NEEDS ASSESSMENT

CHILDRENS 0-5

Warwickshire Joint Strategic Needs Assessment

2022

Warwickshire County Council

REPORT DETAILS

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CONTENTS

Report Details ... 2

Contents ... 3

Executive Summary ... 5

Recommendations ... 15

Introduction ... 20

- National and Local Context ... 20
- Kings Fund Population Health Model ... 23

Local Context ... 25

- Population ... 25
- Age and Gender ... 27
- Ethnicity ... 27
- Inequalities in Health and Deprivation ... 30
- Children in Low Income Families ... 34

Health of Children 0-5 – Pregnancy and Birth ... 38

- Low Birth Weight ... 38
- Preterm Births ... 39
- Healthy Weight in Pregnancy ... 40
- Smoking in Pregnancy ... 43
- Pregnancy with Low Maternal Age ... 45
- Maternal Mental Health ... 47
- Parenting (Antenatal) Education ... 48

Health of Children 0-5 – Early Years ... 49

- Infant Feeding ... 49
- Obesity (child) ... 50
- Oral Health ... 58
- Immunisations ... 60
- Domestic Abuse and Violence ... 64
- Speech, Language and Communication Needs ... 66

Child Hospitalisations ... 68

- A&E Emergency Department Attendances ... 68
- Emergency Hospital Admissions ... 71
- Unintentional Injuries ... 74

Child Deaths 77

Categorising Child Deaths 77
Infant Mortality 79
Modifiable Factors in Infant Mortality 82
Neonatal Mortality 83
Modifiable Factors in Neonatal Mortality 84
Still Birth 86

Services for Children 0-5 88

Health Visitor Services 88
Health Nursing Service 89
Early Intervention Health Visiting Service 91
Early Education and Childcare 91
Children Open to Children & Families Services 96
Service Integration for 0-5s 106
Children and Family Centres 108

EXECUTIVE SUMMARY

This needs assessment presents an in-depth analysis of the national and local picture of children aged 0-5's health needs. The Joint Health and Wellbeing Strategy, published in January 2021, identified a priority to help our children and young people have the best start in life. We know that positive early experiences are vital to make sure children are ready to learn, ready for school, and have good life chances. Support needs to start early, including support for parents in the "1001 Critical Days" (from conception to age two) when the foundations for development are laid.

This needs assessment has highlighted several key themes across its chapters:

- We are seeing an increasing population growth and increasing diversity of needs amongst Warwickshire's young children. Services will need to expand and find new models of working to keep in line with increasing numbers and complexity.

- Deprivation and inequalities are a critical factor for all services and targeted effort needs to take place in more deprived areas.

- There are some key health promotion issues for all services to embed into ways of working and interactions with expectant or new parents – issues include smoking, healthy diet, and vaccinations.

- There are still opportunities to increase the role of early intervention and prevention – current non statutory services could be supporting more families.

- There should be a closer alignment between services reflecting the increasing complexity of needs, particularly in deprived areas.

- There is an opportunity to establish a partnership to centralise the needs of children and to take forward the recommendations from this report.

Scope of the 0-5 JSNA

When approaching this Needs Assessment, it was decided that the following was in or out of the scope of the assessment:

<u>In scope:</u>

- The Health of Children during pregnancy and birth, as in line with the 1001-days policy including low birth weight, healthy weight in pregnancy, smoking in pregnancy, pregnancy with low maternal age, maternal mental health, and parenting (antenatal) education.

- The health of infants and children during their early years including infant feeding, obesity, oral health, immunisations, and domestic abuse and violence.
- Child Hospitalisations including A&E emergency department attendances, emergency hospital admissions and unintentional injuries.
- Child Deaths including categorising child deaths, infant mortality, modifiable factors in infant mortality, neonatal mortality, modifiable factors in neonatal mortality and still birth.
- Service for Children including health visitor services, health nursing services, early intervention health visiting services, early education and childcare, and children open to Children & Family services.

Out of scope:

Whilst this assessment references the important of Speech, Language, and Communication (SCLN) needs for children aged 0-5 we are unable to conduct a detailed assessment due to a paucity in local data and intelligence. Work is currently being undertaken elsewhere to address SCLN.

It was additionally recognised that the mental health of children 0-5 is important but needs to be addressed as separate all ages work in the future, and therefore shall not be focused on in this assessment.

Local Context

There are predicted increases in the number of under 5-year-olds in Warwickshire that needs to be accounted for in the commissioning of services. Some increases are in the immediate term, in particular a 2% year on year growth in numbers is predicted in South Warwickshire. Over the longer term there is a county wide increase in the number of under 5-year-olds by 17.7% in 2043.

There is an increasing ethnic diversity within Warwickshire's children compared to Warwickshire's population at the time of the last Census in 2011. The evidence is that there are differences in long term health outcomes by ethnicity, with most groups having worse outcomes than 'White British'. Given the importance of the first 1,001 days to long term health, services need to ensure that ethnicity is being recorded to support with measuring outcomes by ethnicity at a local level.

Deprivation is often a marker for where more resource is needed to be targeted to achieve the same outcomes as more affluent areas. Relative levels of deprivation are increasing in Warwickshire, and there are higher levels of need in Nuneaton and Bedworth, Rugby town centre and Leamington. This is backed up by evidence that the largest numbers of children in low-income families from 2015/16 to 2018/19 has been in Nuneaton and Bedworth and Rugby.

Children in low-income families are associated with poorer outcomes in adult life, premature mortality, and lower life expectancy, as well as other health issues including

mental health. Within Warwickshire, Nuneaton and Bedworth has the highest number of 0-5 children in relatively low-income families, accounting for 19% of its total 0-5 population.

Deprivation is linked to performance at school and has been shown to have an adverse impact on school readiness. Out of the bottom 10 wards in Warwickshire for achieving a Good Level of Development, 4 of those contain Lower Layer Super Output Areas (LSOAs) in the top 30% most deprived.

Health of Children 0-5 – Pregnancy and Birth

All areas of Warwickshire have a low birth weight rate lower than the England average, however there are inequalities with Nuneaton and Warwick having the highest rates. This fits with the ethnicity profile of the population showing high proportions of mixed ethnic heritages in these areas, and the audit results showing that these groups are more likely to have low birth weight and premature births. Rugby is notable for having low rates despite diverse population.

Obesity during pregnancy increases risk of complications during pregnancy and childbirth. Warwickshire North CCG has higher rates of women with obesity in early pregnancy (25.3%) than the England average (22.1%). South Warwickshire CCG is significantly lower (17.6%). When comparing to LSOA deprivation, the most deprived LSOAs have the highest rates of obesity in early pregnancy (28.52%) and the least deprived have the lowest (15.07%).

Smoking in pregnancy results in increased risk of complications during labour and risk of miscarriage, premature birth, stillbirth, low birth weight, sudden unexpected death in infancy and infant mortality. Warwickshire North has the higher rates of women smoking in early pregnancy (15.88%) compared to the England average (12.76%). South Warwickshire is significantly lower (8.46%). When comparing to LSOA deprivation, the most deprived LSOAs have the highest rates (24.02%) and the least deprived have the lowest rates (4.3%).

Pregnancy with a low maternal age is high in the North, with Nuneaton and Bedworth (23.7 per 1,000) and North Warwickshire (18.1 per 1,000) both higher than the England average (15.7 per 1,000).

The Perinatal Mental Health Dashboard for Coventry and Warwickshire indicated that:

- 18.2% of the referrals are of women living in the most deprived decile.
- 8.1% of the caseload represented women aged 16-20 and 67% were women aged 26-39.
- 72% of the caseload where from white ethnic background, while 3.3% were of Asian descent and 2.5% were of black heritage.

Good quality antenatal or parenting education (PE) can empower families to make healthy choices and decisions about both pregnancy and the early years of an infant's life. Data collected from parents participating in the midwife led virtual classes reported that 95% initiated skin-to-skin contact at birth and 82% initiated breastfeeding highlighting the value of PE. However, this virtual offer only reached 5% of new parents in 2021. This low access figure combined with one of the trusts lacking a specialist PE midwife role identifies both a gap and inequality across the Warwickshire footprint.

Health of Children 0-5 – Early Years

Breastfeeding data is poor. Work is needed to improve definition and collection of this data. However, current indicators show that both South Warwickshire NHS Foundation Trust (81.8%) and University Hospitals Coventry and Warwickshire NHS Trust (73.8%) achieve a higher percentage of infants receiving breast milk at first feed than the National average (72.4%). A lack of data means we do not know rates for George Eliot Hospital NHS Trust at this time.

Warwickshire has less childhood obesity than England as a whole, but both North Warwickshire and Nuneaton and Bedworth have higher rates than the England average. There is also a large increase in children being very overweight in reception (8.6% of children being overweight) to year 6 (16.8%).

All Districts and Boroughs have a better rate of five-year-olds with experience of visually obvious tooth decay than the England average. The highest rates in Warwickshire are in Nuneaton and Bedworth (19.8% of children having visually obvious tooth decay).

There is a drop in vaccine coverage as children get older, most notably the uptake in children aged 5 for the 2nd dose of the MMR vaccine has a 89.6% uptake in 2020/21 compared to the 1st dose uptake for the same cohort of 96.1%. This means that some children had one vaccination but not their second, despite being eligible.

The Warwickshire Domestic Violence and Abuse Joint Strategic Needs Assessment provides evidence to suggest that pregnant women and women with children under the age of 5 are more likely to experience abuse and / or require support from agencies. The assessment included the following specific relevant recommendations:

- There are opportunities for all services/agencies that work with parents, infants, and young children to facilitate disclosures and signpost to appropriate support.
- There is a need to consider the support needs of a child under the age of 5 who has witnessed or experienced domestic abuse to recover from their experience and rebuild their relationship with the non-abusing parent. There is also a need to consider the support needs of the non-abusing parents to recover and move on from their experience.

A paucity in local data and intelligence to assess speech, language and communication needs in Warwickshire children means it has not been possible to accurately assess the local picture at this time. However, the Local Authority Interactive Data tool indicates that Warwickshire scores low (10th out of 11) compared to statistical neighbours for the percentage of children achieving at least the expected level in the Foundation Stage Profile in 2018/19.

Child Hospitalisations

Hospital attendances dropped over the first Covid lockdown but have been recovering since the alpha wave. Successive waves of Covid haven't impacted on this recovery. North place has the highest number of attendances in terms of raw numbers.

Both rates for 0-5 A&E attendance and 0-5 Hospital admissions show higher rates for males then females. Indices of Deprivation show that both rates for 0-5 A&E attendance and 0-5 Hospital admissions in the most deprived areas are most prevalent in North Place, whilst the least deprived areas are the most prevalent in South Place. Ethnicity shows lower proportion of attendances from children with mixed ethnic heritage. South Place particularly has seen increases in attendances following the second lockdown. Rugby has the largest number of childhood injury admissions in Warwickshire, whilst Nuneaton and Bedworth has the lowest.

Unintentional injuries are a leading cause of hospitalisation and major cause of premature mortality for children aged 0-5, often resulting in long-term health issues. The majority of these injuries are preventable and working to prevent these injuries has significant long-term benefits for individuals, families, and society.

The emergency hospital admission rate for unintentional injuries nationally in the 0-5 age range is 38% higher if a child lives in one of the most deprived areas compared with those children who live in the least deprived.

For some injury types this inequality is larger, with children living in the most deprived areas at a 50% higher risk of being burned, scalded or poisoned and this resulting in primary or secondary care attendance, then for those living in the least deprived areas.

The highest rate per 10,000 for hospital admissions caused by unintentional and deliberate injuries in children aged 0-4 years in 2019/20 is in Rugby, which is higher than both the Warwickshire and England average.

The Reducing unintentional injuries in and around the home among children under five years paper advises that Local Authorities could achieve significant improvements through targeting the reduction of five causes of unintentional injuries among the under-fives. These are:

- Choking, suffocation and strangulation
- Falls
- Poisoning

- Burns and scalds
- Drowning

Child Deaths

The largest categories for 0-5 death type are 'chromosomal, genetic and congenital anomalies', and 'perinatal/neonatal event' (including prematurity). There is a relationship with infant mortality and the wider determinants of health, deprivation, and inequalities. Infant mortality rates in Nuneaton and Bedworth, and Warwickshire North are higher than the national average, whilst Warwick and Stratford are below average.

Of the 122 Warwickshire Child Deaths between 2017 - 2021, 45 were cases over a month of age. Of the 45 cases just over a quarter (29%) identified modifiable factors. Out of the factors identified, smoking and unsafe sleeping contributed to over 50% of child deaths. Other factors include alcohol, drugs, consanguinity, maternal BMI, and booking a pregnancy late for services.

Neonatal mortality is defined as deaths within the first 28 days of life – excluding stillbirths. The highest rates are in Warwickshire North (4.1 per 1,000 births) for the 2017-19 reporting period. This rate is considerably higher than the England average (2.9 per 1,000 births).

77 of Warwickshire Child Deaths examined were neonatal cases. Of these cases less than a quarter (22%) identified modifiable factors. Out of the factors identified, smoking and pathway or escalation of care contributed to over 50% of cases. Other factors include consanguinity, maternal BMI, domestic violence and illicit drugs or alcohol.

A stillborn baby is one born after 24 completed weeks of pregnancy with no signs of life. In the period 2017-19 the Warwickshire still birth rate (2.7 per 1,000 births) is comparatively low against the national rate (3.99 per 1,000 births).

However, more recent data collected by place across the Coventry and Warwickshire region suggests a rapid increase in stillbirth between 2019/20 and 2020/21, with both North and South Warwickshire experiencing a doubling of instances of stillbirth.

Services for Children 0-5

The proportion of New Birth Visits completed within 14 days in Warwickshire in 2020/21 was 78.2%. This figure is lower than the England average (88.0%) and has been lower than the England average since 2017/18.

The proportion of infants receiving a 6–8-week review in Warwickshire in 2020/21 was 85.0%, which is higher than the England average (80.2%). The proportion of children receiving a 2 ½ year review in Warwickshire in 2020/21 was 80.8%, which is higher than the England average (71.5%).

Parents and carers of young children in Warwickshire were invited to share their views and experiences of the 0-5 Public Health Nursing Service to help inform future support:

- Almost 80% of respondents stated they knew how to contact their Health Visiting service. However, 46% of respondents said they do not know who their family's health visitor is, 22% did not understand what the Health Visiting service does, 24% were not told what the Health Visiting service does and 16% did not know how to contact the Health Visiting service. It is important to note for this question that Health Visitors operate on a collaborative caseload. This means unless a family is targeted or specialised, a named health visitor will not be assigned.

- When asked to what extent respondents agreed with statements in relation to what the Health Visiting service should offer, 63% of respondents agreed that they would like more support between 3-6 months and 43% said they would like more support between the 2-2.5 years contact and their child entering school. Only 4% agreed that they would be happy with fewer contacts. At the time of the survey Health Visitors were following both National Health Service guidance and COVID guidance, which limited the number of face-to-face visits and meant baby clinics were not open. This may have contributed to the response seen in the survey.

- Before COVID, 43% of respondents said they were very satisfied or satisfied with the Health Visiting service, and 16% were not satisfied or very unsatisfied. Around one quarter of respondents (26.3%) stated this was not applicable as they either did not use the service or did not have a child between 0-5 at the time. Since COVID, 51% of respondents were not satisfied or very unsatisfied, however 24% were satisfied or very satisfied with the service. The demand for specialist and targeted parts of the service has increased throughout and since COVID, which means there is a reduced capacity for the universal elements of the service.

Early education and childcare play a vital role in children's early development and family wellbeing. 68% of parents of 2-4-year-olds reported accessing formal early education or childcare in the period before March 2020. At the start of lockdown this changed radically. Of those who had formal arrangements, just 7% of children continued to attend throughout the lockdown period. By June 2020, 83% of this group reported their child had not returned to formal provision, with almost half (49%) reporting their child was unlikely to return to their provider that month.

School readiness (as measured by the Good Level of Development GLD) is an assessment of how prepared a child is to succeed in school cognitively, emotionally and socially. It is assessed through the Early Years Foundation Stage Framework which considers children's development against 17 Early Learning Goals (ELGs).

Children are said to achieve a 'Good Level of Development' if they are achieving at least the expected level for each goal within the following areas of learning: communication and language; physical development; personal, social and emotional development; literacy; and mathematics.

Overall, in Warwickshire, 71.8% of pupils achieved a Good Level of Development (GLD) in 2019. Almost 3 in 10 children in Warwickshire are not school ready at reception age.

In addition, there are still inequalities in the GLD achievement of certain groups and gaps in attainment of these groups relative to their peers have, in most cases, widened. The largest attainment 'gap' is between students who have a Special Educational Need (SEN) and those who do not, a 48.5% difference.

The second highest gap in GLD achievement is between disadvantaged children and their non-disadvantaged peers, where there is a 19% difference. The Good Level of Development performance of disadvantaged children has fallen over the past 3 years and because the performance of non-disadvantaged children has stayed the same, the disadvantaged gap has widened.

The widest percentage point gap is seen between pupils in the Stratford upon Avon district and the smallest gap is seen in Nuneaton.

Deprivation is linked to performance and has been shown to have an adverse impact on school readiness. The 10 wards in Warwickshire with the weakest GLD outcomes all performed below the Warwickshire average GLD score by between 10% and 30%. Most of these wards contain Lower Super Output Areas that are in the top 30% most deprived areas nationally based on the Index of Multiple Deprivation.

Conversely, the top 10 wards, who all performed above the Warwickshire average by between 9% and 16% are located in areas of social advantage.

Whilst there are differences between the attainment of boys and girls as well those whose first language is other than English, they are not as wide as the SEN or Disadvantaged pupil gaps.

Warwickshire County Council Early Years Needs Assessment 2020 presented longitudinal data from a cohort of children who had not met the expected level of development in 2012. When they left school in 2018 it found from a cohort of over 5,600 pupils that:

- 1,879 (33%) did not achieve a Good Level of Development when they were assessed at the end of Reception in June 2012
- By the time they left school in July 2018, there were 358 pupils of the original 1,879 cohort (19%) that did NOT achieve the expected standard in any of the statutory assessment key headline measures
- KS1-KS2 Progress scores in all subjects were well below zero which indicates that this group of children made significantly less progress, on average, than pupils across England who got similar results at the end of key stage 1

The Warwickshire County Council Early Years Needs Assessment also found that:

- Children who do less well at age five are five times as likely to end up being excluded by the end of primary school (82% more likely after accounting for demographics).

- Children who do less well at age five are over twice as likely to have had contact with children's social care at age eleven (46% more likely after accounting for demographics.

- Children who do less well at age five are nearly three times more likely to be struggling with reading at age eleven.

- Children who do less well at age five are four times more likely to be struggling with writing at age eleven.

In summary. Following improved performance each year from 2014, the percentage of pupils achieving a good level of development in Warwickshire peaked in 2017.

Since then, albeit very slight, the percentage has declined by 0.2% between 2017-2018 and 0.6% between 2018-2019.

Comparing good level of development performance in 2019, Warwickshire was ranked 11th out of 11 amongst statistical neighbour Local Authorities and ranked 6th out of 13 of the West Midlands Local Authorities.

While "early help" does not mean "early years", the over representation of 0-5s at Specialist Help levels suggests that there are significant numbers of children 0-5 whose needs are not being identified early enough.

Children open to Warwickshire's Children & Families Services are broadly supported across five main levels of support:

- Early Intervention
  - Early Help (EH)
  - Early Help with Targeted Support (TS)

- Specialist Help
  - Child in Need (CIN)
  - Child Protection (CP)
  - Child in Care (CIC)

The ratio of Specialist Help to Early Intervention has been increasing from 26% in Early Intervention to 74% in Specialist Help in June 2020, to 35% Early Intervention to 65% Specialist Help in December 2021.

Nuneaton and Bedworth has around 55% more children open to C&F services than the district average for the period (940 children), and North Warwickshire has around 47% less children open to services than the county average. These two districts both

have slightly higher rates of children within the 0-5 cohort (27% and 26% respectively), with Rugby and Warwick having the lowest (at 24% and 23% respectively). Stratford mirrors the Warwickshire wide average at 25% of service users being 0-5.

There are 14 Children and Family centres across Warwickshire and further outreach locations, to provide services for families with children and young people. There are three core elements to the service:

1. Coordination and administration of the designated Children and Family Centres and associated outreach provision.
2. Provision of a range of stay, play and learn opportunities.
3. Building of capacity and resilience within communities, including increased use of volunteers in service delivery.

There is a greater need to utilise outreach venues to ensure the service reaches families within areas of increasing housing development across the county, in particular Rugby and Warwick districts. This is in addition to more rural districts, Stratford and North Warwickshire.

RECOMMENDATIONS

The following recommendations have been identified throughout the report:

Overall:

- We are seeing increasing population growth and increasing diversity of needs amongst Warwickshire's young children. Services will need to expand and find new models of working to keep in line with increasing numbers and complexity.
- Deprivation and inequalities are a critical factor for all services and targeted effort needs to take place in more deprived areas.
- There are some key health promotion issues for all services to embed into ways of working and interactions with expectant or new parents – issues include smoking, healthy diet, and vaccinations.
- There are still opportunities to increase the role of early intervention and prevention – current early intervention services could be supporting more families.
- There should be a closer alignment between services reflecting the increasing complexity of needs, particularly in deprived areas.
- There is an opportunity to establish a partnership to centralise the needs of children and to take forward the recommendations from this report.

Local Context:

- There are predicted increases in the number of under 5-year-olds in Warwickshire that need to be accounted for in the commissioning of services.
- Current evidence is that the number of child births is below yearly average following a lockdown and increases with the relaxation of non-pharmaceutical interventions. This may create peaks in demand for some services to plan for. Early indication is this will average out over the course of a school year.
- There is an increasing ethnic diversity within Warwickshire's children compared to Warwickshire's population at the time of the last Census. The evidence is that there are differences in long term health outcomes by ethnicity, with most groups having worse outcomes than 'White British'. Given the importance of the first 1001 days to long term health, services need to ensure ethnicity is being recorded to support with measuring outcomes by ethnicity at a local level.
- Relative levels of deprivation are increasing in Warwickshire, and there are higher levels of need in Nuneaton and Bedworth, Rugby town centre, and Leamington. Services will need to expand to keep in line with this increasing complexity.

Health of Children 0-5 – Pregnancy and Birth

- All areas of Warwickshire have low birth weight lower than the England average, however there are inequalities and Nuneaton and Warwick have the highest rates. Rugby is notable for having low rates despite diverse population.
- There are clear inequalities in maternal obesity and smoking status. Given younger age of mothers from lower IMD areas, higher rates in younger age groups & interventions targeted at these groups need to be identified.
- Pregnancy with a low maternal age also remains high in the North.
- Parenting (antenatal) education for families should be offered universally to all expectant parents, equitably and in an accessible way, extending reach across Warwickshire. Parenting education could be used to promote healthy lifestyles for families with infants in young children with specific focus on smoking cessation, healthy weight, expectant parents mental health, and safe sleeping.

Health of Children 0-5 – Early Years

- Breastfeeding data is poor. There needs to be more work to improve definition and collection.
- Warwickshire has less childhood obesity than England as a whole, but North Warwickshire is highest, and NWBC is the highest overall. Targeted work in the North of the county is needed to combat these high rates.
- There is a drop in vaccine coverage as children get older, most notably with the 2nd dose of the MMR vaccine getting an 89.6% uptake in 2020/21 compared to the 1st dose uptake of 96.1%. This is below the 90% target for MMR uptake but indicates a lack of convenience as opposed to a hesitancy in uptake. To combat this the focus should be on:
    - Working with GP practices in areas where uptake is lowest to support uptake increases.
    - Increasing access to appointments where possible.
    - Working with schools, early years settings, health visiting, school health and wellbeing services, and children's centres/family hubs to promote uptake.
    - Engaging directly with communities through a range of means to support increasing uptake.
- There are opportunities for all services/agencies that work with parents, babies, and young children to facilitate disclosures and signpost to appropriate support for domestic abuse.
- There is a need to consider the support needs of a child under the age of 5 who has witnessed or experienced domestic abuse to recover from their experience and rebuild their relationship with the non-abusing parent. There is also a need to consider the support needs of the non-abusing parents to recover and move on from their experience.

- Ensure a clear Speech, Language and Communication Needs (SCLN) pathway is in place for birth to 25 years.

Child Hospitalisations

- Unintentional injuries have been identified as a major health inequality. Analysis shows that the emergency hospital admission rate for unintentional injuries nationally in the 0-5 age range is 38% higher if a child lives in one of the most deprived areas compared with those children who live in the least deprived.
- Significant improvements can be made through targeting the reduction of five causes of unintentional injuries among the under-fives. These groupings are:
  - Choking, suffocation and strangulation
  - Falls
  - Poisoning
  - Burns and scalds
  - Drowning

Child Deaths

- There is a relationship with infant mortality and the wider determinants of health, deprivation, and inequalities. Infant mortality rates in Nuneaton and Bedworth, and Warwickshire North are higher than the national average, whilst Warwick and Stratford are well below. This indicates a significant inequality in infant mortality outcomes across Warwickshire which needs to be addressed.
- Smoking and unsafe sleeping contribute to over 50% of child deaths. Elimination or reduction of both factors may be improved by enhanced (ante and postnatal) parental education and communications campaigns highlighting the risks associated with both factors.
- Due to the clear effect of the modifiable factors ‘clinical pathway or escalation of care’ and ‘smoking’ in neonatal survival it may be prudent to review and/or complete audits on smoking cessation in pregnancy services, and clinical pathways for neonatal births across all three hospital trusts.

Services for Children 0-5

- Improve outcomes related to the 'Good level of development' through:
  - Investment in increased capacity of Warwickshire County Council (WCC) Teams to respond proactively to improve the quality of teaching in the early years and childcare sector.
- Address the decline in standards and improve performance of providers deemed Inadequate or Requiring Improvement.

- Provide advice, guidance and support to the early years and childcare sector so that more children are ready for school.
- Provide more freely accessible evidence-based Workforce Development opportunities in relation to themes arising from Ofsted reports and local data.
- Ensure integration at local level, resilience, and sufficient capacity in the system, to reduce inequalities, particularly for disadvantaged groups and young children
- Ensure that practitioners working with children and professionals supporting families are resilient, well trained, knowledgeable, and confident to deliver high quality services
- Build attendance at free Early Years Aspiration Networks to improve practitioner skills and knowledge.
- Improve engagement in transition arrangements and ensure more effective practice.
- Develop the work of the Warwickshire Early Years Teaching School Hub, and the 14 Aspiration Networks to make use of best practice and build a model of quality improvement and support across the early years sector.
- Build and deliver programmes to support new and emerging early years leaders.
- Implement an evidence-based communication and language development programme county wide in 2022 / 2023 to support early years covid recovery and help to close the gap.
- Ensure that Every Children and Family Centre has a member of the team who is trained to Tier 3 within the Time to Talk approach and acts as the centre Communication and Language Champion.
- Begin to close the 20% gap between all children aged 0-5 and disadvantaged children in the 0-5 age range.
- Work with early years providers to develop best practice materials for closing the gap.
- Implement a range of measures to improve take up of 2-year-old places to 75%, which require services to work with more integration to support improved outcomes for children and families in Warwickshire.
- Ensure the improved 3- and 4-year-old take up is sustained and undertake data analysis to ensure that vulnerable groups are accessing the free entitlement offer.
- Adopt an invest to save approach to early years and childcare to help to avert financial pressures required for remedial work and intervention by the Council at a later stage.
- Explore routes to see how funded early years providers could be resourced to undertake statutory duties relating to SEND for two-year-olds.
- Improve routes to identification of SEND needs prior to age two across different service areas.
- Implement a revised integrated check for two-year-olds.

- Provide resourced early years provision for SEND and Social Emotional and Mental Health for early years.
- While "early help" does not mean "early years", the over representation of 0-5s at Specialist Help levels suggests that there are significant number of children 0-5 whose needs are not being identified early enough.
- The ratio of Specialist Help to Early intervention care has been increasing from 26% in Early Intervention care to 74% in Specialist Help care in June 2020 to 35% Early Intervention to 65% Specialist Help in December 2021. It is recommended this ratio continues to be monitored, with a key threshold being a reverse in the ratio.
- As a shifting picture, ongoing monitoring will be important for understanding the distribution across the different levels of support, and to explore the impact of service transformation on this distribution. It is recommended that this reporting is used to support existing reporting for services.
- There is a need to explore options for a more robust way of identifying and matching children 0-5 between C&F and HV services to ensure that families who need support with children 0-5 are known to both services.
- All health services referrals for children of all ages should be increased to effectively use early help to prevent escalation to specialist services.
- Work is needed to increase the breadth of services at each Children and Family centre and utilising outreach venues to deliver services to families to meet local need.
- Development and expansion of service provision at outreach locations to meet local need.

INTRODUCTION

NATIONAL AND LOCAL CONTEXT

The 2018 World Health Organisation (WHO) report: Nurturing care for early childhood development[1] identifies that:

"The period from pregnancy to age 3 is the most critical, when the brain grows faster than at any other time; 80% of a baby's brain is formed by this age. This is a window of opportunity to lay a foundation of health and wellbeing whose benefits last a lifetime and carry into the next generation."

This was further reinforced in the Policy paper, The Best Start for Life (BSL)[2]: a vision for the 1001 critical days published in March 2021. BSL set out a vision for the first 1001 days citing them as the building blocks for the foundation to lifelong emotional and physical health.

This policy realignment in recent years, highlighting the importance of good physical health and emotional wellbeing in very young children has been termed the '1001 days movement'. The 1001 days captures the earliest period of an infant's life from conception to age 2.

Now led by the Parent-Infant Foundation[3], with support from an All Party Parliamentary Group (APPG), the 1001 days movement consolidates the campaign of just under 200 charities and professional bodies to improve outcomes for young children by supporting health and wellbeing during this uniquely critical period of rapid development and growth.

It is recognised that early social, emotional and cognitive development begins in utero and depends on good maternal physical and emotional wellbeing. The interactions between babies, infants and their caregivers are critically important to this period of development. Stress factors which compromise parent's ability to nurture healthy pregnancy and infant relationships are domestic abuse, poor mental health, substance misuse, and poverty.

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[1] https://apps.who.int/iris/bitstream/handle/10665/272603/9789241514064-eng.pdf (Accessed March 2022)

[2] Crown Copyright (2021) The Best Start in Life. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/973112/The_best_start_for_life_a_vision_for_the_1_001_critical_days.pdf (Accessed 25.01.22)

[3] Parent Infant Foundation (2021) An Age of Opportunity. Available at: https://parentinfantfoundation.org.uk/1001-days/resources/evidence-briefs/

The COVID-19 pandemic has placed additional burden on parents with evidence suggesting infants and children aged 0-5 being particularly vulnerable to the effects of lockdowns and scaling back of services. Physical health indicators including activity levels, sleep, vaccination coverage, and oral health are reported to be adversely affected in 0-4 year olds since the beginning of the pandemic (EIF, 2021)[4]. Maternal mental health has been adversely affected during the pandemic and further exacerbated by widening inequalities within health and wider socio-economic systems (Maternal Mental Health Alliance, 2021)[5].

In light of the abovementioned policy focus this Children's Health JSNA covering the ages of 0-5 will consider not just the early years of a child's life but also maternal health and pregnancy, with consideration for very early infancy.

"It tells us that the kind of children we raise today, will reflect the kind of world we will live in tomorrow. It tells us that investing in the start of life is not an indulgence, but economically, socially and psychologically vital to a prosperous society." Jason Knauf, CEO of the Royal Foundation, December 2020.

Overall, a plethora of research evidence tells us that an individual's life chances, health and emotional wellbeing have their foundation in early childhood.

Both nature and nurture (genes and environment) influence children's development, but it is the quality of a child's earliest environments and the availability of appropriate experiences, strong attachments and a nurturing approach at the right time that are crucial to ensure a positive start. Therefore, if we get it right in the early years, we can expect to see children thrive throughout school and their adult lives.

School readiness (as measured by the Good Level of Development GLD) is an assessment of how prepared a child is to succeed in school cognitively, emotionally, and socially. It is assessed through the Early Years Foundation Stage Framework which considers children's development against 17 Early Learning Goals (ELGs).

Children are said to achieve a 'Good Level of Development' if they are achieving at least the expected level for each goal within the following areas of learning: communication and language; physical development; personal, social and emotional development; literacy; and mathematics.

[4] http://www.eif.org.uk/report/growing-up-in-the-covid-19-pandemic-an-evidence-review-of-the-impact-of-pandemic-life-on-physical-development-in-the-early-years (Accessed February 2022)

[5] Centre for Mental Health (2021) Maternal Mental Health During a Pandemic Available at: https://maternalmentalhealthalliance.org/wp-content/uploads/CentreforMH_MaternalMHPandemic_FullReport.pdf

Overall, in Warwickshire, 71.8% of pupils achieved a Good Level of Development (GLD) in 2019.

Nearly three in ten (28.2%) children in Warwickshire did not achieve their potential based on the ‘good level of development’ This is a theme that often starts in the early years and continues throughout the primary school years. Similarly, in 2019 the percentage point gap between disadvantaged children and their non-disadvantaged peers has increased to 20%, rising 4% from the 2017 figures when looking at achievement of the Good Level of Development.

Longitudinal research undertaken in Warwickshire identified that at the end of reception in 2012 a total of 33% did not achieve a Good Level of Development. By the time they left school in July 2018, some 19% did not achieve the expected standard in any of the statutory assessment key headline measure.

When caring, supportive, and stimulating environments are in place they promote good early childhood development. This increases children’s chances of a successful transition to school, which in turn, promotes their chances of achieving better learning outcomes, a better education, employment health, and wellbeing after they have finished school.

For our most vulnerable children, accessing early education opportunities earlier is important because gaps in achievement can be seen at age four. It has become more important than ever to ensure the building blocks to early childhood education are right from the start to secure benefits for individuals and society as a whole.

The impact of Covid-19 provides a new context. During the first national lockdown in 2020 Early Years settings were partially closed with only children of key workers and vulnerable children able to attend. In subsequent lockdowns, early years settings have remained open. Nonetheless, Department for Education data published in December 2021 evidenced that attendance had not returned to pre-pandemic levels.

This means that many children have not benefited from high-quality early education experiences, making the contribution of their home learning environment even more important. However, many families have been and are still wrestling with managing childcare, working at home, caring for others, personal bereavement, and trauma, alongside continued disruption caused by Covid-19 related staff absences in schools and nurseries. This also applies to the practitioner supporting children in education and childcare provision.

A report from the Children’s Commissioner showed that nationally a high proportion of children were living in adverse conditions during lockdown, experiencing poverty, domestic violence, parental mental health issues and parental substance abuse. The negative impacts of this, alongside missed education are only just beginning to be uncovered and must feature in any recommendations for future work. It is also

recognised that to close the achievement gap requires resources to respond to the impact of early trauma and disadvantage.

The Early Intervention Foundation publication: Teaching, pedagogy and practice in early years childcare: an evidence review August 2018 is clear about what works, and this remains true in a post Covid-19 environment:

- Addressing multiple causes of educational underperformance for disadvantaged children
- Supporting both parent and child and help parents to better engage with children's development
- Provide stimulating and high-quality Early Childhood Education combined with delivery by well-qualified individuals
- Active screening and monitoring of children's progress can improve long-term outcomes for disadvantaged children

In summary, the factors that matter the most in determining whether a child's potential is realised in adult life are family background, parental education and effective parenting, combined with access to high quality early learning and education.

KINGS FUND POPULATION HEALTH MODEL

One approach to addressing health inequalities is the Population Health System[6], as presented by The Kings Fund, an independent charitable organisation working to improve health and care in England. In this model, 4 interconnecting pillars of population health are established (figure 1), these are the wider determinants of health, our health and behaviours and lifestyles, an integrated health and care system, and the places and communities we live in and with.

This approach takes a holistic view of everything that impacts people's health and wellbeing. Importance is placed on the links between the pillars to ensure a balanced approach is taken that distributes efforts across all four pillars. This approach has been adopted by Warwickshire County Council as set out in the Health and Wellbeing Strategy which can be read in full here:
https://www.warwickshire.gov.uk/healthandwellbeingstrategy

[6] https://www.kingsfund.org.uk/publications/vision-population-health (Accessed February 2022)

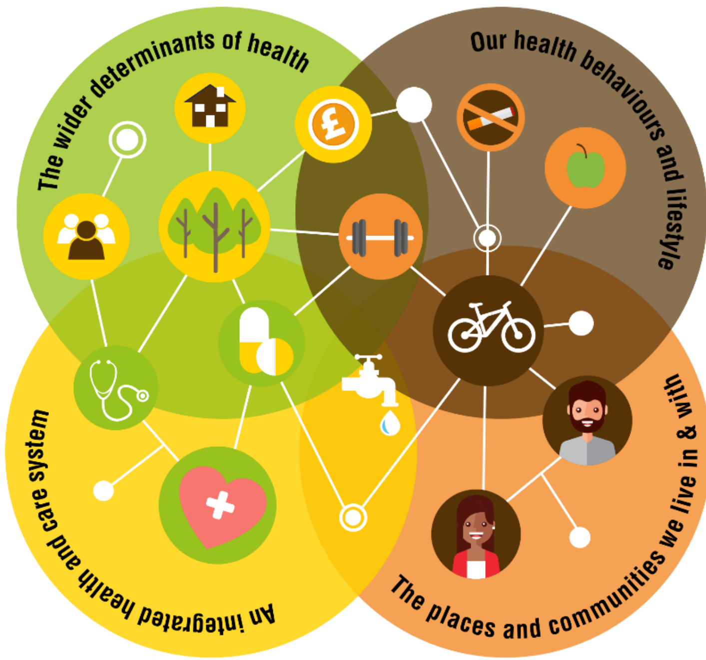


Figure 1: Population Health System
Source: https://www.warwickshire.gov.uk/healthandwellbeingstrategy

LOCAL CONTEXT

POPULATION

Locally, the Joint Strategic Needs Assessment (JSNA) analyses the current and future health and wellbeing needs of the population. Demographic information of the local population is important to understand those needs, and this chapter outlines key aspects of that information and the implications for planning services for young children.

