Aiming for the Best for Children, Young People and Families in Milton Keynes

Public Health Report by the Director of Public Health 2016/17

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Ensuring that every child and young person has the best start in life is a priority: the benefits of a healthy and happy childhood and adolescence can last a lifetime, and should be achievable here in Milton Keynes.

Unfortunately, the repercussions of poor health and adverse childhood experiences are also far reaching. There are a number of common risk factors that occur in childhood that can have devastating impacts on the health, wellbeing and life chances of a child. These can include parental mental health issues, substance misuse and domestic abuse – and they often cluster together. Understanding the risk factors, recognising when a child or young person is at risk and acting upon it is crucial if we are to prevent and minimise future harms.

Through prevention and early intervention we can help our children, young people and their families to be more resilient, as well as identify those who need extra support. Promoting resilience and the ability to cope is just as important as delivering services that deal with problems once they arise.

This report brings together local data and the views of children and young people to highlight key issues, and makes a series of evidence-based recommendations that have the potential to make a real difference.

Listening to our children and young people is key to understanding their needs. Through a series of events and surveys, children and families have had the opportunity to tell us about their health and wellbeing and what is important to them. The findings are used throughout this report.

Milton Keynes has the potential to achieve the best health and social outcomes for our children and young people. We have a diverse, well-educated population and have lower than average levels of deprivation in the city, yet our health outcomes do not always reflect this. I want us to strive to be better.

Public sector budgets are exceptionally stretched and there are no additional resources to deliver this plan. We must make the most of what we have by sharing resources where we can, by focusing on prevention and early intervention, and by ensuring our services deliver the best outcomes and value. We must make the most of new funding opportunities to enable us to achieve our ambition.

No single profession or organisation can single-handedly ensure the best outcomes for our children, young people and families. Achieving the best will require an integrated multi-professional approach to prevention, early intervention, care and support. Our Joint Health and Wellbeing Strategy 2015-18 outlines our partnership commitment and together with this report, embodies our ambition to aim for the best for every child and young person in Milton Keynes.

Muriel Scott
Director of Public Health
Summary of 0-19 Population • Characteristics

0-19 year olds

70,600

(27.2%) of the overall population (2014) – higher than England (23.8%)

Number of 0-4 population 20,500 in 7.9% (2014) - England 6.3%

There are around 3,882 live births each year.

This figure has increased slightly since 2009 but remained fairly stable since 2011.

4,948 (38.4% in 2015)

School children from ethnic minorities.

186

Hospital admissions for Asthma under 19’s

Giving a rate of 272.6 compared to England 216.1 per 100,000 (2014/15)

Estimates of 0-19 by 2025 and the number is expected to increase to 80,700 by 2025

LSOAs in the top 10% most deprived - 9 LSOAs are in the 10% most deprived[1] in England; of which 4 of these are in the Woughton & Fishermead ward, 3 in Bletchley East, and 1 each in Bradwell and Stony Stratford.

8,166 (8.3%)

Children in lone parent households (2011)

8,490 (12.3%)

Number of Children living in all Out-of-work Benefit Claimant Households by Local Authority and Age at May 2015

370 (3.8%) - (2015)

of 16-18 year olds are not in education, employment or training

6,354

Children with Special Educational Need (2016)

1 in 10

Children have experienced neglect

26% of babies have a parent affected by domestic violence, mental health or drug/alcohol problem

1 in 10

Children have experienced neglect

92 Children are subject to a Child Protection Plan

460 Children In Need (2015)

In 2014 there were 98 under 18 conceptions

Safeguarding priorities for children and young people in 2016-19 are: Holding to account, improving practice, growing impact. Engaging with children, young people, families and communities. Focusing on key areas of improvement and challenge activity.
Executive Summary

Purpose of this Report

Every Director of Public Health’s report shines a light on a different aspect of health and wellbeing in Milton Keynes. This report focuses on our most important asset: our children and young people. It sets out the key local issues and makes a series of evidence-based recommendations.

If we get the early years right, we pave the way for a lifetime of achievement. If we get them wrong, we miss a unique opportunity to shape a child’s future.

(Ofsted, 2016) 2

The Challenge

Throughout this report Milton Keynes’s performance is compared to the best outcomes in England. Comparison to the best performance or best 5% (95th centile) of local authorities in the country highlights where we need to improve in order to achieve the best outcomes.

A recent health needs assessment 3 revealed that, overall, the health and wellbeing of children and young people in Milton Keynes is similar to the England average. However, if we compare Milton Keynes to the best areas in the country we are well below in many areas. Considering our local demographics, we have the potential to be amongst the best for health and social outcomes.

As well as aiming to be the best, we need to tackle the significant variation in outcomes within Milton Keynes; some groups of children and young people have significantly worse health outcomes than others. These health inequalities start before birth and accumulate throughout life, but they are preventable.

A report by the National Children’s Bureau into health inequalities in England 4 found that children and young people growing up in more deprived areas tend to have worse health outcomes, yet also found that this was not inevitable. Some very deprived areas are bucking the trend and children are doing as well as, or better than, the national average.

Disadvantage starts before birth and accumulates throughout life. Action to reduce health inequalities must start before birth and be followed through the life of the child. Only then can the close links between early disadvantage and poor outcomes throughout life be broken. That is our ambition for children born in 2010.

(Marmot, 2010) 5

In order to tackle local inequalities and achieve the best outcomes we need to focus on the complex influences affecting children and young people’s health, including their family, environment, life skills, knowledge and experience. Preventing or minimising the impact of risk factors, including adverse childhood experiences is vital. It is equally important to strengthen the protective factors, particularly the resilience (ability to cope) of our children, young people and their families.
The following diagram illustrates the key elements to achieving better outcomes for our children and young people.

The Healthy Child Programme\(^6\) (Department of Health, 2009 Updated March 2015) offers a range of interventions for all children, young people and their families in Milton Keynes from pre-birth to 19 years. There may be times in childhood and adolescence when additional help and support is needed. Earlier identification enables a timely and effective response before issues escalate.

The case for Early Help is well evidenced\(^7\) as is the need for a skilled, multi-agency workforce that communicates well and works together. No single agency can provide the support alone.

A joint partnership approach across all services and agencies working with children, young people and families is being steered by the Joint Health and Wellbeing Strategy 2015-18\(^8\). As a partnership we are focused on delivering our shared vision:

‘We want to be ambitious and aspirational in improving health outcomes for children and young people who live in Milton Keynes.’

A key principle driving our work is listening to the voices of our children, young people and families and ensuring they are at the heart of decision making.

Throughout the report the priorities and recommendations for next steps have been highlighted. These have been informed by the recent Health Needs Assessment – Commissioning Community Health Services for Children & Young People in Milton Keynes\(^9\) and the 2015/16 MK Joint Strategic Needs Assessment.\(^10\)

Data throughout the report are the most recent compiled and published data as of February 2017.
Effective commissioning to improve children’s health

The influences on a child’s health are complex, including their environment, life skills, knowledge and lived experience. The services involved are wide ranging and include Early Years, Health, Education and Social Care.

Evidence suggests that to achieve the best possible children’s health outcomes you need to strengthen the whole system. Commissioners of community health services should work with commissioners of education and social services to develop an integrated system:

A ‘Call to Action’ has been declared for each section to highlight areas most in need of attention. These are summarised below.

