Children's Integrated Needs Assessment

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Strategic intelligence team,
Public Health

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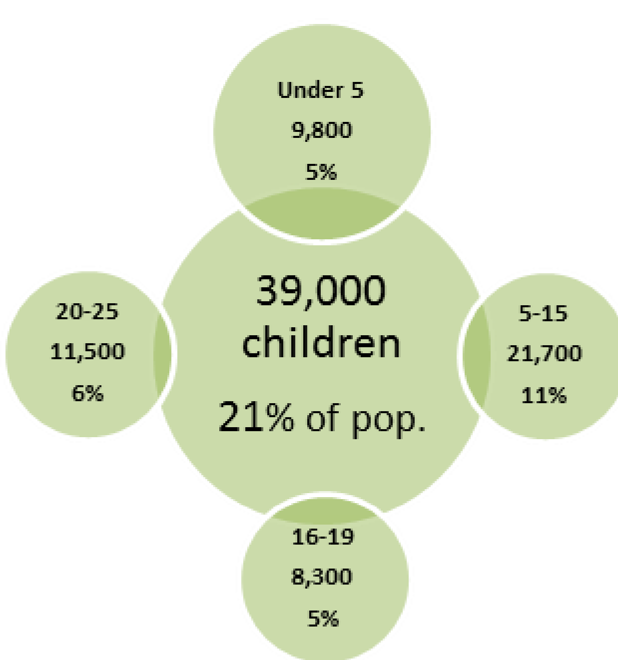
2. Executive summary

Understanding children in Herefordshire



Facts and figures

- Number of children is predicted to rise to 40,400 by 2031.
- Highest proportions are primary and secondary school children, living in rural areas, hamlets and isolated dwellings.
- Lowest number of children aged under 5 years live in rural areas.
- Most under 5s live in Hereford and Leominster (urban areas).
- The number of under 5s is predicted to decline by 2031 to 9,200.
- Higher birth rate in the county is attributed to women from the EU (Poland and Lithuania)
- Live births are between 1,800 and 1,900 each year – highest level since mid-1990s; numbers will decline in the long term.
- Over half of all babies are born to women aged 25-34 years (the age group with the highest fertility rate).
- 93.4% of children are of 'white' ethnicity, with 3.1% of 'other white'. Black, Asian and Minority Ethnic (BAME) = 1.1% and Gypsy/Irish travellers = 0.4%.

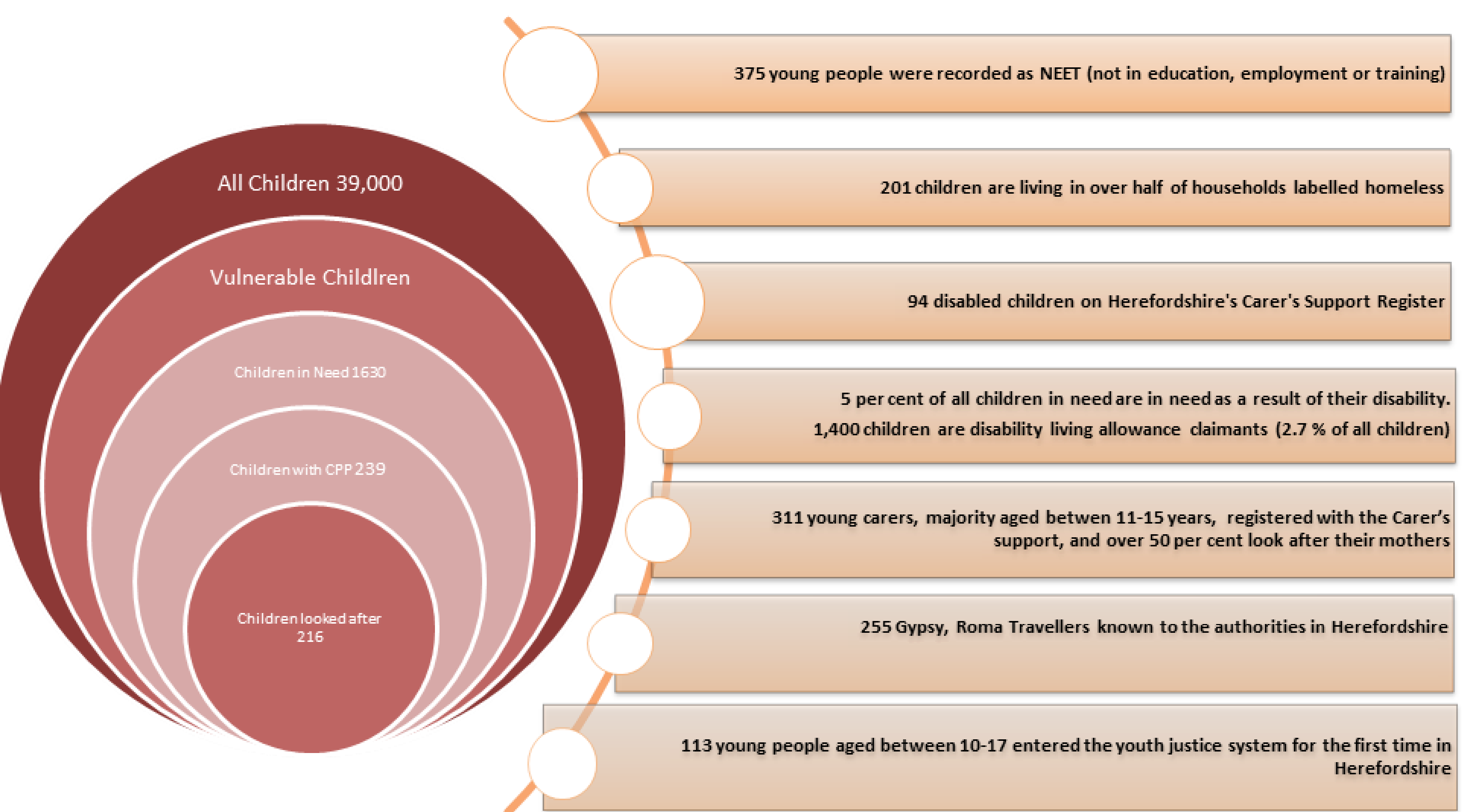
Cross cutting issues

Opportunity for improvement

- Herefordshire has 14.4% of children aged under 16 years living in low income families (i.e. children living in families where income is less than 60% of median income). As a county, the level of child poverty in Herefordshire is better than England's average of 21.1%.
- 4,360 children live in poverty in Herefordshire.
- The 2011 census showed that the employment rate (as a proportion of those aged 16-64 years) in Herefordshire was 76%. This was higher than that for England which stood at 71% and the West Midlands region at 69%.
- The rate for Job Seekers Allowance for the 18-24 year old age group was 4.1%, compared to 6.4% in the West Midlands region and 5.2% for the UK for the period 2006 to 2014.

Challenges

- During 2013, Hereford Food Bank fed 716 children and 1,475 adults. The food bank reported a 50% increase during the first seven weeks of 2014 compared to the same period in 2013.
- The area showing the highest number of NEETs (not in education, employment or training) was Redhill – Belmont Road: 16 young people, 4.3% of NEET cohort (at April 2014).
- Rates of admission for residents of the most deprived areas of the county are significantly high relative to all other areas. The most deprived quartile of population accounted for 35% of all hospital admissions.
- 40% are more likely to be admitted to hospital for respiratory infections.


All Children 39,000
Vulnerable Childlren
Children in Need 1630
Children with CPP 239
Children looked after 216
375 young people were recorded as NEET (not in education, employment or training)
201 children are living in over half of households labelled homeless
94 disabled children on Herefordshire's Carer's Support Register
5 per cent of all children in need are in need as a result of their disability.
1,400 children are disability living allowance claimants (2.7 % of all children)
311 young carers, majority aged betwen 11-15 years, registered with the Carer's support, and over 50 per cent look after their mothers
255 Gypsy, Roma Travellers known to the authorities in Herefordshire
113 young people aged between 10-17 entered the youth justice system for the first time in Herefordshire

Health and wellbeing: how is Herefordshire doing?

Strengths

- **Maternal smoking** - Significantly lower than England's rate at 11.2 per 100 maternities.
- **Infant mortality** - Lower than regional and national rates of 4.1 deaths per 1,000 live births.
- **Perinatal mortality** - Significantly lower than national and regional rates of 4.6 deaths per 1,000 live births.
- **Low birth weight** - Local rate of 5.2%, significantly lower than national average (7.4%).
- **Obesity Reception** - Lower prevalence of both obesity and overweight compared to national and comparator group.
- **Obesity Year Six -** Lower prevalence of both obesity and overweight compared to national and comparator group.

Doing better

Immunisation status first year	Comparable to national and regional coverage at around 94%
Teenage conceptions	Comparable to national rate, ranked 4 out 15 comparator LAs
Child mortality rates (1-17years)	Slightly higher rate than England at 14.8 deaths per 100,000 population
Self-harm (0-17 years)	138.8 admissions per 100,000 population, not significantly worse than England (115.5 per 100,00)

Challenges

Alcohol-related admissions	**Significantly high rate of alcohol-related admissions among young people, ranked 262 of 317 local authorities**
Breast feeding duration	Similar to national average at 47%, though rates are generally poor nationally. Significantly lower than the best performing local authority (LA) (82.8%)
Breast feeding initiation	Marginally lower than England's average at 73% and ranks 8 out of 15 comparator local authorities – 10pp below best-performing comparator LA
Immunisation second year	Considerably lower coverage than national, regional and comparator group for MMR, HibMenC and PCV booster
Immunisation fifth year	Very low coverage for DTTP booster, MMR first and second and HibMen C booster
Dental five years	High rates of tooth decay, ranks 13/14 comparator LA

General health and wellbeing of children

Facts and figures

- Of the 182, 2,000 people registered with 24 GP surgeries in January 2014, 38,200 were under 20 (21%) and 9,400 were aged between 20 and 24 years (5.1%).
- There were 89 deaths for children below the age of five years between 2001 and 2012, over 50% was perinatal or neonatal.
- There were 58 deaths between 2001 and 2013 among those aged between 5-16 years and 40 deaths for those aged 17-19 years.
- Infant mortality rate per 1,000 live births was 4.1% for the period 2009-2011, not significantly different to England's average rate of 4.5 deaths per 1,000 live births.
- Child mortality rate (1-17 years) for 2009-2011, was 14.8% per 100,000 population, very slightly higher than England's average rate of 13.7 deaths per 100,000 population.

Challenges

- Increase of 5% in total admissions of children (0-19 years) in 2012-13. 40% were emergency admissions.
- Sharp increase of children aged 0-4 years (23%) and 5-9 years (18%) in hospital admissions (2011-2013).
- The highest cause of death was transport accidents, accounting for 3% of deaths (2001-2012).
- Viral infections are the most common cause of admissions among children aged 0-4 years (10.5%) of total admissions, followed by upper respiratory infections (10.3% including acute tonsillitis). Chronic lower respiratory diseases (e.g. asthma) account for only 5% of admissions among young children (0-4 years) but around 20% of admissions among those aged 5+ years.
- 15% of total admissions for young people aged 15-19 years are pregnancy related (including medical terminations).
- Alcohol-attributable admission rates for under 18s have decreased between 2010 and 2013, but are significantly higher than the England average and rank 262 of 317 local authorities (where data is published).

Safeguarding: priorities for change in Herefordshire

Strengths

- Dedicated team to work with looked after children (LAC).
- Herefordshire's looked after children have better mental health at a SDQ score of 7.8, than both England's average for LAC (13.8) and the 'norm' for British children (8.8), who are not looked after.
- Looked after children have better rates of immunisation compared to children in the general population; (92% in 2012-2013. 96% for children who were looked after for 12 months).
- Dedicated team with services targeted to improve outcomes for Gypsy, Roma Traveller children and their families.

Needs improvement

- Permanence for looked after children. Richer data required to identify barriers to achieving consistency of care for looked after children. Largest proportions of LAC live in foster homes (195 at June 2013).

The main reasons for children identified as children in need, or becoming subject to a child protection plan and/or becoming looked after by the local authority are exposure to domestic violence and abuse, abuse and neglect.

Challenges

Number of children in need (CIN)	Herefordshire's rate of children becoming CIN (including LAC and CPP) is higher than national and statistical neighbours, and averages at 445.5 children per 10,000 children by 2013-2014 (year to date).
Number of children on child protection plans (CPP)	At June 2013, there were 239 children with a CPP, an increase of approximately 36% since June 2012.
Rate of children becoming subject to CPP	The rate of children becoming subject to a CPP is higher when compared to statistical neighbours and national figures, between 2012-2013. The rate was 79.2 children per 10,000, compared to 46.2 children per 10,000 England's average.
Rate of children subject to CPP for second or subsequent time	The rate is higher than the national average and comparable to Herefordshire's statistical neighbours.
Adoption of LAC	Seven were adopted at June 2013.

Education: How well are children learning in Herefordshire?

Better than national levels

- In 2013, Herefordshire had a higher proportion of children reaching the threshold for good level of development in Early Years Foundation Stage (EYFS) than nationally. Herefordshire was the third highest performing local authority for pupils achieving a good level of development in 2013.

- Overall, students in Key stage 5 perform well with a higher percentage (96%) achieving at least two substantial level 3 qualifications than pupils nationally (92%). In 2013, Herefordshire was the highest performing local authority amongst statistical neighbours for this measure.

Below national levels

- For the past three years the percentage of children reaching the desired level for English, maths and reading at Key stage 2 has maintained a five percentage point rate lower than the national average.
- 56% of Herefordshire pupils achieved 5+ A*-C GCSE (or equivalent) including English and maths. This is 4.7 percentage points below the national average and 8 out of 10 statistical neighbours (for poor performance).

Challenges

- **Across the key stages, there are huge inequalities in achievement between all pupils and the vulnerable groups**
  - 14% of children with special education,34% of those on free school meals and 32% of children with English as an additional language (EAL) are reaching the desired threshold for good level of development in EYFS
  - Pupils whose first language isn't English performed significantly lower than their peers by 24 percentage points
- **Herefordshire's vulnerable groups are performing below national levels when compared to children from the same vulnerable group cohorts**
  - Key stage 2 - those pupils eligible to free school meals performed significantly below the same pupils nationally (49% compared to 60%), at Key stage 4 the difference was 32% compared to 38%
  - Key stage 2 - 63% of EAL pupils locally achieved level 4+ in reading, writing and maths compared to 73% of their cohort nationally
  - Only 35% of EAL pupils achieved 5+ A*-C GCSE (or equivalent) including English and maths compared to 60% of EAL pupils nationally
- **Looked after children and Gypsy, Roma Travellers have the lowest attainment across all key stages, with at least half the children not meeting the desired levels**

3. Introduction

This Children's Integrated Needs Assessment (CINA) report, jointly commissioned by the Children and Young People's Partnership and Herefordshire Council's children's wellbeing directorate, was driven by the Ofsted 2012 inspection of children's safeguarding in Herefordshire.

In June 2012, Ofsted reported that overall children's services had improved and there were no widespread or serious failures that create or leave children being harmed or at risk of harm (at the time of the inspection). Ofsted concluded that the authority is not yet delivering good protection and help and care for children, young people and families. The purpose of the CINA is to support the council to improve the progress of the county's children.

The CINA is part of the wider Joint Strategic Needs Assessment or JSNA[1] process for Herefordshire and provides a broad strategic understanding of major health and wellbeing issues for the county's children. The JSNA (known as Understanding Herefordshire) provides an overview of the health and wellbeing needs of the county's population in order to inform the planning and commissioning of best value services. Likewise, the CINAs intent is to gather data and information structure it and make intelligent sense of it. The detail can assist to identify priorities, comprehend interdependencies and in the long term help shift some of the poor outcomes for children. For the first time in the county, children's needs are summarised in one document, which will be published on the Facts and Figures about Herefordshire website and updated with data and information so that the local authority and its stakeholders are working to the same evidence base.

The Children's Integrated Needs Assessment is underpinned by the 'Methodology for Undertaking an Integrated Needs Assessment', developed by NHS Herefordshire and Herefordshire Council (November 2011). This report provides an epidemiological analysis on a range of existing statistical and survey data relating to vulnerable children and young people and where possible it provides a view of the future, predicting or anticipating potential or unmet need. A literature search and evidence review on best practice initiatives provides potential solutions to entrenched problems currently being experienced in the council. Interviews with key informants and a desk top analysis of departmental (children and wellbeing) reports, strategies and service reviews was also undertaken.

Where appropriate, comparisons are made with Herefordshire's statistical neighbours, England and the United Kingdom, all alongside other information measuring outcomes for children and young people in the county and sub-county (ward and super output area level). An independent qualitative study was commissioned to seek the views of young service users and service providers, the findings of which are included in this report. This report describes the state of the county's children around the themes of:

- Health and wellbeing
- Education, attainment and aspiration
- Safeguarding: Children in need, children in care, children at risk and vulnerable families

This report does not identify or map the services and facilities for children and young people that currently exist across all sectors in Herefordshire as this information was not made available by the time of publication. It was, therefore, not possible to make definitive 'like for like' service comparisons in the literature/evidence review. This report does not include evidence on the mental

[1] The JSNA is a statutory responsibility.

health of children and young people living in Herefordshire. A mental health needs assessment for children is currently underway, led by Herefordshire's Clinical Commissioning Group.

This report uses the term 'children' to mean 'children and young people' and refers to those aged zero to 19 years and also includes those who are over 19 who are receiving services as care leavers, and those over 19 but under 25 years with learning difficulties within the meaning described under that Children's Act 1989.

4. What does Hereford look like: Demography

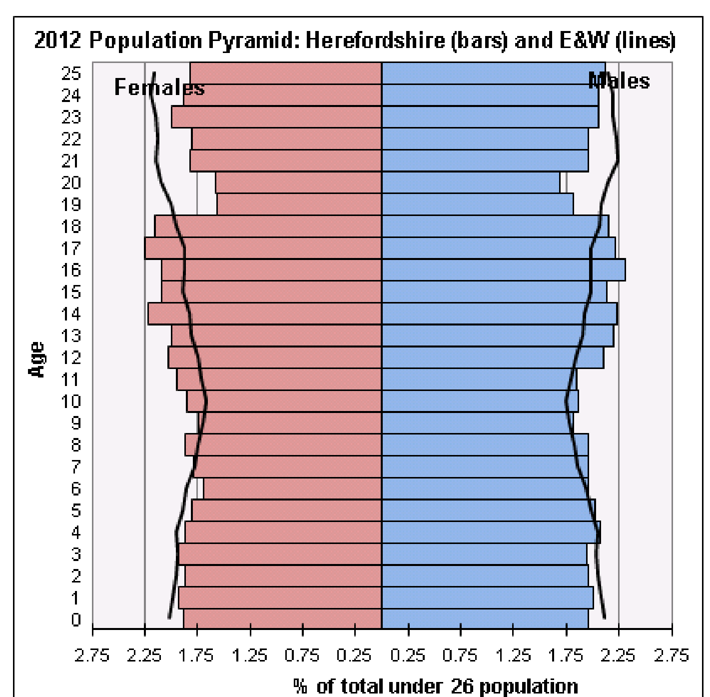
4.1. Current and future population

4.1.1. Resident population overview: Current and recent trends

Herefordshire is home to 39,900 children and young people under the age of 20, who represent one in five (21.9%) of the county's resident population.

The proportion of children in Herefordshire is slightly lower than for England and Wales as a whole (23.8%), although the difference varies for specific ages. The population pyramid below (Figure 1) illustrates how there are relatively older children (10 to 18), but fewer pre-school. The notable drop at 19 coincides with the age that many young people start university; the 2011 census estimated that 3,000 students living elsewhere in the UK during term-time have a home in Herefordshire. Numbers in different age groups are given in (Appendix 1- Population of children in Herefordshire and statistical comparator).

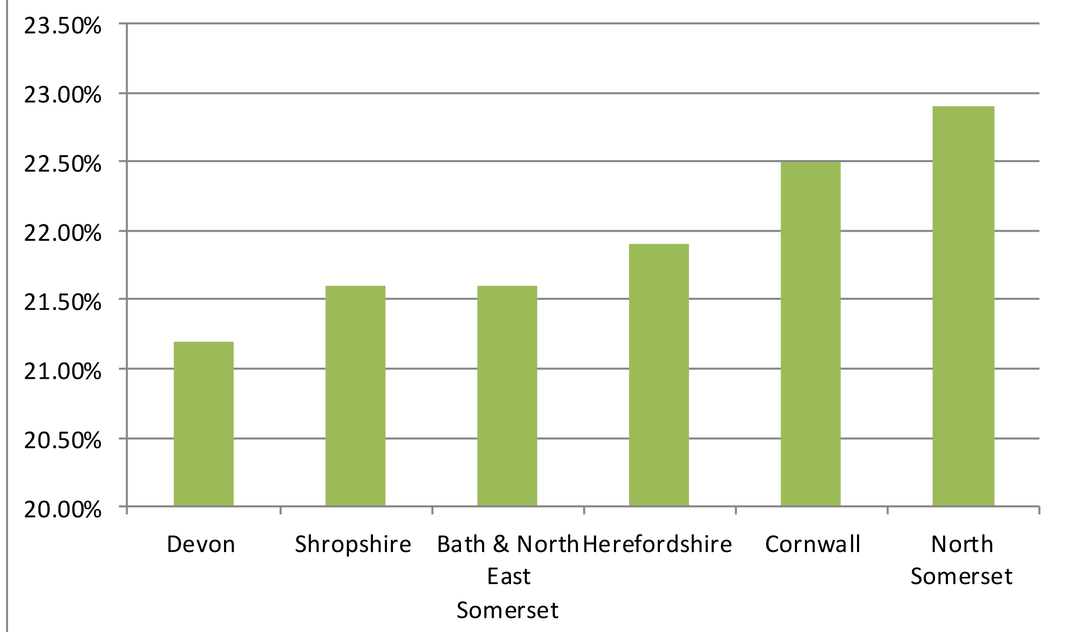
Figure 1: Population pyramid comparing Herefordshire's Children and young people (CYP) population with England and Wales



Source: 2012 mid-year estimates, ONS. Crown Copyright

Herefordshire has a similar proportion of under 20s to several areas of England that have been identified as good statistical comparators in general but also for children and young people's services specifically (Figure 2).

Figure 2: Proportions of children aged under 20 in Herefordshire and statistical comparators (2012)



4.1.2. How Herefordshire's population has been changing

Despite an overall net in-migration of under 18s and their families each year – both from elsewhere in the UK and overseas (three year rolling averages of 200-300 a year), the total number of under 20s living in Herefordshire has been falling consistently. This was because of the high numbers of births (see below) seen in the 1980s and early 1990s – children who were becoming adults during the 2000s. There were not enough births and migrant children during the 2000s to compensate for these children moving out of the age group – so the total number fell.

However, the 2011 census confirmed that increased immigration in the latter part of the last decade slowed the rate of this fall. The current (2012) estimate of 39,900 is 1,700 (4%) fewer than in 2001 (41,600).

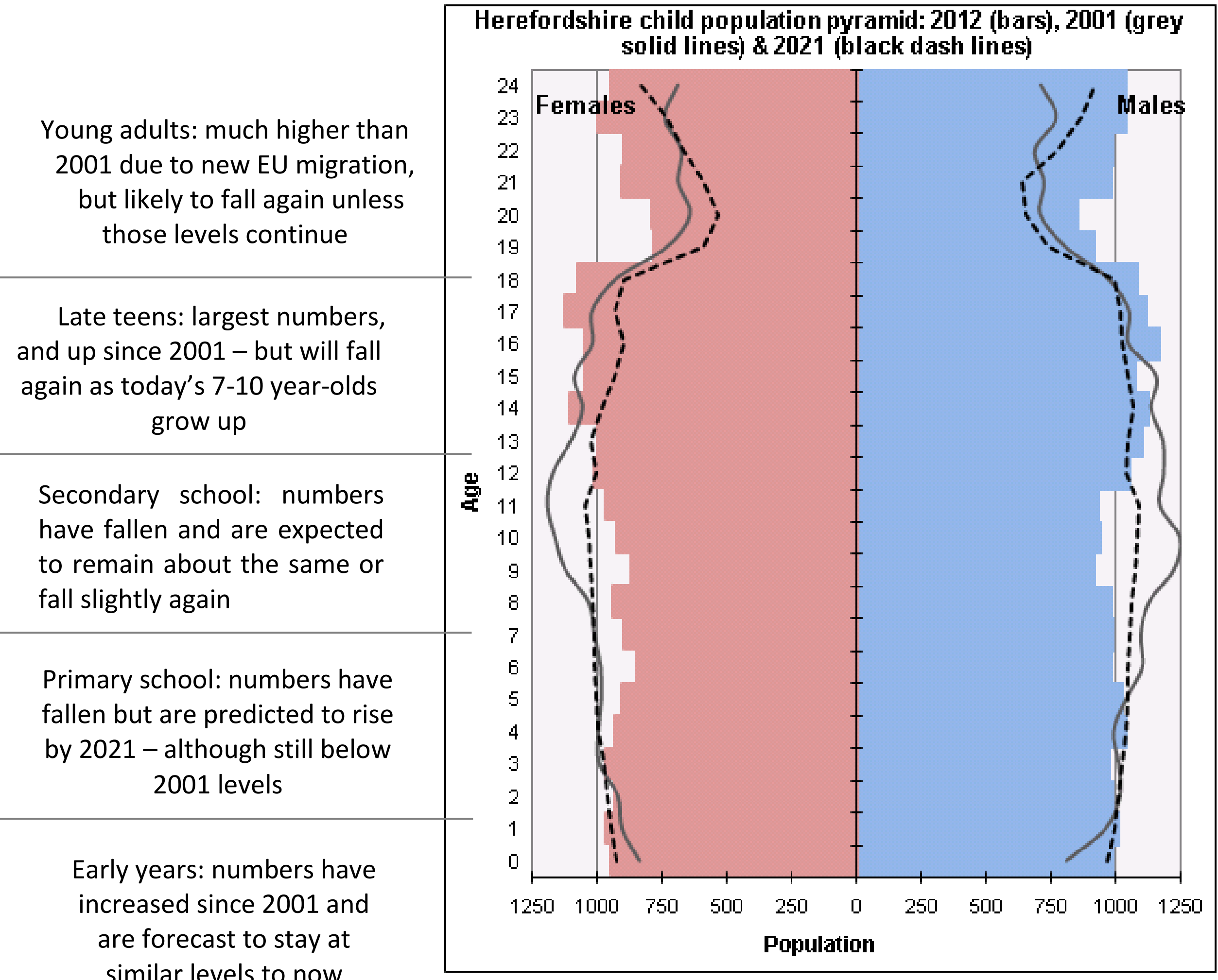
This overall trend masks differences for particular age groups. As Figure 3 and Appendix 1: Estimated and forecast population and change in Herefordshire

	Population				Observed change		Forecast change			
	Observed		Forecast		2001-12		2012-21		2021-31	
Age group	2001	2012	2021	2031	Number	%	Number	%	Number	%
Under 5	9,400	9,800	9,900	9,200	400	4%	100	1%	-700	-7%
5 to 15	24,600	21,700	22,500	23,100	-2,900	-12%	800	4%	600	3%
16 to 19	7,600	8,300	7,100	8,100	700	9%	-1,200	-14%	1,000	14%
20 to 25	8,500	11,500	9,000	9,300	3,000	35%	-2,500	-22%	300	3%
Total under 20	41,600	39,900	39,400	40,400	-1,700	-4%	-500	-1%	1,000	3%

Source: 2001 and 2012 mid-year estimates, ONS. Crown Copyright. 2011 based Herefordshire population forecasts G L Hearn.

Appendix 2 shows that the numbers of under 5s and 16-19s rose by 4% and 9% respectively from 2001, whilst there are currently almost 3,000 fewer school age children than there were then (12% fall). The number of 20-25 year-olds increased by 3,000 – more than a third - from 2001. This was mainly due to the natural 'cohort effect' of there being more teenagers turning 20 than 24 year olds turning 25 after 2004, but over a third of this increase was due to immigration.

Figure 3: Population pyramid – numbers of children in Herefordshire from 2001 to forecast changes by 2021



Source: Mid-year estimates, ONS. Crown Copyright. 2011 based Herefordshire population forecasts, GL Hearn

Considering the different age groups, the forecasts suggest:

- The number of under 5s will remain at a similar level to now (9,800-9,900) until 2023, when they will start a slow decline – reaching 9,200 (- 6.1% by 2031).
- A slight increase in the number of 5-15s between 2015 and 2026, before plateauing at just over 23,100-23,200. This is 6.9% higher than currently (21,700) but still lower than in any year prior to 2007.
- That the number of 16-19s will continue their recent decline (since 2008) until 2021, reaching a low of 7,000 (15.7% lower than 2012). Numbers will then start to increase, reaching 8,100 by 2030 (200 - 2.4% - lower than currently).
- That a decline in the number of 20-24s is likely – from the current high of 11,500 to 8,500 by 2025, followed by an increase to 9,300 by 2031. However, this is the age group most dependent on trends in immigration, so one of the most difficult to predict.

The different trends (recent and future) for specific age groups highlight the different challenges for particular services for children. Maternity and early years' services have had to adapt to rising numbers, whilst overall there is a surplus of school places caused by falling numbers, which is not likely to be reversed in the near future.

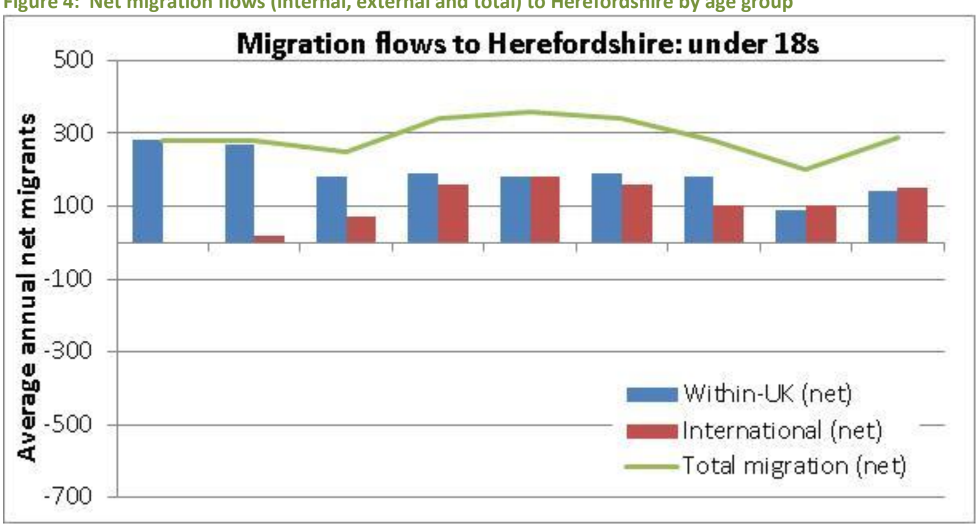
4.2. Components of population change

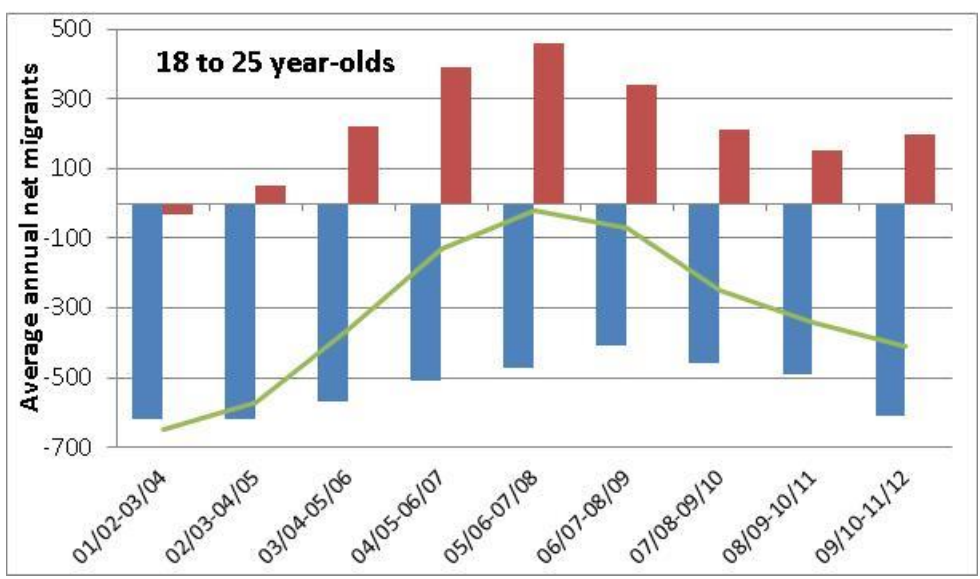
4.2.1. Migration

Migration is a key driver of demographic change in children and young people in Herefordshire and has changed dramatically in recent years.

Whilst births and deaths are recorded very accurately, migration is much more difficult to measure. Young adults are the most mobile of any population. This is not unusual especially in a rural area with limited higher education opportunities. This internal net out-migration continues (Figure 4) and has been increasing again in recent years since falling to a low of 300 in 2008/09, but has been dampened by increased migration from overseas since the expansion of the EU in 2004. The combined effect was an annual average of 400 net out-migrants during the last three years (2009/10 to 2011/12) compared to 650 in 2001/02 to 2003/04. In addition to this, women of child bearing age moving into Herefordshire from the new European states have kept births at higher than expected level since 2007 (see next section).

Figure 4: Net migration flows (internal, external and total) to Herefordshire by age group





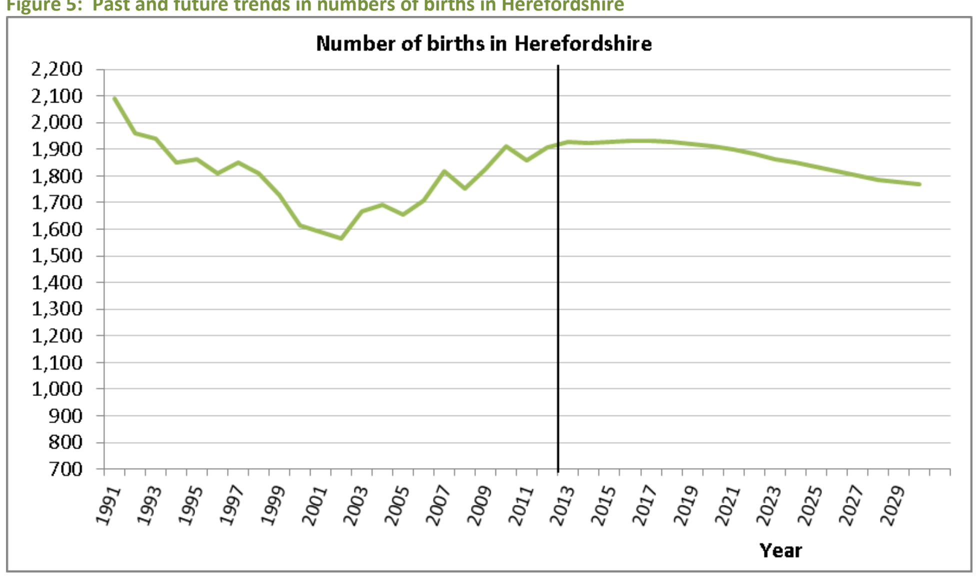
Source: Mid-year estimates, ONS. Crown Copyright. 2011 based Herefordshire population forecasts, GL Hearn

4.2.2. Births and fertility

Recent trends in numbers of births

Since 2007, there have been 1,800 to 1,900 live births to women living in Herefordshire each year. This is the highest level seen since the early to mid 1990s. Numbers fell to 1,600 in the early 2000s, but started to increase in 2003, reflecting national increases in birth rates, but the latest high numbers have been driven by the women of child bearing age who have migrated to the county since the expansion of the European Union in 2004.

Figure 5: Past and future trends in numbers of births in Herefordshire



Source: Mid-year components of change, ONS. Crown Copyright. 2011 based Herefordshire population forecasts, GL Hearn

Whilst the number of births to UK born women has remained fairly constant since 2003 (about 1,600 per year), the number to women born in countries that joined the EU in 2004 has increased from fewer than 20 to over 150 by 2012. These made up 9% of county births in 2012, compared to just 1% in 2004, with women most likely to be from Poland or Lithuania.

Future numbers of births

The latest population forecasts (based on the 2011 census) suggest that births will remain at a similar level to that seen in recent years if the expected 16,500 new dwellings are built in the county between 2011 and 2031.

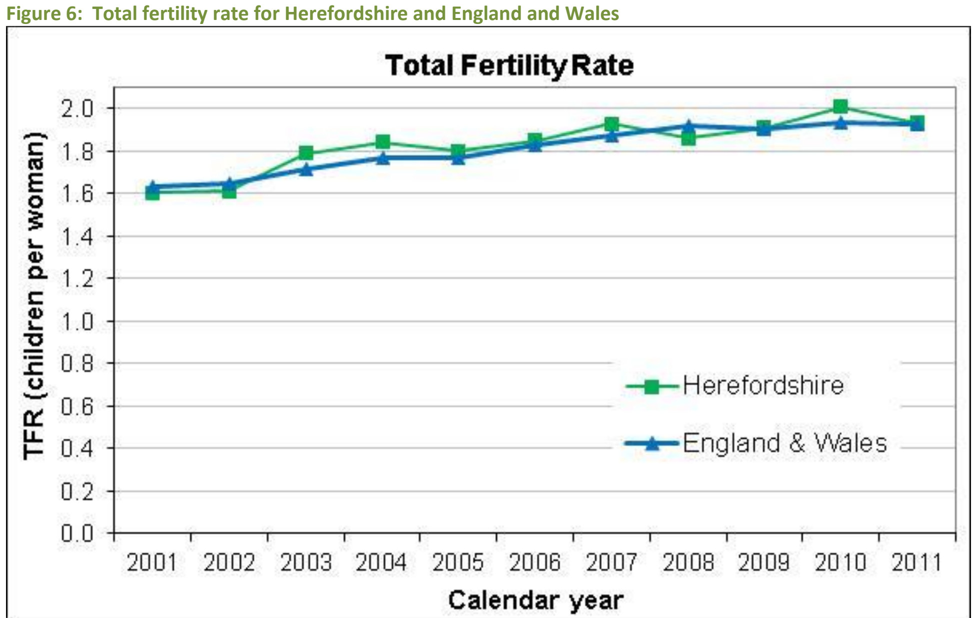
This is based on an assumption that migration will follow similar trends to those observed in the latter half of the last decade and the Office for National Statistics' assumption for their 2010 based national population projections that fertility rates would increase in the short term before declining again in the long term.

Fertility rates

To assess the fertility of populations, that is, its reproductive capacity, rates of child bearing are measured. It is acknowledged that these rates are determined by social custom, economic circumstances and personal relationships (timing of having children) in addition to physiology (changes in fertility).

The total fertility rate (TFR) is the most commonly quoted measure of fertility[2]. The total fertility rate is the average number of children a hypothetical cohort of 1,000 women would bear during their life time if they were to experience age specific fertility rates (ASFR) at each age of their reproductive life. While this measure appears abstract, it allows one to compare populations with different proportions of women of different ages. As a benchmark, a population is considered to be maintaining a constant size if its TFR is equal to 2.0, while it is considered to be expanding or contracting if the TFR is greater or less than this number, respectively. The TFR provides a timely indication of current fertility although it does not necessarily predict how many children women will eventually have.

Figure 6: Total fertility rate for Herefordshire and England and Wales



Source: Based on ONS mid-year estimates and birth statistics, Crown Copyright.
Note: FTR calculation assumes that there is no mortality

[2] The fertility rate is hypothetical. It is not the same as the birth rate, which is the number of children born in a year as a share of the total population.

Herefordshire's TFR has been broadly similar to the national (England and Wales) rate throughout the last decade as shown in Figure 6. Both have risen from 1.63 in 2001 to 1.93 in 2011.

The latest (2012 based) national projections from ONS assume that the rate will fall to and stabilise at 1.90. This is higher than their assumption for the 2010 based projections which assumed the TFR would be higher in the short term, but fall gradually to stabilise at a lower level of 1.85 by 2028.

Evidence indicates that immigration rises tend to raise the fertility rate of the host country in the short term (Anderson and Scott, 2005), as evident from the TFR increase in the UK in 2011. First generation immigrant women usually have higher levels of period fertility compared to the host country's women, but the effect diminishes for the second generation. Evidence points to a number of reasons for the trend, such as delayed or interrupted child bearing shortly before or during migration resulting in child bearing upon entry into the host country (Milewski, 2007); migration for marriage or family (Booth, 2010) or even a defensive response among more disadvantaged communities with a strong cultural or religious identity (McQuillain, 2004).

The total fertility rate masks some differences between the local and national age specific fertility rates (the number of births per thousand women of a particular age).

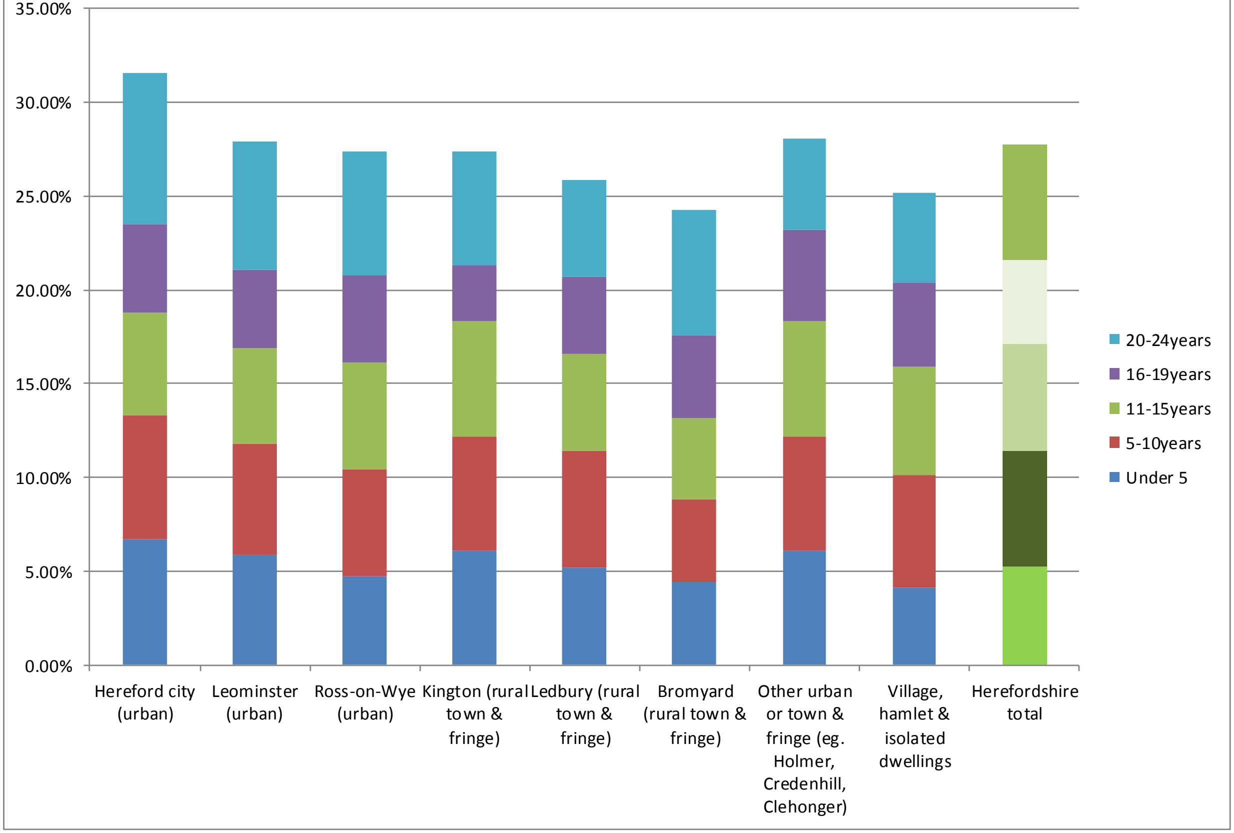
Generally, fertility rates are lower amongst under 20s and over 40s in Herefordshire than in England and Wales. Both locally and nationally, fertility rates remain highest amongst 25-34 year-olds (over 100 per thousand women since 2007) and over half of all babies are born to women in this age group (See Appendix 3 for current rates and future fertility rates). Sobotka (2008) found that the fertility rates of female migrants are more closely linked to the timing of the migration than to age, therefore this feature needs to be taken into account when interpreting age related fertility rates locally and nationally.

The level of adolescent fertility (births to women age 15 to 19 years) may be of special concern because women who start having children at very young ages are more likely to curtail their education and less likely to join the labour force. Early child bearing (before age 18) entails greater risks of maternal death and children born to very young mothers have higher levels of morbidity and mortality.

4.2.3. Spatial distribution by age

Herefordshire's 39,900 under 20s are scattered all over the county, although there are some areas with notably high proportions (illustrated in Figure 7), particularly in South Hereford, Credenhill and one part of Ridgemoor in Leominster (from 34% to 46%, compared to 22% of the county's total population). Generally, Ross-on-Wye, Bromyard and the most rural areas of the county have the lowest proportions (20% to 21%). The difference is only marked, however, amongst the under 5s. See Appendix 4 for map illustration.

Figure 7: Population of Hereford city, market towns and other areas, mid 2012



In general, children in Hereford and Leominster are most likely to be under 5, with numbers falling the older they get. Children in the other market towns are most likely to be of primary school age and least likely to be aged 16-19. The most rural villages, hamlets and isolated dwellings have the lowest proportions of under 5s but the highest of secondary school age.

20 to 25 year olds are only defined as children if they have a learning disability and have a very different distribution to under 20s. Like all ages, they are scattered all over the county, but are particularly over represented in Hereford: 43% of Herefordshire's 20-24 year-olds live in the city, compared to 32% of the county's total population.

4.2.4. Inter-relationship of age and fertility

Age structure rather than population size is the more relevant demographic variable as a more prominent and steady influence on fertility. Age structure reflects changes in the size of the youth population, then adult and finally the older population, as Herefordshire progresses in its demographic transition.

There is a close link between fertility and a population's age structure. Fertility change directly affects population growth and dependency ratios (defined as the number of children and older persons per 100 persons of working age). As fertility declines, the proportion of children in the population falls and the proportion of the population of working age increases, resulting in a lower dependency ratio. This trend enhances economic growth, reduces poverty, reduces child mortality, and improves maternal health. However, in the long run, the projected low fertility rate of 1.89 in 2038 in Herefordshire will result in a decline in the working population and an increase in the population of older people. Future demand for public services may be driven by an ageing

population in Hereford and may result in less expenditure in children's services. The council may need to think on how public services are designed and delivered more efficiently to ensure sustainability of vital services that safeguard vulnerable children.

