

HEALTH AND WELLBEING BOARD

11 June 2019

Title:	BHR Children and Young People's Transformation Board – Best Practice Evidence Review		
Report of the Health and Wellbeing Board			
Open Report		For Information	
Wards Affected: ALL		Key Decision: No	
Report Authors: Florence Henry, Public Health Strategy Officer, London Borough of Barking and Dagenham Paul Starkey, Health Improvement Advanced Practitioner, London Borough of Barking and Dagenham		Contact Details: Tel: 020 8227 3059 E-mail: florence.henry@lbbd.gov.uk Tel: 020 8227 5170 E-mail: paul.starkey@lbbd.gov.uk	
Sponsor: Matthew Cole, Director of Public Health, London Borough of Barking and Dagenham			
Summary: The report was written at the request of the BHR Children's and Young People's Transformation Board to provide the evidence on best practice for the three priority areas mentioned above. It was taken to the board on the 28 th March 2019 supported by a presentation that outlined the three key areas covered in the report. During the writing of the report we were mindful of the fact that in BHR, each council is at a different stage of transformation and the challenges that this creates for developing an integrated BHR health creation approach. It should be noted that the aim was to inform and provoke discussion about what is currently taking place in BHR and how we can best make the changes that will enhance the lives of children and young people. This paper is also being presented at Redbridge and Havering's Health and Wellbeing Boards. The three priority areas identified in this report are the Best Start in Life, Adverse Childhood Experiences (ACEs) and Special Educational Needs and/or Disabilities (SEND). These strategic areas of focus were chosen by the Joint Commissioning Board because of their potential to significantly improve health outcomes for children and young people living in BHR. For each of these priority areas, the purpose of the report was to outline why this is an important area of focus for BHR, by including some headline BHR data and national and international best practice for interventions in these areas.			
Recommendation(s) The Health and Wellbeing Board is recommended: i) To note the report and ii) To discuss how local partners should be working as an integrated care system in this area to improve outcomes for residents.			

1.0 Background/ Introduction

- 1.1** Transforming the experience of health and care for children and young people not only provides the opportunity to improve the experiences of current residents in BHR but is also a key element of prevention and reducing future need. Investment at this stage will create a long-term impact that will span throughout the life course and improve the outcomes for children and young people. To this end, prevention and early intervention have been recognised as key components of the Transformation Board. This will importantly have longer term effects on other transformation programmes, including mental health, long-term conditions and older people. Evidence from the Marmot Review demonstrates that a good start in life, including being physically and emotionally healthy, provides the cornerstone for a healthy, productive adulthood. Ensuring outcomes for BHR children and young people provides the opportunity to prevent key health problems later in life before they take place.
- 1.2** The importance of ensuring this good start for the future health of children, for the sustainability of the NHS and the economic prosperity of Britain is echoed in the NHS Long Term Plan as one of the key themes (2019)¹. In addition, the plan also highlights that the health of children and young people are determined by far more than healthcare. The wider determinants of health such as household income, education, housing, a stable and loving family life and a healthy environment all significantly influence young people's health and life chances. For this reason, in order to make a difference to the outcomes of children and young people in BHR, we will need to work together cross-organisation as an Integrated Care System and importantly look beyond care including the wider work of local authorities, the community and voluntary sector.

2.0 Priority 1: Best Start in Life, focusing on preconception up until the age of 7

2.1 Why is focusing on the Best Start in Life important?

The Marmot Review demonstrates that the first 5 years of life have a substantial impact on physical and mental health for the rest of life. What happens in the early years can impact on a range of health and wellbeing areas including obesity, heart disease, mental health, smoking, educational achievement and economic status. Furthermore, many of the key issues that we are trying to tackle across our health and care system are determined by residents' experience in the Early Years – prioritising the Early Years offers the potential to prevent some of the key health challenges facing the BHR system before they happen. In order to create a sustainable health and care system across BHR, offering a co-ordinated focus on the Early Years could help to reduce the demand for future health and care services, and help to reduce health inequalities and improve health outcomes across the life course. Whilst the traditional Best Start in Life focuses on preconception up until the age of 5, increasing this up to the age of 7 allows for a focus on managing the transition between the school and home effectively, and focuses on providing continuity of care from primary and home including play and communication.¹

There is also a clear economic case for prioritising work in the Early Years. Evidence from Public Health England demonstrates that for every £1 spent in the

¹ Marmot M, Allen J, Goldblatt P, Boyce T, McNeish D, Grady M, et al. Fair Society, Healthy Lives: The Marmot Review. London: UCL; 2010 - <http://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review>

Early Years, £7 would have to be spent in adolescence to have the same impact on health². Evidence shows that later interventions, although important, are considerably less effective when residents have a lack of good early foundations. Therefore, in order to create the most substantial change in successful health and care interventions across the life-course, and interventions across our other transformation boards, and workstreams, especially mental health, help to provide all residents with the Best Start in Life.

2.2 What does the data say about the BHR population?

Additionally, although the three boroughs have different populations, looking at population data for all three boroughs provides further evidence on why this is important. There are increasing numbers of children in all three populations:

- Barking and Dagenham - Barking and Dagenham have the highest proportion of residents aged 0-4 in the UK, and the highest 2017 birth rate in the UK. ³
- Havering - In Havering, there has been an increase in the number of births, equating to an additional 10 births per 1,000 women aged 15-44 between 2004 and 2017. In addition to this, from 2011 to 2016, Havering experienced the largest net inflow of children across all London boroughs⁴
- Redbridge - By 2026, it is predicted that there will be over 118,000, 0-25 years olds living in Redbridge, and nearly 21% of dependent children and young people under 20 years old live in households subject to relative poverty.⁵

2.3 Best practice

Evidence shows that a child's early development score at 22 months is an accurate predictor of educational outcomes at age 26 (Feinstein, 2003), which is in turn related to long-term health outcomes. Therefore, focusing on providing early years programmes are key in order to improve the life chances of those within BHR.

