualised data on children in contact with children's services is available from LAIT and this is the main source of data referenced in this section.

Referrals to children's social care services

Children's Services can be contacted by a variety of professionals or by a member of the public who have a concern regarding a child's safety. On receipt of a contact, 'Front door' Teams will investigate the claim and decide how to proceed. They will decide whether the case needs to be referred to Children's Social Care Assessment teams, referred to Early Help professionals or requires no further action. The Children's Social Care Assessment team may decide; the child needs no further action, should be subject to a Child in Need Plan or a Child Protection Plan or that they should apply to the court to take the child into the care of the authority.

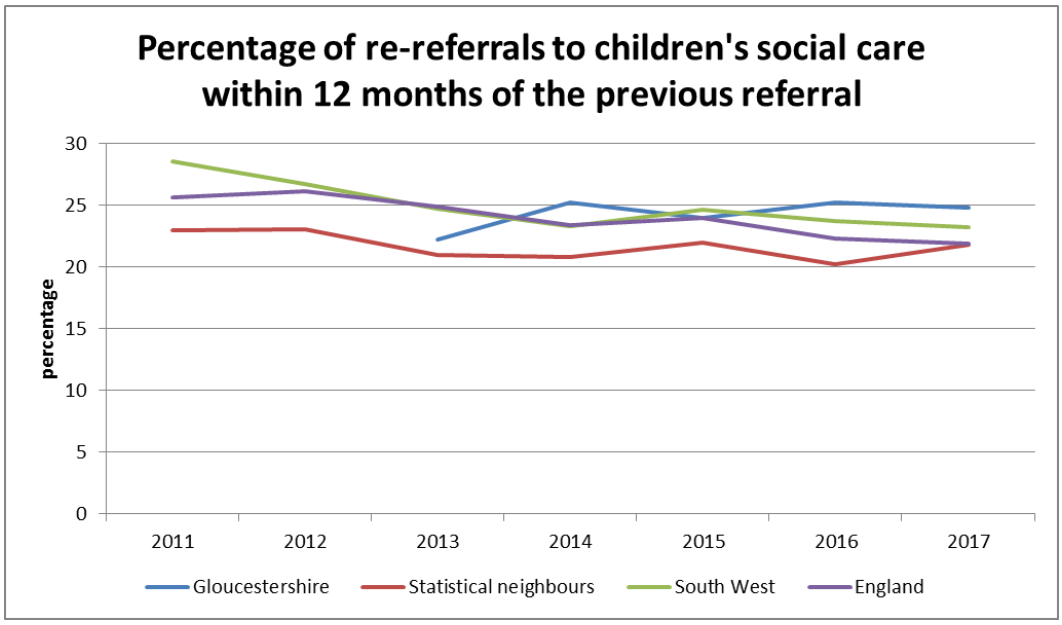
Gloucestershire has above average numbers of referrals to its children's social services than its statistical neighbours. Numbers of referrals are increasing across all comparators but since 2013, in Gloucestershire these have increased by 5.5% more than its statistical neighbours. This may be due to 'Front door' teams being more risk averse than our statistical neighbours or it may be a nuance of how different local authorities consider a contact and record referrals.

Graph to show change in numbers of referrals to children's social care services in Gloucestershire and its statistical neighbours between 2013 – 2017.



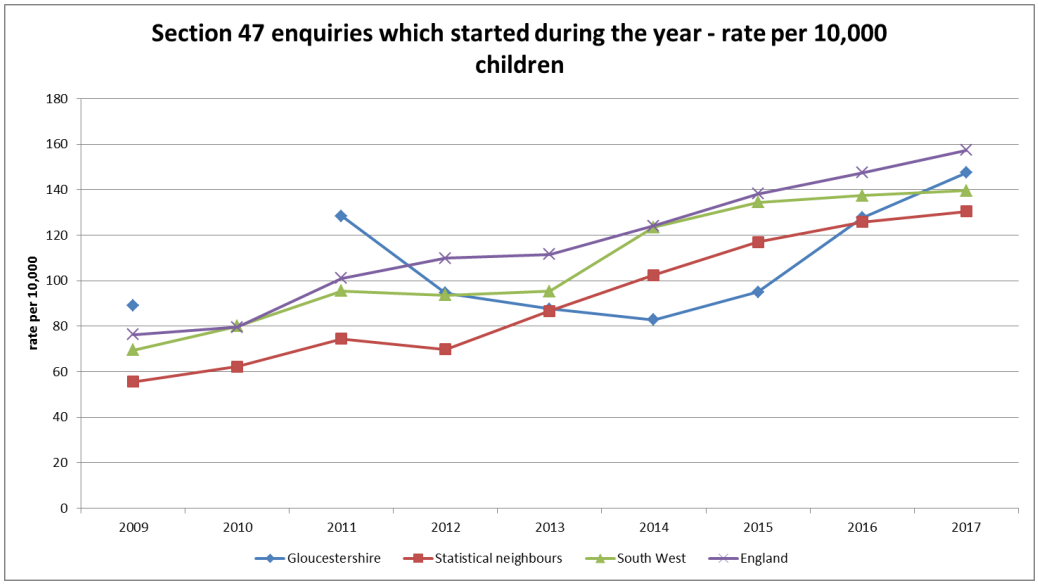
The chart below shows Gloucestershire has on the whole a higher percentage of re-referrals to its social care services than all its geographical comparators. This could be that cases are being closed too quickly and/or children and families have unmet needs that emerge subsequently.

Graph to show percentage of re-referrals to children's social care services within 12 months of the previous referral in Gloucestershire and its comparators between 2011 – 2017.



Following a referral, a section 47 enquiry is initiated to decide whether and what type of action is required to safeguard and promote the welfare of a child who is suspected of or likely to be suffering significant harm. Local authority social workers have a statutory duty to lead assessments under section 47 of the Children Act 1989. The police, health professionals, teachers and other relevant professionals should help the local authority in undertaking its enquiries

The rate per 10,000 population of section 47 enquiries in Gloucestershire fell between 2011 and 2014 when it started to rise again. At roughly 130 per 10,000 population it is now slightly above the regional and statistical comparators but below the England average.



One potential outcome of a section 47 enquiry is that a Child Protection Plan (CPP) is put in place for a child. The child protection plan sets out:

- how social services will check on the child's welfare
- what changes are needed to reduce the risk to the child
- what support will be offered to the family.

Case conferences to review the plan will continue at regular intervals until the child is no longer considered at risk of significant harm or until they are taken into care.

Children in Need (CIN)

Children in need are defined in law as children who are aged under 18 and:

- need local authority services to achieve or maintain a reasonable standard of health or development
- need local authority services to prevent significant or further harm to health or development
- are disabled

The local authority must keep a register of children with disabilities in its area but does not have to keep a register of all children in need.

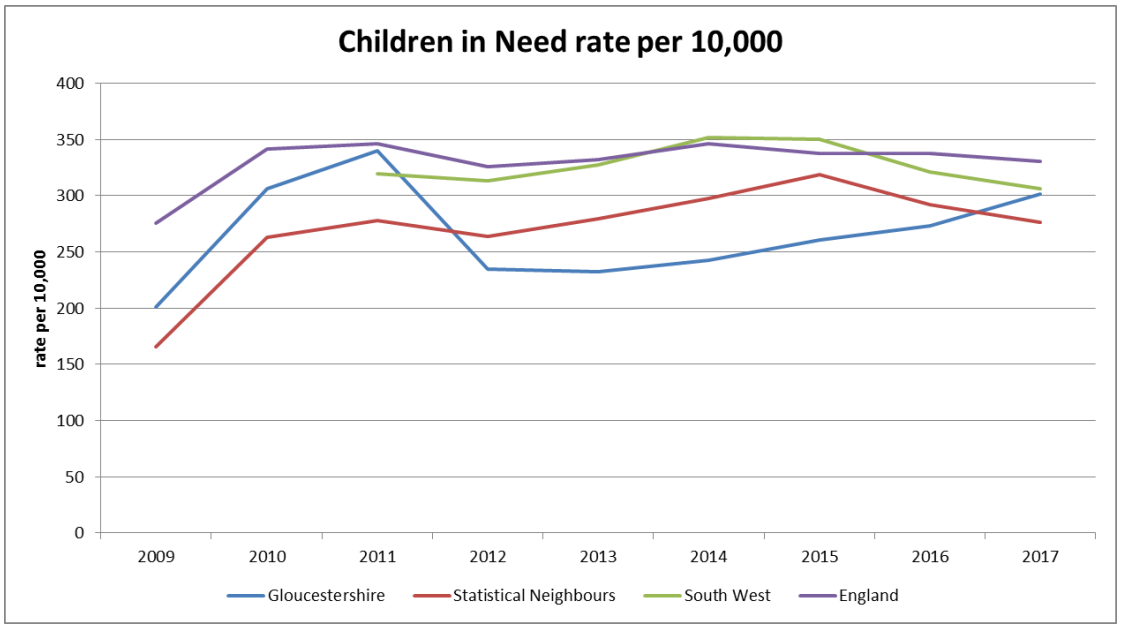
Rates of Children in Need by 10,000 population

Analysis of rates per 10,000 population gives a standardised indicator taking into consideration the fact that different localities have different numbers of children in their population. This allows for a more informative comparison between localities having adjusted for inter locality variations in the

numbers of children and young people. The rates of CIN per 10,000 population for Gloucestershire, its statistical neighbours, the South West and England is shown below.

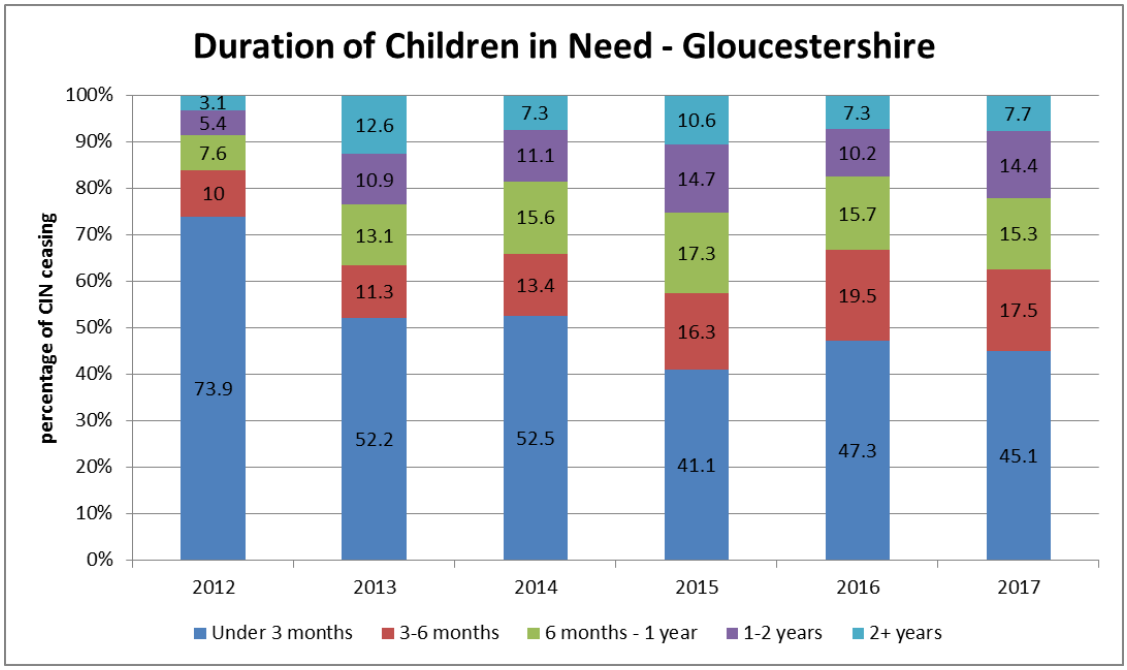
The chart shows that Gloucestershire has a lower rate of Children in Need than its geographic comparators, apart from the last year. There was a significant decrease in the rate between 2011 and 2012 which is thought to be largely down to implementation of a new reporting system and related migration of data. Since 2013, there has been a steady increase in the rate of CIN in Gloucestershire. A similar increase has not been seen in statistical neighbours and the South West. In the last 2 years Gloucestershire has seen a notable increase in its rate of Children in Need bucking the trend of its comparators which have seen a decrease.

Graph to show rates of CIN per 10,000 population for Gloucestershire and its comparators between 2009 - 2017



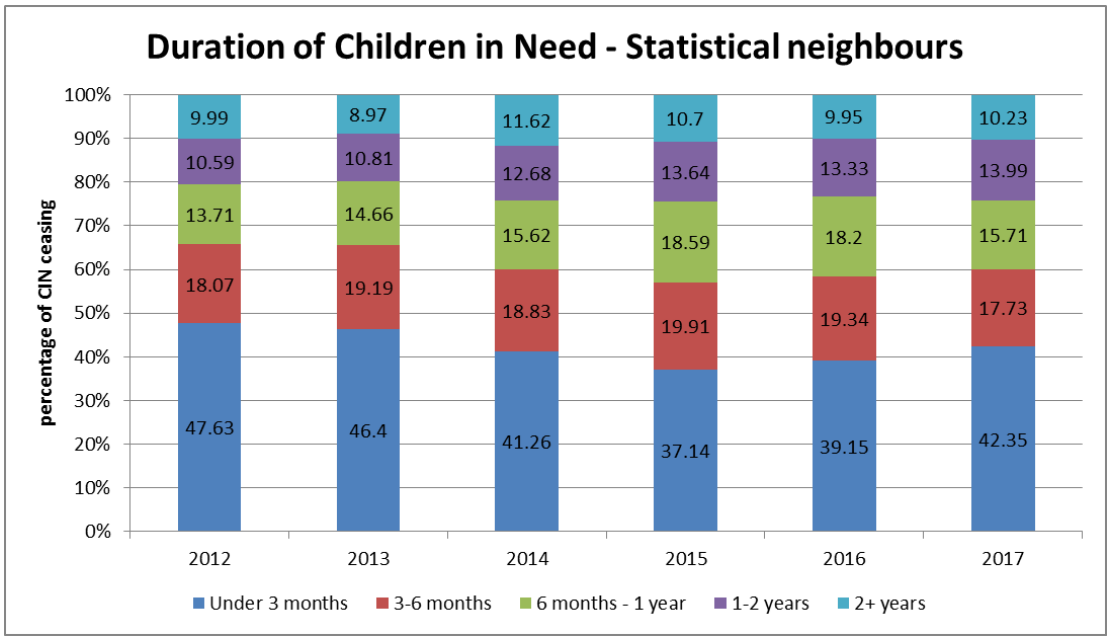
The graph below shows that the proportion of Children in Need receiving intervention/on a plan for up to 3 months has reduced over the last 5 years by almost a third. In contrast, the proportion of CIN in receipt of intervention/on a plan for longer durations has increased, by 7% for durations of 3-6 months and 6 months to 1 year and 9% for duration of 1-2 years. Over the last 5 years, there has been a generally increasing proportion of CIN in receipt of intervention/on a plan for 2+ years with a couple of notable peaks in 2013 and 2015.

Graph to show change in proportions of duration of children recorded as child in need at year end in Gloucestershire between 2012 – 2017.



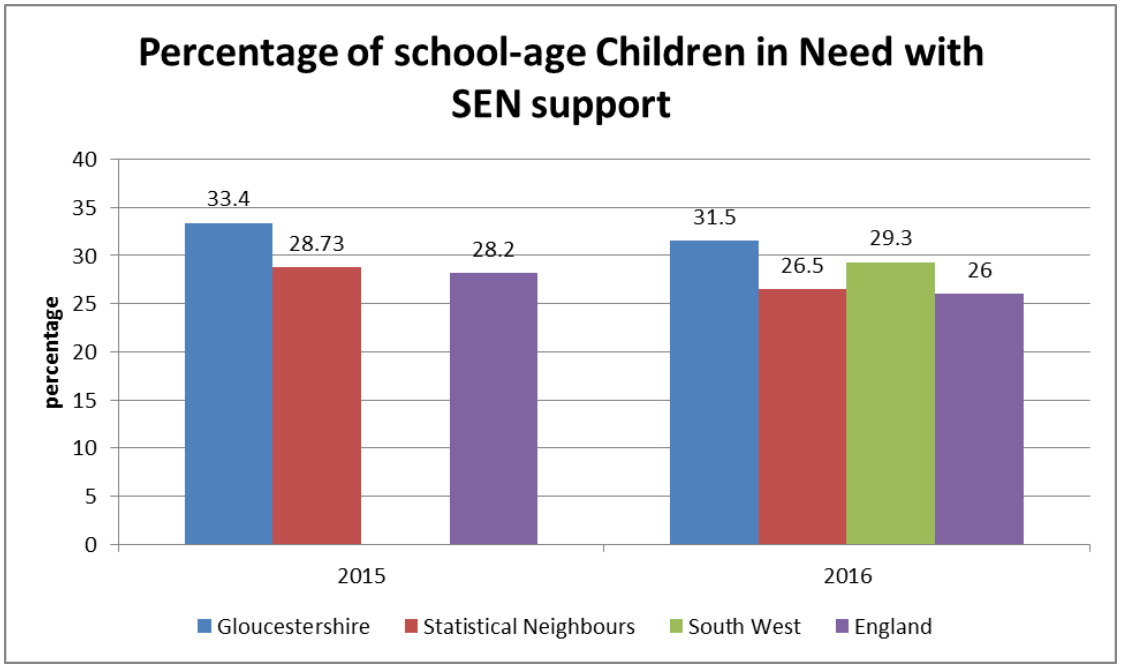
In comparison to statistical neighbours, although these have seen a similar decrease in the proportion of children in need receiving intervention/on a plan for up to 3 months, the decrease has been more gradual over the last 5 years than Gloucestershire's. The proportion of CIN in receipt of intervention/on a plan for longer durations has been steadier in our statistical neighbours than in Gloucestershire. This could be a reflection of population size smoothing the increase over the same period. Although there has been a generally increasing proportion of CIN in Gloucestershire in receipt of intervention/on a plan for 2+ years, in 2017 this proportion is lower on average by 2% than its comparators.

Graph to show change in proportions of duration of children recorded as child in need at year end in statistical neighbours between 2012 – 2017.



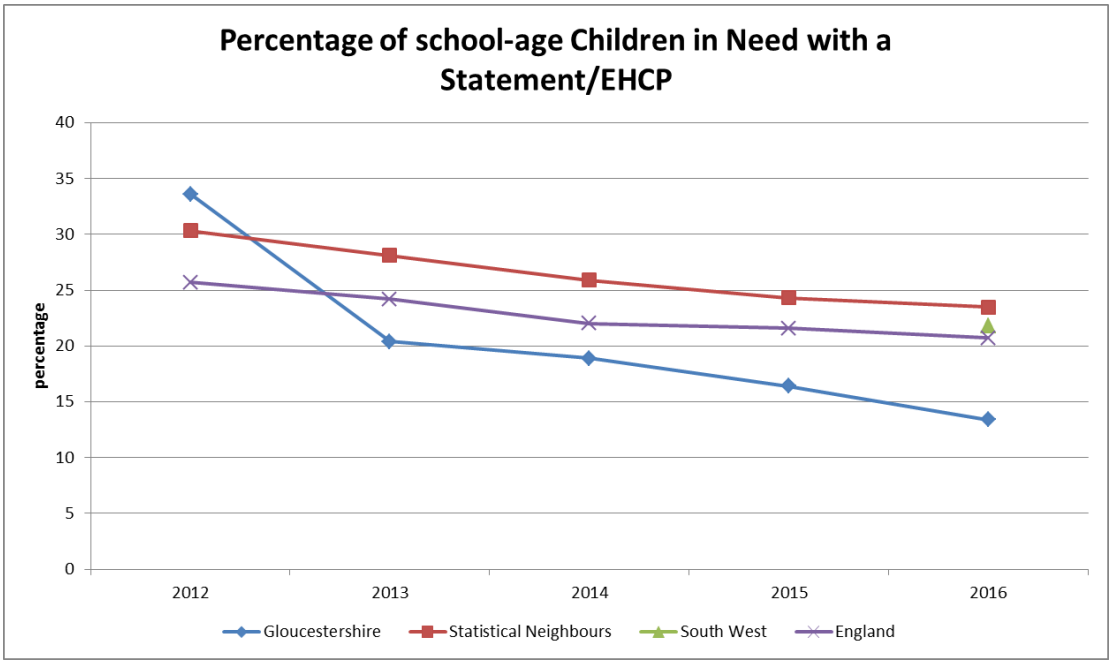
In Gloucestershire, around a third of school aged Children in Need are in receipt of SEN support. This is higher than other comparators. The section Children with Special Educational Needs and Disabilities in this report highlights the proportion of those with an EHCP/Statement who are classified as Children in Need or with a Child Protection Plan is much higher than in the Gloucestershire population as a whole and has been growing over the last five years.

Graph to show percentage of school-aged children in need with SEN support in Gloucestershire and comparators between 2015 – 2016.



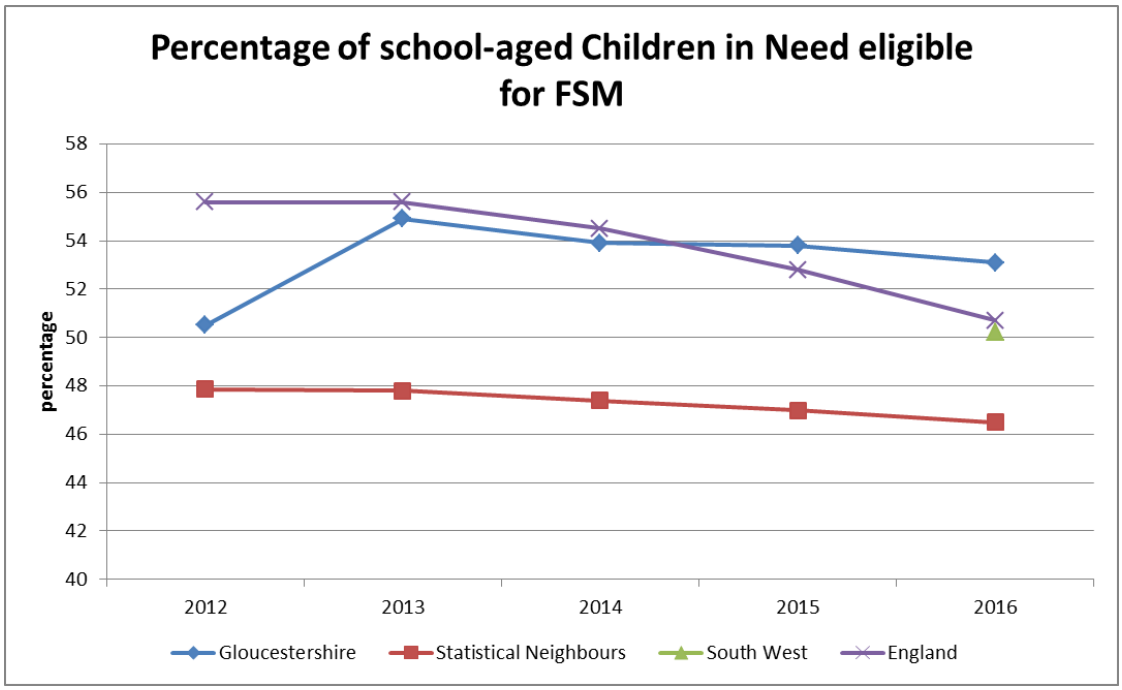
The proportion of school aged Children in Need with a Statement /EHCP has been reducing in Gloucestershire over recent years. This may be as a result of the overall Children in Need cohort increasing faster than those with a Statement/EHCP and thus reducing the overall percentage; it could also be attributed to more considered approach to SEN needs in this cohort.

Graph to show percentage of school-aged children in need with a statement/EHCP in Gloucestershire and comparators between 2012 – 2016.



The chart below shows that Gloucestershire has a notably higher than average proportion of Children in Need eligible for free school meals (FSM) –around 54% for most of the period shown, than its statistical neighbours. For the last two years this proportion has also been slightly higher than England, and for the last year also higher than the South West comparator although not significantly so.

Graph to show percentage of school-aged children in need eligible for free school meals in Gloucestershire and comparators between 2012 – 2016.



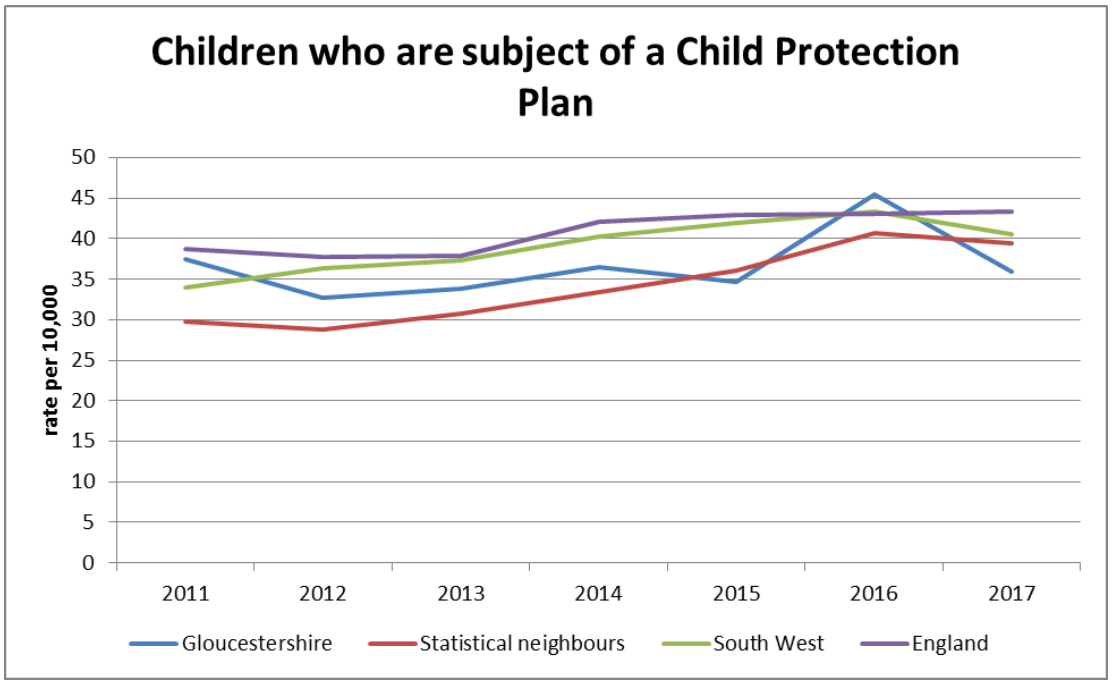
Children who are subject to a Child Protection Plan (CPP)

The local authority will decide whether a child protection plan is needed by taking into account the information discussed at the child protection conference. If the child protection conference decides that the child is suffering, or is likely to suffer, significant harm, the local authority will draw up a child protection plan.

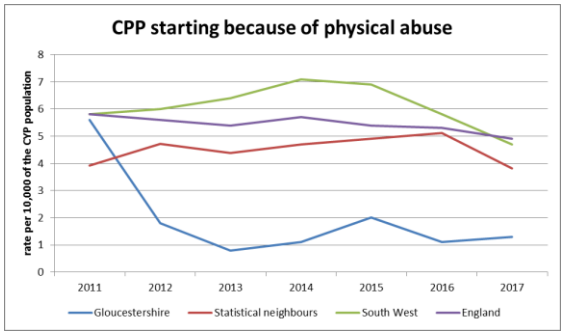
The chart below shows that Gloucestershire has generally had a higher rate of children on a CPP than its statistical neighbours. In 2016 there was a notable increase in the rate which exceeded that for all comparators but then an equally similar decrease leading to Gloucestershire having the lowest rate of children on a CPP in 2017 in comparison to all geographies for this year. The rate of children on a CPP has steadily increased in statistical neighbours and South West between 2012 and 2016 but the trend in Gloucestershire has been much more variable. The sharp increase in 2016 may be some what explained by the following:

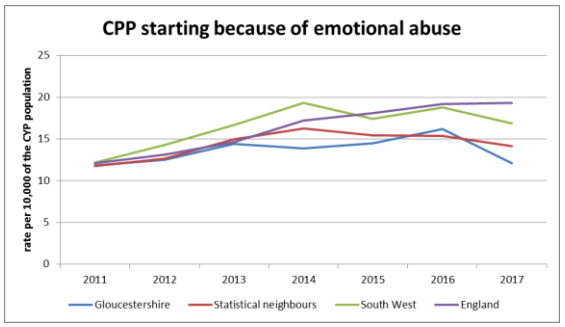
The figures in the chart relate the rate at the snapshot date (31st March of each year). In late 2015 the threshold for a child being escalated to a CPP in Cheltenham CYP Locality was lowered as it was felt to be higher than the other localities. This led to an increase of 140% in the number of children starting a CPP between April 2015 and December 2015 in Cheltenham, which was significantly higher than any of the other localities. There was also an issue of a backlog within the helpdesk and the Police cited in the October report that was suggested as a possible cause for a large increase in the preceding months. The following reduction at the snapshot 2017 point may be attributable to the settling of these factors, the pattern of plans starting and ending each month bears this out, with starts trending downwards, and plans ending increasing between April 2016 and February 2017.

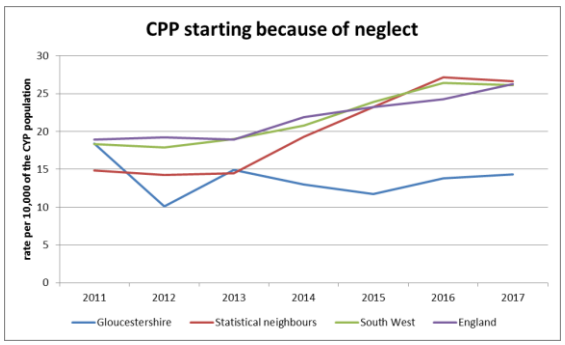
Graph to show rates of CPP per 10,000 population for Gloucestershire and its comparators between 2011 – 2017

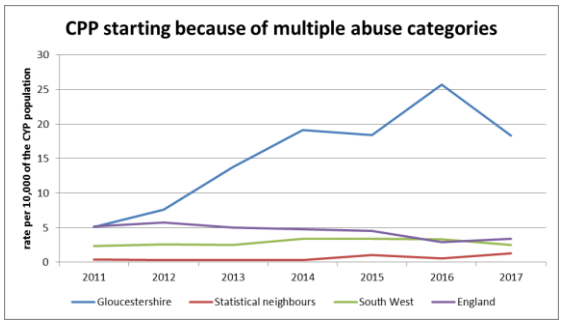


Graphs to show rates of CPP because of physical abuse, emotional abuse, neglect and multiple abuse per 10,000 population for Gloucestershire and its comparators between 2011 – 2017





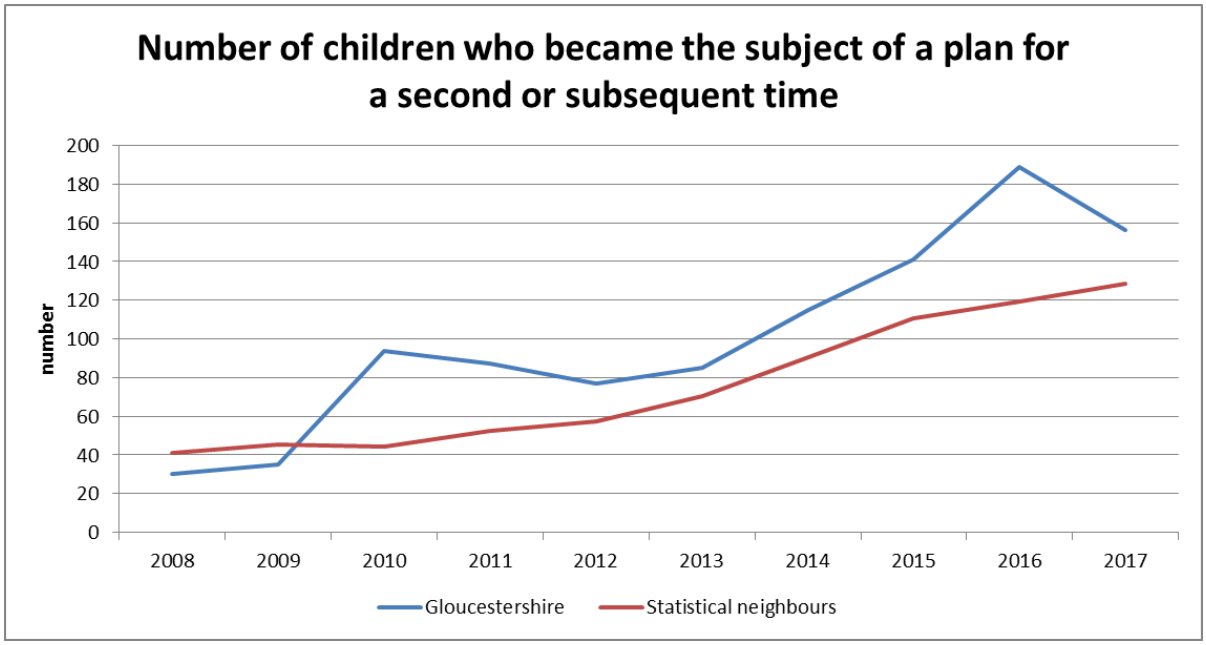




These graphs show that Gloucestershire has lower than average rates of children on CPP because of physical abuse, emotional abuse and neglect than its comparators particularly over the last 4 years. The rate of children on CPP because of emotional abuse has been more comparable to geographies. However, the rate of children on CPP because of multiple abuse categories in Gloucestershire is significantly higher than comparators. This analysis suggests that there is a different approach to the recording of children on CPP within Gloucestershire than its statistical neighbours.

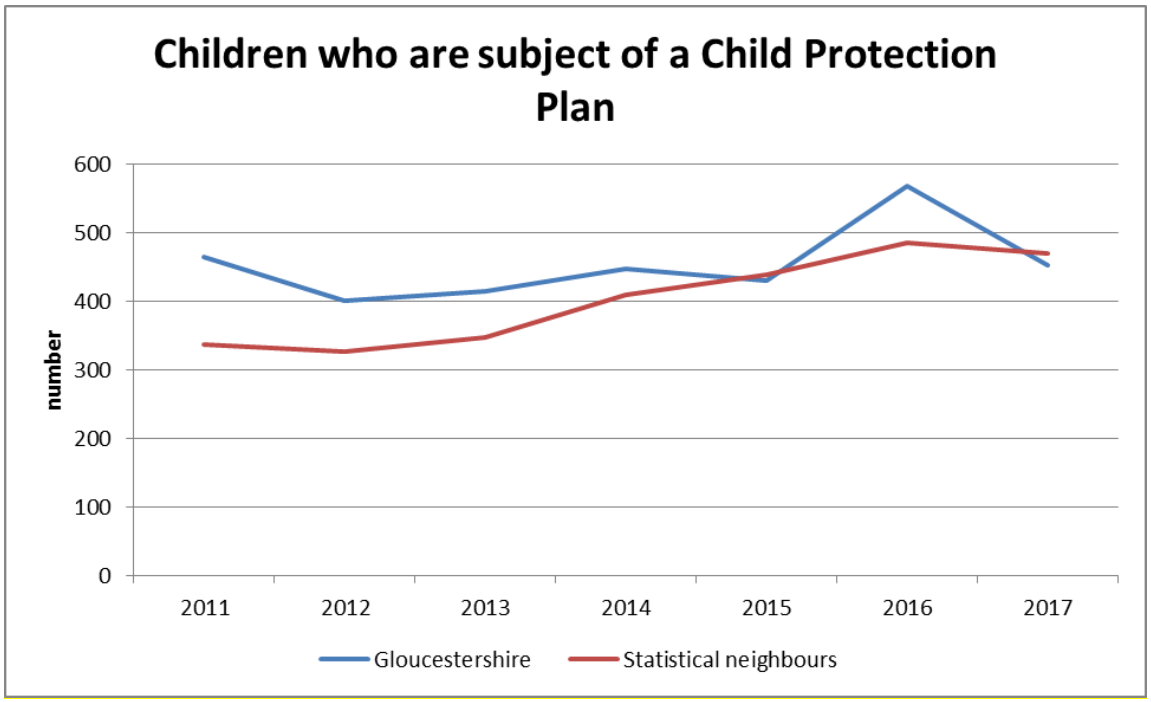
The graph below shows that since 2009, Gloucestershire has a concerning higher number of children on second or subsequent plans and since this time there have been several marked increases than its statistical neighbours.

