Early Help Needs Assessment

Authors: Ian Mather, Angie Collard, Gary Baker and Rob Davies

Organisations: Solihull MBC Public Health and Solihull Observatory

Publishing history: Originally published March 2016. Updated April 2017

Early help needs assessment

Contents

1. Executive Summary

This detailed needs assessment tells a story of relative success. Overall, children and young people born and growing up in Solihull can expect to enjoy health and wellbeing that is as good as, or significantly better than, England as a whole.

But this hides consistent, and often large, health inequalities between the regeneration wards in the north, and the relatively affluent south. This provides justification for a continued focus on providing the best start for all Solihull's children, with a focus on those that need the most help for a fair start in life.

Given Solihull's comparative affluence to the rest of England we should expect it to be doing well, but we are far from best in the country, so can do a lot better.

Below we focus on our lowest performing areas; those that fall below the national average, or are poor performing in comparison to areas with similar demographics to Solihull –called our nearest statistical neighbours.

This summary mirrors the life-course structure of the main report:

- Preconception and pregnancy
- Early years
- School years
- Adolescence
- Vulnerable groups
- Early years provision
- Health inequalities

Preconception and pregnancy

No outcomes were significantly worse than the England average.

Outcomes where Solihull's performance appears worse than its nearest statistical neighbours are:

- Low birth weight babies
- Perinatal mortality

It is important that we monitor trends on this cluster of indicators as there may be underlying issues such as maternal obesity or mental health that are driving them, but for which we don't currently have data.

Our latest data on smoking in pregnancy is out of date due to known problems collecting valid data from our provider the last two years, so we have a blind spot there. Historically we know rates are high in the north of the borough where 1 in 4 pregnant mums smoke, compared to just 1 in 14 in the rest of Solihull.

Early years

Outcomes where Solihull is considerably worse than the national average:

- Breastfeeding initiation

We have a high quality community breastfeeding service which has achieved full accreditation from UNICEF's Baby Friendly Initiative. Breastfeeding rates at 6-8 weeks have risen steadily over the last few years and are similar to national averages (and in the middle range compared to our statistical neighbours). However, the below average levels of breastfeeding initiation on maternity wards limits the improvement that can be made in borough wide breastfeeding rates. There are considerably lower breast feeding rates at 6-8 weeks in the north of the borough compared with the south.

Childhood vaccinations – although Solihull's performance is better than the national average our performance is lower the 95% herd immunity target for MMR at 2 and 5 years.

School readiness – overall Solihull scores are similar to the national average on the Early Years Foundation Stage Profile (EYFSP) and second best among our statistical neighbours. Solihull is strong on two of the seven learning areas - literacy and maths – but is below the national average on all the others.

As the EYFS is being withdrawn there is an urgent need to replace this measure so that child development at this crucial stage can be monitored, and those with the hardest start in life don't fall further behind.

School years

Outcomes where Solihull is considerably worse than the national average:

- School exclusions.

Solihull has a significantly higher rate of both fixed period and permanent exclusions from school compared with England and the highest rate among its statistical neighbours by a large margin.

Childhood obesity – although lower than the England average and similar to statistical neighbours, obesity remains a national problem and one that demonstrates the health inequalities in Solihull. Data from the National Child Measurement Programme reveals that obesity rates are on the increase in the regeneration wards whereas they have levelled off in the rest of Solihull.

Some other findings on the health of school aged children are derived from the Health Related Behaviour Questionnaire (HRBQ) which is completed by nearly 10,000 school pupils in Solihull every other year. The last survey was carried out in March 2016. Analysis carried out by the School Health Education Unit at Exeter University allows us to draw comparisons with other authorities while internal analysis carried out by the Solihull Observatory allows us to compare performance between the five collaborative areas.

Key messages from the HRBQ (2016).

- Self esteem – at all ages self esteem is lower for girls than boys and is lowest among 15 year old girls. Girls in Unity have lower self esteem scores than in other collaboratives. This this is replicated for boys in the north, but the differences are less extreme.

- Bullying – nearly half of girls at primary school this age are “sometimes, often or very often” afraid of going to school. Pupils at different collaboratives report very different levels of bullying, sometimes affecting girls more, sometimes boys.
- Only around 20% of children and young people report eating at least 5 portions of fruit or vegetables in secondary schools. Many school collaboratives report much lover levels.
- Physical activity rates in secondary school decline with age. Girls have strikingly lower physical activity levels than boys.
- Drugs, alcohol and smoking are all down in line with national trends.
- A roughly similar proportion of children and young people are saying that their school cares about whether children are happy in recent years. Although this rate falls from around 80% in primary school to around 50% in secondary school.

Adolescence

There were no adolescent indicators where Solihull’s performance was considerably worse than the national average. Many of the outcomes had wide confidence intervals, meaning only very large differences in outcomes would be detected.

Although not significantly different to the England average, Solihull was the worst performing among its five statistical neighbours for first time entrants to the youth justice system, with many neighbours performing significantly better.

Vulnerable groups

Solihull has significantly higher rates of the following vulnerable groups compared with the national average, and highest rates among our statistical neighbours:

- The number of looked after children (per 10,000 under 18s)
- The number of children in need (per 10,000 under 18s)
- Family homelessness (rate per 1,000 households)

Family homelessness represent people who have approached the council as homeless and are eligible for statutory help because either a woman is pregnant, or there are existing dependents. So this represents a measure of met need.

The council have recently commissioned a youth homelessness hub, which aims to prevent and alleviate the risk and consequences of homelessness affecting 16-24 year olds.

Data from 2014/15 shows that:

- Solihull has a referral rate to Children’s Social Work that is similar to the national average. However, this rate is higher than all its statistical neighbours.
- Rates of S47s and Initial Child Protection Conferences (ICPC) are higher than England as a whole and have increased significantly over the last two years: S47s have doubled and ICPCs are up by 50% during that period.

Early years provision

- Solihull has the highest proportion of three and four year olds benefiting from funded early education among its statistical neighbours. In fact Solihull records the third highest take up rate in the country.
- Spends the second highest amount on two year old funded places (by head of population) compared to its statistical neighbours - and contributes more its allocation than any statistical neighbour.
- Has the second highest number of early years settings rated good or outstanding by OFSTED
- However it is 4th out of the six nearest statistical neighbours in terms of the percentage of qualified staff who work with two year olds.
- Solihull has the lowest spend per head on three and four year olds.

Health inequalities

The difference in health and health-related outcomes between the regeneration wards and the rest of the borough is evident on nearly all the indicators we looked at.

To take just one example, there is a six fold difference between the ward with the least teenage conceptions (Meriden) and the ward with the most (Chelmsley Wood).

As one of the goals of early help is to improve life chances and outcomes for the most disadvantaged by intervening early, there is strong needs-based argument for improvement.

The level of child poverty is lower than the England average, with 15.7% of children aged under 16 years living in poverty in Solihull compared to 18.6% in England as a whole.

Despite this, the latest figures on deprivation in Solihull suggest that economic austerity is having an impact. For the first time Solihull has areas that are in the 5% most deprived in the country. Relative to England, Solihull's poor are falling further behind.

These areas are all located in the regeneration wards and these are the wards where most of our young people live . We need to ensure that our focus is on addressing these health inequalities.

2. How to read this report

To make this report easier to read, data are presented in a consistent format where possible. For each indicator there are two charts:

1) Trend - shows Solihull's performance over multiple years compared to the England average.
2) Benchmark - shows Solihull's performance compared with its five nearest statistical neighbours.

The latest annual data have been used to compile this report, but as data sources vary, so does the latest data available.

Where the number of annual events is small, and consequently random variation is introduced, a three year time period has been used to give a more accurate picture.

Statistical neighbours

Statistical neighbour models provide one method for benchmarking performance. The statistical neighbours used in this report are those derived by the Department for Education and which are deemed similar in terms of the socio-economic characteristics.

Closest Statistical Neighbours

Rank (1=Closest)	Name
1	Stockport
2	Warrington
3	Trafford
4	Cheshire West and Chester
5	Central Bedfordshire

Source: Department for Education

The benchmarking charts have a red-amber-green (RAG) rating according to how they compare to the national average. Interpretation of the colours differs slightly according to the nature of the data.

	If 95% confidence intervals (CIs) shown …	If no CIs shown …
Better	Significantly better than England average	Performance in upper quartile (top 25% of authorities)
Similar	Not significantly different	Performance in inter-quartile range
Worse	Significantly worse than England average	Performance in bottom quartile

A confidence interval gives a range of values that is used to quantify the imprecision in the estimate of a particular indicator. Specifically it quantifies the imprecision that results from random variation in the measurement of the indicator. A wider confidence interval shows that the indicator value presented is likely to be a less precise estimate of the true underlying value.

Throughout this report we use 95% confidence limits which are indicated by the whisker plots (I----I)

3. Population profile

The shaded cells in the following table highlight where the proportion of each age band (2013 ONS latest mid year estimates) in individual wards is higher than the average for Solihull. The North Solihull Regeneration wards (first three rows) are notably younger than the rest of the borough: this is most pronounced for the youngest age group.

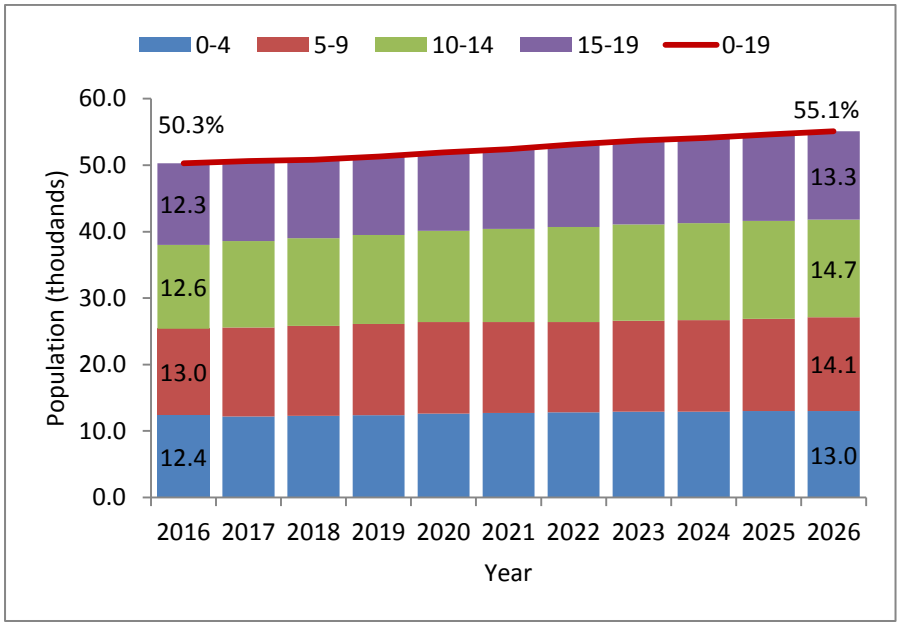
Table 1 Age profile by ward

Ward Name	All Ages	0-4	5-9	10-14	15-19	0-19 (nos)	0-19 (%)
Smith's Wood	12,603	1,046	921	876	941	3,784	30.0%
Kingshurst and Fordbridge	12,976	1,084	933	864	865	3,746	28.9%
Chelmsley Wood	12,601	1,109	910	747	817	3,583	28.4%
Dorridge and Hockley Heath	11,126	523	718	841	791	2,873	25.8%
Shirley East	11,845	672	737	771	773	2,953	24.9%
Lyndon	13,583	808	749	872	880	3,309	24.4%
Blythe	13,423	784	852	755	748	3,139	23.4%
Bickenhill	12,295	697	705	732	730	2,864	23.3%
Meriden	11,931	561	673	795	736	2,765	23.2%
Elmdon	12,324	663	692	740	744	2,839	23.0%
St Alphege	13,570	581	695	839	1,005	3,120	23.0%
Shirley West	11,875	670	661	641	733	2,705	22.8%
Olton	12,408	637	710	695	774	2,816	22.7%
Silhill	12,138	727	680	622	607	2,636	21.7%
Knowle	10,814	470	602	652	621	2,345	21.7%
Shirley South	12,119	596	574	612	743	2,525	20.8%
Castle Bromwich	11,230	437	467	517	699	2,120	18.9%
Solihull	**208,861**	**12,065**	**12,279**	**12,571**	**13,207**	**50,122**	**24.0%**

Source: ONS mid year estimates 2013

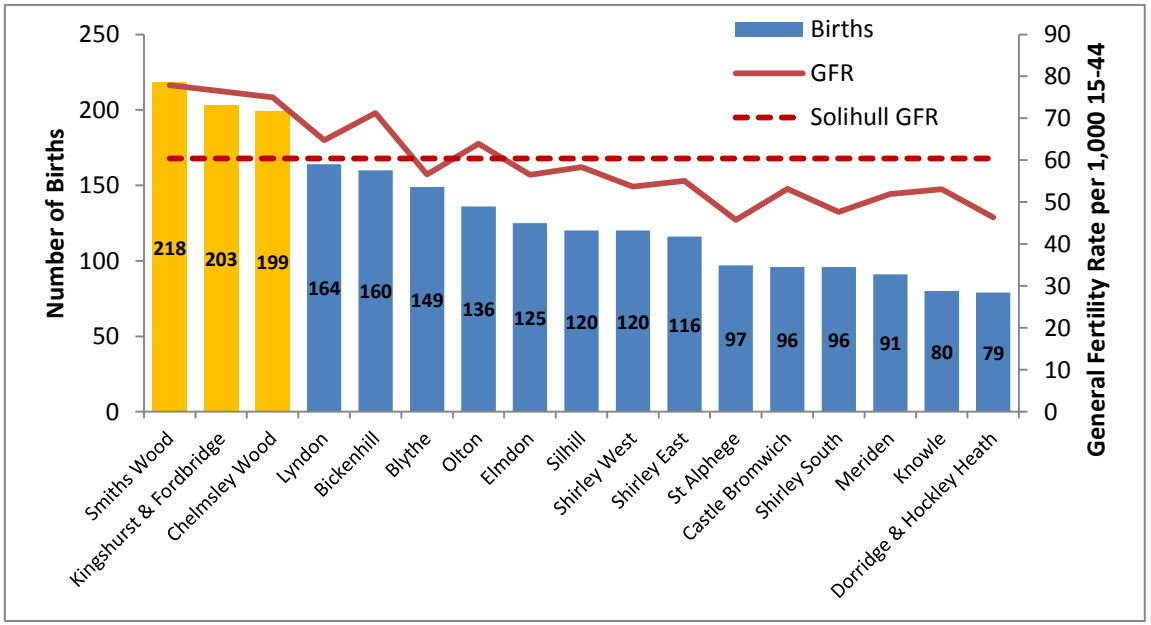
Office for National Statistics population projections for Solihull predict an almost 10% rise in the 0-19 population over the next 10 years (9.8% 2016 to 2026). The fastest rise is predicted in 10-14 year-olds, at 17.6%.

Figure 1a 10-year population projection for Solihull children and young people aged 0-19 year



Source: ONS 2014-based Subnational Population Projections for Local Authorities and Higher Administrative Areas in England

Figure 1b Births and General Fertility Rate (GFR) by Solihull ward. The GFR is the total number of live births per 1,000 women of reproductive age (ages 15 to 49 years) in a population per year. North Solihull Regeneration Wards are coloured orange.



Source: ONS (2013)

The general fertility rate in Solihull has risen steadily over the last five years (by 8% between 2008 and 2013). Over the same period the rate has decreased in England (by 2%) and also across the West Midlands as a whole (by 2.5%).

4. Socio-economic background

The 2015 Index of Multiple Deprivation (IMD) replaces the Indices of Deprivation 2010 as the official measure of deprivation in England. The IMD combines a number of indicators, chosen to cover a range of economic, social and housing issues, into a single deprivation score for individual neighbourhoods called Lower Super Output Areas (LSOAs) in England. There are 32,844 LSOAs in England and 134 in Solihull and the minimum population for a LSOA is 1,000 and the average is 1,500. The Index of Multiple Deprivation, therefore, allows each neighbourhood (LSOA) to be ranked according to their level of deprivation.

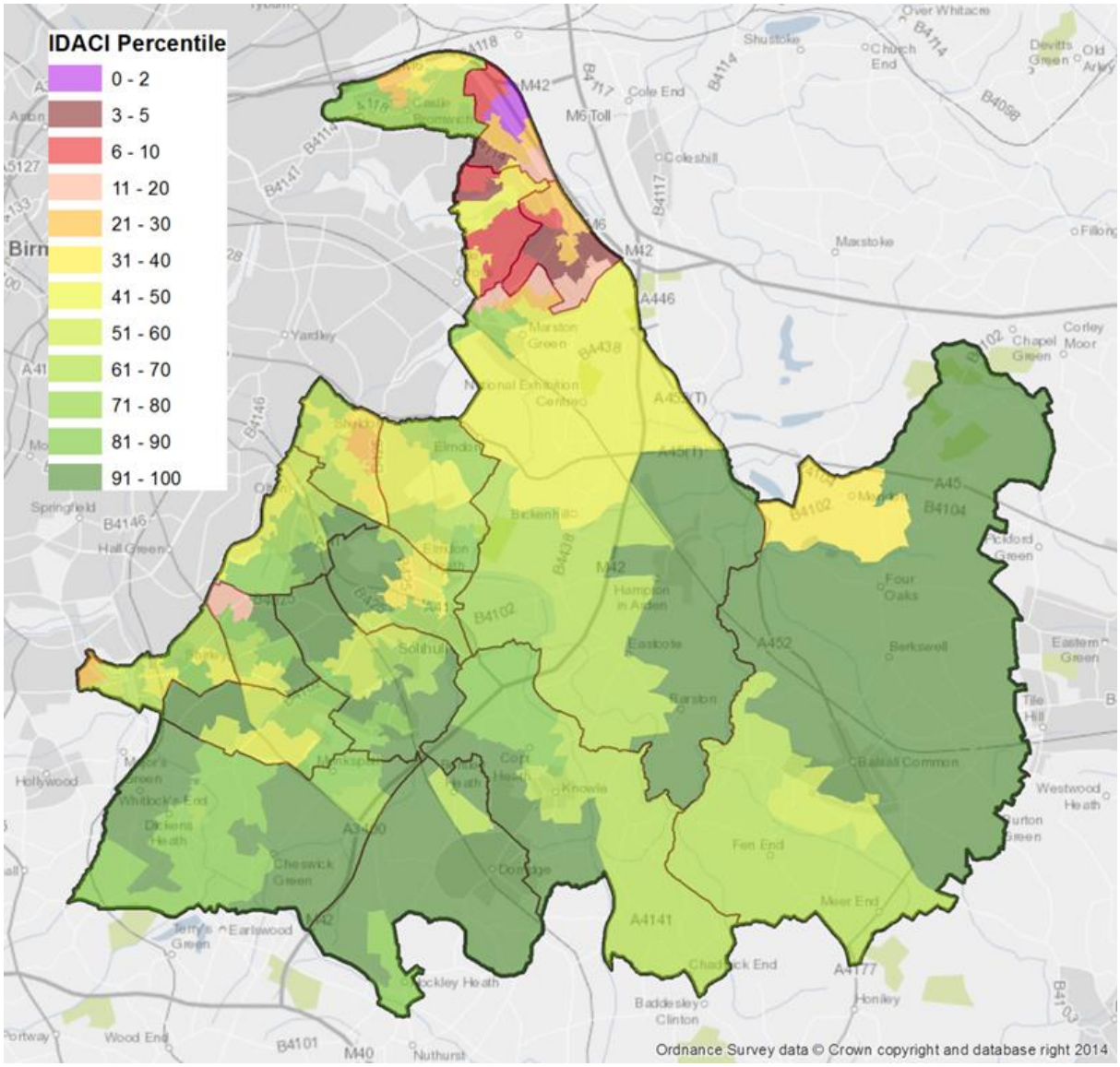
Income Deprivation Affecting Children (IDACI) is a supplementary index of the IMD which measures all children aged 0 to 15 living in income deprived families, with income deprived defined as those families in receipt of out of work benefits and working and child tax credits.

As a borough, Solihull is ranked 197th out of 326 Local Authorities on the IDACI measure, where 1 is the most deprived and 326 the least deprived in the country. This means that Solihull is ranked among the 40% least deprived Local Authority areas in the country.

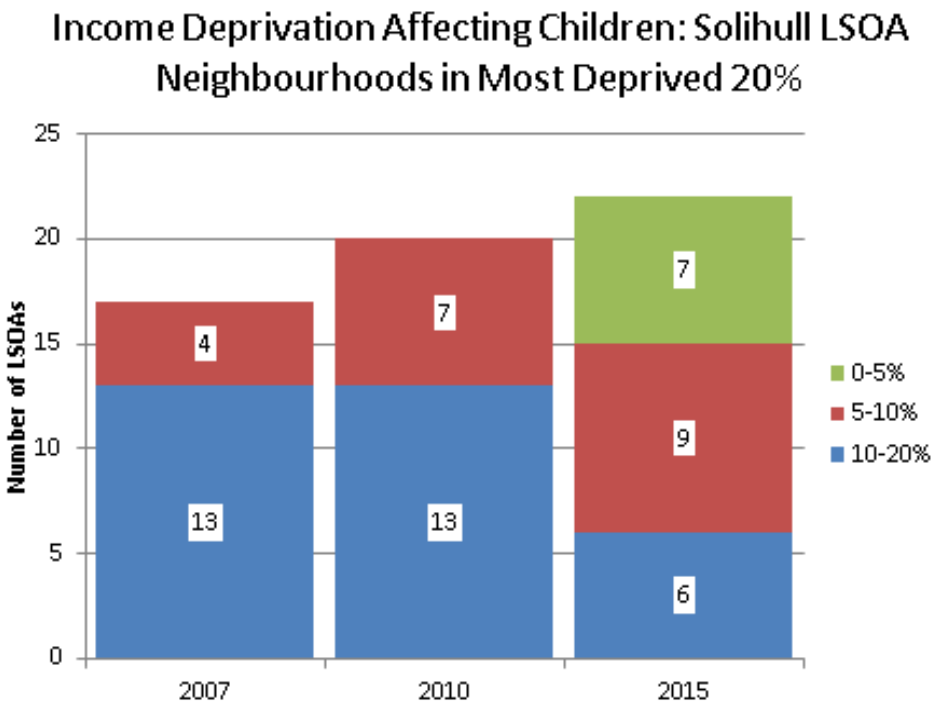
Solihull has 16 LSOAs in the bottom 10% nationally in respect of income deprivation affecting children, with seven in the most deprived 5% of neighbourhoods. All Solihull LSOAs in the bottom 10% in the country are in the North Solihull regeneration area, where The Birds North and The Birds South (Smith's Wood ward) are among the most deprived 2% in the country.

The lowest ranked LSOA outside of the North area is Green Hill (Shirley East) on the 13th percentile, with Hobs Moat North (Lyndon), Park Hall (Castle Bromwich) and Solihull Lodge (Shirley West) the only others in the bottom 30%.

Figure 2 2015 Index of Deprivation Affecting Children

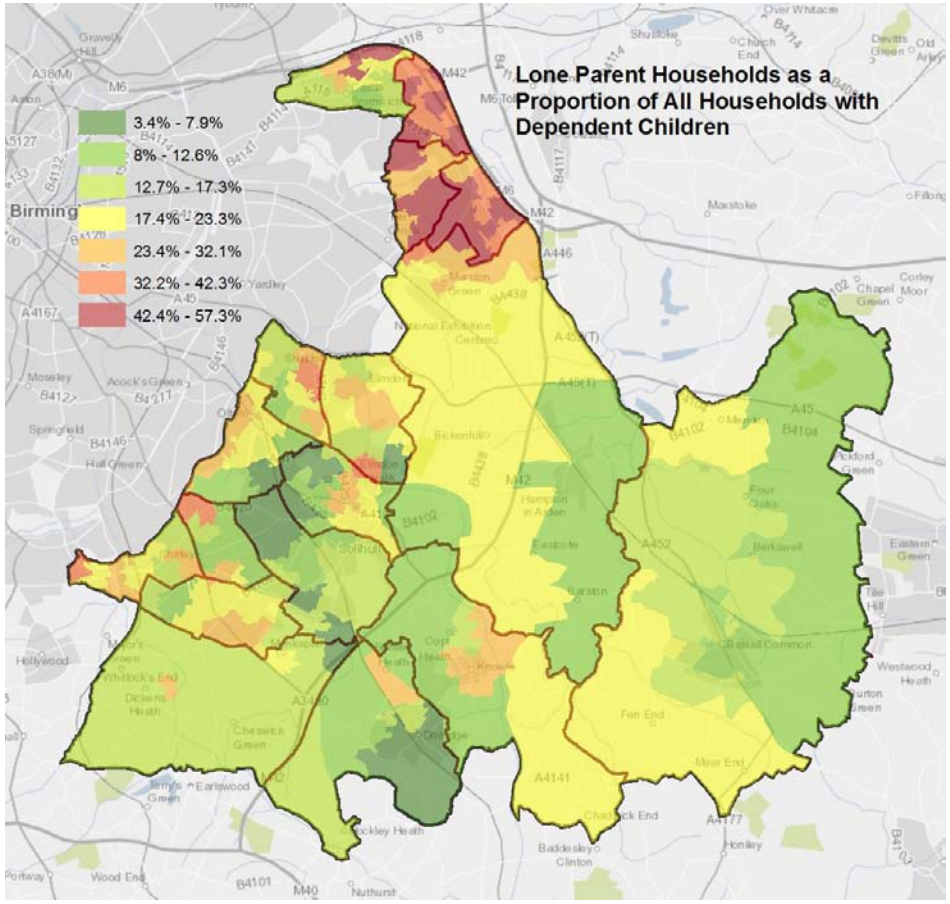


As the chart below shows, the number of Solihull LSOA neighbourhoods in the most deprived 20% in the country has increased over recent iterations of the IDACI index (from 17 in 2007, to 22 in 2015). The latest version of the IDACI is the first time in which any Solihull LSOA has featured in the most deprived 5% in the country.



Source: Index of Multiple Deprivation, DCLG

This second map highlights all Lone Parent households from the 2011 Census and shows a clear association with children living in poverty.



Source: Nomis, Census 2011

The following table from the 2011 Census reveals the ethnic diversity of children and young people across the borough. The table is sorted by ward with Silhill having the largest non-White population in percentage terms, and Dorridge and Hockley Heath the lowest. Asian ethnicity is highest in the wards of the Urban West whereas Black and Mixed groups are more likely to live in North Solihull.

Table 2 *Ethnic breakdown of the Solihull youth population (0 – 19 years)*

Ward Name	White	Asian/Asian British	Black/African/Caribbean/ Black British	Mixed/ Multiple Ethnic	Other Ethnic Group
Silhill	70.70%	19.30%	3.00%	5.50%	1.50%
Olton	74.50%	16.10%	1.80%	6.50%	1.20%
Shirley East	75.60%	17.20%	1.20%	4.80%	1.20%
Blythe	79.30%	14.00%	1.10%	4.60%	1.00%
Lyndon	79.50%	13.60%	1.70%	4.00%	1.20%
St Alphege	79.60%	14.20%	0.70%	3.80%	1.60%
Elmdon	80.50%	12.90%	1.80%	3.70%	1.10%
Shirley West	82.80%	10.90%	0.70%	4.70%	0.90%
Shirley South	83.50%	10.40%	0.50%	4.80%	0.80%
Bickenhill	85.50%	5.30%	2.10%	6.60%	0.50%
Smith's Wood	86.30%	1.20%	3.70%	8.50%	0.20%
Kingshurst and Fordbridge	86.80%	1.70%	2.90%	8.30%	0.20%
Castle Bromwich	87.60%	4.90%	1.70%	5.30%	0.50%
Chelmsley Wood	87.70%	0.80%	3.20%	8.30%	0.10%
Knowle	91.30%	3.70%	0.30%	3.80%	0.90%
Meriden	91.80%	3.30%	0.40%	4.30%	0.20%
Dorridge and Hockley Heath	92.00%	3.60%	0.70%	3.30%	0.40%
Solihull	**83.30%**	**8.80%**	**1.70%**	**5.50%**	**0.80%**

Source: Nomis, Census 2011

Pre-conception and pregnancy

A healthy pregnancy is crucial to the Marmot objective of 'giving every child the best start in life'. The health of the mother is determined by lifestyle factors (such as whether she smokes or not) but also the social circumstances in which her life is lived. There is a complex interplay between living in poverty and factors that affect maternal mental health. Poverty 'gets under the skin' as it were.

Much of the pregnancy advice also applies to pre-conception. Both partners should have as healthy a lifestyle as possible prior to conception. They should also be aware of any medical conditions that could affect a pregnancy and have them under control, e.g. diabetes, thyroid disease, high blood pressure, epilepsy or sexually transmitted diseases, to aid conception but to also give the baby a good start in life.

We now have solid evidence that:

- the effect of a mother's mental health on the subsequent health of her child is equally as important as physical health.
- There are long term effects from exposures during pregnancy such as poor nutrition, obesity, smoking, alcohol and stress.

This is known as 'foetal programming' and has revolutionised thinking about the development of disease later in life. For example, Professor Barker in the late 1980s identified that under nutrition of the baby in the womb can lead to increased rates of coronary heart disease later in life [1]

In this chapter we look at the local prevalence of factors during pregnancy known to have an adverse impact on health outcomes.

The Chief Medical Officer's report[2] outlines the following as the main modifiable factors during pregnancy.

- Tobacco
- Alcohol
- Obesity
- Diet
- Illicit drugs
- Mental illness
- Low socio-economic status
- Psychosocial stress

There were 2,259 live births in Solihull in 2015.

- 21.9% of women giving birth in Solihull in 2015 were aged 35 or above, which compares to 22% nationally; 0.4% of women were under 18 (in 2015), which is below the national rate (1%).

[1] Barker DJP (1995) Fetal origins of coronary heart disease. BMJ 311:171–174.

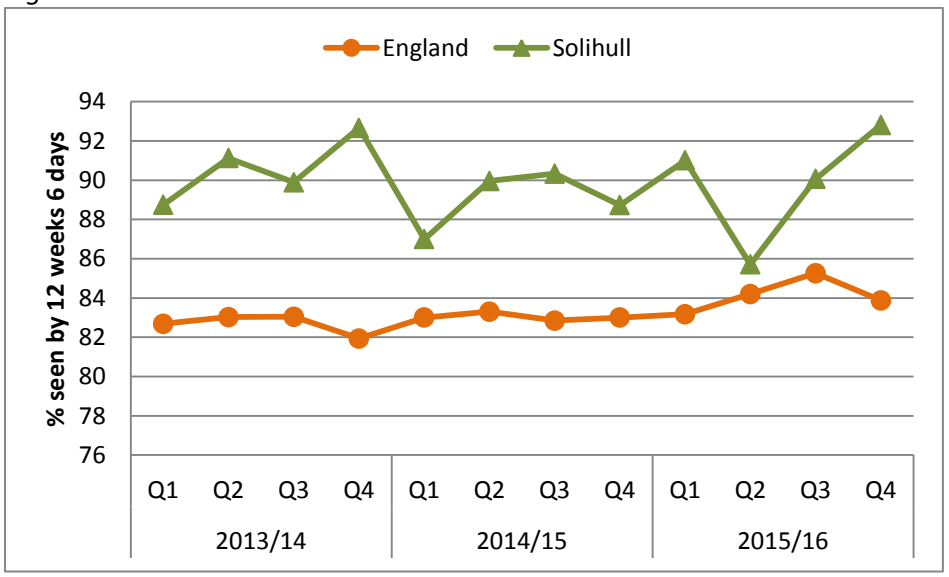
[2] Annual Report of the Chief Medical Officer 2012, Our Children Deserve Better: Prevention Pays

Early booking

Early access in pregnancy to maternity services is essential to facilitate a full health and social care assessment of needs. Early booking gives pregnant women choice and also gives the benefit of personalised maternity care that improves outcomes and experience for both mother and baby. This is particularly important for vulnerable and socially excluded groups in order to reduce the health inequalities experienced by these groups[3].

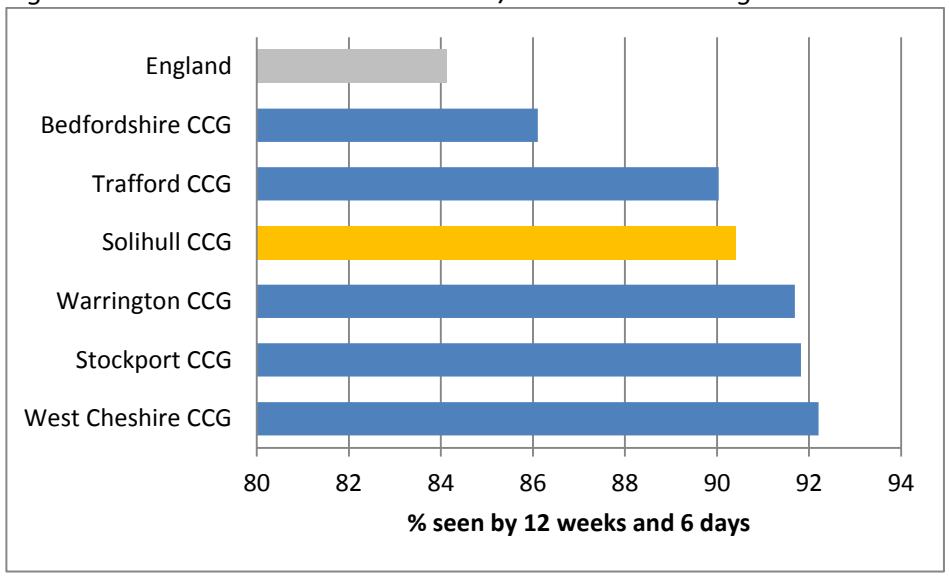
The percentage displayed in Figure 3 is the number of pregnant women seen within 12 weeks as a percentage of the total pregnant women seen. This differs from the Department of Health reported statistic which uses the number of maternities as the denominator and can result in values > 100%. This denominator therefore excludes pregnancies that do not go to term.

Figure 3 12 week risk assessment trend



Source: NHS England

Figure 4 12 week risk assessment 2015/16 – statistical neighbours



Source: NHS England

Key points

- Over the last three years Solihull has consistently had a higher percentage of pregnant women being seen before 12 weeks of pregnancy than England.
- Although Solihull's performance is above the national average, the percentage of early booking achieved in Solihull is less than some of its statistical neighbours (Figure 4). Confidence intervals were not available for this data source so it is not known if these differences are statistically significant.

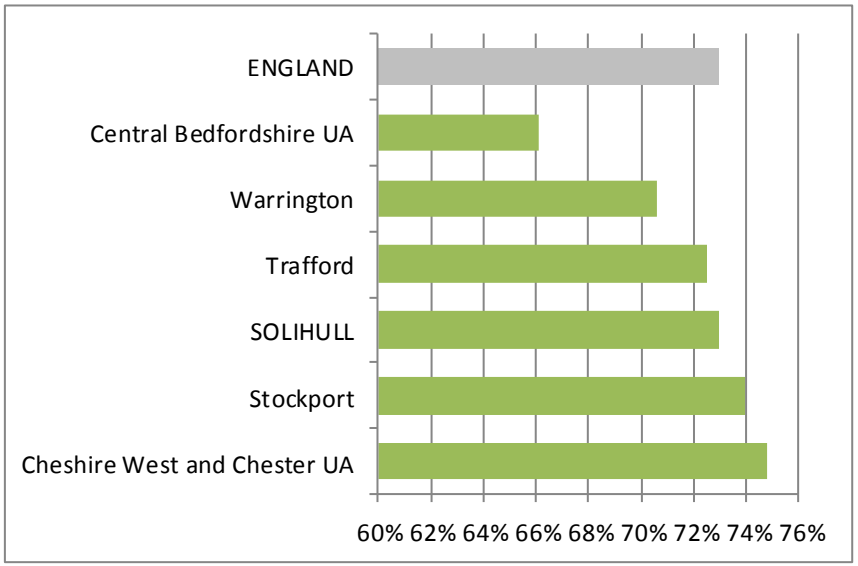
[3] Department of Health: https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2014/03/12-Week-Risk-Assessment-1415Q4.pdf

Healthy Start

The Healthy Start scheme is a national initiative that has existed in one form or another since the Second World War. The scheme provides vouchers to low income families with a child under 4 years that can be exchanged for basic foods such as milk and vegetables. Free vitamins are also provided as a separate part of the scheme.

NICE guidance[4] states that all pregnant and breastfeeding women (particularly teenagers and young women), and infants and children under five years of age, are at higher risk of having a low vitamin D status and are recommended to take a supplement appropriate to their age group. Vitamin D is very important as current research links newborn and infant vitamin D deficiency with various clinical outcomes, including rickets, failure to thrive, type 1 diabetes and other immune-related diseases[5]

Figure 5 Healthy start food vouchers 2014/15



Source: National Healthy Start Team

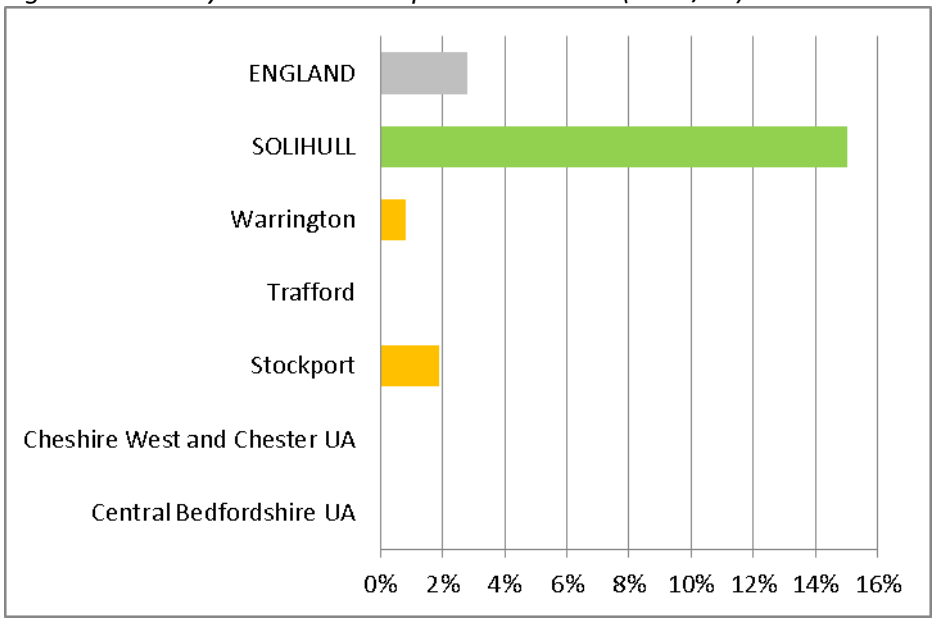
There are different vitamin preparations for mothers (pregnant and breastfeeding) and children – for example the mother's vitamins contain folic acid. However in both cases the uptake nationally is poor. Concerted efforts to set up a robust local system have resulted in figures for Solihull that are much better than the national

[4] https://www.nice.org.uk/guidance/ph56

[5] Haggerty. LL (2011) *Maternal supplementation for prevention and treatment of vitamin D deficiency in exclusively breastfed infants.* Breastfeed Med. 2011 Jun;6(3):137-44

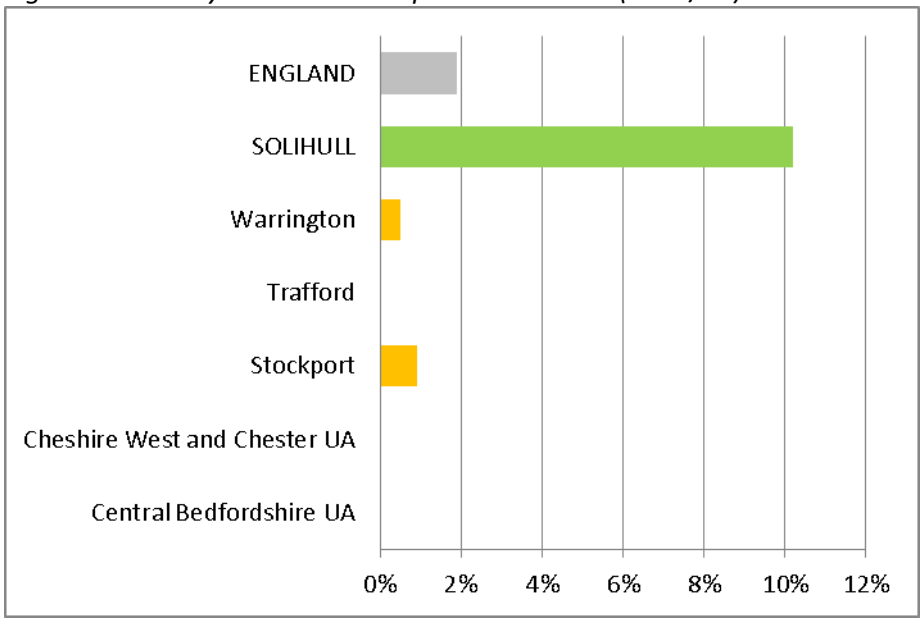
and West Midland's average. As part of a local initiative, free vitamins are made available to all pregnant and breastfeeding mothers in Solihull. Performance of all our statistical neighbours is below the national average (see Figs 6 and 7 below).

Figure 6 Healthy Start vitamin uptake – mothers (2014/15)



Source: National Healthy Start Team

Figure 7 Healthy Start vitamin uptake – children (2014/15)



Source: National Healthy Start Team

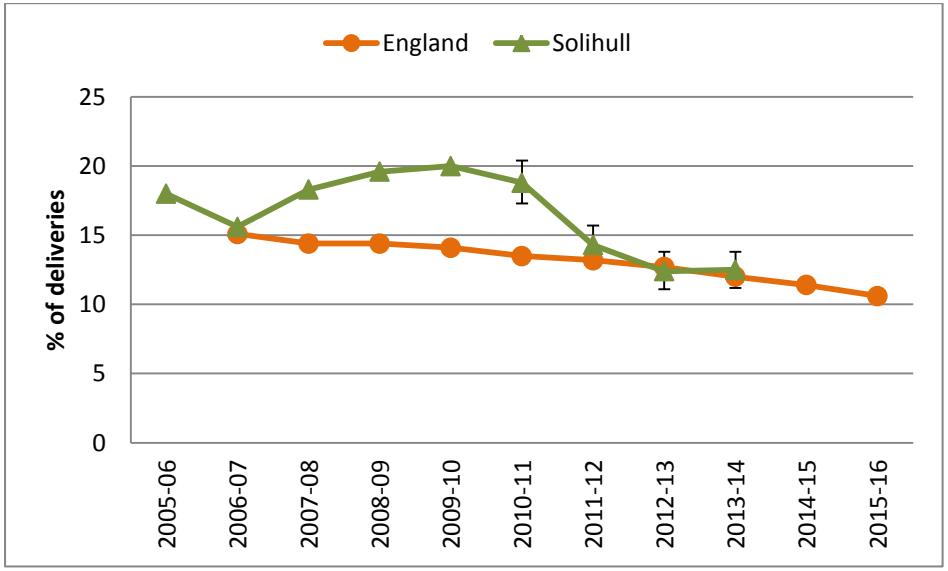
Key points

- Uptake of the food voucher scheme for eligible families in Solihull is the same as the national figure of 73%. This is in the middle of the distribution of our statistical neighbours. However this means that over one-quarter of families that are foregoing a free benefit which could improve children's diets and cut down on family bills.
- Solihull has made great strides to improve uptake of free vitamins. Consideration should be given to how to improve uptake particularly among children.

Smoking in pregnancy

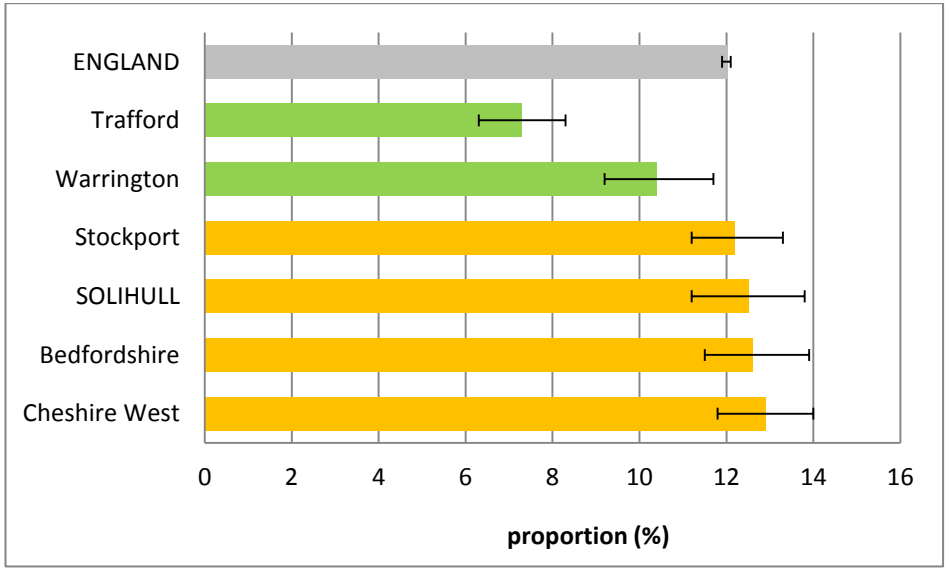
Smoking in pregnancy has well known detrimental effects for the growth and development of the baby and health of the mother. These include complications during labour and an increased risk of miscarriage, premature birth, stillbirth, low birth-weight and sudden unexpected death in infancy. Encouraging pregnant women to stop smoking during pregnancy may also help them kick the habit for good, and thus provide health benefits for the mother and reduce exposure to second-hand smoke by the infant. Mothers recorded as smoking at time of delivery are likely to have smoked throughout their pregnancy.

Figure 8 Smoking at time of delivery trend



Source: Health and Social Care Information Centre, PHOF 2.03

Figure 9 Smoking at time of delivery 2013/14 - statistical neighbours

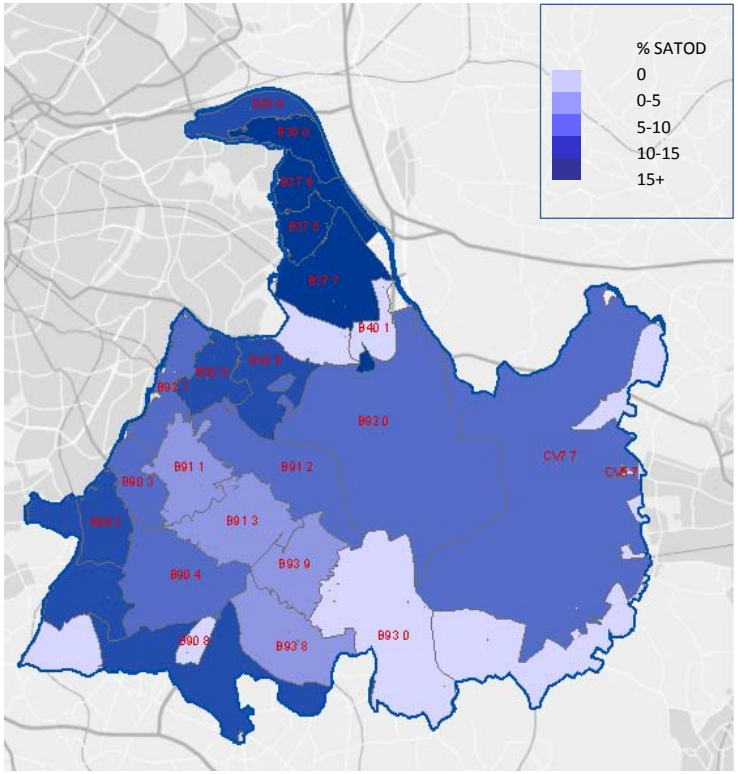


Source: Health and Social Care Information Centre, PHOF 2.03

Key points

- Problems in collecting data by our provider in 14/15 and 15/16 mean that comparative figures for Solihull for those years are unreliable and therefore have not been reported here or in the public health outcomes framework.
- From 2007 to 2010 Solihull had a smoking at time of delivery (SATOD) rate significantly higher than England and was increasing annually.
- Since 2010/11 the SATOD rate has decreased but the rate was still significantly higher than England until 2012/13. At the last comparable data point (2013/14) Solihull's rate was similar to England at 12.5% and 12.0% respectively.
- Solihull's SATOD is higher than three of its statistical neighbours and significantly higher than neighbour Trafford. Both Trafford and Warrington have significantly lower rates than the England average, which Solihull does not.

