Early Years Population Needs Assessment

Summary version

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This Population Needs Assessment was completed prior to the COVID-19 pandemic, and the data in this has not been updated since. It is the intention of the public health team that the data will be reviewed once business as usual resumes. However, it is unlikely that the recommendations would be materially changed, and in fact, the pandemic will probably have reinforced the need for these recommendations.

Introduction

This Early Years Population Needs Assessment has been undertaken to find out the needs of Bexley children and families from conception to 5 years of age. It seeks to provide a picture of with what we know and highlight areas where we need more information. It also seeks to inform development of the Early Years Strategy and work in the early years arena, form part of the children's Joint Strategic Needs Assessment (JSNA) and inform future commissioning of the Healthy Child Programme and other health and care services for this group.

We have aimed to answer the following question:

"What do Bexley children and families need from conception to 5 years of age to have the best start in life?"

To answer this question, this population needs assessment aims to provide an epidemiological overview of early years needs in Bexley, to evaluate the current provider landscape, to include views of local professionals and residents, to describe evidence-based models of good practice, and to identify opportunities to improve local provision to better meet the needs of the population.

Policy context

All work with children and families from conception to 5 years of age sits within a policy context, at both a national and local level. There are many policies and strategies that cover this period of the life course, the most prominent ones are included below.

National Policy Context:

- Health and Social Care Act (2012)
- The Childcare Act (2006)
- The Children and Families Act (2014)
- Early Years Foundation Stage (EYFS)
- Free Early Years Entitlement for 3- and 4-year olds
- Free Early Years Entitlement for 2-year olds
- Public Health Outcomes Framework (PHOF)
- Healthy Child Programme
- Better Births
- NHS Long Term Plan / 5 year forward view
- Childcare Act 2006
- Children and Families Act 2014
- Special Educational Needs and Disability (SEND) Code of Practice 2015, Sec 5
- Equality Act 2010
- Department for Education (DfE) plan for improving social mobility through education

Local Policy Context

- Joint Health and Wellbeing strategy (in development)
- Bexley System-wide Prevention Strategy: Start Well, Live Well and Age Well
- Connected Communities strategy

- Obesity strategy
- LBB Corporate Plan (to be refreshed in 2022)
- Children and Young people plan
- Bexley Family Wellbeing Strategy 2018-2020
- Bexley Special Educational Needs and Disability Strategy 2019-2023
- Bexley Transformation Plan for CYP Mental Health
- Children and Families Centre review
- Bexley Children and Family Centre Strategy (in development)
- Bexley Targeted Youth Service Strategy 2018-2021
- Early Years Peer Review: Social Mobility – October 2018

"In Bexley we want healthy, safe and resilient families, networks, communities that are safe for them so that they attain the skills they need at schools and colleges, growing up to be independent and productive. We want children and young people driving our local growth and engaging in the plans we make and the service we deliver"
- Bexley Shared Vision for children's services

"The vision of the System-wide Prevention Strategy is to create and maximise by 2025, the circumstances that enable Bexley residents to live longer and enjoy better health for more of their lives, and give our younger residents the best start in life and help them to achieve their full potential"
- Bexley System-wide Prevention Strategy

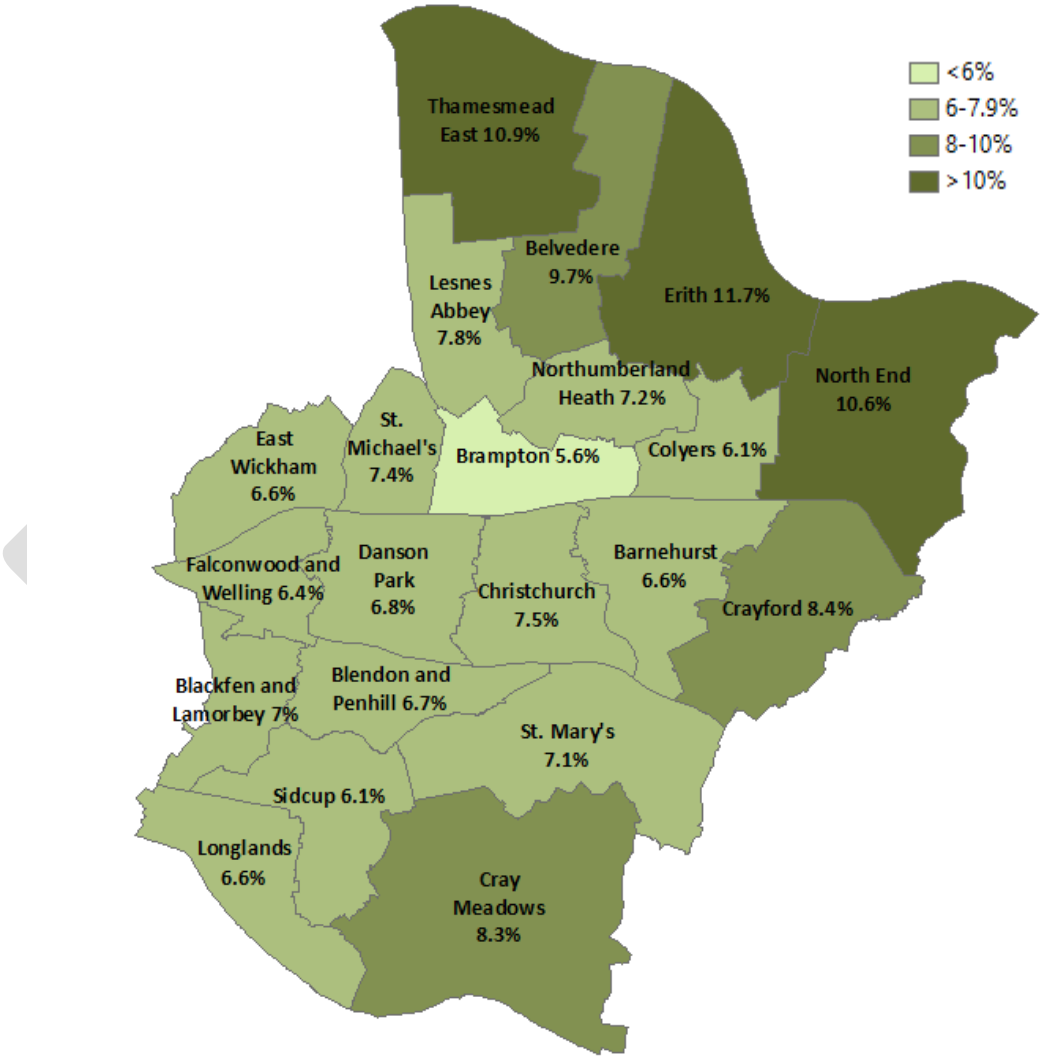
Key Findings

Below is a summary of the key findings of this population needs assessment. They include information on the demographics of this group, why the 0-5 period is so important, how we measure development, the effect that socio-economic status can have on development and health, and other factors which can impact upon health, wellbeing, and development such as family circumstances, parental health and child health conditions.

Demographics

Of the 250,578 people living in Bexley in 2019, an estimated 19,438 are children aged 0-5 years (7.8%). The figure below shows the variation of this percentage between wards – with higher proportions of children aged 0-5 years in the north of the borough (Erith is the highest at 11.7%), and lower proportions in the west and south west. Bexley's population is projected to increase to approximately 274,600 people by 2030, of which an estimated 19,840 will be children aged 0-5, an additional 400 children.

Figure 1: Proportion of ward population aged 0-5 years



Source: GLA 2016-based Demographic Projections :London Ward population projections Housing-led Model

Bexley had a general fertility rate[1] of 62.0 live births per 1,000 women aged 15 to 44 years in 2018, which is comparable to England (59.2) and London (60.1). There are around 3,000 live births each year in Bexley (3,030 born in 2018). The birth rate has remained relatively stable over time. In 2017, there were 57 maternities where the outcome was a multiple birth; a rate of 18.7 per 1000 births, comparable to England and London. Compared with singletons, babies from multiple births have much higher rates of stillbirth, neonatal mortality, infant mortality, preterm birth, low birth weight, congenital anomalies, and subsequent developmental problems. Local data suggests that around 45% of women use maternity services at Darent Valley Hospital, 35% use Queen Elizabeth Hospital, and others use the Princess Royal University Hospital, Guys and St Thomas' and other units further outside the area.

In 2018, there were approximately 15,119 children aged 0-4 registered with a GP in Bexley (not including Bexley resident children registered with GPs outside of Bexley). Children aged 0-4 represent 6.3% of the GP registered population in Bexley (higher than England – 5.6%) with variation by GP Practice from 9.9% at Riverside Surgery in Erith to 3.3% at Dr Thavapalan and Partners Surgery in Bexleyheath.

In Bexley, the life expectancy at birth is 80 years for males, significantly worse than the London average (80.5 years) and 84.1 years for females, comparable to the London average (84.3 years). Both are significantly better than the England average. In Bexley, the healthy life expectancy at birth for males is 65 years and for females is 64 years, comparable to both the England and London values. The inequality in life expectancy at birth (how much life expectancy varies with deprivation) in Bexley is 6.0 years for males and 5.9 years for females.

Importance of Early Years

"The foundations for virtually every aspect of human development – physical, intellectual and emotional – are laid in early childhood. What happens during these early years has lifelong effects on many aspects of health and wellbeing – from obesity, heart disease and mental health, to educational achievement and economic status" **–** Sir Michael Marmot, 2010.

Giving every child the best start in life is essential in reducing health inequalities across the life course. Transition to parenthood and the first 1001 days from conception to age 2 is widely recognised as a crucial period in the life course of a developing child and one of the most important stages in the life cycle.

The first five years of a child's life, including the nine months of pregnancy, are critical to cognitive and non-cognitive development and later life outcomes. The importance of early intervention strategies that ensure that all children are given the best start in life is emphasised in a range of influential reports.

- Around 45% of pregnancies are unplanned or associated with feelings of ambivalence.
- Only a relatively small proportion of women currently modify behaviours pre-pregnancy. Planning pregnancy, promoting healthy behaviours and reducing or managing risk factors are important for improving pregnancy outcomes.

The period of preconception to age 2 provides a unique opportunity for professional involvement because it is the time when parents are often the most receptive to behaviour change interventions and where the evidence suggests it is most effective.

[1] The general fertility rate is the number of live births for every 1,000 women aged 15 to 44 years in the local population.

From birth to age 18 months, connections in the brain are created at a rate of one million per second! The earliest experiences shape a baby's brain development and have a lifelong impact on that baby's mental and emotional health. Ensuring that the brain achieves its optimum development and nurturing during this peak period of growth is therefore vitally important and enables babies to achieve the best start in life.

"There is strong evidence that some economic, demographic, and social risks can harm a child's development and contribute to behavioural problems, failure at school, and poor health outcomes." Sir Michael Marmot, 2010

International studies show that when a baby's development falls behind the norm during the first year of life, it is then much more likely to fall even further behind in subsequent years, than to catch up with those who have had a better start.

Pregnancy, birth and the first 24 months can be tough for every mother and father, and some parents may find it hard to provide the care and attention their baby needs. A baby's social and emotional development is strongly affected by the quality of their attachment (the bond between a baby and its caregiver/s). Preventing and intervening early to address attachment and parenting issues will have an impact on the resilience and physical, mental and socio-economic outcomes of an individual in later life. New parents' skills and confidence may be affected by factors such as:

- economic/social issues (social capital)
- own experience of being parented/adverse childhood experiences (ACEs)
- cycle of poor aspiration
- exposure to domestic violence
- alcohol and substance misuse
- emotional health problems

There is no local data available on parent-baby attachment or poor social and emotional development or mental health in babies and toddlers. In 2018, 2.23% (512 children) of Bexley children of Primary school age were identified as having social, emotional and mental health needs. Factors which may contribute to the level of disorganised attachment and / or poor social and emotional development in Bexley include parental substance misuse, teen mothers, perinatal mental ill health, homelessness, child in care or subject to a child protection plan. These factors are discussed more below.

Outcomes are improved if parenting programmes start in pregnancy and parents can be supported to understand and communicate their feelings about the emotional transition to parenthood and build positive relationships from pregnancy onwards.

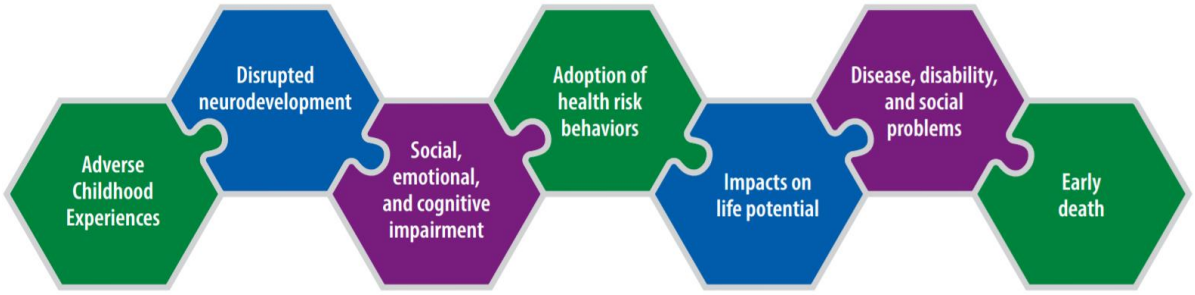
"The early years of life lay the foundations for later resilience in terms of key aspects of children's development, helping and preparing them for adolescence and adulthood." Sir Michael Marmot, 2010

- Childhood and adolescence are key periods for development, growth and education, shaping adulthood (including relationships, behaviours, health, and social outcomes)
- Later health and wellbeing depends on supportive, nurturing, safe and happy childhoods
- If individuals live in damaging circumstances, or are exposed to adverse conditions early in life, this can have negative short- and long-term effects.

Adverse Childhood Experiences (ACEs)

Individuals who have adverse childhood experiences (ACEs) during childhood or adolescence tend to have more physical and mental health problems as adults and ultimately greater premature mortality.

ACEs include: abuse (physical, sexual, verbal); neglect (emotional, physical); Growing up in a household where there are adults with alcohol and drug use problems, mental health problems or domestic violence or where parents have separated; a household where adults have spent time in prison.



Childhood adversity can create harmful levels of stress which impact healthy brain development. ACEs and associated conditions such as living in under resourced neighbourhoods, frequently moving, experiencing food insecurity, and other instability can cause toxic stress. The more adversity a child experiences the more likely it is to impact upon their mental and physical health, with evidence suggesting that children exposed to 4 or more adverse experiences are more likely to participate in risk taking behaviours (such as high risk drinking or substance misuse and find it more difficult to make changes, which can result in long-term effects on learning, behaviour and health (such as increased risk of injury, sexually transmitted infections, mental health problems, teen pregnancy, involvement in sex trafficking, a wide range of chronic diseases including cancer, diabetes, heart disease, and suicide.