Graphs to show the number of children who became subject to a CPP for a second or subsequent time for Gloucestershire and statistical neighbours between 2008 – 2017



The chart below shows that the number of children subject to a CPP in Gloucestershire has remained fairly stable (excluding 2016) since 2012. In relation to the chart above it suggests a higher proportion of children subject to a CPP are on a second or subsequent plan.

Graph to show the number of children who became subject to a CPP in Gloucestershire and statistical neighbours between 2011 – 2017



Children in Care:

A) Numbers of Children in Care in Gloucestershire

KEY FINDINGS- The absolute number of children in care is rising and the year end snapshot number has gone up by 17% over the last 5 years. A rise in numbers of children in care is being seen in our statistical and regional peers but, since 2014, the rate of children in care per 10,000 population is increasing faster in Gloucestershire than for our peer group.

The number of children in care can be looked at in several ways. This includes looking at the snapshot number in care at any one point in time or the number of children who have had at least one episode of care in a given year. In addition, it is possible to consider the number of children who entered care in a given year or conversely the number who left in a given year. Each of these measures is interrelated and will provide a slightly different insight. All these measures will be used at different points throughout this document to give the fullest possible picture of what is happening.

End of Year Snapshot Numbers and Children in Care Annual Movement Data

One way of looking at the numbers of children in care is to look at the total number of children who have been in care at any point over a 12 month period. The annual figures for each of the last five years for this indicator are given below. This figure is higher than the more commonly looked at year end snapshot number but gives an idea of the overall annual fostering capacity required.

Table to show the total number of children in care looked after in the 12 months up to 31 March for the last 5 years

All children looked after during the year ending 31 March excluding those only looked after under a series of short term placements					
	2013	2014	2015	2016	2017
Gloucestershire	705	740	760	840	885

The total number of children looked after per year has increased by 25% between 2013 and 2017. Interestingly, this is greater than the percentage increase in number of CiC at the snap shot year end date which has increased by 17% over the same period. This suggests that there are a growing number of less than 12 month placements taking place. Data around this is explored further in the section on placement duration.

The table below gives headline figures for the number of Gloucestershire children who entered care, left care and the snapshot number of children who were in care at the 31 March year end date.

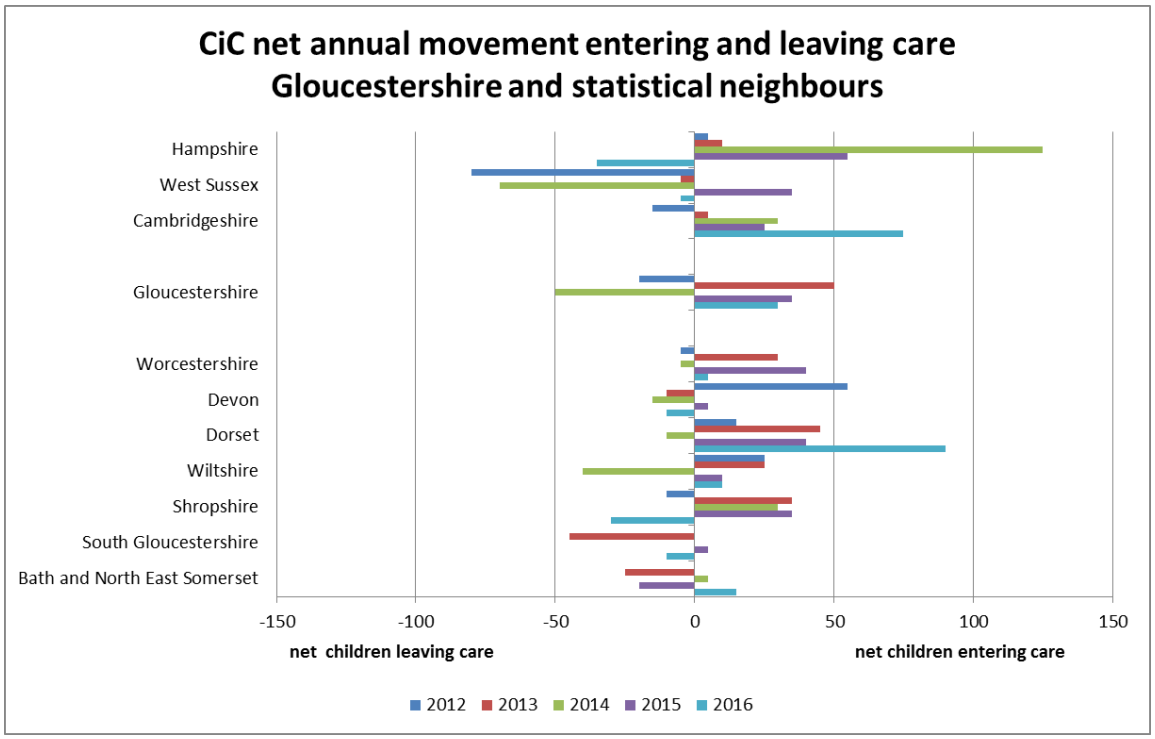
Table to show the annual movement of children into and out of care during the calendar year and the year end snap shot number

Children in Care annual movement						
Gloucestershire	2012	2013	2014	2015	2016	2017
CiC entering care in calendar year	180	250	225	285	330	335
CiC leaving care in calendar year	200	200	275	250	300	
Total CiC 31 March	460	520	480	520	560	610

There has been an 86% increase in the number of children entering care between 2012 and 2017. Although the number of children ceasing to be looked after has also increased, it is not to the same extent (increased by 50%). The relative increase in children entering care appears to be the driver for the increasing numbers in care overall.

The net movement is the difference between the children entering care and those leaving in any one year. If it is positive then more children entered care than left. If it is negative then more children left over the period than entered. The annual net movement figures for Gloucestershire and its statistical neighbours are illustrated below.

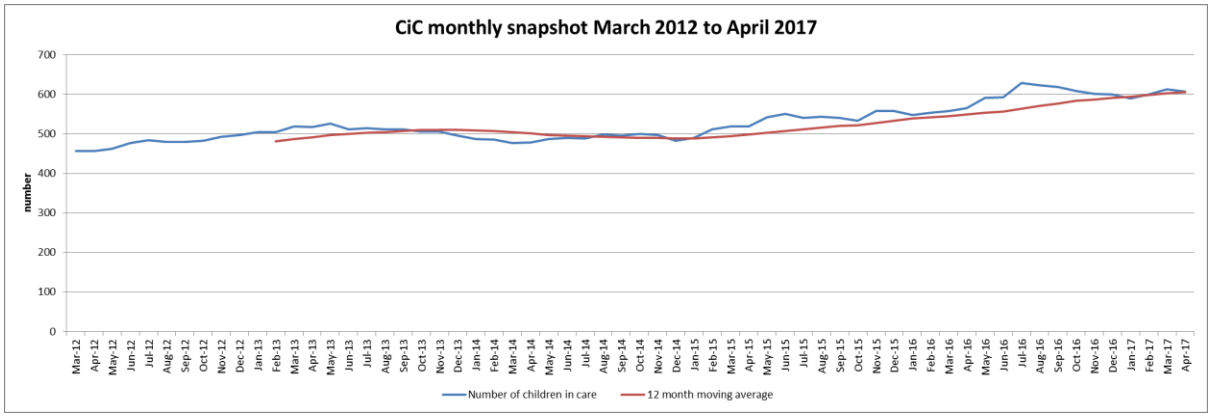
Graph to show the net annual movement of children entering and leaving care between 2012-2016 for Gloucestershire and its statistical neighbours



In Gloucestershire only 2 of the years included in the 5 year period shown above had a net outflow of CiC. This pattern is mirrored in that seen for our statistical neighbours.

The monthly snapshot of CiC in Gloucestershire is shown below. It shows that after remaining fairly static between March 2012 and March 2014 the monthly numbers of CiC has risen steadily between 2014 and 2017.

Graph to show monthly change in numbers of CiC in Gloucestershire between 2012 and 2017



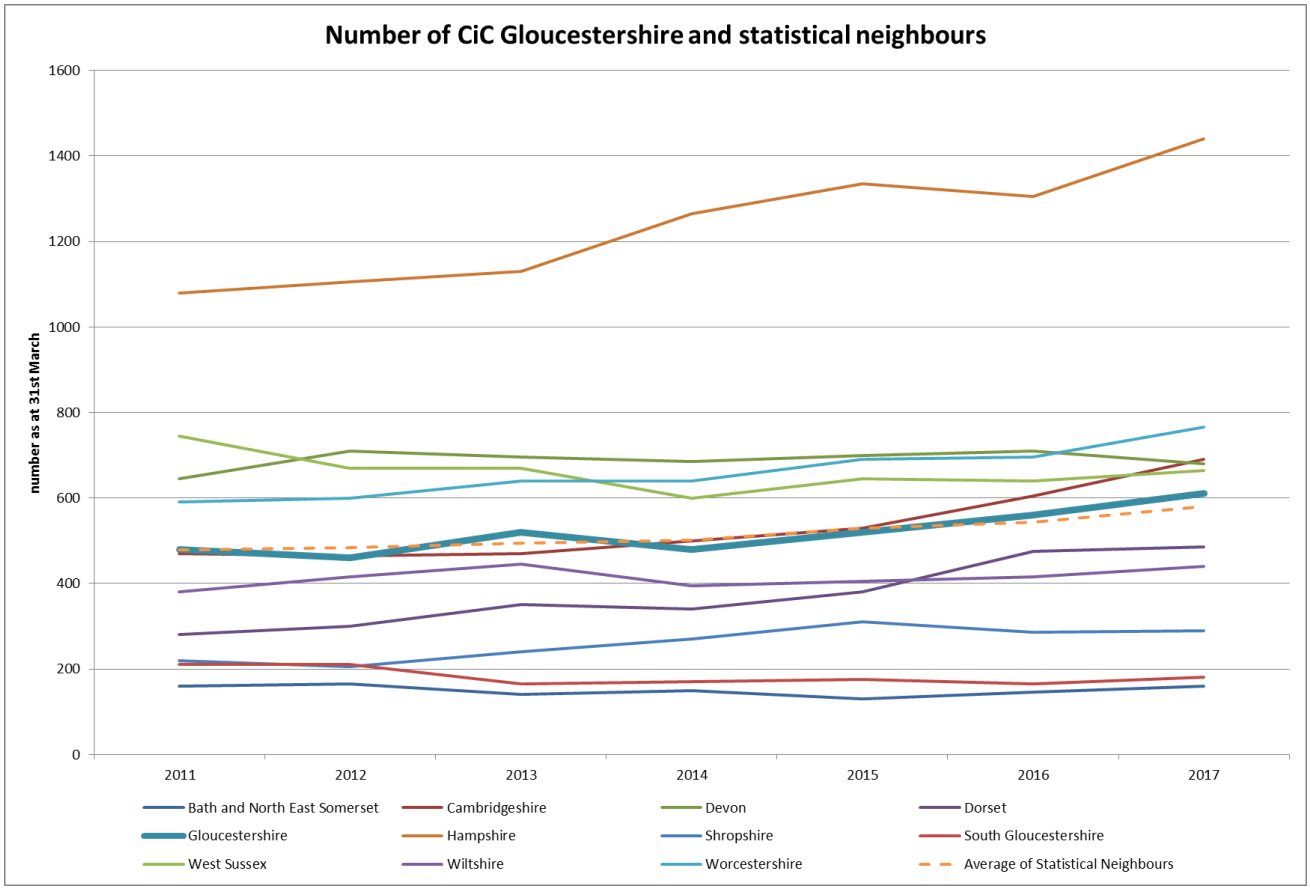
The trend in year end numbers of children in care for Gloucestershire and its statistical neighbours is given in the table below and illustrated graphically in the figure below.

Table to show number of children in care at year end for Gloucestershire and it statistical peers

Local Authority	2011	2012	2013	2014	2015	2016	2017
Bath and North East Somerset	160	165	140	150	130	145	160
Cambridgeshire	470	465	470	500	530	605	690
Devon	645	710	695	685	700	710	680
Dorset	280	300	350	340	380	475	485
Gloucestershire	**480**	**460**	**520**	**480**	**520**	**560**	**610**
Hampshire	1080	1105	1130	1265	1335	1305	1440
Shropshire	220	205	240	270	310	285	290
South Gloucestershire	210	210	165	170	175	165	180
West Sussex	745	670	670	600	645	640	665
Wiltshire	380	415	445	395	405	415	440
Worcestershire	590	600	640	640	690	695	765
Average of Statistical Neighbours	**478**	**484.5**	**494.5**	**501.5**	**530**	**544**	**579.5**

While this increase in numbers has not been seen for all statistical neighbours (see graph below) a similar pattern of steadily increasing numbers has been seen for many of them.

Graph to show the changed in number of children in care for Gloucestershire and its statistical neighbours

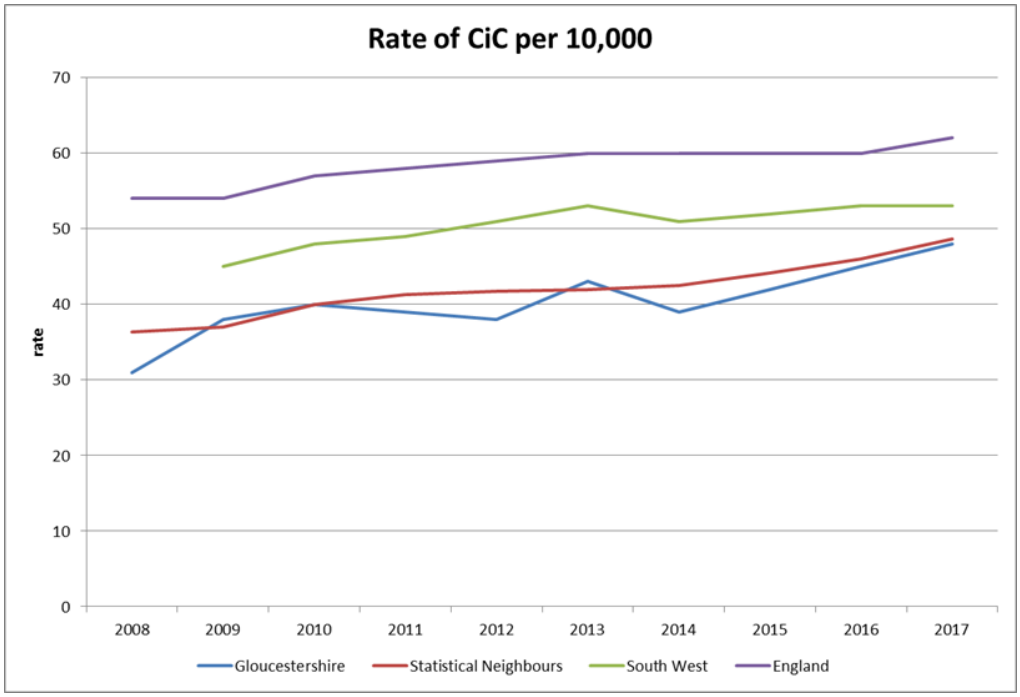


This illustrates that, in terms absolute numbers, Gloucestershire is broadly in line with its statistical neighbours and the increases observed are in line with a broader trend.

Rates of Children in Care by 10,000 population

As well as looking at absolute numbers above, it is useful to look at the rates of children in care. Looking at rates per 10,000 population gives a standardised indicator which takes into account the fact that different localities may have different numbers of children in their population and allows for a more informative comparison between localities having adjusted for inter locality variations in the numbers of children and young people. The rates of CIC per 10,000 population for Gloucestershire, its statistical neighbours, the South West and England is shown below.

Graph to show rates of children in care per 10,000 population for Gloucestershire and its comparators



The rate of children in care per 10,000 of the child population has been increasing across all geographies in the last 10 years. Although Gloucestershire is still below the South West and England rates, the recent rise in rate from 2014 in Gloucestershire is steeper than that at the regional and national level meaning that the rate of children in care in Gloucestershire is increasing faster than for its comparators.

This suggests that the growth in numbers of CiC seen locally is not just attributable to general population growth, but also to an increase in the proportion of children coming into care.

B) Characteristics of Children going into care

In this section we will look at the characteristics of the children who are going into care in terms of age, gender, ethnicity, where they come from and whether they are part of sibling groups. In this section we have chosen where possible to focus on the characteristics of those going into care each year (rather than the characteristics of the year end cohort) as it is likely to be more indicative of future trend and less impacted by the characteristics of the historical cohort. By looking at the profile of those coming into care and the changing patterns and trends we can draw inferences about the likely future profile of those coming into care and plan accordingly.

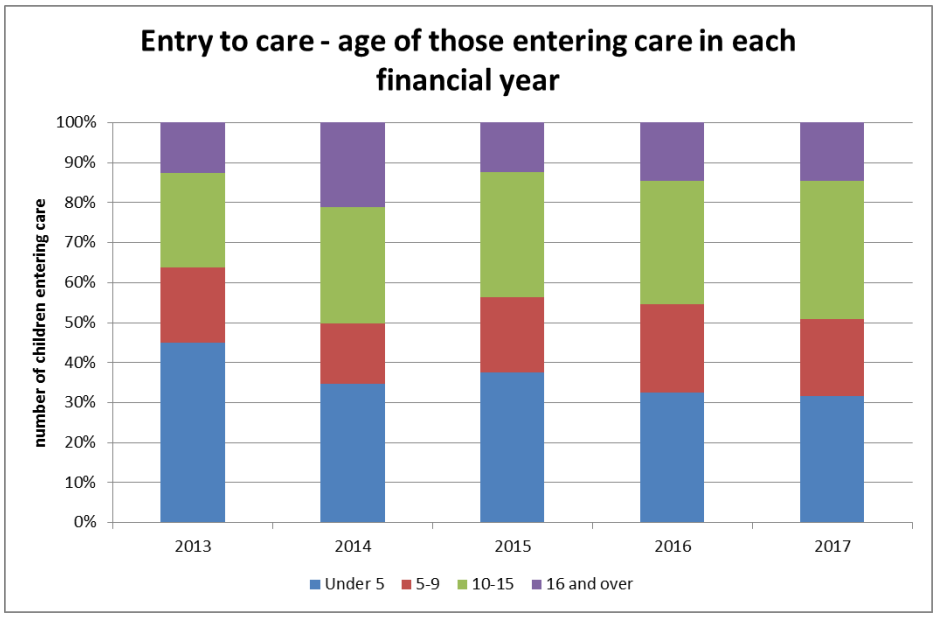
Age

KEY FINDING – The largest proportion of children coming into care (35%) are now in the 10-15 age group. The number of children in this age band has doubled from 61 to 122 in the last five years. Historically the largest proportion (45%) of children coming into care was 0-5 year olds. The numbers in this 0-5 age group have remained stable at just under 120

Analysis of cohort entering care over last 5 years:

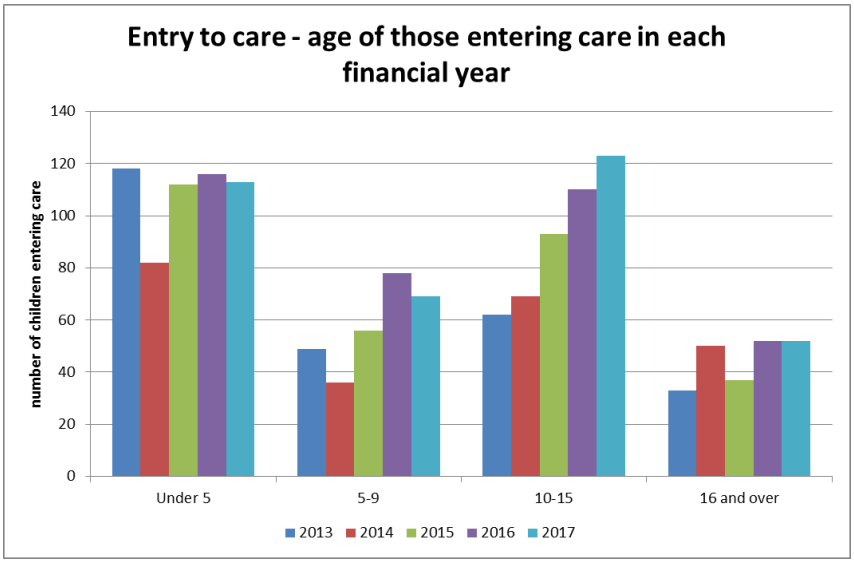
There have been some changes in the age profile of those coming in to care in Gloucestershire in the last 5 years. In terms of proportions, in 2013 0-5s dominated and were almost 45% of the cohort. By 2017 this proportion had shrunk to around 30%. The relative proportions by age band of children coming into care is shown below.

Chart to show proportion of children coming into care in Gloucestershire by age band over time



By looking at the absolute numbers coming into care rather than the proportions above, it can be seen that this decrease in proportion of 0-5 year olds is not due to falling numbers in this age group (it has remained stable) but rather to increases in other age groups. The most notable increase has come in the 10-15 age group which has doubled from 61 in 2013 to 122 in 2017.

Chart to show numbers of children coming into care in Gloucestershire by age band over time

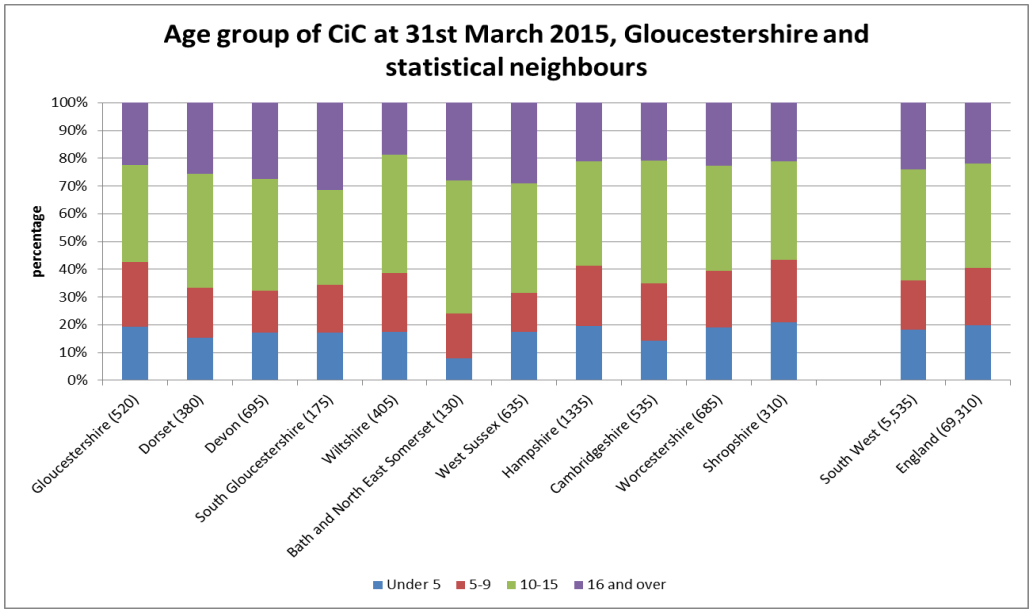


The increase in the size and relative proportion of the 10-15 age group is likely to have significant implications for the type of placement required as the support needed for older children is different to that needed for under 5s.

Analysis of Age at 31st March year end snapshot numbers:

National comparator data is not available for the annual data on children coming into care. However, if we use the year end snapshot cohort then it is possible to make national and regional comparators. The data shows that the age group of CiC in Gloucestershire in 2015 was in line with England but slightly younger than the regional averages and many of the statistical neighbours. This is illustrated below.

Graph to show 2015 proportions of children in care by age bands at year end for Gloucestershire and its comparators



The age at the start of current placement in 2015 in Gloucestershire was inline with the England ages. More recent national comparator data is not available so it is not possible to see if the recent increase in 10-15 year olds has been mirrored in other places, or if the Gloucestershire increase now brings us into line with statistical comparators.

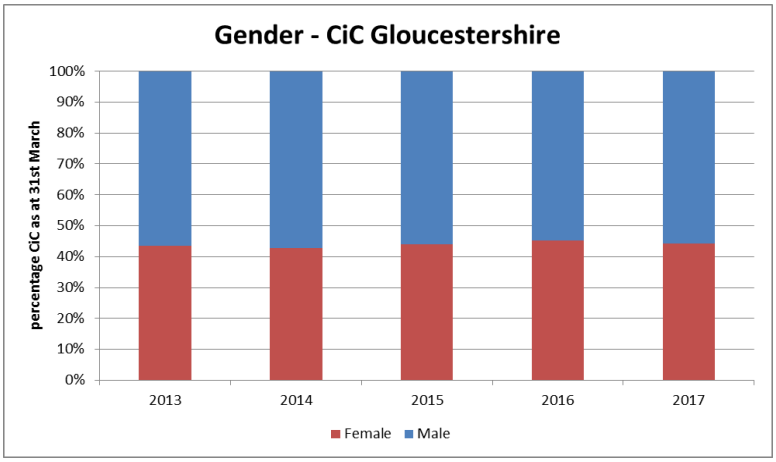
Gender

KEY FINDING – Boys are over-represented in the children in care cohort with around 55% being male. This proportion has been stable over time and is in line with comparators.

The two figures below show the proportion and then absolute numbers of male and female children in care in Gloucestershire over the last five years.

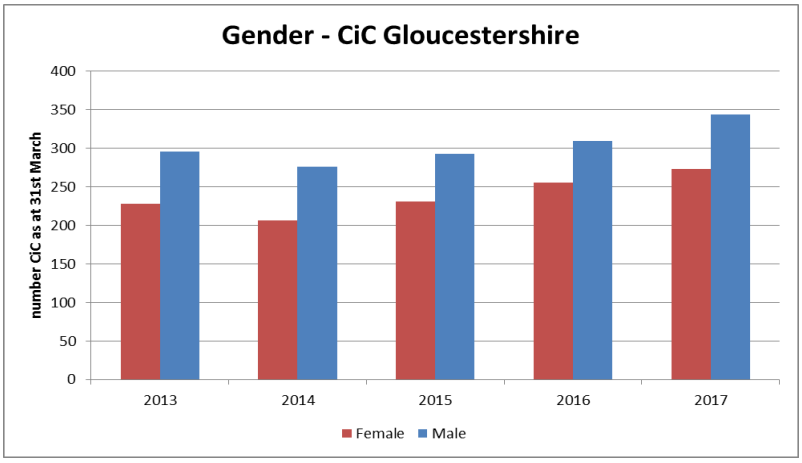
There is roughly a 55% to 45% split with boys making up the majority of children in care. The gender split of CiC in Gloucestershire has remained broadly stable for the previous 5 years.

Graph to show proportion of children in care by gender over time for Gloucestershire



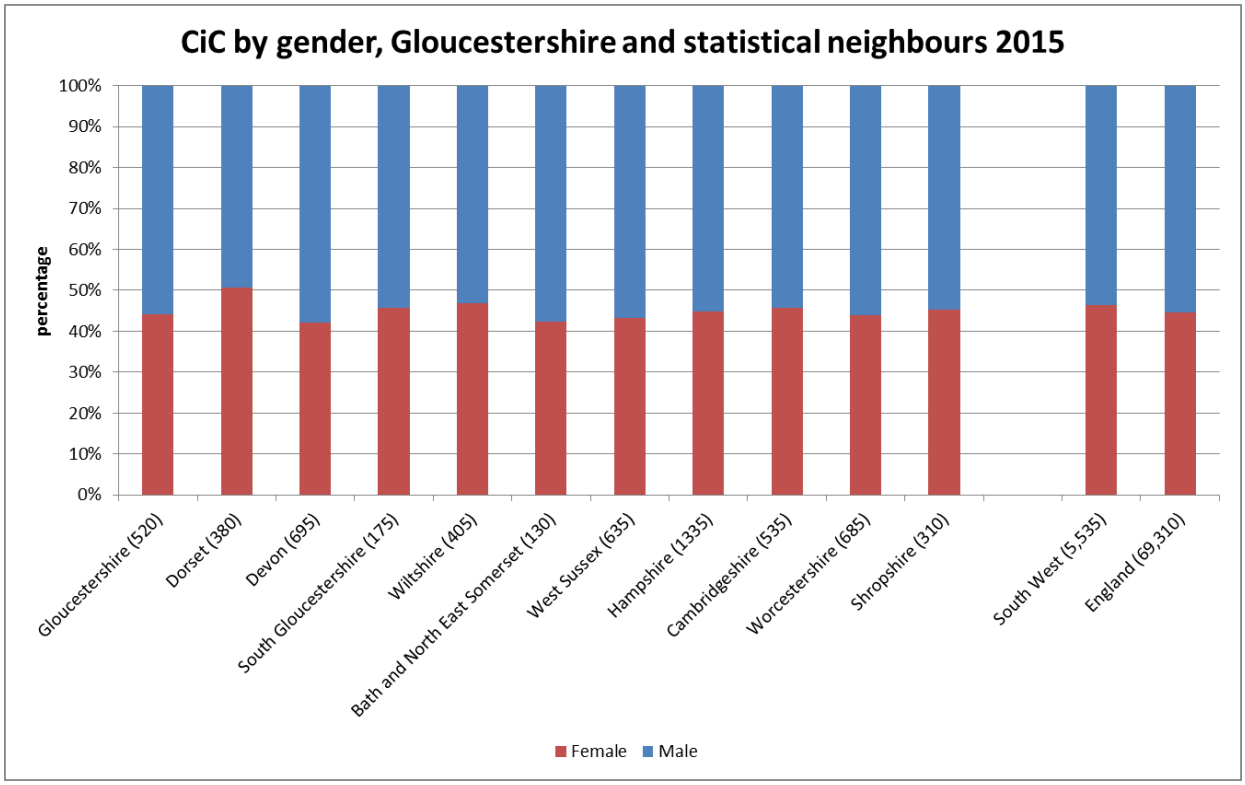
As can be seen in the chart below, the numbers of male and female children in care in Gloucestershire have both increased in absolute number terms. However the rate has been broadly similar which has resulted in the proportions staying the same.

Graph to show number of children in care by gender over time for Gloucestershire



The over representation of boys in care is also seen nationally, regionally and amongst our statistical neighbours. This is illustrated in the graph below.

Graph to show 2015 proportion of children in care by gender for Gloucestershire and its statistical neighbours

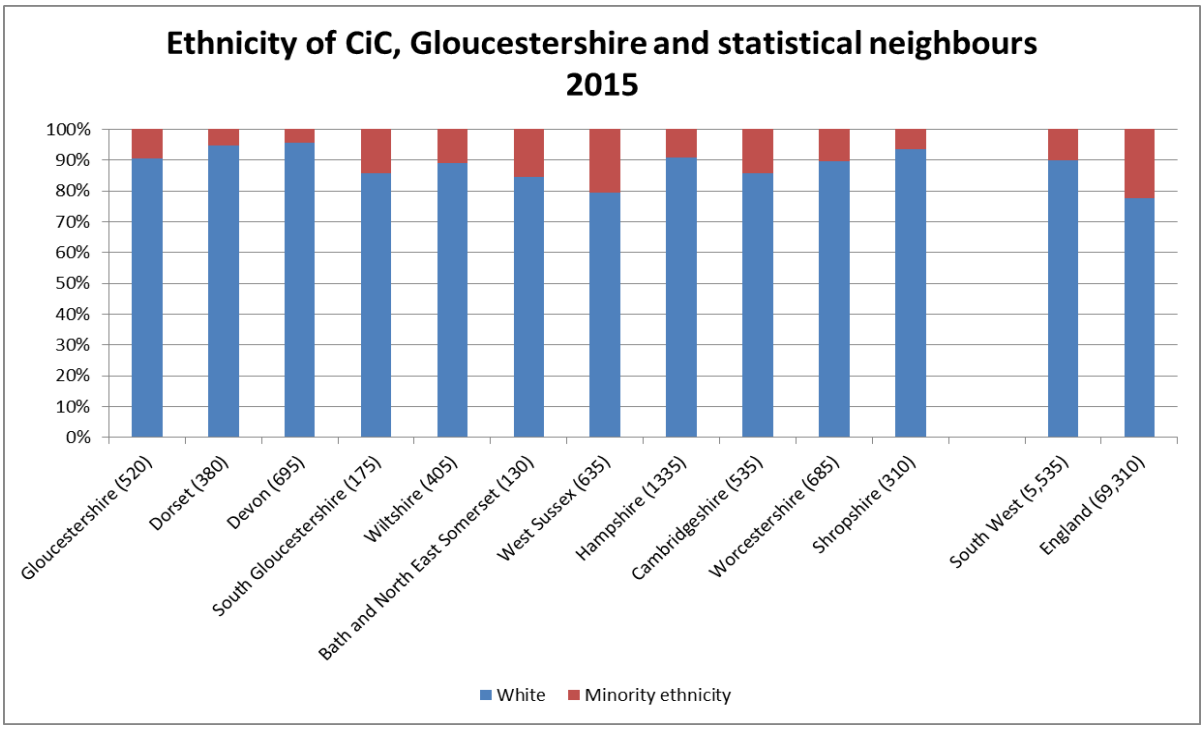


Ethnicity

KEY FINDING – Over the last 5 years there has been an increase in both the number and proportion of minority ethnic children coming into care in Gloucestershire. In 2017 there were approximately 20% of children from minority ethnic backgrounds which is an increase from around 12% in 2013. This is a 67% increase over 5 years and is an over representation compared to the local population.