<table>
<thead>
<tr>
<th>Call to Action</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pregnancy</strong></td>
</tr>
<tr>
<td>All services, particularly maternity, should identify vulnerable women and families as early as possible and take appropriate action to ensure their wellbeing. Relevant information should be shared between professionals to enable a co-ordinated response and prompt access to services.</td>
</tr>
</tbody>
</table>

| **Healthy Birth and Early Years** |
| We need a highly skilled and motivated 0 to 5 workforce capable of high quality assessment and working in an integrated way. Professionals working with children and families must be able to recognise key risk factors including adverse childhood experiences, share information and refer to services where appropriate. |

| **School Years** |
| i) Schools and partners must work together to achieve good emotional, mental and physical health, wellbeing and resilience for all pupils, including for the most vulnerable, through a whole school approach. This should include high quality Personal Social & Health Education, Sex & Relationships Education and Physical Education. |
| ii) All professionals working with children, young people and families must be able to identify mental health issues and refer promptly to accessible, high quality mental health support at the appropriate level. |

| **Vulnerable Children and Young People** |
| All professionals working with children, young people and families must use learning from reviews, inspections and audits to improve practice and outcomes. Progress should be monitored by the local Safeguarding Children’s Board. |

Our population in Milton Keynes is young, with a different age profile to England. Therefore, getting it right for our children and young people is even more crucial.
Snapshot of Health of our 0-4 year olds

More than 90% of mothers-to-be are seen by a midwife early in pregnancy.

10.9% of mothers were smokers at the time of delivery 2015 / 16.

Health and wellbeing of children in MK is similar or slightly better than the England average.

Children’s Health Needs Assessment 2015

Around 1 in 7 babies born in Milton Keynes (13.9%) live with a smoker in the household.

72.7% of mothers who deliver in Milton Keynes start breastfeeding.

50.1% of babies are still breastfed at 6-8 weeks (2015 / 16).

Over 97% of children receive their first childhood immunisations by age 1-2 years. This percentage reduces for the other immunisations with the 5 year Measles, Mumps and Rubella (MMR) vaccination having the lowest uptake of 91.4% (2015/16).

71.6% of children achieved a good level of development at age 5, this is significantly below the England average of 69.3% (2016).

2.8% of babies are born with a low birth weight (2014).


61 children under the age of 1 died, giving the 13th highest rate in England.


An estimated 400-600 women are affected by mild to moderate depression during pregnancy and the year following the birth (2013/14).

Total births in hospital: 3,570 (2014).

82% of eligible 2 year olds took up a nursery place in 2015/16.
Section 1: Healthy Pregnancy

Why is this Period Important?

Pregnancy and the birth of a baby is a critical ‘window of opportunity’ when parents are especially receptive to offers of advice and support. It provides an opportunity to help parents get off on the right foot, and crucially to help set the pattern for effective parenting later on.

All Babies Count, NSPCC, (Cuthbert C., el al 2011) 11

The first 1001 days from conception to age 2 is widely recognised as a crucial period that will have an impact and influence on the rest of the life course. The foundations for good physical health throughout life occur in pregnancy and infancy12.

There is a significant body of evidence that demonstrates the importance of sensitive, attuned parenting on the development of the baby’s brain and in promoting secure attachment and bonding. Preventing and intervening early to address attachment issues will have an impact on resilience and physical, mental and socioeconomic outcomes in later life.

What are we Aiming for?

The kind of lifestyles parents and the wider family have before the baby is conceived, during pregnancy and once the baby is born, can either have a positive or negative effect on their child.

Babies born to parents with unhealthy lifestyles have an increased risk of low birth weight, early illness and even early death.

Encouraging a healthy pregnancy
The best outcomes for both mother and baby happen when mothers are:

Not socio-economically disadvantaged
Managing stress or anxiety
In a supportive relationship - and not experiencing domestic violence
Not smoking, consuming alcohol or misusing illegal substances
Enjoying a well-balanced diet
Not in poor physical, mental or emotional health

There were around 3,88213 live births in Milton Keynes in 2015. Sadly, 61 babies in Milton Keynes died in their first year of life between 2013 and 2015. The infant mortality rate in Milton Keynes is significantly higher than England:
5.3 deaths per 1,000 live births compared to England’s average of 3.9 deaths per 1,000 live births. Our infant mortality rate needs to be reduced.

In 2014/15 modifiable factors were identified in 21% of child deaths in Milton Keynes, which included smoking, consanguinity and unsafe sleeping (Child Death Overview Process Panel Annual Report 2014/15). Continuing to prevent child deaths, by reducing risk factors where possible, is a priority.

Seeing a healthcare professional early in pregnancy is a key opportunity to assess a mother’s health and identify risks. Midwives give advice and offer interventions to support a healthy pregnancy, including weight management during and after pregnancy and support to stop smoking.

Ensuring early access to a midwife, by the 13th week of pregnancy, will equip women with the knowledge and skills they need to modify the preventable risks to their pregnancy. Over 90% of women in Milton Keynes are booked in by their 13th week of pregnancy.

Local maternity services are in the process of implementing the ‘Saving babies lives care bundle’, a set of guidelines for reducing stillbirth.

What are the Risk Factors?

Smoking in Pregnancy

Smoking is the single most important risk factor in pregnancy; maternal smoking during pregnancy is a cause of ill health, for both mother and baby, and a cause of infant deaths.

Smoking in pregnancy in Milton Keynes costs the NHS up to £320,000 a year for pregnancy-related complications and up to £117,000 per year for health effects on infants.

Data from the Public Health Outcomes Framework (PHOF) demonstrates the number of mothers who were smokers at the time they gave birth has been declining and was 10.9% in 2015/16. Babies from less affluent backgrounds are more likely to be born to mothers who smoke, and this is contributing to the gap in health inequalities.

In 2015/16, 13.9% of babies in Milton Keynes lived in a household with a smoker. Exposure to second-hand smoke is particularly harmful to children; extrapolating UK estimates to Milton Keynes suggests that each year exposure to second-hand smoke causes approximately:

- 105 cases of lower respiratory tract infection (in children under 3 years)
- 632 cases of middle ear infection (in children under 17 years)
- 117 new cases of wheeze and asthma (in children under 17 years)
- 3 cases of bacterial meningitis (in children under 17 years)
- 2 sudden infant deaths every 10 years
Referrals to the Milton Keynes ‘Stop Smoking Service’
Since June 2014 the stop smoking referral system is an opt-out system, smokers choosing to opt out are still managed on a smoker’s pathway for antenatal care. The care bundle for smoking ensures:
- All women have carbon monoxide (CO) monitoring at booking to determine if smoking and again at 36 weeks
- Smokers and those with a CO of >4 should be referred to Milton Keynes Council Stop Smoking Services
- Midwives discuss the implications of smoking during pregnancy
- Smokers referred for consultant led care and serial growth scans from 26 weeks until delivery
- Smokers and those with a CO >4 should have CO monitoring at every antenatal appointment

What can we do to reduce smoking in pregnancy?
- Ensure that all pregnant women receive a carbon monoxide test at their booking visit and their antenatal visit with the Health Visitor
- Ensure prompt onward referral for pregnant women and their partner to appropriate support services including the Stop Smoking Service.

Maternal Obesity
Maternal obesity is defined as having a Body Mass Index (BMI) of 30kg/m2 or more at the first antenatal appointment. Being obese during pregnancy increases the health risks for both the mother and child during and after pregnancy (NICE Guidance PH27 201019).

Maternal obesity has been linked to chronic health conditions in children (including asthma and diabetes) and childhood excess weight and obesity. Amongst all women in England of child bearing age (16-44 years) around half are overweight or obese20 (BMI ≥ 30).
One study of maternity services in England found that 15% of women were obese in their first three-months of pregnancy; this would equate to approximately 600 women in Milton Keynes.

Diet and/or exercise interventions during pregnancy can help reduce the amount of weight gain. Advice on how to eat healthily and keep physically active is offered as part of routine antenatal and postnatal care by midwives and health visitors.

**What do we need to do to reduce maternal obesity?**

- Ensure that midwives and other health professionals are able to identify and discuss excess weight with pregnant women, signpost and refer them to appropriate weight management services
- Work with partners to implement the Milton Keynes Council Healthy Weight Strategy 2014 -2019 to help children and families eat more healthily and be more active.

**Teenage Pregnancy**

Young parents and their children experience poorer outcomes.

Mothers under 20 years of age are:

- **Three times more likely to smoke** throughout pregnancy
- **50% less likely to breastfeed**
- At higher risk of postnatal depression and poor mental health for up to three years after birth
- **22% more likely to be living in poverty at age 30** and less likely to be employed or living with a partner
- **20% more likely to have no qualifications at age 30.** Of all young people who are not in education, employment or training, 15% are teenage mothers.