Figure 10 SATOD by postcode



Source: Heart of England Foundation Trust

Local data when mapped by postcode sector (Figure 10) shows that on average 1 in 4 mothers resident in North Solihull Regeneration areas are likely to smoke during pregnancy. This compares to 1 in 14 mothers in the rest of Solihull.

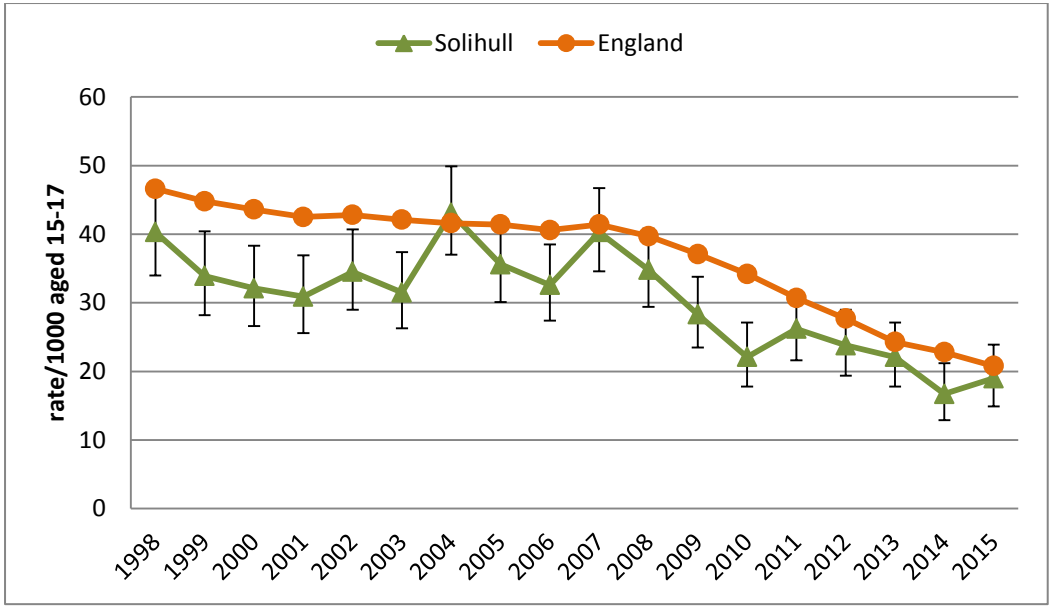
Nationally, mothers aged 20 and under are five times more likely than those aged 35 and over to smoke during pregnancy (45% compared to 9%)[6]. Mothers in routine and manual occupations are more than four times more likely to smoke throughout pregnancy compared to those in managerial and professional occupations (29% compared to 7%)[7]. Pregnant women are also more likely to smoke if they are less educated, live in rented accommodation, are single or have a partner who smokes.

[6] British Market Research Bureau 2007
[7] As above

Teenage conceptions

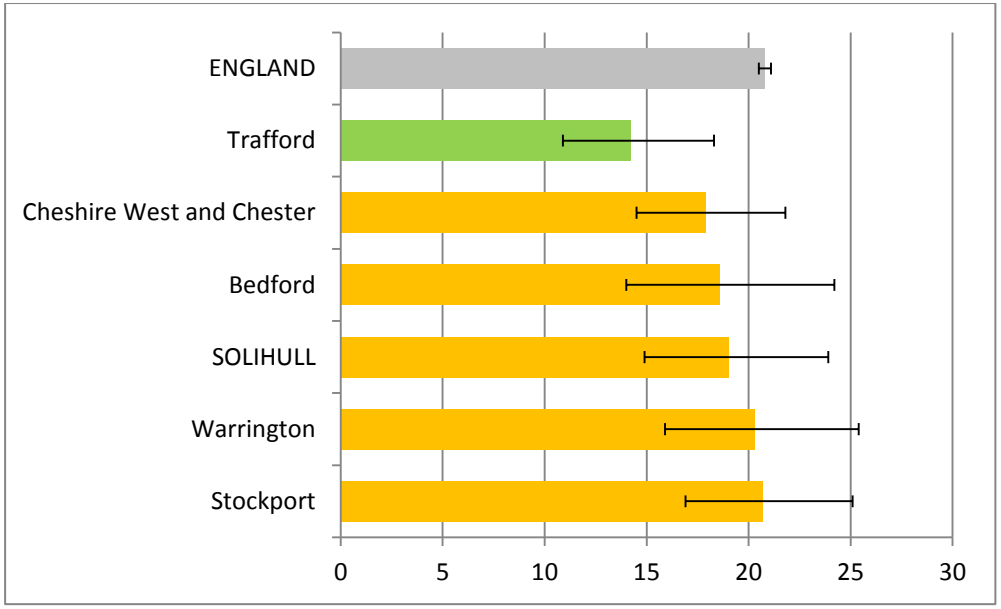
Most teenage pregnancies are unplanned and around half end in an abortion. Research evidence, particularly from longitudinal studies, shows that teenage pregnancy is associated with poorer outcomes for both young parents and their children.

Figure 11 Teenage conceptions trend 1998-2015



Source : ONS, PHOF 2.04

Figure 12 Teenage conceptions 2015

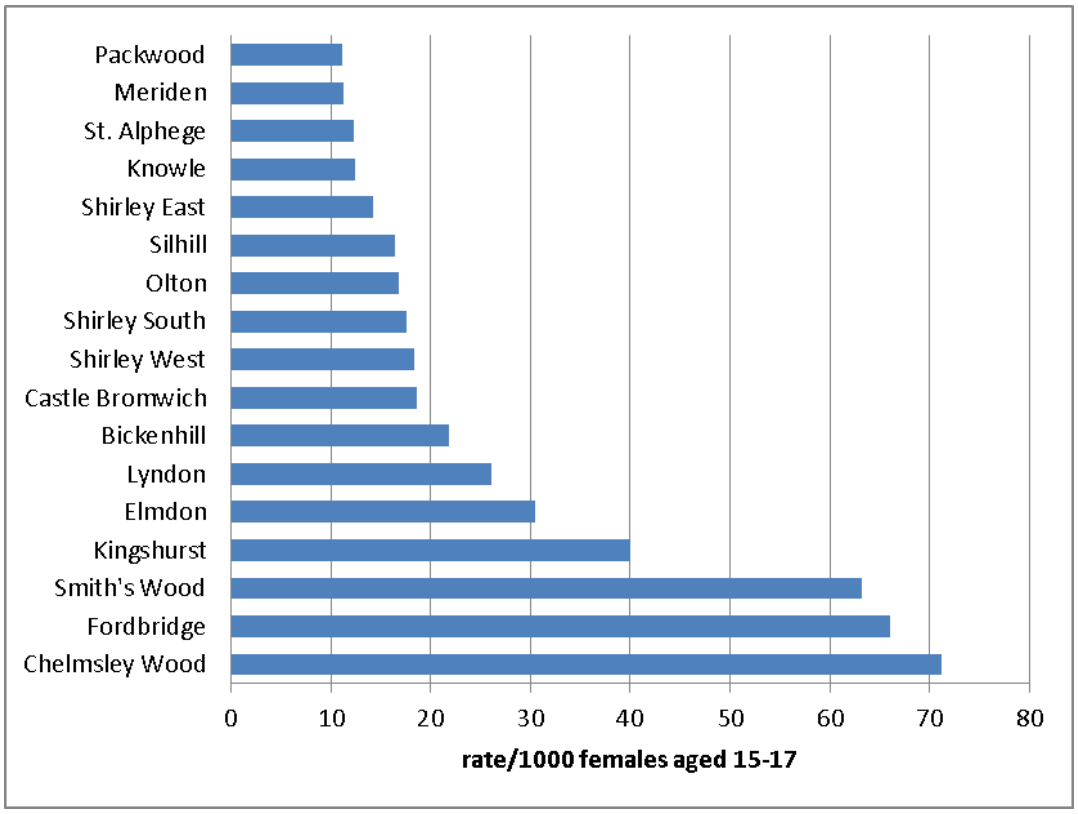


Source: ONS, PHOF 2.O4

Key points

- The teenage conception rate in Solihull has more than halved from 1998 to 2015 when the Teenage Pregnancy Strategy was implemented (Figure 11)
- In the decade 1998 to 2008 Solihull's teenage conception rate fluctuated between around 30 and 40 conceptions per 1,000 15-17 year olds. But since 2008 there has been a notable and steady decline in rates below 30 per 1,000 15-17 year olds.
- In 2015 Solihull had similar rates to England and was not significantly different from any of its statistical neighbours
- There are around 100 teenage conceptions in Solihull per year. Of those around half lead to a live birth the other half resulting in a termination of pregnancy.

Figure 13 Teenage conceptions by ward 2009-2011



Source: ONS

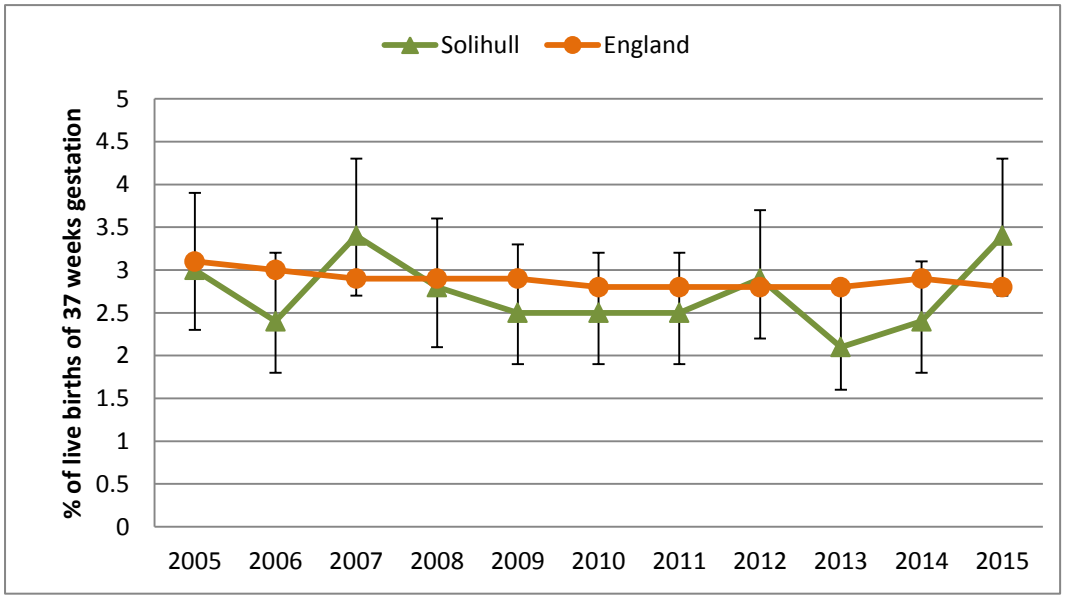
Key points

- The overall teenage conception rate conceals large differences across the borough.
- There is a six fold difference between the ward with the least conceptions and the ward with the most.
- Six out of 17 wards have a rate above the borough average (24.3); five of these wards have a rate above the England average (27.6).
- However, even in the wards with the worst rates, conceptions have reduced since 1998 from rates of 100+ to rates between 63 and 71.

Low birth weight

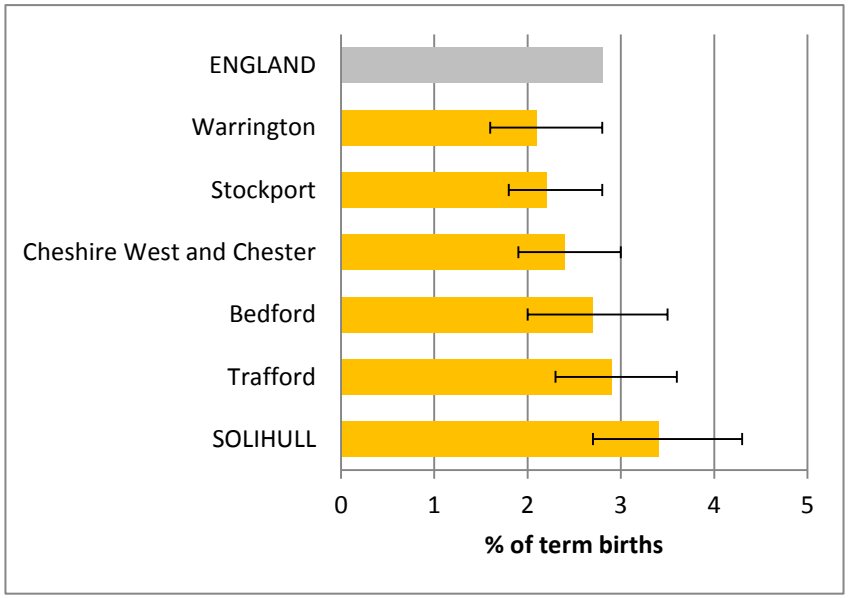
Low birth weight increases the risk of childhood mortality and of developmental problems for the child and is associated with poorer health in later life. At a population level there are inequalities in low birth weight and a high proportion of low birth weight births could indicate lifestyle issues of the mothers and/or issues with the maternity services. Low birth weight is considered to be a baby weighing 2500g or less.

Figure 14 Low birth weight trend (2005 to 2015)



Source: ONS, PHOF 2.01

Figure 15 Low birth weight 2016 – statistical neighbours



Source ONS, PHOF, 2.01

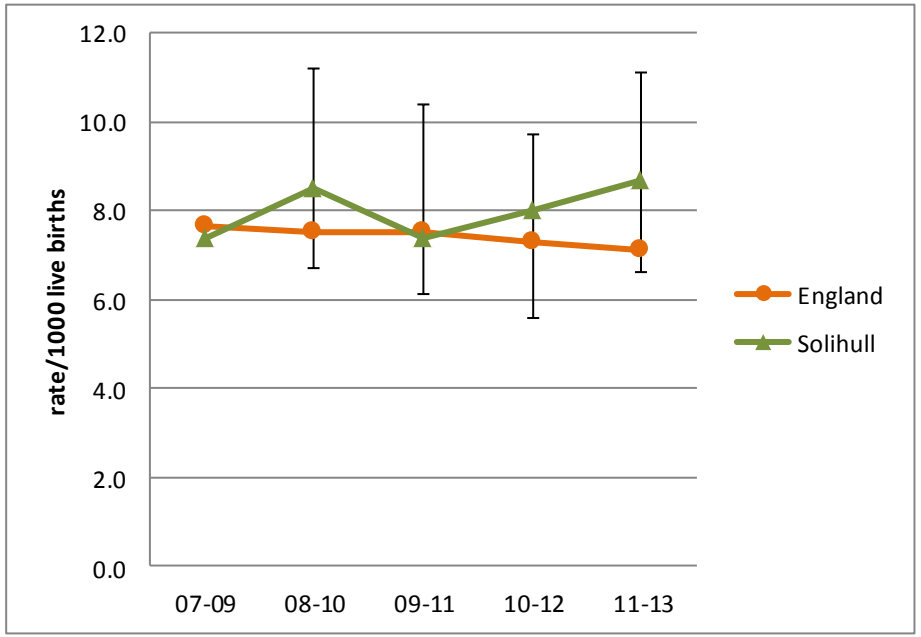
Key points

- Over time the proportion of low birth weight babies born to Solihull mothers is similar to England's proportion and currently sits at 3.4% in Solihull versus 2.8% in England.
- Solihull's rate is the highest among its nearest neighbours, but the difference is not statistically significant.

Perinatal mortality

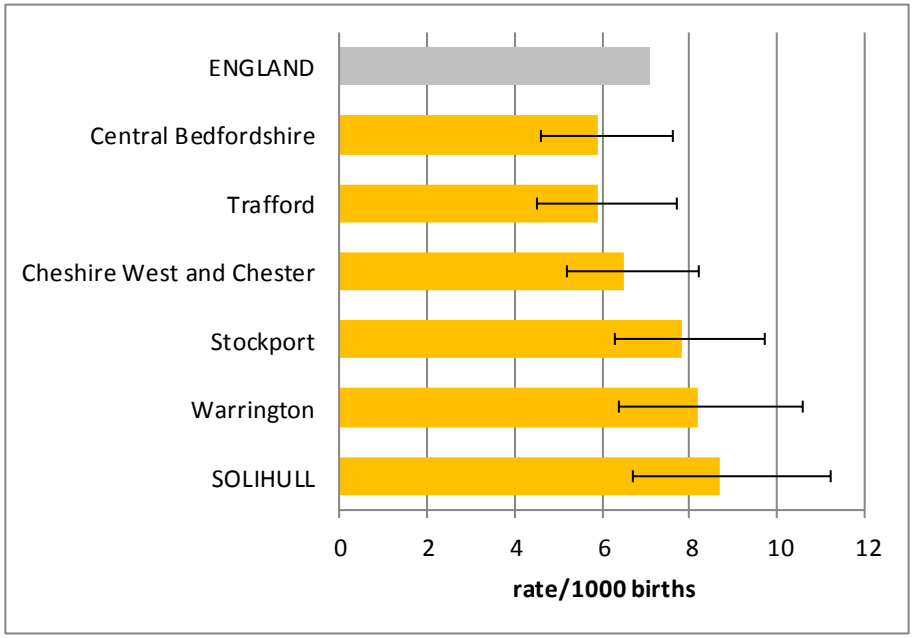
The perinatal period commences at 24 completed weeks of gestation and ends at seven completed days after birth. Perinatal and maternal health are closely linked. Perinatal mortality refers to the number of stillbirths (a stillborn baby is one born after 24 completed weeks of pregnancy with no signs of life) and deaths in the first week of life. There are around 15 to 20 perinatal deaths in Solihull every year, the majority of which are stillbirths. In comparison, there are less than 10 infant deaths (deaths from the first day of life until 12 months) each year.

Figure 16 Perinatal mortality trend



Source: NHSCIC

Figure 17 Perinatal mortality 3 year average 2011-13



Source: NHSCIC

Key points

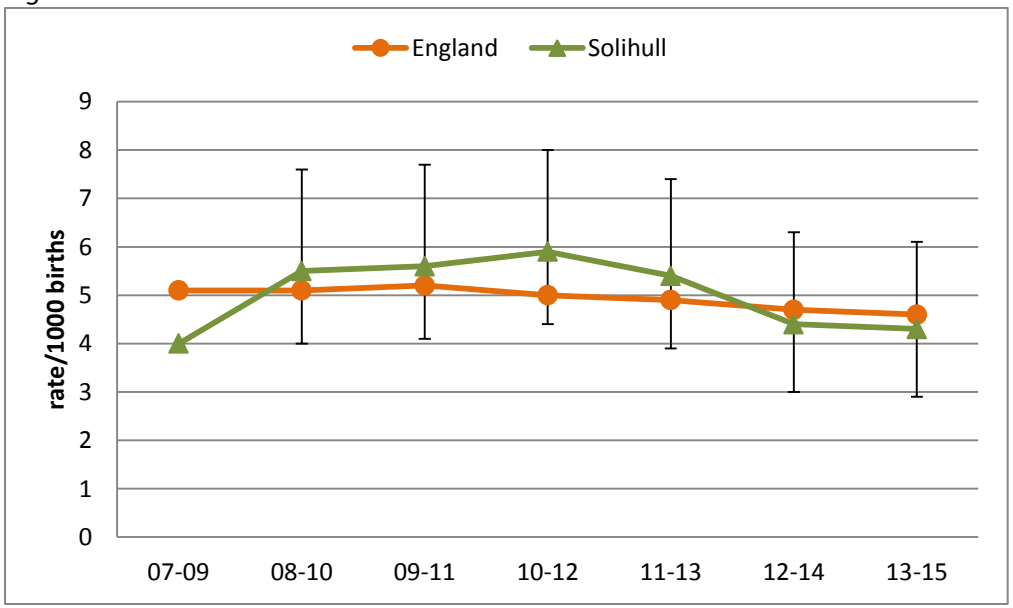
- Over time Solihull appears to have a perinatal mortality rate that is sometimes higher than that seen for England. However, confidence intervals are wide as these events are, thankfully, rare and the data shows that the Solihull (8.7 per 1,000 births) and England (7.1) rates are not significantly different.
- Solihull has the highest perinatal mortality rate in its comparator group but none of the areas are significantly different from each other.

Stillbirths

The stillbirth rate is the number of stillbirths per 1,000 total (live and still) births. Stillbirths in Solihull have declined from 41 in 2010-12 to 29 in 2013-2015, which is a rate of 4.3 stillbirths per 1,000 births. This is in line with the England rate of 4.6 stillbirths per 1,000 births, which has also been in steady decline since 2010..

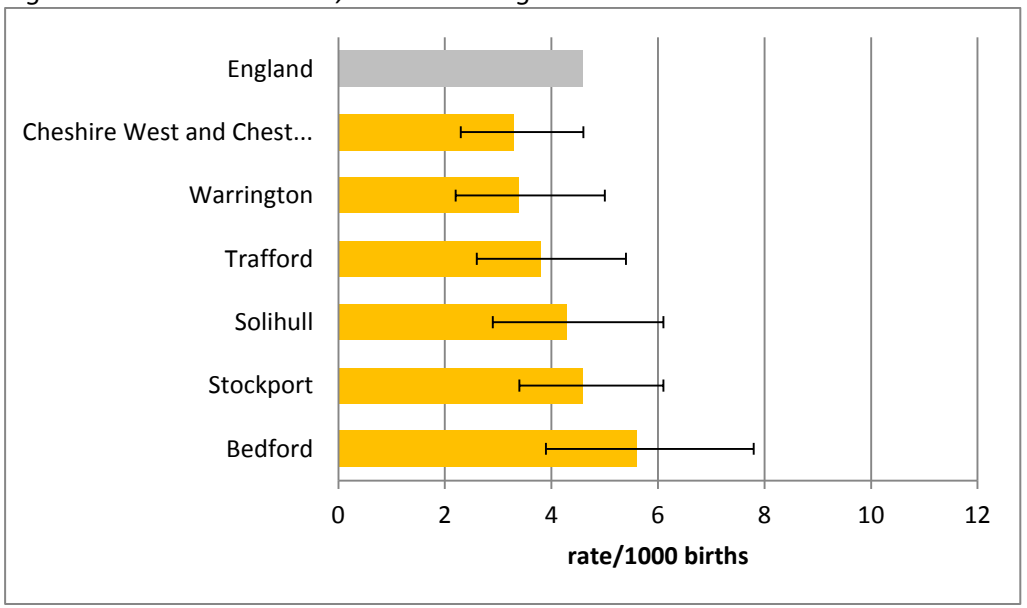
Stillbirths account for 61% of the total perinatal deaths. Stillbirth rates are highest for women aged under 20 or over 40. Although the causes of stillbirths are often unclear, there are associated risk factors. These include, but are not limited to: maternal age, smoking in pregnancy, maternal obesity, socioeconomic position, multiple births and influenza.

Figure 18 Stillbirths - trend



Source: Public Health Profiles

Figure 19 Stillbirths 13-15, statistical neighbours



Source: Public Health Profiles

Key points

- Solihull's stillbirth rate has been below that for England for the last two periods, but it has not been significantly lower.
- Solihull is in the middle of its comparator group but none of the areas are significantly different from each other or England.

Ante and Post natal depression

Post-natal depression (PND), 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.
Children of mothers who have PND are 42% more likely to experience depression by the age of 16.[8] Ante-natal depression (AND) and anxiety pose a significant risk for the baby through the direct action of chemicals on the brain of the foetus; and the fact that AND is a strong indicator for the later development of post-natal depression (PND).

Nationally, it is estimated that 10% of mothers suffer from post-natal depression[9]. Research on ante-natal depression indicates that about 10-20% of pregnant women suffer antenatal depression and anxiety.

Currently, there is no national outcomes measure regarding post or antenatal depression. The Children and Young People's Health Outcomes Forum has recommended a new public health outcomes indicator measuring the proportion of mothers with mental health problems, including postnatal depression.

In Solihull, a screening questionnaire (the Edinburgh Post Natal Depression Score) is sometimes used to identify mothers who are likely to have postnatal depression. Figures from the period January to September 2013 reveal that 6.5% of mothers scored above the threshold for likely post natal depression (i.e. 8 or more).

No data are collected on antenatal depression in Solihull.

[8] Murray L. & Cooper P Effects of postnatal depression on infant development. Archives of Disease in Childhood 1997; 77:99–101

[9] NICE (2007) *Antenatal and postnatal mental health: clinical management and service guidance*, NICE Guideline 45

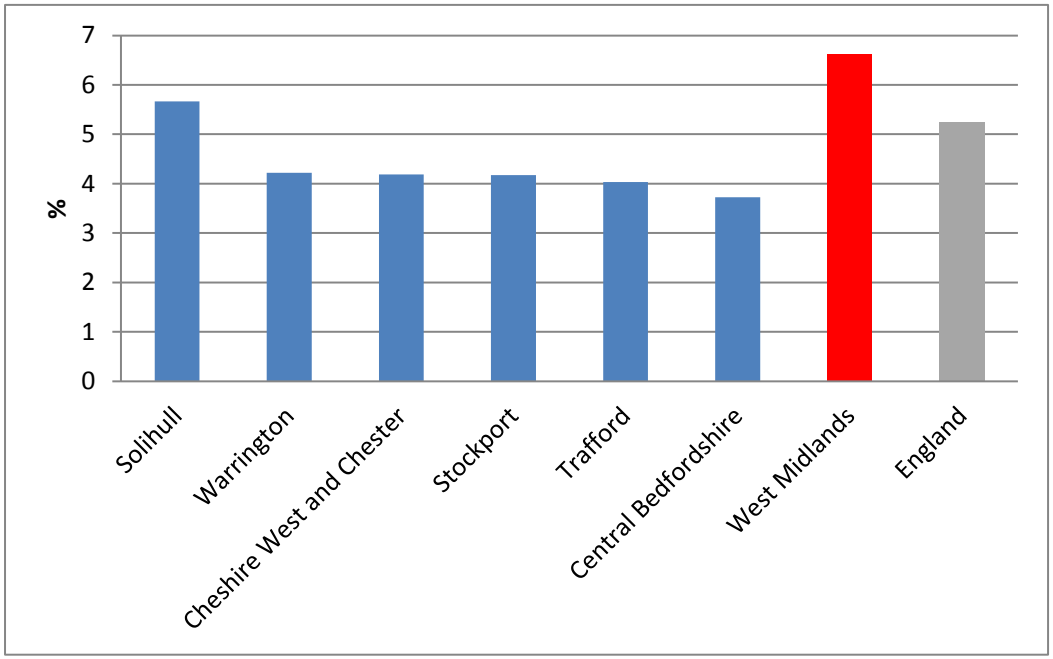
Social support

Women who lack social support have been found to be at increased risk of antenatal and postnatal depression. Having a poor relationship with a partner is also a risk factor for postnatal depression.[10]

ONS statistics show that infant mortality rates are higher among babies that are sole registered than for other registration types.

The number of births which were registered by just the mother is presented here to give a rough indication of the number of women in Solihull that are likely to lack the support of the father during pregnancy and as a new mother. There were 128 sole registrations in Solihull in 2015.

Figure 20 Solihull sole birth registrations 2015



[10] NICE clinical knowledge summaries. Depression - antenatal and postnatal. London: National Institute for Health and Clinical Excellence; 2013)

5. Early Years

The early years (from 0 to 5 years) are critical in shaping health and wellbeing later in life. Giving every child the best start in life is crucial to reducing health inequalities across the life course.

Improving outcomes for children, families and communities, as well as creating services that provide better access and experience are essential. The transfer of responsibility for health visiting and family nurse partnership services to local authorities has the potential to do this by providing a more joined up approach between early years education and health as well as enabling better family support to be delivered, including the troubled families initiative.

During pregnancy, and in the first two years of the child's life, the baby's brain and neurological pathways are set for life. It is the most important period for brain development, and is a key determinant of intellectual, social and emotional health and wellbeing.

The last few years have seen a plethora of reports that emphasise the importance of the early years. In their wake, there has been the establishment of the Early Intervention Foundation and the All Party Parliamentary Group Conception to age 2: First 1001 Days to maintain this focus.

Influential reports on early help include

- Marmot, M. (2010). *Fair Society, Healthy Lives: Strategic Review of health inequalities in England post-2010*,
- Field, F. (2010). *The Foundation Years: preventing poor children becoming poor adults*
- Allen, G. (2011). *Early Intervention: The Next Steps*
- Tickell, C. (2011). *The Early Years: Foundations for life, health and learning*
- WAVE Trust. (2013). Conception to age 2 – the age of opportunity

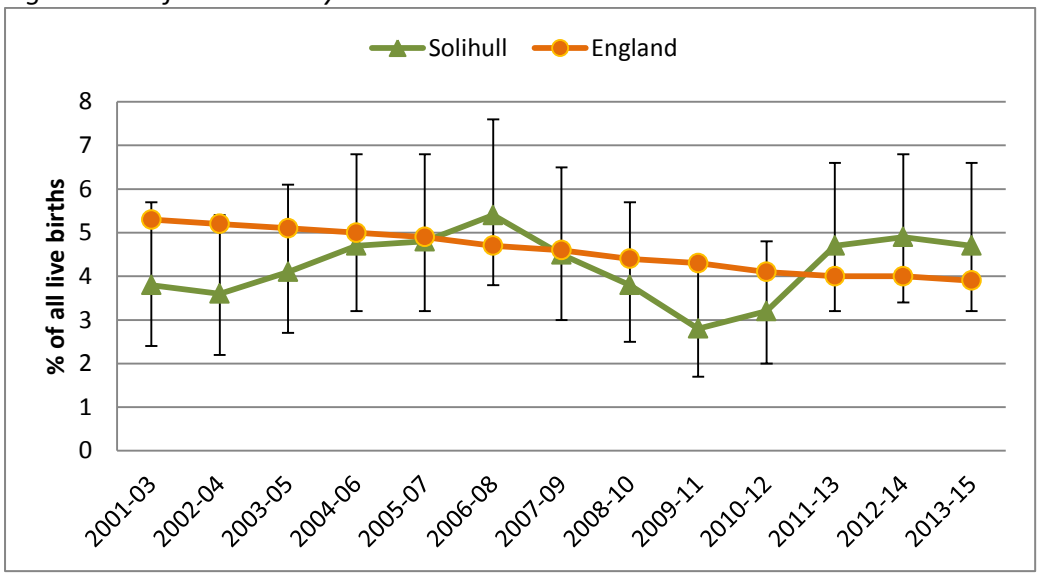
National guidance on health visiting supports effective intervention on the '6 high impact priority areas' – 1) transition to parenthood and the early weeks including early attachment, 2) maternal mental health 3) breastfeeding (initiation and duration), 4) healthy weight (to include nutrition and physical activity), 5) health and wellbeing at 2 (development of the child two year old integrated review and support to be 'ready for school'), 6) managing minor illness and reducing accidents (reducing hospital attendance and admissions).

Infant mortality

The infant mortality rate is the number of infants dying before their first birthday per 1,000 live births. There were 32 infant deaths in Solihull in the period 2013-2015: an infant mortality rate of 4.7 per 1,000 births. Nationally the rate was 3.9.

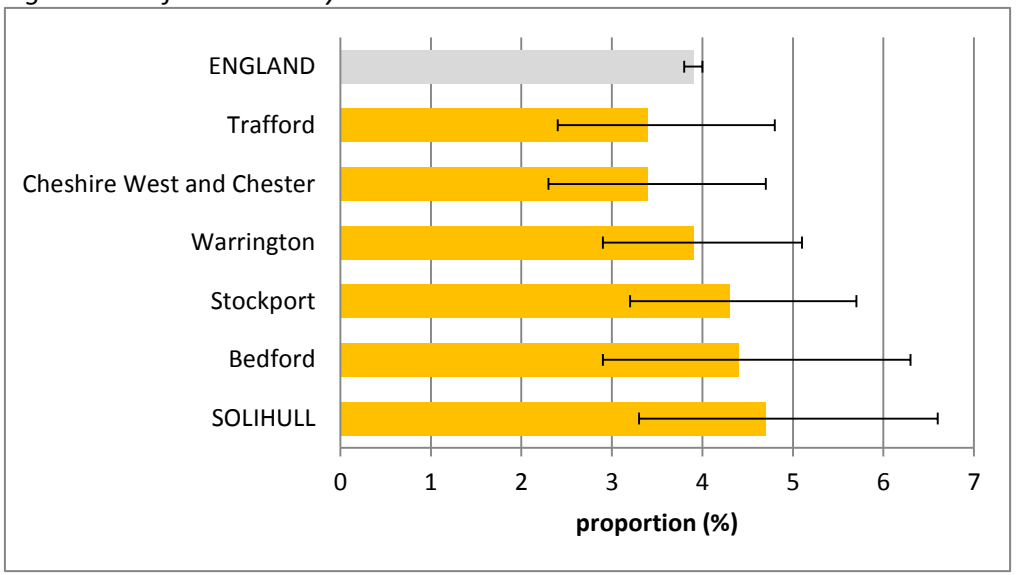
Infant mortality is an indicator of the general health of an entire population. It reflects the relationship between causes of infant mortality and upstream determinants of population health such as economic, social and environmental conditions. Deaths occurring during the first 28 days of life (the neonatal period) in particular, are considered to reflect the health and care of both mother and newborn.

Figure 21 Infant mortality trend



Source: ONS, PHOF 4.01

Figure 22 Infant Mortality 2013-15



Source: ONS, PHOF 4.01

Key points

- Between 2001-03 and 2013-15 the infant mortality rate in Solihull has fluctuated above and below the declining England average, but has never been significantly different from it.
- Solihull currently has the highest infant mortality rates among its nearest neighbours but it is not significantly different from any of the comparators.

Childhood vaccinations

According to the World Health Organisation the two public health interventions that have had the greatest impact on the world's health are clean water and vaccines. In the UK, a child should routinely be vaccinated against 13 diseases by the age of five.

Three measures are commonly used to indicate the effectiveness of the full childhood vaccination programme. These are uptake of

- the measles, mumps and rubella vaccination (MMR) at two and also at five years, and
- the '5-in-1' vaccine.

The latter protects against diphtheria, tetanus, pertussis, polio and Haemophilus influenza type b. The MMR vaccination is given in two doses at 12 months and between three and four years of age.

Figure 23 Population vaccination coverage - Dtap / IPV / Hib (2 years old)

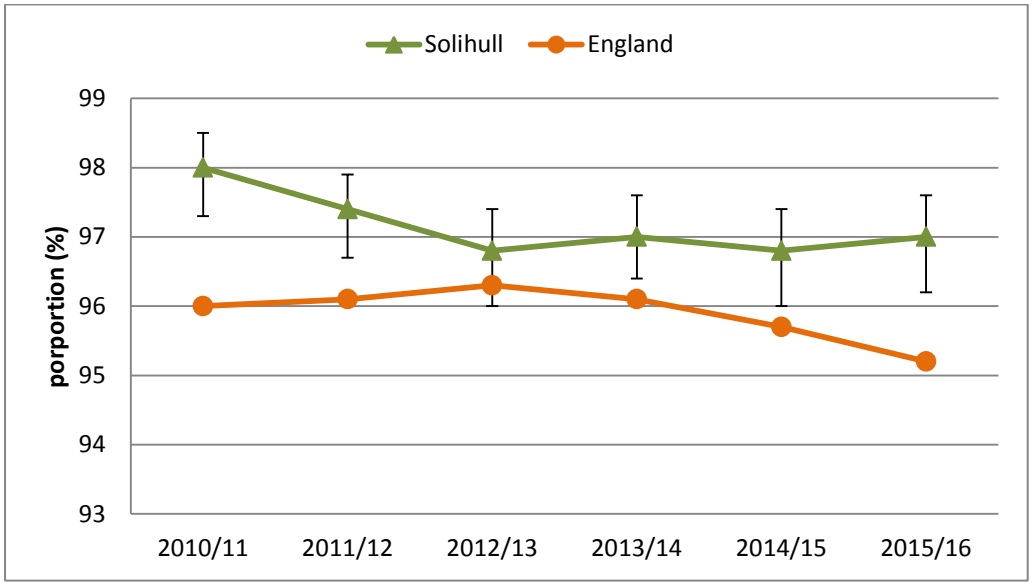
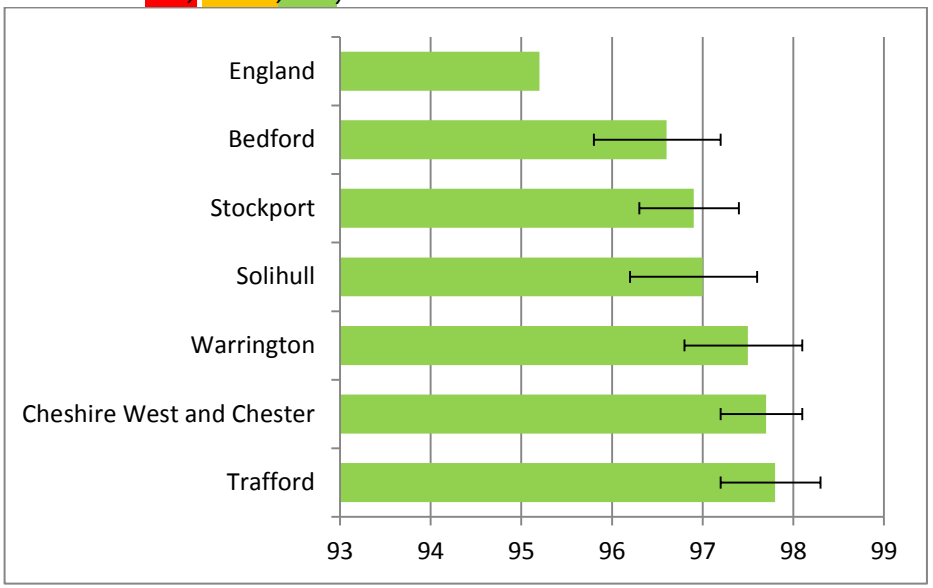


Figure 24 % coverage Dtap / IPV / Hib (2 years old) 15/16 (against target benchmark <90, 90 -95, ≥95)



Source: Cover of Vaccination Evaluated Rapidly (COVER) data collected by Public Health England (PHE). Available from Health and Social Care Information Centre (HSCIC), PHOF 3.03

Figure 25 Population vaccination coverage - MMR for one dose (2 years old) 13/14, trend

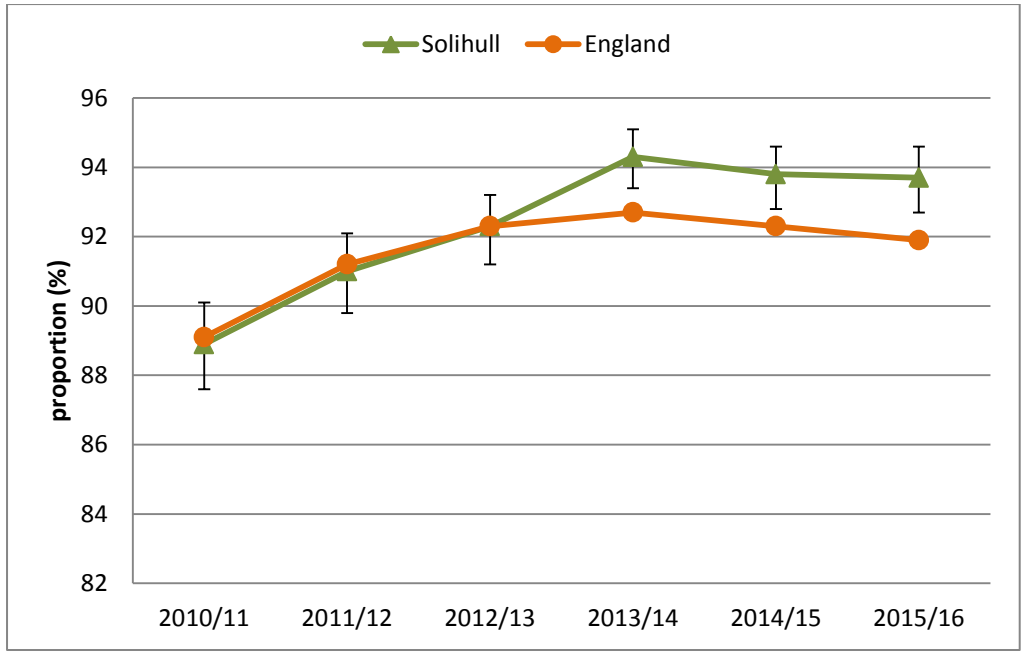
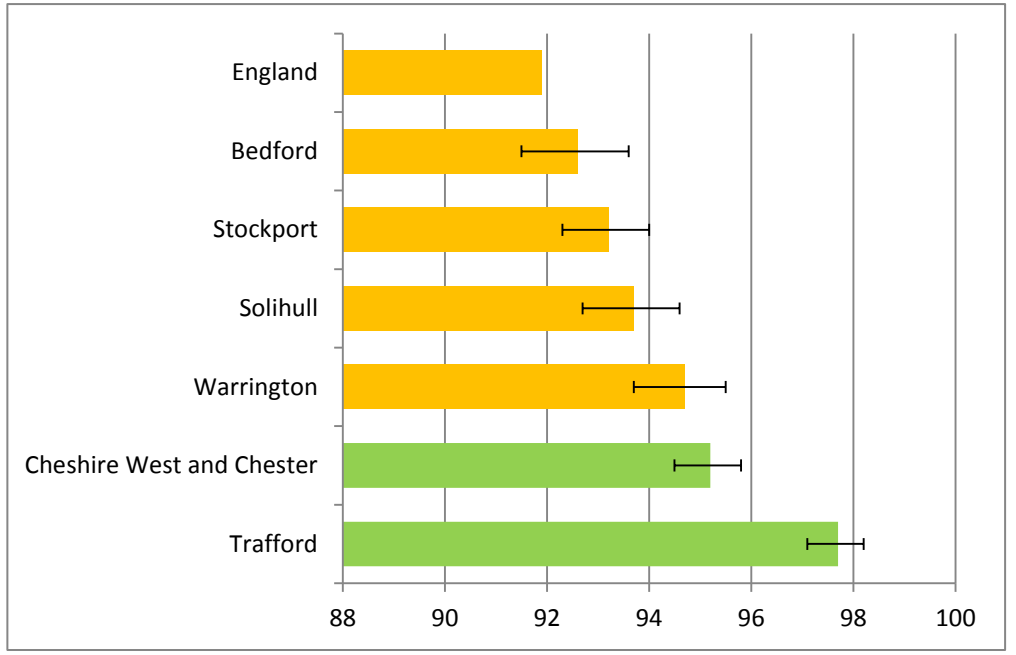


Figure 26 MMR for one dose (2 years old) 15/16 (against target benchmark <90, 90-95, ≥95)



Source: Cover of Vaccination Evaluated Rapidly (COVER) data collected by Public Health England (PHE). Available from Health and Social Care Information Centre (HSCIC), PHOF 3.03

Figure 27 Population vaccination coverage - MMR for two doses (5 years old) 15/16, trend

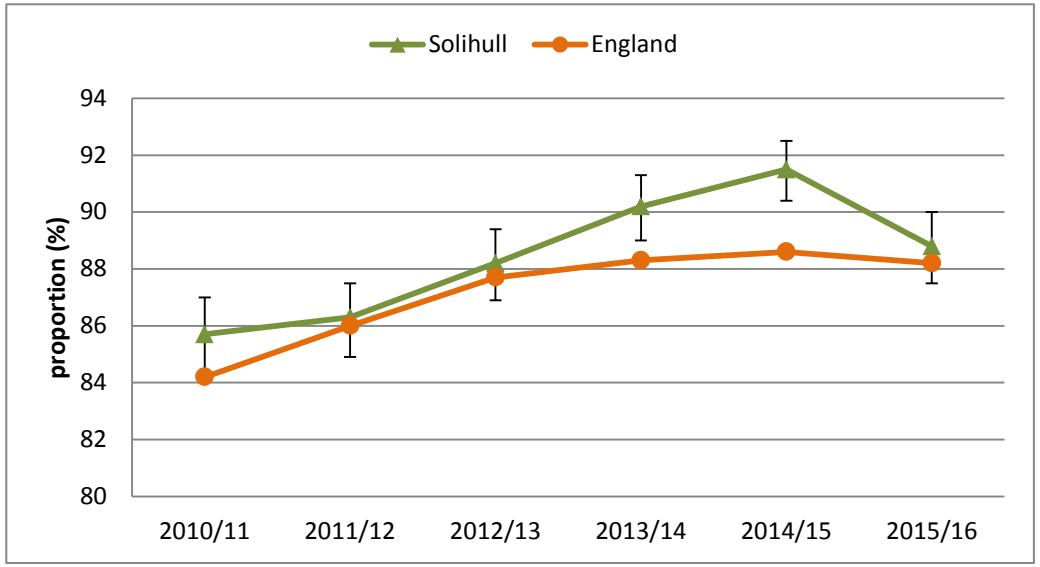
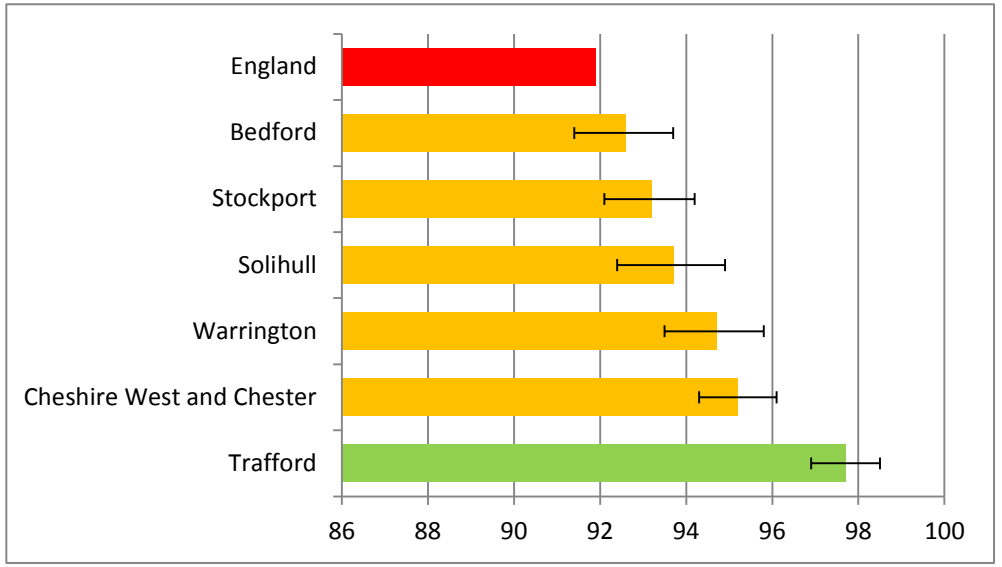


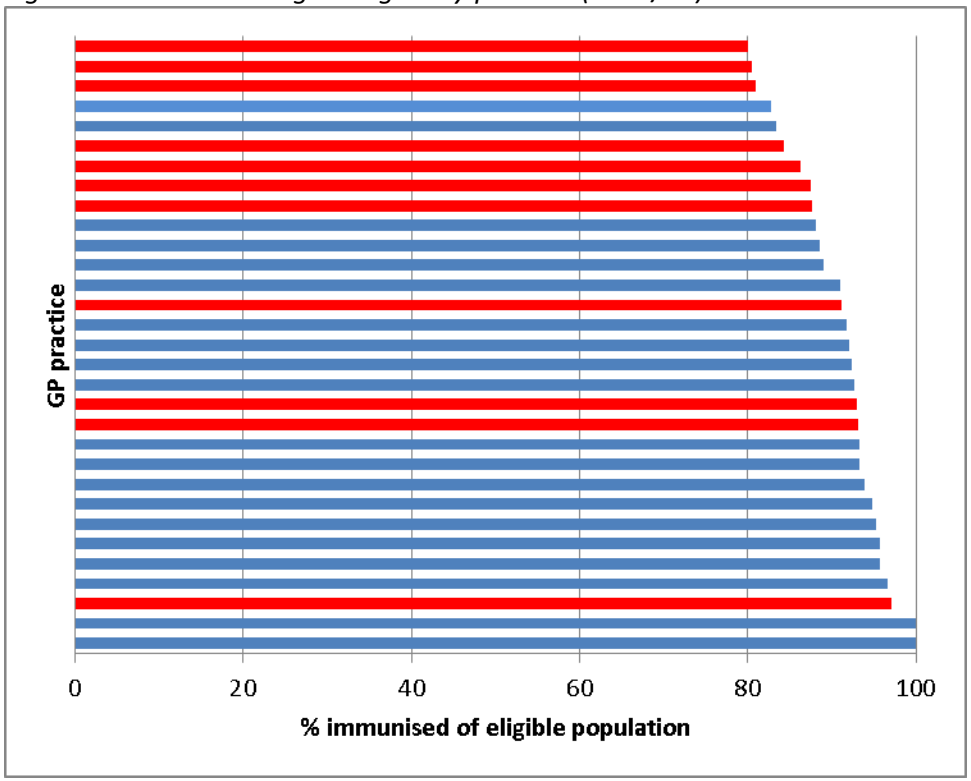
Figure 28 Coverage v stat neighbours - MMR for two doses (5 years old) 15/16



Source: Cover of Vaccination Evaluated Rapidly (COVER) data collected by Public Health England (PHE). Available from Health and Social Care Information Centre (HSCIC), PHOF 3.03

Data on childhood vaccinations are recorded by GP practice and this allows us to see whether there is any variation across the borough. The largest variation between practices was for MMR at age 5 (range 80% - 100%). Practices in the north of the borough are indicated in red and those in the south are in blue.