Research from Wales found that people who reported experiencing four or more ACES are:

- 4x more likely to be a high-risk drinker
- 16x more likely to have used crack cocaine or heroin
- 6x increased risk of never or rarely feeling optimistic
- 3x increased risk of heart disease, respiratory disease and type 2 diabetes
- 15x more likely to have committed violence
- 14x more likely to have been victim of violence in the last 12 months
- 20x more likely to have been in prison at any point in their life

One study suggested that 12% of binge drinking, 14% of poor diet, 23% of smoking, 52% of violence perpetration, 59% of heroin and crack cocaine use and 38% of unintended teenage pregnancy prevalence nationally could be attributed to ACE experience below the age of 18. Reducing these rates would improve health and save money.

Experience of adversity tends to ‘cluster’ (several ACEs co-occurring) - approximately half of the English population have experienced one or more ACEs.

- Whilst all ACEs are present across society, children growing up in disadvantaged areas, in poverty, or with a lower socioeconomic status are more likely to be exposed to ACEs compared to their more advantaged peers – and more likely to experience ‘clustering’ of ACEs.
- ACEs can also be ‘transmitted’ across generations, which perpetuates inequalities in health across generations.

There are certain **risk factors** which could increase the chance that a child will be exposed to adverse experiences – including:

- the context in which families live (such social isolation, living in poverty or deprived areas, or having a low socioeconomic status),
- parental and family factors (such as poor parenting or low parental age), and
- household adversity.

Nationally, 26% of babies in the UK are estimated to be living within **complex family situations** (with problems such as substance misuse, mental illness or domestic violence).

- There are an estimated 9,527 children aged 0-2 in Bexley in 2019.
- Using national estimates, around 2,477 babies in Bexley may be living in complex family situations.
- Younger children and children with disabilities and health care needs are all more likely than other children to experience abuse and neglect.

There is increased potential for **domestic violence and abuse** to escalate or start within a relationship during pregnancy. Early identification of the associated risks and intervening early can reduce the potential for these factors escalating into more serious concerns and affecting the parent-child relationship.

- In 2017 there were 31.8 domestic abuse incidents per 1,000 population[2] reported to the police force area which covers Bexley, compared to 25.1 per 1,000 nationally.

Homelessness is associated with severe poverty and is a social determinant of health.

- Family homelessness in Bexley has been increasing over the last six years from 2.7 households with dependent children or pregnant women accepted as unintentionally homeless and eligible for assistance per 1,000 households to 4.0 per 1,000 in 2017/18; significantly worse than in both London and England. In 2017/18 this equated to 394 households. In 2017/18, there were 394 (4%) applicant households with dependent children or pregnant women accepted as unintentionally homeless and eligible for assistance.
- Bexley also has 1,234 households in temporary accommodation (statutory homelessness); a crude rate of 12.4 per 1,000 households (significantly higher than England but significantly lower than London)
- The rate in Bexley has been increasing over the last five years as has the national and London trend.
- Between October and December 2018, approximately 81% of households in temporary accommodation[3] in Bexley had children[4].
- This indicates a significant number of children who may be at risk of exposure to ACEs and other poorer outcomes associated with homelessness or temporary accommodation.

Living in care (sometimes referred to as 'looked-after children') is another potentially stressful or traumatic experience, which some studies cite as an ACE. Children and young people in care are among the most socially excluded in children in England. There are significant inequalities in health and social outcomes compared with all children and these contribute to poor health and social exclusion of care leavers later in life.

- In 2017/18 there were 41 looked after children (LAC) aged under 5 (a rate of 25.8 per 10,000 children aged under 5), which is lower than the England rate but higher than the London rate.

[2] These rates relate to all incidents - not restricted to households containing children or pregnant women.
[3] Households in temporary accommodation have presented themselves to the local authority but under homelessness legislation have been deemed to be not in priority need.
[4] These are experimental statistics from the Ministry of Housing, Communities and Local Government published in September 2019

- As of 31st March 2019, there were 362 children under 5 known to Children's services in Bexley; 297 Children in Need, 46 children subject to a Child Protection Plan and 19 looked after children.
- As of 31st March 2019, Bexley had 47 children aged 0-5 years (including unborn children) subject to a Child Protection Plan.

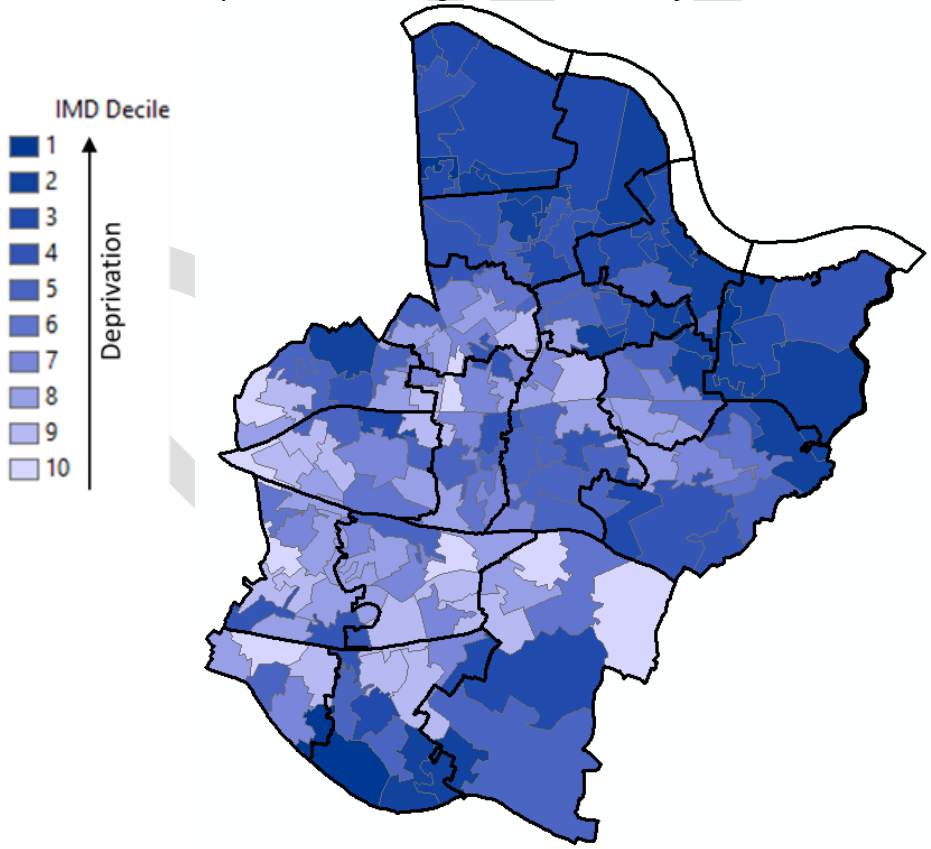
The total economic and social costs to families, communities, and society is enormous. Reducing the health impacts of ACE could decrease pressure on children's social care services, the NHS, and other local support services.

Social Inequalities and development

Socially graded inequalities are present prenatally and increase through early childhood. Giving every child the best start in life is essential in reducing health inequalities across the life course. The literature suggests that babies living in the most deprived areas have a higher rate of congenital abnormalities, including neonatal mortality associated with congenital abnormalities.

Approximately 5.4% of Bexley's population live in the 20% most deprived areas in England and 19.4% of Bexley's children aged 0-15 years live in income deprived households. Income deprivation affecting children is predominantly concentrated in the North of the borough, with small pockets in areas at the far South of the borough (see figure below).

Figure 2: Income deprivation affecting children in Bexley



Source: Index of Multiple Deprivation[5], 2019: Income Deprivation Affecting Children Index

[5] The Index of Multiple Deprivation is an overall measure of the deprivation experienced by people living in an area and is calculated for every lower layer super output area (LSOA), or neighbourhood, in England, which are then ranked according to level of deprivation relative to that of other areas.

- The proportion of children in low income families has decreased between 2006 and 2016 in Bexley (from 19.5% to 16.3%), England (21.8% to 17.0%) and London (32.7% to 18.8%).
- The Bexley figure of 16.3% also masks variation within the borough, ranging from 7% in Brampton to 27.8% in North End.
- Based on the 2011 census, 4.5% of Bexley households with dependent children had no adult in employment (4,162); significantly higher than England but significantly lower than London.

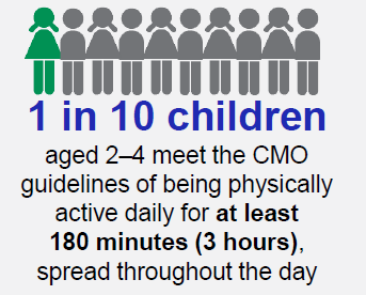
Infant mortality is an indicator of the general health of an entire population. It reflects the relationship between causes of infant mortality and upstream determinants of population health such as economic, social and environmental conditions.

- The infant mortality rate[6] for Bexley in 2015-17 was 3.1 deaths per 1,000 live births (29 deaths) - similar to the national and London rates of 3.9 and 3.3 per 1,000 live births respectively.
- A study of all infant deaths in England and Wales showed an increased risk of death with increasing deprivation (even after adjustment for other factors). It suggested that one quarter of all deaths under the age of one would potentially be avoided if all births had the same level of risk as those to women with the lowest level of deprivation.
- Reducing infant mortality overall and the gap between the richest and poorest groups are part of the Government's strategy for public health.

There is strong evidence that some economic, demographic, and social risks can harm a child's development and contribute to behavioural problems, failure at school, and poor health outcomes. There is an unequal distribution of resources across families in terms of wealth, living conditions, levels of education, supportive family and community networks, social capital and parenting skills.

What a child experiences during the early years lays down a foundation for the whole of their life - their physical, social, and cognitive development during this time strongly influences their school-readiness and educational attainment, economic participation and health. The first year of life is crucial for neuro-development to provide the foundations for children's cognitive capacities. Cognitive ability is a powerful determinant of earnings, propensity to get involved in crime and success in many aspects of social and economic life, as well as health.

Physical activity is an important component of early brain development and learning for young children. It helps develop coordination and movement skills and strengthens muscles and bones. Movement skills such as eye skills and manipulative skills help children access curricular activities with enjoyment and success. Communications skills depend on well-developed physical skills. Physical activity also promotes a healthy weight and helps children develop social skills.



- Children aged 2-4 years should engage in at least 180 minutes activity spread throughout the day.
- Nationally, around one in ten children aged 2-4 years met the recommendations (excluding walking or cycling to/from school, nursery or playgroup)
- The amount of time spent being sedentary should be minimised.
- Nationally, on weekdays, 5% of boys and girls aged 2-4 were sedentary for 6 or more hours per day while at weekends this increased to 8% of boys and 9% of girls.

[6] The infant mortality rate is the number of infants dying before their first birthday per 1,000 live births

School Readiness

The 2-2.5 year health and development review is assessed through the **Ages and Stages Questionnaire 3 (ASQ-3)**, an assessment tool that helps parents and provides information about the developmental status of their child across five areas: communication, gross motor skills, fine motor skills, problem solving, and personal-social. The results of these checks should inform work with children to improve their readiness for school.

> *"Children who arrive at school in a strong position will find it easier to learn, while those already behind will face a growing challenge: early advantage accumulates, but so too does early disadvantage".*
> DfES (2017)

- In 2018/19, 16% of Bexley children did not receive a 2-2.5 year review.
- Out of the 84% receiving a review, 4.7% did not receive an Ages and Stages Questionnaire-3 (ASQ-3).
- Of the 2,397 children receiving the (ASQ-3), as part of the Heathy Child Programme or integrated review, 84.4% were at or above the expected level of development in all five areas (communication, gross motor skills, fine motor skills, problem solving and personal-social development)7.
- Except for development in communication skills (where Bexley children are comparable to the London and England averages) Bexley children perform significantly better across all the ASQ-3 components. However, there is currently no mapping in Bexley of this level of achievement with the sociodemographic factors that are known to be associated with poor development.

Socioeconomic status is associated with a multitude of developmental outcomes for children. Birth weight, postnatal depression, being read to every day, and having a regular bed time at age 3 are all likely to relate to a child's chance of doing well in school. These are strongly influenced by parental income, education and socioeconomic status. The social position of parents accounts for a large proportion of the difference in educational attainment between higher and lower achievers.

- These differences emerge in early childhood and tend to increase as children get older.
- Children who do not achieve a good level of development by age 5 struggle with social skills, reading, maths and / or physical skills which increases their likelihood of poor educational outcomes, involvement in crime, poor health and early death.

Development of early cognitive ability is strongly associated with later educational success, income and better health. If children fall behind in early cognitive development, they are more likely to fall further behind at subsequent educational stages.

- Children of educated or wealthy parents can score poorly in early tests but still catch up, but children of worse-off parents are unlikely to do so.
- There is no evidence that entry into schooling reverses this pattern.

The early years are important for the development of non-cognitive skills such as application, self-regulation and empathy - the emotional and social capabilities that enable children to make and sustain positive relationships and succeed at school and in later life.

The **Early Years Foundation Stage (EYFS) framework** sets the statutory standards for the development, learning, and care of children from birth to age 5. There are 7 different areas of

[7] there are some data quality issues with these statistics and they should be interpreted with caution

learning and development in the EYFS, each with an Early Learning Goal (the standard that a child is expected to achieve by the end of their reception year).

Area of Learning and Development	Early Learning Goals
Communication and Language development	ELG 01 Listening and attention, ELG 02 Understanding, ELG 03 Speaking
Physical Development	ELG 04 Moving and handling, ELG 05 Health and self-care
Personal, social and emotional development	ELG 06 Self-confidence and self-awareness, ELG 07 Managing feelings and behaviour, ELG 08 Making relationships
Literacy	ELG 09 Reading, ELG 10 Writing
Mathematics	ELG 11 Numbers, ELG 12 Shape, space and measures
Understanding the world	ELG 13 People and communities, ELG 14 The world, ELG 15 Technology
Expressive arts and design:	ELG 16 Exploring and using media and materials, ELG 17 Being imaginative

School readiness is a measure of how prepared a child is to succeed in school cognitively, socially and emotionally, assessed by the **'good level of development'** (GLD). Children are defined as having reached a GLD at the end of the Early Years Foundation Stage (EYFS)[8] if they achieved at least the expected level in the early learning goals in the prime areas of learning (personal, social and emotional development, physical development and communication and language) and in the specific areas of mathematics and literacy.

- In 2017/18, 77.1% of Bexley children achieved a good level of development, significantly better than both England and London and showing an improving trend.

Figure 3: What school ready children look like

Source: PHE

[8] This is by the end of Reception

Nationally, the proportion of children achieving a 'good level of development' varies between certain groups, giving rise to gaps.