Further demographic information can be found on the Warwickshire JSNA webpages: https://www.warwickshire.gov.uk/joint-strategic-needs-assessments-1

Warwickshire has an estimated population of 583,786 people (mid-2020), of which there are an estimated 38,446 children aged 0-5. This means that children under 5 are estimated to account for 6.6% of the total Warwickshire population. The district and borough council areas where those children live is shown in Table 1 and Figure 2.

Rugby has a young population, and despite the smaller size has a relatively high percentage of children aged 0-5, accounting for 7.2% of its population.

District/Borough	Total Population	0-5 Population	% 0-5 of Total Population
North Warwickshire	65,452	3,980	6.1%
Nuneaton and Bedworth	130,373	9,683	7.4%
Rugby	110,650	7,988	7.2%
Stratford-on-Avon	132,402	7,749	5.9%
Warwick	144,909	9,046	6.2%
Warwickshire	**583,786**	**38,446**	**6.6%**

Table 1: Number and percentage of population aged 0-5 for Warwickshire districts and boroughs. Source: mid-2020 population estimates, ONS

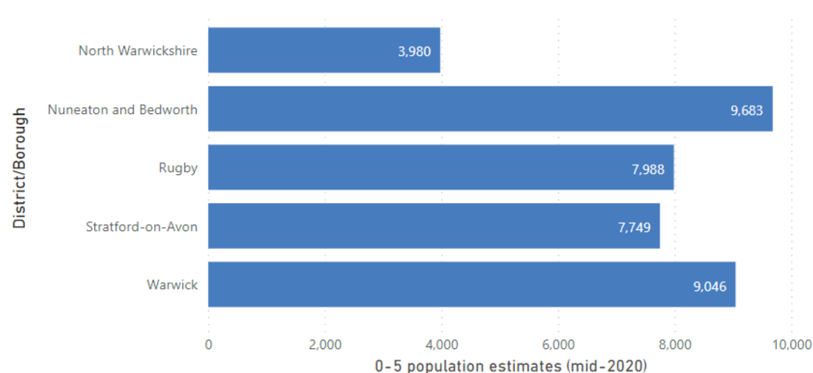


Figure 2: Number of 0-5 in each district and borough (Warwickshire). Source: mid-2020 population estimates, ONS

The Office for National Statistics (ONS) produces estimates of the size of the population in future, which can be used to plan services. The estimates are based on factors such as mortality, migration, and movement around the country, and also trends in birth rates. They cannot account for unknown factors such as economic changes or events such as the pandemic.

The estimates show that the total Warwickshire 0-5 population is expected to increase to 44,749 by 2043, which is an increase of 17.7% from the estimated figure in 2021 (Figure 3 and Table 2). Of this, Nuneaton and Bedworth Borough accounts for the highest percentage of the total 0-5 Warwickshire population (25.2%) and North Warwickshire Borough the lowest (10.4%).

The largest increase in 0-5 population is expected in Stratford-on-Avon District and Warwick District (25.5% and 22.3% increase respectively). They are also the two local authorities likely to see the largest changes in the short term- by 2030 it is projected that there will be 15,280 0–4-year-olds in Stratford-on-Avon District and Warwick District, compared to 13,661 in 2020, an increase of 11.9%.

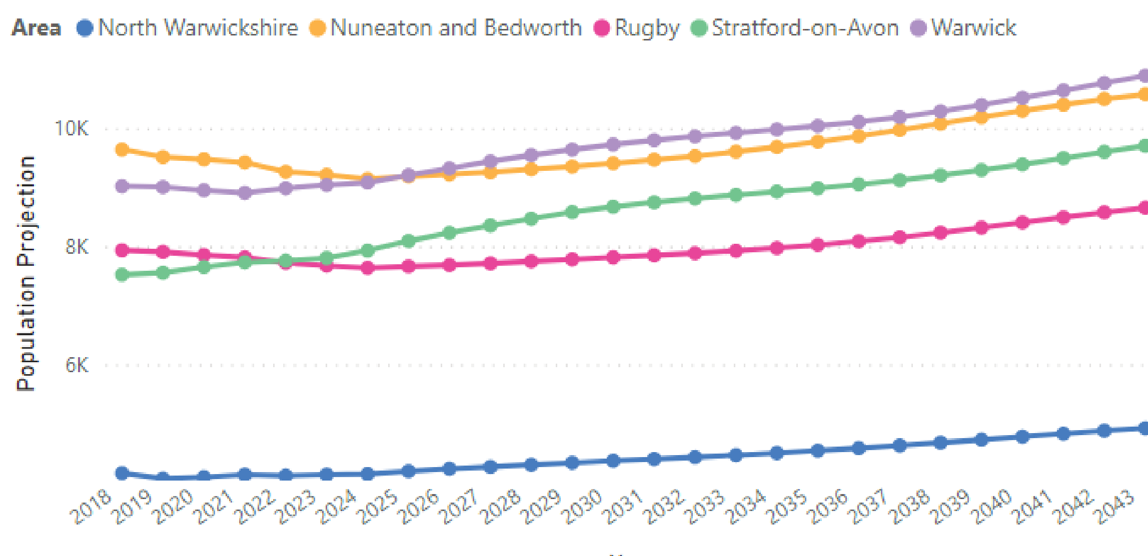


Figure 3: Population projections: 0-5 population from 2018 to 2043 by district and borough
Source: Population projections 2018 to 2043, ONS

Area	Population estimate 2021	Population estimate 2043	Population increase 0-5 (2021 to 2043)	Population increase 0-5 % (2021 to 2043)
North Warwickshire	4,136	4,923	787	19.0%
Nuneaton and Bedworth	9,423	10,576	1,153	12.2%
Rugby	7,814	8,655	841	10.8%
Stratford-on-Avon	7,733	9,704	1,971	25.5%
Warwick	8,907	10,891	1,984	22.3%
Warwickshire	38,015	44,749	6,734	17.7%

Table 2: Estimated population increase from 2021 to 2043 by district and borough
Source: Population projections 2018 to 2043, ONS

Early evidence from the pandemic is that the number of Births decreased in December 2020, January 2021, and February 2021. This relates to live births that would have been conceived during the first lockdown in 2020, suggesting there was not a baby

boom as a result of the restrictions first put in place for COVID-19. However, there was a 1.7% increase in the monthly fertility rate in March 2021 compared to March 2020. These would be babies conceived as lockdown was lifting in the summer of 2020.

AGE AND GENDER

Of the 583,786 population in Warwickshire, as estimated in the mid-2020 ONS population estimate (Table 3), 38,446 are aged 0-5. Of these, 48.57% (18,675) are female and 51.43% (19,771) are male. Across all ages, 50.61% (295,452) are female and 49.39% (288,334) are male.

Sex	Combined		Female			Male		
Area	All Ages	0-5	All Ages	0-5	Percentage	All Ages	0-5	Percentage
North Warwickshire	65,452	3,980	33,148	1,924	48.34%	32,304	2,056	51.66%
Nuneaton and Bedworth	130,373	9,683	66,385	4,670	48.23%	63,988	5,013	51.77%
Rugby	110,650	7,988	55,577	3,937	49.29%	55,073	4,051	50.71%
Stratford-on-Avon	132,402	7,749	68,024	3,786	48.86%	64,378	3,963	51.14%
Warwick	144,909	9,046	72,318	4,358	48.18%	72,591	4,688	51.82%
Warwickshire	583,786	38,446	295,452	18,675	48.57%	288,334	19,771	51.43%

Table 3: Breakdown of age groups within Warwickshire's 0-5 population, by sex
Source: mid-2020 population estimates, ONS

ETHNICITY

There are inequalities in the health of people with different ethnic backgrounds[7]. Inequalities in health are those differences that are unfair and largely preventable. Inequalities in health are influenced by wider socio-economic factors, cannot be attributed to one specific reason, and rely on action across the whole population health framework to mitigate.

Ethnicities other than 'White English' are more likely to encounter racism in some form. Discrimination and racism can negatively affect both physical and mental health of people from ethnic minority groups[8].

Although detailed ethnicity data for new births is not available, in Warwickshire, ethnicity is collected in the School Census and is shown in Table 4. Whilst this describes children in Warwickshire's schools rather than under 5-year-olds living in Warwickshire it does provide a proxy measure for the ethnic diversity of

[7] PHOF Health Equity Report - Focus on ethnicity (publishing.service.gov.uk) (Accessed February 2022)

[8] https://www.kingsfund.org.uk/publications/health-people-ethnic-minority-groups-england (Accessed February 2022)

Warwickshire's children. It is acknowledged that a range of different ethnic heritages and experiences are represented in each category.

The majority of the children in Warwickshire are White and this accounts for 83% of the population. However, there is variation, 77% of children in Rugby Borough, 80% of children in Warwick District, and 82 % of children in Nuneaton and Bedworth Borough are White British, and these are lower than the county average.

Some of the ethnicities with largest numbers are Asian – accounting for between 7% and 9% of all children in Warwick, Nuneaton and Bedworth Borough, and Rugby, and with mixed ethnic heritages accounting for 7% of all children in Warwick and Rugby.

	North Warwickshire		Nuneaton & Bedworth		Rugby		Stratford-on-Avon		Warwick		Warwickshire	
Ethnic Group	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
White	577	93%	1,265	82%	939	77%	1,103	88%	1,090	80%	4,974	83%
Asian/Asian British	7	1%	107	7%	104	8%	26	2%	124	9%	368	6%
Mixed/multiple ethnic groups	24	4%	78	5%	90	7%	56	4%	91	7%	339	6%
Any Other Ethnic Group	8	1%	65	4%	50	4%	60	5%	52	4%	235	4%
Black/African/Caribbean/Black British	3	0%	36	2%	44	4%	2	0%	12	1%	97	2%

Table 4: Ethnicity from school census data
Source: May 2021 School census data

A comparison can also be made to the overall ethnic diversity of Warwickshire's population. This is shown in Table 5.

	North Warwickshire		Nuneaton & Bedworth		Rugby		Stratford-on-Avon		Warwick		Warwickshire	
Ethnic Group	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
White	60,709	98%	114,392	91%	90,565	90%	117,307	97%	122,715	89%	505,688	93%
Asian/Asian British	580	1%	7,880	6%	5,225	5%	1,466	1%	9,945	7%	25,096	5%
Mixed/multiple ethnic groups	506	1%	1,396	1%	1,986	2%	1,258	1%	2,803	2%	7,949	1%
Black/African/Caribbean/Black British	172	0%	1,047	1%	1,987	2%	264	0%	973	1%	4,443	1%
Any Other Ethnic Group	47	0%	537	0%	312	0%	190	0%	1,212	1%	2,298	0%

Table 5: Ethnicity in the Warwickshire population
Source: 2011 Census

The overall diversity of Warwickshire's children is presented below and compared against the wider population (Figure 4). A notable difference is the lower proportion of children from 'White' ethnicities – accounting for 93% of Warwickshire's population but 83% of the school age population according to the 2011 Census.

Whilst this is not a direct comparison – the school census does not include children who attend private schools for instance –Other categories of ethnicity including Asian/Asian British, Black/African/Caribbean/Black British are all higher in Warwickshire's children, which may account for this difference. The largest increase is

amongst young people of mixed or multiple ethnic heritages which account for 1% of Warwickshire's population overall, but 6% of children within Warwickshire.

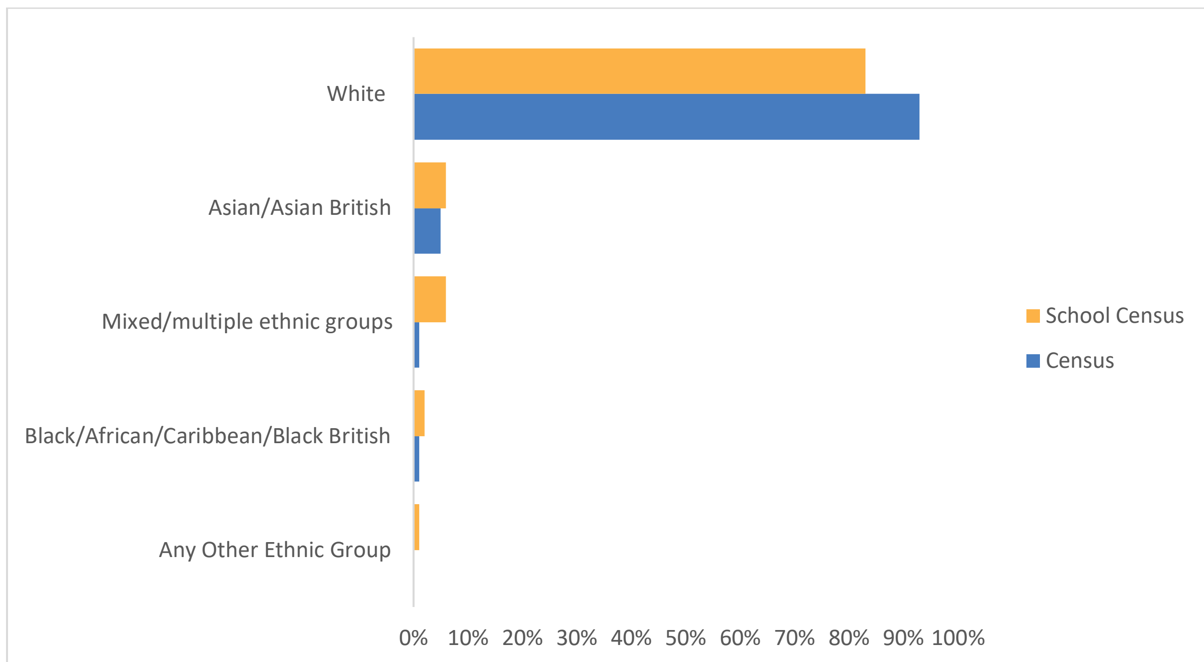


Figure 4: Comparison between ethnicity from Census 2011 and School Census May 2021
Source: May School Census Data and Census

Although the results of the 2021 Census have not yet been published at the time of print, and may well show changes in the adult population, the School Census data gives an early indication about how Warwickshire's population is changing and how services for children will need to account for increasing diversity (Figure 5).

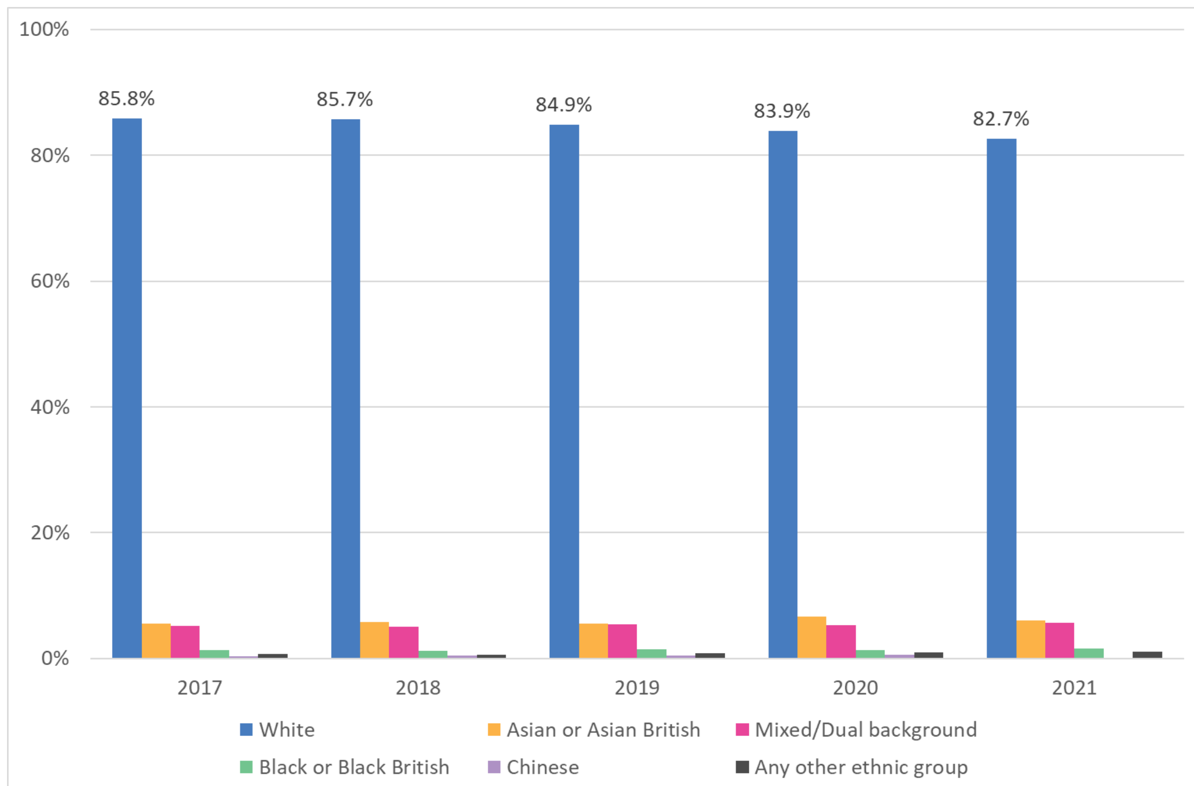


Figure 5: Changes in the ethnicity of children in reception.
Source: Spring term school census 2017 – 2021.

INEQUALITIES IN HEALTH AND DEPRIVATION

Inequalities in health exist when there are avoidable, unfair, and systematic differences in health across the population and between different groups of people within society[9]. These can include differences in:

- Health status (life expectancy, prevalence of health conditions)
- Access to care (availability of treatments)
- Quality and experience of care (levels of patient satisfaction)
- Behavioural risks to health (smoking rates, obesity rates)
- Wider determinants of health (quality of housing, education)

The social gradient of health describes the relationship to health whereby people who live in areas of greater deprivation have worse health than those who live in more affluent areas. There are four factors which health inequalities are often analysed and addressed by; they are:

- Socio-economic factors such as income
- Geography
- Specific characteristics such as sex, ethnicity, or disability
- Socially excluded groups such as people experiencing homelessness

[9] https://www.kingsfund.org.uk/publications/what-are-health-inequalities (Accessed February 2022)

Whilst health inequalities exist, evidence shows that a comprehensive approach to addressing them can make a difference. Addressing health inequalities can be complex and involves examining the ‘causes of the causes’ of health – for example, education, housing, transport, employment, socio-economic status.

The Indices of Multiple Deprivation 2019 is a measure of deprivation that considers a range of factors that influence people’s lives such as education and employment, access to services, health, and the quality of the local environment. These are all factored into a calculation to give an overall score of deprivation.

The deprivation scores can be calculated in small areas with a population of around two thousand people, known as Lower Layer Super Output Areas (LSOAs). They are used to calculate the relative deprivation of local authority areas.

Compared to other upper tier local authorities Warwickshire ranks 121 out of 151 (where 1 is most deprived and 151 is least deprived). However, there is considerable variation in relative deprivation at district/borough level (Figure 6).

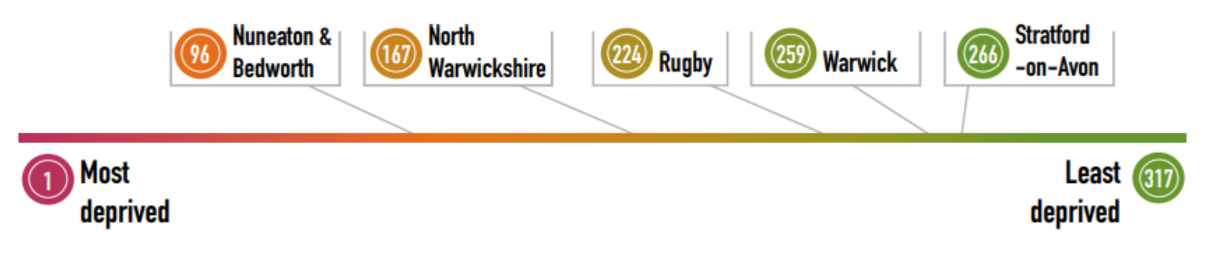


Figure 6: National ranking of districts and boroughs out of the 317 local authorities using the ‘Rank of Average Score’ measure
Source: IMD 2019

It can be seen from this figure that the lower tier local authority councils in the north of the county are the most deprived. Figure 7 shows this in more detail and highlights areas of higher deprivation in each of the districts and boroughs, in particular Nuneaton and Bedworth, Rugby town centre, Leamington, and parts of Atherstone and Stratford town centre have higher levels of deprivation.

Index of Multiple Deprivation (IMD) Decile (where 1 is most deprived 10% of LSOAs) by LSOA name

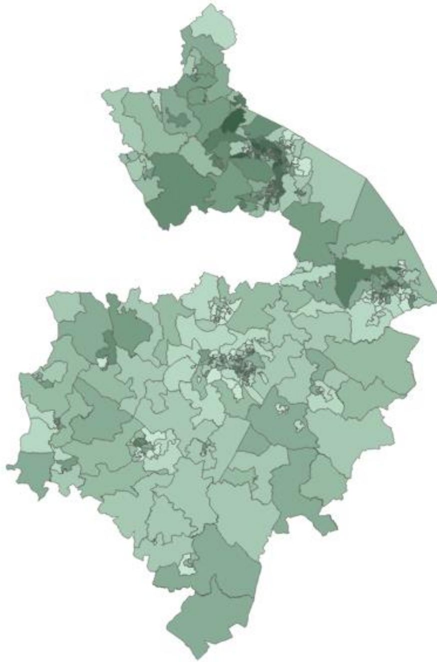


Figure 7: Index of Multiple Deprivation by LSOA, Warwickshire. Darker areas represent higher levels of deprivation
Source: IMD 2019

Income deprivation affecting children (IDAC) shows a similar pattern to overall IMD, with concentrations in the north of the county.

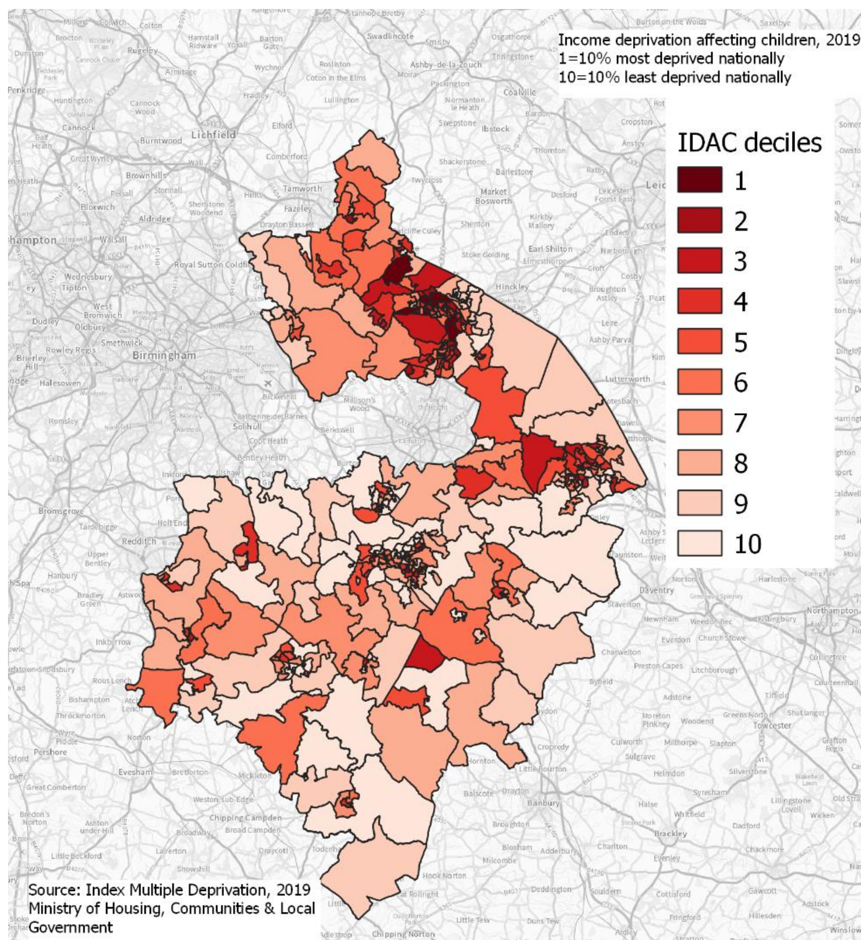


Figure 8: Income deprivation affecting children by LSOA, Warwickshire. Darker areas represent higher levels of deprivation
Source: IMD 2019

All LSOA areas are categorised into one of the 10 deprivation deciles based on their relative ranking on all LSOAs in England. Overall Warwickshire is slowly becoming more deprived when comparing the 2015 IMD statistics with the 2019.

Out of the 339 LSOAs in Warwickshire, 77 (23%) dropped a decile, whereas 32 (9%) increased.

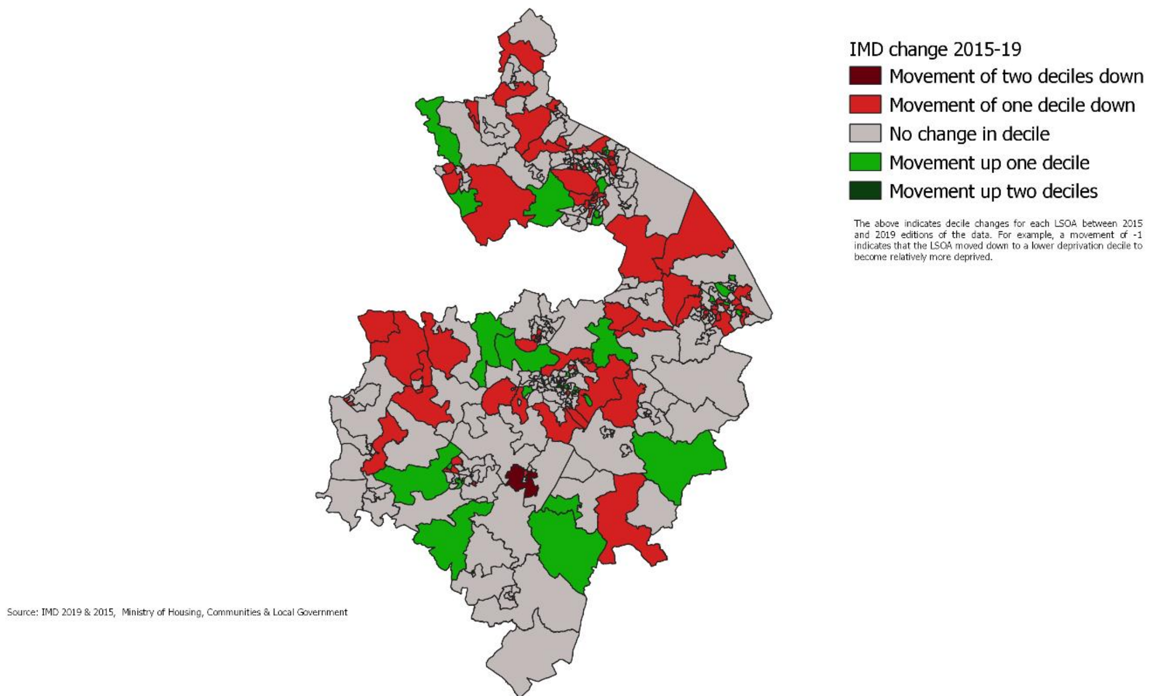


Figure 9: Changes in IMB across Warwickshire.
Source: IMD 2019 & 2015.

In terms of the IDAC, there are 10 LSOAs in decile 1 in 2019, compared to only 7 in 2015. However, when combining deciles 1 to 3, there is one less LSOA in 2019 (38) compared to 2015 (39).

CHILDREN IN LOW INCOME FAMILIES

Children in low income families are associated with poorer health in adult life, such as premature mortality, and lower life expectancy, as well as other health issues including mental health. Within Warwickshire, Nuneaton and Bedworth has the highest number of 0-5 children in relatively low-income families, accounting for 19% of the total 0-5 population. Overall, in Warwickshire during the 2018/19 reporting period there were 5,175 children in relatively low-income families in Warwickshire - 13% of the total 0-5 population. The number of children in low-income families in Warwickshire has remained relatively stable in recent years from 2015/16 to 2018.19 (Figure 10).

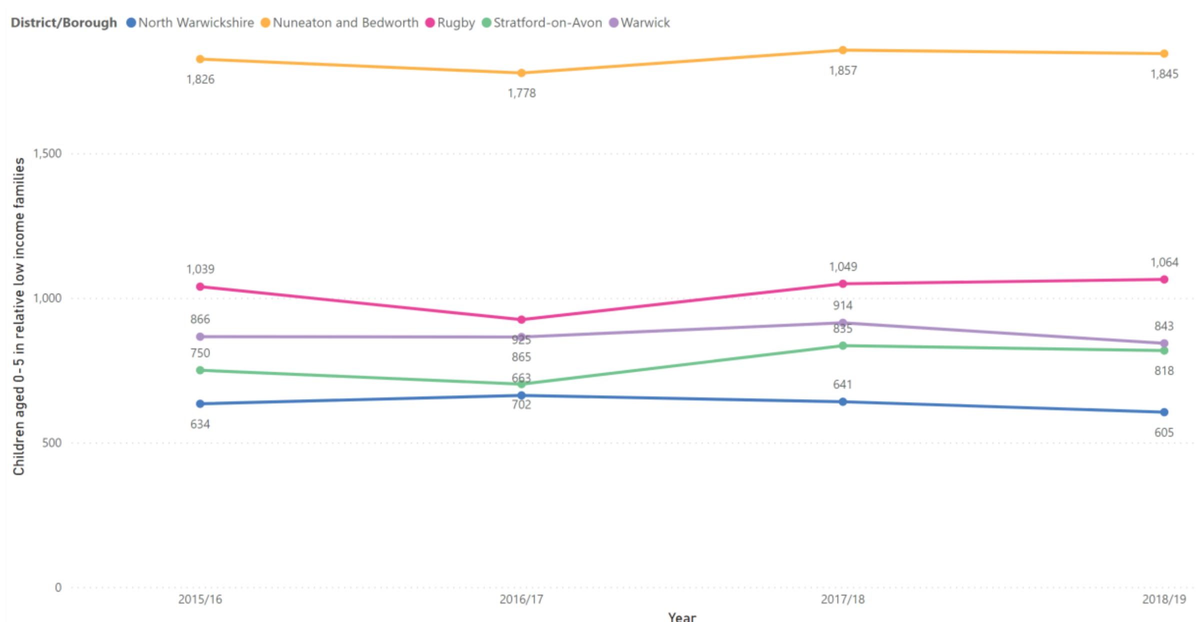


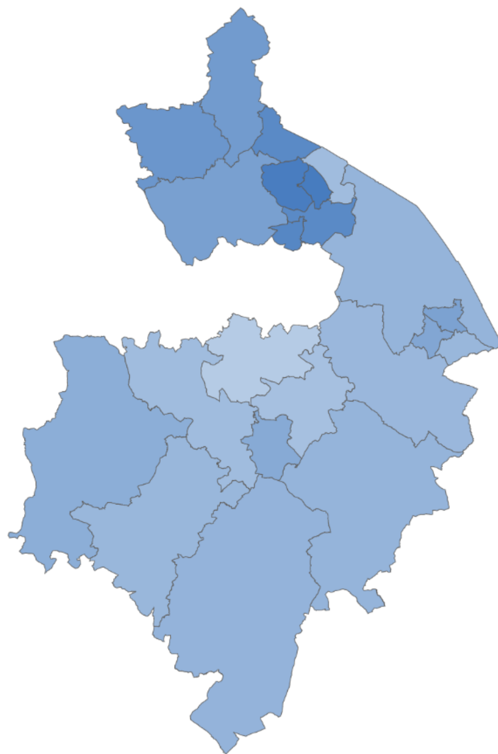
Figure 10: Number of children aged 0-5 in relatively low income families over time, by district and borough (2015/16 to 2018/19)
Source: Department for Work and Pensions

Table 6 shows the breakdown of the number and percentage of the 0-5 population in relatively low-income families. As mentioned above, Nuneaton and Bedworth has the highest proportion (19%), followed by North Warwickshire (15%), both of which are above the Warwickshire average of 13%. Stratford-on-Avon and Warwick are the lowest, with 11% and 9% respectively.

District/Borough	Number of children 0-5 in relative low-income families (2018/19)	%
North Warwickshire	605	15%
Nuneaton and Bedworth	1,845	19%
Rugby	1,064	13%
Stratford-on-Avon	818	11%
Warwick	843	9%
Warwickshire	5,175	13%

Table 6: Number of children in relatively low income families and percentage of total 0-5 population (2018/19), by district and borough.
Source: Department for Work and Pensions

Figure 11 shows the percentage of under 16's in relatively low-income families by the 22 JSNA areas. It shows a similar pattern to Table 6 above, with Nuneaton Central and Nuneaton Common and West with the highest percentages, and Kenilworth with the lowest.



JSNA	2019/20 relative %
Nuneaton Central	29.43%
Nuneaton Common and West	29.10%
Bedworth West	26.82%
Atherstone and Hartshill	26.12%
Bedworth Central and Bulkington	26.04%
Kingsbury	23.06%
Polesworth	21.93%
Coleshill and Arley	20.62%
Newbold and Brownsover	20.20%
Bilton and Town Centre	19.13%
Leamington, Whitnash and Bishop's Tachbrook	18.16%
Henley, Studley and Alcester	17.27%
Wellesbourne, Kineton and Shipston	15.94%
Rugby Rural North	15.74%
Southam	15.70%
Hillmorton	15.01%
Stratford-upon-Avon	14.99%
Rugby Rural South	14.92%
Warwick and Warwick District West	13.90%
Weddington, Horestone Grange and Whitestone	13.82%
Cubbington, Lillington and Warwick District East	12.86%
Kenilworth	10.14%

Figure 11: Percentage of children aged 16 and under in relatively low-income families by JSNA area (2019/20)
Source: Department for Work and Pensions

Deprivation is linked to performance at school and has been shown to have an adverse impact on school readiness, reducing the opportunity for social mobility. Table 7 shows the localities with a Good Level of Development (GLD) below the 2019 Warwickshire average of 71.8% achieving a GLD. Several of these wards contain LSOAs that are in the top 30% most deprived areas nationally based on the Index of Multiple Deprivation. These bottom 10 wards all performed below the Warwickshire average by between 10% - 30%.

Bottom 10 Wards Nationally	Eligible Pupils	% achieving a GLD	Wards containing LSOAs in top 30% most deprived
Wolvey and Shilton, Rugby	29	41.4%	
Studley with Sambourne, Stratford-on-Avon	32	53.1%	
Bulkington, Nuneaton and Bedworth	60	55.0%	
Quinton, Stratford-on-Avon	35	57.1%	
Atherstone South and Mancetter, North Warwickshire	39	59.0%	Yes
Clopton, Stratford-on-Avon	22	59.1%	

Benn, Rugby	91	59.3%	Yes
Clifton, Newton and Churchover, Rugby	30	60.0%	
Abbey, Nuneaton and Bedworth	116	60.3%	Yes
Exhall, Nuneaton and Bedworth	86	61.6%	Yes

Table 7: Localities with a Good Level of Development below the 2019 Warwickshire average of 71.8%
Source: Pupil level EYFSP data supplied by schools

Table 8 shows the percentage of children achieving a GLD at the end of reception, split by whether they are eligible for a free school meal (FSM). There is a 19-percentage points difference across Warwickshire between those not eligible for a FSM (73.7%) and those eligible for a FSM (54.7%) achieving a GLD. The greatest difference is in Warwick District with a 24.4 percentage points difference.

	Eligible for a FSM	Not eligible for a FSM	All Children
North Warwickshire Borough	51.7%	75.0%	72.8%
Nuneaton and Bedworth Borough	58.9%	70.4%	68.5%
Rugby Borough	54.8%	72.9%	71.2%
Stratford-on-Avon District	47.8%	75.7%	73.5%
Warwick District	51.6%	76.0%	74.5%
Warwickshire	54.7%	73.7%	71.8%

Table 8: Percentage of children achieving a good level of development at the end of reception by eligibility for a Free School Meal (FSM) (2019).
Source: Education Team, Business Intelligence, WCC

LOW BIRTH WEIGHT

An infant's weight at birth can be influenced by several factors including gestational age at which the child is born, genetics, and the health of the mother, particularly during pregnancy.

Low birth weight is associated with poorer health outcomes in later life, including increased risk of child mortality and developmental issues. Figure 12 displays the latest low birth weight of term infant's data for 2019 by district and boroughs of Warwickshire in comparison to England. This indicator is the number of live births of term infants with low birth weight (<2500g) as a percentage of all live births. There are inequalities between the district and boroughs with the highest percentage of births of term infants with low birth weight in Nuneaton and Bedworth (2.8%). The Warwickshire overall figure, 2.4%, is considerably lower than the England value (2.9%). This has remained relatively stable over time (Table 9).

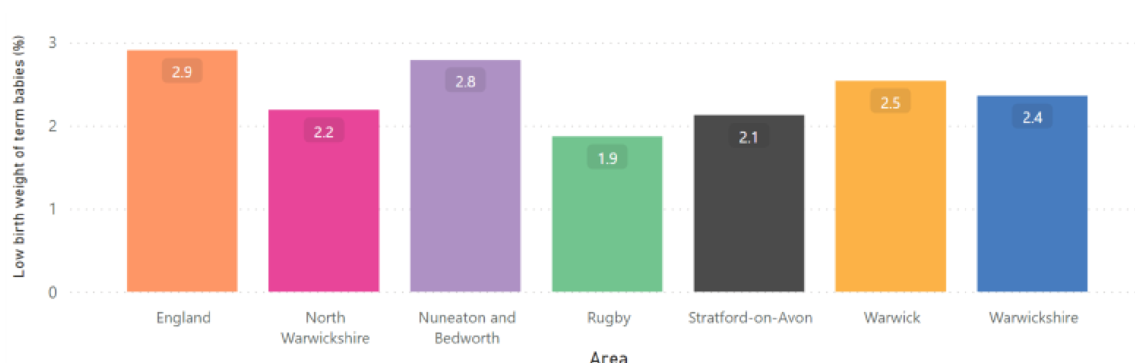


Figure 12: Low birth weight of term babies (percentage) by district and borough and Warwickshire in comparison to England (2019 data)
Source: Public Health England Fingertips

Area Name	2008-2011	2012-2015	2016-2019
England	2.88	2.81	2.84
North Warwickshire	2.46	2.58	1.92
Nuneaton and Bedworth	2.77	2.69	2.85
Rugby	2.73	2.21	2.46
Stratford-on-Avon	1.99	2.26	1.83
Warwick	2.43	2.58	2.43
Warwickshire	2.50	2.47	2.38

Table 9: Heat map: low birth weight of term infants in Warwickshire over time – 4 year combined data average
Source: Public Health England Fingertips

Further data from the Regional Maternity Measures Report shows women of mixed-race heritage were more likely to deliver a low birthweight infant at term. There was also an increase in likelihood of women from Black and Asian backgrounds of delivering an infant with a lower birth weight at term (Figure 13).

