Commissioning Community Health Services for Children and Young People in Milton Keynes 2016
Needs Assessment – Informing future priorities, plans and services for children and young people

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Milton Keynes Council
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Milton Keynes Clinical Commissioning Group
0-19 Transformation Reference Group

Foreword

We want to be ambitious and aspirational in improving health outcomes for children and young people who live Milton Keynes. For most indicators of child health Milton Keynes is either average, or just above or just below average in performance. It is easy to be complacent that this is good enough but for the first time, in this needs assessment; we have compared our performance with the best areas in the country. This shows that we could be achieving much more. There are areas in the country with high levels of deprivation who have managed to buck the trend so we know that this is possible.

We have highlighted needs, reviewed our services and evidence of best practice and carried out stakeholder engagement to inform our key priorities and recommendations going forwards.

These recommendations will be used to inform how we commission services for children young people to ensure that services will support children and families to achieve the best possible health outcomes that they can.
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Executive Summary

Our Priorities

Giving every child the best start in life
(Milton Keynes Health and Wellbeing Strategy 2015)

Purpose of report
This report is to inform the commissioning of Community Health Services for children and young people across Milton Keynes to ensure the best services are commissioned, given the resources available, with the result that children and young people have the best possible health.

The Challenge
Overall the health and wellbeing of children and young people in Milton Keynes shows a mixed picture. Across key indicators relating to health and health services Milton Keynes is similar to the national average. However comparisons to national averages are only part of the picture. In Milton Keynes we are well below the best in the country and too many children have poorer health outcomes than they could have. Furthermore the variation in children’s outcomes is a critical point. These health inequalities start before birth and accumulate throughout the life course. A recent report into health inequalities in England\(^1\) found that children growing up in deprived areas tend to do worse, significantly however, 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.

Effective community health services can improve children’s health both at a population level, through preventative screening and assessment programmes

\(^1\) National Children's Bureau 2015 Poor Beginnings Health inequalities among young children across England

Effective commissioning to improve children’s health

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

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

- Giving every child the best start in life
- Working to achieve shared health outcomes
- Designed based on user need
- Whole system integrated across Health, Education and Social Care
- Focus on early years and prevention

Community health services for children and young people in Milton Keynes are currently commissioned by MKCCG and MKC and the main providers are: CNWL, Newport Pagnell Medical Centre, MK University Hospital FT, Why Weight, Compass, Brook and the Public Health Stopping Smoking Service.
Headlines

Health of our children and young people compared to the England average

Better than average

- Infant mortality
- GCSEs achieved (9 A*-C inc. English and maths)
- Hospital admissions for asthma (under 19 years)

Below Average

- 38% of school children are from an ethnic minority group
- 7,161 children with SEND

Milton Keynes

- Milton Keynes has 9 LSOAs in the 10% most deprived in England
- 17.6% of under 16s live in child poverty
- 340 children who are looked after (March 2018)

What matters to Children and Young People?

- Being informed and having a say in their care
- Child-friendly personalised care
- Access to age-appropriate services as they grow and support though transition to adult services
- Understanding their roles and responsibilities
- The role of the school (CMO, 2013)

Source: 0-19 Stakeholder Engagement Presentation July 2016
A growing younger population
Who lives here?

Our children

In Milton Keynes our population is young, with a different age profile than England as a whole. In 2016 22.8% of the Milton Keynes population were aged under 16 compared with 19% in England. We are a relatively safe place with 71.4 crimes per 1000 residents recorded during 2015. In context Oxford, Reading and Slough recorded 97.9, 79.9 and 79.4 respectively. Economically, we are an area with low unemployment. 16-18 year olds not in education or training (NEET) is now down to just 4.7% (Source: Children’s Progress Check May 2016, Child Census, January 2015)

- 70,600 children and young people between 0-19 years old (2014 estimate\(^2\)). This is about a quarter of the whole population and the number is expected to increase to 80,600 by 2025\(^3\)
- 38.4% of school children are from a minority ethnic group (2015)\(^4\) [child health profile 2016]
- 17.6% of children under age 16 living in poverty\(^3\) (2015).

More information can be found in the full Children’s Services Progress Check May 2016 document\(^5\).

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\(^3\) Milton Keynes JSNA Summary 2015 16

\(^4\) Child Health Profile March 2016

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Deprivation

**Milton Keynes** has a very diverse population:

- 12 LSOAs are in the 10% least deprived\(^5\) in England; examples of the wards these LSOA’s are located in include Olney, Newport Pagnell South, Loughton & Shenley, and Danesborough & Walton.
- 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.

This is illustrated in Map 1 below which shows the range of deprivation\(^5\) to be from 1.9 (very low deprivation) to 62.1 (high deprivation). The average deprivation in Milton Keynes is 18.0 which compares to the England average of 21.8\(^6\).

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LSOAs (lower super output areas) have populations of around 1,500 people

Map 1: Social deprivation by LSOA, showing wards
Children with Additional Needs

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.

Nationally, the number of children with disability has increased, in part due to increased survival of premature babies with complex health problems. In MK, 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.

Number of Children with Disability in MK
There is no single data source that includes all children with disability in MK. Based on national data, there are an estimated 4,900 children aged 0-18 years with disability, as defined by the Equality Act 2010. This is expected to increase as MK is a rapidly growing city. Current knowledge on the needs of children disability in MK from local service data shows approximately

- 5,800 children with SEN, 1,300 with statements of Special Educational Need (SEN) or Education Health Care (EHC) plans
- and 700 children attending special schools
- 260 children have profound, complex or multiple physical or learning disability needing the input of a social worker

- Approximately 60 children have the highest levels of complex health needs

There are a range of needs which are included within the description of special education needs and disability. These include complex medical, emotional and behavioural needs. These are often interlinked and it is vitally important that all service providers supporting children with these needs work in an integrated child-centred way.

Table 1 Placement of children with statements of SEN or EHC plans for England and Milton Keynes

<table>
<thead>
<tr>
<th>Placement</th>
<th>% of MK pupils with statements / EHC plans</th>
<th>% of England pupils with statements / EHC plans</th>
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<tr>
<td>Academies</td>
<td>13.5</td>
<td>15.9</td>
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<tr>
<td>Maintained mainstream school</td>
<td>21.6</td>
<td>29.3</td>
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<tr>
<td>Resourced provision / SEN unit in maintained mainstream school</td>
<td>9.2</td>
<td>5.5</td>
</tr>
<tr>
<td>Maintained special school</td>
<td>46.7</td>
<td>34.5</td>
</tr>
<tr>
<td>Special academies</td>
<td>4</td>
<td>5.7</td>
</tr>
<tr>
<td>Non maintained / independent special schools and other independent schools</td>
<td>2.5</td>
<td>6.5</td>
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Source: DfE data Jan 2015NB, columns do not add up to 100% as provision types with very low % are not shown.

In 2015 in Milton Keynes Table 4 shows that the difference in the proportion of pupils attending special schools between MK and England is even greater for pupils with statements of SEN or EHC plans.
The proportion of pupils with statements of SEN or EHC plans, both in MK and nationally, has been stable at about 3% for over five years. However, due to rapid growth in MK, this translates to a considerable increase in the number of pupils with statements of SEN or EHC plans in MK, as can be seen in the graph below (figure 3). Between 2013 and 2015, there was an increase in the number of pupils with statements or plans in MK of 7.4%. Future growth is expected and will need to be reflected in service capacity.

![Graph showing increase in number of children with statements of SEN or EHC plans in MK by year]

Figure 1: Number of children with statements of SEN or EHC Plans in MK by year

Source: Extracts from Draft Children with Disability in MK Health Needs Assessment Author Dr Samantha Gale Public Health Specialty Registrar August 2016 for full document see DRAFT SEND HNA Author Dr Sam Gale L:\Public Health\health improvement\Children & Young People\Liz Wilson\0-19 HCP development\SEND\Draft SEND HNA 2016.docx

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.

Some of these children are eligible for provision of a ‘continuing care’ package as their needs cannot be met by the universal or local specialist services. Decisions about care packages are made following an assessment using the ‘National Framework for Children and Young Peoples Continuing Care’ (2016). Care packages can be provided through a framework of approved providers, which was developed in response to families wanting more choice about how their care was delivered, or through the provision of a personal health budget.

Key agencies contribute to the costs of care for children with a continuing care packages, depending on identified individual need. To illustrate this Milton Keynes CCG contributed to the continuing care packages of 8 children with physical disability, 5 child with significant learning disability, 4 children with significant mental health difficulties (see mental health and emotional wellbeing section of this needs analysis) in Milton Keynes in 2015.

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 MK has no local provision. The reason for an out of area placements usually relates to the intensity and complexity of need which isn’t able to be met locally.
Safeguarding
Milton Keynes Council has a duty to safeguard children as set out in the Children’s Act (1989 & 2004). All agencies working with children are required to meet the requirements of the statutory guidance called Working Together to Safeguard Children (2015).

