North Somerset Council

0-19 Health Needs Assessment

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Version Control:

Version	Date	Updates made by:	Description of updates:
Final 1.0	11/06/2019	Hayley Burton, Health Improvement Specialist 0-5 years	Updates to document following initial draft being sent to consultees: 1. Updates included from 2019 child health profiles: child mortality rate; under 16s & 18s conception rate; under 18s conceptions leading to abortion 2. Updated ward maps from PHE Local Health: population aged 0-15 years; obese children - reception year & year 6; life expectancy at birth for males & females. 3. Inclusion of comments on draft received from Shaun Cheeseman 4. Updated breastfeeding maps with complete 2018/19 data

Contents

1. How to Use this Document

This document is organised into different sections to enable the reader to have a comprehensive overview of key issues and build an understanding of what actions should follow.

Population Characteristics - The demographic characteristics of the local population are important in understanding the present and future needs of the 0-19 population. There are characteristics such as family income levels which have a direct impact on children's and young people's health, developmental and wellbeing outcomes.

Population Needs – The identified health, wellbeing and development needs broken down by life stage, specifically: maternal, early years, school age. The section on vulnerable groups highlights the particular needs of children and families with these characteristics.

Evidence Based Practice – What published research is telling us about interventions that should be prioritised and how these should be implemented. This helps to ensure that local resources are used effectively and efficiently.

Services for Children and Young People – A high-level mapping of key elements of support for local children, young people and families across a range of providers and commissioning responsibilities.

Service Development Opportunities – A comparison of current service provision with the evidence around what is needed to improve outcomes and identifying gaps where improvements could be made.

Implications for Local Action – A discussion of the key actions that should be taken by commissioners, service providers and local partnerships to meet future needs and opportunities for improving outcomes.

2. Purpose of Needs Assessment

This needs assessment for children and young people aged 0-19 in North Somerset has been developed in recognition of the importance of achieving positive health and wellbeing outcomes for this population group.

Helping children to establish good patterns of health, wellbeing and development is a powerful means of investment for individuals, families and society. The foundations for a happy, healthy and productive adulthood are laid during childhood and adolescence. This has been recognised in many areas of research and policy guidance[1].

Children are among the most vulnerable members of our society and dependent on the support they receive from parents/carers and trusted adults. Having a clear picture of what good health, wellbeing and development looks like is an important way for society to fulfil its duty to give all children the best possible start in life.

For example, action to prevent babies being born early or with medical complications can help to prevent the origins of serious adult health conditions like heart disease and diabetes[2]. Once babies are born, if a child's body and brain develop well, then their life chances are improved. Exposure to stresses or adversity during this period can result in a child's development falling behind their peers[3].

It has also been recognised that taking action in the early years is the most effective way to reduce the gap in outcomes between those with the best health and wellbeing and those with the poorest outcomes[4]. The 2019 House of Commons Health Select Committee report on the first 1000 days of life stated:

Intervening more actively in the first 1000 days of a child's life can improve children's health, development and life chances and make society fairer and more prosperous.[3]

It is intended that this assessment will support future commissioning and provision of services with a focus on achieving measurable improvements to priority outcomes. The assessment will help to focus on how best to target resources and further develop partnership working among local agencies in support of positive change.

3. Population Characteristics

a. Age Profile

The estimated population of North Somerset based on 2016 Office for National Statistics (ONS) mid-year population estimates is 211,747, including approximately 47,200 children aged between 0 and 19 years. Children under 19 years make up 22.3% of the local population. Overall North Somerset has a similar age distribution of children to the South West region and England as shown in **Figure 1**.

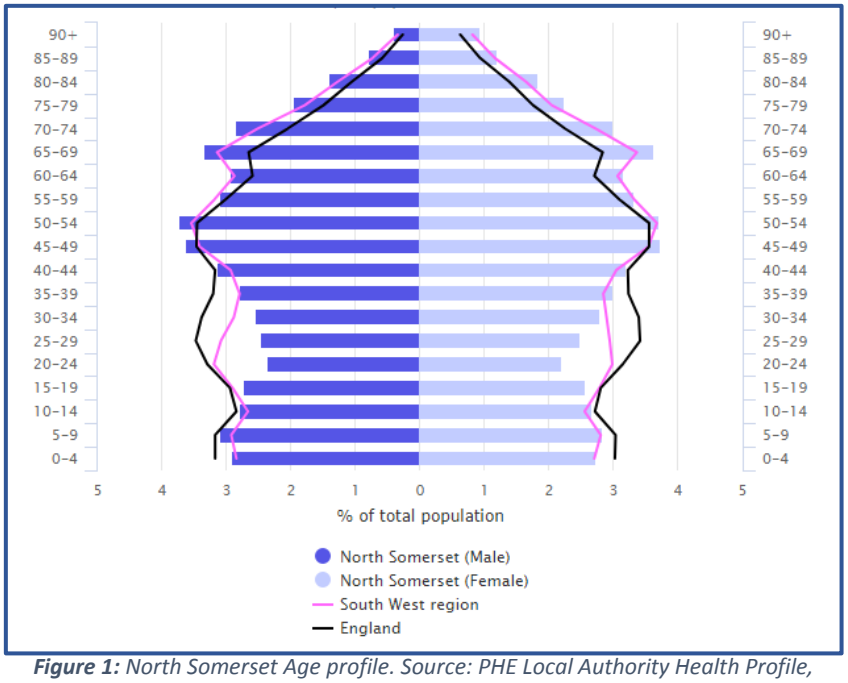


Figure 1: *North Somerset Age profile. Source: PHE Local Authority Health Profile, based on ONS Mid-year 2016 Population Estimates*

The map in **Figure 2Error! Reference source not found.** shows the percentage of the North Somerset population aged under 16 years by electoral ward in 2017. The electoral wards with a highest percentage of children under 16 are: Weston-super-Mare Winterstoke (27.9%); Portishead East (27.8%); Wick St Lawrance & St Georges (24.7%); Weston-super-Mare South (24.0%); Long Ashton (21.9%); and Weston-super-Mare South Worle (21.3%). The wards in North Somerset with the lowest percentage of children under 16 are Weston-super-Mare Hillside (10.0%); Clevedon Walton (12.0%); Weston-super-Mare Central (13.2%) and Weston-super-Mare Kewstoke (13.5%).

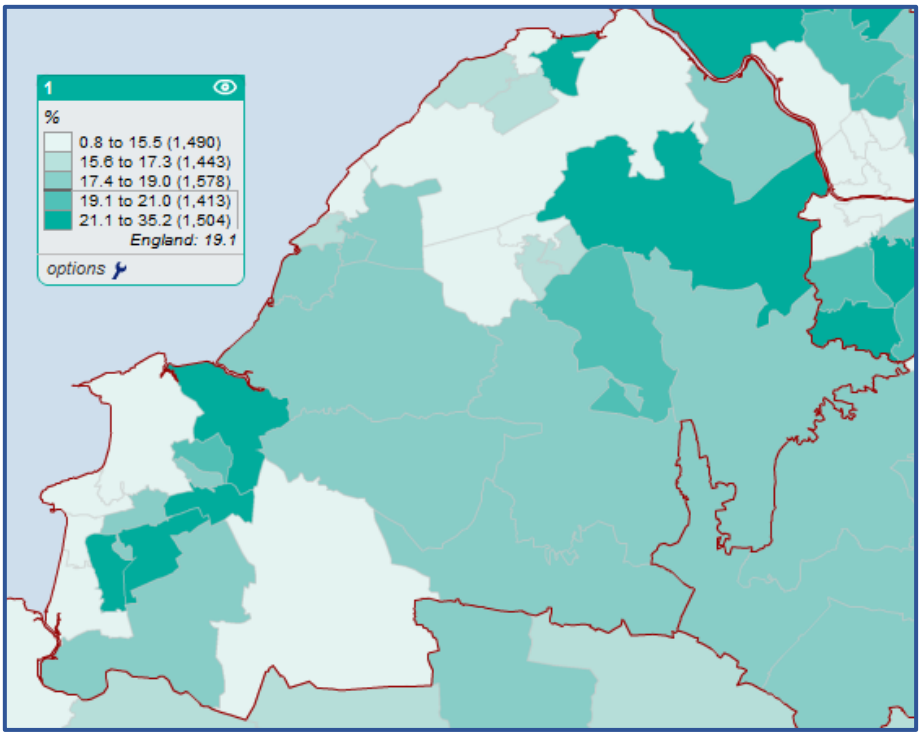


Figure 2: *North Somerset population aged 0-15 years as percentage of the total population by electoral ward (2017). Source: Map from PHE Local Health, based on ONS data*

b. Population Projections

Official population projections produced by ONS, shown in **Table 1** and **Figure 3**, provide an indication of the future size and age structure of the population (based on mid-year population estimates) using assumptions of future fertility, mortality and migration. It projects that the population of children and young people in North Somerset is set to rise by 8.7% over the next 20 years (by 2031). Looking at the breakdown by age band, the fastest population growth for children under 19 is expected to be among children aged 10-14 years (13.9% increase) and 15-19 years (13.4% increase). This has clear implications for local health services with a higher volume of young people needing support for issues that affect this age group such as emotional health and wellbeing, and healthy weight.

Table 1: *North Somerset population projections between 2016-2031 by five-year age groups. Source: ONS, 2016-based subnational population projections*

Age Band (Years)	2016 population (000's)	2021 population (000's)	2026 population (000's)	2031 population (000's)	% change (2016-2031)
0-4	11.9	11.9	12.2	12.4	+4.2
5-9	12.5	12.7	12.6	13.0	+2.0
10-14	11.5	13.0	13.2	13.1	+13.9
15-19	11.2	11.2	12.6	12.7	+13.4
Total 0-19	**47.1**	**48.8**	**50.6**	**51.2**	**+8.7**

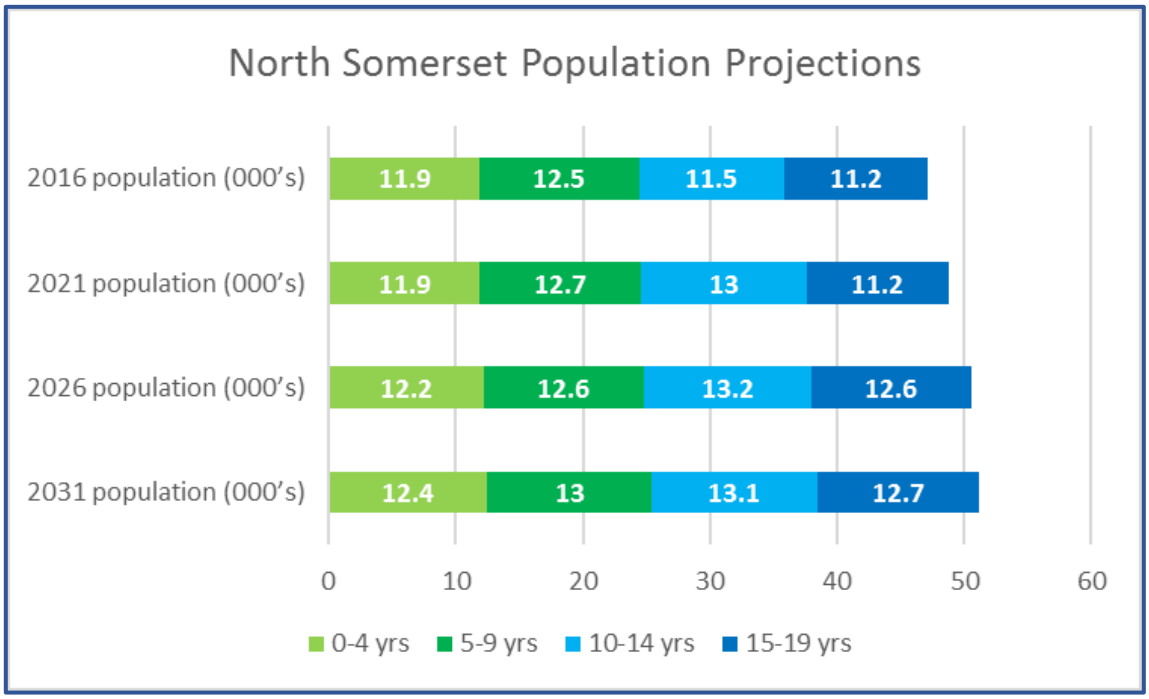


Figure 3: *North Somerset population projections between 2016-2031 by five-year age groups. Source: ONS, 2016-based subnational population projections*

The ONS population projections above do not incorporate assumptions for new housing growth – there are about 25,000 new dwellings set to be built across North Somerset by 2036 as part of the Local Plan. Of these, 13,932 dwellings are already committed in existing plans or have planning permission.

New housing developments, particularly those with affordable housing, are likely to increase the number of children living in the area. For example, the predicted age profile for the new Weston Village developments (shown in **Figure 4**), which is based on a total predicted population increase of 14,880 individuals, shows that the population of this new housing area is likely to be much younger than North Somerset as a whole, with an increased proportion of 0-14 and 25-44 year olds.[5] This will place greater demand for pupil places at local schools and other children focused services.

The local authority Pupil forecasting statistics estimates by 2022 there will be an extra 573 primary school aged children across North Somerset resulting from new housing developments. Taking these additional children into account, it is predicted overall there will still be an excess of 2095 primary school places across North Somerset in 2022; however, in the Weston-super-Mare East group there will be a local shortfall of 31 primary school places. Secondary school places have been forecasted to 2024, and it is estimated there will be an additional 386 secondary school aged children by 2024 resulting from the new housing developments, 258 of these will be in Weston-super-Mare. Overall it is predicted there will be a deficit of 655 secondary school places across North Somerset by 2024.

In addition to accessible schools, children and young people in all the new or expanded communities will require access to pre-schools, children's centres, colleges, youth provision, and health and social care services. Sport, recreation, play spaces and other community facilities will also need to be considered to ensure the new developments are safe and healthy places for children to grow-up.

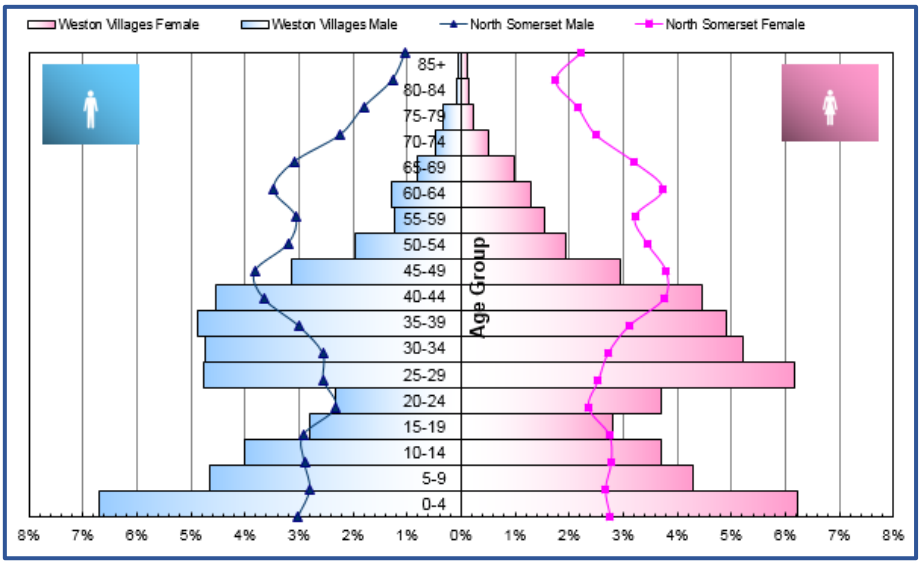


Figure 4: *Population breakdown by sex for Weston Villages and North Somerset. Source: 2011 Census data for North Somerset and Locking Castle LSOAs – Carousel Lane*

c. Birth Rate

The number of births registered in the area gives a good indication of the approximate number of new mothers and babies in the population which has implications for the demand on maternity and children's services. There were 2,060 live births in North Somerset in 2017 - this was a 5.9% decrease from 2016. Nationally there was a 2.5% decrease over the same time period *(Source: ONS)*.

The recent decreasing trend in the number of births shown in **Table 2** and **Figure 5** is reflected in the reduction in general fertility rate (GFR) locally and nationally, shown in **Figure 6**. In 2016 the general fertility rate in North Somerset was 63.5 per 1000, this is statistically similar to the England average of 62.5 per 1,000. In 2017 the Total Fertility rate (TFR) in North Somerset was 1.87 children per women. This is slightly higher than the England TFR of 1.76 children per women.

Table 2: *Number of live births in North Somerset (2013-17). Source: ONS*

Date	No. Live Births	% change from previous year
2013	2,214	
2014	2,192	-1.0
2015	2,234	+1.9
2016	2,188	-2.1
2017	2,060	-5.9

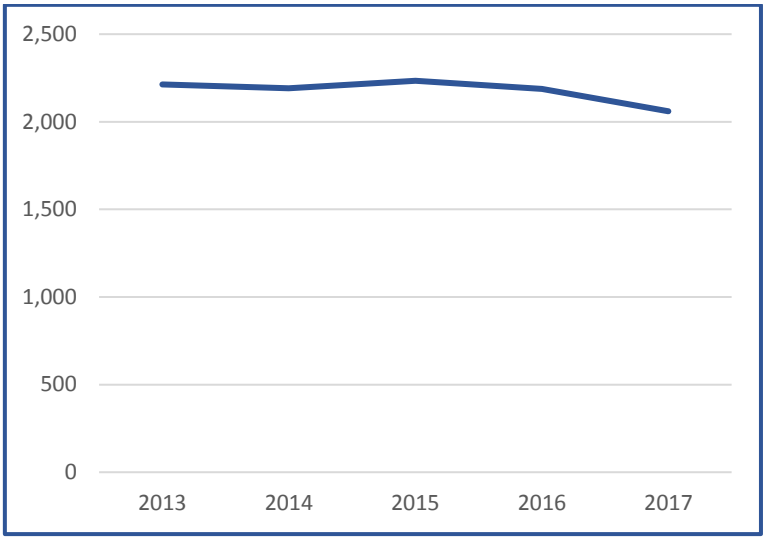


***Figure 5**: Number of live births in North Somerset (2013-17). Source: ONS*

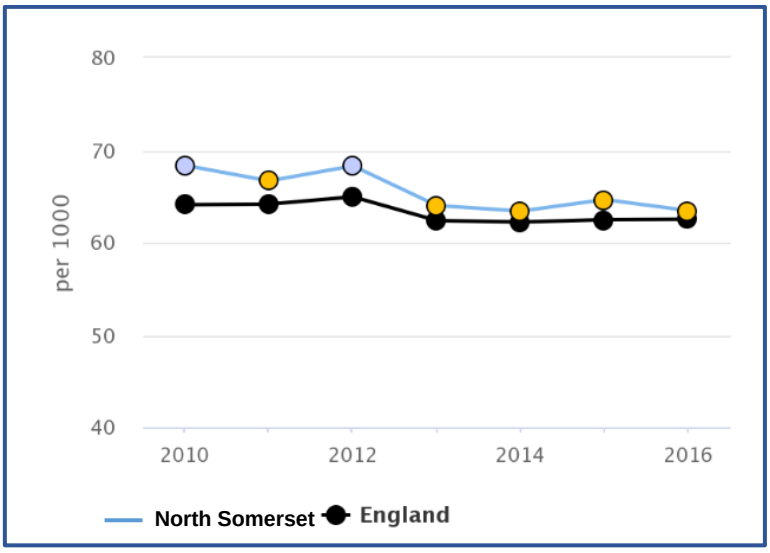


***Figure 6:** North Somerset general fertility rate (2010-2016) - birth rate per 1,000 females aged 15 to 44 years. Source: PHE Local Authority Health Profile, based on ONS data*

When the number of births registered across England in 2017 are broken down by deprivation decile, 59% were registered to a LSOA (Lower Super Output Area) that falls within IMD (Index of Multiple Deprivation) deciles one to five (where one is the most deprived and ten is the least deprived). In North Somerset however this figure was 32%, meaning that 68% of births in North Somerset were to families living in areas that are more affluent than the England average. This contrast in that national and local trends can be easily seen in **Figure 7**.

Figure 8 shows that between 2011-15 the wards with the highest fertility rates were Long Ashton and Weston-super-Mare Winterstoke, both with a rate of 82.8 per 1,000 females. The wards with the next highest fertility rates were Weston-Super-Mare South (81.9); Portishead East (80.7);

Clevedon South (73.9); Weston-super-Mare South Worle (73.4); Portishead North (72.1); Clevedon East (71.7); and Wick St Lawrance & St Georges (71.1).

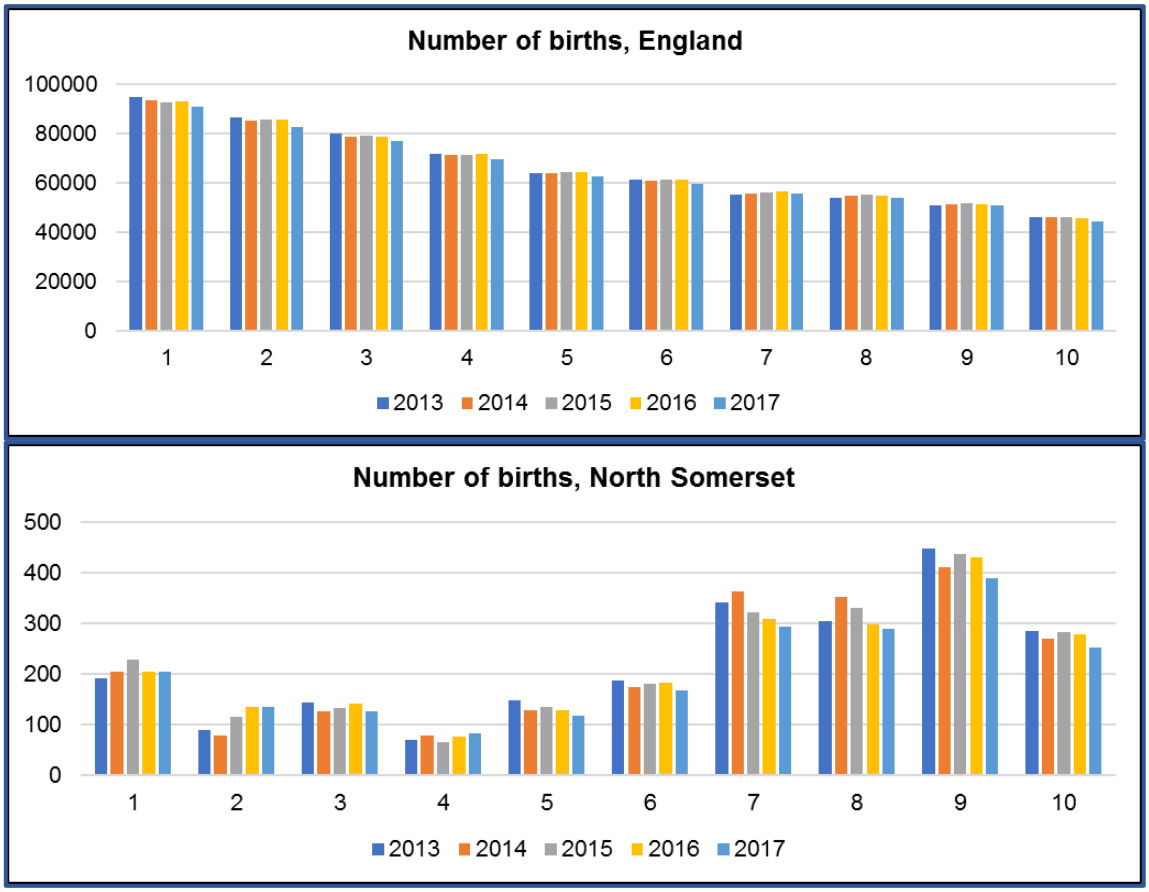


Figure 7: *Number of births in England and North Somerset between 2013 and 2017 by IMD Deciles (where one is the most deprived and ten is the least deprived). Source: ONS (live births for small geographic areas)*

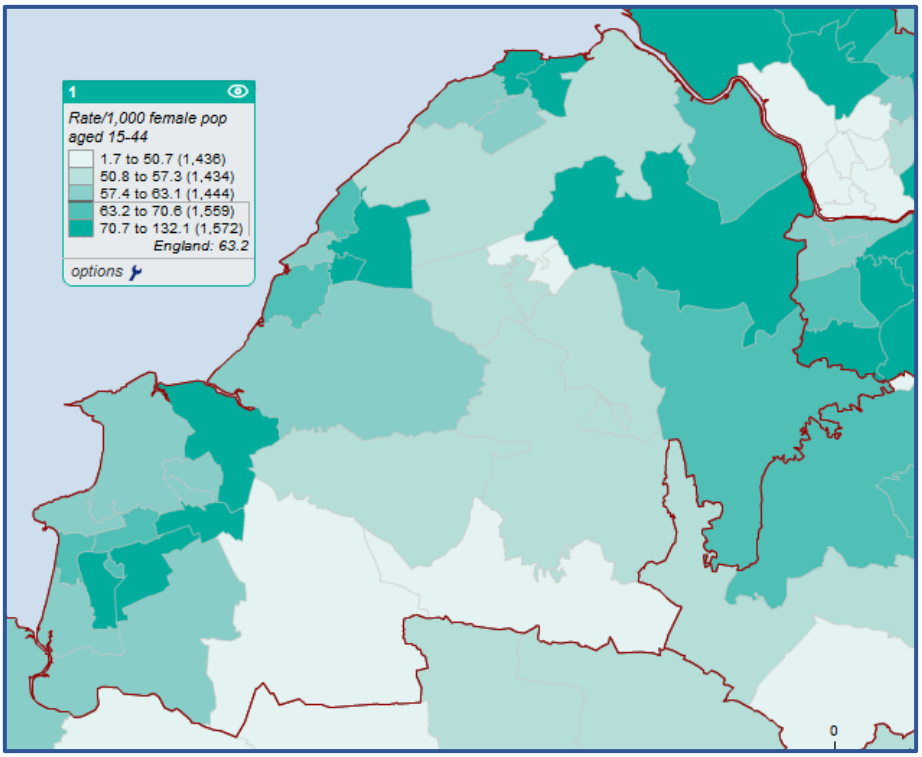


Figure 8: *North Somerset crude fertility rate (live births per 1000 women aged 15-44) by electoral ward (2011/15 – 5 year aggregated population). Source: Map from PHE Local Health, based on ONS data*

d. Ethnicity

Many health outcomes and their determinants are known to vary by ethnic group.

The population of North Somerset is less ethnically diverse than the England average with 97% of the total population classifying themselves as belonging to a white ethnic group *(Source: 2011 Census, ONS)*.

In 2016/17 5.9% of deliveries in North Somerset were to mothers from Black and Minority Ethnic (BME) groups (127 babies) *(Source: PHE Local Authority Health Profile)*. Belonging to a minority ethnic group has been highlighted by some studies as a potential risk factor for perinatal mental illness[6], although the evidence is mixed.

In 2015 18.7% of births in North Somerset were to parents born outside the UK (one or both parents foreign born). Fertility rates are generally higher among foreign-born women than UK-born women. Parents who may have recently arrived in a country may lack social support networks and find it more difficult to access the services they need.

The 2018 school census data shows that 87.9% of North Somerset's school children are of white British ethnicity. The second most common ethnicity is White Eastern European, at 2.8% of the school population (835 children). The school census data indicates around 5.4% of North Somerset's school children have a first language that is known or believed to be other than English.

e. Household Income

Poverty and economic stress lie at the root of many risk factors for children's health and educational outcomes[7]. It can impact significantly on parent's ability to provide a calm, consistent and nurturing environment that supports children's development[8]. Evidence shows money is an important indicator for child outcomes, even when differences between richer and poorer households, such as levels of parental education or attitudes towards parenting are taken into account[7].

A child is said to be living in poverty if their household income is less than 60% of the national average income. In 2016 12.6% of children under 16 years living in North Somerset (4,625 children) were living in a low-income family *(Source: PHE Local Authority Health Profile).* This is lower than the South West regional (14.0%) and England averages (17.0%).

Another measure of children affected by low income is being in receipt of free school meals. The 2018 school census data shows 8.3% of pupils attending a state funded nursery, primary, secondary or a special school in North Somerset were eligible to claim free school meals. This is significantly lower than the South West regional (11.4%) and England (13.7%) averages.

f. Deprivation

Deprivation covers a broad range of issues and refers to unmet needs caused by a lack of resources of all kinds, not just financial. Indices of multiple deprivation (IMD) show us where the most deprived areas across the country are. North Somerset is generally an affluent area as shown by the map in **Figure 9**. Weston-super-Mare South and Central are the two wards with the highest IMD scores and therefore have the highest levels of deprivation in North Somerset, with scores of 52.1 and 48.4 respectively. Weston-super-Mare Hillside has the next highest IMD score at 29.4.

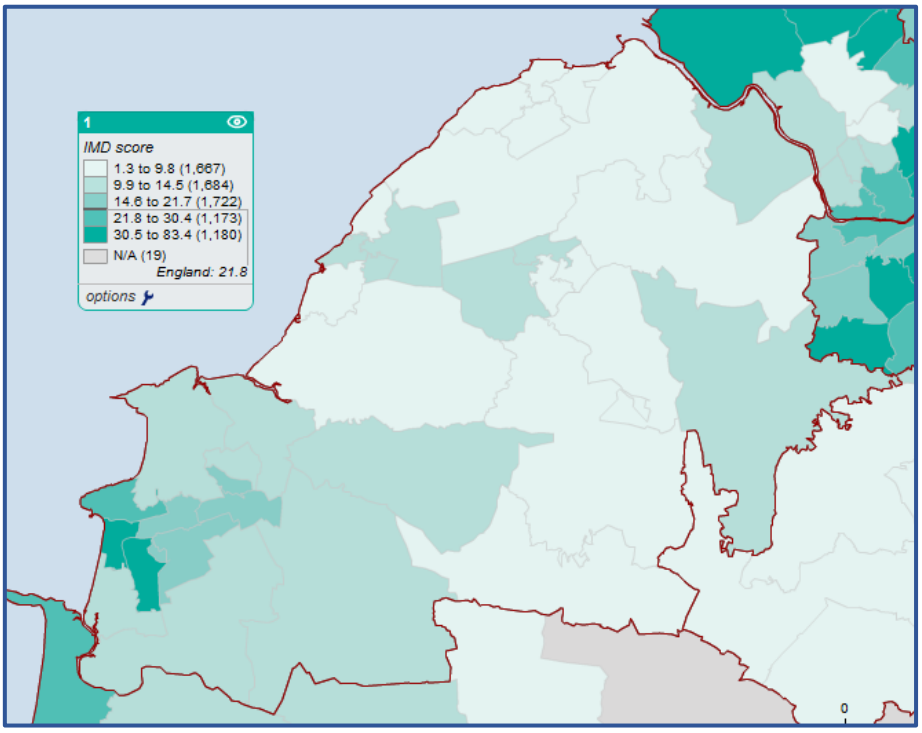


Figure 9: *North Somerset electoral wards by Index of Multiple Deprivation (IMD) Score 2015. Source: Map from PHE Local Health, based on data from Department for Communities and Local Government*

Lower Super Output Areas (LSOAs) are small geographical areas across England and Wales which have a consistent population size - there are 135 LSOAs in North Somerset (as shown in **Figure 10**). North Somerset has the 3rd highest inequality in the country, as measured by the range in national ranking between the most and least deprived LSOAs in the district. North Somerset has 5 LSOAs within the most deprived 5% in England, all within South and Central wards of Weston-super-Mare. Two LSOAs on the Bournville Estate in Weston-super-Mare South were within the most deprived 1% nationally.