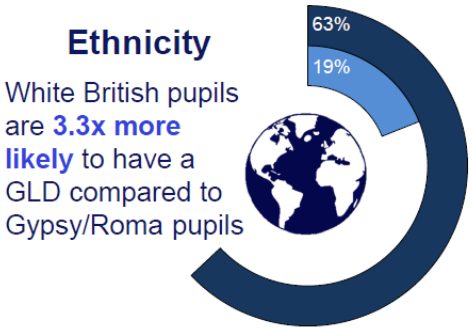
- There was a gap between girls and boys in Bexley of 11.7% in 2018/19.
- There was also a gap between of 37.6% between children requiring Special Educational Needs (SEN) support and children who do not in Bexley in 2018/19.

There is also a gap between children who are disadvantaged and those who are not. Fewer disadvantaged children achieve a good level of development – using free school meal status as a proxy for disadvantage.

- In 2018/19 there was a gap in Bexley of 13.9% between children in receipt of free school meals and those not.
- In 2017/18, the percentage of children with free school meal status achieving a good level of development at the end of reception was 64.1%; significantly better than England but comparable to London. This is also showing an improved trend over the last six years.
- The 2018 the uptake of free school meals among all pupils of primary school age in Bexley was 11.7% (2,677 pupils). This is significantly lower than the England and London proportions. The data suggests that suggests that 572 children were known to be eligible but weren't taking free school meals in 2018.

National data also tells us that pupils from Traveller populations are at high risk of having a lower attainment than white British pupils.

- Bexley had the highest concentration of Gypsies and Travellers in London in the 2011 census, approximately 67% of whom were in the north of the borough.
- In 2015/16 Bexley had the highest proportion of Gypsy/Roma school children in London.
- Children from Gypsy and Traveller communities attain and progress significantly below the national average throughout compulsory education
- Gypsy and Irish Travellers have the lowest employment rates and highest levels of economic inactivity.



Development of Speech and Language

Disparities in child language capabilities are recognisable in the second year of life and are clearly having an impact by the time children enter school. If left unsupported, these children are more likely to fail to achieve their full potential.

- In Bexley in 2017/18, 84.4% of children achieved at least an expected level of development across all Early learning Goals (ELG's) in the communication and language area of learning and development at the end of the EYFS, significantly better than London and England and showing an improving trend over the last six years.

As part of the Department for Education (DfE) plan for improving social mobility through education, their ambition to **close the 'word gap'** focusses on the development of key early language and literacy skills for pupils who are disadvantaged or not achieving their full potential.

- In 2017/18, 77.4% of Bexley children achieved the expected level of development in communication and language area of learning and development **and** literacy area of learning and development.

The term **'speech, language and communication needs'** (SLCN) is used to encompass a range of difficulties that children may have[9]. These include developmental language disorder, developmental speech difficulties, stammering (dysfluency), social communication disorder, voice conditions, special educational needs associated with SLCN as a primary need.

- Children of all ages may have SLCN.
- Some children will have mild problems which will resolve, while others will have difficulties which persist and have a more enduring impact on their lives.
- Children with developmental language disorder may struggle to concentrate, understand, keep pace, or remember new words or concepts, and may therefore be mislabelled as 'naughty' or 'stupid'. They also may have difficulty communicating with peers, which can limit friendships or social opportunities.
- Children with developmental language disorders may experience social, emotional or mental health difficulties, including anxiety, low self-esteem, lack of confidence, and depression. These issues can persist into adolescence and adulthood.

Estimating the number of children in a local area who may be experiencing speech, language and communication difficulties at a given time is problematic. There is considerable variety in the estimates of prevalence of children with language difficulties, alongside variation in the criteria used in studies to assess children with language disorders which makes comparing one study with another difficult. It must also be borne in mind that each child develops differently and so a child experiencing problems at 18 months might not be experiencing them at 3 or 5 years and vice versa.

"Children and young people with communication difficulties are at increased risk of social, emotional and behavioural difficulties and mental health problems. So identifying their speech and language needs early is crucial for their health and wellbeing. Many young children whose needs are identified early do catch up with their peers"
National Institute for Health and Care Excellence (NICE), 2016

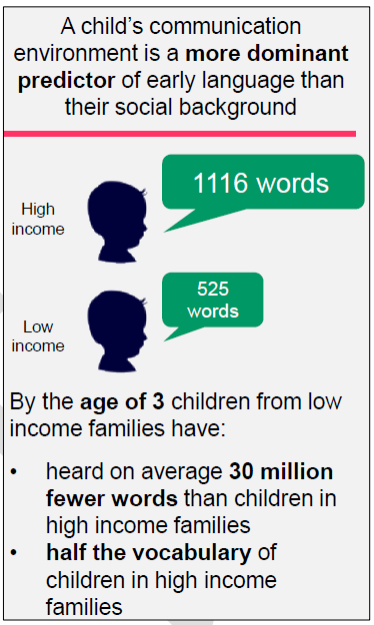
Speech and language delay is a major contributor to poor school readiness. Children who do not develop good oral language in their pre-school years are at greater risk of experiencing problems with literacy later on, potentially impairing his or her ability to reach his or her academic potential. People with developmental language disorders are at increased risk of poor employment outcomes and economic disadvantage.

- Nationally, by the end of primary school 18% of pupils with identified SLCN achieve the expected standard in reading, writing and maths, which is considerably lower than the 64% of all pupils who achieve this standard.
- Early intervention to address any issues with speech, language and communication development can ensure that all children start school in a position to flourish and avoid the development of gaps which can have a lasting detrimental impact on social mobility.
- Boys are more likely to experience early language delay or a specific language impairment (approximately 8% of boys would be expected to have a problem compared with 6% of girls).
- Children born before 37 weeks of gestation (preterm) are at increased risk of experiencing difficulties with speech, language and communication. Based on data from the Office for National Statistics in 2017, 8.0% of live births were born pre-term (born before 37 weeks) in England and Wales. Between 2015 and 2017, there were 687 pre-term births in Bexley; a rate of 73.3 premature live births and stillbirths per 1,000 live births and stillbirths. This is significantly lower than the premature births rate for England and London.

[9] Broadly, speech, language and communication difficulties can be divided into those which exist alongside other physical, sensory or cognitive conditions, and those which cannot be explained in this way. When the problem with language is associated with a physical or cognitive problem such as hearing loss or a learning disability, these will be considered the 'primary condition', with the language difficulty a 'secondary condition.'

There is a pronounced **social gradient** in early language acquisition, with a higher prevalence of poor language skills in young children from disadvantaged backgrounds.

- The strong association between deprivation and language delay is due to differences in the 'communication environment', including the number of words children hear and breadth of parental vocabulary
- It is estimated that amongst the most deprived quintile of children, 18% would have a language difficulty at age 5 – which equates to around 50 children in Bexley. This reduces to just 3% of children in the least deprived quintile – equating to around 20 children in Bexley[10].
- This indicates that far more children from the most deprived families are not developing good speech and language by age 5 and are therefore not school ready. This increases the risk of them not achieving academically and perpetuating the cycle of poor employment and deprivation.
- However, access to enriching resources like books, toys and early educational experiences that promote early language is more influential on language development than the broader socio-economic context of the family.



Children with English as a second language may learn their languages more slowly than those only developing skills in one language. Once children start school differences between them and their peers generally disappear which may be due to their increased exposure to English. Nevertheless, children with English as an additional language can experience long-term language difficulties such as Development Language Disorder and other SLCN requiring access to intervention. The majority of Bexley residents (77%) are White, with just 23% from Black and Minority Ethnic (BME) groups. In 2011, 94% of Bexley residents reported English as their main language, compared to the national average of 91%. However, Bexley is becoming more diverse and BME groups will account for an estimated 30% of the population by 2045, compared to 18% at the 2011 Census. Populations of some ethnic groups (Black, Asian and Mixed) are projected to more than double from the Census to 2050. This could mean more children may have English as a second language, or live in a home where English isn't commonly spoken.

The Marmot Review (2010) clearly demonstrates that disadvantage starts before birth and is accumulated throughout life, and that prevention and early intervention programmes in pregnancy and the early years are of both economic and social value. "Investment in effective, evidence-based early years interventions has a high rate of returns as compared to interventions in the later stages of life." **Social Return on Investment** studies showed returns of between £1.37 and £9.20 for every £1 invested. Investing proportionately across the social gradient in good quality, effective support to parents (including during pregnancy, early education and childcare, and the transition to primary school) provides high returns.

Children having access to positive early experiences is crucial to their development, and the evidence suggests that children from more socially deprived backgrounds have less positive experience than those from wealthier backgrounds. To improve the outcomes of children, we must address this social gradient in access to positive experiences before the age of 5 years of age.

[10] The following estimates should be used with caution.

Key ‘Health’ outcome measures

Maternal Health

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

Many factors affect women’s health in pregnancy. The extent to which these are modifiable varies, for example, once a woman is already pregnant, factors such as age are fixed. However, many risk factors do not begin when a woman becomes pregnant and are often established well before pregnancy. This is the case for obesity, smoking, alcohol and substance misuse and many other social factors such as deprivation, housing and employment. In general, many risk factors are clustered and inter-related. Risk factors associated with poorer outcomes are experienced at higher levels by particular groups of women and their babies.

Maternal age

Existing literature suggests maternal age is an important factor for the health of the baby, with both older and younger mothers more likely to experience poorer outcomes. In Bexley in 2017, 2.3% of births were to mothers aged under 20 years and 4.5% of births were to mothers aged 40 years and over. Most teenage pregnancies are unplanned and around half end in an abortion. In 2017, the under 18 conception rate in Bexley was 17.1 per 1,000 women aged 15-17 years (73 conceptions), of which 46 conceptions (63%) led to abortion (both statistics are comparable to England and London). A well-functioning reproductive health pathway, from relationships and sex education, through to contraception provision and pre-conception advice, can help to reduce the number of women having to go through the experience of an abortion.

In 2017/18, the proportion of delivery episodes where the mother was aged under 18 years in Bexley was 0.6% (five-year average, 2011/12-2015/16 of 0.7%). In 2016, the under 18 births rate was 3 per 1,000 births (13 births), significantly lower than England but comparable to London. Younger mothers are more likely to smoke, less likely to take folic acid, and less likely to access antenatal care in early pregnancy. For many teenagers bringing up a child is extremely difficult and often results in poor outcomes for both the teenage parent and the child. Teenage mothers are less likely to finish their education, are more likely to bring up their child alone and in poverty, and have a higher risk of poor mental health than older mothers. Teenage mothers are three times more likely to suffer from post-natal depression and experience poor mental health for up to three years after the birth. The children of teenage mothers have an increased risk of living in long-term poverty and poor-quality housing and are more likely to have accidents and behavioural problems.

Babies born to women aged under 20 have around a 20% higher risk of low birthweight which impacts on the child's health, increases the risk of infant mortality, and has serious consequences for health in later life. This can be partly explained by their higher smoking rates in pregnancy than the national average. There are social inequalities in low birthweight in England and Wales and these inequalities are likely to affect childhood and adult health inequalities in the future. In Bexley in 2017, 6.4% of all babies were born with low birthweight

(<2500g), significantly lower than London but comparable to England, and 0.89% of all babies were born with very low birthweight (<1500g), comparable to England and London. The proportion of term babies[11] born with low birth weight was 2.4%, comparable to both England and London.

Infant mortality rates[12] for babies born to teenage mothers are around 60% higher than for babies born to older mothers. The infant mortality rate for Bexley in 2015-17 was 3.1 deaths per 1,000 live births (29 deaths). This is similar to the national and London rates of 3.9 and 3.3 per 1,000 live births respectively. Infant mortality is an indicator of the general health of an entire population. It reflects the relationship between causes of infant mortality and upstream determinants of population health such as economic, social and environmental conditions. Young women are also less likely to take folic acid, which protects against the risk of neural tube defects (e.g. spina bifida).

In Bexley in 2017/18, 773 deliveries (24.9%) were to 'older mothers' (women aged 35 years or above) significantly higher than England and significantly lower than London. Older mothers have higher rates of stillbirths, caesarean section and congenital abnormalities. In the period 2016-2018 Bexley had a stillbirth rate of 4.5 stillbirths per 1,000 births[13]. This was similar to the national and London rates of 4.2 and 4.7 per 1,000 births respectively. Caesarean sections are often required for a number of maternal and infant reasons. Because they are often used when there are complications, they are likely to be associated with an increased risk to mother and baby. In 2016/17, 29% of deliveries (851) in Bexley were by caesarean section, significantly higher than the England proportion but comparable to the London proportion.

Modifiable risk factors for pregnancy and future child health include: Improving health before pregnancy; Stopping smoking; Eating a healthy diet including folic acid supplements; Being a healthy weight and physically active; Breastfeeding; Avoiding alcohol and illicit drug use; identifying and addressing mental health problems and psychosocial stress; Supporting families with multifaceted approaches.

Smoking

Smoking in pregnancy and exposure to second-hand-smoke increases the risk of serious pregnancy-related complications including low birthweight, premature birth, complications during pregnancy and labour (such as bleeding during pregnancy, placental abruption and premature rupture of membranes), increased risk of miscarriage and stillbirth, and sudden unexpected death in infancy. On average, babies born to women who smoke are 200g lighter than babies born to non-smokers, increasing the risk of them being of low birth weight. Reducing smoking in pregnancy is part of the NHS England Saving Babies Lives Initiative to reduce stillbirth, which affects 4.5 births per 1,000 births in Bexley. Globally, premature birth[14] is the leading cause of death for children under the age of 5. Between 2015 and 2017, there were 687 premature births in Bexley; a rate of 73.3 per 1,000 live births and stillbirths. This is significantly lower than the premature births rate for England and London.

Household smoking is linked to more illness in babies, particularly respiratory problems, and sudden infant death. Stopping smoking reduces health risks for the woman and family, reduces the likelihood of her children taking up smoking, and saves money - it removes the greatest modifiable risk for poorer pregnancy outcomes. Encouraging pregnant women to stop smoking during pregnancy may also help them kick the habit for good, and thus provide health benefits for the mother and reduce exposure to second-hand smoke by the infant. Partners and others in the household who smoke are encouraged to stop to support women and to

[11] A term baby is one with a gestational age of at least 37 complete weeks
[12] The infant mortality rate is the number of infants dying before their first birthday per 1,000 live births.
[13] The stillbirth rate is the number of stillbirths per 1,000 total (live and still) births.
[14] Birth before 37 weeks gestation

reduce their exposure to second-hand smoke. The Tobacco Control Plan contains a national ambition to reduce the rate of smoking throughout pregnancy to 6% or less by the end of 2022 (measured at time of giving birth).

Exposure to environmental tobacco smoke is associated with an increased risk of chest infections, asthma attacks and sudden infant death syndrome. In addition, children whose parents smoke are likely to become smokers themselves. In Great Britain smoking prevalence amongst adults in households with children has decreased from just over 30% in 2000 to under 20% in 2015, and 69% of all adults said smoking was not allowed inside their homes. In addition, adults living in a household with children were more likely to say that smoking was not allowed anywhere in their home (75% of adults living with children). 74% of people who were aware of the effect of second-hand smoke on asthma risk in children did not allow smoking in their home compared to 42% who did not believe that smoking increased the risk to health and wellbeing during the Early Years. 91% of smokers reported modifying their smoking behaviour in front of children - In 2008/09, 77% of smokers reported not smoking at all in the presence of children, which has increased from 54% in 1997.

