Cabinet

16 May 2018

Public Health and Children and Young People's Services Update: Best Start in Life

Report of Corporate Management Team

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Councillor Olwyn Gunn, Cabinet Portfolio Holder for Children and Young People's Services

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Purpose of the Report

1 The purpose of this joint report between Public Health and Children's Services is to provide an update to Cabinet on national and local developments with regard to giving every child the best start in life.

Background

2 There is robust evidence[1] and national policy guidelines[2] that emphasise the importance of improving the life chances for children from conception, with a particular emphasis on the early years and reducing the gap in health and social inequalities. Moving through the life course to the age of 19, or 25 for SEND and care leavers, there is a drive towards closing the gap in outcomes for those young people who are disadvantaged such as looked after children, young carers or those who have a special educational need or disability[3]. The underpinning factors that impact on CYP outcomes are poverty, parental employment, quality of housing and educational attainment. Whilst the education component of the wider determinants is considered within the scope of this report the other areas (such as poverty) are outwith and are covered through links to existing groups such as the DCC poverty action group.

[1] Marmot (2014)

[2] NHS Five year forward view for maternity services, Better Births 2016

[3] https://fingertips.phe.org.uk/profile/child-health-overview/data#page/1/ati/102/are/E06000047

National policy / guidance

3 Ensuring every child has the best start in life is one of Public Health England's 7 key priorities. Getting a good start in life and throughout childhood, building resilience and getting maximum benefit from education are important markers for good health and wellbeing throughout life. The earliest experiences, starting in the womb, shape a baby's brain development. During the first two years of life the brain displays a remarkable capacity to absorb information and adapt to its surroundings. Positive early experience is therefore vital to ensure children are ready to learn, ready for school and have good life chances. It is shaped by a number of factors such as:

- sensitive parenting in tune with babies needs;
- effects of socio-economic status;
- the impact of high-quality early education and care.

4 Parents have the biggest influence on their child's early learning. For example, talking and reading to a baby can help stimulate language skills right from birth. Language skills help children to develop a range of cognitive skills that are crucial for their development, including working memory and reading skills. This can help prepare children so that they are ready to learn at 2 and ready for school at 5[4].

Strategic context

5 The best start in life is multi factorial, as described above, and will only be achieved through collaborative working as a system of professionals working in a coordinated way with families. There are mechanisms in place to coordinate the system at both a regional and local level.

Regional

6 At a regional level, providers and commissioners are now operating as local maternity systems (LMS), with the aim of ensuring that women, babies and families are able to access the services they need and choose, in the community, as close to home as possible. The LMS boards must deliver a shift in focus from individual organisations delivering components of maternity care to a whole system approach, embedded in the local community, with robust regional pathways to ensure the best possible care is available at the right time at the right place. Maternity services, and the LMS more broadly, must recognise the leadership role they play in supporting parents of all backgrounds to maximise their own mental and physical health whilst also equipping parents with the skills, information and confidence to maximise their child's emotional, physical and cognitive development. The maternity

[4] https://www.gov.uk/government/publications/health-matters-giving-every-child-the-best-start-in-life/health-matters-giving-every-child-the-best-start-in-life

systems are in a position to identify need through robust assessment procedures and either deliver an intervention themselves or refer on to relevant agencies.

7 The North East have agreed seven public health priorities for during the antenatal period which will impact on health outcomes for both mother and baby as part of the best start in life.

1. Reducing smoking in pregnancy.

2. Increase vaccination uptake in pregnancy (flu and whooping cough).

3. Improve perinatal mental health (MH during pregnancy and first year of baby's life).

4. Reduce alcohol consumption in pregnancy.

5. Increase breastfeeding initiation rates and rates of ongoing breastfeeding at 6-8 weeks.

6. Promoting healthy weight and supporting women who are obese pre-conceptually, antenatally and postnatally. This would include promoting a healthy pre-pregnant weight as well as ensuring full implementation of national guidance for women with a BMI of 30 or more at booking and a postnatal referral for structured weight management support referral in those women who have a BMI 30 or above at the 6 – 8 week check.

7. Increase making every contact count.

Local

8 At a County Durham level the LMS seven prevention must do's are being incorporated into the work of the Best Start in Life delivery group which is a sub group of the Children and Families Partnership. County Durham and Darlington Foundation Trust (CDDFT) are an instrumental partner in the BSIL delivery group and in March 2018 the Care Quality Commission highlighted that the maternity services were safe, responsive, caring, effective and well led.

9 A self-assessment process has been undertaken in County Durham through the BSIL multi-agency delivery group. This process generated rich intelligence at a local level on how County Durham is performing on BSIL as a system.

10 The self-assessment process incorporated the following sections:

- Profile of data (intelligence)
- Local need: factors associated with low levels of school readiness
- Leadership, planning and partnership working
- Wider determinants (includes poverty, housing, leisure)
- Pre-conception support (including drug and alcohol, domestic abuse)

- Transition to parenthood, including healthy pregnancy and early weeks
- Breastfeeding (initiation and duration)
- Healthy weight, healthy nutrition (to include physical activity)
- Health, wellbeing and development of the child age two
- Maternal mental health
- Minor illness and accidents.

