Worcestershire County Council

Agenda

Cabinet

Thursday, 19 November 2015, 10.00 am
County Hall, Worcester

This document can be made available in other formats (large print, audio tape, computer disk and Braille) on request from Democratic Services on telephone number 01905 728713 or by emailing democraticservices@worcestershire.gov.uk

If you can not understand the contents of this document and do not have access to anyone who can translate it for you, please contact 01905 765765 for help.

বাংলা। আপনি যদি এই দলিলের বিষয়বস্তু বুঝতে না পারেন এবং আপনার জন্য অনুবাদ করার মত পরিচিত কেউ না থাকলে,অনুগ্রহ করে সাহায্যের জন্য 01905 765765 নম্বরে যোগাযোগ করুন। *(Bengali)*

廣東話。如果您對本文檔內容有任何不解之處並且沒有人能夠對此問題做出解釋，請撥打 01905 765765 尋求幫助。*(Cantonese)*

普通话。如果您对本文件内容有任何不解之处并且没有人能够对此问题做出解释，请拨打 01905 765765 寻求帮助。*(Mandarin)*

Polski eżeli nie rozumieją Państwo treści tego dokumentu i nie znają nikogo, kto mógłby go dla Państwa przetłumaczyć, proszę zadzwonić pod numer 01905 765765 w celu uzyskania pomocy. *(Polish)*

Português. Se não conseguir compreender o conteúdo deste documento e não conhecer ninguém que lho possa traduzir, contacte o 01905 765765 para obter assistência. *(Portuguese)*

Español. Si no comprende el contenido de este documento ni conoce a nadie que pueda traducírselo, puede solicitar ayuda llamando al teléfono 01905 765765. *(Spanish)*

Türkçe. Bu dokümanın içeriğini anlayamazsanız veya dokümanı sizin için tercüme edebilecek birisine ulaşamıyorsanız, lütfen yardım için 01905 765765 numaralı telefonu arayınız. *(Turkish)*

اردو. اگر آپ اس دستاویز کی مشمولات کو سمجھنے سے قاصر ہیں اور کسی ایسے شخص تک آپ کی رسائی نہیں ہے جو آپ کے لئے اس کا ترجمہ کرسکے تو، براہ کرم مدد کے لئے 01905 765765 پر رابطہ کریں۔ *(Urdu)*

کوردی سۆرانی. ئەگەر ناتوانی تێبگەی لە ناوەرۆکی ئەم بەڵگەیە و دەستت بە هیچ کەس ناگات کە وەیگێڕێتەوە بۆت، تکایە تەلەفۆن بکە بۆ ژمارەی 01905 765765 و داوای ڕێنوێنی بکە. *(Kurdish)*

ਪੰਜਾਬੀ। ਜੇ ਤੁਸੀਂ ਇਸ ਦਸਤਾਵੇਜ਼ ਦਾ ਮਜ਼ਮੂਨ ਸਮਝ ਨਹੀਂ ਸਕਦੇ ਅਤੇ ਕਿਸੇ ਅਜਿਹੇ ਵਿਅਕਤੀ ਤੱਕ ਪਹੁੰਚ ਨਹੀਂ ਹੈ, ਜੋ ਇਸਦਾ ਤੁਹਾਡੇ ਲਈ ਅਨੁਵਾਦ ਕਰ ਸਕੇ, ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਮਦਦ ਲਈ 01905 765765 'ਤੇ ਫ਼ੋਨ ਕਰੋ। *(Punjabi)*

Find out more online:
www.worcestershire.gov.uk

worcestershire county council

DISCLOSING INTERESTS

There are now 2 types of interests:
'Disclosable pecuniary interests' and 'other disclosable interests'

WHAT IS A 'DISCLOSABLE PECUNIARY INTEREST' (DPI)?

- Any **employment**, office, trade or vocation carried on for profit or gain
- **Sponsorship** by a 3rd party of your member or election expenses
- Any **contract** for goods, services or works between the Council and you, a firm where you are a partner/director, or company in which you hold shares
- Interests in **land** in Worcestershire (including licence to occupy for a month or longer)
- **Shares** etc (with either a total nominal value above £25,000 or 1% of the total issued share capital) in companies with a place of business or land in Worcestershire.

NB Your DPIs include the interests of your spouse/partner as well as you

WHAT MUST I DO WITH A DPI?

- **Register** it within 28 days and
- **Declare** it where you have a DPI in a matter at a particular meeting
  - you must **not participate** and you **must withdraw**.

NB It is a criminal offence to participate in matters in which you have a DPI

WHAT ABOUT 'OTHER DISCLOSABLE INTERESTS'?

- No need to register them but
- You must **declare** them at a particular meeting where:
  You/your family/person or body with whom you are associated have a **pecuniary interest** in or **close connection** with the matter under discussion.

WHAT ABOUT MEMBERSHIP OF ANOTHER AUTHORITY OR PUBLIC BODY?

You will not normally even need to declare this as an interest. The only exception is where the conflict of interest is so significant it is seen as likely to prejudice your judgement of the public interest.

DO I HAVE TO WITHDRAW IF I HAVE A DISCLOSABLE INTEREST WHICH ISN'T A DPI?

Not normally. You must withdraw only if it:

- affects your **pecuniary interests OR**
  relates to a **planning or regulatory** matter
- **AND** it is seen as likely to **prejudice your judgement** of the public interest.

DON'T FORGET

- If you have a disclosable interest at a meeting you must **disclose both its existence and nature** – 'as noted/recorded' is insufficient
- **Declarations must relate to specific business** on the agenda
  - General scattergun declarations are not needed and achieve little
- Breaches of most of the **DPI provisions** are now **criminal offences** which may be referred to the police which can on conviction by a court lead to fines up to £5,000 and disqualification up to 5 years
- Formal **dispensation** in respect of interests can be sought in appropriate cases.

Simon Mallinson Head of Legal and Democratic Services July 2012 WCC/SPM summary/f

worcestershire
countycouncil

Cabinet
Thursday, 19 November 2015, 10.00 am, County Hall, Worcester

Membership: Mr A I Hardman (Chairman), Mr M L Bayliss, Mr A N Blagg, Mrs S L Blagg, Mr J P Campion, Mr S E Geraghty, Mr M J Hart, Mrs L C Hodgson and Mr J H Smith

Agenda

NOTES

- **Webcasting**

Members of the Cabinet are reminded that meetings of the Cabinet are Webcast on the Internet and will be stored electronically and accessible through the Council's Website. Members of the public are informed that if they attend this meeting their images and speech may be captured by the recording equipment used for the Webcast and may also be stored electronically and accessible through the Council's Website.

Agenda produced and published by Simon Mallinson, Head of Legal and Democratic Services, County Hall, Spetchley Road, Worcester WR5 2NP

To obtain further information or a copy of this agenda contact Nichola Garner, Committee & Appellate Officer on Worcester (01905) 766626 or Kidderminster (01562) 822511 (Ext 6626) or minicom: Worcester (01905) 766399 email: ngarner2@worcestershire.gov.uk

All the above reports and supporting information can be accessed via the Council's website.

Date of Issue: Tuesday, 10 November 2015

This page is intentionally left blank

Department for Education

Sure Start children's centres statutory guidance

For local authorities, commissioners of local health services and Jobcentre Plus

April 2013

Contents

Summary

About this guidance

This is statutory guidance from the Department for Education. This means that recipients must have regard to it when carrying out duties relating to children's centres under the Childcare Act 2006.

This guidance replaces the previous Sure Start children's centres statutory guidance published in October 2010.

Expiry or review date

This guidance will be kept under review and updated as necessary.

What legislation does this guidance refer to?

- The Childcare Act 2006.
- Apprenticeships, Skills, Children and Learning Act (ASCL) 2009 which inserted new provisions into the Childcare Act 2006.
- Safeguarding (references to existing legislation and guidance).

Who is this guidance for?

This guidance is for:

- Local authorities.
- Local commissioners of health services.
- Jobcentre Plus.

Key points

This guidance replaces existing Sure Start children's centres statutory guidance. It:

- clarifies what local authorities and statutory partners must do because it is required by legislation, and what local authorities and partners should do when fulfilling their statutory responsibilities;
- focuses on outcomes for children (the core purpose of children's centres);
- clarifies the duty to secure sufficient children's centres accessible to all families with young children, and targeted evidence-based interventions for those families in greatest need of support; and
- promotes the greater involvement of organisations in the running of children's centres with a track record of supporting families.

Sure Start children's centres statutory guidance

Introduction

This is statutory guidance from the Department for Education for local authorities, commissioners of local health services and Jobcentre Plus on their duties relating to children's centres under the Childcare Act 2006. The guidance, developed in consultation with the Department of Health and Department for Work and Pensions, is issued under the Childcare Act 2006 and replaces the previous Sure Start children's centres statutory guidance.

Local authorities and, where relevant, health services and Jobcentre Plus **must** have regard to the guidance when exercising their functions under the Childcare Act 2006. Having regard to the guidance means they **must** take it into account, and should not depart from it unless they have good reason for doing so.

The guidance seeks to assist local authorities and partners by making clear:

- what they **must** do because it is required by legislation;
- what they should do when fulfilling their statutory responsibilities; and
- what outcomes the Government is seeking to achieve.

The Legislation

Legislation about children's centres is contained in the Childcare Act 2006 (**referred to in this guidance as "the Act"**)[1]. This guidance refers to the following sections of the Act:

- **Section 1:** Duty on local authorities to improve the well-being of young children[2] in their area and reduce inequalities between them
- **Section 2:** Explanation of the meaning of early childhood services.
- **Section 3:** Duty on local authorities to make arrangements to secure that early childhood services in their area are provided in an integrated manner[3] in order to facilitate access and maximise the benefits of those services to young children and their parents.
- **Section 4:** Duty on commissioners of local health services and Jobcentre Plus (as 'relevant partners') to work together with local authorities in their

[1] New provisions were inserted into the Act by the Apprenticeships, Skills, Children and Learning Act (ASCL) 2009. Both Acts can be viewed at www.legislation.gov.uk

[2] A young child is a child beginning with his birth and ending immediately before the 1st September next following the date on which he attains the age of five.

[3] Integrated working is where everyone supporting children work together effectively to put the child at the centre, meet their needs and improve their lives.

arrangements for improving the well-being of young children and securing integrated early childhood services (see Chapter 3).

- **Section 5A:** Arrangements to be made by local authorities so that there are sufficient children's centres, so far as reasonably practicable, to meet local need. This section defines what a Sure Start children's centre is and what arrangements and services constitute a children's centre (see chapters 1 and 2).
- **Section 5C:** Duty on local authorities to ensure each children's centre is within the remit of an advisory board, its make up and purpose (see Chapter 4).
- **Section 5D:** Duty on local authorities to ensure there is consultation before any significant changes are made to children's centre provision in their area (see Chapter 2).
- **Section 5E:** Duty on local authorities, local commissioners of health services and Jobcentre Plus to consider whether the early childhood services they provide should be provided through children's centres in the area (see Chapter 3).
- **Section 98C (Part 3A of the Act):** Duties on local authorities after receiving a report from Ofsted following the inspection of a children's centre. This includes preparing and publishing a written statement (an Action Plan) setting out the action to be taken in response to the report.

Chapter 1: What a children's centre is

Outcome:

Sure Start children's centres improve outcomes for young children and their families and reduce inequalities, particularly for those families in greatest need of support.

Statutory definition of a children's centre

A Sure Start children's centre is defined in the Act[4] as a place or a group of places:

- which is managed by or on behalf of, or under arrangements with, the local authority with a view to securing that early childhood services in the local authority's area are made available in an integrated way;
- through which early childhood services are made available (either by providing the services on site, or by providing advice and assistance on gaining access to services elsewhere); and
- at which activities for young children are provided.

It follows from the statutory definition of a children's centre that children's centres are as much about making appropriate and integrated services available, as it is about providing premises in particular geographical areas.

Early childhood services are defined[5] as:

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

A children's centre should make available universal and targeted early childhood services either by providing the services at the centre itself or by providing advice and assistance to parents (mothers and fathers) and prospective parents in accessing services provided elsewhere[6]. Local authorities must ensure that children's centres provide some activities for young children on site[7].

[4] Sections 5A(4) and (5) of the Act

[5] Section 2 of the Act

6 Section 5A (5)

7 Section 5A(4)(c)

Sure Start-On database

Only facilities that fulfil the statutory definition of a children's centre may be called a Sure Start children's centre[8]. Local authorities should update the Sure Start-On database on a regular basis to reflect any changes to provision. The database has been amended to reflect new arrangements for the inspection of children's centres which take effect from April 2013. This includes the introduction of group inspections of children's centres, for example, where they share leadership and management and some staff and services. Where children's centres are grouped together, local authorities should continue to list the individual children's centre records on the database, as well as assigning the centre to a particular group for inspection purposes on the database by using the 'Delivery Model' field. This is important as the data is used to provide information for parents about children's centres in their area on the GOV.UK website. Children's centres that do not have an individual children's centre record on the database will not be viewable on GOV.UK.

When local authorities put forward proposals on change of use of capital projects which were funded through the Sure Start and Early Years Capital Grant, they must inform the Department of the proposed changes (see the Sure Start and Early Years Capital guidance)

The core purpose of children's centres

The core purpose of children's centres is to improve outcomes for young children and their families and reduce inequalities between families in greatest need and their peers in:

- child development and school readiness;
- parenting aspirations and parenting skills; and
- child and family health and life chances.

Where, in discharging their duty in section 5E of the Act[9], local authorities, commissioners of local health services and Jobcentre Plus decide to make early childhood services available through children's centres, they should do so in ways which enable children's centres to achieve their core purpose.

The core purpose relates directly to the wider duties local authorities have (under section 1 of the Act) to improve the well-being of young children in their area and reduce inequalities between young children in the area.

8 Section 5A(7)

9 Section 5E 'Duty to consider providing services through a children's centre'

Section 1 of the Act places a duty on local authorities to:

- Improve the well-being of young children in the following areas:
    - physical and mental health and emotional well-being
    - protection from harm and neglect;
    - education, training and recreation:
    - the contribution made by them to society; and
    - social and economic well-being.
- Reduce inequalities between young children in those areas; and
- make arrangements[10] to secure that early childhood services in their area are provided in an integrated manner which is calculated to:
    - facilitate access to those services; and
    - maximise the benefit of those services to parents, prospective parents and young children.

Children's centres are key to making this happen. Local authorities should commission children's centres to achieve the core purpose as a key component of their strategy to improve the well-being of young children. They will need to satisfy themselves that there is evidence of the effectiveness of activities undertaken to achieve the core purpose. Annex A is a summary of the relationship between the core purpose of children's centres and statutory duties on local authorities and relevant partners. More detail about what children's centres can do to achieve the core purpose can be found at www.foundationyears.org.uk.

[10] Section 3(2) of the Act

Chapter 2: Sufficient children's centres

Outcome:

Local authorities have sufficient children's centres to meet the needs of young children and parents living in the area, particularly those in greatest need of support.

To secure delivery

Local authorities **must:**

- take steps to identify[11] parents and those expecting a baby in their area who are unlikely to take advantage of early childhood services available and encourage them to use them; and
- ensure there are sufficient children's centres, so far as reasonably practicable, to meet local need[12].

Local authorities should:

- ensure that a network of children's centres is accessible to all families with young children in their area;
- ensure that children's centres and their services are within reasonable reach of all families with young children in urban and rural areas, taking into account distance and availability of transport;
- together with local commissioners of health services and employment services, consider how best to ensure that the families who need services can be supported to access them;
- target children's centres services at young children and families in the area who are at risk of poor outcomes through, for example, effective outreach services, based on the analysis of local need;
- demonstrate that all children and families can be reached effectively;
- ensure that opening times and availability of services meet the needs of families in their area;
- not close an existing children's centre site in any reorganisation of provision unless they can demonstrate that, where they decide to close a children's centre site, the outcomes for children, particularly the most disadvantaged, would not be adversely affected and will not compromise the duty to have sufficient children's centres to meet local need. The starting point should therefore be a presumption against the closure of children's centres;

[11] Section 3(3) of the Act.

[12] Section 5A(2) of the Act – Local need is the need of parents, prospective parents and young children in the authority's area.

- take into account the views of local families and communities in deciding what is sufficient children's centre provision;
- take account of families crossing local authority borders to use children's centres in their authority. Families and carers are free to access early childhood services where it suits them best; and
- take into account wider duties under section 17 of the Childcare Act 1989 and under the Child Poverty Act 2010.

The local authority's role in commissioning sufficient children's centres to meet local need

In determining the best arrangements locally to meet local needs, value for money and the ability to improve outcomes for all children and families, especially families in greatest need of support, should be important guiding considerations. Local authorities should consider involving organisations that have a track record of supporting families and should be aware of the option to set up and transfer into a public service mutual with their employees in line with their 'Right to Provide'.

Significant changes to children's centre provision and the duty to consult

Local authorities **must** ensure there is consultation[13] before:

- opening a new children's centre;
- making a significant change to the range and nature of services provided through a children's centre and / or how they are delivered, including significant changes to services provided through linked sites; and
- closing a children's centre; or reducing the services provided to such an extent that it no longer meets the statutory definition of a Sure Start children's centre.

Local authorities (or a third party acting on the authority's behalf) should consult everyone who could be affected by the proposed changes, for example, local families, those who use the centres, children's centres staff, advisory board members and service providers. Particular attention should be given to ensuring disadvantaged families and minority groups participate in consultations.

The consultation should explain how the local authority will continue to meet the needs of families with children under five as part of any reorganisation of services. It should also be clear how respondents views can be made known and adequate time should be allowed for those wishing to respond. Decisions following consultation should be announced publically. This should explain why decisions were taken.

[13] Section 5D of the Act

Chapter 3: Providing services through children's centres

Outcome:

Families are able to access all the early childhood services they need through children's centres. This means working in an integrated way with other services to share information appropriately and identify and support families in greatest need.

To secure delivery:

Local authorities, local commissioners of health services and Jobcentre Plus must consider providing early childhood services through children's centres[14]. This is related to the wider duty on local authorities[15], which requires local authorities and "relevant partners" to work together to deliver integrated early childhood services.

Health services and local authorities should share information (such as live birth data and data on families with children under five who have recently moved into the area) effectively with children's centres on a regular basis. Local authorities and commissioners of health services should consider developing local partnership agreements or information sharing protocols to enable effective sharing of bulk data (such as live birth data), whilst ensuring that the requirements of the Data Protection Act 1998, and other relevant legal provisions, are complied with. Local authorities might wish to use records of all new births as a vehicle for health visitors to work with families that might benefit most from using the services offered by children's centres.

Getting the most out of services

Local authorities should consider how they can use their network of children's centres to greatest effect through links with other services, including:

- through links to midwifery, GPs and, health visitors. As a minimum it is expected that every children's centre should have access to a named health visitor. The health visitor should work with the children's centre leader and management team to ensure information is shared appropriately. Health visiting will be the responsibility of the NHS Commissioning Board from April 2013 to 2015; and midwifery services will be the responsibility of local commissioning groups. Both should consider the role children's centres can play, particularly in delivering the 0-5 Healthy Child Programme. This statutory guidance will be updated in light of the passage of the Health and Social Care Bill and supporting regulations;

[14] Section 5E of the Act.

[15] Section 4 of the Act.

- through links to Jobcentre Plus to provide parents with access to employment support and advice;
- through links with early education and childcare providers, including childminders and schools, to support families to access early education and childcare, including early education for disadvantaged two year olds; and
- through links with Social Workers and troubled families co-ordinators to form part of the a seamless package of support. Each children's centre should have a link to a named Social Worker.

Providing early learning for two, three and four year olds

Early years providers either run by, or on the site of, children's centres, can provide funded early learning places. Children's centres should also work closely with other providers offering funded early learning places to ensure that families who need it can access integrated support.

Childminder agencies

Children's centres could also help support childminder agencies, which (subject to Parliamentary approval) are expected to start operating from September 2014. Where children's centres are running good childminder networks they may wish to explore turning these into agencies to offer a more comprehensive service to local children. Further guidance on childminder agencies will be issued in due course.

Supporting families' economic wellbeing

The reduction of child poverty should be a priority for local authorities, commissioners and the leaders of children's centres. In addition to links with Jobcentre Plus, children's centres can encourage families to improve their skills, employment prospects and financial situation; for example, through local skills and training providers, voluntary organisations and volunteering, debt advice and other services, depending on the needs of their communities.

Decisions about support offered by (or on behalf of) Jobcentre Plus should be made locally. As a minimum there should be arrangements made at the centre to assist families on gaining access to employment support and advice. The Department for Work and Pensions has published a report (dated 11 August 2011) which presents final findings from the evaluation of the 'Work-focused services in children's centres' pilot.

Local authorities should give consideration to the local childcare market and to their duty to secure sufficient childcare, as far as is reasonably practicable, for working parents, or parents who are studying or training for employment[16].

[16] Section 6 of the Act.

Providing services “through” a children’s centre does not mean that all services should actually be delivered in a children’s centre, or that children’s centres should be given any greater weight as potential service locations than other settings.

Supporting families in greatest need of support

To reduce inequalities in outcomes among young children in their areas, local authorities should commission and support children’s centres as part of their wider early intervention strategy and strategy for turning around the lives of troubled families.

Local authorities should ensure that children’s centres offer differentiated support to young children and their families, according to their needs, by:

- offering access to integrated information and support to all prospective parents, new parents and parents of young children;
- encouraging and providing access to early intervention and targeted support, for those young children and their families who experience factors which place them at risk of poor outcomes; and
- helping troubled families with young children to access appropriate wider and specialist support to meet their needs in conjunction with the troubled families co-ordinator. This should include ensuring these families know what is on offer within/via children’s centres.

To help fulfil their duty to reduce inequalities between young children in the area, local authorities should consider the role that children’s centres can play by:

- providing inclusive universal services which welcome hard to reach families;
- hosting targeted and specialist services on site where appropriate (such as speech and language therapy, parenting programmes, mental health services and social care) or providing access to those services;
- considering the use of multi-agency assessment and referral processes; and
- having children’s centre outreach and family support staff work with other services to:
    - support families before, during and after specialist programmes and/or interventions;
    - provide opportunities to help families develop resilience to risk factors; and
    - promote child development.

Links with the troubled families programme

All Local Authorities are putting in place improved services and systems targeted at the most troubled families locally and should ensure these plans consider the role of Children’s Centres. This might include for example:

- using outreach services to engage the families of children who do not take up the free early education offer or whose development is identfied as delayed (for example in the new integrated check for 2 year olds);
- helping troubled families in touch with children's centres access more intensive familiy intervention by e.g Locating family intervention workers within children centres or providing swift referral from Children's Centres into more intensive services.

Using evidence-based approaches to deliver targeted, family-centred support

Children's centres use universal activities to bring in many of the families in need of extra support. As families build up confidence and relationships with staff and other service users they often become more receptive to appropriate targeted activities.

Children's centres should combine evidence with professional expertise in order to decide which early interventions work best for local families. Where activites are not based on evidence, they should consider stopping these activities.

The following targeted services can make a difference for families with the greatest needs:

- Parenting and family support, including outreach work and relationship support (the quality of the relationship between parents is linked to positive parenting and better outcomes for children). Troubled families may benefit from family intervention delivered by a dedicated worker who overees a family plan who works assertively and provides practical support.
- Provision of integrated support in response to identified strengths and risk factors within individual families and support for troubled families.
- Targeted evidence-based early intervention programmes (such as those recommended by the Early Intervention Foundation, the NAPR, the Wave Trust and C4EO) where published evaluation demonstrates that particular interventions can help those families at greatest risk of falling furthest behind to make accelerated progress in improving outcomes.
- Links with specialist services for families with more specific needs (e.g. support for early speech and language development, support for disabled children, children with major health difficulties, or children likely to be "in need" or where there are safeguarding concerns, as in the Children Act 1989)

More information about the evidence on risk factors and evidence-based programmes can be viewed on the Department for Education website.

Chapter 4: Quality and accountability

Outcome:

Children's centres offer access to high quality early childhood services. Local families and communities have a say in how children's centres are run, and are well informed about what services are available and the quality of the services they offer.

Inspection and sections 98A-G of the Childcare Act 2006

High quality early childhood services delivered through children's centres are essential to improving outcomes for young children and their families, particularly families in greatest need of support.

Inspection continues to be an important part of children's centre accountability, helping to drive up standards. From 1 April 2013, Ofsted will be implementing some changes to the current inspection arrangements, including changes to how inspections will be undertaken. Inspections will be organised according to how local authorities deliver their children's centres. An inspection will either be of a single centre or of a group of centres that share leadership and management and offer integrated services**.** Details can be found on Ofsted's website at http://www.ofsted.gov.uk/early-years-and-childcare/for-early-years-and-childcare-providers/childrens-centres/childrens-centres

Background: Ofsted inspections and reports

Regulations made under section 98A of the Act require Ofsted to inspect all children's centres within five years of opening[17] and then at five-yearly intervals. Section 98B(2) of the Act and associated regulations[18] mean Ofsted must provide a written report that addresses the quality of the leadership and management of the children's centre, including in particular whether:

a) the financial resources made available to the children's centre are managed effectively;

b) young children, parents and prospective parents in the area served by the children's centre who would otherwise be unlikely to take advantage of the early childhood services offered through the centre, are identified and encouraged to take advantage of those services;

c) the needs of young children, parents and prospective parents who attend, or are likely to attend, the children's centre are identified, and early childhood services shown by evidence to meet those needs are delivered;

[17] For children's centres opened on or before 31 August 2010, the inspection must take place by 31 August 2015

[18] The Children's Centres (Inspections) Regulations 2010

d) appropriate policies, procedures and practices for safeguarding and promoting the welfare of young children who attend, or are likely to attend, the children's centre are adopted and implemented.

Action to be taken by local authorities following inspection

Following an inspection, local authorities **must**[19] produce a written statement (an 'Action Plan') which sets out the action they, and any organisation managing the children's centre on their behalf, propose to take in response to the findings of the inspection report, and the period in which action will be taken. The Action Plan should be shared with Ofsted on request.

In preparing an Action Plan, local authorities should consider:

- how to ensure actions are clearly assigned, taken forward promptly and monitored to ensure improvement occurs, particularly for children's centres judged to be unsatisfactory or satisfactory; and
- how parents and users are made aware of the findings of the inspection report and the action that is being taken in response.

Further information about children's centres inspection is available on Ofsted's website.

Role and responsibilities of an advisory board

Local authorities **must**[20] make arrangements to secure that each of its children's centres has an advisory board**.** The Act does not require that each centre has its own board so where it makes sense, centres can cluster together and share an advisory board.

An advisory board advises and helps those responsible for running the centre. It should ensure the centre is clear on parents' views and should play an active role in driving improvement in the children's centre's performance. Local authorities should ensure the advisory board is involved in any Ofsted inspection of the children's centre.

Local authorities should ensure that all advisory boards have simple written terms of reference setting out the responsibilities of the board and what is expected of advisory board members. The chair of the advisory board should ideally be a parent or other member of the community. The children's centre leader may chair the advisory body but this should be as a last resort. Local authorities or providers should offer appropriate support and training to help parents or community members carry out their role effectively.

[19] Section 98C

[20] Section 5C(2)

Membership

Local authorities **must**[21] ensure that the membership of advisory boards represents:

- each children's centre within the remit of the board;
- the local authority; and
- parents and prospective parents in the local authority's area.

Local authorities should ensure that advisory boards have representatives from other interested groups and bodies, for example, health services, Jobcentre Plus, children's centres' staff, local community, faith groups and childcare providers. Involving more disadvantaged or vulnerable groups requires thought and sensitivity if they are to have an active role. If certain communities are unwilling or unable to represent their own views at the advisory board, the children's centre should ensure these families have other opportunities to make their views heard; for example, through using outreach support networks or parent forums.

[21] Section 5C(5)

Chapter 5: Safeguarding

Outcome:

Sure Start children's centres are safe places for children and families to spend time in, and services that are provided through them are safe.

Where children's centres provide childcare this **must** operate using:

The Statutory Framework for the Early Years Foundation Stage (EYFS)

The Early Years Foundation Stage Framework makes clear what early learning and care providers must do to keep young children safe, including what they must do to ensure practitioners and other people aged 16 or over who are likely to have regular contact with children are suitable, including a requirement that such persons who live or work on the part of the premises where the childcare takes place have an enhanced CR disclosure. There must be policies and procedures to safeguard children which should be in line with the guidance and procedures of the Local Safeguarding Children Board (LSCB).

'Working together to safeguard children'

In addition to the requirements of the EYFS, everyone who works with children and young people must have regard to the statutory guidance - 'Working together to safeguard children'.

The Childcare (Early Years Register) Regulations[22]

The regulations require applicants for the provision of childcare and their managers to be suitable and to comply with the EYFS requirements. Both the applicant and manager must have an enhanced CR check. Ofsted have guidance on the registration process, including obtaining enhanced CR checks.

The Safeguarding Vulnerable Groups Act 2006

The Safeguarding Vulnerable Groups Act 2006[23] created statutory duties in "specified places" such as children's centres. Those duties apply to children's centres as follows:

- A children's centre, when acting as a regulated activity provider (RAP), must not knowingly use a barred person in regulated activity. To do so is to commit

[22] S.I. 2008/974

[23] Amended by section 200 of the ASCL Act

a criminal offence. This does not at present[24] create a new duty to check whether an applicant is barred, but if the centre is aware of a bar it must not use the person for such activity.

- Where a children's centre, acting as a RAP, used a person in regulated activity and then dismissed the person (or would have, had the person not left first) because of harm or risk of harm to children, the children's centre must refer that individual to the barring authority[25] who will consider whether to bar the person from regulated activity.

A barred person commits an offence if they apply for regulated activity.

Named Social Worker

It is important that children's centres have robust systems in place to ensure families are able to access early support before they reach the thresholds of social care. Children's centres should therefore have access to a "named social worker", to help build confidence in children's centres to manage risk and take appropriate child protection action where necessary.

Many families are already familiar with the range of services delivered via children's centres including health visitors and wider therapeutic services. Children's centres should know their communities well and are likely already to work holistically with the whole family, acting as hubs for multi-agency teams with access to social work expertise that allows conversations around the types of help and interventions that are needed to support children, young people and families.

[24] The Protection of Freedoms Act 2012, amends the Safeguarding Vulnerable Groups Act 2006 by introducing a new duty on the RAP to check the barred list before starting a new person in regulated activity. This duty is likely to be commenced in in 2013.

[25] The barring authority is now the Disclosure and Barring Service (DBS) .

Annex A: The relationship between the core purpose of children's centres and statutory duties on local authorities and relevant partners

Supporting children's centres to deliver on their core purpose is a means by which local authorities can fulfil a number of wider statutory duties – set out below. (See also footnote[26])

The core purpose of a children's centre	
To improve outcomes for young children and their families, with a particular focus on families in greatest need of support in order to reduce inequalities in: child development and school readiness; parenting aspirations, self-esteem and parenting skills; and child and family health and life chances.	This contributes to local authorities fulfilling their wider duty to improve the well-being[27] of young children in the area and to reduce inequalities (section 1 of the Act).
What children's centres do to achieve their core purpose	
Children's centres help inform local authority assessment of strengths and needs across the area.	This contributes to local authorities meeting their duty in section 5A(1) of the Act to secure sufficient provision of children's centres to meeting local need, so far as is reasonably practicable.
Children's centres provide access to high quality universal early years services.	This contributes to local authorities fulfilling their duty under sections 2 and 3 of the Act to make arrangements to provide in an integrated manner early childhood services. It is also relevant to sections 4 and 5 of the Act – the duty of local authorities to work with 'relevant partners' (local commissioners of health services and Jobcentre Plus) and consider providing services such as health and employment support through a children's centre.

[26] www.foundationyears.org.uk

[27] Well-being in this wider context is defined by the Act as: physical and mental health and well-being; protection from harm and neglect; education, training and recreation; the contribution made by them to society; social and economic well-being.

Children's centres use evidence-based approaches to deliver targeted, family centred support.	This contributes to local authorities fulfilling their duty in section 1(b) of the Act to reduce inequalities between young children, and in section 3(3) of the Act to take steps to identify parents or prospective parents who are unlikely to take advantage of early childhood services that may be of benefit and to encourage them to take advantage of these services[28].
Children's centres act as a hub for the local community, building social capital and cohesion.	This contributes to local authorities fulfilling their wider duty in section 1 of the Act about improving the well-being of young children and reducing inequalities. A hub for the local community and building social capital/ cohesion are ways of building communities' capacity to improve young children's well-being.
Children's centres sharing expertise with other early years settings to improve quality.	This contributes to local authorities fulfilling their duty (under Section 3(4) of the Act) to take all reasonable steps to encourage and facilitate the involvement of a range of persons including in particular early years providers in their area (including those in the private and voluntary sectors), in the arrangements made for providing integrated early childhood services.

[28] The Commissioning Toolkit is a good source of effective evidence-based parenting programmes.

Any enquiries regarding this publication should be sent to us at: www.education.gov.uk/contactus.

This document is available online at www.education.gov.uk.

Reference: DFE-00314-2013

Feedback from the Safeguarding Children Peer Review

As you are aware, the County Council recently asked for a Local Government Association (LGA) facilitated Safeguarding Children Peer Review to take place as part of our desire to be a learning organisation. This review consisted of a team of external colleagues working in the field from local authorities and relevant bodies acting as 'critical friends' to help us evaluate our strengths and weaknesses and our focus on priorities. Ahead of the review we identified key areas that the County Council wanted the reviewers to focus on. These included:

- Have we got the right structures, systems, processes and management focus to deliver children's social care services moving forward?
- Are the current strategies and plans for improvement having impact?
- A view on corporate support for children's safeguarding.
- The quality of front-line practice specifically focusing on how the front door is working.
- A view on the multi-agency partnerships and partners engagement with supporting the improvement of outcomes for children and families.

The reviewers spent time with senior managers, front-line staff, members and partners to have open and honest conversations about our services and how we protect and support children and families in Worcestershire. They identified the following key points in their feedback:

Key strengths

- We have a committed workforce who are keen to make a difference to children and families.
- We have an overall sound strategy and backing from the whole council to make any necessary changes within our service.
- From observations made during their visit, timely decision making at the Access Centre was found and there is good evidence of the rationale of decision making.
- There are many examples of how our work is having a good impact. For example, the POD social work model in our schools, our in-house social worker recruitment drive and the Stronger Families programme.
- We have strong and committed partners and tangible examples of partner engagement.
- We have prioritised resources and there is a commitment within our financial strategy to address cost pressures within children's services.

Key areas for consideration

- Our social care practice is open to further improvement to help keep children safe moving forward.
- Our Family Front Door needs simplifying and there needs to be a clearer understanding of where the Multi Agency Safeguarding Hub will fit in.
- We need to look at the difference between the Worcestershire-wide early help strategy and the council commissioned early help services.
- The Health and Well-being Board could do more to add a unique children's focus in their current strategy.
- Worcestershire Safeguarding Children Board (WSCB) requires more pace and scrutiny, with some multi-agency areas slow to develop.
- We need to further develop consistent financial projections based on forecast demand and complexity.

It is important as a Council we immediately address these areas, again demonstrating we can learn from the review's findings. Therefore with this valuable feedback, we are now going to focus on the following:

- Renewing our focus on safeguarding practice to demonstrate absolute compliance and seek to achieve excellence.
- Addressing confusion about the Family Front Door.
- Creating detailed forecasts to enable a robust financial plan and;
- Reviewing and defining the role of Early Help.

Whilst all of the above will not be achieved in coming days, it will require us to step up our pace and focus in these areas. The reviewers also identified potential 'quick wins' for us to consider and there are a number of actions our teams will now develop and implement. The progress against these will be reported via existing governance arrangements, through the Worcestershire Children's Safeguarding Board and the Children and Young People Overview and Scrutiny Performance Panel.

Finally, I wanted to thank those of you who have contributed to our Peer Review. It can be hard sometimes to hear challenging feedback but essential if we are to learn and improve. A very clear message from the review is that we have staff that are committed and capable of delivering these improvements and I am confident that we can make these necessary changes. I know you will all support us to us to move into focused action, do the things that need doing and positively move away from activities and debates that further complicate or distract us from this.

Regards,

Gail Quinton
Director of Children's Services

Worcestershire County Council – LGA Children's Safeguarding Peer Review

Detailed Findings

The table below highlights the good practice noted by the peer review team and areas for consideration by Worcestershire and its partners:

Vision, Strategy & Leadership	**Strengths:** • Corporate ownership and ambition for the service and the whole organisation. In addition, the Public Sector Executive Group has been established as the place where leadership is brought together across the County (Future Fit, as the council's 20:20 vision, emphasises active alliances) • The Leader of the Council and the Chief Executive provide empowerment and are champions for change – have a positive and unified relationship • Cabinet role focussing on transformation has been important in identifying issues and energising action and this momentum needs to be maintained • Confirmed cross-party support for improvement of children's services • Key leaders evidenced within the Health economy with drive and determination • Focus for improvement in children's services is in the right areas and a good level of awareness from managers and staff of the issues associated with these areas • Workforce strategy is comprehensive and focussed on the right things with incentives for Newly Qualified Social Workers (NQSW's) • The self-assessment showed insight and awareness • The Redditch pilot, where you are trialling with district pooling effort around complex families, is a good example of innovation and prioritisation given the levels of need in an attempt to reduce the care population • Some good initiatives such as the POD in schools, parachute resources and initiatives for professional development led by the Principal social worker • Leadership at school level and officer level is impressive with some examples of good practice. Provision for LAC within schools is good with the Virtual Head teacher and supporting officer putting

1

	commendable strategies in place to ensure engagement, tracking progress and provision in schools and offering excellent support learning programmes for young people. **Areas for further consideration:** • Realising the vision and articulating it – managers and staff were not consistently able to articulate the vision for the service despite clearly supporting the values of being child focused and achieving best possible outcomes • Corporate Parenting could be strengthened across the Cabinet and with frontline councillors • A sense of frustration was expressed by practitioners and partners about too many plans and initiatives, the number of processes and meetings were stifling swift decision making leading to drift in plans and timely outcomes • Response to escalation is felt to be inadequate thus inhibiting the embedding of the desired culture change. A number of partners and managers reported that when issues and concerns are escalated the response is often not helpful with the issues being minimised. This view was consistently expressed and included members from Performance and QA and other agencies. • A sense of whole service ownership and distributed leadership particularly within Children's Social Care (CSC) needs to be established • Demand Management strategies (Early Help and edge of care) are not yet 'biting' – the tracking of contacts and referrals suggest there is limited join up of the various Early Help initiatives and services • There is also no clear referral pathway from initial contact to possible services which results in a range of possibilities that exacerbates the lack of consistency and jeopardises the timely provision of services • Multi-agency CSE strategy – we found an inconsistent understanding of the strategic direction amongst staff and partners, which may be explained by a written strategy being embryonic at this stage • Opportunities for more integrated commissioning could be considered e.g. across Public Health and Adult Services in terms of a family focus and the transfer of commissioning responsibilities for health visiting from October 2015

	• The Safeguarding Board structure review needs acceleration as currently it appears to be taking too long to make the necessary changes. This is evident in the lack of drive and influence in relation to implementation of agreed strategies e.g. Early Help, joint CSE strategy. Findings from audits do not appear to be disseminated swiftly enough • Need to further drive innovation – initiatives and ideas need to be seen through and amended in the light of feedback e.g. the unified front door
Effective practice, service delivery and the voice of the child	**Strengths:** • Through case file audits and discussions with social workers it is clear that the voice of the child does feature in case planning and case work. Children in care seen by the peer team gave a generally positive response feeling they were well supported and their views taken into account • From our observation on-site the thresholds for passing to Section 47 strategy discussions by the Access Team and discussions with the managers showed that there were appropriate decisions made. The view of CAFCASS was that thresholds for care proceedings are now mainly appropriate; however, there are issues about exploring alternatives to care e.g. use of relatives and also the timeliness of planning. However, it is noted that following the case records review the LGA peers did question 3 of the 20 cases reviewed, considering that a Section 47 enquiry should have been raised based on the information (though none of these children were considered to be at significant risk), which aligns with the council's own views from their audits that more work needs to be done on application of thresholds. • The team saw timely decision making at the Access Centre • Social workers spoke positively about supervision and role of Advanced Practitioners in this and confirmed they had regular supervision sessions, though recording discussions was inconsistent • The team saw experienced social workers at the 'front door' who appropriately considered history when making decisions and could evidence their decision making. However, the council's own audits would suggest there are inconsistencies in practice

3

	• Managers are recording assessment plans and setting visiting requirements • Some Early Help services are working well e.g. the POD in schools and Stronger Families programme • A newly established 'Systems Taskforce' operating collaboratively across parts of the whole social care system to take corrective action to improve practice • Evidence of effective practice across the health economy e.g. the contribution to the 'Integrated Health and Care Trust Safeguarding Team' referring all serious injuries (fractures) to the paediatrician with input from orthopaedics which improves recognition of CP cases. • Good or Outstanding residential provision is in place • Evidence of good performance in securing permanency through adoption which has improved over the last year • A Child Protection Conference was observed which was well managed, well attended by all appropriate partners and concluded with a pragmatic and helpful outcome **Areas for further consideration:** • Confusing Front Door – the aspiration of access to services operating through a 'unified front door' is yet to be realised. The Access Centre is still operating as two teams with the Early Help team only receiving telephone contacts (as well as other early help requests). This only consists of around 20% of social care contacts overall. This risks inconsistency in the response to contacts/referrals and confusion amongst staff involved, social workers and managers. The access Centre is not yet effectively managing demand for the service • From the visit to the Access Centre we found that cases did not always get referred on in a consistent manner. It also depended upon what resources were available in a particular area and some referrals were reported to be being sent to an Early Help Service and then being sent back. A waiting list for some early help services is building up and focus is required on prioritisation of need • The Initial Response system (where teams undertake a 'duty' role for a week at a time) divides opinion (the council's own staff survey highlights that 37% of people don't like the system).Whilst the review team could

	understand the rationale for these arrangements and desire to simplify the number of handoffs between social workers the system appears to work best in areas where there is a full complement of experienced staff. In practice the ambition to reduce the number of handoffs between social workers by allowing one worker to hold cases from referral through to completion with work is often compromised as cases are re-allocated due to either inexperience or high caseloads • The imminent implementation of the MASH provides an opportunity to consider where decisions on thresholds for Section 17 and Section 47 enquiries are best made in order to ensure a timely response by the right service. To ensure both consistency and a timely response then a model where decisions and strategy discussions are held in the MASH provides the best opportunity to achieve this. • There may be an opportunity to think through the whole front door system in order to divert demand away from the specialist services wherever possible. This would include considering how the MASH will operate and where best to position a triage function. Establishing a triage process at point of initial contact would enable clear CP cases to be passed to strategy discussions within MASH, low priority passed to Early Help and MASH to share information and determine an appropriate route for 'amber' cases. It is also suggested that a 'no quibble' arrangement is established so that referrals from MASH/Access to appropriate teams are accepted and a regular review process can be put in place to QA the process. • There are significant concerns about the timeliness of responses to Safeguarding referrals, evidenced from the council's own audits, and a follow up case checking exercise on open Section 47 cases carried out by the peer team. This check highlighted significant concerns about safety of practice. More systemically there appear to be issues in relation to timeliness of responses with drift in cases (e.g. a high proportion of out of time assessments with a low proportion of assessments and cases including CP Plans completed within 6 months) • The requirement to complete 'the booklet' to initiate a strategy discussion is cited by staff as a reason why Children in Need rather than Sec.47 processes are

	used in some cases. This means that Working Together guidance is not being consistently followed • We met some social workers who appeared to have manageable caseloads e.g. NQSW with a case load of 12-15 cases and a new recruit with 6 cases, however, a number of social workers reported caseloads of between 25-30 cases with some reporting 30 plus. Some workers felt their caseloads had reduced but most authorities consider caseloads above 25 to be too high. This is an issue well known to the council through their own caseload management information and the workforce strategy is actively addressing these challenges. • Management oversight is also inconsistent and some social workers reported difficulties in contacting managers at times when on duty with the Initial Response Team. There is agreement about the need for more reflective and analytical supervision • Child Sexual Exploitation – some staff we met had a very good understanding of the risks associated with CSE and there are clearly areas of good practice, however, we are aware that the CSE strategy is still at development stage and understanding about roles and responsibilities of some staff and partners is currently inconsistent, despite significant work by WSCB to engage them. We suggest this needs an urgent re-focus supported through the WSCB to ensure collective ownership and accountability. This should include consideration of the management of young people who go missing from home, Care or education. • Though the threshold for a child meeting criteria for consideration of becoming Looked After appears appropriate the gatekeeping and exploration of alternative options is not robust or consistent. For older young people there is a generous interpretation of the Southwark Judgement and limited alternative provision available. For younger children alternatives such as Family and Friends, use of Special Guardianship Orders or other timely interventions seem to be used relatively infrequently (in comparison with other LAs) • There is a need to simplify and clarify the decision making process in relation to LAC and reduce the number of panels. Strong strategic leadership will be required given the significant resources tied up in this area of activity. We saw some signs that recent activity is starting to tackle these issues, determined effort will

	be necessary over time to impact on the high numbers of LAC. • One suggestion is that the stage at which cases transfer to LAC service (currently after a permanency plan is in place) is reviewed; this would potentially help frontline teams so they can focus on improving the assessment and planning. It would also enable LAC teams to engage with children earlier and develop alternative routes to permanency. • Role of CAMHs – access to the service and waiting times, as experienced across the Country, are an issue. Specialist CAMHs support for LAC seems hard to identify and there may be an opportunity with re-commissioning to look at this in a different way • Adolescent self-harm issues have escalated rapidly such that the hospital now has a protocol on how to 'section' adolescents. The needs of adolescents were a concern to all partners • Health colleagues report working with large numbers and complex early help cases that fall below the CSC threshold. Further discussions are needed across the partnership to ensure a shared understanding of thresholds and appropriate use of shared resources.
Outcomes, impact and performance management	**Strengths:** • There are examples of good initiatives that are having a positive impact that have engaged partners and can evidence they are making a difference e.g. the POD model in schools (health, education, social care, police and housing working together in an effective collaboration), in-house social work recruitment, the Stronger Families programme • The Stronger Families initiative has increased activity over recent months and has hit targets within timescales. However, the pathway to this resource is not used consistently and highlights the need for clear guidance and simpler pathways in order to access Early Help so that the service can be better utilised. The council acknowledge that there may have been some confusion with the shift from Phase 1 to Phase 2. • In-house social worker recruitment initiatives have been successful and the strategy is comprehensive. The focus on retention needs to be reinforced together with development and career progression for more experienced staff.

	• Educational outcomes for children in Worcestershire are good with many at or above the national norm but this is not currently sufficiently reflected in the outcomes for Children in Need (CiN) and Looked After Children (LAC). • There is comprehensive and well established activity in relation to Quality Assurance, audit, performance and analytical data. This includes the MACFA process and multi-agency data collection by the WSCB and has assisted in achieving a high level of self-awareness • The Health economy has a good safeguarding assurance process in place across both community and acute settings; these include focus on neonatal deaths, serious incidents and monthly HR reviews to check staff against safeguarding criteria Early Help commissioners have developed an improved contract monitoring tool in the 'early help dashboard' though this is yet to be evaluated **Areas for further consideration:** • The major re-design is not yet having the desired outcome with limited evidence to show that recent changes have addressed issues • There are issues about pace at all levels both strategically and at case level. This includes issues such as achieving timely assessments, disseminating findings from audits and progressing major changes • Whilst quality assurance appeared to be of good quality in itself, findings were not necessarily well understood or owned. The results of a recent deep dive within CSC were being debated by managers and staff had a range of views about priority areas for practice development. • Performance management could be enhanced – it is unclear how performance issues are escalated e.g. team managers were unclear about how delays in processes would be followed by Group Managers. • Senior Managers acknowledged that they hadn't considered incomplete/in progress Section 47 enquiries within their performance information. • There is a need to establish a stronger 'learning loop' that can clearly evidence actions and improvement plans that are focussed, refreshed and informed by on-going audit activity • There is confusion between the Early Help strategy and the range of commissioned early help services. It is too

	early to judge the effectiveness of commissioned early help services at this stage • Children's social care currently has an enthusiastic but relatively inexperienced workforce at both practitioner and team manager level. The risks of this in respect of performance and risk adverse culture need to be managed
Working Together (including Health and Wellbeing Board)	**Strengths:** • The high level buy-in to the partnership is benefitting children's services • Strong and committed partners – Health view is that urgent child protection cases are dealt with effectively (the concern is children who sit on the cusp of the threshold) • Police report positive working relationships with children's social care, they have a good relationship at Group Manager level and have no need to escalate • WSCB has recognised the enormity of its agenda and has taken positive actions to re-structure • Good frontline partnership e.g. reduction in escalations from Police and Health • Tangible examples of partner engagement evidenced by the peer team • Multi-agency training and development was considered to be accessible and effective across partners **Areas for further consideration:** • Ensuring a sense of collective accountability shared across partners which can have impact. The delays in progressing the MASH are an example where partners have different perspectives and may have been able to work together more effectively. Another example is that the team found it difficult to track Serious Case Review processes • From an education perspective more effective communication is deemed to be critical with regard to the WSCB. This might be an opportune time to consider an Educational sub-group to underpin the work of the Board though this must be balanced with current number of sub-groups • The level of challenge and scrutiny within WSCB is under developed and the Board needs to do more to drive improvement (council self-assessment also refers)

	• WSCB has a lot of priorities with a large Executive and Board; there is a need to focus on key areas and improve the relationship between sub-groups and the full Board • Multi-agency arrangements to support partners in managing key risk areas e.g. CSE, MASH have been slow to develop with confusion around Early Help e.g. many uncertain whether the POD model took the place of Early help or was part of it • Police and Crime Commissioner (PCC) has invested £1.3m in CSE to fund posts and a full CSE team, however, this is not yet joined up with missing children service (Police missing person co-ordinators are based elsewhere and there is no join up with low attendance in schools). Performance in respect of Return home interviews has been variable but should now improve with a commissioned service • No workforce development strategy with a plan to train staff, foster carers, residential workers. • Health and Wellbeing Board (HWB) has the potential to make a greater contribution to children and family services e.g. linking to CSE and Early Help. • There are gaps in effective working with Districts around homeless 16/17 year olds and uncertainty around the effectiveness of the Homeless Intervention Team (HIT). • Some head-teachers appear unaware of the breadth and depth of help available from the Virtual School for LAC.
Capacity and managing resources	**Strengths:** • There is now a recognition of and commitment to driving the financial strategy to address cost pressures • Strong corporate ownership with prioritisation of children's services and investment for re-design of the service • Corporate Support for children's services covering IT, Legal, Human Resources, Performance and Property provides a strong foundation on which to build and grow the service. In our view the level of corporate support appears appropriate and is prioritising children's services (e.g. strong workforce development which has resulted in recruitment of many new social workers, flexible working has been enabled and there is good analytical support).

	• Staff report that morale generally is high • Strong capacity in the finance team with robust detailed projections and cost of placements. The new placement team should be beneficial • There is a very positive view held by social workers who feel valued and are especially positive about their support in relation to ASYE and CPD. Team managers and staff demonstrated potential and a commitment to children and families. • Agile working – technology is in place to reap the benefits from flexible working arrangements but staff need to be encouraged to harness and embrace the technology • Sector led improvement work is well developed across the West Midlands Region and Worcestershire are a key member of this group enabling sharing of information to drive improvement and performance • Health capacity for safeguarding appeared strong e.g. a year round school nursing service is being considered which might help the perceived gap in tier 2 CAMHs **Areas for further consideration:** • The previous LAC strategy was not appropriately targeted on reducing the high numbers of children in care and supporting alternative options for vulnerable children and young people. The timescales for reducing LAC numbers and the resulting spend were not realistic, however, from discussions with performance and commissioning managers it was apparent that since the beginning of the year there has been a more rigorous approach that is more likely to achieve the desired results. • The current workforce is a real asset and the focus on retention is correct. There are some unintended consequences emerging within the workforce with pay differentials and career progression being potential risks to retention. As part of a service and financial recovery some consideration of 'invest to save' regarding developing managers and social workers needs to be incorporated into the overall financial projections • Resourcing for the Front Door and MASH need careful consideration to achieve the intended benefits • Some social workers described a feeling of isolation at times due to flexible working arrangements and this

	requires some attention so that they can be best supported particularly after difficult visits. Also staff report a culture and expectation of working long hours; presumably a wider social work health check would allow a better understanding of these issues. • The team would suggest a 'back to basics' approach to tackle the urgent issues around safeguarding. As part of this considering how the role of Team Managers is developing would be worthwhile, given there are no deputising roles in the structure. In the short term they will need to focus on operational practice, assessment, case planning and supporting the social workers. Some rationalisation of meetings and prioritising their roles and responsibilities may be desirable • The council has recognised that the issue of caseloads requires some attention with a mixed picture, some social workers having reasonable caseloads others having high caseloads. The assumptions about a predicted 15% reduction that were made prior to the redesign have not materialised. Resources may need to be allocated more flexibly between teams to reflect differing levels of demand; the team heard that some of this is already in place. The number of experienced social workers in teams plays a pivotal role. Distribution of resources as part of any improvement plan would be helpfully aligned to assessments being turned round with more pace. • Joint/integrated commissioning should be more actively considered e.g. with Public Health and Adult Services to build capacity and streamline services • Some commissioned early help providers considered that the current 3 year contract duration was insufficient to realise full benefits from potential efficiencies and impacted upon their ability to attract and retain staff of quality. A review of procurement/commissioning strategy with longer contract durations might be helpful, alongside consideration of whether the right services have been commissioned.

worcestershire county council

Worcestershire
Health and Well-being Board
Joint Strategic Needs Assessment (JSNA)

Worcestershire Health & Social Care

Early Help Needs Assessment (Age 0-19 Years)

September 2015

http://www.worcestershire.gov.uk/cms/jsna.aspx

NHS Wyre Forest Clinical Commissioning Group

NHS South Worcestershire Clinical Commissioning Group

NHS Redditch and Bromsgrove Clinical Commissioning Group

Early Help Needs Assessment

Project/Commissioning Manager (s)	**Frances Howie/Hannah Needham**
Author	**Liz Altay, Public Health**
Strategic priority	• **Prevention, Early Intervention & Early Help** • **Children, Young People & Families**
Care pathway/Statutory Guidance	*Healthy Child Programme 0-19 (2009) & HCP Rapid review (2015)* *Sure Start children's centres statutory guidance (2013)* *The Statutory Guidance for Local Authorities on Services and Activities to Improve Young People's Well-being (Revised DFE 2012)* *Working Together to Safeguard Children (2015)*
Date	*30th September 2015*
Version	**V04**
Document location	
Review date	

Executive Summary

Early help includes both prevention and early intervention activities that tackle risk factors when identified and problems as they start to develop, at any point in a child's life. An early help strategy should start with an assessment of needs followed by an analysis of sufficiency of service, evidence based interventions and advice and information. The current Worcestershire County Council (WCC) led 2011 early help strategy aimed to reduce numbers of Looked after Children (LACs), numbers of children with a child protection plan (CP), numbers of young people not in education, employment or training (NEETs) and improve educational attainment and health outcomes but there is no evidence that this has occurred.

Worcestershire has a number of poorer outcomes than would be expected for children & young people (CYP), particularly for the under 5 age group and adolescence. Of concern is the relatively low proportion of young children who are school ready compared to the national average, high levels of reported language & communication needs and the unmet emotional and mental health needs of older children and young people. Also of concern is the consistent gap in outcomes between CYP from deprived and non-deprived areas with significantly poorer health, social and educational outcomes in deprived areas.

Although the overall CYP population is decreasing, the proportion of CYP from more deprived communities has increased by 1.5% over the last decade and is projected to continue due to higher fertility rates in these localities. This demographic change will result in additional need for early help (prevention & early intervention) over the next decade,

however, this has not caused the recent accelerated rise in numbers of LAC which is more likely due to social care practice.

An estimate of predicted outcomes for CYP in Worcestershire has been undertaken using the PREview tool developed from quality research evidence. The results indicate that 52% of CYP are likely to have good or very good outcomes and 48% of CYP are likely to require varying levels of preventive interventions. The likely need for preventive interventions is forecast to rise by 1% by 2020. The need differs by geography with greatest need in areas of deprivation and in Worcester, Redditch and Wyre Forest Districts.

Over the last 5 years there has been evidence of rising demand for most targeted and specialist services such as Child & Adolescent Mental Health services (CAMHs), Speech & Language therapy (SALT), A&E. The aim of the 2011 Early Help strategy and subsequent commissioning of District 0-19 Early Help Providers does not appear to have reduced demand on complex or specialist health & social care services or improved outcomes at a population level. The impact, success or outcomes of Early Help Assessments and Early Help Plans have not been measured using a validated or evidence based measurement /tool in either the short or longer term. However, good progress appears to have been made with individual families by the local Troubled Families model (Stronger Families). Just over half of Early Help Assessments (EHAs) undertaken over a 20 month period were for families from the most 40% deprived communities, however modelling suggests 73% of total need. Conversely 28% of EHAs were undertaken in the least deprived 40%; however estimated need for preventive interventions indicates only 7% of need.

The core purpose of Children's Centres (CCs) is "to improve outcomes for young children and their families and reduce inequalities between families in greatest need and their peers in: child development and school readiness; in parenting aspirations and parenting skills and in child and family health and life chances". To achieve this the original policy intention was to deliver provision in the most 30% disadvantaged areas. In Worcestershire there are currently 29 CCs, of which 10 centres do not have any of the 30% most deprived LSOAs in their "reach area". In 2014, 71% of the population aged under 5 accessed a CC (including nursery education provision), however only 56% of the most 30% deprived under 5s accessed a CC during the same period. An analysis of CC activity for provision excluding nursery education identified that 43% of all under 5s and 49% of the most 30% deprived under 5s accessed a CC in 2014 for non-nursery education activities and support. The provision, offer and activities provided in CCs are not consistent across the county and vary by geography. There are relatively low levels of delivery of programmes and activities that have a strong evidence base. All CCs provide parenting and family support but programmes and interventions offered vary, are not the most effective available and do not always retain programme fidelity. All CCs offer stay & play and some offer activities such as baby massage or baby yoga which have none or little evidence of effectiveness.

The Healthy Child Programme (HCP) is a prevention and early intervention public health programme offered to all families. The HCP is a progressive universal service, i.e. it includes a universal service that is offered to all families, with additional services for those with specific needs and risks. It aims to support parents, promote child development, reduce inequalities and thus contribute to improved child health outcomes and health and wellbeing, and

ensure that families at risk are identified at the earliest opportunity. It is underpinned by an up-to-date evidence-base. The HCP involves effective input and coordination from a wide range of professionals, practitioners and the wider children's workforce but is universally led by, midwives during pregnancy, health visitors up to age 5 and school nurses during school years who each hand the baton on to the next. Where issues require input & support from other agencies, a multiagency assessment should be used. In Worcestershire the full HCP has not been fully implemented and is not integrated or embedded within and by other agencies and practitioners across the wider children's workforce. The preventive and early help offers in Worcestershire appear to be operating in isolation resulting in potential duplication and a lack of effective utilisation of all skills and resources available.

"Working Together" (2015) describes effective early help services as the responsibility of all agencies with pathways and strong input from universal services through to targeted & specialist. Areas should have agreed thresholds and pathways between universal, targeted and specialist services and ensure sufficient evidence based interventions, service provision and information and advice to ensure that problems for children and families are identified early, and responded to effectively as soon as possible. The guidance stresses the role of the professionals in universal services in identifying need for early help, providing support & interventions that have a strong evidence base and utilising an inter-agency assessment for coordinated support to prevent needs escalating.

The research evidence base identifies that events that occur in early life (indeed in fetal life) affect health, wellbeing and outcomes in later life. Neuroscience shows that rapid brain development and growth occurs in the early years (birth to 2 years) and again in adolescence and it is crucial that the brain achieves its optimum development and nurturing during these peak periods of growth. In the early years, loving, secure and reliable relationships with parents, together with the quality of the home learning environment, promotes infant mental health & emotional wellbeing, capacity to form and maintain relationships with others, brain development, language and cognitive development. Parental mental health (before and after birth) and levels of secure attachment are key determinants of the quality of that relationship. Poor support or the failure to prevent abuse or neglect, at this stage can have a lifelong adverse impact on outcomes. As children grow, it is better to equip them to deal with life stressors by focusing on building their social and emotional skills to promote resilience at home and through school and by supporting good parenting.

This needs assessment identifies the evidenced preventive activity and interventions that promote development for better outcomes and reduced inequalities and the evidence based early interventions for those identified at risk or when problems have emerged. There are also a number of service and system models of effective prevention and early intervention. There is good evidence that if resources were focused on effective preventive and early interventions that help to avoid or address challenges early in life or as problems emerge, this will improve outcomes for children and families and start to save resources quite quickly. In addition there is strong evidence that spending on the early years of life is the greatest investment which yields returns in future. For example every £1 spent on early years education, £7 has to be spent to have the same impact in adolescence. A range of evidence-based interventions, already recommended in National Institute for Health and

Care Excellence (NICE) guidance, if implemented effectively and at scale could have a dramatic impact, improving children's lives while saving costs to the system.

Recommendations

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

Statement of the Problem

Corporate Prioritisation	The vision of the **Joint Health & Wellbeing Strategy** is that Worcestershire residents are healthier, live longer and have a better quality of life, especially those communities and groups whose health is currently poorest. Health and well-being is influenced by a range of factors over the course of people's lives. To realise the vision "we will place a greater emphasis on prevention, early intervention and early help to avoid future ill health, disability and social problems. We will also continue to integrate and improve the quality and value for money of health and social care services." One of the priorities of the **Worcestershire Children and Young People's**

	Plan 2014-2017, is that "children and young people are helped at an early stage" in accordance with the **Early Help Strategy** (2011). The outcomes of the priority will be to: • Further integrate services across the 0 to 19 age range including mapping of current provision, developing and implementing coherent pathways and ensuring a streamlined approach to assessing and meeting need. • Integrate services for children aged 0 to 5 years with a particular focus on the future role of health visitors, family nurse partnerships and early years practitioners, including those based within Children's Centres. • Re-define Worcestershire's approach to parenting support. • Strengthen the approach for monitoring the quality and performance of all early help services across Worcestershire to demonstrate the impact on outcomes. • Implement Phase 2 of the national Troubled Families agenda ensuring an effective interface with the broader early help provision. This needs assessment estimates need for early help 0-19 years, maps current provision and identify evidence of effectiveness and good practice.
Scope	This needs assessment addresses early help in its widest aspect and considers the continuum of need from prevention and universal provision through to specialist or complex services. There is confusion regarding definitions of early help, however for the purpose of this needs assessment early help includes both prevention activities and early intervention activities that tackle problems as they start to develop. In this respect the Munro definition of early help has been adopted: "Early help is that provided early in the life of a child and early in the emergence of a problem. The provision of early help is vital to keeping a child safe." (Munro, 2011). This needs assessment will identify projected need for early help across Worcestershire to inform a refresh of an Early Help Strategy across all partners; it will also provide the basis for the future commissioning of early help support and provision for 0-19s. The specific commissioned service elements in scope are the district "Early Help Providers" (including Children's Centres), the Stronger Families programme, Early Intervention Family Support (EIFS), Health Visiting, School Nursing and the Family Nurse Partnership. Other commissioned services that contribute to wider prevention and early help will be considered such as maternity provision, early years services, sexual health services and positive activities. In addition, this needs assessment will influence the commissioning of specialist service provision such as CAMHs, Speech & Language therapy and Children's social care through an examination of current demand and the consideration of early help provision to reduce such demand.

<table>
<tr><td>Population of interest</td><td>All children and young people resident in Worcestershire aged from 0-19 years, and some groups of vulnerable young people up to the age of 25 years old.</td></tr>
<tr><td>Key risks factors</td><td>There are a range of risk factors that can influence the need for prevention and early help and these can vary by age. In early years the risk factors are generally associated with social disadvantage, poverty, family circumstances and parenting behaviours. As childhood progresses child and family characteristics and social and neighbourhood factors have a big influence. During adolescence emotional and social wellbeing risk factors can occur. Stressful life events or stressful family events have been shown to place children at greater risk. Parental conditions, behaviours and circumstances such as mental health, long term conditions, substance misuse or lifestyle choices can effect and influence risk factors, need and outcomes.
There is now an increasing understanding of the long-term effects of early life events and an acceptance that what happens during pregnancy and birth both physically and emotionally has an impact on childhood outcomes. The effect of external factors does not stop at birth, studies have identified the impact that adverse childhood events have on the life course of the child. Events such as growing up in a household with a family member who is depressed, exposure to domestic violence, substance misuse, divorce, lack of affection leads to significantly poorer outcomes. The presence of adverse childhood events is cumulative, i.e. the greater the number of adverse events experienced, the higher the likelihood of experiencing more adverse outcomes (Bellis et al, 2013). Social determinants are also key risk factors. NICE identified which social determinants have the most effect in putting children and young people at social, emotional and cognitive risk. The most important factors they identified are: lone parenthood; low income; social housing; living in areas of deprivation; young motherhood; maternal education; and health (NICE 2012).

Risk Factors affecting Outcomes

<table>
<tr><th>Child Characteristics</th><th>Parents & Parenting Style</th><th>Family Factors & Life Events</th><th>Community factors</th></tr>
<tr><td>•Low birth weight/birth injury
•Disability/delayed development
• Chronic illness
• Early behavioural difficulties
• Poor social skills
• Poor attachment</td><td>•Single parent
• Young maternal age
• Drug and alcohol abuse
• Harsh or inconsistent discipline
• Lack of stimulation of child
• Lack of warmth and affection
• Rejection of</td><td>•Family instability, conflict or violence
• Marital disharmony/divorce
• Large family size/rapid successive births
• Absence of father
• Very low level</td><td>•Socioeconomic disadvantage
• Poor housing conditions</td></tr>
</table>
</td></tr>
</table>

	child • Abuse or neglect	of parental education	

"Working Together" (2015) stresses that all professionals and all agencies should identify emerging problems and be alert to the potential need for early help for a child who:

- is disabled and has specific additional needs;
- has special educational needs;
- is a young carer;
- is showing signs of engaging in anti-social or criminal behaviour;
- is in a family circumstance presenting challenges for the child, such as substance abuse, adult mental health problems and domestic violence;
- has returned home to their family from care;
- is showing early signs of abuse and/or neglect.

Context and Background

"Effective Early Help addresses the root causes of social disadvantage, ensuring that everyone is able to realise their full potential by developing the range of skills we all need to thrive. It is about getting extra, effective and timely interventions to all babies, children and young people who need them, allowing them to flourish and preventing harmful and costly long-term consequences" (EIF, 2015). It is estimated that approximately £17billion is spent each year in England and Wales addressing problems such as mental ill health, unemployment and youth crime; this doesn't take into account the wider social and economic costs (Ibid.)

Most local authority areas have an early help strategy to ensure that problems for children and families are identified early, and responded to effectively as soon as possible. The aim is to ensure problems do not escalate to become more acute, and more costly, to the detriment of children and families, by investing in effective community services and multi-agency coordination. Early help requires a collaborative approach from all agencies, including schools, with the active involvement of children, young people, families and carers. Effective early help requires pathways from universal, to support services. There should also be step-down arrangements from acute services, to community support with the aim of full reintegration into mainstream, or universal services. Early help plans should have focused outcomes for children and families, and should be actively planned with them. Plans should deliver evidence based interventions using single agency or common assessment frameworks, and clear thresholds for specific agency intervention e.g. social care, housing, mental health services.

The first Early Help strategy was developed in Worcestershire in 2011. The strategy was informed by an assessment which identified; evidence of significant harm, family breakdown, anti-social behaviour and special educational needs in areas of higher deprivation; a high prevalence of behavioural, emotional and social difficulties impacting on

the education of children aged 5-9 years; domestic abuse as the main cause of children and young people needing child protection services; insufficient services designed to address family breakdown, particularly when young people reach their teens (Edge of Care services); investment in early years was necessary for good child development; families want services to be delivered at the right place at the right time, and to be focused on the whole family; parents want more parenting programmes and easier access to information and advice, including on line; young people want support to deal with issues when they first arise.
The assessment identified five key areas which needed to be improved:

- Information, advice, guidance for parents and young people
- Parenting skills
- Speech, communication and language skills
- Behaviour
- Emotional resilience in children and young people.

The success of the Early Help strategy would be measured by:

- A reduction in the number of children who are looked after
- A reduction in the number of children with child protection plans
- A reduction in the number of young people not in education employment or training at age 19
- An increase in educational attainment
- Improvement in health, including a reduction in health inequalities

A range of early help services available and accessible through Children's Centres, Schools and other settings were reviewed which highlighted inconsistencies in practice, a lack of focus on the impact on outcomes and some gaps in intensive family support provision. The WCC funding for early help provision was "pooled", allocated to each of the six district areas using a formula based on need and six 0-19 early help service arrangements were commissioned, one in each district. There was a phased roll out of the service across the county starting in Wyre Forest (August 2013) and ending in Bromsgrove (August 2014). In addition, a central Early Help Hub was set up and the introduction of a new early help assessment process (which replaced CAF). Following the commissioning of the six Early Help providers, the Early Help providers and services offered have also been aligned with other WCC service provision including the Stronger Families team, early intervention family support (EIFS) and Young Carers. In addition, the public health services of health visiting and school nursing have been aligned geographical with the Early Help arrangements.

During this period, there have also been changes and developments amongst other early help services in Worcestershire. The further establishment and expansion of the national Troubled Families programme (Stronger Families in Worcestershire). The implementation of the new national Health Visitor model accompanied by a 20% increase in Health visitor posts, as part of a national scheme to increase total health visitors in England by 4,200 by 2015 (DH, 2011); there has been a transformation and modernisation of school nursing services to deliver the Healthy Child programme 5-19 and the recent procurement of a Family Nurse Partnership (FNP) for Worcestershire which will provide intensive support for young first time parents from 15/16. Worcestershire was also selected as one of 20 'Pioneering Places' across England as part of the implementation of the Early Intervention Foundation (EIF) and has been working with the EIF.

Legislation and Policy

Policy Context

There is a growing body of evidence of the effectiveness of early help for children and their families and the importance of early intervention during early years. The Field [1] report on child poverty in 2010 found overwhelming evidence that children's life chances are most heavily predicated on their development in the first five years of life. It is family background, parental education, good parenting and the opportunities for learning and development in those crucial years, that together matter more to children than money, in determining whether their potential is realised in adult life. What matters most are a healthy pregnancy; good maternal mental health; secure bonding with the child; love and responsiveness of parents along with clear boundaries and opportunities for a child's cognitive, language and social and emotional development. Later interventions to help poorly performing children can be effective but, in general, the most effective and cost-effective way to help and support young families is in the earliest years of a child's life.

The Marmot Review [2]in 2010 proposed an evidence based strategy to address the social determinants of health. It argued that, traditionally, government policies have focused resources only on some segments of society. To improve health for all and to reduce unfair and unjust inequalities in health, action is needed across the social gradient. The review set out a framework for action under two policy goals: to create an enabling society that maximizes individual and community potential; and to ensure social justice, health and sustainability are at the heart of all policies. Central to the review was the recognition that disadvantage starts before birth and accumulates throughout life. The highest priority was given to the first objective: giving every child the best start in life.

The policy recommendations for giving every child the best start in life were:

1. Increase the proportion of overall expenditure allocated to the early years and ensure expenditure on early years development is focused progressively across the social gradient.
2. Support families to achieve progressive improvements in early child development, including:
    a. Giving priority to pre- and post-natal interventions that reduce adverse outcomes of pregnancy and infancy
    b. Providing paid parental leave in the first year of life with a minimum income for healthy living
    c. Providing routine support to families through parenting programmes, children's centres and key workers, delivered to meet social need via outreach to families
    d. Developing programmes for the transition to school.
3. Provide good quality early years education and childcare proportionately across the gradient. This provision should be:
    a. Combined with outreach to increase the take-up by children from disadvantaged families
    b. Provided on the basis of evaluated models and to meet quality standards.

The Allen[3] report identified the benefits of early intervention programmes. The report focused on 0-3 year olds and children and young people up to 18 years who will in time become parents. It noted that the merits of early intervention were receiving increasing recognition but that provision remained patchy with a bias toward late intervention. The need for an increased focus on early help, intervention and prevention within the family was reinforced by the Munro[4] review of child protection. In setting out the principles of an effective child protection system, Munro highlighted that 'preventative services can do more to reduce abuse and neglect than reactive services', making a strong argument for local agencies to provide early help to strengthen families and reduce risk. Munro recommended a duty be placed on local authorities and statutory partners to provide an 'early offer of help' but this was not accepted by the government, as it considered the existing duty to cooperate set out in sections 10 and 11 of the Children Act 2004 to be sufficient.

The Troubled Families Programme was introduced in April 2012 to incentivise local authorities to 'turn around the lives of 120,000 troubled families in England'. The programme concentrated on working with families where children are not attending school, young people are committing crime, families are involved in anti-social behaviour (ASB) and adults are out of work. The programme offers intensive support to these families. Key factors in the support are: a dedicated worker, practical 'hands on' support, a persistent, assertive and challenging approach, considering the family as a whole, and a common purpose and agreed action. Local authorities are paid £4,000 per family for improvements seen on a payment by results basis. In Worcestershire this is the Stronger Families programme. The programme has been extended to incorporate recognition of two additional key risk factors: domestic abuse or violence; and adults or children with poor physical and mental health. A recent evaluation highlighted that health is one of the main reasons for referral to the programme and promotes an increased emphasis on the health 'offer' as part of the troubled families programme and advocates for greater integration of health and local authority services and support.

In response to the strong evidence base for achieving improved health, social and educational outcomes from a systematic approach to early child development, including early intervention and prevention, the government commenced the Health Visitor Programme in 2011. The programme included an expansion of Health Visitors by 4,200 by 2015 and to create a transformed, rejuvenated health visiting service providing improved outcomes for children and families with more targeted and tailored support for those who need it. A new Health Visiting model has been implemented underpinned by the Healthy Child Programme and provide support for under 5s and their families at the community level, some universal checks, information and advice to every child/family, expert advice and support on specific issues for those that need it (universal plus) and bringing together other relevant services and support where needed (universal partnership). Health Visitors have been shown to have a significant impact on 6 areas:

- Transition to Parenthood and the Early Weeks
- Maternal Mental Health (Perinatal Depression)
- Breastfeeding (Initiation and Duration)
- Healthy Weight, Healthy Nutrition (to include Physical Activity)
- Managing Minor Illness and Reducing Accidents (Reducing Hospital Attendance/Admissions

- Health, Wellbeing and Development of the Child Age 2 – Two year old review (integrated review) and support to be 'ready for school'

From October 2015, the responsibility for commissioning Health visiting and Family Nurse Partnership programmes is transferring to Local Authorities providing a further opportunity to integrate these services with other early help and early years services.

The 1001 Critical Days cross party manifesto was officially launched October 2013. It is a vision for the provision of services in the UK for the early years period, which puts forward the moral, scientific and economic case for the importance of the conception to age 2 period. The Manifesto highlights the importance of acting early to enhance outcomes for children.

More recently evidence has emerged regarding the importance of the adolescence years which is a life stage of significant neural, emotional and physical development and when change is possible. Exploratory behaviours overlap – for example, early substance use is associated with risky sexual behaviour, antisocial behaviour and academic failure. The overlaps are stronger during adolescence than at earlier or later developmental stages and as such issues should not be dealt with separately. As such services need to work effectively together and provide integrated models of service delivery.

The current five year strategy for the NHS (2014) puts prevention at its core, commenting that the future health of millions of children depends on it. The strategy sets out the need to 'get serious about prevention' particularly as regards children and young people and the need to tackle the causes of obesity and ill health such as improving the diet, reducing inequalities and encouraging more physical activity. These prevention efforts should be starting early – even pre-birth; and continued through all the life stages of through to adulthood.

Legislative context

Children's Centres Statutory Guidance (2013)

The Sure Start children's centres statutory guidance (2013) from the Department for Education is for local authorities, commissioners of local health services and Jobcentre Plus on their duties relating to children's centres under the Childcare Act 2006. The Childcare Act 2006 provides:-

- a duty on local authorities to improve the well-being of young children in their area and reduce inequalities between them
- a duty on local authorities to make arrangements to secure that early childhood services in their area are provided in an integrated manner
- a duty on commissioners of local health services and Jobcentre Plus to work together with local authorities in their arrangements for improving the well-being of young children and securing integrated early childhood services
- arrangements to be made by local authorities so that there are sufficient children's centres, so far as reasonably practicable, to meet local need.
- a duty on local authorities to ensure each children's centre is within the remit of an advisory board, its make-up and purpose

- a duty on local authorities to ensure there is consultation before any significant changes are made to children's centre provision in their area
- a duty on local authorities, local commissioners of health services and Jobcentre Plus to consider whether the early childhood services they provide should be provided through children's centres in the area
- duties on local authorities after receiving a report from Ofsted following the inspection of a children's centre. This includes preparing and publishing a written statement (an Action Plan) setting out the action to be taken in response to the report.

A Children's Centre is defined in the Act as a place or a group of places: which is managed by or on behalf of, or under arrangements with, the local authority with a view to securing that early childhood services in the local authority's area are made available in an integrated way; through which early childhood services are made available (either by providing the services on site, or by providing advice and assistance on gaining access to services elsewhere); and at which activities for young children are provided. Early childhood services are defined as:

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

The core purpose of children's centres is described as "To improve outcomes for young children and their families, with a particular focus on families in greatest need of support in order to reduce inequalities in: child development and school readiness; parenting aspirations, self-esteem and parenting skills; and child and family health and life chances". Local authorities must ensure there are sufficient children's centres, so far as reasonably practicable, to meet local need. Local authorities should demonstrate that all children and families can be reached effectively and target children's centres services at young children and families in the area who are at risk of poor outcomes. Local authorities must ensure there is consultation before opening new, making significant changes to or closing children's centres.

Public Health

Section 12 of the 2012 Health and Social Care Act introduced a new duty for all upper-tier local authorities to take appropriate steps to improve the health of the people who live in their areas. Under the act local authorities have a Public Health duty to lead health improvement and commission services to reduce health inequalities and must use the public health ring fence grant to significantly improve the health and well-being of local populations and reduce health inequalities across the life course, including hard-to-reach groups.

From 1 October 2015 local authorities take over responsibility from NHS England for commissioning public health services for children aged 0-5. This includes health visiting and Family Nurse Partnership targeted services for teenage mothers a key part of the national Healthy Child Programme, based on best knowledge/evidence to achieve good outcomes for all children. As part of the transfer parliamentary approval has been obtained to mandate

certain universal elements of the HCP 0-5, namely the antenatal review, new baby review, 6-8 week assessment, 1 year assessment; and the 2-2½ review.

Positive Activities/Youth Offer

Local authorities have a statutory duty to provide suitable services and activities for young people aged 13 to 19, and those with learning difficulties to age 24, to improve their well-being. Under Section 507B of the Education and Inspections Act 2006, local authorities have a duty to secure equality of access for all young people to the positive, preventative and early help they need to improve their well-being. The legislation does not prescribe what should be provided but states there should be sufficiency of positive activities wherever practicable. There are also responsibilities to effectively publicise the overall local offer of all services and activities available to young people and their families and to ascertain the views of young people and involve them in the decision-making about and monitoring of the relevance and effectiveness of services.

Working Together to Safeguard Children (2015)

Local authorities, under section 10 of the Children Act 2004, have a responsibility to promote inter-agency cooperation to improve the welfare of children. The revised 'Working together to safeguard children' (2015) guidance re-emphasises the crucial role of effective early help. It focuses on the collective responsibility of all agencies, including adult services, to identify, assess and provide effective targeted early help services. These are described as responsibility of all agencies with pathways and strong input from universal services through to targeted & specialist. Areas should have agreed thresholds and pathways between universal, targeted and specialist services and ensure sufficient evidence based interventions, service provision and information and advice to ensure that problems for children and families are identified early, and responded to effectively as soon as possible.

The guidance stresses the role of the professionals in universal services in identifying need for early help and provision of support & interventions that have a strong evidence base. Where a child and family would benefit from coordinated support from more than one agency then there should be an inter-agency assessment. These early help assessments, should identify what help the child and family require to prevent needs escalating. It places a duty on LSCBs to ensure that an agreed threshold document is in place so that all professionals are clear when it is their responsibility to help children and families as difficulties emerge. The availability and impact of early help is now assessed in Ofsted inspections of effective child protection.

The Department for Education's 'Statutory guidance on the roles and responsibilities of the Director of Children's Services and the Lead Member for Children's Services' refers to leadership roles in relation to early help, intervention and prevention with children and families. According to the guidance, Directors of Children's Services and Lead Members for Children's Services: 'should understand local need and secure provision of services taking account of the benefits of prevention and early intervention and the importance of cooperating with other agencies to offer early help to children, young people and families.'

Outcomes Assessment

The national child health profiles by Local Authority enables a comparison of local outcomes against the national average and other areas. The Worcestershire Child Health Profile 2015 provides the local value for each outcome benchmarked against others. Red indicates significantly poorer outcomes than England, green significantly better than England and amber no significant difference. The profiles highlight that school readiness is significantly poor in Worcestershire, as is family homelessness, proportion of teenage mothers, smoking in pregnancy rates and breastfeeding rates. Previous annual profiles have also identified significantly higher rates for self-harming and for alcohol related hospital admissions, however these are not significantly different in the 2015 profile.

Figure 1: Worcestershire Child Health Profile 2015.