Young fathers are more likely to have poor education and have a greater risk of being unemployed in adult life.

**Babies born to young women under 20 have a:**

- **15% higher risk of a low birth weight**
- **44% higher risk of infant mortality**
- **63% higher risk of experiencing child poverty**

The latest data (2014) shows that the under 18's conception rate is lower than the England average but not significantly. There were 98 under 18 pregnancies in 2014 that resulted in a live birth or abortion, which is lower than the previous year. Approximately 50% of under 18 conceptions result in abortion.

Supporting young people who choose to become parents is crucial to improve outcomes for both the parents and child. Evidence shows that poor outcomes are not inevitable if early, co-ordinated and sustained support is put in place, which is trusted by young parents and focused on building their skills, confidence and aspirations. This requires a range of services providing support coordinated by a lead professional.

To support young and vulnerable parents a multi-agency support pathway is being developed. The pathway will offer all young and vulnerable pregnant women a range of support to improve their own outcomes, their partner’s and their child's.

**What do we need to do to improve outcomes for teenage parents and their children?**

Ensure effective development and implementation of the Support Pathway for Young and Vulnerable Parents including swift referral processes and coordinated care that is responsive to the need.
Parental Mental Health

The effects of poor mental health go beyond the parent. During the perinatal period (pregnancy to the first year following a birth) poor maternal mental health has important consequences on the infant’s health at birth and the child’s health, emotional, behavioural and learning outcomes. Women are at risk of developing their first episode of mental illness during this time, with more than 1 in 10 women affected.

Mental health issues can impact on the mother’s ability to bond with her baby which can affect the baby’s ability to develop a secure attachment.

Knowing the risk factors and the symptoms can help with early identification and timely support and treatment to minimise the impact on the mother, child and family.

In Milton Keynes an estimated 400 to-600 women will be affected by mild to moderate depression during the perinatal period each year. Maternal depression is also the strongest predictor of paternal depression which is estimated at 4% during the first year after birth.

Postnatal depression

Postnatal depression affects more than 1 in every 10 women within a year of giving birth.

Health professionals should be alert to the increased risk of experiencing mental health problems among teenage mothers and women who have experienced:

- Previous history of mental illness
- A traumatic birth
- A history of stillbirth or miscarriage
- Relationship difficulties
- Social isolation

What do we need to do to support good parental mental health?

- Ensure that perinatal mental health is discussed and reviewed at all key contacts with maternity staff and Health Visitors
- Ensure that the locally developed Perinatal Mental Health Pathway is implemented and effective at identifying mothers at risk during the perinatal period and mothers at risk are offered prompt treatment, including for the infant and father where necessary.
How are we Performing?

How do we Compare?

How can we Improve?

1. All services, particularly maternity, should identify vulnerable women and families as early as possible and take appropriate action to ensure their wellbeing. Relevant information should be shared between professionals to enable a co-ordinated response and prompt access to services.

2. Services should continue to promote the importance of early access to maternity care and monitor where mothers are presenting later to identify if there are any additional needs.

3. We must all expand our focus from the mother to encompass the whole family.

4. All partners must work to tackle infant mortality, by continuing to develop and implement initiatives such as the ‘Saving Babies Lives Care Bundle’.

5. We need to implement robust preparing for parenthood schemes, with multi-agency involvement.

6. Commissioners must closely monitor the perinatal mental health pathway to ensure that it is identifying mothers with, and at risk of, mental illness during the perinatal period and providing timely and appropriate treatment.

Call to Action

All services, particularly maternity, should identify vulnerable women and families as early as possible and take appropriate action to ensure their wellbeing. Relevant information should be shared between professionals to enable a co-ordinated response and prompt access to services.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Milton Keynes</th>
<th>England Average</th>
<th>Aiming for the Best: 95th centile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smoking at time of delivery (2015/16)</td>
<td>10.9%</td>
<td>10.6%</td>
<td>3.6%</td>
</tr>
<tr>
<td>Under 18 conceptions rate per 1,000 females aged 15-17 (2014)</td>
<td>21.1</td>
<td>22.8</td>
<td>8.4</td>
</tr>
<tr>
<td>Under 16s conception rate per 1,000 females aged 13-15 (2014)</td>
<td>3.2</td>
<td>4.4</td>
<td>2.0</td>
</tr>
<tr>
<td>Percentage of low birth weight of term babies (2014)</td>
<td>2.8</td>
<td>2.9</td>
<td>1.6</td>
</tr>
<tr>
<td>Infant mortality rate per 1,000 live births (2013-2015)</td>
<td>5.3</td>
<td>3.9</td>
<td>2.3</td>
</tr>
</tbody>
</table>
A child’s earliest years, from their birth to the time they reach statutory school age, are crucial. All the research shows that this stage of learning and development matters more than any other.

Unknown children destined for disadvantage. (Ofsted 2016) 26

Why is this Period Important?

Families are the most important influence on a child in the early years, and identifying those families who need help as early as possible opens opportunities to offer evidence based interventions.

There are a number of protective factors that can be optimised to reduce risks and improve outcomes. These are:

<table>
<thead>
<tr>
<th>Protective Factors</th>
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</thead>
<tbody>
<tr>
<td>Authoritative parenting combined with warmth, with an affectionate bond of attachment being built between the child and the primary caregiver from infancy</td>
</tr>
<tr>
<td>Parental involvement in learning</td>
</tr>
<tr>
<td>Protective health behaviours e.g. stopping smoking</td>
</tr>
<tr>
<td>Breastfeeding</td>
</tr>
<tr>
<td>Psychological resources including self-esteem</td>
</tr>
</tbody>
</table>

Source: Department of Health, Healthy Child Programme (2009) 27

What are we Aiming for?

A Healthy Childhood

The Healthy Child Programme (HCP) is led by Health Visitors and involves integrated working across all partners including maternity, children’s centres and GPs. It offers every family a programme of screening tests, developmental reviews, immunisations and guidance to support parenting and healthy choices, until the child reaches statutory school age. They provide additional support to families who need it to reduce the risk of poor childhood outcomes.

We are aiming for parents to feel supported to make decisions to improve their child’s health outcomes and life chances, by being their child’s first educator and feeling confident to manage their children’s minor illnesses.

Ensuring Children Are Ready To Learn

The early years (under 5s) framework aims for all children to be prepared and ready for school and for children starting school to reach the expected level of academic development, as well as personal, social and emotional development, physical, communication and language development. 

Improvements in early year’s development would be expected to have positive impacts on health, in the short and long term, but also on education and social wellbeing throughout life.

- In 2015/16, 100% of children in Milton Keynes had an Ages and Stages Questionnaire-3 (ASQ-3) review by health visitors by age 2 to 2 and a half. This is significantly better than the national average of 81.3%.
Milton Keynes has 71.6% of children reported as achieving a good level of development in the Early Years Foundation Stage in 2014/15, which is similar to the national average of 69.3%.

To support parents in their crucial role as their child’s first educator, evidence-based parenting programmes including ‘Just what we need’ and ‘Incredible Years’ are available in Children and Family.

### Ready to learn at 2

- **ABC**
  - **A** (Begin to form sentences and can put two or three words together)
  - **B** (Understand that their teeth need brushing by an adult twice a day)
  - **C** (Play alongside other children and begin to have their own friends)
- **Use a spoon competently to eat**
- **Have up to date immunisations**
- **Be well nourished and within normal weight for height**

Diagram: PHE Ready to Learn at 2

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### Reduced Emergency Hospital Attendances and Admissions

The main causes of A&E attendances and hospital admissions amongst children and young people are acute illnesses, such as gastroenteritis and upper respiratory tract infections, and injuries caused by accidents in the home particularly in the under 5’s. Unintentional injuries are the main cause of death in children and young people.

