

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>



Early Help Needs Assessment

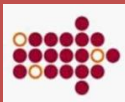
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Strategic priority	<ul style="list-style-type: none">• Prevention, Early Intervention & Early Help• Children, Young People & Families
Care pathway/Statutory Guidance	<i>Healthy Child Programme 0-19 (2009) & HCP Rapid review (2015)</i> <i>Sure Start children’s centres statutory guidance (2013)</i> <i>The Statutory Guidance for Local Authorities on Services and Activities to Improve Young People’s Well-being (Revised DFE 2012)</i> <i>Working Together to Safeguard Children (2015)</i>
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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



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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.

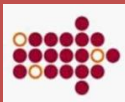
Statement of the Problem

Corporate Prioritisation	<p>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."</p> <p>One of the priorities of the Worcestershire Children and Young People's</p>
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	<p>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:</p> <ul style="list-style-type: none">• 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. <p>This needs assessment estimates need for early help 0-19 years, maps current provision and identify evidence of effectiveness and good practice.</p>
Scope	<p>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).</p> <p>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.</p> <p>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.</p> <p>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.</p>



Population of interest	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.								
Key risks factors	<p>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.</p> <p>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).</p> <p>Risk Factors affecting Outcomes</p> <table border="1" data-bbox="336 1406 1289 1982"> <thead> <tr> <th data-bbox="336 1406 576 1485">Child Characteristics</th> <th data-bbox="576 1406 815 1485">Parents & Parenting Style</th> <th data-bbox="815 1406 1050 1485">Family Factors & Life Events</th> <th data-bbox="1050 1406 1289 1485">Community factors</th> </tr> </thead> <tbody> <tr> <td data-bbox="336 1485 576 1982"> <ul style="list-style-type: none"> • Low birth weight/birth injury • Disability/delayed development • Chronic illness • Early behavioural difficulties • Poor social skills • Poor attachment </td> <td data-bbox="576 1485 815 1982"> <ul style="list-style-type: none"> • 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 data-bbox="815 1485 1050 1982"> <ul style="list-style-type: none"> • Family instability, conflict or violence • Marital disharmony/divorce • Large family size/rapid successive births • Absence of father • Very low level </td> <td data-bbox="1050 1485 1289 1982"> <ul style="list-style-type: none"> • Socioeconomic disadvantage • Poor housing conditions </td> </tr> </tbody> </table>	Child Characteristics	Parents & Parenting Style	Family Factors & Life Events	Community factors	<ul style="list-style-type: none"> • Low birth weight/birth injury • Disability/delayed development • Chronic illness • Early behavioural difficulties • Poor social skills • Poor attachment 	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • Family instability, conflict or violence • Marital disharmony/divorce • Large family size/rapid successive births • Absence of father • Very low level 	<ul style="list-style-type: none"> • Socioeconomic disadvantage • Poor housing conditions
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		child • Abuse or neglect	of parental education	
<p>"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:</p> <ul style="list-style-type: none"> • 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



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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 geographically 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

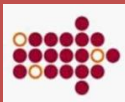
Policy Context

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 Allen³ 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 Munro⁴ 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.

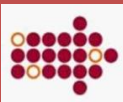
The current five year strategy for the NHS (2014) puts prevention at its core, commenting that the future health of millions of children depends on it. The strategy sets out the need to 'get serious about prevention' particularly as regards children and young people and the need to tackle the causes 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

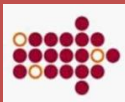
Local authorities have a statutory duty to provide suitable services and activities for young people aged 13 to 19, and those with learning difficulties to age 24, to improve their well-being. Under Section 507B of the Education and Inspections Act 2006, local authorities have a duty to secure equality 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.

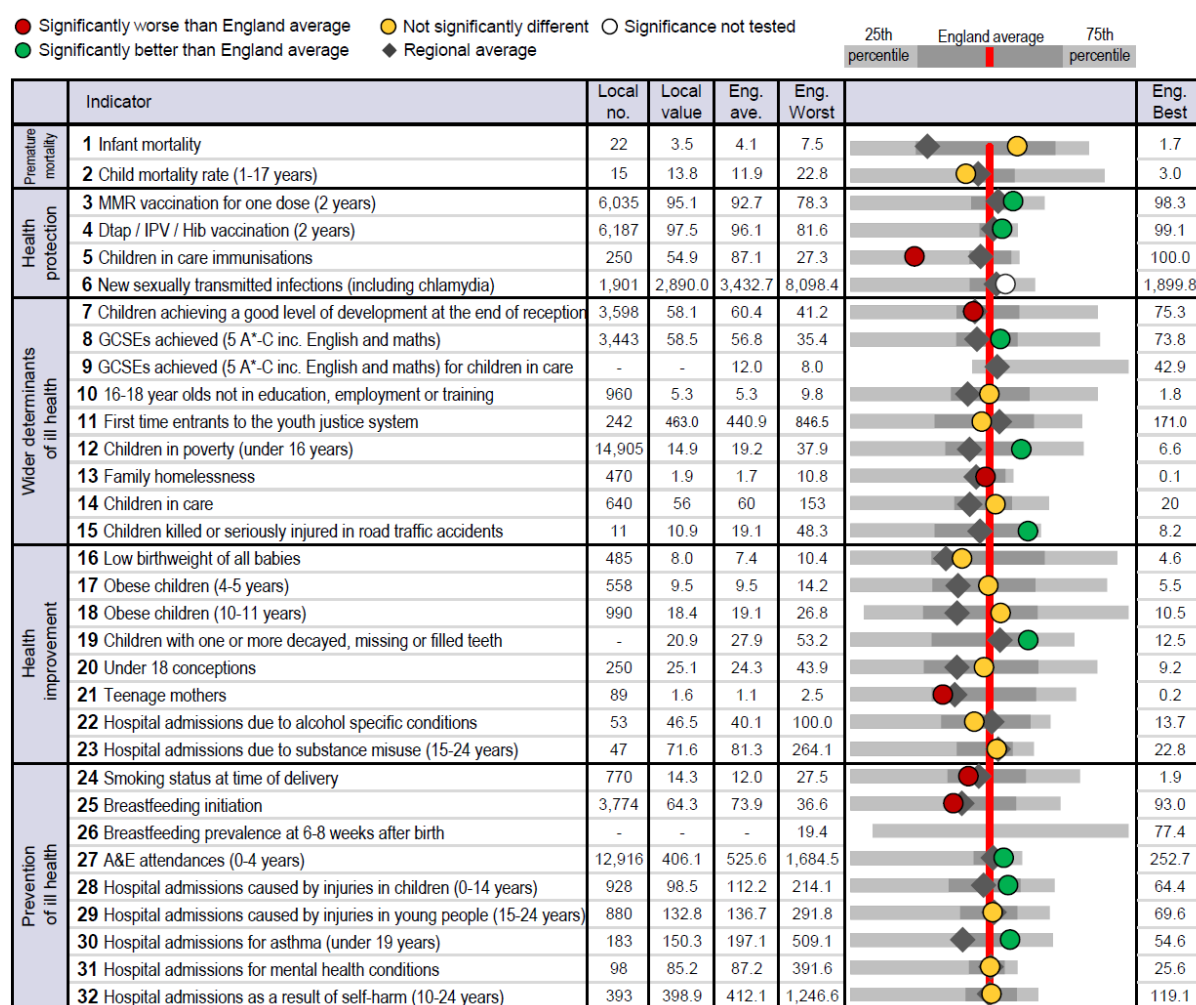
The Department for Education's 'Statutory guidance on the roles and responsibilities of the Director of Children's Services and the Lead Member for Children's Services' refers to leadership roles in relation to early help, intervention and prevention with children and families. According to the guidance, 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

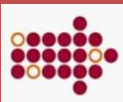
The national child health profiles by Local Authority enables a comparison of local outcomes against the national average and other areas. The Worcestershire Child Health Profile 2015 provides the local value for each outcome benchmarked against others. Red indicates significantly poorer outcomes than 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.



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



Early Help Needs Assessment

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".

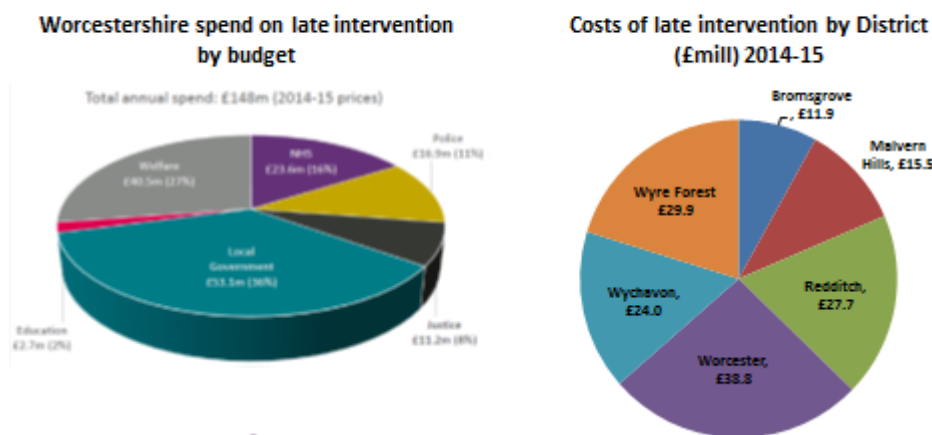
The EIFs aim is to shift spending, action and support for children and families from Late to Early Intervention, from picking up the pieces to giving everyone the best start in life. The EIF estimated that nearly £17 billion per year is spent in England and Wales on the immediate and short-run fiscal 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

Cost of Late intervention

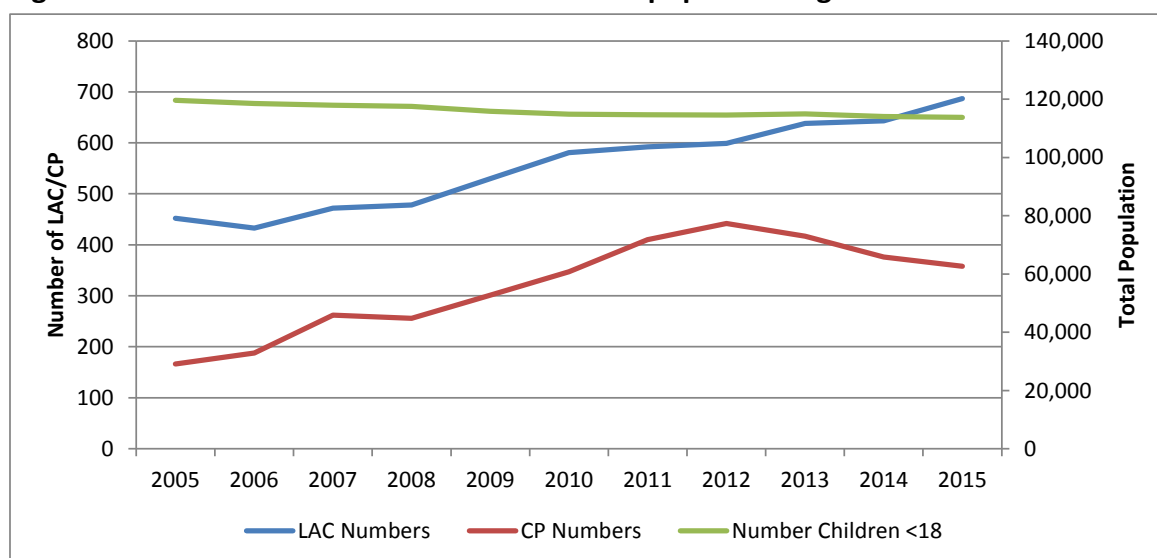


Early Help Strategy Outcomes

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.