● Significantly worse than England average ○ Not significantly different ○ Significance not tested
● Significantly better than England average ◆ Regional average

25th percentile | England average | 75th percentile

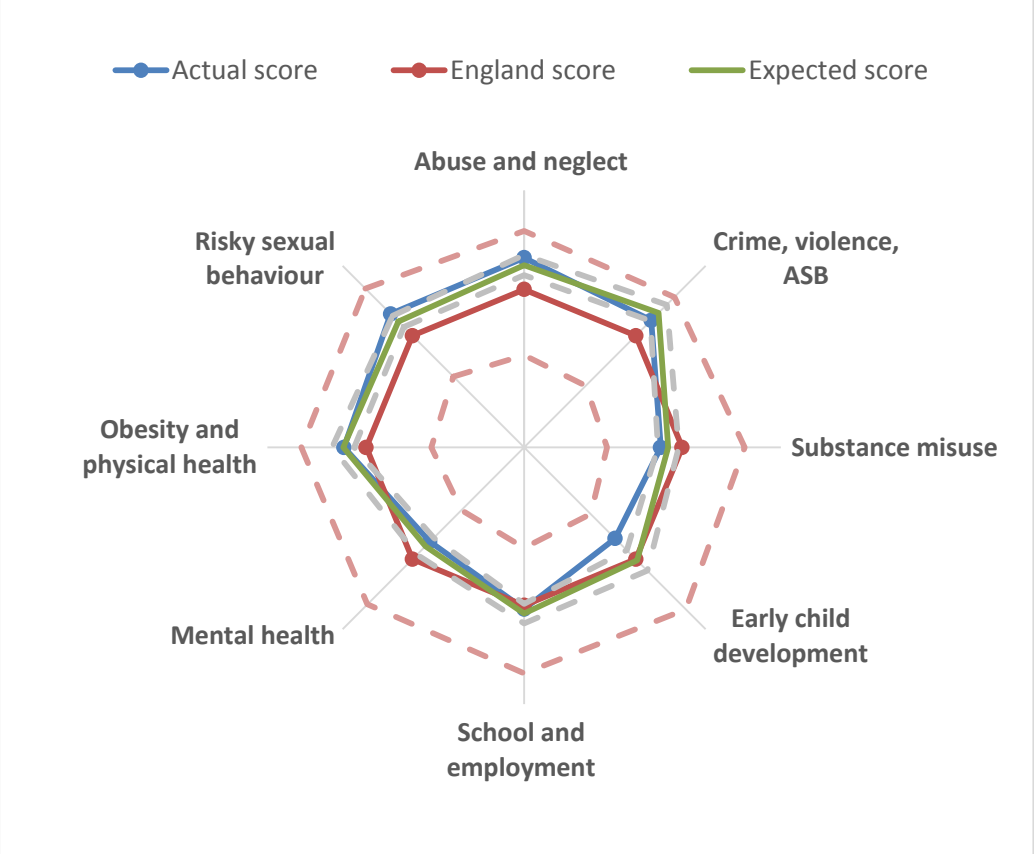
	Indicator	Local no.	Local value	Eng. ave.	Eng. Worst	Eng. Best
Premature mortality	1 Infant mortality	22	3.5	4.1	7.5	1.7
	2 Child mortality rate (1-17 years)	15	13.8	11.9	22.8	3.0
Health protection	3 MMR vaccination for one dose (2 years)	6,035	95.1	92.7	78.3	98.3
	4 Dtap / IPV / Hib vaccination (2 years)	6,187	97.5	96.1	81.6	99.1
	5 Children in care immunisations	250	54.9	87.1	27.3	100.0
	6 New sexually transmitted infections (including chlamydia)	1,901	2,890.0	3,432.7	8,098.4	1,899.8
Wider determinants of ill health	7 Children achieving a good level of development at the end of reception	3,598	58.1	60.4	41.2	75.3
	8 GCSEs achieved (5 A*-C inc. English and maths)	3,443	58.5	56.8	35.4	73.8
	9 GCSEs achieved (5 A*-C inc. English and maths) for children in care	-	-	12.0	8.0	42.9
	10 16-18 year olds not in education, employment or training	960	5.3	5.3	9.8	1.8
	11 First time entrants to the youth justice system	242	463.0	440.9	846.5	171.0
	12 Children in poverty (under 16 years)	14,905	14.9	19.2	37.9	6.6
	13 Family homelessness	470	1.9	1.7	10.8	0.1
	14 Children in care	640	56	60	153	20
	15 Children killed or seriously injured in road traffic accidents	11	10.9	19.1	48.3	8.2
Health improvement	16 Low birthweight of all babies	485	8.0	7.4	10.4	4.6
	17 Obese children (4-5 years)	558	9.5	9.5	14.2	5.5
	18 Obese children (10-11 years)	990	18.4	19.1	26.8	10.5
	19 Children with one or more decayed, missing or filled teeth	-	20.9	27.9	53.2	12.5
	20 Under 18 conceptions	250	25.1	24.3	43.9	9.2
	21 Teenage mothers	89	1.6	1.1	2.5	0.2
	22 Hospital admissions due to alcohol specific conditions	53	46.5	40.1	100.0	13.7
	23 Hospital admissions due to substance misuse (15-24 years)	47	71.6	81.3	264.1	22.8
Prevention of ill health	24 Smoking status at time of delivery	770	14.3	12.0	27.5	1.9
	25 Breastfeeding initiation	3,774	64.3	73.9	36.6	93.0
	26 Breastfeeding prevalence at 6-8 weeks after birth	-	-	-	19.4	77.4
	27 A&E attendances (0-4 years)	12,916	406.1	525.6	1,684.5	252.7
	28 Hospital admissions caused by injuries in children (0-14 years)	928	98.5	112.2	214.1	64.4
	29 Hospital admissions caused by injuries in young people (15-24 years)	880	132.8	136.7	291.8	69.6
	30 Hospital admissions for asthma (under 19 years)	183	150.3	197.1	509.1	54.6
	31 Hospital admissions for mental health conditions	98	85.2	87.2	391.6	25.6
	32 Hospital admissions as a result of self-harm (10-24 years)	393	398.9	412.1	1,246.6	119.1

Source: CHIMAT

The EIF have undertaken benchmarking for each of the 20 early interventions 'Pioneering Places'. Their benchmarking considered a large number of outcomes for children and young people that have been summarised into 8 outcome domains including mental health, substance misuse, abuse and neglect and early child development. The results are summarised in the form of a 'star analysis' or 'spider diagram'. The 'outcome star' provides a

high-level visual summary of major outcome indicators for Worcestershire benchmarked against national and regional comparators (Figure 2). The actual scores for Worcestershire is shown by the blue line, the red line shows the national average score for each domain, and the green line shows the Worcestershire "expected" score given the demographics of the county. In addition, the further out (away from the centre) indicates better outcomes; closer to the centre worse outcomes.

Figure 2 - Outcome star for Worcestershire



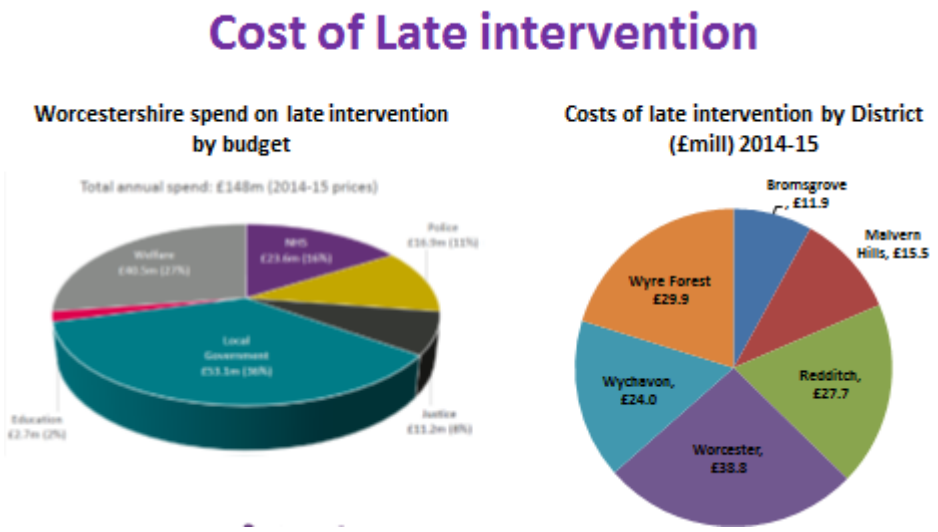
Source: EIF 2014

The EIF outcome star indicates that outcomes in Worcestershire for the domains of abuse & neglect, crime, violence & ASB, risky sexual behaviour and obesity and physical health are better than the England average and around what would be "expected" for the county. The school and employment domain is the same as the national average and as expected. However, the domains for mental health, substance misuse and early child development are worse than the national average and worse than would be "expected". Of most concern in this outcome star is the gap in the early child development score to what would be "expected".

The EIFs aim is to shift spending, action and support for children and families from Late to Early Intervention, from picking up the pieces to giving everyone the best start in life. The EIF estimated that nearly £17 billion per year is spent in England and Wales on the immediate and short-run fiscal costs of Late Intervention and identified to which agency that cost currently falls. For Worcestershire they have estimated the costs of late intervention as

£148million. Using the same methodology the costs of late intervention by District have been determined.

Figure 3 – Costs of Late Intervention 2014/15

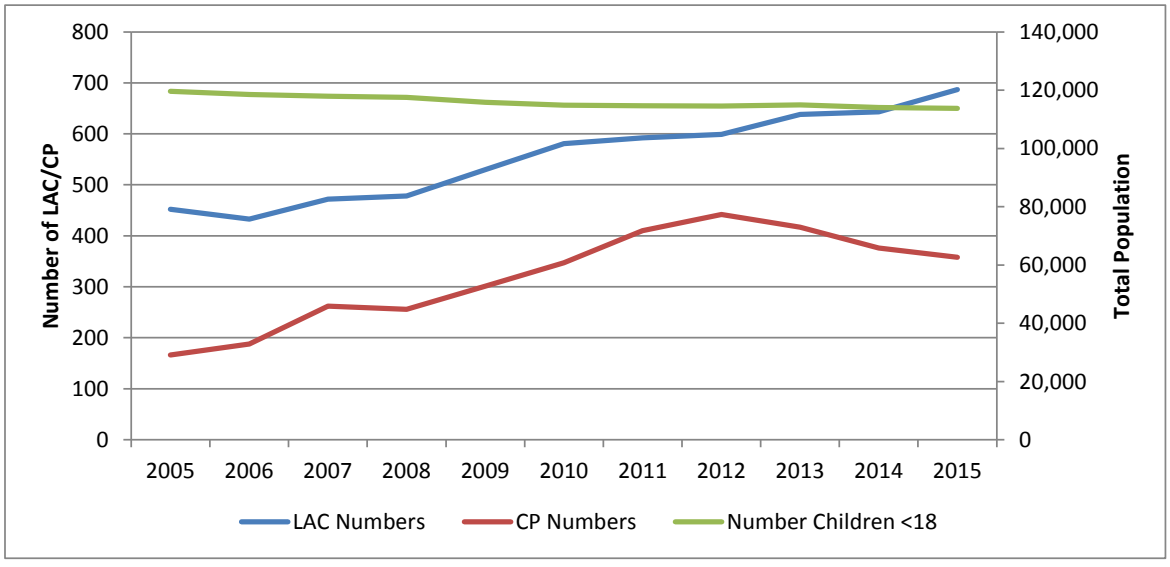


Early Help Strategy Outcomes

The outcomes that the 2011 Early Help Strategy was designed to tackle were numbers/rates of Looked after Children (LAC), numbers/rates of children with a child protection plan (CP), numbers of young people not in education employment or training (NEETs), educational attainment and health improvement and health inequalities.

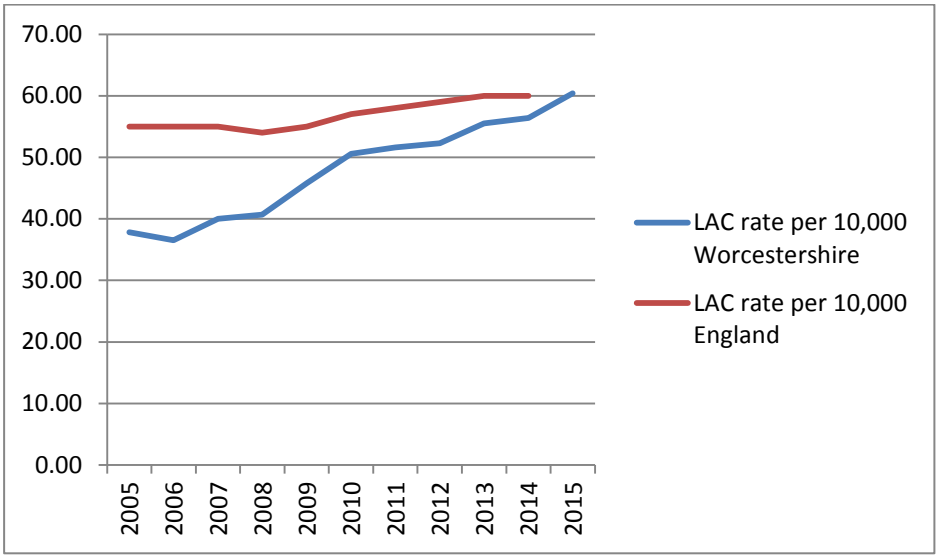
Figure 4 provides the numbers of LAC and CP for Worcestershire from 2005 to 2015. The data are based on a snapshot of numbers at the 31st March each year. The chart shows that although the total population under age 18 has reduced, the number of LACs has increased steadily and the numbers of CP increased up until 2012 and has since started to decline.

Figure 4 - Total Number of LAC and CP and total population aged <18



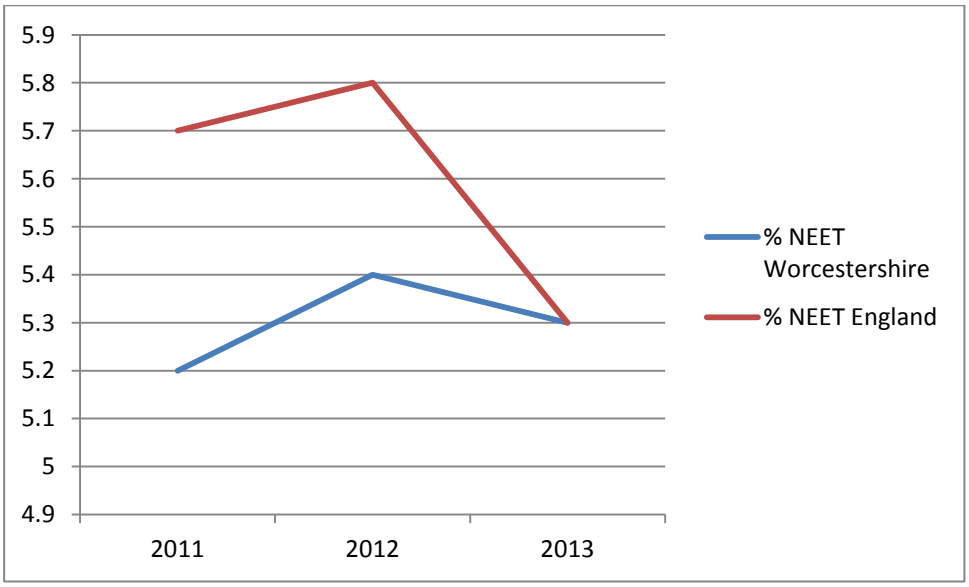
The LAC rate in Worcestershire has increased at a faster rate than the national average. The Worcestershire rate has increased over the decade to reach the England rate (Figure 5).

Figure 5 – LAC rate per 10,000 2005-2015



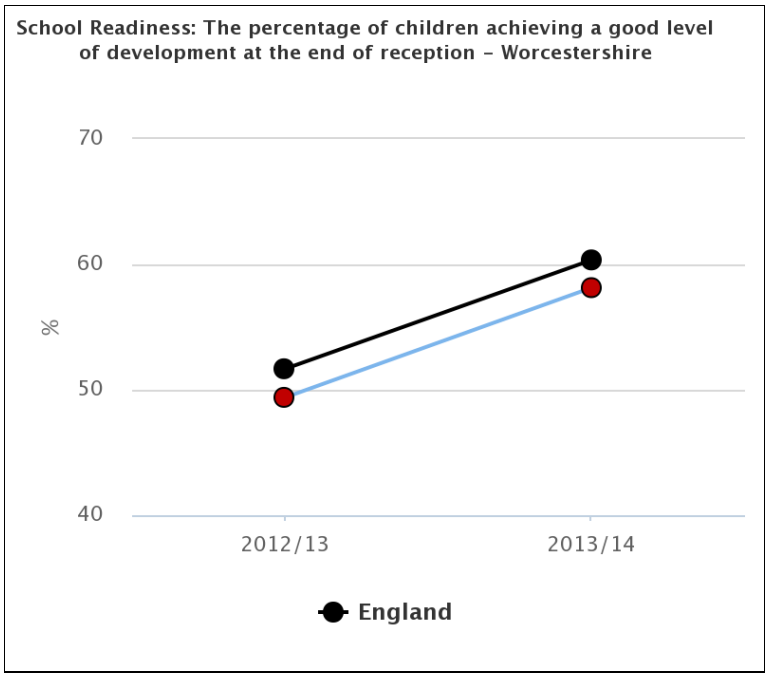
The percentage of young people who are NEET in Worcestershire has historically been lower than the national average (Figure 6). However this data should be treated with caution as it is difficult to be sure of the accuracy of the figures and almost 40% of status was unknown in Worcestershire for 2013 (the third highest proportion of unknowns nationally).

Figure 6 - % of known 16-18 year olds not in education, employment or training (NEET)



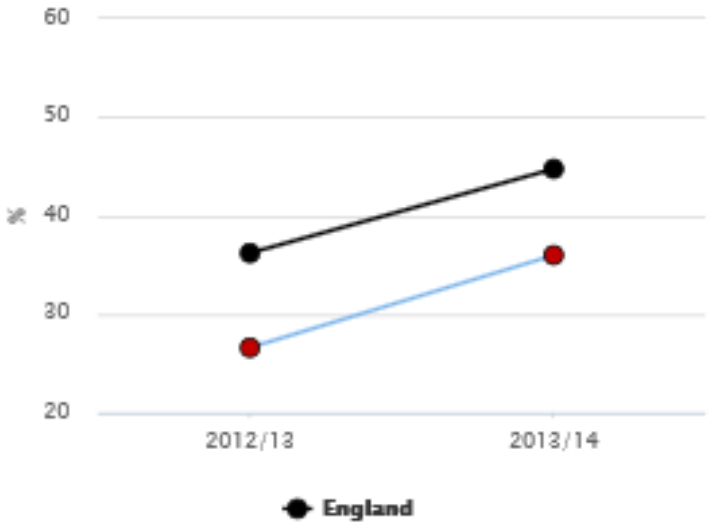
Worcestershire has a significantly lower percentage of children with a good level of development at the end of their reception year compared with the England average (Figure 7). School readiness for children with free school meal status in Worcestershire is considerably lower again than the England average (Figure 8). 'School readiness' is a key measure of early years development across a wide range of areas.

Figure 7 – School Readiness 2012-2014



Source: Public Health Outcomes Framework website available @ http://www.phoutcomes.info/

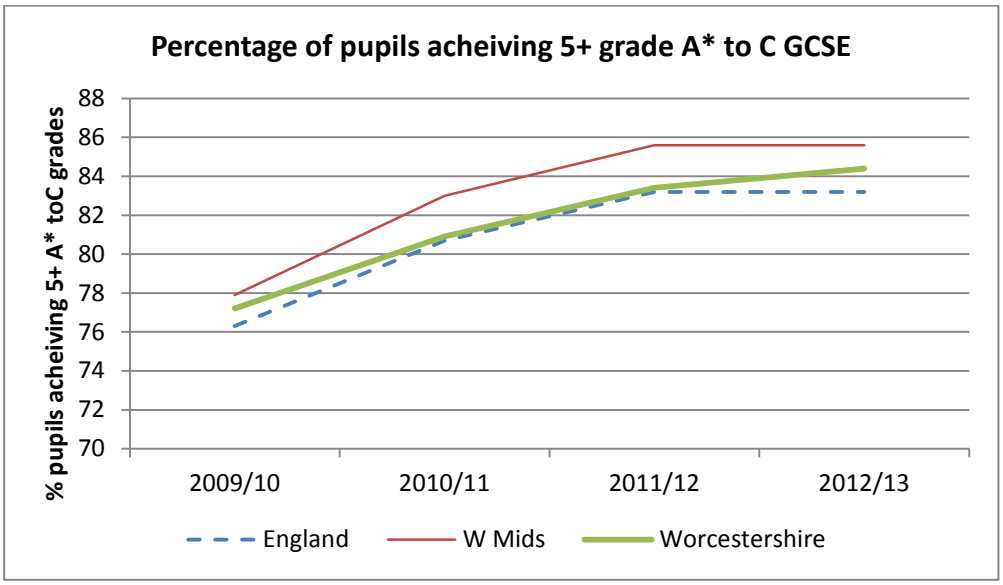
Figure 8 – School Readiness: The % of children with free school meal status



Source: Public Health Outcomes Framework website available @ http://www.phoutcomes.info/

Worcestershire GCSE attainment has remained above the England average but below the West Midlands average (Figure 9).

Figure 9 – GCSE achievement 2009-2013



Source: national pupil database figures 2009/10 to 2012/13. Methodology changed 2013/14 to utilise Key Stage 4 attainment data. This is not comparable to previous years and hence excluded from this trend analysis

Inequalities

Of concern in Worcestershire are the evident inequalities in outcomes for children and young people between groups and across the social gradient. The recent DPH Annual Report (2014) for Worcestershire identified that inequalities in outcomes and particularly those factors which lead to them can be identified right from the beginning of life and even before birth. For example babies from deprived areas are more likely to have been born to younger mothers (Figure 10) and their mothers are more likely to have smoked (Figure 12) or be overweight (Figure 11), all things which mean that the baby starts life with a disadvantage. Then through their early development these disadvantages are widened as they are less likely to be breastfed (Figure 13), their language development is more likely to be delayed (Figure 14) and they are more likely to have poor levels of development by the time they get to school (Figure 17).

Figure 10 - Births by IMD Quintile and Age of Mother 2011/12-2013/14

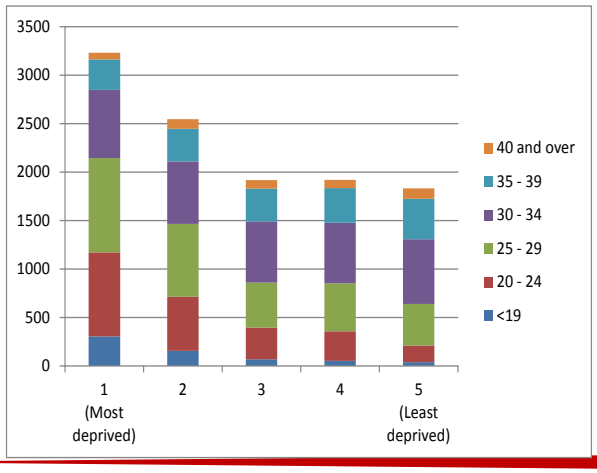


Figure 11 - Overweight in pregnancy by IMD

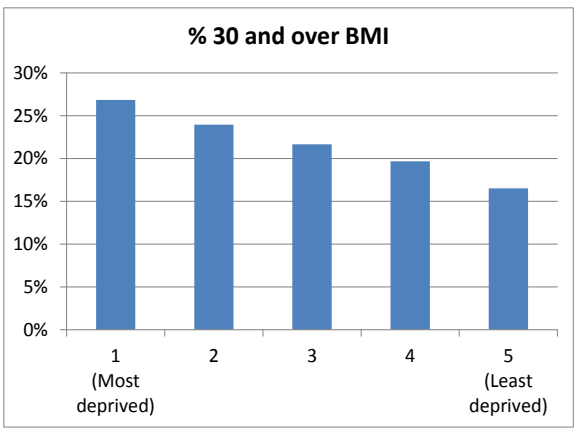


Figure 12- Smoking in pregnancy by IMD

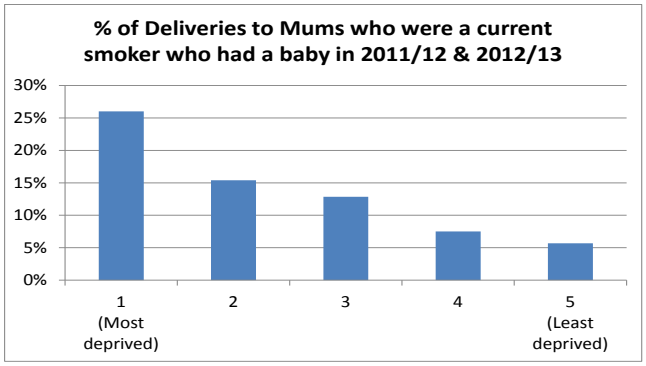


Figure 13 – Breastfeeding by IMD

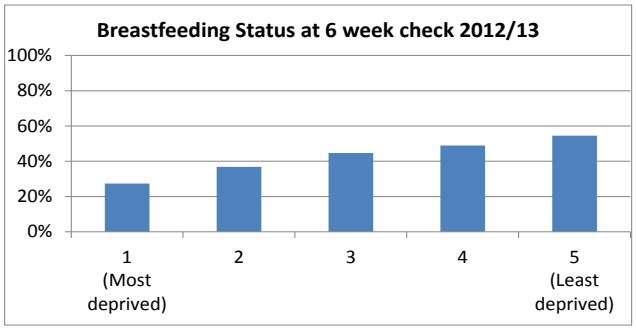


Figure 14 – SALT referrals age 0-4 by IMD

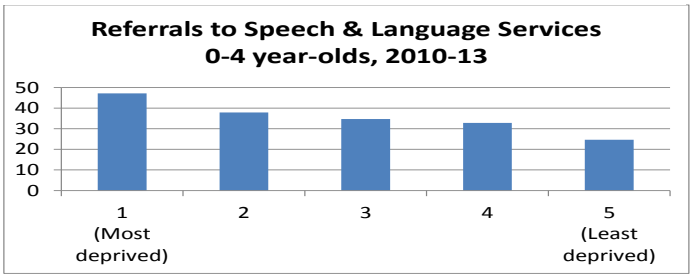


Figure 15 – Emergency Hospital admissions by IMD

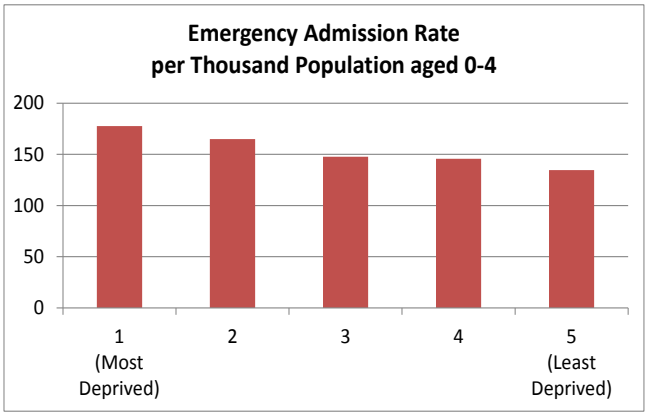


Figure 16 - % of CIN by IMD

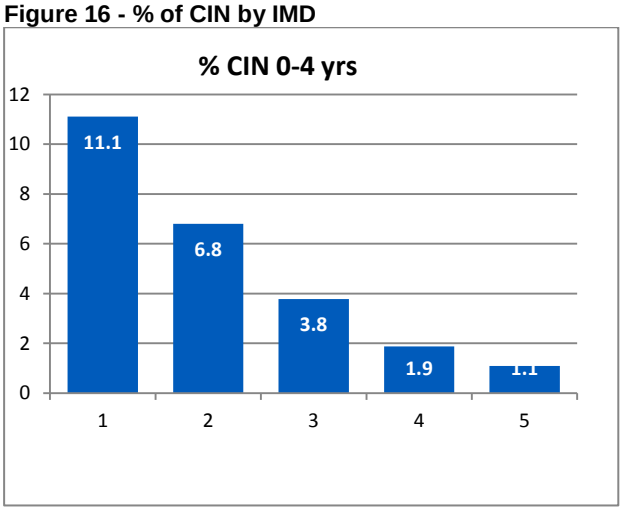
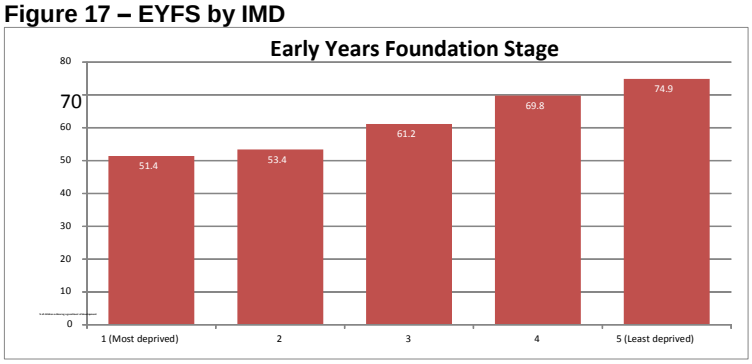


Figure 17 – EYFS by IMD



Once children get to school the inequalities are there from the beginning and get wider as time goes on (Figure 18). Differences in level of achievement that are about 25% at Key Stage 1 rise to 400-500% by Key Stage 5 (Figure 19), whilst those living in deprived areas are far more likely to have special educational needs, be excluded or be subject to child protection plans. They are also more likely to have excess weight, attend A&E more often and more likely to require emergency hospital treatment. Children from the most deprived areas are also the most likely to have mental health problems and be in contact with mental health services.

Figure 18-Educational achievement by IMD

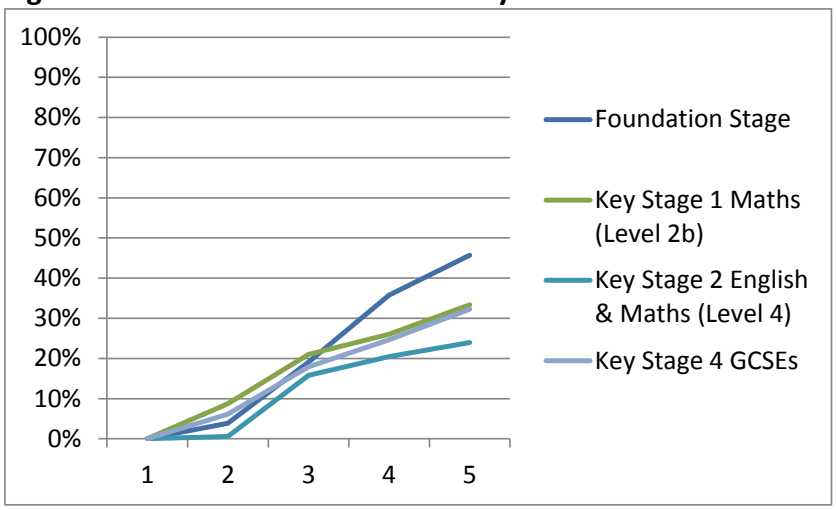
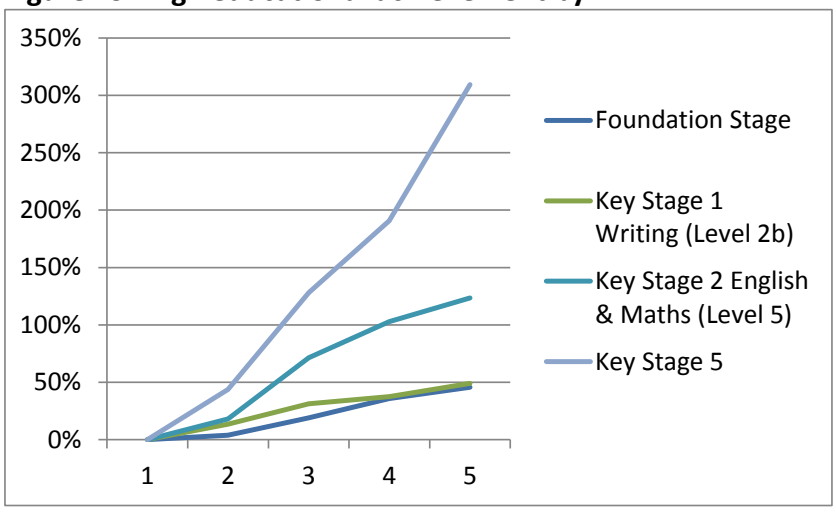


Figure 19- High educational achievement by IMD

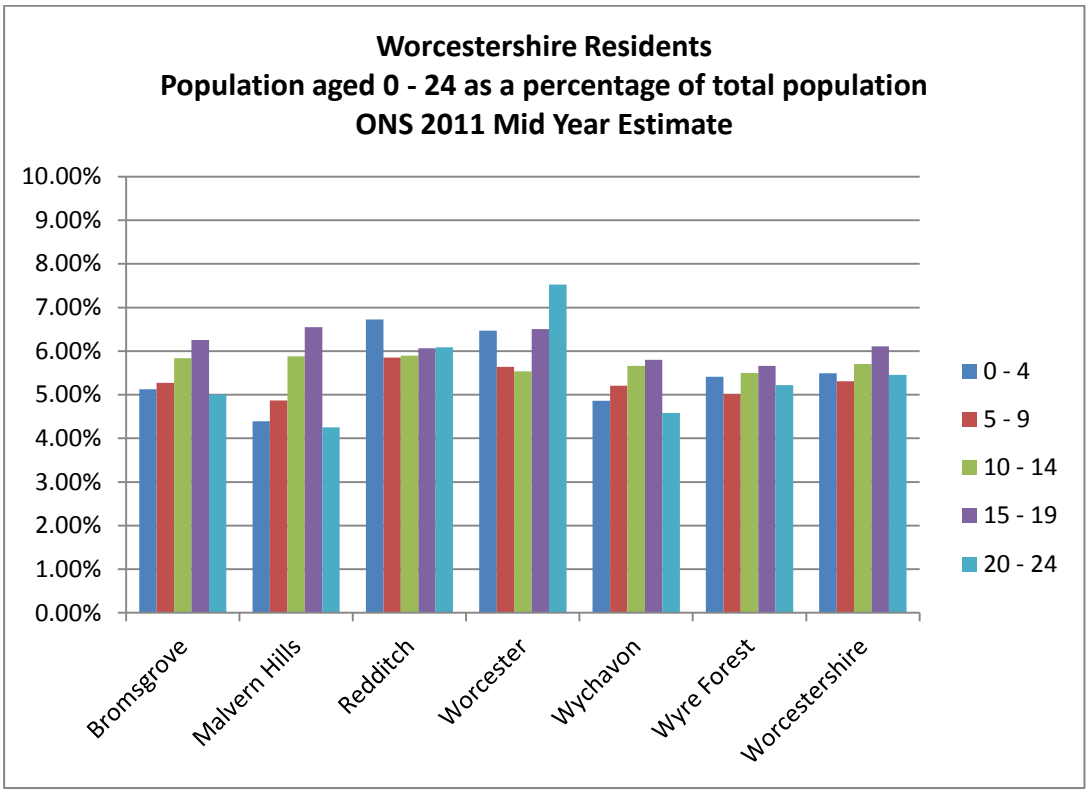


Population Trends and Estimated Need

Worcestershire is a predominantly rural county with a few urban areas of more than 10,000 population including the towns of Worcester, Redditch (on the border with Birmingham), Bromsgrove, Malvern, Kidderminster and Evesham. Age profile - At a county level the largest age group is 15-19 years olds, representing over 6% of the total population and the smallest age group is the 5-9 year olds.

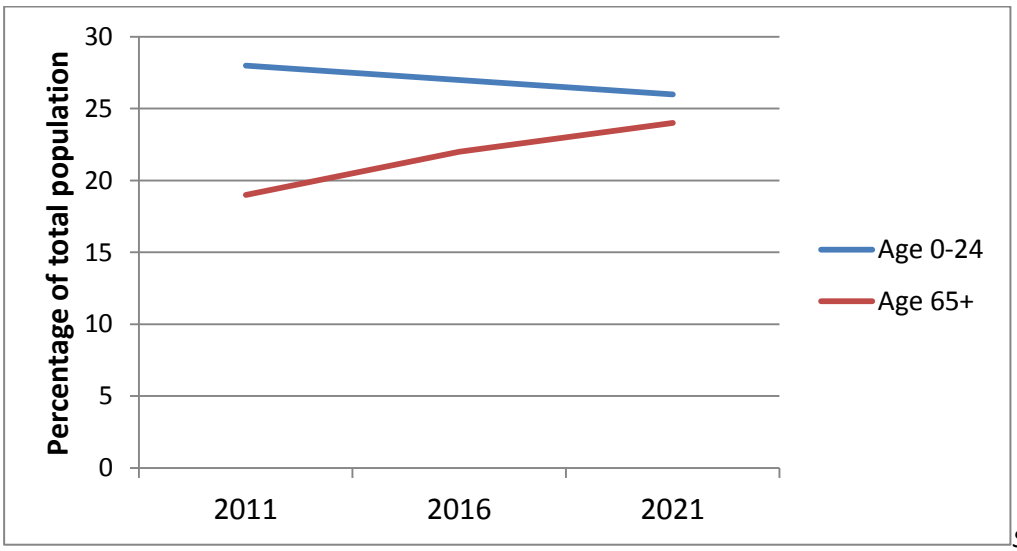
There is variance by district; Worcester City and Malvern Hills have the highest proportion of 15-19 year olds (Figure 20). Redditch and Worcester have the highest proportion of very young children (aged 0-4). Malvern Hills and Bromsgrove have higher proportions of all age teenagers (10-19).

Figure 20-Population by age groups and District



Based on 2011 mid-year estimates the 0-24 age population is projected to decrease steadily over the next few years; conversely the proportion of the population aged 65+ is projected to increase quite rapidly (Figure 21).

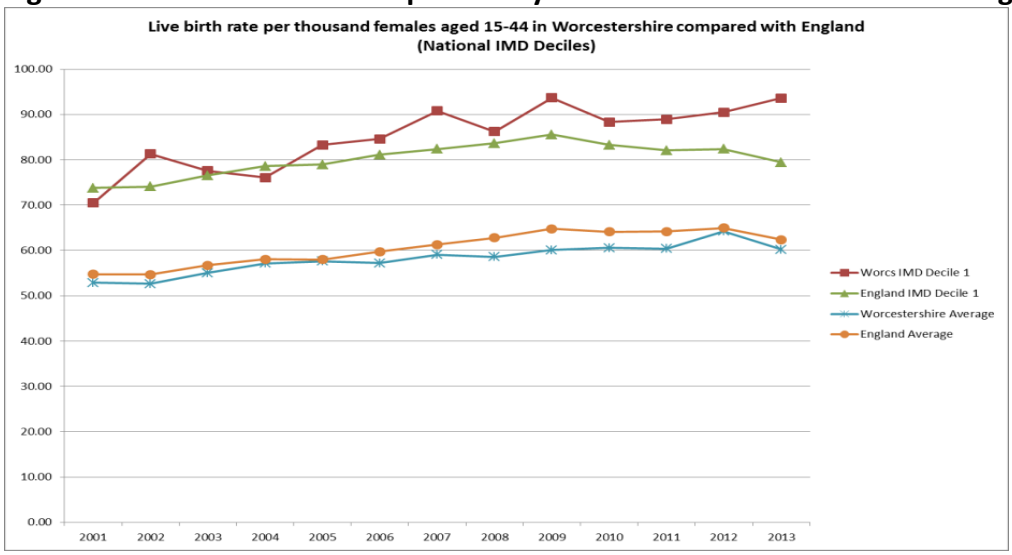
Figure 21 – Projected population change in 0-24 and 65+ age groups in Worcestershire to 2021



Source: ONS population projections (2011 based)

Of note is the higher birth rate amongst the most deprived quintile of the population (Figure 22) in Worcestershire and this is projected to continue to increase (red line) in comparison with a decrease nationally. This trend indicates that although the overall population of children and young people is decreasing, the numbers from the most deprived communities in the county are increasing.

Figure 22 – Live birth rate comparison by IMD decile: Worcestershire vs. England



Source: WCC data/ONS data

To demonstrate the demographic change in the county Table 1 provides the numbers and percentage of the under 18 population living in the 20% most deprived areas in the county.

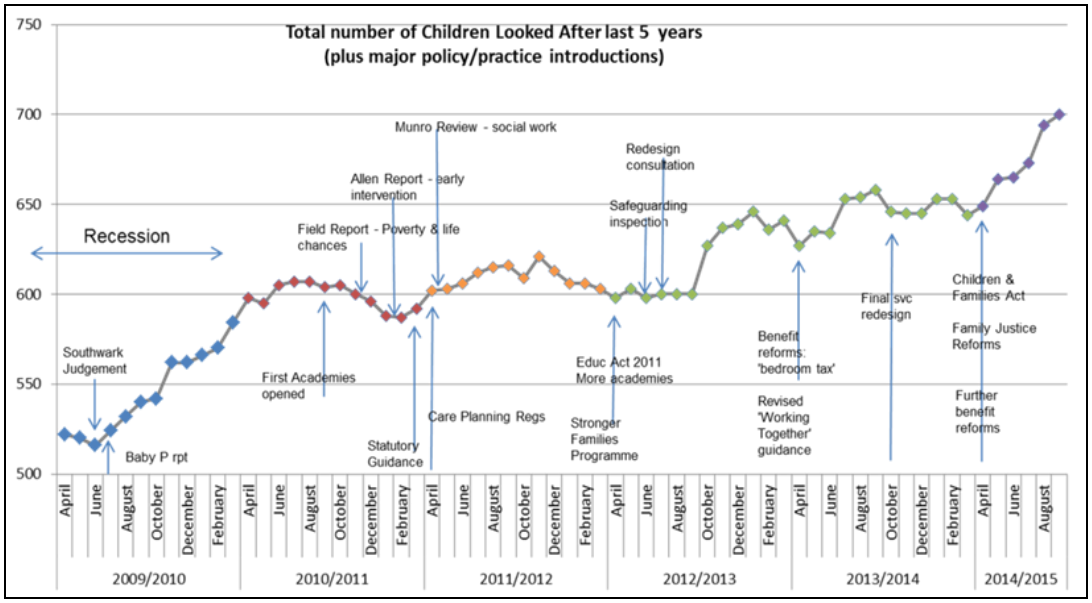
Table 1 – Numbers of Under 18 Population in 20% most deprived areas 2005-2015

	Number Children <18	Number Children <18 in 20% most deprived areas	% of <18 in 20% most deprived areas
2005	119,561	14,153	11.84%
2006	118,499	14,183	11.97%
2007	117,902	14,205	12.05%
2008	117,494	14,273	12.15%
2009	115,796	14,231	12.29%
2010	114,883	14,185	12.35%
2011	114,652	14,360	12.52%
2012	114,568	14,422	12.59%
2013	114,962	14,610	12.71%
2014	114,047	14,945	13.10%
2015	113,773	15,375	13.51%

Need for Children's Social Care/Looked After Children

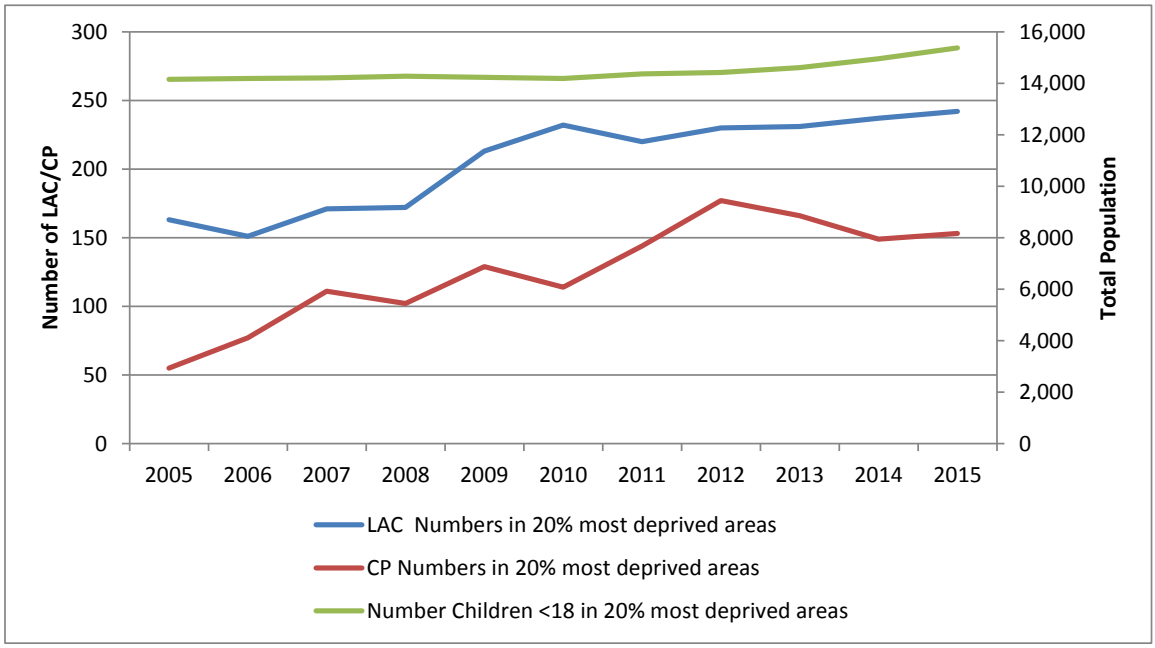
As indicated in Figure 5 the numbers and rate of LAC in Worcestershire have increased at a much steeper rate than the national average. There is ongoing debate as to whether this steep rise is reflected in a rise in "need" or a reflection of changes in social work practice. The LAC rate has risen from 37.8 per 10,000 in 2005 to 60.38 per 10,000 as at 31 March 2015. The steepest increases occurred between 2008 to 2010, a period which saw both the "Southwark Judgement" and the publication of the "Baby P" report and then again between 2012 to 2015, following the local redesign of Children's Social Care in response to a safeguarding inspection (Figure 23).

Figure 23 - Trend in LAC numbers with significant policy and practice events marked



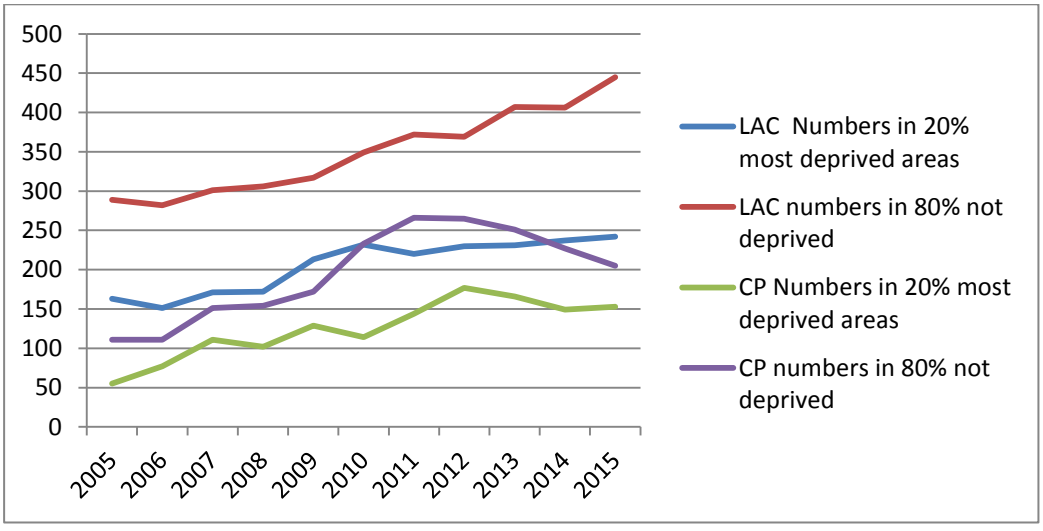
The numbers and rate of LAC and CP is higher for under 18s from the 20% most deprived areas in Worcestershire as would be expected. During this period although the overall population under 18 decreased, the population under 18 in the 20% most deprived areas increased. However Figure 24 shows that the increase in the LAC and CP rate for 20% most deprived have been far steeper than the increase in 20% deprived population.

Figure 24 - Number of LAC and CP and population aged <18 in 20% most deprived areas 2005-2015



Examining LAC numbers further highlights that the increase in LAC has been steeper for the 80% non-deprived population during the decade (Figure 25). Interestingly CP numbers have increased steadily for the 20% most deprived and have only decreased for the 80% non-deprived since 2010.

Figure 25 – Numbers of LAC and CP for deprived and non-deprived population 2005-2015



The additional numbers of children in deprived areas does not account for the rise in numbers of LAC or CP. This is further demonstrated in Figures 26 and 27 which provides the additional LAC and CP numbers standardised for deprivation that have occurred each year compared to both the 2005 and the 2010 rates. Figure 27 indicates that by 2015 there were 240 additional LAC than if the rate had remained at the level it was at in 2005, and 95

additional LAC than the 2010 rate even when standardised for the increase in the deprived population during the same period.

Figure 26 – Numbers of additional LAC since 2005 and 2010 standardised for deprivation.

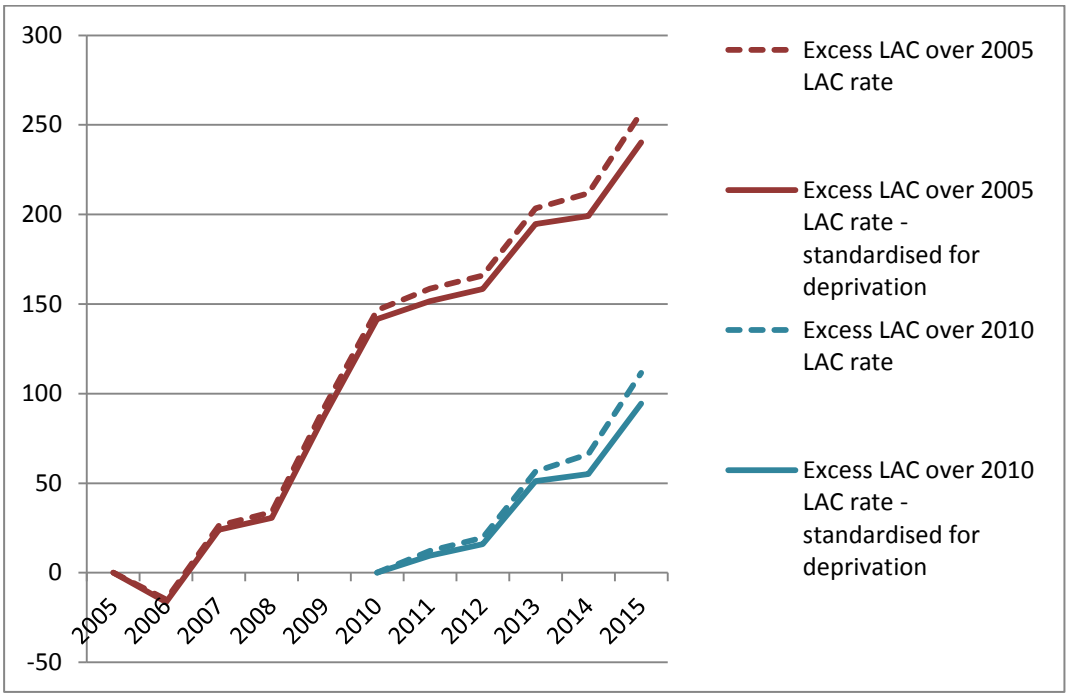
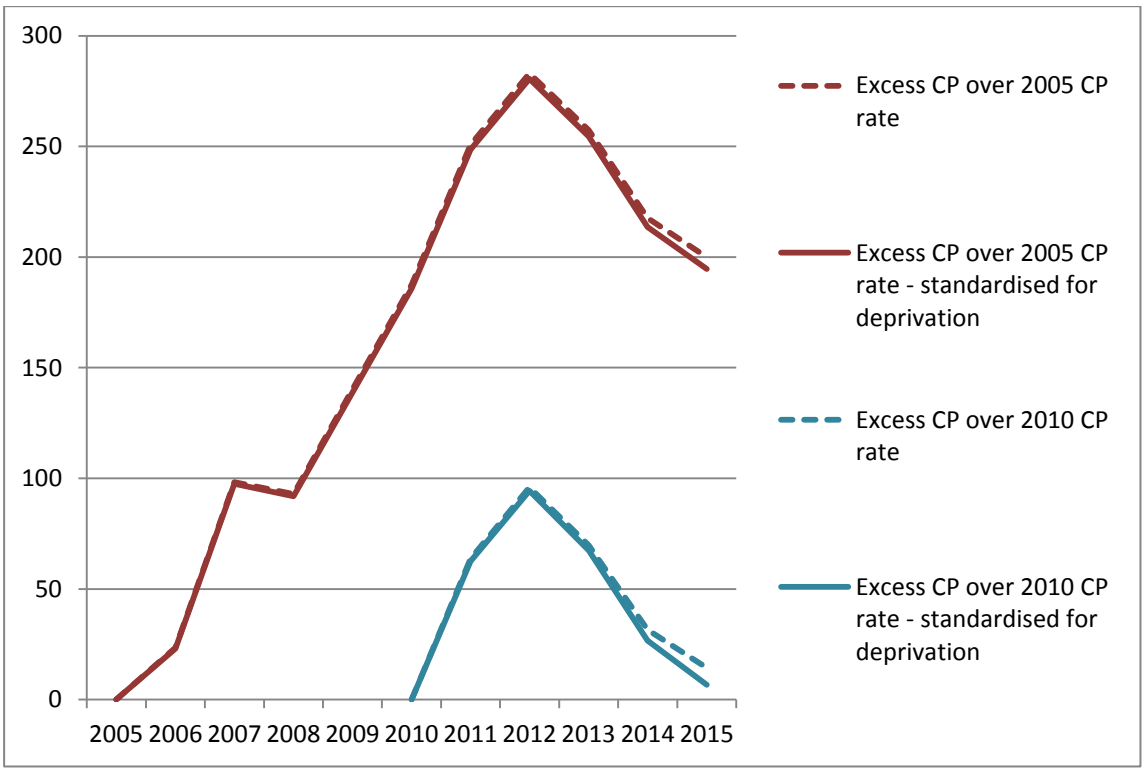


Figure 27 – Numbers of additional CP since 2005 and 2010 standardised for deprivation.



Estimated need for preventive interventions (early help)

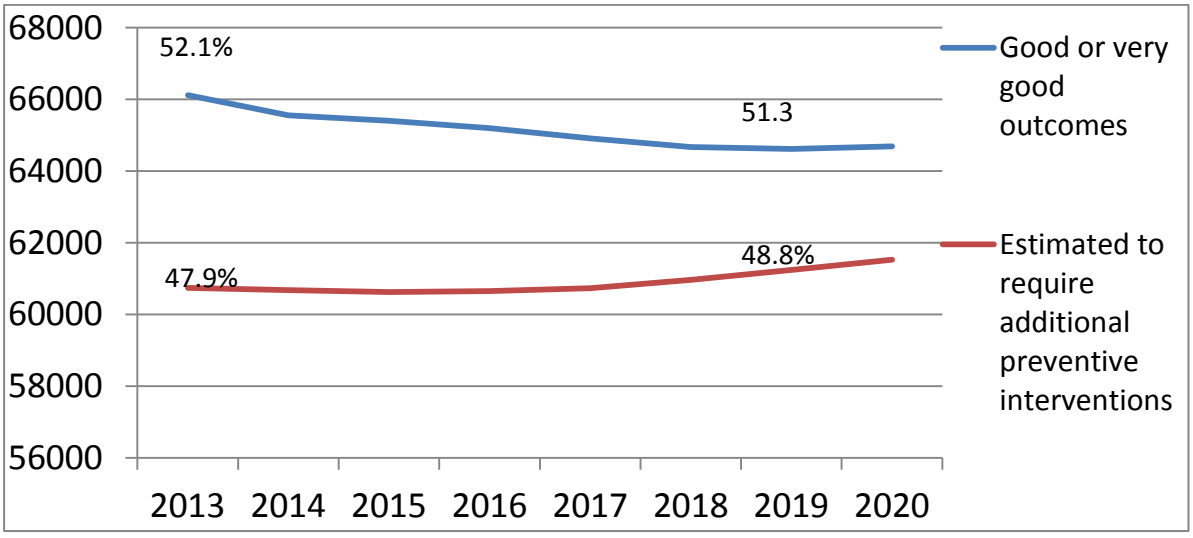
An estimate of need for early help has been calculated applying Worcestershire births data to the "PREview" tool, and incorporating ONS population projections. A model has been developed to estimate the potential need amongst the current 0-19 cohort and estimated need to 2020 (Figure 28). The PREview tool is based on robust evidence and data from the Millennium Cohort Study and identifies the likelihood of various outcomes at age five from the identifiable characteristics and/or risk factors present in pregnancy and post pregnancy. The tool can calculate and map future likely outcomes for children in terms of health, behaviour and learning and development at a population level and so help in decisions about where to target preventive resources in order to make the best return for children in the future.

One year's data from the 2013/14 Worcestershire birth extract (6000 plus births) were loaded into the PREview tool to ascertain which areas in Worcestershire are likely to need more early help. The result is an 'average weighting' for each LSOA area in the county which sums the weightings given for each characteristic such as birthweight, age of mother, smoking status for each birth. This weighting is then allocated to one of 5 outcome groups for each of the 3 dimensions (health, behaviour and learning and development):

- very good outcomes likely
- good outcomes likely
- additional preventive interventions likely
- extra preventive interventions likely
- intensive preventive interventions likely

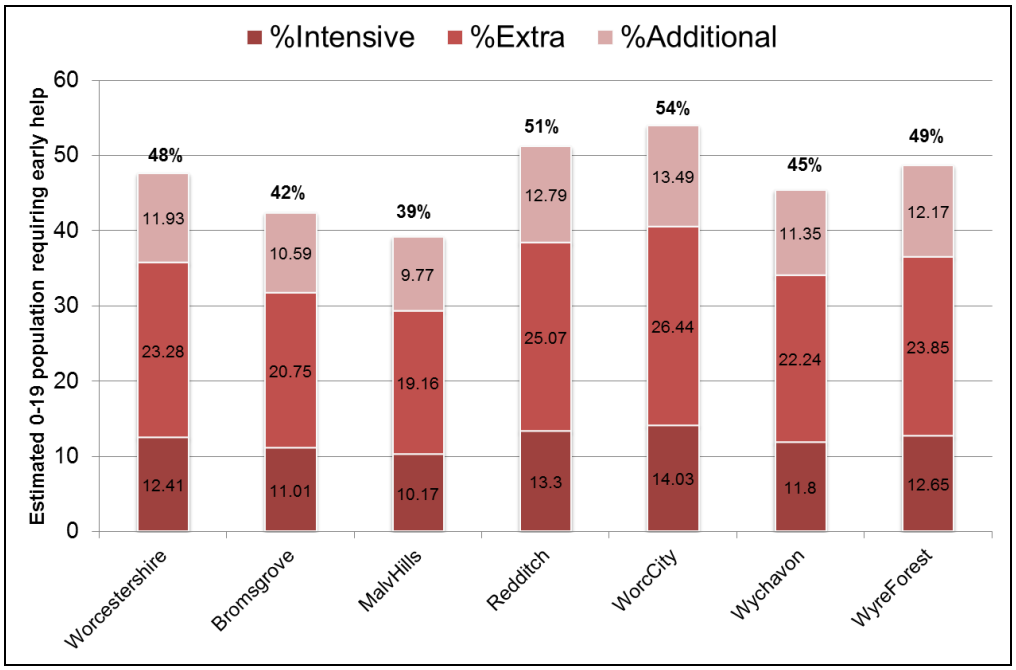
The tool estimated numbers of children for each outcome group and how they were distributed across the population. This information was then further modelled using population and demographic projections to identify the likely need for early help up to 2020. The analysis indicated that currently 52% are estimated to have good or very good outcomes and 48% are likely to need preventive interventions. Figure 28 provides a forecast of the model including projected population changes. This indicates that although overall the 0-19 population is forecast to decrease the numbers and proportion of those likely to need preventive interventions is likely to increase.

Figure 28 – Estimated need for preventive interventions in Worcestershire to 2020



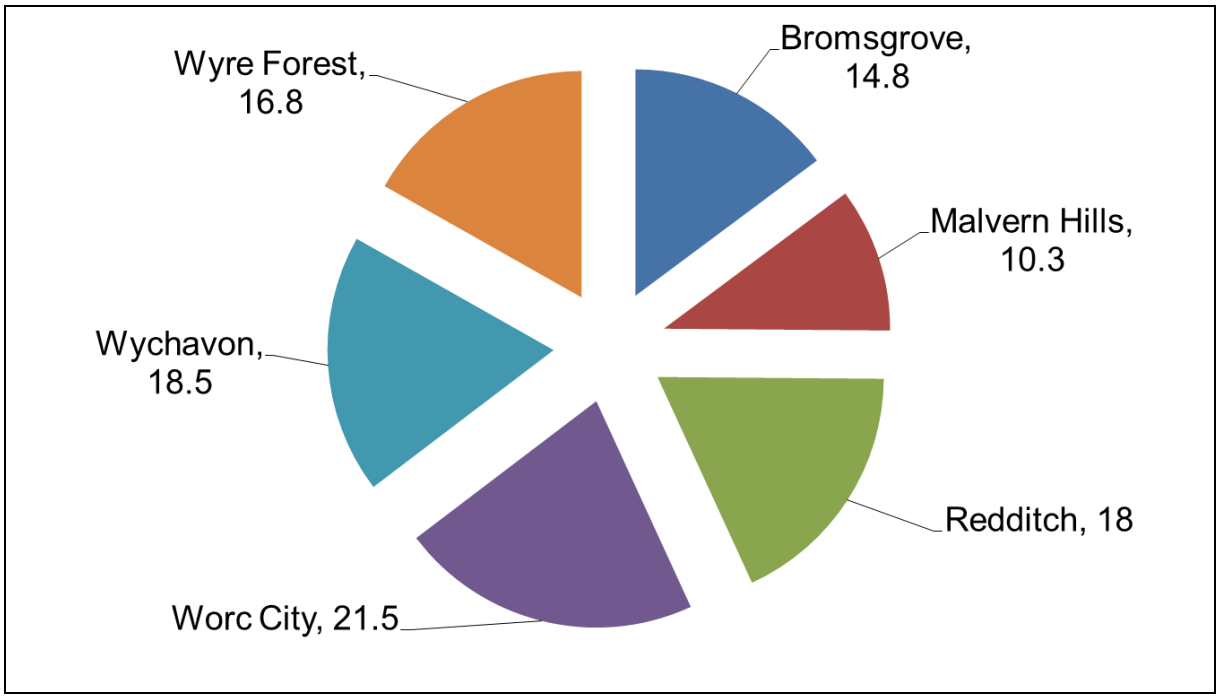
The proportion of 0-19s likely to need preventive interventions varies by District. The following table below identifies this varies from 54% in Worcester City to 39% in Malvern Hills.

Figure 29 - Estimated need for preventive interventions by District



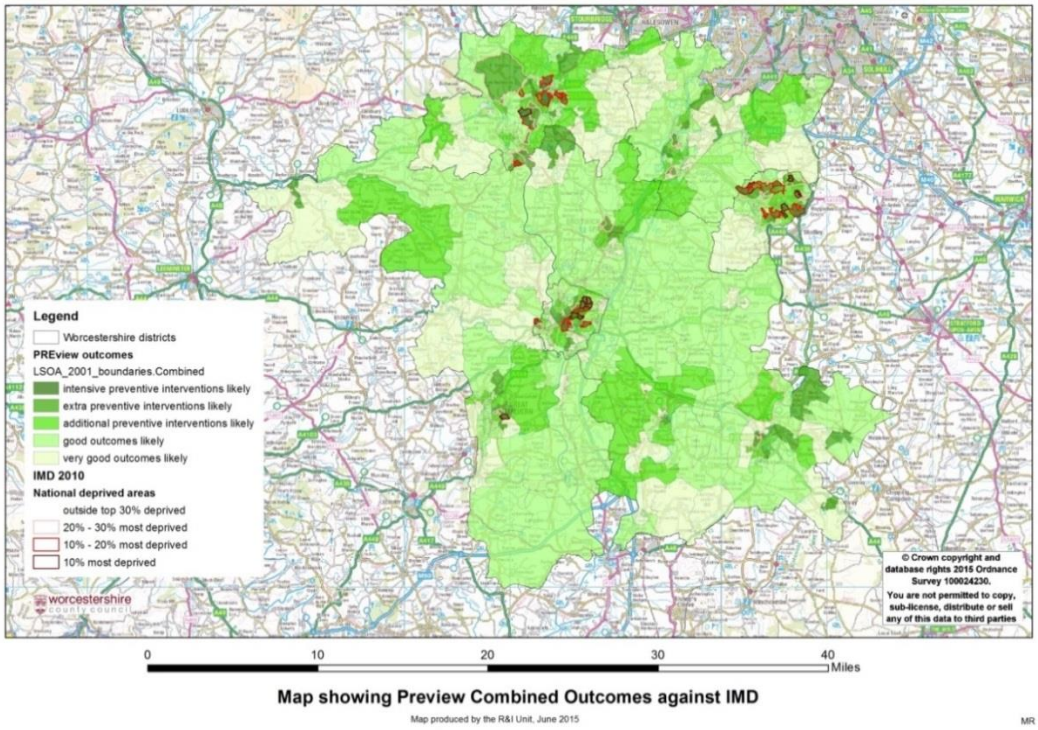
However, not each District is the same size and numbers of 0-19s varies by District. Figure 30 indicates the % of all 0-19s in the county estimated to likely to need preventive interventions by each District.

Figure 30 - % of all Worcestershire 0-19s estimated to likely to need preventive interventions by District



The numbers estimated through the PREview tool by each of the 5 outcome categories for each LSOA have been mapped. The map in Figure 31 shows that generally the LSOAs that are likely to need the most intensive or extra preventive interventions tend to match those areas which are more deprived. In particular, areas in Redditch, Worcester City and Kidderminster correlate strongly with IMD data. However, the deprived areas do not fully describe the predicted poorer outcomes suggesting risk factors amenable to preventive interventions at a lower intensity are present in other parts of the county.

Figure 31- Estimated likely outcomes and areas of deprivation



Estimate of emotional wellbeing and speech, language and communication need

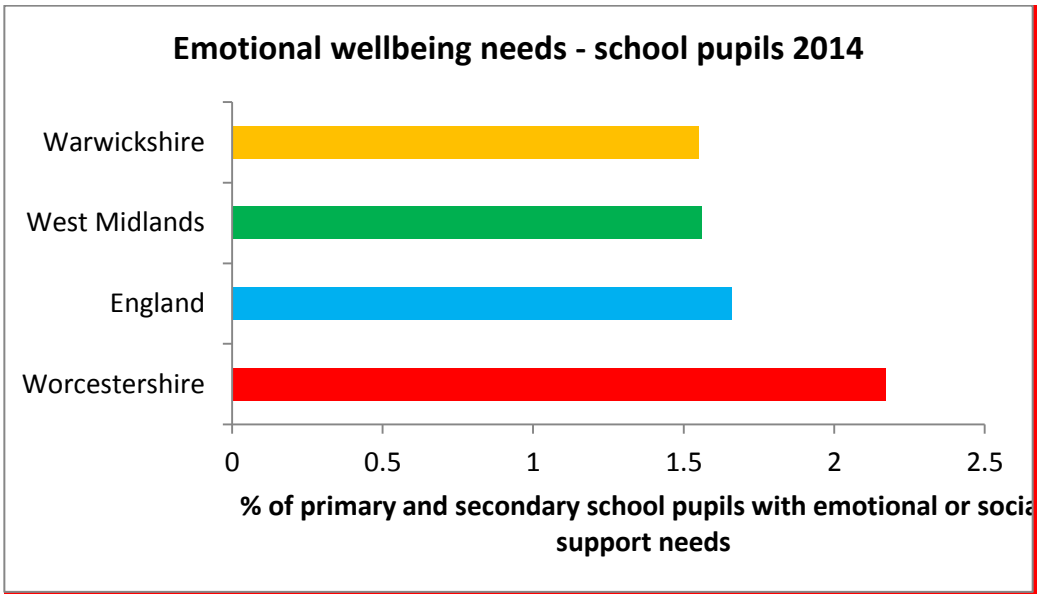
There is concern in Worcestershire regarding perceived high levels of mental health and emotional health and wellbeing need amongst children and young people. Accurate data on the prevalence of mental health amongst children and young people is not available, however Worcestershire has a significantly higher rate of hospital admissions for self-harm (aged 10-24) than England or the West Midlands; higher too than statistical neighbours including Herefordshire and Warwickshire (Figure 32).

Figure 32: Hospital admissions for self-harm (aged 10-24) 2007-2013

	2007-10	2008-11	2009-12	2010-13
Worcestershire	385.9	424.4	425.3	424.2
West Midlands	290	319.4	345.7	364.1
England	329.5	342.3	347.9	352.3

There are a significantly greater proportion of primary and secondary school pupils in Worcestershire with statements of SEN or as School Action Plus where the primary need is behaviour, emotional and social difficulties than England; the highest % in the West Midlands (Figure 33).

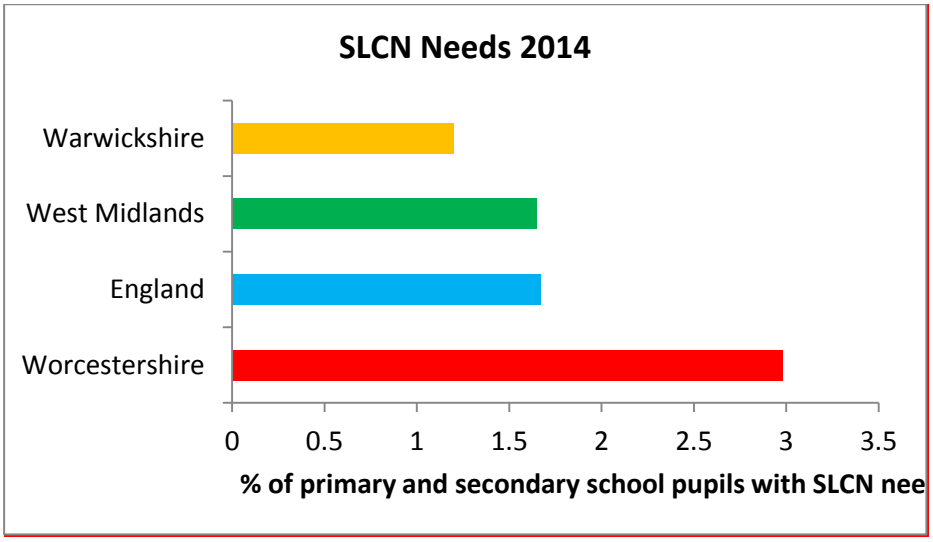
Figure 33 – Emotional wellbeing needs 2014



Source: Children and Young People Mental Health and Wellbeing Profile/ Department for Education [https://www.gov.uk/government/statistics/special-educational-needs-in-england-january-2013]

There is also concern regarding levels of speech, language and communication needs in Worcestershire. One of the domains of the early years foundation stage profile is around communication and language. The Communication, Language and Literacy scores for Worcestershire are performing poorly compared to statistical neighbours and the national average. In addition there are a significantly greater proportion of school pupils in Worcestershire with statements of SEN or as School Action Plus where the primary need is Speech Language and Communication needs (SLCN) compared with England, the West Midlands and our closest statistical neighbours (Figure 34).

Figure 34 – SLCN need 2014



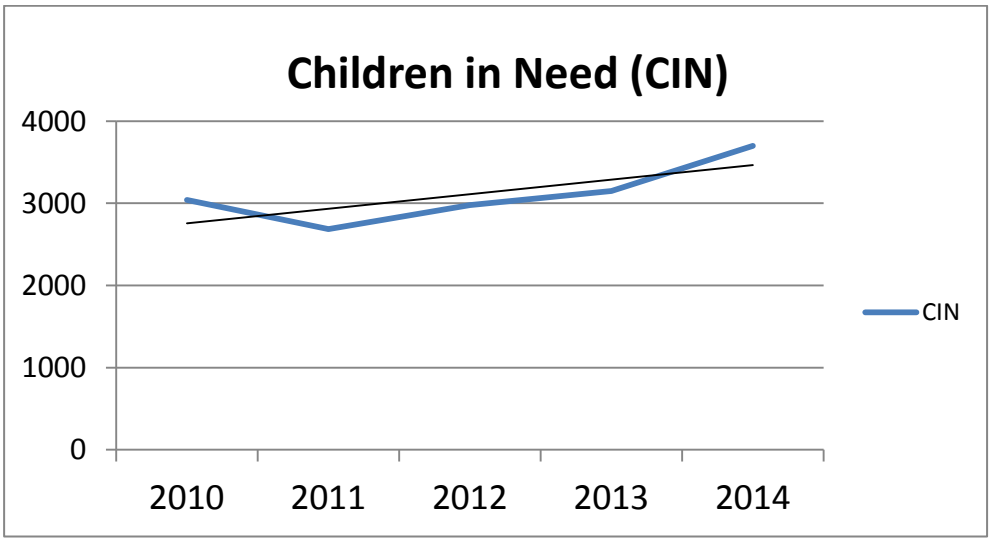
Source: Children and Young People Mental Health and Wellbeing Profile/ Department for Education [https://www.gov.uk/government/statistics/special-educational-needs-in-england-january-2013]

Current Service Provision

Rising demand.

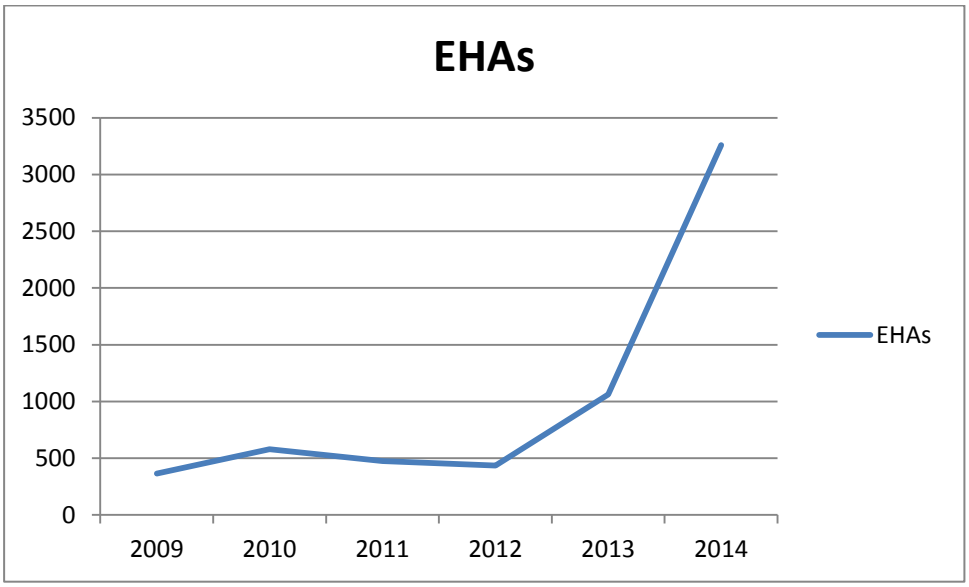
Although outcomes at the population level for children and young people do not appear to be improving activity data shows that an increasing number are being referred to and seen by both health and social care services. As well increases in LAC and CP the tables below highlight the increase in numbers of Children in Need identified and assessed by WCC (Figure 35).

Figure 35 – Numbers of CIN 2010-2014



The number of Early Help Assessments (formerly CAFs) and work undertaken on Early Help plans have increased almost 7 fold since the commissioning of District Early Help Providers (Figure 36).

Figure 36- Number of EHAs 2009-2014



There has also been rising demand amongst health services during the same period (Figures 37 & 38).

Figure 37 – CAMHs referrals 2010/11 to 2013/14

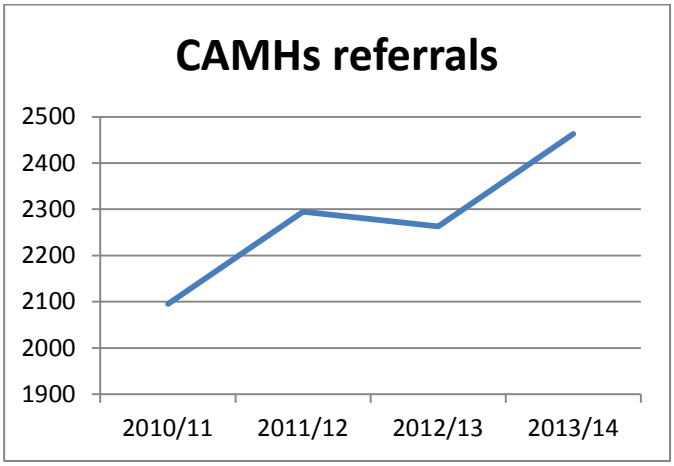
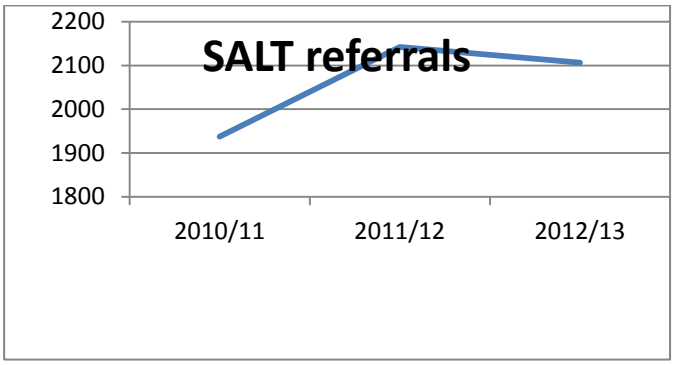


Figure 38 – SALT referrals 201/11 to 2012/13



Early Help Services

The current WCC commissioned or provided early help services include the 6 District 0-19 Early Help Providers, the Stronger Families programme, and the Early Intervention Family Support service (EIFS). The District 0-19 Early Help Providers run the local provision of Children's Centres, Family Support 0-19, NEET prevention and work with other settings and communities. Stronger Families is a more intensive family intervention that incorporates a key worker approach and coordinate whole family assessments and plans. EIFS deliver packages of family support and parenting courses for school age children. All 3 Providers undertake and lead Early Help Assessments (EHAs), formerly known as CAFs, and subsequent early help plans depending on which is most appropriate service. Early help is described as a "range of support given to families that helps to nip problems in the bud before they get worse and require intervention from more specialist services such as social care".

Early Help Assessments

The commissioned District Early Help Providers undertake EHAs and support Early Help plans and undertake preventive work and activities within a range of settings. The District Providers are commissioned to achieve a target number of EHAs (7% of the 0-19 population). To achieve these targets resources and activities are reactively focussed on EHAs as they

present with less capacity for more preventive or proactive support. Families themselves, schools and other agencies and service providers refer to the Early Help hub who then pass the referral to the appropriate District EH Provider. This has potentially resulted in some families receiving support who may not have previously and for some families receiving support that would previously have been provided from universal services. The service is commissioned on outcomes and the evidence based tools, assessments, programmes, interventions or support required to be given to who is not specified in the contract. As a consequence each District Provider offers/provides differing interventions and support and which are not necessarily in accordance with the evidence base. An analysis of all EHAs undertaken during a 20 month period August 2013 to March 2015 identifies that 59% of EHAs were undertaken by the Early Help Provider (EHP), 24% by EIFS and 9.5% by Stronger Families team.

Table 2 – EHAs by Provider Aug 2013 – March 2015

Lead Worker Group	Numbers	%
Early Help teams (which existed before the EHPs)	259	4.73%
EH Providers	3213	58.65%
EIFS	1146	20.92%
Integrated working team lead EHA	156	2.85%
Stronger Families	520	9.49%
Wyre Forest and Hagley Project (WF's version of EIFS)	184	3.36%
Grand Total	5478	100.00%

The rate of EHAs undertaken varies by District and reflects the length of time the contract has been in place (Wyre Forest commenced first in August 2013).

Table 3- Rate of EHAs per 1000 population by Provider Aug 2013-Mar 2015

Rate per Thousand Population	District						
Lead Worker Group	Bromsgrove District	Malvern Hills District	Redditch District	Worcester District	Wychavon District	Wyre Forest District	Grand Total
Early Help teams (pre EHPs)	4.6	2.1		2.7	1.9		2.0
EHP	6.8	15.6	24.6	25.9	19.5	56.7	25.1
EIFS	10.5	11.8	11.7	10.5	8.6	1.1	8.9
Integrated working team	0.9	0.9	1.7	1.0	1.5	1.1	1.2
Stronger Families	1.7	4.0	5.1	5.2	3.0	5.4	4.1
Wyre Forest and Hagley Project	1.0					7.5	1.4
Grand Total	25.8	34.9	43.9	45.6	34.7	72.3	43.0

A greater percentage of EHAs have been undertaken in the more deprived quintiles of the 0-19 population. 52% of all EHAs were undertaken for the most deprived 40% (IMD 1 & 2); however the estimated need for preventive interventions for all 0-19s indicates 73% of need. Conversely 28% of EHAs were undertaken in the least deprived 40% (IMD 4 & 5) however estimated need for preventive interventions indicated 7% of need.