Adult smoking prevalence in Bexley was 12.2% in 2018. Women in routine and manual occupations and teenagers have higher smoking rates, and in the general population rates of smoking are higher in the more deprived areas. In Bexley, prevalence of smoking in routine and manual workers was 20.9% in 2018, with adults in routine and manual occupations being twice as likely to smoke as those not in these occupations. Using Trust-level data for 2018/19, it is estimated that 9% of Bexley mothers (approximately 280 women) reported that they were smokers at their booking appointment. Of these, 23% were aged under 20 years (approximately 64 women); 14% were aged 20-29 years (approximately 39 women) and 12% (approximately 34 women) were aged 30 or over.

In 2018/19, the proportion of mothers smoking at time of delivery in Bexley was 7.6% (201 mothers). This has been declining over the last six years. The proportion of mothers smoking at time of delivery in Bexley is significantly lower than the England proportion but significantly higher than the London proportion. Bexley has the third highest smoking status at time of delivery in London, with Greenwich having the highest at 8.1%. In Bromley, 5.4% of mothers smoke at time of delivery. In neighbouring Kent, 13.8% of mothers smoke at time of delivery.

In 2018/19, the Bexley Stop Smoking Service received 181 referrals of pregnant smokers. Based on the estimated number of women smoking at time of delivery in Bexley in 2018/19 (201), 90% of women were referred. Of these, 76.8% were referred from Darent Valley Hospital. Of the 181 referrals, almost 50% did not respond to follow up, 23% set a quit date with the Bexley Stop Smoking Service and, of these women, 34% quit at 4 weeks. It is also important to support women past their smoking cessation as a national review of pregnancy smoking cessation studies found high rates of relapse - only 13% of women not smoking at delivery and 43% of these smoking again six months after birth.

Healthy Diet & Healthy Weight

An appropriate weight and a healthy balanced diet, with recommended supplements of folic acid and vitamin D, support pregnancy outcomes and future health for the woman and baby.

Being underweight can also reduce fertility and increase some pregnancy risks, such as premature birth and low birthweight. Specialist monitoring and support is needed in pregnancy for women affected by eating disorders.

Excess weight increases health risks for the woman and child during pregnancy – it can cause lower fertility; risk of miscarriage; a higher risk of gestational diabetes, high blood pressure, thrombosis, and pre-eclampsia; and increased risk of birth complications (including long labour, pre-term birth, emergency caesarean and post-operative complications, or having a

baby weighing over 4kg). It also increases longer term risks for health conditions for the woman such as type 2 diabetes, cardiovascular disease and cancers. The risks for the child include a greater risk of stillbirth and metabolic and developmental abnormalities (including neural tube defects), and a higher risk of overweight and obesity, type 2 diabetes and high blood pressure later in childhood.

Obesity may be identified before pregnancy or at the booking appointment. In England in 2013, over a third of women aged 16–24 and half of women aged 25–34 were overweight or obese. Nationally, around 15-20% of pregnant women who are overweight or obese. In Bexley, it is estimated that 46% of women were normal weight at the time of their booking appointment, 28% of women were overweight and 21% of women were obese. Of those who were recorded as obese at the time of booking, 22% were aged 20-29 years, 20% were aged 30-39 years, and 27% were aged 40 years or over.

Achieving a healthy weight before pregnancy reduces the risk of complications for the mother and baby. Building physical activity into daily life, taking 30 minutes moderate intensity activity daily, and avoiding sedentary activities, contribute to having a healthy weight.

Parental substance misuse

Alcohol and non-medical drug use should be avoided in pregnancy or when trying to conceive as they can harm the health of women and babies. Alcohol crosses the placenta and can damage brain cells in the developing foetus by restricting oxygen and nutrient intake. Heavy drinking during pregnancy can lead to the development of foetal alcohol syndrome in the baby. This is a serious condition, characterised by restricted growth, facial abnormalities, and learning and behavioural disorders, which may be lifelong. Foetal alcohol spectrum disorder is less severe but more common, and includes a range of neurodevelopmental defects.

Drug use can damage the health of the woman and baby and cause complications during pregnancy. The effect of cannabis, and many other drugs in pregnancy is uncertain and use should be avoided to reduce possible harm. Some women will be identified as having wider difficulties with misuse of drugs, which may coexist with other health risks such as alcohol misuse and smoking, requiring specialist support and care during pregnancy. Alcohol and non-medical drug use can adversely affect mental health, and may also be a response to mental health problems. A supportive approach towards women who may be using alcohol or drugs can help identify their needs and link them to appropriate services.

The National Treatment Agency for Substance Misuse found that during 2011/12, one third of adults in treatment lived in a household containing children (this includes parents living with their own children and adults living in a house with children who are not theirs, for example step-children or grandchildren). Parents who live with their own children tend to have fewer drug-related problems than others in treatment, are less likely to use the most addictive drugs, and are less likely to inject drugs when compared to non-parents in treatment. They are also less likely to be homeless or arrive in treatment via the criminal justice system.

In Bexley, the latest available data[15] for the proportion of clients in treatment living with children under the age of 18 was higher than the national average for new presentations for treatment for opiates, non-opiates and alcohol. In this group, the proportion of successful completions was lower than the national average for opiates, non-opiates and alcohol. The re-presentation rates within 6 months (following successful completion) for opiates, non-opiates and alcohol were also higher than the national average.

Domestic Abuse

[15] Quarter 1 2019-2020

There is increased potential for domestic violence and abuse to escalate or start within a relationship during pregnancy. Women are more likely than men to suffer domestic or sexual abuse. Domestic abuse includes physical or non-physical abuse, threats, sexual assault or stalking perpetrated by a partner, ex-partner or family member. Domestic violence during pregnancy can affect pregnancy outcomes and affects the physical and mental health of the woman.

In 2017 there were 31.8 domestic abuse incidents per 1,000 population[16] reported to the police force area which covers Bexley, compared to 25.1 per 1,000 nationally. Early identification of the associated risks and intervening early can reduce the potential for these factors escalating into more serious concerns and affecting the parent-child relationship. NICE guidance recommends identifying domestic violence and responding using multi-agency protocols and pathways to offer support and safety for women to reduce harm.

Perinatal Mental Health

Mental health problems in the perinatal period are very common, affecting up to 20% of women at some point during pregnancy or the first year after childbirth. Some women are at a higher risk of experiencing perinatal mental health problems including those with: history of abuse in childhood, previous history of mental health problems (e.g. increased risk of bipolar disorder relapse), teenage mothers, maternal obesity, traumatic birth, history of stillbirth or miscarriage, relationship difficulties, domestic violence, and social isolation.

Women who lack social support have been found to be at increased risk of antenatal and postnatal depression. Having a poor relationship with a partner is also a risk factor for postnatal depression. In 2017, 5.4% of births in Bexley (167 births) were registered by one parent only, comparable to London and England. Based on the 2011 census, 8.3% of households in Bexley were lone parent families. This was found to be significantly higher than England but significantly lower than London.

It is estimated that in Bexley, where 2,940 women gave birth in 2017, 295-445 women experienced mild-moderate depression / anxiety, 445-885 women experienced adjustment disorders and distress, 90 women experienced severe depression, 90 women experienced PTSD, 10 women experienced postpartum psychosis, and 10 women experienced a chronic serious mental health illness during pregnancy and after childbirth[17].

Perinatal mental health problems are a risk to the woman and baby with possible long-term consequences for child development and wellbeing. Poor Maternal mental health is one of the

[16] These rates relate to all incidents and are not restricted to those involving households containing children or pregnant women.

[17] These are based on national estimates and local delivery figures only (rounded up to the nearest five). They do not take into account socioeconomic factors or anything else which is likely to cause local variation. Adding all these estimates together will not give you an overall estimate of the number of women with perinatal mental health conditions, as some women will have more than one condition.

main determining factors of the quality of the mother child relationship, on bonding with their baby, and developing a secure attachment. Poor attachment is associated with cognitive developmental delay and social or interaction difficulties, and development of behavioural problems for the child.

Addressing perinatal mental health issues is particularly important due to the effect they can have on the foetus, baby, wider family and mother's physical health and the fact that problems often are not disclosed, recognised or treated during this period. About 50% of all perinatal depression and anxiety cases go undetected. Many of those which are detected do not receive evidence-based treatment. There is a lack of recognition and awareness of mental ill health and its signs and symptoms, particularly amongst some black and ethnic minority groups.

Ensuring that all women receive access to the right type of care during the perinatal period is a key government priority, seeking to reduce the impact of maternal mental health problems during pregnancy and the first 2 years of life on infant mental health and future adolescent and adult mental health.

Maternal mental illness has significant long-term costs to society, costing just under £10,000 for every single birth in the country - 72% of this relates to adverse impacts on the child. Over 20% of the total costs are borne by the public sector (mainly NHS and social services). The average cost to society of one case of perinatal depression is around £74,000[18].

Good quality, evidence-based perinatal mental health care pathways are shown to:

- improve access to evidence-based treatment with greater detection and improved recovery rates, improving outcomes for women and their children;
- reduce pre-term birth, infant death, special educational needs, and poor school attainment, and depression, anxiety or conduct problems in children;
- reduce costs per birth to NHS caused by mental health problems during perinatal period;
- reduce costs to society of failure to address perinatal mental health problems, which are estimated to be £8.1bn, three quarters of which relate to health and social outcomes of the child.

A review of the evidence for interventions found that:

- Early detection and management of mental health problems around the time of pregnancy is effective in reducing symptoms
- Screening and referral pathways can improve identification and access to care
- Psychological treatments can help women with anxiety and depression, including community approaches using trained health visitors
- The use of psychotropic medication before and during pregnancy requires specialist review

Routine antenatal and postnatal appointments are opportunities for health professionals to discuss emotional wellbeing with women and identify potential mental health problems. Maternity, general practice and health visiting services have frequent contact with the mother, baby and family during the perinatal period and are well placed to provide support, make initial assessment and refer onwards if problems are identified. Improving access to psychological therapy (IAPT) services should be able to meet the needs of both the mother (and/or father) and the infant. Specialist perinatal mental health services are needed for women with complex or severe conditions

[18] This cost and impact burden is likely to be underestimated.

Because the costs of perinatal mental health problems indicate the potential benefits of intervention, even a relatively modest improvement in outcomes as a result of better services would be sufficient to justify the additional spending on value for money grounds. The NHS Five Year Forward View implementation plan includes the objective that there will be increased specialist mental health support in all areas by 2020 to 2021. This will include increasing access to specialist perinatal community teams and providing additional mother and baby inpatient beds when needed.

Community perinatal teams will cover all six boroughs in south east London, including Bexley. The services operate three pathways for all referrals (pre-conception, antenatal and postnatal), which are sourced from a range of professionals (e.g., Midwives, Health Visitors, GPs and mental health teams).

Inequalities need to be identified. Equity of access to provision that promotes good mental health, prevents the escalation of problems and supports early access to treatment is important. Local areas should consider the needs of underserved women and communities alongside identifying assets and protective factors, using this intelligence to identify required improvements to provision.

Childhood Health

Infant mortality
The infant mortality rate is the number of infants dying before their first birthday per 1,000 live births. Infant mortality is an indicator of the general health of an entire population. It reflects the relationship between causes of infant mortality and upstream determinants of population health such as economic, social and environmental conditions. Reducing infant mortality overall and the gap between the richest and poorest groups are part of the Government's strategy for public health. The infant mortality rate for Bexley in 2016-18 was 3.3 deaths per 1,000 live births (30 deaths). This is similar to the national rate of 3.9 per 1,000 live births and the London rate of 3.3 per 1,000 live births.

Stillbirths
The stillbirth rate is the number of stillbirths per 1,000 total (live and still) births. Stillbirth rates in the United Kingdom have shown little change over the last 20 years, and the rate remains among the highest in high income countries. Risk factors associated with stillbirth include maternal obesity, ethnicity, smoking, pre-existing diabetes, and history of mental health problems, antepartum haemorrhage and foetal growth restriction (birth weight below the 10th customised weight percentile). In 2015 the government announced an ambition to halve the rate of stillbirths by 2030. There were 42 stillbirths in Bexley in the period 2016-2018: a stillbirth rate of 4.5 stillbirths per 1,000 births. This was similar to the national rate of 4.2 and the London rate of 4.7 per 1,000 births.

Neonatal and post-neonatal mortality
Deaths occurring during the first 28 days of life (the neonatal period) in particular, are considered to reflect the health and care of both mother and newborn. The first 28 days of life – the neonatal period – represent the most vulnerable time for a child's survival. Smoking is a major risk factor associated with both infant mortality and stillbirth. The 2017 neonatal mortality and stillbirth rate (stillbirths and deaths under 28 days) for Bexley was 7.4 per 1,000 live births and stillbirths. This is comparable to England and London and the trend for Bexley has been improving over the last 15 years. The 2016-18 neonatal mortality rate (deaths under 28 days) for Bexley was 2.06 per 1,000 live births (19 deaths) and the post-neonatal mortality rate (deaths between 28 and 1 year) was 1.19 per 1,000 live births (11 deaths). Both the neonatal and post-neonatal mortality rates for Bexley are comparable to England and London.

According to the Global Burden of Disease Study (2017), neonatal preterm birth is the leading cause of death in children under 5 years although numbers are small.

Hospital admissions

One third of elective admissions[19] of babies aged under one year in 2014/15 were related to a congenital abnormality. Effective antenatal screening can help plan demand for services. An additional 11% of elective admissions of infants related to complications of pregnancy, labour and delivery. The elective admissions rate in the under 1s for Bexley in 2016/17 (97.1 per 1,000 under 1-year olds) is significantly higher than the rate for London and England. There has been an increasing trend in the elective admissions rate for this age group over the previous five years. The rate has been significantly worse in Bexley compared to London in 2015/16 and 2016/17 however prior to this it was significantly better.

High levels of admissions of either mother or babies soon after birth can suggest problems with either the timing or quality of health assessments before the initial transfer or with the postnatal care once the mother is home. Dehydration and jaundice are two common reasons for re-admission of babies and are often linked to problems with feeding. In Bexley, in 2016/17, the crude admission rate for babies aged under 14 days was 151.2 per 1,000 deliveries. This is significantly higher than both the England and London rates. Bexley CCG is doing a piece of work looking into the reasons for these high admission rates and this will inform further recommendations in this area.

Dental caries are a significant reason for elective admissions in children aged 1-4 years nationally. In 2016/17 there were 735 elective admissions in Bexley in this age group (56.2 per 1,000 1-4-year olds). This is comparable to the rate for London and England and there has been no significant change in this rate over the last seven years. In England, in the financial year 2015-16, the cost of tooth extractions in hospital was approximately £7.8 million among children aged under 5 years.