4.3. Ethnicity

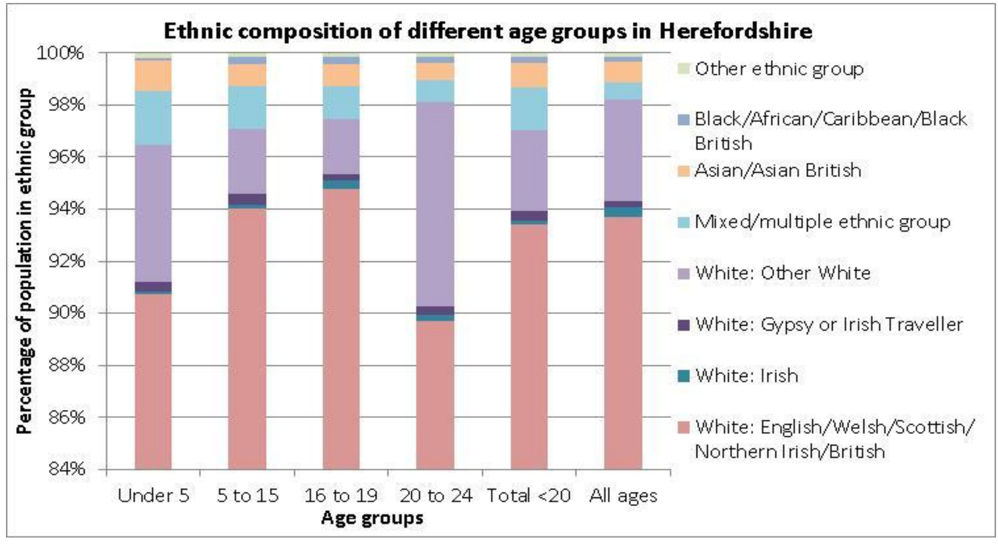
As migration increased, the ethnic composition of Herefordshire's population changed dramatically during the last decade. In 2001, just 2.5% of residents were from an ethnic group other than 'white British' (4,300 people), but by 2011 this had increased to 6.3% (11,600 people) – although still very low by national comparisons (19.5% in England and Wales). The largest growth was in the number of 'white other' (i.e. not British, Irish, Gypsy or Irish Traveller): from around 1% in 2001 to 3.9% by 2011 – a figure very similar to nationally (4.4%).

The overall proportion of Black and Asian Minority Ethnic group (BAME) children (under 20) is only slightly higher than in the total population (6.6%; again low compared to the national figure of 24.2%). The only notable differences are in the proportions of children identified as 'white: Gypsy or Irish Traveller' (0.4% compared to 0.2% of all ages in the county) or 'mixed/multiple ethnic group' (1.7% compared to 0.7%).

There is a relatively high proportion of under 5s who are 'white other' (5.3%) and a very high proportion of 'white other' amongst the 20-24 age group (7.9%; higher than the national figure of 5.7%), in keeping with the trends in migration discussed above. The proportions of other minority ethnic groups in the latter age group are very similar to the population as a whole.

Appendix 5 shows the differences in ethnic composition of children and young people by age group compared to the whole county population and Figure 8 illustrates the differences.

Figure 8: Ethnic composition of children and young people's age groups compared to the whole county population



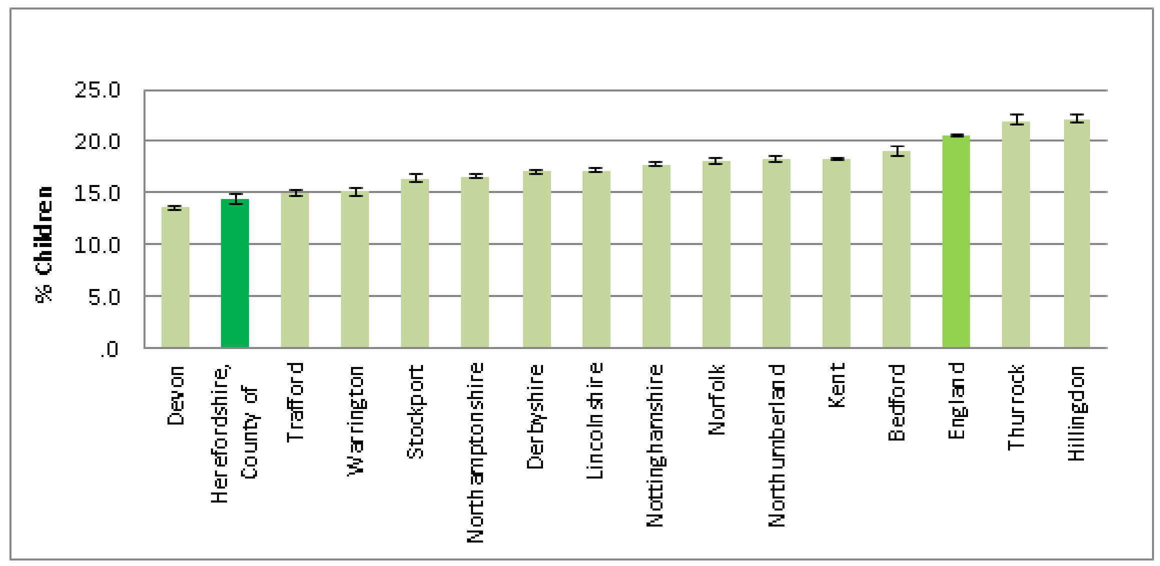
4.4. Children living in poverty and deprivation

4.4.1. Poverty

The **Revised Local Child Poverty Measure** or National Indicator 116 report is defined as "the proportion of children living in families in receipt of out of work benefits or tax credits where their reported income is less than 60% median income." [3]

The proportion of children in poverty is calculated as: the number of children in families in receipt of either out of work benefits or tax credits where their reported income is less than 60% median income divided by the total number of children in the area.

Figure 9 : Percentage of children in relative poverty by local authority comparator group 2011



Herefordshire has 14.4% of children aged under 16 years, for whom child benefit was received, living in low income families (i.e. children living in families where income is less than 60% of median income). It ranks second in terms of performance of 15 comparator local authorities within the same national deprivation decile; locally 4,360 children live in poverty. Herefordshire has a significantly lower rate of child poverty than nationally (20.6%).

As a county, the level of child poverty is better than the England average at 14.8% compared to 21.1%; this trend is also maintained when compared to the region (West Midlands) where the average is 23.1%.

The draft Herefordshire position statement on poverty (April 2014)[4] gives a deeper level of detail on Local Super Output Areas (LSOA) in Herefordshire. The document awaits ratification; therefore, this report does not include all of its research findings.

What is evidenced is that "children growing up in poorer families emerge from school with substantially lower levels of educational attainment. This is a major contributing factor to patterns of social mobility and poverty" (Joseph Rowntree Foundation, 2010). Deprived environments do not

[3] This local measure attempts to create a proxy for the official relative child poverty measure in order to enable local (sub-national) analysis.

[4] Herefordshire Child Poverty: A position statement (April 2014) by Ian Sockett, business intelligence officer, children's wellbeing directorate.

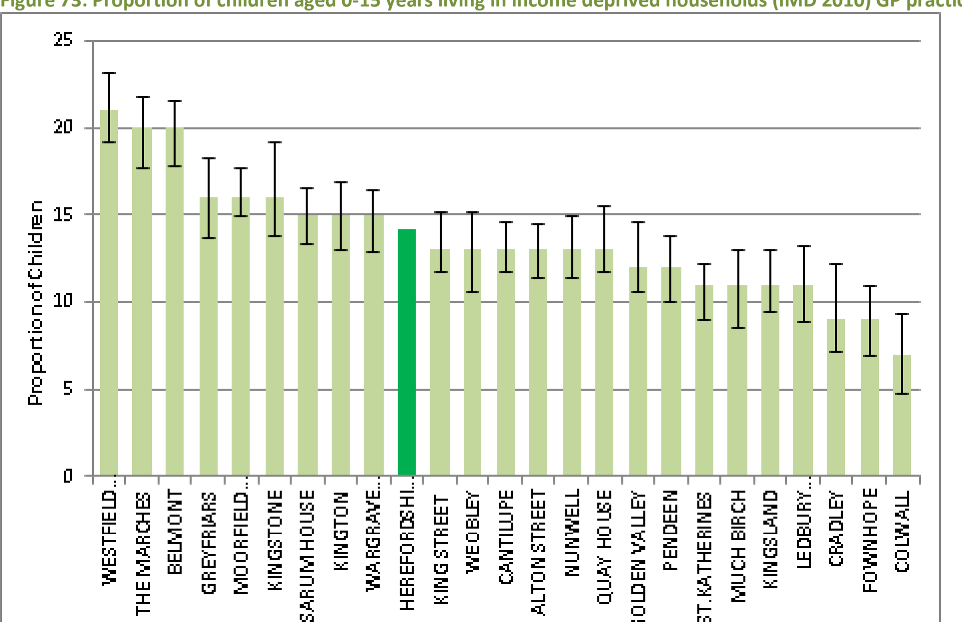
enhance the characteristics of effective learning, such as playing and exploring, active learning and creating and thinking critically (as defined in the early years foundation stage (EYFS) profile undertaken for each child reaching the age of five years).

4.4.2. Deprivation

Deprivation covers a broad range of issues and unmet needs caused by a lack of resources of all kinds, not just financial. The Indices of Deprivation England 2010, use 38 separate indicators, organised across seven distinct indicators (income; employment; health and disability; education skills and training; barriers to housing and other services; crime and living environment) to calculate The Index of Multiple Deprivation 2010 (IMD2010). People in deprived areas are likely to have a higher exposure to negative influences on health and to lack resources to avoid some of them or their effects, than people living in less deprived circumstances, hence deprivation has a huge impact on health.

The proportion of children aged 0-15 years living in income deprived households (IMD2010) vary threefold across the county by GP practice from 7% to 21%. Westfield Walk, The Marches and Belmont practices have the highest rates of income deprivation relative to the Clinical Commissioning Group (CCG) average of 14.2%.

Figure 73: Proportion of children aged 0-15 years living in income deprived households (IMD 2010) GP practice level



A good indication of performance linked to deprivation is the outcome for pupils by free school meals (FSM) eligibility and this aspect is considered later on in this report.

4.4.3. Cross cutting issues

In April 2011, the Government published its first Child Poverty Strategy, "A New Approach to Child Poverty: Tackling the Causes of Disadvantage and Transforming Families' Lives". During this period in time, the UK and global economy faced an economic recession and at the same time there were changes to the benefits system under the Government's Welfare Reform programme. Both of these

factors, along with changes to the way in which child poverty is measured has made it difficult to assess the extent to which poverty impacts on the lives of children and their families.[5]

The Child Poverty Action Group [6] state that "children in low income families are being hit hard by the Government's tax and benefits changes". The Institute of Fiscal Studies predicts that between 2010 and 2020, rather than ending child poverty, the Government's welfare reform programme will mean that some 1.1million more children will live in poverty. An increased financial stress tends to lead to food poverty in most local authority areas. Herefordshire Food Bank for 2013 recorded that 1,235 parcels were provided during 2013. These fed 2,191 people including 1,475 adults and 716 children. The food bank also reported that the three highest reasons for referral were: benefit problems (38%), debt (11%) and physical and mental problems (10%).

A number of studies have looked at how living and growing up in rural areas impacts on young people in a number of ways. Shucksmith (2004) comments that young people felt that they had 'no voice' in rural communities and had 'issues of identity and visibility' living in small hamlets or isolated dwellings. Glendinning et al (2006) identified that the low availability of social opportunities, local employment prospects and good transport networks are constraining for young people. Midgley and Bradshaw (2006) found that strategies for re-engaging youth in education and training failed to take into account rural needs. Commuting out of the rural area to access post 16 educational opportunities was curtailed by limited transport links. Evidence also indicates that people living in rural areas are disadvantaged by poor geographical access to health facilities, (Goddard and Smith, 2001).

Evidence suggests that the wider determinants of health and wellbeing compound other vulnerabilities experienced by children and their families living in rural areas. England is the only country in the UK that does not make a major adjustment for rurality in its NHS formula, and thus, raises the question of whether the health and wellbeing needs of vulnerable children living in rural and sparsely populated areas are addressed adequately, (Asthana et al, 2003).

4.5. Bibliography

Asthana, S., Gibson, A., Moon, G., and Brigham, P.,(2003), Allocating resources for health and social care: the significance of rurality, *Health and Social Care Community*, 11 (6), 486-493.

Booth, T., and Booth, W. (2002). Men in the Lives of Mothers with Intellectual Disabilities. *Journal of Applied Research in Intellectual Disabilities 15(3)*, 187-199.

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[5] In 1995 the United Nations (UN) adopted two definitions of poverty:
Absolute poverty is defined as: a condition characterised by severe deprivation of basic human needs, including food, safe drinking water, sanitation facilities, health, shelter, education and information. It depends not only on income but also on access to services.
Overall poverty takes various forms, including: lack of income and productive resources to ensure sustainable livelihoods; hunger and malnutrition; ill health; limited or lack of access to education and other basic services; increased morbidity and mortality from illness; homelessness and inadequate housing; unsafe environments and social discrimination and exclusion. It is also characterised by lack of participation in decision making and in civil, social and cultural life. It occurs in all countries: as mass poverty in many developing countries, pockets of poverty amid wealth in developed countries, loss of livelihoods as a result of economic recession, sudden poverty as a result of disaster or conflict, the poverty of low-wage workers, and the utter destitution of people who fall outside family support systems, social institutions and safety nets.

[6] Universal Credit: A preliminary analysis of its impact on incomes and work incentives.

Glendinning, A., Nuttal, M., Hendrey, L., Kleop, M., and Wood, S., (2003), Rural communities and wellbeing: a good place to grow up? *The Sociological Research*, No.51 pp129-56.

Goddard, M., and Smith, P., Equity of access to health care services: theory and evidence from the UK, Soc Sc.Med 2001, 53 1149-1162.

Midgley, Jane and Bradshaw, Ruth (August 2006), Should I stay or should I go, *Commission for Rural Communities*, Institute of Public Policy Research.

Milewski N, (2007), First child of immigrant workers and their descendants in West Germany: interrelation of events, disruptions, or adaptations, *Demographic Research* 17: 859-896.

McQuillan K, (2004), When does religion influence fertility? *Population and Development Review* 30: 25-56.

Shucksmith, M., (2007), Young people and social exclusion in rural areas, *Sociologia Ruralis*, Vol 44, Issue 1, pp43-59

Sobotka T, (2008), The rising importance of migrants for childbearing in Europe. *Demographic Research* 19: 225-48.

5. Health and wellbeing

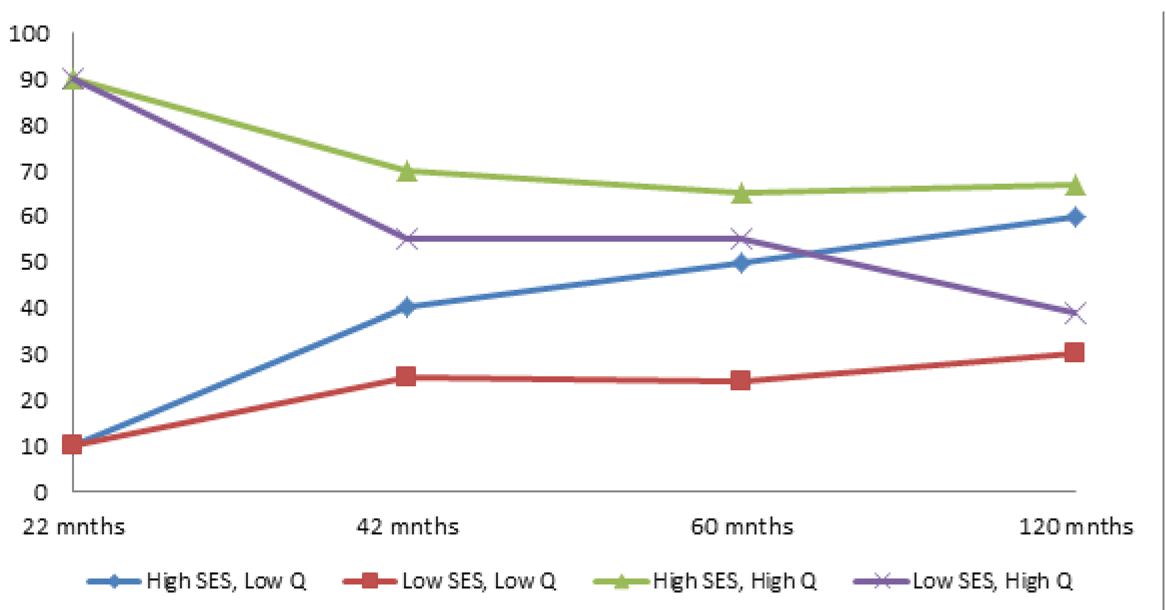
5.1. Introduction and policy context

The first policy objective in Fair society, Healthy Lives (2010) (also referred to as the Marmot Review) states *"Give every child a healthy start in life"* (Department of Health, 2014). To achieve this, the report highlights the need to prioritise pre and post natal interventions that reduce adverse outcomes of pregnancy and infancy. This includes interventions that target modifiable risk factors such as smoking, obesity, alcohol consumption, diet, illicit drugs, psychosocial stress and low socio-economic status. The most effective way to address these risk factors is to employ holistic approaches that allow for women to be assessed on their psychological, physical and social needs as well as capitalising on their assets and empowering them to make informed health and care choices. The policy details eight actions that must be implemented to help fulfil the needs of children:

- Helping families to have the best start in life
- Helping parents to keep their children healthy
- Encouraging healthy living from an early age
- Improving the health visiting service
- Protecting children through immunisation
- Supporting mothers and children with mental health problems
- Improving chances for children with vulnerable mothers
- Providing free school meals

As illustrated in Figure 10, the early years of life lay the foundations for later resilience in terms of key aspects of children's development and investment during this period therefore has considerable potential cost benefits.

Figure 10: Inequality in early cognitive development of children in the 1970 British Cohort Study, at ages 22 months to 10 years



Q = Cognitive score, SES= Social Economic Status
Source: 1970 British Cohort Study (Feinstein, 2003)

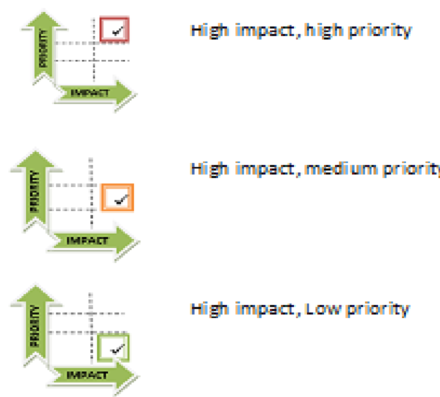
Local authorities are scheduled to take over responsibility from NHS England for commissioning public health services for infants up to 5 years old. This will be effective from 1 October 2015 and

presents an opportunity to bring together a range of different services for children and families with the potential to reduce health inequalities as well as inequalities from other aspects of life e.g. educational attainment.

This section aims to investigate the size of need within Herefordshire, comparing performance statistics of key indicators with national and statistical neighbours' averages and outline the evidence base for achieving better outcomes or performance for each indicator that Herefordshire is not performing well.

Each indicator will be labelled **low priority**, **medium priority** and **high priority**; this is based on how the county is performing compared to national or statistical neighbour's averages as well as the evidence base surrounding how each indicator impacts on a child's life. This will also help commissioners in having a snap shot overview of how Herefordshire is performing. Please note every outcome will have a high impact on the life of the individual child who is affected.

Key



5.2. Registered (health) population

The population registered with Herefordshire GPs does not necessarily match the resident population of the county. People who live in Herefordshire can register with GPs in neighbouring counties and vice versa, often in rural border areas this might be the closest practice. There are other definitional differences as well, for example short term migrants who are not counted in the population can register with GPs, but these are unlikely to affect children.

5.2.1. Current registered population

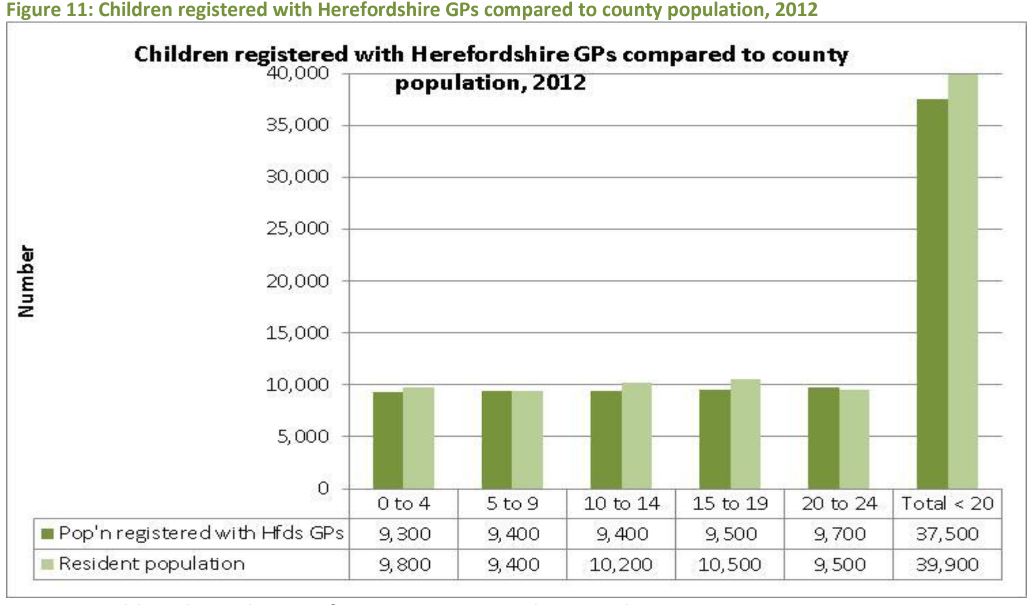
According to the latest data (January 2014), 182,200 people were registered with the 24 GPs in Herefordshire; 3.1% of whom (5,600) lived outside the county. Out of county registrations were highest at practices near the county border: 20% at both Colwall and Cradley, 16% at Kington, 13% at Golden Valley, 12% at Mortimer Medical Practice and 7% at both Ledbury practices.

Of the 182,200 patients, 38,200 of them were under 20: 21.0% – a similar proportion to the resident population. 9,400 were aged 20-24: 5.1% – again similar to the resident population. See Appendix 6 GP practice profile by Herefordshire deprivation quintile.

5.2.2. Registered population compared to resident population

Considering the latest date for which comparable data exists (2012), Figure 11 illustrates the differences between the registered and resident population of children and young people. There were 2,400 fewer under 20s registered with Herefordshire GPs (37,500) than were living in the county (39,900); the differences were spread across all ages except 5-9. These differences could be explained by under registration of children, but they could also be registered with out of county GPs – this data is not currently available.

Figure 11: Children registered with Herefordshire GPs compared to county population, 2012



	0 to 4	5 to 9	10 to 14	15 to 19	20 to 24	Total < 20
Pop'n registered with Hfds GPs	9,300	9,400	9,400	9,500	9,700	37,500
Resident population	9,800	9,400	10,200	10,500	9,500	39,900

Source: Health and Social Care Information Centre and ONS mid-year estimates

Unusually, there were 200 more 20 to 24 year olds registered than lived in the county – it is generally accepted that under registration amongst young adults (particularly males) means the opposite is true. The reason for this difference in Herefordshire could be young people not de-registering with their family GP when they move away from home, but it could also be due to

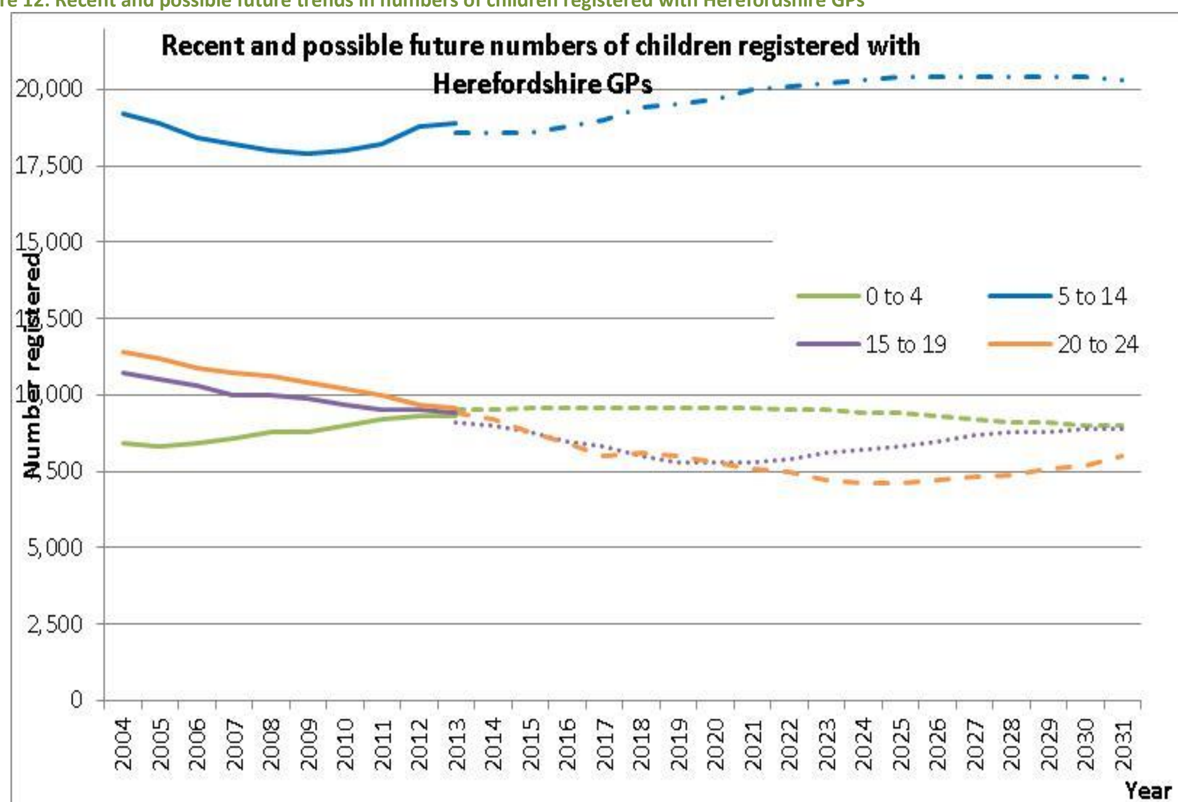
registrations of seasonal workers on farms who would not be counted as part of the resident population. Over a third of the several thousand workers from Eastern Europe who come to work on Herefordshire farms each year are aged 18 to 24.[7]

5.2.3. Trends in registered population and future numbers

There has been little similarity between trends in the total number of children registered with Herefordshire GPs and the number living in the county in recent years. Whilst the population of under 20s fell consistently from 41,400 in 2004 to 39,900 in 2012, the number registered with county GPs fell from 38,300 to 36,600 in 2009, but then increased to 37,600 by 2012.

The number of under 5s registered followed similar trends to residents, with the registered population equating to 95% - 98% of the resident population each year. There is some evidence of a divergence in recent years, which could be due to more people registering out of county, but could also be a sign of under registration.

Figure 12: Recent and possible future trends in numbers of children registered with Herefordshire GPs



Source: Health and Social Care Information Centre data applied to ONS mid-year estimates and GL Hearn population forecasts for Herefordshire Council

Numbers of 5-14s registered followed a similar declining trend to the population until 2009 (registered equating to about 87% of the population), but then started to increase. By 2012 the number registered was 97% of the resident population. There were the same number of 15-19 year olds registered as resident in 2004, but this then fell whilst the number of residents rose. Since 2007, numbers registered have followed a similar trend to the number of residents (average of 87%), although there may be signs of a convergence.

[7] See annual Seasonal Workers on Farms survey: http://factsandfigures.herefordshire.gov.uk/migrantworkers.aspx

The number of 20-24 year olds registered fell whilst the population rose; in 2004 there were 60% more registered than resident, but since 2011 the figure has been below 10%. Historically, it would be expected that more young adults were registered than lived in the county, because of a lag between moving away and registering with a new GP, although it is not possible to quantify this. The increase in the resident population has been driven by international migrants; it is possible that they are under registered.

The observed relationships can be used to calculate some crude indicative estimates of what the future population registering with Herefordshire GPs might be, and these are shown in Figure 12. A point to note is that the realisation of these future trends would rely on future relationships between the registered and resident population being the same as observed in recent years.

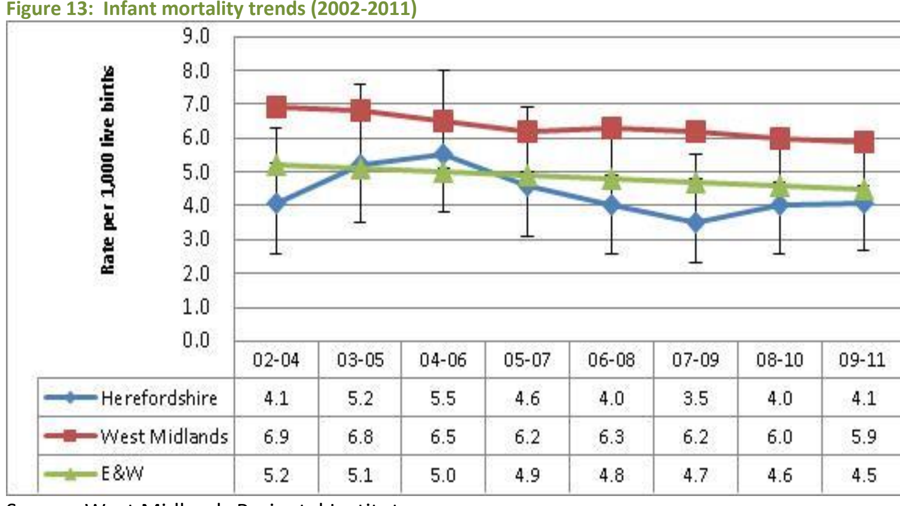
Based on these assumptions, the total number of under 20s registered with Herefordshire GPs would fall from the current (2013) level of 37,600 to 36,900 by 2016, before rising to level off at 38,300 by 2027, as shown in Figure 12. Appendix 7 to Appendix 9 illustrates trends for each age group.

5.3. Perinatal mortality and infant mortality

Perinatal mortality refers to deaths within the first week of life including still births. Infant mortality refers to deaths within the first year of life.

Infant mortality is seen as a key health outcome and there is an evidenced link between social and health inequalities and rates of infant mortality (Office of National Statistics Childhood). In Herefordshire between 2001 and 2012, there were 89 deaths in total for children below the age of five years. Over 50% of deaths in this age group are perinatal or neonatal (deaths within a month of death), with around six such deaths per year across the 12 year period. The infant mortality rate per 1,000 live births in Herefordshire was 4.1 for the period 2009-2011; this is not significantly different to the England’s average rate of 4.5 deaths per 1,000 live births (West Midlands Perinatal Institute).

Figure 13: Infant mortality trends (2002-2011)



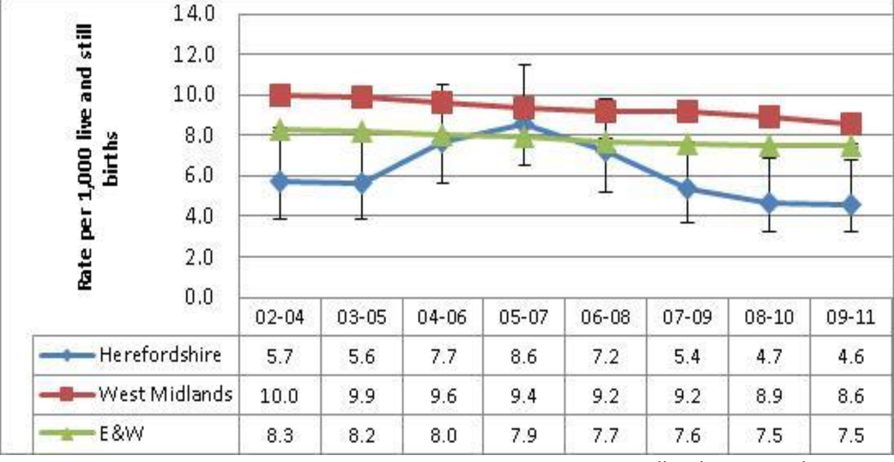
	02-04	03-05	04-06	05-07	06-08	07-09	08-10	09-11
Herefordshire	4.1	5.2	5.5	4.6	4.0	3.5	4.0	4.1
West Midlands	6.9	6.8	6.5	6.2	6.3	6.2	6.0	5.9
E&W	5.2	5.1	5.0	4.9	4.8	4.7	4.6	4.5

Source: West Midlands Perinatal Institute

Figure 13 demonstrates the tendency for local rates to fluctuate year on year within a broadly decreasing trend due to the relatively small number of deaths being measured.

Perinatal mortality rates in Herefordshire are significantly lower than regional and national rates at 4.6 deaths per 1,000 live and still births. Locally, this trend has been decreasing since 2005-2007 by 0.8 deaths per 1,000 live and still births

Figure 14: Perinatal mortality trends 2002-2011



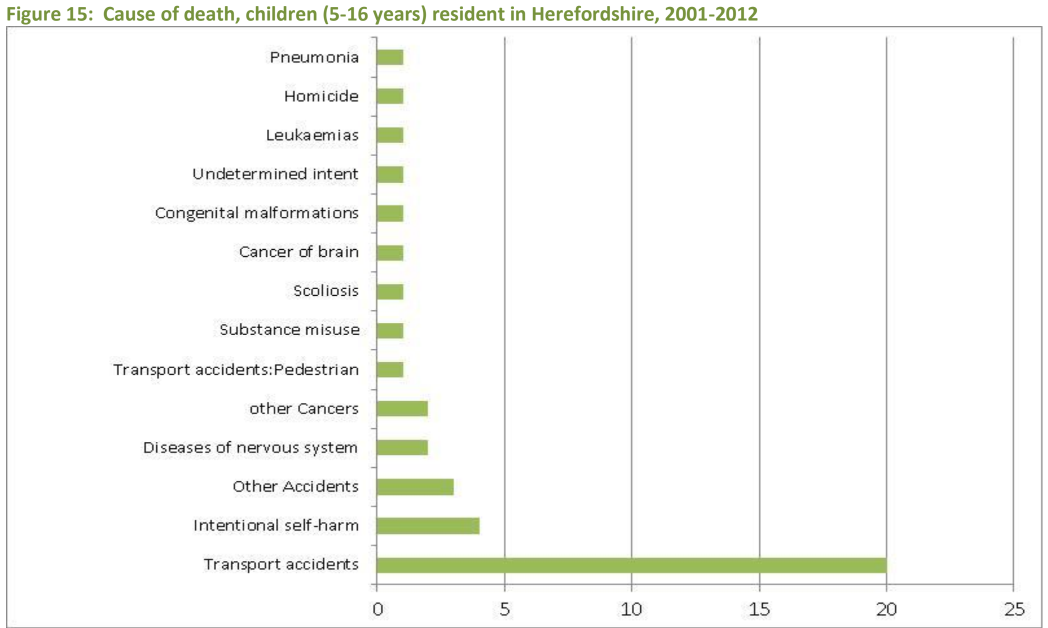
	02-04	03-05	04-06	05-07	06-08	07-09	08-10	09-11
Herefordshire	5.7	5.6	7.7	8.6	7.2	5.4	4.7	4.6
West Midlands	10.0	9.9	9.6	9.4	9.2	9.2	8.9	8.6
E&W	8.3	8.2	8.0	7.9	7.7	7.6	7.5	7.5

Source: West Midlands Perinatal Institute

5.4. Causes of mortality among school aged children (5-16 years) and young people (17-19 years)

There were a total of 58 deaths between 2001-2012 among those aged between 5 and 16 years. The most frequent cause of death was transport accidents which represented around 35% of deaths across the period (see Figure 15). The directly standardised child mortality rate (1-17 years old) for 2009-2011 was 14.8 per 100,000 population. This rate is slightly higher than the England average rate of 13.7 deaths per 100,000 population, though the difference is not statistically significantly.

Figure 15: Cause of death, children (5-16 years) resident in Herefordshire, 2001-2012

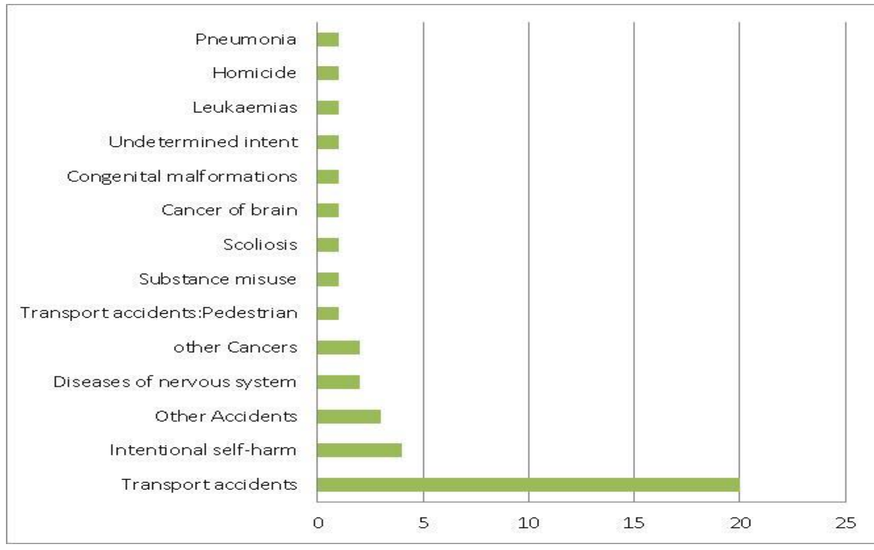


Source: Health intelligence, Herefordshire Council

The local crude rate of children (0-15 years) killed or seriously injured in road traffic accidents in the period 2009-2011 was 16.1 per 100,000 population, not significantly different from the England average rate of 22.1 per 100,000 (Chimat, 2013).

There were a total of 40 deaths between 2001 and 2012 among those aged 17-19 years.

Figure 16: Causes of death, young people (17-19 years), 2001-2012 Herefordshire residents



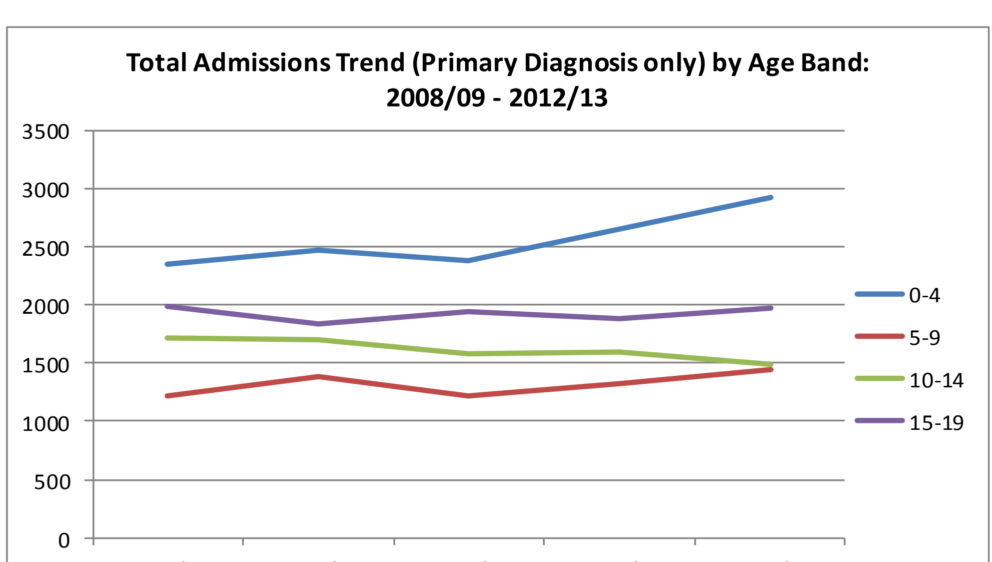
Source: Health intelligence Herefordshire Council

50% of these deaths were due to transport accidents (Figure 16). The crude rate of hospital admissions as a result of self-harm among those aged 0-17 years was 138.8 per 100,000 population in 2011/12. Not significantly different from the England rate of 115.5 admissions per 100,000 population.

5.5. Hospital admissions

There was an average of 7,400 admissions per annum in the five years from 2008/09 to 2012/13 and an increase of nearly 5% in total admissions of children (0-19 years) in 2012/13 specifically. Approximately 40% of admissions in 2012/13 were emergency admissions. There has been a sharp growth in the number of admissions of children aged 0-4 years (23%) and 5-9 years (18%) over the last two years. Admissions of children aged 10+ years have remained static over the same period (see Figure 17). Herefordshire's hospital admissions statistics could not be measured against other areas due to the unavailability of comparator data.

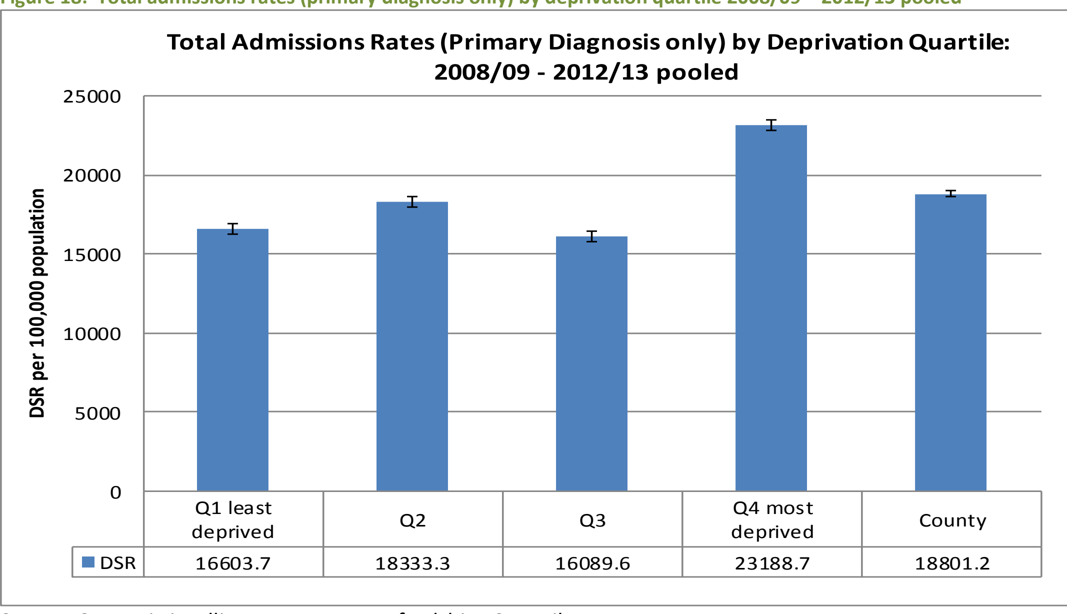
Figure 17: Total admissions trends (primary diagnosis only) by age band 2008/09 - 2012/13



Source: Strategic intelligence team Herefordshire Council

Rates of admission from the most deprived areas of the county are significantly high relative to all other areas (Figure 18); the most deprived quartile of population accounted for 35% of total admissions.

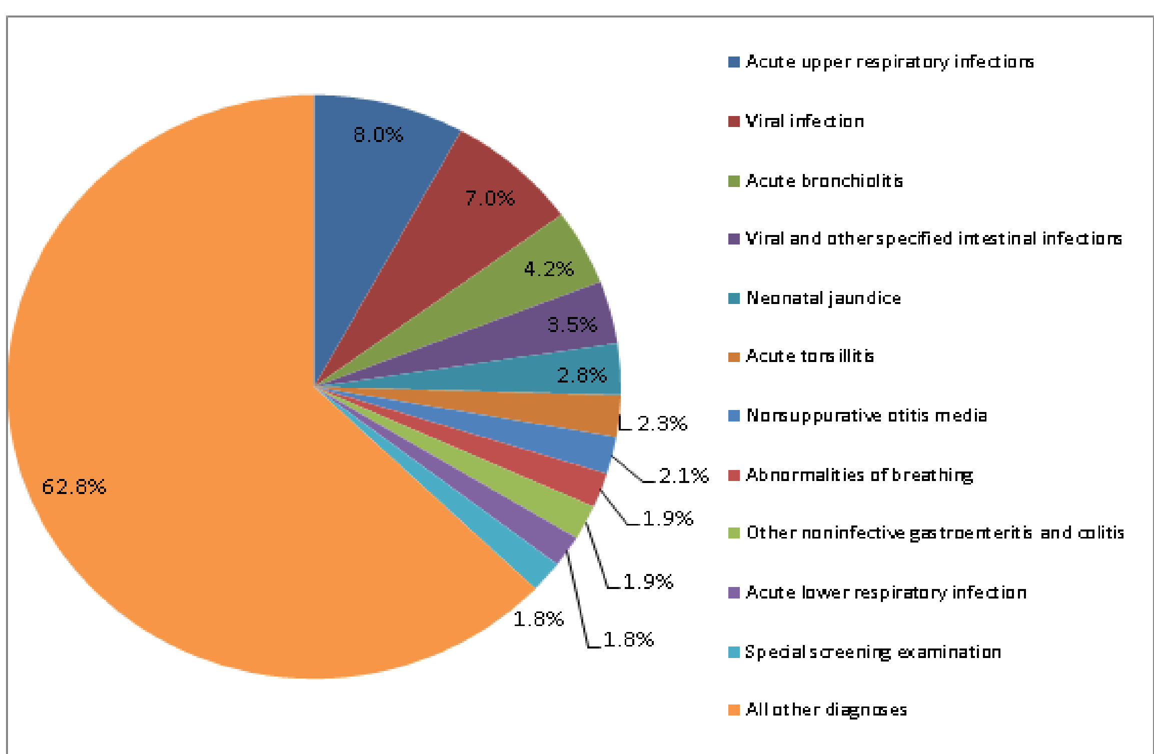
Figure 18: Total admissions rates (primary diagnosis only) by deprivation quartile 2008/09 – 2012/13 pooled



Source: Strategic intelligence team, Herefordshire Council

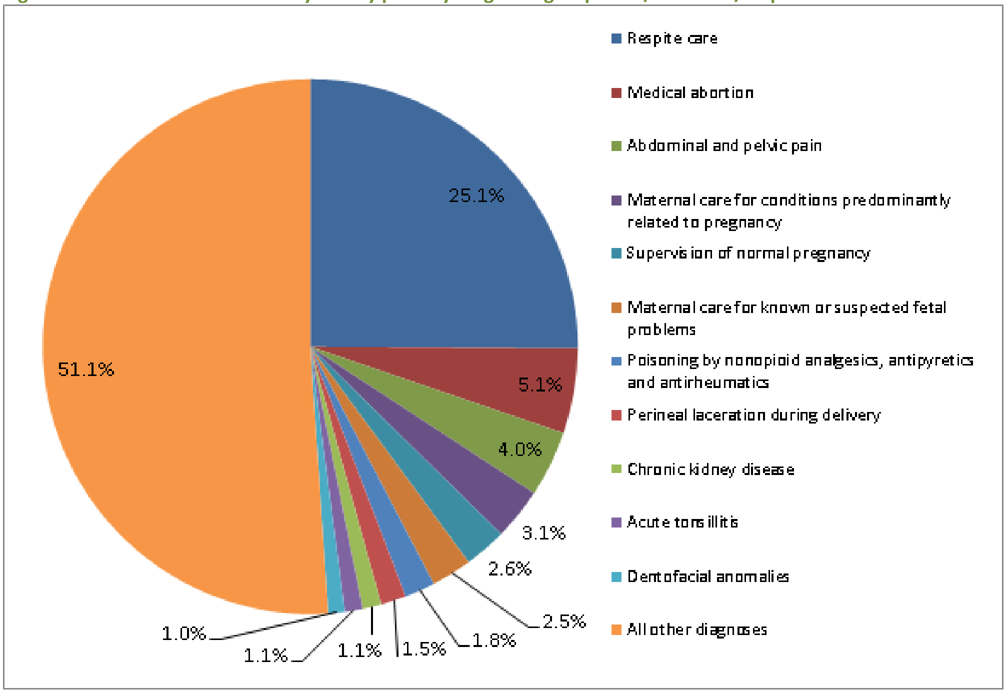
Viral infections (all sites) are the most common specific cause of admissions among children aged 0-4 years representing 10.5% of total admissions. Acute upper respiratory infections (including acute tonsillitis) account for a further 10.3% of admissions as shown in Figure 19.