Figure 29 MMR coverage at age 5 by practice (2013/14)



Source: Local Child Health System

Key points

- Solihull's childhood vaccination coverage is significantly above the national average for:
  - 5-in-1 (Solihull 97% v England 95.2%)
  - MMR at 2 years (Solihull 93.7% v England 91.9%)
- It is not statistically different from the England average for MMR at 5 years
- Coverage is however below the WHO recommended levels to ensure herd immunity of 95% for all but the 5 in 1.
- Solihull falls in the middle of performance against its nearest statistical neighbours for all three measures.
- There are variations in vaccination coverage across the borough with practices in north Solihull generally having lower rates.

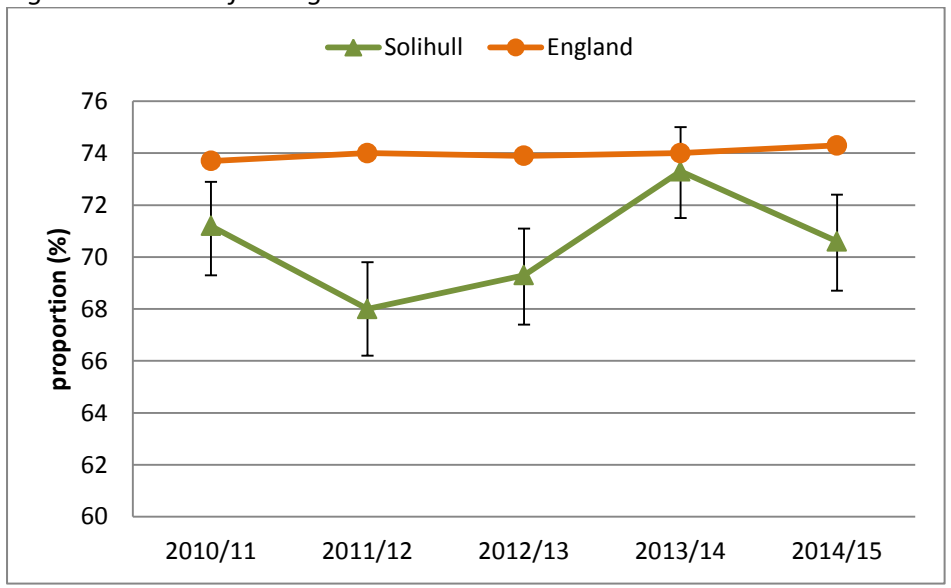
Breast feeding

Breastfeeding reduces illness in young children and has health benefits for the infant and the mother. It also reduces hospital admission for the treatment of infection in infants. Breast milk provides the ideal nutrition for infants in the first stages of life. There is evidence that babies who are breast fed experience lower levels of gastro-intestinal and respiratory infection. Observational studies have shown that breastfeeding is associated with lower levels of child obesity. Benefits to the mother include a faster return to pre-pregnancy weight and possibly lower risk of breast and ovarian cancer (BMA Board of Science, 2009). A beneficial side effect of breastfeeding is the stimulation of production of oxytocin hormone in the mother's brain which activates better bonding with the baby.

Initiation

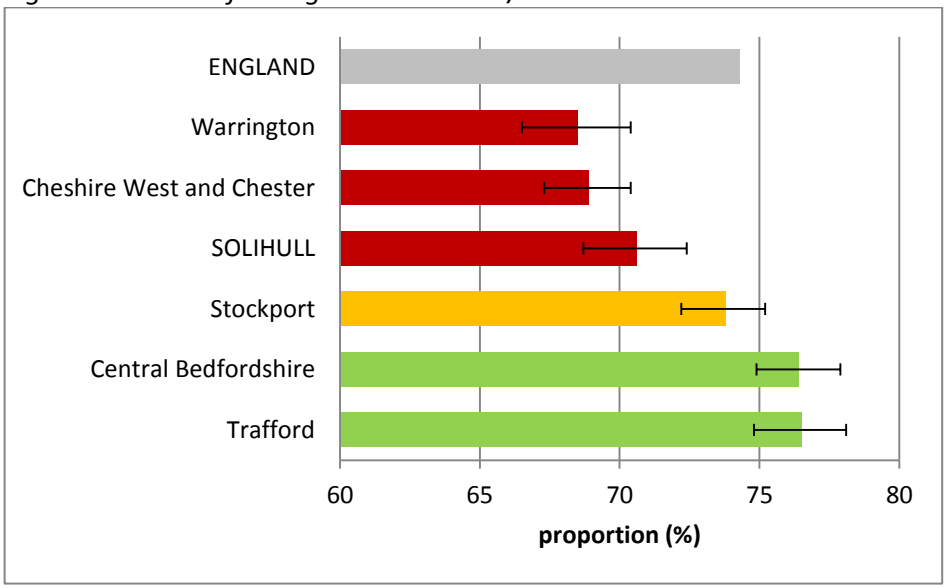
The breast feeding initiation indicator measures the percentage of mothers who give their babies breast milk in the first 48 hours after delivery.

Figure 30 Breast feeding initiation trend



Source: NHSE, PHOF2.02

Figure 31 Breast feeding initiation 2014/15



Source: NHSE, PHOF 2.02

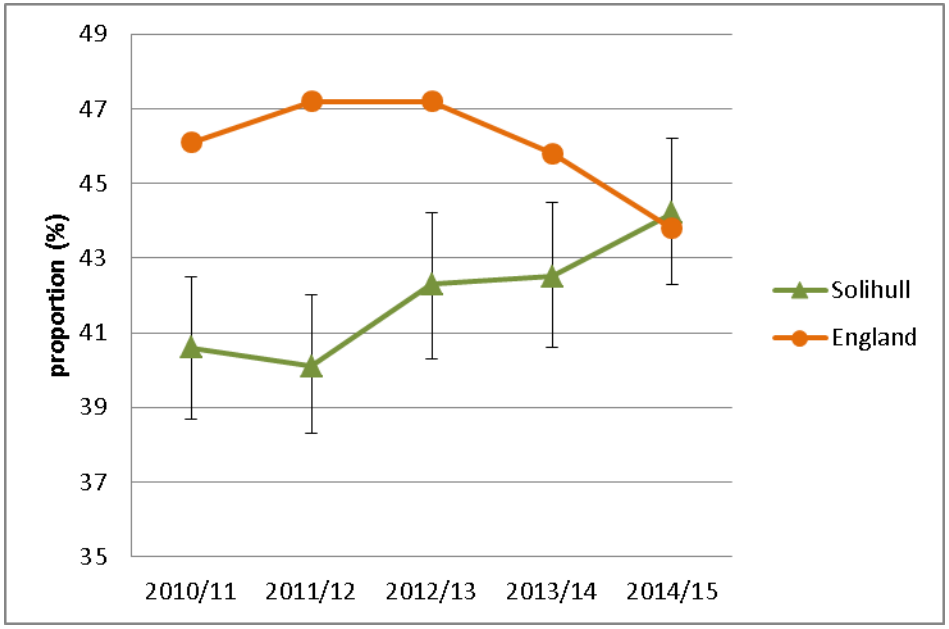
Key points

- Breast feeding initiation rates for England have remained steady at around 74% since 2010/11.
- Between 2010/11 and 2012/13 Solihull's rates were significantly below those for England but in 2013/14 the rate improved so that it was similar to England. Unfortunately the rate fell in 2014/15 to 70.6% making it again significantly lower than England
- Compared to its comparator group, Solihull is mid group significantly lower than Central Bedfordshire and Trafford.

Breast feeding at 6-8 weeks

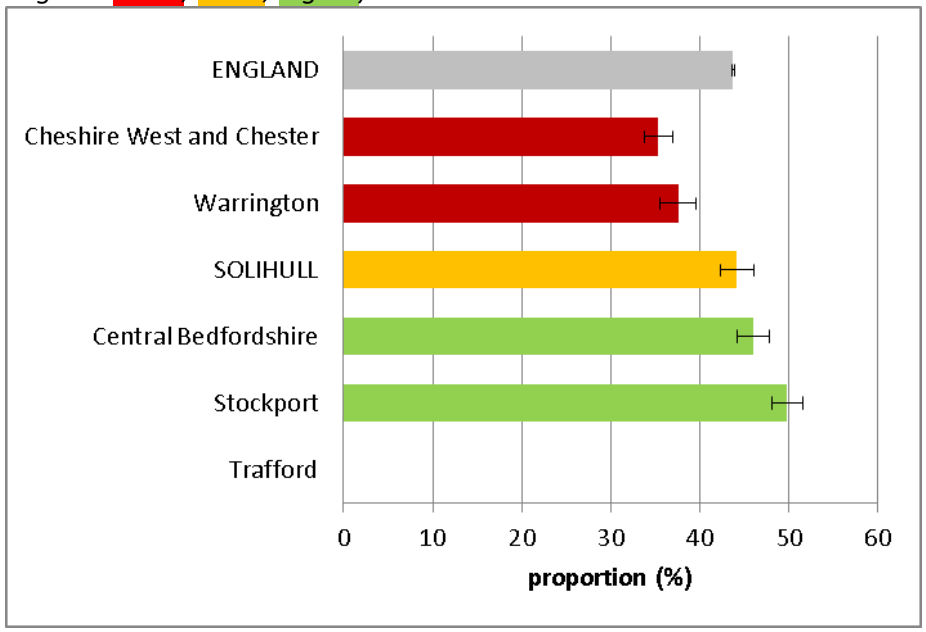
This is the percentage of infants that are totally or partially breastfed at age 6-8 weeks. Totally breastfed is defined as infants who are exclusively receiving breast milk at 6-8 weeks of age - that is, they are not receiving formula milk, any other liquids or food. Partially breastfed is defined as infants who are currently receiving breast milk at 6-8 weeks of age and who are also receiving formula milk or any other liquids or food.

Figure 32 Breast feeding at 6-8 weeks Trend



Source: NHSE, PHOF2.02

Figure 33 Breast feeding at 6-8 weeks 2014/15(significance compared to England lower, same, higher)



Source: NHSE, PHOF2.02

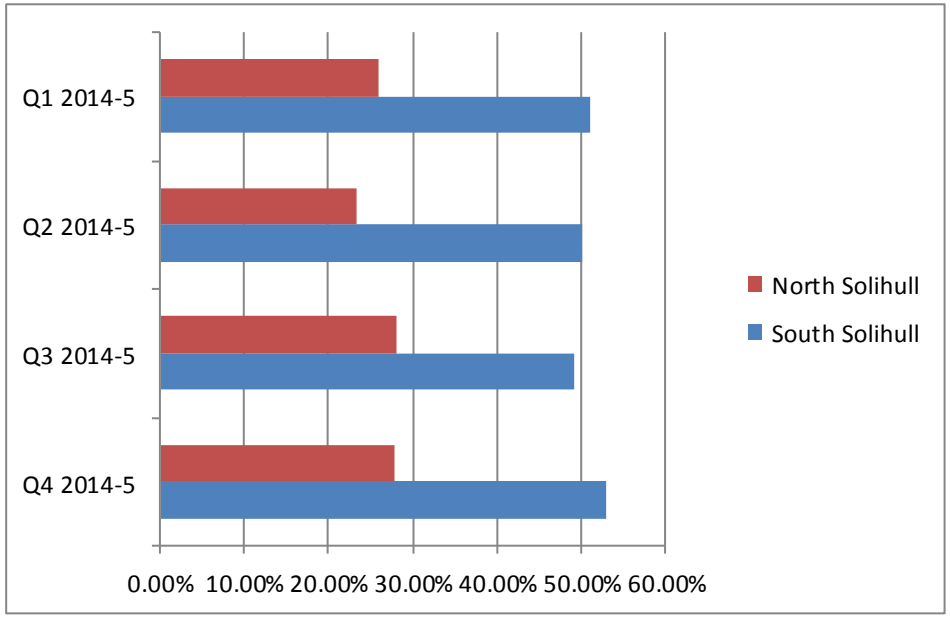
Key points

- The 6-8 week breastfeeding rate for Solihull was significantly lower than that for England between 2010/11 and 2013/14.
- In 2014/15 Solihull's rate increased to 44.2% and is now similar to that for England.
- Compared to its statistical neighbours, Solihull is significantly better than Cheshire West and Chester and Warrington, similar to Central Bedfordshire but worse than Stockport. No data was available for Trafford.
- The 2015/16 update uses a new methodology so no trend data is available and data are missing for multiple statistical neighbours. However, Solihull's figure at 43.5% remains not significantly different to England at 43.2%.

Breastfeeding within Solihull

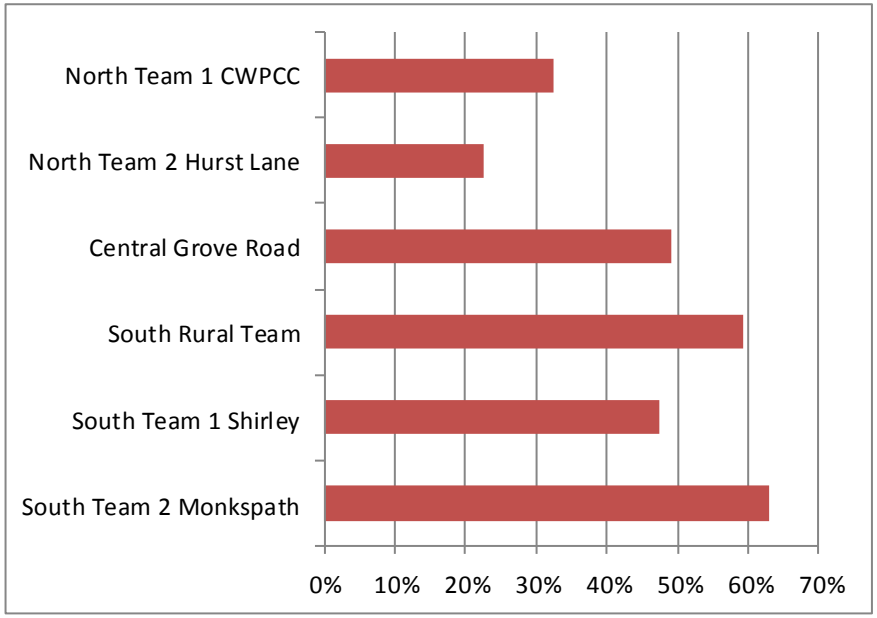
There are significant inequalities in breastfeeding rates within the different areas in Solihull.

Figure 34 A comparison of the prevalence of breastfeeding at 6-8 weeks between north and south Solihull in 2014-5



Source: Heart of England Foundation Trust

Figure 35 Breastfeeding at 6-8 weeks in Q4 2014-15 by Health Visiting Team



Source: Heart of England Foundation Trust

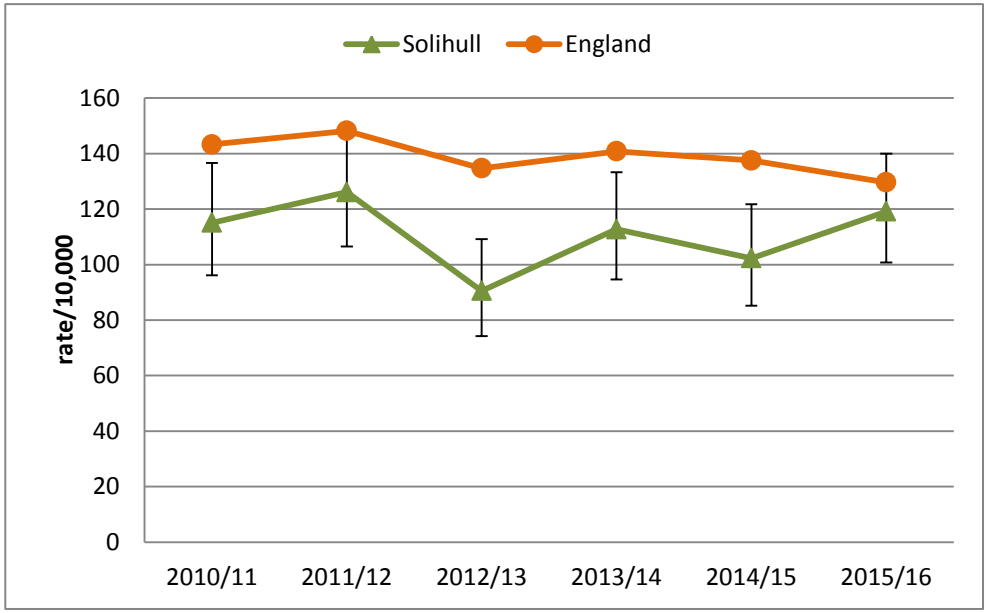
Key Points

- There are marked differences in breastfeeding rates between north and south Solihull
- More affluent women are more likely to breastfeed than the less affluent.
- The gap in breastfeeding prevalence at 6-8 weeks has not consistently narrowed between most and least disadvantaged areas.

Hospital admissions due to injury

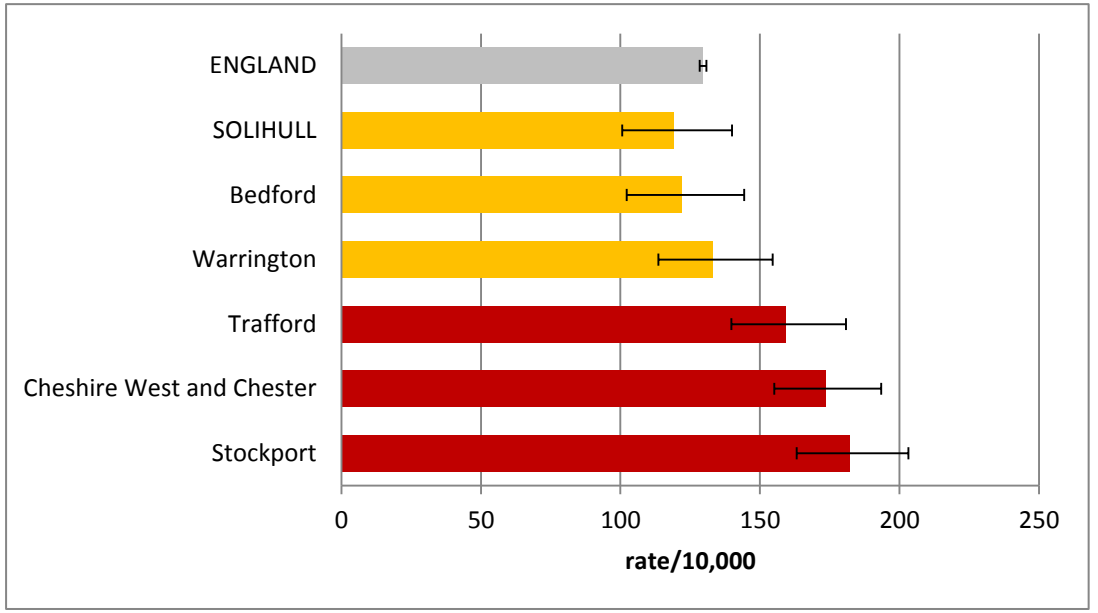
There are two main measures used nationally to gauge how local authorities perform against this indicator. These are hospital admissions and A&E attendances.

Figure 36 Hospital admissions caused by unintentional and deliberate injuries 0-4 years , trend



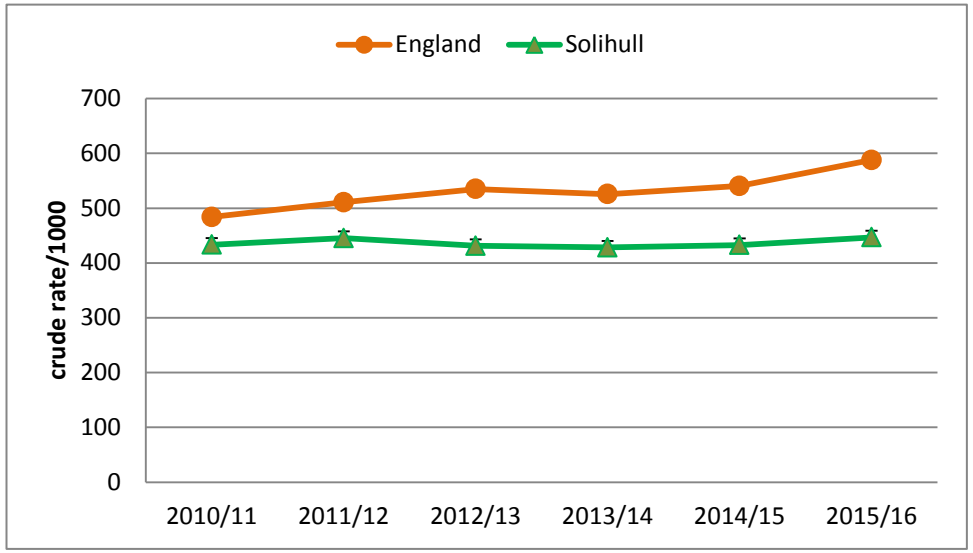
Source: PHE, PHOF2.07i

Figure 37 Hospital admissions caused by unintentional and deliberate injuries 0-4 years (2015/16)



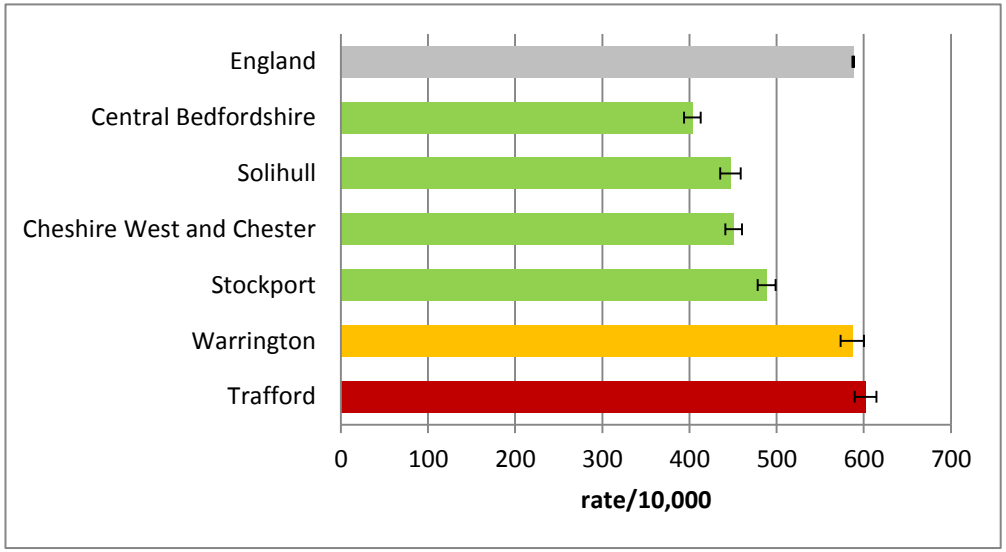
Source: PHE, PHOF2.07i

Figure 38 A&E attendances 0-4 year olds ,trend



Source: Hospital Episode Statistics (HES)Re-used with the permission of HSCIC

Figure 39 A&E attendances 0-4 year olds (2015/16)



Source: Hospital Episode Statistics (HES)Re-used with the permission of HSCIC

Analysis of data over a period of five years in England by the Child Accident Prevention Trust (CAPT) reveals that the majority of accidents to under fives happen in the home.

In England, home-related injuries resulted in approximately 40,000 emergency hospital admissions among children aged under five years and accounted for 8% of deaths of children in this age group (Office for National Statistics). The majority of these injuries are preventable.

There is a strong argument, reinforced by NICE guidance, to focus on tackling the leading, preventable causes of death and serious long-term harm. The CAPT analysis of national data identifies that five injury types should be prioritised:

- Choking, suffocation and strangulation
- Falls
- Poisoning
- Burns and scalds
- Drowning

Table 3 Emergency hospital admissions by accident type: rate per 100,000 (0 to 4 years) 2008/09 – 2012/13 (number of incidents in brackets)

Accident type	Solihull	England
Inhalation of food or vomit	12.2 (7)	11.1
Fall from furniture	107.9 (62)	149.2
Poisoning from medicines	102.6 (59)	99.4
Hot water burning	27.8 (16)	38.4
Drowning in the bath	less than 10.4 (N/A)	1.1

Source: CHIMAT unintentional injuries report/HES

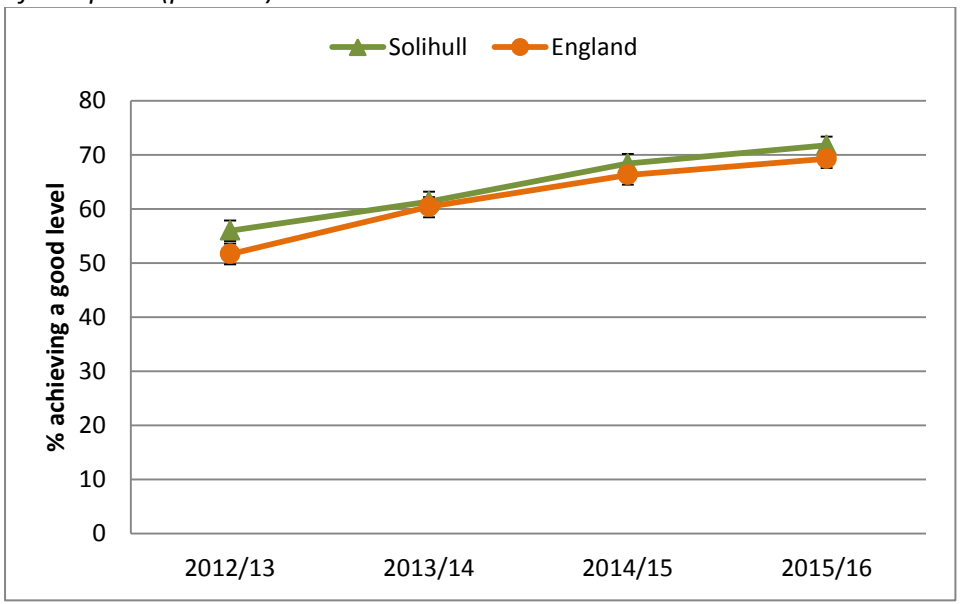
Early years foundation stage

School readiness is gaining currency as an indicator to close the learning gap and improve equity in achieving full developmental potential among young children. It is one of the basket of indicators used by Sir Michael Marmot in his 2013 examination of health inequalities in England.

Children are deemed to have reached a good level of development in the new Early Years Foundation Stage (EYFS) profile if they achieve at least the expected level in the early learning goals in the prime areas of learning (personal, social and emotional development; physical development; and communication and language) and in the specific areas of mathematics and literacy.

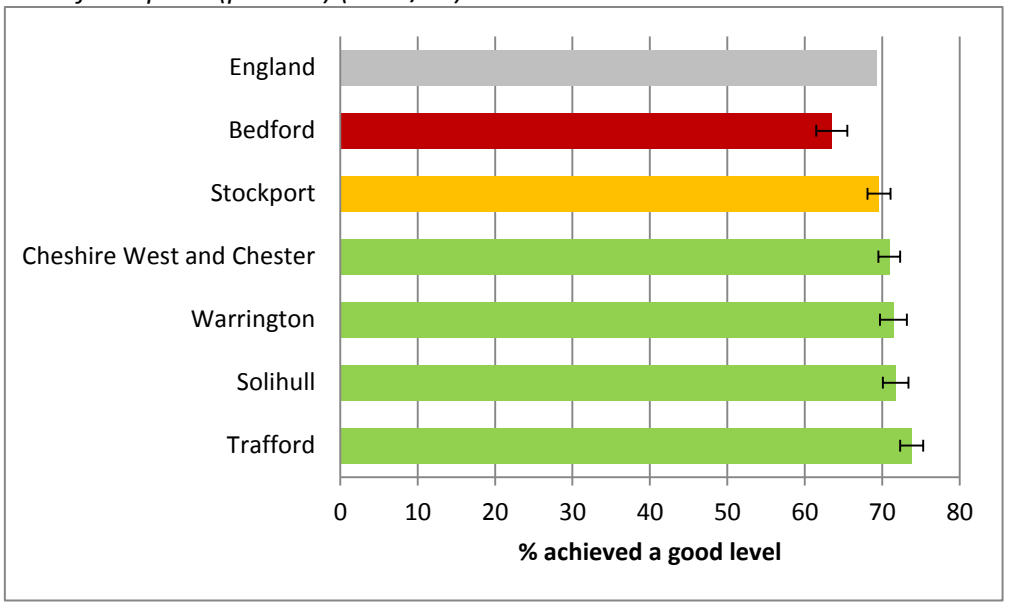
Solihull scores highly on literacy and mathematics but is below the national average on the other early learning goals (see Figure 42).

Figure 40 Proportion of children achieving a good level of development at the end of reception (persons)



Source: PHE, PHOF 1.02i

Figure 41 Proportion of children achieving a good level of development at the end of reception (persons) (2015/16)



Source: PHE, PHOF 1.02i

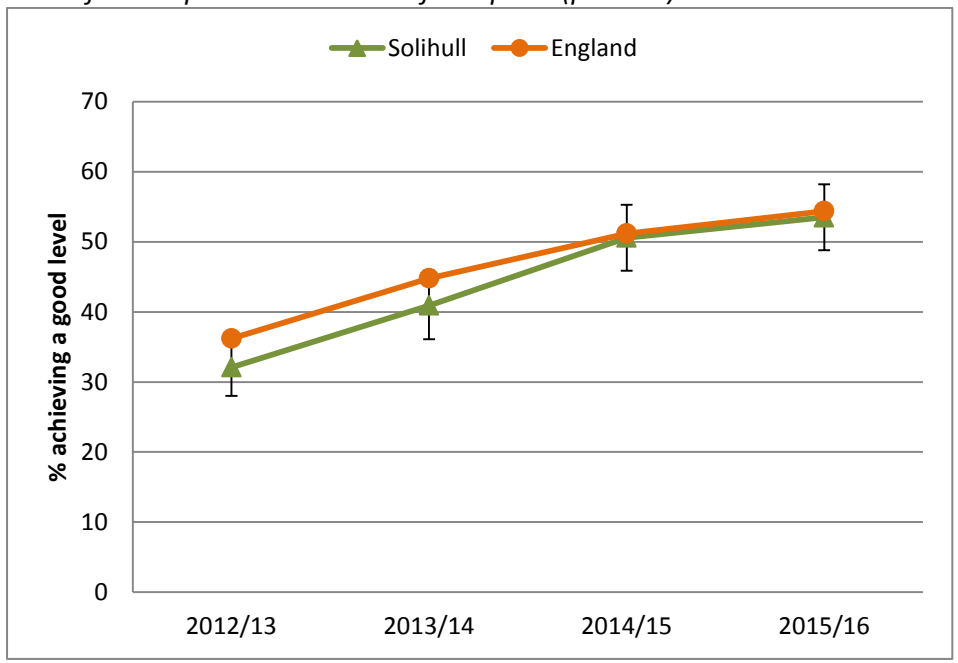
NB: Although the EYFS was introduced in 2008 it was simplified in 2012 following an independent review which mean that data prior to 2012 are not comparable.

Figure 42 Solihull's performance across early learning goals (performance above national average highlighted – all others below national average).

Goal	Learning Area	ENGLAND	SOLIHULL
Communication & Language	1: Listening and attention	85.6	83.8
	2: Understanding	85.3	83.9
	3: Speaking	84.1	83.2
Physical Development	4: Moving and handling	89.7	87.4
	5: Health and self-care	91.2	88.8
Personal, Social & Emotional Development	6: Self-confidence and self-awareness	88.7	86.9
	7: Managing feelings and behaviour	87.4	85.8
	8: Making relationships	89.0	87.1
Literacy	9: Reading	76.1	79.2
	10: Writing	70.8	75.2
Mathematics	11: Numbers	77.4	79.3
	12: Shape, space and measures	80.8	80.3
Understanding the World	13: People and communities	85.0	83.9
	14: The World	85.0	83.1
	15: Technology	91.7	88.2
Expressive arts & design	16: Exploring and using media and materials	87.8	86.1
	17: Being imaginative	87.2	85.0

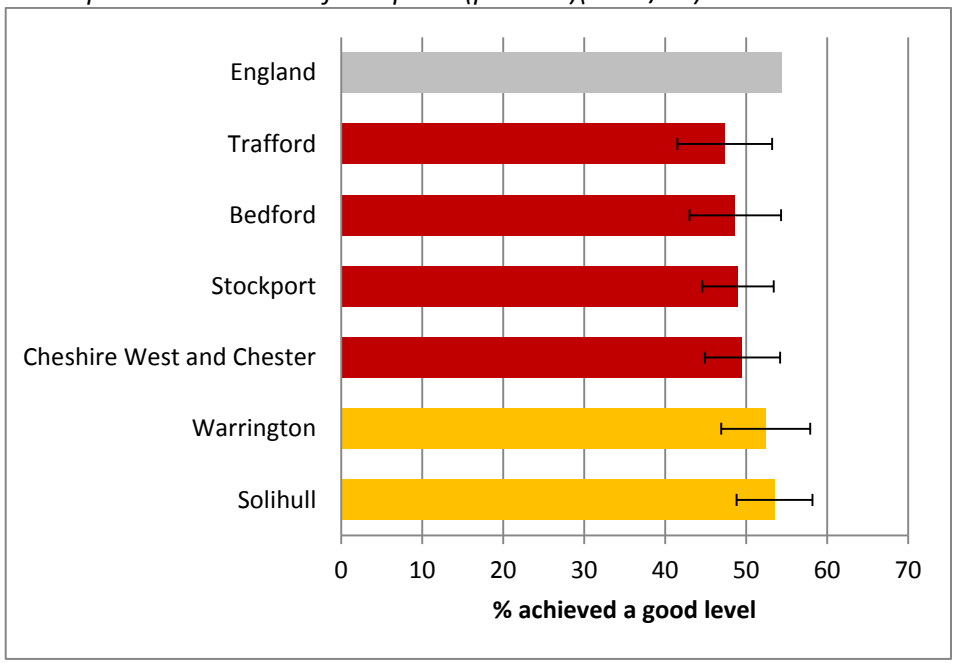
Source Local data, 2014

Figure 43 Proportion of children on free school meals (FSM) achieving a good level of development at the end of reception (persons)



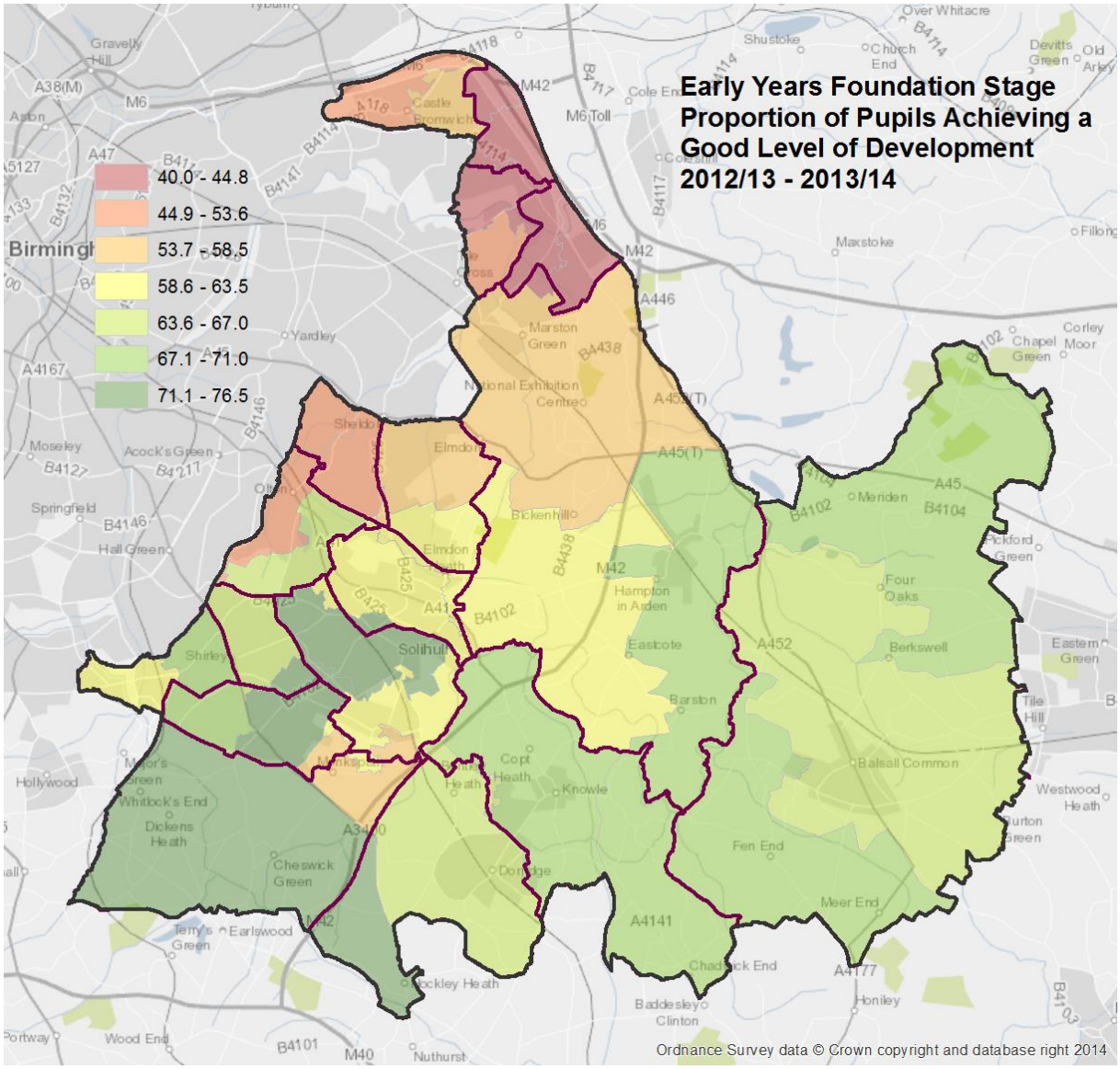
Source: PHE, PHOF 1.02i

Figure 44 Proportion of children on FSMs achieving a good level of development at the end of reception (persons)(2015/16)



Source: PHE, PHOF 1.02i

Figure 45 Proportion of pupils achieving a good level of development



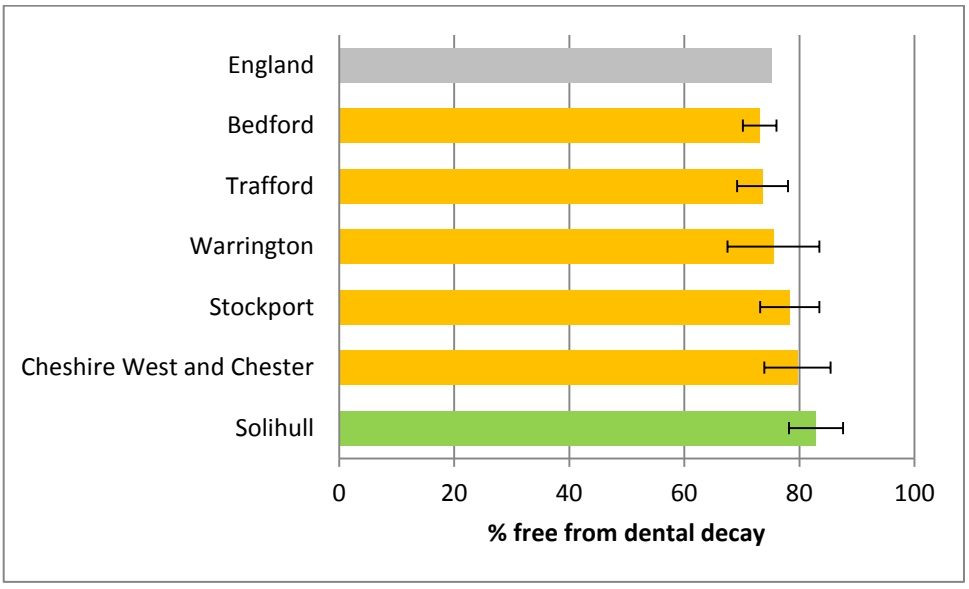
Tooth decay

Tooth decay is a predominantly preventable disease. A report by the Royal College of Surgeons (RCS) published in 2015 showed tooth decay was the most common reason five to nine-year-olds were admitted to hospital.

Oral health is an integral part of overall health and can affect children and young people's ability to sleep, eat, speak, play and socialise with other children. Other impacts of poor oral health include pain, infections, poor diet, and impaired nutrition and growth. Poor oral health may be indicative of dental neglect and wider safeguarding issues

Poor oral health can also be a marker of parental neglect or abuse.

Figure 46 Proportion of five year old children free from dental decay 2014/15



Source: Source: Dental Public Health Epidemiology Programme for England: oral health survey of five-year-old children 2015

6. School years

Education is a key determinant of health. Acquiring good literacy and numeracy skills is not only important in getting a good job and earning a decent income it also impacts on your chance of living a long and healthy life. The Marmot report calculated that, for people aged 30 and above – if everyone had their death rate reduced to that of people with degrees – there would be 202,000 fewer premature deaths in this country each year: that is roughly the size of the Solihull population.

While low achievement in school is a known risk factor for a range of health and social problems (such as drug use, teenage pregnancy and crime) conversely poor health depresses educational attainment.

Schools have the potential to create a virtuous circle providing a positive health environment which can help improve attainment, especially for those children who come from less than optimum home backgrounds and neighbourhoods.

NICE guidance on social and emotional wellbeing in schools advices schools to have programmes to develop children's social and emotional skills and help parents with their parenting skills but emphasises the need for this to take place within the context of a comprehensive 'whole school' approach. The Chief Medical Officer's 2012 report, 'Our children deserve better', supports this approach and points to the increasing evidence that having a 'sense of connectedness with school' is a recognised protective factor for mental health.

Other tools that schools can deploy with the support of the local authority School Education Improvement Services include

- Personal, social, health and economic (PSHE) education (although Ofsted reported in 2012 that in English schools 40% of PSHE required improvement or was inadequate)
- Healthy Schools Standard (a local scheme has been maintained in Solihull and over 80% of Solihull schools are accredited)
- Mental Health First Aid (this has been rolled out across seven schools so far)
- Emotional resilience programmes (e.g. Social and Emotional Aspects of Learning – SEAL – and others)
- Promoting anti-bullying interventions

Schools – local authority cross border movements

Solihull schools have a sizeable number of pupils who live outside of the borough. At secondary school level nearly one-third of the Solihull school population live in neighbouring authorities.

Table 4 Solihull school population by area of residence

	Attends Solihull school			
Local Authority of residence	**Primary**	**%**	**Secondary**	**%**
Solihull	15515	86%	10197	67%
Birmingham	1913	11%	4359	29%
Warwickshire	203	1%	151	1%
Worcestershire	182	1%	82	1%
Coventry	176	1%	385	3%
Other	12	0.1%	11	0.1%
Total on Solihull school roll	18001	100%	15185	100%
Solihull residents who attend school outside of borough	890		1063	
Net inflow to Solihull	1587		3917	
As % of school roll	9%		26%	

Source https://www.gov.uk/government/statistics/schools-pupils-and-their-characteristics-january-2015

Childhood obesity

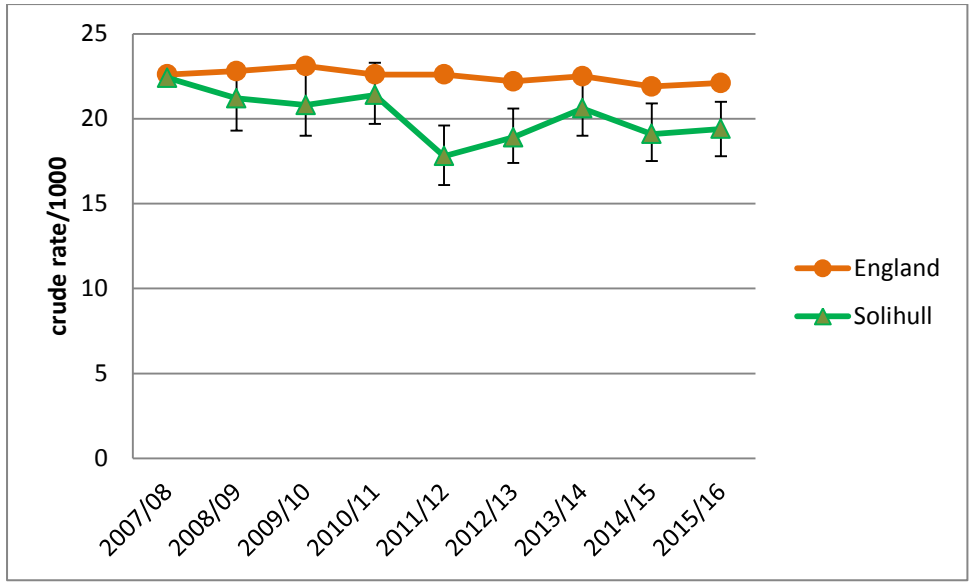
Excess weight (overweight and obesity) in children often leads to excess weight in adults, and this is recognised as a major determinant of premature mortality and avoidable ill health. It can also have a detrimental effect on mental wellbeing as being obese can lead to bullying and loss of self esteem.

The National Child Measurement Programme (NCMP) measures the height and weight of children in reception class (aged 4 -5 years) and year 6 (aged 10 – 11 years) to assess excess weight in children within primary schools. The heights and weights are used to calculate a Body Mass Index (BMI). Figures for England show that the proportion of overweight and obese children rises from approximately a fifth (21.9%) at reception to a third (33.2%) at year 6.

For three out of the last four years, Solihull has been significantly lower than the national average on excess weight in reception year. In the last year for which measurements are available Solihull's rate (19.4%) was the second lowest among our statistical neighbours.