11 A detailed summary of the results generated from the self-assessment tool can be made available upon request. From the detailed intelligence the multi-agency delivery group then prioritised actions to become part of a BSIL framework for action.

12 The table in Appendix 2 shows a list of priorities which can be broken down into three sub sections:

<u>County Durham system improvement (Linked to Healthy Child Programme Board)</u>

1. Planning and commissioning – improved integration
2. Map universal offer - and then add on graded support for more targeted work with SEND, LAC, Care leavers
3. Data and intelligence – local health profiles

<u>Best start in life delivery group: task and finish work</u>

1. Maternal mental health & child emotional wellbeing – assessment, early intervention and appropriate referral to specialist services
2. Healthy weight / obesity – preventing weight gain before reception age
3. Speech and language development – pathway - bump and beyond
4. Universal 1 year assessment- to be built in to revised 0 – 19 commission
5. Support for vulnerable parents beyond the Vulnerable Parent Pathway
6. Unintentional injuries / minor illness – targeted work with social housing
7. Oral health inequalities – targeted work on workforce and tooth brushing.

<u>Regional work (Local Maternity System (LMS) or other groups in County Durham taking work forward</u>

1. Smoking at time of delivery
2. Breastfeeding – call to action task group
3. Alcohol consumption in pregnancy: assessment/ brief intervention (LMS)
4. Vaccination uptake: improved commissioning / increasing uptake(LMS)
5. Making every contact count: work force development (LMS)
6. Child poverty – poverty proofing all polices, plans and interventions. Make greater links with the County Durham poverty action group.

13 From this priority list there are task and finish groups currently underway to progress the work. A BSIL performance score card has been completed,

linked to the identified priorities. The level of ambition to improve in the priority areas has been agreed for the local maternity system priorities and further work is planned for local metrics to set the level of ambition for the rest of the priorities.

14 A County Durham BSIL framework and action plan will be finalised, which will require consultation and ratification at the Children and Families Partnership and the Health and Wellbeing Board.

National and local intelligence and progress against priority areas

15 To understand County Durham's position against the set LMS / BSIL priorities the following section provides a highlight of the main indicators and high level actions which have been progressed.

Perinatal mental health

16 One of the strongest predictors of wellbeing in the early years is the mental health and wellbeing of the mother or caregiver. Up to 20% of women experience a mental health problem during pregnancy or within a year of giving birth - this can have significant and long-term consequences for mother and baby.

17 Children of mothers experiencing perinatal mental illness are at increased risk of prematurity and low birth weight, irritability and sleep problems in infancy. Maternal depression can increase a child's risk of behavioural problems, emotional problems, conduct disorders, language development delays and impaired parent child interaction, all of which can have a negative impact on school readiness.

18 In the most extreme cases, perinatal mental illness increases the risk that children will be abused or neglected. Perinatal depression, anxiety and psychosis carry a total long-term cost to society of about £8.1 billion for each one-year cohort of births in the UK.

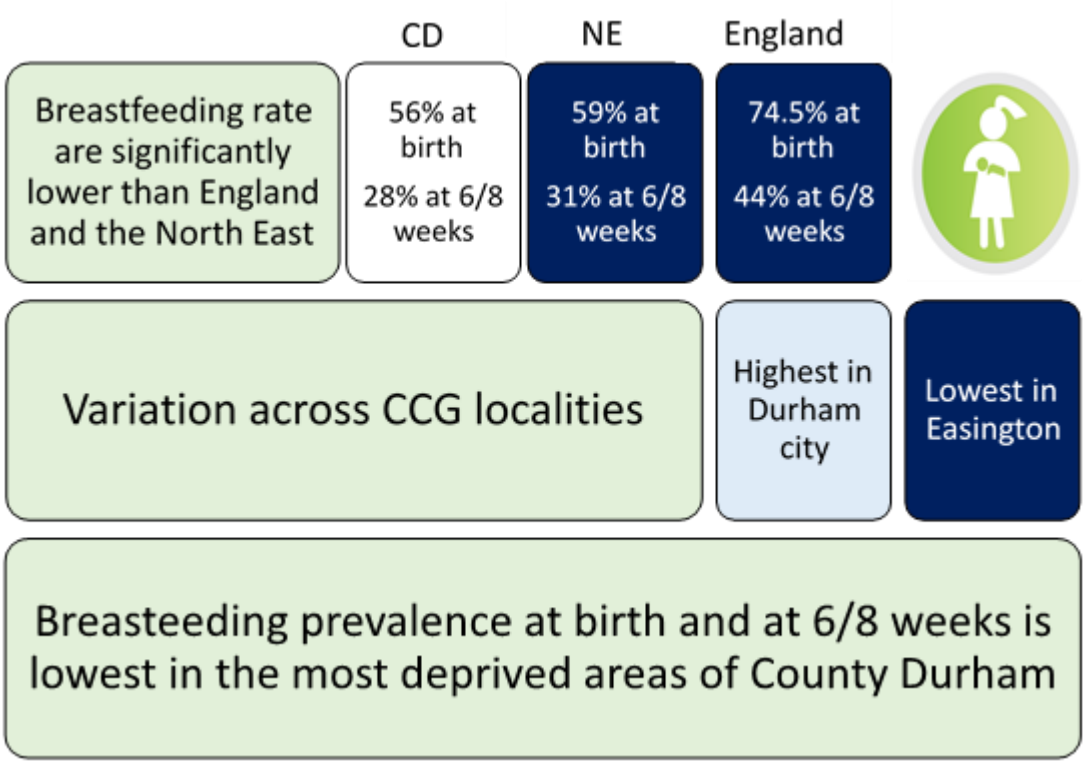
19 The two North East LMS boards are utilising successfully secured PHE funding to roll out a regional workforce development programme to ensure all front line staff (midwives, health visitors, children's services early help staff) are competent and confident to assess, provide brief intervention and sign post / refer women with complex needs into appropriate services.