Figure 19: Total admissions 0-4 years by primary diagnosis group 2008/09 - 2012/13 pooled



Source: Strategic intelligence team, Herefordshire Council

Figure 20: Total admissions 15-19 years by primary diagnosis group 2008/09 - 2012/13 pooled



Source: Strategic intelligence team, Herefordshire Council

Almost 15% of admissions of young people aged 15-19 years are pregnancy related (including medical abortion procedures) as shown in Figure 20.

5.5.1. Respiratory admissions

There were approximately 850 respiratory admissions per annum among children aged 0-19 years in the period 2008/09 to 2012/13. 80% of all admissions were emergency admissions. The proportion of admissions due to acute upper respiratory infections declined from over 50% among those aged 0-4 years to around a third among those aged 5+ years, as shown in Figure 21. The proportion of admissions due to acute lower respiratory infections (e.g. influenza and pneumonia) declines with age from around 37% among those aged 0-4 years to just 12% among those aged 15+ years. Chronic lower respiratory diseases (e.g. asthma) account for only 5% of admissions among young children (0-4 years) but around 20% of admissions among those aged 5+ years.

Rates of admission are significantly higher from the most deprived quartile of population than from across the county as a whole. Children residing in the most deprived areas are almost 40% more likely to be admitted due to a respiratory infection than those living in the least deprived areas as shown in Figure 22.

Admission numbers were up by around 20% in 2012/13 compared to 2008/09 as shown in Figure 23. Acute upper respiratory infections (e.g. tonsillitis) account for almost half of all admissions.

Figure 21: Percentage respiratory admissions (primary diagnosis) by age band 2008/09 - 2012/13 pooled

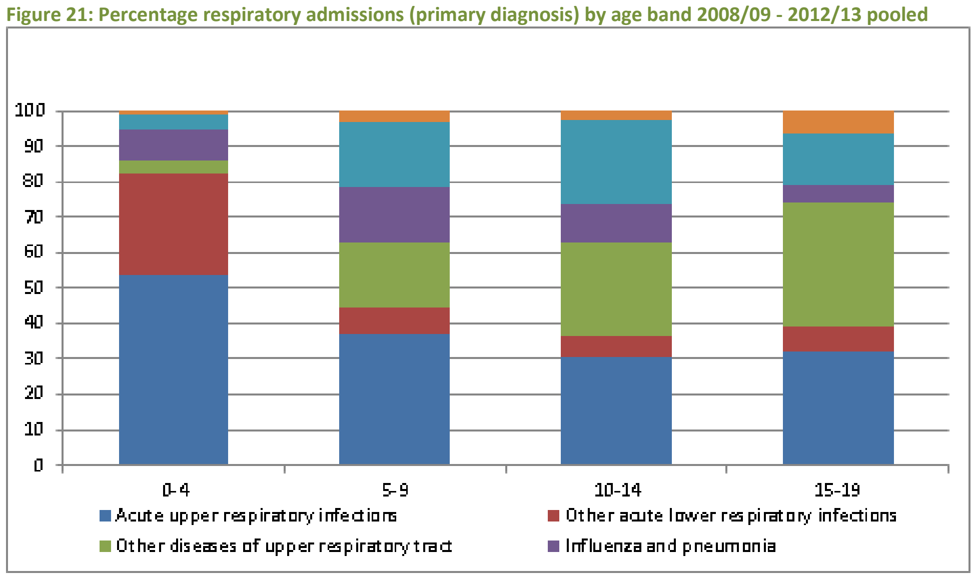
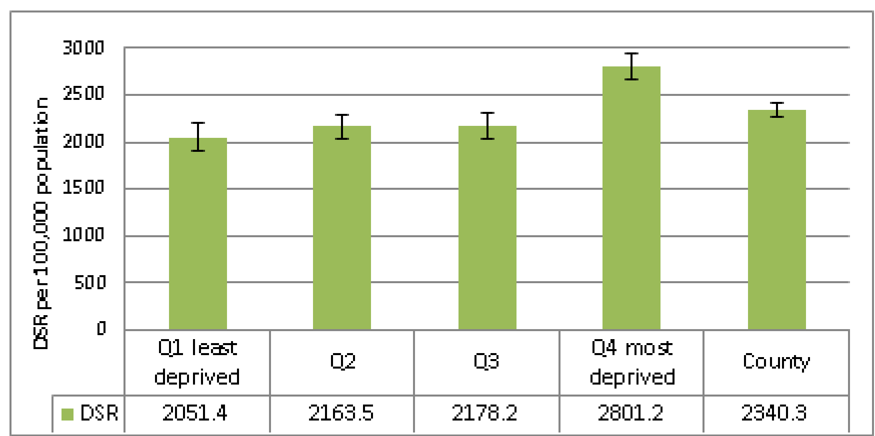


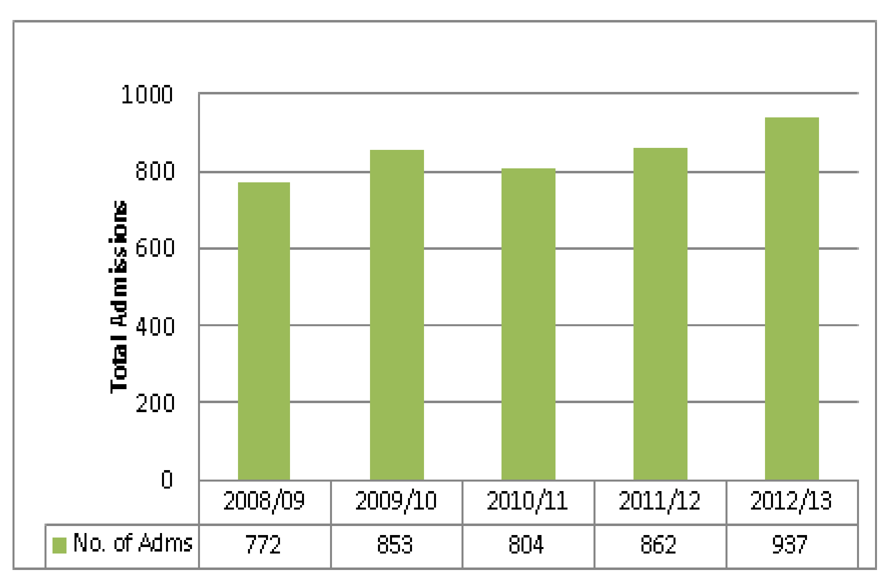
Figure 22: Respiratory admission rates (primary diagnosis) of children by deprivation quartile



	Q1 least deprived	Q2	Q3	Q4 most deprived	County
DSR	2051.4	2163.5	2178.2	2801.2	2340.3

Source: Strategic intelligence team, Herefordshire Council

Figure 23: Respiratory admissions of children trend 2008/09 - 2012/13



	2008/09	2009/10	2010/11	2011/12	2012/13
No. of Adms	772	853	804	862	937

Source: Strategic intelligence team, Herefordshire Council

Figure 24: Respiratory admissions of children by diagnosis group 2008/09 - 2012/13 pooled

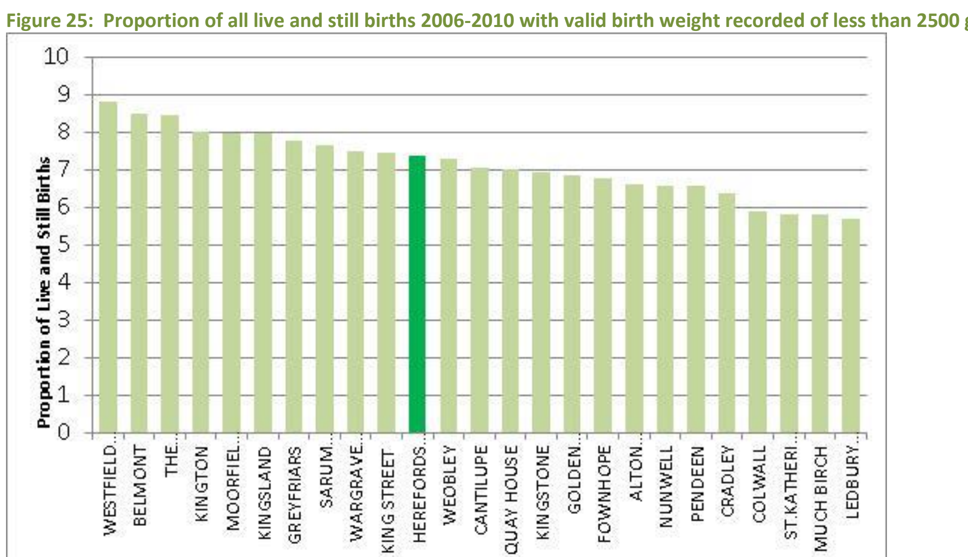
Source: Strategic intelligence team, Herefordshire Council

5.6. Birth weight

Low birth weight (defined as birth weight of less than 2500 grams) is associated with foetal and neonatal morbidity and mortality, impaired cognitive development and the advent of chronic diseases in later life.

National Child Health Profiles reveal that in 2011 the percentage of live and stillbirths with low birth weight in Herefordshire was 5.2% (96 births), a figure significantly lower than the national average of 7.4%, with a minimum of 5% and maximum of 8%. Figure 25 illustrates that the proportion of low birth weight births between 2006 and 2010 ranged locally by GP practice from 5.7% to 8.8% around a county average of 7.4%. Generally practices serving the most deprived practice populations had the highest proportion of such births. Investigations must be carried out to address the reason for such inequalities; for example higher maternal smoking rates and alcohol consumption leading to a higher proportion of low birth weight babies.

Figure 25: Proportion of all live and still births 2006-2010 with valid birth weight recorded of less than 2500 grams



Source: National General Practice Profiles

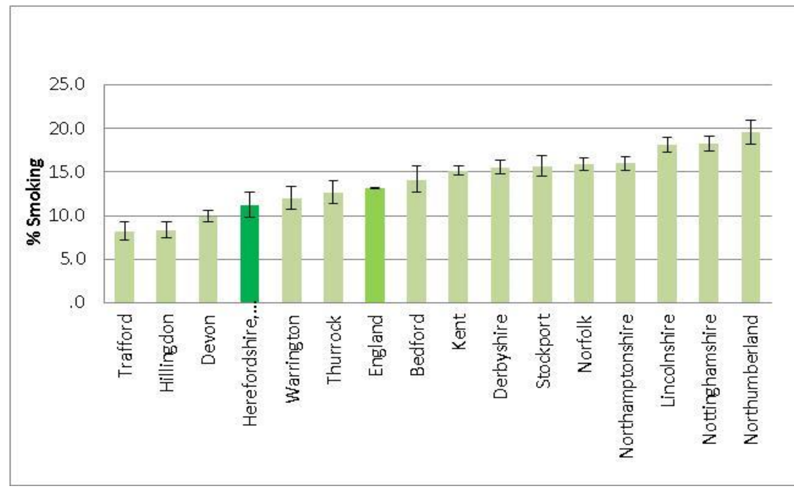
5.7. Maternal health

The health and wellbeing of women before, during and after pregnancy is an important factor in giving children a healthy start in life and the foundation for good health and wellbeing in later life. There are a number of modifiable risk factors that women can change before and during pregnancy to ensure a healthy start for the baby.

5.7.1. Smoking status

Smoking is a modifiable risk factor which has been shown to have a substantial impact on the development of the foetus and subsequent health of the child. In addition, smoking during pregnancy increases the likelihood of babies being born underweight, leading to health problems highlighted in the previous section. On average, women who smoke give birth to babies 200g lighter than non-smoking mothers. Herefordshire has a rate of smoking at time of delivery of 11.2 per 100 maternities (204 of 1,827 maternities in 2011/12).

Figure 26: Smoking status at time of delivery by local authority comparator group 2011/12



Herefordshire ranks fourth in terms of performance out of 15 comparator local authorities within the same national deprivation decile (Figure 26). It has a statistically significant lower rate than England at 13.2 per 100 maternities but is still considerably higher than the maximum rate in England of 3.2 per 100 maternities.

Source: Children and young people health outcomes framework

Unfortunately, there was no data available to investigate any inequalities in smoking rates by GP practice population.

There is no data routinely collected on smoking by partner, which also has both a direct and indirect impact on children and is the most powerful influence on the mother's smoking habit. There is a need for health professionals to also investigate the smoking habits of partners so that a holistic view on all potential negative impacts on a child's life are taken into account and minimised.

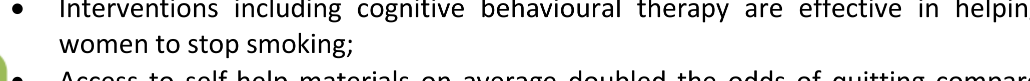
Evidence base

There is no evidence on the interventions that are effective for women from disadvantaged backgrounds, despite the fact that these women are more likely to smoke and

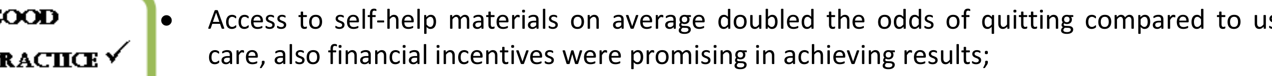
Though Herefordshire is performing relatively better than England, smoking has multiple short and long term adverse effects on both the foetus and child and can be an indicator of a pregnant woman's self-esteem, thus this area remains of **medium priority**. This means smoking cessation services should be maintained to ensure that the few women that

need these services are able to access these them. It must also be noted for those that smoke the impact on a child's health remains **high**.

A systematic review of reviews on interventions to support smoking cessation in pregnancy, (Ryan, 2013) concluded that:



- Interventions including cognitive behavioural therapy are effective in helping pregnant women to stop smoking;



- Access to self-help materials on average doubled the odds of quitting compared to usual care, also financial incentives were promising in achieving results;
- The use of nicotine replacement was equivocal, however better quality studies showed little effect on foetal outcomes.

All of the above findings were echoed in the Chief Medical Officers Report (2013). The NICE and Scottish Guidelines recommend that midwives and health professionals working with pregnant women refer those who smoke to NHS Stop Smoking Services (also called smoking cessation services).

5.7.2. Maternal obesity

Maternal obesity (defined as obesity during pregnancy) increases health risks for both mother and child during and after pregnancy. Unfortunately, there is no routinely collected data in the UK on pregnant women's weight status.

5.7.3. Alcohol consumption

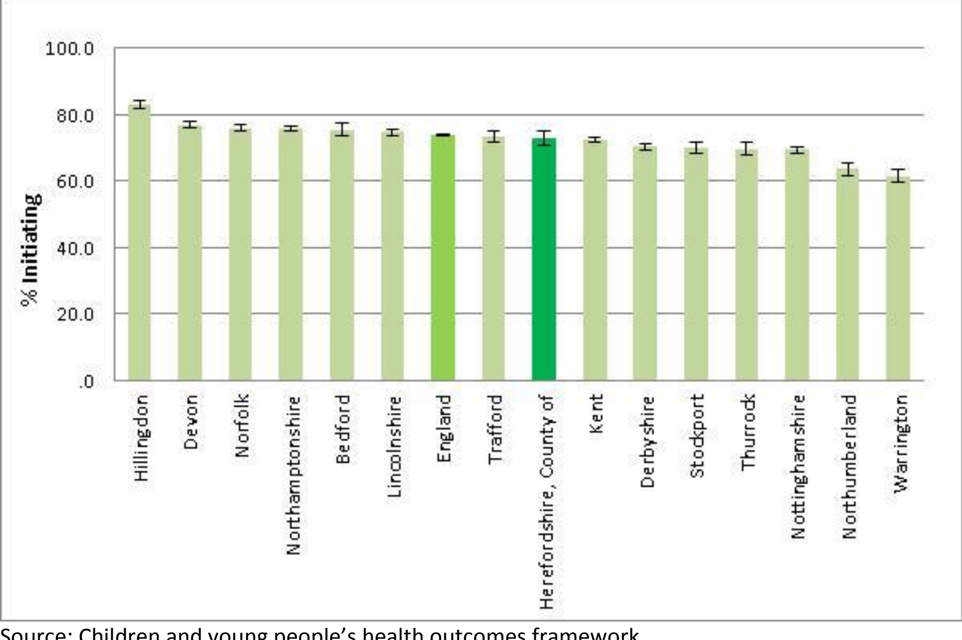
As with smoking, consuming alcohol during pregnancy can seriously affect the development of the baby. Drinking during the first trimester is associated with the increased risk of miscarriage and drinking heavily throughout pregnancy is associated with the development of foetal alcohol syndrome. At the time of the needs assessment there was no data or other intelligence regarding alcohol consumption during pregnancy for Herefordshire.

5.8. Breastfeeding

Breast milk protects against gastroenteritis and respiratory infections as well as against ear infections, urinary tract infections and early onset/juvenile diabetes mellitus. Initiation rates in the UK are among the lowest in Europe and there are high discontinuation rates. Areas of higher socio-economic deprivation tend to have the lowest initiation and duration rates contributing to health inequalities. Lower socio economic areas have the lowest initiation and duration rates contributing to health inequalities.

Herefordshire has a breastfeeding initiation rate (in the 48 hours after delivery) of 73% (1,332 mothers initiating per 1,827 maternities in 2011/12). It ranks eighth in terms of performance of 15 comparator local authorities within the same national deprivation decile and is approximately 10 percentage points behind the best performing authority (Figure 27). Herefordshire has a marginally lower rate of initiation than nationally (74% of mothers) though this is not statistically significant. England's worst and best initiation rates are 43% and 94% respectively.

Figure 27: Breastfeeding initiation by local authority comparator croup 2011/12



Source: Children and young people's health outcomes framework

The breastfeeding duration rate (still breastfeeding at 6 to 8 weeks) is 47.6%, almost identical to England's average rate and ranking fifth best performance among comparator group local authorities. England's worst and best breastfeeding duration rates are 20% and 82% respectively. This performance, though similar to England's average, is poor; therefore this area should be regarded as a **high priority** area. There is a need for breastfeeding campaigns nationally and locally to encourage mothers to breastfeed for longer.

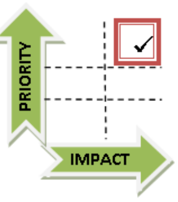
Unfortunately, there is no data to compare performance across the county. This would allow campaigns targeted to specific areas to address potential inequalities.

Evidence review and good practice

Breast milk provides complete nutrition for infants and as such the World Health Organisation (WHO) recommends that babies should be breastfed exclusively for six months. There have been a number of systematic reviews investigating the effectiveness of public health promotions for breastfeeding initiation and duration.

NICE public health guidance recommends that the UNICEF UK Baby Friendly Initiative should be the minimum standard for the NHS and that a combination of interventions including antenatal education, peer support and education and training for health professionals should be put in place. There is a strong evidence base to inform such recommendations (Renfrew, et al, 2005).

5.9. Immunisation status

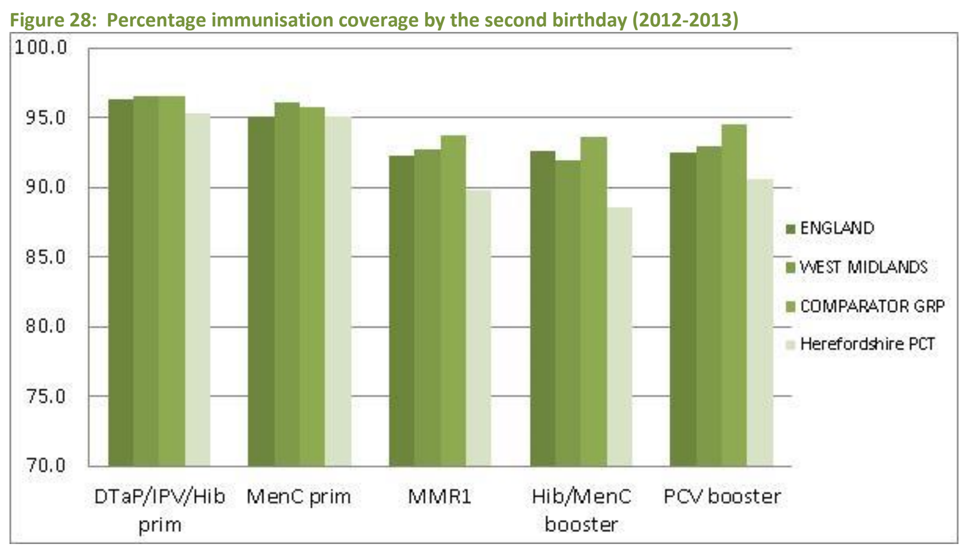


The aim of the routine childhood immunisation programme is to protect all children against a number of preventable diseases - polio, pertussis, diphtheria, tetanus, meningococcal serogroup C (menC), haemophilus influenza type B (Hib), measles, mumps and rubella (MMR) and pneumococcal virus (PCV). High percentage immunisation coverage is required to achieve herd immunity

(individuals are less likely to be a source of infection), therefore ensuring there is a reduction in the number of outbreaks and epidemics.

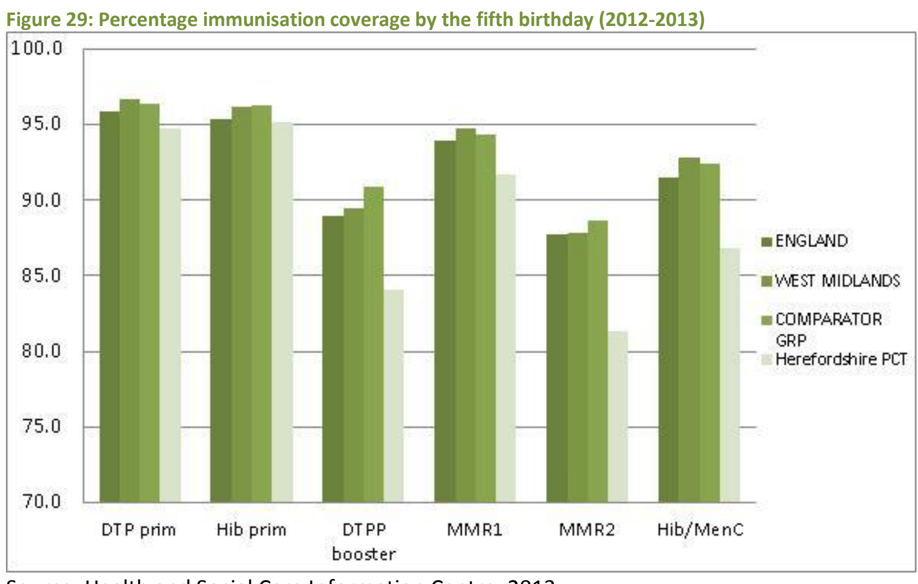
In 2012/13, Herefordshire rates of immunisation of children by their first birthday are broadly in line with national and regional rates at around 94% immunised. However by their second birthday, Herefordshire rates are considerably lower than regional, national and comparator[8] rates for MMR (first dose), HibMenC (booster) and PCV booster (Figure 28), with only 89% - 90% of children receiving their immunisations. This means the county, in line with the rest of the country, is not meeting the 95% recommended coverage set by the WHO.

Figure 28: Percentage immunisation coverage by the second birthday (2012-2013)



This trend continues as immunisation of children by their fifth birthday is comparatively very low for DTPP booster, MMR (first and second dose) and Hib/MenC booster as shown in Figure 29.

Figure 29: Percentage immunisation coverage by the fifth birthday (2012-2013)



Source: Health and Social Care Information Centre, 2013

[8] The comparator group comprises the four most similar health organisation areas (PCTs) to Herefordshire based on ONS classification.

Evidence review and good practice

NICE public health guidance 21 - reducing differences in the uptake of immunisations, lists recommendations for commissioners, local authorities, children services, services for vulnerable families including family nurse partnerships to adopt a multifaceted, coordinated programme across different settings to increase timely immunisation among groups with low or partial uptake. The programme should form part of the local child health strategy. This could be part of universal services within the healthy child programme.

5.10. Dental health

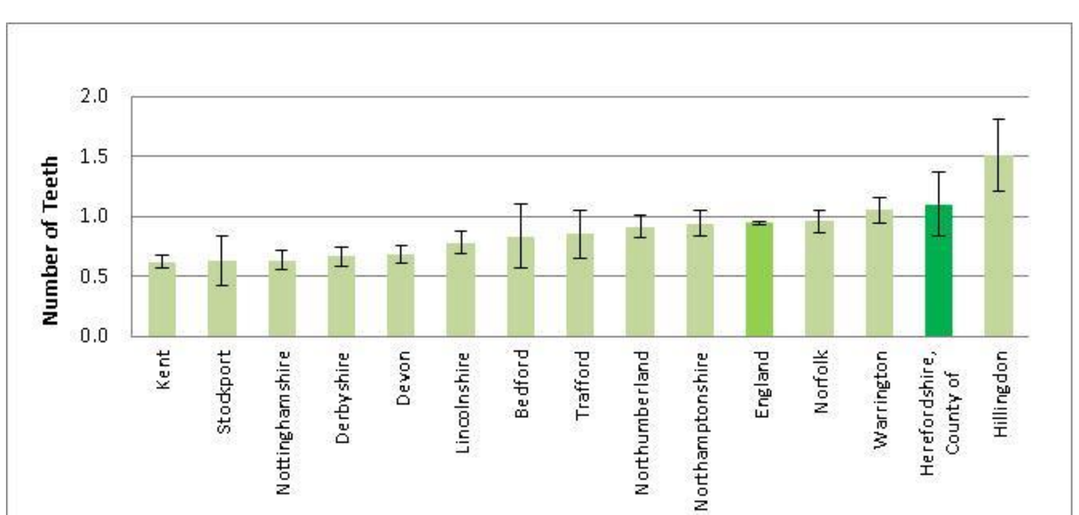
The oral health of a population is related to a range of factors including socio-economic conditions and there is an established relationship between poor oral health and deprivation. Differences in oral health across the county are expected to mirror differences in socio-economic conditions, for example poorer levels of oral health in the more deprived areas of the county.

PRIORITY IMPACT

Herefordshire children aged five years had on average 1.1 teeth per child found to be decayed, missing or filled (d3mft) in 2011/12, compared to the best performing authority value of 0.62 teeth per child. It ranks 13 out of 14 comparator local authorities (for whom data was available) within the same national deprivation decile in Figure 30. Herefordshire has a higher rate of tooth decay than nationally (d3mft=0.94), though not significantly so. This may be due to the fact that Herefordshire's water is not fluoridated. Research shows that levels of tooth decay are associated with fluoride levels in drinking water with fluoridation contributing to reduced decay levels in populations.

The 2008/09 NHS Dental Epidemiology Programme survey of the dental health of 12 year-olds found that in Herefordshire 44.4% of 12 year olds had evidence of dental decay with an average of 1.07 decayed, missing or filled permanent teeth per child (compared to 32% and 0.68 in the West Midlands and 33.4% and 0.74 in England). For those children with evidence of decay, the average number of affected teeth was 2.41 (West Midlands = 2.13; England = 2.21). This is the latest dental survey, however at the time of this needs assessment another was being commissioned.

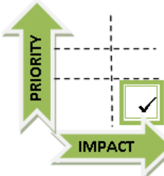
Figure 30: Mean number of decayed, missing and filled teeth (d3mft) per child by local authority comparator group 2011/12



Evidence review and good practice

Guidance on oral health (local authority oral health improvement strategies) is currently under development by the National Institute for Health and Care Excellence. This is expected to be published later this year (October 2014).

5.11. Obesity/overweight



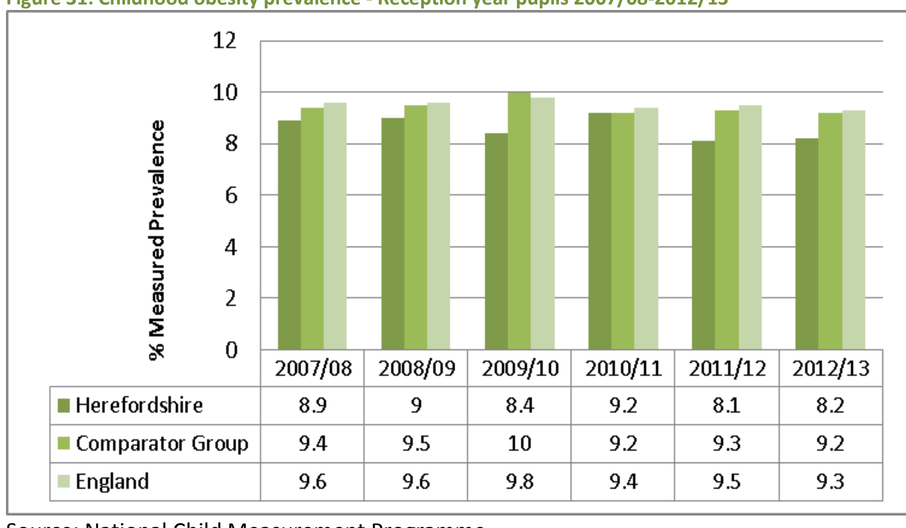
The World Health Organisation (WHO) regards childhood obesity as one of the most serious global public health challenges for the 21st century. Obese children and adolescents are at an increased risk of developing various health problems and are also more likely to become obese adults.

The National Child Measurement Programme (NCMP) measures the height and weight of around one million school children in England every year, providing a detailed picture of the prevalence of child obesity. Herefordshire has a lower prevalence of obesity and overweight among Reception year pupils than a comparator group[9] of PCTs[10] and nationally, though this is not a statistically significant difference (Figure 31).

The prevalence of obesity (based on the three year period 2009/10 to 2011/12) among Reception year pupils varies across the county from 13.5% in South Leominster MSOA to 5.2% in Ross-on-Wye MSOA around an average rate of 8.6%. The county average is not significantly different to the national average of 9.6%, though Greater Ledbury and Ross-on-Wye MSOAs are significantly low in both national and regional terms.

Herefordshire has a significantly lower prevalence of obesity among Year 6 pupils than nationally (see Figure 32). This prevalence varies across the county from 25.7% in South Wye West MSOA to 9.7% in Malvern Beacons MSOA, around a county average rate of 16.5%. The equivalent national rate is 19.0%. South Wye West has a significantly high rate relative to the county average. The county rate is significantly low in national and regional terms.

Figure 31: Childhood obesity prevalence - Reception year pupils 2007/08-2012/13



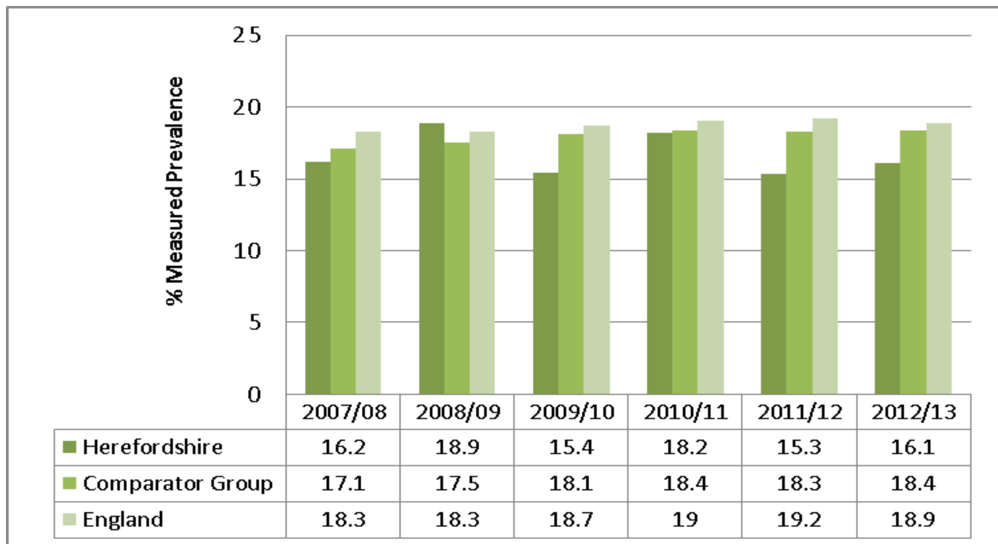
	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13
Herefordshire	8.9	9	8.4	9.2	8.1	8.2
Comparator Group	9.4	9.5	10	9.2	9.3	9.2
England	9.6	9.6	9.8	9.4	9.5	9.3

Source: National Child Measurement Programme

[9] Comparator group comprises Shropshire County, Somerset, Lincolnshire and East Riding of Yorkshire PCTs.
[10] Primary Care Trusts were abolished in March 2013 and replaced by CCGs, though still in existence during the time periods covered by this analysis.

Since April 2013, public health is the responsibility of local government. Ideas for success are outlined in the paper 'Tackling obesity: Local government's new public health role'. At county level this is a high impact but low priority area. There is a need for the local authority to continue with existing services and prioritise those areas with high prevalence of obesity.

Figure 32: Childhood obesity prevalence – Year 6 pupils 2007/08-2012/13



	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13
Herefordshire	16.2	18.9	15.4	18.2	15.3	16.1
Comparator Group	17.1	17.5	18.1	18.4	18.3	18.4
England	18.3	18.3	18.7	19	19.2	18.9

Source: National Child Measurement Programme

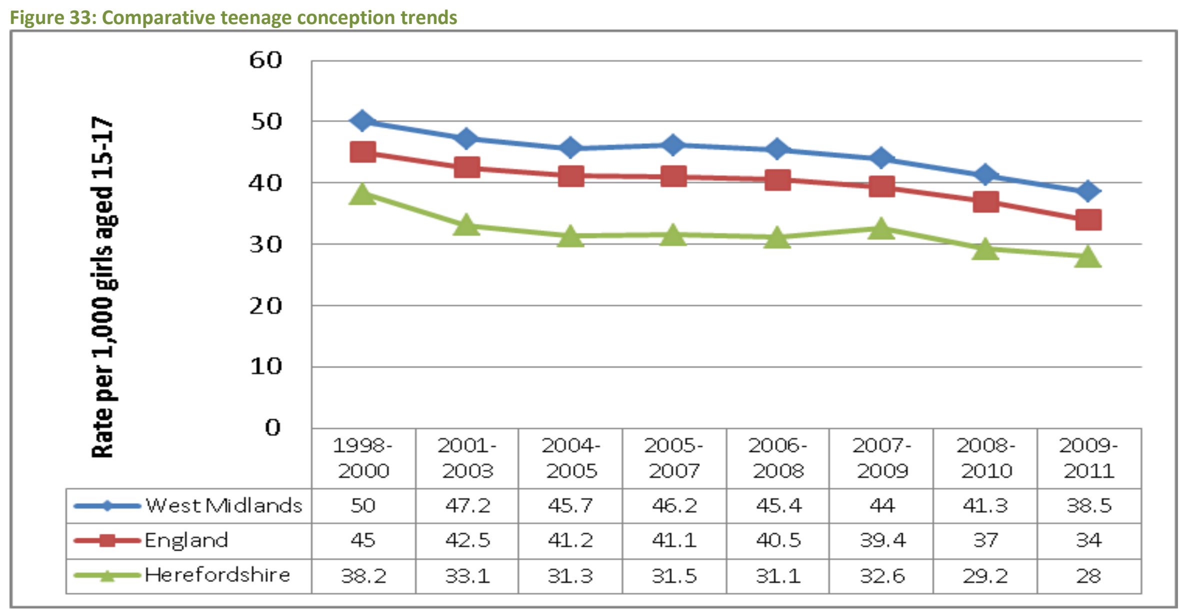
5.12. Teenage conceptions

Herefordshire had a teenage conception rate of 26.0 per 1,000 girls aged 15-17 years in 2011 or 86 conceptions. It ranks fourth (in terms of performance) out of 15 comparator local authorities within the same national deprivation decile. This rate is not significantly different from the national rate of 30.7 per 1,000 girls. In 2011, approximately 55% of teenage conceptions resulted in a maternity episode and 45% in a termination of pregnancy.

Pooled three year conception rates smooth out the fluctuations in annual rates based on small numbers. The latest three year pooled teenage conception rate in Herefordshire is 28.0 per 1,000 girls aged 15-17 years in 2009-11. Local rates have fallen by over 25% since the period 1998-2000 in line with other areas and are consistently lower than national and regional rates (

Figure 33).

Figure 33: Comparative teenage conception trends



	1998-2000	2001-2003	2004-2005	2005-2007	2006-2008	2007-2009	2008-2010	2009-2011
West Midlands	50	47.2	45.7	46.2	45.4	44	41.3	38.5
England	45	42.5	41.2	41.1	40.5	39.4	37	34
Herefordshire	38.2	33.1	31.3	31.5	31.1	32.6	29.2	28

Source: Teenage Pregnancy Unit

The highest conception rate in the county (2009-11 pooled) was recorded in Leominster South ward at 75 conceptions per 1,000 girls; significantly high relative to the county overall. Over 20% of conceptions are accounted for by the South Wye wards of Belmont and St Martins and Hinton.

Evidence review for teenage pregnancy

Evidence shows that if a young person experiences multiple risk factors, she has a 56% chance of becoming a teenage mother compared to a 3% chance of a young person experiencing none of these risk factors (Kiernan, 1995). High risk factors include living in care, living in a deprived area, alcohol and substance abuse, early onset of sexual activity and low educational attainment. Teenage pregnancy, like child poverty, tends to follow inter-generational cycles. As Ermisch et al (2003) found, children disadvantaged by deprivation and poverty are at an increased risk of teenage pregnancy, especially those living in workless households, aged 11-15 years and who leave school at 16 with few or no qualifications. Best practice indicates that early help for young people (aged 8 to 12 years), who are at risk from disengaging from education can reduce the number of teenage pregnancies. Early help includes supporting children to gain skills that help them to make healthier life choices and also to increase their sense of self worth.

From 1 April 2013, local authorities became responsible for commissioning comprehensive sexual health services and evidence suggests that such services can reduce teenage pregnancies. This area of work requires more attention in Herefordshire.

5.13. Smoking, substance and alcohol misuse

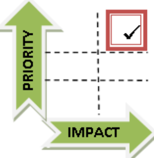
5.13.1. Alcohol misuse

Whilst alcohol misuse can present health problems for all age groups, the risks are far higher in young people as their bodies are still growing and alcohol can interfere with their development. Research has shown that alcohol may leave young people vulnerable to long term damage leading to conditions such as cancer of the mouth and throat, sexual and mental health issues, liver cirrhosis and heart disease.

The latest survey investigating health and lifestyle behaviours in children and young people in Herefordshire was carried out in the 2009 "Every Child Matters Survey". This survey was completed by 7,000 children and young people aged 5-18 years attending Herefordshire schools and colleges. This is now out of date, however still gives some insight on the behaviours of children and young people:

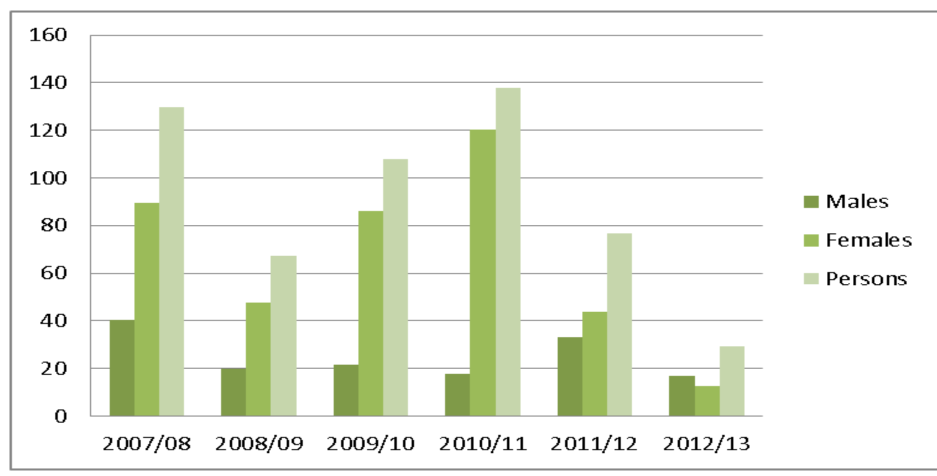
- 47% of children aged 5-8 years said they had 'ever' tasted alcohol and 15% confirmed they had drunk alcohol in the week prior to the survey.
- 9% of 8-11 year olds said they drank an alcoholic drink on at least one day in the week prior to the survey.
- 13% of children aged 11-15 years reported they had been 'drunk' at least once in the month prior to the survey, 13% reported they had drunk two or more units of alcohol in the week before the survey, 14% reported drinking alcohol at home in the past week, 9% at a friend or a relation's home and 6% in a public place.
- 46% of young people aged 15+ years drank alcohol on at least one day during the week before the survey, 6% had never drank alcohol, 42% had been drunk at least once in the past four weeks and of these who had drunk alcohol, 59% had drunk at home, 56% drank in a pub or bar and 18% drank at home.

5.13.2. Hospital admissions attributable to alcohol/substance misuse



Alcohol attributable admission rates for under 18s have shown a decreasing trend between 2010/11 and 2012/13, following a sharp increase in the previous two years (see Figure 34). However, they are still significantly higher than the England average and compare poorly against other areas (ranked 262 of 317 local authorities for which data has been published).

Figure 34: Alcohol attributable admissions (under 18 years only) 2007/08-2012/13



Source: Health intelligence team, Herefordshire Council

Alcohol specific admissions often reflect the effects of binge drinking among young people e.g. conditions such as mental and behavioural disorders due to use of alcohol (ICD10 F10) and accidental poisoning by alcohol (ICD10 X45). The pooling of five years of data in the following analysis reduces the impact of fluctuating small annual numbers of admissions and provides a more robust estimate of trends within the county.

Figure 35: Pooled alcohol specific admission rates (under 18 yrs.) 2008/09 - 2012/13 by deprivation quartile (IMD2010)

Pooled Alcohol-Specific Admission Rates (under 18 yrs) 2007/08 - 2012/13 by Deprivation Quartile (IMD2010)

Crude Rate per 100,000 population

140.0
120.0
100.0
80.0
60.0
40.0
20.0
0.0

	Q1 least deprived	Quartile 2	Quartile 3	Q4 most deprived	COUNTY
Crude Rate	34.8	76.0	60.7	129.5	74.9

Source: Strategic intelligence team, Herefordshire Council

Amongst those aged under 18 years, the pooled crude rate of alcohol specific hospital admissions in Herefordshire across the six year
Herefordshire across the six year period 2007/08 – 2012/13 was 74.9 per 100,000 population. However, there is extreme variation in
However, there is extreme variation in rates of admission of young people within the county, ranging from 34.8 admissions per 100,000
from 34.8 admissions per 100,000 in the least deprived quartile to 129.5 per 100,000 in the most deprived quartile (
deprived quartile (

Figure 35). This is an admission rate ratio between the most and least deprived neighbourhoods of 3.7:1 – a young person from the most deprived areas of the county is almost four times as likely to be admitted due to binge drinking than his/her equivalent from the least deprived areas.

Evidence review for drug and alcohol interventions for young people

Due to the lack of studies exploring interventions specific to young people, definitive statements cannot be made about what is, or is not, effective in young people's substance misuse treatment. The National Treatment Agency published an evidence based report following a review of a number of interventions, though it must be noted that most of the intervention studies reviewed were carried out in the United States.

5.14. Bibliography

Ermisch, J., (2003), Does a 'Teen Birth' have longer term impact on a mother? Suggestive evidence for the British Household Panel Study, *ISER Working Papers*, No.2003-32, Colchester, University of Essex.

Kiernan, K., (1995), Transition to parenthood, Young Mothers and Young Fathers - Associated Factors and later life experiences. *Welfare State Programme Discussion Paper*, WS/113, London School of Economics.