Table 4 - % of EHAs undertaken by IMD Quintile and Provider Aug 2013-Mar 2015

	IMD Quintile					
Lead Worker Group	1	2	3	4	5	Total
Early Help teams (pre EHPs)	0.71%	1.37%	1.10%	0.93%	0.62%	4.73%
EHP	19.81%	13.55%	11.03%	9.16%	5.11%	58.65%
EIFS	3.54%	3.83%	5.00%	4.49%	4.05%	20.92%
Integrated working team	0.80%	0.68%	0.73%	0.46%	0.18%	2.85%
Stronger Families	3.91%	2.17%	1.50%	1.31%	0.60%	9.49%
Wyre Forest and Hagley Project	0.84%	0.69%	0.68%	0.64%	0.51%	3.36%
Grand Total	29.63%	22.33%	20.08%	17.07%	11.17%	100.00%

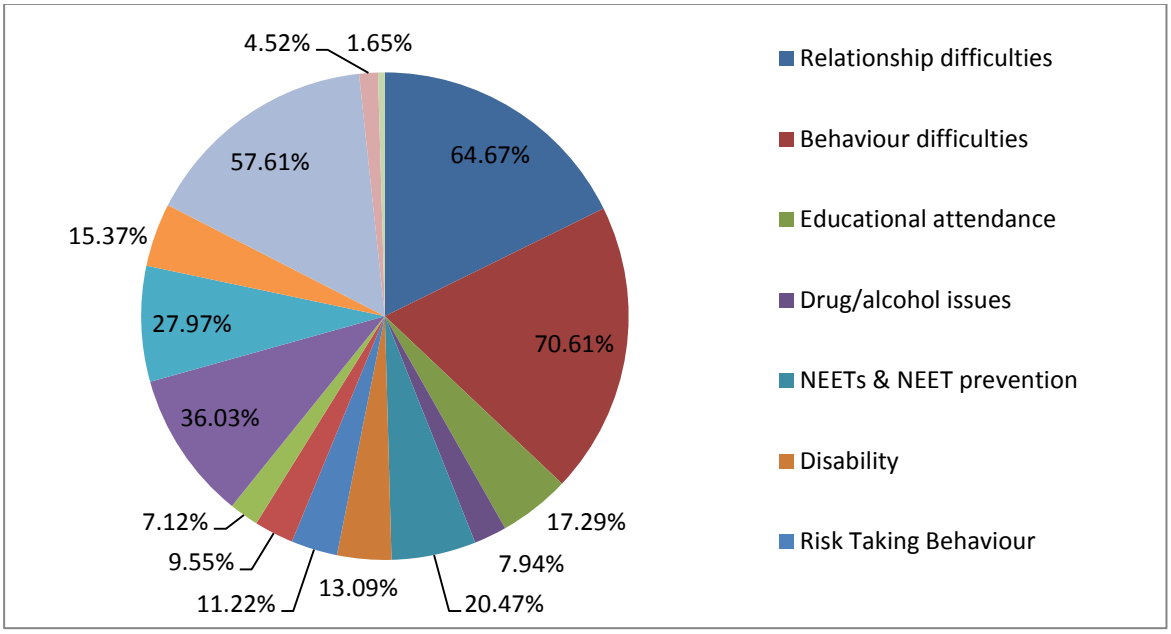
The impact of Early Help assessments and plans are measured via parents and children providing a pre and post self reported score based on a linear scale of 1-5. The "distance travelled" pre and post support is then recorded. The distance travelled is on average 1.94. There is not a robust measure or validated tool used to evaluate or determine the impact of the EHA and the subsequent support provided.

Table 5 – Distance travelled for EHAs undertaken Aug 2013 to Mar 2015

	IMD Quintile (national)					
Distance travelled (on a scale of 1-5)	1	2	3	4	5	County
Average of score	1.87	2.01	2.00	1.92	1.94	1.94

An analysis of the reasons included in Early Help Assessments where usually more than one reason is included for each child/family shows that behaviour difficulties (at home or at school) were present in 71% of all EHAs, relationship difficulties (at home or at school) were present in 65% and mental health/emotional health issues (parent or child) in 58%. However it should be noted that the mental health reason is defined by the EH Provider rather than a clinician or mental health specialist.

Figure 39 - % of reasons given in all EHAs Aug 2013 to Mar 2015



Stronger Families

The Stronger Families programme is Worcestershire's response to the government's 'Troubled Families' agenda. The programme identified over 900 families that met at least two of the national criteria;

•having an adult on out of work benefits,
•children not being in school (unauthorised attendance/exclusions) and/or
•family members being involved in crime and anti-social behaviour.

The programme provides multiagency family support through a key worker, an intensive families intervention project approach, co working with social care teams and support from schools, housing providers and family support teams. The service provides hands-on practical support to families, identifying their needs through a whole family assessment and delivering support through an agreed action plan. Key Workers work together with other professionals to coordinate an integrated family support plan. In the first phase 833 families that were supported met the national outcomes as follows. An extended Phase 2 programme has now commenced.

Table 6 - Stronger Families Phase 1 Outcomes

	Jul-13	Oct-13	Feb-14	May-14	Aug-14	Oct-14	Feb-15	May-15
Number of PbR claims made								
Education & Crime/ASB	33	45	107	82	5	307	88	120
Continuous employment	1	0	9	0	9	2	9	3
ESF only	0	0	2	1	9	1	0	0
Additional progress to work payment	0	0	1	0	1	3	9	10
Additional ESF only payment	0	0	0	1	2	2	0	0
Additional progress to work payment	0	0	0	0	0	1	0	0
Total families claimed results payment for to date	34	79	197	280	303	613	710	833

Children's Centres

There are currently 29 Children's Centres in Worcestershire. The core purpose of Children's Centres is "To improve outcomes for young children and their families, with a particular focus on families in greatest need of support in order to reduce inequalities in:

- child development and school readiness;
- parenting aspirations, self-esteem and parenting skills;
- and child and family health and life chances

- training and employment services to assist parents or prospective parents;
- information and advice services for parents and prospective parents

The Children's Centres provide a range of universal and targeted early childhood services (universal = universally available not universal coverage). All Centres offer family information and advice, access to social services provision, training and employment services, access to Early Help provision through the District 0-19 Provider, access to health service provision (midwifery antenatal clinics and Health Visitor child health clinics), and some VCS provision (NCT, debt advice etc.). In addition, some also host early years provision (education and childcare). There is not a consistent offer in each Centre and there are variations by District. However, all centres deliver a minimum universal offer of 'Stay and Play' and access to some health provision (ante-natal/child health clinics). All EH Providers offer targeted and intensive family support through the EHA Framework, however this varies by District.

Ofsted inspections judge whether Children's Centres have engagement with at least 65% of all families with children under five years who live in the reach area of the children's centre and look for evidence of improved outcomes for target groups (Lone Parents, workless households, BME Groups etc.). This target includes access to nursery education as well as access to other CC provision. In total over 22,000 of young children aged under 5 accessed CCs (including nursery education) in 2014/15 which was 71% of the 0-4s population. The percentage has decreased over the last three years from 76% to 71% (Table 7).

Table 7 – Numbers, % and footfall rate of 0-4s in Children's Centres including nursery education 2012-2014

	2012-13			2013-14			2014-15		
	Numbers of 0-4s seen	% of all 0-4s seen in reach area	Footfall rate	Numbers of 0-4s seen	% of all 0-4s seen in reach area	Footfall rate	Numbers of 0-4s seen	% of all 0-4s seen in reach area	Footfall rate
Bromsgrove	3291	68%	3.52	3386	70%	3.70	3352	70%	3.37
Malvern	2487	75%	5.02	2385	72%	4.42	2308	70%	4.57
Redditch	4684	83%	4.37	4108	73%	3.48	3902	69%	4.23
Worcester	4809	76%	4.40	4663	73%	3.92	4331	68%	4.55
Wychavon	4118	72%	3.85	4194	73%	4.11	4220	74%	3.19
Wyre Forest	4228	80%	5.83	3597	68%	3.95	3945	75%	4.60
County	23617	**76%**	**4.47**	22333	**72%**	**3.90**	22058	**71%**	**4.07**

In addition data is collected regarding the numbers of children and footfall from the 30% most deprived LSOAs in the county. Access for this harder to reach group was the original premise of Surestart Children's Centres and helps monitor if families in greatest need are accessing Children's Centres support. Almost 4000 under 5s from the 30% most deprived population accessed CCs including nursery education provision in 2014/15, which was 56% of the 30% most deprived population. The numbers of 30% most deprived vary by District (Table 8).

Table 8 - Numbers, % and footfall rate of 30% most deprived 0-4s accessing Children's Centres including nursery education 2012-2014

	2012-13			2013-14			2014-15		
	Numbers of 0-4s seen	% of all 0-4s seen in reach area	Footfall rate	Numbers of 0-4s seen	% of all 0-4s seen in reach area	Footfall rate	Numbers of 0-4s seen	% of all 0-4s seen in reach area	Footfall rate
Bromsgrove	209	53%	3.49	240	61%	3.40	249	63%	3.66
Malvern	195	66%	7.30	149	50%	5.96	158	53%	4.75
Redditch	1507	64%	4.73	1267	53%	3.30	1175	50%	3.28
Worcester	1163	63%	5.41	1102	60%	4.63	916	50%	3.64
Wychavon	241	57%	6.08	244	57%	6.01	267	63%	4.50
Wyre Forest	1156	55%	5.23	979	47%	3.67	1163	55%	3.37
County	4471	**60%**	5.19	3981	**55%**	4.00	3928	**56%**	3.57

To assist in establishing population access and utilisation of CC support & provision that is not related to nursery education provision, an analysis of CC activity has been undertaken excluding numbers attending nursery education. This identifies that 43% of all 0-4s accessed a CC in 2014 and that numbers have declined over the last three years (Table 9).

Table 9 – Numbers, % and footfall rate of 0-4s in Children's Centres (excluding nursery education) 2012-2014

	2012			2013			2014		
	Numbers of 0-4s seen	% of all 0-4s seen in reach area	Footfall rate	Numbers of 0-4s seen	% of all 0-4s seen in reach area	Footfall rate	Numbers of 0-4s seen	% of all 0-4s seen in reach area	Footfall rate
Bromsgrove	2003	42%	3.15	2230	46%	3.15	2097	43%	2.84
Malvern	1609	49%	5.02	1591	47%	4.27	1444	42%	4.43
Redditch	3170	56%	4.37	2741	48%	3.42	2473	44%	4.21
Worcester	2940	46%	4.40	2961	48%	4.03	2625	41%	4.47
Wychavon	2342	41%	3.85	2664	46%	4.07	2632	45%	3.10
Wyre Forest	2865	55%	5.83	2335	44%	3.90	2303	42%	4.42
County	14800	**48%**	**4.47**	14521	**46%**	**3.85**	13582	**43%**	**3.98**

The percentage of the most deprived 30% of 0-4s accessing CCs, excluding nursery education, was 49% in 2014 (Table 10). There is variation by District, and over the last 3 years there has been an increasing percentage of 30% most deprived accessing centres in Bromsgrove and a decreasing percentage accessing centres in Malvern, Redditch, Worcester and Wyre Forest. The overall county numbers and percentage have reduced during the last three years. In addition the footfall rate from 30% most deprived LSOAs has reduced from a rate of 5.19 in 2012 to 3.36 in 2014.

Table 10 – Numbers, % and footfall rate of 30% most deprived 0-4s accessing Children's Centres (excluding nursery education) 2012-2014

	2012			2013			2014		
	Numbers of 0-4s seen	% of all 0-4s seen in reach area	Footfall rate	Numbers of 0-4s seen	% of all 0-4s seen in reach area	Footfall rate	Numbers of 0-4s seen	% of all 0-4s seen in reach area	Footfall rate
Bromsgrove	191	48%	3.49	231	54%	3.15	240	59%	3.54
Malvern	194	66%	7.30	170	55%	5.74	154	48%	4.40
Redditch	1557	66%	4.73	1259	50%	3.13	1151	47%	3.15
Worcester	1030	56%	5.41	1085	63%	4.97	926	49%	3.53
Wychavon	237	56%	6.08	245	55%	5.71	260	56%	4.11
Wyre Forest	1092	52%	5.23	962	44%	3.53	1074	47%	3.12
County	4301	**58%**	5.19	3952	**52%**	3.92	3805	**49%**	3.36

Table 11 provides a visual display of the population coverage and utilisation rates (footfall rate), excluding nursery education, for each Children's Centre pooled over the 3 year period 2012-2014. This has been RAG rated to identify centres with high and low rates compared to the county average. There are also a number of Children's Centres that do not have any 0-4s from the most 30% deprived in their reach areas. Of note generally those Children's Centres that have either no 0-4s from 30% deprived LSOAs (N/A) and those where the % seen from 30% most deprived is low (red) also appears to have a corresponding low coverage (% seen) and utilisation (footfall rate) for the whole 0-4s population. Likewise, those Centres that see higher % of most deprived 30% of 0-4s also seem to have corresponding better universal coverage (% seen) and utilisation (footfall rate).

Table 11 – Percentage of 0-4s seen by Children's Centres (excluding nursery education) 2012-2014

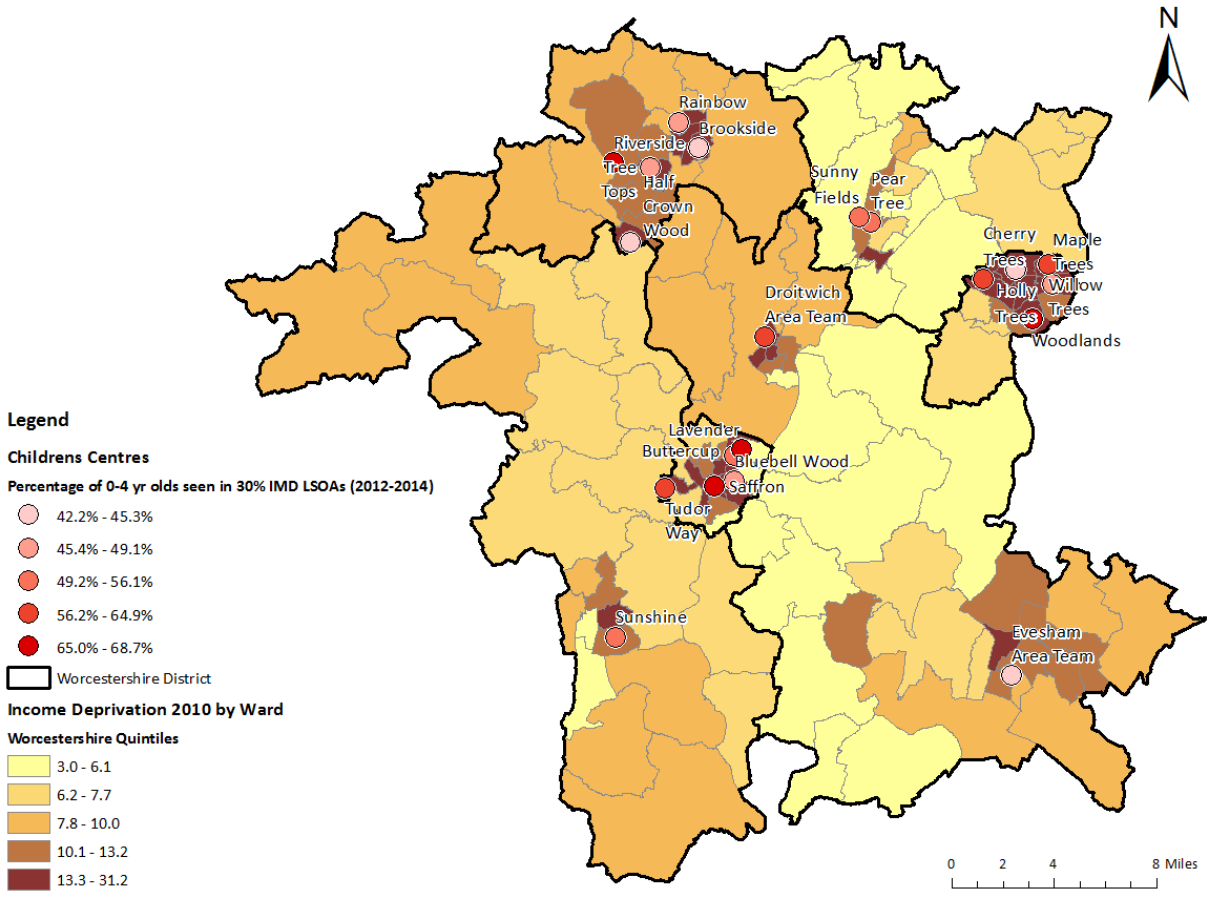
	Pooled 3 Years 2012-2014			
District	% seen from 30% most deprived	Footfall rate for 30% most deprived	% of all 0-4s seen in reach area	Total Footfall rate all 0-4s
BROMSGROVE	**54%**	**3.39**	**44%**	**3.51**
Conkers @ Hagley	N/A	N/A	42%	4.30
Cottonwood @ East Bromsgrove	N/A	N/A	30%	1.70
Pear Tree	53%	3.21	57%	3.83
Sunny Fields @ Charford	54%	3.68	45%	3.42
Tulip tree @ Catshill	N/A	N/A	45%	4.82
MALVERN	**56%**	**5.78**	**46%**	**4.57**
Evergreen	N/A	N/A	50%	6.15
Riverboats @ Upton	N/A	N/A	48%	5.41
Sunshine	56%	5.78	55%	4.94

Teme Valley	N/A	N/A	32%	1.98
REDDITCH	**54%**	**3.65**	**49%**	**4.00**
Cherry Trees	61%	3.96	57%	3.94
Holly Trees	45%	2.86	43%	2.52
Maple Trees	46%	3.14	50%	4.96
Oak Trees	N/A	N/A	45%	4.67
Willow Trees	56%	3.87	54%	5.32
Woodlands	66%	4.83	49%	3.34
WORCESTER	**56%**	**4.62**	**45%**	**4.30**
Blue Bell Wood	45%	2.67	45%	3.56
Buttercup at Fairfield	54%	4.15	52%	5.83
Lavender @ Warndon	69%	5.99	44%	4.55
Saffron at Stanley Rd*	68%	5.38	45%	3.70
Sunflower @ Perdiswell*	N/A	N/A	41%	2.46
Tudor Way	60%	7.56	42%	5.51
WYCHAVON	**55%**	**5.27**	**44%**	**3.67**
Droitwich Cluster	65%	6.59	36%	2.65
Evesham Cluster	44%	3.70	48%	4.26
Pershore Cluster	N/A	N/A	49%	4.20
WYRE FOREST	**48%**	**3.93**	**47%**	**4.71**
Brookside	42%	3.44	40%	4.73
Chestnut @ Franche	N/A	N/A	55%	9.19
Half Crown Wood	45%	3.44	43%	2.87
Rainbow at St Mary's	48%	3.86	47%	2.96
Riverside	69%	6.50	51%	7.16
Tree Tops	49%	4.18	48%	3.64
WORCESTERSHIRE	**53%**	**4.14**	**45%**	**4.10**

**CCs have merged*

To better demonstrate the % of 0-4s from 30% most deprived LSOAs the map below denotes each Children's Centre colour coded overlaid on a map of deprivation (Figure 40). (NB. Only those Children's Centres with 30% most deprived in reach area included)

Figure 40 - Access to CCs (excl. nursery education) of 30% most deprived 0-4s 2012-2014



Healthy Child Programme 0-19

The HCP is the early intervention and prevention public health programme that lies at the heart of universal service for children and families. The HCP's universal reach provides the opportunity to identify families that are in need of additional support and children who are at risk of poor outcomes. It is the key universal public health service for improving health and wellbeing of children through health and development reviews, health promotion, parenting support and screening & immunisation programmes. It is underpinned by an up-to-date evidence-base set out in Health for All Children (Hall and Elliman, 2006) and is aimed at children up to the age of 19 and their families. The HCP evidence for children aged 0-5yrs has recently been reviewed and updated by PHE (2015).

The HCP is a progressive universal service, i.e. it includes a universal service that is offered to all families, with additional services for those with specific needs and risks. A progressive universal HCP is one that offers a range of preventive and early intervention services for different levels of risk, need and protective factors. The HCP enables early identification of those with risk factors, emerging problems and developmental delay which can be dealt with through evidence based interventions and effective signposting and referral to specialist services as necessary. The HCP includes an evidence based schedule of universal reviews at key opportunities for example by 12th week of pregnancy (maternity booking), neonatal check, new baby review, 2.5 year review, school entry review for all

children/families some of which have more recently become mandatory. In addition additional checks, reviews and support can be provided at a level required according to need, this is called the Universal plus or Universal partnership (multiagency) offer. The HCP is delivered on the premise of proportionate universalism, that is the provision of evidence based programme at a universal population level but at an intensity to individuals according to need.

The team delivering the HCP should include a range of health professionals and other children's practitioners and the wider children's workforce. The responsibility for delivering and leading the HCP lies with health professionals – in particular, midwives during pregnancy, health visitors up to age 5 and school nurses during school years who each hand the baton on to the next. The HCP includes activities that require clinical and public health skills and knowledge. They are responsible for ensuring every child receives the schedule of health and development reviews, screening tests, immunisations, health promotion guidance and support for parents tailored to their needs, with additional support when needed and at key times. However many other services contribute to the HCP and the Common Assessment Framework should be used where there are issues that might require support to be provided by more than one agency. It is important that professionals who are involved in assessing the child's and the family's needs work in partnership, and share relevant information as required.

Maternity Services

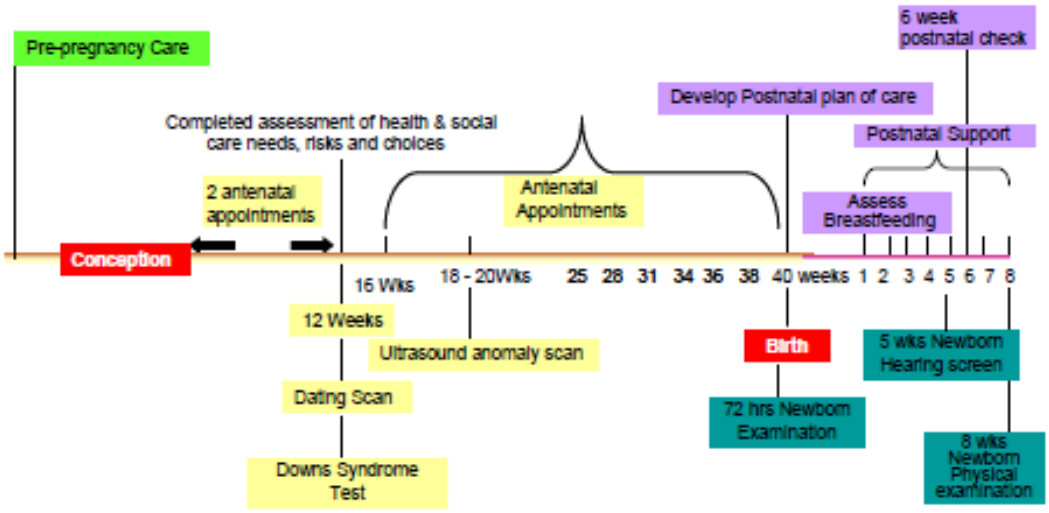
Maternity is one key element along the continuum of a woman's life course and the beginning of the pathway of childhood development. The objective of maternity care is to maximise the health and wellbeing of mothers and babies. The health of mothers is critical to the development of their children both before and after birth. Their nutritional status before and during pregnancy, as well as their mental health is important, as is their lifestyle choices.

Maternity provision offers choice and continuity for families, while also providing more targeted help for those in greatest need. The aim of maternity services is to support the transition from pregnancy to family life with a safe high quality service that is woman and family centred and that enables mothers and baby's to achieve the best possible outcomes. Maternity Services provide the full range of antenatal, intrapartum and postnatal care for women and their families including scheduled and unscheduled care, outpatient, inpatient, community and home based services. Maternity care is provided in accordance with the requirements of national policy guidelines, evidence and best practice and to reflect local needs and priorities. There is a shared explicit philosophy that supports, protects and maintains normality, with the midwife as the lead professional for healthy women with uncomplicated pregnancies and the obstetrician as lead carer for medically high risk women. Maternity services assess both health and social risks in respect of both mother and baby and as such can be the first service to identify vulnerable or at risk women and determine additional needs or refer for targeted support.

It is not clear what percentage of new mothers are socially vulnerable in Worcestershire however there are currently 4 Specialist Midwife posts in the county who offer additional support to very vulnerable pregnant women and provide supervision and support to the

community midwifery teams when dealing with vulnerable women. On average the specialist midwives receive 400-500 referrals each year which is about 8% of all births. This compares to 12.5% of births estimated from the PreView tool likely to need intensive preventive interventions. Most referrals are for domestic abuse, substance misuse, teenagers and where there is existing Children's social care involvement. In addition, they can deal with mothers with learning disabilities and support the perinatal mental health service with mothers with mental illness. It is not clear if the specialist midwife model provided in Worcestershire is evidence based or meeting potential need.

Maternity Pathway



In Worcestershire outcomes for maternity services are generally above average. The early booking rate (women booked before 13 weeks of pregnancy) is above the national average, however smoking in pregnancy rates are significantly high and breastfeeding initiation rates are below average.

Health Visiting

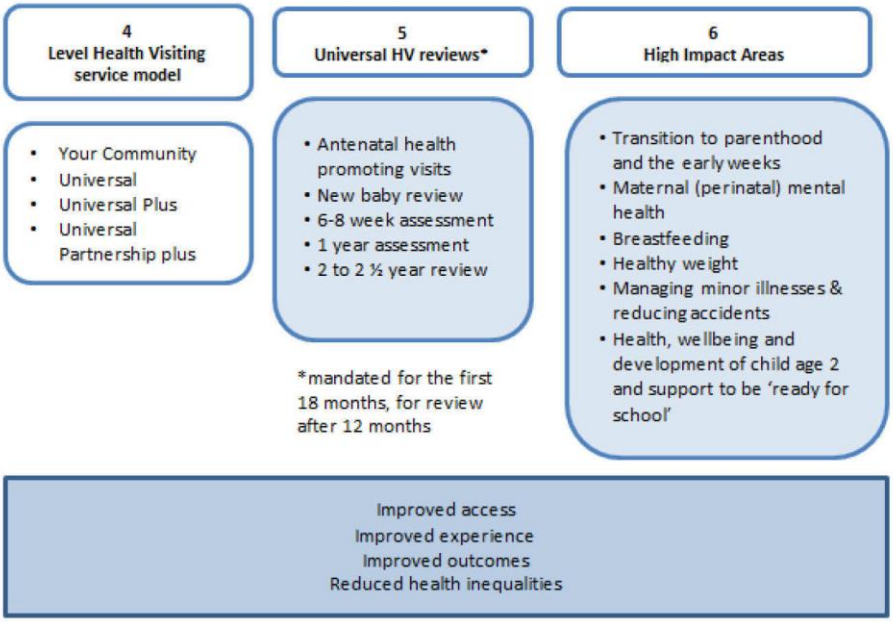
Health Visitors are qualified nurses and/or midwives who have undertaken a year of graduate or post graduate study and registered with the Nursing and Midwifery Council as Specialist Community Public Health Nurses. Health Visitors lead the local delivery of the Healthy Child Programme providing all families with crucial evidence-based support, expert advice and intervention in the first years of life as well as referring or directing them to other support services when required. Research has shown that the interventions of health visitors are effective – such as more relaxed mothering[5], improved mother-child interactions [6] or early identification of post-natal depression [7] – with long-term positive impacts on young children and their families.

Health Visiting Model

The delivery of the Health Visitor service is provided at 4 levels and includes the universal elements of the Healthy Child Programme:

- Community: health visitors have a broad knowledge of community needs and resources available e.g. Children's Centres and self-help groups and work to develop these and make sure families know about them.

- Universal: health visiting teams lead delivery of the HCP. They ensure that every new mother and child have access to a health visitor, receive development checks and receive good information about healthy start issues such as parenting and immunisation.
- Universal Plus: families can access timely, expert advice from a health visitor when they need it on specific issues such as postnatal depression, weaning or sleepless children.
- Universal Partnership Plus: health visitors provide ongoing support, playing a key role in bringing together relevant local services, to help families with continuing complex needs, for example where a child has a long-term condition.



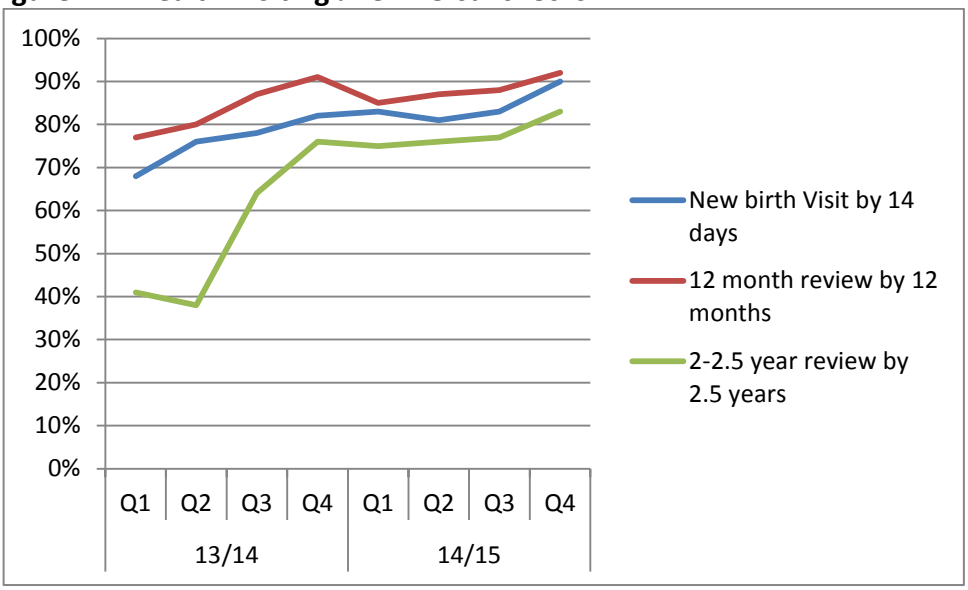
Health Visitors undertake 5 mandatory universal reviews/checks for all families; an antenatal review, a new baby review (10-14 days old), a 6-8 week check, an assessment at 1 year and a review around age 2.5 years. Evidence has identified 6 High Impact Areas where health visitors have a significant impact on health and improving health outcomes. These are:

• Transition to Parenthood and the Early Weeks
• Maternal Mental Health (Perinatal Depression)
• Breastfeeding (Initiation and Duration)
• Healthy Weight, Healthy Nutrition (to include Physical Activity)
• Managing Minor Illness and Reducing Accidents (Reducing Hospital Attendance/Admissions
• Health, Wellbeing and Development of the Child Age 2 – Two year old review (integrated review) and support to be 'ready for school'.

In Worcestershire there has been a 20% increase in Health Visiting numbers since 2011 in line with the national ambition. The responsibility for commissioning Health Visiting is transferring from the NHS to Local Authorities in October 2015 and in preparation the service has been moving supporting the registered population (families registered with Worcestershire GPs) to supporting the resident population to ensure coterminosity with other Local Authority services.

The Health Visiting service contributes to a number of key outcomes such as secure attachment, maternal mental health, breastfeeding, healthy weight and school readiness. The service has focussed in recent years on increasing universal coverage of the HCP mandated reviews/checks.

Figure 41 - Health Visiting % Universal checks



FNP

The Family Nurse Partnership programme (FNP) is an evidence-based, preventive public health home visiting programme for vulnerable first time young mothers aged 19 and under. Structured home visits, delivered by specially trained family nurses, are offered from early pregnancy until the child is two. FNP aims to improve pregnancy outcomes, child health and development and parents' economic self-sufficiency.

Evaluation of FNP has shown that it improves a range of health and development outcomes for vulnerable young mothers and their children in the short, medium and long term. Outcomes from US and Dutch trials of FNP include:

- Improved prenatal health
- Fewer childhood injuries
- Fewer subsequent pregnancies
- Greater intervals between births
- Increased maternal employment
- Improved school readiness

FNP is a licensed programme and so has a well-defined and detailed service model, which must be adhered to and includes a requirement that FNP should be funded until children on it reach the age of two. The purpose of the licence is to ensure that the programme is implemented so as to maximise the likelihood that good outcomes will be achieved. In Worcestershire an FNP for 100 places has been newly commissioned, funded by the NHS. The responsibility for commissioning FNP however is transferring to the Local Authority in October 2015.

School Nursing

School nurses are qualified nurses who hold an additional specialist public health qualification, which is recordable with the Nursing and Midwifery Council. School Nursing lead, coordinate and deliver the HCP (5-19) working with a number of partners including health and social care teams, teachers and youth workers to deliver the evidence based public health interventions as outlined in the HCP(5-19). The HCP (5-19) offers children and young people a schedule of health and development reviews, screening tests, immunisations, health promotion guidance and tailored support for children and families, with additional support when they need it most and aims to:

• Help parents develop and sustain a strong bond with children;
• Encourage care that keeps children healthy and safe;
• Protect children from serious disease, through screening and immunisation;
• Reduce childhood obesity by promoting healthy eating and physical activity;
• Identify health issues early, so support can be provided in a timely manner;
• Make sure children are prepared for and supported in education settings;
• Identify and help children, young people and families with problems that might affect their chances later in life.

School nursing ensure all children and young people receive the full service offer (HCP 5-19) the including universal access and early identification of complex needs from school entry, with timely access to specialist services. The school nursing service provides public health, social and emotional wellbeing and interventions at 4 levels.

- Community offer: to provide advice to all school-aged children and their families with the local community (5-19yrs), through maximising family support and the development of community resources with the involvement of community and voluntary resources.
- Universal offer: Working in partnership with children, young people and families to lead and deliver the healthy child programme (5-19) working with health visitors to programme a seamless transition upon school entry.
- Universal plus offer: to identify vulnerable children, young people and families, provide and co-ordinate tailored packages of support, including emotional health and wellbeing, safeguarding, children and young people at risk with poor outcomes and with additional or complex health needs
- Universal partnership plus offer: to work in partnership with partner agencies in the provision of intensive and multi-agency targeted packages of support where additional health needs are identified.

In Worcestershire, school nursing services were reviewed in 2013 to ensure delivery of the 4 levels of school nursing offer.

Evidence Review

Evidence for prevention and early intervention

There is evidence that if energy and resources were focused on effective preventive and early interventions that help to avoid or address challenges early in life or as problems

emerge this will improve outcomes for children and families and start to save resources quite quickly. Taking steps to prevent problems before they occur or deteriorate, as the Early Action Taskforce has argued, offers a 'triple dividend – thriving lives, costing less, contributing more'.[8] Spending on the early years of life should be seen as an investment which will yield returns in future. For every £1 spent on early years education, £7 has to be spent to have the same impact in adolescence. [9]A review into the economic case for investment suggests returns on investment on well-designed early years interventions significantly exceed their cost. UK Social Return on Investment studies showed returns of between £1.37 and £9.20 for every £1 invested in early years.[10] The benefits of early intervention are significantly higher than the costs, with rates of return on investment significantly higher than those obtained from many other sources of public and private investment.

Pregnancy

To get the best possible start in life, a baby's mother needs to be healthy before and during pregnancy and childbirth and be helped to make healthy choices during pregnancy. During pregnancy most women want to do 'the best for baby' and this heightened motivation can provide leverage for tackling unhealthy lifestyle choices and promoting healthy ones. However, a woman's social circumstances can constrain her from making healthy choices which may in turn be reflected in poorer outcomes of pregnancy and subsequent child development. Low birth weight in particular is associated with reduced child development [11] as well as poorer long-term health and educational outcomes [12] . Evidence suggests that maternal health is related to socioeconomic status [13], and that disadvantaged mothers are more likely to have babies of low birth weight [14]. Smoking, maternal stress, and a relative lack of pre-natal health care, maternal nutrition and maternal education have also been reported to be associated with low birth weight [15]. Effective measures to reduce risky behaviours such as smoking, drug and alcohol consumption during pregnancy can impact on low birth weight, reduce levels of foetal alcohol syndrome, improve child IQs and reduce levels of mental difficulty.

The effect of a mother's mental health on the subsequent health of her child is equally important as her physical health. Evidence shows that being brought up in poverty, having low self-esteem and feelings of being socially excluded affects maternal mental health and that this is associated with biological changes which can be transmitted to the foetus which in turn can adversely affect future child health and development [16]. Children born to mothers who experienced antenatal stress, anxiety or depression have more emotional difficulties, especially anxiety and depression, and symptoms of ADHD and conduct disorder than children born to non-stressed mothers [17]. These children also perform at a lower cognitive level. Stress, anxiety and depression during pregnancy are however frequently undetected and so not treated. Research indicates that about 10-20% of pregnant women suffer antenatal depression and anxiety, and that levels at 32 weeks of pregnancy are greater than postnatally. Evidence has demonstrated that targeting those exhibiting the 'warning' signs for postnatal depression (PND) in the ante-natal period has been shown to reduce the incidence/seriousness of depression following birth.

Certain behaviours, circumstances and events, if they occur during pregnancy, increase the risk of poor outcomes for either the pregnancy or future child health or both. Some of these

risk factors such as smoking, alcohol, drugs, obesity, and poor mental health can be prevented or modified. However many of these risk factors cluster together in certain groups of women suggesting that tackling them individually is inappropriate and a multi-faceted approach simultaneously tackling a range of risk factors within a social context is better. Evidence has shown that intensive targeted support for some vulnerable groups such as the Family Nurse Partnership can reduce risk factors and improve outcomes for these groups [18]. A number of studies suggest there can be an increased incidence of domestic violence during or shortly following pregnancy[19] which can be reduced or prevented if such risks are identified in pregnancy.

It is clear then that to give every child "the best start in life" priority should be given to interventions that reduce adverse outcomes of pregnancy within both universal and targeted services. Optimising maternal mental health during pregnancy needs to be given equal prominence to optimising maternal physical health as it is a major influence on future child development and outcomes. This may require review of and implementation of guidance in terms of identification, referral support, appropriate treatments and further education and training for those who work with pregnant women and new mothers. Social disadvantage appears to constrain a woman's ability to make healthy choices and results in inequalities in pregnancy outcomes. Tackling social disadvantage early in pregnancy through programmes such as FNP can lead to major improvements in child health.

Infancy & early years

What happens early in a baby's life, including in the first few weeks, affects its development and future outcomes. Research shows conception to age 2 is a crucial phase in developing solid psychological and neurological foundations and how we treat infants shapes their future lives[20]. Loving, secure and reliable relationships with parents, together with the quality of the home learning environment, foster a child's emotional and mental wellbeing; capacity to form and maintain positive relationships with others; language and brain development and their ability to learn[21]. As such the nature of the day-to-day relationship between the child and primary care giver is crucial. Parental mental health (before and after birth) and levels of secure attachment are key determinants of the quality of that relationship. Secure children are more resilient and are better able to regulate their emotions and development during the early years[22] and across the life span[23]. Insecurely attached children are more vulnerable and have poorer outcomes. It is suggested that around 35-40% of all parent-infant attachments are insecure and this is more prevalent amongst vulnerable and disadvantaged families[24]. Attachment evolves during the first and second years of life in response to early parenting. Evidence from longitudinal studies has demonstrated that securely attached children function better across a range of domains including emotional, social and behavioural adjustment, as well as peer-rated social status and school achievement[25], in addition to having better physical outcomes[26]. Toxic stress, which is characterised by the infant or toddler's prolonged exposure to severe stress that is not modulated by the primary caregiver, who may be experiencing a range of problems (e.g. poverty, mental health problems, domestic violence and substance/alcohol dependency), has been identified as having a significant impact on the young child's rapidly developing nervous system, development, health and wellbeing across the life span. Promoting early attachment and preventing and intervening early to address attachment issues through

universal assessment can then have an impact on resilience and physical, mental and socio-economic outcomes in later life.

Poor maternal mental health and well-being at age nine months and/or at three years is strongly associated with poor child behaviour at age five[27]. Maternal ill health is common and 10 per cent of mothers are reported to experience post-natal depression[28]. Children of mothers with mental health issues are twice as likely to experience a childhood psychiatric disorder themselves[29]. Post-natal depression and other forms of mental illness are linked to an increase in insecure attachment in toddlers, behavioural disturbance at home, less creative play and greater levels of disturbed or disruptive behaviour at primary school, poor peer relationships, and a decrease in self-control with an increase in aggression[30]. Approximately 8% of pregnant women will subsequently be emotionally ill enough to warrant a referral to a specialist perinatal mental health service. It is important then to ensure high quality universal assessment of maternal mental health, provision of preventive interventions and access to perinatal mental health support.

The early years are important in terms of building children's physical resilience. Optimal nutritional intake alongside the development of healthy eating and activity patterns have been identified as key to building resilience and protecting against later chronic diseases. Breastfeeding, for example, protects children from a range of later problems including reducing the risk of ear and lung infections, asthma, obesity and diabetes, sudden infant death syndrome (SIDS), dermatitis, gastrointestinal disorders and leukaemia[31], and may also have an impact on neurodevelopmental outcomes including intelligence[32]. Recent research also shows that many children consume inappropriate foods during the preschool years, many of which are introduced during infancy, and which are in excess of their energy requirements[33]. In addition pre-school children are less physically active than previously and some 3 year olds already have a predominantly sedentary lifestyle. There is consensus that addressing feeding styles, activity levels and parental practices in early life influences later weight status and health outcomes and there are benefits in intervening to prevent the development of obesity in infants and toddlers. Health visitors and early years education workers have a key role, particularly in terms of supporting parents to provide the optimal nutritional intake and enhancing physical activity during the preschool years.

Parenting influences child development, health and wellbeing and children's early socio-emotional development. Positive, proactive parenting (e.g. involving praise, encouragement and affection) is strongly associated with high child self-esteem and social and academic competence[34], and is protective against later disruptive behaviour and substance misuse[35]. Whereas harsh, inconsistent discipline, little positive parental involvement with the child, and poor monitoring and supervision is associated with later child antisocial behaviour[36]. Parental sensitivity, engagement and verbal stimulation in interaction have also been shown to be important in terms of early speech, language and learning but this is likely to be compromised in parents who are poor, less educated and know less about parenting[37]. The factors which influence a parent's capacity to parent are poverty, low income, low maternal education, young maternal age, family size, social support, partner support as well as impacts of mental health, substance misuse and domestic violence.

A range of methods have been identified that help parents and improve parenting capability. The Healthy Child Programme recommends the provision of methods of supporting early parenting (e.g. skin-to-skin care and infant carriers) and the use of universal-level services to identify families who are in need of additional support, using techniques such as ante and postnatal promotional interviews[38]. It also recommends the use of a range of targeted methods of working to promote early attachment and positive parenting methods more generally. A review of attachment-based interventions that focus on changing parental behaviours and capacity has shown that they are effective in improving parental sensitivity and infant attachment security[39]. There is also consistently strong evidence to support the use of interventions such as home visiting programmes (e.g. FNP) during the perinatal period. Brief, group-based parenting programmes that are focused on enabling parents to support their children's growing independence using positive methods of discipline and good supervision have been shown to be effective in the short term in improving both parental psychosocial functioning[40] and the emotional and behavioural adjustment of young children[41]. There is then evidence of a range of parenting programmes designed for families with children of a particular age are effective if delivered in accordance with the evidence based model.

The preschool years are as such an optimal time for the development of early receptive and expressive language skills, and recent research suggests that the age of functional language acquisition impacts on not only later reading and language behaviour, but also the 'corresponding neurocircuitry that supports linguistic function into the school-age years'[42]. There is however a wide disparity in children's exposure to words across socio-economic groups during the first three years of life where children from professional families are exposed to twice as many words as welfare families. Early exposure to language-rich environments and reading schemes at home and in early years settings have been shown to enhance language development[43]. A number of longitudinal studies have also shown that early cognitive ability influences later educational outcomes, with evidence to suggest that assessments of ability at 22 and 42 months predict educational outcomes at age 26 years[44]. To reduce inequalities in language and cognitive development there is evidence about the importance of intensive early intervention to address the quality of the home learning environment and early preschool education, particularly for children living in socio-economically deprived circumstances[45].

Good quality early childhood education and care can help to address inequalities in life chances. Marmot indicated that effective multi-agency practice to address social determinants of health was key to improving outcomes. Children in families which suffer a number of different disadvantages and risk factors have varied patterns of problems and services need to be flexible enough to support them without passing them to lots of different agencies. Children's centres provide access to a wide range of services including family and employment support, and help with housing and financial problems. Evidence also suggests that early intervention by midwives or other health engagement at children's centres can lead to a direct reduction in young children's risk of poor outcomes[46]. Evidence suggests areas should develop effective multiagency, integrated working and delivery to ensure all services are working together, sharing information and developing whole system approaches[47]. There are good examples of where Children's centres are providing integrated services (e.g. Brighton & Hove, Burnley) with Health Visiting leading or supervising teams.

Evaluation of the original Sure Start Local Programmes (SSLPs) showed they had successfully engaged the most vulnerable groups in the most deprived areas, though it often took considerable time to encourage vulnerable families to engage with services[48]. The early SSLPs had beneficial effects on parenting which persisted until the children were age 7 in all areas regardless of level of deprivation, and to all children and families regardless of family deprivation. However, the evaluation found no evidence of sustained beneficial impact on child outcomes. A further evaluation identified that whilst most of the children's centres provided a range of evidence-based programmes[49], they were not always applied with fidelity to the model and many were providing non evidence based programmes suggesting. Centres need to approach the provision of evidence-based support very rigorously to drive measureable improvements in outcomes. The latest Oxford evaluation of 30% most deprived identified (June 2015) a move from less universal to more targeted delivery, fewer numbers going through evidence based programmes, that centres were still providing non-evidence based programmes and ongoing issues of model fidelity. However, research indicates that Children's Centres should prioritise high quality outreach and family support to work with the most vulnerable families giving emphasis to evidence based programmes and interventions around parenting and social and emotional and language development.

School Years

Marmot identified that the impact of investment in the pre-school years is likely to evaporate unless it is sustained through school, particularly through the years of primary education. Children who fail to acquire basic skills in the primary years are likely to fall further behind, as success in later stages of education relies on literacy and numeracy as well as on non-cognitive life skills. The strength of this evidence supports the argument that priority should be given to early cognitive and non-cognitive development, starting in the early years and continuing through childhood. It is crucial that effective early programmes are followed through with effective provision in the primary years: even the most effective early years interventions can be 'washed out' by poor quality primary education. Families assessed as in need of progressively intensive support in the early years should continue to be provided with help throughout the transition to school.

Rather than focus on single risk factors or issues, evidence has shown it is better to equip children to deal with life stressors by focusing on building their social and emotional skills to promote resilience[50]. Strengthening protective factors or assets in schools, in the home and in local communities can make an important contribution to reducing risk for those who are vulnerable and in so doing promote their chances of leading healthy and successful lives[51]. Families and parents dynamically impact on a child's life chances, emotional wellbeing and outcomes. In particular the quality of parental engagement and the differing levels of support offered by parents influences both positive mental health and educational attainment [52]. Overall, studies of family communication and parenting highlight a component critical to the establishment of resilience in childhood, that of having access to at least one supportive, caring adult. There is evidence that structured parenting programmes can assist parents in providing a supportive and caring relationship and a structured home environment;[53] for example, The Incredible Years group programme or the Triple P stepped approach, both based on social learning theory, aim to improve child–parent interaction.

School can be an important driver of resilience by providing children with the learning opportunities and competencies to develop a positive identity and healthy behaviours, as well as the skills that enable successful negotiation of life challenges. There appears to be a strong association between a sense of belonging to school and resilience[54]. School connectedness appears to be generated in schools through extra-curricular activities, positive classroom management and tolerant disciplinary polices.[55] PSHE at school is an important part of the way in which schools can contribute to improving resilience and health among children, however the quality of PSHE input and teaching experienced by children and young people appears to be highly variable[56]. The contribution of schools to developing resilience and enhancing wellbeing as a component of the curriculum is grounded in an extensive evidence base (e.g. Healthy Schools, SEAL whole school initiatives).

Success in learning at school is rooted in the stimulation and encouragement a child receives at home, in the family and in the community. Where parents have not gained these skills themselves, disadvantage is passed from one generation to another. School based interventions need to be linked to work with parents, the family and the community, with an emphasis on enabling parents to support their child's cognitive development and life skills. Success at school is rooted in the stimulation and encouragement a child receives at home and in the community. School-based interventions need to link better with families and communities.

Regular participation in physical activity offers children and young people an array of positive health and social benefits, impacting not only on physiological health and development, but also on psychological and social wellbeing; for example, participation in sporting activities has been associated with reductions in social anxiety among primary school children. Despite the positive benefits of physical activity, over the last decade studies have consistently identified that few children and young people achieve the guideline for physical activity of one hour of moderate-to-vigorous physical activity every day[57]. However physical activity programmes in schools can have positive influences on cognitive performance, with demonstrable positive results in academic attainment, concentration, memory and classroom behaviour[58]. Physical activity undertaken as part of leisure time provides opportunities for children to build positive personal attributes such as self-esteem and self-confidence. In addition, only about a quarter of children are likely to eat the recommended five portions of fruit and vegetables a day, and their diets tend to contain high levels of energy-dense foods and sugar. A multifactorial whole-school approach to healthy eating has been associated with having a positive impact on improving the diet of children in schools[59].

School nurses are well placed to adopt a leadership role in the promotion of resilience and health and emotional wellbeing among the school-aged population. There is some evidence suggesting that they are perceived by young people as offering authoritative and credible information[60], however, the evidence base relating to the impact of school nurses on the health of the school aged population is small and relatively weak.
A recent review published demonstrates there is a closer link than previously thought between the health and well-being of children and their education attainment. For example, pupils with better emotional wellbeing at age seven had a value-added key stage 2 score 2.46 points higher than pupils with poorer emotional wellbeing.[61]

Adolescence

Science has shown there is a period of rapid brain development during early adolescence, and that brain development continues into the early 20s if not beyond. Areas that develop rapidly are those dealing with social relationships, with taking risks and with controlling feelings and emotions. This helps understand why adolescents are particularly vulnerable to peer influences and why there appears to be a 'window of vulnerability' to risky behaviours around ages 14 to 17 years, particularly in the presence of peers[62]. Adolescence is the most significant period in the life course for the initiation of a wide range of behaviours that are associated with the largest health burdens in adult life such as smoking, alcohol and cannabis. Once initiated, these behaviours track strongly into adult life, highlighting the importance of intervention in adolescence to prevent health burden[63]. Health risk behaviours and mental and physical health problems co-occur in adolescence to a greater degree than in adulthood: common factors such as deprivation, poor parental connection, low self-esteem and poor mental health are responsible for a range of exploratory behaviours [64].

The major transitions and developmental changes occurring during adolescence make the teenage years a time of immense potential for preventive interventions and building resilience in young people. Common interventions and approaches should be used to prevent or reduce substance use, improve sexual health, reduce injuries and improve mental health, focusing on common risk factors across behaviours/problems. Evidence has shown that building resilience amongst young people is effective. Resilience can be built through a focus on identifying and supporting healthy relationships, building strengths and life skills, reducing NEETs, providing integrated age appropriate young person friendly provision[65].

The best approach to reducing NEETs is to prevent them from becoming NEET in the first place. In order to achieve this, local authorities' work with schools to identify and support children at risk of becoming NEET (RONI) is important.[66] This includes: recognising achievements in general skills and those that increase employability, managing transitions and supporting children and young people between educational stages, minimising or preventing permanent exclusions, and protecting and enhancing children and young people's mental wellbeing. These actions should be available for all children (universal), but targeted proportionately more towards those in greater need of support.[67] The evidence suggests successful strategies to reduce NEET, particularly those aged 16-18, requires early help, tracking those at risk of NEET (RONI) and monitoring their progress, working across organisational and geographical boundaries and working with local employers. To re-engage NEETs, barriers and obstacles such as housing problems, debt, physical and mental health issues, and relationship concerns should be addressed.

Parenting

The quality of parenting affects children's long-term physical, emotional, social and educational outcomes and therefore differences in parenting between social groups have implications for outcomes. Positive, warm parenting, with firm boundaries and routines, supports social and emotional development and reduces behavioural problems. There is evidence that a range of parenting programmes designed for families with children of a particular age are effective. However, to improve outcomes and reduce health inequalities,

the commissioning of parenting programmes should be part of a wider local system of measures to support parents.[68] For example the UCL Institute of Health Equity evidence briefing identified the following wider interventions that support good parenting:

Better living conditions for families
1. More parents economically secure, including in pregnancy.
2. More parents free from domestic violence.

Better wellbeing for mothers
3. More parents with good mental health, including in pregnancy.
4. Fewer women who smoke, drink and take drugs during pregnancy.
5. Fewer obese mothers.
6. More women breastfeeding.

Good parenting actions
7. More children with secure attachment – more parents engaging positively with, and actively listening to, their children.
8. An increase in the number and frequency of parents regularly talking to their children using a wide range of sentence structures and reading to their children every day.
9. More parents setting and reinforcing boundaries.

Improved outcomes for children
10. Improved cognitive, social and emotional, language and physical health outcomes

The evidence base around parenting programmes is broad and many different programmes have been found to be effective. Rather than advocating individual programmes, the literature instead promotes particular approaches. In general, successful parenting programmes need to have:

- a defined focus on the parent-infant relationship
- fidelity to model (e.g. consistency and quality of delivery)
- clarity on the programme purpose and expectations
- clarity on who the programmes are for, with appropriate targeting
- attention on recruitment and retention of parents
- good staff in terms of skills, training and their ability to have on-going relationship with parents
- a theoretical basis
- good communication and liaison with stakeholders; and must also
- avoid the use of stigmatising language and labelling.

The literature is divided on the benefits of universal vs. targeted care. Whilst universal programmes are beneficial for improving parenting in the general population, minimising stigma and identifying families most at risk; targeted programmes are better for those with identified needs such as teenage parents, abusive parenting and parenting and parenting in families with mental illness and drug and alcohol misuse. It is suggested that a combination of both universal and targeted approaches is likely to be most effective (Stewart-Brown & Schrader-McMillan 2010). The Marmot Review (2010) advocates the use of a proportionate universalism approach; focussing on those with the most disadvantage would not reduce health inequalities sufficiently, instead actions should be universal, but with a scale and intensity that is proportionate to the level of disadvantage.

Many parenting programmes, which have shown positive evaluation results, can be delivered at different stages of a child's development. These programmes are designed to involve work with parents, teachers and children. An analysis of specific parenting programmes and their applicability to the Worcestershire context can be found in Appendix 1.

Mental health

ONS surveys have shown that nationally 10% of 5-15 year olds have a clinically diagnosable mental disorder. The most common problems are conduct disorders, attention deficit hyperactivity disorder (ADHD), emotional disorders (anxiety and depression) and autism spectrum disorders. Mental health problems in children and young people can be long-lasting. It is known that 50% of mental illness in adult life starts before age 15 and 75% by age 18. There are strong links between mental health problems in children and young people and social disadvantage, with those from poorest households three times more likely to have a mental health problem than those from better-off homes.[69] Parental mental illness is associated with increased rates of mental health problems in children and young people, with an estimated one-third to two-thirds of children and young people whose parents have a mental health problem experiencing difficulties themselves.[70] Mental health problems in children and young people are associated with excess costs estimated as being between £11,030 and £59,130 annually per child [71] which fall to a variety of agencies (e.g. education, social services and youth justice).

There are clinically proven and cost-effective interventions. The following preventive and early interventions have been identified:

- the detection and treatment of postnatal depression (e.g. group cognitive behavioural therapy and individual counselling for depression of perinatally identified cases) , improving relationship quality in the first year of life (e.g. video feedback interactive programmes)
- pre-school curricula to enhance children's readiness for school, in particular skills in language and literacy (e.g. Early Literacy and Learning Model)
- parenting group programmes to improve children's behaviour (e.g. Incredible Years)
- parent and child therapy programmes to improve children's relationships with their parents/carers (e.g. parent–child interaction therapy)
- home-visiting programmes to improve children's relationships with their parents/carers (e.g. Nurse- Family Partnership)
- intensive child and family support programmes to improve behaviour and children's relationships with their parents/carers (e.g. multidimensional treatment foster care).
- specific child maltreatment prevention programmes based on family therapy and social learning principles which achieve increased maternal educational attainment and parent involvement in school as well as decreased family problems [72]

Up to the age of 11, conduct disorders are best treated through modification of parenting practices. Parent training delivered in group formats is more cost effective. In more severe cases of conduct disorder, parent– child interaction therapy, which helps parents to modify their behaviour with their child in real time, is efficacious. The key factor is improving positive parenting. Interventions tend to be less effective for those aged over 12. However,

Multisystemic therapy, brief strategic family therapy and functional family therapy appear effective for moderate-to-severe cases. There are effective treatments for depression in children and young people. Cognitive behavioural therapy for depression has been shown to be effective in both individual and group settings, but is most likely to be helpful in the acute phase of the disorder and in individuals who are motivated. Interpersonal psychotherapy and family therapy are also effective.

The report of the recent Children and Young People's Mental Health and Wellbeing Taskforce, Future in Mind, places the emphasis on building resilience, promoting good mental health, prevention and early intervention and ensuring timely access to clinically effective mental health support when needed. [73] The report recommends promoting good mental wellbeing and resilience, by supporting children and young people and their families to adopt and maintain behaviours that support good mental health; preventing mental health problems from arising, by taking early action with children, young people and parents who may be at greater risk; early identification of need, so that children and young people are supported as soon as problems arise to prevent more serious problems developing wherever possible. The report highlights the need to invest in promotion of maternal mental health during and post pregnancy and to strengthen attachment, intervene early with evidence-based parenting programmes for children with behavioural problems, universal services to deliver mental health promotion and prevention activities through building resilience particularly in schools and to harness the power of digital technology to promote resilience and self help.

The evidence regarding the screening efficacy of the Child Behavioural Checklist and the Strengths and Difficulties Questionnaire supports the continued use of these for identifying behavioural and mental health problems. [74]

Evidence of prevention and early intervention for those identified "at risk" or those where problems have emerged

Pregnancy – NICE Clinical Guidance 110 identifies evidence and best practice for additional care and support during pregnancy of pregnant women with complex social problems including poverty, substance misuse, migrants and refugees, women under 20 years old and women suffering domestic violence. It sets out issues to consider in service organisation, training of staff and delivery of care.[75]

Early Years - NICE Public Health guidance on the social and emotional wellbeing of vulnerable children aged under 5 years. The term 'vulnerable' is used to describe children who are at risk of, or who are already experiencing, social and emotional problems and need additional support. The guidance recommends intensive antenatal and post natal home visiting for vulnerable children and their families, high quality early education and childcare, provision of targeted and outreach services embedded into a universal service and a focus on social and emotional well-being to offset the risks relating to disadvantage. [76]

School age - NICE Public Health guidance for primary school aged children (all educational settings serving children aged 4–11 years) recommends safe, nurturing environments, prevention of bullying and development of social and emotional skills integrated into

curricula and delivered by trained staff supported by specialist skills as needed. Primary schools should help parents develop their parenting skills.[77] The guidance specifically states:

- Local authorities should ensure primary schools provide an emotionally secure environment that prevents bullying and provides help and support for children (and their families) who may have problems.
- Schools should have a programme to help develop all children's emotional and social wellbeing. It should be integrated it into all aspects of the curriculum and staff should be trained to deliver it effectively.
- Schools should also plan activities to help children develop social and emotional skills and wellbeing, and to help parents develop their parenting skills.
- Schools and local authorities should make sure teachers and other staff are trained to identify when children at school show signs of anxiety or social and emotional problems. They should be able to discuss the problems with parents and carers and develop a plan to deal with them, involving specialists where needed. Those at higher risk of these problems include looked after children, those in families where there is instability or conflict and those who have had a bereavement.

Adolescence - NICE's formal guidance on promoting the social and emotional wellbeing of young people in secondary education focuses on interventions to support all young people aged 11-19 who attend any education establishment. Social and emotional wellbeing includes being happy, confident and in control, with the ability to solve and cope with problems and have good relationships with other people.[78] Six recommendations cover: strategy, the key principles and conditions, working in partnership with parents, families and young people, the curriculum, and training and professional development. They include:

- Secondary education establishments should have access to the specialist skills, advice and support they require.
- Practitioners should have the knowledge, understanding and skills they need to develop young people's social and emotional wellbeing.
- Secondary education establishments should provide a safe environment which nurtures and encourages young people's sense of self-worth, reduces the threat of bullying and violence and promotes positive behaviour.
- Social and emotional skills education should be tailored to the developmental needs of young people.

Parenting - Group based parenting programmes for children of all ages with and without behaviour problems have been found to improve the short term psychosocial wellbeing of parents.[79] Both Triple P [80]and Incredible Years parenting programmes appear to be effective.[81] There is also support for classroom based emotional and problem solving programmes for children 3-7 years old in schools where a high proportion are at risk of developing behaviour and conduct problems.[82] Parenting programmes can be effective for conduct disorders. NICE clinical guidance 158 provides guidance for the recognition, intervention and management guidance for anti-social behaviour and conduct disorders. The guidance suggests to offer group parent training programme to parents of children between 3-11yrs who are at high risk of developing oppositional defiant disorder or conduct disorder, have oppositional defiant disorder or conduct disorder or are in contact with the criminal justice system because of anti-social behaviour. Offer a group foster carer/guardian training programme to children between 3-11yrs who are at high risk of developing oppositional

defiant disorder or conduct disorder, have oppositional defiant disorder or conduct disorder are in contact with the criminal justice system because of anti-social behaviour. Offer group social and cognitive problem solving programmes to children and young people between 9-14yrs who are at high risk of developing oppositional defiant disorder or conduct disorder, have oppositional defiant disorder or conduct disorder are in contact with the criminal justice system because of anti-social behaviour. Offer multi-modal interventions e.g. MST to C&YP between 11&17 yrs. for the treatment of conduct disorder. The guidance sets out what these programmes should consist of. Offer classroom based emotional & problem solving programmes for children 3-7yrs in schools where high proportion of children are at risk of developing oppositional defiant disorder or conduct disorder.[83]

Assessments of specific evidence based interventions

A variety of organisations and publications have addressed what works in terms of evidence based prevention and early intervention programmes for children, young people and families. In 2011, the Allen review [3] assessed interventions for effectiveness and impact and recommended that the top 19 interventions should be supported. The Social Research Unit at Dartington launched a website in 2013, "Investing in Children" which lists interventions that focus on the health, educational attainment, emotional well-being, behaviour and relationships of children aged 0-22 years evidence of what works in designing and delivering services for children and their families. [84]Their assessment of whether programmes work is based on standards of evidence that focus, respectively, on what the programme is, how it has been evaluated, what the evaluations show in terms of impact, and whether the programme is ready for implementation in public service systems. Programmes that meet the standards are badged as 'Blueprints approved'. The Early Intervention Foundation have more recently provided an online early intervention guidebook and library of 50 programmes for what works for children and for commissioners, identifying the level of evidence for each programme.[85]

Evidence of effectiveness of Early Help Services

Ofsted undertook a thematic inspection to evaluate the effectiveness of the early help services for children and families provided by local authorities and their partners in 12 LAs (March 15). [86]They found in all the local authority areas visited, arrangements were in place to provide early help to children and their families. Partner agencies in those places inspected were committed to an early help approach and improving the coordination of the local early help offer. However, opportunities to provide early help for children and their families were missed by all statutory partners with a responsibility for this. Many assessments were ineffective because they failed to sufficiently analyse or focus on what the child and family needed. Professionals did not always identify or meet the individual needs of children within a family. Early help plans did not focus sufficiently on the child, often lacked clear objectives, failed to specify what needed to change and were not regularly or robustly reviewed. Management oversight of early help was often underdeveloped and failed to identify or rectify weaknesses in the work being undertaken. When children were referred to social care services because there were concerns about their welfare, the service or referrer often did not consider or follow through the need for early help. As a result, nothing was put in place to prevent the child's circumstances from deteriorating. This led to further referrals for statutory social care support. Too often, feedback on referrals was neither sought nor offered. Partner agencies did not fully evaluate the impact and

effectiveness of their early help services. The planning of local services did not sufficiently recognise or address the needs of children living with parental substance misuse, mental ill health or domestic abuse. LSCBs were not effectively overseeing or challenging partner agencies with regard to effective early help.

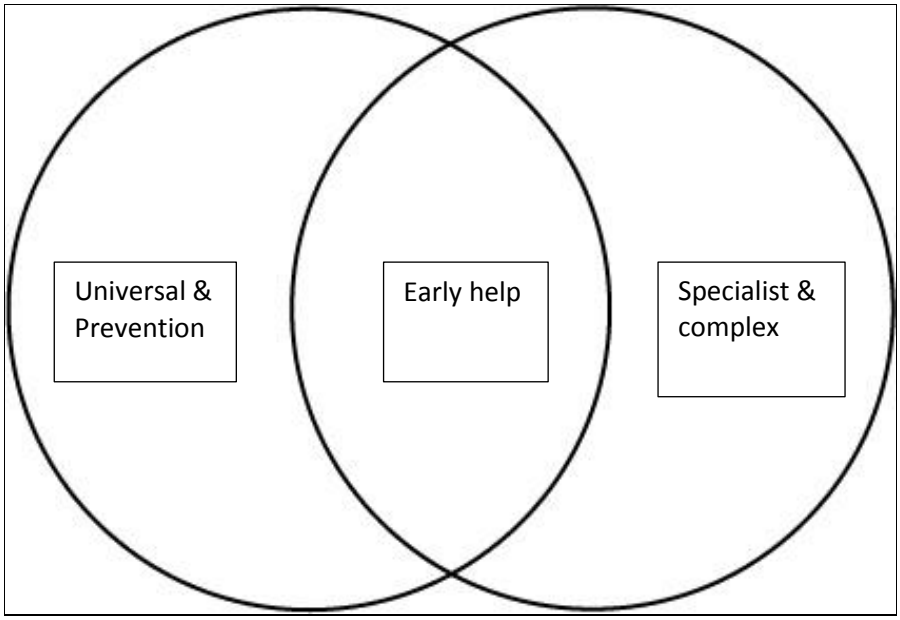
The report concluded that the current statutory framework does not give sufficient clarity and priority to the roles and responsibilities of individual agencies for early help provision. They recommended Local authorities and partner agencies delivering early help to children and families should improve the quality and consistency of assessment and plans by:

- promoting the use of evidence- and research-informed assessment practice
- improving the quality of analysis in assessments
- ensuring that assessments reflect the views and experience of the child and family
- making the purpose clearer and improving the intended outcome
- ensuring plans are regularly reviewed and that these reviews evaluate the child's and family's progress
- provide professional supervision to all staff delivering early help and ensure that their work receives regular management oversight, particularly in respect of decisions about whether families need more formal help
- ensure that all early help professionals have access to effective training
- ensure that children's needs for early help arising from parental substance misuse, mental ill health and domestic abuse are addressed in commissioning plans.

Models of Early Help

Effective early help can be provided for children and young people identified as being vulnerable or at risk of poorer outcomes or for emerging problems particularly around the family. Any model of early help should address a continuum of needs from universal to complex. A range of services and support are required universally (provided to all) increasing in complexity and intensity in accordance with need with clear pathways into specialist or complex services when required.

Figure 42 – Model of Early Help



A review of models elsewhere identifies that an integrated model appears to be effective. Most effective are whole system integration rather than integration of services. Examples are available from other areas where health, local authority (Children's Centre professionals and social care professionals) and VCS are co-located and have implemented integrated pathways. (See technical appendix). The key appears to be the supervisory function from a lead professional (health or social care professional), the appropriate sharing of information and risk assessments and the full consistent implementation of integrated pathways and a suite of evidence based interventions.

Manchester model

In response to the 40% of children who are not "school ready" and the late intervention costs this causes, Greater Manchester have implemented an Early Years New Delivery Model (EYNDM), a whole system shift from dealing with the symptoms of failure, to investing in preventative and early intervention services. The vision was to move from fragmented services that can miss the wider factors influencing a child's development, to a 'whole child' and 'whole family' approach. From multiple separate assessments, to an integrated and progressive series of assessments timed around crucial child development milestones. From funding a wide variety of programmes which often have a weak evidence base, to funding interventions that are proven to be effective and good value for money. From the most vulnerable and disadvantaged families being allowed to slip through the net, to services that reach out and provide additional support where necessary. From a system where all the obligations are on the State, to one that recognises that parents need to have both rights and obligations, promoting children's development as a shared responsibility.[87]

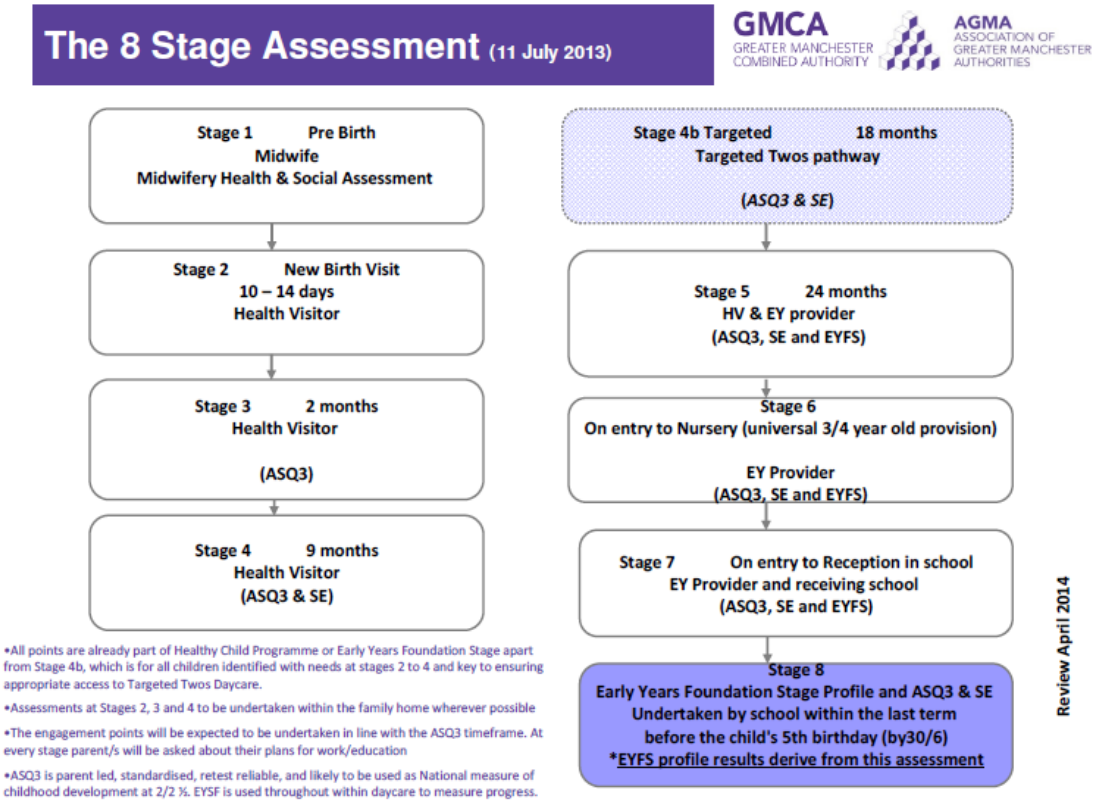
The key features of the EYNDM include:

- A shared outcomes framework, across all local partners;
- A common assessment pathway across Greater Manchester: eight common assessment points for an integrated ('whole child' and 'whole family') assessment at key points;
- Evidence-based assessment tools;
- A suite of evidence-based interventions, to be sequenced alongside other public sector interventions as a package of transformational support to families;
- Ensuring better use of day-care, new parental 'contract' to support parents eligible for targeted two-year-old day-care to engage in sustainable employment;
- A new workforce approach, to drive a shift in culture: enabling frontline professionals to work in a more integrated way in support of the 'whole family';
- Better data systems to ensure the lead professional undertaking each assessment has access to the relevant data, to reduce duplication and to track children's progress; and
- Long-term evaluation to ensure families' needs are being addressed and add to national evidence for effective early intervention.

The central aim is to move from multiple non-evidence based assessments, to a progressive series integrated and centred around crucial child development milestones that identify needs early. The model is based on integrated working between midwives, health visitors,

schools and other early help professionals and is structured around assessment at eight key stages in a child's life. It includes most of the requirements of the Healthy Child Programme and uses the Ages and Stages Questionnaire 3 and social and emotional (ASQ-3/ASQ-SE) as the main assessment tool. The eight stage assessments are used as trigger points for evidence based interventions through a whole family approach, supported by assertive outreach.

Figure 43 – Greater Manchester NDM assessments



At each assessment evidence based screening tools are used by all staff for both universal (e.g. Newborn behaviour observation, ASQ3, EPND) and targeted assessments (Neo-natal behaviour assessment scale, CAF, Beck Anxiety/Depression). Where assessment at any point indicates the need for additional targeted support, this is followed up by offering evidence based interventions through a whole family approach and supported by assertive outreach from early years professionals. A suite of evidence based interventions have been commissioned for example universal; HCP, Children's centres, Solihull approach, ECAT and for targeted interventions; FNP, Incredible Years, Triple P, Communication & language groups, targeted 2s day-care. The core pathways are: parent infant attachment; parental mental health; communication and language; social, emotional and behavioural; employment and skills; young parents; special needs and disability; maternal health in pregnancy; domestic abuse; and drugs and alcohol. The EYNDM has required additional investment in the early years, particularly in the first 5 years, however this invest to save case has been modelled to provide substantial longer term savings to Local Authorities and other public sector agencies from the population shift in school readiness and increase in parental employment.

There are other various models or degrees of integration. These range from coordination of services around the individual, collaboration or co-location between different teams or organisations, and large-scale integrated commissioning for a population. A Locality integrated early help hub is a community based model emerging in a number of areas, combining all relevant agencies in multidisciplinary team under the auspices of a locality manager. These provide suitable, accessible community-based facilities, some co-located, and others forming a wider 'virtual' team. All the interventions are focussed on improving outcomes for families experiencing difficulties leading to a positive impact on the communities they live in too.

For example in Brighton and Hove the entire health visiting service for the city has been seconded into the council through a Section 75 agreement, and they work as an integral part of the children's centres service. The integrated children's centre teams are led by health visitors who supervise outreach workers. In addition, there are specialist city-wide teams offering specific support, for example, breastfeeding coordinators to encourage initiation and sustain breastfeeding in areas of the city where this is low. Traveller and asylum seeker families are supported by a specialist health visitor and early years visitor post. A Citywide Family Nurse Partnership Programme is also managed as part of the service. This model is believed to have delivered value for money, effective use of resources, and safe, evidenced-based health care delivery.

Swindon Health visitors, speech and language therapists, school nurses and family nurse practitioners are fully integrated in Early Help (EH) teams (consisting of educational welfare, educational psychology, targeted mental health, youth engagement workers and Families First) within the LA in a single directorate together with social care. One senior management team is in place and it operates across Early Help and social care. This process began in 2008, with health staff being subject to Transfer of Undertakings (TUPE) into the LA in 2011.
The benefits of having achieved integrated teams were described as being worth the challenges and time involved in developing this model.

Children's centres are vital to the delivery of integrated services, often providing the base for the delivery of services and location of staff. Islington has an integrated model with its 16 children's centres playing a central role. The 16 children's centres are contracted through Service Level Agreements (SLAs) to a mix of providers that includes the LA, schools and the voluntary and community sectors. A key feature has been to support the centres to have well-qualified staff: all have at least one qualified teacher and the majority are also led by teachers. Most of the family support and outreach area managers (FSOAMs) have a social work qualification, and the family support and outreach workers and nursery staff are qualified to at least Level 3. Each children's centre has its own nursery and up to one third of the early education and childcare places are offered through a priority referral system for children identified by a range of professionals as having particular risk factors. Most of the other places are offered with subsidised childcare, based on income bands, in order to provide affordable childcare and encourage a mixed community within the setting. A key feature in Islington is priority given to the development of early years staff, with many Children's Centre heads and Family Support Outreach Area Managers having completed the National Professional Qualification in Integrated Centre Leadership.

Solihull Children's Centres have changed. From October 1 2015 Children's Centre services and activities will become part of the new 'Early Help' system in Solihull. The new system is for children and young people aged 0-19 and their families. To use resources more efficiently, Solihull has reduced their children's centres from 14 to 4 located within those areas of greatest need with other early childhood services being provided in other community venues across the Borough . The remaining children's centres have integrated with wider health, learning and care services. The aim is to secure more targeted support for families that need extra help, and to support local people to lead and run community services for under fives.

The EIF have identified some of the common and more emerging features of integrated models as summarised in table 12 below. [88]

Table 12: Features of integrated models

Common features of an integrated model	Promising features of integrated services still at an early stage of development
• A single common method of assessing needs used by all early years practitioners. • An early help 'assessment hub' where all data and information is shared and assessment or referrals are made using a common assessment of needs. • Reconfiguration of delivery structures, such as multidisciplinary locality teams • Consistent use of Early Intervention Programmes by all early years practitioners. • Multidisciplinary/agency support packages.	• A consistent approach to assessment used by all early years professionals (integrated universal assessment pathway). • Integrated pathways for targeted Early Intervention Programmes support. • Workforce development, new early years support roles.

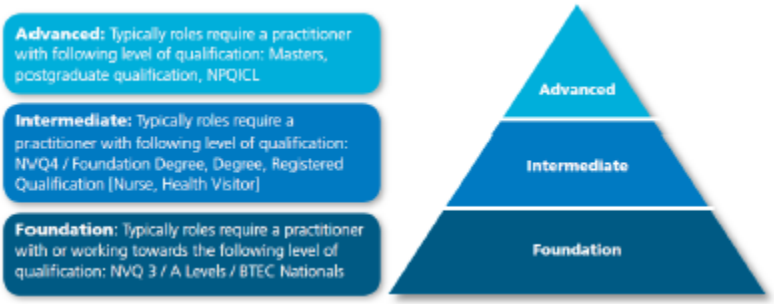
A commonly used approach to a single assessment of need is to have a multi-agency panel or meeting where the assessments are discussed. Examples of these are:
Hertfordshire has a 'Team Matters' meeting, where relevant professionals come together to discuss the CAF and agree support
Westminster Council reviews families of concern at a monthly meeting between health and children's centres, including cases picked up by the two-year development review
Warwickshire has a weekly 'Family Matters' multi-agency meeting at children's centres where there are regular discussions about families with a CAF, Child in Need or Child Protection Plan. Packages of support for families are also discussed.

A number of areas have developed, or are developing, a 'Single Point of Access' for professionals to refer a child with an identified need or to ask advice. This concept is a common approach although precise models vary. Some provide information hubs and are able to signpost to services, whereas others are part of the delivery model for Early Intervention. Essex has established an Early Help Hub, which covers all ages and supports

activities responding to needs classed as level 2 and level 3. Information, advice and guidance are available to advise practitioners on available services and offers an opportunity to discuss the best course of action including signposting to relevant support. Swindon has also set up a Family Contact Point, which offers a single point of advice for people who have any queries about children and families. A health visitor is always present to help deal with enquiries.

There is a wide range of practitioners and volunteers that work in universal and early help provision with a diverse skill set that need to be used to best effect. Leeds City Council has looked at identifying the workforce required to support the needs of local families. They mapped family needs against workforce competences and skills, and identified the future desired workforce that is now supported by a competency training framework. Leeds have moved to an integrated service model and pathway based on evidence and local needs. To support the delivery of the model steps were taken to integrate the workforce through development of a shared framework used by all professionals. External facilitators brought together managers, practitioners and professionals from each agency in a series of workshops. Delegates were asked to define family needs and what support would be required to meet their needs. The group agreed on what they understood as the hierarchy of need, and mapped tasks against competencies and the competency levels to support levels of need were agreed.

Leeds Competency and Skills Triangle



Some areas are exploring opportunities to develop the Health Visitor leadership role across early years settings as well as provide more intensive support for more complex families. In Stockport some Health Visitors are acting as lead workers for families helped by the Troubled Families Programme and are working with the whole family as well as coordinating the input of other agencies. In Nottinghamshire the leadership role of the Health Visitor has been developed, both at management level where they lead multi-agency teams in children's centres and practitioner level, where individual Health Visitors hold responsibility for children with complex needs across a range of services.

Some areas are developing new roles such as 'early help key workers' or 'health and wellbeing workers'. These roles provide support for families often as part of wider 'team around the family' arrangements supervised by more skilled practitioners such as Health Visitors. Practitioners in these roles are often being trained in child development and how to support attachment and positive parent child interactions and need to have the skills to work with complex family problems. They may also need to have the generic skills needed to provide practical help across wider areas of family life. It may be more effective for workers

in these roles to be recruited from the local community rather than established practitioners.

Luton is piloting the model of 'Flying Start key workers', who are highly trained generalists working alongside midwives to support families. These workers are part of the midwifery team; their role is to build relationships, give practical help, advice, sign posting and support to families to help them develop key skills, build resilience and engage with a range of preventative programmes. The Flying Start workers are encouraging the promotion of healthy lifestyles and support the delivery of high quality services to improve outcomes for babies, young children and families and have a positive impact on their lives. Nottingham City is developing a new workforce of paid (male and female, parent and grandparent) 'Family Mentors' recruited from the local community as part of their Better Start model which will be tested in 4 wards initially. They are trained and supported to provide intensive one to one and group support through a range of programmes designed to improve child development outcomes. They will literally 'walk alongside' families in the target wards, working in partnership with existing statutory services. They will be trained to model good interaction with children and will provide advice and support on how to raise children in language-rich environments. They will also share developmental norms with parents to raise aspiration around what children can achieve and will be attuned to pick up on any degree of developmental delays which they can discuss with the specialist such as Speech and Language Therapists if needed. This will create 66.5 new full-time equivalent jobs for people from the local community. However, both these schemes will need to be evaluated for effectiveness.

Conclusions

Worcestershire has a number of poorer outcomes than would be expected for children & young people (CYP), particularly for the under 5s and adolescence. Of concern is the relatively low proportion of young children who are school ready, high levels of reported language & communication needs and the unmet emotional and mental health needs of older children and young people. There are inequalities in outcomes across the social gradient where CYP from more deprived communities have significantly poorer health, social and educational outcomes than CYP from less deprived areas.

Although the overall CYP population is decreasing, the proportion of CYP from more deprived communities has increased and is projected to continue due to higher fertility rates in these localities. This demographic change will result in additional need for early help (prevention & early intervention) over the next decade, however, this has not caused the recent accelerated rise in numbers of LAC but is more likely due to social care practice.

The aim of the 2011 Early Help strategy and subsequent commissioning model of District 0-19 Early Help Providers does not appear to be reducing demand on complex or specialist health & social care services or improving outcomes at a population level. The impact, success or outcomes of Early Help plans are not measured using a validated or evidence based measurement /tool in either the short or longer term. However, good progress has been made with individual families by the local Troubled Families model (Stronger Families). Just over half of Early Help Assessments (EHAs) undertaken over a 20 month period were for families from the most 40% deprived communities, however modelling suggests 73% of total

need. Conversely 28% of EHAs were undertaken in the least deprived 40%; however estimated need for preventive interventions indicates only 7% of need.