In Milton Keynes the rate of A&E attendances amongst 0 to 4 year olds is below the England average (2014/15); however the rate of admissions into hospital as an emergency is significantly worse than England: 184 per 1,000 compared to 147 per 1,000 for England.

In the UK, one in 11 children have asthma and every 20 minutes a child is admitted to hospital due to an asthma attack. Asthma causes approximately one death each year in under-19’s across Milton Keynes.

- **Hospital admissions for asthma** in those age under 19 years in Milton Keynes was **272.6 per 100,000** in 2014/15. This is significantly higher than the England rate of 216.1.

A number of initiatives have been developed by Milton Keynes CCG to address the high level of admissions for asthma in children.

### What are the Risk Factors?

#### Adverse Childhood Experiences (ACEs)

Adverse childhood experiences include a range of risk factors that impact on a child, including neglect or abuse. They are one of the strongest predictors of poor health and social outcomes in adults.
The term adverse childhood experiences (ACEs) incorporates a wide range of stressful events that children can be exposed to. These include harms that affect the child directly, such as neglect and physical, verbal and sexual abuse; and harms that affect the environment in which the child lives, including exposure to domestic violence, family breakdown, parental loss, and living in a home affected by substance abuse, mental illness or criminal behaviour.

(Ford et al. 2016) 31

Often risk factors occur together; particularly children living in a family affected by the ‘toxic trio’ of parental mental illness, substance misuse and domestic violence. Over a quarter (26%) of babies in the UK have a parent affected by one of these issues. (1001 Critical Days) 32

Studies are increasingly exposing relationships between childhood trauma and the emergence of health damaging behaviours and poor health and social outcomes in adulthood (Bellis et al, 2013) 34. Children and young people who witness and live with these stressful incidents are more likely to have low self-esteem, attachment issues and difficulties managing their emotions.

Parental problem drug and alcohol use can have adverse consequences for children, which are typically multiple and cumulative and will vary according to the child’s stage of development. These include poverty, abuse or neglect, inadequate supervision, toxic substances in the home, exposure to criminal or other inappropriate behaviour, and social isolation.

In over 70% of cases where a baby has been killed or seriously injured, at least one of parental mental health, substance misuse and domestic violence is present.

In Milton Keynes, parental drug and alcohol misuse along with domestic abuse and parental mental ill-health are the issues most likely to place children and young people at risk of abuse and/or neglect. In 2013/14, parental drug misuse was recorded as a prevalent factor in 30% of child protection conferences. Parental alcohol misuse was recorded as a prevalent factor in 27% of child protection conferences 33.

Individuals who experienced four or more Adverse Childhood Experiences have an increased risk of having poorer outcomes as adults, as shown in the table below.

<table>
<thead>
<tr>
<th>A person with 4 or more ACEs is:</th>
<th>At greater risk of:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 4 x more likely to be a regular heavy drinker or smoker</td>
<td>• Poor educational and employment outcomes</td>
</tr>
<tr>
<td>• 3 x more likely to be morbidly obese</td>
<td>• Low mental wellbeing and life satisfaction</td>
</tr>
<tr>
<td>• 9 x more likely to be in prison</td>
<td>• Involvement in recent violence</td>
</tr>
<tr>
<td></td>
<td>• Chronic health conditions</td>
</tr>
</tbody>
</table>

Bellis et al, 2013 34

What do we need to do to minimise the impact of adverse childhood experiences?

• All agencies working with children and families to understand and recognise the risk factors for ACE and ensure early intervention and support for parents to minimise the impact on the child/ren
Breastfeeding Duration

Breastfeeding is an important public health priority. Supporting families to breastfeed and increasing the number of babies who are breastfed gives babies the best possible start. The longer breastfeeding continues, the longer the protection lasts and the greater the benefits. There is extensive evidence on the breastfeeding benefits to mothers and their babies’ health, as well as evidence on how breastfeeding increases the level of attachment and bonding between mothers and their babies. The World Health Organization and the Department of Health recommend exclusive breastfeeding for the first six months of life.

Breastfeeding has health benefits for the mother, and the longer she breastfeeds, the greater the benefits. Breastfeeding lowers the risk of:

- breast cancer
- ovarian cancer
- cardiovascular disease
- osteoporosis (weak bones) in later life
- obesity
- allergies

The Department of Health recommends exclusive breastfeeding for the first 6 months

Breastfed babies have lower rates of:

- gastroenteritis
- respiratory infections
- sudden infant death syndrome
- obesity
- allergies

The UK has some of the lowest breastfeeding rates in the world. Rates of any breastfeeding until 6 months:

<table>
<thead>
<tr>
<th>Country</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>UK</td>
<td>34%</td>
</tr>
<tr>
<td>USA</td>
<td>49%</td>
</tr>
<tr>
<td>Germany</td>
<td>50%</td>
</tr>
<tr>
<td>Switzerland</td>
<td>62%</td>
</tr>
<tr>
<td>Senegal</td>
<td>99%</td>
</tr>
</tbody>
</table>
In Milton Keynes Hospital 72.7% of new mothers initiate breastfeeding their babies, this is below the England average of 74.3%. In 2014/15, 50.1% of mothers were still breastfeeding at 6-8 weeks after giving birth, which is above the England average of 43.2%.

**What do we need to do to increase breastfeeding duration?**
- Raise awareness that breastfeeding matters, amongst parents, health professionals, children centres and wider society
- Provide effective professional support to mothers and their families, by implementing the UNICEF UK Baby Friendly Initiative standards across all of our services
- Improve access to support, encouragement and understanding within mothers’ communities

**Preventable Childhood Diseases**

Antenatal and new-born screening is part of the routine maternity care pathway. Through the robust programme provided locally it can help prevent infection of the new-born child and ensure appropriate care is made available. The antenatal and new-born screening timeline goes from pre-conception to 8 weeks after birth.

Vaccination is recognised as one of the most effective public health interventions in the world and the UK has one of the best immunisation programmes. Coverage of over 95% protects the whole community, not just those vaccinated, by reducing the likelihood of infectious diseases being able to spread.

Measles, Mumps and Rubella (MMR) vaccination is usually given in a combined vaccination at 12-13 months old with a booster after age 3yrs 4 months. This is particularly important to monitor as measles can be fatal but uptake of MMR vaccinations continue to be affected by a public scare based on flawed scientific evidence.

Milton Keynes reached the national targets for all childhood vaccinations except for MMR at age 5 years (target of 95%).
- Milton Keynes uptake in 2015/16 of the first MMR dose by age 5 was 96.9%, which was slightly better than the England average of 94.8%.
- Milton Keynes uptake in 2015/16 of the first and second MMR dose by age 5 was 90.1%, which is slightly better than the England average of 88.2%.

**Importance of Immunisation**

**Diseases protected against**
- 1st dose of 5 in 1 Diptheria, tetanus, pertussis (whooping cough) polo and Haemophilus influenza type b (Hib)
- 1st dose of Pneumococcal (13 serotypes)
- 1st dose of Meningococcal group B (MenB)
- 1st dose of Rotavirus gastroenteritis

**Diseases protected against**
- 2nd dose of 5 in 1 Diptheria, tetanus, pertussis polo and Hib
- Meningococcal group C (MenC)
- 2nd dose of Rotavirus

**Diseases protected against**
- 3rd dose of 5 in 1 Diptheria, tetanus, pertussis polo and Hib
- 2nd dose of MenB
- 2nd dose of Pneumococcal (13 serotypes)

**Diseases protected against**
- Hib and MenC
- Booster dose of Pneumococcal (13 serotypes)
- 1st dose of Measles, mumps and rubella (German measles)
- Booster dose of MenB

**Diseases protected against**
- Influenza (each year from September from age 2 to 6)

**What do we need to do to protect against childhood diseases?**
- Ensure effective call/recall and chase up systems to ensure completion of recommended doses of all childhood vaccinations
Oral Health
Good oral health is an important component of general health. Poor dental health in childhood can lead to speech difficulties, pain and sensitivity, reduced self-esteem, and can affect adult teeth coming through.

