South Gloucestershire Council

Delivering for you

Children & Young People's

Needs Assessment 2023

Full Version

Children and Young People's Needs Assessment

Contents

Produced by South Gloucestershire Public Health and Wellbeing, with support from the multi-agency CYP Needs Assessment working group.

May 2023

Scope and context

What is a Needs Assessment?

In general, a Needs Assessment is a way of using a range of data and information to understand more about a population, community' or group of people to help identify what their health, care or other needs might be. This information is brought together and analysed to give insight into what might be priorities for a particular population, to make recommendations that help review and plan services and to raise questions that tackle particular issues or challenges. Needs Assessments are based on the data and information that is available at the time, so provide a 'snapshot' of the needs of the population which can then be used as a comparison with future data to help us understand any changes that may have occurred.

What is this Needs Assessment for (and what doesn't it include)?

This is a Children and Young People's Needs Assessment (CYPNA) for South Gloucestershire. It aims to capture a range of information, data and intelligence about the health, care and other needs of the children and young people in our area. This is a huge population, and a wide range of data has been included and considered. Because of that this needs assessment won't have captured everything about everyone. There are hundreds of different services that are available to children and young people, and this needs assessment was not able to cover them all or provide specific information about them. We also know that some data isn't captured or isn't captured in a way that allows us to analyse and understand it. So, we have done our best to bring together information to identify broad cross cutting needs, inequalities and subjects that are of concern or require further investigation. We hope this needs assessment provides a good foundation for more specific work.

Please note: in some cases, where more specific needs assessments already exist such as the Children and Young People's Mental Health Needs Assessment, rather than reiterating their specific findings and recommendations those needs assessments have been reviewed as part of this work and are included in the references.

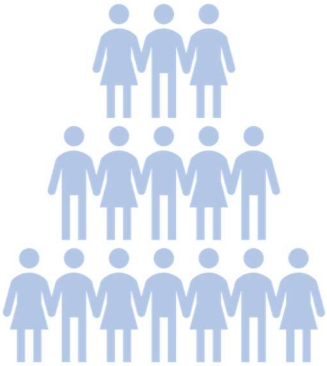
Who was involved in the development of the Needs Assessment?

A group of professionals across a range of children and young people's services, including the NHS, schools, South Gloucestershire Council, and other partners worked together to identify data and information linked to children and young people. The group also looked at a range of wider 'qualitative' data that captured the insights and feedback from children and young people, their carers and families. With specialist data support, this information was pulled together under a few key themes which are captured in this document. The group also suggested recommendations under each theme and recommendations that are systemwide, including where more targeted work is needed.

What will happen next?

This information will be shared widely with organisations and agencies who work with children and young people, their families, and carers. It is hoped that they will use the data captured in the needs assessment and the finding from the analysis to better inform strategies, priorities and work planning and the short medium and long term.

Demographics

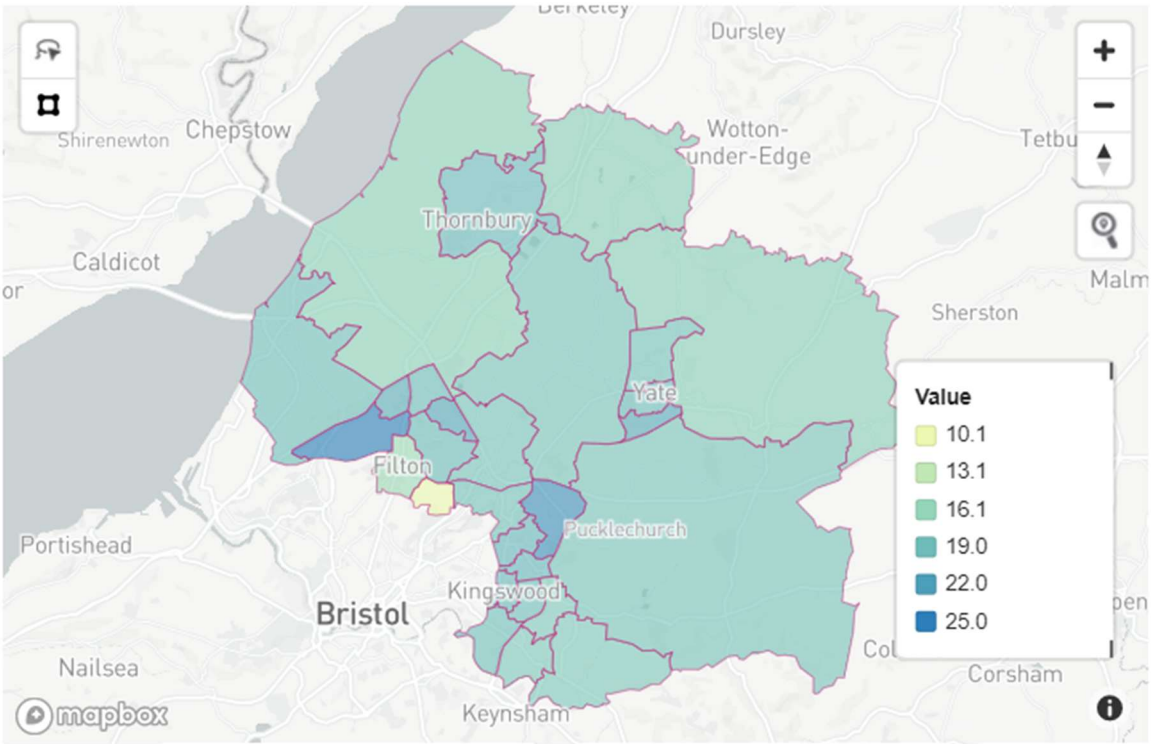


The Office of National Statistics (ONS) population estimates show that the children and young people (CYP) population has increased over the last decade [1], and 2021 census data report that there were just over 62,000 children aged 0-18 living in South Gloucestershire (21%), 16,000 of which are aged 0-4, 40,000 aged 5-16 and 6,000 aged 17-18 [2]. Projections for 2018-2043 predict that the CYP population will further increase and increases more than has been seen previously [3].

South Gloucestershire doesn't rank highly as a deprived area, but there are inequalities within and evidence that income deprivation may affect children more than the population in general or older adults specifically. Whilst relative deprivation is generally low, there has been an increase in the proportion of children eligible for free school meals, which has almost doubled from around 7% in 2017 to 14% in 2022. These increases are in line with those seen regionally and nationally [4].

CYP populations vary by ward with largest CYP populations in Emersons Green, Staple Hill and Mangotsfield and Stoke Gifford. There are also variations by age with Staple Hill and Mangotsfield having younger CYP populations with Stoke Park & Cheswick and Filton having older CYP populations.

Figure 1: % of population aged 0-15 by ward, 2020 [5]



Census data from 2021 for all ages shows that 8.8% of the all-age population are from an ethnic minority background (non-white-British), whereas amongst under 18s, it is 18%, and for 0-4s it is 20% a slight increase from 2011 [2]. Looking at the CYP population through the school census, approximately 20% of pupils are from an Asian, black, mixed or other minority ethnic background, a

proportion which has increased by five percentage points over the last five years. Mixed ethnic and Asian backgrounds are the most common ethnic groups with 8% and 5% respectively, and the wards with the highest proportion of ethnic minority background pupils include areas around Bradley Stoke (North & South), Stoke Park & Cheswick, Filton and Charlton & Cribbs. Mixed picture by area deprivation - pupils with mixed and black backgrounds were higher in the more deprived areas, but pupils from Asian or Chinese backgrounds were more common in the least derived areas [6].

The majority (73%) of dependent children live in households with married or cohabiting parents but 20% live in lone parent households [2]. Detail on CYP disability will become available from the census in due course but school census data but school census data of 5–16-year-olds suggests 0.5% (1 in 200) have a physical disability, 0.5% (1 in 200) have a hearing or visual impairment and 0.4% have a severe or profound leaning disability [7].

The Online Pupil Survey (OPS) can provide some insight into the gender identity and sexuality of children who take part in this comprehensive biannual survey. Of the 2,800 secondary and 6th form aged pupils who completed questions on sexual identity, 91% self-reported their gender as male or female and 3.7% didn't know, 1.9% were no-binary, 1.9% gender fluid and 1.3% other. 75% of young people identified as heterosexual, 10% as bisexual, 4% as gay or lesbian and 5% as other [8].

Wider determinates and Vulnerable groups

There are many disparities in health and educational outcomes, and these are often related to wider determinates, or building blocks of wellbeing. For children these include:

- health
- family
- education
- housing
- local environment
- income

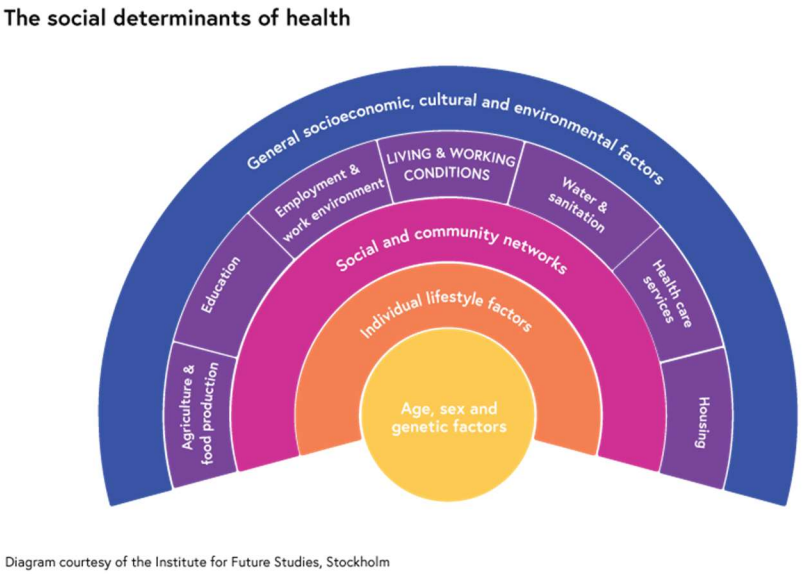
Many children will experience hardship in one or more of these building blocks, and those with more challenges may experience greater adversity in relation to many aspects of their lives including health, wellbeing, educational attainment, and their ability to thrive.

Wider determinates

Poor housing, limited access to educational and employment opportunities, and poor diet are all likely to have damaging effects on the health of children and young people living in poverty today.

As well as sometimes having a direct and immediate effect on physical health, some of the building blocks of health and wellbeing can have an indirect hidden or lasting effect on physiological systems, as the body adapts to its environment, leading to increased risk of a number of chronic diseases, a concept known as allostatic load and related to adverse childhood experiences and toxic stress [9]

Figure 2: The Social Determinates of Health Model



Poverty & deprivation

Women, racial and ethnic minorities, children, single parents, persons with disabilities and members of other historically marginalized groups have faced disproportionately higher risks of poverty and changes to taxes and benefits since 2010. These have taken the highest toll on those least able to bear it [10].

A child is considered to be growing up in poverty if they live in a household whose income is below 60% of the average (median) income for that year. This is called 'relative poverty'. Childhood poverty has been increasing both locally and nationally over the last decade and there is a growing body of evidence that poverty and deprivation adversely affect children's development in several different ways. Adverse effects can start before birth, can lead to premature mortality and poor health outcomes in adulthood [11] and there is also a clear and graded relationship between early years development and level of deprivation [12]

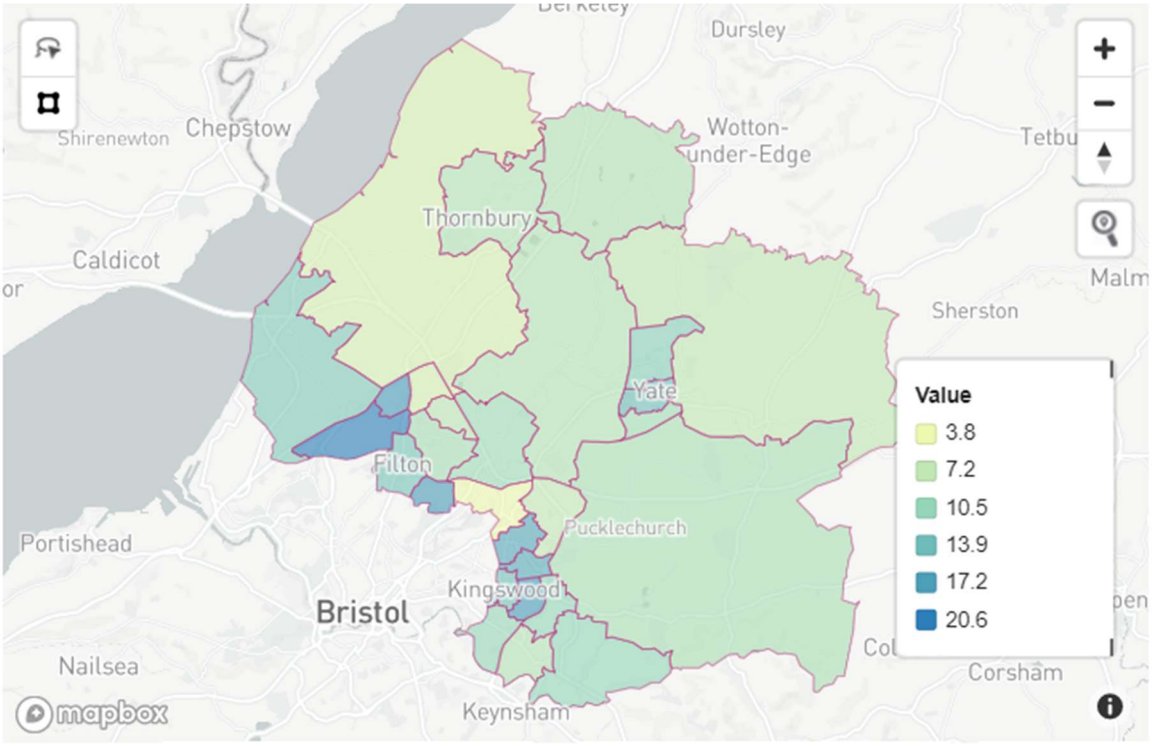
Income can have an adverse impact on the psychological functioning of mothers [13] and there is a strong association between the lack of control perceived by mothers from low-income backgrounds and the social and emotional wellbeing of children which include the level of self-esteem and behavioural issues [13]. It has also been found that children and families from the lowest 20% of household income are three times more likely to have common mental health problems than those in the richest 20% [14].

For children that live in low-income families, levels of good development are higher in more deprived areas than in less deprived areas [12] suggesting that being poor in a poor area is less detrimental to development than being poor in an affluent area such as South Gloucestershire.

This report documents inequalities along poverty and deprivation lines in both health and educational outcomes so whilst South Gloucestershire may not be classified as a low income area, there are many individuals and groups that will be experiencing acute and lasting adverse effects due to their personal circumstances.

There is a greater proportion of children in the South Gloucestershire in low-income groups than older adults or the populations as a whole [15], and there are certain areas where low income effecting children is higher than the Local Authority (LA) average, including Charlton & Cribbs, Patchway Coniston, Woodstock & Stoke Park & Cheswick [5].