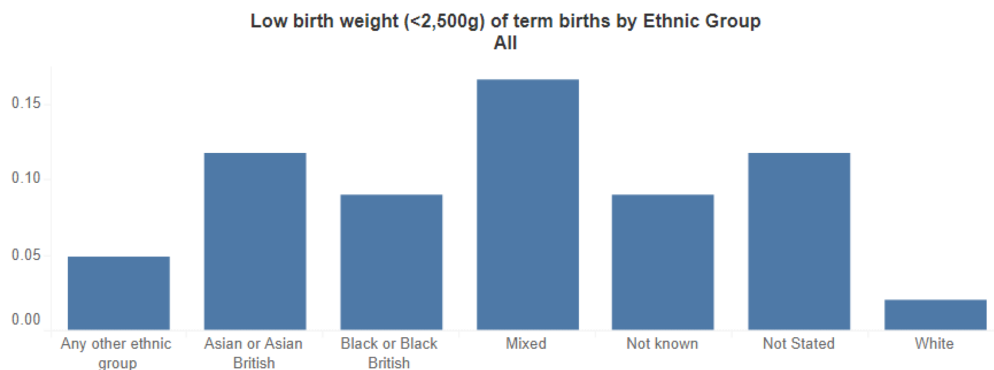


Figure 13: Low Birth Weight of term births by ethnic group
Source: Regional Maternity Measures Reporting Tool

PRETERM BIRTHS

A contributary factor of low birth weight is prematurity. Preterm births are defined as infants born before 37 weeks of pregnancy. The mortality rate is higher for infants who are born preterm, and there is also an increased likelihood that preterm infants are born with a disability.

The Regional Maternity Measures Report indicated that a higher proportion of women of mixed-race heritage delivered before 37 weeks gestation and women were more likely to come from the most deprived areas (Figure 14).

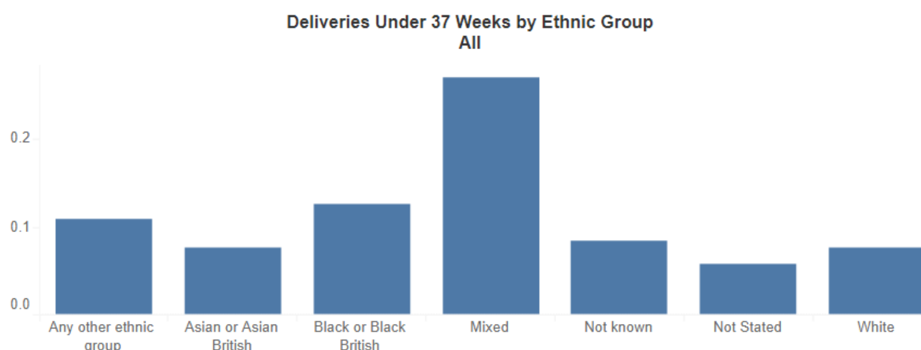


Figure 14: Deliveries under 37 weeks by ethnic group
Source: Regional Maternity Measures Reporting Tool

This was also true of deliveries of 27 weeks gestation or under, with women from Mixed, Black, Asian, or other ethnic minority groups proportionately more than double the risk than women from a white ethnic group to deliver at <27weeks (Figure 15).

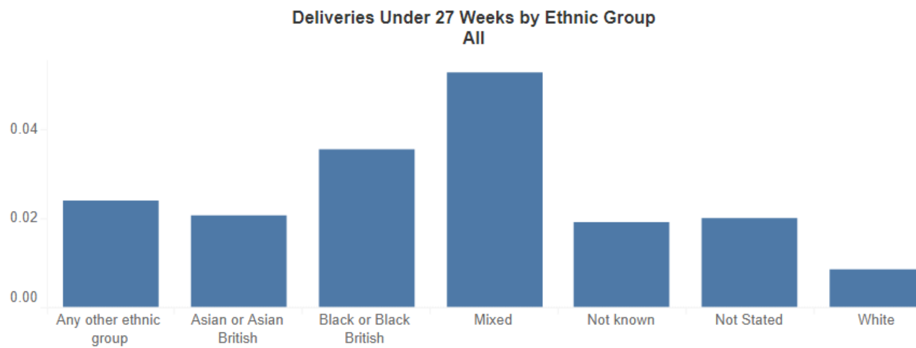


Figure 15: Deliveries under 27 weeks by ethnic group
Source: Regional Maternity Measures Reporting Tool

The Regional Maternity Measures Reporting Tool measures data at a regional (Coventry and Warwickshire) level. Data quality issues at a local level mean it has not been possible to separate out Coventry data from these datasets and could bias results. However, with increasing numbers of children with ethnically diverse heritage living in Warwickshire, it is important to consider this inequality in birth outcomes for future births within the county.

HEALTHY WEIGHT IN PREGNANCY

In adults, obesity is defined as a body mass index (BMI) greater or equal to 30kg/m^2. Obesity during pregnancy increases risk of complications during pregnancy and in childbirth – including diabetes, miscarriage, thromboembolism for women. Infants have higher risk of foetal death, stillbirth, and congenital abnormalities.

Figure 16 shows the proportion of women with obesity in early pregnancy in Warwickshire compared to nationally in 2018/19. Data is split into pre-2021 clinical commissioning groups (CCG).Warwickshire North CCG was higher (25.3%) than the national average (22.1%). In contrast South Warwickshire CCG reports a considerably lower percentage (17.6%) than both neighbours in the North of the county and national data. This indicates a significant health inequality for pregnant women and their infants within Warwickshire. It is not possible to get up to date data at this level now as there is now one CCG instead of three in Warwickshire.

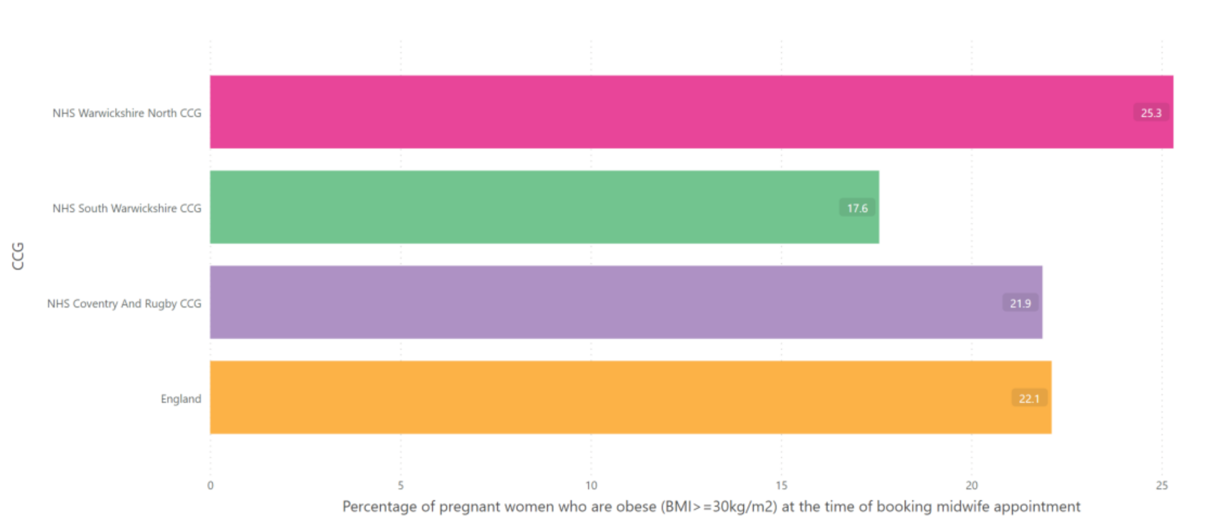


Figure 16: Percentage of pregnant women who are obese at the time of booking appointment with midwife, 2018/19 (experimental data)
Source - Fingertips

The following graphs (Figures 17 to 19) represent the percentage of pregnant women who at the time of their midwifery appointed had a BMI greater than 35 or less than 18 at the three hospital trusts serving Warwickshire residents during 2020/21. Unhealthy weight is defined as BMI <18 (underweight) or >35 (obese). Local reporting measures mean it is not possible to separate data between underweight and obese. However, if we look at national data, we know that less than 2% of women on average are underweight (ref PHE). Therefore it may be concluded that the majority of the numbers in the data below represent obese women. Figure 17 representing UHCW indicates a relatively stable percentage, with around 8% of women from Rugby and Coventry being an unhealthy weight at the time of booking. Figure 18 representing bookings in South Warwickshire at SWFT indicates a marginal increase between 2020 and 2021 from around 8% to 10%. A steeper increase can be seen at GEH bookings rising from around 8% in 2020 to approximately 13% in 2021. This indicates that along with obesity in pregnancy being more prevalent in Warwickshire North, it is also growing at a faster rate compared to other areas within the county.

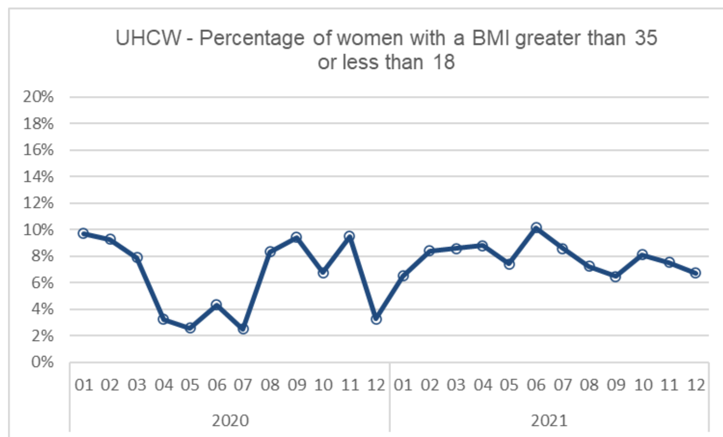


Figure 17: Percentage of women with a BMI greater than 35 or less than 18 at UHCW
Source: UHCW Maternity Athena K2 system

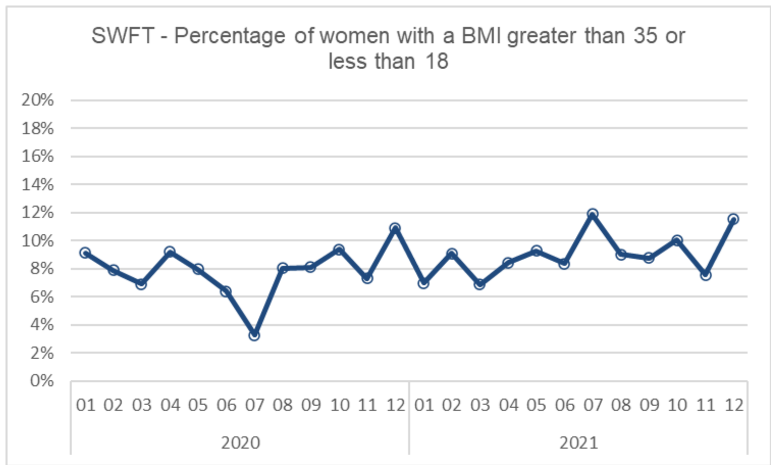


Figure 18: Percentage of women with a BMI greater than 35 or less than 18 at SWFT. Source: SWFT & GEH Maternity Badgernet system

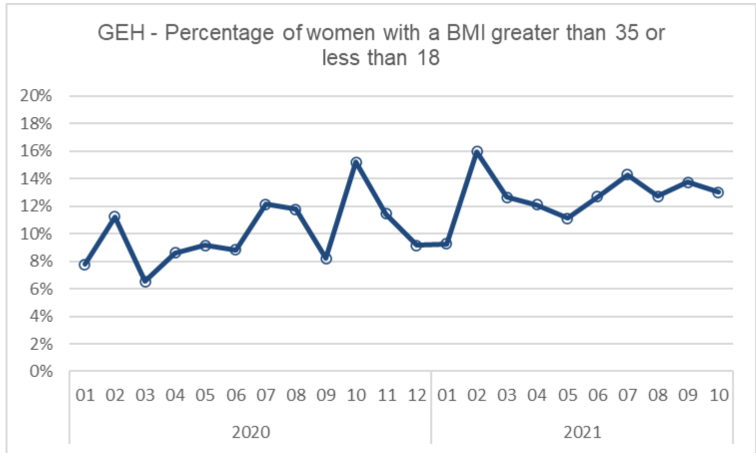


Figure 19: Percentage of women with a BMI greater than 35 or less than 18 at GEH Source: SWFT & GEH Maternity Badgernet system

Figure 20 below displays national data on obesity early in pregnancy by IMD deprivation decile. The graphs indicate that the more deprived an area a woman lives in, the higher the chance of her being obese in early pregnancy. This is congruent with higher reported rates of maternal obesity in Warwickshire North, which is comprised of more high deprivation LSOAs than neighbouring areas within Warwickshire County as a whole.

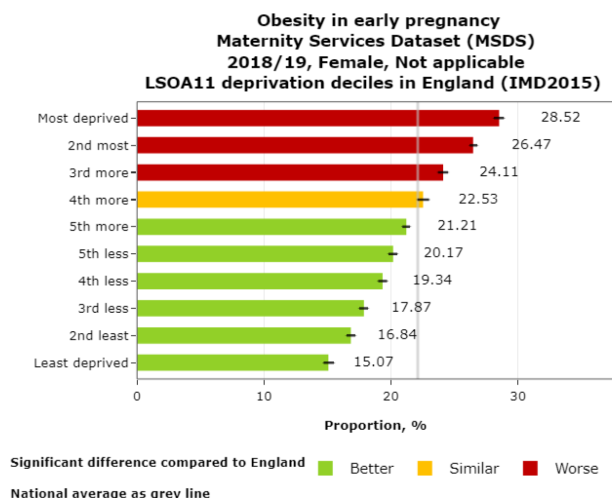


Figure 20: Obesity in early pregnancy by level of deprivation
Source: Perinatal Health Equity Audit Report

SMOKING IN PREGNANCY

Smoking in pregnancy results in an increased risk of complications during labour and risk of miscarriage, premature birth, stillbirth, low birth weight, sudden unexpected death in infancy, and infant mortality.

The Maternity high impact area: Supporting parents to have a smoke-free pregnancy report[10] estimated that smoking causes up to 2,200 premature births, 5,000 miscarriages and 300 perinatal deaths every year in the UK and is associated with a 47% increased risk of stillbirth. The report also indicates that women who smoke are less likely to breastfeed their baby and are more likely to develop serious health conditions such as oral cancer and coronary heart disease. Infants born to women who smoke have increased health risks, including increased risk of asthma, congenital heart defects and visual problems.

2018-19 data shows geographical differences in smoking in pregnancy rates across Warwickshire. Figures 21 and 22 provide an overview of the proportion of women smoking in early pregnancy by area, ethnicity, IMD deprivation decile, and age. Warwickshire North is an outlier within the system with a higher proportion of women smoking at the start of pregnancy than the national average. Women who smoke are more likely to be white or of mixed-race heritage. Smoking rates during pregnancy are closely linked to deprivation, with women living in the most deprived areas, most likely to smoke, with rates declining proportionately in line with decreasing deprivation decile (see Figure 22). Maternal age is also linked to smoking with the youngest mothers most likely to smoke in early pregnancy, and risk decreasing with increased age. In Warwickshire mothers aged under 30, living

[10] Maternity high impact area: Supporting parents to have a smoke free pregnancy, Public Health England, 2020

within the top three deprived areas are most likely to smoke in early pregnancy, which mirrors the data seen at a national level.

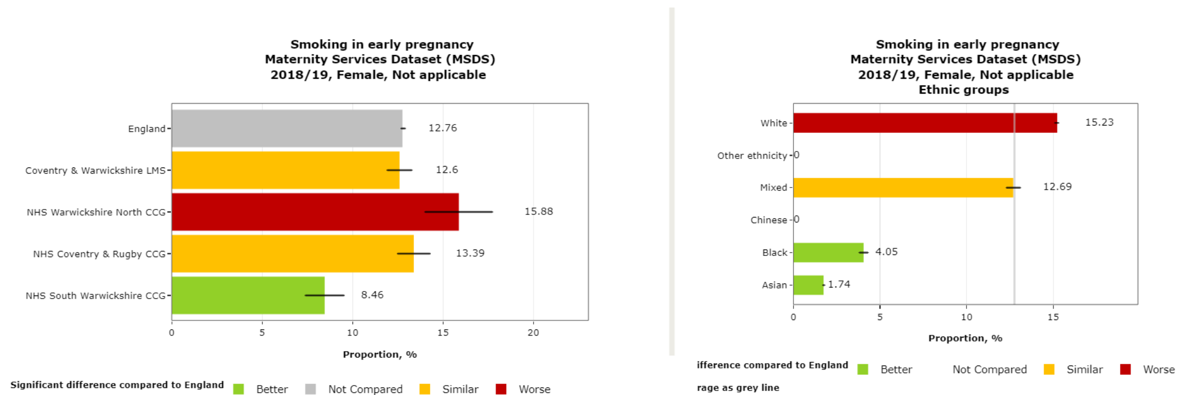


Figure 21: Smoking in early pregnancy by CCG area and ethnicity
Source: Perinatal Equity Audit report

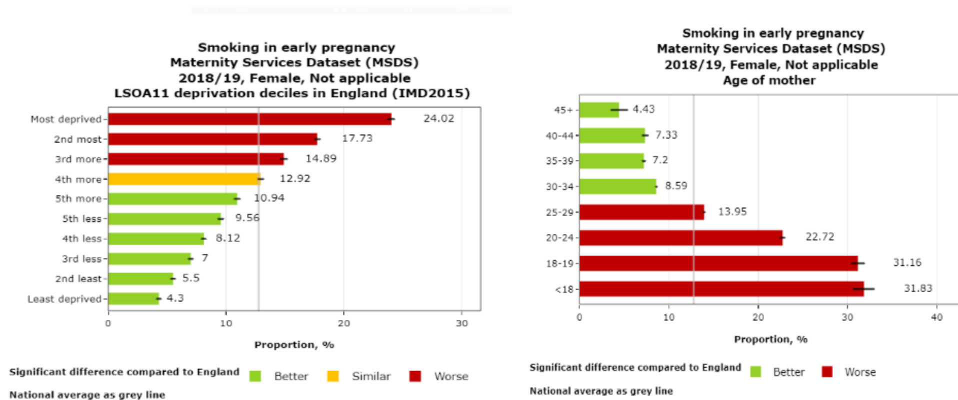


Figure 22: Smoking in early pregnancy by deprivation decile and age
Source: Perinatal Equity Audit report

Smoking status at the time of delivery (SATOD) is an additional indicator of the prevalence of smoking in pregnant women. A national target of 6% of women to be smoking at time of delivery has been set nationally for areas to aspire to. The Maternity high impact report concluded that of those women who manage to quit smoking during pregnancy, approximately 3 in 4 women return to smoking within the first 6 months of their infants' birth. The report also stressed that where women live with another smoker in their household, they are six times more likely to smoke throughout pregnancy than those who don't and more likely to relapse once the baby is born.

Figure 23 indicates the number of mothers known to be smokers at the time of delivery as a percentage of all pregnancies over time. The highest percentage of pregnancies with SATOD in Warwickshire is Warwickshire North CCG (13.8%). This is significantly higher than the England figure (9.6%), whereas South Warwickshire CCG is noticeably lower (4.7%). This highlights a significant inequality across the footprint.

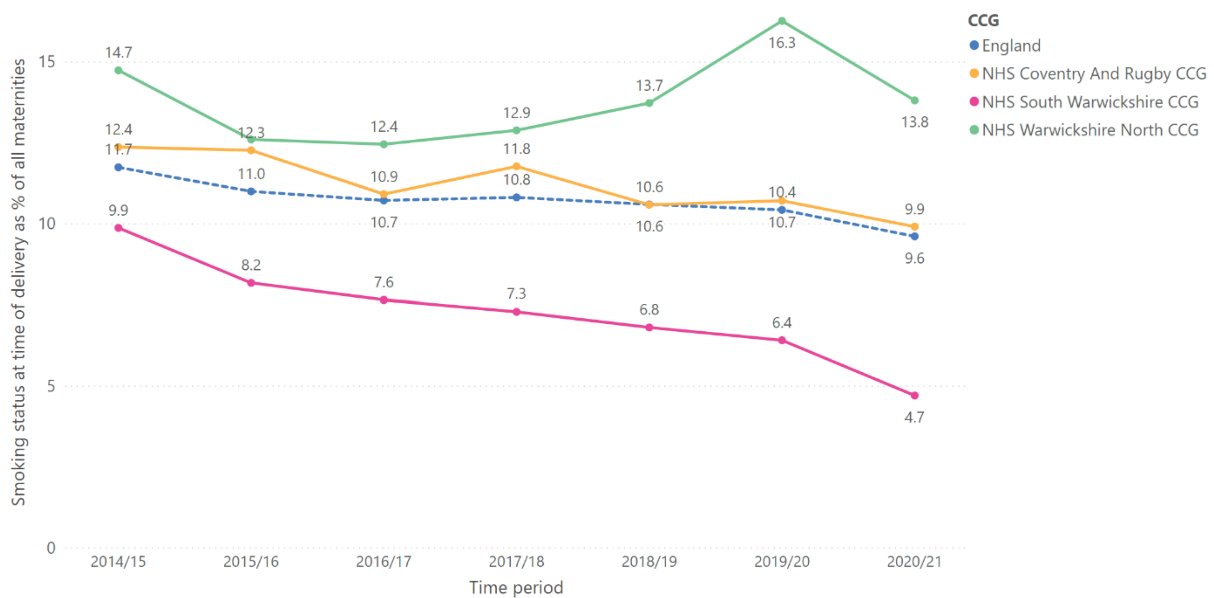


Figure 23: Smoking at time of delivery (SATOD) over time by CCG in comparison to England
Source: Public Health England Fingertips

Comparing data from the proportion of women who smoke in early pregnancy to SATOD, there is no change within women who live in Warwickshire North unlike women in South Warwickshire with reductions in number of smokers seen at the time of delivery.

The Coventry and Warwickshire Smoking in Pregnancy review (May 2020)[11] found that the stillbirth rate for smokers was almost twice as high as it was for non-smokers – the figures were 6.1 per 1,000 births amongst smokers compared to 3.2 among non-smokers. A similar pattern is seen for other outcomes, and the proportion of preterm births was 15% among smokers compared to 8% among non-smokers, and similarly the proportion of low birthweight babies was 16% for smokers compared to 7% among non-smokers.

The review noted approximately 1,549 smokers at booking each year across Coventry and Warwickshire. Of the smokers identified at booking, it was estimated that 27% (approximately 365) quit, showing an opportunity to improve health if this number could be increased. It is important to note that these figures are specific to a one-off review and cannot be compared like for like against other data sources.

PREGNANCY WITH LOW MATERNAL AGE

Pregnancy with maternal age under 18 is associated with poorer social and health outcomes for both parent and child including greater risk of low educational

[11] https://www.happyhealthylives.uk/download/clientfiles/files/CW%20Smoking%20In%20Pregnancy%20Review.pdf (Accessed January 2022)

attainment, poor emotional wellbeing, maltreatment or harm, and illness, accidents, and injuries.[12]

Infants born to teenage mothers experience higher rates of infant mortality, increased risk of low birthweight and subsequent impact on the long-term health of the child. There is also risk of mental health issues in teenage mothers including post-natal depression and poor mental health outcomes up to three years after birth, and an increased risk of living in poverty. Nationally, although conceptions to women aged under 18 have been declining over time, a gap remains between conceptions in the least deprived and most deprived IMD deciles. With teenagers living in the most deprived IMD deciles conception rate 23.6 per 1,000, and teenagers living in the least deprived deciles at 9.5 per 1,000.[13]

Figure 24 displays under 18 conceptions per 1,000 females in Warwickshire. Under 18 conceptions rate and % of teenage mothers has decreased in recent years. The highest rate of under 18 conceptions is in Nuneaton and Bedworth - 23.7 per 1,000 under 18 conceptions compared to 15.7 per 1,000 for England.

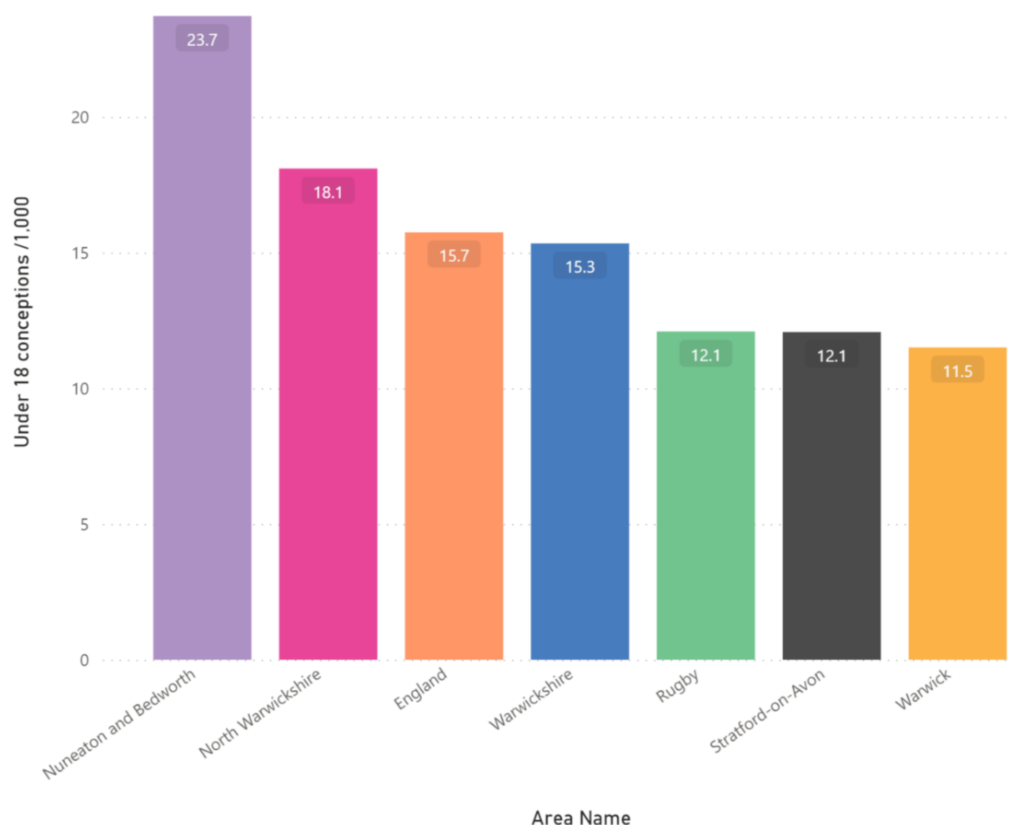


Figure 24: Under 18 conceptions rate per 1,000 by district and borough compared to England, 2019 data Source: Public Health England Fingertips

[12] Teenage Pregnancy Prevention Framework, Public Health England, 2018

[13] https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/conceptionandfertilityrates/bulletins/conceptionstatistics/2018#conceptions-by-index-of-multiple-deprivation (Accessed February 2022)

Figure 25 displays the percentage of delivery episodes where the mother is aged under 18 years. The highest percentage of teenage mothers in Warwickshire North CCG and Coventry and Rugby CCGs, 0.79% and 0.75% respectively (higher than England figure, 0.63%, 2018/19 data).

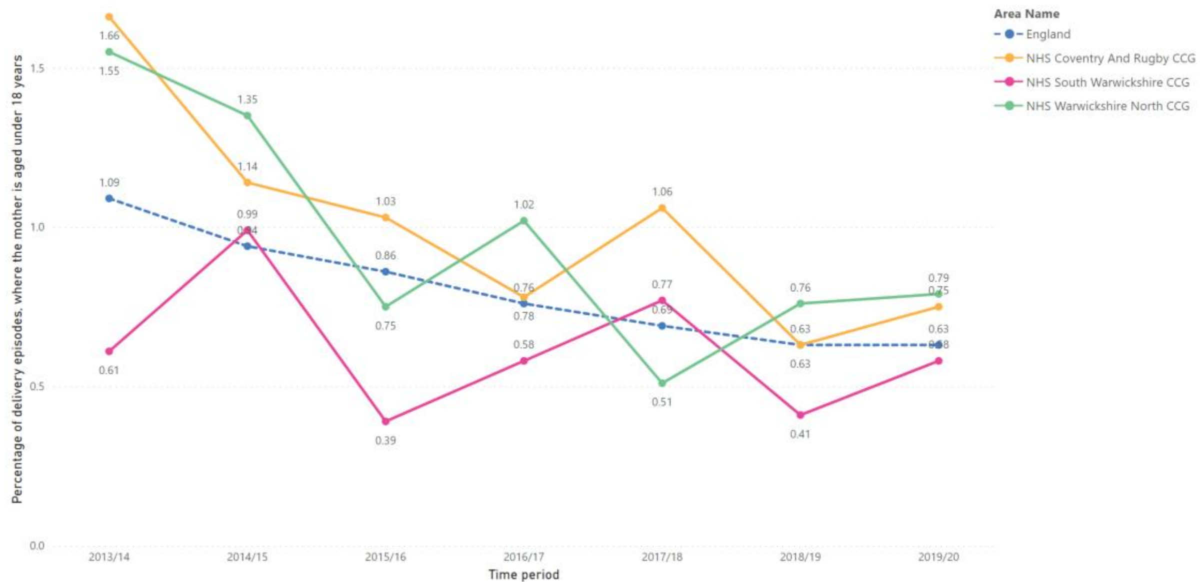


Figure 25: Percentage of delivery episodes where the mother is aged under 18 years by CCG over time
Source: Public Health England Fingertips

Figure 25 illustrates that despite births to women aged under 18 decreasing nationally over time since 2013/14, this decrease is beginning to slow, plateauing between 2018/19 and 2019/20. In Warwickshire North rates have been increasing since 2017/18 and, like Coventry and Rugby, are on average higher than the national rate. Rates in South Warwickshire on average remain lower than the national rate.

MATERNAL MENTAL HEALTH

The Maternity high impact area: Supporting good parental mental health[14] highlighted that mental health problems during the perinatal period affects between 10 to 20% of women. These issues can have significant long-term impacts on parents, their child, and the broader family.

Women may be reluctant to disclose how they are feeling due to fear of judgement or stigmatisation leading to a delay in mothers seeking and accepting timely treatment. The Maternity high impact report goes on to say that nearly 50% of all cases of perinatal depression and anxiety go undetected and fail to receive evidence-based treatment. The report also indicates a further barrier is the lack of recognition of poor mental health

[14] https://dera.ioe.ac.uk/37997/1/Maternity_high_impact_area_2_Supporting_good_parental_mental_health.pdf (accessed March 2022)

and its signs and symptoms, particularly amongst some culturally and ethnically diverse communities.

The report also highlighted that while there is a low risk of women developing a severe mental health condition such as postpartum psychosis or severe depressive illness, a woman's risk of mental illness is higher in the weeks following childbirth than at any other time in her life. Psychiatric problems are a significant cause of maternal death with maternal suicide being the second largest cause of direct maternal deaths occurring during or within 42 days of the end of pregnancy and remains the leading cause of direct deaths occurring within a year after the end of pregnancy.

Perinatal Mental Health Dashboard for Coventry and Warwickshire indicated that:

- 18.2% of the referrals and caseload to mental health services are of women living in the most deprived decile.
- 8.1% of the caseload represented women aged 16-20 and 67% were women aged 26 – 39.
- 72% of the caseload where from a white ethnic background, while 3.3% were of Asian descent and 2.5% were of black heritage.

It may be prudent to consider the abovementioned report indicates a barrier of poor recognition of maternal mental health amongst some culturally and ethnically diverse communities, when interpreting this regional data.

PARENTING (ANTENATAL) EDUCATION

Good quality antenatal or parenting education (PE) can empower families to make healthy choices and decisions about both pregnancy and the early years of an infant's life. PE can tackle issues such as smoking, healthy weight, infant feeding and parent-infant mental health and wellbeing. Due to the COVID-19 pandemic the PE offer for families across Warwickshire has been varied with one NHS trust scaling back to only offer virtual resources such as YouTube videos and Facebook groups. The other two trusts developed a virtual offer of antenatal classes led by a specialist PE midwife.

Data collected from parents participating in the midwife led virtual classes reported that 95% initiated skin-to-skin contact at birth and 82% initiated breastfeeding highlighting the value of PE. However, this virtual offer only reached 5% of new parents in 2021. This low access figure combined with one of the trusts lacking a specialist PE midwife role identifies both a gap and inequality across the Warwickshire footprint. Addressing this inequality could have positive impact on many of the above-mentioned health in pregnancy issues and promote healthy and secure starts to life for infants.

INFANT FEEDING

Breastfeeding contributes to the health of both the mother and infant in the short and long term. The UK has some of the lowest breastfeeding rates in the world and is an emotive subject for many parents and families. The UNICEF Baby Friendly Initiative[15] acknowledges the challenges facing families who experience barriers, and trauma experienced through guilt-inducing language when trying to establish breastfeeding. UNICEF advocate a systems-based approach to improving breastfeeding rates including input from Public Health, Government, communities, health services and families to create a supportive infant feeding culture in the UK.

If the number of infants breastfed increased and continued for longer periods in the UK, the incidence of common childhood illnesses such as ear and chest infections would reduce and could save the NHS up to £50 million annually (UNICEF, 2021).

The Regional Maternity Measures report provides percentage of infants receiving breast milk at first feed at national, regional and hospital trust levels. Table 10 below indicates that regionally levels for this indicator are above the national average. However, at a trust level a lack of data means we do not know rates for George Eliot Hospital, serving women in Warwickshire North. South Warwickshire foundation trust rate is 81.8%, noticeably higher than the national average (72.4%), with University Hospitals Coventry and Warwickshire at a similar rate (73.80%).

Description	Org_Level	Organisation	Latest Value
Proportion of babies receiving breast milk at first feed	England	National	72.40%
Proportion of babies receiving breast milk at first feed	STP	Coventry and Warwickshire	76.20%
Proportion of babies receiving breast milk at first feed	Trust	South Warwickshire NHS Foundation Trust	81.80%
Proportion of babies receiving breast milk at first feed	Trust	George Eliot Hospital NHS Trust	no available data
Proportion of babies receiving breast milk at first feed	Trust	University Hospitals Coventry and Warwickshire NHS Trust	73.80%

Table 10: Percentage of infants receiving breast milk at first feed at national, regional and hospital trust levels.
Source: Regional Maternity Measures Report

A limitation of the abovementioned measure is that it only provides data for an infant's very first feed. The next widely available data point is 6-8 weeks after birth. Figure 26 below indicates that breastfeeding rates at 6-8 weeks postnatally are just under 50% in Warwickshire. Whilst being congruent with the England average, this signals a significant drop-off in breastfeeding by this age. Data is not currently available at a

[15] https://www.unicef.org.uk/babyfriendly/about/breastfeeding-in-the-uk/ (Accessed January 2022)

local level to understand when this drop-off occurs. Furthermore, qualitative data is not currently collected to understand the reasons behind cessation of breastfeeding in the early days and weeks after birth.

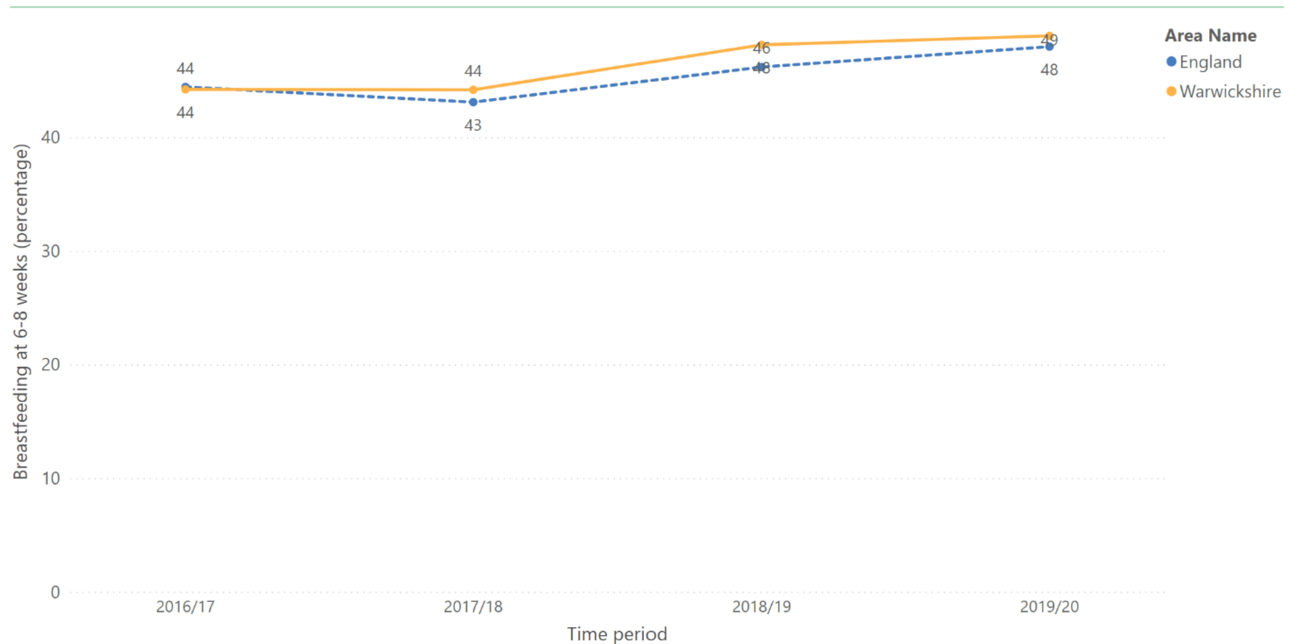


Figure 26: percentage of women breastfeeding at 6-8 weeks
Source: Fingertips

Due to quality issues 2020/21 data indicating breastfeeding at 6-8 weeks postnatally is not available for Warwickshire. Most recent available data (2019/20) shows Warwickshire rates (48.9%) for total or partial breastfeeding at 6-8 weeks. When broken down, 35.5% of infants in Warwickshire are totally breastfed, 13.4% partially breastfed and 46.4% not at all breastfed at 6-8 weeks after birth.

