

ARCHIVE DOCUMENT

This document was republished in 2017 with **updates to the Demography and National Child Measurement Programme sections.**

For the latest document, go to: thurrock.gov.uk/jsna

Thurrock

Joint Strategic Needs Assessment

Children and Young People

Key Contact:

Maria Payne, Health Needs Assessment Manager, Public Health Team –
publichealth@thurrock.gov.uk / 01375 652626

Contents

Executive Summary	10
Introduction.....	13
Purpose/Aims/Objectives.....	13
1. Demographics.....	14
What do children and young people think about their health?	17
2. Being Healthy.....	19
Breastfeeding	19
What do we know?.....	19
What are we doing in Thurrock?	22
Recommendations.....	23
Low Birth Weight.....	23
What do we know?.....	24
What are we doing in Thurrock?	24
Recommendations.....	25
Healthy Weight.....	25
What do we know?.....	28
What are we doing in Thurrock?	34
Recommendations.....	36
Oral Health.....	37
What do we know?.....	37
What are we doing in Thurrock?	40
Recommendations.....	41
Immunisations and Screening	41
What do we know?.....	42
What are we doing in Thurrock?	49
Recommendations.....	49
Sexual Health.....	49
What do we know?.....	51
What are we doing in Thurrock?	52
Recommendations.....	53
Teenage Pregnancy	53
What do we know?.....	54
What are we doing in Thurrock?	57

Recommendations.....	58
Smoking	58
Smoking in Children and Young People.....	58
What do we know?.....	61
Smoking in pregnancy	61
What do we know?.....	62
What are we doing in Thurrock?	63
Recommendations.....	64
Substance Misuse	64
What do we know?.....	65
What are we doing in Thurrock?	68
Recommendations.....	69
Long Term Conditions.....	69
What do we know?.....	70
What are we doing in Thurrock?	74
Recommendations.....	75
Mental Health.....	75
What do we know?.....	76
What are we doing in Thurrock?	82
Recommendations.....	87
3. Staying Safe	88
Children In Need.....	88
What do we know?.....	89
What are we doing in Thurrock?	91
Recommendations.....	95
Children subject to a Child Protection Plan.....	95
What do we know?.....	97
What are we doing in Thurrock?	98
Recommendations.....	100
Looked After Children.....	100
What do we know?.....	102
What are we doing in Thurrock?	105
Recommendations.....	106
Children With Disabilities	108

What do we know?.....	108
What are we doing in Thurrock?	109
Recommendations.....	111
Children with Special Educational Needs	111
What do we know?.....	112
What are we doing in Thurrock?	113
Recommendations.....	116
Young Carers.....	116
What do we know?.....	117
What are we doing in Thurrock?	117
Recommendations.....	118
Gypsy, Roma and Traveller Children	118
What do we know?.....	119
What are we doing in Thurrock?	119
Recommendations.....	120
Young Offenders.....	120
What do we know?.....	121
What are we doing in Thurrock?	125
Recommendations.....	126
Children experiencing sexual violence	126
What do we know?.....	126
What are we doing in Thurrock?	128
Recommendations.....	128
Accidental Injury and Death	128
Infant and Child Mortality	128
What do we know?.....	129
What are we doing in Thurrock?	131
Recommendations.....	131
Childhood Injuries and Accidents	132
What do we know?.....	132
What are we doing in Thurrock?	135
Recommendations.....	136
4. Enjoying and Achieving.....	137
School Readiness	137

What do we know?.....	137
What are we doing in Thurrock?	139
Recommendations.....	140
School Attendance.....	140
What do we know?.....	141
What are we doing in Thurrock?	143
Recommendations.....	144
Educational Attainment.....	144
What do we know?.....	146
What are we doing in Thurrock?	152
Recommendations.....	153
5. Making a Positive Contribution	154
What do we know?.....	154
What are we doing in Thurrock?	155
Recommendations.....	156
6. Achieving Economic Wellbeing.....	157
Low Income Families and Child Poverty	157
What do we know?.....	158
What are we doing in Thurrock?	160
Recommendations.....	161
Further Education, Employment or Training.....	161
What do we know?.....	162
What are we doing in Thurrock?	164
Recommendations.....	165
Appendix 1: References.....	166
Appendix 2: Glossary of Terms.....	171
Appendix 3: Document Contributors	174
Appendix 4: Version Control.....	176