Excerpts from Children’s Services Progress Check May 2016 state ‘In Milton Keynes we work to a well-established model of intervention that sets out four levels of needs; universal, additional, considerable and specialist. All partners on the Milton Keynes Safeguarding Children’s Board (MKSCB) are signed up to the model. The MKSCB Levels of Need Document has recently been reviewed and was re-approved by the MKSCB on 30th September 2015’.

Universal Services, Early Help, Children and Family Practices, Multi agency safeguarding hub (MASH) are a crucial part of this process.

- During 2015/16 246 children and their families took part in a family group conference. Of these 203 (82.5%) children were able to remain with their initial carers or are living with family or friends.
- As a result of the family support approach, we have a low number of children subject to formal child protection plans compared to all other local authorities. 92 children per 10,000 compared to national comparator rates of around 42.1 per 10,000 (published England Average 2013/14). The majority of child protection plans are as a result of neglect. In March 2016 the percentage of children subject to a child protection plan because of neglect was 80.4%.
- Child protection consultations provide practitioners with the opportunity to seek advice from a Child Protection Coordinator, independent of the case. Actual decision-making lies with the responsible Team Manager.
- During 2015/16, a total of 127 child protection consultations took place, involving 271 children. 53.4% of consultations progressed to Initial Child Protection Conference. This represented an increase in activity. In comparison during 2014/15 a total of 94 child protection consultations took place, involving 206 children.
- Our well established family assessment and support team (FAST) provides intensive support to children and families that are open to Children’s Social Care. The FAST service also includes Primary Mental Health Workers (PMHW).
- Missing Children. Nationally, approximately 100,000 children go missing from their homes or placements each year. Around a quarter of this total are considered to be at serious harm or abuse. A total of 608 children in care (518) or were care leavers (90) during 15/16. Of these, 88 children went missing or were absent from their placement during the year on 425 separate occasions. However, on most occasions (337) they were returned quickly on the same day. 87 episodes, involving 34 young people lasted over 24 hours.
- Child Sexual Exploitation (CSE) has been a priority for us and our MKSCB partners since Oct 2012. A baseline audit was undertaken in 2013 to enable MKSCB fully to understand what information and intelligence partner agencies held regarding CSE in Milton Keynes.
- Multi agency risk management meetings (MARMM) are held monthly. To April 2016, 135 children have been considered at a MARMM meeting.
- **Female genital mutilation (FGM)** An FGM screening tool is used in Milton Keynes. Between January and May 2016 the monthly FGM panel has reviewed 41 screening tools.

- **Healthy Relationships project - Domestic Violence intervention** By the end of April 2016 there had been 113 referrals to the programme.

Extracts from Children’s Services Progress Check Document May 2016, for full document please see L:\Public Health\health improvement\Children & Young People\Liz Wilson\0-19 HCP development\Childrens services progress check - Update May 2016_final.pdf

**Specialist Services**

A range of services are commissioned to provide support for children with additional needs including.

**Occupational Therapy (CCG & LA)**
The CCG commissions CNWL to provide a Children’s Occupational Therapy service to enable children and young people to reach optimal functioning within the community setting. The provider achieves this by offering assessment and practical advice; targeted and specialist interventions; identification and management of functional difficulties; recommendation of equipment and adaptations.

Milton Keynes Council commission CNWL to provide occupational health assessment and support for children and young people who have a need specified within their care plan.

**Physiotherapy**
The CCG commissions MKUHFT to provide a range of physiotherapy services to children and young people in the community and in hospital to meet a range of needs. In addition dedicated provision is provided for children attending Redway special school to ensure that children and families have access to consistent support to meet their health and educational therapy needs.

**Speech and Language Therapy – SALT (Schools, LA & CCG)**
The CCG commissions CNWL to provide a Speech and Language Therapy service for all children with speech, language, communication and dysphagia (developmental or acquired eating and drinking difficulties) through provision of specialist assessment and responsive, evidence-based interventions.

Milton Keynes Council commission CNWL to provide speech and language services for children and young people who have a need specified within their Statement or Education, Health and Care plan (EHC).

**Community Paediatric Services**
The CCG commissions CNWL to provide a community paediatric service which undertake a range of assessments and clinical interventions for

- Child Development/Childhood Disability
- Complex Condition Management associated with inherited intellectual impairment
- Complex Neurodevelopmental disabilities; and

And assessment for social communication disorders and Autism Spectrum Disorder.

**Acute Paediatrics**
MKUHFT provides arrange of in-patient and outpatient services to meet a range of acute and long term conditions for children and young people.
**Hospital Community Paediatric Nursing**
The CCG commissions MKUHFT to provide a children’s community nursing service to support neonates, children and young people who have required hospital admission or treatment to enable babies and children to be discharged home as early as possible and prevent readmission to hospital.

**Children with Complex Needs team**
The CCG commissions CNWL to provide a community nurse led service that provides assessment, care, case management and the provision of supplies to children with complex health needs within the Milton Keynes area. This includes assessment of healthcare / nursing needs carried out by a qualified paediatric nurse; training of parents/carers and staff in education and other settings i.e. short break / respite provisions to carry out clinical procedures; supervision and training of primary carers and education staff through an agreed competency framework to deliver the specific care needs of children with continuing care needs; and providing of end of life care.

**Health of Children in Care, Looked After Children (LAC)**
The Health of Children in Care Draft Annual Report 2015/16 states, ‘The vulnerability of children and young people in the care system is widely recognised 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.

The LAC health team continues to ensure the delivery of high quality health assessments through the weekly quality assurance meeting, service audits, supervisions/peer review and training. The plan in the coming year is to introduce a staged quality assurance with individual practitioner taking responsibility and completing stage1 of the quality assurance process.

- **Children In Care (CIC) - National Statistics:** (Department of Education National Statistics 2016) The number of children in care has steadily increased over the past 7 years and is now higher than at any point since 1985. As of 31st March 2015 there were 69,540 children in the care of local authorities in England compared to a figure of 68,800 in 2014. Looking at figures over the last 5 years there has been an increase of 5,140 (7.4%).

- **Children In Care- Milton Keynes Statistics:** (Statistics supplied by Performance Management Team Children’s Social Care) There were 523 children in the care of Milton Keynes Local Authority at some point in the period in comparison to last year’s figure of 471. This indicates a significant increase of 52 cases (10 %) and an increase of 18% (96) cases since 2012. This figure fluctuates month by month as children and young people come into care but then may leave depending on individual need and circumstance.

- **The number of children continuously looked after by Milton Keynes Children’s Social Care for 12 months or on 31/3/16:** Total 220: This figure indicates a relatively stable picture of children continuously looked after by comparison to last year’s figure of 221.

- **The number of children in the care of Milton Keynes Local Authority as on 31st March 2016:** Total: 345. Data shows that number of children coming into care continues to rise. In the past decade this would amount to a 35.59% increase. This has been due to a combination of factors including serious case reviews
from high profile cases and the continued and rapid growth and diversity of the population locally (Strategy for Children in Care 2013-2016).

- However compared to national data and our statistical neighbours, the number of children in care is below average although slightly higher than the average in the south East.

- **Rates of Children In Care:**

  Graph 1: Numbers and Rates of Children In Care Captured (2007-2016)

**Graph 1** shows that the rate per 10,000 children and young people in the care of Milton Keynes Local Authority (age 0-17) has begun to rise above the current recorded rate 2014/2015 for South East England. It remains below current recorded figures for our Statistical Neighbours and England. **NB:** The statistics for England, South East and our Statistical Neighbours have yet to be reported on for 2015/2016.

**Looked After Children Assessment**

The CCG commissions CNWL to provide initial and review health assessments and develop care plans for looked after children and as set
out in Promoting the Health and Well-being of Looked After Children (DoE / DoH 2015).

Young People seeking Asylum: Young people seeking asylum with MK-CSC this reporting year has been relatively stable (31-34). The male/female ratio was 9:1. Young people assessed have been in need of varying levels of health care support. Of these 34, 3 young people have actively gone missing during the assessment process and 4 were assessed as over 18 years of age.

“[Section 22G of the Children Act 1989] requires local authorities to take steps that secure, so far as reasonably practicable, sufficient accommodation within the authority’s area which meets the needs of children that the local authority are looking after, and whose circumstances are such that it would be consistent with their welfare for them to be provided with accommodation that is in the local authority’s area (‘the sufficiency duty’)…”

Strengthening Families
The national Troubled Families Programme commenced in 2012. In April 2015 the programme was expanded to include a wider range of issues families experience. Milton Keynes have committed to working with 1600 families during phase two programme (which runs until March 2020). The criteria for the current programme is:
1. Parents and children involved in crime or antisocial behaviour.
2. Children who have not been attending school regularly.
3. Children who need help: children of all ages, who need help, are identified as in need or are subject to a Child Protection Plan.
4. Adults out of work or at risk of financial exclusion or young people at risk of worklessness.
5. Families affected by domestic violence and abuse.
6. Parents and children with a range of health problems.