5.14.1.1. Inferences: Children and young people's health and wellbeing

Health outcome	Comments
Maternal Smoking status	Significantly lower than England's rate at 11.2 per 100 maternities. No locality or GP practice data available
Infant mortality	Lower than regional and national rates at 4.1 deaths per 1,000 live births
Perinatal mortality	Significantly lower than national and regional rates at 4.6 deaths per 1,000 live births
Low birth weight	Local rate of 5.2%, significantly lower than national average (7.4%)
Obesity Reception	Lower prevalence of both obesity and overweight compared to national and comparator group
Obesity Year Six	Lower prevalence of both obesity and overweight compared to national and comparator group
Immunisation status first year	Comparable to national and regional coverage at around 94%
Teenage conceptions	Comparable to national rate, ranked 4 out 15 comparator LAs

Child mortality rates (1-17years)	Slightly higher rate than England at 14.8 deaths per 100,000 population
Self-harm (0-17 years)	138.8 admissions per 100,000 population, not significantly worse than England (115.5 per 100,00)
Alcohol related admissions	Significantly high rate of alcohol related admissions among young people, ranked 262 of 317 local authorities
Breast feeding duration	Similar to national average at 47%, though rates are generally poor nationally. Significantly lower than the best performing LA (82.8%)
Breast feeding initiation	Marginally lower than England's average at 73% and ranks 8 out of 15 comparator local authorities – 10pp below best performing comparator LA
Immunisation second year	Considerably lower coverage than national, regional and comparator group for MMR, HibMenC and PCV booster
Immunisation fifth year	Very low coverage for DTTP booster, MMR first and second and HibMen C booster
Dental five years	High rates of tooth decay, ranks 13/14 comparator LA

(green)	Better performance
(orange)	Comparable performance
(red)	Poor performance

6. Safeguarding children in need and children in care

6.1. Introduction

All children have the right to be safe and protected and it is everyone's responsibility (Children's Act 2004). Safeguarding legislation[11] and government guidance state that safeguarding activity includes:

- Protecting children from maltreatment
- Preventing impairment of children's health or development
- Ensuring children are growing up in circumstances consistent with the provision of safe and effective care
- Undertaking the role so as to enable those children to have optimum life chances and to enter adulthood successfully

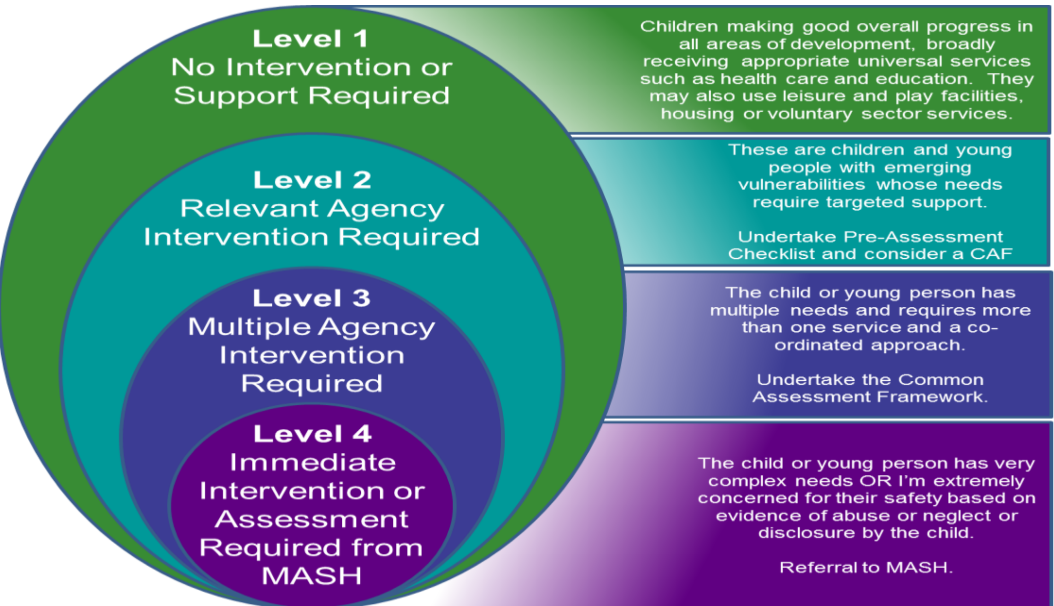
Child protection is one element of safeguarding and refers to all activity undertaken to protect specific children or groups of children who are suffering or likely to suffer significant harm. Introduced by the Children Act 1989, the term 'significant harm' is used to denote a degree of predictability or reliability in order to support the conclusion that a statutory intervention is justified to safeguard and protect a child.

[11] The legislative framework in England and Wales for consideration of the welfare and protection of children is set up in the Children Act 1989.

Levels of need

'Working Together to Safeguard Children' 2013[12] requires every local safeguarding children board to publish a threshold document that includes the criteria, including the level of need, for when a case should be referred to local authority children's social care for assessment and for statutory services.

Figure 36: Levels of need thresholds in Herefordshire (June 2014)



Herefordshire configures its children's services on a threshold model which identifies four levels of need. Each level has a set of indicators or descriptors to assist practitioners to assess needs and identify appropriate service responses (interventions). The model aims to achieve a consistent approach to integrated working on a multi-agency basis. See Figure 36.

As the threshold model indicates, children in Herefordshire at Level 1 require no additional support beyond that which is universally available. Those at Level 2 have emerging vulnerabilities that cannot be met by universal services and those known to agencies are identified for additional targeted support. Such children may have additional educational needs, be children of asylum seekers, have minor disabilities or have challenging behaviour that their parents are unable to manage. At Level 3, the child's health and wellbeing is adversely affected and a common assessment form (CAF) may be initiated to identify the child's needs. Needs may also be met through a single or multi-agency 'Child in Need' plan.

At Level 4, the threshold is met for statutory involvement as issues cannot be resolved within families. Children with significant emotional and/or behaviour problems, chronic ill health, mental health problems, substance misuse problems, disabled and homeless children or where parenting is compromised all fall into this category where intensive support is required. Young carers also receive Level 4 interventions. Children may be subject to child protection plans. At the highest level of need are children in care or looked after children for whom Herefordshire provides care and accommodation. Children in care may be fostered or adopted.

Legal definition of a child in need

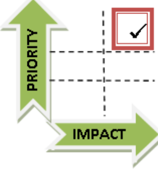
[12] 'Working Together to Safeguard Children: A Guide to Inter-Agency Working to Safeguard and Promote the Welfare of Children' (Department of Health 2013).

The broader concept of 'a child in need', introduced by the Children Act 1989, states that a child is presented as a child In need (CIN)[13] if:

1. He/she is unlikely to achieve or maintain, or have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision for him/her of services by a local authority;
2. His/her health or development is likely to be significantly impaired[14], or further impaired, without the provision for him/her of such services; or
3. He/she is a disabled child.

Herefordshire Council has a general duty to safeguard and promote the welfare of children in their area who are 'in need' and to provide a range and level of services appropriate to those children's needs. As mentioned above, to be eligible for a service, children will meet Level 3 or Level 4 threshold of need.

6.2. Profile of children in need in Herefordshire



At the end of June 2013, Herefordshire had a population of 1,604 children in need (including LAC and CPP) and 1,139 children excluding the two sub-groups. The data available from the children's wellbeing directorate (Improvement Board, December 2013) reveal the following trends:

Herefordshire's rate of children becoming a child in need (CIN) (including looked after children (LAC) and children with child protection plans (CPP) is higher than national (325.7 per 10,000 children) and statistical neighbours (301.5 per 10,000 children) averages at 445.5 children per 10,000 children by 2013-2014 (year to date). This current rate is higher than the target which is set at 271.4 - 331.7 children per 10,000 children.

The number of children in need, including looked after children (LAC) and children with protection plans (CPP) has been increasing over the past five years as shown in Figure 37.

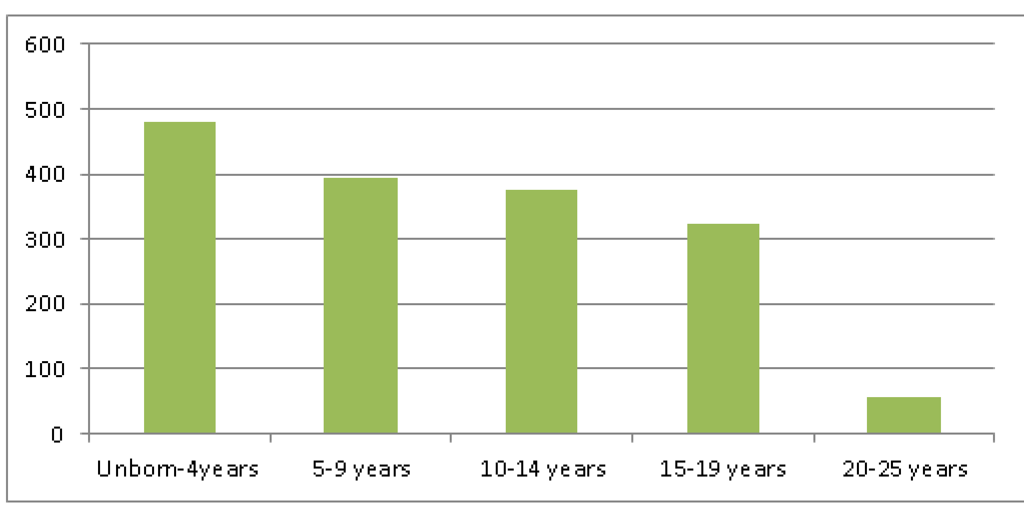
Figure 37: CIN population (0-25years) trend over five years

Source: Herefordshire children's services, MTFC trend data

Figure 38: Age at which a child became CIN - June 2013

[13] Under the Section 17(10) of the Children Act 1989 which places a general duty on local authorities to provide services to safeguard and promote the welfare of children within their area who are in need.

[14] "Likely to be significantly impaired" denotes a degree of predictability or reliability supporting that conclusion and risk of impairment exists as a continuum, from low to high risk.



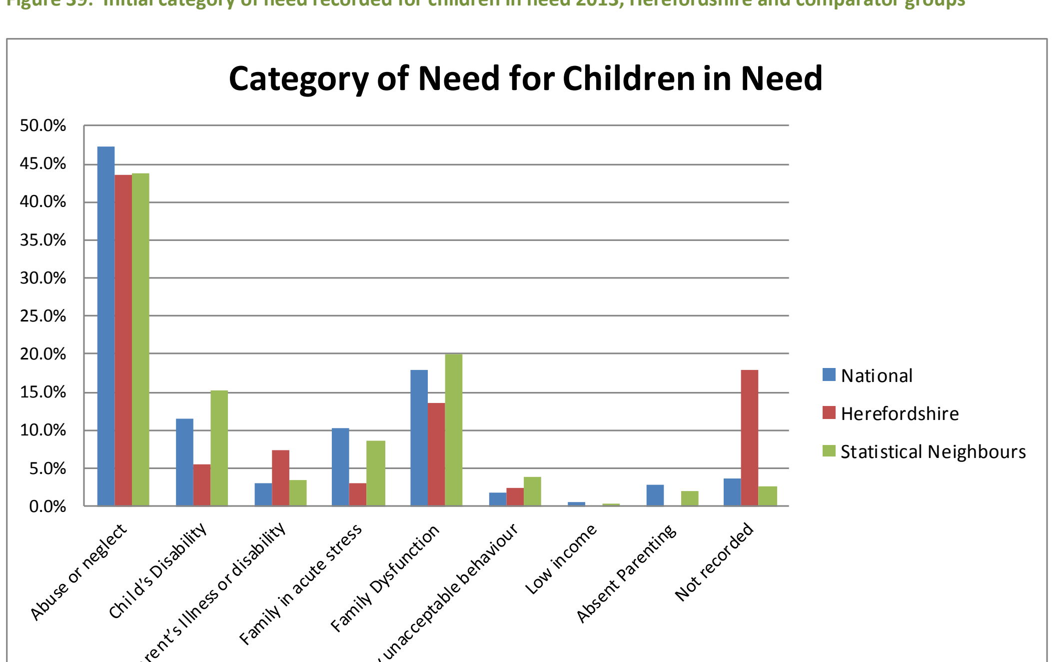
Source: Herefordshire children's services, MTFC trend data

6.2.1. Children in need by initial category of need

Children identified as children in need in Herefordshire have an initial category of need or a primary reason for need, at initial assessment. Over 40% of the primary reason for children reaching the Level 4 threshold of need is abuse or neglect, followed by family dysfunction (family illness, family issues). See Figure 39, which also shows that Herefordshire has a high percentage of non-recorded entries compared to national and statistical neighbours' figures. The reason for this is unknown and this discrepancy reduces the quality of data when attempting to shape services according to need.

The category on 'low income' is hardly ever recorded by most local authorities including Herefordshire. In a paper by Bywaters (2013), it was noted that 79 of 152 local authority returns in 2011, either did not complete or gave the 'low income' category a score of 0. This category appears to have fallen into disuse alongside studies suggesting low income is related to health and social inequalities.

Figure 39: Initial category of need recorded for children in need 2013, Herefordshire and comparator groups



Key to categories of need

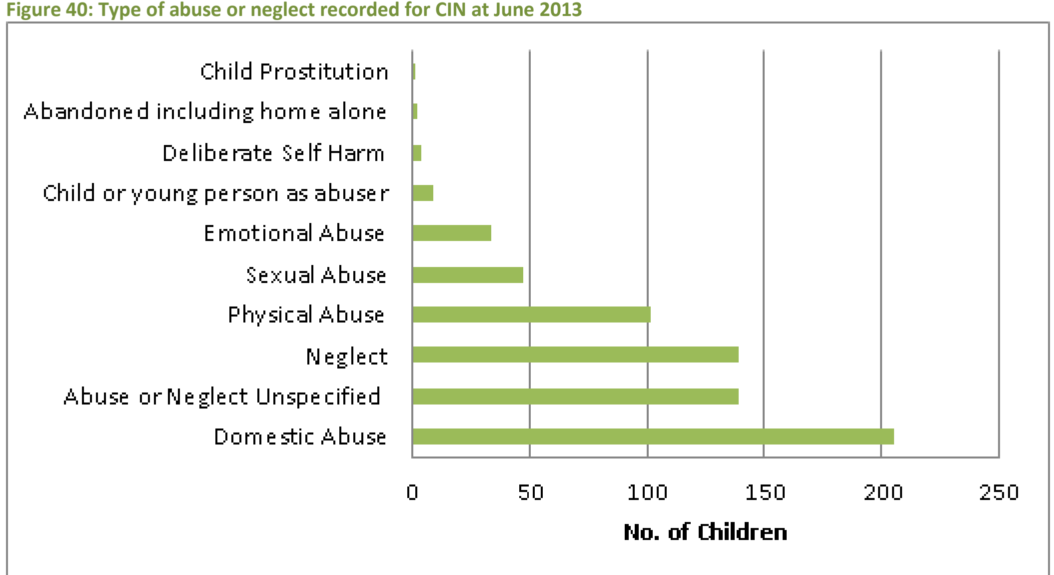
- **Physical, emotional and sexual abuse or neglect**: that is, children at risk of 'significant harm' and those subject to domestic violence and abuse.
- **Disabled children**: children with physical disabilities, sensory disabilities, learning disabilities or emotional and behavioural disabilities.
- **Parental illness/disability**: children with alcohol or drug misusing parents, acutely ill parents (short term), chronically disabled parents, chronically mentally ill parents, children assuming responsibility for chronically ill, addicted or disabled parents.
- **Family in acute stress**: homeless family, unsupported single parent, death of carer.
- **Family dysfunction**: inconsistent or impaired parenting, family breakdown (other than DVA).
- **Socially unacceptable behaviour**: disorderly behaviour, offending, truancy, unsafe sexual behaviour.

6.2.2. Types of significant harm

There is a requirement on statutory social services to establish a specific form of harm[15] when a concern for a child has been raised and to establish whether the harm is significant or not. For local purposes, significant harm has been sub-divided into further forms of harm (Figure 40). Domestic abuse as the main factor leading to a child becoming a child in need in Herefordshire (30%) followed by neglect (20%) suggesting that abuse and neglect are priority areas for social care intervention.

The use of some of these categories for the collection of data is unclear. For example, the category described as 'child or young person as abuser' is not a type of harm but arguably the cause of harm. Abandonment may be classed as a form of neglect and child prostitution could be labelled a form of sexual abuse or sexual exploitation. It would be useful to reconsider these categories for data collection in order to provide a higher level of accuracy of numbers linked to types of significant harm.

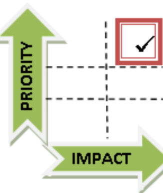
Figure 40: Type of abuse or neglect recorded for CIN at June 2013



Source: Herefordshire children's services, MTFC trend data

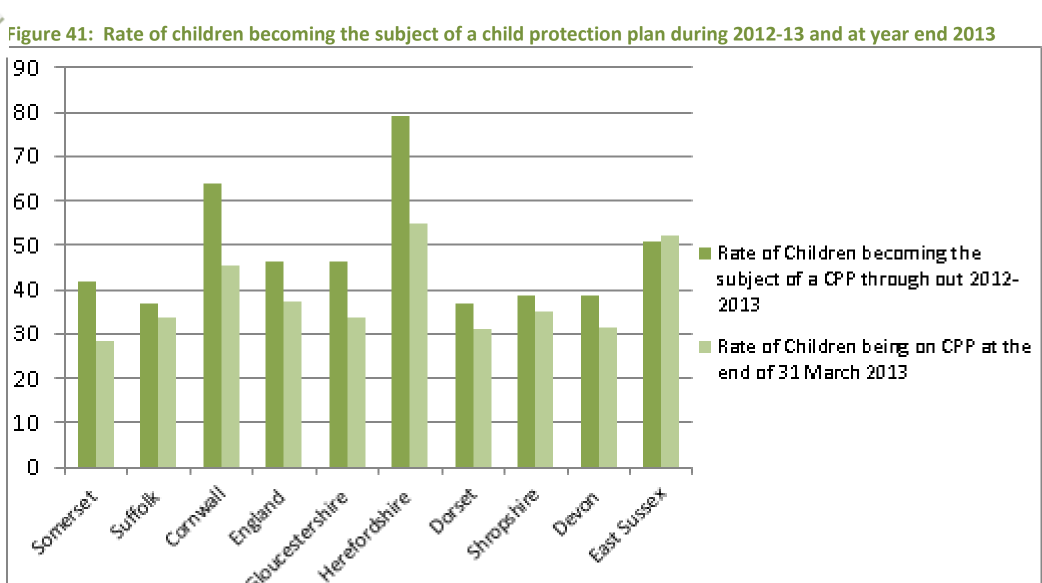
6.3. Children with child protection plans

[15] Specific forms of harm through abuse is defined in Working Together (HM Government 2006) and the legal definition of harm is provided by the Children's Act 1989 Section 31(9) (as amended) in England and Wales.



A child suspected to be at risk of significant harm may be safeguarded by being made subject to 'a child protection plan' or CPP, (the Level 4 threshold of need in Herefordshire). A CPP may be lifted if the situation improves for the child and Herefordshire may continue to support the child and family with a child in need plan. If the child is deemed to be at immediate significant risk of harm or if a CPP proves ineffective, the child may be removed and become a 'looked after child' (LAC).[16]

Figure 41: Rate of children becoming the subject of a child protection plan during 2012-13 and at year end 2013



Source: Department of Education, Children in Need Census, SFR45-2013

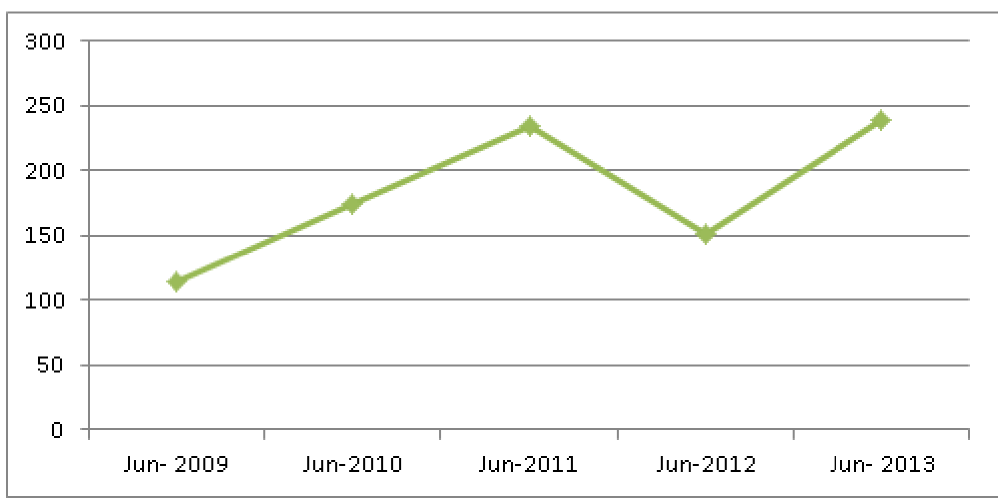
In Herefordshire, as at June 2013, there were 239 children with a CPP, an increase of approximately 36% since June 2012, consequently the rate at which a child became subject to a CPP also increased.

Herefordshire has the highest rate when compared to the statistical neighbours and national figures. This performance is also evident in the numbers and rates of children becoming subject to a CPP throughout the year. In 2012-2013 the rate was 79.2 children per 10,000, compared to 46.2 children per 10,000 England's average (see

Figure 41).

Figure 42: Children with child protection plans population (0-18 years) trend over five years

[16] An emergency protection order (EPO) is an order from the court that allows the child to be removed from home if the child is in imminent danger and grants parental responsibility to the local authority for a short period of time to allow for securing a more permanent solution for the child's safety.



Source: Herefordshire children's services, MTFC trend data

Trends since 2009 show a dip in numbers of children with CPPs in 2012 (Figure 42 above), which may be explained by the 2012 Ofsted inspection. Ofsted reported that many children on child protection plans no longer met the threshold resulting in the lifting of many plans in place and consequently led to a significant reduction in numbers of children with CPPs.

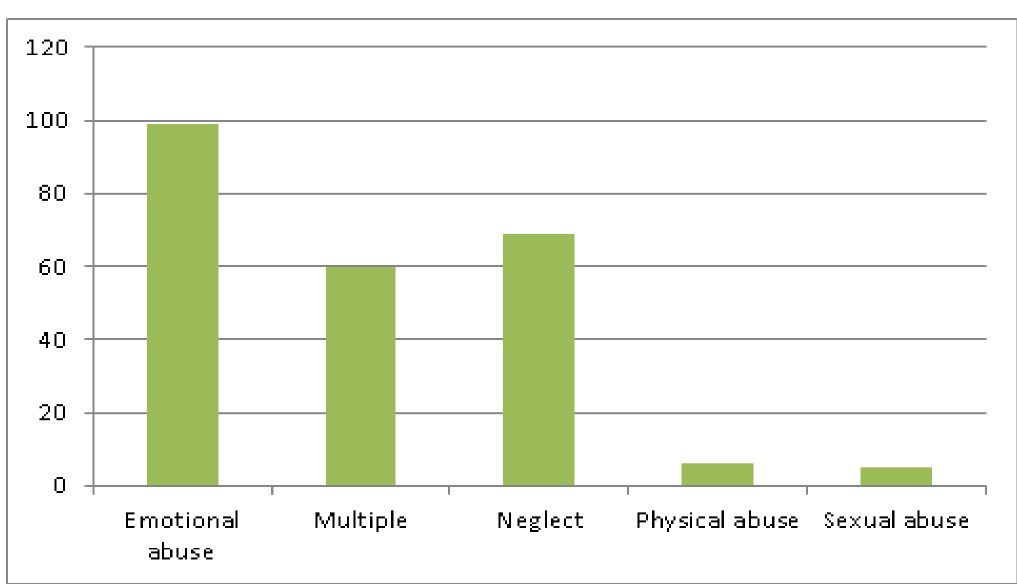
Figure 43: Percentage of children who became the subject of a plan for a second or subsequent time

Source: Department of Education, Children in Need Census 2012-2013, SFR45 2013

Herefordshire's rate of a child being subject to a CPP for a second or subsequent time is higher than the national average and is about average compared to its statistical neighbours as shown in Figure 43. The reasons for the high rate were not confirmed but the data may suggest that the initial decision for placing a child under a protection plan was not sufficiently rigorous.

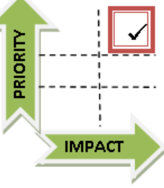
In Herefordshire, the highest proportion of children subject to child protection plans is recorded as having an initial category of emotional abuse, followed by neglect.

Figure 44: Initial category of need for children subject to a CPP, June 2013 (Herefordshire)



Source: Children's wellbeing directorate, Herefordshire Council

6.4. Looked after children or children in care



The term 'looked after children' (LAC) was introduced by the Children Act 1989 and generally means those looked after by the state and those subject to a care order or temporarily classed as looked after on a planned basis for short breaks or respite care. The term also applies to a child who is accommodated by the local authority either as a result of voluntary agreement by their parents or as a result of a care order issued by a court of law to safeguard the child.

There are a number of routes to permanence for children separated from their birth families. Children may be reunited with their families (if safe to do so), live with relatives or friends, live long term with foster families, live in children's homes or specialist units or be adopted. Sometimes, children are placed outside of the county. Sometimes children who are looked after are referred to as 'children in care' and Herefordshire is charged with their welfare and wellbeing throughout the period they are in care.

A child ceases to be 'looked after', when they reach the age of 18 years or 25 years if disabled, and/or are adopted. At 18 or 25, the young adult may transfer to adult social care, subject to eligibility for adult services.

6.4.1. Profile of Herefordshire's looked after children population

In June 2013, there were 216 looked after children in Herefordshire. This was an increase of 54% since June 2009 (Figure 45).

The 2011/12 rate for LAC was 58.3 per 10,000 children; increasing to 67 per 10,000 by the end of December 2013, equating to 241 children. This current rate is significantly higher than the averages for both statistical neighbours and national rates which are 47 per 10,000 children and 59.0 per 10, 000 children respectively.

The current LAC rate target for Herefordshire is set at between 42.3 and 51.7 per 10,000 children.

As at December 2013, there were seven children who were looked after subject to child protection plans (Improvement Board Report, November 2013). Datasets to compare this with other areas were not available.

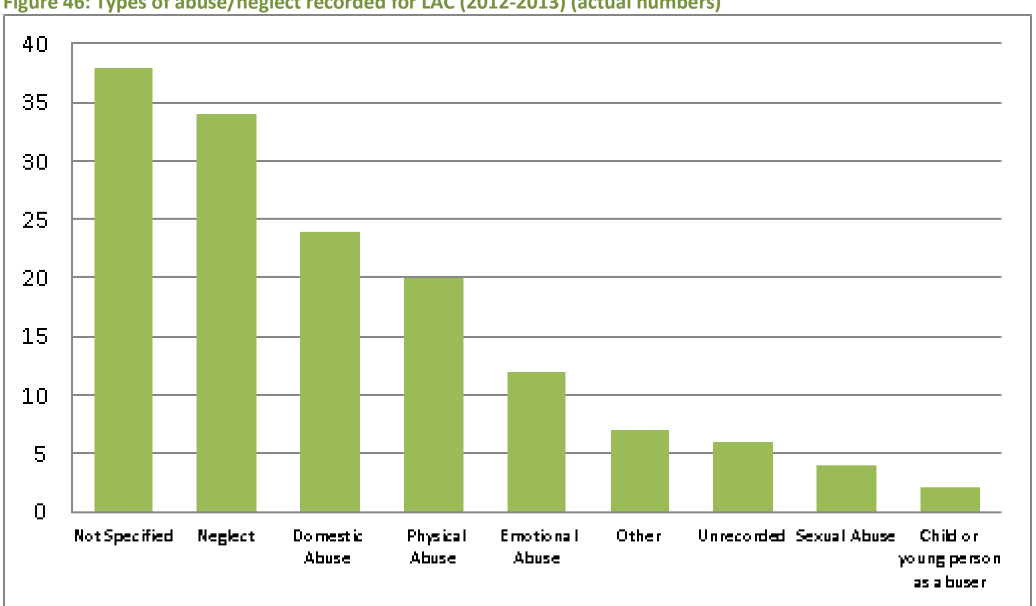
Figure 45: LAC population (0-18 years) trend over five years

Source: Herefordshire children's services, MTFC trend data

The increased rate has been attributed to increased management oversight, initiation of care proceedings, robust review of open cases and changes in practice in relation to young people presenting as homeless.

During the period 2012-2013, the largest initial reason for a child becoming LAC was abuse and neglect, accounting for 68% of all cases (147 children). This is similar to the most prevalent reason for children becoming children in need. There were a small proportion of children reporting sexual abuse. See Figure 46.

Figure 46: Types of abuse/neglect recorded for LAC (2012-2013) (actual numbers)



Source: Herefordshire children's services, MTFC trend data

Again, Figure 46 illustrates the lack of recording specific details for children when they enter care; for example, a high proportion of children are recorded under 'unspecified reasons'. In a smaller proportion of cases, reasons for becoming LAC are not recorded.

6.4.2. LAC with disability

The Department of Health, Social Services and Public Safety in England and Wales collect data on looked after children which includes their disability or illness. However, comparative data for Herefordshire is not available.

6.4.3. Type of placements

At June 2013, there were 216 LAC in Herefordshire and the majority of these children were placed in either internal or agency foster care (see Figure 47). Children are placed away from the county due to a lack of provision locally to meet their needs; however, more detailed information and data is not available on children placed outside of Herefordshire. Data on the length of placements for looked after children was also not available. This data would be useful to determine if Herefordshire's children in care are achieving consistent care, enjoying stable relationships and a secure 'family' base throughout childhood. Evidence from the national helpline for children - Child Line, revealed that children with frequently moved placements found it deeply unsettling, making it hard for them to build trusting relationships. Those with stable permanence enjoyed better mental and emotional wellbeing.

Figure 47: Type of placement for looked after children in Herefordshire (June 2013)

Type of placement	Number of LAC
Foster placement with other foster carer	138
Foster placement with relative or friend	37
Homes and hostels	10
Placed with own parents	10
Placed for adoption	7
All residential schools	4
Independent living with or without formal support	3
Residential care home	3
Placed for adoption	2
Secure unit	1
Young offender institution or prison	1

6.4.4. Outcomes for looked after children

Research evidence supports the findings in Herefordshire that the majority of children enter care because they are abused and/or neglected. Meltzer et al (2002) found that 45% of looked after children have a diagnosable mental health condition. The study found that looked after children were four times more likely than children living in private households to smoke, drink and take drugs (8% compared with 2%). Children with a mental disorder were much more likely to have all three lifestyle behaviours than those with no disorder (13% compared with 4%). Children with a mental health disorder were also more likely to smoke and take cannabis (14% compared with 5%). In contrast, around three quarters of children with no mental disorder neither smoked, drank or took cannabis compared with less than half of those with a disorder (74% compared with 45%). Comparative data for looked after children in Herefordshire is unavailable, but would be useful to capture so that intelligence can be applied to prioritising and meeting special needs. The views and experiences of looked after children would provide an insight into their quality of life in the county.

6.4.5. Mental health and wellbeing

From April 2008, the Government imposed a duty on local authorities to administer the strength and difficulties questionnaire (SDQ)[17] annually to primary carers of all children aged 4-16 years who are LAC for at least one year. This score is a good screening device for mental disorders and a reliable indicator used to compare comparable local authorities.

59% of SDQ forms were returned during the year 2012 – 2013 for Herefordshire LAC and the average SDQ score was 7.8. 20 children (29%) had a score of 16 or more. Of these half were girls, the majority of whom (seven) were accessing CAHMS. The three girls not accessing CAHMS, were assessed by CAHMS to have needs too complex for them to deal with so therefore had no further input. England's average SDQ score for LAC is 13.8 and the 'norm' for British children is 8.8. Herefordshire looked after children have better mental health than both England's average and British children who are not looked after.

6.4.6. Physical health

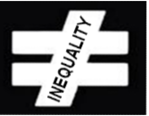
Looked after children have better rates of immunisation compared to children in the general population

In 2012/13, 92% of looked after children had an up to date immunisation record. This record is even higher for those children who had been in care for at least one year, at 96%. The outstanding 4% are noted to have refused their final school leaver booster immunisation or had not completed HPV immunisations**.** These rates show that the looked after children are meeting the recommended immunity levels (unlike the rest of children in Herefordshire).

In the same year, 87% of LAC had a dental assessment overall, (75% of those entering care for the first time and 92% by the time of their second health assessment).

Annual health assessments are not specifically recorded, however the attendance rate is kept on record. In 2012/12 the attendance rate for assessments was 86%; however this is not the same as completion as those that do not attend will be given another appointment or at times goes out of care. Therefore the attendance rate is likely to be lower than the completion rate. This figure can, however be used as a proxy measure for completion of a health assessment check.

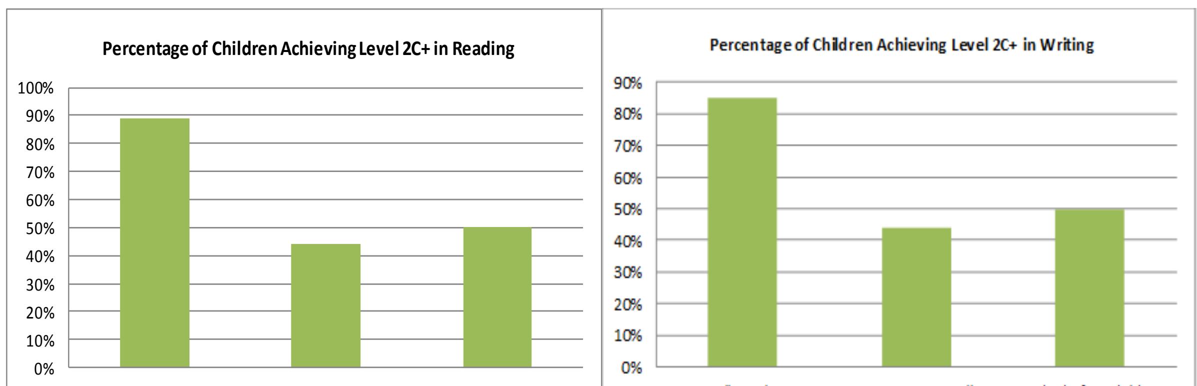
6.4.7. Education attainment

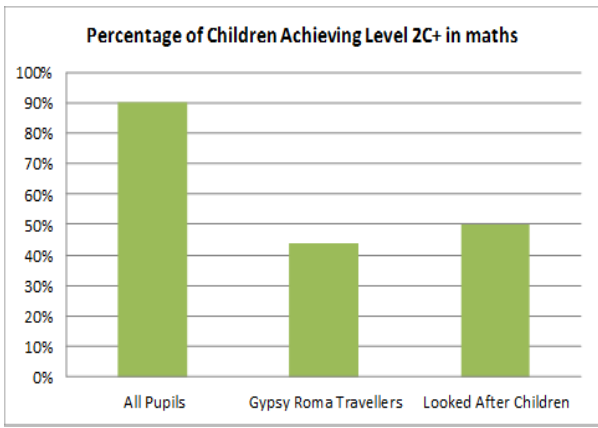


On all key stages, educational achievement rates amongst looked after children were lower than all other groups considered, including those with a special educational needs, those receiving free school meals and those from some ethnic minority groups (excluding Gypsy, Roma Travellers). See Figure 48 to Figure 50.

[17] The questionnaire has 20 items relating to emotional symptoms, conduct problems, hyperactivity and peer problems which are summed up to create a 'total difficulty' symptoms score ranging from 0-40, where scores 17 and above are a cause for concern (Goodman and Goodman, 2012).

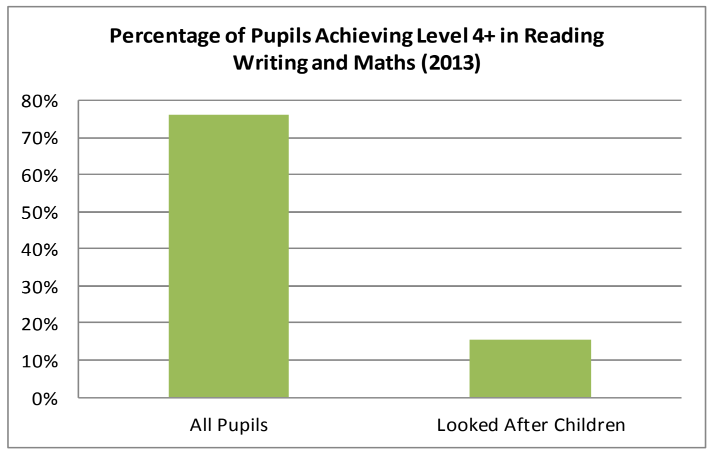
Figure 48: Education attainment for looked after children (2013), Key stage 1





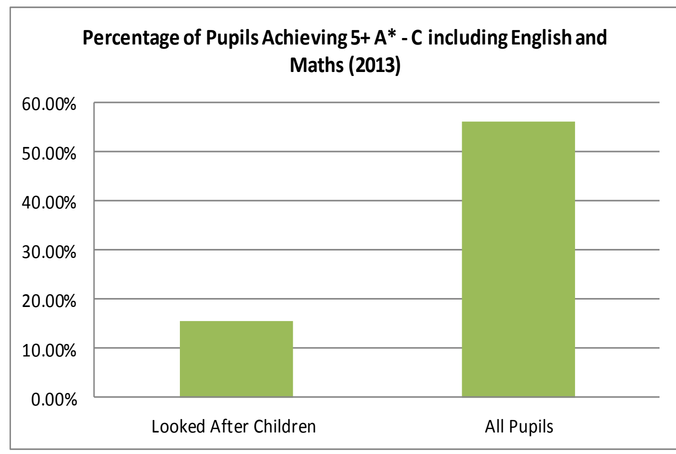
In 2013, for Key stage 1, 50% of LAC achieved level 2C+ in reading, writing and maths. There was at least a 30 percentage point gap between the number of LAC who achieved level 2C+ and all pupils.

Figure 49: Attainment for LAC Key stage 2 (2013)



In 2013, there were 13 LAC in the cohort and of these only two children (15%) achieved level 4+ in reading, writing and maths, presenting a percentage point gap of over 50. There is no comparison data from statistical neighbours or nationally.

Figure 50: Attainment for LAC Key stage 4 (2013)

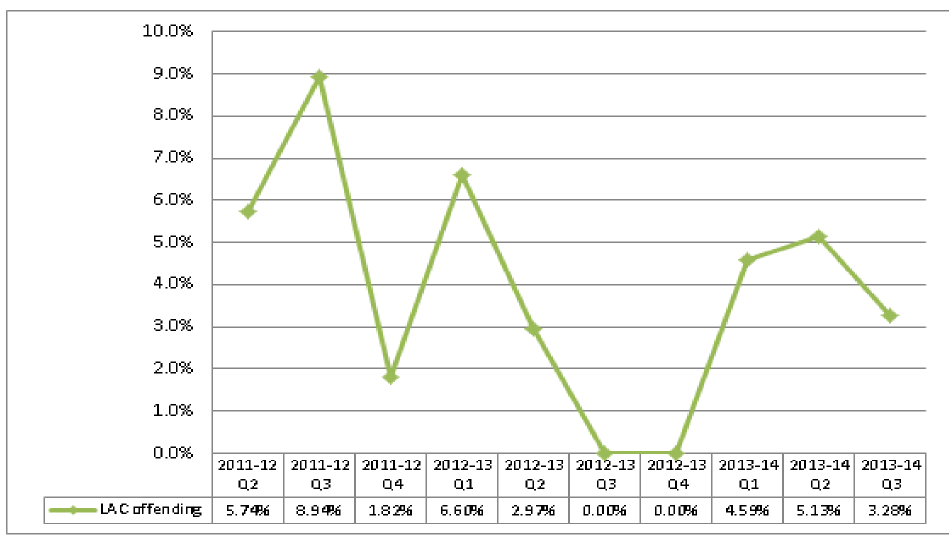


Similar to Key stage 2, in 2013 there were 13 LAC in the cohort and of these only two children (15%) achieved 5+ A* - C including English and maths, presenting a percentage point gap of at least 40. Overall, Herefordshire's GCSE performance is below national by four percentage points. There is no comparison data from statistical neighbours or nationally.

6.4.8. Offending behaviour

For Herefordshire, there is no definite trend in offending by looked after children and there are also very small numbers. As presented in Figure 51, in 2013-14 Q3 and Q4, there was no offending at all by young people from this group. The actual numbers of offenders is between 0-11.

Figure 51: Percentage of 10-17 year old looked after children offending



6.5. Summary of evidence

Indicator	Findings
Number of children in need (CIN)	Herefordshire's rate of children becoming CIN (including LAC and CPP) is higher than national and statistical neighbours and averages at 445.5 children per 10,000 children by 2013-2014 (year to date).
Reason for becoming a child in need	In 2013, the primary reason for over 40% of children is abuse and neglect. Over 200 children in need are recorded as exposed to domestic abuse.
Number of children on child protection plans	In June 2013, there were 239 children with a CPP, an increase of approximately 36% since June 2012.
Rate of children becoming subject to child protection plans	In 2012-2013, the rate of children becoming subject to a CPP is higher when compared to statistical neighbours and national figures. The rate was 79.2 children per 10,000, compared to 46.2 children per 10,000 England's average.
Reason for children having CPPs	The main reason is emotional abuse for nearly 100 children, followed by neglect for over 60 children.

Number of looked after children (LAC)	216 LAC at June 2013
Rate for LAC	The current rate (67 per 10,000) is significantly higher than the averages for both statistical neighbours and national rates which are 47 per 10,000 children and 59.0 per 10,000 children respectively, at December 2013.
LAC with CPP	At December 2013, there were seven LAC who were also subject of a child protection plan.
Number of LAC who are offending	The actual number of offenders is between 0-11 in Q3 of 2013.
Physical health	87% of LAC have up to date health assessment checks.
Mental health and wellbeing	During the year 2012-2013 the average SDQ score was 7.8 and 20 children (29%) had a score of 16 or more. England's average SDQ score for LAC is 13.8 and the 'norm' for British children is 8.8. Herefordshire looked after children have better mental health than both England's average and British children who are not looked after.
Reason for being taken into care	For the period 2012-2013, the main reason for being taken into care is abuse and neglect, accounting for 68% of all cases (147 children).
Permanence for LAC	Foster placements with a foster carer was the highest type of placement for LAC (138), followed by foster placement with a relative or friend (37).

6.5.1.1. Evidence review and best practice

6.5.1.2. Best practice for children subject to child protection plans

The 'Learning Together' Social Care Institute for Excellence (SCIE) review undertaken with Gloucestershire, one of Herefordshire's statistical neighbours, found that high CPP rates were linked to:

- An emphasis on offering services as opposed to appreciating the real needs of the child;
- A distorted sense of security when a child becomes subject to a CP plan, which leads to further reactive intervention when the CPP proves ineffective;
- An over emphasis on medical opinion in determining physical abuse, without the use of professional challenge.

The SCIE Learning Together approach summarised in the following illustration identifies the key ingredients of safe best practice.

Figure 52: SCIE's Learning Together approach

'Anatomy' of a Learning Together finding

What are we drawing on?

Where in the process does this happen?

Systems framing: risks and hazards

What are the implications for the reliability of the multi-agency child protection system?

Final review team meetings

- Staff experience (review team and case group)
- Local performance data (review team)
- National evidence
- Relevant research

What is known about how widespread or prevalent the issue is?

What makes it underlying (rather than an issue particular to the individuals involved?)

Focus of second 'follow on' meeting with staff

'View in the tunnel' and analysis of Key Practice Episodes, including identification of contributory factors

How did the issue manifest in the case?

Individual conversations and the first 'follow on' meeting

© Sheila Fish 2012

The SCIE model provides a wider approach to social services case reviews. It encourages exploration and reflection on how and why practitioners and leaders negatively influence professional practice. The Learning Together approach has been applied successfully to three case reviews in the North

West of England and has the potential to be applied to serious case reviews in Herefordshire.[18] For example, the model's emphasis on progressing multi-agency integrated chronologies in the Gloucestershire study, adds value to inter-agency collaboration to safeguard a child. The use of integrated chronologies, along the lines of the SCIE model, can also help to safeguard a child in courts where a single agency's own chronology may lack credibility and has less impact.

6.5.1.3. NICE guidance for looked after children and young people, ph28 published in October 2010 (review due in 2017)

The focus of the joint guidance from NICE and the Social Care Institute for Excellence (SCIE) is on how organisations, professionals and carers can work together to help looked after children and young people reach their full potential and enjoy the same opportunities in life as their peers.

Reducing numbers of looked after children in Herefordshire

Herefordshire's high and rising rate of looked of children is of serious concern. A literature review found one key study that might be helpful in addressing these concerns.

Research commissioned by the Association of Directors of Social Services Cymru (ADSS Cymru) and the Welsh Local Government Association (WLGA)[19] found that local authorities which had successfully reduced numbers of looked after children had invested and managed change in a few key areas. An evaluation of the research report indicates that these characteristics are equally applicable to English settings. These were:

1. **Early intervention and prevention.** A multi-agency approach, based on early intervention work with children and families helped prevent escalation of need and supported stepping down out of statutory services. Success was achieved by maximum buy in from stakeholders, top management and political commitment, clear management of risk and clear mechanisms to measure outcomes.
2. **Approach to practice**. Those local authorities found to have low numbers of LAC have a clearly defined approach to professional social work practice and give practitioners and managers sufficient time to implement this approach with children and families. There were effective quality assurance mechanisms in place with an outcome focus for both children and the local authority. Oliver, Owen, Statham and Moss [2001], for example, also linked high numbers of LAC to high levels of staff involvement in procedure driven intervention and increased bureaucracy allowing lower level of contact and professional work with vulnerable children and families.
3. **Intelligence on performance.** Those with relatively low rates of looked after children collected high quality intelligence (data, analysis, performance, quality assurance) that provided valuable insight into how effective their LAC system was in terms of achieving good outcomes for children in care. It also drove improvement in areas that were doing less well.

[18] Access: www.scie.org.uk/children/learningtogether/index.asp. The Association of Directors of Children's Services (ADCS) has called for an overhaul of the current statutory guidance 'Working Together', and reducing the levels of prescriptive processes that surrounds serious case reviews, so that practitioners can adopt a 'learning from practice' systems approach.
[18] (independent of the SCIE model). ADCS 2010:4. This does not imply that social work practice should be less compliant with the guidance, only that it can be more creative in finding solutions given bureaucratic constraints.
[19] Cordis Bright Consulting, May 2013, Differences in the Looked After Children Population, ADSS Cymru/WLGA.

The study found that successful implementation of LAC strategies had to be driven by top management in order to allow lower tiers of management to focus on building an effective service. A key message from this study is that there is no 'ideal' rate for looked after children and one cannot make projections of future number of children entering the care system. Data analysis of this type was deemed as meaningless.