Outside Weston-super-Mare there are six LSOAs which are below the national average deprivation levels: Pill – West; Kewstoke – Coast; Banwell & Winscombe - Banwell Village; Clevedon Central - Oldville Avenue; Clevedon East - Teignmouth Road; and Portishead South & North Weston - Severn Road.

Table 3 shows the percentage of North Somerset children living in each deprivation decile (the population split into ten groups). Overall 25% of children aged 0-15 years living in North Somerset live in one of the most deprived half of LSOAs nationally, and 75% live in one of the least deprived half of LSOAs. North Somerset LSOAs falling in the most deprived decile contain 7% of all children in the area (2,604 children).

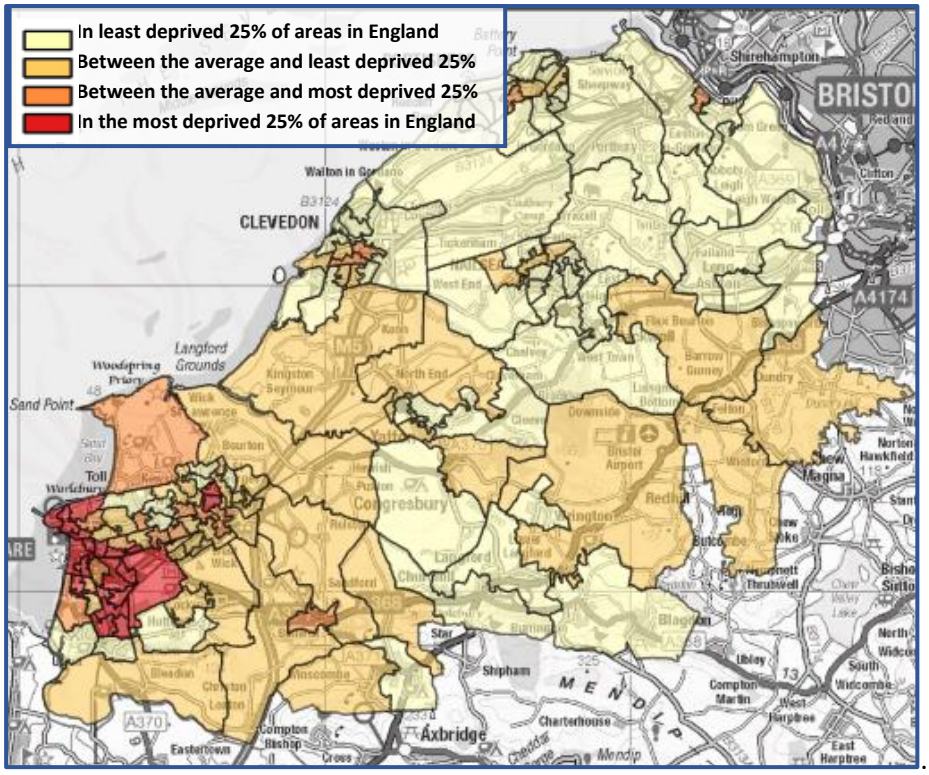


Figure 10: *Map of North Somerset showing Index of Multiple Deprivation 2015 by Lower Super Output Area. Source: Earthlight. ©Crown copyright and database rights 2018 Ordnance Survey 100023397. You are not permitted to copy, sub -license, distribute or sell any of this data to third parties in any form ©Aerial Photography 2009 and 2014 Imagery copyright Getmapping PLC. www.getmapping.com. ©and database right ''Crown Copyright and Landmark Information Group Ltd'' (All rights reserved (2018)).*

Table 3: Proportion of North Somerset's Children who live in areas within each deprivation decile. Source ONS

IMD Decile (1 = Most Deprived)	Dependent children aged 0-15 (mid 2017)	Percentage	Grouped percentage
1	2604	7%	25%
2	1717	4%	
3	1938	5%	
4	1206	3%	
5	2298	6%	
6	3079	8%	75%
7	5942	15%	
8	5604	15%	
9	8543	22%	
10	5644	15%	
Total	**38575**		

g. Life Expectancy

The overall life expectancy at birth in North Somerset is 80.0 years for males, and 83.6 years for females *(2015-17, Source: PHE Local Authority Health Profile)*. Overall life expectancy in North Somerset is 0.4 years above the England average for males, and 0.5 years for females.

Currently, there is a 9.6 year life expectancy gap between the most and least deprived males in North Somerset *(2015-17, Source: PHE Local Authority Health Profile).* For females this gap is 8.8 years. When compared to the rest of the areas in the South West the inequality in life expectancy for both sexes in North Somerset is high.

Figure 11 shows that life expectancy for men in North Somerset is lowest in Weston-super-Mare Hillside (72.7 years) and Weston-super-Mare Central ward (72.8 years). **Figure 12** shows that life expectancy for women in North Somerset is lowest in Weston-Super-Mare South (77.8 years) and Weston-super-Mare Central (78.1%). These are also the wards with the highest levels of deprivation. Clevedon Yeo has the highest life expectancy for men and women in North Somerset (86.2 years and 93.0 years respectively).

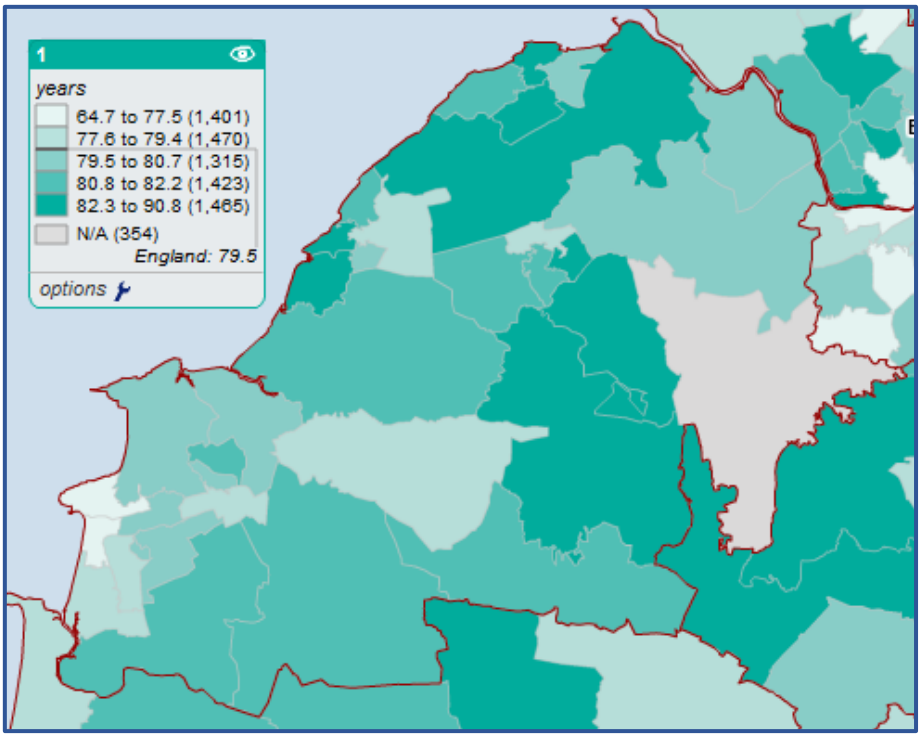


Figure 11: *North Somerset life expectancy at birth for males by electoral ward, 2013-2017. Source: Map from PHE Local Health, based on ONS data (Note: data missing for Winford)*

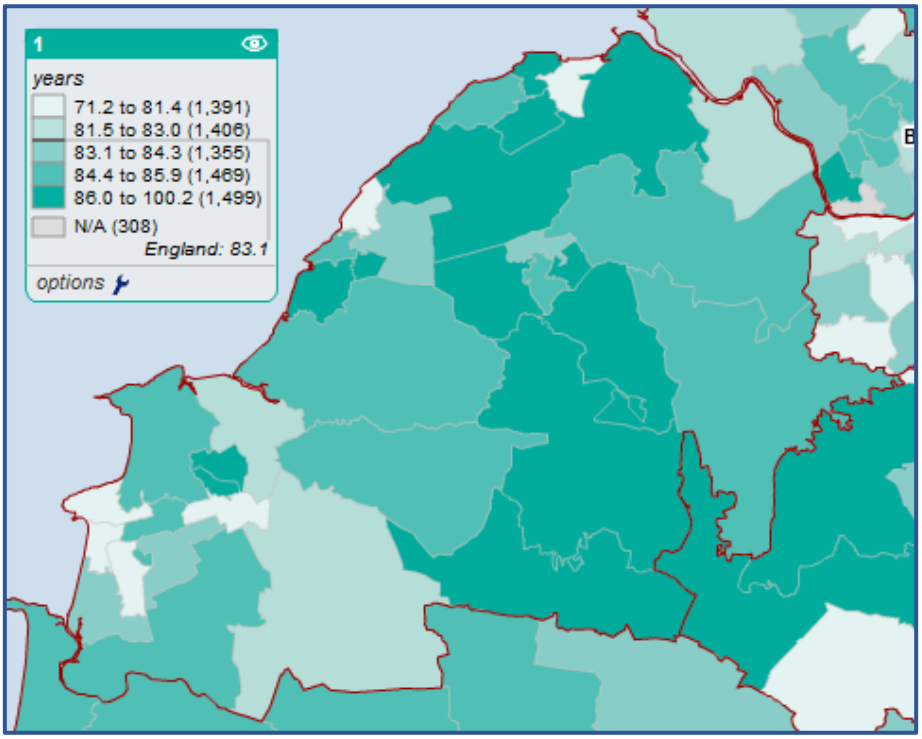


Figure 12*: North Somerset life expectancy at birth for females by electoral ward, 2013-2017. Source: Map from PHE Local Health, based on ONS data*

Healthy life expectancy is an estimate of the average number of years a newborn baby would live in good general health in the area if he or she experienced the age-specific mortality rates and prevalence of good health for that area and time period throughout his or her life. The healthy life expectancy in North Somerset is 66.2 years for males and 65.4 years for females; these are both significantly above the England average *(2015-17, Source: PHE Local Authority Health Profile)*.

Targeting children and families living in the more deprived areas, who are at greater risk of poor health, and understanding different health behaviours and the key risk factors that affect long term health, will demonstrate the greatest impact on health outcomes and reduction in inequalities[4].

4. Population Needs

Maternal and Parental Health

a. Maternal Age

In 2017 in North Somerset there were 10 live births to teenage mothers aged under 18, and 57 to young mothers under the age of 20 (**Table 4**). Locally and nationally the percentage of births from teenage mothers has shown a significant downward trend, as shown in **Figure 13**. The reduction in under 18 mothers has largely been achieved through a national long-term teenage pregnancy strategy.[9] The strategy included local areas making changes to the way they delivered relationship and sex education in schools, provided access to contraceptive services and improved support to young parents.[10] Other social changes may have also had an effect, including the rise in the number of young people going to university, the perceived stigma around being a young mother, and the easier access to information through digital technology about sex, relationships and contraception[11].

Despite significant progress the teenage birth rate in England still remains higher than a number of other Western European countries, and prevalence is concentrated in geographically more deprived areas.[10,12] **Figure 14** shows the deliveries to teenage mothers in North Somerset are largely concentrated in electoral wards in Weston-super-Mare, with a small concentration also in Pill.

Reducing teenage pregnancy is important for child health as it is widely understood that early motherhood is associated with:

- **Stillbirth** - 24% higher rate for children born to women under 20.[13,14]
- **Low birth weight** – 30% higher rate for babies born to women under 20.[13,14]
- **Infant mortality rate -** 75% higher rate for babies born to women under 20.[13,14]
- **Maternal Smoking** - Mothers under 20 are 3 times more likely to smoke throughout pregnancy.[13,14]
- **Breastfeeding -** Mothers under 20 are half as likely to be breastfeeding at 6 to 8 weeks.[13,14]
- **Maternal mental health** - Mothers under 20 have higher rates of poor mental health for up to 3 years after birth.[13,14]
- **Early years development -** Children of teenage mothers are more likely to have developmental delays.[13,14]
- **Adolescents not in education, employment or training (NEET) -** Around 1 in 5 young women aged 16 to18 who are not in education, training or employment, are teenage mothers.[13,14]

Table 4: North Somerset live births by age of mother (2017). Source: ONS

Age of mother	Number	% of births
under 18	10	0.5
under 20	57	2.8
20-24	279	13.5
25-29	568	27.6
30-34	627	30.4
35-39	431	20.9
40-44	93	4.5
45 and over	5	0.2
All	**2,060**	

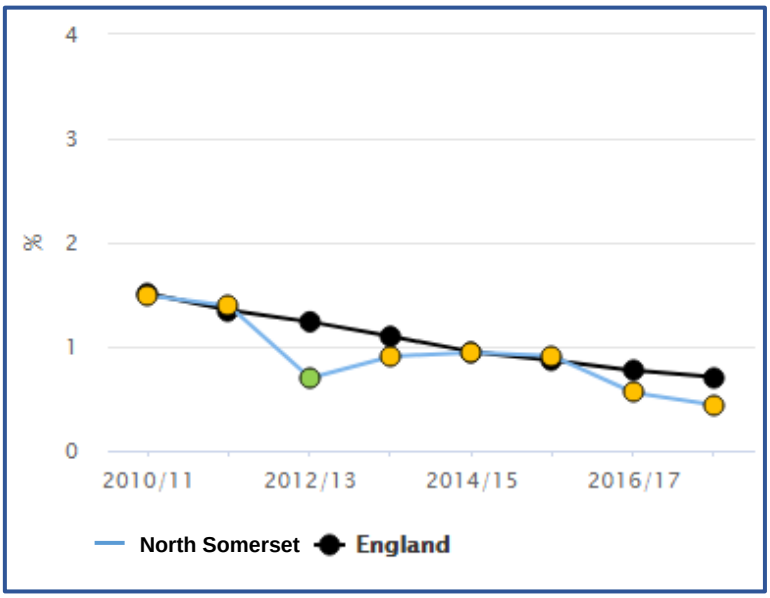


Figure 13: Percentage of delivery episodes where the mother is aged under 18 years (2010/11-2017/18). Source: PHE, based on Hospital Episode Statistics

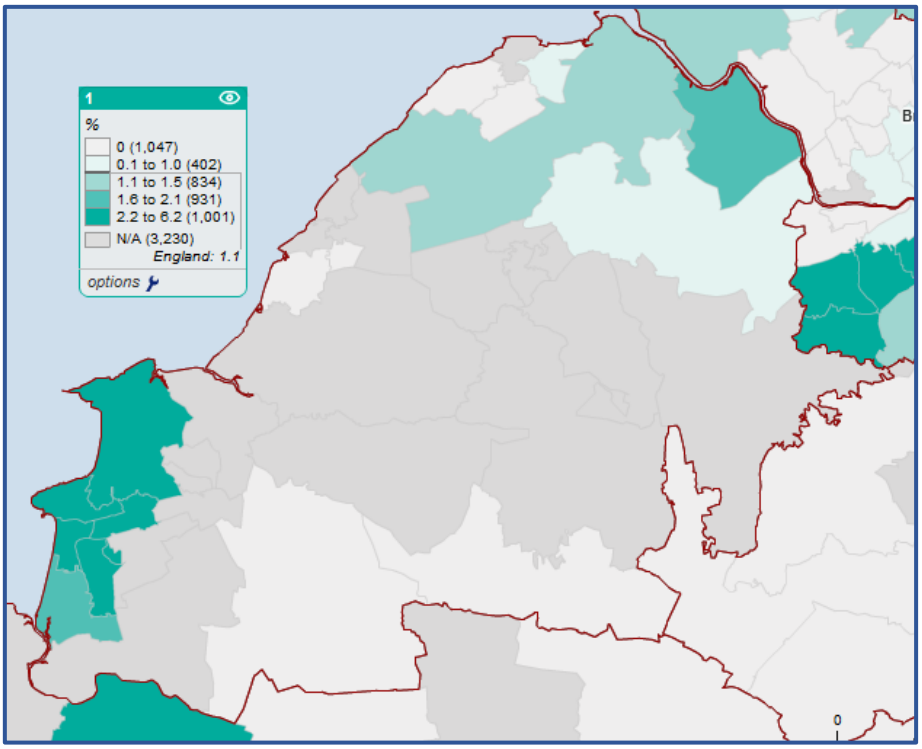


Figure 14: *Percentage of deliveries to teenage mothers (under 18 years) across North Somerset electoral wards (2011/12 – 2015/16). Source: Map from PHE Local Health, based on Hospital Episode Statistics*

Table 4 shows the age of all mothers giving birth in North Somerset in 2017. Nationally since 2004 women aged 30-34 years have the highest fertility rate of any age group, and the fertility rates for women aged 40 years and over have continued to rise, indicating women are progressively delaying childbearing to older ages. This may be due to several factors such as increased importance of a career and higher education, the rising costs of having a family and housing factors.

As women get older, both mothers and their babies face an increased risk of pregnancy and birth complications, congenital abnormalities, still birth and emergency caesarean section[15,16,17,18]. It is therefore recommended that women planning a later pregnancy should be helped to have an increased awareness of the risks of genetic disorders and the screening tests available, ensuring any medical conditions are managed and stable (for example, high blood pressure, diabetes or obesity) and ensure that folic acid and vitamin supplements are taken around the time of conception. Mothers aged 30 or over are more likely than younger mothers to start breastfeeding, and to continue for six months or more which is positive for infant and maternal health[19].

b. Maternal Smoking

Smoking in pregnancy is one of the most important modifiable risk factors of poor pregnancy outcomes and infant mortality[20]. It increases the risk of complications including miscarriage, perinatal death, premature birth and low birth weight[21,22]. It also increases the risk of the child developing a number of conditions in later life including respiratory conditions, problems of the ear, nose and throat, and obesity[23].

The 2017 Tobacco Control Plan for England has set an ambitious goal of reducing smoking amongst pregnant women to 6% by the end of 2022.[24] The NHS Long Term plan also has a specific action to cut smoking in pregnancy, and partners, through implementing a new smoke-free pregnancy pathway including focused sessions and treatments[25].

In North Somerset in 2017/18, 10.9% of mothers were smoking at the time of their delivery – equating to 268 infants born to smoking mothers in that year. **Figure 15** shows that the local trend in maternal smoking status has only shown slow signs of decline over recent years and therefore a targeted action plan would be required if the national target is to be reached by 2022 locally.

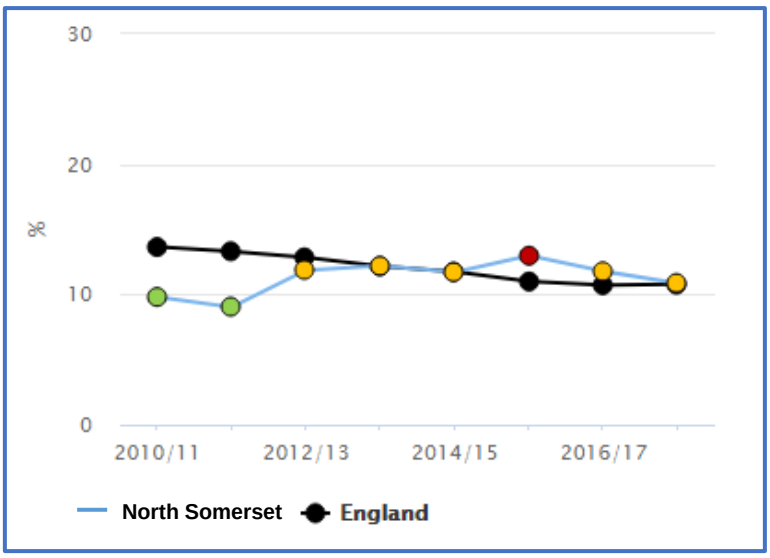


Figure 15: *The number of North Somerset mothers known to be smokers at the time of delivery as a percentage of all maternities (2010/11-2017/18). Source: PHE Local Authority Health Profile, Calculated by PHE from the NHS Digital return on Smoking status at Time of delivery (SATOD)*

Smoking during pregnancy is a major health inequality and the overall percentage of women smoking at time of delivery hides large variation by deprivation of the area in which individual women live[26]. Smoking prevalence among pregnant women in more disadvantaged groups and those aged under 20 remains considerably higher than in older and more affluent groups, meaning these women are at much greater risk of complications during pregnancy. Referral data from the local smoking cessation service shows the two wards with the highest number of referrals of pregnant smokers were Weston-super-Mare South Ward (19% of referrals) and Weston-super-Mare Central Ward (16% of referrals) - these are the two most deprived wards in the area. It is estimated that around 860 dependent children in North Somerset live in a house which falls below the poverty line due to the cost of smoking in the household[27].

In 2016, about half (48%) of children nationally reported having some level of exposure to second-hand smoke in the last year[28]. Smoking in the home is associated with a threefold increase in the risk of sudden infant death syndrome (SIDS)[21].

Children that live with parents or siblings who smoke are up to three times more likely to become smokers themselves than children of non-smoking households[29]. This further perpetuates the cycle of disadvantage and poor health.

c. Maternal Weight

It is estimated that 19% of women of reproductive age in England (about one in five) are obese (a body mass index of 30 or above), and 50% (one in two) are either overweight (a body mass index of 25 or above) or obese[30]. In 2017/18, 22.7% of North Somerset women were obese at the antenatal booking appointment (around 440 women) *(Source: South West Maternity Dashboard)*, that is therefore above the national average.

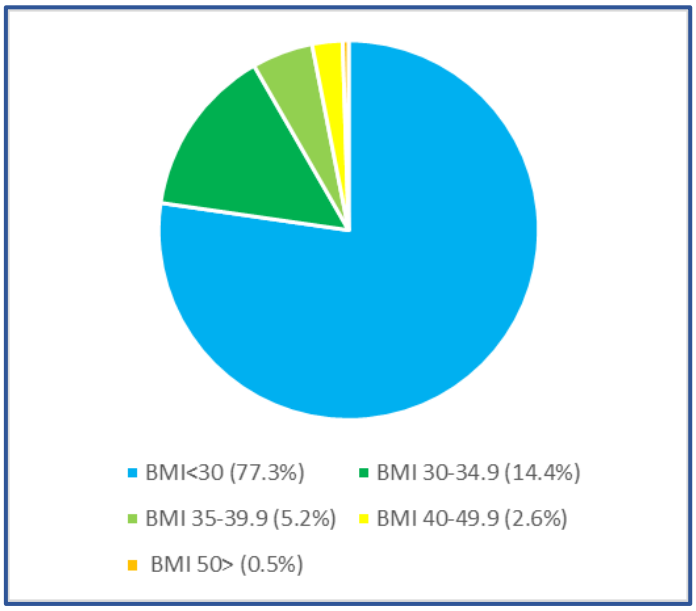


Figure 16: *North Somerset maternal obesity prevalence by BMI (2017/18). Source: South West Maternity Dashboard.*

Figure 16 presents the North Somerset maternal obesity prevalence broken down by Body Mass Index (BMI). There is an increased risk of many major adverse maternal and perinatal outcomes for women with a BMI>30, including increased risk of miscarriage, stillbirth and gestational, as summarised in **Figure 17**[20]. Due to the increased risks, these women experience reduced choices about where and how they give birth including being more likely to deliver in hospital and higher rates of medical intervention[31]. There may be longer term health implications for the infants as maternal obesity is one of several influences that appear to underlie the foetal origins of later risk of non-communicable disease, such as obesity, type 2 diabetes, cardiovascular disease and asthma[32].

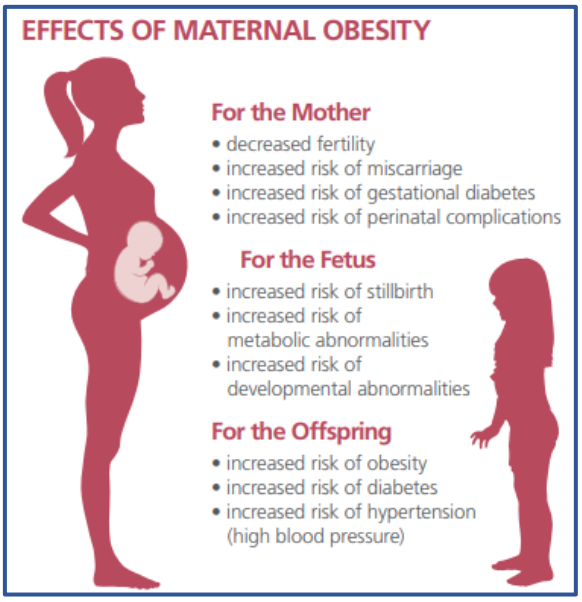


Figure 17: *Effects of maternal obesity for the mother, fetus, and offspring. Source: CMO Annual Report 2014*[20]

d. Maternal Screening & Immunisations in Pregnancy

There are currently six antenatal and newborn screening programmes which aim to detect a number of rare but serious disorders: (1) Fetal Anomaly; (2) Infectious Diseases in Pregnancy; (3) Newborn and Infant Physical Examination; (4) Newborn Blood Spot; (5) Newborn Hearing; and (6) Sickle Cell and Thalassemia[33]. In North Somerset performance across all six screening programmes is above target, and therefore we can be reasonably confident that any of the health problems screened for will be picked up quickly so that appropriate treatment can be offered.

During flu season all pregnant women should be encouraged to have the seasonal flu vaccination which will protect both mother and baby[34]. There is good evidence that pregnant women have a higher chance of developing complications if they get flu, particularly in the later stages of pregnancy. Developing flu in pregnancy can increase the risk that the baby is born prematurely or has a low birthweight, and may even lead to stillbirth or maternal death[35]. In 2017/18 North Somerset had the highest uptake rates of the flu vaccine for pregnant women in the South West region at 57.3%, compared to the England average of 47.2%.

Between gestational weeks 16 and 32 all pregnant women should also be offered a single dose of pertussis (whooping cough) vaccine which maximises the likelihood that the baby will be protected against whooping cough during the early weeks after birth until 8 weeks when the childhood immunisation schedule commences[36]. Data from quarter 1 2018/19 (Apr-Jun 2018) shows 84.4% of eligible pregnant women in North Somerset received the pertussis vaccine, against an England average of 72.1%.

e. Maternal Mental Health

Mental health problems in the perinatal period (during pregnancy and one year after birth) are common, affecting up to 20% (one in five) of women[37]. If left untreated maternal mental illness can impact on the quality of parenting and mother-infant bond, and adversely affect a child's cognitive,

emotional and behavioural development[38]. Almost a quarter of maternal deaths between 6 weeks and one year after pregnancy are attributed to mental health related causes[35].

Examples of maternal mental illnesses include antenatal and postnatal depression, anxiety, obsessive compulsive disorder (OCD), post-traumatic stress disorder (PTSD) and postpartum psychosis. Postnatal depression affects more than 1 in every 10 women within a year of given birth. Based on the number of women giving birth in North Somerset in 2016, the figures in **Table 5** show how many women we would expect to have certain mental health problems in pregnancy and the postnatal period based on national prevalence.

Table 5: *Estimated prevalence of maternal mental illness in North Somerset (based on 2016 birth rates). Source: PHE Mental health in pregnancy, the postnatal period and babies and toddlers report[39].*

Estimated annual number of North Somerset women with:	
Postpartum psychosis	5
Chronic severe mental illness (SMI)	5
Severe depressive illness	65
Mild-moderate depressive illness and anxiety (lower – upper estimate)	220 – 325
Post-traumatic stress disorder	65
Adjustment disorders and distress (lower - upper estimate)	325 – 650

Some women are at higher risk of experiencing mental health problems. Risk factors include: history of abuse in childhood; previous history of mental health problems; teenage mothers; maternal obesity; traumatic birth; history of stillbirth or miscarriage; relationship difficulties and social isolation.

f. Parental Alcohol & Substance Use

Updated guidelines from the UK Chief Medical Officers' state that, for women who are pregnant or planning a pregnancy, the safest approach is to not drink alcohol at all, to keep the risks to the baby to a minimum[40]. Evidence suggests that nationally around 40% of women drink alcohol in the early stages of pregnancy and two to three percent of all mothers continue to engage in harmful levels of alcohol consumption throughout their pregnancies. Drinking alcohol during pregnancy can increase the risk of miscarriage and low birth weight, as well as the risk of developing Fetal Alcohol Spectrum Disorder (FASD)[41].

Non-medical drug use should also be avoided in pregnancy and when trying to conceive as these substances can harm the health of women and babies.

There is currently no national measure for the number of women who drink or take other substances during pregnancy.

g. Parental Domestic Violence and Abuse

Domestic abuse occurring in a relationship includes emotional abuse, threats and intimidation, physical abuse, and sexual abuse[42]. Anyone can be a victim of domestic abuse regardless of gender, age, ethnicity, socio-economic status, sexuality or background[42]. Currently one in four women, and

one to six men experience domestic abuse over their lifetimes[42]. Over a third of domestic violence towards women starts or gets worse when a woman is pregnant.

In 2016 there were 19.3 domestic abuse incidents per 1,000 population reported to the police force area which covers North Somerset, compared to the England average of 22.5 per 1,000 *(Source: PHE Local Authority Health Profile)*. Note that these figures relate to all domestic abuse incidents and are not restricted to those involving households containing children or pregnant women. There is likely to be significant under reporting of domestic abuse so the true population need is likely to be much higher.

Living in a household where domestic violence is occurring has an impact on children's mental, emotional and psychological health and their social and educational development. Early identification of the associated risks and intervening early can reduce the potential for these factors escalating into more serious concerns and affecting the parent-child relationship.

The First Five Years of Life

a. Stillbirth & Infant Mortality

Stillbirth rates (fetal deaths occurring after 24 weeks of gestation) in the United Kingdom remain among the highest of high income countries.[43] In November 2015, the Department of Health announced a new ambition to reduce the rate of stillbirths, neonatal and maternal deaths in England by 50% by 2030, with a 20% reduction by 2020.[43] Risk factors associated with stillbirth include maternal obesity, ethnicity, smoking, pre-existing diabetes, and history of mental health problems, antepartum haemorrhage and fetal growth restriction. The stillbirth rate in North Somerset is similar to the England average at 3.5 per 1000 births (23 babies between 2014-16) *(Source: PHE Local Authority Health Profile)*.