Figure 1: Percentage of total population by single year of age, 0-19 year olds.....	14
Figure 2: Population projections 2012-2037	15
Figure 3: Population Distribution for people aged under 15 years by LSOA.....	15
Figure 4: Ethnicity of 0-17 population and all age population in Thurrock.....	16
Figure 5: Ethnicity of our school aged population by ward.....	16
Figure 6: Breastfeeding Initiation in Thurrock, East of England and England, 2010/11-2012/13.....	19

Figure 7: Breastfeeding prevalence at 6-8 weeks in Thurrock, East of England and England.....	20
Figure 8: Breastfeeding Status at 6-8 weeks for Thurrock	21
Figure 9: Breastfeeding Status at 6-8 weeks for England.....	21
Figure 10: % of infants totally or partially breastfed at 6-8 weeks at GP practice level for Quarters 1-3 combined, 2013-14.....	21
Figure 11: Percentage of Low Birth Weight Births (all live and still births) in Thurrock Wards, 2007-11..	24
Figure 12: Tier Pathway, costs estimated per person based on commissioned services 2012/13	26
Figure 13: Obesity prevalence in Reception-aged children from 2006/07–2014/15 for Thurrock and East of England.	29
Figure 14: Weight Categories for Reception-aged children, 2014/15.....	29
Figure 15: Obesity prevalence across Thurrock in Reception-aged children, 2011-14.....	30
Figure 16: Obesity prevalence in Year 6-aged children from 2006/-7–2014/15 for Thurrock and East of England.	31
Figure 17: Weight Categories for Year 6-aged children, 2014/15.....	31
Figure 18: Obesity prevalence across Thurrock in Year 6-aged children, 2011-14	32
Figure 19: Correlation between obesity prevalence and IMD in Reception-aged children	33
Figure 20: Correlation between obesity prevalence and IMD in Year 6-aged children	33
Figure 21: Percentage of five year olds across Essex with experience of dental decay 2007/8	38
Figure 22: Percentage of 12 year olds across Essex with experience of dental decay 2008/09	39
Figure 23: Average number of decayed, missing and filled deciduous teeth (d3mft) in 5-year-olds and permanent teeth (D3MFT) in 12-year-olds, 2007/08 and 2008/09.	39
Figure 24: Percentage of 0-19 year old children admitted to hospital for extractions in Thurrock, East of England and England, 2012/13.....	40
Figure 25: Routine Childhood Immunisations from summer 2014	42
Figure 26: Uptake of childhood vaccinations in Thurrock, East of England and England, 2012-13	43
Figure 27: DTaP/IPV/Hib Year 1 Uptake by Thurrock GP practice for 2012-2013.....	44
Figure 28: Year 2 Pneumococcal coverage by Thurrock GP practice for 2012-2013	44
Figure 29: Hib/MenC Year 2 uptake by Thurrock GP practice for 2012-2013.....	45
Figure 30: MMR Year 2 coverage per GP practice for 2012-2013.....	46
Figure 31: Pre-school booster Immunisation uptake children aged 5, 2012-13	46
Figure 32: MMR Booster Year 5 uptake by Thurrock GP practice for 2012-2013.....	47
Figure 33: HPV coverage of all three doses for 2012-2013 for 12 to 13 year old females by school.	48
Figure 34: Influences on Safer Sex Practice.....	50
Figure 35: Key Objectives: A Framework for Sexual Health Improvement in England, 2013	51
Figure 36: Under 18 conception rates in Thurrock, East of England and England, 1998-2012.....	55
Figure 37: Percentage of under 18 conceptions leading to abortions in Thurrock, East of England and England, 1998-2012.....	56
Figure 38: Under 16 conception rates in Thurrock, East of England and England, 2009-2012.....	57
Figure 39: Age at which smokers started smoking regularly, 2011.....	59
Figure 40: Women who smoked before or during pregnancy, by socio-economic group.....	62
Figure 41: Women who smoked before or during pregnancy, by age group	62
Figure 42: Percentage of mothers smoking at time of delivery in Thurrock, East of England and England, 2010/11-2013/14	63
Figure 43: The age of young people entering treatment services in Thurrock in 2012/13.....	65