Breastfeeding

20 Breastfeeding has an important role to play in reducing health inequalities and especially if sustained for the first six months of life, can make a major contribution to an infant's health and development and is also associated with better health outcomes for the mother. Despite the evidence of the benefits of prolonged exclusive and partial breastfeeding, England has one of the lowest breastfeeding rates in Europe, with some areas of County Durham recorded as having the lowest breastfeeding rates in England.

21 The reasons for this are multifaceted and include the influence of society and social and cultural norms. The uptake of breastfeeding is also strongly associated with ethnicity, high maternal socio-economic status and educational attainment. Lower income groups, which have a higher incidence of low birth weight infants and infectious diseases in childhood, have the potential for greatest health gain from increased breastfeeding.

Figure 1: Key information on breastfeeding initiation and 6/8 week prevalence in County Durham. Source: Fingertips, Public Health England and County Durham Breastfeeding Health equity audit



22 Improving breastfeeding rates is a complex process that requires an integrated approach involving a multi-agency response. There is a County Durham plan for Breastfeeding with a planned communication strategy during 2018/19. Aspirational improvement targets have been set to work towards improving breastfeeding rates over the next five years.

Smoking in pregnancy

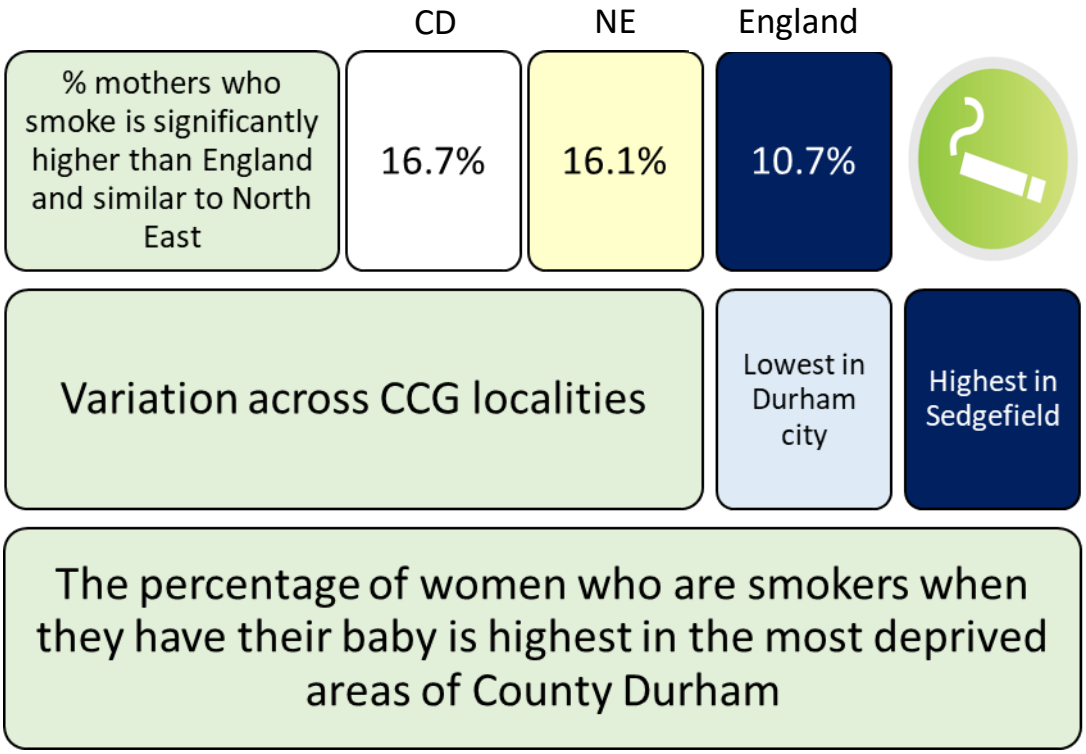
23 Smoking can have devastating consequences for expectant mothers and their babies. Smoking during pregnancy increases the risk of stillbirth, and babies born to mothers who smoke are more likely to be born underdeveloped and in poor health. Maternal smoking after birth is associated with a threefold increase in the risk of sudden infant death. The Governments 2017 tobacco plan aims to reduce the number of women smoking during pregnancy to improve life chances for children.