The infant mortality rate is the number of deaths under age 1 per 1,000 live births. The majority of deaths in the first year are neonatal deaths which occur during the first month and the main causes related to prematurity and congenital abnormalities.[44] The infant mortality rate in North Somerset is 2.9 per 1,000 (2015/17) - this is statistically similar to the England average of 3.9 *(Source: PHE Local Authority Health Profile)*. The number of infants who die is relatively small and subject to considerable variation year on year. Key risk factors for infant mortality include sociodemographic variables (poverty, ethnicity, maternal education), birth characteristics (preterm birth, maternal age and maternal smoking), post-natal factors (breastfeeding and child management) and health service factors[45].

b. Preterm Birth & Low Birthweight

Preterm delivery, occurring before 37 completed weeks of pregnancy, is the most prominent risk factor for infant mortality. Between 2015-17 there were 69.7 premature births per 1,000 births (still and live births less than 37 weeks gestation) in North Somerset (453 babies). The England average was higher at 80.6 per 1,000 births *(Source: PHE Local Authority Health Profile).*

Low birth weight is defined as a birth weight of less than 2500g (that is, about five-and-a-half pounds), as per the World Health Organization (WHO). Babies with a low birth weight have a greater

than 20 times risk of dying than babies with a birth weight over 2500g. It is also an important marker along the trajectory of early child development, indicating an increased risk of poor health outcomes from birth onward[26,46].

In 2017, 2.89% of North Somerset babies born at term had a low birthweight (54 babies) – this is similar to the England average of 2.82% *(Source: PHE Local Authority Health Profile).* Overall, 5.8% of all babies born in North Somerset during 2016 (live and stillborn) were considered to have a low birth weight (123 babies), with 1.42% having a very low birth weight of under 1500g (30 babies) *(Source: PHE Local Authority Health Profile).*

c. Attachment, Infant & Preschool Mental Health

Social and emotional wellbeing in the early years is important as it is the 'building blocks' for healthy behaviour and educational attainment.[47] This includes having good attachment (a secure relationship with a main care giver, usually a parent)[47].

It is not possible to provide a reliable estimate for the prevalence of poor attachment in the local population as it is not routinely measured, however we may expect to see higher levels of disorganised attachment for infants who experience the following risk factors[39]:

- Parental mental illness
- Alcohol and drug misuse in the home
- Teenage parenthood
- Looked-after children and child maltreatment
- Homelessness

National data indicates one in eighteen (5.5%) of preschool children aged 2 to 4 years has at least one mental disorder[48] (as shown in **Figure 18**). Preschool boys (6.8%) are more likely than girls (4.2%) to have such a disorder. Less common disorders and behavioural disorders are the most common disorder types in preschool children (2.8% and 2.5% respectively). Less common disorders include autism spectrum disorder (ASD); attachment disorders; selective mutism; and feeding, sleeping and toileting disorders.

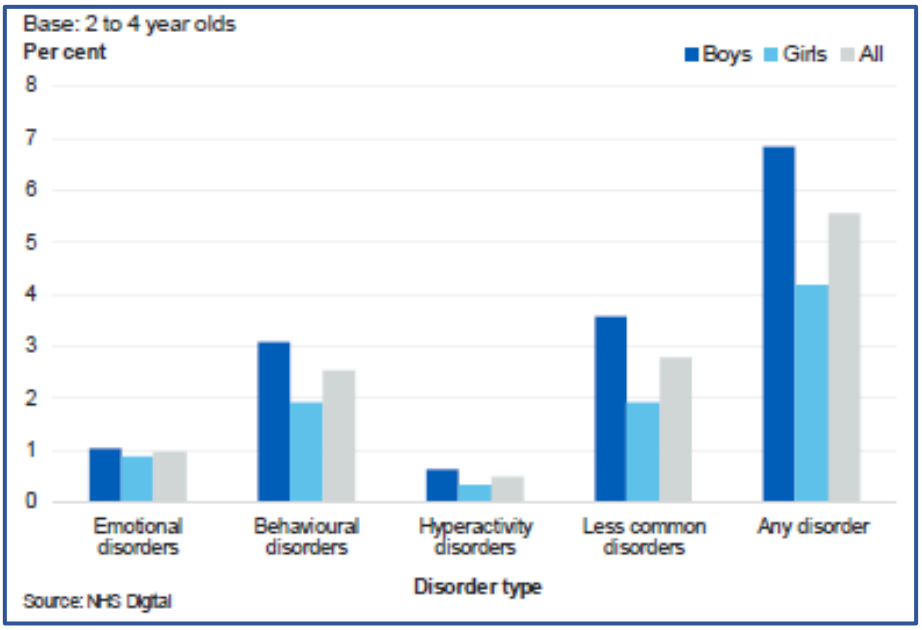


Figure 18: *Prevalence of mental disorders in preschool children by sex, 2017. Source: NHS Digital*[48]

d. Breastfeeding

Breastfeeding is an important public health priority as it makes a major contribution to maternal and child health[49]. Breastfeeding is known to reduce the risk of infections and allergies as well as future obesity and diabetes for the infant, while benefits to mothers include a reduced risk of breast and ovarian cancer[50,51]. In addition to this, mothers who breastfeed benefit for a faster return to pre-pregnancy weight[50].

Exclusive breastfeeding is recommended for around the first six months of life with continued breastfeeding alongside solid foods for at least the first year[49].

In 2016/17, 82.1% of mothers in North Somerset initiated breastfeeding at birth (better than England average of 74.5%) *(Source: PHE Profile)*. Breastfeeding prevalence (exclusive and partial breastfeeding) falls to 62.7% after 2 weeks, and 47.8% after 6-8-weeks of birth (better than England average of 44.4% at 6-8 weeks in 2016/17) *(Source: local data from health visiting EMIS records)*. Overall there is a positive upwards trend in the number of babies who are breastfed at 6-8 weeks across North Somerset, as shown in **Figure 19**.

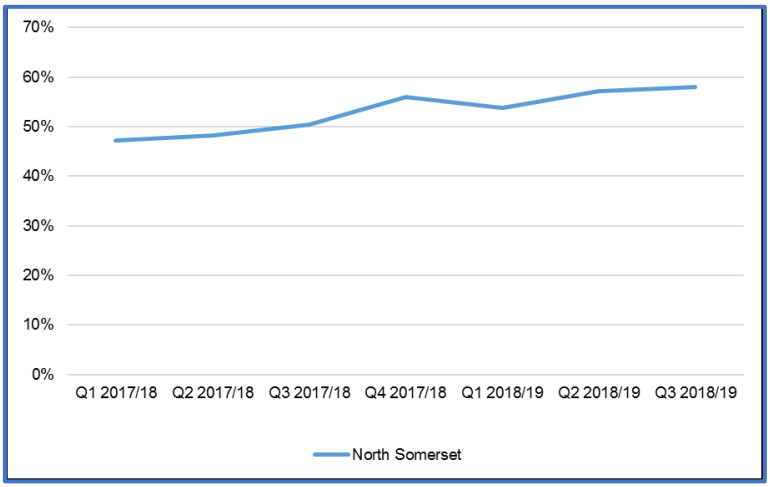


Figure 19: *Breastfeeding prevalence at 6-8 weeks in North Somerset between quarter 1 2017/18 and quarter 3 2018/19. Source: Local analysis of health visitor EMIS records (North Somerset Community Partnership). Note: this data only includes babies who have had a 6-8-week health visiting review and therefore prevalence higher than the official figures reported through national collection where any babies who have not had a check are counted as 'not breastfeeding'*

Breastfeeding is closely related to factors such as maternal age, social economic status, and ethnicity. Young mothers; mothers from routine and manual professions; mothers who left education early; and white mothers are less likely to breastfeed their babies.[20] Improving breastfeeding rates in these groups can play an important role in reducing health inequalities.

Error! Reference source not found. shows the large differences in breastfeeding rates at 6-8 weeks between the North Somerset Children's Centre group areas (there are 14 children's centres in North Somerset grouped into four Children's Centre groups – North Group; Central Group; Weston East Group and Weston South Group). Breastfeeding prevalence has been traditionally below the England average in both Children Centre groups in Weston-super-Mare. Data from Q1-Q3 2018/19 has shown promising increases in 6-8-week breastfeeding prevalence across all areas of North Somerset which can reasonably be attributed to the expansion of the Baby Friendly Initiative (BFI) programme and peer support network in the area. The 12.2% increase in breastfeeding prevalence in Weston South group reduces the gap between the North group and Weston South group from 27% in 2017/18 to 16.3% in 2018/19.

Dehydration and jaundice are two common reasons for re-admission of babies under 14 days and are often linked to problems with feeding *(Public Health Outcomes Framework)*. North Somerset has fewer readmissions of babies under 14 days (122 in 2016/17, 56.6 per 1000) compared to the South West (89.7 per 1000) and England (71 per 1000) average *(source: PHE Local Authority Health Profile, based on Hospital Episode Statistics)*. This would suggest the timing and quality of health assessments to ensure feeding is effective before the mothers and child goes home, and the postnatal care once they are at home is good in North Somerset.

Breastfeeding is protective against gastro and respiratory tract infections, making these good health outcomes to monitor. North Somerset has significantly fewer admissions of babies under one year for gastroenteritis (24 in 2016/17, 106,2 per 10,000) compared to the South West (198.4 per 10,000) and England average (176.5 per 10,000). Admissions of babies under one year for respiratory tract

infections (159 in 2016/17, 704 per 10,000) is similar to the South West average (716 per 10,000), but slightly higher than the England average (625 per 10,000)

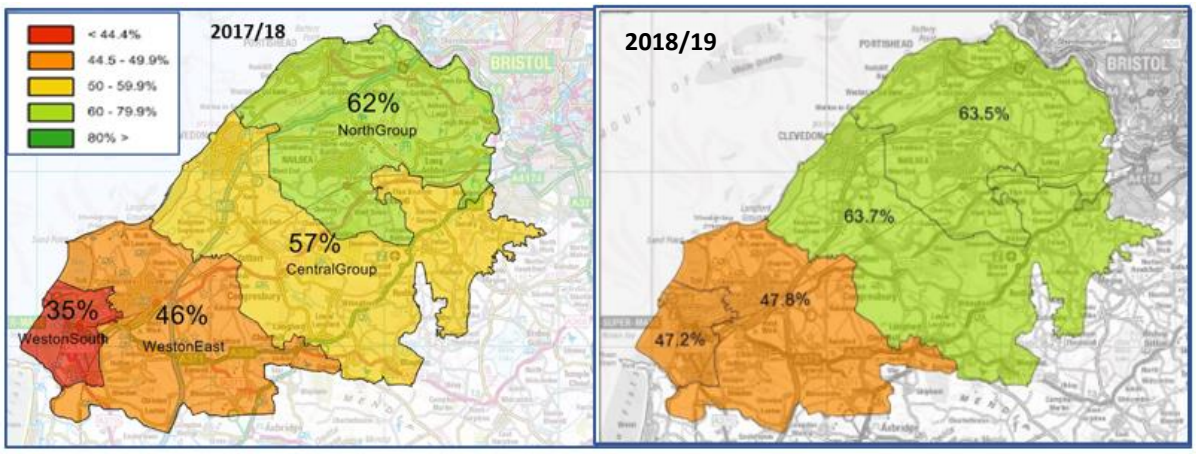


Figure 20: *North Somerset breastfeeding prevalence at 6-8 weeks by children's centre group area 2017/18 and 2018/19. Source: Local analysis of health visitor EMIS records (North Somerset Community Partnership).*

e. Early Nutrition & Physical Activity

Healthy weight in the early years can be improved through good maternal and family diet, breastfeeding, timely and appropriate introduction to solid foods and physical activity in line with guidelines[52]. Currently only 1 in 10 children aged two to four meet the UK Chief Medical Officers' physical activity guidelines for this age group nationally[53] and, by implication, thus so in North Somerset.

Healthy Start is a UK-wide government scheme to improve the health of low-income pregnant women and families with children under four who are on benefits and tax credits[54]. All women who are under 18 and pregnant also qualify for the scheme. In 2014/15, 75% of all eligible families in North Somerset were signed up to the scheme - this was in line with the national average of 73%.

Pregnant women, women with a baby under one year old, and children from six months old to their fourth birthday on Health Start will also receive a vitamin coupon every eight weeks. These coupons can be exchanged for women's vitamin tablets or children's vitamin drops. Nationally the number of eligible families claiming Healthy Start vitamins is low – an evaluation showed only 1% of vitamin coupons were redeemed[55]. This low number of claims is also reflected locally, and there has been a year on year decline in distribution of both types of vitamins as shown in **Figure 21**. A report from First Steps Nutrition suggests there are numerous reasons why Healthy Start uptake may have declined including lack of awareness of the scheme; barriers in the application process; changes in the commissioning process; and a reduction in the eligible pool of households because more parents are in work[56].

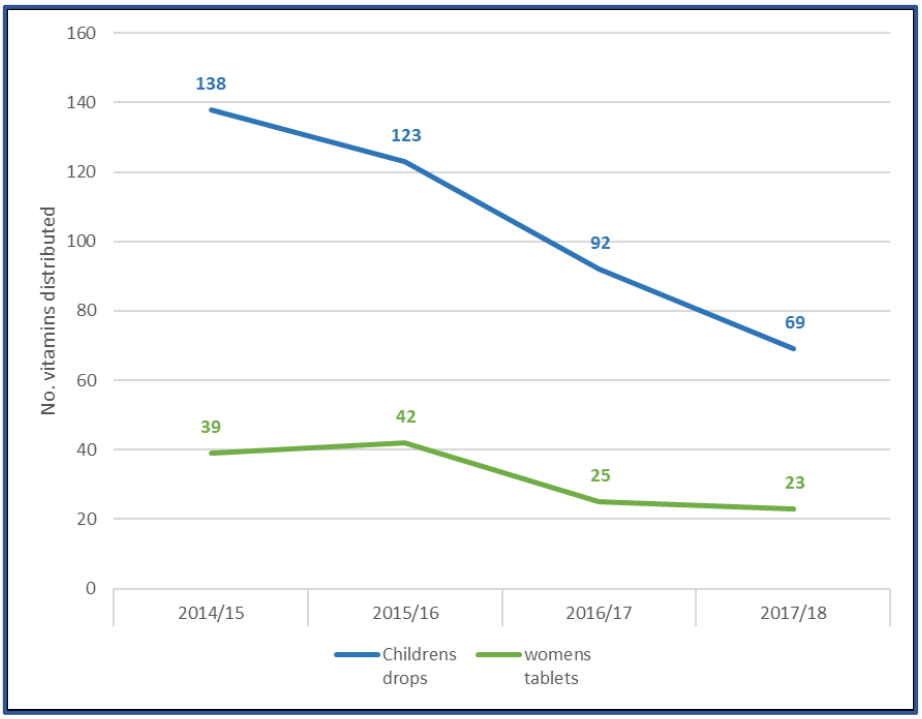


Figure 21: *Number of Health Start vitamins claimed in North Somerset between 2014/15 and 2017/18. Source: Quarterly Healthy Start Vitamin Return forms from North Somerset Community Partnership (NSCP)*

f. Oral Health

Tooth decay in children is a predominantly preventable disease that can cause pain, sleep loss, time off school, and in some cases treatment under general anaesthetic[57]. Children who have high levels of disease in their primary teeth have an increased risk of disease in their permanent teeth, which is likely to require long-term maintenance throughout life[57].

It is recommended that all children have a dental check by aged one to maximise the delivery of preventative advise and/or treatment as necessary[58]. In North Somerset 30% of one year's olds saw a dentist in 2017/18, meeting the NHS England target of over 30% *(Source: PHE South West).*

National survey data suggests that dental health in children aged five years in North Somerset is significantly better than the England average[59]. 14.8% of 5-year olds in North Somerset had one or more decayed, filled or missing teeth in 2016/17, compared to the England average of 23.3%. Among the children with obvious decay, the average number of teeth that were decayed, missing or filled at age five was 2.9. This is again better than the England average of 3.4 teeth.

The population average does however mask inequalities in oral health, as children are more at risk of developing tooth decay if they are from areas with higher levels of deprivation[57].

Grossly decayed teeth in young children will often require extraction, usually under a general anaesthesia. Local dental extraction data shown in **Table 6** shows that there were 37 children under five years requiring an extraction in 2016/17 and 166 children aged 5-9 years. In total 317 children and young people under 19 years in North Somerset had a general anaesthetic which carries a small but real risk of life-threatening complications.

Table 6: North Somerset Hospital dental extractions under general anaesthetic (2016/17) Source: PHE South West

	0-4 years	5-9 years	10-14 years	15-19 years	Total 0-19 years
North Somerset	37	166	73	41	**317**

g. Infant & Preschool Immunisations

All children should receive the national childhood immunisation programme[60] during infancy and before they start school to protect them from serious and wholly-avoidable childhood infectious diseases.

North Somerset is currently below the 95% recommended coverage for children receiving the second dose of MMR vaccine by 5 years at 92.3%. **Table 7**, shows population vaccination coverage based on GP practices within each Children's Centre group. This breakdown shows coverage of MMR second dose is lower in Weston South and Central groups with 86.1% and 91.6% respectively.

Table 7 also shows vaccination coverage of Dtap/IPV at 5 years old (4-in-1 pre-school booster which protects against diptheria, tetanus, pertussis (whooping cough), and polio) which is given at the same time as the second dose of MMR vaccine is 90.6% for North Somerset, with Weston South and Central group both under 95% at 84.9% and 89.7% respectively.

Weston South group also falls below the 95% for PCV (pneumococcal conjugate vaccine) (1 year) and MMR for one dose (2 years). Recommended coverage has been achieved for all other vaccinations across North Somerset.

Table 7: North Somerset population vaccination coverage by Children's Centre group (2017/18). Key: Green: 95% and over; Amber: 90% to less than 95%; red: under 90%. Source: NHS Digital Childhood Immunisation CCG/GP Practice level Coverage Statistics (Management Information)

Children's Centre group	DTaP/IPV/Hib (1 years)	DTaP/IPV/Hib (2 years)	DTaP/IPV Booster (5 years)	PCV (1 years)	MMR - 1 dose (2 years)	MMR - 1 dose (5 years)	MMR - 2 doses (5 years)
Central group	97.8%	99.1%	89.7%	97.6%	95.8%	97.7%	91.6%
North group	98.4%	97.8%	95.7%	98.4%	97.3%	98.2%	96.3%
Weston East	98.2%	98.6%	92.2%	98.4%	95.3%	98.0%	95.0%
Weston South	93.4%	97.6%	84.9%	94.2%	92.9%	96.6%	86.1%
North Somerset	97.0%	98.3%	90.6%	97.1%	95.3%	97.6%	92.3%

As part of the routine schedule infants are also immunised against Rotavirus and Meningitis B (MenB)., Haemophilus Influenzae type b (Hib), and Meningitis C (Men C). In 2017/18 the North Somerset coverage of the Rotavirus vaccine was around 93% at 12 months, and coverage of the

Hib/MenC booster was 94.3% at 2 years and 96.5% at 5 years *(source: PHE COVER data).* The Meningitis B vaccine was a new programme introduced to the schedule in 2015 and local uptake appears to be good with 93% uptake in 2017-18 (quarter 3).

Flu vaccine uptake in GP practices for children aged two to four years continues to show year on year increase locally. In North Somerset at age two coverage was 56.2% in 2017/18, and at age three 58.4% - which surpasses the target for both age groups which is 48%.

Differences in childhood immunisation uptake are associated with a range of social, demographic, maternal and infant-related factors.[61] Evidence has shown that the following groups of children and young people are at risk of not being fully immunised[61]:

- those who have missed previous immunisations (whether as a result of parental choice or otherwise)
- looked after children
- those with physical or learning disabilities
- children of teenage or lone parents
- those not registered with a GP
- younger children from large families
- children who are hospitalised or have a chronic illness
- those from some minority ethnic groups
- those from non-English speaking families
- vulnerable children, such as those whose families are travellers, asylum seekers or are homeless.

h. Unintentional Injuries in the under 5's

Unintentional injuries in and around the home are a leading cause of preventable death and are a major cause of ill health and serious disability for children under five[62]. In England injuries in the home account for 6% of deaths of children aged between one month and four years *(Source: ONS, 2016).* The personal costs of childhood injury can be devastating, for example a severe bathwater scald can require years of painful skin grafts, or a fall can result in permanent brain damage[62]. Acquired disabilities can lead to high health, educational and social care costs as well as loss of earnings for the family[62].

Unintentional injuries disproportionately affect children living in socioeconomic disadvantage, and deaths from injuries in childhood have the steepest social gradient of any cause of death in childhood[4,62]. Poor housing and overcrowded conditions can lead to increased numbers of accidents[63].

Accident and emergency department (A&E) attendances in children aged under five years are commonly caused by accidental injury, as well as minor illnesses. A&E attendance of children aged 0-4 years in North Somerset is lower than the England average, with 5,758 attendances in 2017/18 (rate of 490.8 per 1000). **Figure 22** shows that nationally there is a slight upward trend in the number of A&E attendances for this age group.

Figure 23 show the wards with highest A&E attendance in under 5s are clustered in Weston-super-Mare. This may partly be a reflection of higher risk of injury in these areas due to levels of deprivation, but may also be due to the ease of access to the A&E department at Weston General

Hospital which may result in more parents attending with their children rather than using alternative health services.

There were 127 hospital admissions caused by unintentional and deliberate injuries in children aged 0-4 years in North Somerset in 2017/18 (rate of 108.3 per 10,000). The rate of admissions due to injury is similar to the South West regional and England average as shown in **Figure 24**.

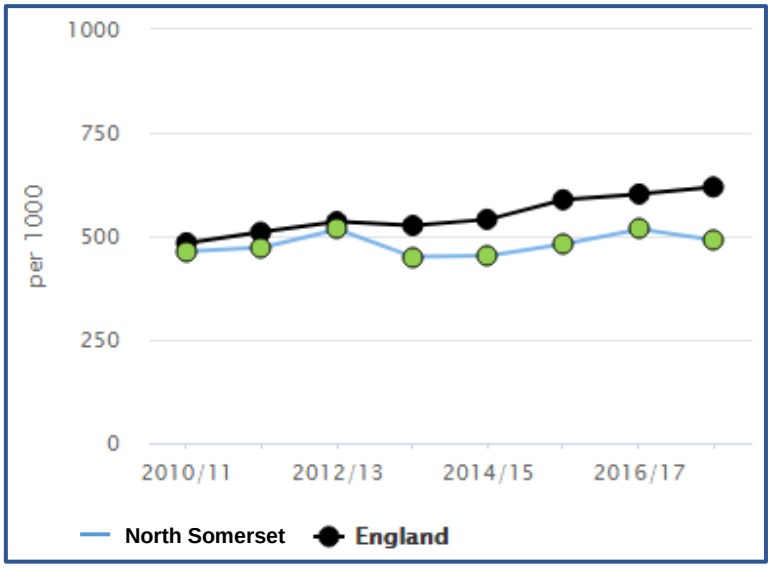


Figure 22: *North Somerset A&E attendance rate aged 0-4 years per 1,000 population (2010/11-2017/18). Source: PHE Local Authority Health Profile, based on Hospital Episode Statistics*

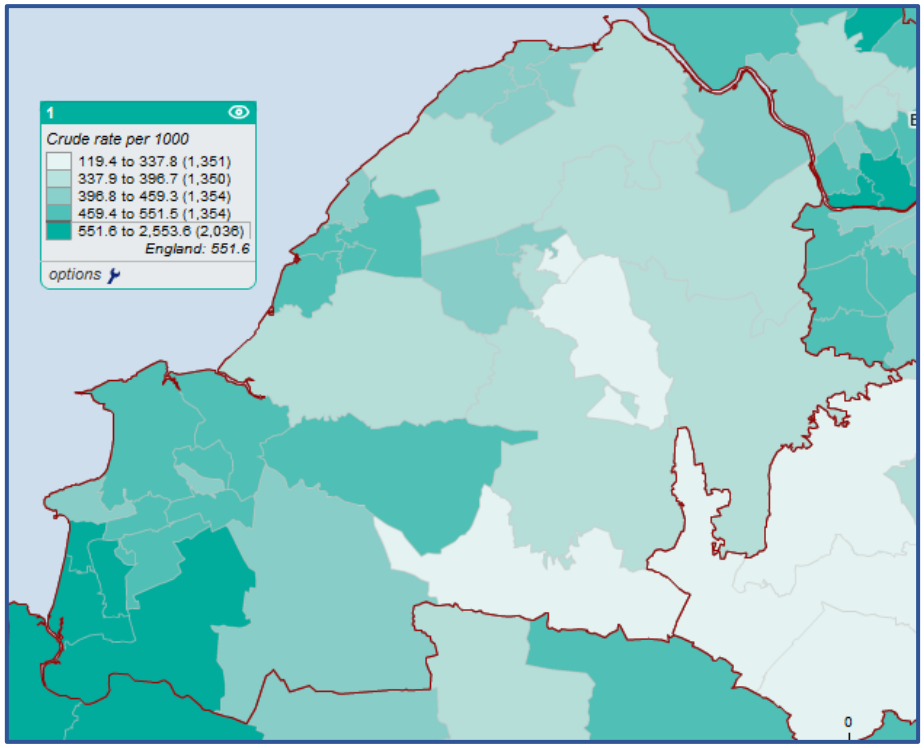
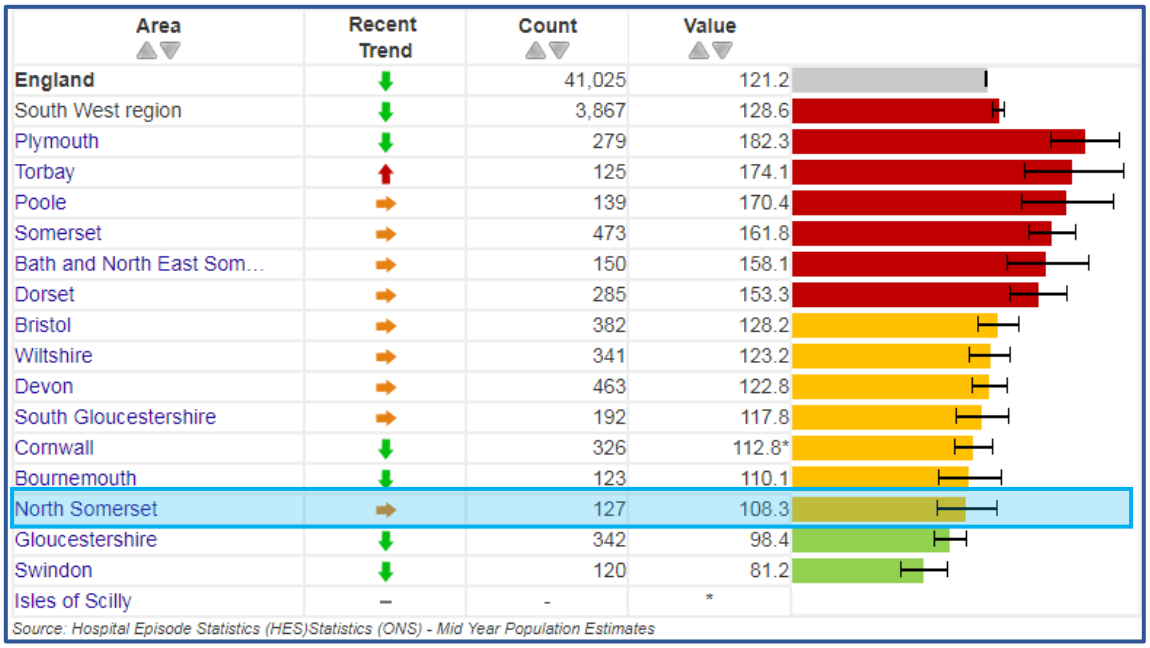


Figure 23: *North Somerset crude rate of A&E attendance rate per 1,000 population aged 0-4 years by electoral ward, 2012/14-2015/16). Source: Map from PHE Local Health, based on Hospital Episode Statistics*



Area	Recent Trend	Count	Value
England	↓	41,025	121.2
South West region	↓	3,867	128.6
Plymouth	↓	279	182.3
Torbay	↑	125	174.1
Poole	→	139	170.4
Somerset	→	473	161.8
Bath and North East Som...	→	150	158.1
Dorset	→	285	153.3
Bristol	→	382	128.2
Wiltshire	→	341	123.2
Devon	→	463	122.8
South Gloucestershire	→	192	117.8
Cornwall	↓	326	112.8*
Bournemouth	↓	123	110.1
North Somerset	→	127	108.3
Gloucestershire	↓	342	98.4
Swindon	↓	120	81.2
Isles of Scilly	–	-	*

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

Figure 24: *Crude rate of hospital admissions caused by unintentional and deliberate injuries in children aged under 5 years per 10,000 resident population aged under 5 years (2017/18). Source: PHE Local Authority Health Profile, based on Hospital Episode Statistics*[i]

National data shows that there are five causes that account for 90% of unintentional injury hospital admissions for under-fives - these are (1) choking, suffocation and strangulation; (2) falls; (3) poisoning; (4) burns and scalds; and (5) drowning[62]. National data shows that hazards change over time, particularly as products on the market become more popular such as hair straighteners, liquid detergent capsules, button batteries, cot bumpers and sleeping pods[62].

The number of 0-4 year old child emergency hospital admissions due to exposure to heat and hot substances in North Somerset is significantly higher than the South West regional and England averages (as shown in **Table 8**). All other causes of unintentional injury in North Somerset are in line with or below the South West regional and England averages. Preventing scalds from the hot tap and burns from food and hot fluids could therefore become a focus for local injury prevention activities.

[i] *The horizontal black bars on the graph indicate confidence intervals. The true underlying value of the rate is 95% likely to be within the confidence interval presented. The wider the confidence interval, the less precise the estimate of the true underlying value. Where confidence intervals overlap there may be no statistically significant difference between the true underlying values.*

Table 8: *Rates of the main causes of emergency hospital admissions for under-fives following unintentional injuries in and around the home in 2014/15-2016/17 (rate per 100,000 resident population of children aged 0 to 4 years). Count is shown in brackets. Source PHE, Reducing unintentional injuries in and around the home among children under five years - Report for North Somerset, based on Hospital Episode Statistics*

	Falls	Exposure to animate mechanical forces	Exposure to inanimate mechanical forces	Exposure to heat and hot substances	Accidental poisoning
North Somerset	482.2 (174)	44.3 (16)	199.6 (72)	152.4 (55)	99.8 (36)
South West	534.3 (4,920)	45.6 (420)	215.2 (1,982)	103.4 (952)	179.7 (1,655)
England	509.1 (52,412)	43.3 (4,454)	233.1 (23,992)	77.6 (7,984)	145.5 (14,976)

i. Early Years Development & Language

Child development is currently universally assessed at the 2-2½ year health visiting review as this is considered a key stage of preschool development and an opportunity for very early intervention. As part of the review, health visitors and community nursery nurses will work with parents to complete an Ages and Stages Questionnaire (ASQ3) which covers five domains of development: (1) communication; (2) gross motor skills; (3) fine motor skills; (4) problem solving; and (5) personal-social development.

Poverty and disadvantage are known to have particularly negative impact on children's development, and income-related learning gaps can be seen in children cognitive, social and emotional skills by the time children are two years[8]. This may be due to parental confidence in supporting their child's development – factors such as mental health, economic stress or on-going conflict in a relationship can all influence the early learning environment[8].