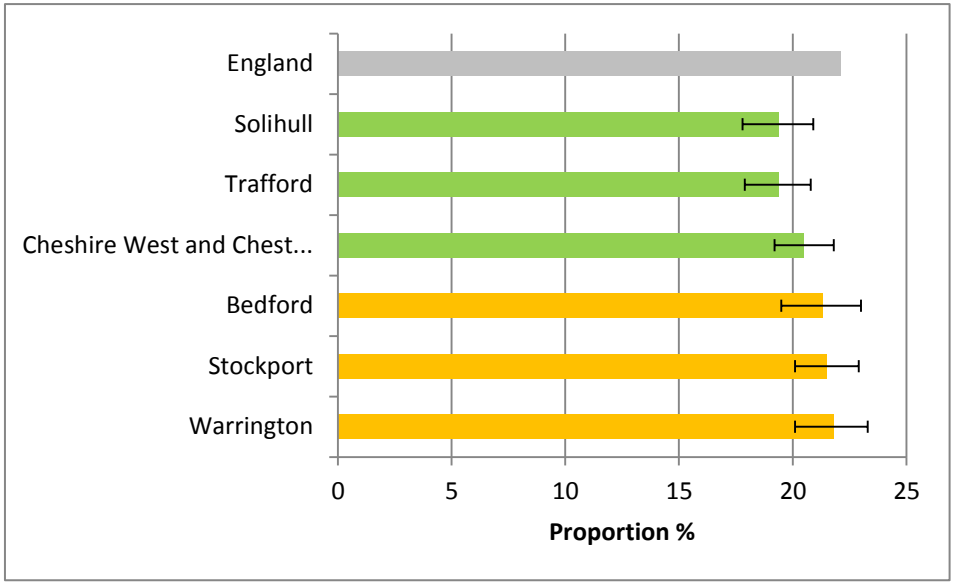
Excess weight (overweight and obesity) – Reception Year

Figure 47 Trend for excess weight in reception year (2015/16)



Source: NCMP

Figure 48 Excess weight in reception year (2015/16)

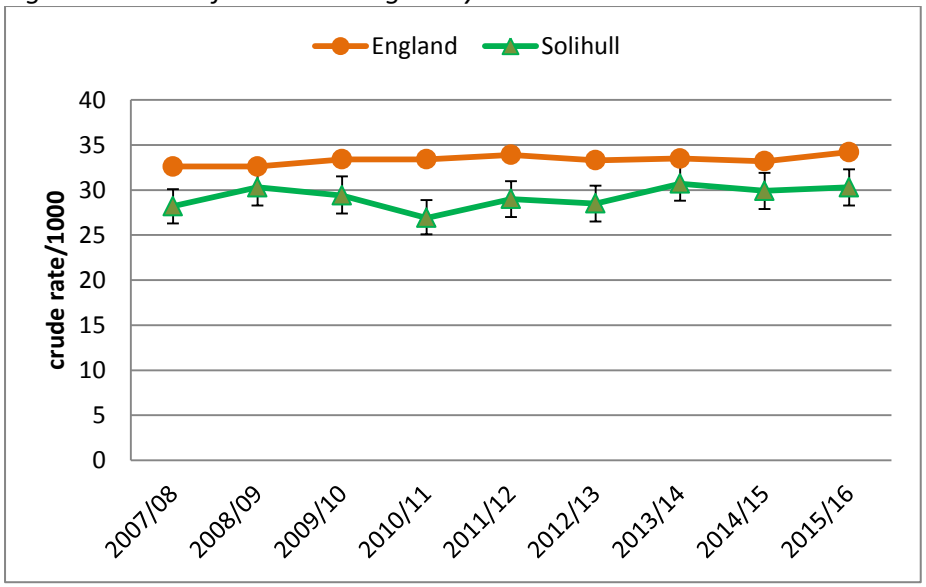


Source: NCMP

Excess weight (overweight and obesity) – Year 6

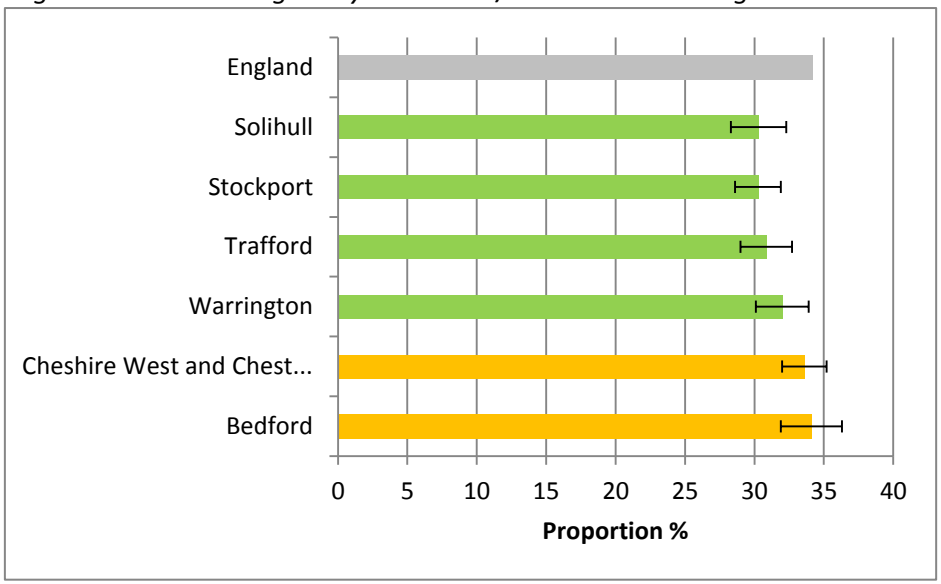
Solihull's prevalence of excess weight at year 6 has remained at 30% or just below since NCMP measurements began in 2006. Again this is significantly lower than the national average and is similar to its statistical neighbours.

Figure 49 Trend for excess weight in year 6



Source: NCMP

Figure 50 Excess weight in year 6 2015/16 – statistical neighbours



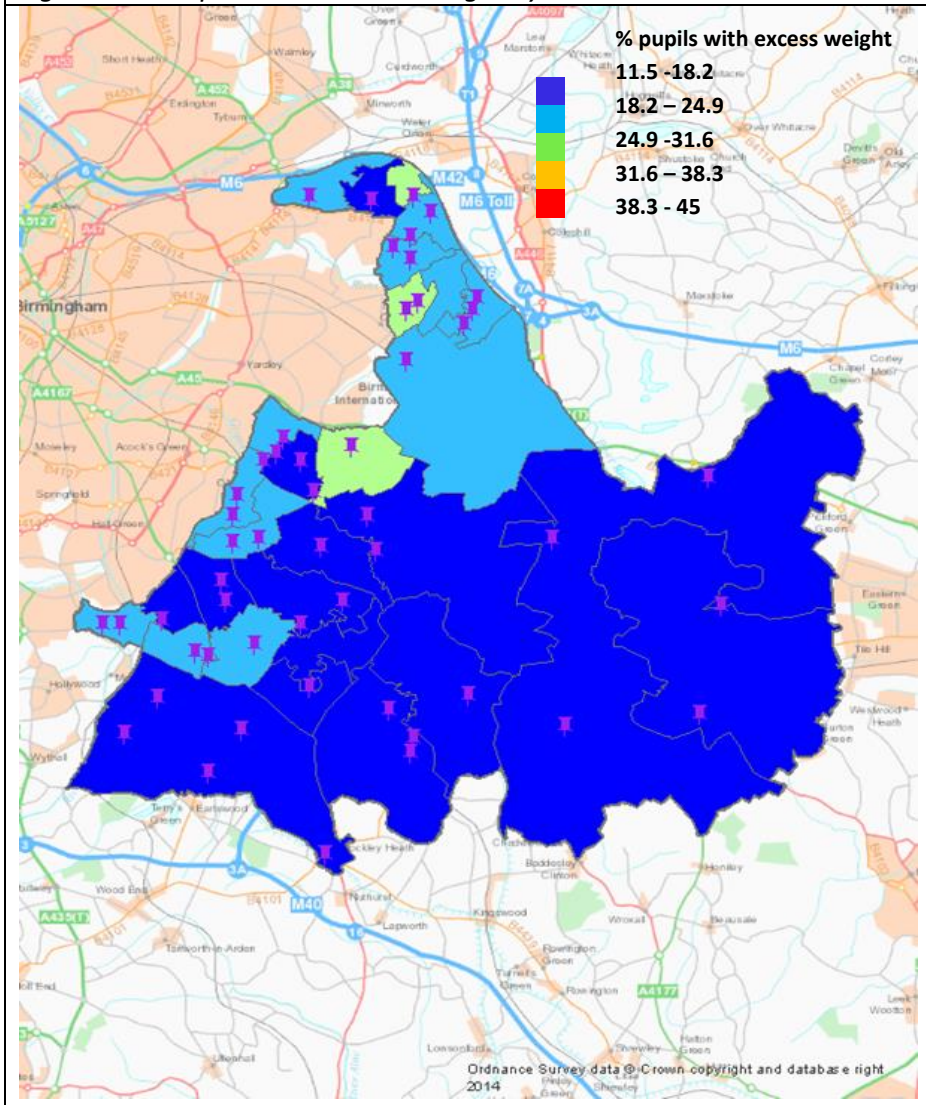
Source: NCMP

Inequalities within Solihull

There is a strong relationship between deprivation and childhood obesity, such that nationally, obesity prevalence of the most deprived 10% of the population is approximately twice that of the least deprived 10% Data from Public Health England also shows that socioeconomic inequalities in obesity prevalence have widened over the years (2006-2014).

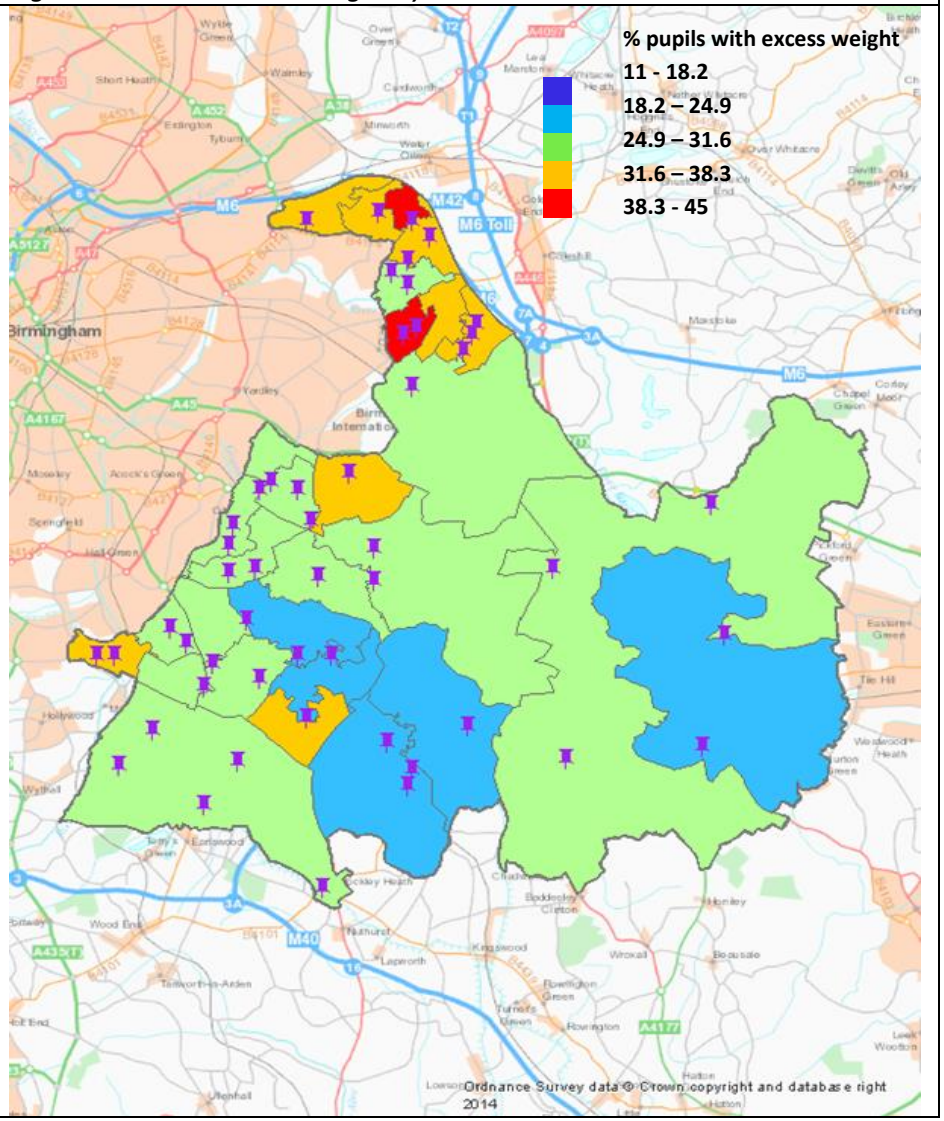
The following maps highlight the extent of the inequality gap in Solihull and demonstrate the link with socio-economic deprivation. (NOTE: primary schools are indicated by purple pins on these maps).

Figure 51 Reception Year excess weight by MSOA 2011-14



Source: NCMP

Figure 52 Year 6 excess weight by MSOA 2011-14

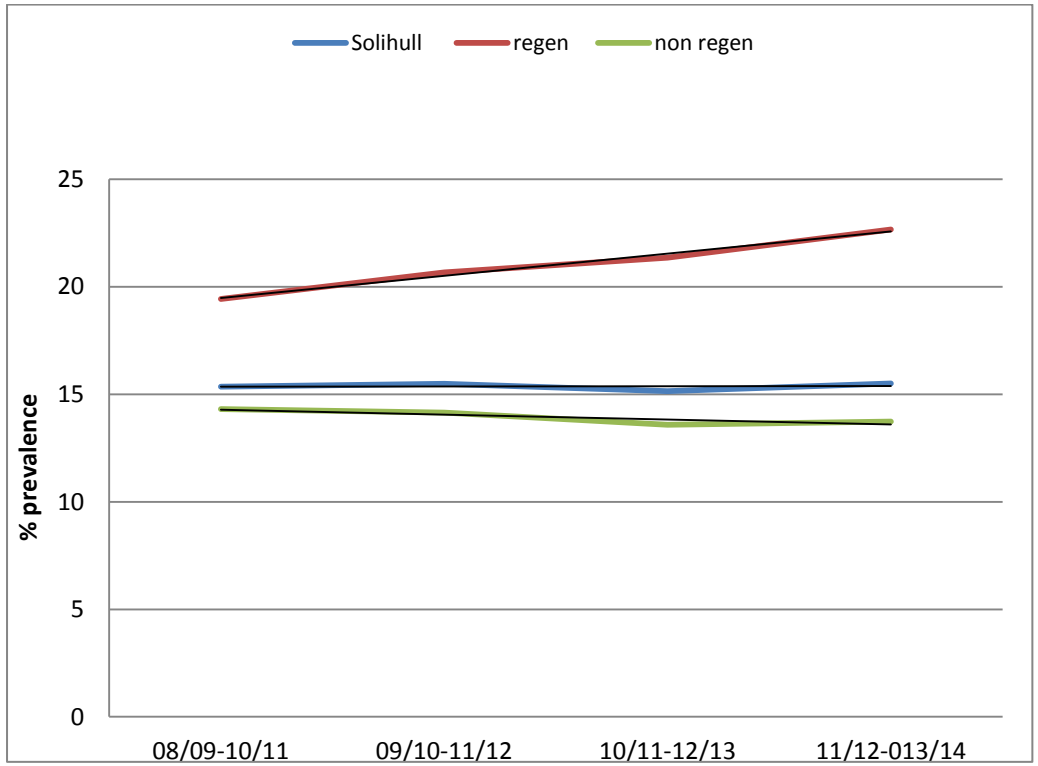


Source: NCMP

Some detailed analysis carried out on NCMP data in Solihull between 2009 and 2014 came to two conclusions. First, that there is a significant upward increase in obesity prevalence in the regeneration areas, and second, that a genuine gap between the regeneration wards and non-regeneration wards exists and is greater in year 6.

It would appear that although rates of excess weight have remained fairly constant, or perhaps even have reduced slightly in Solihull at reception and year 6, rates in the north regeneration wards have risen, serving to widen the inequality gap.

Figure 53 Excess weight at Year 6 across Solihull



Source NCMP

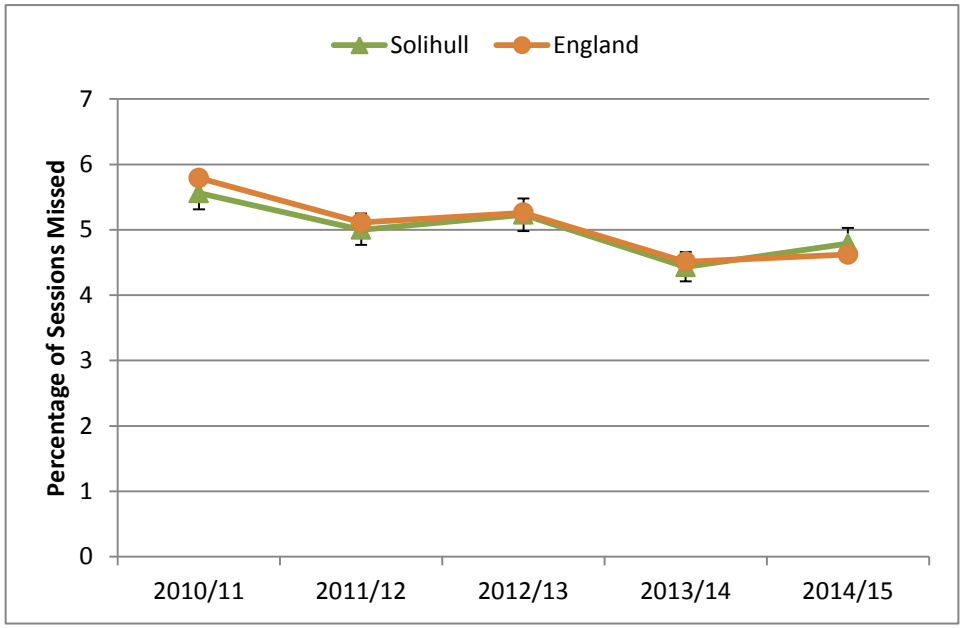
Key points

- Although children in Solihull are significantly less obese than in the country as a whole, nevertheless 30% are overweight or obese by the time they reach year 6.
- There is a widening gap in rates of obesity when looking at the more deprived wards in the north compared to the rest of Solihull.

Total School Absence

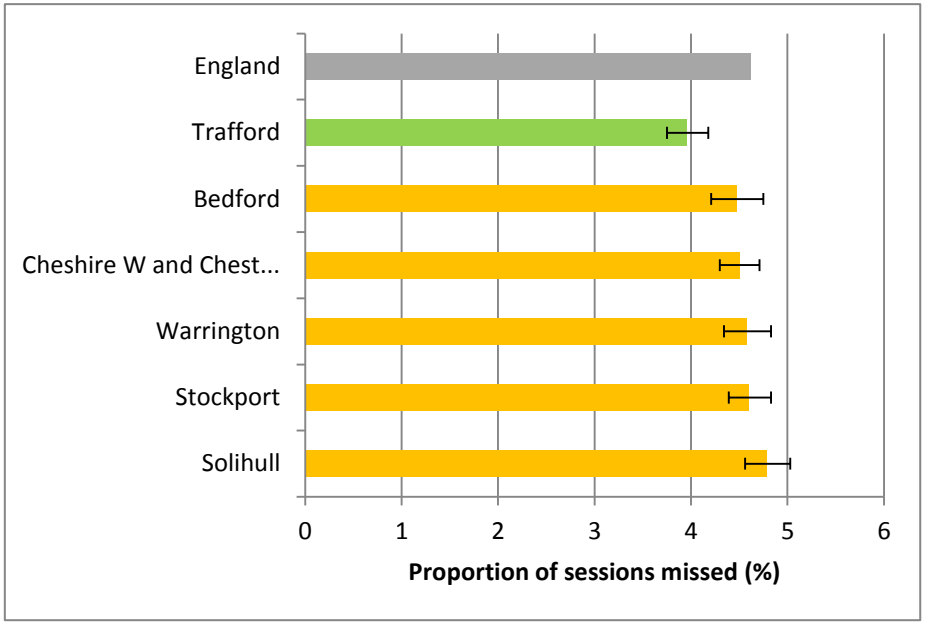
Young people not in school are not only less likely to achieve academically they are also at greater risk of criminal and anti-social behaviour. Pupil absence (unauthorised and authorised) relates to the proportion of pupil enrolments (half-days or sessions) missed in all state-funded schools by location of the school, for pupils aged 5 to 15 at the start of the school year.

Figure 54 Trend for pupil absence (unauthorised and authorised)



Source: PHOF 1.03

Figure 55 Pupil absence 2014/15 (unauthorised and authorised)

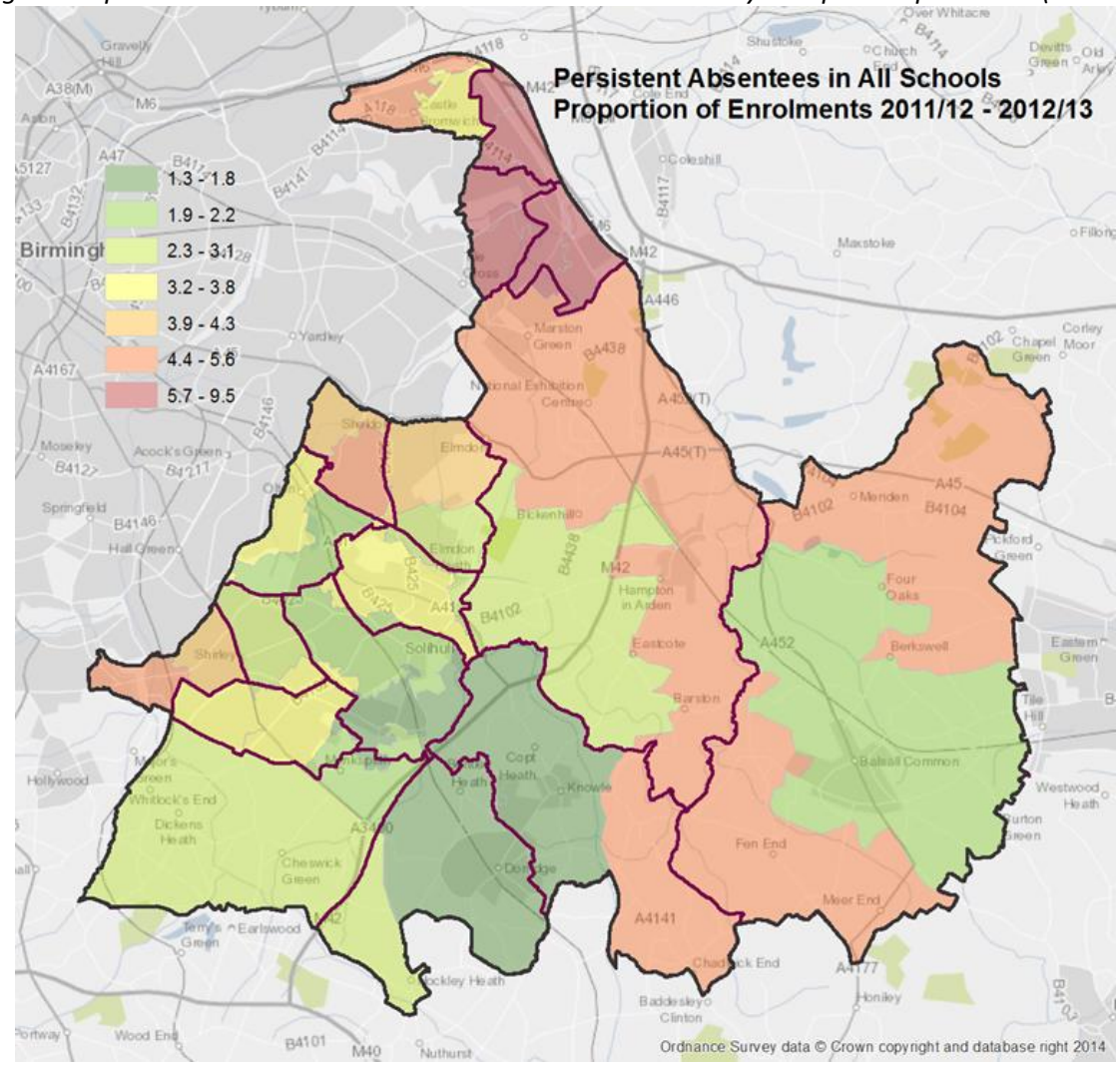


Source: PHOF 1.03

- The pattern for Solihull has followed England since 2010/11 and at 4.8% for 2014/15, is similar to England (4.6%) and nearest statistical neighbours, with the exception of Trafford, (4.0%) which does significantly better.

Persistent absence is the number of half-days for all absences where the pupils is a persistent absentee (absent for 46 or more sessions during the year) as a proportion of all possible enrolments for all pupils. This measure is not available within national benchmark tools but is available from ONS neighbourhood statistics and is a better measure than Total School Absence for comparing inequality across the borough.

Figure 56:persistent absence in all schools – Solihull Middle Layer Super Output Areas (MSOAs)

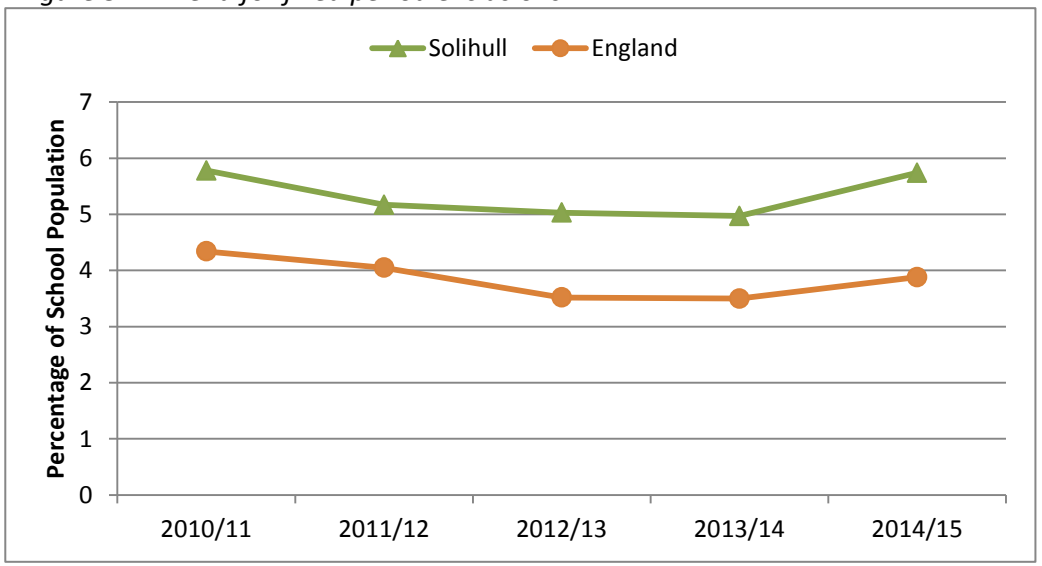


Source: Neighbourhood statistics, ONS

Fixed Period Exclusions

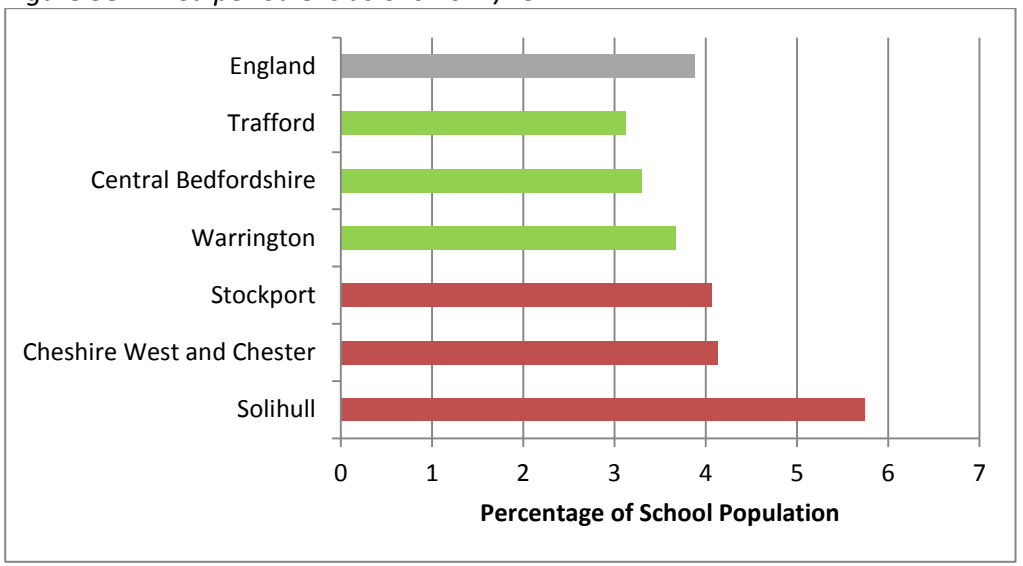
There are two measures for school exclusions, for both of which Solihull is in the worst performing quartile of local authorities in England. Solihull has a level of 5.7% for fixed period exclusions (of the school population) compared with 3.9% for England and 0.21% for the permanent exclusions equivalent (compared with 0.07%)[11].

Figure 57 Trend for fixed period exclusions



Source: LAIT, Department for Education

Figure 58 Fixed period exclusions 2014/15



Source: LAIT, Department for Education

Analysis by school type confirms that Solihull has the highest rate of fixed period exclusions compared to its statistical neighbours for both primary and secondary schools.

[11] Department for Education: https://www.gov.uk/government/statistics/permanent-and-fixed-period-exclusions-in-england-2014-to-2015

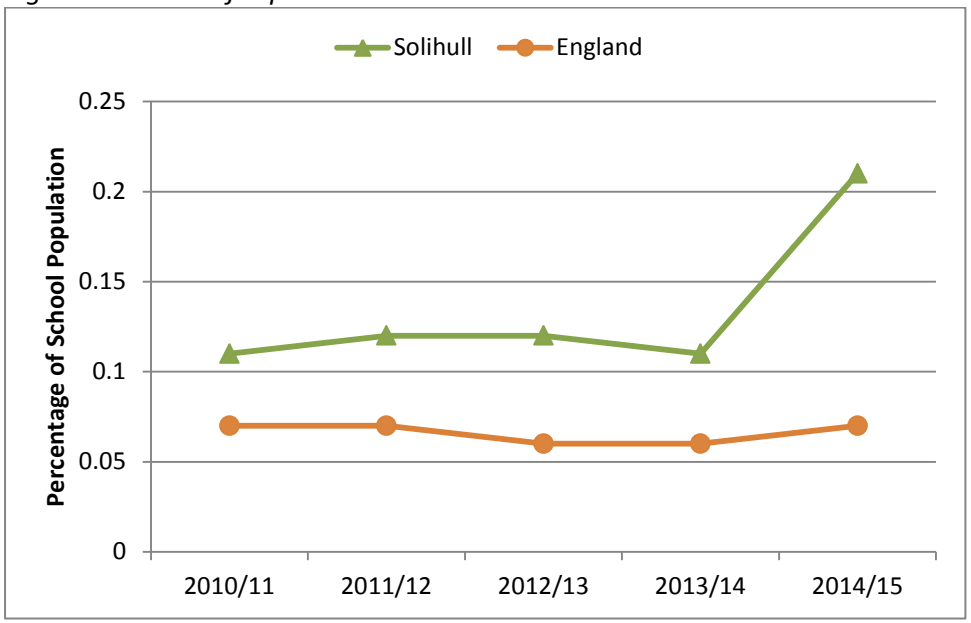
Total fixed term exclusions by type of school 2013/14 (% of the school population)

Authority	Primary school	Secondary school
ENGLAND	0.49	3.64
SOLIHULL	0.53	5
Stockport	0.4	4.52
Cheshire W	0.35	3.42
Warrington	0.41	3.15
Trafford	0.2	2.79
Central Beds	0.51	2.66

Source: LAIT, Department for Education

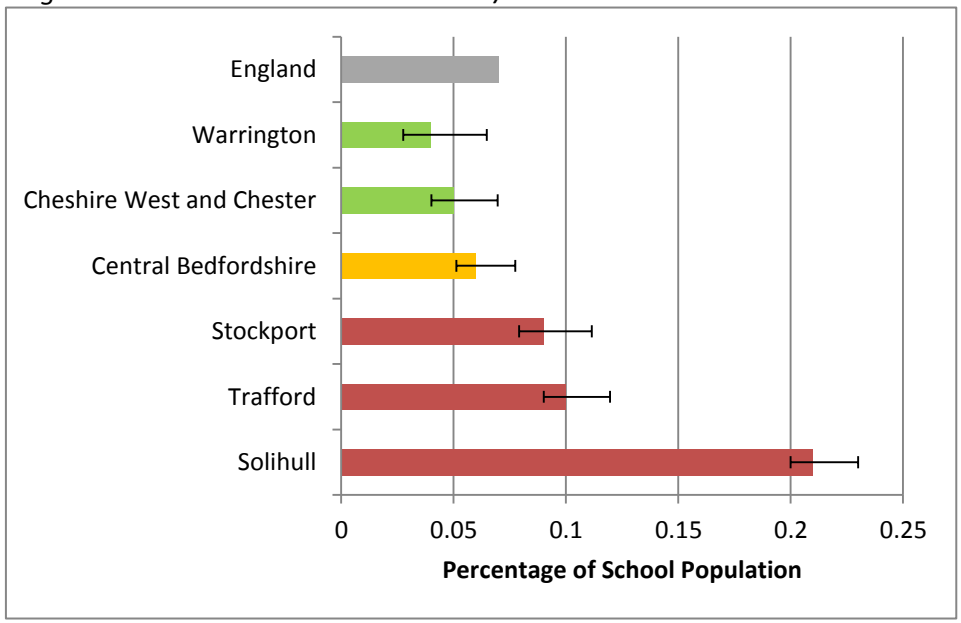
Permanent Exclusions[12]

Figure 59 Trend for permanent exclusions



Source: LAIT, Department for Education

Figure 60 Permanent exclusions 2014/15



Source: LAIT, Department for Education

Key points

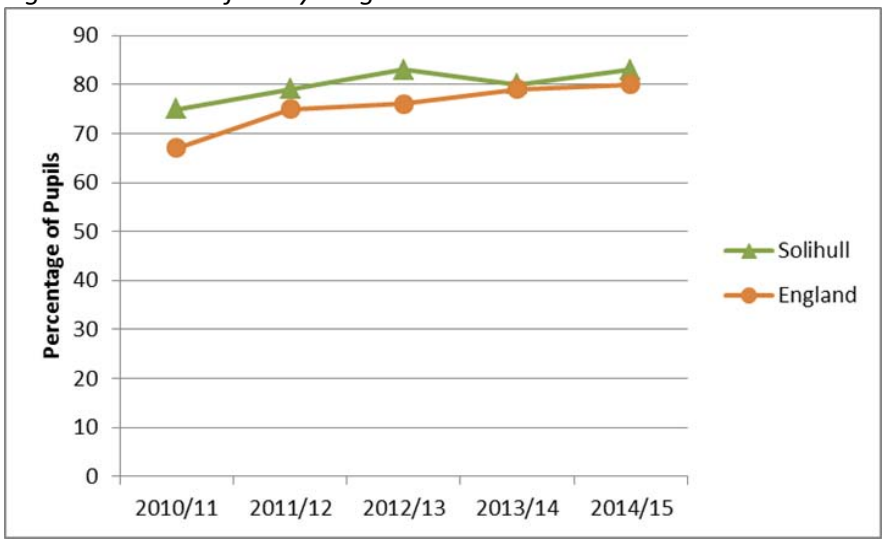
- Absence rates in Solihull are at the national average and similar to statistical neighbours.
- Solihull's rate of exclusions is above the national average and in the case of fixed term exclusions is the highest among the statistical neighbours.

[12] Department for Education: https://www.gov.uk/government/statistics/permanent-and-fixed-period-exclusions-in-england-2014-to-2015

Key Stage 2 Attainment at 11 years of age

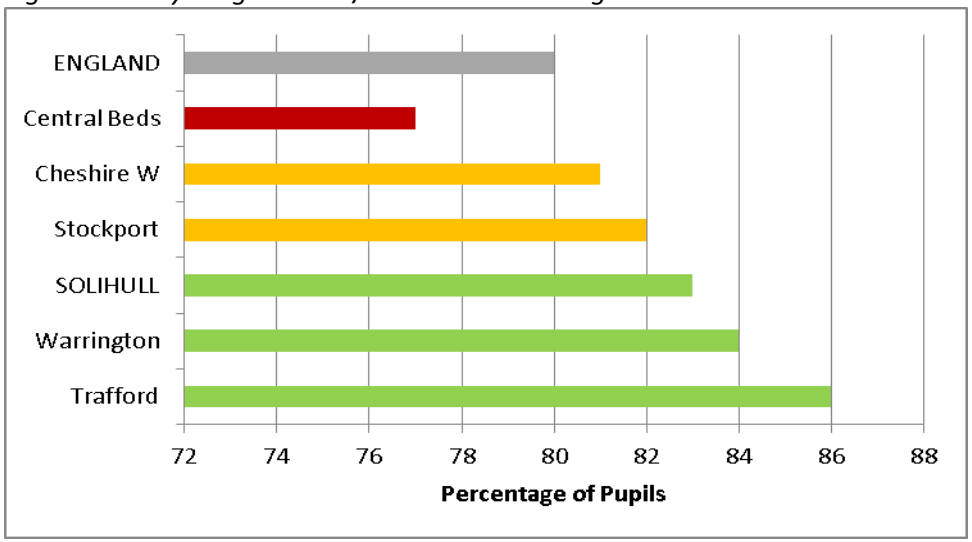
Solihull (83%) is significantly better than England (80%) for Key Stage 2 attainment as measured by the percentage of pupils achieving Key Stage 2 Level 4+ Reading, Writing and Maths in 2014/15.

Figure 61 Trend for Key Stage 2



Source: LAIT, Department for Education

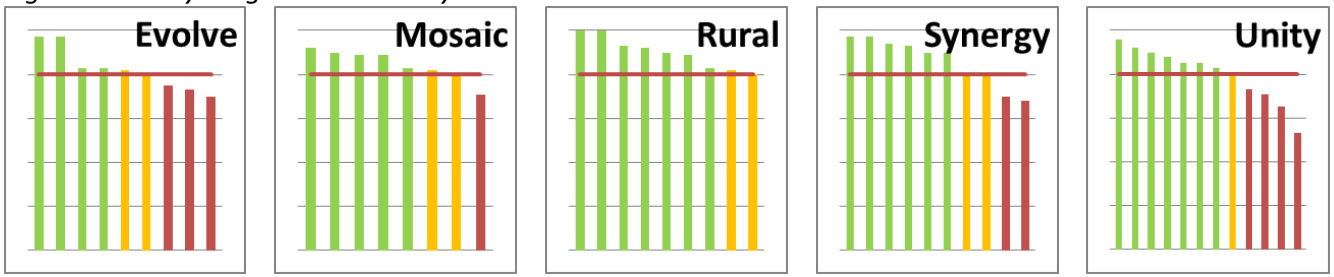
Figure 62 Key Stage 2 2014/15 – statistical neighbours



Source: LAIT, Department for Education

It is notable that the difference in school attainment within collaboratives for this measure is much greater than the difference between them. The bold line is the Solihull average of 83% and each school is represented by a bar. A note of caution needs to introduced when interpreting this finding as some schools outcomes will be based on a small number of pupils.

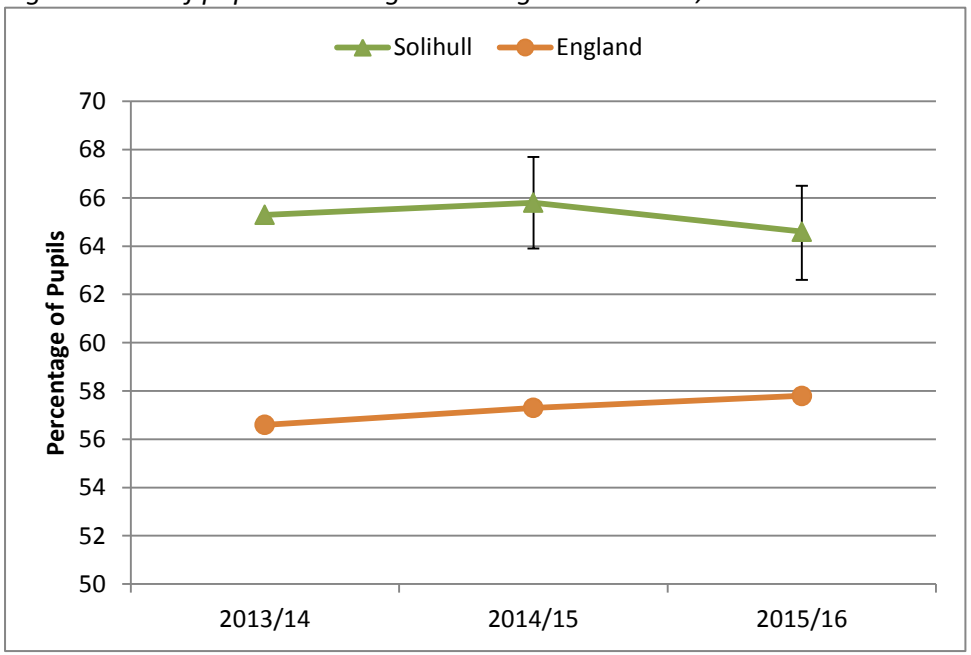
Figure 63 Key Stage 2 – schools by collaborative



Pupils achieving 5+ GCSE grades A*to C at 16 years of age

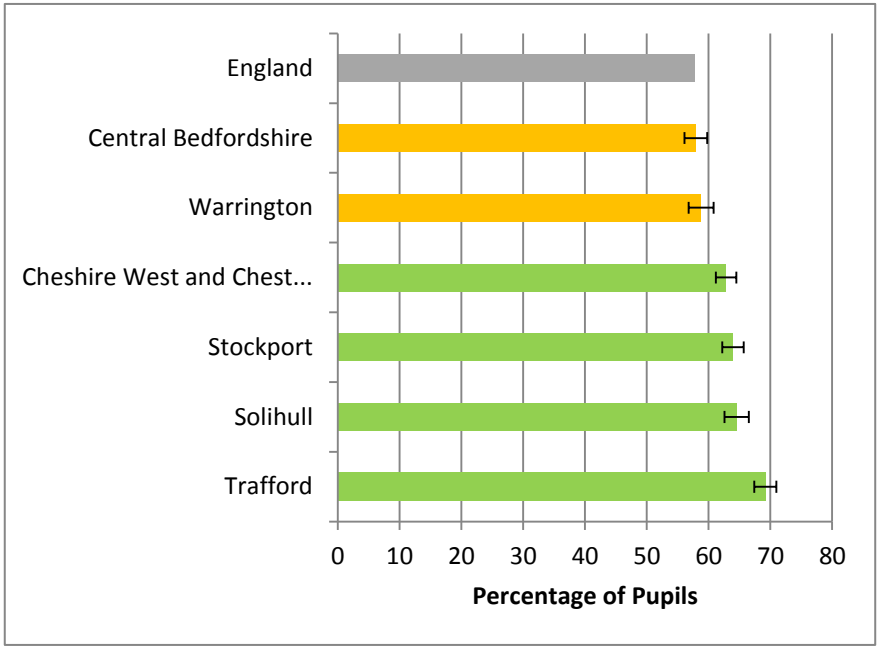
Education can directly affect an individual's employment prospects as well as influencing his or her ability to make informed healthy choices about how he or she leads his or her life[13].

Figure 64 % of pupils achieving 5+ GCSE grades A to C, trend*



Source: PHE (DfE data)

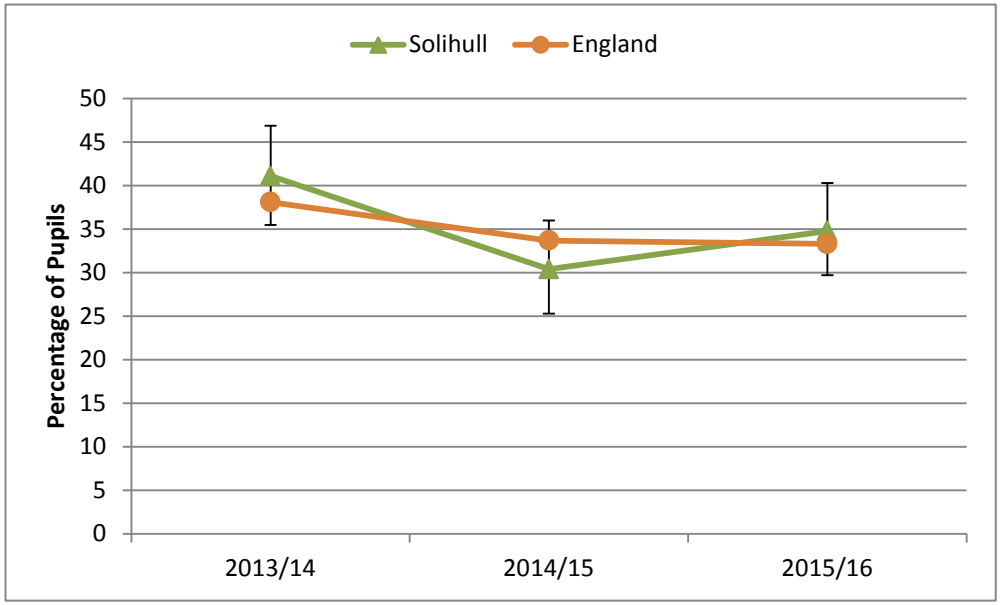
Figure 65 % of pupils achieving 5+ GCSE grades A to C, 2015/16*



Source: PHE (DfE data)

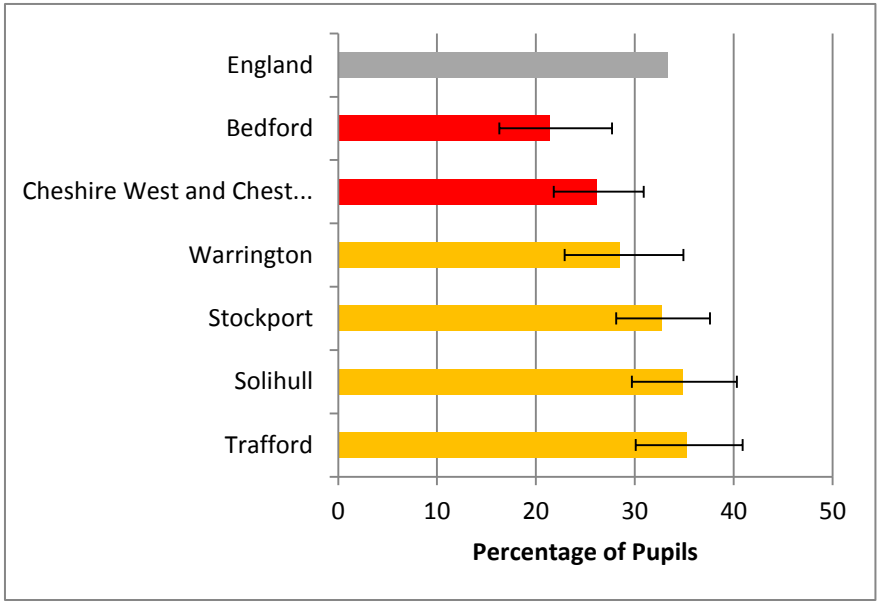
[13] Local Authority Child Health Profiles Indicator guide 2015, http://www.chimat.org.uk/profiles/data

Figure 66a % of pupils eligible for free school meals achieving 5+ GCSE grades A* to C



Source: PHE (DfE data)

Figure 66b % of pupils eligible for free school meals achieving 5+ GCSE grades A* to C*, 2015/16*



Source: PHE (DfE data)

Key Points

- Overall educational attainment at Key Stage 2 and 4 is above the national average.
- But the proportion of pupils eligible for free school meals who achieve 5+ GCSEs in Solihull is not significantly better than the England average (34.8% v 33.3%).
- Solihull's achievement on GCSEs in 2015/16 is one of the best in its comparator group, only Trafford achieving a higher percentage. This holds for all pupils, irrespective of whether they receive free school meals.