NICE guidelines recommendations are a helpful resource to draw on. Within Best Start in Life, they cover home visiting, early education and childcare for vulnerable children. They state that a 'life course perspective', recognising that disadvantage before birth and in a child's early years can have life-long, negative effects on their health and wellbeing. A focus on the social and emotional wellbeing of vulnerable children as the foundation for their healthy development helps to offset the risks relating to disadvantage. This is in line with the overarching goal of children's services, that is, to ensure all children have the best start in life. The aim is to ensure universal, as well as more targeted services, provide the additional support all vulnerable children need to ensure

² PHE, Health Matters: Ensuring all children have the best start in life

<https://publichealthmatters.blog.gov.uk/2015/08/10/ensuring-all-children-have-the-best-start-in-life/>, 2015

³ <https://modgov.lbbd.gov.uk/internet/documents/s126826/JSNA%20Report%20-%20App.%20A%20Draft%20JSNA.pdf>

⁴ https://www.haveringdata.net/wp-content/uploads/2018/09/Published-201819_Havering-Demographic-Profile-v4.1.pdf

⁵ https://www.redbridge.gov.uk/media/4814/health-wellbeing-strategy-2017_2021.pdf

their mental and physical health and wellbeing (Key services include maternity, child health, social care, early education and family welfare.)⁶

The Kings Fund also makes a series of recommendations to provide effective early years support to improve health and reduce inequalities, partners should work to look at targeting:

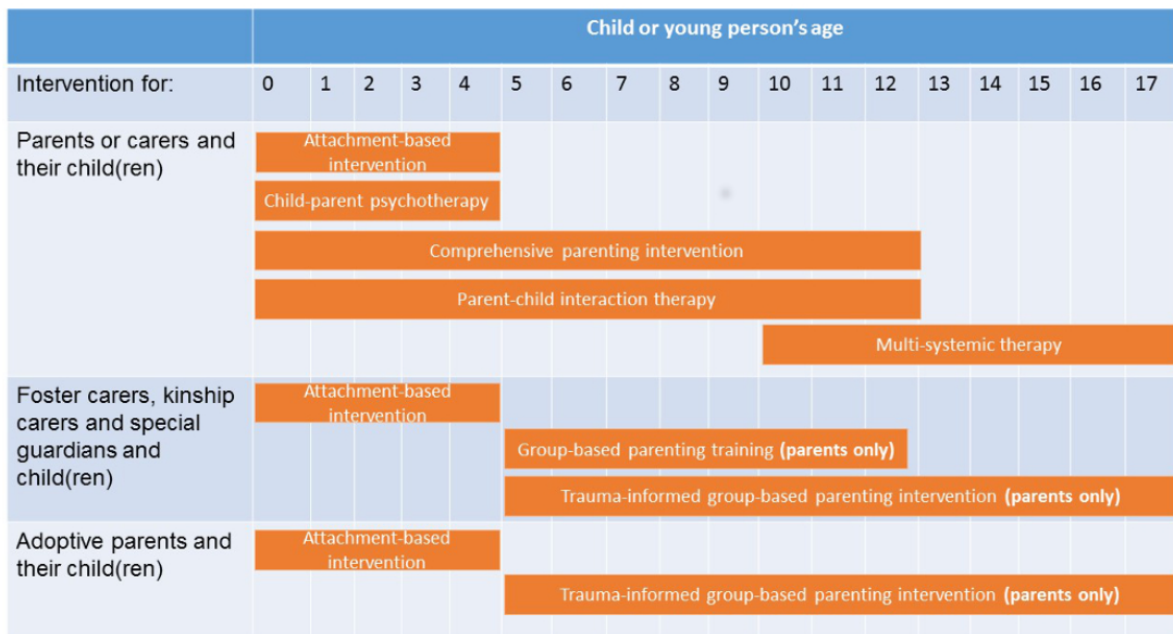
- **Focus on promoting early childhood development, especially social and emotional development** – Evidence demonstrates that a child’s early development score at 22 months, is an accurate predictor of educational outcomes at the age of 26, which is also related to long-term health outcomes. **Strategies identified as effective in supporting personal, social and emotional development in children including staff modelling prosocial behaviour, small group activities that supported children to work together, share and take turns, a consistent approach to behaviour management and using snacks and mealtimes as an opportunity to foster prosocial behaviour.**
- **Target the most disadvantaged children and their families with intensive support, supplementing specific interventions with mainstream universal family support services.** Successful interventions tend to be behaviour focused – for example, coaching parents during play sessions with children, rather than simply providing information can be more effective in improving outcomes.⁷ Across our health and care systems, we have a key opportunity to intervene during the early years – not only are the early years a time when our health and care systems have frequent contact with parents, evidence demonstrates the early years are a key time to intervene to effectively improve outcomes.
- **Using multisystemic therapy for neglect** – The early years are also a key time to identify and support out most vulnerable children. We know that NICE guidance on child abuse and neglect makes a number of best practice recommendations for child abuse and neglect. These include offering early help for families, multi-agency response and therapeutic interventions.⁸

⁶ – Social and emotional wellbeing: early years – Public health guideline (PH40) – Published date: October 2012

⁷ <https://www.kingsfund.org.uk/projects/improving-publics-health/best-start-life>

⁸ <https://www.nice.org.uk/guidance/ng76/chapter/Recommendations>

Figure 1 Interventions following physical abuse, emotional abuse or neglect



Multi-systemic therapy is one form of therapeutic intervention that can be effective for neglect. Multi systemic therapy for Child Abuse and Neglect was developed to treat families who have come to the attention of Children’s Services due to physical abuse and/or neglect and who have one or more children aged 6 to 17 years who are subject to a child protection plan. Evaluation in trials demonstrates that MST-CAN was twice as effective as the alternative outpatient therapy at preventing out-of-home placement. Moreover, MST-CAN was more effective at reducing parent and child mental health problems and increasing natural social supports. In the UK, of the 71 families evaluated during the pilot period:

- 98% of the children remain at home
- 97% are in school or working

There has been work to establish the cost effectiveness of MST-CAN within UK, Europe and US. A recent evaluation study in Leeds established during the pilot phase, there was a £1.59 return for every £1 spent on the programme.⁹

- **Further exploring the link between family poverty, child abuse and neglect**
An evidence review by the Joseph Rowntree Foundation (2016) explores the relationship between poverty, child abuse and neglect and had 3 key findings:

1) There is currently a lack of joined up thinking and action about poverty, and child abuse and neglect in the UK. It recommends a secure recognition of the strong association between families’ socio-economic circumstances and the chance of being subject to abuse or neglect through:

- child protection policies including explicit and specific consideration of the impact of families’ socio-economic circumstances
- all anti-poverty policies include the relationship to Child abuse and Neglect (CAN) as a significant dimension
- training programmes for frontline staff to develop thinking around.

⁹ <http://www.mstuk.org/about-mst-uk/mst-can>

2) There is currently a need for an improved evidence-base

In the UK, there is limited evidence base in terms of official data and research. The paper recommends that there is a need to expand this evidence-base through official data collected on child protection systems should include a common core dataset that supports comparisons of which children and families are involved, how services intervene and the short, medium and long-term outcomes:

- identify ways of including information on family socio-economic circumstances or linking data on family circumstances to CAN data
- develop improved measures of the longer term economic and social outcomes of child protection systems for individual children beyond the current information around care leavers up to age 21.

3) There should be a focus on reducing family poverty in the population

- Work on anti-poverty policies which reduce inequities in child health and education and incorporate a focus on their relevance for Child Abuse and Neglect
- data gathering which enables groups and neighbourhoods.

- **Focus on vulnerable mothers from pregnancy until the child reaches the age of 2.** Programmes that involve health visitors and specialist nurses undertaking home visits have had successful outcomes, including improvements in prenatal health, fewer childhood injuries, fewer subsequent unplanned pregnancies and increases in maternal employment and children's school readiness.

Family Nurse Partnership is one example: hip (FNP), a voluntary internationally accredited home visiting programme for vulnerable mothers from early in pregnancy until their child is 2, has generated savings of more than five times the programme cost, and is an example of an evidence-based licensed programme. The programme has three aims: to improve pregnancy outcomes, improve child health and development and improve parents' economic self-sufficiency. It offers intensive and structured home visiting, delivered by specially trained nurses, from early pregnancy until the age of 2.

The criteria for women to be offered the FNP are: all first-time mothers age 19 and under at conception; living in the catchment area; eligible if previous pregnancies ended in miscarriage, termination, still-birth; enrolment no later than 28th week of pregnancy and as early as possible. 30 years of high-quality US research has shown benefits for vulnerable young families including improvements in antenatal health, reduction in child injuries, neglect and abuse, improved early language development, school readiness and academic achievement, increased maternal employment and reduced welfare use as well as fewer subsequent pregnancies and improved parenting.¹⁰ As this demonstrates, the wide-ranging impact on improving outcomes for BHR children and reducing demand for further health and care systems of an effective FNP service would be substantial and long-term.

¹⁰https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/729018/Making_the_case_for_preconceptioncare.pdf

- Identifying mental health issues early: evidence from the WHO demonstrates that maternal mental health problems can have negative impacts on child development – it can impact breastfeeding, mother-child bonding and parenting quality. Suicide is one of the commonest causes of maternal mortality, and 20% of women experience mental health issues in pregnancy and the first year after birth, and up to 10% fathers suffer from postnatal depression ¹¹The Kings Fund also highlights that early intervention to support people experiencing mental health problems can produce significant cost savings and productivity improvements in the longer term, for the NHS, local authorities and others. For example, **health visitors identifying and treating post-natal depression improves productivity and leads to cost savings** in the medium to short term and targeted parenting programmes to prevent conduct disorder pay back £8 over six years for every £1 invested with savings to the NHS, education and criminal justice systems.¹² Nationally, it is considered that the ability to identify post-natal depression with screening tools would have a large impact. Warwick University have created the Parent-Infant Interaction Observation Scale (PIIOS) in screening parent-infant interaction at 2-7 months.
- Smoking during pregnancy has a range of impacts on both mother and child, which are also outlined in the mayoral healthy early years London programme. The diagram below demonstrates some of the impacts:



Importantly it has increased costs to the NHS, and our health and care system more widely – an economic report by the Public Health Research Consortium aimed to estimate the additional costs to the NHS during pregnancy and the year following birth, of a mother continuing to smoke during pregnancy. **The research estimates that the total cost of smoking during pregnancy for maternal outcomes for the NHS could be as much as £64 million**, whereas the total cost of infant outcomes as a consequence of smoking during pregnancy to the NHS could be as high as **£23.5 million**. This is NHS specific research, so importantly are conservative estimates given the wider costs to the health and care system. **The research finds that low cost smoking cessation programmes could have economic cost savings for the NHS.** Spending between £13.60 and £37 per pregnant smoker would yield positive cost savings for the NHS, plus further costs across our health and care system. ¹³

¹¹https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/216864/The-Family-Nurse-Partnership-Programme-Information-leaflet.pdf

¹² Kings Fund, Best Start in Life, <https://www.kingsfund.org.uk/projects/improving-publics-health/best-start-life>

¹³ Public Health Research Consortium. 'Estimating the costs to the NHS of smoking in pregnancy for pregnant women and infants' http://phrc.lshtm.ac.uk/papers/PHRC_A3-06_Short_Report.pdf