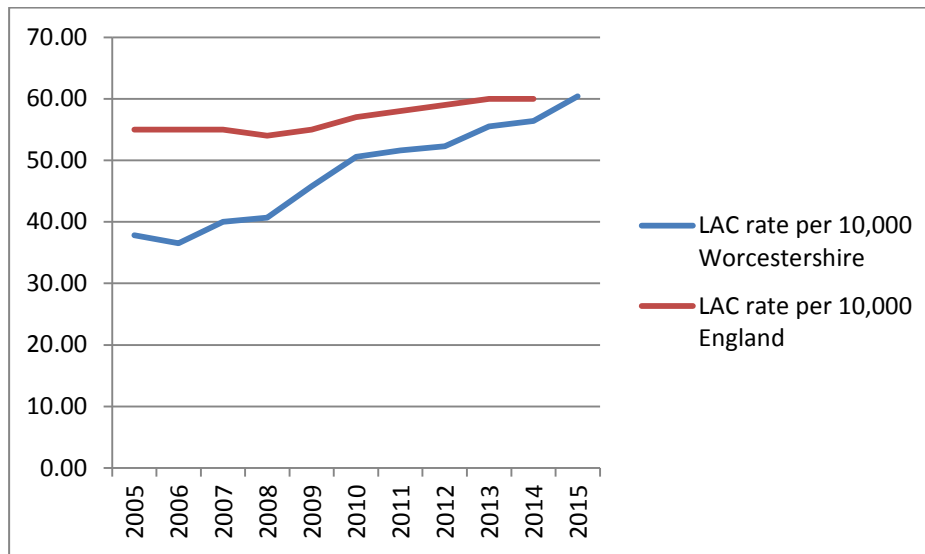
Figure 4 - Total Number of LAC and CP and total population aged <18





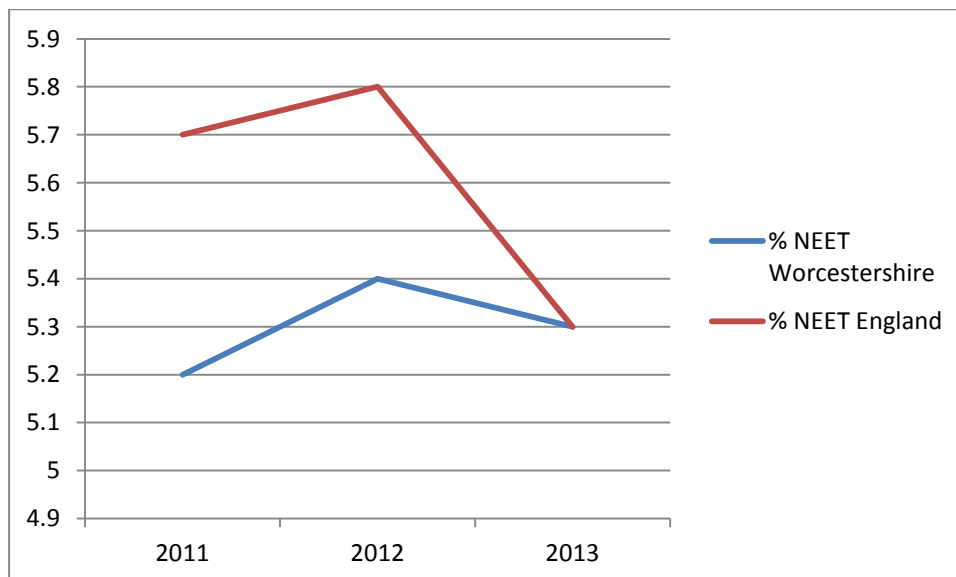
The LAC rate in Worcestershire has increased at a faster rate than the national average. The Worcestershire rate has increased over the decade to reach the England rate (Figure 5).

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).

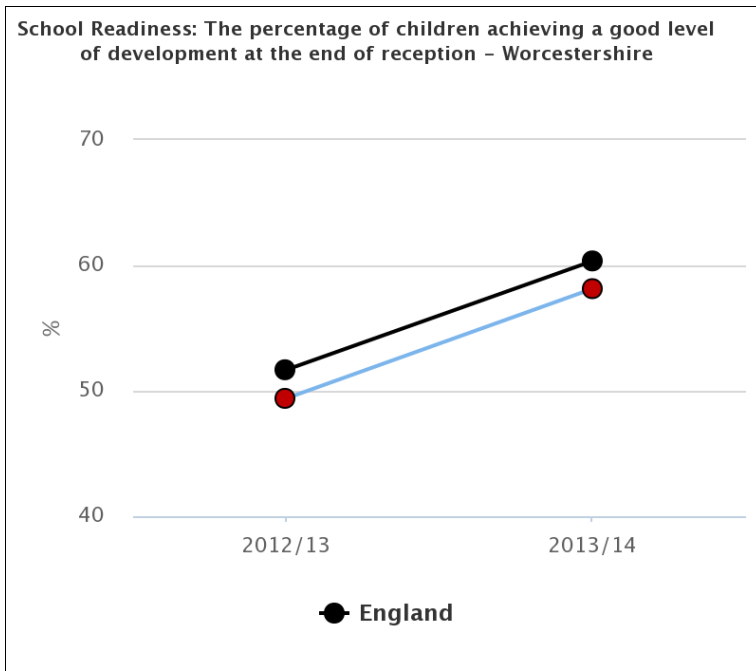
Figure 6 - % of known 16-18 year olds not in education, employment or training (NEET)



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.

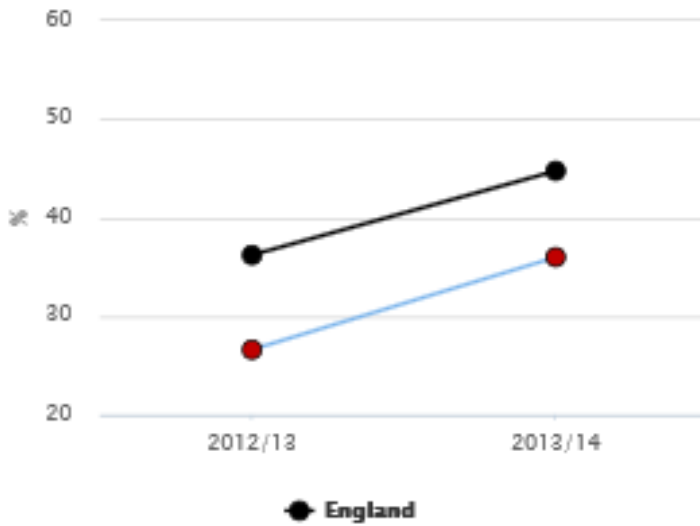


Figure 7 – School Readiness 2012-2014



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

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

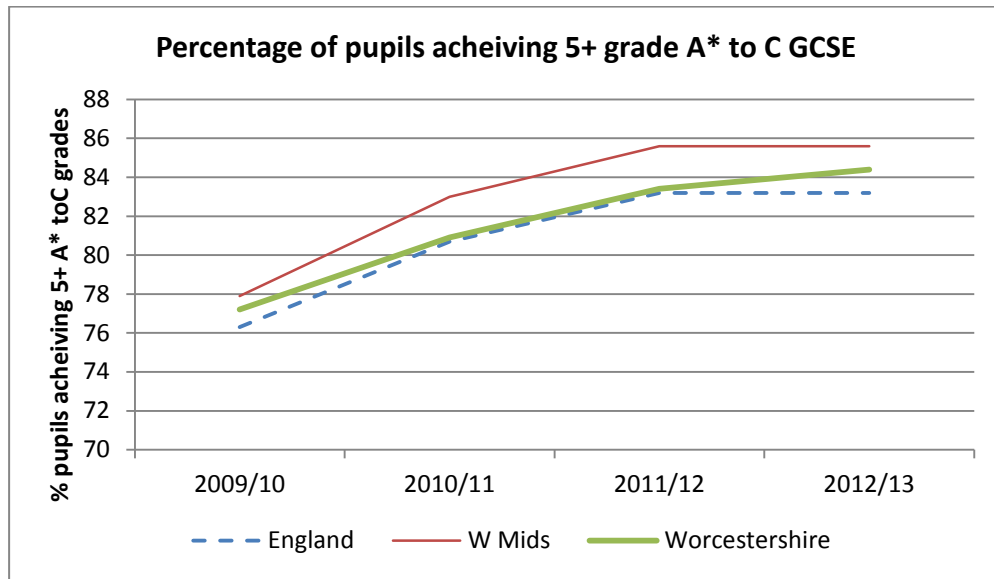


Source: Public Health Outcomes Framework website available @ <http://www.phoutcomes.info/>

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

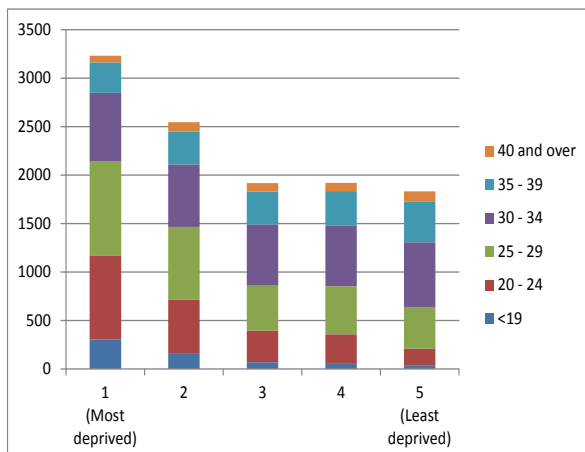
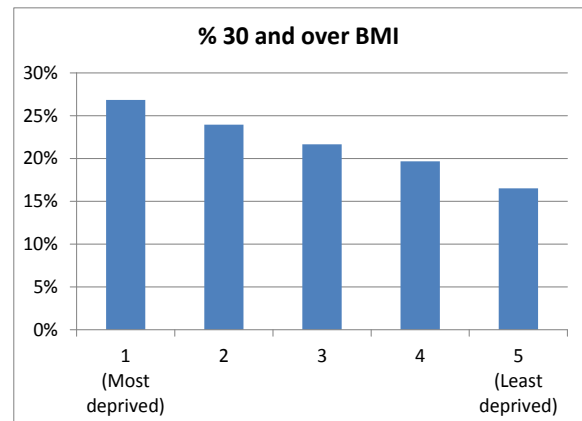


Figure 11 - Overweight in pregnancy by IMD



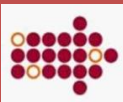


Figure 12- Smoking in pregnancy by IMD

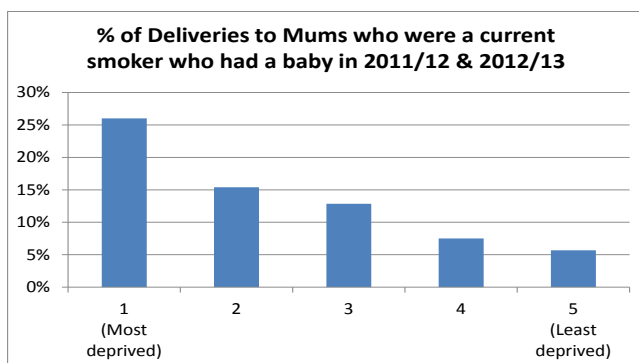


Figure 14 – SALT referrals age 0-4 by IMD

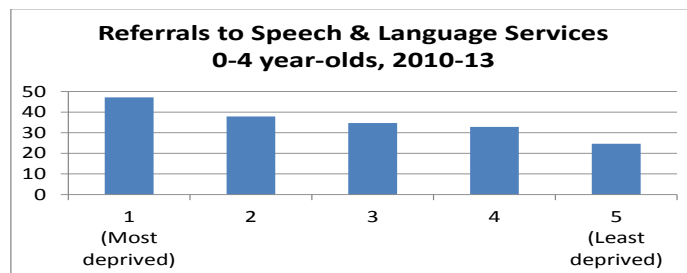


Figure 13 – Breastfeeding by IMD

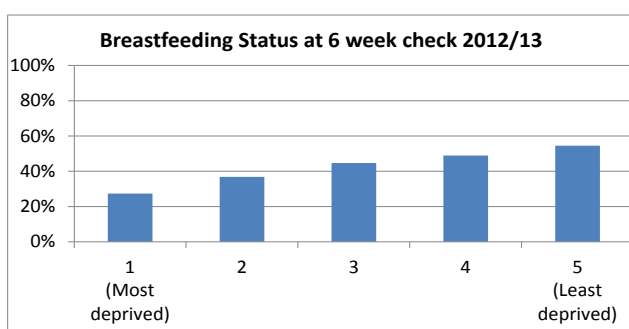


Figure 15 – Emergency Hospital admissions by IMD

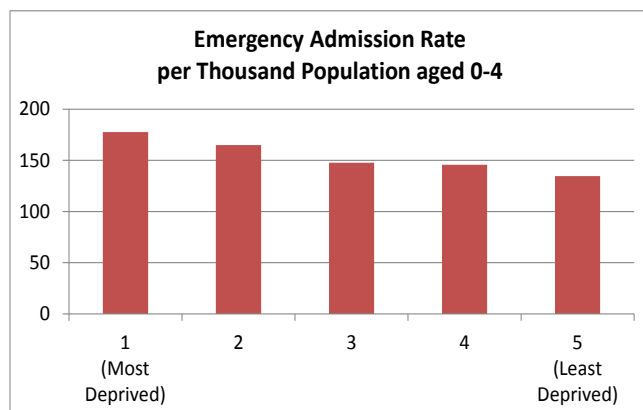


Figure 16 - % of CIN by IMD

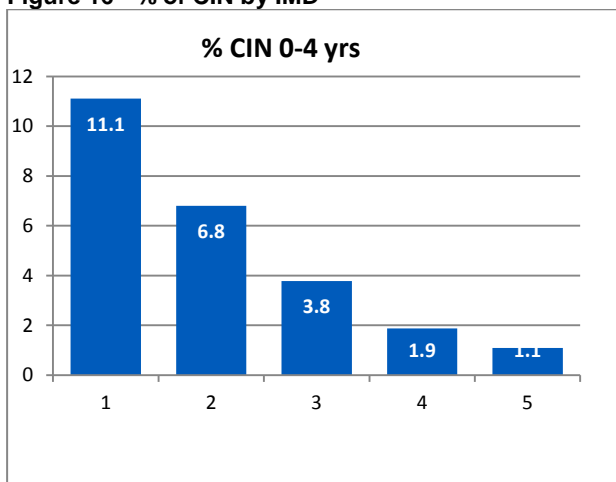
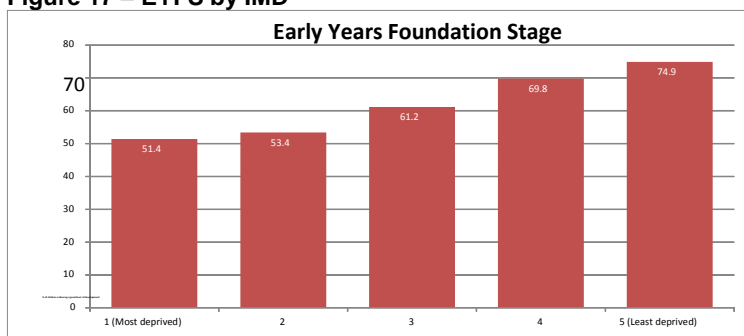