The rate of attendances at Accident and Emergency (A&E) in children under 5 is significantly lower in Bexley in comparison to England, including attendances in children under 1 year, children 0-4 years and children aged 1-4 years. In comparison to London, Bexley also has significantly lower attendance rates for children aged 0-4 and 1-4 years however the attendance rate in children aged under 1 year is significantly higher in Bexley. In 2016/17, there were 3,188 A&E attendances recorded in children under 1 (a crude rate of 1018.5 per 1,000 under 1-year olds) and 4,531 attendances in children aged 1-4 years (a crude rate of 346.2 attendances per 1,000 1-4-year olds).

Approximately 35% of all admissions in the NHS in England are classified as emergency admissions[20], costing around £11 billion a year. Admitting a patient to hospital as an emergency case is costly and frequently preventable, yet the number of emergency admissions to hospital has been rising for some time, nationally. From a public health point of view, emergency admissions data gives an indication of wider determinants of poor health, linked to areas such as housing and transport.

In Bexley 2016/17, there were 1,938 emergency admissions in children under 1 year of age (crude rate 619.2 per 1,000 children aged under 1) – this is significantly higher than the rate for both England and London and Bexley had the second highest emergency admission rate in London for this age group and the rate has been increasing. There were also 1,176 emergency admissions in children 1-4 years of age (crude rate 89.8 per 1,000 children aged

[19] An elective admission is an admission in which the decision to admit can be separated in time from the actual admission (so not emergency).

[20] An emergency admission is an unplanned, often urgent admission (often via A&E), which occurs when a patient is admitted at the earliest possible time

1-4), significantly higher than London although significantly lower than England. The recent trend is of increasing emergency admissions in children aged 1-4 years old.

Each year, an average of 55 children under the age of 5 die due to an unintentional injury. Around 1 in 11 children utilise hospital outpatients and 1 in 10-15 are admitted overall, with emergency hospital admission rates for unintentional injuries among the under 5s 38% higher for children from the most deprived areas compared with children from the least deprived areas. Illnesses such as gastroenteritis and upper respiratory tract infections, injuries caused by accidents in the home, and poor oral health are the leading causes of A&E attendances and hospitalisation amongst children under 5.

In 2017/18 there were 139 hospital admissions caused by unintentional and deliberate injuries in Bexley children aged 1-4 years, a crude rate of 87.4 per 10,000 children under 5 years of age. This is comparable to the rate for London but significantly lower than the rate for England. There has been no significant change in the rate of hospital admissions due to injuries in this age group in Bexley over the previous 8 years.

Unintentional injuries are also a major cause of illness and early death for children and young people in England. Unintentional injuries for the under 5s tend to happen in and around the home. They are linked to a number of factors including child development, the physical environment in the home, the knowledge and behaviour of parents and other carers (including literacy), overcrowding and homelessness, the availability of safety equipment, consumer products in the home. The personal costs of an injury can be devastating and can have major effects on education, employment, emotional wellbeing and family relationships. The majority of unintentional injuries are preventable.

There are 5 causes accounting for 90% of unintentional injury hospital admissions for this age group - choking, suffocation and strangulation; falls; poisoning; burns and scalds; and drowning. Understanding local causes can help focus local action. Hazards change, especially as new products such as hair straighteners or liquid detergent capsules emerge, and the risks will vary according to the developmental age of the child. Rates of admission for accidental poisoning are significantly higher in Bexley than London, with 53 children being admitted[21]. Rates of falls are also higher than for London. In 2018/19, there were 170 inpatient activity episodes for children aged 0-5 years with a trauma-related diagnosis. The majority of these (82%) were non-elective, and over half of these were males (54%).

The average NHS short-term financial cost of a hospital admission for ≥2 days for a burn, poisoning or fall in the under-fives (the 3 most common causes of hospital admissions in this age group) ranges from £2,500-£3000. The NHS cost of an admission for ≤1 day from £700-£1,000 and for an emergency department attendance without admission from £100-£180. These figures do not include costs for NHS or social care for longer term follow-up of more severely injured children, and therefore underestimate the true costs of injuries.

Over 25% of emergency hospital admissions in children aged under 5 years in 2014/15 was for respiratory infections. Factors such as smoking in the home and damp housing are known to increase the risk and severity of respiratory infections in young children. In Bexley, in 2016/17, there were 243 admissions for respiratory tract infections in infants aged under 1 year, significantly worse than the England and London rates and the highest admission rate of all the London boroughs. Admissions for infants aged 1 year and for 2, 3 and 4-year olds were comparable to the England and London averages.

In Bexley, the 2016/17 rate of admissions for gastroenteritis in infants aged under 1 year (293.9 per 10,000 children under 1 year) and the rate of admissions for infants aged 1 year

[21] Over the period *2014/15-2016/17*

(104.6 per 10,000 children aged 1 year) are significantly higher than the rates for London. This could mean that the following measures are not working as well as they could be: encouraging breast feeding, better diet, hygiene and management of infections; better support for young parents in the care of their children and in the management of illnesses in the home; providing support as well as facilitating access to health advice and therapy through NHS Direct; and enhanced primary care. For children aged 2, 3 and 4 years there were 29 admissions (29.2 per 10,000 2-4 year olds); this is comparable to the rate for London and significantly lower than the rate for England.

Continence

Continence is the ability to maintain bladder and bowel control until a socially appropriate time and place to urinate or defecate has been reached. Continence problems include bedwetting, daytime urinary incontinence, or constipation and faecal incontinence, or a combination of these. Full control is normally acquired in early childhood as the result of an active learning process. Toilet training should start at 18 months – 2 years, but there is evidence that this is happening later, which causes problems at school entry and an associated increased risk of daytime wetting in primary school children. Children with day and night time wetting at ages 4 – 9 years are 23 times more likely to have enuresis at 14 years of age and 10 times more likely to have daytime wetting continuing into adolescence.

Childhood constipation is one of the most common reasons for referral to paediatrics, and accounts for 3% of general paediatric consultations. The prevalence of childhood constipation is 10–20% in the UK, depending on the criteria used for diagnosis, with some estimates suggesting it ranges from 5-30% of children. In the UK, 30% of children aged 4–11 years will have constipation lasting less than 6 months, and 5% will have constipation lasting more than 6 months with the peak incidence of constipation occurring around the time of toilet training (typically around 2–3 years of age). Constipation is largely under-reported as the signs and symptoms frequently go unrecognized. It may manifest with withholding behaviours to prevent the painful passage of stools; these are often confused with straining. Parents may not be aware of the link between soiling and constipation.

Generally speaking, 9/10 children are expected to be toilet trained by the age of 3 and all are expected to be dry during the day by the age of 4. Increasingly however this seems not to be the case with 70% of schools reporting that they experience children starting school who are not toilet trained. Not being toilet trained by the age of 3 or 4 can give rise to the following issues: mental health effects or effects of stigma, feelings of inadequacy, lack of feelings of independence, negative impact on the relationship with parents, physical consequences (including increased urinary tract infections and incontinence), hindered participation in age-appropriate activities (including school), fear of the toilet (which can lead to increased accidents and with wetting or soiling of clothes, and constipation with knock on medical affects), an impact on academic achievement due to feeling ill or not attentive or engaged.

Child mental health

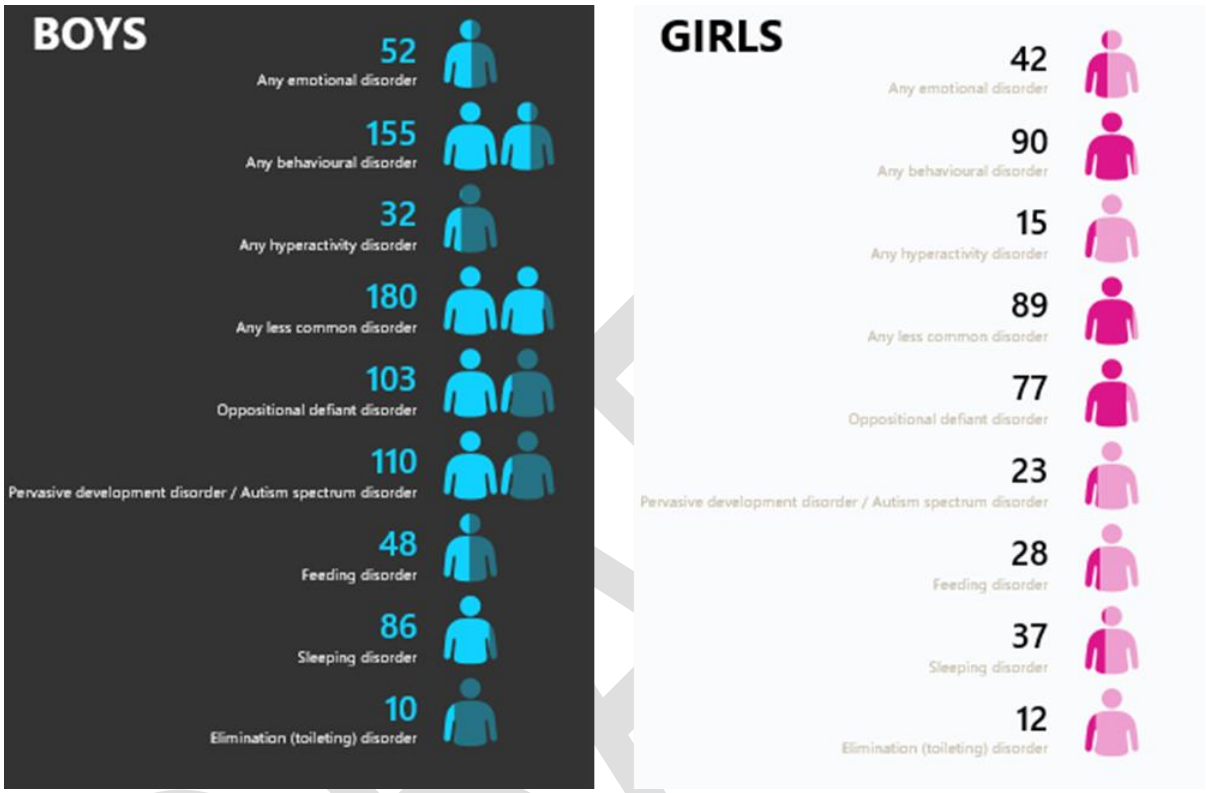
It is challenging to reliably estimate the number of children aged five and under with poor mental health, particularly at a local level. In Bexley in 2018, the proportion of school children of Primary school age identified as having social, emotional and mental health needs was 2.23% which equates to 512 Bexley Primary school children.

National surveys of the mental health of children and young people in England provide the best source of data on trends in child mental health. Surveys have been conducted in 1994, 2004 and most recently in 2017. As part of the 2017 survey, the mental health of preschool children (2-4-year olds) was assessed.

The 2017 survey found that 1 in 18 (5.5%) preschool children were identified with a mental disorder, with higher rates in boys (6.8%) than in girls (4.2%). It also found that mental

disorders were more common in preschool boys of White ethnic backgrounds (8.4%) than boys of Black or other minority ethnic backgrounds (2.9%). Applying these findings to the Bexley population suggests that there are approximately 540 preschool children with a mental disorder in Bexley. This varies by gender, with approximately 345 boys aged 2-4 in Bexley estimated to have a mental disorder and 195 girls.

Applying the national prevalence estimates for specific mental disorders to the Bexley 2-4-year old population suggests that, in Bexley, there are approximately:



Vaccinations and Immunisations

Immunisation is considered one of the most cost-effective public health interventions. Preventing the suffering and death associated with infectious diseases ensures that national, regional and local priorities such as education and economic development are achieved. To protect the population's health through both individual and herd immunity, the World Health Organization (WHO) recommends that at national level, a minimum of 95% of UK children should be immunised against vaccine preventable diseases (specifically, diphtheria, tetanus, pertussis, polio, Haemophilus influenza B, measles, mumps and rubella). The routine childhood immunisation programme for the UK includes these immunisations recommended by WHO as well as additional selective others as advised by the UK Joint Committee on Vaccination & Immunisation.

In 2018/19, vaccination coverage for **all** of the standard vaccines on the childhood schedule was below 95%. At 2 years old, less than 90% of children have had one dose of MMR vaccine, and by 5 years of age just 82.7% have had the 2 does that they should have by this point. This puts Bexley children at risk of an outbreak of the diseases these vaccines seek to protect against, especially children who are immunocompromised or are unable to have vaccinations.

Childhood Nutrition

Breast feeding

In the UK, many women start but do not continue breastfeeding, and breastfeeding rates are relatively low compared to other countries. Babies of women from low income groups are least likely to be breastfed. Nationally, 73% of women initiate breastfeeding yet only 17% of babies are exclusively breast fed at 3 months.

Based on data from NHS Trusts in which Bexley women give birth, in 2018/19 it is estimated that approximately 66% of babies received maternal or donor breast milk as their first feed and 18% of babies did not. In Bexley, 52% of those infants with a feeding status recorded were totally or partially breastfed at age 6-8 weeks in 2018/19. This is above the England and London averages.

Breastfeeding has short and long-term health benefits for the woman and baby. For babies, it can reduce the risk of infections, diarrhoea, vomiting, sudden infant death syndrome, and future risks of obesity and cardiovascular disease in adulthood. Breastfeeding can help bonding of the mother and baby, and aid maternal weight loss after pregnancy, with some evidence of lower future risks of breast and ovarian cancer, osteoporosis, cardiovascular disease and obesity.