24 Through the North East, the council commissioned regional tobacco programme 'Fresh-Smokefree North East', is co-ordinating a regional approach with maternity services and stop smoking services to implement and embed the NICE Clinical guidance for reducing smoking in pregnancy and after birth. The continuation and drive for this is being lead through the Regional Smokefree NHS/Treating Tobacco Dependency Task force.

25 In County Durham 16.5% of women continue to smoke in pregnancy. This is almost 900 babies born every year to mothers who continue to smoke throughout their pregnancy. There is also greater variance in smoking in pregnancy across the county with higher rates in Durham Dales Easington and Sedgefield (DDES) CCG than North Durham CCG. To address this a smoking in pregnancy incentive scheme has been implemented to increase the uptake to stop smoking support amongst these women. The final results will be available Autumn 2018.

26 The success of the implementation of NICE clinical guidance locally has resulted in the County Durham stop smoking service achieving the highest percentage of pregnant smokers quitting in the north east and amongst the highest in the England.

Figure 2: Key information on % mothers smoking at time of delivery in County Durham. Source: Fingertips, Public Health England and DCC Public Health Intelligence team analysis

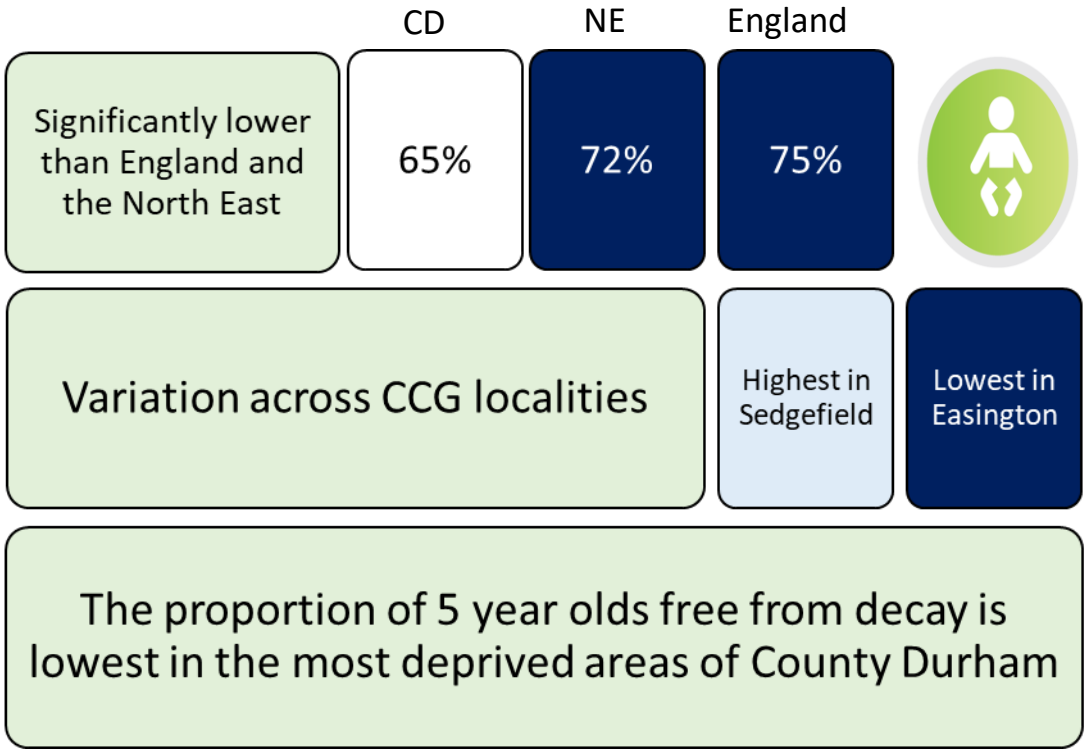


Oral health

27 Tooth decay can have a significant impact on children - and those who have toothache or need treatment may have difficulties with eating, sleeping and socialising. Poor oral health may also impact on school readiness / absence and is the top cause of child admissions to hospital for 5-9 year olds. Dental neglect can also be an indication of wider safeguarding issues.