Figure 25 shows the difference in the proportion of children reaching the threshold for all five domains of development between the four children's centre group catchment areas. Children living in Weston South and Weston East groups are less likely to meet the thresholds than children living in the North and Central group areas - these are also the areas of North Somerset which have higher levels of deprivation. Locally the most noticeable difference in development for children living in more deprived areas can be seen around communication skills, this is also reflected nationally *(Source: PHE Child development at 2 to 2 and a half years: 2017 to 2018).*

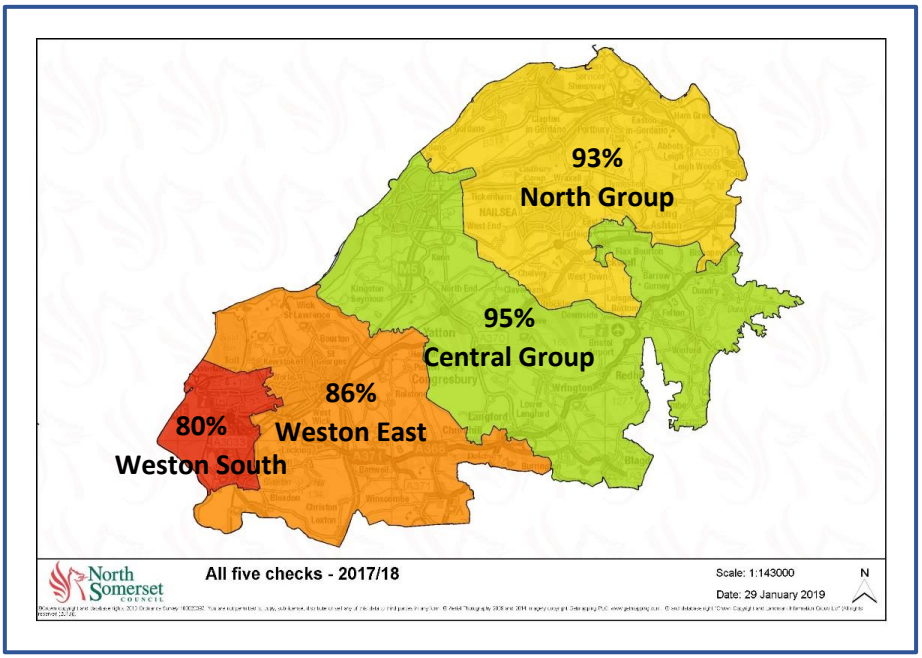


***Figure 25**: Proportion of North Somerset children aged 2-2 ½ who are meeting the threshold for all five ASQ domains by children centre group catchment area 2017/18.). Source: Local analysis of health visitor EMIS records (North Somerset Community Partnership).*

Proportion passed threshold	<80%	80-89.9%	90-94.9%	95-99.9%	100%

In 2017/18, overall 75.5% of children in North Somerset achieve a good level of development within the Early Years Foundation Stage Profile (EYFS)[64] by the end of reception year (children aged 4 to 5 years). This means they are recaching at least the expected level within the following areas of learning: communication and language, physical development, personal, social and emotional development, literacy and mathematics. This level of achievement locally is significantly higher than the South West region (71.2%) and England average (71.5%), as shown in **Figure 26**.

Figure 27 shows however, that in 2015 only 48.0% of children living in Weston-super-Mare South ward were achieving a good level of development by age 5 which is a significant inequality when compared to the rest of North Somerset. Weston-super-Mare Uphill and Central wards also had a low percentage of children meeting the threshold, with 58.9% and 58.8% respectively. This reflects the potentially detrimental impact that deprivation can have on children's early development and school readiness.

This is also demonstrated by the significant difference between the number of children eligible for free school meals achieving a good level of development compared to children who are not eligible. In 2017/18 51.8% of children with free school meal status in in North Somerset achieved a good level of development, which was lower than both the South West regional (52.3%) and England (56.6%) averages. There does appear to be an upward trend in this outcome, as shown in **Figure 28**, however there is still a substantial gap between the two groups of children.

Area	Recent Trend	Count	Value
England	↑	466,668	71.5
South West region	↑	42,870	71.2
Plymouth	↑	2,058	67.9
Cornwall	↑	4,089	68.5
Bristol	↑	3,807	69.0
Gloucestershire	↑	4,743	69.2
Dorset	↑	2,892	70.3
Torbay	↑	993	70.4
Swindon	↑	2,083	70.8
Devon	↑	5,574	71.7
Somerset	↑	4,134	71.8
Wiltshire	↑	3,928	72.1
Bath and North East Somers	↑	1,388	72.6
Poole	↑	1,136	74.5
North Somerset	↑	1,841	75.5
Bournemouth	↑	1,534	75.9
South Gloucestershire	↑	2,647	77.3

Figure 26: *All children defined as having reached a good level of development at the end of the Early Years Foundation Stage (EYFS) in reception as a percentage of all eligible children (2017/18). Source: PHE Local Authority Health Profile, based on Department for Education data*

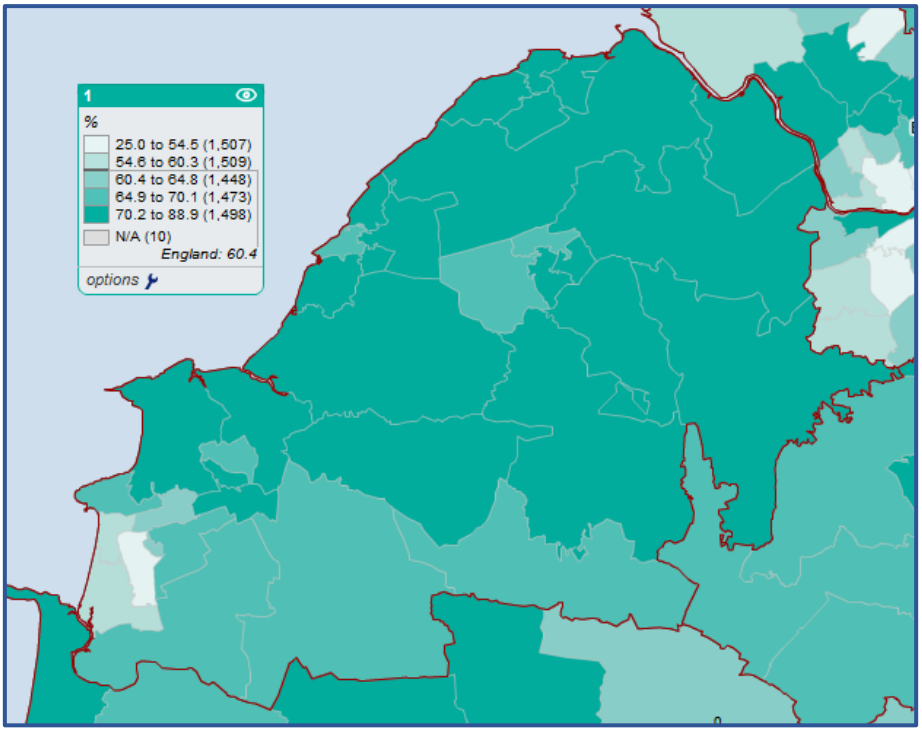


Figure 27: *Percentage of pupils achieving a good level of development at age 5, 2015. Source: Map From PHE Local Health, based on Department for Education data*

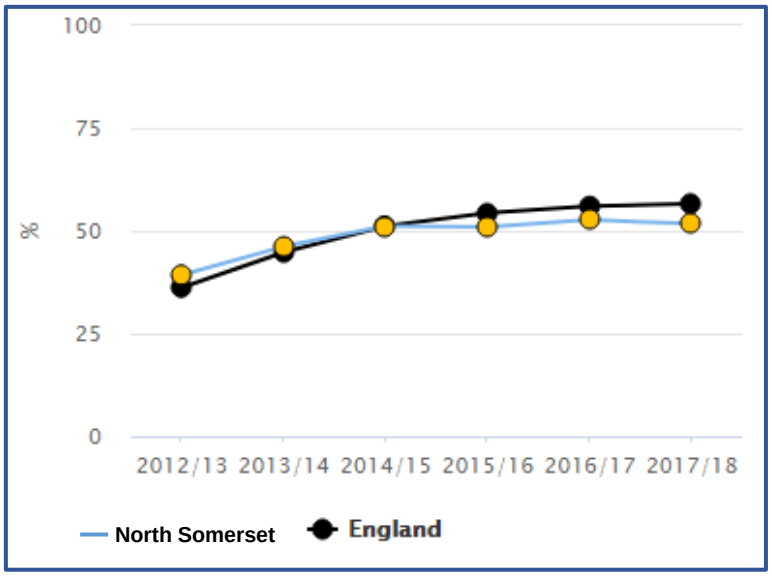


Figure 28: *Children with free school meal status defined as having reached a good level of development at the end of the EYFS as a percentage of all eligible children with free school meal status (2012/13-2017/18). Source: PHE Local Authority Health Profile, Department for Education*

Similarly, in 2017/18 85.7% of North Somerset children in Year One (children aged 5 to 6 years) met the expected level in the phonics screening check, which is slightly higher than the South West and England averages (both 82.5%). Again however, the percentage of children with free school meal status is significantly lower at 70.9.4%; this is higher than the South West (68.2%) and in line with the England average (70.1%).

Early speech and language skills impact on many areas of child development: it contributes to children's ability to manage emotions and communicate feelings, to establish and maintain relationships, to think symbolically, and to learn to read and write[65,66]. The increased prevalence of speech, language and communication delay among disadvantaged children is thought to contribute to the achievement gap that exists throughout school until they leave[66]. Undiagnosed language problems are likely to contribute to poor literacy, reduced achievement in school and employment in adulthood, and also an increase likelihood of mental health problems in adulthood[66].

From 5 to 19 Years Old

a. Child Mortality

The child mortality rate (directly standardised rate[ii] per 100,000 children aged 1-17 years, 2015-2017) in North Somerset is 9.8 – this is similar to the South West regional and England averages of 9.7 and 11.2. There are around 4 deaths of children aged 1-17 years old each year in North Somerset.

[ii] *A directly standardised rate accounts for differences in the size and age structure of the population over time*

Figure 29 below shows the cause of death amongst 5-14 year-olds of both sexes in the UK, with each box area proportional to the number of deaths. Non-communicable diseases (chronic diseases) are the main cause of deaths amongst 5-14 year olds in the UK, followed by injuries and communicable disease (infectious diseases). The need to provide adequate support to those children and families with life-limiting or life-threatening conditions should be recognised.

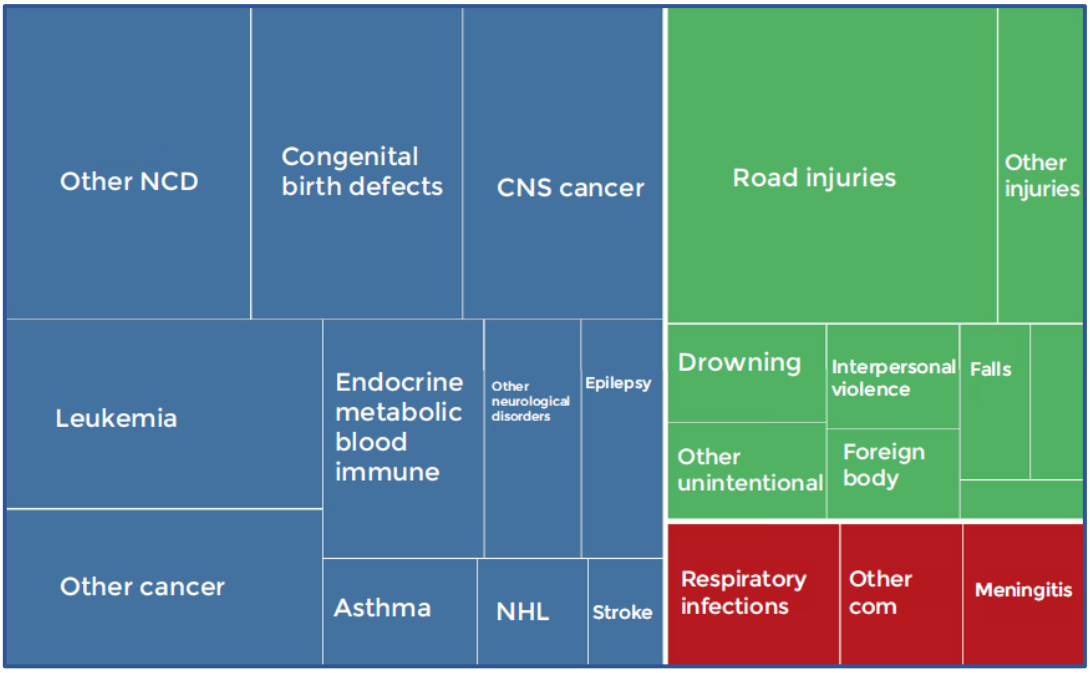


*Figure 29: Cause of death amongst 5-14 year-olds of both sexes in the UK across all non-communicable disease (in blue), communicable diseases (red) and injuries (green). **note:** NCD = non-communicable disease; CNS = Central Nervous System; NHL = Non-Hodgkin's Lymphoma. Source: Royal College of Paediatrics and Child Health (RCPCH) Child Health in England in 2030 report, from 2016 Global Burden of Disease Study[45]*

b. Mental Health & Emotional Wellbeing

The most recent data suggests that one in eight (12.8%) of 5 to 19 year olds had at least one mental disorder when assessed in 2017[48]. Rates of mental disorder are highest in the older age groups - with 16.9% of adolescents aged 17 to 19 likely to have a disorder. Three in four mental illnesses start before a child reaches their 18th birthday and half of all mental health problems in adult life take root before the age of 15[46].

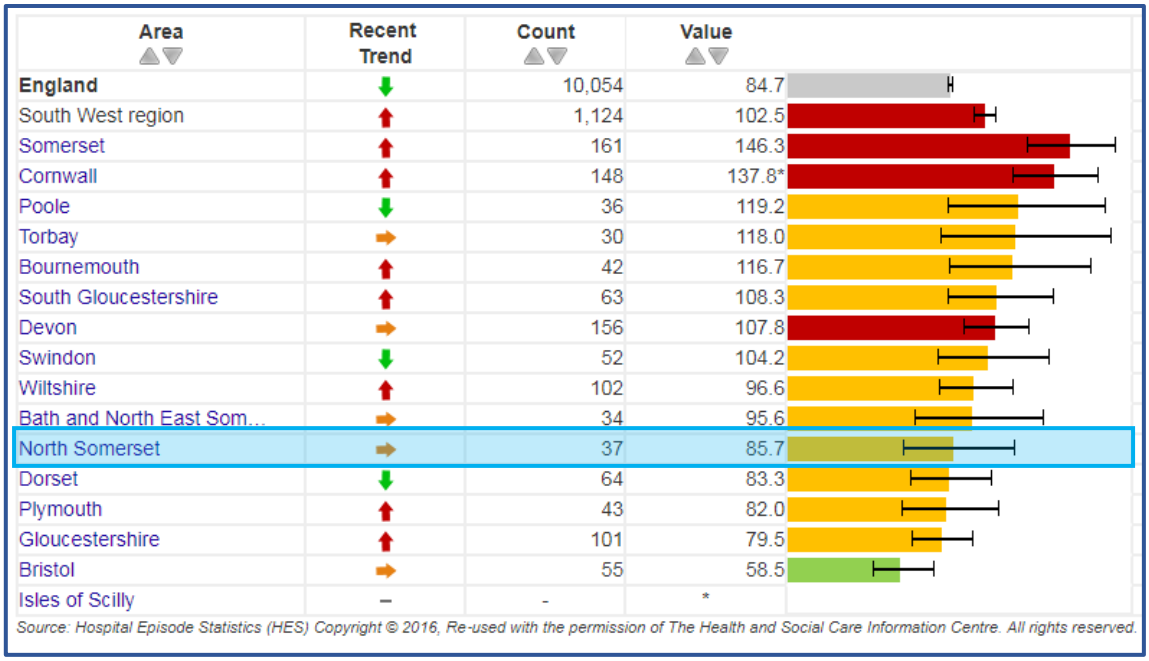
Mental disorders in children and young people can be grouped in four broad types[48]:

- **Emotional disorders** – includes anxiety disorders, depressive disorders, and mania and bipolar affective disorder.
- **Behaviour (or conduct) disorders** – A group of disorder characterised by repetitive and persistent patterns of disruptive and violent behaviour.
- **Hyperactivity disorder** – Disorders characterised by inattention, impulsivity and hyperactivity.
- **Other less common disorders** – Include autism spectrum disorder (ASD), eating disorders, tic disorders, and a number of very low prevalence conditions.

Groups of children are at particular risk of poor mental health. For example, it is linked to gender, socioeconomic status, ethnicity, disability, sexual orientation, being a looked-after child or being involved with the youth justice system[67]. Teenage mothers also have higher rates of poor mental health for up to a year after the birth of their child[13].

The percentage of North Somerset school pupils who have been identified as having social, emotional and mental health needs is 2.32% or approximately 701 pupils *(2018, source: Department for Education special educational needs statistics)*. This is statistically similar to the South West regional (2.87%) and England (2.39%) averages for this indicator. These pupils have been identified as having special educational needs (SEN) where the primary need is social, emotional and mental health. However, considering 12.8% of children aged 5 to 19 are estimated to have a mental disorder nationally, there is likely to be a significant number of children in North Somerset whose needs have not been identified and therefore are not receiving support. It has been estimated that only 25% of (one in four) children with a diagnosable mental health condition nationally has access to support[69,68].

The number of children aged under 18 years in North Somerset who were admitted to hospital with a primary diagnosis of a mental health disorder (37 admissions, 85.7 per 100,000) is below the South West regional average (102.5 per 100,000), but slightly above the England average (84.7), as shown in **Figure 30**.



Area	Recent Trend	Count	Value
England	↓	10,054	84.7
South West region	↑	1,124	102.5
Somerset	↑	161	146.3
Cornwall	↑	148	137.8*
Poole	↓	36	119.2
Torbay	→	30	118.0
Bournemouth	↑	42	116.7
South Gloucestershire	↑	63	108.3
Devon	→	156	107.8
Swindon	↓	52	104.2
Wiltshire	↑	102	96.6
Bath and North East Som...	→	34	95.6
North Somerset	→	37	85.7
Dorset	↓	64	83.3
Plymouth	↑	43	82.0
Gloucestershire	↑	101	79.5
Bristol	→	55	58.5
Isles of Scilly	–	-	*

Figure 30: *Inpatient admission rate for mental health disorders per 100,000 population aged 0-17 years (2017/18). Source: PHE Local Authority Health Profile, based on Hospital Episode Statistics*

Self-harm is strongly associated with mental disorders such as depression, as well as family issues (including poverty, parental criminality, parental separation and divorce) and being abused[69]. The emotional causes of self-harm may require psychological assessment and treatment. Nationally it is reported one in ten young people will self-harm.[69] In 2017/18 in North Somerset there were 37 hospital admissions of 10-14 year olds as a result of self-harm (rate 315.5 per 100,000, compared to

the South West rate of 308.7), and 78 admissions of 15-19 year olds (rate 712.0 per 100,000, compared to the South West rate of 965.7) *(Source: PHE Local Authority Health Profile).*

In a survey of 15 year olds (**Figure 44 on page 53**), 13.6% of young people in North Somerset had reported low life satisfaction in North Somerset, which was very similar to the South West regional and England averages (13.4% and 13.7% respectively). This represents one in seven children having low life satisfaction. National data shows girls, young people who are black or Asian, young people who identify as LGBTQ+, or those living in more deprived areas are more likely to have low life satisfaction[69].The same survey indicated the percentage of 15 year olds reporting being bullied in the last couple of months in North Somerset is higher than the South West regional and England average (more than 6 in 10 children compared to 5.5 in 10 for the England average). Bullying can take several forms, including physical bullying and psychological/emotional bullying, which comprises virtual bullying using technology such as social media websites, apps and text messages (cyber-bullying). Bullying is detrimental to both mental and physical health. Studies have shown that children who are chronically bullied are more likely to self-harm, suffer from anxiety or depression, and are also more likely to be overweight as young adults[68].

c. Sexual Health

Young people aged between 15 and 24 years experience the highest diagnosis rates of the most common sexually transmitted infections (STIs), and this may be due to greater rates of partner change[70]. This is reflected in North Somerset as shown in **Figure 32**, where in 2016, 54% of diagnoses of new STIs made in sexual health services were in young people in this age-group, compared to 50% in England. In numbers, this is just over 550 cases diagnosed for this age group in a year.

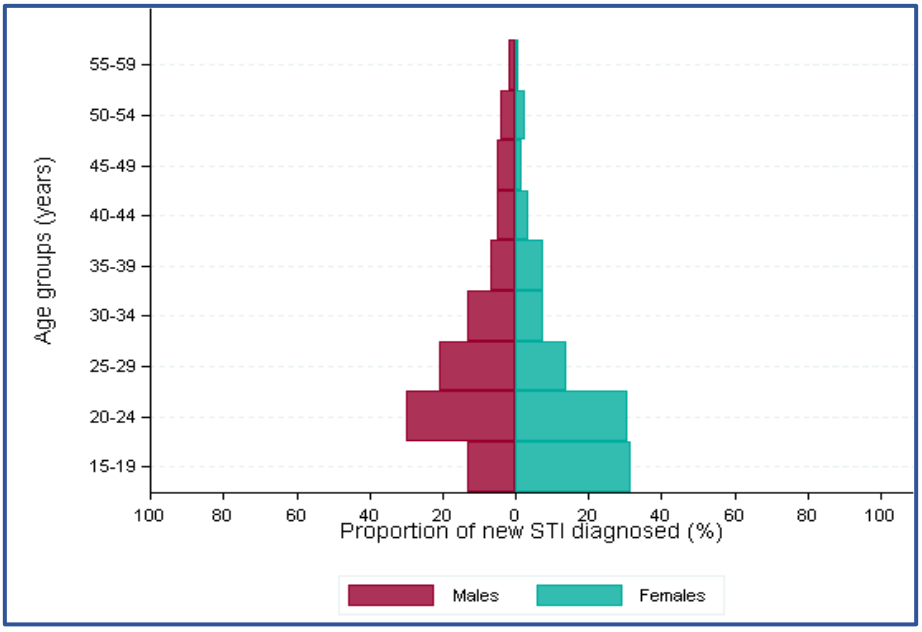


Figure 31: *Proportion of new STIs by age group and gender in North Somerset (2016). Source: PHE North Somerset Local Authority HIV, Sexual and Reproductive Health Epidemiology Report (LASER)*

Young people are also more likely to become re-infected with STIs, contributing to infection persistence and council-funded health service workload. In North Somerset, an estimated

13.8% of 15-19 year old women and 12.9% of 15-19 year old men presenting with a new STI during the five year period from 2012 to 2016 became re-infected with an STI within 12 months. That represents about one in eight young people with an STI having a secondary infection. Adolescents may be at increased risk of re-infection because they lack the skills and confidence to negotiate safer sex.

d. Teenage Pregnancy

Teenage pregnancy rates have fallen considerably over the last 15 years both locally and across England, (resulting in the reduction in births to teenage mothers discussed in section **5a Maternal Age**). This has largely been achieved through a national long-term teenage pregnancy strategy[9]. The current rate (2017) of under 18 conceptions in North Somerset is 12.6 per 1,000 females under 18 *(Source: Public Health Outcomes Framework*). This is slightly below the South West regional (15.8 per 1,000) and England average (18.8 per 1,000).

Because numbers of teenage pregnancies in North Somerset are relatively small, there will be variation in the rate each year, but levels have remained relatively stable since 2012 (as shown in **Figure 32**). In 2017, there were 43 under 18 conceptions, of which 9 were under 16 years *(Source: Public Health Outcomes Framework)*.

With the conception rate declining the number of abortions for this age group have also fallen[10]. In 2017 in North Somerset 24 under 18s' conceptions led to abortion – 55.8% of conceptions *(Source: Public Health Outcomes Framework*).

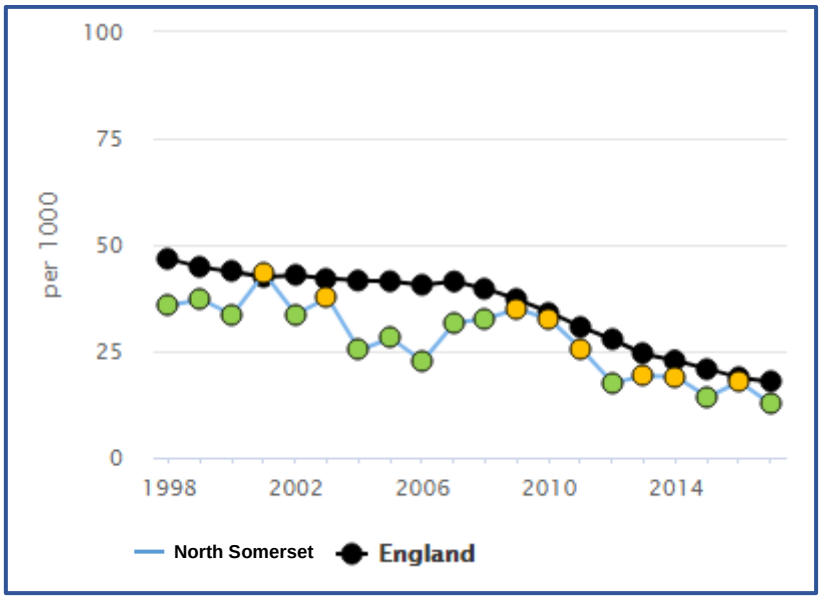


Figure 32: *Rate of conceptions per 1,000 females aged 15-17 in North Somerset (1998-2017). Source: Public Health Outcomes Framework, ONS statistics*

e. Alcohol & Substance Use

Children and young people are advised not to drink alcohol before the age of 18[71], and as a whole drinking alcohol does seem to be on the decline amongst young people[11,41]. The proportion of

children in the UK drinking alcohol however remains well above the European average, and British children are more likely to binge drink or to get drunk than their European counterparts[72].

A national 2014/15 survey of 15-year olds found 71% of those surveyed from North Somerset reported ever having had an alcoholic drink; 7.4% reported being regular drinkers and 22% reported being drunk in the last four weeks (as shown in **Figure 44** on **page 53)**. The percentages of those trying a drink and being drunk in the preceding four weeks are both significantly higher than South West regional and England averages.

A national survey of pupils aged 11 to 15 years suggests those who are white or mixed ethnicity are most likely to drink alcohol (51% and 45% respectively)[73]. This compares to 28% of Black pupils and 13% of Asian pupils. Over 90% of North Somerset's school aged population are from a white ethnicity (see section **4d Ethnicity**), this may therefore account for why the overall number of young people who drink alcohol may be higher in North Somerset compared to other more diverse local authority areas across England. Other factors which are associated with young people choosing to drink alcohol include whether their family does or doesn't discourage drinking; whether there are drinkers within the home environment; the age of the young person; and other behaviours such truancy, smoking and drug taking[73].

There is an association with young people's alcohol consumption and risky behaviours, such as alcohol-related accident or injury, violent or antisocial behaviour, and risky sexual activity including not using contraception and therefore an increased risk of teenage pregnancy and STIs[71]. Young people who start drinking alcohol at an early age tend to drink more frequently and more in total than those who start drinking later in their life; as a result, they are more likely to develop alcohol problems in adolescence and adulthood[71].

In North Somerset, the rate of admissions to hospital for under 18s where the primary diagnosis or any secondary diagnosis are an alcohol-specific condition is higher than the England average, but lower than the South West regional average, as shown in **Table 9**. The reasons for hospital attendance is not recorded but could include alcohol poisoning, acute intoxication, injury or assult[71].

Table 9: *Rate of hospital admissions of Children and Young People for alcohol specific conditions and substance misuse (2015/16 – 17/18). Source PHE Local Authority Health Profile.*

	Hospital admissions for alcohol-specific conditions (under 18s) – Rate per 100,000 population	Hospital admissions due to substance misuse (15-24 years) - Rate per 100,000 population
North Somerset	35.7	90.1
South West	43.6	100.8
England	32.9	87.9

Young people who binge drink at an early age are also more likely to experience drug use and dependence[71]. The immediate and long-term risks of recreation drugs use to young people's health and wellbeing vary with the type of drug taken[73]. There is evidence to suggest that there could be a risk of damage to mental health including suicide, depression, psychotic symptoms and disruptive

behaviour disorders[74]. Drug use is also associated with a range of adverse experiences and behaviour, including truancy or exclusion from school, homelessness, time in care, and serious or frequent offending[73].

Cannabis is the drug most likely taken by young people in England[73]. **Figure 44** shows that 12.2% of 15-year-olds in North Somerset reported ever trying cannabis, and 5.9% reported having taken cannabis in the last month. 2.1% of the young people also reported that they had taking other drugs (excluding cannabis) in the last month, which was significantly higher than the South West regional (1.4%) and England (0.9%) averages. Overall the national survey found cannabis and other drug use was significantly higher in the South West region compared to the rest of England[75]. The number of young people admitted to hospital due to substance misuse in North Somerset is above the England average but lower than the South West regional average, as shown in **Table 9**.

The reasons why pupils chose to take drugs were analysed in a survey of pupils aged 11 to 15 years, shown in **Figure 33**. The most frequent reason given for the first occasion was curiosity and 'to see what it was like'; and for subsequent occasions 'to get high or feel good'.

Some young people are particularly vulnerable to misusing alcohol and drugs, including young offenders, those with poor mental and emotional health and those experiencing child sexual exploitation and abuse. Therefore, services need to provide early intervention and support for vulnerable young people to reduce risks associated with alcohol and substance misuse, for example referral to support and treatment programmes[71].

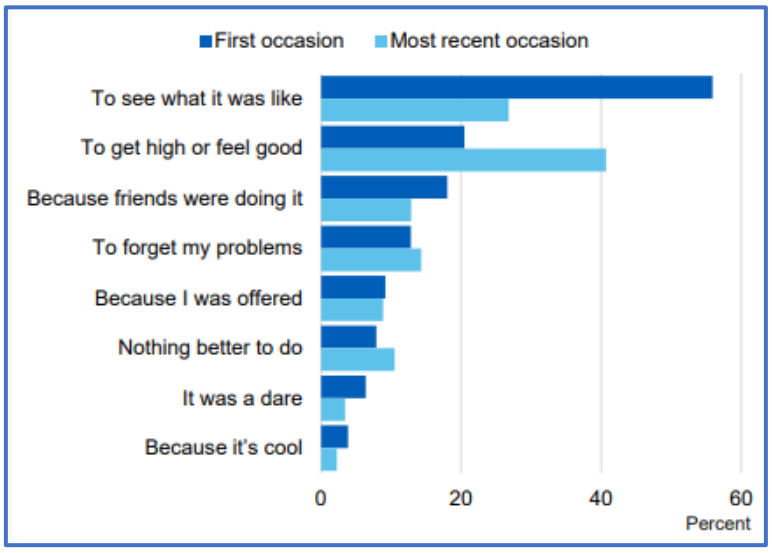


Figure 33: *Reasons given by pupils aged 11-15 in a national survey on why they took drugs on the first and most recent occasion. Source: NHS digital[73]*

f. Smoking

There is a large body of evidence showing that smoking is an addiction which often starts in the teenage years and continues into adulthood[24].