Data measuring points which are widely and consistently reported at other key times in an infant's life, such as at hospital discharge, 5 days old, 10 days old along with collection of qualitative data would give a better picture of risk of breastfeeding cessation.

OBESITY (CHILD)

Obesity during childhood has a range of physical and emotional health consequences, and risk of continuation into adulthood. Children who are obese are more likely to experience stigmatisation, bullying and low self-esteem. Obesity in childhood can lead

to high blood pressure, breathing difficulties, muscular-skeletal problems, and early type II diabetes (PHE, 2020)[16].

Figure 27 shows the prevalence of overweight children (including obese and severely obese) in reception over time by District/Borough in comparison to England. Whilst the England average has remained consistent over time, an increase can be seen in the overall Warwickshire picture, with Rugby, Stratford-on-Avon and Warwick showing specific increases. Whilst North Warwickshire and Nuneaton and Bedworth are both higher than the England and Warwickshire average, they have remained at similar levels over time.

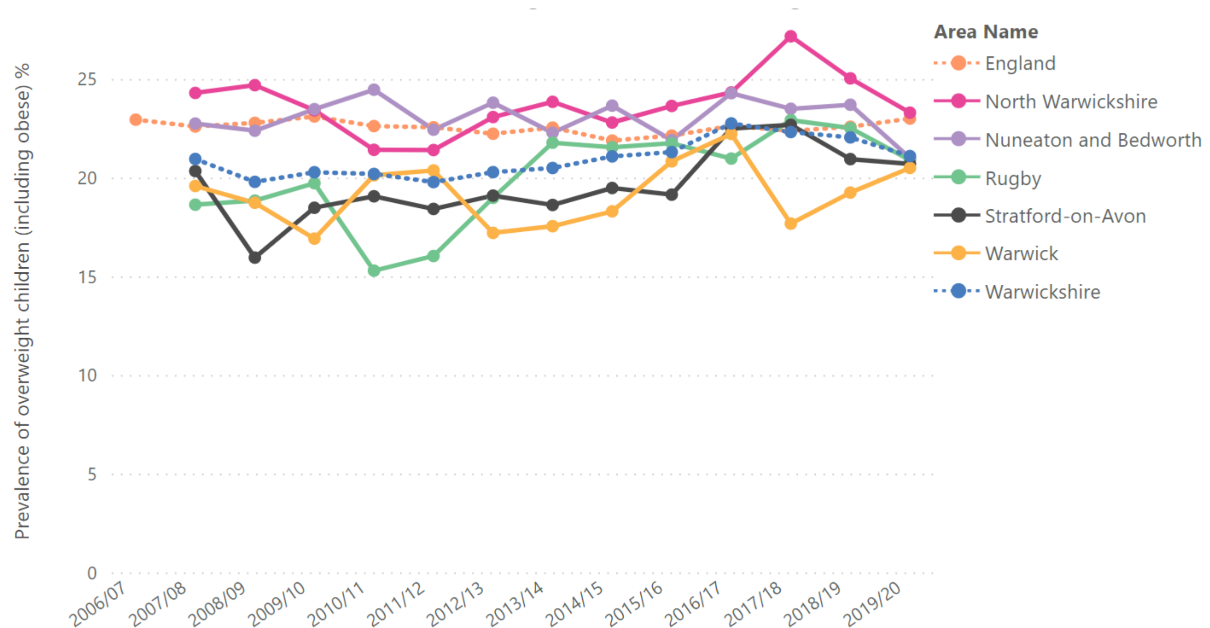


Figure 27: Reception: Prevalence of overweight children (including obese and severely obese) over time by District/Borough in comparison to England
Source: Public Health England Fingertips

Figure 27 breaks this down to show only the prevalence of obese and severely obese children in reception over the same time. Similar patterns can be seen here, with Warwickshire showing a steady increase.

[16] https://www.gov.uk/government/publications/childhood-obesity-applying-all-our-health/childhood-obesity-applying-all-our-health (Accessed February 2022)

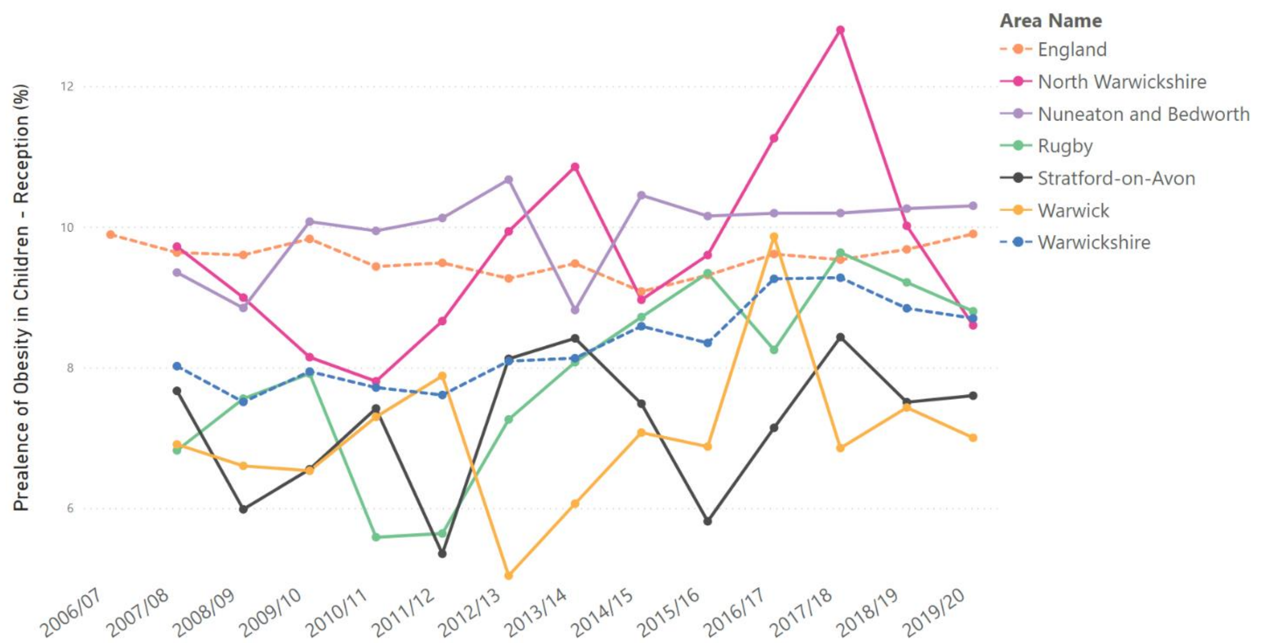


Figure 28: Reception: Prevalence of obese and severely obese children over time by District/Borough in comparison to England
Source: Public Health England Fingertips

Figure 29 shows the prevalence of overweight children (including obese) in Year 6 over time by District/Borough in comparison to England. Here we can see an increase in both the England and Warwickshire pictures, with North Warwickshire and Nuneaton and Bedworth both higher than the England and Warwickshire average. The only area to not show an increase is Warwick, which shows a decrease over time.

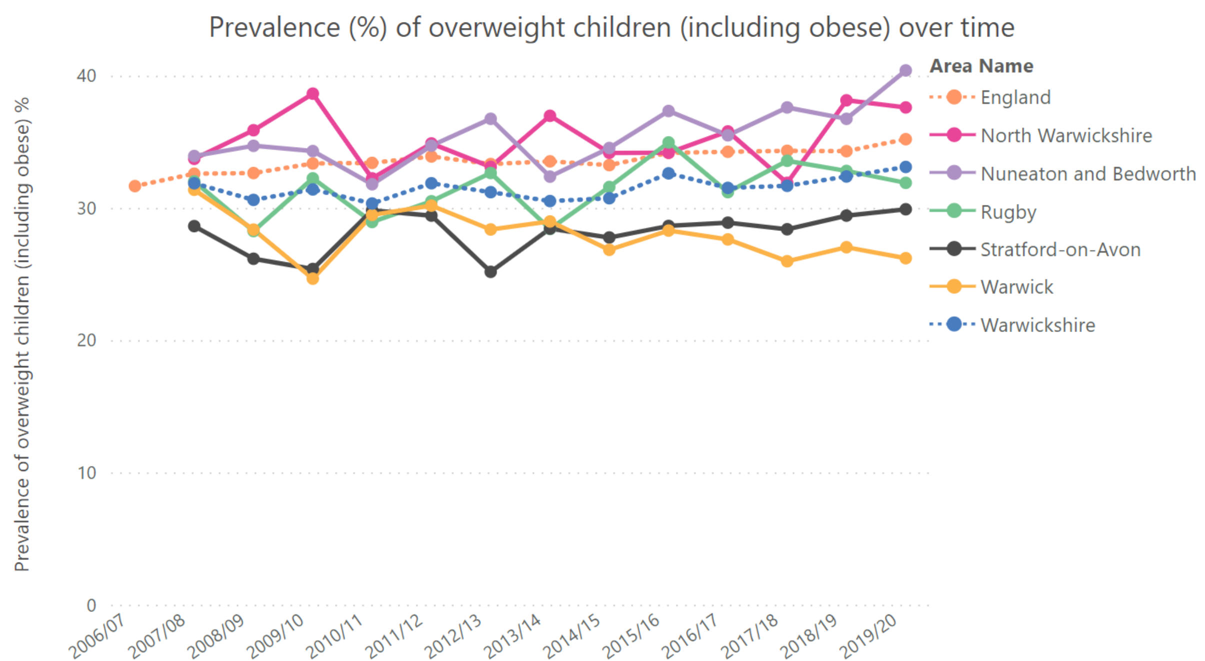


Figure 29: Year 6: Prevalence of overweight children (including obese) over time by District/Borough in comparison to England
Source: Public Health England Fingertips

Figure 30 breaks this down to show only the prevalence of obese and severely obese children in year 6 over the same time. Similar patterns can be seen here, with Warwickshire showing a steady increase.

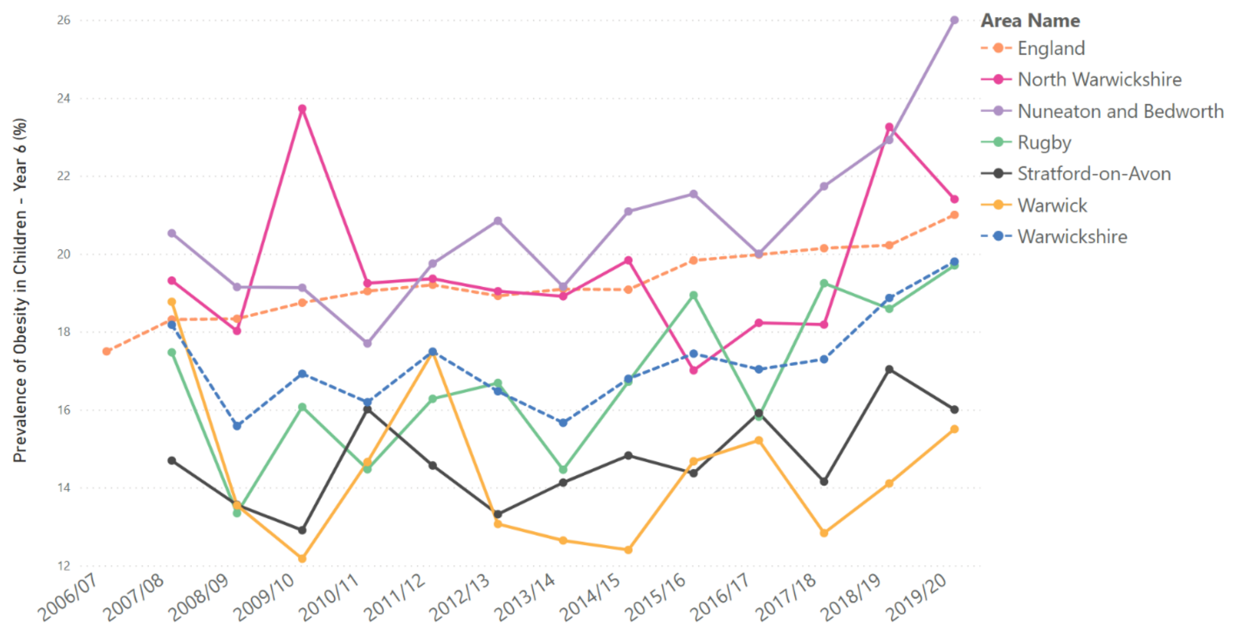


Figure 30: Year 6: Prevalence of obese children (including severely obese) over time by District/Borough in comparison to England
Source: Public Health England Fingertips

Comparing Figure 27 and Figure 29, and Figure 28 and Figure 30 shows an increase in percentage of the number of children who are overweight, and those who are obese and severely obese in Year 6 compared to Reception.

This is further demonstrated by Figure 31, which shows the percentage of children who are a healthy weight, not known, overweight, underweight, or very overweight in Reception and Year 6. In this graph we see an increase of 8.2% of children who are very overweight from Reception to Year 6, and an increase of 1% of children who are overweight from Reception to Year 6.

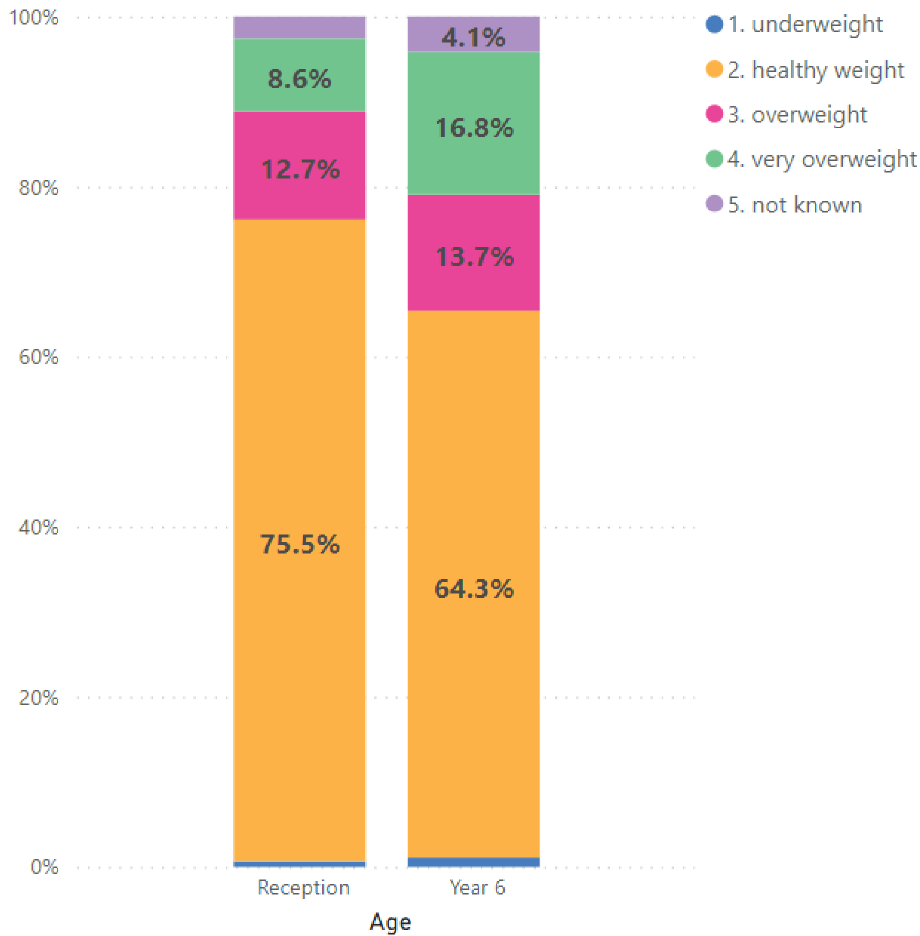


Figure 31: National Child Measurement Programme (NCMP) Reception and Year 6, Warwickshire
Source: NCMP combined 5 year data – 2014/15 to 2018/19

When looking at the breakdown of percentage of overweight and very overweight children in reception by JSNA areas within Warwickshire (Table 11), we can see the highest levels are in Atherstone and Hartshill (26.7%), Coleshill and Arley (25.1%), and Nuneaton Common and West (25.1%), whereas the lowest areas are Kenilworth (15.4%), Southam (17.1%), and Cubbington, Lillington and Warwick District East (18.1%). This is then further visualised in Figure 32.

JSNA Area	healthy weight	not known	overweight & very overweight	underweight
Atherstone and Hartshill	70.0%	2.8%	26.7%	0.5%
Bedworth Central and Bulkington	72.4%	2.7%	23.9%	1.0%
Bedworth West	74.0%	2.3%	23.2%	0.5%
Bilton and Town Centre	76.2%	2.2%	20.8%	0.8%
Coleshill and Arley	73.4%	1.3%	25.1%	0.2%
Cubbington, Lillington and Warwick District East	79.1%	2.4%	18.1%	0.5%
Henley, Studley and Alcester	71.1%	6.7%	21.8%	0.3%
Hillmorton	76.1%	2.3%	21.1%	0.5%
Kenilworth	81.8%	2.0%	15.4%	0.9%
Kingsbury	77.2%	1.6%	21.2%	0.0%
Leamington, Whitnash and Bishop's Tachbrook	76.4%	1.9%	20.4%	1.2%
Newbold and Brownsover	74.7%	2.2%	22.4%	0.7%
Nuneaton Central	75.4%	1.9%	22.1%	0.7%
Nuneaton Common and West	72.7%	1.7%	25.1%	0.5%
Polesworth	73.7%	2.9%	22.8%	0.6%
Rugby Rural North	75.8%	2.5%	21.3%	0.4%
Rugby Rural South	76.7%	2.0%	20.5%	0.8%
Southam	79.6%	3.1%	17.1%	0.2%
Stratford-upon-Avon	76.8%	4.2%	18.6%	0.5%
Warwick and Warwick District West	75.7%	2.0%	21.6%	0.7%
Warwickshire	75.5%	2.6%	21.3%	0.6%
Weddington, Horestone Grange and Whitestone	77.6%	2.2%	19.1%	1.1%
Wellesbourne, Kineton and Shipston	73.4%	2.9%	22.9%	0.8%

Table 11: Childhood obesity (National Child Measurement Programme) by JSNA area (Reception), 5 years combined data from 2014/15 to 2018/19
Source: NCMP

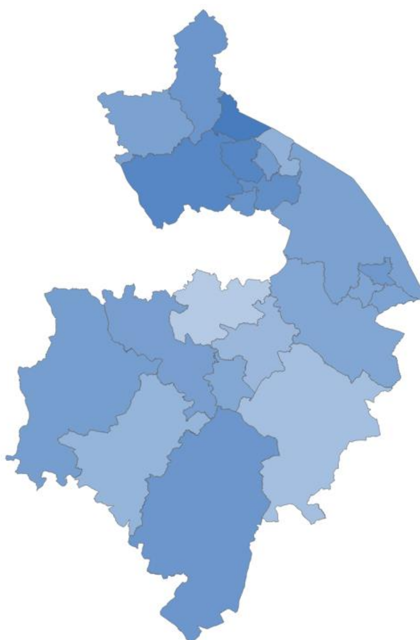


Figure 32: Childhood obesity (National Child Measurement Programme) by JSNA area (Reception), 5 years combined data from 2014/15 to 2018/19 – combined overweight and very overweight
Source: NCMP

Figure 33 shows the levels of obese children in reception by ward compared to the England average. Those in red are worse than the England average, those in yellow are similar, and those in green are better. Here we can see Polesworth East, Baddesley and Grendon, Atherstone Central, Camp Hill and Wolvey and Shilton all at worse levels than the England average, and Coton and Boughton, Kenilworth Park Hill, Kenilworth St John's and St Nicolas all at better levels than the England average. Those in grey are not compared, perhaps due to a lack of data. This can then be compared to Figure 34 which shows the levels of obese children in year 6 by ward compared to the England average.

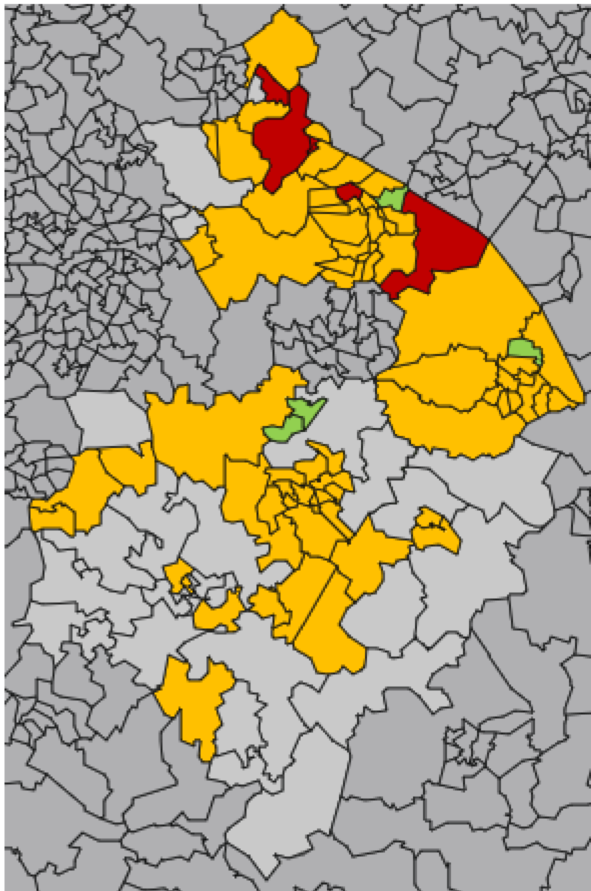


Figure 33: Obese Children in Reception in Warwickshire by ward, three-year average (2017/18 - 2019/20): levels compared to England average
Source: NCMP

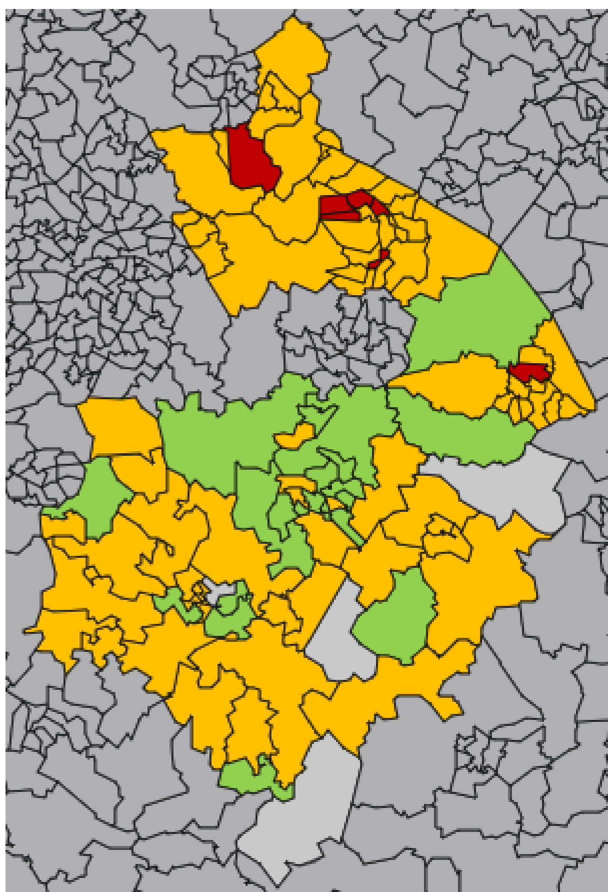


Figure 34: Obese Children in Year 6 in Warwickshire by ward, three-year average (2017/18 - 2019/20): levels compared to England average
Source: NCMP

While we do not have deprivation data at a ward level, there is a correlation to IMD, with more wards high for obesity in the north of the county where deprivation levels are also higher. For example, within the Nuneaton & Bedworth Borough, 30 of the 81 LSOAs are within the most deprived 0-30% nationally. This figure is 13.2% for North Warwickshire Borough, 11.5% for Rugby Borough, 5.8% for Warwick District and 1.4% for Stratford District

National Child Measurement Programme (NCMP) data for the 2020/21 reporting period is only available at national and regional level due to reduced participation rates during the COVID-19 pandemic. However, there have been concerning signs of increase in childhood obesity prevalence for both reception and Year 6 in this release, and higher prevalence in children living in the most deprived areas compared to the least deprived. NCMP indicates that there is a 4.5% increase in 0-5 obesity data from 2019/20 – 2020/21, a stark increase as previous years data highest indicated rise was less than a 1% increase. The West Midlands cohort was reported to be above the national for 0-5 years obesity rates.

Obesity prevalence in reception has gone from 9.9% in 2019/20 to 14.4% in 2020/21, whilst in the same period in Year 6 we see an increase from 21.0% to 25.5%. Comparing the most deprived areas to the least deprived, in reception 20.3% of

children living in the most deprived areas were obese whilst 7.8% of children living in the least deprived areas were obese. In year 6, 33.8% of children living in the most deprived areas were obese compared to 14.3% living in the least deprived areas[17].

The Rapid Review to Update Evidence for the Health Child Programme 0-5 highlights that the most effective way to prevent child obesity and treat children who are overweight and obese is a simultaneous improvement to their diet and physical activity in all areas of the child's lives, especially involving the parents and the rest of the family. Other effective ways to prevent and treat include:

- Decreasing pre-schoolers' screen time.
- Decreasing the consumption of high fat/calorie drinks/foods.
- Increasing physical exercise.
- Increasing sleep.
- Modifying parental attitudes to feeding.
- Promoting authoritative parenting.

In addition to the abovementioned lifestyle changes which focus on personal responsibility, PHE[18] recommend Local Authorities (LAs) take a 'whole systems' approach to prevent child obesity. A multi-stakeholder approach including LAs, Integrated Care Partnerships, the voluntary sector, community led organisations and local business is recommended to develop non-obesogenic environments for families to play, live, learn, and work in. LAs are encouraged to develop a 'Health in all Policies' (HiAP) approach and utilise Making Every Contact Count (MECC) initiatives to support families to maintain healthy weight and physical activity. Warwickshire LA adopted a HiAP approach, forming a partnership in 2021 to take a whole systems approach to health for Warwickshire residents.

ORAL HEALTH

The percentage of five-year-olds with experience of visually obvious tooth decay in Warwickshire is significantly better than for England as a whole. At a District / Borough level, all Districts and Boroughs are better than England except for Nuneaton and Bedworth whose rate is similar to the England average (Figure 35).

[17] https://digital.nhs.uk/data-and-information/publications/statistical/national-child-measurement-programme/2020-21-school-year (Accessed February 2022)
[18] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/750679/promoting_healthy_weight_in_children_young_people_and_families_resource.pdf (Accessed March 2022)

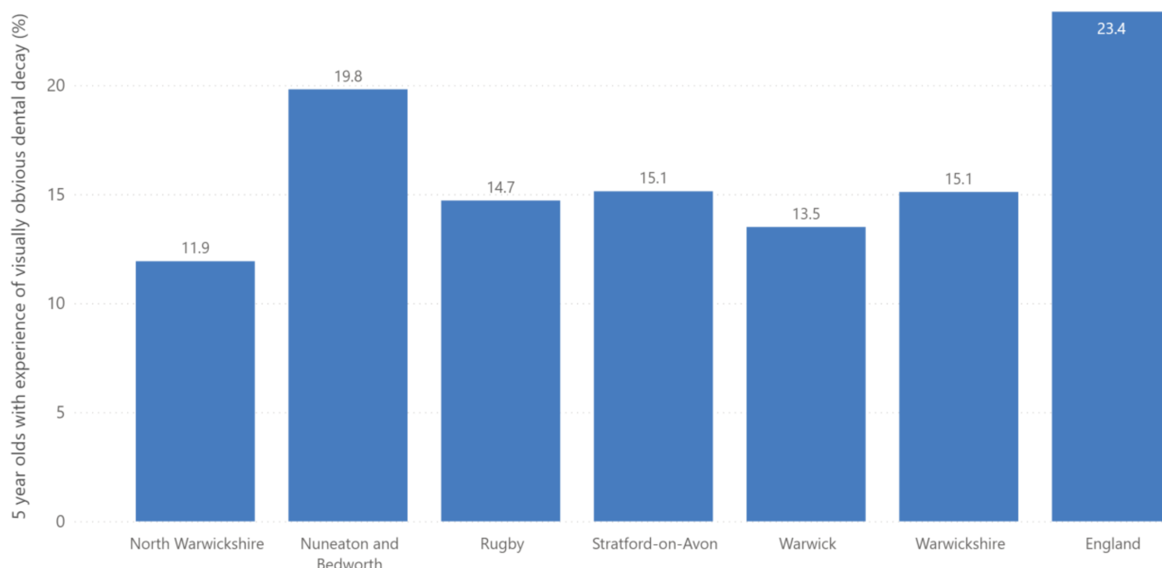


Figure 35: percentage of five-year-olds with experience of visually obvious tooth decay, 2018/19
Source: OHID Fingertips

The rate of hospital admissions for dental caries (for children aged 0-5) was 39.2 per 100,000 in 2017/18-2019/20, this is well below both the West Midlands rate of 118.4 per 100,000 and the England rate of 286.2 per 100,000.

There is evidence that groups of children who are overweight or obese may have higher levels of dental caries compared to non-obese children[19]. At a national level, local authority data that has been collected shows a weak to moderate correlation between dental caries and obesity prevalence observed at age 5. This means that as the rate of children who are obese or overweight increases, so will the rate of dental caries. Initiatives that tackle risk factors for overweight and obesity will also tackle dental caries as they have common risk factors such as the high intake of free sugars.

One reason as to why the prevalence of dental caries is lower in Warwickshire than the England average is the presence of water fluoridation in the area. Fluoride is a naturally occurring substance, and populations whose drinking water contains higher levels of fluoride have been found to have lower levels of dental caries then those living in areas where the drinking water contains lower levels of fluoride, thereby acting as a protective factor for oral health[20]. Figure 36 shows the areas in England that are currently on fluoridation schemes or have high levels of naturally occurring fluoride.

[19] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/466334/Caries_obesity_Evidence_SummaryOCT2015FINAL.pdf (Accessed February 2022)

[20] https://post.parliament.uk/water-fluoridation-and-dental-health/

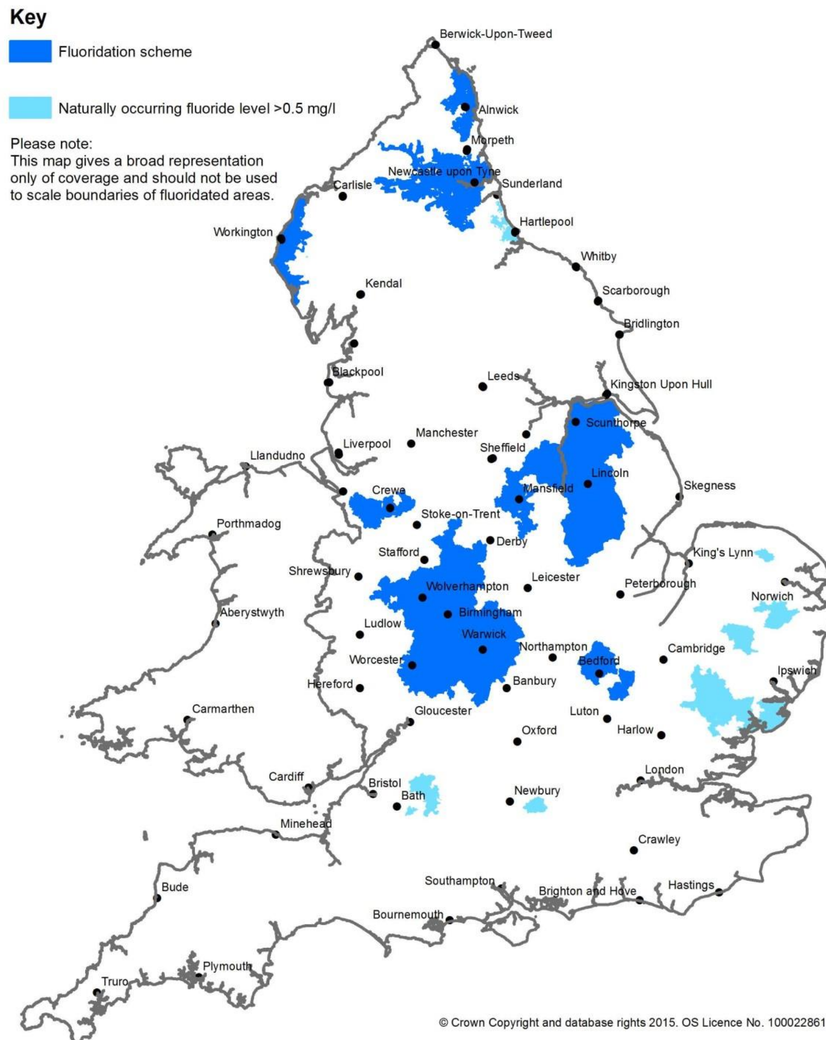


Figure 36: Areas of fluoridation schemes and of naturally occurring fluoride .0.5mg/l during 2014
Source: https://post.parliament.uk/water-fluoridation-and-dental-health/

IMMUNISATIONS

There are several complications related to infection with measles, mumps, and rubella (MMR) including meningitis, encephalitis, and deafness, in addition to complications in pregnancy and risk of miscarriage. Two doses of the MMR vaccine by 5 years of age offers combined protection against measles, mumps, and rubella.

In Warwickshire, MMR coverage of both doses is higher than both England and West Midlands figures (Figure 37). There has been a decline in percentage coverage in Warwickshire since the 2016/17 reporting period followed by an increase from 2019/20

to 2020/21 of 1.6%. MMR coverage for 2020/21 was 89.6%; this is slightly below the lower goal of 90%. Please note, however, that the reduction in 2017/18 was associated with a change in provider of Child Health Information Systems. After detailed review of the data, it was established that uptake data for the years prior to 2017/18 was not collected in the standardised way, meaning it was a likely overestimate of our local uptake.

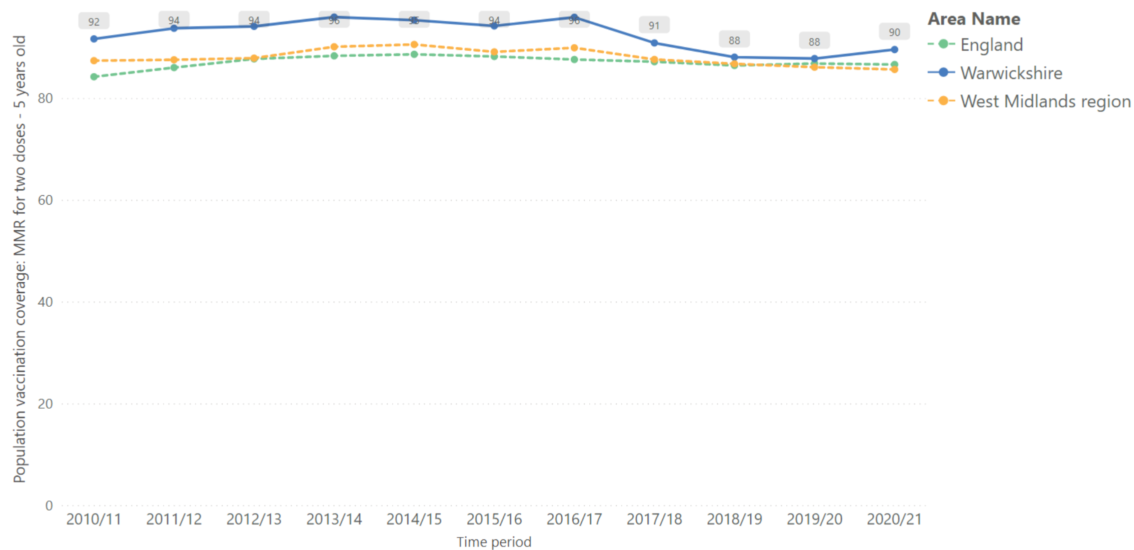


Figure 37: MMR coverage (both doses) in Warwickshire over time, compared to England and West Midlands
Source: Public Health England Fingertips

Figure 38 shows the percentage uptake of vaccines recommended for 1-year olds. The drop that can be seen in 2017/18 is attributable to the reasons noted above with previous years being overestimates. Since 2017/18 there has been a slight increase in uptake across all vaccines, with all vaccines in 2020/21 having over 93% uptake.

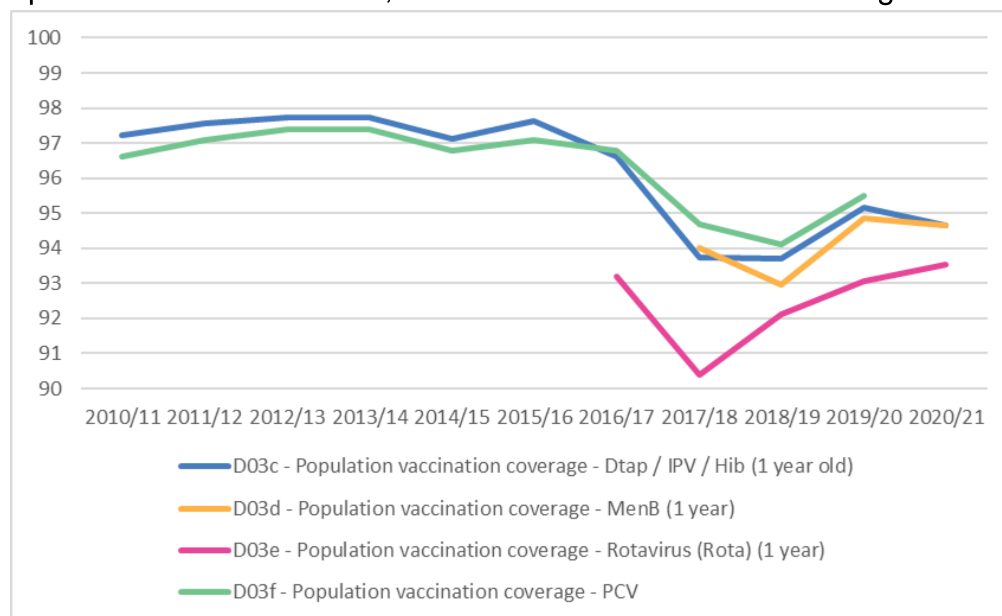


Figure 38: Percentage uptake of vaccines for 1-year olds
Source: Public Health Outcomes Framework

In the percentage uptake of vaccines for 2-year-olds we see the same dip in 2017/18 as 1-year olds, and overall, we see the same pattern of increase from 2017/18. Compared to 1-year-old uptake, we see similar levels for Dtap/IPV/Hib uptake (94.7% in 2020/21 for 1-year-olds compared to 96.1% for 2-year-olds) and for the PCV booster (95.5% in 2019/20 for 1-year-olds compared to 93.7% for 2-year-olds) (Figure 29).