28 County Durham has an established oral health strategy which is making progress against the action plan. Following Cabinet approval in December 2017 the feasibility of expanding the community water fluoridation scheme across County Durham is being considered. Working in partnership between public health, dentists, early years and health visitors there is a targeted tooth brushing scheme being rolled out in nurseries within the top 30% most deprived areas of County Durham

Figure 3: Key information on % five year old children free from dental decay in County Durham. Source: Fingertips and County Durham Dental Health profile 2015, Public Health England.



Childhood obesity

29 Since the inception of the National Child Measurement Programme levels of childhood obesity have remained unacceptably high. It is acknowledged that overweight children are more likely to maintain their overweight status as they progress through childhood into their adult years, which in turn has implications for their overall health and life expectancy.

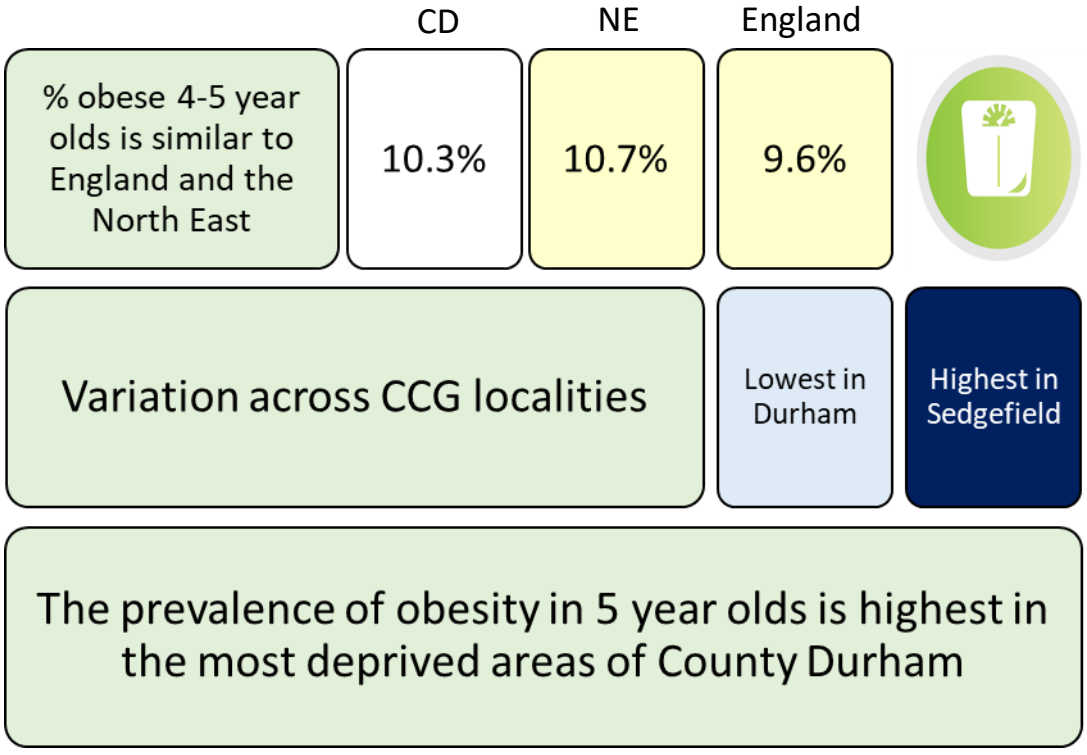
30 It is also recognised that there is a strong correlation between the levels of obesity and overweight and socioeconomic deprivation, with the poorest children having the greatest rates of obesity.

31 The national Childhood Obesity Plan tasks PHE with leading on many actions, including:

- working with the food industry to take 20% of sugar out of food products;
- working with the Department for Education to give support to schools and public health professionals to encourage children to meet the Chief Medical Office's guidelines for physical activity;
- creating resources which support parents to make positive decisions to adopt healthy lifestyle, guiding local authorities to use these for their communities and signpost their residents to these materials.

32 At a local level County Durham has recently refreshed its vision for achieving healthy weight targets and clear actions are in place being progressed by the Healthy Weight Alliance.

Figure 4: Key information on % children aged 4-5 measured as obese in County Durham. Source: Fingertips and County Durham Dental Health profile 2015, Public Health England



Teenage pregnancy

33 Pregnant teenagers have three times the rate of post-natal depression of older mothers, higher rates of poor mental health for up to 3 years after the