School survey data

The data in the next section of this report is derived from the Health Related Behaviour Questionnaire (HRBQ). This is a survey that primary pupils aged 6 to 11 and secondary pupils aged 12 to 15 in the majority of schools in Solihull complete every two years.

The HRBQ is administered by the School Health Education Unit at Exeter University and has taken place five times in Solihull.

When it was last conducted in 2016 a total of over 8,900 pupils took part in 74 Solihull Infant, Primary, Secondary and Special schools.

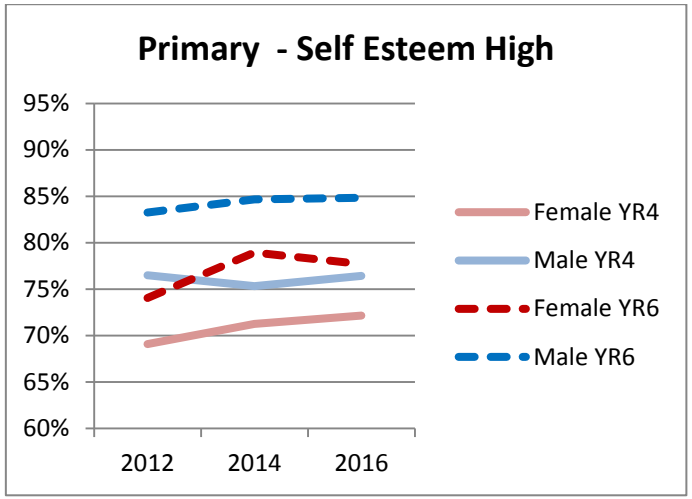
It should be noted that charts in this section are available by school collaborative where the postcode sector of the respondent is known. Note also that the gender splits by school year are for all respondents including those resident outside of Solihull.

Topics include:-

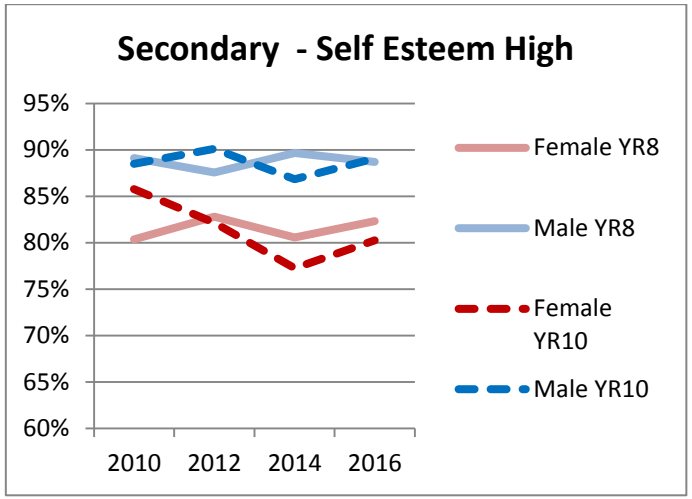
- Citizenship
- Drugs, Alcohol and Tobacco
- Emotional Health and Wellbeing
- Healthy Eating
- Internet Use
- Leisure
- Physical Activity
- Safety
- School and Career
- Sex and Relationships

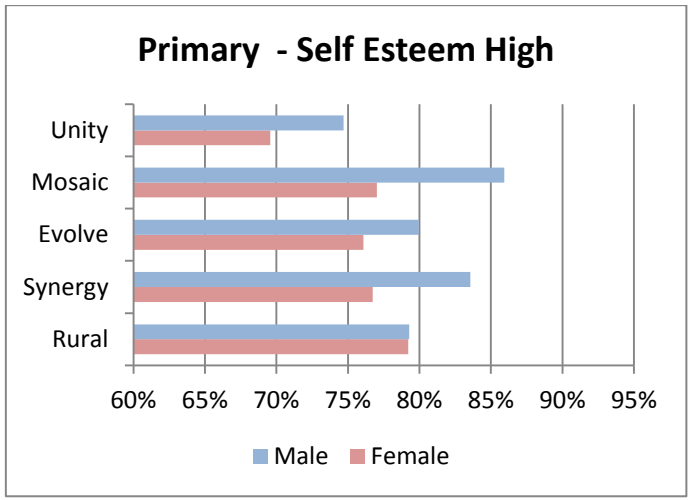
Self Esteem

The HRBQ includes a series of questions which are used to generate a composite self esteem score. The following charts show the proportion of respondents that have a score of either 'med-high' or 'high'.

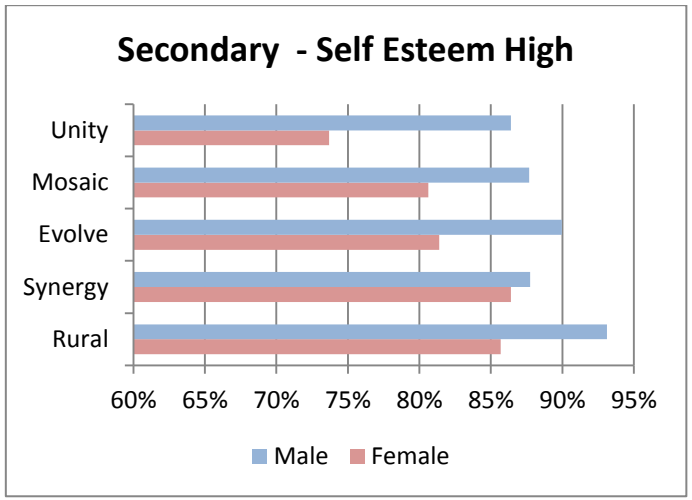


Self Esteem is higher for boys across both gender and all age groups, although there is no obvious shift over time. However, despite an improved position for girls at year 6 between 2012 and 2014 there has been a marked decline from 2010 to 2014 at year 10.



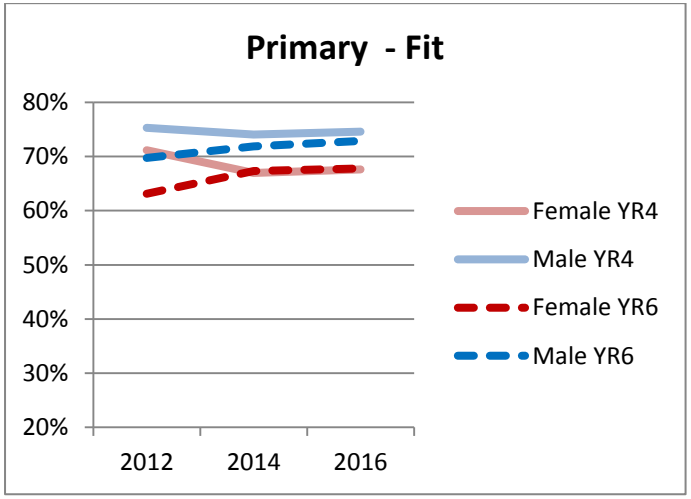


Boys are higher than girls across all collaboratives by school stage. There is no obvious geographic pattern for boys although girls are lowest in Unity at both primary and secondary stage.



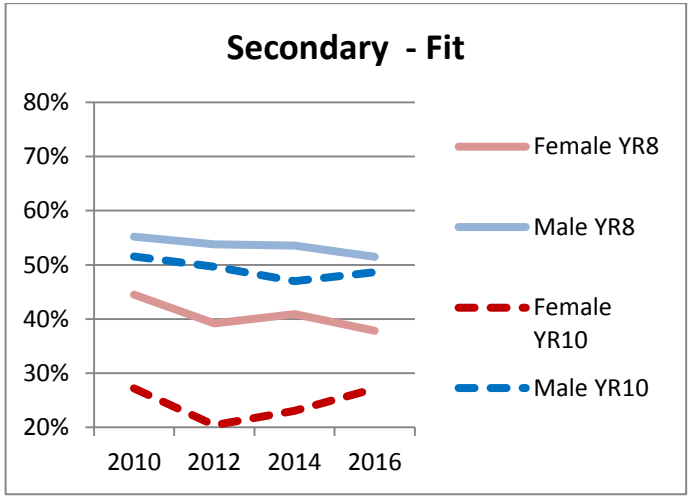
Fitness.

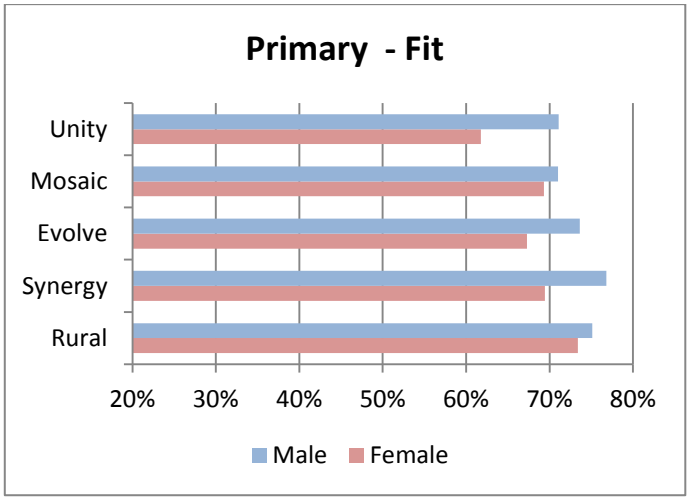
The following charts show pupils responses to the question 'How fit do you think you are?'



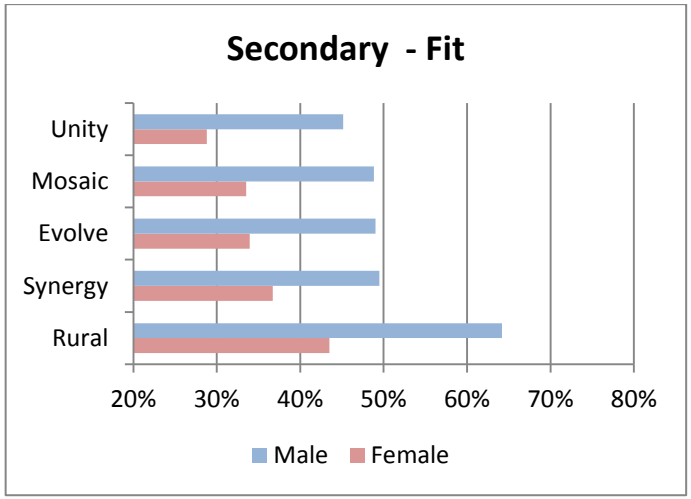
Although gender is important, particularly for girls in year 10 – the reduction from primary to secondary year 8 and again to year 10 is perhaps more cogent.

71% of pupils in Solihull primary schools describe themselves as 'fit' or 'very fit'. This is higher than the 63% who said this in the reference sample..



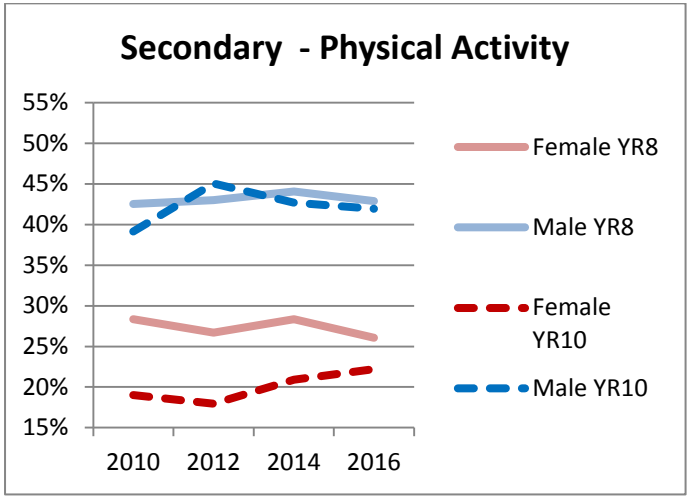


Within primary settings there is very little variance either by collaborative or gender. This would also appear to apply for boys within secondary schools, although Rural stands out as particularly good. However, there is a notable gap between boys and girls within Unity secondaries.

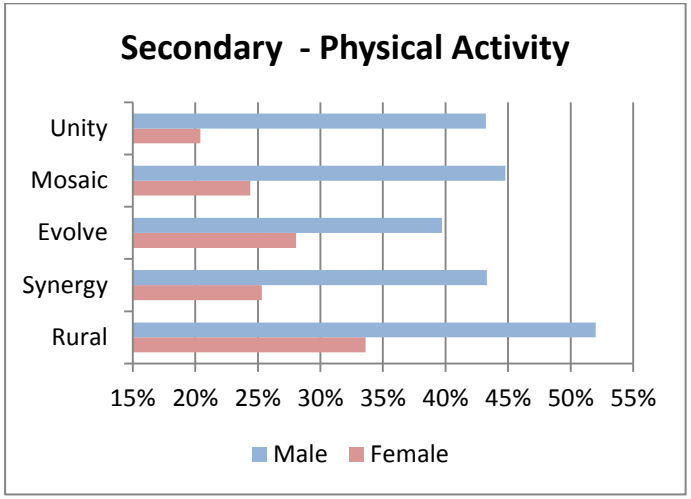


Physical Activity

The following charts reveal the proportion of respondents answering five or more to 'On how many days in the last week have you been physically active for an hour or more?' Note that this question is only asked within secondary schools.

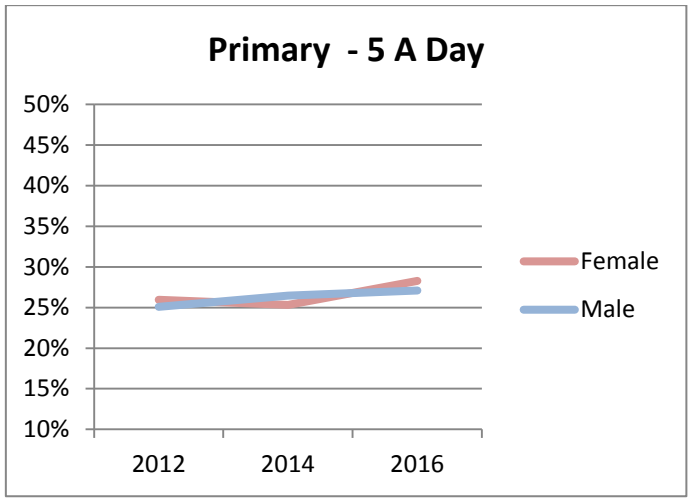


The patterns across gender year group and collaborative are unsuprisingly very similar to self reported fitness.



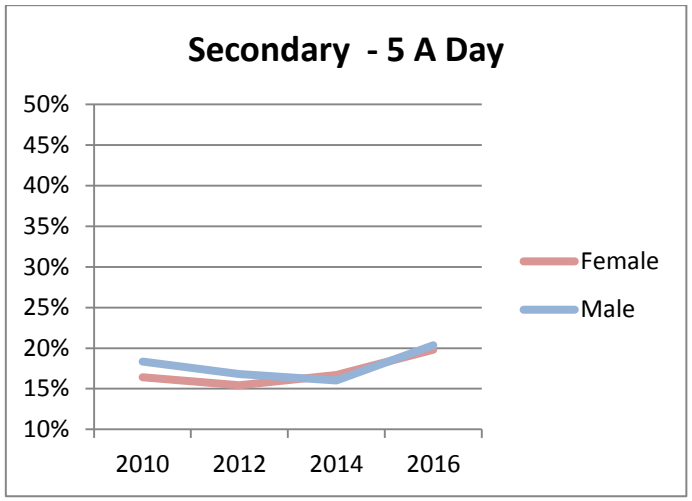
Five a Day

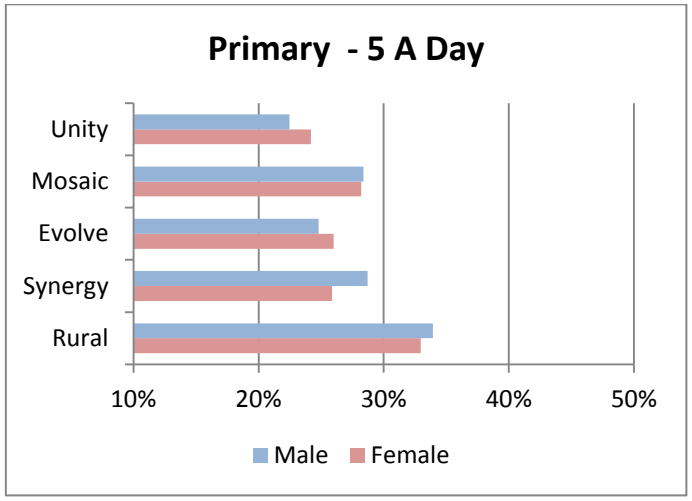
The following charts reveal the proportion of respondents stating '5 or more' to the question 'How many portions of fruit and vegetables did you eat yesterday?'



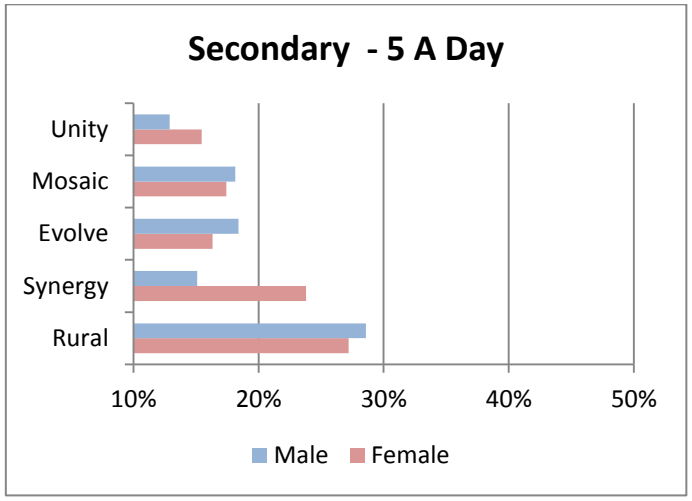
There is very little difference by gender but a small upward trend is evident from 2014 to 2016.

53% of primary pupils said that they have vegetables 'onmost days'. This is lower than the 60% of pupils saying this in the reference sample..



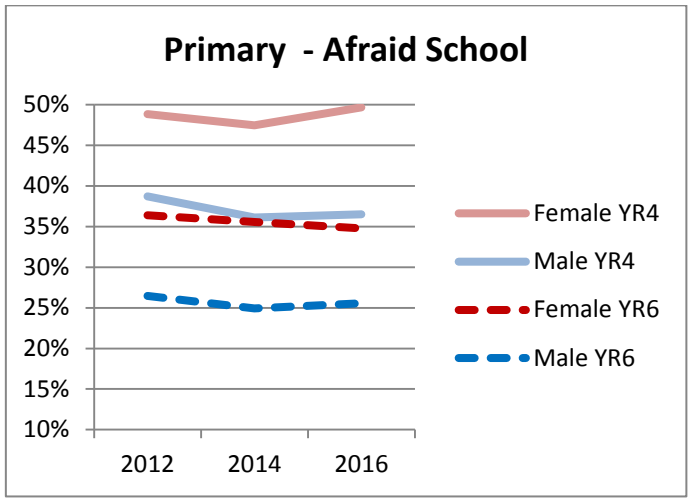


The main difference is the gap between boys in Synergy secondary schools and the better performance of rural collborative as a whole.

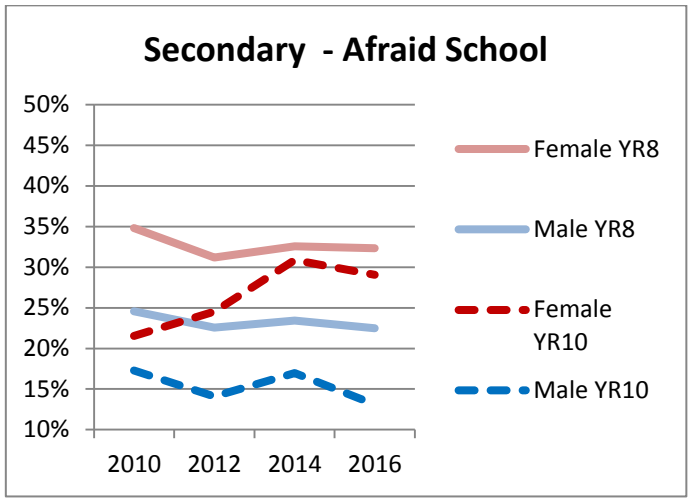


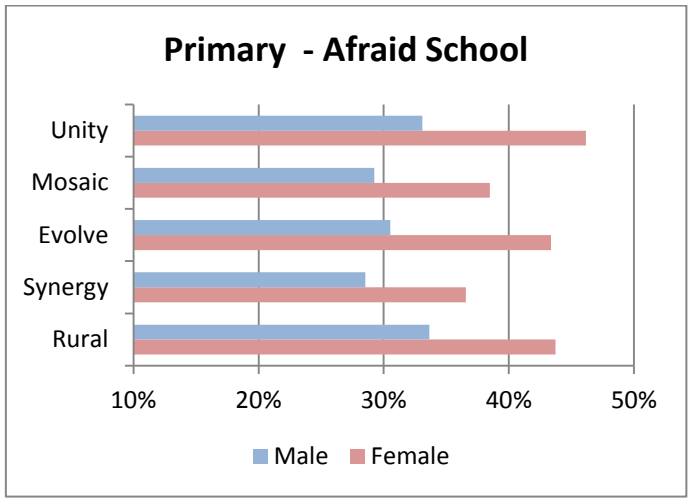
Bullying

The following charts reveal the proportion of respondents replying 'sometimes', 'often' or 'very often' to 'Do you ever feel afraid of going to school because of bullying?'.

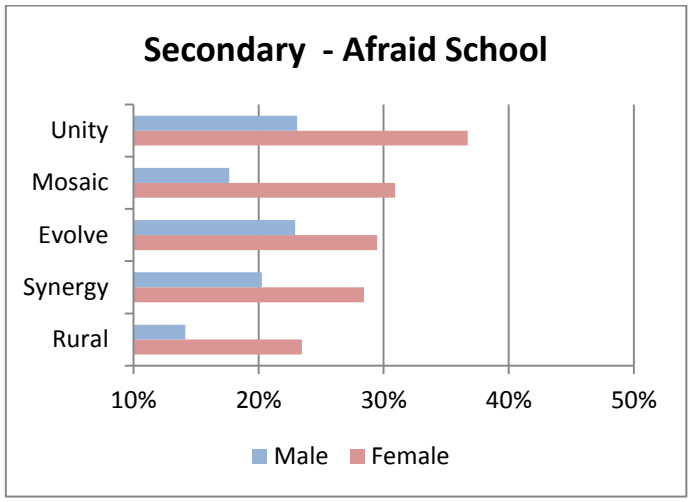


There is a clear gender gap even while the feelings of being afraid of 'bullying' recede with advancing age. The trend over time is steady apart from a significant deterioration for girls in year 10.



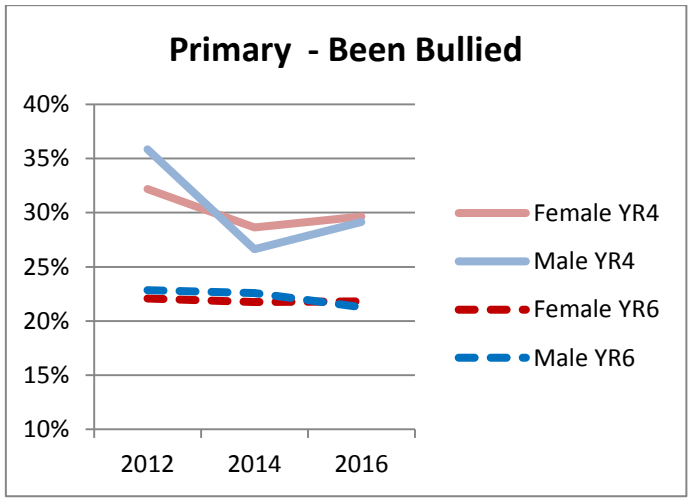


There is a consistent gender gap for all collaboratives across both primary and secondary schools – Unity appears to stand out for secondaries.

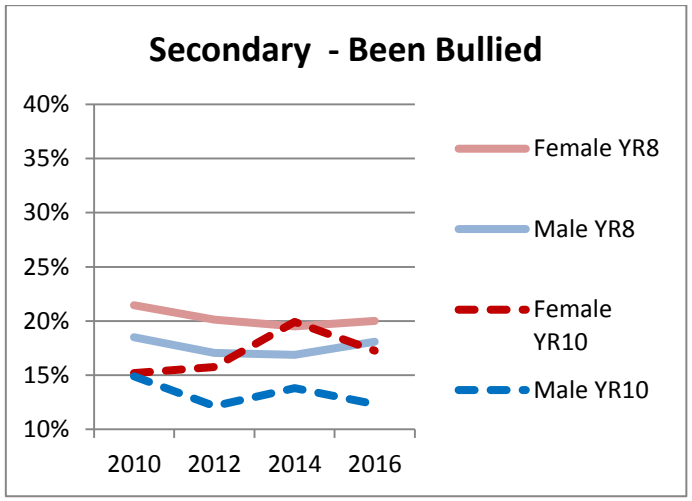


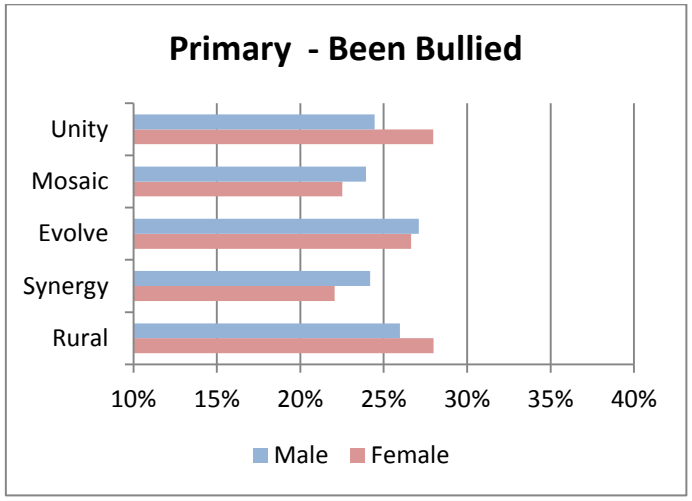
Been Bullied

The following charts reveal the proportion of respondents answering in the affirmative to 'Have you been bullied at or near school in the last 12 months?'

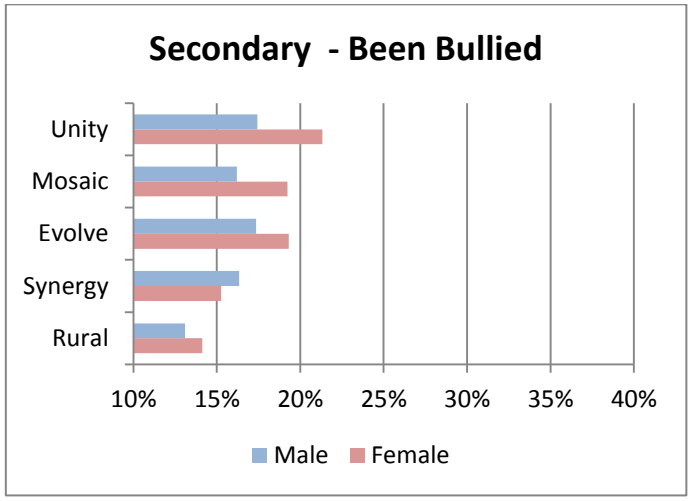


It is notable that self reported incidences of bullying peak in year 4 for both boys and girls, although there is significant improvement from 2012 to 2014. However, there has been a deterioration for girls in year 10 from 2010 to 2014.



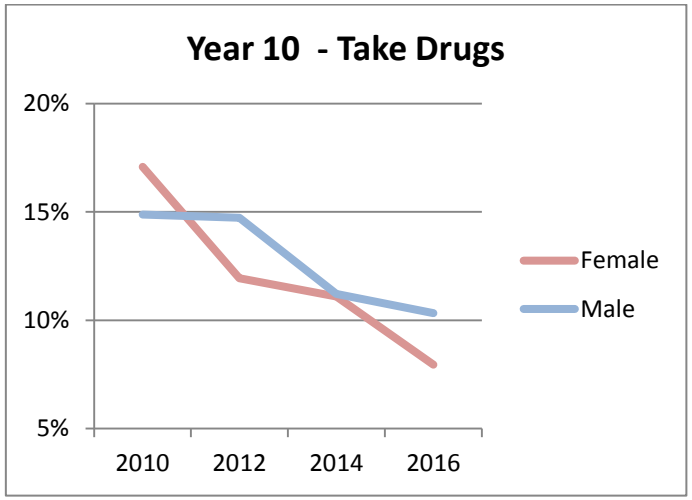


Bullying in secondary school is less likely than primary, with different parimary and secondary school collaborations showing different gender trends. Rural collaborative has the lowest rates of bulying in secondary school.

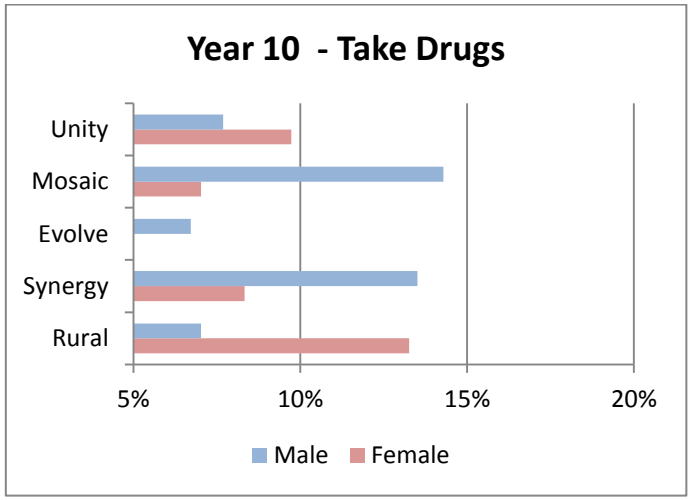


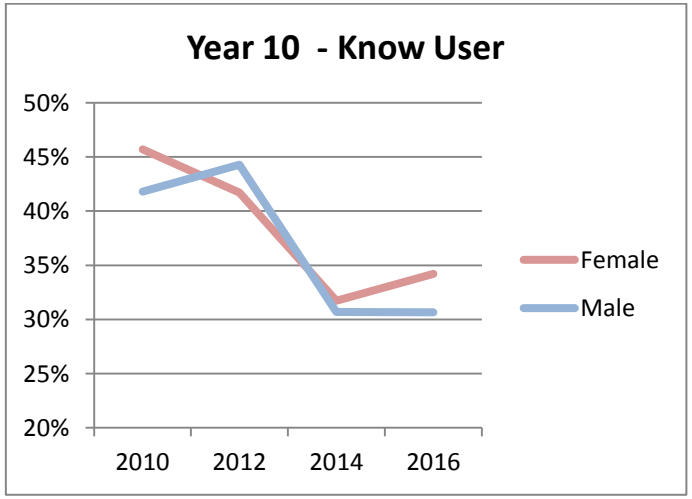
Taken Drugs / Know User

A list of drugs was provided in the survey to which respondents were asked whether they had ever taken any of them. The following charts show the proportion that stated yes to at least one of the drugs listed. Note that results for only year 10 pupils (age 14-15) in secondary schools are shown. A further question that asks 'Do you know anyone personally who you think takes any of the drugs' was also asked.



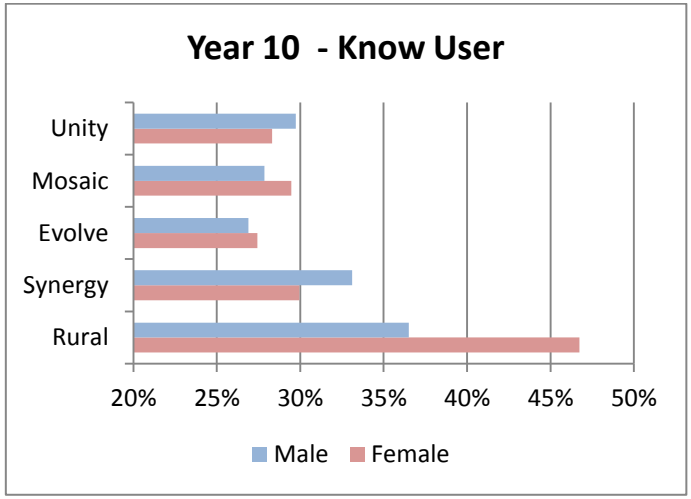
The HRBQ suggests considerable improvement in this self reported measure in recent years with both boys and girls at 10% or below. Different gender gaps are apparent across different school collaborations.





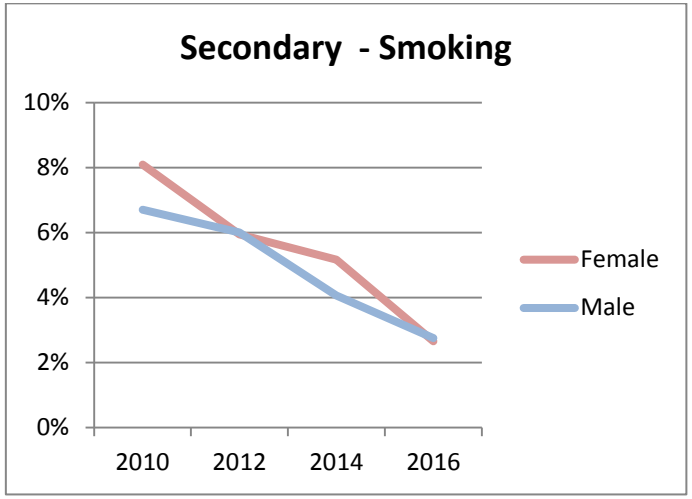
The rural collaboration stand out as reporting much higher proportions of others using drugs.

Overall, 21% of secondary school pupils said that they know someone personally who uses drugs. This is lower than the 29% of pupils in the reference sample.



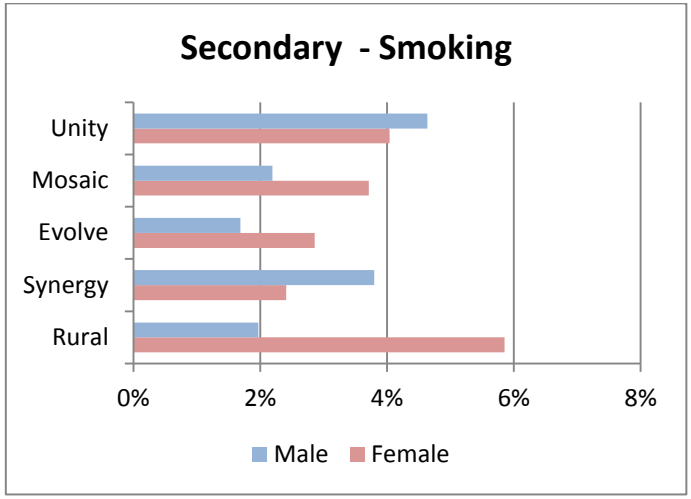
Cigarettes / Alcohol

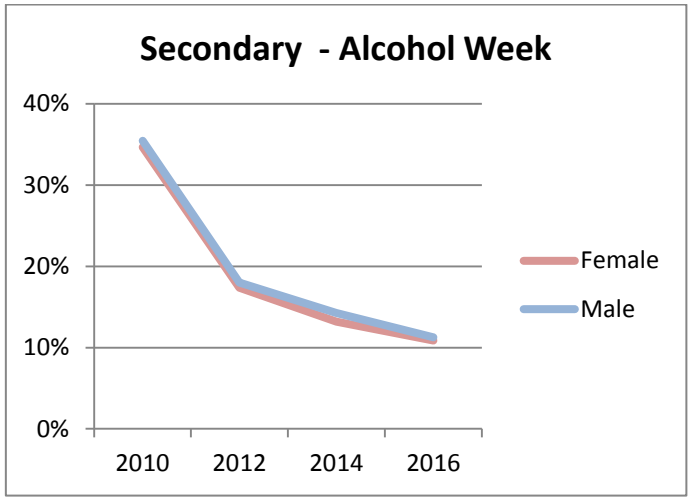
Cigarette habit highlights whether the respondent describes themselves best as 'smoke occasionally' or 'regularly' - alcohol, whether you have had an alcoholic drink the 7 days leading up to the survey. Note the charts show all secondary stage pupils.



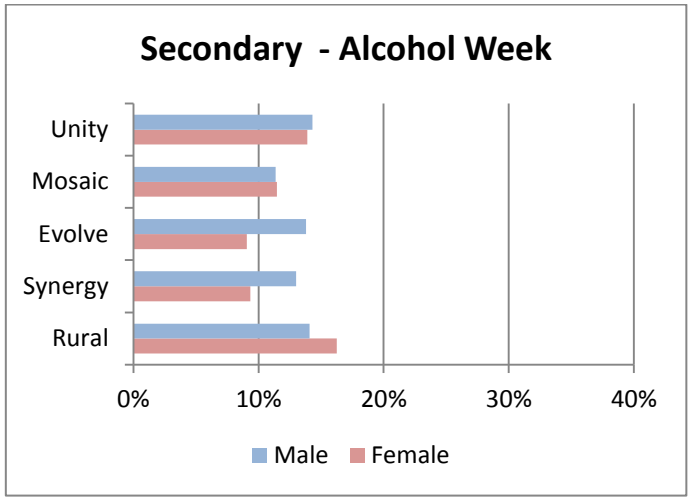
Improvements in recent years is consistent across both genders, although girls In Rural are perhaps of concern.

88% of secondary pupils said they have never smoked at all compared with 82% of the reference sample..



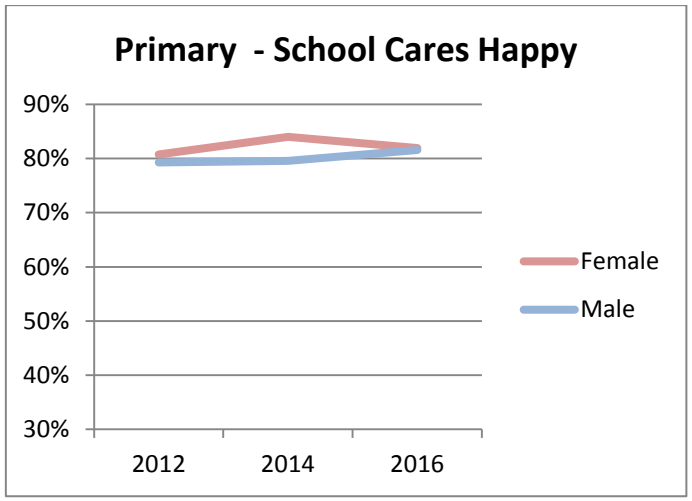


The significant reduction in recent years is particulary pronounced. However, 2014 HSCIC report for 15 year olds suggests that Solihull at 24% for girls and 22% boys compares less favourably with 17% and 20% respectively for England.

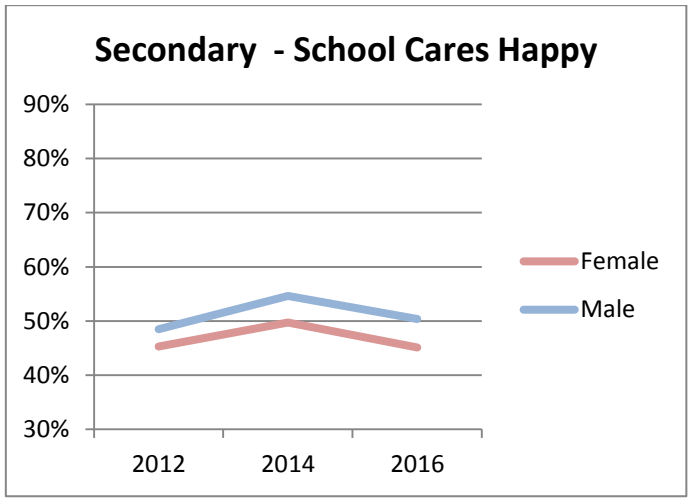


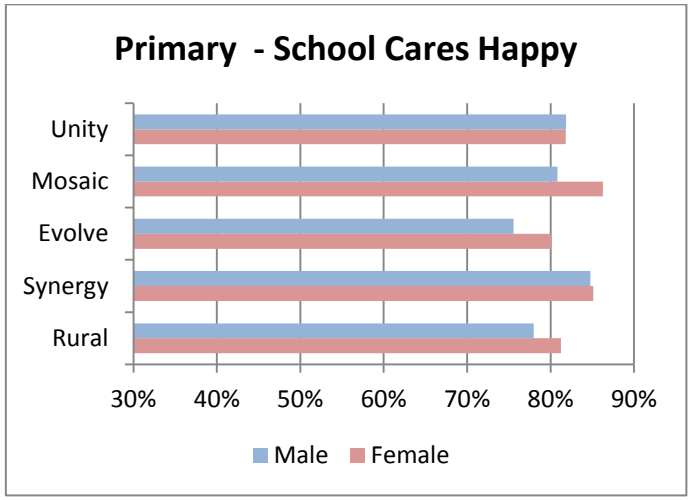
The school cares whether I am happy or not

The following charts reveal the proportion of respondents agreeing with the above statement.

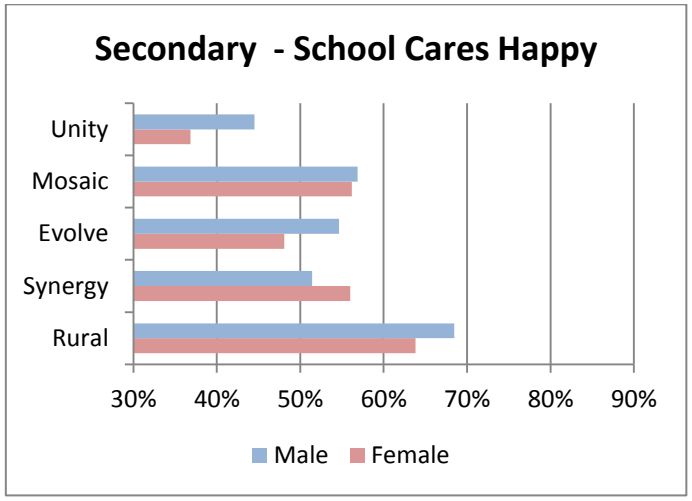


The gap between primary and secondary is most noteable. As is the decline from 2014 to 2016 in secondary schools



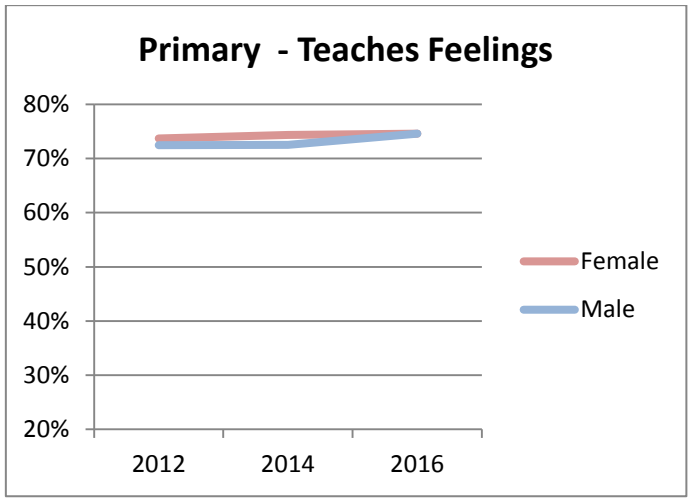


The gap between primary and secondary is largest within Unity. Furthermore, the gap between Unity and Rura secondary schools, particularly for girls, is also notable.

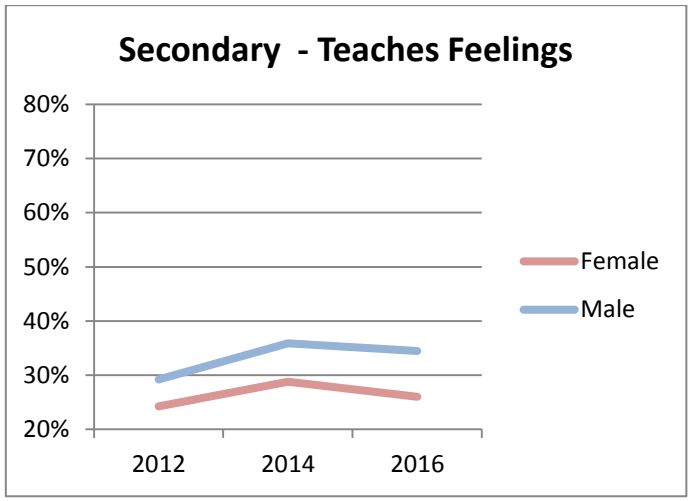


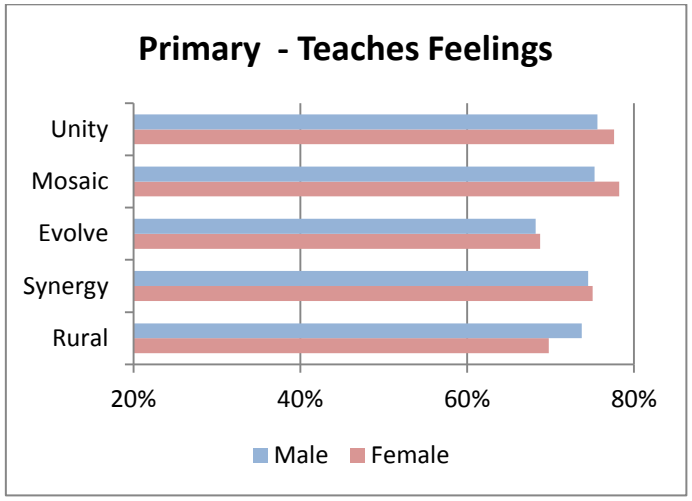
The school teaches me how to manage my feelings

The following charts reveal the proportion of respondents agreeing with the above statement.



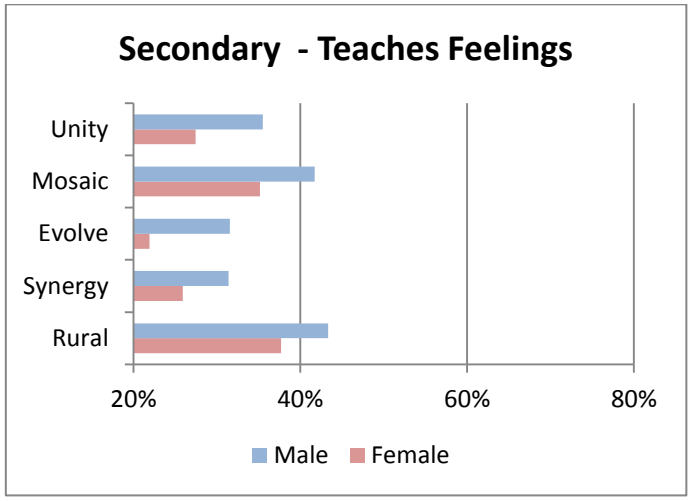
The gap between primary and secondary is most noteable. As is the decline from 2014 to 2016 in secondary schools





Boys in secondary schools report higher agreement with this statement than girls. And the gender difference can be pronounced, as is the case with Evolve collaborative.

Agreement is much more consistent across collaboratives and genders in primary school.



7. Adolescence

The World Health Organization (WHO) defines an adolescent as any person between 10 and 19 years of age[14]. Adolescence is a transitional time of growth and development between childhood and adulthood: it is also the time when people first start to learn about the world and find their place in it and develop the skills required needed in adulthood. This involves trying out new experiences, some of which may be risky or even dangerous.[15]

At a time when young people are establishing their independence, many can face pressure from their peers to use alcohol, cigarettes or other drugs and to initiate sexual relationships at earlier ages. Consequently, they are putting themselves at risk of intentional and unintentional injuries, unintended pregnancies and sexually transmitted infections (STIs). Many adolescents may also suffer a wide range of adjustment and mental health problems. Behaviour patterns that are established during this time, such as drug use or non-use and sexual risk taking or protection, can have long-lasting positive and negative effects on future health and well-being.