There has been a reduction in children aged 5 in Milton Keynes with one or more decayed, missing or filled teeth: this was 25.1% of 5-year olds in 2012, which reduced to 21.5% in 2015. This is better than the England average of 24.7% in 2015.

How are we Performing?

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Milton Keynes</th>
<th>England Average</th>
<th>Aiming for the Best: 95th centile</th>
</tr>
</thead>
<tbody>
<tr>
<td>New-born Blood Spot Screening Coverage (2014/15)</td>
<td>96.1%</td>
<td>95.8%</td>
<td>99.6%</td>
</tr>
<tr>
<td>New birth visits within 14 days by Health Visiting (2015/16)</td>
<td>82.8%</td>
<td>87.0%</td>
<td>95.1%</td>
</tr>
<tr>
<td>Breastfeeding: initiation (2014/15)</td>
<td>72.7%*</td>
<td>74.3%</td>
<td>90.8%</td>
</tr>
<tr>
<td>Breastfeeding: 6-8 weeks (2015/16)</td>
<td>50.1%*</td>
<td>43.2%</td>
<td>65.4%</td>
</tr>
<tr>
<td>ASQ-3 (Ages and Stages Questionnaire-3) age 2-2½ (2015/16)</td>
<td>100%</td>
<td>81.3%</td>
<td>100%</td>
</tr>
<tr>
<td>MMR two doses by age 5 (2015/16)</td>
<td>90.1%</td>
<td>88.2%</td>
<td>95.4%</td>
</tr>
<tr>
<td>Early Years Foundation Stage: good level of development at age 5 (2015/16)</td>
<td>71.6%</td>
<td>69.3%</td>
<td>75.8%</td>
</tr>
<tr>
<td>Domestic abuse incidents per 1,000 (2014/15)**</td>
<td>22.7</td>
<td>20.4</td>
<td>14.8</td>
</tr>
<tr>
<td>Hospital admissions for asthma in under 19s, per 100,000 (2014/15)</td>
<td>272.6</td>
<td>216.1</td>
<td>73.4</td>
</tr>
</tbody>
</table>

* Data quality issue: does not meet the minimum data quality standard of 95%  
** Local police area i.e. figure for entire Thames Valley area combined

Sources PHOF/ChiMat/NHSE/NHSDigital
We are falling short of the England average for new birth visits within 14 days by Health Visiting, breast feeding initiation and domestic abuse incidents. We could be performing better at new-born screening, breastfeeding at 6-8 weeks, MMR vaccination, and Early Years Foundation Stage development.

How can we Improve?

1. We need a highly skilled and motivated 0 to 5 workforce capable of high quality assessment and working in an integrated way. Professionals working with children and families must be able to recognise key risk factors including adverse childhood experiences, share information, and refer to services where appropriate.

2. We need to strengthen integrated working and develop skills across early years and health to ensure children and families are identified and offered support earlier, including through effective use of the Early Help Assessment and implementation of the Integrated Two Year Review.

3. We must ensure consistent messages are given across health and early years providers to promote breastfeeding, smoke-free environments and immunisation uptake.

4. We must all ensure parents and carers of children under 5 have access to early support, to act as their child’s first teacher and access free early education places when needed.

5. We must work to increase breastfeeding initiation, by implementing the UNICEF breast feeding initiative standards across all providers.

6. Reduce hospital admissions for under 19 year olds for health problems that can be managed outside hospital such as asthma, respiratory infections and gastroenteritis.

Call to Action

We need a highly skilled and motivated 0 to 5 workforce capable of high quality assessment and working in an integrated way. Professionals working with children and families must be able to recognise key risk factors including adverse childhood experiences, share information and refer to services where appropriate.
**Snapshot of Health of our 5-19 year olds**

**Milton Keynes children levels of obesity.**
- 9.6% at age 4-5 years and 19.0% at age 10-11 years (2015/16)

A survey of 15 year olds carried out in 2014 found that in Milton Keynes 76.8% have never smoked. In the same survey 10.5% of 15 year olds in Milton Keynes had ever tried cannabis.

What About YOUth? 2014 (WAY 2014)

**61.1% of 15 year olds in Milton Keynes reported that they had High or Very High life satisfaction scores.**

What About YOUth? 2014 (WAY 2014)

25.1% i.e. 1 in 4 children have a decayed, missing or filled tooth by the age of 5 years.

Public Health England, Child Health Profile 2016

97.4% of girls in school year 8 have received the Human Papilloma Virus (HPV) vaccine.

South Essex Partnership Trust

98 girls aged between 15 and 17 years became pregnant during 2014. The rate in Milton Keynes is 21.1 per 1,000 is similar to the England rate of 22.8 per 1,000.

Joint Strategic Needs Assessment, Milton Keynes

10 children aged under 18 admitted to hospital for alcohol specific conditions each year.

Public Health England, Child Health Profile 2016

In a survey 56.0% of 15 year olds in Milton Keynes had ever had an alcoholic drink, and 10.7% had been drunk in the past 4 weeks.

What About YOUth? 2014 (WAY 2014)

An estimated 3,755 children in Milton Keynes aged 5-16 years and 530 males and 1,600 16-19 suffer from a neurotic disorder.

An estimated 25 15-24 year olds admitted to hospital for substance misuse.

Public Health England, Child Health Profile 2016
Why is this Period Important?

Over the past 10 years there has been significant research emerging around young people’s brain development. Puberty is a time of a major ‘second wave’ of brain activity (Giedd et al 1999)[38], where the brain is developing its skills to make decisions, empathise and reason. At the same time the body achieves its maximum potential for fitness, physical strength and reproductive capacity. This is a crucial time to embed healthy behaviours and minimise risky ones.

What are we Aiming for?

There is good evidence that a key approach to promote health and wellbeing is to strengthen children’s social and emotional skills and build resilience. This can be achieved by strengthening health assets (protective factors) around the child.

For children, better social and emotional skills, communication, the ability to manage your own behaviour and mental health mean a stronger foundation for learning at school, an easier transition into adulthood, better job prospects, healthier relationships and improved mental and physical health.

Early Intervention Foundation (2016)[39]

Adolescence is recognised as the most significant time for introducing behaviours that can have long term health impacts, for example smoking, substance and alcohol misuse. Health during adolescence is strongly linked to educational outcomes, including attainment and employment.

Improving emotional health and wellbeing and building resilience

Good emotional health and wellbeing amongst children and young people promotes healthy behaviours, good attainment and helps prevent behavioural and mental health problems. (NICE 2013)[41].

What does good emotional health look like?

- Good thinking skills
- Healthy secure relationships
- Ability to regulate own emotions
- Good self-efficacy and self-esteem

Action for Children (2007)[42]

Most children and young people are part of happy and healthy families, and their parents/carers are the providers of their emotional support. Sometimes though, children and young people need support.

Families, schools and local health and social care organisations have a vital role in helping children and young people to build resilience and to support them through life’s adversities.
We are aiming for children and young people to have good levels of resilience to enable healthy relationships and life choices

Milton Keynes Health and Wellbeing Awards and the Healthy Young People’s Network encourage all organisations working with Children and Young People in Milton Keynes to work towards a ‘whole system’ approach, which prioritises the emotional health and wellbeing of children and young people.

Resilience – ‘the capacity to resist or bounce back from adversity’

Rutter M (1985)43

Public Health England has released eight key principles44 to promote a whole school and college approach to emotional resilience, self-esteem and interpersonal skills, as outlined in the diagram below. These principles should be adopted locally to further strengthen our approach to improving the wellbeing and resilience of our children.

Improving emotional health and wellbeing and building resilience

Emotional wellbeing

- Leadership and management
  - that supports and champions efforts to promote emotional health and wellbeing

- An ethos and environment that promotes respect and value diversity

- Staff development to support their own wellbeing and that of students

- Working with parents / carers

- Identifying need and monitoring impact of interventions

- Targeted support and appropriate referral

- Curriculum, teaching and learning to promote resilience and support social and emotional learning

- Enabling student voice to influence decisions

Curriculum, teaching and learning to promote emotional health and wellbeing
What are the Risk Factors?