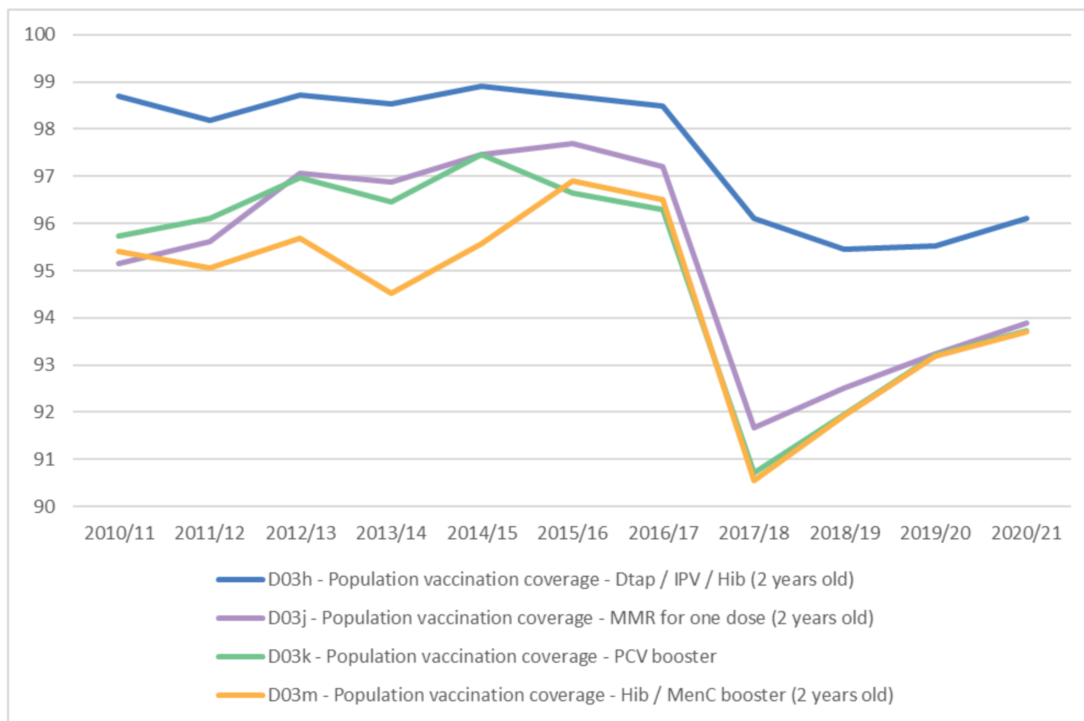


Figure 39: Percentage uptake of vaccines for 2-year-olds
Source: Public Health Outcomes Framework

The percentage uptake for the flu vaccine for 2-3-year-olds is the lowest of the 0-5 vaccines but has seen a large increase from 46.5% in 2014/15 to 64.8% in 2020/21 (Figure 40), which is likely to have been influenced by the pandemic.

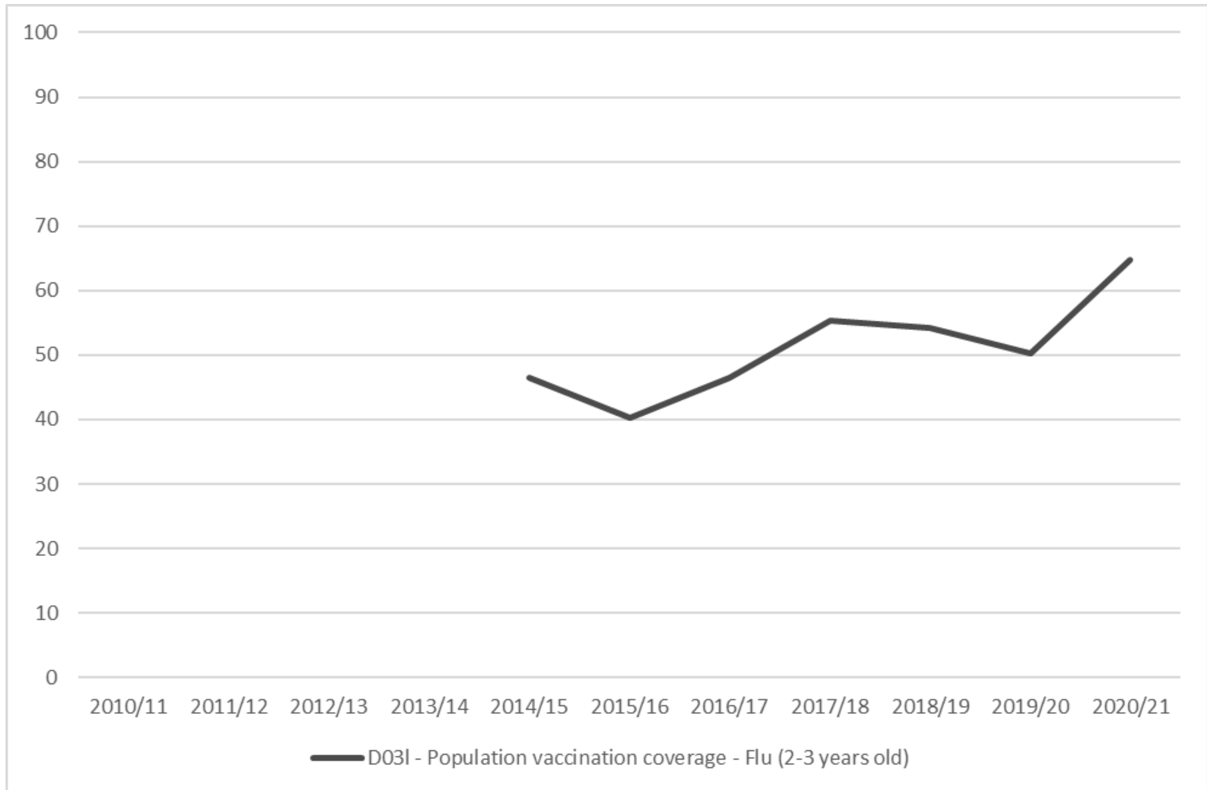


Figure 40: Percentage uptake of flu vaccine for 2-3-year-olds.
Source: Public Health Outcomes Framework

For vaccines among 5-year-olds we see the same dip in 2017/18 but less of an increase in uptake after that. For the DTaP/IPV booster there was an uptake rate of 88.9%, much lower than the 1-year-old uptake (94.7%) and 2-year-old uptake (96.1%). There is also a lower uptake for the second dose of MMR, with a 96.1% uptake in 2020/21 for the first dose and an 89.6% uptake for the second dose (Figure 41).

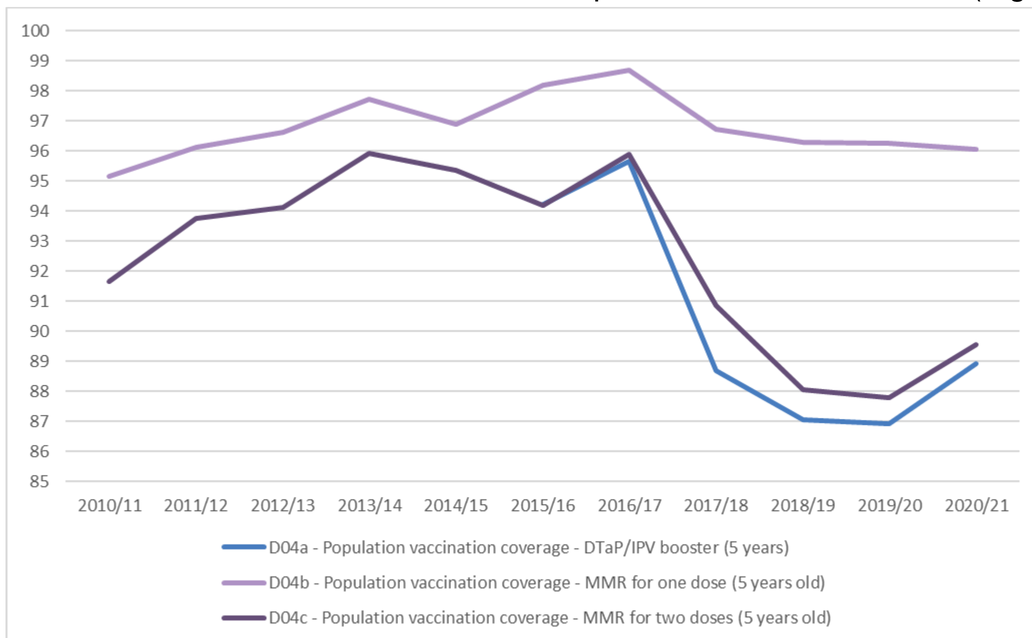


Figure 41: Percentage uptake of vaccines for 5-year-olds.
Source: Public Health Outcomes Framework

It is clear that uptake for the "pre-school boosters" (scheduled from age 3 years and 4 months) is much lower than uptake of the primary course of vaccinations in the first year of life. There are potentially several reasons for this, and a plan to improve uptake of childhood immunisations has been established by a Coventry and Warwickshire-wide Immunisation task and finish group.

The plan focuses on a "whole system" approach to improving immunisation uptake and is likely to also include efforts to improve uptake of national screening programmes, building on our experiences of promotion of the COVID-19 vaccination programme. The plan currently being agreed focuses on:

- Working with GP practices in areas where uptake is lowest to support uptake increases.
- Increasing access to appointments where possible.
- Working with schools, early years settings, health visiting, school health and wellbeing services, and children's centres/family hubs to promote uptake.
- Engaging directly with communities through a range of means to support increasing uptake.

DOMESTIC ABUSE AND VIOLENCE

According to latest national crime survey[21], 5.5% of adult respondents stated they had experienced domestic abuse once or more in the year ending March 2020. Based on this result, there were an estimated 32,113 incidents of DVA in Warwickshire in 20202.

During that period approximately 1,000 victims were supported by the Warwickshire Domestic Violence and Abuse Service, 3% of the total number of victims likely to be experiencing Domestic Abuse (DA). Given the prevalence of DA in Warwickshire, it is likely that there will be a significant number of children aged 0-5 that are witnessing or living in a household where domestic abuse is occurring, over and above those known to the local authority and local Domestic Abuse Services.

The Warwickshire Domestic Violence and Abuse Joint Strategic Needs Assessment[22] provides evidence to suggest that pregnant women and women with children under the age of 5 are more likely to experience abuse and / or require support from agencies. The DA Needs Assessment included the following specific relevant recommendations:

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[21] https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/domesticabuseinenglandandwalesoverview/november2020 (accessed March 2022)
[22] https://api.warwickshire.gov.uk/documents/WCCC-1350011118-3054 (accessed March 2022)

- There are opportunities for all services / agencies that work with parents, infants, and young children to facilitate disclosures and signpost to appropriate support.

- There is a need to consider the support needs of a child under the age of 5 who has witnessed or experienced domestic abuse to recover from their experience and rebuild their relationship with the non-abusing parent. There is also a need to consider the support needs of the non-abusing parents to recover and move on from their experience.

Local Authorities are required to record risk factors in Child Statutory Social Care Assessments. There are three relevant risk factors in relation to domestic abuse. The following table shows the number of unborn children and children aged 0-5 where Domestic Abuse risk factors were recorded over the last three years (2019-2021). This data indicates that unborn children and children aged 0-5 are more likely to experience or live-in households where Domestic Abuse is taking place. Over the last three years, in Warwickshire, unborn children and children aged 0-5 accounted for:

- **44% of the total number of children** with a Statutory Social Care Assessment risk factor of Domestic Violence: **concern about the child being subject to domestic violence (Table 12).**
- **46% of the total number of children** with a Statutory Social Care Assessment risk factor of Domestic Violence: **concerns about the child's parent(s)/carer(s) being the subject of domestic violence' (Table 13).**
- **41% of the total number of children** with a Statutory Social Care Assessment risk factor of Domestic Violence: **concerns about another person living in the household being the subject of domestic violence (Table 14).**

Based on Child's Age at start of Statutory Social Care Assessment	2019	2020	2021	Total
Unborn:	42	33	30	105 (5%)
0-5yrs:	310	209	269	788 (39%)
Total	**797**	**562**	**637**	**1996**

Table 12: Child Statutory Social Care Assessment completed with a risk factor of '3A -Domestic violence: concerns about the child being the subject of domestic violence'.
Source: Child Statutory Social Care Assessment

Based on Child's Age at start of Statutory Social Care Assessment	2019	2020	2021	Total
Unborn:	111	97	110	318 (6%)
0-5yrs:	659	688	713	2060 (40%)
Total	**1622**	**1662**	**1865**	**5149**

Table 13: Child Statutory Social Care Assessment completed with a risk factor of '3B Domestic violence: concerns about the child's parent(s)/carer(s) being the subject of domestic violence'.
Source: Child Statutory Social Care Assessment

Based on Child's Age at start of Statutory Social Care Assessment	2019	2020	2021	Total
Unborn:	26	23	17	66 (6%)
0-5yrs:	136	120	128	384 (36%)
Total	**374**	**293**	**392**	**1059**

Table 14: Child Statutory Social Care Assessment completed with a risk factor of '3C Domestic violence: concerns about another person living in the household being the subject of domestic violence.'
Source: Child Statutory Social Care Assessment

The needs of children aged 0-5 is further reinforced in the 2021 Warwickshire Safe Accommodation Needs Assessment. The Needs Assessment included the demographic profile of the households that have presented as homeless in Warwickshire as a result of Domestic Abuse over the last three years[23]. Of those households that had children, 46% (296) of those children were aged 0-5.

The Domestic Abuse Act came into effect in April 2021, within the Act the definition of a victim of Domestic Abuse was extended to children who live in a household where Domestic Abuse is occurring. Warwickshire County Council (WCC), as a tier 1 authority, has a new statutory duty to assess the need of all victims of Domestic Abuse for “Safe Accommodation Support”. Warwickshire's Safe Accommodation Strategy[24] outlines how WCC and Warwickshire’s Violence Against Women and Girls partners will respond to the findings of the Safe Accommodation Needs Assessment to ensure that the Safe Accommodation Support needs of adult and child victims of Domestic Abuse are met in future.

SPEECH, LANGUAGE AND COMMUNICATION NEEDS

Effective communication is an essential skill for life and is the foundation for a child’s social, emotional, and educational development[25]. Speech, language, and communication skills are crucial, from brain development in the first 1,001 days and beyond, attachment in early years, to expressing ourselves and understanding others as we develop emotionally, to thinking, learning and social interaction in school and the workplace[26].

A paucity in local data and intelligence to assess speech language and communication needs in Warwickshire children means it has not been possible to

[23] 2018/19, 2019/20, 2020/21
[24] https://safeinwarwickshire.files.wordpress.com/2021/09/warwickshires-safe-accommodation-strategy-2021-2024-.pdf (accessed March 2022)
[25] Department for Children and Family Services. The Bercow Report: A review of services for children and young people (0-19) with speech, language and communication needs. 2008.
[26] I CAN & Royal College of Speech & Language Therapists. Bercow: 10 Years On. 2018.

accurately assess the local picture at this time. However, the Local Authority Interactive Data Tool (LAIT) does provide an insight that Warwickshire scores low compared to statistical neighbours (10th out of 11) for the percentage of children achieving at least the expected level in the Foundation Stage Profile or Communication & Language in 2018/19 (Table 15). This is an indication of the future work needed in this area.

The percentage of children achieving at least the expected level in the Foundation Stage Profile for Communication & Language 2018/19	
2019	Warwickshire Statistical Neighbour View: 10/11 National Rank 77 / 151 Quartile: C

Table 15: Percentage of children achieving at least the expected level in the Foundation Stage Profile for Communication & Language 2018/19.
Source: LAIT

CHILD HOSPITALISATIONS

A&E EMERGENCY DEPARTMENT ATTENDANCES

In Coventry and Warwickshire in 2019/20 there were 33,836 A&E emergency department attendances for children 0-5 years, a decrease of -1% from 2018/19. In 2020/21 the attendance figure dropped to 20,112, a decrease of -40.56% from the previous year. Figure 42 breaks this down into A&E attendances by Place (North, Rugby South). In mid-late 2021 we see a rise in admissions across all places, however there is a particularly dramatic increase in the number of attendances for North Place (North Warwickshire and Nuneaton and Bedworth), peaking at just below 1,600, the highest peak shown. Across the whole date range shown, North Place has the highest rate, followed by Rugby. South Place (Warwick and Stratford-on-Avon) has the lowest rates.

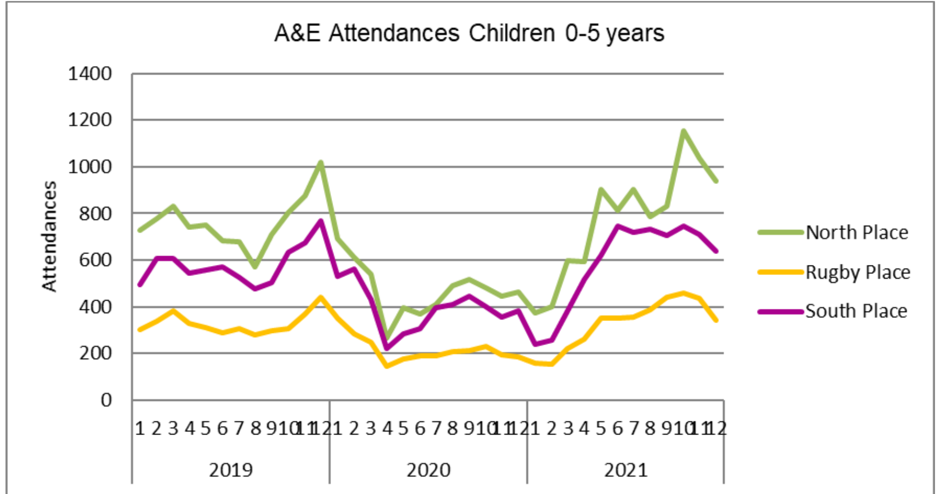


Figure 42: A&E attendances for Children 0-5 years in Warwickshire and Coventry. Source: SUS- Secondary user services

Table 16 shows the A&E attendances for children aged 0-5 per 1,000 of the population by place. The figure for the 0-4 age group for England in 2018/19 was 655.3 per 1,000, and for the West Midlands region the figure was 629.7 per 1,000 (Table 17). All places are therefore below the England average, although North Place is higher than the West Midlands region average.

Attendances per 1,000 by 0-5 population

	North Place	Rugby Place	South Place
1819	619.8	487.3	389.3
1920	629.0	478.2	405.4
2021	377.8	284.0	243.7

Table 16: A&E attendances per 1,000 for 0-5 ages. Source - SUS- Secondary user services

Indicator	Period	England	East Midlands region	East of England region	London region	North East region	North West region	South East region	South West region	West Midlands region	Yorkshire and the Humber region
A&E attendances (0-4 years) (Persons, 0-4 yrs)	2018/19	655.3	626.1	520.5	755.2	967.4	776.3	573.4	522.1	629.7	624.5

Table 17: A&E Attendances per 1,000 for ages 0-4.
Source - Fingertips

Across all places there is a higher percentage of males to females who attend the A&E department (Table 18). For males this ranges between 55% - 58%, and females between 42% - 45%.

	2018/19		2019/20		2020/21	
	Male	Female	Male	Female	Male	Female
North Place	56%	44%	55%	45%	57%	43%
Rugby Place	56%	44%	57%	43%	55%	45%
South Place	58%	42%	57%	43%	57%	43%

Table 18: Percentage of A&E attendances by gender.
Source: SUS- Secondary user services

The four leading chief complaints for A&E attendances are Airway and breathing, Head and Neck, General/minor/admin and Gastrointestinal. Since April 2021 there has been increase across all complaints (Figure 43).

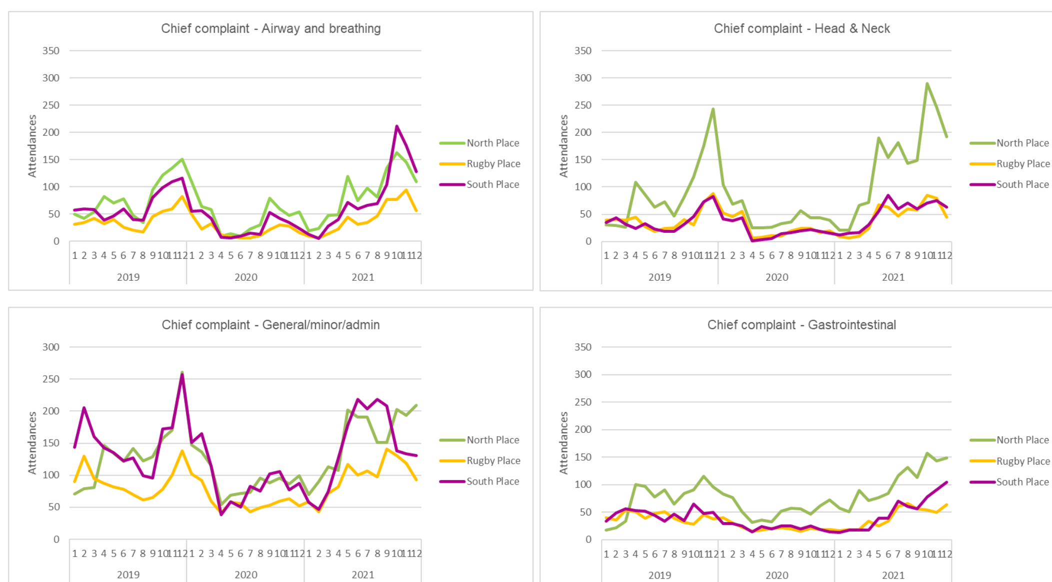


Figure 43: Leading Chief complaints for A&E attendances in ages 0-5.
Source: SUS- Secondary user services

A&E attendance figures for ethnicity shows the highest percentage attending is for the white group, accounting for between 73% - 76% A&E attendances across the years 2018/19 – 2020/21. There has been an 8% - 11% attendance rate for Asian, and 4% for Black (Figure 44).

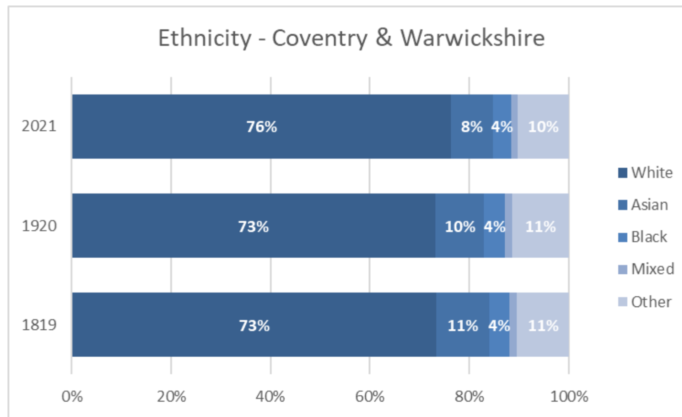


Figure 44: A&E attendance by Ethnicity
Source: SUS- Secondary user services

The Indices of Deprivation identify the most deprived Emergency department attendances, with 1 being the most deprived and 10 being the least deprived (Figure 45). It clearly identifies North Place having the most deprived Emergency department attendances, and South Place having the least.

Figure 45: Indices of Deprivation for Emergency department attendances
Source: SUS – Secondary User Services

EMERGENCY HOSPITAL ADMISSIONS

Coventry and Warwickshire hospital admissions in 2019/20 for children 0-5 years were 8,745, a decrease of -12.52% from 2018/19. In 2020/21 the attendance figure plummeted to 5,160, a decrease of -40.99% from the previous year, clearly the pandemic having an impact, and in 2021/22 we see those figure increase again. South Place has the highest number of admissions, followed by North Place, with Rugby Place with the lowest number (Figure 46).

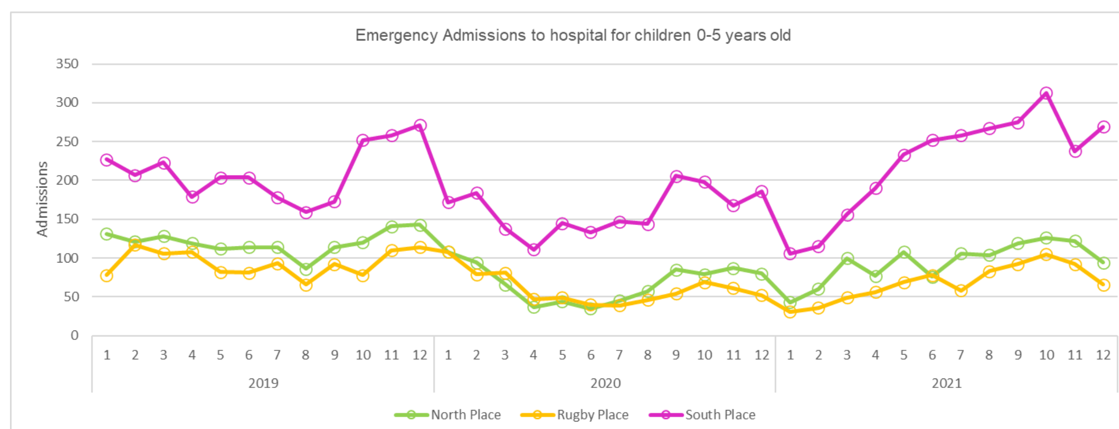


Figure 46: Emergency admissions to hospital for children aged 0-5 by Place
Source: SUS- Secondary user services

South Place has the highest rates of emergency admissions per 1,000 for the 0-5 age range, followed by Rugby Place, and North Place with the lowest (Table 19). in 2019/20, the England emergency admissions rate per 1,000 for the 0-4 age range was 162, and the West Midlands Region rate was 171.8 (Table 20). Compared to these for the year 2019/20, all Warwickshire Places were lower than both the England and West Midlands Region rate.

Emergency admissions per 1,000 by 0-5 population

Year	North Place	Rugby Place	South Place
1819	110.9	142.8	161.3
1920	96.5	136.7	141.5
2021	54.3	72.0	108.7
2122	67.6	87.7	137.4

Table 19: Emergency admissions per 1,000 for 0-5 age range by CCG Place
Source: SUS- Secondary user services

Indicator	Period	England	East Midlands region	East of England region	London region	North East region	North West region	South East region	South West region	West Midlands region	Yorkshire and the Humber region
Emergency admissions (aged 0-4) (Persons, 0-4 yrs)	2019/20	162.0	145.6	154.5	113.1	233.9	229.2	147.9	176.8	171.8	153.0

Table 20: Emergency admissions per 1,000 for 0-4 age range in 2019/20
Source: fingertips

Across all places there is a higher percentage of males to females who are admitted to hospital (Table 21). For males this is between 56% - 59% and for females between 41% - 44%.

	2018/19		2019/20		2020/21	
	Male	Female	Male	Female	Male	Female
North Place	58%	42%	59%	41%	56%	44%
Rugby Place	56%	44%	58%	42%	59%	41%
South Place	58%	42%	58%	42%	57%	43%

Table 21: Hospital admissions by gender
Source: SUS- Secondary user services

Hospital admission figures for ethnicity shows the highest percentage attending is for the white group, accounting for between 73% - 76% or hospital admissions across the years 2018/19 – 2020/21. There has been a 9% - 11% attendance rate for Asian, and 4% for Black (Figure 47).

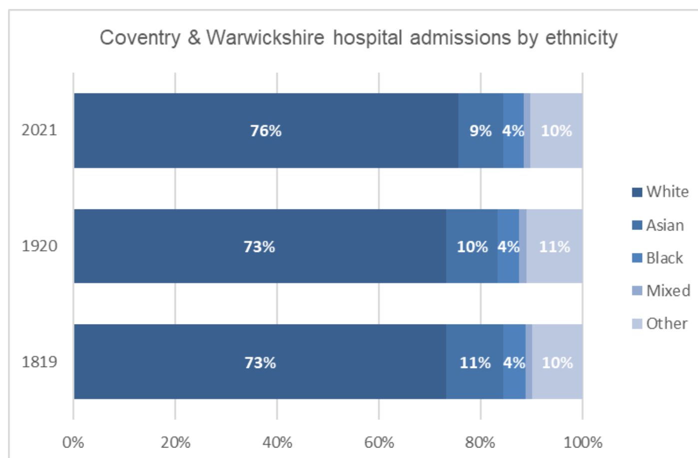


Figure 47: Hospital admissions by ethnicity
Source: SUS- Secondary user services

The Indices of Deprivation identify the most deprived hospital admissions, with 1 being the most deprived and 10 being the least deprived (Figure 48). It clearly identifies North Place having the most deprived admissions attendances, and South Place having the least.

Figure 48: Indices of Deprivation for Hospital admissions
Source: SUS – Secondary User Services

The top 10 diagnosis groups for admissions are shown in the table below with B25-B34 other viral diseases group at the top, followed by respiratory infections, fetal growth, injuries of the head and general symptoms and investigations (Table 22).

	North Place			Rugby Place			South Place		
Diag_Group	1819	1920	2021	1819	1920	2021	1819	1920	2021
B25-B34: Other viral diseases	244	171	107	146	155	80	467	331	211
J20-J22: Other acute lower respiratory infections	195	167	33	154	142	25	384	289	79
J00-J06: Acute upper respiratory infections	138	145	50	147	131	31	359	339	189
R50-R69: General symptoms and signs	124	112	75	81	76	67	167	169	184
R00-R09: Symptoms and signs involving the circulatory and respiratory systems	93	74	34	39	49	19	34	26	40
J40-J47: Chronic lower respiratory diseases	62	41	12	38	24	2	25	23	7
A00-A09: Intestinal infectious diseases	58	58	18	41	35	14	151	130	46
S00-S09: Injuries to the head	53	32	44	62	55	30	54	56	64
P50-P61: Haemorrhagic and haematological disorders of fetus and newborn	40	26	22	34	33	25	50	53	40
R10-R19: Symptoms and signs involving the digestive system and abdomen	36	33	18	25	25	8	49	26	49
Grand Total	1043	859	413	767	725	301	1740	1442	909

Table 22: Top 10 diagnosis groups for admissions
Source - SUS- Secondary user services

UNINTENTIONAL INJURIES

Unintentional injuries are a leading cause of hospitalisation and major cause of premature mortality for children aged 0-5, often resulting in long-term health issues. The majority of these injuries are preventable and working to prevent these injuries has significant long-term benefits for individuals, families and society.

Unintentional injuries have been identified as a major health inequality. Analysis shows that the emergency hospital admission rate for unintentional injuries nationally in the 0-5 age range is 38% higher if a child lives in one of the most deprived areas compared with those children who live in the least deprived. Research also indicates that for some injury types, this inequality may be larger. For example, there is a 50% higher risk for children living in the most deprived areas of being burned, scalded, or poisoned and this resulting in primary or secondary care attendance, then for those living in the least deprived areas.

The highest rate per 10,000 for hospital admissions caused by unintentional and deliberate injuries in children aged 0-4 years in 2019/20 is in Rugby, which is higher than both the Warwickshire and England average (Figure 49).

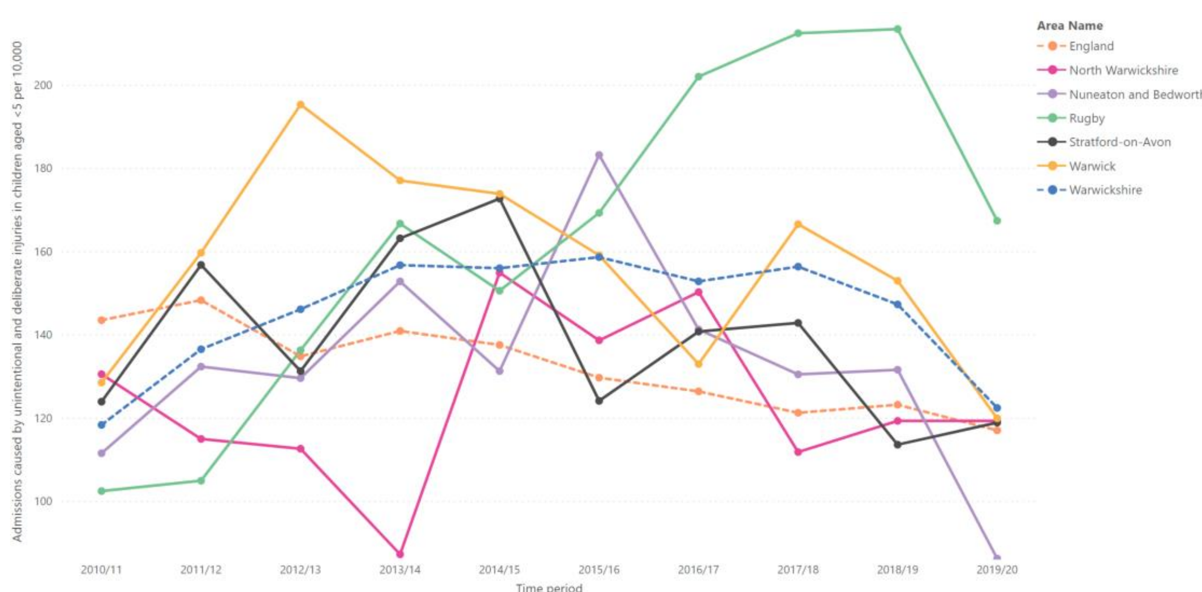


Figure 49: Hospital admissions caused by unintentional and deliberate injuries in children aged 0-4 years per 10,000 population by district and borough over time
Source: Public Health England Fingertips

In all areas except for Warwick, the male admission rate in the 0-4 years age range is higher than the female rate (Figure 50). This matches the national picture, where boys have higher rates of hospital admissions and death. Between 2012/13 and 2016/17, 55% of hospital admissions were for boys and 45% for girls. In the same period, boys had 64% of deaths and girls 36%

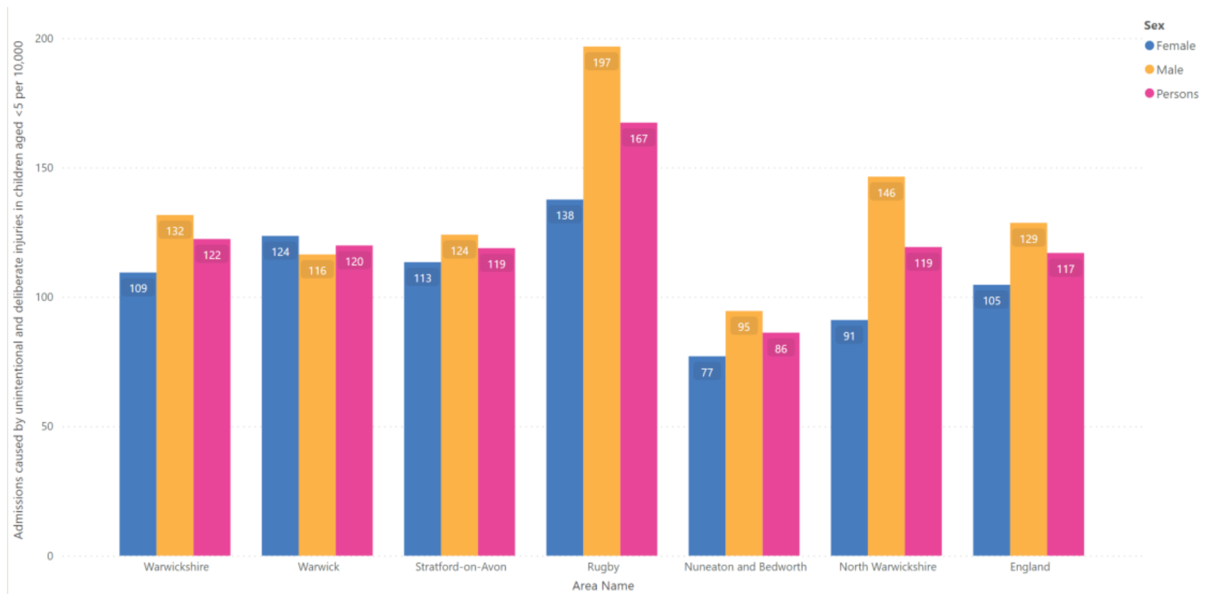


Figure 50: Hospital admissions caused by unintentional and deliberate injuries in children aged 0-4 years per 10,000 population by sex, 2019/20 data
Source: Public Health England Fingertips

Unintentional injuries in the 0-5 age range most commonly happen in and around the home. Several factors have been identified as contributing to unintentional injuries including:

- Child development
- The physical environment in the home
- The knowledge and behaviour of parents and other carers
- Overcrowding and homelessness
- The availability of safety equipment
- Consumer products in the home

The Reducing unintentional injuries in and around the home among children under five years paper[27] produced by Public Health England advises that Local Authorities could achieve significant improvements through targeting the reduction of five causes of unintentional injuries among the under-fives. This group includes the most severe and preventable injuries, including those that result in high death rates and the largest number of emergency hospital admissions. These groupings are:

1. Choking, suffocation and strangulation
2. Falls
3. Poisoning
4. Burns and scalds

[27] Reducing unintentional injuries among children and young people - GOV.UK (www.gov.uk) (Accessed February 2022)

5. Drowning

The paper identifies 3 prevention opportunities:

Providing leadership

Since the responsibility for improving health and reducing health inequalities was transferred to local authorities in The Health and Social Care Act (2012), local authorities are in an ideal place and encouraged to provide strategic leadership for unintentional injury prevention through focused planning, coordination of services and commissioning to support a collaborative approach and effectively use resources.

Mobilising existing services and working partnerships

To optimise the use of existing services and programmes in reducing unintentional injuries and being consistent with the Making Every Contact Count (MECC) approach, it is recommended to incorporate safety into all relevant interactions, including professionals' home visits. It is key to provide a strong lead to ensure injury prevention is high on the agenda of all relevant partners.