Figure 17 – EYFS by IMD





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

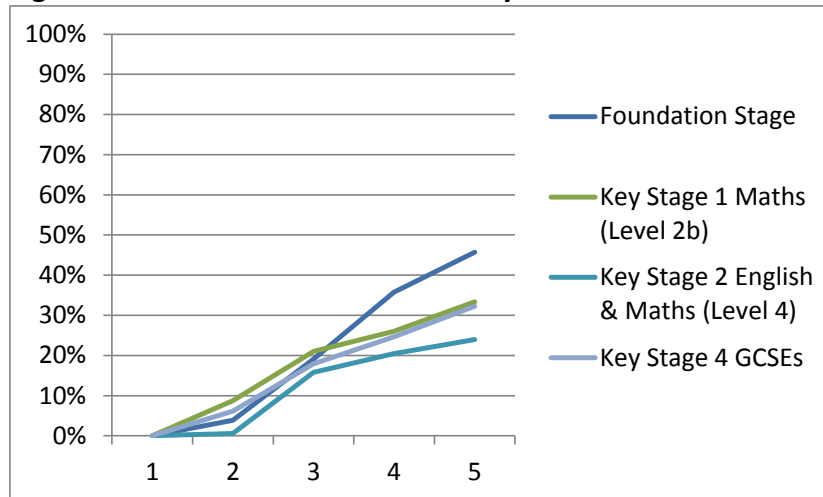
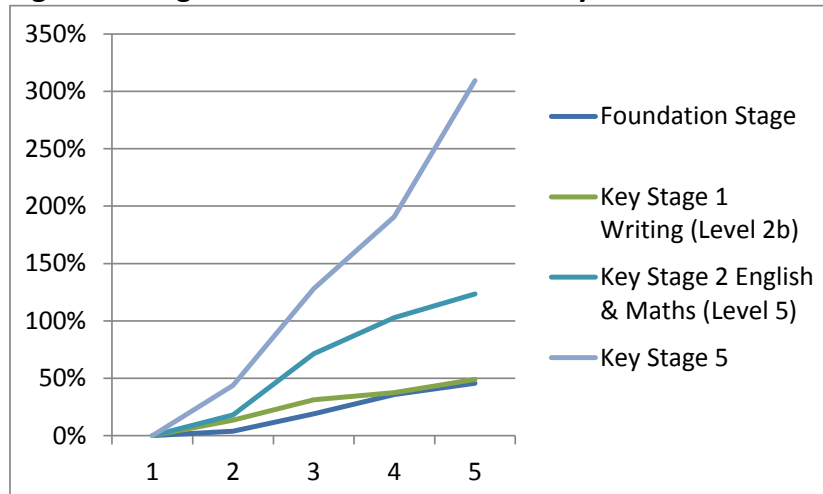


Figure 19- High educational achievement by IMD



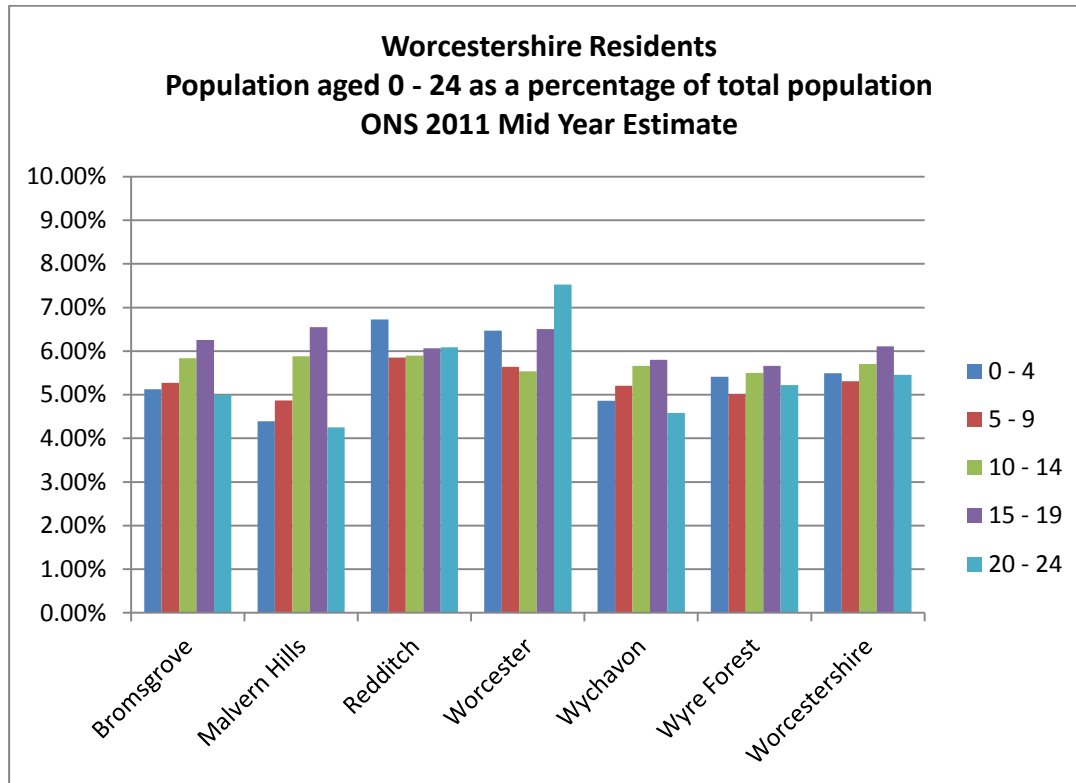
Population Trends and Estimated Need

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.



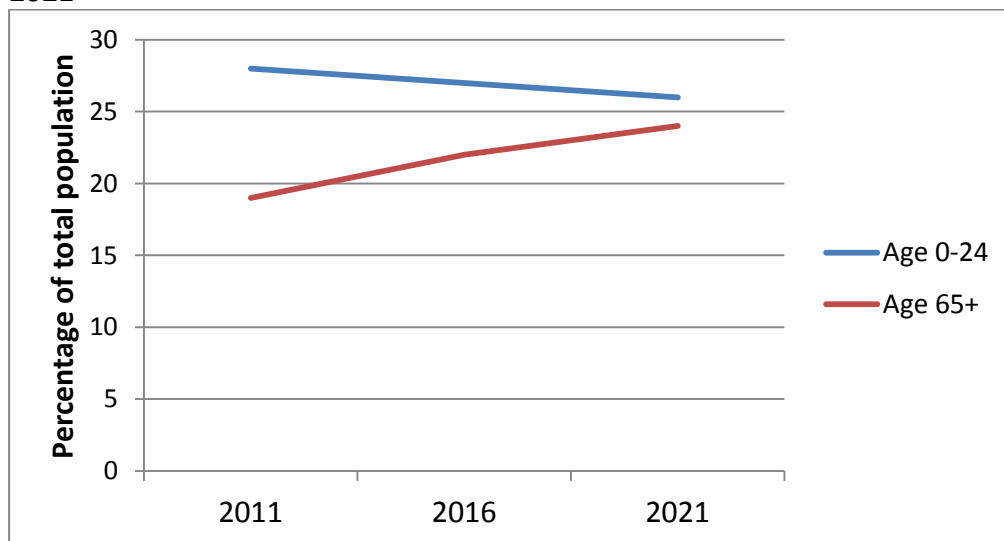
There is variance by district; Worcester City and Malvern Hills have the highest proportion of 15-19 year olds (Figure 20). Redditch and Worcester have the highest proportion of very young children (aged 0-4). Malvern Hills and Bromsgrove have higher proportions of all age teenagers (10-19).

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



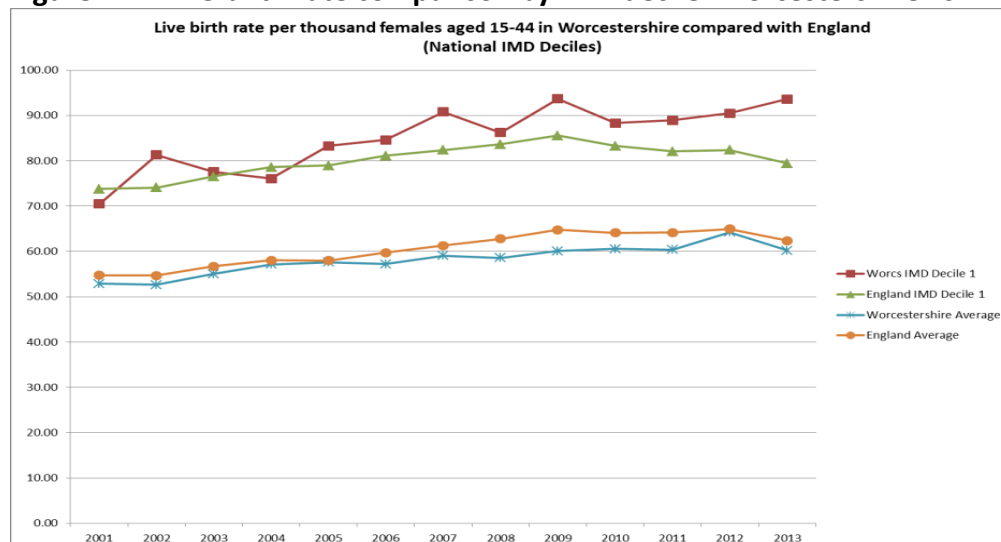
Source: ONS

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

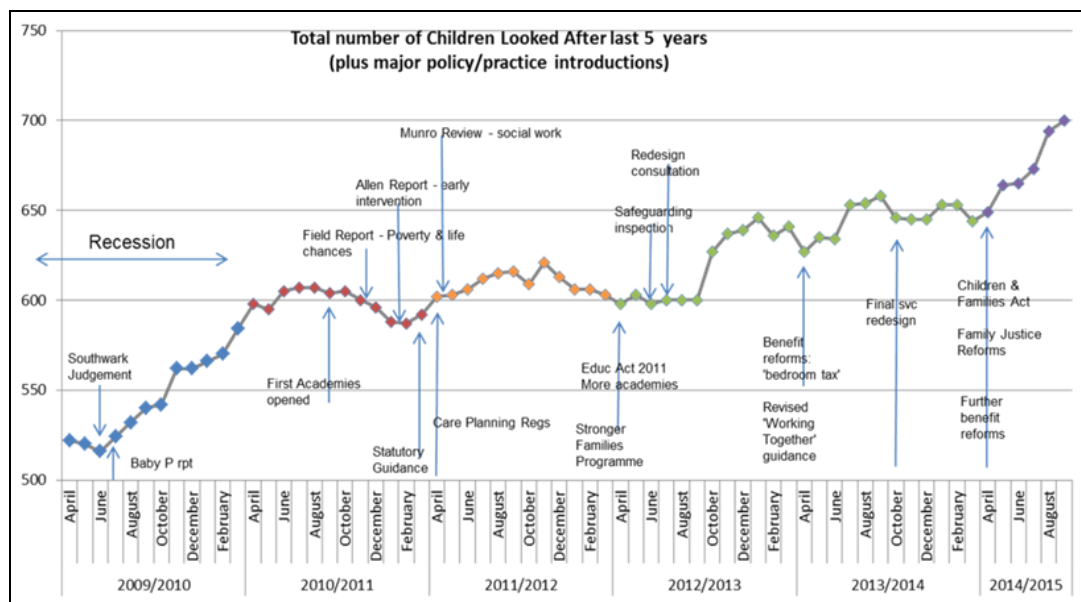
	Number Children <18	Number Children <18 in 20% most deprived areas	% of <18 in 20% most deprived areas
2005	119,561	14,153	11.84%
2006	118,499	14,183	11.97%
2007	117,902	14,205	12.05%
2008	117,494	14,273	12.15%
2009	115,796	14,231	12.29%
2010	114,883	14,185	12.35%
2011	114,652	14,360	12.52%
2012	114,568	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).