**Mental Ill Health**

As described in chapters one and two, parental mental health can have significant impacts upon the life-long outcomes of a child, including increasing their risk of mental illness. Children suffering with mental ill health are at risk of poor physical health outcomes, poor educational attainment, and are at greater risk of unhealthy behaviours such as taking up smoking.

There are relatively little data about prevalence rates for mental health disorders in pre-school age children but by the time they reach school age, one in ten children need support or treatment for mental health problems. This means that in a class of 30 school children, three will suffer with a mental health disorder such as depression, conduct disorders, anxiety, and hyperkinetic disorders (e.g. Attention Deficient Hyperactivity Disorder).

Over half of all mental ill health starts before the age of 14 years, and 75% has developed by the age of 18.

Joint Commissioning Panel for Mental Health (2015)

The prevalence of mental health problems in children and adolescents was last surveyed nationally in 2004, which estimated the following:

- Among 5 to 10 year olds, 10% of boys and 5% of girls had a mental health problem
- Among 11 to 16 year olds, the prevalence rose to 13% for boys and 10% for girls.

**Excess Weight**

Children with excess weight (either overweight or obese) are more likely to become overweight and obese adults, and have a higher risk of poor health, disability and premature mortality in adulthood. There is also a link between obesity and poor mental health in teenagers, with weight stigma increasing vulnerability to depression, low self-esteem, poor body image and maladaptive eating behaviours. Nationally, by age 11, almost a third of children are overweight or obese, and this proportion is predicted to rise if concerted action is not taken.

Lower numbers of children who are overweight or obese would result in lower levels of a wide range of health problems, including diabetes, and could help improve educational and social outcomes.

The National Child Measurement Programme (NCMP) weighs and measures children in their first year at school, reception and again in Year 6. The NCMP is used to identify children who are underweight, overweight and obese so that they can be offered support, as well as being used to monitor trends. (Healthy Weight, Healthy Nutrition)

In Milton Keynes in 2015/16, the levels of excess weight (overweight and obesity) in children was similar to the England average:

- In year R: 23.1% of children were overweight or obese, compared to 22.1% in England
- In year 6: 33.8% of children were overweight or obese, compared to 34.2% in England

As well as helping children and young people maintain a healthy weight, there is increasing evidence of the mental health benefits of exercise in children and young people. Regular activity helps children and young people to feel good about themselves and concentrate better, as well as many other benefits.
Alive 'N' Kicking is a children's lifestyle weight management service that helps overweight children and young people and their families to reach and maintain a healthier weight. The service provides age specific programmes for families with children aged between 5 to 18 years old.

The School Time Obesity Prevention (STOP) programme provides a school-based intervention to raise awareness of healthy eating and physical activity, which enables children aged 8 to 11 years old to explore how they can positively impact their lives through food and activity choices.

For further information http://www.whyweightmk.co.uk

Tackling excess weight requires a 'whole systems' approach, including health, local planning teams and education. Plans to create strong links with stakeholders to tackle obesity are formalised in the Milton Keynes Healthy Weight Strategy 2014-2019 and Implementation Plan.

What do we need to do to ensure a healthy weight and promote physical activity?

- Create environments that promote physical activity and healthier lifestyle choices.
- Ensure excess weight is everybody's business by working in partnership, and by developing a workforce which is confident and competent in addressing excess weight.
Reducing Health-Related Risk Taking Behaviours

Young people’s risk taking behaviour is a public health concern due to the short and long term risks to health. It includes smoking, substance misuse and risky sexual behaviour. Whilst the majority of research is showing that risk taking behaviours amongst young people are on the decline, there seems to be an upward trend of children and young people experiencing poor emotional health (PSHE Association, 2015). There is also evidence of a link between risk taking behaviours and poor mental health.

Risky behaviours can ‘cluster’ and are linked to poor outcomes, such as low educational attainment, being bullied and emotional health problems (Cabinet Office 2014). Effective interventions during adolescence have the potential to reduce multiple risk taking behaviours.

Smoking

Smoking continues to be a major cause of ill health, particularly heart and lung disease. Many people start smoking as adolescents and some will continue to smoke into adulthood. However, across England the number of young people who reported trying smoking has fallen and is now at the lowest levels since 2003 (HSCIC, 2014).

The WAY survey indicates that smoking prevalence in Milton Keynes at age 15 is higher than the England average. Smoking tobacco is associated with increased prevalence of all mental disorders, with smokers 50% more likely to suffer from a mental disorder than non-smokers and more than twice as likely to attempt suicide. It is therefore crucial that people with mental disorders have appropriate access to support services.

The Milton Keynes Stop Smoking Service takes a whole family approach to supporting smokers to quit, and works with schools, children’s centres, midwives and other professionals to promote smoke-free homes and cars. Smokers of any age can be supported on a 12 week quit programme. The service is delivered in some schools, with programmes held during school time to facilitate access to support.

Tobacco remains the main cause of preventable morbidity and premature death in England. Beyond the well-recognised effects on health, tobacco also plays a role in perpetuating poverty, deprivation and health inequalities.
Alcohol and Substance Misuse

Drug and alcohol misuse can have significant harmful impacts on young people, beyond the immediate health impacts. This can affect educational outcomes, employment, relationships, and increase the likelihood of criminal behaviour. Cannabis and alcohol are the most common substances used by young people, although there is evidence that young people also use new psychoactive substances (NPS), also known as ‘legal highs’.

A local survey conducted in five Milton Keynes secondary schools, in 2013, found that 4% of pupils had taken some form of illegal drug in the month before the survey. 6% said they had taken illegal drugs at some point, most commonly cannabis.

- In 2015/16, 88 young people under 18 accessed specialist substance misuse interventions in MK, the majority for cannabis, mephedrone, new psychoactive substances (NPS) and/or alcohol. 79% of these young people completed treatment in a planned way.
- A further 200 young people accessed targeted support, mainly for cannabis and alcohol.

Hospital admissions due to alcohol specific conditions in under 18 year olds or substance misuse in 15-24 year olds are relatively rare but are a useful indicator as the ‘tip of the iceberg’ of substance misuse and its impacts.

- Hospital admissions due to alcohol-related conditions was 15.6/100,000 in under 18 year olds, this is significantly better than the national average of 36.6/100,000 (2012/13-2014/15)
- Hospital admissions due to substance misuse was 92/100,000 in 15 to 24 year olds, which is similar to the national average of 88.8/100,000 (2012/13-2014/15).

Compass Drug and Alcohol Service

Compass is a drug and alcohol support service for children and young people aged under 18 years. Compass offer information, advice and structured 1-2-1 and group interventions for young people who are using or at risk of using drugs or alcohol. They also offer advice and information to parents, family members and professionals.

http://www.compass-uk.org/compass-milton-keynes-young-people/

Sexual Health

As young people become sexually active they are at risk of acquiring sexually transmitted infections (STIs), such as chlamydia, gonorrhoea or HIV, and also unintended pregnancies.

Chlamydia is the most common, curable sexually transmitted infection in the UK. Chlamydia often has no symptoms and if left untreated it can result in pelvic inflammatory disease and/or infertility. For this reason there is a chlamydia screening programme aimed at screening young people between the age of 15 and 24 years.

In Milton Keynes during 2015 there were:

- 7,627 (27.3%) people aged 15-24 screened for Chlamydia compared to the England average of 22.5% (2015)
- The Chlamydia detection rate was 2,514 per 100,000 for people aged 15-24 compared to England 1,887 (2015)

In Milton Keynes, the number of young people screened in 2015 was higher than the England rate and the rate of detection was also one of the best in the region.
There is a school based sexual health provision in the majority of secondary schools in Milton Keynes. Targeted outreach work is delivered to young people identified as more vulnerable, this includes looked after children, young people from areas of high teenage pregnancy and young people not in employment, education or training.