NICE guidance PH11 in 2008 recommended health professionals encourage breastfeeding by providing information, practical advice and ongoing support, tailored to the needs of the woman. Exclusive breastfeeding for six months is recommended, when infants should progress to nutritious food in addition to milk

Offering any form of support to women, especially if tailored to their needs, helps them start breastfeeding and breastfeed for longer. Skilled professional support is also beneficial. Informal small group sessions are effective in helping women from a range of backgrounds to initiate breastfeeding. For women on low incomes, both one-to-one and peer support programmes were also useful. For babies in neonatal units, professional and peer support, as well as approaches such as skin-to- skin contact and offering advice on breastmilk pumping, improve duration of breastfeeding

Healthy Start

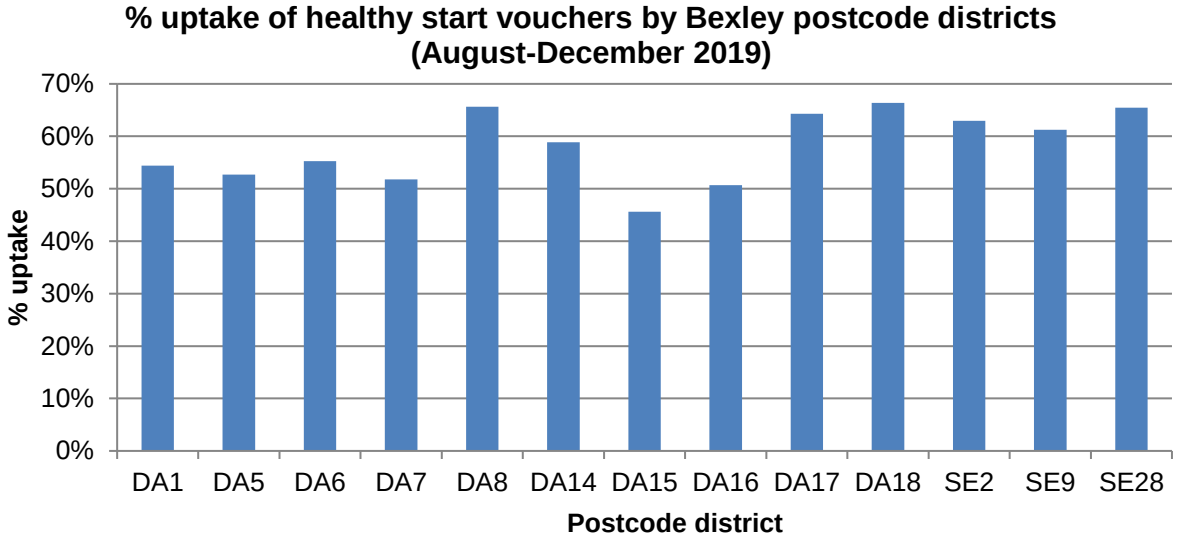
Healthy Start is a means-tested government voucher programme available in England, Wales and Northern Ireland that helps pregnant women and young children in low income families to purchase healthy food. From 10 weeks of pregnancy, eligible women receive one Healthy Start voucher a week worth £3.10. Eligible infants from 0-12 months receive two vouchers a week, worth a total of £6.20 and eligible children aged 1-4 years old receive one voucher a week worth £3.10. The evidence suggests that they act as a nutritional safety net for people on low incomes to support and improve nutrition and diets of mothers and infants, including helping to increase the intake of fruit and vegetables.

Healthy Start vouchers are available for all pregnant women under the age of 18 regardless of income, as well as pregnant women and families with children under the age of four who qualify for certain benefits. The evidence suggests that these narrow eligibility criteria exclude some families who are on low incomes who could potentially benefit from the scheme.

Those eligible for the Healthy Start voucher scheme are also entitled to receive Healthy Start vitamins. The vitamins provide essential nutrients at a very important time of life where it may

become more challenging to meet nutrient needs however, they should be made available earlier.

Nationally and similarly in Bexley, uptake rates of the Healthy Start scheme have been declining. In 2019, only around 55% of eligible Bexley residents have applied and been approved to received healthy start vouchers. There is some variation in uptake by postcode.



In Bexley, around £150,000 was underspent in 2018 where families eligible for the scheme were not claiming their vouchers. Local consultation suggests many eligible residents are unaware of the scheme. There is no data available on what proportion of these who received vouchers have spent them.

The NICE Maternal and Child Nutrition guideline highlights the Healthy Start scheme as a key quality statement, stating that local arrangements should be in place to ensure pregnant women and families with children under 4 who may be eligible for the Healthy Start scheme receive the information and support to apply. They specify opportunities where the scheme can be promoted including at antenatal booking appointments, 6-8-week health visitor appointments, developmental reviews, 2-2½ year health reviews and vaccination appointments.

Increasing the uptake of the Healthy Start scheme is included as a deliverable action in the Obesity Strategy with a commitment to increase and maintain uptake of the scheme to 75% by 2024. Since April 2019 much work has been done to re-launch the Healthy Start scheme in Bexley including Healthy Start briefings delivered to midwives (at Queen Mary's Hospital and Darent Valley Hospital), to Childminders and Early Years Teams, and generally promoted at Community Centres, Libraries, Children Centres and Family Wellbeing Services. All these sites have copies of the Healthy Start leaflet which has the application form enclosed. In July 2019 Bexley Public Health team commissioned Healthy Start vitamins. Those eligible receive a coupon every 8 weeks to redeem for Healthy Start vitamin tablets for the mother and Healthy Start vitamin drops for the child. These can be redeemed from health visiting clinics in Bexley and from Queen Mary's Hospital Midwifery service.

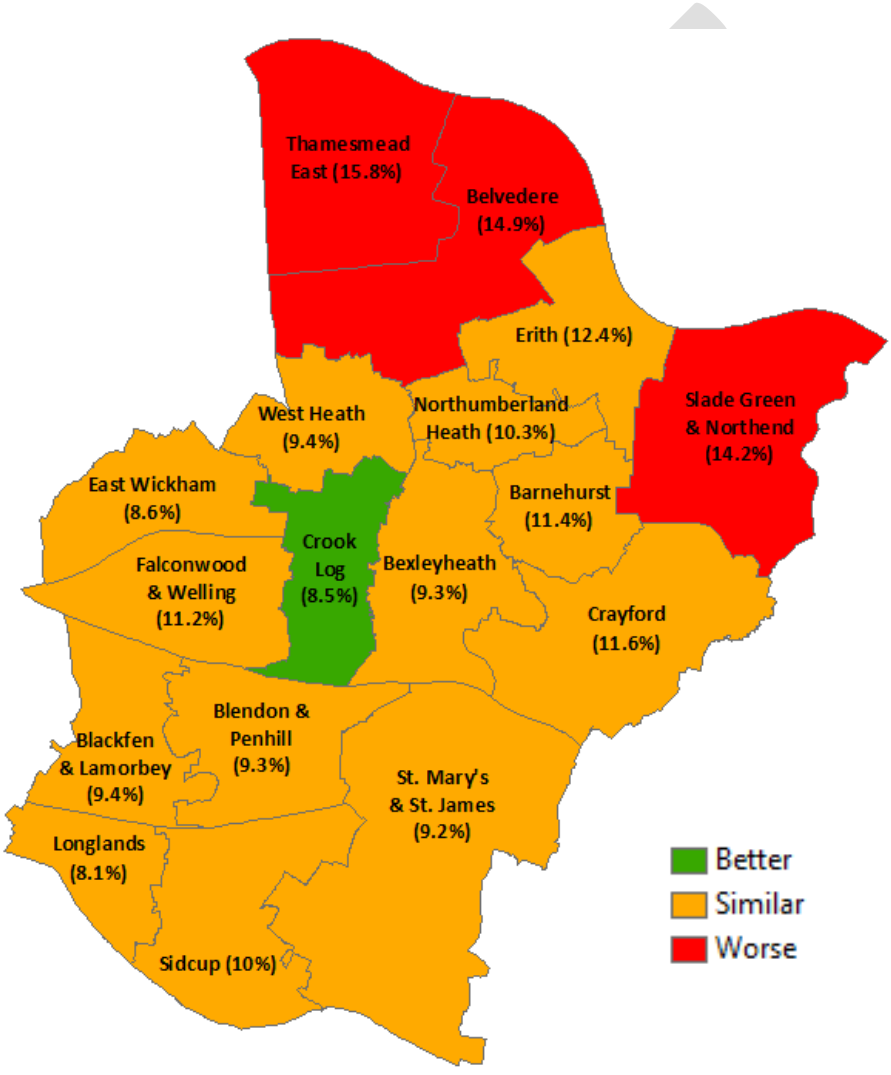
Childhood Obesity

The UK is experiencing an epidemic of obesity affecting both adults and children. In England, the proportion of boys and girls aged 2 to 15 who were classified as obese increased from 11.7% in 1995 to 16.0% in 2016, peaking at 18.9% in 2004. Children living in deprived areas

are disproportionately affected by overweight and obesity, and the gap is widening due to the obesity rate in most deprived areas growing.

The percentage of Bexley children in Reception year (aged 4/5 years) who are overweight or obese has increased from 20.2% in 2007/8 to 23.1% in 2018/19. Bexley has a higher proportion of Reception year overweight and obesity than our CIPFA nearest neighbours, London and England. There is a marked difference in rates of excess weight in different socio-economic groups in Bexley, with higher rates in the more socially deprived North of the borough.

Figure 4: Proportion of obese 4-5-year olds by ward compared to Bexley average (2015/16-2017/18)



Children who are born into a deprived family are more likely to be exposed to perinatal risk factors for obesity such as the mother smoking during pregnancy, being overweight prior to conception, being born prematurely or being small or large for gestational age. Moreover, families with a lower socio-economic status have fewer opportunities to access healthy affordable food.

Children who are born to mothers who are overweight during pregnancy are at an increased risk of developing overweight or obesity as a baby and during infancy. Babies who are not breastfed or who are not exclusively breastfed for six months is a strong risk factor for the

development of childhood obesity. Babies where baby-led weaning has not taken place or who are weaned before 6 months have an increased risk of childhood obesity.

Ethnicity is one major determinant of excess weight. Children from black African ethnicity groups experience greater risks of overweight and obesity, and this exists across both the younger and older age groups.

There is concern about the rise of childhood obesity and the implications of such obesity persisting into adulthood. The risk of obesity in adulthood and risk of future obesity-related ill health are greater as children get older. The health consequences of childhood obesity include: increased blood lipids, glucose intolerance, Type 2 diabetes, hypertension, increases in liver enzymes associated with fatty liver, exacerbation of conditions such as asthma and psychological problems such as social isolation, low self-esteem, teasing and bullying.

The Government released two chapters of its Childhood Obesity: A Plan for Action which sets out its national ambition to halve childhood obesity and significantly reduce the gap in obesity between children from the most and least deprived areas by 2030. This included recommendations such as:

- Promotion and support of breastfeeding for all infants
- Improved early years education to inform and promote appropriate introduction of solids to an infant's diet
- Improved access to evidence-based multi-component interventions starting with expectant mothers, infants and preschool children and their families as recommended by NICE
- Recognition of the national Healthy Start scheme and commitment to continue support and continuation of the programme

The London Child Obesity Taskforce recommendations include:

- Exclusive breastfeeding during the first six months of life is protective for the child and mother. Women should be supported to initiate and breast feed for longer.
- Early childhood is an important stage of life for a child to establish their taste preferences and dietary habits, therefore it becomes more important for the mother and family to adopt healthy eating habits early and encourage baby-led weaning. Most infants should not start solid foods until around 6 months. Breast milk, infant formula and water should be the only drinks offered after 6 months of age
- Skill up early years professionals by providing food training programmes for those who work with young children and specific qualifications for chefs and caterers
- Ensure all nurseries and schools are enabling health for life – by creating 'ambassador' nurseries and schools that lead the way with good practice and calling on Ofsted to place a stronger emphasis on the need for healthy diets and activity
- Make free water available everywhere – by making water appealing to children and ensuring water is freely available in public spaces, and the introduction of 'water-only' schools – where just water would be allowed as drinks, in addition to plain reduced fat milk

Bexley's vision is to halt the rise of excess weight among children by reducing rates by a minimum of 2%, with a stretch target of 5%, creating a downward trajectory by 2024. The aim of the strategy is to create healthy environments in schools, workplaces and throughout the borough. To specifically address healthy eating during the early years there is a commitment to increase breastfeeding initiation and maintenance, work collaboratively with the Early Years Team to establish a Healthy Physical Environment Commitment Scheme Kite mark to recognise early years settings committed to the development of the environment, curriculum and attitudes in respect of public health and offer training in outdoor play activities to staff in early years settings. The Obesity Strategy also recognises the need to provide training for

Early Years Practitioners to equip them with the skills and knowledge to support children to get a healthy start in life, this will include general training around 'raising the issue of weight' and a specialist childhood nutrition training for the early years' workforce.

Oral Health

Oral health is an integral part of overall health; when children are not healthy this affects their ability to learn, thrive and develop.

Tooth decay is a predominantly preventable disease. High levels of consumption of sugar-containing food and drink is also a contributory factor to other issues of public health concern in children – for example, childhood obesity.

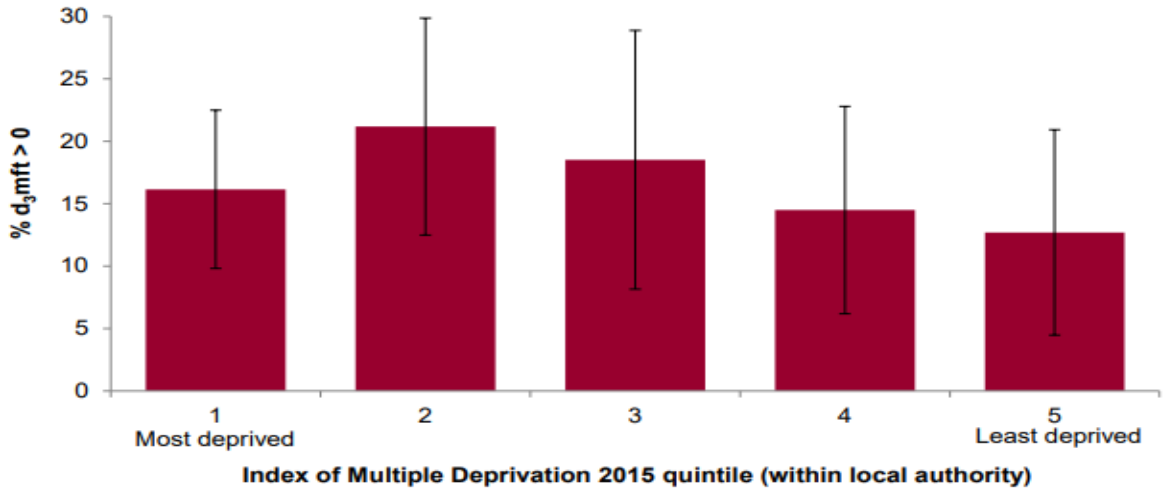
The prevalence and severity of disease at age five can be used as a proxy indicator for the impact of early years services and programmes to improve parenting, weaning and feeding of very young children

In the 2015 National Dental Epidemiology Programme survey, 401 children were clinically examined in Bexley. The survey showed that, in Bexley:

- 14.4% of 5-year olds had dental decay extending to the dentine layer which can be detected by visual observation alone; significantly lower than both England and London.
- The mean number of decayed, missing of filled teeth in five-year-olds is 0.38 per child; significantly better than both England and London.
- There was no significant difference, or clear trend, in tooth decay across levels of deprivation in Bexley.

This survey will be repeated in 2019/20 and will be focussing on early years, so more data will be available on this age group in 2020.

Figure 5: Prevalence of decay by Index of Multiple Deprivation 2015 quintiles for Bexley (including 95% confidence limits shown as black bars)



Source: Public Health England

This indicator therefore links to a key policy - Getting the Best Start in Life. Poor oral health is a priority under Best Start in Life; it was also a topic of a Health Select Committee inquiry, and the most common cause of hospital admission for 5-9-year olds.