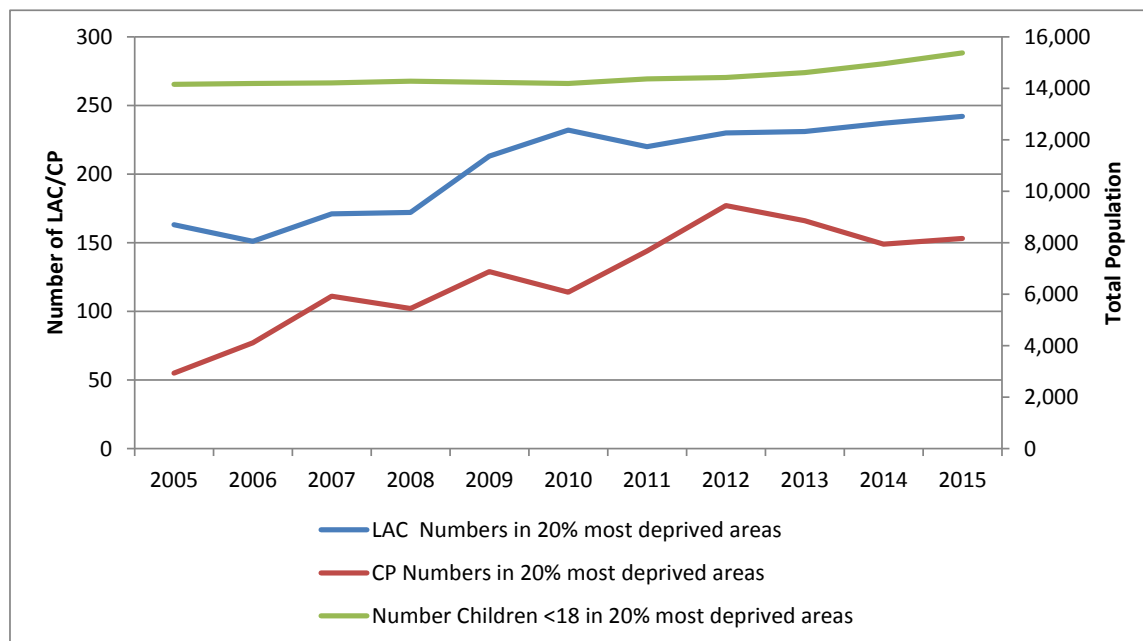
Figure 23 - Trend in LAC numbers with significant policy and practice events marked



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.

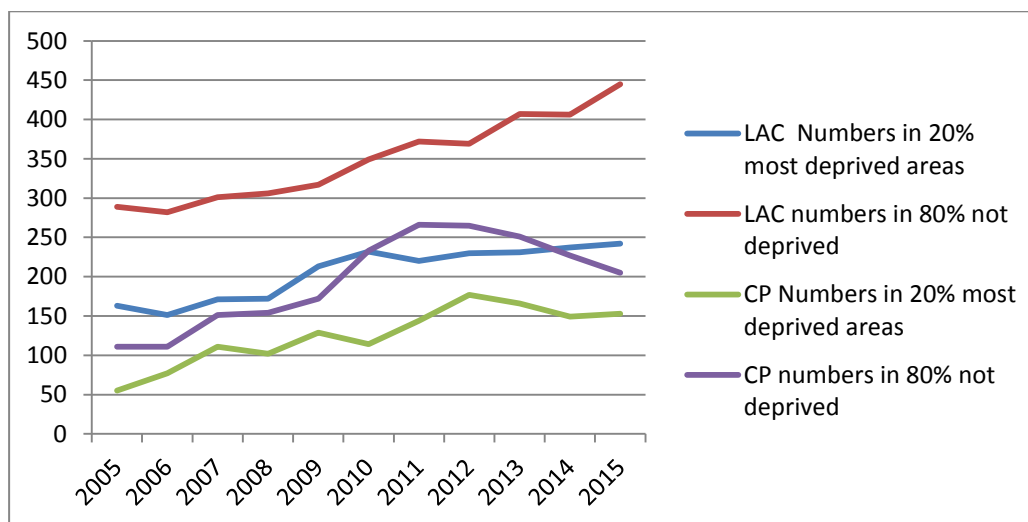


Figure 24 - Number of LAC and CP and population aged <18 in 20% most deprived areas 2005-2015



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.

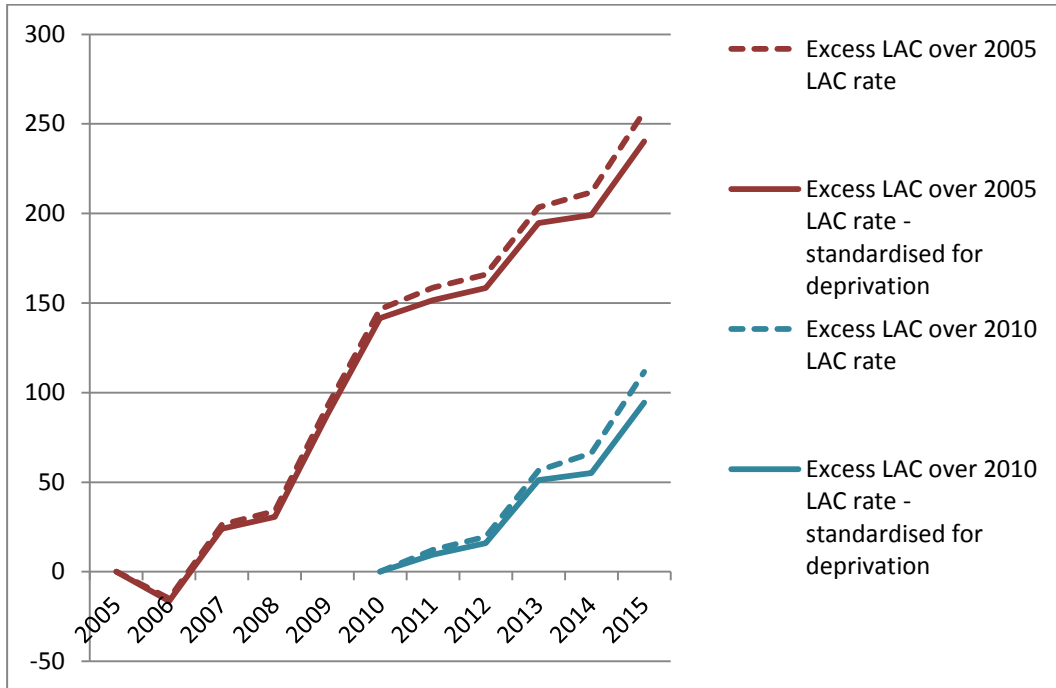
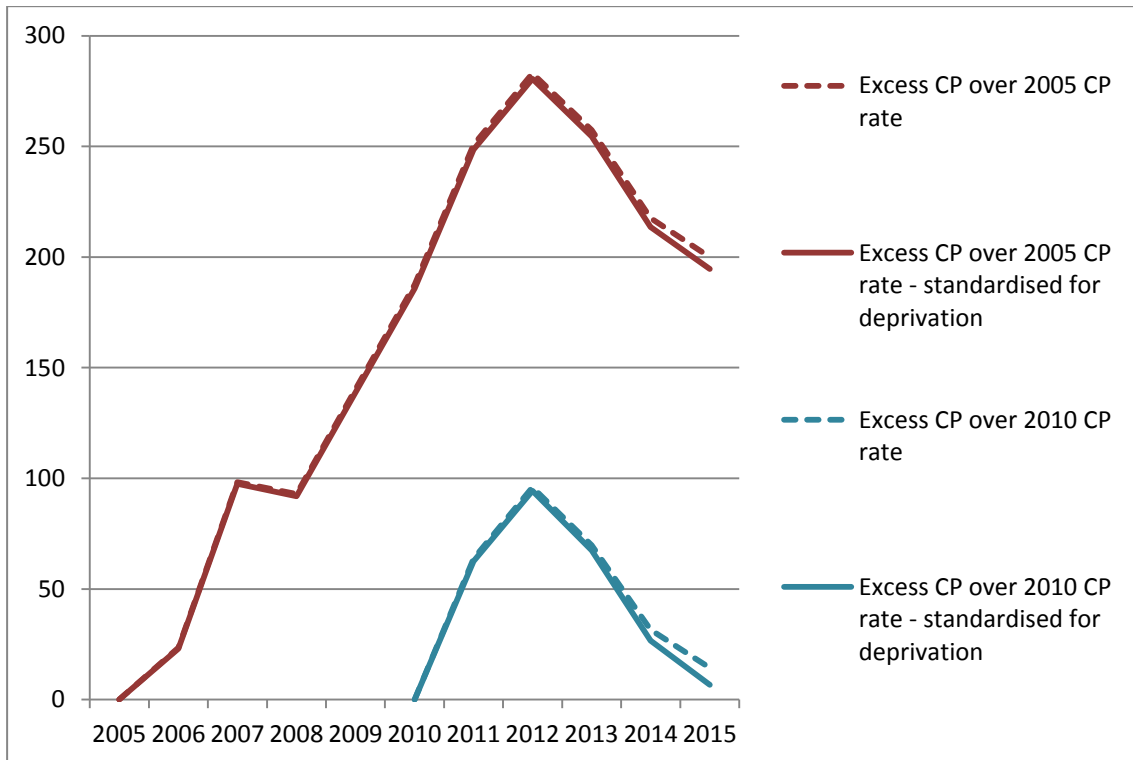


Figure 27 – Numbers of additional CP since 2005 and 2010 standardised for deprivation.





Estimated need for preventive interventions (early help)

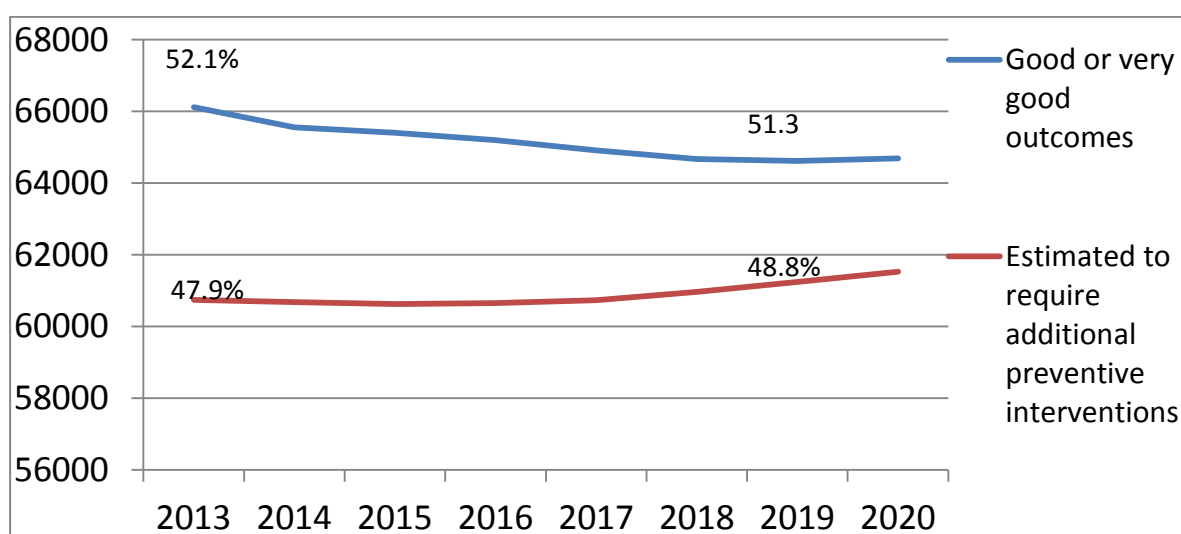
An estimate of need for early help has been calculated applying Worcestershire births data to the "PREview" tool, and incorporating ONS population projections. A model has been developed to estimate the potential need amongst the current 0-19 cohort and estimated need to 2020 (Figure 28). The PREview 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.