Figure 44: Young people entering treatment services in 2012/13 in Thurrock and England by substance type.....	66
Figure 45: Risk Harm Profile of young people entering treatment in Thurrock, Comparator Areas and England, 2012/13.....	67
Figure 46: Types of substance misuse interventions accessed by young people in Thurrock and England, 2012-13.....	68
Figure 47: Unplanned Hospitalisation in Thurrock CCG and England for Asthma, Diabetes and Epilepsy in under 19s, 2010/11-2012/13.	70
Figure 48: Emergency hospital admissions for asthma for children under 19 in Thurrock and England, 2009/10-2012/13.	71
Figure 49: Emergency hospital admissions for epilepsy for children under 19 in Thurrock and England, 2009/10-2012/13.	72
Figure 50: Emergency hospital admissions for diabetes for children under 19 in Thurrock and England, 2009/10-2012/13.	73
Figure 51: The range of CAMHS services delivered in Thurrock, 2014	83
Figure 52: Proposed model of the Children and Young People's Emotional Wellbeing and Mental Health Service for Southend, Essex and Thurrock	86
Figure 53: Royal College of Psychiatry workforce recommendations and actual numbers of Tier 2 and 3 staff.....	87
Figure 54: Referrals per month in Thurrock in 2014/15 and 2013/14	89
Figure 55: % of referrals that are repeat referrals per month in Thurrock in 2014/15 and 2013/14	89
Figure 56: Volume of assessments completed per month.....	90
Figure 57: Proportion of assessments completed within 45 working days	90
Figure 58: Rate per 10,000 of section 47 enquiries undertaken	97
Figure 59: Rate per 10,000 of children subject to a Child Protection Plan	98
Figure 60: Children subject to a Child Protection plan in Thurrock by category of abuse, 2014	98
Figure 61: Primary Need for a service, England as of 31st March 2013.....	101
Figure 62: Age Profile of Looked After Children in Thurrock, June 2014	103
Figure 63: Ethnicity of Looked After Children in Thurrock, 2012 and 2014.	103
Figure 64: Percentage of pupils with SEN in Thurrock, East of England and England, 2014.....	113
Figure 65: Offences in Thurrock in 2013/14 by ethnic group.....	122
Figure 66: Assessed Risk Factors in Young Offenders in Thurrock, 2013-14.....	123
Figure 67: Number of young people (13-21 or <25 with learning disabilities) accessing specialist sexual violence services in Thurrock, 2011/12 to 2013/14.	127
Figure 68: Breakdown of young people (13-21 or <25 with learning disabilities) accessing specialist sexual violence services in Thurrock by ward 2013/14.....	127
Figure 69: Infant Mortality in Thurrock, East of England and England, 2001-03 – 2010-12	129
Figure 70: Crude Death Rate per 100,000 population aged 0-17 years, 2008-2014.....	130
Figure 71: Number of A & E admissions for 0 – 19 years by MSA in Thurrock, April 2012-March 2014	135
Figure 72: Percentage of children achieving a Good Level of Development in Thurrock and England ...	138
Figure 73: Percentage of children achieving a Good Level of Development in Thurrock and England by gender.....	138
Figure 74: Fixed term exclusions in Thurrock and England primary schools, 2006-2013	143
Figure 75: Fixed term exclusions in Thurrock and England secondary schools, 2006-2013	143