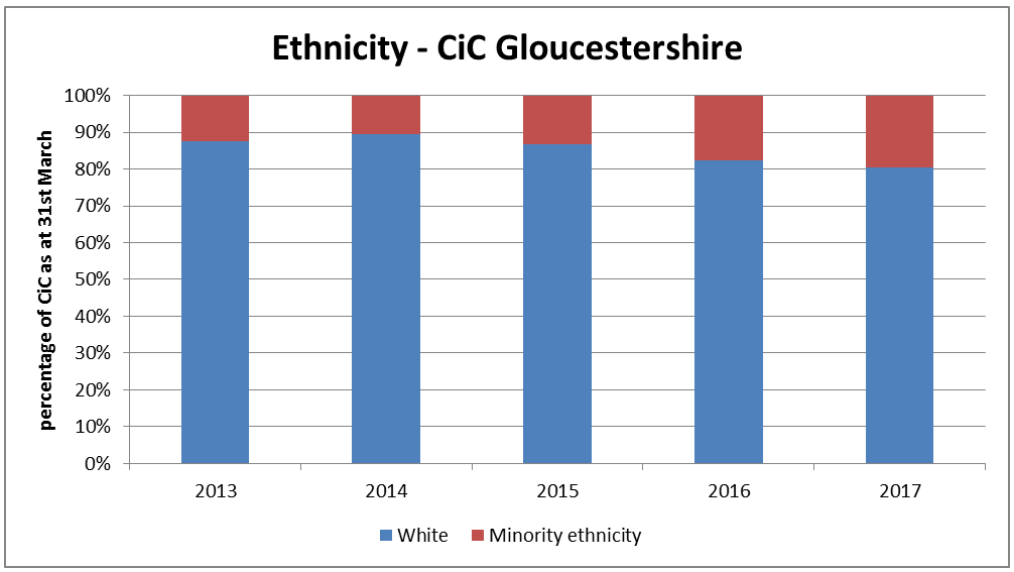
In 2015 the ethnic split of CiC in Gloucestershire was inline with the regional average but had proportionately fewer minority ethnic and more white children in care than the England rate. This is likely to be linked to the wider ethnic profile of the general population of Gloucestershire and the region which has a lower proportion of minority ethnic residents than that seen nationally.

Graph to show 2015 proportions of children in care by ethnicity for Gloucestershire and its statistical neighbours

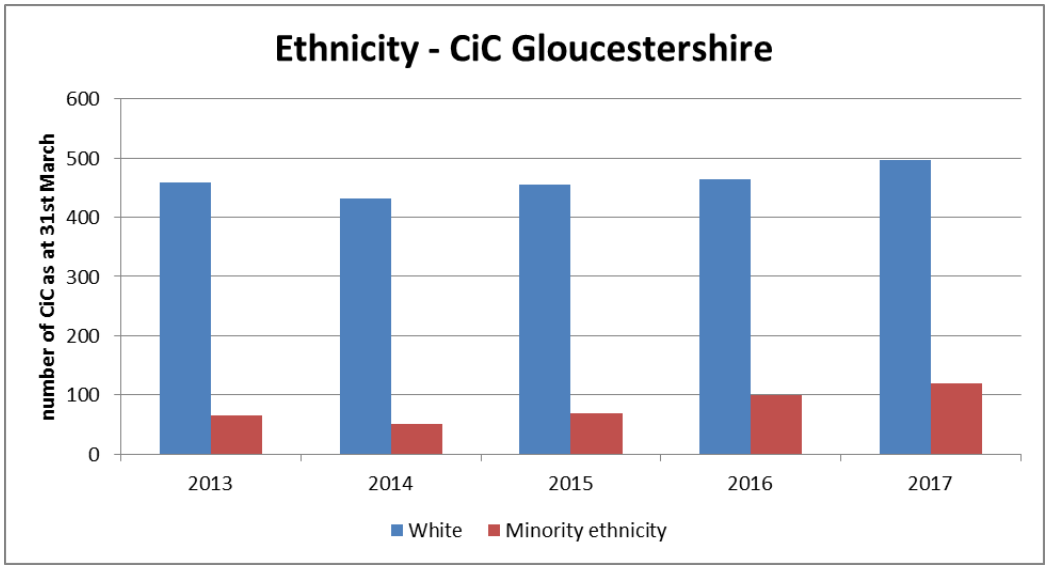


When looking at the ethnicity of Gloucestershire CiC in the previous 5 years however it is clear there has been an increase in the proportion of children in care that are from minority ethnic groups. This proportion has increased from 12.4% to 19.5% in the period. This increase has been largely seen in 2016 and 2017 cohorts.

Graph to show proportion of children in care by ethnicity for Gloucestershire over time



Graph to show proportion of children in care by ethnicity for Gloucestershire over time



Again, looking at the absolute numbers by ethnicity, the chart shows that while the numbers of both white and minority ethnicity children in care have increased locally the rate od increase for minority ethnicity children has been greater and this is what has driven the increase in the proportion of minority ethnic children in care.

This finding may have implications for the type of foster homes needed. If this trend continues then it is likely that more foster homes suitable for minority ethnic children (eg language capabilities) may be required to meet the needs of children in care locally.

Sibling Groups

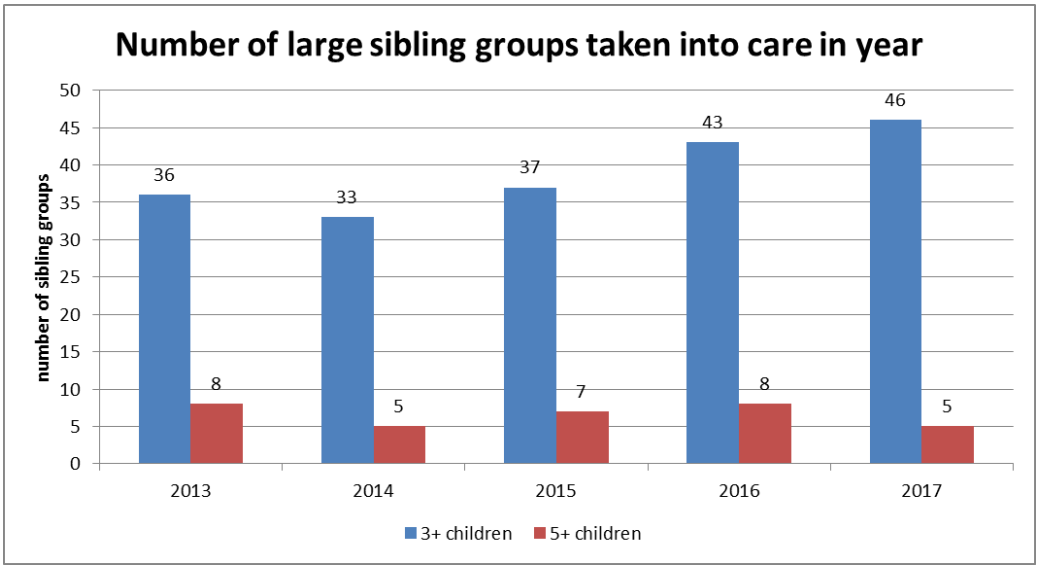
KEY FINDING – In the last five years there has been a 28% increase in number of large (3+) sibling groups. In 2017 there were 46 sibling groups of 3 or more children, up from 36 in 2013… Sibling groups containing 5+ children have remained stable over the last 5 years at around 5 to 8.

In the majority of cases, when a sibling group is taken into care, unless there are special circumstances it is desirable for the sibling group to be placed together. Not every foster carer can accommodate three or more children at a time and achieving the aim of keeping the sibling group together requires placements with capacity for large groups.

The figure below shows the rise in sibling groups of three or more over the last 5 years. In 2017 46 such groups required placement; this is a 28% increase in the last 5 years.

In addition to groups of three or more, there are also groups of 5 or more siblings requiring care placements. The number of such groups has remained stable at around 5-8 each year.

Graph to show number of large sibling groups taken into care annually for 2013-2017



Needs of the Children Coming Into Care

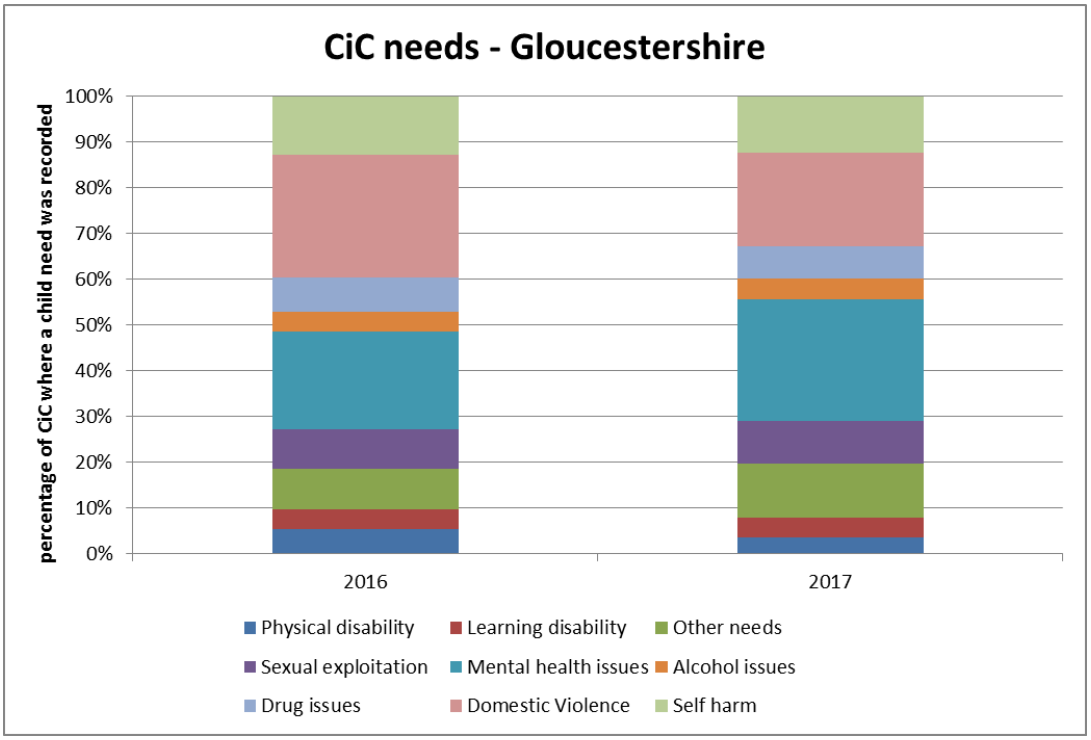
KEY FINDING – There has been an increase in the proportion of children identified as having mental health support needs. The number with substance misuse problems or contact with the criminal justice system has fallen since 2009. All children coming into care are likely to have experienced a number of adverse childhood experiences and this will need to be addressed to stop these adverse experiences having lifelong negative social, health and wellbeing impacts.

Children coming into care will have a number of needs that will need to be met by their placement. In 2017 the biggest identified need for CiC was mental health issues, with experience of living with domestic violence the next highest factor. Between 2016 and 2017 mental health represented the biggest growth in proportion with domestic violence showing the biggest decline in proportion. Interestingly the decline in domestic violence as a proportion of parental need over the same period is not seen (see next section). This suggests that the decline in its relative contribution for children is likely to be driven by an increase in the number of other issues recorded rather than a decline in incidence. The proportional requirement for support around physical difficulties fell but learning difficulties stayed at roughly the same percentage.

In the light of the growing evidence bases around adverse childhood experiences, it should be noted that all children coming into care will have experienced a number of adverse childhood experiences including neglect, abuse, and living in households affected by parental mental health, substance misuse and domestic abuse. The growing evidence base suggests that if the sequalae from these experiences are not addressed they can go on to cause long term health, wellbeing and social issues for the children and young people. Developing strong relationships and core life skills from successful placements can be effective in boosting resilience and overcoming the impact of the adverse experiences. Poor placements and/or placement breakdown causes further trauma and

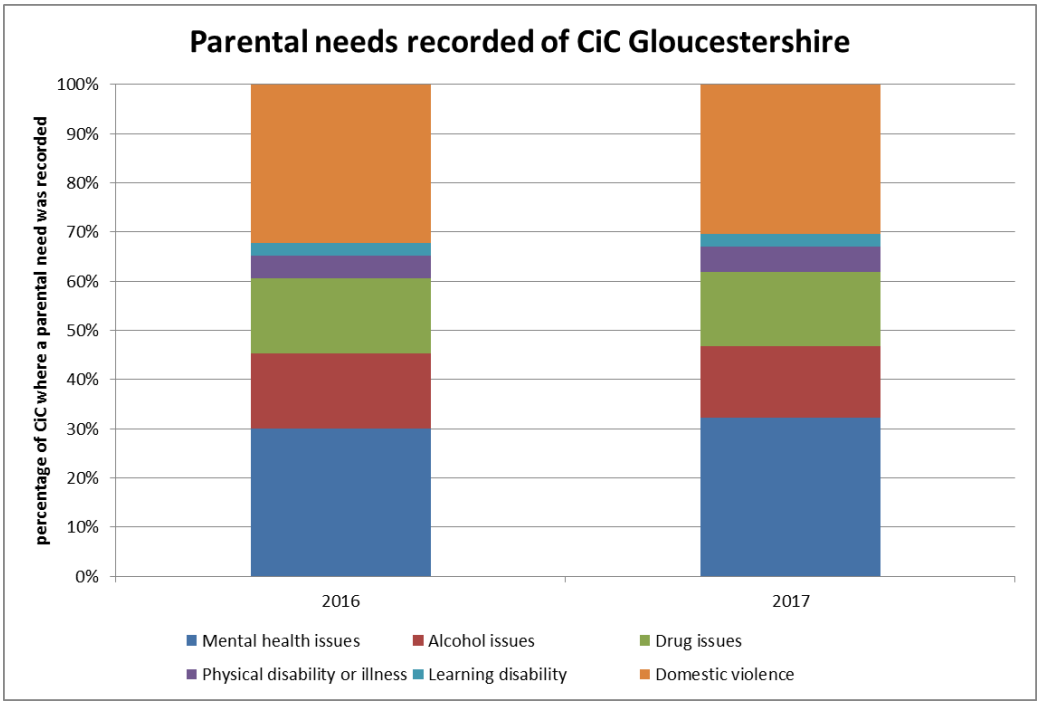
exacerbates the issues. Thus getting the right placement first time is of the upmost importance both to the individual and to the future health and wellbeing of the county.

Chart to show the proportions of children in Gloucestershire having a specific need recorded on entry into care



NB children can have more than one need recorded.

Reasons for Children Coming Into Care – Recorded Parental Needs

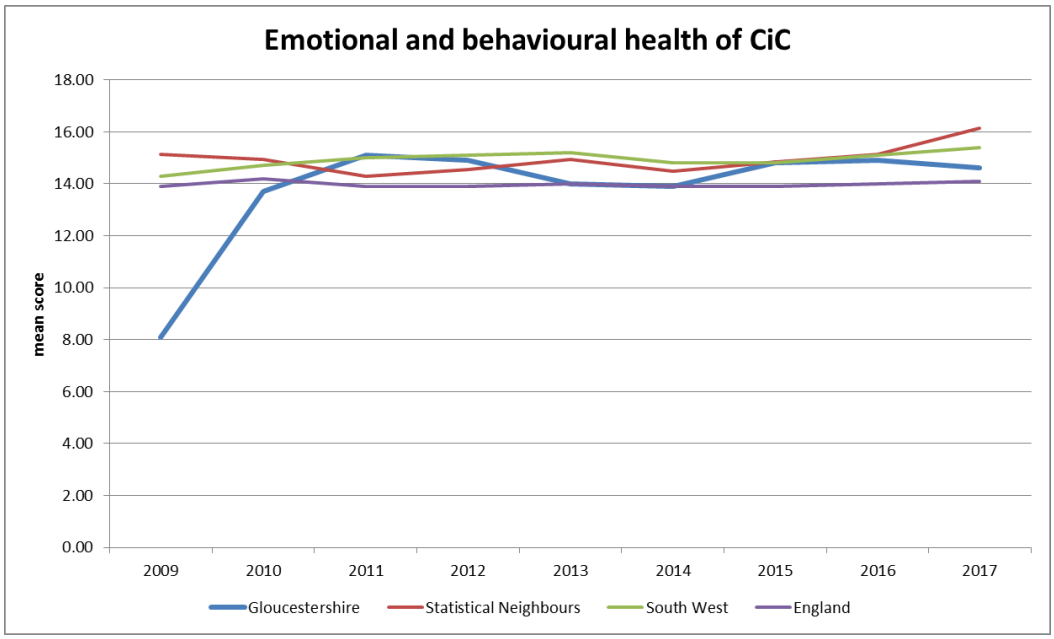


The parental need which is causing children to come into care has remained broadly constant between 2016 and 2017. Mental health and domestic violence remain the two largest issues proportionately.

Emotional Health of Our Children in Care

The emotional health of all children in care is assessed using the Strengths and Difficulties Questionnaire (SDQ). This is brief behavioural screening questionnaire suitable for 3-16 year olds. It is a validated tool and can be used for comparisons. A score of 0-13 is considered normal, 14-16 is border line and 17-40 is cause for concern. The mean scores over time are shown below.

Chart to show mean SDQ score for children in Gloucestershire and comparators over time

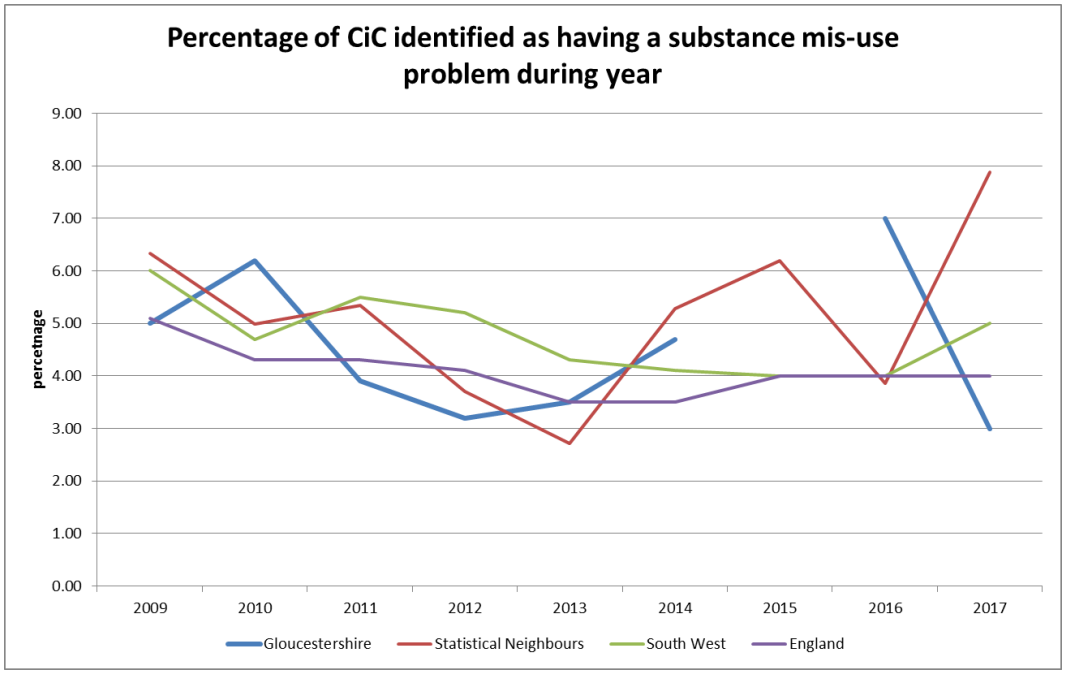


Since 2011 the mean scores for Gloucestershire CiC have remained around 14-16. This is in the borderline range and is fairly consistent with our comparators. It should be kept in mind that this is a mean score and many children may have high scores with high needs while others achieve low scores.

Substance Misuse in Children in Care

The data around this indicator is not complete and so is hard to draw firm conclusions from. There is some evidence that this indicator is showing a downward trend since 2009 and is roughly in line with the UK. The national average runs at around 4% of the children in care population. Again this represents a cohort that needs specialist care and placements able to support their needs. During the course of a year 4% roughly equates to between 25 and 35 children in care in Gloucestershire with substance misuse problems.

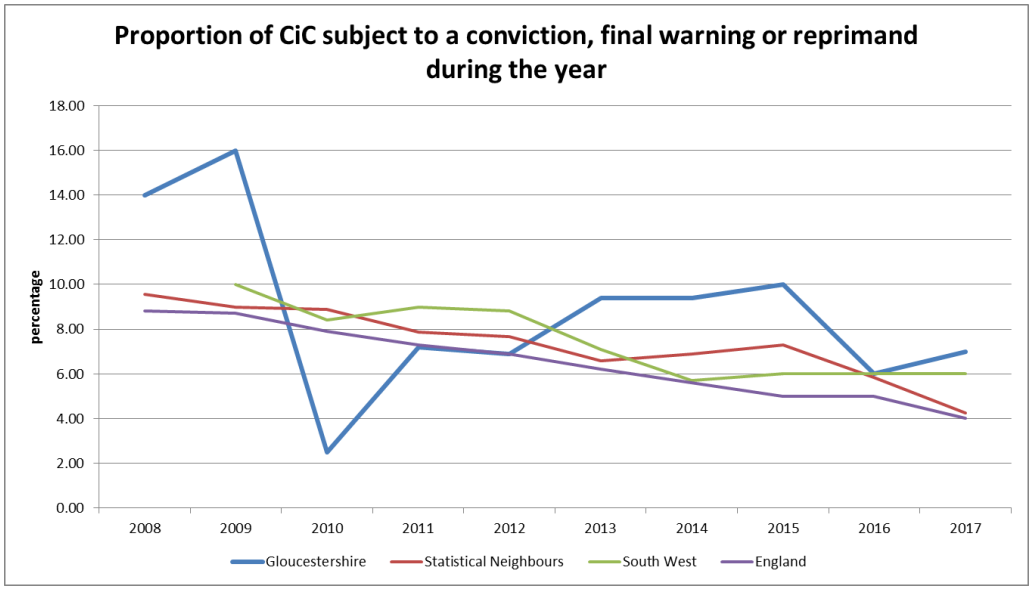
Graph to show proportion of children in care in Gloucestershire with substance misuse problems over time



Contact with the Criminal Justice System

As can be seen in the graph below the percentage of children in care who are in contact with the criminal justice system has decreased since 2009 and remains broadly in line with the national trend.

Graph to show change in proportion of children in care in Gloucestershire and comparators in contact with criminal justice system over time



C) Type of Placement

In the previous section we looked at the characteristics of the children going into care. In this section we will look at placement characteristics.

Placement type

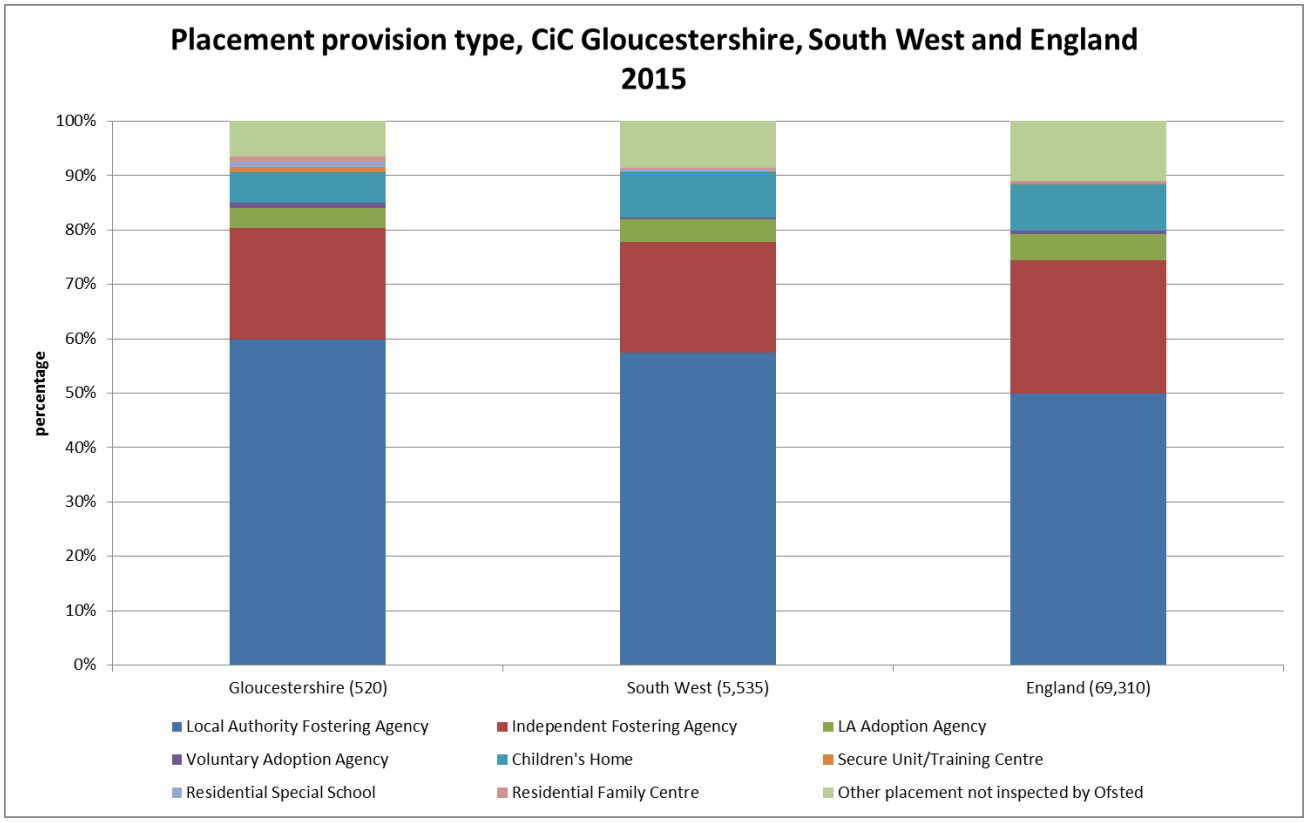
KEY FINDINGS – Gloucestershire uses a higher proportion of Local Authority foster placements compared to peers. Gloucestershire also uses a lower proportion of "other non-Ofsted placements and residential homes than peers

There are a number of placement types available for children in care and the chart below shows how the relative proportions by type of placement vary in Gloucestershire and compare to the South West region and England averages.

The chart below shows Gloucestershire placed a higher proportion of children in Local Authority fostering agency placements (60%) than both the South West (58%) and England (50%) averages in 2015 (latest available comparator data). Correspondingly, it placed a smaller proportion in independent fostering agencies. This difference is particularly marked compared to the England pattern.

Gloucestershire also used "other placements not inspected by Ofsted" options (often with family or friends) in proportionately fewer cases than the regional and national averages. Residential special schools were over represented compared to the South West of England picture.

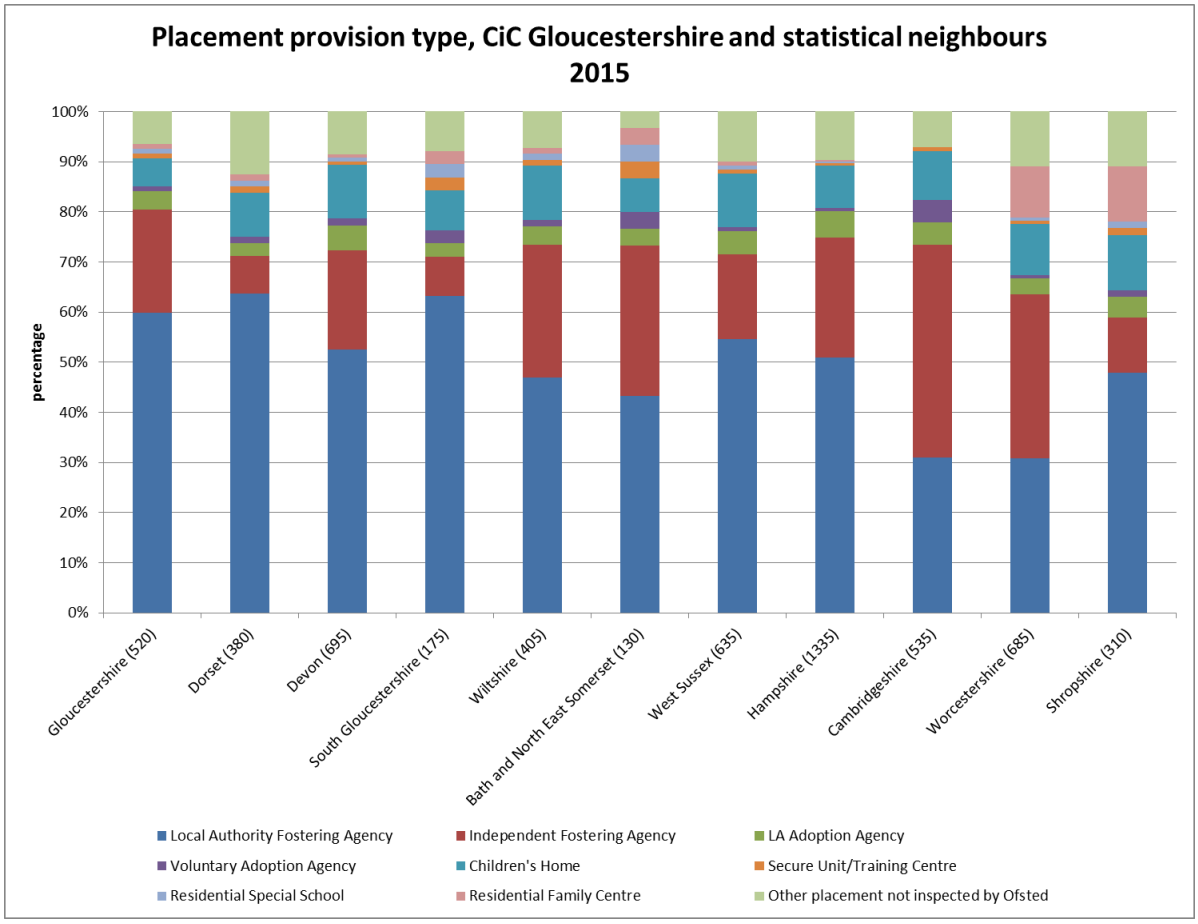
Chart to how 2015proportion of placement provision by type for Gloucestershire and comparators



The 2015 data set is the latest data set for which the comparator data is available for this indicator. It should be kept in mind that the picture may have changed in the last 2 years. To aid with this, the Gloucestershire trend data by placement type is presented in a later section.

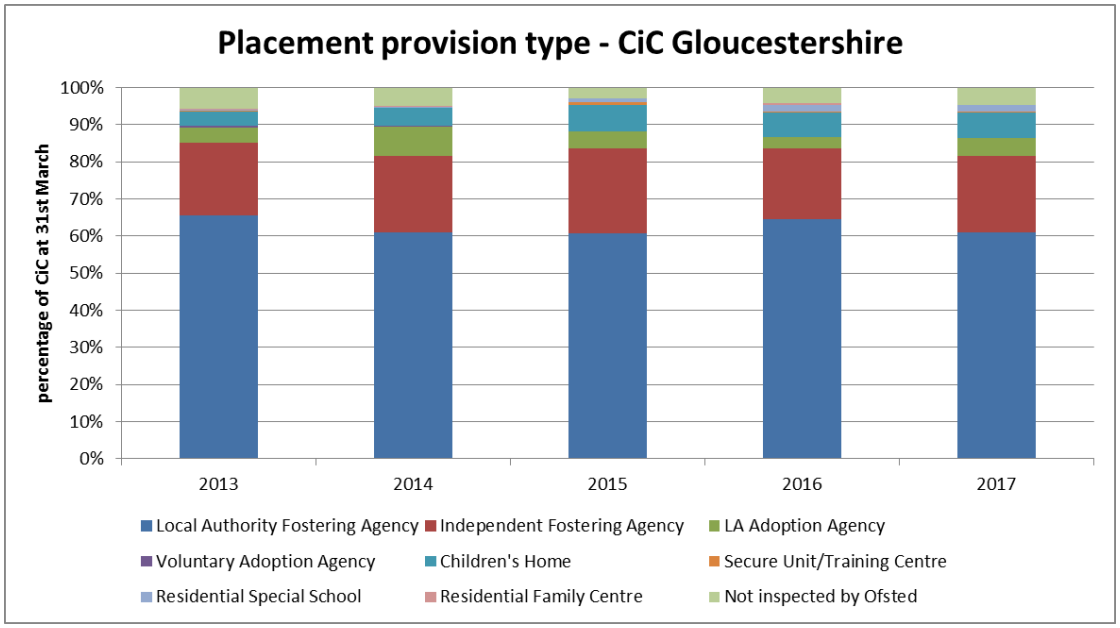
When looking at the 2015 data for Gloucestershire in comparison to its statistical neighbours the difference between use of different placement types is marked. Only Dorset and South Gloucestershire use a similar proportion of LA fostering placements, all other LA are using more independent fostering agency placements. All the statistical neighbours use proportionately more placements in children's homes than Gloucestershire. This is illustrated in the chart below.

Chart to show 2015 proportion of placements by type for Gloucestershire and statistical peers



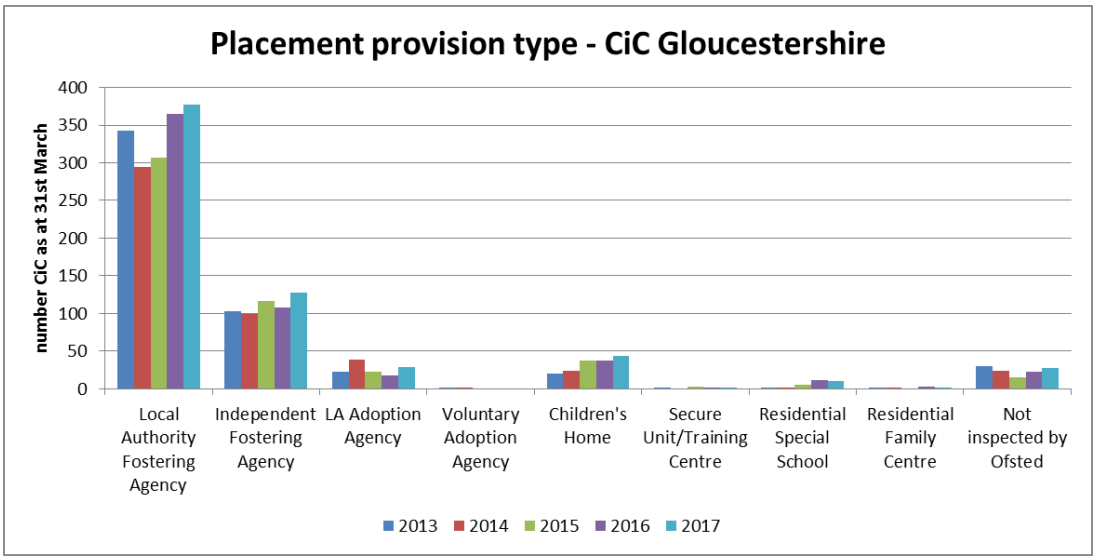
As mentioned in the previous section, it is also helpful to look at how the trend by placement type has changed for Gloucestershire over the last 5 years . During the previous 5 years the proportional use of different providers for placements has remained fairly stable. The use of placements in children's homes seems to have increased in Gloucestershire from 3.8% to 7%. There has also been a slight increase in placements in Residential Special schools in the period from 0.4% to 1.6%. This may be attributed to the opening of a new special school, Cambian Southwick Park School in 2012.

Graph to show proportion of placements by type for Gloucestershire for 2013-2017



As well as looking at the relative proportions above we can also look at the absolute numbers in each type of placement. The numbers of children placed in each provision type has also been increasing since 2013 in all but LA adoption agency which has been more inconsistent. This is illustrated in the chart below.

Graph to show change in numbers by placement type for Gloucestershire for 2013-2017



Placement Distance From home

KEY FINDING – Gloucestershire has traditionally performed well in keeping children close to their locality base but in the last 2 years the trend line for children being placed more then 20 miles from home locality has increased faster than for the national or statistical neighbour peers. This is a concerning trend.