- Obesity is a significant problem across BHR, and London. The cost of obesity nationally is substantial – at least £5.1 billion to the NHS and tens of billions to UK society every year. Evidence from Lambeth and Southwark estimate that the total cost of childhood obesity to Lambeth and Southwark’s economy is £17 million due to direct costs of treating obesity and consequences of obesity and the indirect costs of obesity, through the loss of earnings due to sickness and premature mortality.¹⁴ BHR has higher childhood obesity rates than Southwark and Lambeth, suggesting the economic cost of obesity would be higher. **25 studies with a total of 226,508 participants showed that breastfeeding was associated with a significantly reduced risk of obesity in children.** Therefore, looking at levels of breastfeeding in BHR, and interventions to include breastfeeding could have a future impact on our childhood obesity rates.¹⁵
- Addressing violence against women and girls is important, as evidence from the WHO demonstrates that violence against girls and women’s preconception and during pregnancy, results in adverse physical, psychological consequences as well as increased risk for premature delivery and low-birth weight infants. In addition, Female Genital Mutilation (FGM) increases the risk of neonatal death by 15% to 55%.¹⁶ With Domestic violence and abuse a big problem across BHR, and half of all reported cases of FGM (48% of newly recorded cases, and 48% of total attendances in the NHS) relate to the London region,¹⁷ provision and support, and investigating how to prevent this from occurring in these areas could help to ensure the health of BHR children. FGM is an issue currently gaining national attention - on the 8th February, the British Parliament voted on an FGM proposal, called the Children Act 1989 (amendment – female genital mutilation bill) which intends to improve the 2003 law that prohibited the practice by allowing family courts to make interim care orders about children deemed at risk, simplifying the process. Although this bill was controversially blocked by MP Christopher Cope, there are expected to be further debates and discussions on FGM.¹⁸

In addition, Barking and Dagenham have the highest rate of reported domestic abuse in London and have just launched a cross-partner Domestic Violence commission, which will look at the causes of the normalisation of domestic abuse in the borough and how to address the issues.

- The What Works Centre for Children’s Social Care, including the Early Intervention Foundation, ensures that our children have the best start in life, requires looking across our health and care system and looking beyond care. The What Works Centre for Children’s Social Care is a new initiative to foster evidence-informed practice in England led by Nesta and promoted by the Social Care Institute of Excellence (SCIE). As well as launching a new evidence store, as an innovation unit, they are looking for pilot sites to be involved to further help their work. They are currently calling for local authority partners to embark on a series of pilot studies to explore the use of predictive analytics in children’s social care and specifically to test if it can help to reduce the escalation of cases. The centre hopes these pilots will help to answer key questions including: can

¹⁴ <https://www.gsttcharity.org.uk/what-we-do/our-programmes/childhood-obesity-0/why-childhood-obesity/cost-childhood-obesity>

¹⁵ <https://bmcpubhealth.biomedcentral.com/articles/10.1186/1471-2458-14-1267>

¹⁶ https://www.who.int/maternal_child_adolescent/documents/preconception_care_policy_brief.pdf

¹⁷ <https://digital.nhs.uk/news-and-events/news-archive/2017-news-archive/annual-statistical-publication-for-fgm-shows-5-391-newly-recorded-cases-during-2016-17>

¹⁸ <https://inews.co.uk/news/politics/christopher-chope-fgm-bill-blocked-details-explained/>

predictive analytics be useful in children's social care? If so, in what circumstances? and importantly, just because we use predictive analysis, should we? Participating local authorities will be expected to make case notes and outcome data available to the What Works Centre and the Office of the Children's Commissioner, and to participate in occasional workshops to help us understand the results of the analysis. This would provide the opportunity for BHR to be at the forefront of investigating stepping down social care.

The Early Intervention Foundation are looking to partner with four local authorities to participate in a 12-month intensive, applied programme to develop the local maternity and early years system in the light of the latest evidence. Barking and Dagenham council have been successful in progressing to the final stage of assessment, the process remains a competitive one with the council aspiring for partnership. Academy partnership could see transferable learning around how best to transform BHR systems to improve the outcomes for our children, young people and families.

2.4 Priority 1: Best Start in Life: Key areas for discussion

Given the evidence above, the Children and Young People's Board are asked to consider:

As there are wide-ranging impacts, are there key learnings from the Family Nurse Partnership that we could take into consideration in BHR? How different are our health visiting services within the Family Nurse Partnership?

N.B. Redbridge has a Family Nurse Partnership, hosted by NELFT, who are also the providers of the 0-19 Healthy Child Programme.

Level of development at the age of 5 is a key indicator of outcomes later in life and impacts educational attainment. As a Transformation Board, how can we work together to help improve this indicator?

Maternity and Health Visiting services are a universal offer for our population, how can we ensure that BHR work on MECC helps to identify those vulnerable residents to make a difference?

Is the Health Visiting Offer equitable across BHR and what are the potential consequences?

The first years of life have a substantial impact on health and physical outcomes for the rest of life as listed above. The Marmot Review highlights that health inequalities are widespread in this area. How can we work as an integrated care system to reduce health inequalities?

Are our smoking cessation services currently effective and accessible? Are they working to improve outcomes for mothers and children?

Should BHR local authorities express an interest in working with the What Works for Children's Social Care Centre? A commitment across all three local authorities could help to identify the journey across the health and care system

3.0 Priority 2: Adverse Childhood Experiences (ACEs)

3.1 Why is focusing on ACEs important?

A growing body of research identifies the harmful effects that ACEs occurring during childhood or adolescence (e.g. child maltreatment or exposure to domestic violence) have on health throughout life. Individuals who have ACEs tend to have more physical and mental health problems as adults than those who do not have ACEs and ultimately greater premature mortality³. Chronic toxic stress resulting from ACEs can impact on the neurological, immunological and hormonal development of children. Repercussions of such impacts include substantive increases in risk of adopting anti-social and health harming behaviours, accelerated development of chronic disease and premature death⁴.