In order to be eligible for the programme, families must meet at least two of the above headline criteria and consent is sort from all families. The programme adopts a whole family approach, taking into account the needs of all family members.

Homelessness
Family homelessness can mean living in poor quality temporary accommodation that is detrimental to health and wellbeing.
- A study conducted by the homeless charity Shelter found children were frightened, insecure or worried about the future as a result of being homeless.
- A Shelter survey found that homeless children missed an average of 55 school days a year due to the disruption of moving into or between temporary accommodation. A third of parents responded that their children had problems at school, and almost half described their children as ‘often unhappy or depressed’.
- A study undertaken in Birmingham found that 40% of the homeless children in the study were still suffering mental and developmental problems one year after being rehoused.

The family homelessness figure measures statutory homeless households with dependent children or pregnant women per 1000 households.

In Milton Keynes
- The rate of family homelessness in 2013/14 was 3.6 (per 1000) which equates to 364 families.
- The number and rate of family homelessness in Milton Keynes has increased over recent years and is currently higher than the national average.
• In 2012/13 the rate was 2.9 (per 1000) which equates to 296 families whereas in 2007/08 the rate was just 0.6 (per 1000) equating to 55 families.

• During the same period the national average has remained reasonably consistent ranging from 1.9 (per 1000) in 2007/08 to 1.7 (per 1000) in 2013/14.

• The view of the Milton Keynes Council Housing & Community Team is that the most common cause of homelessness across the country over the previous five years, and of which Milton Keynes is of no exception, is the ending of private sector tenancies. On a local level, lower income bracket households are less able to afford the rents and where previously a private landlord has been willing to rent to Housing Benefit recipients, they are able to command a higher rent affordable to only those whom are in employment.

• 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.

• Homelessness is now identified as a priority in the Council Plan for 2016/20 and the draft Homelessness (Statutory Need) Strategy, arising from the work of the Task & Finish Group, has been agreed for consultation.
The Health of Local Children and Young People

Children’s health and wellbeing matters and there is a strong evidence base for a life course approach. We know that what happens to and around a child during pregnancy, through the early years and school age, and into adulthood, has implications on their health and wellbeing both now and in the future.

Significance of early life events

- Pregnancy is the very start of child development. Unhealthy choices and exposure to maternal stress can impact on future child health.
- Children's brains go through rapid growth during two key phases: birth to two years and adolescence - key elements of development, particularly emotional development, continue until the early 20s.
- The foundations for lifelong obesity, smoking, substance misuse, sexual health and mental health are established in childhood and adolescence.
- Adverse events (e.g. growing up with a depressed parent or domestic violence) during childhood have been associated with poorer outcomes including higher rates of substance misuse, imprisonment, mental health problems, heart disease, obesity and unemployment.

(Chief Medical Officer, 2013)

How Do We Compare?

Health and wellbeing of children in Milton Keynes shows a mixed picture which is similar to the national average. The infant (under 1 year old) mortality rate is significantly worse than both England and the South East regional figures and the child mortality rate (1-17 years) is higher than both England and the South East region average, and are therefore of concern.

Milton Keynes is performing better than the national average in some indicators, such as MMR vaccination levels and children in care immunisations, children under 16 in poverty, hospital admissions for dental carries (1-4 year), children in care, children killed or seriously injured in road traffic accidents, teenage mothers, A&E attendances in 0-4 year olds, and hospital admissions due to injuries and alcohol specific conditions.

Some indicators are similar to the national average such as childhood obesity, low weight of term babies, children achieving a good level of development at the end of reception, first time entrants to the youth justice system, smoking status at time of delivery, and hospital admissions as a result of self-harm and substance misuse.

Some indicators are worse than the national average, particularly those relating to mortality rates, hospital admissions due to preventable and manageable conditions, and outcomes related to education. Table 1 overleaf shows all those indicators in which Milton Keynes is performing worse than the England average. Three of these are coloured red as they are significantly worse than the England average. Four indicators are coloured amber as although they are not significantly different from the
England average, they are worse than the England average. One of these, child mortality rate is close to the 25th percentile.

As can be seen in Table 1:

- For ‘infant mortality’ the number of deaths has risen compared to the previous period; the rate has increased to 5.4 deaths per 1,000, and is now RAG rated red. Milton Keynes is therefore performing significantly worse than the England average of 4.0 per 1,000 on this indicator.
- ‘Child mortality rate (1-17 years)’ has risen slightly from 12.1 per 100,000 in 2015, to a value of 12.8 per 100,000 in 2016. The rate for 2016 is higher than the England average of 12.0 per 100,000, and is therefore an indicator to be closely observed.
- Although the percentage of ‘GCSE’s achieved (5 A*-C including English and Maths)’ has risen from just 49.2% in 2015 to 54.1% in 2016, Milton Keynes is still sitting significantly worse than the England average of 57.3%, and is therefore flagged as red for the second consecutive year.
- Although ‘first time entrants to youth justice system’ has dropped to 423.6 per 100,000 in 2016, from 482.9 per 100,000 in 2015, Milton Keynes is still sitting in a less desirable position than the 2016 England average of 423.6 per 100,000.
- The number of ‘obese children (10-11 years)’ has seen an increase from 18.5% in 2015 to 19.4% in 2016. The 2016 England average is 19.1%, therefore Milton Keynes is currently performing worse than the England average.
- The number of ‘hospital admissions due to substance misuse (15-24yrs)’ has risen from 78.2 per 100,000 in 2015 to 92.0 per 100,000 in 2016. Milton Keynes is performing worse than the 2016 England average of 88.8 per 100,000 for this indicator.
- ‘Hospital admissions for asthma (under 19 years)’ is flagged red when compared to the 2016 England average as the Milton Keynes value is significantly higher than the England average, for the second year running. The Milton Keynes rate has increased from 233.8 per 10,000 in 2015, to 272.6 per 10,000 in 2016, and is therefore significantly higher than the 2016 England average of 216.1 per 10,000.

<table>
<thead>
<tr>
<th>Number</th>
<th>Indicator</th>
<th>Type</th>
<th>Time Period</th>
<th>MK Number</th>
<th>MK Value</th>
<th>England Average</th>
<th>England Worst</th>
<th>England Best</th>
<th>Trend 2011-2016 profiles</th>
<th>Milton Keynes Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Infant mortality</td>
<td>per 1,000 live births</td>
<td>2012-2014</td>
<td>21</td>
<td>5.4</td>
<td>4.0</td>
<td>7.2</td>
<td>1.6</td>
<td></td>
<td>MK: 5.4</td>
</tr>
<tr>
<td>2</td>
<td>Child mortality rate (1-17 years)</td>
<td>DSR per 100,000</td>
<td>2012-2014</td>
<td>8</td>
<td>12.8</td>
<td>12.0</td>
<td>19.3</td>
<td>5.0</td>
<td></td>
<td>MK: 12.8</td>
</tr>
<tr>
<td>7</td>
<td>GCSEs achieved (5 A*-C inc. English and maths)</td>
<td>%</td>
<td>2014</td>
<td>1,658</td>
<td>54.1</td>
<td>57.3</td>
<td>42.0</td>
<td>71.4</td>
<td></td>
<td>MK: 54.1</td>
</tr>
<tr>
<td>10</td>
<td>First time entrants to the youth justice system</td>
<td>per 100,000</td>
<td>2014</td>
<td>107</td>
<td>423.6</td>
<td>409.1</td>
<td>808.6</td>
<td>132.9</td>
<td></td>
<td>MK: 423.6</td>
</tr>
<tr>
<td>17</td>
<td>Obese children (10-11 years)</td>
<td>%</td>
<td>2014/15</td>
<td>620</td>
<td>19.4</td>
<td>19.1</td>
<td>27.8</td>
<td>10.5</td>
<td></td>
<td>MK: 19.4</td>
</tr>
<tr>
<td>25</td>
<td>Hospital admissions due to substance misuse (15-24yrs)</td>
<td>per 100,000</td>
<td>2012/13-2014/15</td>
<td>25</td>
<td>92.0</td>
<td>88.8</td>
<td>278.2</td>
<td>24.7</td>
<td></td>
<td>MK: 278.2</td>
</tr>
<tr>
<td>30</td>
<td>Hospital admissions for asthma (under 19 years)</td>
<td>per 10,000</td>
<td>2014/15</td>
<td>186</td>
<td>272.6</td>
<td>216.1</td>
<td>553.2</td>
<td>73.4</td>
<td></td>
<td>MK: 216.1</td>
</tr>
</tbody>
</table>
### Aiming for Best

Although overall the health of children in Milton Keynes is as good as or better than the national average, this is not the full story. Another way of understanding health in Milton Keynes is to look for the best results in other parts of the country. This is important because it suggests what could be achieved locally and gives targets to aim for. For this reason in the rest of this section wherever possible we present Milton Keynes outcomes alongside both the national outcomes and the best results achieved anywhere in the country.