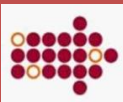
One year's data from the 2013/14 Worcestershire birth extract (6000 plus births) were loaded into the PREview tool to ascertain which areas in Worcestershire are likely to need more early help. The result is an 'average weighting' for each LSOA area in the county which sums the weightings given for each 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.

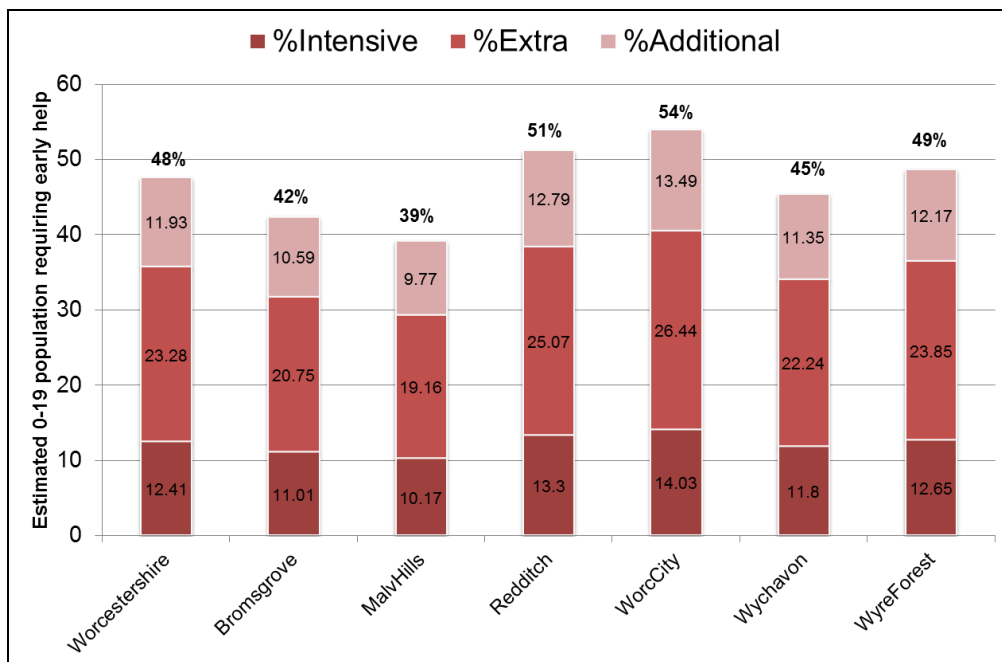
Figure 28 – Estimated need for preventive interventions in Worcestershire to 2020





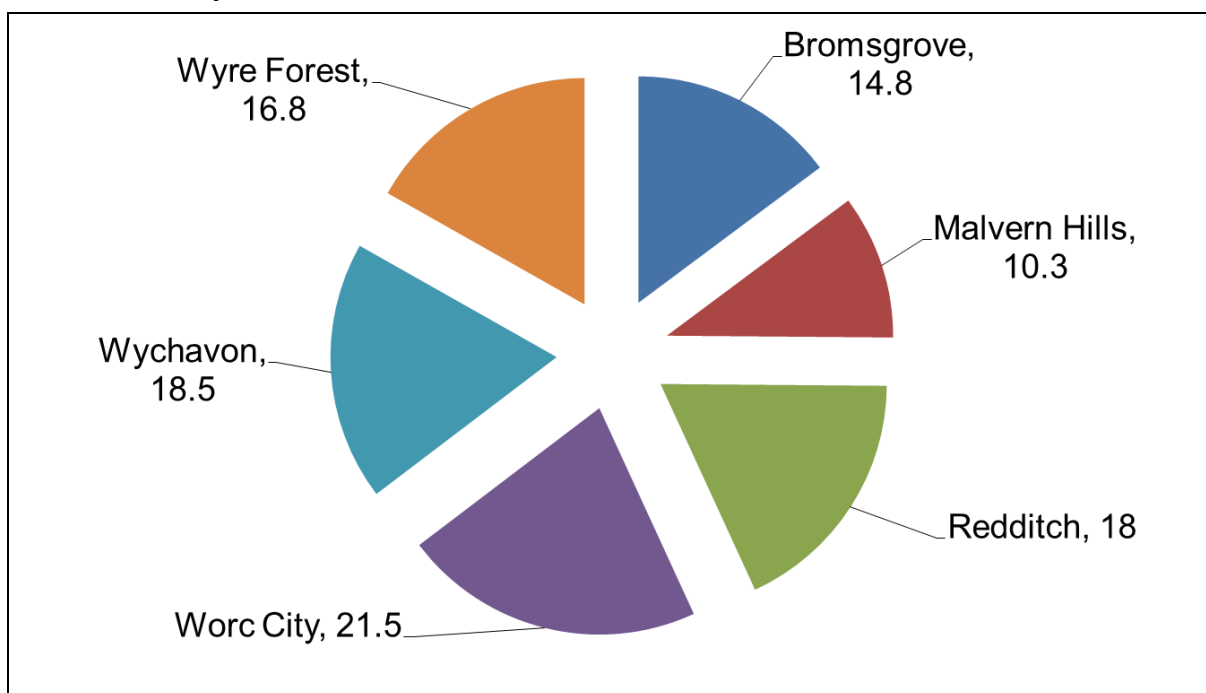
The proportion of 0-19s likely to need preventive interventions varies by District. The following table below identifies this varies from 54% in Worcester City to 39% in Malvern Hills.

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.

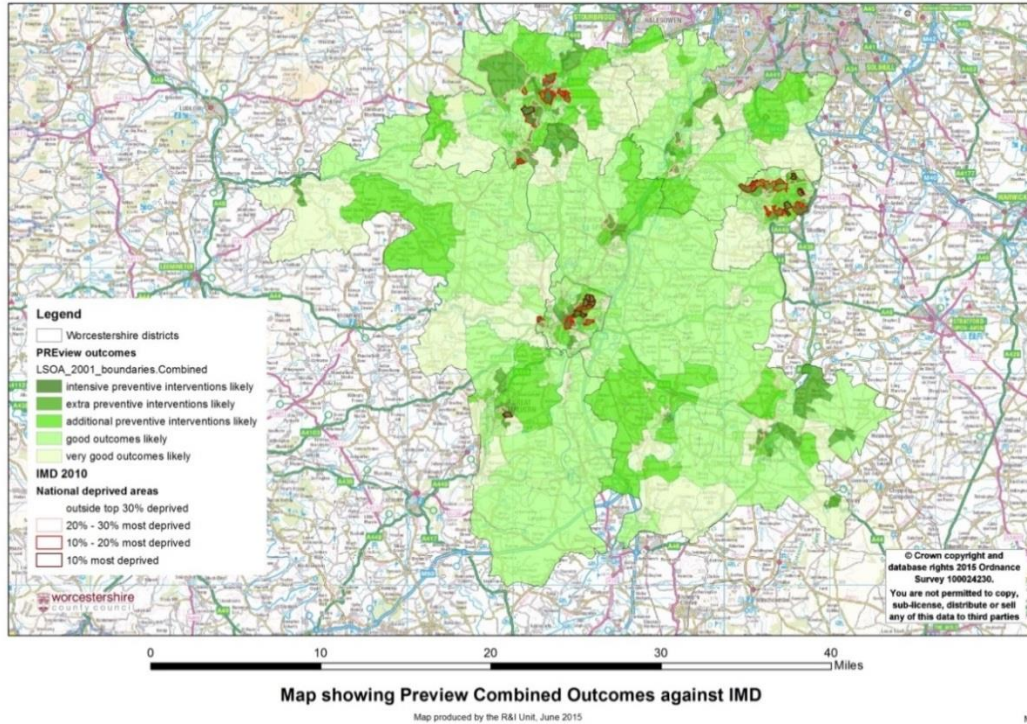
Figure 30 - % of all Worcestershire 0-19s estimated to likely to need preventive interventions by District





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.

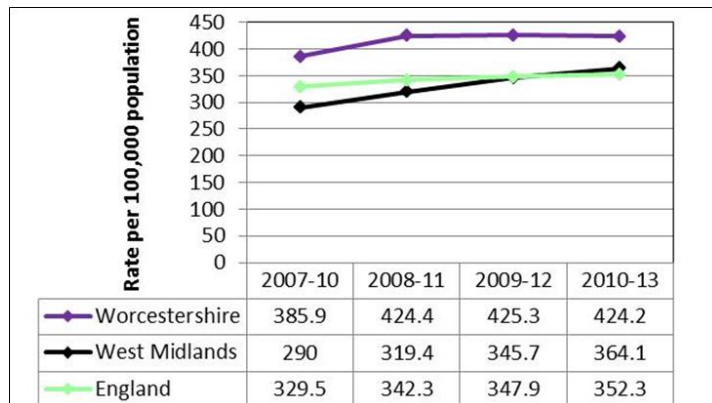
Figure 31- Estimated likely outcomes and areas of deprivation



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).

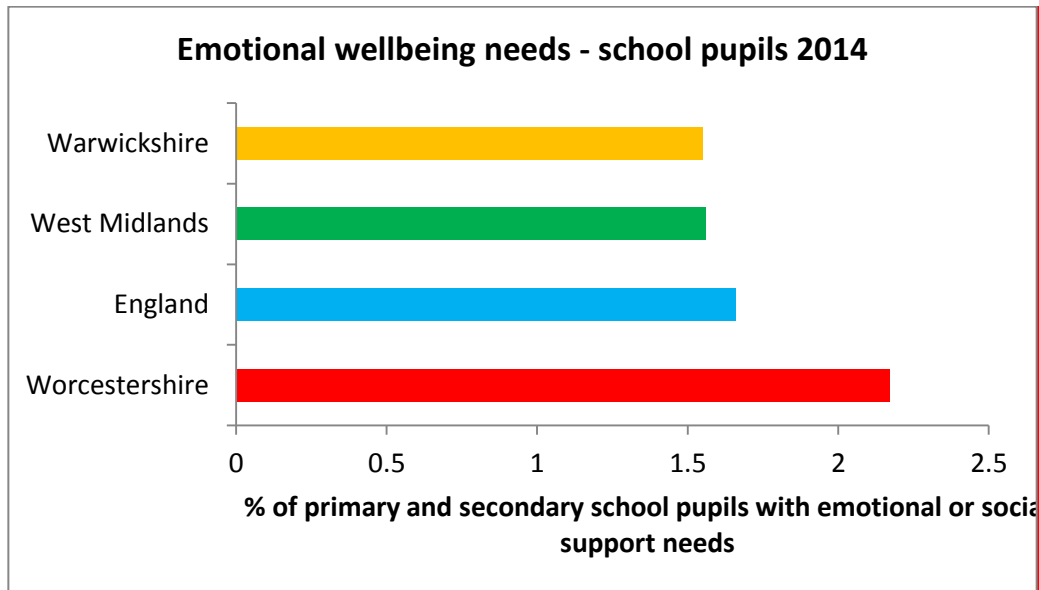
Figure 32: Hospital admissions for self-harm (aged 10-24) 2007-2013





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).

