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Public Health & Social Research Unit

WEST SUSSEX

Early Years Needs Assessment

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Report by the
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List of Abbreviations

ASD	Autistic Spectrum Disorder
CBT	Cognitive Behavioural Therapy
CCG	Clinical Commissioning Group
CDH	Child Dental Health survey
CFC	Children and Family Centre
ChiMat	National Child and Maternal Health Intelligence Network
CMACE	Centre for Maternal and Child Enquiries
CPP	Children subject to a Child Protection Plan
CSEW	Crime Survey for England and Wales
CVD	Cardiovascular Diseases
DCLG	Department for Communities and Local Government
DCSF	Department for Children, Schools and Families
DfE	Department for Education
DLA	Disabled Living Allowance
DMFT	Decayed/Missing/Filled teeth
DWP	Department for Work and Pensions
ECS	Early Childhood Service
EHC	Education, Health and Care Plan
ELG	Early learning goals
EPPSE	Effective Preschool, Primary and Secondary Education
ETS	Environmental tobacco smoke
EYFS	Early years foundation stage
FGM	Female genital mutilation
FNP	Family Nurse Partnership
FRP	Family Reference Person
GFR	General Fertility Rate
GLD	Good level of development
GP	General Practitioner
HCP	Healthy Child Programme
HES	Hospital Episode Statistics
Hib	Haemophilus Influenzae type B
HLP	Home Learning Project
HRP	Household Reference Person
HSCIC	Health and Social Care Information Centre
HSE	Health Survey for England
HWB	Health and Wellbeing Boards
ICD-10	International Statistical Classification of Diseases and Related Health Problems
ID2010	Index of Multiple Deprivation 2010
ID2015	Index of Multiple Deprivation 2015
IDACI	Income deprivation affecting children index

IFS	Institute of Fiscal Studies
IVF	In-vitro fertilisation
JSNA	Joint Strategic Needs Assessment
KS3	Key Stage 3
KS4	Key Stage 4
LAC	Looked after children
LFS	Labour Force Survey
LSOA	Lower super output area
MenB	Meningitis B
MenC	Meningitis C
MMR	Measles Mumps and Rubella
MSOA	Middle Super Output Area
NCMP	National Child Measurement Programme
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
NPEU	National Perinatal Epidemiology Unit
NSPCC	National Society Preventing Cruelty to Children
NS-SEC	National Statistics Socio-economic Classification
OA	Output area
ONS	Office for National Statistics
PCHI	Permanent Congenital Hearing Impairment
PCT	Primary Care Trust
PCV	Pneumoccocal Vaccine
PHE	Public Health England
PHOF	Public Health Outcomes Framework
PIP	Personal Independent Payment
PTSD	Post-traumatic stress disorder
SEND	Special Educational Needs and Disability
SHA	Strategic Health Authority
SIDs	Sudden Infant Deaths
SLCN	Speech Language and Communications Needs
TFR	Total Period Fertility Rate
UNICEF	United Nations Children's Fund
WHO	World Health Organisation

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1 Introduction

The Early Years Needs Assessment is part of the West Sussex Joint Strategic Needs Assessment (JSNA), which examines the health and wellbeing needs of the local population. The health and wellbeing of children from conception to the age of two is a priority of the West Sussex Health and Wellbeing Board and the Future West Sussex Plan. This assessment aims to identify the needs of children under 5 and their families, from pre-birth, and to make evidence based recommendations to support the commissioning of services to meet these needs. In addition, from 1 October 2015, the responsibility for commissioning some public health services for 0-5 year olds transferred from NHS England to local authorities, particularly the Healthy Child Programme, which includes health visiting and the Family Nurse Partnership (FNP) programme.

1.1 Objectives

Given the broad range of needs and services for children under 5 years, this report is not an in depth review of any one specific service, but instead aims to provide an overview. The objectives of this needs assessment therefore include the following:

- To describe the population profile of children under 5 and their families in West Sussex
- To identify relevant national guidance and local policy in relation to early years
- To identify current and existing service provision in relation to domains impacting on early childhood outcomes; physical, psychosocial and emotional, cognitive and language development
- To identify gaps, barriers and unmet needs in current service provision
- To identify risk factors that impact on maternal, infant and child outcomes
- To provide an overview of the wider determinants of health and their impact on the under 5s and their families
- To provide an overview of services for children aged 0 – 19 years, vulnerable children, and/or at risk groups
- To provide an overview of maternal services that support parenting
- To provide evidence-based recommendations to ensure that the needs of 0-5 year olds are met in West Sussex.

1.2 Key Questions

Key questions that were asked as part of this needs assessment include:

- What are the characteristics of the population aged 0-5 years and their families in West Sussex?
- What is the current status of health and wellbeing of under 5 population and their families?
- What risks and supportive factors impact on early years development/child outcomes?
- What services and programs are currently provided/available to meet the needs of 0-5 year olds in West Sussex?
- How are the current services for under 5s meeting the needs of the various domains that impact on maternal, infant and child outcomes i.e. physical, cognitive, psychosocial domains?
- What are the barriers in accessing services?

- How do children and families perceive their needs?
- What family support services are available at different stages of early childhood?
- What services are available for under 5 high risk groups?

1.3 Methods

A mixed methods approach was used in carrying out the Early Years Needs Assessment in order to give a comprehensive overview of current and future needs. The approaches used included:

- An epidemiological approach (describing population characteristics, diagnosed incidence and prevalence of disease, and current services);
- A qualitative approach; views of families with children under 5 and professionals working with young children were sought through interviews, focus groups and an online survey;
- A comparative approach, comparing service provision between populations (comparative data is also used, where appropriate, to provide a relative profile of West Sussex with the South-East region and England);
- A corporate approach (obtaining views of professionals who work with children and their families);
- In addition, a literature review on evidence-based interventions was carried out.

1.4 Structure of the report

The report describes the state of children under 5 and their families in West Sussex and focusses on the following themes:

- A healthy start – summarising child health and wellbeing indicators
- Tackling disadvantage – determinants of child health, risk and protective factors
- Children with special educational needs and disabilities/safeguarding children
- Importance of communities and partnerships

2 BACKGROUND

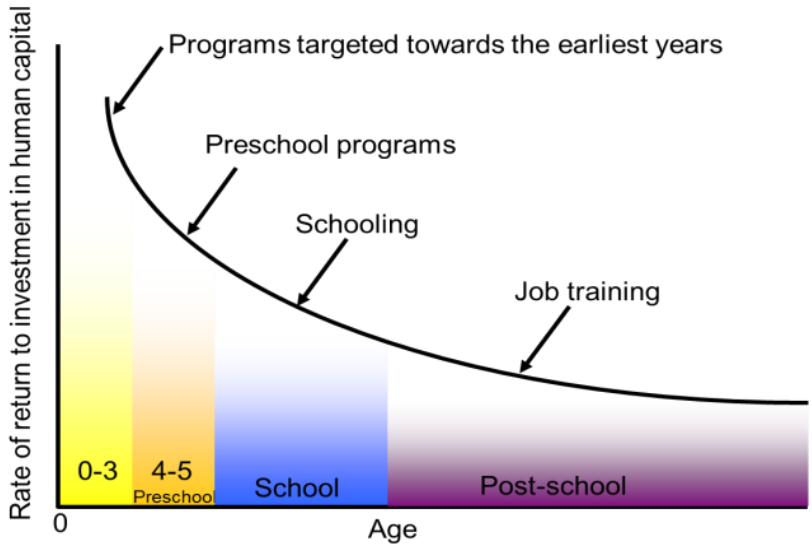
Early Years Child Development

2 Background information - Early years child development

The early years of a child's life, starting from prenatal development to the first five years, are one of the most important periods in their development[1, 2]. There is strong evidence that some economic, demographic, and social risks can harm a child's development and contribute to behaviour problems, failure at school, and poor health outcomes[3]. The Marmot report on health inequalities reiterates that social and biological influences on development start at conception, or earlier in terms of genetic effects, and these accumulate throughout pregnancy to influence the health of the child at birth[4]. Early years, therefore, provide a window of opportunity for child and family interventions to ensure that every child has the best start in life. Moreover, there is emphasis on the first 1,000 days of life (from conception), which offer a critical point for establishing a good foundation for a healthier and prosperous future for the child[5]. Consequently, an understanding of early years development can assist in the identification of interventions that can complement or enhance current programs for children and families [6].

Investment in early years has a high rate of returns as compared to interventions in the later stages of life [7, 8], (Figure 1). For example, every £1 invested in quality early care and education saves taxpayers up to £13 in future costs[i] and early years parenting programmes to prevent conduct disorder pay back £8 over six years for every £1 invested[9]. While there is considerable evidence for increased investment in the early years, arguably, there is an established pattern of under-investment in early years interventions in the UK, when compared to other areas of expenditure[4, 10]. One of the main reasons for under-investment is that the long term benefits accrue to different stakeholders (e.g. NHS, Local Authority, police) over a period of time, and this may act as a disincentive for any single organisation to invest within the early years. However, economic benefits should not be the sole focus for investment, rather, investment in the health and wellbeing of children should also be prioritised in order to give children the best start in life.

Figure 1 - Returns on human capital across the age span



Source: Heckman and LaFontaine, 2007

[i] Public Health England. Improving school readiness. Creating a better start for London https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/459828/School_readiness_10_Sep_15.pdf

2.1 Determinants of Child Health and Development

Childhood growth and development encompasses three key interdependent domains[11]:

1. **Physical growth and development** – changes in body size, shape, appearance, functioning of body systems (including the formation of tissues, perceptual capacities and muscle strength)
2. **Cognitive development** – focuses on changes in intellectual abilities, including learning, memory, reasoning, social and emotional skills and language development
3. **Social/emotional development** - Changes in the unique way the child relates to the world and caregivers, including understanding and expression of emotions, interpersonal skills and trust

Each child's development has a unique trajectory, influenced by these developmental domains, biological factors (including the child's genetic makeup) and the wider social and environmental context, which, together, contribute to health and wellbeing. Children do not grow up in isolation; rather, human character and competence are shaped by the continuity and changes in families, schools, peers and communities.[12]

An ecological approach takes into account a lifespan perspective and recognises that giving children a better start depends on "services that attend to children's psycho-educational development and social and economic circumstances at multiple levels in a coherent and integrated way"[13]. To capture the wide range of determinants of child health and wellbeing, this needs assessment takes on an ecological view of pregnancy and early years, which focuses on the interactions between both nature and nurture[14]. Thus the domains noted above place some children at risk in early life; however, life experiences and circumstances such as support, nurturance and stimulation by family, peers and social institutions can mediate this risk [2]. Accumulating risk factors during childhood produce high levels of inequality in educational achievements and development.

Child development risk factors are those factors, conditions or attributes that contribute to a child having poor outcomes whilst protective factors are those that mitigate or eliminate risk. Research has found that, although not deterministic, a number of risk and protective factors contribute to the probability of children in their early years (0-5) and later life experiencing social, emotional and cognitive development difficulties[12]:

Child Development Risk Factors

- Low birth weight
- Smoking in pregnancy
- Drug and/or alcohol misuse in pregnancy
- Maternal/parental mental illness
- Domestic abuse/violence
- Poverty/socio-economic deprivation
- Teenage parenthood
- Worklessness

Protective factors

- Stable and supportive family relationships

- Parental education level
- Good maternal nutrition and healthy weight
- Stable maternal/parental mental health
- Non-misuse of substances, tobacco, drugs and/or alcohol
- Breastfeeding and nutrition
- Higher socio-economic status
- Immunisations
- Environment (including access to green spaces and housing)
- Good quality early years education/childcare.

2.1.1.1 Pregnancy and maternal health

Child development begins before birth when the health of a baby is significantly influenced by the health and well-being of their mother[7]. A wealth of evidence support that the mother's physical and mental health can have an impact on the development of the foetus during pregnancy. As a result, the mother's lifestyle choices, such as smoking and/or excessive alcohol consumption can expose the baby to toxins, negatively affecting their growth, brain activity and development. Moreover, mental illness during pregnancy and after birth, such as postnatal depression, can have a negative impact on infant feeding, interactions between mother and baby and the mother's perceptions of the baby's behaviour and increases the risk of the child developing long-term developmental problems.

2.1.1.2 Nutrition

Poor nutritional intake during pregnancy can have a significant impact on the development and growth of the foetus, including cognitive and psychosocial development. Under-nutrition pre-birth has been associated with low birth weight, which is also linked to later adult disease such as coronary heart disease, and high blood pressure.[15, 16] Baker also postulates that, in order to sustain its development in cases of inadequate nutrition, the foetus adapts to under-nutrition during pregnancy and these adaptations permanently changes their structure and metabolism, programming later coronary heart disease[16].

There is clear evidence that breast milk is the best source of nutrition after birth. Breastfeeding provides a protective factor for the health of the baby and the mother and can also reduce potential health risks in later childhood. Breast milk is also important for cognitive development. The Millennium Cohort study found that children who were breastfed were one to six months ahead in terms of cognitive development when compared to those who were never breastfed.

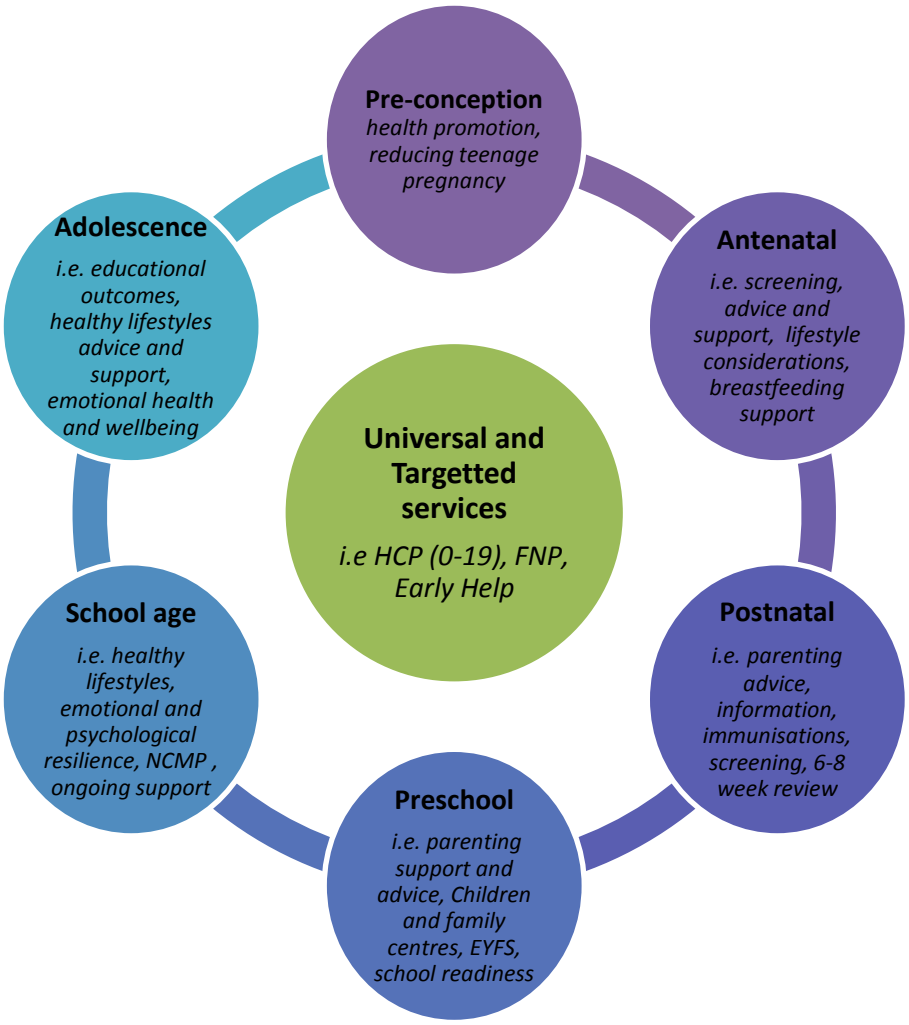
2.1.1.3 Children's socio-economic circumstances

Studies conducted show that children from lower socioeconomic classes are at an increased risk of premature mortality, morbidity and disability. The WAVE trust review highlighted that children experiencing persistent low socio-economic status at both 9 months and 3 years are more likely to have poor behavioural, learning and health outcomes. However, inequalities in health and household income can have adverse effects on children that go beyond mortality and morbidity[3]. For example, poverty can increase the risk of adverse outcomes, such as unemployment, being a teenage parent, and poor housing, and can reduce their ability to improve their circumstances[15].

2.1.2 Children and young people (0 -19) services across life stages

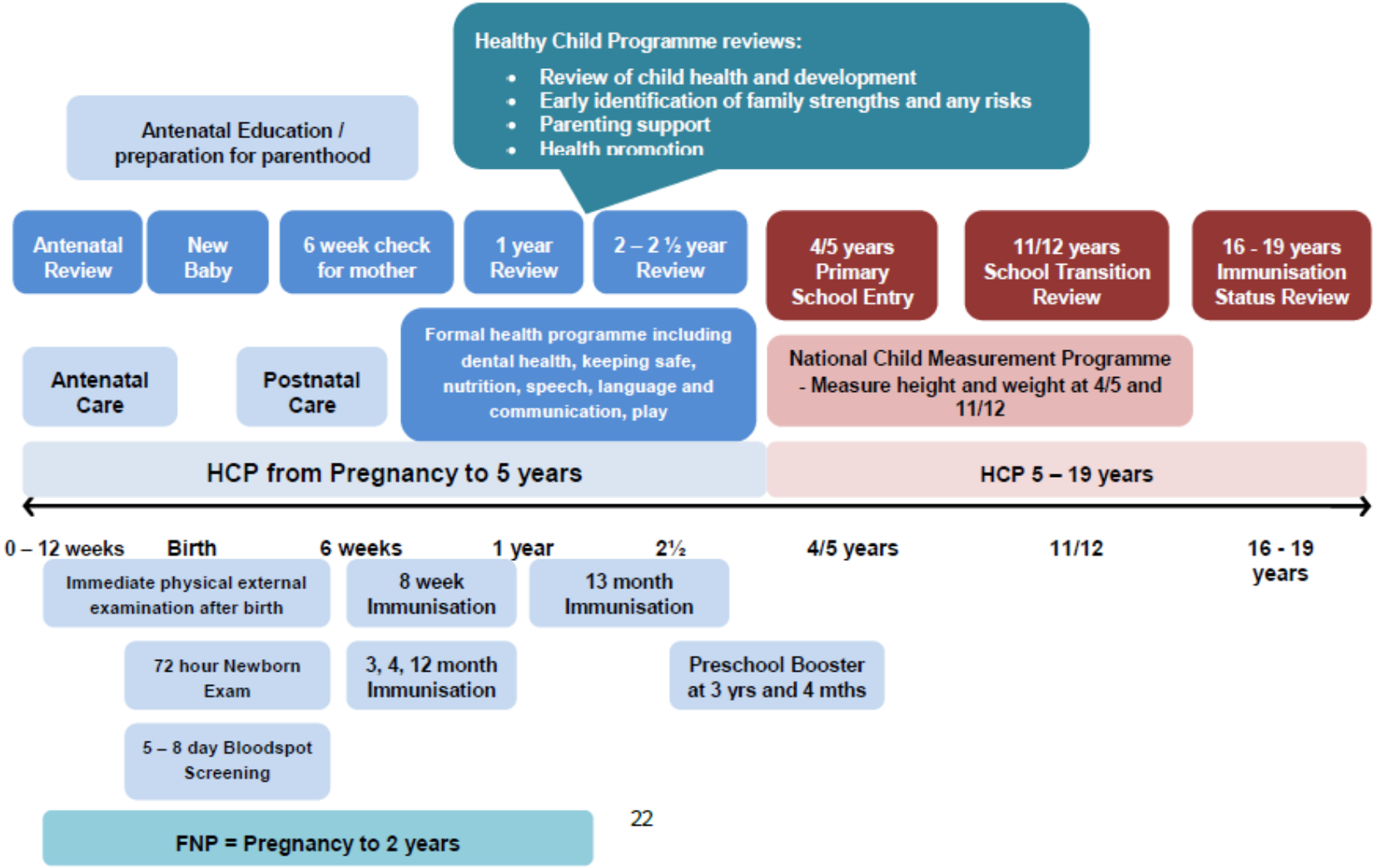
Early years outcomes (cognitive and non-cognitive) are an important predictor of later outcomes across the lifespan, including teenage pregnancy and wider health[4]. The early years of life lay the foundations for later resilience in terms of key aspects of children's development, helping and preparing them for adolescence and adulthood. The transfer of commissioning of public health services for children aged 0-5 from the NHS to local authorities presents an opportunity to strengthen services for children and families using the life stage approach as shown below.

Figure 2 - Children and young people (0 -19) services across life stages



During the antenatal, post natal and pre-school periods there are a number of statutory contact/visits, supporting maternal and child health. These also provide opportunities for the identification of children and families requiring additional support and ensure effective targeting of interventions (Figure 3).

Figure 3 - The Universal Elements of the Healthy Child Programme



Source: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/192978/27_Children_s_Public_Health_Services__pregnancy_to_5__VARIATION_130422_-_NA.pdf

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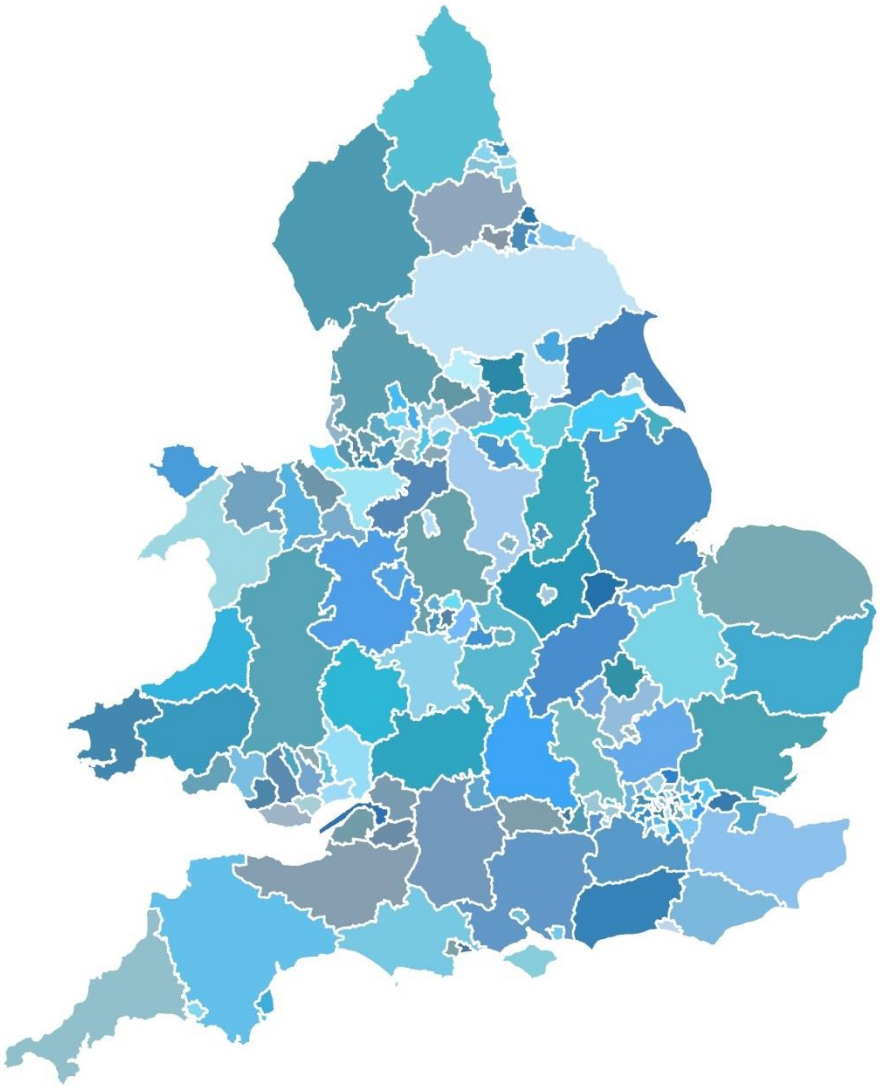
3 NATIONAL POLICY

Context and Background



3 National policy context and background

The drive to target children and families during the early years has been pushed forward by a range of national policies in this area:

3.1 Healthy Child Programme 0-5 (HCP)[17]

The Healthy Child Programme (HCP) is a universal early intervention and prevention public health programme for children and their families from pregnancy to five years. It offers every family a programme of screening tests, immunisations, developmental reviews, and information and guidance to support parenting and healthy choices – all services that children and families need to receive if they are to achieve their optimum health and wellbeing. The HCP provides an opportunity to identify families that need additional support and children who are at risk of poor outcomes. It includes referral to specialist services and signposts families to wider sources of support. The provision of a high-quality, visible and accessible HCP is a core health responsibility contributing to the goals of *Every Child Matters* (HM Government, 2004) and services provided in Sure Start children's centres.

The core element of the programme is the delivery of integrated services, led by health visitors, and includes Sure Start children's centre staff, GPs, midwives, community nurses and others, all providing support to families with young children. The effective implementation of the HCP should lead to:

- strong parent–child attachment and positive parenting, resulting in better social and emotional wellbeing among children;
- care that helps to keep children healthy and safe;
- healthy eating and increased activity, leading to a reduction in obesity;
- prevention of some serious and communicable diseases;
- increased rates of initiation and continuation of breastfeeding;
- readiness for school and improved learning;
- early recognition of growth disorders and risk factors for obesity;
- early detection of – and action to address – developmental delay, abnormalities and ill health, and concerns about safety;
- identification of factors that could influence health and wellbeing in families; and
- better short- and long-term outcomes for children who are at risk of social exclusion.

3.2 Early Years Foundations Stage (EYFS)[18]

The Early Years Foundation Stage (EYFS) was introduced in 2008 and it sets the statutory standards that all early years providers must meet. The overarching principles of the EYFS framework are:

- every child is a unique child, who is constantly learning and can be resilient, capable, confident and self-assured;
- children learn to be strong and independent through positive relationships;

- children learn and develop well in enabling environments, in which their experiences respond to their individual needs and there is a strong partnership between practitioners and parents and/or carers; and
- children develop and learn in different ways and at different rates. The framework covers the education and care of all children in early years provision, including children with special educational needs and disabilities.

An evidence-led independent review of the EYFS was conducted in 2011 by Dame Clare Tickell and a total of 46 recommendations were made. The Tickell review was followed by an update of the EYFS Framework 2012, and the most recent update in September 2014. The Early Years Foundation Stage (EYFS) 2014 comprises of seven areas split between prime and specific areas of learning and development as follows:

Prime areas

- Communication and language development
- Physical development
- Personal, social and emotional development

The specific areas of learning are:

- Literacy
- Mathematics
- Understanding the world
- Expressive arts and design

As of 2016/17, there are likely to be some changes to the assessment and reporting arrangements for the Early Years Foundation Stage Profile. From September 2016 the Early Years Foundation Stage Profile will no longer be compulsory. The Early Years Foundation Stage itself will continue to be statutory, supporting children to experience a broad and engaging programme of learning in reception[ii].

3.3 Supporting Families in the Foundation Years[19]

The importance of the foundation years has been recognised by the Government in the *Supporting Families in the Foundation Years*, which sets out the vision for the services that should be offered to parents, children and families. *Supporting Families in the Foundation Years*, is a joint policy by the Department for Education (DfE) and the Department of Health (DH) and brings together the Government's policies for early years, from pregnancy to age five. It describes the system needed to make this a reality, building on what has already been achieved.

Following a series of evidence based reviews and recommendations, the paper focuses on the key factors for promoting child development and family health and their implementation;

- Child health and development

[ii] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/297595/Primary_Accountability_and_Assessment_Consultation_Response.pdf

- Early childhood education and childcare
- Supporting parents and families
- Early intervention
- Workforce
- Special educational needs

3.4 Maternity and Early Years: Making a Good Start to Family Life [20]

The journey from early pregnancy to parenthood is the Government's main focus in its vision for maternity and early years' services. Experiences in pregnancy and early childhood have an influence on children's physical and emotional health, learning and behaviour throughout their lives. In order to build stronger foundations for children, early family life is critical and, in this strategy, the Government highlights the importance of strong family relationships, health and healthy lifestyles of mothers and fathers, positive communities and environmental settings and support from services. This strategy also acknowledges the crucial role existing services play in supporting children and families during pregnancy, birth and parenthood and the need to ensure an integrated service that takes on a whole family approach to maternity and early years services.

3.5 The Marmot Review: Fair Society, Healthy Lives [7]

The Marmot review into health inequalities in England proposed evidence based strategies for reducing health inequalities. Given the negative impact of health inequalities on well-being and life expectancy, the review asserts the need for a life course approach that addresses the social determinants of health in tackling inequalities.
The six key policy areas identified to reduce inequalities are:

- Giving every child the best start in life
- Enabling all children young people and adults to maximise their capabilities and have control over their lives
- Creating fair employment and good work for all
- Ensuring a healthy standard of living for all
- Creating and developing healthy and sustainable places and communities
- Strengthening the role and impact of ill health prevention

The review identified the key time points in delivering policies that give every child the best start in life are during the early developmental life cycle (children below the age of 5). The review stresses that, given the strong evidence that early years have lifelong effects on health and wellbeing, there is a need to tackle health inequalities by addressing the social gradient in children's access to positive early life experiences. One of the recommendations made by Sir Marmot is support for families, including the provision of high quality maternity services, parenting programmes, childcare and early years' education to meet needs across the social gradient.

3.6 Early intervention: the next step[8]

"*many of the costly and damaging social problems in society are created because we are not giving children the right type of support in their earliest years, when they should achieve their most rapid development*" G. Allen

Graham Allen MP chaired an independent review on early intervention. This focused on the identification of best practice in Early Intervention and the dissemination and delivery of best practice at a local level. The second part of the report focuses on new ways to fund early intervention in the future. The review stresses the importance of early interventions in breaking the cycle of poverty and disadvantage and improving children and young people's outcomes. It makes a strong case for investment in Early Intervention, drawing on scientific evidence across health, economics, and social sciences to support the cost effectiveness of early intervention and its benefits to society.

The Early Intervention: Next Steps report identified the following as the top 3 recommendations:

1. The 19 'top programmes' identified in the report should be supported and work undertaken with local areas to explore how they might be expanded. However, this list of 19 should not be regarded as exhaustive or complete.
2. Early Intervention should build on the strength of its local base by establishing 15 local Early Intervention Places, run by local authorities and the voluntary sector, to spearhead its development.
3. The establishment of an independent Early Intervention Foundation to support local people, communities and agencies, with initial emphasis on the 15 Early Intervention Places.

3.7 Health and Social Care Act 2012

The Health and Social Care Act 2012 brought about the reorganisation of the health and wellbeing commissioning landscape, including the commissioning of early years services. From 1 April 2013, Primary Care Trusts (PCT) were abolished and Health and Wellbeing Boards (HWB), NHS England and Clinical Commissioning Groups (CCG) were established. The responsibility of commissioning most health and wellbeing services was transferred from PCTs to:

- **CCGs** – responsible for commissioning the majority of NHS services including urgent and emergency care, maternity and new-born services and children's healthcare services.
- **Local Authorities** – responsible for commissioning or providing public health and social care services, including those for children between five and 19 years old. In addition, the responsibility of commissioning public health services for 0-5 year olds transferred from NHS England to local authorities on 1 October 2015.
- **NHS England** – responsible for commissioning some primary care and specialist services, including national screening and immunisation programmes for children.

3.8 Public Health Outcomes Framework (PHOF)

PHOF sets out a vision for public health, the outcomes and indicators that captures how well public health is being improved and protected. The framework focuses on the wider determinants of health, with two high-level outcomes to be achieved across the public health system, and groups further indicators into four 'domains' that cover the full spectrum of public health. The overarching outcomes are:

1. Increased healthy life expectancy
2. Reduced differences in life expectancy and healthy life expectancy between communities.

Table 1 – The PHOF indicators related to children under 5

Domain	Indicator
1. Improving the wider determinants of health	• Children in poverty • School readiness • Killed and seriously injured casualties on England's roads
2. Health improvement	• Low birth weight of term babies • Breastfeeding • Smoking status at time of delivery • Under 18 conceptions • Child development at 2-2½ years (under development) • Excess weight in 4-5 and 10-11 year olds • Hospital admissions caused by unintentional and deliberate injuries in children and young people aged 0-14 and 15-24 years • Emotional well-being of looked after children (data not currently available for West Sussex)
3. Health protection	• Population vaccination coverage
4. Healthcare public health and preventing premature mortality	• Infant mortality • Tooth decay in children aged 5

3.9 The United Nations Convention on the Rights of the Child (UNICEF 1989)

The Convention on the Rights of the Child recognises the human rights of children and stipulates the basic human rights that must be realised for children to develop their full potential, free from hunger, neglect and abuse. The Convention also acknowledges the individuality of the child as a member of a family and community, with rights and responsibilities appropriate to his or her age and stage of development. In-order to fulfil its obligation under the Convention, the Government's strategies for children and early years are underpinned by these general principles and basic health and welfare articles.

4 LOCAL POLICY

Context and Background

4 Local Policy context and background

4.1 West Sussex Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy 2015-18

The Health and Social Care Act 2012 introduced Health and Wellbeing Boards (HWB), which now have a duty to develop and provide Joint Strategic Needs Assessments (JSNA) and Joint Health and Wellbeing Strategies. JSNAs are the means by which organisations, including local authorities, NHS, voluntary and community sectors, work together to understand and agree the needs of the local population, and the joint health and wellbeing strategy sets the priorities for collective action. JSNAs and joint health and wellbeing strategies sit at the heart of commissioning decisions, underpinning improved health, social care and public health outcomes for the whole community.

The first West Sussex Joint health and wellbeing strategy (2012-2015) identified three priority areas: children and families; healthy workforce and dementia. This was refreshed in 2015 and 3 key priorities were identified as shown in Table 2.

Table 2 – West Sussex Health Joint Health and Wellbeing strategy

Priority	Outcome
Early years (0-2 olds)	To optimise life opportunities for 0-2 year olds by supporting families
Wellbeing and Resilience	A comprehensive system to support wellbeing and resilience for the whole of the West Sussex population, that is locally based and better integrated with treatment services
Workforce	A vibrant and motivated workforce with the right training and the right values to support a high quality health and care system.

Source: WS Health and Wellbeing Board

4.2 West Sussex Early Help Action Plan 2014-17

The West Sussex Early Help Action Plan[iii] sets out its vision to provide help and support at the earliest opportunity to families experiencing problems. The Early Help Plan aims to ensure that effective early help systems, processes and services are in place throughout West Sussex to support children in the county. The Early Help approach for all organisations working with children and young people is;

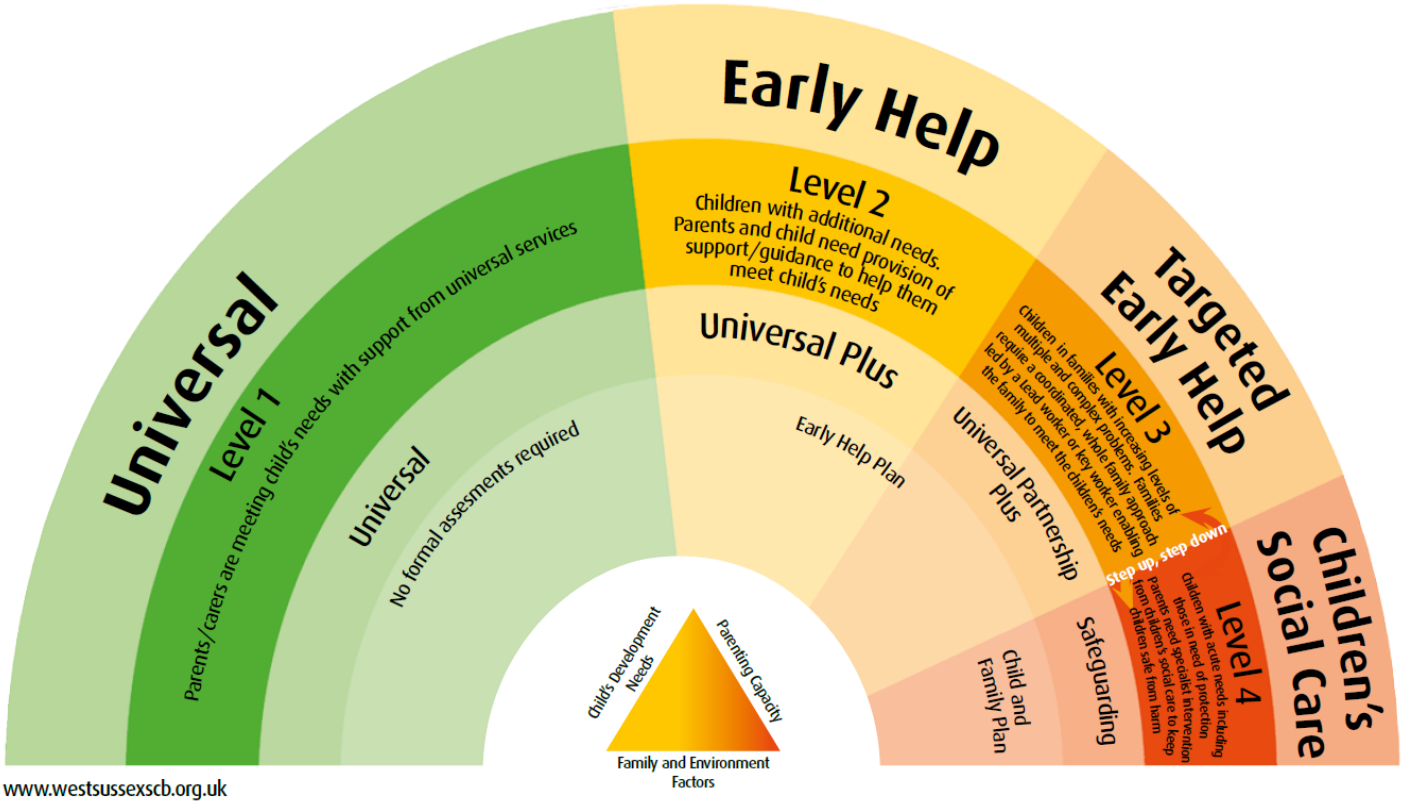
'Smarter in the way we do things; children, young people and families will get what they need **sooner**; we will ensure children live in strong protective families where they are **safer** and that outcomes for them will be **stronger"**.

The plan maps onto the West Sussex continuum of need (Figure 4) targeting families who need early help, at levels 2 and 3, and is predicated on the provision of good universal services that support families such as

[iii] The West Sussex Think family partnership. Early help action plan for West Sussex 2014-17. https://www.westsussex.gov.uk/media/4944/early_help_action_plan.pdf

the health visiting service. The continuum of need is a tool that practitioners use to make sense of services and the needs of the families who use them.

Figure 4 – The West Sussex Continuum of Need



To deliver this vision all organisations commit to a set of overarching principles described below. These provide guidance for commissioning and the delivery of Early Help services.

1. Early help and intervention is everyone's job.
2. Most families with a little support can, and do overcome difficulties.
3. The best outcomes are often achieved when people are enabled to sort out their own problems, rather than us doing it to them or for them.
4. Barriers that stop families getting the Early Help they need must be identified and removed.
5. The voice and experience of children, young people and families should influence service design and delivery.
6. Make best use of reducing public sector resources.

4.3 Future West Sussex Plan

Future West Sussex Plan outlines the initiatives the council will be delivering, in collaboration with its partners and the 3 priorities for 2015-2019 are as shown in Table 3.

Table 3 - Future West Sussex Priorities

Priorities	Outcomes
Giving children the best start in life	• Improved physical and emotional wellbeing • Families receive the support they need early • Children are safe and secure • Young people are ready for school and ready for work
Championing the West Sussex economy	• Growth of jobs • Growth of enterprise • Skills: ensuring local people of all ages have support to access work • Improving infrastructure that business and local communities need to support economic growth
Supporting independence in later life	• Increased financial security • Adults are safe and secure • Increased independence • Healthy life expectancy

5 LOCAL CONTEXT

General demographic and socio-economic factors

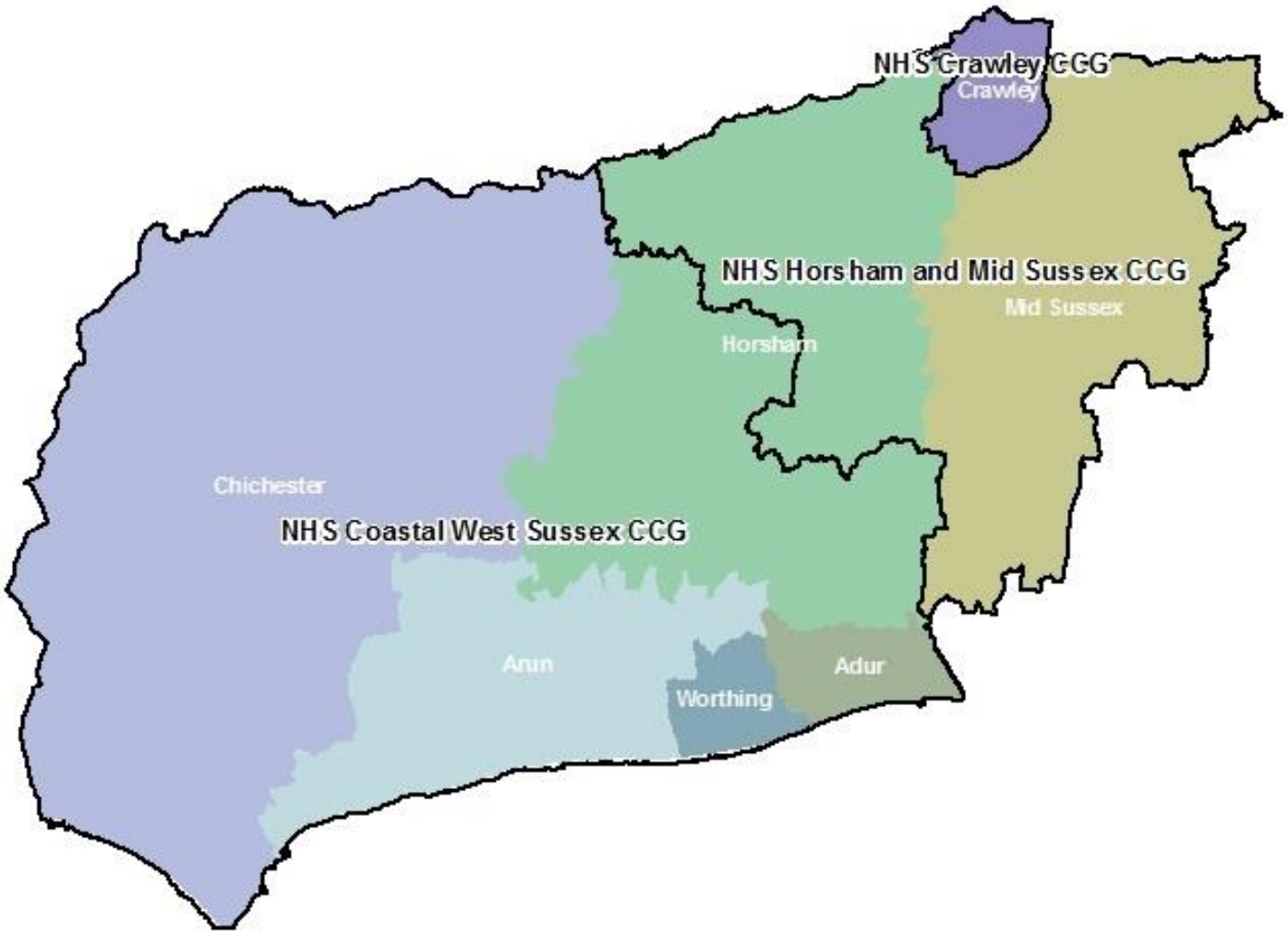
5 General demographic and socio-economic factors

5.1 Setting the Scene

West Sussex covers a large geographical area (769 square miles). There are a number of small to medium sized rural towns (such as Midhurst and Arundel), larger town/city centres (Chichester, Crawley and Horsham), and a coastal strip, with small to medium-sized coastal towns (such as Worthing, Bognor and Littlehampton). The county is bordered by East Sussex to the east, Hampshire to the west and Surrey to the north.

West Sussex consists of seven districts and boroughs (Adur, Arun, Chichester, Horsham, Mid Sussex, Crawley and Worthing). These are contained within three Clinical Commissioning Groups (CCGs): Coastal West Sussex, Horsham and Mid Sussex and Crawley CCGs (Figure 5).

Figure 5 - Clinical commissioning groups (CCGs) and their districts in West Sussex



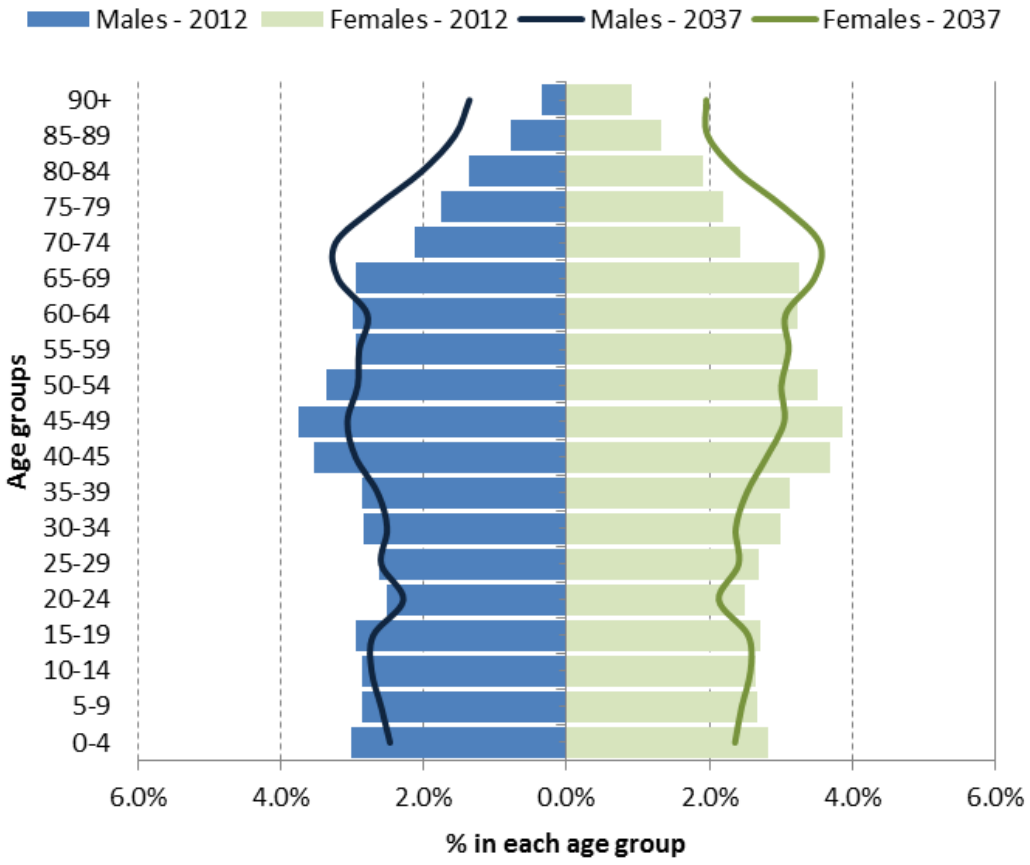
Map produced by V Pinkney (Public Health Research Unit)

5.2 Resident Population

West Sussex has a resident population of approximately 828,400 people[iv]. Of the local authorities, Arun has the largest population (approximately 154,400 people) and Adur has the smallest population (approximately 63,200 people).

The West Sussex population is projected to increase from 815,000 (2012) to 881,000 (2022) and 971,000 (2037 - Figure 6). The age structure of the population is continuing to age, with larger increases projected in older aged groups (85+ and 90+ years) and decreases projected in working age adults (20-54 years) and young children (<5 years).

Figure 6 – Age-sex pyramid of West Sussex. Projected change in size of the population by age group (2012 – 2037).



Source: West Sussex JSNA

5.3 Number of Children under the Age of 5

The 2014 mid-year population estimate show that there are approximately 47,980 children aged 0-4 years living in West Sussex[v]. This represents 5.8% of the total population of West Sussex. This compares to 6.2% in the South East region and 6.3% in England.

[iv] ONS – Mid-year population estimates, 2014 (released Jun-2015)
[v] ONS - "Population Estimates for UK, England and Wales, Scotland and Northern Ireland, Mid-2014" (released Jun-15)

In 2014, the resident population of children under the age of 5 within each CCG[vi] are approximated at:

Coastal West Sussex CCG:	26,620
Crawley CCG	8,470
Horsham and Mid Sussex CCG	12,890

The proportion of children under the age of 5 varies across the different local authorities in West Sussex (Table 4). Crawley has the highest proportion of its population aged under 5 (7.7%) and Chichester has the lowest proportion (5.0%).

Table 4 - Total number of resident children aged 0-4 years in West Sussex, 2014

	0-4 years			
	Male	**Female**	**Persons**	**% of population**
Adur	2,040	1,880	3,920	6.2%
Arun	4,120	3,820	7,940	5.1%
Chichester	2,980	2,740	5,730	5.0%
Crawley	4,490	3,990	8,470	7.7%
Horsham	3,710	3,460	7,170	5.3%
Mid Sussex	4,440	4,250	8,700	6.0%
Worthing	3,130	2,940	6,070	5.7%
West Sussex	**24,910**	**23,070**	**47,980**	**5.8%**
South East	**281,410**	**266,860**	**548,270**	**6.2%**
England	**1,757,740**	**1,673,220**	**3,430,960**	**6.3%**

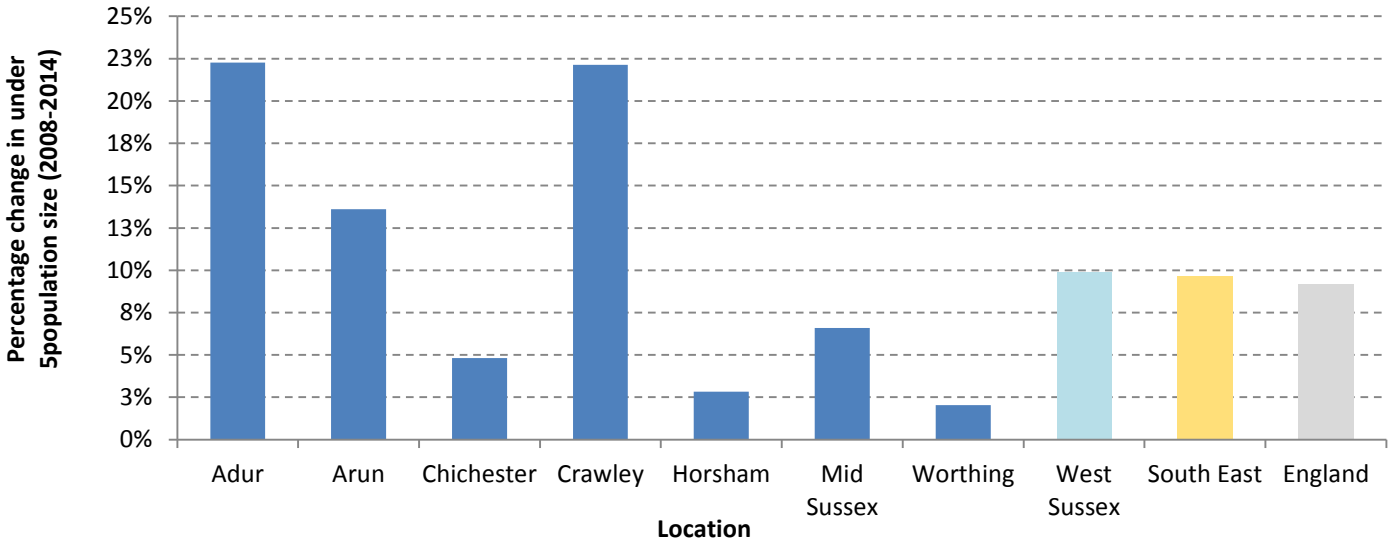
Note: Due to rounding (nearest 10) totals may not be the sum of the individual cells.
Source: ONS - "Population Estimates for UK, England and Wales, Scotland and Northern Ireland, Mid-2014" (Jun-15)

The population of children aged under 5 in West Sussex has seen a gradual increase over time, from 43,660 children in 2008 to 47,980 children in 2014 (a percentage increase of 9.9%). This compares to an increase of 9.6% in the South East and 9.2% in England.

Figure 7 shows the percentage change in the size of the under 5 population using mid-year population estimates from 2008 and 2014. There is variation across local authorities, with Adur seeing the largest increase in the population of under 5s (+22.3%), and Worthing seeing the smallest increase (+2.0%).