Preventing children and young people from entering care

The Ofsted report, 'Edging Away From Care: how services successfully prevent young people entering care' (2011) looks at how services in 11 local authorities (including Herefordshire) and their partner agencies successfully prevented children (5-18 years) entering care. Drawing on 43 families identified as having successful outcomes, the report assesses which interventions were most successful. The report found that:

1. The quality of the relationship between the key professional and the child and family is a critical element to achieving good outcomes where the professional's honesty, openness and a non-judgemental approach are highly valued.
2. Persistence and reliability to continue working effectively with families. That is, the consistency of having one key professional working over a long period of time with a child, children or family, which is very effective in building trust.
3. The strengths of the family are the primary focus, not its weaknesses; thus, building on confidence and self-esteem of individuals and the whole family.
4. Flexible responsive services, including out of hours, addresses the needs of the whole family.
5. Clear models and methods of intervention enables professionals to be confident in their practice, be well informed and create better, creative, more clearly defined outcomes for the young person and family.
6. Referral pathways and thresholds are clearly defined and consistent, helping clean decision making.
7. Case records clearly record outcomes which have consistent criteria and measures.
8. A strong multi-agency approach helps achieve consistent good outcomes for a better home environment, confident parenting, better parent-child relationships and improved health and self-esteem.
9. The family's ongoing support needs are assessed when intervention is ended.
10. Cost savings and cost effectiveness of interventions are calculated.

The survey found that if early help had not been present or effective, the situation for the identified cohort is likely to have deteriorated and entering care would have been inevitable.

7. Safeguarding: Children at risk and vulnerable families

7.1. Introduction

The term 'vulnerability' is without a universal definition, but evidence suggests that the degree to which a child is 'vulnerable' depends on how their characteristics (personal, social and environmental) and their circumstances interact at a given time. The National Institute of Health and Care Excellence (NICE) describe the term 'vulnerable' in terms of 'risk' as follows:

"The term vulnerable is used to describe children who are at risk of, or who are already experiencing, social and emotional problems." Vulnerable children include those who are exposed to:

- Parental drug and alcohol problems
- Parental mental health problems
- Family relationship problems, including domestic violence
- Criminality

Vulnerability may be linked to disadvantage and poverty and may include those who are in single parent families or born to mothers aged under 18 years, have low educational attainment and are / or were children looked after by the state.

Children may also be vulnerable as a result of an all-encompassing characteristic such as ethnic origin, gender or sexual orientation, which may make them vulnerable to harm due to exposure to prejudice. Links to disadvantage may include homelessness and living in deprived environments which results in poor developmental outcomes (irrespective of age although children under five are at most risk of harm).

Vulnerable families often experience problems that reduce their capacity to function effectively. This can lead to poor developmental outcomes for children living in these families, both in childhood and later on as adults.

Figure 53: Risk factors for becoming a vulnerable person

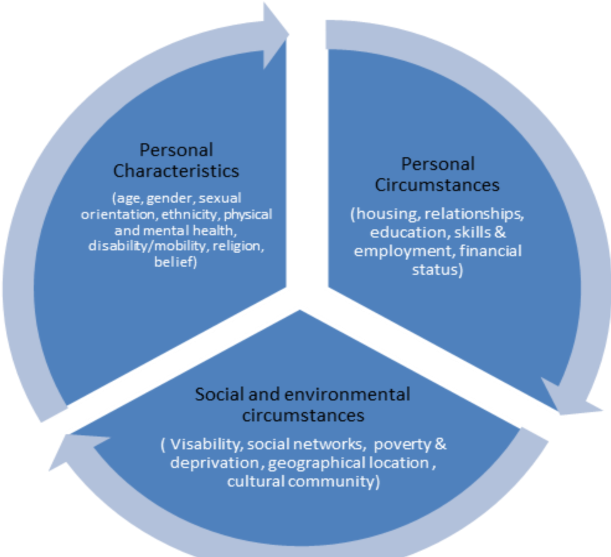


Figure 53 illustrates characteristics and circumstances that can potentially become risk factors with the likelihood of adverse outcomes for a child. Due to its cumulative effect, the presence of one increases the likelihood that more will emerge and many are inter-dependent. Multiple risk factors are known to have a negative impact on a child's developmental outcomes.

Through national legislation and local policy, the following have been identified as statutory 'vulnerable' groups in Herefordshire:

1. Children at risk of abuse and neglect
2. Disabled children
3. Homeless children and families
4. Young carers
5. Care leavers

6. Roma Gypsies and Travellers
7. Troubled families
8. Other vulnerable groups

Needs of the above groups are considered in turn.

7.2. Children at risk of abuse and neglect

7.2.1. Domestic violence and abuse in families

The Home Office definition of domestic violence is:

"Any incident or pattern of incidents of controlling, coercive or threatening behaviour[20], violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse:

- Psychological
- Physical
- Sexual
- Financial
- Emotional

The prevalence of domestic abuse as the main reason leading to a child becoming a child in need in Herefordshire (30%), followed by neglect (20%), with emotional abuse as the primary reason why children were made subject to child protection plans was highlighted earlier in this report. This suggests that domestic abuse and other forms of abuse and neglect are priority areas for social care intervention.

In Herefordshire there are at least 250 children accessing West Mercia Women's Aid services each quarter.

Evidence shows that domestic violence and abuse (DVA) is prevalent in society across gender, age, sexual orientation, socio-economic background, race, ethnicity and geographical location. The majority of victims are female adults and children of both genders (Felitti, Anda and Nordenberg, 1998). Domestic violence is also categorised as a form of gender based violence against women and girls, (alongside rape, female genital mutilation, trafficking, sexual exploitation and honour killings). More recently, there has been a rise in the reporting of adult male victims of domestic abuse in same sex and heterosexual partnerships. In some situations, abuse may be carried out by more than one perpetrator of ether gender.

The 2011/2012 British Crime Survey (CSEW), found that 7% of women aged 16-59 reported to have been a victim of domestic abuse in the past year and 5% of men. This was acknowledged to be an under-estimation. Women with children are three times more likely to experience domestic abuse

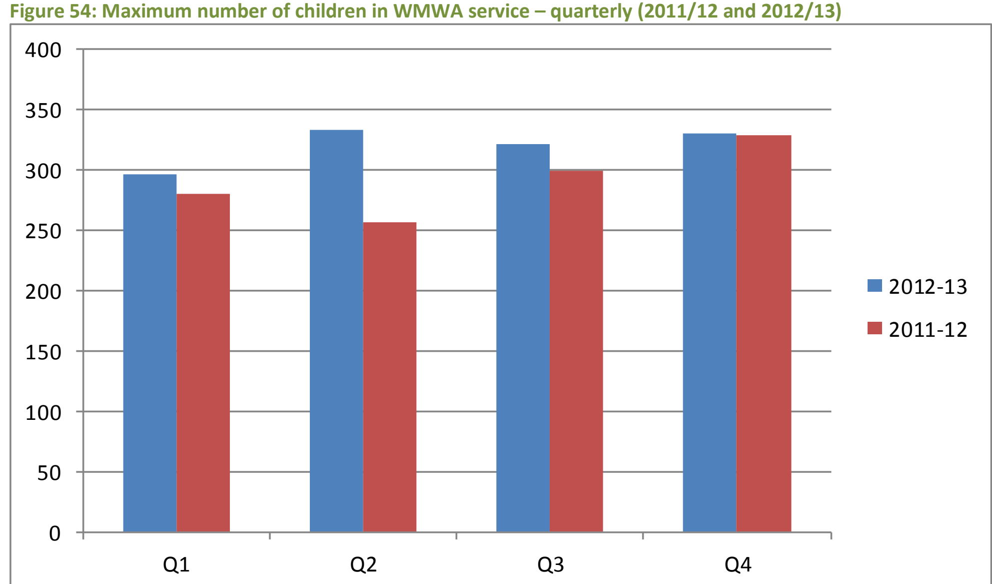
[20] Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour. Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish or frighten their victim.

than childless women. Domestic abuse may commence or escalate during pregnancy with the period just after giving birth being the period of greatest risk.

It is not clear whether the national trend reported by the CSEW above is similar to Herefordshire, however if applied to the local population that would equate to 3,600 females and 2,500 males experiencing DVA in the county. There is no national data routinely collected on children exposed to domestic violence, therefore comparisons between local authorities cannot be made.

Figure 54 below illustrates the maximum number of children in West Mercia Women's Aid (WMWA) services quarterly, showing at least 250 children using the services each quarter since 2012/13. Based on the same data, on average there are at least 120 children involved in criminal investigations and/or social care services each month. There is a balance between those children leaving and entering services each month, with 70 children entering and leaving WMWA services in 2012-2013.

Figure 54: Maximum number of children in WMWA service – quarterly (2011/12 and 2012/13)



Source: West Mercia Women's Aid, 2014

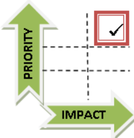
7.2.2. Links between child abuse and domestic abuse

1. Children are at a greater risk of being maltreated in homes where adult domestic violence exists according to research evidence. Radford, et al, 2011 found a direct link between physical child abuse with domestic violence. An earlier US study (Chang et al, 2008) found that psychological abuse (emotional and mental abuse) perpetrated by the abuser increased the likelihood of child neglect, particularly if the perpetrator of that the abuse was a male and the victim, the mother of the child. The risk of neglect and emotional abuse increased for children when both partners were involved in partner psychological abuse.[21]
2. Evidence suggests that different types of abuse and neglect rarely occur in isolation and children who experience repeated maltreatment often experience multiple forms of abuse (Higgins, 2004).

[21] In the US and Canada, a distinction is made between the definition of DVA and family violence. The DVA definition is the same as the UK, but family violence is described as where both partners are both perpetrators and victims of violence and abuse with an overlap with child maltreatment. This distinction does not exist in the UK and arguably confuses public understanding and awareness of the complexities of DVA.

3. Sexual abuse is also linked to DVA. In the UK, over 50% of the case files of the National Society for the Prevention of Cruelty to Children (NSPCC) involved domestic violence and where the perpetrator of the abuse was the child's father, stepfather or other 'father' figure (e.g. the mother's boyfriend). Such perpetrators are sometimes referred to as 'predatory males' as they are fully aware of and take advantage of a family's vulnerabilities. The same study found that young people experiencing family violence were between 2.9 and 4.4 times more likely to experience physical violence and neglect from a caregiver than those young people not exposed to family violence.
4. DVA is a consistent feature of serious case reviews (SCRs) into child deaths in England and Wales (Rose & Barnes, 2008). An overview of SCRs in England identifies high levels of domestic violence in the 189 cases studied (Brandon, et al, 2009). An in-depth study of 40 of those cases revealed that over 50% of the children were living with past or present DVA, often with a combination of parental mental health and substance abuse problems.
5. For women victims of DVA, studies have found that mothers experiencing or who had experienced DVA are depressed, suicidal, self-harmed and experienced post-traumatic stress disorder (PTSD). PTSD could manifest at any time in their lives, not necessarily just after separation. (Humphreys and Thiara, 2003).
6. An evaluation of Sure Start programmes reported that domestic abuse featured in the lives of mothers experiencing antenatal and postnatal depression and this inevitably leads to the demise of parenting skills (Ball and Niven, 2007).
7. There is limited evidence of the raised risk of adults and children with disabilities or long term illnesses living with DVA. Several studies and surveys indicate a link, but also highlight the differences in definitions of different forms of abuse by disability agencies and DVA agencies (Povey, 2004) and (Radford, et al, 2011).

7.3. Impact of domestic abuse on children



A synthesis of evidence from a detailed literature review reveals the following unhealthy outcomes for children who are continuously exposed to domestic violence and abuse, and experience direct abuse and neglect.

- Brain scan imagery shows that there is a divergence of brain physiology in children under the age of two. The natural development of parts of the brain are impaired (much smaller, shrivelled brain) in neglected children compared to normal healthy brain growth in un-neglected children. This finding indicates that nurture has a profound impact on nature (genetic predisposition) with a number of subsequent neuroscience studies showing that developing brain architecture can provide a weak or strong foundation for the future health and wellbeing of a child. (UNICEF, 2006; Berry, 2003).
- A parent's violent treatment resulting in death or near death of the parent impacts negatively on a child's long term physical and mental health and longer term prospects generally. Femicide in the UK is strongly linked to DVA; with most murders taking place after the woman leaves her partner (Povey, 2004). Pregnant women are most vulnerable.
- The post-separation period represents a time of heightened risk to victims of domestic violence and abuse. A study of 251 DVA incidents reported by the police to children's social services in England, found that over 50% of cases occurred where parents had separated (Stanley, et al, 2010).
- Black, Asian and minority women (BAME) experience prolonged post separation violence compared to the general population of non-BAME groups. Beside this, it is usually impossible for mothers and children to return to their cultural communities leading to further social isolation. Children grow up without the support of an extended family

structure and are likely to experience greater difficulties in cultural assimilation later on in adult life.

- An abusive parent can disrupt the attachment a child has to the non-abusive parent by undermining that relationship. This is known to escalate after the parents have separated where how children are disciplined becomes an area of continuous conflict between parents during contact arrangements.
- The majority of perpetrators have a fathering role (Salisbury, Henning and Holdford, 2009) and access to children by fathers (perpetrators) sets the context for continued abuse (threats, abuse and violence) of both mothers and children, post separation.
- CAFCASS[22] and HMICA[23] also noted that up to 70% of family proceedings cases involved domestic violence issues (Her Majesty's Inspectorate of Court Administration (HMICA), 2005).
- Also associated with DVA is child abduction (using the legal definition), by perpetrators taking the children or mothers fleeing the home and domestic abuse by taking children with them.
- Children develop dysfunctional coping mechanisms and often become disruptive, socially inept, with an inability to respect social boundaries and sometimes take to bullying in school.
- Behaviour changes can include excessive irritability, sleep problems, emotional distress, fear of being alone, immature behaviour and problems with toilet training and language development.
- The National Society for Prevention of Cruelty to Children [NSPCC][24] states that there are 800,000 disabled children in the UK (6% of all UK children). Furthermore, disabled children are over three times more likely to be abused or neglected than non-disabled children.
- In a study of intimate relationships, 22 out of 55 children with learning difficulties had experienced physical or sexual violence in adult life, mainly from their partners (Booth and Booth, 2002).
- There is a clear link between alcohol and domestic violence with the risk of DVA increasing when the perpetrator has been drinking (Finney, 2004), but that the disinhibiting effects of alcohol on their own do not account for violence and lack of responsibility for one's own bad behaviour (Galvani, 2004).
- An evaluation of Sure Start programmes reported that domestic abuse featured in the lives of mothers experiencing antenatal and postnatal depression and this inevitably leads to the demise of parenting skills (Ball and Niven, 2007).
- For women victims of DVA, studies have found that mothers experiencing or who had experienced DVA were depressed, suicidal, self-harmed and had post-traumatic stress disorder (PTSD) (Humphreys and Thiara, 2003). This inevitably has a profound impact on children's emotional and mental wellbeing.
- Honour killings and forced marriage impacts on young females in black, Asian and minority communities. In the case of forced marriage, abuse is implicit and is likely to become a feature of the marriage itself (Khanum, 2008). Girls who are subjected to forced marriage have not consented and often are not ready, developmentally, for the range of adult experiences they will encounter. Forced marriages take place across several ethnic groups, for example, South Asian groups, Chinese, East Europeans, East African, Middle Eastern and South American groups (Chandler et al, 2009).

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[22] CAFCASS - Children and Families Court Advisory and Support Services. Cafcass was set up on 1st April 2001 under the provisions of the Criminal Justice and Court Services Act.

[23] HMICA: Her Majesty's Inspectorate of Court Administration

[24] http://www.nspcc.org.uk/what-we-do/the-work-we-do/priorities-and-programmes/disabled-children/disabled-children-theme/disabled-children_wda86192.html

- Stalking is linked with DVA where perpetrators stalk their victims (usually mothers and children) following separation (Finney, 2004).
- The effects of child abuse and neglect can lead to a wide range of adverse health outcomes in adulthood such as obesity, anxiety disorders and psychosis. (Sachs et al, 2009; Kendall and Tackett, 2002).

7.3.1. Evidence review for what works well to protect children

A literature review showed a bias towards studies of incidence and prevalence of abuse and health consequences of long term abuse, with less evidence on the efficacy of therapeutic and service interventions. There is common ground on the need to take a holistic view of children and family needs and that a multi-disciplinary and multi-agency approach is the most effective way to tackle the complex challenges of domestic violence and abuse.

Some key features of successful interventions for children exposed to domestic violence and abuse are:

1. **Building resilience**. As highlighted above, evidence has established child and family risk factors that make children vulnerable to or at greater risk of abuse and neglect. Research has also shown that the effects of risk factors can be mitigated by building child and family resilience or 'protective' factors, such as enjoying good health, having good problem solving skills and coping strategies, parental interest and care from at least one parent, a social peer group, extended family support and access to extracurricular school activities (Wisdom and Czaja, 2007).

2. **Respecting culture and tradition**. A professional holistic approach that considers the family's uniqueness, including ethnicity, culture, religion and relationship to the family's extended family and community, encourages a more customised, child-centred service response. Best practice indicates that the purpose of ongoing child protection services is to assist the family in making changes to behaviour(s) or condition(s) that have caused risk to a child, rather than to change the unique character of a family system. A key requirement of work with cultural groups is training on diversity issues so that some forms of so called cultural practice can be challenged (such as female genital mutilation) and the difference between forced marriage and arranged marriage is understood. The latter is where mutual consent is given to the marriage by both partners.

3. **Talking therapies and other therapeutic interventions**. Cognitive behavioural therapy (CBT), biodynamic psychotherapy and play therapy for traumatised children which produce successful outcomes. Uptake of these interventions is discretionary and very much dependent on the 'journey' the child takes and if there are other events taking priority place in the child's life, for example, continued harassment from the perpetrator, parents involved in criminal proceedings, living in temporary accommodation as a result of fleeing domestic abuse and financial worries. Some ethnic specific women's aid groups also provide bespoke male mentoring services for young males, as evidence suggests that vulnerable males who have been abused have a higher likelihood of repeating the cycle of violence and abuse as adult males (Chapple et al, 2003; Ehier et al, 2004; Bevan and Higgins, 2002).

4. Evidence points to some key features that need to be considered when interventions are planned:

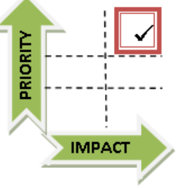
   - There is a cumulative effect of adverse life experiences on children's health and development on how they function as adults, (Edwards, Holden, Felini and Anda, 2003) with the level and type of impact dependent on age.

- The impact of domestic abuse on a child has a deferential effect on each child living in the same household despite them all experiencing the same level of abuse.
- Outcomes are not only determined by a child's direct experience of the abuse, threats of abuse or witnessing violence, but also subsequent family and environmental factors.
- Continuous exposure to an abusive climate within a household is different to isolated incidents of abuse and violence.
- Extensive studies on sexual abuse have shown that the impact on children depends on the severity of the abuse, the age and developmental stage of the child and the context of care and support that preceded and followed the actual event of abuse.
- Miller-Perrin and Perrin (2007) found that the way abuse and neglect affects children as adults is dependent on their age when maltreatment occurred; the severity of maltreatment; the frequency and duration of maltreatment; the relationship they had with the perpetrator; the type/s of abuse/neglect; whether the abuse or neglect was detected and if appropriate action was taken to assure and protect the child by relatives, friends or the state.

Key message

Given the significant impact of domestic abuse and associated maltreatment on children and their families current service provision and multi-agency arrangements in Herefordshire may need to be reviewed in order to assess the effectiveness of help being provided to children and families, especially early help which can mitigate the long term effects of abuse and neglect.

7.4. Disabled children (0-24 years)



The Code of Practice (2014) provides statutory guidance on duties, policies and procedures relating to Part 3 of the Children and Families Act 2014 and associated regulations and applies to England. It relates to children and young people with special educational needs (SEN) and disabled children and young people. The Code of Practice defines SEN as follows:

- A child or young person has SEN if they have a learning difficulty or disability which calls for special educational provision to be made for him or her.

- A child of compulsory school age or a young person has a learning difficulty or disability if he or she: has a significantly greater difficulty in learning than the majority of others of the same age, or has a disability which prevents or hinders him or her from making use of facilities of a kind generally provided for others of the same age in mainstream schools or mainstream post-16 institutions.

Furthermore, the guidance provides definition of a disability 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'.

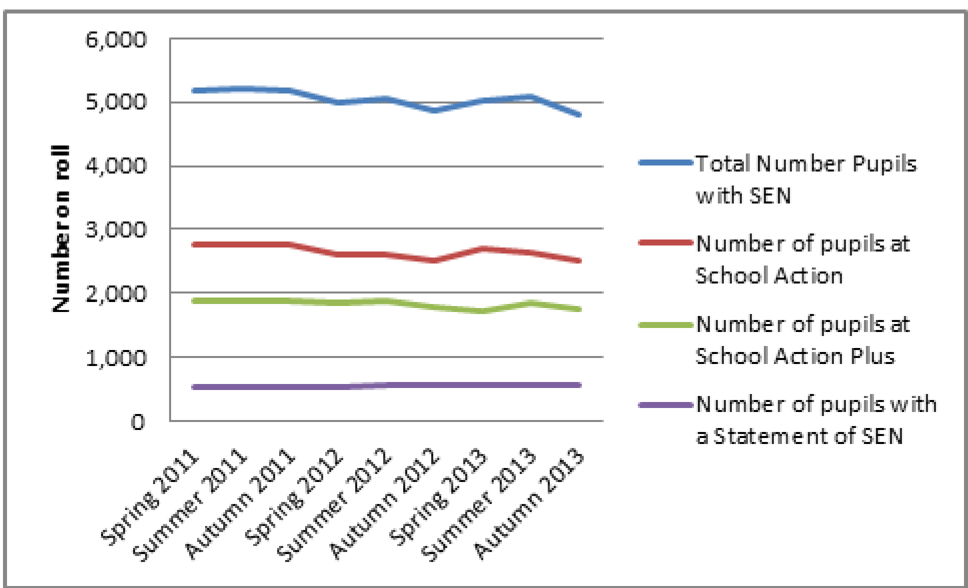
7.4.1. Herefordshire disabled children's profile

As Herefordshire does not have one single database with disabled children, this section will provide disabled children statistics from a number of sources. See Figure 58 for a summary.

From spring 2011 to autumn 2013, the total number of pupils with SEN in Herefordshire fell by 409 pupils. Within the SEN cohort, the total number of pupils at School Action fell by 270 (10%), at

School Action Plus by 150 pupils (8%) whilst those with a statement of SEN has increased by 29 (5.5%). Over the period, the highest total number of SEN (5,219) was recorded in summer 2011, as was the highest number at School Action (2,778) and School Action Plus (1,897). The highest number of pupils with a statement (574) was recorded in summer 2013. See Figure 55.

Figure 55: Pupils with special education needs

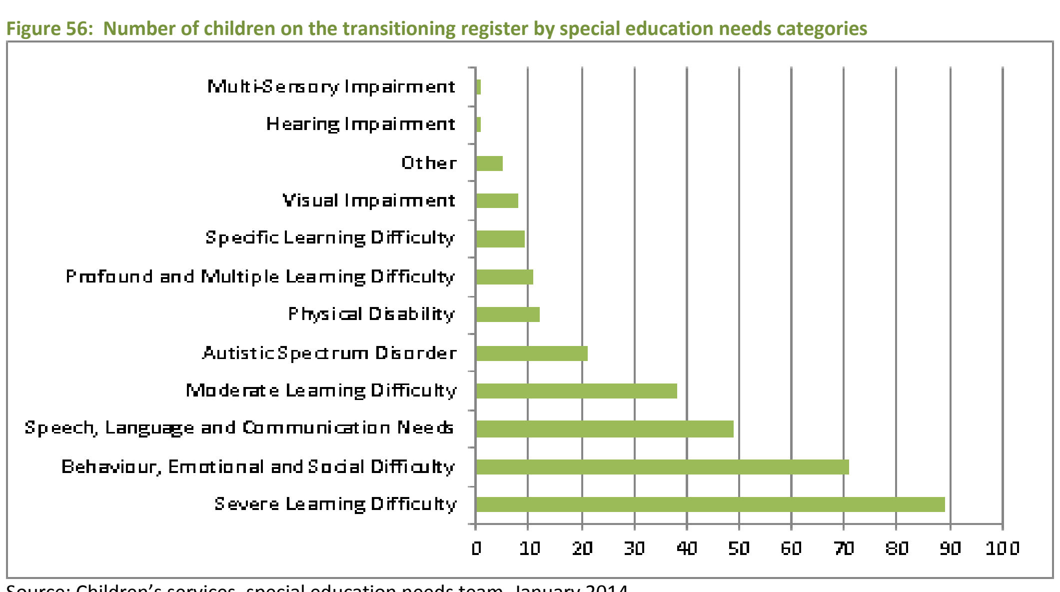


A child who has a statement of special education needs will need a 'transition plan' drawn up in Year 9, helping to plan for their future after leaving school. Herefordshire keeps a register for all children with statements. Keeping this register enables the local authority to start to fulfil the vision that **every child should be given the best chance to succeed in life.**

7.4.1.1. Transitioning register

See Figure 57 for overall numbers and description. The figure below is a breakdown of categories for the children on the transitioning register:

Figure 56: Number of children on the transitioning register by special education needs categories



Source: Children's services, special education needs team, January 2014

7.4.1.2. Disability living allowance claims

See Figure 57 for overall numbers and description. The majority of claimants claim for the following broad reasons as shown in the table below:

Figure 57: Percentage of all claimants aged under 18 and aged between 18-24 years old

Disabling condition	% of claimants aged under 18 years			% of claimants aged 18-24 years		
	Herefordshire	West Midlands	England	Herefordshire	West Midlands	England
Learning difficulties	40	44	44	38	45	43
psychosis	1	~	~	13	7	7
Hyperkinetic syndrome	13	10	12	7	3	7
neurological diseases	7	7	7	7	8	8
Blindness	2	2	2	7	2	2
behavioural	7	7	7	2	3	3

Source: Nomis, DWP, DLA claimants by disabling condition, August 2013

Herefordshire has higher proportions of claims due to psychosis (18-24 years) and hyperkinetic syndrome (under 18 years).

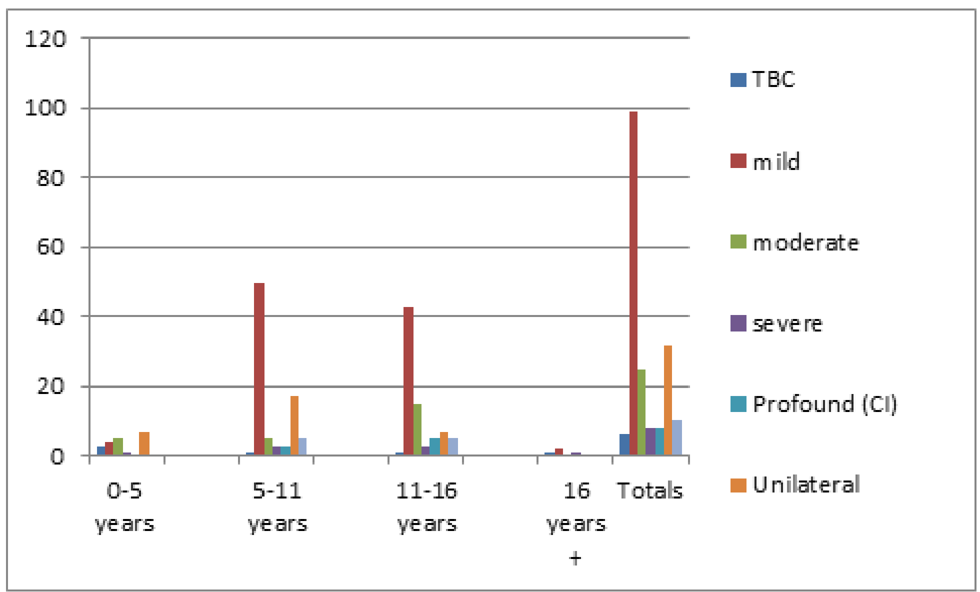
Figure 58: Summary of numbers of disabled children from different data sources

Data Source	Date	Number of disabled children	Description
Herefordshire Carer's Support Register	January 2014	• **94** children - 26% (24) had CAF - 66% (62) had a statement	Register for children with disabilities; however it is not mandatory for every child with a disability to be on the register, thus making it a voluntary register.
Transitioning Register special education needs team	January 2014	• **329** children - 97 children had cases open to social care	Register which holds a summary of transitioning information for disabled children with special education needs statement. This register though useful does not reflect the spectrum of disability and is a weak alternative measure of severe disabilities.
Disabled Living Allowance claims	August 2013	• **1,400** children, 2.7% of Herefordshire children and young people population (0-24years)	Gives a view on the number of children who are disabled, as well as the disabling condition and allows for comparisons with national and regional figures. In comparison, Herefordshire has a lower proportion of children claiming disability allowance – West Midlands 3.3% and England 3.0%.
Census	2011	• **418** children declared they had a long term health problem that limited their daily activity a lot (1% of 0-15 population) • **617** children reported 'limited a little'(2% of 0-15 population)	A long term health problem or disability that limits a person's day to day activities and has lasted or is expected to last at least 12 months. This includes problems that are related to old age. People were asked to assess whether their daily activities were limited a lot or a little by such a health problem or whether their daily activities were not limited at all.

7.4.1.3. Deaf and hard of hearing

In Herefordshire the current cohort of children receiving support for additional needs have 188 children with a hearing impairment. The breakdown in severity is presented in the figure below:

Figure 59: Children with a hearing impairment by age and severity of impairment



Source: Additional Needs- Hearing Impairment team, (2014)

7.4.1.4. Registered blind

In 2008 there were 26.6 per 10,000 population aged 0-17 in Herefordshire who were registered blind and 51.8 per 10,000 population aged 0-17 who were registered partially sighted.

The table below shows how this compares to regional and national data.

Figure 60: Blind and partially sighted children aged 0-17 (rate per 10,000 population)

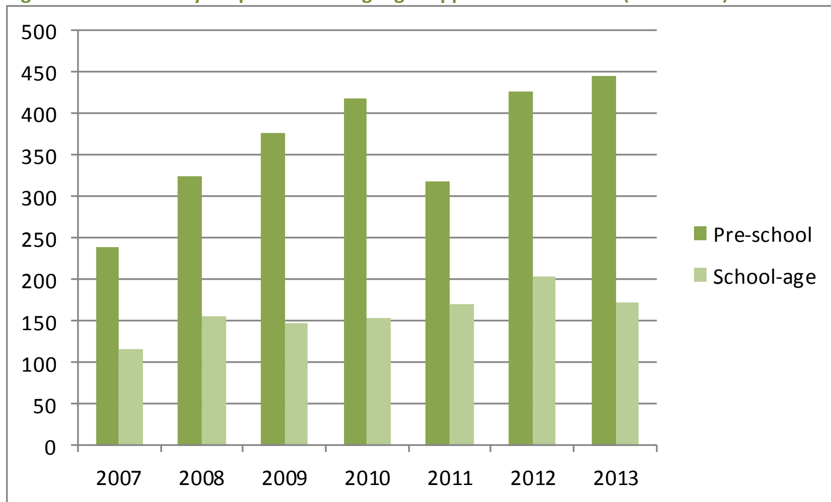
	Registered blind, 0-17 (2006)	Registered blind, 0-17 (2008)	Registered partially sighted, 0-17 (2006)	Registered partially sighted, 0-17 (2008)
Herefordshire	4.1	26.6	1.4	51.8
England	3.5	4.3	4.4	5.3

Source: Child and Maternal Health Unit

Herefordshire has a higher rate of children who are registered blind compared to England. This could be as a result of the presence of the Royal National College for the Blind in the county.

7.4.1.5. Speech and language support

Figure 61: Trend analysis speech and language support Herefordshire (2007-2013)



Source: Speech and Language Support, Wye Valley

In Herefordshire there are 1,190 children receiving speech and language therapy (SLT) support with a further 500 on the waiting list.

Since 2007 there has been a steady increase in the number of preschool children needing SLT support. The dip in 2011 was unexpected as there was funding from National Strategies via the Every Child a Talker project.

Pre-school referrals are reported to have started to grow as funding from Sure Start has ceased. School age referrals are reported to have shown an increase in 2008; prior to this there was funding for a programme called Teaching Talking. This was a joint project with the LA learning support team (no longer in existence) which allowed primary school children to be screened and have low level interventions if needed, therefore preventing referrals.

7.4.2. Disabled children education attainment

There are very large gaps in the educational attainment of children with special education needs and those with no special educational needs identified, as shown in Figure 62 to Figure 65.

Figure 62: Trend analysis percentage of children achieving a good level of development in EYFS 2011-2013

Discrepancies in the way that the level of development of children with special educational needs at early years framework stage (EYFS) is recorded and reported means it is very difficult to make comparisons or draw conclusions. However, there is a gap in development compared to non-SEN children locally. Those with a statement of SEN seem to struggle to reach the threshold for a good level of development at all.

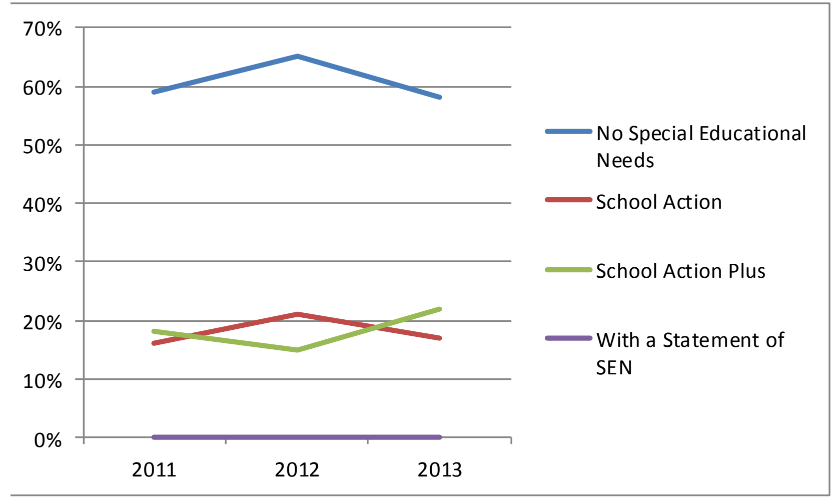
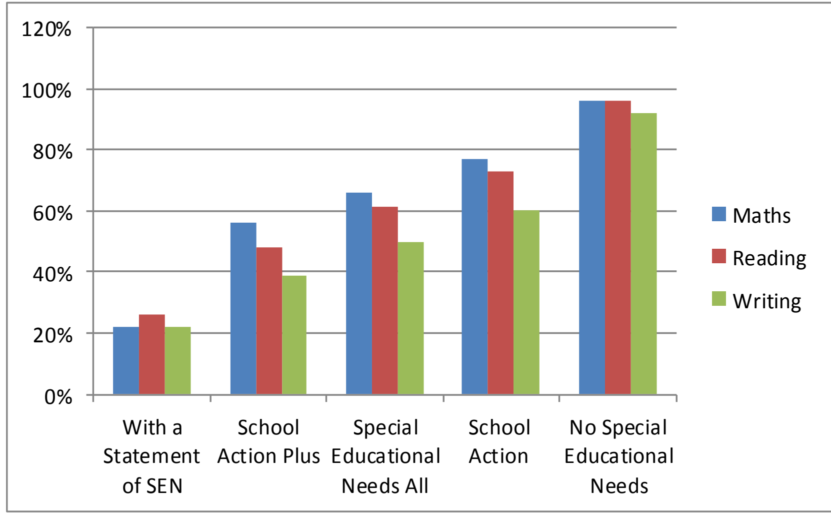


Figure 63: Percentage of children achieving level 2C+ in reading, maths and writing by characteristics Key stage 1 (2013)



As with the EYFS, the gap between children with special education needs is evident later in primary school attainment for all subject areas, with writing presenting the largest gap.

Figure 64: Percentage of pupils achieving level 4+ in English and maths by characteristics Key stage 2 (2011-2013)

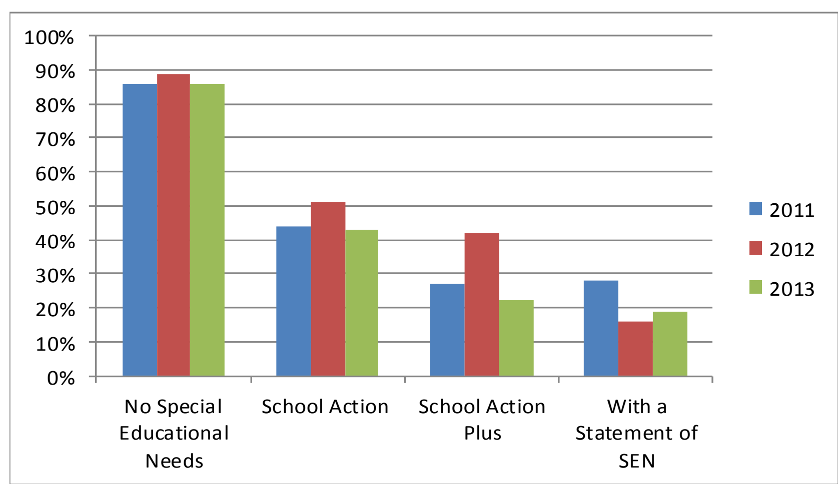
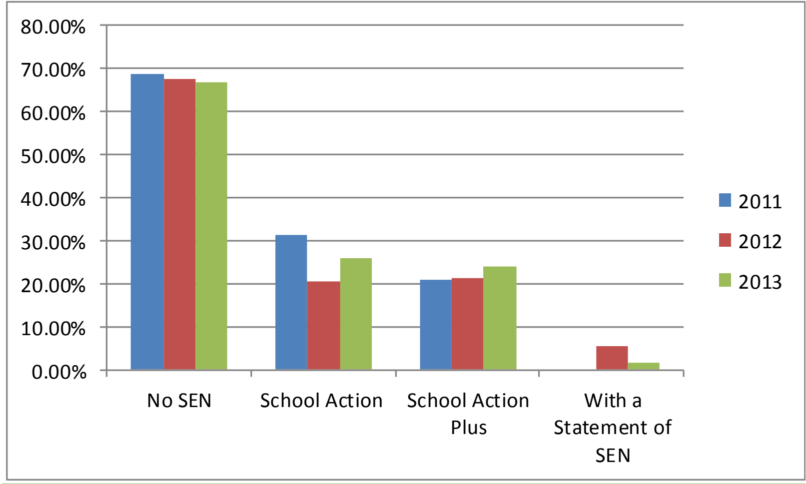


Figure 65: Percentage of pupils achieving 5+ A* - C including English and maths by characteristics Key stage 4 (2011-2013)



The inequalities in achieving 5+ A*-C including English and maths seems to widen with less than 20% of children with SAP/SAP Plus achieving this. In 2012, less than 5% of children with a statement achieved 5+ GCSEs including maths and English.

7.4.3. Impact of disability for vulnerable children

To recap, out of the 94 disabled children registered in Herefordshire, 24 have a CAF and 62 a statement. Additionally, 97 children on the special education needs team register are open to social care. It is very likely that some children are on both registers and also exposed to domestic violence and experiencing abuse. However, this is difficult to confirm as this level of detail in the data was unavailable and so further in-depth analysis was not possible for this report.

A review of data from research studies into prevalence and risk of violence against disabled children found pooled prevalence estimates of 26.7% for combined violence measures, 20.4% for physical violence and 13.7% for sexual violence. Disabled children are three to four times more likely to be victims of violence and sexual abuse than their peers. Risk estimates for disabled children were 3.7, 3.6 and 2.9 times higher respectively for combined violence measures, physical violence and sexual violence, (Jones, 2012).

An earlier study found that severely disabled children were suspected of being abused by their parents almost three times more often than typically developing children (Hershkowitz, Lamb and Horowitz, 2007). In England, 12% of serious case reviews involved disabled children, 21 out of a total of the 178 reviews originally notified in 2009-12, (Brandon, et al, 2009). This suggests that this area is of high priority, but figures for Herefordshire are unavailable.

A MENCAP survey (MENCAP, 2007) found that nearly 8 out of 10 young people with a learning disability have experienced bullying. The Department for Education (DfE) confirm that disabled children and young people currently face multiple barriers which make it more difficult for them to achieve their potential, to achieve the outcomes their peers expect and to succeed in education. It found that the educational attainment of disabled children is unacceptably lower than that of non-disabled children; that fewer than 50% of schools have accessibility plans and that disabled young people aged 16-24 were less satisfied with their lives than their peers. Critically, there is a tendency for support to fall away at key transition points as young people move from child to adult services.[25]

The DfE also found that families with disabled children report particularly high levels of unmet needs, isolation and stress, but only 4% of disabled children are supported by social services. A report by the Audit Commission in 2003 found that there was a lottery of provision, inadequate strategic planning, confusing eligibility criteria and that families were subject to long waits and had to jump through hoops to get support.

The reason for the lack of support for vulnerable disabled children was researched by the National Society for the Prevention of Cruelty to Children (NSPCC). The findings indicated that not all disabled children are protected because there is:

- A lack of belief that disabled children are abused;
- A lack of understanding between behaviors indicating possible abuse and behaviors as a result of a child's impairment, resulting in a lack of recognition or speedy response to child protection concerns;
- Disabled children may lack awareness and vocabulary about abuse and find it difficult to seek help;

[25] Local data for comparison is unavailable.

- Practitioners and provider agencies who are untrained on disability issues sometimes fail to protect disabled children adequately as their focus is on the child's impairment rather than a consideration of other indicators for safeguarding a child.

Reviews of serious case reviews (Brandon et al, 2012) where the child was disabled also revealed some worrying trends:

- Support services were poorly co-ordinated leaving vulnerable disabled children and their families unsupported and isolated. Isolation is widely recognised to be a risk factor for abuse.
- A lack of comprehensive and multi-agency assessments and planning leads to both a failure to promote the child's welfare and a failure to identify early indications of possible abuse.
- There is a heavy reliance on carers (parent, family or paid carer) to be a source of information on a child. This practice may stem from an assumption that the disabled child's impairment prevents or impedes communication or an assumption that the disabled child cannot act on his or her own behalf (for example, in cases of severe learning disability, mental incapacity). Both assumptions may be true, but they can also serve to act as blocks to making child protection referrals.

Evidence review and best practice

How can we best safeguard and protect disabled children?

Evidence based best practice indicates the following:

1. Collect and analyse local statistical/data information relevant to disabled children.
2. Review of existing local and inter-agency mechanisms to promote the safeguarding of disabled children and/or develop local mechanisms for monitoring and reviewing child protection policies, procedures, practices and strategies relating to disabled children.
3. A disabled child may be dependent on an abuser for personal care, for communication assistance and to assist with mobility. Investigation and care planning needs to take account of this. If initial thresholds and risks concerning disabled children are not recognised cases will not go to conference, which can result in losing the opportunity to protect disabled children.
4. Decisions on non-disabled children are informed by 'developmental milestones' in health and social psychology but these may not apply to disabled children and a lack of knowledge about appropriate milestones may 'take one's eye' off underlying safeguarding issues. Appropriate training on disability issues can help up-skill staff. The rights of parents and carers may conflict with the rights of a child, but for children to receive protection equal to that of their non-disabled peers, it is important to ensure that the disabled child remains at the centre of all services.
5. Ensure professionals are trained and equipped to promote the safeguarding of disabled children and to respond effectively to specific child protection concerns. For example, research points out that some professionals feel that the carer "is doing their best under the circumstances" and leave children in situations where this is a high level of neglect and sometimes abuse that is not immediately apparent.
6. Promote safety and awareness programmes for disabled children and their families in educational, health, council and community settings. Generally speaking, society tends to devalue and disempower disabled people, some of it in institutionalised ways. Hate crime against disabled children and families is an unacceptable form of violence and abuse as it is not random and comes from within the community a child lives in. Carers who are looking after severely disabled children need support, training and education so that they are better able to

understand the specific needs of their disabled children and this early help can help safeguard vulnerable children.

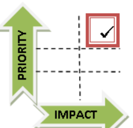
7.5. Homeless children and families

A person is legally defined as homeless if there is nowhere, in the UK or elsewhere, that is available for occupation by them and anyone who normally lives with them as a member of their family or who it would be reasonable to expect to live with them as a member of their family.

Homelessness can significantly increase child vulnerability, which may result in the child being taken into care or made subject to a child protection plan. The main trigger for youth homelessness is the breakdown of family relationships, often compounded by difficulties experienced elsewhere (such as poverty at home, separation and divorce of parents, crime, substance abuse and other mental health problems). Other common causes are leaving care and being unable to afford rent. By getting by, such as rough sleeping and squatting, their vulnerability increases.

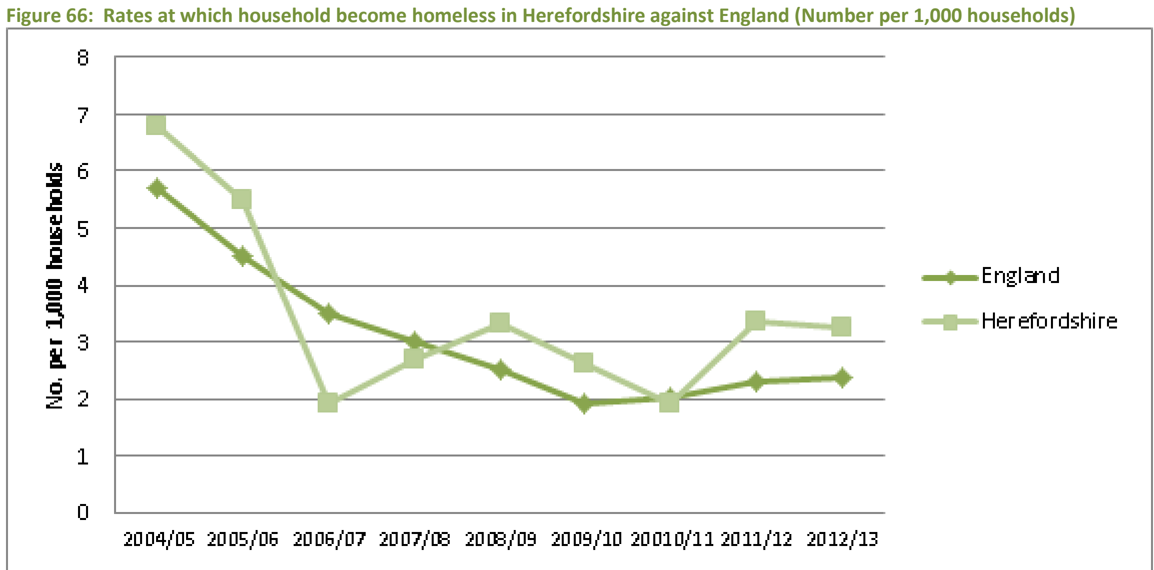
Evidence suggests that homeless young people have already experienced a wide range of negative influences in their childhood. For example, one study of 16 to 17 year olds accepted as homeless by their local authority found 54% had been excluded from school, 44% had parents with mental health issues and 17% had experienced sexual abuse.[26] Fleeing domestic abuse accounts for statutory homelessness of mothers and children in England.