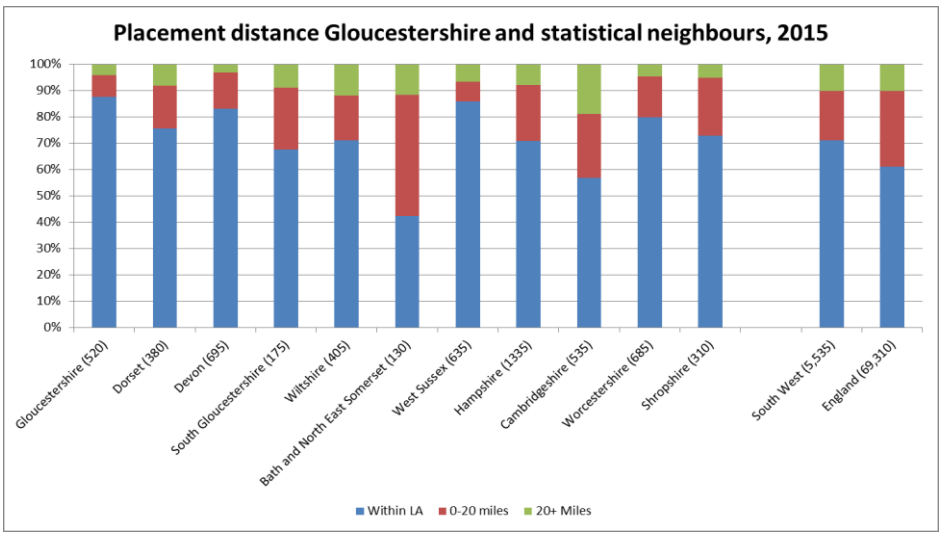
The table below shows the top 10 areas of Gloucestershire where children are taken into care from.

10 LSOAs with highest origin postcodes for CiC	2016	IMD
BARTON AND TREDWORTH 4	11	1
WESTGATE 1	10	1
BARTON AND TREDWORTH 2	9	1
BARTON AND TREDWORTH 7	9	1
ELMBRIDGE 2	9	1
LYDNEY EAST 1	9	1
MATSON AND ROBINSWOOD 6	9	1
MORELAND 3	8	1
KINGSHOLM AND WOTTON 2	8	1
BREAM 1	8	2

There is evidence that while in some cases a distant or out-of-authority placement may be the right decision for a child, for many children such placements are not in their best interests. Children placed at a distance from home are likely to achieve poorer educational and other outcomes than those placed within their home area. Local authorities will find it harder to act as an attentive corporate parent where children are living far away.

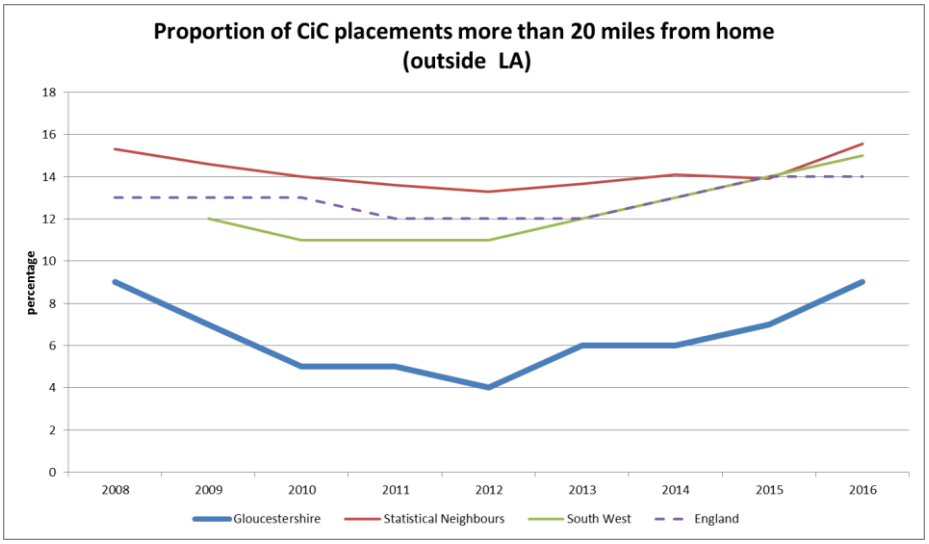
An indicator around placement more than 20 miles from locality helps monitor the capacity of councils to have sufficient placements near to home to facilitate contact with natural parent(s), siblings and other relatives and local communities. Apart from in very few cases, the further from home a child is placed, the harder it is to maintain links with their family and for them to return to their community when they leave school or care. The chart below shows that in 2015 a higher proportion of CiC in Gloucestershire were placed within the LA in comparison to all its statistical neighbours and the regional and national averages.

Graph to show placement distance from locality for Gloucestershire and peers



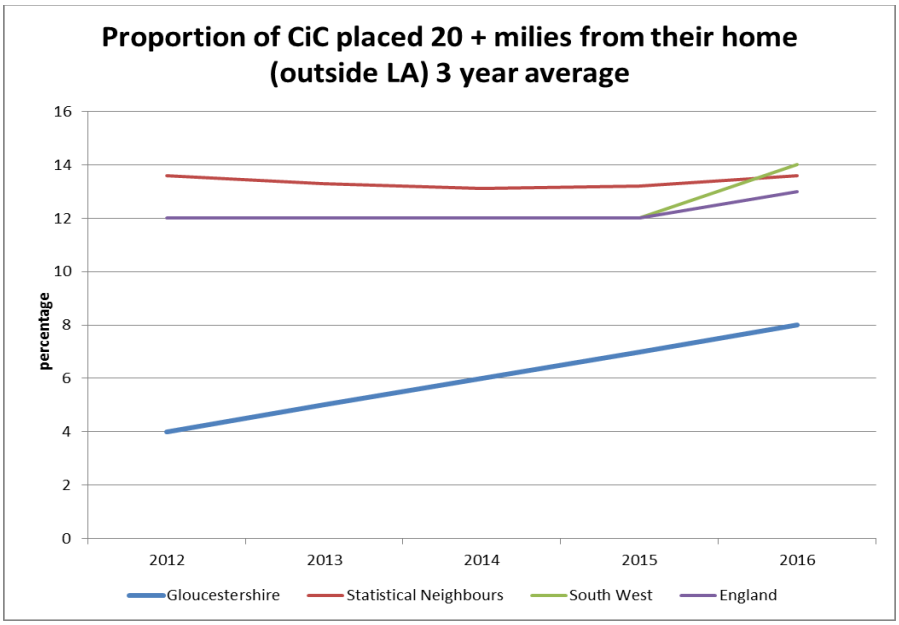
However, although Gloucestershire had a lower percentage of CiC placed more than 20 miles from their home locality in 2015, the recent trend since 2012 shows a sharp increase in comparison to our statistical neighbours and the England average in the same period.

Chart to show change in proportion of children placed more than 20 miles from home locality



To analyse the trend in more detail 3 year averages can be looked at. The increase, when looking at the 3 year average, is more pronounced in Gloucestershire than statistical neighbours, regional and England averages. This suggests Gloucestershire is getting worse at placing children near home at a rate faster than its comparators and that is relatively strong performance in this indicator is being eroded.

Chart to show three year average for the proportion of children placed more than 20 miles from home locality

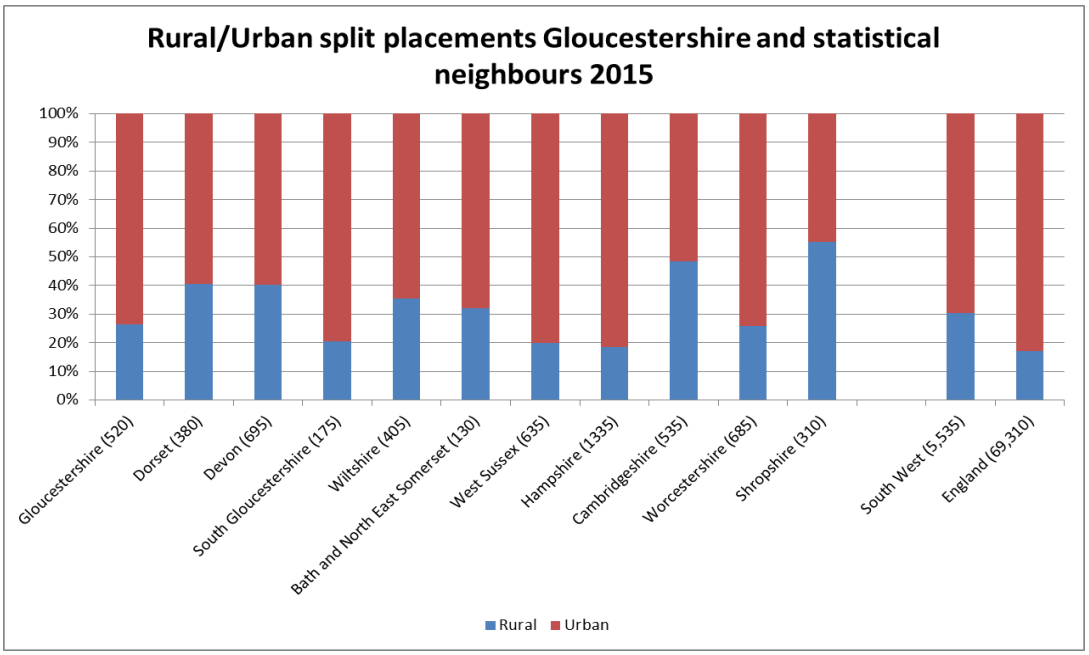


Urban/Rural split of placements

KEY FINDING – The majority of placements are classified as urban with roughly three quarters of children being placed in urbanlocations

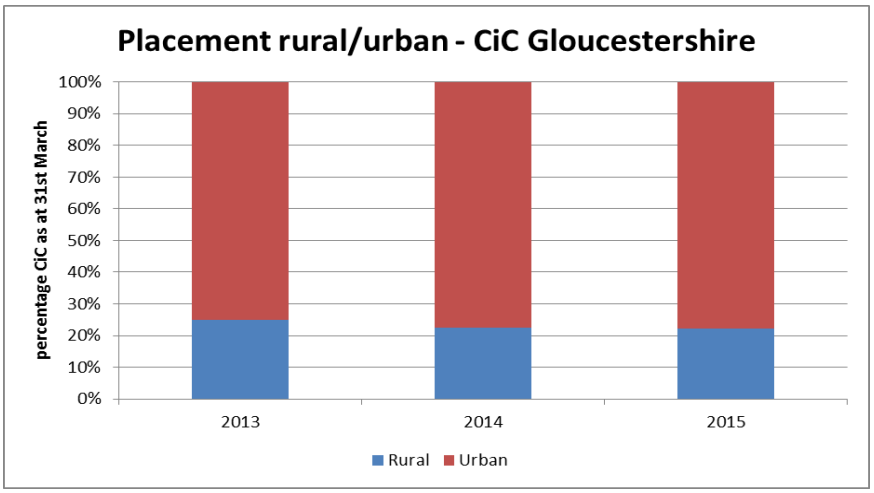
Despite being relatively rural, Gloucestershire had a higher proportion of CiC placed in urban placements than the England average but is inline with the regional average for 2015. The top 10 locations for place of origin for CiC are urban

Chart to show rural/urban placement split for Gloucestershire and statistical peers in 2015

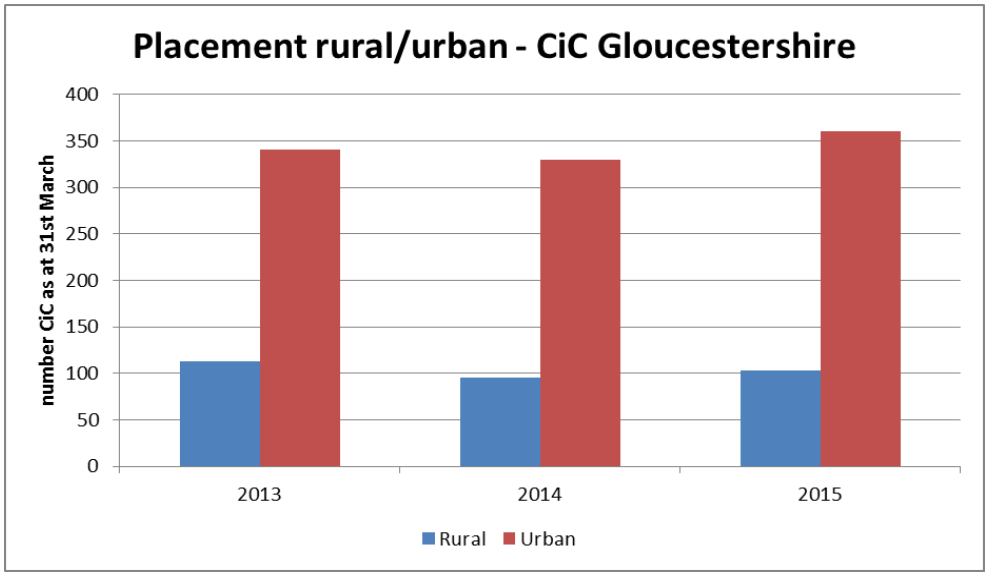


The proportion of placements in rural areas has remained roughly stable between 2013 and 2015 and both have grown proportionately in terms of increased numbers.

Graph to show proportion of placements in Gloucestershire by location between 2013 and 2015



Graph to show number of placements in Gloucestershire by location between 2013 and 2015



Placement Duration

KEY FINDINGS – There has been a large increase in numbers of short term placements of less than 12 months. In the care leaving cohort, this proportion has increased from 42% to 62% over the last 5 years. Most notably the number of placements in care leavers of less than 6 weeks has doubled in the last 5 years to around 45, and the number of placements lasting 4-6 months has quadrupled over the same period to 42.

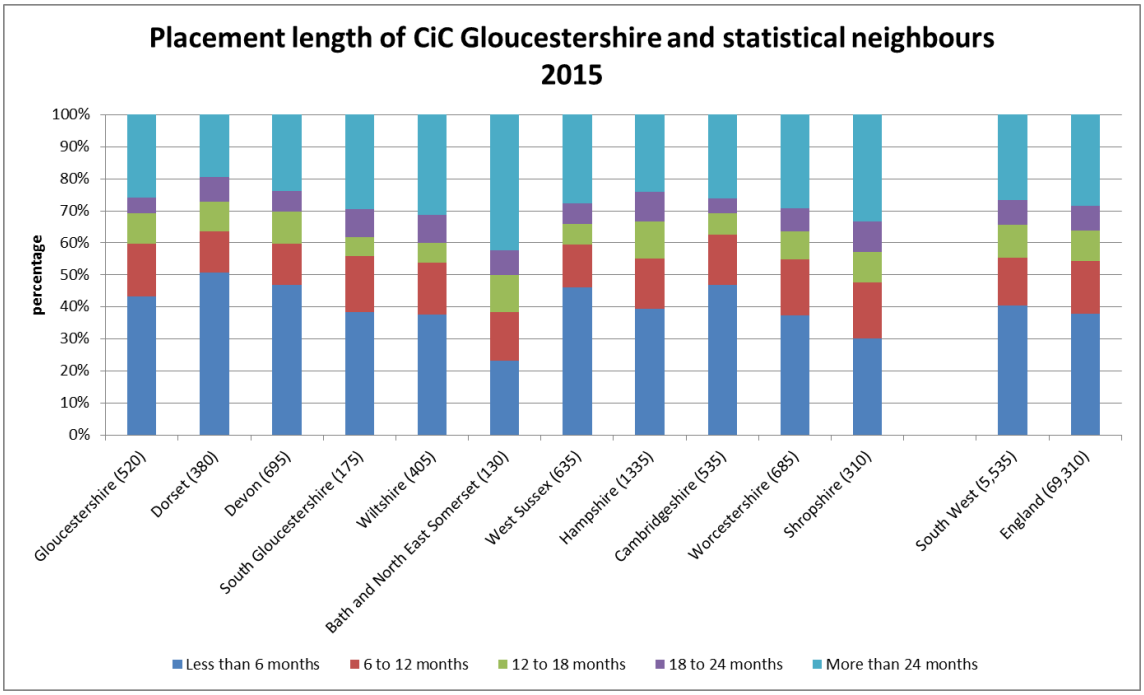
As when looking at the characteristics of those in care data on changes in the year end cohort can be looked at or it is also possible to look at changes in the characteristics of placements for those who leave care in any given year. Both statistics are presented in this section but, when considering trends more weight has been given to those for the care leaving cohort as they are more likely to represent future trends.

Placement stability can be an important part of ensuring children feel cared for and flourish in their placements. The proportion of CiC in Gloucestershire in each placement length group was similar to the England average in 2015.

Placement duration data based on year end cohort analysis

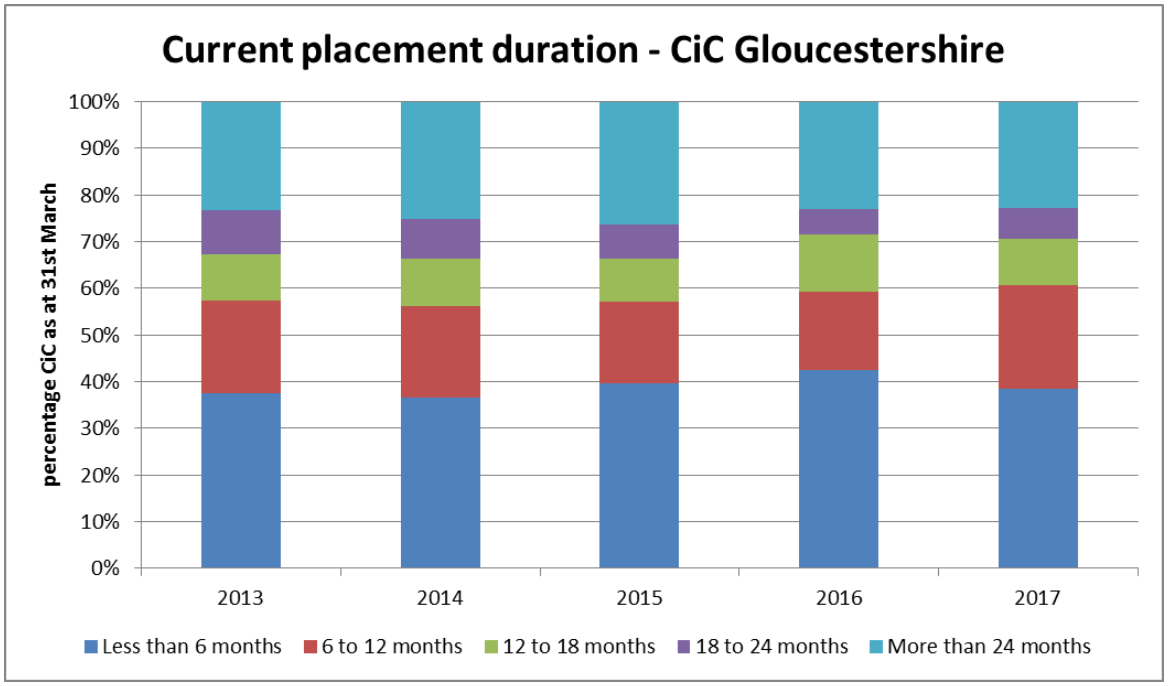
If year end cohort data is used then it is possible to look at comparator performance in terms of 2015 data and also to compare this to trends for the same indicator in Gloucestershire over time. This data is illustrated in the following graphs.

Graph to show placement length as of 2015 year end for Gloucestershire and statistical peers

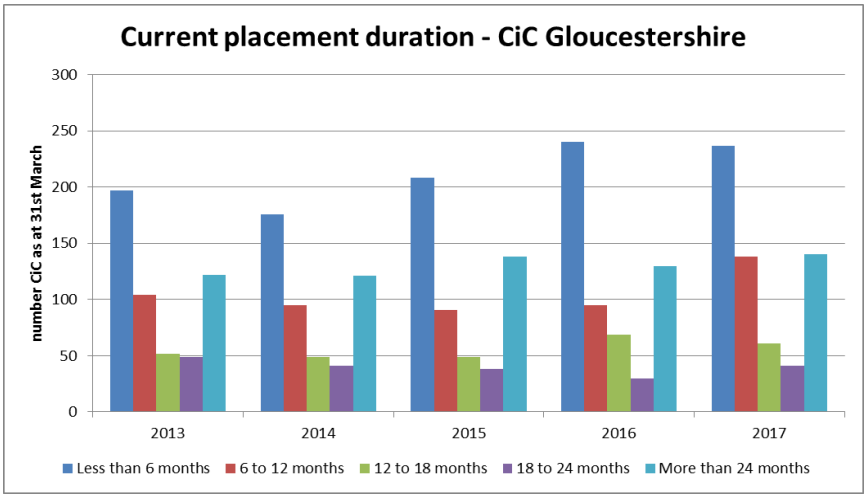


In terms of proportions the placements durations for the year end snap shot cohort have remained broadly similar over the last 5 years and this is shown below.

Graph to show change in proportions in placement duration for those in care at year end in Gloucestershire between 2013-2017



Graph to show numbers by placement duration of current placement for those in care in Gloucestershire at year end by time



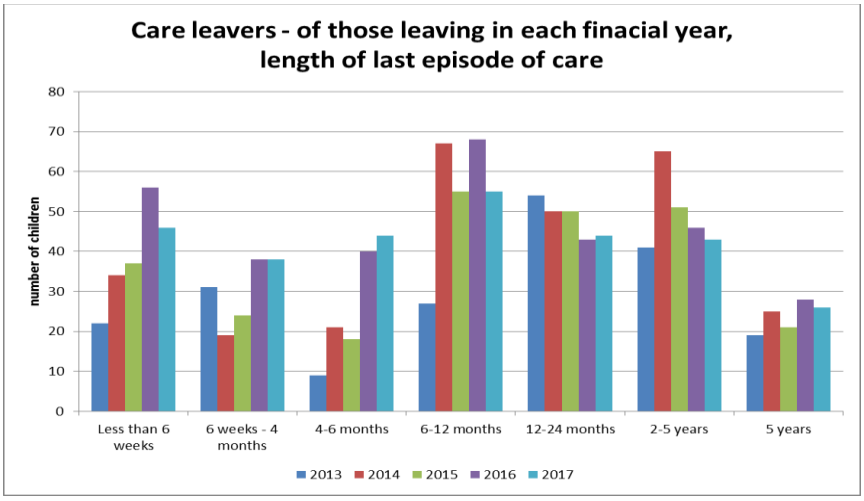
In terms of absolute numbers, the most striking change is the increase in placements of less than six months duration and also in those of 6-12 months duration.

Placement duration data based on those leaving care during the year.

The data presented to date in this section so far has been based on snapshot year end numbers. Another way of looking at placement duration is to review the duration of placement for care leavers. Again this helps us understand what is happening for episodes of care currently without the artefact of those still in placements that is seen in the year end figures.

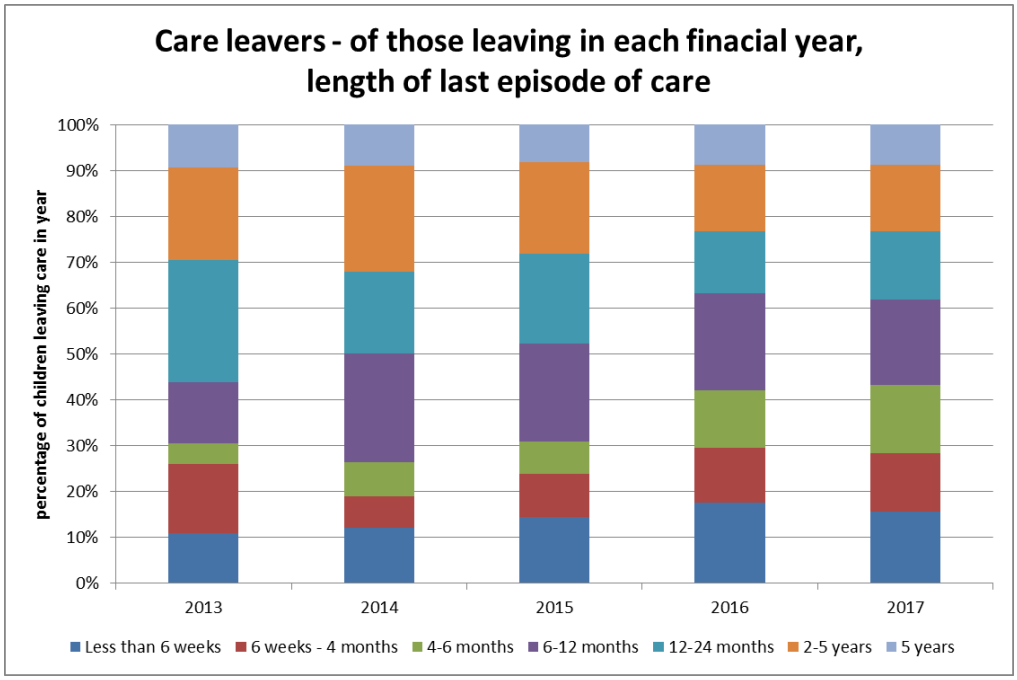
The graph below shows that, broadly speaking, number grew for placements of less than 6 weeks, 6 weeks to 4 months and 4-6 months as well as for over 5 years and remained static in other placement durations except for 18- 24 months where number fell.

Graph to show changes in number by time for duration of last care placement for Gloucestershire children leaving care in successive financial years



In terms of proportions the graph below shows that the proportion of less than 6 week placements has increased and now lies at around 15%. The proportion of 4-6 month placements has also grown substantially and now accounts for over 10 % of placements. The greatest reduction in placement duration is in the 12-24 month category which accounted for around a quarter of all placements in 2013 and is now closer to a tenth.

Graph to show changes in proportion by time for duration of last care placement for Gloucestershire children leaving care in successive financial years

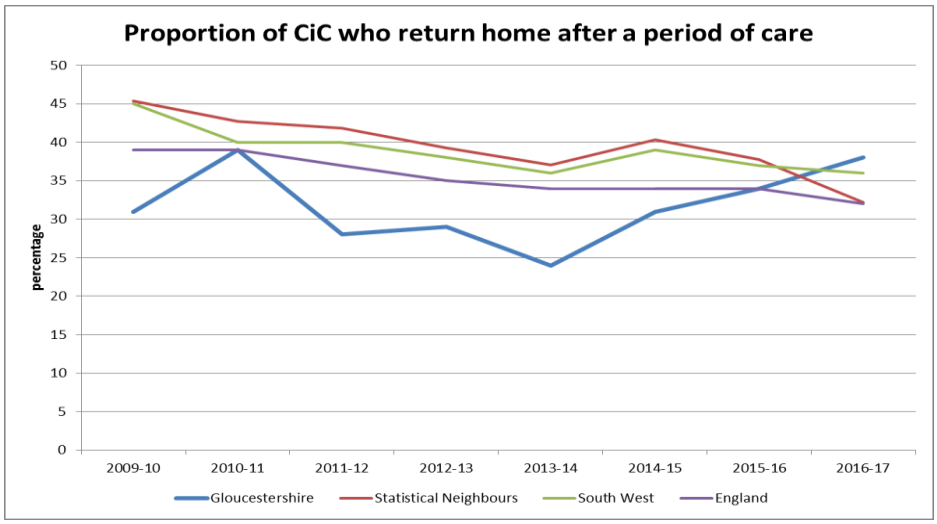


Proportion of Children returning home after a period of care

KEY FINDINGs – The proportion of children returning home after a care placement has been increasing in Gloucestershire since 2013 and as of 2016/17 was just under 40%. Gloucestershire is an outlier in terms of increasing trend of children returning home and also in the proportion of children who do.

In terms of where children go at the end of a placement the single largest group return home. In Gloucestershire, this proportion has been growing steadily since 2013 and is the opposite of the trend seen in regional, and statistical neighbours as well as the national trend. The reasons for Gloucestershire bucking the trend are not clear. This may represent a positive trend or, if children are bouncing back into care, this may show that Gloucestershire is returning children home too optimistically.

Graph to show proportion of children returning home at the end of a placement in Gloucestershire and comparators

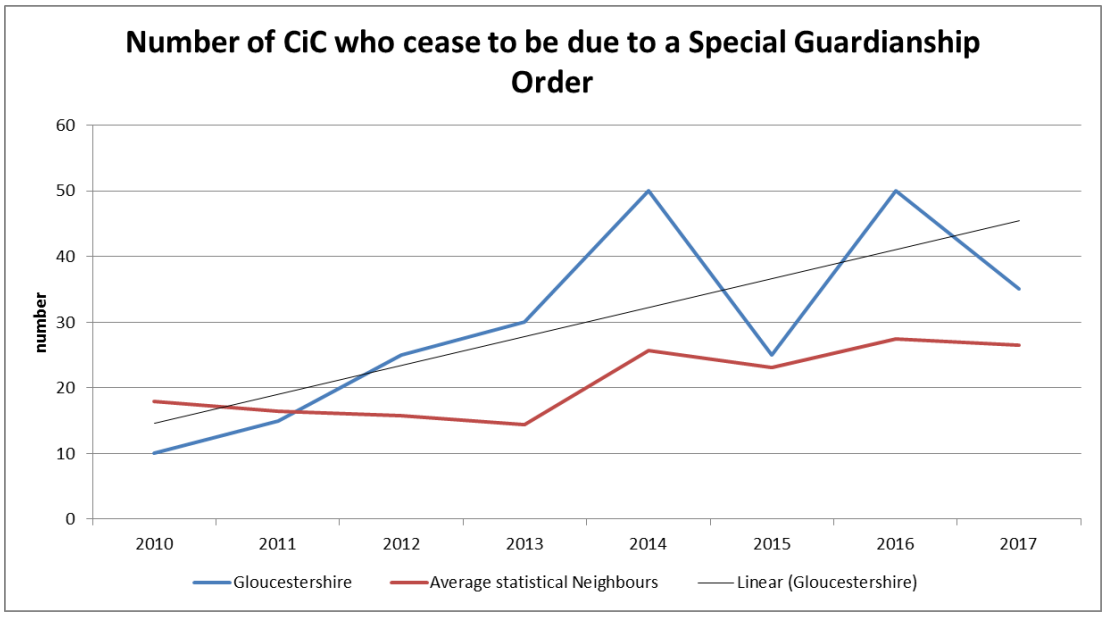


Special Guardianship Orders

KEY FINDING – In 2017 35 children ceased to be in care due to special guardianship orders. This number is rising year on year and Gloucestershire is performing better on this indicator than statistical neighbours.

A number of children end their period in care through a special guardianship order. Since 2010 this number has been on an upward trend. The relatively small numbers make the graph look rather jerky. A linear trend line has been inserted show the trajectory more clearly. This suggests that Gloucestershire is performing better than its statistical neighbours on this indicator.

Graph showing the number of children in care for Gloucestershire and statistical neighbours who leave care due to a special guardianship order

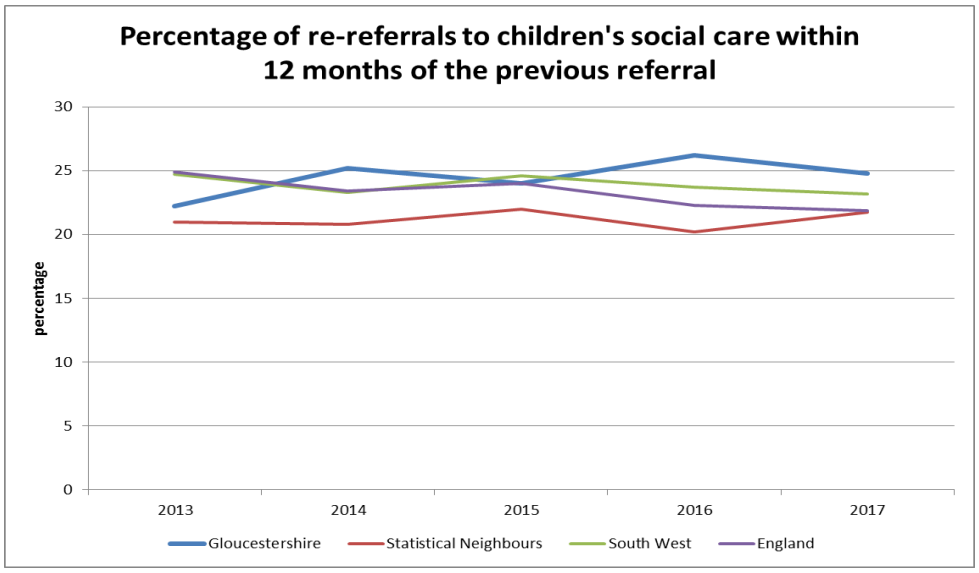


Re-referrals

KEY FINDING- Gloucestershire has a higher proportion of re-referrals into care within 12 months than its comparators. The proportion currently stands at around 25%. In the last 4 years the re-referral number within six months has decreased slightly but over the same time period the number of re-referrals within 12 months has increased slightly. This is an area of concern.

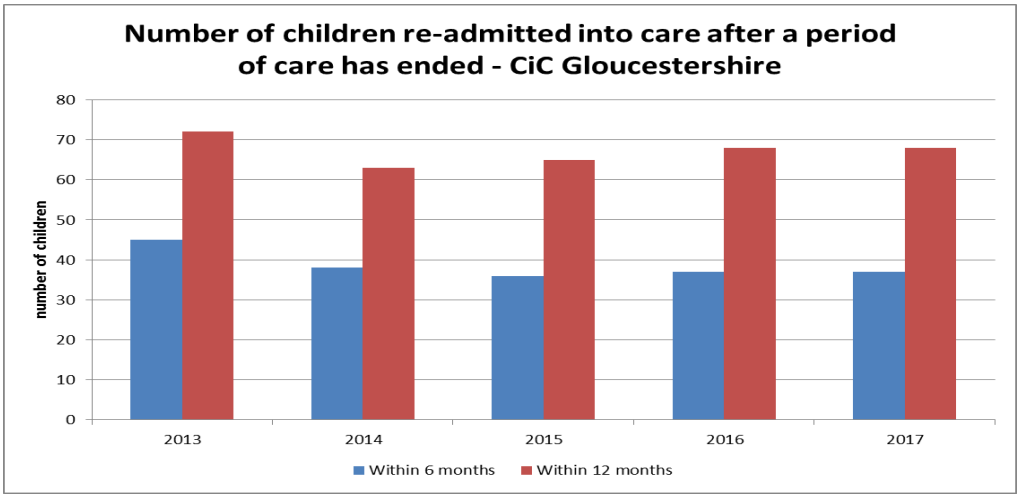
The graph below shows that Gloucestershire has a higher percentage of re-referrals to children's social care within 12 months of the previous referral than our statistical neighbours, regional neighbours or the national average.

Graph to show proportion of re- referrals to children's services within 12 months of end of previous placement



The trend in re-referrals since 2014 has been that those happening with in 6 months has decreased slightly but those happening within 12 months has increased slightly.