[vi] ONS - "Clinical Commissioning Group Mid-Year Population Estimates, Mid-2014 (experimental)" (released Oct-14). Note. Includes those miss-assigned to NHS Guildford and Waverley CCG

Figure 7 - Percentage change in population size of children under 5 in West Sussex from 2008 to 2014

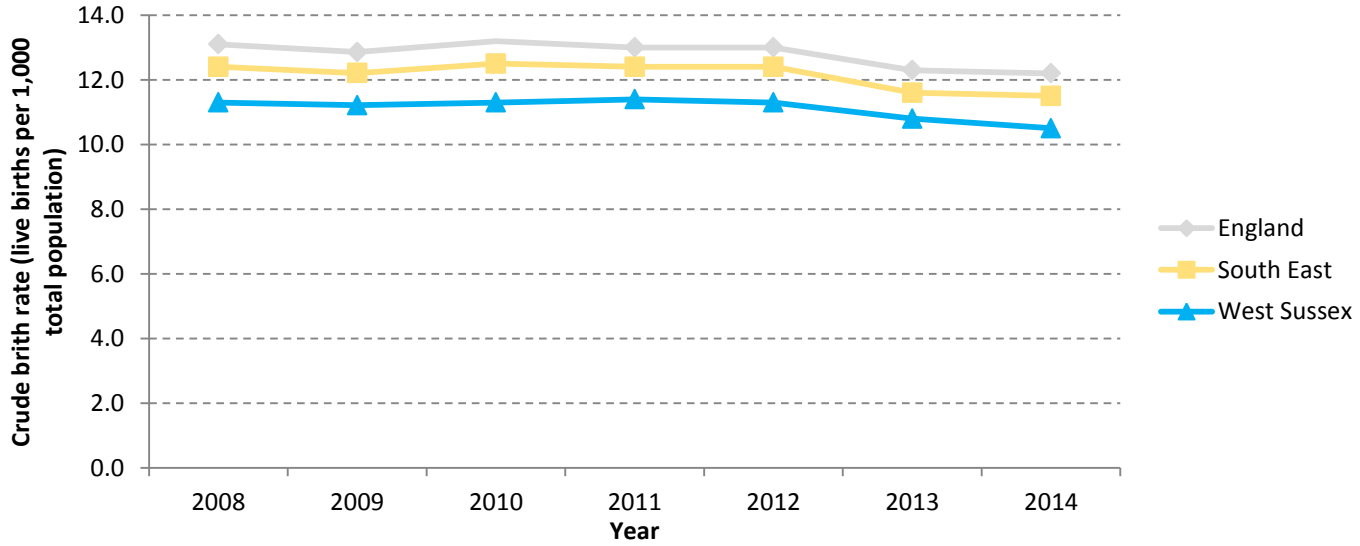


Source: ONS – "Population Estimates for UK, England and Wales, Scotland and Northern Ireland, Mid-2014" (released Jun-15) and "Revised Annual Mid-Year Population Estimates 2001 to 2010" (released Dec-13)

5.4 Births

After a period of growth from the early to mid-2000s the number of births in West Sussex has remained relatively stable over recent years at approximately 8,500 to 9,000 births per year (Figure 8)[vii]. In 2014, there was a slight fall in the number of births in West Sussex; approximately 8,720 live births were estimated to have occurred in 2014 compared to 8,885 in 2013 – a percentage decrease of 1.3%.

Figure 8 - Crude birth rate (the number of live births per 1,000 population) in West Sussex, the South East and England (2008-2014)



Source: ONS – "Births by Area of Usual Residence of Mother, UK" (Reference Tables 2008-2014)

[vii] ONS – Births by Area of Usual Residence of Mother, UK (Reference tables 2008-2014) – released Sept-2015

The number and rates of births in West Sussex varies by local authority (Table 5). Crawley has the highest crude birth rate (14.7 live births per 1,000 population) and Chichester has the lowest (9.2 live births per 1,000 population). Due to population differences, the smallest number of live births occurred in Adur in 2014 (approx. 690 live births), despite this district having the second largest crude rate (11.0 live births per 1,000 population). The greatest number of live births occurred in Crawley (approx. 1,620 live births).

Table 5 – Number and crude rate of live births in West Sussex, the South East and England 2014

	mid-2014 population	Live births	Crude birth rate
Adur	63,180	690	11.0
Arun	154,410	1,460	9.5
Chichester	115,530	1,060	9.2
Crawley	109,880	1,620	14.7
Horsham	134,160	1,230	9.2
Mid Sussex	144,380	1,520	10.5
Worthing	106,860	1,140	10.6
West Sussex	**828,400**	**8,720**	**10.5**
SOUTH EAST	8,873,820	102,400	11.5
ENGLAND	54,316,620	661,500	12.2

Note: Due to rounding (nearest 10) totals may not be the sum of the individual cells.
Source: ONS – "Births by Area of Usual Residence of Mother, UK 2014" (released Sept-2015)

5.5 Fertility rate

There were approximately 142,500 women of childbearing age (15 to 44 years) in West Sussex in 2014 (mid-year estimate) representing approximately 33.4% of the total female population.

Table 6 – Female population of West Sussex (2014)

	Females (all ages) mid-2014 population	Females aged 15-44 mid-2014 population
Adur	32,570	10,790
Arun	80,550	23,960
Chichester	60,220	17,920
Crawley	55,230	23,520
Horsham	68,990	21,910
Mid Sussex	73,810	25,330
Worthing	55,480	19,010
West Sussex	**426,830**	**142,450**
SOUTH EAST	4,509,010	1,666,520
ENGLAND	27,543,420	10,631,530

Note: Due to rounding (nearest 10) totals may not be the sum of the individual cells.
Source: ONS – "2014 mid-year population by sex and age for local authorities UK" (released Jun-2015)

The general fertility rate (GFR)[viii] is an estimate of current fertility levels. This denotes the number of live births per 1,000 women aged 15-44. It should be noted that GFR does not account for different sized cohorts of women of childbearing age and should be interpreted with caution. In 2014, the GFR for West Sussex was 61.2 per 1,000 women aged 15-44 years; this compares to 62.2 for England and 61.4 for the

[viii] The GFR is calculated as (B/Pf15-44) x 1,000, where B = total live births in the year, and Pf15-44 = female population aged 15-44.

South East[ix]. Crawley has the highest GFR of the local authorities in West Sussex (68.8 per 1,000 women aged 15-44), and Horsham has the lowest GFR (56.1 per 1,000 women aged 15-44).

The total fertility rate (TFR) is the average number of children a woman would bear if she experiences current age-specific fertility rates throughout her reproductive lifespan[x]. In 2014, the TFR for West Sussex was 1.88 meaning on average, women in West Sussex would be expected to have between 1-2 children each by the time they finish childbearing (if the 2014 rate is applied throughout their childbearing lifespan). The TFR for England and the South East are 1.83 and 1.86 respectively. Across the local authorities in West Sussex, the TFR is highest in Adur (1.99) and lowest in Horsham (1.81).

5.6 Summary of Vulnerable Children

Vulnerable groups include children who might be more likely to have poor health and wellbeing due to a number of risk factors (see section 2.1). Table 7 - Table 9 summarise the estimated size of the population of some of the vulnerable groups in West Sussex (those affected by a disability, with SEN, or safeguarding concerns). These are **not** discrete groups, and there is a large proportion of overlap. See section 8 for further information.

Table 7 – Approximate number and proportion of the population in West Sussex with SEN/D

Population	Year (Source)	Count	Proportion
All Children:			
Children under the age of 5	MYE 2014 (ONS)	47,980	-
Special Educational Needs:			
Children with SEN completing EYFSP	2014-15 (WSCC data)	750	7.8% of pupils completing EYFSP
Children with SEN in primary schools	Jan-2015 (DfE)	9,020	14.5% of all primary pupils
Children with SEN (all ages)	Jan-2015 (DfE)	20,660	17.2% of all pupils
Children with a disability:			
Day-to-day activities limited (< 5 yrs)	2011 (Census)	860	1.8% of all under 5's (*2011 census)
DLA claimants (< 5yrs)	At Feb-2015 (DWP)	540	1.1% of all under 5's (*MYE 2014)

Note. *Source for denominator. Values have been rounded to the nearest 10.

[ix] ONS – "Births by Area of Usual Residence of Mother, UK 2014" (released Sept-2015)

[x] TFR is a measure of independent variations in the age distribution of women of child bearing age. It is interpreted as representing the completed fertility of a synthetic cohort of women; that is the average number of live children a group of women would have if they experience the age-specific fertility rates for the calendar year in question throughout their childbearing lifespan (http://www.ons.gov.uk/ons/guide-method/user-guidance/health-and-life-events/births-metadata.pdf). Therefore, TFR is a synthetic rate; a measure of the fertility of a hypothetical woman who passes through her reproductive life subject to all the age-specific fertility rates for ages 15-44yrs that were recorded for a given population in a given year.

Table 8 – The proportion of under 5s with a disability, limited day-to-day activities or identified SEN by local authority in West Sussex

Area	Disability Living Allowance (Feb-2015)		Limited day-to-day activities (census 2011)		SEN (WSCC data)	
	No. of DLA claimants aged under 5	% of under 5s (*MYE-2014) who claim DLA	Day-to-day activities limited	% of all under 5s (*2011 census) limited	Pupils with SEN	% of pupils (* completing EYFS) who have SEN
Adur	50	1.3%	80	2.3%	80	11.7%
Arun	90	1.1%	150	2.0%	140	9.1%
Chichester	60	1.0%	90	1.6%	60	5.5%
Crawley	100	1.2%	160	2.0%	110	6.9%
Horsham	70	1.0%	120	1.7%	140	8.7%
Mid Sussex	80	0.9%	140	1.7%	100	5.6%
Worthing	80	1.3%	110	1.8%	120	9.6%
Unidentified	N/A	N/A	N/A	N/A	10	4.3%
West Sussex	540	1.1%	850	1.8%	750	7.8%
South East	6,690	1.2%	10,300	1.9%	N/A	N/A
England	46,940	1.4%	70,920	2.1%	N/A	N/A

Sources: DLA - Benefits claimants – disability living allowance by disabling condition (DWP – February 2015)
Limited day-to-day activities - 2011 Census
SEN – 2015 Early Years Foundation Stage Data, WSCC
Note: *denominator. Values rounded to nearest 10. Totals may not sum due to rounding.

Table 9 – Approximate population size and rate (per 10,000 under 5's) of children looked after, children in need, and children subject to a child protection plan (aged under 5 years) in West Sussex

Population	Year	Count	Rate per 10,000 under 5's
All children under the age of 5	2014 (ONS)	47,980	-
Children Looked After	5th Oct-2015	115	24.0
Children currently in need	23rd Oct-2015	1,175	244.9
Children currently subject to a Child Protection Plan	At 30th Mar-2015	245	51.1

Source: WSCC data
Note. Rates have been calculated using the ONS 2014 mid-year estimate of the under 5 population in West Sussex

5.7 Ethnicity

The 2011 Census revealed that in West Sussex the majority of children aged under 5 are White British (83.6%; Table 10). This proportion is considerably higher than in England (70.7%) and the South East (78.8%).

In Crawley, the proportion of White British children under the age of 5 is lower (62.2%) than for the other local authorities in West Sussex (ranging from 84.6% in Worthing to 90.6% in Chichester). 17.4% of children under the age of 5 are Asian/Asian British and 4.9% are Black/African/Caribbean/Black British in Crawley.

Table 10 - Number and percentage of West Sussex children aged 0-4 by ethnic group

Ethnicity	Numbers	%age of children aged 0-4
White: **British**	38,840	83.6%
White: **Irish**	90	0.2%
White: **Gypsy or Irish traveller**	120	0.2%
White: **Other white background**	1,870	4.0%
White total:	**40,910**	**88.0%**
Mixed/multiple ethnic group: **White and Black Caribbean**	440	0.9%
Mixed/multiple ethnic group: **White and Black African**	490	1.1%
Mixed/multiple ethnic group: **White and Asian**	820	1.8%
Mixed/multiple ethnic group: **Any other mixed**	460	1.0%
Mixed/multiple ethnic group total:	**2,200**	**4.7%**
Asian/Asian British: **Indian**	790	1.7%
Asian/Asian British: **Pakistani**	630	1.4%
Asian/Asian British: **Bangladeshi**	270	0.6%
Asian/Asian British: **Chinese**	130	0.3%
Asian/Asian British: **Any other mixed**	740	1.6%
Asian/Asian British total:	**2,550**	**5.5%**
Black/African/Caribbean/Black British: **African**	390	0.8%
Black/African/Caribbean/Black British: **Caribbean**	40	0.1%
Black/African/Caribbean/Black British: **Other Black**	170	0.4%
Black/African/Caribbean/Black British total:	**600**	**1.3%**
Any other ethnic group:	**220**	**0.5%**
Total	**46,490**	**100.0%**

Source: NOMIS – "Ethnic group by sex and age" (Census 2011)

5.8 Deprivation

There are two main sources of information relating to the overall level of deprivation experienced by people within specific areas or neighbourhoods: Department for Communities and Local Government (DCLG) rankings (Indices of Deprivation 2015) and data collated from the decennial census (2011 census).

5.8.1 Index of Multiple Deprivation 2015

The Index of Deprivation 2015 (ID2015) is the most commonly reported assessment of local area deprivation. In addition, the Income Deprivation Affecting Children Index (IDACI) provides a focused viewpoint on the level of income deprivation affecting households with children under the age of 16.

- Using information from the ID2015, West Sussex is a relatively affluent county. In 2015, West Sussex was the 21st least deprived county in England[xi]. County level data however masks considerable differences within small areas, and there are some very deprived neighbourhoods.
- The most deprived lower-tier local authority in West Sussex is Adur (ranked 159th least deprived of the 326 lower-tier local authorities in England)[xii]. The least deprived is Mid Sussex (ranked 321st).

[xi] Rank of average score was used. The average score is a population weighted average of the combined scores for the LSOAs in a larger area. These scores are then ranked (1 most deprived). This gives a measure of the whole are covering both deprived and non-deprived areas. The main difference from the average rank measure is that more deprived LSOAs tend to have more "extreme" scores than ranks. So highly deprived areas will not average out to the same extent as using ranks (highly polarised areas will tend to score higher on average score than average rank measure).

[xii] A rank of 1 = most deprived

- In relation to neighbourhood level deprivation, West Sussex has four small areas (all within Arun) that are amongst the 10% most deprived areas in England. These four small areas fall within the River, Courtwick with Toddington and Bersted wards in Arun[xiii].
- Amongst the CCGs in West Sussex, NHS Crawley CCG was the most deprived (134th of 209 CCGs in England), and NHS Horsham and Mid Sussex CCG was the least deprived (205th). NHS Coastal West Sussex CCG was ranked 160th.

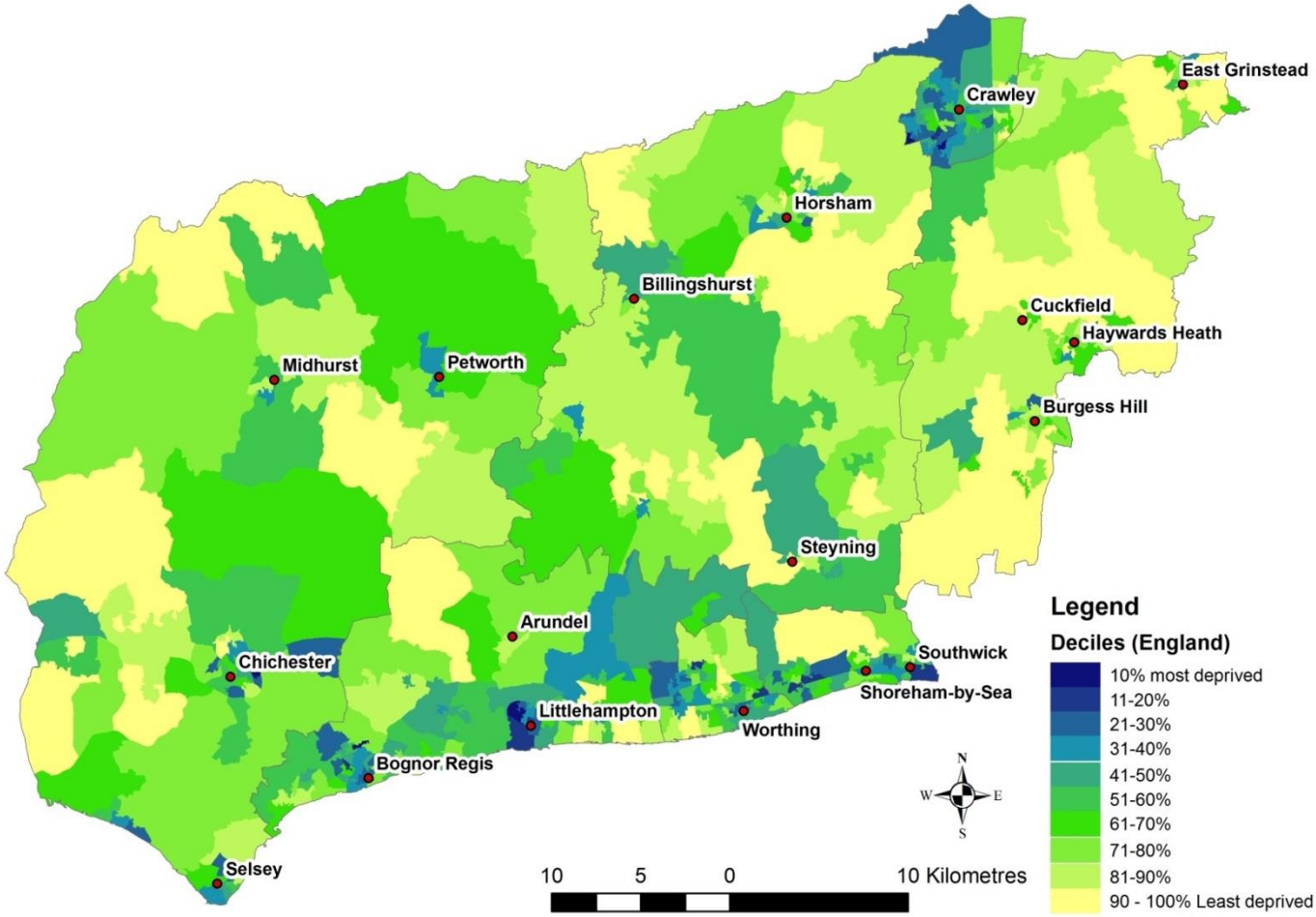
5.8.1.1 Income Deprivation Affecting Children Index (IDACI) 2015

The 2015 IDACI represents children aged 0-15 living in income deprived households.

- In 2015, West Sussex was the 23rd least deprived local authority on the IDACI measure of deprivation affecting children aged 0-15. Approximately 12.9% of children aged 0-15 live in income deprived households in West Sussex.
- NHS Crawley CCG has the greatest proportion of children aged 0-15 living in income-deprived households (14.2%). Horsham and Mid Sussex CCG has the smallest proportion (7.7%).
- Of the local authorities in West Sussex, Crawley (18.2%) and Adur (17.0%) have the highest proportion of children aged 0-15 living in income-deprived households. Mid Sussex (7.5%) and Horsham (8.4%) have the lowest proportion.
- Six LSOAs within West Sussex County are amongst the 10% most deprived in England based on the income deprivation affecting children measure. Three of these are also LSOAs (within the Bersted, River and Courtwick with Toddington wards) that are amongst the 10% most deprived small areas in England across the multiple indices. A further two are within Crawley (Bewbush and Broadfield South wards), and one is within the Chichester area (Chichester East ward).

[xiii] The Courtwick and Toddington and River ward boundaries have changed recently. The ward Ham has now been merged into these two wards.

Figure 9 - LSOAs in West Sussex by IDACI national decile (1 = most deprived)



5.8.2 2011 Census – Indices of Deprivation

The 2011 census collected a wide variety of information, which can be used to identify some of the characteristics common to deprived households. The census examined four dimensions of deprivation:

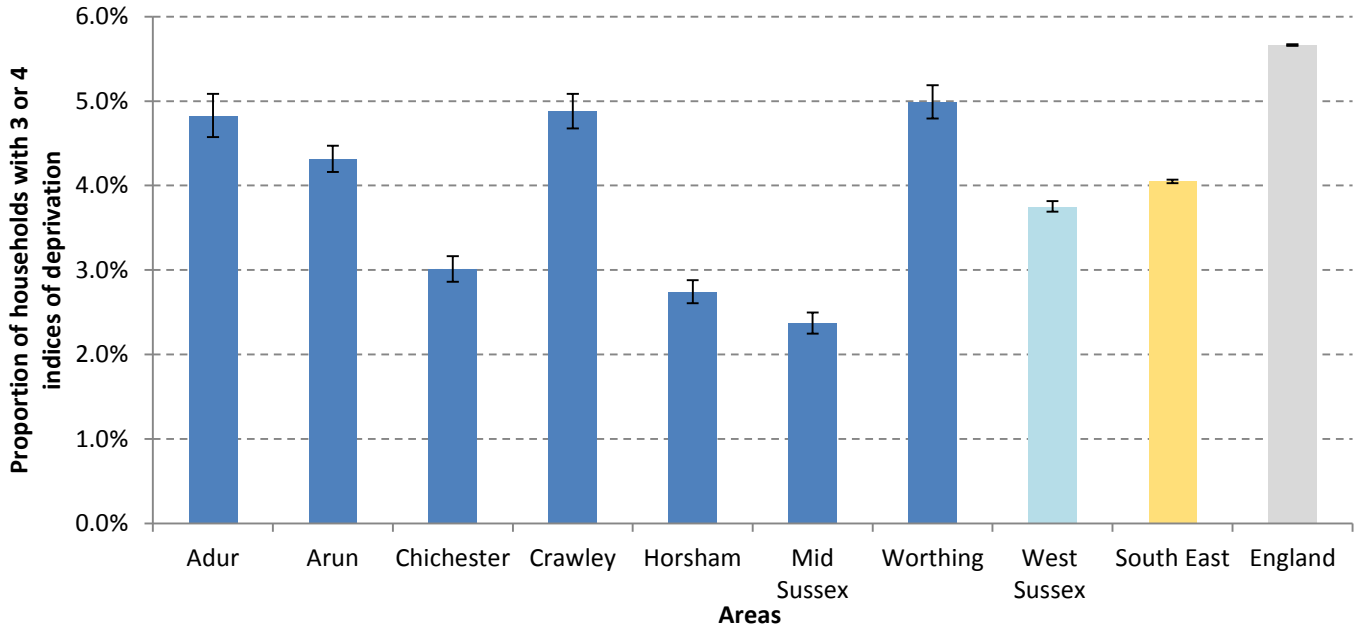
- Employment *(deprivation identified where any member of a household not a full-time student is either unemployed or long-term sick).*
- Education *(deprivation identified where no person in the household has at least level 2 education, and no person aged 16-18 is a full-time student)*
- Health and disability *(deprivation identified where any person in the household has general health 'bad or very bad' or has a long term health problem).*
- Household overcrowding *(deprivation identified when the household accommodation is either overcrowded, with an occupancy rating -1 or less, or is in a shared dwelling, or has no central heating.)*

Information is provided where households have none of the above, and where households "score" on one, two, three, or all four dimensions of deprivation.

Nearly 13,000 households were deprived in 3 or 4 dimensions in the 2011 census in West Sussex; approximately 3.8% of all households in the county. This is significantly lower than England (5.7%) and the South East (4.0% - Figure 10). Worthing has the highest proportion of households with 3 or 4 indices of

deprivation (5.0%), and Mid Sussex has the smallest proportion (2.4%), although all local authorities in West Sussex have significantly fewer deprived households (on three or four domains) than in England.

Figure 10 – The proportion of households with 3 or 4 measures of deprivation in West Sussex, the South East and England (2011 Census)



Source: NOMIS (2011 Census – Households by Deprivation Dimensions)

Table 11 reveals the ten LSOAs with the highest proportion of households with 3 or 4 measures of deprivation. These areas represent the most deprived locations in the county. The two maps below show LSOAs in West Sussex that have households with at least one measures of deprivation (Figure 11), or 3 or 4 measures of deprivation (Figure 12).

Table 11 – Ten most deprived LSOAs in West Sussex (with the greatest proportion of households with 3 or 4 measures of deprivation) – 2011 Census

	LSOA	Ward	District	Proportion of households that have 3 or 4 measures of deprivation
1	E01031404	Bersted	Arun	17.3%
2	E01031427	River/Courtwick and Toddington	Arun	14.1%
3	E01031819	Northbrook	Worthing	13.3%
4	E01031456	River	Arun	13.0%
5	E01031371	Southlands	Adur	12.1%
6	E01031779	Broadwater	Worthing	11.9%
7	E01031808	Heene	Worthing	11.8%
8	E01031432	Hotham	Arun	11.6%
9	E01031436	Marine	Arun	10.8%
10	E01031358	Mash Barn	Adur	10.7%

Source: 2011 Census – Households by deprivation dimensions

Figure 11 - The proportion of households that have 1 or more measure of deprivation

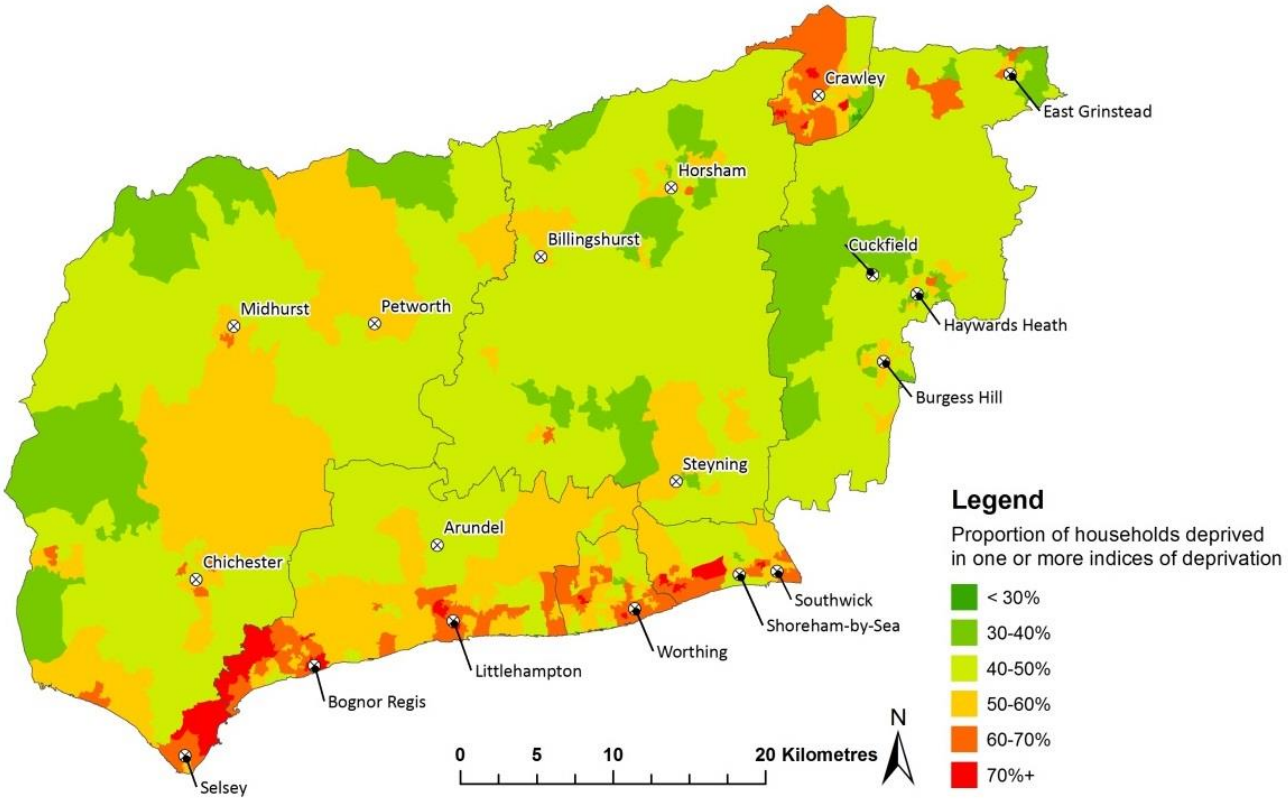
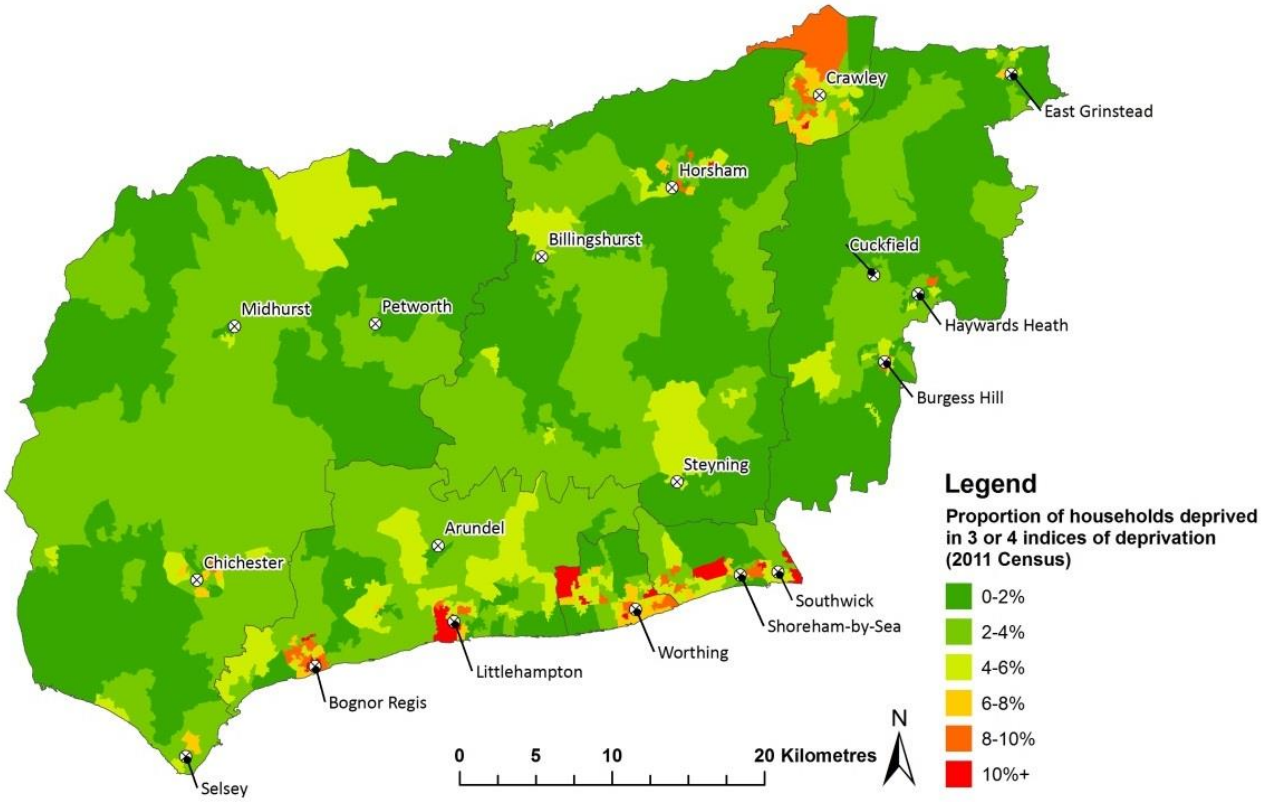


Figure 12 - The proportion of households that have 3 or 4 measures of deprivation



Maps produced by V Pinkney – Public Health Research Unit (Sept-2015)

5.9 Child Poverty

There is strong evidence to link poverty and early years adversity to children's outcomes in later life[7]. Although there is no clear and direct impact of poverty on a child's health, there are mediating variables such as lifestyle choices (e.g. smoking in pregnancy, sedentary lifestyles and diet), and socioeconomic factors, which all impact on maternal and child outcomes.[21] The negative impact of poverty on health and life chances was highlighted within the Marmot Review.[4] In terms of investment, children from the highest poverty neighbourhoods have been reported to achieve returns more than four times higher than those for children from less disadvantaged areas.[15] Risk factors identified for child poverty include:

- Lone parents
- Parental unemployment
- Teenage parents
- Parents with mental health problems
- Families with a disabled or sick child
- Families with three or more children
- Certain ethnic minority groups

5.9.1 National and West Sussex Profile: Child Poverty

The Children in Low-Income Families Local Measure shows the proportion of children living in families in receipt of out-of-work benefits or in receipt of tax credits where their reported income is less than 60% of the UK median income.

Approximately 6,500-7,000 children aged under 5 live in low income families in West Sussex (Table 12). Rates of child poverty vary considerably across the county, with a greater proportion of children under 5 living in poverty in Arun, Adur and Crawley.

Table 12 - Number and proportion of children under the age of 5 living in poverty (2009 to 2013)

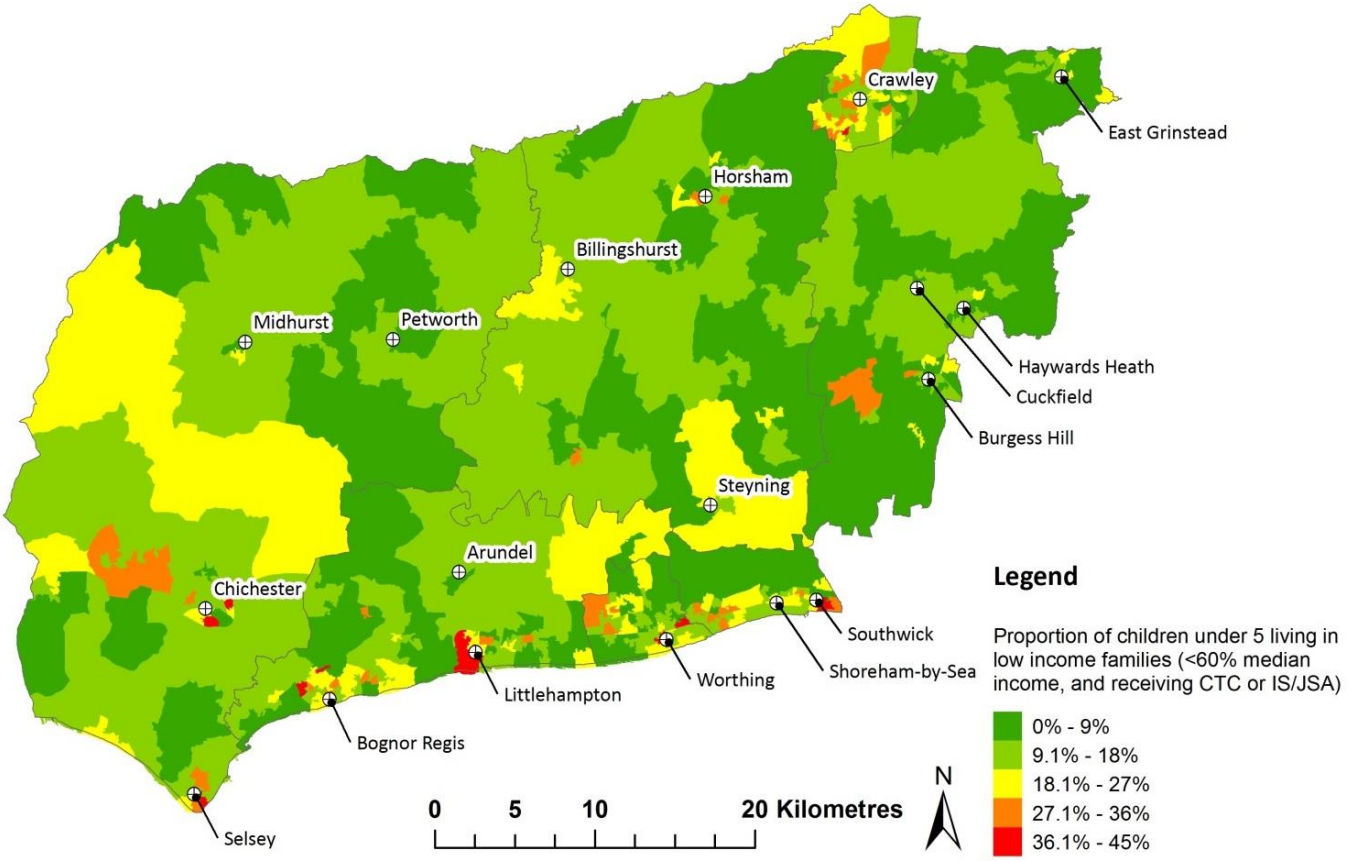
	CHILDREN AGED 0 – 4									
	2009		2010		2011		2012		2013	
	N	%	N	%	N	%	N	%	N	%
Adur	695	20.9%	690	20.1%	685	19.6%	655	17.9%	615	17.1%
Arun	1,350	18.9%	1,335	18.4%	1,450	19.5%	1,435	18.6%	1,390	18.4%
Chichester	810	14.8%	810	14.7%	835	15.0%	770	13.6%	780	15.5%
Crawley	1,480	21.2%	1,575	21.2%	1,605	20.6%	1,475	18.6%	1,495	19.3%
Horsham	760	11.2%	775	11.4%	735	10.9%	735	10.9%	695	11.7%
Mid Sussex	745	9.8%	705	9.1%	700	9.0%	710	9.0%	630	9.3%
Worthing	1,070	18.3%	1,055	17.7%	1,040	17.0%	915	15.0%	925	16.2%
WEST SUSSEX	6,940	16.0%	6,955	15.7%	7,065	15.7%	6,685	14.7%	6,530	15.4%
SOUTH EAST	88,955	18.0%	87,905	17.4%	88,660	17.2%	85,520	16.4%	83,245	17.5%
ENGLAND	749,615	23.9%	734,090	23.0%	735,425	22.7%	707,815	21.5%	689,470	22.1%

Source: HMRC Personal Tax Credit Statistics – Children in low-income families local measure (released Nov-2015) and Child Benefit Statistics (released Feb-2014).

Note. Changes to child benefit system in Jan 2013 mean that claimants with an individual income exceeding £50,000 can opt-out of receiving child benefit. Therefore, whilst child benefit data includes those who opt-out, high income families who decide not to make an initial claim for child benefit, or who decline to fill out the opt-out form are not included in the denominator. Values are approximate as are based on rounded figures.

The map below (Figure 13) displays the proportion of children under the age of 5 who live in low-income families in West Sussex by lower super output area (LSOA). In some LSOAs, over 40% of children under 5 are considered to be living in poverty (see Table 13).

Figure 13 – The proportion of under 5's living in low-income families, LSOAs in West Sussex (2013)



Map created by V Pinkney – Public Health Research Unit (Sept-2015).

Table 13 – The ten LSOAs in West Sussex that have the highest proportion of children under 5 living in poverty (2013). Wards and districts of each LSOA are provided for context.

	LSOA	Ward of LSOA	District	Proportion of children under 5 living in low income families (2013)
1	E01031779	Broadwater	Worthing	41.7%
2	E01031429	Courtwick with Toddington	Arun	40.0%
3	E01031347	Eastbrook	Adur	40.0%
4	E01031427	River/Courtwick with Toddington	Arun	38.1%
5	E01031404	Bersted	Arun	38.1%
6	E01031451	Pevensey	Arun	38.1%
7	E01031790	Central	Worthing	38.1%
8	E01031482	Chichester East	Chichester	37.5%
9	E01031558	Broadfield South	Crawley	37.0%
10	E01031492	Chichester South	Chichester	36.8%

5.10 Families and Household Composition

Family and household composition are some of the indicators of family outcomes, and have a potential bearing on a child's development. Research indicates that the family structure in which a child grows can have negative and positive consequences on the child's developmental outcomes, and parental marital status at the child's birth is a predictor of long-term family stability and complexity.[22] Children born to married biological parents have been reported to have better outcomes as compared to children from single parent households or cohabiting parents. Additionally, children from single parent households are more likely to have behavioural problems and lower cognitive scores.[22] Some of the potential mediating factors include economic resources, time resources and parental resources such as parenting quality and parental mental health.

5.10.1 National and West Sussex Profile: Families with Dependent Children

The ONS defines a family as a married, civil partnered or cohabiting couple with or without children, or a lone parent with at least one child[xiv] who lives at the same address[xv].

In 2011, there were approximately 92,660 families with dependent children in West Sussex. Of these, 36,180 families had at least one dependent child under the age of 5 (Table 14). The majority of families with a child under 5 were married/same-sex civil partnership couples (61.6%). Cohabiting couples (21.0%) and lone parent (17.3%) families accounted for smaller proportions.

Table 14 - Proportion of all families with a dependent child under the age of 5 by family type in West Sussex, the South East and England (2011 Census data)

	Where the youngest dependent child is aged 0 to 4 years						
	Total number of families	Married or same-sex civil partnership couple		Cohabiting couple		Lone parent	
Adur	2,785	1,480	53.2%	735	26.4%	570	20.4%
Arun	5,840	3,200	54.8%	1,460	25.0%	1,180	20.2%
Chichester	4,345	2,750	63.4%	880	20.3%	710	16.4%
Crawley	6,285	3,640	57.9%	1,230	19.6%	1,415	22.5%
Horsham	5,520	3,840	69.6%	1,010	18.3%	670	12.1%
Mid Sussex	6,495	4,620	71.1%	1,170	18.0%	705	10.9%
Worthing	4,910	2,765	56.3%	1,130	23.0%	1,015	20.7%
West Sussex	36,180	22,295	61.6%	7610	21.0%	6,270	17.3%
South East	415,245	252,095	60.7%	549,615	20.8%	86,290	18.5%
England	252,095	1,418,960	54.8%	619,085	21.2%	76,860	23.9%

Note. Totals rounded to the nearest 5. Totals may not sum due to rounding.
Source: NOMIS – 2011 Census – DC1118EW – "Youngest dependent child in family by family type"

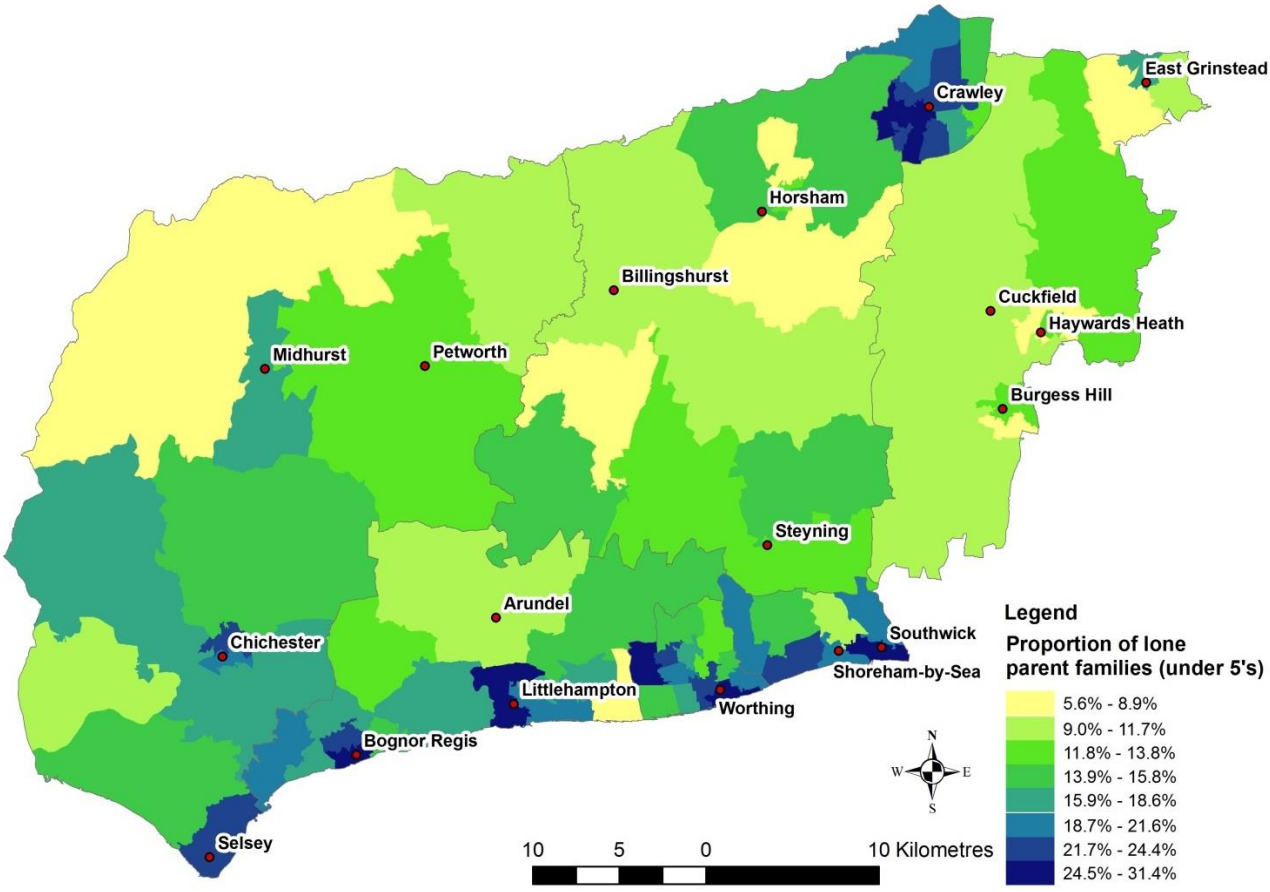
[xiv] Children can be dependent or non-dependent. Dependent children are defined as those living with their parent(s), and either (a) aged under 16, or (b) aged 16 – 18 in full-time education, excluding children aged 16 – 18 who have a spouse, partner or child living in the household. Non-dependent children are those living with their parent(s), and either (a) aged 19 or over, or (b) aged 16 to 18 who are not in full-time education or who have a spouse, partner or child living in the household.
[xv] Grandparent(s) with dependent grandchild(ren) but without the intervening generation are also considered a family.

5.10.2 National and West Sussex Profile: Lone parents

In West Sussex, 17.3% of families with a dependent child under the age of 5 were lone parent families[xvi]. This is a smaller proportion than in England (23.9% - Table 14). There is considerable variation in the proportion of lone parent families across the county. In Crawley 22.5% of families where the youngest child was under 5 were lone parent families; more than half that in Mid Sussex (10.9%).

In England, women account for 89.1% of all lone parents with a dependent child[xvii]. Women are much more likely to be the primary caregiver of dependent children when a relationship ends. Of all lone parent families with dependent children in West Sussex, approximately 10.4% are male lone parents.

Figure 14 – The proportion of lone parent families with a dependent child under the age of 5 in West Sussex (middle super output areas (MSOAs)) - 2011 Census data



Source: Map created by V Pinkney (Oct-2015).
NOMIS - 2011 Census: DC1118EW – "Youngest dependent child in family, by family type"

5.10.2.1 Lone Parent Families and Poverty

In West Sussex, there were 13,830 children (all ages)[xviii] living in lone parent families with an income below 60% of the UK median income, and receiving child tax credits, income support or job seekers allowance (in

[xvi] 2011 Census – DC1118EW – "Youngest dependent child in family by family type"
[xvii] 2011 Census – DC1118EW – "Youngest dependent child in family by family type"
[xviii] Includes all children under 16, and children under 20 in full-time education/training who live with their parents, and who are not married, in a civil partnership, or living with a partner

2013). This accounts for 71.3% of all children in families living in poverty. The wards Bewbush, Broadfield South, Broadfield North (Crawley Borough), and Ham (now part of the new Courtwick with Toddington ward and River ward in Arun District) all have in excess of 300 children in lone parent families living in poverty.

5.10.3 National and West Sussex Profile: Concealed Families

Statistics on concealed families are used as an indicator of housing demand[xix]. A concealed family is defined as a couple or single parent family living in a multi-family household where the Family Reference Person (FRP[xx]) is not the Household Reference Person (HRP). Therefore, a concealed family can include young adults living with a partner and/or child in the same household as their parents, older couples living with an adult child and their family, and unrelated families sharing a household. Many factors contribute to why more than one family may share a household. For example, whilst financial pressure is one factor in determining the likelihood of a concealed family, other factors such as the health, age and culture of the occupants can contribute to the overall size of a household.

In 2011, it was estimated that there were 1,200 concealed families with dependent children in West Sussex, accounting for 1.3% of all families with dependent children in the county[xxi]. Of the local authorities, Crawley had the greatest proportion of concealed families with dependent children (1.8%), whilst Horsham and Mid Sussex had the smallest proportion (1.0%). A larger proportion of concealed families with dependent children in West Sussex were lone parents (63%) than couples (37%).

5.10.4 National and West Sussex profile: Adults not in employment with dependent children (all ages)

In West Sussex, there were approximately 93,120 households with dependent children, 8,690 (9.3%) of which had no adults in employment (Table 15)[xxii]. In England, 14.4% of households with dependent children had no adults in employment, and in the South East this figure was 10.6% of households. Across West Sussex, there is some variation (Figure 15); Crawley has the highest proportion of households with dependent children that have no adults in employment (13.2%), and Mid Sussex has the lowest proportion (5.4%).

[xix] For example, in "Estimating housing need" by the Department for Communities and Local Government (Nov-2010) https://www.gov.uk/government/publications/estimating-housing-need

[xxi] NOMIS: 2011 Census "LC1110EW – Concealed family status by family type by dependent children by age of Family Reference Person (FRP)"

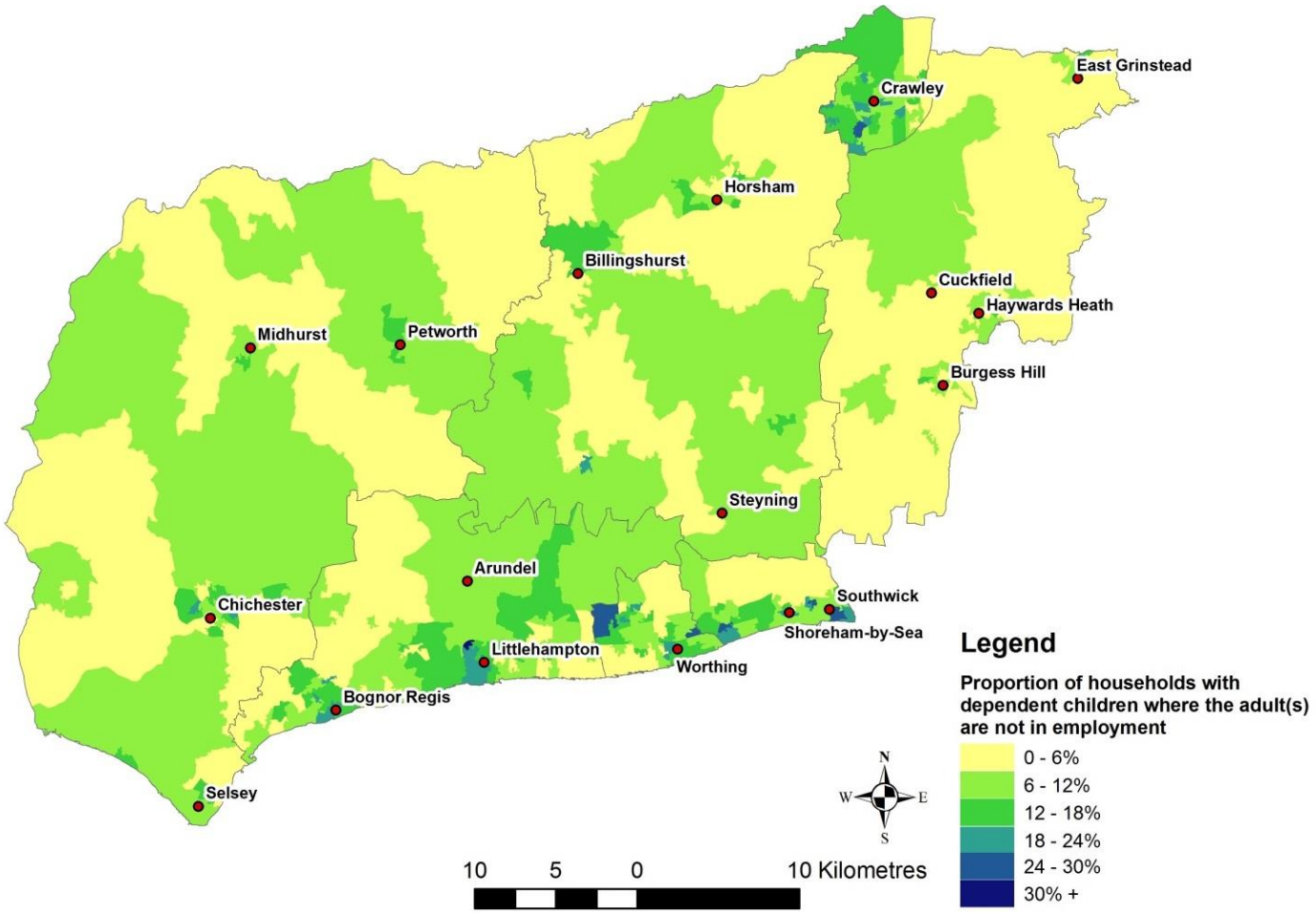
[xxii] NOMIS: 2011 Census – KS106EW Adults not in employment and dependent children and persons with long-term health problems or disability for all households.