3.2 What are ACEs?

ACEs are stressful or traumatic events and include:

- Physical abuse
- Sexual abuse
- Emotional abuse
- Physical or emotional neglect
- Intimate partner violence or mother treated violently
- Substance Misuse within the household
- Household mental illness
- Parental separation or divorce
- Incarcerated household member

3.3 What is the impact of ACEs?

As the diagram below demonstrates, individuals who have 4 or more ACEs in childhood (compared to those with none) have a range of adverse health outcomes, these include:

- Unhealthy health behaviours and social outcomes – more than twice as likely to smoke and nearly 6 times as likely to be problem alcohol users.
- An increased risk of illnesses - twice as likely to develop conditions such as cancer and heart disease, and more likely to have poorer mental health problems.
- Increased utilisation, and consequently cost, to public services - those with ACEs are predictors of high-cost health users. Those who have 4 or more ACEs in childhood are more likely to be increased users of health services at three levels - GP level, A&E and hospitalisation across the life-course.

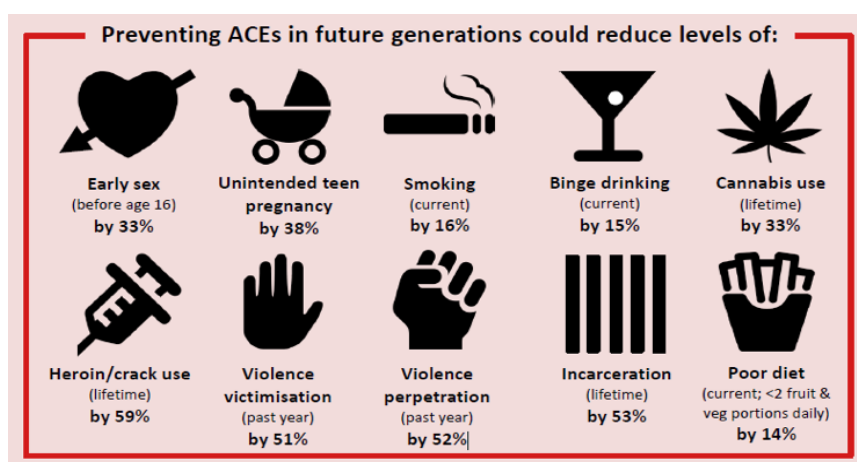
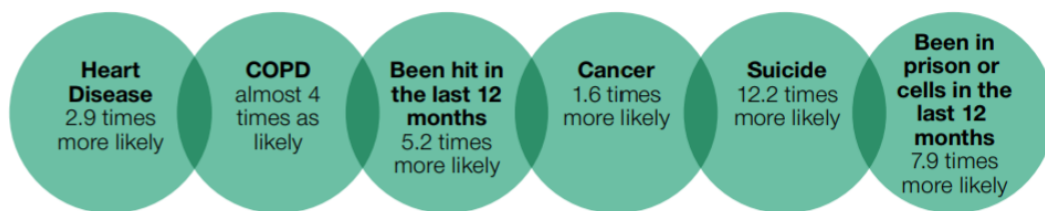


Figure: Preventing ACEs in future generations.....¹⁹



3.4 How can we moderate ACEs?

If we can intervene before these problems become a crisis, we can help individuals while reducing the demand for our health, social care and wider local authority services.

The concept of **developing resilience in children** as a moderator of ACE harms is widely advocated. A range of factors may moderate the impact of ACEs on life course health, providing resilience to developmental harms and consequently, better outcomes despite a history of multiple ACEs. Although many definitions are available, resilience typically describes the ability to adapt successfully to disturbances that threaten development of a positive life course or the ability to resume one following periods of adversity⁵. Sources of resilience can include, but are not limited to, cultural engagement, community support, opportunity to control one's personal circumstances and access to a trusted adult throughout childhood who can provide sanctuary from the chronic stress of ACEs. A range of interventions aim to enhance resilience through supporting parents, strengthening links with other family members, peers and schools; developing team working, decision-making abilities and confidence; and enhancing academic, athletic and other individual strengths.

3.5 What the data says about ACEs

It is not currently possible to measure the levels of ACEs within our populations due to lack of screening, however the available data from our population suggests that there may be a high level of ACEs in the population. For instance:

- The Mayor's Office for Policing and Crime (MOPAC) data suggests that Havering had the highest reported rate of child sexual exploitation in London in 2015/16, with Barking and Dagenham the 3rd highest, and Redbridge the 13th highest London borough. This demonstrates that child sexual exploitation is an issue across BHR.
- Domestic abuse is a national problem, and fear of reporting causes lots of domestic abuse to go unreported. Data also demonstrates that Barking and Dagenham has the highest rates of reported domestic abuse in London, with Havering the 17th highest rate of reported domestic abuse offences and Redbridge has the 20th highest rate of reported domestic abuse.
- It is also worth noting that across BHR, there has been a recent spike in knife crime. From January 2017 to January 2019 the following data was reported across BHR for possession of an article with a blade or point:
-

¹⁹[http://www2.nphs.wales.nhs.uk:8080/PRIDDocs.nsf/61c1e930f9121fd080256f2a004937ed/00c40b58ce773d5e80257f3700390f65/\\$FILE/ACE%20Infograph%20FINAL%20\(E\).pdf](http://www2.nphs.wales.nhs.uk:8080/PRIDDocs.nsf/61c1e930f9121fd080256f2a004937ed/00c40b58ce773d5e80257f3700390f65/$FILE/ACE%20Infograph%20FINAL%20(E).pdf)

London Borough Barking and Dagenham	151 offences
London Borough Havering	141 offences
London Borough Redbridge	146 offences

Source: Metropolitan Police Crime Data Dashboard

National evidence and those who work within our Youth Offending Services report that those who are involved with serious violent crime across the board have experienced 4 or more ACEs in childhood.