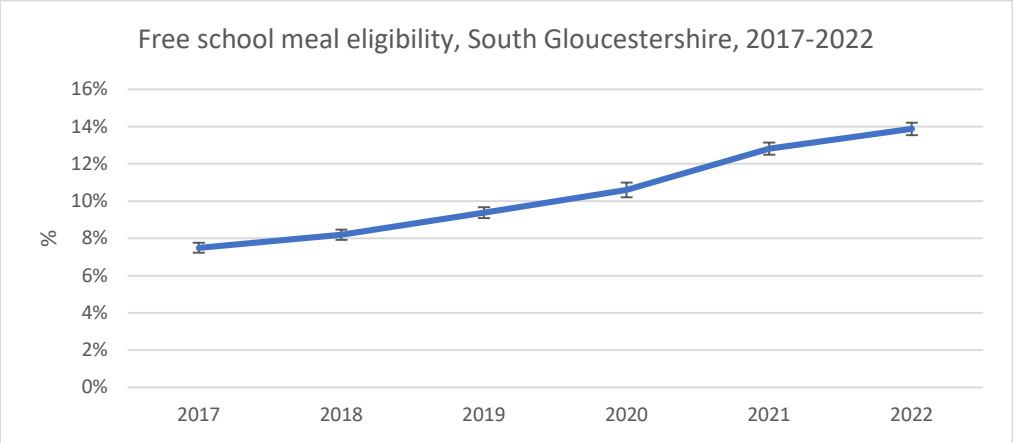
Figure 3 Income Deprivation affecting Children (IDACI) by ward 2019 [5]



The rate of children living in relative poverty has been increasing and in 2020/21 it affected approximately one in 10 children locally [16], this could be an undercount as it doesn't factor in housing costs. When housing costs are factored in, child poverty could affect as many as one in five in some areas of South Gloucestershire [17] and these figures are likely to further increase with the current cost of living crisis.

A useful representation of children experiencing poverty can be found in the proportion eligible for free school meals. In South Gloucestershire this has been increasing steadily in both primary and secondary phases, nearly doubling over the last five years and affecting approximately 14% of pupils [18]. These increases are in line with those observed at a national and regional level [4].

Figure 4: Free school meal eligibility, South Gloucestershire, 2017-2022 [18]



The Online Pupil Survey (OPS) has found that 9.3% of children experience food poverty at least monthly or more, meaning that on those occasions they went to school or to bed hungry as there was not enough food at home, with 2.8% experiencing it weekly and 2.1% experiencing it most days [8].

Housing

Living conditions, particularly housing, are inextricably linked to physical and mental health [19]. Direct effects include increased risk of accidents and spread of disease, respiratory conditions, lead and asbestos ingestion, and physical effects of overcrowding (for example on heart rate). There are also indirect effects on relationships, feeling of safety and refuge, social status and sense of inclusion.

As well as the physical qualities of accommodation, other important factors are the tenure of housing; housing insecurity; homelessness, and neighbourhood deprivation. Secure housing acts not just a physical shelter but also provides a sense of stability and security, for example in allowing for continuity and stability of education.

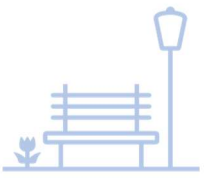
Children in poor housing are more likely to have mental health problems, respiratory problems, experience long-term ill health and disability, experience slow physical growth, and have delayed cognitive development [20].

Nationally, almost 1 in 7 houses do not meet the 'Decent homes standard' (meaning they are not free from the most serious health and safety hazards such as fall risks, fire risks or carbon monoxide poisoning) and this rises to nearly 1 in 4 in privately rented homes [21] with low-income households more likely to live in non-decent homes, compared to high income households [22].

Compared to other tenures, the private rented sector tends to be more insecure, of poorer quality and also is more expensive. Census data shows that most South Gloucestershire residents are owner occupiers but 11% are social renters and 16% are private renters, tenure types that have increased since the last census [23]. 12-13% of houses have a housing health and safety rating system 'category one hazard' mostly relating to heat and falls risks, and hazards were highest in rural areas [24].

Homelessness is associated with poor health, education, and social outcomes, particularly for children. The end of a shorthold tenancy is the main reason for home loss for 20% of households owed a prevention of relief duty by local authorities [22]. Homelessness in households with dependent children or where the main applicant is 16-24 is measured by assessing the number of people owed a prevention or relief duty under the Homelessness Reduction Act (the statutory duty councils are required to give to prevent or relive homelessness) where the household includes one or more dependent children or the main applicant is aged 16-24. Nearly half of all prevention or relief duty owed in South Gloucestershire relate to households with children and a further fifth relate to young people aged 16-24. 12 out of every thousand households with dependent children in South Gloucestershire were owed a duty of prevention or relief for homelessness, the majority (78%) were prevention related. For 16-24s, it was one in one thousand households [25].

Environment



Health Foundation research reports that in the adolescent population, high levels of crime and low perceived safety in the local neighbourhood are associated with increased levels of mental health problems, cannabis use, decreased physical activity and increased body mass index [20]. The OPS reports that 15% of South Gloucestershire secondary aged pupils feel unsafe from crime in their area [8]

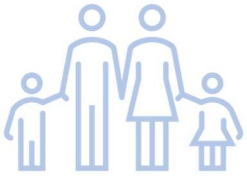
Though specific research on children and young people is required, there is growing evidence to support the beneficial effects on physical and mental health from access to green space in urban areas on all age-groups. Young people surveyed in the UK from low-income families are more likely to live in areas with fewer green spaces, and many would never visit a local park [20]

Local analysis of Office for National Statistics (ONS) data shows that most areas of South Gloucestershire have access to green spaces with little association between are deprivation score and average distance to nearest park, private garden or playing field, the average size of the nearest park or playing field, or the average number of parks, public gardens or playing fields per 1km [26]. Whilst physical proximity appears to be good in South Gloucestershire, the safety of the green space is not known.

The local environment can directly affect health due to air pollution. Air pollution, especially fine particulate matter, can pose a risk to life and health and there is strong evidence that air pollution causes the development of coronary heart disease, stroke, respiratory disease, and lung cancer, exacerbates asthma, and has a contributory role in mortality [27].

Family

Various aspects of family, social and community life are associated with child development. In South Gloucestershire the majority (56%) of households with dependent children are family households with married or civil partner couples, 17% are households with a cohabiting couple, 20% are lone parent families, and 7% are other household types with dependent children [28].



Familial violence, lack of cohesiveness, and conflict within the family has been associated with depression and internalising problems in adolescence [20]. 23% of secondary and year 12 pupils reported that they or a family member had been the victim of domestic abuse or domestic violence, a figure that has increased from previous surveys. For most pupils the abuse or violence was occasional but for some (7%) it occurred often or most days and many pupils (16%) reported the abuse as continuing [8].

Nine to eleven year olds were more likely to indicate that they were unhappy with their relationships with their family or friends than younger children, and correlational evidence suggests a link between poorer social relationships, including poorer family connectedness, and problems with family functioning, and mental health problems in children and young people [29]

Parental interest in their child's schooling has been associated with improved self-rated health in young adults and a lower risk of obesity and diabetes in adulthood [20].

Family connectedness (which can include interest, support, and control) seems to be one of the principle factors in young people's later outcomes [20].

There are many reasons that children will need to provide a caregiver role in their family, and care could be for a parent, sibling or other relative. Young adult carers face significant social and health inequalities; those aged 16-18 are twice as likely not to be in education, and young carers are 1.5 times more likely to have a special educational need or disability and are more likely to report a mental health problem [20]

Many Young Carers are hidden and many miss school and social opportunities. The Children Society report 39% of young carers said nobody in their school was aware of their caring responsibility and 27% missed school as a result of their responsibilities [30]. Young carers locally have to provide emotional support to parents, clean, cook and care for siblings. They report that they are stressed,

worried, lacking in confidence, unable to socialise and finding it difficult to concentrate in schools [31].

Poor parental mental health is a risk factor that may increase childhood vulnerability and reduce children's emotional wellbeing. Sometimes a parent who is experiencing poor mental health may struggle with normal routine which can in turn affect any children or young people living in the household. For example, mealtimes, bedtimes, taking them to school, and attending appointments for CYP medical or dental could all be adversely effected [32]. Parental mental health is reported as being a significant caring need amongst young carers (20% of all 'cared for' needs) and that young carers often struggle to support a parent with mental health issues [31].

Similarly, Children living in a household where a parent or carer misuses substances doesn't mean a child will experience abuse, but it does make it more difficult for parents to provide safe and loving care. They can be at greater risk of neglect and emotional and physical abuse and impact on brain development due as abuse and neglect are Adverse Childhood Experiences (ACE) see section below [33].

Children whose parents are involved in the criminal justice system, in particular, face a host of challenges and difficulties including psychological strain, antisocial behaviour, suspension or expulsion from school, economic hardship, and criminal activity [34] and parental imprisonment or involvement with the justice system short of imprisonment is a cause of damaging chronic stress and adverse childhood experience [35].

Vulnerable groups

Whilst it is recognised that children in particular are a vulnerable group in their own right, there are some children that experience additional aspects of their lives that make them more vulnerable than the average child of their age. They are at greater risk of experiencing physical harm or poor outcomes in their lives due to one or more factors in their lives [36].

Significant and growing, body of evidence that stressful experiences (adverse childhood experiences-ACES) during childhood have a profound impact on an individual's life chances. These experiences alter development of the brain and of the hormonal, nervous and immunological systems [9] [37].

Children growing up in poverty or with lower socioeconomic status are more likely to be exposed to ACEs, and to have 'clusters' of 2 or more ACEs. Children in care are also more likely to have experienced a relatively higher number of ACEs. Other factors increasing the risk of ACEs include poor and harmful parenting approaches and the relative stress in which families live. Adults who have experienced ACEs are more likely to be raising their children in similar environments. Due to variations in the prevalence of ACEs and the observed negative impacts of ACEs on health and wellbeing, it is likely that ACEs are contributing to inequalities. It is therefore important that an ACEs approach is integrated into work around child poverty, early help and inequalities [38].

Early Help prevents escalation of problems and enables interventions to take place before critical thresholds are crossed and pathways become more irreversible for young people. It means getting timely and effective support to children, young people and families who need it and aims to enable children to flourish and to enhance long term outcomes and life chances. Early Help refers both to help in the critical years of a child's life (including pre-birth and pregnancy) and also to responding as soon as possible, at any age, through childhood and adolescence when difficulties emerge [39].

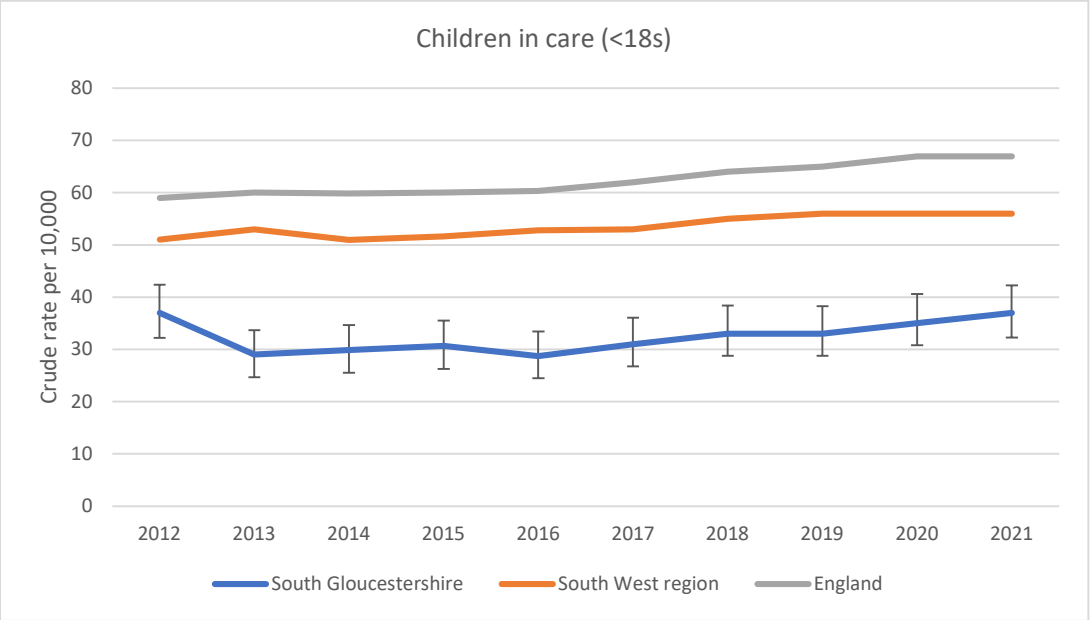
Early Help for children and families that takes place in the community happens on an informal basis, provided by community organisations and services alongside their core business. Data that is collected measures only those pieces of Early Help that have been formally recorded using the Early Help Assessment and Plan (EHAP) process. These include 'Community EHAPs' led by community organisations and the EHAPs held by South Gloucestershire Council's Preventative Services. It is therefore difficult to quantify and explore how this service is used and by whom.

There is evidence that the prevalence of vulnerable groups is growing. The number and rate of Social Care referrals has been increasing recently following several years of declining rates, and non-white ethnicity appears to be over represented in referrals compared to the general population [40]. The majority of referrals come from the police followed by schools and then health services, with the proportion originating from this latter source having steadily increased over the last five years [4]

The rate and count of child protection plans is also increasing, representing disproportionately non-white children and with neglect or emotional abuse being the most common reason, [40] rates of re-referral are increasing and higher than statistical and national comparators also [4].

Children in care are likely to have experienced many adverse experiences and are both vulnerable, and at risk of less favourable life outcomes than children who haven't experienced such adversity.

Figure 5: Children in care, 2012-2021 [16]



The number and rate of children in care has been increasing steadily locally [16] and there has been a particularly high rate of children entering care in 2022 with the number of children who started to be looked after increasing more than Statistical neighbours (local authorities with similar demographic profiles) [4].

The majority of children in care have been in the same placement for 2 years or more but 6% have had 3 or more placements. Although it has been increasing, comparatively few children are placed more than 20 miles from their home. Health checks and immunisation cover is generally good among children in care but only 75% have had a dental check-up, it is not known how this differs to the general population [4].

As covered in the education section, children that are looked after perform less well on average than their peers at all levels of education assessed from reception through to GCSEs. For GCSE attainment there have been improvements however and the difference between all pupils and those that are looked after is less in South Gloucestershire than comparators. Children in care appear to be around three times more likely to have a Special Educational Need (SEN) and are nearly 9 times more likely to have a statement or Education Health and Care Plan (EHCP) and rates locally are higher than statistical neighbours or England. Rates of fixed term and permanent exclusion and rates of persistent absences in children in care in South Gloucestershire are substantially higher than the all-pupil average locally and higher than statistical neighbours and the national averages for children in care [4].

The rate of children in need has been relatively stable in South Gloucestershire and is similar to regional averages. The majority have been receiving help for more than 2 years but there has been a notable increase in the proportion needing short term help (<3 months) in the last year [4].

There is a lot of cross over and intersectionality between vulnerable groups. Half of children in need are eligible for free school meals, nearly a third have an EHCP and a quarter have SEN support. School absence rates are substantially higher amongst Children in Need compared to the all-pupil average and slightly higher than children in care. More than half of all children in need are classified as persistent absentees [4].