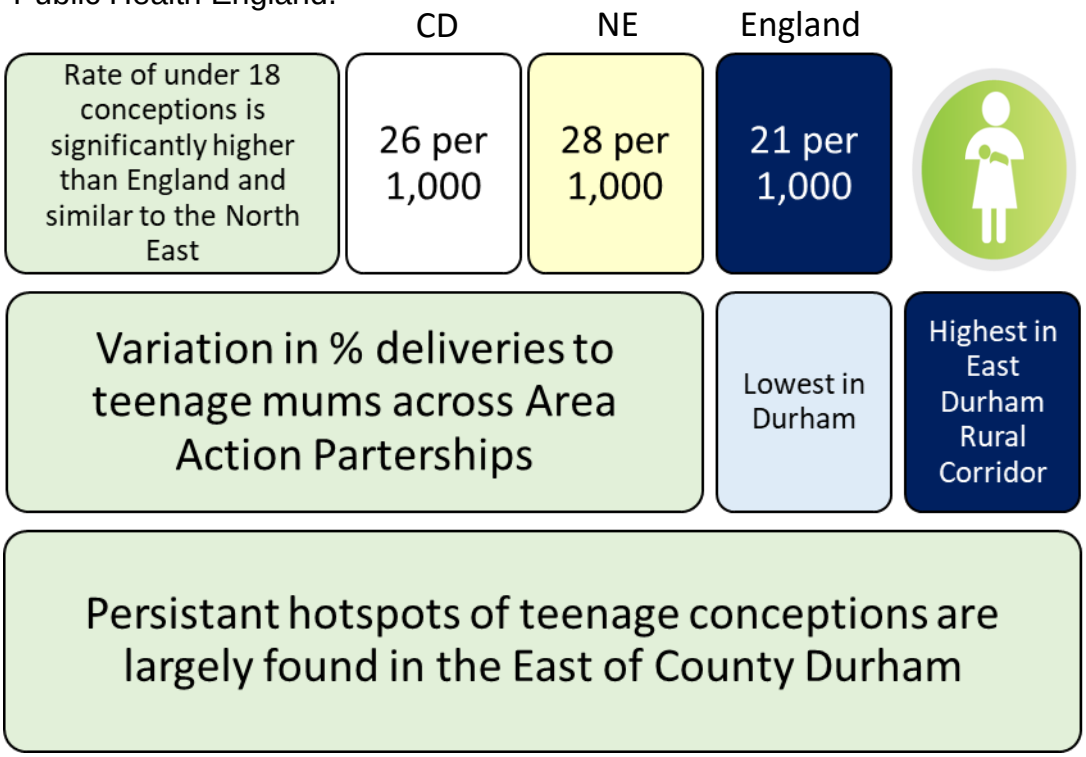
birth, are more likely to live in poor quality housing and are at a higher risk of partnership breakdown and isolation.

34 PHE has developed a framework for supporting teenage mothers and young fathers, which is designed to maximise the assets of all services and practitioners to create a joined-up care pathway. The framework is aimed at helping commissioners and service providers review current support arrangements for young parents in their local area. At a strategic level, good support:

- is integral to safeguarding, the early help agenda and improving life chances;
- is key to giving every child the best start in life;
- breaks intergenerational inequalities;
- reduces future demand on health and social services;
- contributes to public health and NHS outcomes.

35 At a local level in County Durham there is a teenage pregnancy strategy and action plan being actively progressed and more in depth work reviewing the looked after children population and care leavers who have a higher propensity to become a young parent. CD has had a 60.3% change in U18 conception rates from 1998-2016.

Figure 5: Key information on rate of under 18 conceptions and deliveries to teenage mothers in County Durham. Source: Fingertips and Local Health, Public Health England.