The core purpose of Children's Centres (CCs) is "to improve outcomes for young children and their families and reduce inequalities between families in greatest need and their peers in: child development and school readiness; in parenting aspirations and parenting skills and in child and family health and life chances". To achieve this the original policy intention was to deliver provision in the most 30% disadvantaged areas. In Worcestershire there are currently 29 CCs, of which 10 centres do not have any of the 30% most deprived LSOAs in their "reach area". In 2014, 71% of the population aged under 5 accessed a CC (including nursery education provision); however only 56% of the most 30% deprived under 5s accessed a CC during the same period. An analysis of CC activity for provision excluding nursery education identified that 43% of all under 5s and 49% of the most 30% deprived under 5s accessed a CC in 2014 for non-nursery education activities and support. The provision, offer and activities provided in CCs are not consistent across the county and vary by geography. There are relatively low levels of delivery of programmes and activities that have a strong evidence base. All CCs provide parenting and family support but programmes and interventions offered vary, are not the most effective available and do not always retain programme fidelity. All CCs offer stay & play and some offer activities such as baby massage or baby yoga which have none or little evidence of effectiveness.

The Healthy Child Programme (HCP) is a prevention and early intervention public health programme offered to all families. The HCP is a progressive universal service, i.e. it includes a universal service that is offered to all families, with additional services for those with specific needs and risks. It aims to support parents, promote child development, reduce inequalities and thus contribute to improved child health outcomes and health and wellbeing, and ensure that families at risk are identified at the earliest opportunity. It is underpinned by an up-to-date evidence-base. The HCP involves effective input and coordination from a wide range of professionals, practitioners and the wider children's workforce but is universally led by, midwives during pregnancy, health visitors up to age 5 and school nurses during school years who each hand the baton on to the next. Where issues require input & support from other agencies, a multiagency assessment should be used (CAF or EHA). In Worcestershire the full HCP has not been fully implemented and is not integrated or embedded within and by other agencies and practitioners across the wider children's workforce. The preventive and early help offers in Worcestershire appear to be operating in isolation resulting in potential duplication and a lack of effective utilisation of all skills and resources available. "Working Together" (2015) describes effective early help services as the responsibility of all agencies with pathways and strong input from universal services through to targeted & specialist. Areas should have agreed thresholds and pathways between universal, targeted and specialist services and ensure sufficient evidence based interventions, service provision and information and advice to ensure that problems for children and families are identified early, and responded to effectively as soon as possible. The guidance stresses the role of the professionals in universal services in identifying need for early help, providing support & interventions that have a strong evidence base and utilising an inter-agency assessment for coordinated support to prevent needs escalating.

The evidence base identifies that events that occur in early life (indeed in fetal life) affect health, wellbeing and outcomes in later life. Neuroscience shows that rapid brain development and growth occurs in the early years (birth to 2 years) and again in adolescence and it is crucial that the brain achieves its optimum development and nurturing during these peak periods of growth. In the early years, loving, secure and reliable relationships with parents, together with the quality of the home learning environment, promotes infant mental health & emotional wellbeing, capacity to form and maintain relationships with others, brain development, language and cognitive development. Parental mental health (before and after birth) and levels of secure attachment are key determinants of the quality of that relationship. Poor support or the failure to prevent abuse or neglect, at this stage can have a lifelong adverse impact on outcomes. As children grow, it is better to equip them to deal with life stressors by focusing on building their social and emotional skills to promote resilience at home and through school and by supporting good parenting.
This needs assessment identifies the well evidenced preventive activity and interventions that promote development for better outcomes and reduced inequalities as well as good evidence based early interventions for those identified at risk or when problems have emerged. There are also a number of models of whole system effective prevention and early intervention. There is good evidence that if resources were focused on such effective preventive and early interventions that help to avoid or address challenges early in life or as problems emerge this will improve outcomes for children and families and start to save resources quite quickly. In addition there is strong evidence that spending on the early years of life is the greatest investment which yields returns in future. For example every £1 spent on early years education, £7 has to be spent to have the same impact in adolescence [9]. A range of evidence-based interventions, already recommended in National Institute for Health and Care Excellence (NICE) guidance, if implemented effectively and at scale could have a dramatic impact, improving children's lives while saving costs to the system.

Recommendations

The Marmot Report called for 'proportionate universalism' to address inequalities – actions that are universal, but with a scale and intensity proportionate to need. In practice, this involves making services available for everyone, with additional services for those with greater needs. Proportionate universalism – improving the lives of all, with proportionately greater resources targeted at the more disadvantaged identifies that a combination of approaches are needed; those that target and those that are more universal. Universal approaches tend to be the most upstream, targeted approaches can be both preventative e.g. seeking to reduce risk to specific high risk groups, or secondary prevention, also known as early intervention – seeking to act once early signs are seen, e.g. speech and language interventions.

Redesign the approach to 0-19 prevention and early help with a progressive universalism approach to improve the lives of all but with greater resources targeted at those at risk or where problems have emerged.

The Healthy Child Programme (HCP) is a well evidence based prevention and early intervention public health programme offered to all families. The HCP is a progressive universal service, i.e. it includes a universal service that is offered to all families, with additional services for those with specific needs and risks. The HCP requires input and coordination from a wide range of professionals, practitioners and the wider children's workforce but is universally led by, midwives during pregnancy, health visitors up to age 5 and school nurses during school years who each hand the baton on to the

next. Some elements of the HCP require clinical and specialist public health nursing, whilst other elements can be delivered by partners and by using skill mix, with the health professionals taking leadership. The clinical workforce is relatively small and cannot deliver the extensive Healthy Child Programme in isolation.

Fully implement the local HCP led by universal midwifery, health visiting and school nursing included and supported by a range of other children's practitioners and workforce providing preventive and early intervention services including parenting, family support and building family and community resilience

Although there is a lack of a robust evidence base on the outcomes that can be achieved through integrating systems and services for children, young people and families there is a consensus within the research and a very strong logic that integration provides consistency, is cost effective and makes a difference. There are a number of models and degrees of levels of integration; however there is a compelling narrative that full whole system integration is likely to be most effective rather than merely co-location or integration of services.

Fully integrate the children's early help system and workforce across agencies and across health and social care to ensure consistency of approach.

Evidence shows that these are key times to ensure that parents are supported to give their baby or child the best start in life, and to identify early, those families who need extra help (early interventions). Some of these key times have been identified in the HCP and many have been mandated to ensure these elements of the programme are protected and achieved universally to improve outcomes at the population level. There has been recent growth in Health Visiting numbers to achieve universal coverage of these key reviews to ensure no children slip through the net. At the reviews a full social and health risk assessment is required to identify any risk factors or emerging issues that require early intervention.

Ensure that key health & social risk assessments/reviews are undertaken and achieve full population coverage

Integrated pathways map the journey of a child and family through a range of services. They identify a single process for the child and family, but may involve a number of different services, support or agencies. "Working Together" describes early help as the responsibility of all agencies with pathways and strong input from universal services through to targeted & specialist. Areas should have agreed thresholds and pathways between universal, targeted and specialist services. Where a child and family would benefit from coordinated support from more than one agency then there should be an inter-agency assessment. These early help assessments, should identify what help the child and family require to prevent needs escalating. It places a duty on LSCBs to ensure that an agreed threshold document is in place so that all professionals are clear when it is their responsibility to help children and families as difficulties emerge.

Review and ensure all thresholds, pathways and referrals are agreed, understood and in accordance with need between universal, targeted and specialist services to support the system including the EHA process

This needs assessment has reviewed and identified a range of evidence based interventions for both prevention and early intervention across the life course. Interventions and support currently provided does not adhere to the evidence base, can lack fidelity to the model and appears inconsistent across the county.

Review, identify and commission only evidence based preventive and early intervention provision and interventions consistently across the county and in accordance with NICE guidance.

A review of the evidence base identifies the importance of early intervention and investment in the early years and the importance of resilience and emotional wellbeing in adolescence.

Ensure a renewed focus in early years provision on maternal mental health; secure attachment, nutrition and exercise, language & communication, high quality early years education and childcare to improve school readiness. Review local provision for supporting parenting, promoting resilience and good emotional health & wellbeing and for the prevention of NEETs.

There is a wide range of practitioners and volunteers that work with children, young people and families with a diverse skill set that includes: midwives; health visitors; GPs; children's centre outreach workers; job centre plus workers; speech and language therapists; schools and social workers. It is the skills and competency of these practitioners in their work with families that often makes the difference to effective support for parenting and children's development. Behaviour change in families and the improved outcomes for children that can result are attributable in large part to the skills and competency of the practitioner and the relationships they build with families.
Develop a new workforce approach, to drive a shift in culture: enabling frontline professionals to understand their role, work in a more integrated way in support of the 'whole family' and with other services to collectively reduce dependency and empower parents

Current data shows that a third of children's centres do not reach children/families in the most deprived 30% population. Only 49% of families with children under the age of five are regularly using the children's centres and only some of these will actually visit a children's centre building to receive a service. Many activities such as training for parents do not require a building designed for small children, and could be delivered in other community venues. A number of activities provided at Children's centres do not have a robust evidence base of effectiveness.
Reduce the number of Children's Centres to focus on disadvantaged areas making use of a "virtual" service in more advantaged areas.

Review and implement an effective digital advice and information service to parents and families promoted and supported by the early help workforce.

[1]Field F. The Foundation Years: preventing poor children becoming poor adults. The report of the Independent Review on Poverty and Life Chances. s.l. : HM Government, 2010
[2] Marmot M. 'Fair Society Healthy Lives' (The Marmot Review). 2010.
[3] Allen, Graham MP. Early Intervention: The Next Steps. An independent report to Her Majesty's Government. 2011.
[4]Munro, E. Munro review of child protection: final report - a child-centred system. s.l. : The Stationery Office Limited, 2011
[5] Wiggins, M., Oakley, A., Roberts, I., Turner, H., Rajan, L., Austerberry, H., et al. (2005)
[6] Puura, K., Davis H., Mäntymaa M., et al. (2005). The Outcome of the European Early Promotion Project: Mother-Child Interaction. International Journal of Mental Health Promotion, 7(1), 82-94
[7]Brugha, T. S., Morrell, C., Slade, P., and Walters, S. (2011). Universal prevention of depression in women postnatally: cluster randomized trial evidence in primary care. Psychological Medicine, 41(4), 739
[8] Early Action Taskforce (2013). The Triple Dividend, Community Links.
[9] DCSF. The Impact of Parental Involvement on Children'sEducation. London: DCSF; 2008
[10] WAVE Trust and DfE. Conception to Age Two. The Age of Opportunity. Surrey, WAVE Trust, 2012
[10] Hack, M. Klein, N.K. Taylor, H.G. (1995). Long term developmental outcomes of low birth weight infants. Future Child, 5(1), 176-196
[12]Jefferis, B.J.M.H. Power, C. Hertzman, C. (2002). Birth weight, childhood socioeconomic environment, and cognitive development in the 1958 British birth cohort study. BMJ, 325, 305
[13] Jenkins, H. Meltzer, P.B. Jones, T. Brugha, P. Bebbington, M. Farrell, D. Crepaz-Keay. Knapp, M. (2008). Foresight Mental Capital and Wellbeing Project. Mental health: Future challenges. London: The Government Office for Science
[14] Jefferis, B.J.M.H. Power, C. Hertzman, C. (2002). Birth weight, childhood socioeconomic environment, and cognitive development in the 1958 British birth cohort study. BMJ 325, 305
[15] Chevalier, A. O'Sullivan, V. (2007). Mother's education and birth weight. UCD Geary Institute Discussion Paper Series, Draft 2.2. Dublin:UCD
[16] Gray, R (2012). Chapter 5, Annual Report of the Chief Medical Officer 2012, Our Children Deserve Better: Prevention Pays
[17] Talge, N.M. Neal, C. Glover, V. (2007). Early stress, translational research and prevention science network: fetal and neonatal experience on child and adolescent mental health. Journal of Child Psychology and Psychiatry, 48, 245-61
[18] Nurse-Family Partnership. Trial Outcomes 2011 [cited 10 May 2013]. Available from: www.nursefamilypartnership. org/Proven-Results/Published-research.
[19] Richardson, J. Coid, J. Petruckevitch, A. Chung, W.S. Moorey, S. Feder, G. (2002). Identifying domestic violence: cross sectional study in primary care. BMJ, 324, 274
[20] Balbernie, R. (2001). Circuits and Circumstances: The Neurobiological Consequences of Early Relationship Experiences and how they shape later behaviour. Journal of Child Psychotherapy, 27 (3), 237-255
[21] Fearon, R.P. Bakermans-Kranenburg, M.J. van Ijzendoorn, M.H. Lapsley, A.-M. Roisman, G.I. (2010). The significance of insecure attachment and disorganization in the development of children's externalizing behavior: a meta-analytic study. Child Development, 81 (2), 435–456
[22] Sroufe LA. Attachment and development: a prospective, longitudinal study from birth to adulthood. Attachment and Human Development. 2005; 7 (4):349-67
[23] Fraley, RC. Attachment stability from infancy to adulthood: Meta-analysis and dynamic modelling of developmental mechanisms. Personality and Social Psychology Review. 2002; 6: 123-151.
[24] Barlow, J. Svanberg P.O. (2009). Keeping the Baby in Mind: Infant Mental Health in Practice. London: Routledge.
[25] Sroufe LA. Attachment and development: a prospective, longitudinal study from birth to adulthood. Attachment and Human Development 2005; 7 (4):349-67
[26] Maunder RG, Hunter JJ. Attachment relationships as determinants of physical health. Journal of the American Academy of Psychoanalytic and Dynamic Psychiatry. 2008 Spring;36(1):11-32.
[27] CHI Mat. 2010. Preview maternal indicators in pregnancy. Evidence from the Millennium Cohort Study. York: CHI Mat.
[28] NICE (2007) Antenatal and postnatal mental health: clinical management and service guidance, NICE Guideline 45
[29]Ghate, D. Hazel, N. (2002). Parenting in poor environments: stress, support and coping. London: Jessica

Kingsley Publishers
[30] Cummings, E. M. Davies, P. T. (1994). Maternal depression and child development. Journal of Child Psychology and Psychiatry 35 (1), 73-112
[31] Ip S, Chung M, Raman G, et al. Tufts-New England Medical Center Evidence-based Practice Center. Breastfeeding and maternal and infant health outcomes in developed countries. Evid Rep Technol Assess (Full Rep). 2007; 153(153):1-186
[32] Kramer MS, Aboud F, Mironova E, et al. Promotion of Breastfeeding Intervention Trial (PROBIT) Study Group. Breastfeeding and child cognitive development: new evidence from a large randomized trial. Arch Gen Psychiatry. 2008; 65(5):578-584
[33] Dwyer JT, Butte NF, Deming DM, et al. Feeding infants and toddlers study 2008: progress, continuing concerns, and implications. Journal American Dietetic Association. 2010; 110: S60-S67
[34] Byford M, Kuh D, Richards M. Parenting practices and intergenerational associations in cognitive ability. International Journal of Epidemiology. 2012; 41(1):263-72
[35] Kumpfer KL, Bluth B. Parent/child transactional processes predictive of resilience or vulnerability to substance abuse disorders. Substance Use & Misuse, 2004; 39(5), 671-98
[36] Scott S, Doolan M, Beckett C, Harry S, Cartwright S, and the HCT team. How is parenting style related to child antisocial behaviour? Preliminary findings from The Helping Children Achieve Study. London: DfE
[37] Raviv T, Kessenich M, Morrison FJ. A mediational model of the association between socioeconomic status and three-year-old language abilities: The role of parenting factors. Early Childhood Research Quarterly. 2004;19,528-547
[38] Purra K, Davis H, et al (2005). The Outcome of the European Early Promotion Project. Mother child interaction. The International Journal of Mental Health Promotion 7(1): 82-94
[39] Bakermans-Kranenburg MJ, Van IJzendoorn MH, Juffer F. Less is more: Meta-analyses of sensitivity and attachment interventions in early childhood. Psychological Bulletin, 2003;129, 195-215
[40] Barlow J, Smailagic N, Huband N, Roloff V, Bennett C. Group-based parent training programmes for improving parental psychosocial health. Cochrane Database of Systematic Reviews, 2012; Issue 6.
[41] Barlow J, Smailagic N, Ferriter M, Bennett C, Jones H. Group-based parent-training programmes for improving emotional and behavioural adjustment in children from birth to three years old. Cochrane Database of Systematic Reviews Issue 3. 2010
[42] Preston JL, Frost SJ, Mencl WE, Fulbright RK, Landi N,Grigorenko E, et al. Early and late talkers: School-age language, literacy and neurolinguistic differences. Brain. 2010;133(8), pp.2185-2195
[43]Zuckerman B, Khandekar A (2010). Reach Out and Read: evidence-based approach to promoting early child development. Current Opinion in Pediatrics. 22(4): 539-44
[44] Feinstein, L. (2003). Inequality in early cognitive development of British children in the 1970 cohort. Economica, 2003;70: 73-97
[45] Evangelou M, Sylva K, Edwards A, Smith T. Supporting Parents in Promoting Early Learning: The Evaluation of the Early Learning Partnership Project (ELPP), 2009, London: DCSF.
[46] Matrix Evidence Ltd (2009) Valuing Health: developing a business case for health improvement. [Online] Available at: www.idea.gov.uk/idk/aio/15246941
[47] Identified as part of the DH Task and finish group Report - Children's centres and health visitors: unlocking the potential to improve local services for families
[48] Birkbeck University. (2012). BBK NESS Site [Online] Available at: http://www.ness.bbk.ac.uk/
[49] University of Oxford. (2009). Evaluation of Children's Centres in England [Online] Available at: http://www.education.ox.ac.uk/research/fell/research/evaluation-of-children-centres-in-england-ecce
[50] McNeil B, Reeder N, Rich J. A framework of outcomes for young people. The Young Foundation, 2012
[51] Morgan A, Ziglio E. Revitalising the evidence base for public health: an assets model. International Journal of Health Promotion and Education. 2007; Promotion and Education Supplement:17-22
[52] Youngblade L, Theokas C, Shulenberg J, Curry L, Huang I, Novak M. Risk and promotive factors in families, schools, and communities: a contextual model of positive youth development in adolescence. Pediatrics. 2007;119:S47-53
[53] National Institute for Health and Clinical Excellence (NICE). Parent-training/education programmes in the management of children with conduct disorders. London: NICE, 2006
[54] Morgan A, Haglund B. Social capital does matter for adolescent health: evidence from the English HBSC study. Health Promotion International. 2009;24(363-372)
[55] Weissberg R, O'Brien M. What works in school based Social and Emotional Learning Programs for PositiveYouth Development. Annals of the American Academy of Political and Social Science. 2004;591: 86-97

[56] Ofsted. Not yet good enough: personal, social, health and economic education in schools, 2013
[57] Chief Medical Officers. Start Active, Stay Active: A report on physical activity for health from the four home countries. London: Department of Health, 2011
[58] Trudeau F, Shephard R. Physical education, school physical activity, school sports and academic performance. International Journal of Behavioral Nutrition and Physical Activity. 2008;5(10): www.ijbnpa.org/content/5/1/10
[59] Townsend N, Murphy S, Moore L. The more schools do to promote healthy eating, the healthier the dietary choices by students. Journal of Epidemiology and Community Health. 2011;65(10):889-95
[60] Crouch V, Chalmers H. The role of the school nurse. In: Aggleton P, Dennison C, Warwick I, editors. Promoting Health and Wellbeing Through Schools. London:Routledge; 2010
[61] Public Health England (2014) The link between pupil health and wellbeing and attainment, London: Public Health England
[62] Steinberg L. A behavioral scientist looks at the science of adolescent brain development. Brain Cogn 2010; 72(1): 160–4
[63]Degenhardt L, Chiu WT, Sampson N, et al. Toward a global view of alcohol, tobacco, cannabis, and cocaine use: findings from the WHO World Mental Health Surveys. PLoS Med 2008; 5(7): e141
[64] (2011) The science of adolescent risk-taking. Washington DC: Institute of Medicine and National Research Council
[65] PHE. Improving young people's health and wellbeing A framework for public health 2015
[66] Audit Commission. Against the odds: Re-engaging young people in education, employment or training 2010 [11/01/2014].
[67]UCL Institute of Health Equity. Reducing the number of young people not in employment, education or training (NEET). Health Equity briefing 3. September 2014.
[68] UCL Institute of Health equity. Good quality parenting programmes. Health Equity briefing 1a. September 2014
[69] Green H, McGinnity A, Meltzer H, Ford T, Goodman R: Mental health of children and young people in Great Britain, 2004. A survey carried out by the Office for National Statistics on behalf of the Department of Health and the Scottish Executive. Basingstoke: Palgrave Macmillan, 2005.
[70] Manning C, Gregoire A: Effects of parental mental illness on children. Psychiatry 2009, 8: 7-9
[71] Suhrcke M, Puillas D, Selai C: Economic aspects of mental health in children and adolescents. In Social cohesion for mental wellbeing among adolescents. Copenhagen: WHO Regional Office for Europe, 2008:43-64
[72] Murphy M, Fonarghy P. Mental health problems in children and young people. In Annual Report of the Chief Medical Officer 2012, Our Children Deserve Better: Prevention Pays
[73] DH/NHS England 2015. Future in mind. Promoting, protecting and improving our children and young people's mental health and wellbeing
[74] Screening efficacy of the Child Behavior Checklist and Strengths and Difficulties Questionnaire: a systematic review. Warnick EM, Bracken MB, Kasl S. 2, 2008, Child and Adolescent Mental Health, Vol. 13, pp. 140-147
[75] National Institute for Health and Clinical Excellence. Pregnancy and complex social factors. Clinical Guidance 110. London : NICE, 2010.
[76]National Institute for Health and Clinical Excellence. Social and emotional wellbeing: early years. Public Health Guidance 40. London : NICE, 2012
[77] National Institute for Health and Clinical Excellence. Social and emotional wellbeing in primary education. Public Health Guidance 12. London : NICE, 2008.
[78] National Institute for Health and Clinical Excellence. Social and emotional wellbeing in secondary education. Public Health Guidance 20. London : NICE, 2009.
[79] Barlow J, Smailagic N, Huband N, Roloff V, Bennett C. Group-based parenting programmes for improving parental psychosocial health. Art No: CD002020. s.l. : Cochrane Database of Systematic Reviews, 2012 (Issue 6)
[80] A comprehensive meta-analysis of Triple P Positive Parenting Program using hierarchical linear modelling: effectiveness and linear modelling. Nowak C, Heinrichs N. 3, 2008, Clinical Child and Family Psychology Review, Vol. 119, pp. 114-144.
[81] Is stacking intervention components cost-effective? An analysis of the incredible years programme. Foster EM, Olchowski AE, Webster-Stratton CH. 11, 2007, Journal of the American Academy of Child and Adolescent Psychiatry, Vol. 46, pp. 1414-1424.
[82] School-based interventions for aggressive and disruptive behaviour: update of a meta-analysis. Wilson SJ, Lipsey MW. 2, 2007, Am J Prev Med, Vol. 33, pp. S130-S143
[83] National Institute for Health and Clinical Excellence. Anti-social behaviour and conduct disorders in children and young people: recognition, intervention and management. Clinical Guideline 158. London : NICE, 2013.

[84] Investing in Children . Social Research Unit at Dartington. [Online] http://dartington.org.uk/.
[85] EIF Guidebook. http://guidebook.eif.org.uk/about-the-guidebook
[86] Ofsted. Early Help, whose responsibility? March 2015
[87] AGMA. GM Early Years Business Case. Oct 2012
[88] Messenger C, Molloy D (EIF). GETTING IT RIGHT FOR FAMILIES: A REVIEW OF INTEGRATED SYSTEMS AND PROMISING PRACTICE IN THE EARLY YEARS. 2014

APPENDIX 1 –Review of Parenting Interventions

Age group Pre-birth 0-4 5-9, 10-14 15-19 20-24	Level of inter-vention 1 = Population 2 = Universal 3 = Targeted	Name of programme	Brief description	Benefits	Evidence/Source	Criticisms of the programme / issues for consideration in Worcestershire	Notes
0-4 5-9	1	Triple P	Parent programme – information		Results of a universal Triple-P study are currently awaited.	There are difficulties in proving effectiveness of population based approaches as an RCT would be very difficult to apply.	

0-4 5-9	2	Triple P	Parent Programme Standard Triple P is for parents of children aged two to 12 with concerns about the child's emotions or behaviour. Parents attend between eight and 10 individual or group sessions where they learn strategies for interacting positively with their child and discouraging unwanted behaviour. The group course is delivered to eight to 10 parents over a period of eight weeks. Four sessions involve the entire group of parents and four sessions are conducted with the parents individually over the phone. A single practitioner delivers both the individual and group versions of the programme.	Triple P (2009) US System Population trial reported fewer child out of home placements and cases of child maltreatment	PPET **** rating Uni Warwick 2010 (SR of SR) "Triple P causes positive changes in parental wellbeing, parenting skills and child problem behaviour in a small to moderate range. Larger effects were found on parent report as compared to observational measures and more improvement was associated with more intensive and initially more distressed families. .	Some limitations pertain to the small evidence-base of certain formats of Triple P and the lack of follow-up data beyond 3 years after the intervention. The majority of the Triple P evidence base has been undertaken by people who are connected to the Triple P programme (Sanders et.al). Those that haven't (e.g. one RCT in Birmingham) have not shown an effect. The Birmingham RCT reported not only zero benefits but when the sessions were poorly attended, produced potentially iatrogenic effects. Triple P may be affected by the skills of the practitioner and the fidelity to model.	Triple P has very clear short and long term goals for those participating in the programme. Badged as a "universal" programme, however, this does NOT mean it is delivered universally, it is universally available in that any parent has the option to self-refer into the programme (it is also "expected" that these parents will have concerns about the behaviour of their children. Programme fidelity is maintained through the following processes: • Fidelity checklists that are completed by the practitioner at the end of each session • Highly detailed training resources that provide step-by-step instructions on how to conduct each session • Ongoing in-house and peer supervision • Practitioner accreditation.

0-12	3	Triple P	Parent programme Enhance parenting competence and prevent/alter dysfunctional parenting practices Enhanced Triple is designed to be offered in combination with other Triple P programmes to families experiencing very serious difficulties, including parental depression, severe couple conflict or extreme levels of stress.	WHO 2009 - Swiss RCT (aged 2-12) percentage of participating mothers reporting dysfunctional child behaviour from 48% before to 22% after (compared to 52% before and 55% after in control)	

3-8	3	Incredible Years	Parent programme Incredible Years Early Years (IYEY) BASIC is for parents with serious concerns about the behaviour of a child between the ages of three and six. Parents attend 12 weekly group sessions where they learn strategies for interacting positively with their child and discouraging unwanted behaviour. IYEY BASIC can be combined with Incredible Years ADVANCE for families with more complex issues, including parent anger management and mental health issues. When combined with ADVANCE, parents attend between 20 and 22 group sessions.	Improved child behaviour, Reduced child maltreatment (actual or risk), Improved parenting practices/competency, Reduced parent stress/depression/mental health problems	PPET ** rating WHO 2009 – Norwegian RCT reported greater reduction in problematic behaviour than in the control, also showing decrease at 1yr follow up	Case studies of neighbouring incredible years programmes have suggested that their inability to produce the effects shown in the initial clinical trials could be down to engagement, recruitment and retention of parents. Particular attention should be paid to promoting the programme amongst stakeholders and communities; and to addressing the physical and psychological barriers that may be preventing parents from participating. Referrals from the Incredible Years programme are locally determined, would require practitioners having detailed knowledge to appropriately signpost to services.

3-11	2 and 3	Families and Schools Together (FAST)	Community based parent programme Families and Schools Together (FAST) is for any parent or carer of a child between the ages of three and 11 who is interested in supporting their child's development and being involved in their community. FAST is typically offered in socially disadvantaged communities and schools experiencing difficulties in engaging parents. The programme content and practitioner qualifications are appropriate for families with these characteristics. Parents and children attend eight weekly sessions where they learn how to manage their stress and reduce their isolation, become more involved in their children's school, develop a warm and supportive relationship with their child and encourage their child's pro-social behaviour. After parents 'graduate' from the eight-week programme, they continue to meet together through parents' sessions that occur on a monthly basis.	Improved child behaviour, Improved child achievement , Improved child social skills, Reduced risk of child substance misuse, Reduced risk of child offending, Improved parenting practices/competency, Improved parent wellbeing	PPET **** rating, Strong theoretical framework and content. FAST has strong evidence of improving children's social skills and reducing their aggression and anxiety. FAST also has evidence of helping parents make friends and reducing their social isolation. Evidence that "foot in the door" trial session resulted in more parents staying for the duration of the programme	Consider eligibility criteria and number and spread of people in Worcestershire accessing this service. Particular attention should be paid to promoting the programme amongst stakeholders and communities; and to addressing the physical and psychological barriers that may be preventing parents from participating. FAST has very specific requirements of its venue in that it must have a kitchen and area for the group to eat. FAST is a multi-disciplinary session (crossing health, communities and schools). Would require detailed promotion with targeted stakeholders.	FAST is typically delivered through schools, although any community venue will do. Each session follows the same format, including group work, parent/child only time and family time. There is also a lottery where families win a cash prize. A key feature of FAST is the weekly meal shared by the families and children together. The first meal is prepared by the FAST team. The family (or families) who wins the weekly lottery is then expected to prepare the next meal with their lottery winnings. The lottery is set up so that each family's name will be drawn during the course of the programme. A graduation ceremony is held at the end of the programme for parents who have attended six sessions or more. Parents are then given a small allowance to run their own parents group on a monthly basis for the following two years.

Pre-birth 0-2	3	Nurse Family Partnership / Family Nurse Partnership UK	Parent programme, nurse/home visiting low-income first-time mothers aged under 19 (from early pregnancy until the child is 2) Includes a prevention programme - a psycho-educational approach - focussing on adaptive behaviour change. The family nurse provides the mother with advice and support on: • Personal health • Environmental health • Life course development • Maternal role • Friends and family • Health and human services • Pregnancy advice	Long term benefits – USA RCT 15 years after their mothers receiving NFP, reported fewer incidences of running away, arrests, convictions, violations of probation and behavioural problems related to drugs and alcohol than controls	PPET **** rating "Family Nurse Partnership has strong evidence of providing long-term benefits for young mothers and their children, including a reduced risk of child maltreatment, improved children's school readiness and a greater likelihood of mothers finding work or completing their education" FNP is currently being evaluated in the UK – results of RCT to be reported in 2014. WHO 2009 Large USA RCT – cases 48% less likely to be the perpetrators of maltreatment than the controls. MacMillan et al. 2009 "Family Nurse Partnership is the most effective intervention known for preventing child Maltreatment"	The evidence base for FNP has been built up in the USA – its applicability to the UK where there is a different maternity / HV model should be considered (the results of the UK RCT are not yet available). Also, the benefits are mainly realised within an urban setting, how would this relate to the Worcestershire rural areas, where time may be lost in travel? This would certainly have an effect on the cost-effectiveness of the programme. Expensive interventions. Studies have suggested that in interventions such as FNP, the greatest benefits are in those with the greatest need, therefore to provide a cost-effective service FNP should be specifically targeted to the communities most in need (whilst being mindful of the effect that providing such a service to disparately located families may have on practitioner time lost in travel). May create an emotional attachment / expectation between the practitioner and service user- any information on the impact of this? FNP is currently targeted at first time mothers below 19 in low-socioeconomic groups, however is this the only group that should be targeted? Second time mothers? Older age groups? There is a need for clarity of the eligibility requirements to practitioners.	To be commissioned by local authorities from 2015 (currently commissioned by NHS England) A key aim of FNP is to help the mother identify resources within the community that will support the health and development of herself and her child. It is likely that the mother and her child will be referred to additional services on an ongoing basis during the programme. A web-based system collects information about programme fidelity at the level of the individual client, nurse and site

	3	Early Start	Parent programme intensive home visiting programme targeted at families facing stress and difficulty	WHO 2009 NZ RCT cases had 1/3 rate of parental-reported abuse than controls (however more likely to be referred to other agencies)	Similar issues to FNP above.
Pre-birth 0-5	1		Media interventions Leaflets to all new parents in maternity wards	WHO 2009 Univ. Warwick 2010 (in systematic review of SR's e.g. Montgomery (2001) Media-based behavioural interventions are more effective than no treatment for children with behavioural problems and are recommended as part of stepped-care provision.	

10-18	3	Functional Family Therapy (FFT)	Functional Family Therapy (FFT) is for families with a young person (between 10 and 18 years) involved in serious delinquent behaviour and/or substance misuse. Its primary aims are to reduce youth offending, substance misuse and out-of-home placement. Young people are typically referred into FFT through the youth justice system. The young person and their parents then attend eight to 30 weekly sessions (depending on need), where they develop strategies for improving family functioning and addressing the young person's behaviour. The young person and his or her parents attend a one- to two-hour session with the FFT therapist on a weekly basis for as long as the family needs. Families with moderate needs typically require eight to 14 sessions; families with more complex needs may require up to 26 to 30 sessions spread over a six-month period. The FFT model has five discreet phases: • Engagement in Change, • Motivation to Change, • Relational/interpersonal Assessment and Change Planning	Improved child behaviour, Reduced risk of child substance misuse, Reduced risk of child offending, Reduced parent stress/depression/mental health problems	PPET **** rating *A UK RCT on FFT has not yet reported its results*	Referral to FFT is usually through the youth justice system, would require awareness raising amongst stakeholders. This is an Intensive model support, fidelity to the model is therefore key. Consideration should be given to the appropriateness of FFT to the Worcestershire rural populations, sparsely populated areas. There is little evidence available regarding the UK setting, long-term follow up outcomes are also unknown.	FFT therapists are trained to continuously assess whether the young person or parents would benefit from additional services. The FFT programme developers work closely with host agencies to make sure that the programme is embedded within a cross-agency referral system so that families can be immediately referred into other services should the need arise. At the final phase of the programme (Generalisation) the therapist works closely with the family and outside agencies to make sure that an appropriate package of support is in place once the therapy is completed.

4-11	3	Parent Management Training, Oregon Model (PMTO)	Parent Management Training, Oregon Model (PMTO) is for parents who are concerned about the behaviour or emotions of their child between the ages of four and 11. Parents attend 19 or more weekly individual or group sessions where they learn strategies for interacting positively with their child and discouraging unwanted behaviour. PMTO can either be delivered to families individually, or to groups of parents. The group format is delivered over 14 weekly sessions lasting 90 minutes. The individual format is delivered over 19 to 30 sessions, lasting 60 minutes each. Children may attend the individual sessions, depending on the family's needs. Both versions are delivered by a single practitioner. The content of the following sessions is flexible, depending on the family's specific needs and the child's age – but will always cover the following issues: • Monitoring the child's activities and friends • Family problem solving • Promoting school success • Positive parent involvement.	Improving children's behaviour and achievement at school and reducing parental depression	PPET **** rating	Enrolment, follow up and referral procedures are locally determined. Recruitment and retention to the programme will be key to success. There is some evidence to suggest that in general shorter term programmes are more effective than those where there is in excess of 16 sessions, however, applicability to the PMTO model is unknown. This is a very intensive programme and whilst open to all families may achieve the best cost to benefit ratio for those families in the greatest need, consider targeting.	PMTO typically delivered within a CAMHS service

10-14	1	The Strengthening Families Programme	The Strengthening Families Programme 10-14 (SFP 10-14) is for all parents with children between the ages of 10 and 14. Parents and their children attend seven weekly group sessions where they learn how to communicate effectively, set appropriate limits and resist peer pressure to use drugs and alcohol. The SFP 10-14 programme therefore aims to teach parents and young people skills that will reduce family risks and increase family protective factors.	Improved child behaviour, Improved child achievement, Reduced risk of child substance misuse	PPET **** rating – promising evidence base	Issues around recruitment and retention of families, practitioners will need sufficient capacity for the intensive enrolment and follow up processes. Requires use of appropriate and de-stigmatising language. Practitioners are expected to be able to refer parents on to other services so must be in receipt of relevant signposting information	Badged as "universal" however, the SFP 10-14 assumes that some individual and family circumstances place young people at risk for misusing drugs and alcohol, whereas other family factors protect young people from using substances and engaging in risky behaviour.

3-11	2	Solihull Approach Parenting Group (SAPG)	The Solihull Approach Parenting Group (SAPG) is for any parent who wants to learn more about sensitive and effective parenting. Parents attend 10 weekly group sessions where they learn how to respond sensitively to their child's needs and effectively manage their child's behaviour.	Improved child behaviour, Reduced parent stress/depression/mental health problems	PPET * rating PPET criticised the Solihull Approach for not defining its target population. Developers advocate its use from 0-18 but the evidence is only there from 4-11.	Issues around recruitment and retention, this is generally a self-referral programme so would require promotion within communities and with stakeholders as to the purpose and benefits of the programme. Enrolment usually consists of an initial home visit so may be resource intensive in the more rural areas of Worcestershire. There is no eligibility requirements for the SAPG programme, consideration should be given to likely cost/benefit of a Worcestershire wide service. Practitioners are expected to be able to refer parents on to other services so must be in receipt of relevant signposting information.

3-11	2	Family Links Nurturing Programme (FLNP)	The content of the Family Links Nurturing Programme (FLNP) is most appropriate for parents with children between the ages of four and 11, who want to know how best to support their child's development and learn effective parenting strategies. Parents attend 10 weekly group sessions where they learn how to respond to their child more empathetically and effectively manage unwanted child behaviour.	Improved child behaviour, improved parental empathy	PPET*** rating	There are no eligibility requirements for the programme, consideration should be given to likely cost/benefit of a Worcestershire wide service. There are limited details available on how progress is monitored throughout the programme.	While the developers state that the programme is suitable for parents with children between the ages of nought to 18, the programme content is best suited for parents with children between the ages of four and 11.
Pre-birth 0-4	1	Skin to skin care at delivery			Univ. Warwick 2010 "The level of evidence available to support these interventions was relatively sparse and less robust than that supporting the conclusions in some other sections of the review. However, on the basis of their low, or no, cost and the low level of possibility of harm they can be recommended". SSC contact between mother and baby at birth reduces crying, improves mother-baby interaction, keeps the baby warmer and helps women breastfeed successfully.	Limited evidence of effectiveness however this is a low/no cost intervention that could be easily promoted within existing programmes.	

0-4	1	Neonatal Brazelton Assessment Scale (NBAS)	Developmental guidance programme - a brief professional intervention shortly after birth in which the clinician shows the parents, or helps the parents show themselves, the infant's sensory and physical abilities	Enhance parental sensitivity and atunement in the perinatal period	Univ. Warwick 2010 Demonstrations or parental administrations of the NBAS with detailed explanations have a small to moderate effect on the quality of parenting.	Implementation would require a wide range of practitioners being trained on the NBAS and "train the trainer" approaches so that new-born parents could be shown how to use the scale.
0-4	1	Baby massage		Enhance parental sensitivity and atunement in the perinatal period	Univ. Warwick 2010 (SR of SRs)	Limited evidence of effectiveness however this is a low/no cost intervention that could be easily promoted within existing programmes.
Pre-birth 0-4		Kangaroo care	Kangaroo care involves close contact care of the baby either in arms, pouch or sling on an ongoing basis	Enhance parental sensitivity and atunement in the perinatal period	Univ. Warwick 2010 (SR of SRs) "The level of evidence available to support these interventions was relatively sparse and less robust than that supporting the conclusions in some other sections of the review. However, on the basis of their low, or no, cost and the low level of possibility of harm they can be recommended". Kangaroo care for preterm infants increases parental attachment. Kangaroo care is safe for preterm infants and may have important benefits for growth and development.	Limited evidence of effectiveness however this is a low/no cost intervention that could be easily promoted within existing programmes.

District	Children's Centre	Address
Bromsgrove	Conkers - Hagley Primary School	Park Road, Hagley, Stourbridge, DY9 0NS
Bromsgrove	Pear Tree - Sidemoor (Standalone building)	Broad Street, Sidemoor, Bromsgrove, B61 8LW
Bromsgrove	Sunny Fields - Charford First School	Lyttleton Avenue, Charford, Bromsgrove, B60 3FG
Bromsgrove	Tulip Tree - Catshill First School	Gibb Lane, Catshill, Bromsgrove, B61 0JP
Malvern Hills	Riverboats - Upton upon Severn Primary School	Price's Lane, Upton-upon-Severn, WR8 0LY
Malvern Hills	Sunshine - Pickersleigh Poolbrook Centre	Poolbrook, Bluebell Close, Malvern, WR14 3SW
Malvern Hills	Sunshine - The Grove Primary School	Pickersleigh Road, Malvern, WR14 2LU
Redditch	Cherry Trees - Batchley First School	Cherry Tree Walk, Batchley, Redditch, B97 6PD
Redditch	Holly Trees - St Stephen's First School	Mabey Avenue, Redditch, B98 8HW
Redditch	Holly Trees - St George's First School	Stevenson Avenue, Redditch, Worcestershire, B98 8LU
Redditch	Maple Trees - Ten Acres First School	Quilbury Close,Winyates East, Redditch, B98 0PB
Redditch	Maple Trees - Roman Way First School	Colts Lane, Winyates West, Redditch, B98 0LH
Redditch	Oak Trees - Oak Hill First School	Wirehill Drive, Lodge Park, Redditch, B98 7JU
Redditch	Oak Trees - St Luke's First School	Plymouth Road, Redditch, B97 4NU
Redditch	Woodlands - Woodrow First School	Longdon Close, Woodrow, Redditch, B98 7UZ
Worcester City	Bluebell Wood - Perry Wood Primary School	St. Alban's Close, Worcester, WR5 1PP

District	Children's Centre	Address
Worcester City	Buttercup - Fairfield Centre	Fairfield Primary School, Carnforth Drive, Worcester, WR4 9HG
Worcester City	Lavender - Oasis Academy Warndon	Edgeworth Close, Worcester, WR4 9PE
Worcester City	Saffron - Stanley Road Primary School	Stanley Road, Worcester, WR5 1BD
Worcester City	Tudor Way - Dines Green Primary School	Tudor Way, Worcester, WR2 5QH
Wychavon	Apple Vale - Broadway First School	Lime Tree Avenue, Broadway, WR12 7BD
Wychavon	Orchard Vale / Spring Vale - Evesham Nursery School	Four Pools Lane, Evesham, WR11 1BN
Wychavon	Blossom Vale - Abbey Park First School	Abbey Road, Pershore, WR10 1DF
Wychavon	Greenwood - Wychbold First School	School Lane, Wychbold, Droitwich, WR9 7PU
Wychavon	WANDS - Westlands First School	Farmers Way, Droitwich, Worcestershire, WR9 9EQ
Wyre Forest	Rainbow - St Mary's Primary School	Stoney Lane, Kidderminster, Worcestershire, DY10 2LX
Wyre Forest	Chestnut - Franche Primary School	Chestnut Grove, Kidderminster, Worcestershire, DY11 5QB
Wyre Forest	Tree Tops - Birchen Coppice Primary School	Woodbury Road, Kidderminster, Worcestershire, DY11 7JJ
Wyre Forest	Half Crown Wood - St Bartholomew's Primary School	Princess Way, Stourport-on-Severn, Worcestershire, DY13 0EL
Wyre Forest	Half Crown Wood - Stourport Primary School	Park Lane, Stourport-on-Severn, Worcestershire, DY13 8SH
Wyre Forest	Riverside - Bewdley Primary School	Stourport Road, Bewdley, DY12 1BL
Wyre Forest	Brookside - Comberton Primary School	Borrington Road, Kidderminster, Worcestershire, DY10 3ED

Non Worcestershire County Council Buildings (currently rented by the 0-19 Early Help Providers)

District	Children's Centre
Malvern Hills	Evergreen – Malvern Link
Redditch	Willow Trees - Church Hill Community Centre
Malvern Hills	Teme Valley
Bromsgrove	Cotton Wood - Wythall Library
Worcester City	Sunflower (virtual centre)

This page is intentionally left blank

Inequalities in Health in Worcestershire

Worcestershire Public Health Annual Report 2014

Contents

Forward

This Year's Annual Report focuses on health inequalities. In our thriving county it is easy to assume that the population is healthy. However, although overall health and well-being is good in Worcestershire, this picture hides some marked variations between different groups of people.

The technical definition of health inequalities can mean any variations in health between different groups of people. The inequalities we are interested in here are variations that cannot be explained by biological factors such as age, sex or genetic inheritance alone. These are inequalities that are due to social, environmental and behavioural factors such as education, housing, smoking and access to services. These differences are ones that we can change, by making changes to our communities, the environment around us, our behaviours and the services available.

Health inequalities are a key area of interest for a Director of Public Health for three main reasons. Firstly, because they act as a 'brake' on the health of the overall population; Poor health reduces people's opportunities and their ability to contribute to society, leads to lost productivity, and creates additional demands on health, social care and other public services. Secondly, because they can be avoided – or at least reduced; Poor health in certain groups is not inevitable, it is a consequence of people's circumstances and choices. These can be influenced with action by statutory agencies, businesses, communities, families and individuals. Finally it is important to remember that they affect the whole population. This is not just about the difference between the very healthy and the very unhealthy; it is about the potential of everyone to improve their health.

A previous Annual Public Health Report considered health inequalities in 2008. This new report shows that the position has got better over the last 5 years, with improvements in health overall and especially in people whose health was poorest. This is a huge achievement and something to be celebrated. However the variations persist and there is more that could be done. This Report aims to highlight those variations, how they are being tackled and what further action should be considered. The aim is to stimulate discussion and debate, and influence organisations and individuals to take account of health inequalities in their decision making.

Dr Richard Harling

Director of Adult Services and Health

Worcestershire County Council

Authors

Peter Fryers

Dr Frances Howie

Liz Altay

Karen Wright

Janette Fulton

Recommendations

1. Intensive ongoing support for vulnerable families
2. Intensive focus on early years development in priority areas
3. Employment opportunities in priority areas
4. Change to a place & asset-based approach to commissioning
5. Strengthen and improve prevention of ill-health

Recommendation	Priorities for Action
1. Intensive ongoing support for vulnerable families	1.1. Review the availability and intensity of parenting support to ensure evidence based parenting advice and support is provided across all ages in proportion to need 1.2. Children's Centres (Early Help) to prioritise evidence based outreach and family support to work with the most vulnerable families 1.3. Ensure progressive intensive support to targeted vulnerable families continues from early years to transition to school, through primary school & beyond where necessary 1.4. To promote and improve resilience and school connectedness, schools & colleges to act as health & well-being promoting settings, to strengthen their delivery of PSHE and increase opportunities for participation in physical activity both in & out of school 1.5. Develop targeted evidence based interventions towards clusters of adolescent children identified as being at high risk of multiple poor behaviours, rather than providing single issue services only 1.6. Focus on reducing the attainment gap. To support schools to deliver better educational outcomes across the social gradient there should be a focus on raising educational standards among the most vulnerable children and young people
2. Intensive focus on early years development in priority areas	2.1. Ensure that all disadvantaged or vulnerable families are identified and offered intensive ante-natal and post natal home visiting including the implementation of a Family Nurse Partnership programme for teenage first time mothers. 2.2. Integrate the delivery of all 0-5s services including Maternity, Health Visiting, Early Help and Early Years services to better enable a seamless provision of progressive universalism – universal coverage with evidence based targeted programmes for disadvantaged and vulnerable families to improve outcomes. 2.3. Target early learning and language of disadvantaged children using intensive, high-quality home and centre-based interventions. 2.4. Develop better understanding of early years educational and childcare interventions to determine whether evidence based and meeting quality standards

Recommendation	Priorities for Action
3. Employment opportunities in priority areas	3.1. Extend ongoing learning & support up to age 25 for those disadvantaged through a coordinated approach 3.2. Continue to prioritise active labour market programmes to achieve timely interventions to reduce long-term unemployment and ensure that these reach the most disadvantaged 3.3. Encourage and incentivise the implementation of measures to improve the quality of work across the social gradient by ensuring public and private sector employers adhere to equality guidance and legislation 3.4. Ensure that guidance on stress management and the effective promotion of wellbeing and physical and mental health at work is widely distributed and implemented 3.5. Develop greater security and flexibility in employment by prioritising greater flexibility of retirement age and encouraging and incentivising employers to create or adapt jobs that are suitable for lone parents, carers and people with mental and physical health problems
4. Change to a place & asset-based approach to commissioning	4.1. Shift from an 'Areas of Highest Need' to a 'Healthy and sustainable Communities' place based model in priority areas. Through this build on existing 'assets based' approaches which seek to identify and harness skills, knowledge, networks and resources in communities so that local residents can play a part in locally based solutions. 4.2. Roll out a programme of workforce development to support an asset based approach to commissioning and service redesign. 4.3. Prototype, with partners models of assets based commissioning, focussing initially on priority areas, in both urban and rural areas. 4.4. Establish a model of social prescribing to more effectively engage primary care in an assets based model and early intervention.
5. Strengthen and improve prevention of ill-health	5.1. Research measures that impact fuel poverty, with a particular focus on disadvantaged communities; 5.2. Improve understanding of issues affecting rural areas, with a focus on measures to address social isolation; 5.3. Review the Public Health Ringfenced Grant (PHRG) spend against all the priorities in the DPH report and reprofile and prioritise accordingly; 5.4. Strengthen the evidence base on the PHRG spend on Housing Related Support in terms of the prevention of ill-health; 5.5. Strengthen local understanding across the County of the evidence on behaviour related ill-health, and its links to social deprivation; 5.6. Review cross-agency funding on ill-health prevention and facilitate a shared approach to spend which will narrow the health gap; 5.7. Strengthen social marketing to maximise behaviour change among target groups, including the uptake of existing prevention initiatives.

Introduction

What is a Public Health Annual Report?

> *"A vehicle for informing local people about the health of their community, as well as providing necessary information for decision makers in local health services and authorities on health gaps and priorities that need to be addressed."*
>
> *Faculty of Public Health*

Public health annual reports have been a statutory requirement of Directors of Public Health (DsPH) for many years and this has not changed with the move of Public Health back into Local Authorities under the Health & Social Care Act 2012. The annual report is not a statement about the policy of the organisation for which they work, but is a personal assessment of the health of the population they serve. It is there to raise concerns about health problems or poor outcomes in the local area, to assess progress against local Public Health objectives and inform local multi-agency action.

According to guidance from the Faculty of Public Health, DPH annual reports should:

- Contribute to improving the health and well-being of local populations.
- Reduce health inequalities.
- Promote action for better health, through measuring progress towards health targets.
- Assist with the planning and monitoring of local programmes and services that impact on health over time.

Why do Health Inequalities Matter?

There is a sound economic case for tackling inequalities. Those extra years of life and more importantly the greater extra years of disability free life would have an economic benefit both in terms of increased productivity and reduced costs to health and social care. The estimated costs of the additional limiting illness suffered by the most deprived nationally is £31-32 billion in productivity, with loss of tax and increased welfare in the region of £20-32 billion and the healthcare costs estimated at £5.5 billion[1].

Reducing health inequalities is also a matter of fairness and social justice and the argument for doing so is primarily a moral one. People on the lowest incomes lose up to 17 years of disability free life expectancy compared to those on the highest incomes due to worse living conditions and this alone is reason enough to try to address some of the factors that lead to this situation.

Action taken to reduce health inequalities will benefit society in many ways. It will have direct benefit to individuals lives both in quantity and quality. It will benefit local and national economies through increased productivity and reduced welfare costs and it will benefit wider society through having a healthier more active population better able to engage in society, especially in older age.Inequalities in health also result in a disproportionate use of resources by people in disadvantaged groups, which is both inefficient and impacts the whole population.

1 Frontier Economics (2009) Overall costs of health inequalities. Submission to the Marmot Review. *www.ucl.ac.uk/gheg/marmotreview/Documents*

Summary

Overall health in Worcestershire is on the whole better than the national average. Life expectancy and healthy life expectancy, especially for men are significantly better in the County than for England and mortality from common conditions and those considered preventable are consequently lower than average.

However theses overall figures mask some differences across the County and as with all Local Authority areas there are inequalities that persist

In general health inequalities in Worcestershire are no worse than other similar places across the country, but the problems associated with health inequalities are wide and far reaching. This report is an assessment of where we currently stand on health inequalities and in particular how things have progressed since this issue was last looked at in an Annual Report in Worcestershire, in 2008.

Since then the Marmot report on health inequalities has been published and made specific recommendations on how to address them. We have followed the Marmot chapters in the layout of this report and at the end of each chapter we have assessed our own progress against the Marmot recommendations and then identified priorities for local action to address these recommendations.

In terms of overall health inequalities on the broad outcome measures of differences in life expectancy and mortality, the picture is a positive one, with inequalities having reduced in absolute terms whichever way they are measured. However, underneath this there remain many inequalities both in health outcomes and in the factors which in the long-term affect life chances and health.

As part of addressing this issue we have identified the areas in Worcestershire which have the worst health outcomes as being health hotspots. These are largely the same as they were when the exercise was last done in 2008, but there are some that are expanded and a couple of different areas, in particular two rural areas have been identified as having worse health outcomes.

Give every child the best start in life

Health inequalities and particularly those factors which lead to them can be identified right from the beginning of life and even before birth. So, for example babies from deprived areas are more likely to have been born to younger mothers and their mothers are more likely to have smoked or be overweight, all things which mean that the baby starts life with a disadvantage. Then through their early development these disadvantages are widened as they are less likely to be breastfed, their language development is more likely to be delayed and they are more likely to have poor levels of development by the time they get to school. While progress has been made in this area, Worcestershire has a worse than average number of children who have a good level of development by the end of reception year and more needs to be done across all agencies to implement a multi-faceted approach to addressing early years development in disadvantaged areas and families.

Enable all children, young people and adults to maximise their capabilities and have control over their lives

Once children get to school the inequalities are there from the beginning and only get wider as time goes on. Differences in level of achievement that are about 25% at Key Stage 1 are 4-500% by Key Stage 5, whilst those living in deprived areas are far more likely to have special educational needs, be excluded or be subject to child protection plans. They are also more likely to have excess weight, attend A&E more often and more likely to require emergency hospital treatment. Children from the most deprived areas are also the most likely to have mental health problems and be in contact with mental health services. Although much has been done to try to address these gaps, they are very persistent and an increased focus on intensive support and parenting advice to vulnerable families throughout the children's time at school is required to build on what has already been done. A more joined up approach to dealing with problem behaviours is needed along with schools and colleges doing more to promote health & wellbeing.

Create fair employment and good work for all

Although unemployment in Worcestershire is relatively low at 2.2%, there are individual wards where it as high as 6.6%. Also, whilst the rate of those unemployed for less than a year has not changed significantly, the rate of those who have been claiming for over a year has gone up. There is a strong association between areas of high unemployment and high mortality and other poor health outcomes. Local initiatives like Worcestershire Works Well are aimed at encouraging healthy

workplaces, but more could be done to develop work opportunities across the social gradient aimed at reducing the gap and for disadvantaged groups.

Ensure a healthy standard of living for all

There is an association between income and health outcomes and although Worcestershire has generally relatively low levels of low income households compared to other areas, these are fairly concentrated. In the 20% most deprived areas 37% of children are classed as living in poverty compared to just 5% in the 20% least deprived areas. In addition in Worcestershire the proportion of households in fuel poverty is higher than the national average.

Creating Healthy and Sustainable Communities

Worcestershire as a County offers good access to green space and has good air quality, although there are small pockets of poor access and poor air quality in the urban areas. These same areas also have the highest levels of deprivation. They also have lower levels of satisfaction with the area and the lowest levels of feeling of belonging to an area. In order to address these multiple issues a change is needed to an asset-based approach to commissioning, which involve local people, skills and resources in the planning and process of commissioning and decisions which affect the local area.

Strengthen the role and impact of ill health prevention

A small number of conditions cause the majority of premature mortality and morbidity, and these are all linked to health related behaviours, smoking, poor diet, physical inactivity and drinking too much alcohol, on the part of the individual, which can be changed. Recent improvements in these have almost all been in the higher socio-economic groups. Worcestershire follows this pattern, with people in the most deprived areas most likely to have one or more of these unhealthy behaviours. In order to maximise the potential for health improvement across the County the targeting of prevention and use of Public Health and other resources needs to be strongly evidenced and linked to reducing the health gap.

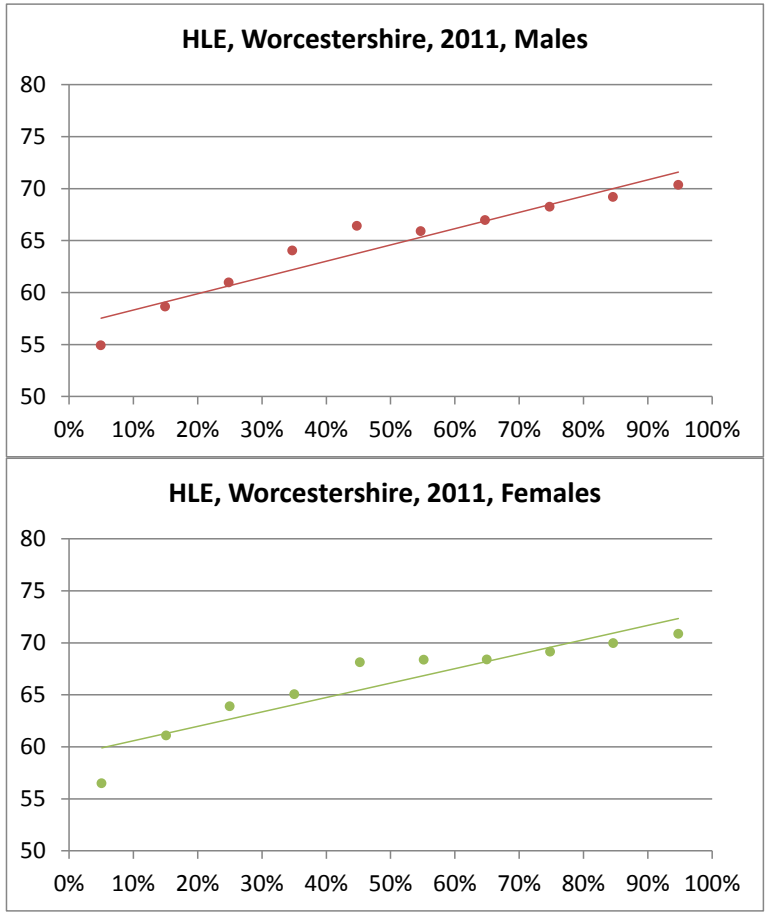
Chapter 1 Inequalities in Worcestershire

Overarching Indicators

The two overarching indicators in the Public Health Outcomes Framework (PHOF) are healthy life expectancy and life expectancy. Life expectancy is presented as an overall score, as a slope index of inequality in life expectancy where the gradient of the slope across deprivation deciles is calculated (see box on page 10) and also as the gap between the local authority area and England as a whole. On all of these Worcestershire has relatively good outcomes compared to the average.

- Life expectancy for men in Worcestershire in 2011-2013 was 79.8 years.
- The figure for women in 2011-2013 was 83.4 years.
- The slope index of inequality (SII) in life expectancy for men in 2011-2013 was 7.7 years.
- For women the SII in life expectancy in 2011-2013 was 5.4 years.
- Using locally calculated estimates for healthy life expectancy based on 2010-2012 life expectancy and data on general health status from the 2011 Census gives overall healthy life expectancy for men of 65.3 and for women of 66.7 (The figures from PHOF for 2009-2011 are 65.3 and 65.9 respectively).
- These locally calculated data can also be used to look at inequalities in health life expectancy. The inequalities between the most deprived and most affluent areas in the County in healthy life expectancy are higher than those for life expectancy. However the difference between men and women is not as great (Figure 1).
- The SII for healthy life expectancy for men is 15.6 years and for women is 13.9 years.
- For men the healthy life expectancy in the least deprived 10% of areas was 70.3 years compared with just 54.9 years in the most deprived.
- For women those in the least derived 10% of areas could expect to live 70.8 years in good health whereas those in the most deprived 10% can only expect 56.5 years of good health.
- Putting the life expectancy and healthy life expectancy together for 2010-2012 men in Worcestershire would expect about 13 years and women about 16 years of not good health at the end of their lives.

Figure 1 – Slope Index of Inequality in Healthy Life Expectancy



Source: Primary Care Mortality Database
ONS Mid-Year Population Estimates
2011 Census General Health Status

Notes: Calculated locally using estimates for health status at LSOA level based on broad age categories in Census table LC3302EW

Changes in Life Expectancy over Time

- Life expectancy at birth in Worcestershire has increased by 6½ years over the last quarter of a century (Figure 2).
- The increase has been more rapid for men than women (over 7 years for men and 5½ years for women).
- If these trends continue the gap between male and female life expectancy will be about 3 years by 2020.
- Figure 3 & Figure 4 show the slope of inequality for life expectancy across the ten deciles of deprivation in Worcestershire for the three years 2007-09 and 2011-13.
- The slope index of inequality (SII), which is the gradient of the slope of the lines through all the points has changed little over this period (6.4 to 6.6), which means that life expectancy has increased by a similar amount across all deprivation groups.
- The SIIs for men and women have similarly changed little, with that for men going from 7.6 to 7.7 and for women from 5.2 to 5.4.

Figure 2 - Life Expectancy in Worcestershire

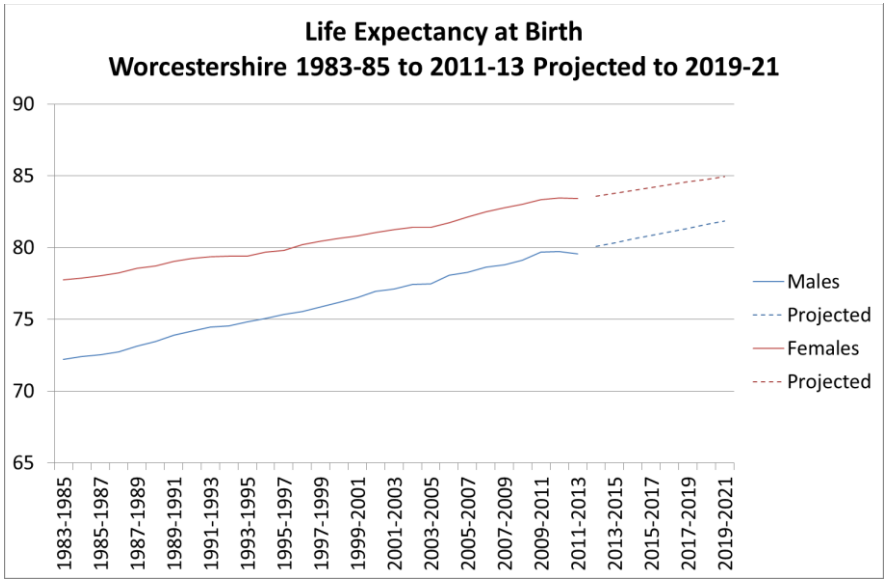


Figure 3 - - Life Expectancy Slope of Inequality 2007-09

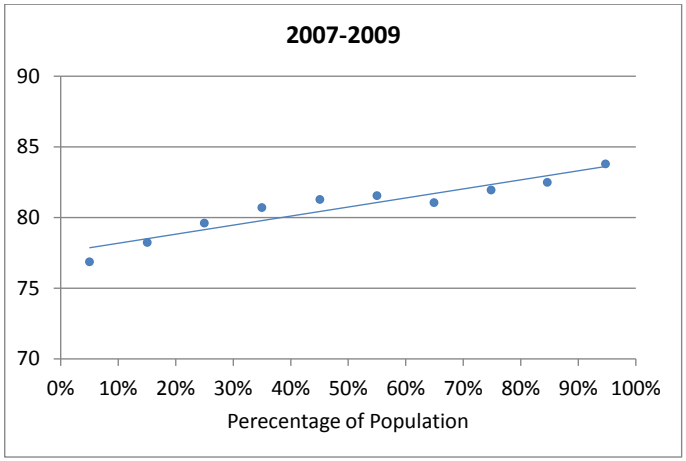
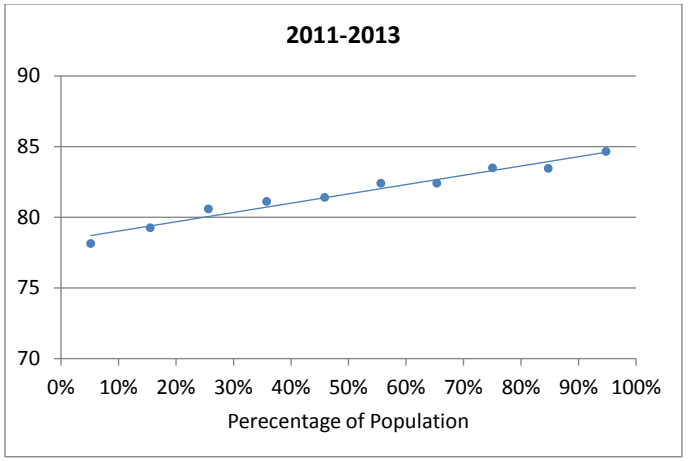


Figure 4 - Life Expectancy Slope of Inequality 2011-13



Slope Index of Inequality (SII)

This is calculated by grouping the population into equal groups according to the relative deprivation level of the area they live in and working out the average life expectancy in these groups (usually 10 groups or deciles). The gradient across these groups is the slope index of inequality or SII. The higher the number the greater the relative inequality and an SII of zero means there is no inequality across the groups.

Inequalities in mortality

- Looking at data for age-standardised all-cause mortality by lower level super output areas (LSOAs – Areas containing between 1,000 and 3,500 people) a pattern of reducing inequalities emerges.
- In Figure 5 mortality rates for each LSOA have been calculated and then they have been shown in rank order from highest mortality to lowest.
- Comparing the resulting lines for 2007-09 and 2011-2013 shows that not only has the line overall dropped slightly, but that this is more obvious at the left or higher end, which suggests that the biggest improvements have come in areas with the worst mortality rates.
- Figure 7 & Figure 6 show the slope across IMD deciles in under 75 mortality.
- The gradient has reduced by more than 10% from 2007-09 to 2011-13.

Figure 5 - All Age All-Cause Mortality per 100,000 by ranked LSOA

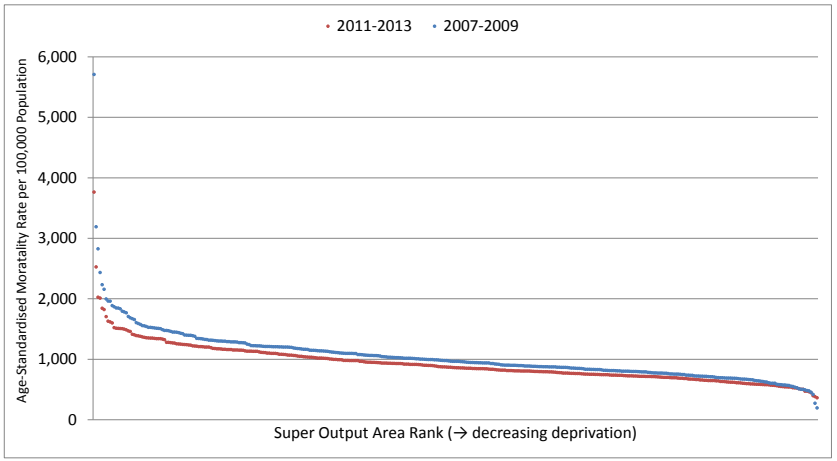


Figure 7 - Under 75 Mortality per 100,000 by IMD 2007-2009

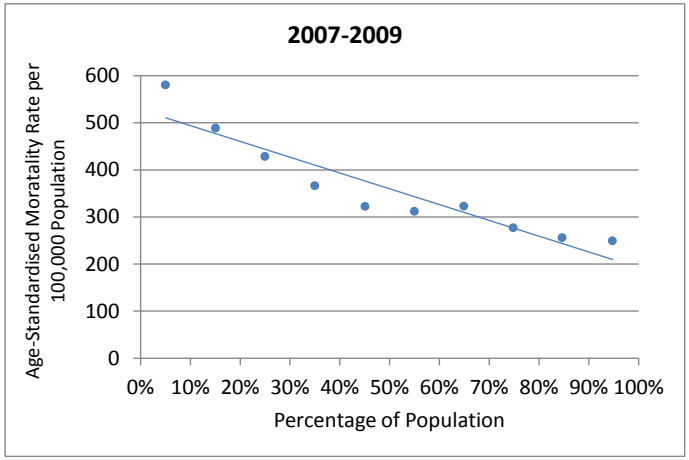
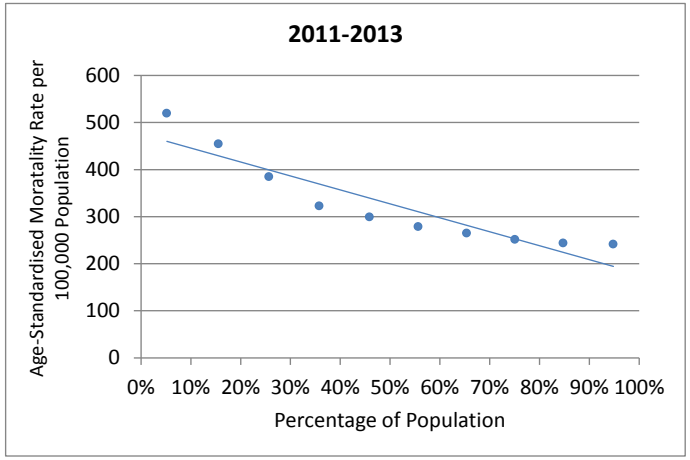


Figure 6 - Under 75 Mortality per 100,000 by IMD 2011-2013



Standardised Mortality

The graphs on this page show standardised mortality rates. These are calculated using age-specific death rates for each area which are then applied to a standard population to allow for comparison between areas with different population age structures. The result is expressed as a rate per 100,000 population which is what the actual rate would be if the structure of the population was exactly the same as the standard.

Health Hotspots

Background

The Public Health Annual Report for Worcestershire in 2008 was focused on health inequalities and the identification of local "health hotspots" which were areas with poor health outcomes compared to the rest of the County. In this section we revisit that work and see if the hotspots have changed in any way. In order to target health and other interventions, it is important to know where these will have the biggest impact both in terms of overall improvement in health and in reducing inequalities. This can best be achieved by identifying areas where health outcomes are worst – our "health hotspots".

Methodology

In order to identify hotspots we have examined 4 key indicators. These had to be available at a level of detail and in sufficient numbers to allow analysis at lower level super output area (LSOA) level such that the areas were small enough to identify reasonably small neighbourhoods or areas. The four data items looked at were:

- Overall Index of Multiple Deprivation for 2010 (IMD 2010)
- The health component of the IMD 2010
- All cause mortality aged under 75
- Mortality from causes amenable to healthcare aged under 75

LSOAs were identified on the latter two by whether they had significantly higher mortality than the County average and on the former two by dividing the area into deciles of deprivation.

There was no specific preconceived number of hotspots we wished to identify. The process was first to identify areas that had significantly worse mortality on at least one of the two measures. Then we looked to see if there were adjacent LSOAs which had relatively poor outcomes and/or high deprivation that created more meaningful neighbourhoods when combined with the identified areas of high mortality.

Where the hotspots are

Largely the hotspots that were identified were the same as had previously been identified. Health Inequalities and particular these long-term outcomes do not change rapidly and therefore we would expect the same areas that had the worst outcomes in the past to have the worst outcomes still in general.

The main change has been the identification of more areas that have poor outcomes and the expansion of the existing areas. Comberton in Kidderminster has emerged as a hotspot in this latest analysis, being in the most deprived fifth of areas nationally on both the overall IMD and the health component and also having significantly high all cause and amenable cause mortality.

Areas that have expanded are the area previously called Abbey, Batchley and Central, which now incorporates most of the West Redditch area and has been called West Redditch, Nunnery, which is now Ronkswood and Nunnery, Westlands which now includes the Berry Hill area and Greenhill and Broadwaters, which includes a broader part of these areas.

In addition to these and the existing other areas, there are two rural areas that have been identified. These display slightly different properties, but show significantly high mortality rates from both all causes and amenable causes. The North Wyre Forest area which covers Trimpley, Fairfield and Cookley scores relatively highly on the IMD measures, being mostly in the 3rd decile on the health component and also has significantly high mortality. The Deblin's Green & Madresfield area is not particularly deprived, but has significantly high mortality on both measures.

Table 1 - Health Hotspots 2014 Key Data

Hotspot Area	Population (2013)	Males (2013)	Females (2013)	Number Aged <15 (2013)	% Aged <15 (2013)	Number Aged 85+ (2013)	% Aged 85+ (2013)	AAACM* (2011-2013)	<75 Mortality** (2011-2013)
Charford	3,939	1,966	1,973	820	20.8%	107	2.7%	1,056.3	544.5
Church Hill	4,216	2,135	2,081	880	20.9%	38	0.9%	1,176.5	568.9
Comberton	3,120	1,519	1,601	565	18.1%	84	2.7%	1,018.2	517.9
Deblin's Green & Madresfield Rural	1,125	567	558	124	11.0%	58	5.2%	1,154.0	467.9
Dines Green	1,694	841	853	446	26.3%	24	1.4%	915.9	470.2
Greenhill & Broadwaters	5,481	2,775	2,706	1041	19.0%	115	2.1%	1,247.2	547.2
Greenlands	2,982	1,513	1,469	741	24.8%	19	0.6%	937.6	437.7
North Wyre Forest Rural	5,267	2,565	2,702	661	12.5%	216	4.1%	1,228.4	460.3
Nunnery & Ronkswood	5,325	2,648	2,677	1150	21.6%	104	2.0%	1,154.4	502.0
Old Warndon, Gorse Hill & Rainbow Hill	14,263	7,208	7,055	3150	22.1%	176	1.2%	1,166.2	529.7
Oldington & Foley Park	7,155	3,671	3,484	1492	20.9%	122	1.7%	1,001.2	454.6
Pickersleigh	1,681	824	857	431	25.6%	27	1.6%	1,103.6	483.3
Sidemoor	1,941	958	983	424	21.8%	30	1.5%	1,220.3	588.2
Redditch Centre & West	19,502	9,832	9,670	3758	19.3%	556	2.9%	1,439.9	533.6
Westlands & Berry Hill	3,156	1,585	1,571	719	22.8%	25	0.8%	1,059.4	563.7
Winyates	1,676	857	819	352	21.0%	11	0.7%	822.9	520.3
ALL OTHER AREAS	502,123	249,103	253,020	77822	15.5%	13447	2.7%	928.8	298.5
WORCESTERSHIRE TOTAL	584,646	290,567	294,079	94,576	16.2%	15,159	2.6%	959.2	321.8

* Age-standardised all age all cause mortality expressed as a number of deaths per 100,000 population

** Age-standardised under 75 mortality expressed as a number of deaths per 100,000 population

The maps on the following pages show the hotspots against the four measures used in identification.

Figure 8 - Index of Multiple Deprivation 2010 and Health Hotspots

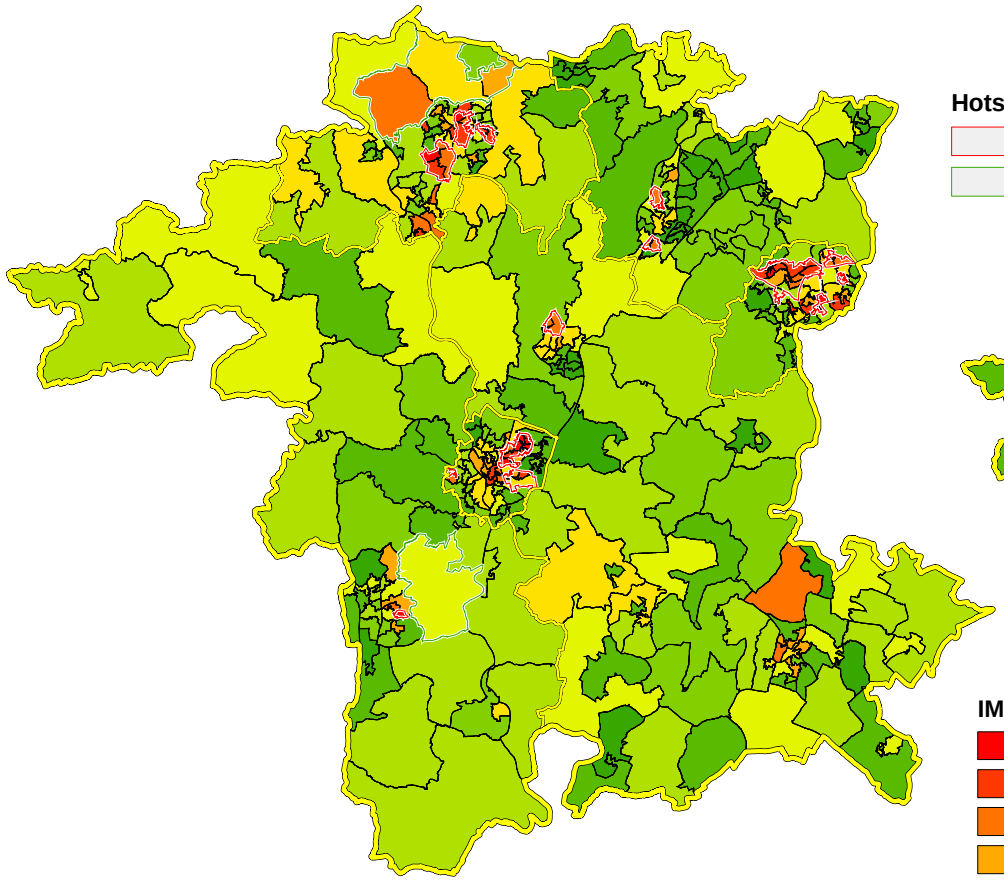


Figure 9 - IMD 2010 Health Component and Health Hotspots

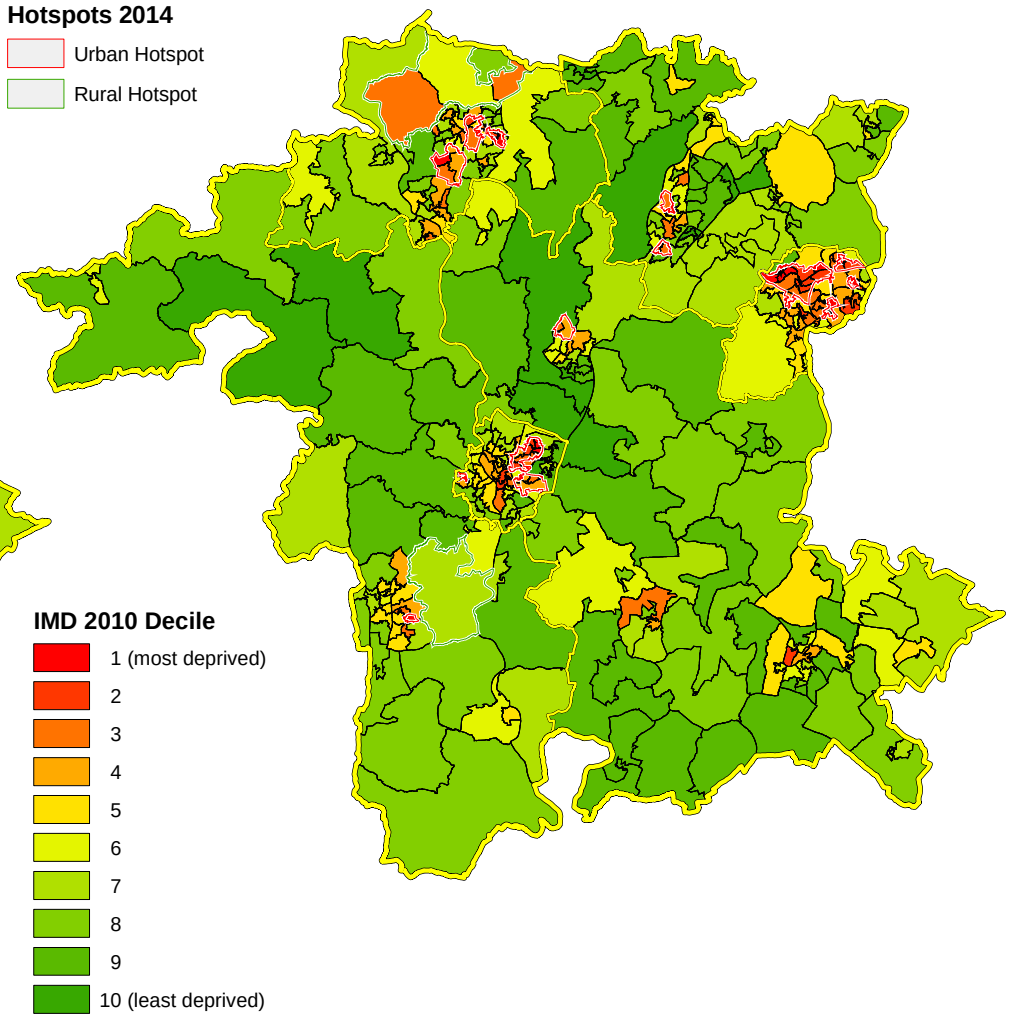


Figure 10 – All Cause mortality <75 and Health Hotspots

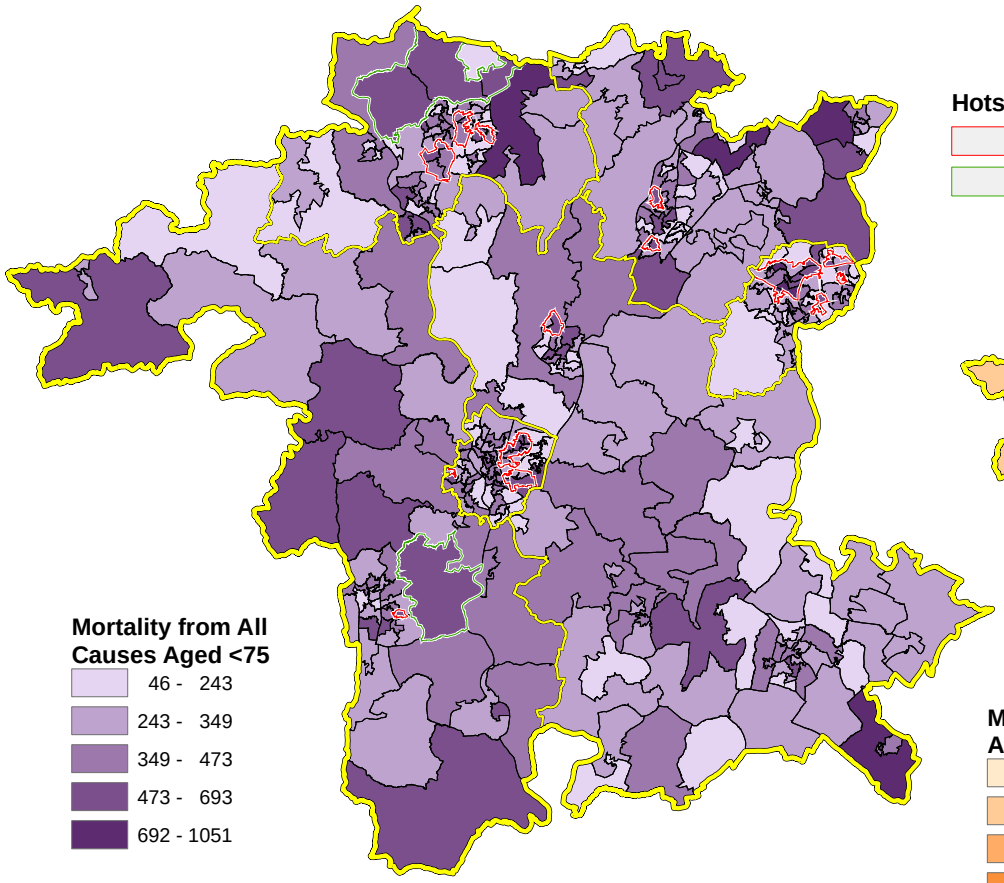
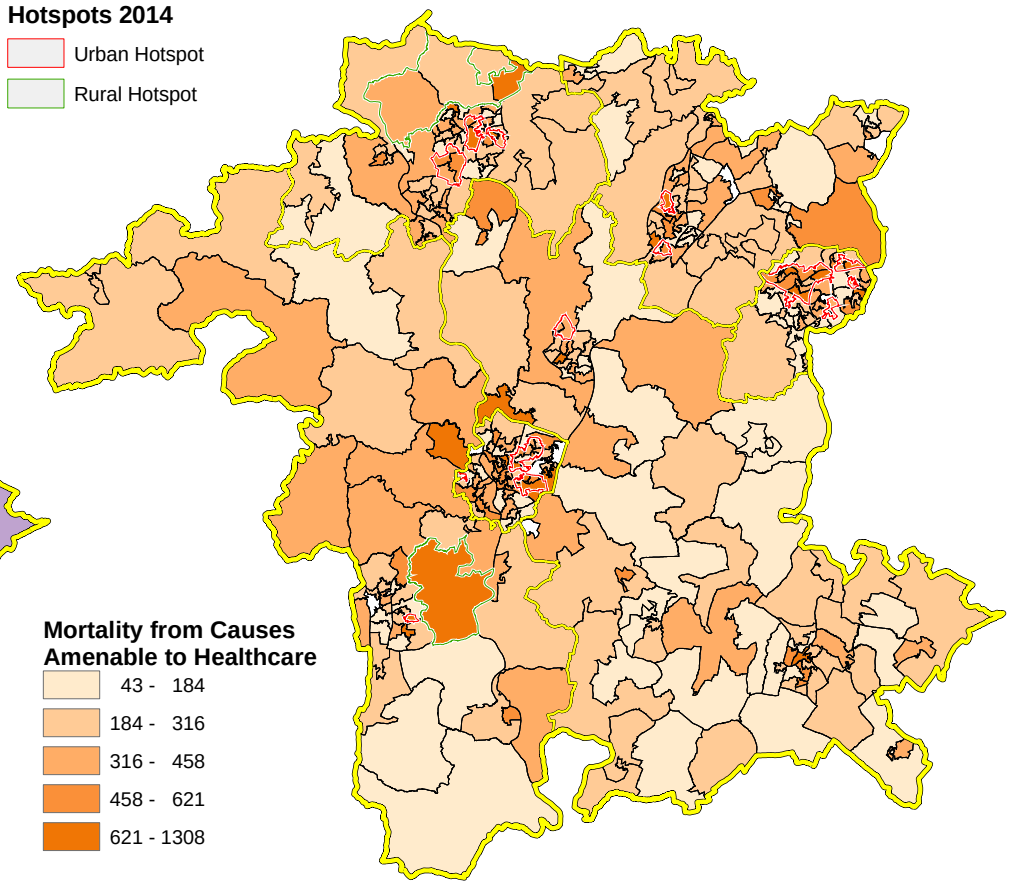


Figure 11 – Mortality from Amenable Causes and Health Hotspots



Mortality in hotspot areas

- Figure 12 and Figure 13 show all age and under 75 all-cause mortality in the hotspot areas compared to all other areas in Worcestershire for 2007-2009 and 2011-2013. The charts show error bars which indicate the degree of uncertainty associated with measuring mortality for a small area at a single point in time. Where error bars do not overlap, the difference between the rates can be said to be statistically significant.
- As can be seen in all the charts most of the hotspot areas have significantly high mortality, which is not surprising as this was how they are defined.
- However it can be seen that in 2007-09 rates were generally higher and more dispersed. In fact for all age mortality no area has gone up significantly and seven have gone down significantly. For under 75 mortality the Deblin's Green & Madresfield and Westlands & Berry Hill areas have gone up from the 2007-2009 figures, but six areas have gone down significantly.
- The biggest difference from the non-hotspot areas is in under 75 mortality especially in 2011-2013. This is in part due to demographic differences between the hotspot areas and the rest of the County (they tend to be younger populations) and partly that premature mortality is a more sensitive measure, which makes it a better indicator of inequality.
- The areas with particularly high rates in 2007-2009 that have reduced most have been ones that have been especially targeted with effort to address inequalities in recent years. In the case of Winyates, Old Warndon, Gorse Hill & Rainbow Hill, Pickersleigh and Oldington & Foley Park these have been the areas identified as Areas of High Need in their respective districts and have all seen significant falls in under 75 mortality and all but one in all age mortality.