Table 15 –The proportion of households with dependent children (all ages) where no adults in are in employment in West Sussex, the South East and England (2011 Census)

	All households with dependent children (all ages)	Households with no adults in employment, with dependent children	
		N	%
Adur	6,985	850	12.1%
Arun	15,495	1,670	10.8%
Chichester	11,830	1,045	8.8%
Crawley	14,075	1,855	13.2%
Horsham	15,530	1,005	6.5%
Mid Sussex	17,045	920	5.4%
Worthing	12,160	1,345	11.1%
West Sussex	93,120	8,690	9.3%
South East	1,044,890	110,425	10.6%
England	6,792,625	922,190	14.4%

Note. Values rounded to the nearest 5.
Source: 2011 Census, NOMIS – "KS106EW - Adults not in employment and dependent children"

Figure 15 – The proportion of households with dependent children (all ages) within West Sussex, where the adult(s) are not in employment (2011 census)



5.11 Household Overcrowding

Information on bedroom occupancy rating was collected as part of the 2011 Census. For each household, a bedroom occupancy rating is determined by subtracting the notional number of bedrooms recommended by the bedroom standard from the number of bedrooms actually available. The bedroom standard definition is as follows:

A separate bedroom shall be allocated to the following persons -

a) A person living together with another as husband and wife (whether that other person is of the same sex or the opposite sex)
b) A person aged 21 years or more
c) Two persons of the same sex aged 10 years to 20 years
d) Two persons (whether of the same sex or not) aged less than 10 years
e) Two persons of the same sex where one person is aged between 10 years and 20 years and the other is aged less than 10 years
f) Any person aged under 21 years in any case where he or she cannot be paired with another occupier of the dwelling so as to fall within c), d) or e).

An occupancy rating of zero implies that a household has the precise notional number of bedrooms recommended by the bedroom standard for the number and composition of people living within the household. An occupancy rating of -1 or less suggests that the household has at least one bedroom too few and is therefore overcrowded. Conversely, an occupancy rating of +1 or more suggests that the household has at least one bedroom more than is recommended by the bedroom standard.

5.11.1 National and West Sussex profile: Household overcrowding

In West Sussex, approximately 7,000 households with dependent children (all ages) are overcrowded (Table 16). This equates to 7.5% of all households with dependent children in West Sussex. This is significantly lower than the South East region (8.4%) and England (10.9%, Figure 16).

Table 16 - The number of households with dependent children at each occupancy rating in West Sussex, the South East and England (2011 Census data)

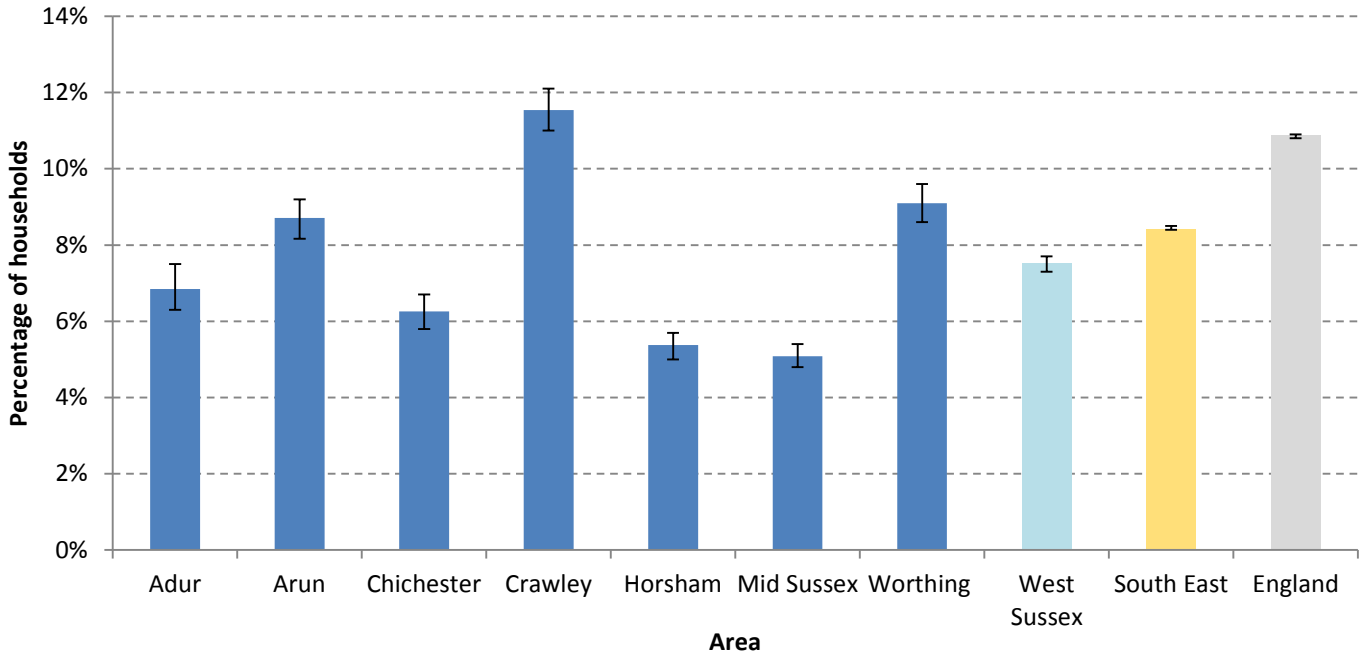
	Total	Occupancy rating			
		-1 or less	0	+ 1	+2 or more
West Sussex	93,100	7,000	33,430	35,615	17,055
South East	1,044,635	87,900	370,445	379,180	207,115
England	6,423,940	697,900	2,418,525	2,288,840	1,018,670

Note. Values are rounded to the nearest 5.
Source: NOMIS – 2011 Census – "LC4105EW – Occupancy rating (bedrooms) by household composition"

Variation in the proportion of overcrowded households with dependent children exists across the county. Crawley has both the greatest number (1,624 households) and proportion (11.5%) of overcrowded households with dependent children, and is the only local authority to significantly exceed the proportion for England. Mid Sussex has the smallest proportion of overcrowded households with dependent children (5.1%), and also the greatest number of additional bedrooms per household. 64.9% of households with dependent children have one or more additional bedroom in Mid Sussex. This compares to 45.7% in

Crawley. In West Sussex, 56.6% of households have additional bedrooms, compared to 56.1% in the South East and 51.5% in England.

Figure 16 – Proportion of households with dependent children that have an occupancy rating of -1 or "overcrowded" in West Sussex, the South East and England (2011 Census data)



Source: 2011 Census data

5.12 Family Homelessness

The UN Convention on the Rights of the Child highlights that every child has the right to an adequate standard of living. Homelessness is associated with poor outcomes for children including severe poverty and poor health and wellbeing.

5.12.1 National and West Sussex Profile: Homelessness

Overall West Sussex has a low rate of homelessness. In 2013/14, just over 350 households were accepted as unintentionally homeless and in priority need in West Sussex; a rate of 1.0 households per 1,000 households[xxiii]. This is significantly fewer than in England (1.7 households per 1,000 households). However, the rates of homeless across the county vary with far higher rates of homeless in Crawley (4.5 per 1,000 households) than other areas in the county and the England rate[xxiv] (Table 17).

[xxiii] ChiMat – Child Health Profiles for Local Authorities (accessed Oct-2015)
[xxiv] DCLG – "Table 784 local authorities' action under the homelessness provisions of the Housing Acts, financial years 2004/05 to 2014/15" (accessed Oct-2015)

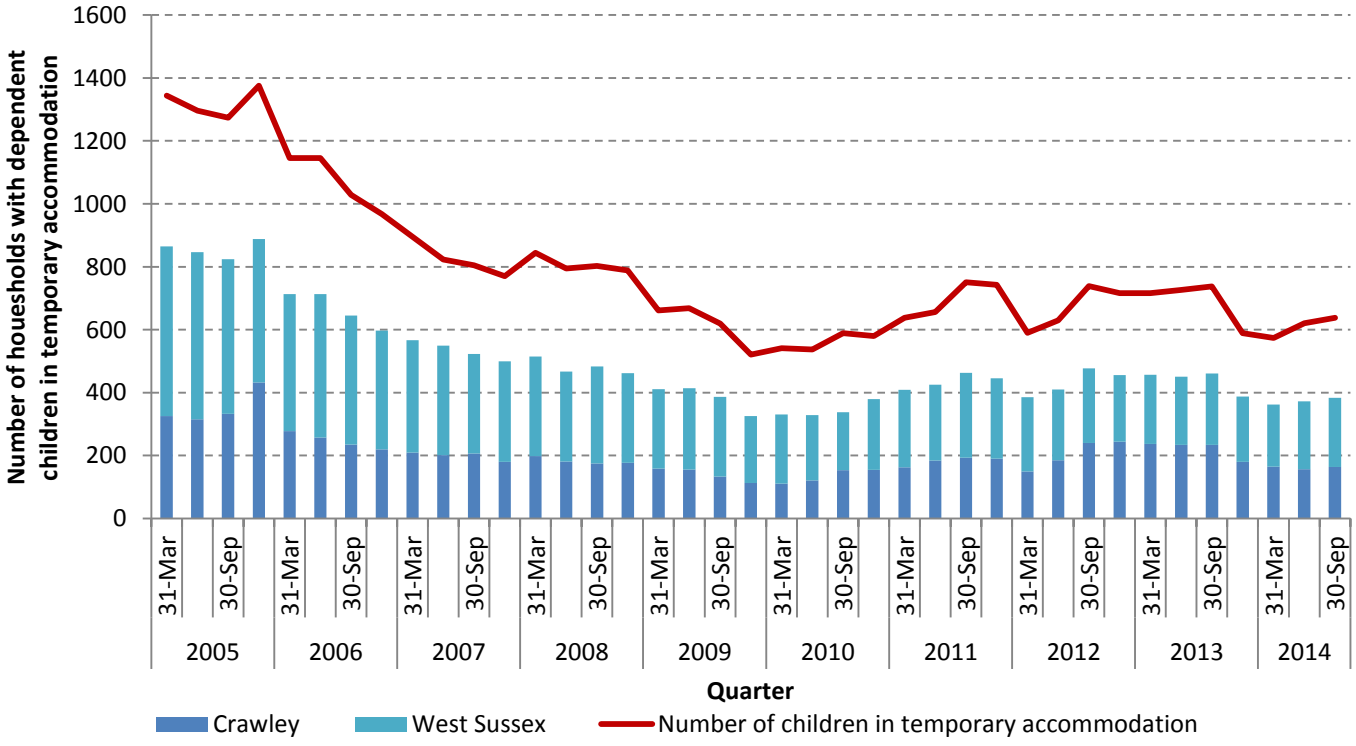
Table 17 – Rate of households accepted as homeless and in priority need (per 1,000 households)

	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
Adur	5.4	5.9	3.8	2.7	2.6	2.7	3.3	2.2	1.4	0.4	0.3
Arun	2.3	1.7	1.6	0.9	1.3	0.8	1.2	1.5	1.9	1.6	2.8
Chichester	1.3	1.7	1.7	1.1	1.4	0.9	1.0	1.0	0.9	0.7	0.7
Crawley	6.0	3.9	2.1	2.6	1.6	2.0	3.0	3.5	3.6	4.2	4.5
Horsham	2.5	1.8	1.4	1.1	1.5	1.7	2.3	4.3	2.2	2.0	1.6
Mid Sussex	1.6	1.1	1.2	0.8	0.5	0.6	0.9	0.7	0.9	0.8	0.6
Worthing	2.4	2.8	2.2	1.6	0.7	0.4	0.4	0.3	0.2	-	-
England	5.7	4.5	4.4	3.0	2.5	1.9	2.0	2.3	2.4	2.3	2.4

Source: DCLG; "Table 784: Local authorities' action under the homelessness provisions of the Housing Acts, 2004/05 to 2014/15"
Note. – Figure suppressed due to being less than 5 or to prevent calculation

At any one time, approximately 350 – 450 households with dependent children are living in temporary accommodation in West Sussex and nearly half of these families live in Crawley (Figure 17). A small number of families with dependent children are placed in temporary bed and breakfast accommodation for longer than 6 weeks in West Sussex, contrary to national guidelines. For example, in the final quarter of 2014, 5 families with dependent children had been living in bed and breakfast accommodation for more than 6 weeks. In the past, the majority of these families were living in Crawley, however in the past 2 years there have been no reported instances of families with dependent children living in bed and breakfast accommodation for more than 6 weeks in Crawley.

Figure 17 – The number of families with dependent children living in temporary accommodation in West Sussex and Crawley (2005 – Q3 2014)

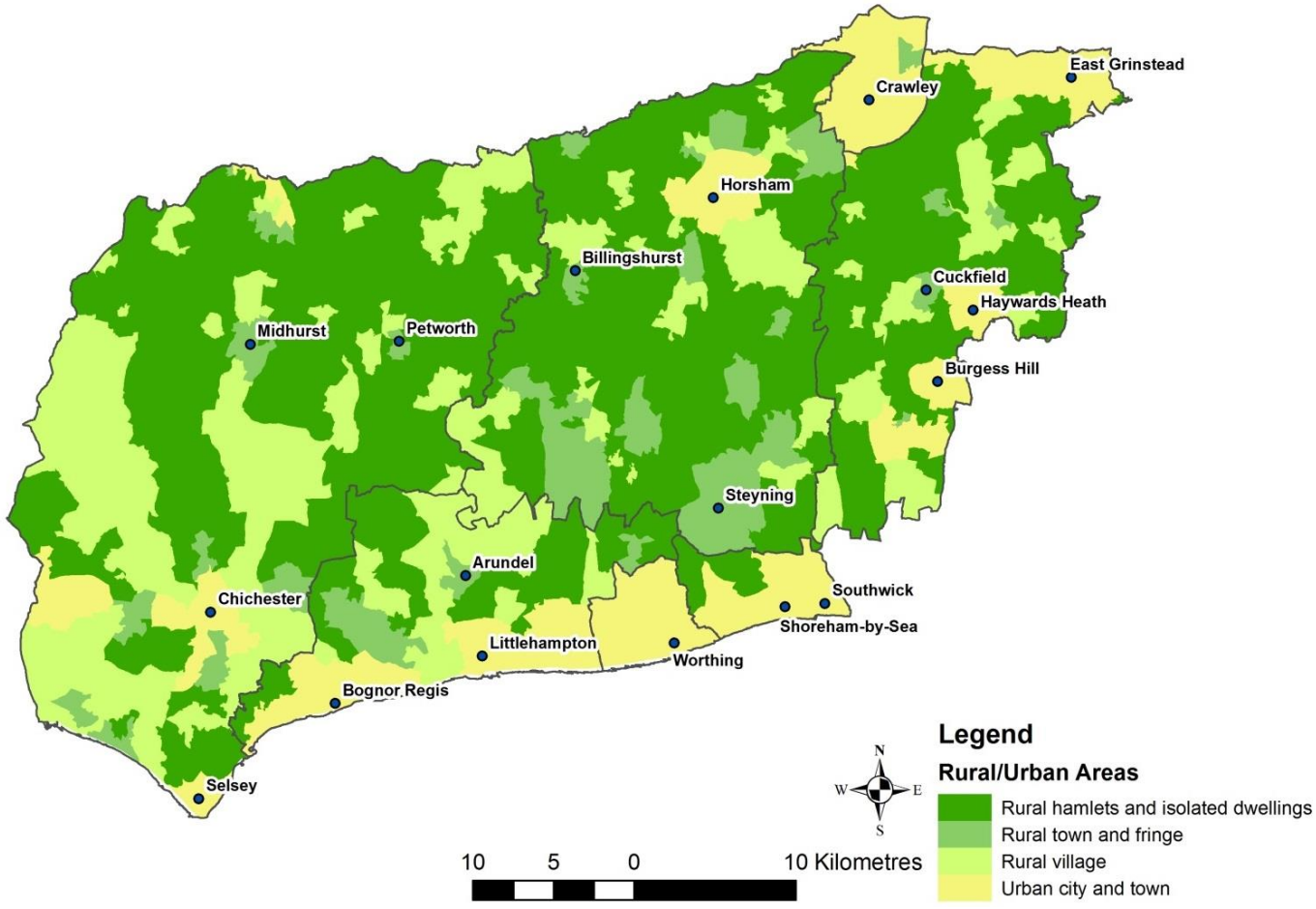


Source: Shelter DataBank (accessed Oct-2015: http://england.shelter.org.uk/professional_resources/housing_databank)

5.13 Rural areas

The West Sussex county consists of a number of large towns/city centres (e.g. Chichester, Crawley and Horsham) as well as smaller coastal towns (e.g. Bognor Regis and Worthing) and rural market towns (e.g. Midhurst and Arundel). Over half of the county is protected countryside. These areas (including the South Downs national park and Weald) are relatively unpopulated, with approximately 23.7% of the resident population of West Sussex living in rural areas[xxv]. 2011 census data suggests that rural households in West Sussex are less likely to be deprived than urban areas; 52.1% of rural households were not deprived in any deprivation dimension in the 2011 census, compared to 44.7% of urban areas[xxvi].

Figure 18 – Rural-Urban classification of output areas in West Sussex



Source – ONS Open Geography
Map created by V Pinkney, PH Research Unit (Oct-2015)

5.13.1 Under 5's living in rural areas

Data from the 2011 census suggests that a greater proportion of under 5's (20.5%) live in rural areas in West Sussex when compared to England (14.0%) and the South East (17.3% - Table 18). The majority of under 5's in rural areas reside in rural towns or fringes (56.9%), whilst the rest reside in rural villages (24.6%) or rural hamlets and isolated dwellings (18.5%).

[xxv] NOMIS, 2011 Census - "KS102EW – Age Structure"
[xxvi] NOMIS, 2011 Census – "QS119EW – Households by deprivation dimensions"

Table 18 – The number and percentage of under 5s living in urban and rural areas in West Sussex (2011 Census data)

	Urban		Rural	
	Number	Percentage	Number	Percentage
Adur	3,510	99.2%	30	0.8%
Arun	6,210	84.1%	1,175	15.9%
Chichester	2,630	46.6%	3,020	53.4%
Crawley	8,060	99.8%	15	0.2%
Horsham	3,150	44.0%	4,000	56.0%
Mid Sussex	7,035	84.3%	1,305	15.7%
Worthing	6,345	100.0%	0	0.0%
West Sussex	36,940	79.5%	9,545	20.5%
South East	441,975	82.7%	92,260	17.3%
England	2,854,235	86.0%	464,215	14.0%

Source: NOMIS, 2011 census – "KS102EW – Age Structure"

Of all families with dependent children (all ages) living in rural areas in West Sussex, the greatest proportion are married couple families with one (23.3%) or two or more (43.3%) dependent children[xxvii]. Lone parent families account for the next largest proportion of families with dependent children living in rural areas (15.6%), whilst cohabiting couples (11.4%) and other households (6.5%) account for the remainder.

5.14 Car or van availability

Table 19 describes the percentage of households with dependent children (all ages) by the availability of a car or van. The 2011 census revealed that over 90% of households with dependent children had access to at least one car or van in West Sussex. This compares to 82.5% of households with dependent children in England and 89.4% in the South East region.

Table 19 - Percentage of households with dependent children by access to a car or van, West Sussex, the South East and England (2011 Census data)

Area	Households with dependent children			
	No access to a car or van	Access to 1 car or van	Access to 2 or more cars/vans	Total
West Sussex	9.2%	35.7%	55.1%	93,100
South East	10.6%	35.3%	54.1%	1,044,635
England	17.5%	38.5%	44.0%	6,423,940

Source: NOMIS - DC1401EW – "Household composition by car or van availability"

[xxvii] NOMIS: 2011 census – "QS113EW – Household composition – Households"

6 A HEALTHY START

Child Health and Wellbeing Indicators

6 A Healthy Start to Life - Child health and wellbeing indicators

The health and wellbeing of children in their early years influences their outcomes and, given that adult onset illnesses and conditions often originate in childhood, a wide variety of domains and measures are used to assess levels of children's health and wellbeing. These provide a mechanism which can be used to monitor health status and wellbeing, and include mortality rates, child morbidity and health burdens that result from preventable disease (e.g. vaccine preventable infectious diseases), and modifiable risk factors (e.g. smoking, obesity, drug and alcohol consumption).

This section aims to investigate the size of need within West Sussex, comparing indicators of wellbeing with national and regional averages and outlines the evidence base for consideration by commissioners and providers, in order to achieve better outcomes for children under the age of 5 and their families.

6.1 Infant Mortality

Infant mortality refers to the death of a child before the age of one. This also includes stillbirths, neonatal, perinatal deaths and Sudden Infant Deaths (SIDs). Infant mortality rates measure child survival and are a useful indicator of the community's social, economic and environmental conditions, including access to health care (WHO). As well as being a predictor of health inequalities, infant mortality is also linked with socio-economic deprivation. There are large inequalities in infant mortality rates between areas and between population groups.[4] Babies born with a weight of less than 2,500g and preterm babies (births occurring before 37 weeks of gestation) make up a high proportion of infants who die before age of one, and consequently, populations with high rates of low birth weight are likely to be followed by high infant mortality rates. Multiple pregnancies are also associated with increased risk of complications such as preeclampsia, gestational hypertension, haemorrhage, foetal and neonatal mortality compared to singleton pregnancies, all of which can have an impact on birth weight and mortality.

Risk factors for infant mortality are similar to the risk factors for low birth weight, such as smoking, alcohol and substance misuse in pregnancy, domestic violence, maternal mental health, and deprivation. The Marmot review found that in a study of all infant deaths in England and Wales (excluding multiple births), deprivation, births outside marriage, non-white ethnicity of the infant, maternal age under the age of 20 and male gender of the infant were all independently associated with an increased risk of infant mortality[4].

6.1.1 National and West Sussex Profile: Infant Mortality

6.1.1.1 Stillbirths (after 24 weeks of pregnancy)

Stillbirth is defined as a baby born dead after 24 weeks of completed pregnancy[xxviii]. Stillbirth rate is the number of stillbirths per 1,000 total births (live and still) per year. The rate of stillbirths has remained relatively stable in West Sussex with 4.0 stillbirths per 1,000 births in 2011-13, compared to 4.4 in 2010-12 (Table 20). This is marginally lower than the rate of stillbirths for England (4.9 per 1,000 births) and similar to the South East (4.6 per 1,000 births).

[xxviii] If the baby dies before 24 weeks are completed this is known as a miscarriage or late foetal loss.

Table 20 - Stillbirth rate (95% confidence intervals) in West Sussex, the South East and England (3-year aggregates)

	2008-10	2009-11	2010-12	2011-13
West Sussex	4.0 (3.3 – 4.8)	4.1 (3.4 – 4.9)	4.4 (3.7 – 5.3)	4.0 (3.3 – 4.8)
South East	4.6 (4.4 – 4.8)	4.8 (4.5 – 5.0)	4.7 (4.5 – 5.0)	4.6 (4.3 – 4.8)
England	5.1 (5.0 – 5.2)	5.2 (5.1 – 5.3)	5.0 (4.9 – 5.1)	4.9 (4.8 – 5.0)

Source: HSCIC Indicator Portal: HSCIC Indicators - "Stillbirths, crude rate, 3-year average" (released Feb-2015)

Causes of stillbirth (national data only)

The most frequent cause of stillbirth was "remaining antepartum deaths" (likely reflecting difficulty identifying a primary cause), which accounted for 53.0% of linked[xxix] infant stillbirths in England and Wales during 2013[xxx]. "Asphyxia, anoxia or trauma (antepartum)" accounted for the next largest cause (20.4%) and congenital anomalies resulted in 15.6% of stillbirths[xxxi].

6.1.1.2 Perinatal Mortality (stillbirths and < 7 days)

The perinatal mortality rate is the number of stillbirths and the number of early neonatal deaths per 1,000 total (live and still) births. Early neonatal deaths occur within 7 days since birth. For 2011-13, 160 perinatal deaths were recorded in West Sussex. This results in a perinatal mortality rate of 5.9 in every 1,000 births[xxxii]. This is significantly lower than national rates (England; 7.1) and is similar to regional rates (South East; 6.4).

Perinatal death rates are available at local authority level for 2011-13. Caution should be taken when interpreting these figures as these rates were calculated from less than 20 counts and such small numbers of events may affect their reliability. The highest rate of perinatal mortality occurred in Arun (7.4 deaths per 1,000 live and stillbirths) and the lowest in Horsham (4.4 deaths per 1,000 live and stillbirths), although the rates for these areas do not significantly differ from one another.

6.1.1.3 Neonatal Mortality (< 28 days)

Neonatal mortality rate is defined as the number of deaths of babies aged less than 28 days old compared to the total number of live births. In 2011-13, the rate of neonatal mortality for West Sussex was estimated at 2.3 per 1,000 live births[xxxiii]. This is comparable to the rates for England (2.9 per thousand live births) and the South East (2.4 per thousand live births). These figures have not changed significantly from 2008-10.

6.1.1.4 Post-Neonatal Mortality (28 days – 1 year)

Post-neonatal mortality is defined as the death of a baby aged between 28 days and 1 year old. In 2011-13, the post neonatal mortality rate was 1.1 per 1,000 live births in West Sussex. This does not differ to a rate of 1.3 in England and 1.1 in the South East (per 1,000 live births)[xxxiv].

[xxix] Linked stillbirths are the number of stillbirths occurring in 2013 that have been successfully linked to their corresponding birth registration records

[xxx] ONS – Childhood, Infant and Perinatal Mortality in England and Wales, 2013 (released Mar-2015)

[xxxi] The remaining 11% of stillbirths were attributed to a range of causes and conditions, including: antepartum infections; external conditions; intrapartum asphyxia, anoxia or trauma; other specific conditions; and other conditions.

[xxxii] HSCIC – Perinatal mortality: crude rate, still births and < 7 days, 3-year average (released Feb-2015)

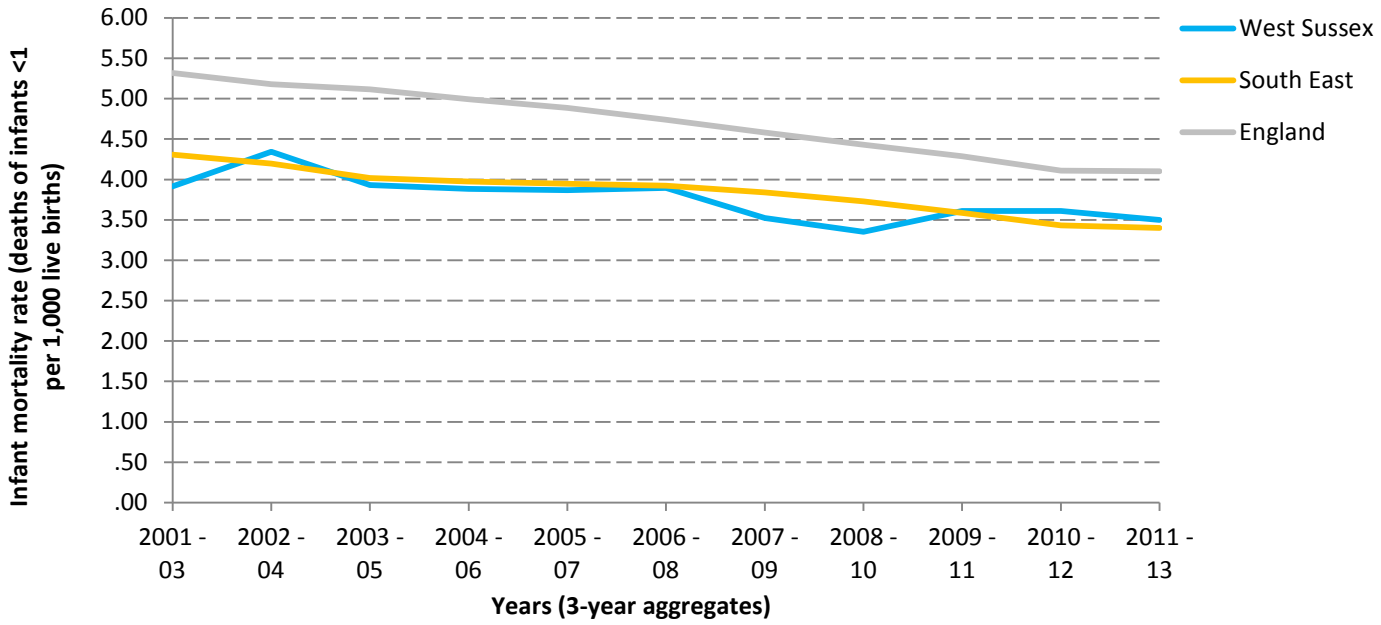
[xxxiii] HSCIC – Neonatal mortality: crude rate, <28 days, 3-year average (released Feb-2015)

[xxxiv] HSCIC – Postneonatal mortality: crude rate, 28 days-1 year, 3-year average (released Feb-2015)

6.1.1.5 Infant Mortality (all infant deaths < 1 year)

In 2011-13, the number of infants dying before their first birthday in England was estimated at 4.0 deaths per thousand live births[xxxv]. The infant mortality rate in West Sussex is similar (3.3 per 1,000 live births) to national and regional rates (4.0 and 3.3 deaths per 1,000 live births respectively). This value has not changed significantly over time, with an infant mortality rate of 3.9 per 1,000 live births in West Sussex in 2001-03 (Figure 19). In comparison, the rate of infant mortality for England has seen a steady and significant decline falling from 5.3 deaths per 1,000 live births in 2001-03 to 4.0 deaths in 2011-13.

Figure 19 - Infant mortality rates for England, the South East and West Sussex



Source: Public Health Outcomes Framework: "Indicator 4.01: Infant Mortality"

Causes of infant mortality (national data)

In England and Wales, the most common cause of infant mortality within the first year of life remains conditions related to immaturity, which accounted for 43.9% of deaths in 2013[xxxvi] (Table 21). Congenital anomalies were the second largest cause of infant mortality accounting for a further 28.4% of deaths. This picture is similar for early neonatal and neonatal mortality. The causes of death during the post-neonatal period of life are more broadly distributed, with the greatest proportion of infants dying due to congenital anomalies (32.5%), other conditions (18.5%) and sudden infant deaths (16.6%) than factors associated with immaturity (13.6%).

Table 21 - Percentage of linked* early neonatal, neonatal, post-neonatal and infant deaths in England and Wales (2013) due to causes classified by the ONS[xxxvii]

	Deaths (%age of total)			
	Early neonatal	Neonatal	Post-neonatal	Infant

[xxxv] PHOF – "Indicator 4.01: Infant Mortality"
[xxxvi] ONS – Childhood, Infant and Perinatal Mortality in England and Wales, 2013 (released Mar-2015)
[xxxvii] See the "Child Mortality Statistics metadata" report by the ONS for more detail (released Mar-2015)

Immaturity	60.5%	56.8%	13.6%	43.9%
Congenital anomalies	25.0%	26.6%	32.5%	28.4%
Asphyxia, anoxia or trauma (intrapartum)	9.3%	8.4%	2.4%	6.6%
External conditions	0.2%	0.3%	2.7%	1.0%
Antepartum infection	1.6%	2.8%	0.6%	2.1%
Infections	0.8%	1.4%	10.8%	4.2%
Sudden infant deaths	0.4%	0.9%	16.6%	5.6%
Other specific conditions	1.0%	1.0%	2.3%	1.4%
Other conditions	1.3%	1.9%	18.5%	6.9%
	100.0%	**100.0%**	**100.0%**	**100.0%**

Note. This table contains the number of infant deaths occurring in 2013 that have been successfully linked to their corresponding birth registration records and comprise the 2013 infant death cohort.
Source: ONS – Childhood, Infant and Perinatal Mortality in England and Wales, 2013

Factors relating to Infant Mortality

Birth weight (national data): Low birth weight and immaturity is strongly associated with greater risk of infant mortality. Table 22 demonstrates that the lower the birth weight of an infant, the greater the instance of death across all time points prior to their first birthday.

Table 22 – Infant mortality rates for England and Wales 2013

	Stillbirth	Perinatal	Neonatal	Post-neonatal	Infant
All	**4.7**	**6.7**	**2.6**	**1.1**	**3.8**
<2500g	42.2	61.9	25.6	6.7	32.4
<1500g	159.6	256.1	140.7	23.3	164.0
<1000g	226.2	399.7	270.3	38.0	308.3

Source: ONS – Childhood, Infant and Perinatal Mortality in England and Wales, 2013

Maternal age and birth weight (national data): In addition, the effects of birth weight and maternal age on infant mortality interact. In particular, rates of stillbirth are highest for infants of low birth weight (<1000g) born to mothers under the age of 20 (250.0 per 1,000 births), or over the age of 40 (260.7 per 1,000 births). This pattern remains for low birth weight infants born to younger mothers for infant mortality (409.8 per 1,000 live births), but not for low birth weight infants born to older mothers (284.2 per 1,000 live births).

6.1.2 National and West Sussex Profile: Sudden Infant Death Syndrome (SIDs)

The ONS produces data on SIDs which includes deaths of infants under the age of 1 year that were due to "sudden infant death", "cot death", "crib death" or similar on the death certificate. In England and Wales, approximately 160[xxxviii] sudden infant deaths were recorded in 2013[xxxix]. This equates to a rate of 0.23 sudden infant deaths per 1,000 live births.

At regional and local levels, the number and rate of unexplained deaths are reported. This includes sudden infant deaths and unascertained deaths as recorded on the death certificate. Due to small counts, data are pooled for all available years. In 2004-2013, approximately 330 unexplained infant deaths occurred in the South East, accounting for a rate of 0.32 per 1,000 live births. This compares to an unexplained death rate

[xxxviii] Note data from 2013 is provisional.
[xxxix] ONS – Unexplained deaths in infancy: England and Wales, 2013 (released Aug-15)

of 0.40 per 1,000 live births in England. In West Sussex, approximately 25 unexplained infant deaths occurred between 2004-2013; a rate of 0.29 per 1,000 live births. At a local level, there is little variation in the number and rate of unexplained infant deaths. Due to such small counts (<20 deaths for all local authorities), the data in Table 23 should be interpreted cautiously.

Table 23 – Rate of unexplained infant deaths per 1,000 live births (2004-2013) in local authorities in West Sussex

Area	Unexplained infant deaths per 1,000 live births (2004-2013 pooled)		
	Rate	Lower bound CI	Upper bound CI
Adur	0.44*	0.09*	1.29*
Arun	0.55*	0.24*	1.08*
Chichester	-	-	-
Crawley	0.39*	0.14*	0.85*
Horsham	-	-	-
Mid Sussex	0.20*	0.04*	0.58*
Worthing	0.25*	0.05*	0.74*
West Sussex	0.29	0.19	0.42

Source: ONS – Unexplained deaths in infancy: England and Wales 2013. The rate for West Sussex has been calculated manually using the number of births for the time period from ONS as the denominator.
Note. * denotes low reliability. – denotes data suppressed where < 3 counts.

6.2 Childhood Mortality (1-4 years)

Evidence indicates that infant mortality risk factors have an effect on mortality in later childhood and also that there are significant inequalities in survival chances between social classes[23]. As children get older, non-health related causes of death, such as injuries and poisoning violence are likely to increase, however, major causes differ by age group and sex[24].

6.2.1 National and West Sussex Profile: Childhood Death (1-4 years)

Childhood mortality data for England and Wales spanning 1980 to 2013 is released by the ONS[xl]. The age-specific rate of deaths of children aged 1-4 was 51 per 100,000 children in 1980; this has decreased to 15 per 100,000 children in 2013.

The HSCIC provide three-year averages of age-specific death rates per 100,000 population[xli]. In 2011-13, the national mortality rate of children aged 1-4 was estimated at 17.0 per 100,000. For the South East region and West Sussex county, the mortality rate of children aged 1-4 was lower at 14.1 and 11.3 (per 100,000 children aged 1-4) respectively. These values have decreased from 2008-10 (rates for England: 19.0, the South East: 17.6, and West Sussex: 12.2 per 100,000 children aged 1-4 years).

Causes of Childhood Mortality (national data)

[xl] ONS – Childhood, Infant and Perinatal Mortality in England and Wales, 2013 (released Mar-2015)
[xli] HSCIC – Mortality from all causes: crude death rate, by age group, 3-year average (released Feb-15)

Causes of mortality are categorised using definitions from the International Classification of Diseases 10th edition (ICD-10). The most common cause of childhood mortality in England and Wales in 2013[xlii] was neoplasms, accounting for 18.8% of deaths. Congenital malformations, deformations and chromosomal abnormalities (such as heart defects and Down syndrome) and diseases of the nervous system (such as meningitis and epilepsy) were the next largest cause groups accounting for 14.4% and 14.2% of all childhood deaths respectively. Finally, diseases of the respiratory system (e.g. influenza, asthma and pneumonia) and external causes (e.g. falls, road accidents and assaults) accounted for 11.4% and 10.1% of childhood deaths. These five groups accounted for nearly 70% of all childhood deaths aged 1-4 (Table 24).

Table 24 - The most common causes of childhood mortality (aged 1-4 years) in England and Wales, 2013

Causes of childhood mortality (ICD-10 cause groups)	%age of total
Neoplasms	18.8%
Congenital malformations, deformations, and chromosomal abnormalities	14.4%
Diseases of the nervous system	14.2%
Diseases of the respiratory system	11.4%
External causes of morbidity and mortality	10.1%
Certain infectious parasitic diseases	8.0%
Endocrine, nutritional and metabolic diseases	5.7%
Diseases of the circulatory system	5.0%
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	5.0%
Other*	7.4%
	100.0%

Source: ONS – Childhood, Infant and Perinatal Mortality in England and Wales, 2013
Note. * Due to the large number of cause groups, the causes that contributed < 5% of total childhood deaths were grouped together. See the full database by the ONS for further detail.

Causes of Childhood Mortality (West Sussex data)

All available data for West Sussex has been pooled due to small counts (2001-14). The causes of death are reported in Table 25. It should be noted that despite using all available years (2001-14), the numbers of childhood deaths for each cause group were small. As such, this data should be taken with caution, as it is volatile to small changes. Similarly to national data, the most common cause of death was neoplasms, accounting for 21.3% of childhood deaths. External causes of morbidity and mortality (e.g. road accidents, falls, accidental fires, drowning) was the next largest cause group in West Sussex, accounting for 16.9% of childhood deaths. Congenital malformations, deformations and chromosomal abnormalities (12.4%) and diseases of the nervous system (11.2%) were the next largest causes of childhood death.

[xlii] ONS – "Table 4 – Postneonatal and childhood deaths: broad underlying causes groups, age and sex 2013" from "Childhood, Infant and Perinatal Mortality in England and Wales, 2013" (released Mar-2015)

Table 25 – Causes of childhood deaths in West Sussex (between 2001 and 2014)

Underlying cause group	% of 1-4 year olds (2001-14)
II Neoplasms	21.3%
XX External causes of morbidity and mortality	16.9%
XVII Congenital malformations, deformations and chromosomal abnormalities	12.4%
VI Diseases of the nervous system	11.2%
XVIII Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	7.9%
I Certain infectious parasitic diseases	6.7%
X Diseases of the respiratory system	6.7%
IX Diseases of the circulatory system	5.6%
XI Diseases of the digestive system	5.6%
IV Endocrine, nutritional and metabolic diseases	4.5%
III Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism	1.1%
ALL	**100.0%**

Source: Primary Care Mortality Database (PCMD) for West Sussex

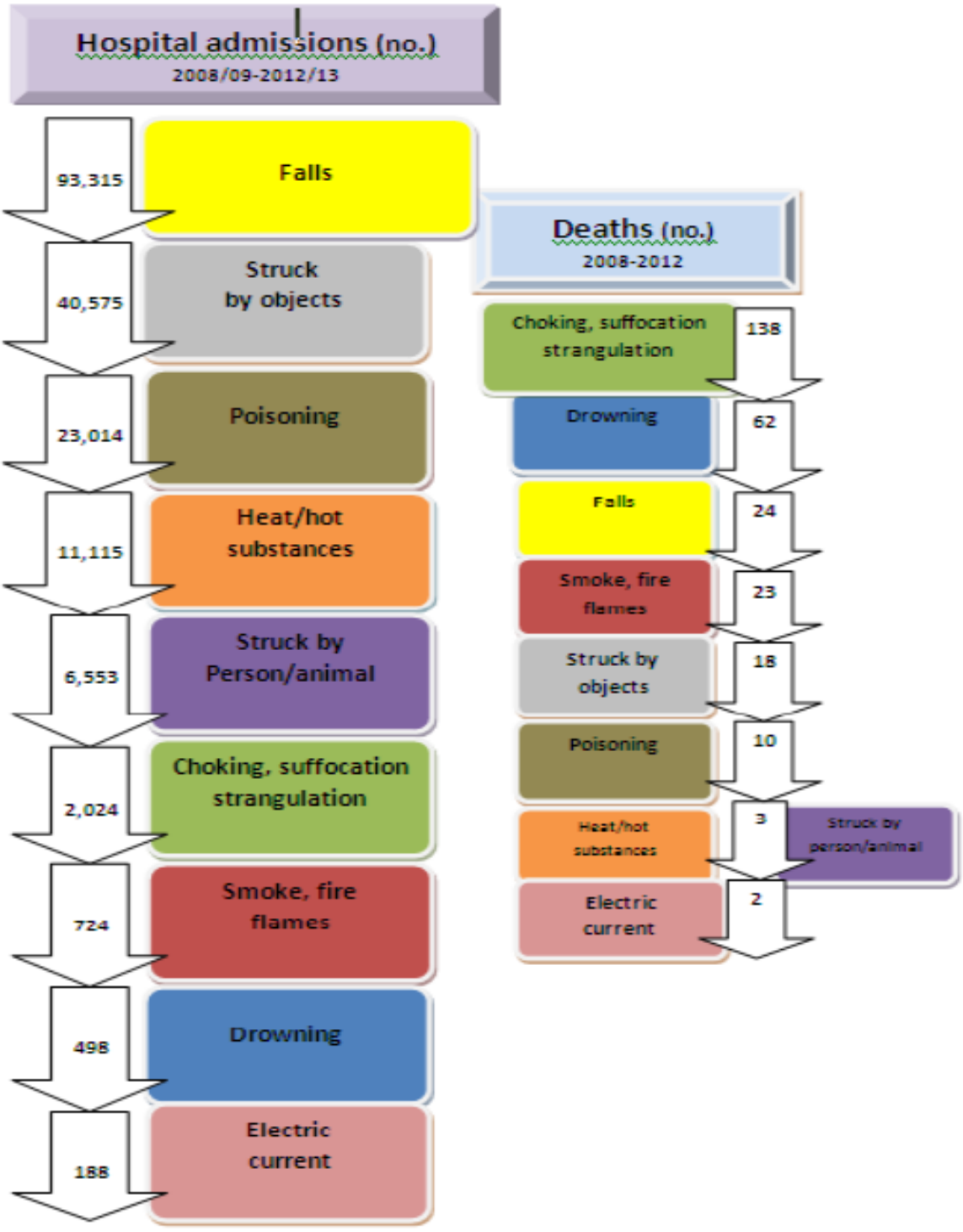
6.2.2 Considerations for Commissioners and Providers

Estimates suggest that approximately 21% of child deaths involved modifiable or preventable factors. Reducing inequalities through improvements in maternal and child health and the wider determinants of health such as education and housing are some of the key recommendations for the reduction of child and infant mortality[4]. Evidence based interventions targeted at high-risk groups, such as teenage mothers (e.g. Family Nurse Partnership (FNP)), who smoke in pregnancy and those living in deprived areas, are key in reducing child mortality and giving every child the best start in life. Other interventions that target risk factors, such as increasing the initiation and duration of breastfeeding, smoking cessation during pregnancy, and comprehensive pre and postnatal care, are also effective in reducing infant mortality.

6.3 Unintentional Injuries and Emergency Hospital Admissions

Unintentional injuries are some of the leading causes of death among children and young people aged 1–14. Whilst the pattern of risks associated with unintentional injury in children varies, epidemiological data indicate that the risk of an unintentional injury is greatest among households living in the most deprived circumstances (NICE guidance PH30). Children and young people from lower socioeconomic groups whose parents have never worked (or who are long-term unemployed) are 13 times more likely to die from such an injury than those whose parents are managers and professionals (Edwards et al. 2006 cited by NICE PH30). This is potentially due to differences in a child's exposure to risks between different socio-economic classes, however, the evidence is less than clear cut.[25] Other interrelated factors that can potentially increase the risk of injury include overcrowded housing conditions, lack of safety equipment, age, gender, culture, ethnicity, maternal mental health and child behavioural problems (NICE PH30)[26].

Figure 20 – The main causes of hospital admissions and deaths for under-fives following unintentional injuries in, and around the home



Source: PHE Report – Reducing unintentional injuries in and around the home among children under five years (Jun-2014) https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/322210/Reducing_unintentional_injuries_in_and_around_the_home_among_children_under_five_years.pdf

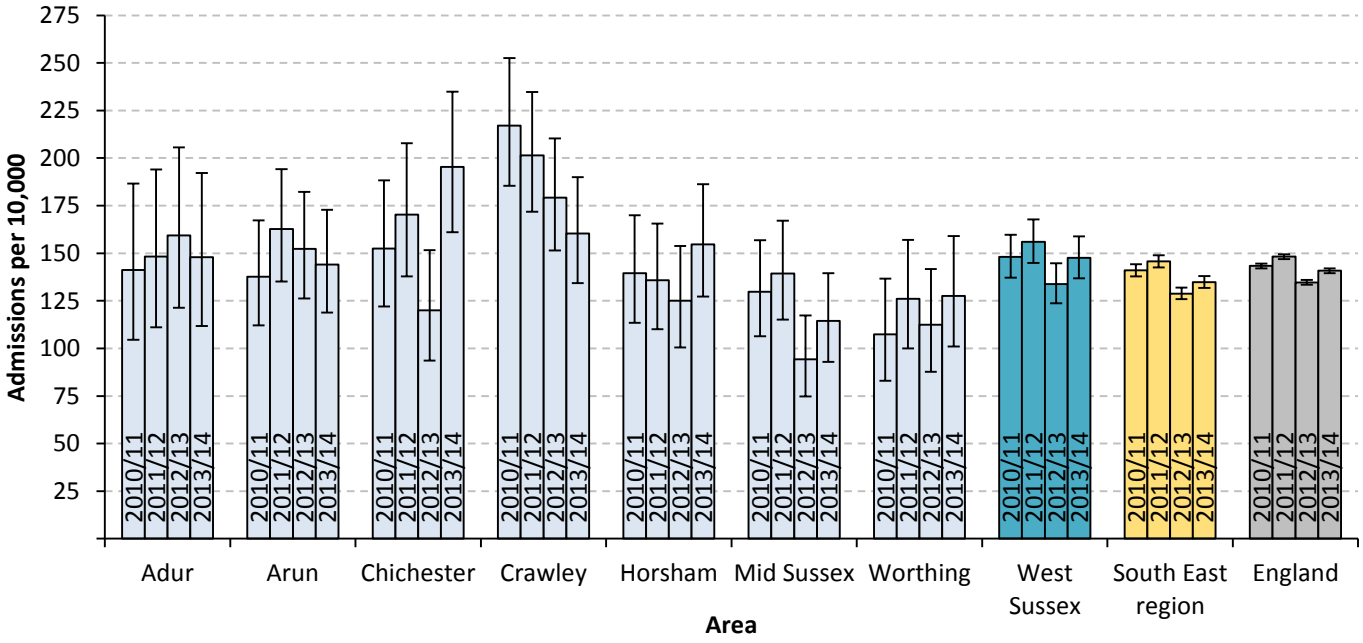
6.3.1 National and West Sussex Profile: Injuries and Emergency Hospital Admissions

6.3.1.1 Hospital admissions of children aged 0-4yrs due to unintentional or deliberate injury

In 2013/14, approximately 710 children under the age of 5 were admitted to hospital due to an unintentional or deliberate injury in West Sussex (Figure 21). This equates to a rate of 147.6 admissions in every 10,000 children aged 0-4. This is similar to England (a rate of 140.8) and is significantly higher than the South East region (a rate of 134.8).

Of the local authorities in West Sussex, admission rates were highest in Chichester (195.4 admissions per 10,000 under 5's) and lowest in Mid Sussex (114.5 admissions) in 2013/14. The rate of admissions in Chichester significantly exceeded the rates for England and the South East, as well as Mid Sussex and Worthing (Figure 21). The rate of under 5's admitted to hospital in Crawley due to unintentional or deliberate injury appears to be decreasing year-on-year.

Figure 21 - The number of finished emergency admissions due to unintentional and deliberate injuries in children aged 0-4 years in local authorities in West Sussex



Source: PHOF: indicator 2.07i – hospital admissions caused by unintentional and deliberate injuries in children (aged 0-4)

Causes of admissions due to unintentional injuries of under 5s (national and West Sussex data)

A study of mortality and hospital admissions over a five-year period (2008/09-2012/13)[xliii] found that there were approximately 40,000 hospital admissions each year for under-5s following unintentional injuries in England. Between 2008 and 2012, 311 children under the age of 5 died from unintentional injuries in England, resulting in a mortality rate of 1.90 per 100,000 population for this period. This study also indicated that local authorities should prioritise the reduction of five causes of unintentional injuries among the under-5s, including choking, suffocation and strangulation, falls, poisoning, burns and scalds

[xliii] PHE, RoSPA (Royal Society for the Prevention of Accidents) and CAPT (Child Accident Prevention Trust) – Reducing unintentional injuries in and around the home among children under five years (published Jun-2014) http://www.chimat.org.uk/earlyyears/injuries

and drowning. Table 26 shows the crude rates of emergency hospital admissions of under 5s for these cause groups (2008/09 - 2012/13). In West Sussex, there were 360 emergency admissions of children under the age of 5 due to falls from furniture, which equates to an admission rate of 157.8 per 100,000 population. There were also 185 admissions due to poisoning from medicines; a rate of 81.1 per 100,000 population.

Table 26 – Crude emergency hospital admission rates of children under the age of 5 (per 100,000 population) due to unintentional injuries (2008/09-2012/13)

	West Sussex	England
Suffocation and strangulation (including hanging)	0.0	0.5
Inhalation of food or vomit	11.4	11.1
Falls from furniture	157.8	149.2
Poisoning from medicines	81.1	99.4
Hot tap water scalds	5.3	6.8
Drowning in the bath	< 2.6*	1.1

Note. * denotes where counts were below 6, rates are presented as if there were 6 admissions. The actual rate is therefore greater than 0 but less than the rate shown.
Source: ChiMat - Reducing unintentional injuries in and around the home among children under five years (http://atlas.chimat.org.uk/IAS/profiles/profile?profileId=56&geoTypeId=)

6.3.1.2 Accident and Emergency Attendances (age 0-4 years)

In 2013-14, there were over 1,800,000 A&E admissions of children aged between 0-4 in England. This accounts for 9.8% of all admissions[xliv]. In West Sussex, there were approximately 383.3 A&E attendances of children aged 0-4 years per 1,000 of the 0-4 population[xlv]. This is significantly lower than England (estimated at 525.6 admissions) and the South East region (431.2 admissions per 1,000 children aged 0-4).

6.3.2 National and West Sussex Profile: Road Casualties

In 2014, 186 children (aged under 16) were road casualties in West Sussex (Table 27). This represents a 27% decrease from the 2005-09 average (254 child casualties)[xlvi]. Thirty of these children were seriously injured[xlvii]. There were no reported child fatalities in West Sussex in 2014.

Table 27 – The number of reported child road casualties in West Sussex, the South East and England (2010 – 14 and 2005/09 average)

	2005-09 average	2010	2011	2012	2013	2014	*2014 % change on 2005-09 average*
South East	3,149	2,597	2,713	2,365	2,237	2,433	*-23%*
West Sussex	254	175	194	180	203	186	*-27%*
England	20,996	17,168	17,150	15,276	13,926	14,902	*-29%*

Source: DfT – "RAS30039: reported child casualties by region and local authority, England, 2010-14 and 2005-09 average"

[xliv] HSCIC – "Accident and Emergency Attendances in England 2013-14" (released Jan-2015)
[xlv] ChiMat – "A&E attendance rate for children aged 0-4 years, top level local authority 2011/12"
[xlvi] Department for Transport (DfT) - "RAS30039 – Reported child casualties by region and local authority, England, 2010-2014 and 2005-09 average" (updated Sep-2015)
[xlvii] DfT – "RAS30058 - Reported casualties by county, lower tier local authority, severity, child KSI and all ages, England, 2014"

6.3.3 Considerations for commissioners and providers

Unintentional injuries in the home are more common for children under 4 and outside the home for school age children. A number of factors are associated with unintentional injuries in children, and these include:[27]

- Child development
- The physical environment in the home
- The knowledge and behaviour of parents and other carers (including literacy)
- Overcrowding or homelessness
- The availability of safety equipment
- New consumer products in the home.