The Online pupil survey allows pupils to self-report being in any vulnerable groups that aren't routinely captured in the school census data. Currently around 4.6% report having a social worker, 0.6% are a young carer (although 5.9% report having missed school to care for a relative), 10.4% have had a family member in prison and 1.3% have a parent in the armed forces [8] Other potentially vulnerable groups such as children of care leavers or siblings of disabled or life limited children are not captured at.

Young carers often fall under the radar with respect to receiving additional help which they may need. There is evidence that young carers are 1.5 times more likely to have a special educational need or disability and are more likely to report a mental health problem themselves [20]. The local Young Carers charity report that a large proportion of children that care for a parent do so due to parental mental health problems and it has been reported that suicidal ideation and behaviour in children is liked to parental mental health problems [20].

When considering all the above, it is important to recognise the additional impact of Covid-19 in recent years. Covid-19 has exposed significant inequality and had implications on the levels of need in relation to bereavement, financial hardship, mental health, domestic violence, and complex safeguarding across the population. The combination of existing trauma, as well as trauma linked to Covid-19, is likely to cause serious and lasting harm, particularly to those who are already the most disadvantaged [41] [42] [43] [44].

Wider determinants and vulnerable groups key points

- Both adverse childhood experiences and long-term socioeconomic disadvantage can have direct and indirect impact of physiological systems leading to poor health and have long term implications on children's ability to thrive.
- Poverty and related factors such as housing and local environment has direct and indirect effects on health, wellbeing, and educational attainment.

- The number and proportion of children who experience poverty and adversity is increasing, is higher in some areas than others and is likely to continue to increase with the cost-of-living crisis.
- The home is not a safe space for every child, some will experience cold and damp, housing insecurity and exposure to domestic violence. For some home is not a conducive place to learn or a place of sanctuary.
- There have been increases in certain disadvantaged education sub-groups including children eligible for Free School Meals (FSM), whose first language is not English, have an SEN (SEN support & EHC Plans) or are from a Black Minority Ethnic (BME) background.
- There have been increases in the number and rate of vulnerable children being referred to and needing help from social services, and potential disparities along ethnic lines.
- The Online Pupil Survey (OPS) provides valuable insight into both vulnerable and disadvantaged groups and the degree to which some children face disproportionate stress, worry and poor mental health.
- Some vulnerable groups are largely hidden in routine data, these include young carers, children with family experience of prison, and children of care experienced parents.
- There is a large degree of intersectionality between vulnerable and disadvantaged groups.
- Many disadvantaged groups experience poorer health and worse educational outcomes than their peers.

Wider determinants and vulnerable groups recommendations

- Continue to use, promote and expand the use of trauma informed practices.
- Expand routine information collected on vulnerable groups to with particular needs for example young carers and children affected by parental offending.
- Continue to and expand the practice of taking an inequalities-based look at outcomes and experiences of health, wellbeing and education
- Continue to use and promote the use of the OPS to capture information and experience of vulnerable groups.
- Consider intersectionality and multiple disadvantage at an individual level
- Improve data and insights sharing relating to housing, education and social care to enable to big picture to be visible to all
- Review which vulnerable groups require a detailed needs assessment to understand met and unmet need.

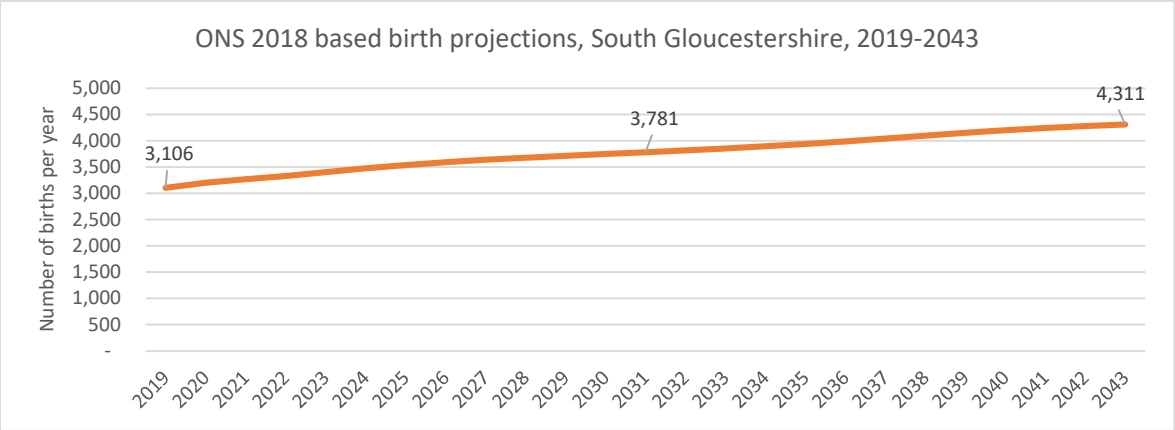
Maternity and Early years

There is no universal accessible early years client management system that is available for Integrated Care Board (ICB) partners to use for planning and research purposes. Data are obtained from various national and local organisations and there can be issues surrounding delays in data availability and level of detail.

Pregnancy & Birth

Over the last 20 years there have been, on average, 3,000 births a year in South Gloucestershire [45]. Whilst the general fertility rate (GFR) has declined between 2017 and 2020 [16], the Office of Nation Statistics (ONS) predicts that the number of births will increase and be closer to 4,000 per year by 2040, with a slight increase in mothers aged 40+ along with a decrease in mothers aged under 20 [3]. Whist there is discrepancy between the declining GFR and the projected births, the ongoing expansion of housing in South Gloucestershire will result in a larger population, as has been demonstrated in the last decade and there is evidence to suggest that birth rates are likely to be higher in areas with significant housing development [1]. The rate of under 18 conceptions in South Gloucestershire has fallen substantially over the last decade and has remained lower than national rates, but there are known inequalities at a national level with higher rates of teen conceptions in more deprived areas [16].

Figure 6: ONS 2018 based birth projections, South Gloucestershire, 2019-2043 [3]

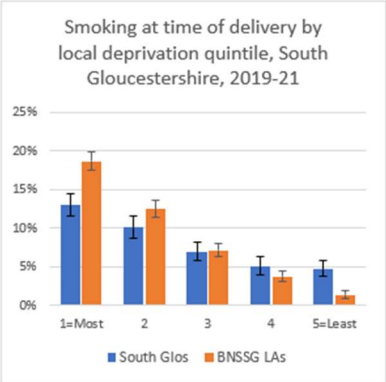


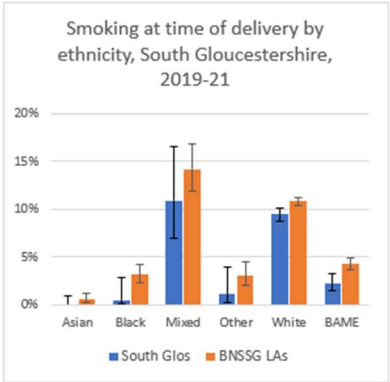
Neonatal mortality and stillbirth are rare but there are still, on average, 18 that occur per year [16]. National level data show these are more common in boys, babies born to oldest and youngest mothers (<20 & 40+) and babies born to mothers living in the most deprived areas [16].

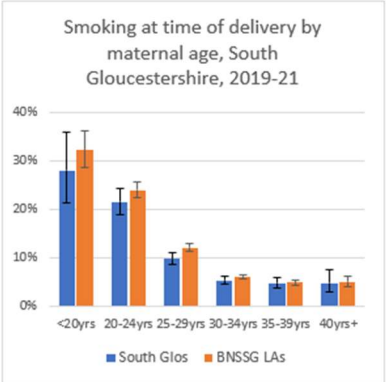
The majority of expectant mothers have early access to maternity care, but this can vary by several factors. Late midwife bookings are higher in areas with more movement in and out of the area (for example, Filton). Black mothers more likely to have a late booking than all other ethnicities and there are strong associations with area deprivation and maternal age, with a higher rate of late bookings amongst those living in more deprived areas and amongst younger mothers [46].

Smoking during pregnancy is reducing, especially in smoking at time of booking, but inequalities remain with higher rates amongst mothers living in more deprived areas, amongst mothers of mixed and white ethnicities and amongst younger mothers [46]. There has been concern raised locally about mothers reporting the use of cannabis whilst pregnant. Little is known about alcohol or substance misuse locally but national level data indicates that inequalities exist by ethnicity and area deprivation [16].

Figure 7: Inequalities in Smoking at time of delivery (SATOD) [46]

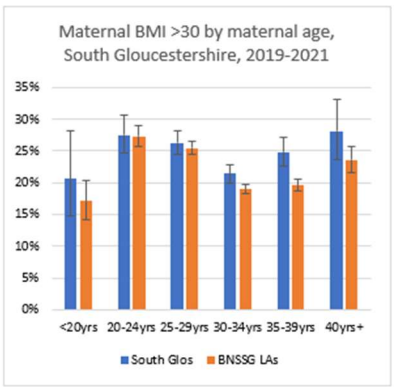


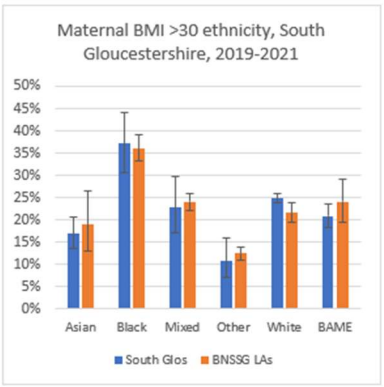


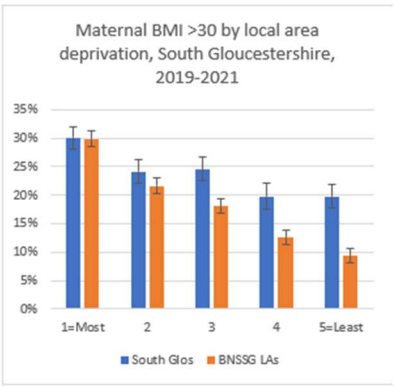


Two maternal risk factors increasing locally are maternal obesity and mothers aged 40+ [46] and mothers aged 40+ is predicted to increase by 73% by 2043 [3]. There are inequalities in maternal obesity with higher rates in black mothers and those living in the most deprived areas [46]. The proportion of mothers aged 40+ has been increasing and is predicted to increase further over the next 20 years [3].

Figure 8: Inequalities in high maternal BMI [46]

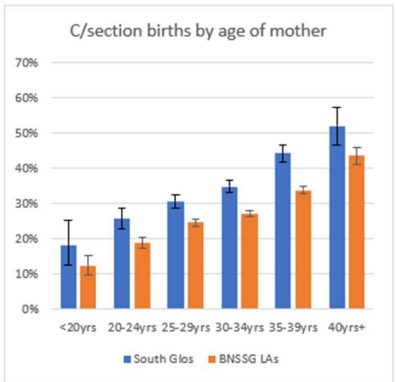


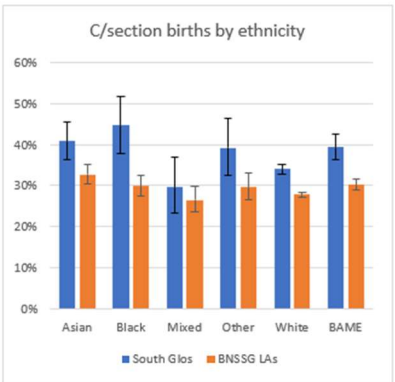


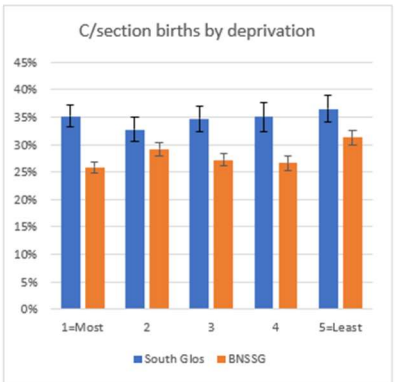


There have been some shifts in delivery method over the last decade with an increase in C-sections [16], which is largely driven by National Institute of Health and Care Excellence (NICE) guidance increasing choice but also possibly demographic and health factors. There are disparities in C-section rate with increasing likelihood with increasing age and greater prevalence amongst Black mothers compared to white mothers [46].

Figure 9: Inequalities in C-Section rates [46]

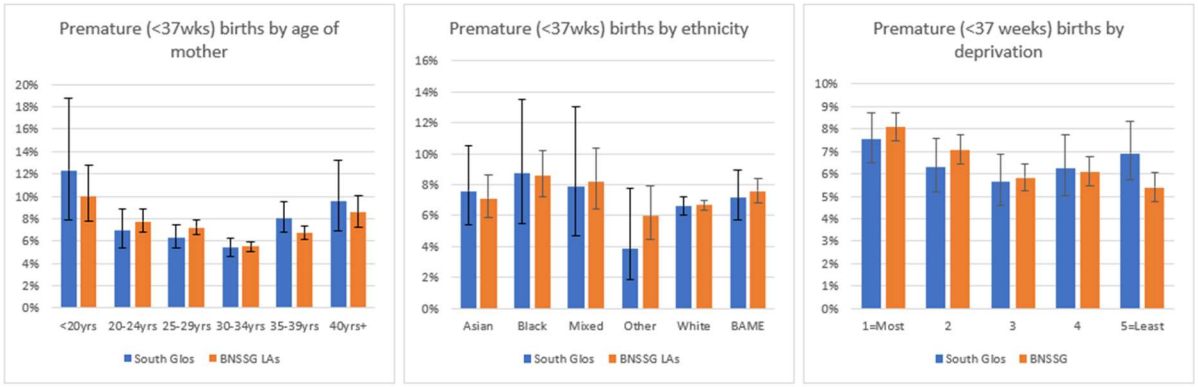






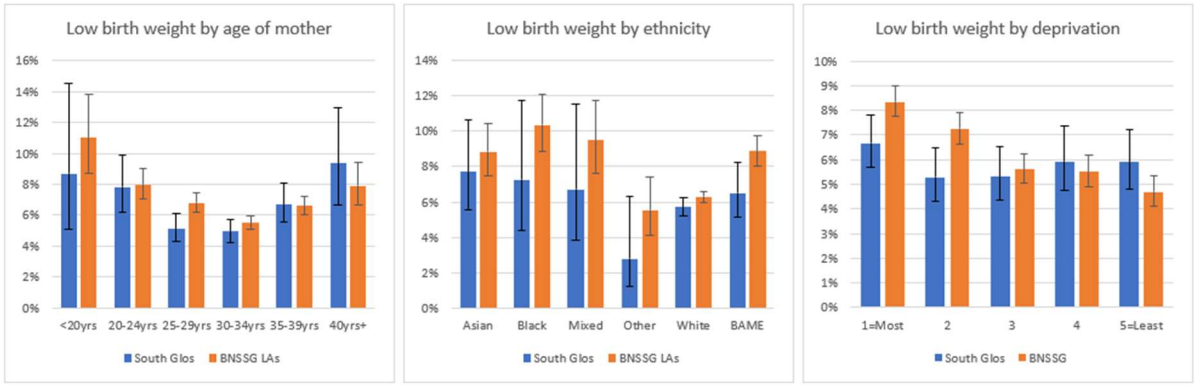
Around 7% of births are premature (<37 weeks gestation) [16], there are inequalities by age with higher prevalence in younger and older mothers, disparities by ethnicity with highest rates amongst black mothers, and association with area deprivation with higher rates in more deprived areas [46].