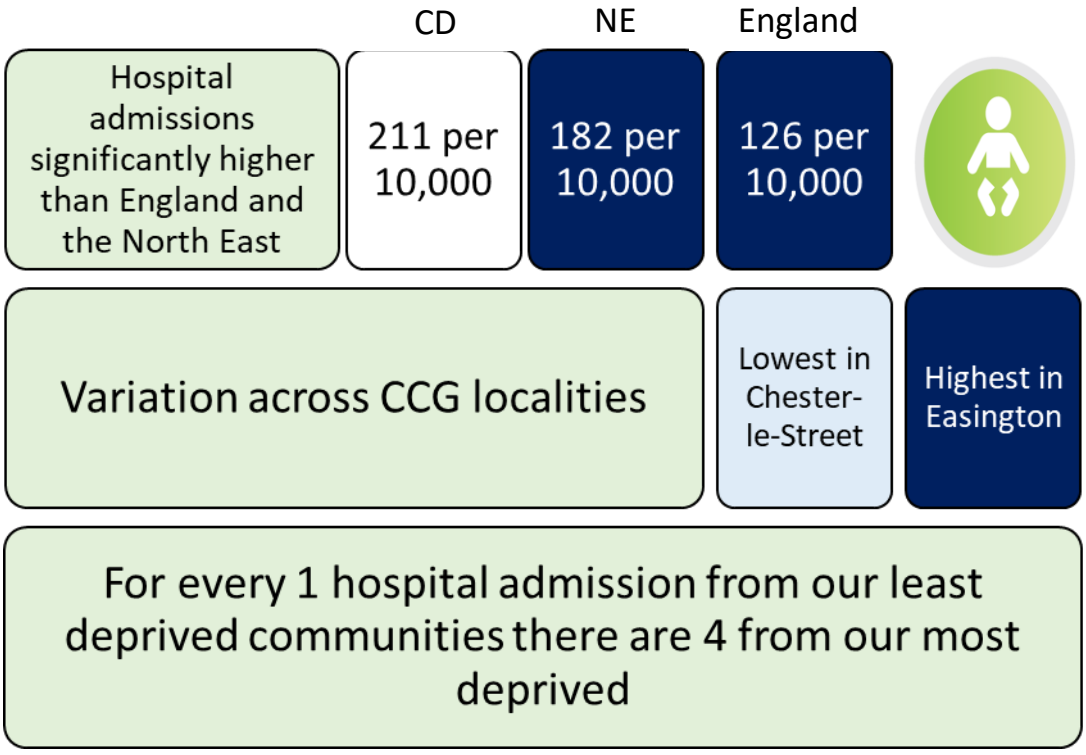


Unintentional injuries

36 There is a strong link between child injuries and social deprivation – children from the most disadvantaged families are far more likely to be killed or seriously injured due to accidents.

37 At a local level in County Durham there is an unintentional injuries framework with a clear action plan. For children aged 0 – 4 years the most common place for an unintentional injury to occur is in the home environment. There is work taking place between housing colleagues and health to reduce these incidences.

Figure 6: Key information on hospital admissions for unintentional and deliberate injuries in children aged 0-4 years. Source: Fingertips and Local Knowledge and Intelligence Service – North East, Public Health England



Speech, language and communication

38 Reducing inequalities in speech, language and communication development is a BSIL priority and PHE has been working with a range of organisations to emphasise the health, as well as the educational, benefits of an improvement in speech, language and communication.

39 PHE has commissioned the Education Endowment Foundation to carry out a review of evidence on early language development to assess current need and provision and to identify the most promising approaches and programmes to support children's language development from 0-5 years.

40 At a local level the pathway for speech and language, starting from conception, is being reviewed to understand what support is available from a universal to targeted level. The mandated Health Visitor contact at 2-2.5 years assesses the speech and language development of the child. Within the next 12 months this data will be nationally available for benchmarking and to better monitor improvement trajectories.

Early Years – Children's Centres

41 Following the implementation of the Children's Centres review in March 2015, a strategy was developed to reduce inequalities in the county and ensure that the most vulnerable children and families would benefit from local services, at the same time providing opportunities for children to get the best start in life.

42 A concerted effort has been made to target services to those who live in deprived communities or who are vulnerable for other reasons, such as teenage parents, children in need and children on the child protection list. As part of the strategy, the One Point service and the early years team within the Education Development Service both support its quality improvement framework.

43 There has been an overall improvement in the number of children registered with a Children's Centre since 2013 and a significant improvement in registrations and contacts with families who live in the top 30% most deprived wards and with teenage parents and other vulnerable groups. This reflects the intention of the Children's Centre review and is evidence that the new approach is successful in supporting children and families who most need services.

44 The percentage of children under the age of five years who are registered with a Children's Centre, who live in the top 30% most deprived wards, is 91%. This compares to only 66% in 2010 and 86% in 2013 and shows a steady increase in registrations over the past five years. (No national or statistical data are available for comparison.)

45 The percentage of children under the age of five years who live in the top 30% most deprived wards and have been contacted by a Children's Centre is 85%. This compares to 43% for 2010 and 68% in 2013. (No national or statistical data are available for comparison.)

46 The percentage of children under two years who live in the top 30% most deprived wards with sustained contact (four or more contacts) with the Children's Centre in the last year is 87%. Sustained contact data for 2015 was 83%. Historical data is not available, as it was not collected at the time - but it is likely to have been substantially less. (No national or statistical data are available for comparison.)

Vulnerable groups

47 A key role for Children's Centres is to identify and provide additional support to children and families at risk of poor outcomes, aimed at reducing

inequalities. Children and families on or above level 3 on the County Durham Level of Need Staircase, including those with special education needs and disability and children of teenagers, are specifically targeted for additional support.

48 The percentage of teenage mothers with at least one contact with a Children's Centre is currently 97%. This compares to 72% in 2012 and 86% in 2015. Six centres have achieved 100% contact.

49 The percentage of teenage mothers with sustained contact is currently 83%, this compares with 35% for 2014. Sustained contact data for previous years is not available as it was not collected at that time.

50 There has been a noticeable decline in actual numbers of teenage mothers since 2012 - in part due to the success of the teenage pregnancy strategy in helping to reduce the size of the cohort - but a much higher percentage is now supported through Children's Centres.

Free early education and childcare

51 The Early Years Team in the Education Development Service works together with Children's Centre Leaders to identify eligible families who are not taking up the offer of free nursery places for two year olds. The offer was first introduced in the 2014 autumn term. There has been an increase in the number of families taking up this offer and County Durham data compare favourably with the regional and national data.

	2015	**2016**
National	62%	70%
Regional	69%	81%
Durham	68%	87%

52 From September 2017, the Government increased the amount of free childcare for three and four year olds, from 15 hours entitlement to 30 hours, over 38 weeks of the year. Schools in County Durham and private and voluntary and independent (PVI) settings and childminders are being encouraged to make provision available five days a week and in school holidays.