Figure 12 - All Age All-Cause Mortality in Hotspot Areas

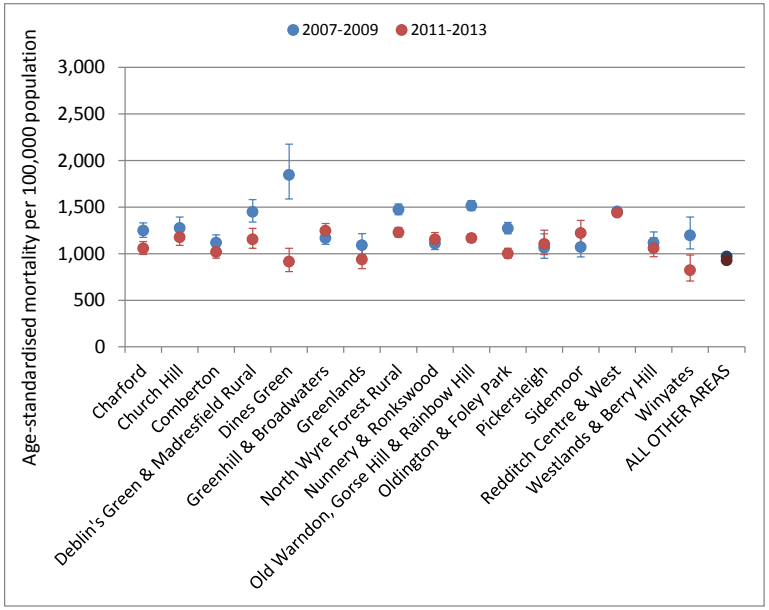
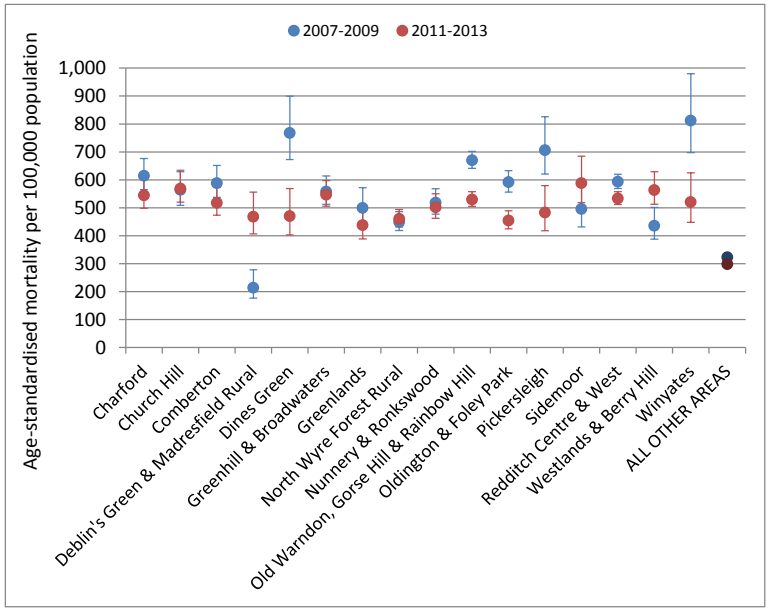


Figure 13 - Under 75 Mortality in Hotspot Areas



Chapter 2 Give every child the best start in life

In this chapter we look at the first years of a childs life, through the very early development up until they are old enough to go to school. There is considerable evidence that what happens to a child in pregnancy and in their early years and development has a lifelong impact on the health and wellbeing of a person, affecting not only their risk of diseases, but also their educational achievement and economic status. During pregnancy poverty, maternal stress, maternal mental health, poor diet, alcohol, smoking and drug misuse can impact on pregnancy outcomes and future child development. In the early years the quality of parent-infant attachment, parenting, health services & childcare as well as opportunities for cognitive, social, language & emotional development impact on later outcomes.

> *The foundations for virtually every aspect of human development – physical, intellectual and emotional are laid in early childhood. What happens during these early years, starting in the womb, has lifelong effects on many aspects of health and well-being from obesity, heart disease and emotional health to educational achievement and economic status. To have an impact on health inequalities we need to address the social gradient in children's access to positive early experiences and ensure that we give every child the best start in life.*
>
> *(Fair Society, Healthy Lives The Marmot Review, 2010).*

To have an impact on health inequalities, investment and action in early years needs to be evidence based, cost effective and proportionate to need across the social gradient. Later interventions are considerably less effective where good early foundations are lacking. Evidence shows it is more cost effective to intervene in early years than later in life, for every £1 spent in early years would require £7 in adolescence for the same effect. Returns on investment on well-designed early years interventions significantly exceed their cost.

The Marmot review recognised that disadvantage starts before birth and accumulates throughout life. Marmot recommends that action to reduce health inequalities must start before birth and be followed through the life of the child. Only then can the close links between early disadvantage and poor outcomes throughout life be broken. This is why giving every child the best start in life was his highest priority.

Early access to evidence based support can prevent difficulties from escalating and act as a gateway to more intensive or specialist support for those who need it. Early years key workers need the skills to provide advice and support to parents on child development, to identify where there are additional needs and facilitate access to specialist input, including child health, where required.

Insecurely attached children have poorer outcomes. Insecure parent-infant attachment is more prevalent amongst vulnerable and disadvantaged families. Attachment evolves during the first and second years of life in response to early parenting.

Evidence suggests areas should develop effective multiagency, integrated working and delivery to ensure all services are working together, sharing information and developing whole system approaches.

The Worcestershire Picture

Pregnancy and birth

- More babies are born in the most deprived communities
- More women from deprived communities in Worcestershire have babies and at a younger age
- Most women (91.7%) have accessed maternity services (attended their first "booking" visit for antenatal care) by 13 weeks of pregnancy
- However, health behaviours during pregnancy are worse amongst women from more deprived communities: for example 25% of pregnant women from IMD1 smoke; over 25% are obese.
- In turn, pregnancy outcomes and subsequent child health and development outcomes are worse for babies from IMD1 disadvantaging them from the beginning: Over 10% of babies are born pre-term (before 37 weeks); over 3% are of low birth weight

Figure 15 - Maternity early booking by IMD

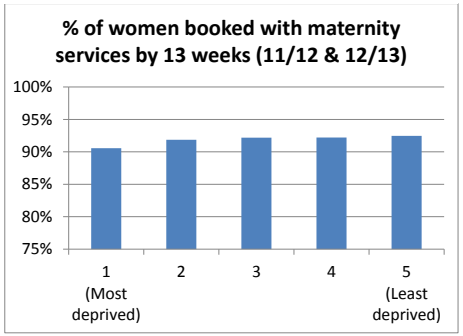


Figure 14 - Births by IMD Quintile and Age of Mother 2011/12-2013/14

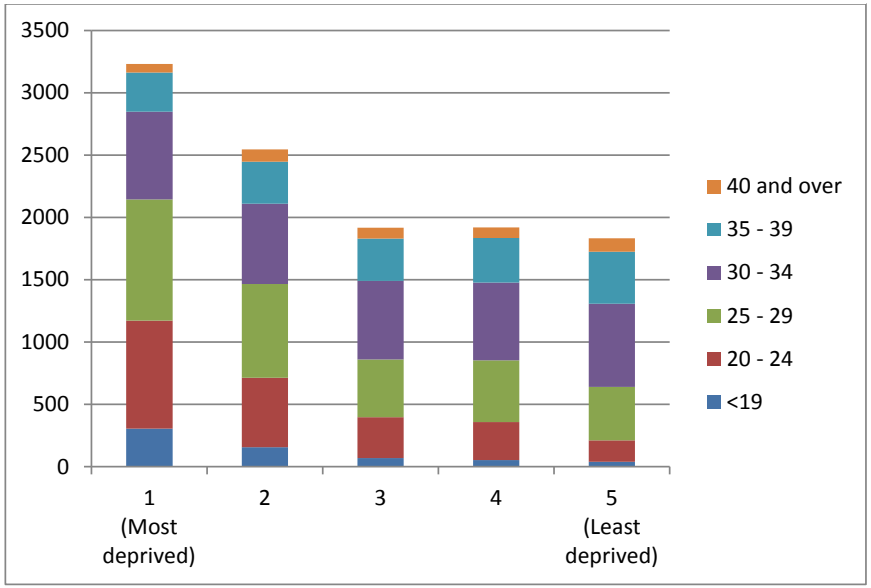


Figure 16 - Overweight in pregnancy by IMD

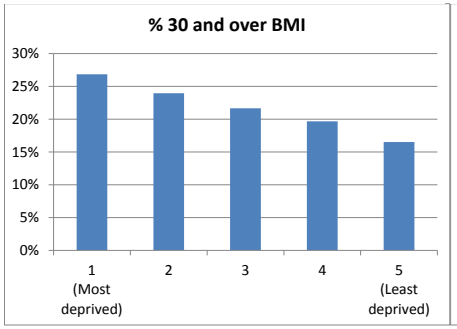


Figure 17 - Smoking in pregnancy by IMD

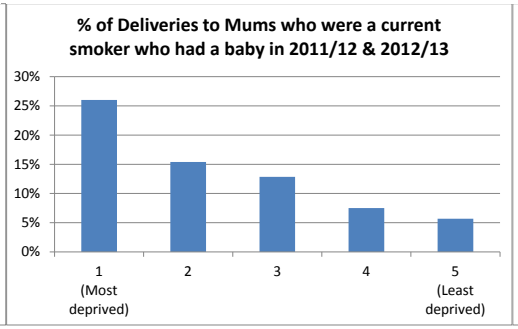


Figure 18 - Pre-term deliveries by IMD

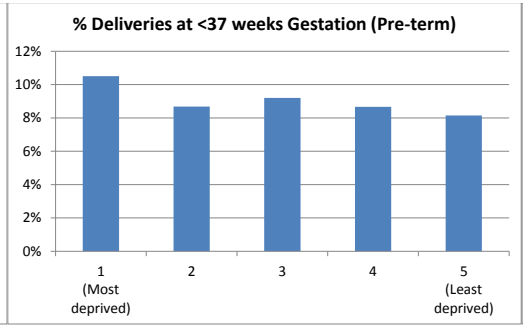
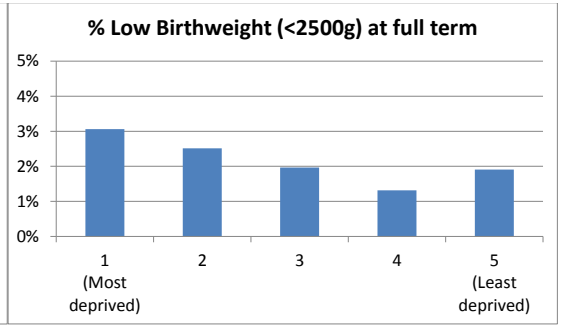


Figure 19 - Low Birthweight by IMD



Early development

- Breastfeeding has been shown to improve a child's future health and neurodevelopment. Only 58% of mothers from IMD1 start to breastfeed their baby compared to 81% from IMD5.
- It is recommended that babies are breastfed as long as possible. At 6 weeks only 22% of mothers from IMD1 were breastfeeding compared to 57% from IMD10. So not only do fewer women start to breastfeed from IMD1 the drop off rate before 6 weeks is also greater
- Nationally it is estimated that over half of the nursery-age children living in areas of disadvantage have language delay. In Worcestershire the referral rate for under 5s referred to Speech & Language Therapy Services over 3 years is twice as high in the most deprived decile than the least deprived
- Inequalities for under 5s can be summarised by looking at the results of the Early Years Foundation Stage (EYFS) which assesses all children against 7 learning areas in the final term of the year they turn 5. This indicator is often used as the indicator for school readiness. The % of children achieving a good level of development (78 or above CLL PSE) for Early Years Foundation Stage ranges from 20% to 100% by LSOA. The average % score for children living in IMD 1 was 51% compared to 75% for those living in IMD 5.

Figure 23 - Early years foundation stage achievement by IMD

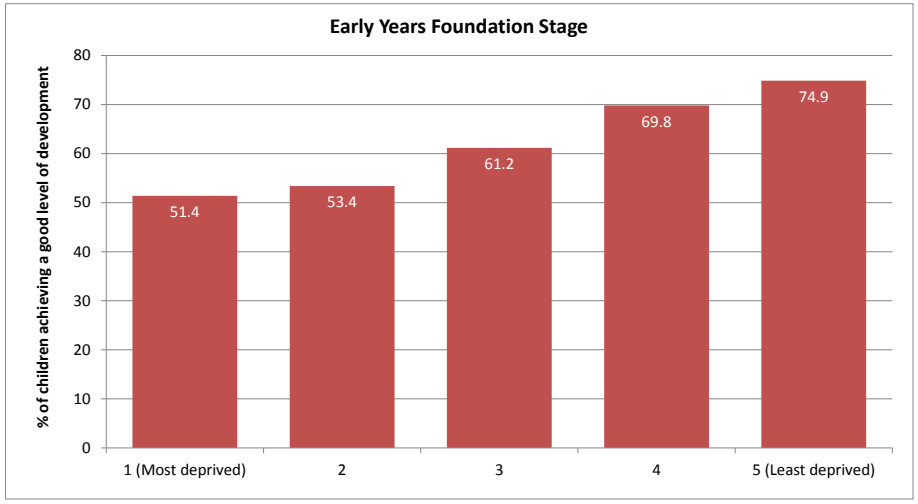


Figure 20 - Breastfeeding initiation by IMD

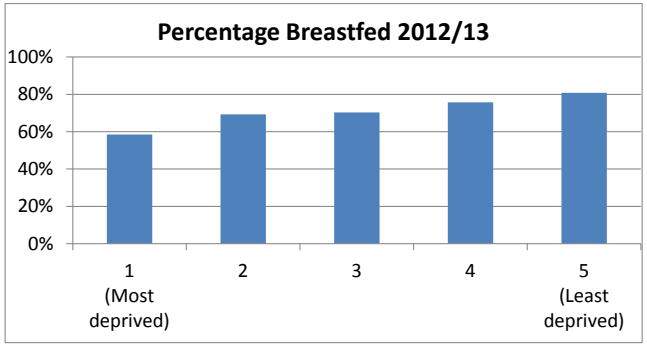


Figure 21 - Breastfeeding at 6 weeks by IMD

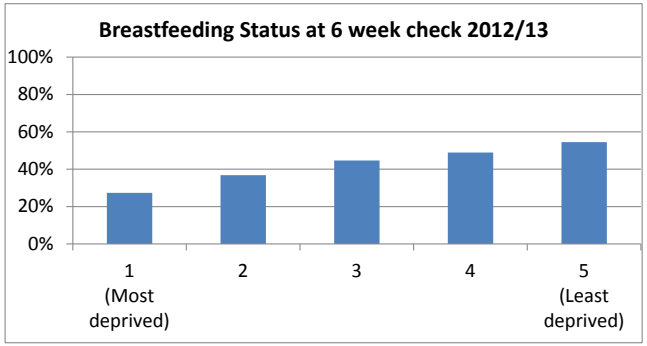
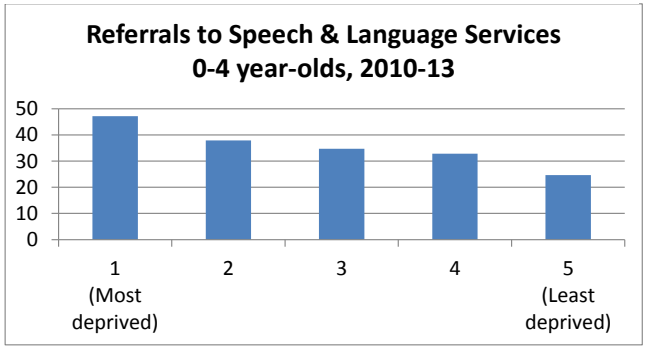


Figure 22 - Referral rates to speech and language service by IMD



Health outcomes

- Hospital emergency admissions rates are higher for young children from IMD1 and there is a gradient across all levels of deprivation as shown in Figure 24.
- The rate of A&E and MIU attendances per 100,000 population are significantly higher from IMD1 than IMD10.Figure 25 shows that the gradient is fairly flat after the first 3 deciles.
- The average number of decayed, missing or filled teeth is 6 times greater in the most deprived decile than the least deprived and again is particularly high in the first three deciles compared to the rest (Figure 26)
- Over ¼ of Reception age children (4-5 years) are overweight or obese from IMD 1 compared to 1/5 from IMD 5 (Figure 27)

Figure 24 - Emergency Admissions in under 5s by IMD

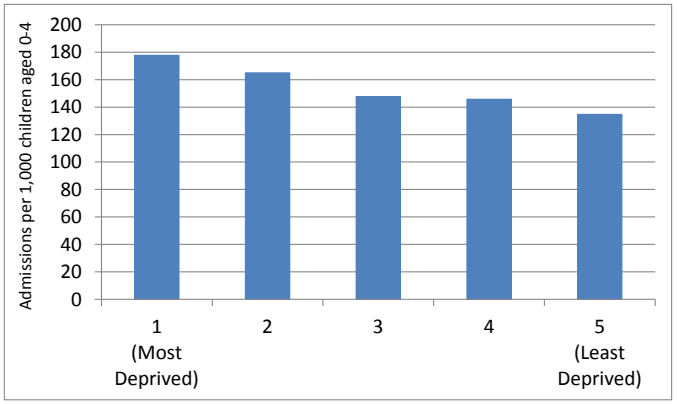


Figure 25 - A&E and MIU attendance rates for 0-4 year-olds per 1,000 children aged 0-4, 2010-2012

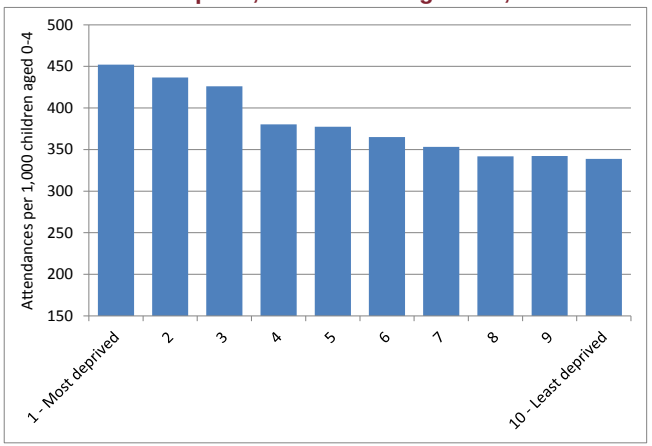


Figure 26 - Number of Decayed, Filled or Missing teeth (DFMT) of 5 year olds in Worcestershire

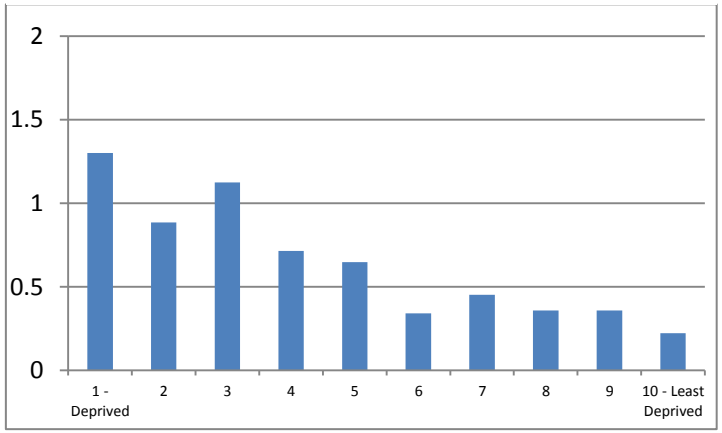
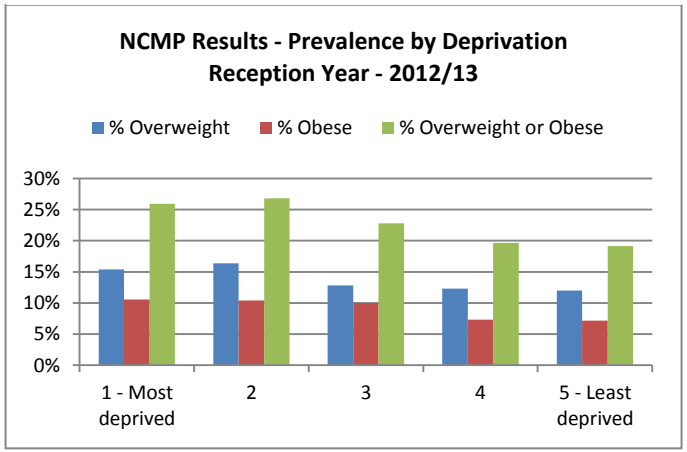


Figure 27 - Overweight and obesity in children by IMD



Access to services

- The overall percentage of young children accessing Children's Centres in Worcestershire was 48% in 2013. The reach is greater for those in IMD1 at 53% than least deprived communities.
- The uptake of funded childcare places for 3 and 4 year olds (15 hours per week for 38 weeks per year) is good in Worcestershire and 100% for those from IMD 1 & 2.
- The average % of Children in Need age 0-4 in IMD1 is 11% compared to 1% in IMD5. (A child in need is defined under the Children Act 1989 as a child who is unlikely to reach or maintain a satisfactory level of health or development, or their health or development will be significantly impaired, without the provision of services, or the child is disabled). Children in Need are then those children who are referred to Children's Social care even if no further action is taken.

Figure 28 - Children's centres attendance rates by IMD

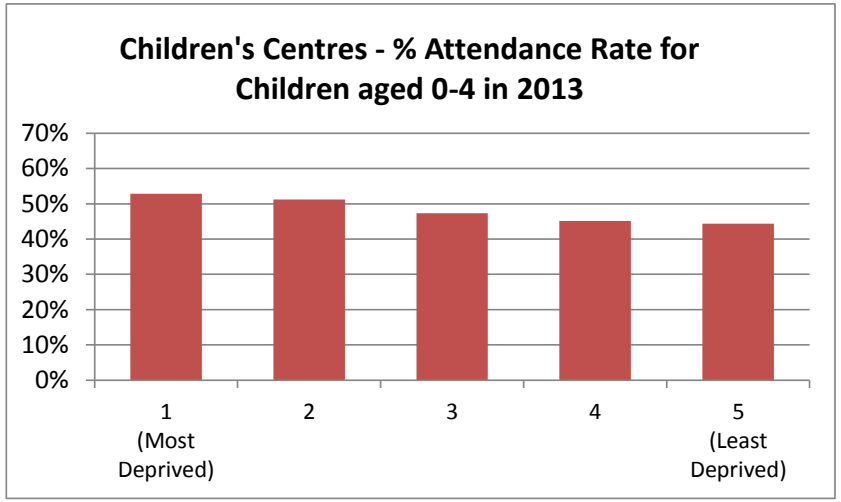


Figure 29 - Funded childcare uptake by IMD

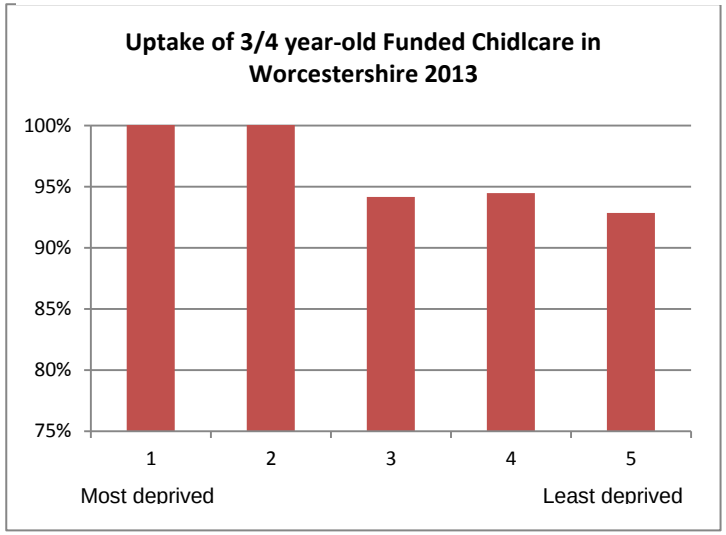
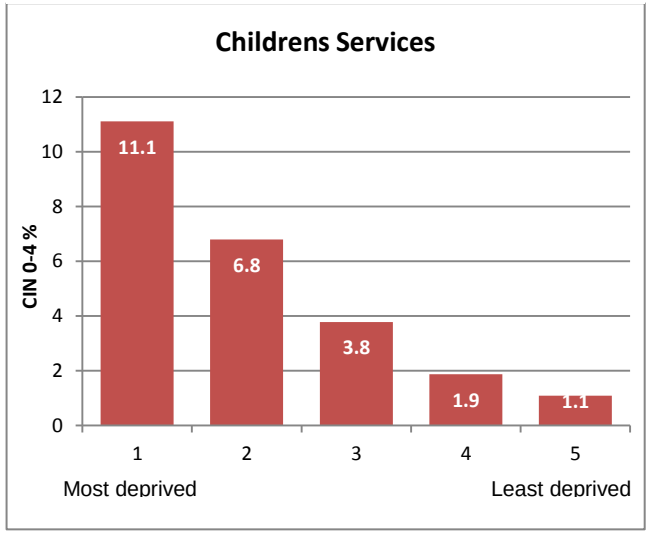


Figure 30 - Percentage of Children in Need



To have an impact on health inequalities we need to address the social gradient in children's access to positive early experiences. Later interventions, although important, are considerably less effective where good early foundations are lacking. To reduce inequalities in early child development Marmot identified 3 priority objectives and associated policy recommendations, our progress against each recommendation has been highlighted.

Progress against Marmot

Marmot Priority Objectives:	Marmot Policy Recommendations:	Worcestershire practice:
• Reduce inequalities in the early development of physical and emotional health, and cognitive, linguistic, and social skills.	• Increase the proportion of overall expenditure allocated in early years and ensure expenditure is focused progressively across the social gradient.	• The local Worcestershire data identifies most of the significant inequalities across the social gradient form in pregnancy and the early years. • In Worcestershire there has not been a shift of expenditure towards early years apart from the national increase in Health Visiting numbers and roll out of additional free funded nursery provision. The spend on both early years and later childhood has not been determined across Worcestershire. WCC budgets for Children's Centres, Connexions, Youth Support and early intervention have been pooled to commission Early Help services 0-19 years. • Universal early years provision is generally provided across Worcestershire in accordance with population size with some weighting for deprivation rather than being focussed progressively across the social gradient
• Build the resilience and well-being of young children across the social gradient.	• Provide good quality early years education and childcare proportionately across the gradient. This provision should be: - Combined with outreach to increase the take-up by children from disadvantaged families - Provided on the basis of evaluated models and to meet quality standards.	• There is good access and coverage of funded early years education and childcare across Worcestershire. However there is a steep social gradient in school readiness measure (EYFS). • The quality of early years education, childcare provision and associated workforce has not been identified or analysed across the social gradient • A variety of outreach activity takes place from Children's Centres, however this has not been analysed by social gradient. • It is not clear whether early years education or childcare provision is provided in accordance with evidence based evaluated models or quality standards

Marmot Priority Objectives:	Marmot Policy Recommendations:	Worcestershire practice:
• Ensure high quality maternity services, parenting programmes, childcare and early years education to meet need across the social gradient.	• Support families to achieve progressive improvements in early child development, including: - Giving priority to pre- and post-natal interventions that reduce adverse outcomes of pregnancy and infancy - Providing paid parental leave in first year of life with a minimum income for healthy living - Providing routine support to families through parenting programmes, children's centres and key workers, delivered to meet social need via outreach to families - Developing programmes for the transition to school.	• Progressive ongoing support is not provided consistently across early years - All families are provided with information, advice and support during pregnancy and birth and some receive additional support in accordance with the Healthy Child Programme if there is an identified need. There are no intensive pre or post natal programmes or support available in Worcestershire which have been shown to be effective in improving the health, well-being and self-sufficiency of low income, young first-time parents and their children. - Routine home visiting support is provided by Health Visiting with additional or specialist support provided if there is an identified need in accordance with the Healthy Child programme. There are no intensive programmes of home visiting or ongoing support during the early years for disadvantaged families. - Routine outreach services are provided through Children's Centres (now Early Help Centres) where families can receive integrated services, information and support. However half of the under 5s population did not access Children's Centres last year. Access across the social gradient was similar, rather than Children's Centres reaching those families who could benefit the most. An analysis of uptake of outreach support has not been analysed by social gradient. - There are few evidence based early intervention programmes available across Worcestershire and are not available consistently across the county. New Early Help services for 0-19s have recently been commissioned to help families with a range of issues and aim to nip problems in the bud before they get worse, however this is resulting in the emergence of a variety of differing local models and programmes of support. - In Worcestershire early years services across agencies are not integrated and it is not clear who is the key worker - A variety of parenting support and programmes are provided for different ages and by various agencies. The support and programmes are not consistent, targeted or provided progressively.

Priorities for Action

- Ensure that all disadvantaged or vulnerable families are identified and offered intensive ante-natal and post natal home visiting including the implementation of a Family Nurse Partnership programme for teenage first time mothers.
- Review the availability and intensity of parenting support to ensure evidence based parenting advice and support is provided across all ages in proportion to need
- Integrate the delivery of all 0-5s services including Maternity, Health Visiting, Early Help and Early Years services to better enable a seamless provision of progressive universalism – universal coverage with evidence based targeted programmes for disadvantaged and vulnerable families to improve outcomes.
- Children's Centres (Early Help) to prioritise evidence based outreach and family support to work with the most vulnerable families
- Target early learning and language of disadvantaged children using intensive, high-quality home and centre-based interventions.
- Develop better understanding of early years educational and childcare interventions to determine whether evidence based and meeting quality standards

Chapter 3 Enable all children, young people and adults to maximise their capabilities and have control over their lives

Inequalities in educational outcomes affect physical and mental health, as well as income, employment and quality of life. The graded relationship between socioeconomic position and educational outcome has significant implications for subsequent employment, income, living standards, behaviours, and mental and physical health. To achieve equity from the start, investment and action in the early years is crucial. However, maintaining the reduction of inequalities across the gradient also requires a sustained commitment to children and young people through the years of education. Central to this is the acquisition of cognitive and non-cognitive skills, which are strongly associated with educational achievement and with a whole range of other outcomes including better employment, income and physical and mental health.

> *"Overall, success in education brings many advantages. If we are serious about reducing both social and health inequalities, we must maintain our focus on improving educational outcomes across the gradient. Inequalities in educational outcomes are as persistent as those for health and are subject to a similar social gradient. Despite many decades of policies aimed at equalising educational opportunities, the attainment gap remains. As with health inequalities, reducing educational inequalities involves understanding the interaction between the social determinants of educational outcomes, including family background, neighbourhood and peers, as well as what goes on in schools.*
>
> *Learning does not just happen in schools and it does not stop when we leave school. To enable people to fulfil their potential, opportunities for lifelong learning and skills development need to be promoted, not only in formal educational settings, but also in the workplace and in communities."*
>
> *(Fair Society, Healthy Lives The Marmot Review, 2010).*

Marmot stressed that effective provision in the early years needs to be followed through with effective provision in the primary years: even the most effective early years interventions can be 'washed out' by poor quality primary education. The review emphasised that families assessed as in need of intensive support in the early years should continue to be provided with help throughout the transition to school.

Evidence shows it is crucial to establish resilience in childhood. Parental engagement and support, communication within families and positive parenting styles are critical in establishing childhood resilience. Structured parenting programmes can assist parents to achieve this.

Good, effective PSHE in school can contribute to improving resilience and health among children as can a sense of belonging or connectedness to school. School connectedness can be generated in schools through extra-curricular activities, positive classroom management and physical activity. Physical activity programmes in schools also have positive results in academic attainment, concentration, memory and classroom behaviour.

During adolescence major transitions and rapid developmental changes occur making the teenage years a time of immense potential for applying preventive interventions and building resilience. However as health risk behaviours co-occur in adolescence and that common risk factors underlie such behaviours interventions and approaches to focus on these risk factors have great potential to prevent multiple problems.

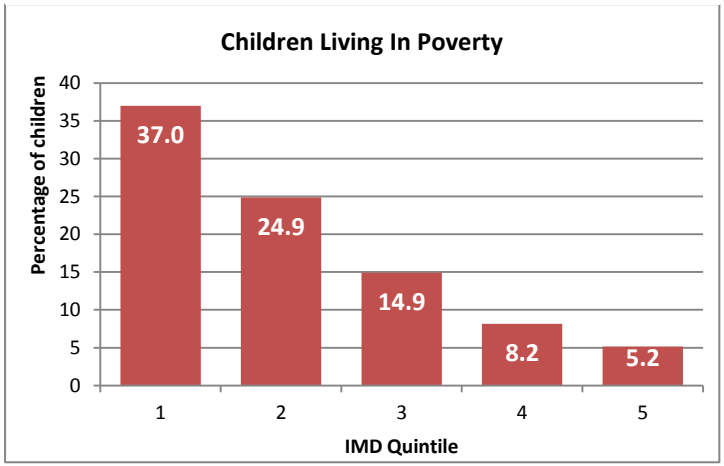
Evidence shows the importance of providing opportunities to acquire higher levels of skills and qualifications beyond compulsory education. However higher education disproportionately benefits middle class young people and those with higher academic attainment. It is therefore important to ensure that disadvantaged young people receive individualised support to gain skills starting well before they leave school and maintaining this support through the transitional years from 16–25.

The Worcestershire Picture

Children in poverty

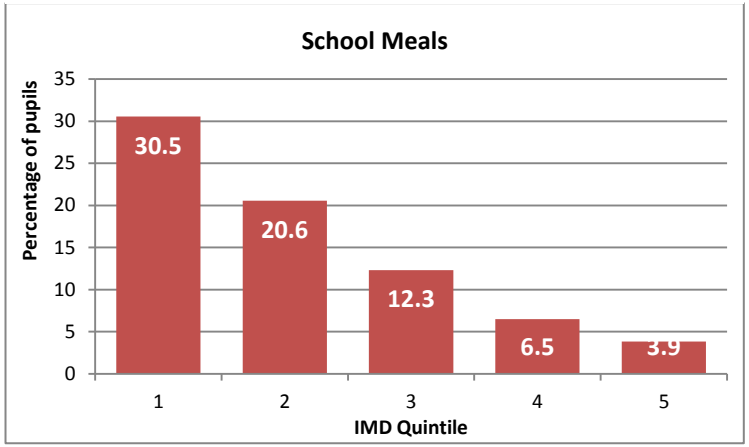
- There is a steep social gradient for percentage of children living in poverty. 37% of children from areas in IMD 1 are living in poverty whereas only 5% in IMD 5

Figure 31 - Proportion of Children living in Poverty



- This gradient is also then seen in percentage of children in receipt of free school meals with 30% of pupils from IMD1 within free school meals group vs 4% in IMD1.

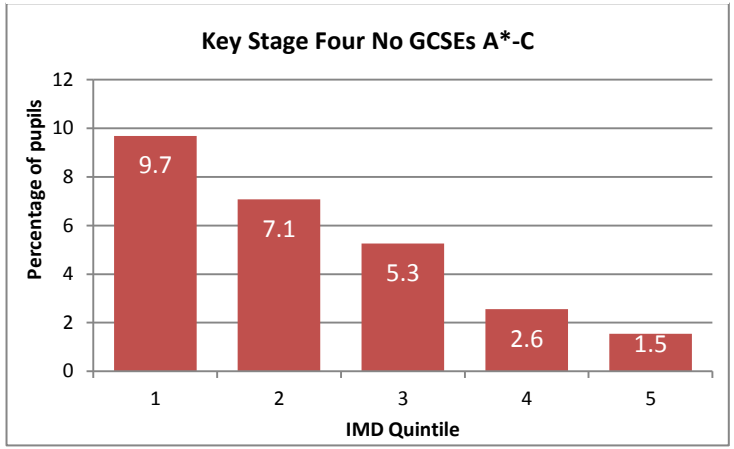
Figure 32 - Proportion of Pupils on Free School Meals



Educational achievement

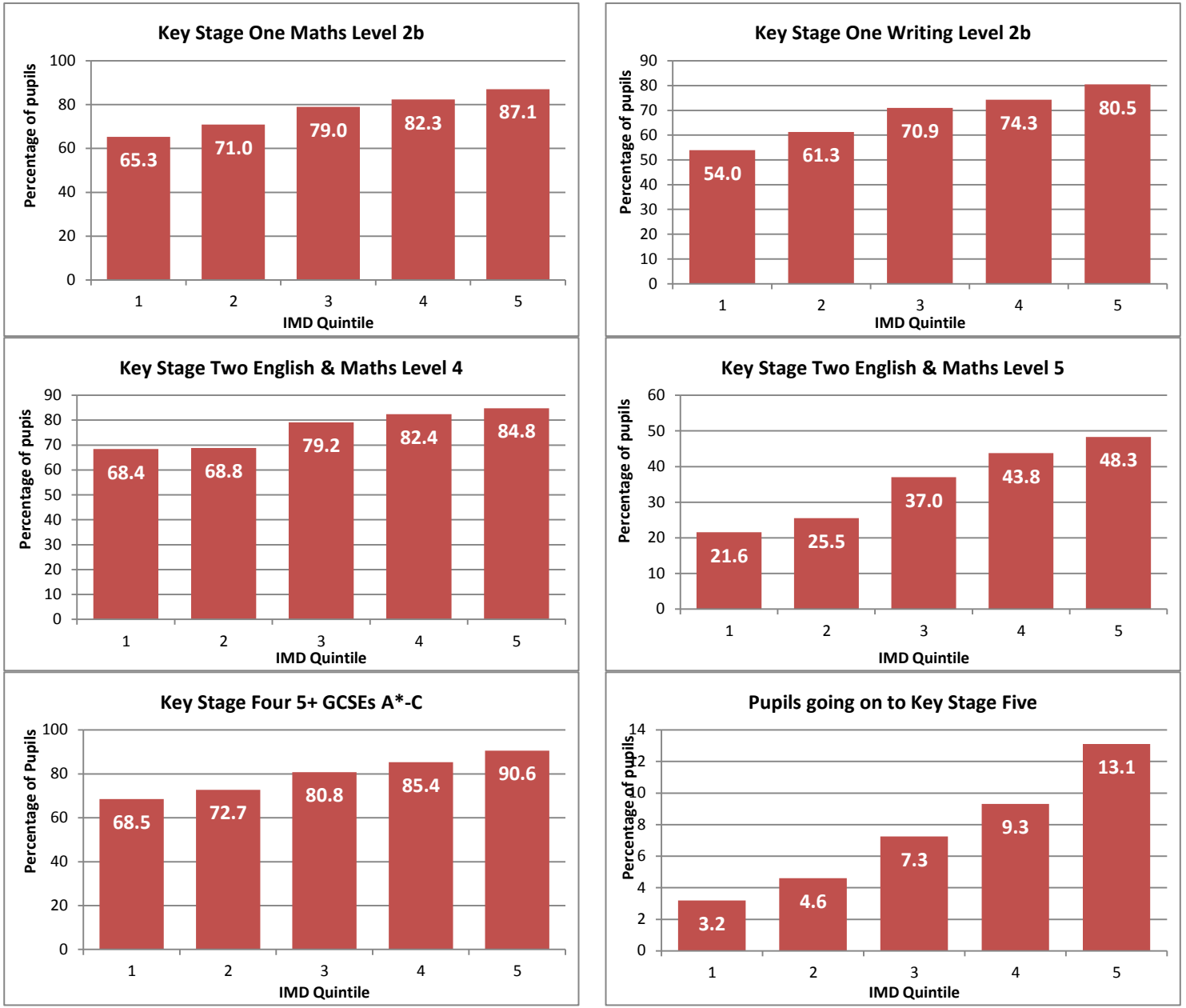
- The series of charts in Figure 34 on educational achievement show that from Key Stage 1 through to Key Stage 5 there is a social gradient in achievement
- The percentage of children from IMD1 who achieve a Level 4 or above in Maths and English at Key Stage 2 is 68% whereas it is 85% in IMD5.
- The social gradient is more marked for those children who have achieved a Level 5 at Key stage 2 with over twice as many in IMD5 (48%) than IMD1 (22%).
- The inequality in achievement has widened by Key Stage 4 (age 16). Almost 10% of pupils in IMD1 achieve no GCSEs compared to 1.5% in IMD5 (Figure 33).
- Looked after children results for 2012 show just 12% achieving 5 or more GCSEs and although this had improved to 45% in 2013 the average across county was 84% for both years.

Figure 33 - Proportion achieving no GCSEs by IMD



- 68% of pupils in IMD1 achieve 5 or more GCSEs whereas in IMD5 90.6% achieve that level.
- More Young People go on to Key Stage 5 in IMD 5.
- The % of pupils achieving A to G is similar but % achieving best grades (A*-A) was 13% in IMD 5 vs 3% in IMD1.

Figure 34 - Educational attainment by IMD



Children in need and child protection

- The social gradient for the percentage of Children in Need is similar in all ages. For those age 0-17s the average % in IMD1 LSOAs was 10.7% in IMD1 vs 1.6% IMD5. A child in need is defined under the Children Act 1989 as a child who is unlikely to reach or maintain a satisfactory level of health or development, or their health or development will be significantly impaired, without the provision of services, or the child is disabled.
- The rate of CIN per 1000 population aged 0-17 as at 31/3/13 was 60.7 from IMD1 compared to 9.7 per 1000 from IMD5.
- The rate of children subject to a child protection plan as at 31/3/13 was 10.3 per 1000 (0-17 years) from IMD1 compared to 0.4 per 1000 from IMD5
- The rate of Looked after Children (LAC) as at 31/3/13 was 14.4 per 1000 (aged 0-17) from IMD1 compared to 1.0 per 1000 from IMD5
- The percentage of children who received fixed term exclusions is higher in IMD1 (3.7%) than IMD5 1.1% Exclusions
- The percentage of children with statement of SEN is twice as high from IMD1 (4.9%) than IMD5 (2.5%)

Figure 35 - Children in Need per 1,000 population

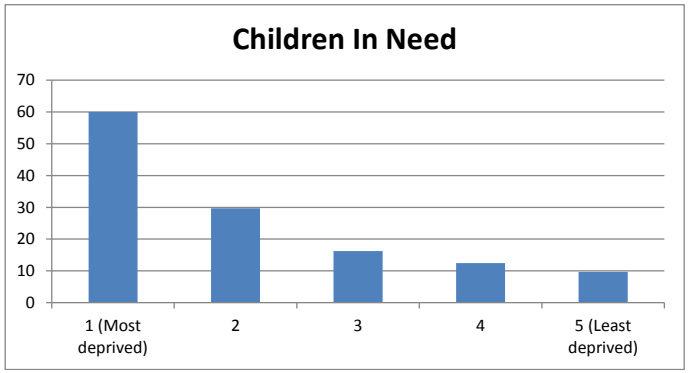


Figure 36 - Children subject to Child Protection Plans per 1,000 population

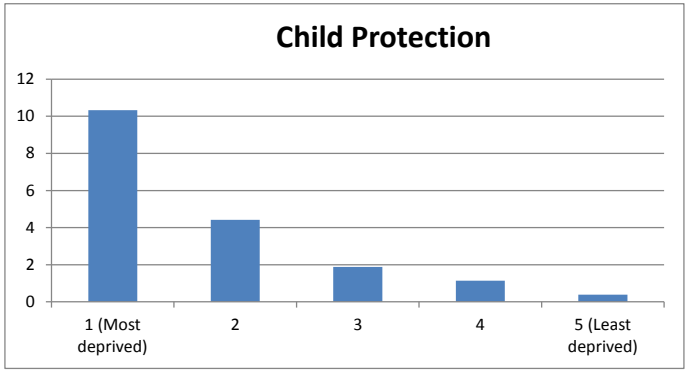


Figure 37 - Rate of Looked after Children per 1,000

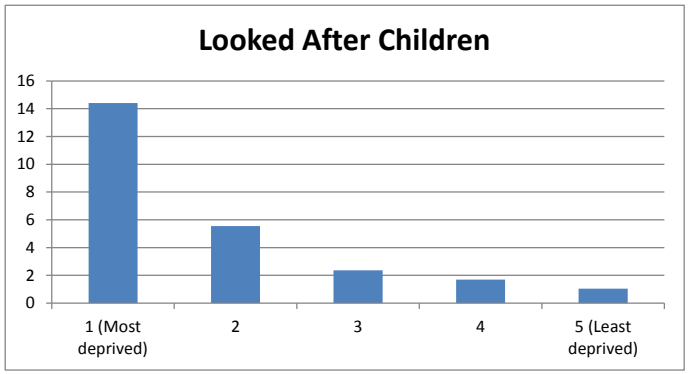


Figure 38 - Percentage of Pupils with Fixed Term Exclusions

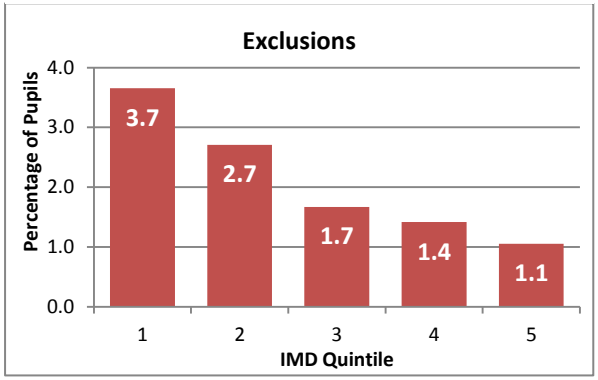
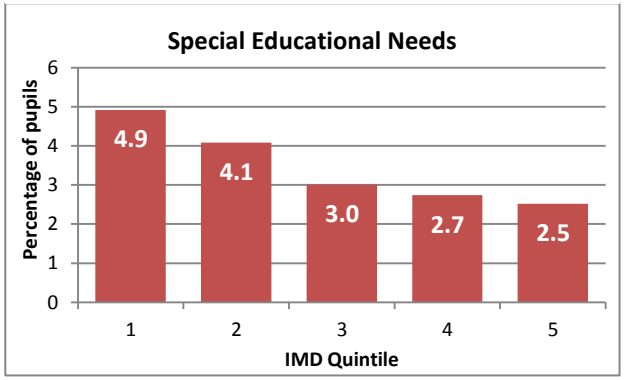


Figure 39 - Percentage of Pupils with Special Educational Needs



Health outcomes

- Figure 40 shows the results from the National Child Measurement Programme for year 6 pupils in the 2012/12 academic year.
- As with reception there is a gradient with IMD, but this is a steeper gradient in year 6.
- In 2012/13, 20% of children in the most deprived fifth of areas were obese compared with 13% in the least deprived fifth.
- There is a consistent social gradient for A&E attendance rates which becomes more pronounced in the older groups as shown in Figure 41
- There is a slight gradient in emergency admissions for the 5-11s and 12-15s, it is much steeper in the 16-24s as seen in Figure 42.

Figure 40 - Overweight & Obesity in Year 6 by IMD

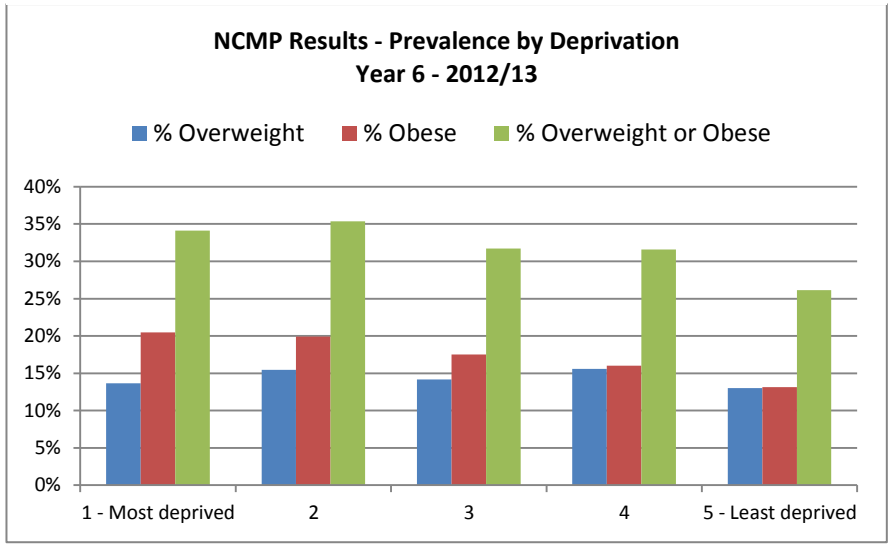


Figure 41 - A&E and MIU Attendance Rates

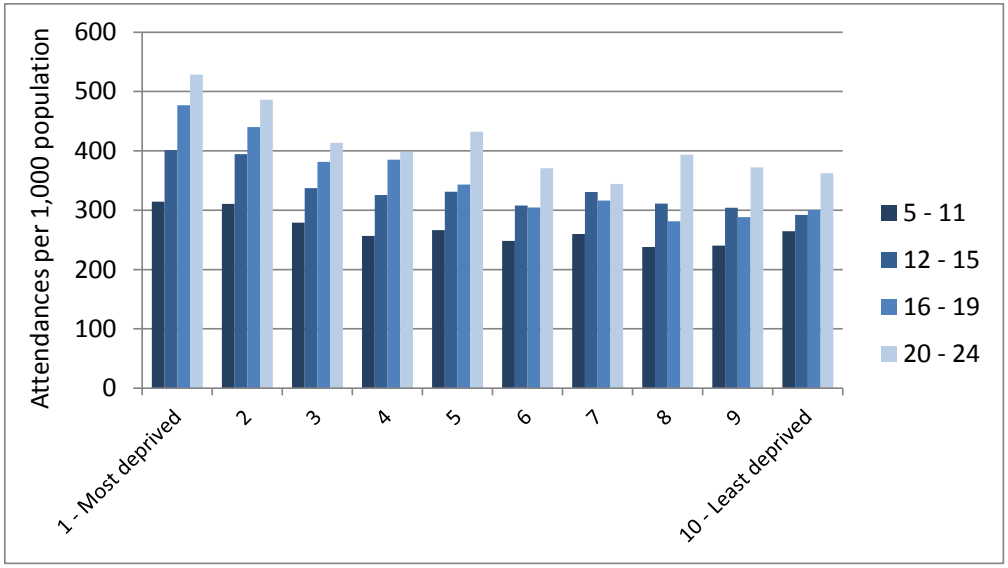
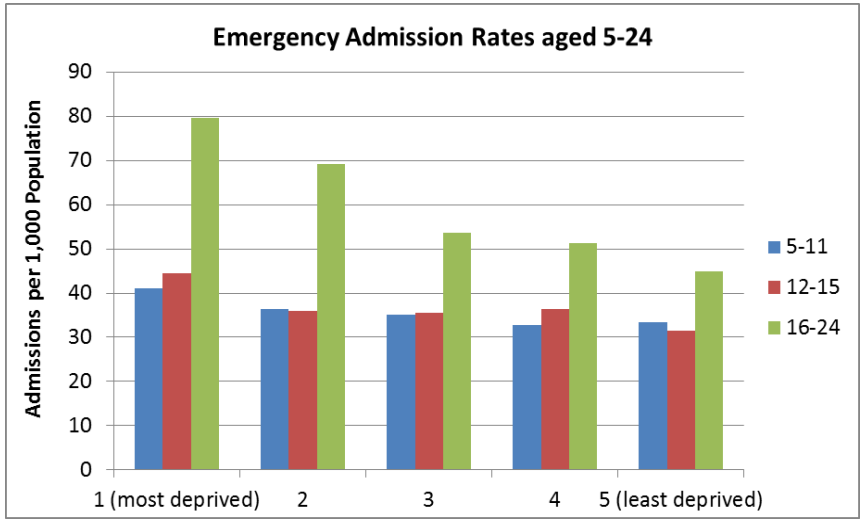


Figure 42 - Emergency Admissions to Hospital



Mental health

- Emergency admission rates for self-harm for both 12-15 year-olds and 16-19 year-olds have a marked gradient with deprivation.
- The main difference for 12-15 year-olds is in the most deprived 20%, with the rest being fairly similar.
- For 16-19 year-olds the rates are highest in the most deprived 2 quintiles, with the other 60% being similar and much lower.
- The number of referrals of 0-17 year-olds to mental health services shows a similar picture with the most deprived 10% having far more referrals and slightly raised numbers in the next 2 deciles (Figure 46)
- The same pattern of high rates in the most deprived quintile of the population is seen in Figure 45 which shows admission rates for alcohol-related conditions in 16-24 year-olds.

Figure 43 - Self Harm in 12-15 year-olds by IMD

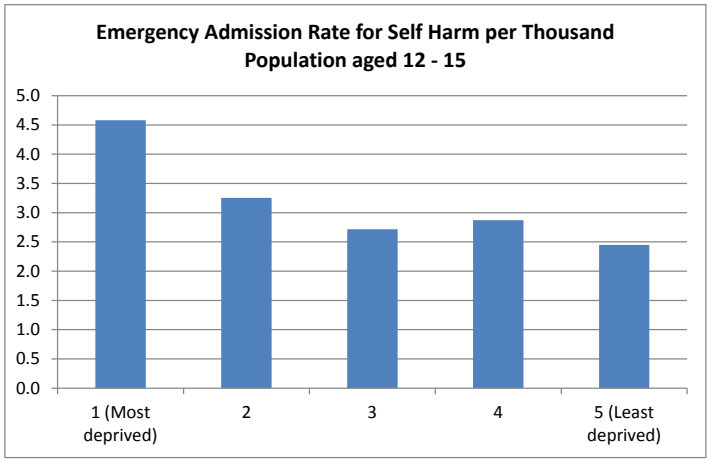


Figure 44 - Self Harm in 16-19 Year-olds by IMD

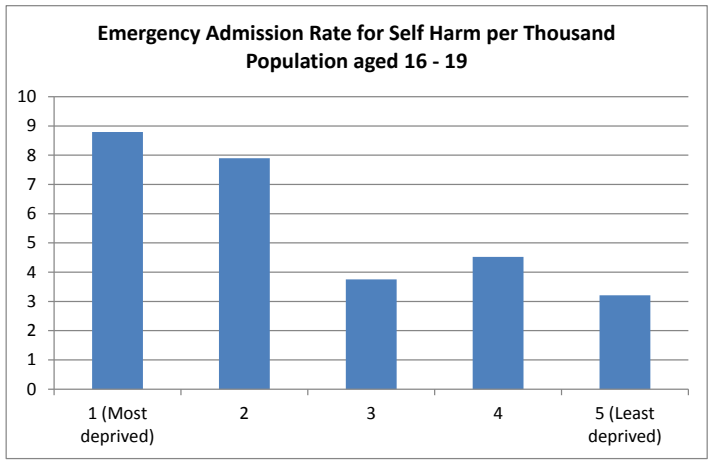


Figure 46 - CAMHS Referrals per thousand aged 0-17 by IMD

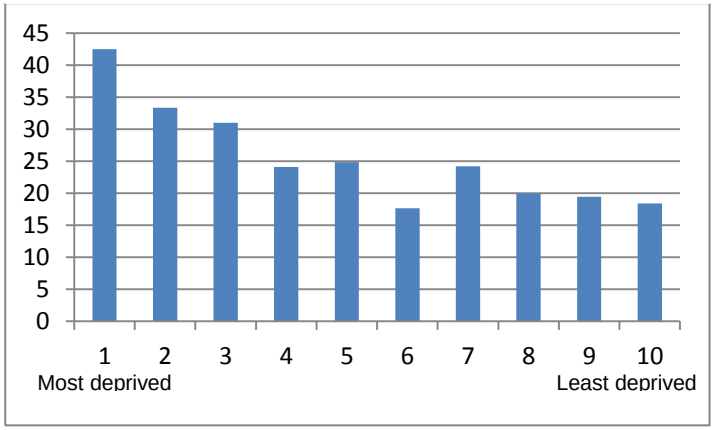
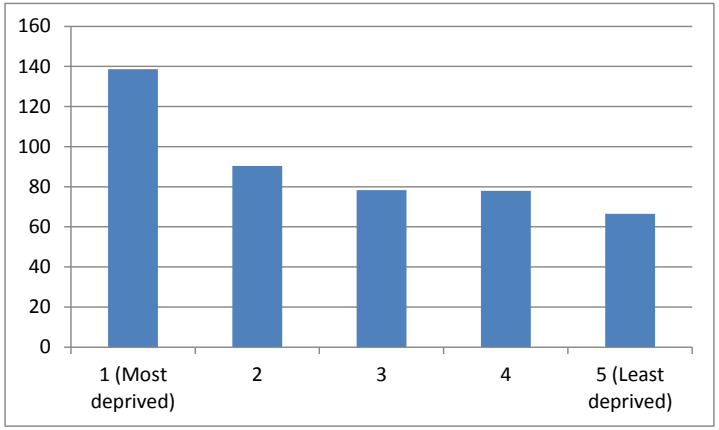


Figure 45 - Alcohol related admissions per thousand aged 16-24 by IMD



To have an impact on health inequalities in childhood, adolescence and early adult life we need to address the social gradient in educational attainment, skills and qualifications as well as improving the resilience, self-esteem and well-being of children and young people. Marmot identified that the impact of investment in the pre-school years is likely to evaporate unless it is sustained through school, particularly through the years of primary education. Strengthening protective factors or assets in schools, in the home and in local communities can make an important contribution to reducing risk for those who are vulnerable. Families and parenting can positively influence the resilience of children and young people however material disadvantage and poor parental mental health can impact on their ability to engage, provide support and offer important developmental opportunities. Opportunities to continue to acquire skills, qualifications and education beyond compulsory education and receive ongoing support and advice into adulthood should continue to be focussed across the social gradient.

Progress against Marmot

Marmot Priority Objectives:	Marmot Policy Recommendations:	Worcestershire practice:
• Reduce the social gradient in skills and qualifications.	• Ensure that reducing social inequalities in pupils' educational outcomes is a sustained priority.	• The educational outcomes in Worcestershire identify a steep social gradient. Inequalities that are evident at the start of school as seen by EYFS scores and then Key stage 1 appear to remain and indeed widen throughout all key stages. • It is not clear whether families that are supported during early years receive continued support through transition to school and beyond
• Ensure that schools, families and communities work in partnership to reduce the gradient in health, well-being and resilience of children and young people.	• Prioritise reducing social inequalities in life skills, by: - Extending the role of schools in supporting families and communities and taking a 'whole child' approach to education - Consistently implementing 'full service' extended school approaches - Developing the school-based workforce to build their skills in working across school– home boundaries and addressing social and emotional development, physical and mental health and well-being.	• Parenting programmes are widely, but not universally, available and almost exclusively targeted at families with children under 12 years. • The quality of PSHE input and teaching experienced by children and young people appears to be highly variable • The mental health programme SEAL ('social and emotional aspects of learning'), has been promoted as has the Healthy Schools programme. There is a need to continue to promote schools as settings for healthy behaviours and utilise "whole school" approaches to improving health behaviours • School based interventions need to better link with parents, the family and the community, with an emphasis on enabling parents to support their child's cognitive development and life skills.
• Improve the access and use of quality lifelong learning across the social	• Increase access and use of quality lifelong learning opportunities across the social	• There remain gaps in the provision of vocational skills development for other groups of young people and in access to work-based learning routes. Young people are still

Marmot Priority Objectives:	Marmot Policy Recommendations:	Worcestershire practice:
gradient.	gradient, by: - Providing easily accessible support and advice for 16-25 year olds on life skills, training and employment opportunities - Providing work-based learning, including apprenticeships, for young people and those changing jobs/careers - Increasing availability of non-vocational lifelong learning across the life course.	the group most likely to be unemployed and to be in low skilled jobs. • Support and advice over ongoing learning, training, housing, debt, physical and mental health and relationship concerns is particularly important for the 16–25 age group. • Locally the Support Guidance & Skills service no longer exists and has been replaced by schools taking responsibility for careers advice, Early Help and post 16 team picking up other aspects of support and advice but with resources predominantly for 13-19s. • There appears a lack of join up of support & advice for young people aged 13-25 across the county and it is unclear which young people should be targeted • Provision around apprenticeships/learning is available but not clearly planned and coordinated

Priorities for Action

- Ensure progressive intensive support to targeted vulnerable families continues from early years to transition to school, through primary school & beyond where necessary
- Review & strengthen parenting advice & support across all ages (In previous chapter)
- To promote and improve resilience and school connectedness, schools & colleges to act as health & well-being promoting settings, to strengthen their delivery of PSHE and increase opportunities for participation in physical activity both in & out of school
- Develop targeted evidence based interventions towards clusters of adolescent children identified as being at high risk of multiple poor behaviours, rather than providing single issue services only
- Focus on reducing the attainment gap. To support schools to deliver better educational outcomes across the social gradient there should be a focus on raising educational standards among the most vulnerable children and young people
- Extend ongoing learning & support up to age 25 for those disadvantaged through a coordinated approach

Chapter 4 Create fair employment and good work for all

What is the problem?

Being in good employment is protective of health and conversely unemployment contributes to poor health. To reduce health inequalities it is therefore very important to get people into work. Long-term unemployment in particular has significant impact on physical and mental health (Marmot 2010).

Unemployed people have many elevated health risks. For example, they have increased rates of limiting long-term illness, mental illness and cardiovascular disease. The experience of unemployment has also been consistently associated with an increase in overall mortality, and in particular with suicide. The unemployed have much higher use of medication and much worse prognosis and recovery rates (Marmot 2010).

Other aspects of employment are also important for health, these include: sustainability, quality, a living wage, opportunities for development, flexibility to enable a work life balance and protection from adverse working conditions (Marmot 2010).

Unemployment is highest in those with no or few qualifications and skills, people with disabilities and mental ill health, those with caring responsibilities, lone parents, ethnic minority groups, older workers and, in particular, young people. When in work, these same groups are more likely to be in low-paid, poor quality jobs with few opportunities for advancement, often working in conditions that are harmful to health. Many are trapped in a cycle of low-paid, poor quality work and unemployment (Marmot 2010).

Patterns of employment both reflect and reinforce the social gradient (Marmot 2010). Evidence suggests policy to reduce the social gradient in employment and working conditions should be focused on two interrelated aims: first, to reduce the adversity of working conditions and employment and second, to target interventions proportionately towards lower socioeconomic groups (Marmot 2010).

Young people who are not in education, employment or training (NEET) are at greater risk of a range of negative outcomes, including poor health, depression or early parenthood (PHOF Indicator Definitions and Supporting Information, accessed 27 March 2014).

The Worcestershire Picture

Unemployment

- In November 2013, the unemployment benefit claimant rate in Worcestershire was relatively low at 2.2%, or about 7,600 people
- 1,300 of these are in the Redditch district.
- This was below the West Midlands (3.7%) and the national (2.9%) rates.
- The rate varied between the county districts as depicted in the Figure 47 which compares rates in November 2013 with November 2012. All districts saw a decrease.
- A relatively low county rate conceals some pockets of very high unemployment, however, and this has an influence on many other conditions, including deprivation, poverty and substance misuse.
- Table 2 lists the wards in Worcestershire that had the highest unemployment rates at November 2013.
- These local unemployment proportions were lower than in 2012.
- The unemployment benefit claimant proportion in many of the top ten wards was higher than the West Midlands (3.7%) and England (2.9%) rate, and all but Wychavon district were represented.
- There are more wards from Worcester City District represented in this top 10 list than any other area of Worcestershire.
- In 2013, however, it was closely followed by Wyre Forest with 3 areas in the top 10.
- There was some correlation as expected, with the areas of higher deprivation (and the lowest life expectancy) in the county, including Oldington & Foley Park, Warndon, Gorse Hill and Rainbow Hill and Broadwaters.
- Three new wards entered the top ten (Charford, Areley Kings and Sidemoor Central);
- Redditch, although it has the most areas of high deprivation and the largest hotspot areas, only has one ward in the list.

Figure 47 - Unemployment Benefit Proportion % of the population (aged 16-64) Nov 2013

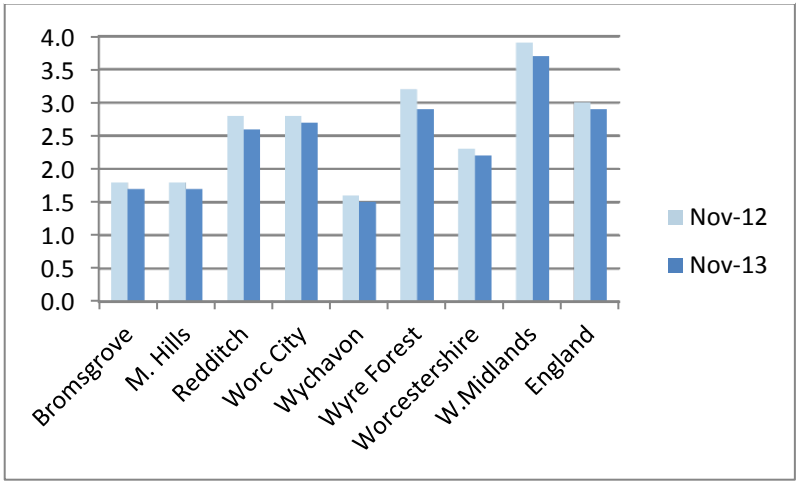


Table 2 - Top 10 wards for unemployment proportion in Worcestershire November 2013

Rank (2012)	Ward	District	% Claimants 16-64
1 (1)	Oldington & Foley Park	Wyre Forest	6.6%
2 (3)	Warndon	Worcester City	5.4%
3 (2)	Gorse Hill	Worcester City	5.3%
4 (4)	Cathedral	Worcester City	4.9%
5 (6)	Broadwaters	Wyre Forest	4.6%
6 (6)	Pickersleigh	Malvern Hills	4.4%
=6 (5)	Rainbow Hill	Worcester City	4.4%
7 (8)	Charford	Bromsgrove	4.0%
8 (-)	Areley Kings	Wyre Forest	3.8%
9 (-)	Sidemoor	Bromsgrove	3.7%
10 (-)	Central	Redditch	3.6%

Source: WCC Monthly Economic Summary December 2013 (RIU) using ONS 2013 downloaded from NOMIS

- During the recession the male claimant count rate increased at a faster pace than the female rate. Post-recession the male rate began to fall again, although not back to pre-recession levels, whilst the female rate has remained at the higher level (Worcestershire Economic Summary November 2013).
- The greatest number of people is seeking employment within Elementary occupations - 2,190 people (28.7%) in November 2013.
- This has shown a decrease of 675 claimants when compared with November 2012.
- In November 2013 the number of claimants aged 18-24 was 2,000.
- This represents a decrease of 875 fewer claimants compared to November 2012.
- The proportion of claimants aged 18-24 is 4.8%, lower than the England average.
- The district with the highest proportion of claimants aged 18-24 was Wyre Forest (6.4%). The greatest decrease in absolute terms (between November 2012 and November 2013) took place in Wychavon with a fall of 195 claimants.

Long-term unemployed

- Figure 48 shows how long and medium-term unemployment rates have changed over the last 6 years.
- Whilst the rate of those claiming for 6-12 months has a great deal of variation year-on-year and month-on-month between about 10% and 25%, there is no evidence that there is an overall increase over the long-term.
- In contrast the rate of those claiming for more than 12 months has increased from 5-10% to over 25% and is now higher than for those claiming for 6-12 months.

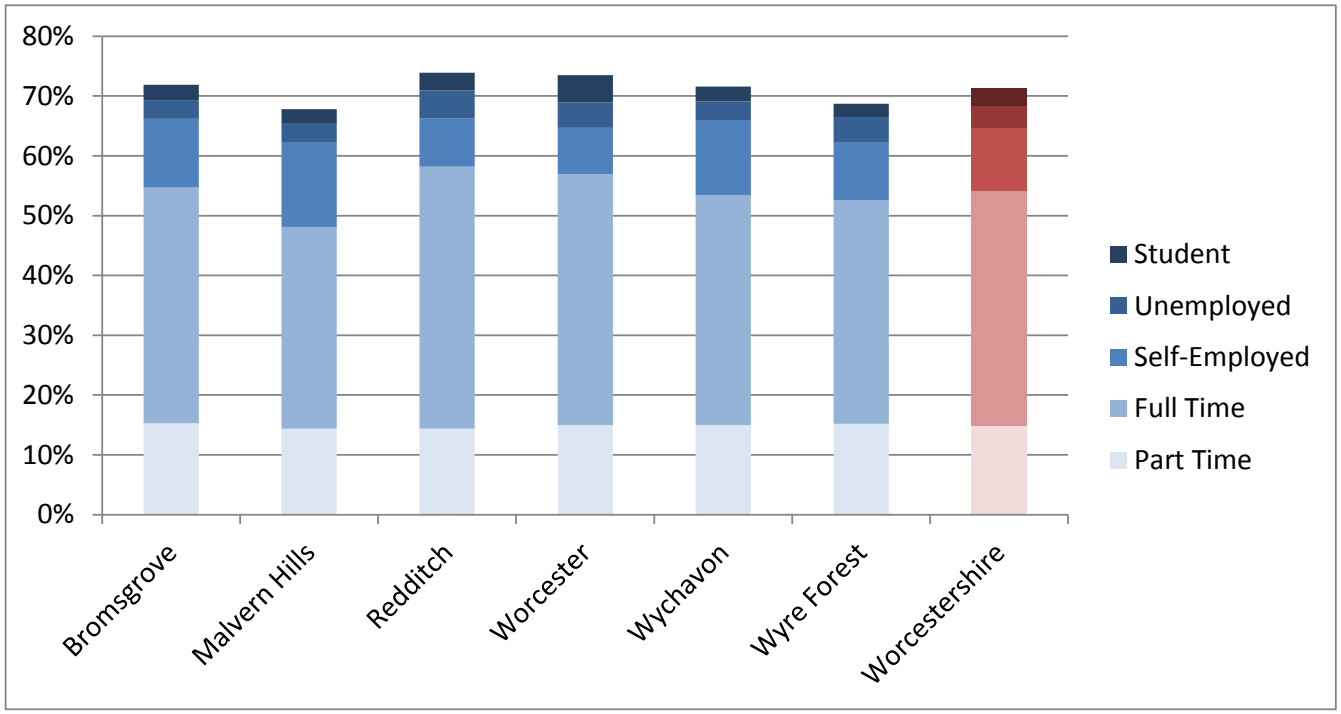
Figure 48 - Percentage of unemployed claiming more than 6 months in Worcestershire

Source: Worcestershire Economic Summary November 2013

Economic activity

- Figure 49 summarises some key features of economic activity in the Worcestershire districts.
- The highest proportion of full time economically active persons is in the Redditch district with 43.8% followed by Worcester City with 41.9%; these are both higher than the county average of just over 39%.
- Part time economically active people represent around 15% of the population with the highest percentage in Bromsgrove District with 15.3% (county average is 14.9%).
- The highest proportion of self-employed people occurs in the Malvern Hills (14.2%) which is way above the county average of only just over 10%.
- The highest proportion of students is in Worcester city with 4.6% which is nearly double the county rate.

Figure 49 - Economic activity in Worcestershire by district, 2011



Source: Census 2011: Economic activity, local authorities in England and Wales

Employment deprivation and health outcomes

- The Index of Deprivation 2010 employment deprivation score measures the extent of involuntary exclusion of the working age population from the world of work. Employment deprivation is defined as those who would like to work but are unable to do so through unemployment, sickness or disability.
- The most deprived fifth of wards in Worcestershire have an average employment deprivation score of 13% compared to 3.5% in the least deprived wards. This means that a typical individual living in the most deprived areas has a likelihood of being out of work nearly four times as high as someone in the least deprived areas.
- There is a strong positive association between premature mortality (mortality rates in those under 75) and the employment deprivation score in Worcestershire Wards (Figure 50). In other words the higher the employment deprivation score the higher the premature mortality rate. However, this does not establish whether poor health causes employment deprivation or vice versa and in reality the relationship is likely to be complex.
- Analysis by quintile (Figure 51) also shows that there is an association between employment deprivation and premature mortality rate. The most deprived wards (quintile 1) have an average premature mortality rate which is more than 50% higher than the least deprived wards (quintile 5).

Figure 50 - Employment deprivation and mortality

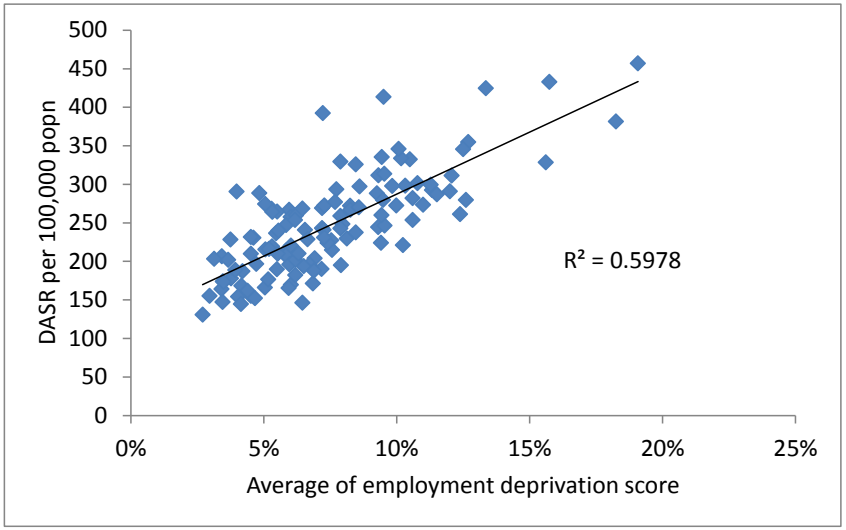
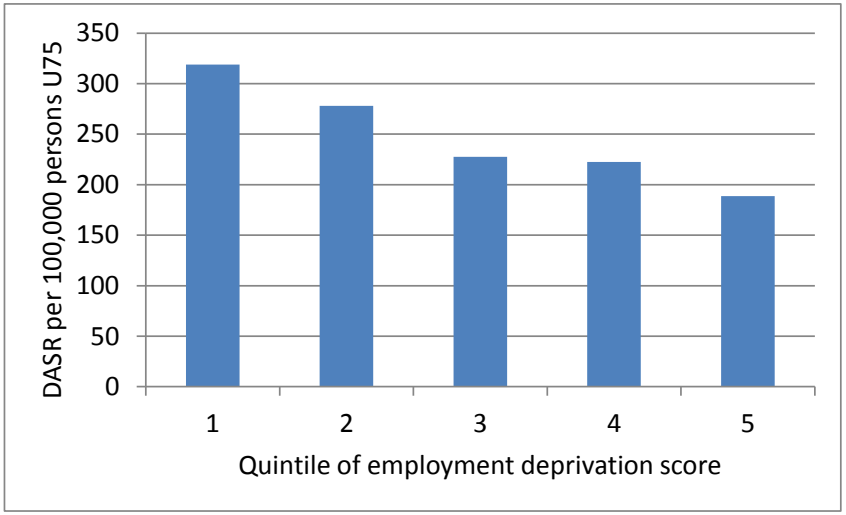


Figure 51 - Employment deprivation and mortality



Source: Index of Deprivation 2010, Ward mortality rates 2008-12 using Public Health Mortality Files
DASR=Directly Age Standardised Rate per 100,000 population

Employment, health and disability

- The estimated proportion of people of working age with long-term health problems who are in work is higher in Worcestershire than England as a whole (73% compared to 63%).
- The gap in the estimated employment rate between those with long-term health problems and the overall employment rate is also lower in Worcestershire than in the West Midlands as a whole and nationally, though the differences are not statistically significant.
- Only 95 out of 1,325 aged 16-64 with learning difficulties in Worcestershire are in employment.
- Although this is slightly higher than the GB average, the gap between the rate for this group and the overall employment rate is larger than for GB as a whole.