Balanced against this is the fact that, from a biological perspective adolescence is the best time of life because most physical and mental functions are at their peak.

Public Health England (PHE) have produced a framework for thinking about young people's health. This is based on six principles that take as their starting point the evidence that treating different, specific health issues separately will not tackle the overall wellbeing of this generation of young people.

'Young people's mental and physical health are intertwined, and at the heart of health and wellbeing are their relationships with others.'[16]

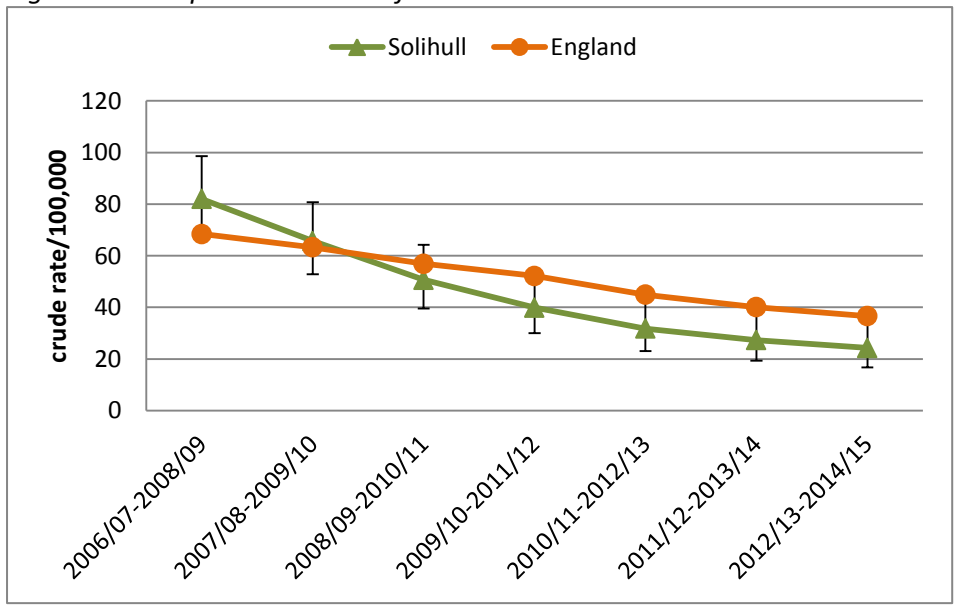
[14] http://www.who.int/maternal_child_adolescent/topics/adolescence/dev/en/
[15] http://www.rcpsych.ac.uk/healthadvice/parentsandyouthinfo/parentscarers/adolescence.aspx

[16] PHE/Association for Young People's Health 'Improving young people's health and wellbeing: a framework for public health' (2015)

Hospital admissions for alcohol under 18

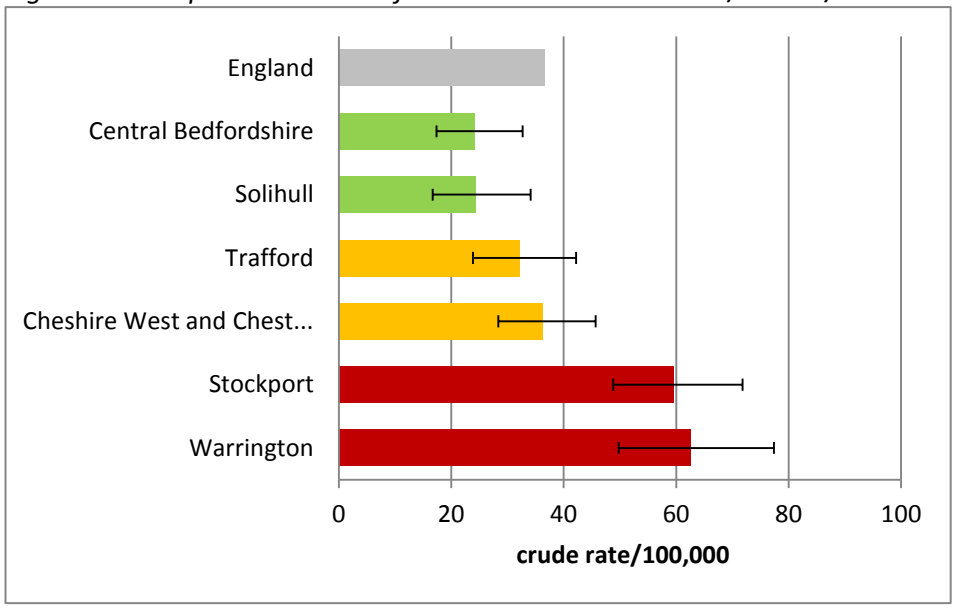
Alcohol misuse at any age has health and social consequences. Alcohol misuse in young people is a major contributor to criminal and antisocial behaviour. Although evidence suggests that the number of teenagers who drink has decreased in recent years, the amount drunk by young people who do drink has increased[17]. Excessive alcohol consumption in the under 18s is an avoidable cause of hospital admissions.[18]

Figure 67 Hospital admissions for alcohol under 18 trend



Source: CHIMAT LA profiles and Fingertips Tool, PHE

Figure 68 Hospital admissions for alcohol under 18 2012/13 - 14/15



Source: CHIMAT LA profiles and Fingertips Tool, PHE

Key Points

- Hospital admissions for Solihull adolescents aged under 18 for alcohol specific conditions fallen by almost a factor of 4 since 2006/07 (from 82/100,000 to 24.3/100,000)
- Solihull's admission rate has been significantly lower than England for the past 4 years (2009/10-2014/15).
- Solihull has one of the lowest rates of admission in its comparator group.

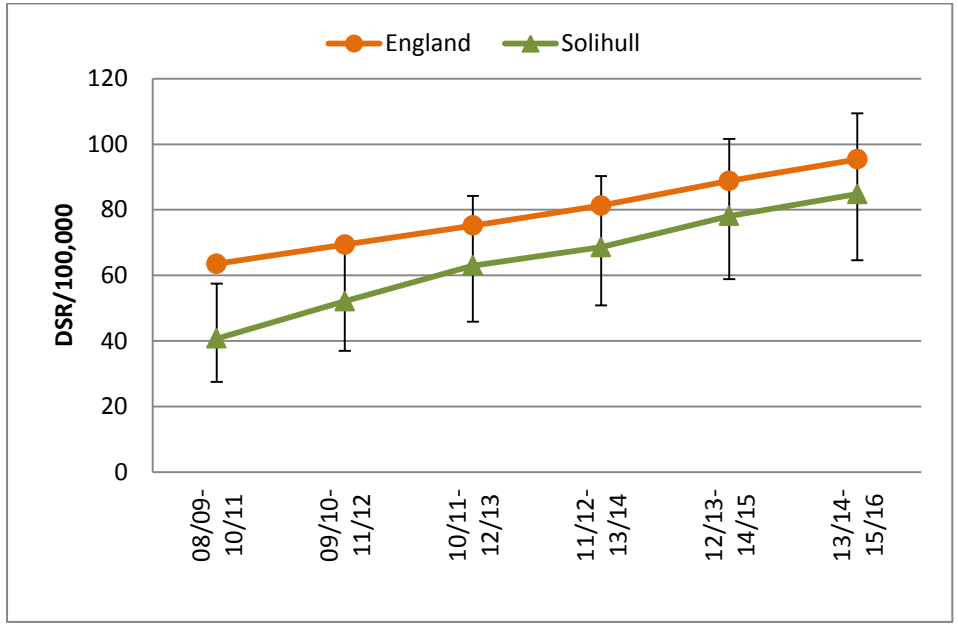
[17] Local Authority Child Health Profiles Indicator guide 2015, http://www.chimat.org.uk/profiles/data

[18] Local Alcohol Profiles for England (LAPE) Indicator 5.01 http://fingertips.phe.org.uk/profile/local-alcohol-profiles/data#page/6/gid/1938132833/pat/6/par/E12000005/ati/102/are/E08000029/iid/90856/age/173/sex/4

Hospital admissions due to substance misuse (15-24 years)

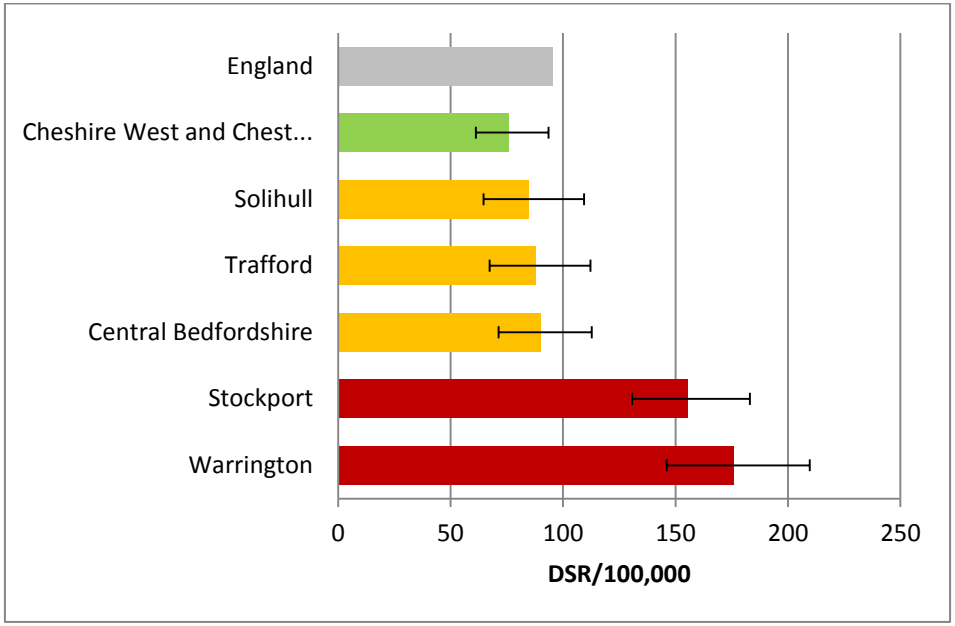
There is evidence to suggest that young people who use recreational drugs run the risk of damage to mental health including suicide, depression and disruptive behaviour disorders. Regular use of cannabis or other drugs may also lead to dependence[19].

Figure 69 Hospital admissions due to substance misuse (15-24 years)



Source: CHIMAT LA profiles and Fingertips Toll, PHE

Figure 70 Hospital admissions due to substance misuse (15-24 years) 2013/14-15/16



Source: CHIMAT LA profiles and Fingertips Toll, PHE

Key Points

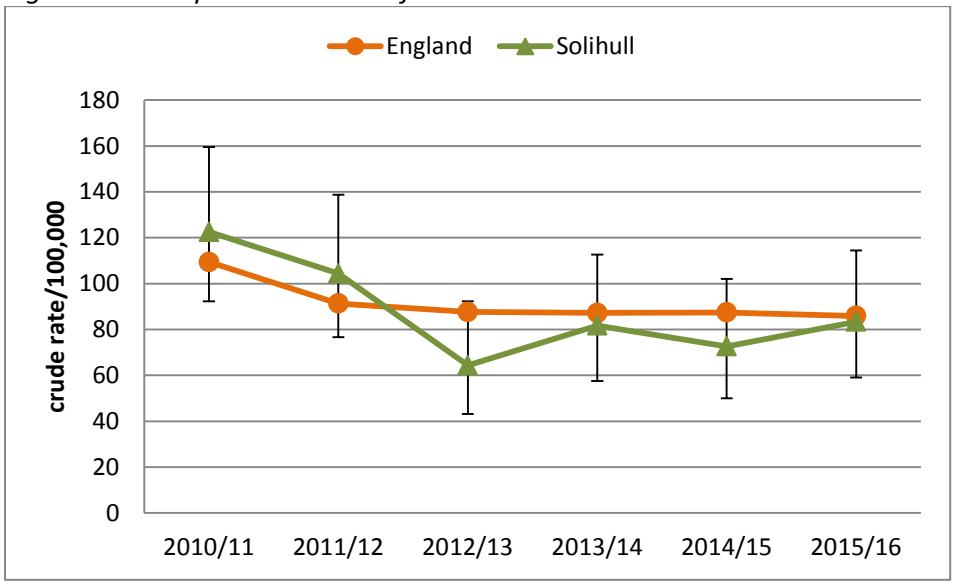
- Hospital admissions for 15-14 year olds due to substance misuse have doubled since 2008/09-10/11 for Solihull from 40 per 100,000 to 84.8 per 100,000. There were 31 admissions in 2008/09-10/11 rising to 60 in 2013/14-15/16.
- Solihull's rate over this time has remained below that for England but the difference is not statistically significant as the low number of events create very wide confidence intervals.
- Solihull has one of the lowest rates in its comparator group (only Cheshire West and Chester's rate is lower).

[19] Local Authority Child Health Profiles Indicator guide 2015, http://www.chimat.org.uk/profiles/data

Hospital admissions for mental health in under 18s

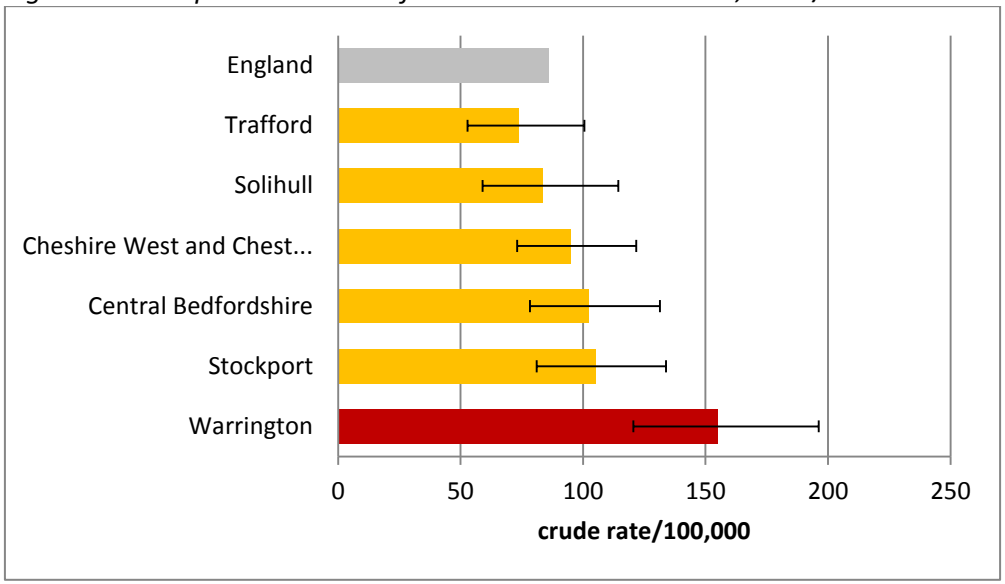
One in ten children aged 5 to 16 years has a clinically diagnosable mental health problem and, of adults with long-term mental health problems, half will have experienced their first symptoms before the age of 14. Self-harming and substance abuse are known to be much more common in children and young people with mental health disorders – with 10% of 15 to 16 year olds having self-harmed. Failure to treat mental health disorders in children can have a devastating impact on their future, resulting in reduced job and life expectations[20].

Figure 71 Hospital admissions for mental health under 18



Source: CHIMAT LA profiles and Fingertips Toll, PHE

Figure 72 Hospital admissions for mental health under 18, 2015/16



Source: CHIMAT LA profiles and Fingertips Toll, PHE

Key Points

- In 2015/16 there were 38 young people under 18 admitted to hospital for mental health reasons.
- Mental health admissions for young people under 18 have stayed relatively constant for England and Solihull over the last 4 years, coming off the back of a decline pre 2011.
- Solihull's rate of admission is similar to that for England both over time and for the latest reported period. It has a lower rate than 4 of 5 of its comparators.

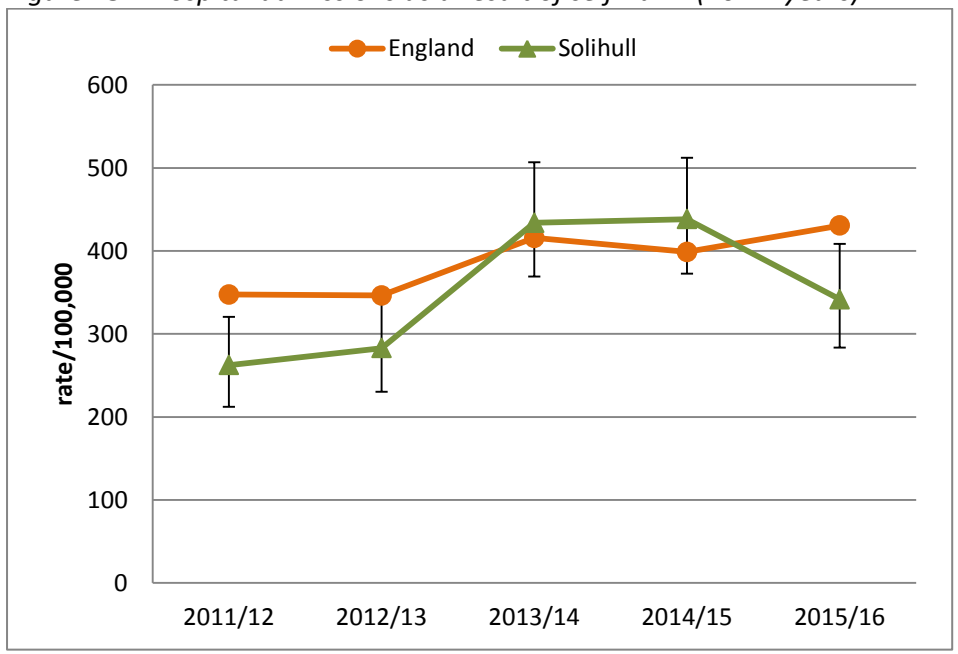
[20] Local Authority Child Health Profiles Indicator guide 2015, http://www.chimat.org.uk/profiles/data

Hospital admissions for self harm (10-24 years)

Self-harm is a very private behaviour and a very sensitive topic, which means that there is a shortage of reliable information unless young people present at accident and emergency services. Recent estimates from the Health Behaviour of School Aged Children survey (Brooks et al, 2015) suggest that overall 22% of the 15 year olds in the study had self-harmed. These rates were three times as high for girls (32% of girls compared to 11% of boys).

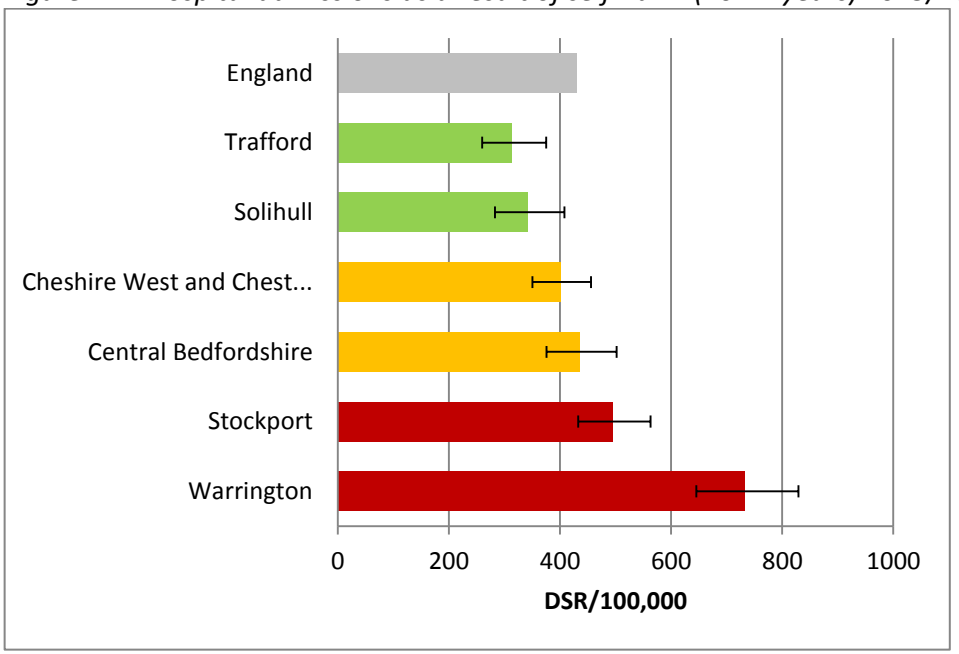
A minority of people who are self-harming will end up in hospital, but these cases provide important information about this behaviour. Some young people will be admitted several times over the course of a year. Researchers studying hospital statistics have noted that relationship issues were the main reported cause in adolescents.[21]

Figure 73 Hospital admissions as a result of self-harm (10-24 years)



Source: CHIMAT LA profiles and Fingertips Toll, PHE

Figure 74 Hospital admissions as a result of self-harm (10-24 years) 2015/16



Source: CHIMAT LA profiles and Fingertips Toll, PHE

Key Points

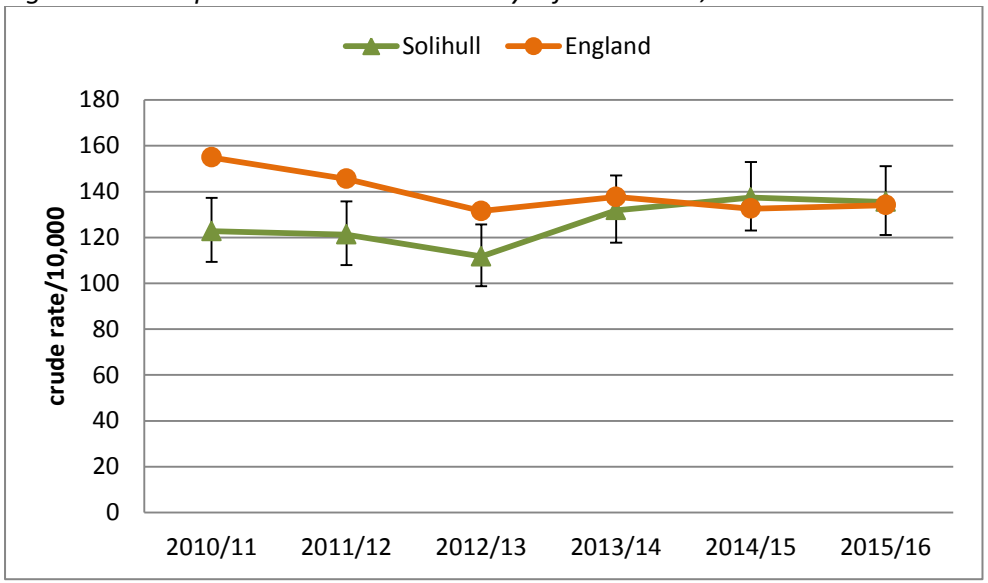
- There were 122 hospital admissions for self harm among 10-24 year olds in 2015/16.
- Hospital admissions for self harm in Solihull are currently below the national average, and second lowest amongst our nearest statistical neighbours.

[21] Key Data on Adolescence, 2015 (Association for Young People's Health)

Hospital admissions caused by injuries (15-24)

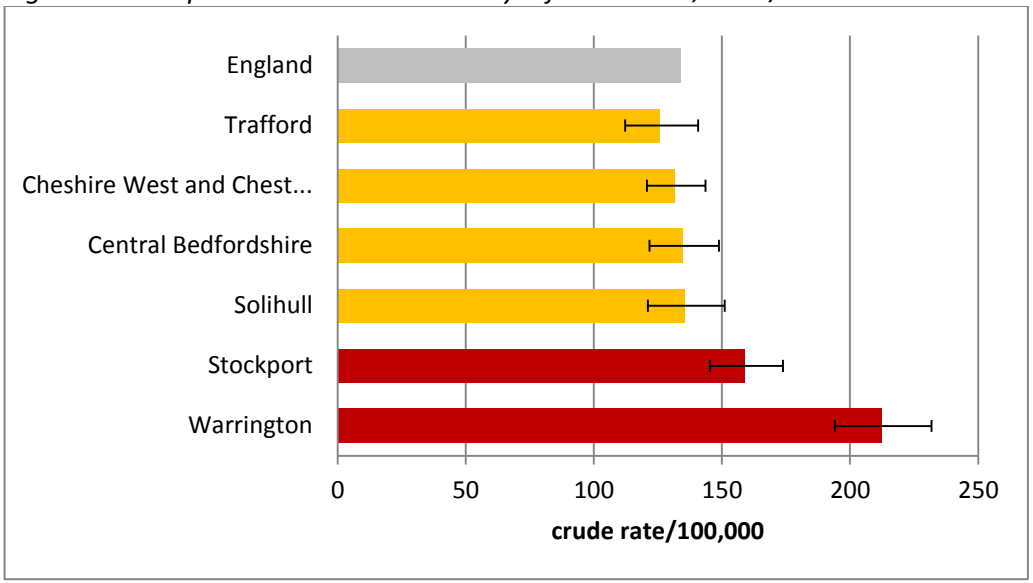
The highest rate of unintentional injury or death occurs in young men aged 15-19 years, more than any other age of childhood (European Child Safety Alliance, 2012). Accidents at this age are therefore an important part of the picture of health, and may be affected in part by behaviour.[22]

Figure 75 Hospital admissions caused by injuries 15-24, trend



Source: CHIMAT LA profiles and PHOF2 .07,PHE

Figure 76 Hospital admissions caused by injuries 15-24, 2015/16



Source: CHIMAT LA profiles and PHOF 2.07,PHE

Key Points

- There were 322 emergency admissions following injury among 15-24 year olds in 2015/16.
- Hospital admission rates for injuries for 15-24 year olds in Solihull have risen gradually since 2010/11 at the same time as the national average has been declining. This has meant Solihull used to be below the national average but is now very similar.
- Solihull's admission rate is similar to its statistical neighbours, with the exception of Warrington, which has a significantly higher rate.

[22] Key Data on Adolescence, 2015 (Association for Young People's Health)

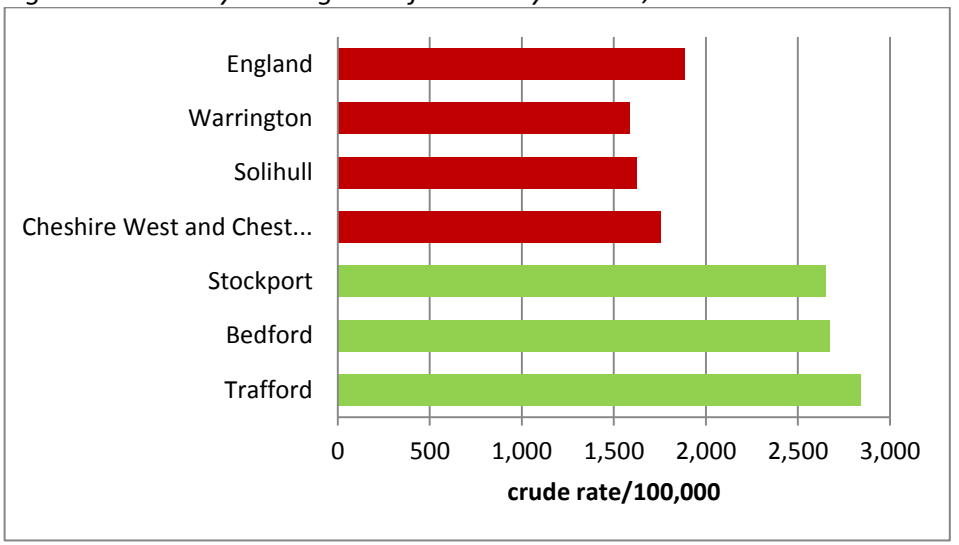
Chlamydia diagnoses (15-24 years)

Sexually transmitted infections continue to be an important public health problem in England. Chlamydia is the most commonly diagnosed sexually transmitted infection. It causes avoidable sexual and reproductive ill-health, including symptomatic acute infections and complications such as pelvic inflammatory disease (PID), ectopic pregnancy and tubal-factor infertility. The chlamydia detection rate amongst under 25 year olds is a measure of chlamydia control activities. It represents infections identified (reducing risk of sequelae in those patients and interrupting transmission onto others)[23]. The chlamydia detection rate is not a measure of morbidity since differences will be to a great extent determined by the effectiveness of the system for screening that is in place.

Figure 77 Chlamydia diagnoses for 15-24 year olds, trend

Source: CHIMAT LA profiles and PHOF 3.02,PHE

Figure 78 Chlamydia diagnoses for 15-24 year olds, 2015



Benchmarking against goal

Key Points

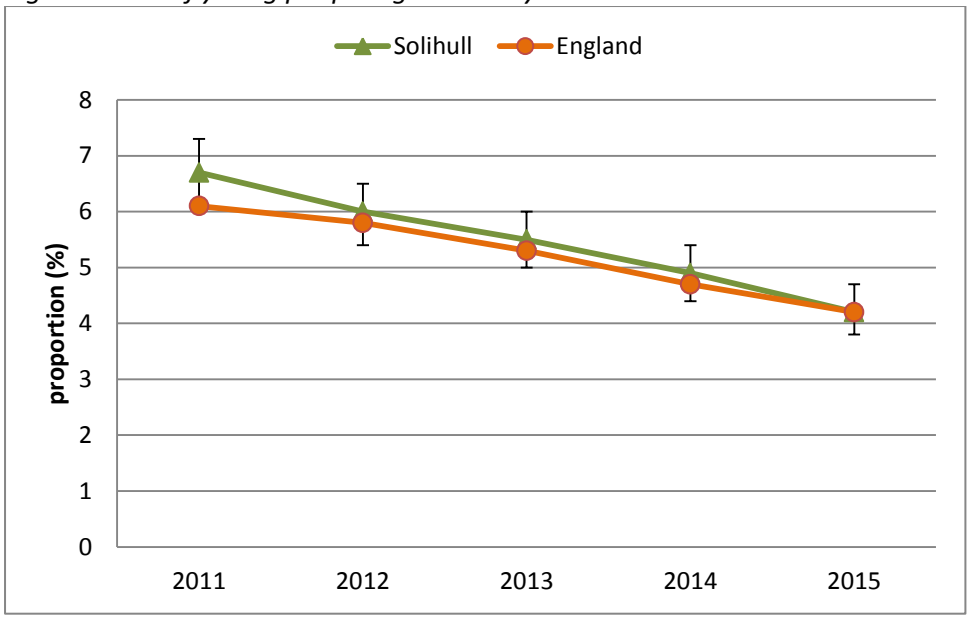
- Detection rates for Solihull show a trend significantly lower than the national average, but marginally so.
- However Solihull was rated red since 2013 when benchmarked against the goal because the minimum diagnostic rate of 1900/100,000 had not been reached
- Three of Solihull's statistical neighbours have managed to meet and exceed the benchmarking goals, whereas Solihull remains the second worst performer.

[23]Rationale PHOF INDICATOR 3.02, http://www.phoutcomes.info/public-health-outcomes-framework#page/6/gid/1000043/pat/6/par/E12000005/ati/102/are/E08000025/iid/90776/age/156/sex/4

% 16-18 year olds who are Not in Education, Employment or Training (NEET)

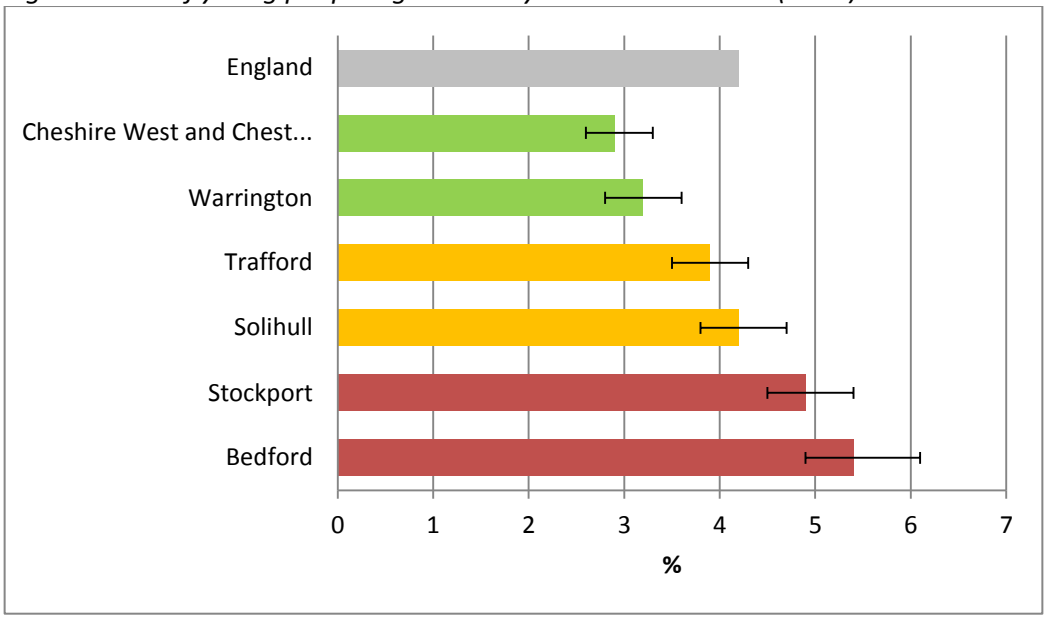
Young people who are not in education, employment or training are at greater risk of a range of negative outcomes, including poor health, depression or early parenthood.

Figure 79 % of young people aged 16-18 years who are NEET



Source: PHOF 1.05, PHE

Figure 80 % of young people aged 16-18 years who are NEET (2015)

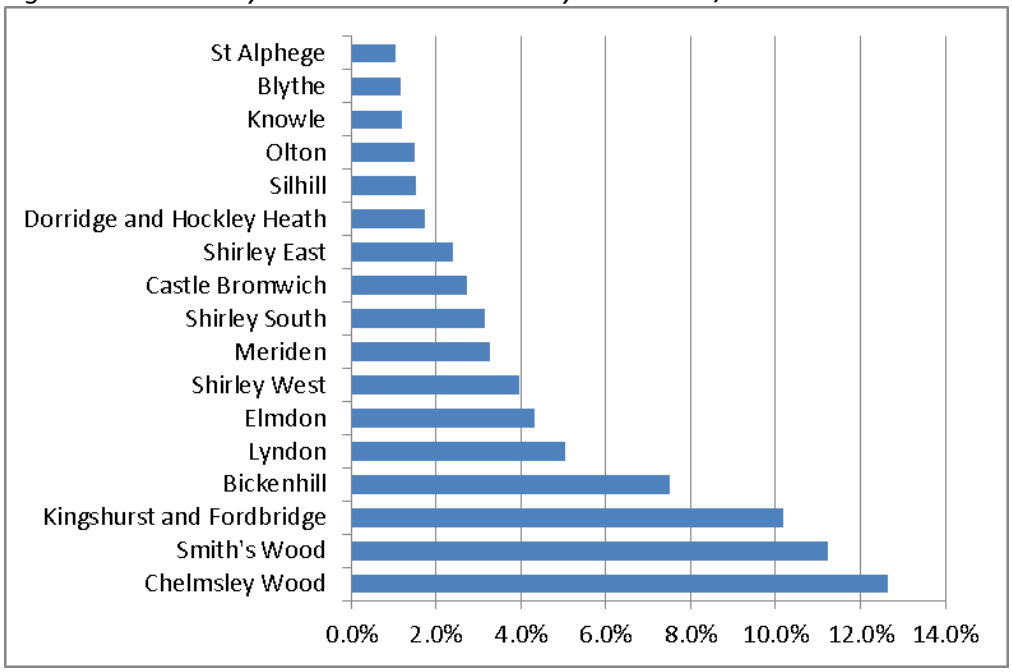


Source: PHOF 1.05, PHE

Key Points

- Over time Solihull's rate of NEETs has been the same as that for England. Both have decreased over time, and both currently sit at 4.2% (2015)
- Solihull is in the middle of the pack among its comparator group. Two of its neighbours have achieved significantly lower % NEETs than the England average, something Solihull is yet to achieve in its recent past.

Figure 81 % 16-18 year olds who are NEET by ward 2014/15



Source: Local data

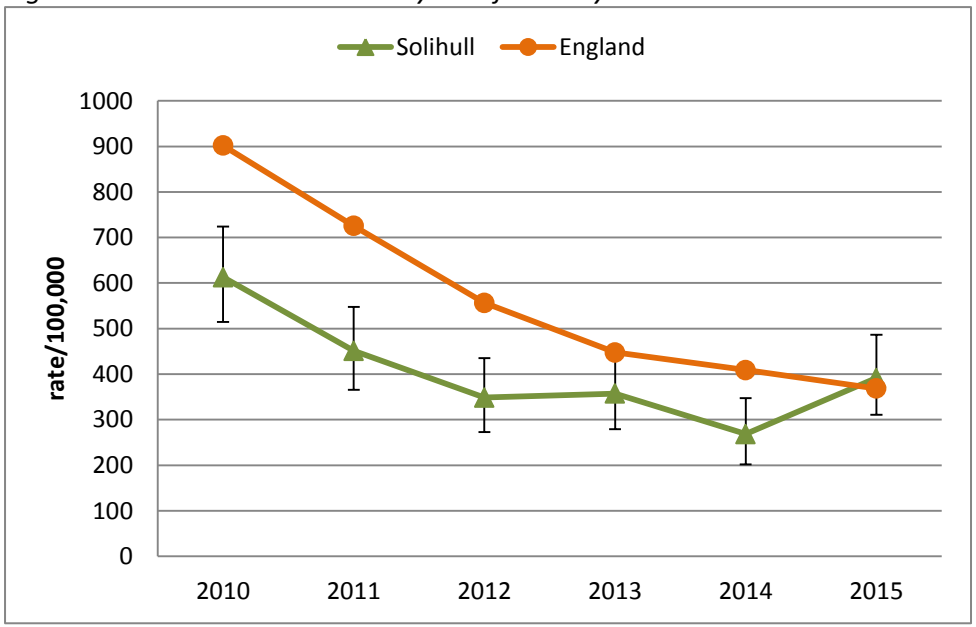
Key points (cont'd)

- 16-18 years olds that are NEET are highest in the regeneration wards, Chelmsley Wood, Kingshurst and Fordbridge and Smith's Wood.
- Lyndon and Bickenhill also have percentages above the Solihull rate of 4.9% (2014/15 figures)

First time entrants to the youth justice system aged 10-17

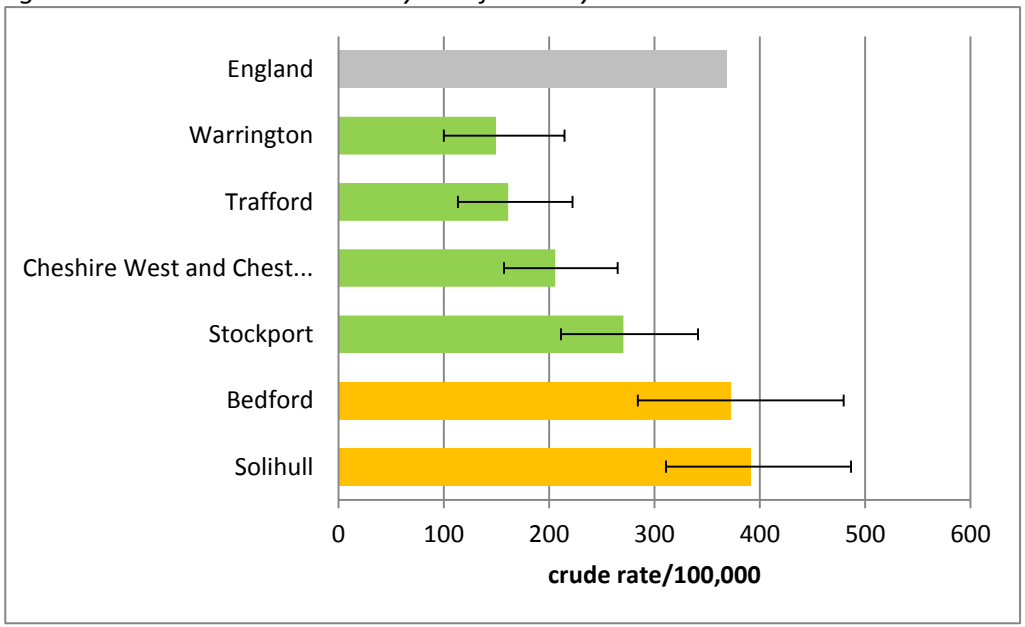
Children and young people at risk of offending or within the youth justice system often have more unmet health needs than other children[24] A lack of focus in this area could result in greater unmet health needs, increased health inequalities and potentially an increase in offending and re-offending rates, including new entrants to the system. This indicator measures those young people aged 10-17 receiving a first reprimand, warning or conviction.

Figure 82 First time entrants to youth justice system - trend



Source: PHOF 1.04, PHE

Figure 83 First time entrants to youth justice system 2015



Source: PHOF 1.04, PHE

Key Points

- England's rate of first time entrants to the youth justice system has continued to decline whereas Solihull's appears to have plateaued following a similar decline. Solihull no longer has a lower rate than England, which has been historically the case.

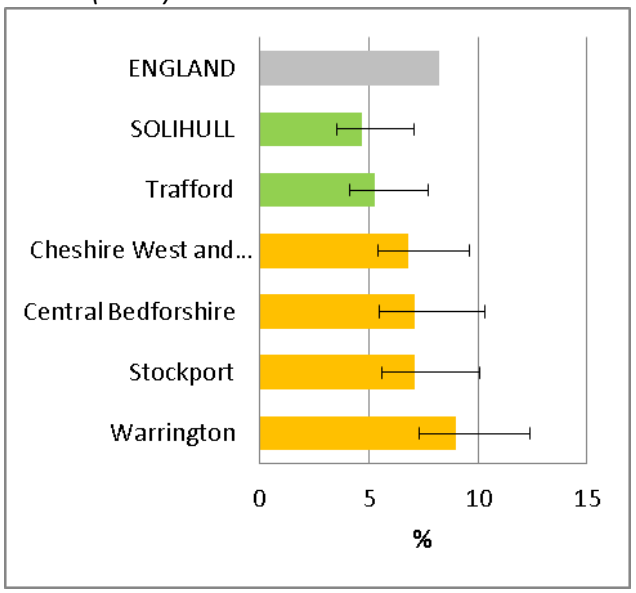
  Most of Solihull's statistical comparators have rates significantly lower than the England average, Solihull has the highest rate of the group, and significantly higher than 3 of its 5 neighbours.

[24]Rationale PHOF Indicator 1.04, http://www.phoutcomes.info/public-health-outcomes-framework#page/6/gid/1000041/pat/6/par/E12000005/ati/102/are/E08000029/iid/10401/age/211/sex/4

Smoking at 15 (What About YOUth (WAY) survey)

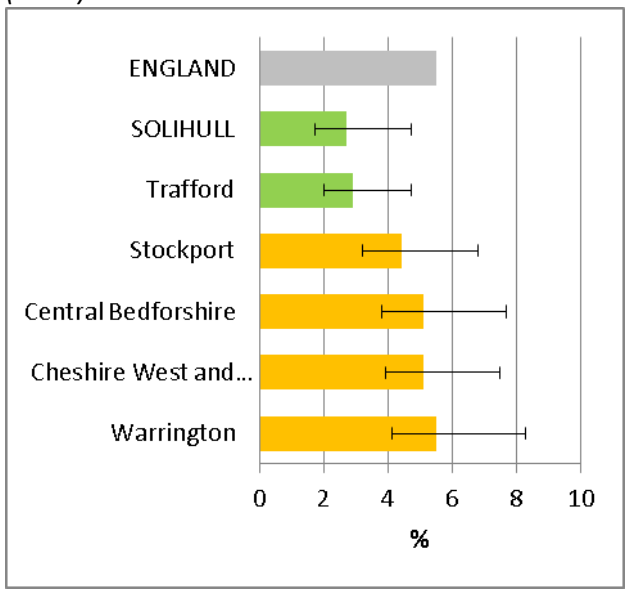
Smoking remains the major cause of preventable morbidity and premature death. Repeated Department of Health 'Smoking, Drinking and Drug Use' (SDDU) surveys of 11-15 year olds in England have shown that smoking is clearly related to age. Hence, smoking is much more prevalent in 14-15 year olds than 11-13 year olds.
The WAY survey is a home postal survey designed to fill a gap in our knowledge of smoking prevalence in teenagers. The questionnaire was sent to 15 year olds in every local authority in England in 2015. The response rate is not declared but the sample size is deemed to be significantly large to provide a reasonable estimate

Figure 84 % of 15 year olds who are currently smoke (2015)



Source: PHOF 2.09i, PHE

Figure 85 % of 15 year olds who regularly smoke (2015)



Source: PHOF 2.09ii, PHE

Figure 86 % of 15 year olds who are occasional smokers (2015)

Source: PHOF 2.09iii, PHE

Key Points

- This is a new indicator so there is no trend data available.
- Solihull has a significantly lower rate of current and regular smokers when compared to England
- It also has the lowest rate for these categories when compared to its statistical neighbours although none of the comparators are significantly different from each other.
- When compared to England, Solihull has a similar rate of occasional smokers. Solihull's rate is also similar to all the comparator areas.

8. Vulnerable groups

This section looks at the needs of children and young people with particular characteristics who need targeted support due to vulnerability. These include those in local authority care, youth custody, care leavers, young carers, homeless young people, asylum seekers, young people excluded from education and teenage parents.

It has been estimated that more than 40% of young people on community service orders have emotional and mental health needs and the prevalence of mental illness among children in custody and in care is higher[25]. In too many cases the health and social care needs of children in care or in contact with the youth justice system go unrecognised and unmet.

Within its corporate parenting responsibilities, Solihull has a high percentage of unaccompanied asylum seeking children who come predominantly from conflict zones around the world.

The key groups dealt with in this report are as follows:-

- Looked after children (including emotional and behavioral health and immunisation)
- Children in Need
- In receipt of a Child Protection Plan

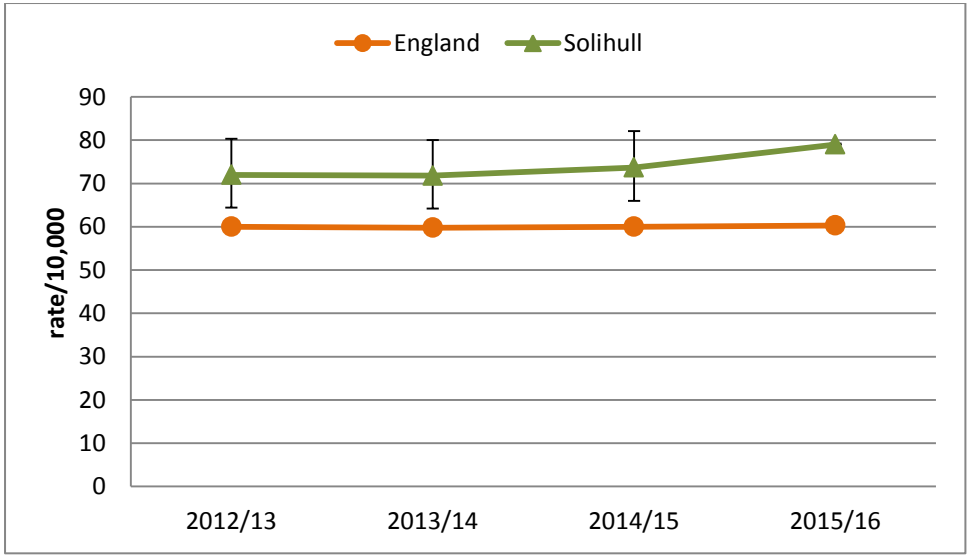
[25] Newman R et al (2012) Turning young lives around. Prison Reform Trust / Young Minds

Looked After Children (LAC)

The rate of Looked After Children per 10,000 population under 18 in Solihull at 31st March 2016 was 79 which is the highest in the comparator chart and also above England (60).