Graph to show number of children in Gloucestershire re admitted to care following a previous episode of care within the last 6 or 12 months



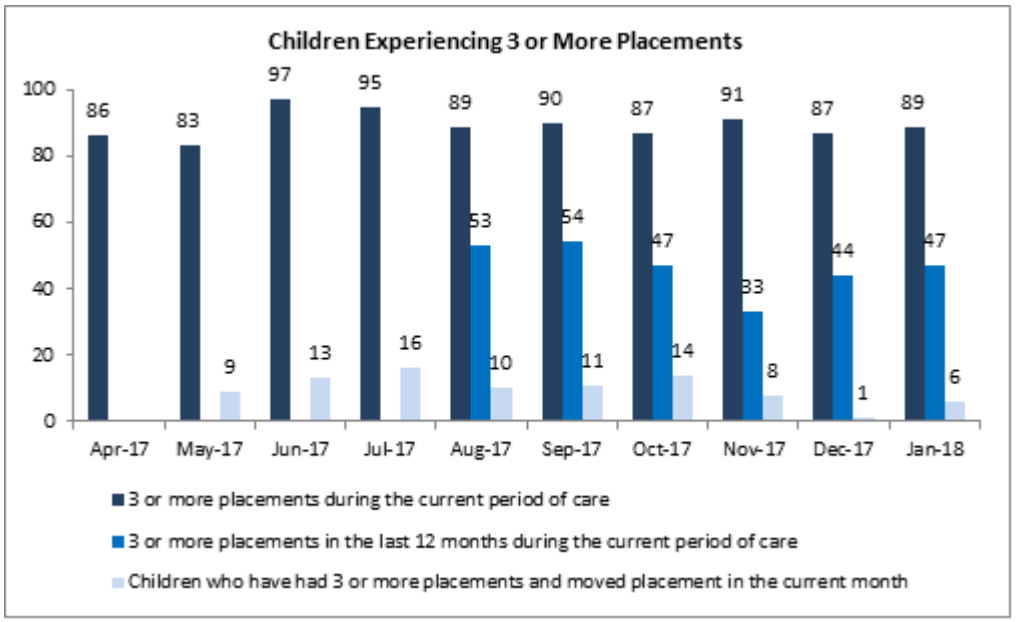
The high rates of re-referral are of concern and it is important that the reasons that underlie it are investigated and addressed. In the light of the unusually high rates of return home after care it would be interesting to understand if premature return to the family situation is involved in the high re-referral rate.

Multiple placements in episode of care

KEY FINDINGS – For the last 9 months in Gloucestershire at any one period of time there have been around 90 children in the system who have had three or more placements in their current period of care. There does not appear to be a sustained improvement in this indicator.

Multiple placements within an episode of care can cause significant issues for the child. The chart below shows the monthly snap shots over the last 10 months for multiple placements. The number of children experiencing 3 or more placements in the current period of care has remained fairly constant at around 90 since August 2017. For children experiencing 3 or more placements in the last 12 months , the number fell form 53 in Aug 2017 to 33 in Nov 2017 but has since risen to 47 in jan 2017.

Graph to show numbers of children in care in Gloucestershire experiencing 3 or more placements in the current period of care

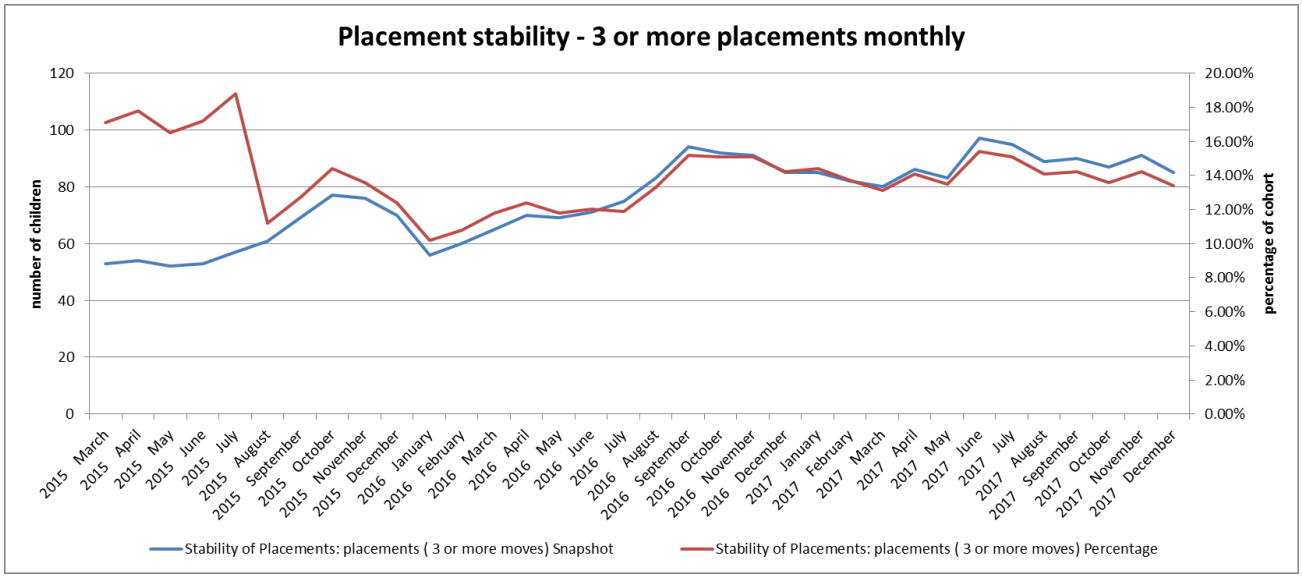


Due to methodology changes it is hard to look at a meaningful benchmarking time series of placement stability[117]. What we can say is that, in 2016 9% of CiC locally experienced 3 or more

[117] *In previous publications of Performance Tables, CiC who go missing from their placement for a period of 24 hours or more had their missing period included as a placement, therefore if a child went missing from care and then returned within a year this counted as three separate placements. From 2015 the way missing episodes were recorded changed so they were no longer counted as an episode. From 2016 the reason for a new episode was collected so it was possible to distinguish between placement changes that involve staying with the same carer. If a child does not change carer in a new*

placements which was in line with the England level (9%) and below our statistical neighbours (10.9%) and the South West (12%).

Graph to show monthly changes in placement stability for children in care in Gloucestershire



Projections

KEY FINDING – If current rates of increase in the proportion of children in care are maintained, then by 2020 there will be an estimated 760 children in care. If interventions to slow the rate of increase are effective, and the proportion of children in care can be maintained at current levels then by 2020 this estimate falls to 628 children in care. Even at the most conservative level of estimates this suggest increased care places will need to be found in the short term.

The chart below shows projections for the numbers of children at various levels of children's services intervention. The projections shown are based on linear trend projections using the 16/17 observed rate of increasing proportion of children in care, in need or on child protection plans.

In practice, the recent Ofsted review is likely to have an impact on this as often after such reviews rates of intervention go up before falling again. However, as an indication of the numbers that can be expected based on linear trends it is worth noting that by 2020, if nothing occurs to disrupt the rate in increase observed and this is maintained at the 2016/17 level, then there would be an estimated 760 children in care in Gloucestershire in 2020. At the more conservative level, assuming interventions are effective and the proportion of children in care can be kept at the current level there would be an estimated 628 children in care in 2020.

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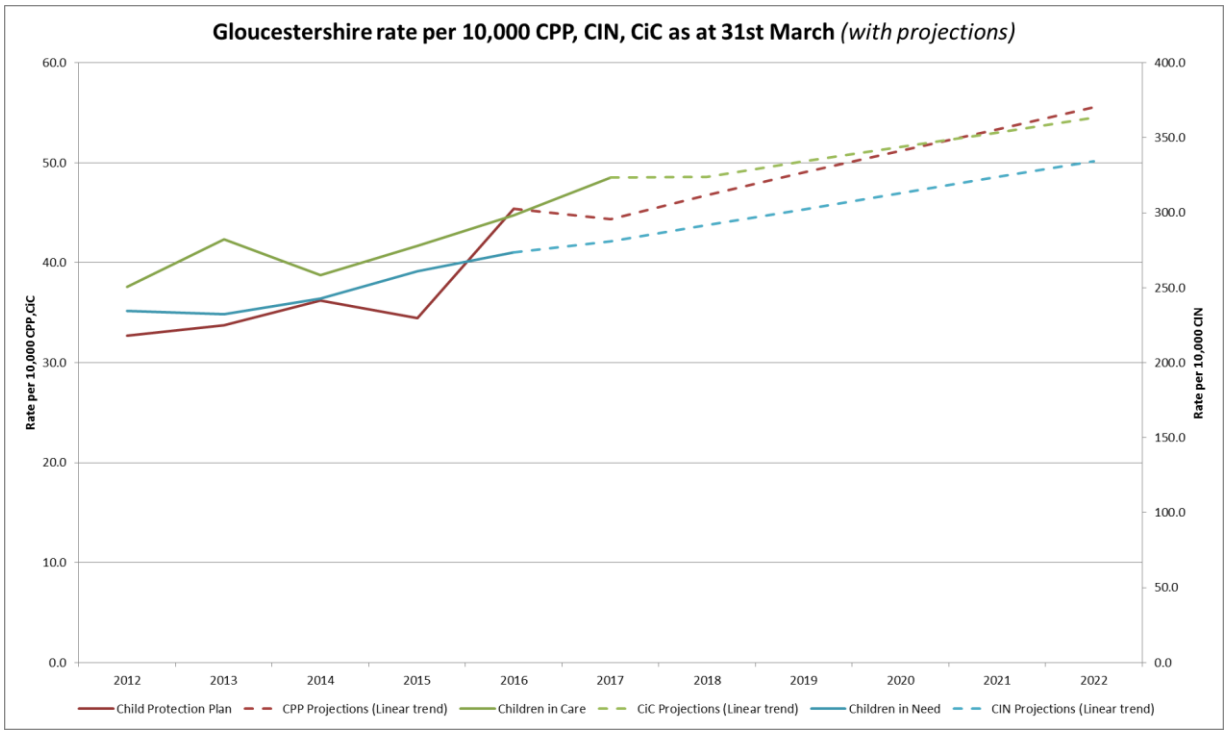
placement this does not now get counted as an additional placement. Due to the methodology changes earlier years are not comparable.

Graph to show projections for the future rates of Child Protection Plans, Children in Need and Children in Care per 10,000 population.



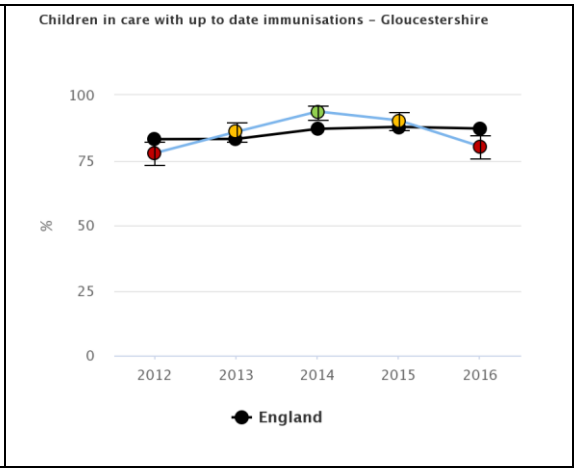
Wider needs of Children in Care

As well as looking at placement data there are a number of other important areas to consider for children who are looked after. Public Health England collates a number of these into its public health outcomes framework. These include data on educational performance and health status. The relative educational attainment of children in care has been considered in the education section.

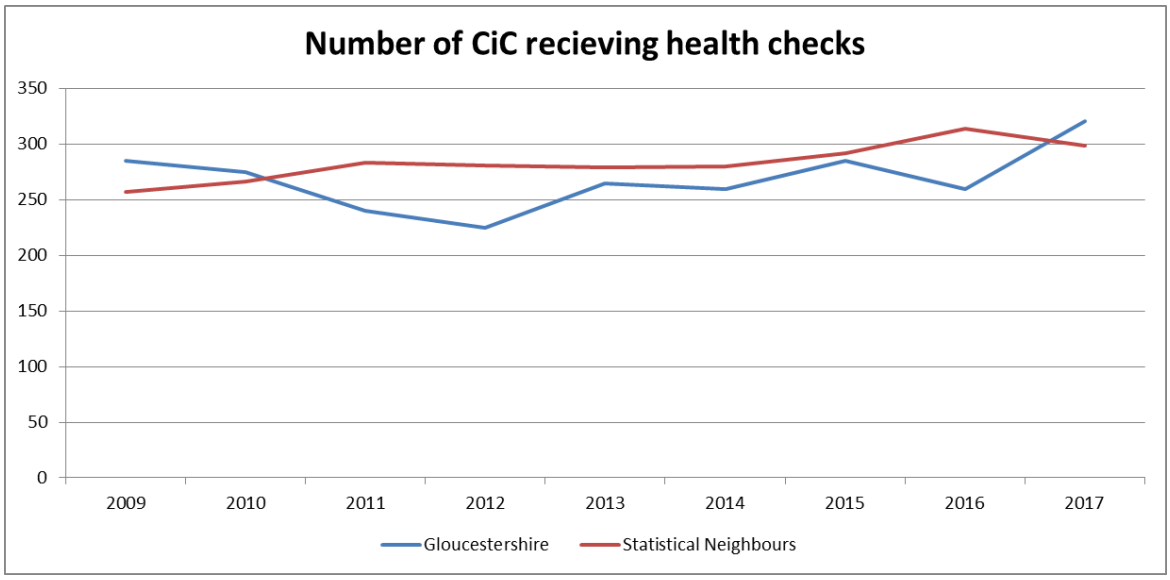
In terms of immunisations, Gloucestershire performs poorly in relation to its peers with only 80% of children in care being up to date on immunisations. The trend data shows this proportion has been dropping since 2014.

Area	Value	Lower CI	Upper CI
England	87.2*	86.4	88.0
South West region	82.9*	80.0	85.9
Cornwall	100*	98.7	100
South Gloucestershire	95.0*	88.8	97.8
Bristol	93.4*	90.7	95.3
Wiltshire	93.1*	89.6	95.5
North Somerset	93.1*	87.8	96.2
Plymouth	92.3*	88.4	95.0
Bath and North East Som...	90.5*	83.4	94.7
Swindon	88.2*	82.5	92.3
Somerset	88.1*	84.1	91.1
Bournemouth	85.7*	79.8	90.1
Torbay	84.1*	78.7	88.3
Poole	81.8*	73.6	87.9
Gloucestershire	80.3*	75.7	84.2
Dorset	60.8*	54.7	66.6
Devon	48.9*	44.2	53.5
Isles of Scilly	*	-	-

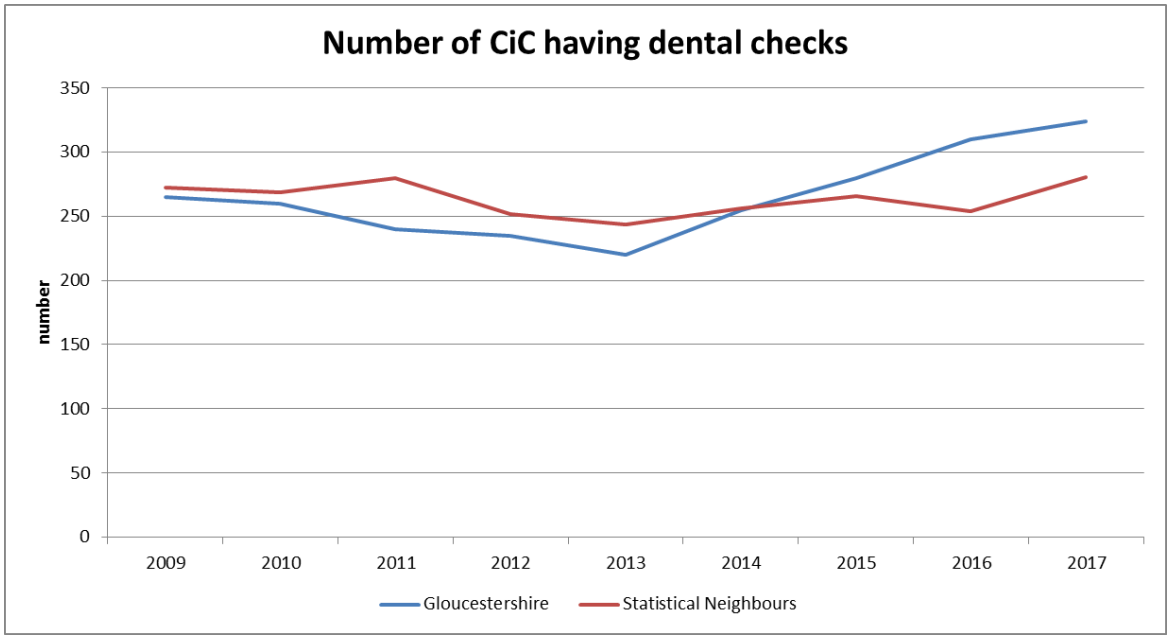
Source: Department for Education



In terms of health checks, since 2010 Gloucestershire has underperformed its statistical neighbours in terms of numbers performed, but since a steep increase in 2016 this situation has reversed.



Dental checks is another health area where Gloucestershire was performing less well than its statistical neighbours but this trend started reversing in 2013 and has continued on an upward trajectory since.



Local Service Provision

Early Help Service Approach

All children receive Universal Services, however, some children will need extra support in order to be healthy, safe and to achieve their potential.

Early help is about providing support to potentially vulnerable children, young people and their families as soon as problems begin to emerge to prevent issues and problems escalating and becoming serious and harmful. Provision of early help support can be at all stages of a child's life; pre-birth, during pregnancy, childhood or adolescence

For illustrative purposes, the kinds of needs and services that are available are outlined in the table below:

Level	Needs	Services (Examples)
Level 1 – Universal Open access to provision	Children and young people are making good overall progress in all areas of their development. They are very likely to be living in a protective environment where their needs are well recognised and met accordingly. These children will require no additional support beyond that which is universally available.	Examples include: ✓ Education Providers ✓ Health Visitors ✓ Midwives ✓ GP's ✓ Universal services accessed through Children and Family Centres, e.g. Stay and Play ✓ Childminders/Nurseries ✓ Leisure centres Advice and guidance to families and professionals is available through **Gloucestershire Family Information Service**.
Level 2 – Additional A coordinated response, through an Early Help Plan – 'My Plan' which may require a single or multi-agency response. The Lead Practitioner will coordinate support and review progress through the Team Around the Child/Team Around the Family where a multi agency response is required.	Children and young people with additional needs, who would benefit from extra help - often from practitioners who are already involved with them. They may need help to: • Improve education • Improve parenting and/or behaviour • Meet specific health or emotional needs • Improve their material situation • Respond to a short-term crisis such as bereavement or parental separation	Examples include: ✓ Early Years Services ✓ Health visitors ✓ Speech and language therapy ✓ Education providers ✓ Educational psychology ✓ Group work accessed through Children and Family Centres, e.g. Rainbows Autism Support Group; Young Carers ✓ 2gether CYPS ✓ Youth Support Service ✓ Families First – Early Help Coordinators providing support with the Graduated Pathway ✓ Housing support ✓ Services provided on a voluntary basis
Level 3 – Intensive	Vulnerable children and	Examples include:

Targeted early help response taking a multi-agency approach through an Early Help Assessment - 'My Assessment and My Plan+'. The Lead Practitioner will coordinate support and review progress through the Team Around the Child/ Team Around the Family.	their families with multiple needs or whose needs are more complex, such as children and families who: • Exhibit anti-social or challenging behaviour • Have poor engagement with key services, such as school and health • Are not in education or work long-term	✓ Specialist health services ✓ Police ✓ Youth Justice ✓ Youth support services ✓ Education providers ✓ Educational psychology ✓ Children and Family Centres – Targeted Family Support (for children aged 0-11); Group Work (e.g. Solihull, Webster Stratton, Best Start) ✓ 2gether CYPS ✓ Families First – Targeted Family Support (0-19); Advice and Guidance through Early Help Coordinators and Community Social Workers ✓ Housing support ✓ Services provided on a voluntary basis
Level 4 – Specialist Children in Need of Specialist Support from Children's Social Care, including Children in Need of Protection and Children in Need of Care	A child or young person living in circumstances where there is a significant risk of abuse or neglect, where the young person themselves may pose a risk of serious harm to others or where there are complex needs in relation to disability. **These children will have complex needs across a range of domains that requires an assessment under the Children Act 1989**	Examples include: ✓ Children's Social Care ✓ Police ✓ Youth Justice ✓ Youth support services ✓ Specialist Education providers ✓ Specialist Health Providers ✓ GDASS

There are a wide range of services which fall within the definition of early help, many of which are offered by voluntary and community groups (see table above). Some services are specifically commissioned to identify needs early on and/or provide interventions including children's centres; community health services, support for domestic abuse victims, and some youth support services. Families First Teams coordinate multi-agency allocations groups in each locality and also undertake direct work with families. Community Social Workers and Early Help Co-ordinators within these teams offer advice, consultation and support to partners working with families.

Schools are increasingly taking on responsibilities for attendance and behaviour support and are making a wide range of support available within school; there is also a strong connection with support for pupils with special educational needs.

Health provision including health visitors, school nursing and primary mental health care workers also plays an important role in identifying issues early on and providing a range of interventions (e.g. parenting skills) as well as ensuring support is available in local areas.

Children may have a range of different needs at different levels and need help from one or more professionals. The Graduated Pathway is Gloucestershire's response to ensuring early help is available to all children, young people and their families with additional needs, including whether these are educational, social or emotional needs arising from a disability. It supports children/young people from the very early stages when support is needed and focusses on what parents and local communities can offer within their own resources. It sets out a graduated approach to ensure support is appropriate and proportionate to the level of need for a child, young person and/or family.

All services and interventions seek to work openly with the child (if age appropriate), young person and family in order to support them address all their needs at the lowest possible level and prevent them from escalating. Higher level services will only be sought after everything possible has been done to meet a child or young person's needs at the current level.

Advice and information on Gloucestershire's early help offer is available through the Council's Family Information Service and the GlosFamilies Directory www.glosfamiliesdirectory.org.uk Professional advice is also available from the 2gether NHS Trust children & young people service CYPS helpline.

Service Approach for Children in Care

More information on this can be found in the Sufficiency Strategy due to be published summer 2018. Guidance for professionals on a child in need and child protection procedures can be found on the Gloucestershire Safeguarding Children Board website (www.gscb.org.uk) .

In this section we will concentrate on services focussed on children in care but it should be remembered that CiC can also access all the universal services around health, mental health school nursing etc.

The Diversion from Placement Support Team (DPST) can provide intensive services to ensure that, where appropriate, children on the edge of care are kept in their own home with a strong support package.

For those where coming into care is the best option there is a focus on getting a good and timely assessment and taking the time and care to ensure each child gets the right placement first time.

Gloucestershire has an in-house **fostering team** but also has an individuals commissioning team to source independent fostering agencies and residential placements where needed. In addition semi-independent placements are also commissioned where appropriate.

Within the in-house fostering service there are a number of special schemes that can be used to meet the individual needs of a child (or sibling group). These include:

Intensive Recovery and Intervention Service (IRIS) – this supports some of the most complex children and young people and helps them prepare to return home or settle in long-term foster care

Parent and child fostering – this provides a safe and secure home for a parent and their child. The foster carer is in the unique position of helping the parent develop alongside the child. This kind of care can help a family stay together.

Short-term Emergency Placements Scheme (STEPS) – this is for emergency placements that may last longer then the normal 72 hours. Such placements allow time to plan the next move for a child and support the right placement, first time aim.

Supported Lodgings - Supported lodgings carers help a young person aged 16 or 17 prepare to be independent. They offer practical support in developing independent living skills in young people.

The services are planned around promoting permanence and, as the young person grows, in planning for a successful transition into an independent adulthood.

Evidence around What Works

In line with national policy, there are numerous NICE and PHE guidance on improving the outcomes of LAC]. [118] [119] [120]These include:

Policy:

- Create strong leadership and strategic partnerships to develop a vision and a corporate parenting strategy that:
    - focuses on effective partnership and multi-agency working
    - addresses health and educational inequalities for looked-after children and young people.
- Ensure that local strategic plans adhere to national guidance, primarily Statutory guidance on promoting the health and well-being of looked after children
- Ensure local plans and strategies for children and young people's health and wellbeing fully reflect the needs of looked-after children and young people, and care leavers, and set out how these needs will be met. They should describe how to:
    - meet the changing needs of looked-after populations and provide high-quality care
    - provide services that meet the emotional health and wellbeing needs of children and their carers, including child and adolescent mental health services (CAMHS), core health services (for example, immunisation) and enhanced services (for example, paediatrics)
    - promote healthy lifestyles
    - provide access to extra-curricular activities
    - improve the stability of placements and education.

[118] NICE, Looked-after children and young people [QS31]. 2013.
[119] DoH, Promoting the health and well-being of looked-after children. 2015
[120] NICE, Looked-after children and young people [PH28]. 2010

- Ensure senior managers in partner agencies provide strong, visible leadership to raise aspirations and attainment, and promote joint working to meet the needs of looked-after children and young people.
- Ensure effective corporate parenting by complying with guidance on the role of lead members for children's services and directors of children's services in helping looked-after children and young people improve their aspirations and outcomes.
- Ensure services are developed taking account of the views of looked-after children and young people
- Provide an annual report to the children-in-care council, the local authority overview and scrutiny committee, the director of public health, the NHS commissioner and the leader of the council. This report should cover the effectiveness of services for looked-after children and young people when evaluated against local plans for health and wellbeing, the local pledge to children in care, national indicators and local targets.
- Publish and update regularly a directory of resources for looked-after children and young people to aid social workers, and a resource guide for looked-after children and young people and care leavers.
- Ensure local authorities reflect in their yearly 'pledge' to looked-after children and young people the needs and challenges raised by children-in-care councils about improving services to achieve better outcomes.

(There is currently a new sufficiency strategy being developed with these principles in mind)

Community/Neighbourhood

- Build communication networks with key partner organisations and publish, publicise and update regularly a local map that identifies all agencies that are involved with looked-after children and young people.

Discussion, Gap Identification and Recommendations

Strengths in this area:

- The Ofsted improvement plan is currently ensuring that significant effort and expertise is being applied to making improvements to how children's services work

Areas of Concern

- Numbers of children in care and in contact with Children's services are rising both nationally and locally and this is in danger of becoming financially unstainable

- The current burden the system is under means that focussing on early prevention work that will see its benefits several years down the line can be de prioritised due to the overwhelming need to focus on children who are currently in crisis

Recommendations

Early prevention work that addresses factors that go on to make children at risk needs to be embedded in the system

Continue to implement the Ofsted improvement plan to optimise services.

Children with Special Education Needs and Disabilities

Children with Special Education Needs and Disabilities

Introduction

Special educational needs and disabilities (SEND) can affect a child or young person's ability to learn. They can affect their:

- behaviour or ability to socialise, for example they struggle to make friends
- reading and writing, for example because they have dyslexia
- ability to understand things and make educational progress
- concentration levels and attendance, for example because they have ADHD
- physical ability

SEN is defined as having 'a learning difficulty or disability which calls for special educational provision to be made'. SEN provision is defined as 'additional to or different from that generally made for others the same age' in mainstream settings. This means that where schools have the skills and resources to respond to children with higher levels of need without needing to seek advice and support from local specialist services, fewer children will 'have' SEN.

In most cases, additional support is identified and provided within the child's school and what is called 'SEN support'. Children with more enduring difficulties are provided an Education, Health and Care plan (EHCP) following a statutory assessment by the local authority.

A more detailed picture of the data around this topic can be found in "Special Educational Needs and Disabilities 2017: A profile of children in Gloucestershire with SEND, and the financial picture" https://inform.gloucestershire.gov.uk/get/ShowResourceFile.aspx?ResourceID=1070

Policy Context

The Children and Families Act 2014 has led to changes in the ways education, health and social care agencies identify and meet the needs of children and young people (0-25 years) with special educational needs and disabilities. These include closer co-operation of education, health and social care services with the child/young person and parents/carers in supporting and managing their needs, a strengthened expectation that children and young people participate in decisions made about them and improving the transition of students with SEND from school to post-16 provision and to adult life. The Act initiated a new process for Education, Health and Care (EHC) plans and the transfer of Statements of SEN to EHC plans. This transition is due to be completed by April 2018.

The legal test of when a child or young person requires an EHC plan remains the same as that for a statement under the Education Act 1996 i.e. a child with SEN receives an EHC plan when assessed as requiring one.

Local authorities have long standing duties in the 1989 Children's Act and Chronically Sick and Disabled Persons Act 1970 that relate to children and young people with SEND. The Care Act 2014 introduces new requirements for assessing and supporting children and young people with SEN when they are detained in and released from youth custody, as well as the needs of young carers and parent carers of disabled children.

In Gloucestershire, the Building Better Lives policy https://www.gloucestershire.gov.uk/health-and-social-care/disabilities/building-better-lives/ sets the direction for the provision of education, care and support to people with a disability in Gloucestershire from 2014 to 2024. The policy promotes and drives inclusion and involvement of people with a disability in the workplace, their communities, groups, clubs, leisure activities etc enabling them to lead full and meaningful lives along with other people in their community.

A new inspection framework by Ofsted and CQC has been introduced. The framework considers how well a local area identifies and supports the needs of children and young people with SEN and disabilities and how well they achieve the best possible educational and other outcomes, such as being able to live independently, secure meaningful employment and be well prepared for their adult lives.

Epidemiological Data Review

In Gloucestershire, in January 2017, there were 13,835 puplis with SEN. This equates to 14.7% of the total school population which is in line with the national figure of 14.4%[121].

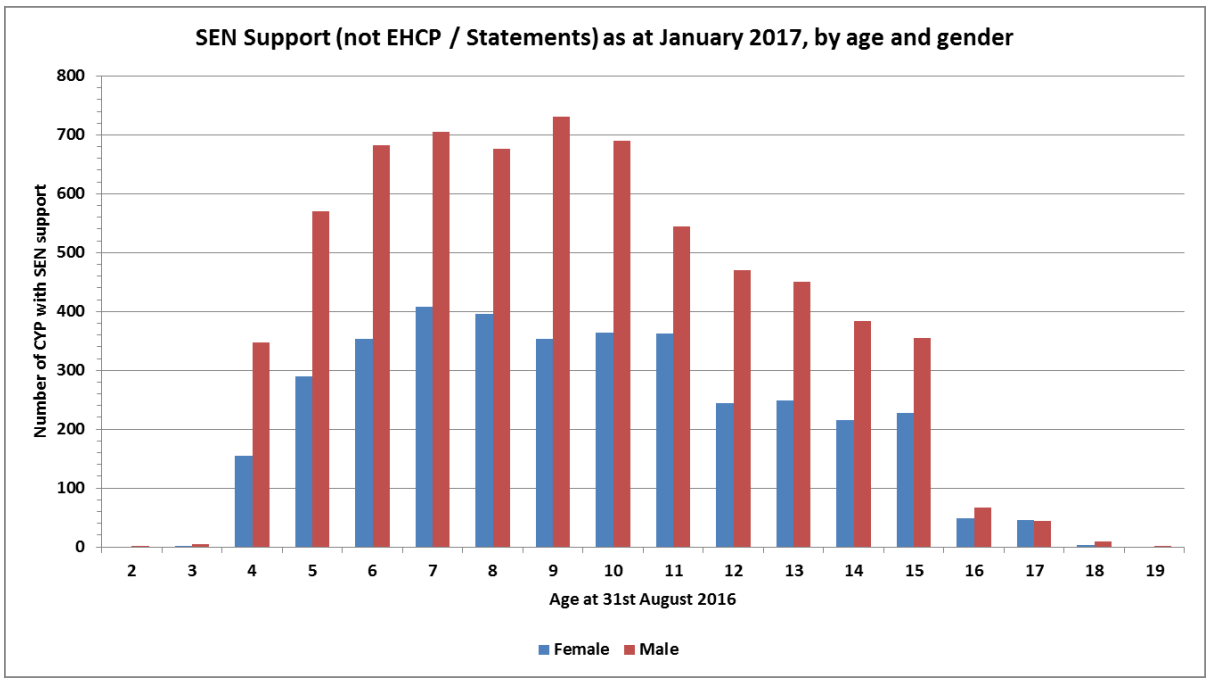
Nationally, the number of pupils with SEN in schools in England has fallen by one fifth in the last decade to 1.23 million in January 2016. This fall has been driven by recent reforms and criticism by Ofsted that schools were identifying too many children as having SEN.

SEN Support

In January 2017, there were 11,398 pupils receiving some form of SEN support. This equates to 12.1% of the school population which is slightly higher than the national figure of 11.6%[122]. The gender split is skewed towards males, with 36% of this cohort female, and 64% male. The gender and age distribution is shown below[123]:

[121] Information based on data published in the DfE SFR *Schools, pupils and their characteristics, 2017* see https://www.gov.uk/government/statistics/schools-pupils-and-their-characteristics-january-2017 (Local authority and regional tables: SFR28/2017).
[122] *Ibid.*
[123] Breakdowns by age, gender and primary need are based on pupils recorded as SEN Support in state funded primary, secondary and special schools and academies in Gloucestershire in the January 2017 School Census, This means that we do not have definitive information on **all** children in Gloucestershire schools, but only those schools that make a school census return to the authority.

Graph to show SEN support without EHCP/Statements in 2017 by age and gender.

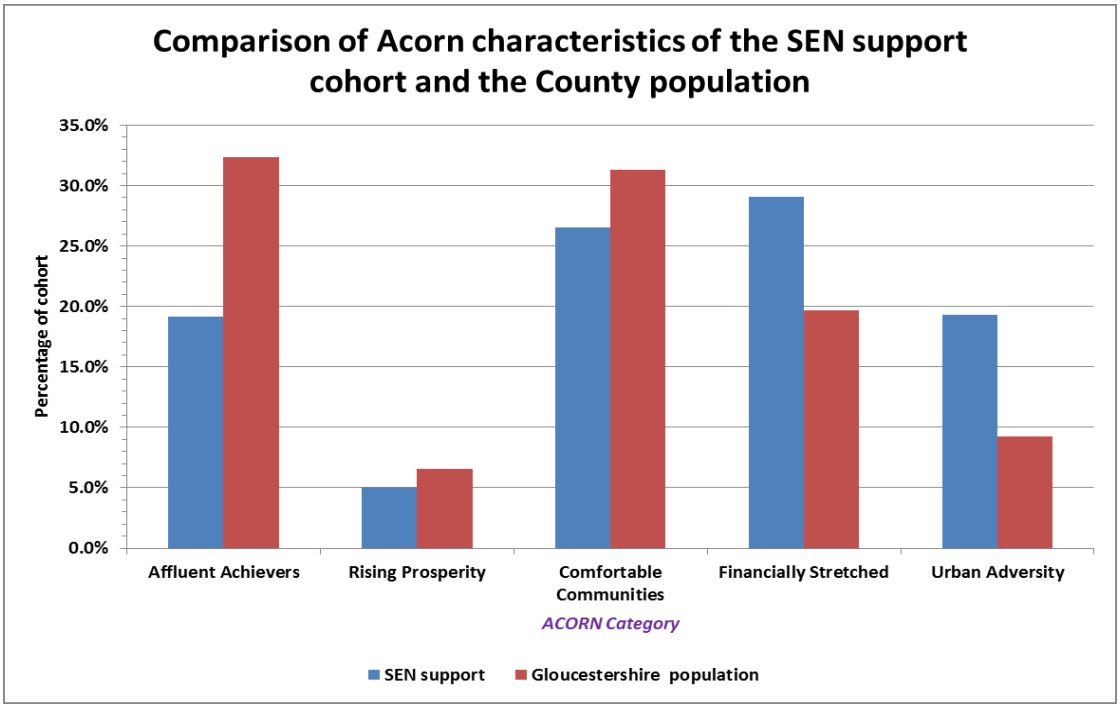


Based on School Census January 2017. Special Educational Needs and Disabilities 2017 report

The primary need for SEN support is recorded by each school, with moderate learning difficulty (MLD) being the most frequently recorded need, accounting for 35% of needs in the whole group.