SEND

Autism is thought to occur in at least 1% of children. Using population data from the Office for National Statistics (2017), this would equate to at least 595 children in Bexley. In 2018, there were 808 children in primary, secondary and special schools in Bexley with special educational needs (SEN) whose primary need is autistic spectrum disorder.

In Bexley in 2018, there were 2,837 (12.4%) primary school pupils with a special educational need (SEN). In 2019, 2.8% of children in Reception had a Statement or Education, Health and Care Plan (EHCP) in Bexley, equating to 87 children. This is projected to increase to 3.7% by 2024; 123 children. Of the 87 children in 2019 with a Statement or EHCP, 78% are in mainstream schools.

This is a complex and important area to cover - a bespoke 'SEND from 0-25' chapter will explore this group across the whole age range of childhood and adolescence.

Current service provision

The following services are those available to children and families in Bexley:

- Universal provision: Maternity and Midwifery Services
- Level 1 Universal Provision
    - Health Visiting Service
    - Children's Centre facilities
    - Primary Care and General Practice
    - Leisure Centres
    - Voluntary Sector Services
    - Childminders and Nurseries
    - Baby and Toddler Groups
- Level 2 Additional/Targeted Provision
    - Health Visiting Service
    - Children's Centre facilities
    - Voluntary Sector Services
- Level 3 Intensive Provision
    - Perinatal Mental Health Service
    - Family Wellbeing Service
    - SOLACE
- Level 4 Specialist Provision
    - Children with Disabilities Service
    - Special Educational Needs and/or Disabilities
    - Early Intervention Team in Early Years
    - Specialist Children's Services
    - Community Paediatrics
    - Speech and Language Therapy
    - Occupational Therapy
    - Physiotherapy
    - Children's Nursing
    - Audiology
    - Portage Service

Further mapping of these services is needed, including referral routes and criteria.

Some conditions which can result in children experiencing difficulties with speech, language and communication may only affect a small number of children in a local area. It remains important to ensure that services are commissioned which meet their needs. Local commissioners may wish to consider the needs of these children as part of their overall planning. Some of these children will require specialised treatment such as cleft lip and/or palate services which are likely to be commissioned at a national level by NHS England. The care children receive in specialist centres will include help with their speech, language and communication but similar support in the child's local community may also be needed.

What is on the horizon?

- 2-2 ½ Year Integrated Review
- E-Red Book
- National Review of the Healthy Child Programme (HCP)
- Association of Directors of Public Health Sector Led Improvement for Health Visiting and School Nursing
- Public Health England Strategy 2020-2025

Local views

To fully assess the needs of the early years population in Bexley, it is necessary to include the voices of parents and carers of under 5s and the professionals delivering services to them. Consultation with this wider group of stakeholders has yielded rich data on the needs of families and the identification of issues and emerging needs.

Views of parents and carers were captured using one to one semi-structured interviews in settings around the borough (e.g. child health clinics, baby groups, and voluntary sector groups for under 5s), and an online survey which was promoted widely by LBB and partners and advertised though corporate social media channels. Desk research was conducted to include qualitative data from other relevant consultations relating to the needs of the early years population carried out in the preceding 12 months in LBB.

Consultation was also carried out with a range of organisations/teams/services working with the early years population using focus groups in team meetings, one to one interviews with key informants, an online survey which was promoted within all services and gave the opportunity for individual staff members to respond.

A thematic analysis was undertaken, and the key themes are presented below.

Local parents and carers

Pre-conception advice and support

The online survey identified that only 24% of those responding had received help support or advice when they were planning to have a child. The professional that was most frequently identified was the GP. Other professionals included gynaecologists and midwives. Some people had sought advice from friends and family or the internet. The main topics of support described were fertility and the recommendation to take folic acid.

Summary of parents/carers views of support during pregnancy

Parents/carers reported receiving support on preparing for birth (classes or visits to the maternity unit at the hospital), healthy eating, healthy start vitamins and vouchers, exercise and quitting smoking.

COMMENTS ON THE SUPPORT RECEIVED	WHAT ELSE WOULD HAVE HELPED?
• Reductions in support received compared to previous pregnancies; • Poor/insufficient breastfeeding support; • Positive experience of support from children and family centres; • Positive experience of support from maternity services; • Positive experience of home visits from health visiting service; • NCT – many parents reported paying for antenatal classes from the NCT	• Antenatal classes; • Hypnobirthing classes; • Peri-natal mental health support; • Breastfeeding support – more accessibility; • More information – especially for new mums on pregnancy, birth, parenting and places to go, things to do; • Opportunities to meet other parents/parents to be

Early education and/or childcare

Of the parents/carers completing the on-line survey, 52% have children at nursery and 45% in pre-school. Respondents suggested that the support required to ensure that children are Ready to Learn at 2 and Ready for School at 5 includes the elements in the table below.

SUPPORT REQUIRED	DESCRIPTION
Childcare	Free, flexible childcare for working parents
Parenting/ child development support	To understand child development and key milestones
Free Groups	To include stay and plays, parent toddler groups
Mentor/buddy system	To provide peer support
Support for dads	Peered support and mental health support available outside of working hours
Access to specialist help	Clear referral pathways to specialist services

The big issues for parents and carers

We asked parents and carers about the issues being faced by families with children under 5 years and they cited the following:

The most difficult issues raised included childcare costs, debt or money pressures, not being able to get adequate housing or facing homelessness due to costs of housing, mental health issues for mothers and fathers, knowing how to help their children develop well, lack of consistency of care in health care services, a lack of breastfeeding support, the challenge of returning to work and balancing work and childcare, difficulties with getting support for children with SEND, conflicting advice from health care professionals.

Parents felt that the following could help with these issues: free or low-cost groups, support with breastfeeding, money advice, peer support, flexible childcare, more financial support for childcare, and more flexible working hours.

We asked parents and carers what support they felt parents needed to be the best parents that they could be.

- The most significant number of responses related to parenting support and guidance, including information on helping children to develop and be ready for education, how to promote good behaviour and physical development, age appropriate activities, information and support on breast feeding and weaning, and toilet training.
- There was also positive feedback on the offer from children's centres – but most felt that more was needed, the range of what was offered needed altering, and the cost of classes needed considering.
- Many parents / carers wanted more opportunity to interact with or buddy up with other parents / carers to reduce isolation, offer peer support, and build friendship circles.
- Parents / carers were also stating that more access to health visitors would be of importance in helping them to be better parents.
- A key theme throughout all support suggestions was that they wanted it to be free, unbiased, open, approachable, and non-judgemental.
- Many parents also wanted something which is available on the weekends.

We also asked parents and carers about the play and leisure offer in Bexley – they reported significant usage of parks, playgrounds, libraries, and 'stay and play' sessions at children's centres. The main issues that they reported with these facilities were broken or dirty equipment, having to pay for activities, people 'hanging out' in the play areas, and a lack of facilities for children under 5.

'It really is encouraging to be asked about my views. Whilst I don't have much to offer in terms of ideas, it's always good to see that Bexley are looking for feedback and searching for ways to improve. There are a lot of disadvantaged families in Bexley who could really benefit from support without feeling judged or degraded. At the same time, I know it is hard to reach out to those particular families but babies and young children all deserve the best start. Good luck Bexley!'

Professionals

A range of professionals responded to the online survey, and many were engaged in individual conversations. They included teachers, early years practitioners, health visitors, child minders, SEND practitioners, family lives staff, children and family centre staff, and a number of staff in services such as safeguarding, schools, portage, education, and mental health.

When asked about the support parents/carers needed prior to conception, during pregnancy and after the baby was born, they listed the following areas:

PRECONCEPTION SUPPORT/CARE	SUPPORT DURING PREGANACY AND AFTER THE BABY IS BORN
Parenting support	Preparing for birth
Sexual & reproductive health, contraception	Peer support
Peri-natal mental health	Professional support
	Parenting/health advice
	Peri-natal mental health

They were also clear on a number of issues and gaps which are present in the system, including:

- detrimental effects on families who were not in contact with service (or who had a lack of contact with services),

- a lack of access to services (caused by places being difficult to get to, poor transport availability, lack of confidence to access services, services not reaching out to people are at risk),
- services being focused on those already in crisis and not providing enough support to prevent families developing vulnerabilities,
- a lack of continuity of care,
- a lack of parent education sessions, leaving families unprepared and at risk of struggles
- a lack of information disseminated about services available
- a lack of specific and practical support with different aspects of parenting (including breast feeding, adapting to parenthood, antenatal and postnatal support, weaning, domestic abuse, mild to moderate mental health issues, young parents)
- equity of service (concerns were raised on different levels of service at the 3 main hospitals where Bexley women give birth and the fact that none of these are within the borough, and the reduction of locations of community midwifery clinics)
- pathways from maternity services into health visiting services are not smooth
- there is a lack of breastfeeding support and the health visiting service has not achieved the level 3 UNICEF Baby Friendly Initiative award
- children not attending the 2 year developmental reviews and any development issues not being picked up early enough

When asked the most common issues with children's development that they see in Bexley, key issues raised were:

- speech, language and communication issues
- toilet training (with many not toilet trained by the time they start reception)
- autistic spectrum disorder (high levels presenting, and many undiagnosed)
- lack of independence (including dressing themselves, using the toilet, using cutlery, holding pens and pencils
- poor attention skills (including sitting and listening skills)
- poor personal, social and emotional development (children lacking age appropriate skills, having a lack of socialisation, and having behavioural difficulties due to lack of boundaries
- issues relating to exposure to adverse home environment (including domestic abuse, poverty, unsuitable housing)
- poor eating habits (obesity, fussy eaters, poor diets, weaning, lack of variation in diet)
- special educational needs (high level of complex needs children, parents not accessing health services, lack of engagement to appropriate support, families feeling isolated, unable to access activities and gain advice or support)

We asked the professionals that we engaged with what they felt that parents and carers needed to ensure that their children are, ''ready to learn at 2 and ready for school at 5''. One of the main things suggested was **parenting support** (classes, information and advice, and face to face support) to help parents:

- understand expectations for language, behaviour, education
- understand the need for school readiness and how to achieve it
- understand how their child's brain works and how to help their child to develop in the right way
- give them tips for speaking and listening to their children, reading with them, and playing with them
- meet other parents and professionals
- develop structure, routine and confidence with parenting
- with practical tips on how to toilet train their children
- support with behaviour management

"There should be investment in this area as I believe it is fundamental to the development of our society and the next generation"

The professionals also thought that parents would benefit from more funded childcare, and enough preschool places available so people can access them in the right places. They also thought that more support and advice was needed for parents of children with additional needs such as ASD and ADHD. Another area raised was supporting parents with their needs, for example, adult literacy.

Another issue raised was families not taking up their entitlement to free early years education at 2 years and 3-4 years (and there being no way of finding which ones are entitled but not taking it up in a timely way).

- It was felt that advertising and promotion (physical and digital) would be a good approach to try to increase take-up, including making information available at services such as doctors, hospital, health visitor, library, children centres.
- They also raised the suggestion of making sure that there was a range of support available and that local establishments were able to offer what parents need – including support for parents, flexibility on times and hours.
- Some raised that some families may not want to access it due to them or extended family wanting to spend time with the child.
- The professionals felt that it was important to raise awareness amongst parents and carers of the importance of early education, to showcase the benefits and encourage parents to learn with their children, and giving them easy advice on where they can go and what the child will gain from the experience.
- Promotion by other professionals was also highlighted as an important driver to increase take up – health visitors were sited as a particularly important professional for this, but that responsibility was also shared between all services.
- Some felt that the clarity of the offer could be improved to help parents understand what is on offer, whether they are eligible, and help them engage in the process

Professionals we also asked what they felt were the key issues for families with children under 5 years – their responses included:

- Lack of parenting skills and knowledge
  - Behaviour management
  - Toilet training
  - SLC
  - Weight management
- Finance
- Housing
- Domestic violence
- SEND
- Peri-natal mental health
- Advocacy for parents
- Access to services

Services also raise some issues which their services were experiencing:

- Volume of referrals
- Levels of Need
- Service performance
- High thresholds for children's services

Issues which are emerging included:

- SEND – increasing numbers and complexity, finding appropriate placements for these children
- English as an Additional Language (EAL)
- Gap between rich and poor

- Parental wellbeing
- Child development concern
- Early identification of Need
- Families with no recourse to public funds
- Use of food bank vouchers increasing
- Universal credit
- Changing nature of presenting issues
- Services are strained
- Young parents

Another issue identified in conversations was that children are developing behaviour issues early on (both those due SEND/medical conditions and those due to parenting technique) which are not being identified and addressed early enough, and the child being excluded from school by Year 2 or only allowed in school for small amounts of time due to level of support required for them in school.

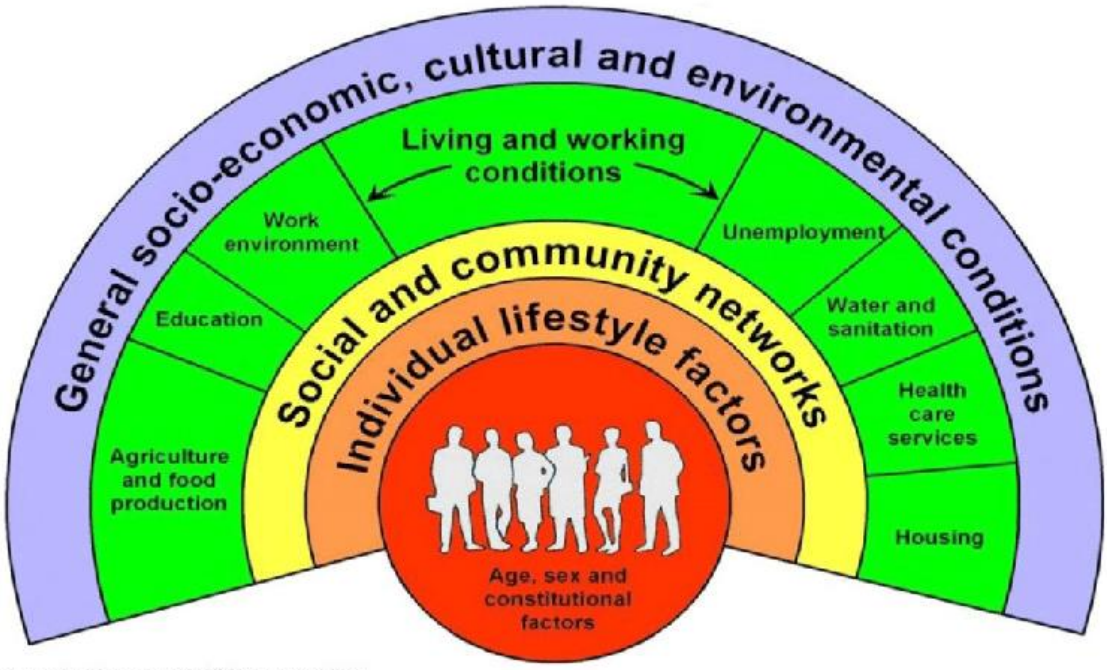
Healthy Start vitamins and vouchers

Healthwatch Bexley carried out a consultation on the Healthy Start scheme with women, parents, families and professionals in Bexley to get an understanding of the level of awareness in the borough, knowledge about the scheme, where vouchers can be used and ease of applying and using. The consultation was carried out in August 2019 and the findings were presented at the Healthy Start event in September 2019. The key issues identified from the research included:

- A lack of knowledge for parents around the Healthy Start voucher scheme. Many parents had not heard of the scheme.
- The scheme is not consistently publicised and advertised sufficiently at key venues such as baby clinics, nurseries, children's centres and food banks
- Some health and early years professionals were not fully aware of the qualifying criteria to be eligible for the scheme or actively promoting the scheme
- Application forms are not being signed in a timely basis by health professionals
- The turnaround time of application forms once signed is slow, with some people not getting a response after applying

Evidence of what works

A range of interventions across the determinats of health are necessary to improve child health and development outcomes. This includes targeted interventions for those at most risk of poor outcomes, but also universal services (such as health visiting) and action through changes in policies and structural levers that affect the socio-economic, cultural and environmental conditions which children and familes live, work, learn and play in Bexley.