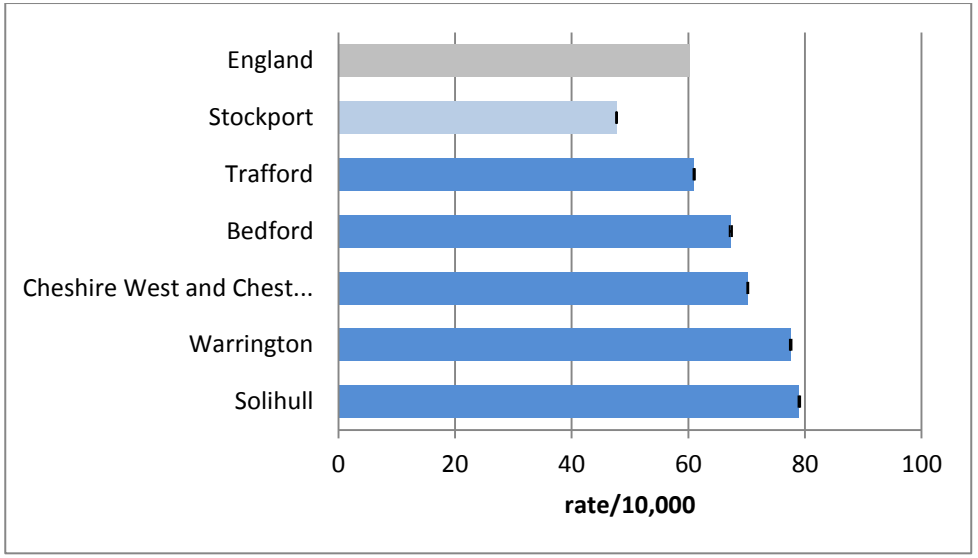
It should be noted that it is difficult to compare rates for LAC, as Solihull's rate includes a number of Unaccompanied Asylum Seeking Children (UASC). However, the gap has clearly closed with England in recent years[26].

Figure 87 Looked After Children



Source: Public Health Profiles

Figure 88 Looked After Children 2015/16



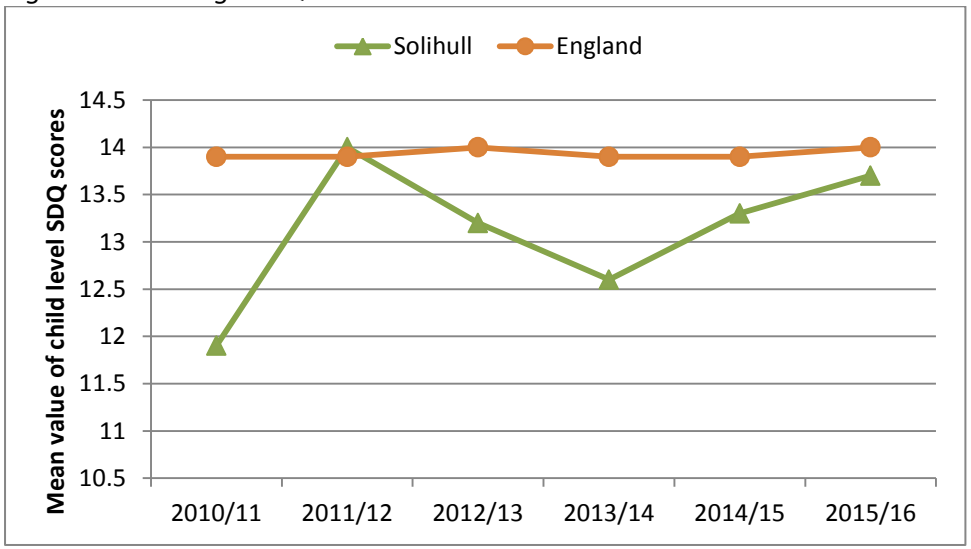
Source: Public Health Profiles

[26] Department for Education: https://www.gov.uk/government/statistics/children-looked-after-in-england-including-adoption--2

LAC Strengths and Difficulties Questionnaire Scores

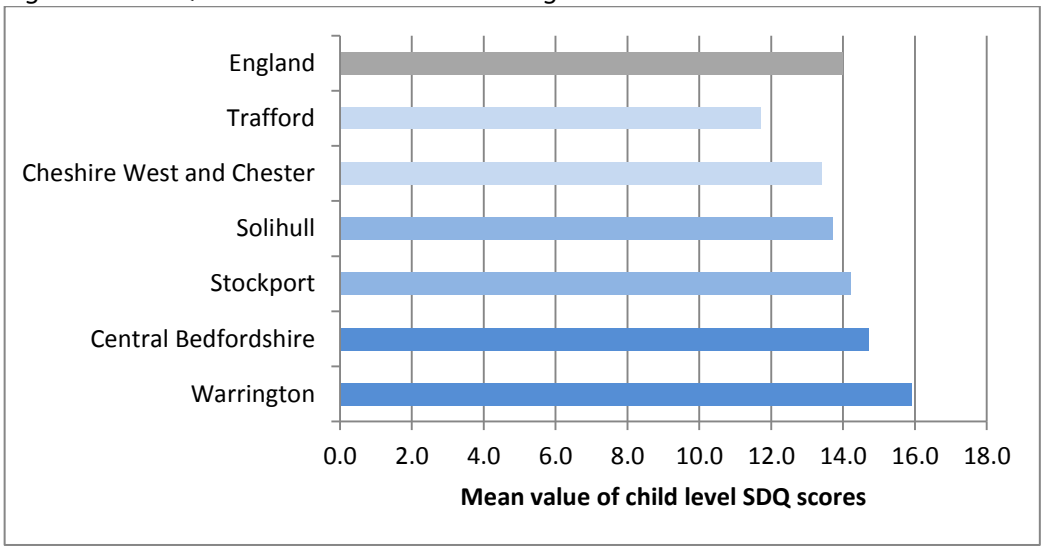
The Strengths and Difficulties Questionnaire (SDQ) is a way of measuring the emotional wellbeing of children who are looked after. It produces a single summary figure for each child ranging from 0 – 40. A higher score indicates greater difficulties (a score of under 14 is considered normal; 14-17 is borderline cause for concern and 17 or over is a cause for concern).

Figure 89 Average SDQ Scores trend



Source: ONS Children looked after in England including adoption: 2015 to 2016

Figure 90 SDQ Scores 2016 – statistical neighbours



Source: ONS Children looked after in England including adoption: 2015 to 2016

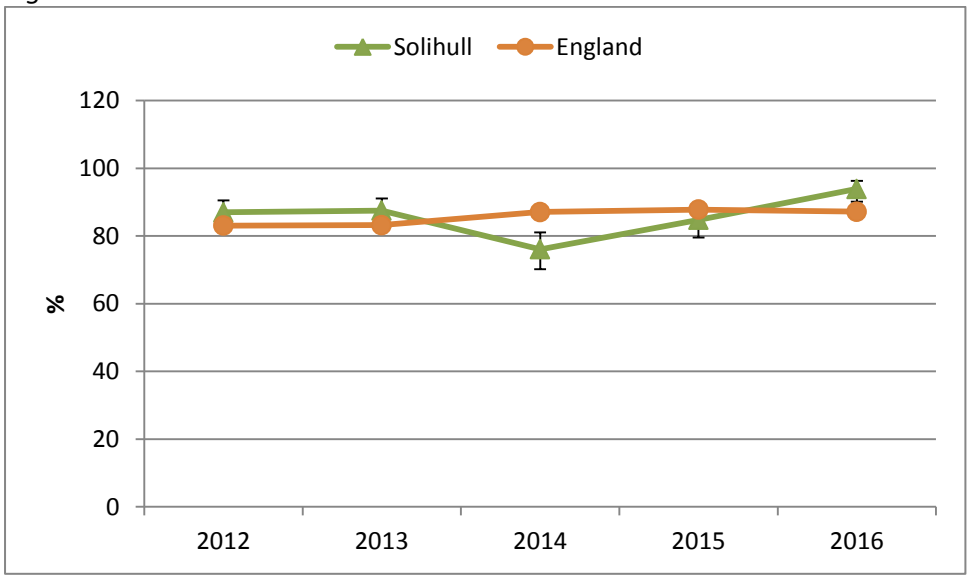
Key points

- The trend in Solihull has been historically lower than the national average, although this has converged in the most recent 2 years.
- Solihull's average score is better than 3 of its 5 nearest statistical neighbours (it's statistical significance relative to England could not be determined)

LAC Immunisation Rates

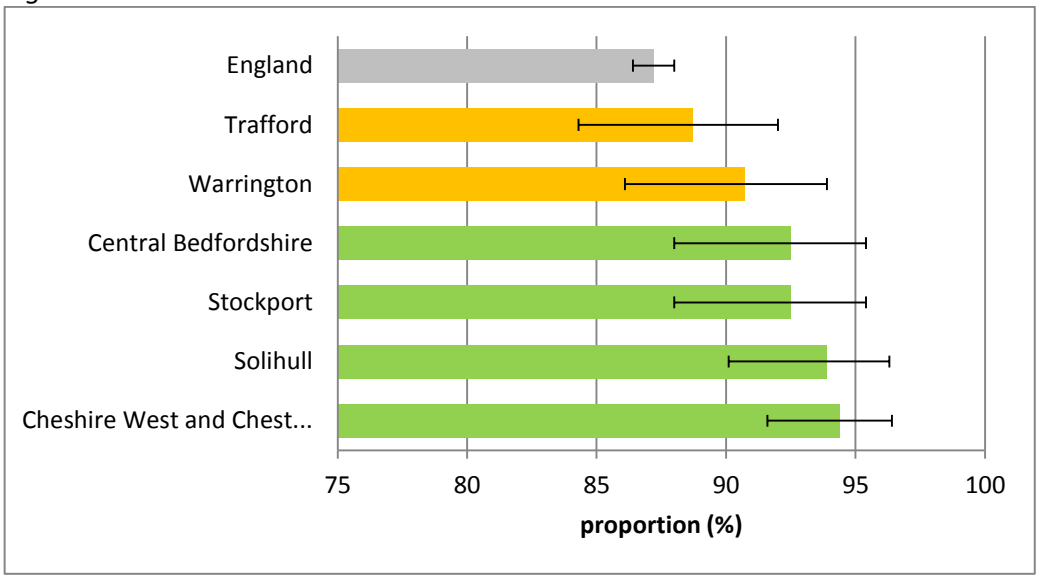
In 2016 the proportion of LAC receiving an immunisation fell to 93.9%, which is significantly higher than the England average of 87.2%[27].

Figure 91 LAC immunisation rates trend



Source: CHIMAT LA profiles

Figure 92 LAC immunisation rates 2016



Source: CHIMAT LA profiles

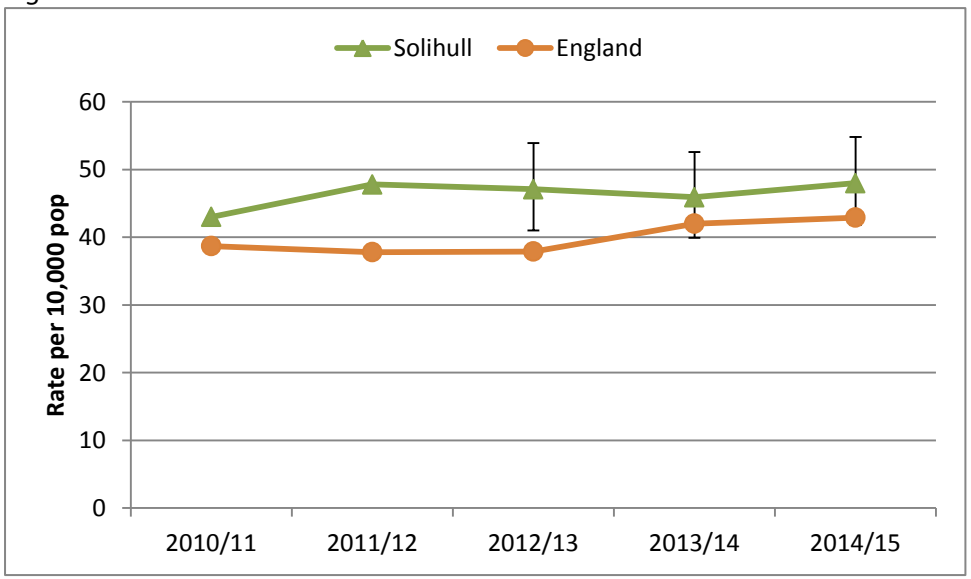
[27] Public Health England: National Child and Maternal Health Intelligence Network

Child Protection Plans

The rate of children who are subject to a Child Protection Plan (CPP) per 10,000 has risen from 43.0 in 2010/11 to 47.8 in 2014/15 following a similar upward trend to England.

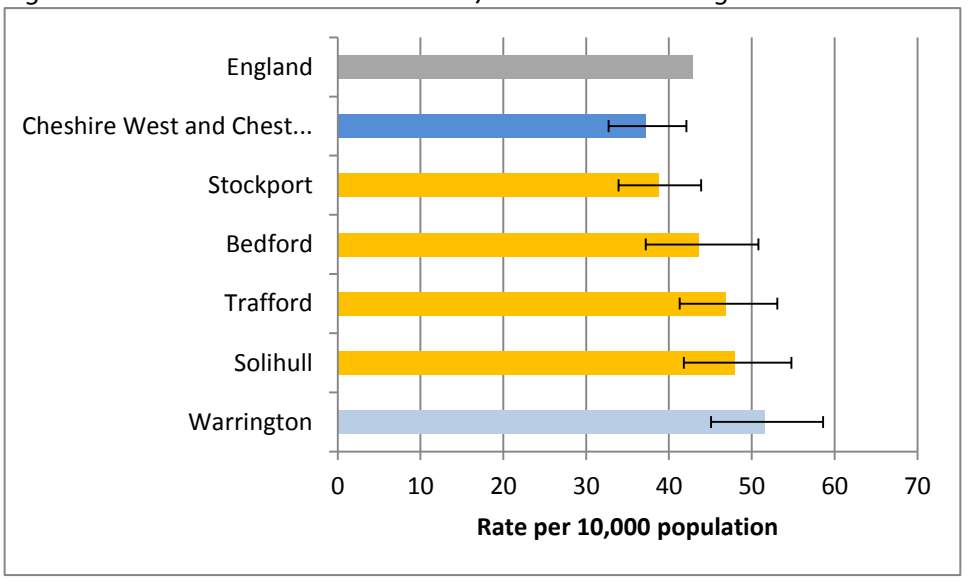
Solihull is no statistically different to the average England level in 2014/15, and is at the higher end compared with its nearest statistical neighbourhood group[28].

Figure 93 Child Protection Rates trend



Source: CHIMAT LA profiles

Figure 94 Child Protection rates 2014/15 – statistical neighbours



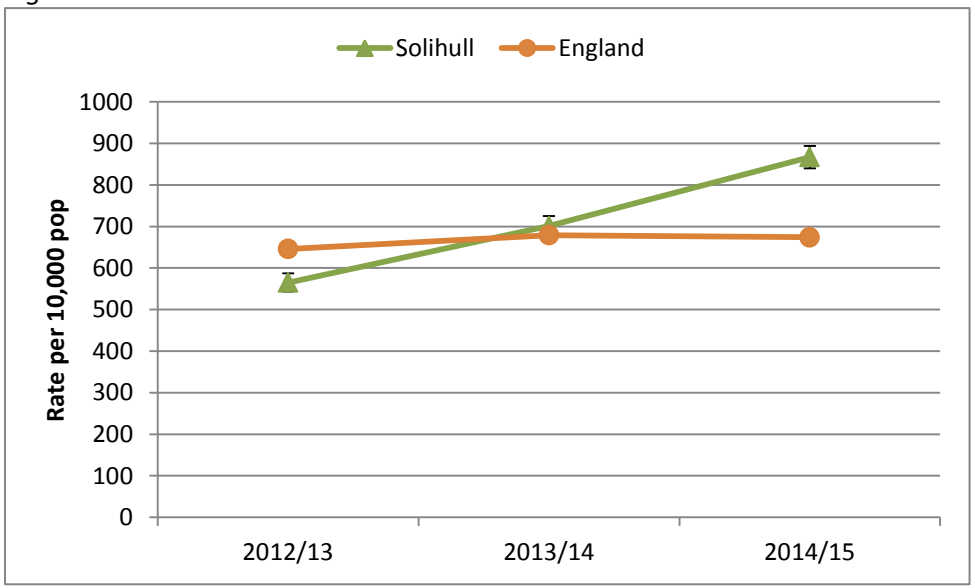
Source: CHIMAT LA profiles

[28] Department for Education: https://www.gov.uk/government/statistics/characteristics-of-children-in-need-2013-to-2014

Children in Need

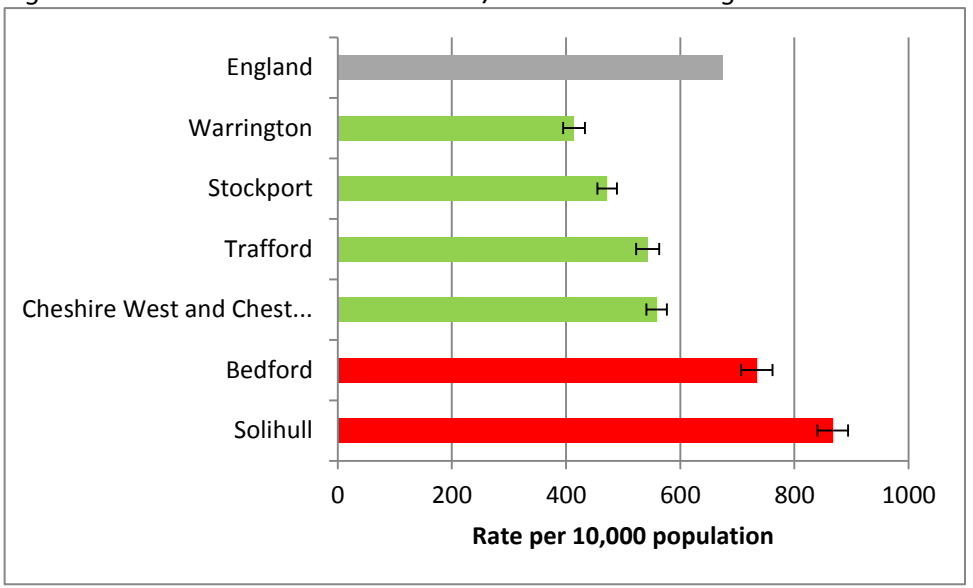
The Children in Need (CiN) rate per 10,000 under 18 for Solihull has increased from 565 per 10,000 people under 18 in 2012/13 to 867 in 2014/15 while England's rate has remained comparatively stable, at 674 in 2014/15[29]. Solihull has the highest rate of looked after children among its statistical neighbours.

Figure 95 Children in Need rates trend



Source Child Health Profiles

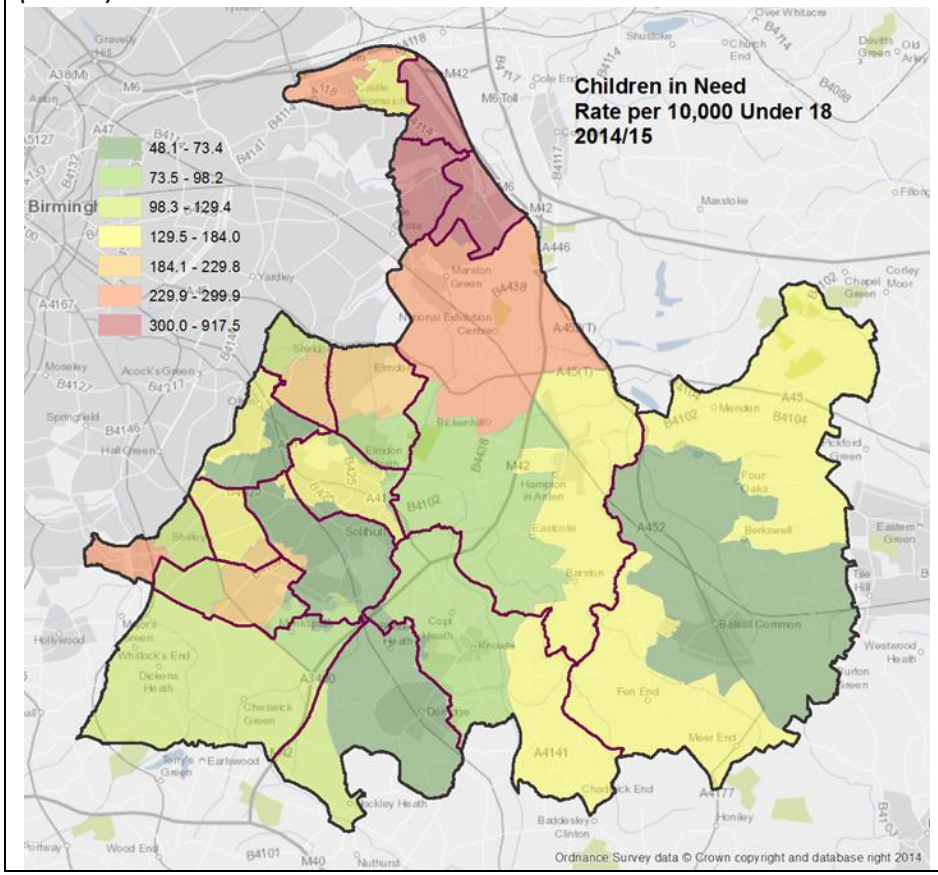
Figure 96 Children in Need rates 2014/15 – statistical neighbours



Source Child Health Profiles

[29] Department for Education: https://www.gov.uk/government/statistics/characteristics-of-children-in-need-2013-to-2014

Figure 97 Children in Need rates by Middle Layer Super Output Area (MSOA)



The map in Figure 97 reveals that there is a large inequality gap of across the borough for the Children in Need rate. Note that the rates are not directly comparable with the charts above, as it is based on local system data.

Source: Local data

Children and young people at risk of sexual exploitation

CSE is a form of abuse where children receive something (accommodation, drugs, affection, gifts, money, drugs) in 'exchange' for sexual activity. There are many different methods and approaches to sexually exploit children and young people, which can be undertaken by an individual, peers, groups and gangs.

While there is no specific criminal offence of 'CSE', common offences can include rape and other forms of sexual assault, trafficking and child abduction.

The West Midlands Metropolitan Region issue regular snapshots of the nature and scale of child sexual exploitation (CSE) across the West Midlands, based on data from the seven Local Authorities within the West Midlands Police boundary.

There are three categories of risk from low to high:

- Level 1 'At risk' – these young people will receive support from the Early Help Direct Work team supported by a member of the CSE team where necessary.
- Level 2 'Significant risk'
- Level 3 'Serious risk' - both Level 2 and 3 will be allocated in social worker and the CSE team may be involved to complete specific interventions as part of a wider care plan.

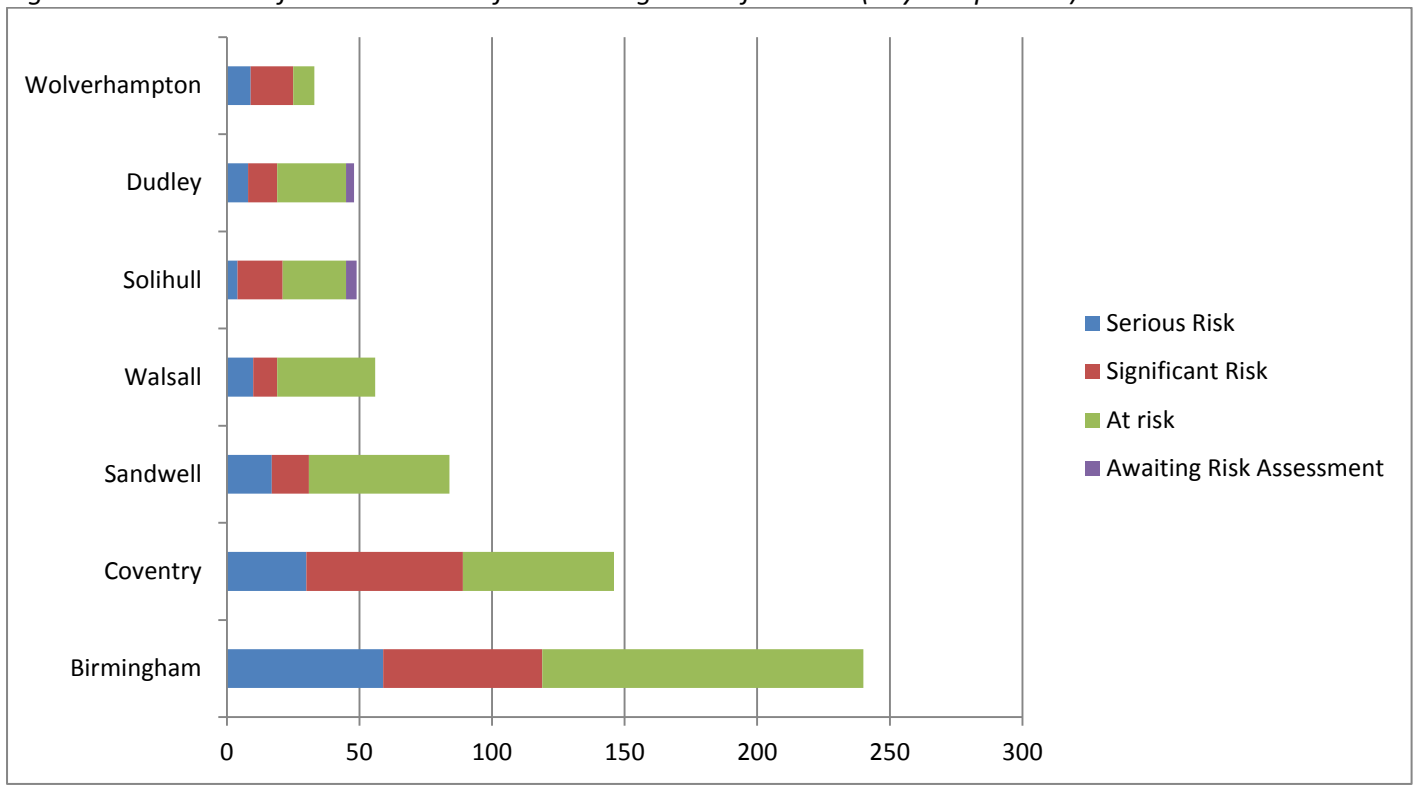
Solihull is one of three local authorities in the West Midlands that have an established CSE team.

Consequently as a result of improved recording there are a higher percentage of young people identified at risk of CSE in Solihull than neighbouring areas. However, the rate (0.11% of the 0 – 17 year population) is still likely to be an underestimation of the true number of children who are victims of sexual exploitation.

The latest snapshot report from the West Midlands CSE Manager (September 2015) points to the need to improve identification of younger children who are victims and also the growing trend of exploitation on line.

At September 2015, Solihull had 49 young people at risk of CSE, 46 of whom were female and 3 male. A breakdown between the risk levels compared to other authorities is shown below.

Figure 98 Numbers of under 18s identified as being at risk from CSE (July – Sept 2015)



Source West Midlands CSE Operations Group

Family Homelessness

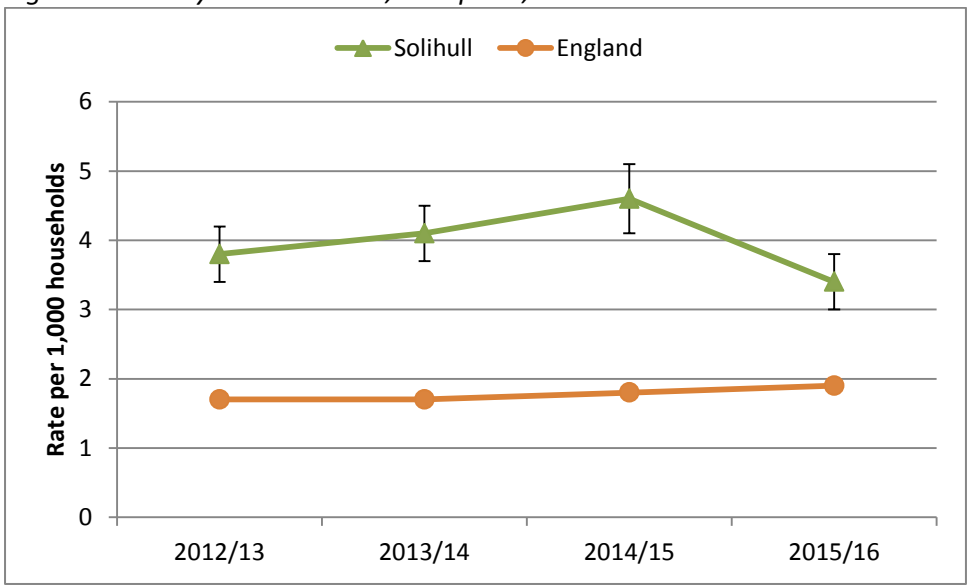
The UN Convention on the Rights of the Child highlights the right of every child to an adequate standard of living. Children from homeless households are often the most vulnerable in society.

Family homelessness is a national indicator that records the number of households with dependent children or pregnant woman that have applied and been accepted as unintentionally homeless and eligible for assistance by local authorities.

Solihull has a number of structural factors contributing to its high homelessness figures, including[30]:

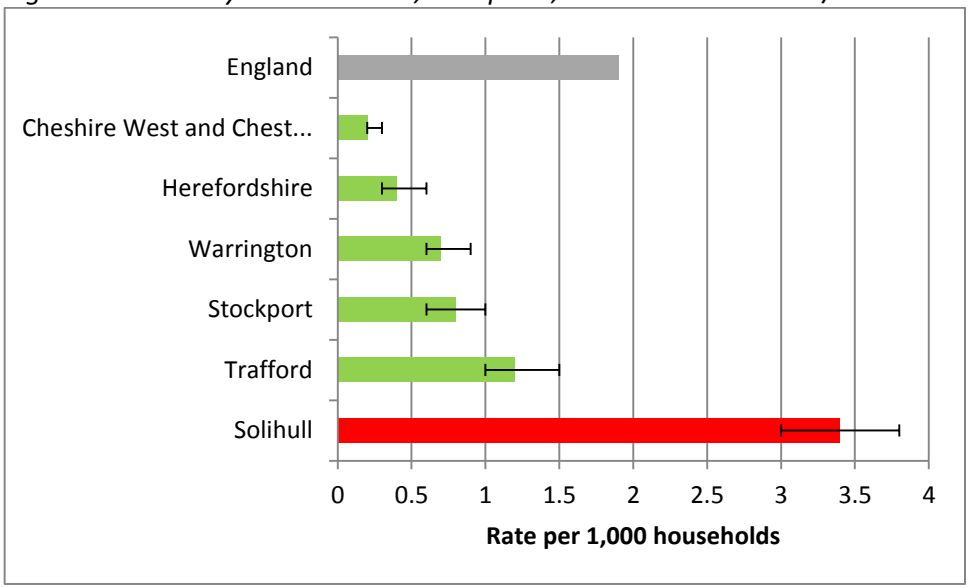
- growth in the number of single person households;
- a slowdown in house building leading to a shortage of affordable and specialist housing and exceptionally high pressure on the social housing waiting list;
- a fall in the number of social rented lettings accompanied by an increase in the proportion of lettings to homeless households;
- average house prices and private rents that are markedly higher than the West Midlands region and;
- despite recent growth, a relatively small private rented sector.

Figure 99 Family homelessness, rate per 1,000 households.



Source Child Health Profiles

Figure 100 Family homelessness, rate per 1,000 households.2015/16



Source Child Health Profiles

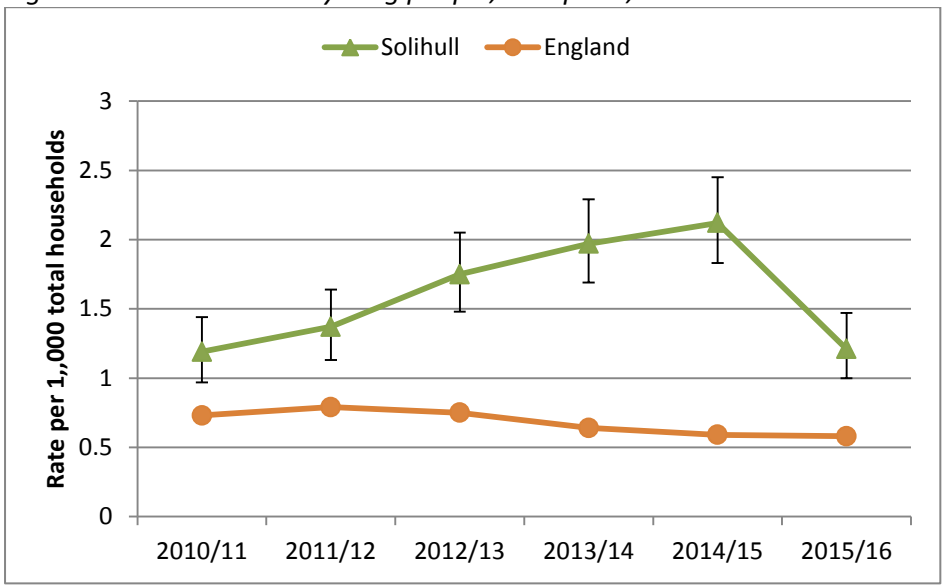
[30] Solihull Statutory Homelessness 2015/16

Homeless young people aged 16-24

Homelessness has a serious impact on both the young people affected and the wider society. Young people describe their lives as being 'on hold' while they are homeless, making it much harder for them to achieve their goals and ensure their own well-being.

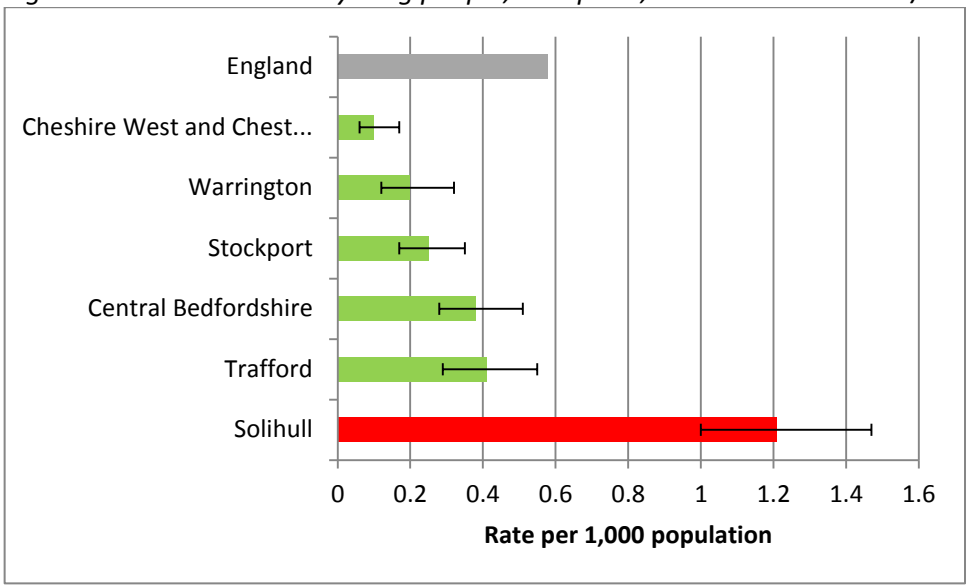
This measure represents homeless households headed by applicants aged 16-24 (rate per 1,000 total households) that have applied and been accepted as unintentionally homeless and eligible for assistance by local authorities. In 2015/16, 107 16 -24 year olds were accepted as homeless in Solihull, lower than in recent years, but still higher than the England average.

Figure 101 Homelessness young people, rate per 1,000 households.



Source Child Health Profiles

Figure 102 Homelessness young people, rate per 1,000 households.2015/16



Source Child Health Profiles

Key points

- Both family homelessness and homeless among young people aged 16-24 are significantly higher in Solihull than the England average and highest - by a large margin – than all our nearest statistical neighbours.
- Solihull's rate of family homelessness and young people homelessness is around triple it's next nearest statistical neighbour Trafford, with others, lower still.
- In 2015/16, 301 Solihull lone parents or pregnant women applied and were accepted as homeless and helped by the Council. This represented the vast majority of all homelessness acceptances that year across any age or eligibility group (71.8% of 419)[30].
- Solihull's rate of family homelessness is historically around double the national average, although the last two-year trend shows a slight narrowing of this gap.

9. Service utilisation

This section of the needs assessment looks at activity and referral data from children's social care services. An important part of any needs assessment is to look at existing service provision. Although social care services are not early help the demands placed on these services can often be attributed to a lack of early intervention at an early stage or an absence of early help provision.

The data presented here are largely derived from the Children In Need census which is a statutory requirement on local authorities.

Referral source and presenting need

Over half of the referrals to children's social work are from the police and education. Health (18%) and local authority services (10%) make up the majority of the rest of the referral workload.

In terms of the presenting needs, nearly half (49%) are referred because 'family in acute crisis'. Abuse or neglect is the next highest category and accounts for one-quarter of all referrals.

	Presenting need											
Referral source	Family in acute stress	Abuse or neglect	Parental disability/illn	Socially unacceptabl	Family dysfunction	Absent parenting	Child's disability/illn	Cases other than	Low income	Unknown	TOTAL	TOTAL (%)
Police	464	102	31	46	10	4	-2	2	0		657	26%
Education	223	220	48	100	30	4	9	2	0	0	636	25%
Health: hospital/acute	117	64	65	25	10	0	6	0	0	0	287	11%
Health: GP and community	53	52	30	16	21	0	6	0	0	0	178	7%
LA services : other internal or external	67	31	26	9	8	0	6	1	0	0	148	6%
Individual: Family member/relative/carer	65	42	9	15	4	0	0	0	0		135	5%
Housing (LA housing or housing association)	101	14	5	3	1	0	0	0	3		127	5%
LA services: Social care e.g. adults social care	45	31	15	4	3	0	3	1	0		102	4%
Other legal agency: Including courts, probation, immigration, CAFCASS, prison	45	27	12	3	4	2	0	0	0		93	4%
Other: Including children's centres, independent agency providers, voluntary organisations	23	19	20	3	3	1	0	0	0		69	3%
Individual: Acquaintance (including neighbours and child minders)	14	16	8	5	3	0	0	0	0		46	2%
Individual: Self	1	0	0	1	4	23	3	0	0		32	1%
Anonymous	11	1	2	0	1	0	0	0	0		15	1%
Individual: Other (including strangers, MPs)	6	7	0	0	1	0	0	0	0		14	1%
Not Coded	0	1	0	0	0	0	0	0	0	2	3	0%
ALL SOURCES	1235	627	271	230	103	34	31	6	3	2	2542	100%
ALL SOURCES %	49%	25%	11%	9%	4%	1%	1%	0%	0%	0%		

Figure 103 Source of referrals to children's social care (2014/15)

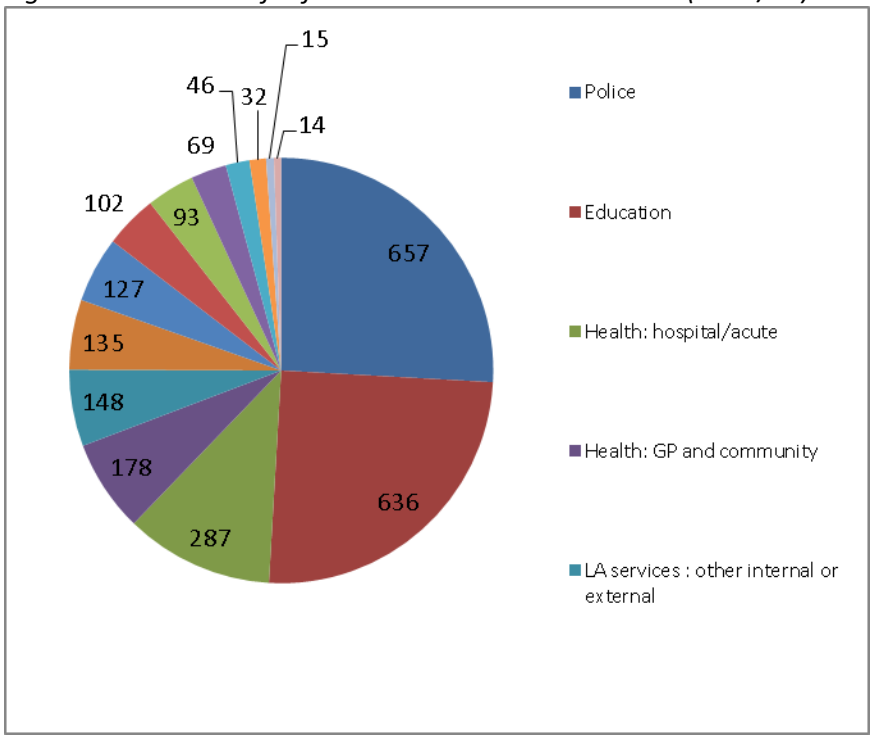
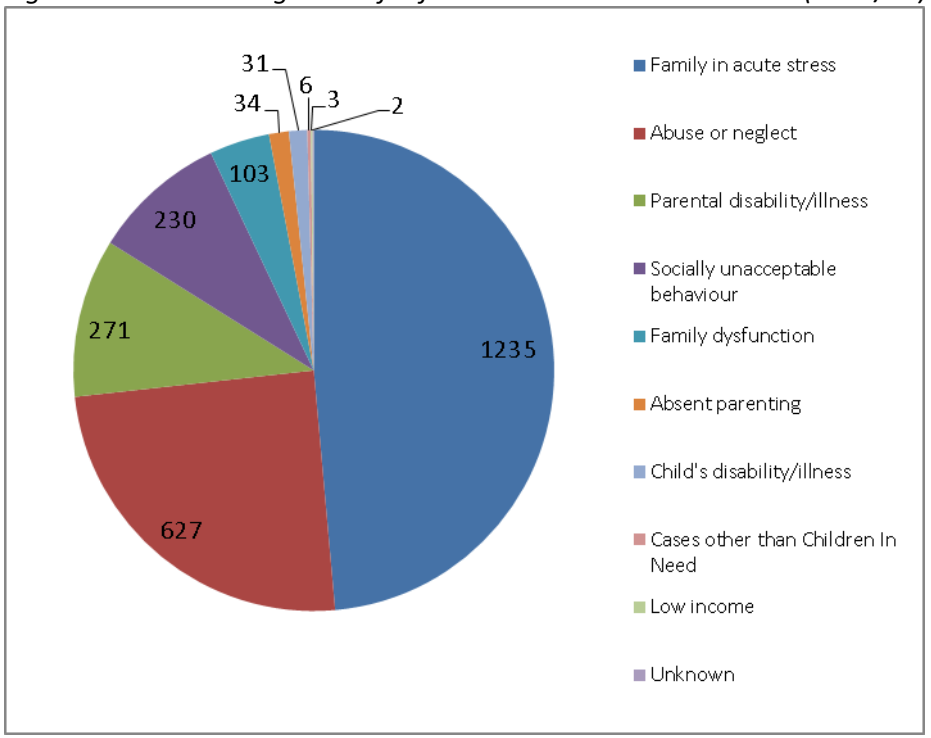
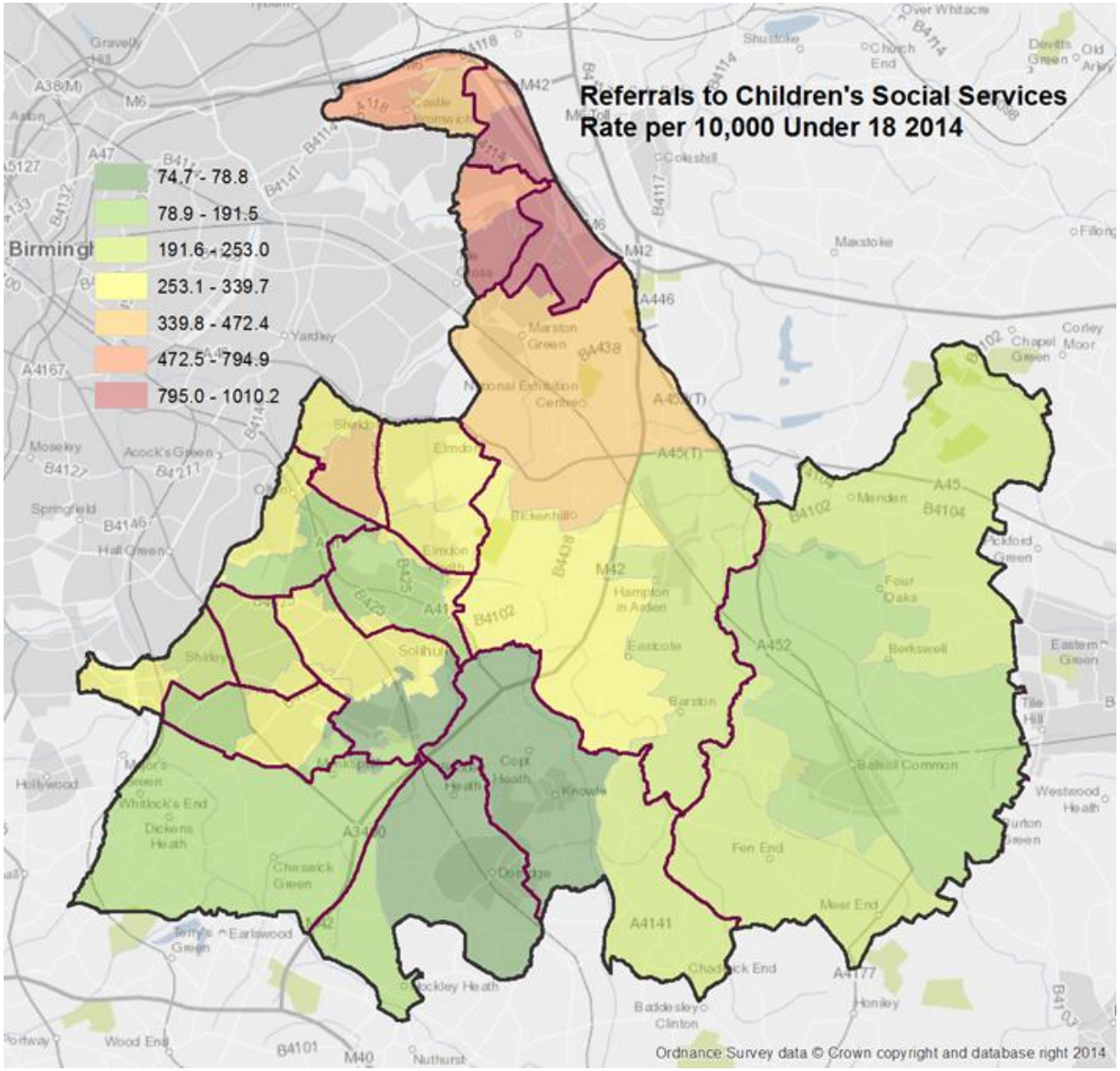


Figure 104 Presenting need of referrals to children's social care (2014/15)



Where do referrals come from?

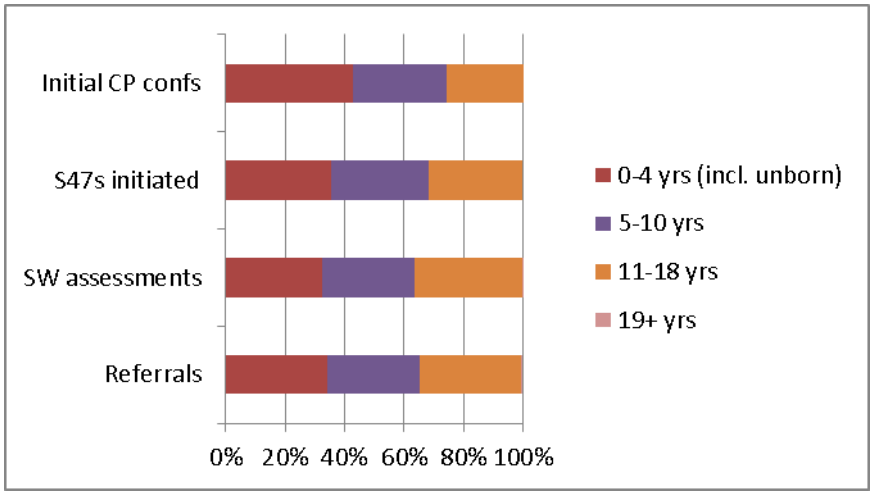
The rate of referrals for Children's Services from 2014 activity data again reveals the focus on the North Solihull Regeneration Area.