The ‘Count’ of children with different health related problems reveals there are still far too many who have poorer health outcomes than they could have.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Period</th>
<th>Milton Keynes</th>
<th>Best of Milton Keynes</th>
<th>England average</th>
<th>Best in England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Count</td>
<td>Value</td>
<td>CIPFA nearest neighbours (value)</td>
<td>(value)</td>
</tr>
<tr>
<td>Infant mortality (per 1,000 live births)</td>
<td>2012-14</td>
<td>62</td>
<td>5.4</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Child mortality rate (1-17 years) (per 100,000)</td>
<td>2012-14</td>
<td>25</td>
<td>12.8</td>
<td>7.9</td>
<td>12</td>
</tr>
<tr>
<td>GCSE's achieved (5 A*-C incl. English &amp; Maths) [%]</td>
<td>2014-15</td>
<td>1,658</td>
<td>54.10</td>
<td>68</td>
<td>57.30</td>
</tr>
<tr>
<td>First time entrants to youth justice system, 10-17 year olds receiving their first reprimand, warning or conviction (per 100,000 population)</td>
<td>2014</td>
<td>107</td>
<td>424</td>
<td>169</td>
<td>409</td>
</tr>
<tr>
<td>Reception: prevalence of overweight &amp; obesity among children (age 4-5) [%]</td>
<td>2014-15</td>
<td>825</td>
<td>22.00</td>
<td>19.3</td>
<td>21.9</td>
</tr>
<tr>
<td>Year 6: prevalence of overweight &amp; obesity among children (10-11 years) [%]</td>
<td>2014-15</td>
<td>1,084</td>
<td>33.9</td>
<td>27.3</td>
<td>33.2</td>
</tr>
<tr>
<td>Hospital admissions due to substance misuse (15-24 years) (per 100,000)</td>
<td>2012-13-2014/15</td>
<td>76</td>
<td>92</td>
<td>37.3</td>
<td>88.8</td>
</tr>
<tr>
<td>Hospital admissions for asthma (under 19 years) (per 100,000)</td>
<td>2014-15</td>
<td>186</td>
<td>272.6</td>
<td>85.4</td>
<td>216.1</td>
</tr>
<tr>
<td>15 year olds who currently smoke</td>
<td>2014</td>
<td>-</td>
<td>9.6</td>
<td>4.7</td>
<td>8.2</td>
</tr>
</tbody>
</table>

---

4 Calculated from Milton Keynes Child Health Profile 2015, unless otherwise indicated (http://fingertips.phe.org.uk/profile/child-health-profiles/data#page/1/gid/1938132948/par/6/par/E12000008/ati/102/are/E06000042 )

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th></th>
<th>2015</th>
<th></th>
<th>2011-12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children with special educational needs or disability (Jan 2016) (%)</td>
<td></td>
<td>4,986</td>
<td>10.7</td>
<td>8.7</td>
<td>11.6</td>
</tr>
<tr>
<td>No. of Troubled Families worked with &amp; turned around (%)</td>
<td></td>
<td>401</td>
<td>94.35</td>
<td>100</td>
<td>98.9</td>
</tr>
<tr>
<td>Children aged 5 have one or more decayed, missing or filled teeth (%)</td>
<td></td>
<td>-</td>
<td>25.1</td>
<td>19.2</td>
<td>27.9</td>
</tr>
</tbody>
</table>

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**High Impact pathways**

The following 6 pathways have been identified as having the highest impact on child health outcomes. Full and effective delivery of the Healthy Child Programme is recommended to achieve the best outcomes.

**Transition to Parenthood and the Early Weeks**
The transition to parenthood and the early weeks of being a parent are recognised as crucial and have an impact far into the rest of the child’s life. This is also a good opportunity for effective intervention by health services as parents are particularly receptive to messages in this period. Contact during the antenatal period and early weeks can be used to inform the level and type of support needed later including for safeguarding concerns, potential and actual mental health issues, domestic violence and abuse and alcohol and drug issues. Specific groups receive additional support such as children with disability or special needs, children in care or families troubled by criminal justice or employment problems. These are described later in this section.

**Maternal Mental Health (Perinatal Mental Health)**
Maternal mental health is a key determinant of the health of children. Local numbers of women suffering from mental health problems can be approximated from national estimates derived from epidemiological studies. Table 4 shows these estimates. Although the numbers for the more severe problems are small, as the impact on both mother and child is potentially severe this still represents a significant health burden.

**Table 4: Maternal Mental Health**

<table>
<thead>
<tr>
<th>Estimated number of women affected in Milton Keynes/ year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Postpartum or Puerperal psychosis</td>
</tr>
<tr>
<td>&lt;10</td>
</tr>
<tr>
<td>Chronic serious mental illness</td>
</tr>
<tr>
<td>&lt;10</td>
</tr>
<tr>
<td>Severe depressive illness</td>
</tr>
<tr>
<td>110</td>
</tr>
<tr>
<td>Mild-moderate depressive illness and anxiety states</td>
</tr>
<tr>
<td>350-550</td>
</tr>
<tr>
<td>Post-traumatic stress disorder</td>
</tr>
<tr>
<td>110</td>
</tr>
<tr>
<td>Adjustment disorders and distress</td>
</tr>
<tr>
<td>550-1100</td>
</tr>
</tbody>
</table>


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10 Department of Health (2014) Overview of the Six Early Years High Impact Areas
Breastfeeding

NB Local un-validated data
In Milton Keynes Hospital 74.8% of mothers start breastfeeding Local Provider reported data 2015. This is better than the NHS recorded national average of 74.3% 2015/16.

In England breastfeeding initiation ranges from 35.1% to 92.4% NHS England local provider reported data 2015/16. 50.3% of mothers are still breastfeeding at 6-8 weeks after birth. This is above the England Average Quarterly Data of 43.8%.

Milton Keynes is far below the best levels nationally which are 92.9% for breastfeeding initiation and 81.5% for breastfeeding at 6-8 weeks (2015/16).

Higher breastfeeding levels would be expected to result in decreased rates of gastroenteritis, respiratory disease and childhood obesity, as well as decreased levels of maternal breast cancer.

Healthy Weight, Healthy Nutrition

22.0% of children aged 4-5 years old were overweight or obese in the 2014/15 school year. This does not differ significantly from the national average of 21.9%, but it somewhat worse than the prevalence of the best of Milton Keynes’ CIPFA nearest neighbours (19.3%).

Map 5 shows the Excess Weight prevalence in 4-5 year olds (average of 2011/12 to 2013/14 3 year aggregated data), at Ward level, to range from 15.3% to 29.7%.

33.9% of children aged 10-11 years old were overweight or obese in the 2014/15 school year. Again, this does not differ significantly from the national average of 33.2%, but Milton Keynes sits in worse position than the best of the CIPFA nearest neighbours (27.3%).

Map 6 shows the Excess Weight prevalence in 10-11 year olds (average of 2011/12 to 2013/14 3 year aggregated data), at Ward level, to range from 26.8% to 40.4%.

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

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11 Ward and MSOA obesity prevalence data - NCMP. 2011/12 to 2013/14
https://www.noo.org.uk/visualisation
12 http://fingertips.phe.org.uk/profile/national-child-measurement-programme/data#page/0/gid/8000011/pat/6/par/E12000008/ati/102/are/E06000042
Map 5: Proportion of Overweight and Obese Children in Reception year in Milton Keynes.

Map 6: Proportion of Overweight and Obese Children in Year 6 in Milton Keynes.
Managing Minor Illness and Reducing Accidents (Reducing Hospital Attendance/Admissions)⁴

Child Health Profile 2016 states:

- Seven children aged 0-14 were killed or seriously injured in road traffic accidents between 2012-2014 (12.1 local value) which is higher than England’s best of 5.5.
- There were 6,622 A&E attendances (0-4 years) in 2014/15. This represents a local value of 322.9 (per 1,000) for Milton Keynes. This is better than the national average but well above the best in the country where the rate is 263.6.
- 515 emergency hospital admissions caused by injuries in children (0-14 years) in 2014/15. This is a rate of 92.4 per 10,000 which is better than the national average but worse than the best area in the country which has a rate of 61.3

Success in lowering injuries and minor illness would not only reduce the burden of ill-health on children but would also reduce the amount of spending needed on health services such as A&E, thus freeing up funding for other services which can improve health.

Specific conditions that relate to the highest number of contacts for unscheduled care

- A& E – Those who are admitted to hospital for less than 24 hours which we define as a zero length of stay (ZLOS)
- Under 18 years PAU admissions of less than 24 hours (asthma, bronchiolitis, Pyrexia, D&V, ENT) - April – July 2015 = 332 & April – July 2016 = 315. Activity Change 15-16 = -17 (-5%)
- Activity Data 2013-16 MK Hospital attendances MK CCG patients 0 -18 years of age. In 2016/17 there was an 7.5% increase in 0-18 years A&E attendances compared to the previous year.
- A 1.5% increase was expected as a result of population growth. To date in 2016/17 there has been a 9% increase in 0-18 year A&E attendances compared to the previous year.