Nationally the prevalence of young people smoking has been steadily declining since 1996[73], and cigarette use amongst young people in the UK is lower than many other European countries[72]. This declining trend could be due to a combination of government legislation which has banned smoking

in workplaces and enclosed public spaces; raised the legal age to purchase of tobacco from 16 to 18; outlawed the display of tobacco products in shops; and introduced compulsory plain packaging[11]. Children are heavily influenced by adult role models that smoke, therefore one of the most effective ways to reduce the number of young people who smoke is to reduce the number of adults[24].

One of the national ambitions in the government's new tobacco control plan published in 2017, is to reduce the number of 15-year olds who regularly smoke to 3% or less by 2022[24]. Overall, smoking prevalence in 15-year olds in North Somerset is close to or lower than South West regional and England averages. As shown in **Figure 44 on page 53**, 8.8% of 15 year olds surveyed from North Somerset in 2014/15 reported being a current smoker (5.1% reported being a regular smoker and 3.7% an occasional smoker). 14.8% also reported that they have tried other tobacco products (e.g. shisha pipe, hookah, hubble-bubble, and/or waterpipe).

Whilst electronic cigarettes cannot be legally sold to anyone under the age of 18 in the UK[73], 15.3% of the 15-year olds surveyed in North Somerset in 2014/15 had reportedly tried these products (**Figure 44 on page 53)**. There is currently no evidence that electronic cigarettes act as a gateway into smoking[76], but this remains an area for further research.

g. Unintentional Injuries in the 5-19's

There were 3,929 A&E attendances for children aged 5-9 years in North Somerset; 4,643 for children aged 10-14 years and 4,324 for young people aged 15-19 years in 2016/17. The 5-9 and 10-14 year age groups show an upward trend in the rate of attendances locally and nationally (**Figure 35** and **Figure 36**), which will have an impact on the capacity of busy A&E departments and the minor injury units.

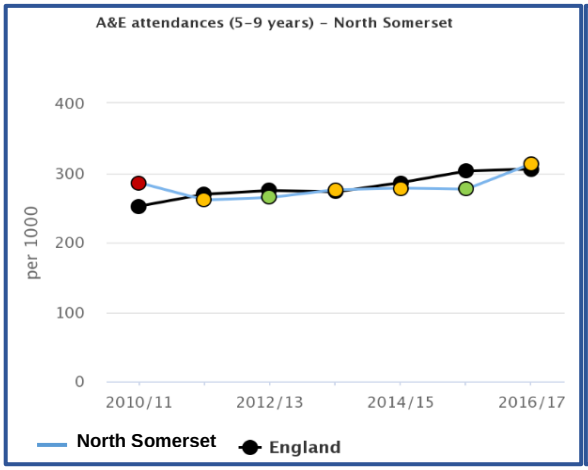


Figure 34: A&E attendance rate per 1,000 population aged 5-9 years (2016/17). Source: PHE Local Authority Health Profile, based on Hospital Episode Statistics

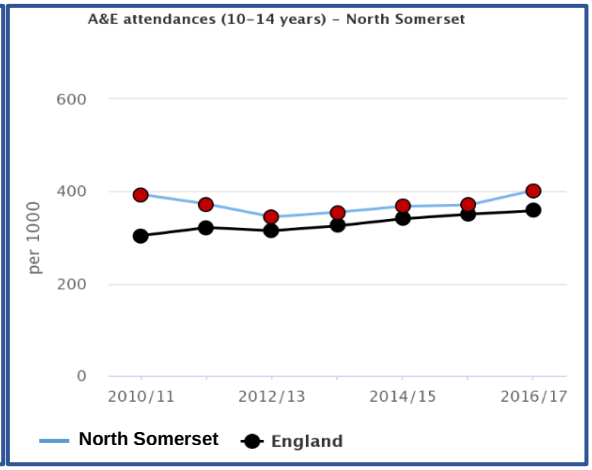


Figure 35: A&E attendance rate per 1,000 population aged 10-14 years (2016/17). Source: PHE Local Authority Health Profile, based on Hospital Episode Statistics

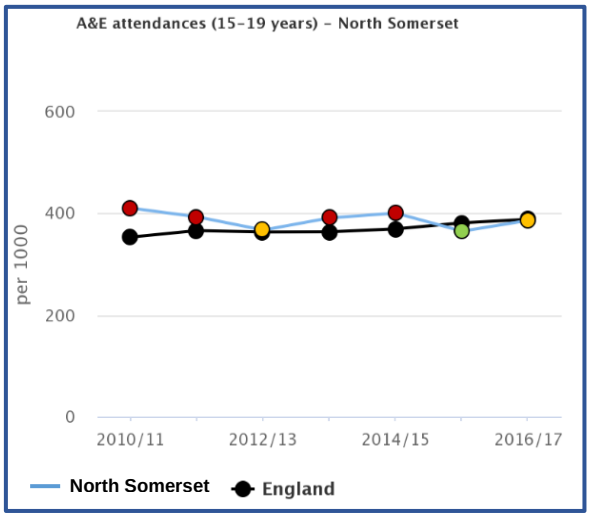


Figure 36: *A&E attendance rate per 1,000 population aged 15-19 years (2016/17). Source: PHE Local Authority Health Profile, based on Hospital Episode Statistics*

Hospital admission rates for unintentional and deliberate injuries for children aged 0-14 years, shown in **Figure 37** are lower in North Somerset compared to South West regional and England averages. **Figure 38** however shows admissions for young people aged 15-24 years are higher than the England average, but in-line with the South West regional average. The higher rates of admissions for unintentional and deliberate injuries in the 15-24 year age group across the South West region may be correlated to the increase levels of admissions for self-harm, as well the increased potential risk of injury and accidents through a higher prevalence of young people using alcohol and drugs across the region.

Area	Recent Trend	Count	Value
England	↓	96,910	96.4
South West region	↓	9,164	99.5
Poole	→	331	130.7
Plymouth	↓	582	130.5
Torbay	↑	264	123.6
Somerset	→	1,090	118.9
Dorset	↓	729	115.6
Bath and North East Som...	→	337	113.8
Bristol	→	837	103.0
Devon	→	1,221	101.0
Bournemouth	→	299	96.7
Wiltshire	→	814	92.0
Cornwall	↓	817	91.1*
North Somerset	→	328	90.3
South Gloucestershire	→	440	89.3
Swindon	↓	308	72.3
Gloucestershire	↓	767	72.3
Isles of Scilly	–	-	*

Source: Hospital Episode Statistics (HES)

Figure 37: *Crude rate of hospital admissions caused by unintentional and deliberate injuries in children aged under 15 years per 10,000 resident population aged under 15 years (2017/18). Source: PHE Local Authority Health Profile, based on Hospital Episode Statistics*

Area	Recent Trend	Count	Value
England	↓	88,181	132.7
South West region	↑	9,900	153.1
Poole	→	336	212.6
Somerset	↑	1,135	203.7
Swindon	↑	461	198.6
Torbay	↑	257	195.1
Wiltshire	↑	894	178.8
Dorset	→	688	173.9
Bournemouth	↑	502	172.3
Bristol	→	1,147	150.9
North Somerset	↓	307	150.3
South Gloucestershire	↑	484	146.3
Cornwall	↓	840	137.6*
Devon	↓	1,148	133.2
Plymouth	↓	492	123.0
Gloucestershire	↓	811	117.9
Bath and North East Som...	↓	398	116.0
Isles of Scilly	–	-	*

Source: Hospital Episode Statistics (HES)

***Figure 38**: Crude rate of hospital admissions caused by unintentional and deliberate injuries in young people aged 15-24 years per 10,000 resident population aged 15-24 years (2017/18). Source: PHE Local Authority Health Profile, based on Hospital Episode Statistics*

Between 2015-17 North Somerset has had 13 children aged under 16 killed or seriously injured in road traffic accidents. This risk increases with age, especially after young people can start using cars and motorcycles[77].

Children and young people aged 10-14 years and, living in deprived areas are 3.7 times more likely to be killed or seriously injured on the roads[77]. National data shows there are peak times for when children under 16 years are likely to be injured which coincide with journeys to and from school[77].

Local authorities have a statutory duty to promote road safety[iii], and can introduce a range of measures to reduce road casualties including working with schools to improving safety for children travelling to and from school; introducing 20mph limits and zones in priority areas; and set up local partnerships to plan and evaluate road safety activities. These actions could also result in wider public health benefits such as promoting active travel resulting in improved physical and mental health, as well as reducing noise and air pollution.

Unintentional injuries in children and young people are both driven by inequalities in life circumstances and when they occur are a further cause of inequality, for example, stress, physical disability, cognitive or social impairment, and lower educational attainment and employment prospects[4,62,77].

h. Child Obesity

Overweight and obesity in childhood is associated with overweight and obesity in adulthood, with subsequent increased risk of cardiovascular disease, type 2 diabetes, and other obesity related non-

[iii] (STATS19)Department for Transport, Reported Road Casualties Great Britain

communicable diseases[78]. Childhood obesity is also associated with poor mental health, low self-esteem, stigma and bullying[78].

Excess weight is assessed in primary school aged children through the National Child Measurement Programme (NCMP) by calculating BMI - with overweight being defined as greater than or equal to the 85th centile (the heaviest 15% of children) and obesity greater than or equal to the 95th centile (the heaviest 5% of children) of the growth reference for age and sex.

North Somerset has a lower prevalence of childhood overweight and obesity compared to the South West regional and England averages *(Source: PHE Local Authority Health Profile, 2017/18).* In 2017/18 NCMP identified 20.4% of North Somerset children in reception year (aged 4-5 years) as being of excess weight (overweight or obese), with 7.8% being obese. **Figure 39** shows that there has been a recent drop in the number of children in reception with excess weight or obesity.

By year 6 (aged 10-11 years), 26.9% of children in North Somerset are of excess weight, and 15.1% of children are obese. **Figure 40** shows a clear downwards trend in the number of year six children with excess weight in North Somerset. Comparing the graphs below, it appears children in North Somerset are less likely to gain excess weight during primary education compared to the rest of England.

Poor family diet and low levels of physical activity are the primary causal factors to excess weight, with sugar consumption being a major contributing factor to children's weight gain[78,79]. Children aged 4-10 years are consuming on average the equivalent of 13 sugar cubes a day, which is more than double the recommended upper limit of 5 to 6 cubes.

Around 60% of 15-year olds surveyed from North Somerset reported eating 5 portions or more of fruit and veg per day (as shown in **Figure 44)** which is above the England average. Only 15.2% of those surveyed were meeting the national guidelines for physical activity of one hour per day seven days a week, which is in line with the England average.

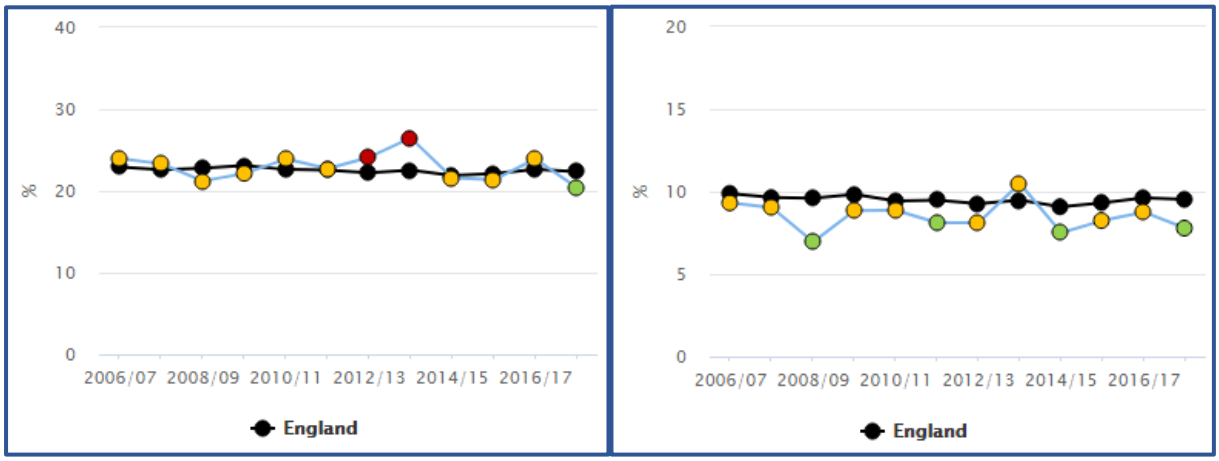


Figure 39: *Left graph – Prevalence of overweight (including obese) amongst North Somerset children in reception (aged 4-5 years) Right graph - Prevalence of obesity amongst North Somerset children in reception (aged 4-5 years). (2017/18) Source: PHE Local Authority Health Profile, based on NCMP data*

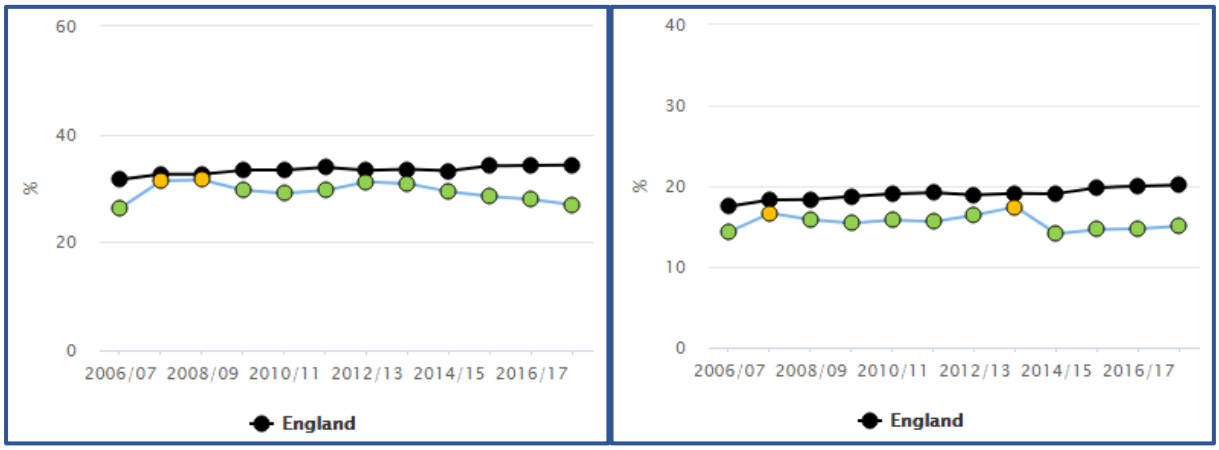


Figure 40: *Left graph – Prevalence of overweight (including obese) amongst North Somerset children in year 6 (aged 10-11 years) Right graph - Prevalence of obesity amongst North Somerset children in year 6 (aged 10-11 years). (2017/18) Source: PHE Local Authority Health Profile, based on NCMP data*

Childhood overweight and obesity is a significant health inequality, with higher rates amongst children of overweight parents, those in disadvantaged areas and some ethnic groups (most BME groups are more likely to be overweight and obese compared to white groups)[78]. Children living in the most deprived areas of England are more than twice as likely to be obese as those living in the most affluent areas (based on the relative index of inequality)[80]. The relative affluence of North Somerset and lower levels of children from BME groups may account for why the proportion of children with excess weight is lower than other more diverse local authority areas.

Figure 41 and **Figure 42** shows the North Somerset electoral wards estimated to have the highest and lowest prevalence of children with obesity based on residence. In reception year (age 4-5 years) prevalence of obesity ranges from 4% in Nailsea Golden Valley ward to 13.1 % in Weston-super-Mare Central and South wards. In year six (age 10-11 years) prevalence of obesity ranges from 8.4% in Nailsea Golden Valley to 23.3% in Weston Central ward. Hence the national childhood obesity trends related to deprivation are reflected locally, with childhood obesity being more prevalent in the areas with higher levels of deprivation.

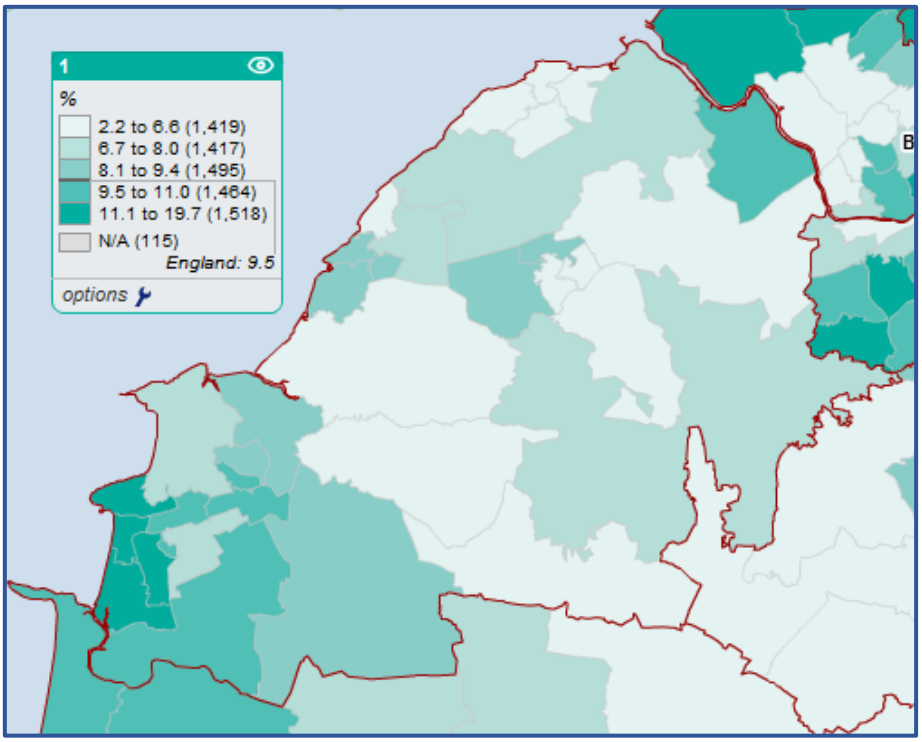


Figure 41: *Percentage of North Somerset children who were classified as obese in reception year (aged 4-5 years) by electoral ward (2015/16-2017/18). Source: Map from PHE Local Health, based on NCMP data*

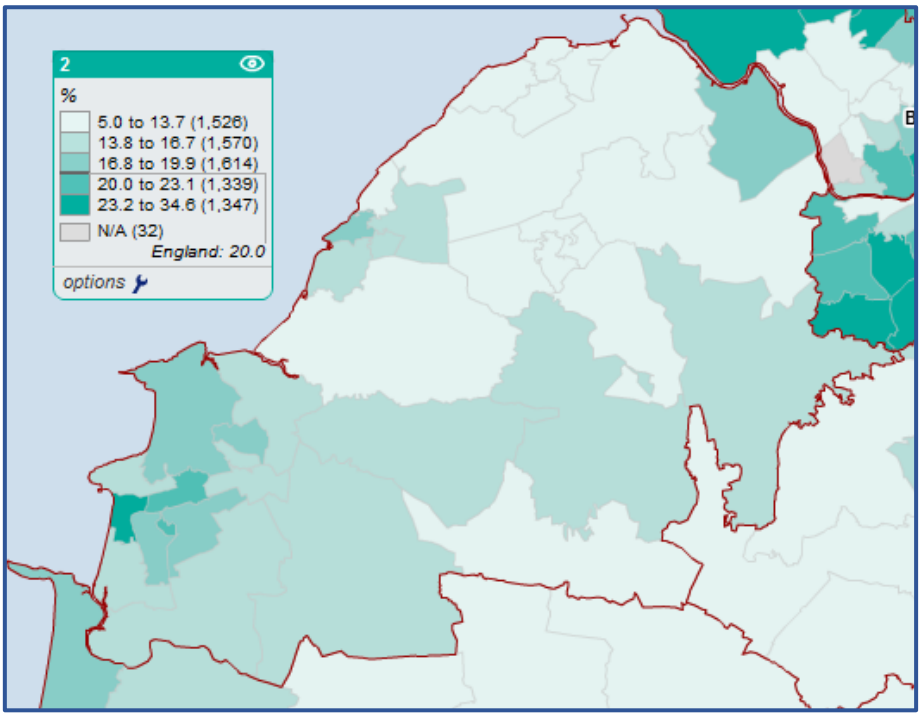


Figure 42: *Percentage of North Somerset children who were classified as obese in year six (aged 10-11 years) by electoral ward (2015/16-2017/18). Source: Map from PHE Local Health, based on NCMP data*

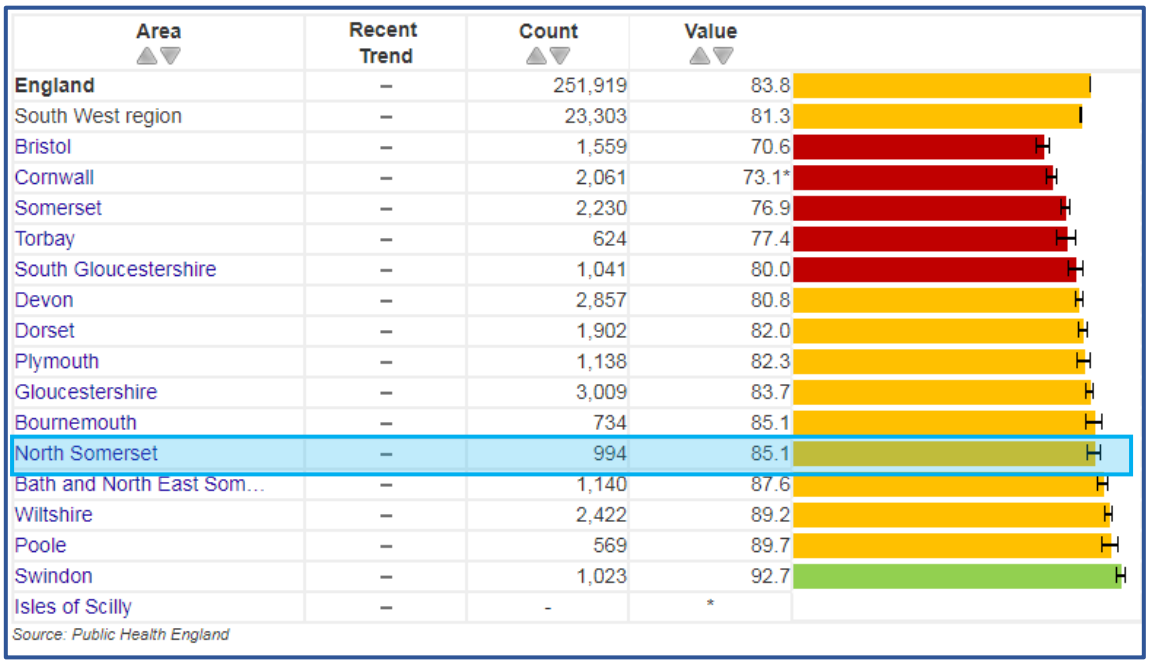
i. School Aged Immunisations

The school-based flu programme has a national annual target of 65% uptake. North Somerset's programme is delivered by the school nursing service and is amongst the top three performing local programmes in the South Region, exceeding the target in all age groups as shown in **Table 10**.

Table 10: *North Somerset School Flu Programme coverage (2018/18). Source: North Somerset Health Protection Annual Assurance Report 2017/18*

Reception (age 4-5)	Year 1 (age 5-6)	Year 2 (age 6-7)	Year 3 (age 7-8)	Year 4 (age 8-9)
72.4%	72.5%	70.4%	69.8%	66.9%

School-aged girls aged 12 to 13 years are offered the HPV (human papilloma virus) vaccine to protect against four types of HPV which are associated with the vast majority of cases of cervical cancer and also a cause of genital warts. In 2017/18 the percentage of eligible 12-13 year old girls in North Somerset receiving one dose of the vaccination was 88.5%, which is higher than the South West regional (85.4%) and England (86.9%) averages (see **Figure 43**). Nationally, between 2009 and 2017, diagnoses of genital warts declined by 90% in 15-17-year-old girls and 70% in 15-17 year old boys. Following updated evidence from the Joint Committee on Vaccination and Immunisation (JCVI) there are plans to extend the existing HPV vaccination programme to boys as well as girls this year to protect them from genital warts and certain cancers[81].



Area	Recent Trend	Count	Value
England	–	251,919	83.8
South West region	–	23,303	81.3
Bristol	–	1,559	70.6
Cornwall	–	2,061	73.1*
Somerset	–	2,230	76.9
Torbay	–	624	77.4
South Gloucestershire	–	1,041	80.0
Devon	–	2,857	80.8
Dorset	–	1,902	82.0
Plymouth	–	1,138	82.3
Gloucestershire	–	3,009	83.7
Bournemouth	–	734	85.1
North Somerset	–	994	85.1
Bath and North East Som...	–	1,140	87.6
Wiltshire	–	2,422	89.2
Poole	–	569	89.7
Swindon	–	1,023	92.7
Isles of Scilly	–	-	*

Source: Public Health England

Figure 43: *All girls aged 12-13 years who have received the first (priming) dose of the HPV vaccine within each reporting area (local authority) as a percentage of all girls aged 12-13 years within each area (2017/18). Source: PHE Local Authority Health Profile*

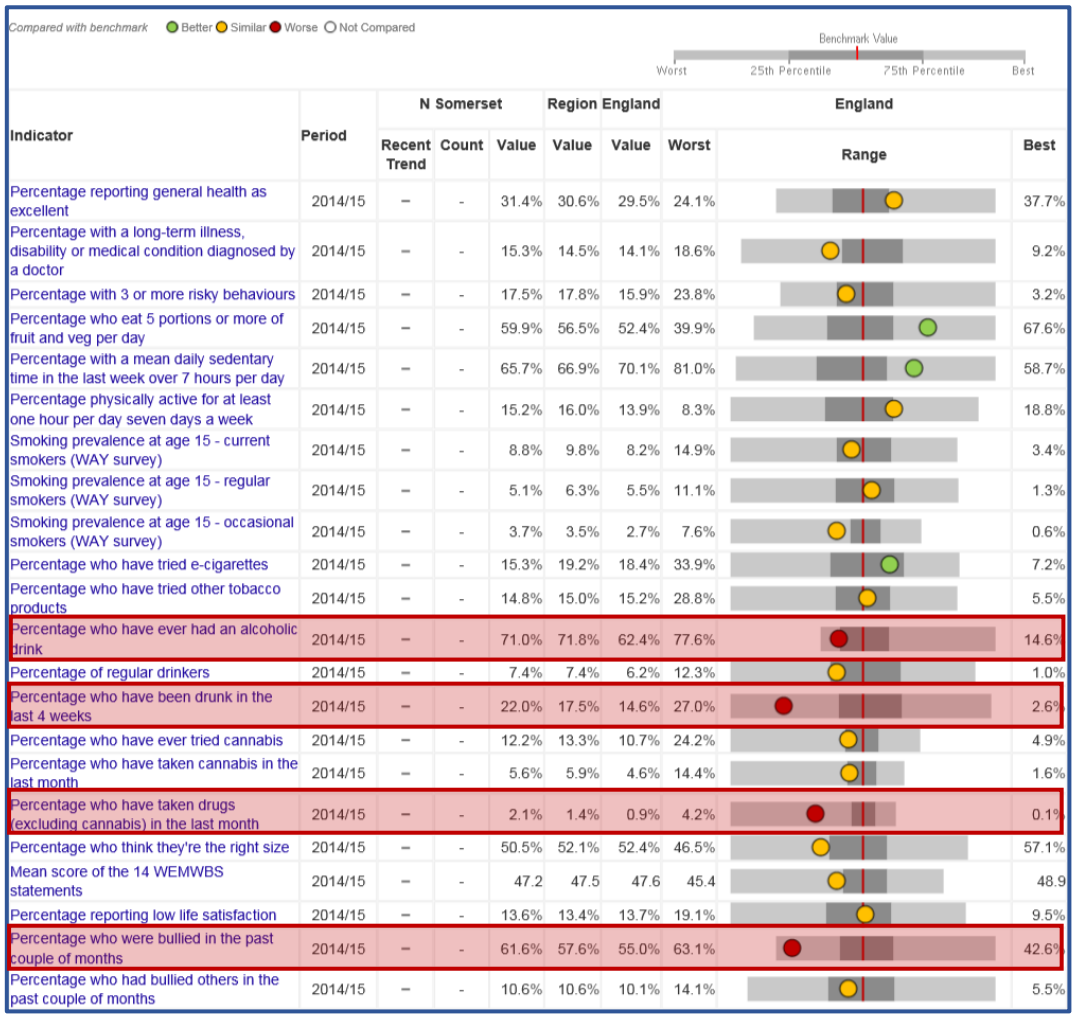
At 14 years old (school year 9 and 10) all adolescents should also have a Td/IPV school leaver booster (tetanus, diphtheria and polio). Coverage for North Somerset in 2016/17 (85.3% in year 9, and 82.5% in year 10) was above the England averages (83% in year 9, and 81.7% in year 10).

The MenACWY immunisation is also offered to adolescents to protect against meningococcal ACWY infections. In North Somerset coverage is 77.8% in year 11 (aged 15-16 years), and 77.2% in year 12 (aged 16-17 years), this is similar to the England averages of 79% in year 11, and 71.4% in year 12.

j. Health and wellbeing at 15

The What About Youth (WAY) survey collected data from over 100,000 15 year-olds in England during 2014[75]. The questions covered a number of topics, including diet and physical activity, smoking, alcohol, use of drugs, bullying and wellbeing. Results from the survey for North Somerset are summarised in **Figure 44**. Overall the proportion of young people reporting excellent health was above South West regional and England averages at 31.4%. The three areas of concern for North Somerset identified in the survey – alcohol use, drug use (excluding cannabis) and bullying – have already been highlighted under these topic areas on pages 42 to 43.

Unlike many local authority areas North Somerset does not have an annual health school survey which would give more up to date intelligence around health and wellbeing in the school aged population.