Age profile

The table and chart below show the age profile of those in contact with children's social care services in 2014/15. The distribution among the three different age groups (0-4, 5-10 and 11-18 years) is fairly equal except in the case of initial child protection case conferences where 43% are for the 0 – 4 age group.

	Refs received		SWAs completed		S47s initiated		ICPCs held	
		%		%		%		%
0-4 yrs (incl. unborn)	875	34%	578	33%	278	36%	154	43%
5-10 yrs	780	31%	548	31%	257	33%	112	31%
11-18 yrs	866	34%	638	36%	245	31%	92	26%
19+ yrs	7	0%	1	0%	0	0%	0	0%
Not recorded	14	1%	4	0%	2	0%	0	0%
All Ages	2542		1769		782		358	



Referral pathways

	2014/15	
	Children	**Conversion rate**
Refs received	**2,542**	
Outcome*: further action resulted (i.e. typically SWA and/or S47)	2200	87%
Outcome*: NFA Refs	342	13%
Refs that were a repeat ref within 12 months	582	23%
Refs where further action resulted**	**2200**	
Outcome*: SWAs completed	1,769	80%
Outcome*: S47s initiated	782	44%
S47s initiated	**782**	
Outcome*: ICPCs held	358	46%
Outcome*: ICPC not required	424	54%
ICPCs held	**358**	
Outcome*: CPPs started	299	84%
Outcome*: CPP not required	59	16%

*caveat: assumes that all outcomes relate to refs received in-year & that the outcome of all refs would have occurred in-year; in reality timing differences will occur across years

** note that further action resulting from a single referral can be one or more SWAs and/or one or more S47s

Referrals received – 2,542 referrals were received during 2014/15, a 5% increase on the previous year. 13% of referrals resulted in no further action being taken. This compares with 9% in 2013/14.

Repeat referrals – 582 referrals were repeat referrals within the year, which accounts for 23% of all referrals.

Compared to statistical neighbours, Solihull has the highest referral rate of children to social care services; it is also just above the national rate in 2015. The proportion of referrals resulting in no further action is around the national average and compares favourably with statistical neighbours.

Figure 105 Referral rate per 10,000 to children's social care 2014/15

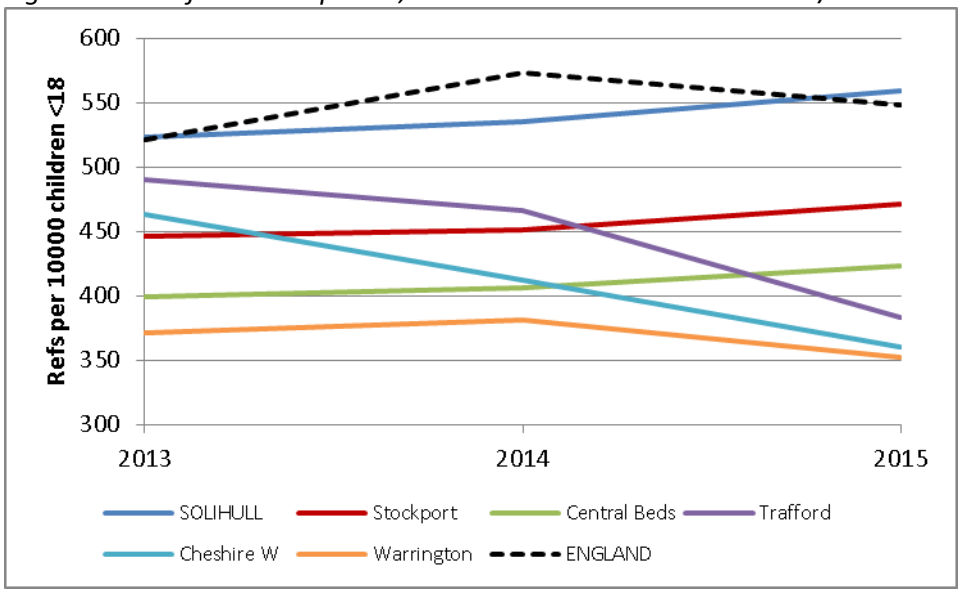
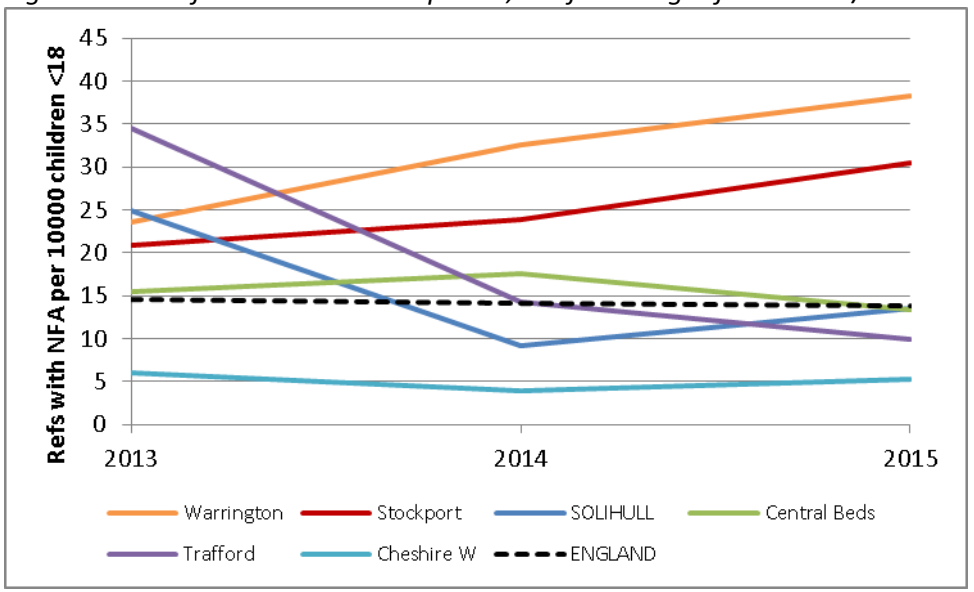


Figure 106 No further action rate per 10,000 following referral 2014/15



Section 47 enquiries – 782 S47s were initiated during the year, a four year high and an increase of 32% compared with 2013/14.

Initial Child Protection Conferences (ICPC) – 358 ICPCs were held which represents an increase of 24% on the previous year. The proportion of S47 enquiries that resulted in an ICPC was 46%, down from 49% in 2013/14.

Solihull has the highest rate of S47s and ICPCs when compared to statistical neighbours. Rates are higher than England as a whole and have increased significantly over the last two years: S47s have doubled and ICPCs are up by 50% during that period.

Figure 107 Children subject to a S47 (2014/15)

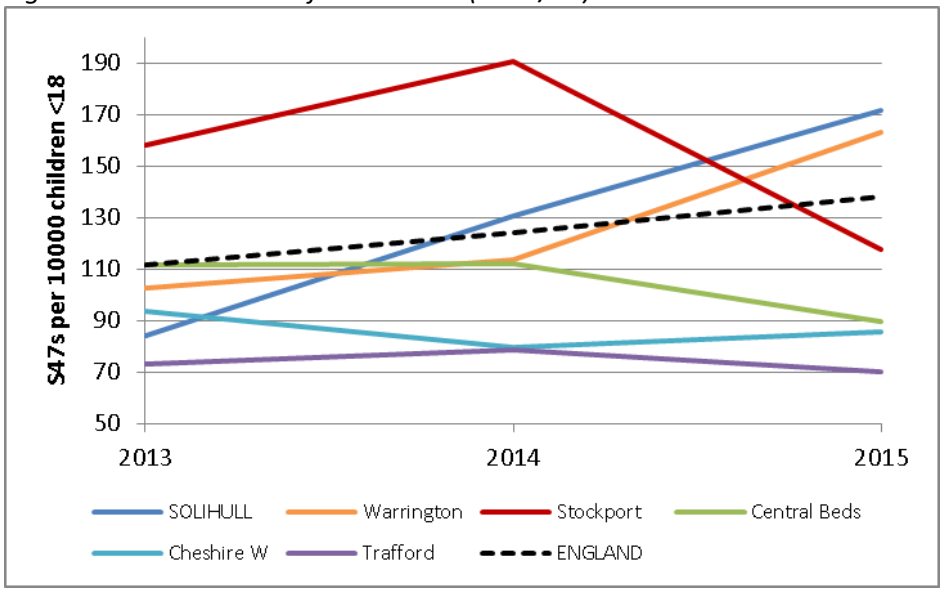
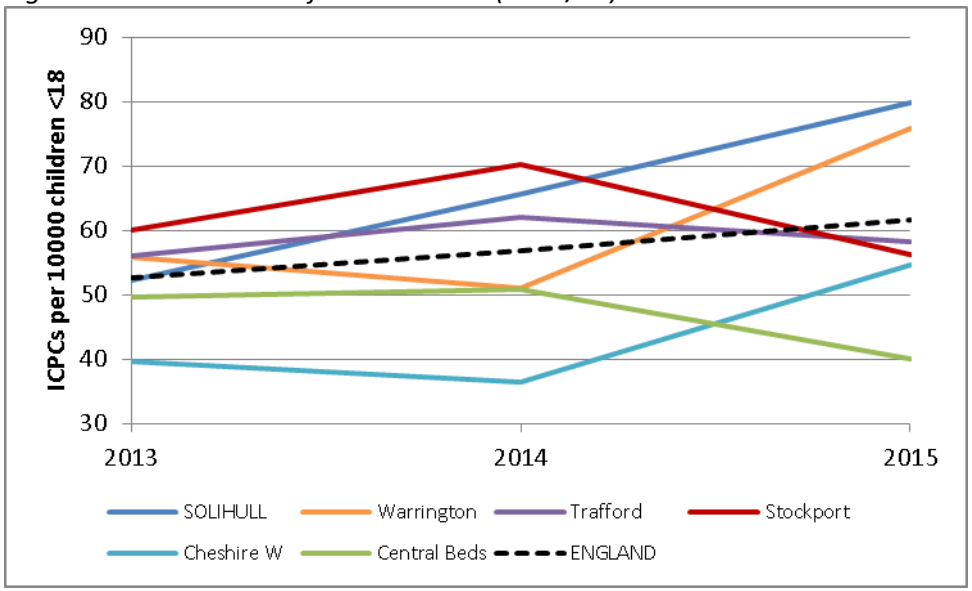


Figure 108 Children subject to an ICPC (2014/15)



Current early help provision

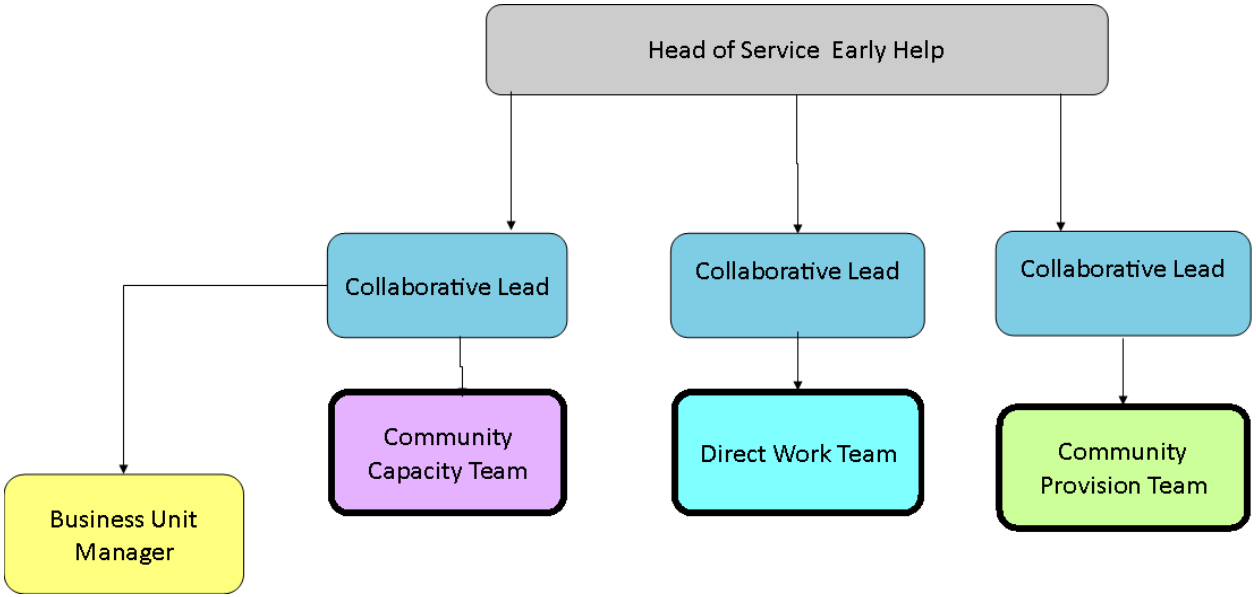
A new early help offer has been designed in Solihull based on the five principles contained in the Early Help Strategy

A management of change process with SMBC was undertaken which impacted on 10 services and over 100 staff. The aim of this was to bring together those staff that are currently delivering elements of early help within a more coherent structure which will enable support to be given to families that is more coordinated and family centred.

The new service came into being on 1st October 2015. It is geographically based on the five school collaboratives and includes the following divisions

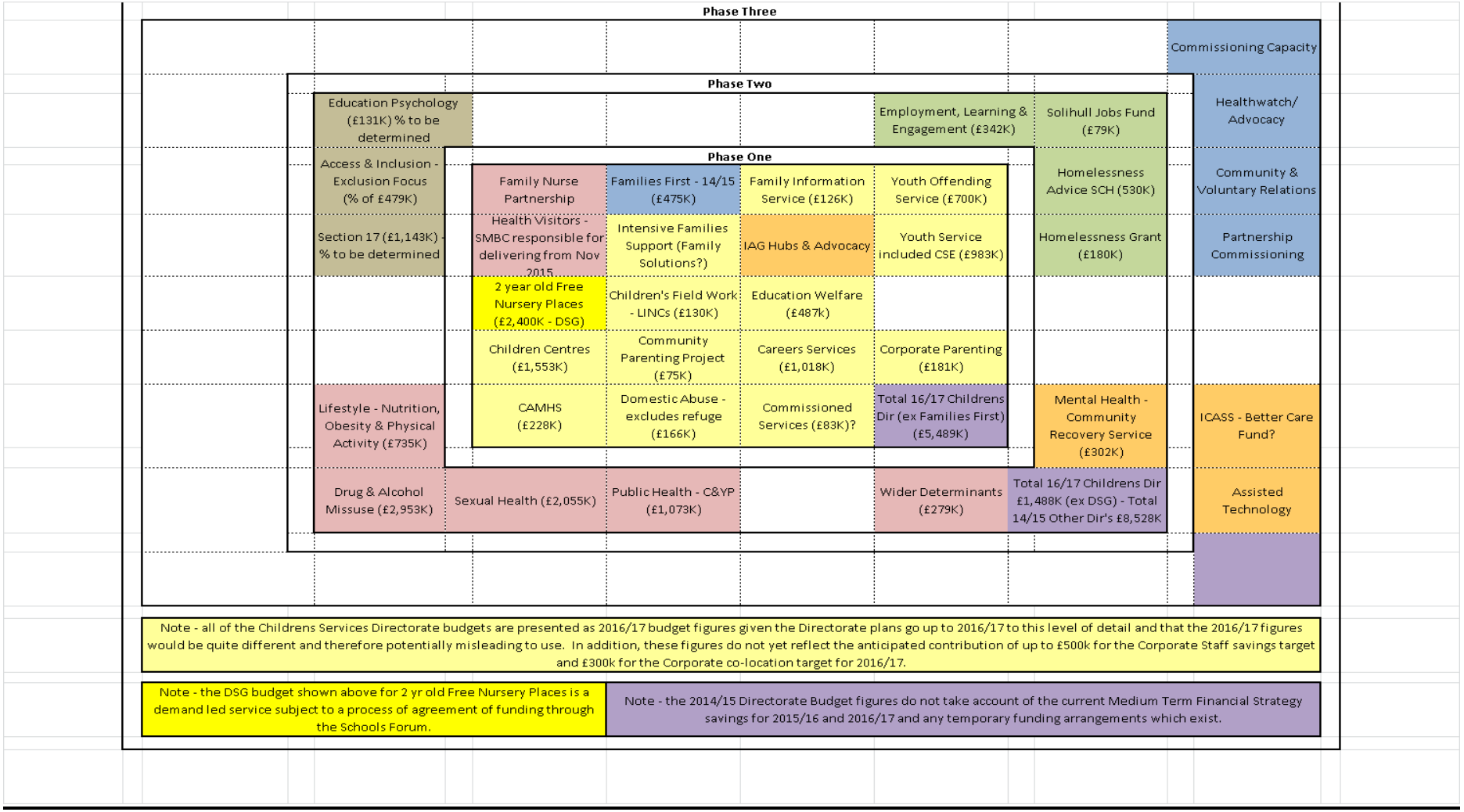
- Direct work
- Community development
- Community capacity

Figure 109 Structure of the new Early Help System



The new system will operate in a matrix management style so that each of the collaborative leads will have geographical responsibility for an area and also functional responsibility for an element of early help delivery.

However, early help is not a discrete entity and covers a wide spectrum of services including midwifery, health visiting, Family Nurse Partnerships (FNPs) school nursing as well as services provided by the voluntary and community sector. The diagram below attempts to identify the funding streams that contribute to early help in Solihull.

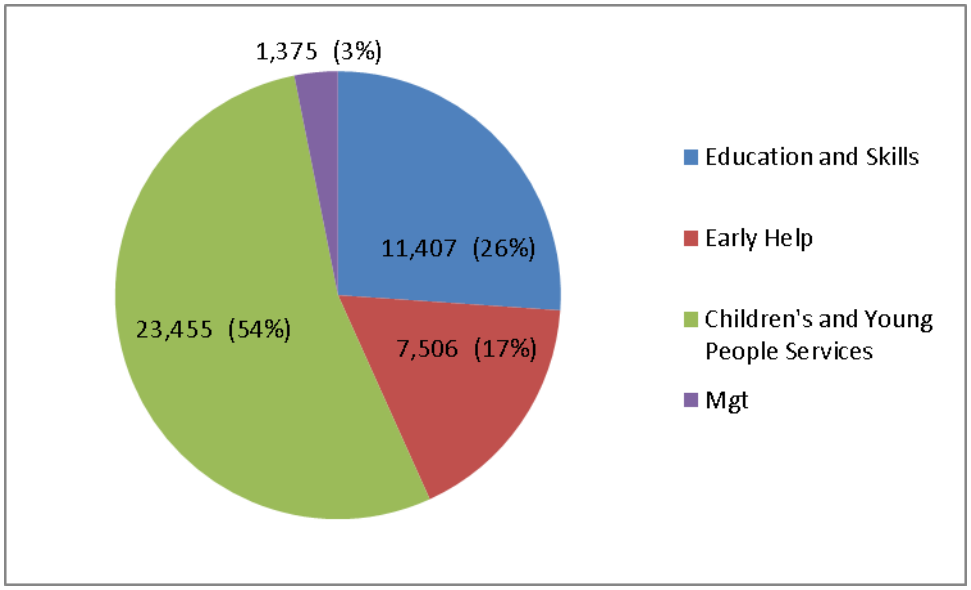


Health services, such as health visiting, FNPs and school nursing, are now commissioned by the council and therefore create the potential to provide a more coordinated and integrated service model. Health visiting has a key role to play in the new system as it is a universal service. Health visitors lead on the Healthy Child Programme[31] for 0-5 years and they are a substantial workforce (45 whole time equivalent health visitors are employed in Solihull).

Early help spend

Within core spending on children's services in Solihull – which amounts to just over £6m - early help makes up 17% of the total budget.

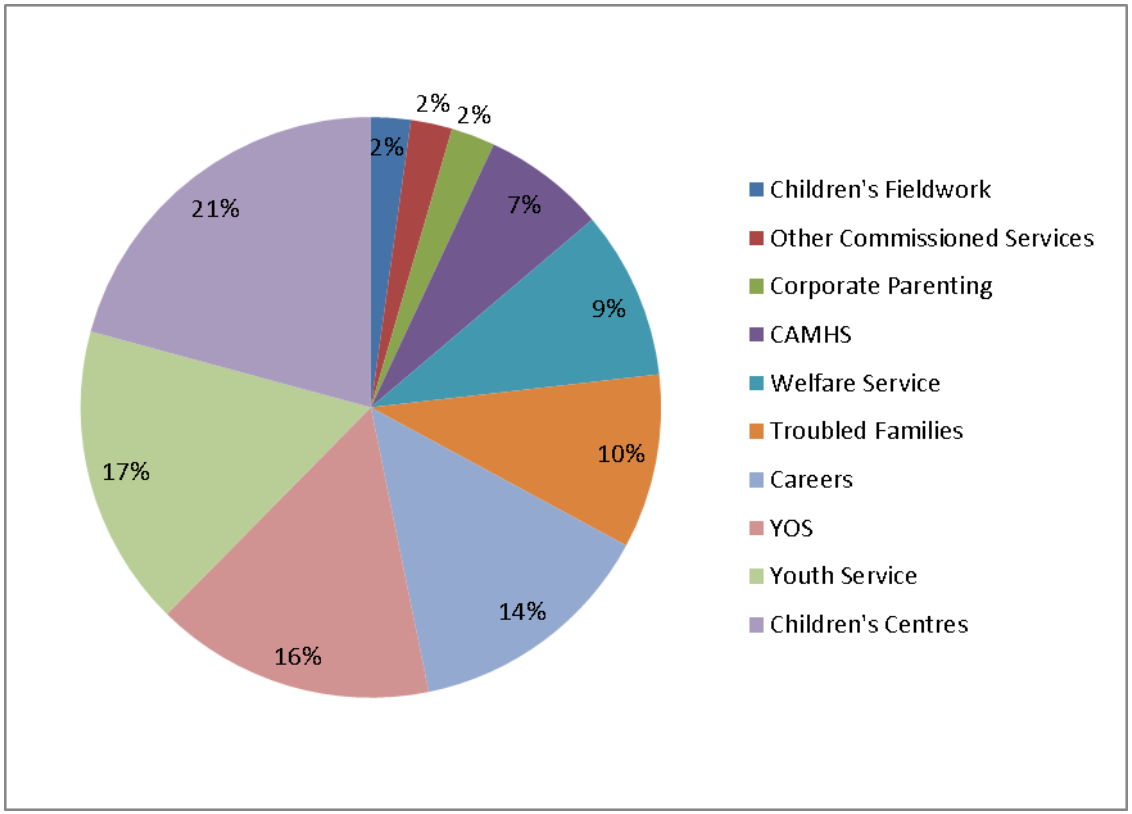
Figure 110 Children's services and skills budgets 2015/16 (£ 000's)



The early help budget comprises of separate budgets that were brought together as part of the management of change exercise that took place over the summer of 2015. The breakdown is shown in the pie chart below.

[31] The Healthy Child Programme (HCP) is the key universal public health service for improving the health and wellbeing of children through health and development reviews, health promotion, parenting support, screening and immunisation programmes.

Figure 111 Breakdown of early help budget 2015/16 (£ 000's)



There are however other dedicated resources that are a key component of early help, such as health visiting, Family Nurse Partnerships (a more intensive version of health visiting that targets teenage mothers), school nursing and breastfeeding support. The responsibility for commissioning health visiting and Family Nurse Partnerships was transferred from the NHS to Solihull Council on 1 October 2015.

Service	**Directorate**	**Budget (£ 000's)**
Health visiting/FNP	Public health	£2,800
School nursing	Public health	£550
Breastfeeding support	Public health	£124
TOTAL		**£3,474**

In addition, other service budgets make an important contribution to early help. The new Emotional Wellbeing and Mental Health Service for Children and Young People, delivered by BSMHFT in partnership with Barnardos, coordinates all the parenting programmes within Solihull. This includes the antenatal 5 week programme, the Solihull Approach 'Understanding Your Behaviour' courses as well as more targeted interventions such as Mellow Parenting.

Spend compared to statistical neighbours

It is difficult to compare spend on early help with other authorities as there is no common agreement on what constitutes early help and models of delivery will differ around the country. For example, some local authorities will define early help as only providing services to 0-5 years.

All local authorities are required to prepare an education and children and young people's budget statement each year. This is disaggregated across the following budget headings

- Education Welfare
- Youth
- Youth Justice
- Childrens Centres

In Solihull, these areas are all incorporated in to the new early help service and so a comparison with other authorities is useful. The analysis of this spend is shown below, firstly looking at proportion of spend within the borough and then comparing spend per head with our five closest statistical neighbours.

NOTE: 'services for young people' includes youth work, activities for young people, services to support young people's participation in education or training etc. Children's centres include those managed directly by the local authority and those commissioned from another body.

Figure 112 Planned spend in Solihull, 2015/16

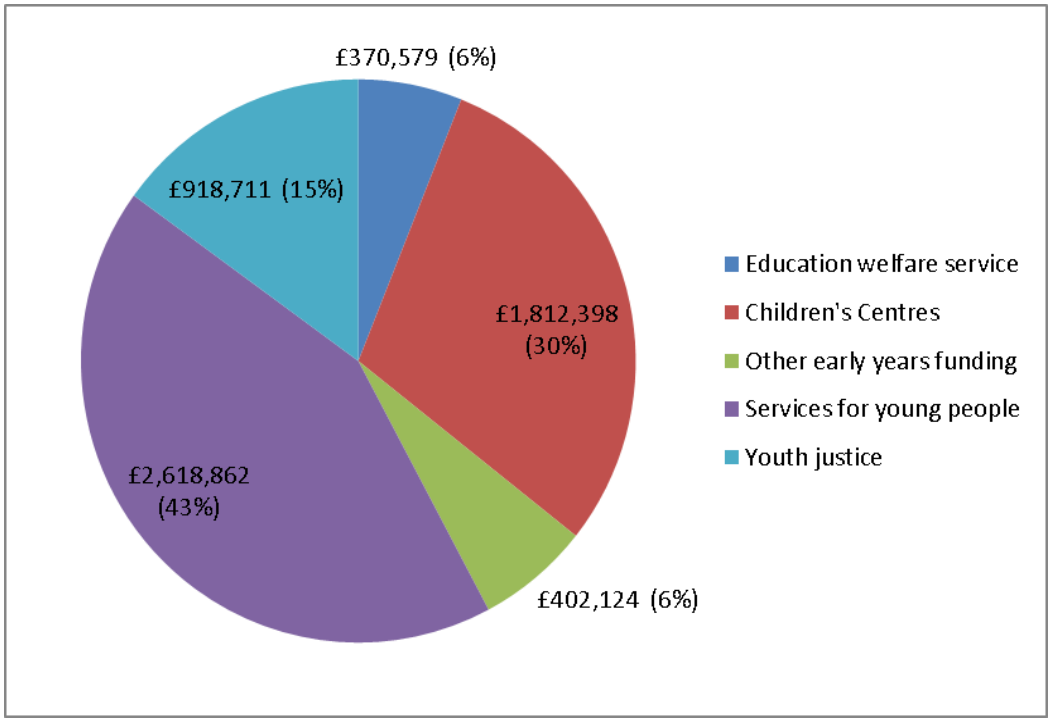
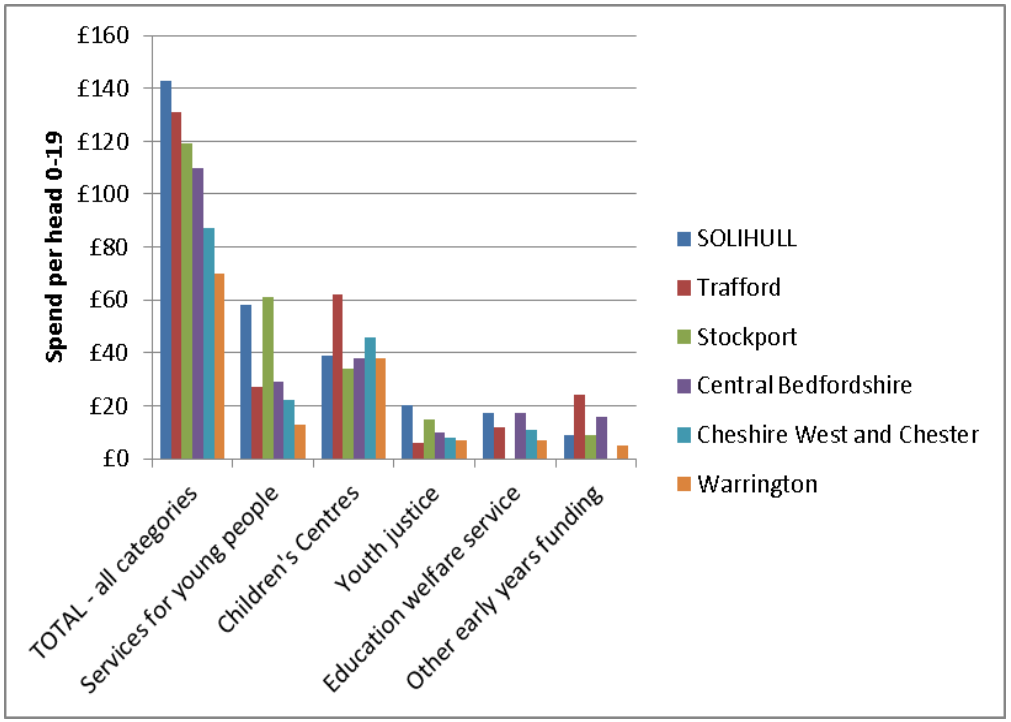


Figure 113 Planned spend per capital compared to similar authorities



Source Section 251 Local Authority returns

Compared to its statistical neighbours Solihull appears to spend more per head of population in these areas. This should be treated with some caution as theses figures are obtained from Section 251 returns and completion is subject to a degree of local interpretation.

Early years provision

Another area of early help spend and performance where comparisons can be drawn is early years expenditure. Every year the Department for Education publishes benchmarking tables which allow authorities to compare themselves on a range of early help measures including funding, quality, take up of funded early education and staff qualifications.

The overall conclusions that can be drawn from the benchmarking analysis are

- Solihull has the highest proportion of three and four year olds benefiting from funded early education among its statistical neighbours (in fact Solihull records the third highest take up rate in the country).[32]
- spends the second highest amount on two year old funded places (by head of population) compared to its statistical neighbours - and contributes more its allocation than any statistical neighbour.
- Has the second highest number of early years settings rated good or outstanding by OFSTED.
- However it is 4/6 in terms of % of qualified staff who work with two year olds.
- Lowest spend per head on three and four year olds.

Figure 114 % of 3 & 4 year olds taking up funded early education (13/14)

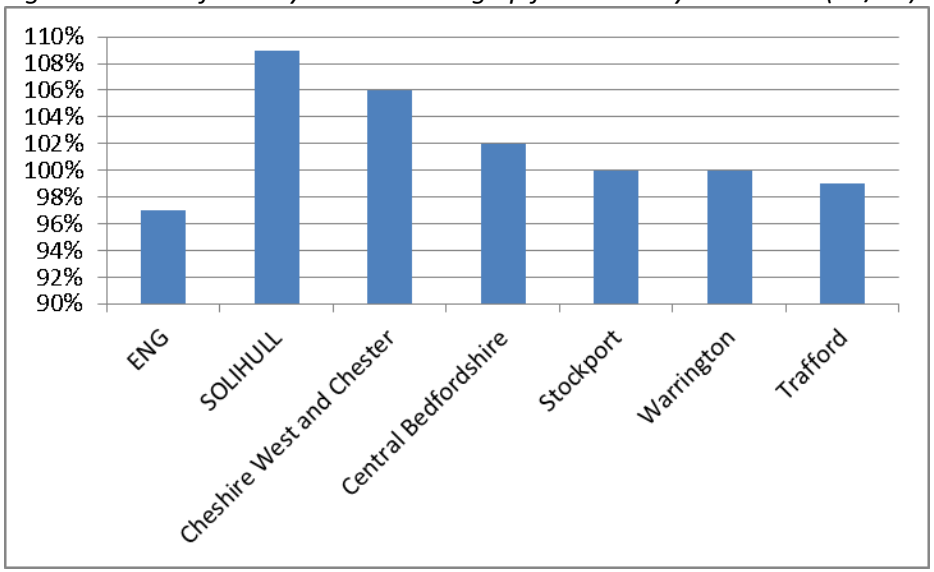
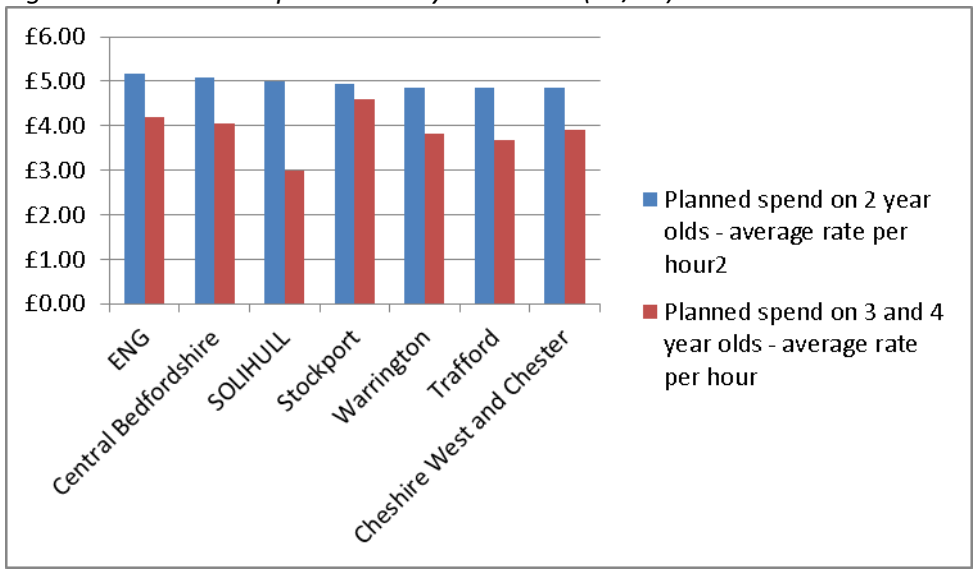


Figure 115 Planned spend on early education (13/14)



[32] Take up rates over 100% reflect the fact that population estimates at sub national level are derived from ONS mid year estimates and are subject to a margin of error.

Figure 116 % of children's and early years settings rated good or outstanding by OFSTED (as at August 2014)

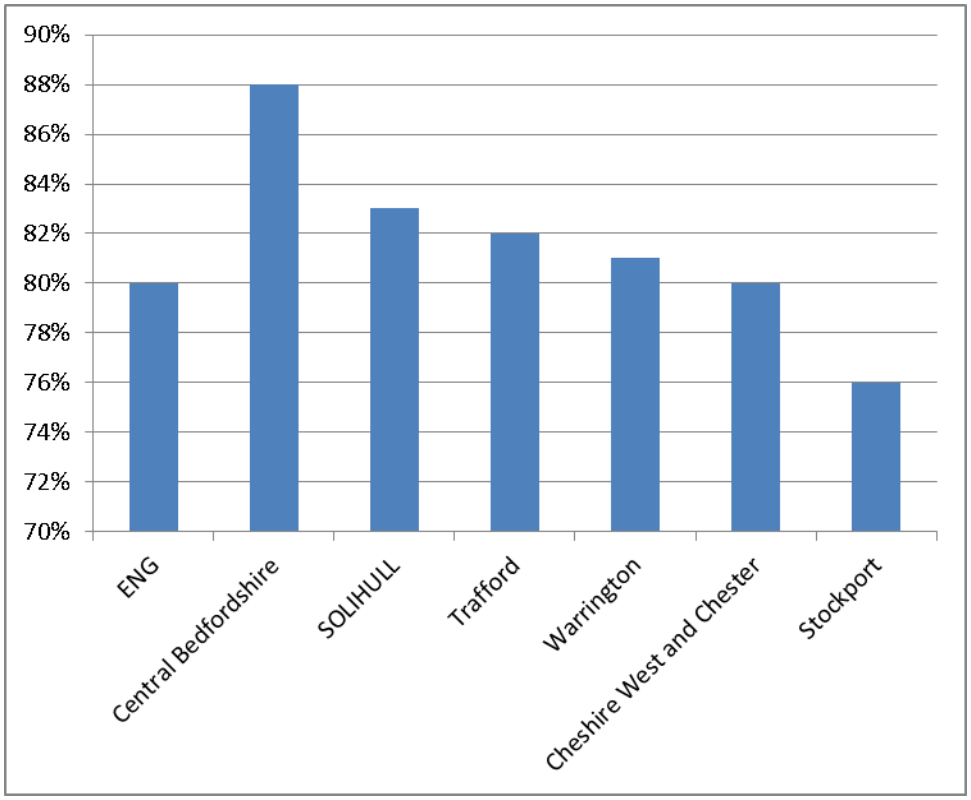


Figure 117 Percentage of PVI providers with staff with QTS/EYPS who work directly with two year olds (14/15)

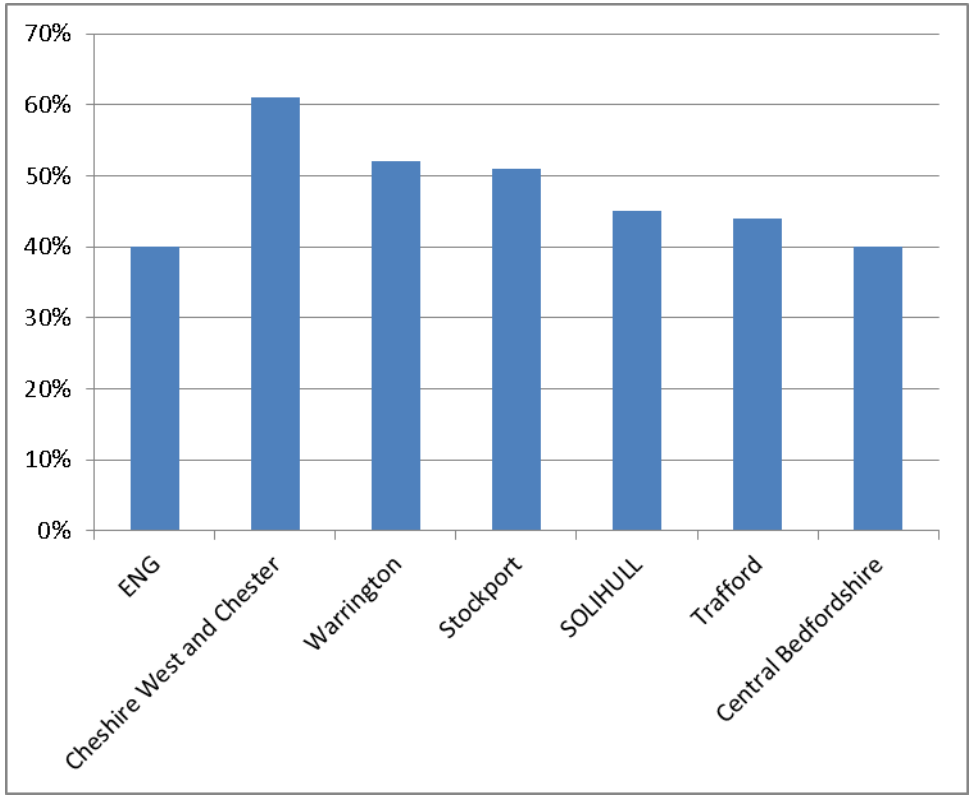
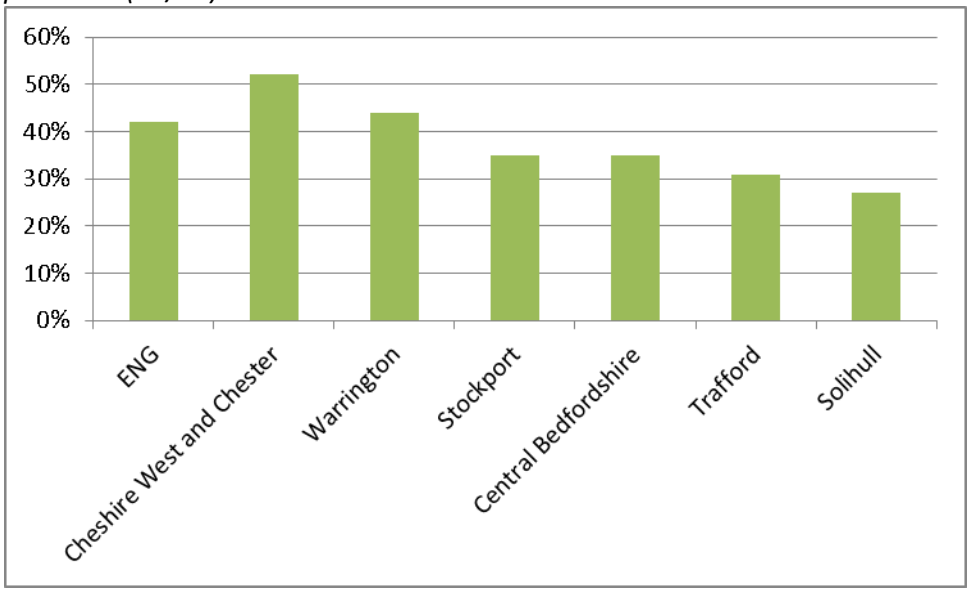


Figure 118 % of 3 and 4 year olds receiving funded early education in PVI providers (13/14)



10.What works

The Early Intervention Foundation (EIF) – of which Solihull is one of 20 pioneer members – has reviewed 50 early help programmes in terms of the strength of evidence. These have a part to play in any early help offer but they are mainly manualised programmes, which require training to deliver and which come at a cost. A full list of these programmes, broken down according to the level of supporting evidence, can be found in Appendix 1.

The way early help staff go about their work, and the systems they work within, are crucial to the effectiveness of delivery of services. The EIF publication *Getting It Right for Families* stresses the importance of integrated pathways. These 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. Core pathways are described as: 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 report goes on to say:

> *'During our discussions a clear view emerged that the key benefit of developing integrated pathways is the engagement and commitment from partners achieved through the process of planning and developing the pathways. Mapping services also increases knowledge about what other agencies are providing. It often enabled teams to identify duplication and begin to plan for gaps in provision'.*

In order to build pathways it is necessary to know what services are on offer. Below are a few examples.

Service	**What early help staff need to know**
Umbrella (the name of the partnership led by University Hospital Birmingham that provides sexual health services provided across Birmingham and Solihull)	What services are available and where • Condoms and Long Acting Reversible Contraception • Pregnancy testing • Testing for sexually transmitted illnesses • Emergency hormonal contraception (the morning after pill)
Antenatal parenting programmes	This is a 5 week course that goes beyond the traditional delivery of such programmes which focus on child birth. It is facilitated by midwives and is available to all mums-to-be
Healthy Start vitamins	These are available free to all pregnant and breastfeeding women and to infants under 4 who are on certain benefits
Breastfeeding support	SMBC commission a specific breastfeeding support service. Staff can help raise the profile of breastfeeding cafes which

	run in parts of the borough and encourage dads to support breastfeeding
Eat Well Move More	This is a family weight management programme which delivers in schools and also 12 week programmes in leisure centres and other venues.
Book Start and Read Me Well	Encouraging parents to read to their children is one of the most effective and cheapest interventions. The evidence shows that it is the most important determinant of language and emergent literacy. Read Me Well is a scheme in libraries that provides therapeutic books suitable for 2-11 year olds and their parents
Making Every Contact Count	Making Every Contact Count (MECC) encourages conversations based on behaviour change methodologies (ranging from brief advice, to more advanced behaviour change techniques).

Other things that early help can do

Some findings from the literature include

- Encourage the take up of free early education places (at 2, 3 or 4). There is lots of evidence for the provision of universal and high quality early childhood education and care. (e.g. Melhuish E**:** *The Impact of Early Childhood Education and Care on Improved Wellbeing* from "If you could do one thing..." Nine local actions to reduce health inequalities published by the British Academy).
- Ensure a whole family approach is adopted and facilitate multi agency working with health, education and social welfare input as appropriate.
- Promoting mental wellbeing (e.g. the Five Ways to Wellbeing approach).
- Early identification of young carers
- Influence the home learning environment where possible – e.g. whether the child has regular bedtimes and mealtimes, frequency of learning activities: anyone at home reads to child, takes child to library, helps with alphabet, writing, reading, numbers/counting, learning songs, poems and rhymes, musical activities, does drawing and painting.

11.Evidence-based resources

Healthy Child Programme 0-5

A rapid review of evidence for the Healthy Child Programme was published in 2015 (Public Health England, 2015). It summarises evidence for

- Maternal mental health
- Smoking
- Drugs and alcohol
- Intimate partner violence
- Preparation and support with childbirth and transition to parenthood
- Attachment
- Parenting support
- Keeping safe
- Nutrition and obesity prevention
- Oral health
- Promotion of child development, including speech, language and communication issues

A summary of the evidence is attached to this paper (see Appendix 2).

A review of the Healthy Child Programme 5-19 is due to start soon.

'Our children deserve better' (report of the Chief Medical Officer, 2012)

This report recommends implementation of a range of strongly evidence-based interventions (already in NICE guidance) that, if implemented at scale, could have a dramatic impact, improving children's lives while saving costs to the system. These include:

- Support for breastfeeding (PH11, Maternal and child nutrition)
- Promoting smoking cessation for pregnant women and preconception (PH26 Quitting smoking in pregnancy and following childbirth)
- Developing and implementing accident prevention strategies targeting home safety and road traffic injuries (PH29, 30, 31 on prevention of unintentional injuries in under 15s)
- Providing parenting support that does not stigmatise, and school-based approaches to well-being (for example CG158, Anti-social behaviour and conduct disorders in children and young people)

Early Intervention Foundation publications

The EIF have published a number of 'what works' publications:

The Best Start at Home

This review is concerned with interventions that promote parent-child interaction from conception through to when children are aged five years. More specifically, the aim of this review was to identify practices that encourage positive parent and child interaction in order to promote: i.

attachment and parental sensitivity; ii. social, emotional and behavioural development, from early childhood; iii. children's language and communication skills.

Early Intervention in Domestic Violence and Abuse

This report assesses the extent to which evidence on domestic violence and abuse can be an important cause of long term problems for children and families, and the role of early intervention in pre-empting this. The report preliminarily assesses a suite of preventative programmes for children and young people, early intervention initiatives for families at risk and perpetrator programmes.

Social and Emotional Learning: Skills for life and work

This review bolsters the evidence on the strong links between social and emotional skills in children and how they fare as adults. Evidence indicates that children with well-developed social and emotional skills have a better chance of being happy and healthy adults than those who are just academically able.

National guidance on health visiting

This 2014 guidance supports effective intervention on the '6 high impact priority areas'

1. transition to parenthood and the early weeks including early attachment
2. maternal mental health
3. breastfeeding (initiation and duration)
4. healthy weight (to include nutrition and physical activity)
5. health and wellbeing at 2 (development of the child two year old integrated review and support to be 'ready for school')
6. managing minor illness and reducing accidents (reducing hospital attendance and admissions).

Health and well-being offer for ages 10-18

This Public Health England framework, published in 2015, sets out a recommended health and well-being offer for young people.

Improving young people's health and wellbeing: a framework for public health

The full report draws on evidence that treating different, specific health issues separately will not tackle the overall wellbeing of this generation of young people. Young people's mental and physical health are intertwined, and at the heart of health and wellbeing are their relationships with others. Young people think about their health holistically. They want an integrated, youth friendly approach that recognises their particular needs, makes them feel supported, emphasises the positives and helps them to cope.

Improving the public's health: a resource for local authorities

In 2013 the Kings Fund looked at evidence based interventions in nine areas including 'Best start in life' and 'Healthy schools and pupils'.