Table 3 - Employment and long-term health problems

	Worcestershire	West Midlands	Great Britain
No. in employment with health problems lasting more than 12 months (est)	**71,900**	615,300	7,489,900
All people with health problems lasting more than 12 months (est)	**98,900**	1,027,800	11,871,200
% in employment with health problems lasting more than 12 months	**72.8**	59.9	63.1
% in employment (all people)	**75.9**	68.3	70.7
Gap	**3.1**	8.4	7.6

Source: NOMIS, Annual Population Survey (2012)

Table 4 - Employment and learning disabilities

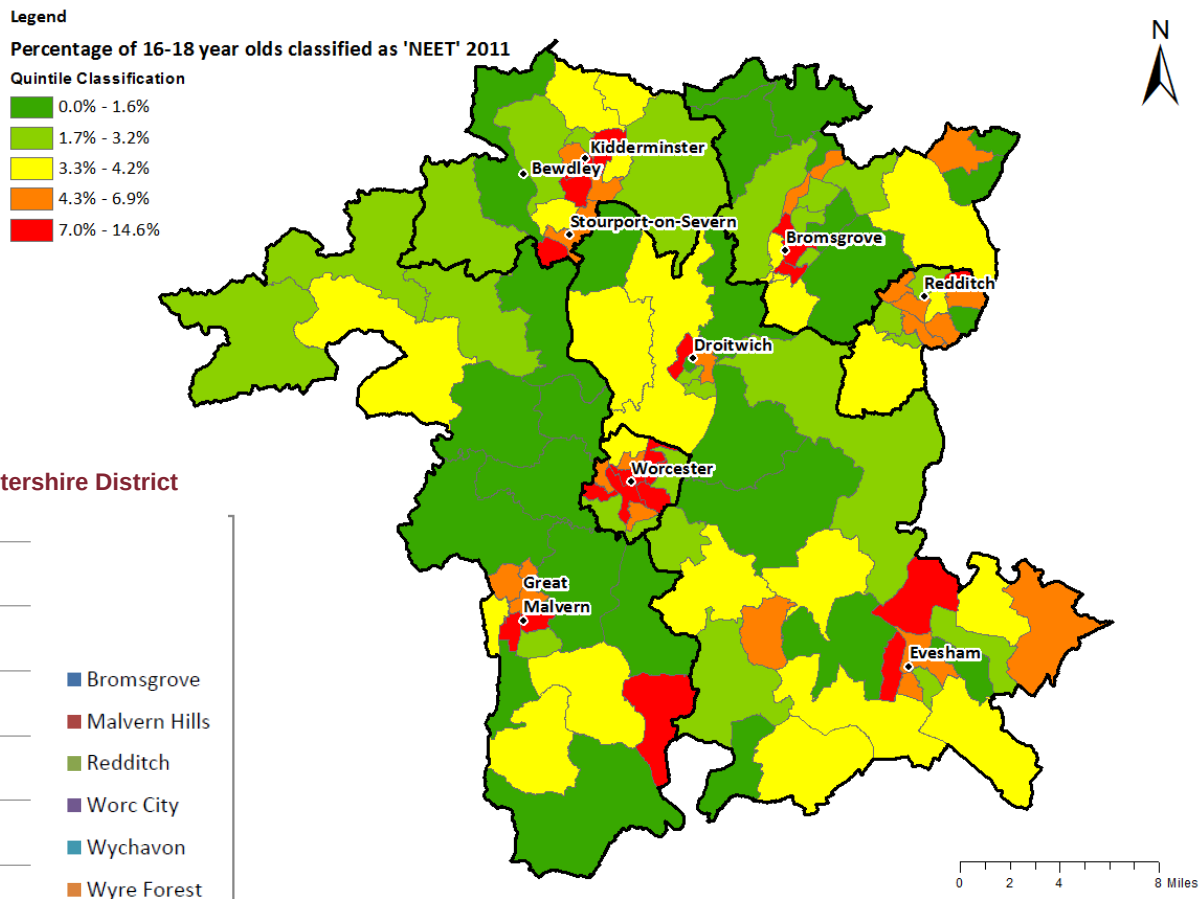
	Worcestershire	Great Britain
Number of working age learning disabled clients in employment	**95**	
Number of working age learning disabled clients	**1,325**	
% in employment - aged 16-64	**73.8**	70.2
% of working age learning disabled clients in employment	**7.3**	7.1
Gap	**66.5**	63.1

Source: NOMIS, ASCOF (clients known to Councils with Adult Social Services Responsibilities; 2011/12)

Young people not in education employment or training (NEET)

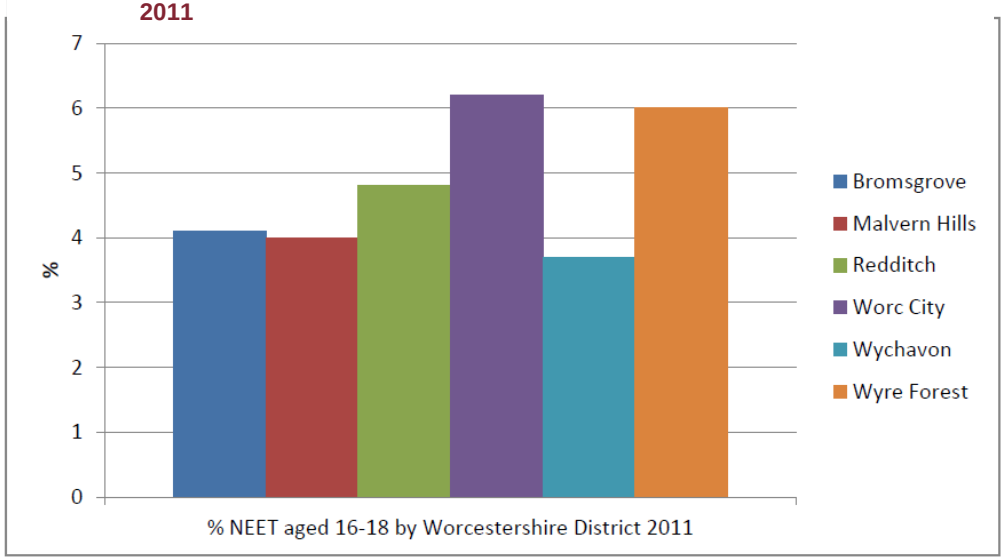
- Compared with England as a whole Worcestershire has a lower percentage of 16-18 year olds not in education employment or training (2012 5.8% vs 5.4% respectively; source Department for Education).
- However, there is a clear but small variance between the different districts as shown in the graph below (JSNA Summary; Sept 13).
- The Marmot indicators of health inequality illustrate the need to focus on maintaining 16-18yr olds in education or training (JSNA Summary Sept 2013).

Figure 52 -Percentage of 16-18 year olds classified as 'NEET' by Worcestershire Ward Area in 2011



Source: Worcestershire County Council Instant Atlas Toolkit. Quintile classification is based on quintiles calculated for the whole of Worcestershire

Figure 53 -Young people aged 16-18 classified as NEET by Worcestershire District 2011



Source: Marmot indicators for local authorities

Progress against Marmot

Marmot Priority Objectives:	Marmot Policy Recommendations:	Worcestershire practice:
• Improve access to good jobs and reduce long-term unemployment across the social gradient	• Prioritise active labour market programmes to achieve timely interventions to reduce long-term unemployment	• Worcestershire County Council in conjunction with partners maintains Worcestershire. Business. Central - a website which provides a single point of access for businesses to find support and opportunities • The Worcestershire plan includes a commitment for faster broadband • Support for apprenticeships including organising REAL Apprentice events which enable pupils in years 10 - 13 to meet employers with jobs and apprenticeships on offer • Identification of four priority areas - 'Game Changers' – where development and infrastructure projects can facilitate significant impact on economic growth
• Make it easier for people who are disadvantaged in the labour market to obtain and keep work	• Develop greater security and flexibility in employment by prioritising greater flexibility of retirement age and encouraging and incentivising employers to create or adapt jobs that are suitable for lone parents, carers and people with mental and physical health problems	• The Adult Services and Health Directorate is piloting a revised version of the Council's "2 Ticks" policy which ensures all applicants with a disability who meet the minimum criteria for a job vacancy are interviewed and considered for a post on their abilities
• Improve quality of jobs across the social gradient	• Encourage, incentivise and, where appropriate, enforce the implementation of measures to improve the quality of work across the social gradient by ensuring public and private sector employers adhere to equality guidance and legislation and implementing guidance on stress management and the effective promotion of wellbeing and physical and mental health at work	• Worcestershire Works Well - a free accreditation scheme designed to enable local businesses improve the health and well-being of the work force

Priorities for Action

- Prioritise active labour market programmes to achieve timely interventions to reduce long-term unemployment
- Encourage, incentivise and, where appropriate, enforce the implementation of measures to improve the quality of work across the social gradient by ensuring public and private sector employers adhere to equality guidance and legislation and implementing guidance on stress management and the effective promotion of wellbeing and physical and mental health at work
- Develop greater security and flexibility in employment by prioritising greater flexibility of retirement age and encouraging and incentivising employers to create or adapt jobs that are suitable for lone parents, carers and people with mental and physical health problems

Chapter 5 Ensure a healthy standard of living for all

What is the problem?

There is a relationship between poor health and low income. Particular social groups are at higher risk of having a low income because of reduced employment opportunities; they include disabled adults, people with mental health problems, those with caring responsibilities, lone parents and young people (Marmot, 2010).

The Joseph Rowntree Foundation has developed the concept of a minimum income standard which is based on what members of the public think people need to achieve an acceptable standard of living. In 2013 this suggested single people need to earn at least £16,850 a year before tax and couples with two children need to earn at least £19,400 each (Joseph Rowntree Foundation, 2013). Figures showed a continuing squeeze on incomes relative to rising costs, only partly alleviated by increased tax allowances and that families with children have had the greatest setbacks in terms of earning enough to make ends meet, since they rely most on the state support that is now being cut back (Joseph Rowntree Foundation, 2013).

Child poverty is an important issue for public health and there is evidence that it leads to premature mortality and poor health outcomes for adults. Reducing the numbers of children who experience poverty should improve these adult health outcomes and increase healthy life expectancy (PHOF Indicator Definitions and Supporting Information, 2014).

Homelessness is associated with adverse health, education and social outcomes, particularly for children. To be deemed statutorily homeless a household must have become unintentionally homeless and must be considered to be in priority need. As such, statutorily homeless households contain some of the most vulnerable and needy members of our communities. Preventing and tackling homelessness requires sustained and joined-up interventions by central and local government, health and social care and the voluntary sector (PHOF Indicator Definitions and Supporting Information, 2014).

People may become homeless by being evicted because of rent arrears caused by money problems or the breakdown of your relationship with your partner, parents or family. Others have to leave because of domestic violence or abuse. Some become homeless due to illegal eviction or harassment by a landlord or because of a disaster such as a fire or flooding (Shelter; 2014).

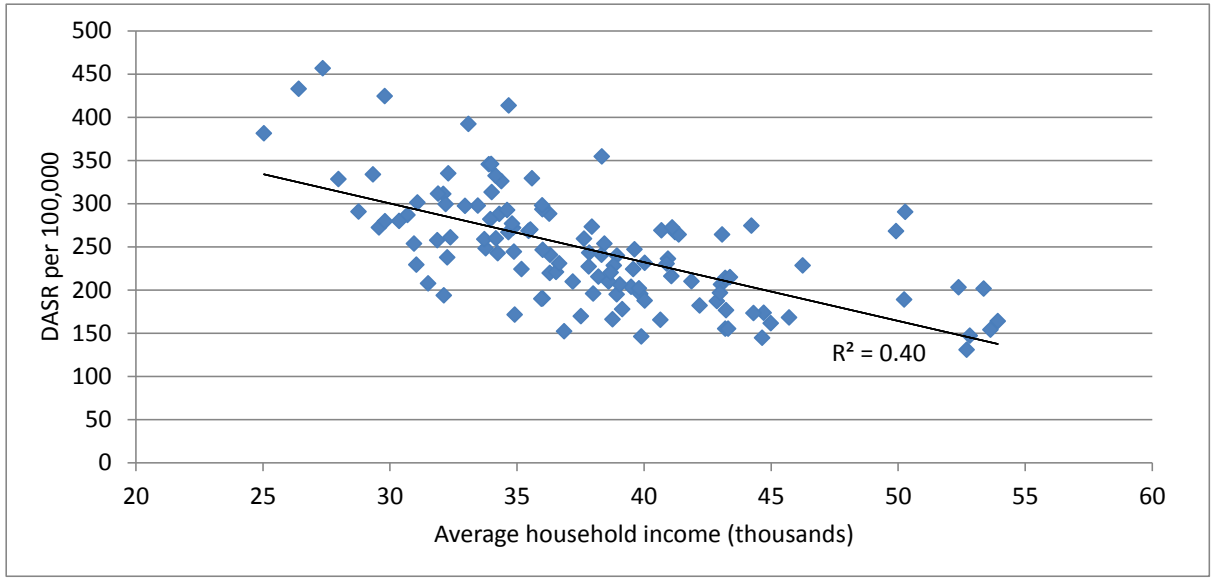
A report commissioned by the Department of Energy and Climate Change concluded that living at low temperatures as a result of fuel poverty is likely to be a significant contributor not just to the excess winter deaths, but to a much larger number of incidents of ill-health and demands on the NHS and a wider range of problems of social isolation and poor outcomes for young people (Hills, 2012).

The Worcestershire Picture

Income, benefits and health

- In 2013, 12% of households in Worcestershire were estimated to earn less than £10,000 a year[2] and the ward with the highest estimated average household earnings had an estimated average household earning over twice that of the lowest (Ripple; £54,400 vs Linthurst; £24,605).
- Figure 54 shows there is a strong association between the estimated average household income and the premature mortality rate for Worcestershire wards. The R^2 value shows that about 40% of the variation in mortality can be predicted by the differences in income.
- In 2012 Worcestershire had a lower percentage of people in households in receipt of means-tested benefits than the West Midlands region and England as a whole (11.0%, 17.0% and 14.6% respectively)[3].

Figure 54 –Average household income vs under 75 mortality by Ward in Worcestershire



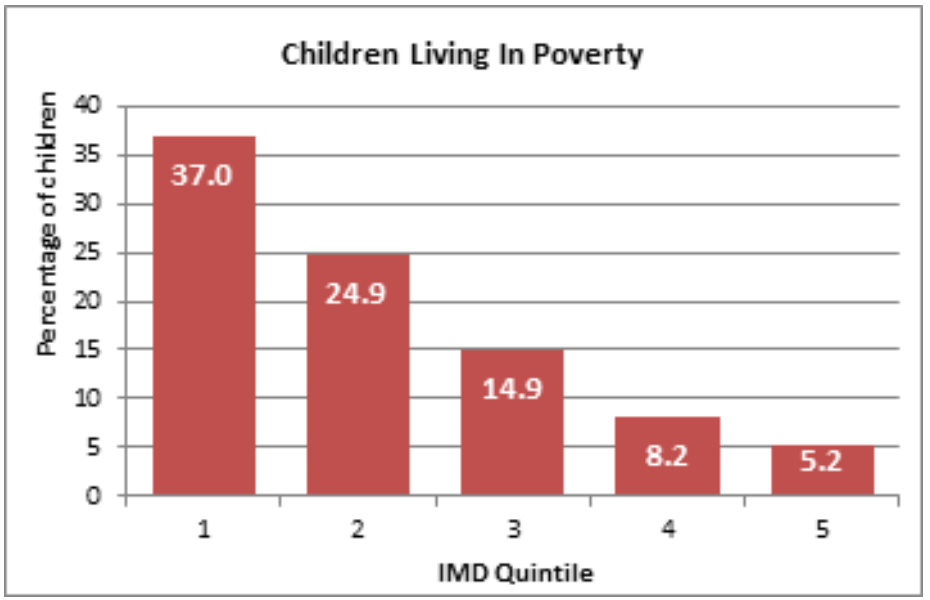
- The Inequality in percentage receiving means-tested benefits is a measure of the range of benefit receipt across the population of the local authority from the most to the least deprived. The higher the value the greater the inequality within the area. In 2012 the figure for Worcestershire was slightly lower than that of England but not significantly (24.1% points vs 29.0% points respectively[4].

[2] PayCheck, CACI
[3] Source: Income Domain of the Index of Multiple Deprivation 2010 – Department for Communities and Local Government; percentages for LAs - London Health Observatory
[4] Source: Slope Index of Inequality - London Health Observatory based on analysis of the Income Domain of the Index of Multiple Deprivation 2010 from the Department for Communities and Local Government

Children living in poverty

- In 2011 Worcestershire had 15.7% of children under 16 living in poverty. This was lower than for England as a whole at 20.6%, but still represented 15,620 children (HM Revenue and Customs Personal Tax Credits: Related Statistics - Child Poverty Statistics; PHOF).
- This figure also masks large variations between areas, for example, in 2010, the percentage of children under 16 living in poverty in Worcestershire ranged from 0% to 63.5% in some lower super output areas (LSOAs).
- Figure 55 shows that for the most deprived fifth of LSOAs in Worcestershire the average percentage of children living in poverty is 37% compared to 5.2% in the least deprived fifth of LSOAs. This means that a typical child living in the most deprived areas is seven times more likely to be living in poverty than a child in the least deprived areas.

Figure 55 - Children living in poverty



Homelessness

- In 2011/12 there were 700 homelessness acceptances in Worcestershire and the rate of homelessness acceptances was higher than for England (3 households per 1,000 households vs 2.3 in England)[5] and higher than the rate in 2010/11.
- In 2011/12 there were 130 households in temporary accommodation. This was a lower rate than for England (0.6 households per 1,000 households vs 2.3)[6].

[5] Statutory homeless households, crude rate per 1,000 estimated total households, all ages Source: Department for Communities and Local Government
[6] Source: Department for Communities and Local Government

Progress against Marmot

Marmot Priority Objectives:	Marmot Policy Recommendations:	Worcestershire practice:
• Establish a minimum income for healthy living for people of all ages	• Develop and implement standards for minimum income for healthy living	• These are issues that are best addressed at a national level.
• Reduce the social gradient in the standard of living through progressive taxation and other fiscal policies	• Review and implement systems of taxation, benefits, pensions and tax credits to provide a minimum income for healthy living standards and facilitate upwards pathways	
• Reduce the cliff edges faced by people moving between benefits and work	• Remove 'cliff edges' for those moving in and out of work and improve flexibility of employment	

Priorities for Action

- Take opportunities to lobby for national policies that ensure a minimum income level for healthy living for all

Chapter 6 Creating Healthy and Sustainable Communities

The health and wellbeing of individuals is influenced by the environment and communities in which they live and work. These influences range from the sense of belonging and involvement in a community, feelings of safety and security, the quality of housing and services and the ease of access, for example to open green space, through to the quality of the air that people breathe.

The creation of healthy and sustainable communities go hand in hand with the agenda of mitigating against the effects of climate change, whilst positively contributing to the objective of people feeling part of inclusive communities in which people can flourish.

Marmot shows us that environmental inequalities, impact disproportionately on health and wellbeing and conspire to reinforce, rather contribute to the reduction of inequalities.

This chapter, as others will identify Worcestershire's position against Marmots two recommendations and will, in particular focus on work to create healthy communities in both urban and rural priority areas, tackling fuel poverty and the need to gather data to assess our performance in priority areas.

The Worcestershire Picture

Air quality and health inequalities

- Air quality affects people nationally and locally differently according to where they live and work and there is strong evidence that reductions in traffic to reduce air pollution are successful in improving health.
- In Worcestershire there are ten declared Air Quality Management Areas (AQMAs) for exceeding the annual average air quality objective for NO2. These data are set out in the Air Quality Action Plan for Worcestershire (September 2013).
- Actions are clearly identified; however there is no reference to the disproportionate impact on disadvantaged communities, as these are largely in urban areas with the worst air quality and many are in the health hotspot urban areas.

Fuel poverty

- Worcestershire has a higher percentage of households that experience fuel poverty than England as a whole (12.8% vs 10.9% respectively)[7].

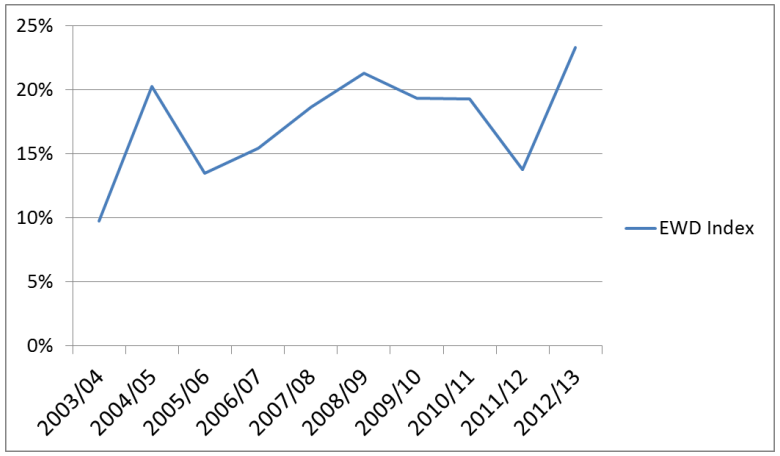
Access to good quality space across the social gradient

- Overall 55.2% of Worcestershire residents are within 5km of sites that are 100ha or larger (county-scale sites) and 31.8% are within 10km of sites that are 500ha or larger (sub-regional scale sites).
- This falls short of the Natural England Target of 100% for each of these categories, but not a significant issue compared to urbanised more areas. What is not understood is the differential level of access across the social spectrum to both large and small local parks.
- Whilst the green infrastructure plans recognises the importance of green outdoor space in promoting health and wellbeing, there is no reference to inequalities and the need to ensure access across the social spectrum., In local programmes in priority areas, lack of access to good quality play areas, in which people feel safe has been raised as a barrier to outdoor play and recreation, as have transport barriers to accessing larger green spaces, such as the Wyre Forest.

Energy efficiency of housing across the social gradient

- Energy efficiency of homes is important both to households who are faced with increasing fuel bills and also due to the impact in carbon emissions.
- Of particular concern across Worcestershire is the high rate of excess winter deaths and fuel poverty.
- 20% of households across the county are off mains gas and disproportionately represent difficult to treat properties that have solid walls or subject to planning restrictions in terms of implementing for energy efficiency measures which affect the external appearance of the property.

Figure 56 - Excess Winter Deaths Index - Worcestershire



[7] Source: Department of Energy and Climate Change (DECC); 2011). based on the "Low income, high cost" methodology. PHOF.

- The measure of fuel poverty has recently changed (January 2014) which has impacted on the number of fuel poor households across Worcestershire. This shows 7000 households being lifted out of fuel poverty due to the change in definitions. This reduction occurred in rural areas predominantly, some of which are those identified as health hotspots.
- Under the original definition of fuel poverty, households were considered fuel poor if they spent 10% or more of their income on heating.
- The new definition takes in to account low income and high energy costs. After household costs (rent, bills etc) have been paid, the resident is left with an income at or below the poverty line (60% of median income – about £9,500 in 2013) and higher than expected energy costs. This definition does not take account of those residents who may be under heating their home due to the costs.
- Under the new definition of fuel poverty, around 7,000 households in Worcestershire are no longer considered fuel poor. These are predominantly in rural areas of the County.
- The maps below highlight fuel poverty by LSOA area under both definitions. The old definition (10% of income) shows higher levels of fuel poverty in the rural areas of Worcestershire and comparatively lower levels in urban centres. The new definition shows far less 'red areas' of 20%+ of residents in fuel poverty.
- It is not clear, the extent to which the 7000 home removed from fuel poverty under the new definition, are poorly heated and thus putting residents at risk of poor health or death.

Figure 57 - Fuel poverty by LSOA (Old Measure)

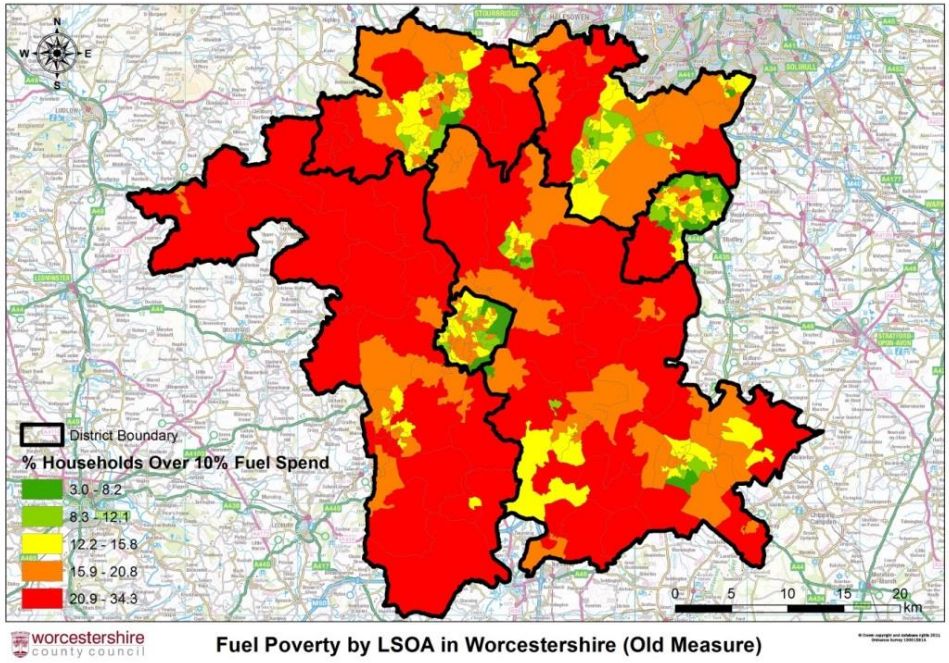
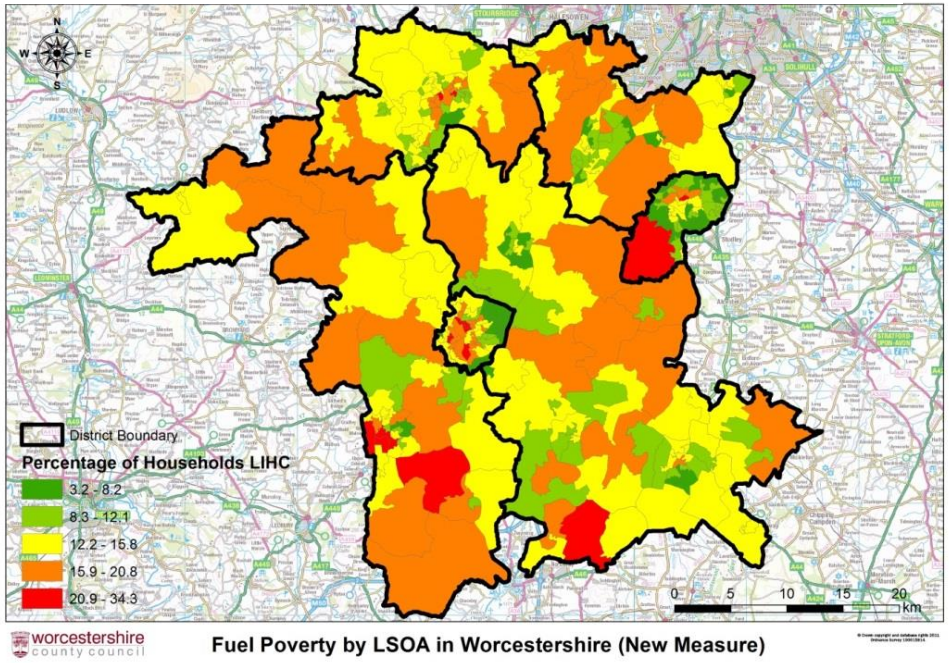


Figure 58 - Fuel poverty by LSOA (New Measure)



Food environment across the local social gradient

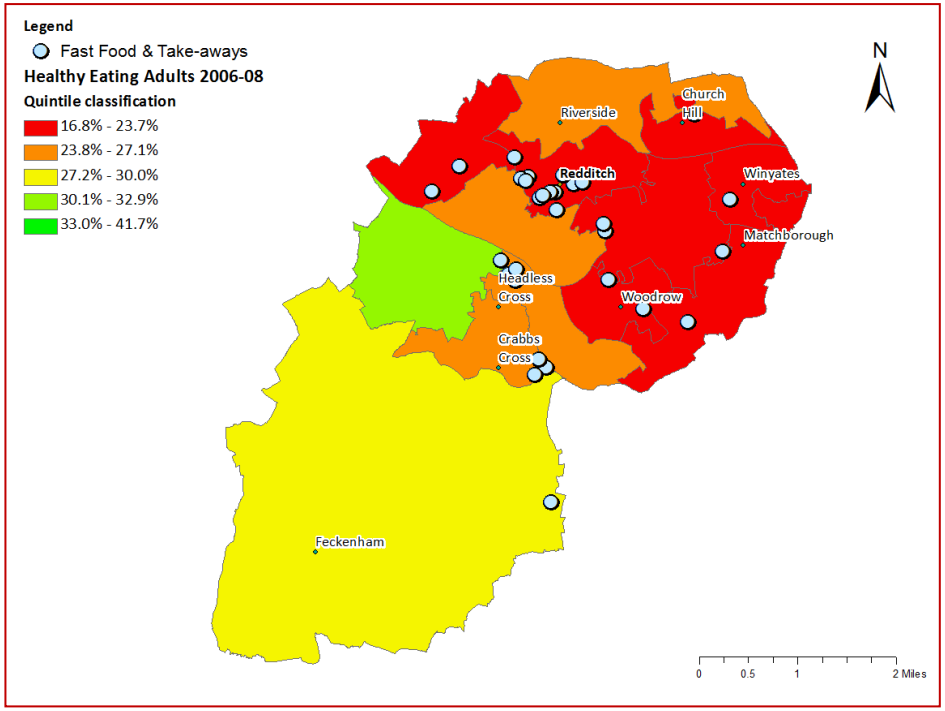
- Obesity is a growing problem and evidence shows us that obesity disproportionately affects communities from lower socio economic groups. Deprived communities are disproportionately affected by greater access to unhealthy food and we know that the low income and deprivation are both barriers to accessing healthy fresh foods.
- Information from the National Obesity Observatory presented in Table 5 below shows the number of fast food outlets in each district of Worcestershire. In terms of crude rate per population, Worcester and Wyre Forest clearly have the highest prevalence of fast food outlets.
- Some recent work was done focusing on health in Redditch and Figure 59 shows the map of healthy eating in Redditch alongside the location of take-aways/fast food outlets. Although there is no clear pattern, it can be seen that the majority of these establishments fall into those areas of Redditch where a low proportion of the adult population are considered to be eating healthily. There is also a correlation between these areas and the health hotspots identified in Redditch.

Table 5 - Number of Fast Food Outlets in Worcestershire Districts

LA Name	Number of fast food outlets	Total population 2010	Crude rate per 100,000
Bromsgrove	53	93,441	56.7
Malvern Hills	29	75,381	38.5
Redditch	49	78,666	62.3
Worcester	76	94,763	80.2
Wychavon	55	117,028	47.0
Wyre Forest	76	98,147	77.4

Source: Data from National Obesity Observatory.

Figure 59 - Percentage of Healthy Eating Adults in Redditch 2006/08 by MSOA with Take-Aways/Fast Food Outlets

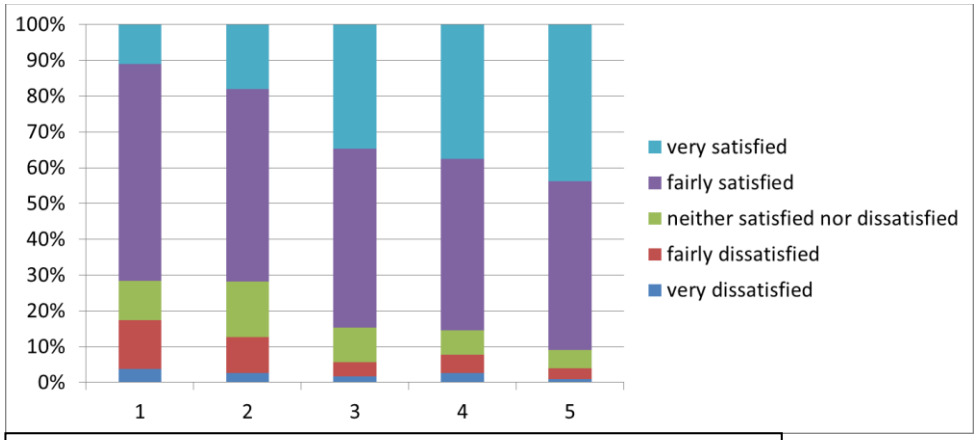


Source: Association of Public Health Observatories
Data for fast food outlets was sourced from the Food Standards Authority

Create and develop sustainable communities

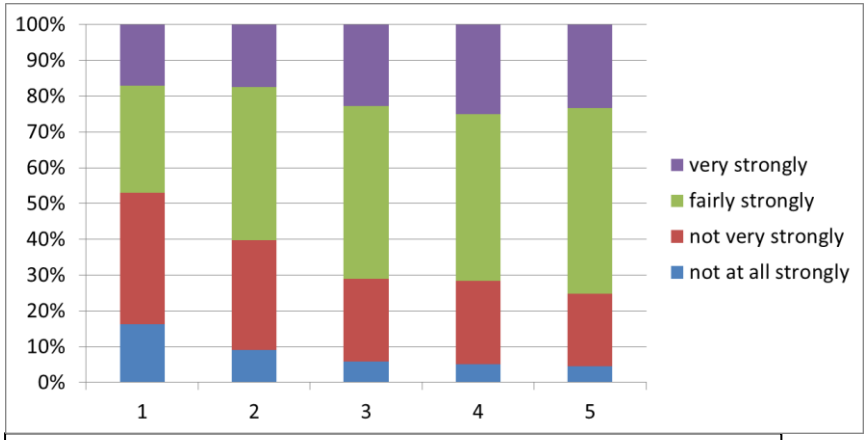
- Community Cohesion and community involvement is measured through a range of indicators.
- Figure 60 shows that across the social gradient there is a reduction in the levels of satisfaction with the local areas in which people live, with nearly 90% of respondents in upper quintile being either satisfied or very satisfied with tier local area compared to 71% in the quintile 1, which reflects Marmots findings
- Sense of belonging is important to the wellbeing of an individual and sense of connectedness. The sense of belonging is significantly higher in quintile 5 than 1 (Figure 61) reflecting Marmots findings and the need to focus on priority areas.
- There is little difference in the levels usage (Figure 62) and satisfaction with public services across the social gradient, which raises the questions of the effectiveness of those services being able to contribute to reducing inequalities. Local work focused in priority communities in Wyre Forest would suggest that there are difficulties in accessing low level support services and as consequent community wellbeing hubs are being developed in Wyre Forest in conjunction with residents, utilising community assets.

Figure 60 – Satisfaction with area by IMD quintile



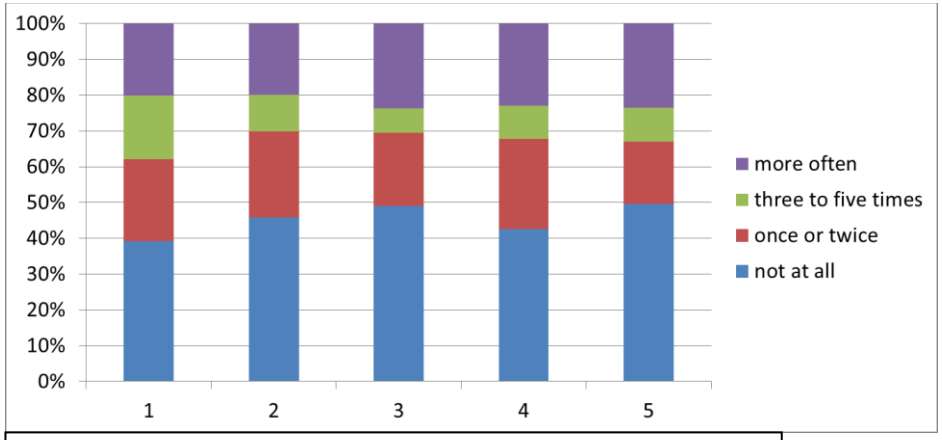
Source: Worcestershire ViewPoint Survey Nov '13

Figure 61 - Feeling of belonging to local area by IMD Quintile



Source: Worcestershire ViewPoint Survey Nov '13

Figure 62 - Use of leisure services by IMD quintile



Source: Worcestershire ViewPoint Survey Nov '13

Progress against Marmot

Marmot Priority Objectives:	Marmot Policy Recommendations:	Worcestershire practice:
• Develop common policies to reduce the scale and impact of climate change and health inequalities.	• Prioritise policies and interventions that both reduce health inequalities and mitigate against climate change by; - Improving active travel across the social gradient - Improving good quality spaces available across the social gradient - Improving the food environment in local areas across the social gradient - Improving the energy efficiency of housing across the social gradient	• Data are not available on current levels of active travel across the social gradient. 'Choose how you move' in Redditch is one example of an intervention to promote behaviour change to active. Whilst active travel is promoted across the county more targeted interventions may be needed in priority areas, although the case for prioritising additional action in this area is not strong, when compared with other priorities. **AMBER** • Worcestershire has considerable green space, but access levels across the social gradients are unclear. It is also not clear what the quality and access to local play space is and how this access to and use of small parks compares across the social gradient. • Community place based interventions and Friends of Parks programme are examples of interventions that are both increasing use of the environment. **AMBER** • Local programmes focussed on improving fruit and vegetables availability in priority areas, including community growing schemes, fruit and vegetable market stalls in priority communities. Mapping of Fast Food Store, but no strategy in place to influence planning decisions for new fast food stalls. • Evidence of increased access to fast food outlets and lower levels of fruit and veg consumption in these areas. **AMBER** • Warmer Worcestershire Partnership delivering targeted interventions and cited as good practice by LGA, including home energy checks, insulation and boiler , warmer homes advice in flu clinics, training for frontline staff and wide distribution of thermo cards. Primary care engagement in identifying priority patients need further development, as does more effective targeting of vulnerable households, particularly in rural areas. • Lack of understanding of the fuel poverty issues across rural areas and the implications for health, particularly for isolated older people. **AMBER**

Marmot Priority Objectives:	Marmot Policy Recommendations:	Worcestershire practice:
• Improve Community Capital and reduce isolation across the social gradient	• Fully integrate the planning, transport, housing environmental and health systems to address the social determinants of health in each locality • Create and develop communities • Support locally developed and evidenced based community regeneration programmes that: • Remove barriers to community participation and action • Reduce social isolation	• Integration has begun over the past 12 months, however, it is unclear how effective work has been in tackling social determinants of health in priority areas due to a lack of data **AMBER** • Pockets of good practice embedded in each of the priority areas and evidence emerging of constructive participation and reduced social isolation but this work is small scale and not universally supported across the county. Examples of good practice include the Pickersleigh Ambassadors Project and the Motor vehicle project promoting local employment. In other areas, such as the Walshes and Oldington and Foley Park, Community Health Hubs have been established with residents. Opportunity Vale of Evesham pioneered community research to identify 'Super Connectors' in rural communities and then proceeded to support community based services developed by residents to tackle rural isolation. • Limited work in rural areas to understand and tackle rural isolation, although good practice developed through Opportunity Vale of Evesham programme to identify super connectors in Broadway and subsequent community based interventions to increase involvement of and support to vulnerable older people. • **AMBER/RED**

Prorities for Action

- Research and implement measures that reduce fuel poverty, with a particular focus on disadvantaged communities;
- Improve understanding of issues affecting rural areas, with a focus on measures to address social isolation;Consider local assets and hyper-local approaches in the design and review stages of commissioning
  - Shift from an 'Areas of Highest Need' to a 'Healthy and sustainable Communities' place based model in priority areas. Through this build on existing 'assets based' approaches which seek to identify and harness skills, knowledge, networks and resources in communities so that local residents can play a part in locally based solutions.
  - Roll out a programme of workforce development to support an asset based approach to commissioning and service redesign.
  - Prototype, with partners models of assets based commissioning, focussing initially on priority areas, in both urban and rural areas.
  - Establish a model social prescribing to more effectively engage primary care in an assets based model and early intervention.

Chapter 7 Strengthen the role and impact of ill health prevention

Much of this report has focussed on non-health interventions, understanding what Marmot calls the 'causes of the causes' of ill-health. These are the structural determinants of health, which set the environment in which an individual lives, and within which their life chances are formed. The report has considered how these can best be influenced to narrow inequalities in health outcome.

This chapter takes a different focus and looks specifically at those individual behaviours which lead to the health conditions which cause the biggest burden of ill-health. It considers their local association with health inequalities. A small number of conditions cause the majority of premature mortality and morbidity, and these are all linked to health related behaviours on the part of the individual, which can be changed.

The key conditions causing the biggest burden of ill-health and premature mortality are:

- Cancer;
- Heart disease;
- Stroke;
- Lung disease;
- Liver disease.

The risk of developing these conditions is significantly linked to four key individual behaviours, each of which is modifiable:

- Smoking;
- Poor diet;
- Being physically inactive;
- Drinking too much alcohol.

According to a recent report on the clustering of unhealthy behaviours over time by The King's Fund, the proportion of people engaging in multiple unhealthy lifestyle behaviours has fallen significantly. However, almost all the improvement has been among higher socio-economic and better educated groups, exacerbating health inequalities (Clustering of unhealthy behaviours over time: Implications for policy and practice, The Kings Fund, D. Buck and F. Frosini, August 2012.) Using data from the Health Survey for England, the report examined how four lifestyle risk factors – smoking, excessive alcohol use, poor diet, and low levels of physical activity – co-occur in the population and how this distribution has changed over time. It found that the overall proportion of the population that engages in three or four of these unhealthy behaviours has declined significantly, from around 33 per cent of the population in 2003 to around 25 per cent by 2008. However, these reductions have been seen mainly among those in higher socio-economic and educational groups. In contrast, people with no qualifications were more than five times as likely as those with higher education to engage in all four poor behaviours in 2008, compared with only three times as likely in 2003.

The National Picture

Smoking

The evidence base on the links between smoking and ill-health is perhaps the best known of all public health evidence. Smoking kills. Extensive national interventions to reduce smoking prevalence have included: restrictive legislation such as banning smoking in the workplace and public places; steady increases in tax payable on cigarette; increasing the age at which it is legal to smoke; strengthening educational messaging on tobacco products; restricting advertising and developing smoking cessation services through the NHS. As a consequence, there has been a steady drop in smoking rates over the last decades.

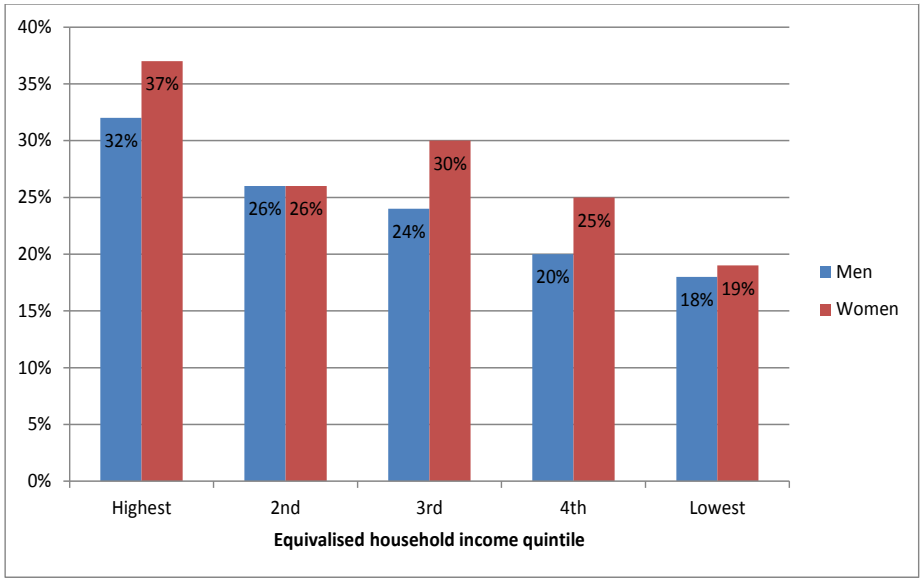
However, smoking also accounts for around half the difference nationally between the lowest and highest income groups, and smoking-related death rates are two to three times higher among disadvantaged social groups than among the better off (Scarborough etc al, 2008; Jarvis and Wardle, 2006). Smoking prevalence is far higher in disadvantaged social groups than it is among the least disadvantaged.

Eating a poor diet

The national picture on obesity is well-known. About two-thirds of adults are overweight or obese, and if current trends do not change, about two-thirds will be obese by 2050. Childhood obesity was covered in and presents a similarly dramatic picture, with current trends suggesting this will be the first generation to die at a younger age than their parents, simply as a consequence of obesity.

There is an evidenced (Health Survey for England 2007, DH 2014) link between consumption of five or more portions of fruit and vegetables per day with household income, with the lowest consumption being in the lowest income group. **Fast food outlets are covered in chapter 6.** Low income groups are more likely to consume fat spreads, non-diet soft drinks, pizza, processed meats, whole mild and table sugar (FSA 2007), and in general the economy lines of food tend to be less healthy, with higher salt and fat content (National Consumer Council 2006.)

Figure 63 - Proportion of adults (aged 16 and over) consuming five or more portions of fruit and vegetables per day, by equivalised household income and sex, England 2009



Source: Health Survey for England 2009

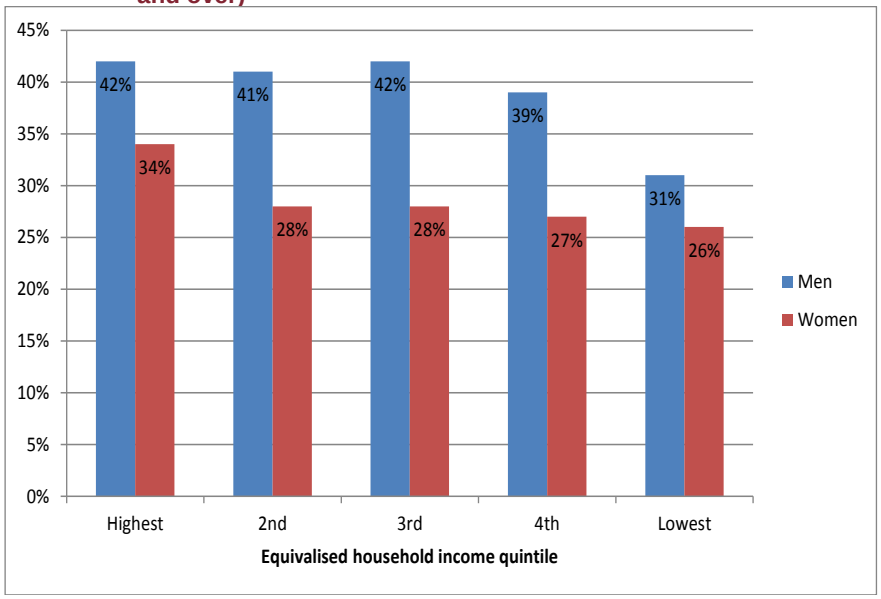
[a] Equivalised household income is a measure that takes account of the number of people in the household. For this analysis, households were split into five equal-sized groups banded by income level (income quintiles). Physical activity levels were compared between these groups.

Physical inactivity

The benefits to health of physical activity are significant. Both mental and physical health is maximised by meeting the government targets of 30 minutes moderate exercise on five days a week for adults, and sixty minutes for children. The risk of developing coronary heart disease due to being physically inactive is comparable to that of smoking (DH 2004c). If an inactive, population changes behaviour to meet these targets, the health harm of obesity can be reduced significantly, with a reduction too in coronary heart disease and other chronic disease (WCRF 2009). Meeting these targets would significantly improve the mental health of inactive people, and depression in particular (ibid.)

Levels of physical activity are linked to social deprivation, with recreational walking for example lowest among the lowest socio-economic group (Kamphuis et al 2009) and those from the highest income households most likely to meet government recommendations.

Figure 64 - Proportion of adults meeting physical activity recommendations, by equivalised[a] household income and sex, 2008 (base: aged 16 and over)



Source: Health Survey for England 2008 Report

[a] Equivalised household income is a measure that takes account of the number of people in the household. For this analysis, households were split into five equal-sized groups banded by income level (income quintiles). Physical activity levels were compared

Drinking too much alcohol

As with obesity, there is now an unprecedented national burden of disease and, unless behaviours change, the consequences of drinking too much will place unmanageable burdens on the NHS and social care. The Chief Medical Officer has drawn attention to the significant health harms of alcohol consumption in her Annual Report twice in recent years (DH 2011 and 2014). She has made a number of key points: In 2012, the UK population consumed about twice as many units of alcohol per person as the population fifty years ago (DH 2014); liver disease is the only major cause of mortality and morbidity on the increase in England although it is decreasing among our European peers; between 2000 and 2009, deaths from chronic liver disease and cirrhosis in the under 65s increased by around 20% ; and all 3 major causes of liver disease - obesity, undiagnosed infection, and harmful drinking - are preventable (CMO 2012).

Alcohol-related health harm is linked to social deprivation, although the relationships are complex. People with lower socio-economic status are more likely to abstain from drinking alcohol but, if they do drink, are more likely to have problematic drinking patterns and dependence. Those with higher socio-economic status are more likely to drink more often, but to consume smaller amounts (Marmot 2009, Task Group 8.)

National Prevention: modifiable health-related behaviours

Prevention can be understood at three levels:

- primary prevention, to prevent the problem from starting at all;
- secondary prevention, to identify the problem early and stop it getting worse;
- tertiary prevention, to limit the adverse effects of the problem for the individual

Nationally, there have been long-term government efforts to prevent lifestyle related ill-health. These have included primary prevention such as tobacco control, restrictions on alcohol licensing, and educational campaigns around stopping smoking, drinking sensibly, eating healthily and being physically active. Secondary prevention efforts have included screening programmes so that cancers can be identified early; introduction of health checks to identify cardio-vascular risk in the 40 – 74 year old population; and encouragement of brief interventions by front-line staff to identify problem drinking. Tertiary prevention has included treatments such as cardiac surgery, statins prescribing, alcohol detoxification and liver transplant, joint replacement, and bariatric surgery.

However, despite these prevention efforts, the Marmot Report shows clearly that the prevalence of behaviour associated with ill-health has continued to rise, and the health inequality gap has widened too. Prevention has not been effective across the social gradient and thus the inverse care law (Tudor Hart, 1971) has continued to be evident: that the uptake of prevention has tended to vary inversely with the need of the population.

The Worcestershire Picture

There is evidence of a link between social deprivation and health related behaviours here as there is nationally.

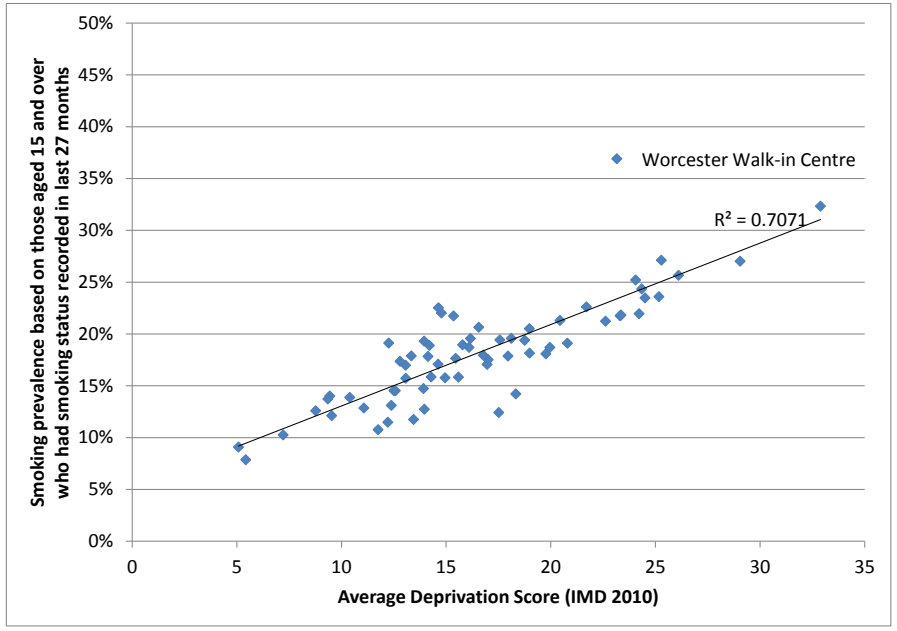
Smoking

- In Worcestershire, smoking rates are different across the County, and are highest in the areas of highest deprivation.
- Figure 65 shows smoking prevalence from the GP Practice registers against estimated practice deprivation. There is a very strong association between smoking prevalence and practice deprivation.

Physical inactivity

- Physical activity is a key determinant of wellbeing in older people. As people get older, the benefits of taking regular moderate physical activity become more important in reducing or reversing much of the physical, psychological and social deterioration which often accompanies advancing age.
- Physical activity rates tend to decrease quite steeply with age from the age of 45 as can be seen in Figure 68.
- When comparing Worcestershire to the Region and England it is noticeable that participation rates are relatively high up to the age of 75, but fall behind for those aged over 75. Due to the small sample sizes for these age groups, the rate for those aged 75 and over is not statistically different compared to the national rate. However the 2008/9 survey also showed a relatively low value for people aged over 75 and participation rates in Worcestershire above the national average all the other age groups. This suggests that there may be some room for improvement for over 75s in the county.

Figure 65 - Smoking Prevalence 2013/14, by average deprivation score, Worcestershire GP Practices



Regression line fitted excluding Worcester Walk-in Centre as this is a clear outlier and has a very unusual demographic composition.

Figure 66 - Percentage Participation in Sport (at least once a week) of Adults (16+) by year (Local Sport England Profiles 2014)

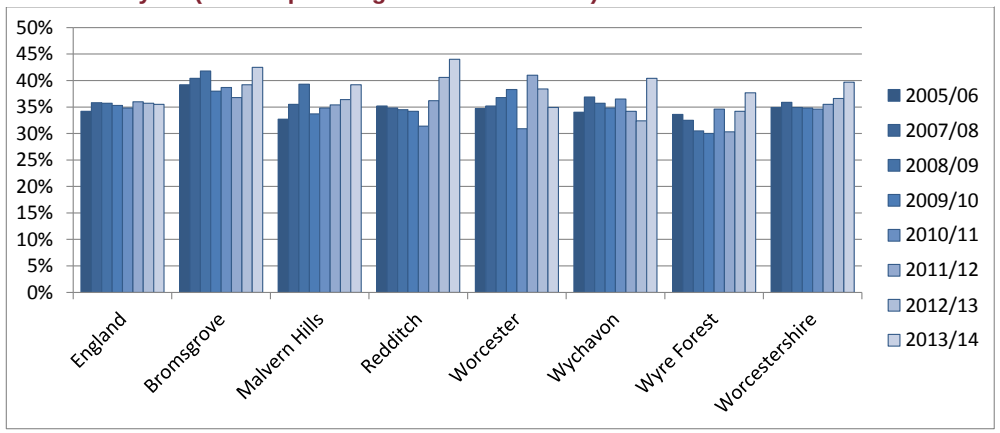


Table 6 - Participation in physical activity by age group

At least 3 days a week with 30 minutes moderate participation in sport or active recreation, all adults (National Indicator 8)			
	Worcestershire	England	Significance
16-24	38.6%	36.0%	Not sig
25-34	35.1%	30.2%	higher
35-44	31.4%	28.5%	Not sig
45-54	26.8%	25.4%	Not sig
55-64	21.1%	19.2%	Not sig
65-74	18.2%	15.7%	Not sig
75+*	6.6%	7.5%	Not sig
*** very small sample size (41)**			
Source: Active People Survey Oct 2011 - Oct 2013, Sport England			

Figure 68 - Participation in physical activity by age group

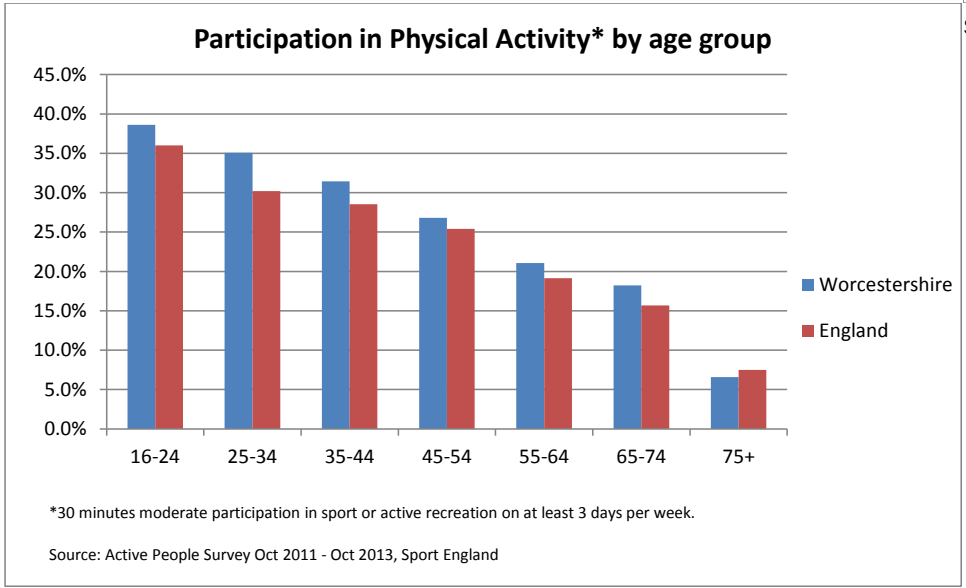
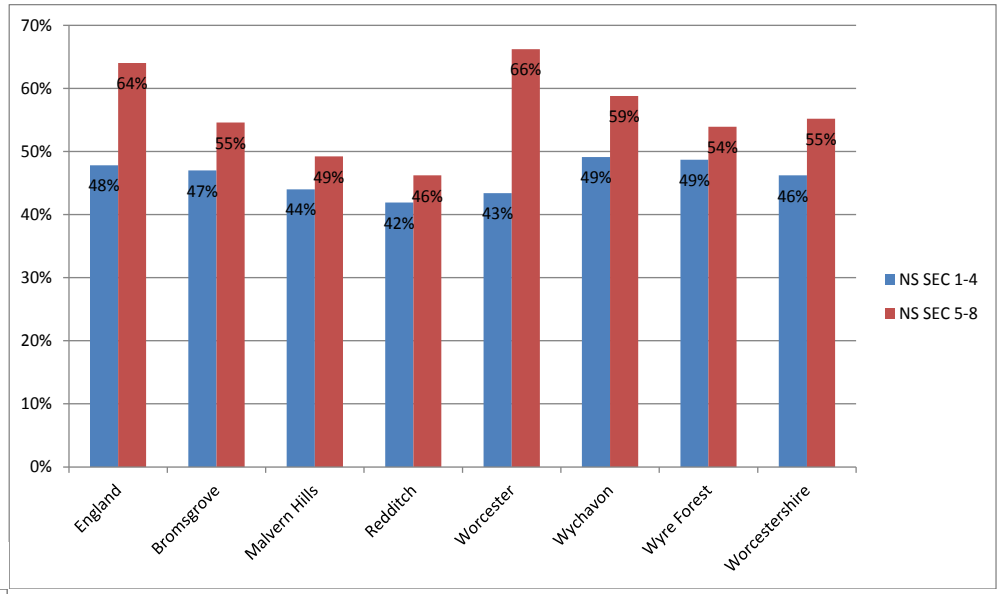


Figure 67 - The proportion/number of adults (aged 16 and over) who have not participated in any sessions of sport, at any intensity or for any duration, in the last 28 days by NS SEC Group



Source: Active People Survey Analysis Tool 2014

Drinking too much alcohol

The local evidence shows a clear association between higher alcohol related hospital admissions and higher social deprivation. At District level, mortality linked to drinking too much is higher in the Districts with the highest levels of social deprivation:

Table 7 – Worcestershire Nearest Neighbour Comparison by District Area

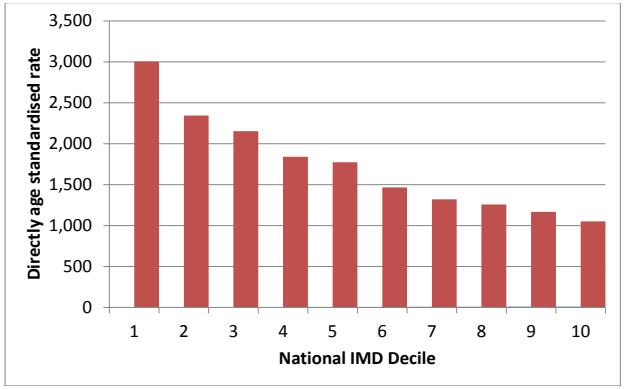
District	Nearest Neighbour Comparison									
	Months of Life Lost due to alcohol: Males aged less than 75 years (2008-2010)		Months of Life Lost due to alcohol: Females aged less than 75 years (2008-2010)		Alcohol-Specific Mortality: all genders (2008-2010)		Liver Mortality: all genders (2008-2010)		Alcohol Attributable Mortality all genders (2008-2010)	
Bromsgrove	5.79	↓	4.17	↓	0.07	↓	0.07	↓	0.27	↓
Malvern Hills	11.07	↓	5.26	↓	0.13	↓	0.17	↓	0.38	↑
Redditch	9.76	↑	4.87	↓	0.08	↑	0.10	↑	0.26	↓
Worcester	11.05	↑	6.50	↑	0.13	↑	0.15	↑	0.30	↑
Wychavon	7.66	↓	3.92	↑	0.07	↑	0.10	↑	0.27	↑
Wyre Forest	12.51	↑	5.11	↓	0.16	↑	0.18	↑	0.41	↑

	Local Authorities with the most amount of harm compared to the benchmark	↑ Harm generally increasing since 04/06
	Local Authorities with higher harm levels compared to the benchmark	
	Local Authorities with lower harm levels compared to the benchmark	↓ Harm generally decreasing since 04/06
	Local Authorities with the least amount of harm compared to the benchmark	

Source: Alcohol and drugs: JSNA support pack Key data to support planning for effective alcohol prevention, treatment and recovery
Substance Misuse Needs Assessment: Worcestershire County Council 2014

Looking in more details within Districts, higher social deprivation is linked to higher rates of hospital admission for alcohol related causes (Figure 69)

Figure 69 - Alcohol Related Hospital admissions 2007/08 to 2011/12 (pooled), by national IMD Decile, Worcestershire



Source: PHIT calculation based on NWPHO methodology, standardised to 2011 Census Population
Based on IMD of LSOA of patient's residential address

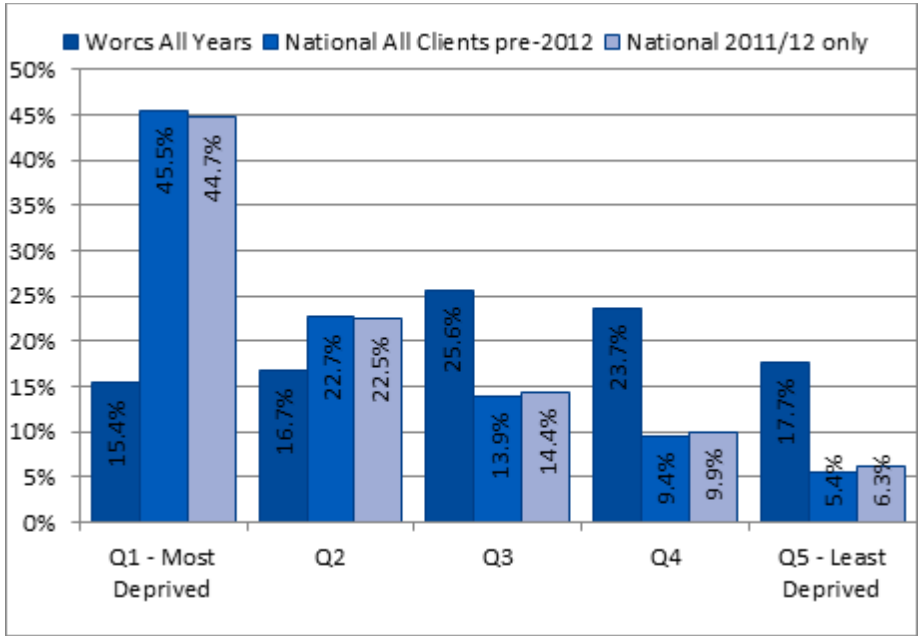
Local prevention services

Health trainers: Much of the local effort to impact on life-style related behaviours has been through the Health Trainer service, which was designed to give one-to-one support to people who live in the most deprived areas, and who have lifestyle related ill-health. Local evaluation of the service has found that these ideals have not been robustly met, with as many clients from Quintile 5 as from Quintile 1 (Figure 70).

It can be quite clearly seen that Q1 and Q2 have formed a comfortable majority of the clients attending Health Trainer service nationally. Worcestershire compares poorly in attracting clients from the more deprived areas, with around 32% of clients from the two most deprived quintiles attending Health Trainer services compared to over 67% nationally.

Stop Smoking Services: The NHS and, more recently, the Local Authority, has commissioned specialist stop smoking services which are designed to assist smokers to quit. These services are known to have lower impact in areas of social deprivation and, to address this, commissioning was changed to a payment by results model some time ago. The payments schedule was structured to reward success in deprived areas. However, this incentive has not changed the overall trend, which is of a strong association between higher quit rates and lower social deprivation.

Figure 70 - Proportion of Health Trainer Clients by Deprivation Quintile in Worcestershire and England



Source: National data is taken from the DCRS National Health Trainers Service Review June 2012; Worcestershire data is taken from the local DCRS. It should be noted that the 2013/14 data is for the period from 1st April 2013 to 31st July only

Table 8 - Smoking Cessation Clients 2011/12 by IMD of LSOA of residence

IMD national decile	Quit after 4 weeks	not quit	all clients	Popn 2011	Quit rate %	Quitters per 10000 popn	Clients per 10000 popn
1	104	169	273	19,537	38%	53.2	139.7
2	184	225	409	36,758	45%	50.1	111.3
3	146	167	313	37,893	47%	38.5	82.6
4	103	169	272	34,466	38%	29.9	78.9
5	242	263	505	62,230	48%	38.9	81.2
6	175	177	352	68,789	50%	25.4	51.2
7	229	226	455	89,499	50%	25.6	50.8
8	210	179	389	81,108	54%	25.9	48.0
9	193	130	323	82,725	60%	23.3	39.0
10	101	75	176	53,164	57%	19.0	33.1
Total	1687	1780	3467	566,169	49%	29.8	61.2

Source: Analysis from Worcestershire Smoking Cessation Service database based on IMD of LSOA of client's address

Screening and immunisation programmes

Key NHS screening programmes include:

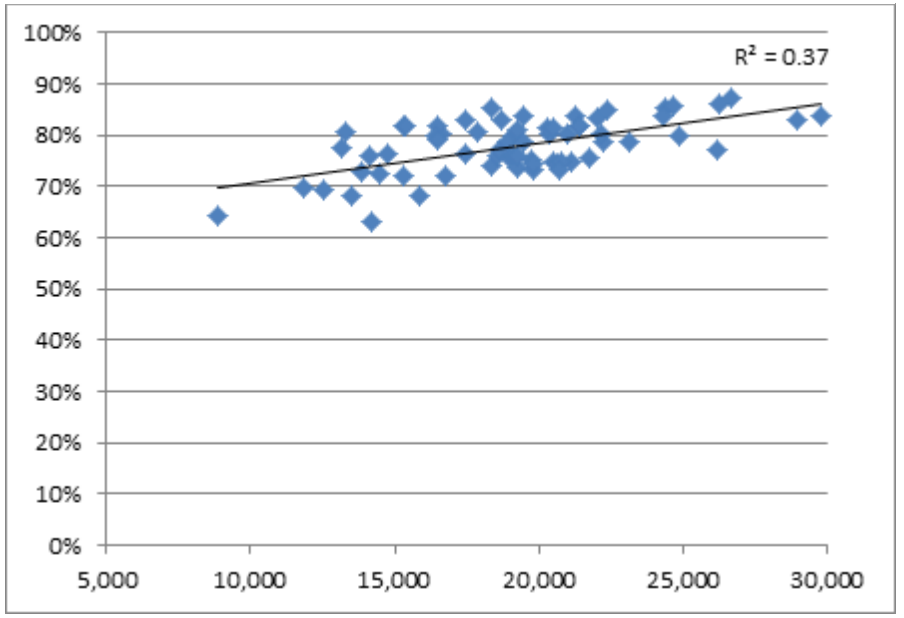
- health checks for those aged 40 – 74 years;
- breast screening;
- cervical screening;
- bowel cancer screening.

Immunisation programmes include:

- influenza vaccination for the over 65s and vulnerable groups;
- pneumococcal immunisation for the over 65s and vulnerable groups; and
- the childhood programmes which are covered in Chapter 2**.**

All these programmes are designed to be universal interventions, which bring benefit to a whole population by achieving universal coverage. However, the local evidence suggests that these is variation in uptake across the County, and that this too is related to social deprivation as can be seen in the cervical screening uptake rates by practice deprivation in Figure 71.

Figure 71 - Cervical Screening rate and practice deprivation 2006/7-2010/11



Progress against Marmot

Marmot Priority Objectives:	Marmot Policy Recommendations:	Worcestershire practice:
• Prioritise prevention and early detection of those conditions more strongly related to health inequalities.	• Prioritise investment in ill health prevention and health promotion across government departments to reduce the social gradient.	• Investment in the major prevention and early identification of risk programmes (health checks; NCMP; health trainers; brief interventions training and delivery) is mainly from the DH/PHRG, with minimal investment from other government departments; • Health promotion and education campaigns are delivered by Public Health in WCC, by CCGs, by PHE, and by NHS Trusts. The 2012 NHS reforms have resulted in some fragmentation, but all this is funded from DH. **RED**
• Increase availability of long-term and sustainable funding in ill-health prevention across the social gradient.	• Increase the development and roll-out of a programme of preventive interventions that are effective across the social gradient, including: - Increasing the scale and quality of drug treatment programmes; - Focus on public health lifestyle interventions to reduce the social gradient in, for example, obesity, smoking and alcohol.	• Drug treatment programmes are commissioned from the PHRG, and these, as elsewhere in the country, are not strongly effective. A procurement exercise is underway which gives new focus and requires an end-to-end recovery model; • Smoking cessation services are commissioned from the PHRG, using a tariff payment by results model, which incentivises achieving quitters from the most deprived areas, recognising that greater time will be needed to change behaviours for this group of clients. The budget is uncapped. Uptake and success rates are lowest among the most deprived populations; • Alcohol treatment services and campaigns around sensible drinking are mainly commissioned from the PHRG, although police and Road Safety Partnership deliver drink driving campaigns especially at Xmas. There is poor market penetration, with services reaching a very small proportion of the total population at risk; • Recommissioniong of the health trainer service from 2015 to focus on areas of social deprivation as well as patients on the bariatric pathway. The revised service specification requires setting up mutual aid groups in Areas of Highest Need, with maximum use of volunteers, to create sustainable support for long-term behaviour change, and to build social capital and local community assets; • Increasing physical activity does not currently have WCC focus. There is fragmentation of responsibility between County, District, and national (SportEngland) levels. **GREEN/AMBER**

Marmot Priority Objectives:	Marmot Policy Recommendations:	Worcestershire practice:
	• Refocus the core efforts of public health departments on interventions related to the social determinants of health.	• There is limited evidence of this from the re-profiling of Housing Related Support (HRS) as part of the Future Lives programme. This has removed former WCC base budget spending on HRS to vulnerable groups such as those experiencing Domestic Violence and Abuse or Homelessness, and replaced it at a reduced level from the PHRG. However, the interventions were already in place and the evidence base for them was weak in terms of improving their risk of premature mortality; • Strengthening the systematic application of the Five Ways to Well-being would contribute to delivery of this recommendation. This work is in development and is piloting in one part of the County; • The financial challenges for WCC and the extent of committed PHRG spend limits the opportunity for achieving this this recommendation. **AMBER**

Priorities for Action

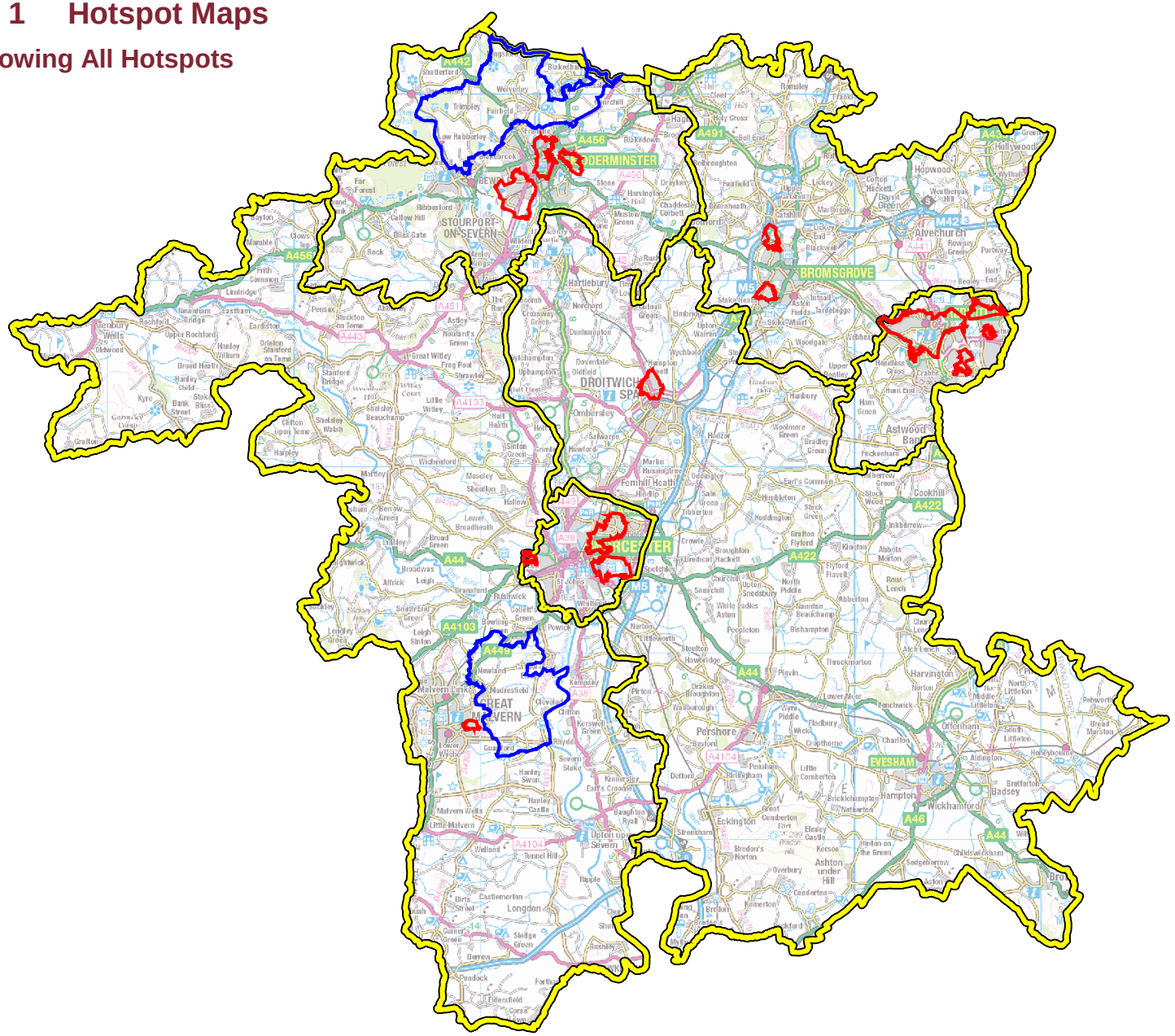
- Review the Public Health Ringfenced Grant (PHRG) spend against all the priorities in the DPH report and reprofile and prioritise accordingly;
- Strengthen the evidence base on the PHRG spend on Housing Related Support in terms of the prevention of ill-health;
- Strengthen local understanding across the County of the evidence on behaviour related ill-health, and its links to social deprivation;
- Review cross-agency funding on ill-health prevention and facilitate a shared approach to spend which will narrow the health gap;
- Strengthen social marketing to maximise behaviour change among target groups, including the uptake of existing prevention initiatives.

References.

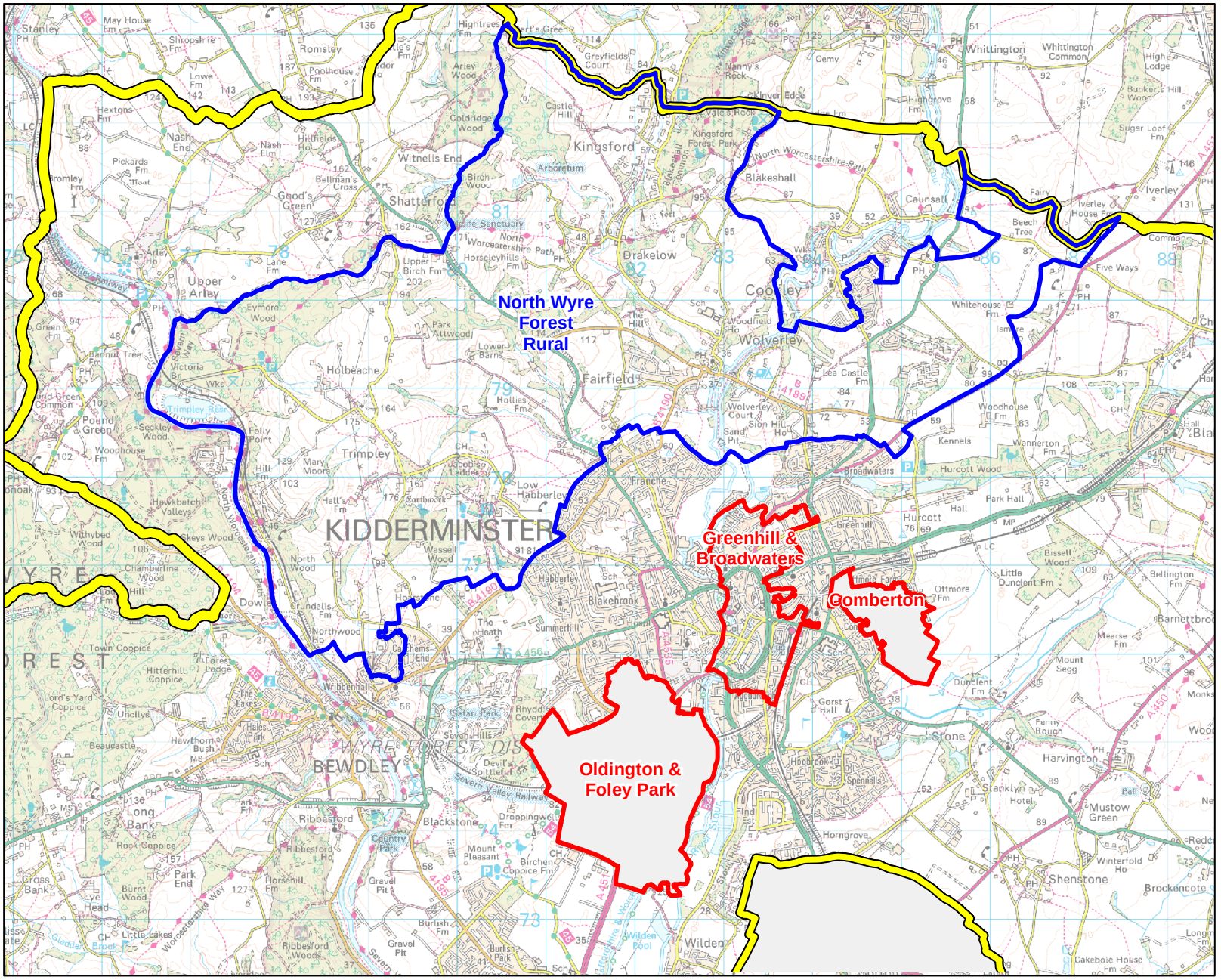
DH 2011; 2014 Chief Medical Officer: Annual Report, on the state of the nation's health.
Tudor Hart, J. (1971) 'The Inverse Care Law', The Lancet 297, pp. 405-412.
NOO (National Obesity Observatory) Data Factsheet: Obesity.