Figure 10: Inequalities in premature birth [46]



Low birth weight has changed very little over the last decade [16] but there are disparities by maternal age with highest rates amongst younger and older mothers (<20 and >40), by ethnicity with highest rates in black, mixed and Asian mothers, and a strong association with area deprivation with the highest rates in the most deprived areas [46]. There is also a higher prevalence of low APGAR score in black mothers [46] which may be related to low birth weight and premature birth.

Figure 11: Inequalities in low birth weight [46]



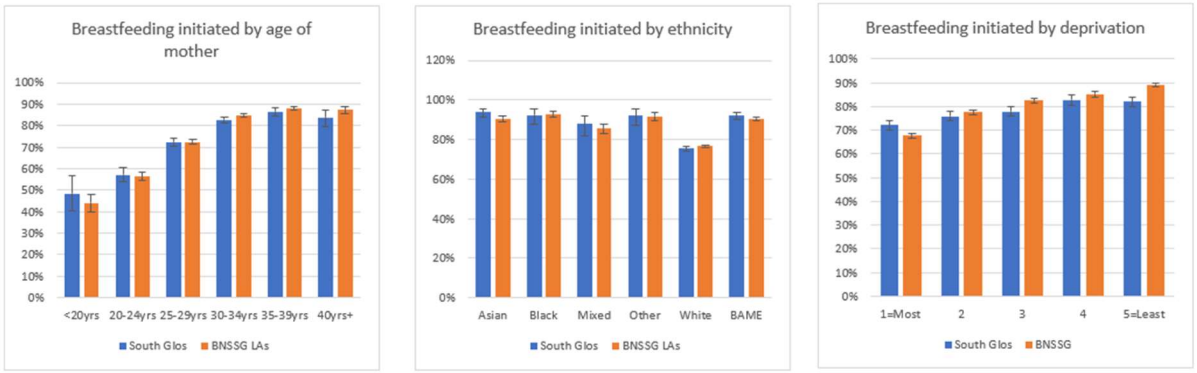
There is little to no local data on perinatal or post-natal mental health, or parental / familial mental health more generally. National data from 2017/18 has some estimated counts for conditions such as postpartum psychosis, depressive illnesses, Post Traumatic Stress Disorder (PTSD) and adjustment disorders based on the number of deliveries in the same year. These counts suggest that, during the postpartum period, 0.2% of mothers may experience postpartum psychosis or severe mental illness, 2.5% could experience severe depressive illness or PTSD, between 8.2 and 12.3% could experience mild to moderate mental illness, and between 12.3% and 24.6% could experience adjustment disorders [47].

If replicated locally, as many as 750-1,200 women per year in South Gloucestershire may experience some kind of mental health issue in the postpartum period. Qualitative reports and feedback [48] [49] have indicated a local increase in need for perinatal mental health support, including for those who do not have pre-existing mental health conditions.

Babies first years

There are known benefits of breastfeeding for both mother and baby and rates have been improving in South Gloucestershire [16] but rates reduce substantially between initiation [46], at age 1 week and at 6-8 weeks [50]. There are clear disparities at all stages by age, ethnicity and area deprivation with the lowest rates in younger mums, white mothers and mothers living in the most deprived areas [50] [46].

Figure 12: Inequalities in breastfeeding initiation [46]



The majority (>90%) of babies and mothers receive their Health visitor mandatory touch points on time and there have been improvements in coverage over recent years [16].

84% of children achieve a good level of development across the five key areas measured at age 2-2 ½, as measured by the Ages and Stages Questionnaire (ASQ) but while around 95 % have good development in gross and fine motor skills and problem solving skills, around 93% have the expected personal and social skills and 90% have the expected communication skills [16].

There are some gaps in understanding of ASQ data locally, whilst the proportion achieving a good level of development in each of the five areas assessed is available at the South Gloucestershire level, more granular detail is not available to assess inequalities.

National level data show an association with area deprivation with a lower proportion of children achieving a good level of development at age 2-2 ½ in the combined measure and across each of the five domains in the most deprived areas compared to the least deprived areas [16]. Due to locally observed inequalities in birth risk factors, birth outcomes and inequalities in educational indicators, which will be covered in the education section, it can be expected that there will be local inequalities here too. Knowing what the disparities are may help to inform early help.

There is little universal information about children available to all ICB partners, and no routine contact points in the period between exiting the Health Visitor (HV) service, and starting school. Whilst many children attend a nursery or childminder at some point before starting school, the vast majority are private organisations. Some data are captured for those eligible for free childcare at age 2, and based on children it is estimated that approximately 14% of 2-year-olds attend a nursery using the free hours [51].

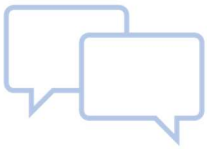
Given the eligibility criteria relating to low income and receipt of certain benefits, these funded places disproportionately relate to children living in the more deprived parts of South Gloucestershire. There is better data collection for 3-4 year-olds who utilise the free childcare offered but it appears that only 60% attend a nursery setting funding through the free childcare

offer and this is lowest in the most deprived areas [51]. There is currently no information about the children who attend and fund nursery on an entirely private basis, or about those who attend no early year's childcare settings.

Babies and preschool children often spend a lot of time in the home and this environment can have a significant direct and indirect impact on the health of mothers and children. The majority of injuries to 0-4s that result in admission to hospital occur in the home [52], and homes can directly impact health due to cold, damp and mould as well as risks of falling [22]**.** Midwives have reported concerns locally about the housing situation of new mothers [53].

Local Insight

Engagement with mothers of babies in South Gloucestershire reported that access to consistent and good quality parenting information and support, support with infant feeding and perinatal mental health, and places to meet other mums with babies would all help keep them healthy and well [49].



Maternity & Early Years Key points

- The size of this population is increasing and an increase in births is projected
- There is no universally accessible database available to plan services proactively.
- Inequalities exist in risk factors including late booking, smoking and maternal obesity by maternal age, ethnicity, area deprivation and geography.
- There are inequalities in birth outcomes (premature birth, Low Birth Weight, still birth, low APGAR score) by maternal age, ethnicity and area deprivation.
- Demographic changes such as higher maternal age at birth and greater proportion of mothers from ethnic minority backgrounds may impact birth risk factors and outcomes further.
- There has been an increase in proportion of C-sections, in part due to increase in at risk groups, and due to patient choice
- There is no local information on maternal mental health but national data suggests there is a growing need.
- There are inequalities in breastfeeding along deprivation, age and ethnicity lines and rates decline between initiation to 6–8-week check.
- There is no local understanding of inequalities and disparities in early years development, but inequalities are evident in 4–5-year-olds in school.
- There is a gap in universal services contact between the end of Health Visitor contact to a child starting school.
- The impact of housing may be particularly acute for mothers and infants

Maternity & Early Years Recommendations

Based on the key points raised and combined with local and national policy [54] [55] [56] [57] [58] the following recommendations have been suggested. These are broad aspect recommendations and reflect the broad nature of the needs assessment. It is anticipated that specific recommendations will be identified as part of subject specific needs assessments.

- Improve data collection and analysis in the Early Years to gain a better understanding of emerging needs before children go to school.

- Improve connections with mental health services around perinatal or postnatal health, facilitate data and knowledge sharing to gain understanding of problems locally.
- Explore inequalities and trends in local early years development data with providers.
- Continue to improve communication between Midwifery and Health Visitors services especially in relation to housing and wider determinates of health.
- Understand and support the role of fathers and partners in the parenting journey.
- Increase opportunities for qualitative feedback of service users and health professionals.

Education & Child Development

There is little universal information about children available to all Integrated Care Board (ICB) partners. The Office of National Statistics (ONS) population estimates show that the children and young people (CYP) population has increased over the last decade [1] and projections for the next 20 years predicts that the CYP population will increase far more than has been seen previously [3].

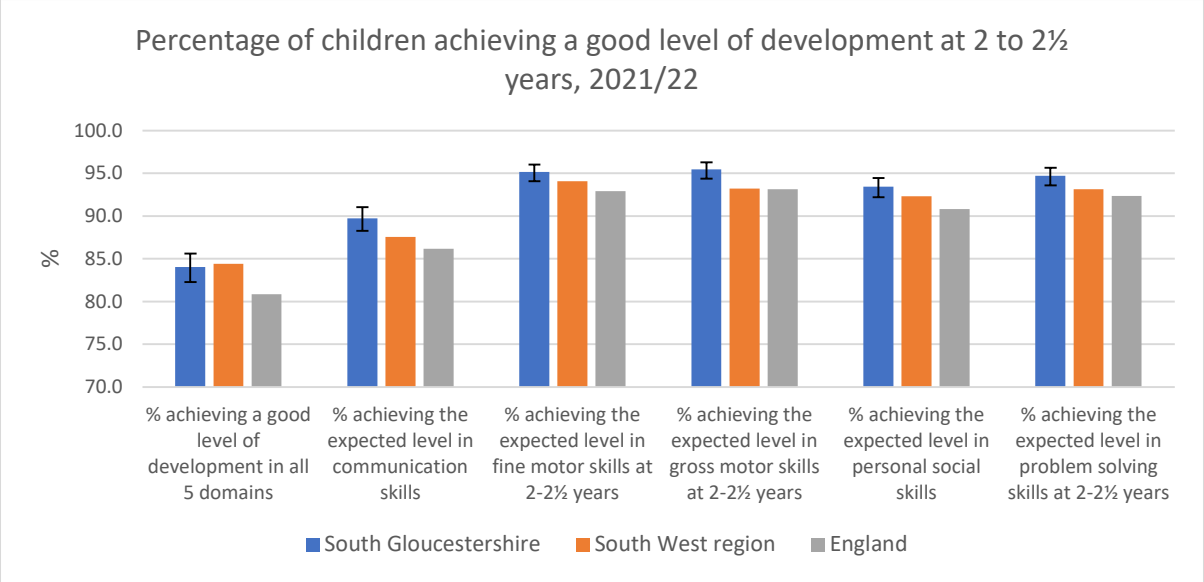
Early Years development

There are 130 nurseries and preschools in South Gloucestershire with 91% of these rated as good or outstanding. Whist data are not available for nursery children as they were in the school census, some data are captured for those eligible for free childcare. It is estimated that approximately 14% of 2-year-olds attend a nursery via the free childcare offer [51]. Given the eligibility criteria relating to low income and receipt of certain benefits, these places disproportionately relate to children living in the more deprived parts of South Gloucestershire.

A greater proportion of 3-4 years olds are eligible for free childcare and approximately 60% attend a nursery setting this way, with the lowest prevalence in the most deprived areas. There is a lower than expected proportion of children from ethnic minority backgrounds that access free early years education compared to the school census [51]. There is no information available about the children who attend and fund nursery on an entirely private basis, or about those who attend no early years childcare settings.

The earliest stage of child development measured is the Ages and Stages Questionnaire (ASQ) conducted as part of the 2-2 ½ year review. 84% of children achieve a good level of development across the five key areas measured by the ASQ, but while around 95 % have good development in gross and fine motor skills and problem solving skills, around 93% have the expected personal and social skills and 90% have the expected communication skills [16]. There is concern that pandemic has negatively affected children's communication and language development as well as on their personal, social, and emotional development [59].

Figure 13: % of children achieving a good level of development at age 2-2 1/2 by ASQ domain [16]

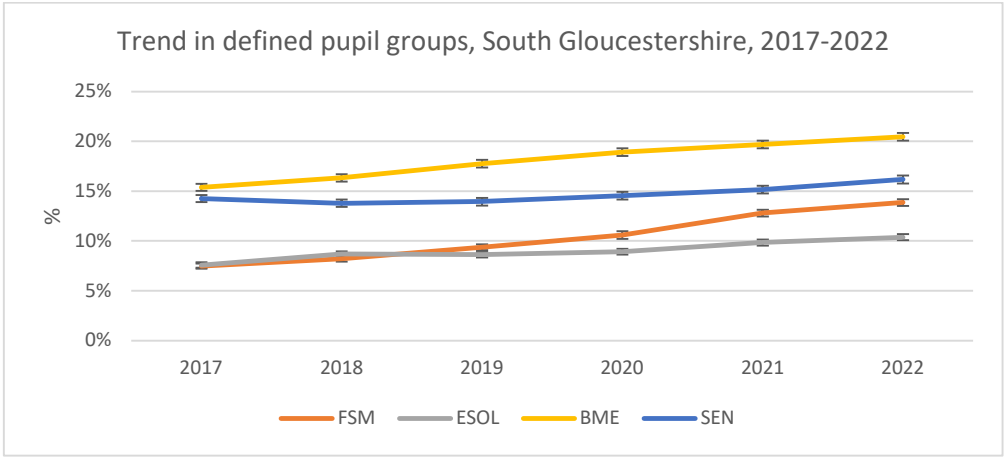


There are some gaps in understanding of ASQ data locally. Whilst the proportion achieving a good level of development in each of the five areas assessed is available at the South Gloucestershire level, more granular detail is not available to assess inequalities. National level data show an association with area deprivation with a lower proportion of children in the most deprived areas achieving a good level of development at age 2-2 ½ in the combined measure and across each of the five domains compared to those in the least deprived areas [16].

Schools and their populations

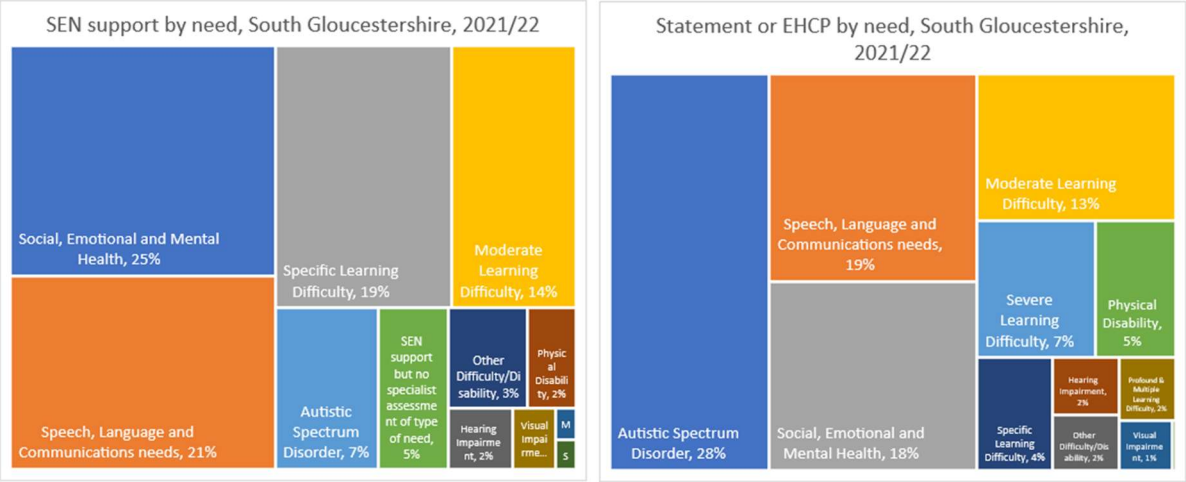
in 2021/22, 94% of primary and 76% of Secondary schools are rated as good or outstanding in South Gloucestershire [60] and 96% of primary age and 83% of secondary age children attend a South Gloucestershire school [61]. Approximately 1.3% of South Gloucestershire pupils are educated in special schools and 0.2% in a Pupil Referral Unit [18] similar to national averages. Around 0.3% are in alternative provision [62] and an estimated 0.5% primary and 2.1% secondary are electively home educated [63].