7.5.1. Prevalence in Herefordshire



Herefordshire's rate of a household being accepted as homeless has decreased by at least 50% since the period 2004/05; however, this rate has been predominantly greater than the national average.

Figure 66: Rates at which household become homeless in Herefordshire against England (Number per 1,000 households)



Source: Department for Communities and Local Government, homelessness statistics

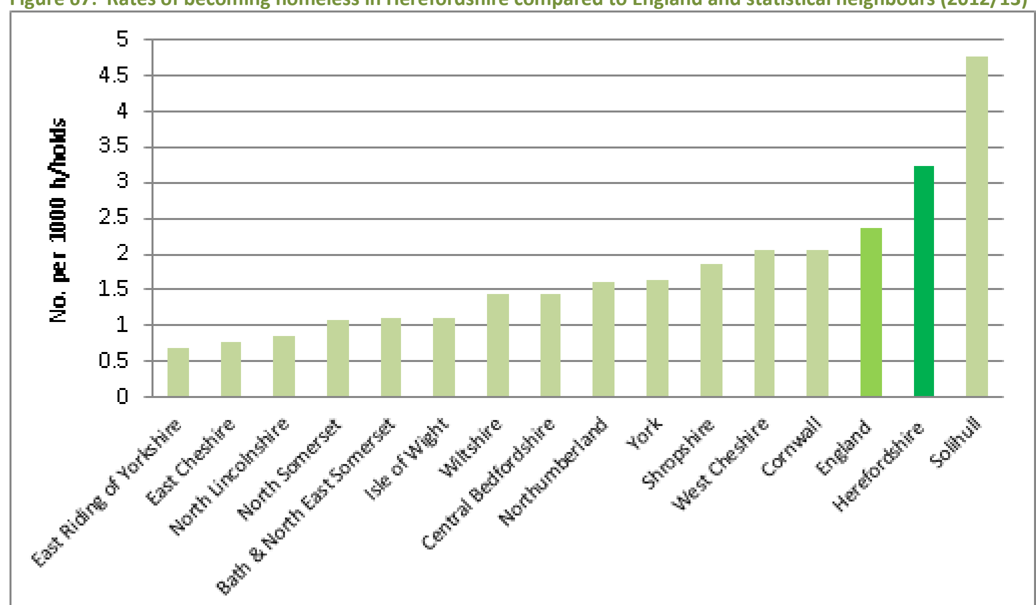
There was a large decrease between the periods 2005/06 and 2006/07. This is a 12 year low and is attributed to the new homeless prevention measures aiming to prevent people from becoming homeless (see Figure 66). The measures targeted individuals or households before they applied as

[26] Department of Communities and Local Government (2008) Statutory Homelessness in England: The experiences of families and 16-17 year olds.

homeless, putting in place interventions such as mortgage rescue. However, after an initial decrease numbers increased again between 2006/07 and 2008/09 only to decrease again in 2009/10. It is possible that this increase was due to the effects of the recession.

The county's homelessness rate is the second worst when compared to its statistical neighbours, the best performing rate is 0.68 per 1,000 households (East Riding of Yorkshire) compared to 3.23 per 1,000 households in Herefordshire (Figure 65). In the last three quarters (Q1-Q3 2013/14), over half of households labelled homeless have dependent children equating to 201 children (see Figure 68). Since Herefordshire has a high rate of homelessness, this means that more children compared to the national and statistical neighbours' average will become homeless.

Figure 67: Rates of becoming homeless in Herefordshire compared to England and statistical neighbours (2012/13)



Source: Department for Communities and Local Government, homelessness statistics

Figure 68: Total in accommodation arranged by the local authority, as a result of being homeless at the end of each quarter

	Apr/Jun 2013	Jul/Sept 2013	Oct/Dec 2013	Total cases of homelessness
Total number of households	68	75	57	200
Households with children	41	42	30	**113**
Number of children/expected children	69	79	53	**201**

Source: Department for Communities and Local Government, homelessness statistics

Evidence of impact on children

The housing profile for children indicates that Herefordshire has a problem in providing secure and suitable accommodation for children and their families. This report does not cover an in-depth housing needs analysis. However, as an identified vulnerable group, it is clear that the impact of poor housing conditions and transitional accommodation (for example, bed and breakfast) has a detrimental impact on children's health and social wellbeing.

A literature review on the impact of poor housing on children and families revealed the following findings:

- Shelter (the housing and homelessness charity) found that children and families in bed and breakfasts were often living in traumatic environments. Almost half of the families interviewed reported children witnessing very disturbing incidents, including open drug use and threats of violence. Over half had to share a bathroom or toilet with strangers and most felt unsafe in their accommodation. Two thirds of respondents to a Shelter survey said their children had problems at school and nearly half described their children as 'often unhappy or depressed' (Shelter, 2004).
- 25% of children who persistently lived in accommodation in a poor state of repair had a long standing illness or disability compared to 19% who lived in this type of bad housing on a short term basis (National Centre for Social Research , 2008).
- Homeless children are three to four times more likely to have mental health problems than other children (British Medical Association, 2003).
- The Office of the Deputy Prime Minister (2004) found that:
  - There is a direct link between childhood tuberculosis and overcrowding.
  - There are strong links between overcrowding and particular health conditions, in both children and adults, including respiratory conditions, meningitis and helicobacter pylori (a cause of stomach ulcers).
  - Research has established that disturbed sleep patterns can be a particular problem for people having to sleep in communal rooms.

Key message

Planning integrated care services for children (and their families) need to address their housing needs to ensure positive outcomes in health, education and social wellbeing.

7.6. Young carers

A carer is someone who, unpaid, provides help and support to a relative, friend or neighbour who could not manage without that help due to frailty, long term illness, disability or addiction. A young carer is an individual under the age of 18 whose life is in some way restricted because of the need to take responsibility for the care of someone who is ill, has a disability, experiencing mental distress or is affected by substance misuse (Carers UK definition). Children (anyone under the age of 18) who are providing or intend to provide substantial amount of care on a regular basis are assessed, in Herefordshire, as part of the Common Assessment Framework (Children Act 1989).[27]

Young carers form a group identified as at risk. Around three million children in the UK have a family member with a mental or physical illness, disability or substance misuse problem and there are over 50,000 children and young people looking after someone with a mental health problem in the UK[28].

7.6.1. Local profile

As of the last Census (2011), 38,000 individuals were recorded as carers in Herefordshire. As of March 2014, out of 4,200 carers registered with Herefordshire Carer's Support (only 11% of the total figure from the 2011 Census), 311 children and young people were registered as young carers.

[27] The Act requires children services to ensure that children and young people looking after an adult are not left with unreasonable caring responsibilities, nor should they be expected to carry out 'inappropriate' levels of care. A young carer's wish to continue education, to work or participate in leisure or training would apply.

[28] The Princess Royal Trust for Carers – Carers Fact Sheet, http://professionals.carers.org.

It is not mandatory for carers to register with Carer's Support, however, registering allows for services to be planned according to carer's needs and they are able to get support whenever needed. Figure 69 shows that the majority of young carers on the register are aged between 11-15 years. This is similar to the majority age reported by a national survey[29] that found that the majority of young carers are aged 12 years.

Figure 69: Age distribution of Herefordshire's young carers on the Herefordshire's Carers Support Register (March 2014)

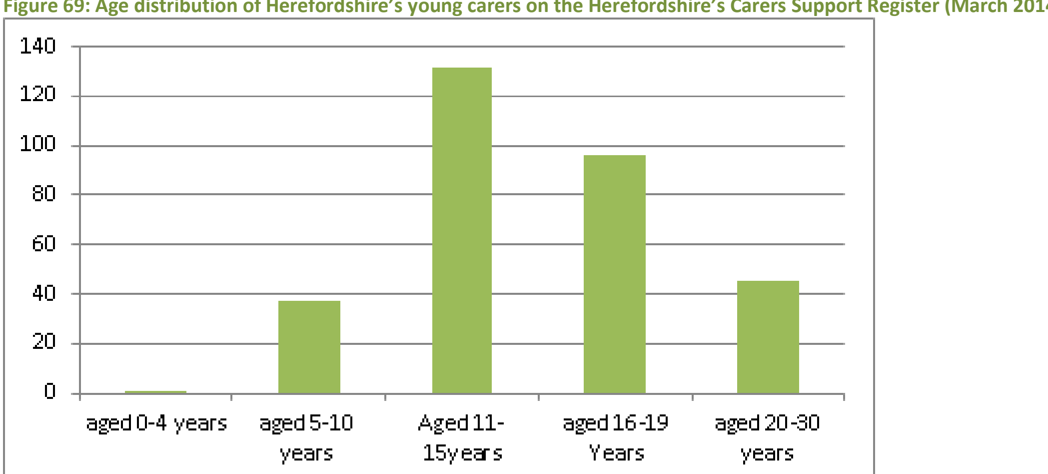
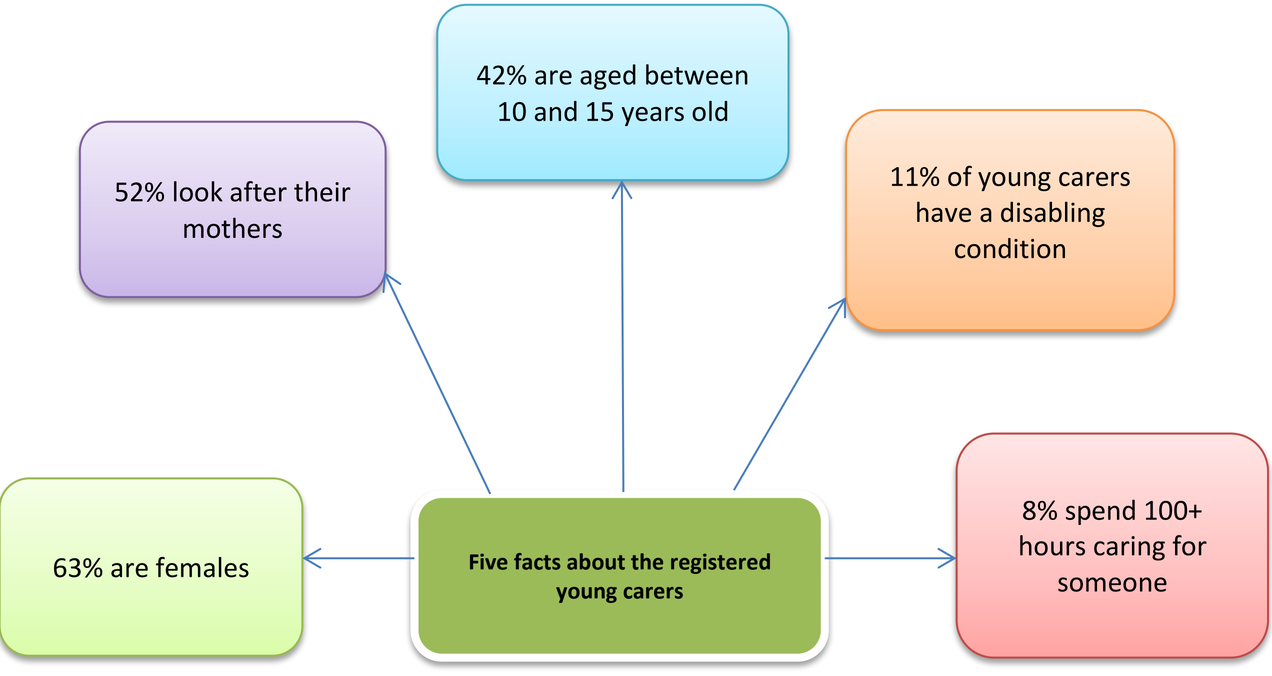


Figure 70: Facts about the registered young carers in Herefordshire



7.6.2. Impact of being a young carer

A study undertaken by the Children's Society draws on Government commissioned data on over 15,000 pupils aged 13 and 14. It examines how many of these children had caring responsibilities, the socio-economic characteristics of their families, young carers' educational attainment and their chances of being in training or paid work. (The Children's Society, 'Hidden from View', 2013).

[29] C. Dearden and S. Becker, Young Carers in the UK: The 2004 Report, http://www.carersuk.org/media/k2/attachments/Young_carers_in_the_UK.pdf

The findings were:

- Around one in 20 children miss school because of their caring responsibilities.
- Young carers have significantly lower educational attainment at GCSE level - the equivalent to nine grades lower overall than their peers.
- Young carers are more than one and a half times as likely to be from black, Asian or minority ethnic communities and are twice as likely to not speak English as their first language.
- The average annual income for families with a young carer is £5,000 less than families who do not have a young carer.
- Young carers are more likely than the national average to be 'not in education, employment or training' (NEET) between the ages of 16 and 19.
- Despite improved awareness of the needs of young carers, there is no strong evidence that young carers are any more likely than their peers to come into contact with support agencies.

There was no local data to investigate the extent of the need in Herefordshire, so the above could be applied to the county's population.

The Princess Royal Trust commissioned work led by Manchester University[30] which revealed that implications of being one of the UKs 175000 known young carers include risk of truancy, under achievement, isolation, mental and physical ill health, poverty and stress.

A literature review revealed that research and inquiry reports tend to focus on adult carers[31] not young carers.

Key message

Herefordshire acknowledges that 'carers are the first line of prevention and as such need to be properly identified and supported' [32] regardless of age. Herefordshire Carer's Strategy (2012) outlines priorities for both adult and young carers, but it is more adult focused. Specific consideration given to vulnerable young carers would help safeguard their interests and meet their particular needs.

7.6.3. Evidence base and good practice

Local authorities in England and Wales implement a wide range of initiatives to support young carers so that they are able to experience normal childhood lives alongside their caring duties. Some of these 'protective' factors are (not in order of priority):

- Good access to information advice and advocacy – this supports the resilience of carers to be resourceful, seek appropriate help in a crisis and mitigate impact on them.
- Young carer's clubs where carers can meet and make friends and offer each other support.
- Educational support for ensuring standards of learning are met and support in schools for missed lessons due to unplanned absences due to caring duties, including access to educational psychologists.
- Respite, so young carers can take a break from their caring duties.

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[30] 'At What Cost to Young Carers' 2009.

[31] For example, The Association of Directors of Adult Services (July 2011) identify risk factors that increase the risk of abuse from carers as unmet or unrecognised needs of their own. The Dilnot Commission (2011) recorded 52% of carers in one study needing treatment for stress and 63% higher likelihood of early death in carers as opposed to non-carers.

[32] Supporting Carers – The Case for Change 2011.

- Specialised workshop style training in caring for specialised needs (e.g. diet, lifting, communications)
- Supportive networks – someone to go to for guidance, protection and safety.
- Holidays (funded by the independent sector).
- Adult social services intervention for the need of the adult cared for when required.
- Celebratory events for young carers – sponsored by councils to give recognition to the work of children in the role of carer.

7.7. Care leavers

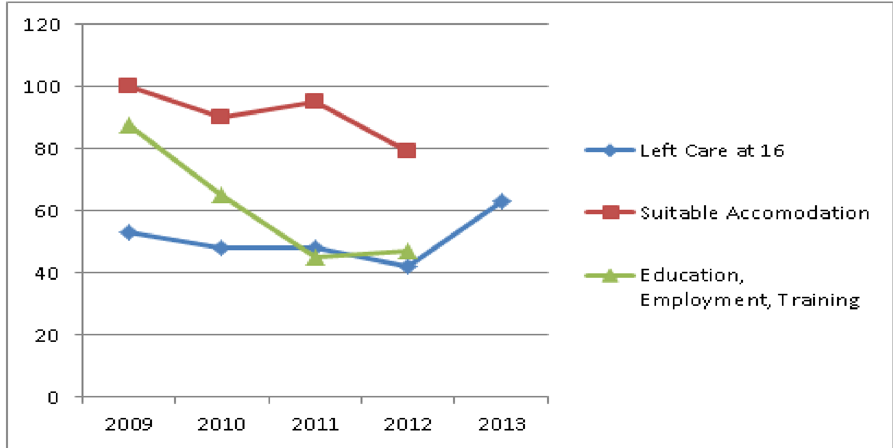
The Children (Leaving Care) Act 2000 seeks to improve the life chances of young people living in or leaving local authority care. The Act requires councils to plan for looked after children so that they are prepared for leaving care, such as appropriate support (finance, accommodation, personal support) when they make the transition from discharged care to the wider community. Governmental policy ('improving adoption services and the lives of looked after children') outlines steps to improve corporate parenting so that care leavers are more resilient to the many changes they will face in adulthood.

Vulnerable children sometimes end up as vulnerable adults if they do not reach the threshold of need set by Herefordshire and therefore, unable to access services that they benefited from as children. Recent welfare reforms have had a negative impact on care leavers as the underlying assumptions for some reform is the expectation that a young adult is living in the parental home, without the costs associated with independent living.

A care leaver is defined as a person aged 25 or under, who has been looked after away from home by a local authority for at least 13 weeks since the age of 14 and who was looked after away from home by the local authority at school leaving age or after that date.

Young people leaving care are one of the most vulnerable groups in our society with studies showing they are three times more likely to be cautioned or convicted of an offence, four times more likely to have a mental health disorder, five times less likely to achieve five good GCSEs and eight times more likely to be excluded from school. One in five homeless people have been in care.

Figure 71: Five year trend on three outcomes for care leavers in Herefordshire



Source: Department of Education SFR36_2013 and the Herefordshire matrix (August 2013)

As the trends show in Figure 71, higher proportions are leaving care at the age of 16, compared to those staying in care until the age of 18. The proportion of care leavers living in suitable

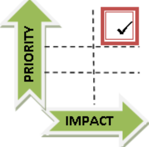
accommodation has been decreasing over the past five years. Herefordshire is ranked 128 out of 236 local authorities. The latest England average was 88.3% compared to the county's 78.9%.

In 2008, 94% of care leavers were in education, employment or training. In 2012, this proportion fell to 47%. Herefordshire is ranked number 114 out of 252 local authorities and when compared to England's average.

Key message

Capturing key intelligence (data and analysis) on care leavers would help the local authority to prepare and plan appropriate support. An assessment of the effectiveness of current local provision would help identify any gaps in this area. Herefordshire's high ranking compared to other local authorities is an indication that this area may be a high priority for both children's social care service and their potential transition to adult social care services.

7.8. Young offenders



A young offender is a young person who has been convicted or cautioned for a criminal offence.

There are 17,200 young people aged 10 to 17 in Herefordshire. In 2012 there were 275 youth justice sanctions (reprimands, final warnings or convictions) made on Herefordshire young people. A total of 225 individual young people accounted for these 275 outcomes, 1.3% of the youth population.

Of the 225 young people entering or in the youth justice system in 2012, 70% were male. The majority, 79%, were aged 15 to 17 years. The peak age of offending for both young males and females was 17 years.

(Source: Youth Offending Service)

The numbers for re-offending have remained within the 30% to 40% region for the periods between October 2005 and September 2011 for Herefordshire. This is comparable to the national trends.

(Source: Herefordshire Community Safety Partnership)

7.8.1. First time entrants

In 2012/13 there were about 113 people aged 10-17 who entered the youth justice system for the first time. This equates to 671 first time entrants per 100,000 youth population. This is higher than the West Mercia rate of 546 per 100,000. The reasons for this higher rate are likely to be multiple and complex but the use of community resolutions and detection rates appear to offer some answers. However, much more detailed analysis would be required to ascertain the actual contribution of the factors to the higher rates of first time entrants in Herefordshire. Use of community resolution is also thought to influence performance throughout the youth justice system.

(Source: Herefordshire Community Safety Partnership)

7.8.2. Challenges faced by a young offender

Local information to inform this report was unavailable. Based on national reports and research evidence, young offenders are more likely to have been in care, with a history of frequent changes to placements in the care system. They are more likely to have experienced difficult childhoods with parents who have had criminal convictions or also been in care.

As a result, young offenders find difficulties excelling in school with poor attainment. Unable to cope, frustrations manifest in challenging behaviours that exasperates the situation and they become socially isolated. One study found that young offenders leave school without any qualifications or do not know what qualifications they have. Offending by young people is also associated with truancy, exclusion, low levels of literacy and numeracy and bullying.[33] As a consequence of this, many end up in unemployment or low skilled unemployment resulting in financial problems and a lack of fixed income. The abuse of drugs and alcohol is high in this group with all the obvious problems related to that; for example, one in three young people in custodial settings has a mental health issue[34]. A proportionally large percentage of this group comes from a different cultural background facing problems of assimilating into the host community.

Key message

Targeted early help for young offenders would give them a better chance in life in terms of good education, access to training and improved job prospects.

7.9. Gypsy, Roma Travellers

The ministerial report[35] (2012), reports that the Gypsy, Roma Travellers (GRT) are held back by some of the poorest outcomes of any group, across a wide range of social indicators. It outlines commitments that local government has to act on:

- Improve health outcomes for GRT
- Improve education outcomes
- Provision of appropriate accommodation
- Tackle hate crime against Gypsies and Travellers
- Improve interaction with the National Offender Management Service
- Improve access to employment and financial services
- Improve engagement with service providers

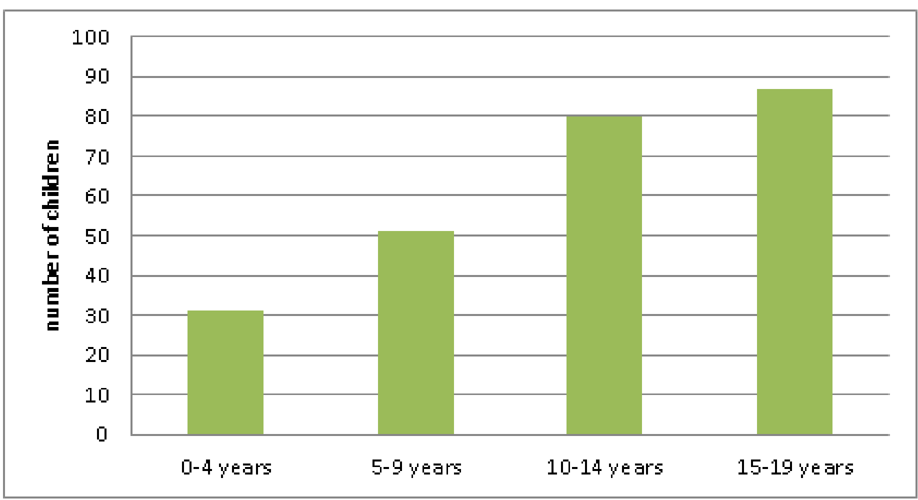
In Herefordshire, a Gypsy, Roma Travellers Strategy aims to fulfil these commitments and a GRT integrated needs assessment is currently underway.

7.9.1. GRT children's profile in Herefordshire

The data provided here comes from the school census and attainment records held by Herefordshire. As of October 2013, there were 255 children and young people aged 0 – 19 known to the local Gypsy, Roma Traveller team. This is the most accurate source, as most families do not declare their ethnicity as GRT on official documents.

[33] Audit Commission, Against the Odds, Targeting Young Offender: the briefing paper, August 2010
[34] Children and Young People in the Youth Justice System Report of seminars organised by the All Party Parliamentary Group for Children 2009/10
[35] Department for Communities and Local Government (2012), progress report by the ministerial working group on tackling inequalities experienced by Gypsies and Travellers https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/6287/2124046.pdf

Figure 72: Current numbers of children and young people known to the GRT team: October 2013



Source: Herefordshire Council GRT team

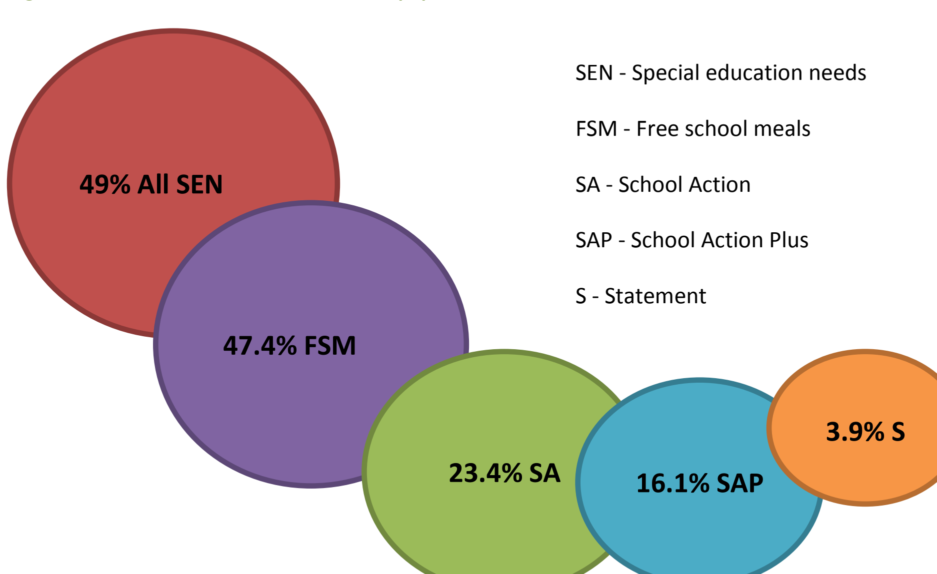
Most of the GRT children known to the team are older, as shown in Figure 72; this is mostly because children are unknown until they start school.

7.9.2. Outcomes for GRT children

7.9.2.1. Attainment

Although attainment is improving and Herefordshire's GRT children perform better than nationally, the gap between GRT children's attainment and Herefordshire's children remains wide, see the section on education, aspirations and attainment in this report.

Figure 73: Characteristics of GRT education population



SEN - Special education needs

FSM - Free school meals

SA - School Action

SAP - School Action Plus

S - Statement

7.9.2.2. Exclusions

The rate of exclusion per GRT pupil is higher than both local and national rates. This rate is noted to be increasing, however it must be noted that this is a small number of pupils who repeatedly incur exclusions and the vast majority of GRT pupils in Herefordshire schools have no exclusions.

Figure 74: Rate of exclusion per pupil (GRT against local trends)

7.9.2.3. Health outcomes

National studies show costly inequalities regarding the GRT population, for example, the life expectancy of gypsies is at least ten years lower than the rest of the population and suicide rates are at least three times higher. As with many socially excluded or vulnerable groups, the evidence on health outcomes and successful interventions for GRT remains unknown or weak.

The traveller health team, jointly responsible with Wye Valley NHS Trust, for the immunisation of children from this population was decommissioned in 2013. Herefordshire does not hold any data regarding specific health outcomes for GRT children.

Key message

Findings from the GRT Integrated Needs Assessment will help inform the commissioning of services for GRT children and families. The need to actively engage with the 'hard to reach' GRT community supports the county's safeguarding of its vulnerable children[36] and ensures positive outcomes for them.

7.10. Other vulnerable groups

This report did not include intelligence on children from other minority and 'hard to reach' groups or on young parents, orphans or children struggling with bereavement, bullying, children whose parents have mental health issues or substance misuse issues.

[36] There is no formal data relating to the prevalence of DVA in GRT communities, but anecdotally it is reported that there are high rates of domestic abuse against women.

The data relating to this was unavailable.

7.11. Bibliography

Ball, N., and Niven, L. (2007). *Domestic Violence and Sure Start Local Interventitions.* Nottingham: DfES.

Berry, E. (2002). Childhood Experiences and the expression of genetic potential: What childhood neglect tells us about nature and nurture. *Brain and Mind 3*, 79-100 (cited in Marmot review).

Bevan, E. and Higgins, D. (2002). Is domestic violence learned? The contribution of five forms of child maltreatment to men's violence and adjustment. *Journal of Family Violence*, *17*(3), 223–245.

BMA. (2003). *Housing and Health: Building for the future.* London: British Medical Association.

Booth, T. and Booth, W. (2002). Men in the Lives of Mothers with Intellectual Disabilities. *Journal of Applied Research in Intellectual Disabilities 15(3)*, 187-199.

Brandon, M., Bailey, S., Belderson, P., Gardner, R., Sidebotham, P., Dodsworth, J., . . . Black, J. (2009), *Understanding Serious Case Reviews and their Impact: A biennial analysis of serious case reviews 2005-07. (Research Report No DCS F-RR129.)* . lONDON: DCSF.1.

Chang, J., Theodore, A., Martin, S. and Runyan, D. (2008). Psychological Abuse Between Parents: Association with maltreatment from a population-based sample'. *Child Abuse and Neglect 32 (8)*, 819-829.

Child and Maternal Health Intelligence Network. (2014, March). *Disability Needs Assessment*. Retrieved from Child and Maternal Health Intelligence Network: http://atlas.chimat.org.uk/IAS/profiles/profile?profileId=46&geoTypeId

Chapple, C. (2003). Examining intergenerational violence: violent role modelling or weak parental controls? *Violence & Victims, 18*(2), 143–162.

Edwards, V., Holden, G., Felini, V. and Anda, R. (2003). Relationship between multiple forms of childhood maltreatment and adult mental health in community respondence: Results from adverse childhood experiences study. *American Journal of Psychiatry 160*, 1453-1460.

Felitti, V., Anda, R. and Nordenberg, D. (1998). The relationship of adult health status to childhood abuse & household dysfunction. . *American Journal of Preventive Medicine 14(4)*, 245-258.

Finney, A. (2004). *Domestic violence, sexual assult and stalking: findings from the 2004/5 British Crime Survey.* Home Office Online Report.

Galvani, S. (2004). Alcohol and Domestic Violence: Womens Views. *Violence Against Women* , 641-662.

Her Majesty's Inspectorate of Court Administration (HMICA). (2005). *Domestic Violence, Safety and Family Proceedings, Thematic Review of the Handling of Domestic Violence Abuse Issues by Children and Family Court and Advisory Support Services and the Adminstration of Family Courts in HMCS.* London: HMICA.

Herefordshire Children's Provider Services. (November 2013). *Early Help Services Position Statement.*

Hershkowitz, I., Lamb, M. and Horowitz, D. (2007). Victimisation of children with disabilities. *American Journal of Orthopsychiatry 77(4)*, 629-635.

Humphreys, C. and Thiara, R. (2003). Mental Health and Domestic Violence: 'I Call it Symptoms of Abuse'. *British Journal of Social Work*, 209-226.

Jones, L. (2012). Prevalence and risk of violence against children with disabilities: A systematic review and metaanalysis of observational studies. *The Lancet*, 899-907.

Kendall-Tackett, K. (2002). The health effects of childhood abuse: four pathways by which abuse can influence health. *Child Abuse & Neglect, 26* (6–7), 715–729.

Khanum, N. (2008). *Forced Marriage, Family Cohesion and Community Engagement: National Learning through a case study of Luton.*

Meetoo, V. and Mirza, H. (2007). There is Nothing 'Honourable' about Honour Killings': Gender, violence and the limits of multiculturalism'. *Women's Studies International Forum 30 (3)* , 187-200.

Miller-Perrin, C. and Perrin, R. (2007). *Child maltreatment: an introduction*. Thousand Oaks: Sage Publications.

MENCAP. (2007). *Bullying Wrecks Lives: The experiences of children and young people with a learning disability.* London: MENCAP.

National Centre for Social Research. (2008). *The Dynamics of Bad Housing .* National Centre for Social Research.

Office of the Deputy Prime Minster. (2004). *The impact of overcrowding on Health and Education: A review of Evidence and literature.* London: Office of the Deputy Prime Minster.

Oliver, C., Owen, C., Statham, J. and Moss, P. (2001). *Facts and Figures: Local Authority Variance on Indicators Concerning Child Protection and Children Looked After,.* London: Thomas Coram Research Unit.

Povey, D. (2004). *Crime 2003: Supplementary Volume 1 – Homicide and gun crime,.* London: Home Office.

Radford, L., Corral, S., C, B., Fisher, H., C, B. and Hwatt, N. (2011). *'The maltreatment and victimisation of children in the UK: NSPCC report on a national survey of young peoples', young adults' and caregivers' experiences.* London: NSPCC.

Rose, W. and Barnes, J. (2008). *Improving Safeguarding Practice: Study of Serious Case Reviews 2001-2003. (Research Report DCSF-RR022) .* Nottingham: Department for Children, Schools and Families.

Salisbury, E., Henning, K. and Holdford, R. (2009). Fathering by Partner-Abusive Men Attitudes on Children's Exposure to Interparental . *Child Marltreatment 14(3)*, 232-242.

Shelter. (2004). *Shelter Temporary Accomodation Survey .* Shelter (cited in Living in Limbo).

Stanley, N, Miller, P., Richardson, Foster, H., Thomson, G. and Watson, J. (2010). ' A Stop-start Response: Social Services' interventions with children and families notified during domestic violence incidents', . Sullivan, P., & Knutson, J. (2000). Marltreatment and Disabilities: a population-based epidemiological study. *Child Abuse and Neglect 24(10)*, 1257-1273.*British Journal of Social Work (6) 19*.

Sullivan, P. and Knutson, J. (2000). Marltreatment and Disabilities: a population-based epidemiological study. *Child Abuse and Neglect 24(10)*, 1257-1273.

UNICEF. (2006). *Behind Closed Doors: The Impact of Domestic Violence on Children.* UNICEF.

8. Education, attainment and aspirations

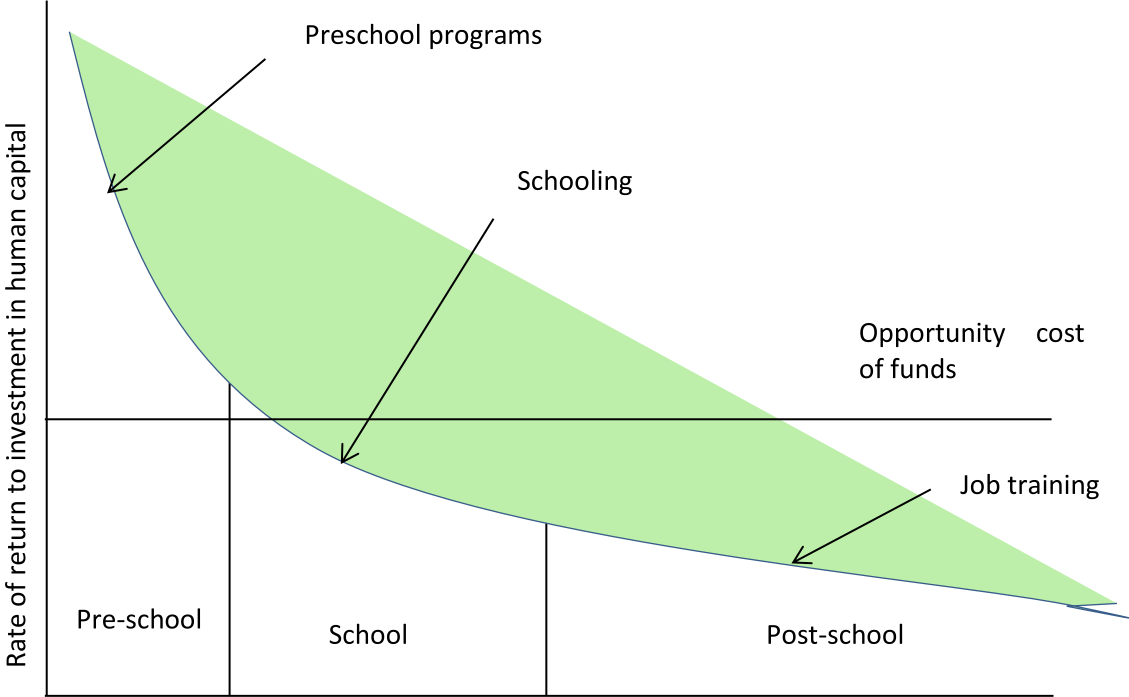
8.1. Introduction and policy context

Educational inequalities persist with significant variations in educational outcomes being associated with the learners' social background especially socio-economic status. However, evidence suggests that only 10%-20% of the variation can be attributed to schools; therefore addressing inequalities in education requires action outside of schools, as well as within.

The Marmot Review recommends that local authorities ensure that reducing social inequalities in pupils' educational outcomes is a sustained priority. This recommendation requires continued work to improve the quality of schools as well as targeted and universal work to ensure that all children receive the best education possible. This includes reducing truancy and (the behaviours leading to) exclusion, provision of special education and the support for those placed in the lower sets and positioning for further education at 16 onwards.

As already noted in the preceding chapters, interventions are more cost effective if they prevent problems emerging rather than treating those problems. It is important to also note that returns of investment are greater in early childhood than in adolescence as illustrated in Figure 75.

Figure 75: Return on investment for education and training interventions



Rates of return to human capital investment initially setting investment to be equal across all ages

Source: Figure reproduced from "Fair Society, Healthy Lives".

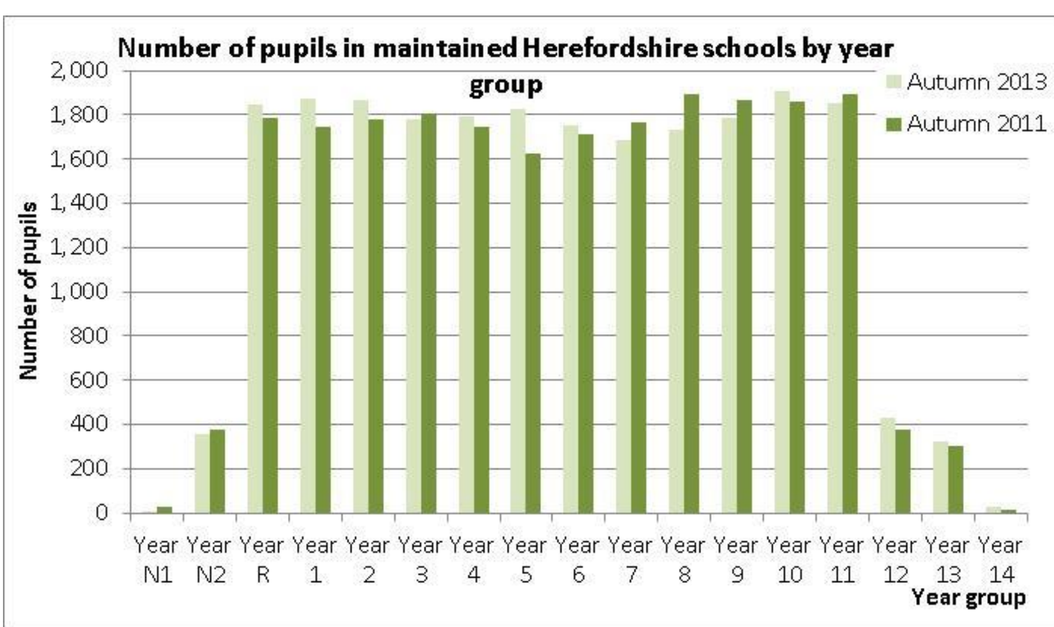
8.2. Education population

Not all children who live in Herefordshire will attend state maintained schools in the county. Some will commute to schools in other counties or go to schools outside the state sector (e.g. private, vocational) or be home educated. Conversely, some children that live outside the county will attend Herefordshire schools. The information in this section is taken from analysis and modelling of pupil data undertaken by the children's wellbeing business intelligence and sufficiency, planning and capital investment teams.

8.2.1. Current school population

The latest validated school census (October 2013) counted 21,700 children attending state maintained schools[37] in Herefordshire for compulsory education: 12,700 at primary level and 8,900 at secondary. There were also 350 attending state maintained nursery education (50 fewer than the same time in 2011) and 800 in sixth forms attached to schools (100 more than in 2011). Figure 76 shows the current number in each year group in comparison with 2011.

Figure 76: Number of pupils in maintained Herefordshire schools by year group (2011 and 2013)



Source: Herefordshire School Census, Herefordshire Council children's wellbeing directorate

8.2.2. School population compared to resident population

Just over 900 (4%) of the 22,850 pupils of all ages (i.e. including nursery and sixth forms) in 2013, lived in neighbouring counties. About 400 were from Gloucestershire, 170 from Powys, 160 from Worcestershire, 120 from Shropshire and 74 from Monmouthshire.

Older school level data from 2012 shows that out of county pupils were more common in secondary schools (3.1% of pupils) than primary schools (2.0%). The highest numbers attended schools nearest the borders, which may be the closest schools for those children. Although much smaller numbers,

[37] Excludes pupil referral units (PRUs) as they were not required to submit an autumn census return and many pupils at PRUs are registered at mainstream schools as well.

a fifth of the post 16 students were from out of county; mostly attending John Kyrle High School and Sixth Form Centre in Ross-on-Wye.

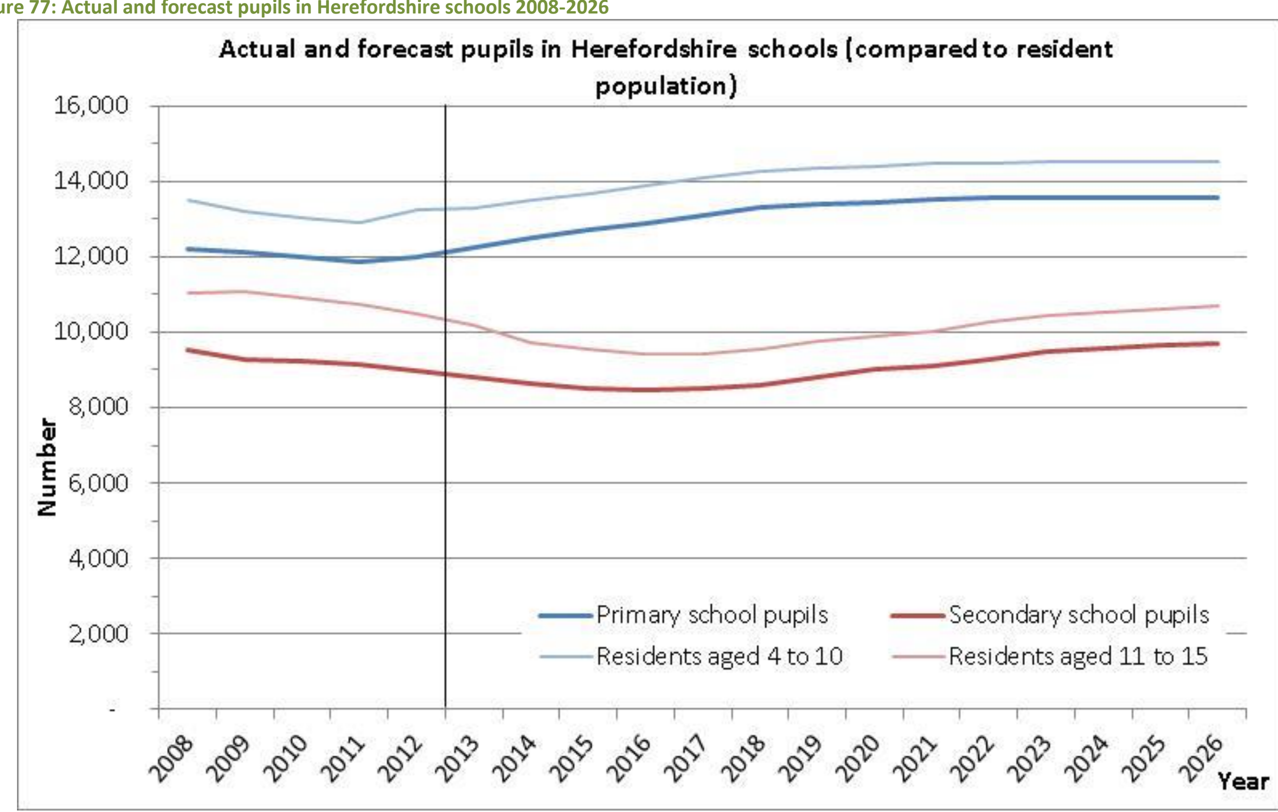
It has not been possible to obtain data on the number of Herefordshire children attending schools outside the county, nor the number attending non-maintained schools. However, on average the number of reception year pupils in maintained Herefordshire schools is 93.4% of the resident population of four year olds. This is used as the basis for forecasts of the school population (see below). Older year groups are predicted based on the numbers already in school.

8.2.3. Future school population

County level 2012 based pupil forecasts produced in 2013, indicate that the number of primary school age pupils will continue the rise that started in 2011; increasing by 14% from their low of 11,900 in 2011 to 13,600 by 2022, although this would still be 4% below the 14,200 places currently available in county primary schools.

The number of secondary school pupils will continue to fall until 2016, mirroring the trend seen in primary schools five years earlier. This lowest point of 8,500 pupils would be 13% below the current capacity in Herefordshire's secondary schools (9,800 places). The forecasts suggest that numbers will rise to 9,700 by 2026; 1% below current capacity.

Figure 77: Actual and forecast pupils in Herefordshire schools 2008-2026



Sources: 2012 based county level pupil forecasts, Herefordshire Council and 2011 based population forecasts: GL Hearn for Herefordshire Council

8.2.4. Education population by characteristics

8.2.4.1. Number of pupils eligible for free school meals

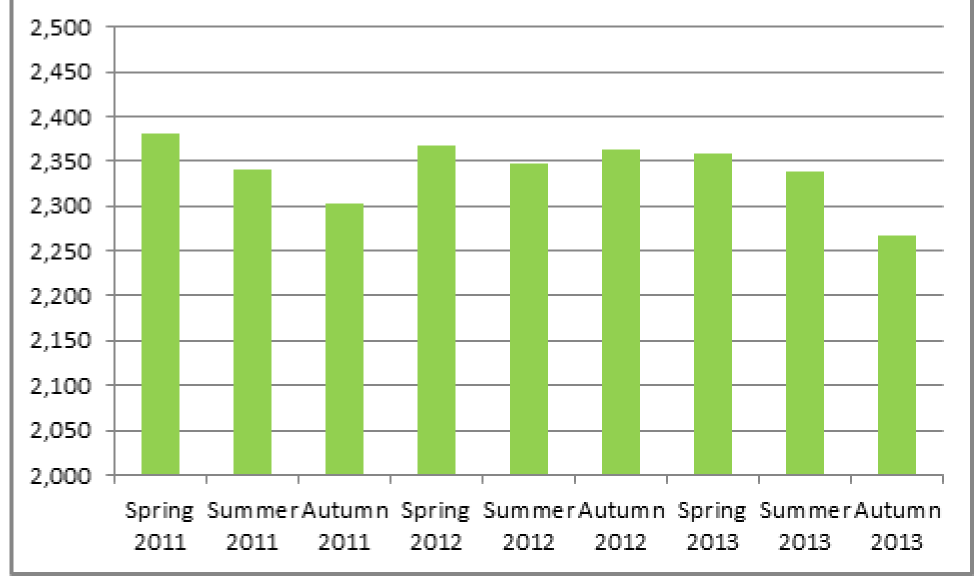
In 2012, only 11% of Herefordshire primary school children were eligible for free school meals, compared to 18% nationally. Only 32% of these eligible primary school children took up free school meals compared to 46% nationally. However, a higher proportion of Herefordshire's secondary school children took up meals: 42% of eligible children compared to 40% nationally.