Appendix 1 Hotspot Maps

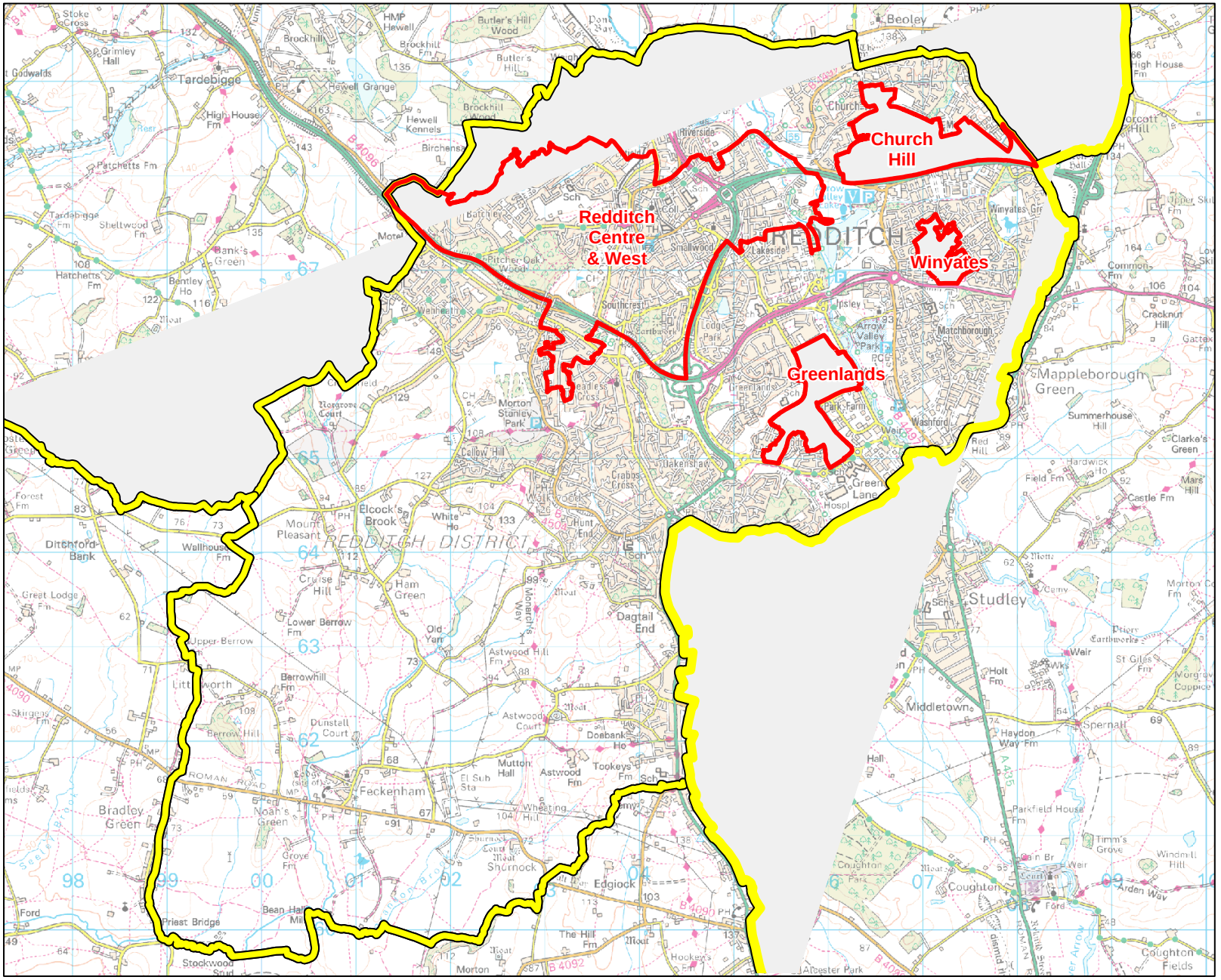
Map of Worcestershire Showing All Hotspots



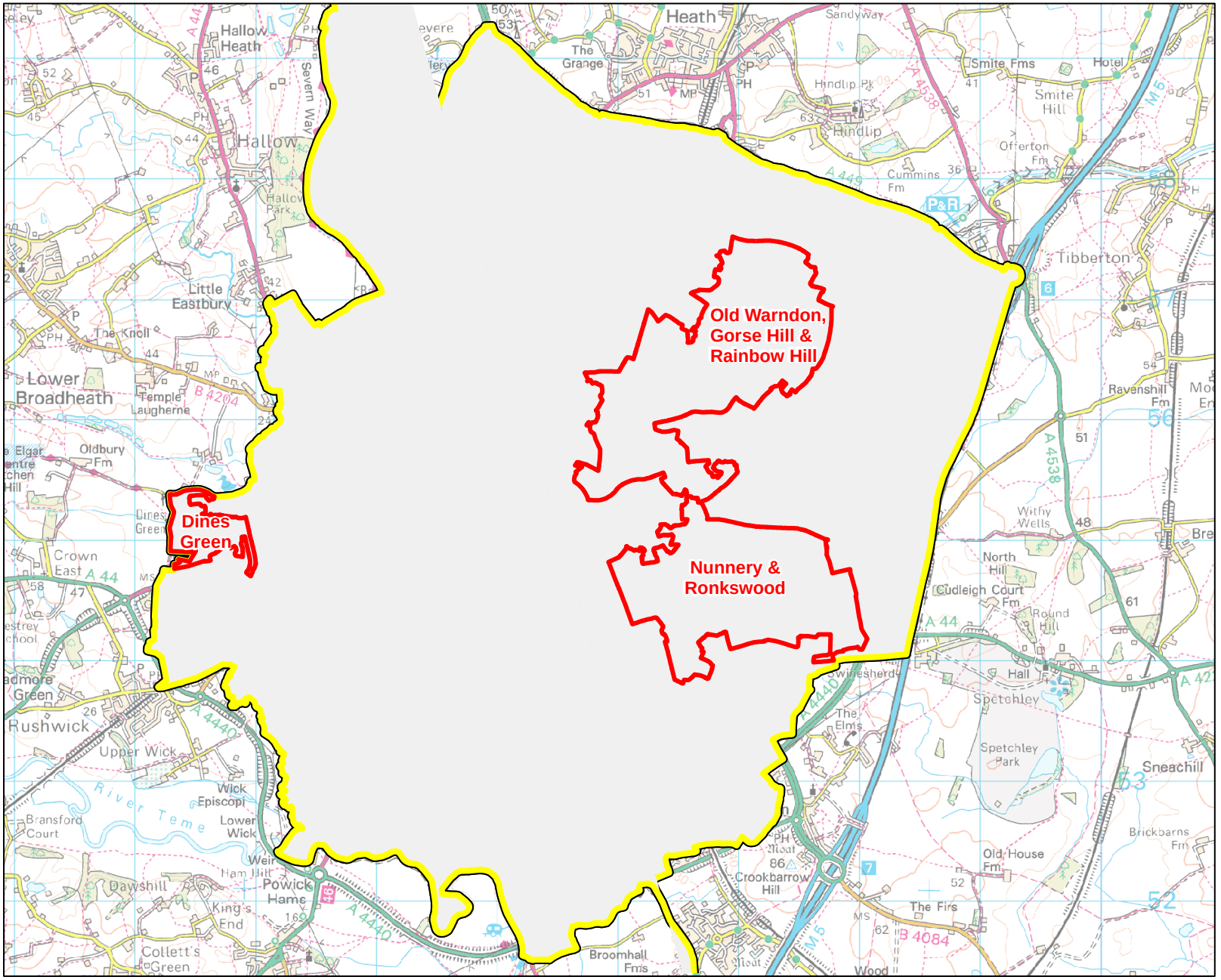
Wyre Forest Hotspots



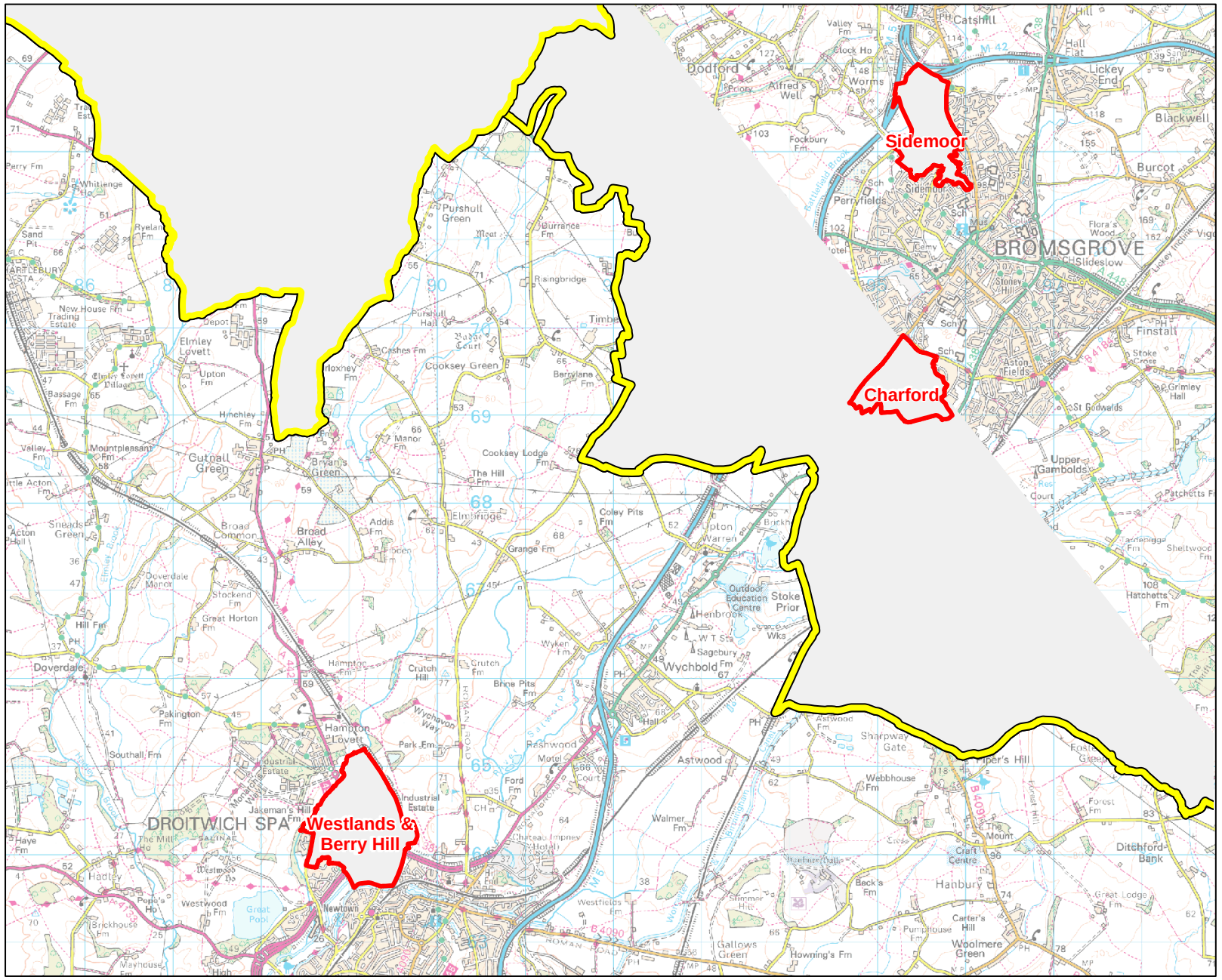
Redditch Hotspots



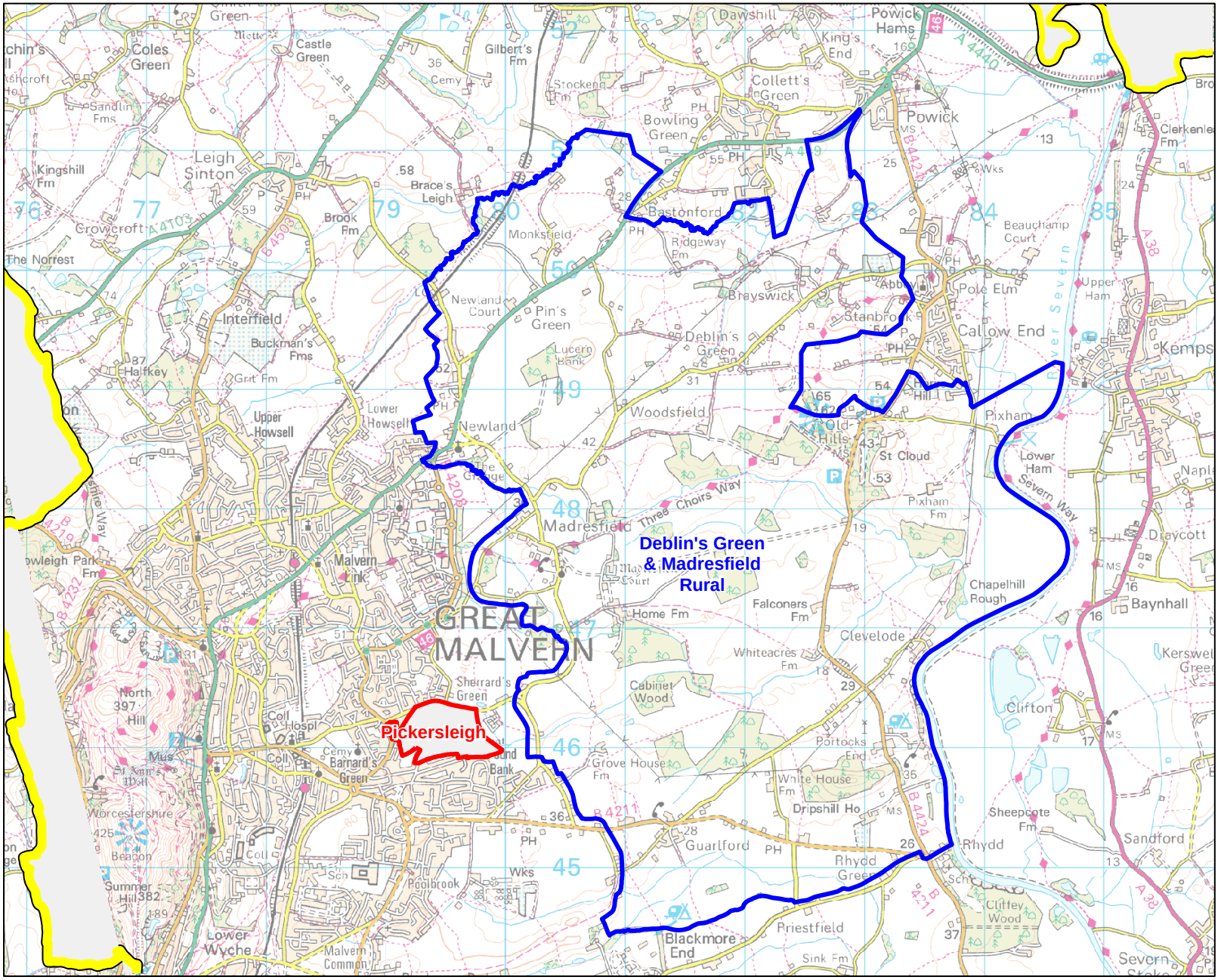
Worcester Hotspots



Bromsgrove and Wychavon Hotspots



Malvern Hills Hotspots



Definitions

IMD	Index of Multiple Deprivation. The English Indices of Deprivation 2010 provide a relative measure of deprivation at small area level across England. Areas are ranked from least deprived to most deprived on seven different dimensions of deprivation and an overall composite measure of multiple deprivation. Available from http://data.gov.uk/dataset/index-of-multiple-deprivation.
Life Expectancy	This is the average number of years a person would be expected to live if they experienced the current age-sex specific mortality of the group to which they belong.
Healthy Life Expectancy	This is the average number of years a person would be expected to live in good or fairly good health if they experienced the current age-sex specific mortality and health status rates of the population group to which they belong.
Standardised mortality (DASR)	The calculation of directly age standardised mortality rates (DASR) allows the comparison of death rates between areas with different population age structures. The number of deaths for each age band are divided by the population for each age band to give age specific death rates for the area. These age specific rates are multiplied by the standard population for each age group respectively and aggregated across all the age groups to give the age adjusted count of deaths for the area. This age adjusted count of deaths is divided by the total standard population for the whole age range included in the indicator, and multiplied by 100,000 to give the age standardised mortality rate for the area.
AAACM	All age all-cause mortality rate. The mortality rate for a population from all causes for all ages, standardised to account for differences in the age demographics of different populations.
Excess Winter Deaths	Excess Winter Deaths Index (EWD Index) is the excess winter deaths measured as the ratio of extra deaths from all causes that occur in the winter months (December to March) compared with the expected number of deaths, based on the average of the number of non-winter deaths (the preceding months August to November and the following months April to July).
LSOA	Lower level Super Output Area. These are geographical areas defined for the publication of statistical information such as the Census and contain on average 650 households or 1,500 residents.
MSOA	Middle level Super Output Area. These are aggregates of LSOAs to form larger statistical areas containing an average population of 7,500 residents.
Children in Poverty	This is a relative measure and defines a child as in poverty if live in households with needs adjusted income below 60% of the median income.

This page is intentionally left blank

Draft Joint Health and Well-being Strategy 2016 to 2019

Document Details:

Status: Draft Version 1

Date: October 2015

Document Location: http://www.worcestershire.gov.uk/info/20043/health_and_well-being/1114/adults_sexual_health_services_survey

Contact: Janette Fulton

Contents

Introduction

1. This will be Worcestershire's second Joint Health and Well-being Strategy It is a statement of the Health and Well-being Board's vision and priorities for 2016-19, based on the findings of the Joint Strategic Needs Assessment and public consultation. Preparation of the Strategy is a statutory duty for the County Council and the Clinical Commissioning Groups under the Health and Social Care Act 2012. The Strategy is a basis for the public to hold local organisations to account for achieving the stated outcomes.

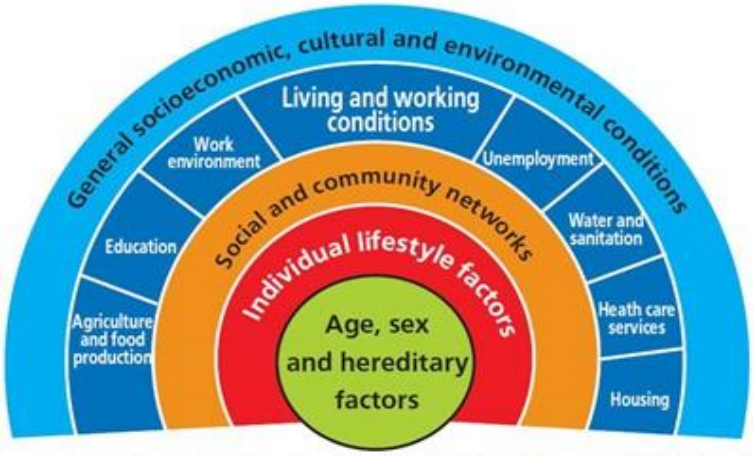
2. The Strategy sets the context for other health and well-being plans and for commissioning of NHS, public health, social care and related children's services. We will work with all partners to help align policies, services, resources and activities with the Strategy. This will enable joined-up action to tackle issues that will benefit from multi-agency working.

3. The Board expects that the commissioning plans of the County Council and the local NHS are consistent with the Strategy, as required by the Health and Social Act 2012. The Strategy will provide a basis for commissioners of NHS, public health, social care and related services to integrate commissioning plans and pool budgets wherever possible, using the powers under Section 75 of the NHS Act 2006 where appropriate.

Context

National Policy

4. Health and well-being is influenced by a range of factors over the course of people's lives. These factors are related to people's surroundings and communities as well as their own behaviours. Collectively they have a much greater impact on health and well-being than health and social care services. To improve health and well-being it is these factors that we need to influence.



The Determinants of Health (1992) Dahlgren and Whitehead

5. Subsequent national policy has emphasised the importance of prevention. Two Government White Papers on public health in the last decade have focussed on the need to develop a wide-ranging and effective approach to prevention. These have made recommendations from changing individual behaviour through education and empowerment, to changing what choices are available by regulating the availability and sales of tobacco, unhealthy food and alcohol.

6. These have not yet proved sufficient to reduce the burden of avoidable disease. In response to this, the NHS has recently produced a **Five Year Forward View**, which argues that the future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a **radical upgrade in prevention and public health**. It particularly calls for all parts of the system to work together on prevention right through life.

7.

8. Prevention duties are increasingly being articulated within legislation and statutory guidance including the Health and Social Care Act 2012 and the Care Act 2014. The Childcare Act 2006 requires the Council to improve the well-being of young children and reduce inequalities; the Education and Inspections Act 2006, requires the Council to secure equality of access for all young people to the positive, preventive and early help they need to improve their well-being.

9. The Care Act 2014 articulated three levels of prevention and noted that these were a shared responsibility across the health and care system:
   - Primary prevention. To **prevent** ill health and the need for care before it occurs. Includes these services for people who currently have no particular health and care needs, and they help people to avoid developing needs. They focus on promoting well-being, good health, and independence;
   - Secondary prevention. To **reduce** the impact of health problems by detecting them as soon as possible and intervening early. Includes services are designed for people who have an increased risk of developing needs, where provision of services or resources may slow down or reduce the development of that need;
   - Tertiary prevention. Getting the right help to people who already have needs and giving support to prevent those needs escalating and **delay** the need for more intensive care. Includes services for people with established health conditions who need support to regain skills or to delay deterioration.

Health and Well-being in Worcestershire

10. There are around 575,400 people living in Worcestershire. The county has a greater proportion of older people resident than the nation in general. The population of Worcestershire is projected to increase by 21,579 to around 597,000 in the next 10 years with the biggest increase projected to be in the older age groups. This is especially apparent in the 75-79 age range, although proportionally the projected rise in the 90-plus age range is higher. The forecast increase in numbers of older people is due to increased life expectancy resulting in greater numbers of older people, surviving to very old age[1].

11. Overall health in Worcestershire is better than the England average. The average number of years a person born today in Worcestershire would expect to live in good health is 66.4 years for women and 66 years for men compared to 63.9 and 63.3 nationally[2]. Death rates from causes that could potentially be avoided by public health interventions in the broadest sense are below national rates and have been declining[3].

12. There are also some serious ongoing challenges to health and well-being:
    - A growing number of elderly and frail people with complex health needs;
    - An ongoing burden of avoidable ill-health related to lifestyles - about two thirds of adults are overweight or obese, a third of men and half of women don't get enough exercise, about a third of people drink too much alcohol, and one in six adults smoke.
    - An increasing cost of providing health care due to the introduction of expensive new drugs and technologies;
    - The growing need for savings due to pressures on public sector finances;
    - Persistent inequalities between the most disadvantaged and the most affluent communities - the average number of years a person born today in Worcestershire would expect to live in good health is 15.4 years lower for men and 14.3 years lower for women in the most disadvantaged 10% of communities compared to the 10% most affluent.

Vision

13. The vision of the Board is that ***Worcestershire residents are healthier, live longer and have a better quality of life, especially those communities and groups with the poorest health outcomes.***

14. The Board works to **six key principles** and these underpin the Strategy:

i. **Working in partnership.** We will facilitate partnership and ensure that organisations work together across the public, voluntary and private sectors to maximise their contribution to health and well-being.
ii. **Empowering individuals and families.** We will encourage and enable individuals and families to take responsibility and improve their own health and well-being. We will also ensure that targeted support is available where necessary to increase individual, family and community resilience and self-reliance.
iii. **Taking Local action.** We will recognise local assets and strengthen the ability of communities to develop local solutions to local issues.
iv. **Using evidence in decision making.** We will draw on the evidence of what works when develop ping strategies and plans for action.
v. **Involving people.** We will respect the views of the public, patients, service users and carers and ensure that they have an opportunity to shape how services are organised and provided.
vi. **Being open and accountable.** We will be clear about the impact we expect from investment and action to improve health and well-being, and open about the progress we are making.

15. Meeting the challenges described above will require renewed a emphasis on prevention with action in the long term to address the wider influences on health and well-being, as well as more immediate action to continue to improve the quality and value for money of health and social care and to make sure that prevention is embedded in care pathways.

16. The Board will ensure that actions to implement this Strategy align with our **five approaches to prevention**:
    - ✓ **Creating a health promoting environment** by developing and enforcing healthy public policy and taking health impact into account systematically in decision making.
    - ✓ **Encouraging and enabling people to take responsibility for themselves, their families, and their communities** by promoting resilience, peer support and the development of community assets.
    - ✓ **Providing clear information and advice** across the age-range, so that people make choices that favour good health and independence.
    - ✓ **Commissioning prevention services** for all ages based on evidence of effectiveness and within the funding available.
    - ✓ **Gate-keeping services** in a professional, systematic and evidenced way, so that services are targeted to the people who would benefit most, regardless of their personal characteristic or circumstances.

Priorities

17. We will focus on a small number of **priorities**. These priorities have been chosen because individually and collectively they:
    - Have high direct and indirect economic costs both now and in the future
    - Affect people across all age groups
    - Relate to major causes of ill health and premature death
    - Are linked to good evidence of potential to improve outcome
    - Are of high importance to the local public
    - Are linked to JSNA data which suggests a worsening situation, and/or a situation that is worse than would be expected for Worcestershire
    - Show clear geographical and/or population inequalities in health and well-being outcomes
    - Need strong partnership working to improve outcomes
    - Affect large numbers of people in Worcestershire, and these numbers will rise significantly if we do not deliver change.

18. Our priorities for 2016-19 will be:
    - Mental health and well-being throughout life
    - Being active at every age
    - Reducing harm from alcohol at all ages.

Mental health and well-being throughout life

19. We will focus on **building resilience to improve mental well-being,** and **dementia**.

20. People who are more resilient do better in life, being happier, more able to cope with adversity and less at risk of developing mental health conditions such as anxiety and depression. There is growing evidence about how to improve resilience throughout life.

21. The numbers of people with dementia are expected to rise by almost one third between 2012 and 2020. There are things that can be done to reduce the risk of getting dementia. There are also things that can be done to help people live with dementia so early

- Mental ill health costs the economy £105 billion per year
- Mental health has an impact on people's physical health: for young people, mental il health is strongly associated with behaviours that pose a risk to their health, such as alcohol and drug use and smoking
- In Worcestershire 70,000 adults and 7,000 children are living with mental ill- health at any time
- A higher proportion of adults (7.8%) are diagnosed with dementia than the national average (5.8%)
- 50 people take their own life each year

diagnosis is important - only 40% of cases are diagnosed currently.

22. We will also focus on four groups:

Under 5s and their parents. Because building resilience from an early age will have life-long benefits: resilient children do better at school and grow up to be resilient adults; resilient parents will support their children well through childhood and adolescence.

Young people. Front-line professionals across the health, education, and social care system are expressing concern about a deterioration in the mental health and well-being of young people. There has been an increase in Emergency Department attendances for self-harm related reasons in this age group..

Older people. Dementia is more common in older people. Worcestershire has a higher proportion of people aged 65 or over than the national average and the number of people in this age group is going to grow by over a third between 2014 and 2029. There are large numbers of people who care for people with dementia, and this can put a significant strain on mental health and well-being.

Populations with poorer health outcomes. Building resilience can help people to succeed, improving health and social outcomes. This will help to reduce the gap in in health outcomes across the county, between different social groups and between different geographical areas.

Being active at every age

23. We will focus on **increasing everyday physical activity** because this is a low or no cost option, and because long-lasting behaviour change is most likely to be achieved by making changes to daily routines.

- Being inactive is a major cause of ill health throughout life - including heart disease, diabetes and some cancers.
- The negative health impact of being inactive is both avoidable and in some cases reversible
- In Worcestershire at least a third of people do not meet the recommended guidelines for being physical active

24. We will also focus on three groups:

Under 5's and their parents. One in four children in Worcestershire are overweight or obese by 5 years old and one in three children by 11 years old. Being physically active can easily become a life-long behaviour if it is started in early childhood. Physical inactivity can reduce the chances of doing well at school for children, and is associated with poorer mental health in childhood.

Older people. Physical activity reduces the risk of depression in adults and older adults as well as the risk of cognitive decline and dementia, including Alzheimer's disease. Physical activity builds and maintains muscle mass, which will increase older people's ability to live independently and reduce the risk of falls.

Populations with poorer health outcomes. People living in deprived areas are less likely to physically active and more likely to develop ill health. Some people, such as those with a learning disability or sensory impairment, have particular challenges in being physically active.

Reducing harm from drinking too much alcohol

- Alcohol is ranked by the World Health Organisation as the third leading cause of death and disability in the developed world
- Around three quarters of Emergency Department attendances at night time and 40% during day time are associated with drinking too much alcohol
- Drinking too much also have long-term social consequences such as family break-up, domestic abuse, unemployment, homelessness and financial problems.
- In Worcestershire 85,000 people drink more alcohol than the recommended limit, which puts their physical and mental well-being at risk

25. As well as **reducing consumption of alcohol** we will focus on **reducing risky behaviour** associated with drinking too much. Alcohol can influence people's decisions such that they do things that they would not have done without a drink – such as being careless, not practicing safe sex, or becoming aggressive. Alcohol is the biggest single cause of accidents in the home. It increases the likelihood of being a perpetrator or a victim of violence. It is associated with two third of suicide attempts.

26. We will also focus on three groups:

Middle aged. Heavy drinking in middle age is a growing problem, and usually takes place outside of public places, making it harder to regulate.It increases blood pressure and cholesterol levels, both of which are major risk factors for heart attacks and strokes.

27. **Older people.** Alcohol has a greater effect on older people. The Royal College of Psychiatrists now recommends that people over 65 should not drink more than half the recommended maximum daily limits for adults under 65 years. A third those who experience problems with alcohol do so for the first time later in life, often as a result of big changes like retirement, bereavement or feelings of boredom, loneliness and depression.

28. **Populations with poorer health outcomes.** People living in deprived areas are more likely to drink more alcohol than the recommended limit. This will include specific attention

to young people since, although overall patterns of drinking among young people are becoming less risky, there remain some issues in disadvantaged areas.

From strategy to action

29. The Strategy requires action by a range of different organisations and individuals. The Board will ask that the statutory partners respond by:
    - Working together and with others to ensure the Strategy is implemented. Board members, commissioners, providers, elected members, communities and individuals will all have role – as set out in 'Working Together' below.
    - Making sure that this Strategy is taken in account in drawing up organisational commissioning and service development plans. For the Clinical Commissioning Groups this will be a requirement for their authorisation and approval of their commissioning plans.

30. The Board will in addition support implementation by:
    - Ensuring that the Strategy is widely available and raising awareness of it at every opportunity.
    - Providing leadership and advocacy.
    - Encouraging participation and contributions from the voluntary sector, businesses, schools and others.
    - Facilitating debate on difficult issues.
    - Building relationships and enabling partner organisations to align policies, services, resources and activities to increase their collective impact on health and well-being.
    - Publicising examples of good work
    - Overseeing progress and offering challenge and support where necessary.

31. The Board will hold statutory partners to account for implementation of the Strategy by:
    - Delegating to the Health Improvement Group (HIG) the responsibility to agree a set of detailed Plans with clear actions, responsibilities, milestones and timescale.
    - Receiving bi-annual reports from the HIG about progress against these Plans.
    - Tracking progress against a set of performance indicators which will be reported bi-annually to the Board.

Measuring progress

32. A range of performance indicators will be used to measure the impact of this Strategy – as set out below. These will be presented as a single outcome framework with baseline data, direction of travel and targets. These are selected from indicators which are already embedded in the performance frameworks of

partner organisations and are intended to enable sharper focus and a new opportunity for the Board to challenge, debate, and support progress :

Partner Responsibilities

To improve the health and wellbeing of Worcestershire residents we all need to work together.

Health and Wellbeing Board Members will

Encourage integrated working between health and social care commissioners

Encourage close working between commissioners of health-related services (such as housing and many other local government services) and commissioners of health and social care services

Provide a forum where agencies in Worcestershire can focus on reducing health inequalities.

All Partners will

Co-produce services and resources with other health, social care and community organisations

Tailor services and resources and target them according to where they are most needed

Plan services that are person centred and developed with input from service users

Design services that promote independence rather than impose dependence

Support communities and individuals to become more empowered and resilient

Commissioners will

Commission services and resources that support the priorities of the Health and Wellbeing Board and Strategy

Ensure that services and resources are measured for effectiveness

Engage with and seek the views of individuals and communities

Consider the physical, mental and emotional wellbeing of individuals needing care

Providers will

Ensure that services and resources are measured for effectiveness

Engage with and seek the views of individuals and communities

Support communities and individuals to become more empowered and resilient

Councillors will

Act as leaders for their communities, deliverers of services and catalysts for change

Promote the importance of prevention to improve health and wellbeing to its communities

Engage with and seek the views of individuals and communities

Support communities and individuals to become more resilient and empowered.

Communities will

Take ownership and responsibility for their own health and wellbeing

Be proactive and access those services and resources readily available to them to increase their resilience

Work with organisations and commissioners to coproduce services and resources

Support more vulnerable members of the community to maintain good health and develop strong social connections.

Individuals will

Take ownership and responsibility for their own health and wellbeing

Be proactive and access those services and resources readily available to them to increase their resilience

Use services and resources that are limited and high cost wisely and only when essential.

Performance indicators

Priority	**Performance indicators**
Good Mental Health and Well-being throughout life	• Satisfaction with life measure (National Wellbeing Survey) • School readiness: all children achieving a good level of development at the end of reception as a % of all eligible children by free school meal status • Hospital admissions as a result of self-harm (10-24 years) • Referrals to Child and adolescent mental health services • Diagnosis rate for people with dementia • Health-related quality of life for people with long-term conditions • % of adult social care users who have as much social contact as they would like • Proportion of adults in contact with secondary mental health services in paid employment

Being Active at every age	• Age standardised mortality rate from all cardio-vascular diseases under 75 years of age • % of children meeting Chief Medical Officer guidelines for physical activity • Length of time spend in sedentary activities by children • % of children aged 4-5classified as overweight or obese • % of children aged 10 – 11 classified as overweight or obese • Cycling Walking travel measures for adults to be confirmed • % of adults taking 30 minutes physical activity on 5 days a week • Numbers of older people taking up Strength and Balance training • Numbers of people taking part in health walks • Numbers of people training as volunteers for health walks
Reducing harm from Alcohol at all ages	• Age-standardised rate of mortality considered preventable from liver disease in those aged under 75. • Under 18s hospital admissions for alcohol related conditions • All hospital admissions for alcohol related conditions • Alcohol related crime

Worcestershire's Children and Young People's Plan

2014 to 2017

WORCESTERSHIRE
SOURCE OF EXCELLENCE

Children's Trust

Introduction

Welcome to the Children and Young People's Plan (CYPP) for Worcestershire. This plan is the single plan for all children and young people in Worcestershire aged from 0-19 years, and some groups of vulnerable young people up to the age of 25 years old. It has been led by the Worcestershire Children's Trust Executive Board, a sub group of Worcestershire's Health and Well Being Board which approved the plan.

The Children's Trust in Worcestershire recognises and embodies the importance of partnership working and co-operation between agencies working with children, young people and families in improving their life chances. This plan covers 2014 to 2017 and builds on the substantial work previously undertaken and recognises the important role that the emerging Local Children's Trusts will have in the future, working closely with early help providers and partners at a locality level.

The period of the last CYPP was one of significant change and challenge, particularly given the level of financial reductions faced by all partners. The scale of this challenge is likely to remain throughout the period of this new plan. One of the major changes in response to this has been, and will continue to be, the commissioning of the right services for children and young people so that they are provided at the right place, at the right time and at the right price. Our successes in commissioning early help services in all six district areas and the continued development of joint commissioning arrangements between the local authority and NHS Worcestershire demonstrate how Children's Trust partners have come together to improve outcomes for children and young people despite budget reductions. This new Children and Young People's Plan, therefore, comes at a time when Children's Trust partners are moving into a new phase of planning, commissioning and delivery of services to children, young people and their families.

In this plan we have refreshed our visions, values and priorities. To help decide on the priorities for this Children and Young People's Plan there has been widespread consultation with children, young people, their parents and carers and those that work with them. The voice of children and young people is vital to all that we do going forward. The recently established Local Children's Trusts have been a significant part of consultation and will have a lead role in turning the ambitions and priorities outlined in the plan into reality. As a result, the plan articulates a commitment to participation, co-operation and collaboration by Children's Trust agencies. However, the challenge is how we channel our energy and increasingly limited resources into what makes most difference for children and young people.

We recognise that every child and young person is an individual. We have high aspirations for every one of them and want every one of them to grow up with the opportunity to realise their full potential. The Children's Trust will now do its best to make this a reality.

Publication of this plan would not have been possible without the support of all those who contributed to consultation. The Children's Trust would like to thank all those who have taken part, especially the children, young people, parents and carers whose input has been invaluable in shaping the plan.

Councillor Liz Eyre
Chair of Worcestershire
Children's Trust

Gail Quinton
Director of Children's Services

What is a Children and Young People's Plan?

A Children and Young People's Plan is a joint, strategic overarching plan for all agencies that work with children and young people. It outlines how Children's Trust partners will work together to improve outcomes for children and young people in the county, setting out the vision for improving those outcomes through to 2017. The plan outlines the Children's Trust's values and ways of working as well as the strategic priorities. The plan is important as it is demonstrates how partners will work together, what actions and activities will take place and how we will know we have made a difference. The plan covers all services for children and young people aged 0 to 19 years old and some groups of vulnerable young people up to the age of 25 years old.

The Children and Young People's Plan and its priorities have been informed by and are aligned with the priorities of Worcestershire's Sustainable Community Strategy and the Health and Well-being Strategy. A variety of strategies and operational plans developed by individual Children's Trust agencies sit underneath the Children and Young People's Plan.

There are two main parts to this plan. The first is a look at how well we delivered our priorities for 2011 to 2104. The second part outlines our vision, values and priorities for the future and how these will be delivered.

Worcestershire's Children's Trust

The Children's Trust is a partnership of organisations that work with children and young people, along with representatives of children, young people and parents/carers. Its main purpose is to improve outcomes for all children and young people in Worcestershire through planning services as well as promoting and enabling joint commissioning. The Trust is a sub-group of the Health and Well-being Board and works closely with Worcestershire Safeguarding Children Board and the Corporate Parenting Board. The Children and Young People's Plan is aligned to the plans and strategies of these boards.

Local Children's Trusts are an important part of our Children's Trust arrangements and we are currently working to establish Local Children's Trust in each of the six district areas. The main purposes of a Local Children's Trust are:

- to make sure that there is local plan which demonstrates how the priorities in the Children and Young People's Plan and any other local priorities are going to be delivered in the local area
- to ensure that planning of services at a local level helps to improve outcomes for children and young people, including through local commissioning arrangements.

Children, young people, parents and carers are also an important part of the Children's Trust. They provide advice to the Children's Trust Executive Board, tell the Board about what matters to them and how well they think we are doing on key issues. We actively encourage the participation of children, young people, parents and cares in the planning services.

How well have we done 2011-2014?

The Children and Young People's Plan for 2011 – 2014 set out five priorities and what we would do to achieve them. This section outlines the progress made.

We said...

Children and young people will be protected from harm and neglect

We achieved...

- There has been a small increase over the life time of the plan in children with a Child Protection Plan and those with a Child Protection Plan for a second or subsequent time, but Worcestershire remains better than the national average.
- Over the same time period, there has been a decrease of 15.4% in Child Protection Plans where domestic abuse was identified. This means that we are doing better than the target we set ourselves.
- We have improved safeguarding services which were rated 'adequate' by Ofsted in 2012. Significant service redesign has taken place and two peer reviews in 2013 have helped us to improve services further. No child was found to be at immediate risk of significant harm.
- There continues to be pro-active and effective work being undertaken to protect children when required and also to ensure families are enabled to care for their own children safely where this is possible. Worcestershire Safeguarding Children's Board has worked to raise the understanding of all partners of the thresholds for a child needing a Child Protection Plan and there is robust oversight of Child Protection Plans.
- An Early Help Strategy is in place and Early Help services have been commissioned in all six district areas, informed by local priorities and need so that services are locally responsive. The Early Help Hub has been operational since April 2013 acting as a single point of contact to raise and notify any concerns about a child, young person or family where there is perceived to be no risk of significant harm. CAF was re-launched in Autumn 2013 as the Early Help Assessment (EHA) that assesses a family's needs and identifies the required outcomes.
- The Stronger Families initiative has been proactive in identifying supporting, intensive and challenging work with families who meet the criteria for the project. As of January 2014, we have worked with/are working with 583 Stronger Families, and have claimed payment by results for 191 families.
- There has been a decrease in the percentage of children and young people who say they have experienced bullying or aggressive behaviour from 70% in 2009 to just less than 50% in 2013.

We said...

Educational outcomes will be outstanding for all children and young

We achieved...

- 84% of pupils are now educated in good or outstanding schools and almost 86% of early years providers are good or outstanding. 71.7% of Looked After Children are educated in good or outstanding schools.
- In 2009 the local authority was ranked 90th out of 153 for GCSE performance. It is now ranked 50th. There has been an improvement of 8% over the course of the plan in the percentage of pupils achieving five or more A*-C including English and Maths with 62.9% of pupils achieving this in 2012/13. This means that we are doing better than the target we set ourselves as well as the national and statistical neighbours' averages.
- An improvement in the percentage of early years pupils achieving an overall level of good level of development to 64% in 2012, but the government introduced a new method of assessment which meant that there was a decline to 49% in 2013. The Early Years and Childcare Service and the School Improvement Service challenge and support settings and schools to ensure that provision is appropriate to enable all children to make at least expected progress.
- An improvement in the percentage of year six pupils attaining age related expectations at the end of Key Stage 2 to 77% in 2012 but the government then introduced a new measure of attainment which meant there was a decline to 72% in 2013.
- An improvement in inequalities in educational outcomes for some vulnerable groups of pupils, including Key Stage 2 pupils eligible for Free School Meals, although the improvement is not as good as the improvements made nationally and by our statistical neighbours.
- 15.4% of Looked After Children attained 5 A*-C, including English and Maths at GCSE in 2013, and increased from 9.5% (4 children) in 2013. 33% of Looked After Children attained Level 4+ Reading, Writing and Maths at end of Key Stage Two in 2013. A tracking system is in place to chart progress of Looked After Children in their educational outcomes.
- The local authority has continued to support schools and other settings to improve the quality of teaching and learning and has also provided targeted intervention in schools in challenging circumstances, ensuring the curriculum is appropriate to the needs of pupils.

We said...

Young people will move successfully into adulthood

We achieved...

- An improvement over the life of the plan in the percentage of 16 to 18 year olds who are not in employment, education or training (NEET), such that 5.2% of young people were NEET in March 2013. This is a 0.3% improvement despite the economic recession. This means that our target was met as Worcestershire's performance was better than the national average. Looked After Children and care leavers are a priority for 'Open for Business' addressing Entry to Employment. As a Corporate Parent, Worcestershire County Council is prioritising those schools with high numbers of Looked After Children to support work experience and progression to apprenticeships.
- More Care Leavers live in suitable accommodation and more are in education, employment or training in 2013/14 than at the start of the plan. We are performing better than our target. There is now a specialist team which is supporting care leavers in their transition to adulthood, including supporting them in finding education, employment and training, promoting their health and well-being and supporting them to find somewhere safe and secure to live. A Protocol and provision for 16/17 year old Homeless Young People has been developed with District Housing Officers, including Safe Base accommodation.
- Drop-in venues for Care Leavers have been developed and implemented across the county, providing welfare and health advice.
- There has been some improvement in educational outcomes for 19 year olds, although there is still some improvement to make so that we meet our targets. We have been strengthening links between post-16 providers to enable challenge, support and identification of good practice.
- A Young Adults' Team for young people aged 16 to 24 with complex disabilities and health needs has been in place since 2012 to improve transitions between children's and adults' services.

We said...

Children and young people will have the opportunity to grow up in stable and secure families

We achieved...

- There has been a rise in the social care referral rate over the life time of the plan meaning our target for reduction has not been reached. Children's Social Care is continuing to work to reduce referrals through identification of help at an earlier stage in partnership with the Early Help Hub.
- Following the completion of an in depth needs assessment, the Looked After Children (LAC) Strategy has been developed to prevent children from needing to be looked after; to enable children to return to their birth family where possible and where this is not possible, to identify a secure and stable alternative home.
- Numbers of Looked After Children are managed through the LAC Action Plan and work has been undertaken to address the increase in numbers through the social care service redesign and the support offered through the Early Help Strategy.
- There has been an increase of 5 per 10,000 in the number of Looked After Children in Worcestershire from 50 per 10,000 to 55 per 10,000 in 2012/13 throughout the life time of the plan. Worcestershire has a lower figure than the national average. A pilot inspection of services for Looked After Children undertaken by OFSTED in November 2012 did not find any child who should not have been looked after.

We said...

Children and young people will grow up healthily

We achieved...

- Speech, Language and Communication Needs have been re-commissioned and there has been a significant decrease in waiting times for these services. The talking walk-in service has provided early intervention to children under 5 years with approximately 100 unique children and their parents visiting the drop-ins within each quarter, with positive feedback from parents. The service has also trained professionals such as health visitors, early years settings staff and school staff to be able to identify speech, language and communication difficulties and support strategies to address those.
- Re-commissioned a Child and Adolescent Mental Health Services with a single point of access and out of hours assessment and support, as well as a specialist service for LAC. There has been a significant decrease in waiting times.
- Services for children and young people with disabilities have been redesigned, including the development of both community and specialist short breaks services that better meet need. This gives families more choice and control over the services they could buy to meet their assessed needs through direct payments and the development of an integrated equipment resource service that allows professionals and the families they work with to access equipment more readily.
- Work has been commissioned in Areas of Highest Need to address health inequalities and improve health outcomes, including additional play schemes, after school clubs, breakfast clubs, projects to reduce risky behaviour (e.g. alcohol, drugs), healthy cooking sessions and community food workers.
- A healthy weight service has been put in place for pregnant and new mothers as well as a breastfeeding support service and healthy lifestyle community programmes have been piloted.

Our Vision, Values and Approach

In shaping our vision for 2104-2017, we have considered what it is like for children and young people in Worcestershire today. To do this, we have depicted Worcestershire as a village with 100 children and young people and used this as a baseline from which to help identify what outcomes we need to improve.

Our vision is:

We will work together to make Worcestershire a place where children and young people from all communities and backgrounds are healthy, feel safe and have opportunities to enjoy their lives and reach their full potential.

If Worcestershire was a village with 100 children and young people in 2017:

Our vision for Worcestershire in 2017 is that children, young people and families achieve their potential in a safe environment so that they lead successful lives. So if Worcestershire was a village with 100 children and young people in 2017 we would expect to see more children and young people:

Values

The Children's Trust wishes families to be at the centre of all it does or strives to do. Our values take account of the United Nations Convention for the Rights of the Child and are:

- all children and young people matter;
- to listen to, hear, respect and value children and young people;
- to celebrate diversity, whilst acknowledging individual rights and responsibilities;
- to stretch the most able, support those who need it, and protect and nurture the most vulnerable;
- that families will be encouraged and empowered to help themselves;
- where possible, to prevent problems from happening;
- to provide the right support at the right time and at the right place;
- to involve children and young people in decision-making, particularly those decisions that affect their family life;
- for agencies and professionals to work in partnership with each other and with families;
- for services to be of high quality, no matter who delivers them.

Approach

The priorities contained in this plan:

- are based on evidence of need;
- incorporate recommendations from external assessment of the performance of some services in Worcestershire by Ofsted and peer reviews;
- reflect local views, wishes and aspirations of children, young people and their parents and carers, as well as local community leaders such as elected members;
- draw upon the knowledge and experience of operational staff and managers.

Our approach will be to:

- remain focused on outcomes so that we can demonstrate not how much we do, but what impact it has had;
- focus actions on those children, young people and families living on a low income as well as those children, young people and families who are vulnerable, including those in rural areas ;
- encourage local solutions to local problems/issues;
- provide services that deliver value for money;
- promote personalisation;
- work in partnership whenever and wherever possible;
- do what we know has been proven to work.

Being Outcomes Focused

The Children's Trust wishes to become more outcome-focused in its approach and has agreed a terminology that will be used to ensure that the work of the Children's Trust remains focused on outcomes and so that we can demonstrate impact. For this purpose, an outcome is defined as 'an end result,' for example, Looked After Children are healthy. It is not what activity has taken place, but the consequences of that activity.

For the purposes of this plan, an indicator is a measure which permits us to quantify the extent to which outcomes are being achieved, or to tell what difference we have made or what impact we had. Using the example of Looked After Children being healthy, the percentage of Looked After Children who are obese could be used as an indicator to measure success.

Whilst our vision extends through the life of the Children and Young People's Plan to 2017, the rest of this plan outlines what we will do in the coming twelve months to progress the priorities that we have identified.

Our Priorities

Children and young people have a healthy lifestyle

Our areas of focus are:

- to improve the emotional health of children and young people, including access to mental health support;
- to encourage children and young people to eat healthily and participate in physical activity and sport;
- to reduce the harm caused by, and improve young people's awareness of, smoking, drugs and alcohol.

Children and young people reach their full potential in education

Our areas of focus are:

- to increase the diversity and further improve the quality of learning opportunities and access to them for all children and young people;
- to reduce educational attainment gaps between vulnerable learners and their peers;
- to match learning opportunities to the child or young person;
- to help parents and carers to be involved in their child's learning (with a focus on parents with poor literacy skills).

Children and young people are helped at an early stage

- Our areas of focus are as identified in the Early Help Strategy.

Children and young people are protected from abuse and neglect

Our areas of focus are:

- to improve services that help to keep children safe;
- to reduce the impact on children and young people of domestic abuse, parental mental health issues and substance misuse;
- to protect children and young people who go missing and from child sexual exploitation;
- to help children and young people feel safe wherever they are.

Children and young people grow up in secure and stable families

- Our areas of focus are as identified in Corporate Parenting Strategy.

Young people have the life skills they need so they feel ready for adult life

Our areas of focus are:

- to work with businesses and other organisations to improve the range of work experience, jobs, apprenticeships and volunteering opportunities for young people, especially for those who are not currently in education, training or employment or those who are in care;
- to help all young people to gain the information and skills that will help them to live independently, especially those young people who are about to leave care;
- to improve transition arrangements between children's and adults' services for children with special educational needs and disabilities.

Children, young people and their parents/carers know where to go for information about services and support

Our areas of focus are:

- to continue to develop the internet as a point of access for children, young people and their parents/carers requiring information, advice and guidance on all aspects of a child's life;
- to continue to develop and promote existing information on services for children, young people and their parents/carers, the support they offer and how to access them;
- to improve accessibility of information on what to do when there are concerns about the welfare and safety of a child or young person.

Outcome:

children and young people have a healthy lifestyle

Our areas of focus are:

- to improve the emotional health and well-being of children and young people, including access to mental health support;
- to encourage children and young people to eat healthily and participate in physical activity and sport;
- to reduce the harm caused by, and improving young people's awareness of, smoking, drugs and alcohol.

Why is this important?

- Mental health and well-being, obesity and alcohol are priorities in Worcestershire's Health and Well-being Strategy. There are approximately 9,500 children with mental health problems in Worcestershire. Good emotional and mental health is just as important as good physical health and can affect all other areas of a child's life, including attainment at school.
- Consultation indicates that more needs to be done to improve the emotional health and wellbeing of children and young people and to improve referral and access to mental health support. It was ranked within the top ten issues identified in the Make Your Mark Survey undertaken by Worcestershire Youth Cabinet.
- There is an increased risk and rate of poorer mental health in children and young people living in families with low incomes compared to those in better-off households.
- The needs assessment indicates that in 2011/12 almost a quarter of children in reception and a third of children in year six were either over weight or very over weight. The prevalence is significantly higher for boys than girls. Obesity can lead to a range of health problems later in life, including diabetes, high blood pressure, heart attack, stroke and cancers.
- Very over-weight children in both reception and year 6 are more likely to live in areas that are more deprived and children growing up in poverty are less likely to have a healthy diet, access to fresh fruit and vegetables and take regular exercise.
- Levels of alcohol-specific hospital stays amongst those under 18 are worse than the English average. Excess alcohol consumption leads to social problems including crime, antisocial behaviour, domestic abuse and family breakdown. It can also lead to a range of health problems later in life including high blood pressure, stroke, cancers and depression.
- The percentage of women who smoke in pregnancy are higher than the English average. Smoking in pregnancy can cause serious pregnancy-related health problems. These include complications during labour and an increased risk of miscarriage, premature birth, still birth and sudden unexpected death in infancy.

What will be done?

- More services and support will be planned and commissioned jointly across agencies to reduce duplication and increase the quality and efficiency of local services in order to reduce health inequalities, particularly in areas of deprivation.

- Drug and alcohol services will be re-commissioned taking account of the spectrum of need from children to adults.
- The Worcestershire Mental Well-being and Suicide Prevention Plan will be implemented focusing on early intervention and promotion of mental well-being across all settings and all ages.
- The Worcestershire Healthy Weight, Healthy Lives Strategy and action plan, including the Infant Feeding Plan will be implemented. This will include work to empower families to take responsibility for their diet and physical activity.
- A comprehensive county-wide response to the prevention of self-harm and suicide in children and young people, to include self-help information for children and young people, training and awareness raising in schools and other settings around self-harm and information will be developed.
- Information from children and young people on their experience of healthcare services will be captured to ensure that services meet needs, including the development of mechanisms for capturing young people's feedback on the support for emotional well-being that has been accessed from early intervention services provided by schools, early help providers and school nurses.
- Continue the redesign of unit based residential short breaks provision as well as work to create integrated health and social care teams for services that children with disabilities need.
- Commission school nurses to work in partnership with schools and the community to improve health outcomes for children and young people. This will include improving the awareness of the harm caused by smoking, drugs and alcohol, the promotion of healthy weight and emotional health and well-being.

What will success look like?

- Children and young people will access appropriate, high quality mental health support and services that meet their needs in a timely manner.
- More children and young people eating healthily and participating in sport regularly.
- Redesigned school nursing services and drug and alcohol services in place, focusing on areas of highest need.
- A decrease in health inequalities for children and young people across the county.
- More young people are aware of the harm caused by smoking, drugs and alcohol.

How will success be measured?

- A reduction is hospital admissions as a result of self-harm (10-24 years) from 416 per 10,000 in 2012/13 to 377.5 per 10,000 in 2014/15.
- 33% or fewer year 6 pupils with excess weight in 2013/14 (academic year).
- Reduce the gap between the percentage of year 6 pupils from disadvantaged communities with excess weight from 8% in 2012/13 to 7.5% in 2013/14 (academic year).
- A reduction in alcohol-specific hospital admissions amongst those under 18 from 57.2 per 100,000 in 2012/13 to 47.1 per 100,000 in 2014/15.
- 14% or fewer of mothers smoking at the time of delivery in 2014/15.
- An increase in the percentage of mothers breastfeeding at 6-8 weeks so that Worcestershire is not significantly different from the England average.

Outcome:

children and young people reach their full potential in education

Our areas of focus are:

- to increase the diversity and further improve the quality of learning opportunities and access to them for all children and young people;
- to reduce educational attainment gaps between vulnerable learners and their peers;
- to match learning opportunities to the child or young person;
- to help parents and carers to be involved in their child's learning (with a focus on parents with poor literacy skills).

Why is this important?

- Giving children and young people access to high quality education is crucial to enable them to reach their full potential and fulfil their aspirations. Even high performing schools, further education colleges, early years and other settings can continue to improve so that they become amongst the best nationally. High quality leaders, including governors, are essential to such improvement.
- The needs assessment indicates that educational outcomes for the Early Years Foundation Stage, Key Stage Two and Key Stage Five in Worcestershire are just below national averages in 2013.
- Inequalities exist in the educational outcomes for specific groups of children and young people compared to the outcomes for the wider range of children and young people of which the groups form a part. This is particularly apparent for pupils eligible for Free School Meals, Looked After Children and some black and minority ethnic groups. Such vulnerable children and young people often require additional support to enable them to achieve as well as their peers.
- Children from lower socio-economic groups are at much greater disadvantage at every stage in their education than those from higher socio-economic groups particularly if they form a small proportion of a school's population. However, educational attainment determines outcomes in later life and is a route out of living in poverty. The national Child Poverty Strategy prioritises preventing poor children becoming poor adults through raising their educational attainment.
- Three quarters of respondents to the View Point Survey said that learning opportunities should be matched to the child or young person and two thirds said that improving the range and quality of learning opportunities was important.
- National research shows that parental involvement in their child's learning is an important in improving a child's academic attainment and achievements, as well as their overall behaviour and attendance. The role of parents during a child's earliest years is the single biggest influence on their development.

What will be done?

- Schools and other settings will work in collaboration, particularly through local partnerships, school-to-school support and through the involvement of teaching schools, National and Local Leaders in Education
- Services will be commissioned to enable schools and other providers to improve their quality of provision and specific initiatives will be implemented to address identified areas of weakness.
- The Special Education Needs and Disability review will be implemented.
- Every school or setting will provide a learning environment (including the curriculum) that is appropriate for its learners.

- Schools and other settings that are not yet rated good by Ofsted will be challenged and supported, and their progress will be monitored regularly, including intervention where appropriate.
- Targeted support for schools and settings with vulnerable children, including identifying children and young people whose prior attainment and progress indicate that they are at risk of underachieving when compared to their peers.
- The progress of pupils from vulnerable groups will be tracked and monitored. An appropriate curriculum, adequate resources and targeted support will be provided so that provision meets the full range of pupils' needs.
- Schools and other settings will enable the active involvement of parents and carers in the education of their children.

What will success look like?

- Fewer schools and other settings in Ofsted categories of concern and fewer schools below floor standards, and more rated by Ofsted as outstanding.
- An improvement in educational outcomes for children and young people of all ages
- An improvement in the educational outcomes of children and young people from vulnerable groups at all key stages and a reduction in gap in educational outcomes for vulnerable groups of children and young people and the cohort of which the group is a part, particularly for those eligible for Free School Meals, Looked After Children, those with special educational needs and those from some black and minority ethnic groups.
- Better engagement at school and other educational settings by children and young people from vulnerable groups and families, including improved attendance and exclusions.

How will success be measured?

- An increase in the percentage of pupils who achieved a good level of development in the Early Years Foundation Stage from 49% in 2012/13 to 53.5% in 13/14 (academic year).
- The attainment gap at foundation stage to be 37% or lower in 2013/14 (academic year)
- An increase in the percentage of pupils that achieve at level 4 or above in Reading, Writing and Maths at Key Stage 2 from 72% in 2012/13 to 74% in 13/14 (academic year).
- An increase in the percentage of pupils achieving five or more A*-C at GCSE or equivalent including English and Maths from 62.9% in 2012/13 to 64% in 13/14 (academic year).
- A decrease in the percentage gap in achievement between pupils eligible for Free School Meals and their peers achieving the expected level at Key Stage 2 from 26.2% in 2012/13 to 24% in 13/14 (academic year).
- A decrease in the percentage gap in achievement between pupils eligible for Free School Meals and their peers achieving the expected level at Key Stage 4 from 30% in 2012/13 to 28% in 13/14 (academic year).
- A decrease in the achievement gap between LAC obtaining 5 GCSEs A* - C or equivalent from 38.6% in 2012/13 to 36% in 13/14 (academic year).
- A decrease in SEN/Non SEN attainment gap at Level 4+ at Key Stage Two Reading, Writing and Maths from 56.3% in 2012/13 to 54% in 13/14 (academic year).
- A decrease in the SEN/Non SEN attainment gap for 5 or more A*-C at GCSE including English and Maths from 50% in 2012/13 to 48% in 13/14 (academic year).

Please also refer to the priority on young people having the life skills they need, so they feel ready for adult life.

Outcome:

children and young people are helped at an early stage

- Our areas of focus are as identified in the Early Help Strategy

Why is this important?

- difficulties arise for approximately 30% of families nationally which, if nipped in the bud early enough, can be prevented from escalating to needing specialist services such as Social Care. Effective prevention and early intervention from universal and targeted services can bring about savings as specialist services are more costly to provide.
- 70% of respondents to the View Point Survey thought that preventing problems from happening and helping early on when they do should be an area of focus in the Children and Young People's Plan.
- The need to make the journey of the child and their family as seamless as possible through assessment and intervention as well as focusing support on the areas and families with highest need was a central theme that came from consultation.
- Over the last twelve months, we have commissioned early help services across Worcestershire, including Children's Centres. An Early Help Hub acts as a single point of contact for families and practitioners to raise any concerns about a child, young person or family who may have needs that cannot be met by universal provision and where there is perceived to be no risk of significant harm. This is supported by Early Help Assessment and Support Plans. These services and new ways of working need to be embedded.
- The needs assessment indicates that 2470 Early Help Notifications have been generated and 859 Early Help Assessments have been initiated since 1st April 2013.
- The government estimates that 900 families in Worcestershire meet the national Troubled Families criteria of having an adult on out of work benefits; children not being in school and/or family members being involved in crime and anti-social behaviour. The Stronger Families Programme has worked with 600 families across Worcestershire since April 2012 to achieve the outcomes of getting parents back to work, improving school attendance and anti-social behaviour.

What will be done?

- Further integrate services across the 0 to 19 age range including mapping of current provision, developing and implementing coherent pathways and ensuring a streamlined approach to assessing and meeting need.
- Integrate services for children aged 0 to 5 years with a particular focus on the future role of health visitors, family nurse partnerships and early years practitioners, including those based within Children's Centres.
- Re-define Worcestershire's approach to parenting support.
- Strengthen the approach for monitoring the quality and performance of all early help services across Worcestershire to demonstrate the impact on outcomes.
- Implement Phase 2 of the national Troubled Families agenda ensuring an effective interface with the broader early help provision.

What will success look like?

- Commissioned early help services for children, young people and their families will prevent issues from escalating further meaning fewer families require support from specialist services.
- Early Help services, including Children's Centres and parenting programmes, are integrated, accessible and responsive to local needs.
- More children and young people attend school and fewer are excluded.
- Better co-ordination and information sharing between service providers.
- Fewer children and young people requiring social care services.

How will success be measured?

- A decrease in referrals to children's social care from 308 per 10,000 in 2012/13 to 261.8 per 10,000 in 2014/15.
- A decrease in those who became subject to a child protection plan for a second or subsequent time from 20.5% in 2012/13 to 15.8% in 2014/15.
- A decrease in permanent exclusions to 0.065% in 2013/14.
- A decrease in persistent absence from 4.3% in 2012/13 to 4.28% in 13/14 (academic year).
- A decrease in the percentage of 16 to 18 year olds not in education, employment and training from 4.7% in 2012/13 to 4.5% in 2014/15.

Outcome:

children and young people are protected from abuse and neglect

Our areas of focus are:

- to reduce the impact on children and young people of domestic abuse, parental mental health issues and substance misuse;
- to protect children and young people who go missing and from child sexual exploitation;
- to help children and young people feel safe wherever they are

Why is this important?

- Protecting children and young people from abuse and neglect is the joint responsibility of all partners involved in Worcestershire's Children's Trust and the Worcestershire Safeguarding Children Board (WSCB).
- The areas of focus are key themes within the Worcestershire Safeguarding Board Strategic Plan.
- Ensuring that children and young people are safe and protected was rated as the top priority during consultation with all stakeholders.
- National research indicates that the experience of watching, hearing or otherwise being aware of domestic abuse can impact on children and young people's physical, emotional and social development. This is a priority in Worcestershire's Community Safety Strategy and WSCB's Strategic Plan.
- Children with Child Protection Plans are often from families where there is a high incidence of domestic abuse, parental alcohol and drug misuse, parental mental health issues and parental offending history.
- Being bullied can seriously affect a child's physical and mental health, lead to feelings of isolation and worthlessness and affect longer term life chances. The WSCB Bullying Survey indicated that 47% of children and young people responding to the survey said they had been bullied and 37% had experienced bullying in the last year. Many knew how to report bullying to their school or an adult, but felt that they did not receive enough support once they had reported it. The Worcestershire Youth Cabinet Make Your Mark Survey ranked bullying as the top issue for children and young people.
- It is estimated that nationally 100,000 children under the age of 16 run away from home or care every year. Running away can be symptomatic of wider problems in a child's life and those who run away are at greater risk of harm. There are longer term implications: half of all sentenced prisoners ran away as a child and adults who present as homeless often ran away as a child.

What will be done?

- The key activities set out in the WSCB Strategic Plan for 2014-2017 will be delivered.
- The effectiveness of arrangements for responding to missing children will be monitored and in particular the number of Looked After Children who go missing.
- Awareness of links to child trafficking and child sexual abuse will be raised and procedures and

guidance for working with, and identification of, those at risk of child sexual exploitation (CSE) will be embedded.

- Procedures will be put in place to prevent forced marriage and female genital mutilation.
- Safeguarding services will be improved through continued implementation and embedding of service redesign and recruitment of suitably qualified and experienced social workers.
- Think Family approaches will be developed to identify and support families where there is domestic abuse, parental mental health issues and substance misuse.
- Awareness of bullying issues for specific groups (including black and ethnic minority groups, children with learning difficulties and/or disabilities, those on low incomes and Lesbian, Gay, Bisexual and Transgender young people) will be raised and peer support approaches for those who have been bullied will be promoted through Worcestershire's Health and Well-being Strategy.

What will success look like?

- Children are safer from the risk and effects of domestic abuse through a greater awareness of the impact of domestic abuse on children and young people amongst practitioners.
- More support is given to children and young people affected by domestic abuse particularly those regularly exposed to this.
- Children and young people who require support receive timely and consistently high quality services.
- Fewer children and young people requiring social care or repeated social care support as a result of early intervention.
- Consistent application of thresholds and processes for access to services by all agencies involved in safeguarding children and young people.
- All agencies involved in safeguarding children and young people work co-operatively and share information in a timely and appropriate way.
- Children and young people say they feel safe wherever they are.
- Children and young people say that their school and other agencies deal with bullying well and are responsive when it occurs.

How will success be measured?

- A decrease in the number of children with a child protection plan from 33 per 10,000 in March 2014 to 31 per 10,000 in 2014/15.
- A decrease in those who became subject to a child protection plan for a second or subsequent time from 20.5% in 2012/13 to 15.8% in 2014/15.
- A reduction in the proportion of Child Protection Plans where domestic abuse is identified as a factor (baseline and target to be set).
- A reduction in the number of children and young people who go missing to below 29 per month.

Outcome:

children and young people grow up in secure and stable families

- Our areas of focus are as identified in Corporate Parenting Strategy.

Why is this important?

- Looked After Children are amongst the most vulnerable children and young people in society and local authorities and their partner agencies have a corporate parenting responsibility to improve the life chances for the children and young people who are in their care.
- Our vision for Looked After Children is to enable them to live in a safe home, with people who care, support and encourage them into recognising and reaching their personal aspirations for their future. Our aspirations and goals as Corporate Parents are the same as any good parent. We will require the best for them not just 'good enough'.
- There has been an increase in the number of Looked After Children in Worcestershire such that there are around 650 Looked After Children in our care. Our Looked After Children Strategy aims to ensure that all children are looked after by the right people in the right place at the right time.
- Nationally, children living in poverty are 700 times more likely to become Looked After.
- A Looked After Children Needs Assessment has been undertaken in Worcestershire which is being used as a basis for commissioning services and support for Looked After Children and those on the edge of care.

What will be done?

- Implement the Looked After Children Commissioning Strategy, including commissioning of high quality provision and services for Looked After Children and prevent children and young people coming into care.
- Implement the Corporate Parenting Strategy and the Healthy Care Action Plan.

What will success look like?

- More children safely and securely cared for at home, and thus fewer who are looked after.
- Looked After Children achieving good outcomes in all areas of their life, including education, health and employment.
- The right children come into care and are looked after by the right people in the right place at the right time.

How will success be measured?

- The Looked After Children rate to be 58 per 10,000 by the end of 2014/15.
- 70 children are adopted in 2014/15.

Outcome:

young people have the life skills they need so they feel ready for adult life

Our areas of focus are:

- to work with businesses and other organisations to improve the range of work experience, jobs, apprenticeships and volunteering opportunities for young people, especially for those who are not currently in education, training or employment or those who are in care;
- to help all young people to gain the information and skills that will help them to live independently, especially those young people who are about to leave care;
- to improve transition arrangements between children's and adults' services for children with special educational needs and disabilities.

Why is this important?

- Young people not in education, employment or training (NEET) are at risk of not achieving their potential, economically or socially. National research suggests that there is a reasonable expectation that 1 in 6 of young people who are NEET will never secure long term employment. Supporting families into work and increasing their earnings is one of the priorities of the national Child Poverty Strategy.
- Whilst there has been an improvement in the percentage of young people who are NEET in Worcestershire, there are variations across the county. Many of these young people are from some of the most vulnerable groups, including care leavers and young people from families already living in poverty. Low aspirations, poor educational achievement and economic circumstances mean that many are then subject to lifelong unemployment, benefit dependency or low paid employment.
- The Worcestershire Youth Cabinet Make Your Mark Survey indicates that children and young people thought there should be a better range of work experience opportunities and apprenticeships. Three quarters of respondents to the View Point Survey felt this should be a priority within the Children and Young People's Plan. Their 'Ready for Work' Survey also indicated that 66% of respondents had not undertaken work experience. Of the 33% that had accessed work experience, 25% felt it had not been useful in preparing them for the world of work.
- Transition between children's and adult's services and agencies is a key point in a young person's life, but can be a time of change, anxiety and uncertainty for the young person and their parents or carers. Successful transitions need to be planned well in advance to ensure that there is continuity in service provision or support.
- Many young people, including children leaving care, say that they feel unprepared for adulthood. Health care pathways for those leaving care are also insufficiently defined and young people have limited advice and information at this transitional stage. Consultation indicates that there is a lack of available good quality housing for young people, particularly care leavers and/or young parents. Young people feel that they need more training for independent living and skills for adult life, including money management skills.

What will be done?

- Businesses, schools and colleges and other organisations will work together to improve the range of work experience, jobs, apprenticeships and volunteering opportunities for young people, especially for those who are not currently in education, training or employment or those who are in care.

- Support will be provided for young people who are currently NEET to enable them to re-engage in education, employment and training.
- An appropriate mix and balance of flexible high quality education, training and employment opportunities for all young people will be developed.
- The pathways (and future commissioning intentions) for young people and families who are at risk of and/or become homeless will be clarified.
- Local Children's Partnerships will advocate volunteering as activity in which children and young people can engage.
- Transparent, consistent and personalised pathways for transition between a range of children's and adult's services and agencies will be implemented and inter-linkages with the SEND review and Well-Connected will be identified.
- The Special Education Needs and Disability (SEND) Review will ensure that 16 to 25 year olds with SEND will be supported in further education.

What will success look like?

- More young people, including those from vulnerable groups, engaged in a diverse range of high quality education, employment and training opportunities, including apprenticeships.
- Improved educational outcomes for young people between the ages of 16 and 19.
- More young people with special education needs and disabilities receive appropriate support to ensure a smooth transition between children and adult services and agencies.
- Young people who are living independently have appropriate life skills and are living are in suitable accommodation.

How will success be measured?

- A decrease in the percentage of 16 to 18 year olds not in education, employment and training from 4.7% in 2012/13 to 4.5% in 2013/14.
- The proportion of young people attaining the level 2 threshold at age 19 to be in line with statistical neighbours' average
- The proportion of young people attaining the level 3 threshold at age 19 to be in line with statistical neighbours' average
- An increase in the percentage of care leavers in employment, education and training from 47% in 2013/14 to 52% in 2014/15.
- An increase in the percentage of care leavers in suitable accommodation at from 85.3% in 2012/13 to 90% in 2014/15.

Outcome:

children, young people and their parents/carers know where to go for information about services and support

Our areas of focus are:

- to continue to develop and promote existing information on services for children, young people and their parents/carers, the support they offer and how to access them;
- to continue to develop the internet as a point of access for children, young people and their parents/carers requiring information, advice and guidance on all aspects of a child's life;
- to improve accessibility of information on what to do when there are concerns about the welfare and safety of a child or young person.

Why is this important?

- Availability and accessibility of information about services and support was a key theme in consultation with parents, carers and young people. 80% of those responding to the View Point Survey felt it should be a key priority.
- Access to information and advice is essential for families who need, or may need services or support. It can empower families to help themselves when issues arise and reduce the need for more costly interventions, advice or support later on.
- Families living in poverty tend to be least pro-active in seeking the information, advice, guidance and support that will enable them to access universal and targeted services such as childcare, benefits and tax credits, training, transport and employment.

What will be done?

- Consultation will take place with parent carers on what information they require and how they would like it provided.
- Implement Worcestershire County Council's Digital Strategy so that information, advice and guidance is provided through digital channels and to enable on-line referral to/assessment for services such as the Early Help Hub, Social Care Access Centre and for pupils with special education needs.
- Develop the Early Help Hub as a single point of access for information on commissioned providers of services and activities for children with disabilities
- Better coordinate the provision of information and advice relating to the SEND Reform local offer, Early Help and Future.
- Partners will ensure that information on what to do when there are concerns about the welfare and safety of a child or young person are visible on their website.

What will success look like?

- Information on services and support available is more accessible to families and meets local needs.
- Parents, carers, children and young people from vulnerable groups are able to access information, advice and guidance on universal and targeted services when and where they need it.

How will success be measured?

- A decrease in referrals to children's social care from 308 per 10,000 in 2012/13 to 261.8 per 10,000 in 2014/15.

What else is needed to support the achievement of the priorities?

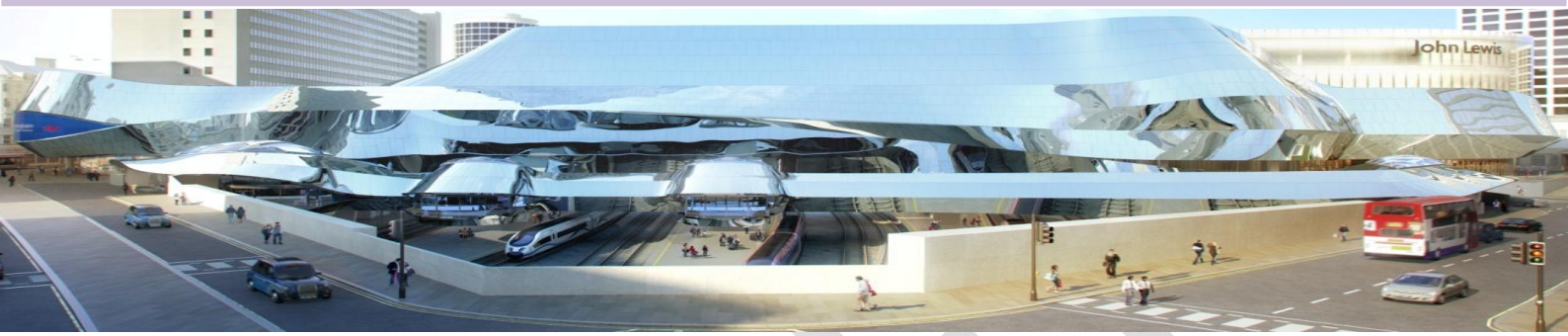
In order to achieve what this plan sets out to do, we will have to:

- put effective arrangements in place for reporting progress on this plan and managing performance.
- build effective partnerships locally and strategically, including Local Children's Trusts with local plans outlining how the priorities in the Children and Young People's Plan will be delivered in their area;
- commission services using joint and pooled budgets from a range of providers. This includes the development of pooled budgets and the commissioning of a range of local services that meet local needs;
- target resources on areas and communities of highest need and support communities to find local solutions to local problems;
- develop and train the workforce to ensure that it has the skills required to deliver universal, targeted and specialist services and better outcomes for children, young people and their families;
- continue to listen to the voice of children, young people and their parents/carers, and engage them in the development of services.

WORCESTERSHIRE
SOURCE OF EXCELLENCE
Children's Trust

A Rail Vision for the West Midlands

"driving sustainable economic growth & improved social cohesion through enhanced connectivity, greater rail network capacity & local accountability"



Forward: A Rail Vision for the West Midlands

"A rail network which supports sustainable economic development, job creation and social cohesion"

This updated "***Rail Vision for the West Midlands***" represents the culmination of a workstream that started back in 2011/12 with the aim of creating an up-to-date pan-regional rail policy document.

It sets out the high level context and rail-specific regional aspirations for key ongoing (and future) workstreams including the significant investment by Government in the new high speed rail line ***HS2,*** the **Midlands Connect** initiative, the rail industry's business planning process for 2019-24 and the move towards a locally specified, more locally accountable provision of regional rail services as part of the **West Midlands Rail** devolution proposal.

The West Midlands rail network already contributes significantly to the region's economic, environmental and social needs, connecting communities with the regional centres and providing access to jobs and services in a safe, efficient and low carbon manner.

Strategically located at the hub of the national long distance rail network, West Midlands businesses are also well-connected with their customers across UK, Europe and, via the deep sea ports, the world, keeping significant volumes of traffic off the region's trunk road network.

The "*Rail Vision for the West Midlands*" sets out how the regional rail network can be developed to enable it to play an even greater role in supporting future regional prosperity and higher rates of employment.

Improved rail connectivity between regional and national centres will drive economic growth and job creation across the region, through a combination of faster journey times, more frequent services, better, more sustainable, access to the network and, where appropriate, new stations, freight terminals and services to meet market demand.

Strong growth, over and above that predicted in industry and government forecasts, is continuing in the regional and intercity passenger markets and also in the rail freight sector. As a result, greater capacity will be needed to meet this growing demand.

HS2 will be a key element in providing extra rail capacity and the high speed line will also put the West Midlands at the heart of the future UK strategic transport network.

Significantly, HS2 also facilitates a step-change in journey time reductions between the West Midlands and the South East from 2026 and between the West Midlands and the economic centres in Yorkshire, North West England and Scotland from the 2030's.

As a result, HS2 will undoubtedly reshape the economic geography of the UK, acting as a catalyst for local economic growth. The local rail network will therefore need to provide the regional connectivity to HS2 in order to maximise these economic benefits across the West Midlands region.

The future West Midlands rail network will make best use of capacity released by HS2 and also provide the additional network, train and station/terminal capacity & capability required to meet the growing demands of both passenger and freight markets, with funding for infrastructure enhancements, station improvements and additional carriages secured using an evidence-based approach.

Finally, the "*Rail Vision for the West Midlands*" sets out the requirement for a modern, predominantly electrified regional rail network, providing a higher quality and more consistent passenger service offer, the delivery of which will be locally managed in order to be more responsive to the needs of our passengers, businesses & other stakeholders.

1. A Rail Vision for the West Midlands

1.1 "**A Rail Vision for the West Midlands**" sets out a vision to create a world class integrated rail network for the wider West Midlands.

1.2 The rail network represents a vital asset for the economy of the region and has the potential to play an even greater role in supporting regional prosperity and higher rates of employment.

1.3 The West Midlands Rail Vision has been developed as a pan-regional document for the wider Travel to Work area (including neighbouring parts of the East Midlands), which encompasses the objectives and aspirations of a Local Enterprise Partnerships, Local Authorities, businesses and passengers.

1.4 These objectives can be summarised as follows:

"A rail network which supports sustainable economic development, job creation and social cohesion in the West Midlands region"

… this will be achieved through:

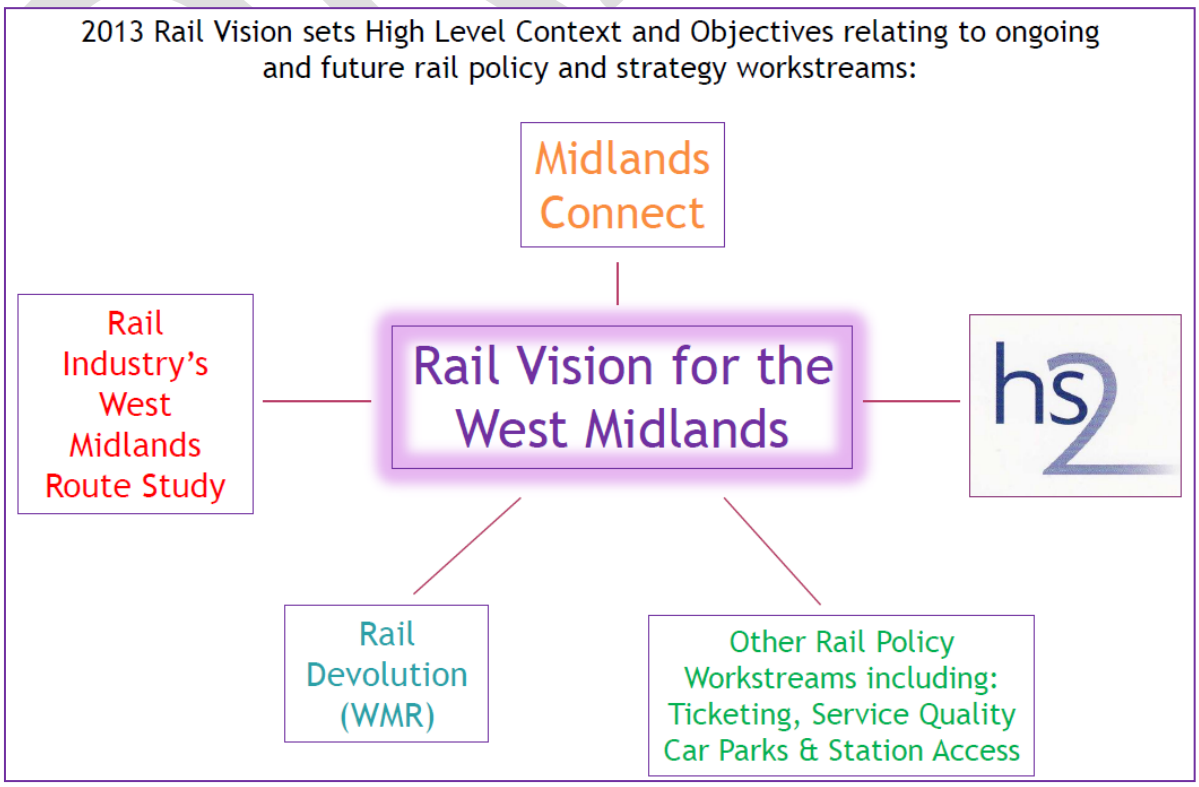
- *improving connectivity to:*
  - *current and emerging centres of economic activity and population*
  - *national and international centres (either through direct links or improved connections to transport hubs such as Birmingham Airport, New St Station & future HS2 Stations)*
- *providing the capacity enhancements needed by the region to cater for growth across all rail sectors*
- *creating an efficient, effective structure for the operation and management of the West Midlands Rail franchise that is more closely aligned to regional priorities and objectives*
- *maximising the regional benefits of future national rail investment such as HS2 and railway electrification*

1.5 These objectives cannot be considered in isolation and individual measures to achieve the above will still be subject to meeting the appropriate, deliverability, affordability and value-for-money criteria.

1.6 The West Midlands Rail Vision reflects the objectives of a range of established regional policy documents including Local Enterprise Partnership Strategic Economic Plans, Local Transport Plans, Local Development Plans, the West Midlands Freight Strategy, Centro's Public Transport Prospectus and more recent documents such as the draft Birmingham Mobility Action Plan & Coventry Rail Story.

1.7 It also acknowledges Network Rail's finalised Delivery Plan for 2014-19 (Control Period 5 - CP5) http://www.networkrail.co.uk/publications/delivery-plans/control-period-5/cp5-delivery-plan/ and welcomes the rail industry's new Long Term Planning Process, in particular the 2013 Market Studies (Regional and Urban; Long Distance Passenger; and Rail Freight), which identified "Conditional Outputs" for the development of these rail markets on a corridor basis up to the 2040s.