Source: Dahlgren and Whitehead, 1991

To support better outcomes during the 'early years' period in Bexley, we must provide the right environment, care and support, at the right time, in the right place. The System Wide Prevention Strategy for Bexley focuses on primary, secondary and tertiary prevention. In this context, this includes:

- Primary prevention: creating an environment that promotes good health and good parenting; preventing poor parenting, poor health and adverse childhood experiences; identifying families who may be at risk and intervening early to prevent difficulties
- Secondary prevention: identifying families experiencing difficulties and providing the support to get the back on track
- Tertiary prevention: identifying children and families experiencing the effects of disadvantage or trauma and a) preventing further harm and b) supporting them to recover

The 0-5 Healthy Child Programme covers the 'Pregnancy and the first 5 years of life' period. It is an evidence-based programme, led by Health Visitors, and produces improved outcomes across the 6 high impact areas identified by PHE – parenthood and early weeks, maternal mental health, breastfeeding, minor illness and accidents, and healthy 2 year olds - 'ready to learn, narrowing the word gap'. This is a universal service and offers support and guidance to all parents. Some families may need a bit of extra support and these are covered by the 'universal partnership' and 'universal partnership plus' models, where additional time, support and referrals are given to help families. There are 5 key reviews within this period which offer

assessment, advice and support across the high impact areas. This approach is aligned with the Early years foundation stage profile: 2018 handbook and Public Health England Public Health Profiles. When commissioning the Healthy Child Programme, local authorities can use PHE and NICE guidelines to ensure that an effective and cost effective health visitor and school nursing service is delivered that acts as a key public health resource and can also help to achieve indicators in the Public Health Outcomes Framework.

The place-based approach of the Healthy Child Programme offers opportunities to help meet the challenges faced by public health and the health and social care system. This impacts on the whole community and aims to address issues that exist at the community level, such as poor housing, social isolation, poor or fragmented services, or duplication or gaps in service provision. A place-based, or community-centred, approach aims to develop local solutions that draw on all the assets and resources of an area, integrating services and building resilience in communities so that people can take control of their health and wellbeing, and have more influence on the factors that underpin good health. Improving outcomes is everyone's business, working across both traditional and non-traditional settings such as the workplace, green spaces and community centres.

Investing in quality early years care and education to promote school readiness gives a greater return on investment than many other economic development options – every £1 invested saves up to £13 in future costs. Investing early is beneficial because waiting until adolescence means that £7 would have to be invested to achieve the same impact as £1 in early years. Targeted parenting programmes to prevent conduct disorders give savings to the NHS, education and criminal justice system of £8 for every £1 invested.

What works to improve school readiness?

Good maternal mental health, learning activities (including speaking to babies and reading to children), enhancing physical activity, parenting support programmes, and high quality early education programmes are they keys to improving school readiness.

The evidence suggests that 2 in 5 children miss out on 'good' parenting. Parenting has a bigger influence on a child's life chances in the early years than education, wealth or class – effective, warm, authoritative parenting gives children confidence, and stimulates brain development and the capacity to learn. Supporting parents with parenting programmes has a positive impact on both parents' and children's wellbeing and mental health, and is an important part of prevention and early intervention.

Actions to improve parenting support programmes include

- **Understand** parent's needs and how to engage them
- **Intervene early** to maximise impact and reduce longer-term costs
- **Increase** the **accessibility** of programmes
- Ensure **better integration** and **co-ordination** of parenting support services
- **Improve** the **quality** and build the **evidence base** for support services

Programmes that offer early family training / parenting support give improvements in outcomes such as numeracy skills, vocabulary, letter identification, emergent writing skills, and parent-child interaction.

Other more targeted programmes, such as the family nurse partnership, can produce better language development, vocabulary and mental processing, emotional development and attention behaviour.

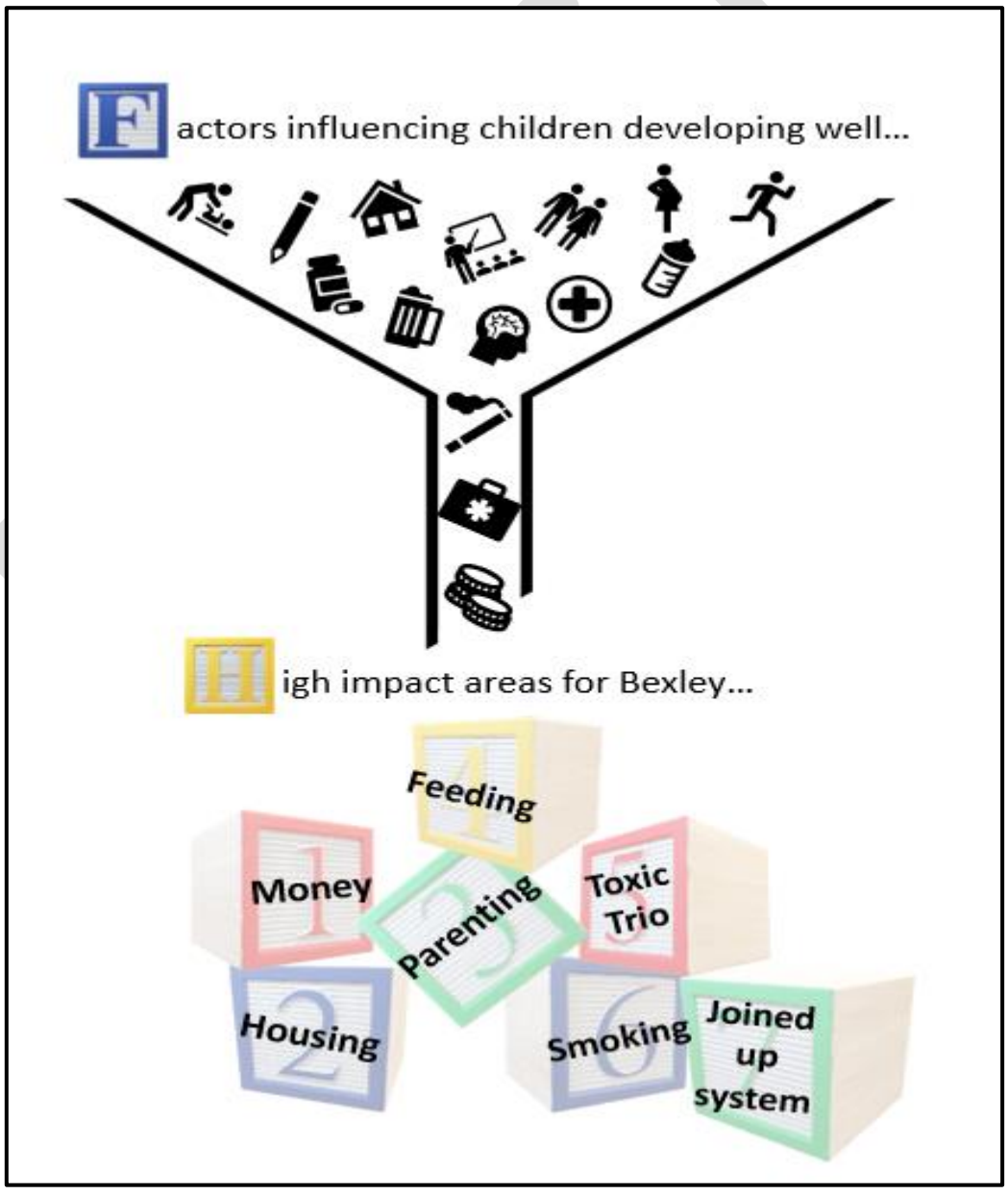
High quality early education is another area which improves school readiness, alongside improved future academic attainment and productivity, higher levels of employment and less involvement in crime. To improve and maintain high quality education the focus needs to be on systems development, structural development and process development

Systems development	Structural development	Process development
• Continued and increasing investment • Integrated services • Workforce training	• Favourable staff:child ratios • Encouragement of parents to support and engage more actively • Focus on cognitive and non-cognitive aspects of learning	• Adoption of more responsive and nurturing staff:child relationships • Work towards an equal balance of child and adult initiated activity

What does this tell us?

The first 1001 days of a child's life (from conception to 2 years of age) is the best opportunity to shape the outcomes for that child. It is the time when the effects of negative factors (such as Adverse Childhood Experiences, social disadvantage, poor parenting, and poor parental health) can damage development and increase the risk of poor health, development and life outcomes, or the effects of protective factors (such as good attachment, good parental health, good early education, accessible services, and healthy living conditions) can help put a child on the path to fulfilling their potential. **The evidence is clear – the early years period is the time to offer the right advice, the right support and the right environment for good growth and development.**

Many factors contribute to the development of children, including early education, health services, health visiting, midwifery, parental health, money, smoking, physical activity, housing / homelessness, parenting ability, breastfeeding & weaning, and the 'Toxic Trio' of mental illness, substance misuse and domestic abuse.

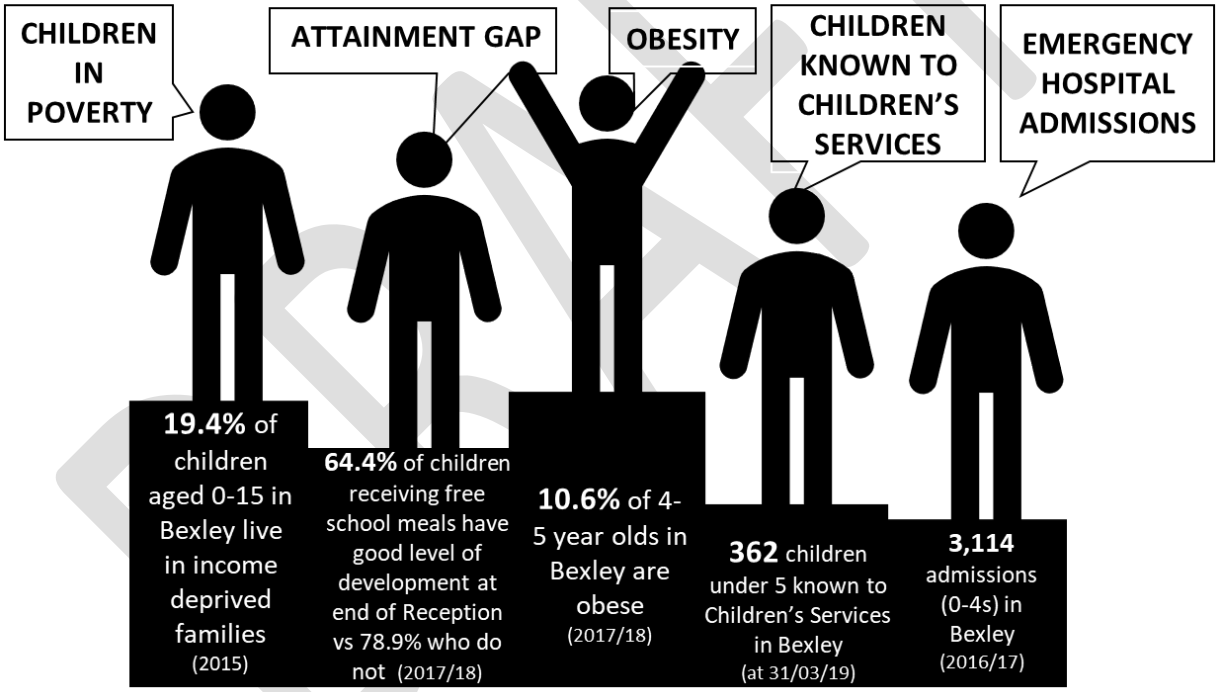


Based upon the evidence presented in this Population Needs Assessment, the suggested high impact areas for Bexley are:

- **Money** (poverty, cost of childcare, poor employment attainment, accessing correct benefits, inclusive growth)
- **Housing / homelessness**
- **Parenting ability**
- **Feeding** - Breastfeeding & weaning
- The **'Toxic Trio'** (of mental illness, substance misuse and domestic abuse)
- **Smoking** in pregnancy
- A **joined-up system** (improved ease of navigating the system)

The figure below presents 4 of the major outcomes which could demonstrate whether progress is being made in the high impact areas in Bexley. These are all areas where Bexley needs to reduce their rates and are the demonstrable outcomes of where the system isn't currently succeeding.

Figure 6: Major outcomes demonstrating progress in high impact areas in Bexley



What should we do next?

Recommendations for consideration

	Recommendation	Lead(s)
1	Increased and improved parenting support in the first 1001 days (including breast feeding and weaning, developmental cues, promoting development, helping children to be school ready, toilet training)	Children's (Education and Early Years), with Public Health and CCG commissioners and providers
2	Full and thorough mapping out of all services and clearly detailing referral routes/pathways etc.	All
3	Improved access to services – better joining up of the system so parents and families access via their 'front door' and can then be navigated around seamlessly	Public Health lead but a joint effort of Children's, CCG, voluntary sector, other council departments and all providers.
4	Thorough investigation into data sharing between services – what is currently done, what are the gaps which are causing issues, what the options are for rectifying this, actions moving forwards	All
5	Further deep dives into the following topics: Child and perinatal mental health Traveller populations Housing Hospital admissions Children being missed Inequalities across the system	All done in collaboration but suggested leads below: CCG led Council led Public Health / Housing led CCG led Collaboration Public Health led
6	Focus on reducing smoking in pregnancy and in homes where young children live.	Public Health and CCG partnership
7	Using a 'Health in All Policies' approach to improve health and development outcomes across the board – with increased focus on reducing social inequalities using levers such as housing and inclusive growth.	Public Health and other council departments
8	A needs assessment chapter covering children with disabilities and / or special educational needs from 0-25 should be written (as 0-5 is too narrow a focus for this group).	