53 The Children's Centres are supporting the delivery of this entitlement by providing support for families who need additional help to access the offer. This also involves supporting parents to gain employment.

54 The collection of Early Years Foundation Stage (EYFS) performance data enables the early years Education Development Service to share local

information with the Children's Centre Leaders, so that they can agree how to work with partners to continue to improve local performance.

55 There has been an increase in the number of children achieving a good level of development in the EYFS and the table overleaf shows how County Durham compares with the national average.

	2014	2015	2016
National	60.4 %	66.3%	69.3%
Durham	56.7 %	63.5%	69.1%
National / Local Authority gap	3.7 % points	2.8 % points	0.2 % points

56 The latest data for County Durham (Quarter 2, 2017/18) shows a continued improvement at 72.0%.

Next steps

57. The next steps for Best Start in Life is to embed the work into the newly formed children's integration steering group and the priorities will feature in any future children's strategy.

Recommendations and reasons

58 Cabinet is recommended to:

(a) Note the contents of this report;

(b) Agree to receive further updates in relation to Children and Young People's Services on a quarterly basis.

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Appendix 1: Implications

Finance – None.

Staffing – None.

Risk – As the 'Best Start in Life' programme is dependent on a wide range of agencies, including local authorities and stakeholders such as schools, partnerships and project boards, there is a risk from variable commitment and investment of time/resources. Governance is in place to mitigate this risk as far as possible.

Equality and Diversity / Public Sector Equality Duty – All engagement with all aspects of the programme complies with equalities legislation. An increased emphasis on diversity is implicit in the BSIL framework and action plans.

Accommodation – None.

Crime and Disorder – None.

Human Rights – None.

Consultation – None.

Procurement – None.

Disability Issues – The programme complies fully with disabilities legislation.

Legal Implications – None.

Appendix 2: LMS and BSIL key priorities

Key action	Leadership	Action	Comments
1. Planning and commissioning	Healthy Child Programme Board (HCPB) BSIL Delivery Group	Raise profile of BSIL Joint planning Joint commissioning Joint leadership	Detail to be worked through by HCPB (BSIL subset of 0–19 /24 SEND/CLwork)
2. Map universal offer – who does what? - and then add on graded support for more targeted work	HCPB BSIL Delivery Group	Visual depiction of who delivers what and when Wrap around wider determinants pathways Purpose - front line staff all have shared understanding of pathways of support	Build picture from conception to three and then increase age range through HCPB
3. Data and intelligence	HCPB BSIL Delivery Group	Health intelligence team to create BSIL profiles for County Durham at children centre cluster levels	Will require sharing data on partner systems
4. Maternal mental health Child emotional wellbeing	CYP mental health local transformation plan group HCPB LMS	End to end pathway available in County Durham with single point of contact Workforce appropriately trained PNMH action	Awaiting national funding roll-out for specialist pathway PNMH training to all midwives with LMS funding
5. Healthy weight / obesity	BSIL Delivery Group Healthy Weight Alliance Active Durham Partnership LMS	Workforce development Review and plan quality metrics for early years settings HENRY programme?	Part of whole systems approach to obesity
6. Speech and language development	BSIL Delivery Group HCPB	SAL pathway from conception Design intervention for early years setting Workforce development	Universal through to a graded response for targeted need
7. Universal 1 year assessment	BSIL Delivery Group	Review current tools, pilot, review and roll-out Workforce development Earlier universal intervention	Links to speech and language pathway above

8. Support for vulnerable parents beyond the Vulnerable Parent Pathway	LSCB HCPB	Review vulnerable parent pathway and graded response to need Parents with additional needs and pathways of support available	Gap in BSIL self-assessment but a clear need identified for drug and alcohol, adult mental health
9. Unintentional injuries / minor illness	BSIL Delivery Group HCPB	Review data on non-elective admissions for 0-5 population Target populations and spend based on need Housing and Early help to target work	Link to unintentional injuries framework and poorly child pathway Baby Buddy app
10. Oral health	BSIL Delivery group	Workforce development Implement targeted tooth brushing schemes in top 20% areas of need with higest oral health inequalities	Oral health strategy
11. Smoking at time of delivery	County Durham tobacco alliance	Implement NICE guidance	
12. breastfeeding	Breastfeeding action group	Action the BF action plan and call to action	Requires community and system level sign up
13. Child poverty	Child poverty group	Ensure that child poverty is reflected in all policies, plans and commissions	Increase the profile of poverty in BSIL self-assessment
14. Alcohol consumption in pregnancy	LMS Alcohol harm reduction group	Establish baseline levels and design and implement standard pathway	
15. Vaccination uptake	LMS Regional Public Health Oversight Group	NHS England to commission maternity units directly	
16. Making every contact count	LMS Regional MECC group	Develop standardised module for staff on maternity pathway	