Ensuring a focus on ACEs within BHR has huge potential for change. This could in turn both help improve outcomes and reduce demand for health services.

3.6 What is the best practice for mitigating the impacts of Adverse Childhood Experiences?

Mitigating some of the impact of ACE's can be done through existing services such as health visiting - our local health visiting services are good examples of local best practice of working with mothers and families directly to build resilience. In addition to this, there are both national and international examples of further work on ACEs.

Blackburn and Darwen Borough Council have adopted an ACE assessment that was developed and robustly tested in the United States. It provides an evidence-based assessment of the impact of childhood trauma such as emotional and sexual abuse and physical and emotional neglect. These studies led Blackburn and Darwen to develop the Routine Enquiry about Adversity in Childhood (REACH) screening tool to enable practitioners to identify adults with high ACE scores who have experienced multiple adverse experiences, which may lead to not only poor health and social outcomes but also to higher risks of exposing their own children to adverse experiences¹⁰.

Liverpool John Moores University have published a report entitled: *Routine Enquiry about Adverse Childhood Experiences Implementation pack pilot evaluation (May 2018)*. It states that in 2016 the Department of Health commissioned Lancashire Care NHS Foundation Trust to implement a pathfinder project to develop a standalone Implementation Pack to support services in developing, implementing and embedding REACH (highlighted above), and to pilot its use across 3 services in North West England (pilot sites)¹¹.

For those who have experienced ACES, trauma-informed care also provides the opportunity to mitigate the impact of trauma and helps survivors to rebuild a sense of control and empowerment. Trauma-informed care means that services take into consideration the impact of trauma of individuals and behaviours, so for instance services being designed with an awareness that trauma has wide-ranging impacts on individuals and can affect their behaviour and responses.

In addition to the serious violence summit that was held in Barking and Dagenham, CSP have commissioned community and voluntary organisations to deliver trauma informed positive diversionary activities to children and young people. This would support the links to the CSP, and professionals can refer to these programmes. This

increases the range of services available to young people that offer a trauma informed response. It is worth noting that Havering and Redbridge are also planning the next summits to keep the conversations going across the boroughs and partnership boards. Redbridge will be leading on the next summit in the summer of this year.

3.7 Priority 2: Adverse Childhood Experiences: Key areas for discussion

Given the evidence above, the Children and Young People's Transformation Board are asked to consider:

How we can increase awareness of ACEs within staff across our health and care system?

For instance, would partners on the Children and Young People's Transformation Board sign up to, offering training to all staff on ACEs and their impacts?

If so, there is a number of useful resources that could be used: the section above in this paper on ACEs could be used as a resource to staff across BHR; BHR public health staff also have a presentation on ACEs. There is also a range of useful resources online, including this video from Public Health Wales <https://vimeo.com/189604325>.

In addition, within local authorities and local Community Safety Partnerships there is ongoing work on ACEs that we can learn from within health and care. For instance, Barking and Dagenham Domestic Violence Commissioning have been working on bids for funds to train people across partners and opened this up to elements of health. The Barking and Dagenham Community Safety Partnership have also just secured funding for ACEs specific training which improves behaviours. The training provides knowledge on how this impacts the brain and the body after prolonged trauma from ACE's. In this light, there may be learnings and evaluations that we can benefit from across all three local authorities and Community Safety Partnerships.

Screening tool – Would it be possible to implement an ACE screening tool across BHR health and care systems? How would we use this screening tool to make sure that it was both safe and effective? What would the role of the screening tool be and what would the changes to services be?

Identifying those with ACEs provides the opportunity to offer them targeted interventions. How could we work with partners (including education) to implement and share an ACE screening tool?

How can we link ACEs into work being done in the borough on Making Every Contact Count (MECC)?

Work is already being done across BHR on MECC. Would this be an enabler to improving experiences of those with ACEs.

How can we ensure that the action taken by the Children and Young People's Transformation Board, and key health and care partners, are linked up to the Community Safety Partnerships' work on ACEs and referral pathways to trauma-informed care models?

The first tri-borough Serious Violence Summit for BHR took place in Dagenham on Wednesday 16th January with key partners across the three boroughs. Future tri-

borough summits are due to take place in Havering and Redbridge. Working with our local Community Safety Partnerships and through these forums could provide the opportunity to discuss a cross-organisation approach to ACEs.

4.0 Priority 3: Special Educational Needs and/or Disabilities (SEND)

4.1 Why is focusing on SEND important?

A number of recent studies have shown that a 'hidden majority' of adults identified in childhood as having a learning disability are not identified as such within health and social care services. The studies analysed data from the Understanding Society Survey which follows the lives of 40,000 UK households to provide valuable evidence about 21st century life. The survey collects information from more than 20,000 adults aged 16-49 years about many aspects of their lives, including their health and the wider social determinants.

Pervasive socio-economic inequalities are experienced by people with learning disabilities, who are less likely to be 'doing alright' financially or 'living comfortably', are less likely to be employed for 16 hours or more each week, live in an affluent neighbourhood, feel safe outside in the dark, have two or more close friends or go out socially. People with learning disabilities were also more likely to have experienced threatened or actual violence and being a victim of hate crime. The poorer health of people with learning disabilities can therefore consistently be accounted for by differences in social determinants.

Further evidence shows that there are a range of ways in which disability links to health and the wider determinants of health and links to poorer outcomes:

- Disabled people remain significantly less likely to be in employment than non-disabled people
- Disabled people are around 3 times less likely to hold a degree level qualification
- Around 19.2% of working age disabled people do not hold any formal qualification
- National employment rate for disabled people is 45%, equating to a 30% gap between employment rate for disabled and non-disabled people.²⁰

Working across an integrated health and care system provides the opportunity to improve these poor outcomes.