Focusing on what works and addressing inequalities

NICE PH30 makes five recommendations to help guide local planning:

1. Prioritising households at greatest risk
2. Working in partnership
3. Co-ordinating delivery
4. Ensuring families with children at high risk of injury are provided with home safety assessments and advice and referred to safety equipment schemes
5. Integrating home safety into all home visits

CHILD DEATHS

The death of any child is a devastating loss that poses profound grief to all those whom it affects. The Child Death Overview Panel (CDOP) provides a systematic review of the deaths for all children who die in England aged between birth and the day prior to their eighteenth birthday. Data within this section is drawn from PHE and the Warwickshire CDOP.

CATEGORISING CHILD DEATHS

When reviewing deaths, the type of death is categorised into one of ten different domains, examining these domains against the borough area and age of the child highlights areas where commissioning can be applied (Table 23).

Category 1; Deliberately inflicted injury, abuse or neglect
Category 2; Suicide or deliberate self-inflicted harm
Category 3; Trauma and other external factors
Category 4; Malignancy
Category 5; Acute medical or surgical condition
Category 6; Chronic medical condition
Category 7; Chromosomal, genetic and congenital anomalies
Category 8; Perinatal/neonatal event *(including prematurity)*
Category 9; Infection
Category 10; Unexplained or SIDS

Table 23: CDOP categories of child death type
Source: CDOP

When examining the type of death by age of the child, neonatal deaths within Warwickshire are mainly attributable to either ‘Chromosomal, genetic and congenital anomalies’ (category 7) or a ‘Perinatal/neonatal event’ (category 8). This noticeably alters for children who are in the age group of up to one year where categories of death become most pertinent in the category of ‘Unexplained or SIDS’. The latter ages stages all illustrate a higher category context within ‘Chromosomal, genetic and congenital anomalies’ (category 7). This category 7 congruence between the latter ages (within the 0-5 age group) highlights the cohort of children in 0-5 living and dying with life limiting conditions (Figure 51).

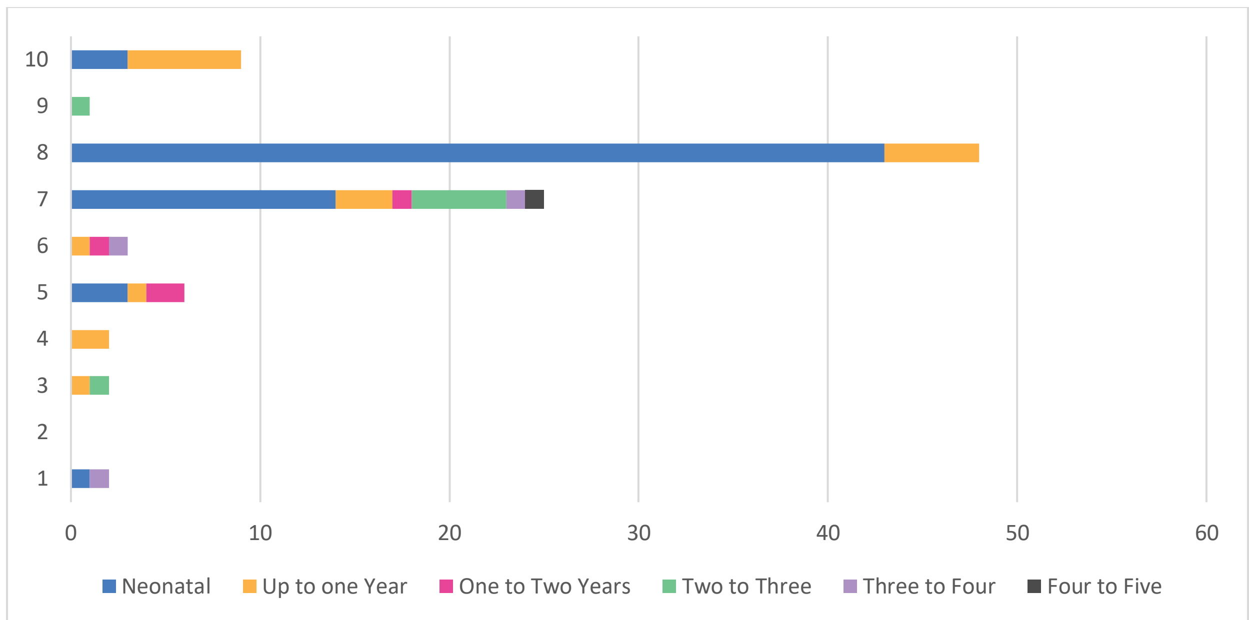


Figure 51: Warwickshire Children who have died between 2017 and 2021 by category and age
Source: Warwickshire CDOP

When examining these categories of death by borough (Figure 52) the distribution highlights regional differences. Although the category of 'Perinatal/neonatal event' (category 8) is fairly well stratified with distribution, there is categorical outliers in both the borough of Rugby and Nuneaton and Bedworth.

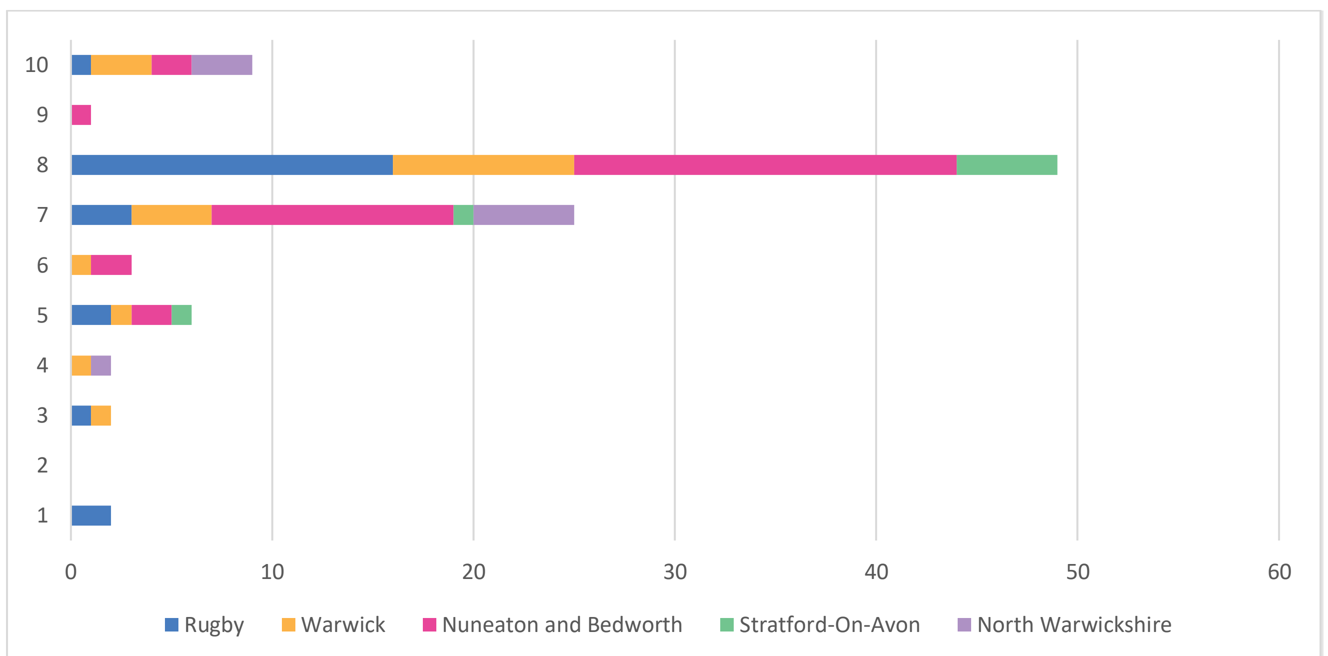


Figure 52: Warwickshire Children who have died between 2017 and 2021 by category of death and district and borough
Source: Warwickshire CDOP

INFANT MORTALITY

Infant mortality is an indicator of the general health of the population and includes deaths within the first year of life as a rate per 1,000 live births. There is a relationship with infant mortality and the wider determinants of health, deprivation, and inequalities. Infant mortality rates in Nuneaton and Bedworth, and North Warwickshire are higher than the national average, whilst Warwick and Stratford are well below. This indicates a significant inequality in infant mortality outcomes across Warwickshire (Figure 53).

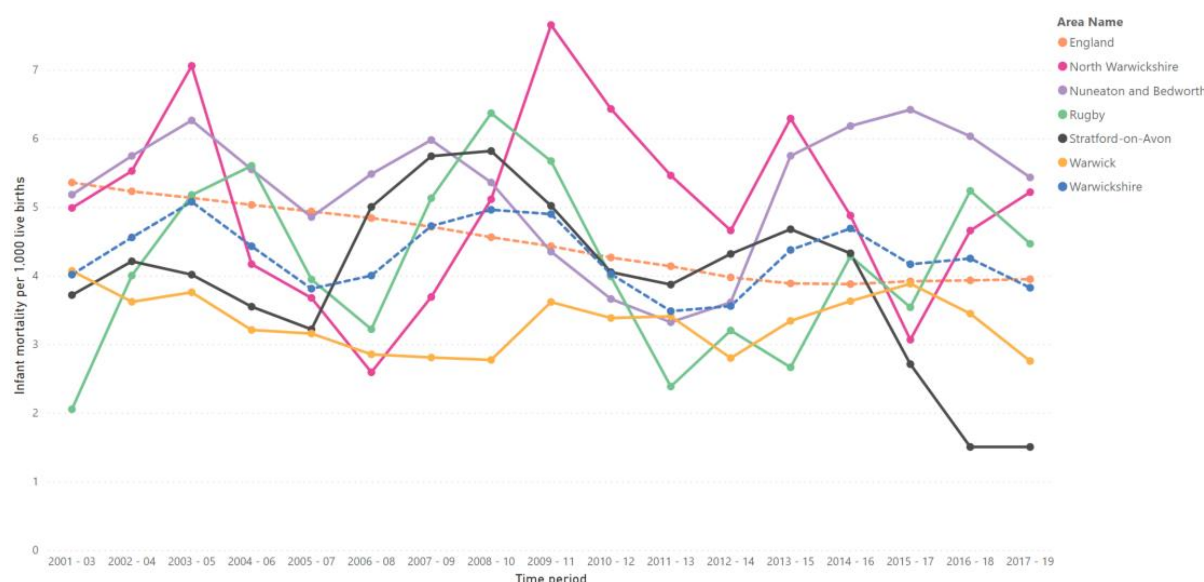


Figure 53: Infant mortality rate (per 1,000 live births) over time by district and borough in comparison to England
Source: Public Health England Fingertips

CDOP examined 122 child deaths in Warwickshire between 2017-2021.
These children were subdivided into age ranges of neonatal (aged 0- 30 days), below one year, one to two years, two to three years, three to four years and four to five years. The deaths within the age ranges (Figure 54) highlight the highest loss of life to fall within the neonatal period. The deaths within this period illustrate neither an increase nor decrease in prior trends. Although it should be noted that since 2018, ‘signs of life’ has led to a greater number of pre-term babies of non-survivable gestation being recognised and reviewed via child death partners.

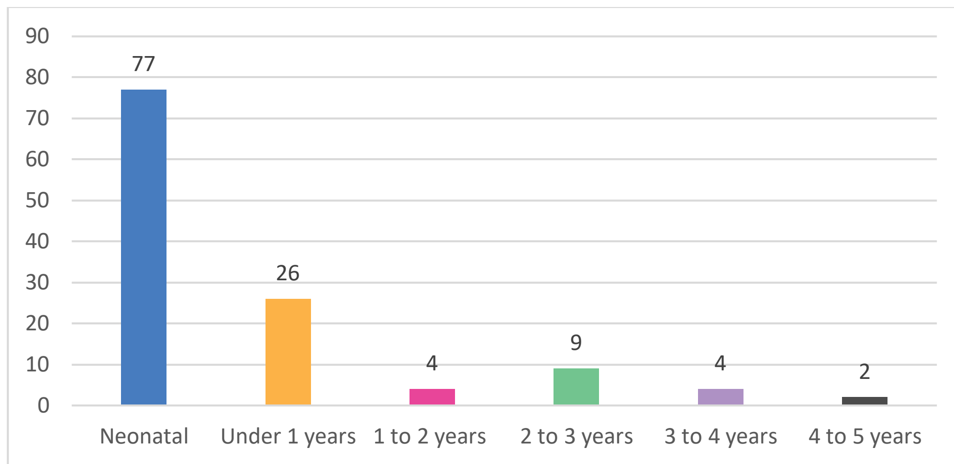


Figure 54: Warwickshire Children who have died between 2017 and 2021 by Age
Source: Warwickshire CDOP

Further examining the child deaths highlights the difference in deaths per borough of Warwickshire (Figure 55) with the highest number of deaths occurring in Nuneaton and Bedworth.

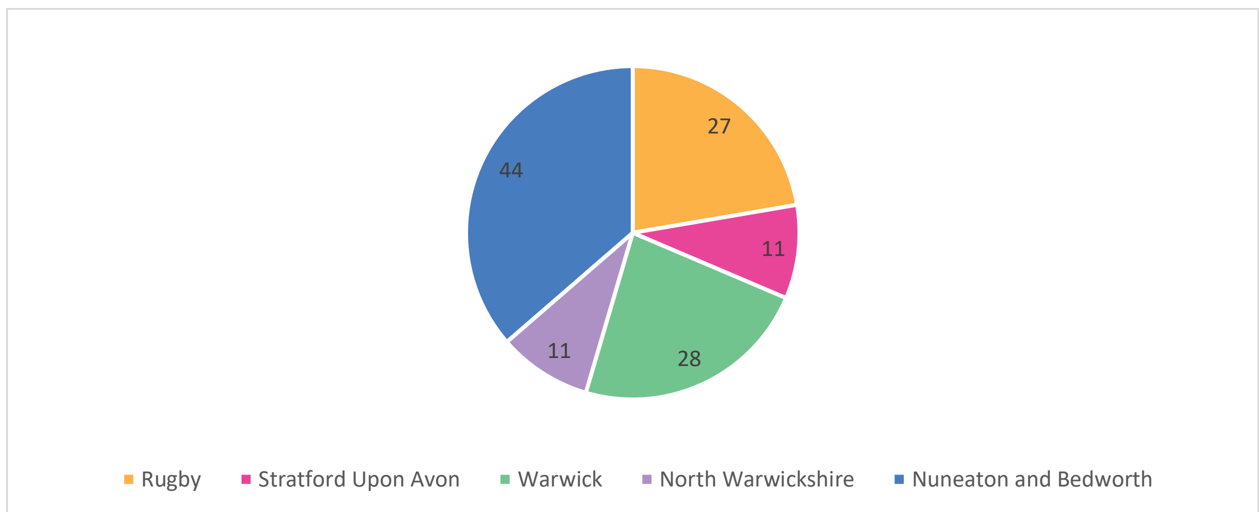


Figure 55: Warwickshire Children who have died between 2017 and 2021 by district and borough
Source: Warwickshire CDOP

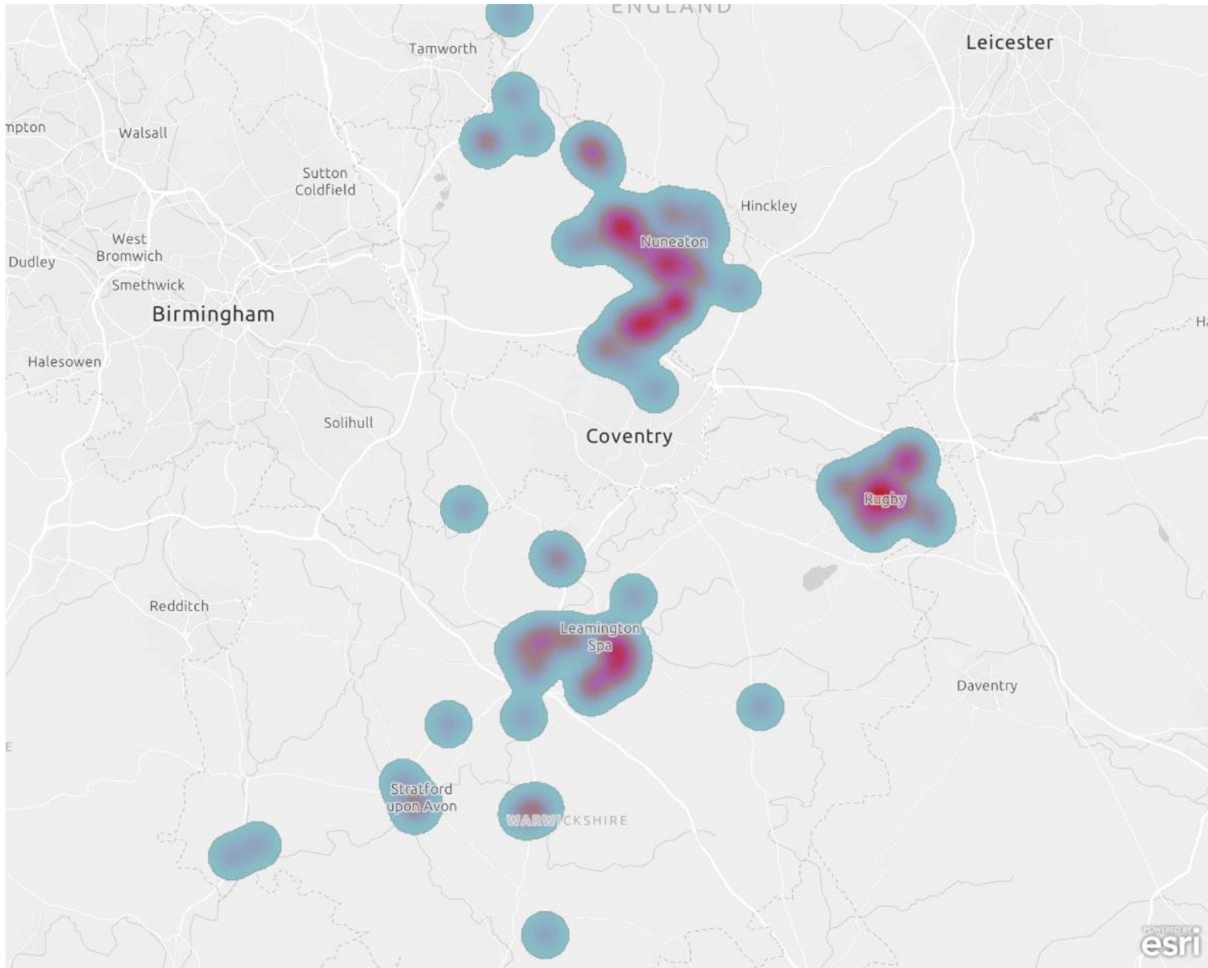


Figure 56: Heat map of child deaths in Warwickshire, May 2016 to March 2021
Source: CDOP

The variance and type of deaths becomes even more apparent when examining the age of death within each borough (Figure 57).

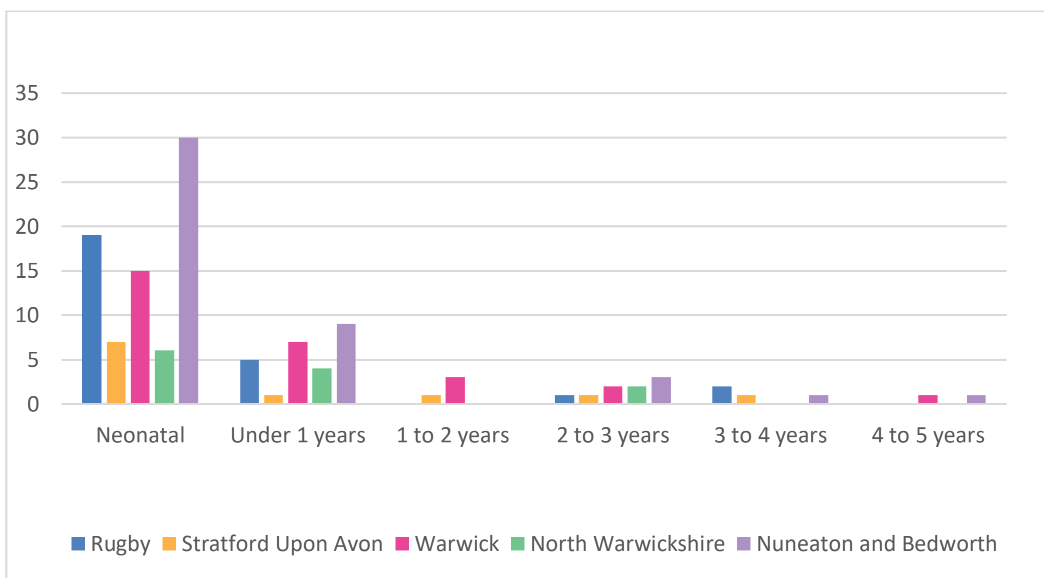


Figure 57: Warwickshire Children who have died between 2017 and 2021 by district and borough and age
Source: Warwickshire CDOP

In terms of ethnicity, the data shows that this largely follows the ethnicity of the population according to the limited data available. Where ethnicity is known, 83.0% are of "White" ethnicity, compared to 82.7% in Reception year school census of May 2021. Numbers for other ethnicities are too small for useful comparison.

MODIFIABLE FACTORS IN INFANT MORTALITY

Of the 122 Warwickshire Child Deaths, 45 were cases over a month of age. Of the 45 cases just over a quarter (29%) identified modifiable factors (Figure 58). Nationally, via the 'National Child Mortality Database' ('NCMD') it is regarded that the average percentage of modifiable deaths for CDOP is 36%, highlighting that Warwickshire cases of deaths over a month of age and under five have less modifiable factors than the national average.

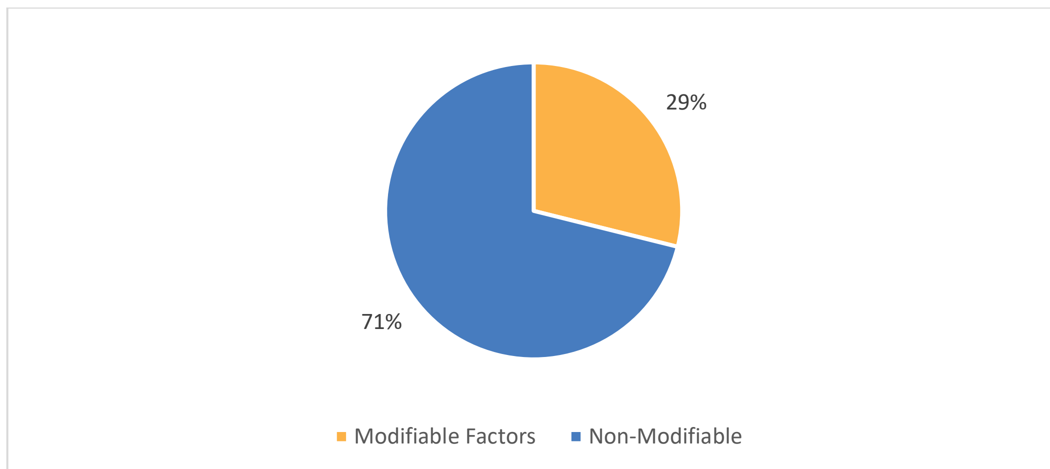


Figure 58: Modifiable Factors Identified in 1 month old to 5 years old death
Source: Warwickshire CDOP

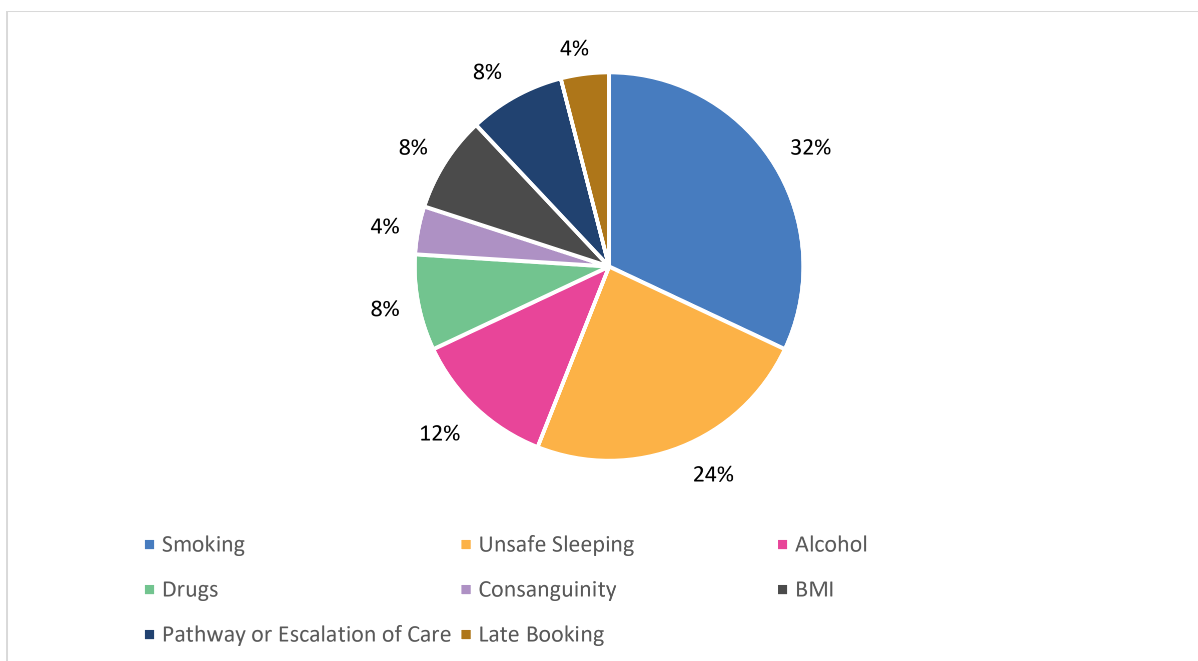


Figure 59: Child death in Warwickshire by modifiable factors (1 month to 5 years old) 2017-2021
Source: Warwickshire CDOP

Figure 59 above provides a breakdown of modifiable factors associated to child death (age one month to five years) in Warwickshire. Smoking and unsafe sleeping contribute to over 50% of child deaths. Recent analysis by CDOP identified themes around lack of safe sleeping and late identification or management of infections where parents may have been less inclined to visit the GP due to the COVID-19 pandemic. Elimination or reduction of these factors may be improved by enhanced (ante and postnatal) parental education and communications campaigns highlighting the risks associated with them.

NEONATAL MORTALITY

Neonatal mortality is defined as deaths within the first 28 days of life – excluding stillbirths. This reflects the health and care of both the mother and new-born infant and is the most vulnerable time for the child's survival. Causes include prematurity, low birth weight, and birth defects. There are several risk factors for neonatal mortality: diabetes, infections, clotting disorders, and lifestyle factors (including smoking, stress, alcohol)

The highest rate for deaths within 28 days per 1,000 births is in Warwickshire North CCG for 2017-19 reporting period, considerably higher than the England rate (Figure 60). This is then shown over time in Figure 61, showing a recent decline to below the England average in South Warwickshire CCG and NHS Coventry and Rugby CCG.

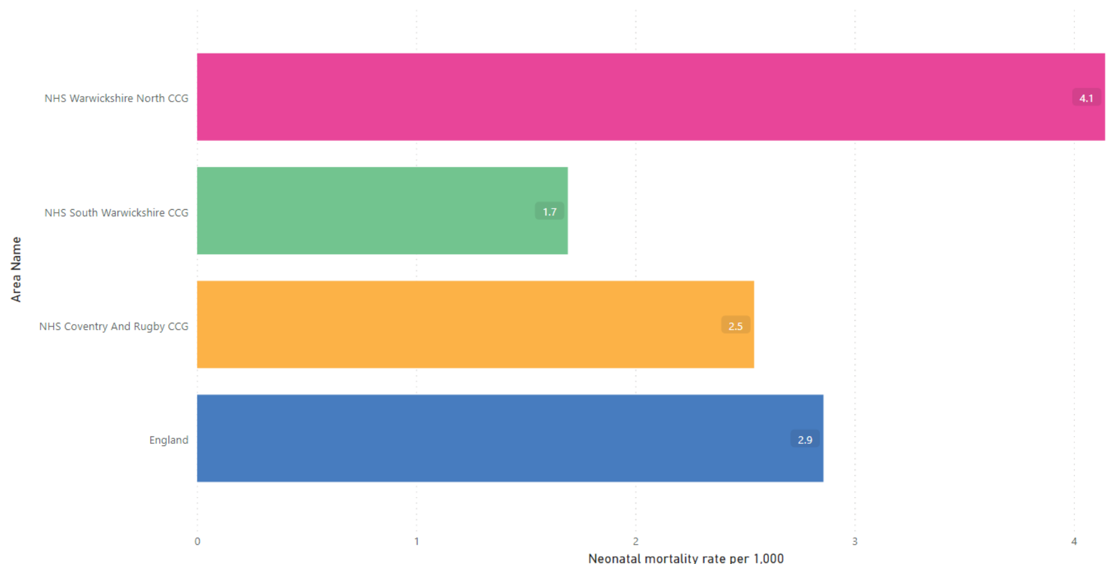


Figure 60: Neonatal mortality rate per 1,000 births by CCG in comparison to England, 2017-19
Source: Public Health England Fingertips

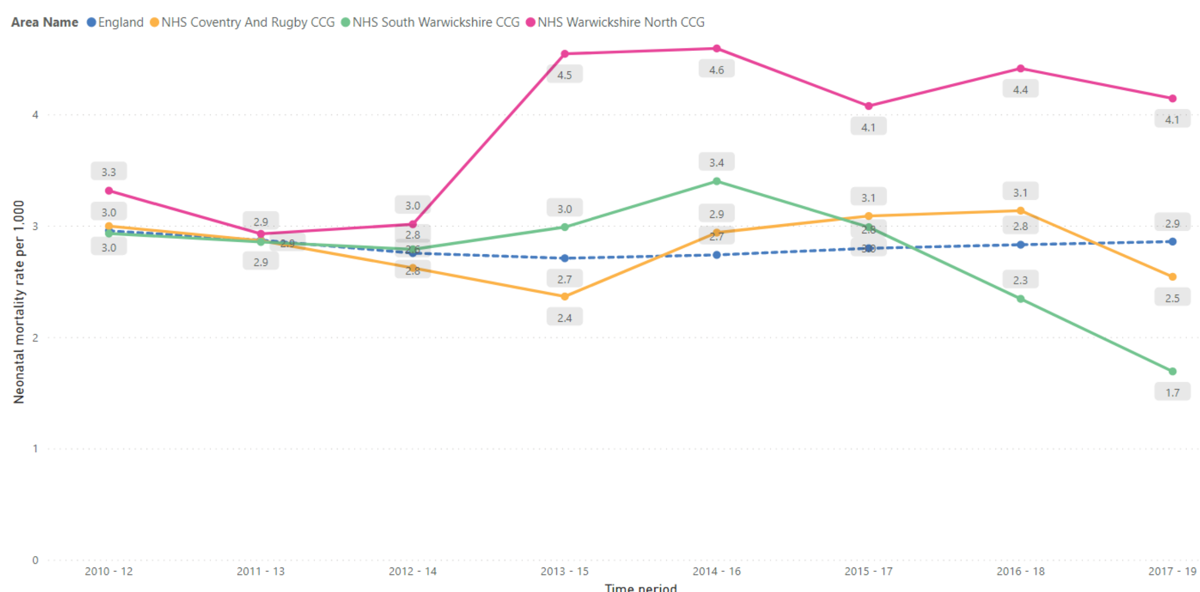


Figure 61: Neonatal mortality rate per 1,000 births over time by CCG in comparison to England
Source: Public Health England Fingertips

MODIFIABLE FACTORS IN NEONATAL MORTALITY

Modifiable factors are highly relevant to neonatal mortality as they are a guide for what factors can be changed or adapted through healthcare and commissioning interventions.

77 of Warwickshire Child Deaths examined were neonatal cases. Of these cases less than a quarter (22%) identified modifiable factors (Figure 62).

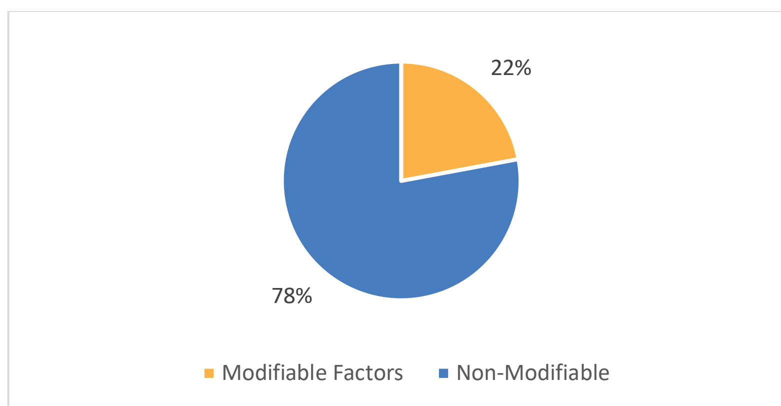


Figure 62: Modifiable Factors Identified in neonatal death in Warwickshire
Source: Warwickshire CDOP

However, when examining the cases with modifiable factors in neonatal child death the categories of modifiability become more apparent. These categories identify areas of change that could be made to reduce future child deaths within the Warwickshire neonatal age range (Figure 63).

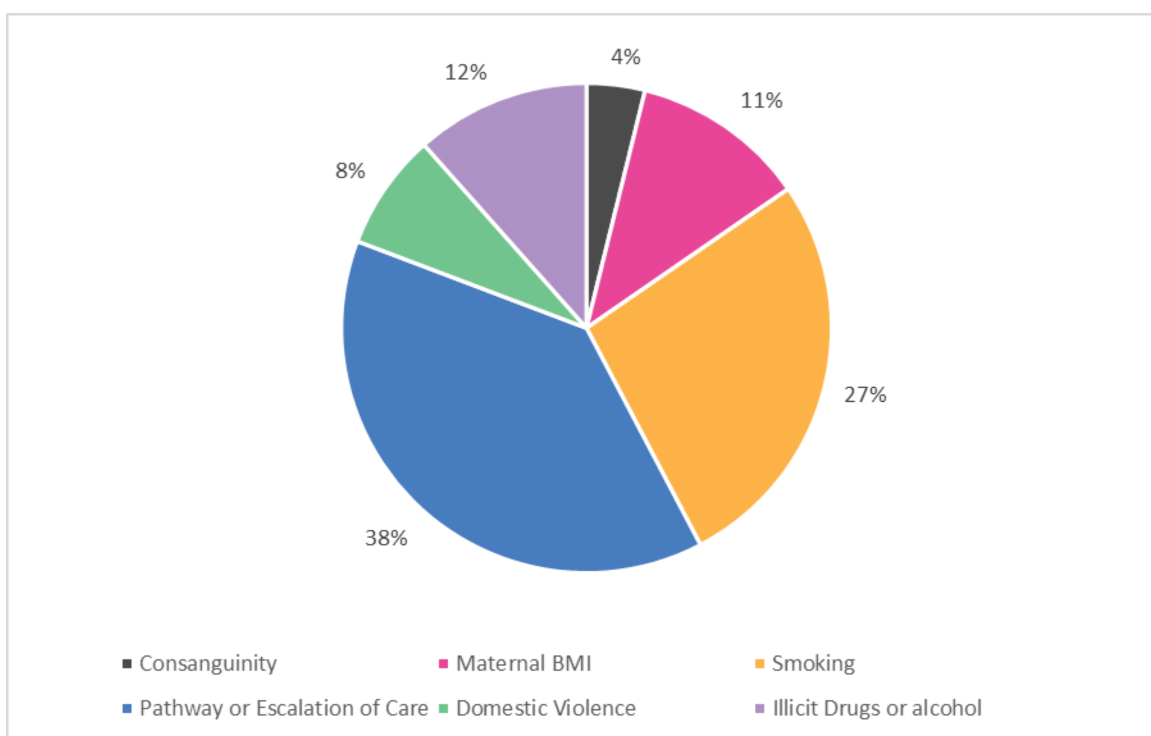


Figure 63: Modifiable Factors within Neonatal Deaths
Source: Warwickshire CDOP

The breakdown of neonatal deaths with modifiable factors highlights that clinical pathway or escalation of care is the largest contributory factor in Warwickshire, closely followed by smoking. Warwickshire is served by three hospital trusts covering a large geographical area. Data is currently unavailable to understand the breakdown of neonatal deaths due to clinical pathway or escalation of care by trust.

Due to the clear effect of these modifiable factors in neonatal survival it may be prudent to review and/or complete audits on smoking cessation in pregnancy services, and clinical pathways for neonatal births across all three hospital trusts.

STILL BIRTH

A stillborn baby is one born after 24 completed weeks of pregnancy with no signs of life. The national stillbirth rate is 3.99 per 1,000 births. Risk factors associated with stillbirth include maternal obesity, ethnicity, smoking, pre-existing diabetes, history of mental health problems, antepartum haemorrhage, and fetal growth restriction.

Figure 64 displays still birth rate per 1,000 births which has been relatively stable over time. Warwickshire still birth rate (2.7 per 1,000 births for 2017-19) is comparatively low within the West Midlands (Figure 65).

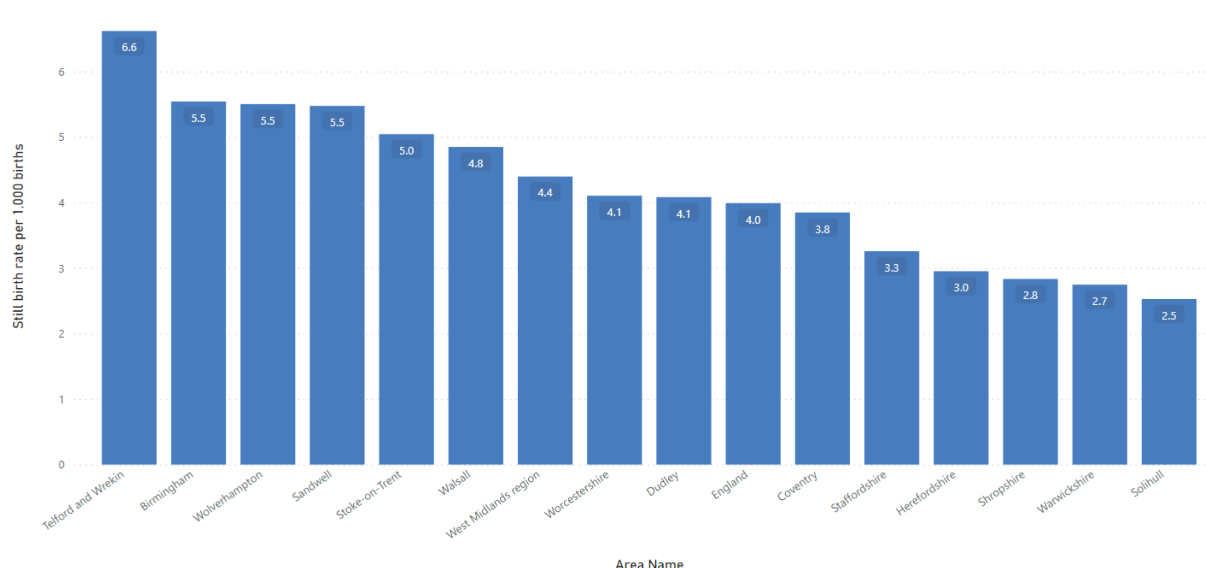


Figure 64: Still birth rate per 1,000 births for local authorities in the West Midlands and England, 2017-19
Source: Public Health England Fingertips

Figure X displays the rate over time up to 2017/19. There is a decrease across England, West Midlands region and Warwickshire, with Warwickshire being consistently lower than both the England and West Midlands region average.