Compared with benchmark: Better, Similar, Worse, Not Compared

Benchmark: Value — Worst | 25th Percentile | 75th Percentile | Best

Indicator	Period	N Somerset			Region England	England	England		
		Recent Trend	Count	Value	Value	Value	Worst	Range	Best
Percentage reporting general health as excellent	2014/15	–	-	31.4%	30.6%	29.5%	24.1%		37.7%
Percentage with a long-term illness, disability or medical condition diagnosed by a doctor	2014/15	–	-	15.3%	14.5%	14.1%	18.6%		9.2%
Percentage with 3 or more risky behaviours	2014/15	–	-	17.5%	17.8%	15.9%	23.8%		3.2%
Percentage who eat 5 portions or more of fruit and veg per day	2014/15	–	-	59.9%	56.5%	52.4%	39.9%		67.6%
Percentage with a mean daily sedentary time in the last week over 7 hours per day	2014/15	–	-	65.7%	66.9%	70.1%	81.0%		58.7%
Percentage physically active for at least one hour per day seven days a week	2014/15	–	-	15.2%	16.0%	13.9%	8.3%		18.8%
Smoking prevalence at age 15 - current smokers (WAY survey)	2014/15	–	-	8.8%	9.8%	8.2%	14.9%		3.4%
Smoking prevalence at age 15 - regular smokers (WAY survey)	2014/15	–	-	5.1%	6.3%	5.5%	11.1%		1.3%
Smoking prevalence at age 15 - occasional smokers (WAY survey)	2014/15	–	-	3.7%	3.5%	2.7%	7.6%		0.6%
Percentage who have tried e-cigarettes	2014/15	–	-	15.3%	19.2%	18.4%	33.9%		7.2%
Percentage who have tried other tobacco products	2014/15	–	-	14.8%	15.0%	15.2%	28.8%		5.5%
Percentage who have ever had an alcoholic drink	2014/15	–	-	71.0%	71.8%	62.4%	77.6%		14.6%
Percentage of regular drinkers	2014/15	–	-	7.4%	7.4%	6.2%	12.3%		1.0%
Percentage who have been drunk in the last 4 weeks	2014/15	–	-	22.0%	17.5%	14.6%	27.0%		2.6%
Percentage who have ever tried cannabis	2014/15	–	-	12.2%	13.3%	10.7%	24.2%		4.9%
Percentage who have taken cannabis in the last month	2014/15	–	-	5.6%	5.9%	4.6%	14.4%		1.6%
Percentage who have taken drugs (excluding cannabis) in the last month	2014/15	–	-	2.1%	1.4%	0.9%	4.2%		0.1%
Percentage who think they're the right size	2014/15	–	-	50.5%	52.1%	52.4%	46.5%		57.1%
Mean score of the 14 WEMWBS statements	2014/15	–	-	47.2	47.5	47.6	45.4		48.9
Percentage reporting low life satisfaction	2014/15	–	-	13.6%	13.4%	13.7%	19.1%		9.5%
Percentage who were bullied in the past couple of months	2014/15	–	-	61.6%	57.6%	55.0%	63.1%		42.6%
Percentage who had bullied others in the past couple of months	2014/15	–	-	10.6%	10.6%	10.1%	14.1%		5.5%

***Figure 44**: Health Behaviours in 15 year olds, North Somerset. Source: PHE Local Authority Health Profile, from What About YOUth (WAY) survey, 2014/15*

k. School Age Development & Academic Attainment

There is a clear association between education, health and wellbeing: people with higher levels of education experience better health and lower levels of morbidity, mortality and disability[82]. Educational qualifications are a determinant of an individual's labour market position, which in turn influences income, housing and other material resources[83].

Regular school attendance throughout the school-aged years has been shown to result in better health, education and socio-economic outcomes[84,85]. In 2016/17 8.5% of North Somerset primary school children and 14.1% of secondary school children were persistently absent from school (defined as missing 10% or more of possible sessions). These figures were slightly higher than the England averages of 8.3% for primary school and 13.5% for secondary school aged children *(Source: Department for Education)*.

In 2015/16, 57% of North Somerset pupils achieved five or more GCSEs at grades A*-C (including English and Maths), which is slightly below the South West regional (58.4%) and England (57.8%) averages (shown in **Figure 45**). **Figure 46** shows the North Somerset wards which had the lowest percentage of pupils achieving five or more GCSEs in 2013/14 - these were Weston-super-Mare South (30.8%), Weston-super-Mare Uphill (37.8%), Weston-super-Mare Central (44.9%) and Weston-super-Mare Winerstoke (48.8%). Backwell ward had the highest percentage of pupils achieving five or more GCSEs with 83.7%.

Evidence shows the income-related learning gap which starts in the early years persists and grows throughout primary and secondary school[8,83]. For children with free school meal status in North Somerset the number achieving 5 or more GCSEs falls to 29% of pupils, which is also below the South West regional (29.5%) and England (33.3%) averages (2014/15) - See **Figure 46**.

Legislation states that all young people should remain in some form of education or training until they turn 18[86,87]. Evidence shows young people who are not in education, employment or training (NEET) are at greater risk of a range of negative outcomes, including poor health, depression or early parenthood[87]. In North Somerset in 2017, 6.1% of 16-17 year olds are NEET, which is in-line with the South West and England averages of 6.7% and 6.0% respectively (see **Figure 47**). The likelihood of a young person being NEET affects disadvantaged young people disproportionately[87].

Area	Recent Trend	Count	Value
England	–	309,517	57.8
South West region	–	30,425	58.4
Plymouth	–	1,246	50.2
Bristol	–	1,831	51.9
Somerset	–	3,040	56.4
Torbay	–	763	56.6
Swindon	–	1,298	56.7
North Somerset	–	1,226	57.0
Dorset	–	2,363	58.8
South Gloucestershire	–	1,650	58.9
Cornwall	–	3,238	59.6*
Bournemouth	–	876	59.8
Wiltshire	–	2,931	59.9
Devon	–	4,374	60.2
Poole	–	848	60.6
Gloucestershire	–	3,711	61.4
Bath and North East Som...	–	1,030	65.8
Isles of Scilly	–	-	*

Source: Data downloaded from the Department for Education website

Figure 45: *Percentage of pupils achieving five or more GCSEs at grades A*-C (including English and Maths) or equivalent, based on local authority of the pupil's residence, at the end of the academic year (2015/16). Source: PHE Local Authority Health Profile, based on Department for Education data*

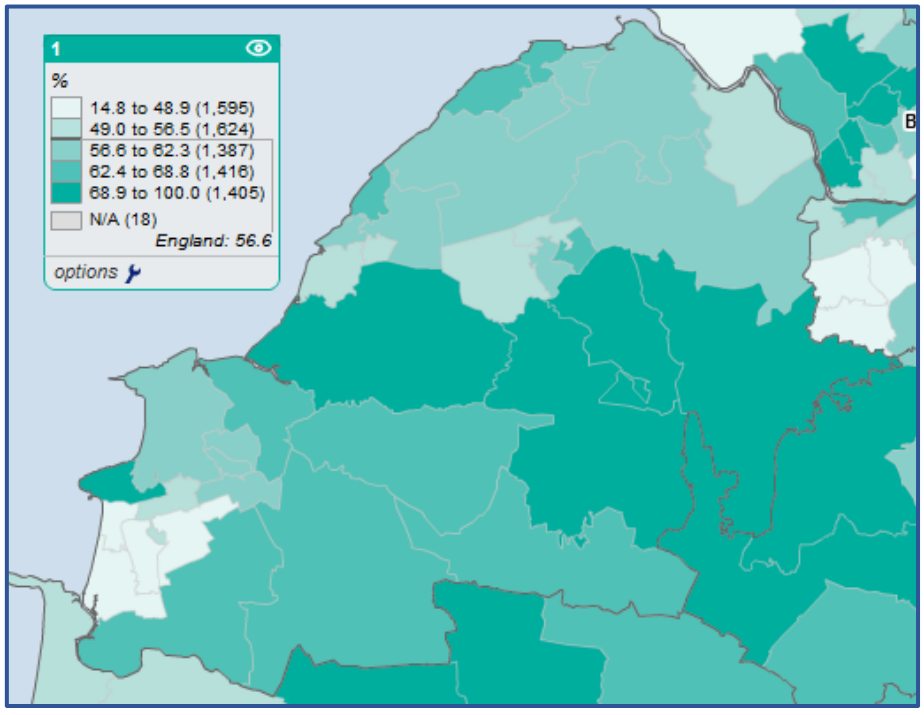


Figure 46: *Percentage of North Somerset pupils achieving five GCSE grades of A*-C including English and Maths, at the end of the academic year 2013/14. Source: Map from PHE Local Health, based on Department of Education data*

Area	Recent Trend	Count	Value
England	–	68,070	6.0
South West region	–	7,380	6.7
Wiltshire	–	1,120	11.3
Somerset	–	1,020	9.0
Bristol	–	710	8.8
Plymouth	–	350	6.8
Swindon	–	330	6.7
Gloucestershire	–	780	6.1
North Somerset	–	270	6.1
Cornwall	–	670	5.8
Devon	–	850	5.5
Bath and North East Som...	–	180	5.4
Bournemouth	–	170	5.3
Torbay	–	150	5.3
Dorset	–	410	5.1
South Gloucestershire	–	270	4.7
Poole	–	100	3.3
Isles of Scilly	–	-	*

Source: Department for Education

Figure 47: *Proportion of 16-17 year olds who are not in education, employment or training (NEET) or whose activity is not known. (2017). Source: PHE Local Authority Health Profile, based on Department for Education data*

Vulnerable Children and Young People

a. Looked After Children (Children in Care)

The rate of children aged under 18 years in the care of the local authority in North Somerset in 2018 was 55 per 10,000 children - this is the same as the South West regional average, but lower than the England rate of 64 per 10,000 children. The overall number of children in care in 2018 in North Somerset was 235. The number of children in care in North Somerset has remained relatively stable over the last five years as shown in **Figure 48**.

Children are taken into care for a variety of reasons, but the most common primary need is 'abuse or neglect'[88]. 'Family dysfunction', 'family being in acute stress' and 'absent parenting' are the next most common reasons nationally - 'absent parenting' includes unaccompanied asylum-seeking children.

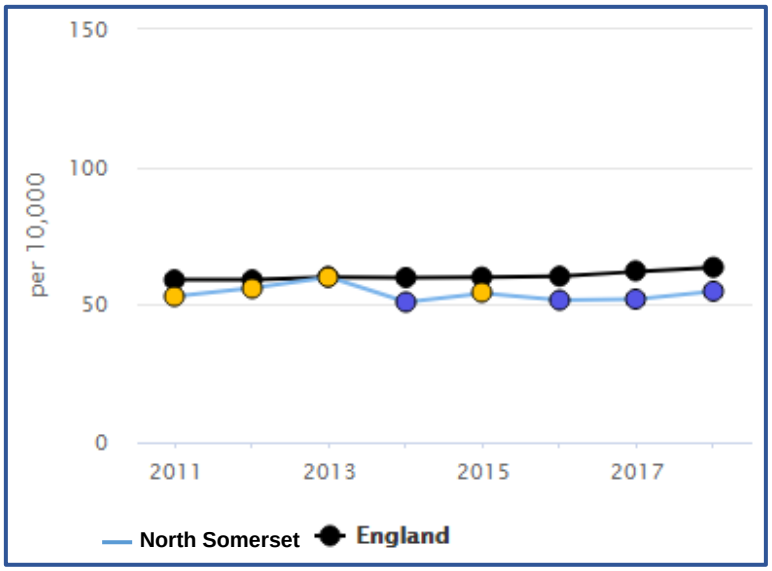


Figure 48: *Children looked after at 31 March (rate per 10,000 population aged under 18 years) (2011-2018). Source: PHE Local Authority Health Profile, Data from Children looked after in England, Department for Education.*

There are significant inequalities in educational, health and social outcomes for looked after children compared to non-looked after children. Over half of children in care have a diagnosable mental health disorder and two-thirds have special education needs (SEN)[67]**Error! Bookmark not defined.**. It is therefore important that specialist support services, including child and adolescent mental health services (CAMHS), are accessible to this vulnerable group, as not meeting these needs can contribute to poorer health and wellbeing outcomes of care leavers later in life.

Looked after children can be at higher risk of missing out on childhood immunisations. Among children in care in North Somerset, the reported rate of children up to date with their immunisations according to the routine childhood immunisation schedule was 88.8% in 2018, which was above the South West regional (87.8%) and England (85.3%) averages *(Source: PHE Local Authority Health Profile)*.

A key summary measure of educational attainment at Key Stage 4 is the 'Attainment 8', which reports the average achievement of pupils with up to eight qualifications including English, maths, and further options from a specified list. The average 'Attainment 8' score of children in North Somerset in 2017/18 was 46.6, which is comparable to the South West regional and England average of 46.7 *(Source: PHE Local Authority Health Profile)*. The average 'Attainment 8' score for children in care in North Somerset in 2017/18 was 19.4. This is slightly above the South West average of 18.0 and England average of 19.3 for this group of children *(Source: PHE Local Authority Health Profile)*. This difference in 'Attainment 8' achievement however demonstrates the significant gap in educational attainment between children in care and the wider school age population. This difference is reduced when the proportion of children with special educational needs (SEN) is considered**Error! Bookmark not defined.**.

b. Young Carers

Young carers include children and young people aged under 18 who provide regular and ongoing care and emotional support to a family member who is physically or mentally ill, disabled or misuses

substances. In the 2011 census 4.1% of dependent children in North Somerset lived in a household where at least one family member has a long-term health problem or disability, which was in-line with the South West regional average of 4.09%, and below the England average of 4.62% *(Source: PHE Local Authority Health Profile)*.

Research shows young people often find caring very rewarding, bringing emotional and psychological benefits[89]. However, if the level of care-giving and responsibility becomes excessive or inappropriate for the child there is a risk that it can impact on their own emotional or physical wellbeing, education participation and ability to concentrate due to tiredness[89].

Data from the 2011 census shows that North Somerset was one of several authorities in the South West where the percentage of children aged 0-15 years providing unpaid care was above the England average (**Figure 49**). 1.28% of children under 15 (468 children) provided unpaid care in North Somerset in 2011 compared to 1.21% in the South West region, and 1.11% in England. 0.2% of children under 15 in North Somerset (73 children) provided over 20 hours per week of unpaid care.

Children providing unpaid care (aged 0-15) 2011

Area	Recent Trend	Count	Value
England	–	111,423	1.11
South West region	–	11,260	1.21*
Torbay	–	373	1.72
Plymouth	–	618	1.38
Cornwall	–	1,217	1.35
Devon	–	1,646	1.34
Swindon	–	551	1.33
Bournemouth	–	370	1.31
Poole	–	328	1.28
North Somerset	–	468	1.28
Dorset	–	834	1.24
Somerset	–	1,094	1.16
Bristol	–	860	1.09
Bath and North East Somer...	–	323	1.09
Wiltshire	–	970	1.07
South Gloucestershire	–	524	1.05
Gloucestershire	–	1,084	1.02
Isles of Scilly	–	0	0.00

Source: Census

Figure 49: *Percentage of children aged 0-15 years providing at least one hour of unpaid care (2011). Source: PHE Local Authority Health Profile, data from 2011 Census*

c. Young Offenders

The number of first-time entrants into the youth justice system has fallen considerably in North Somerset and nationally in recent years, as shown in **Figure 50**. The North Somerset rate per 100,000 is 220.2, compared to 290.3 for the South West regional and 292.5 for the England average. The number of first-time entrants has fallen each year from 176 in 2010 to 41 in 2017.

Figure 51 shows that the rate of children aged 10-18 in the youth justice system in North Somerset in 2016/17 was 5.0 per 1,000 young people aged 10-18. This is slightly above the South West

regional average (4.2) and England average (4.8). In 2015/16 in North Somerset there were: 35 children aged 10-14 years; 23 aged 15 years; 28 aged 16 years; and 41 aged 17 years in the Youth Justice System – a total of 127 young people across all age groups. National data shows 84% of young people in the youth justice system are male[90].

Young people at risk of offending or within the youth justice system often have greater mental health needs than other young persons - rates of self-harm and suicide are particularly high amongst young offenders[69].

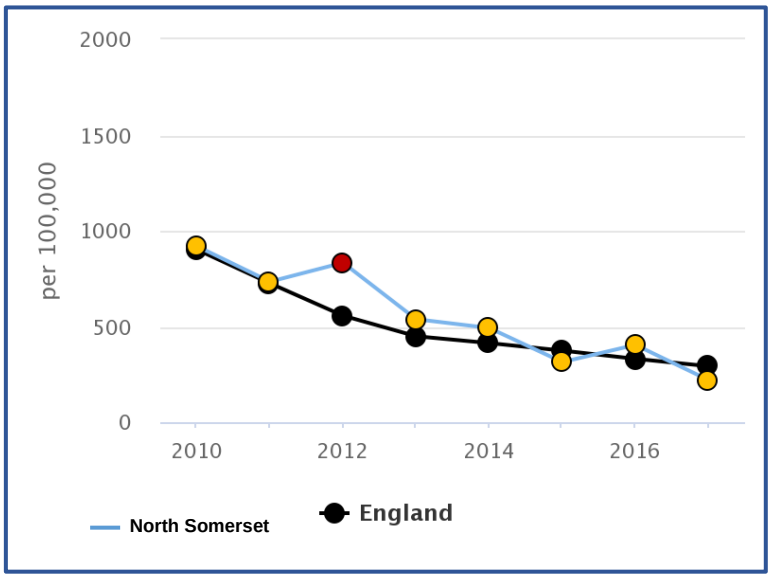


Figure 50: *Rates of juveniles receiving their first conviction, caution or youth caution per 100,000 10-17 year old population, North Somerset (2010-2016). Source: PHE Local Authority Health Profile*

Area	Recent Trend	Count	Value
England	–	-	4.8
South West region	–	-	4.2
Bristol	–	-	8.3
Torbay	–	-	8.3
Swindon	–	-	6.5
North Somerset	–	-	5.0
Plymouth	–	-	5.0
South Gloucestershire	–	-	4.5
Bath and North East Som...	–	-	4.4
Bournemouth	–	-	4.2*
Dorset (Cty)	–	-	4.2*
Poole	–	-	4.2*
Gloucestershire	–	-	3.9
Wiltshire	–	-	3.3
Somerset	–	-	2.9
Devon	–	-	2.8
Cornwall	–	-	2.6*
Isles of Scilly	–	-	2.6*

Source: Youth justice statistics - Annual statistics: https://www.gov.uk/government/collections/youth-justice-statistics

Figure 51: *Children and Young people aged 10 to 18 years supervised by a youth offending team, rate per 1,000 population (2016/17). Source: PHE Local Authority Health Profile, data from youth justice statistics*

d. The Homeless; Gypsy and Traveller; and Migrant Children and Young People

Children and young people from these groups are more likely to experience health inequalities due to their living circumstances, risk of poor-quality accommodation and community discrimination – these populations may also find it harder to engage with education and other key support services[84].

Homelessness is associated with severe poverty and the health and wellbeing of people who experience homelessness are poorer than the general population[63,91]. The rate of family homelessness (see **Figure 52**) and homeless young people in North Somerset is lower than the England average rate.

In 2017/18 there were 77 households with dependent children or pregnant women who were accepted as unintentionally homeless and eligible for assistance in North Somerset. Many families may however be hidden from homelessness statistics as they only reflect those seeking assistance from the local housing authority[63]. Those living in temporary accommodation, including bed and breakfast, may not always be captured in statistics. Temporary accommodation can cause severe disruption to education and children living in cramped accommodation may experience disturbed sleep, poor diet, higher rates of accidents and infectious diseases[91]. Homeless children and young people are also more likely to experience stress and anxiety, resulting in depression and behavioural issues[91].

In 2017/18 there were 29 homeless young people aged 16-24 in North Somerset *(Source: PHE Local Authority Health Profile, data from Department for Communities and Local Government).* These statistics are again thought to be an underestimate, as homeless young people may choose to remain 'hidden' by staying temporarily with friends and family and may not access public service in the same way as adults[91]. Young people leaving care, young people who have run away, BME young people, LGBTQ+ young people and young people with experience of the criminal justice system, young refugees and asylum seekers, and young people from rural areas are at greater risk of homelessness[91].

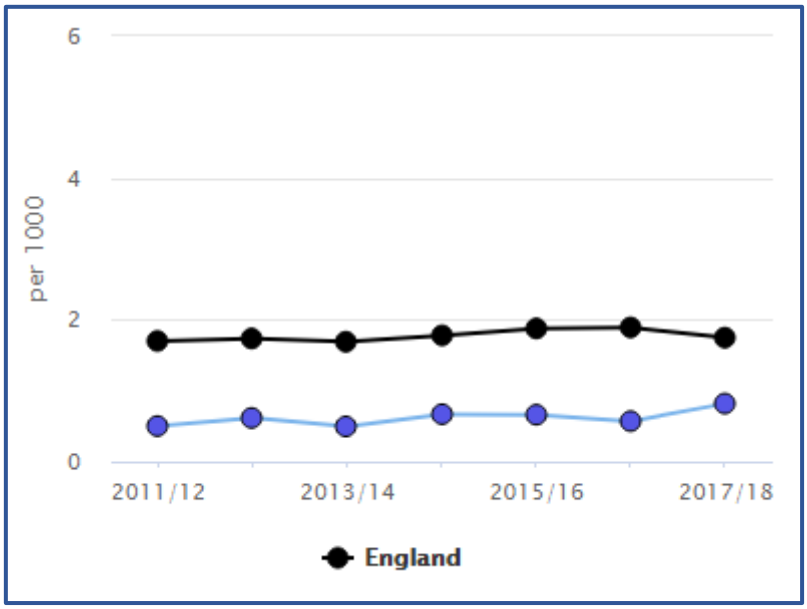


Figure 52: *Family homelessness - households eligible for assistance as unintentionally homeless and in priority need (dependant children or pregnant women). 2017/18. Source: PHE Local Authority Health Profile, data from Department for Communities and Local Government*

Gypsies and Travellers have considerably poorer health status compared to other ethnic minority groups in England or the general population[92]. **Table 11** shows the number of children from these communities in North Somerset schools based on local data from the local authorities Vulnerable Learners Service. Locally the number of children accessing secondary education is particularly low. Research shows fewer gypsy and traveller children achieve a 'good level of development' in the early years compared to other white children, and a significantly lower proportion achieve the GCSE threshold[93,94].

Educational outcomes for Gypsy and Traveller children are significantly below the national average, as well as other child health outcomes, including[93,94]:

- higher infant mortality rates
- lower birth weight
- lower levels of breastfeeding
- lower immunisation rates
- higher rates of accidents
- higher rates of mental ill health

Table 11: *Number of gypsy and traveller children in North Somerset Schools. Source: North Somerset Gypsy Traveller JSNA Chapter*

School type	Number of children
Pre-school	14
Primary schools	60
Secondary schools	14
Elective Home Education (EHE)	19
College	2
Total	**109**

Certain groups of **migrant children, young people and families** may be particularly vulnerable to potential health needs because of their experiences either before, during or after migration[95]. These include asylum seekers and refugees, unaccompanied children, those who have been trafficked, undocumented migrants and low paid migrant workers[95]. Refugees, those seeking asylum and others from a migrant background can suffer from a range of physical and mental health problems according to the migration histories and experience in their originating country and can also experience the same problems as other excluded groups linked to poverty and poor accommodation[96].

e. Special Educational Needs

Children and young people with Special Educational Needs (SEN) have learning difficulties or other disabilities that can make it harder for them to learn than most children and young people of the same age[9798]. Having SEN can affect children's[97]:

- behaviour or ability to socialise, for example they struggle to make friends
- reading and writing, for example because they have dyslexia
- ability to understand things
- concentration levels, for example because they have ADHD
- physical ability

The percentage of primary school pupils with SEN in North Somerset (11.3%) is significantly lower than both South West regional (14.9%) and England (13.8%) averages. In total there are 1,981 primary school aged pupils with SEN in 2018 (**Figure 52**).

Similarly, the percentage of secondary school pupils with special educational needs (SEN) in North Somerset (10.1%) is significantly lower than both South West regional (12.9%) and England (12.3%) averages. In total there are 1,249 secondary school aged pupils with SEN in 2018 (**Figure 54**).

In total there are 3,521 school children who are identified as having SEN in North Somerset in state-funded primary, secondary and special schools (2018, *Source: PHE Local Authority Health Profile, based on Department for Education special educational needs statistics).*

648 school aged pupils in North Somerset were recorded as having moderate (544 pupils); severe (98 pupils), or profound and multiple (42 pupils) **learning difficulties** as a primary special educational need in 2018. This is a rate of 21.8 per 1000 pupils, which is below the South West regional (29.9) and England (33.9) average rate *(Source: PHE Local Authority Health Profile, based on Department for Education special educational needs statistics).*

239 school aged pupils in North Somerset were recorded as having **autistic spectrum** disorders in 2018. This is a rate of 7.6 per 1000 pupils, which is significantly below the South West regional (12.3) and England (13.7) average rate *(Source: PHE Local Authority Health Profile, based on Department for Education special educational needs statistics).*

Area	Recent Trend	Count	Value
England	–	650,453	13.8
South West region	–	62,668	14.9
Dorset (Cty)	–	4,547	17.2
Devon	–	9,728	16.8
Plymouth	–	3,514	16.3
Gloucestershire	–	7,710	16.2
Wiltshire	–	6,237	16.1
Torbay	–	1,700	15.8
Swindon	–	3,216	15.3
Bath and North East Som...	–	2,069	15.2
Bournemouth	–	1,743	13.5
Cornwall	–	5,784	13.4
Bristol	–	4,916	13.4
Poole	–	1,421	13.3
Somerset	–	5,236	13.3
South Gloucestershire	–	2,866	12.5
North Somerset	–	1,981	11.3
Isles of Scilly	–	0	0.0

Figure 53: *The number of primary school age children who are identified as having special educational needs expressed as a percentage of all school pupils (2018). Source: PHE Local Authority Health Profile, based on Department for Education special educational needs statistics*

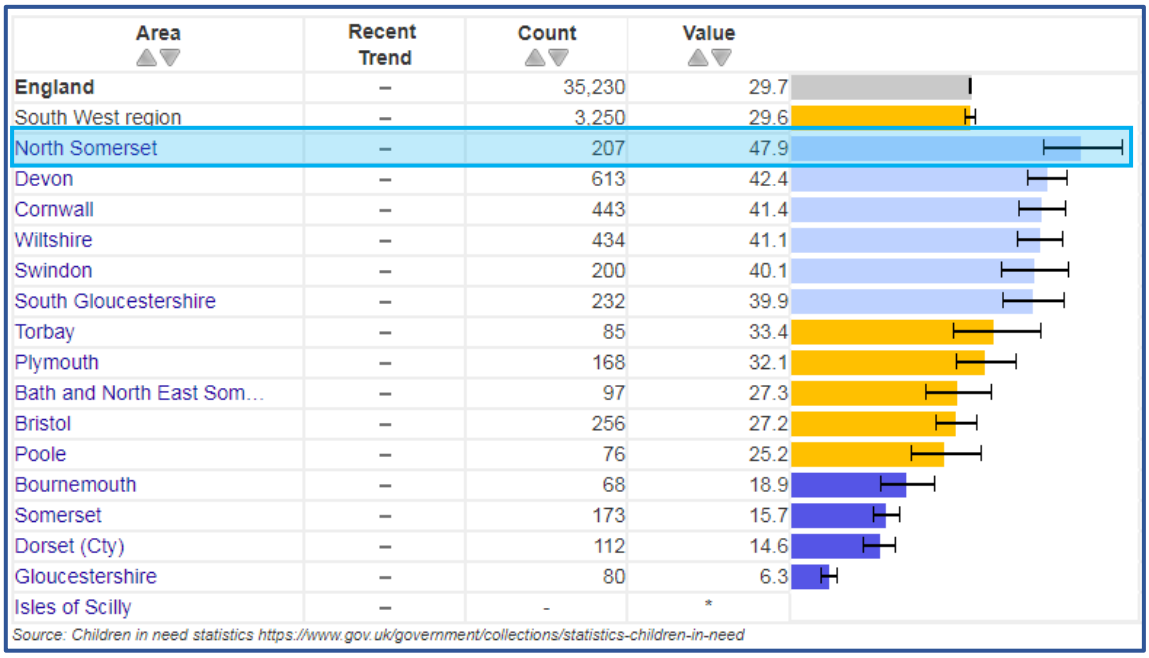
Area	Recent Trend	Count	Value
England	–	399,802	12.3
South West region	–	40,330	12.9
Poole	–	1,398	16.8
Torbay	–	1,294	15.2
Swindon	–	1,801	14.5
Bristol	–	3,023	14.5
Devon	–	5,578	14.1
South Gloucestershire	–	2,035	12.9
Plymouth	–	2,142	12.9
Dorset (Cty)	–	3,661	12.7
Cornwall	–	3,651	12.6
Somerset	–	3,722	12.6
Wiltshire	–	3,613	12.5
Isles of Scilly	–	33	12.2
Bournemouth	–	1,221	12.1
Gloucestershire	–	4,459	11.7
Bath and North East Som.	–	1,450	11.2
North Somerset	–	1,249	10.1

Figure 54: *The number of secondary school age children who are identified as having special educational needs expressed as a percentage of all school pupils (2018). Source: PHE Local Authority Health Profile, based on Department for Education special educational needs statistics*

f. Disabled Children and Young People

Many children and young people with or without SEN may have a physical disability or mental impairment under the Equality Act 2010 – that is '…a physical or mental impairment which has a long-term and substantial adverse effect on their ability to carry out normal day-to-day activities'[98]. This definition includes sensory impairments such as those affecting sight or hearing, and long-term health conditions such as asthma, diabetes, epilepsy, and cancer[98].

Local data on the prevalence of physical disability needs in the childhood population is based on those children identified as 'in need due to child disability or illness', which means they were receiving support from children's social care, for example through the disabled children's service[99]. In 2018 207 children in North Somerset were recorded as being 'in need' due to child disability or illness (see **Figure 55**). This is a rate of 47.9 per 10,000 pupils, which is the highest rate in the South West region (South West average of 29.6, and England average of 29.7).



Area	Recent Trend	Count	Value
England	–	35,230	29.7
South West region	–	3,250	29.6
North Somerset	–	207	47.9
Devon	–	613	42.4
Cornwall	–	443	41.4
Wiltshire	–	434	41.1
Swindon	–	200	40.1
South Gloucestershire	–	232	39.9
Torbay	–	85	33.4
Plymouth	–	168	32.1
Bath and North East Som...	–	97	27.3
Bristol	–	256	27.2
Poole	–	76	25.2
Bournemouth	–	68	18.9
Somerset	–	173	15.7
Dorset (Cty)	–	112	14.6
Gloucestershire	–	80	6.3
Isles of Scilly	–	-	*

Source: Children in need statistics https://www.gov.uk/government/collections/statistics-children-in-need

Figure 55: *The number of children identified as 'in need' due to child disability or illness on 31st March expressed as a rate per 10 000 resident population under 18 years (2018). PHE Local Authority Health Profile, based on children in need statistics*

g. Long Term Health Conditions

It is important to ensure children and young people with long term conditions or complex health needs are supported to achieve the best possible outcomes and can engage with learning, whilst maintaining their health and social wellbeing[100]. Education attainment can be affected by school absences due to hospitalisation, frequent appointments or lack of support to promote attendance. There may also be an impact on the child's ability to integrate with their peers and affect general wellbeing and emotional health[100]. People with chronic conditions have a 2-6 times higher risk of mental health illness.[69]

Overall North Somerset has a lower rate of emergency hospital admissions for children and young people under 19 years for asthma, diabetes and epilepsy compared to the South West regional and England averages, as shown in **Table 12**. As the number of admissions for these conditions are low small changes in numbers can have large impact on the rates.

In the WAY survey of 15 year olds (**Figure 44, on page 53**) 15.3% of those surveyed from North Somerset reported having a long-term illness, disability or medical condition diagnosed by a doctor. This was slightly above both the South West regional (14.5%) and England (14.1%) average. Consideration needs to be made to how the needs of these young people can be understood and responded to, for example tracking through GP or school nurse records.