4.2 Learning disabilities and autism

A section of the newly published NHS Long Term plan focuses on learning disability and autism. It also makes a commitment for the whole NHS to improve its understanding of the needs of people with learning disabilities and autism and work together to improve their health and wellbeing. Sustainability and Transformation Partnerships (STPs) and integrated care systems (ICS) will be expected to make sure all local healthcare providers are making reasonable adjustments to support people with a learning disability or autism.

²⁰ Public Health Matters (2016) 'Health inequalities and the hidden majority of adults with learning disabilities' - <https://publichealthmatters.blog.gov.uk/2016/10/04/health-inequalities-and-the-hidden-majority-of-adults-with-learning-disabilities/>

The three local authorities in BHR have different populations, and the evidence below provides some brief information about SEND:

Information from Public Health England shows that the levels of children with learning disabilities, known to schools, varies across the three boroughs:²¹

London average	23 per 1000
England average	33.9 per 1000
Barking and Dagenham average	37.7 per 1000
Havering average	31.1 per 1000
Redbridge average	26.2 per 1000

This highlights that all three boroughs have higher rates of children with learning disabilities known to schools than London averages. **Barking and Dagenham is the only local authority within BHR to have higher levels of children with learning disabilities known to schools higher than the England average.**

The Department of Education also publish annual data on the percentage of pupils with statements or EHC plans:

- Barking and Dagenham – 2.5%**
- Havering – 2.5%**
- Redbridge – 2.5%²²**

Both the London and outer London average is 3% of pupils, so as well as having higher than average rates of children with learning disabilities known to schools, the percentage of pupils with statements or EHC plans is lower than the London average.

4.3 What is the best practice around SEND?

Involving disabled people, their families and organisations’ groups in decision making – Integrated Personal Commissioning (IPC) looks to involve patients in their own care and is based on 5 key shifts in people’s experience of care as shown in the diagram below:²³



²¹ Public Health England, Fingertips data on learning disabilities - <https://fingertips.phe.org.uk/profile/learning-disabilities>

²² <https://www.gov.uk/government/statistics/statements-of-sen-and-ehc-plans-england-2018>

²³ <https://www.england.nhs.uk/ipc/what-is-integrated-personal-commissioning-ipc/>

NICE guidelines recommend that those with possible autism who are referred to an autism team for a diagnostic assessment have the diagnostic assessment started within 3 months of their referral, and that those who have a diagnostic assessment for autism are also assessed for co-existing physical health conditions and mental health problems. People with autism should have a personalised plan.²⁴

The programme is a partnership with the LGA and NHS England and has been working to integrate health, care and education services around people rather than organisations. There are strong indications that when individuals take part in designing their care, they have a better experience with improved outcomes and more efficient use of limited resources. IPC sites across the country are taking different approaches, with the programme operating across the whole of England by 2020. Although none of the current Integrated Personal Commissioning areas are within BHR, Tower Hamlets and Islington are both IPC areas. SEND is one of four priority areas that Tower Hamlets are focusing on. The focus in Tower Hamlets has been working with these cohorts to find out what they think of current services, the integration between health and social care, and improving care partners.

4.4 Best Practice within BHR

Working with individuals to design their care has started in BHR. Barking and Dagenham has a strong track record of supporting children and young people with SEND inclusively in local mainstream education settings wherever possible and appropriate to their needs, building on the key aims of the borough's 'Inclusive Framework Strategy for Children and Young People with SEND'. These aims include to enable the best possible outcomes for all children and young people with SEND; and the provision of local education and training with high quality support, mainstream where appropriate.

As part of the work for a new upcoming SEND and Inclusion Strategy, a consultation was carried out and has identified some key areas supported by parents of those with SEND:

- Develop more local specialist provision in BHR to meet the needs of our children and young people
- Promote independence for children, young people and their families
- Prepare young people with SEND for adulthood which includes appropriate training, employment and leisure opportunities
- Develop the capacity of therapies (especially Speech and Language) to meet demand
- Provide better support for children and young people with health issues (including mental health)
- Ensure good progress and outcomes for children and young people with SEND in their educational setting from their relevant starting points
- Keep children, young people and their families involved in the planning and designing of provision.

A consultation took place with headteachers, SENCO's, school governors, local authority staff, social care colleagues, health colleagues, nurseries, pre-schools,

²⁴ <https://www.nice.org.uk/guidance/qs51>

educational psychologists, commissioners and young people, with a positive response.²⁵

4.5 National best practice examples

SEND is a wide-ranging area, but there are a number of national examples in a variety of areas that can help to guide discussions about how we can transform the BHR system.

In terms of building resilience for those children and young people with mental health problems, there are examples of good practice. Devon has a programme called Early Help 4 Mental Health. The prevention and early intervention programme focus is on culture change. The programme is carried out in schools and the aim is to build mentally healthy behaviours and resilience. The programme was initiated after Devon received an inadequate judgement by Ofsted. The targeted prevention and interventions to support the mental health of children and young people between 11-18 years was aimed at young people who are vulnerable and whose mental health is beginning to deteriorate. The programme has demonstrated real value and improvements in children's emotional wellbeing. A rigorous performance management and reporting system was created which provides detailed data relating to outcome measures being used by providers, set into contracting arrangement. Devon captures this information through:

- Measuring the impact of the direct support offer; by using YP-Core tool which measures emotional wellbeing following individual counselling sessions
- Introducing a goal-based outcome measure where young people create their own goal and then score to what extent they feel they are achieving this intervention.

In a report entitled: Developing and sustaining an effective local SEND system published by the Local Government Association (2018) the following four areas of good practice for local SEND systems are identified: **taking a pro-active, evidence-informed, strategic approach to shaping local support, services and provision** emphasises the importance of gathering and triangulating data, intelligence and feedback, and using this to inform discussions with partners and stakeholders, as well as individual young people and families, about the shape of local support and services.