Figure 76: Attainment gap from age 11 to age 19 by eligibility for free school meals, 2012-13	145
Figure 77: Percentage of pupils achieving a level 2B or above in Reading, 2011-2014	146
Figure 78: Percentage of pupils achieving a level 2B or above in Writing, 2011-2014	147
Figure 79: Percentage of pupils achieving a level 2B or above in Maths, 2011-2014	147
Figure 80: Variation by Free School Meal eligibility in Thurrock and England, 2008-2013.....	148
Figure 81: Percentage of pupils achieving a level 4 or above in Reading, 2012-2014	148
Figure 82: Percentage of pupils achieving a level 4 or above in Writing, 2012-2014	149
Figure 83: Percentage of pupils achieving a level 4 or above in Maths, 2012-2014	149
Figure 84: Variation by gender in Thurrock and England, 2008-2013.....	150
Figure 85: Percentage of pupils achieving 5 or more GCSE's at grades A*-C including English and Maths, 2010-2014.....	151
Figure 86: Percentage of pupils achieving AAB or above at A Level in Thurrock and England	152
Figure 87: Income Deprivation Affecting Children (IDACI) across Thurrock by LSOA, 2010	159
Figure 88: The percentage of 16-18 year olds who are not in education, employment or training in Thurrock, East of England and England, 2011-2013.....	162
Figure 89: Thurrock NEET young people by age and month, September 2013 to August 2014.....	163
Figure 90: Thurrock NEET young people by gender and month, January to August 2014.....	163
Figure 91: NEET young people and other vulnerabilities	164
Table 1: Summary of changes to national immunisation programmes for children in 2013/14	47
Table 2: Headline under 18 conception figures for Thurrock, East of England and England	54
Table 3: Headline under 16 conception figures for Thurrock, East of England and England	57
Table 4: Entrants into Thurrock treatment services in 2012/13 by source of referral.	66
Table 5: The length of time young people were in treatment services in Thurrock, 2012/13.	67
Table 6: Variation in prevalence of mental health disorders observed by Green et al (2004)	77
Table 7: Estimated number of children with mental health disorders in Thurrock by age and gender	78
Table 8: Expected number of children in Thurrock with mental health disorders by type, 2012.....	78
Table 9: Estimated number of children with learning disabilities who might experience mental health problems in Thurrock	79
Table 10: Estimated number of children with learning disabilities with mental health needs.....	79
Table 11: Estimated number of children in care who might have had mental health needs in Thurrock, 2012.....	80
Table 12: Estimated need for CAMHS services in Thurrock	84
Table 13: Children in Care in Thurrock and England, 2009-2015. Data as of 31st March each year.	102
Table 14: Age of Looked After Children in Thurrock and type of placement.....	104
Table 15: Nature of disabilities experienced by the 1399 previously known or open cases to Social Care, 1992-2014.....	108
Table 16: Statement of SEN by category of need.....	112
Table 17: Medical Referrals by year	115
Table 18: Offences in Thurrock in 2013/14 by age of offender	121
Table 19: Offences in Thurrock in 2013/14 by type of offence.....	121
Table 20: Summary of SET Local Child Death Review Activity 1st April 2008 – 31st March 2014	130
Table 21: Hospital Admissions in Thurrock and England.....	132

Table 22: Emergency admissions to children aged 0–19 years shown by primary diagnosis, 2012/13 and 2013/14	133
Table 23: Emergency admissions to children aged 0–19 years shown by incident location and age group, April 2012-March 2014.....	134
Table 24: Eligible children and children accessing early education in Thurrock, Spring 2013	139
Table 25: Summary of early education and childcare in Thurrock.....	139
Table 26: Percentage of Total and Persistent Absences at primary schools in Thurrock and comparators, 2008/09 – 2012/13.....	141
Table 27: Percentage of Total and Persistent Absences at secondary schools in Thurrock and comparators, 2009/10 – 2012/13.	142
Table 28: Children living in low income families, 2006-2012.....	158
Table 29: Employment Profile, 2012	159
Table 30: Factors leading to an increased chance of becoming NEET for 6 months or more.....	161

Executive Summary

Demography

1. Thurrock has a higher proportion of children and young people aged 0-19 years (26.84%) than the national average (23.9%).
2. The number of 0-19 year olds in Thurrock is set to increase to 50,500 by 2037.
3. Thurrock's younger population is more ethnically diverse than the all-age population, with areas to the west of the borough seeing the highest proportion of school-children from minority ethnic groups.

Being Healthy

1. Breastfeeding initiation in Thurrock has remained significantly lower than regional and national averages, with only 69.5% mothers initiating breastfeeding in 2012/13.
2. Data from 2014/15 indicates that 9.3% of reception-aged children and 21.3% of Year 6-aged children in Thurrock are obese – giving us a significantly higher proportion of Year 6-aged obese children than the national average.
3. Child oral health in Thurrock is fairly poor, and it is estimated that about 30% of children and young people in Thurrock have experience of tooth decay that can lead to pain and costly NHS procedures.
4. Although Thurrock exceeded the national target for vaccination of Year 1 DTaP/IPV/HiB, uptake is considerably lower than the national targets for Year 2 PCV, Year 2 MMR and Year 5 MMR.
5. Thurrock has a significantly lower rate of Chlamydia diagnoses than the national (2,016 per 100,000) and regional (1,719 per 100,000) averages.
6. Thurrock had a rate of 30.5 per 1,000 under 18 conceptions in 2012, which is similar to the national average, and has been decreasing.
7. 4% of Thurrock children in years 6, 8 and 10 usually smoke at least one cigarette per week, which was the same as the national average but higher than the regional average (3.4%).
8. The percentage of women smoking at time of delivery has decreased in recent years to 10.6% and is similar to the national average.
9. South West Essex has the highest number of children with sickle cell disorders in Essex, with an estimated 66.5% of all children with these disorders living in the South West of the county. Work is underway to review the existing sickle cell service to ensure needs are appropriately met.
10. It has been identified that further work needs to take place to meet the needs of children and young people with mental health disorders and problems in Thurrock, and plans are in place to deliver an integrated service known as the Children and Young People's Emotional Wellbeing and Mental Health Service (The CYP EWMH Service).