1.8 The Rail Vision provides the context for key workstreams such as West Midlands Rail devolution, Midlands Connect, the LEPs' Strategic Economic Plans, HS2, and supports the broader objective of securing greater investment in the West Midlands rail network through the rail industry's business planning processes for CP6 (2019 - 2024) and beyond.



2. Supporting the West Midlands Economy through Improved Connectivity

2.1 The West Midlands region has a widening economic output gap and the second highest level of unemployment in England, driven partly by the shift from traditional manufacturing to service industry.

2.2 With public sector employment likely to continue to fall over the short to medium term, policies that support the long term structural change towards the private sector economy will be vital to the economic growth and enhanced productivity of the West Midlands.

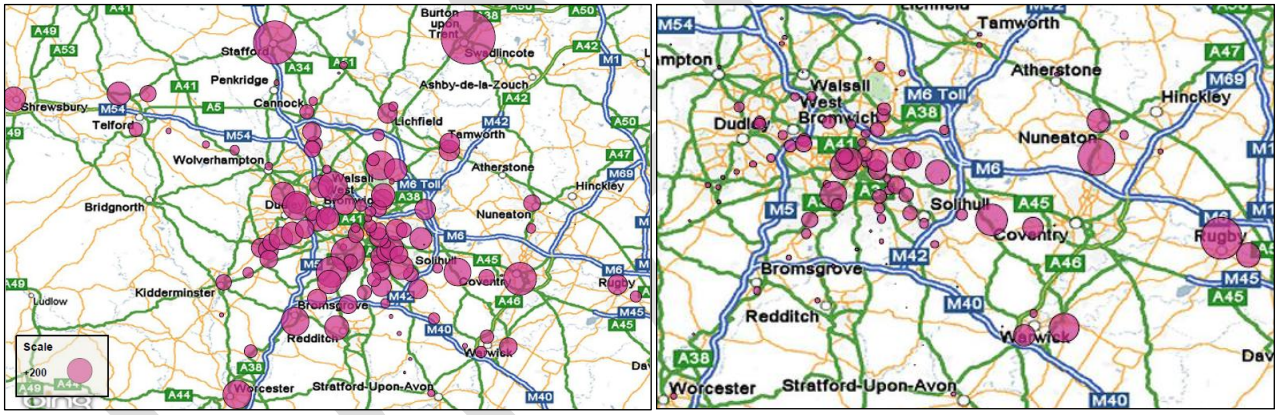
2.3 Long term growth sectors of the West Midlands economy require a wide pool of high quality labour. Improved rail connectivity helps provide for employers, and so encourages economic activity.

2.4 Interventions which support both existing businesses and the long term structural change towards the knowledge/service economy, such as **improved rail connectivity** to centres of employment, markets and suppliers will therefore be vital to the economic growth and enhanced productivity of the region.

2.5 Rail connectivity can be measured in terms of Generalised Journey Time (GJT) which comprises three main components:

- **Journey Time**
- **Service Pattern/Frequency**
- **Access to the Network**

The importance of rail connectivity to the regional economy can best be demonstrated by work undertaken by independent consultants in 2012. This showed that just a 5 minute reduction in Generalised Journey Time (GJT) can have a significant impact on the labour market available to centre of economic development.



Example impacts on Employment of a 5 Minute reduction in rail Generalised Journey Times (GJT) to Central Birmingham (right) and Coventry (left)

2.6 For example, a 5% reduction in GJT to **Birmingham** would significantly increase the available labour market from areas including **Shrewsbury, Burton-on-Trent, Coventry, Telford Stafford and Worcestershire**, improving employment prospects for residents of those areas, whilst simultaneously making it easier for people from the conurbation to reach employment in these other regional centres.

2.7 Similar benefits accrue from Generalised Journey Time savings to/from our other regional towns and cities and to neighbouring centres in the East Midlands.

2.8 The economic analysis also demonstrated that a exemplar "Rail Package" of seven rail connectivity enhancement schemes (including measures such as electrification or new network infrastructure) could significant deliver economic benefits across the 6 Local Enterprise Partnership areas which cover the West Midlands region, including:

- **15,000+ additional jobs**
- **£1.2bn+ GVA** benefits **per annum**

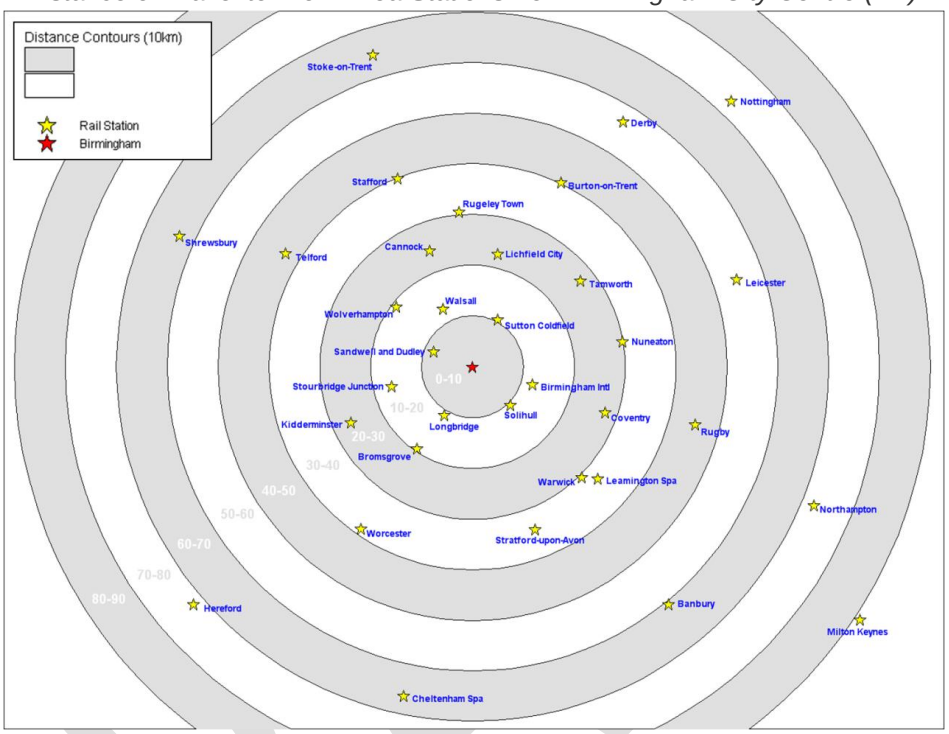
2.9 Rail schemes that improve connectivity through reductions in Generalised Journey Time can therefore have a major positive impact on the regional economy and support the Local Enterprise Partnerships in delivering their specific objectives for economic growth and employment.

2.10 **Improving Connectivity through Reducing Journey Times**

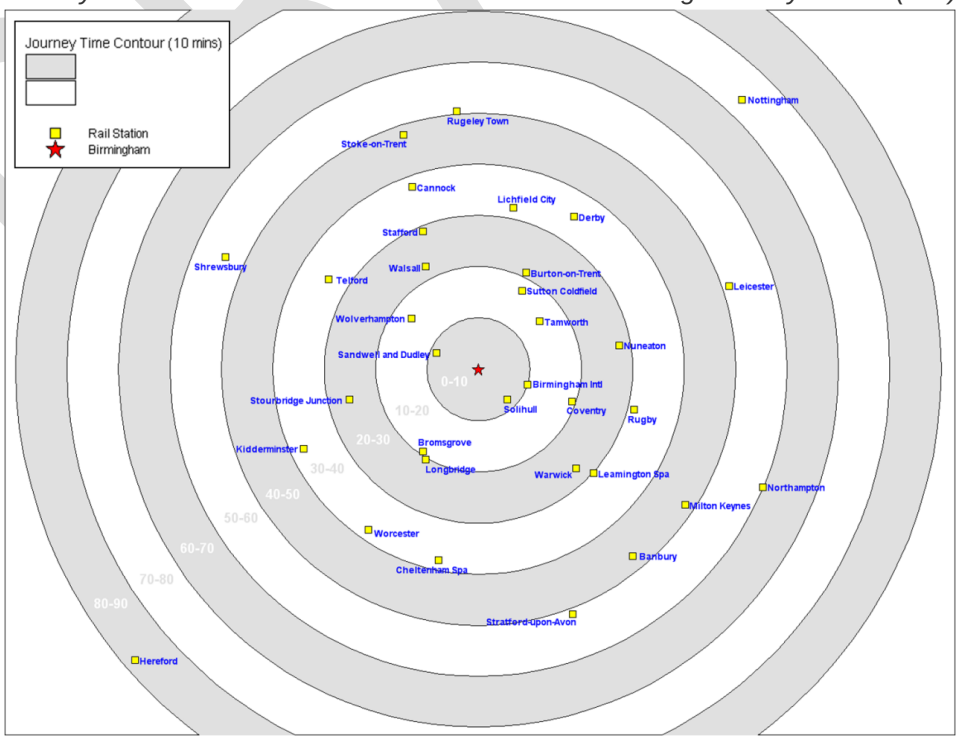
2.10.1 Average train speeds between key regional centres vary widely across the region. Routes with lower average speeds result in longer journey times which can deter people from travelling or which are uncompetitive with car travel even on congested roads. Providing faster connections between people and jobs removes barriers to travel and reduces commuting and business travel times

2.10.2 Improved Journey Times have the power to transform the economic geography of a region. By way of example, the potential impact on Birmingham's travel to work area is clear from the two maps below.

Distance of Travel to Work Area Stations from Birmingham City Centre (km)



Journey Time from Travel to Work Area Stations to Birmingham City Centre (min)



2.10.3 The first map shows the actual distance (in km) of stations in the Travel to Work area relation to Birmingham City Centre, which acts as the principal, although by no means only, interchange hub for

the wider regional rail network. The second map shows the perceived "distance" as experienced by the passenger in terms of journey time.

2.10.4 What is immediately apparent is that rail as a mode has the potential to shrink the economic geography of the region.

2.10.5 The presence of fast rail connections effectively brings Milton Keynes, Derby, Burton-on-Trent, Stoke-on-Trent and Cheltenham Spa significantly closer to Central Birmingham. Indeed, in terms of journey time, each of these locations is "closer" to Birmingham than Stratford-upon-Avon or Rugeley. The slow journey times from latter two stations, along with Hereford, result in a much worse than expected connectivity to other parts of the region.

2.10.6 The maps indicate that reducing journey times from Lichfield, Cannock, Kidderminster, Stourbridge and Nottingham to/from Birmingham should deliver worthwhile economic benefits.

2.10.7 A similar argument could be made for reducing journey times on other key regional flows notably:

- Coventry - Leicester – Nottingham and Stratford – Coventry - Nuneaton
- Worcester – Hereford
- Walsall – Wolverhampton and Walsall – Cannock - Stafford
- Shrewsbury – Wolverhampton
- Black Country – Birmingham International - Coventry / Warwickshire

2.11 **Improving Connectivity through Higher / More Evenly Spaced Service Frequencies**

2.11.1 Certain routes suffer from infrequent, irregular and unevenly spaced rail services. This can make journeys seem slow and uncompetitive and services may not run at convenient times for passengers.

2.11.2 Irregular services create timetables that are difficult to remember and may act as a barrier to travel. Overall, they make rail less attractive and can keep rail from fulfilling its full potential on some routes.

2.11.3 Better service frequencies can therefore, play a key role in improving connectivity and increasing the attractiveness and convenience of rail travel.

2.11.4 The following indicative service frequency outputs would deliver a consistent passenger offer across the region, subject to there being sufficient demand for any additional services.

Service Frequencies	Peak	Off-Peak	Even'g	Sat Daytime	Sun Daytime	Trains to London
Conurbation Centres	6 - 10	4 - 8	4 - 6	4 - 8	4 - 8	1 - 3
Regional Centres	2 - 4	2 - 4	2 - 4	2 - 4	2 - 4	1
Suburban Areas	4 - 6	4 - 6	2 - 4	4 – 6	4 - 6	0 - 1
Rural Areas	2	1 - 2	1 - 2	1 - 2	1 - 2	0 - 1

2.11.5 There is a specific issue with **Sunday service frequencies**, which have not kept pace with increased demand for shopping and leisure trips into the region's retail and tourist centres.

2.11.6 The Rail Vision therefore seeks a move towards creating a **standard off-peak and Saturday/Sunday daytime journey pattern** across the West midlands rail network.

2.12 Improvements to Early Morning and Evening Connectivity

2.12.1 At present, the timings of first and last trains vary widely between routes. Early morning access to the rail network, especially for services to local economic centres and also to transport hubs for onward connections to other regional and national centres, is important for both commuter and business travel.

2.12.2 Similarly there is a market for late evening return trips both from centres of leisure activities (theatres, concert venues, bars etc) and from principal hubs where people connect out of long distance or other regional services in order to catch their local train home.

2.12.3 Although specific routes and regional centres will have different requirements, the Rail Vision sets outs the following principles as to what might represent good (or at least acceptable) levels of early/late service provision.

Early Morning / Late Evening Services To / From Major Regional Centres

Service Provision	Good	Acceptable	Needs Improvement	Priority for Improvement
Regional				
Weekday First Arrival	06:30	07:00	08:00	08:00+
Saturday First Arrival	07:00	08:00	08:30	08:30+
Sunday First Arrival	09:00	10:00	11:00	11:00+
Weekday Last Departure	23:30	23:00	22:00	22:00-
Saturday Last Departure	23:30	23:00	22:00	22:00-
Sunday Last Departure	23:00	22:00	21:00	21:00-
Long Distance				
Weekday First Arrival	08:00	08:45	09:30	09:30+
Saturday First Arrival	08:00	09:00	09:30	09:30+
Sunday First Arrival	10:00	10:30	11:00	11:00+
Weekday Last Departure	23:00	22:00	21:00	21:00-
Saturday Last Departure	23:00	22:00	21:00	21:00-
Sunday Last Departure	23:00	22:00	21:00	21:00-

2.12.4 Once again there is a specific issue with Sunday services, where early morning rail service provision has not kept pace with either market demand or the requirement to get employees in the retail and leisure sectors to their workplace.

2.13 Airport Connectivity

2.13.1 At present there are no rail services serving Birmingham Airport in the early morning which a key arrival time for passengers catching early morning flights. This is a barrier to more airport passengers using rail to access the Airport.

2.13.2 Early morning rail access to (& late access from) Birmingham Airport is therefore a regional priority with passengers for early morning flights needing to arrive before 05:00 (ideally an 04:00 arrival to cater for airport and airline staff).

2.13.3 Resolving this issue would require changes to the rail networks maintenance and operating practices with an initial focus on the Birmingham New St – Birmingham International – Coventry rail corridor which directly serves the airport.

2.13.4 The continued development of Birmingham Airport as an international gateway is strongly supported across the region and improved direct rail access to Birmingham International for the Airport / NEC (and future HS2 Station / UK Central development) remains a key priority for the Black Country and the wider region.

2.13.5 However, improved rail access to other UK airports, notably Heathrow and Manchester is also important for the region as a whole. New links, such as the Western rail access to Heathrow could facilitate direct inter city services between the UK's largest airport and West Midlands regional centres including a connection to Birmingham Airport via Birmingham International Station.

2.14 Connectivity with London

2.14.1 The economic importance of direct links with London is a key issue for local business and is strongly supported by local Chambers of Commerce and Local Enterprise Partnerships.

2.14.2 Provision of (at the very least) a direct peak time service to/from London for towns such as Shrewsbury, Telford and Walsall is a high regional priority.

2.14.3 Capacity released by HS2 should facilitate further improvements and enable the provision of fast, frequent inter city services from the Black Country, Staffordshire, Shropshire, Coventry and Warwickshire to Milton Keynes and London.

2.15 Connectivity with Other Core Cities

2.15.1 Currently rail journey times between the West Midlands and the other Core Cities are not always competitive with other modes. Speeds are often slow (below 50 mph) whilst service frequencies can be as low as hourly or less.

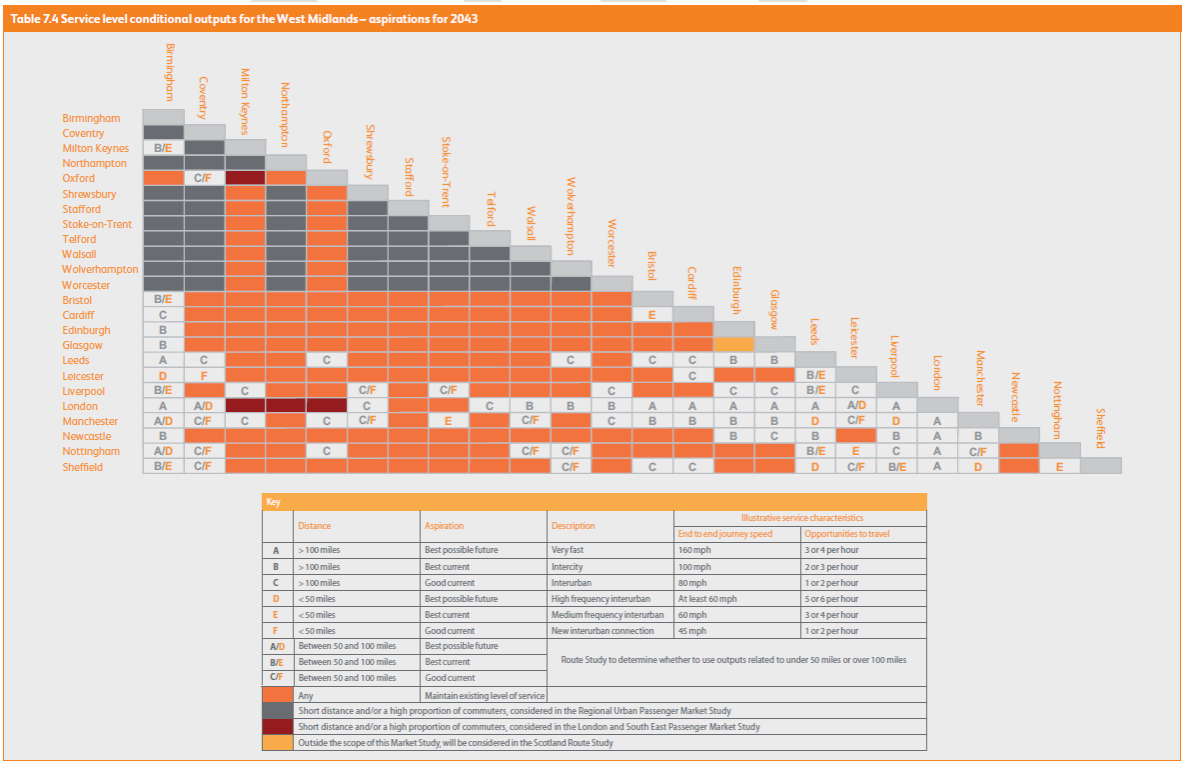
2.15.2 Poor connectivity between the country's major cities acts as a barrier to economic employment and growth which needs to be addressed at national level.

West Midlands to:	Bristol	Cardiff	Edinburgh	Glasgow	Leeds	Liverpool	Manchester	Newcastle	Nottingham	Sheffield
Generalised Speed (MPH)	48	43	63	64	47	44	43	55	35	48
Trains per Hour	2	1	1.5	0.5	1	2	2	2	2	2

Source: Network Rail

2.15.3 HS2 will dramatically improve connectivity with London from 2026 and with the cities of the north from the 2030s, but incremental improvements in Generalised Journey Time between the West Midlands and other city-regions should still be progressed in the short to medium term.

2.15.4 Network Rail's Long Distance Market Study (LDMS) identified the following "Conditional Outputs" for 2043 to address current connectivity gaps.



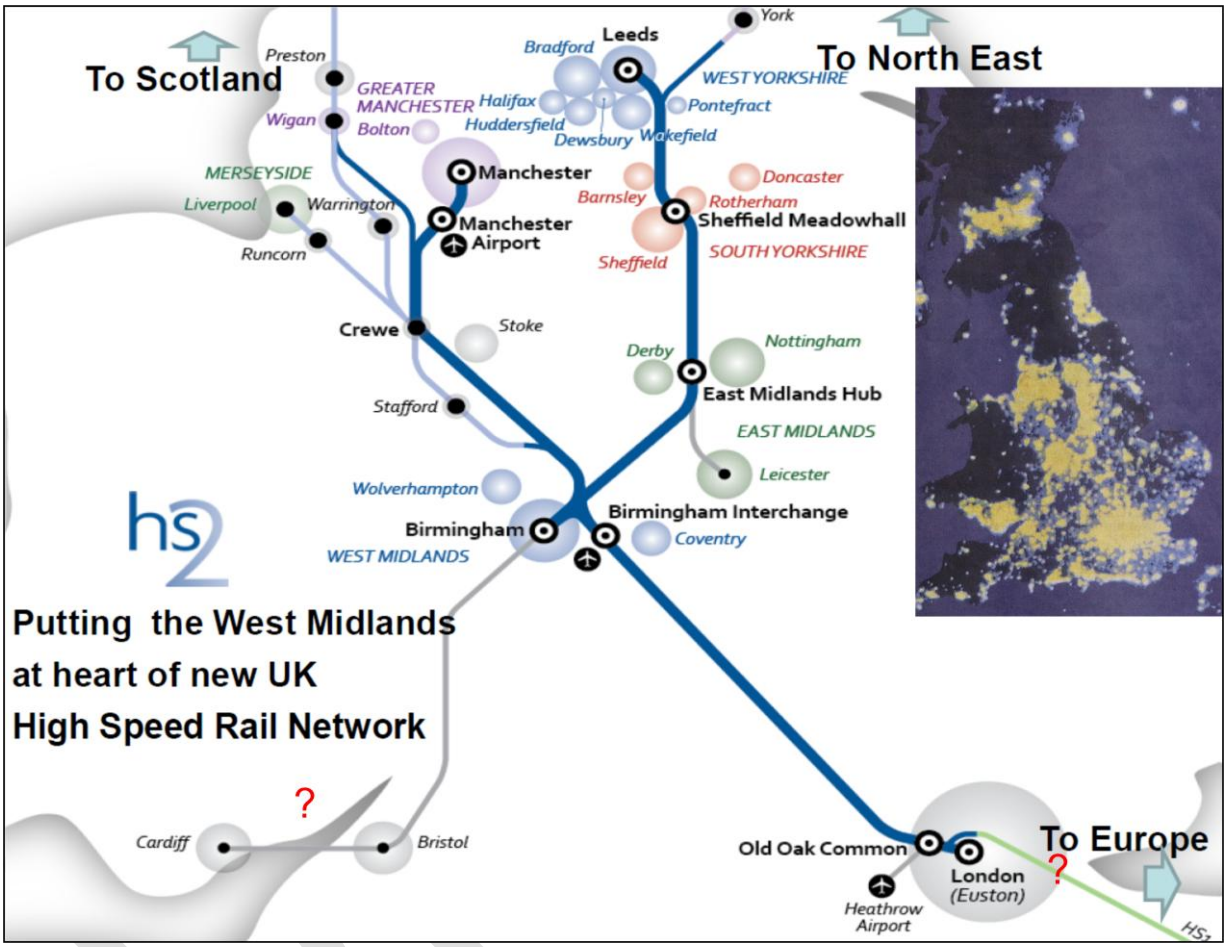
The above outputs are a guide for the rest of the Long Term Planning Process and should be taken to mean "as fast and frequent as operationally feasible given value for money and affordability.

2.15.5 The Rail Vision welcomes Network Rail's "Aspirations for 2043" and endorses a similarly evidence-based approach to meet the region's wider ambitions for improved rail connectivity with other national economic centres.

2.16 **Improving National and International Connectivity through HS2**

2.16.1 The decision to build HS2, a high speed rail line will place the West Midlands region at the heart of a new national high speed rail network, which will bring about a step change in both addition network capacity and improved connectivity with other national economic centres.

2.16.2 It is recognised that the construction of the new line will have some local impacts which will need to be alleviated through appropriate mitigation measures. However, with HS2 dramatically reshaping the economic geography of large parts of the country, the West Midlands needs to be ready to both capitalise on the economic and social benefits of the new line and stations and also to secure the local connectivity improvements that will be required to spread these benefits across the wider region.



2.16.3 There will be two West Midlands HS2 stations. One is located in Birmingham City Centre, adjacent to Birmingham Moor St Station and in the heart of Birmingham's Curzon Development Area. The other is an Interchange Station, located within Solihull's UK Central Hub development zone (near Junction 6 of the M42) which will be connected via a fast "People Mover" link to Birmingham International station, Birmingham Airport and NEC.

2.16.4 HS2 and its two West Midlands stations will dramatically reshape the economic geography of the country, shrinking journey times between the region and many of the country's other major economic centres, as shown below:

Phase 1 HS2 Journey Times 2026:	**HS2**	**Current**
• Birmingham Interchange – Crossrail	31 mins	N/A
• Birmingham – London Euston	45 mins	(1hr 24)
• Walsall – London Euston	1hr 30	(2 hrs)
• Wolverhampton – Canary Wharf (via Crossrail)	1hr 50	(2 hrs 25)
• Birmingham – Heathrow (via Crossrail)	64 mins	(2 hrs 27)
• Stourbridge Junction – Heathrow (via Crossrail)	1hr 40	(3 hrs 05)

Phase 2 HS2 Journey Times 2030+:	**HS2**	**Current**
• Birmingham – Manchester	41 mins	(1hr 30)
• Coventry – Manchester	1 hr 05	(2 hrs 10)
• Worcester – Leeds	2 hr 15	(3 hrs 25)
• Shrewsbury – London (via HS2 at Crewe)	1 hr 40	(2 hrs 40)

2.16.5 However, in order to maximise the economic and social benefits of the new line to the wider region, the West Midlands must continue to engage with Government, HS2 Ltd and the rail industry in order to secure::

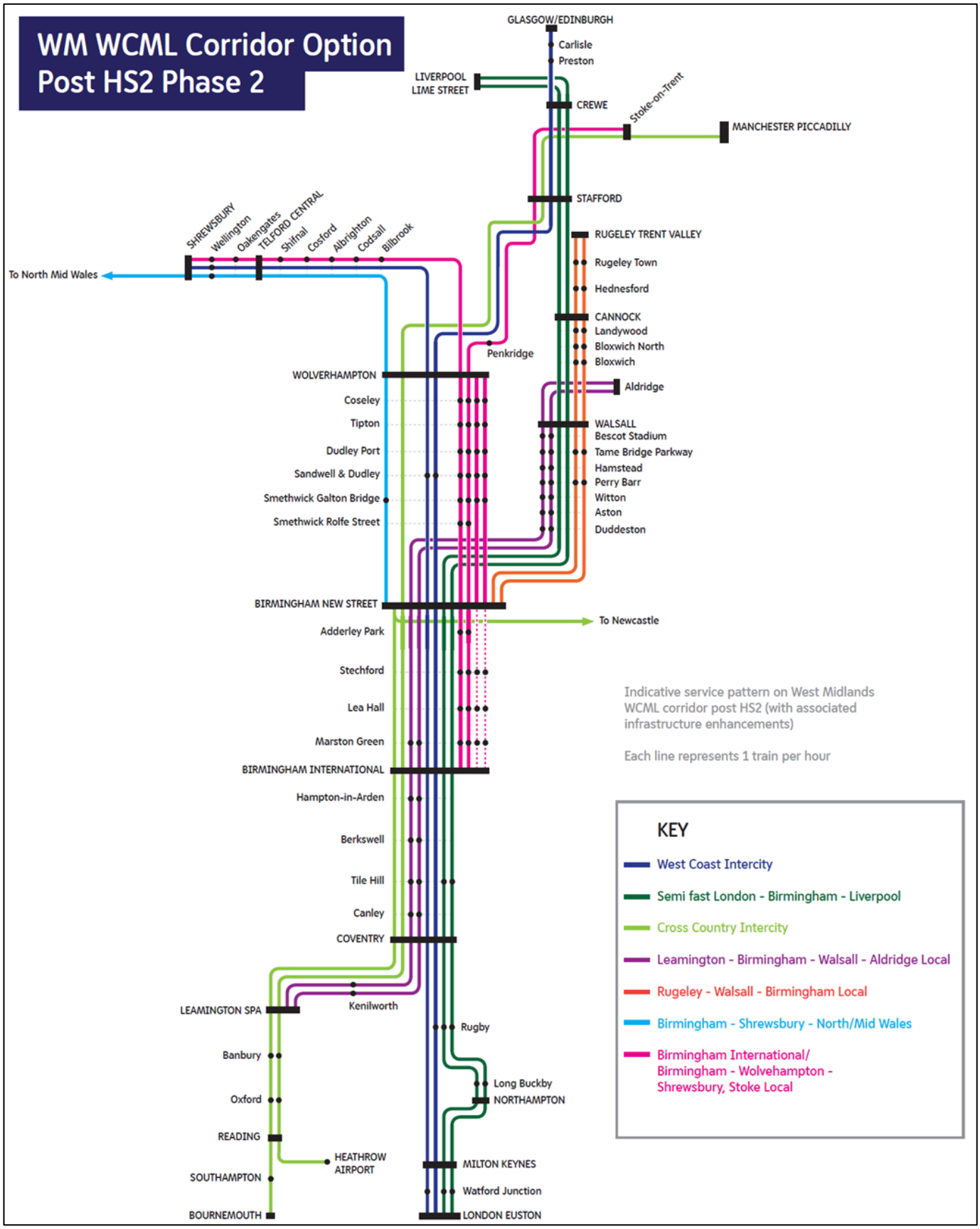
- A package of new and improved transport links to the new HS2 hubs (as outlined in the *West Midlands Connectivity Package: HS2 Unlocking the Benefits* *www.centro.org.uk/media/208188/highspeedtwolocalconnectivitypackagefinal_1662.pdf*)
- use of capacity released by HS2 on the classic rail network to:
  - provide fast, frequent inter city services from the Black Country, Staffordshire, Shropshire, Coventry and Warwickshire to Milton Keynes and London
  - improve cross-regional connectivity on the following corridors and connecting routes
    - Warwickshire – Coventry – Birmingham International – Birmingham – Black Country – Shropshire / Staffordshire
    - Crewe – Stoke – Stafford – Lichfield – Tamworth – Nuneaton - Rugby
  - improve long distance connectivity through more direct services to other regions
  - cater for growing passenger & freight demand
- additional direct services between the West Midlands HS2 Interchange Station and Northern England & Scotland
- direct high speed rail services between the West Midlands & the High Speed 1 line for both domestic and European markets
- a connection between HS2 and the regional rail network to facilitate through classic high compatible services (e.g. between North and South West) via the West Midlands
- maintaining the ability to provide further additional rail infrastructure capacity in the longer term (e.g. through four-tracking the Birmingham - Coventry corridor)

2.16.6 The proposed West Midlands HS2 Local Connectivity Package designed to improve access to the new HS2 Hubs for the wider region includes:

- Better urban design to minimise the interchange penalty for passengers transferring between Birmingham Curzon St and Moor St Stations
- Midland Metro link to minimise the interchange penalty for passengers transferring Birmingham New St and Curzon St Stations
- Capacity and service frequency enhancements on existing routes into Birmingham International Station, Moor St Station
- Further electrification of the rail network to reduce journey times and increase capacity
- Further expansion of the regional rail network e.g.
  - new services into Moor St Station from new stations in South/East Birmingham and the Tamworth and Nuneaton corridors via the proposed Camp Hill Chords
  - direct services to Birmingham International from a wider range of regional centres

2.16.7 Capacity released by HS2 can be used to improve cross regional and long distance connectivity as well as providing capacity for passenger and rail freight growth.

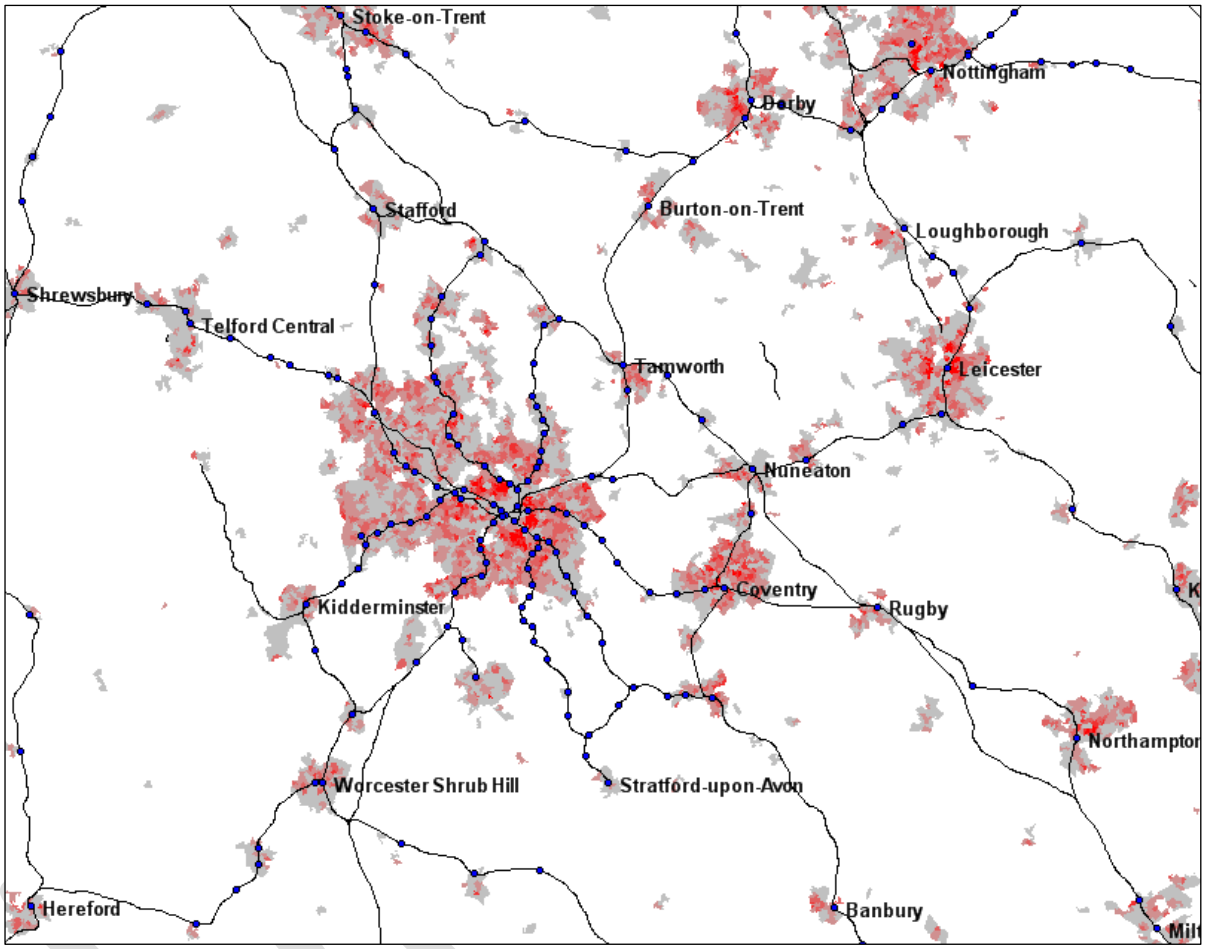
2.16.8 One of several possible options for improved cross-regional / national links post HS2 appears below:



2.17 Improving Connectivity through New Stations

2.17.1 At present, some population centres do not have rail stations and therefore have no direct access to the rail network. This lack of a station can deter people from using the rail network for their journey or deter people from making a journey particularly if they don't have access to a car. Those willing to use the train must travel to rail stations in other areas in order to access the rail network which usually involves using a car.

2.17.2 Overlaying the rail network on a regional map of population density shows that most centres are served to some extent by the existing rail network and stations.



West Midlands Rail Network and Population Densities

2.17.3 However, there are still some significant population centres which have no direct access to rail services. Such areas include parts of: Telford & Wrekin; Dudley; Walsall; Birmingham; Coventry; Worcestershire; and Warwickshire.

2.17.4 Whilst some of these gaps could be addressed through new stations, especially on lines already served by local passenger trains as at Coventry Arena, others would require completely new services and significant infrastructure expenditure.

2.17.5 Some areas are likely to continue to be challenging in terms of direct rail access provision but, subject to demand and practicality constraints, there may be scope for strategic Park and Ride Stations with good access to the highway network.

2.17.6 To fulfil a strategic Park and Ride role such stations will need to have:

- a good level of service frequency
- available capacity on peak train services
- a fare and car park pricing structure that is attractive to potential passengers

2.17.7 All new station / train service schemes will need to demonstrate that they are the most appropriate solution to problems such as poor transport connectivity and also have sound business cases if local and national funding is to be secured.

2.18 **Connectivity at Stations between Rail & Other Modes**

2.18.1 The rail network forms the fast, high capacity core of the regional public transport network. However, across many parts of the region there is relatively poor integration between different public transport and sustainable transport modes.

2.18.2 An integrated public transport system should ensure easy and affordable transfer between modes and services for journeys across the region. However, to achieve this requires some degree of coordination of network planning, which can be difficult to achieve in the deregulated transport environment where operators often see each other as competitors rather than potential partners.

2.18.3 The Rail Vision supports working with operators and other partners to deliver a more integrated public transport network through development and promotion of:

- an integrated, affordable ticketing structure using convenient electronic ticketing systems
- high quality interchanges between modes including real-time information

2.18.4 Wherever possible passengers will be encouraged to access stations via sustainable modes of transport in order to relieve high demand for parking, tackle congestion, reduce CO2 emissions and promote healthier lifestyles through walking and cycling alternatives.

2.18.5 Station Travel Plans can help achieve this through measures such as improved walking and cycling routes, better cycle storage and specified parking bays for car sharers.

2.18.6 However, because of the high quality of service and greater speed of rail travel compared to other public transport modes, people are prepared to travel longer distances to access rail services. Provision of car parking at stations will, continue to need to be provided and developed for those rail users for whom more sustainable access is unattractive or simply not an option.

2.18.7 In the West Midlands metropolitan area, the 6,600 car park spaces available (2011) were estimated to take 2.75 million car journeys off the road each year reducing carbon emissions by 6,200 tonnes.

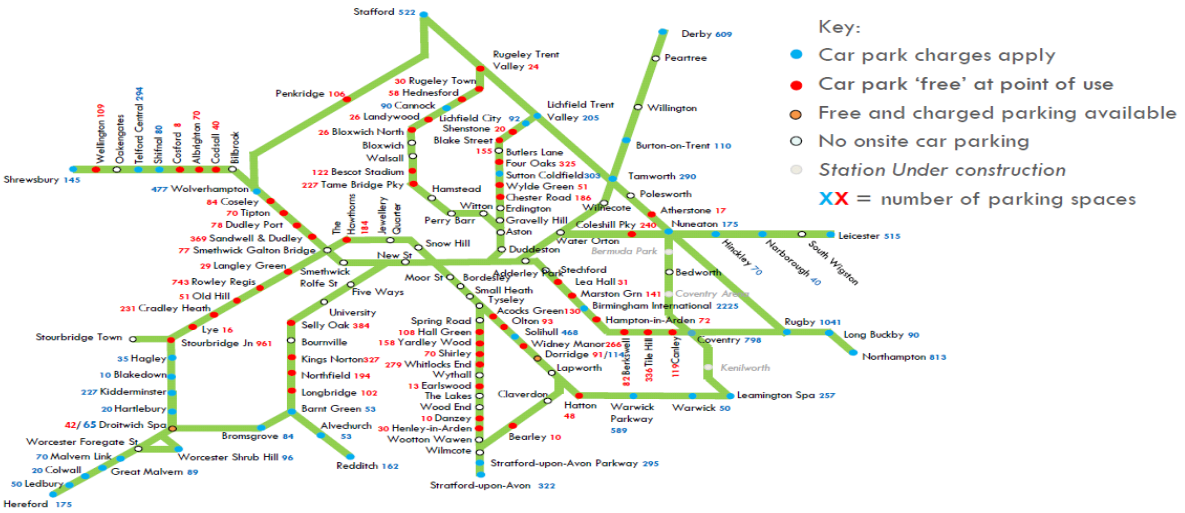
2.18.8 The amount of car parking available can, therefore, have a significant impact on the effective capacity of a station. If station car parks are filled by peak time commuters then there is no space available for off-peak parking even if there is significant capacity available on the trains.

2.18.9 Most recent car park expansion schemes at the stations on the inter city network have sought to grow the longer distance markets. However, the cost of parking at many of these stations is at level that discourages their use by local commuters and leisure travellers. For example, the combination of higher fares and car park charges at Tamworth encourages travellers into the Metropolitan area to either drive or to railhead to stations on the Cross City line stations where fares are lower, services are more frequent and there are no car park charges.

2.18.10 Nevertheless there is some evidence that levying a small charge at station car parks can deter passengers who live within walking/cycling distance from the station (or who have good bus access) from driving to the station, thereby freeing up parking space for passengers arriving from further afield and making best overall use of a scarce commodity.

2.18.11 Where car parks are proved there should be consistent standards of car park provision, based on location and size, applied across the region.

Car Park Capacity for the West Midlands - 2014



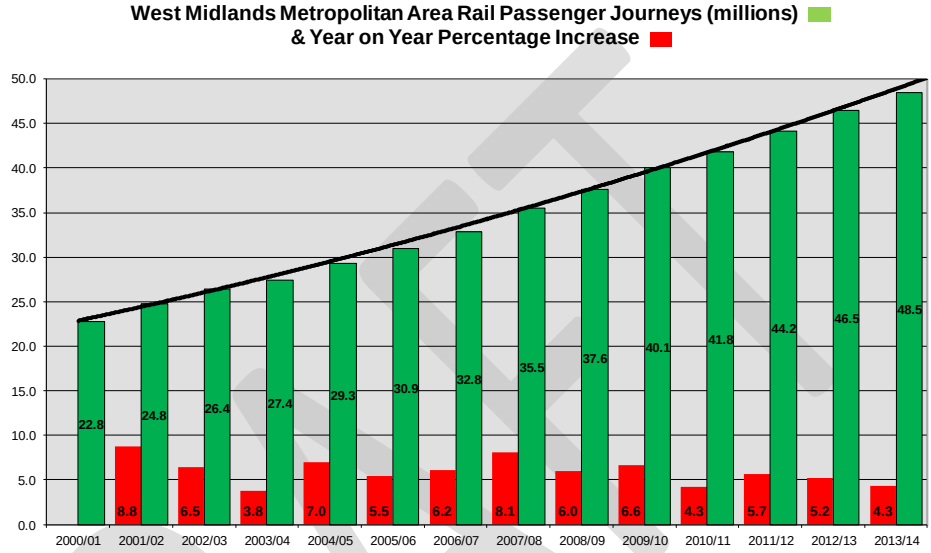
3. Providing Capacity for Growth

3.1 The West Midlands & Chilterns Route Utilisation Strategy (2011) demonstrated that the rail network is becoming increasing congested, with some sections of route already operating at or near capacity.

3.1.1 Strong growth, over and above that predicted in the RUS, is continuing in both the regional and intercity passenger markets and also the rail freight sector, which will require continued investment to provide longer/more frequent trains and additional infrastructure capability in order to meet demand.

3.2 Passenger Growth

3.2.1 The increasing importance of the rail network in meeting the region's economic connectivity and social mobility requirements is evidenced by the fact that in the West Midlands Metropolitan area alone, rail patronage has more than doubled from 22.8m passengers per annum in 2000/1 to 48.5m in 2013/14.



3.2.2 In spite of the recent economic downturn annual rail passenger growth has continued to average 5.2% throughout Control Period 4 (2009-2014).

3.2.3 Rail's success story has been repeated across the wider West Midlands. According to the latest Office of Rail Regulation's Regional Passenger Journeys figures below, the West Midlands (Metropolitan & Shire areas) has see the highest levels of passenger growth of any region since 1995.

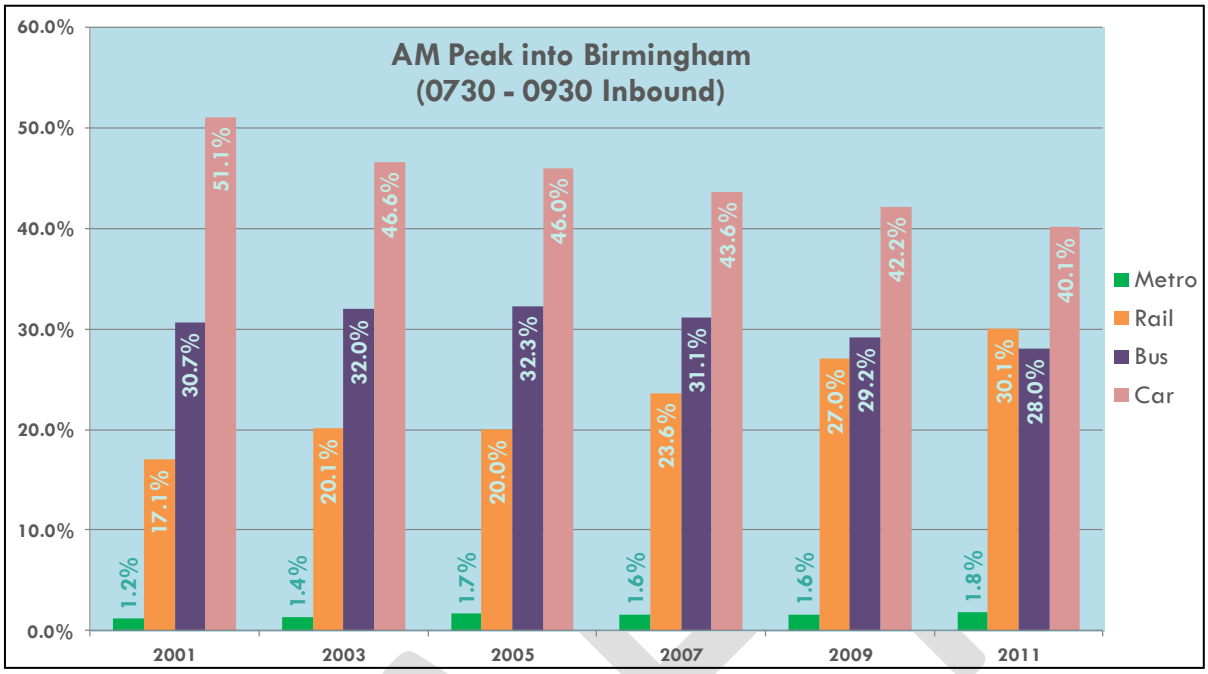
3.2.4 This trend has continued in recent years with the ORR's figures indicating that passenger journeys from or within the wider West Midlands region have actually doubled in just 7 years.

Regional Passenger Journeys 1996-2012

				Growth 1995/6 to 2012/13		Growth 2005/6 to 2012/13	
Gov't Office Region	**1995/6**	**2005/6**	**2012/13**	**Actual**	**%**	**Actual**	**%**
Great Britain	589,499	827,395	1,269,024	679,525	115%	441,629	53.4%
East Midlands	14,469	23,748	30,518	16,049	111%	6,770	29%
East of England	78,832	126,299	159,254	80,422	102%	32,955	26%
London	378,888	502,425	787,469	408,581	108%	285,044	57%
North East	7,565	11,271	14,252	6,687	88%	2,981	26%
North West	39,850	64,044	113,921	74,071	186%	49,877	78%
Scotland	48,944	69,331	89,625	40,681	83%	20,294	29%
South East	145,830	214,374	281,924	136,094	93%	67,550	32%
South West	21,732	32,070	46,607	24,875	114%	14,537	45%
Wales	14,487	20,428	28,393	13,906	96%	7,965	39%
West Midlands	**23,001**	**37,024**	**74,051**	**51,050**	**222%**	**37,027**	**100%**
Yorkshire/Humber	25,134	43,099	64,257	39,123	156%	21,158	49%

3.2.5 As well as growth in absolute terms, the last decade has also seen some substantial changes in travel patterns, with commuters increasingly switching from the private car to rail.

3.2.6 For example, rail transport's share of the commuter market into Birmingham has soared from just 17.1% in 2001 to over 30% in 2011.



3.2.7 According to the 2011 West Midlands and Chilterns Route Utilisation Strategy, the number of passenger rail journeys made to/from and within the West Midlands region was predicted to increase by 30% between 2008/09 and 2020/21, equivalent to a 2.2 per cent increase per annum.

3.2.8 The average forecast increase was 2.3% on the routes into Birmingham, which, crucially, are used by the Department for Transport and Network Rail to estimate future regional capacity requirements and the rail industry's plans for Control Period 2014-19 will therefore provide an additional 3,600 seats in the morning peak by 2019, representing a welcome 10% increase in capacity (12% in the high peak hour).

3.2.9 However, with actual growth now outstripping industry forecasts there is a real concern that the proposed additional capacity for 2014-19 will fail to meet the increasing levels of passenger demand and that this will, in turn, lead to greater overcrowding, a worsening passenger experience and reverse the recent modal shift to rail in a region where the private car remains a viable alternative for many commuters.

3.2.10 West Midlands regional stakeholders will therefore need to work closely with the rail industry and government to make the case for further investment in the infrastructure and rolling stock capacity required to meet future passenger growth demands.

3.3 Network Capacity/Capability at Stations

3.3.1 Station capacity is generally determined by the number of platforms, track layout and the flexibility (or otherwise) of the signalling arrangements.

3.3.2 Increasing the number of platforms at locations such as Rugby, Wolverhampton and Milton Keynes has therefore played an important role in improving the overall capacity and reliability of the West Coast Main Line.

3.3.3 Similarly further additional platforms at key stations such as Coventry, Tamworth/Burton, Rowley Regis and Birmingham Snow Hill could both relieve existing congestion and allow new or more frequent services to operate, reducing Generalised Journey Times and provide more passenger capacity.

3.3.4 Restrictive signalling arrangements at the busiest stations such as Birmingham Snow Hill can impact on service provision across the wider region, whilst lack of track and signalling connections between adjacent routes (such as between the Coventry and Leicester lines at Nuneaton) can act as a physical barrier to the provision of through services between regional centres.

3.3.5 Track layouts on the approaches to stations can also restrict overall station capacity. The congested eastern approach to Birmingham New St where services from 7 routes (Walsall, Cross City, Derby, Nuneaton, Coventry, Solihull and Camp Hill) converge on just 2 pairs of tracks remains a key region constraint, which has been a key factor in the failure to realise the rail industry's own recommendation to introduce local services to Nuneaton and Tamworth by 2019, which would have reduced Generalised Journey Times and provided additional capacity on these busy rail corridors.

3.3.6 Conversely, plans to increase capacity on routes into stations (e.g. Coventry – Leamington), though welcome, will only be fully effective if station layouts have the capability to cope with additional traffic.

3.4 Station Passenger Capacity

3.4.1 A further constraint is the number of passengers which can be safely handled by a station. It is this factor which has been the key driver behind the Birmingham New St Gateway project which will tackle the passenger congestion issues at a facility which was designed for 60,000 passengers per day, but which is now handling up to 200k a day).

3.4.2 There are similar passenger capacity constraints at many of the West Midlands stations serving key regional centres, notably Wolverhampton, Coventry and University, each of which have developed, but as yet unfunded, schemes to address the issues.

3.5 Options to Improve Capacity

3.5.1 There are several schemes to improve network capacity / capability and regional connectivity which are expected to be delivered (all or in part) during the current Control Period 5 (2014-19). These include schemes taken forward as part of Network Rail's Delivery Plan (such as Walsall – Rugeley Electrification) or by third party promoters (such as Kenilworth Station). A full of these interventions appears in Appendix 1.

3.5.2 Other options to improve local rail network capacity or connectivity have also been proposed by the West Midlands Local Enterprise Partnerships (LEPs) for example: Coventry Station Masterplan; Wolverhampton Interchange; Aldridge Station; Snow Hill Lines Capacity & Connectivity.

3.5.3 These LEP schemes, which have been promoted principally on their potential to deliver economic benefits, may also be progressed before 2019, subject to funding and deliverability constraints, and a full list of these appears as Appendix 2.

3.5.4 There will also be a requirement for further ongoing investment in the rail network to deal with existing and emerging capacity/connectivity constraints for both passenger and freight traffic (such as the Water Orton corridor which was originally included in the 2011 Initial Industry Plan) and this will be addressed as part of an evidence-based approach to securing future investment in Control Period 6 and beyond.

3.6 Opportunities for Future Electrification

3.6.1 The Government's 2012 High Level Output Specification for CP5 recognised that electric trains provide the significant advantages over diesel traction which include the fact that electric traction enables faster acceleration & reduced journey times for passenger and freight services which can improve utilisation of scare network capacity. Electric trains are also cheaper to operate & maintain and more energy efficient than diesel trains, causing less wear on the track and create less noise and air pollution, whilst also providing a cleaner, quieter passenger environment with reduced vibration.

3.6.2 The West Midlands Rail Vision also strongly supports further electrification of the rail network and the consequent move towards a better connected, higher capacity, lower cost, lower carbon railway, including the following principal corridors.

- Worcester - Stourbridge – Birmingham – Stratford / Leamington Spa (Snow Hill Lines)
- "Electric Spine" connections to West Midlands Intermodal Freight Terminals
- Felixstowe – Leicester - Nuneaton - Birmingham for freight & passenger services
- Derby – Birmingham - Bristol Main Line (plus connections)
- Chiltern Main Line (West Midlands to London)
- Wolverhampton – Shrewsbury
- Walsall – Aldridge - Castle Bromwich (Sutton Park Line) for freight & future passenger services

4. Improving the Rail Passenger Experience

4.1.1 The Rail Vision for the West Midlands aims to create a World Class Rail Network for the region and its passengers. This will build on the work being undertaken by Centro as part of the new "**Transforming Rail Travel**" initiative.

4.1.2 The rail network should deliver high levels of customer satisfaction with a service that provides excellent value for money. However, whilst passenger services in the West Midlands are largely provided by modern trains, the overall journey experience is not always a consistently high quality one.

4.1.3 This Rail Vision seeks to improve the entire passenger experience from journey planning and ticket purchase, through to the quality, accessibility and reliability of trains and station facilities.

4.2 Consistent Levels of Passenger Facilities

4.2.1 The aim will be to provide a consistent level of quality across the network with facilities, including station staffing, appropriate to the type of station.

4.2.2 The work currently underway under the Birmingham New St Gateway project, should deliver a modern rail interchange hub for the region by 2015.

4.2.3 However, many of the region's other stations provide a disappointing passenger experience and would benefit significantly from improved facilities which Regional Rail Forum members will work with industry partners and developers to deliver.

4.2.4 Passenger **Safety and Security** will continue to be improved through the Safer Travel initiative as well as physical improvements to stations and car parks.

4.3 Accessibility to the Rail Services and Stations

4.3.1 The West Midlands is relatively fortunate in that the majority of stations already provide step-free access to platforms for passengers who are mobility-impaired or who are encumbered by pushchairs or luggage.

4.3.2 The Rail Vision therefore seeks to target those stations, where such improvements would provide the most benefits based on the following criteria:

- station footfall (above 200k p.a.)
- interchange stations between different services
- proximity to other accessible stations

4.3.3 On the above criteria, outstanding/unfunded priorities for accessible station access would include:

- Barnt Green
- Butlers Lane
- Dudley Port
- Great Malvern
- Hagley
- Perry Barr
- Rugeley Trent Valley
- Smethwick Rolfe St
- Stechford
- Tyseley

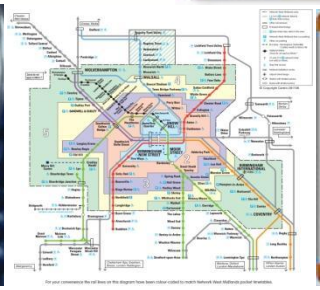
4.3.4 The majority of trains in the West Midlands are now largely compliant with the Technical Specification for Interoperability for Persons with Reduced Mobility (PRM TSI) which becomes a legal requirement from 2020. The West Midlands local transport authorities will work with Train Operators to ensure that the remaining non-compliant train fleets are made accessible to all passengers at the earliest opportunity.

4.4 Fares & Ticketing

4.4.1 The Rail Vision also aims to dramatically improve the ticketing offer through:

- new rail / multimodal products on Smartcard, Smartphone & other electronic ticketing media
- Removal of fares disparities (e.g. comparatively higher fares Tamworth / Nuneaton corridors)
- Standardisation of ticketing restrictions (e.g. peak / off-peak use)
- Introduction of an expanded more easily understood Zonal Ticketing Structure for whole West Midlands region (see example option below)

Example of Travel to Work Area Revised Fare Zone Guidelines		
Zone	Miles from Birmingham	Possible Extent of New Boundaries
1	> 1	Birmingham City Centre, Five Ways, Jewellery Quarter
2	1 to 4	Bournville, Smethwick GB, Perry Barr, Gravelly Hill, Adderley Park, Tyseley
3	4 to 6	Kings Norton, Rowley Regis, Sandwell & Dudley, Hamstead, Chester Rd, Lea Hall, Olton, Yardley Wood
4	6 to 8	Longbridge, Old Hill, Tipton, Sutton Coldfield, Water Orton, Marston Green, Widney Manor, Whitlocks End
5	8 to 20	Redditch, Bromsgrove, Stourbridge Town, Kidderminster, Codsall, Cannock, Lichfield TV, Tamworth, Coleshill Parkway, Coventry, Hatton, Claverdon, Wootton Wawen
6	20 to 25	Droitwich Spa, Cosford, Penkridge, Rugeley Town, Polesworth, Nuneaton, Atherstone, Bedworth, Leamington Spa, Wilmcote
7	25 to 30	Worcester SH & FS, Oakengates, Stafford, Rugeley TV, Burton-on-Trent, Hinckley, Stratford-upon-Avon
8	30 to 40	Gt Malvern, Wellington, South Wigston, Rugby
9	40 to 55	Cheltenham Spa, Gloucester, Hereford, Shrewsbury, Crewe, Stoke, Derby, Leicester, Northampton, Banbury



5. West Midlands Rail: A Locally Managed Passenger Network for the Region

5.1 The Rail Vision strongly supports the concept of a devolved "West Midlands Rail" franchise which is specified and managed locally in order to enable local rail services to be more responsive to the economic and social requirements of the region.

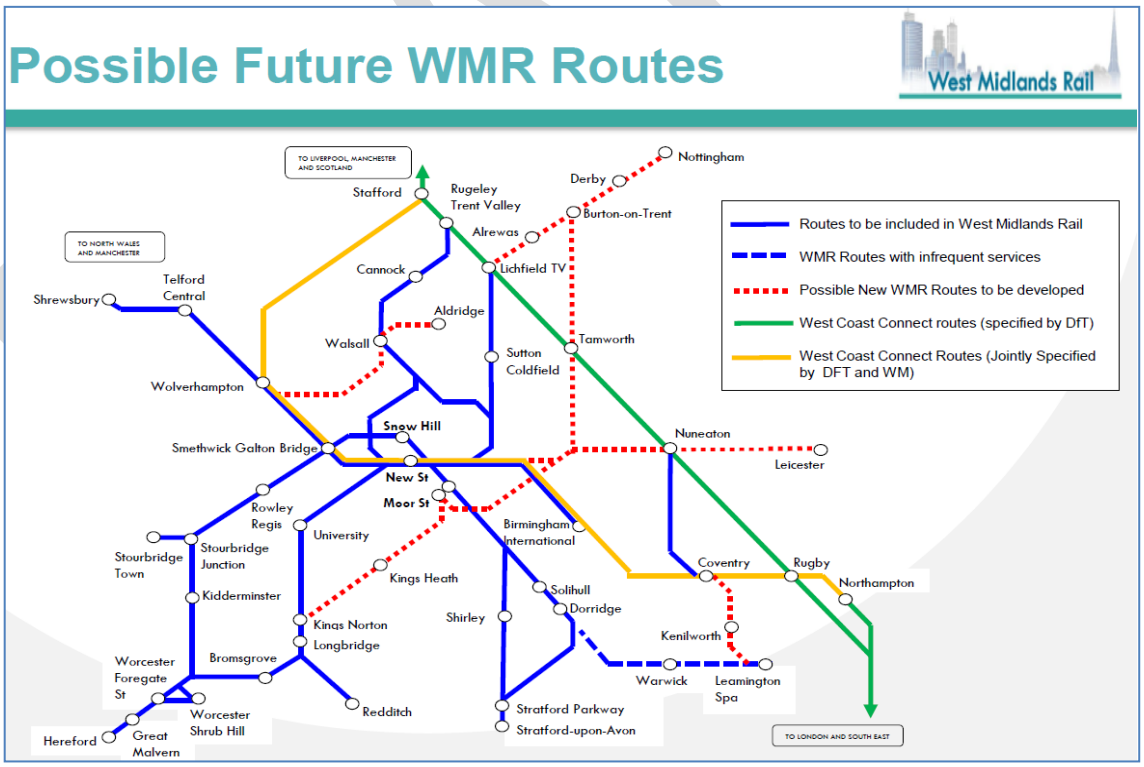
5.2 There is strong evidence from other parts of the country) that devolving responsibility for local rail services can deliver significant benefits. Such benefits can include:

- Better quality rail services for passengers
- Greater ability to improve integration and ticketing arrangements (e.g. Smart tickets)
- Greater ability to change services to reflect local needs
- Better targeted local investment
- Greater ability to hold operator to account for delivery (e.g. ticketless travel, service performance and passenger satisfaction)
- Greater ability to influence national rail investment programmes

5.3 The Department for Transport has recognised that increasing local control of local rail services could deliver improved outcomes for the economy, local passengers, local stakeholders and taxpayers. It is therefore seeking a formal proposal to devolve responsibility for local rail services that has the endorsement of all local transport authorities from across the network.

5.4 The opportunity therefore exists for a transition from the current "London Midland" franchise, which currently stretches from Liverpool to Euston and is wholly specified and managed by the Department for Transport in London, to a new, more regionally focussed "**West Midlands Rail**" contract.

5.5 This West Midlands Rail contract would be jointly specified and managed by the DfT and a partnership of West Midlands Local Authorities, initially covering the blue lines on the map below, but potentially expanding later to incorporate other new routes and services such as those shown in red.



5.6 A prerequisite for taking on this responsibility would be having a funding agreement in place with the DfT which guarantees the protection of a baseline level of service consistent with current service levels. A guarantee of funding for subsequent contracts would also be required.

5.7 This would deliver rail services which improve connectivity, drive economic growth, support social and environmental policies and ensure that the region is better placed to benefit from the opportunities arising from HS2.

5.8 The West Midlands Local Transport Authorities will continue to work with the Department for Transport to realise the devolved West Midlands Rail franchise objective from 2017.

6. Rail Freight

6.1 The movement of freight by rail supports the West Midlands regional economy by providing cost effective, reliable links between our businesses and their suppliers and customers. In particular, direct rail freight access to deep sea ports provides West Midlands companies with the worldwide connectivity required in today's global economy

6.2 At the national level the rail freight industry supports an economic output of £5.9 billion and in 2011/12 rail freight transported 101.7 million tonnes of goods worth over £30 billion.

6.3 Rail freight also reduces the number of long distance road based freight movements which helps relieve congestion on our regional motorway and trunk route network and also reduces, air pollutants, carbon emissions as well as reducing the negative impacts of freight transport on residents and communities.

6.4 The positive benefits and resulting demand for rail growth present a challenge to the rail industry in order to provide the capacity and capability to meet projected demand.

6.5 Network Rail's 2013 Freight Market Study outlined rail freight forecasts up to 2043 and identified key requirements for the West Midlands rail freight market including:

- Capacity for major increases in container traffic by 2043:
    - International container traffic up from 15.7 million tonne lifted p.a. to 72.8 million tonnes
    - Domestic container traffic up from 2.8 million tonne lifted p.a. to 61.5 million tonnes
- Extended train lengths and six days per week running
- An increase in Strategic Rail Freight Interchange (SRFI) capacity with both new facilities and expansion of existing locations
- Ability to react to changing UK power generation policies (although longevity of new fuels such as biomass is uncertain)

6.6 In the light of the above, rail freight has the potential to contribute significantly to the region's local objectives for economic development, employment growth and sustainable transport provision.

6.7 However, we need to ensure that our business have the required access to rail freight services and that future demand for rail freight to and through the region is both planned and catered for.

Photo: Network Rail

6.8 **New and Expanded Intermodal Freight Terminals**

6.8.1 The 2013 West Midland Freight Strategy recognised that West Midlands businesses need efficient and convenient access to the rail freight network. This is currently provided primarily through the existing Intermodal Rail Freight Terminals (IRFTs), which, together with the growing Strategic Rail Freight Interchange (SRFI) at Daventry, are predominantly located in the western side of the region.

6.8.2 Whilst acknowledging that the wider logistics industry is normally best placed to determine future SRFI and IRFT requirements, the Rail Vision recognises the key role of Planning Authorities in permitting the development of new or expanded Rail Freight Interchanges, especially where these are located close to centres of economic activity which are currently poorly served by the rail freight industry.

6.8.3 The West Midlands is projected to have a supply gap of 16.8 million sq feet of rail connected warehousing up to the period 2027. In particular, there appears to be a market requirement for at least one new SRFI to serve businesses in the Black Country and Staffordshire. However, on smaller scale there may also opportunities to encourage additional rail freight at underutilised facilities such as the Telford International Railfreight Park.

6.8.4 The West Midlands needs to support the freight industry and SRFI promoters in developing suitable terminal facilities, away from residential areas, to meet continuing demand. It is estimated that if this gap in rail freight terminal provision was fully addressed, it would generate 34,000 net jobs and provide economic benefits worth an additional £600M GVA per annum to the West Midlands region.

6.9 **Additional Rail Network Capacity and Capability for Freight**

6.9.1 As with the passenger sector, capacity remains the key constraint to future rail freight growth. The West Midlands Regional Rail Forum, Cross LEP Transport Group and West Midlands ITA fully endorse the proposals put forward by the Rail Industry to support the growth of freight in CP5 (2014-19) through targeted improvements to improve the capacity and capability of key corridors into the region. We also acknowledge that capacity released by HS2 will help meet some longer term rail freight growth.

6.9.2 However, there is a recognition that, as in the passenger sector, further investment will be required to meet both the growing demand for rail freight, especially in the intermodal sector and the potential for additional traffic to/from locations such as London Gateway, and the Channel Tunnel route on which freight charges have recently been reduced.

6.9.3 Improving the capacity and capability of the network to cater for longer, faster and, in the case of intermodal traffic, taller trains should be a priority as should the creation of more electrified routes better suited to the needs of the rail freight market.

6.9.4 The 2014 West Midlands Freight Study (Future West Midlands Rail Network Capacity Requirements) identified requirements for additional network capacity including the removal of existing bottlenecks such as Water Orton Junction.

6.9.5 Similarly work must begin now on resolving future bottlenecks which may emerge as a result of passenger or freight enhancements planned elsewhere on the network (e.g. freight crossing moves at Coventry Station are likely to increase significantly following completion of the Electric Spine).

6.10 **Electrification for the Rail Freight Market**

6.10.1 Use of electric traction can bring similar benefits

6.10.2 The Electric Spine announced for CP5 will link the deep sea port of Southampton to the West Midlands by 2020. However, the benefits of electric freight trains services will only be fully realised because the routes to the main West Midlands container terminals at Lawley St (Birmingham), Hams Hall (Coleshill) and Birch Coppice (A5/M42) will not be wired for electric traction.

6.10.3 Similarly the electrification of the freight corridor between the intermodal deep sea ports Felixstowe/Harwich and the West Midlands via Peterborough, Leicester and Nuneaton should also be regarded as a national priority if the potential advantages of an electrified Strategic Freight Network are to be realised.

6.10.4 It is recognised that it is unlikely to be cost effective to electrify every freight branch line and terminal. However, the industry needs to be encouraged to follow the lead of companies such as DRS and introduce more Dual Power (Electric / Diesel) locomotives which would be capable of serving terminals such as Birch Coppice without the need to electrify the branch line from Kingsbury.

7. A Rail Vision for the West Midlands: Conclusions

7.1 The West Midlands rail network contributes significantly to the region's economic, social and environmental wellbeing both and the local level and by virtue of our location at the crossroads of the UK's national intercity and rail freight networks.

7.2 In particular the rail network:

- links employers with employees, especially in the increasingly important service & retail sectors
- connects business people to their suppliers, partners and customers at regional and national level
- provides customers with access to retail and leisure facilities with some shoppers travelling long distances (e.g. north & mid Wales) to access centres such as the Bullring
- provides businesses with a product distribution network with a global reach connecting the region with the deep sea container ports and enabling easy movement of high value exports including those from the automotive industry
- reduces congestion in the region's road network and contributes to a more sustainable, lower carbon economy both at local level and in keeping transiting passenger and freight off the West midlands motorway network

7.2.1 However, rail has the potential to play an even greater role in these areas if an ongoing programme of future investment can be secured.

7.3 Improving Connectivity

7.3.1 There are significant opportunities to support the local economy further by improving connectivity through reducing the generalised cost of rail travel for both passengers and freight.

7.3.2 This can be achieved through:

- faster journey times
- more frequent services
- improving connections at principal interchanges
- providing better access for those parts of the market poorly served by the rail network through provision new services, stations and freight terminal facilities

7.3.3 At the national level, both government and opposition have committed to the new High Speed 2 rail network which will bring about a step-change in connectivity between the West Midlands (including our major regional airport and the nec) and the economic centres in the North West, North East, Scotland and the South East with the region at the heart of new, high quality transport network.

7.3.4 HS2 can also provide better connectivity with some of the major European centres and improve connectivity to the rest of the world via improved access to airports.

7.4 Providing Capacity for Growth

7.4.1 Rail use in both the passenger a freight sectors continues to grow strongly, in many instances at a rate significantly which is significantly above government and industry forecasts.

7.4.2 The West Midlands region welcomes recent announcements for investments in further electrification, additional rolling stock, infrastructure capability & capacity and, in the longer term, HS2.

7.4.3 However, further significant investment in the regional rail network is required if we are to:

- meet this demand for new services and additional capacity
- deliver our objectives for growing the region's economy and employment opportunities through improved connectivity
- maximise the benefits of investment such as electrification and HS2 across the wider region

7.4.4 As an example case of this latter point, independent analysis has concluded that a package of supporting investment in infrastructure capacity could improve regional connectivity to the two HS2 stations could double the value of this new infrastructure to the region, facilitating the creation of over 45,000 jobs and growing the local economy by £4bn GVA per annum.

7.5 Improving the Passenger Experience

7.5.1 The Rail Vision for the West Midlands is to create a World Class Rail Network for the region and its passengers.

7.5.2 A high quality passenger experience is not always delivered, especially in terms of station facilities and ticketing cost and availability.

7.5.3 The Rail Vision supports the view that many of the customer focussed improvements might best be delivered through a locally specified and locally managed "West Midlands Rail" franchise which can determine appropriate standards for provision of services and facilities on a more consistent basis across the local rail network.

7.6 Midlands Connect: Providing the Evidence Base for future West Midlands Rail Investment

7.6.1 The Cross-LEP Transport group and Network Rail have now agreed to work jointly on a new "Midlands Connect" initiative designed to provide the evidence base for a package of multi-modal connectivity improvements for delivery in CP6 and beyond.

7.6.2 This package will be aligned to ensuring that we can maximise the regional benefits from HS2 and which will support economic growth in line with the HS2 Taskforce recommendations. As such it will build on the rail elements of the initial **HS2 Connectivity Package** which ideally needs to be developed further as part of the **Network Rail / HS2 Integrated Plan** workstream, requested by the Secretary of State for Transport.

7.7 Securing a Future Rail Investment Package to Support Jobs a Growth

7.7.1 Whilst "Midlands Connect" will provide the evidence base for future investment, the West Midlands transport authorities and Local Enterprise Partnerships have already identified some measures to meet the region's economic, social and environmental objectives and meet the growing capacity challenge.

7.7.2 These interventions, which would provide both capacity for growth and deliver much of the improved connectivity which is required to stimulate growth in the regional economy and create jobs and improved regional GVA, include:

- Coventry Arena / Bermuda Park Stations & more frequent Coventry – Nuneaton services
- Coventry Station Master Plan
- Wolverhampton Interchange
- Kenilworth Station and new services
- Worcester Parkway
- Snow Hill Lines Capacity and Connectivity
- Aldridge Station
- Local services on Tamworth/Nuneaton corridors / addressing bottleneck at Water Orton Jcn
- Camp Hill Line passenger services and new local stations

7.8 Towards Modern, Electrified Regional Rail Network

7.8.1 The West Midlands also strongly supports Government proposals to further electrify the national rail network.

.

7.8.2 Electric trains can reduce journey time and are cheaper to operate, easier to maintain and more energy efficient than diesel trains. They also cause less wear on the track and create less noise and air pollution, whilst also providing a cleaner, quieter passenger environment with reduced vibration.

7.8.3 The Rail Vision therefore regards the further electrification of both the West Midlands regional rail network and our main rail links with the rest of the country, as a huge opportunity to simultaneously improve connectivity (and support further economic growth) , maximise use of available capacity and also reduce the ongoing cost and environmental impact of rail transport.

Appendix 1: Rail Network Capacity/Capability Enhancements Planned for 2014-19

Infrastructure Scheme	Principal Outputs	Estimated Delivery
Cross City South Capacity	3 Cross City trains per hour to Redditch leading to: - Reduced GJT - Additional capacity	December 2014
Northampton Station	Additional Station Capacity	January 2015
Bromsgrove Station (Worcestershire / Centro scheme)	Increased Station Capacity for longer trains and more frequent services More Car Parking	May 2015
Cross City South Electrification to Bromsgrove	3 Cross City trains per hour extended from Longbridge - Reduced GJT - Additional capacity	May 2016
Birmingham New St Gateway	Additional Station Passenger Capacity Improved Access to City Centre Enhanced passenger environment Regeneration	2015
Walsall – Rugeley Electrification Line Speed Improvements	Reduced GJT through Faster Journeys with option for further reduction with more frequent services Additional Capacity from Longer Electric Trains Operating Cost Reductions Releases Diesel Trains for Capacity Elsewhere Diversionary electrified route to North West Scotland Potential future electric services to Stafford & NW?	December 2017
Stafford Area Capacity	Faster Journeys Stafford – Crewe Additional freight capacity to North West / Scotland Additional hourly train from London to North West Additional hourly train from W Mids to Manchester	December 2017
Southampton – West Midlands Freight Enhancement	Operation of longer 775m freight trains to from Southampton Container Port - More efficient operation - Better use of infrastructure capacity	2016
Coventry – Nuneaton New Stations (Coventry / Warwickshire scheme)	New Connectivity for areas around New Stations at Coventry Arena and Bermuda Park (Nuneaton)	2016
Coventry – Leamington Capacity (Scope to be determined - Linked to Electric Spine and Kenilworth Station)	Additional Capacity for 2 freight trains per hour Additional Capacity and GJT reductions from: - 2 local passenger trains per hour - 2 long distance passenger trains per hour (post HS2)	2019+ (TBC)
Kenilworth Station (Warwickshire Scheme: Linked to Electric Spine and Coventry – Leamington Capacity)	New connectivity for Kenilworth to Coventry and Leamington Spa	2016 (TBC)
Electric Spine (Scope to be Determined) includes: Coventry – Nuneaton Coventry – Leamington – Oxford – Reading - Southampton	Reduced GJT Additional Network Capacity Longer Trains	2019+ (TBC)

Appendix 2: West Midlands Rail Schemes promoted by Local Enterprise Partnerships as part of their Strategic Economic Plans

Output	Scheme	LEP area	Indicative Timescale
Improved passenger capacity Improved connectivity between station and city centre Improved public transport interchange	Coventry Station Masterplan	CWLEP	CP5/6
Improved regional and national connectivity for Kenilworth	Kenilworth Station (NUCKLE 2)	CWLEP	2016
Improved connectivity on Coventry – Nuneaton corridor through GJT reductions	Coventry Station Bay platform and infrastructure enhancements to facilitate a more frequent (half-hourly) rail service (NUCKLE 1.2)	CWLEP	2017
Improved passenger capacity Improved connectivity between station and city centre Improved public transport interchange	Wolverhampton Interchange	BCLEP	CP5
Improved regional and national connectivity for Aldridge	Aldridge Station	BCLEP	CP5
Improved regional and national connectivity for Worcestershire	Worcester Parkway	WLEP	CP5
Improved network capacity Improved connectivity and passenger train capacity	Local services on Tamworth/Nuneaton corridors / addressing bottleneck at Water Orton Jcn	GBSLEP	CP6 (not prioritised)
Improved Network and Passenger Capacity Enhanced Regional Connectivity	Snow Hill Platform 4 and Rowley Regis Turnback	BCLEP GBSLEP	CP5 (not prioritised)
Improved access and connectivity	University Station Interchange	GBSLEP	2016
Improved access and connectivity	Longbridge Area Connectivity	GBSLEP	2016
Improved business access to rail freight network	Mid-Cannock container depot and freight interchange	GBSLEP	CP5
Additional network capacity into Central Birmingham Improved access and connectivity for south and east Birmingham	Camp Hill Chords	GBSLEP	CP6 / 7 (not prioritised)
Improved connectivity and passenger capacity	Wolverhampton – Shrewsbury Electrification	Marches LEP	CP6

Developing positive local policy

WCC's positive approach to renewable energy is set out in its Corporate Plan and in the Worcestershire Partnership's Climate Change Strategy. A draft WCC Renewable Energy Strategy is due to be adopted in 2015. This strategy sets out the council's intention to identify viable renewable energy schemes on its land, and to explore joint opportunities with partners.

Successful WCC energy projects to date

WCC has invested in renewable energy on its estate by installing biomass boilers (including at County Hall) and solar panels on WCC buildings. WCC receives payments for energy generated by these schemes, making them attractive investments. The solar panels on the Wildwood building, for example, will pay for themselves in seven years, after which WCC will continue to receive payments for the remaining thirteen years of the index-linked tariff period. Solar panels have been installed on all viable WCC corporate sites, including Kidderminster and Redditch libraries and Stourport civic centre. For technical reasons, no further opportunities are currently available on WCC buildings (the County Hall roof, for example, is not strong enough to support solar panels). WCC has also provided £700,000 in low-cost loans to allow 43 schools to install solar panels and keep the feed in tariff payments themselves. This saves £95,000 and 190 tonnes of CO_2 per year, with an average payback of under 7 years. These schemes have generated positive publicity for WCC and the schools, who benefit from the free electricity.

Investigating large-scale opportunities

The renewable energy developments outlined above are small scale. Officers have investigated whether any larger solar farms could be developed on WCC land to increase the financial and environmental benefits[1]. All WCC landholdings, including former landfill sites and tenanted farmland, have been evaluated. No opportunities to develop profitable solar farms have currently been identified. The main barriers, and the steps being taken to overcome these, are:

- Lack of capacity in the electricity distribution network
  Schemes tend to need grid connections to be financially viable, but the grid was never designed to carry electricity 'upstream'. Rapid growth in renewables means that, in almost all areas of the county, the grid cannot accommodate extra generation within safe limits. This will be the case even after grid upgrades in 2016, and is a nationwide problem. Where capacity exists, connection costs can be high; grid costs of £102k for a solar farm at the old Quantry Lane landfill site, for example, render the scheme unviable.
  - **WCC officers continue to liaise with Western Power Distribution.**
  - **WCC's Cabinet Member and Worcester's MP have lobbied WPD to express concern.**

- Capital costs are too high on landfill sites
  On closed landfill sites, the protective surface layer cannot be penetrated, meaning that development is more expensive than for greenfield sites.
  - **WCC officers will monitor viability as capital costs continue to fall and as industry experience of working on these challenging sites develops.**

- Planning constraints
  Planning permission is an uncertainty anywhere, but some sites are riskier than others. Madeley landfill site, for example, is in the green belt. The planning system also discourages development on the highest-quality farmland, but establishing this quality requires costly, site-specific assessment. Any planning application would also require

[1] Other technologies, including hydro, anaerobic digestion and wind, are currently ruled out for technical or political reasons.

extensive supporting evidence, and could cost around £30k. There is currently insufficient confidence of approval on any WCC site to justify this expenditure.
  - **WCC planning officers monitoring changes to planning policy and guidance.**

- Community sensitivities
  Solar farms could be a concern to local residents. This is especially the case if there have already been controversial developments in the immediate area.
  - **WCC's Renewable Energy Research Paper will help to communicate the benefits of renewable energy, which should improve understanding and reduce concerns.**

- Tenanted farmland
  If WCC developed projects on tenanted farmland, the exact share of risks/liabilities would need to be agreed. A major difficulty in developing tenanted farmland is maintaining community relations. Land on WCC farms would ideally only be used for energy generation before a new tenancy had begun, as this would avoid the need to reach agreement with incumbent tenants. Failure to deal with tenants sensitively could damage community relations and potentially cause reputational damage to WCC.
  - **Proposals on tenanted farms must first be discussed with WCC's Land Agents.**

- National political direction
  The Government has stressed its opposition to solar development on farmland and the August announcement proposed tariff cuts makes any future development highly risky and jeopardises our strategy of investing in renewable energy. Furthermore, achieving planning permission may be more difficult if policy and guidance is revised.
  - **WCC continuing to heavily promote the installation of solar panels to schools to try to increase uptake before potential tariff reductions.**
  - **WCC officers continue to monitor changes to planning policy and guidance.**

Other options considered

n.b. Due to the grid issues noted above, these considerations are largely academic at the current time, but provide a useful comparison when looking at investment options.

- The county council could invest in non-WCC renewable schemes in the county and elsewhere. These options will be considered with partners.
- WCC land could be leased to a solar developer, with rental income typically being between £1,000 – £2,000/acre per annum. Over the typical 20 year tariff period, a 30 acre scheme could therefore provide a total rental income of around £900,000. WCC would receive no saving from the use of electricity or income from sales and tariffs, and would lose the income from agricultural tenants over this period.

Next steps

Alongside the actions set out under each barrier to investment above, WCC will:

- Adopt Renewable Energy Strategy and Research Paper to set context for future projects.
- Explore opportunities to invest in schemes not on WCC land, either alone or in partnership with communities, the county-wide Place Partnership, and others.
- Continue liaison with local authorities to inform opportunities/share best practice. Build on discussions with Norfolk, Cornwall, Warwickshire, Glos, and Telford & Wrekin.
- Keep business cases under review and continue to seek further opportunities.