Health, Wellbeing and Development of the Child at Age 2 – Two year old review (integrated review) and support to be ‘ready for school’

Improvements in early years 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.

- Public Health England report that in 2015/16 100% of children across Milton Keynes have had a review using the ‘Ages & Stages Questionnaire (ASQ) 3 Tool’. This is significantly better than the national average of 81%.
- In partnership with Children’s Centres, Health Visitors are ensuring that those most vulnerable are accessing the review and, where necessary are linked into other early help support services. It is anticipated that a recent reorganisation of Children Centres and the development of Family Centres will help strengthen the relationship with Health Visitors and ensure that current levels of performance are maintained.
- 67% of children are reported as achieving a good level of development in the Early Years Foundation Stage in 2014/15. This compares reasonably favourably to the national average of 63.3%.

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¹³ Programme delivery assurance tool Q1 2015/2016 - health visiting
Key indicators of child health

Vaccinations
It is very important to achieve high levels of vaccination coverage over 95% as this protects the whole community, not just those vaccinated, by reducing the likelihood of infectious disease spreading through the community.

Measles, Mumps and Rubella vaccination is usually given in a combined vaccination once at 12-13 months old with a booster after age 3yrs 4 month. This is particularly important to monitor as measles can be fatal and there has over recent years been a public scare based on flawed scientific evidence. Local estimated uptake \([1]\) of the first dose is 95.9% which is better than the national average of 92.7%. However, there is still improvement needed to reach the best area in the country where uptake is 98.3% (2014-15). Local uptake for two doses before age 5 has been recorded at 91% which is better than the regional average of 86.8% and the England average of 88.6%. Milton Keynes has further improved its own performance by vaccinating 92.4% of its eligible children with two doses of preschool MMR vaccination by the end of December 2016.

For older girls Human Papilloma Virus vaccine has been introduced to reduce the risk of cervical cancer. In Milton Keynes 97.4% of the 12-13 year old girls have received first dose of HPV vaccination in the year 20914-15; and out of these 92.7% girls have completed two doses of the vaccination, uptake is better than the England average, but it remains below the best areas which achieve uptake of over 95%.\(^{[14]}\)

Dental Health
Good oral health is an important component of general health. Poor dental health can lead to difficulty with speaking due to loss of teeth, inability to enjoy foods, and worsening of quality of life due to pain, sensitivity and reduced self-esteem.

- The latest available survey data (2015)\(^{[1]}\) for children aged 5 shows a reduction in decay from 25.1% (2012) to 21.5% of children aged 5 who have one or more decayed, missing or filled teeth in Milton Keynes which is better than the national average of 24.7%. The best area of the country has a level of 14.1% (South Gloucestershire).
- A 2013 survey\(^{[15]}\) of younger children (age 3) showed that 3.7% had one or more decayed, missing or filled teeth in Milton Keynes similar to the national average of 3.07%. In the best areas of the country <1.8% of 3 year olds have one or more decayed, missing or filled teeth.

\(^{[14]}\) PHE Health Protection Profile/Tool: [http://fingertips.phe.org.uk/profile/health-protection/data](http://fingertips.phe.org.uk/profile/health-protection/data)

Mental Health

Parental mental health is one of the key factors in mothers with social and complex needs this includes substance misuse and domestic abuse – which often occur together and can significantly impact on the outcomes of the child. Parental mental health, during the perinatal period and beyond, has strong links with the infant’s health at birth and the child’s health, behavioural, emotional and learning outcomes.

One in ten children need support or treatment for mental health problems. This means that in a class of thirty school children, 3 will suffer with a mental disorder such as conduct disorders, anxiety, depression and hyperkinetic disorders (e.g. Attention Deficient Hyperactivity Disorder). Children with mental health problems are at greater risk of physical health problems, and are also more likely to smoke. 16

In Milton Keynes it is estimated17 that:
- 3,755 children aged 5-16 have a mental health disorder, with a higher number seen in the 11-16 year old age group and in boys.
- Amongst 16-19 year olds, a further 1,600 have a neurotic disorder.

CAMHS Tier 2 & 3: The prevalence of mental health problems in children and adolescents was last surveyed in 2004. This study estimated that:
- 9.6% children and young people aged between 5-16 years have a mental disorder
- 7.7% children aged 5-10 years have a mental disorder
- 11.5% young people aged between 11-16 years have a mental disorder


- This means in an average class of 30 schoolchildren, 3 will suffer from a diagnosable mental health disorder
- The most common diagnostic categories were conduct disorders, anxiety, depression and hyperkinetic disorders (1)

Source: Overview of Camhs Tier 2 2015 – 16

Between September 2014 and June 2015 Milton Keynes Clinical Commissioning Group (CCG) in partnership with Milton Keynes Council (MKC) undertook a significant review of mental health and emotional wellbeing services in Milton Keynes for children and young people.

This review took in views from a range of organisations and stakeholders, as well as feedback from over 320 young people, carers and parents. The review also compared the current services against regional and national standards.

The review covered a catchment population of 64,200 of 0-19 year olds and looked at the support provided to children, young people and their families with a wide range of mental health and emotional needs. This ranged from those who need simple advice and guidance to those who need more long term intensive care.

There are five key themes that have emerged from the local review that have direct synergy with findings from the national Children and Young People’s Mental Health and Wellbeing Taskforce:
- Children and Young People need to be at the heart of what we do
- A whole system/whole family approach will provide a more resilient and sustainable model
- Early intervention - providing support early will increase resilience and prevent escalation of difficulties
• Our most vulnerable children and those who work with them should have access to specialist support and advice as and when required
• A need to develop the skill and competency of the wider children’s workforce.


Risky Behaviours and Protecting Health

Adolescence is a significant time when new health behaviours are initiated that can continue into adult life and contribute to ill health.

Smoking

In Milton Keynes, Tobacco remains the main cause of preventable morbidity and premature death in England and Bedford Borough. Beyond the well-recognised effects on health, tobacco also plays a role in perpetuating poverty, deprivation and health inequalities.

Smoking and Young People

• It is estimated that each year around 207,000 children in the UK start smoking. Among adult smokers, about two-thirds report that they took up smoking before the age of 18 and over 80% before the age of 20.2 The 2011 General Lifestyle Survey of adult smokers revealed that almost two-fifths (40%) had started smoking regularly before the age of 16.

Young people smoking and prevention

In 2010 a national survey carried out for the NHS Information Centre of 7,296 pupils from 246 schools in England, found that 27% of pupils had tried smoking at least once. The proportion of pupils who had ever smoked was 53% in 1982, and the proportion continues to decline. (NHS Information Centre, 2010)
• Nationally in 2010, 12% of 15 year-olds stated that they were regular smokers with girls being more likely to smoke than boys. 5% of pupils (age 11 to 15) reported being regular smokers (at least once a week). However prevalence of regular smoking increased with age: from 0.5% of pupils aged 11 years old to 12% of 15 year-olds with girls being more likely to smoke than boys
• Those young people who do experiment run the risk of addiction and of becoming long term smokers. The earlier young people become regular smokers, the greater their risk of developing lung cancer or heart disease if they continue smoking into adulthood (NHS Information Centre, 2010).

The 2010 survey also suggests a range of factors associated with a young person who begins to smoke:
• Sex and age: Once other factors were controlled for, the girls were more likely than boys to be regular smokers (odds
Age was also associated with regular smoking; with each additional year of age, the odds of a pupil becoming a regular smoker increased by 1.65 times.

- Children who are looked after have very high rates of smoking. These young people have very high rates of smoking. Data from England in 2003 show that one in three (32%) looked after young people, aged 11 to 17 were current smokers. Seven in every 10 (69%) children in residential care were smokers, compared with just over one in five of those in foster care (22%). The study reported that these children began to smoke very young – nearly one in three (32%) had started smoking at age 10 or younger (BMA, 2007) for more information on this survey and for full review.

**Teenagers smoking in pregnancy**

- In the Infant Feeding Survey (2005) early results showed teenage mothers were the only age group where smoking rates in pregnancy increased between 2000 and 2005. In 2005, 45 per cent of teenage mothers smoked throughout their pregnancy, showing a five percentage point increase between 2000 and 2005.

- Lone parenthood, poor education, young age and low socio economic status all increase the risk of maternal smoking. The 2004 Families and Children Study showed that half of lone mothers smoked.

**Smoking in Pregnancy**

- Since June 2014 there has been a gradual increase in the number of referrals we receive from midwifery. Before this date no formal referral system was in place and there had been a breakdown in communication between midwifery and PH since the previous Stop Smoking service was disbanded.

Source: Milton Keynes Stopping Smoking Service Recommendations please see Appendix.

**Drugs and Alcohol**

Young people’s substance use is a distinct problem. The majority of young people do not use drugs and of those that do, most are not dependent. However, substance misuse can have a major impact on young people’s education, health, their families and their long-term life chances. Cannabis and alcohol are the most common substances used by young people, although evidence has emerged that young people are also taking new psychoactive substances (NPS), also known as ‘legal highs’ instead of or as well as other drugs.