Developing co-productive relationships shows that local SEND systems should include many different partners, organisations and sets of interests and responsibilities. Getting it right in supporting young people with SEND effectively is not something that any one organisation or agency, support group or provider can achieve on their own. Meaningful partnerships, based on a shared appreciating of the context and challenges, and with solutions developed through co-productive working are crucial to effective operation of local SEND systems.

Effective processes and routines identify the need to consider the multi-faceted nature of local SEND systems and therefore that consistent practice in identifying needs, putting in place support, reviewing support plans, planning for young people's progression which is crucial in enabling young people with SEND to make the most of their education and childhood and pursue their aspirations as they move into adulthood. This is not about having a "one-size-fits-all" approach, it is about

²⁵ Internal work on SEND from Education Team, led by Joy Barter

established mechanisms that enable professionals to be pro-active, creative and person-centred when working with young people with SEND and their families.

Focusing on long-term outcomes consists of the need for a joined-up, coherent approach to preparing young people for adulthood from their earliest years. Too often, it was highlighted within this report that what goes under the banner of “transition planning” is simply preparing the young person for their next placement, rather than something focused on the young person’s long-term goals. Within local SEND systems, a focus on specific outcomes for young people needs to be at the heart of system-level commissioning decisions as well as individual support for young people and their families.

Although not an example of best practice as such, the 0-25 SEND code of practice: a guide for health professionals, provides advice for clinical commissioning groups, health professionals and local authorities (February 2016). This was published by the Department for Education and the Department of Health shows that for too long, health was the missing partner in the SEND system. However, the SEND reforms introduced by the Children and Families Act 2014 aimed to change that with a focus on two key themes: greater co-operation between education, health and social care and a greater focus on the outcomes which will make a real difference to how a child or young person lives their life.

Echoing the ideas for integrated personal commissioning, the report shows that partners must engage children and young people with SEND and children’s parents in commissioning decisions. Local authorities, CCGs and NHS England should develop effective ways of harnessing views of their local communities so that commissioning decisions on services for those with SEND are shaped by users’ experiences, ambitions and expectations. To do this, local authorities, CCGs and health professionals should engage with local Healthwatch organisations, patient representative groups, Parent Carer Forums, groups representing young people with SEND or disabilities and other local voluntary organisations and community groups.

4.6 Priority 3: SEND: Key areas for discussion

Given the above, the Children and Young People’s Transformation Board are asked to consider:

What co-production of services, and involvement in service planning and care with SEND service users currently exists across BHR? How could this be strengthened? The new GMS contract includes provision for physiotherapists that needs to be considered in this too.

For our CAMHS service, what are the quick wins to create a service that improves outcomes for residents and saves our system money?

Speech and language is a key priority area for SEND and has substantial impacts for the rest of life. What are the barriers to speech and language services? within BHR? How can partnership working help to improve this?

Service provision in relation to SEND varies across the three local authority boundaries – residents’ experience will be dependent on the borough in which they live. With this in mind, are there opportunities for joint commissioning in these areas?

5.0 Points for discussion

To summarise the points for discussion within each priority theme, The Children and Young People's Transformation Board are recommended to discuss:

How can we increase awareness of ACEs within staff across our health and care system?

Screening tool – Would it be possible to implement an ACE screening tool across the BHR health and care systems?

How can we link ACEs into work being done in the borough on MECC?

How can we ensure that the action taken by the Children and Young People's Transformation Board, and key health and care partners, are linked up to the Community Safety Partnerships' work on ACEs?

What co-production of services, and involvement in service planning and care with SEND service users currently exists across BHR? How could this be strengthened?

For our CAMHS service, what are the quick wins to create a service that improves outcomes for residents and saves our system money?

5.1 General points for discussion

Across the three priorities: what are the next steps and 'quick wins' in these above areas?

Should BHR express an interest in working with the What Works in Children's Social Care?

What opportunities are there for Joint Commissioning in these three areas across the boroughs?

Given the increase in the number of pupils with special needs in mainstream schools, should the board consider commissioning more Specialist School Nurses for mainstream schools?

6.0 Integration

- 6.1 As a partnership document across BHR, the Children and Young People's Transformation Board – Best Practice Evidence Review outlines the importance of focusing on the three priority areas to support the key health outcomes for children and young people.

7.0 Financial Implications

Implications completed by Murad Khan, Group Finance Manager:

- 7.1 This report is mainly for information and sets out to provide the Health and Wellbeing Board the evidence base required for best practice in three key priority areas of Best Start in Life, Adverse Childhood Experiences (ACEs) and Special Educational Needs and/or Disabilities (SEND). As such, there are no financial implications arising directly from the report.

8.0 Legal Implications

Implications completed by Dr. Paul Feild Senior Governance Lawyer

- 8.1** This is an information and discussion item. The Health and Social Care Act 2012 conferred the responsibility for health improvement to local authorities. In addition, as a best value authority under the Local Government Act 1999 there is a duty on the Council to secure continuous improvement. The Health and Well-Being Board terms of reference established its function to ensure that the providers of health and social care services work in their delivery in an integrated manner. The report from Barking Havering Redbridge (BHR) Children's and Young People's Transformation Board highlights three priority areas for young people being Best Start in Life, Adverse Childhood Experiences (ACEs) and Special Educational Needs and/or Disabilities (SEND). These strategic areas of focus were chosen by the Joint Commissioning Board because of their potential to significantly improve health outcomes for children and young people living in BHR. For each of these priority areas, the purpose of this report is to outline why this is an important area of focus for BHR, by including some headline BHR data and national and international best practice for interventions in these areas.

Public Background Papers Used in the Preparation of the Report:

None.

List of Appendices

None.