According to PHE, the three key action areas to reduce unintentional injuries are:

- Providing leadership and mobilising existing services prevents injuries;
- The early years workforce needs support and training to enable it to strengthen its central role in helping to reduce unintentional injuries; and
- Focusing on 5 main kinds of injuries for under 5s, which, based on national data are; choking, suffocation and strangulation; falls; poisoning; burns and scalds; and drowning.[27]

Therefore, consideration should be given to effective interventions that prevent or reduce the incidence of unintentional injuries in children, through safeguarding, transport planning, social and public health policies. Furthermore, parenting interventions provided within the home, as part of a multifaceted intervention, have been found to be effective in reducing child injury and improving home safety through a variety of mechanisms[28]. Evidence indicates that maternal mental health and child behavioural problems are associated with childhood unintentional injury, therefore, by improving maternal psychological wellbeing and reducing child behavioural problems, parenting programs may also reduce such injuries.[26] There is also evidence to support home safety interventions such as education, promotion of smoke alarms, poison prevention practices, and the use of stair-gates. Cost implications of these should, however, be considered, particularly for disadvantaged families with low socio-economic status.

6.4 Child Morbidity

6.4.1 NHS Newborn Screening Programmes

The Newborn Screening Programmes (including hearing and blood screening) are important to provide early identification of abnormalities that may affect later development. The timely completion of the screening process is essential to increase coverage and to optimise the benefits of screening.

6.4.1.1 Newborn Hearing Screening Programme

The incidence of significant permanent congenital hearing impairment (PCHI) is about 1 in 1,000 live births in most developed countries although this may be 3-4 times higher in certain communities or parts of the UK. The incidence almost doubles by ten years of age because of acquired hearing loss from meningitis, mumps, measles, trauma and other causes[xlviii]. Early identification and intervention leads to better speech

[xlviii] The UK NSC recommendation on Hearing screening for newborns. http://legacy.screening.nhs.uk/hearing-newborn

and language, social and educational outcomes for children with hearing impairment. The importance of this is recognised by the Public Health Outcomes Framework indicator 2.21v "the percentage of babies eligible for newborn screening for whom screening process is complete within 4 weeks", which includes:

- babies for whom a conclusive screening result was available by 4 weeks of age (for hospital screening programmes) or,
- babies for whom a conclusive screening result was available by 5 weeks of age (for community screening programmes) or,
- babies referred to an audiology department because a newborn hearing screening encounter was inconclusive.

6.4.1.2 National and West Sussex Profile: Newborn Hearing Screening Programme

In 2013/14, 99.2% of newborns had their hearing screened within the first four weeks of life in West Sussex. This level of coverage is significantly higher than national (98.5%) and regional (98.7%) values[xlix].

6.4.1.3 Newborn Bloodspot Screening Programme

The NHS newborn blood spot screening programme helps identify several rare but serious diseases before they become symptomatic. Early detection of these conditions makes it possible to treat them and reduce their severity. Newborn blood spot screening is offered to all babies in the UK up to one year of age for:

- sickle cell disease
- cystic fibrosis
- congenital hypothyroidism and
- inherited metabolic diseases, which are genetic diseases that affect the metabolism.

6.4.1.4 National and West Sussex Profile: Newborn Bloodspot Screening Programme

Data is not yet available for newborn bloodspot screening in West Sussex. 96.5% of eligible infants underwent bloodspot screening in the South East. This is significantly higher than the uptake for England (93.5%)[l].

6.4.2 Immunisation and Screening

From birth and in early infancy and childhood, humans are exposed to countless numbers of foreign antigens and infectious agents in the everyday environment. Immunisation is a critical element of preventive care and is one of the most cost effective health investments. Vaccines are available for some deadly childhood diseases (see Table 28). A recent addition to the UK childhood immunisation program includes the Meningitis B vaccine. Low or poor immunisation coverage poses an increased risk in the incidence of disease and the possibility of outbreaks and epidemics.

[xlix] Public Health England – indicator 2.21v "newborn hearing screening – coverage"
[l] Public Health England – indicator 2.21iv "newborn bloodspot screening - coverage"

Table 28 - The childhood immunisation program UK

Age	Diseases protected against
Two months old	• Diphtheria, Tetanus, Pertussis (whooping cough), Polio and Haemophilus influenzae type b (Hib) • Pneumococcal disease • Meningococcal group B disease (MenB) • Rotavirus
Three months old	• Diphtheria, tetanus, pertussis, polio and Hib • Meningococcal group C disease (MenC) • Rotavirus
Four months old	• Diphtheria, tetanus, pertussis, polio and Hib • MenB • Pneumococcal disease
Between 12 and 13 months old – within a month of the first birthday	• Hib/MenC • Pneumococcal disease • Measles, mumps and rubella (German measles) • MenB
Two, three and four years old[li] and children in school years 1 and 2	• Influenza (from September)
Three years four months old or soon after	• Diphtheria, tetanus, pertussis and polio • Measles, mumps and rubella

Source: Public Health England – "the complete routine immunisation schedule from summer 2015" (https://www.gov.uk/government/publications/the-complete-routine-immunisation-schedule)

6.4.2.1 National and West Sussex Profile: Childhood Immunisations

The World Health Organisation (WHO) has set a vaccination target at global and regional levels, which has been adopted by the Department of Health at national and local levels. The 95% target level for vaccination coverage is required to ensure control of vaccine preventable diseases within the UK, and a 90% coverage level is the current benchmark for comparison for each region/county. By monitoring coverage, possible rises in disease prevalence can be anticipated when uptake drops.

For the majority of vaccinations, the population coverage in West Sussex exceeds the 90% benchmark. The only instance where this is not the case is for the second dose of the MMR vaccine, where 86.7% of West Sussex children were immunised with both doses by their 5th birthday (Table 29); this is similar to the level of coverage achieved in the South East region (86.6%), but significantly lower than England (88.3%).

[li] This is defined as children aged two, three or four year (but not five years) on 31 August 2015.

Table 29 - Percentage of children who have received each routine vaccination in West Sussex (2013-14)

	West Sussex	South East	England
For children under 12 months:			
5 in 1 DTaP/IPV/Hib vaccine (all 3 doses)	95.5%	93.6%	94.3%
MenC vaccine*	95.1%	93.6%	93.9%
PCV vaccine	95.1%	93.2%	94.1%
For children aged 24 months			
MenC/Hib vaccine (booster)	94.3%	91.7%	92.5%
PCV vaccine (booster)	91.4%	91.4%	92.4%
MMR vaccine (1 dose)	93.9%	91.8%	92.7%
For children aged 5 years:			
MMR vaccine (1 dose)	93.0%	92.6%	94.1%
MMR vaccine (both doses)	86.7%	86.6%	88.3%

Note. * data from 2012/13
Source: Public Health Outcomes Framework (indicator 3.03)

Population vaccination data spanning 2010 to 2014 shows that, for the majority of routine immunisations offered, the level of coverage in West Sussex has remained stable over time. The only exception is for the MMR vaccine, where significantly greater population coverage was observed between 2010 and 2012 (at all ages and doses) in West Sussex, although slight decreases have been seen in 2013/14.

6.4.2.2 Considerations for providers and commissioners

Evidence has shown that the following groups of children and young people are at risk of not being fully immunised (NICE PH21):

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

NICE (PH21) recommends a multifaceted and targeted approach to increase immunisation uptake among groups with low or partial uptake. Childhood immunisation is an important part of the HCP, and children who are not up-to-date with vaccinations may also be behind on other HCP activities – or may have other health needs. The parents (including those with parental responsibility) of these children and young people may need additional support, information and encouragement to ensure their children complete the vaccination programme. Evidence based interventions include patient recall reminder systems.

Research also indicates that the uptake of MMR has declined at a greater rate among children of more highly educated parents and among those living in more affluent areas (Wright and Polack 2005 cited by NICE PH21). Pearce et al. (2008) found that maternal education to degree level was a risk factor for not

receiving the MMR triple vaccine[29]. In contrast, late MMR vaccination was associated with socioeconomic disadvantage[30].

6.4.3 Speech, language and communication needs

The term speech, language and communication needs (SLCN) encompasses a wide range of difficulties related to all aspects of communication in children and young people. These can include difficulties with fluency, forming sounds and words, formulating sentences, understanding what others say, and using language socially.[31] SLCN may be a child's primary or secondary educational need.[31] SLCN may be a child's primary or secondary educational need. A primary SLCN includes specific difficulties of which there is often no obvious cause and secondary SLCN are associated with other difficulties that the child may be experiencing such as autism, cerebral palsy, hearing loss or more general learning difficulties. A significant proportion of children and young people in both primary and secondary school with special educational needs have SLCN as their primary need.

Speech, language and communication skills are key predictors in a child's readiness for school. Delays to development during the early years show a significant socio-economic gradient, with disadvantaged children being significant more likely to show signs of cognitive and language delays. The preschool years therefore represent a prime opportunity to promote the language and communication of all children, but particularly those who may need additional input.[28]

West Sussex Speech and Language

SALT service in West Sussex are divided into 4 localities, Mid Sussex and Crawley in the North of the county and Chichester and Worthing in the south. The service is accessed via referral from both professionals e.g. GP, Health Visitors, Consultant Paediatricians educational staff, and parents/carers.

Information concerning access and waiting times for Speech and Language was not reviewed as part of this needs assessment, as this data was not available at the time of this report.

6.4.4 Oral health/tooth decay

Dental caries in early childhood are frequently associated with pain, infection and tooth loss, as well as the emotional distress and potential consequences of medical interventions. They also affect young children's general health and wellbeing, including their body weight and growth. Despite being preventable, the prevalence of tooth decay remains high in children and young people in England and poor oral health in childhood is linked with poor dental health in adulthood (Chou et al, 2013a).[28] NHS England is responsible for commissioning primary care dental services, although local authorities and CCGs have an obvious interest in the promotion of good oral health.

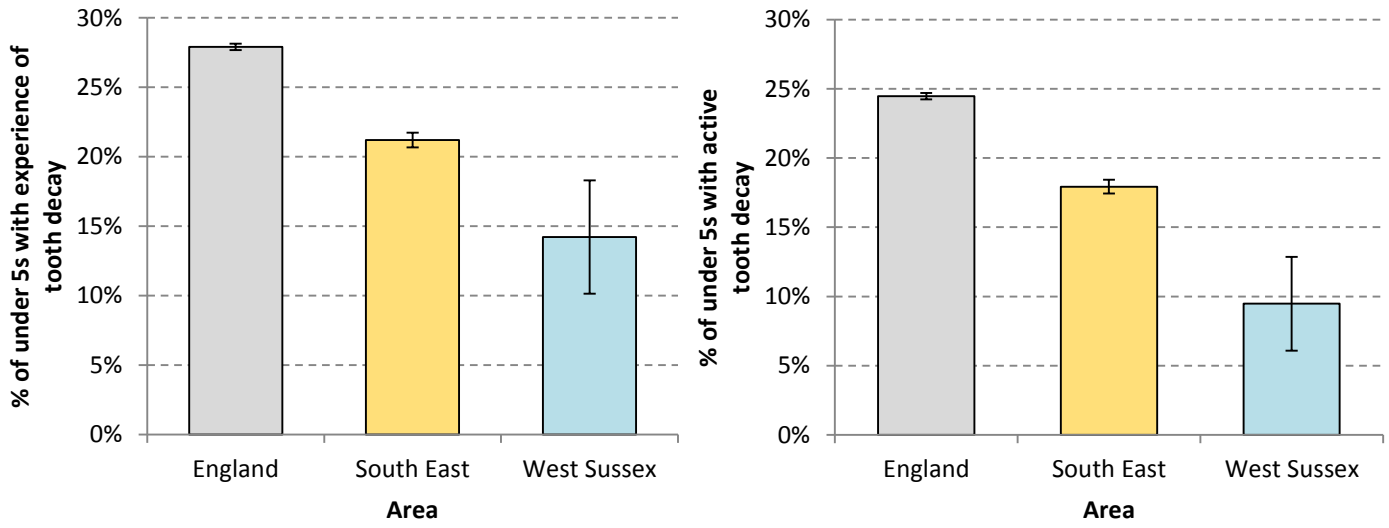
6.4.4.1 West Sussex and National Profile: The Oral Health Survey – Tooth Decay

Tooth decay is the most common oral disease affecting children and young people in England despite being largely preventable. In 2012, 27.9% of five-year-old children in England who participated in the Oral Health Survey had experience of tooth decay[lii].

As part of the Oral Health Survey, visual examinations for decayed, missing or filled teeth were conducted on a sample of 5-year old children whose parents actively consented to their participation in the survey. The key findings from the Oral Health survey in 2012 were:

- 14.2% of five-year-old children in West Sussex had experience of tooth decay in 2012[liii] (Figure 22, left). This is significantly lower than national (27.9%) and regional (21.2%) estimates.
- For children with tooth decay in West Sussex, an average of 2.9 teeth were decayed, missing or filled (DMFT). This is similar to England and the South East (3.4 and 3.2 DMFT respectively).
- The percentage of five-year-old children with current/active decay (i.e. with one or more obviously decayed teeth) at the time of the survey was 9.5% for West Sussex (Figure 22, right). This is significantly lower than England (24.5%) and the South East (17.9%).

Figure 22 - Percentage of five-year-old children with experience of tooth decay (left), and active tooth decay (right) in West Sussex, the South East and England 2012



In addition to the data collected by the Dental Public Health Intelligence Programme, the Child Dental Health Survey (CDH)[liv] is conducted once per decade to assess the dental health of children aged 5, 8, 12 and 15 years of age in England, Wales and Northern Ireland. NHS dentists and nurses conduct dental examinations in schools on a random sample of children. Changes in oral health over time can be examined by comparing the most recent data gathered during 2013/14 with the last CDH survey in 2003.

[lii] PHE - "National Dental Epidemiology Programme for England: Oral health survey of 5-year-old children 2012. A report on the prevalence and severity of dental decay" (released Sept-2013)
[liii] PHE – "National Dental Epidemiology Programme for England: Oral health survey of 5 year old children 2012: upper tier local authority results tables, 2012" http://www.nwph.net/dentalhealth/survey-results5.aspx?id=1 (accessed Apr-2015)
[liv] HSCIC – "Child Dental Health Survey 2013, England, Wales and Northern Ireland" (released Mar-2015)

Whilst data is only presented for England, Wales and Northern Ireland, the breadth of the survey provides an additional level of insight into factors associated with the oral health of young children.

The key findings from children aged 5 years from the 2013 report were[lv]:

- 31% of 5-year-old children had obvious decay experience[lvi] in their primary teeth. The average number of primary teeth with obvious decay experience (DMFT) was 0.9. Among five year olds with such decay, the average number of teeth affected was 3.0.
- Children eligible for free school meals were more likely to have poor oral health than those who were not eligible. 41% of 5-year-old children who were eligible for free school meals had obvious decay in primary teeth, whilst 21% had severe or extensive tooth decay. This compares to 29% and 11% of children who were not eligible.
- Children eligible for free school meals were more likely than those not eligible for free school meals to: brush their teeth less than twice per day (31% compared to 15% of 5-year-olds) and not attend the dentist for a check-up (19% compared to 9% of 5-year-olds).
- 52% of 5-year-old children were considered to have good overall oral health, indicating an absence of obvious decay, no calculus, or sever tooth surface loss.

6.4.4.2 Considerations for Commissioners and Providers

NICE recommends that children have dental check-ups at least every 12 months depending on their oral health status.

There are social inequalities in oral health, mediated through determinants such as socio-economic status, education, genetics and lifestyle factors. [32] Dental caries disproportionately affect deprived and disadvantaged children. Individuals with disabilities and children under 5 have an increased risk (Bazian Ltd., 2014) [28]. Risk factors to poor oral health include unhealthy diet and nutrition with frequent exposure to dietary sugar, giving sugar-sweetened drinks in feeding bottles, lack of regular oral hygiene practices, tobacco and alcohol consumption, and limited availability and access to dental services[32]. Many of these risk factors – diet, oral hygiene, smoking, alcohol, stress and trauma – are similar to those of many chronic conditions, such as cancer, diabetes and heart disease. Therefore, interventions that address these risk factors will improve general health as well as oral health (NICE guidance PH55).

6.5 Long Term Conditions

6.5.1 Asthma

Asthma is a common chronic condition that can be managed successfully with treatment. It occurs in all age groups and with appropriate asthma management plans, the severity and mortality of the disease can be significantly reduced. As such, asthma is the focus of many public health interventions to reduce the mortality and morbidity of the disease[lvii].

[lv] HSCIC - "Child Dental Health Survey: Executive Summary. England, Wales and Northern Ireland, 2013" (released Mar-2015)
[lvi] Obvious decay experiences includes untreated decay requiring fillings or tooth extraction, filling and teeth lost because of decay, DMFT for primary and permanent teeth (includes visual dentine caries).
[lvii] Bousquet, J. et al. (2005). The public health implication of asthma. Bulletin World Health Organisation, 83(7), 548-54.

6.5.1.1 Prevalence of asthma for children aged under 5 in Crawley and Horsham and Mid Sussex CCGs

Over 5.4 million people in the UK are currently receiving treatment for asthma; 1.1 million children (1 in 11) and 4.3 million adults (1 in 12)[lviii].

In the north of the county (both Crawley and Horsham Mid Sussex CCGs), there are nearly 400 children aged under 5 years who have been identified as having asthma (Table 30). This equates to approximately 1.9% of the population across both Crawley and Horsham Mid Sussex CCGs. A significantly greater proportion of boys (2.3%) than girls (1.4%) aged under 5 have been identified as having asthma. If this proportion is applied to the GP registered population of under 5s for the county (46,775), it is estimated that there are approximately 880 under 5s in West Sussex that have asthma[lix].

Table 30 - Number and rate (per 100,000) of under 5s with asthma in Crawley and Horsham and Mid Sussex CCGs (as at May-2015)

Under 5's	Number of patients	Number of patients with asthma	Rate per 100,000 under 5 population	Confidence
Crawley CCG	8,340	180	2,195.6	1,889.0 – 2,537.7
Horsham and Mid Sussex CCG	12,540	210	1,667.2	1,448.8 – 1,909.2
Total (both CCGs)	20,870	390	1,878.2	1,696.8 – 2,073.7
Males	10,800	250	2,306.4	2,028.8 – 2,611.4
Females	10,080	140	1,419.4	1,196.3 – 1,672.0

Note. Counts have been rounded to the nearest 10, so totals may not sum.
Source: Artemus DOCOBO (extracted May-2015)

6.5.1.2 Admissions for children (under the age of 19) with asthma

In 2012/13, there was a crude emergency admission rate of 219.1 children (0-18 years) with asthma per 100,000 children in England[lx]. In West Sussex CCGs, the emergency admission rate for children with asthma varied (Table 31). Horsham and Mid Sussex CCG has a significantly lower rate (132.2 per 100,000 children) than Coastal West Sussex (239.5 per 100,000) and Crawley (304.2 per 100,000) CCGs. Crawley CCG has a significantly higher emergency admission rate for children with asthma than England.

Table 31 - Emergency admissions for children (0-18yrs) with asthma in West Sussex CCGs, 2012/13

Commissioning Region	N of emergency asthma admissions	Crude rate of emergency admissions for children with asthma (2012/13) per 100,000			Comparison with England
		Rate	LCI	UCI	
Coastal West Sussex CCG	228	239.5	209.4	272.7	Same
Crawley CCG	91	304.2	244.9	373.5	Worse
Horsham and Mid Sussex CCG	66	132.2	102.2	168.2	Better
England	26,638	219.1	216.5	221.7	n/a

Source: PHE – INHALE fingertips data portal; ChiMat Disease Management Information Toolkit (Paediatric Asthma)

[lviii] www.asthma.org.uk
[lix] HSCIC – GP registered population (Oct-2015) used as the denominator in this instance.
[lx] PHE – INHALE fingertips data portal 2012/13

6.5.1.3 Mean length of stay and bed days for emergency admissions of children with asthma

The mean length of stay of emergency admissions for children with asthma is similar across the CCGs in West Sussex (ranging from 0.90 – 0.97 days; Table 32). Crawley and Coastal West Sussex CCGs have significantly better performance than England, where the average length of stay was 1.25 days.

The rate of emergency bed days occupied by children with asthma is significantly lower in Horsham and Mid Sussex CCG (128 per 100,000; Table 32) than the other CCGs in West Sussex and national estimates. Variation in the rate of emergency bed days is not necessarily a reflection on hospital/CCG performance. It may instead reflect differences in the provisions available at each hospital (for example, with the sickest children being sent to a hospital with known specialist services).

Table 32 - Rate of emergency asthma admissions, bed days (per 100,000 population), and the mean length of stay for children with asthma (< 19 years) in West Sussex and England (2012/13)

Commissioning Region	Rate of emergency asthma admissions per 100,000	Rate of bed days per 100,000 population	Average length of stay (days)
Coastal West Sussex CCG	239.5	226	0.94
Crawley CCG	304.2	274	0.90
Horsham and Mid Sussex CCG	132.2	128	0.97
England	219.1	277	1.25

Source: PHE – INHALE fingertips data portal; ChiMat Disease Management Information Toolkit (Paediatric Asthma)

6.5.2 Prevalence of Cancer (children aged under 5)

The rate of under 5s with a diagnosis of cancer is 340.2 per 100,000 patients in both Crawley CCG and Horsham and Mid Sussex CCG in West Sussex. If this rate is applied to the registered GP population for the county, it is estimated that there are approximately 160 under 5s in West Sussex with a diagnosis of cancer.

Table 33 - Number of under 5s with a diagnosis of cancer in Crawley CCG and Horsham and Mid Sussex CCG (as at May 2015)

	Number of under 5s	Number of under 5s with cancer	Rate of cancer per 100,000	Confidence
Crawley and Horsham Mid Sussex CCGs	20,870	70	340.2	265.7 – 429.1
Males	10,800	30	259.4	172.3 - 374.8
Females	10,080	40	426.8	308.9 – 574.9

Note. Counts have been rounded to the nearest 10, so totals may not sum.
Source: Artemus DOCOBO (extracted May-2015)

6.5.3 Prevalence of Epilepsy (children aged under 5)

It is estimated that in West Sussex, there are approximately 90-100 children under the age of 5 who have a diagnosis of epilepsy. This figure is based on the number of under 5s with epilepsy in Crawley and Horsham Mid Sussex CCGs; the rate of which is applied to the GP registered population for the whole county.

6.6 Obesity

Obesity carries significant risk for non-communicable diseases such as cardiovascular diseases (CVD), diabetes, some cancers, musculoskeletal diseases and it is one of the leading causes of mortality and morbidity worldwide.

Obesity in pregnancy increases the risk of adverse health outcomes for both mother and baby, as compared to the general population. Maternal obesity is also related to health inequalities, particularly socioeconomic deprivation, inequalities within ethnic groups and poor access to maternity services (*NICE guidance PH11*). Maternal obesity is one of the identified risk factors for stillbirth, congenital abnormalities, hypertensive disorders, gestational diabetes, induction of labour, caesarean section, postpartum haemorrhage, and an increased risk of the child being obese in infancy and beyond.[33-35] Some of the evidence points towards an increase in infant mortality odds, with an increasing maternal obesity.[35]

6.6.1 National Profile: Maternal Obesity

Statistics for the prevalence of maternal obesity are not routinely collected in the UK. Trend data from the Health Survey for England (HSE) show that since 1993, the prevalence of overweight and obesity amongst women of childbearing age (16-44 years) has increased. Approximately 12.4% of women aged 16-44 years were obese in 1993, compared to 19.4% in 2013. In 2013, approximately 19.4% of women of childbearing age were obese, and a further 29.1% were overweight. This equates to nearly half of all women of childbearing age in England (48.5%)[lxi].

The Centre for Maternal and Child Enquiries (CMACE) commenced a three-year, UK wide Obesity in Pregnancy project in 2008[lxii]. The project included a national survey of maternity services for women with obesity; a national cohort study of 5,068 women with maternal obesity (BMI ≥ 35) who gave birth in March and April 2009; and a clinical audit of maternity care received by 905 women with a BMI ≥ 35.

The main findings of this national project were:

1. The UK prevalence of women with a known BMI ≥ 35 at any point during pregnancy, who gave birth ≥ 24 weeks' gestation is 4.99%. This equates to approximately 38,500 maternities each year.
2. West Sussex falls within the South East Coast SHA. The prevalence of women with a BMI ≥ 35 who gave birth during March or April 2009 was 4.4%.
3. 34% of pregnant women living in England with a BMI ≥ 35 were in the most deprived quintile of deprivation (from the ID2010).
4. The proportion of women aged 35 years or more increased with each increasing BMI category. For example, 31% of women with a BMI ≥ 50 were over the age of 34.
5. Babies born to mothers with a BMI ≥ 35 have a greater risk of perinatal mortality. The rate of stillbirths is substantially higher for infants of mothers with a BMI ≥ 35 (8.6 stillbirths per 1,000 live births) compared to the general population rate (3.9 per 1,000 births).

[lxi] For further information see: http://www.noo.org.uk/NOO_about_obesity/maternal_obesity_2015
[lxii] Centre for Maternal and Child Enquiries (2010) Maternal obesity in the UK: findings from a national project

6.6.2 Childhood Obesity

Childhood obesity is associated with an increased risk of adult obesity, and premature death and disability in adulthood. Furthermore, as well as increased future risks, obese children experience breathing difficulties, increased risk of fractures, hypertension, early markers of CVD, insulin resistance and the psychological effects of obesity (*WHO*).

6.6.3 National and West Sussex Profile: The National Child Measurement Programme (NCMP)

The NCMP[lxiii] for England is an annual record of height and weight measurements of children in state-maintained schools in reception (aged 4-5 years) and year 6 (aged 10-11 years). The measurements of children in reception are most relevant to the Early Years, and reflect instances of obesity in children aged 5 and under at national, regional, county and local authority level.

The NCMP uses the British 1990 (UK90) growth reference to assign each child a body mass index (BMI) centile whilst taking into account weight, height, age and gender.

The reported participation rate of reception age children for West Sussex County Council was above the 85% target (89.7%) in 2014/15[lxiv].

Since 2006/07, the prevalence of overweight and obese children in West Sussex has been consistently lower than England. In 2014/15, 19.7% of reception age children were measured as overweight or obese in West Sussex (Table 34). This does not differ than the prevalence amongst the South East region (20.3%), and is significantly lower than the prevalence in England (21.9%).
Prevalence of obesity is significantly higher amongst boys than girls. In reception, 22.6% of boys and 21.2% of girls were overweight or obese in England. In West Sussex, approximately 20.4% of boys and 19.0% of girls were overweight or obese in 2014/15.

Whilst prevalence rates within local authorities of West Sussex are varied, no significant change in the percentage of overweight/obese children was seen for any one West Sussex local authority in 2014/15 when compared to the previous year (Figure 23). The prevalence of obesity is greatest in Arun (10.2%) for reception age children and this significantly exceeds that of Chichester (5.7%), Crawley (7.2%), Horsham (6.0%) and Mid Sussex (6.1%).

In 2014/15, the percentage of children in West Sussex with a healthy weight (79.7%) was greater than the rest of England (77.2%).

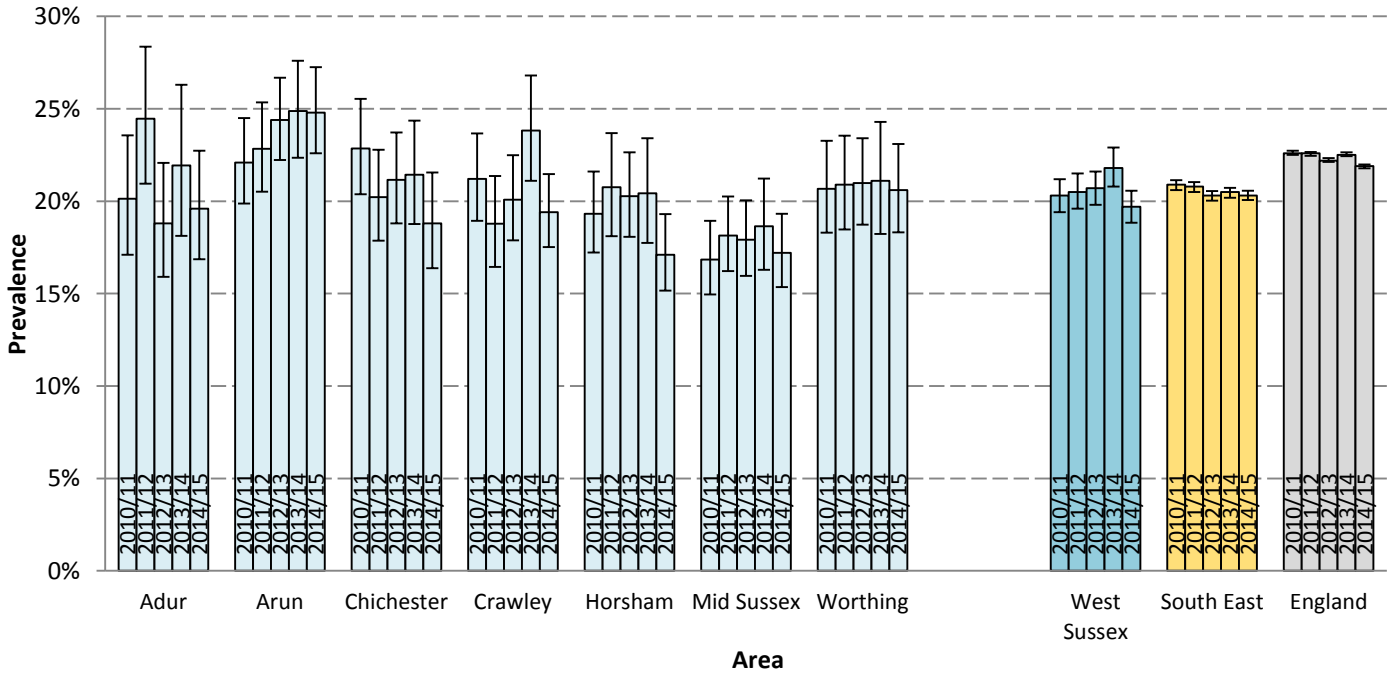
[lxiii] HSCIC – "National Child Measurement Programme – England, 2014/15" (released Dec-2015)
[lxiv] The reported participation rate for 2013/14 was below the 85% target (61.2%) because of data extraction problems following a change in provider information systems during the summer term. Thus data for 2013/14 may be less reliable than data from other years.

Table 34 - Prevalence rates of overweight/obese, and obese reception age children in England, the South East and West Sussex, 2014/15 academic year.

	CHILDREN in reception measured as part of the NCMP (2014/15)		
	Overweight including obese	Obese	Number of children measured
Adur	19.6%	7.4%	700
Arun	24.8%	10.2%	1,320
Chichester	18.8%	5.7%	870
Crawley	19.4%	7.2%	1,535
Horsham	17.1%	6.0%	1,270
Mid Sussex	17.2%	6.1%	1,385
Worthing	20.6%	7.9%	1,095
West Sussex	19.7%	7.3%	8,185
South East	20.3%	7.9%	96,800
ENGLAND	21.9%	9.1%	610,635

Source: HSCIC – NCMP England 2014/15 school year. Values have been rounded to the nearest 5, as such totals may not sum.

Figure 23 - Prevalence of reception age children measured as overweight/obese in West Sussex local authorities between 2010/11 – 2014/15.



Source: HSCIC (2010/11 to 2014/15 NCMP statistics)

At smaller geographies, there is significant variation in the proportion of children who are overweight or obese (Figure 24). For example, nearly 3 in 10 children in reception who reside in the Felpham CFC area were measured as overweight or obese (29.8%), compared to less than 1 in 10 in the Petworth CFC area (9.9%). Consistent with local authority level data, all except one (East Preston) CFC in Arun featured among the ten CFCs with the highest prevalence of reception age children measured as overweight or obese. However, it should be noted that the small number of children measured in each reach area means this data may be liable to substantial change over time.

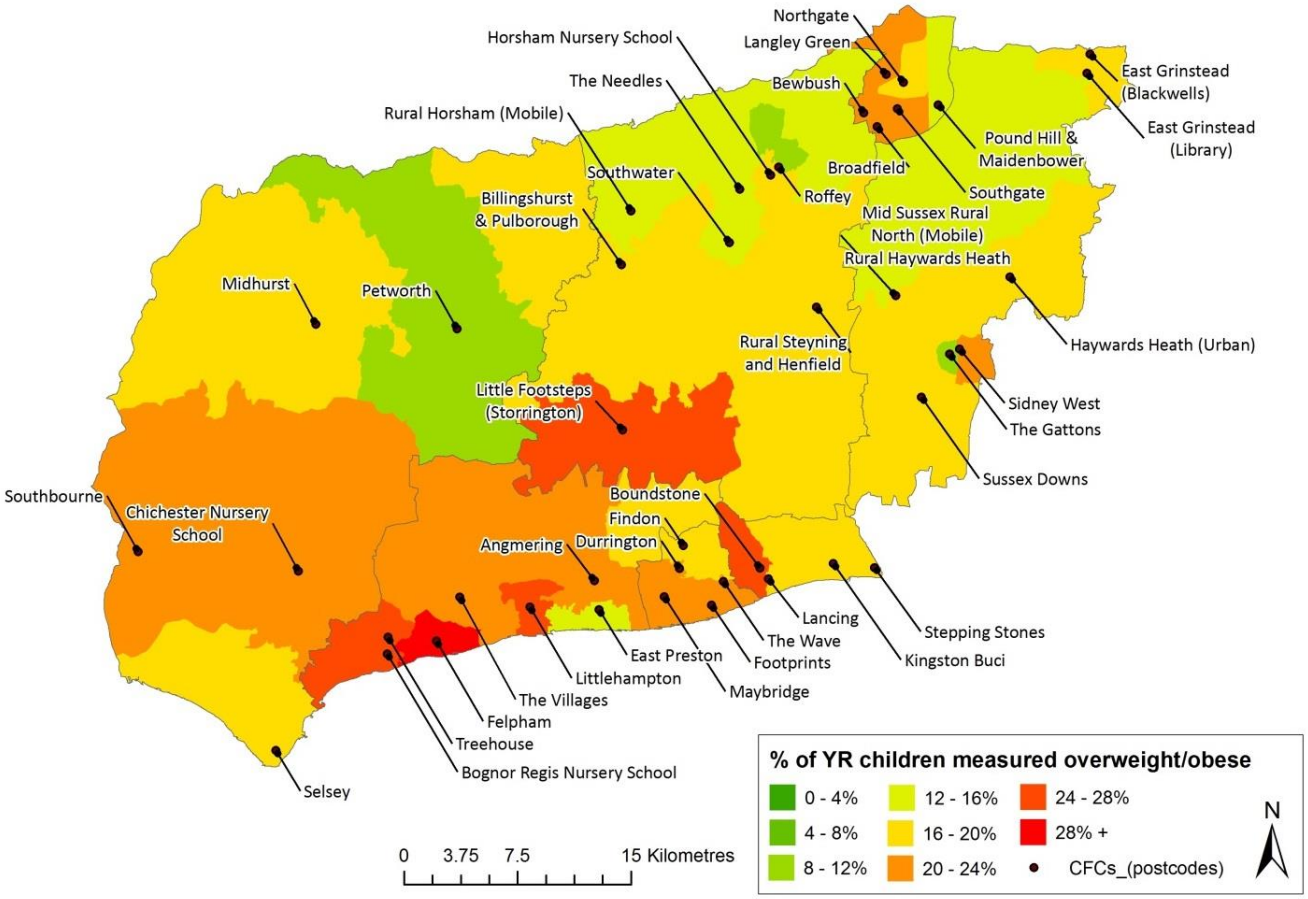
Table 35 - The ten CFC reach areas with the greatest prevalence of reception age children who were measured as overweight or obese in 2014/15.

CFCs	District	Reception children measured in 2013/14 as part of the NCMP		
		Number measured	Number overweight or obese	Proportion overweight or obese
Felpham	Arun	180	55	29.8%
Littlehampton	Arun	225	60	26.1%
Bognor Regis Nursery	Arun	255	65	26.1%
Little Footsteps	Horsham	115	30	25.7%
Treehouse	Arun	165	40	25.5%
Boundstone	Adur	180	45	24.3%
Langley Green	Crawley	255	60	23.7%
Angmering	Arun	195	45	23.7%
Southgate	Crawley	265	60	22.8%
The Villages	Arun	155	35	22.4%

Source: NCMP (2014/15).

Note: Counts have been rounded to the nearest 5.

Figure 24: The proportion of measured children in reception who were overweight or obese in West Sussex Children and Family Centres (2014/15)



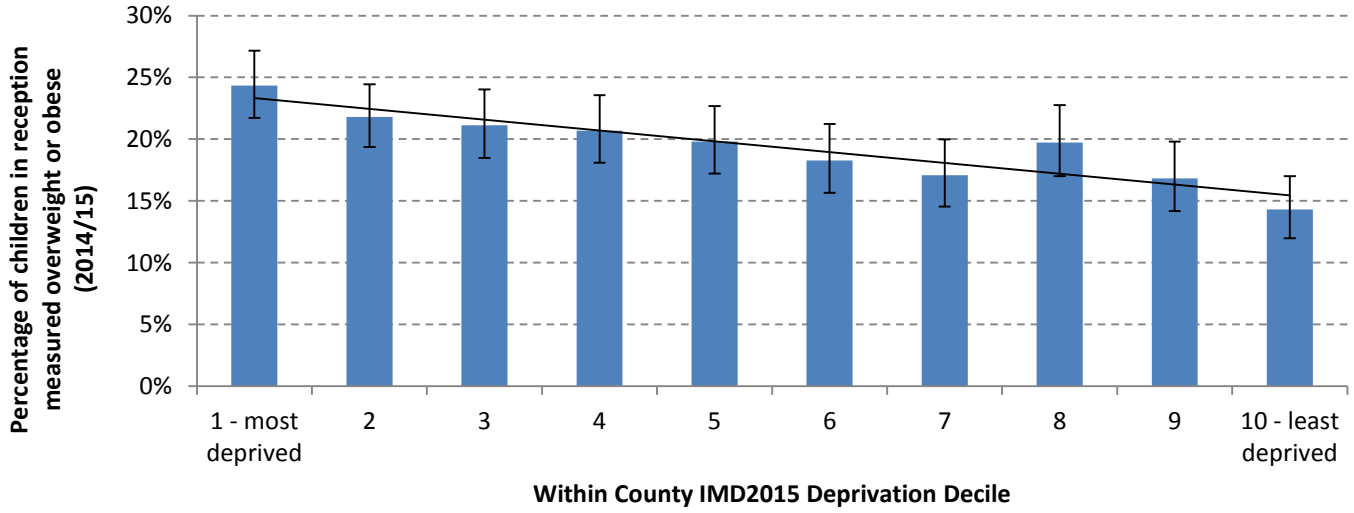
Map produced by V Pinkney, WSCC Public Health Research Unit (Nov-2015)

Obesity prevalence, income and deprivation

Prevalence of obesity is strongly related to deprivation[lxv]. Deprivation is based on the 2010 Index of Multiple Deprivation (ID2010) [lxvi] which classifies children into a deprivation decile based on their home postcode (1 = most deprived, 10 = least deprived). The 2014/15 NCMP reported that 12.0% of reception age children in the most deprived decile were obese compared to 5.7% of those in the least deprived decile in England; these differ significantly from the national average (9.1%)[lxvii].

Figure 25 shows the percentage of reception age children measured as overweight or obese in West Sussex by within county[lxviii] ID2015 deprivation decile (based on their home postcode). Children in the 6th, 7th, 9th and 10th deciles (where 10 = least deprived) were significantly less likely to be overweight or obese when compared to children in the most deprived decile.

Figure 25 - Percentage of reception age children measured overweight or obese by ID2015 within county deprivation decile in 2014/15 (West Sussex average: 19.7%)



Source: DCLG: indices of deprivation 2015 (calculated into within county deciles) and NCMP 2014/15 data

6.6.4 Considerations for Commissioners

Universal healthcare checks in the early years provide an opportunity for professionals to identify families who may need additional support. Several socio-demographic factors are associated with a lack of physical activity, indicating groups of children and families to be given special attention. Research found that families from minority ethnic backgrounds and low-income populations were less likely to identify their children as obese, and therefore may not request or engage with additional support from services. Consequently, programmes to address child overweight and obesity may not be effective as the family may not recognise that the child is obese.[28]

[lxv] National Obesity Observatory (PHE) - http://www.noo.org.uk/NOO_about_obesity/inequalities/deprivation

[lxvi] The 2010 Index of Multiple Deprivation (IMD) ranks areas from least to most deprived based on seven different dimensions of deprivation (such as income and crime deprivation).

[lxvii] HSCIC – "National Child Measurement Programme: England, 2014/15" (released Dec-2015)

[lxviii] Each LSOA within West Sussex was assigned a deprivation decile in order to reflect variations in deprivation within the county.

There is evidence that interventions that use a multi-component and holistic approach to improve children's diet and physical activity are effective in the prevention and treatment of overweight and obesity. Such interventions involve parents/the whole family, physical activity, nutritional education, and – for children in school/preschool – support from teachers.[28] Narrow interventions focusing on single aspects of behaviour are unlikely to achieve long-term change in efforts to tackle obesity and there is strong evidence that the involvement of whole families (parents and children) in interventions that promote both healthier diet and more exercise can have an impact on reduction of BMI.[28] Furthermore, interventions need to consider the social and environmental factors that impact on children's lives.

Effective components of interventions identified involve decreasing pre-schoolers' screen time; decreasing consumption of high fat/calorie drinks/foods; increasing physical exercise; increasing sleep; modifying parental attitudes to feeding; and promoting authoritative parenting.[28] In terms of the promotion of healthy eating, the most effective strategies to increase children's acceptance of unfamiliar (and healthy) foods are: intensive; incorporate behavioural strategies; give a clear message; and are tailored to the educational level and material resources of families.[28]

There is strong evidence that breastfeeding reduces the risk of infant and child obesity, and interventions to promote breastfeeding are also important in reducing childhood obesity. Some home visiting programmes delivered during the postnatal period have positive effects on family/parental nutritional practices (e.g. increased duration of breastfeeding, delayed introduction of solid foods, less use of food as a reward or to make children feel better) .[28] The complexity of excessive weight gain during pregnancy means that it requires multifaceted approaches. Interventions that can be effective in restricting gestational weight gain and reducing post-partum weight retention include lifestyle interventions that address diet and physical activity[36].

7 TACKLING DISADVANTAGE

Determinants of Child Health, Risk and Protective Factors

7 Tackling disadvantage - Determinants of child health, risk and protective factors

Children's life circumstances and experiences have an impact on their physical, cognitive and socio-emotional development and so can potentially increase or reduce the risks of adverse outcomes. Although these circumstances and experiences are not deterministic, there is a complex and dynamic interaction between the child, family and environment, which influences their outcomes. Whilst risk factors increase the likelihood that children under 5 will experience difficulties with their development, protective factors are a near opposite mirror image of the risk factors, and they protect children against adverse developmental outcomes.

7.1 Low Birth Weight

The WHO defines low birth weight as weight at birth of less than 2,500grams (5.5 pounds).[37] A baby's weight at birth is an important indicator of overall health and it is strongly associated with mortality risk during the first year and also with some developmental problems in childhood. In addition, it also increases the risks of non-communicable diseases such as diabetes and cardiovascular disease later in life. Low birth weight is a result of preterm birth or restricted intrauterine foetal growth and these are influenced by a number of factors, such as smoking and drinking during pregnancy, poor maternal health, deprivation, and inadequate living conditions. Rates of low birth weight and preterm birth of a population can vary depending on demographic factors such as maternal age distribution and multiple birth rate.

7.1.1 National and West Sussex Profile: Low Birth Weight

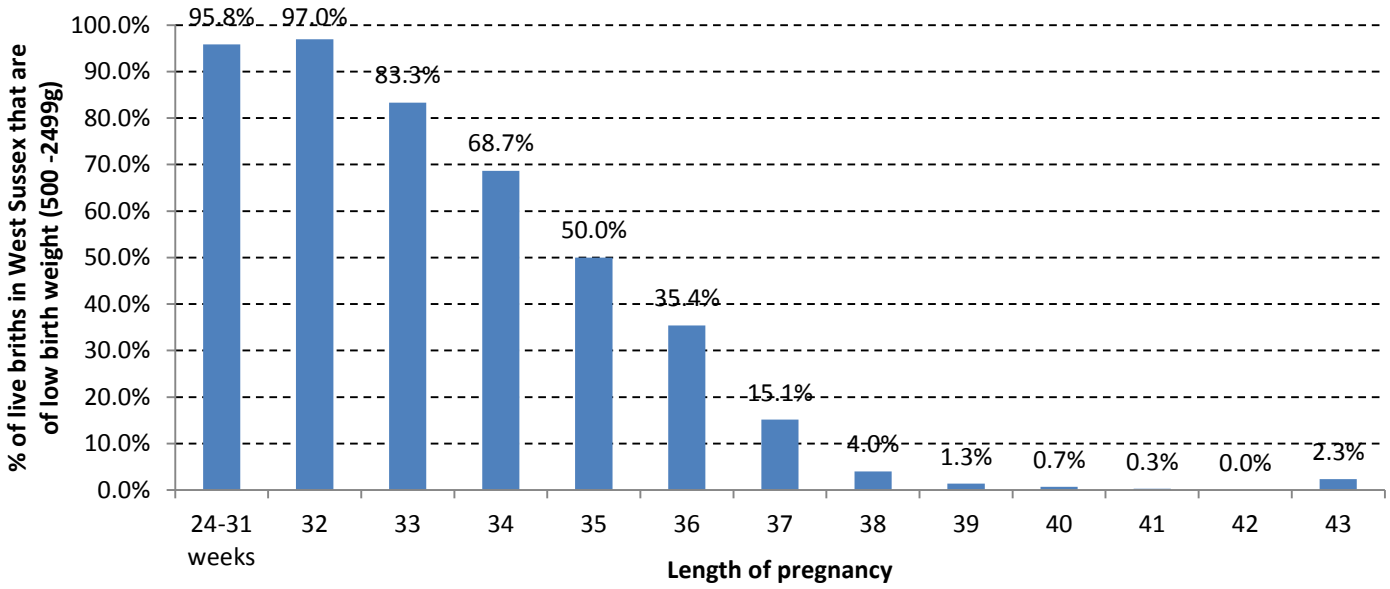
In 2012, approximately 180 full-term (≥ 37 weeks) babies were recorded to be of low birth weight (< 2500 grams) In West Sussex[lxix]. This equates to 2.1% of all full term live births with a recorded birth weight in West Sussex. This is significantly lower than the proportion of low birth weight, full term infants in England (2.8%) and is similar to the South East region (2.3%).

Of all live births in West Sussex born at 24 weeks or more, approximately 550 infants (6.5% of all live births) were of a low birth weight (between 500 and 2499gs) in 2013. Of these, approximately 80 infants (1.0% of all live births) were of a very low birth weight (between 500 to 1499gs)[lxx].

The proportion of low birth weight babies varies by length of pregnancy (Figure 26). Of all infants born in 2013, less than 1% were of low birth weight and born at 40 weeks or more. Note that for each additional week of pregnancy, the proportion of babies born at low birth weight decreases. This demonstrates the direct relationship between low birth weight and duration of pregnancy.

[lxix] Public Health England – Indicator 2.01 Low birth weight of term babies (data from 2012 reported)
[lxx] West Sussex Birth Notification database 2008-13. Note that a low cut off was used (500g) for a viable low birth weight as a number of entry errors were discovered in the birth notification database.

Figure 26 - The percentage of all live births in West Sussex (2013) that were of low birth weight (between 500 – 2499g) at each week of pregnancy



Source: West Sussex Birth Notification database, 2013

7.1.2 Considerations for commissioners and providers

The processes that cause low birth weight, duration of gestation and intrauterine growth rate, are complex and influenced by several factors which relate to the infant, mother or the physical environment, including[37]:

- Maternal nutrition, diet and lifestyle factors (smoking, drug and alcohol use during pregnancy)
- Maternal physical and mental health
- Deprived socioeconomic conditions
- Maternal birth weight.

Consequently, evidence based interventions aimed at reducing the factors that impact on these processes will contribute towards reducing and preventing low birth weight. Programmes such as the HCP and FNP, for teenage mothers who are at risk, have been evidenced to improve maternal and child health. Other interventions that have been proven to help prevent and reduce the incidence of low birth weight include; promotion of smoking cessation during pregnancy, antenatal care, and micronutrient diet supplementation[38]. Furthermore, evidence suggests that early intervention by midwives or other health engagement at children's centres can help reduce children's adverse risk factors such as reducing the incidence of low birth weight.[15]

The effectiveness of evidence based interventions lie in their use or delivery mechanisms, which address different aspects of targeted problems. This implies that commissioners, providers and practitioners need to ensure that the implementation of these programs is in accordance with the core elements, in order to capture the specific aspects of the programme's content to bring about the targeted outcomes.[36]

7.2 Breastfeeding

Breastfeeding has both short term and long term benefits for the child, particularly reducing the risk of morbidity and mortality from certain health conditions. WHO recommends early initiation of breastfeeding within the first hour of life and exclusive breastfeeding for the first six months to achieve optimal growth, development and health. Research indicates that breastfed children experienced lower blood pressure, and the prevalence of overweight/obesity and type 2 diabetes was lower among breastfed children. Furthermore, breastfeeding has been found to have a positive effect on the child's cognitive development[15, 39] and is also beneficial to the mother's health. Some studies have indicated that women who formula feed are more likely to develop epithelial ovarian cancer and breast cancer than women who breastfeed.[40]

7.2.1 National and West Sussex profile: Breastfeeding

7.2.1.1 Breastfeeding initiation

In West Sussex, 81.4% of mothers gave their babies breast milk within 48 hours of delivery in 2012/13. This is significantly higher than the percentage for England (73.9%) and the South East (77.1%).[lxxi]

7.2.1.2 Breastfeeding prevalence at 6-8 weeks after birth

Due to data quality reasons, breastfeeding prevalence at 6-8 weeks after birth has not been published for West Sussex since 2011/12. 55.0% of West Sussex mothers were estimated to be breastfeeding 6-8 weeks after birth[lxxii]. This is significantly higher than regional (50.9%) and national (47.2%) estimates. This suggests that although a large proportion of West Sussex mothers initiate breastfeeding within 48 hours of delivery, there is a drop-off rate of approximately 26% between birth and 6-8 weeks.

7.2.1.3 Health Visiting Service

In addition to the data presented in the PHOF, Health Visitors collect information on breastfeeding at the 6-week check. This data was collected in West Sussex during April 2014 and March 2015. Data from Health Visitors revealed that 56.3% of West Sussex mothers reported breastfeeding their infant to some degree during the first 6 weeks of life. Of these mothers, 40.5% reported that they had exclusively breastfed their infant during this time.

Variation exists across the county (Table 36). For example, a greater proportion of infants checked in Mid Sussex and Horsham were exclusively breastfed when compared to the West Sussex average. Conversely, significantly fewer infants who received a check in Crawley and Arun were exclusively breastfed compared to the West Sussex average. The proportion of infants exclusively or partially breastfed at Children and Family Centre level is presented in Figure 27. The five CFCs with the highest proportion of infants exclusively or partially breastfed are all within the Mid Sussex and Horsham areas, whilst the lowest five centres are more widely located across the county (falling within Adur, Arun, Worthing and Chichester).