Numbers of eligible children tend to be at their highest in the spring term of each year (see Figure 78), but the total number has fallen slightly over the last two years even taking this seasonal variation into account: there were 22 fewer in spring 2013 than spring 2013 and 36 fewer in autumn 2013 than in autumn 2011.

Reasons for poor FSM uptake

- Not all children living in poverty are entitled to them
- Not all children who are entitled make a claim
- When the families have made a claim not all children eat them (Children's Society, 2012)

Figure 78: Total number of pupils eligible to free school meals (FSM)



As part of implementing the Giving Every Child a Healthy Start Policy, the Government announced in March 2014, that from September 2014 all pupils in Reception, Year 1 and Year 2 in state funded schools in England will be eligible for free school meals (FSMs). This will include academies, free schools, pupil referral units and alternative provision as well as maintained schools. Introducing the universal FSMs is envisaged to have a positive impact on take up of free school meals as hopefully the stigma attached to this will be eliminated.

Existing entitlements to free school meals for disadvantaged pupils in nursery classes and at Key stages 2 to 4 will continue as now, based on the existing free school meals eligibility criteria.

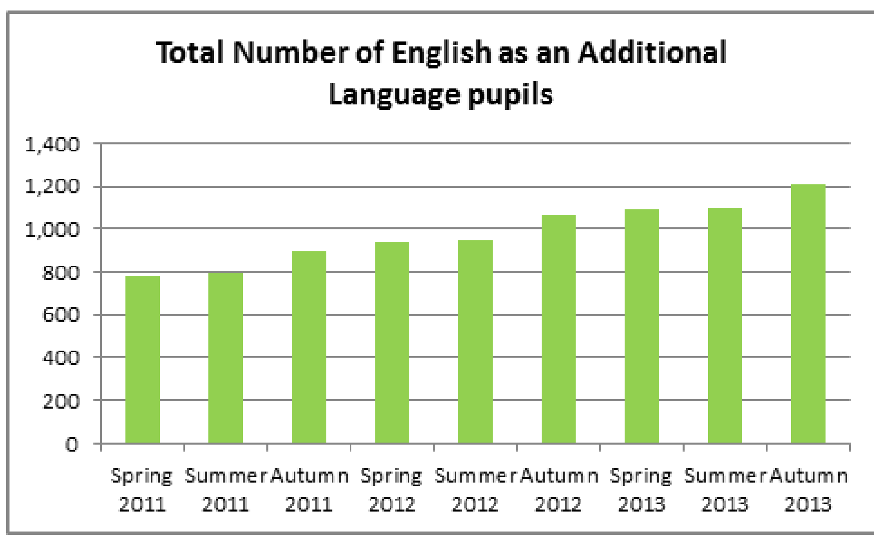
8.2.4.2. English as an additional language (EAL)

Evidence suggests that EAL pupils tend to struggle in the early years, however once they have an understanding of the English language, make accelerated progress compared to their English speaking peers.

Schools record a first language other than English where a child was exposed to that language during their early development and continues to be exposed to it in the home or community.

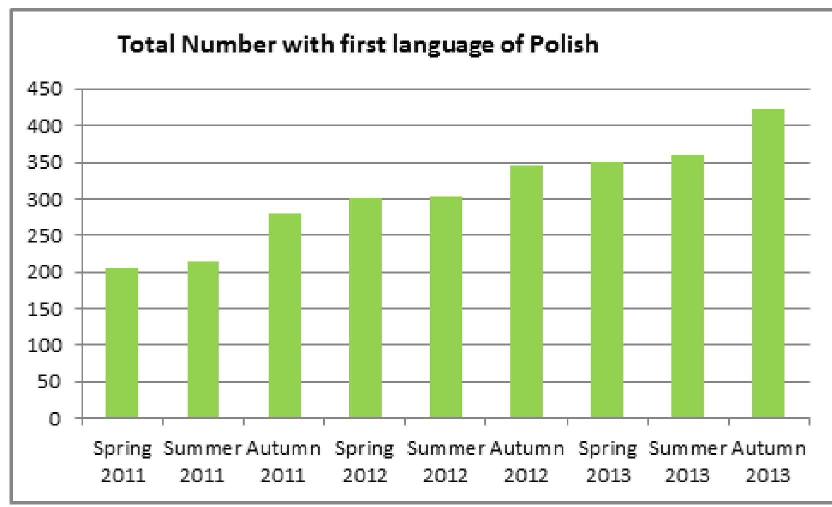
In Herefordshire there has been a continuous and significant increase in pupils with English as an additional language. Over the short period numbers have increased from 783 to 1,208, an increase of 54.3 percentage points. Between spring 2013 and autumn 2013, there has been an increase of 9.9 percentage points, see Figure 79 .

Figure 79: Total number of English as an additional language pupils



The single largest identified language other than English is Polish. During the period, numbers that identify Polish as a first language more than doubled from 204 in spring 2011 to 422 in autumn 2013. Some of this increase might be attributable to schools becoming better at recording specific language groups; however the increase in numbers is more significant than this alone.

Figure 80: Total number with first language of Polish



Whilst the Polish community in Herefordshire has been a feature for many years, a significant number of the population tended to be aged 30 years and below. It is perhaps only recently that this cohort has become parents and as a result their children have started to form part of the Herefordshire school population.

8.2.4.3. Black, Asian and minority ethnic (BAME) group

Similar to EAL numbers, the number of Black, Asian and minority ethnic (BAME) pupils has increased annually, from 329 in 2011 to 514 in 2013; a 56.2 percentage point increase. The largest single identified BAME group is White Eastern European, which directly correlates with the increasing number of Polish speaking pupils in schools. In a similar way to EAL, schools need to invest resources to ensure that they can properly cater for pupils in minority groups. This might be in the form of specialist teachers or offering a more diverse cultural range of activities. It is also essential to educate all groups about the traditions and faith of minority groups if there is to be community cohesion amongst the population.

8.3. Attainment

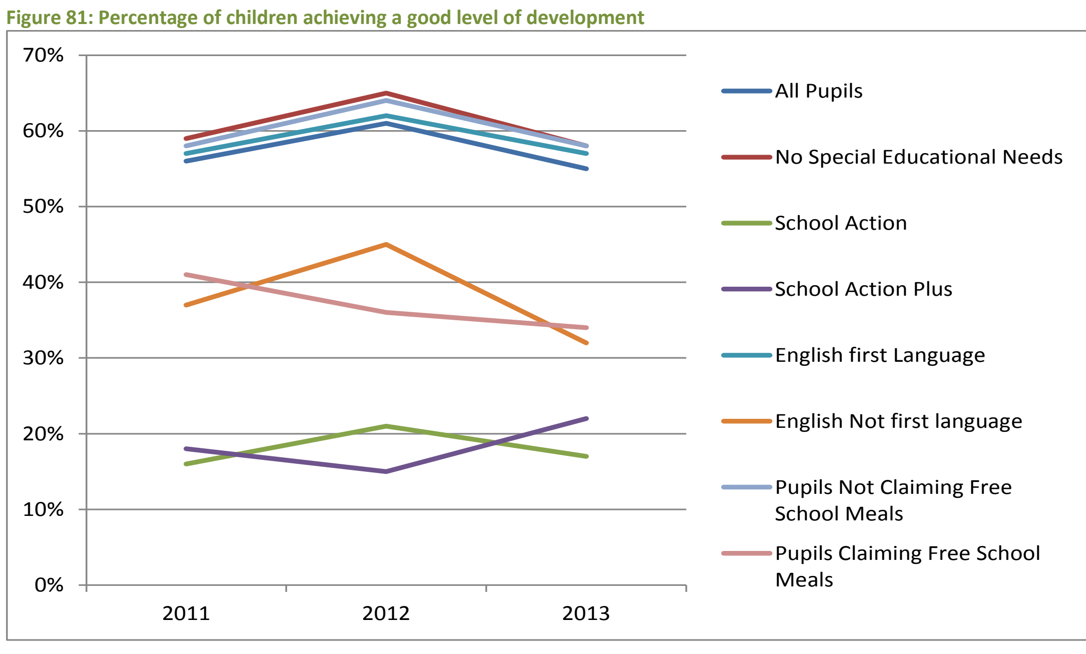
8.3.1. Early years foundation stage profile

The Early Years Foundation Stage Profile (EYFSP) is an assessment of a child carried out during their reception year at school (aged 4 - 5 years).

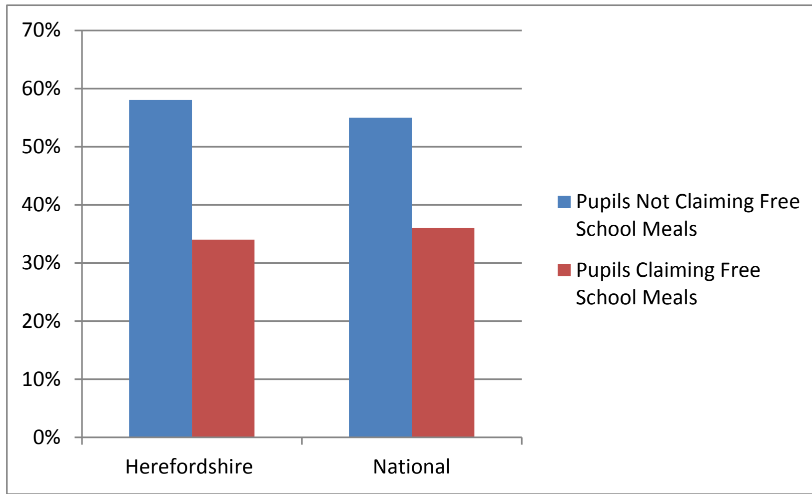
In 2013 Herefordshire pupils overall performed better than the national average with 55% achieving a good level of development. Both boys and girls performed above the national average.

Performance was below national average for those pupils having English as an additional language. Only 32% of this cohort achieved a good level of development compared to 44% nationally. Pupils eligible to free school meals in Herefordshire also performed below the national average for this cohort (34% and 36% respectively).

Figure 81: Percentage of children achieving a good level of development



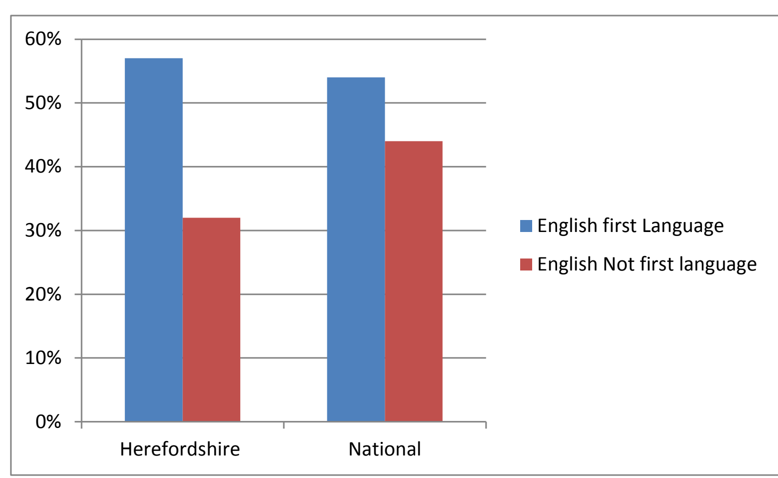
In terms of statistical neighbours, Herefordshire was the third highest performing local authority for pupils achieving a good level of development in 2013. Although 2013 data has been compared here to previous years, note there was a change to the assessment methods and subjects.

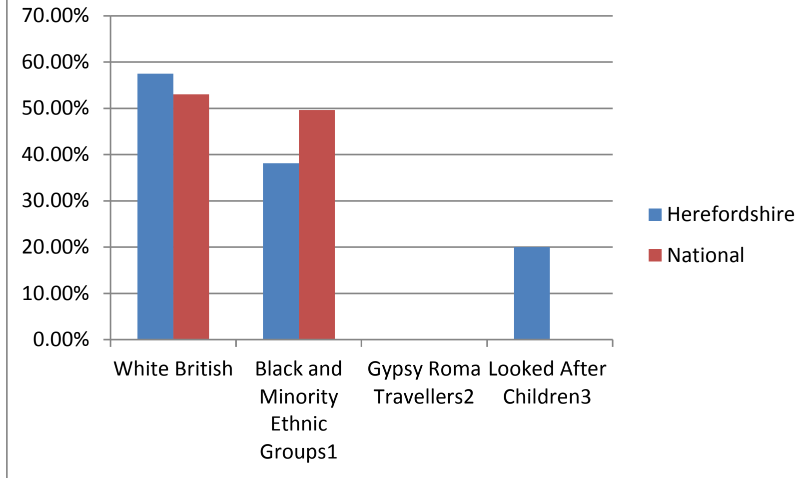


Only 34% of the children claiming free school meals achieved a good level of development compared to 58% of non-claimants.

This percentage is slightly higher than the national rate of 32%.

Herefordshire children who identified as EAL performed worse than their peers in the same category nationally by 12 percentage points, with only 32% achieving good development. This equates to almost 100 children not meeting the development threshold at the end of EYFSP.





There were only three EYFSP children identified as GRT in 2013. Small numbers may be as a result of parents choosing to identify as White British rather than GRT. None of these children had achieved good development by the end of EYFSP. There is no national data to allow for comparisons.

Similar to EAL, Herefordshire's children from the BAME group performed worse than their peers across England with 39% achieving good development compared to 50%. The gap in achievement is even greater when compared to the White British group locally, with 57% achieving good development; which was better than the national rate of 53%.

8.3.2. Key stage 1 (KS1)

Key stage 1 is the stage of education that covers years one and two in primary school (ages 5 – 7 years). Children are assessed at the end of this stage in reading, writing and maths.

The percentage of pupils achieving at least a level 2 in reading in Herefordshire in 2013 was in line with pupils nationally. Similar to the national trend, girls outperformed boys in 2013 and, similar to performance in early years, pupils whose first language was other than English (EAL) performed significantly below their peers nationally (71% versus 86%), as shown in Figure 82. Similar trends are shown for writing and mathematics. Compared to statistical neighbours, Herefordshire performed better than four but not as well as six for reading. There was only a three percentage point variation between the highest performing neighbour (Devon at 90%) and the lowest (East Sussex at 87%).

Figure 82: Trend analysis - Percentage of children achieving level 2C+ in reading

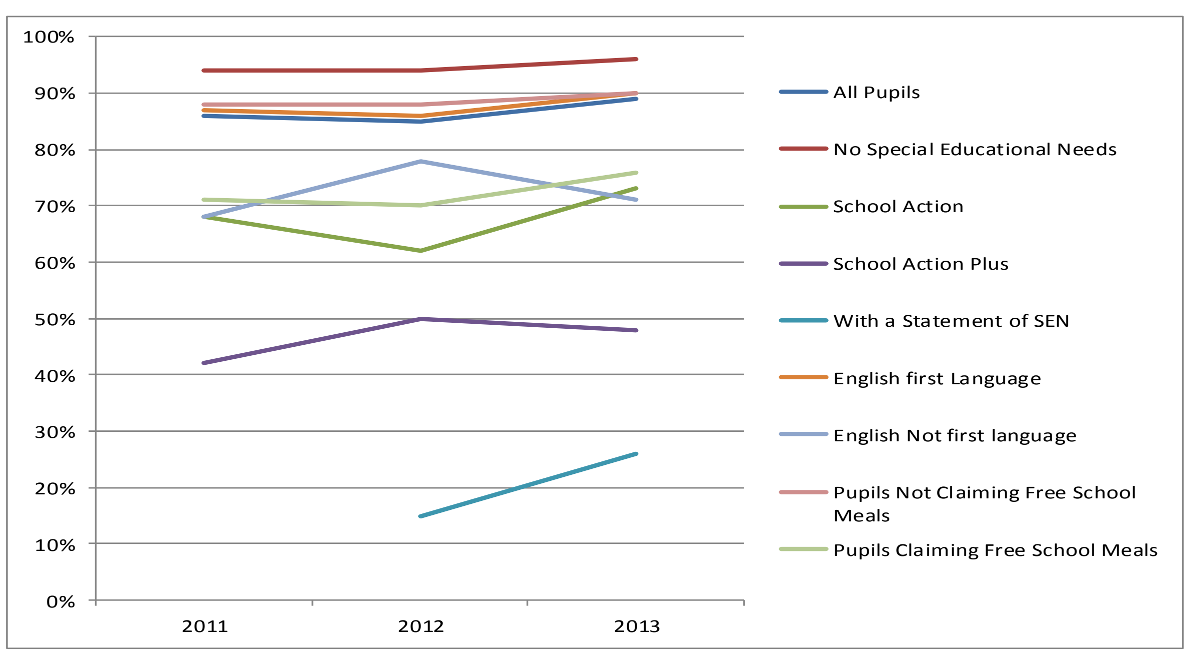


Figure 83: Percentage of children achieving level 2C+ in writing

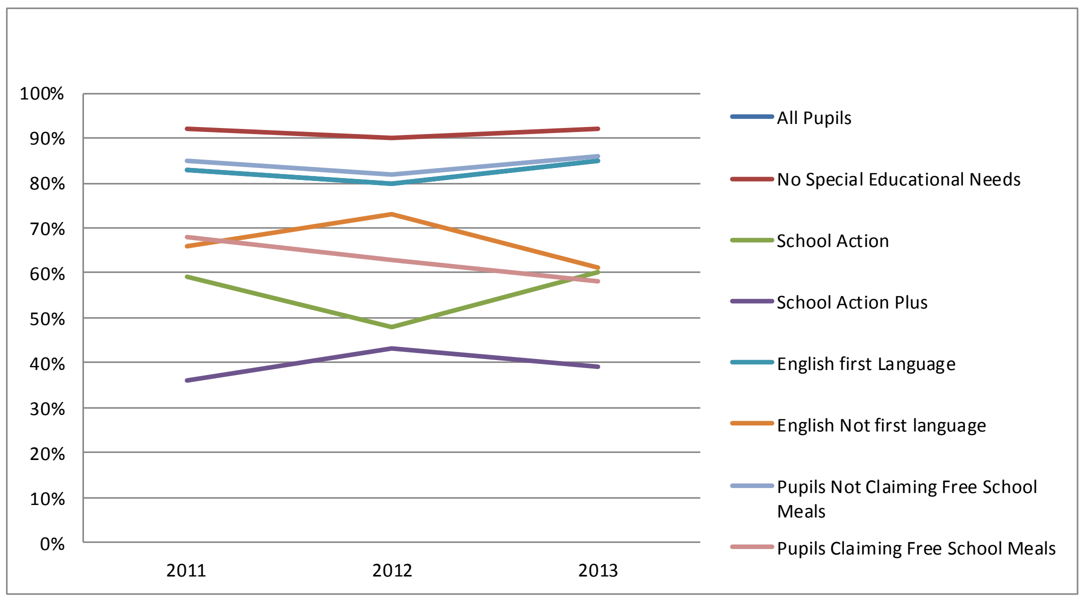
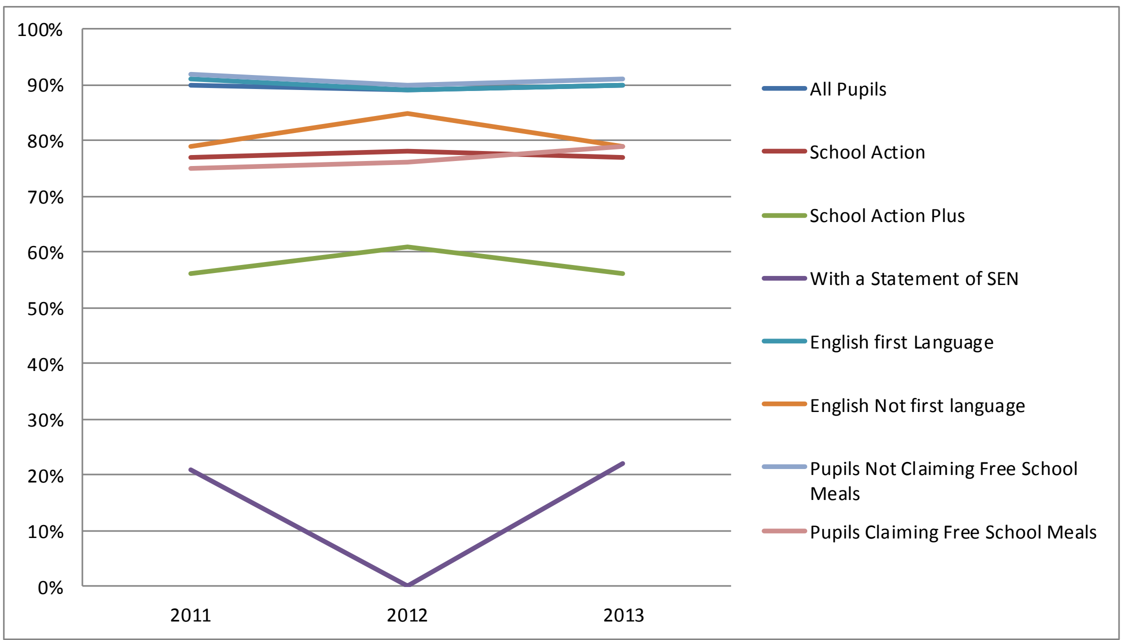
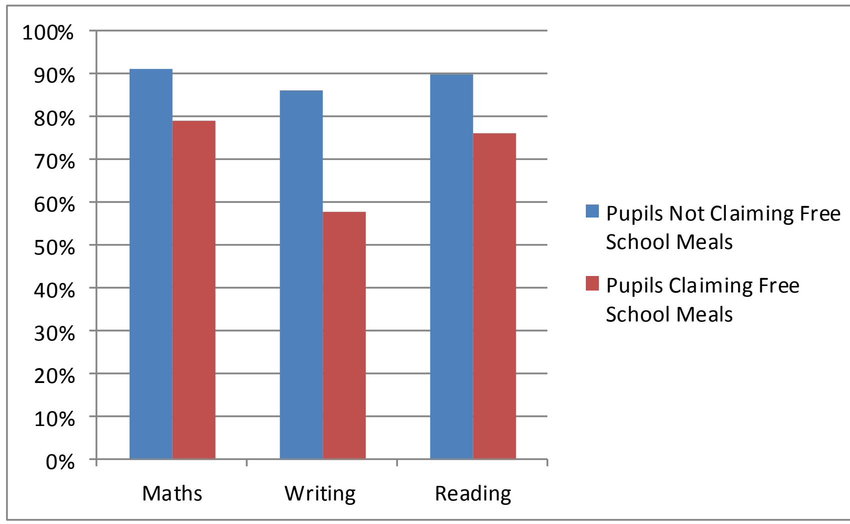


Figure 84: Trend analysis – Percentage of children achieving level 2C+ in maths



8.3.2.1. Gap analysis – Attainment by characteristics 2013

Figure 85: Percentage of children achieving 2C+ in writing, maths and reading by FSM (2013)



Overall Herefordshire's children claiming free school meals performed below national levels. The greatest difference for local and national was in writing. Locally the gap is by 28 percentage points. When compared with children claiming FSM nationally the gap is by 15 percentage points.

Figure 86: Percentage of children achieving 2C+ in writing, maths and reading by English as a first language (2013)

Similar to children claiming FSM, children whose English is not their first language are performing below their peers with the biggest performance gap in writing. When compared to children with the same characteristic nationally, Herefordshire children are below the national level by 20 percentage points.

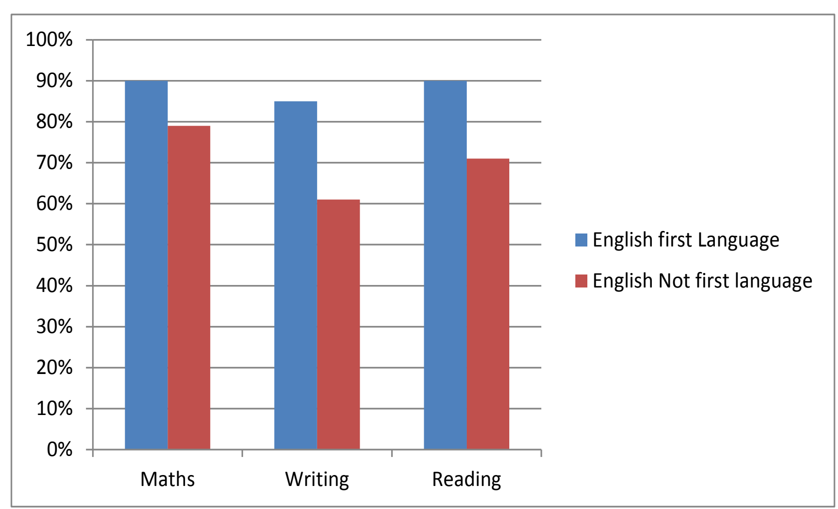
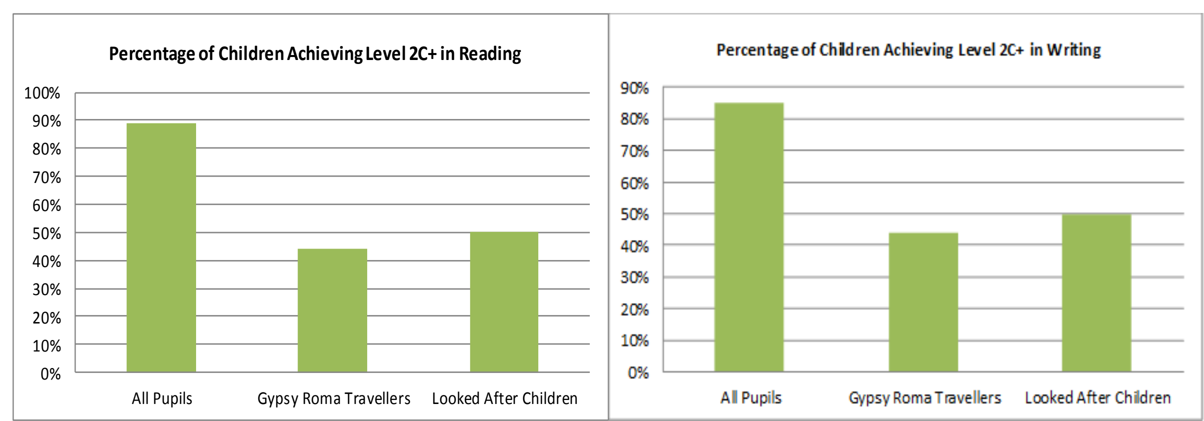
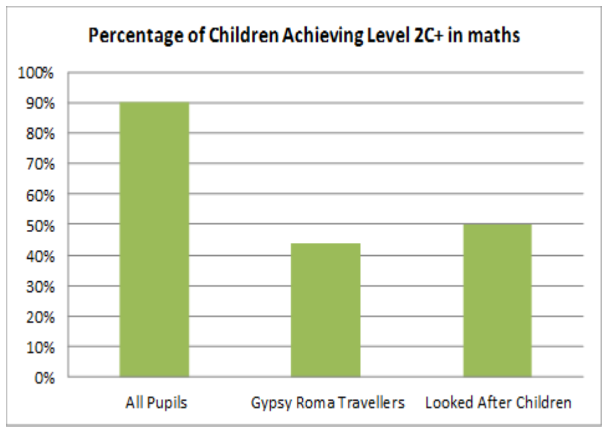


Figure 87: Education attainment for looked after children (2013) Key stage 1





In 2013, for Key stage 1, 50% of LAC achieved level 2C+ in reading, writing and maths. There was at least a 30 percentage point gap between the number of LAC who achieved level 2C+ and all pupils.

Summary -Attainment by pupil characteristics against national performance

Special education needs (R, W) School Action (R, W) Statement of SEN (R)	Claiming free school meals (R, W) BME groups (R, W) Statement of special education needs (W) English as an additional language (R, W) School Action Plus (R, W)
National data unavailable Looked after children Gypsy, Roma and Travellers	

R = reading, W= writing - Better than England = [green] Worse than England= [red]

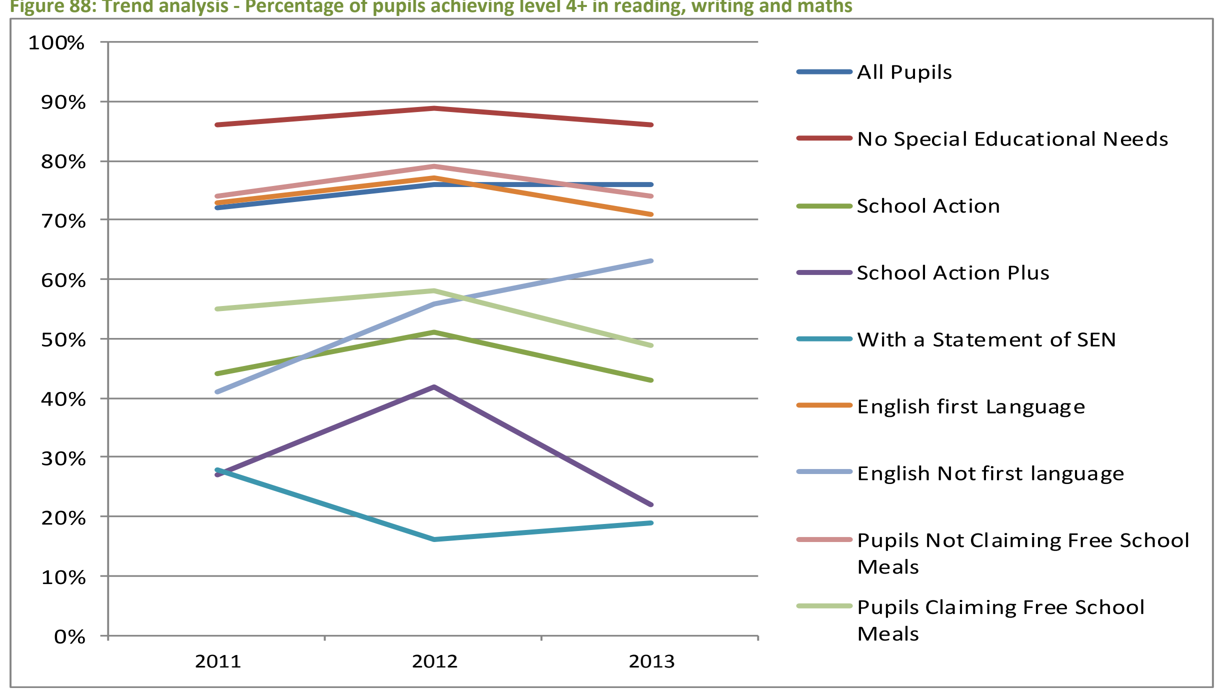
8.3.3. Key stage 2 (KS2)

Key stage 2 is the stage of education that covers years three to six in primary school (ages 7 – 11 years). Children sit tests at the end of this key stage in reading, maths and grammar, punctuation and spelling. They are also assessed in writing. The Department for Education performance tables measure the percentage of pupils in each school and local authority achieving a level 4 or above in reading, writing and maths combined. They also measure the percentage of pupils making two or more levels of progress between KS1 and KS2 in reading, writing and maths separately.

The percentage of pupils achieving level 4+ in reading, writing and maths in 2013 in Herefordshire was five percentage points lower than the national average with boys in Herefordshire achieving three percentage points below their peers nationally and girls six percentage points below. Similar patterns of inequality of outcomes are shown for different groups in Figure 88.

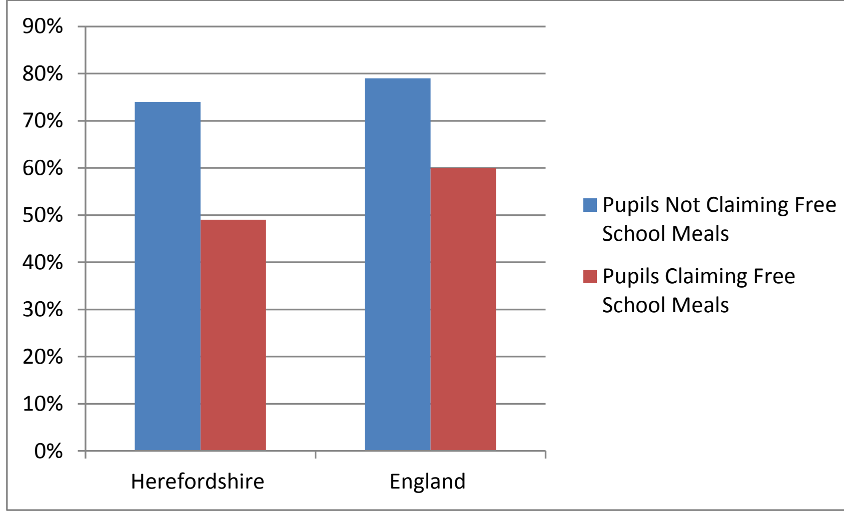
Amongst statistical neighbours, Herefordshire was the second lowest performing local authority. Only in Suffolk (70%) did a smaller percentage of pupils achieve level 4+ in reading, writing and maths in 2013. The highest performing statistical neighbour was Gloucestershire where 79% of pupils achieved the standard.

Figure 88: Trend analysis - Percentage of pupils achieving level 4+ in reading, writing and maths



8.3.4. Gap analysis - Attainment by characteristics 2013

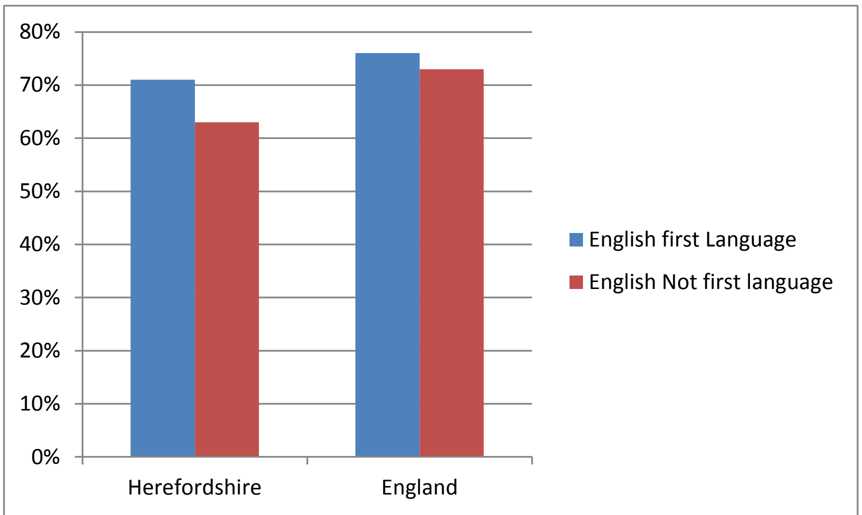
Figure 89: Percentage of pupils achieving level 4+ in reading, writing and maths by claiming FSM



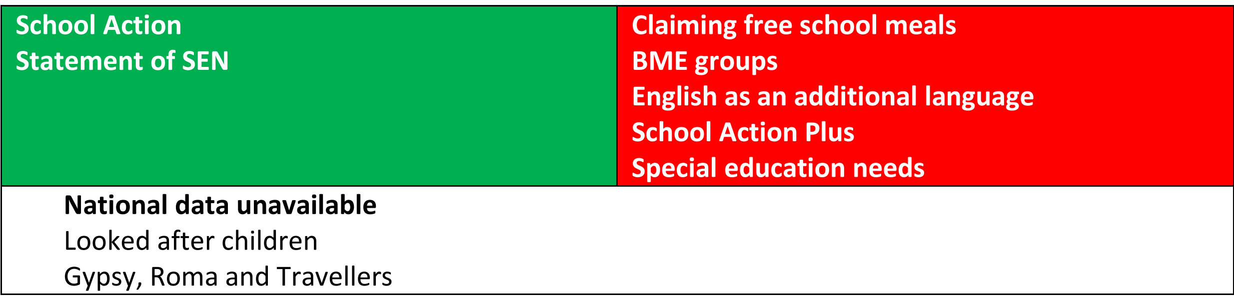
Those pupils eligible to free school meals performed significantly below the same pupils nationally (49% compared to 60%). The gap in performance is wider locally than it is nationally with those claiming FSM falling behind by 25 percentage points.

Figure90: Percentage of pupils achieving level 4+ in reading, writing and maths by EAL

63% of EAL pupils locally achieved level 4+ in reading, writing and maths compared to 73% of their cohort nationally. The gap in performance between children whose English is their first language and EAL is wider locally than nationally by nine percentage points compared to three percentage points.



Summary - Attainment by pupil characteristics Key stage 2



Better than England	Worse than England
School Action **Statement of SEN**	**Claiming free school meals** **BME groups** **English as an additional language** **School Action Plus** **Special education needs**

National data unavailable
Looked after children
Gypsy, Roma and Travellers

R = reading, W= writing - Better than England = ■ Worse than England = ■

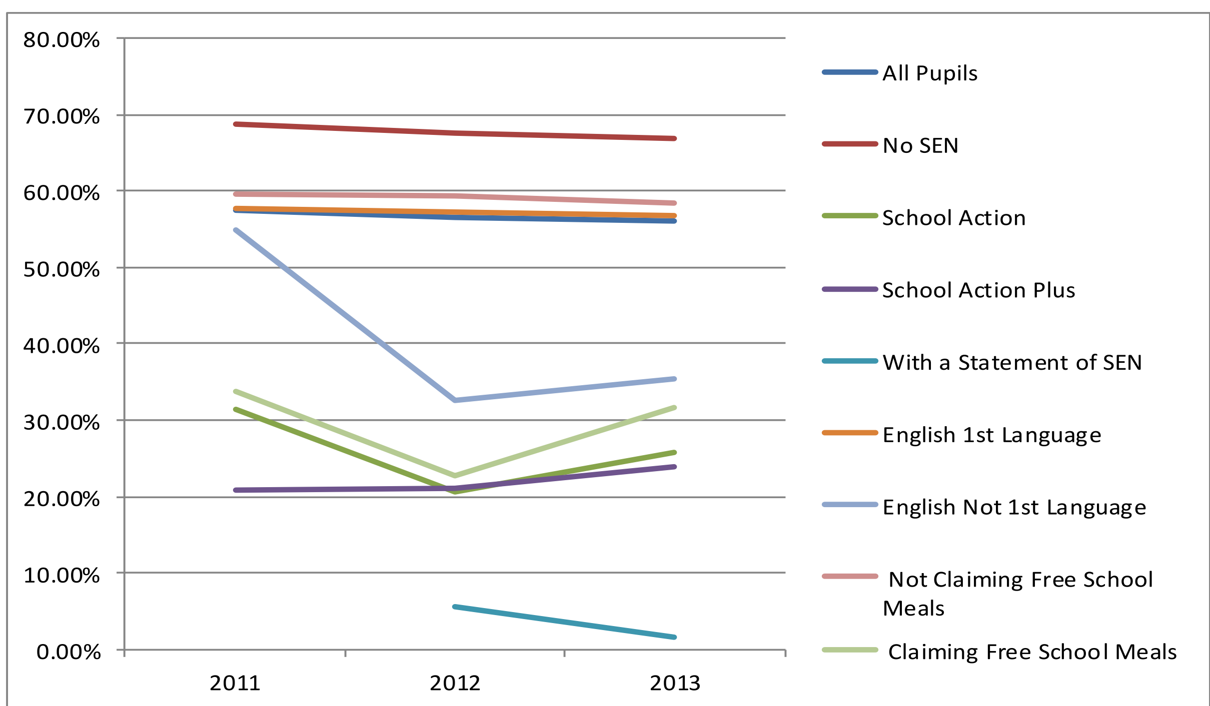
8.3.5. Key stage 4 (KS4) - GCSE

Key stage 4 is the stage of education that covers national curriculum years 10 and 11 in secondary school (ages 14 – 16). Pupils sit General Certificate in Secondary Education (GCSE) examinations at the end of this key stage.

At KS4 in 2013, 56.1% of Herefordshire pupils achieved 5+ A*-C GCSE (or equivalent) including English and maths. This was 4.7 percentage points below the national average and lower than 8 out of 10 of its statistical neighbours. The percentage of boys achieving the standard in Herefordshire was 12.4 percentage points lower than girls. Nationally girls outperformed boys by 10.0 percentage points. See Figure 91.

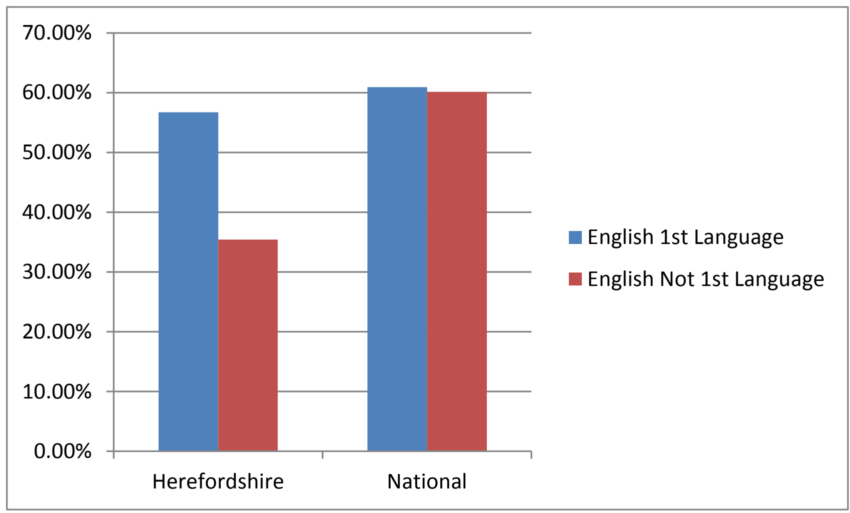
Herefordshire's overall performance at this key stage has remained constant over the past three years (see Figure 91).

Figure 91: Trend analysis - Percentage of students achieving 5+ A*-C including English and maths



8.3.5.1. Gap analysis

Figure 92: Percentage of students achieving 5+ A*-C including English and maths by EAL (2013)



As evidenced throughout other key stages, pupils with English as an additional language (EAL) in Herefordshire performed significantly below their peers nationally. Only 35.4% of EAL pupils achieved 5+ A*-C GCSE (or equivalent) including English and maths compared to 60.1% of EAL pupils nationally. Herefordshire was the lowest reported local authority for the measure and the gap between EAL and non-EAL pupils achieving the standard in Herefordshire was the second largest amongst all authorities.

Figure93: Percentage of students achieving 5+ A*-C including English and maths claiming FSM (2013)

A lower proportion of pupils eligible to free school meals in Herefordshire achieved (31.7%) compared to the same cohort nationally (38.1%). The inequality gap between those pupils eligible to free school meals and those not narrowed significantly in Herefordshire in 2013. The ambition of all local authorities is to narrow the FSM inequality gap by increasing the achievement of all pupils, but the achievement of FSM pupils more rapidly.

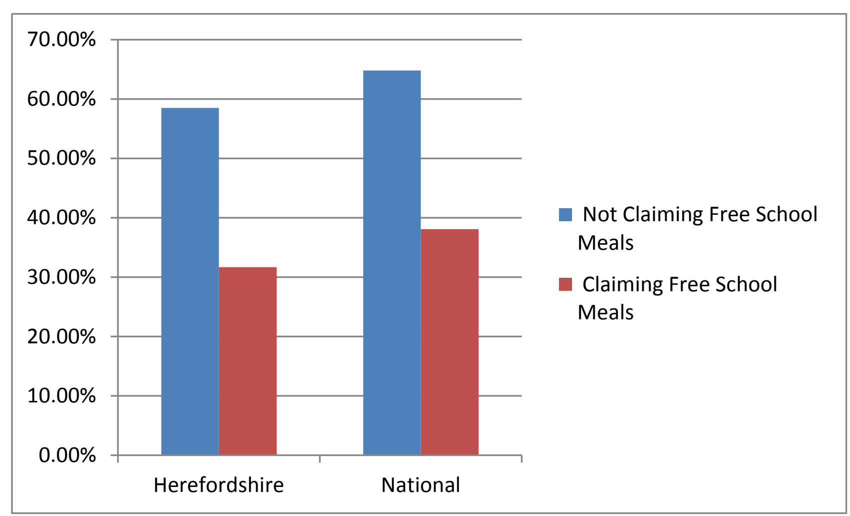
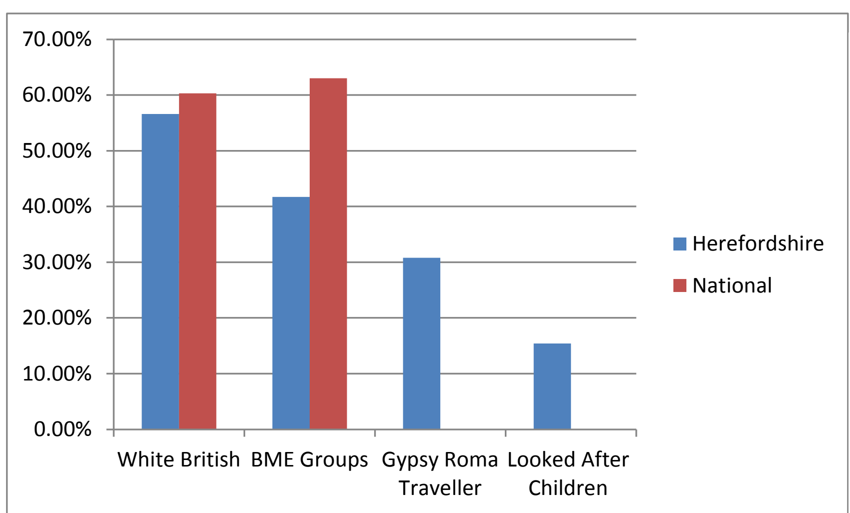


Figure 94: Percentage of students achieving 5+ A*-C including English and maths by ethnicity, LAC (2013)



8.3.6. Attendance

Absenteeism is recorded by two measures - overall absence and persistent absence.