In 2013, a health related behaviour survey was carried out in five Milton Keynes secondary schools with 1300 pupils in years 8 and 10. 4% of pupils said that they 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, 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 old’s 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.
• In MK, hospital admission rates due to alcohol specific conditions is 15.6 per 100,000 compared to a national average of 36.6 per 100,000 (2012/13 – 2014/15)
• Hospital admission rates due to substance misuse is 92 per 100,000, similar to the national average of 88.8 per 100,000 (2012/13 – 2014/15).

Parental substance misuse and the impact on children
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 MK in 2015/16, 108 adults accessing specialist drug treatment had at least one child living with them, equating to 22% of the drug treatment population. 49 adults accessing specialist alcohol treatment had at least one child living with them (45% of the alcohol treatment population.

In MK, parental drug and alcohol misuse along with domestic abuse and parental mental ill-health make up ‘the toxic trio’ of 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 issue in 27% of child protection conferences. Ref 1 Public Health England Child Health Profile 2015

Sexual Health
Chlamydia in young people As young people become sexually active they are at risk of acquiring a number of sexually transmitted infections, the most common being chlamydia. Chlamydia as well as being one of the most common sexually transmitted infections in the UK often has no symptoms and if left untreated, 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, the number of young people screened in 2015 was 27.3%, higher than the England rate of 22.5%. The rate of detection was also one of the best in the region - 2514 out of every 100,000 (the England average was 1887)

Other STI’s in Young people
There are a number of other STI’s that affect young people the most common being gonorrhoea, genital herpes and genital warts. In Milton Keynes during 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 815/100,000.

Teenage Pregnancy
Teenage pregnancy is a complex issue, affected by personal, social, economic and environmental factors. Under 18 conception data is used to monitor rates. It accounts for all conceptions that result in either a live birth or abortion.

In Milton Keynes:
• The under 18 conception rates decreased in Milton Keynes from 2014 - 2015. In 2013/14, the local value was 0.8 (actual number 30) and in 2014 the local value was 0.6 (actual number 19). This is less than England’s average which is 0-9, England’s best is 0

Further Information: A full range of indicators related to child health can be found in the Joint Strategic Needs Assessments for Milton Keynes

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Current Services and System

Services and Need

An overview of current services is shown in table below. These services are interdependent and have evolved gradually over time. The table also shows the current commissioners (e.g. Milton Keynes Clinical Commissioning Group or Public Health) in Milton Keynes. Not all the below services will be recommissioned in April 2018. Those that will be include the 0-19 Healthy Child Programme (Health Visiting and School Nurses) and specialist community health services.. There is an opportunity to jointly recommission some services including occupational therapy, physiotherapy and speech and language therapy.

Effective community health services can improve children’s health both at a population level through preventative screening and assessment programmes (e.g The Healthy Child Programme), as well as more targeted interventions and specialist referral services. Some services combine both a universal and targeted approach.
Health Services for Children and Young People
0-19 (25 years SEND) across Milton Keynes
Scope of Commissioning for Community Health Services

NHS TRUST PROVIDER(s)
MODEL

SPECIALIST
- Occupational Therapy (LA CNWL)
- Drug & Alcohol (LA Compass)
- Sexual Health (LA Brook)
- CAMHS T3 (CCG CNWL)
- Specialist Nursing DM (CCG MKUHFT)
- Specialist Nursing Epilepsy (CCG CNWL)
- Specialist Nursing Respiratory (CCG MKUHFT)
- Community Paeds Services (CCG CNWL)
- Children's Primary Care Team (CCG UCS)
- Safeguarding Medicals (CCG MKUHFT)

TARGETED
- Acute Paeds (CCG MKUHFT)
- Looked After Children Assessments (CCG MKUHFT)
- MASH provision (CCG CNWL)
- Designated Dr for CP (CCG)
- Physio for Redway children in the community (CCG MKUHFT)

LOCAL AUTHORITY
- Health Visiting (LA CNWL)
- School Nursing (LA via CCG Contract CNWL)
- General Practice (NHSE/CCG General Practice)
- Breastfeeding/Baby Friendly Initiative (LA CNWL)
- Immunisations and Vaccinations (NHSE)
- Smoking Cessation (LA Public Health LA)
- Dental/oral Health Promotion (LA CNWL)

KEY
- Current Commissioners shown in[]
- Not in Scope for recommissioning

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Evaluating the impact of the current system and services

The current system already has many of the desirable system characteristics, including a focus on early years and prevention and some integration. However this could be greatly strengthened and more explicitly designed into the services and system being commissioned. There are several ways to understand the strengths and weaknesses of the current child community health system.

Service Reviews

0-5 Health Visiting, Family Nurse Partnership and Oral Health

Overall Draft Recommendations from National and Local documents, Performance data, Staff, Service users and Stakeholders are below:
1. Develop a fully integrated 0-19 locality model with centralised functions such as admin etc
   - Look at skill mixes within staff teams
   - flexible hours, more flexible approaches when arranging to meet families
   - training and development opportunities such as resource unit, social prescribing, upskilling others include
   - Specialism roles supporting gaps in services by having specialism roles, role of HV Champion e.g. perinatal mental health act as a spear head for initiatives, antenatal support could be developed more instead of just home visiting
   - Look at what parts of the FNP model can be shared across e.g. relationships, responding to issues and concerns, help advice and support – timely

2. Include more collaborative integrated working with other professionals

3. Review and refresh Referral pathways
   - ensuring they are followed
   - review processes for Cross counties boundaries
   - define roles for professionals working with same families

4. Introduce and include more client service involvement, particularly fathers

5. Review current KPI's
   - think of innovative ways to capture information
   - working towards Government initiatives - can do more with families

6. Raising Awareness of the services and what is provided to families and professionals
   - include training
   - regular advice drop in
   - links with schools, more education sessions
   - what is available and how they can access and work collaboratively

7. To look into information technology issues to develop improved processes
   - for mobile working
   - for data collection
• and also to cascade health promotion information to families

**Baby Friendly Initiative**

• A contract variation for CNWL (Health Visiting service) is being explored from June 2016 - March 2018 to deliver BFI in the community

• Public Health outcomes that the service(s) contribute to: 2.02i - Breastfeeding - Breastfeeding initiation, 2.02ii - Breastfeeding - Breastfeeding prevalence at 6-8 weeks after birth

• Contract management arrangements: The quality and performance of the service will be monitored in line with Milton Keynes Council’s contract monitoring process.

• Service delivery arrangements are in place: Health Visiting will lead on Baby Friendly Initiative implementation and accreditation in Children’s Centres alongside their own service.

• Contractual performance indicators and targets in place

The BFI accreditation process has not started in Milton Keynes for Health Visiting and Children’s Centres. It is hoped that this will begin in July 2016

**School Nursing**

Where we are at now - June 2016 Review Refresh

• Extracted immunisations from School Nurse specification from Sept 2016

• Developed Service Level Agreements (Replacing Tiered model) to work with Schools to agree roles and responsibilities of SN and Schools, including Universal offer and any other activities agreed.

• Scoping workload and capacity (from imms extraction and some potential opt outs for extra activities from schools) with the view to prioritise community health drop ins for home schooled children and plan and provide some PSHE work

• Understand the implications for the School Nursing Service of population growth in Milton Keynes and the new schools and explore options to increase capacity if needed

• Monitoring and reporting process in place for active referrals to Sexual Health and Drugs and Alcohol services and other referrals from hearing and screening by including on System One template. Amended NCMP letter so that the letter states SN will automatically refer to the weight management service. Use the referral pathways and information available on HYP Network Webpages as soon as available and work to support knowledge and signposting to others for support when not applicable to school nursing service.

• Discuss and agree on CAMHS training and development needs

• School Nurse representation on panel of the Healthy Young People Award.

**WhyWeight**

This is a brand new service, initial recommendations are:

• WhyWeight deliver a school time obesity programme (STOP), which has currently been delivered in 9 primary schools to years 4, 5 & 6 across Milton Keynes.

• The flexibility of this programme highlights opportunities for future lifestyle services, with a focus on behaviour change and increasing emotional resilience across the 0-19 CYP pathway.

• Early years services for consideration incorporation into the pathway include HENRY and the WhyWeight Toddlers programme.

**HENRY**
To date HENRY delivery has not achieved the targets and outcomes required by the service level agreement.

There are a number of reasons why the required targets and outcomes have not been reached. Both Children’s Centre leadership and Public Health have been working to rectify these and new challenges as they present themselves. The restructure of Children’s Centres has led to issues around programme delivery due to changes in staffing and centres now operating in a cluster delivery model. Early in the SLA there were difficulties with facilitator training and having the adequate number of HENRY facilitators trained to deliver the programme which delayed HENRY delivery in 2014/2015.