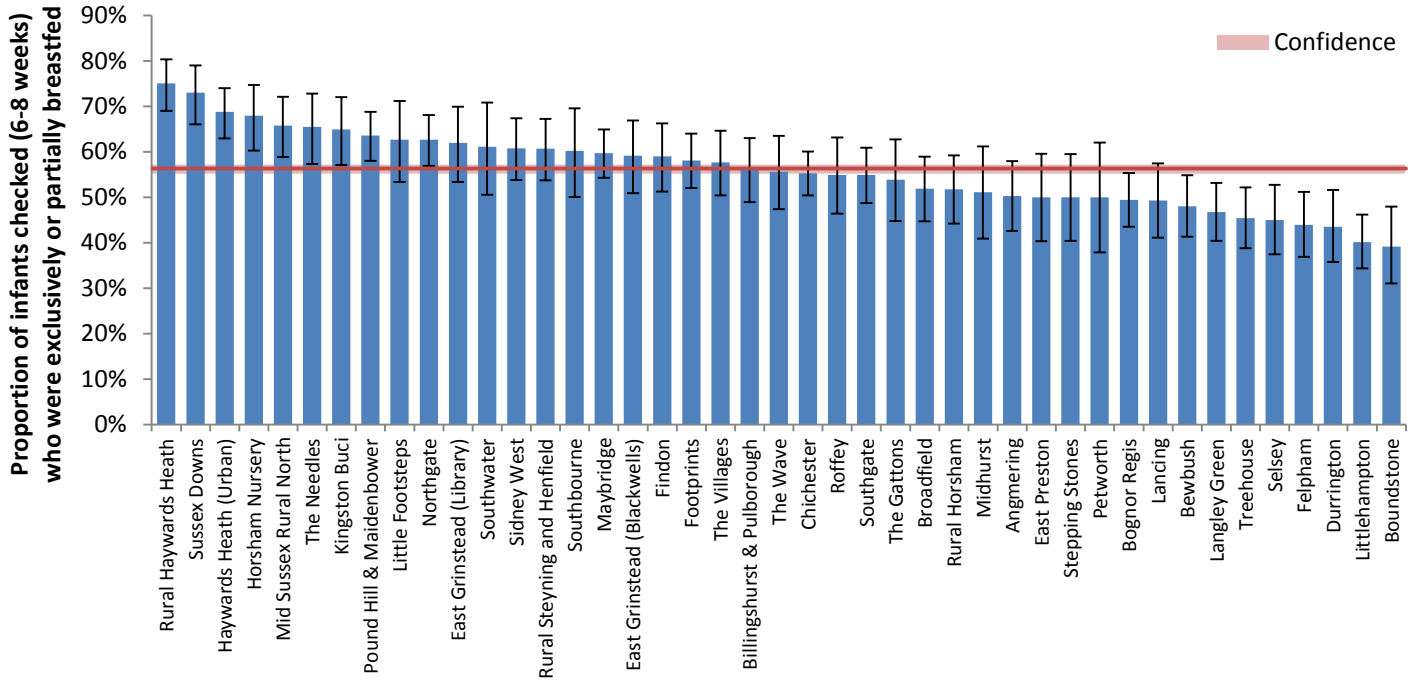
[lxxi] PHOF: "Breastfeeding – Breastfeeding initiation". Note that 2013/14 data is available for national, regional and county level but values were not published for West Sussex due to data quality reasons.
[lxxii] PHOF: "Breastfeeding: Breastfeeding prevalence at 6-8 weeks"

Table 36 – Data from the 6 week check recording breastfeeding status for the first 6 weeks of life (2014/15) by local authority in West Sussex

	Number of babies receiving 6 week check	Exclusive breastfeeding				Partial or exclusive breastfeeding			
		N	%	LCL	UCL	N	%	LCL	UCL
Adur	530	190	36.1%	32.2%	40.3%	280	51.7%	47.5%	55.9%
Arun	1390	490	35.2%	32.8%	37.8%	660	47.8%	45.1%	50.4%
Chichester	850	330	39.5%	36.3%	42.9%	450	53.4%	50.0%	56.7%
Crawley	1460	530	36.1%	33.6%	38.6%	810	55.6%	53.0%	58.1%
Horsham	1130	520	46.0%	43.1%	48.9%	670	59.8%	56.9%	62.6%
Mid Sussex	1440	680	47.3%	44.7%	49.9%	950	66.1%	63.6%	68.5%
Worthing	1000	410	41.2%	38.2%	44.3%	570	56.3%	53.2%	59.4%
WEST SUSSEX	7,800	3,160	40.5%	39.4%	41.5%	4,390	56.3%	55.2%	57.4%

Note. Values have been rounded to the nearest 10. Totals may not sum due to rounding.
Source: Health Visiting (CHB)

Figure 27 – The proportion of infants exclusively or partially breastfed at the 6 week check (recorded in 2014/15) by Children and Family Centre in West Sussex (red line represents the West Sussex average)



7.2.2 Considerations for Commissioning

Breastfeeding initiation rates are closely related to social class, income and educational levels[40]. Research indicates that in those high-income countries where breastfeeding rates are typically low, the lowest rates are found among women in low-income groups. Different types of health education interventions, both one-to-one, needs-based, informal repeat sessions and generic, formal antenatal sessions across the prenatal, perinatal and postnatal periods have been evidenced to increase the initiation of breastfeeding among low income women[40]. Strategies that rely mainly on face-to-face support are significantly more likely to begin and sustain breastfeeding than advice offered from a distance (e.g. via telephone) or written information [28]. There is also some evidence that e-based interventions, i.e interventions promoting breastfeeding delivered online, have a moderate positive effect on breastfeeding and may therefore

improve the likelihood of success.[28] In addition, interventions such as peer support and antenatal group work, which has an interactive component and involves local experienced breast feeders as volunteers, are among a range of effective interventions to support the initiation and continuation of breastfeeding[28]. NICE recommends the use of peer support, which achieves an estimated 20% point increase in breastfeeding initiation, and would save the NHS money over the long term (NICE 2007). NICE guidelines also recommends offering proactive support during the postnatal period; and implementing structured programmes that encourage breastfeeding – with the UNICEF '*Baby Friendly Initiative'* as a minimum standard[41].

7.3 Maternal Age

Birth notification data from 2013 shows that the average age of mothers in West Sussex was 30 years with a range of 15-51 years. There is little variation in the age of mothers across the county, with the oldest mothers in Mid Sussex (31 years) and the youngest in Crawley (29 years). Maternal age in West Sussex has remained constant, with an average age of 29.9 in 2008 and 30.0 in 2013. Approximately 59.4% of mothers in West Sussex gave birth between the age of 25 and 34 years in 2013.

In 2014, over 2,000 live births in West Sussex were to mothers aged 35 or above (23.3% of all live births - Table 37)[lxxiii]. In England, this figure was estimated at 21.0%, and in the South East 23.9% of live births were to mother aged 35 or above.

Table 37 – Rates (per 1,000 women in age group) and proportion of live births by age group in West Sussex, the South East and England (2014)

	West Sussex		South East		England	
	Rate	Proportion	Rate	Proportion	Rate	Proportion
<20	10.9	2.8%	12.6	3.2%	15.4	3.7%
20-24	60.4	13.7%	53.4	13.9%	59.8	16.0%
25-29	112.3	28.3%	102.1	26.2%	100.5	28.2%
30-34	113.1	32.0%	118.5	32.7%	110.6	31.2%
35-39	66.4	19.0%	69.2	19.0%	65.1	16.7%
40-44	11.9	4.0%	15.0	4.6%	13.9	3.9%
45 +	0.9	0.3%	1.0	0.3%	1.0	0.3%

Source: ONS – Live births by area of usual residence of mother (released Sept-2015)

7.3.1 Infant Mortality and Maternal Age (national and West Sussex data)

Maternal age at birth is related to infant mortality (see Figure 28). Greater instances of infant death tend to occur at either end of the age continuum, with greater instances for younger mothers (<20 years) and older mothers (>40 years – Table 38). For example, stillbirths are more common in younger and older mothers. In England and Wales, 5.9 and 6.1 stillbirths per 1,000 total births were estimated to have occurred to mothers under the age of 20 and over the age of 40 respectively (Table 38[lxxiv]). This compares to a stillbirth rate of 4.2 per 1,000 births for mothers aged 30-34.

[lxxiii] ONS – Live births by area of usual residence (released Sept-2015)

[lxxiv] ONS – Table 10 - Childhood, Infant and Perinatal Mortality in England and Wales, 2013 (released Mar-2015)

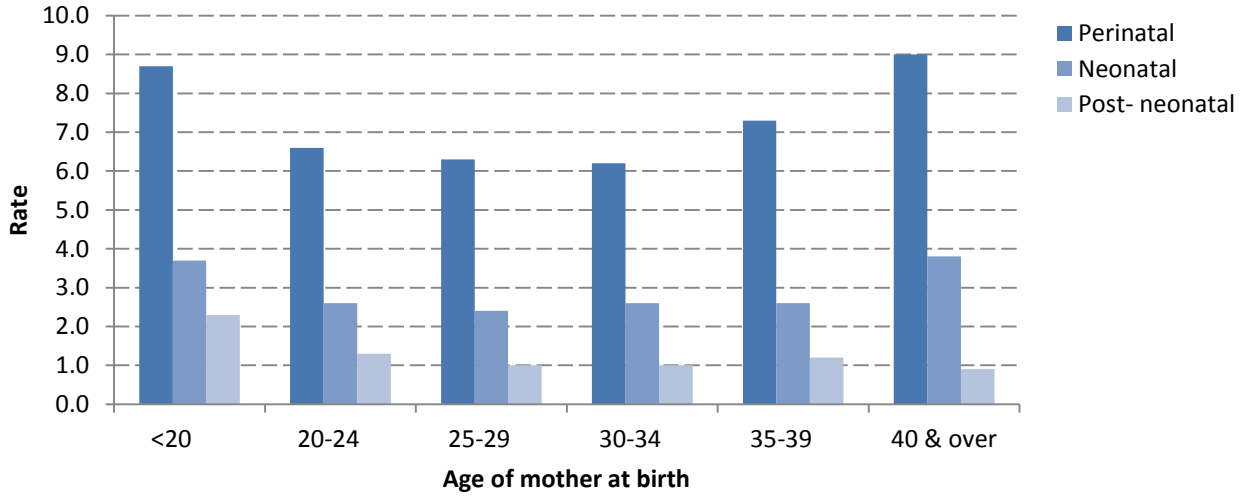
Table 38 – Rates of infant death (< 1 year of age) by age of mother, England and Wales (2013)

	Stillbirth	Perinatal	Neonatal	Post-neonatal	Infant
All	**4.7**	**6.7**	**2.6**	**1.1**	**3.8**
<20	5.9	8.7	3.7	2.3	6.1
20-24	4.7	6.6	2.6	1.3	3.9
25-29	4.3	6.3	2.4	1.0	3.4
30-34	4.2	6.2	2.6	1.0	3.6
35-39	5.5	7.3	2.6	1.2	3.8
40 & over	6.1	9.0	3.8	0.9	4.7

Source: ONS – Childhood, Infant and Perinatal Mortality in England and Wales, 2013

The picture is similar for infant mortality rates within the first year of life, with higher rates of perinatal mortality and neonatal mortality among infants born to younger (< 20 years) and older (> 40 years) mothers. In contrast, post-neonatal mortality rate is highest for mothers under the age of 20 (2.3 per 1,000 live births), but remains low for mothers over the age of 40 (a rate of 0.9 per 1,000 live births). According to the National Perinatal Epidemiology Unit (NPEU), "neonatal mortality rates are especially sensitive to events during pregnancy, delivery and the neonatal period … (whilst) post-neonatal mortality is thought to be influenced to a greater extent by parental circumstances, including their socio-economic position, and the care they provide for their infant"[lxxv]. This may explain the lower rates of post-neonatal mortality for older mothers who may be more likely to be economically stable than their younger counterparts.

Figure 28 - Rate of perinatal (per 1,000 live and stillbirths), neonatal and post-neonatal (per 1,000 live births) by maternal age for England and Wales 2013

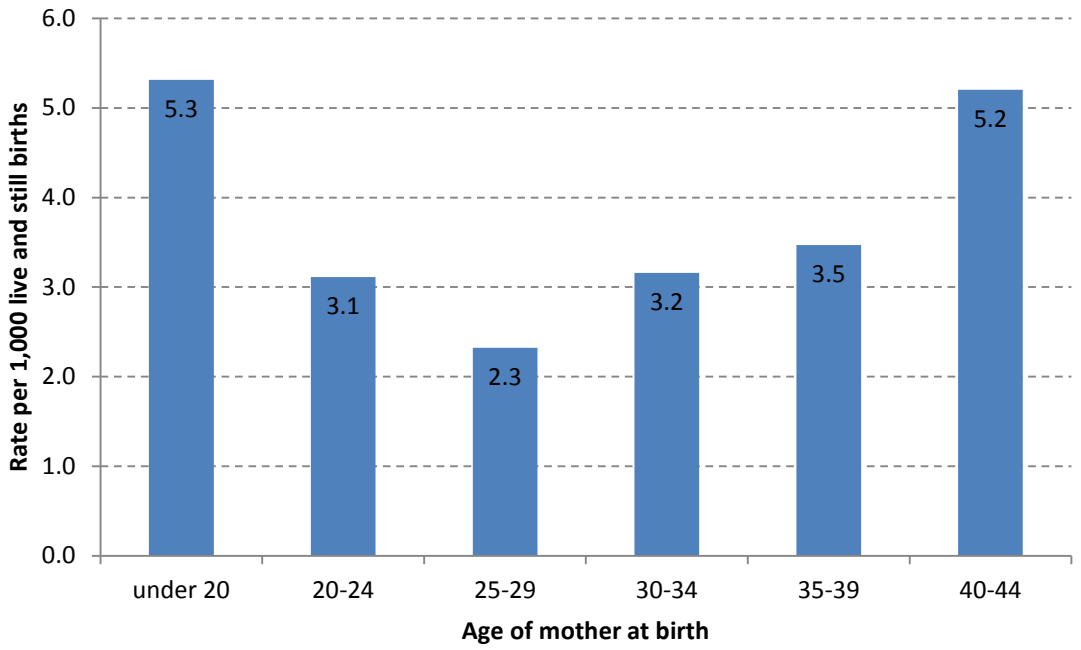


Source: ONS – Childhood, Infant and Perinatal Mortality in England and Wales, 2013: Table 10 (released Mar-2015)

In West Sussex, birth notification data suggests a similar relationship between maternal age and rates of stillbirth (Figure 29). Younger (< 20 years) and older (40-44 years) mothers had greater rates of stillbirth between 2009-13.

[lxxv] Neonatal Perinatal Epidemiology Unit, University of Oxford (2009) "Inequalities in infant mortality project briefing paper 1: Infant mortality: overview and context"

Figure 29 – Estimated rate of stillbirths (per 1,000 live and stillbirths) by maternal age in West Sussex (data pooled for 2009-2013)



Source: Birth notification data (2009 – 2013). Note that no stillbirths were reported for mothers aged 45+ in this time period

7.4 Teenage Conception and Pregnancy

Teenage conception rates are one of the indicators of health inequalities and there is a close association between teenage pregnancy and deprivation. Strong evidence indicates that children born of young mothers are more at risk of adverse outcomes; with each teen-birth there is an increased risk of preterm birth, infant and child mortality, developmental delays, and accidental and non-accidental injuries.[42] Furthermore, the social, educational and economic outcomes for the children and the teenage mothers tend to be worse, with a danger of a poverty-trap/poverty-cycle developing .[43] Teenage repeat pregnancies are also prevalent and they are associated with an increased risk of adverse maternal and child health and wellbeing.

The UK has one of the highest rates of teenage pregnancy in Western Europe with over 32,500 pregnancies to women under the age of 18[lxxvi].

[lxxvi] Public Health England. "Teenage Pregnancy Atlases, Forecasts and other Resources" http://www.apho.org.uk/resource/view.aspx?RID=116350

7.4.1 National and West Sussex Profile: Teenage Conceptions

Teenage conceptions are defined as:

- pregnancies that occur to women aged under-18 that result in either one or more live or stillbirths or a legal abortion under the Abortion Act 1967

The teenage conception rate is a reflection of the number of conceptions that occur per 1,000 women aged 15-17 years. The National Teenage Pregnancy Strategy (1999)[lxxvii] aimed to halve the number of under-18 conceptions by 2010 using the figures from 1998 as a performance baseline. By 2010, the number of under-18 conceptions had fallen by 26.6% to a rate of 34.2 conceptions per 1,000 women aged 15-17 years. In 2012, this rate has fallen further to 27.7 conceptions per 1,000 women aged 15-17; which constitutes a drop of 40.6% from the 1998 baseline.

In 2013, the teenage conception rate of young women in West Sussex was 18.9 per 1,000 women aged 15-17 years (Table 39). This conception rate is significantly lower than England (24.3) and similar to the South East region (20.5)[lxxviii]. However, there are variations across the county.

Table 39 – Number and rate of conceptions (per 1,000 women) aged 15-17 in West Sussex (2008-2013)

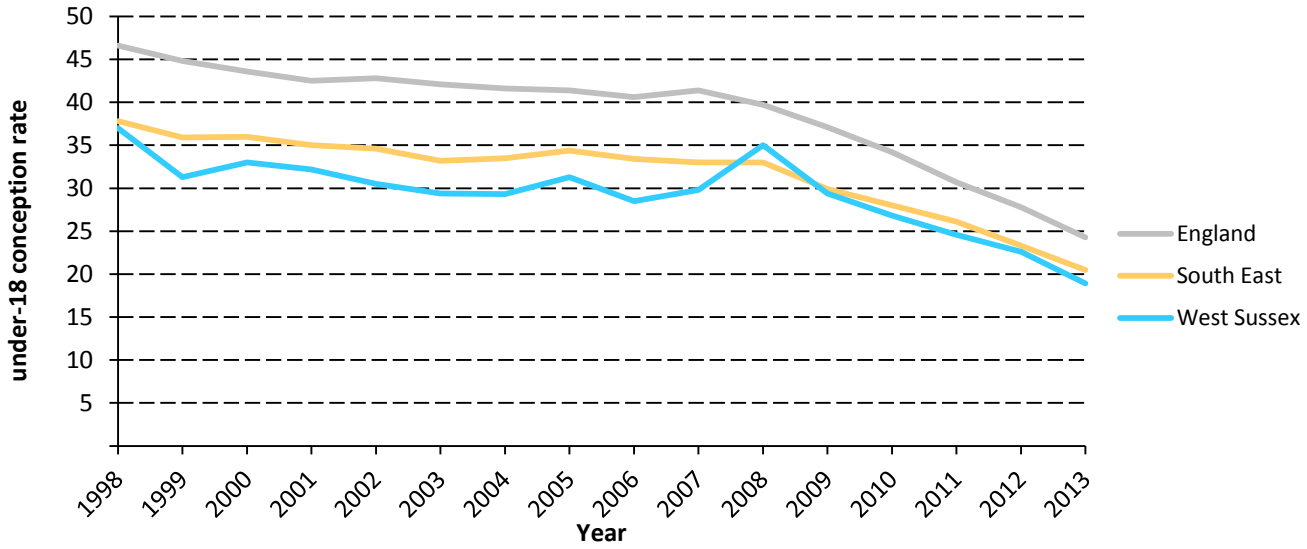
	Under-18 Conception Number (N) and Rate											
	2008		2009		2010		2011		2012		2013	
	N	Rate	N	Rate	N	Rate	N	Rate	N	Rate	N	Rate
Adur	35	28.8	45	40.0	30	27.5	35	32.0	35	32.6	35	33.9
Arun	110	47.1	65	29.5	90	39.8	75	32.5	55	24.2	55	25.1
Chichester	65	33.4	40	23.2	01	23.3	50	28.2	45	24.8	25	14.1
Crawley	100	50.5	85	42.1	75	39.8	60	31.0	55	30.0	45	26.1
Horsham	60	23.1	50	20.1	40	16.3	35	13.2	35	13.3	25	9.1
Mid Sussex	65	25.9	65	24.7	45	17.4	35	12.9	40	14.9	35	13.1
Worthing	70	37.3	60	35.5	45	28.0	55	33.3	50	29.3	40	22.9
West Sussex	**500**	**35.0**	**410**	**29.4**	**370**	**26.8**	**340**	**24.6**	**310**	**22.5**	**260**	**18.9**
SOUTH EAST	**5,225**	**33.0**	**4,725**	**29.9**	**4,385**	**28.0**	**4,085**	**26.1**	**3,615**	**23.2**	**3,185**	**20.5**
ENGLAND	**38,785**	**39.7**	**35,965**	**37.1**	**32,550**	**34.2**	**29,165**	**30.7**	**26,155**	**27.7**	**22,830**	**24.3**

Note. Due to rounding totals may not be the sum of the individual cells.
Source: ONS Conception Statistics, England and Wales, 2013

[lxxvii] Social Exclusion Unit - The National Teenage Pregnancy Strategy (1999)
[lxxviii] Source: ONS Conception Statistics, England and Wales, 2013 (released Feb-2015)

Figure 30 suggests that since 1998, the number of teenage conceptions is following a downward trend.

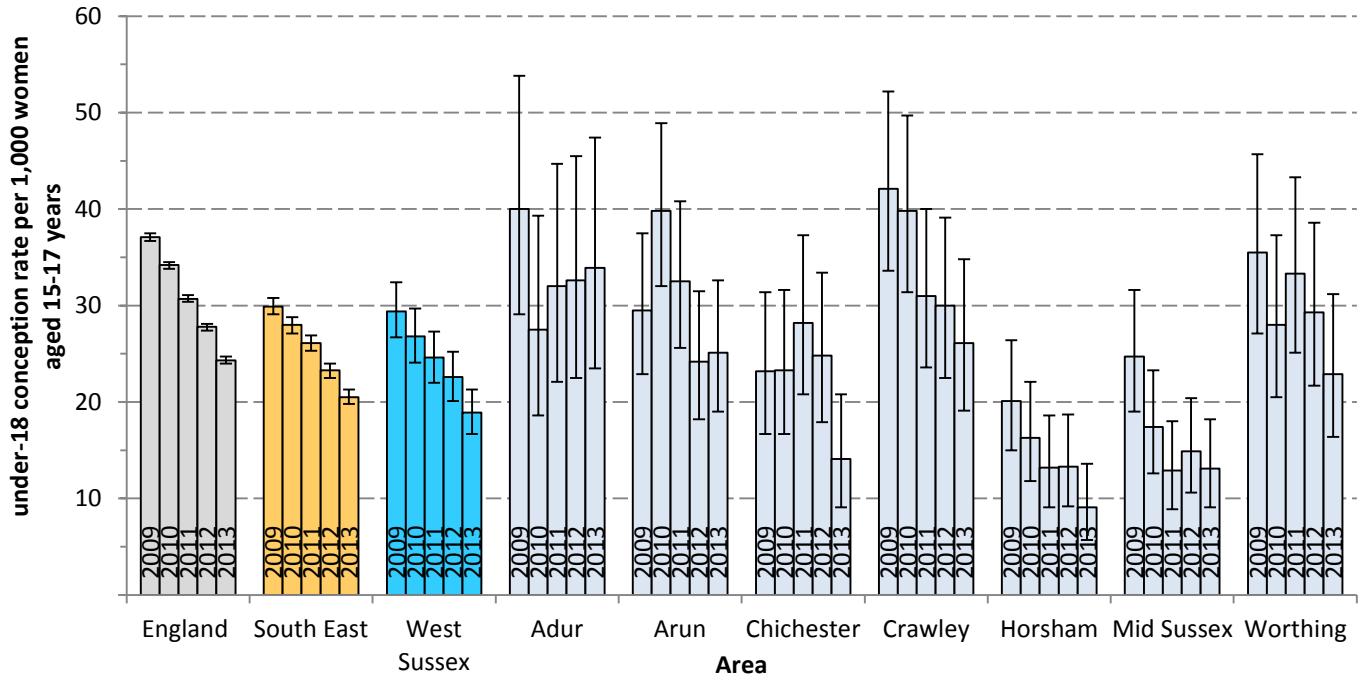
Figure 30 - Rate of conceptions to women (aged 15-17yrs) in West Sussex, the South East and England (1998-2013)



Source: ONS – 'Conception Statistics, England and Wales, 2013 (Feb-2015)

The number of conceptions that occur to women under the age of 18 varies by local authority (Table 39 and Figure 31). In 2013, Adur had a significantly higher rate of under-18 conceptions (33.9) than Horsham (9.1), Mid Sussex (13.1) and Chichester (14.1 conceptions per thousand women aged 15-17 years). For all local authorities in West Sussex, the under-18 conception rate in 2013 was lower than in 2009.

Figure 31 - Under-18 conception rates from 2009-2013 for England, the South East and West Sussex



Source: ONS – 'Conception Statistics, England and Wales, 2013 (Feb-2015)

Of all under-18 conceptions in West Sussex in 2013, over half (58.8%) led to an abortion. In England and the South East, 51.1% and 52.9% led to a termination of the pregnancy.

7.4.1.1 Under-18 conceptions in small areas 2011-13 (ward level)

In 2011-13, a small number of wards in West Sussex significantly exceeded the national rate of under-18 conceptions (England – 27.6 per 1,000 women aged 15-17 years). The wards Orchard and River in Arun, Bewbush in Crawley, and Central and Heene in Worthing had significantly higher under-18 conception rates than the national average. Conversely, the wards Maidenbower (Crawley) and Gaisford (Worthing) had significantly lower rates of under-18 conceptions when compared to England.

7.4.1.2 Under-16 conceptions

In 2013, approximately 0.5% of all conceptions in England were to women aged under 16. This represents a conception rate of 4.8 per 1,000 women aged 13-15 years. In West Sussex, the number of under-16 conceptions account for 0.4% of all conceptions to women aged 15-44. This translates to an under-16 conception rate of 2.7, and is significantly lower than the England rate.

In 2011-13, 63.7% of under-16 conceptions resulted in abortion in West Sussex. This figure was 63.3% in the South East and 60.8% in England.

7.4.2 Births to Teenage Mothers

In 2014, approximately 0.6% of West Sussex mothers were under the age of 18 at birth (approximately 55 births)[lxxix]. For mothers under the age of 20, there were approximately 240 live births in West Sussex; 2.8% of all live births in the county. In comparison, 0.9% of live births in England were to mothers under the age of 18, and 3.7% were to mothers aged under 20.

7.4.3 Considerations for Commissioning

Teenage pregnancy has costly consequences, not only for the individual involved but also the child, family and society as a whole. Teenage mothers are more likely to have lower educational attainment, and therefore vulnerable to reduced job opportunities.[10] As a result, they have a greater chance of relying upon government assistance to provide additional benefits, such as child and housing benefits, and health services for the mother and child. Groups with an increased risk of teenage pregnancy include daughters of teenage mothers, young people looked after by the local authority and leaving care, school non–attendees due to truancy or exclusion, Not in Education, Employment or Training (NEETs) and homeless or runaway teenagers.[44] NEETs make up 15% of teenage mothers or pregnant teenagers.[45] Research highlights that interventions such as the accessibility and provision of counselling and contraceptive services, school-based educational programmes, are effective in reducing the rates of teenage conceptions.[44] Behaviour change interventions in schools have been reported to be cost-effective when considering longer-term paybacks. For example, for every £1 spent on contraception to prevent teenage pregnancy, £11 is saved through fewer costs from terminations, antenatal and maternity care (Teenage pregnancy associates 2011, cited by Kings Fund). There is evidence that the use of multiple strategies, such as education, skills training for jobs and personal development and contraception promotion, can be effective in reducing teenage pregnancy.[46] However, the evidence is not sufficient to support the effectiveness of promoting the use of contraceptive measures alone.[46]

[lxxix] ONS - "Births by Area of Usual Residence of Mother, UK, 2014" (released Sept-2015)

Good practice includes targeting sex and relationships education and sexual health advice at the at risk groups, such as NEETs, young people excluded from school, children in and leaving care, and those in supported housing.[45] Early intervention and the provision of services aimed at preventing adverse health and social outcomes, such as antenatal care, parenting support for teenage parents[44] (including FNP and HCP) also significantly contribute towards improving outcomes for children and teenage parents. Other interventions based on international evidence include holistic youth development focused programs such as the Teen Outreach Program (TOP)[10] and the Carrera Adolescent Pregnancy Prevention Program.

7.5 Smoking in Pregnancy

Tobacco use during pregnancy has significant influences on foetal and early brain development[4] and is associated with a number of negative infant and child outcomes such as low birth weight, preterm birth, Sudden Infant Death Syndrome, perinatal mortality and birth defects.

7.5.1 National and West Sussex Profile: Maternal Smoking at Delivery

The Tobacco Control Plan aims to reduce the rate of smoking throughout pregnancy to less than 11% by the end of 2015. There has been a steady decline in the percentage of women smoking at the time of delivery in England, from 15.1% in 2006/07 to 11.4% in 2014/15.

The HSCIC provides quarterly summaries on maternal smoking rates at the time of delivery for each CCG[lxxx]. In 2014/15, significantly more mothers in Coastal West Sussex CCG were smokers at the time of delivery than in Crawley CCG or Horsham and Mid Sussex CCG (Table 40). Of the 50 CCGs in the South of England, 28 had met the national ambition by the end of March 2015.

Table 40 - Maternal smoking at time of delivery for West Sussex CCGs (2014/15)

CCG	2014 - 2015				Total 2014/15
	Quarter 1	Quarter 2	Quarter 3	Quarter 4	
Coastal West Sussex CCG	13.2% (11.4 – 15.4)	11.2% (9.5 – 13.0)	13.3% (11.4 – 15.4)	12.9% (11.1 – 15.0)	12.6% (11.7 – 13.6)
Crawley CCG	7.6% (5.5 – 10.5)	6.7% (4.7 – 9.4)	6.9% (4.9 – 9.7)	6.9% (4.8 – 9.9)	7.0% (5.9 – 8.4)
Horsham and Mid Sussex CCG	5.4% (3.8 – 7.7)	4.7% (3.3 – 6.8)	5.8% (4.1 – 8.1)	4.9% (3.4 – 7.0)	5.2% (4.4 – 6.2)
England	11.5% (11.3 - 11.7)	11.5% (11.3 – 11.6)	11.4% (11.3 – 11.6)	11.1% (11.0 – 11.3)	11.4% (11.3 – 11.5)

Source: Health and Social Care Information Centre – Maternal Smoking and Delivery

For West Sussex, it was estimated that 9.6% of mothers were smoking at delivery in 2014/15; this is significantly lower than estimates for England (11.4%).

The HSCIC also release quarterly summaries on NHS Stop Smoking Services in England[lxxxi]. In 2014/15, 18,887 pregnant women set a quit date with the NHS Stop Smoking Services. Approximately 47% of these women reported that they had successfully quit at 4 weeks (27.5% setting a date were confirmed to have quit by carbon monoxide (CO) validation), however 23% were lost to follow up. In West Sussex, 187

[lxxx] HSCIC – "Statistics on Women's Smoking Status at Time of Delivery: England. Quarter 4 - April 2013 to March 2014" (released Jun-2014).
[lxxxi] HSCIC – Statistics on NHS Stop Smoking Services, England – April 2014 to March 2015 (released Aug-2015)

pregnant women set a quit date with NHS Stop Smoking Services, approximately 46% of whom reported that they had successful quit at 4 weeks (24% CO validated quitters of all setting a quit date). However, 30% of pregnant women in West Sussex were lost to follow up.

7.5.2 West Sussex Profile: Maternal Smoking during and after pregnancy (Health Visiting Service data)

Health visitors record smoking status of new mothers at the health visitor check, as well as prevalence of smoking in the household. As a result, the information that is provided regarding smoking at time of delivery is retrospective. Data from 4,353 women were recorded in the health visitor check database in West Sussex; this compares to approximately 8,700 births recorded within 2014. It is possible that the data recorded represent cases of higher "need" as identified by health visitors, and so estimates of maternal smoking may be higher than the true prevalence for the county.

Data from health visitors revealed that[lxxxii]:

- At the time of booking, 477 women (11.0%) of the 4,343 who provided information said that they smoked.
- At the time of delivery, 366 women (8.4%) of the 4,343 who provided information said that the smoked.
- At the time of their check, 426 women (9.9%) of the 4,318 who provided information said that they smoked.

Mothers were asked whether anyone (including herself) smoked at home. 19.1% (811 of the 4,245 women who answered the question) said that there was someone at home who smoked. Table 41 shows estimated prevalence of maternal smoking by local authority. This data also relates to the health visitor check and therefore there are a number of missing/incomplete records. There is variation across the county with a significantly higher proportion of smokers in the home of a new baby in Crawley, and significantly lower proportion of smokers in the home in Mid Sussex (when compared to West Sussex average).

[lxxxii] Only "yes" and "no" responses have been included. Non-responses and "don't know" responses have been removed from these calculations. This means that the total number of responses to each question may differ.

Table 41 – Proportion of mothers who responded to the questions at the health visitor check (recorded during 2014). Smoking in the home reports the proportion of infants living in a household where there is at least one smoker present

	Smoking at booking			Smoking at delivery			Smoking at check			Smokers (any) in the home		
	%	*LCL*	*UCL*	%	*LCL*	*UCL*	%	*LCL*	*UCL*	%	*LCL*	*UCL*
Adur	15.5%	*10.7%*	*21.9%*	9.9%	*6.2%*	*15.4%*	12.4%	*8.2%*	*18.4%*	18.1%	*12.9%*	*24.8%*
Arun	14.1%	*11.8%*	*16.8%*	10.8%	*8.8%*	*13.2%*	12.1%	*10.0%*	*14.6%*	22.4%	*19.6%*	*25.5%*
Chichester	12.4%	*9.7%*	*15.8%*	9.0%	*6.7%*	*11.9%*	12.2%	*9.5%*	*15.5%*	20.9%	*17.4%*	*24.9%*
Crawley	12.0%	*9.9%*	*14.5%*	9.1%	*7.3%*	*11.3%*	10.4%	*8.5%*	*12.8%*	23.3%	*20.4%*	*26.5%*
Horsham	8.8%	*6.6%*	*11.4%*	7.4%	*5.5%*	*10.0%*	8.4%	*6.4%*	*11.1%*	15.0%	*12.2%*	*18.3%*
Mid Sussex	6.7%	*5.2%*	*8.6%*	5.2%	*3.9%*	*7.0%*	6.1%	*4.7%*	*8.0%*	13.8%	*11.6%*	*16.3%*
Worthing	10.7%	*8.2%*	*13.8%*	8.0%	*5.9%*	*10.9%*	9.4%	*7.0%*	*12.4%*	19.9%	*16.5%*	*23.8%*
West Sussex	11.0%	*10.1%*	*11.9%*	8.4%	*7.6%*	*9.3%*	9.9%	*9.0%*	*10.8%*	19.1%	*18.0%*	*20.3%*

Source: Health Visiting data at health visitor check (CHB) 2014

7.6 Exposure of Children to Household Environmental Tobacco Smoke

Exposure to environmental tobacco smoke (ETS) is associated with an increased risk of chest infections, asthma attacks and sudden infant death syndrome.[47] In addition, children whose parents smoke are likely to become smokers themselves.

7.6.1 National profile: attitudes to smoking in people's homes and presence of children

Data on adults' smoking behaviour and attitudes are taken from the ONS Omnibus Survey, the latest version of which was "Smoking-related behaviour and attitudes, 2008/09". The survey sampled adults aged 16+ in private households[lxxxiii].

In Great Britain, 69% of all adults said smoking was not allowed inside their homes. Heavy smokers (20+ cigarettes a day) were the least likely to say smoking was not allowed in their homes (21%) compared with 28% of light smokers. In addition, adults living in a household with children were more likely to say that smoking was not allowed anywhere in their home (75% of adults living with children). Of all adults, those who were most aware of the potential harm of second hand smoke to children and non-smoking adults were more likely to say that smoking was not allowed in their home. For example, 74% of people who were aware of the effect of second-hand smoke on asthma risk in children did not allow smoking in their home compared to 42% who did not believe that smoking increased the risk. Smokers were also more likely to modify their smoking in front of children than in front of non-smoking adults; 91% of smokers reported modifying their smoking behaviour in front of children. In 2008/09, 77% of smokers reported not smoking at all in the presence of children, which has increased from 54% in 1997.

7.7 West Sussex Profile: Children and Family Centres –Smoking Cessation Clinics

There are 3 Children and Family Centres (CFCs) in West Sussex that provide smoking cessation clinics; Bognor Regis Nursery School CFC, Chichester CFC and Littlehampton CFC. Activity data for 2014/15 is

[lxxxiii] HSCIC – Statistics on Smoking 2014. Tables 3.14, 3.16 and 3.17 (http://www.hscic.gov.uk/catalogue/PUB14988/smok-eng-2014-rep.pdf)

presented in Table 42. Small numbers of people (<30) accessed stop smoking services via CFCs in West Sussex, with approx. 52% successfully quitting.

Table 42 – 2014/15 activity data for 3 CFC stop smoking clinics in West Sussex

Number accessed service	Outcomes		
	No. quit	No. lost to follow-up	No. not quit
27	14	6	7
-	51.9%	22.2%	25.9%

Source: smoking cessation services 2014/15 activity data (provided by Programme manager for Tobacco Control)

7.7.1 Considerations for commissioners

Smoking prevalence is higher in areas of deprivation, however, babies from all backgrounds are at risk from problems that can arise if their mothers smoke during pregnancy[15]. Smoking cessation is one of the few effective strategies for the prevention of low infant birth weight, premature birth and neonatal mortality[28]. Evidence suggests that some interventions are effective in reducing smoking or promoting stop smoking during pregnancy, such as[28]:

- financial incentives
- psychosocial interventions during pregnancy can increase the proportion of women who stop smoking in late pregnancy, and reduce low birth weight and preterm births.
- proactive telephone counselling for pregnant women who smoke and seek help from quit lines.
- Self-help smoking cessation interventions for pregnant smokers
- Behaviour change interventions.

Women who quit smoking during pregnancy may demonstrate high rates of relapse after pregnancy, and consequently may need additional support.

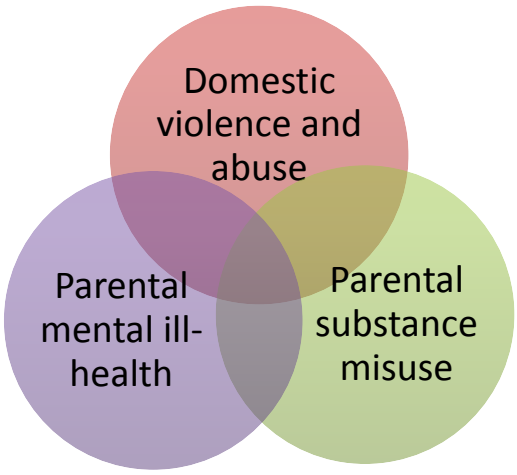
An evidence review conducted by Public Health England reported that the evidence for the efficacy of interventions to establish smoke-free homes in pregnancy and in the neonatal period is inconclusive[28]. However, in order to protect children from second-hand smoking, the Government recently introduced new legislation in England and Wales, making it illegal to smoke in a vehicle carrying someone who is under 18 years of age. It is now also against the law for a driver not to stop someone smoking in these circumstances[lxxxiv].

7.8 The Toxic Trio

The term 'Toxic Trio' (Figure 32) has been used to describe the issues of domestic abuse, mental ill-health and substance misuse which have been identified as common features of families where harm to women and children has occurred. They are viewed as indicators of increased risk of harm to children and young people.[48]

[lxxxiv] DoH and PHE. Smoking in cars with children banned. Oct 2015. https://www.gov.uk/government/news/smoking-in-cars-with-children-banned-from-today

Figure 32 – The Toxic Trio



7.8.1 Domestic Abuse

Domestic abuse is defined as any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality (Home Office 2013). The abuse includes psychological, physical, sexual, financial and emotional and also female genital mutilation (FGM). Intimate partner violence is strongly associated with a range of poor outcomes for both infants and young children, including Post Traumatic Stress Disorder (PTSD) and emotional and behavioural problems. Similarly, domestic abuse is strongly associated with poor outcomes in children and is a factor in the development of emotional and behavioral problems, as well as other mental health disorders. Prolonged and/or regular exposure to domestic abuse can have a very serious impact on children's safety and welfare and it rarely occurs in isolation.[15] Parents may also misuse drugs or alcohol, be mentally or physically ill or have a history of poor childhood experiences themselves.[15]

The Department of Health estimates that 750,000 children experience domestic abuse every year, and over any 100-day period, an estimated 205,000 children will witness domestic abuse. However, the true prevalence of domestic violence is likely to be higher as it often goes unreported. The effects of domestic abuse on a child or young person can include:

- Physical injury, including broken bones and bruises;
- Death;
- Premature birth, low birthweight and/or brain damage;
- Stress-related illness, e.g. asthma and bronchitis;
- Failure to thrive or weight loss;
- Speech and language delays;
- Bed-wetting;
- Sleep disturbance, including nightmares;
- Eating difficulties;
- Self-harm;
- Substance and alcohol misuse;
- Mental health issues such as increased anxiety or depression;

- Increased risk to health or accidental injury associated with living in temporary accommodation.

7.8.1.1 National and West Sussex profile: Domestic Abuse

Police forces in England record incidents of domestic abuse. In 2013/14, the police in Sussex recorded approximately 20,150 incidents of domestic abuse[lxxxv]. However, it is not known how many of these incidents occurred in households where children were present.

Children's and Young People's Mental Health and Wellbeing Profile: rate of domestic abuse incidents

The Children's and Young People's Mental Health and Wellbeing Profile by PHE provides the crude rate of domestic abuse incidents recorded by the police (per 1,000 population aged 16+) in 2012/13[lxxxvi]. In West Sussex, the incidence rate of domestic abuse was estimated at 13.7 per 1,000 population aged over 16 years. This is significantly lower than the rate for England, and the South East (18.8 and 16.6 per 1,000 population aged 16+ respectively). Again, this is likely to be an underestimate of the true extent of domestic abuse due to a high degree of under-reporting of these incidents.

Crime Survey for England and Wales 2013/14 (national data)

The Crime Survey for England and Wales (CSEW) is a face-to-face survey asking people who are resident in households in England and Wales about their experiences of a range of crime in the past year. Nationally, 4.5% of men and 8.5% of women (aged 16 to 59) reported they were victims of domestic abuse during the past year in the CSEW (2013/14)[lxxxvii]. This is equivalent to an estimated 1.4 million women victims and 700,000 male victims. These figures are likely to be an underestimate of the true prevalence of domestic abuse, as due to its personal nature, it frequently goes unreported.

Among men and women, the prevalence of domestic abuse was higher for younger age groups. Women aged 16-19 and 20-24 were more likely to be victims of domestic abuse (13.1% and 10.1% respectively), than older age groups (45-54: 7.1%, and 55-59: 5.9%). Similarly, young men aged 16-19 and 20-24 were more likely to have experienced domestic abuse (7.5% and 6.5% respectively) than men aged 45-54 (3.5%) and 55-59 (2.4%) in the last year.

Women who were separated from their partner had the highest prevalence of domestic abuse in the last year (22.1%) compared to all other groups (e.g. married: 3.7%, cohabiting: 8.9%, and divorced: 15.5%).

15.3% of men and 27.3% of women who were victims of domestic abuse reported the presence of children within their household. Over 1 in 5 women living in lone parent households were victims of domestic abuse in the past year (22.5%) compared with around 1 in 15 living in a household with other adults and children (6.7%). A similar pattern was seen for men, with 11.4% of men from lone parent households experiencing domestic abuse in the past year, compared to 3.9% of men living in a household with other adults and children.

Adult Independent Domestic Violence Advisor (IDVA) services (national data: 2013/14)

[lxxxv] ONS – "Appendix tables - Focus on Violent Crime and Sexual Offences 2013/14" (released Feb-2015)
[lxxxvi] Children's and Young People's Mental Health and Wellbeing Profile – Domestic abuse: incident rate per 1,000 population aged 16+ (2012/13).
[lxxxvii] ONS – "Bulletin tables – focus on violent crime and sexual offences, 2013-14 (released Feb-2015)

Independent Domestic Violence Advisor services are specialised services for people at risk of repeated domestic violence. They provide impartial, independent emotional and practical support for high-risk victims of domestic violence, and work in partnership with other agencies to increase the safety of their clients.

Data released by SafeLives summarises information from 27 IDVA services across England and Wales, covering over 5,500 individual cases[lxxxviii]. This data can provide an indication of the approximate number of clients with children who have presented to IDVA services. Approximately 65% of all IDVA clients had children, with an average of 1.9 children per households with children. An estimated 39.1% of children in high-risk domestic violence households were under the age of 5 in 2013/14.

Table 43 – Number of clients presenting to IDVA services who have children, England and Wales (2013/14)

Cases presenting to IDVA services	Number
Clients with children	3,620 (65%)
Clients who are pregnant	450 (8%)
Total number of children	6,940
Average number of children per household with children	1.9

Source: SafeLives (2015), Insights Idva National Dataset 2013-14. Bristol: SafeLives.

7.8.2 Parental Substance Misuse

Parental substance misuse has detrimental effects on foetal development, and negative long-term impacts after birth for a child's development, including their health and behaviour.[28] Heavy drinking in pregnant women is associated with foetal alcohol syndrome, which is linked to intellectual disabilities, as well as prenatal and postnatal growth deficiencies.[49] The misuse of substances (drugs and/or alcohol) may adversely affect the ability of parents to attend to the socio-emotional, physical and developmental needs of their children, thereby affecting the parent-child relationship. Children whose parents misuse substances are at a higher risk of neglect, abuse and of substance misuse in later life[28].

7.8.2.1 National and West Sussex Profile: Parental substance misuse and alcohol consumption

Data regarding illicit substance misuse of women during pregnancy is not routinely measured and as a result, estimates of prevalence are likely to be conservative. The Hidden Harm inquiry focused on identifying the number of children in the UK with a parent, parents, or guardian whose drug use has serious negative consequences for themselves and those around them. The inquiry estimates that there are between 200,000 and 300,000 children in England and Wales where at least one parent has a serious drug problem. This represents about 2-3% of children under the age of 16.

[lxxxviii] SafeLives (2015), Insights Idva National Dataset 2013-14. Bristol: SafeLives. (http://www.safelives.org.uk/sites/default/files/resources/Insights%20Idva%20national%20dataset%202013-2014.pdf)

Diagnostic Outcomes Monitoring Executive Summary (DOMES)

a) Pregnant women presenting to drug treatment services (2012/13)

Data from the DOMES for West Sussex show that in 2012/13 eight pregnant women presented to drug treatment services. This equated to 6.3% of all new female presentations. The national average was 4.9%. However, this does not provide a complete picture of the situation in West Sussex[lxxxix].

b) Clients presenting to drug treatment services who live with children (2014/15)

Data from the DOMES (2015/16 quarter 1 report) for West Sussex is presented in Table 44. Between Jul-14 to Jun-15 the proportion of clients who are receiving treatment for alcohol and/or substance misuse and who live with children (aged under 18) in West Sussex ranges from 26.5% of clients receiving treatment for alcohol and non-opiate use to 41.2% of clients receiving treatment for non-opiate use.

Table 44 – The proportion of current clients with children under the age of 18 by treatment type in West Sussex (2014/15)

	% in West Sussex	National average
Opiate	32.2%	30.7%
Non-opiate	41.2%	24.8%
Alcohol	32.3%	25.4%
Alcohol and non-opiate	26.5%	24.2%

Source: DOMES quarter 1 report (2015/16)

c) Clients with children successfully completing drug treatment (2014/15)

The proportions of clients who live with children who successfully complete treatment are presented (of all clients completing treatment) in Table 45. The greatest proportion of successful completers who live with children are those treated for alcohol misuse (43.9%).

Table 45 – The proportion of successful completions of clients who live with children (as all clients in treatment who live with children) during 2014-15

	% successful completers in West Sussex who live with children
Opiate	6.0%
Non-opiate	28.6%
Alcohol	43.9%
Alcohol and non-opiate	36.5%

Source: DOMES quarter 1 report (2015/16)

West Sussex JSNA Drug and Alcohol Reports 2012/13

Table 46 presents data from the West Sussex JSNA Drug and Alcohol reports for 2012/13 and shows the number of drug/alcohol users in treatment who live with children; users who are parents but do not live with children; and users for whom there is incomplete data. The data suggests that national trends are replicated at a local level, although there is a slightly higher than average proportion of adults receiving alcohol treatment living with children in West Sussex.

[lxxxix] West Sussex Alcohol and Drug Needs Assessment (http://jsna.westsussex.gov.uk/jsna-Comprehensive-Needs-Assessments?item=301)

Table 46 – Percentage of service users who are parents/have families 2012/13

	West Sussex		National	
	N	% of treatment population	N	% of treatment population
Adults receiving drug treatment who are in contact with children				
Living with children	466	33%	64,862	33%
Parents but not living with children	309	22%	41,532	21%
Incomplete data	0	0%	4,691	2%
Adults receiving alcohol treatment who are in contact with children				
Living with children	334	55%	32,113	52%
Parents but not living with children	268	45%	27,197	44%
Incomplete data	0	0%	2,517	4%

Note. Higher than national Same as national Lower than national
Source: West Sussex Alcohol and Drug Needs Assessment (pg 144)

Crime Survey for England and Wales – adults (with children within the households) reporting illicit substance misuse in the past year (national data)

The CSEW collects data from persons aged 16-59 years old on illicit drug use in the past year (2013/14), by presence/absence of children in their primary household. 8.3% of adults living alone with at least one child reported using an illicit drug in the past year (Table 47). This compares to 5.8% of households with resident adults and at least one child present. More men (11.8%) than women (5.8%) use illicit substances, and the mean age of people who had used any illicit substance within the last year was 29.3 years.

Table 47 - Proportion of 16 to 59 year olds reporting use of illicit drugs in the last year by household structure in England (2013/14 CSEW)

	Structure of household		
	Single adult and child(ren)	Adults and child(ren)	Adult(s) and no children
Any Class A drug	2.9%	1.7%	4.0%
Any stimulant	3.5%	1.8%	4.4%
Any drug	8.3%	5.8%	10.7%

Source: CSEW 2013/14 – Table D02 "proportion of 16 to 59 year olds reporting use of illicit drugs in the last year by household and area characteristics"

Infant Feeding Survey 2010 – Drinking behaviour of mothers before, during and after pregnancy (national data)

The Infant Feeding Survey collects retrospective data from new mothers on drinking behaviour before, during and after pregnancy[xc]. The most recent survey was conducted in 2010.

In 2010, 41% of mothers reported that they drank alcohol during their pregnancy in England. This compares to 55% of mothers in 2005. Older mothers (aged 35 or over; 52%), mothers from managerial and professional occupations (51%), and mothers from a White ethnic background (46%) were more likely to drink alcohol during their pregnancy.

[xc] HSCIC – Infant Feeding Survey UK 2010 (released Nov-2012)

The Infant Feeding Survey found that 47% of mothers aged 30-34, and 52% of mothers aged 35 or more reported drinking during pregnancy. This compares to 28% of mothers under the age of 20. White mothers were far more likely to drink alcohol before and during their pregnancy than any other ethnicity.

Among mothers who drank during pregnancy, consumption levels were low. Only 3% of mothers in England consumed more than 2 units of alcohol per week on average during their pregnancy (Table 48). The most common reason mothers gave for giving up or cutting down on the amount they drank during pregnancy was that alcohol might harm the baby (86%).

Table 48 - Drinking behaviours of women (who drank alcohol prior to pregnancy) during pregnancy as measured with the Infant Feeding Survey in 2005 and 2010 in England

	2005	2010
Gave up drinking	33%	48%
Drank less	62%	47%
No change/drank more	4%	2%

Source: HSCIC – Infant Feeding Survey UK 2010 (released Nov-2012)

7.8.3 Maternal/parental mental health

Maternal mental health is important in child development and it is one of the key determining factors of the quality of the mother infant/child relationship. As well as affecting the mother, poor attachment or mother child relationship has a negative impact on the child's development and is also associated with cognitive developmental delay and social or interaction difficulties and the development of behavioural problems for the child[50]. Poor maternal mental health also reduces the likelihood of breastfeeding. Depression and anxiety are the most common mental health problems during pregnancy and postnatal period, with around 12% of women experiencing depression and 13% experiencing anxiety at some point during pregnancy, (many women will experience both). In the first year after childbirth, 15-20% of women experience depression and anxiety (NICE CG192). Depression during pregnancy and after birth sometimes goes unrecognized because many of the discomforts of pregnancy and the post natal period mimic symptoms of depression[51].

As well as the impact it has on outcomes for the child and mother, maternal mental health has significant long-term costs to society. The Centre for Perinatal mental health report found that[xci]:

- Perinatal mental illness (depression, anxiety and psychosis taken together) carry a total long-term cost to society of about £8.1 billion for each one-year cohort of births in the UK. This is equivalent to a cost of just under £10,000 for every single birth in the country.
- Nearly three-quarters (72%) of this cost relates to adverse impacts on the child rather than the mother.
- The average cost to society of one case of perinatal depression is around £74,000, of which £23,000 relates to the mother and £51,000 relates to impacts on the child.

[xci] Centre for perinatal mental health
http://www.centreformentalhealth.org.uk/publications/costs_perinatal_mh_problems.aspx?ID=711

However, the report acknowledged some limitations due to data availability, leading to the underestimation of the scale and cost of perinatal mental health.

Similarly, the mental health of fathers has an impact on the child's cognitive, social and behavioural development. For example, the fathers' depression around the time of birth has been associated with some emotional and behavioural problems in their children, particularly boys, in the longer term .[52] In addition, there is some evidence that there is a moderate correlation between the father's mental health and mother's mental health. Several factors have been highlighted to impact on paternal depression in the postnatal period and these include being young, of low income, having a depressed partner and being unsatisfied with the couple-relationship or timing of the pregnancy.[53] There is a paucity of research on interventions focusing on the fathers' mental health, however, in the Early Years High Impact areas, the Government stressed the importance of supporting fathers in transition to parenthood through health visitors. This includes assessing the fathers' mental health as well as mothers, as part of their role of 'family workers'.[54]

7.8.3.1 West Sussex Profile: Perinatal Psychiatric Disorder

Perinatal mental health problems are those which complicate pregnancy and the postpartum year. Table 49 shows approximate rates of perinatal psychiatric disorders (per 1,000 maternities) and the estimated perinatal mental health morbidity for the West Sussex population based on the number of maternities in 2014.