There are a number of other STI's that affect young people such as gonorrhoea, genital herpes and genital warts. In Milton Keynes in 2015, there were:

- 543 new diagnoses of sexually transmitted infections per 100,000 people aged 15-24 (excluding Chlamydia). This is lower than the England average of 815.

Brook Milton Keynes is a specialist contraceptive and sexual health service for under 25 year olds. The service provides free contraception, including condoms, emergency contraception and Long Acting Reversible Contraception (LARC) as well as STI testing and chlamydia screening.

A counselling service is also provided for issues surrounding sexual health, relationships, sexuality, gender and pregnancy choices.

Teenage pregnancy is a complex issue, affected by personal, social, economic and environmental factors. Under-18 conception data is used to monitor teenage pregnancy rates; it includes all conceptions that result in either a live birth or abortion. Since 1998 there has been a 51% reduction in under 18 conceptions across England.

Milton Keynes has seen a further decrease in the Under 18’s Conception rate from 24.1 per 1,000 (110) in 2013/14 to **21.1 per 1,000 (98)** in 2014/15, which is less than England’s average which is 22.8; England’s best is 12.8. As a consequence the number of teenage mothers is also reducing.

Under 18 conception rates 1998-2014

The Framework for Sexual Health Improvement (DH 2013) recommends that in order to reduce teenage conception rates, improve sexual health and support young people to develop healthy and safe relationships, it is vital to have the provision of high quality comprehensive sex and relationships education (SRE) in schools and youth settings delivered by trained educators. This should be complemented by open discussion with parents/carers, and the provision of easy access, young people friendly, sexual health and contraception services.
What do we need to do to reduce risk taking behaviours?

- Help parents, carers and families to teach their children the healthy behaviours that will continue in adult life, by ensuring that children and young people are informed of the effects of risky behaviours and are supported to make healthy choices
- Support schools to provide high quality Personal, Social and Health Education
- Continue to provide early intervention programmes, such as ASPIRE
- Raise awareness and improve access to age-appropriate support services for children, young people and their families.
- Ensure development and effective implementation of a support pathway for young and vulnerable mothers

How are we Performing?

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Milton Keynes</th>
<th>England Average</th>
<th>Aiming for the Best: 95th centile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion of 15 Year olds eating 5 fruit of vegetables a day (2014/15)</td>
<td>53.9%</td>
<td>52.4%</td>
<td>62.3%</td>
</tr>
<tr>
<td>Reception children age 4-5 overweight and obese (2014/15)</td>
<td>23.1%</td>
<td>22.1%</td>
<td>14.3%</td>
</tr>
<tr>
<td>Year 6 children aged 10-11 overweight and obese (2014/15)</td>
<td>33.8%</td>
<td>34.2%</td>
<td>22.9%</td>
</tr>
<tr>
<td>Pupil absence: percentage of half days missed (2014/15)</td>
<td>4.6%</td>
<td>4.6%</td>
<td>4.1%</td>
</tr>
<tr>
<td>16-18 year olds not in education, employment or training (NEET) (2015)</td>
<td>3.8%</td>
<td>4.2%</td>
<td>1.5%</td>
</tr>
<tr>
<td>Under 16s conception rate per 1,000 females aged 13-15 (2014)</td>
<td>3.2</td>
<td>4.4</td>
<td>2.0</td>
</tr>
<tr>
<td>Under 18 conceptions rate per 1,000 females aged 15-17 (2014)</td>
<td>21.1</td>
<td>22.8</td>
<td>8.4</td>
</tr>
</tbody>
</table>

We are falling short of the England average for a number of indicators including: reception year children who are overweight or obese, current smokers at age 15 years, hospital admissions because of asthma, hospital admissions because of substance misuse and first time entrants to the youth justice system. We could be performing better in all of the indicators in the table compared to the best in the country.
How can we Improve?

1. Schools and partners must work together to achieve good emotional, mental and physical health, wellbeing and resilience for all pupils, including for the most vulnerable, through a whole school approach. This should include high quality Personal Social & Health Education, Sex & Relationships Education and Physical Education.

2. All professionals working with children, young people and families must be able to identify mental health issues and refer promptly to accessible, high quality mental health support at the appropriate level.

3. Commissioners must keep children and young people at the centre of all we do, by actively listening and seeking their views to inform local plans and the actions we take.

4. We must all help parents, carers and families to build emotional resilience in children and young people to develop the healthy behaviours that will continue in adult life.

5. All organisations need to support the implementation of the Milton Keynes Healthy Weight Strategy 2015-2019 to address childhood excess weight.

6. Providers must tackle risky behaviours by supporting parents and families to access support as early as possible.
Call to Action

i) Schools and partners must work together to achieve good emotional, mental and physical health, wellbeing and resilience for all pupils, including for the most vulnerable, through a whole school approach. This should include high quality Personal Social & Health Education, Sex & Relationships Education and Physical Education.

ii) All professionals working with children, young people and families must be able to identify mental health issues and refer promptly to accessible, high quality mental health support at the appropriate level.
Aiming for the Best for Children, Young People and Families in Milton Keynes

Snapshot of
Health outcomes of vulnerable children and young people

Children in care are 4 times more likely than their peers to have a mental health difficulty.

Living in a household with domestic violence and abuse:
- impacts on the child’s mental, emotional and psychological health and their social and educational development.
- affects their likelihood of experiencing or becoming a perpetrator of DV&A as an adult, as well as exposing them directly to physical harm.
Public Health, Milton Keynes

Children in care are less likely than their peers to do well at school.
Department for Education (2014)

Young carers could be looking after a parent who is alcohol or drug dependant.
Young carers have significantly lower educational attainment at GCSE level. Department of Health (2014)

Children with learning disabilities are six times more likely to have mental health problems than other children. CHIMAT (2011)

Children who are sexually exploited are more likely to be affected by:
- teenage parenthood
- failing examinations or dropping out of education altogether
- mental health problems
- alcohol and drug addiction
- criminal activity
Department of Health (2014)

Children and young people in the criminal justice system are far more likely to experience mental health problems than their peers.

Mothers under 20 are:
- 22% more likely to be living in poverty at age 30 and less likely to be employed or living with a partner.
- 20% more likely to have no qualifications at age 30. Of all young people who are not in education, employment or training, 15% are teenage mothers.
Milton Keynes Joint Strategic Needs Assessment

Children who offend have health, education and social care needs, which, if not met at an early age, can lead to a lifetime of declining health and worsening offending behaviour.
Prison Reform Trust/Young Minds
Section 4: Vulnerable Children and Young People

Why Is This Group Important?

Identifying children and young people with vulnerabilities and strengthening professional curiosity

Being professionally curious means looking to identify indicators of neglect and not being reliant on legal thresholds alone. Professionals should instead explore the significance of one or a number of indicators of neglect when investigating an incident in a home setting or elsewhere.

National Multi Agency Care Neglect Strategic Work Group – October 2015

Vulnerable children and young people are those facing additional challenges that can impact negatively on their lives. They may be at risk of harm and face poorer outcomes unless they are offered support through early intervention. The risk factors are broad and often interrelated, so understanding and recognising when a child or young person is at risk relies upon a culture of professional curiosity across all services. It is also crucial that there are appropriate referral mechanisms in place and that these are understood by all.

While there are statutory responsibilities for some, including those with special educational needs and disabilities (SEND) or in social care, there are many children who are not known to local organisations with warning signs that they are becoming at risk of harm. All agencies working with children are required to meet the requirements of the statutory guidance ‘Working Together to Safeguard Children (2015)’

What Are We Aiming For?

Implementing the Early Help Offer

The range of risk factors affecting vulnerable children and young people indicates the varied response and support that may be needed.

It should not be the expectation that our vulnerable children and young people will experience poorer educational and health outcomes in Milton Keynes. Across all partners we want to ensure that all children, young people and their families receive the care and support they need in order to thrive, regardless of their circumstances. Every child, young person and family will access universal services over their lifetime, through the delivery of the Healthy Child Programme; however, some will need additional support, including specialist targeted support.