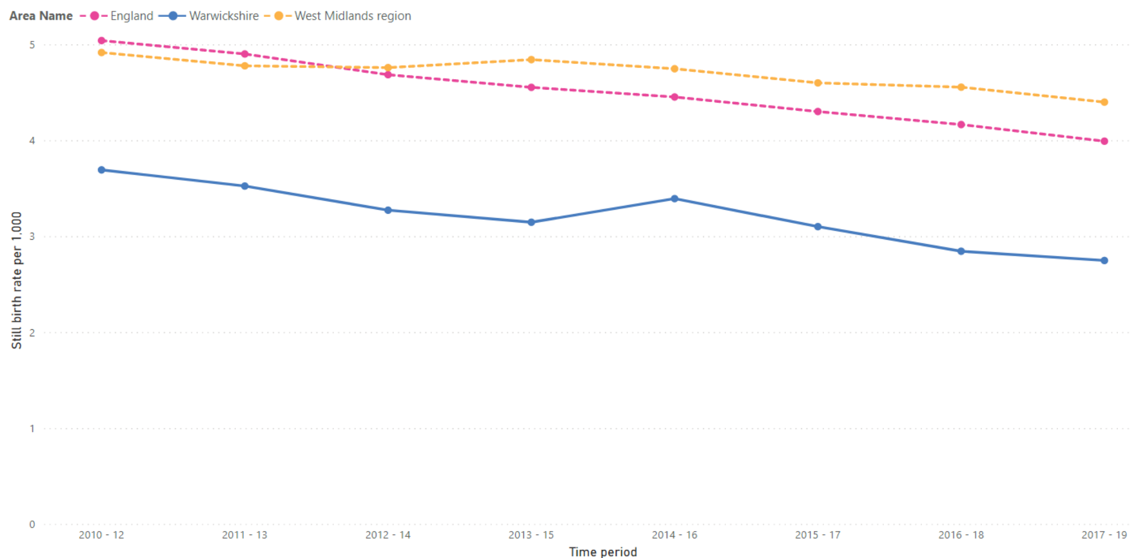


Figure 65: Still birth rate per 1,000 births over time
Source - Fingertips

However more recent data collected by place across the Coventry and Warwickshire region suggests a rapid increase in stillbirth between 2019/20 and 2020/21, with both North and South Warwickshire experiencing a doubling of instances of stillbirth (Figure 66).

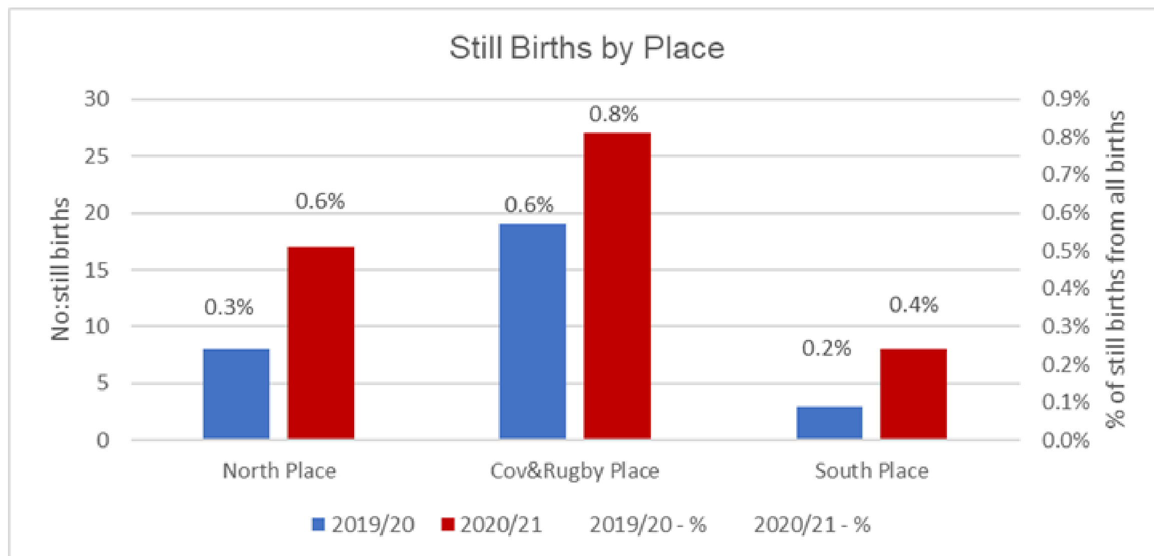


Figure 66: Still births by Place
Source: SUS

Reasons for these increases are unclear and work is required to understand the impact of the COVID-19 pandemic on attendance to maternity clinics. The Coventry and Warwickshire Local Maternity & Neonatal System (LMNS) are currently working on communications to highlight the importance of hospital attendance in instances of reduced foetal movement experienced by pregnant women.

SERVICES FOR CHILDREN 0-5

HEALTH VISITOR SERVICES

Health Visitors play a fundamental role in the identification and management of health needs in the preschool population. They link with midwifery services antenatally, primary care services with liaison with General Practice and, if required, with school nursing services on transition into school. As children grow and develop, health visitors can link with other services and agencies to ensure positive outcomes for families are achieved including early years settings and social care.

The current population (Feb 2022) is 27,900 preschool children but for health visitors their population includes parents, carers, and the wider community. In Warwickshire there are 4 health visiting teams in North Warwickshire, 2 in East Warwickshire (Rugby) and 8 teams in South Warwickshire.

The health visiting service operate to the Healthy Child Programme (2009 updated 2021). This means there are 3 different levels of service offer with everyone being offered the universal service and if they require additional support a targeted or specialist offer is given.

The Outcomes Star is a suite of person-centred tools for supporting and measuring change when working with families (Figure 67). The Parent & Baby Star is both a keywork tool, supporting effective interventions, and an outcomes tool, giving management data on progress towards the end outcome. Because of this dual role, it brings together measurement and service delivery and can provide a shared language and framework across operations and data management for departments and between commissioners and service providers. The Parent and Baby Star has been developed to help parents who need support with their perinatal mental health and well-being.

The Parent & Baby star has a five-point scales arranged in a star shape. Each point on each scale has detailed descriptors setting out the attitudes and behaviour typical of that point on the scale. Underpinning these scales is a model of change (the Journey of Change) describing the steps towards the end goal that both the service and service user are trying to achieve.

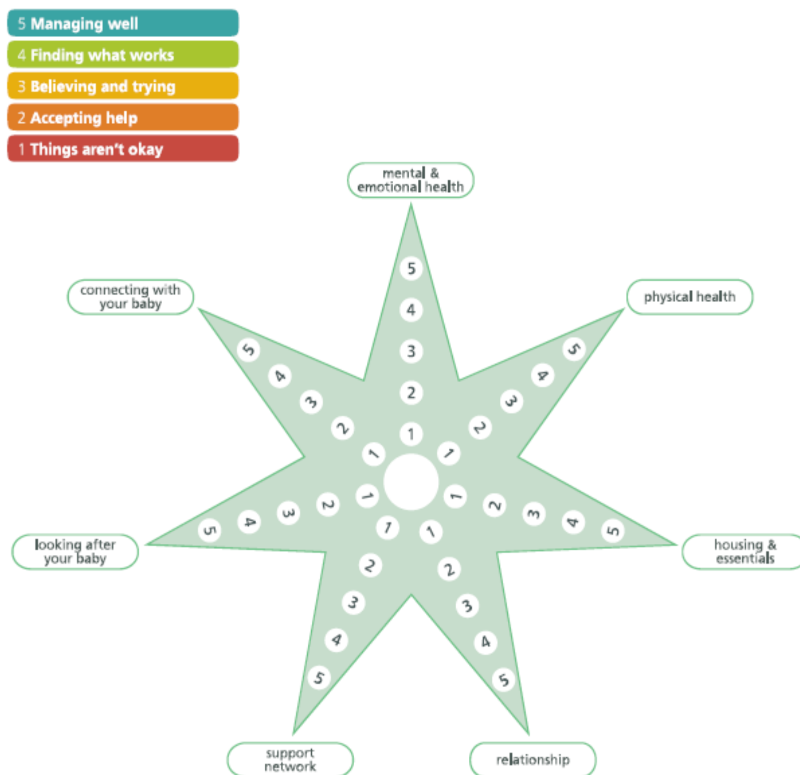


Figure 67: The Parent and Baby Star
Source: Parent and Baby start summary data for Warwickshire Hv teams Nov 2021

The proportion of New Birth Visits completed within 14 days in Warwickshire in 2020/21 was 78.2%. This figure is lower than the England average (88.0%) and has been lower than the England average since 2017/18.

The proportion of infants receiving a 6–8-week review in Warwickshire in 2020/21 was 85.0%, higher than the England average (80.2%). The proportion of children receiving a 2 ½ year review in Warwickshire in 2020/21 was 80.8%, higher than the England average (71.5%).

HEALTH NURSING SERVICE

Warwickshire County Council is responsible for the 0-5 Public Health Nursing Service which supports parents from pregnancy to the time their child starts school[28]. It includes both:

- Health Visiting, which works with every family with a child of pre-school age, and typically involves five contacts with the health visiting team from the antenatal period (28 weeks) to when the child reaches two and a half years old.

[28] 0-5 Public Health Nursing provision in Warwickshire – Parents & Carers Survey, Warwickshire County Council, 2021

- Family Nurse Partnership (FNP) is a home visiting parenting programme for first time young mums until the child is 2 years of age.

The 0-5 Public Health Nursing Service helps to build the confidence of parents; promote child development; and strengthen parent, infant and family health and wellbeing. It works with families who all have different needs, to get them the right help at the right time. Parents and carers of young children in Warwickshire were invited to share their views and experiences of the 0-5 Public Health Nursing Service to help inform future support. Warwickshire County Council wanted to hear about the experiences of the people who have used this service. The feedback is being used to review the service and shape of the future offer.

Almost 80% of respondents stated they knew how to contact their Health Visiting service. However, 46% of respondents said they do not know who their family's health visitor is, 22% did not understand what the Health Visiting service does, 24% were not told what the Health Visiting service does, and 16% did not know how to contact the Health Visiting service. It is important to note for this question that Health Visitors operate on a collaborative caseload. This means unless a family is targeted or specialised, a named health visitor will not be assigned.

When asked to what extent respondents agreed with statements in relation to what the Health Visiting service should offer, 63% of respondents agreed that they would like more support between 3-6 months and 43% said they would like more support between the 2-2.5 years contact and their child entering school. Only 4% agreed that they would be happy with fewer contacts. At the time of the survey Health Visitors were following both Health Service National guidance and COVID guidance, which limited the number of face-to-face visits and meant baby clinics were not open. This may have contributed to the response seen in the survey.

Positive comments about the Health Visiting service included frequent positive support and advice and positive phone call support. Some less favourable comments included outdated advice, minimal interaction and the feeling of services being a tick box exercise.

Since the survey took place a new 0-5s website has been created which includes a user friendly and improved contact details section. This has been widely advertised to combat the issues highlighted by the survey.

Warwickshire's Health Visiting service has a ChatHealth texting service which is used to text a health visitor. Respondents were asked if they have ever used this service and if they have how they would rate the service. Figure 13 shows that only 13.4% (n=25) of respondents had used this service, 56.5% (n=105) had not used it as they didn't know about it, and 30.1% (n=56) hadn't used it as they did not require the service. Since the survey took place the ChatHealth service has been advertised more widely, including social media pushing, posters at key venues, and stickers on Red Books.

Before COVID, 43% of respondents said they were very satisfied or satisfied with the Health Visiting service, and 16% were not satisfied or very unsatisfied. Around one quarter of respondents (26.3%) stated this was not applicable as they either did not use the service or did not have a child between 0-5 at the time. Since COVID, 51% of respondents were not satisfied or very unsatisfied, however 24% were satisfied or very satisfied with the service. A further open text question identified that lack of contact was one of the main themes emerging as a reason for this. The demand for specialist and targeted parts of the service has increased throughout and since COVID, which means there is a reduced capacity for the universal elements of the service. Families may have experienced periods of time where they are not contacted by a Health Visiting team, although they are still able to access the service.

The past 2 years have seen both workforce challenges and unprecedented demand for Health Visiting services. Work to adapt to these challenges is now prioritised, and underway throughout Warwickshire.

EARLY INTERVENTION HEALTH VISITING SERVICE

Since January 2022, two fulltime specialist intervention visitors have been operating in North Warwickshire. They are experienced Health Visitors working within the Family Nurse Partnership to offer intensive, early home visiting to targeted families with extra vulnerabilities for clients of 21 years and under at conception. Their visit times include:

- 4 times antenatally
- New birth contact
- 6-8 week visit
- 3 month visit
- 6 month visit
- 9-10 month visit

As this is a new service it is still getting an accurate picture of the capacity it can take, however their current estimate is 50 cases per health visitor. They are expecting a clearer picture of their capacity and potential around Easter 2022.

EARLY EDUCATION AND CHILDCARE

The wider impact of starting school behind is significant and can be devasting to a child's progress and prospects. The Warwickshire County Council Early Years Needs Assessment tracked a cohort of children who had not met the expected level on half of their early learning goals through to the end of primary school and found that they were doing less well than their peers not just in terms of education, but also in their social outcomes.

Crucially this analysis found that this held true even after they had controlled for other factors such as gender and free school meal eligibility. They found:

- Children who do less well at age five are five times as likely to end up being excluded by the end of primary school (82% more likely after accounting for demographics).
- Children who do less well at age five are over twice as likely to have had contact with children's social care at age eleven (46% more likely after accounting for demographics).
- Children who do less well at age five are nearly three times more likely to be struggling with reading at age eleven.
- Children who do less well at age five are four times more likely to be struggling with writing at age eleven.

The analysis shows that knowing how children are doing at age five gives a better picture of which children might be likely to struggle later. It is possible to accurately predict 54% of those children who are below the expected standard in KS2 writing when their levels of development at age 5 are included, compared to 41% when only looking at demographic information such as whether they are living in poverty.

School readiness is currently measured by achievement of the 'Good Level of Development' at the end of the reception year of statutory schooling. It determines how prepared a child is to succeed in Key Stage 1 cognitively, emotionally, and socially.

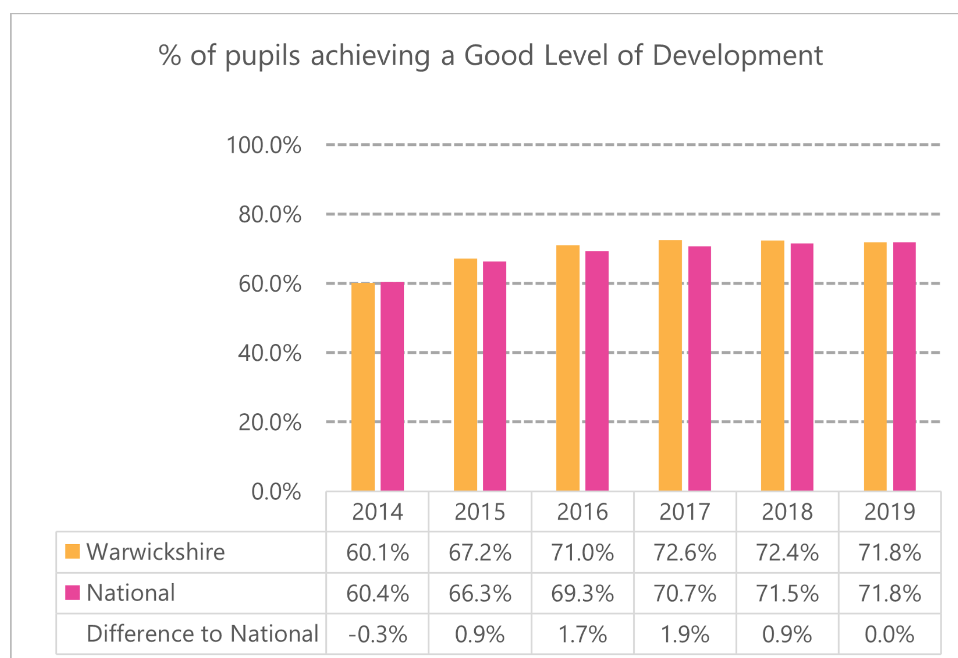
It is assessed through the Early Years Foundation Stage Framework which considers children's development against 17 Early Learning Goals (ELGs). However, the skills and abilities that lead to successful social and academic outcomes are supported by a wider context.

For a child to be school ready they will be an independent and curious learner, developed through positive interactions and investigation within safe, secure environments. They will be confident to communicate their needs, can regulate their emotions and will have become an emotionally resilient, happy child who is supported by aspirational parents/carers, Early Years settings, and Schools.

- <u>Children's readiness</u> – focuses on what a child should know and be able to do in order to enter school confidently with an enthusiasm for learning and is applicable to all children, particularly those that are economically disadvantaged and vulnerable.
- <u>Early Years Settings and Schools readiness</u> – promote a child friendly learning environment which recognises and adapts to the needs of individual children and families and supports the smooth transition into reception.
- <u>Families Readiness</u> – promotes the positive involvement of parents and carers regarding children's early learning, development, and transition to school.

- Service Readiness – Health, Social Care and other agencies will support families collaboratively to address health and social care issues that impact on the child and family's ability to become school ready.

Following improved performance each year from 2014, the percentage of pupils achieving a good level of development in Warwickshire peaked in 2017. Since then, albeit very slight, the percentage has declined by 0.2% between 2017-2018 and 0.6% between 2018-2019 (Figure 68).



	2014	2015	2016	2017	2018	2019
Warwickshire	60.1%	67.2%	71.0%	72.6%	72.4%	71.8%
National	60.4%	66.3%	69.3%	70.7%	71.5%	71.8%
Difference to National	-0.3%	0.9%	1.7%	1.9%	0.9%	0.0%

Figure 68: Percentage of pupils in Warwickshire and against the National average achieving a good level of development.
Source - Warwickshire County Council Early Years Needs Assessment

Since 2015, performance in Warwickshire has always been above the national average. Almost 3 in 10 children in Warwickshire are not school ready at reception age. Comparing good level of development performance in 2019, Warwickshire was ranked 11th out of 11 amongst statistical neighbour Local Authorities and ranked 6th out of 13 of the West Midlands Local Authorities.

The Local Authority Interactive Data Tool (LAIT) compares Local Authorities against performance targets for 0-5's (Table 24). Whilst Warwickshire compares well against the national average, it tends to rank mid-low between statistical neighbours, particularly with percentage of children achieving a good level of development in Foundation Stage Profile Assessment (FSP) and the percentage of children achieving at least the expected level in the Foundation Stage Profile for Communication and Language.

Warwickshire has made recent improvements in Percentage take up of 3 and 4-year-olds benefiting from some free early education, percentage of 2-year-old children benefiting from funded early education in good/outstanding provider, and percentage

of 2, 3 and 4-year-olds in funded early education at providers with staff with graduate status.

National Data Set and Warwickshire performance in 2018/19	2018/19 outcome	National	Statistical Neighbour	LA Rank /151	Change from 17/18
1. Percentage of children achieving good level of development in FSP	71.8%	71.8%	10/11	73/151	↓
2. The standard score and percentage inequality gap in achievement across all the Early Learning Goals	31.6%	31.8%	4	56	↓
3. The percentage of children achieving at least the expected level in the Foundation Stage Profile for Communication & Language	31%	32.4%	10	77	↓
outcome				**change from 2020**	**2021**
4. Percentage of 2-year-old children benefitting from funded early education	63%	62%	9	74	↓
5. Percentage take up of 3- and 4-years olds benefiting from some free early education	95%	88%	5	28 + 77 places	↑
6. Percentage of 2-year-old children benefitting from funded early education, in Good/Outstanding provider	98%	97%	5	49 + 25 places	↑
7. Percentage of 3 & 4 year old children benefitting from funded early education, in Good/Outstanding provider	93%	93%	9	73	↓
8. Percentage of 2, 3 & 4 yr olds in funded early education at providers with staff with graduate status	58%	51.5%	5	45 + 8 places	↑
Warwickshire Measures					
9. Percentage of early years providers that are judged by Ofsted as good / outstanding for overall effectiveness at least match the national figure	95%	95%	NA	NA	NA
10. The gap in GLD measure at age five for disadvantaged learners compared with **All** learners in Warwickshire	18% (2017/18 17%)	17/8%	NA	NA	NA
11. The gap in GLD measure at age five for disadvantaged learners compared with non-disadvantaged learners in Warwickshire	20% (2017/18 – 19%	Not available	N/A	N/A	N/A

Table 24: Comparison to statistical neighbours from Local Authority Interactive Data Tool. Source: Local Authority Interactive Data Tool.

The Good Level of Development performance of disadvantaged children has fallen over the past 3 years and with the performance of non-disadvantaged children staying the same, the disadvantaged gap has widened (Table 25).

		Warwickshire							
		Cohort size			% achieving GLD				
	Pupil characteristic	2017	2018	2019	2017	2018	2019	Difference 2018 minus 2019	Direction of travel 2018 to 2019
Gender	**All Pupils**	6605	6527	6456	72.6%	72.3%	71.8%	-0.5%	↓
	Boys	3342	3353	3330	65.1%	66.2%	64.7%	-1.5%	↓
	Girls	3263	3174	3126	80.4%	78.8%	79.4%	0.6%	↑
	Gap: Boys - Girls				-15.2%	-12.6%	-14.7%	-2.1%	Gap widened
Disadvantaged	Disadvantaged	619	686	685	58.2%	55.7%	54.0%	-1.7%	↓
	Non-Disadvantaged	5986	5841	5771	74.1%	74.3%	73.9%	-0.4%	↔
	Gap: Dis - Non Dis				-16.0%	-18.6%	-19.9%	-1.3%	Gap widened
	Gap: Dis - All Pupils				-14.5%	-16.7%	-17.8%	-1.1%	Gap widened
SEN	No SEN	6007	5949	5882	77.8%	77.1%	76.6%	-0.5%	↓
	SEN Support	521	489	460	23.6%	27.4%	28.0%	0.6%	↑
	EHC Plan/Statement	77	89	114	3.9%	1.1%	3.5%	2.4%	↑
	Gap: SEN Support - No SEN				-54.2%	-49.7%	-48.5%	1.2%	Gap narrowed
	Gap: SEN Support - All Pupils				-49.0%	-44.9%	-43.8%	1.2%	Gap narrowed
	Gap: EHCP - No SEN				-73.9%	-76.0%	-73.1%	2.9%	Gap narrowed
	Gap: EHCP - All Pupils				-68.7%	-71.2%	-68.3%	2.9%	Gap narrowed
Term of Birth	Autumn born	2263	2223	2209	82.3%	80.3%	81.8%	1.5%	↑
	Spring born	2156	2140	1995	74.4%	73.3%	72.5%	-0.8%	↓
	Summer born	2186	2162	2249	60.8%	63.3%	61.4%	-1.9%	↓
	Gap: Summer - Autumn				-21.5%	-17.0%	-20.4%	-3.4%	Gap widened
	Gap: Summer - All Pupils				-11.8%	-9.0%	-10.4%	-1.4%	Gap widened

Table 25: Percentage of pupils in Warwickshire achieving Good Level of Development broken down by Gender, Disadvantaged, SEN and Term of Birth.
Source: Warwickshire County Council Early Years Needs Assessment (Pupil level EYFSP data supplied by schools during the statutory collection periods; June/July 2017, 2018 and 2019).

Whilst the Good Level of Development performance of SEN Support children is low at 28%, there has been a steady increase in achievement for this group of children over the past few years. With performance overall declining slightly, the gap between SEN Support and All pupils has narrowed by 1 percentage point. The same is true for children with an EHCP. With an improvement of nearly 3 percentage points in 2019, the gap between this group of children and All pupils has also narrowed by 3 percentage points.

Children born in the summer term do not achieve quite as well as spring or autumn born cohorts. A 2% drop in Good Level of Development achievement has contributed to a widening of the gaps.

Early education and childcare play a vital role in children's early development and family wellbeing. 68% of parents of 2-4-year-olds reported accessing formal early education or childcare in the period before March 2020. At the start of lockdown this

changed radically. Of those who had formal arrangements, just 7% of children continued to attend throughout the lockdown period.

By June 2020, 83% of this group reported their child had not returned to formal provision, with almost half (49%) reporting their child was unlikely to return to their provider that month.

Many parents reported a particularly negative impact on their child's social and emotional development and wellbeing, including over half (53%) of those who had been unable to return to their provider. Losing access to high quality early education is likely to widen already existing school readiness gaps.

65% of parents at home whose child hadn't returned to their provider by June reported they felt stressed, worried, or overwhelmed by their childcare arrangements. Mothers are much more likely to report feeling overwhelmed compared to fathers (30% vs 18%).

Two thirds (67%) of providers in the PVI (private, voluntary, and independent) sector reported being temporarily closed during lockdown, including 79% of pre-schools, 59% of nurseries and 41% of childminders. Settings in more deprived areas were more likely to have remained open; 36% in the most deprived local authorities, compared to 30% in the least deprived.

65% of PVI providers expected to reopen on 1st June 2020, with 20% of providers expecting not to and 15% uncertain.

Early Years providers have suffered significant financial pressures during the lockdown period. Providers in the most deprived areas were more than twice as likely to have needed a business rates holiday compared to the least deprived (35% compared to 16%). As a result, a third of settings (34%) in the most deprived areas reported they were unlikely to still be operating next year, compared to 24% of those in the least deprived areas.

CHILDREN OPEN TO CHILDREN & FAMILIES SERVICES

Children open to Warwickshire's Children & Families Services are broadly supported across five main levels of support:

- Early Intervention
    - Early Help (EH)
    - Early Help with Targeted Support (TS)

- Specialist Help
    - Child in Need (CIN)
    - Child Protection (CP)

- Child in Care (CIC)

Outside of these formal support plans is the Universal Offer which can be accessed by any Warwickshire family, at any time, and is delivered online and by Children and Families (C&F) partners across the county. Children aged 0 to 5 who were only open to universal support at the snapshot dates **are not** included in this section, although many of the children who are included would have been receiving universal support as part of their C&F plan. This means that all children in the analysis have had an assessment to understand the help they need, and then opened to a support plan using the Warwickshire Spectrum of Support guidance[29] (Figure 69).

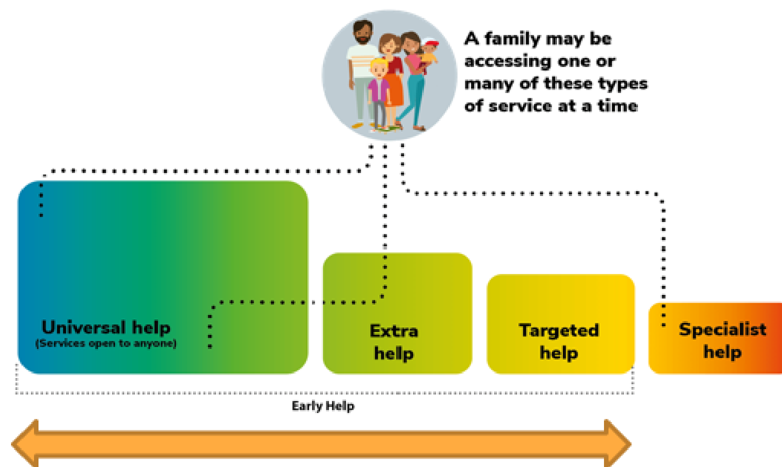


Figure 69: Spectrum of Support
Source: https://www.safeguardingwarwickshire.co.uk/images/downloads/ID10827-_WCC20034_Spectrum_Of_Support_Brochure_V7.pdf

In April 2020, Warwickshire's Early Help Offer was relaunched to include two levels of **Early Help and Targeted Support**, above the universal offer. When a family is showing signs of needing Early Help, a professional in the early help network, or through the Front Door, will recommend a co-ordinated, multiagency response to support them to make positive progress on their issues through an Early Help Pathway to Change plan (EH:PTC). This pathway contains a triaging step that helps to identify the family's needs and establishes the level of professional support required. Families who are identified as having needs that are complex, escalating or reaching crisis point are triaged as Orange, therefore having their Early Help Pathway enhanced with a Targeted Support Officer. This gives the EH:PTC greater scrutiny and supports the professionals who are helping the families to access the appropriate interventions.

The EH:PTC is a voluntary and consensual process, involving the whole family and seeks to understand the child's voice at every stage. The child, young person and their family will work alongside the practitioners to determine the holistic needs they would

[29] https://www.safeguardingwarwickshire.co.uk/images/downloads/ID10827-_WCC20034_Spectrum_Of_Support_Brochure_V7.pdf (Accessed March 2022)

like to address, to this end, a family can have needs across all spectrums of the early help triage tool (Figure 70) and will create and review actions together.

CHILDREN & FAMILIES TRIAGE TOOL

Children and Families Triage Tool

KEY:
GREEN issues only = information, advice and guidance / signposting
1 YELLOW or ORANGE issue = single-agency response
2 or more YELLOW and/or ORANGE issues = multi-agency response
Any PURPLE issues = specialist support (non - Early Help)

	Green = Universal Help	Yellow = Extra Help	Orange = Targeted Help	Purple = Specialist Help
Family members have their developmental, physical and mental health needs met	Green Minor concerns regarding child's development Child occasionally misses health checks Adult / child has minor physical health issues Adult / child has low level mental health issues and dips in emotional well-being Adult / child at risk of / occasional incident of substance/ alcohol misuse Adult / child has poor presentation / is socially isolated	Yellow Child has poor attachments Child has SEND or speech and language difficulties Child has delay in meeting developmental milestones Family members are missing health appointments Adult / child has some physical or mental health needs Adult / child is impacted by historical substance / alcohol misuse Child is at early risk stage in substance use Teenage pregnancy in household Adult / child has poor presentation / personal hygiene	Orange Child is not meeting some developmental milestones Child is displaying some signs of emotional behavioural disorder Adult / child has chronic or recurring health problems Family is not engaging with health professionals Adult / child has disabilities which impact access to services Adult / child is at harmful substance use / misuse stage Adult / child's mental health needs are not being met	Purple Child is not meeting developmental milestones or there is evidence of non-organic failure to thrive Child is displaying significant signs of emotional behavioural disorder Adult / child has significant unmet mental health needs incl. self-harm or suicide attempts Child has a life threatening eating disorder Child is pregnant / teenage parent under the age of 13 Substance dependency is severely impairing development
Children and young people are accessing their full entitlement to education	Green Child has episodes of lateness / incidents of absence from school Child is at risk of fixed term exclusion Child's behaviour in school is leading to risk of exclusion	Yellow Child has over 10% average absence from school Child has episodes of truancy Child has 1-2 fixed term exclusions from school during the last three terms Child is in alternative provision for behaviour problems Child is persistently late Pre-school child is not accessing early years provision	Orange Child has 3+ exclusions, is at risk of permanent exclusion, or has been permanently excluded in last 3 terms Child is not registered with school or is missing from education Child is persistently absent from school Concerns around child's home education Educational setting cannot meet child's needs Family not engaging with education professionals	Purple Child is continuously receiving fixed-term exclusions Child has been permanently excluded and has no school place Child / young person is on a part-time timetable for 3 months, with no clear reintegration plan Significant concerns regarding a home educated child that has not been seen within 12 months
Children and young people are safe from crime, exploitation and ASB	Green Child displaying early signs of low level anti-social or offending behaviour Family is exposed to low levels of community criminal activity or anti-social behaviour Concerns around a child / young person's safety online Child is displaying signs of developmentally inappropriate sexual behaviour	Yellow Child / young person has had a missing episode Child is displaying potential offending behaviour Child of prisoner / parent with community orders Family is experiencing harassment or discrimination Evidence child is being groomed / targeted for purposes of exploitation Child is displaying potentially unhealthy / unsafe sexual behaviour Household member is being discussed in ASB forums or has an active ABC	Orange Child / young person has had multiple missing episodes Child is at risk of arrest Family impacted by prison sentence / release of significant person Adult / child is displaying extremist views Family at risk of harm due to harassment or discrimination Indicators present that child is being exploited Child's sexual behaviour is unsafe and/or unhealthy Household member is being considered for injunction / CBO Persistent police call-outs to family address	Purple Child has offended Child has repeated missing episodes of longer duration Child is displaying harmful behaviour towards other children Adult / child is engaging others in extremist views Family is repeated victim of harassment or discrimination Child is victim of exploitation and/or at risk of trafficking Child's sexual behaviour has led to police enquiry / strategy meeting Family member is at risk / victim of faith-based abuse, forced marriage, honour-based violence or FGM
Families are financially stable, appropriately housed, and work ready	Green Family has debts that are not well managed Credits and support allowances are not being claimed Adult is claiming out of work benefits or Universal Credit and is subject to work-related conditions Change in family finances due to divorce, new baby, separation, sickness, reduction in working hours, etc Family at risk of social exclusion due to finances Family has 1-2 months rent arrears (no repossession action)	Yellow Young person is at risk of becoming NEET, or is NEET Poor home environment impacting on family's health Family is overcrowded or in temporary accommodation Family is benefit dependent or has unmanageable debt Family has poor access to core services Major change in family's finances due to divorce, death, separation, disability, loss of employment Family has 2-3 months rent arrears / repossession action has started	Orange Family is at risk of becoming homeless Family is significantly impacted by poverty or worklessness Family has no recourse to public funds / dependent on charity Transient family is not accessing services Family is reliant on emergency service such as food banks Family has 4+ months rent arrears / served eviction notice Home conditions are poor, overcrowded and/or putting child at increased risk of harm	Purple Family have been evicted Young person over 16 is presenting as homeless Family is intentionally homeless Family is in extreme poverty which is significantly affecting child well-being Home conditions are putting child at significant risk of harm
Parents and carers feel well-supported, skilled and confident in their parenting	Green Parent / carer experiences occasional behavioural challenges Occasional incidents of inconsistent care arrangements or poor supervision by parent or carer Occasional incidents of poor parent-child relationship Unclear boundaries and routines in place, including around bedtimes, mealtimes etc Parent / carer is isolated and / or lacks support networks Child lives in household where other household members have care needs	Yellow Parent / carer experiences regular behavioural challenges Inconsistent care arrangements, supervision and lack of routines and boundaries Parent-child relationship is impacting child well-being Parent / carer has poor response to emerging needs Parent / carer is not maintaining home conditions Parental isolation is impacting family well-being Child is a young carer	Orange Parent / carer experiences persistent behavioural challenges Evidence of persistently poor parent-child relationship / inconsistent parenting and/or care arrangements Parent / carer has barriers to parenting due health and/or development needs, or own lived experiences Parent / carer presents as non-compliant with professionals Parent / carer has been prosecuted under the Education Act Child is undertaking a regular caring role of parent / carer	Purple Child's behaviour is beyond parental control Child is suspected / actual victim of abuse or neglect Parent / carer encourages abusive or offending behaviour Parenting / care arrangements put child at risk of harm Professional judgement that parents / carers are persistently non-compliant or are disguising compliance Child is not protected from adults who poses risk of harm Parental control is undermined by exploitation or other factors Child is continuously undertaking role of parent / carer
Family members are free from parental conflict, domestic abuse and violence	Green Parent relationships are mostly equal and co-operative but there are some unresolved or recurring difficulties One or both parents report lack of open and honest communication, with difficulties minimised, not recognised or addressed Conflict between adults beginning to adversely impact on children	Yellow Parent relationship is at risk of breakdown Inter-parental conflict is persistent and unresolved Concerns raised about previous domestic abuse Adult / child in the household is suffering from the impact of previous domestic abuse or violence Child is impacted by persistent unresolved conflict between adults	Orange Inter-parental conflict at risk of becoming violent Parent reports experiencing controlling or abusive behaviour Mental health of family members is impacted due to domestic abuse or violence Parents are not engaging with professionals around healthy relationships Children are showing significant signs of distress due to parental conflict	Purple Child is at risk of significant harm from domestic abuse Family experiences a combination of domestic abuse with substance misuse and/or mental health issues Adult is victim of coercive control and physical harm, or fear of violence / death Adult relationship has a clear abuser and victim Child is significantly adversely affected or traumatised by abusive adult relationships

Figure 70: Early Help Triage Tool
Source: https://www.safeguardingwarwickshire.co.uk/images/downloads/ID10827-_WCC20034_Spectrum_Of_Support_Brochure_V7.pdf

The data used in this section has been taken from four date snapshots since the Early Help relaunch, in order to explore changes over time and to support ongoing monitoring:

- 30th June 2020
- 31st December 2020
- 30th June 2021
- 31st December 2021

These snapshots count the number of children open Children and Family Services as at midnight on the snapshot date. A child who is open to support across multiple snapshots will be counted on each date. Averages have been calculated to get an overall measure across the four points in time.