Data captured in the school census shows that a number of protected characteristic and vulnerable groups have been increasing in recent years. Children eligible for free school meals has almost doubled from 7.5% to 14% and there have also been increases in the proportion of children where English is a second language and an increase in children in care.



There has also been an increase in pupils with a Special Educational Need (SEN) or Education health and Care Plan (EHCP), increasing from 14% to 16%, of which Autistic Spectrum Disorder (ASD), social, emotional, and mental health needs and speech, language and communication needs have increased the most [7]. For pupils of school age with an SEN, the most common need locally is for social, emotional, and mental health needs (25%) followed by speech, language, and communication needs (21%) and specific learning disability (19%). Amongst those with an EHCP the most common need is ASD (28%) followed by speech, language and communication needs (19%) and social, emotional and mental health needs (18%) [7].

Figure 14 SEN support and EHCP by defined need [7]



The prevalence of SEN and EHCP is lowest in 5-year-olds and peaks amongst 10-year-olds before declining slightly in older age groups [6] which is a pattern observed nationally too [7]. Inequalities were observed with substantially higher rates in boys compared to girls, higher rates amongst children living in the most deprived compared to least deprived areas of South Gloucestershire, and rates are higher amongst white pupils compared to Black, Asian and other ethnicities. Inequality by area deprivation varied by SEN need, with no disparities by area deprivation lines for ASD, but strong associations with all other SEN need types especially amongst children with social, emotional and mental health needs and speech, language or communication needs [6].

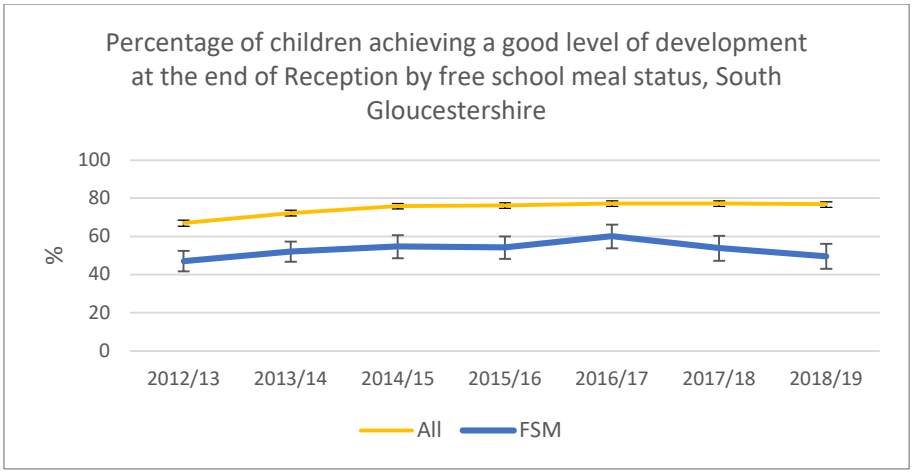
Around 0.5% of Children have a physical disability, 0.3% have a hearing impairment and 0.2% have a visual impairment, and these proportions have been relatively stable over the last 7 years [7],

Other vulnerable groups where data capture could be improved include children include young carers, but it is understood that this will be captured in school censuses in the future.

Educational attainment

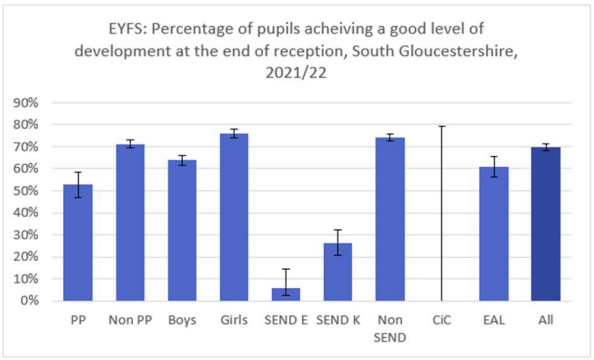
There has been a slight reduction in the percentage of children achieving a good level of development at the end of reception locally and nationally since the pandemic, with the local proportion falling from 77% in 2018/19 to 70% in 2020/21 and could be linked to the negative effects of the pandemic on communication and language development, and personal, social and emotional development in the early year.

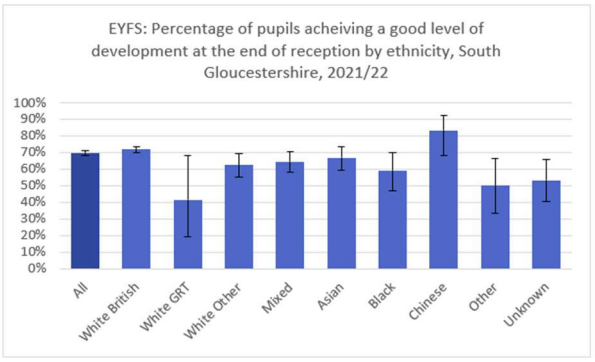
Figure 15: Good level of development at the end of reception by free school meal eligibility [16]



There are inequalities evident with just 49% of those eligible for free school meals achieving a good level of development - a larger gap than observed nationally- and boys have had a consistently lower proportion than girls at both the all pupil and Free School Meals (FSM) eligible level [16]. Local data showed further inequalities, with children with pupil premium, English as an additional language and those with EHCP or SEN support as well as children with Gypsy Roma Traveller (GRT) ethnicity less likely to achieve a good level of development compared to the all pupil average [64].

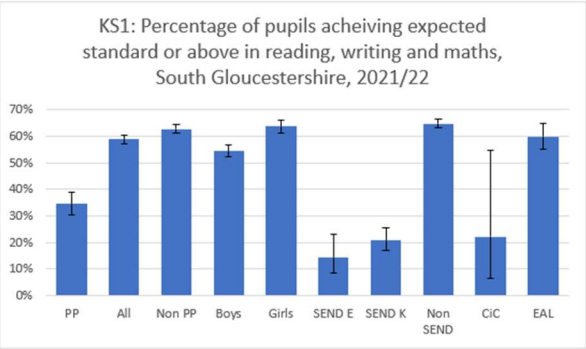
Figure 16: Inequalities in good level of development at end of reception [64]

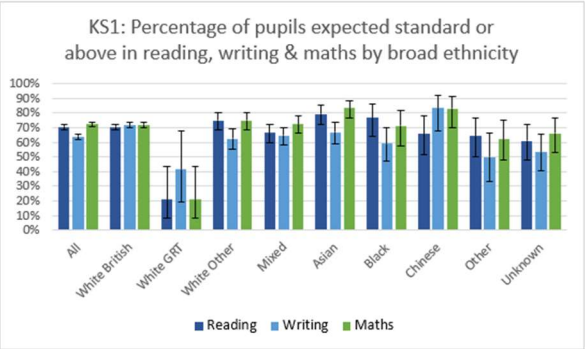




At Key Stage 1, there has been a fall in the percentage of children achieving expected standard in the phonic check since before the pandemic from 85% to 78%, the fall amongst FSM pupils was larger, falling from 69% to 55% and this is currently lower than national averages [16]. There were also inequalities with children with pupil premium, children in care, and those with EHCP or SEN support, with all of these groups less likely to meet the standard. There were also inequalities in the proportion of children achieving the expected standard in reading writing and maths, with those with EHCP or SEN support, children on pupil premium, children in care, boys and GRT pupils all less likely to meet expected standards [64].

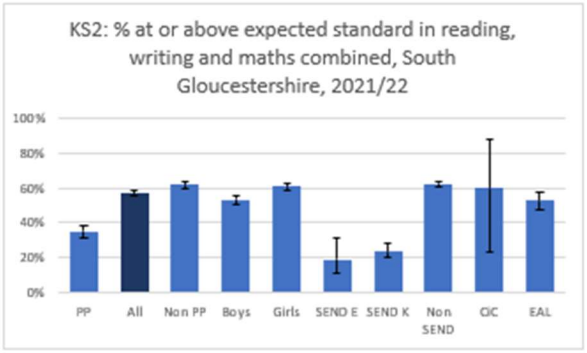
Figure 17: Inequalities in KS1 attainment [64]

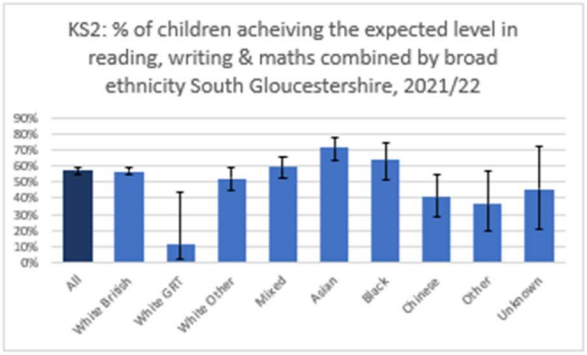




Whilst there have been improvements in the percentage of children meting the expected standards at Key Stage 2 in reading post-pandemic, there were falls in writing, maths and the combined measure [60]. There were inequalities with those with EHCP or SEN support, children on pupil premium, boys, GRT, Chinese and other ethnic background pupils less likely to achieve the expected standards in reading, writing and maths [64].

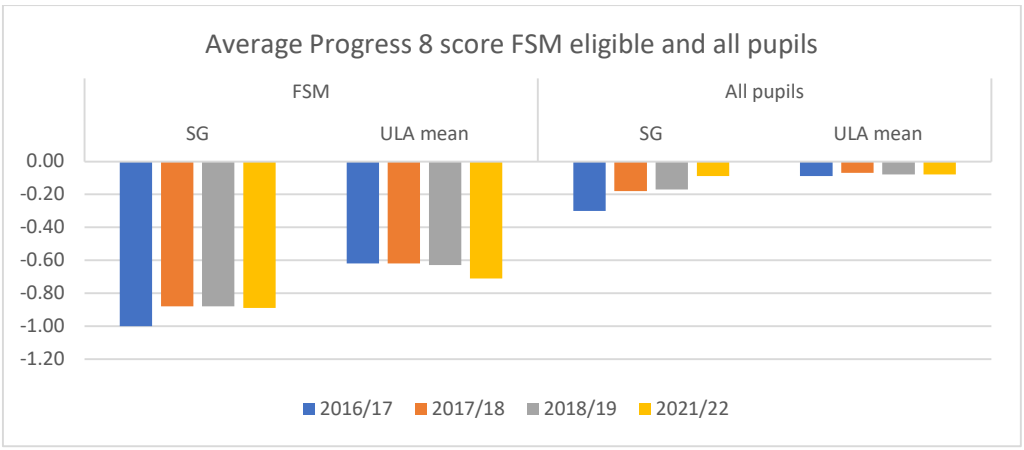
Figure 18: Inequalities in KS2 attainment [64]





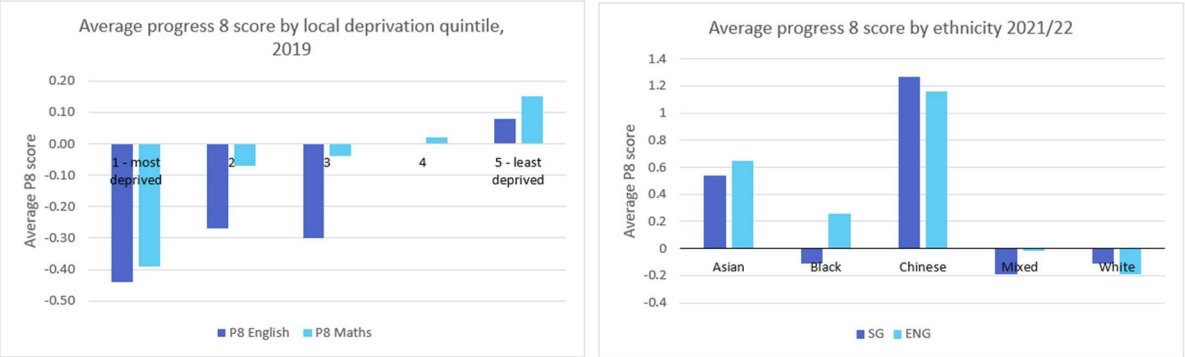
The progress children make between the end of primary school and GCSE stage is demonstrated by progress 8 scores. They measure the relative progress from KS2 to KS4 of children who start at a similar attainment level. Whilst progress 8 scores have been historically low in South Gloucestershire, there have been improvements in recent years and it is now similar to unified authority averages [60]. However, there are inequalities with children eligible for free school meals making significantly less progress than non-FSM eligible pupils. The FSM gap is now larger than pre-pandemic levels and larger than the all-unitary authority averages [60].

Figure 19: Average progress 8 by free school meal status [60]



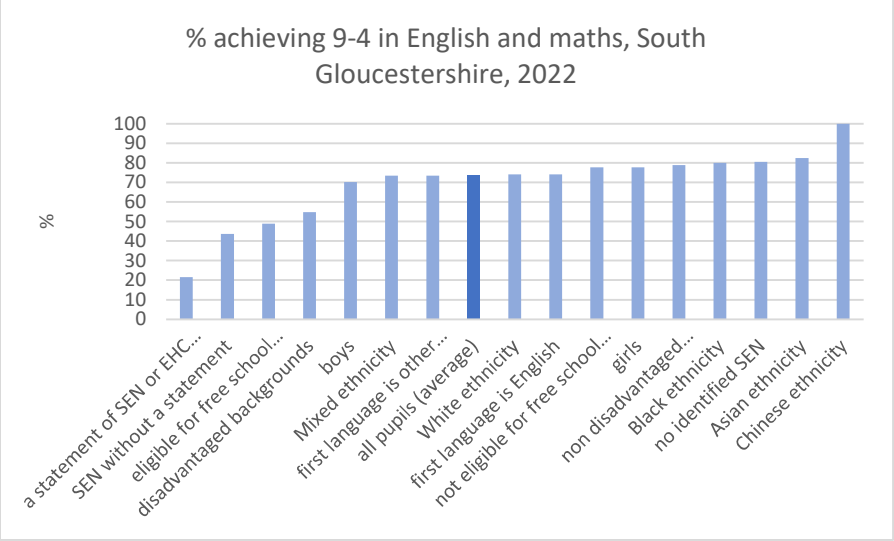
There were also inequalities by ethnicity, with mixed ethnic, black, and white children all doing relatively worse than their counterparts who started at the same level in the country as a whole [60]. Local analysis has also showed that there were clear associations with area deprivation in relation progress in maths and English, with those in the most deprived areas doing less well than their counterparts, and those in the least deprived doing better than their counterparts nationally [65].