Early help means, as a partnership, we will identify and provide support to a child, young person or family, as soon as a difficult situation surfaces. Early help is particularly important for the most vulnerable groups, to tackle emerging problems as soon as possible and prevent their situations becoming more serious. Narrowing the gap in outcomes for vulnerable children and young people needs a long-term focus.

National Children’s Bureau, 2015
What are the Risk Factors?

Vulnerable young people can be:
- Disabled and have specific additional needs
- A young carer
- Have special educational needs
- Showing signs of engaging in anti-social or criminal behaviour
- In challenging family circumstances such as substance abuse, adult mental health problems and domestic abuse
- Those returned home to their family from care
- Showing early signs of abuse and/or neglect.
- A Looked After Child (LAC)
- A young parent
- At risk of/experienced Child Sexual Exploitation (CSE)
- At risk of/ been a victim of Female Genital Mutilation (FGM)
- An asylum seeker, refugee or new migrant

Safeguarding

Milton Keynes Council has a duty to safeguard children as set out in the Children's Act (1989) and associated legislation and guidance. All agencies working with children must comply with the statutory guidance called Working Together to Safeguard Children.

Milton Keynes works to a well-established model of intervention that sets out four levels of need: universal, additional, considerable and specialist. All partners on the Milton Keynes Safeguarding Children's Board (MKSCB) are signed up to the model: Universal Services, Early Help, Children and Family Practices, and Multi-agency safeguarding hub (MASH).

The Milton Keynes Family Support Approach seeks to manage child protection concerns safely and effectively, without entering formal child protection processes if appropriate. As a result, there are low numbers of children subject to formal child protection plans compared to all other local authorities:
- Milton Keynes has a rate of 8.7 per 10,000 children (0-17) subject to a Child Protection Plan; this is significantly below the England average of 42.9 per 10,000 (2014/15).
- The majority of child protection plans in Milton Keynes are a result of neglect. In March 2016 the percentage of children subject to a child protection plan because of neglect was 80.4%.

Milton Keynes Safeguarding Children Board produces a detailed annual report on their work; further information can be found on their website:
http://www.mkscb.org/

Special Educational Needs and Disability (SEND)

Children with disability are known to experience significant inequalities. These include poverty, living in unsuitable housing, social exclusion and bullying, increased risk of abuse and child sexual exploitation, lower educational attainment and increased likelihood of being not in education, employment or training at 19 years of age.

There is no single local data source that includes all children with disability. Based on national data, there are an estimated 4,900 children aged 0-18 years in Milton Keynes with disability, as defined by the Equality Act 2010.

Nationally, the number of children with disability has increased, in part due to increased survival of premature babies with complex health problems. In Milton Keynes, this is likely to have been amplified by a rapidly growing child population, with a 46% increase in the number of infants from 2001 to 2011, and a 37% increase in the number of 1-4 year olds. Some of these children with disability will have long and enduring, multi-agency support needs.
A health needs assessment for children with disability has been completed with the following recommendations given to the Milton Keynes SEND Reform Board;

- Improve local data on children with disability
- Develop a participation and communication strategy
- Improve access to mental health support for children
- Improve effective working across service boundaries
- Tackle barriers to community participation
- Ensure all children’s services consider the needs of children with SEND
- Respond to specific service issues raised

(source: Children with Disability- Health Needs Assessment –August 2016)

**Homelessness**

Family homelessness can mean living in poor quality temporary accommodation, which is detrimental to health and wellbeing.

In recognition of increasing homelessness in the population as a whole the Homelessness Task and Finish Group was established in the summer of 2015 and published its report in March 2016.

**Children with Complex Needs**

Some children have complex and enduring health conditions, which may also be life limiting. These children need a high level of care and support to keep them safe and as healthy as possible. Examples of these are children requiring long term ventilation, degenerative neurological conditions, chromosomal abnormalities, or severe learning difficulties. Whilst there are relatively few children with this level of need, they incur a high financial cost to the system.

A small number of children are not able to access the care they need in Milton Keynes and are placed in provision in other areas. The majority of these placements involve needs relating to challenging behaviour, or attachment/emotional/social difficulties. They may also be admitted to an inpatient mental health unit as Milton Keynes has no local provision. The reason for an out of area placement usually relates to the intensity and complexity of need, which isn’t able to be met locally. This is an emerging picture both locally and nationally. It is increasingly clear that there is a need to work differently and with a more integrated, needs focussed approach.

**Health of Children in Care, Looked after Children (LAC)**

The Health of Children in Care draft Annual Report 2015/16 highlights that the vulnerability of children and young people in the care system is a widely recognised concern both locally and nationally. Abuse and neglect remain the main reason why children come into the care of the local authority. The profile of the health needs remain the same, mainly developmental delay for children below the age of five (particularly speech and language delay) and emotional health and conduct difficulties in the older age group.

How can we Improve?

There is evidence available to bring further improvements to other groups of vulnerable children in Milton Keynes; however, learning from serious case reviews, local inspections and case conferences have identified that we will have a dramatic impact on the outcomes for children and young people if we strive collectively to improve the following:

**Homelessness**

- Seeking ways of working differently with partners to prevent homelessness.
- Supporting recommendations of the Homelessness partnership.
- Agreeing the approach to meeting the needs of non-statutory homeless people.
- A review of how MKC responds to dealing with people living in tents.
- Development of a policy around provision of basic accommodation, sanitary facilities and support to this group.

The Council Plan 2016-20 highlights homelessness as one of its key priorities and makes a number of commitments, including:

- The creation of a ‘One Stop Shop’ style service by March 2017 to focus on prevention of homelessness and to ensure support services are there to assist all those in danger of homelessness.
- Development and implementation of a rough sleeper action plan by November 2016.
- The creation of additional facilities that provide emergency shelter and support for those in crisis by November 2017.

**Domestic Abuse**

A working group has begun focusing on domestic abuse and ‘best practice’ recommendations related to prevention and early identification.

- Consider implementing evidence based social development programmes for pre-school children which focus on positive relationship development, problem solving and conflict resolution.
- Consider implementing evidence based resilience building programmes for school aged children.
- Consider offering programmes to promote ‘safe dating’ and violence reduction to secondary school aged children.
- Ensure universal screening for domestic abuse is in place with swift referral and support mechanisms.
- Ensure local services comply with Guidance on the National Institute of Clinical Excellence (PH50) relating to domestic violence.
What do we need to do to support our vulnerable young people?

1. All professionals working with children, young people and families must use learning from reviews, audits and inspections to improve practice and outcomes. Progress should be monitored by the local Safeguarding Children’s Board.

2. Work in partnership to identify children and young people who are experiencing issues early to ensure they are able to access support, advice and opportunities to improve their health and wellbeing and enable them to reach their potential.

3. For commissioners to agree indicators to monitor and improve identification of vulnerable children.

4. Shared training to develop professional curiosity and strengthen a consistent integrated approach.

5. Ensure that the broadest range of services and support are available to meet the needs of particularly vulnerable groups, in the most effective and cost efficient way.

Call to Action

All professionals working with children, young people and families must use learning from reviews, audits and inspections to improve practice and outcomes. Progress should be monitored by the local Children’s Safeguarding Board.
References and useful documents


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28 Early Years – Ready to Learn

29 Child Health Profiles:
http://fingertips.phe.org.uk/

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33 MK Safeguarding Children Board Annual Report 2015/2016:


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http://cpd.screening.nhs.uk/timeline [accessed February 2017]

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Milton Keynes Safeguarding Children Board: Levels of need
http://mkscb.org/our-resources/

MKC Children and Families Strategy for Children in Care 2013-2017

Milton Keynes Safeguarding Childrens Board-Business Plan:
http://www.mkscb.org/about/who-we-are/mkscb-business-plan/

Public health England and UNICEF- Baby Friendly Initiative: Breastfeeding