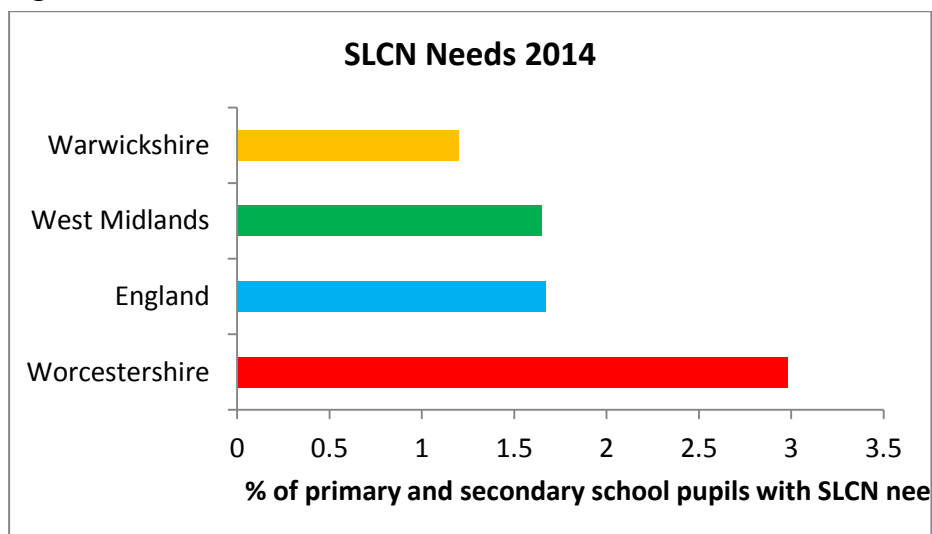
Figure 33 – Emotional wellbeing needs 2014



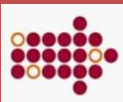
Source: Children and Young People Mental Health and Wellbeing Profile/ Department for Education [<https://www.gov.uk/government/statistics/special-educational-needs-in-england-january-2013>]

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>]

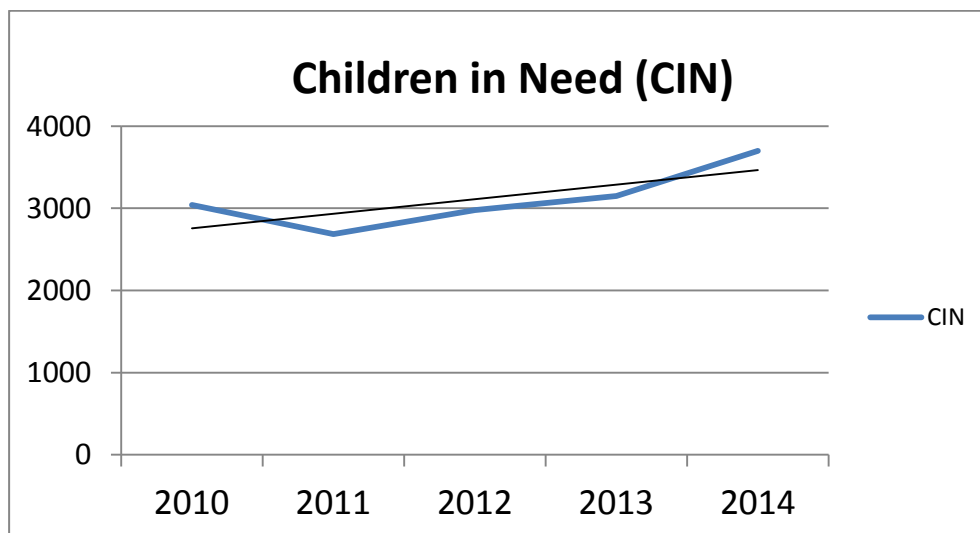


Current Service Provision

Rising demand.

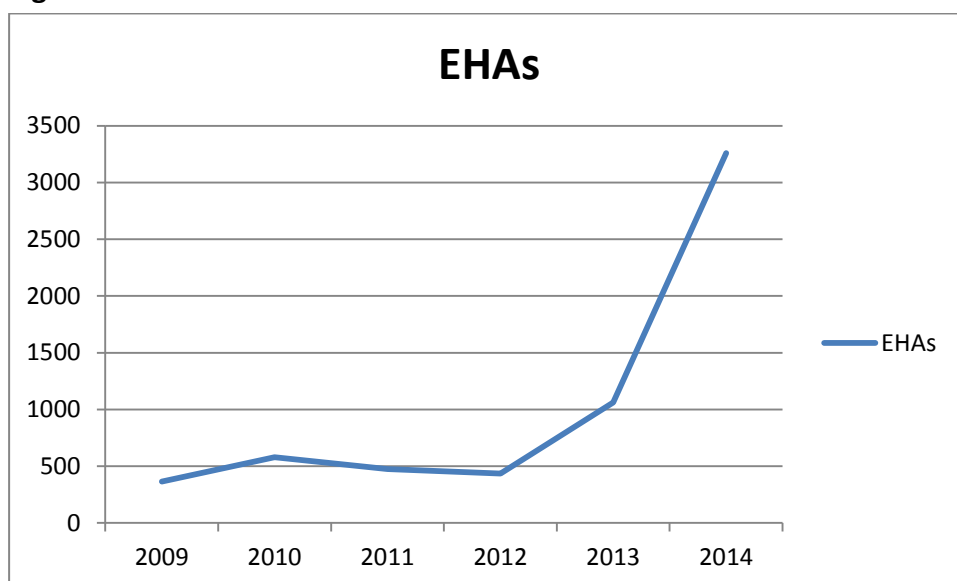
Although outcomes at the population level for children and young people do not appear to be improving activity data shows that an increasing number are being referred to and seen by both health and social care services. As well increases in LAC and CP the tables below highlight the increase in numbers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

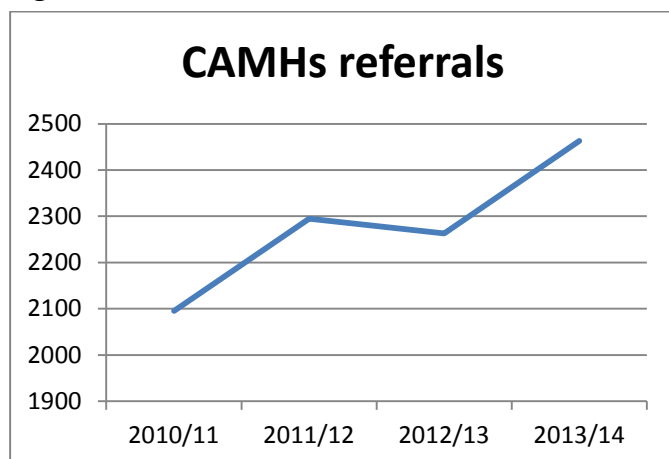
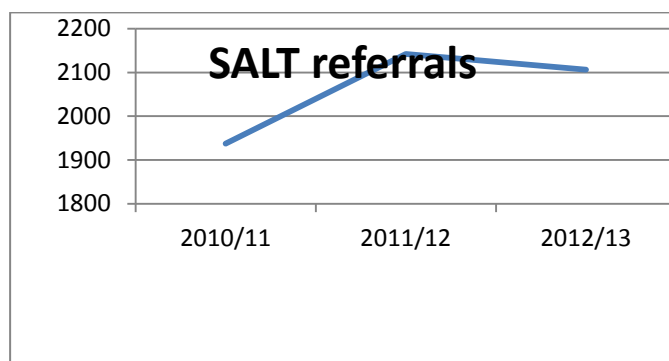


Figure 38 – SALT referrals 201/11 to 2012/13



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%
EHP 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						Grand Total
	Bromsgrove District	Malvern Hills District	Redditch District	Worcester District	Wychavon District	Wyre Forest District	
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

Lead Worker Group	IMD Quintile					Total
	1	2	3	4	5	
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%

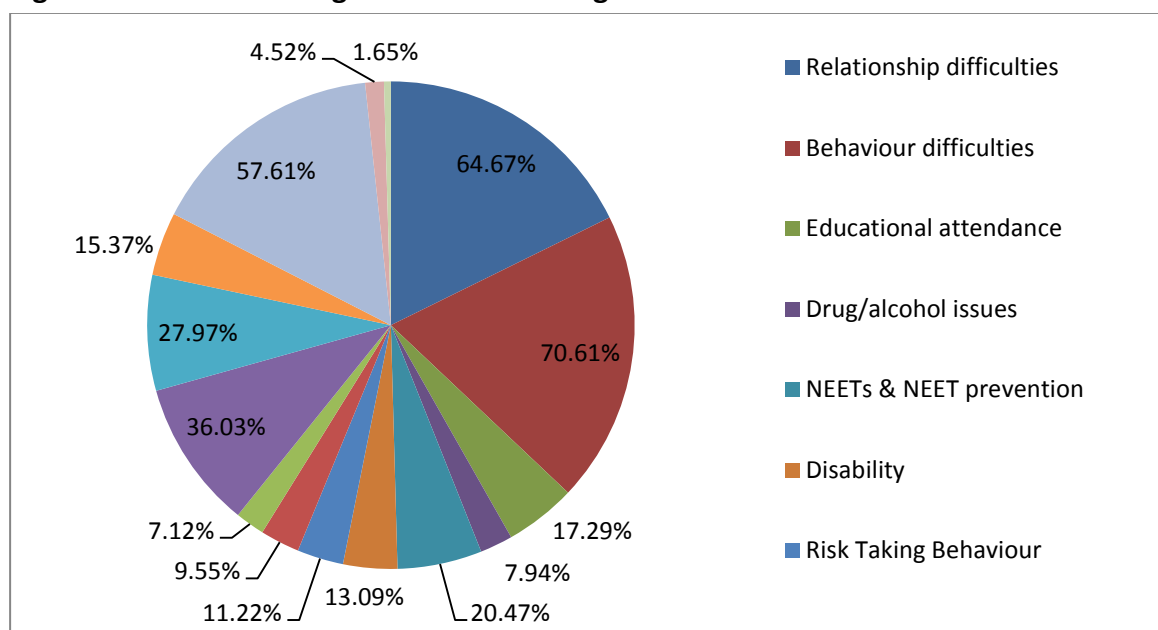
The impact of Early Help assessments and plans are measured via parents and children providing a pre and post self reported score based on a linear scale of 1-5. The "distance travelled" pre and post support is then recorded. The distance travelled is on average 1.94. There is not a robust measure or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

Distance travelled (on a scale of 1-5)	IMD Quintile (national)					County
	1	2	3	4	5	
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.

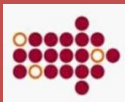
Table 6 - Stronger Families Phase 1 Outcomes

	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		
	Number s 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	Number s 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).

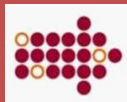


Table 8 - Numbers, % and footfall rate of 30% most deprived 0-4s accessing Children's Centres including nursery education 2012-2014

	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		
	Number s 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	Number s 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.

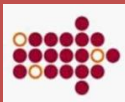


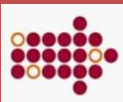
Table 10 – Numbers, % and footfall rate of 30% most deprived 0-4s accessing Children's Centres (excluding nursery education) 2012-2014

	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

District	Pooled 3 Years 2012-2014			
	% 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



Early Help Needs Assessment

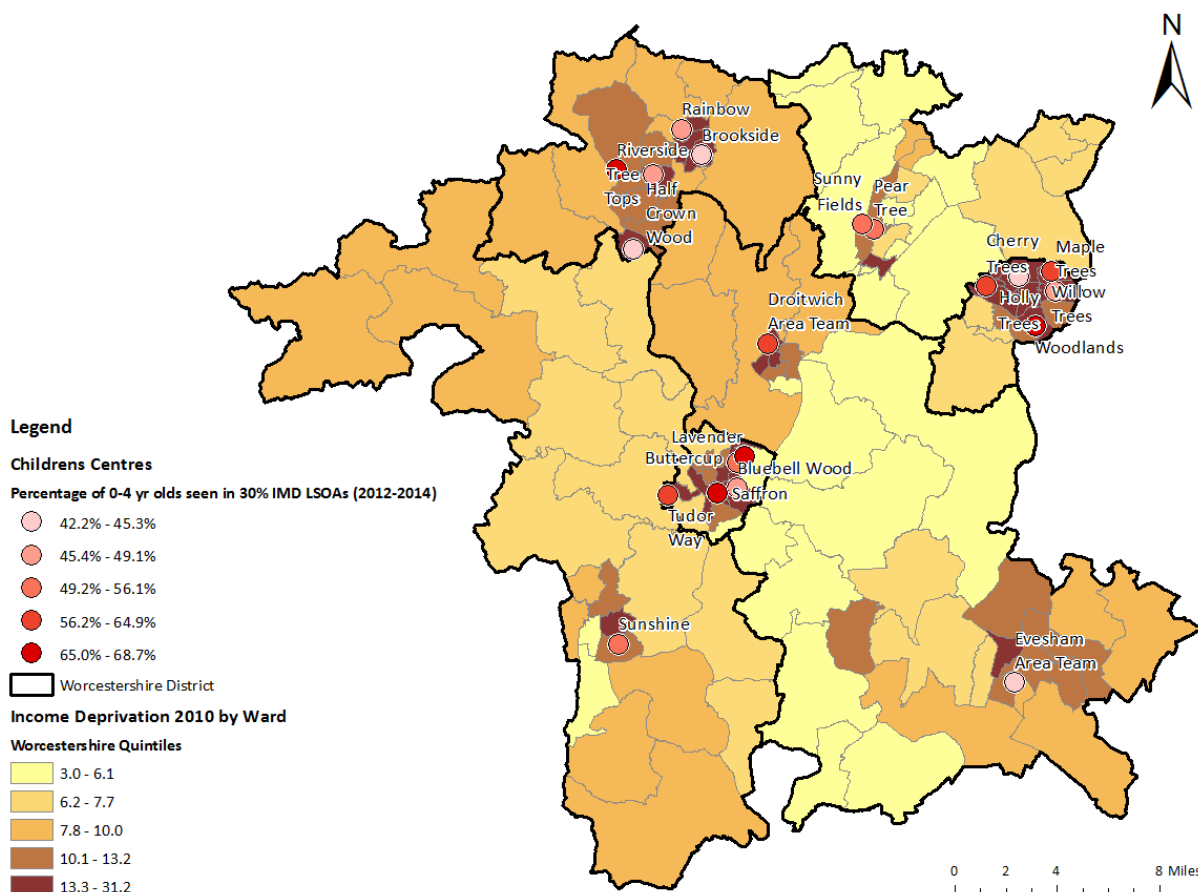
Teme Valley	N/A	N/A	32%	1.98
REDDITCH	54%	3.65	49%	4.00
Cherry Trees	61%	3.96	57%	3.94
Holly Trees	45%	2.86	43%	2.52
Maple Trees	46%	3.14	50%	4.96
Oak Trees	N/A	N/A	45%	4.67
Willow Trees	56%	3.87	54%	5.32
Woodlands	66%	4.83	49%	3.34
WORCESTER	56%	4.62	45%	4.30
Blue Bell Wood	45%	2.67	45%	3.56
Buttercup 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.