There are some gender differences in the needs seen. While numbers of females with SEN support are lower overall, the proportion of females with MLD and specific learning difficulty (SPLD) are significantly higher than the proportion of males. Conversely, the proportion of males with social emotional and mental health needs (SEMH) and speech, language and communication needs (SLCN) are significantly higher than the proportion of females. There is only a small proportion of children who have autistic spectrum disorders recorded as their primary need.

In terms of deprivation, the Index of Multiple Deprivation (IMD) 2015 shows that children and young people with SEN support are over represented in areas of high deprivation and underrepresented in areas of low deprivation. This is seen both when the population is grouped according to deprivation quintile or by the more descriptive ACORN characteristics. This is illustrated below:



Special Educational Needs and Disabilities 2017 report

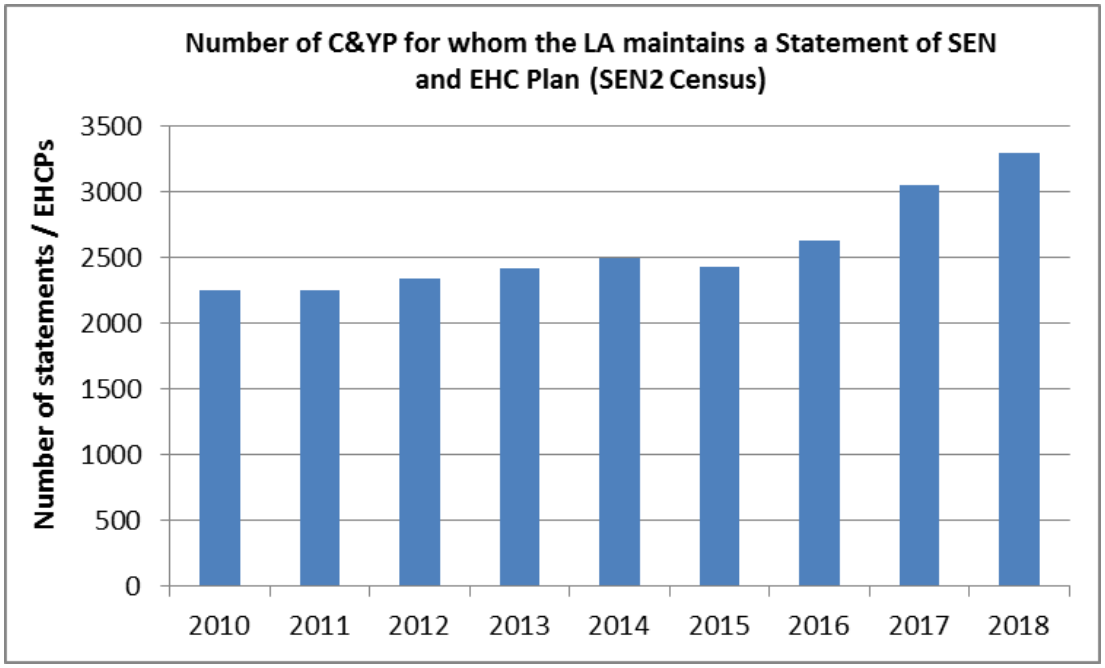
This data shows that those needing SEN support are more likely to come from financially stretched households or those living in pockets of adversity. It is not possible to tell if this link is a cause or an effect of poverty but it does represent a noteworthy health and wellbeing inequality.

Education Health and Care Plans /Statements of Special Educational Needs

In January 2017, there were 3,044 children and young people aged 0 to 25 with a statutory Education, Health and Care Plan (EHCP) or a statement of special educational needs maintained by the local authority. This equates to 1.7% of the 0-25 population in Gloucestershire[124]. Since the SEN reforms came into effect in September 2014[125], the number of children and young people with a statement or an EHCP in Gloucestershire has increased by 35%. Some of this increase is accounted for by the increased age range but not all of it. The number of children and young people with a statement or an EHCP increased to 3,290 in January 2018 (1.9% of the 0-25 population).

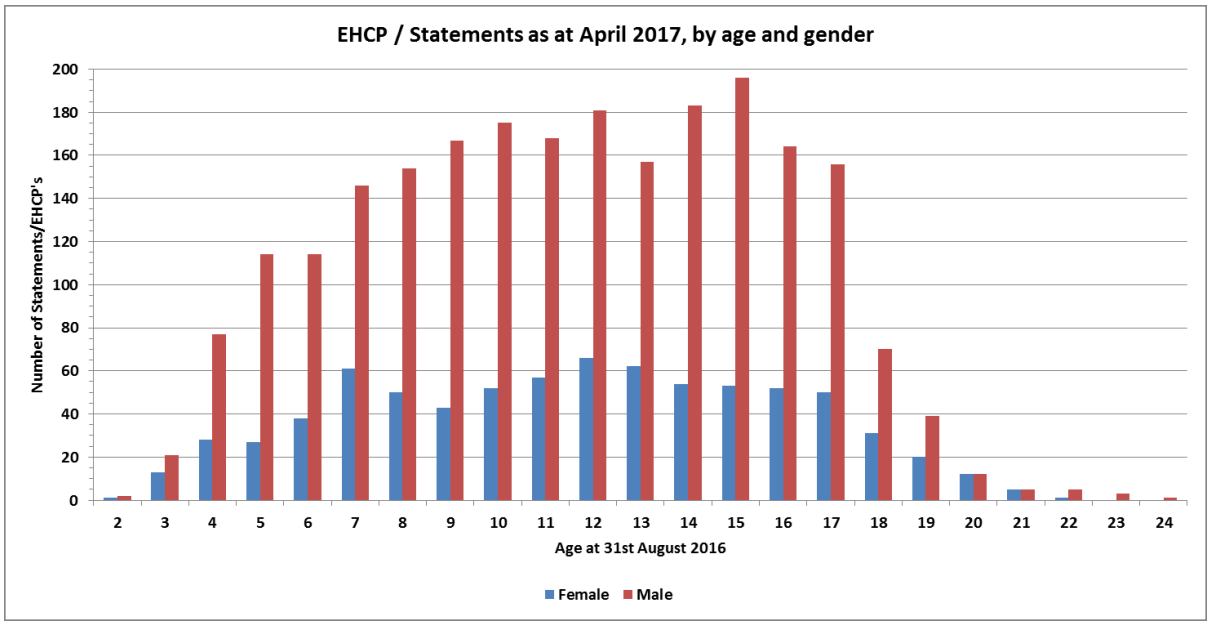
[124] Figures based on data from the SEN2 Census. The return is the only source of data to report on all statements of SEN and EHC plans maintained by individual local authorities. For further information see https://www.gov.uk/government/statistics/statements-of-sen-and-ehc-plans-england-2017

[125] Education, Health and Care (EHC) plans for children and young people aged up to 25 were introduced on 1 September 2014 as part of the Special Educational Needs and Disability (SEND) provisions in the Children and Families Act 2014.



In the January School Census, 2,437 pupils were identified as having a statement or an EHCP (this is a subset of the total above). This equates to 2.6% of the school population which is slightly below the national figure of 2.8% of pupils with a statement or an EHCP in all schools.

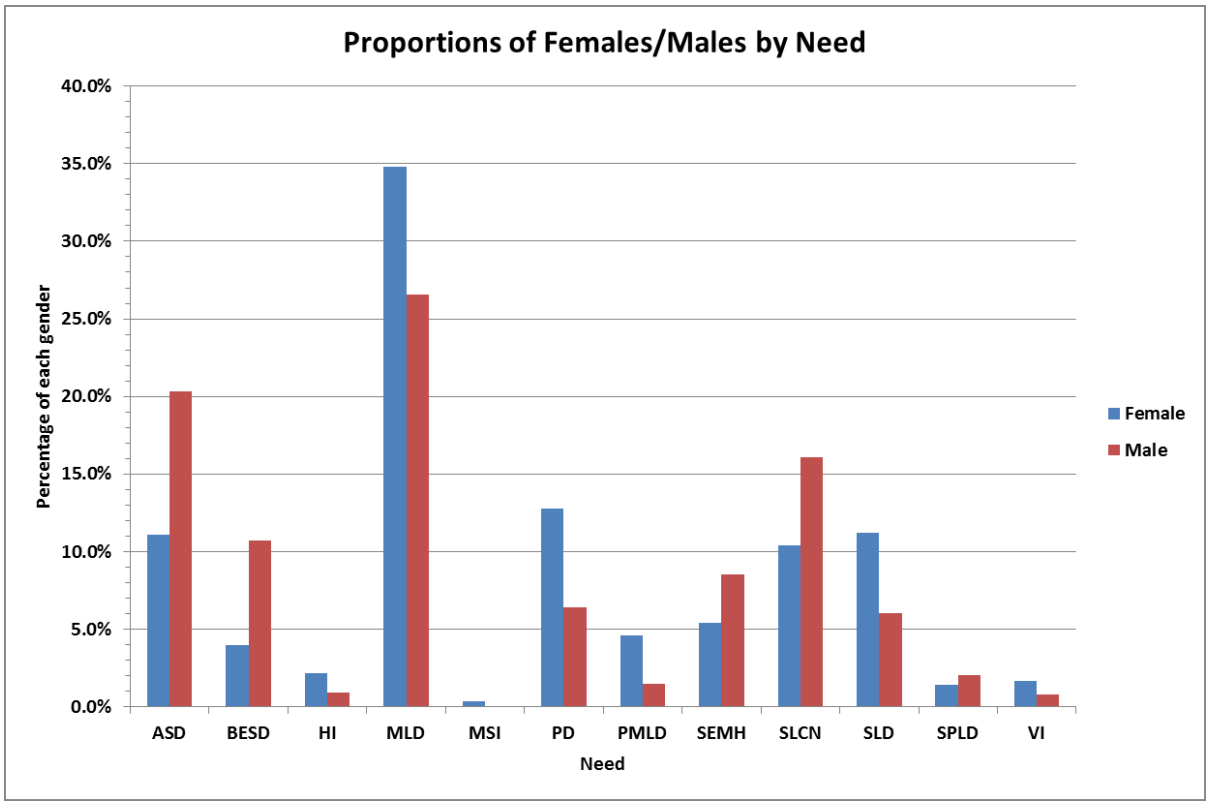
As with other SEN support indicators, males are over represented at all age levels with the overall ratio being 3:1 more males with an EHCP/Statement. This higher proportion of men has remained constant for a number of years both nationally and locally.



Special Educational Needs and Disabilities 2017 report

In terms of reasons for having an EHCP, the most prevalent need is Moderate Learning Disabilities (MLD), followed by Autistic Spectrum Disorder (ASD) and then Speech Language and Communication Needs (SLCN). While there are greater numbers of males in most of these categories of need, a

significantly higher proportion of males are in the ASD need category (20.3% compared to 11.1% of females). Likewise, the proportion of males in the SLCN category is significantly higher (16.6% compared to 10.4% of females). When looking at the group with MLD we see the opposite picture, with females having a significantly higher proportion in this category of need (34.8% compared to 26.5% of males). Both Physical Disability (PD) and Severe Learning Difficulty (SLD) also show a significantly higher proportion of females in these categories of need.



Percentage of categorised needs, for each gender. Special Educational Needs and Disabilities 2017 report

In line with the national picture, the highest percentage of new EHC plans issued during the 2016 calendar year were for children aged 5 to 10 years old (45%). This group has accounted for the highest percentage of new EHC plans issued since 2009 . The proportion in this age band peaked in 2014 at 56.1%. The percentage of new EHC plans issued for children and young people aged 16 to 19 increased by 5.6% in 2016 (Gloucestershire and nationally). The lowest percentage of new EHC plans were issued for young people aged 20 to 25 (0.27% in Gloucestershire, 2.1% in England). The age breakdown remains relatively consistent for the 2017 calendar year to July 2017 (30% under 5; 51% 5-10; 14% 11-15; 4% 16-19; 1% 20-25).

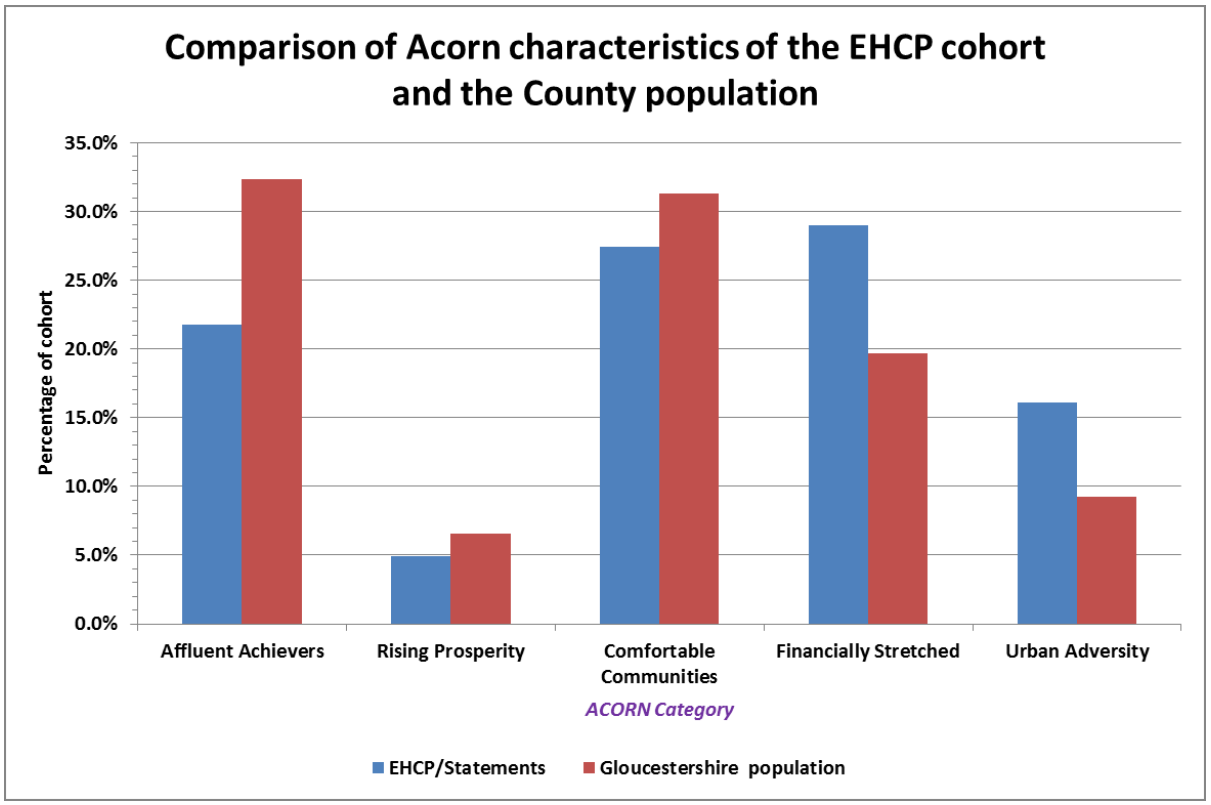
Place of Education for those with EHCP/Statements

In Gloucestershire, the highest percentage of children and young people with a statement or an EHC plan as at January 2017 were receiving provision in mainstream school settings (43.5%), followed by special settings (37.9%). Nationally 44.8% of pupils were receiving provision in mainstream settings and 42.5% in special settings.

Of those pupils in special settings in the county, 33.9% were receiving provision in LA maintained special schools and academies. This is slightly lower than nationally (36%). Fewer pupils with statements and EHC plans maintained by Gloucestershire were receiving provision in non-maintained and independent special schools (4%) than nationally (5.2%). Of Gloucestershire's statistical neighbour authorities only Worcestershire had a lower percentage of pupils with statements and EHC plans in non-maintained and independent special schools (3.3%).

The majority of post 16 learners with a statement or an EHC plan were receiving provision in general FE colleges (12.1% in Gloucestershire compared to 9.1% nationally). A slightly higher percentage of young people are in Specialist post-16 institutions (2%) compared to nationally (1.1%).

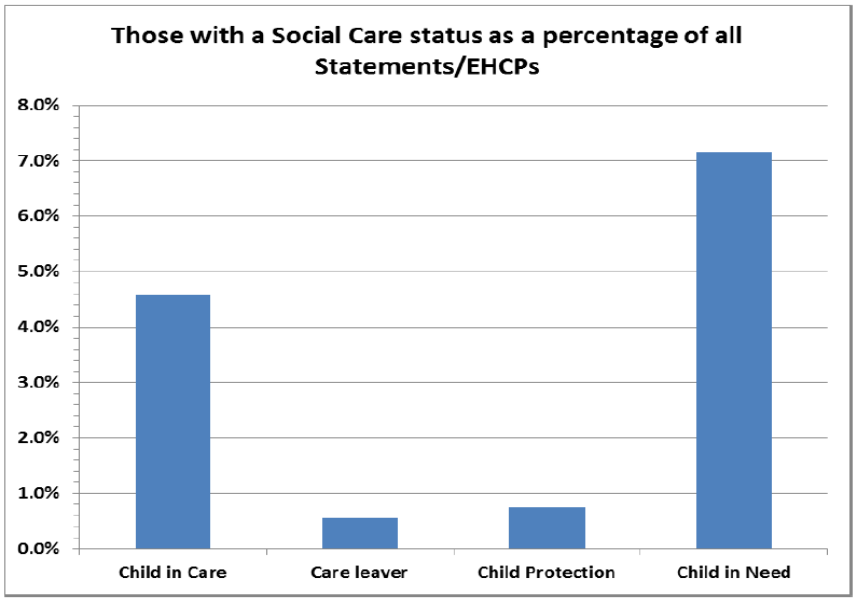
Those with an EHCP/Statement are more likely to be from the financially stretched and urban adversity categories, and less likely to be in the affluent achievers category when compared to the county population.



Comparison of Acorn characteristics of those with an EHCP/Statement in comparison to the population of Gloucestershire. Special Educational Needs and Disabilities 2017 report

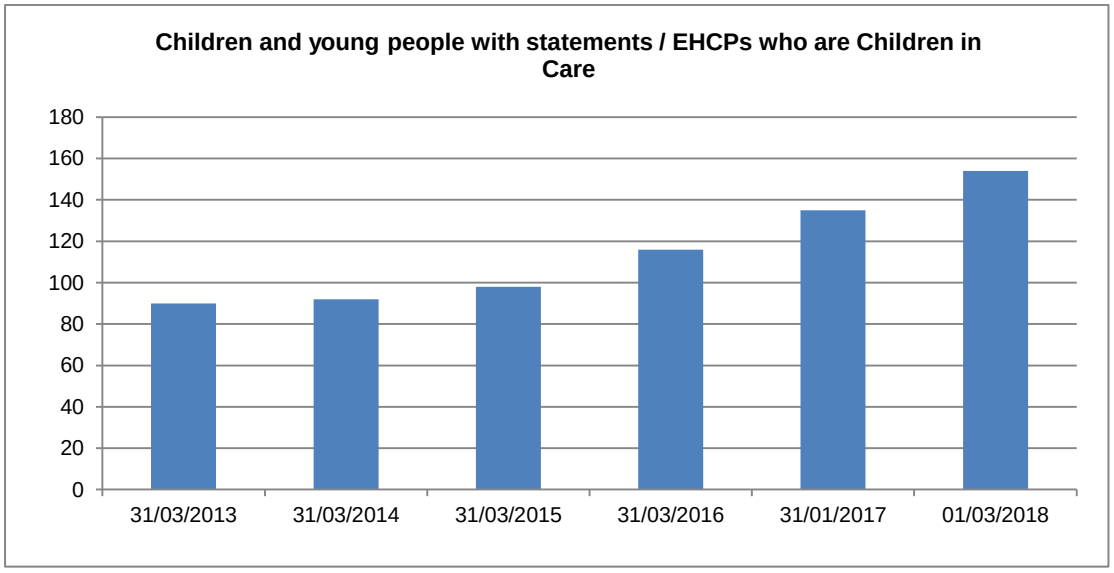
SEN and contact with Children's Services

The number of children and young people with SEN with some form of Children's Social Care status in April 2017 was 402, which accounted for 13% of the total number of children and young people with an EHCP / Statement at this date. The following chart gives the breakdown of children and young people with SEN and children's social care involvement.



Special Educational Needs and Disabilities 2017 report

For comparison, the equivalent percentage (of under-18s) who are in care in the county is 0.45%. The Gloucestershire proportions for Child Protection, and Children in Need are 0.46% and 2.7% respectively. The proportion of those with an EHCP/Statement who are classified as Children in need or with a Child Protection Plan is much higher than in the Gloucestershire population as a whole. This proportion has been growing over the last five years



From SEND Data Dashboard Feb 2018

High Needs Cohort

Local authorities receive funding for schools and early years through the Dedicated Schools Grant (DSG). Within the DSG there is a block for funding for pupils aged 0-25 with "high level needs" which covers a range of support for children with additional needs in both mainstream and specialist provision. These include:

- SEND in the early years
- Top-up funding in mainstream schools to meet additional needs costing over £6,000 p.a.
- Special schools
- Specialist placements in independent schools
- Post 16 education
- Alternative provision for children and young people whose needs cannot be met in mainstream or who have been excluded from school
- Specialist services e.g. the Virtual School for Children in Care and the Hospital Education Service

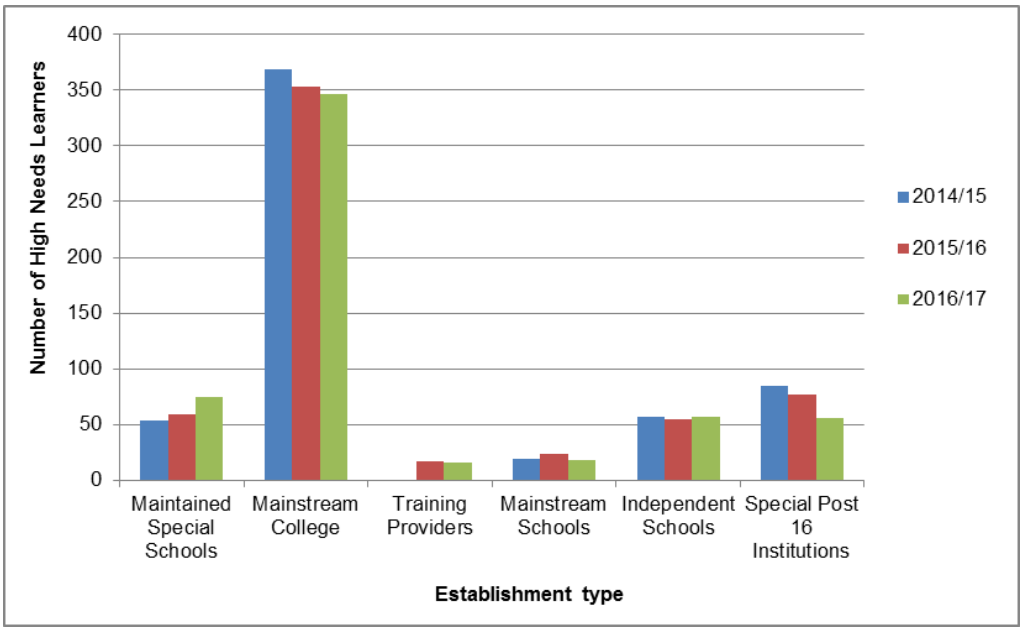
Gloucestershire, in line with national trends, expects to see this cohort grow which is likely to have a large impact on the services and associated costs in the future. Central government funding is not expected to grow at the same rate.

During the 2016/17 academic year, there were 568 High Needs learners aged 16-25 in Gloucestershire. Of these:

- 61% of students attended mainstream further education colleges
- 13% of students (in the age range 16-18) were placed in one of the four Post 16 units in Gloucestershire's special schools
- 3% of students (in the age range 16-18) attended mainstream school sixth forms
- 20% of students (aged 16 to 25) were placed in independent schools or colleges
- 7% of students attending independent schools or colleges were in residential placements
- 3% of students were on roll with a training provider.

Further detail of educational provision, costs, need etc for SEND learners aged 16-25 can be found in 'SEND Gloucestershire needs assessment for learners aged 16 to 25'.

The graph below shows the number of high needs learners aged 16-25 by establishment type from academic years 2014-15 to 2016-17.

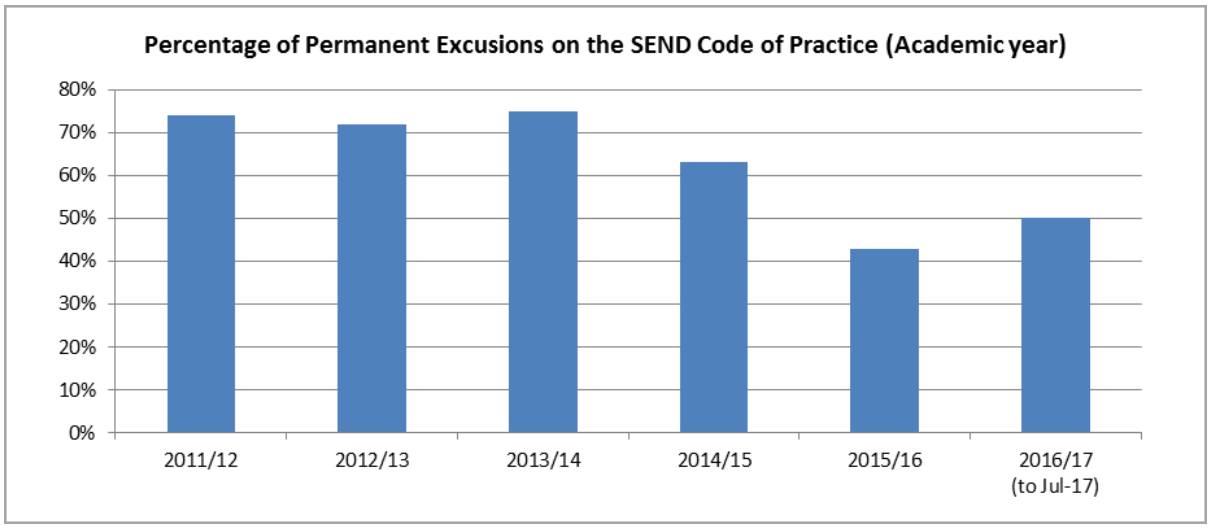


SEND Gloucestershire needs assessment for learners aged 16 to 25.

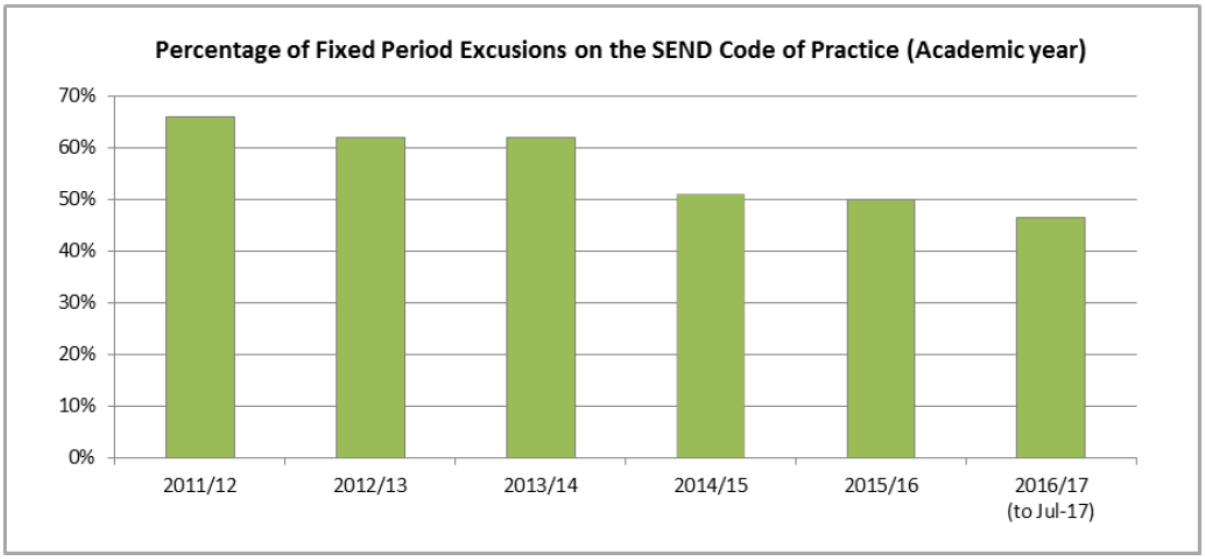
SEND and Exclusions

Gloucestershire is the authority in the South West (2016/17) that has the highest rate of permanent exclusions based on rates per head of population. It also has a high level of fixed term exclusions compared to comparator areas. There are complex reasons for this which may include the current school accountability measures, zero tolerance behavior policies, budgetary constraints and a shortage of high quality alternative provision providers.

During the 2016/17 academic year, 52% of permanent exclusions and 46% of fixed period exclusions related to children and young people with SEND. As the graphs below shows this proportion has been decreasing but it still disproportionately high.



Special Educational Needs and Disabilities 2017 report

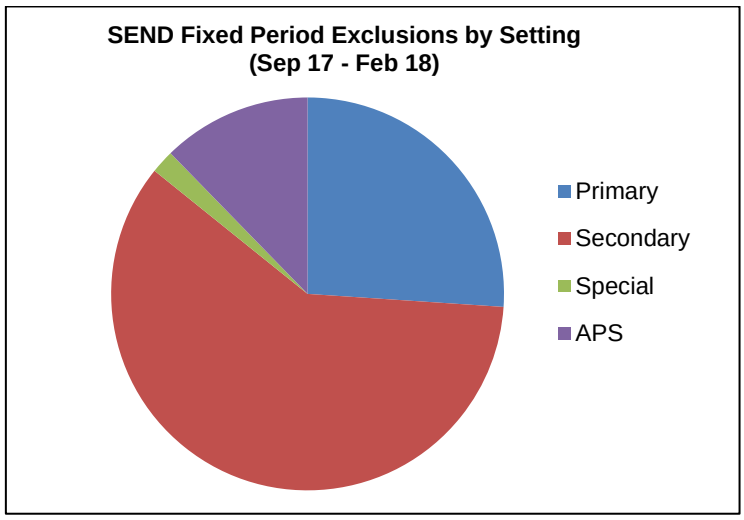


Special Educational Needs and Disabilities 2017 report

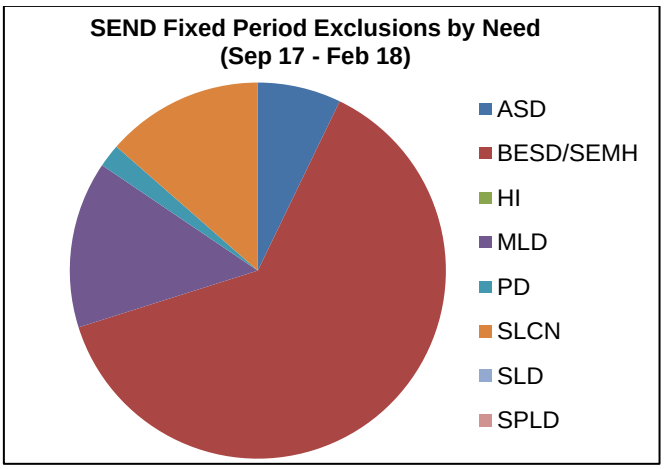
In the current academic year (as at Sep 17 to Feb 18), there have been 284 Primary (26%), 651 Secondary (60%), 21 Special (2%) and 134 Alternative School (12%) fixed period exclusions of

children and young people with SEND in comparison to 38 Primary (4%), 868 Secondary (9%) and 57 Alternative School (6%) fixed period exclusions of children and young people that are non SEND.

53% of all children and young people given a fixed period exclusion to-date in 2017-18 have SEND which is a concerning proportion. The majority of fixed period exclusions (63%) are of children and young people with Social Emotional and Mental Health needs (SEMH), Moderate Learning Difficulty (MLD) (14%) and Speech, Language and Communication needs (SLCN).



From SEND Data Dashboard Feb 2018



From SEND Data Dashboard Feb 2018

The Institute of Public Policy Research 'Making the Difference report' (October 2017) found that excluded children are twice as likely to be in care, four times more likely to have grown up in poverty, seven times more likely to have a special educational need and ten times more likely to suffer recognised mental health needs than their peers. The long term cost to society of exclusion are staggering – it is estimated that every cohort of permanently excluded pupils will go on to cost the state an extra £2.1 billion in education, health, benefits and criminal justice costs.

Gloucestershire's Alternative Provision schools have been running over capacity, they have been asked to meet the diverse needs of a range of children including those awaiting special school placements and they have sometimes been receiving children whose needs are not well understood or documented.

SEND and Educational Attainment

% Good level of development achived - Pupils on SEN support (Foundation)				14%	19%	18%	↓		27%
% Good level of development achived - Pupils with an EHCP (Foundation)				4%	1%	4%	↑		4%
% Good level of development achived - Pupils with no identified SEN (Foundation)		56%	61%	70%	72%	73%	↑		76%
% of year 1 pupils meeting the expected standard of phonic decoding - SEN without statement/EHCP		32%	35%	36%	41%	38%	↓		47%
% of year 1 pupils meeting the expected standard of phonic decoding - Statement/EHCP		16%	13%	13%	15%	16%	↑		18%
% of year 1 pupils meeting the expected standard of phonic decoding - no identified SEN		80%	83%	83%	87%	87%	→		87%
KS2 Attainment of SEN Non Statemented / EHCP children - Reading, Writing and Maths					17.0	16.0	↓	17.5	21
KS2 Attainment of SEN Statemented / EHCP children - Reading, Writing and Maths					6.0	8.0	↑	9.5	8.0
KS2 Attainment of pupils with no identified SEN - Reading, Writing and Maths					64.0	73.0	↑	69.8	71.0
Attainment 8 score - pupils with SEN support					33.70	31.10	↓	31.50	31.90
Attainment 8 score - pupils with SEN statement / EHCP					15.50	14.70	↓	14.53	13.90
Attainment 8 score - pupils with no identified SEN					55.60	51.50	↓	49.65	49.70
Progress 8 score - pupils with SEN support					-0.64	-0.60	↑	-0.49	-0.43
Progress 8 score - pupils with SEN statement / EHCP					-1.18	-1.09	↑	-0.99	-1.04
Progress 8 score - pupils with no identified SEN					0.06	-0.02	↓	0.00	0.07
% KS4 SEN Pupils without statement/EHCP going to, or remaining in, education & employment/training (overall)		84.0	85.0	89.0	87.0	not currently available	↓	88.70	88.00
% KS4 SEN Pupils with statement/EHCP going to, or remaining in, education & employment/training (overall)		90.0	95.0	92.0	89.0	not currently available	↓	90.8	91.0
% KS4 None SEN pupils going to, or remaining in, education & employment/training overall		92.0	93.0	95.0	95.0	not currently available	→	96.0	95.0
% of KS4 SEN Cohort in Education, Employment or Training at 17	78.0%	84.0%	86.0%	89.0%	88.0	not currently available	↑	89.20	88.00
16-17 year old with SEN in education & training			88.0%	85.5%	83.75	not currently available	↑	87.83	87.52
%19 years olds qualified to level 2, inc. E&M - SEN without statement	23.1%	25.3%	28.6%	32.0%	32.9%	not currently available	↑	36.84	37.00
%19 years olds qualified to level 2, inc. E&M - Statement/EHCP	12.0%	11.3%	12.2%	11.6%	16.4%	not currently available	↑	14.82	15.30
%19 years olds qualified to level 2, inc. E&M - Non SEN	77.8%	79.0%	78.3%	78.2%	76.9%	not currently available	↓	78.73	78.10
%19 years olds qualified to level 3 - SEN without statement	21.2%	24.9%	25.6%	27.3%	28.8%	not currently available	↑	29.57	31.20
%19 years olds qualified to level 3 - Statement/EHCP	10.3%	12.4%	11.4%	10.6%	12.9%	not currently available	↑	12.2	13.7
%19 years olds qualified to level 3 - Non SEN	68.9	68.4	67.0	66.3	65.4	not currently available	↓	64.2	64.8

From SEND Data Dashboard Feb 2018

The educational levels of attainment achieved by children and young people with special educational needs are significantly lower than those learners with no identified SEN. Children and young people with an EHCP or statement achieve significantly lower levels of attainment than their counterparts with no identified SEN, though this is broadly in line with national comparator figures.