Table 12: *Hospital admissions for asthma, diabetes and epilepsy of children and young people under 19 years - crude rate per 100,000. Source: PHE Local Authority Health Profile, based on Hospital Episode Statistics (HES)*

Long Term Condition Admissions	Count	North Somerset	South West region	England

Admissions for asthma (2017/18)	66	144.9	147.0	186.4
Admissions for diabetes (2016/17)	15	33.1	56.4	55.1
Admissions for epilepsy (2016/17)	27	59.6	76.5	72.1

h. Adverse Childhood Experiences

Adverse Childhood Experiences (ACEs) are traumatic events that affect children while growing up, such as suffering child maltreatment or living in a household affected by domestic violence, substance misuse or parental mental illness. Evidence shows children and young people exposed to ACEs have an increased risk of health-harming behaviours across the life course, including increased binge drinking, poor diet, smoking, violence perpetration, substance misuse, unintended teenage pregnancy and increased risk of interface with criminal justice[8]. Research into the long-term impact of multiple risk factors within a child's home environment shows a strong association between the number of ACEs and the risk of mental health problems, chronic diseases, involvement in crime and other poor outcomes in later life[8].

***Table 13**: Estimated number of North Somerset adults (≥20 years) and children (≤19 years) who have experienced each type of ACE during childhood based on % of England adults reporting as experiencing each ACE during childhood. Source: English national ACE study (Bellis et al[101]), population based on ONS Mid-year 2016 Population Estimates*

Adverse Childhood Experience (ACE)	% of adults in England who have experienced each ACE	Estimated number of North Somerset adults (≥20 years)	Estimated number of North Somerset children (≤19 years)
Verbal abuse	18%	29,592	8,478
Physical abuse	15%	24,660	7,065
Sexual abuse	6%	9,864	2,826
Parental separation	24%	39,456	11,304
Domestic violence	13%	21,372	6,123
Mental Illness	12%	19,728	5,652
Alcohol abuse	10%	16,440	4,710
Drug use	4%	6,576	1,884
Incarceration	4%	6,576	1,884

A national study found for every 100 adults in England, 48 suffered at least one ACE during their childhood and nine have suffered four or more[101]. Modelling that for the current North Somerset population of 164,400 adults aged 20+ years *(based on ONS Mid-year 2016 Population Estimates),* means 78,912 North Somerset adults possibly experienced at least one ACE during childhood, with 14,796 possibly having experienced four or more.

Table 13 shows the percentage of adults in England who reported suffering each ACE at some point during their childhood. These figures have been extrapolated to the North Somerset adult and child population. These figures suggest there could be a large amount of unmet need in the population which impacts on adult's individual health and wellbeing, and in their role as parents. However, ACEs are not predictive at an individual level and impacts of early life adversity differ widely from person to person, and experiencing ACEs in childhood does not necessarily reflect a person's current situation, needs or risks[8].

If all 47,100 children under 19 in North Somerset reach adulthood with the same predicted number of ACEs, there will be an additional 22,608 adults with at least one ACE and 4,239 with four or more. Reducing the number of children experiencing ACEs through early intervention could significantly reduce future levels of health and social needs in the population (**Figure 56**). The Early Intervention Foundation calculated the cost of late intervention in North Somerset to be £48 million (£229 per person)[102].

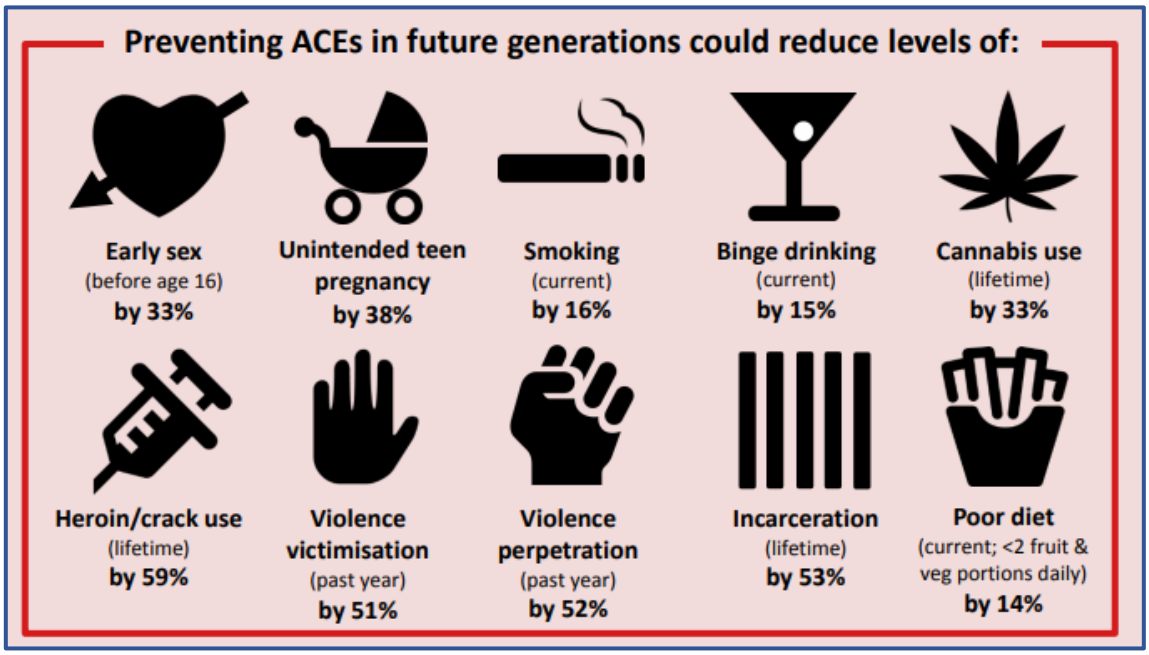


Figure 56: *Estimated reduction of health-harming behaviours if ACEs in childhood were prevented. Source: English national ACE study (Bellis et al[101]).*

5. Evidence Based Practice

This section sets out what the evidence tells us about what interventions will be most effective in improving outcomes for children and young people at both the early years (under-fives) and school age (5-19 years) stages.

Early intervention, evidenced-based, programmes can have a significant impact for all children, young people and families and especially those needing more targeted support[8].

Health Child Programme: Pregnancy and the first five years of life

The Healthy Child Programme: Pregnancy and the first years of life is a key vehicle for realising the ambition of 'giving children the best start in life'. [103104]

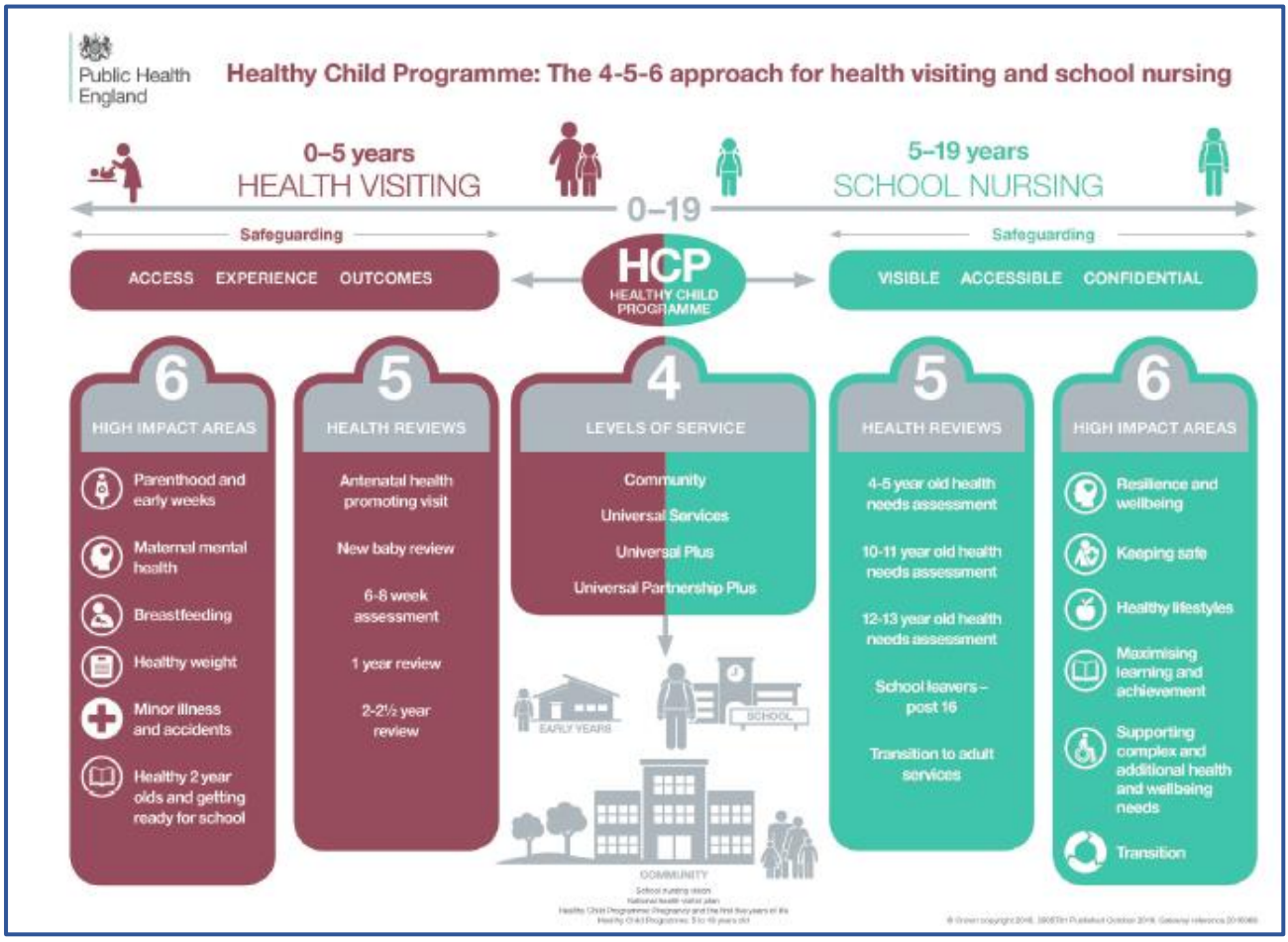


Figure 57: *The 4-5-6 model (4 levels of service; 5 key contact points and 6 high impact areas): an evidence-based framework on which health visitors and school nurses, as leaders of the Health Child Programme, can maximise their contribution. Source: Public Health England[84]*

As shown in **Figure 57** within the Healthy Children Programme there are four levels of services (Community, Universal, Universal Plus, and Partnership Plus)[105]:

'Community' level services aim to build resilience in the population and strengthen parent's capacity to support their own children's development and enable families to take control of their own health and wellbeing.

Making Every Contact Count (MECC) is an approach to health promotion and behaviour change that utilises everyday interactions that people have, to ultimately lead to positive effects on health and wellbeing[106]. MECC can be used by all those who have contact with children, young people, their parents, carers and the wider family in the community to have health promoting conversations about all the Healthy Child Programme high impact area health topics.

'Universal' services are available to all families and are vital elements of the Healthy Child Programme which include five mandated child health and development reviews (see **Figure 57**) delivered by the health visiting service, screening, immunisations, social and emotional development support for parenting and health promotion activities[107]. Universal services also provide a means to identify children and families in need of extra support.

'Universal Plus' services are provided to those who could benefit from more intensive support to address specific concerns on health issues. **'Universal Partnership Plus'** services provide seamless multi-agency support for children with complex health and/or additional needs, including safeguarding. In this document 'Universal Plus' and 'Universal Partnership Plus' services are referred to as **'targeted' services.**

The six early years high impact areas shown in **Figure 57** are the areas which have been shown to provide the biggest impact in improving outcomes for children. These have recently been revised to link to current policy drivers and recent evidence[84,107].

a. High Impact Area 1: Transition to Parenthood

Promoting preconception care and being fit for pregnancy are key aspects of improving pregnancy and early years outcomes[30]. Pregnancy presents an opportunity to influence lifestyles and maximise health and wellbeing as for many new parents-to-be it will be the first time they have had sustained contact with health services[108]. Evidence suggests parents-to-be should be provided with information around the following lifestyle considerations during the preconception and antenatal period, and offered interventions to support behaviour change where needed[108]:

- **Stopping smoking:** Identifying smokers through discussion and a CO test and referring them to NHS Stop Smoking Services and psychosocial behaviour change interventions helps achieve smoking cessation in pregnancy[107,109]. Evidence for the effectiveness of nicotine replacement therapy is mixed[107,109]. Financial incentives to stop smoking in pregnancy may be helpful, especially for socio-economically disadvantaged women, but more research is needed[107,109].
- **Healthy diet and nutritional supplements**: The benefits of a healthy balanced diet with supplements of folic acid and vitamin D should be discussed before conception early in pregnancy[110]. The Healthy Start scheme and vitamins should be promoted to eligible women[110,111].
- **Physical activity:** The benefits of physical activity and moderate exercise should be discussed with all pregnant women, as well as the potential dangers of certain activities e.g.

contact sports[110,112]. Women who have been sedentary before pregnancy are recommended to follow a gradual progression of exercise[112].

- **Healthy weight**: Achieving a healthy weight pre-pregnancy will have a greater influence on pregnancy outcomes[108,113]. Interventions in pregnancy for women with obesity (BMI over 30), particularly promoting a healthy diet, can reduce weight gain and may reduce risk of some complications[113]. Dieting during pregnancy is not recommended[113]. Structured weight-loss programmes for obese women after childbirth can improve outcomes for subsequent pregnancies[111,113].
- **Antenatal and new-born screening** and **immunisation programmes** should be offered routinely to all pregnant women[33,34,36].
- **Alcohol and substance consumption:** Women should be given advice that whilst pregnant the safest approach is not to drink alcohol[40]. Pregnant women who misuse substances (alcohol and/or drugs) should be referred to an appropriate substance misuse programme[114].
- **Domestic Violence and abuse:** Women should be given the opportunity to disclose domestic violence in an environment in which they feel secure[110]. Women who disclose that they are being abused should be given information about agencies who can provide support, including third-sector agencies[114].

Transition to parenthood and the 1001 critical days from conception to age 2 is widely recognised as a crucial period in the life course of a developing child[47]. There is a significant body of evidence that demonstrates the importance of sensitive attuned parenting on the development of the baby's brain and in promoting secure attachment and the foundations of early language[1]. Attachment-focused perinatal parenting programmes have been shown to improve outcomes and improve the relationships between parents and their baby from pregnancy onwards[115,116]. Evidence supports the use of validated tools to identify infants who may be at risk of poor attachment and parents who need more support to attune to their infants[116].

Transition to parenthood may be more difficult for parents and carers who are experiencing complex social factors, such as social deprivation, substance misuse, exposure to domestic violence and abuse, and own experience of ACEs[84]. Other factors which may affect parenting ability include, parental and infant disability and chronic illness, perinatal mental illness, teenage parents, family conflict and/or social isolation[84]. Guidelines suggest parents with additional complex social needs should have a multi-agency needs assessment, including any safeguarding issues, and referral to additional support services[114].

Intensive home visiting programmes are recommended for children who are vulnerable to poor social and emotional wellbeing[117]. Guidance also suggests baby massage and video interactive guidance (VIG) as evidence-based interventions to improve maternal sensitivity and mother-infant attachment for vulnerable groups[117].

For more information on this high impact area: Early years high impact area 1: transition to parenthood

b. High Impact Area 2: Maternal Mental Health

Ensuring that women receive access to the right type of mental health care during the perinatal period is a key government priority[118].

NICE Guidance highlights the importance of having multi-disciplinary care pathways and integrated service models delivering effective mental health care to mothers, fathers and their infants during the perinatal period[119,120]. Validated tools should be utilised by trained health professionals at routine antenatal and postnatal contacts to assess and identify early any issues with mother's mental health and/or infant attachment[119,116].

Specialist health visitors in perinatal and infant mental health and health visitor champions are recommended to provide specialist training and consultation to the wider health visiting and early years workforce[121].

Women experiencing poor mental health in the perinatal period should be signposted or referred to specialist interventions and therapeutic support at an early stage so they can make a good recovery and prevent the long-term effects on the relationship with the baby and on the child's later development[38].

The prevention concordat for better mental health gives guidance for local areas to take positive and much needed action to improve public mental health and prevent mental health problems across the life course[122]. Whole population approaches to public mental health include: Improving health literacy; developing mentally healthy communities and places; and reducing stigma and discrimination[122].

For more information on this high impact area: Early years high impact area 2: Maternal mental health.

c. High Impact Area 3: Breastfeeding

The national Better Births Review and the Maternity Transformation Programme highlights the importance of providing support for breastfeeding[123,124]. Maternity and health visiting services should work closely together to provide seamless support and care for pregnant women and mothers, giving them an opportunity to learn about infant feeding, the benefits of breastfeeding and the risks associated with not breastfeeding[111].

It is recommended that a whole systems approach is applied to promoting breastfeeding through the implementation of the UNICEF Baby Friendly Initiative (BFI) across maternity, health visiting, neonatal and children's centre services[125,126,111]. As part of these standards all midwifery and health visiting staff should receive training in breastfeeding support and be able to provide practical help and advice to mothers on how to breastfeed and help with managing and resolving breastfeeding problems, and this should be embedded in NHS and local authority commissioning documents[126,111].

Evidence shows breastfeeding support is effective when offered by skilled professionals or lay/peer supporters, or a combination of both[127,126,111]. Guidance suggests infant feeding and social support should be available if required e.g. through children's centres, peer support groups and telephone and online support[125,126]. Specialist support services should be available to those experiencing more complex issues related to breastfeeding[126]. Targeted support for young parents and those living in socially disadvantaged areas may improve breastfeeding rates in these areas[126,111].

It is recommended that mothers are supported to feel confident about feeding their babies when out and about by receiving information about local businesses, shops and public premises within the local authority which have signed up to be breastfeeding friendly environments[126].

When women decide not to breastfeed they should be supported in that decision and provided with individual information on how to make up a feed, types of milk available and encouragement to use only first milk until the baby is one year old[111,128]. Support should also be given to promote bonding and secure attachment between mother and infant independent of what feeding method thy have chosen, and this should be embedded in NHS and local authority commissioning documents[125].

For more information on this high impact area: Early years high impact area 3: Breastfeeding.

d. High Impact Area 4: Healthy Weight, Healthy Nutrition

In 2016, the government published 'Child Obesity A Plan for Action' with the aim of significantly reducing childhood obesity by supporting healthier choices[53]. In 2018 new measures were announced in chapter 2 of the plan to halve childhood obesity and significantly reduce the gap in obesity between children from the most and least deprived areas by 2030[129]. Obesity is a complex problem with many drivers, including behaviour, environment, genetics and culture. Government policy therefore sets out a whole system approach to tackling obesity and promoting healthy eating and physical activity across the life course[53,129].

Maternal overweight is an indicator for future childhood overweight, therefore it is important to address maternal weight as women prepare for pregnancy and during the antenatal and postnatal period[110,113]. Involving partners in conversations is important as paternal overweight is also an indicator for childhood overweight.

Parents should receive consistent messages and opportunities to discuss issues or concerns, advice on behaviours, attitudes and family practices around food and physical activity[130]. Midwives and Health Visitors should also discuss the importance of the Healthy Start scheme with eligible families[56,111].

It is recommended early years settings including nurseries, creches, childminders and playgroups have a food policies and have a 'whole-settings' approach by taking every opportunity to encourage children to handle and taste a wide range of foods that make up a healthy diet[111].

Support should be provided through community-based initiatives which should aim to make a balanced diet more accessible to people on a low income e.g. food cooperatives, cook and eat clubs, weaning groups and baby cafes[111]. It is recommended that families with children identified as being overweight or obese are given information about and referred to local healthy lifestyle and weight management programmes[131].

For more information on this high impact area: Early years high impact area 4: Healthy weight, healthy nutrition.

e. High Impact Area 5: Managing Minor Illnesses and Reducing Accidents

Illnesses such as gastroenteritis and upper respiratory tract infections, along with injuries caused by accidents in the home, and poor oral health are the leading causes of attendance at A&E and hospitalisation amongst under 5s[84].

Improving child oral health requires a whole systems approach with action across the sector, from national and local policy, healthcare to families and the food and drink industry[57]. Guidance suggests families should be provided with information around the top three interventions for improving tooth decay[58]**Error! Bookmark not defined.**:

- Reducing the consumption of foods and drinks that contain sugars
- Brushing teeth twice daily with fluoride toothpaste
- Taking children to the dentist when the first tooth erupts, at about 6 months and then on a regular basis

Socially disadvantaged children are more likely to have poor oral health. It is recommended that the following targeted programmes are considered for children at higher risk of poor oral health[132,133]:

- Supervised tooth brushing schemes
- Provision of free toothbrushes and toothpaste
- Community fluoride varnish programmes

Water fluoridation is the only oral health improvement intervention that does not require behaviour change by individuals. However, introducing water fluoridation is a significant political decision[58].

Using a health promotion approach with families, with a focus on prevention and self-efficacy can help reduce unnecessary visits and burden on primary care and A&E[84]. This includes improving parent's health literacy to manage minor illnesses, including providing evidence-based information relating to immunisations, antimicrobial resistance and the appropriate use of antibiotics[84]. Parents should also receive advice on signs and symptoms of more serious diseases such as meningitis and sepsis, and when to seek urgent medical attention[84], and this should be embedded in NHS and local authority commissioning documents.

Consistent evidence-based and developmentally-specific safety advice and support should be promoted across all early year's services during routine contacts, focusing on the five leading causes of injury[134]. Health visiting, and school nursing teams should review all A&E and routine hospital attendances and offer follow up where concerns are highlighted[135], for example repeat A&E attendances, families where there are known vulnerabilities, delayed presentation of injury, inconsistent explanation, serious head injuries, burns and fracture or dental injuries.

Guidelines suggest home safety assessments, including education, advice and information, and the supply and installation of home safety equipment should be targeted to families most at risk, including low income families, those living in poor accommodation, and young parent families [62,136,].

For more information on this high impact area: Early years high impact area 5: Managing minor illnesses and reducing accidents (improving health literacy).

f. High Impact Area 6: Health, Wellbeing and Development of the Child Aged 2

The mandated 2–2½ year health and development review delivered by the health visiting service is an opportunity to assess a child's progress, aiming to optimise child development and emotional wellbeing, reduce health inequalities and promote school readiness[84]. Parents should be given the opportunity to actively participate in their child review through the use of the Ages and Stages Questionnaire (ASQ) which forms part of the holistic assessment[84]. This development review provides an opportunity to promote responsive parenting, behaviour management including sleep,

promoting development, play and a language-rich home learning environment and the promotion of free early years childcare offer for eligible families[84]. Where the child is already attending an early years' service this review should be integrated with the Early Years Foundations Stage (EYFS) progress check carried out at age two[84,64].

To close the word gap (early language and literacy skills) often faced by disadvantaged children, there needs to be a focus on creating learning rich home environments through evidence-based programmes and improving the availability and take-up of high-quality early years provision by disadvantaged children[65,66,137]. Evidence-based early intervention programmes and practices have shown to help parents and practitioners to support children's development and improve outcomes[8]. Where signs of speech and language delay have been identified early intervention and specialist support should be offered, and this support needs to be effectively commissioned by the NHS and local authority[66].

Multidisciplinary meetings should take place for children in the early years who have a disability and/or complex health care need to help coordinate care. An integrated Education, Health and Care (EHC) plan should be developed jointly with the parents to support early years children with SEN or disabilities[98]. Appropriate packages of care and support should be commissioned by the NHS and local authority to meet these needs.

Where the need for additional support is identified or there are safeguarding concerns there should be timely referrals to appropriate multi-agency support packages including early help, the troubled families programme, and safeguarding[138]. It is important that NHS and local authority commissioners design services with these needs in mind.

For more information on this high impact area: Early years high impact area 6: Health, wellbeing and development of the child aged 2: Ready to learn, narrowing the 'word gap'.

Summary table of evidence-based practice for the early years population:

Early Years	Transition to Parenthood	Maternal Mental Health	Breastfeeding	Healthy Weight, Healthy Nutrition	Manage Minor Illness and Reducing Accidents	Health, Wellbeing and Development
Community	• Use health promotion and Making Every Contact Count (MECC) to promote health behaviours and healthy lifestyles across all high impact areas • Local community and voluntary-led activities including children's centre activities, libraries, group-based support, peer support, father & partner groups, joint developments with parent volunteers and services • Promotion of national social marketing campaigns and online resources e.g. Start4life, change4life, One You, Choose Well, Stay Well This Winter, Dental Checks by One, Smoke free					
		• Local adoption of the prevention concordat for Better Mental Health, including initiatives to improve health literacy and reduce mental health stigma and discrimination	• Provide breastfeeding support groups and cafes, breastfeeding peer support programmes, telephone and online breastfeeding support • Breastfeeding friendly environments	• Provide safe active play and physical activity opportunities, fruit & vegetable co-operatives, cook & eat clubs, food bank activities • Whole early years setting approach to promoting healthy nutrition and physical activity	• Water fluoridation to reduce tooth decay	
Universal	• Promote preconception care in routine primary care contacts with women of reproductive age (e.g. GPs, pharmacies, health visitors) • Provide antenatal education around preparing for parenthood • Apply a universal preventative approach to promoting positive parenting and early attachment • Use validated tools to identify infants who may be at risk of poor attachment	• Complete a holistic maternal needs assessment at antenatal booking appointment to identify women with a history of mental illness or those who may be at increased risk • Use of validated tools at routine antenatal and postnatal contacts to identify women in need of additional support around mental health and attachment	• Provide antenatal education around the benefits of breastfeeding • Universal implementation of the UNICEF BFI standards across maternity, health visiting, neonatal and children's centre services • Consistent evidence-based messages & support around responsive formula feeding, bonding and attachment	• Health visitors monitor child weight through clinics and as part of the universal reviews	• Promote the national childhood immunisation programme • Provide consistent evidence-based messages around oral health promotion, managing minor illness and improving health literacy at routine contacts • Provide safety advice to parents around the 5 main causes of injuries at routine contacts and following injuries presented to primary and secondary care • Health visitors to review all A&E and hospital attendances to identify children who require further assessment and interventions	• 2–2½ year health and development review delivered by health visitors using the Ages and Stages Questionnaire (ASQ), integrated with the Early Years Progress Check • Parents and caregivers provided with information on ways to promote learning rich home environments
Targeted	• Signpost and refer (pre-conception, during and after pregnancy) to specialist lifestyle support services, including weight management & smoking cessation • Provide targeted attachment-focused perinatal parenting programmes for families at greater risk • multiagency needs assessments and additional support for families experiencing complex social factors • Provide Intensive home visiting programmes & family support for vulnerable families, including targeted interventions such as baby massage and VIG	• Specialist health visitors in perinatal and infant mental health and Health Visitor Champions to deliver home and family-based low-level interventions • Signposting and referral to primary care and specialist support services depending on severity of need, including IAPT services (Improving Access to Psychological Therapies), specialist perinatal mental health services, secondary adult mental health services, CAHMS (child and adolescent mental health services)	• Targeted breastfeeding support for teenage parents and those living in socially disadvantaged areas • Provide specialist breastfeeding support services for mothers experiencing more complex issues	• Promote the Healthy Start scheme & vitamins to eligible families • Signpost and refer overweight or obese parents into specialist lifestyle support services, including maternity and adult weight management services • Deliver evidence- based parenting & healthy lifestyle / weight management programmes for families	• Provide targeted oral health programmes such as fluoride varnish, supervised brushing, and provision of free toothbrushes and toothpaste • Provide targeted home safety assessments and supply and installation of safety equipment	• Promote free early education and childcare for eligible children • Signpost and refer into early intervention and specialist support where developmental and/or speech & language delay and additional needs are identified • Develop an Integrated Educated, Health and Care (EHC) plan for early years children with disability and/or complex health care needs • Refer into multi-agency support packages where risks to the child's welfare or safety are identified

Healthy Child Programme: From 5 to 19 Years Old

Figure 57 on **page 67** provides an overview of the Healthy Child Programme: From 5 to 19 years old, which puts the school nursing service as the lead health professionals in the delivery of the school aged programme.[139,104,140,141]

There are four levels of service for the Healthy Child programme for school aged children and young people (Community, universal, Universal Plus and Universal Partnership Plus)[105].

At a **community level** a whole-school-approach is recommended to support child health promotion at a population level[142], for example through schools participating in a 'healthy school' programme. Research shows that education and health are closely linked, and therefore schools provide an ideal location to improve both educational and health and wellbeing outcomes[84]. Further and higher education colleges and Pupil Referral Units (PRUs) should also be considered as opportunities to reach young people. Out-of-school, arts and leisure provision (e.g. creative activities, music and sports and volunteering) provide further opportunities for reaching children and young people.

It is important to ensure **'universal'** and **'targeted' ('Universal Plus' and 'Universal Partnership Plus')** interventions and services for school aged children and young people are delivered in locations and at times that are appropriate to their needs[84]. This may include home visits or community locations as well as at schools and colleges.

Local health services should be encouraged to adopt the 'You're Welcome' quality criteria for young people friendly health services[143]. Improving accessibility of services includes using technology e.g. texting health advice service, using safe social media approaches and email contact. Coproduction with children, young people and their parents when services are designed will help advise how local services can be most effective in reaching local needs, and local commissioners should routinely work in this way.

The six high impact areas for the school aged years 5 to 19 (shown in **Figure 57**) have been developed based on the evidence of which areas can provide the biggest impact on health and wellbeing outcomes for this age group.

a. High Impact Area 1: Resilience and Emotional Wellbeing

The government has set out its vision for a step-change in children and young people's mental health. The Five Year Forward View for Mental Health sets out an ambition for transforming mental health services to achieve greater parity of esteem between mental and physical health[144]. Future in Mind highlighted the need to build resilience, promote good mental health through prevention, and to provide early identification and co-ordinated support[68].

Young people who have low resilience will be more likely to respond to stress by developing anxiety and depression. Public Health guidance suggests local authorities and schools can improve children and young people's resilience by[145]:

- Establishing a local culture that prioritises resilience and improving young people's personal coping skills.

- Enhancing the availability and quality of local support e.g. voluntary sector mental health provision, opportunities for regular physical activity and places to go including access to youth settings, sexual health advice, and housing.
- Picking the moment to intervene by focusing on 'stress' points such as transition points, and more vulnerable young people, including those in care, those with long-term conditions or those who have had support from Child and Adult Mental Health Services (CAHMS).

Guidance supports adopting a whole school or college approach to prompting social and emotional wellbeing and resilience[122,146,147,148]. **Figure 58** presents the eight principles to promoting emotional health and wellbeing in schools and colleges[149].

***Figure 58**: Eight principles to promoting a whole school and college approach to emotional health and wellbeing. Source: PHE[149]*

Personal, social, health, economic education (PSHE) has been identified as a cost-effective prevention activity to promote good mental health and reduce the impact of poor mental health in children[122,150]. The Department of Education (DE) also advocates for all schools to have structures in place which allow pupils to have a real say in issues that affect them and to know that their opinions count, including school councils[151].