Figure 20: Inequalities in average progress 8 scores



Overall, the percentage of pupils achieving grades 9-4 in English and maths is similar to national averages, and both locally and nationally there was a noticeable jump during the teacher assessment year of the pandemic and a fall in the most recent year. There were similar inequalities in the other measures with pupils with EHCPs, SEN support and those eligible for free school meals substantially lower than the all pupil averages, and boys and children of mixed ethnicity slightly lower than the all pupils average [60].

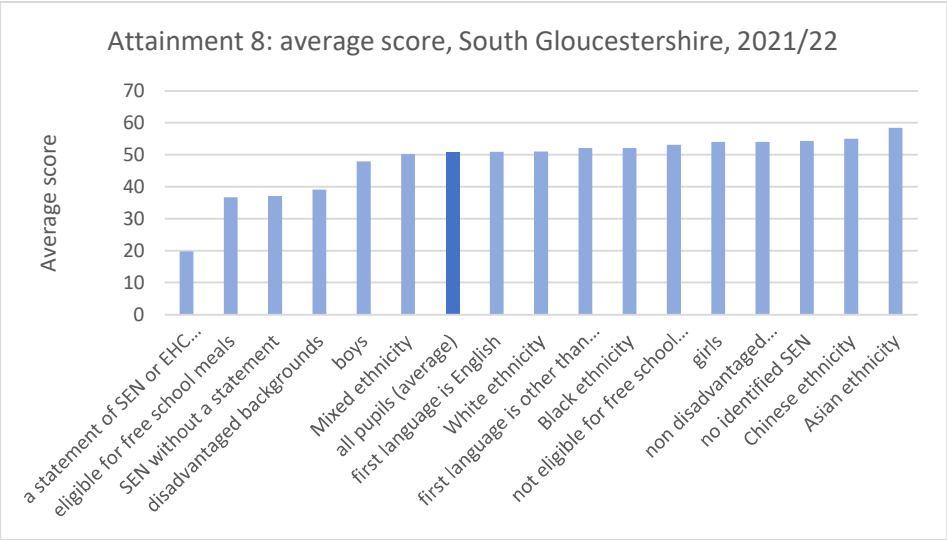
Figure 21: Inequalities in % achieving 9 - 4 in GCSE maths & English.



The average attainment 8 score followed a broadly similar pattern to % passing English and maths both locally and nationally, with a sharp increase in the teacher assessed years, and a fall to rates more in line with the expected trajectory pre-pandemic. Again there were inequalities with pupils with EHCPs, those eligible for free school meals, pupils with SEN support substantially lower than the all pupil averages and boys and children of mixed ethnicity slightly lower than the all pupils average [60]. Data for average attainment 8 score for children in care are only available up to 2020/21 when

GCSEs were graded differently to normal. The average score in 20/21 was 27.5, substantially lower than the 52.4 average for all pupils and would place it between EHCP and FSM eligible children.

Figure 22: Inequalities in average attainment 8 score



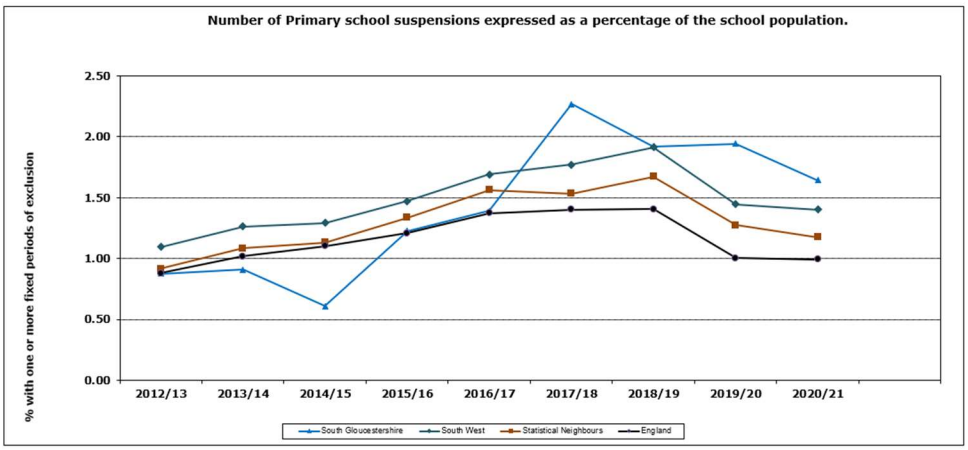
In many of the educational stages, although children with EHCPs had the lowest attainment rates, the fact that children eligible for FSM was broadly similar to children with SEN support was a surprise finding and needs further research.

Absences and exclusions

Persistent absences are lower than or similar to national averages from primary and secondary pupils at 7% and 15% respectively. However there are inequalities in vulnerable groups such as children in need and children on child protection plans of whom 48% and 50% respectively were classified as persistent absentees in 2021 [4] and there is evidence that more hidden vulnerable groups such as young carers may also have higher persistent absence rates (see vulnerable groups section).

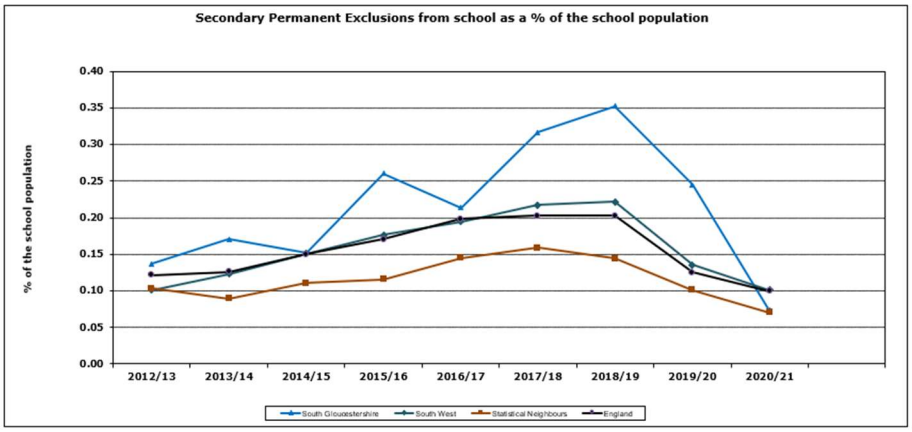
There had been increases in the proportion of fixed term exclusions (FTE) at primary and secondary phase prior to the pandemic, followed by a slight fall in the rate since. However, whilst in the secondary phase the rates are similar to national averages, at the primary phase they are higher than the England average.

Figure 23: Primary fixed term exclusions trend [4]



Permanent exclusions are and have historically been low at primary level, and whilst there has historically been a high permanent exclusion rate at secondary, the rate has fallen substantially since 2018/19.

Figure 24: Secondary permanent exclusions trend [4]



There is some evidence that there may be inequalities in exclusions with higher rates of FTE in Children looked after and Children in need, and higher rates of permanent exclusion amongst children in need [4]. Further inequalities in exclusions are suggested by local reports, with students from non-white backgrounds being both overrepresented in comparison with white school pupil exclusions, and students from ethnic minority backgrounds having on average fewer fixed term exclusions before a permanent exclusion than white students [66].

How pupils feel about school

Local insight gathered from the Online Pupil survey (OPS) captures South Gloucestershire pupils feelings about how stressed or worried they feel about school and how well supported they feel.

The majority of primary aged children (Years 4-6) didn't feel stressed by work, didn't worry about school and felt that they had enough help with emotional support. However, there was some variation by year group, gender and ethnicity with older children and girls more likely to feel stressed by school than younger children or boys, girls more likely to worry about going to school than boys and non-white pupils less likely to feel emotionally supported than white pupils.

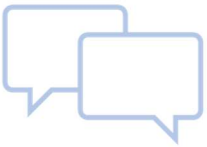
Overall, secondary pupils (years 8-10) report more stress and worry and feel less supported and there are again differences within these statistics. Feeling stressed was more common amongst older pupils and girls compared to younger pupils and boys. Girls and those who self-identify as 'other' are more likely to report worrying about going to school than boys. Feeling supported emotionally was less common amongst girls and those who identify their gender as other compared to boys, and less common amongst non-white pupils compared to white pupils [67].

There were inequalities by self-identified vulnerable groups, compared to children that didn't report belonging to any vulnerable groups. Children who reported having an SEN, receiving FSM, being a young career or having a social worker were more likely to report school related stress. Children with a SEN, a social worker or young carers were more likely to worry about going to school and children with a social worker were less likely to report getting enough help with emotional support. Conversely, children with SEN of EHCP were more likely than children with no vulnerabilities identified to report that they received enough help with emotional support [67].

When secondary children were asked about the extent to which they worried about certain topics girls were worried or very worried about every topic mentioned but all pupils were particularly concerned about their appearance and doing well at school. Pupils who did not identify as male or female were also worried about discrimination [8].

Local service insight

A variety of services working with young people, and various engagement events have provided feedback from young people in South Gloucestershire. Mental health was a key theme, including requests for early mental health support before crisis is reached and without stigma, confidentiality and privacy when accessing support, and targeted 1-2-1 support [68] [69] [70] [71]. Feedback from services working with vulnerable young people also indicated a need for good trauma informed understanding and responses from wider services [68].



Other key things young people say they needed to keep healthy and well were access to safe and affordable travel options to access services, healthy lifestyle knowledge and support including affordable nutrition, exercise, sexual health and drugs/alcohol advice [68] [71] [71]. Key factors for improvement of experience were knowledgeable staff, including LGBTQ+ knowledge and up to date advice on healthy social media usage, and more safe places for young people to socialise were also indicated as needed [68] [72] [71] [71].

Education and Child development Key Points

- The population is predicted to increase.
- There have been increases in the proportion of the school population that are eligible for Free School meals (FSM), have a Special Educational Need (SEN support & Educational Health Care Plans), are from an ethnic minority background and who have English as a second language (EASL).
- Amongst pupils with an EHC Plan, Autistic Spectrum Disorders (ASD) was the most common need, and among pupils with SEN support, Social, Emotional and Mental Health (SEMH) needs, and Speech, Language and Communication (SLC) needs are most commonplace.
- There are disparities in prevalence of SEN (SEN support & EHC Plans) by deprivation and ethnicity with higher rates in more deprived areas and among white pupils.
- Little is known about local variation or disparities in early years development.
- The Covid-19 Lockdown has impacted in children's development, especially in relation to communication and social skills
- Inequalities in educational attainment exist at all stages of compulsory education from reception through to end of Key stage four.
- The biggest gaps between the all-pupil average attainment at all key stages and specific groups identified in educational data are seen in those with a SEN (SEN support & EHC Plans), children in care and children eligible for free school meals.
- Boys and certain ethnicities, particularly Gypsy Roma Traveller, also exhibited notable gaps in educational outcomes to the all-pupil averages across the majority of the stages.
- Certain vulnerable groups, including young carers, children in need and children with child protection plans, are at greater risk of persistent absences.
- There are inequalities in rates of fixed term and permanent exclusions when observed by vulnerable group and ethnicity.

- Stress and worry about school increase with age and is more prevalent in girls, students that define their gender as other, amongst SEN (SEN support & EHC Plans) pupils and those in vulnerable groups.
- Students reported stress was most commonly related to schoolwork and their appearance.
- Feeling supported in school was less prevalent amongst girls, other gender, non-white students and those with social worker.

Education and Child Development Recommendations

Based on the key points raised and combined with local and national policy [57] [58] [56] and the council plan, the following recommendations have been suggested. These are broad aspect recommendations and reflect the broad nature the needs assessment. It is anticipated that specific recommendations will be identified as part of subject specific needs assessments.

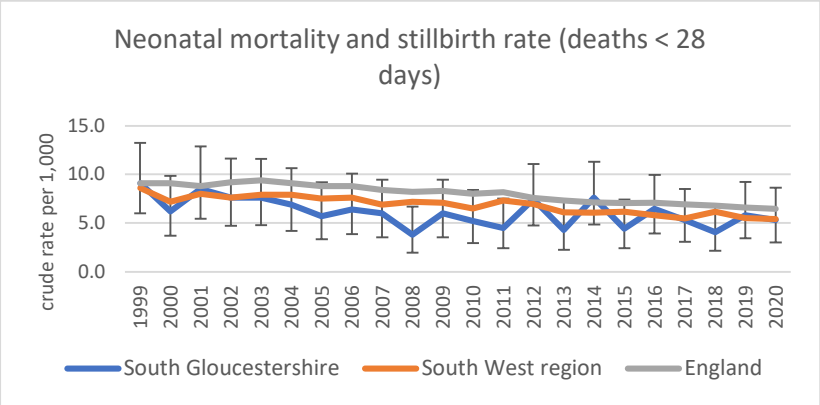
- Improve data collection and analysis in the Early Years to gain a better understanding of emerging needs before children go to school.
- Explore local variation and potential inequalities in early years development and issues with speech and language development through the ASQ
- Focus on improving communication skills in Early Years settings and first year of Primary school
- Conduct education needs assessment focusing on inequalities and intersectionality (attainment, attendance, exclusions)
- Explore how secondary schools can further support their students with stress and worry and monitor via the Online Pupil Survey (OPS)
- Utilise the school census to collect information on and monitor vulnerable groups including but not limited to young carers and children with social worker
- Ensure all services use insight from OPS to inform service and operational plans.

Health & Healthcare use

Mortality and morbidity

Mortality rates amongst babies, children and young people are similar to national averages and the overall health in children in South Gloucestershire is generally similar to or better compared to national averages but there are variations and disparities at a national level which are likely to be applicable locally too [16].

Figure 25: Neonatal mortality and still birth rates, 1999 – 2000 [16]



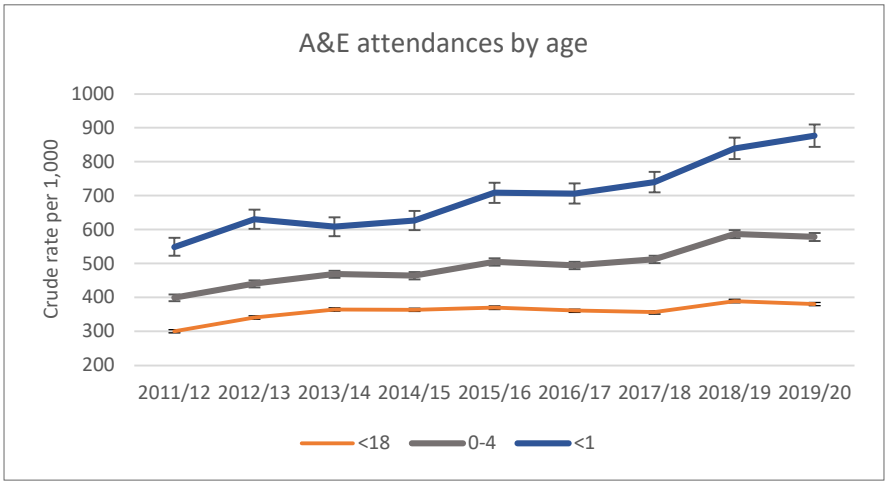
There are no readily accessible age specific disease or disability registers for children but school census data of 5–16-year-olds suggests 0.5% (1 in 200) have a physical disability, 0.5% (1 in 200) have a hearing or visual impairment and 0.4% have a severe or profound leaning disability. Data on immunisations suggests that coverage against all major childhood diseases is similar to or better than national averages, although coverage for HPV vaccine in 12–13-year-old girls is low and declining [16]

Healthcare use

Access to primary care and system wide data are not directly available to the local authority, most of the healthcare use identified here relates to A&E attendances and admissions to hospital and is therefore only a small part of a much bigger picture.