Those children and young people receiving some SEN support do moderately better in Gloucestershire than those with an EHCP or statement but worryingly are not achieving comparable levels of attainment as nationally. This is particularly notable for children achieving a good level of development in early years (18% Gloucestershire, 27% National), children meeting the expected standard of phonic decoding in Year 1 (38% Gloucestershire, 47% National), children's reading, writing and maths levels in Year 3 (Gloucestershire 16%, National 21%) and young people's achievement of Level 2 at age 19 (32.9% Gloucestershire, 37% National, 2016 figures).

Local Service Provision

Education, health and social care services together support children and young people with special educational needs and disabilities.

Educational services

Education provision across the county is made up of:

- Over 850 early years settings
- 246 primary schools (37 of which are stand alone academies, 5 sponsored and 1 primary free school)
- 39 secondary schools (27 of which are stand alone academies and 6 sponsored)
- 12 special schools (3 of which are sponsored academies)
- 4 colleges
- 5 alternative provision schools (1 of which is a free school and one is the Hospital Education Service)
- 25 independent mainstream schools and 4 independent special schools
- There are currently 10 Multi Academy Trusts (MATs) in the county.

The majority of children and young people with SEND are supported in mainstream settings, learning alongside their peers in their local community. However, Gloucestershire has a number of special schools/settings to meet the needs of those children and young people whose SEND needs require a more specialised environment. Creating a range of provision which reflects the whole spectrum of need is a focus for development.

Social care services

The local authority's social care and its partners help children and young people achieve the best outcomes possible. This is delivered through the Graduated Pathway of Early Help and Support and through the Early Help Offer within the disabled children and young people's service when a greater level of support may be required. Social care provide support and services to children who have statutory plans and make every effort to join up these processes and work in partnership with the Independent Reviewing Officers (IRO's), Virtual School and Care Leaving Services to enable needs to be met.

The disabled children and young people's service provides support through childhood and in preparation for and during the transition to adulthood and aims to minimise frequency of "telling the story". The service provides Early Help assessments and support as well as statutory assessments and support e.g. information, advice and guidance; signposting to other services e.g. Enablement; Carers Assessments and related support; support with finding and securing employment at transition age and/or personal budgets etc.

The disabled children and young people's service link with SEN colleagues and partners within health to support a young person prepare for adulthood and support through transition. Some young people may receive support from Social Care teams outside of this team.

Health services

NHS Gloucestershire Clinical Commissioning Group CCG is a clinically led membership organisation (although GP practices are commissioned directly by NHS England, all 81 GP practices in Gloucestershire are members) responsible for commissioning local NHS services to meet the needs of local people. Currently the provider organisations commissioned to provide these services are:

- Gloucestershire Care Services NHS Trust;
- Gloucestershire Hospitals NHS Foundation Trust;
- 2gether NHS Foundation Trust

Gloucestershire Care Services (GCS) NHS Trust provides community health services including health visiting, school nursing, the children in care nursing service and the children's therapy services. It works with partner agencies to help children and young people achieve the best outcomes possible.

The Health Visiting and School Nursing service are part of the GCS Public Health Nursing service. These services are universal services available to all children and families in Gloucestershire. There are screening programmes at specific ages in both services to help identify if children may have additional health needs that may impact on their educational needs. There are specific members of the health visiting team whose role is to work with children and families who are known to have additional needs including SEND. There is also special school nursing team who work closely with the special educational needs schools to ensure that health needs are being met to ensure that the children's education is not negatively impacted.

The Speech and Language Therapy, Occupational Therapy and Physiotherapy are part of the therapy services for GCS. Therapists are involved if a child has been referred into the service and assessed to require ongoing support to address the highlighted health issue identified. Therapists provide advice, training and support to teaching and support staff or other professional as appropriate, to facilitate children and young people accessing their education provision. Some of the special education needs schools have therapy services based on site and are able to see children in the education setting.

The Children's Community Nursing Team (CCNT) delivers community-based nursing services to children and young people with specific medical conditions requiring nursing treatment. For children with complex health issues this can be for gastrostomy management, nasogastric care, assessment of care needs for provision of complex care packages and intravenous medication. The CCNT is a countywide service for children and young people up to the age of 18 who have a designated consultant paediatrician managing their on-going care. The CCNT provide care in a variety of settings, including schools. In delivering their services the CCNT aim to cause as little disruption to a child's education as possible.

All GCS children's services engage with the Education and Health Care plan processes and contribute towards the analysis of assessment for these plans. They also use the 'Ready, Steady, Go' approach to transition young people into adult services. This transition process starts when the young person is over 11 years old and has a long-term condition. Ready, Steady, Go aims to help the young person gain the confidence, knowledge and skills required to manage their condition.

Community paediatricians, maternity services and acute paediatric care are provided by the Gloucestershire Hospitals NHS Foundation Trust. The Hospital Trust provides specialist assessment through the inpatient and outpatient facilities, starting the journey of support for children through maternity services, or from birth or the newborn intensive care unit. It also provides emergency services and specialist day surgery. The different hospital specialist teams liaise and work with all professionals involved in the care of the child/young person using the graduated pathway of support, aiming to support the best possible health and wellbeing outcomes.

2gether NHS Trust provides specialist mental health and learning disability support to the people of Gloucestershire. The Child & Adolescent Mental Health (CAMHs) service, known as the Children and Young Peoples' Services (CYPS) is managed by the 2gether NHS Foundation Trust and supports children and young people up to the age of 18, including those with additional needs.

The Community Learning Disability Teams (CLDT) work with people with a learning disability from the age of 18 and works closely with CYPS to ensure a smooth transition for young people to adulthood and adult services. The service delivers an adapted Ready Steady Go programme for young people with additional needs.

In accordance with The Children and Families Act 2014 which requires local authorities to provide information advice and support about special educational needs (SEN), disability, health and social care to children, young people and parents. The local authority provides:

- The Local Offer - a central source of information on services for children and young people aged 0-25 years with special educational needs and disabilities and their families in Gloucestershire. It includes specialist activities and support and is provided by the Gloucestershire Family Information Service http://www.glosfamiliesdirectory.org.uk/
- The Special Educational Needs and Disability Information Advice and Support Service (SENDIASS) Gloucestershire. This provides free, confidential, impartial advice, information and support on matters relating to children and young people aged 0-25 with special educational needs and disabilities (SEND) and helps parents/carers play an active and informed role in their child's education http://sendiassglos.org.uk/

Family Link Plus provides tailored support packages, in and out of the family home, to families with disabled children aged 0-18 years in Gloucestershire. There are many families in Gloucestershire caring full time for their disabled child, these families are often in real need of a short break, this time allows them to relax, spend time with other members of their family or just complete necessary tasks like the weekly shop; tasks that can be really challenging as a full-time carer. The service is open to children with physical disabilities, severe learning disabilities, autistic spectrum disorders, complex medical needs and those with special education needs.

Family Link Plus can provide day-time care and overnight care for disabled children in the carer's home e.g. at teatimes after school, a regular weekend break, breaks from the family home during school holidays etc. Family Link Plus Support Workers also offer additional services such as befriending, travel support, sibling support, help at mealtimes and bed times and support to enable disabled children to participate in educational and recreational activities in the community.

Allsorts Gloucestershire is commissioned by the local authority to increase opportunities of young people with disabilities or additional needs to work towards independence and develop life and work skills; have increased opportunity to develop and maintain a social life and active involvement in their community; and to develop their capacity for self-advocacy and meaningful co-production of services.

Active Gloucestershire is commissioned by the local authority to develop county wide physical activity and sport opportunities for disabled people. The project aims to create a greater range of inclusive sports opportunities in the county and effectively communicate these; to develop the capacity of county wide community groups to engage disabled people in regular activity (through sport specific and disability awareness training and sharing knowledge and connection to local funding bodies); and to create new opportunities that reach some of the most inactive people in our communities.

Active Impact is commissioned by the local authority to provide a range of community based, out of school/college and holiday short breaks to disabled children, young people, young adults (up and including 25 years old) their siblings and families in Gloucestershire. Inclusive art and leisure activities are targeted to develop children and young people's independence skills, self confidence, social skills, decision-making skills, risk management, citizenship and aspirations towards employment. Active Impact delivers the 'Of Course We Can' programme, a programme of between 24-28 events for disabled and non-disabled young people over weekends and school holidays run by the Voluntary and Community Sector/independent organisations. Active Impact also co-ordinate and administrate the 'Inclusion Needs You' training programme on welcoming and including disabled children and young people in groups, activities, clubs and settings to people working with children, young people and families outside of school.

Forest Pulse is commissioned by the local authority and provides a range of after school, weekend and holiday social, sport and recreational activities for disabled children and young people up to the age of 19 in the Forest of Dean. Activities are varied and provide opportunity for disabled children and young people to meet up with friends, have fun and learn alongside their non-disabled peers. Staff are all trained and experienced in meeting all needs enabling participation whatever an individual's ability or mobility. The charity also provides guidance, advice and support to parents and carers and opportunities for families to meet and share experiences.

Glo-Active is commissioned by the local authority and provides weekend clubs and activities to disabled children, young people and young adults (up and including 25 years old in Gloucester, Cheltenham, Forest of Dean and Stroud. Glo-Active provides daily activities, evening social groups, school holiday playscheme, a Saturday club and other stimulating and fun sessions to disabled children, young people and their siblings and families.

Hartwood House in Stroud provides short break facilities for children aged between 8 and 18 years, with a disability, and can accommodate a maximum of 6 children at any one time. A variety of activities e.g. visits to the cinema, swimming, shopping, trips out, artwork, music, and development of self help skills are offered which provides opportunities for children to mix with other people and develop new experiences.

Evidence around What Works

Given the diverse range of needs that are included under SEND it is very difficult to provide a unifying list of evidence around what works in each individual circumstance. Recent Ofsted guidance has suggested focussing on the following to drive quality improvement and good practice

- improving the quality of assessment and consistency of need identification
- ensuring that where additional support is provided, it is effective
- improving teaching and pastoral support early on so that additional provision is not needed later
- developing specialist provision and services strategically so that they are available to maintained and independent schools, academies and colleges
- simplifying legislation so that the system is clearer for parents, schools and other education and training providers

- ensuring that schools do not identify pupils as having special educational needs when they simply need better teaching
- ensuring that accountability for those providing services focuses on the outcomes for the children and young people concerned.

Discussion, Gap Identification and Recommendations

Strengths in this area:

- The largest proportion of EHCPs issued during 2017 were for children aged 5-10 (51%), 30% were issued to under 5s indicating that teaching and pastoral support is identifying additional needs early on in a child's development.

Areas of Concern

- We do not have definitive information on the number and outcomes of children and young people with special educational needs and disabilities
- Special educational needs remain more prevalent in males that females
- Children and young people with SEND are overrepresented in financially stretched households and areas of high deprivation
- The total number of children and young people with a statutory EHCP or statement continues to increase
- Children and young people with SEN are overrepresented in Children in Care and Children in Need figures. The number of Children in Care with SEN is increasing
- It is anticipated there will be insufficient funding to meet the needs of all children and young people with SEND in the next few years
- 52% of permanent exclusions and 46% of fixed period exclusions are of children and young people with special educational needs

Recommendations

Ensure local educational provision is planned strategically to meet the whole spectrum of SEND, demand for places geographically and avoid the creation of access issues for children or young people with SEND. Improve access of children and young people with SEND into non maintained and independent schools and the distribution of specialist post-16 places.

Investigate whether a local solution can be found or lobby central government to identify and implement a solution that reports information on all children and young people with special educational needs and disabilities in all educational establishments to ensure quality and coherence of services and support to all children with SEND.

Ensure continued provision of training and childcare recruitment of suitably qualified staff to support early and high quality identification of needs within children. This will ensure children have appropriate additional or specialist support/intervention they need from the earliest stage.

Continue to use the Graduated Pathway of Early Help and Support which seeks to identify all possible needs impacting on a child, young person or family as early as possible to prevent these from escalating. By agencies working in partnership to plan and co-ordinate support to a child including those with additional special needs, children will be able to achieve better outcomes.

Continue to highlight to central government the anticipated shortfall in funding that could put at risk provision of appropriate and effective support to children and young people with SEND and their potential to achieve successful outcomes.

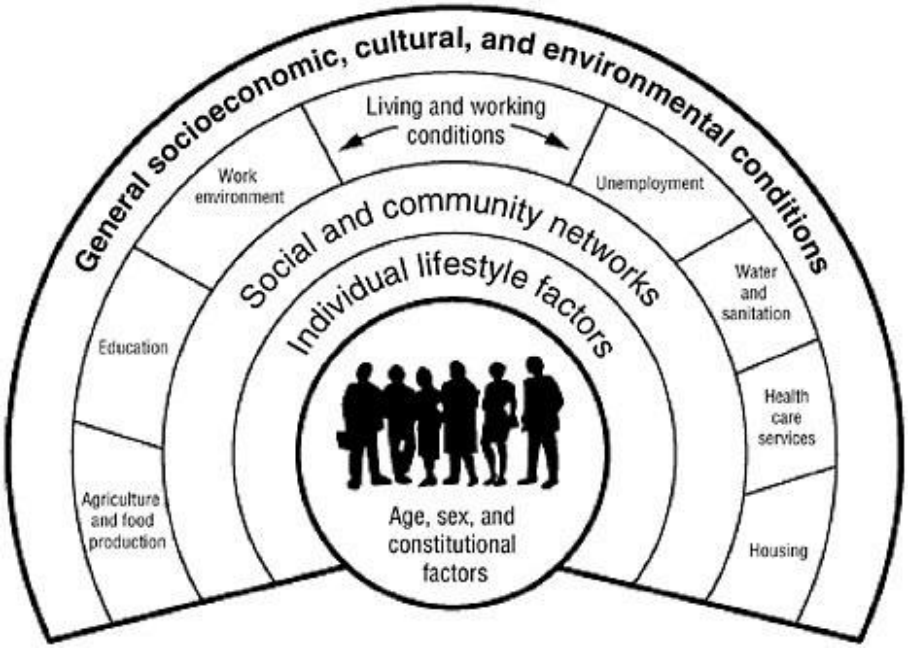
Address the significant use of permanent and fixed term exclusions within Gloucestershire schools. Ensure that teachers, staff and schools have appropriate skills, knowledge, processes and support from other services to address challenging behaviour and other learning and social difficulties of children to only use exclusion as an absolute last resort after other interventions have been tried.

The Wider Environment

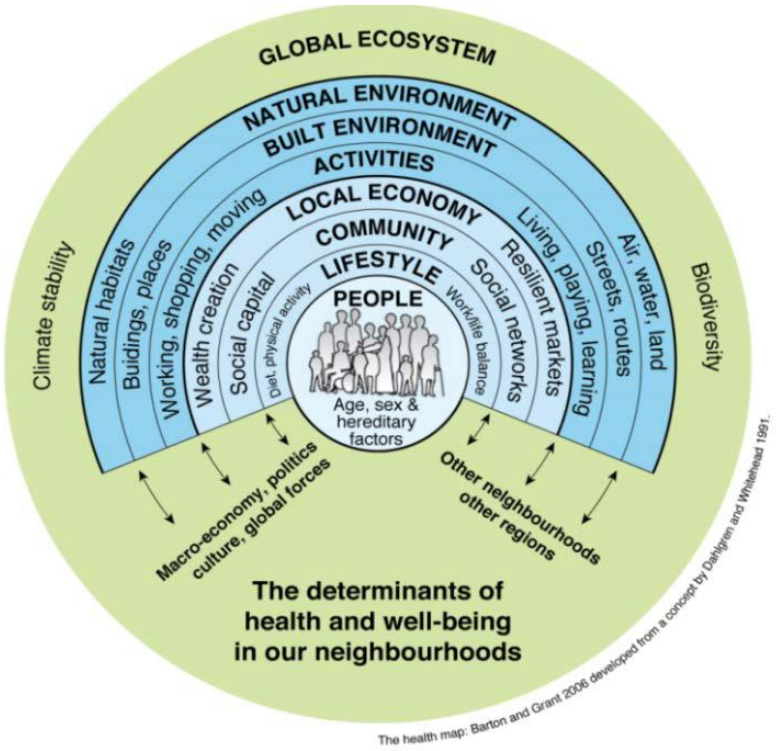
The Wider Environment

Wider determinants, also known as social determinants, are a diverse range of social, economic and environmental factors which impact on people's health. These factors are influenced by the local, national and international distribution of power and resources which shape the conditions of daily life. Wider determinants define the extent to which different individuals have the physical, social and personal resources to identify and achieve goals, meet their needs and deal with changes to their circumstances.

The classic view of wider determinants of health was introduced by Dahlgren and Whitehead and is illustrated in the image below.



This was further amended by Barton and Grant who developed the model in to the "Health map" illustrated below.



The Marmot review, published in 2010, raised the profile of wider determinants of health by emphasizing the strong and persistent link between social inequalities and disparities in health outcomes. Variation in the experience of wider determinants is considered the fundamental cause of health outcomes (ie they are causes of causes). As a result, health inequalities are likely to persist through changes in disease patterns and behavioral risks so long as social equalities persist. Thus addressing these wider determinants of health has a key role in reducing health inequalities.

Several studies have attempted to estimate the contribution of the wider determinants to population health(Kuznetsova, 2012; McGuinness, Williams-Russo & Knickman, 2002. It is difficult to quantify with precision, the impact of the built and natural environment on health. However, research does seem to consistently report that the majority of our health outcomes are explained by factors other than healthcare. It is, therefore, an important aspect of public health in terms of informing preventative action and reducing inequalities.

As a result, to fully consider the health and wellbeing needs of our children, young people and families it is important to look at the wider determinants of health and consider how they can be shaped to maximise health and well being.

A) Natural Environment

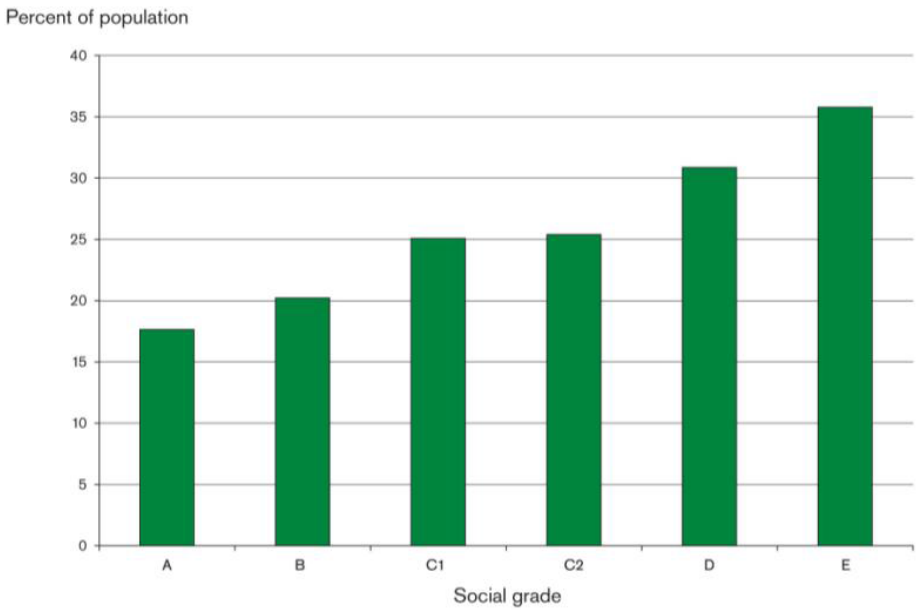
Green/Open Space

One of Gloucestershire's greatest assets is its great natural beauty and abundance of green space.

The Marmot review[126] states that access to good quality green space has a clear effect on physical and mental health and well-being. It identifies many studies which show the positive effect of good quality green space, highlighting how it helps decrease blood pressure and cholesterol, improve mental health and the ability to face problems, and reduce stress levels. The report also emphasises that green space encourages social contact and reduces social isolation, provides space for physical activity and play, improves air quality and reduces urban heat island effects.

There is strong evidence that provision of green space effectively improves mental health and less strong/inconclusive evidence that it improves levels of physical activity. The report also notes the importance of the green space being high quality as access to poor quality greenspace doesn't show the same benefits.

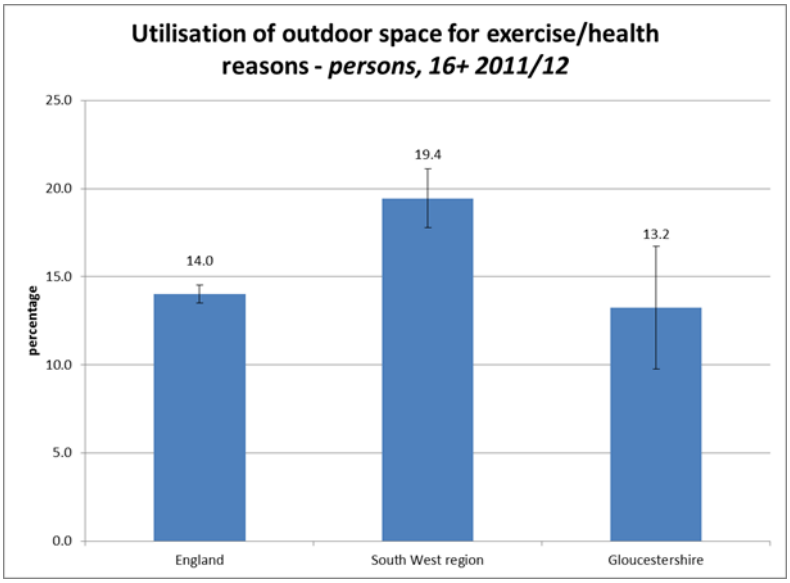
The report also raises concerns about the significant difference in the frequency of different social groups visiting green spaces, with more deprived groups making significantly fewer visits. The report suggests this is likely to be due to both the low availability and bad quality of green space in deprived areas. The national social gradient observed in those accessing green space is shown below. As social gradient rises the percentage of the population accessing green spce increases



Gloucestershire Data on utilisation of green space

The chart below shows the reported utilisation of outdoor space. The data is from 2011/12 but is the most recently reported data and there is no clear reason for anticipating significant shifts in the pattern of utilisation over the last 5 years.

[126] Fair Society Healthy Lives (2010)
http://www.parliament.uk/documents/fair-society-healthy-lives-full-report.pdf



This shows that only around 13% of people in Gloucestershire are using the available green space for healthy recreation. This is in line with the England average but significantly below the South West regional average on 19.4%.

While local data on use by different socio-economic groups is not available there is no local reason to suggest that, in line with the pattern seen nationally, rates of use are significantly lower in the more deprived communities due to lack of access to high quality green space.

Pollution

There is clear evidence of the adverse effects of outdoor air pollution, especially for cardio-respiratory mortality and morbidity[127]. Poorer communities tend to experience higher concentrations of pollution and have a higher prevalence of cardio-respiratory and other diseases. Sixty-six per cent of carcinogenic chemicals emitted into the air are released in the 10 per cent most deprived wards. Air pollution correlates well with noise pollution, especially in areas where air pollution is caused by car or air traffic. Noise pollution therefore often adds to the environmental burden shouldered by poorer sections of society - studies have shown that noise pollution is worse in areas of high density housing, rented accommodation, areas of deprivation and areas which are highly urbanised. It has also been demonstrated that noise pollution has adverse effects on mental health - it can result in increased stress levels and reduced educational outcomes in children, and increased stress and hypertension in adults. There is strong evidence that reductions in traffic to reduce air pollution are successful in improving health[128]. Children are also more likely to live in areas where air pollution is high[1].

[127] Fair Society Healthy Lives (2010)http://www.parliament.uk/documents/fair-society-healthy-lives-full-report.pdf

[128] Fair Society Healthy Lives (2010)http://www.parliament.uk/documents/fair-society-healthy-lives-full-report.pdf

[1] Fecht, D. et al Associations between air pollution and socioeconomic characteristics, ethnicity and age profile of neighbourhoods in England and the Netherlands. Environmental Pollution, 2015; 198: 201. A summary of the article is available at: http://www3.imperial.ac.uk/newsandeventspggrp/imperialcollege/newssummary/news_26-1-2015-12-17-52

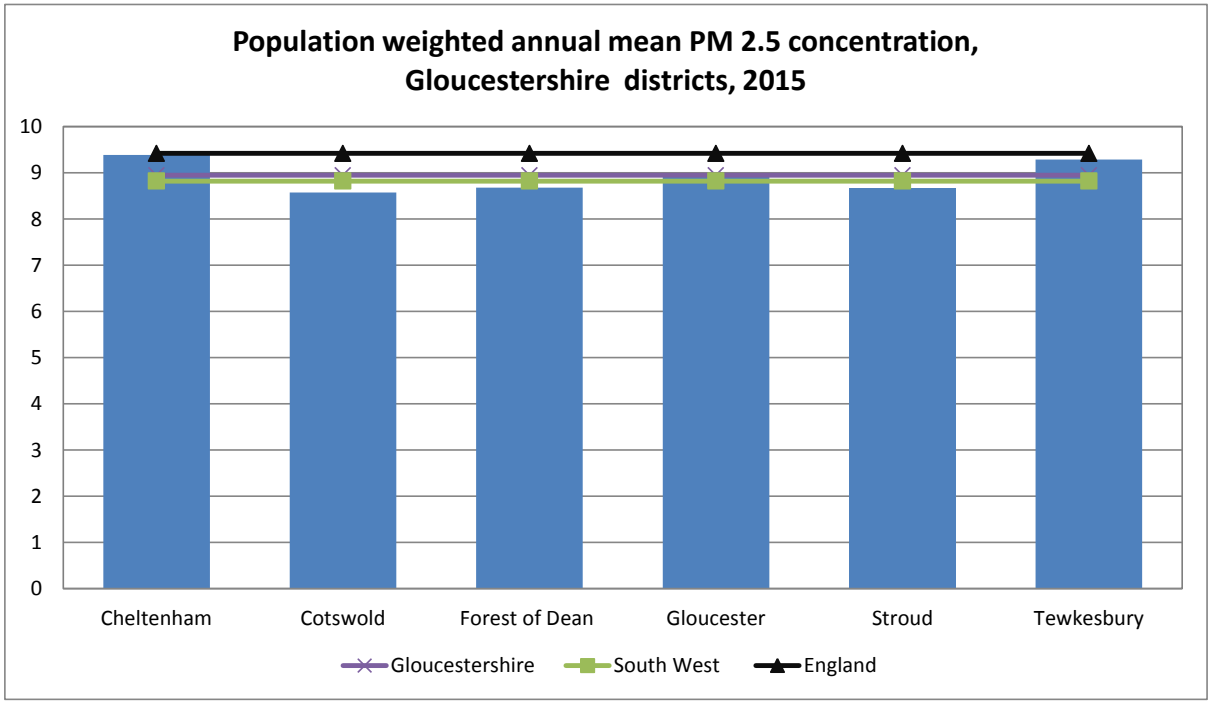
Gloucestershire Data on Air Pollution

DEFRA assesses air quality in the UK through a combination of monitoring and modelling. DEFRA has no monitoring sites in Gloucestershire so relies on modelling data which uses information about local sources of pollution and infrastructure to estimate levels of pollution.

Current WHO Air Quality Guidelines levels for PM2.5 are set at 10 ugm-3[129]. DEFRA estimates that in 2015 the total annual mean PM2.5 concentration in Gloucestershire was below this level at 8.9 ugm-3. Gloucestershire was also below the national average of 9.4 ugm-3 and in line with the regional average of 8.8 ugm-3.

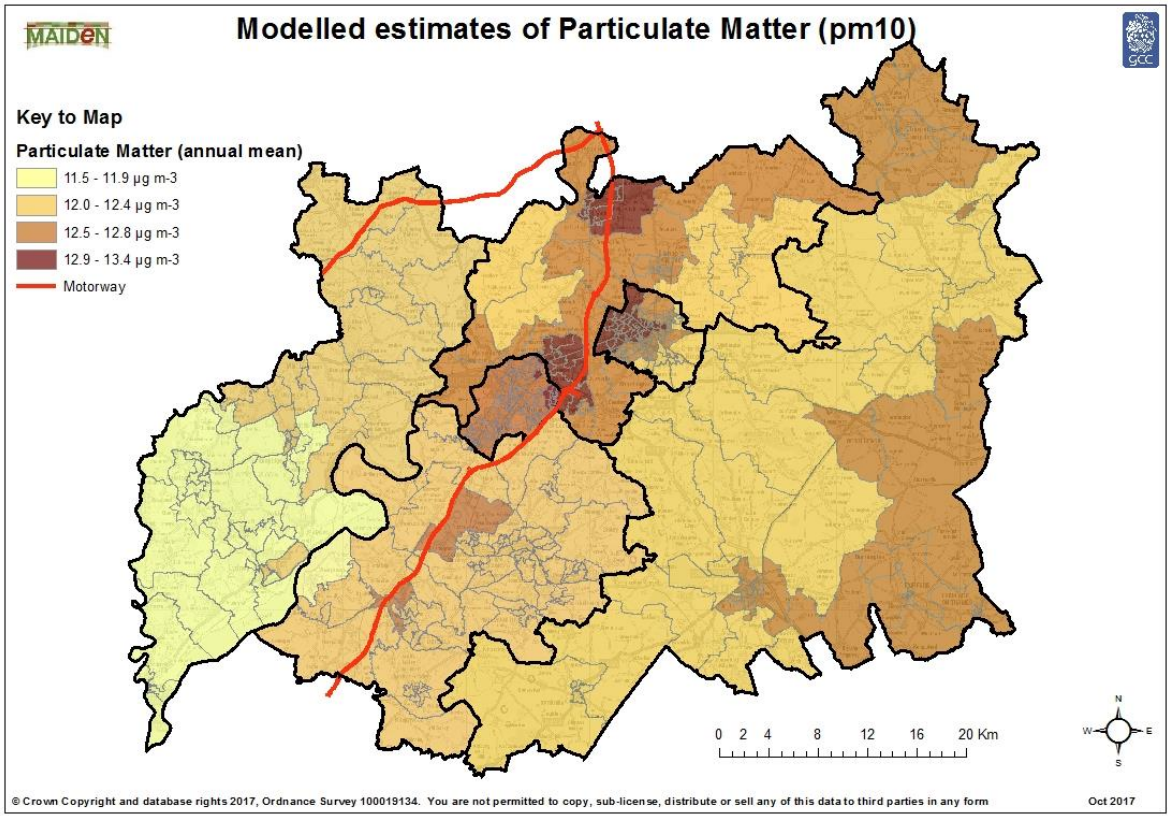
Estimates can be broken down by district and are shown below. The estimates suggest within Gloucestershire levels of PM2.5 are highest in Cheltenham and Tewkesbury where they exceed regional averages.

Population weighted annual mean PM2.5 concentration, Gloucestershire and its districts



PM10 particulate matter, another contributor to air pollution, is also not distributed evenly through out the county. PM10 levels are estimated to be at their highest in the Churchdown and Ashchurch areas of Tewkesbury and the west of Cheltenham. This is shown on the map below

[129] WHO Air quality guidelines for particulate matter, ozone, nitrogen dioxide and sulfur dioxide, World Health Organisation http://apps.who.int/iris/bitstream/10665/69477/1/WHO_SDE_PHE_OEH_06.02_eng.pdf



Alongside the two types of particulate matter already reviewed Nitrogen Dioxide is a significant gaseous contributor to air pollution. Nitrogen Dioxide levels are estimated to be at their highest in North Gloucester, Cheltenham and around Gloucestershire Airport. The current WHO Air Quality Guideline levels for Nitrogen Dioxide are set at 40 ugm,-3 meaning all Lower Super Output Areas in Gloucestershire meet recommended levels.

Children tend to be more likely to live in areas where air pollution is high[130], and also suffer some of the worst consequences. The table below shows levels of nitrogen dioxide are higher in areas in Gloucestershire that have a higher proportion of children (compared to national data), conversely levels of nitrogen dioxide are lower in areas that have a higher proportion of people aged 20+.

	Nitrogen Dioxide average annual mean (ugm/3)
Higher % 0-4 year olds than nationally	8.8
Lower % of 0-4 year olds than nationally	7.7
Higher % 5-19 year olds than nationally	8.4

[130] Fecht, D. et al Associations between air pollution and socioeconomic characteristics, ethnicity and age profile of neighbourhoods in England and the Netherlands. Environmental Pollution, 2015; 198: 201. A summary of the article is available at: http://www3.imperial.ac.uk/newsandeventspggrp/imperialcollege/newssummary/news_26-1-2015-12-17-52

Lower % of 5-19 year olds than nationally	7.9
Higher % 20+ year olds than nationally	7.8
Lower % of 20+year olds than nationally	8.7

Exposure to poor air quality contributes to premature mortality. Based on national modelled data applied to Gloucestershire (not adjusted for attributes of Gloucestershire and the local population) exposure to particulate matter air pollution is estimated to contribute to (as one of a number of factors) around 278 deaths a year, representing a annually loss of 2,848 life years. These estimates are based on the research evidence of mortality risk, combined with modelled levels of the background air pollution to which populations are exposed at local authority level.

Table to show Local mortality burdens associated with particulate air pollution[131]

	Attributable deaths[132]	**Associated life years lost[133]**
Cheltenham	55	579
Cotswold	42	405
Forest of Dean	37	368
Gloucester	52	575
Stroud	53	497
Tewkesbury	39	424
Gloucestershire	278	2,848
England	25,002	264,749

Overall, it can be seen that the natural environment in terms of the air that we breath and the land water, flora and fauna we engage with, can have a major impact on our health and well being. Its effect can be wellbeing promoting or health harming. As the data above shows, in Gloucestershire the available green space that has the potential to be health promoting is generally under utilised

[131] *Ibid.*

[132] Attributable deaths- long term exposure to anthropogenic particulate air pollution is estimated to have an effect on mortality risks equivalent to the number of attributable deaths. Air pollution is likely to contribute a small amount to the deaths of a larger number of exposed individuals rather than being solely responsible for the number of deaths equivalent to the calculated figure

[133] Associated life years lost - the years of life lost to the population due to increased mortality risk attributable to long term exposure to particulate air pollution

with the least well off benefitting least while levels of health damaging air pollution are highest in some of the least well off areas. This highlights that improving the quality of the natural environment and increasing the amount that our population engages with it would be health enhancing for our young people and reduce the current inequalities.