- Overall absence is the percentage of possible half days recorded as an absence from school for whatever reason.
- Persistent absence is defined in terms of those pupils missing 15% or more half day school sessions. The persistent absence threshold for autumn and spring 2012/2013 equates to 38 or more half day sessions (or 19 full days).

The graphs below show levels of overall and persistent absence over three consecutive years: 2010/11, 2011/12 and 2012/13. Figures 95 to 98 show two measures of absence; overall absence and persistent absence for schools in the county by type.

Figure 95: Absence in Herefordshire primary schools

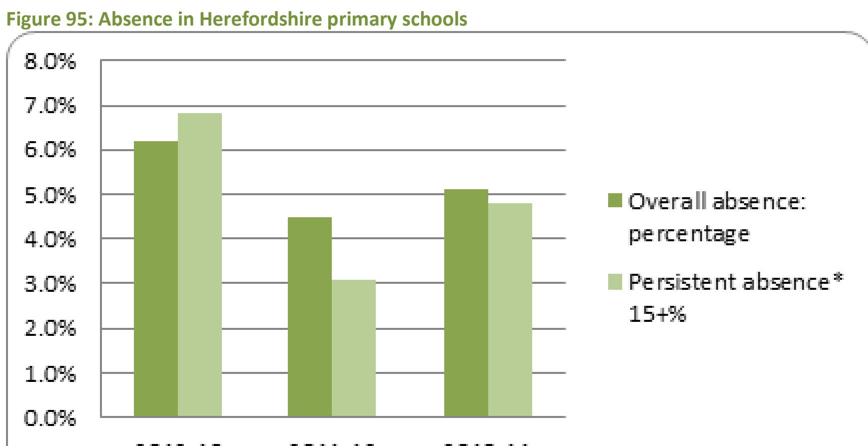


Figure 96: Absence in England's state funded primary schools

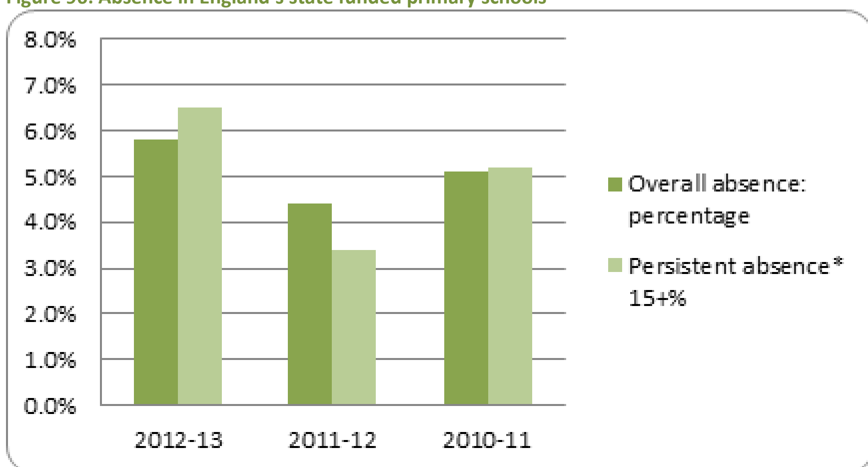


Figure97: Absence in Herefordshire secondary schools

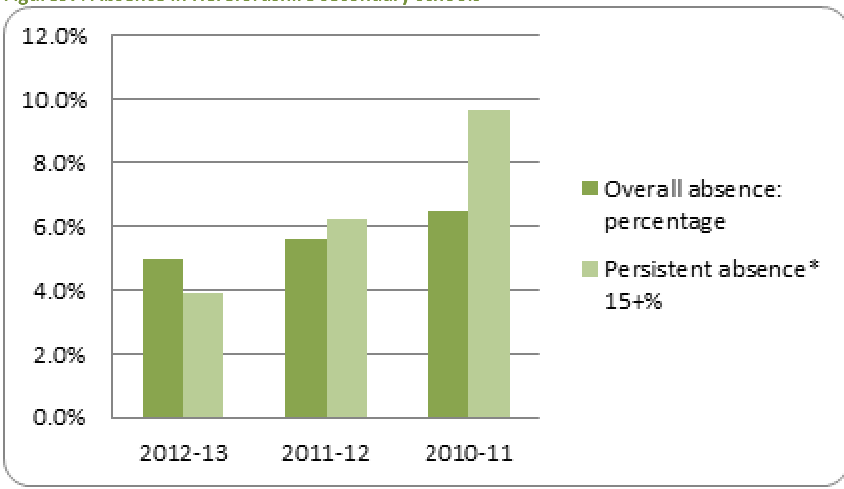
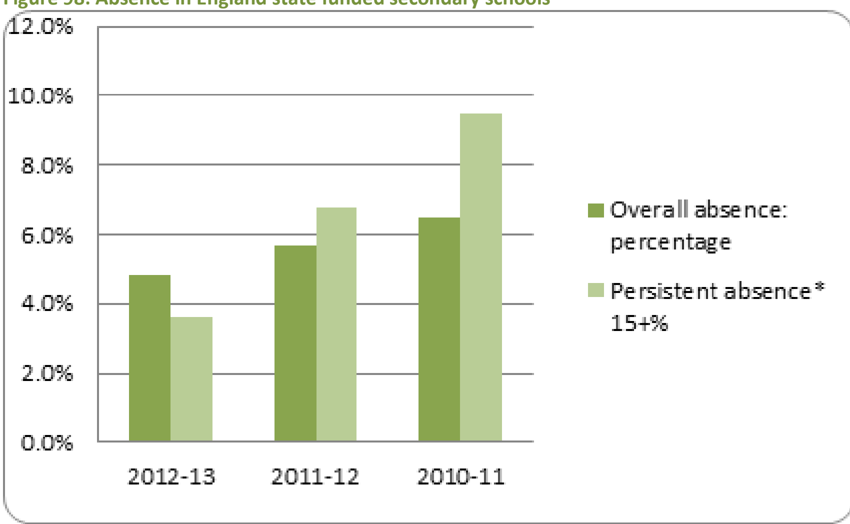


Figure 98: Absence in England state funded secondary schools



The report 'Improving attendance at school'[38], carried out by Charlie Taylor for the Department for Education in 2010, explains that there is a clear link between poor attendance at school and lower academic achievement. The report highlights:

- Of pupils who miss more than half of school sessions only 3% manage to achieve five or more GCSEs at grades A*-C including maths and English.
- 73% of pupils who have over 95% attendance, achieve five or more GCSEs at grades A*-C.

Advice from the National Strategies, which is also held on the National Archives website, explains that schools should make sure pupils and parents are aware of the direct correlation between high absence and low attainment, as well as the impact this has on a pupil's future employment prospects[39].

The evidence shows that children with poor attendance are unlikely to succeed academically and they are more likely not to be in education, employment or training (NEET) when they leave school[38].

8.3.7. Key stage 5 – Further education

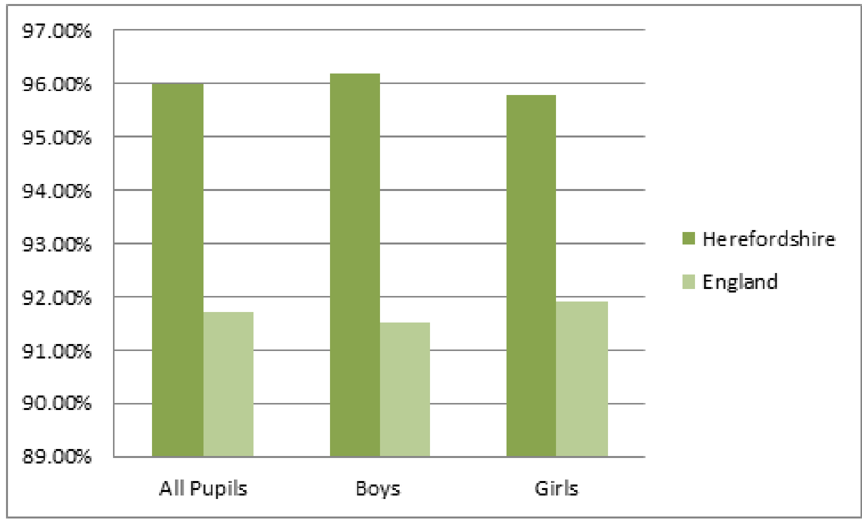
Key stage 5 is the non-compulsory, advanced level stage of education that generally covers national curriculum years 12 and 13, where students are in the age range of 16 to 18 years. In the majority of cases this will be those students at the end of two years of advanced level study (akin to a traditional sixth form), but may include those students completing in one year or three.

Herefordshire has five maintained secondary schools or academies with a sixth form facility, however the majority of A-level qualifications are taken at the city's sixth form college.

The majority of A-level and other level 3 qualifications are taken in establishments that are not under the control of the local authority. Overall, students in Key stage 5 perform well with a higher percentage achieving at least two substantial level 3 qualifications than pupils nationally. In 2013 Herefordshire was the highest performing local authority amongst statistical neighbours for this measure.

[38] Charlie Taylor (2010) Improving attendance at school, Department for Education. http://www.education.gov.uk/schools/pupilsupport/behaviour/a00208164/taylor-review
[39] Improving attendance and reducing persistent absence, The National Strategies. http://webarchive.nationalarchives.gov.uk/20110809101133/nsonline.org.uk/node/98020

Figure99: Percentage of students achieving at least two substantial level 3 qualifications



9. Young people not in education, employment or training (NEET)

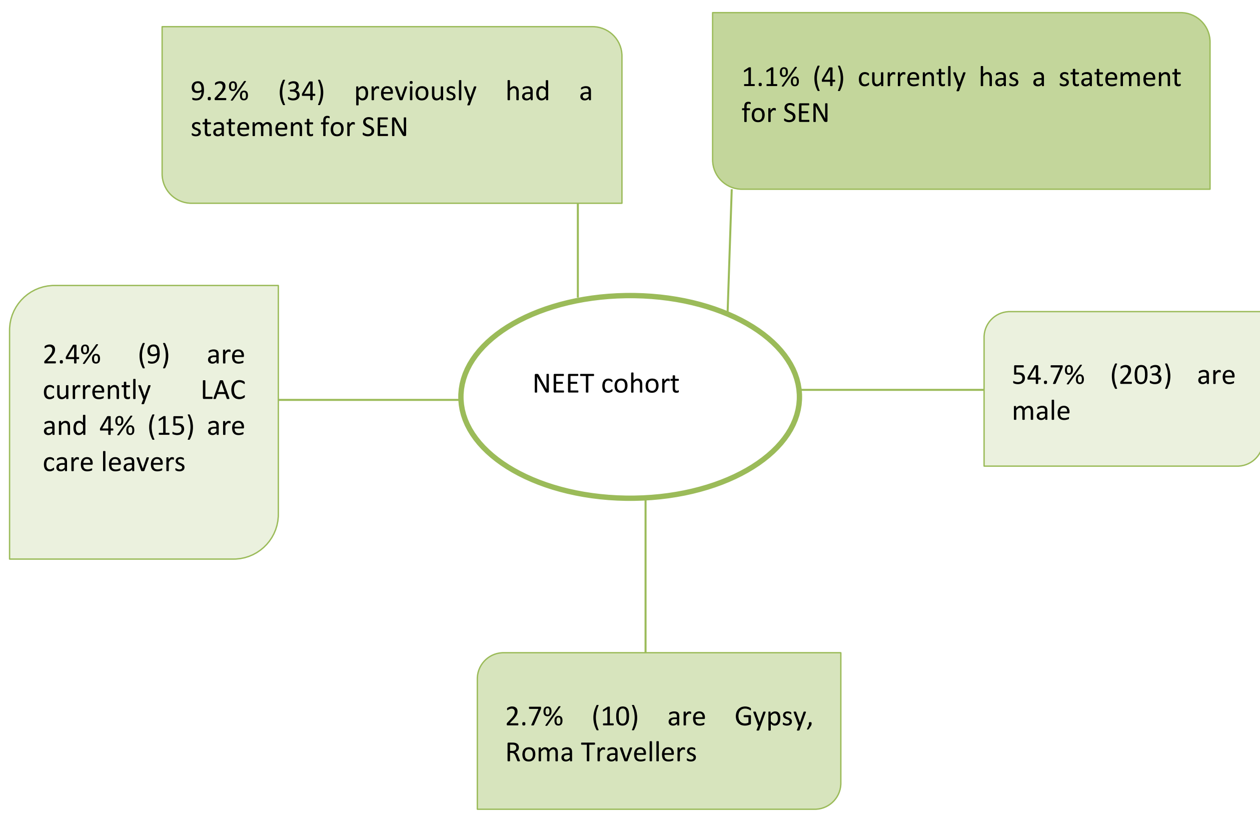
Local authorities have statutory duties in relation to 16 to 19 year olds, including supporting those who are not in education, employment or training (NEET). They offer a variety of services for young people, sometimes through their own offices but also in partnership with other organisations.

A particular challenge for Herefordshire during 2012/13 has been the number of "not known" in the county. This is where there is no traceability of the young person. Much work has been done to tackle this during recent months, resulting in a positive fall in the percentage of "not known" from 10.1% at the end of 2012 to 3.5% in January 2014.

Figure100: Snapshot of Herefordshire's performance for 2014

2014 Jan	16-18 year olds known to the local authority	16-18 year olds NEET		% whose activity is not known
		Estimated number	%	
Herefordshire	5,712	371	6.7%	3.5%

Herefordshire's NEET cohort characteristics



10.Summary: Qualitative research

The Children's Integrated Children's Needs Assessment: Qualitative Data Report (May 2014) was commissioned in January 2014. The three months field work was based around four areas:

1. What are the main issues facing vulnerable children and young people?
2. How are services addressing the needs of vulnerable children and young people? What could be done differently?
3. What support do children and their families need to prevent children becoming children in need/looked after?
4. How well are services (non-statutory) meeting those needs?

The overall findings of the report are:

1. Non-statutory service providers are finding innovative and creative ways to plug gaps in services in a time of severe budget restrictions and uncertainty.
2. There is a lack of voluntary sector activities for 0-19 year olds, and therefore, there is considerable scope for developing the market, for example, peer led network of services which will nurture young people.
3. The voluntary sector recognised the value of early help and early intervention to mitigate the escalation of need to crisis point and statutory intervention.

4. The sample of children interviewed did not feel that they were listened to. The report suggests that a child centred, more participatory model of involvement and consultation would be helpful.
5. Organisations value the MASH mechanism but the CAF system received mixed reviews, a major issue is the understanding of the thresholds.

11. Conclusion and considerations

The purpose of CINA is to inform Herefordshire's Children and Young People Partnership and the Health and Wellbeing Board, the two system leaders that shape the local health and care system for children and young people in the county. The report aims to determine or estimate the nature and extent of the needs of the population at greatest risk so that services can be planned, commissioned, and delivered. Evidence from this needs analysis can indicate where resources might best be focused and deployed, within the context of other factors such as national policy and guidance, evidence based practice, market analysis and risk analysis. To this end, this report synthesizes the evidence into four areas for consideration.

11.1. Local intelligence and information

This needs assessment has been compiled from existing available data from a wide range of sources. Throughout the development of the CINA, there have been cases where data is unavailable, inaccessible and inaccurate or is held in a way that makes its retrieval complicated. These complications related to one or more issues including quality of the data, data protection or system design. Health data is stored across a number of systems separate to social care or education systems, without any record links across all systems.[40] [41]

Rich data tells the story of the area, its people and the longer term future. Consideration of a range of data and indicators (from health, education, social care and other disciplines) builds a more complete picture for particular groups of people as well as a deeper understanding of their experiences. Rich data relies on clear and consistent measurement at the initial source of capture (collection, input and pertinent). This allows for intelligent analysis to draw out key issues and clarifies where needs are not met or results in poor outcomes. It informs service planning and the commissioning of services, their design and delivery. Such intelligence can challenge previous assumptions and get to the core of what children need to improve their chances in life. To do this, commissioning decisions must have a significant and lasting impact on children's lives and also maximise the social return on investment. To provide a robust 'business case' for future services, further iterations of this or any other needs assessment is reliant on excellent data and information systems across the council.

Key considerations

1. Consider improving current recording of data (making it easy), data quality (complete, validated, and reliable) and data management and retrieval systems at a local level.
2. Consider the use of appropriate technologies that enable data to be captured painlessly and accurately by practitioners.

[40] Evans, S. (2012). Assessing the health needs of vulnerable children, are the data fit for purpose. *Journal of Public Mental Health Vol 11 no.3*, 117-204.

[41] Arguably, the adoption of the NHS number as a unique identifier within education and social care information systems could be an important step towards creating integrated records with health.

3. Consider creating electronic need based profiles around the needs of each looked after child, care leaver, young carer and children and their families where whole families are supported.
4. Consider more effective sharing of information about children, their families, their circumstances, aspirations and expectations across sectors and providers (system wide) to meet the needs of children.
5. Consider improving processes to ensure the sharing of vital data and information at a strategic level so that at all levels, leadership is informed and active in driving forward the transformation of services.

11.2. Early help and early intervention

This report has reviewed evidence that makes the case for early help and early intervention, particularly for young children. For instance, the independent review carried out by Professor Eileen Munro in 2010[42] reiterates the key role of early help. In the same year, the Centre for Excellence in Outcomes [43](C4EO) observed that "it is better to identify problems early and intervene effectively to prevent their escalation than to respond when the problem has become so acute as to demand action". The Marmot Review[44] also stated that every aspect of human development are laid in early childhood and it acknowledges that disadvantage in a child's early years can have a lifelong, negative effect on their health and wellbeing and children living in disadvantaged circumstances are more likely to experience social, emotional and behavioural difficulties as a result of poor health, education and employment outcomes. There is now a better understanding of the life course of a child, even before birth, making it easier to identify emerging problems or anticipate them earlier or clear risk factors are identified in order to take remedial action.

This report highlights evidence that children aged under five years are some of the most vulnerable groups in Herefordshir, and have poor outcomes, suggesting that services for this group may not be effectively co-ordinated across disciplines and agencies. Properly targeted preventative services and early intervention can tackle many of the causes of poor outcomes for those very young children and families that face multiple issues. A key feature of early intervention work is seeking to enhance a child's 'protective' factors and evidence confirms that it reduces the number of children with protection plans or taken into care. Resilience in children results in high attainment, good social and emotional skills and a reduction of substance misuse.[45]

This report found that the primary reasons for children becoming a child in need, subject to child protection plans or being looked after are domestic abuse, abuse and neglect. Munro [Munro,2010] confirms that (early) preventative services do more to reduce abuse and neglect than reactive services and paying attention to coordinating services, is essential. Thus, evidence of high child protection plans, rising numbers of children in need and children looked after in Herefordshire suggests that current arrangements may not be as effective as perhaps once thought. The qualitative data report found that cross sector professionals wanted greater focus on early holistic intervention and support, suggesting that there is buy-in from non-statutory agencies for early help and early intervention measures.

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[42] E. Munro, 2010: The Munro review of child protection interim report: The child's journey; www.dera.ioe.ac.uk.

[43] Grasping the Nettle: Early Intervention for children, families and communities; Centre for Excellence and Outcomes (2010).

[44] Fair Society, Healthy Lives: 2010 – The Marmot Review.

[45] Wolstenholme D. et al, (2008). Factors that assist early identification of children in need. SCIE research briefing 27.

Key consideration for early intervention

1. Consider developing clear early help/early intervention for children aged under five years, based on robust multi-agency working (both operationally and strategically) with a strong emphasis on an outcome and evidence based commissioning and provision. An early help framework would provide a prompt, persistent and flexible approach, resulting in clear and consistent needs led referral pathways. For example, focus on:
   - Children's centre services.
   - Awareness rising for a host of agencies and staff involved in looking after under 5s, to support uptake of early help.
2. Consider under 5s in level 2 and 3 of need (Herefordshire's threshold of need) where emerging problems can be tackled in a number of ways, with clear links to need led priorities determined by children's strategies and improvement plans. Invest resources in the following activities:
   - Mapping of services and service providers and identifying gaps in the market.
   - Developing an asset based community strategy for multi-agency provision. Asset based approaches identify the protective factors that support health and wellbeing, offering the potential to enhance the resilience of individuals and the community as a whole. It is an empowerment approach that fits well with the principles of co-production with users of services.
   - Developing the market and supporting innovative enterprises in order to provide a range and choice of service interventions for children and families. The council can act as a catalyst and lead organisation to drive innovation and change.
   - Improving MASH and MAG mechanisms and effective use of the Common Assessment Framework to triage the most vulnerable children.
3. Consider improving targeted health campaigns to improve health outcomes (e.g. for immunisation and dental health for five year olds, breastfeeding initiation and duration rates).
4. Consider improving the ability of schools, colleges and educators to support child welfare and safeguarding concerns and taking action to address emerging problems, where appropriate, in partnership with all agencies. Improve the use of the school readiness measure, so that the gap that separates disadvantaged children from their more affluent peers can be reduced or closed.

11.3. Integrated delivery of care

The achievement of personal outcomes for individuals is the focus of integrated care and support. The delivery of integrated care and support has to be responsive to local assets and partnerships and successful integration depends on individuals and agencies reaching across boundaries and disciplines to deliver the right care, in the right place, at the right time.

At the heart of integration lays two inter-locked concepts: the concept of **whole systems thinking** which embodies the concept and practice of **sustainability**. Evidence confirms that persistent and intractable service level problems arise directly from the inability to 'see' the interconnections or coherence between different systems, be it health, social care, education or the environment. There is no wellbeing unless there is a sense of security for children and therefore, delivering integrated care has to be viable or sustainable at a local level. In other words, integrated delivery of care is more than joined up provision; care has to be consistent, purposeful and flexible so that it evolves with need and demand.

Key considerations

1. Consider aspects of culture, capacity and processes that are proving to be barriers to making whole system changes to integrated practice/delivery of care, so as to ensure that children receive a high quality joined up service, planned and delivered across organisational boundaries. For example, in serious case reviews, school leavers – safeguarding processes in schools and colleges.
2. Consider utilising a 'whole system' based approach so large scale, sustainable, preventative strategies may address seemingly intractable challenges at a population level. For example, poor dental health could be addressed by implementing cleaning teeth in preschools and schools. Another is the opportunity for changing behaviour accessing the PSHE curricula on a countywide approach. Long term solutions can be achieved by addressing both the social and criminal aspects at a population level.
3. Consider improving the workforce capability and awareness of a range of specialist topics, such as domestic violence and abuse, child sexual exploitation, substance misuse, disability, mental health and diversity so that professional work with children and families is sharply focussed, **making every contact count**. Likely candidates for workforce development are professional social workers and their supervisors, health practitioners, preschool, school and college staff, police and housing providers.

11.4. The voice of the child

The qualitative data report, (which forms part of the CINA report) found that 27% of respondents to the survey felt that they were not listened to. Often the moral aspects of hearing the child's voice are asserted, but there is a varied understanding of how a 'child's voice' can support service planning and delivery. In his report 'Beyond Boundaries', Sir Jeremy Beecham gives a clear explanation: "Increasingly complex social goals, especially preventative measures, cannot be achieved by doing things **to** people, as opposed to doing things **with** them" [46](Beecham, 2006). Not listening to children's wants and wishes can lead to risk averse and reactive service cultures. Evidence shows that co-production with young people and families with young children means getting involved in making decisions on their own lives, greater ownership of personal change and greater accountability on the part of service providers. Meaningful engagement with children helps build relationships, as well as regular support being timely. This last point has synergy with early holistic intervention and support.

Key considerations

1. Consider further development for capturing the voice of the child/young person/young carer from their perspective and reflecting the journey of the child. Clearly 'evidence' to them that their views are being listened to and have been taken into account. Where appropriate, co-produce communication channels using different modes of communication. Establish friendly feedback mechanisms to capture their 'lived' experience, with a clear process for children's complaints and redress.

[46] Beecham, S. J. (2006). Beyond Boundaries: Citizen Centred Local Servoces for Wales: Review of Local Service Delivery-Report to the Welsh Assembly Government. Welsh Assembly Governement.

2. Consider developing technologies for children and young people to engage and access support and to self-manage emerging problems e.g. where can I get? Do I have? What do I when?
3. Consider using technologies as a tool for early intervention, e.g. smart phone apps for young people to track their own health and wellbeing, which is in turn tracked by their key or lead worker to intervene and support before need escalates. Capturing this type of data provides detailed insight at different points on a child's journey.
4. Consider developing mechanisms for engagement and direct work with families to capture the voice of disabled children, children with mental health problems, children from minority groups with linguistic needs and hard to reach children (e.g. BAME, Roma, Gypsy Travellers).

11.5. Conclusion

The development of Herefordshire's Children's Integrated Needs Assessment places an expectation on its council to provide care for all its children, especially those children who are identified as being in need and those who are taken into care. As this report found, however, an appropriate flexible response to a child's identified need is never so straightforward, for multiple adversities experienced in childhood may come to express themselves in a number of ways, for example, in the experience of homelessness, underachievement in schools, imprisonment, drug and alcohol addiction or physical and mental health problems. As the report found, the lives of children in Herefordshire are also influenced by a number of wider determinants such as the environment, housing, deprivation, family and community. These factors are systematically linked key aspects of child welfare and wellbeing and act to produce differential outcomes for a child living in rural Herefordshire, compared to a child living in an urban environment elsewhere in England.[47] All play a part in delivering good outcomes for children. In order to ensure that children in the county are safe, happy and reach their full potential, a suitable system has to be created so that this can happen. A shared understanding of the direction of travel and how that might be achieved lies at the heart of the Children's Integrated Needs Assessment (CINA).

12. Priorities for future work

In the course of developing the CINA, some areas were identified for further work, areas not covered in depth by this report. They are:

- Mapping existing services against needs to identify gaps, develop market provision and commission high quality services.
- Children who are victims of sexual abuse and child sexual exploitation.
- Disabled children and disability issues relating to young carers.
- Rurality, the experience of children living in hamlets and isolated dwellings in rural Herefordshire.
- Orphans (including the experience of bereavement).
- Children with parents who have mental health and substance abuse issues.
- Bullying in schools and in the community.

[47] P.Bywaters, Inequalities in Child Welfare: Towards a New Policy, Research and Action Agenda, British Journal of Social Work (2013) 1-18.

13. Appendices

Appendix 1: Estimated and forecast population and change in Herefordshire

Age group	Population				Observed change		Forecast change			
	Observed		Forecast		2001-12		2012-21		2021-31	
	2001	2012	2021	2031	Number	%	Number	%	Number	%
Under 5	9,400	9,800	9,900	9,200	400	4%	100	1%	-700	-7%
5 to 15	24,600	21,700	22,500	23,100	-2,900	-12%	800	4%	600	3%
16 to 19	7,600	8,300	7,100	8,100	700	9%	-1,200	-14%	1,000	14%
20 to 25	8,500	11,500	9,000	9,300	3,000	35%	-2,500	-22%	300	3%
Total under 20	41,600	39,900	39,400	40,400	-1,700	-4%	-500	-1%	1,000	3%

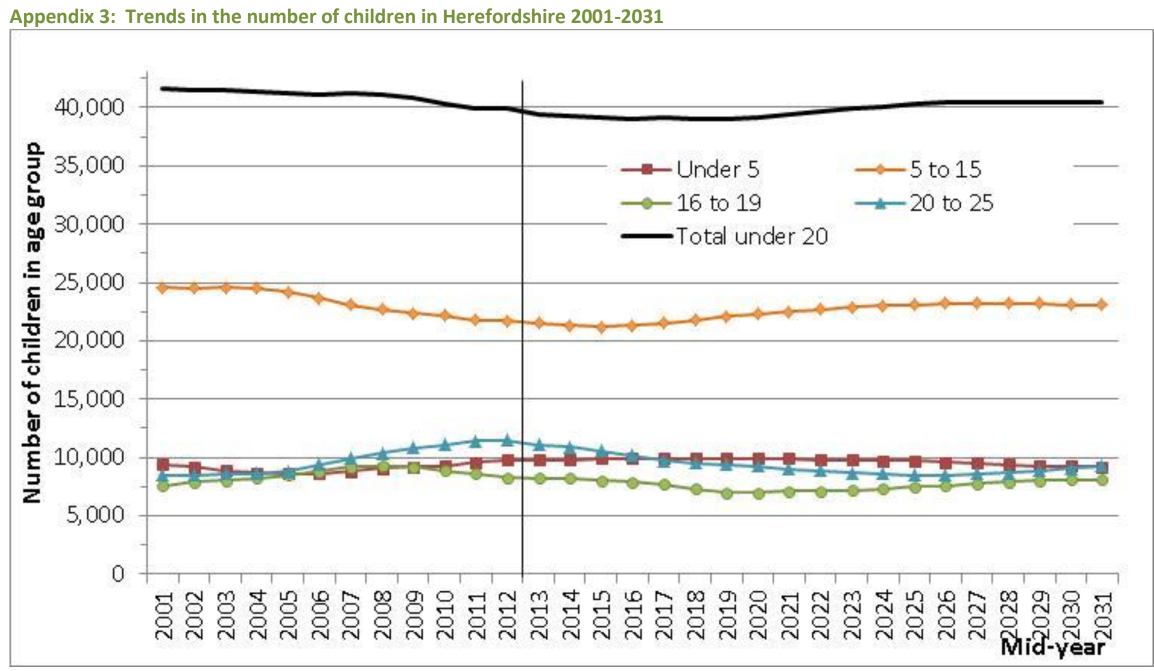
Source: 2001 and 2012 mid-year estimates, ONS. Crown Copyright. 2011 based Herefordshire population forecasts G L Hearn.

Appendix 2: Population of children in Herefordshire and statistical comparators (2012)

Local authority		All ages	Under 5	5 to 15	16 to 19	20 to 25	Total under 20
Devon	No.	753,200	38,300	85,400	35,700	52,200	159,400
	%	100%	5.1%	11.3%	4.7%	6.9%	21.2%
Herefordshire	No.	184,900	9,800	21,700	8,300	11,500	39,900
	%	100%	5.3%	11.7%	4.5%	6.2%	21.6%
Cornwall	No.	537,900	28,300	62,500	25,400	34,700	116,200
	%	100%	5.3%	11.6%	4.7%	6.5%	21.6%
Shropshire	No.	308,200	15,700	37,000	14,900	20,000	67,600
	%	100%	5.1%	12.0%	4.8%	6.5%	21.9%
North Somerset	No.	204,400	12,000	25,000	9,000	11,500	46,000
	%	100%	5.9%	12.2%	4.4%	5.6%	22.5%
Bath & North East Somerset	No.	177,600	9,300	20,500	10,700	19,700	40,600
	%	100%	5.2%	11.5%	6.0%	11.1%	22.9%
Wiltshire	No.	476,800	28,800	62,700	22,700	30,600	114,200
	%	100%	6.0%	13.2%	4.8%	6.4%	24.0%

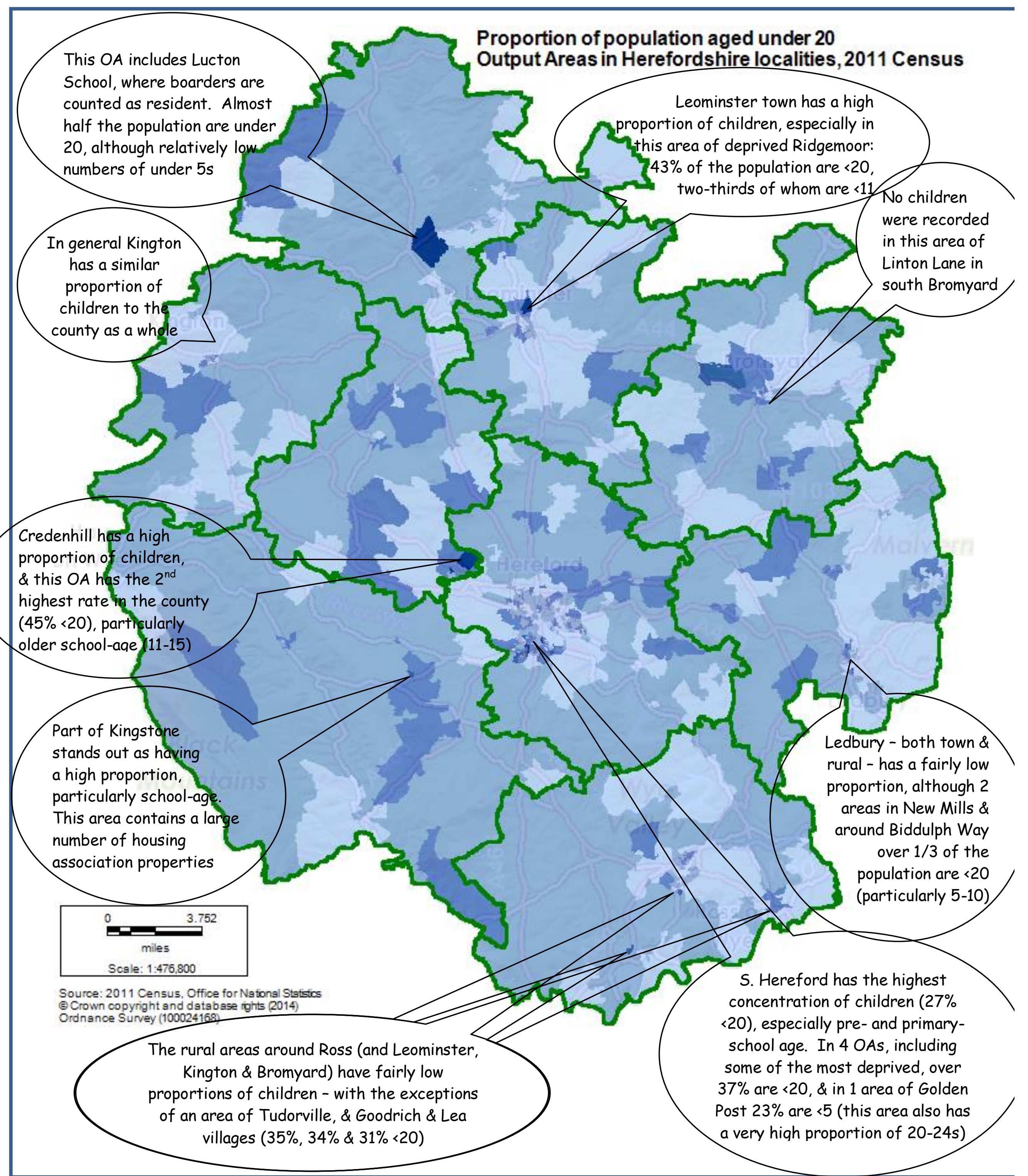
Source: Office for National Statistics 2012 mid-year population estimates

Appendix 3: Trends in the number of children in Herefordshire 2001-2031



Source: Mid-year estimates, ONS. Crown Copyright. 2011 based Herefordshire population forecasts, GL Hearn.

Appendix 4: Map of proportion of population aged under 20 years in Herefordshire

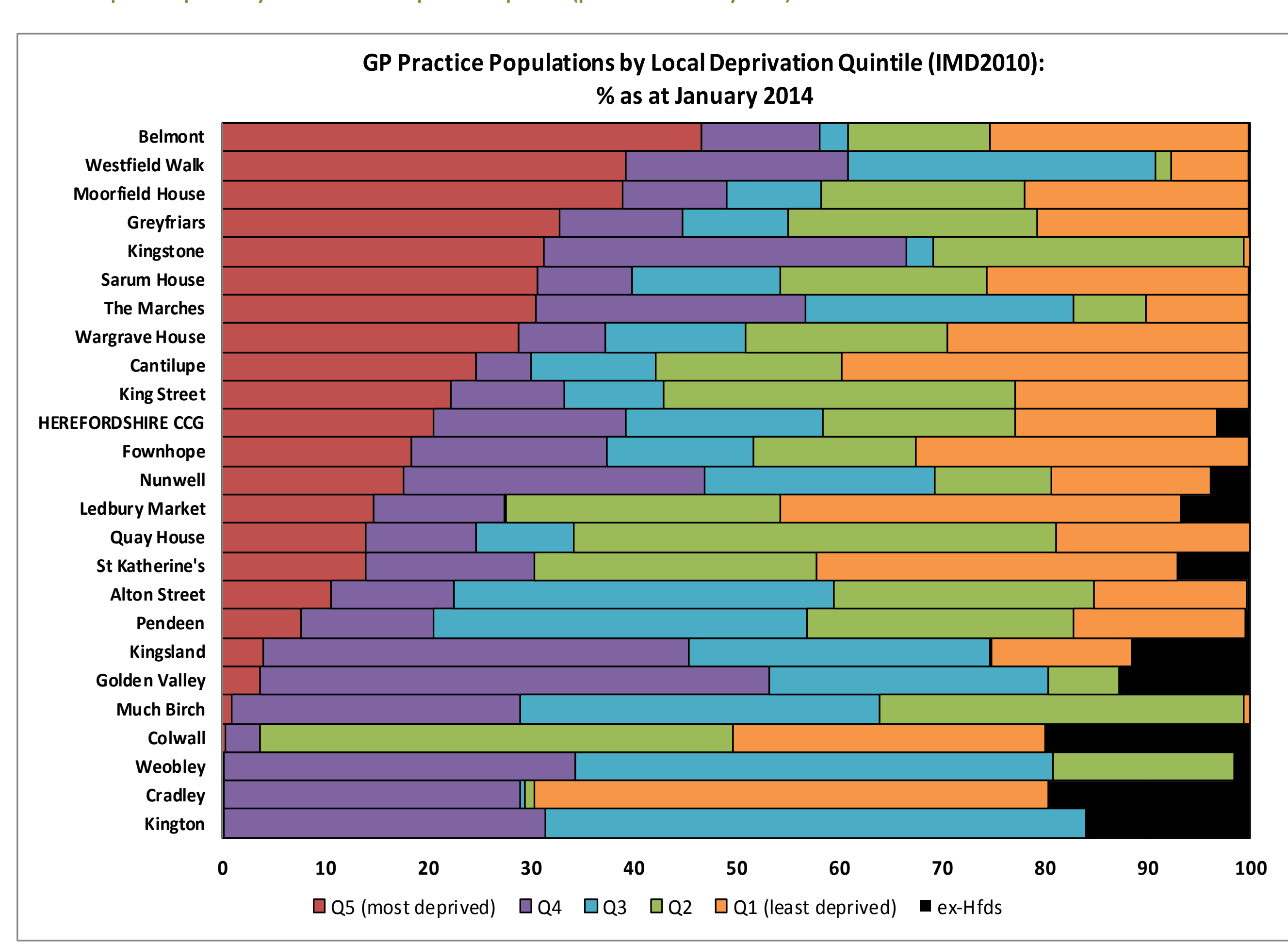


Appendix 5: Numbers of births and fertility rates (2001, 2006 and 2011) and assumed future fertility rates (2011-31) in Herefordshire

Age group	Actual births			Observed ASFRs			ASFRs assumed for 2011 based population forecasts			
	2001	2006	2011	2001	2006	2011	2011-16	2016-21	2021-26	2026-31
Under 20	107	111	99	22.3	20.3	18.8	17.7	16.4	15.3	14.9
20-24	246	307	355	71.4	82.0	79.3	87.4	82.6	78.8	76.1
25-29	413	422	515	92.5	105.1	110.3	121.2	116.6	112.8	110.1
30-34	508	490	504	86.3	102.4	106.4	118.8	114.7	112.3	111.5
35-39	255	309	298	39.6	50.0	58.4	58.6	56.4	55.4	54.9
Over 40	53	71	88	8.6	10.4	13.6	12	11.7	11.3	11.2
TFR				1.60	1.85	1.93	2.08	1.99	1.93	1.89
% aged 25-34	58%	53%	55%							

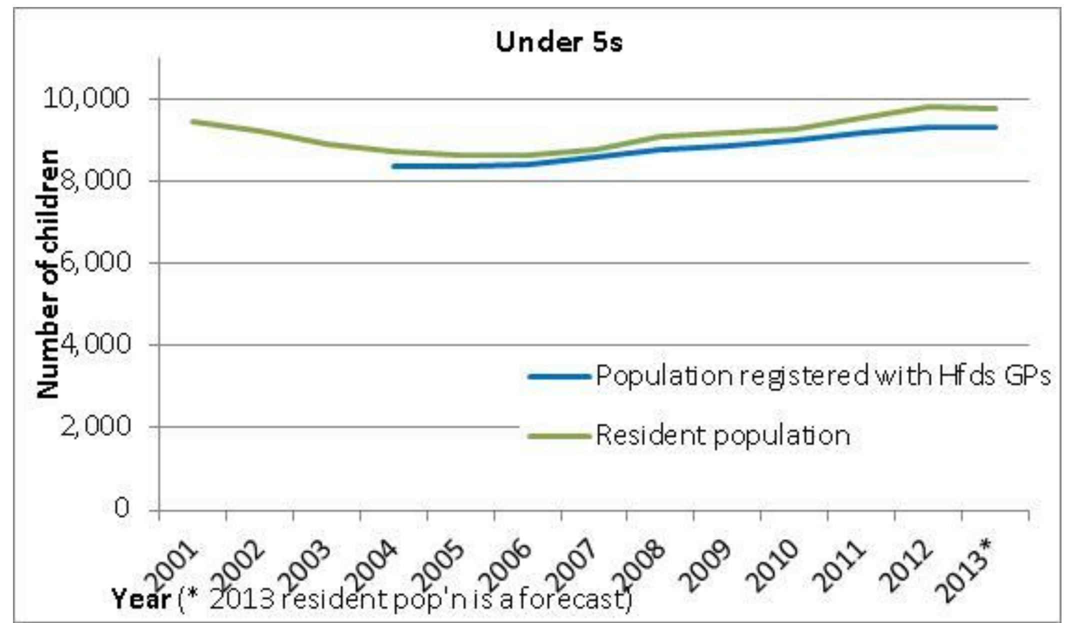
Source: ONS Vital Statistics and mid-year estimates; GL Hearn population forecasts

Appendix 6: GP practice profile by Herefordshire deprivation quartile (percent at January 2014)



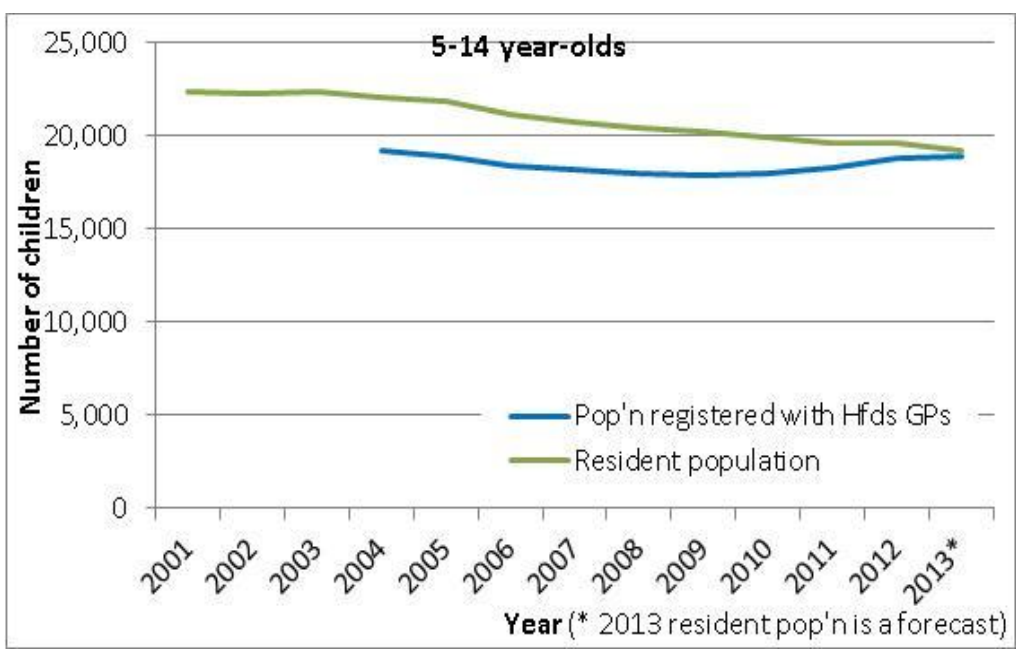
Source: Health and Social Care Information Centre and Indices of Deprivation (Department for Communities and Local Government)

Appendix 7: Trends in under 5s population registered with Herefordshire GPs compared to resident population

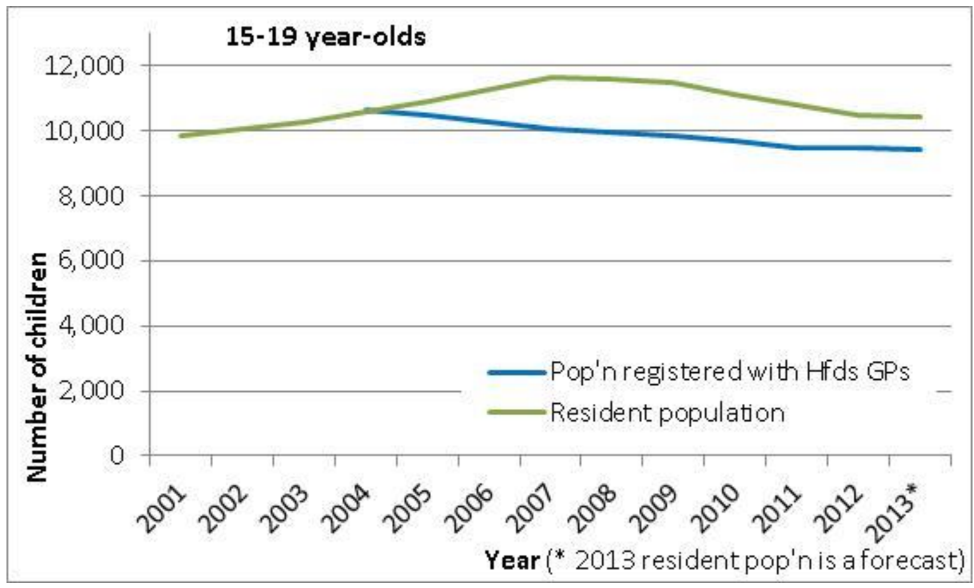


Source: Health intelligence team, Herefordshire Council

Appendix 8: Trends in 5-14 population registered with Herefordshire GPs compared to resident population



Appendix 9: Trends in 15-19 population registered with Herefordshire GPs compared to resident population



Appendix 10: Trends in 20-24 population registered with Herefordshire GPs compared to resident population