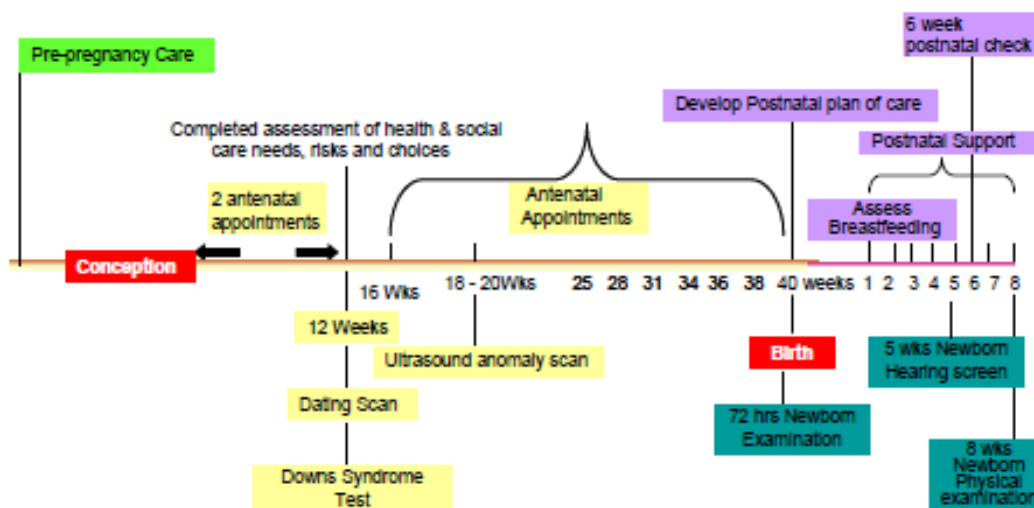
Maternity provision offers choice and continuity for families, while also providing more targeted help for those in greatest need. The aim of maternity services is to support the transition from pregnancy to family life with a safe high quality service that is woman and family centred and that enables 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 mothering⁵, improved mother-child interactions⁶ or early identification of post-natal depression⁷ – with long-term positive impacts on young children and their families.

Health Visiting Model

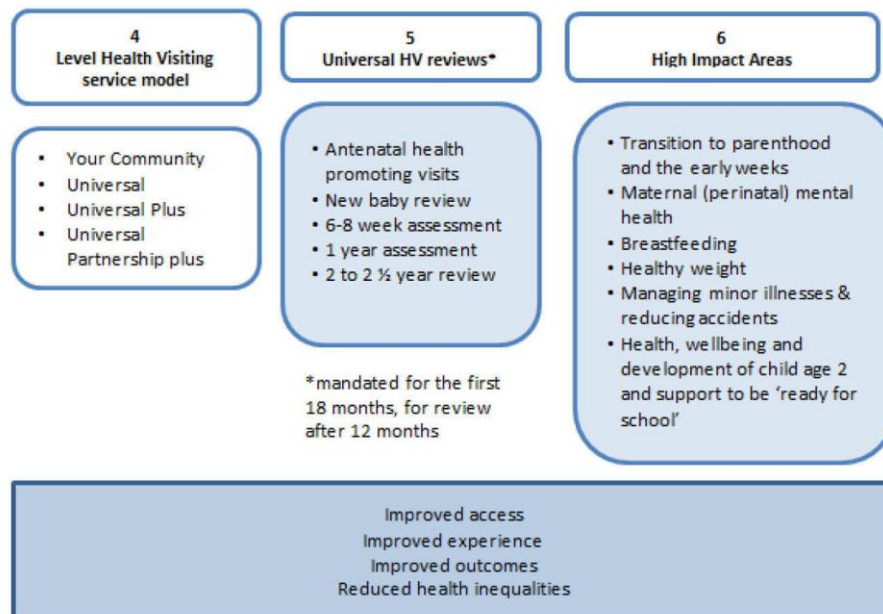
The delivery of the Health Visitor service is provided at 4 levels and includes the universal elements of the Healthy Child Programme:

- 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.



Early Help Needs Assessment

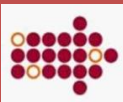
- Universal: health visiting teams lead delivery of the HCP. They ensure that every new mother and child have access to a health visitor, receive development checks and receive good information about healthy start issues such as parenting and immunisation.
- Universal Plus: families can access timely, 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:

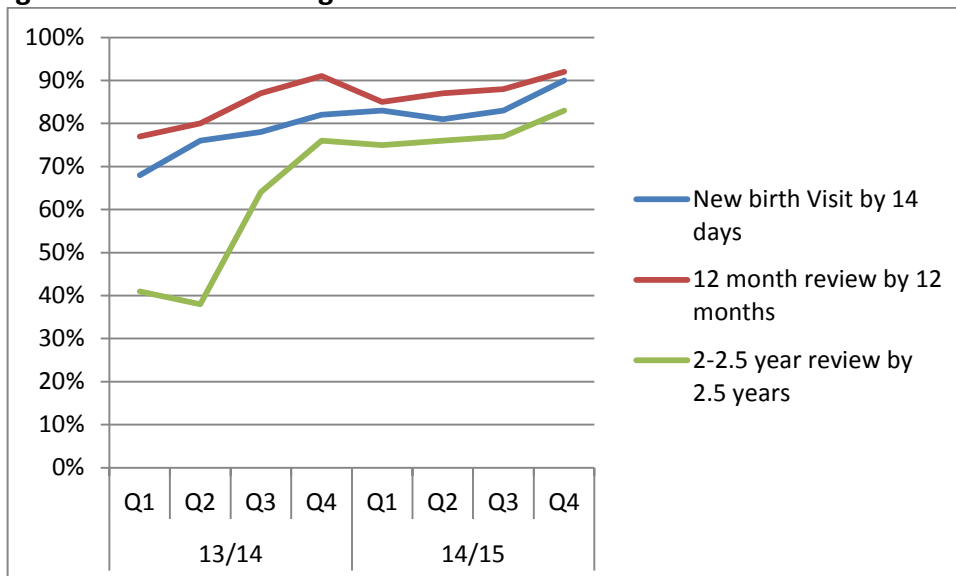
- Transition to Parenthood and the Early Weeks
- Maternal Mental Health (Perinatal Depression)
- Breastfeeding (Initiation and Duration)
- Healthy Weight, Healthy Nutrition (to include Physical Activity)
- Managing Minor Illness and Reducing Accidents (Reducing Hospital Attendance/Admissions)
- Health,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

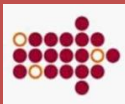
The Family Nurse Partnership programme (FNP) is an evidence-based, preventive public health home visiting programme for vulnerable first time young mothers aged 19 and under. Structured home visits, delivered by specially trained family nurses, are offered from early pregnancy until the child is two.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

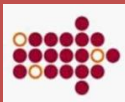
- Community offer: to provide advice to all school-aged children and their families with the local community (5-19yrs), through maximising family support and the development of community resources with the involvement of community and voluntary resources.
- Universal offer: Working in partnership with 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 development¹¹ as well as poorer long-term health and educational outcomes¹². Evidence suggests that maternal health is related to socioeconomic status¹³, and that disadvantaged mothers are more likely to have babies of low birth weight¹⁴. 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 weight¹⁵. 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 development¹⁶. 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 mothers¹⁷. 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 groups¹⁸. A number of studies suggest there can be an increased incidence of domestic violence during or shortly following pregnancy¹⁹ 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 lives²⁰. 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 learn²¹. 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 years²² and across the life span²³. 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 families²⁴. 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 achievement²⁵, in addition to having better physical outcomes²⁶. 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 five²⁷. Maternal ill health is common and 10 per cent of mothers are reported to experience post-natal depression²⁸. Children of mothers with mental health issues are twice as likely to experience a childhood psychiatric disorder themselves²⁹. 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 aggression³⁰. 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 leukaemia³¹, and may also have an impact on neurodevelopmental outcomes including intelligence³². 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 requirements³³. 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 competence³⁴, and is protective against later disruptive behaviour and substance misuse³⁵. Whereas harsh, inconsistent discipline, little positive parental involvement with the child, and poor monitoring and supervision is associated with later child antisocial behaviour³⁶. 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 parenting³⁷. 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 interviews³⁸. 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 security³⁹. 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 functioning⁴⁰ and the emotional and behavioural adjustment of young children⁴¹. 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 development⁴³. 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 years⁴⁴. 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 circumstances⁴⁵.

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 outcomes⁴⁶. Evidence suggests areas should develop effective multiagency, integrated working and delivery to ensure all services are working together, sharing information and developing whole system approaches⁴⁷. 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 services⁴⁸. 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 programmes⁴⁹, 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 resilience⁵⁰. 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 lives⁵¹. 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 attainment⁵². 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 resilience⁵⁴. School connectedness appears to be generated in schools through extra-curricular activities, positive classroom management and tolerant disciplinary policies.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 variable⁵⁶. 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 day⁵⁷. However physical activity programmes in schools can have positive influences on cognitive performance, with demonstrable positive results in academic attainment, concentration, memory and classroom behaviour⁵⁸. 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 schools⁵⁹.

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 information⁶⁰, 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 peers⁶². 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 burden⁶³. 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 behaviours⁶⁴.

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 provision⁶⁵.

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.

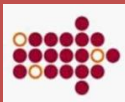
Improved outcomes for children

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 child⁷¹ 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 problems⁷²

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 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 P⁸⁰ 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 review³ 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.

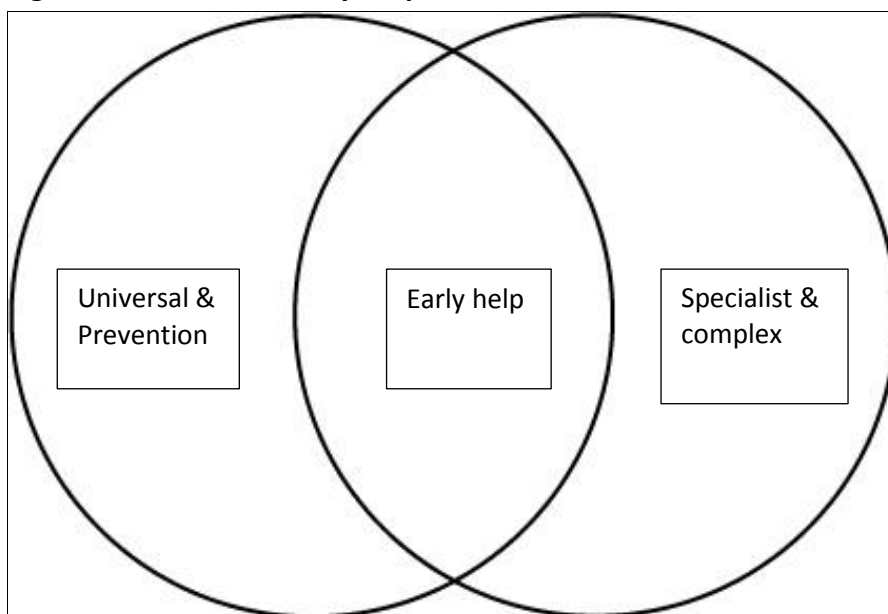
The report concluded that the current statutory framework does not give sufficient clarity and priority to the roles and responsibilities of individual agencies for early help provision. They recommended Local authorities and partner agencies delivering early help to children and families should improve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

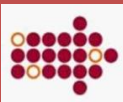
Manchester model

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.