Table 49 – Approximate rates of perinatal psychiatric disorders per 1,000 maternities, an estimated number of women affected in West Sussex

Disorder	Rate per 1,000 maternities	Estimated number of women affected in West Sussex
Postpartum psychosis	2/1,000	17
Chronic serious mental illness	2/1,000	17
Severe depressive illness	30/1,000	259
Mild-moderate depressive illness and anxiety states	100-150/1,000	862 to 1,293
Post-traumatic stress disorder	30/1,000	259
Adjustment disorders and distress	150-300/1,000	1,293 to 2,586

Note. Rates are sourced from the Joint Commissioning Panel for Mental Health: Guidance for Commissioners of Perinatal Mental Health Services (https://www.rcpsych.ac.uk/pdf/perinatal_web.pdf). These rates have been applied to the number of maternities reported by the ONS for West Sussex in 2014 (8,621 maternities)

7.8.3.2 West Sussex Profile: Post-natal depression

Little data is available on the prevalence of mental health issues during pregnancy and the postnatal period. Effective assessment is essential in assisting professionals to identify the needs of families and children and offer appropriate support. Due to the well-documented negative outcomes associated with poor parental mental health for both parents and children, further assessment of mental health particularly in the postnatal period is warranted. There is also a need to focus on the Toxic Trio, and the linkages and interdependence that exist between these, in order to minimise risks.

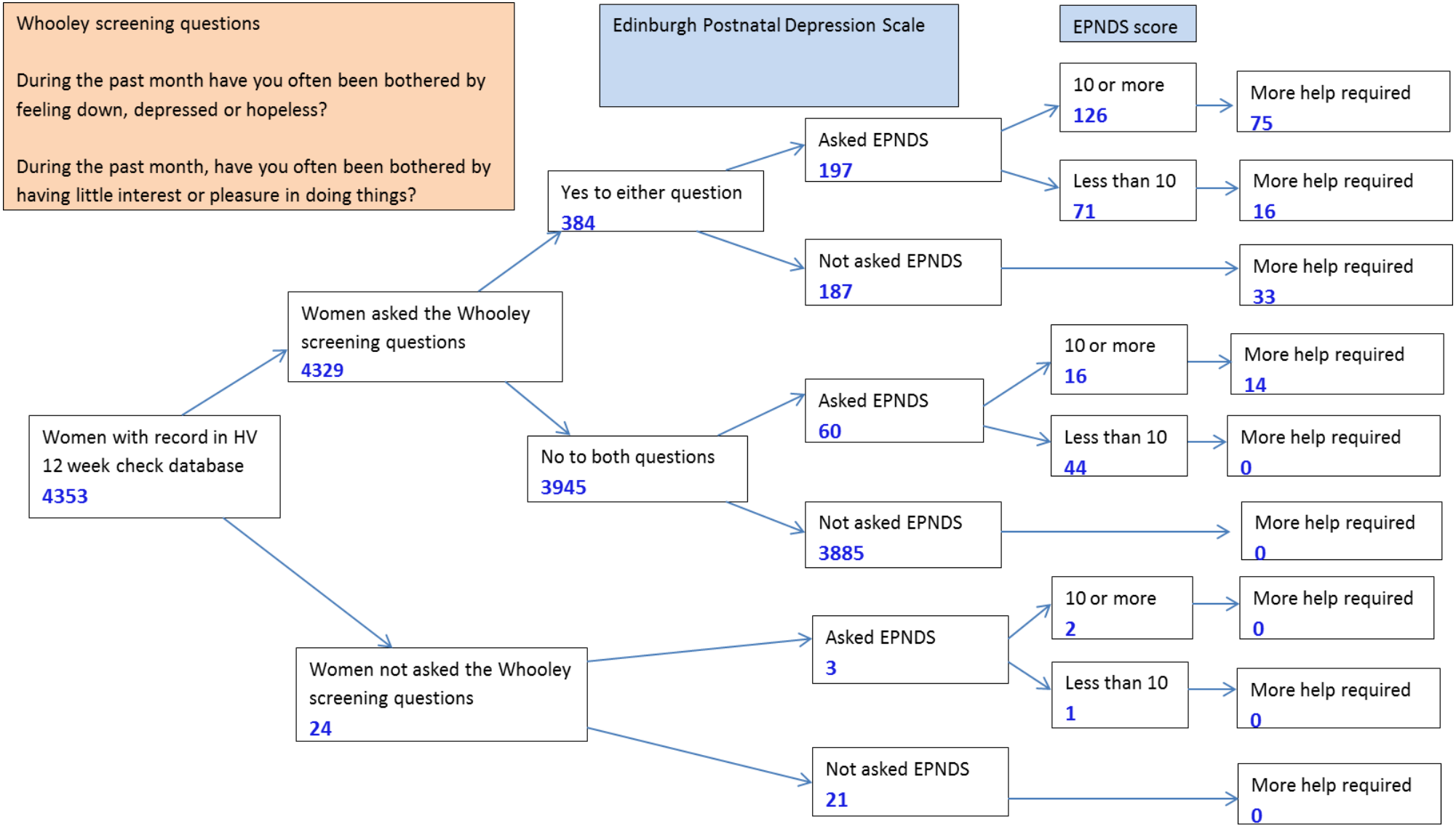
The diagram below shows how women are currently being screened and identified for support via the health visitor check in West Sussex. This data relates to the 2014 calendar year. The figures in blue represent the number of women at each stage of the process.

Of the 4,353 women with recorded information, 4,329 had been screened using the Whooley questionnaire. The data show that various paths had been followed with the screening tools. A small number of women had no initial screening data but then had been assessed using the Edinburgh scale, some had been identified using the Whooley but then not assessed using the Edinburgh tool.

The data reflect the fact that the process by which women are identified as having, or being at risk of having, post natal depression is inconsistent across West Sussex. The information below relates to 4,350 women, this is compared to approximately 8,700 births.

Figure 33 shows that of the women where the Whooley tool was used, 138 women requested more help.

Figure 33 - Process of identification of postnatal depression using the Whooley tool (numbers of mothers at each stage are in blue).



7.8.3.3 Considerations for commissioners and providers

Domestic abuse

The NICE guidance on domestic violence and abuse (NICE 2014b, PH50) reported that while insufficient evidence was found to recommend screening or routine enquiry within healthcare settings, routine enquiry is viewed as best practice by some professionals. The review of evidence underpinning the NICE (2014b) guidance found insufficient evidence for the efficacy of primary prevention programmes relating to IPV.[28] However, there is evidence that CBT based interventions can support pregnant women who are at risk or who have experienced Intimate Partner Violence.[28]

Parental substance misuse

Interventions for reducing drug and alcohol misuse in pregnant women include;

- Brief interventions
- Psychological interventions such as CBT and psychosocial interventions
- Home visiting programs

Maternal/parental mental health

Some of the risk factors that can affect parental mental health include, increased life stress, history of depression, lack of social support including intimate partner support, domestic abuse, teenage/unintended pregnancy, single/non-cohabitation status, and poor intimate relationship quality.[13] The Marmot review recommended the implementation of interventions that address the social determinants of health, including those that would potentially improve parental mental health through improvement to the conditions in which people live and work. The review particularly stressed on interventions that are effective in tackling different key policy areas such as; start of life, skills development, employment and work, ill-health prevention, sustainable communities and places, and healthy standard of living.

Prevention and early intervention are key in improving maternal mental health outcomes. The NICE guidance on antenatal and postnatal mental health (NICE 2014), recommends early assessment of the woman's mental health at first contact with healthcare. Furthermore, the use of effective and acceptable screening tools is recommended, in order to ensure that those who are depressed can be identified and treated with appropriate interventions. As well as assessing mental health, there is a need to assess the mother-baby relationship at all postnatal contacts (NICE CG192) .[28] Targeted low-intensity and high-intensity psychological interventions such as CBT, alone or in combination with medication have been recommended as treatment options for women with depression and or anxiety, in line with the NICE recommendations for the specific mental health problems (NICE guideline CG192). Group-based parenting programmes can also improve a number of aspects of maternal mental health, including depression and anxiety, although they are not recommended as primary treatments for these conditions. Interventions should also provide support to the family as a whole, in order to minimise depression amongst fathers whose partners are affected by perinatal mental illnesses[55].

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8 READINESS FOR SCHOOL

Childcare and Schools

8 Readiness for school and childcare

8.1 Early education and development

During the early years, children spend several hours in childcare settings, and there is evidence to support that the quality of early years childcare and education settings have an impact on the child's developmental outcomes. The provision of quality early care and education is also cost effective, for example, every £1 invested in quality early care and education saves taxpayers up to £13 in future costs[62]. The Effective Pre-school, Primary and Secondary Education (EPPSE) research project funded by the DfE explored the influence of preschool (from age 3) on children's academic and socio-behavioural outcomes.[63] The study also looked at the role of the home learning environment (HLE), the family, neighbourhood and other school experiences on children's learning, progress and dispositions. Key findings are outlined below:[63]

- Pre-school has a positive and long-term impact on children's attainment, progress and social-behavioural development.
- At school entry (age 5), attending pre-school improved children's academic and social outcomes with an early start (before age 3) and attending a high quality setting being particularly beneficial. Pre-school continued to influence outcomes throughout primary school especially if it was of high quality. At age 11, high quality pre-school was especially important for boys, pupils with SEN and those from disadvantaged backgrounds. High quality pre-school enhanced the maths outcomes for disadvantaged pupils and for those of low qualified parents.
- The pre-school influence continued during secondary school. Those who attended high quality pre-school had higher attainment and better social-behavioural development at age 14 (KS3). By age 16 (KS4) there were no lasting pre-school effects on social behaviours but attending a pre-school predicted better GCSE results.
- The Institute of Fiscal Studies (IFS) estimated that pre-school attendance and attending a pre-school of high quality led to positive financial returns over life time earnings to the individual, a household and the Exchequer.

8.2 Readiness for school

School readiness is a measure of how prepared a child is for the transition to school, in order to succeed in key developmental domains such as cognitive, social and emotional domains. According to UNICEF, 'school readiness is a product of the interaction between the child and the range of environmental and cultural experiences that maximize the development outcomes for children'[64]. The Allen Report placed emphasis on the promotion of evidence based early intervention programmes to make sure that all children can be 'school ready' when they start school. The Field Report also set out the key role that pre-school education plays and how the home background influences a child's readiness for school. A holistic approach to school readiness focuses on the 3 dimensions that must work in tandem[64];

1. Ready children (focusing on children's learning and development)
2. Ready schools (focusing on the school environment along with practices that foster and support a smooth transition for children into primary school and advance and promote the learning of all children)

3. Ready families (focusing on parental and caregiver attitudes and involvement in their children's early learning and development and transition to school)

School readiness is associated with socioeconomic status, and there is a persistent gap in educational attainment between children from lower socio economic background and those who are better off.[23, 62, 65] School readiness is also associated with ethnicity and gender. In the UK, Pakistani and Bangladeshi children lag far behind white children in school readiness and vocabulary. Moreover, Black children (including Black British, Black Caribbean and Black African children) also perform lower than white children, particularly in vocabulary.[62] On the other hand, whilst Indian children lag behind in vocabulary at age 3, they caught up with their peers by the age 5, scoring comparably to white children on school readiness at age 3.[62]

Evidence also indicates that there is a developmental delay in boys' school readiness, compared to girls. The longitudinal EPPE study[66], supported by evidence from other international research, found that during early education, girls made greater cognitive gains in preschool compared to boys. For example, girls achieved better in pre-reading, early number concepts and non-verbal reasoning than boys over the pre-school period[66]. However, the quality of preschool education was found to have an impact on boys' progress, suggesting that the provision of good quality preschool education can contribute towards improving boys' attainment levels and possibly reduce the gender gap. The study also found that home learning environment differed for boys and girls, potentially indicating gender differences in parenting styles[66].

8.2.1 Free childcare entitlement for two, three and four year olds

Disadvantaged two year olds, who meet the eligibility criteria, are entitled to access 570 hours of free early education, equivalent to 15 hours of provision a week for 38 weeks per year. Similarly, **all** 3 to 4-year-olds in England can get 570 hours of free early education or childcare per year. An analysis of take-up of formal childcare by two, three and four year olds showed that take-up is lower amongst the more disadvantaged groups for whom it is more beneficial (compared to the richest quintile). [19] Some of the barriers identified for the low uptake of services include access to information, location of services, language and cultural considerations, particularly for ethnic minority groups.[67] Formal childcare use e.g. nurseries and pre-schools, is higher in less deprived areas, and children from working and higher-income families are more likely to use formal childcare than those from non-working and lower-income families.[68] The use of informal childcare, such as care from relatives or partners also has an impact on the uptake of formal childcare services and the Rowntree report[67] found there was significant support from partners/parents, grandparents and other family members among various groups.

Increasing access to high quality care is one way of improving their educational development and narrowing the gap. The Government paper *Supporting families in the foundation years* highlighted that health visitors and children's centres have an important role in identifying families and encouraging them to take up their free entitlement, particularly families of disabled children and those with more complex needs. Improving the take-up of free early education and childcare requires ensuring that parents are aware of their entitlements, and have easily accessible information to help them make informed choices about which options are best for their child.

8.2.2 National and West Sussex Profile: Free childcare entitlement

Free Early Education: 2 year olds

From September 2013, the entitlement of 15 hours of funded education was extended to disadvantaged 2-year-olds. The criteria for determining entitlement include:

The child must have a parent in receipt of

- Income Support
- Income-based Jobseekers Allowance
- Income-related Employment and Support Allowance
- Support through part 6 of the immigration and Asylum Act
- The guaranteed element of State Pension Credit
- Tax credits and have an annual income under £16,190 before tax
- Universal Credit

Children are also entitled to a place if; they are looked after by a local authority, they have a current statement of SEN or and EHC plan, they get DLA, or they have left care under a special guardianship order, child arrangement order or adoption order.

In January 2015, 1,670 children under the age of 2 benefitted from funded early education in West Sussex[xcii]. It is estimated that 62%[xciii] of the eligible 2-year-olds in the county received some funded early education. Approximately 95.4% of 2-year-olds entitled to early education in West Sussex met economic criteria, whilst 2.2% children with high-level SEN or disability, and 2.4% were looked after children or adopted from care.

The majority of 2-year-olds receiving funded early education are in private and voluntary provision (97%)[xciv]. In West Sussex, there are an estimated 361 providers delivering funded early education, 357 of which are private and voluntary sector providers, and 3 are maintained nursery schools. The majority of 2-year-olds receiving funded early education are in settings rated as outstanding or good by Ofsted (Table 50).

[xcii] Local Authority Interactive Tool (LAIT) – downloaded 21/12/2015 (last updated 16 Dec 2015)

[xciii] Numbers of 2 year olds taking up places is expressed as a percentage of the 2 year old population eligible for a funded early education. The estimated number of eligible children is derived from data provided by the DfE and DWP on the number of children believed to meet the benefit and tax credit eligibility criteria.

[xciv] DfE: Provision for children under 5 years of age: January 2015 https://www.gov.uk/government/statistics/provision-for-children-under-5-years-of-age-january-2015 (updated Jul-2015)

Table 50 – The number and percentage of 2-year old children benefitting from funded Early Education in private, voluntary and independent providers, and in maintained nursery, primary, secondary and special schools by Ofsted inspection rating in West Sussex and England (Jan 2015)

	West Sussex		England	
	Number of 2-year-olds	%	Number of 2-year-olds	%
Outstanding	257	18%	23,604	17%
Good	1,074	74%	94,679	68%
Satisfactory/Requires Improvement	89	6%	16,373	12%
Inadequate	36	2%	4,245	3%

Source: DfE: Provision for children under 5 years of age: January 2015 (Jul-2015)
Note. Some 2-year-old children were not matched to Ofsted and so are not included in the calculation above (N = 215 in West Sussex, N = 18,135 in England)

Free Early Education: 3 and 4 year olds

All 4-year-olds have been entitled to a funded early education place since 1998 and in 2004 this was extended to include all 3-year-olds.

In West Sussex, approximately 97% of all 3 and 4 year olds were benefiting from some free early education (Table 51). The majority of these children were in private and voluntary provision (62.1%), or maintained nursery and state funded primary schools (37.2%). Private and voluntary providers have the greater share of 3-year-olds (91.6%), whereas maintained nursery and state-funded primary schools have the greater share of 4-year-olds (65.2%).

Table 51 – The number and percentage take up of 3 and 4 year olds benefiting from some free early education (as part of Early Years Census, Jan 2015)

	Number and percentage take up of 3 and 4 year olds benefiting from some free early education			
	2009		2015	
	Number	%	Number	%
West Sussex	16,686	97%	19,070	97%
South East	187,900	96%	214,080	96%
England	1,158,755	95%	1,321,897	96%

Note. This reflects a head count of children in receipt of some funded early education. The eligible population used to calculate take-up rates is the ONS population estimate.
Source: LAIT,

In West Sussex, it is estimated that there are 726 providers delivering funded early education to 3- and 4-year olds, the majority of which (505 – 69.6%) are private and voluntary providers, or nursery and infant classes in primary schools (207 – 28.5%). There are also 4 maintained nursery schools, 2 state-funded secondary schools and 8 special schools providing free early education to 3- and 4-year olds in the county.

Approximately 88% of 3 and 4-year-olds benefiting from funded early education were in settings rated as outstanding or good (Table 52).

Table 52 – The number and percentage of 3 and 4-year old children benefitting from funded Early Education in private, voluntary and independent providers, and in maintained nursery, primary, secondary and special schools by Ofsted inspection rating in West Sussex and England (Jan 2015)

	West Sussex		England	
	Number of 3 and 4-year-olds	%	Number of 3 and 4-year-olds	%
Outstanding	3,762	22%	252,901	21%
Good	11,504	66%	782,966	64%
Satisfactory/Requires Improvement	1,751	10%	162,531	13%
Inadequate	286	2%	22,967	2%

Source: DfE: Provision for children under 5 years of age: January 2015 (Jul-2015)
Note. Some 2-year-old children were not matched to Ofsted and so are not included in the calculation above (N = 1,765 in West Sussex, and N = 100,532 in England)

8.3 Early Years Foundation Stage (EYFS) Profile

The Early Years Foundation Stage (EYFS) sets the statutory standards to be met by all early years' providers for the care, development and learning of children from birth to 5 years old. All schools and Ofsted-registered early years providers must follow the EYFS, including child-minders, preschools, nurseries and school reception classes. The EYFS comprises of seven areas split between prime and specific areas of learning and development. The prime areas of learning are as follows:

- Communication and language development
- Physical development
- Personal, social and emotional development

The specific areas of learning are:

- Literacy development
- Mathematics
- Understanding the world
- Expressive arts and design

Teacher assessments are made in the summer term and they summarise each child's achievement as emerging, expected or exceeding against the 17 ELGs. The good level of development (GLD) measure is the most widely used assessment of child development in early years. Those that have reached a good level of development are deemed to have achieved the expected level in the ELGs in the prime areas of learning (personal, social and emotional development, physical development, and communication and language) and in the specific areas on mathematics and literacy[xcv].

8.3.1 National and West Sussex Profile: EYFS 2014/15

In West Sussex, the percentage of eligible children who were achieving a GLD at the end of reception was estimated at 63.5% in the 2014/15 academic year. Whilst this has increased from 58.8% the previous year,

[xcv] Department for Education – Statistical first release: early years foundation stage profile attainment by pupil characteristics, England 2014 (released Nov-2014)

the proportion of children achieving a good level of development in West Sussex is lower than the national average (66.3%) and the South East (70.1%).

Table 53 – The total number of pupils and percentage who achieved a good level of development (GLD) in West Sussex, the South East and England (2014/15)

	Total number of pupils	% of pupils achieving a GLD
West Sussex	9,358	63.5%
South East	105,096	70.1%
England	655,016	66.3%

Source: DfE – Early Years Foundation Stage Profile Results: 2014 to 2015 (updated Nov-2015)

Of the local authorities in West Sussex, Arun has the smallest proportion of pupils assessed who have a good level of development (57.5% - Table 54). This is significantly lower than all other district and boroughs in the county besides Crawley. Mid Sussex has the greatest proportion of pupils with a good level of development (68.7%).

Table 54 – The percentage of children achieving a GLD at the Early Years Foundation Stage by lower-tier local authority in West Sussex (2014/15)

	Number of pupils assessed	Pupils with a GLD			
		Number	%	LCL	UCL
Adur	699	472	67.5%	64.0%	70.9%
Arun	1,485	854	57.5%	55.0%	60.0%
Chichester	1,064	673	63.3%	60.3%	66.1%
Crawley	1,610	984	61.1%	58.7%	63.5%
Horsham	1,603	1,061	66.2%	63.8%	68.5%
Mid Sussex	1,729	1,188	68.7%	66.5%	70.9%
Worthing	1,286	807	62.8%	60.1%	65.4%

Source: EYFS Profile data 2014/15 for West Sussex (EPoD) provided by the Early Years Childhood Service
Note. Totals may differ with higher geographies due to differences in how the data is aggregated to lower levels.

Across the prime and specific areas of learning, the percentage of children achieving at least the expected level of development varies (Table 55). National, regional and local level data suggests that children have the most difficulty with literacy, with 67.8% of children achieving at least the expected level in West Sussex (70.1% in England, and 73.9% in the South East). Highest performance tends to be for physical development and expressive arts, and design.

Table 55 – The percentage of all children assessed at the Early Years Foundation Stage who achieved at least the expected level across the prime and specific areas of learning (2014/15)

		PRIME AREAS OF LEARNING			SPECIFIC AREAS OF LEARNING			
	N	Communication and Language	Physical Development	Personal, Social and Emotional Development	Literacy	Mathematics	Understanding the World	Expressive Arts and Design
Adur	699	81.4%	89.8%	84.4%	71.0%	80.1%	86.1%	89.6%
Arun	1485	76.4%	84.6%	80.9%	61.8%	71.7%	78.5%	83.0%
Chichester	1064	82.5%	89.9%	83.7%	69.2%	78.9%	83.8%	89.3%
Crawley	1610	80.3%	89.2%	84.0%	66.1%	75.5%	82.1%	86.1%
Horsham	1603	84.1%	91.0%	87.1%	70.9%	79.9%	87.5%	90.7%
Mid Sussex	1729	86.6%	91.0%	87.6%	73.0%	82.2%	89.8%	90.0%
Worthing	1286	82.0%	87.6%	83.0%	66.7%	76.0%	85.0%	88.7%
West Sussex	9,358	81.8%	88.9%	84.4%	67.8%	77.2%	84.4%	87.8%
South East	105,096	84.0%	90.1%	86.9%	73.9%	80.6%	87.0%	89.6%
England	655,016	80.3%	87.2%	83.7%	70.1%	75.8%	82.1%	85.3%

Source: EYFS Profile data 2014/15 for West Sussex (EPoD) provided by the Early Years Childhood Service

8.3.1.1 Development and gender

Level of development also varies by gender. In West Sussex, 55.0% of boys and 72.9% of girls achieved a good level of development in 2014/15, a gender gap of 17.8% (Table 56). A similar pattern exists for the proportion of girls and boys achieving at least the expected level of development across all early learning goals, with girls (71.4%) consistently outperforming boys (52.8%). For the South East region, girls similarly outperform boys across all early learning goals and a good level of development however; both sexes perform better than West Sussex.

Table 56 – The proportion of pupils who have achieved at least the expected level of development across all early learning goals, and who have achieved a good level of development in West Sussex, by gender (2014/15)

				% achieving at least expected level across all ELGs				% achieving a good level of development			
	N	Girls	Boys	All	Girls	Boys	Gap	All	Girls	Boys	Gap
Adur	699	348	351	66.7%	75.6%	57.8%	17.8%	67.5%	76.7%	58.4%	18.3%
Arun	1485	683	802	55.2%	67.2%	44.9%	22.3%	57.5%	68.8%	47.9%	20.9%
Chichester	1064	496	568	60.4%	70.4%	51.8%	18.6%	63.3%	74.4%	53.5%	20.9%
Crawley	1610	749	861	58.8%	67.0%	51.7%	15.3%	61.1%	69.3%	54.0%	15.3%
Horsham	1603	776	827	64.8%	74.1%	56.0%	18.1%	66.2%	75.1%	57.8%	17.3%
Mid Sussex	1729	835	894	67.4%	77.0%	58.4%	18.6%	68.7%	77.1%	60.9%	16.2%
Worthing	1286	614	672	62.1%	71.2%	53.7%	17.5%	62.8%	71.5%	54.8%	16.7%
West Sussex	9,358	4,447	4,911	61.6%	71.4%	52.8%	18.6%	63.5%	72.9%	55.0%	17.8%
South East	105,096	51,267	53,829	68.6%	77.0%	60.7%	16.3%	70.1%	78.0%	62.5%	15.5%
England	655,016	319,286	335,730	64.1%	72.6%	56.0%	16.6%	66.3%	74.3%	58.6%	15.6%

Source: EYFS Profile data 2014/15 for West Sussex (EPoD) provided by the Early Years Childhood Service

Gender differences are also apparent for specific and prime areas of learning in West Sussex. In particular, boys appear to have more difficulty with literacy (a percentage point gap of 16.6%); 60.3% of boys achieved at least the expected level of literacy compared to 76.7% of girls. This follows a similar pattern for the South East and England.

Table 57 – The proportion of pupils who have achieved at least the expected level of development in each of the prime and specific areas of learning in West Sussex by gender (2014/15)

	Boys		Girls	
	N at least expected	% at least expected	N at least expected	% at least expected
Communication and language	3,911	77.2%	4,009	87.3%
Physical development	4,263	84.1%	4,332	94.3%
Personal, social and emotional development	4,025	79.4%	4,141	90.2%
Literacy	3,057	60.3%	3,534	77.0%
Mathematics	3,763	74.3%	3,728	81.2%
Understanding the World	4,121	81.3%	4,062	88.5%
Expressive arts, designing and making	4,170	82.3%	4,338	94.5%

Source: EYFS Profile data 2014/15 for West Sussex (EPoD) provided by the Early Years Childhood Service

8.3.1.2 Development and ethnicity

In West Sussex, the percentage of eligible children who were achieving a good level of development varies by ethnicity (Table 58). For example, in 2014/15 Asian pupils tended to perform less well (57.1%) when compared to White pupils (64.7%). However small numbers of pupils for some ethnic groups means that comparisons between ethnicity should be made with caution. Data for England suggests less variation between ethnicities (ranging from 68% of pupils of mixed ethnicity to 64% of Asian pupils), although this may be due to the small number of pupils in West Sussex for some ethnic groups.

Table 58 - Proportion of eligible children with a good level of development at the Early Years Foundation Stage by Ethnic Group in West Sussex (2014/15)

Ethnic Group	Total number of pupils assessed	% with a GLD
White	7,800	64.7%
Mixed	450	62.8%
Asian or Asian British	440	57.1%
Black or Black British	40	51.2%
Chinese	20	80.0%
Other Ethnic Groups	40	38.5%
Refused	70	72.3%
Information Not Yet Obtained	710	58.3%
Unknown	100	54.6%

Source: EYFS Profile data 2014/15 for West Sussex (EPoD) provided by the Early Years Childhood Service
Note: Total number of pupils have been rounded to the nearest 10

8.3.1.3 Development and deprivation

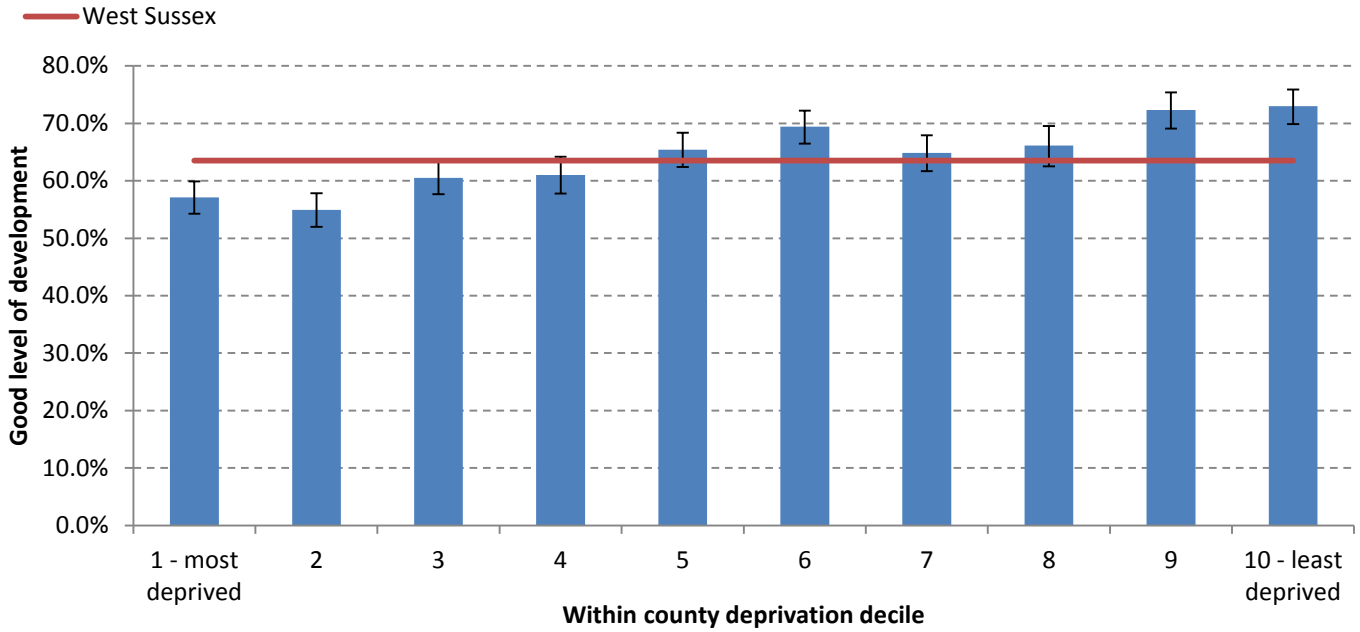
Children from poorer backgrounds are at a greater risk of poorer development. Differences by social background have been seen to emerge early on in life. Free school meals eligibility can be used as an indirect indicator of low income. In West Sussex, 781 children were eligible for free school meals in 2014/15, 44% of whom were considered to have attained a GLD. This is lower than the proportion of pupils who were not eligible for free school meals (65%)[xcvi].

In addition to free school meal eligibility, the income deprivation affecting children index (IDACI) reveals differences between areas of high and low deprivation. For example, the proportion of children who have

[xcvi] DfE: Early Years Foundation Stage Profile Attainment by Pupil Characteristics, England 2015 (SFR36/2015) – updated Oct-2015

achieved a good level of development decreases by each deprivation decile based on IDACI score; 55% of children living in the 10% most deprived areas achieved a good level of development, compared to 77% in the least deprived decile in England. Locally the picture is similar, with significantly fewer children in more deprived deciles achieving a good level of development (57.1% in the most deprived decile in West Sussex), compared to less deprived deciles (73.0% in least deprived decile in West Sussex - Figure 34).

Figure 34 – proportion of children achieving a good level of development by IDACI decile within West Sussex (2014/15)



Source: EYFS Profile data 2014/15 for West Sussex (EPoD) provided by the Early Years Childhood Service. The IDACI scores for each LSOA in West Sussex were ranked and then assigned to a decile - with the 10% highest ranked LSOAs assigned a decile of 1, and 10% lowest ranked LSOAs assigned a decile of 10.
Note. Approximately 200 children were unable to be assigned to a deprivation decile

8.4 Early Years Pupil Premium

Early years pupil premium (EYPP) is additional funding for early years settings to improve the education they provide for disadvantaged 3-4 year olds[xcvii]. Eligible children include those from low income families (defined as meeting the criteria for free school meals); children looked after by the local authority; children that have been adopted from care; children who have left care through special guardianship' and children subject to a child arrangement order. Settings are allocated 53p per hour per eligible pupil, which equates to £302.10 for each child who takes up the full 570 hours of state-funded early education they are entitled to. The government estimates that 170,000 children could benefit from EYPP in 2015/16.

[xcvii] DfE: Early Years Pupil Premium – Guide for Local Authorities: https://www.gov.uk/early-years-pupil-premium-guide-for-local-authorities (updated Mar-2015)

For the 2015/16 financial year, the DfE estimated that West Sussex is likely to have 1,327 eligible children for EYPP (estimated part-time equivalent (i.e. 1 child taking 570 hours a year) = 1,391 children)[xcviii]. This equates to £400,783 for EYPP allocations. This figure is based on an estimate of how many hours of state-funded education children who attract the EYPP will take up in each area. In autumn 2015, data will be collected from early years providers to identify the uptake of EYPP to establish whether some local authorities have more or fewer eligible children than anticipated.

8.5 Childcare sufficiency [xcix]

The Childcare Act 2006 places a duty on the Local Authorities to undertake a childcare assessment to ensure, as far as reasonably practicable, that the provision of childcare is sufficient to meet the requirements of children and their parents in their area. The West Sussex Childcare sufficiency Assessment was updated in March 2014 and indicated that, as at 31st March 2014, there were:

- 17,661 Free Entitlement places available for 2, 3 and 4 year olds providing 15 hours care and education each week for 38 weeks of the year.
- 28,836 childcare places for which parents would be able to use the childcare element of the Working Tax Credit.

The assessment highlighted that the current childcare supply appears to be meeting demand across the districts and boroughs. However, it also identifies some key actions and progress made towards some potential childcare gaps in some district and boroughs, for example, due to housing developments or closure of facilities (details can be found online https://www.westsussex.gov.uk/media/5945/ccsuff14.pdf)

The times at which childcare is available

Patterns of childcare use can be complex, depending on the age range of children, working patterns and availability of family and friends to support childcare. Child-minders are the most flexible childcare providers, with some offering evening, weekend and overnight care. In West Sussex, there are 592 child-minders/settings that offer emergency or temporary cover, 716 that specified they can be flexible, 143 that provide overnight care and 337 that provide childcare during unsociable hours and at weekends.

The number of places available for children who require specialist care

There are 7 holiday schemes with 255 places, and 3 pre-school/playgroups with 130 places that provide specialist care for disabled children and those with special educational needs. However, all child-minders and settings have a duty to operate an inclusive admissions policy in accordance with Ofsted requirements.

8.5.1 West Sussex Profile: Ofsted Performance – Early Years Settings

Table 59 shows the number and percentage of Early Years' service providers by Ofsted rating. Percentages should be considered alongside the number of providers that have been assessed.

[xcviii] DfE: Early Years Pupil Premium and funding for two-year-olds: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/323495/EY_Funding_ConDoc_-Branded_final_with_foreword.pdf

[xcix] West Sussex Childcare Sufficiency Assessment Annual Refresh 2014. https://www.westsussex.gov.uk/media/5945/ccsuff14.pdf accessed 01/09/2015

Table 59- The number and percentage of providers assessed by Ofsted as good or outstanding in "overall effectiveness" as at 31 August 2015

	Total N of providers assessed	Inadequate		Requires improvement		Good		Outstanding	
		N of providers	% of providers	N of providers	% of providers	N of providers	% of providers	N of providers	% of providers
CFCs	**16**	**-**	**-**	**6**	**38%**	**8**	**50%**	**2**	**13%**
Nursery Schools	**4**	**-**	**-**	**-**	**-**	**3**	**75%**	**1**	**25%**
All Early Years (including:)	**976**	**8**	**1%**	**105**	**11%**	**691**	**71%**	**172**	**18%**
Childcare on Domestic Premises	1	-	-	-	-	-	-	1	100%
Childcare on Non-Domestic Premises	370	6	2%	36	10%	246	66%	82	22%
Childminders	605	2	0%	69	11%	445	74%	89	15%

Source: OFSTED dataview (accessed 23/12/2015)

Consideration for commissioners, providers and policy makers

When children are not ready for school and fail to achieve a good level development at age 5, schools and colleges often struggle to close the gaps sustained during these early years.[62] Evidence from Ofsted indicates that there is a disproportionate distribution of good and outstanding schools in affluent areas as compared to deprived areas. As already noted in the preceding chapters, early interventions are more cost effective as they aim to prevent problems emerging rather than treating those problems. Evidence highlights that educational policies in isolation are not adequate to address these inequalities and there is need for high quality early intervention strategies that cross social care, health and educational boundaries.[62, 65]

The weight of the impact of poverty, ethnicity and gender on school readiness suggest that poverty has the highest impact, followed by gender and then ethnicity[62]. This indicates that boys from poor socio-economic backgrounds, regardless of ethnicity are likely to be one of the more disadvantaged groups[62]. However, a number of factors widen the gaps in school readiness include parenting styles, the home learning environment, quality early years education, maternal health and child health. Therefore, some of the interventions proven to work to improve school readiness are those that address these factors, including:

Good quality early education; evidenced action areas include:

- provision of well trained and qualified early years workforce
- provision of integrated services which bring together health, education, social care and economic strategies
- Expansion of high quality, part time early education has been evidenced to improve school readiness, i.e. free entitlement for 2 and 3-4 year olds. This includes increasing the uptake of free early years entitlement by those eligible.
- Favourable staff: child ratio in early years
- Use of pedagogical practices that combine both teaching and providing play activities[62]
- Encouraging high levels of active parent engagement in their child's learning

- Quality interactions between staff and children; i.e. responsive, sensitive, nurturing relationships
- Developing 'enhanced service' primary schools, which work closely with Children's Centres and other early years services on a locality basis.[62]

Support for parents during pregnancy and early years;

- Provision of universal and targeted interventions focusing of parenting styles (e.g. parent sensitivity and responsiveness/ nurturance including warmth and love, appropriate supervision and boundaries) and enhancing the home learning environment.
- Other evidence based interventions to improve school readiness include Incredible years program, FNP, Triple P (positive parenting program) and PEEP (Peers Early Education Partnership) and Home Instruction for Parents of Preschool Youngsters (HIPPY).[8, 69]

Maternal mental health;

- As previously highlighted, early identification (through screening) and treatment of post natal depression is crucial.
- Provision of targeted and universal early interventions, aimed at reducing risk factors such as teen pregnancy, smoking, substance misuse and mental illness.
- Other evidence based programs include HCP, FNP, Incredible years, and treatment strategies such as CBT for smoking and screening for postnatal depression.[8, 36]

Children and family centres also play a key role in tackling disadvantage and the Early Years literature review concluded that the most successful Children's Centres work to engage parents who don't know how to support their children's learning (teach) and give them the tools to be teachers too.[62]

9 SPECIFIC GROUPS

Children with Special Educational Needs, Disability and Safeguarding

9 Children with special educational needs and disabilities/safeguarding children

Some groups of children are considered to be more vulnerable to poor outcomes due to a number of risk factors. Children in need of services or looked after by local authorities, and children with special educational needs and disabilities (SEND) are among the vulnerable groups in society. They need effective support from statutory health, education, social care and the voluntary services in order to minimise the risk factors and enable them to reach their full potential. The following section focuses on these particular vulnerable groups.

9.1 Children with special educational needs and disabilities (SEND)

A child or young person has SEN if they have a learning difficulty or disability which calls for special educational provision to be made for them[56]. The Children and Families Act 2014, has introduced some extensive changes to support children with SEND. It has extended the SEND system from birth to 25 and SEN statements have been replaced with new Education, Health and Care (EHC) plan from birth to 25, which brings services together and is focused on improving outcomes. It also offers personal budgets for families with an EHC plan. In addition, the previous "school action" and "school action plus" categories are being gradually replaced by "SEN support".

Children with SEND may experience educational inequalities such as lower levels of attainment, lower rates of sustained education, and higher rates of absence or exclusion. Given the strong body of evidence to support the importance of early years education in improving children's outcomes, there is need to ensure high quality early education and childcare that is accessible to all children, including children with SEND. All early years providers, therefore, have a responsibility to identify and support children with special educational needs, as part of the EYFS framework, and ensure that[c]:

- they get the support they need
- engage in the activities of school alongside children who do not have SEN
- a teacher is designated to be responsible for co-ordinating SEN provision (the SEN co-ordinator, or SENCO)
- parents are informed when providers are making special educational provision for a child

Moreover, professionals from health services such as health visitors and from early years settings need to work with parents to assess the development of all children to clarify where they need additional support or a different approach, in particular through the health and development review for children aged between 2 and 2½ years (DfE 2014).

9.1.1 West Sussex profile: Early Years Pupils with a statement of SEN or EHC plan (as at 3/11/2015)

At the beginning of November 2015, there were approximately 170 Early Years children with a statement of SEN or an EHC in West Sussex[ci]. Of these children, 37.5% were attending a maintained special school and 32.1% were attending a maintained mainstream school. The remaining children were attending a

[c] DfE Special educational needs and disability code of practice: 0 to 25 years.
[ci] Data retrieved from SEND data and Research Officer for WSCC (provided as at 3/11/2015)

mainstream academy, resourced provision, early years setting with free nursery education, maintained free school or non-maintained special school. In addition, the October School Census identified a further 50 Early Years children who were receiving SEN support.

The most common primary types of need of Early Years children with an EHC (or statement of SEN) in West Sussex were Speech Language and Communication Needs (43.5%), or Autistic Spectrum Disorder (21.4%). Those with communication needs were more likely to be attending a mainstream school (with or without resourced provision – 68%), whereas those with ASD were more likely to be attending a special school (58%).

9.1.2 National and West Sussex profile: Prevalence and characteristics of children with SEN (DfE data)

DfE describes key information on pupils with SEN and learning difficulties and/or disabilities in England[cii]. The following data is sourced from the School Census statistical return for Spring 2015. As such, this data relates to the new SEN system including the introduction of EHC plans.

9.1.2.1 DfE School Census (Spring 2015) – pupil characteristics

Proportion of all pupils with SEN, 2015 (all ages)

Table 60 shows the number of pupils of all ages and at all schools that have SEN in West Sussex, the South East and England. Over 20,600 pupils have SEN in West Sussex. This equates to 17.2% of all pupils in West Sussex schools. In comparison, 15.4% of pupils in England, and 15.2% of pupils in the South East have special educational needs.

Table 60 - The number and percentage of pupils with SEN[1] (of all pupils on roll) based on where the pupil attends school (2015)

	Pupils with statements or EHC plans		Pupils with SEN Support[2]		All pupils with SEN	
	N	Incidence	N	Incidence	N	Incidence
West Sussex	3,538	2.9%	17,118	14.2%	20,656	17.2%
SOUTH EAST	40,035	2.9%	167,695	12.3%	207,735	15.2%
ENGLAND	236,165	2.8%	1,065,280	12.6%	1,301,445	15.4%

Note. [1]All schools. [2]Pupils with SEN Support includes some pupils at school action and school action plus. From 2015, SEN support replaces school action and school action plus but some pupils remain with these provisions in place in the first year of transition.

Source: DfE – Special Educational Needs in England: January 2015 (released July 2015)

The incidence of SEN appears to be declining, with 21.1% of pupils in England with SEN in 2010 compared to 15.4% in 2015. This decrease is due to fewer numbers of pupils receiving SEN support (or School Action and School Action Plus that have yet to transition to SEN support), as there has been no change in the proportion of children with an EHC plan/statement of SEN in England for a number of years (at approximately 2.8%).

[cii] All links to the data found in this section can be found at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/472575/Special_educational_needs-_an_analysis_and_summary_of_data_sources.pdf

A similar pattern is revealed for West Sussex where 22.9% of pupils had SEN in 2010 compared to 17.2% in 2015. This is also due to a decrease in the proportion of pupils receiving SEN support (20.1% in 2010 and 14.2% in 2015), with little change overtime in the proportion of pupils with a EHC plan or statement of SEN (2.8% in 2010, and 2.9% in 2015).

Special Educational Needs: Age (national data)

National data is available on SEN prevalence by age (Table 61). In 2015, there were approximately 79,795 children under the age of five with identified SEN in England. This translates to 8.4% of all pupils under the age of five who were in state-funded primary, secondary and special schools.

There were approximately 73,175 children with SEN attending state funded primary schools who were under the age of 5 in 2015. This equates to 7.8% of all under 5s attending primary schools. A further 835 pupils aged under 5 with SEN were attending state-funded secondary schools, and 5,785 under 5s with SEN were attending special schools in England in 2015 (Table 61). Under 5s with SEN account for the vast majority (96.7%) of pupils under the age of 5 who attend a special school in England.

Table 61 - Number of pupils with SEN by age at state-funded primary, secondary and special schools in England (2015)

Age	All pupils	Pupils with SEN with SEN support	Pupils with SEN with statements or EHC plans	Proportion of all pupils with SEN support or an EHC plan/statement of SEN
< 2	43,835	1,130	200	3.0%
3	263,305	15,855	1,435	6.6%
4	646,755	52,020	9,155	9.5%
0 – 4 years total	**953,895**	**69,005**	**10,790**	**8.4%**

Source: DfE: SFR25 - Special Educational Needs in England: Jan 2015 – National tables, table 3 (released May 2015)

Special Educational Needs: Type of school (nationally and locally)

Locally, data is available by primary or secondary school[ciii] (Table 62). In West Sussex, the incidence of SEN is higher for pupils in secondary schools (16.8%) than primary schools (14.5%). In the South East and England, SEN incidence is similar for pupils in primary (14.4% and 13.7% respectively) and secondary education (14.3% and 13.7% respectively).

Table 62 – Number and incidence (of total number of pupils in each school) of SEN at state-funded primary and secondary schools in West Sussex (2015)

	Pupils with statements or EHC plans		Pupils with SEN Support[1]		All pupils with SEN	
	N	Incidence	N	Incidence	N	Incidence
State-funded primary	835	1.3%	8,185	13.2%	9,020	14.5%
State-funded secondary	700	1.6%	6,710	15.2%	7,410	16.8%
All schools	**3,540**	**2.9%**	**17,120**	**14.2%**	**20,656**	**17.2%**

Source: DfE: Special Educational Needs in England: Jan 2015 – Local Authority Tables (12 and 13) (released May 2015)

[ciii] Assuming that the majority of children attending primary school are aged between 5 and 11, this can give some indication of SEN by age.

Special Educational Needs: Gender (national data)

National data is also available by gender. SEN is more prevalent in boys than girls. For children under the age of 5, 9.9% of boys are receiving SEN support compared to 4.4% of girls (Table 63). 1.6% of boys and 0.7% of girls aged under 5 had SEN with an EHC plan or statement of SEN.

Table 63 – Number (incidence) of SEN by age and gender in England (2015)

Age	All pupils		SEN with SEN support		SEN with statements or EHC plans	
	Boys	Girls	Boys	Girls	Boys	Girls
< 2	21,845	21,990	745 (3.4%)	385 (1.8%)	105 (0.5%)	95 (0.4%)
3	134,290	129,015	11,115 (8.3%)	4,740 (3.7%)	920 (0.7%)	515 (0.4%)
4	331,545	315,205	36,615 (11.0%)	15,410 (4.9%)	6,585 (2.0%)	2,575 (0.8%)
0 – 4 years total	**487,680**	**466,210**	**48,475 (9.9%)**	**20,535 (4.4%)**	**7,610 (1.6%)**	**3,185 (0.7%)**

Source: DfE: Special Educational Needs in England: Jan 2015 (released May 2015)

Special Educational Needs: Primary Type of Need (national and West Sussex data)

Table 64 shows the percentage of primary school pupils with SEN by primary type of need (data is not available by age group). A larger proportion of primary school children with SEN had speech, language and communication needs in West Sussex (31.5%) than in the South East (27.5%) or England (27.7%). Similarly, a larger proportion of primary school children with SEN in West Sussex had specific learning difficulties (16.6%) than in England and the South East, but fewer had moderate learning difficulties (19.5%).

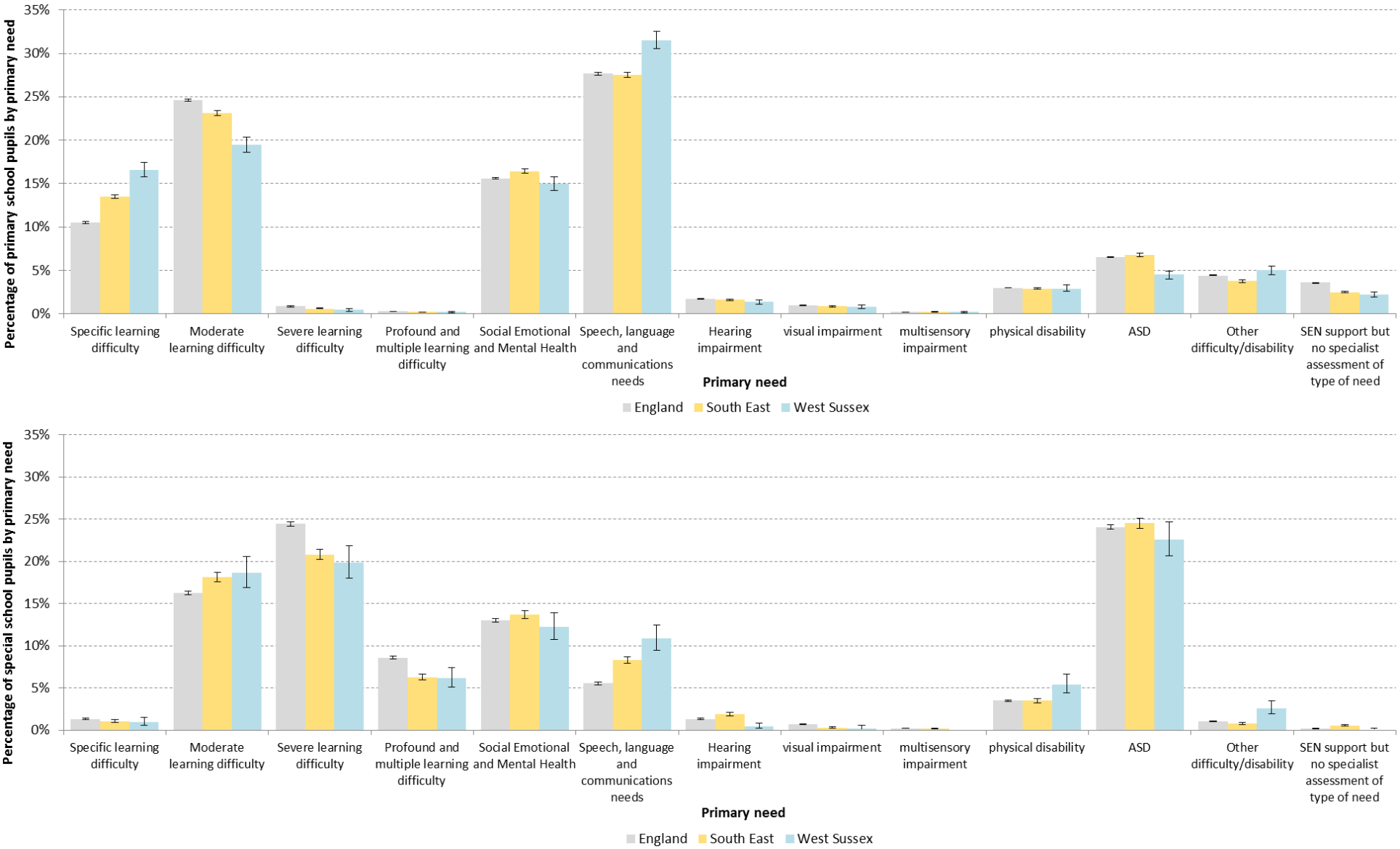
Table 64 – The percentage of state-maintained primary school pupils with SEN by primary need in West Sussex, the South East and comparison with England (2015)

	State-funded primary school				
	West Sussex		South East		England
Specific learning difficulty	16.6%	↑	13.5%	↑	10.5%
Moderate learning difficulty	19.5%	↓	23.1%	↓	24.6%
Severe learning difficulty	0.5%	↓	0.6%	↓	0.9%
Profound and multiple learning difficulty	0.2%	-	0.2%	↓	0.3%
Social, emotional and mental health	15.0%	-	16.4%	↑	15.6%
Speech, language and communication needs	31.5%	↑	27.5%	-	27.7%
Hearing impairment	1.4%	↓	1.6%	-	1.7%
Visual impairment	0.8%	-	0.9%	-	1.0%
Multi-sensory impairment	0.2%	-	0.2%	-	0.2%
Physical disability	2.9%	-	2.9%	-	3.0%
Autistic spectrum disorder	4.5%	↓	6.8%	-	6.5%
Other difficulty/disability	5.0%	-	3.8%	↓	4.4%
SEN support but no specialist assessment of type of need	2.2%	↓	2.5%	↓	3.6%
Total	100.0%	-	100.0%	-	100.0%

Source: DfE: Special Educational Needs in England: Jan 2015 – Local Authority tables (released May-2015)

The distribution of need of children attending special schools (all ages) is quite different. For example, far greater proportions of children attending special schools have a primary need of Autistic Spectrum Disorder (ASD) or severe learning difficulties, and a smaller proportion of pupils have speech, language and communications needs. Figure 35 shows the distribution of need of primary and special school pupils (all ages) who have SEN in West Sussex, the South East and England (2015).

Figure 35 - Proportion of primary school pupils with SEN by primary need (top) and proportion of special school pupils with SEN by primary need (bottom)



Looked after Children by SEN (nationally and locally)

In 2014, 79.1% of children (all ages) who had been looked after by West Sussex local authority for at least 12 months had SEN (Table 65). In comparison, 66.6% of CLA continuously for at least 12 months in England and 70.1% in the South East had SEN.