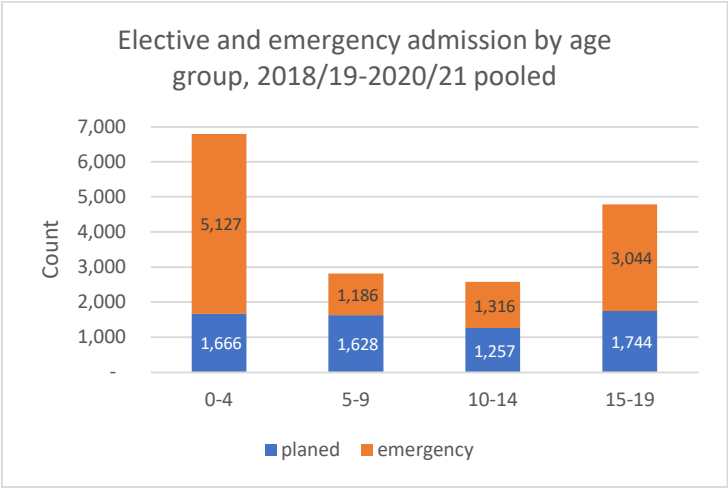
Accident and Emergency (A&E) attendance rates have been steadily increasing amongst children over the last decade and rates are highest (and have increased most) in babies under one and children under five [16].

Figure 26: Trend in A&E attendances by age group [16]

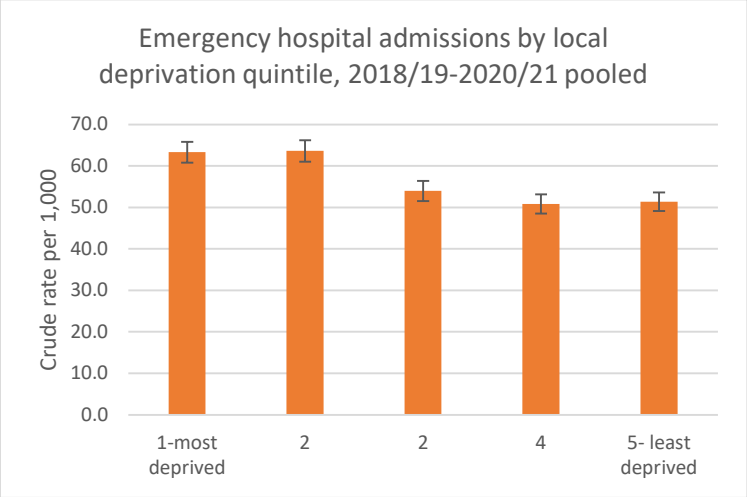


The majority of children's hospital admissions are for emergency rather than planned care, this is particularly true for 0-4- and 15–19-year-olds.

Figure 27: Elective and emergency admissions by age group [73]



Like A&E attendances, rates of emergency hospital admissions have been steadily increasing for over a decade, and rates are highest amongst youngest age groups (<1) [16] and amongst people that live in more deprived areas [73].



Hospital admissions relating to long term conditions such as Diabetes, Asthma and Epilepsy in under 18s are similar to national averages, with a reduction in the rate of asthma admissions seen over the last five years [16].

Healthy Lifestyles

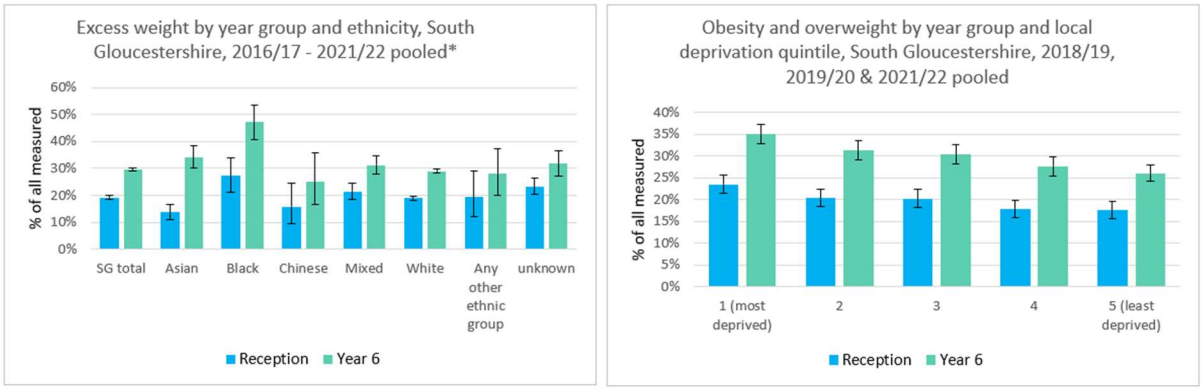
Diet, Physical activity & healthy weight

Diet and physical activity are important components of young lives. National survey data estimate that less than half of South Gloucestershire children meet the recommendations for an average of an hour of physical activity a day [16] and OPS data show 35% of girls and 44% of boys are close to meeting the recommendations [67] . The amount of exercise done per week generally declines with age and are lower amongst girls compared to boys [67].

Approximately a third of primary aged children report eating five or more fruits or vegetables a day, this falls to a sixth amongst secondary aged children [67]. Over a third of children report consuming sugary drinks (not including fruit juice / diet drinks) on at least a daily basis, more frequent consumption is slightly higher amongst older children and amongst boys. High sugar caffeinated energy drinks are reported to be consumed daily by 7% of primary aged children and 9% of secondary aged children [67]. There are known inequalities along economic lines in relation to access to healthy food and opportunities for physical activity.

Diet and physical activity are linked to healthy weight. Excess weight in 4–5-year-olds has been relatively steady locally over the last decade and occurs in around a fifth (20%) of reception aged children. There are however, disparities within South Gloucestershire with higher rates amongst children living in the most deprived areas compared to the least deprived, and higher rates amongst pupils from black backgrounds compared to white and Asian pupils (or the all-pupil average). Amongst 10–11-year-olds the rate of excess weight has been increasing with nearly a third of children overweight or obese. There are disparities within these statistics, with higher rates compared to the all pupil average seen amongst boys (though this could be due to opt out amongst girls), amongst children living in the most deprived areas, children from black ethnic backgrounds, and in children living in certain wards [74].

Figure 28: Inequalities in childhood excess weight [74]

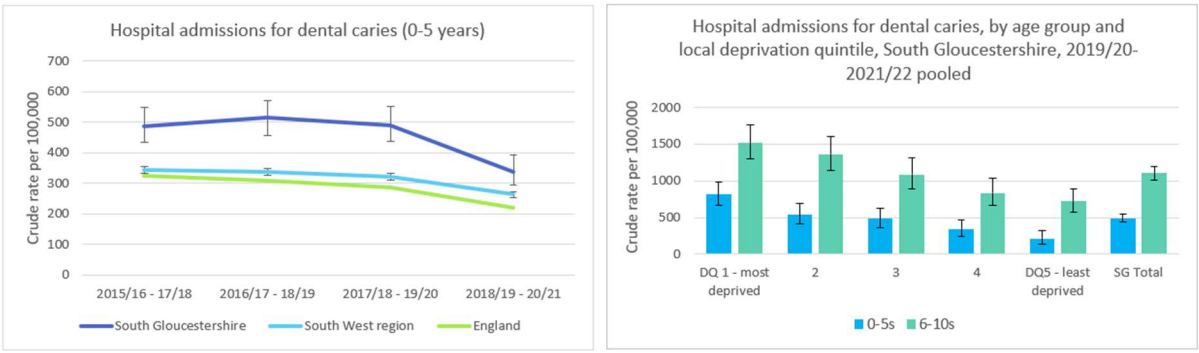


Oral Health

Diet is also a component part of oral health, along with dental hygiene practices and access to dentistry services. Whilst survey data looking at the number of filled, decayed or missing teeth in three and five-year-old hasn't historically indicated oral health as an issue locally [16], the latest release of the oral health survey data suggests that the average number of decayed, missing or filled teeth in 5 year olds has risen from 0.31 in 2018 to 0.72 in 2022. Although the numbers examined as part of the survey were small, it suggests that 17.4% of five year olds have decayed, missing or filled teeth, lower than national or regional values, but of these children, there is an average of 4 decayed, missing or filled teeth per child, higher than national or regional averages, with the majority (80%) of these being decay rather than fillings or extracted teeth [75]. This suggests that although decayed, missing or filled teeth may affect a smaller proportion of the 5-year-old population than at a national level, the dental health of these affected children could be worse than it is at a national level.

The removal of teeth due to decay represents the final option in response tooth decay and almost always involve admission to hospital and general anaesthetic. The rates of admission to hospital for tooth extraction amongst young children in South Gloucestershire is substantially higher than it is nationally [16]. There are an average of 94 hospital admissions per year amongst 0–5-year-olds and 178 admissions per year for 6-10-year-olds, accounting for over a third of all planned hospital admissions in this age group. Rates are substantially higher in more deprived areas compared to less deprived areas, and there are wards that stand out as having higher rates compared to the South Gloucestershire average [73]. There is also evidence that rates can be particularly high amongst people with learning disabilities and Autistic Spectrum Disorders [76].

Figure 29: Hospital admissions for tooth extraction due to dental caries [16]& [73]

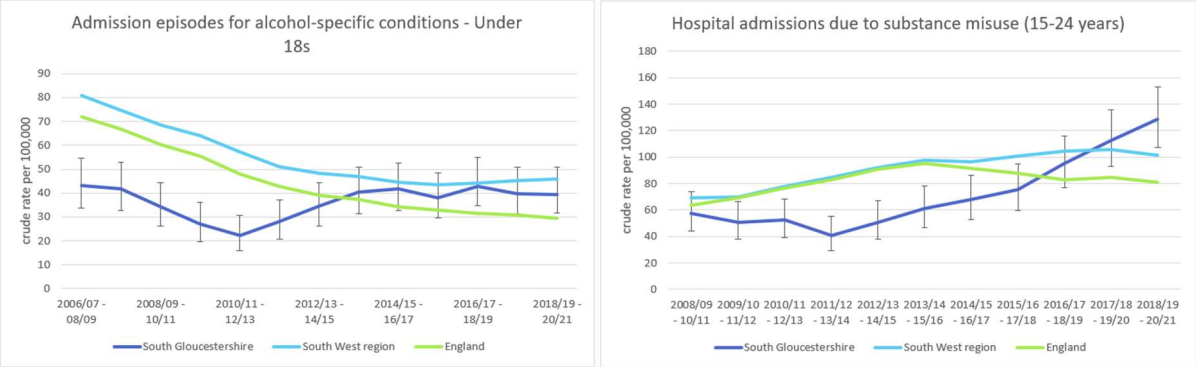


Smoking, alcohol, and substance misuse

The South Gloucestershire Online Pupil Survey (OPS) provides some insight into smoking, drinking and substance misuse. The vast majority (94%) of secondary age children have never tried illegal drugs and 83% of secondary school children never drink alcohol and 90% report having never smoked. One in fifty children reporting drinking alcohol monthly or more, with boys more likely to have tried it once or twice or drink regularly than girls. Girls are more likely to have tried smoking or smoke monthly with 1 in 25 reporting that they smoke monthly. These smoking figures do not include vaping or e-cigarettes [67].

Hospital admissions for alcohol specific conditions amongst under 18s, though having not increased in the last decade, have been higher than national averages for a number of years [16], though there are no current inequalities observed by sex or area deprivation [73]. Substance misuse admissions in 15-24 –year-olds have been steadily increasing for the last decade and are higher than national averages, but with no clear inequalities observed within these statistics.

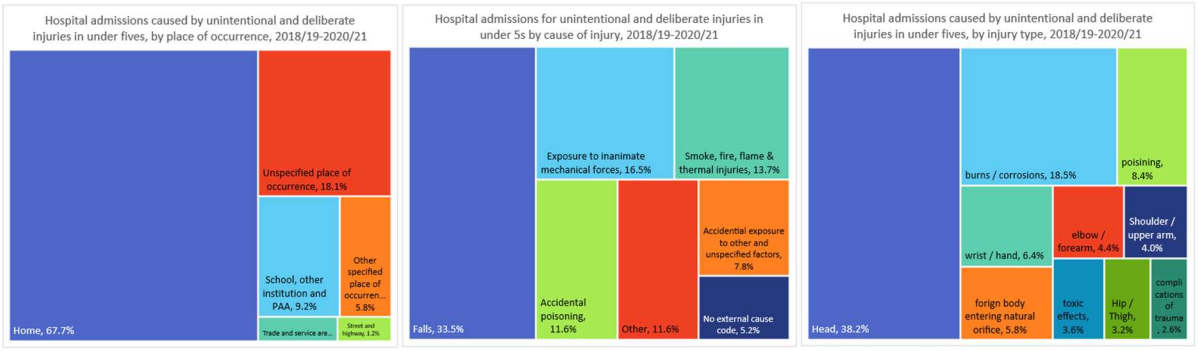
Figure 30: Alcohol specific and substance misuse hospital admissions [16]



Injuries

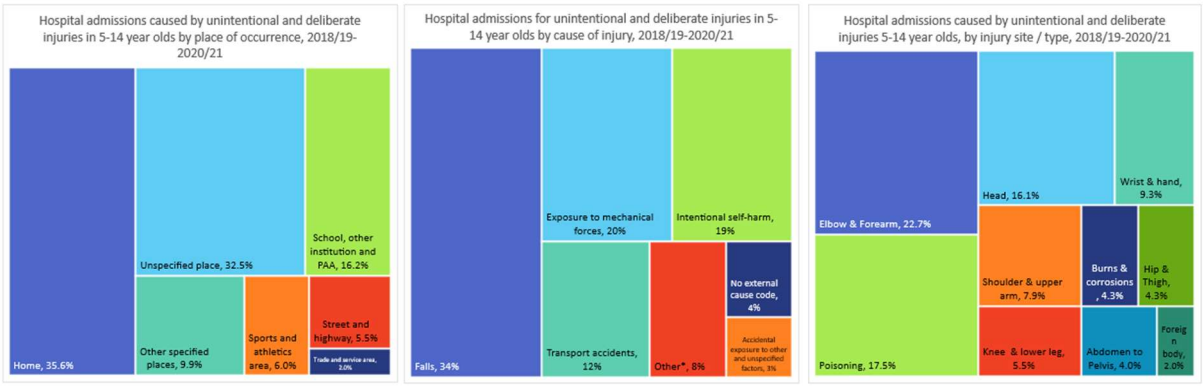
Whilst respiratory illnesses are the most common reason for emergency admission to hospital amongst babies, in children more generally, injuries caused by unintentional and deliberately are the leading cause of emergency admission to hospital and account for an average of 58 admissions per year in South Gloucestershire [16]. The rate of admissions for injuries in 0-4-year-olds has been relatively stable over the last five years, with previous inequality gaps by area deprivation having recently narrowed. The majority of injuries occur in the home, the most common injuries are head injuries and burns. Falls and contact with hot substances are the most common causes of these injuries [73].