Staying Safe

1. Thurrock has a high rate of children subject to child protection plans, and it increased by 41% since 2012/13.
2. The number of Looked After Children in Thurrock has been increasing over recent years and is projected to increase further.
3. Thurrock has a higher proportion of pupils with SEN that have Statements than the regional or national averages.

4. As of September 2014, there are 462 Young Carers known to Thurrock Council's Young Carer services – 50 of whom are aged between 4-8 years.
5. The latest available data (2012) indicates that Thurrock may have a slightly higher prevalence of Gypsy, Roma and Traveller children than the national average (0.3% compared to 0.2%).
6. Due to high migration from the London Boroughs Thurrock YOS is supervising a number of young people who have links to serious youth violence and gangs.
7. The number of young people accessing services for sexual violence has increased to 130 in 2013/14 (2012/13 figure was 97); however research indicates that the need remains higher than this.
8. The rate of infant mortality in Thurrock is significantly lower than regional and national averages.
9. Emergency hospital admissions for children in Thurrock have increased by 18.9% between 2012/13 and 2013/14.
10. Thurrock has recently launched a Multi Agency Safeguarding Hub (MASH) which brings together representatives from numerous different organisations in order to share relevant information and work together to safeguard vulnerable children and young people.

Enjoying and Achieving

1. 66% of Thurrock's reception-aged children achieved a 'Good Level of Development' in their Early Years Foundation Stage in 2014, which is 6% higher than the national average.
2. School attendance has been improving in both primary and secondary schools, with Thurrock having similar levels of absence to regional and national averages.
3. Fixed-term exclusions have been decreasing in both primary and secondary schools, with Thurrock having lower levels of fixed-term exclusions in secondary schools than the national average.
4. The gender inequality observed in EYFS outcomes (14% difference) is dramatically reduced by Key Stage 2 – where the difference between male and female outcomes is only 8%.
5. 57.4% of pupils at the end of Key Stage 4 achieved five or more GCSEs at grade A*-C or equivalent including English and Maths in 2013/14. Thurrock is ranked 59th out of 151 authorities and is currently above the national average of 56.1%.

Making a Positive Contribution

1. Thurrock has two successful routes to enable young people to become involved in local democracy: the Youth Cabinet and the Children in Care Council. Members of these groups have been actively involved in local decision making and influencing policy, and encouraging other young people to get involved.
2. Work is underway to enhance the range of volunteering opportunities available to Thurrock young people, as the uptake of young volunteers is lower than the national average.

Achieving Economic Wellbeing

3. 20.0% of children in Thurrock are living in low income families, which is greater than the national average. Deprivation varies across the borough – one LSOA in Corringham and

Fobbing only has 3% of children living in poverty, whilst one LSOA in West Thurrock and South Stifford has 54% of its children living in poverty.

4. The proportion of young people aged 16-19 who are NEET (Not in Education, Employment or Training) has decreased in recent years to 5.4% and is now similar to regional and national averages.