Table 65 – Number and percentage of children looked after with SEN (2014)

	Number of CLA for > 12 months	CLA without SEN		Children looked after with SEN					
				SEN no statement		SEN with statement		All CLA with SEN	
		N	%	N	%	N	%	N	%
West Sussex	295	60	20.9%	120	41.2%	110	37.8%	235	79.1%
SOUTH EAST	4,220	1,260	29.9%	1,640	38.8%	1,320	31.3%	2,960	70.1%
ENGLAND	32,870	10,980	33.4%	12,360	37.6%	9,530	29.0%	21,890	66.6%

Note. Percentage of all CLA matched to school census data
Source: DfE: Outcomes for children looked after by local authorities (Mar-2015)

9.1.2.2 DfE School Census (Spring 2015) – placement

Placement of children and young people with a statement of SEN or EHC plan (nationally and locally)

In West Sussex, the majority of pupils with an EHC plan are placed within maintained special schools (45.0%), or maintained mainstream schools (23.5%) in West Sussex[civ]. This pattern is similar to England and the South East (Table 66).

Table 66 – Placement of children (all ages) for whom West Sussex maintain a statement of SEN or EHC plan (2015)

Setting	West Sussex	South East	England
Non-maintained early years settings (private and voluntary sector)	0.6%	0.4%	0.4%
Resourced provision in maintained mainstream schools	9.5%	4.7%	3.4%
SEN units in maintained mainstream schools	0.0%	2.8%	2.1%
Maintained mainstream schools (incl. foundation schools)	23.5%	25.8%	29.3%
Maintained special schools (incl. foundation schools)	45.0%	37.0%	34.5%
Non-maintained special schools, independent special schools and other independent schools	10.2%	8.4%	6.5%
Hospital schools (incl. foundation schools) and pupil referral units	0.3%	0.4%	0.5%
Academies (incl. free schools)	8.7%	13.1%	15.9%
Special academies (incl. free schools)	0.0%	5.3%	5.7%
Alternative provision academies (incl. free schools)	0.0%	0.0%	0.1%
General further education and tertiary colleges/higher education	0.0%	0.1%	0.0%
Educated other than in school	**1.1%**	**1.3%**	**1.0%**
Awaiting provision	**1.1%**	**0.8%**	**0.4%**

Note. Due to rounding, totals may not sum.
Source: DfE – "SF14/2015 Tables – Statements of SEN and EHC plans: England 2015" (updated Jul-2015)

[civ] DfE: Statements of SEN and EHC plans: England 2015 (updated Jul-2015) – based on the SEN2 survey

9.1.2.3 DfE School Census (Spring 2015) – attainment

Early Years Foundation Stage Attainment by SEN (2014/15 –locally)

Of the estimated 9,660 children who completed the EYFS profile in 2014/15, approximately 750 children were identified as having SEN (approx. 7.8% of all pupils). Pupils with SEN are less likely to achieve a good level of development in the Early Years Foundation Stage Profile (EYFSP – see section 8.2.1 above). For example in 2014/15, 21.4% of pupils with SEN achieved a good level of development, compared to 67.3% of pupils without SEN (Table 67).

Table 67 – The percentage of pupils with and without SEN provision achieving a good level of development in West Sussex (2014/15)

Provision	% GLD
Pupils with SEN Support, School Action, or School Action +	26.8%
Pupils with an EHC plan or statement of SEN	7.5%
Pupils with SEN	21.4%
Pupils without SEN	67.3%
All pupils	63.5%

Source: EYFS Profile data 2014/15 for West Sussex (EPoD) provided by the Early Years Childhood Service

Key Stage 1 attainment of children with SEN (2015 – nationally and locally)

Table 68 shows the percentage of pupils achieving at least level 2 or above in KS1 by SEN provision in West Sussex in 2015. Similarly to the South East and England, attainment at KS1 decreases by SEN provision, with around 1/3 of pupils with a statement/EHC plan attaining at least level 2 at KS1. This compares to approximately 97% of pupils without SEN.

Table 68 – The percentage of pupils achieving level 2 or above in KS1 teacher assessments by SEN provision (2015)

		No SEN	Pupils with SEN		All pupils
			SEN Support	SEN with an EHCP or statement	
Reading	West Sussex	97%	65%	33%	91%
	SOUTH EAST	97%	67%	31%	92%
	ENGLAND	96%	64%	27%	90%
Writing	West Sussex	95%	56%	29%	88%
	SOUTH EAST	96%	57%	24%	89%
	ENGLAND	95%	55%	21%	88%
Mathematics	West Sussex	98%	72%	37%	93%
	SOUTH EAST	98%	76%	33%	94%
	ENGLAND	98%	73%	29%	93%
Science	West Sussex	97%	73%	33%	92%
	SOUTH EAST	98%	73%	29%	93%
	ENGLAND	96%	69%	25%	91%

Source: SFR32/2015 Key Stage 1 Attainment, Local Authority Tables

9.2 Children with disabilities

9.2.1 Disability Living Allowance

Disability Living Allowance (DLA) is a tax-free benefit that helps with the extra cost of living that disabled children and adults face because of their disabilities[cv]. As of April 2013, DLA is being replaced with a new benefit called Personal Independent Payment (PIP) for people of working age (16 – 64) with a disability. Thus, DLA is now only applicable for:

- children under the age of 16
- who have difficulties walking or needs more looking after than a child of the same age who doesn't have a disability

In order to be eligible, the child must have had these difficulties for at least 3 months and expect them to last for at least 6 months. If they are terminally ill, then they do not need to have had these difficulties for 3 months.

As at February 2015, there were 540 children under the age of 5 who were receiving DLA in West Sussex. This equates to 12.9% of DLA claimants under the age of 16. Table 69 shows the number of children under the age of 5 who are in receipt of DLA by disabling condition. Children with learning difficulties constitute the largest group of under 5's receiving DLA.

Table 69 – DLA claimants under the age of 5 years by disabling condition in West Sussex (February 2015)

Disabling condition	DLA claimants
Blindness	10
Behavioural disorder	50
Bowel and stomach disease	10
Chest disease	10
Cystic Fibrosis	10
Deafness	30
Diabetes mellitus	10
Disease of the muscles, bones or joints	20
Epilepsy	20
Heart disease	10
Learning difficulties	170
Malignant disease	10
Neurological diseases	50
Renal disorders	10
Skin diseases	20
Unknown	100
Total	**540**

Source: Benefits claimants – disability living allowance by disabling condition (DWP – February 2015)

[cv] Disability Living Allowance for Children - https://www.gov.uk/disability-living-allowance-children/rates

9.2.2 Limiting day-to-day activities by a health problem or disability (Census 2011)

The 2011 Census[cvi] asked respondents to assess whether their daily activities were limited a lot, a little, or not at all by a health problem or disability. For this purpose, a long-term health problem or disability was defined as:

> "A long-term health problem or disability that limits a person's day-to-day activities, and has lasted, or is expected to last, at least 12 months"

Table 70 shows the number of children under the age of 5 whose day-to-day activities were limited by a long-term health problem or disability in the 2011 Census. Over 850 children under the age of 5 were limited in their day-to-day activities by a long-term health problem or disability in West Sussex. This equates to approximately 1.8% of the under 5 population in West Sussex. There is little variation across the county, with 2.3% of under 5's limited in their day-to-day activities by a long-term health problem or disability in Adur, compared to 1.6% in Chichester.

Table 70 – The number of children under the age of 5 whose day-to-day activities are limited by a long-term health problem or disability

	Day-to-day activities limited	Day-to day activities not limited	% of under 5s with day-to-day activities limited
Adur	80	3,455	2.3%
Arun	150	7,230	2.0%
Chichester	90	5,555	1.6%
Crawley	160	7,900	2.0%
Horsham	120	7,020	1.7%
Mid Sussex	140	8,195	1.7%
Worthing	115	6,225	1.8%
West Sussex	855	45,580	1.8%
South East	10,295	523,410	1.9%
England	70,920	3,244,945	2.1%

Source: NOMIS (2011 Census) – long term health problem or disability by sex by age (LC3101EW)

9.2.2.1 Number of under 5's recorded in the Children and Family Centre Database who have a lifelong limiting illness

In addition to the 2011 census, the West Sussex Children and Family Centre database records the number of children under the age of 5 who have a disability. This is defined as a lifelong limiting illness to match the census definition (above). The database has a record of 975 children under the age of 5 who have a disability. The figures (see Table 71) are broadly consistent with the 2011 census.

[cvi] NOMIS – "Census 2011 - DC3302EW – long term health problem or disability by health by sex by age"

Table 71 – Number of children under the age of 5 with a disability as recorded in the CFC database

	Number of children (<5yrs) recorded as having a disability
Adur	85
Arun	180
Chichester	130
Crawley	185
Horsham	135
Mid Sussex	145
Worthing	110
West Sussex	975

Note. Data sourced from the Early Childhood Service in Nov-2015. Values are rounded to the nearest 5.

9.3 Safeguarding Children

Local authorities have a duty to safeguard and promote the welfare of children. They have a number of statutory functions under the 1989 and 2004 Children Acts, including specific duties in relation to children in need and children suffering, or likely to suffer, significant harm.

Safeguarding and promoting the welfare of children as defined by the guidance includes[cvii]:

- protecting children from maltreatment;
- preventing impairment of children's health or development;
- ensuring that children grow up in circumstances consistent with the provision of safe and effective care;
- taking action to enable all children to have the best outcomes

9.3.1 Children in need

Section 17 of the Children Act 1989 defines a child as being in need if:

- He or she is unlikely to achieve or maintain or have the opportunity to achieve or maintain a reasonable standard of health or development without provision of services from the local authority
- His or her health or development is likely to be significantly impaired, or further impaired, without the provision of services from the local authority
- He or she has a disability[cviii].

A child in need is one who has been assessed by children's social care to be in need of services, which the local authority has an obligation to provide under the Children's Act 1989. These services can include, for example, family support (to help keep together families experiencing difficulties), leaving care support (to help young people who have left local authority care), adoption support, or disabled children's services (including social care, education and health provision) (DfE 2013). Children who come into care are often known to social services for a number of years before action is taken to bring the child into care.[57] Delays in identifying and making appropriate referrals for children in need increases the child's risk of

[cvii] DfE March 2015. Working together to safeguard children: A guide to inter-agency working to safeguard and promote the welfare of children.

[cviii] Children Act 1989 – Section 17(10) http://www.legislation.gov.uk/ukpga/1989/41/section/17

experiencing poor outcomes, and may result in a child becoming subject to Child Protection Plan or becoming a CLA. Early intervention and also timely decision making are crucial in minimising the risk of negative outcomes in children in need.

For those children in need, the common primary need at initial assessment include:

- Abuse or neglect
- Family dysfunction
- Child's or parent's disability or illness
- Family in acute stress
- Absent parenting
- Socially unacceptable behaviour (*DfE 2013*)

9.3.2 National and West Sussex profile – Children in need

9.3.2.1 Children currently in need: all ages

In England, there were 390,960 children currently in need as at 31 March 2015[cix]. This equates to a rate of 337.3 children currently in need per 10,000 children. In West Sussex, there were 4,765 children in need; a rate of 282.3 per 10,000 children. This is similar to the rate for the South East, estimated at 282.9 children in need per 10,000 children.

9.3.2.2 Children currently in need: under 5's

Approximately 25.3% of all children in need in England were under 5 years of age (excluding unborn children) as at 31 March 2015.

In West Sussex, there were approximately 1,175 children aged under 5 (including unborn children) who were considered to be in need as at 23rd October 2015[cx]. This accounts for 26.7% of all children in need (aged under 18) in the county (approx. N = 4,405). Table 72 shows the distribution of children in need by single year of age in West Sussex. Excluding unborn children, the proportion of under 5's in need is similar for each consecutive year of age, accounting for approximately 20% each[cxi].

Table 72 – Number and proportion of under 5's in need by single year of age in West Sussex (as at 23rd October 2015).

Age	Number	Proportion of under 5's in need
< 1 year (including unborn children)	295	25.1%
Aged 1	220	18.7%
Aged 2	215	18.3%
Aged 3	230	19.4%
Aged 4	215	18.4%
Total under 5's	**1,175**	**100.0%**

Note. Data have been rounded to the nearest 5. Due to rounding, totals may not sum.
Source: West Sussex Children's Performance Sharepoint

[cix] DfE – Characteristics of children in need: 2014 to 2015 (released Oct-2015)
[cx] West Sussex Children's Performance Sharepoint
[cxi] Approximately 5% of children aged under 5 years were unborn.

9.3.2.3 Characteristics of children in need

Gender: under 5's (as at 23rd October 2015)

In West Sussex, the gender split for children in need was similar; 51% of all under 5's who were currently in need were boys[cxii].

Disability: all ages (as at 31 March 2015)

In England, approximately 13.0% of children currently in need have a disability[cxiii]. This figure is similar for West Sussex, where approximately 13.8% of children in need have a disability.

9.3.2.4 Primary need: under 5's (national data only – at 31st March 2015)

Table 73 shows the proportion of under 5's in need in England by primary type of need at assessment. Abuse or neglect was the most common primary type of need, accounting for nearly 57% of all cases. Family dysfunction (19.6%) and acute stress (8.0%) were the next two most frequent primary needs.

Table 73 – Proportion of under 5's currently in need by primary need at assessment in England (as at 31st March 2015)

Primary need of under 5's currently in need	Proportion of under 5's
Abuse or neglect	56.9%
Family dysfunction	19.6%
Family in acute stress	8.0%
Child's disability or illness	3.6%
Parent's disability or illness	3.4%
Socially unacceptable behaviour	1.0%
Cases other than children in need	0.7%
Absent parenting	0.5%
Low income	0.4%
Unknown	5.7%
Total	**100.0%**

Note. Under 5's excludes unborn infants.
Source: West Sussex Children's Performance Sharepoint

9.3.3 Child Protection Plans (CPP)

Children become subject to Child Protection Plans to safeguard their welfare if they are considered to be, or likely to be, suffering significant harm. Categories of abuse that may result in a child becoming the subject of a child protection plan include; neglect; emotional abuse; physical abuse and sexual abuse. CPP rates can give an indication of future safeguarding needs of vulnerable children as they may become children in need of services or looked after. However, this does not mean that all vulnerable children will become children looked after or children subject to CPP. Once a child becomes the subject of a child protection plan, their plan needs to be reviewed within the first 3 months and then at intervals of not more than 6 months. Children cease to be subject to a CPP when they are no longer considered to be at risk of significant harm; if the family permanently move out of the local authority area; or if the child turns 18. If a child remains subject to a child protection plan for an extended period of time, this can be an indication

[cxii] West Sussex Children's Performance Sharepoint
[cxiii] DfE – Characteristics of children in need: 2014 to 2015 (released Oct-2015)

that the risk of significant harm to the child is not reducing. On the other hand, if a CPP ceases prematurely, the child's family may not sustain their reduced risk status and the child may subsequently become at risk of significant harm and potentially subject to a further CPP.

There are variations in the proportion of children on CPP and those looked after by the local authority across England and research has attributed these variations to child welfare inequalities in a child or parent's chances, experiences and outcomes of engagement with child welfare, that are related to social advantage/disadvantage.[58] These mirror markers of inequalities in health such as inequalities in morbidity and mortality, access to services, and quality of services. [58] Research has indicated that children's chances of being looked after or being on a CPP is associated with levels of deprivation, with an increase in CPP and LAC as deprivation increases. However, although there is an increased risk in lower socioeconomic groups, children on CPP and CLA can be found across all socio-economic groups. This may indicate that universal and targeted approaches could reduce the rates of CPP and CLA, as compared to only addressing the most deprived areas.[59]

Some of the common characteristics and factors found in children subject to CPP are similar to those for CiN and CLA, such as parental substance misuse and deprivation. However, although these can be used as indicators or the risk, their presence is not proof of abuse.

9.3.4 National and West Sussex Profile: Children subject to a Child Protection Plan

9.3.4.1 Children with a CPP: all ages

At March 31st 2015, nearly 50,000 children under the age of 18 were the subject of a CPP in England[cxiv]. This equates to a rate of 43.9 children with a CPP per 10,000 children. In West Sussex, approximately 500 children were the subject of a CPP at 31st March 2015; a rate of 29.7 per 10,000 children. This is lower than the national rate. In comparison, the rate of children who were the subject of a CPP in the South East was estimated at 40.9 per 10,000.

9.3.4.2 Children with a CPP: under 5's (as at 30th March 2015)

Of all children with a CPP in England, approximately 20,430 were aged under 5 (including unborn children). This equates to an estimated 41.1% of all children (under 18) who were the subject of a CPP in England.

In West Sussex, 244 children aged under 5 had a CPP in place at 30 March 2015. Children under 5 account for 47.3% of all children (under 18) with a CPP in the county. Table 74 shows the number of children under the age of 5 with a CPP in West Sussex in 2014/15. Children under the age of 1 (including unborn children) account for nearly 3 in 10 (29.1%) child protection plans for under 5's.

[cxiv] DfE – Characteristics of children in need: 2014 to 2015 (released Oct-2015)

Table 74 – The number and proportion of children under the age of 5 with a CPP by single year of age in West Sussex (as at 30th March 2015)

Age	Number	Proportion of under 5's with a CPP
< 1 year (including unborn)	70	29.1%
Aged 1	40	17.2%
Aged 2	50	20.5%
Aged 3	40	16.4%
Aged 4	40	16.8%
Total under 5's	245	100.0%

Note. Data have been rounded to the nearest 5. Due to rounding, totals may not sum.
Source: West Sussex Children's Performance Sharepoint

9.3.4.3 Category of abuse: under 5's

Emotional abuse (57.0%) and neglect (27.9%) were the most frequent categories of abuse for under 5s with a CPP in West Sussex, whilst sexual and physical abuse accounted for a smaller proportion (15.2% of under 5s with a CPP at 30 March 2015)[cxv]. This differs to national estimates, where neglect was the most frequent category of abuse (48.3%) for under 5s in England, followed by emotional abuse (31.1%)[cxvi]. Physical (10.1%), sexual (3.2%) and multiple forms of abuse (7.4%) accounted for the remaining 20.7% of under 5's subject to a CPP in England.

9.3.4.4 Primary reason of support: under 5's

The primary reason for support for under 5's in West Sussex was abuse or neglect, accounting for 71.3% of CPPs for this age group[cxvii]. Parental illness or disability (10.7%) and family in acute stress (7.8%) were the next most frequent primary reasons for support. Small numbers of under 5's with a CPP had a primary reason of disability, family dysfunction, absent parenting, or socially unacceptable behaviour (10.2% total).

9.3.5 Children looked after/children in care

A child is legally defined as "looked after" by the Children Act 1989 if he or she is:

- provided with accommodation for a continuous period for more than 24 hours;
- is subject to a care order; or
- is subject to a placement order.

This definition ceases after a child turns 18 years of age.

Children looked after's (CLA) vulnerabilities are increased by the fact that they live away from their birth families, as a result of care orders or voluntary agreement of their parents. CLA usually live in foster homes, but may also be in residential placements or with family members and they also include unaccompanied asylum seeking children. Reasons for children under 5 going into care include[cxviii]:

- Parental mental illness, especially mothers

[cxv] West Sussex Children's Performance Sharepoint
[cxvi] DfE – Characteristics of children in need: 2014 to 2015 (released Oct-2015)
[cxvii] West Sussex Children's Performance Sharepoint
[cxviii] NICE guidelines PH28 Evidence Expert paper 21 (EP21).

- Alcohol and substance misuse by parent
- Domestic violence and abuse
- Young/ teenage parents in and leaving care, especially those under 18 years, are often at risk of not being able to care adequately for their babies, because of their own lack of parenting and attachment, as well as grandparent support
- Neglect, abuse and safeguarding from harm and abuse.
- Non accidental injuries and frequent contact with Accident and Emergency Departments
- Youth offending by mother, with possible custodial sentence

9.3.6 National and West Sussex Profile: Children Looked After

9.3.6.1 Children looked after: all ages (as at 31st March 2015)

There were 69,540 children looked after (CLA) in England as of 31 March 2015[cxix]. This is an increase of 1.1% compared to 2014 and an increase of 6.2% compared to 2011. The number of CLA has increased steadily over the past five years and is now higher than at any point since 1985. Approximately 19.9% of all CLA in England were under the age of 5.

In West Sussex, there were approximately 640 CLA as of 31 March 2015[cxx]. The rate of CLA for West Sussex is 38 per 10,000 children (under the age of 18). In comparison, the rate of CLA in the South East region and England were estimated at 49 and 60 CLA per 10,000 children <18 years old respectively[cxxi]. Contrary to national data, the number of CLA in West Sussex has generally seen a decrease over time, with 745 CLA in 2011 compared to 640 in 2014; a percentage decrease of 14.1%.

9.3.6.2 Children looked after: under 5's (as at 5 October 2015)

At 5 October 2015, 115 children aged under 5 were being looked after by West Sussex local authorities[cxxii]. This age group accounts for 18.0% of the estimated 640 CLA (aged under 18) in West Sussex.

Table 75 provides the distribution of children under 5 looked after in West Sussex by single year of age. Children under 2 years of age account for 60.8% of all under 5's looked after in the county.

[cxix] Department for Education - "Children looked after in England, including adoption" (released Oct-2015)
[cxx] DfE - "Children looked after in England, including adoption" (released Oct-2015)
[cxxi] Calculated by the DfE using the mid-year population estimates provided by the ONS
[cxxii] West Sussex Children's Performance Sharepoint

Table 75 – The distribution of children looked after in West Sussex by age (under 5's – as at 5 October 2015)

Age	Number	Proportion of under 5's looked after	CLA (under 5) as a proportion of all children looked after (all ages)
< 1 year	35	30.4%	5.5%
Aged 1	35	30.4%	5.5%
Aged 2	10	10.4%	1.9%
Aged 3	15	13.9%	2.5%
Aged 4	15	14.8%	2.7%
Total under 5's	115	100.0%	18/0%

Note. Data have been rounded to the nearest 5. Due to rounding, totals may not sum.
Source: West Sussex Children's Performance Sharepoint

9.3.6.3 Characteristics of children looked after: under 5's (as at 5 October 2015)

The majority of CLA under 5 years of age were of white ethnicity (86.1%). In addition, slightly more were boys (54.8%) than girls (45.2%). Approximately 40 children aged under 5 in West Sussex had been looked after continually for at least 12 months.

9.3.6.4 Category of need (as at 5 October 2015)

The most frequent category of need of under 5's looked after was abuse or neglect, accounting for approximately 7 in 10 cases (70.1%) in West Sussex. Acute stress of the family (13.0%) and parental illness or disability (10.4%) were the next most frequent categories of need for under 5's in the county. The remaining proportions of under 5's were distributed across the various categories of need, including family dysfunction, disability of the child and cases other than children in need.

9.3.6.5 Placements of CLA (as at 5 October 2015)

In West Sussex, the majority of CLA aged under 5 were placed within foster care (66.1%) or for adoption (27.0%). The remaining proportion of under 5's looked after in West Sussex were placed with their parents/a person with parental responsibility, or within a family centre or mother and baby unit. Of all children looked after in West Sussex placed for adoption, 72.1% were aged under 5 years (at 5 October 2015).

82.6% of under 5's looked after by West Sussex local authorities were provided with a placement that was within the county.

9.3.6.6 Adoptions

During 2014/15, 325 children (all ages) ceased to be looked after in West Sussex[cxxiii]. Of these children, 40 were adopted (13% of all children who ceased to be looked after in 2014/15).

In England, 5,330 CLA were adopted in 2014/15, an increase of 5.5% from 2013 and 71.9% from 2011. Of all CLA adopted in England in 2015, the majority were aged 1 to 4 (76.0%), with an average age of 3 years 3 months at adoption. This is 2 months younger than in 2014 and 7 months younger than in 2011.

[cxxiii] DfE – Children looked after in England (including adoption and care leavers) year ending 31 March 2015 (released Oct-2015)

The average time between entry into care and adoption of CLA (all ages) is 2 years 3 months in England. This is shorter for children who enter care at younger ages. For example, the average time between entry into care and adoption for children under the age of 1 (on entering care) is 2 years.

9.3.6.7 Outcomes for children looked after (all ages)

Children looked after (and SEN (2013/14)

A large proportion of CLA have special educational needs. In England, 66.6% of children who had been looked after continuously for at least 12 months had SEN[cxxiv] at 31 March 2014. This figure is considerably higher for West Sussex, with an estimated 79.1% of children looked after for at least 12 months with SEN. This compares to 70.1% of CLA in the South East.

Children looked after and Health Care (2013/14)

Of the 420 children in West Sussex who had been looked after continuously for at least 12 months, the majority were up to date with their health care (assessed as part of an annual health assessment)[cxxv]. 88.1% of looked after children for 12 months or more were up to date with immunisations, and 92.9% had been seen by a dentist within the past year. In addition, 95.2% had received an annual health assessment from a doctor or qualified professional within the previous year (twice yearly if under the age of 5). However, due to small numbers (N = 10) the number of looked after children under the age of 5 (for 12 months or more) whose developmental assessments were up to date could not be reliably determined. In England, 86.8% of looked after children under the age of 5 were up to date with their developmental assessments. This figure is similar in the South East (87.6%).

9.4 Considerations for commissioners, providers and professionals

Research suggests that the age at which children enter care, history of abuse and neglect and the degree of emotional and behavioural difficulties, as well as systemic factors such as delays in placement and availability of high quality placements, all have an impact on the stability and outcomes of the child's placement.[60] Entering care is also strongly associated with poverty and deprivation including low income, parental unemployment and relationship breakdown, (NICE guidelines, PH28). As has been highlighted previously, babies and children under five years are greatly affected by their home care, key carers and families, and a stable placement provides a sense of permanence. Therefore, there is a need to ensure high quality care, stable placements and nurturing relationships for looked-after children, as frequent placement changes can severely lessen the sense of identity and self-esteem of a child or young person (NICE PH28). Early entry into care followed by sensitive parenting in a stable placement, with good professional support from a range of agencies, including education, and health are some of the protective factors that minimise the risks of negative outcomes for children.[60]

NICE and SCIE (Social Care Institute for Excellence) produced a guidance aimed at promoting the quality of life of looked after children and young people. The guidance was produced in 2010 and refreshed in 2015.

[cxxiv] Data include children looked after continuously for at least 12 months as at 31 March 2014 excluding those in respite care. Only children who were matched to the 2014 census data and aged 4 or above at 31st March 2014 were included. DfE – Outcomes or children looked after by local authorities (updated Mar-2015)

[cxxv] DfE – Outcomes for children looked after by local authorities (updated Mar-2015).

The guidance highlights the importance of early and preventative interventions for babies and young children to avoid placement breakdown and reduce the impact on a child's ability to develop meaningful relationships in the longer term. The recommendations include:

- Assessing the needs of babies and young children and ensuring access to services
- Ensuring there are specialist services for babies and young children
- Ensuring carers and frontline practitioners working with babies and young children receive specialist training
- Reducing moves and achieving permanence for babies and young children
- Supporting foster carers and their families

A study conducted in the UK to capture the scale and pattern of recurrent care proceedings found that, between 2007 and 2013, 25% of all children in care proceedings were linked to recurrent cases.[61] A high proportion of these recurrent cases were infants under the age of 12 months, possibly indicating that in the majority of cases, women were pregnant again during or shortly after care proceedings. In addition, the study reported that 50% of birth mothers caught in a cycle of repeat care proceedings were young mothers aged 24 and under.[61] This gives an indication of the need for multifaceted interventions, particularly in high risk groups, to address the risk factors such as parental unemployment, and the toxic trio. In *Promoting the wellbeing of children: messages from research*, the National Society Preventing Cruelty to Children (NSPCC)[57] found that the common themes of the evidence based programs that impact on the outcomes for children on the edge of care (i.e. children in need), include;

- Stabilising the family unit and addressing risk factors such as substance misuse
- Comprehensive assessment of the family and child situation to inform decision making about placement
- Reducing the number of placements endured by the child
- Reducing the time-lag between entry into care and permanent placement
- Training and supporting foster carers.

10 EARLY YEARS SERVICES AND UTILISATION

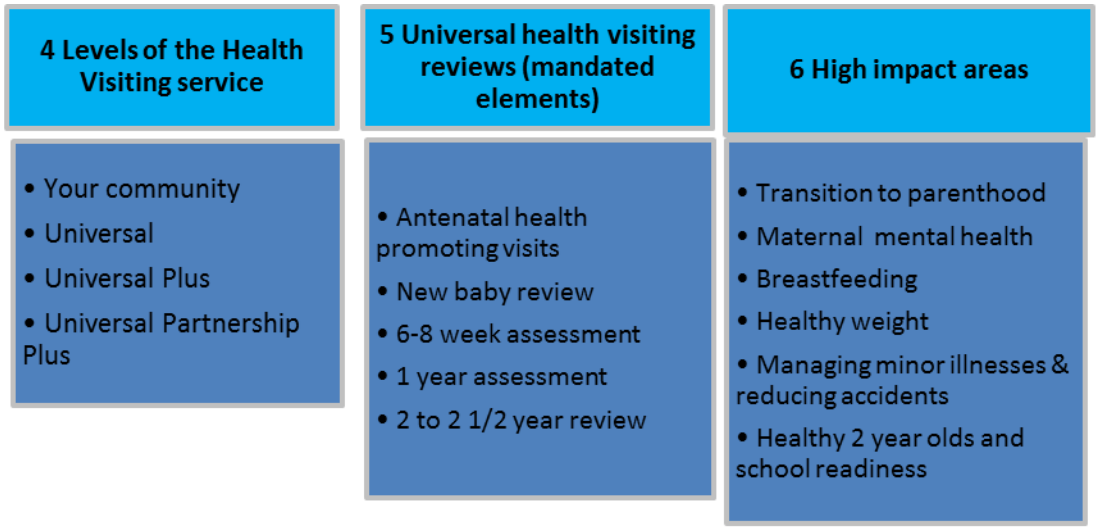
10 Early years services and utilisation

10.1 Health visiting services

Health Visitors have a crucial role in ensuring that children have the best possible start in life, and lead the delivery of the Healthy Child Programme (HCP) 0-5 years, in partnership with other health and social care colleagues. The HCP is made up of universal services which are offered for all children and families, and progressive universal services, which are offered to families and children with additional needs to mitigate high risk factors. The Health Visiting Service works across services and organisational boundaries for babies and children 0-5 and their families to improve child health outcomes, promote child development, support parents and ensure that families at risk are identified at the earliest opportunity[70]. HCP (0-5) reviews provide an opportunity for screening tests and developmental surveillance, assessing growth, discussing social and emotional development with parents and children, and for linking children to early years services.

The HV service has undergone some growth over the last few years, and the 4-5-6 model of health visiting summarises the key elements of the Health Visiting national service specification for the delivery of the HCP 0-5 (Figure 36).

Figure 36 – 4, 5, 6 Health Visiting Model



10.1.1 Current provision

Health visitors currently work against the national service specification, which includes the following mandated universal elements of the HCP (0-5):
These include;

- Antenatal health promoting visits;
- New baby review;
- 6-8 week assessment;
- 1 year assessment;
- 2-2½ review.

Aside from specialist staff (e.g. within safeguarding), West Sussex has approximately 145 WTE, which includes the Family Nurses in FNP and dually qualified School Nurses/health visitors. Staff are allocated according to need, which is calculated using levels of child protection, looked after children, and social deprivation data to weight caseloads.

New Baby Review (within 14 days of birth)

Across West Sussex, more than 9 in 10 new babies and their families received a review from a health visitor within 14 days of birth (during quarter 1 of 2015/16). A further 5.1% of infants were visited by a health visitor within 14-17 days. Overall, 99.6% of eligible infants received a health visitor review at some point during quarter 1 of 2015/16. There is some variability across the county, with greatest coverage in Crawley A health visiting area (98% of eligible infants receiving a review within 14 days).

Table 76 - Number of infants receiving a new baby review from a health visitor within 14, 15-17 and 17+ days of birth in West Sussex (quarter 1, 2015/16)

Q1 2015/16	N of eligible infants	% achieved 14 day	% achieved 15-17 days	% achieved 17+ days
Adur	210	90.5%	9.0%	3.8%
Arun	122	93.4%	2.5%	4.1%
Bognor	154	96.1%	0.0%	3.9%
Chichester	147	91.2%	4.8%	4.1%
Crawley A	151	98.0%	2.0%	0.0%
Crawley B	137	86.1%	8.8%	2.9%
Crawley C	151	86.8%	7.3%	6.0%
Horsham	197	87.8%	3.6%	3.0%
Mid Sussex 1	67	91.0%	7.5%	1.5%
Mid Sussex 2	150	87.3%	5.3%	7.3%
Mid Sussex 3	151	95.4%	1.3%	3.3%
Worthing East	134	76.1%	12.7%	9.0%
Worthing West	144	88.9%	8.3%	2.8%
South Rural	91	96.7%	2.2%	1.1%
Weald	123	96.7%	0.8%	3.3%
TOTAL	**2,129**	**90.6%**	**5.1%**	**3.9%**

Source: Healthy Child Programme data (SCT)

6-8 Week Review

For the 6-8 week review, approximately 88.0% of eligible infants received a review of their health in West Sussex in quarter 1 of 2015/16 (Table 77). Lower levels of coverage were achieved in the Worthing East area (53.1%)[cxxvi] when compared to the rest of the county, where at least 80% of eligible infants received a visit.

[cxxvi] The lower levels of coverage in the Worthing East area was due to high levels of staff sickness, and later roll-out of the new baby review when compared to other areas in the county

Table 77 - Number of infants receiving a 6-8 week review by Health Visitor Team

Q1 2015/16	Eligible	% achieved
Adur	218	90.8%
Arun	122	92.6%
Bognor	144	92.4%
Chichester	131	85.5%
Crawley A	141	94.3%
Crawley B	107	95.3%
Crawley C	123	89.4%
Horsham	180	93.3%
Mid Sussex 1	70	94.3%
Mid Sussex 2	136	94.1%
Mid Sussex 3	153	94.1%
Worthing East	179	53.1%
Worthing West	139	88.5%
South Rural	119	92.4%
Weald	147	81.6%
TOTAL	**2,109**	**88.0%**

Source: Healthy Child Programme data (SCT)

One Year Review

Table 78 shows the number of eligible infants and the proportion of those that received a 1 year review by a health visitor in West Sussex. Across the county, 78.1% of eligible infants received a 1 year review. Similarly to the 6-8 week check, coverage was lowest in Worthing East, where 48.4% of eligible infants received a review.

Table 78 – Number of eligible infants and the proportion of received a 1 year review by a health visitor in West Sussex (quarter 1, 2015/16)

	1 year review	
	N eligible children	% achieved
Adur	199	73.4%
Arun	147	77.6%
Bognor	147	72.1%
Chichester	146	76.0%
Crawley A	171	92.4%
Crawley B	126	92.9%
Crawley C	170	66.5%
Horsham	164	91.5%
Mid Sussex 1	85	95.3%
Mid Sussex 2	172	83.1%
Mid Sussex 3	154	79.2%
Worthing East	155	48.4%
Worthing West	144	65.3%
South Rural	100	88.0%
Weald	145	82.1%
TOTAL	**2,225**	**78.1%**

Source: Healthy Child Programme data (SCT)

2 – 2 ½ Year Developmental Review

In quarter 1 of 2015/16, 71.5% of 2 ½ year old children had received a developmental review (Table 79). The proportion of children who received a review varies by location. For example, fewer children in Adur (52.1%) had received a 2-2 ½ year check than in parts of Crawley (Crawley B – 90.1%).

Table 79 – Number and proportion of eligible infants who had received a 2-2 ½ year developmental review by HV area team (Q1 2015/16)

	2 year review	
	Eligible	% achieved
Adur	219	52.1%
Arun	142	72.5%
Bognor	163	54.6%
Chichester	159	54.7%
Crawley A	142	87.3%
Crawley B	101	90.1%
Crawley C	156	58.3%
Horsham	174	87.4%
Mid Sussex 1	77	79.2%
Mid Sussex 2	168	73.8%
Mid Sussex 3	176	80.7%
Worthing East	149	83.2%
Worthing West	134	67.9%
South Rural	128	72.7%
Weald	168	75.0%
TOTAL	**2,256**	**71.5%**

Source: Healthy Child Programme data (SCT)

Health Visiting and Safeguarding Vulnerable Children

Table 80 shows the proportion of all children who are supported by health visitors under Universal Partnership Plus (UPP). This includes all children looked after by the local authority, children in need, and children with a child protection plan in place. In the most recent quarter of 2014/15, children who are supported by UPP accounted for 1.6% of the total caseload of the health visiting service.

Table 80 - The percentage of children supported by health visitors under Universal Partnership Plus (UPP) in West Sussex (SCT), 2014/15

	2014/15			
	Q1	Q2	Q3	Q4
Percentage of children supported by HVs under UPP	1.7%	1.8%	1.6%	1.6%

Source: Healthy Child Programme data (SCT)

Health Visiting and Monitoring Maternal Mental Health

Table 81 shows the proportion of mothers who received a maternal mood review by the time the infant was 6-8 weeks of age. In the final quarter of 2014/15, 88% of mothers had received a mood review by the time the infant was 8 weeks old.

Table 81 – The percentage of mothers who received a maternal mood review by the time the infant is 6-8 weeks of age in West Sussex (SCT), 2014/15

	2014/15			
	Q1	Q2	Q3	Q4
Percentage of mothers who received a maternal mood review by the time the infant is aged 6-8 weeks	no data	65%	86%	88%

Source: Healthy Child Programme data (SCT)

10.2 Family nurse partnership

Family Nurse Partnership (FNP) is an evidence based and licenced intervention programme for first time parents and their families. It is an intensive nurse home visiting programme designed to improve the health, well-being and self-sufficiency of first-time parents and their children. Visits start early in pregnancy and continue until the child reaches two years.[71] The specially trained nurse home-visitor's attention is focused on the social, emotional and economic context of her client's life, and her activities are based on understanding human interactions.

The evidence based programme effects are;

- Improved prenatal health
- Fewer childhood injuries
- Fewer subsequent pregnancies
- Greater intervals between births
- Increased maternal employment
- Improved school readiness

However, a recent study conducted in the UK to evaluate the effectiveness of FNP on infant and maternal outcomes found no differences in short term outcomes (smoking in pregnancy, birth weight, emergency attendance and hospital admissions for the child and subsequent pregnancy) between the comparison groups[72].

The core elements of the program include; involvement in early pregnancy, voluntary participation by clients and eligible clients include high-risk first time young mothers only (i.e. low resource mothers, teens)[cxxvii]. The nurse-home visitors build clients' skills, confidence and hope in a paradigm that values the clients' ability to determine their own futures.

10.2.1 West Sussex Profile: Family Nurse Partnership

The West Sussex FNP team was set up in 2011 and has a nationally recognised reputation for being among the highest performing teams in the country. The team has hosted national and international visits from other healthcare providers interested in starting new programmes.

There are currently 8 members of the Family Nurse Partnership team in West Sussex, all of whom work full-time. The team consists of 6 family nurses, 1 supervisor and 1 administrator. Each family nurse can take up to a maximum of 25 families each (maximum capacity of 150 families), and this depends on their

[cxxvii] http://fnp.nhs.uk/commissioning-and-delivery/preparation-and-delivery/core-model-elements

ability to provide the programme in its entirety to each family enrolled. Due to the large size of the West Sussex county and therefore large travelling distances, current caseload tends to sit at 23 families per nurse. One of the nurses has recently been recruited, and all new nurses are required to complete an intensive training programme over a period of 12 months to steadily build up a full caseload. The current active caseload of the FNP in West Sussex is 126 families (as at September 2015), which exceeds the expected caseload for the current position of the team (104 families).

The family nurses are all based within Children and Family Centres (CFCs) in Crawley, Chichester, Horsham, Lancing, Littlehampton and Worthing. Currently, the programme can be offered to approximately 20% of eligible young mothers in West Sussex. In the past 3 months 75% of eligible mothers offered FNP accept the service, which is in line with programme expectations.

A goal of the FNP programme is to enrol at least 60% of clients into the programme by the 16th week of pregnancy, and 100% no later than the 28th week. In the past 12 months, 58 families were enrolled in the service by 16 weeks of pregnancy. This equates to 48.3% of clients enrolled by 16 weeks[cxxviii].

Attrition

West Sussex is performing well in overall attrition, with 31% of FNP clients not completing the programme through disengagement or moving from the county; this is 9% lower than the fidelity goal (40%). Whilst attrition during pregnancy is higher than the expected target (12.1% compared to 10% target), West Sussex has significantly lower levels of attrition during infancy (8.6%) compared to 20% target, and similar rates during toddlerhood (10.3% compared to 10% target)[cxxix].

Dosage

Dosage relates to the number of visits offered to clients in each stage of the programme. The stretch goal for FNP is that: 100% of clients are offered at least 80% visits in pregnancy, 65% in infancy, and 60% in toddlerhood. West Sussex are performing above national averages for each stage of the programme: 68% of clients received at least 80% visits in pregnancy compared to a national average of 58%. Infancy was 16% higher and toddlerhood was 6% higher than the national averages for these stages.

Key Performance Measures for FNP

Smoking: A greater proportion of clients being enrolled are smoking at time of intake; 80% of pregnant mothers have stopped or reduced cigarette intake to fewer than 5 per day at 36 weeks of gestation. This exceeds national estimates.

Table 82 – Smoking during pregnancy, FNP clients

Smoking	Past 12 months		Past 3 years	
	West Sussex FNP	National FNP	West Sussex FNP	National FNP
Clients smoking at intake	44.1%	34.3%	32.4%	35.6%
Clients smoking at 36 weeks gestation	36.1%	31.2%	22.2%	32.1%
Clients smoking fewer cigarettes at 36 weeks gestation	80.0%	50.0%	50.0%	60.1%

Source: FNP Annual Report 2014/15 (released Nov-2014)

[cxxviii] FNP Advisory Board Quarterly Summary Report (Sept-2015)
[cxxix] FNP Annual Report 2014/15 (released Nov-2014)

Birthweight: In West Sussex, FNP babies are being born of a normal birthweight; 0% of full term FNP infants were of a low birthweight in the past 12 months in West Sussex, compared to 3.8% nationally. The percentage of babies born prematurely is similar to national data (10.2% in West Sussex, compared to 7.3% nationally), with a higher proportion (17.4%) spending time in Special Care Baby Unit (SCBU; 11.3% nationally), although for fewer days than the national picture. Low numbers makes this data difficult to interpret, as time in SCBU for example, might reflect local practices.

Breastfeeding: FNP clients in West Sussex appear to be open to trying breastfeeding, however, encouraging continued breastfeeding for long periods (6 weeks +) is an area for further focus.

Table 83 – Breastfeeding initiation and continuation of FNP clients in West Sussex

Breastfeeding initiation and continuation	Past 12 months		Past 3 years	
	West Sussex FNP	National FNP	West Sussex FNP	National FNP
Percentage of clients initiating breastfeeding	65.2%	58.3%	58.5%	57.8%
Percentage of clients breastfeeding at 6 weeks infancy	13.5%	17.3%	13.6%	17.0%
Clients breastfeeding at 6 months infancy	5.6%	7.2%	5.9%	7.5%
Clients breastfeeding at 12 months infancy	4.8%	9.0%	4.8%	8.1%

Source: FNP Annual Report 2014/15 (released Nov-2014)

Immunisations: In the past 12 months, over 90% of infants were up-to-date with immunisations at 6 and 12 months (90.6% and 94.4% respectively), and 100% of infants were up-to-date at 24 months.

Safeguarding: Approximately 40% of the FNP caseload had some experience of Social Care.

10.3 Children and family centres

The purpose of children's centres is to improve the outcomes for young children and families and reduce inequalities between families in greatest need and their peers in:

- Child development and school readiness
- Parenting aspirations and parenting skills; and
- Child and family health and life chances[cxxx]

This includes the provision or signposting of childcare services, in order to encourage and enable parents in continued training, education or employment. Promoting the overall health and wellbeing of young children and their families is a core aim of children's centres with the goal of improved outcomes for children including those from deprived backgrounds.

In West Sussex the term children and family centres (CFC) is used to describe the range of services across the continuum of need, as set out in national children's centre guidance and practice documents. The West Sussex Health4Families programme provides a systematic, structured and evidence based approach for improving health outcomes for children pre-birth to five and their families living in West Sussex. Many health services will either be located in children's centres or will work very closely with them.

[cxxx] DfE – Sure Start children's centres statutory guidance (released April 2013)

10.3.1 National and West Sussex Profile: Children and Family Centres

There are currently 43 CFCs in West Sussex, each covering a 'reach' area of around 1000 children pre-birth to five[cxxxi] (Figure 37). These CFCs fall within 12 CFC groups (shown on Figure 37). Every family with a child, pre-birth to five, living in West Sussex has access to some CFC services. The centres have developed at different times, and for different levels of population need. CFCs deliver a range of services according to a graduated model of service delivery, with services in more deprived areas opening in the first phase to deliver a broader range of services.

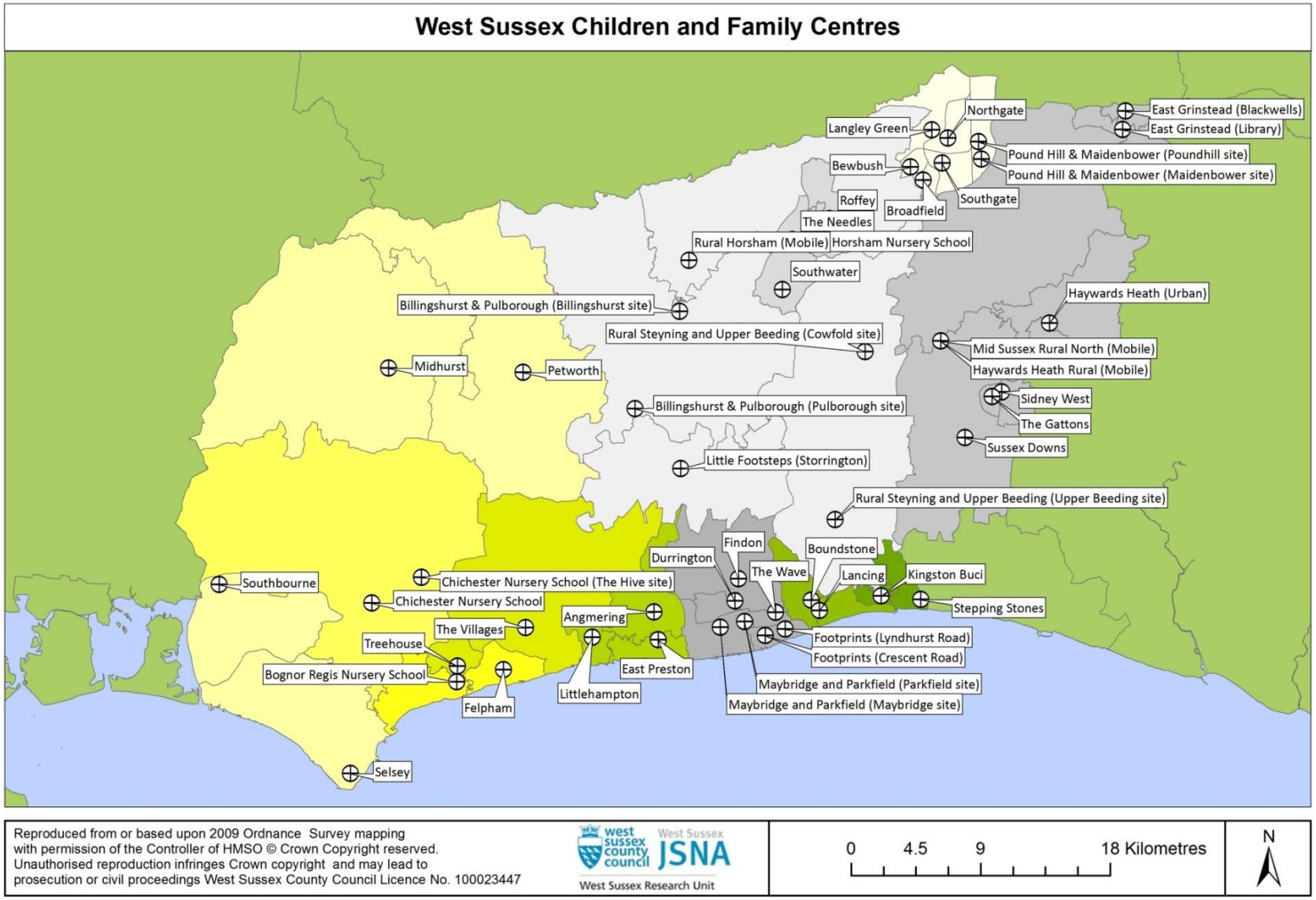
The West Sussex Health4Families Programme (H4FP) is an evidenced based framework that supports the integrated Children's Workforce (health services, early years, private and voluntary sector) to improve health outcomes that most affect families and children from conception to five years old.

The key public health priorities focus on the following areas:

- Infant feeding
- Healthy eating and healthy weight
- Physical activity
- Improving oral health of children
- Improving mental health/emotional health and wellbeing of parents and children
- Improving children's speech, language and communication
- Reducing teenage pregnancy rates and supporting teenage parents
- Reducing alcohol and substance misuse
- Increasing smoking cessation
- Increasing coverage of childhood immunisation rates
- Reducing childhood accidents
- Reducing the risk of sudden infant deaths.

[cxxxi] Note that some CFCs consist of more than one physical location (e.g. Maybridge) and some are mobile units.

Figure 37 - Location of current CFCs in West Sussex (as at November 2015)



10.3.2 CFCs Ofsted Inspections

Ofsted inspect and regulate services involved in the care of children and young people, and services providing education and skills for learners of all ages[cxxxii]. From April 2013, Ofsted have made changes to how inspections will be undertaken. Inspections are now organised according to how local authorities deliver their children's centres; this includes inspections of single centres, or of a group of centres that share leadership and management. As a result, there are currently fewer CFC group Ofsted reports than there are single CFC reports.

Inspections of children's centres occur within five years of opening, and then at five-yearly intervals. Inspectors focus on the impact of children's centres on targeted young children and their families, especially those judged in the most need of support and intervention. They make three key judgements that contribute to the "overall effectiveness" rating of the centre. These judgements are:

1. *Access to services by young children and their families.* This judgement deals with how children's centres identify families with young children in their communities, and how those that are most in need of services are helped and encouraged to utilise them.
2. *The quality and impact of practice and services.* This judgement deals with how children's centres plan, integrate and implement activities and services, including the extent to which some services are available to all families and others targeted at those in most need. This includes assessment of how well services improve outcomes in a range of areas such as improved parenting, readiness for school, developing healthy lifestyles, and providing opportunities to improve education and employability of parents.
3. *The effectiveness of leadership, governance and management.* This judgement deals with how efficiently and effectively the centre is managed at all levels of leadership. This includes governors, the local authority and any private, voluntary or independent provider commissioned to run the centre on behalf of the local authority.

When judging the overall effectiveness of the children's centre, inspectors use the following scale:

- Grade 1: outstanding
- Grade 2: good
- Grade 3: requires improvement
- Grade 4: inadequate

Formal feedback is provided at the end of the inspection. Any aspects that have been judged inadequate or outstanding are explained. See the framework for children's centre inspection provided by Ofsted for more detail.

DataView hosted by Ofsted[cxxxiii] provides a summary of Ofsted inspection outcomes for CFCs. DataView shows "state of the nation" data. This means that the most recent inspection outcomes for all providers open at a particular point in time are summarised. "State of the nation" data gives a more balanced view of

[cxxxii] Ofsted – Children's centre inspection outcomes (released March 2015)
[cxxxiii] Ofsted: DataView: www.dataview.ofsted.gov.uk (accessed 23/12/2015)

the current quality of providers at a set time, although some inspections are inevitably a few years old. Those providers that have not yet been inspected are excluded.

For CFC figures, the number of providers refers to a combined total of inspections. This can include single CFC inspection outcomes and/or group CFC inspection outcomes; this depends on when the inspection was carried out and how the local authority delivers the services from the CFCs. As such, this data does not reflect the actual number of CFCs in an area.

At 31 August 2015, Ofsted had conducted inspections of 5 CFC groups (Adur East, Arun East, Arun West North, Crawley and Worthing), and 11 individual centres. These 5 CFC groups account for 18 individual centres in West Sussex. As such 29 CFCs had been inspected as at 31st August 2015.

Table 84 shows the number[cxxxiv] and percentage of inspections in West Sussex by "overall effectiveness" score as at 31st August 2015. Direct comparisons between areas should be made with caution due to small numbers of inspected CFCs at county level.

Table 84 - The proportion of inspected Children and Family Centres by Ofsted ratings for "Overall Effectiveness" in West Sussex, the South East and England as at August 31st 2015

	West Sussex		South East		England	
	N	%	N	%	**N**	**%**
Inadequate	0	0%	1%	3	35	2%
Requires Improvement	6	38%	32%	112	724	33%
Good	8	50%	57%	196	1,242	55%
Outstanding	2	13%	10%	35	225	10%

Source: Ofsted DataView

Note. The calculations above report the number of inspections, not the number of CFCs. As a result, some of these inspections cover groups of CFCs (depending on how the local authority delivers the service), whilst others are inspections of single centres. As such, an Ofsted rating for a CFC group is directly compared to an Ofsted rating of a single-site CFC.