HENRY delivery has been beset by a number of further difficulties in 2015/2016. The HENRY coordinator left post without warning in March 2015 and a replacement coordinator was not identified until September 2015. Local evaluation shows a positive impact on whole family lifestyle for families who have accessed the HENRY group programme across Milton Keynes.

A good working relationship is established between Public Health and Children’s Centres. A service improvement plan lead to key improvements in 2015/2016 and a revised service level agreement is in place for 2016/2017.

**Sexual Health**

- We should consider co-locating drugs and alcohol services, child and adolescent mental health services with sexual health services to enable young people to access a number of specialist services relating to their physical, sexual and emotional health in the same building.

- Consideration should be made to extend Saturday services and to reduce waiting times for walk in sessions.

- Some young people wished for more information in schools this could work with joint sessions in educational establishments with the young people’s drugs and alcohol team.

**Drugs and Alcohol**

- Consider joining up drugs and alcohol services with sexual health and emotional & mental health services into a ‘one-stop-shop’ model offering preventative, early and targeted interventions, with access to specialist support under the same roof. As part of this, consider digital resources such as CHAThealth to improve access to services.

- Co-location with other children and family services, such as CFP’s should continue.

- Partnerships with health services, in particular GP’s and school nursing services need to be strengthened and formalised.

- The reasons why non-white British young people do not access the service need exploring and addressing to ensure the service is genuinely accessible for all young people and their parents or carers.

- 18 years olds should remain with the young people’s service rather than transferring to the adult service (as assessed on a case by case basis).

- The service needs to be better promoted to parents and carers.

- Young people must be fully involved in the development and review of their care plans.
Support for schools needs to be reconsidered carefully as current provision is limited and patchy. This should include a consideration for bringing together drugs and alcohol education with sex and relationship education into a more holistic offer for schools.

Advice and support for parents and carers is limited and needs to be considered in future service models.

Future service provision should include family support and interventions.

**Stopping Smoking**

- Recommendations: Consideration of implementation of an evidenced based Schools Stop Smoking Programme such as that recommended by NICE Guidance PH23https://www.nice.org.uk/guidance/ph23/chapter/1-recommendations#recommendation-3-peer-led-interventions.
- Due to capacity issues in the Stop Smoking service training in schools to increase the number of staff able to support students in house and ensure students are aware of services available to them.
- Allocated budget for work with young people, separate to the service targets and objectives as they currently stand.
- Encourage engagement through HEY and HYP awards & network and promote schools signing up to be smoke free.
- Support schools to offer their own health stands and health awareness days and provide basic packages or display items on loan and access to relevant literature for young people.
- Provide updates with regards to legislation, policy changes and new developments or research in smoking/vaping.
- Encourage local people to make their homes and cars smoke free with the support of partners within local services.
- Continue to provide training and refresher sessions on Brief Interventions particularly to front line staff in health and education, ensuring that ‘every contact counts’.
- Look to find alternative access points to the service for local youngsters such as social media.
- Work alongside maternity to increase numbers of pregnant teenage smokers accessing the service and work with health visitors to keep support postnatal.

**Camhs**

The recommendations from the review informed the development of the Milton Keynes Children & Young People’s Mental Health & Wellbeing Local Transformation Plan. The nine key priority areas are:

- Improving our Community Eating Disorder Service
- Better care for children and young people with complex/challenging behaviour
- Better support and care for children who have a mental health crisis and need urgent care either in hospital or at home
- Better psychological support for children and young people with either complex physical care needs or social care needs
- Improving core skills and confidence to better support children and young people suffering from emotional difficulties
- Better access to specialist mental health care for children and young people
- Better care for mothers suffering either poor emotional or mental health around the time their baby is born
- Ensuring support for young people returning to Milton Keynes after receiving care elsewhere
• Early help for those suffering from Psychosis

Maternity
The recommendations from the review should be implemented, so locally we have:
• Undertaken a local gap analysis and recommendations have been developed in conjunction with Maternity:MK the local Maternity Services Liaison Committee
• A workshop to further review this analysis and develop a plan to progress the recommendations in Milton Keynes is planned for January 2017.
• Progressed the development of a regional maternity dashboard
• Are implementing the Saving Babies Lives Care Bundle
• Linked with other commissioners and providers across the local Sustainability and Transformation Plan (STP) footprint to enable clarification of our ‘local maternity system’
• Engaged with Thames Valley and East of England Clinical Networks to secure support and understand learning from pilot and early adopter sites.

Caring for Children Closer to Home
The CCG response has been to establish the Care for Children Closer to Home project to address many of the standards in facing the future for Child Health and address local need though delivery of the following work streams:

Deliver and evaluate the Children’s Primary Care Team pilot:
• By establishing a team of qualified paediatric nurses to support children in the community
Continuing to build confidence and capacity in Primary Care:
• By developing condition specific care pathways and by providing GP training and education
Continuing to build confidence in families:
• By continued delivery and evaluation of the parent training programme

Achieve cost savings associated with reduced admissions and Emergency Department activity

Health Outcomes
The health outcomes of children within Milton Keynes, as described above, are generally good and similar to the national average but remain well below the best in country. This health status will be due to a range of factors ranging from the economy, geography and urban design locally, to the strength of the education system and health services. This multifactorial complex interaction means it is hard to determine the impact of individual services. Where there is a clear strong relationship between an intervention and an outcome – for example vaccination preventing specific infections – then the health outcome can reasonably be attributed to these individual interventions and services.

User feedback
Service users and their families are a critical source of knowledge about current services and ideas for improving them. There is not currently a
unified transparent system of feedback which allows an assessment of the system as a whole.

Feedback from key stakeholders
Views of both the professionals working within the services and young people were sought to better understand the strengths and weaknesses of the current system. A summary of their feedback is shown in pages 41 and 42.

Measuring outcomes in the future system
Where services (such as those delivering the Healthy Child Programme) provide a more holistic service it will be necessary to use a combination of measures including:

- Process measures – to measure activity and progress
- Evidence of effectiveness of interventions (e.g. follow NICE Guidance)
- Shared outcome measures to consider impact on overall health
- User feedback (child and/or parent)
### Rethinking the future; working together to ensure that all Milton Keynes children have a healthy start in life

#### 7 July 2016 Stakeholder Engagement Session Themes

<table>
<thead>
<tr>
<th>Building on what's going well</th>
<th>Shaping the future...</th>
<th>Commitment to action and next steps</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Examples of best practice from a range of services and teams</td>
<td>• Working together to explore and shape different models of delivery</td>
<td>• Co-production - involve CYP and their families as early as possible</td>
</tr>
<tr>
<td>• Excellent partnership arrangements and many examples of integrated working</td>
<td>• Reducing fragmentation creating opportunities for integrated pathways and service delivery</td>
<td>• Develop a set of overarching key principles for all services to adopt</td>
</tr>
<tr>
<td>• Positive engagement with children, young people and their families'</td>
<td>• Working differently; realising the potential of on-line/social media</td>
<td>• Map existing services and understand gaps/duplication</td>
</tr>
<tr>
<td>• Creative marketing and branding of services</td>
<td>• Expanding approaches that have demonstrated they work</td>
<td>• Set up governance to oversee the process</td>
</tr>
<tr>
<td>• Key services working really well</td>
<td>• Improving information sharing and workforce development/training across the system</td>
<td>• Communications plan to outline process and disseminate information</td>
</tr>
</tbody>
</table>

S4 attendees from the following: MKC members, School Nursing, Health Visiting, Speech and Language, Pre-School Learning Alliance, Youth Faculty MKC, Q:Alliance, Family Centres MKC, Milton Keynes University Hospital, MKCCG, MK Dons, MKC Public Health and Children’s Commissioning, Healthwatch, CHWL leads, Oral Health, YIS - Youth Counselling, Family Nurse Partnership, Compass, Carers MK, Brook, British Pregnancy Advisory Service, Breastfeeding Café, MK College, Newport Pagnell Medical Centre, Why Weight, Keech, CAMHS & Youth Offending Team
Consultation with young people

Consultation with Children and Young People in Milton Keynes has been completed within the following recent pieces of work:

- School Nursing Review
- Children and Families access to Children’s Care Services, GP’s and A&E
- CAMHS review
- Children with Disabilities Health Needs Assessment as well as the mysaymk annual conference workshops held Jan 2016.

Children and young people have told us what they are looking for in a Child and Adolescent Mental Health Service...

- Choice and flexibility in how they get their care
- They want to know that they are not being judged and that it’s ok to ask for help
- They want help early...when they start having problems, they don’t want to wait until things get worse
- They want help from people who show they care and understand what they are feeling and thinking
- They want to be recognised as experts and be involved in shaping how services are delivered

Source: Overview of Camhs Tier 2 contract 2015-16

Children and Young People told us during the mysaymk conference 2016 that their views on the Health and Wellbeing Strategy were...