Discussion and recommendations

The above sections highlight that there is good evidence for the mental and physical health and wellbeing benefits of having access to green space and reducing levels of pollution. The data presented also illustrate that Gloucestershire's population would benefit from engaging more with green space and lowering levels of pollution in some areas.

The preservation of a number of Gloucestershire sites as designated regional parks or nature destinations could potentially encourage local residents to visit them and also preserve them for future generations of young people. The available evidence suggests that increased utilisation of such sites will have a impact on our young people increasing their well being and improving mental health (an area of recognised need locally).

B) Built Environment

The built environment encompasses a broad and varied range of things including the houses we live in, the transport we take and the work and recreational places we go. Five aspects of the built and natural environment were identified as the main characteristics that can influenced by local policy. The natural environment was discussed in the section above so this section will focus on the remaining four aspects namely housing, transport, neighbourhood design and healthier food.

Housing

A considerable amount of time is spent daily in the home. Housing is a basic human right and the quality and affordability of houses can determine the health status of residents. It is estimated that 20% of the UK's housing stock does not meet decent home standard and that the cost to the NHS of poor quality housing is £2.5 billion per annum (BRE, 2010). Living in good quality and affordable housing is associated with numerous positive health outcomes for the general population and those from vulnerable groups.

Over the past 20 years, the poorest groups have become concentrated in social housing[134], and the association between social housing and negative outcomes applies across several domains, including health, education, self-efficacy and income[135]. A study suggested that children in bad housing are more likely to have mental health problems, such as anxiety and depression, to contract meningitis, have respiratory problems, experience long-term ill health and disability, slow physical growth and delayed cognitive development[136].

[134] Hills J, Centre for Analysis of Social Exclusion. Ends and means : the future roles of social housing in England. [London : London School of Economics and Political Science, 2007.

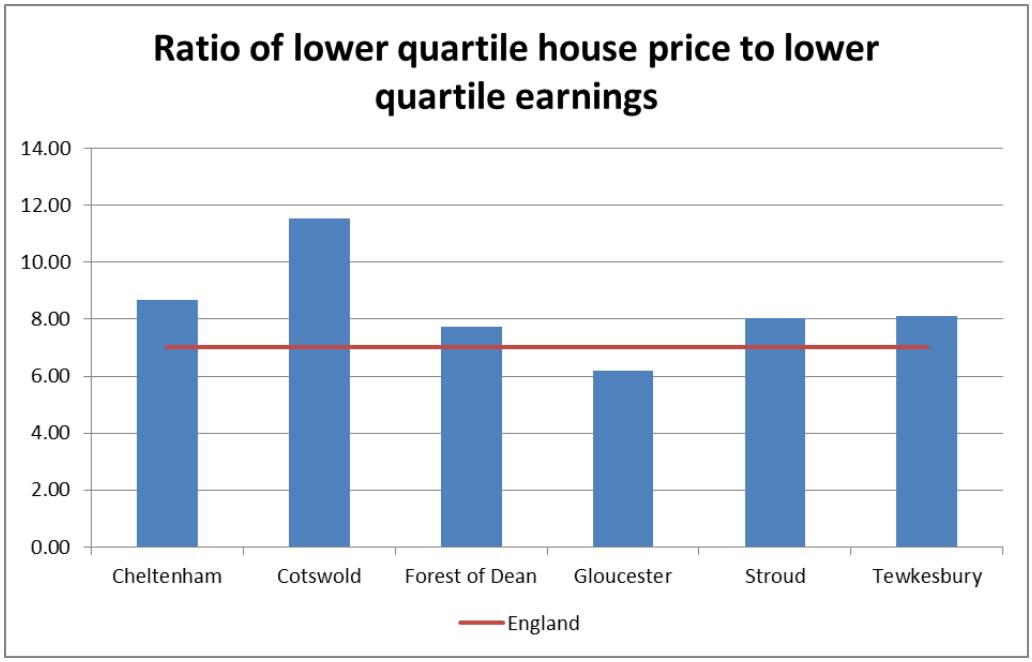
[135] Feinstein L, Smith Institute (. The public value of social housing : a longitudinal analysis of the relationship between housing and life chances. London : Smith Institute, 2008.

[136] Harker L, Shelter (Organization). Chance of a lifetime : the impact of bad housing on children's lives. London : Shelter, 2006.

Cold housing is also a risk to health, affecting the levels of winter deaths and respiratory diseases. Evaluation of home insulation programmes concluded that targeting home improvements at low-income households significantly improved social functioning, as well as physical and emotional well-being [137]. Adequate heating systems improve asthma and reduce the number of days off at school[138].

Gloucestershire Data on Housing

Some of the issues around housing have been discussed in the section on child poverty. Availability of affordable housing varies across the county. The highest ratio of house prices to lower quartile earnings is in Cotswold where it is almost 12x earnings. Even in Gloucester where the ratio of house price to lower quartile earnings is 6x this puts buying a house out of many peoples grasp since the average mortgage is around 3.5x earnings.



The lower the availability of affordable housing the more likely people are to accept substandard rented accommodation due to the lack of other options in their price bracket.

Evidence Based Principles for healthy housing

[137] Webb R, Richardson J, Esmail A, Pickles A. Uptake for cervical screening by ethnicity and place-of-birth: a population-based cross-sectional study. Journal of Public Health 2004; 26(3):293-296.
[138] Howden-Chapman P, Pierse N, Nicholls S, Gillespie-Bennett J, Viggers H, Cunningham M et al. Effects of improved home heating on asthma in community dwelling children: randomised controlled trial. British Medical Journal 2008; 337(7674).

A recent PHE commissioned umbrella evidence review[139] has established the following principles to improve the positive health and well being impact of housing.

In terms of children and young people the specific intervention shown to have the most positive impact is the provision of affordable rental housing

1. Improve quality of housing:

- There is evidence to suggest that living in a warm and energy efficient property can improve general health outcomes, reduce respiratory conditions, improve mental health and reduce mortality. Retrofitting modifications to improve housing warmth and energy efficiency may help to reduce health inequalities among those from low-income groups, notably older adults and those living with chronic pre-existing conditions. ,
- Good quality housing can also reduce the risk of unintentional injury or death. For example, improvements to residential lighting and interventions to reduce hazards in the home can lead to improved social outcomes and reduce fall-related injuries among older adults.
- Evidence suggests that housing refurbishment, including damp proofing, re-roofing, and new window installation is associated with improvements in general health outcomes and reduce health inequalities
- The impact of living in fuel poverty on health was outside the remit of this umbrella review. However, in a report produced by the Marmot Review Team, fuel poverty was shown to be associated with excess winter deaths, increased prevalence of chronic conditions, and poorer mental health outcomes (Marmot Review Team, 2011)
- Although this review did not identify any eligible evidence relating to daylight and ventilation and health outcomes, the linkages between poor indoor air quality and ill health, particularly CVD, respiratory symptoms, sensory irritation, lung cancer and other cancers, are well established . Ventilation can help control air contaminants and humidity thereby improving indoor air quality

2. Increase provision of affordable and diverse housing:

- Provision of diverse forms and types of housing has been associated with increased physical activity
- the provision of mixed land use and affordable housing is strongly associated with improved safety perceptions in the neighbourhood, particularly among individuals from low-income groups . However, the impact of such housing provision on improving health outcomes and reducing health inequalities is unclear

3. Increase provision of affordable housing for groups with specific needs:

- there is broad agreement that the provision of affordable housing for vulnerable groups (including adults with intellectual disability and adult substance users) can lead to improvements in social, behavioural and health-related outcomes

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https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/625568/Spatial_planning_for_health_an_evidence_resource.pdf

- evidence shows that the provision of secure and affordable housing for those with some chronic medical conditions, such as HIV/AIDS, can increase engagement with healthcare services which has been shown to lead to improved health-related outcomes. Furthermore, provision of secure and affordable housing has also been shown to reduce engagement in risky health-related behaviours
- the provision of affordable housing for the homeless has consistently been shown to increase engagement with healthcare services, improve quality of life and increase employment. It has also been shown to contribute to improvements in mental health status

Transport

Transportation plays an important role in supporting daily activities. Active travel (cycling, walking and use of public transport) can increase physical activity levels and improve physical and mental wellbeing. Prioritisation of active travel can also reduce over reliance on motorised transport, contributing to improved air quality and a reduction in road injuries.

The relationships between transport and health are multiple and complex, and transport also provides access to work, education, social networks and services, which can improve people's opportunities[140].

There is strong evidence that traffic interventions reduce road accidents, while there is some weak evidence that they improve physical activity[141]. The impact of transport on health inequalities is greatest when looking at deaths from road traffic injuries, especially for children, as they are four times more likely to be hit by a car in the 10 per cent most deprived wards than in the least deprived wards. Fatal accidents on the road are also particularly high among children of parents classified as never having worked or as long-term unemployed.

Evidence Based Principles for Healthy Transport

A recent PHE commissioned umbrella evidence review[142] has established the following principles to improve the positive health and well being impact of transport.

In terms of children and young people the specific intervention shown to have most impact on children directly was increased public transport provision has a tangible positive impact on children and young people using active travel methods

1.Provision of active travel infrastructure:

• there is a wealth of high quality evidence to show that investing in infrastructure to support walking can increase physical activity levels and improve mobility among children, adults and older adults. There is moderate to high quality evidence that indicates that prioritising active travel,

[140] Great Britain.Department of the Environment TatR, University of North London.Transport Research and Consultancy. Social exclusion and the provision and availability of public transport : report by TRaC at the University of North London for the Department of the Environment, Transport and the Regions. London : Department of the Environment, Transport and the Regions, 2000.

[141] Boyce T, Patel S, The Kings Fund. The Health Impacts of Spatial Planning Decisions. 2009.

[142] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/625568/Spatial_planning_for_health_an_evidence_resource.pdf

through investment in cycling infrastructure, can lead to numerous health gains. For example the implementation of new cycle lanes can lead to improved cardiovascular outcomes and improved weight status among children, adults and older adults

2. Provision of public transport:

• evidence suggests that combining public transport with other forms of active travel, such as walking and cycling, can improve cardiovascular fitness. Provision of high quality public transport is associated with higher levels of active travel among children

• active travel in areas with low pollution levels is associated with increased physical activity among older adults. The perception of air pollution appears to constitute a barrier to participating in outdoor physical activity and active transport

3. Prioritise active travel and road safety:

• attempts to prioritise pedestrians and cyclists through changes in physical infrastructure are associated with positive behavioural and health outcomes. For instance, the separation of cycling and pedestrian infrastructure from road traffic can encourage active travel

• traffic calming measures, including speed humps, speed tables, cushions and roundabouts, are associated with increased walking behaviour and a reduced risk of pedestrian injury. However, the impact of such measures on reducing health inequalities is not yet known. A recent report by the Royal Society for the Prevention of Accidents (ROSPA) suggests that traffic calming measures are effective when used in 20mph zones. This umbrella review found no review level evidence relating to the effectiveness of home zones that met eligibility criteria. However, there are reports in the grey literature that home zones, which can effectively reduce traffic speed to 10mph -15mph, reduce risk of road traffic collisions

• public realm improvements, such as street lighting, have been shown to increase physical activity participation among older adults and reduce the incidence of road traffic collisions

4. Enable mobility for all ages and activities

• there is evidence that built environment strategies to promote physical activity can have a positive impact upon engagement in physical activity behaviours. For example, increasing access to playgrounds and recreational facilities is associated with increased walking among adolescents.

• evidence from high quality studies affirms a positive association between active travel to school or work and improved cardiovascular outcomes.

• the specific impacts of living in a rural setting on health were outside the remit of this umbrella review, however, a recent report by Active Living Research (2015) suggests that active travel is difficult to achieve in rural areas where residents live far away from local amenities and social services. This finding comes from a study that has not been quality assessed by the reviewers of this report.

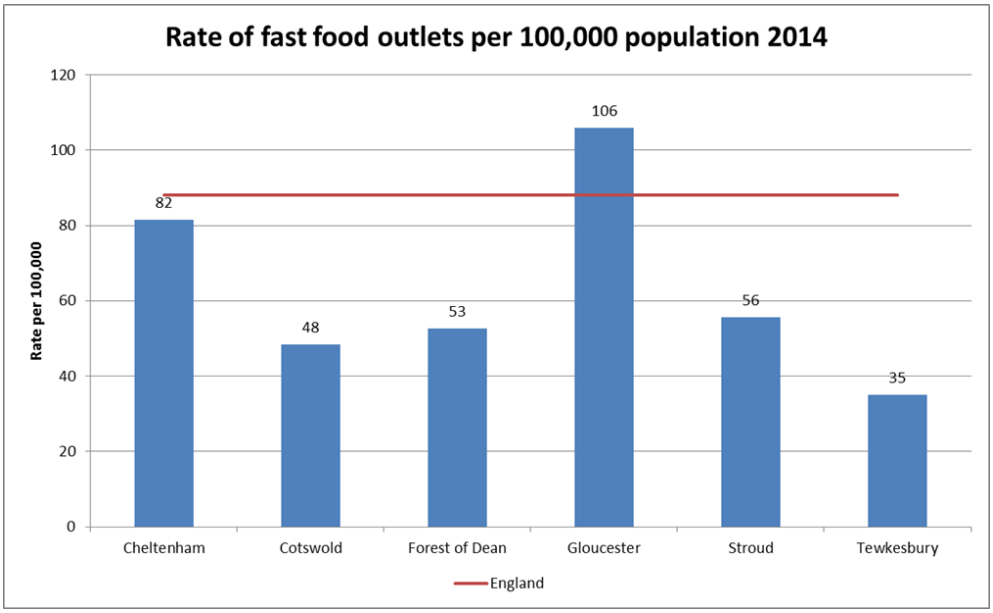
Food Environment

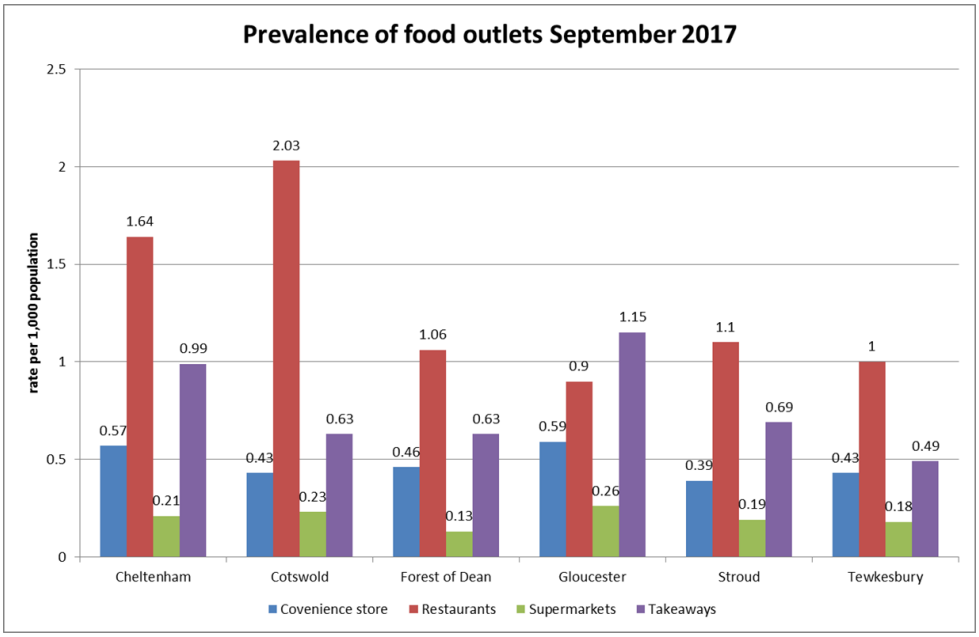
The food environment plays an important role in promoting a healthy diet, but this is a complex system influenced and determined by a series of factors, including a person's proximity to food retail outlets and the type of food available. Vulnerable groups, including those on a low income, children, young people, those who are overweight or obese, and those of certain ethnicities, are less likely to achieve a healthy and balanced diet. To date, there is relatively limited good quality review level evidence on the influence of the food environment on health and wellbeing outcomes. However, existing evidence indicates that making healthier foods more accessible and increasing provision of low cost healthier food could be effective interventions, but these are likely to be more effective as part of a whole system approach to diet and obesity.

In terms of evidence, low income and area deprivation are both barriers to purchasing fresh or unfamiliar foods, while lower income households are the hardest hit by food price fluctuations. However, there is only anecdotal evidence that local access to healthy foods improves diets, although there are indications that residents in deprived areas could benefit from interventions aimed at low-mobility groups, increasing their access to better shopping facilities. Studies on greater access to unhealthy food in the UK have shown that this may disproportionately affect those in more deprived areas

Gloucestershire Data on Food Environment

The proportion of fast food outlets per 100,000 population vary substantially across the county. As can be seen in the charts below there is some correlation with areas of increased deprivation.





Department for Communities and Local government, Housing Market
https://www.gov.uk/government/statistical-data-sets/live-tables-on-housing-market-and-house-prices

Evidence Based Principles for Healthy Food Environments

A recent PHE commissioned umbrella evidence review[143] has established the following principles to improve the positive health and well being impact of healthy food environments

Specifically, in terms of children and young people provision of healthier foods in school has been shown to have a positive impact of children's eating behaviours.

1. Healthy, affordable food for the general population:

• research of moderate quality indicates that increased access to healthy, affordable food for the general population (e.g., food in schools, neighbourhood retail provision) is associated with improved attitudes towards healthy eating and healthier food purchasing behaviour . It also indicates that improved dietary behaviours, such as increased fruit and vegetable consumption, are associated with increased access to healthy, affordable food vegetables

• research indicates that increased access to unhealthier food retail outlets is associated with increased weight status in the general population, and increased obesity and unhealthy eating behaviours among children residing in low income areas a consistent body of evidence suggests that provision of healthy, affordable food in schools is associated with improved healthier food sales, dietary behaviours and nutritional outcomes. Evidence suggests that multi-component

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https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/625568/Spatial_planning_for_health_an_evidence_resource.pdf

interventions, and taking an integrated, whole school approach, are effective in improving children's diet and food choices in schools

• some evidence indicates that increased access to retail outlets selling healthier food is associated with improvements in dietary behaviours and adult weight status

• the impact of access to unhealthy food in the workplace on health was outside the remit of this umbrella review. However, a UK based empirical study found that exposure to takeaway food outlets was positively associated with consumption of takeaway food, particularly around the workplace Evidence from primary studies conducted in Northern Europe suggests environmental strategies at worksites may help towards a more healthy diet

2. Enhance community food infrastructure:

• there is limited, newly emerging evidence showing a positive association between urban agriculture and improved attitudes towards healthier food, increased opportunities for physical activity and social connectivity, and increased fruit and vegetable consumption. The overall evidence base for these associations is relatively small and is based on and requires further research to clarify causal links

• findings from a recent non-systematic literature review suggest that gardening in an allotment setting in the UK may result in numerous positive physical and mental health-related impacts and outcomes

Neighbourhood Design

Neighbourhoods are places where people live, work, and play and have a sense of belonging. The design of a neighbourhood can contribute to the health and well-being of the people living there. Several aspects of neighbourhood design (walkability and mixed land use) can also maximise opportunities for social engagement and active travel. Neighbourhood design can impact on our day-to-day decisions and therefore have a significant role in shaping our health behaviours.

Neighbourhoods also influence social capital and community participation. Community capital differs in areas of deprivation, with less volunteering and unpaid work, less socialising and less trust in others, in the neighbourhoods that are perceived to be less safe. Evidence of the association between social capital and health is significant and improving: in many communities facing multiple deprivation, stress, isolation and depression are all very common46, and low levels of social integration, and loneliness, significantly increase mortality. Social participation acts as a protective factor against dementia and cognitive decline over the age of 65 and also have an impact on the risk of mortality by aiding recovery when becoming ill. Furthermore, there is some evidence that increasing community empowerment may result in communities acting to change their social, material and political environments[144].

Evidence Based Principles for Healthy Neighbourhoods

[144] Fair Society Healthy Lives (2010)
http://www.parliament.uk/documents/fair-society-healthy-lives-full-report.pdf

A recent PHE commissioned umbrella evidence review[145] has established the following principles to improve the positive health and well being impact of healthy neighbourhoods

1. Enhance neighbourhood walkability:

• improved street connectivity, mixed land use and compact residential design are considered to be important features of a walkable neighbourhood

• there is evidence to suggest that walkable neighbourhoods can encourage active travel and thereby promote physical activity

• improving neighbourhood walkability, and access to recreational and non-recreational destination (such as grocery stores, schools and other amenities) can also impact positively upon social interaction among older adults

• evidence suggests that investing in infrastructure to support walking can increase levels of physical activity among all age groups

2. Build complete and compact neighbourhoods:

• compact neighbourhoods, ie neighbourhoods with higher street connectivity (typically designed using finer grid patterns) with diverse land use mixes and greater residential densities are generally more conducive to non-motorised transport

• long distance trips for travel or recreation, steep inclines, and increased proximity to amenities have been identified as having a negative impact on walking and cycling

• provision of local amenities can improve mobility and social engagement among older adults). Mixed land use developments that prioritise access to schools, recreational centres and social amenities can increase physical activity among children, adolescents and older adults

3. Enhance connectivity with safe and efficient infrastructure:

• enhancing street connectivity via provision of walking and cycling infrastructure and improving access to public transportation, can help reduce perceptions of long distance trips and provide alternative routes for active travel

• public realm improvements such as provision of street lighting in residential areas can prevent road traffic collisions and increase pedestrian activity. General environmental improvements have the potential to reduce fear of crime

Discussion and recommendations

There is a good body of evidence around designing the built environment to promote wellbeing and ensuring that this is incorporated into all new build projects locally would contribute to improving

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https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/625568/Spatial_planning_for_health_an_evidence_resource.pdf

the heath and wellbeing of children. Early Health Impact Assessments and ensuring that wellbeing promoting design aspects are not dropped part way through development are important.

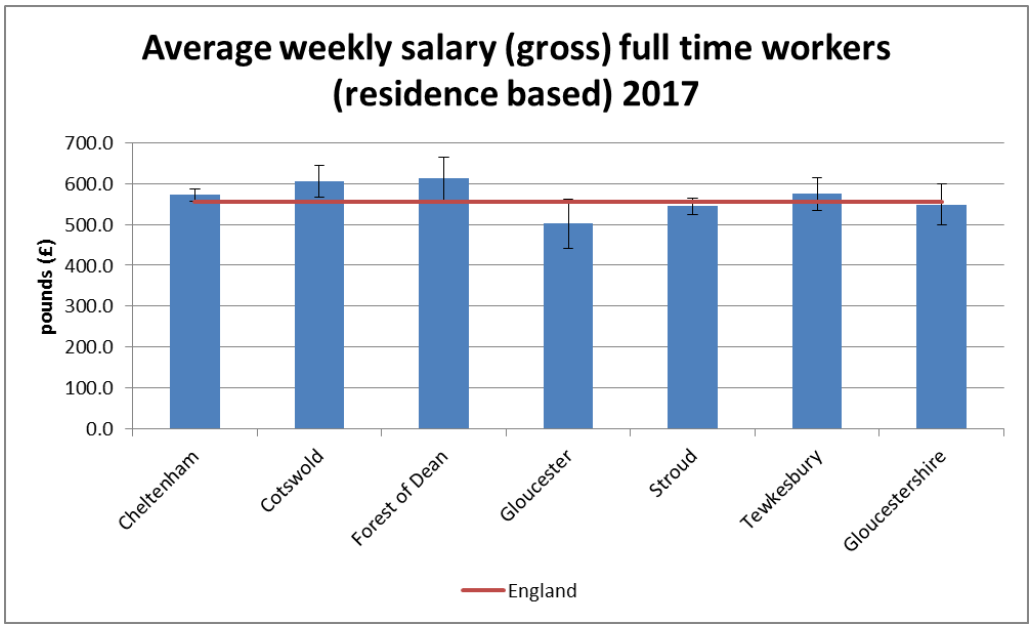
C) Employment Environment

The employment environment is a significant wider determinant of health, a significant driver of economic prosperity.

The current employment environment impacts the family conditions children are currently growing up in, and any change in employment prospects will have an impact on what jobs are available to today's young children, and will impact the conditions they bring up their own children in. In addition, children are affected by whether people can be recruited into the services such as education, health and social care, designed to directly support their needs.

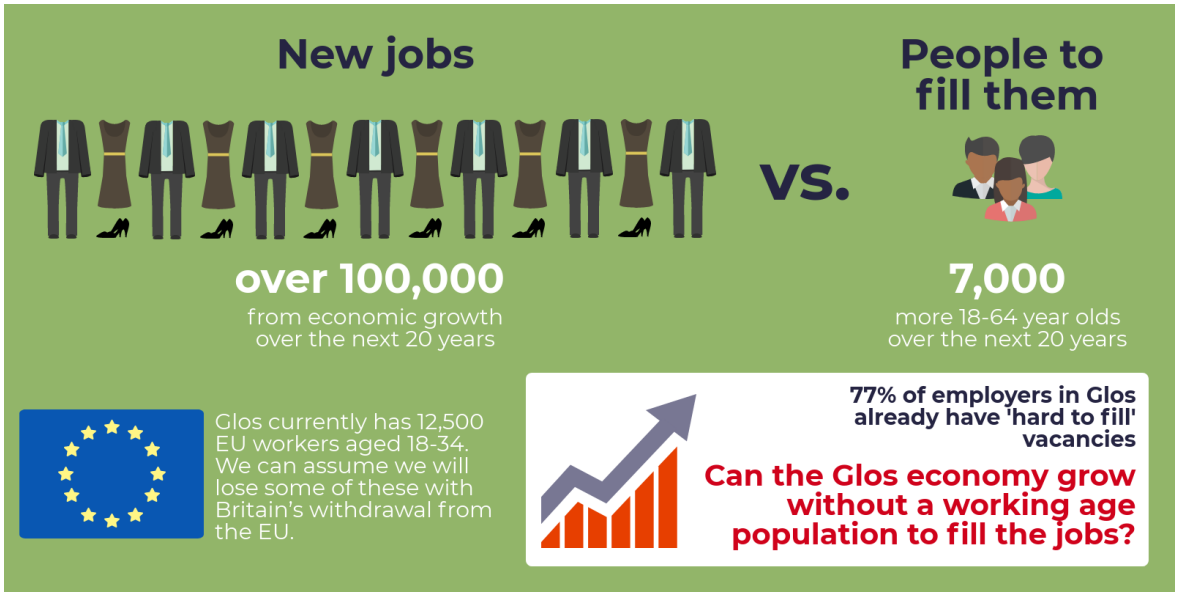
Gloucestershire Data on the Economic Environment

Current average weekly salary for full time workers by district of residence is shown below. Gloucester lags behind the rest of the county. For comparison, an employee on the non- London weighted living wage would expect to earn £350 per week.



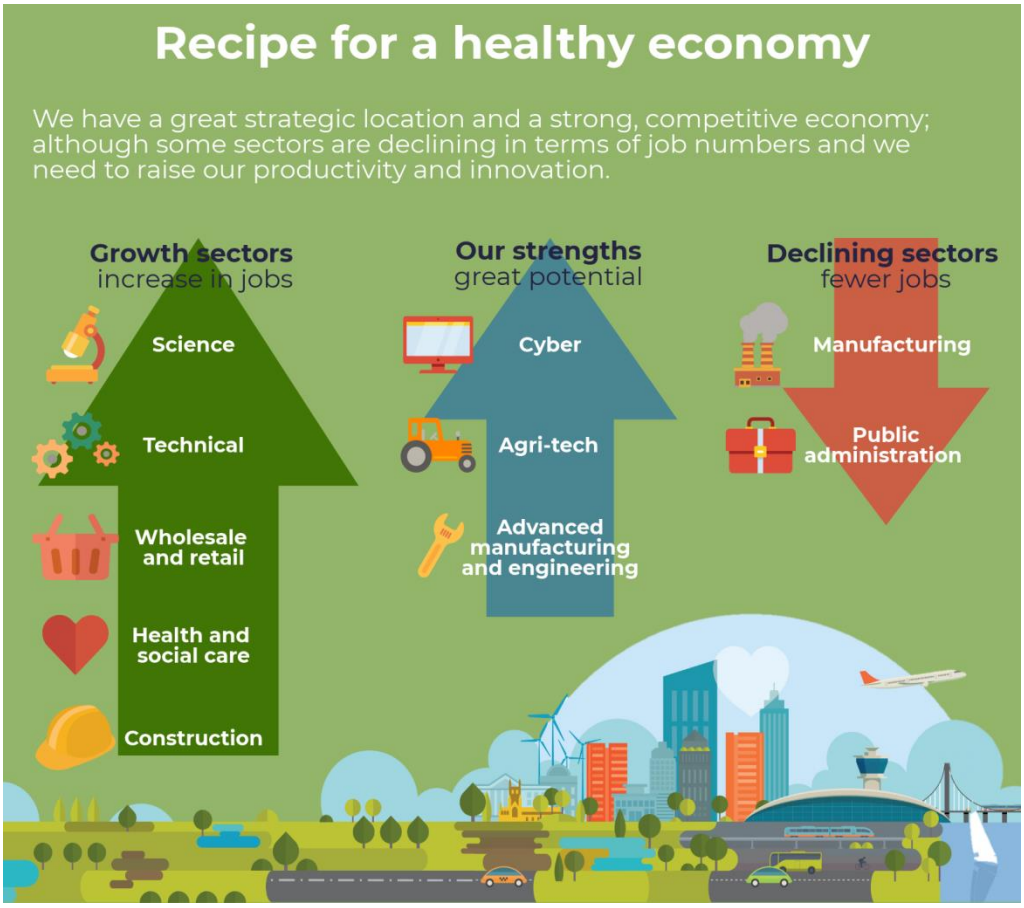
Work for Gloucestershire 2050 has suggested that while the number of jobs in Gloucestershire will grow, the number of 18-64 year olds to fill them will grow more slowly. The current estimates and

beliefs are summarised in the infographic below.



The projections suggest that there will be jobs available in the future and that Gloucestershire's high levels of employment are likely to continue. However, the projections also suggests that the difficulties in filling key jobs in services that support children may continue, and even worsen , given the potential competition for workers.

It is predicted that the nature of employment available in Gloucestershire will change. The infographic below (source Gloucestershire 2050) gives an indication of the expected changes in the nature of employment over the next 20 years. It should be noted that this predicts the changes expected if the desired changes for Gloucestershire 2050 are realised eg developing a cyber technology hub.



This suggests that for some families parental employment may be negatively impacted by reductions in the number of manufacturing and public administration jobs. It also gives an indication of the kind of skills today's children will need to acquire if they are to take advantage of the local employment market.

Public Health Evidence on Work and its Impact on Health

Is Work Good for You?

In 2006 The Department of Work and pensions commissioned an independent academic review of the scientific evidence around the impact of work on health called "Is work good for you?"[146]

This report concluded that

1. Work is generally good for the physical and mental health and well-being of healthy people, many disabled people and most people with common health problems. Work can be therapeutic for people with common health problems. Work can reverse the adverse health effects of unemployment.
2. In general, provided due care is taken to make jobs as safe and 'good' as reasonably practicable, employment can promote health and well-being, and the benefits outweigh any 'risks' of work and the adverse effects of (long-term) unemployment or sickness absence.

[146] Gordon Waddell and Kim Burton, 2006, Is work Good for you? The Stationary Office.

3. There are some people whose health condition or disability makes it unreasonable to expect them to seek or to be available for work (i.e they fulfil the criteria for entitlement to incapacity benefits) but that does not necessarily imply that work would be detrimental. There are a few people with specific health conditions who should not be exposed to specific occupational hazards (e.g. occupational asthma). However, for healthy people, many disabled people and most people with common health problems, 'good' jobs, if necessary with appropriate accommodations and adjustments, should not be detrimental to health and well-being. T he likely benefits outweigh any potential risks.

The report highlights that the quality of evidence is mixed and that it is particularly limited by looking only at short term effects and lonely having limited data around the size of the positive effect. In addition it highlights limitations in being able to fully understand the complex balance of positives/adverse affects on working vs retirement in older people, returning to work for those with long term health conditions and what makes a "good" job.

In the context of the employment market forecasts these findings are generally positive for the future health and wellbeing of the County given the estimated increase in job availability. However, the caveat around these positive outcomes being realised in practice is that is that the jobs generated must be "good jobs".

Evidence around what makes a "good" job in terms of increasing health and wellbeing

In 2015 PHE and the UCL Institute of Health Equity produced a report on "Local action on health inequalities - Promoting good quality jobs to reduce health inequalities". This had several important findings as summarised below:

1. Features commonly associated with good jobs include: adequate pay; protection from physical hazards; job security and skills training with potential for progression; a good work-life balance and the ability for workers to participate in organisational decision-making. Skilled work typically has more protective elements and less health-adverse conditions.
2. The most important determinant of an employee's work quality is their position in a company's hierarchy: jobs that are manual and routine are more likely than professional and managerial jobs to have health-adverse conditions, though this is not universally the case.
3. There is evidence of an increase in high-paid and low-paid jobs at the expense of middle-ranking jobs. Increasing the quantity of jobs in England without consideration of job quality is likely to exacerbate social and health inequalities and create unequal economic growth.
4. There are four ways in which the nature of work can adversely affect health: through adverse physical conditions of work; adverse psychosocial conditions at work; poor pay or insufficient hours; and temporary work, insecurity, and the risk of redundancy or job loss.
5. Creating a strategy to avoid industries or sectors with poor health outcomes is largely unrealistic and potentially damaging. However, where those industries do exist, public health professionals should do all they can to help companies and their employees reduce the risks – through adherence to health and safety recommendations and healthy workplace initiatives.
6. To develop better jobs for local populations, local partnerships can draw on what is known about the features of good and poor quality work, and can learn from emerging strategies

that promote good quality jobs with employers. Local partners should encourage jobs where workers are valued, receive a living wage at minimum, have opportunities for promotion, and are protected from adverse conditions – like shift work – when possible.

7. Working to improve the skills base of people in local and regional labour markets may help to attract more skilled employment to the area, and contribute to improving the quality of work. This is particularly important in more economically deprived regions.

Discussion and recommendations

In the context of the employment market forecasts, the projections and evidence around work and health and wellbeing are generally positive for the future health and wellbeing of the county given the estimated increase in job availability. However, the caveat around these positive outcomes being realised in practice is that is that the jobs generated must be "good jobs". ie jobs must have adequate pay, good physical and psychosocial conditions and good job security. A broad range of good jobs across the entire employment spectrum is desirable to ensure inequalities do not get widened.

Care needs to be taken that, as potential employment opportunities grow faster than the available workforce, steps are taken to ensure that key roles in health, education and social care services that support children and families are filled with high quality workers. To ensure this there should be a focus on ensuring employment conditions in such roles are attractive and have pay levels that allow a good quality of life and are secure.