[cxxxiv] Note - For CFCs figures, the number of providers refers to a combined total of inspections. This can include single CFC inspection outcomes and/or group CFC inspection outcomes. As such, this data does not reflect the actual number of CFCs in an area unless stated otherwise.

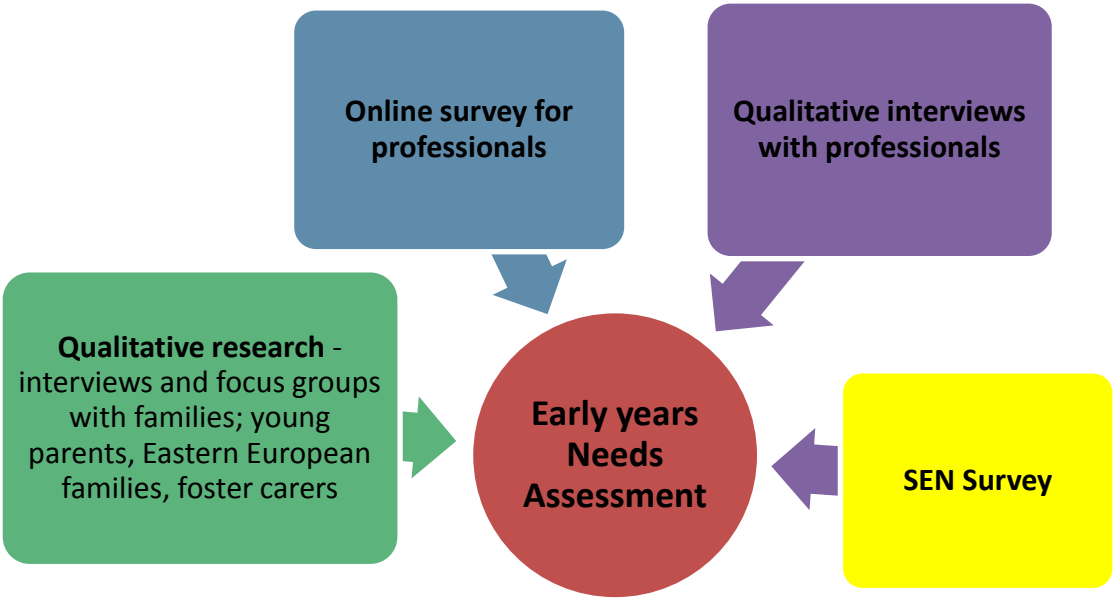
11 IMPORTANCE OF COMMUNITIES AND PARTNERSHIP WORKING

Stakeholder Views

11 Importance of communities and partnership working - Stakeholder views

In order to obtain views of families/carers, to inform this needs assessment, qualitative research was undertaken with various groups of families and also professionals (Figure 38). The following section presents the findings from this research. The full reports from the qualitative research are available at: http://jsna.westsussex.gov.uk.

Figure 38 - Stakeholder views



11.1 Findings across target groups

The interviews with families from various target groups were based around the following areas:

- Access to services
- Children and family centres
- Sources of information and advice
- Access to community resources

There were some salient issues specific to families from each particular target group, i.e. young parents, Eastern European families, Travellers and Foster carers, and these are explored in the main summary. However, the following key points highlight issues that were identified across various target groups, and the key messages;

Barriers to accessing CFCs

- Lack of awareness of all services offered by CFCs
- Feeling judged by staff and other parents
- CFCs considered too busy
- Unfamiliarity with CFCs or not having a friend to go to CFC with

Sources of information and advice

- Family and friends play a central role as they were identified as the main sources of information and advice regarding the child.
- The internet and some social media were seen as other key sources of information.
- Those who were aware of the Family information service reported that it was a useful service.
- Professionals such as health visitors were identified as a source of information particularly informing families about CFCs.

Services and resources

- Libraries were viewed as valuable and offer a variety of activities for children such as Rhyme time, storytelling.
- Parks, green spaces and beaches were also viewed as valuable and regularly accessed by families
- CFC services such as the toy library were positively regarded by those parents who were aware of it.

Key messages

To encourage target groups engagement with CFCs:

- A communication strategy for branding and promotion-understanding the concerns and interests of the target groups and making sure information reaches them. Using parent's stories and different media to reach and support families
- Making every contact count and ensuring that all contacts (statutory and community) are able to give families detailed, accurate and relevant positive information about CFC and local offer.
- Using community and asset based approaches to identify and support those in the target groups who are willing to be community champions, encouraging other parents.
- 'Buddying' system to help some parents who lack confidence, for example, to look round the centre or greet on the first day and introduce them to others.
- Greater participation of families in making decisions such as timing of activities, and trying new activities.
- Sharing what works across CFCs in West Sussex.

11.2 Young parents' and Eastern European parents' views and responses of service providers

Qualitative research was undertaken to consult with some of the parents who do not use services regularly and explore with them their experience and perception of gaps, barriers and unmet needs in the service provision currently being offered.

Working with CFCs in 3 cluster areas the following target groups were selected:

- **Rural Horsham** - Young Parents
- **Bewbush Crawley -** Young Parents

- **Treehouse Bersted -** Polish and Eastern European group (30% of births) Identified by Ofsted as a priority group

The recruitment of participants for the research was through the Children and Family Centres (CFCs), and also through other statutory service providers and the voluntary sector. All those referred were mothers of children from 0-5, with the exception of one mother who had a child 10 years ago when she was a teenager. The young parents were between 17 and 25. The Eastern European parents mostly came from Poland but 3 mothers came from other parts of Eastern Europe; Bulgaria, Ukraine and Lithuania.

Data was collected from March to August 2015 through semi structured interviewing with a total of 22 mothers (with additional data from a focus group and 2 small surveys), followed by interviews with 18 service providers who had experience of working with these target groups.

11.2.1 Summary of Findings

The Children's Society (Breaking Barriers report[cxxxv]) suggest that for Children's Centres there are three steps involved in supporting a family's sustained engagement with services:

1. **Awareness of children's centre services**-ensuring parents are aware of the existence of the centre and what is on offer through it.
2. **Getting Families engaged**-promoting the value of services available and ensuring ease of access
3. **Keeping families engaged and developing involvement**-developing a welcoming environment and providing volunteer opportunities

This framework has been used to consider findings; the themes from interviews with mothers and the key responses of service providers who work with these target groups.

The full report of this research can be found at http://jsna.westsussex.gov.uk/

11.2.2 Awareness of Children and Family Centres

Mothers views on their awareness of CFCs:

- Some of the participants had spent the first year of motherhood mostly on their own at home and described feeling isolated and lonely. Most of the young mothers had little preparation for the birth describing it as 'traumatic or a 'shock'. Some of the Eastern European parents had not been in the UK long and lacked confidence to go out because they did not speak English.
- There was very little awareness of the CFC, until it was suggested by their Midwife or Health Visitor that they should use the drop in clinic there.

Service providers' responses:

- Provision in CFCs is becoming more targeted and that is creating a barrier.

[cxxxv] https://www.gov.uk/government/publications/estimating-housing-need accessed Nov-2015

- The name of CFCs may be unhelpful, *Family Centres* were for 'needy parents' –there may be a stigma
- There is a lack of clarity about the role and purpose of Children and Family Centres.
- There is discussion about who is being targeted, how to define a 'young' parent, age range and what to offer.
- A key service for Eastern European families is being lost; Connecting communities have been advising and giving information in their own language, but are closing in November 2015.
- English classes used to be free but are now around £70-80 a term.
- Local relationships and partnerships are important in referring families for CFC provision and there is some effective partnership work including joint registration and data sharing. Health Visitors and Midwives are making referrals. Early Help Plans are being put in place.

11.2.3 Engagement

Mothers views – first visits to CFCs:

- Young mothers may feel judged by other parents and service providers. They are nervous of new places with people older than them and of 'authority'.
- Eastern European parents struggle with bureaucracy, are also wary of authority and can feel distressed when they are unable to understand what is being asked of them.
- Young mothers found it very daunting to visit a CFC. Trusted service providers can persuade them, but it may take time building a relationship before they reach this point.

Service providers' responses:

- The Family Nurse Partnership (FNP) is an evidence based intervention, they are able to build relationships with young parents. There are not enough FNP posts to meet the need. There are new posts 'young parent champion' Health Visitors.
- CFC outreach work was effective in relationship building and supporting young parents to access provision.

Mothers views – finding out about CFC offers:

- Friends are more of an influence in considering accessing provision than the wider family. They were much more likely to go along to a new activity if they went with a friend.
- Communication about universal provision offered at the CFCs was hit and miss. Word of mouth is more effective than written information. Sometimes information was passed on by Health Visitors but most found out about activities from friends. For young mothers, meeting up with friends was a key reason for going to activities.
- Young mothers lack the detailed information about universal activities at CFCs that they would like. Some young parents found the information leaflet from CFCs useful but several found it difficult to follow. The Eastern European mothers were unaware that this information was available (and may not be able to make use of it as it is only available in English). Health Visitors were not able to give mothers more detailed information about groups.

Service providers' responses:

- Increased use of Facebook and texting by service providers.
- Communicating with young people is recognised as a skill, training by youth workers has been helpful.

Mothers views – Health Clinic Drop-Ins:

- For most the Health Clinic drop-in is their introduction to CFCs this was not always positive and occasionally acted as a disincentive to attend other activities. Young mothers sometimes find it helpful to ask Health Visitors for advice, but also sometimes feel patronised and judged. The advice given may be inconsistent and some Health Visitors seemed to young parents to be rigid or 'by the book'.

Service providers' responses:

- Young parents are assessed at CFCs and this will feel like 'judgement'. Some service providers thought it was unsurprising that young people would not want to expose themselves to the judgement of staff and other mothers.
- Young parents have often had poor relationships with others and are slow to trust. Eastern Europeans are also slow to trust others even those in their community because of the history of their countries. However service providers no longer have the capacity to build relationships over time by doing home visits as in the past.
- Eastern Europeans are resistant to involvement if their child has special educational needs because they are fearful of having their child "investigated".
- Providers need an understanding of cultural difference. Eastern Europeans have a different expectation of early years and primary school provision

Mothers views – getting advice as a parent:

- CFCs are not seen as the first place to go for advice. Some use websites and social media as the main source of information
- Advice and tips are shared on Facebook and websites are also used for information. Young mothers can find it worrying if they try to find out medical information and prefer to ask friends for advice on Facebook.

Service providers' responses:

- Having a reputation for giving good advice would help to engage but keeping track of services is becoming more of a challenge. There are different models and different provision across the county and changes in staff.
- There is a need for community workers and volunteers who speak Eastern European languages to welcome, signpost, explain and support.

11.2.4 Keeping Families Engaged and Developing Involvement

Mothers views – staying engaged and involved:

- All the mothers were unsurprisingly more comfortable with their contemporaries and found it easier to try out new places and activities with a friend. However some Eastern European mothers were also keen to mix more with English mothers.
- Eastern Europeans do not think the health checks happen frequently enough when their child gets older. They consider health checks very important and are motivated to attend these. Some speak little or no English and are very relieved if a member of CFC staff can speak a language they speak (usually Polish).
- Bumps and Babes was the main universal activity attended by young mothers. When their child had outgrown that group those interviewed had not sustained involvement for a range of reasons including employment, timing, transport, and child's safety**.**

Services provider's responses:

- With budget restraints funding for taxis is not available. It is hoped that a volunteer driver can be found to transport those who live in rural areas to CFCs

Mothers views – expectations and meeting their needs:

- For the Eastern Europeans, barriers also included cultural differences and expectations about provision i.e. hygiene and staff health checks are more rigorous in Eastern Europe and activities are more structured.
- Most of the young mothers were more enthusiastic about attending groups with those of the same age as themselves. Some found it harder to talk to the older parents.
- There was enthusiasm for groups for young parents, both the Youth Service group (no longer running) and the group at Northgate. There was an initial nervousness, they were concerned that these groups might gossip or be 'bitchy', but they found them enjoyable and supportive. They valued opportunities to participate in shaping those groups.

Service providers' responses:

- Effective relationships are key.
- Greater participation leads to sustained involvement
- There is need for programmes for young people/young mothers to help them plan their futures as well as a need to help them with parenting.
- There is a need for more programmes for grandparents caring for children while parents work.
- Young mothers can be sensitive to being given parenting advice and perceive that their ability to parent their child is being questioned.
- The majority of Eastern European school children are not eligible for pupil premium but there is a need for funding to ensure they receive the support needed. One school is funded for 10 English as Additional Language children but has 57.
- There is insufficient funding for Connecting Communities which is closing in December 2015 and will mean the loss of a valuable resource for the Eastern European community.

- Continuity-there has been a lack of trust because of the closure of some groups and changes to others. The momentum has been lost when groups are closed down over summer holidays.

Mothers views – greater participation and ideas to encourage attendance:

- There was a lack of opportunity to shape services, both groups wanted to contribute and shared ideas of what would encourage attendance. Young parent's ideas included buggy runs, more for dads, lunch groups, help with CVs and job and college applications. Polish parents would like opportunities to do activities with English parents such as drama or singing groups and they would like a book library for children in their first language.
- Both groups included parents who said it would be more convenient to go to activities in the afternoon.

Service providers' responses:

- Some providers had ideas and plans for reaching these target groups.
    - One school would like to do English classes for Eastern European parents but does not have the capacity. English classes at CFCs were also suggested.
    - A pack for Eastern European parents who are new to the area would be helpful
    - Posters in shops promoting CFCs and continuation of Connecting Communities to assist.
- A young parents group has been sustained by becoming peer led (training and support by providers is ongoing).

11.2.5 Alternative Activities

Mothers views on alternative activities:

- Playgroups in churches were used occasionally and seen as a useful low-cost activity. Most of the young mothers who live in Crawley attended the library and were enthusiastic about activities such as Rhyme Time. Parks were often visited by families from both target groups if the weather is fine and highly valued as a good cost free activity. The Eastern European mothers lived in the coastal area and enjoyed going to the beach with their children.
- Young mothers living in towns or with transport took their children to soft play centres particularly Mini Mayhem, the mothers saw it as a break and a chance for a coffee and chat with friends while their children enjoy themselves. They were considered expensive but worth it, as they could spend as long as they wanted there.

Service providers' responses:

- Access to the library is non-stigmatising and inclusive.

11.2.6 Recommendations for further Research

There is a need for consultation with the other family members of these target groups, both fathers and grandparents, which was not possible within the timescale of this research.

11.3 Foster carers: key findings

Another piece of research that was carried out to gain more insight on the needs of children under 5 was done through interviews with foster carers. Evidence shows that looked after children are more likely to

have poorer outcomes compared to their peers, therefore, the research aimed to obtain views of foster carers of children under the age of 5. An email invitation to take part in the research was sent out to all foster carers who currently or have recently fostered children under the age of 5. However, there was a low uptake and a very small number of foster carers took part. Although this was a small scale piece of research, findings **(in bold text)** are very much in line with the research with other target groups outlined above. There are also some specific issues for foster carers which are outlined and summarised below.
Key messages from the foster carer interviews:

11.3.1 Access to services

Services such as health visitors, midwives and GPs were reported to be accessible and helpful. The Health visitors were the main support in regards to the child's health, making regular visits.
"…Literally within hours, the midwives were here. I'm not Mum, but it was if I was Mum, and they were so helpful. Then that got transferred from the midwives to the health visitor, and again, absolutely fantastic"

The foster carers reported that they are able to access other health services for the child and the GPs make referrals to other services, such as speech and language or hearing services, when required. However there was also an element of responsibility on the foster carer's side to organise the child health care needs.
"He (foster child) had to have some quite specialist blood tests. He was born out of county, and it was really left with me to liaise the handover from where he was born to the… So yes, too much onus, really, on the carer, rather than the medical people talking to each other."

11.3.2 Immunisations and health services

Health visitors provide information about the vaccinations the foster children have had, what is due, and when. The red book also provides some information about vaccinations; however, as this is not always up to date. The foster carers interviewed reported that they have the responsibility of making arrangements for the child to be vaccinated, by contacting the GP.

"I was surprised that there wasn't a service in place that you automatically get called. I'm together; I've gone through it with my four children, but if I was a mum struggling, or indeed where Baby has gone now, slightly chaotic- … I feel there should be something in place that you are getting a letter, 'Your child is due this. Come on this date'. I felt too much was left to me to follow that up".

"With my present placement, he wasn't up to date with his immunisations; he'd only had one. So I phoned his doctor and spoke to the immunisation nurse and we booked him in for an appointment".

11.3.3 Access to community resources

Services such as libraries were also reported to be valuable by the foster carers. They reported that their foster babies received a library card automatically and they found this helpful.

"the library is very good. They do…I think it's called Rhyme Time now or something".

One other thing that arrived after Baby had left was a library card from him, and that was from the local authority. West Sussex sent that to me with a cover letter, a really lovely letter, saying how important it is to read with a child, and that all children in care are given this card, and you don't get charged for late books... I thought it was very good, especially as he was a newborn, but who's to say I didn't have someone

else in my care who was older that, for the newborn, made me think, "Oh, what a good idea. Let's all go?" So I thought it was superb".

Parks and green spaces are a useful resource that the foster carers reported to use regularly, taking children out for a walk or going to the playground, depending on the child's age.

11.3.4 Children and family centres

The foster carers interviewed hadn't accessed Children and family centres services, although they highlighted that they had heard of them but didn't know much about them. Reasons for not accessing their services were:

- **CFCs were considered too busy,**
- **Unfamiliarity with the CFC,**
- **Not knowing other people who go there,**
- **Lack of awareness of services on offer,**
- Child's contact times with birth parents.

Also, given that they foster children of different ages, some foster carers have resources such as toys and books in their homes, and as a result, don't see the need to access some services, like the toy library.

"You do find you've got them (toys) and everything, so that's the one reason I don't use the toy library…. I know they do sensory toy bags so that would be something that I would probably – if I'd got a child that needed something like that then yes, I would definitely call on it as a starter until I got some bits and bobs of my own that I needed for my placement".

The promotion and raising awareness of services and activities offered by CFCs is one of the key ways to encourage foster carers to access CFC services and this was highlighted by the foster carers.

"I know the family centres are there. I don't know exactly what goes on there. Other foster carers could be like that as well. So it might be, because most of the foster carers have emails, they (CFCs) could email what is going on at the centres, different things, so that they know."

11.3.5 Toddler/parent child groups

Toddler groups were reported to be helpful and a source of information and advice, however, the foster carers are not always able to make use of these groups. The toddler group(s) attended depended on the times the child had contact with his/her birth parents 'contact time', the individual child's needs and, the foster carer knowing other people who attend the group. If a child has contact time, everything has to be planned around it and that means sometimes the contact times clash with groups and other service times. Also, after contact time, some foster carers feel the child might need a break instead of taking them to a group. Local groups run by local people or foster carers were accessed by foster carers and their foster children.

"It depends when their contact is as well, with foster children, as to which ones you can go to. I was going to a toddler with my placement now because the hours were convenient, but then, they changed his contact times to make them longer. So I'm unable to go to toddler groups now"

"The Victoria Drive one (toddler group), that's run by foster carers… I know there are lots of others around in my area but you tend to go to ones where you know people... The one at Aldwick Baptist Church, other foster carers go there so we use it as a time to meet up and discuss things..."

11.3.6 Sources of support and information

Health visitors provide information about services such as local toddler groups, and vaccinations and the foster carers felt they could contact them in regards to the child's health or queries. The foster carers themselves have their own support workers who are their first contact if they have any problems or need assistance. The support workers were highly regarded as a source of support, and also helping with things like finding equipment for the baby such as pushchairs, car seats.

In terms of informal support, other foster carers are a valuable source of support and information. The foster carer meetings and toddler groups run by foster carers provide an opportunity to meet other foster carers and share experiences and also support and information. Friends and family were also identified as a source of support for the foster carers, although due to confidentiality, they are not allowed to discuss the child in detail.

"I think I feel as a parent of four, I had them (parenting skills). With Baby coming to me after what? – our youngest is now nearly 15 – a lot has changed? I rang friends. I rang another foster carer who I knew had recently had a baby"

The internet is another source of information that was identified as useful. The foster carers reported using internet searches for information, although there was an element of caution doing so. They also reported that they have personal social media accounts, but do not often use them for advice for their foster children.

"I read online, such as milestones. I look up milestones, and I looked at weaning guides online. The health visitor was able to talk to me about his skin, because I appreciate things change and the thinking behind it, such as now, it's six months before you give them any milk. So from lots of different places, and I did need that. It was necessary. A little scary if you didn't have that ability to look all that up, because there were things that have changed, like the teats on the bottles. Just little things have changed since I did it. So you're given a baby and yes, like any parent, you learn a little bit as you're going along".

"I did use the internet (checking the child's symptoms)…. I, sometimes, think the internet can be quite frightening; you can frighten yourself by it. I'd prefer talking to the health visitor or whatever and see what she's got to say rather than the internet.

11.3.7 Training and parenting skills

A variety of core and optional courses are available for foster carers to attend, and these are helpful in preparing foster carers for their role and to meet the individual needs of the child.

"I think some of the courses have been absolutely fantastic. I've learnt all about attachment, which, certainly, with my children, I didn't really know a lot about. I've read quite a bit independently following on from that".

However, one of the foster carers relatively new to fostering commented

With the foster care, there's a minimal amount of training that you have to do; first aid, fire and safety. I had done that. When we collected Babe from hospital, he was worryingly small. There was a big team sat around a table, and they did say, "So you remember your baby first aid?" You're just, "Yes." Terrifying. Luckily, I didn't need to call on any of it. You do your Skills to Foster course, which is done before you're approved. So I feel, for me, it was as much looking at what fostering was and me making my mind up as it was them giving me some training. So then you're approved, and then, I imagined, you do courses, but it doesn't quite work like that. You're approved, and then with me, within an hour or two, I had the first child. Talk about learning on the job. As a mother of four, you think you know, but you don't know at all. It's continuous learning".

The foster carers interviewed had their own children and so reported using their experiences with their own children in caring for the foster children, although there is an acknowledgement the need to keep learning as things change.

"I think they assume when you become a foster carer you know how to parent a child…when you've been fostering little ones, you tend to learn on the job and you know things"

11.4 Traveller parents' views – Key findings

This research was conducted to capture some of the views of Traveller families, in-order to inform the early years needs assessment A focus group was conducted with women from the Travelling community, who had children under the age of 5. Findings in **bold text** are in line with the research findings from other target group outlined above. A total of 8 women participated, 2 currently living in West Sussex and 5 who have lived in and accessed early years services in West Sussex in the last 2 years. All women with children under 5 were registered with a GP.

The women in the focus group reported that they were aware of and had accessed at least one of the following early years services:

- Midwives during pregnancy
- Children and family centres: play groups, loaning toys, training course
- Play groups: Stay and play and Sure start play groups
- 2 year funding and also 3 year funding

However, engagement with these services varied and some barriers to accessing these services and other services were identified by the women.

11.4.1 Identified barriers in accessing services:

- Lack of permanent address was reported to make it difficult for them to register with some services. *"I had problems with registering in West Sussex when I didn't actually have a permanent site before. So, they said, you have to, give an address. Because I didn't have an address in West Sussex they made that difficult"*
- Difficulties in contacting services such as midwives sometimes resulted in delays accessing services.
- Lack of sensitivity for the women's privacy by health professionals during home visits at the traveller sites. *"I actually I got I had a really bad experience… I was pregnant, got in touch with them (doctors) and then I miscarried about two months in. I phoned the midwives and told them and they*

still turned up at the site. And they then had a look at other people's caravans looking for me. And like, obviously, you don't really want your neighbours to know that you are pregnant, especially if something has happened, because I didn't really tell anyone there."

- **Most women reported that they were reluctant to go to a CFC alone, or without a friend or someone they know** *"the first few times when I took my son I never really wanted to go by myself. I'd only ever go if someone else was with me…. Sounds a bit silly but it's just that fear of like- I sort of felt like all the mums there are obviously a group and I'm like this kid just who just started school. Like you feel like maybe there might have been a bit of- they've got their own group"*
- **Differences in staff approaches in engaging with the families, with some finding the staff** "*too clinical*" or "*rude and patronising*".
- **Feeling judged by the staff in CFCs**
- Difficulties travelling to the CFCs as some of them are not close.

11.4.2 Awareness of services

Families play a central role in children's early years, and there is need to provide them with timely support, advice and information.[19] The women reported that they obtained information and advice from different sources, however, **informal support from family and friends was highly valued and used**. As highlighted in the Government document '*Supporting families in the foundation years*[19]' most parents look first to family and friends for advice about parenting issues, and then to professionals and other trusted organisations, largely from the voluntary and community sector. *" It would take quite a lot to go to a doctor. He'd have to be really ill to go to a doctor."* In addition, they also used **the internet and social media for information, although indicated need for caution when using the internet for advice.**

11.4.3 Community resources accessed

Most of the women reported having accessed the following community resources, which they found to be helpful, however the frequency of access varied:

- **Parks**
- **Libraries**
- **Beach/seafront**
- Swimming (free for children)

11.4.4 What works well?

- **Some of the CFC groups such as Drop and Stay and play group**
- CFC toy loan scheme
- Having services provided on site i.e. by midwives/health visitors.
- Free nursery places
- **Children's activities in Libraries, such as storytelling and groups**
- **Green spaces and playgrounds** "*There's a big, the big green quite near ours that's really good because you're allowed dogs on there"*
- Family information service
- **Library services and activities for children** *"That's quite good on a Friday they have books- well like Friday at like nine in the morning. Forty-five minutes you get of story-telling children and stuff like that."*

11.4.5 What could be improved?

- Services coming onsite as many people can't drive to get to them
- Training midwives and health visitors in traveller cultural awareness
- Using the children and family centre as a care of (C/O) address to register with the CFC if homeless or no fixed abode.
- More creative and learning activities for children *"something where they actually learn something, especially if they might not go to school or they might be moving."* such as music, dancing and other creative activities. Other activities mentioned were cooking, gardening clubs.
- Having a calendar or something similar to give an overview of CFC activities and children's activities
- Introducing a service similar to one in Brighton, a play bus run Children's centres that goes onsite.

11.5 Professionals views: Key findings

Professionals who work with children under 5 years of age and their families were invited to take part in an online survey which was conducted via survey monkey. The research was conducted from July till August 2015 and a total of 174 professionals responded to the online survey. Responses were from a range of professionals from the Health, Education, Social care, voluntary sector and Local Authority early years sectors. The early years needs assessment used mixed methods to collect data from families of children under 5 and professionals who work with these families. This survey was one strand of the research that was conducted and a summary of the findings are below.

11.5.1 Early engagement and targeted services

Early engagement with children and families was highlighted to be a feature, with most sectors working with children and families from preconception and Education sector starting from late pregnancy. This is important as it highlights the services available for children and families at an early stage, for early intervention. Furthermore, the majority of the professionals indicated that they provide certain targeted services, particularly for children with disabilities and child protection. The provision of targeted services, as well as universal services, is essential to meet the needs of those children and families who need more support than is offered by universal services alone.

11.5.2 Information for professionals

Professionals working with children and families play a crucial role in providing information to families, as well as signposting and making referrals where appropriate. This also indicates the need to effectively communicate and update professionals of any changes, in ways that are suitable for that particular professional group. The majority of professionals (56%) reported that there is enough information on early years services for professionals.

"I think there is enough information if a professional knows where to look and has good local knowledge. It can be difficult for professionals to know what services are available and how families or professionals can access them".

The key issues identified by those who felt there wasn't enough information were:

- Inaccessibility of information
- **Lack of provision of information in other languages for those whose first language is not English**

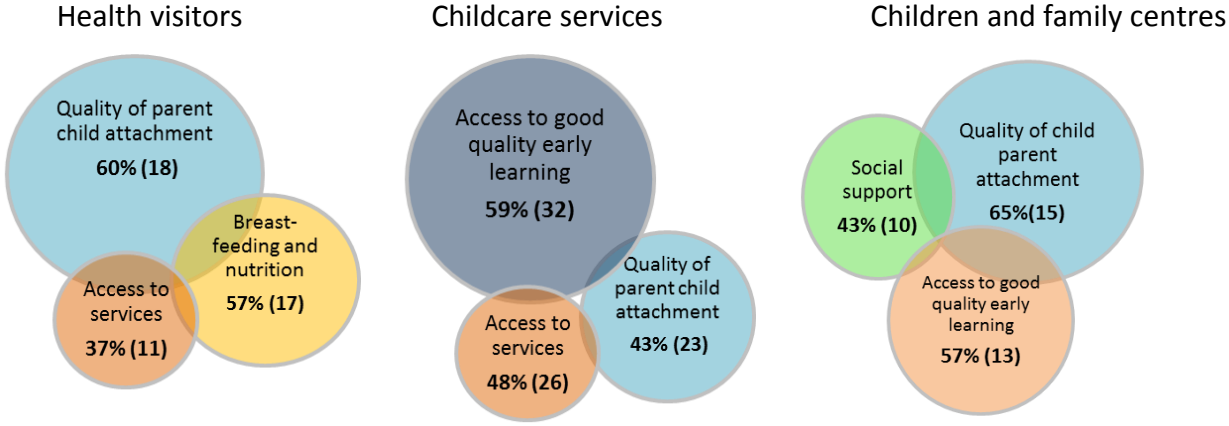
- Lack of clarity in the information or support available to enable professionals to make referrals or signpost families.
- Timeliness in communicating information about service changes.
- Lack of or inadequate specialised information i.e. mental health, substance misuse and housing.

However, some professionals reported that WSCC website, CFCs and Family Information Service are useful sources of information.

11.5.3 Factors influencing outcomes for young children

From a list of factors identified, professionals were asked to identify the 3 key issues for their services. The majority of professionals (54%) felt that the quality of parent child attachment was a key issue within their services, followed by access to services (42%) and good quality early learning (38%). However, there was a difference in the weighting that the professionals gave to the issues that they identified as key to their services as shown below (Figure 39). This could be an indication of the differing priorities across services and, in addition, highlights the role of CFC, which can be viewed as encompassing both health and education sectors.

Figure 39 - Key factors influencing outcomes for children identified by professionals



11.5.3.1 Barriers to accessing services

From a list of barriers provided, the 3 most frequently mentioned barriers faced by families, as identified by professionals were:

- **Lack of awareness of services** (47%)
- Family's negative perception of services (41%)
- **Inaccessibility due to transport problems** (29%)

The responses varied across different sectors, which provides some potential key areas of focus for each sector in breaking down the barriers and improving accessibility to services. Other barriers included:

- **Lack of capacity/resources to engage with all those eligible**
- **Parents feeling judged or stigmatised** *"Feeling judged/stigmatised/singled out"*
- Parents lacking confidence to request or engage in services
- Eligibility criteria or lack of eligibility criteria
- Lack of interest in the service by the parents

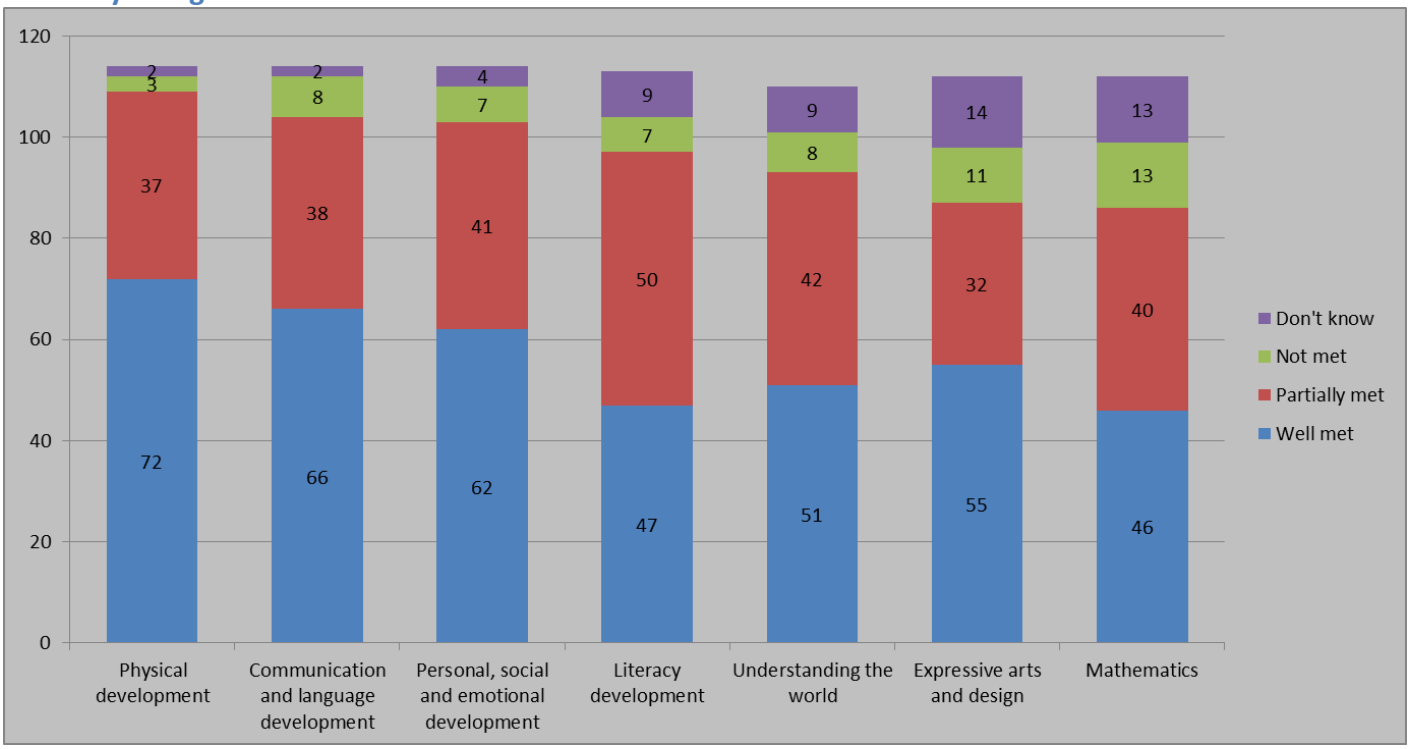
- Parental mental health or complex needs

"Parents lack of confidence in accessing services due to poor mental health. Parents finding it difficult to co-ordinate where they have to be and when- sometimes forgetting appointments or groups until they have missed them".

11.5.4 Early Years Foundation Stage (EYFS) and school readiness

The EYFS framework sets seven areas of learning and development and the majority of the professionals who responded to this question felt that needs in all areas, except literacy, were well met (Figure 40). Across all areas of the EYFS framework, childcare services had the highest number of responses and, the majority of responses from these professionals indicated that the children's needs across all areas are well met. This is different when comparing responses to other service areas where, in most cases, the majority of responses were 'partially met'. These differences in views could possibly be an indication of the different ways in which the professionals view the needs of children and potentially the differing priorities and efforts that need to be taken into account in meeting these needs.

Figure 40 - Responses to the question 'which areas of learning and development do you think are currently being well met or not met?'



The findings from professionals reflect the data on children achieving a good level of development, where literacy development is the lowest, and this is the only area that the majority of all professionals felt needs were partially met. Furthermore, the data indicates that West Sussex is lagging behind regional averages (and national averages in literacy development). Given that all childcare providers work to the EYFS framework, and the majority responded that needs are well met, it could be an indication that childcare services are offering the services to meet these needs but other areas that impact on school readiness are not well served, for example, parenting skills to enhance the home learning environment.

11.5.4.1 Areas of good practice

Several professionals identified some areas of good performance or good practice in West Sussex. However there is an indication that these vary across the county, and consequently, some of these issues have also been identified as areas of poor performance. The key areas identified were:

- CFC provision of a wide range of services for children and families

"I think West Sussex has services to meet needs but they are difficult to find out about. Children and family centres are a great place for accessing information but it would be beneficial for more integrated work with pre-schools and nurseries."

"*Children and Family Centres work closely with families to support and aid their child's development but if the family are hard-to-reach and/or are suffering with Mental Health issues then these children may miss out as the family do not/cannot engage in groups or home visits*

- Support available for children and families through targeted and universal services such as FNP, health visiting, Think Family and child health clinics
- Monitoring children's development and progress, breastfeeding, immunisation uptake, and the provision of services for young parents
- Good quality and quantity of childcare provision, and dedicated workforce
- Provision in deprived areas, although there were variations as some professionals felt there wasn't enough provision in deprived areas
- Good quality and wide range of training provided to Early years workforce
- Improved service coordination and partnership working, however, there are variations across the county

Although some of the responses seem to contradict, they highlight the importance of targeted and universal provision of services across different population groups to meet needs and give all children the best start in life. Also, these areas could be used as assets to further develop services and also provide examples of good practice, highlighting key areas of action.

11.5.4.2 Areas requiring improvement

There was a mix of responses from professionals in regards to areas where improvement is needed across West Sussex. Although some issues where identified by professionals as areas of good performance, some of these were also highlighted as areas that need improvement. The key themes that emerged were:

- Inadequate support for families

Children are struggling in both pre-school and primary school and showing challenging behaviour. We know that parenting skills have a part to play, so more support in both pre-school and primary school for parents in these areas would be of great help to their children as well as more professional targeted support.

"Need more affordable nursery placements and basic child development sessions for parents to understand what their child should be working towards - understand the detrimental impact of lack of stimulation etc".

- Low service capacity

- Insufficient funding for early years services and providers

"Lack of funding prevents achieving well in all areas… However we are providing the limited support that funding allows".

- Inadequate speech and language provision

"It feels as though there is still not enough 'people on the ground' to support these families and there can be long delays with getting the right help from other services. For example a child needs to see a Speech & Language therapist, or a referral to the Child Development Centre and this can take a long time".

- Difficulties accessing services

"Not enough services available in rural villages for non-drivers and with the lack of public transport this means these people miss out although they may fit the deprivation criteria".

- Inadequate professional support for early years service workforce
- Lack of/inadequate mental health service provision for families

"Resources are very tight for mental health workers for parents, this seems to be one of our biggest areas of weakness, without supporting these parents there is very little we can do to change the lives of the children"

11.5.4.3 Resources required to improve some areas

Seventy-seven professionals responded to this question and made suggestions and comments on issues or resources to improve underperforming areas. Key themes that emerged from the comments were:

- Increasing staff capacity, including training and communication
- Increasing funding for early years services
- Provision of services to meet the mental health needs of children and families (child and parental mental health support)
- Increasing support and offering tailored advice to parents
- Inadequate evaluation of activities and services

"There are a wide range of activities and services available to children and families in the area but it is felt that these are not always evaluated effectively and services continue to run as they have for many years! … More emphasis should be focussed on parents understanding the fundamental early years and that they are their child's most enduring educators. More hands on ways and events would be beneficial to parents to enable them understand child development and give them the confidence to practice this with their children…".

Overall, just over half of the respondents felt that current services are meeting the needs of children 0-5 and their families.

	Number	Percentage
Meeting all needs	4	2%
Partially meeting needs	93	53%
Not meeting needs	2	1%
Hard to say/ don't know	9	5%
Not Stated	66	38%
TOTAL	174	99%*

** Not all percentages will add to 100%, due to rounding*

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12 SUMMARY AND RECOMMENDATIONS

12 Summary and Recommendations

The early years of life are crucial for long-term physical, social, emotional and mental wellbeing. Experiences in the early years can have lifelong consequences. It is a period of rapid cognitive development, a period where social skills and relationships are established. The evidence is clear, investment in, and a policy emphasis on, the early years of life yields better long-term outcomes than interventions in later years; the return on investment is higher, although benefits may take longer to be realised. A 'good start' for all children will improve health, social, educational and economic outcomes in West Sussex, and will act to reduce inequalities and increase social mobility within the population.

Staff in the West Sussex Public Health Research Unit have reviewed local and national evidence and engaged with families and professionals to identify how needs of the 0-5 years population are currently being met, what is working well and also where things could be better. We are very grateful to all the people who have contributed their time, experience and views.

The objective of this needs assessment is to inform commissioning priorities in West Sussex. This Needs Assessment forms part of the West Sussex Joint Strategic Needs Assessment and is comprised of a number of products:- a detailed report, reports on the different elements of the qualitative research, data profiles centred on children and family centres and this summary; all are available online (http://jsna.westsussex.gov.uk/).

Local views, experiences and opinions were gathered from parents and carers and from local stakeholders, including staff employed in early years' services. In relation parents and carers views were specifically sought from parents /carers of children with a disability (via a postal survey), foster carers and families from the gypsy and traveller community. There were in depth interviews with teenage parents and eastern European families.

This summary (see full document) is structured around four themes:-

1) **A healthy start to life –** summary of the key health and development outcomes, universal services in early years and the identification of children and families at risk of poorer outcomes who may need short term support.
2) **Tackling disadvantage** – needs of children and families who may require longer term and specialist support.
3) **The importance of communities and working in partnership**
4) **Transforming services, co-designing** – a discussion.

The recommendations for the first three themes are presented here. Against each recommendation, potential actions are outlined and a lead organisation, agency or partnership identified.

The data in this document have been used to devise the recommendations, and are not shown in this section to prevent duplication. However, all key data used to determine the recommendations are provided alongside them in the summary document (West Sussex Early Years Needs Assessment: Summary and Recommendations: http://jsna.westsussex.gov.uk/).

These are recommendations for commissioners, providers and organisations to consider. We have, where possible, identified possible measures to monitor progress. Given the wider range of issues examined these have been identified as the main recommendations.

REF	RECOMMENDATION	ACTION	ACTION FOR?	POSSIBLE MEASURES
OVERALL				
1	Improving child development and tackling inequality in the early years of life should be countywide priorities, for all public sector organisations. Interventions should be evidence based.	Increased work on prevention and the promotion of good child development, work should be extended beyond children's services. For example work with local planning departments to develop environments conducive to physical activity and play, and work with the private sector to support paternal leave, and dependent's leave for grandparents, where appropriate. Commissioners should utilise the considerable evidence base available, including that collated by the Early Intervention Foundation, to ensure the most effective use of resources.	All. Public Health - increase engagement with Local Plan development.	Business plans reference evidence base. Evidence of "wider" engagement on the early years agenda, for example work between public health and local authority planning departments, communities directorate and early childhood service.
A HEALTHY START TO LIFE				
2	There are universal, targeted and specialist services; the pathways to, and between, them should be clear and evidence based. The research for this needs assessment found some confusion on what is available, where, and for whom. All staff, in all sectors, should be confident of using pathways.	There should be good quality information detailing pathways and referral routes. Of note staff should be clear on how to seek help in relation to services for child and adult mental health, substance misuse treatment and domestic violence. This may require additional training for staff in the identification of these issues. Equity audits should be undertaken to ensure there is a good understanding of those accessing, and benefitting from services provided.	WSCC (Children and Family Commissioning, Public Health, Early Childhood Service) and CCG Commissioners	Pathways in place, and well documented. Short, regular staff surveys could be used to establish whether pathways and referral routes are understood. Audits to ensure pathways are working as designed. Equity auditing reports for services. Data sharing agreements in place to improve the understanding of risk factors and their prevalence.

REF	RECOMMENDATION	ACTION	ACTION FOR?	POSSIBLE MEASURES
A HEALTHY START TO LIFE CONTINUED				
3	There should be an increased emphasis on maternal mental health, from screening and identification, and a range of services available to women across the county. Women need prompt access to evidence-based interventions. There should be robust county-wide mental health pathways in place for mothers/primary carers, and fathers.	Screening, and support, should be reviewed in line with NICE guidance. Development of a shared strategic vision and plan, with services, and capacity within those services, reviewed. The Early Years workforce should be trained, and understand the pathways/referral routes to appropriate support. All children's workforce staff should have a good understanding of the perinatal mental health pathway in West Sussex. Consider (with mental health commissioners) the inclusion of "pregnancy" within the dataset collected by mental health services.	WSCC and CCG Commissioners (Children and Family Commissioning, Public Health, Early Childhood Service, Mental Health Commissioners), health and social care staff i.e. social workers, midwives and health visitors	Early years' workforce trained in the identification of anxiety and depression. % of mothers requiring support and at what stage referral made/support accessed. % of mothers in receipt of support recorded.
4	Ensure that recommendations in the West Sussex Alcohol and Drug Needs Assessment (2014) relating to the need for improved linkages between maternity services and specialist drug and alcohol treatment services have been progressed.	Review progress and pathways between maternity services and specialist drug and alcohol treatment services.	WSCC and CCG Commissioners Public Health Substance Misuse Commissioner / Midwifery and maternity Services.	Pathways established, and evidence of referrals made.

REF	RECOMMENDATION	ACTION	ACTION FOR?	POSSIBLE MEASURES
A HEALTHY START TO LIFE CONTINUED				
5	All opportunities should be taken to reduce maternal smoking, and smoking in households with infants and young children. Ensure that recommendations in NICE guideline PH26 (Smoking: stopping in pregnancy and after childbirth) are implemented.	Early years' staff (including health visitors, midwives, early childhood service staff) are well placed to engage with target groups, including families on low incomes and teenage parents. Services should adopt the *"Making every contact count"* approach. Training should be provided to ensure staff are able to make referrals and provide services to risk groups, for example training in assessment and brief interventions for smoking cessation. Children's workforce support and promote Smokefree campaigns across West Sussex.	WSCC Public Health commissioners / Health Visitors / Midwifery / Children and Family Centres / Early Years workforce	Levels of referrals to smoking cessation from early years' workforce. Numbers of staff trained in Level 1 and Level 2 Smoking Cessation, including training in very brief advice (VBA). % of mothers smoking at time of delivery, at booking and at check. % of mothers who have sustained cessation at child's 1st/2nd birthday. Increase in the number of mothers accessing specialist smoking cessation provision.
6	Take forward the recommendations of the national obesity strategies and NICE guidance and quality standard (QS94). Implement interventions to prevent and treat maternal and childhood obesity. Implementing NICE recommendations to improve breastfeeding rates.	Work with local communities to identify and develop physical activity and healthy eating opportunities available in local areas. Pregnant women should be screened at an early stage to identify obese and overweight women. Public health lifestyle interventions to support change in relation to diet and physical activity need to be in place. A physical activity needs assessment for West Sussex should be undertaken.	Comprehensive action to tackle obesity requires action from across the county and organisations including WSCC, CCGs and Local Authorities.	Reduction in the percentage of children measured as overweight or obese in reception and Year 6. Physical Activity Needs Assessment to include activity in early years, including opportunity for outdoor play.

REF	RECOMMENDATION	ACTION	ACTION FOR?	POSSIBLE MEASURES
A HEALTHY START TO LIFE CONTINUED				
7	School readiness at age 5 is strongly associated with future educational attainment and life chances. West Sussex is lagging behind the South East and England in children achieving a good level development. There should be further work to improve school readiness across West Sussex.	A well trained and qualified early years workforce (in all sectors) should be prioritised, with a focus on workforce development in the most deprived areas of the county. Parents should be supported during pregnancy and early years, through universal and targeted services focusing on parenting styles and full engagement in their child's learning. An evidence review of interventions to reduce gender differences in attainment.	WSCC Early Childhood Service, Early Help	Improved child development measures and outcomes. Although it is recognised that measures are changing, West Sussex outcomes should be expected to be significantly higher than the England average. Quality of childcare – Ofsted judgements of local provision. Reduced variation in readiness for school/ attainment, by location, gender, social gradient and ethnicity.
8	National research finds that most unintentional injury in the early years are preventable, work at a local level can act to reduce their number. Implement the three key actions areas for reducing unintentional injuries, recommended by Public Health England.	Training for early years' staff to help reduce the number of unintentional injuries. Local data aligns with national findings on main types of injury and work should be reviewed and commissioned in relation to:- - Falls (including falls from furniture); - choking, suffocation and strangulation; - poisoning; - burns and scalds; - drowning. Consider the implementation of home safety interventions such as education, promotion of smoke alarms, and the use of stair gates.	WSCC and CCG Commissioners Health Visitors / Early Years workforce Social care, transport planning, fire service	Number of hospital admissions for injury and unintentional harm in 0-4 year olds. Data relating to A&E attendances should be reviewed.

REF	RECOMMENDATION	ACTION	ACTION FOR?	POSSIBLE MEASURES
TACKLING DISADVANTAGE				
9	There are neighbourhoods, and groups, within West Sussex, where many children have poor educational, social and health outcomes; inequalities are significant and appear persistent. There should be a shared understanding of those inequalities, outcomes should be tracked and information shared.	Inequalities should be monitored, and commissioners have an up to date understanding of outcomes at a neighbourhood/group level. Work should be developed in line with the national work on social mobility and life chance indicators.	WSCC Public Health and Social Research h Unit	Maintain a basket of indicators on child outcomes and social mobility. Annual report / dashboard on child outcomes.
10	**Pathways -** Risk and protective factors for child development are well evidenced. To tackle inequalities there should be greater investment into those children and families with the greatest need. Although not the only vulnerable group, young parents should be a priority group across all services	Commissioners should ensure that 0-19 HCP service redesign and procurement includes planning for a robust pathway for vulnerable parents.	WSCC Children and Family Commissioning / Early Help / CCG Commissioners	Pathways in place, and well documented and staff aware of the pathways.

REF	RECOMMENDATION	ACTION	ACTION FOR?	POSSIBLE MEASURES
11	**Identification -** The greatest potential for early identification of those who need additional support lies in universal services.	The movement of 0-5 commissioning into the local authority may provide an opportunity to improve identification and the speed at which help is provided. Staff should to be able to identify risk factors, in terms of context and also early warning signs, and understand the pathway to support. How data are stored and shared remains an issue. To reduce the proliferation of data systems and databases there should be a review of whether a single database could be established.	WSCC Children and Family Commissioning / Early Help / CCG Commissioners	Data sharing to aid early intervention should be reviewed.
12	Speech and language support is highly valued by staff and parents/carers. There should be timely access to support. Parents/carers should also be supported in relation to the home learning environment.	Access and waiting times for speech and language was not reviewed as part of this needs assessment. Information on the waiting time for those referred should be analysed. Support, for example drop-in sessions, in settings to be provided/continue to be provided. Consider the introduction of a measure relating to the home learning environment.	WSCC and CCG Commissioners / Speech and Language Service Health Visitors / Early Years workforce	Information on numbers of 0-4 year olds referred to and receiving support to be available, including data on waiting times. Possible adoption of a home learning environment measure.

REF	RECOMMENDATION	ACTION	ACTION FOR?	POSSIBLE MEASURES
TACKLING DISADVANTAGE CONTINUED				
13	Services and organisations should ensure that families in temporary accommodation, or with no fixed address, are able to access services and maintain service usage.	Organisations should review processes to ensure that there are no barriers to parents/families in the registration for and use of services.	All	Review of registration for services and ability to maintain use. Identify best practice for families subject to frequent moves.
14	Parents should be able to easily access education, training and employment advice and support, from a variety of settings and organisations.	Increase local contacts with local training providers, employers and Job Centre Plus to develop opportunities for parents with young children.	WSCC Children and Family Commissioning / Early Help / Early Childhood Service / Job Centre Plus	% of children (0-4) in workless households. % of teenage parents NEET.
15	The qualitative research found that parents greatly valued programmes which supported their own parenting and understanding of child development. These programmes should be continued and expanded, with some targeted services for young women.	There was considerable praise for activities such as “Bumps and Babes” and an appetite for follow on programmes to support the understanding of child development. Some of the young parents interviewed had limited contact with services prior to birth, commissioners should explore whether additional services for young women could be developed to improve their engagement.	WSCC Children and Family Commissioning / CCGs / Early Childhood Service / Early Help	Reduction in late ante-natal booking by young mothers.

REF	RECOMMENDATION	ACTION	ACTION FOR?	POSSIBLE MEASURES
THE IMPORTANCE OF COMMUNITIES AND PARTNERSHIPS				
16	The 2 - 2½ year integrated review provides an early assessment of the progress of children and identification of additional needs. This should generate information for the improved planning of services. The integrated review should be widely supported.	All partners, to promote the implementation and use of the review. Information gained should be appropriately shared to inform service planning and delivery.	WSCC Children and Family Commissioning / Early Childhood Service / Early years settings and providers	Engagement of parents/carers in reviews. Number of IRs completed. Adoption of data from reviews at population level to track progress in child development, for example information from the Ages and Stages Questionnaire (ASQ-3$^{TM)}$ at population level.
17	Parents/carers should have a good understanding of what is on offer in their local area and how to access services.	Clearer "branding" of early years' services including children and family centres.	WSCC Children and Family Commissioning / Early Childhood Service.	Consistent branding of materials and communications; parent/carer perception of branding should be captured on a regular basis.
18	Community and asset based approaches should be used with local communities/families. Co-production should be sought where possible and this requires high level senior management commitment. A clearer understanding of the term "co-production" is required.	Volunteers should be supported (or continued to be supported) to provide peer support, for example to improve breastfeeding rates, and encourage others to access Children and Family Centres. Greater emphasis should be placed on co-producing services; additional resources may be required to support involvement of families in the design and delivery of services.	WSCC Children and Family Commissioning / Early Childhood Service	Use of self-assessment toolkit to track progress in line with the six principles of co-production.

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