It is important that targeted interventions are available for those children more at risk of poor resilience and mental health; in 2017 a Mental Health Green Paper set out the following three proposals[67]:

- Designated mental health leads in all schools
- New mental health support teams prioritising working with children experiencing mild to moderate mental health problems
- Trialling reduced waiting times for specialist mental health services, e.g. CAHMS, counselling services

These prioritise will be considered for local implementation through multiagency partnerships.

For more information on this high impact area: School aged years high impact area 1: Resilience and emotional wellbeing.

b. High Impact Area 2: Reducing Risky Behaviours

Risky behaviours are those that potentially expose young people to harm, or significant risk of harm which will prevent them reaching their full potential[84]. These include early or risky sexual behaviour, drug and alcohol misuse, smoking, and behaviours which increase the risk of accidents and injury.

Introducing and delivering the new compulsory Relationships Education (RE) in all primary schools, and compulsory Relationship and Sex Education (RSE) in all secondary schools will become legislated, making covering the subjects a statutory duty[152]. Whilst the most pressing safeguarding concerns relate to Relationships and RSE, wider concerns about child safety and wellbeing, such as understanding of the risks of drugs and alcohol[153], smoking, growing up in a digital world, and physical and mental health should be included in the wider PHSE curriculum. These topic areas should be integrated into the wider curriculum of a range of subjects including biology, chemistry, citizenship, information technology and media studies.

Guidance suggests as well as ensuring alcohol education is an integral part of the education curricula, children and young people who are thought to be drinking harmful levels of alcohol should be offered brief, one-to-one advice of the harmful effects and how to reduce risks. Where appropriate they should be offered a referral to external more specialist services[153].

It is recommended schools have smoke-free policies; run smoking prevention activities and staff training and development[154].

Children and young people need access to timely, confidential services where they can access advice on risk taking behaviours e.g. school nursing services. This also includes access to specialist substance misuse services, smoking cessation services, sexual or reproductive health services, child sexual exploitation and sexual abuse services, and teenage pregnancy advice services.

The Teenage Pregnancy Prevention Framework endorses a 'whole systems' approach to reducing teenage pregnancy, which includes building the knowledge, skills, resilience and aspirations of young people and providing easy access to welcoming services[13]. Partnership working, and commissioning plans should reflect these prevention and health improvement approaches for this vulnerable group.

For more information on this high impact area: School aged years high impact area 2: Keeping safe: Reducing risky behaviours.

c. High Impact Area 3: Improving Lifestyles

Children and young people face many different factors which influence their ability to live a healthy lifestyle: this includes personal choices and behaviours, the environment, social networks and the media[84].

Children, young people and their parents and carers should be provided with consistent evidence-based messages and support around oral health promotion, encouragement to eat healthily in line

with national guidelines[155] (including recommended daily sugar consumption), and the recommended levels of physical activity[52].

It is recommended that schools create a healthy school culture and promote healthy lifestyles as the norm[156]. A whole school approach includes having a healthy eating policy, delivering PSHE relating to healthy lifestyles, and using national health promotion resources to support lessons. Weighing and measuring of children in primary schools should be explained to pupils and they should learn about healthy lifestyles after they have been weighed and measured[84]. A healthy schools programme exists in North Somerset which could be used to encourage schools to address important issues identified in local strategies.

The National Childhood Obesity Strategy states that working with, and supporting, schools is one of the key priorities[53,129]. At least 30 minutes of physical activity should be delivered in school every day through active break times, PE, extra-curricular clubs, active lessons, or other sport and physical activity events, with the remaining 30 minutes supported by parents and carers outside of school time[53]. School should be supported by local authorities and county sports partnerships in how they spend Primary PE and the Sport Premium funding for maximum impact. Community and voluntary-led initiatives including youth provision, sports clubs, and cooking classes can provide opportunities for children and young people to learn about healthy lifestyles[84].

Health and care professionals should be supported to feel confident about talking about weight management with families of children or young people with excess weight and referring families to weight management services[157], particularly following parents receiving NCMP (National Child Measurement Programme) results. An effective range of weight management services is needed to support families to achieve and maintain a healthy weight[131].

For more information on this high impact area: School aged years high impact area 3: Improving lifestyles.

d. High Impact Area 4: Maximising Learning and Achievement

Promoting health literacy skills to children at the transition from primary to secondary school builds young people's knowledge and skills about health and wellbeing and empowers them to make decisions about their own health and how to access and use health services appropriately[158].

Vulnerabilities that impact on a child or young person's education and school attendance should be identified early and support offered to help access additional services. Vulnerable groups include: children in care; young people who are NEET; young carers; young offenders; the homeless; travelling families; asylum seekers and refugees; children from military families; children experiencing ACEs; teenage pregnancy; and those experiencing poor mental health or bullying. It is important that services continue to be provided and remain accessible to these vulnerable groups.

Statutory guidance states all children in care must receive an initial health assessment by a registered medical practitioner, with regular reviews, and have an up-to-date individual health plan based on the health assessment[98]. Local services should recognise and give due account to the greater physical, mental and emotional health needs of looked after children, and this should be reflected in commissioning plans of the local authority, CCG and NHS England[98].

Local authorities are expected to take 'reasonable steps' to identify children in their area who are young carers and carry out an assessment if it appears that a young carer has needs for extra support and respite[159].

For more information on this high impact area: School aged years high impact area 4: Maximising learning and achievement.

e. High Impact Area 5: Supporting Complex and Additional Health and Wellbeing Needs

Whilst many children with complex and additional health needs (including diabetes, asthma, bladder and bowel issues (continence problems) or disability) will have their needs met within mainstream education settings, some will need additional support from specialist services. Specialist services include services for children with special educational needs (SEN), learning disability or autism, physical disability, and children with long-term conditions or complex health care needs.

Health, education and social care should work together with parents and carers to identify any additional support required for identified children[98,99]. Children and young people with more complex needs may need an Education, Health and Care (EHC) needs assessment and plan[98]. This should include regular reviews, and the whole process should be delivered in partnership with their parents or carers. The North Somerset SEND action plan will address these issues and outcomes should be tracked and monitored to demonstrate progress.

Governing bodies of all schools and academies have a duty to ensure that there are arrangements in place to support pupils with health needs, including developing relevant policies e.g. medicines management[100]. Some children with long term or complex medical conditions may require support, medication or care during the school day to ensure they remain well. School staff should be competent and have confidence in their ability to support pupils with medical conditions and be provided with advice, liaison and suitable training. Schools may arrange training with the local school nursing service, community paediatric nursing, community paediatricians, or from another relevant healthcare professional. Locally training for schools is led by the school nursing service and commissioning plans need to reflect this.

Access to universal health advice to meet the normal adolescent development needs, for example sexual health services, is equally important for young people with complex health needs[84].

For more information on this high impact area: Supporting complex and additional health and wellbeing needs. School nurses leading the Healthy Child Programme 5-19.

f. High Impact Area 6: Seamless Transition and Preparation for Adulthood

The health and wellbeing of all children should be supported at school entry and at transition points, for example from primary to secondary school, to further and higher education and/or employment, from home to independent living as a self-supporting adult, and for some the transition from child services to adult services[84]. There should be clear local pathways to support children and young people at these transition points.

Improving health literacy will help young people develop skills around informed consent and decision making about their own health, and to access and use health services appropriately[158]. This includes encouraging young people to be registered with a GP, dentist and optician if they are not already. PHSE sessions provide an opportunity to deliver 'well health' sessions, including information

about being breast/testicle cancer aware, sexual and reproductive health and drug and alcohol use[84].

Research suggests young people may be particularly vulnerable during transitional phases including those who have gender identity issues or who are part of the LGBTQ+ community, young carers or young parents[84]. Local services should therefore ensure these groups are adequately supported during these transition points.

It is important that services are in place to ensure the young person's voice is heard and that their needs are met during the transition from children's to adult's services, particularly for young people with long term health conditions or disabilities, including learning disabilities, as well as children in care[84]. Commissioning plans across NHS and local authority services should include mechanisms for effective coproduction with vulnerable young people.

For more information on this high impact area: School aged years high impact area 6: Seamless transition and preparation for adulthood.

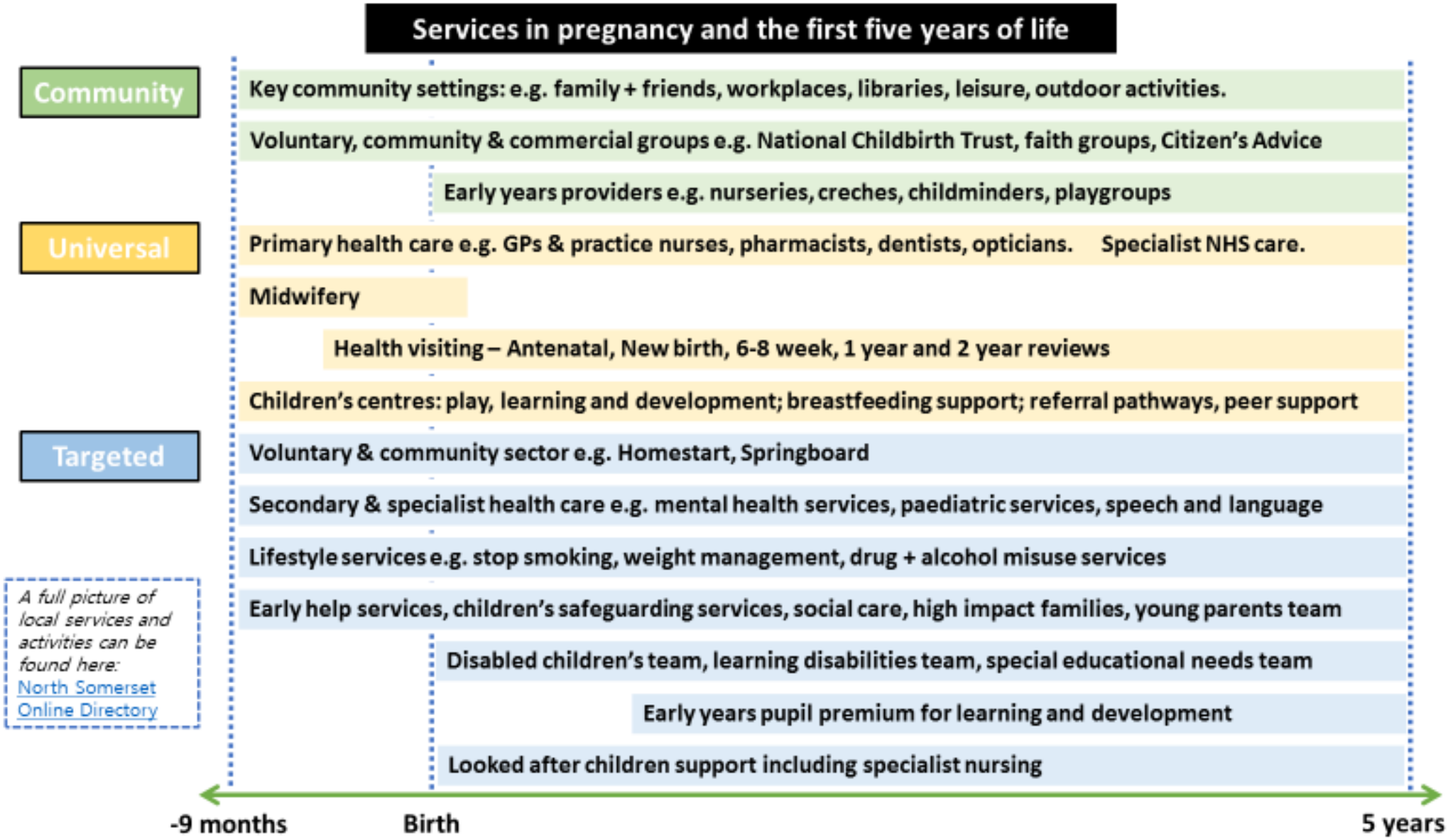
Summary table of evidence-based practice for the school aged population:

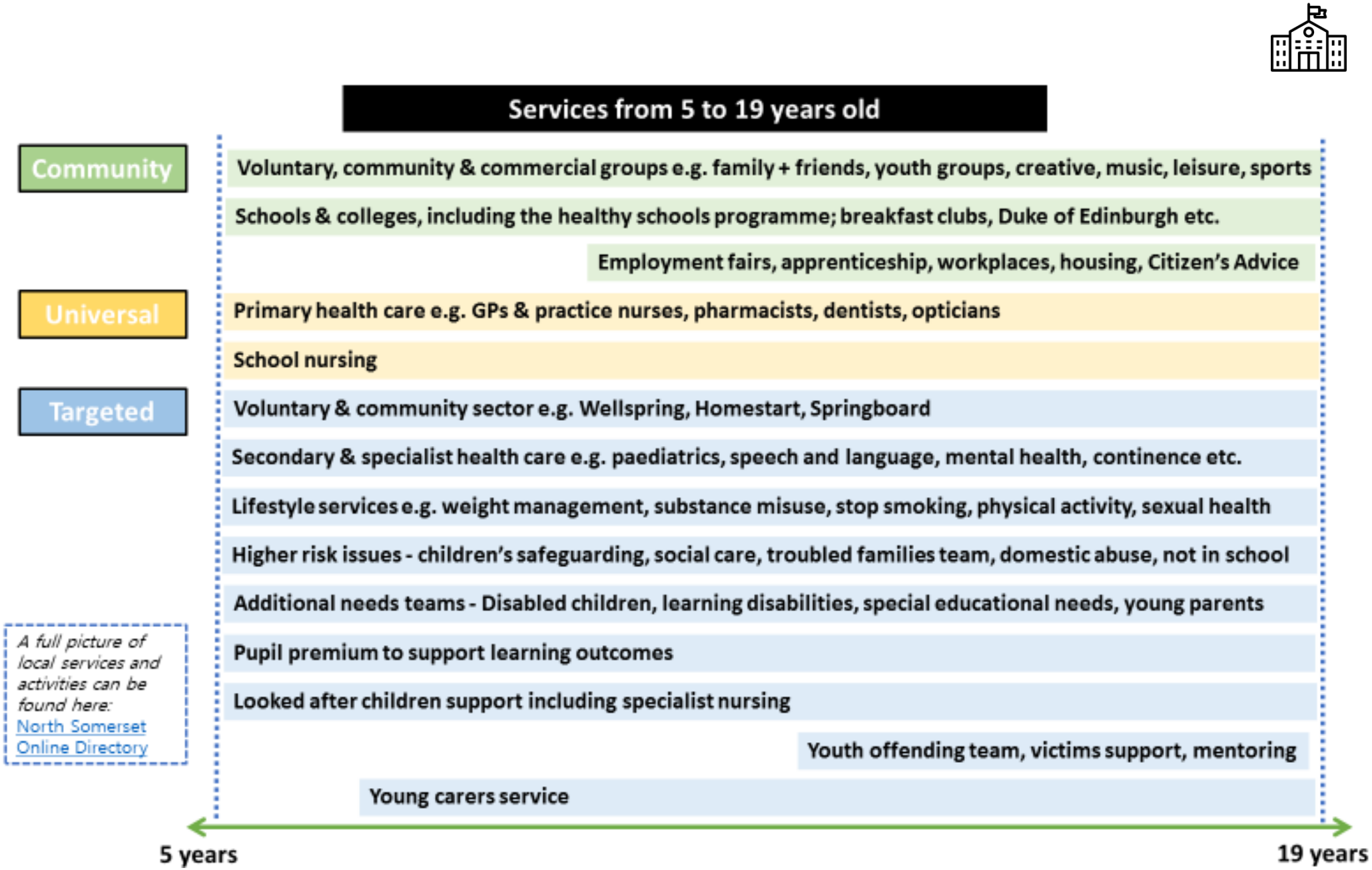
School Years	Resilience & Emotional Wellbeing	Risky Behaviours	Improving Lifestyles	Learning and Achievement	Complex and Additional Health and Wellbeing Needs	Transition and Preparation for Adulthood
Community	• Use health promotion and Making Every Contact Count (MECC) to promote health behaviours and healthy lifestyles across all high impact areas • Local community and voluntary-led activities including libraries, group-based support, physical activity opportunities, youth services, joint developments with parent volunteers and services • Promotion of national social marketing campaigns and online resources e.g. Change4life, One You, Choose Well, Stay Well This Winter, Smoke free, Rise above • Whole school approach to promote health behaviours and healthy lifestyles across all high impact areas					
	• Local adoption of the prevention concordat for Better Mental Health, including initiatives to improve health literacy and reduce mental health stigma and discrimination		• Community and voluntary led healthy lifestyle activities e.g. Streetplay and outdoor activities, fruit and vegetable cooperatives, cooking classes			• Health promotion approach to improve children and young people's health literacy to build knowledge and skills and empower them to make decisions about their health and how to use health services appropriately
Universal	• Develop school-based interventions to tackling mental health and promoting resilience, including: delivering PSHEE; having designated mental health leads in schools; programmes to prevent bullying; delivering social emotional learning programmes; school councils • Holistic assessment of children and young people's mental health and wellbeing needs during school nurse health assessments and at routine contacts e.g. at health drop ins	• Whole school approach to preventing smoking including smoke-free policies and peer-led interventions • Identify risk taking behaviours during school nurse health assessments and at routine contacts, offering one-to-one advice on reducing the risks and where to find sources of support • All schools to introduce and deliver the new compulsory relationships education (RE) in primary schools, and relationships and sex education (RSE) in secondary schools, alongside the wider PHSE curriculum	• Develop school-based interventions to support health lifestyles, including having healthy eating policies, delivering PSHEE relating to healthy lifestyles, creating physical activity opportunities • Identify lifestyle needs during school nurse health assessments and at routine contacts e.g. at health drop ins • Consistent approach to the management of lifestyle concerns related to NCMP results, offering individual support to parents and families using evidence-based techniques such as motivational interviewing to support lifestyle behaviour change	• Holistic assessment of children needs at school entry review and at other routine contacts e.g. at health drop ins to support early identification of vulnerabilities that may impact on the child or young person's education or school attendance	• Schools have arrangements to support pupils with health needs, including medicine management policies and staff supported with advice, liaison and suitable training	• Holistic assessment of children needs at school entry and other transition points • Delivery of 'well health' messages during PHSEE sessions e.g. being breast/testicle aware, how to choose and access health services appropriately
Targeted	• Early intervention and therapeutic support for mild to moderate mental health problems • Referral into primary care and specialist mental health services depending on severity of need e.g. GPs, CAHMS, counselling services	• Provision of targeted support and referral into specialist support services, including substance misuse services, smoking cessation services, sexual or reproductive health services, child sexual exploitation and sexual abuse services, teenage pregnancy advice services	• Signpost and refer into to specialist lifestyle support services when needs identified e.g. weight management programmes (tier 2 and 3) and dental services	• Refer and signpost to specialist support services to support learning and achievement, including young carers services, speech and language services, services to support social and behavioural issues • Delivery of holistic health assessments and health plans for all children in care	• Refer and signpost to specialist support services, including services for families with children with SEN , children with learning disability or autism, children with a physical disability, children with long-term conditions or complex health care needs • Education, Health and Care (EHC) needs assessment and plan developed for children with complex needs, including regular reviews	• Identify individual vulnerability factors and provide additional support during transitional phases, including LGBTQ+ children and young poeple, young carers, young parents • Additional support for young people transitioning to adult services, including those with long term health conditions or disabilities, learning disabilities, metal health conditions and young people in care

6. Services for Children and Young People

The two images on the next two pages provide a high-level mapping of key elements of support for local children, young people and families across a range of providers and commissioning responsibilities. These images are not intended to be an exhaustive list of all services – this can be found on the North Somerset Online Directory.

However, they do provide a useful overview of the types of support that is currently available to inform future service delivery. The subsequent opportunities for service development section provides some analysis of the gap between what is currently on offer and what is needed to achieve priority outcome improvements.


Services in pregnancy and the first five years of life
Community
Universal
Targeted
Key community settings: e.g. family + friends, workplaces, libraries, leisure, outdoor activities.
Voluntary, community & commercial groups e.g. National Childbirth Trust, faith groups, Citizen's Advice
Early years providers e.g. nurseries, creches, childminders, playgroups
Primary health care e.g. GPs & practice nurses, pharmacists, dentists, opticians. Specialist NHS care.
Midwifery
Health visiting – Antenatal, New birth, 6-8 week, 1 year and 2 year reviews
Children's centres: play, learning and development; breastfeeding support; referral pathways, peer support
Voluntary & community sector e.g. Homestart, Springboard
Secondary & specialist health care e.g. mental health services, paediatric services, speech and language
Lifestyle services e.g. stop smoking, weight management, drug + alcohol misuse services
Early help services, children's safeguarding services, social care, high impact families, young parents team
Disabled children's team, learning disabilities team, special educational needs team
Early years pupil premium for learning and development
Looked after children support including specialist nursing
A full picture of local services and activities can be found here:
North Somerset Online Directory
-9 months
Birth
5 years


Services from 5 to 19 years old
Community
Universal
Targeted
Voluntary, community & commercial groups e.g. family + friends, youth groups, creative, music, leisure, sports
Schools & colleges, including the healthy schools programme; breakfast clubs, Duke of Edinburgh etc.
Employment fairs, apprenticeship, workplaces, housing, Citizen's Advice
Primary health care e.g. GPs & practice nurses, pharmacists, dentists, opticians
School nursing
Voluntary & community sector e.g. Wellspring, Homestart, Springboard
Secondary & specialist health care e.g. paediatrics, speech and language, mental health, continence etc.
Lifestyle services e.g. weight management, substance misuse, stop smoking, physical activity, sexual health
Higher risk issues - children's safeguarding, social care, troubled families team, domestic abuse, not in school
Additional needs teams - Disabled children, learning disabilities, special educational needs, young parents
Pupil premium to support learning outcomes
Looked after children support including specialist nursing
Youth offending team, victims support, mentoring
Young carers service
A full picture of local services and activities can be found here:
North Somerset Online Directory
5 years
19 years

7. Service Development Opportunities

This section brings together all the information from the previous sections of the document to summarise the local service development opportunities.

The tables on the next two pages provides an overview of:

- **Unmet population needs** – these are the local population needs based on areas identified in section four where outcomes for children and young people in North Somerset are below regional or national averages and could therefore be improved.

- **Service development opportunities** - Section five described what the evidence tells us about the interventions that will be most effective in improving outcomes for children and young people at both the early years (under-fives) and school age (5-19 years) stages. This information has been compared to the information in Section six which sets out, at a high level, the types of support currently available to children and young people in North Somerset (as a snapshot taken in March 2019). The table combines these two sources of information to show where there are local gaps in services which could improve the health and wellbeing of children and young people and how we might go about addressing these.

Summary table of local service devlopment opportunites for the early years population:

Early Years	Service Level	Transition to Parenthood	Maternal Mental Health	Breastfeeding	Healthy Weight, Healthy Nutrition	Manage Minor Illness and Reducing Accidents	Health, Wellbeing and Development
(1) Unmet Needs	All Services	• Reduce the number of pregnant women smoking at the time of delivery to reach the national target of 6% by 2022 • Reduce the number of women with a BMI> 30 (obese) • Develop a parent infant attachment outcome measure	• Develop a maternal and infant mental health outcome measure(s)	• Reduce the inequalities in breastfeeding prevalence between least and most deprived wards	• Increase the uptake of Healthy Start vouchers and the number of vitamins claimed by eligible families	• Increase the number of dental checks by age 1 years • Increase the coverage of MMR and preschool booster to >95% • Reduce the trend in number of A&E attendances for children aged 0-4 years for illness/injury • Reduce the number of children being admitted to hospital with scalds and burns	• Increase the number of children eligible for free school meals achieving a good level of development at the end of the early year's foundation stage
(2) Service development opportunities based on evidence	Community	• Ensure all services are engaged with Making Every Contact Count (MECC) • Ensure easy to access and up to date information on accessing local community and voluntary groups and activities • Promote campaigns and information to parents, grandparents and carers					
			• Local adoption of the prevention concordat for better mental health including interventions to reduce stigmatisation		• Develop a whole early years setting approach to promoting healthy nutrition and physical activity		
	Universal	• Promotion of preconception care • Consistent delivery of antenatal parent education groups • Develop a universal preventative approach to promoting parenting and early attachment	•	• Sustained implementation of UNICEF BFI standards across all services • Review infant feeding messages given in antenatal education sessions		• Develop interventions to Provide consistent evidence-based messages around managing minor illness and improve parental health literacy	• Integrate the 2–2½ year health and development review and Early Years Progress Check • Develop universal interventions for promoting learning rich home environments
	Targeted	• Improved delivery of targeted parental healthy lifestyle interventions (preconception, antenatal and postnatal) • Sustained delivery of evidence-based targeted parenting programmes • Pathway defined for intensive home visiting programmes for vulnerable families	• Multidisciplinary care pathway and competency framework defined across BNSSG CCG footprint	• Targeted breastfeeding support for teenage parents and those living in socially disadvantaged areas	• Use of evidence-based techniques such as motivational interviewing to support families with behaviour change	• Provision of targeted oral health programmes such as fluoride varnish, supervised brushing programmes, and provision of free toothbrushes and toothpaste	• Multidisciplinary pathway defined for children with additional speech and language needs

Summary table of local service devlopment opportunites for the school years population:

School Years	Service level	Resilience and Emotional wellbeing	Risky Behaviours	Improving Lifestyles	Learning and Achievement	Complex and Additional Health and Wellbeing Needs	Transition and Preparation for Adulthood
(1) Unmet Needs	All Services	• Develop a mental health outcome measures for children and young people • Reducing the number of young people aged 15 reporting that they have been bullied	• Reducing the number of young people aged 15 reporting that they have taken part in risky behaviours around consuming alcohol and/or drugs	• Reducing the number of children in reception with excess weight (overweight / obese), with a focus on deprivation • Monitor rate of children in care up to date with all their immunisations	• Increase the number of children eligible for free school meals achieving 5 GCSEs		
(2) Service development opportunities based on evidence	Community	• Ensure all services are engaged with Making Every Contact Count (MECC) • Ensure easy to access and up to date information on accessing local community-led and voluntary groups and activities • Promote campaigns and information to children & young people, parents, grandparents and carers • Promote co-production of services with children and young people • Encourage whole-school approaches to health and wellbeing through participation in the Healthy Schools programme					
		• Local adoption of the prevention concordat for better mental health including interventions to reduce stigmatisation • Voluntary sector support for young people					
	Universal	• Support to schools to combat bullying • Use of a need's assessment tool for all children to help identify and support mental health	• Improving accessibility of the school nursing service with more routine contacts to provide support • Development of the statutory RE and RSE curriculum within the PHSE curriculum	• Improving accessibility of the school nursing service and increasing routine contact opportunities to ensure needs are identified and support offered • Improved lifestyle information provided following NCMP results		• Arrangements to ensure schools are enabled to support pupils with health needs	• Increasing routine contact opportunities at transition points to ensure support is offered • Interventions to improve children and young people's health literacy • Encourage schools to include 'well health' messages in the PHSE curriculum
	Targeted	• Early intervention and therapeutic support for mild to moderate mental health problems • Referral pathway defined for children and young people across all levels of need	• Specialist services to meet holistic needs of children and young people demonstrating risky behaviours	• Specialist services to meet holistic needs of children and young people to improve lifestyle behaviours	• Consistent approach to ensure vulnerabilities are identified early and pathways to specialist support followed	• Consistent approach to ensure vulnerabilities are identified early and pathways to specialist support followed • Ensure all children with complex needs have an Education, Health and Care (EHC) needs assessment and plan developed and reviewed regularly	• Consistent approach to ensure vulnerabilities are identified early and pathways to specialist support followed • Pathways defined for young people transitioning to adult services,

8. Implications for Local Action

At a high level, the process of developing a needs assessment for children and young people has identified several themes that should be considered by service commissioners, service providers and partnerships or organisations working to improve outcomes for this group.

Overarching principles:

1. **The variation in outcomes between different groups of children and young people in North Somerset is marked and persistent throughout a child's life**. There is a need to build services that operate on the principle of proportionate universalism – that is, an approach which develops whole society services and settings but with additional help for those that have notable poorer outcomes. Often poorer outcomes for these more vulnerable groups are experienced across a range of areas, for example, education, development and health and wellbeing.
2. **The population of children and young people in North Somerset is changing**. New housing development will create new areas of demand for services. Interestingly, the number of new births is much higher in more affluent groups than more deprived people in North Somerset. This is in direct contrast to the national trend. In general, service need in affluent areas is lower and this may mean more resources can be targeted at those with more complex needs.
3. **Children and families need support to access the right support at the right time and in the right place**. The development of digital approaches has good potential to connect more families to offers of support that are local and relevant to their needs and preferences. However, this requires services to have good insight into the everyday life circumstances of families and to enable service users and parents/carers to co-produce service improvement plans. Plans should aim to build in self-help and resilience where possible for families but with a clear assessment and referral process for those with identified needs.

Needs through the life stages:

4. **Maternal health and wellbeing provides a crucial platform for child and family development**. A more holistic view of investment in pregnancy should be embraced by all public sector organisations and workplaces. This should go beyond the common focus on the birth of the child and consider parent(s) preparation for their role (especially for the first child). Protecting and enhancing support for this crucial window of life opportunity can secure positive patterns of behaviour in the long term. Support should meet high standards of quality and equity.
5. **Early intervention to address needs is critical.** The ground-breaking report on Health Inequalities by Professor Michael Marmot was clear that action in the earliest years of life (0-2) has the greatest effect on long-term health and wellbeing outcomes and represents society's best investment. Assessing and meeting needs early can provide significant dividends for child and family wellbeing and creates a more efficient model for long-term service planning.

6. **Child development and learning is a critical building block for realising children's potential.** There is a clear need to create a strong home learning and development environment, alongside provided care and/or education. A supportive home environment depends on well informed and confident parenting skills. Good assessment and access to a range of interventions to address any needs in this area is required. Budget pressures have meant some of these services have been reduced in recent years; where possible these approaches should be encouraged in the future.
7. **There is a lack of insight and contact with school aged children and their parents/carers.** The frequent and detailed contact provided in the early years tails off as children move through primary to secondary school. The aim should be to improve health and wellbeing outcomes across the life-course of childhood. A regular source of data including opinions on young people's priorities would help to strengthen the development and targeting of appropriate support. Service commissioners should consider developing this type of routine engagement and analysis.

Priority topics that require more attention:

8. **Childhood obesity remains a significant need for children at all stages of development.** Local data shows that around one in five children arrive at primary school an unhealthy weight and about one in four leave for secondary school an unhealthy weight. Parents and schools should receive more support to address this issue – measurement of the problem is not enough. Future commissioning plans should reflect this alongside whole society action to implement changes that can address the causes - physical inactivity and unhealthy diet.
9. **Poor mental and emotional health and wellbeing is a significant and growing need for young people that needs greater action**. Evidence is growing from national research and local patterns of referral that a significant number of children are not having their needs met. This presents short, medium and long-term challenges for the affected young people and their families. Early intervention has the greatest potential to solve or manage a problem effectively, but this type of support is not widely available or easy to access.
10. **There needs to be good transitions between services in the stages of childhood and into adult support.** This is particularly true for more vulnerable children with complex needs as disruptions to support can have significant impacts on those children and their families. Proactive planning for these changes should be a routine part of service commissioning and delivery.

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