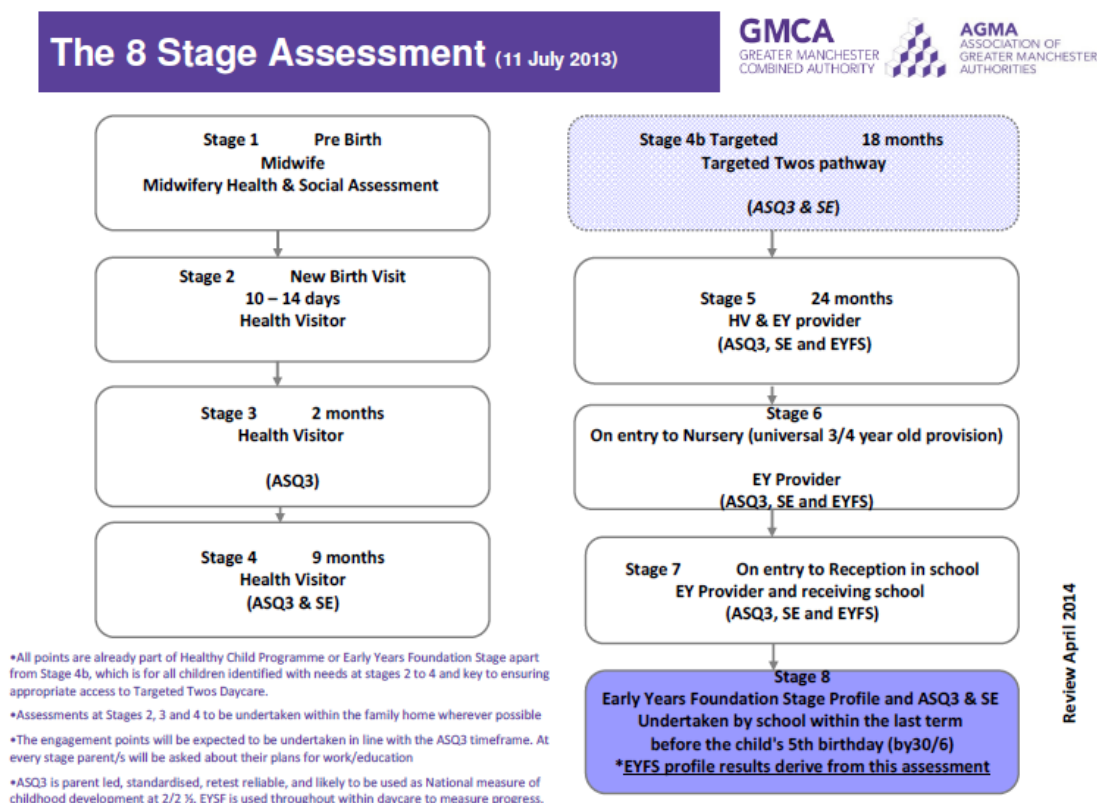
The central aim is to move from multiple non-evidence based assessments, to a progressive series integrated and centred around crucial child development milestones that identify needs early. The model is based on integrated working between midwives, health visitors,



Early Help Needs Assessment

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.



Early Help Needs Assessment

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
<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • 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.

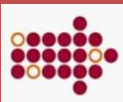
A commonly used approach to a single assessment of need is to have a multi-agency panel or meeting where the assessments are discussed. Examples of these are:

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.

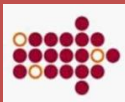
The aim of the 2011 Early Help strategy and subsequent commissioning model of District 0-19 Early Help Providers does not appear to be reducing demand on complex or specialist health & social care services or improving outcomes at a population level. The impact, success or outcomes of Early Help plans 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 adolescence⁹. 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.



Early Help Needs Assessment

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

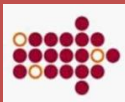
Current data shows that a third of children's centres do not reach children/families in the most deprived 30% population. Only 49% of families with children under the age of five are regularly using the children's centres and only some of these will actually visit a children's centre building to receive 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.



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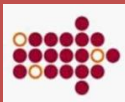
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APPENDIX 1 –Review of Parenting Interventions

Age group	Level of intervention	Name of programme	Brief description	Benefits	Evidence/Source	Criticisms of the programme / issues for consideration in Worcestershire	Notes
Pre-birth 0-4 5-9, 10-14 15-19 20-24	1 = Population 2 = Universal 3 = Targeted						
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	<p>Parent Programme</p> <p>Standard Triple P is for parents of children aged two to 12 with concerns about the child's emotions or behaviour.</p> <p>Parents attend between eight and 10 individual or group sessions where they learn strategies for interacting positively with their child and discouraging unwanted behaviour.</p> <p>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.</p>	<p>Triple P (2009) US System Population trial reported fewer child out of home placements and cases of child maltreatment</p>	<p>PPET **** rating</p> <p>Uni Warwick 2010 (SR of SR)</p> <p>"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.</p>	<p>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.</p> <p>The majority of the Triple P evidence base has been undertaken by people who are connected to the Triple P programme (Sanders et.al).</p> <p>Those that haven't (e.g. one RCT in Birmingham) have not shown an effect.</p> <p>The Birmingham RCT reported not only zero benefits but when the sessions were poorly attended, produced potentially iatrogenic effects.</p> <p>Triple P may be affected by the skills of the practitioner and the fidelity to model.</p>	<p>Triple P has very clear short and long term goals for those participating in the programme.</p> <p>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.</p> <p>Programme fidelity is maintained through the following processes:</p> <ul style="list-style-type: none"> • 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.
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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.

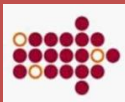
WHO 2009 - Swiss RCT (aged 2-12) percentage of participating mothers reporting dysfunctional child behaviour from 48% before to 22% after (compared to 52% before and 55% after in control)



3-8	3	Incredible Years	Parent programme	Improved child behaviour,	PPET ** rating	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.
			<p>Incredible Years Early Years (IYEEY) 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. IYEEY 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.</p>	<p>Reduced child maltreatment (actual or risk), Improved parenting practices/co mpetency, Reduced parent stress/depre ssion/mental health problems</p>	<p>WHO 2009 – Norwegian RCT reported greater reduction in problematic behaviour than in the control, also showing decrease at 1yr follow up</p>	<p>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.</p> <p>Referrals from the Incredible Years programme are locally determined, would require practitioners having detailed knowledge to appropriately signpost to services.</p>



3-11	2 and 3	<p>Families and Schools Together (FAST)</p>	<p>Community based parent programme</p> <p>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.</p> <p>FAST is typically offered in socially disadvantaged communities and schools</p> <p>experiencing difficulties in engaging parents. The programme content and practitioner qualifications are appropriate for families with these characteristics.</p> <p>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.</p>	<p>Improved child behaviour, Improved child achievement , Improved child social skills, Reduced risk of child substance misuse, Reduced risk of child offending, Improved parenting practices/co mpetency, Improved parent wellbeing</p>	<p>PPET **** rating, Strong theoretical framework and content.</p> <p>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.</p> <p>Evidence that "foot in the door" trial session resulted in more parents staying for the duration of the programme</p>	<p>Consider eligibility criteria and number and spread of people in Worcestershire accessing this service.</p> <p>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.</p> <p>FAST has very specific requirements of its venue in that it must have a kitchen and area for the group to eat.</p> <p>FAST is a multi-disciplinary session (crossing health, communities and schools). Would require detailed promotion with targeted stakeholders.</p>	<p>FAST is typically delivered through schools, although any community venue will do.</p> <p>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.</p>
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Early Help Needs Assessment

Pre-birth 0-2	3	Nurse Family Partnership / Family Nurse Partnership UK	<p>Parent programme, nurse/home visiting low-income first-time mothers aged under 19 (from early pregnancy until the child is 2)</p> <p>Includes a prevention programme - a psycho-educational approach - focussing on adaptive behaviour change.</p> <p>The family nurse provides the mother with advice and support on:</p> <ul style="list-style-type: none"> • Personal health • Environmental health • Life course development • Maternal role • Friends and family • Health and human services • Pregnancy advice 	<p>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</p>	<p>PPET **** rating</p> <p>"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"</p> <p>FNP is currently being evaluated in the UK – results of RCT to be reported in 2014.</p> <p>WHO 2009</p> <p>Large USA RCT – cases 48% less likely to be the perpetrators of maltreatment than the controls.</p> <p>MacMillan et al. 2009 "Family Nurse Partnership is the most effective intervention known for preventing child Maltreatment"</p>	<p>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.</p> <p>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).</p> <p>May create an emotional attachment / expectation between the practitioner and service user- any information on the impact of this?</p> <p>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.</p>	<p>To be commissioned by local authorities from 2015 (currently commissioned by NHS England)</p> <p>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.</p> <p>A web-based system collects information about programme fidelity at the level of the individual client, nurse and site</p>
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	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.	



<p>10-18 3</p>	<p>Functional Family Therapy (FFT)</p>	<p>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.</p> <p>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.</p> <p>The FFT model has five discreet phases:</p> <ul style="list-style-type: none"> • Engagement in Change, • Motivation to Change, • • Relational/interpersonal Assessment and Change Planning 	<p>Improved child behaviour, Reduced risk of child substance misuse, Reduced risk of child offending, Reduced parent stress/depression/mental health problems</p>	<p>PPET **** rating</p> <p><i>A UK RCT on FFT has not yet reported its results</i></p>	<p>Referral to FFT is usually through the youth justice system, would require awareness raising amongst stakeholders.</p> <p>This is an Intensive model support, fidelity to the model is therefore key.</p> <p>Consideration should be given to the appropriateness of FFT to the Worcestershire rural populations, sparsely populated areas.</p> <p>There is little evidence available regarding the UK setting, long-term follow up outcomes are also unknown.</p>	<p>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.</p>
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4-11 3	<p>Parent Management Training, Oregon Model (PMTO)</p>	<p>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.</p> <p>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.</p> <p>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:</p> <ul style="list-style-type: none"> • Monitoring the child's activities and friends • Family problem solving • Promoting school success • Positive parent involvement. 	<p>Improving children's behaviour and achievement at school and reducing parental depression</p>	<p>PPET **** rating</p>	<p>Enrolment, follow up and referral procedures are locally determined.</p> <p>Recruitment and retention to the programme will be key to success.</p> <p>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.</p> <p>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.</p>	<p>PMTO typically delivered within a CAMHS service</p>
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10-14	1	<p>The Strengthening Families Programme</p>	<p>The Strengthening Families Programme 10-14 (SFP 10-14) is for all parents with children between the ages of 10 and 14.</p> <p>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.</p> <p>The SFP 10-14 programme therefore aims to teach parents and young people skills that will reduce family risks and increase family protective factors.</p>	<p>Improved child behaviour, Improved child achievement , Reduced risk of child substance misuse</p>	<p>PPET **** rating – promising evidence base</p>	<p>Issues around recruitment and retention of families, practitioners will need sufficient capacity for the intensive enrolment and follow up processes.</p> <p>Requires use of appropriate and de-stigmatising language.</p> <p>Practitioners are expected to be able to refer parents on to other services so must be in receipt of relevant signposting information</p>	<p>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.</p>
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3-11	2	<p>Solihull Approach Parenting Group (SAPG)</p>	<p>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.</p>	<p>Improved child behaviour, Reduced parent stress/depression/mental health problems</p>	<p>PPET * rating</p> <p>PPET criticised the Solihull Approach for not defining its target population.</p> <p>Developers advocate its use from 0-18 but the evidence is only there from 4-11.</p>	<p>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.</p> <p>Enrolment usually consists of an initial home visit so may be resource intensive in the more rural areas of Worcestershire.</p> <p>There is no eligibility requirements for the SAPG programme, consideration should be given to likely cost/benefit of a Worcestershire wide service.</p> <p>Practitioners are expected to be able to refer parents on to other services so must be in receipt of relevant signposting information.</p>
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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	<p>There are no eligibility requirements for the programme, consideration should be given to likely cost/benefit of a Worcestershire wide service.</p> <p>There are limited details available on how progress is monitored throughout the programme.</p>	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			<p>Univ. Warwick 2010</p> <p>"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".</p> <p>SSC contact between mother and baby at birth reduces crying, improves mother-baby interaction, keeps the baby warmer and helps women breastfeed successfully.</p>	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.