Countywide Picture

The Warwickshire wide picture indicates that on average, the largest cohort of children open to Children and Family Services are supported at Child in Need level. This pattern is evident across the 0-18 population, and for the 0-5 cohort:

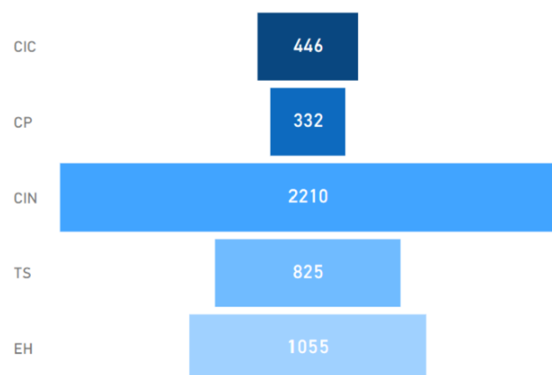


Figure 71: Average no. of 0-18s per support level
Source: Mosaic

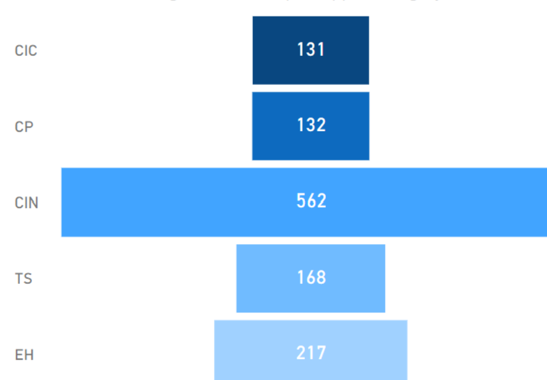


Figure 72: Average no. of 0-5s per support level
Source: Mosaic

In a traditional "pyramid of need", the highest number of service of users would sit at the bottom of the pyramid (at the lowest level of support) and the count would get smaller as the level of support increases. This is not evident in the Warwickshire picture over the current time period, particularly for the 0-5 cohort who are relatively evenly distributed across the other categories outside of Child in Need. However, in figure 71, the total of early help interventions (EH and TS) is 1,880, only 330, less than in the CiN category. Approximately 200 children at any one time are "stepping-up" or "stepping-down" between Child in Need and Targeted Support – this means they are double counted across the two categories.

This picture is complicated slightly by some data caveats that will influence the overall counts for all data in this section:

1. Children with Disabilities (CwD) are included in Children in Need figures, although a cohort of CwD service users are formally supported with a lower level "early help" offer
2. On average, there are approximately 300 Children in Care (CIC) who are placed outside of Warwickshire at any one time. These children have been excluded from this count as their placement address does not match to a Warwickshire postcode. This results in an underreporting of CIC figures
3. As aforementioned, approximately 200 children at any one time are "stepping-up" or "stepping-down" between Child in Need and Targeted Support – this means they are double counted across the two categories

These are recognised data quality / reporting caveats that are routinely included in C&F analysis and apply consistently to all four snapshot dates in this chapter. For monitoring

purposes therefore, these figures do provide comparable baselines for exploring changes over time and geographical difference.

Overall, children in the 0-5 cohort (including unborn children) make up approximately a quarter of all children (0-18) open to Children and Family Services, with some slight variation over time:

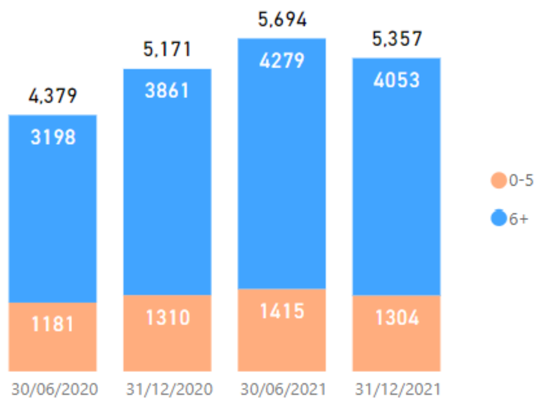


Figure 73: no. of children per snapshot date by age group Source: Mosaic

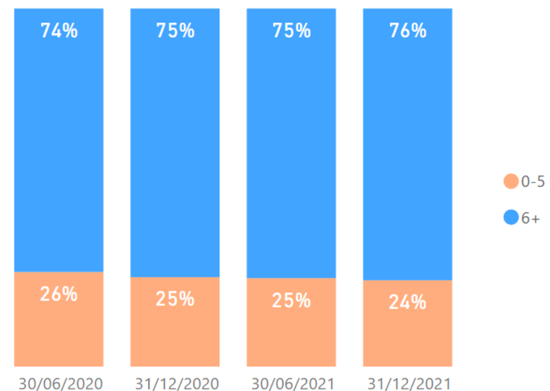


Figure 74: % of children per snapshot date by age group. Source: Mosaic

However, when broken down into Early Intervention and Specialist Help status, the average figures over the period show a greater representation for 0-5s within the specialist cohort than in the Early Intervention cohort:

Figure 75: average % of children 0-5 per statutory status by age group Source: Mosaic

Representation for 0-5s is more unequal when comparing levels of support, with 0-5s disproportionately over-represented in Child Protection plans, compared with total specialist status and the service wide averages:

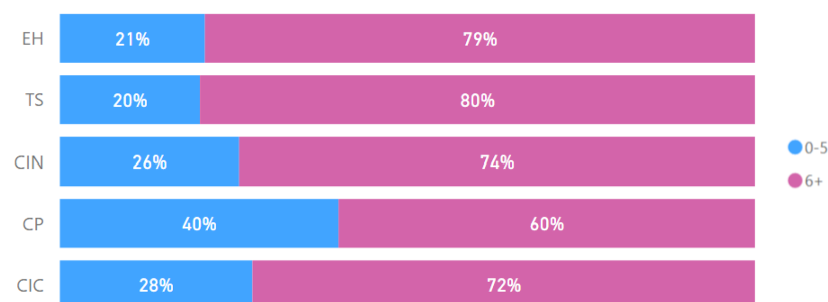


Figure 76: average % of children 0-5 per support level by age group Source: Mosaic

Out of all children open to Children & Families Services, the largest single cohort is the +6 group at CIN level (at approximately 35% of all children open to the service), followed by the +6 group at EH level (at approximately 18%):

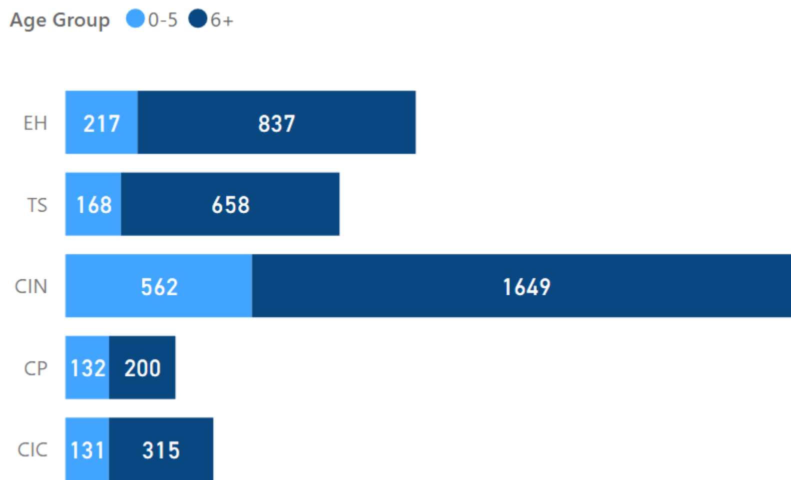


Figure 77: No. of children open to C&F by age group and support category
Source: Mosaic

In a distribution that aligns with a traditional pyramid of need and follows the principles of early intervention, we would aim to see a larger number of children (of all ages) at EH and TS levels, and a disproportionality large cohort of 0-5s at these lower levels. While "early help" does not mean "early years", the over representation of 0-5s at statutory levels suggests that there are significant number of children 0-5 whose needs are not being identified and acted upon early enough.

Over time however, this picture is improving with the ratio of Specialist Help to Early Intervention plans suggesting a steady shift in which children 0-5 are being supported:

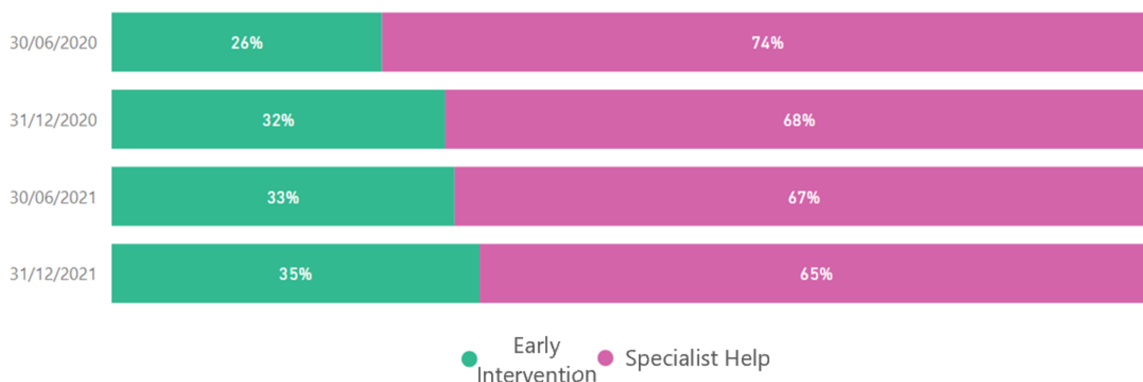


Figure 78: % of children 0-5 per statutory status by snapshot date
Source: Mosaic

In June 2020, this equated to 0.35 children being supported at Early Intervention level for every child being supported at Specialist Help level. By December 2021, this had

increased to 0.55 children at Early Intervention level per child at Specialist Help level. This will be an important indicator to monitor moving forward, with a key threshold being a reverse in the ratio, where more children 0-5 are supported at Early Intervention level that at Specialist Help.

Another important monitoring activity is to count and compare the number of children at each level of support, to highlight the key shifts in distribution over time:

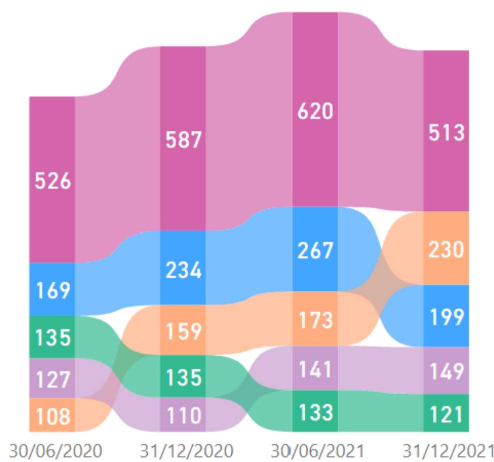


Figure 79: no. of children 0-5 by level of support
Source: Mosaic

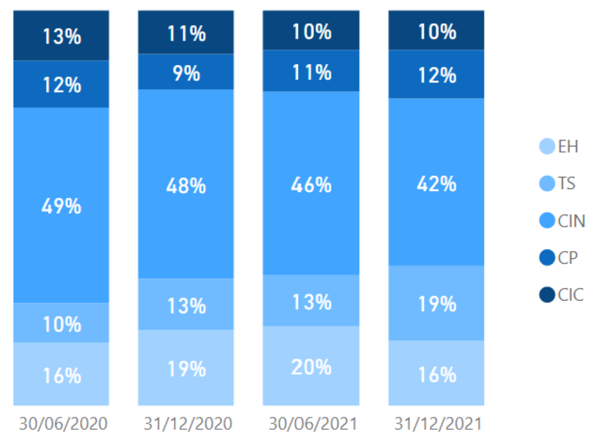


Figure 80: % of children 0-5 by level of support
Source: Mosaic

These figures indicate that the number of children 0-5 who are open to Targeted Support has more than doubled since the relaunch of Early Help in 2020, to become the second largest cohort of 0-5s in December 2021 (19%). While this is positive in terms of identifying complex need earlier; the decrease in the number and percent of 0-5s supported at the lower Early Help level suggests that more children are requiring more intensive support, to prevent them from reaching Specialist Help status. At the same time, the period has ended with the lowest numbers of Children in Need and Children in Care living in Warwickshire, but the highest number of Child Protection Plans for 0-5s. As a shifting picture, ongoing monitoring will be important for understanding the distribution of this cohort across the different levels of support, and to explore the impact of service transformation on this distribution.

Local Picture

In terms of how these shifts and differences are represented locally, it is important firstly to outline the varying composition of the C&F population across each of Warwickshire's district-boroughs. Nuneaton and Bedworth has around 55% more children open to C&F services than the district average for the period (940 children), and North Warwickshire has around 47% less children open to services than the county average. These two districts both have slightly higher rates of children within the 0-5 cohort (27% and 26% respectively), with Rugby and Warwick having the lowest (at 24% and 23%

respectively). Stratford mirrors the Warwickshire wide average at 25% of service users being 0-5:

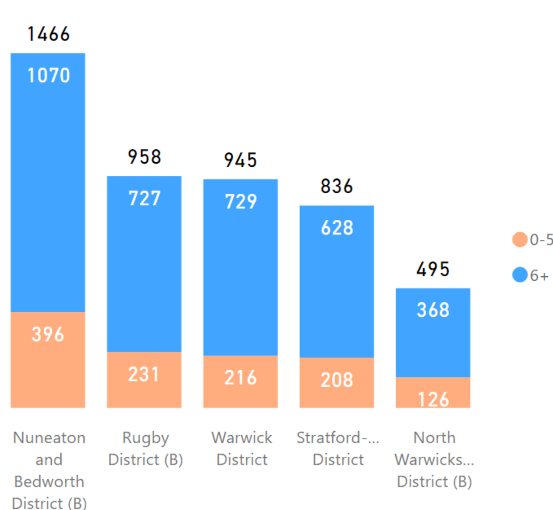


Figure 81: no. of children per district by age group
Source: Mosaic

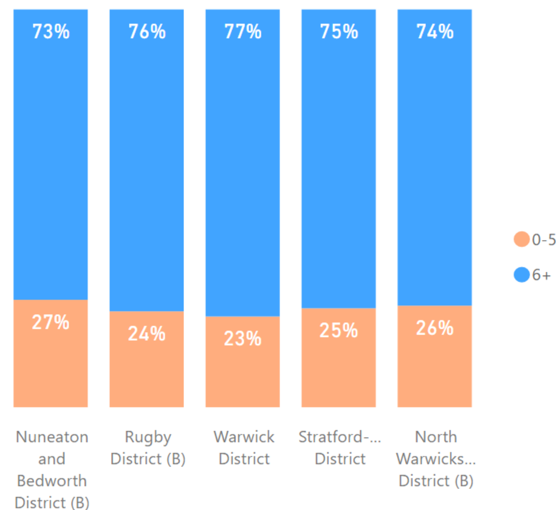


Figure 82: % of children per district by age group
Source: Mosaic

This suggests there are some differences at district level with how services are engaging and supporting 0-5s. For example, Rugby has the second highest rate of 0-5s for its population size, but the second lowest rate of 0-5s within its C&F cohort. To explore this further, it is useful to express this difference in relation to other measures, particularly low-income:

District/Borough	0-5 population estimate (ONS 2020)	% 0-5 of total population	% of children 0-5 open to C&F services	% of children in low income families
North Warwickshire	3,980	6.1%	3.2%	15%
Nuneaton & Bedworth	9,683	7.4%	4.1%	19%
Rugby	7,988	7.2%	2.9%	13%
Stratford-on-Avon	7,749	5.9%	2.7%	11%
Warwick	9,046	6.2%	2.4%	9%

Table 26: Percentage of children open to C&F services and percentage in low income families
Source: Mosaic

These measures indicate a relationship between the percent of children 0-5 open to C&F services and the percent of children 0-5 living in relative low-income families:

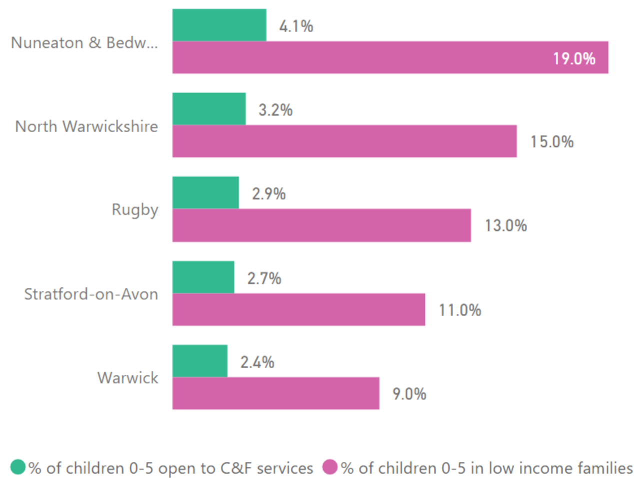


Figure 83: % of children 0-5 open to C&F services and in relative low-income families
Source: Mosaic

On average across all children (0-18) open to Children & Families Services, North Warwickshire has the lowest percentage of children open to Specialist Help support (55%), closely followed by Warwick (57%). Nuneaton and Bedworth has the highest rate of Specialist Help support, at 66%:

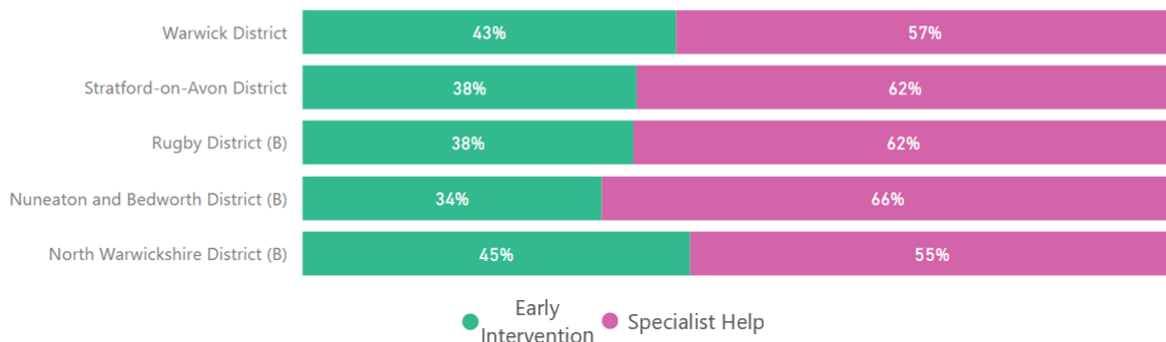


Figure 84: % of children 0-18 per Specialist Help status by district-borough
Source: Mosaic

Within the 0-5 cohort, all districts show a higher rate of Specialist Help support when compared with 0-18 population, but with a slightly more balanced picture across the districts (except North Warwickshire, which retains the lowest statutory rate) - with only 3 percentage points separating them:

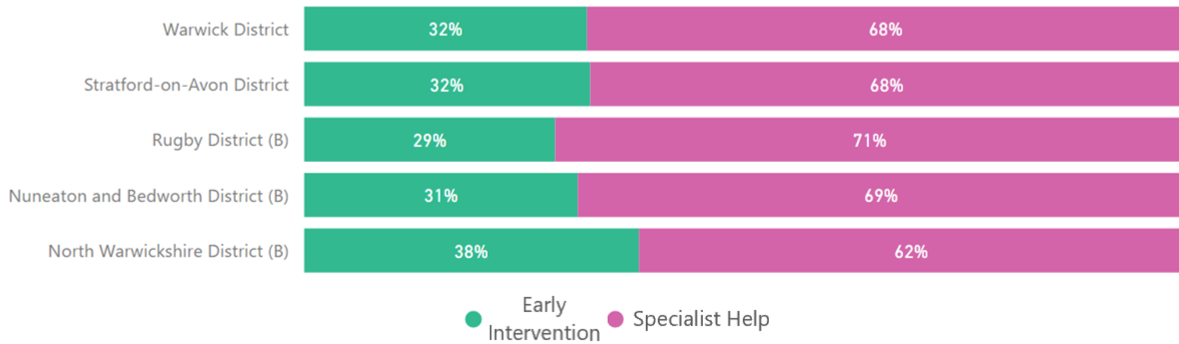


Figure 85: % of children 0-5 per Specialist Help status by district-borough
Source: Mosaic

While the Warwickshire wide picture shows a positive trend towards an increasing ratio of children 0-5 opening to Early Intervention support than Specialist Help support, the picture locally is more complex. In Rugby, Stratford and Warwick, the trends for 0-5s are broadly following the county picture, while North Warwickshire and Nuneaton and Bedworth are seeing a more varied picture:

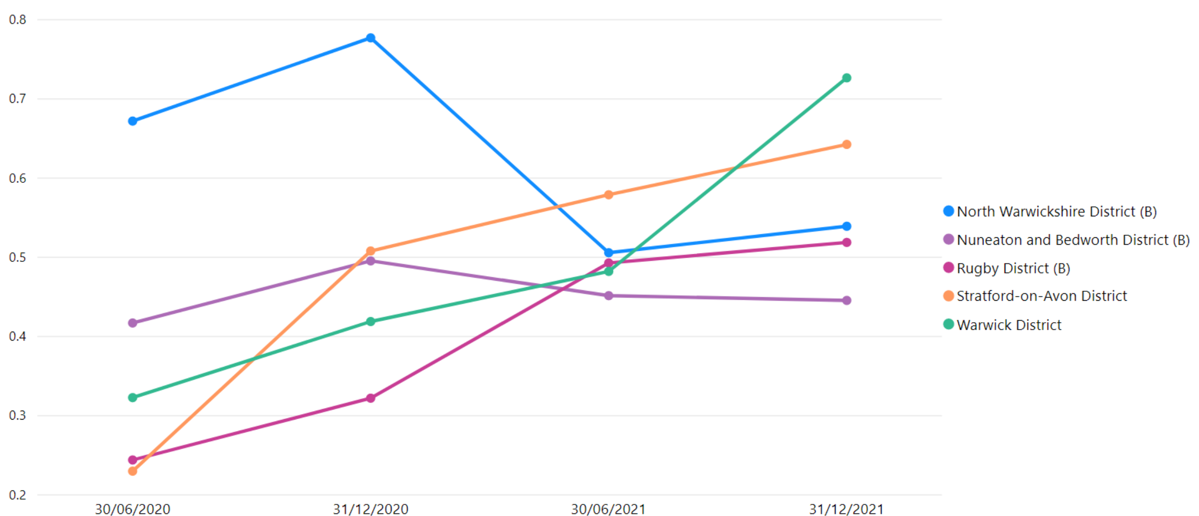


Figure 86: no. of children 0-5 open to Specialist Help support per child 0-5 open to Early Help support
Source: Mosaic

This figure indicates that while North Warwickshire retains a higher-than-average ratio of Early Intervention to Specialist Help support for children 0-5 (with more than 0.5 children open to Early Intervention support per child open to Specialist Help support), it has not experienced the continued upward trend seen in Rugby, Warwick, and Stratford. Compared with the other districts, Nuneaton and Bedworth's ratio has remained relatively stable, at between 0.42 and 0.49 to 1 over the period. Stratford in particular has seen a significant shift in the balance between Specialist Help and Early Intervention support for 0-5s, from having the lowest ratio (0.23:1) in June 2020 to the second highest (0.64:1) in December 2021.

While no district has seen a reverse in ratio for 0-5s, this has happened in the 6+ cohort for Warwick, with 1.22 children open to Early Intervention support per child open to Specialist Help support in December 2021. North Warwickshire and Rugby were also close to a 1:1 relationship (at 0.98:1).

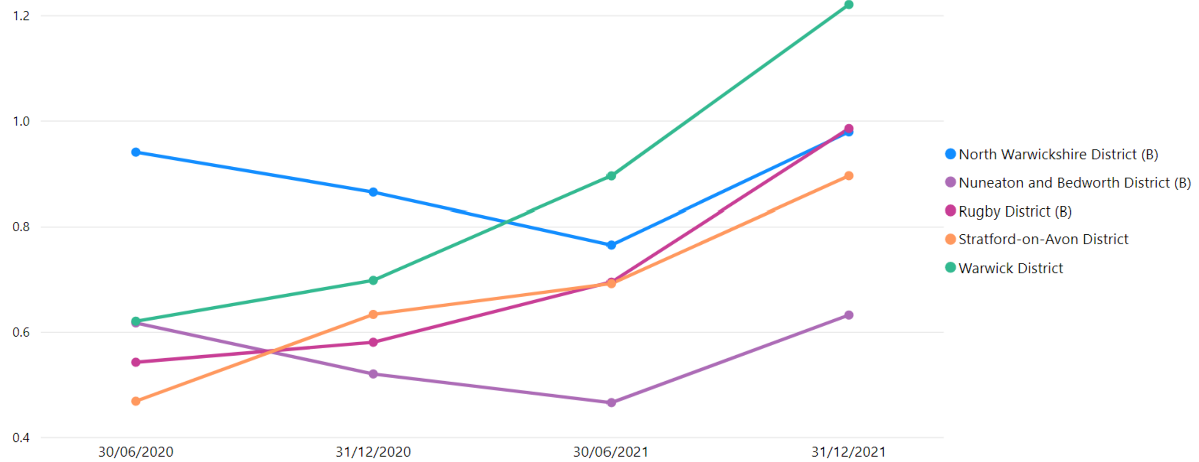


Figure 87: no. of children 6+ open to non-statutory support per child 6+ open to statutory support Source: Mosaic

SERVICE INTEGRATION FOR 0-5S

Warwickshire's Children & Family Services are currently exploring more accurate ways of identifying and matching children across its partner services. The objective is to develop a clearer picture of how services are being used, outcomes for children open to multiple services, and most important, to identify hidden need and "missed" children. This is currently a manual and time-intensive task, primarily monitored through case management and auditing. The challenge, therefore, for reporting on service integration is that while the service pathways and operational objectives can be defined, any measures or analysis on the efficiency and effectiveness of these pathways will be less reliable.

For example, a crude postcode matching exercise between the postcodes of children 0-5 open to C&F Services on 31st December 2021, and area postcodes reported by Health Visiting teams, identified 210 children that did not match to a HV team:

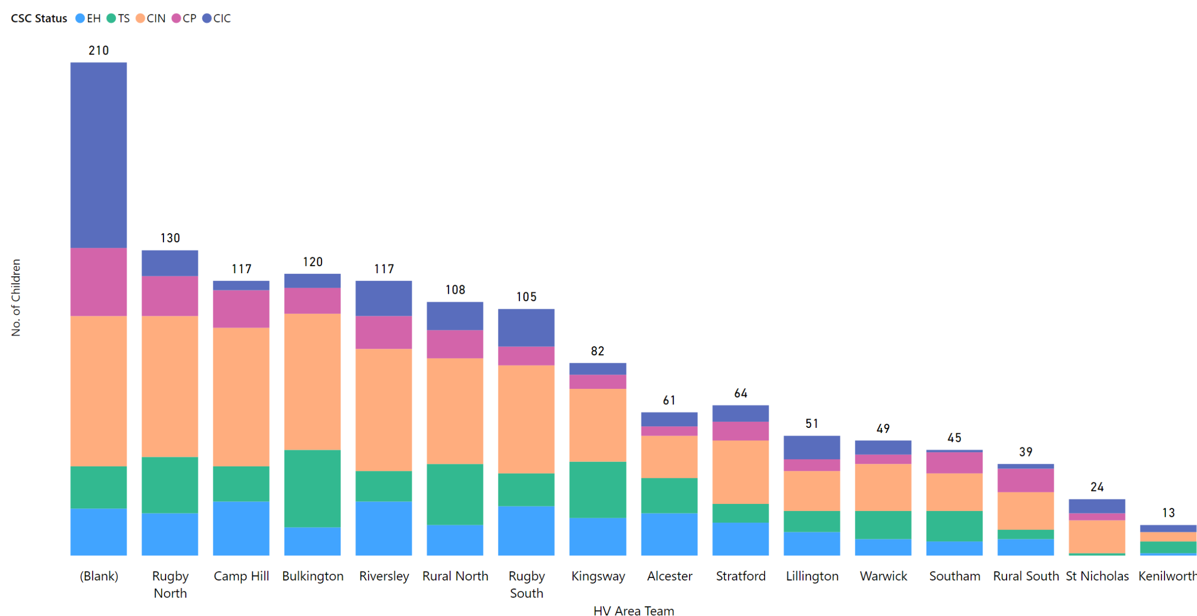


Figure 88: No. of children 0-5 open to C&F services o 31/12/21 with postcodes matched to HV area team postcodes
Source: Mosaic

Approximately 115 of these 210 children did not match to a Warwickshire postcode at all (explained by data quality issues, new build housing, or being out of area), with the remainder matching to a Warwickshire postcode but not to an HV team. The key recommendation here is explore options for a more robust way of identifying and matching children 0-5 between C&F and HV services to ensure that families who need support with children 0-5 are known to both services.

All children with a Warwickshire postcode would be covered by one of the 14 health visiting teams. The postcode coverage is drawn together by teams from their active caseloads and therefore there may be areas where pre-school children (Health Visiting services operate until the child starts school so for some this would be just post fourth birthday) do not currently reside, or due to data quality issues the postcodes are missing from the lists- however would be covered by a team.
Some of the teams within Warwickshire have a more rural coverage and therefore individual postcodes for individual properties- Rural South, Rural North, Kenilworth, Alcester and other more town central would have postcodes covering streets and several properties so more likely to be captured.

From 1st April 2020, all Health Services referrals equated to 4% into the Family Information Services, 0.58% for an EH:PTC plan and 16.5% into the Front Door.
Health services are involved in EH:PTC plans, but these have generally been initiated by other professionals for older aged children (with the under 5 year old being part of the support plan) rather than health services initiating them themselves. [please note: this period did cover the COVID 19 pandemic]. The FIS and EH&TS teams have proactively visited Health Services teams to encourage the use of upstream Early Help

approaches and the initiation of EH:PTC plans for identified vulnerable families. This is also including supporting health and early years colleagues to access training and network opportunities to increase their confidence, capability and capacity to initiate Early Help support.

The Children and Family Centres service works together with partners using an asset-based approach, focusing on those families who find it most difficult to access services and delivering early intervention to meet needs. Partners utilise the centres to collocate and to deliver their services locally to families. Due to the impact from covid, many partners, including the Children and Family Centres, delivered virtual service models rather than delivery at the centres or outreach locations. In addition, many outreach venues that had been used previously had closed during this time. 5 core centres remained open to enable midwifery to deliver appointments.

The Children and Family Centre service resumed face to face support for vulnerable families towards the end of 2020, with all core centres open for access by partners and appointments. During 2021, more partners resumed delivering services from the centres with demand increasing as restrictions eased. Further work is needed to increase the breadth of services at each centre and utilising outreach venues to deliver services to families to meet local need.

Due to data sharing across organisations the integration of services isn't simple however there is work being done around referral pathways, DPIA's communication between services to identify the most appropriate practitioner and service. In North Warwickshire there have been two early years workers from the Children and Family Centres working within Health Visiting teams and this model is being reviewed to look at earlier and more effective identification of families requiring support from other early intervention services.

CHILDREN AND FAMILY CENTRES

Warwickshire County Council commission the Children and Family Centre service to two providers. The core aim is to enable every child in Warwickshire to have the best start in life. By working together with partners and using asset/strengths-based approaches, this will be achieved by focusing on those families who find it most difficult to access services and delivering early intervention services to meet individual needs.

There are 14 Children and Family Centres across Warwickshire and further outreach locations, to provide services for families with children and young people, pre-birth to 19 (or 25 for those with Special Education Needs and/or Disabilities) with particular focus on the 1001 critical days, from conception until the age of 2.

Aligned with the County Council's "stepped approach" to delivering support, the service provides, or enables the provision of, a range of universal and targeted services. The services are either delivered by Children and Family Centre staff, or by partners who are providing their services at the centres. For example, a family could access a stay and play session for under 5's, attend an antenatal midwifery appointment, access advice from Citizen's Advice, or attend a support group for dads ran by volunteers.

There are three core elements to the service:

1. Coordination and administration of the designated Children and Family Centres and associated outreach provision;
2. Provision of a range of stay, play and learn opportunities;
3. Building of capacity and resilience within communities (especially those geographical communities in which the Children and Family Centre and outreach venues are located), including increased use of volunteers in service delivery.

The service delivers a range of stay, play and learning activities for under 5's. Using data reporting period 1/1/21 - 31/12/21, 35% of all attendances at centre led activities are by children 0-5 years with the average age of 1.3 years and 4.3 years[30]. In comparison, attendances at centre led activities by children and young people aged between 5-19 years is 2.6% and 26%.[31] 3% of attendances at centre led services were by children and young people with Special Education Needs and/or Disabilities, further analysis of data reporting including age range is required.

A sizeable proportion of attendances at centre led activities are by adults, accompanying children to the activities or accessing other support provided by the centres.

Other services at the centres and outreach locations are provided by partners, predominantly providing 0-5 years services. Using the same data period, out of all sessions delivered by partners, 54% were delivered by Midwifery and a further 23% by Health Visiting.18% of children aged 0-5 years attended services provided by partners.

35% of all referrals to the service by partners for families needing support were generated by Health Visiting, with a further 37% of referrals sent from schools to one

[30] 01/01/21 - 31/12/21: 1.3% Barnardo's; 4.3% The Diocese of Coventry Multi-Academy Trust (St Michael's)

[31] 01/01/21 - 31/12/21: 2.6% Barnardo's; 26% The Diocese of Coventry Multi-Academy Trust (St. Michael's)

of the service providers.[32] Further work is needed by the Children and Family Centre service to raise awareness with partners of the support the service can offer families across the age range and levels of need.

Children and Family Centre locations

There are 14 core centres across the county. Except for North Warwickshire and Bedworth districts, each district has 3 centres. Additional outreach venues are used across the districts, to support families accessing services locally, particularly in more rural areas. Figure 89 highlights the core centre locations, denoted by colour coding red and light blue.

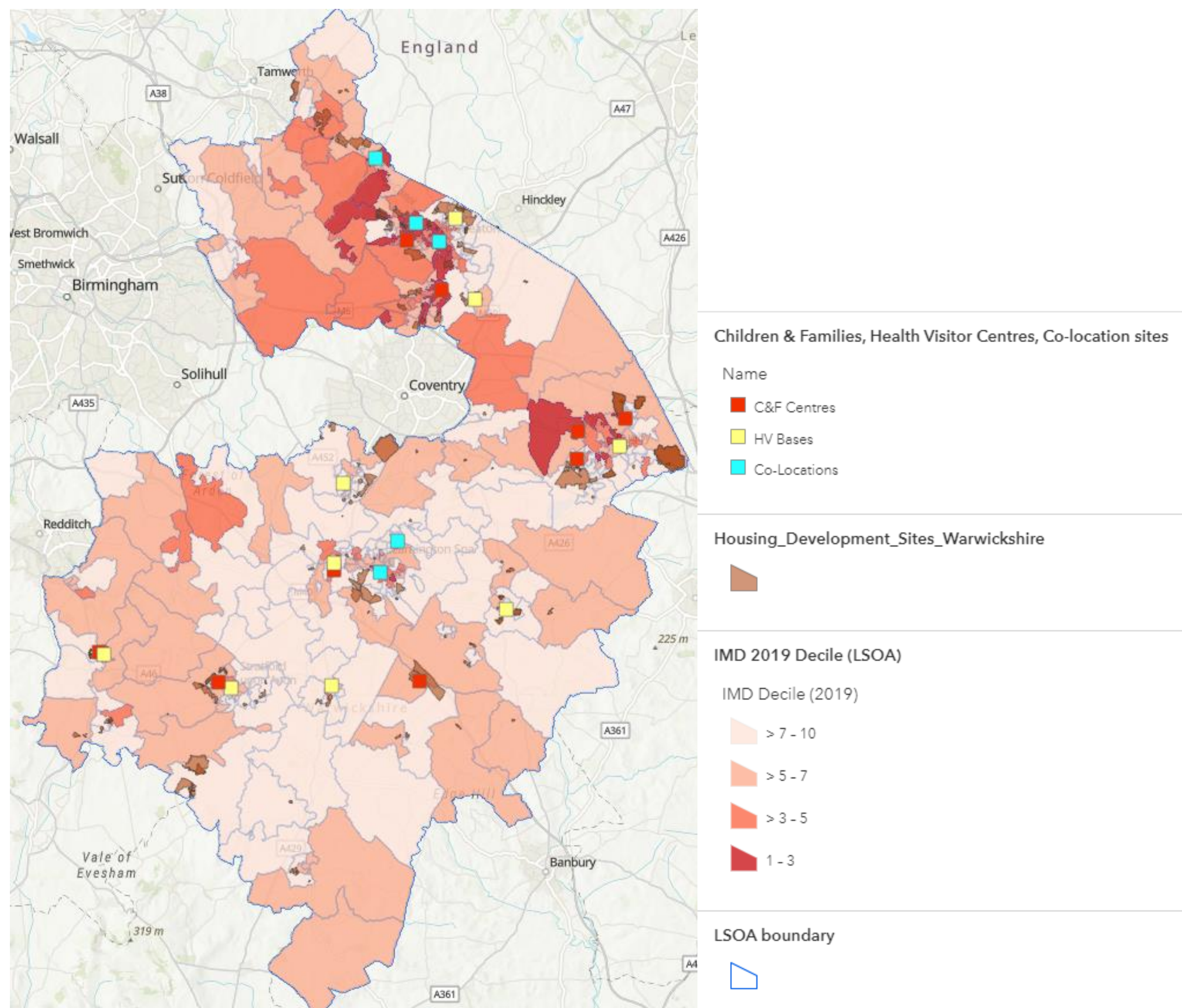


Figure 89: Map of Children and Family Centre locations

The service offer focuses on improving the outcomes and life chances for all children, young people and their families by offering effective preventative and early intervention services that focus on those who are hardest to reach and are

[32] The Diocese of Coventry Multi-Academy Trust (St. Michael's)

experiencing the greatest challenges in life. Using the IMD indicates whether the service is reaching those in most and the locations of the centres. 57% of the centre locations are within IMD 1-3.

Analysis of the total attendance at centre led services and activities by areas of IMD 1-3, by district.

District	% of total attendance from IMD decile 1	% of total attendance from IMD decile 1, 2 or 3
North Warwickshire x1 core centre	2.9%	16.4%
Nuneaton x3 core centres	18.7%	48.5%
Bedworth x1 core centre	0.4%	50.4%
Rugby x3 core centres	0%	14.3%
Warwick x3 core centres	0%	12.6%
Stratford x3 core centres	0%	2.4%

Data period: 01/0/21-31/12/21

Using the IMD findings and with increasing housing development across the county, in particular Rugby and Warwick districts, there is a greater need to utilise outreach venues to ensure that the service reaches families. This is in addition to more rural districts, Stratford and North Warwickshire. Outreach venues are often community-based premises which vary in terms of access and premises facilities, which may restrict some partners being able to deliver services as well as the Children and Family Centre staffing capacity.