Mental Health

- Having specialist support for mental health readily available, looking at the whole picture/whole child, study time support example highlighted as good practice, other sessions to support low level mental health issues, more environments for children and young people to go to talk about problems support with self-esteem, confidence
- More awareness and support groups in schools needed for mental health issues, make children and adults more aware of signs of mental/physical illness with support for parents so they are enabled to support mental health issues in children
- Support for bullying

Education Personal Social and Health Education

- Fragmented service, Specialist services coming into schools preferred to schools teacher particularly around Sex Education
- Need more regular visits from these services, Schools need to take more seriously e.g. cancelled sessions, make sure they are happening and to break some taboos
- Talk to children about PHSE issues at a younger age. Positive relationship guidance and support

Obesity

- More information and guidance for families, Information and advice to schools on healthy school meals and pack lunches, out of school to improve exercise
- More advice and guidance on being underweight
- Look at the whole picture as to why someone is overweight/obese, Give healthy lifestyles advice on what you should do not what you shouldn’t
Homelessness
- Give homeless people more support, use existing housing, Make more shelters for people
- Help homeless health
- Help homeless youth

Special Educational Needs
- More support and training to support people with Special Educational Needs

Teenage Pregnancy
- More help and education

Environment and external influences
- More open spaces for older young people
- Cheaper options to enable healthier lifestyles, food, and physical activity
- Make fast food less accessible and regulate
- A&E - Children and Young People see everything, blood, the walk-ins have children’s areas
- Look at neglected and abused children and try to help and improve their lives
- Make opportunities to see what’s wrong
- Choices about your life

Additional Comments Made from my say MK:
- Liz Wilson
- Mysaymk
- Mysaymk Starting Life Well Conference What Young People Said 22nd Jan 2016.docx
### Evidence of Best Practice

#### What Makes An Effective System?

<table>
<thead>
<tr>
<th>Characteristics of an Effective Community Health System for Children and Young People</th>
<th>Evidence suggests that to achieve the highest possible level of children’s health an approach based on strengthening this whole system is needed. Commissioners of community health services for children need to work together with commissioners of education and social services to do this.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Focus on Early Years and Prevention</strong></td>
<td>Health in early life influences health across the life course so services and investment should be weighted towards giving children the best start in life.</td>
</tr>
<tr>
<td><strong>Integration</strong></td>
<td>This includes across health, social care and educational settings. It required development of a shared culture and shared learning.</td>
</tr>
<tr>
<td><strong>Family Centred</strong></td>
<td>The interaction between the health of everyone in the household means that to achieve the best health for children it is important for parental health problems be recognised and addressed and for the family to be considered as a whole.</td>
</tr>
<tr>
<td><strong>Flexible Design Based on User Needs</strong></td>
<td>The whole system needs to be shaped to be flexible around the needs of the child/young person and their families, for example by allowing access to anywhere in the system from everywhere in the system (‘no wrong door’ approach).</td>
</tr>
<tr>
<td><strong>Shared Outcomes</strong></td>
<td>An agreed set of shared outcomes will help with integration and allow better evaluation of progress. These should include information on distribution of outcomes (‘inequalities’) and not only averages for the whole population.</td>
</tr>
</tbody>
</table>

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For more details see Best Practice Evidence Review 2015 L:\Public Health\health_improvement\Children & Young People\Liz Wilson\0-19_HCP development\Best Practice Evidence Review 2015.docx
**Adverse Childhood Experiences (ACE)**

UCL INSTITUTE OF HEALTH EQUITY drafted the following document, ‘The Impact of Adverse Experiences in the Home on the Health of Children and Young People, and Inequalities in Prevalence and Effects.’

Their key messages are as follows:

**Key Messages – What are ACEs and why are they important?**

- ACEs, or adverse experiences, refer in this report to maltreatment (sexual, physical or emotional abuse; neglect) and household adversity (adult/s in the household with mental illness, substance abuse problems, or criminality; the presence of domestic violence or parental separation; or living in care), experienced from the ages of 0 to 18.
- CYP who are exposed to ACEs have an increased risk of negative health outcomes across the life course.
- At the most extreme, maltreatment can result in death or injury under the age of 18 – either at the hands of someone else or as a result of suicide or self-harm.
- ACEs are also related to premature mortality. In men, the risk of death before the age of 50 is 57% higher amongst those who experienced 2 or more ACEs compared to those who experienced none. In women, the risk is 80% higher.
- An increased risk of disease has also been found to be present amongst those who experienced ACEs. This includes heart disease, cancer, lung disease, liver disease, stroke, hypertension, diabetes, asthma, and arthritis.
- ACEs have a clear correlation with mental health outcomes across the life course. WHO estimates that 30% of adult mental illness in 21 countries could be attributed to ACEs.
- There are three potential pathways by which ACEs may impact on health:
  - An increase in health-harming behaviours such as substance or alcohol misuse, smoking, sexual risk behaviour, violence and criminality, or behaviours leading to obesity. For example, those who experienced 4 or more ACEs have an increased odds ratio of 10.88 for using heroin or crack cocaine.
  - An impact on the ‘social determinants of health’ – particularly evident is a negative impact on educational, employment and income outcomes – each of which have an impact on health.
  - An impact on genetic, epigenetic and neurological functioning.
- The costs of child maltreatment and household adversity are high. One estimate puts child maltreatment alone at £735 million a year.
- An English study has suggested that 11.9% of binge drinking, 13.6% of poor diet, 22.7% of smoking, 52% of violence perpetration, 58.7% of heroin/crack cocaine use, and 37.6% of unintended teenage pregnancy prevalence nationally could be attributed to ACEs, creating a clear need for prevention – for personal, societal, and economic reasons.
- Those who experience adverse conditions are more likely to be children of parents who themselves were exposed to ACEs. This intergenerational transmission of adversity increases inequalities.

Executive REACh research Summary April 2015 can be found [here](L:\Public\Health\0-19 HCP\ACE REACh Exec Summary Evaluation.pdf)
Social Sense Pilot

- Buckinghamshire Local Authority have commissioned Social Sense supporting key schools for three years (2015). [http://www.rudifferent.co.uk/about/](http://www.rudifferent.co.uk/about/)
- The R U Different? Programme first assesses current attitudes, perceptions and behaviours through an online baseline survey then aims to correct those misperceptions through a suite of fun, engaging and digital-focussed interventions.
- MKC PH & Children’s Commissioning team were involved in Social Sense’s presentation. There were plans for one pilot with 8 schools to replace the commissioned SHEU questionnaire.
- This was no viable at the time of commissioning, but the evidence base shows this approach encourages wide and positive engagement with Young people, families and their schools.

The Good Childhood Report 2016

- Recommendation 3 Local authorities across the UK should ensure that children have a voice in decision-making about their local areas.
- Evidence from this year’s report shows the major impact that children’s experiences of their local environments can have on their lives – with children’s experiences of safety in their local area, local facilities and local adults all having a significant impact on their well-being. Local authorities can do a great deal to deliver change for children in respect of their environment, but our evidence shows that this must start from the perspective of listening to children’s own voices about what matters to them about their local area.
- For this reason, we recommend that local authorities look at how they can better embed children and young people’s voices into local decision-making.

Such action should include:

- Developing a process, co-designed and co-chaired with young people locally, to allow children and young people to debate the issues affecting their lives and to assist in decision-making over setting priorities for the year ahead.
- Bringing people together at a neighbourhood level to improve children’s access to, and their perception of safety in, their local environment – including local parks and open spaces.
- Producing an annual children and young people’s local profile that brings together the range of data that is available on children’s lives in the area. This profile could be significantly enhanced by local work to measure children’s well-being in order to better understand what the key issues are affecting children’s lives, and what more could be done to address these issues.

Source: The full summary of report and recommendations can be found: [https://www.childrenssociety.org.uk/sites/default/files/pco90_summary_web.pdf](https://www.childrenssociety.org.uk/sites/default/files/pco90_summary_web.pdf)
Conclusions

- Children and Young people in more disadvantaged areas have poorer health outcomes and this does not need to be the case.
- A life course approach with a focus on the early years has the most impact.
- Full and effective delivery of the Healthy Child programme is key.
- Effective commissioning of community health services is an opportunity to contribute to improved health outcomes.
- There are gaps in local services that mean some families do not have access to parenting support.
- There is a need to focus more on getting feedback from users to influence service development.
- Commissioning and provision of services is fragmented and pathways between services are not always clear. There are great opportunities to integrate commissioning and delivery arrangements.
- Navigation into and around services is difficult and confusing for children, young people and families.
- Children, young people and families need better access to good quality information.
- The review identified a lack of understanding of the services provided and their impact of health outcomes.

Draft Outline Recommendations

1. Develop a fully integrated 0-19 locality model with centralised back office functions
2. Adopt a principle of Progressive Universalism so that services are able to help reduce inequalities in health
3. Make services easier to access and understand and ensure referral pathways are clear.
4. Develop better systems for client/service user feedback and involvement, particularly fathers
5. Develop expected outcomes for services and measures that ensure we know what the impact is
6. Use information technology to help ensure services work efficiently and are children and family friendly