Figure 31: Hospital admissions for unintentional and deliberate injuries in 0-4s by place of occurrence, cause of injury and injury type [73]



Amongst 5–14-year-olds, injury admission rates have been falling slightly and there is greater variation in places in which injury occur. A large proportion are injuries to the hand, wrist, forearm, upper arm or shoulder, with a notable proportion of head injuries and poisonings. Falls are again the leading cause of injuries but there has been an increase in the proportion of these which are caused by intentional self-harm, mostly in the older children in this age group.

Figure 32: Hospital admissions for unintentional and deliberate injuries in 5–14-year-olds by place of occurrence, cause of injury and injury site / type [73]



Amongst 15-24-year-olds, the rates have been increasing steadily, driven by large increases in intentional self-harm, which accounts for nearly 60% of admissions in this age group, with poisonings being the most common 'injury' type and mostly occurring in the home. There is strong evidence of inequalities by area deprivation and sex in older teens with higher admission rates amongst girls and those living in the most deprived areas [73].

Figure 33: Hospital admissions for unintentional and deliberate injuries in 15-24-year-olds by place of occurrence, cause of injury and injury site / type [73]

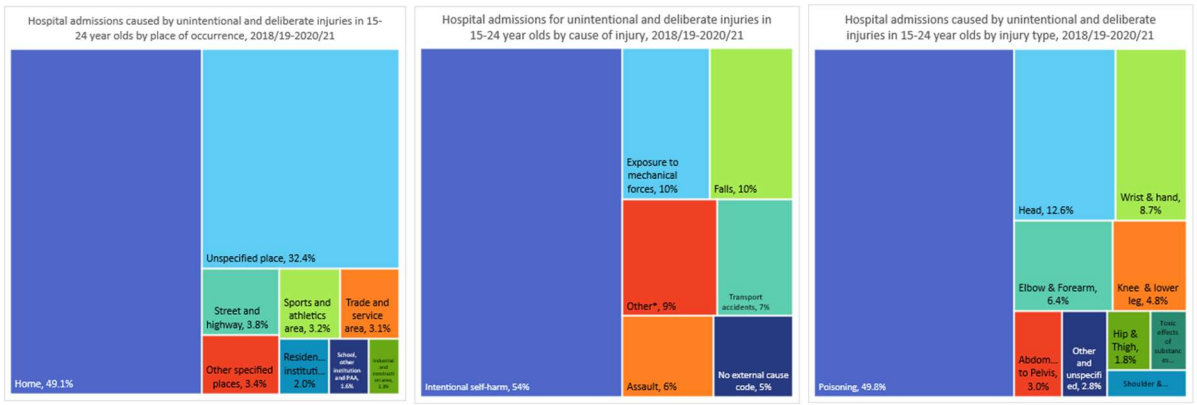
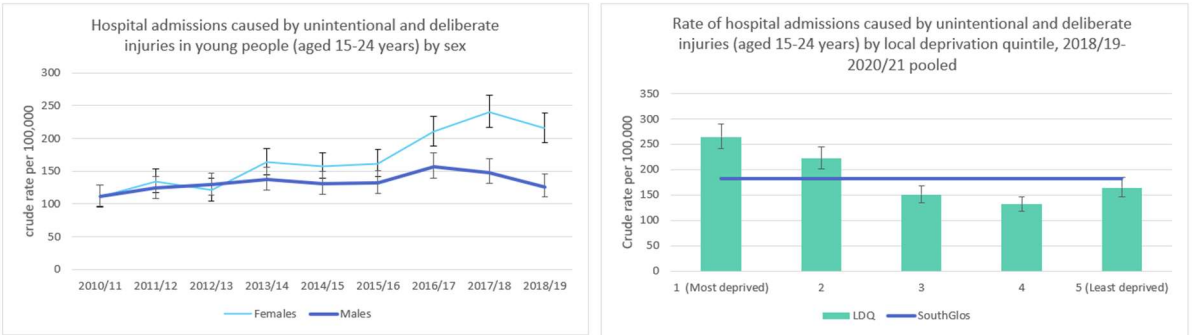


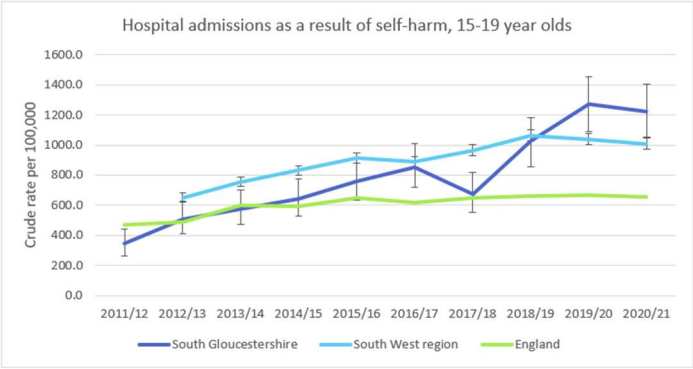
Figure 34: Inequalities in hospital admissions for unintentional and deliberate injuries in 15–24-year-olds

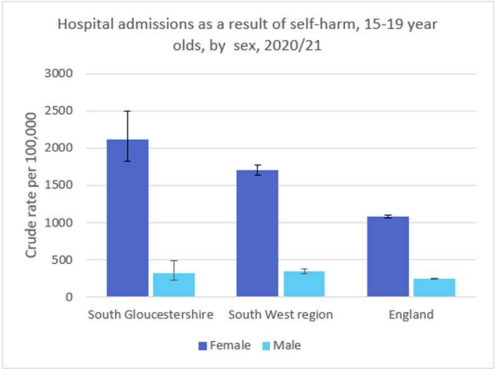


Mental Health and intentional self-harm

Intentional self-harm (ISH) admissions have been steadily increasing over the last decade and are substantially higher than national averages. Rates amongst 15–19-year-old girls are seven times that of boys [16] and means that, on average, one in 50 girls aged 15-19 will be admitted to hospital for ISH.

Figure 35: Hospital admissions as a result of self-harm in 15–19-year-olds [16]

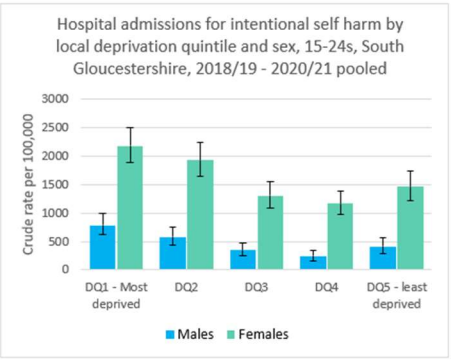


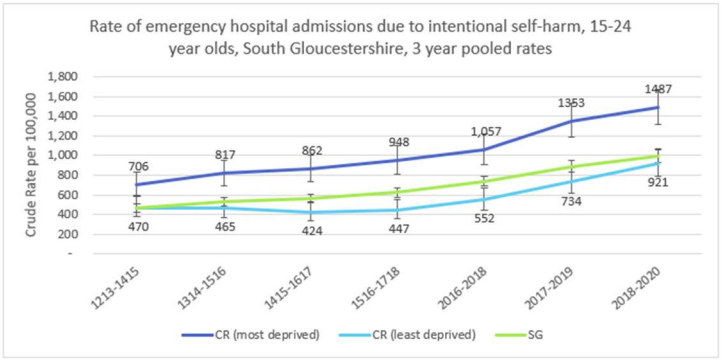


The majority (80%) of ISH admissions are for poisonings, mostly due to non-opioid analgesics such as paracetamol, but a substantial proportion are from prescription medicines such as antidepressants, antipsychotics and sedatives. Sharp object injuries account for 16% of admissions [73] but are possibly less likely to require an admission compared to an overdose.

Whilst 15–19-year-olds have the highest rates of ISH admissions amongst teens, there are an average of 35-40 self-harm admissions amongst 10–14-year-olds every year, though the rate appears to be relatively stable [16]. Inequalities by sex and area deprivation have been observed to be a persistent feature across all ages in relation to self-harm, with higher rates in more deprived areas and several wards have higher rates than the South Gloucestershire average [73].

Figure 36: Inequalities in hospital admissions for intentional self-harm [73]





Not all ISH will end up as a hospital admission and whilst an estimated 1% of the 15-19 population will end up with an ISH hospital admission, self-reported ISH in the OPS suggests that 26% of secondary school and year 12 pupils have self-harmed or deliberately taken an overdose in 2021, with 8.5% doing it once or twice (experimental self-harmers), 7.4% report doing it occasionally (monthly), and 8.9% reporting doing it frequently (weekly or more). The frequency of self-harm has increased since 2015 and girls are more likely to regularly self-harm than boys. While 9% of

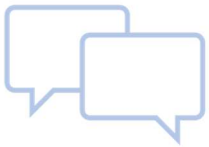
secondary and year 12 pupils reported having ever taken an overdose, cutting was the most common form of self-harm [67] [8].

Self-reported happiness and confidence about the future has been shown to decline with age in the last four years of OPS results, and mental health has declined since the Covid-19 pandemic in both primary and secondary pupils with more pupils reporting poor mental health. Children and young people who are young carers, those living in poverty and those with family members in prison have the lowest ratings for mental wellbeing compared to all pupils and other groups. Nearly a quarter of primary and secondary children repot being so worried about something that they cannot sleep at night, with girls being more stressed than boys and the gap increasing with age [8].

The recent Children's and young people's Mental Health and Wellbeing Needs assessment contains a broad overview of children's mental health and wellbeing as well as mental health services available. It highlights the importance of family, schools and access to universal services for emotional wellbeing, the impact Covid 19 has had on children's mental health, and the importance of early intervention and consideration of barriers and intersectionality when delivering services [32].

Local service insight

Local service provider insight and CYP engagement events relating to health and healthcare use amongst children and parents, provided some common themes. on what would help to keep people healthy. These include mental health support, accessible services, healthy eating and nutritional advice [70] [68] [71]. Safe places to have fun, building confidence, independence, and to be listened to [70] [72] [68]. Reducing drug use, removing stigmas associated with mental health support, support with sexual health and healthy social media use, and to have resources specifically adapted for young people were also identified as beneficial for health and wellbeing [70] [72] [68] [71]. Access to good quality parenting information and support was cited by parents of babies [50].



Health & Healthcare Key points

- Around a third of children self-report diet and exercise practices that do not align with recommendations on fruit and vegetable consumption and regular exercise.
- Around a third of children measured as part of the National Child Measurement Programme (NCMP) are classified as overweight or obese.
- There are high rates of tooth extraction due to decay in under 10s which contribute a large proportion of planned hospital admissions, and rates are disproportionately high in more deprived areas.
- A&E and emergency admission rates are rising in line with national trends.
- Inequalities in emergency admissions are apparent, with disproportionately more emergency admissions amongst people living in more deprived areas.
- Injuries in under 5s are a common cause of emergency admission and predominately occur in the home. Overall rates are stabilising and inequalities reducing.
- Intentional self-harm constitutes a growing and significant proportion of admissions to hospital in teens, drives high injury admission rates and disproportionally effects girls and those living in more deprived areas.
- There are high hospital admission rates for alcohol specific conditions compared to national figures, and high and increasing rates of substance misuse admissions amongst young people in South Gloucestershire

- Many intentional self-harm (ISH) incidents won't be captured in official data as only a small proportion result in hospital admissions. OPS data suggests 9% of secondary school age pupils self-harm regularly, with cutting the most common form of Intentional Self Harm.
- Stress and worry amongst students disproportionally effects girls, students identifying their gender as other, older students, non-white students, and vulnerable groups such as young carers and those with a social worker.

Health & Healthcare Recommendations

Based on the key points raised and combined with local and national policy [57] [55] [54] [58] [56] [77] the following recommendations have been suggested. With the exception of the mental health related recommendations, which are cross referenced against the CYPMHNA, the recommendations are broad aspect recommendations and reflect the broad nature the needs assessment. It is anticipated that specific recommendations will be identified as part of subject specific needs assessments.

- Work with ICB to gain improved understanding of A&E and emergency hospital admissions in relation to admission causes and patterns of use.
- Improve access to dental data and information and conduct an oral health needs assessment.
- Improve our understanding of inequalities in and barriers to healthy lifestyles and what evidence-based support could facilitate healthy eating and active lifestyles for children.
- Continue to help schools to support their pupils with stress, worry and mental health, especially vulnerable groups.
- Ensure information and advice on subjects children and parents want to know about is accessible and tailored to the user.
- Continue to explore issues relating to Intentional Self Harm (ISH) and possible strategies for early intervention.
- Focus resources on providing young people with social educational opportunities, through increased support for sports and youth clubs.
- See the bigger picture – issues with use of A&E, diet, oral health and physical activity could all be related and could benefit from a joined-up approach.

Systemwide recommendations

Whilst many recommendations can align with a single thematic area, there were a number which cut across all areas and need to be seen as system wide recommendations or aspirations. These recommendations have been based on the issues raised in each thematic area where a single systemwide recommendation may address a number of issues raised in separate areas, and where possible these have been aligned with local and national policy [57] [55] [54] [58] [56] [77].

- Use a Common Outcomes Framework, notably the Supporting Families Outcomes Framework to show progress across the system.
- Explore local access options to Child health Information System and direct access to maternity data to better understand current and future needs, inequalities as well as facilitate any local equality impact assessments or deep dive needs assessments.
- Increase opportunities for qualitative feedback of service users and health professionals, for example complete Family Feedback forms with service users and health professionals on a quarterly basis.

- Continue to and expand the practice of taking an inequalities-based look at outcomes and experiences of health, wellbeing, and education.
- Whole system to focus on Early Help and early intervention and improve support to children, young people and families at Universal and Universal Plus levels.

Summary

Whilst the health and wellbeing of the children and young people in South Gloucestershire is on the whole good, there are notable inequalities in relation to health, mental health, education engagement and educational outcomes, which impact children's foundations from which to move into adulthood. Many of these inequalities are related to the wider determinates of health, circumstances for which children have no control, and many of the poorer outcomes experienced as a result of adversity are preventable or attenable to some degree.

Poor mental health is a clear issue for children and young people, and whilst unhealthy diet and exercise habits appear relatively common and may be related to outcomes such as excess weight and tooth decay, there is a desire from children and young people to be more knowledgeable on how to remain healthy. Children and young people would like to have increased and more accessible services, early help, especially for mental health, and these expressed needs are recognised in the recommendations. There is a need to pay particular attention to vulnerable groups, improve our understanding of less visible groups, and approach addressing issues in a trauma informed and shame sensitive way.

There is also a lot that we don't know, or that we don't monitor, with systemwide recommendations for improved data collection and monitoring, and to encourage an evidenced based practice in relation to service planning, especially relating to vulnerable groups and wider determinate. Whilst there may not be any specific service level recommendations, this review provides the opportunity to summarise the high-level issues that children and young people face that align with local and national policy recommendations, and service leads may want to look further into conducting specific needs assessments to identify and address any service gaps.

Juliet Young Illustration

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