Summary of Final Recommendations

- To reduce smoking in pregnancy targeted particularly within more deprived areas
- To offer more school based interventions and prevention programmes with a focus in secondary schools to ensure pupils know how to access advice and support about preventing and stopping smoking
- To work with children centres and schools to improve family diets and raise awareness about nutrition and access to more affordable food
- To work in partnership with schools around raising the awareness of the importance of increasing physical activities incorporating family programmes
- To look at the close proximity of takeaways to schools in Thurrock and work with food outlets within close proximity to schools to promote healthier options.
- To work with children centres and schools to educate parents and children on portion sizes
- To ensure consistent oral health messages (e.g. around the use of fluoride toothpaste, smoking cessation and diet) are delivered by health professionals and those working with children in children's centres and schools
- To ensure that services will be commissioned to ensure our young people are safe from sexual exploitation.
- To engage all secondary schools around sexual health education and promotion from the new school nursing service including flexible confidential drop-in services, specialist and up-to-date advice on sexual health
- To engage primary schools in appropriate early sex education
- To raise the profile of good mental health with children and young people to reduce stigma and health inequalities.
- To increase the ratio of foster caring enquiry to approval to 10% in 2014/15.
- To Identify which types of foster carers are specifically needed and target advertisements and information accordingly
To ensure that the mental health needs of children with SEND is addressed as part of the delivery of CAMHS services.
- To ensure new systems are in place to address the continued increase in migration from the London boroughs, especially in relation to the management of young people who have been involved in serious youth violence. Also to develop partnership working and form working relationships with the London boroughs
- To encourage parents of eligible two year olds to take up the offer of free childcare and early education.
- To look to minimise variation between schools in the borough to ensure all children and young people have access to high quality education
- To develop the next stage of Thurrock's response to child poverty by writing the new strategy for 2015-2018
- To focus on early intervention – strategies aimed at young people before the age of 16 years to prevent them from becoming NEET are likely to have the largest impact
- To develop strategies to address hidden harm for young people with the changing demographics of BME populations and migration of families from London.

Introduction

This Chapter provides an overview of the needs of children and young people in Thurrock. It demonstrates the various considerations that affect and define children's health, wellbeing and chances in life and looks at these in a national and local context.

Starting as early as pregnancy the mental health and health behaviour of a mother can have a substantial effect on the wellbeing of their unborn child. Socioeconomic status, parents' health, subjective wellbeing and education are all closely interconnected. The first five years establish an important foundation for their later wellbeing and is a particularly critical time for the development of social skills needed to contribute to future wellbeing. As the child continues to grow family relationships are an important predictor of children's wellbeing. Quality family time and good sibling relationships predicts higher levels of wellbeing and these children with positive family relationships go on to enjoy good relationships during their school life. Family relationships continue to be important during adolescence, although growing older often results in lower levels of wellbeing for both genders, reaching its lowest point in 14-15 year olds and then improving for 16-17 years as they become more independent and have greater choices in their lives.

Purpose/Aims/Objectives

The purpose of this document is to provide a comprehensive picture of the health and wellbeing needs of children and young people, now and in the future.

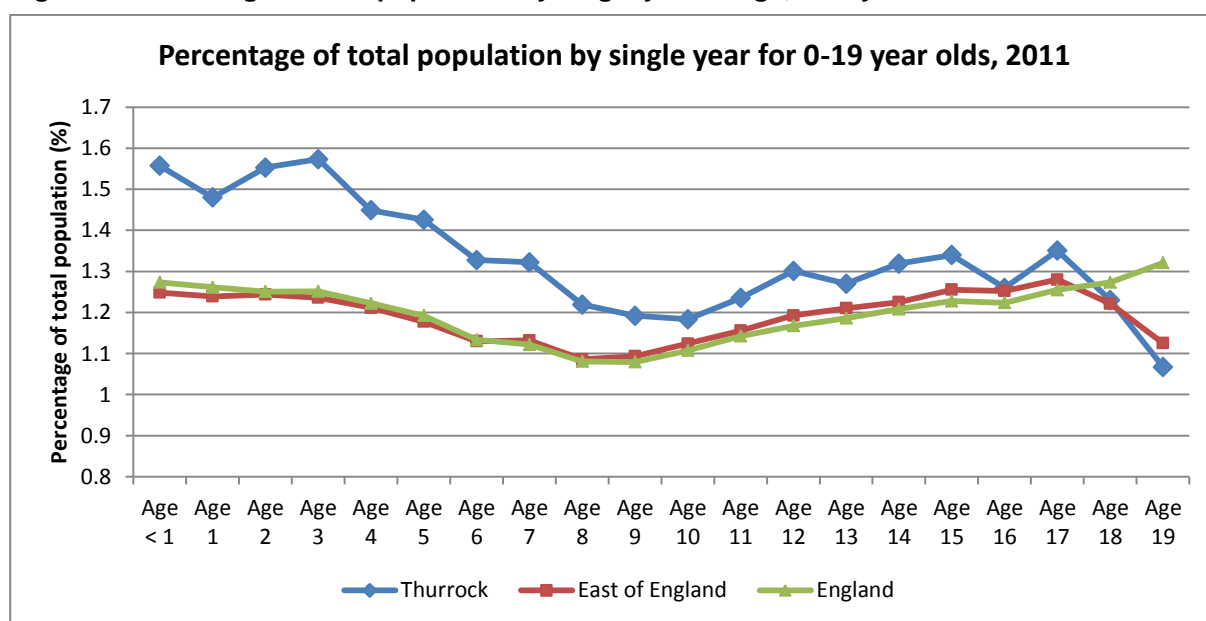
This report will help us:

- Understand the health and wellbeing needs and assets of children and young people in Thurrock.
- Benchmark against national standards and/or best practice
- Identify priorities for Thurrock's children and young people
- Review Thurrock's strategic plans
- Review existing evidence to establish the key determinants affecting children and young people's health and wellbeing
- Provide analysis of data to show health and social wellbeing status of children and young people
- Define and identify where inequalities exist and making recommendations for improvement
- Produce recommendations for the Health and Wellbeing Board
- Influence the commissioning of children's services

1. Demographics

Thurrock has a higher proportion of young people than the national average, with 26.84% of the Thurrock population aged between 0-19 years, compared to 23.9% of the national population being aged 0-19 years. Figure 1 compares the percentage of residents in Thurrock, East of England and England who are aged 0-19 years by single year, and shows Thurrock to have a higher proportion of young people for almost all ages than the regional and national averages. The proportion of those aged 17-19 decreases in Thurrock and East of England, but rises nationally.

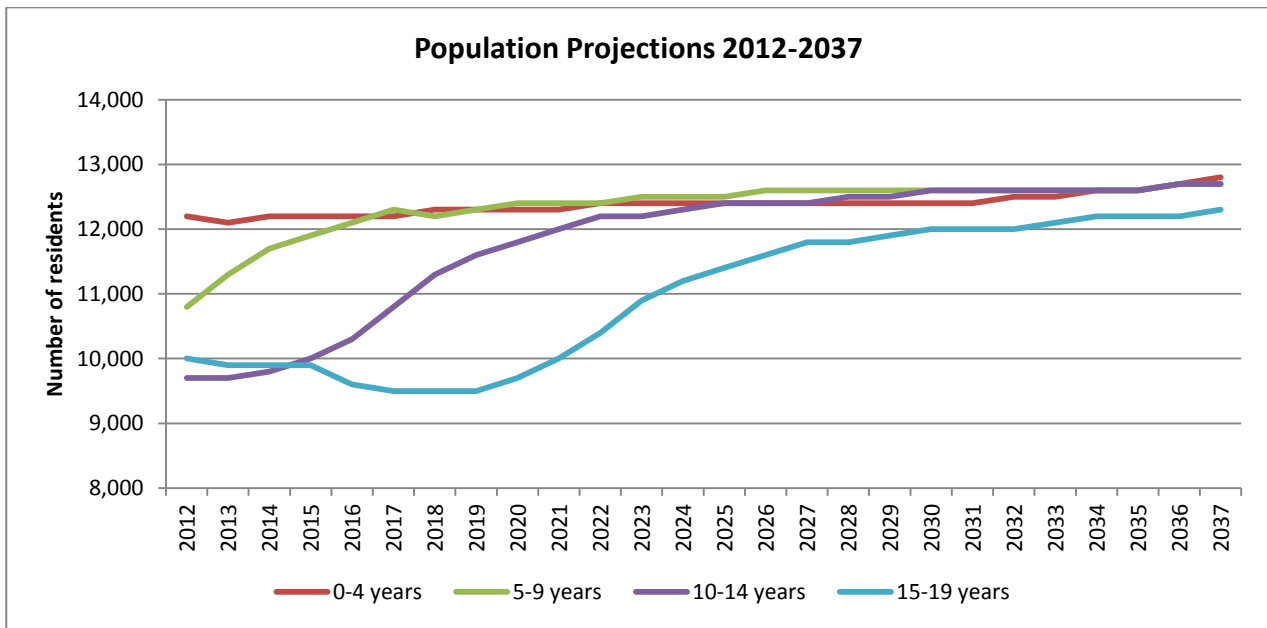
Figure 1: Percentage of total population by single year of age, 0-19 year olds



Source: ONS

According to ONS subnational population projections, the number of young people aged 0-19 years in Thurrock is going to increase from 42,700 in 2012, to 50,500 in 2037. When breaking this down by age group, Figure 2 shows that, other than a small decrease between 2015-2019 for 15-19 year olds, all age groups will see an increase up to 2037, with the largest increase seen in the 10-14 year old age group.

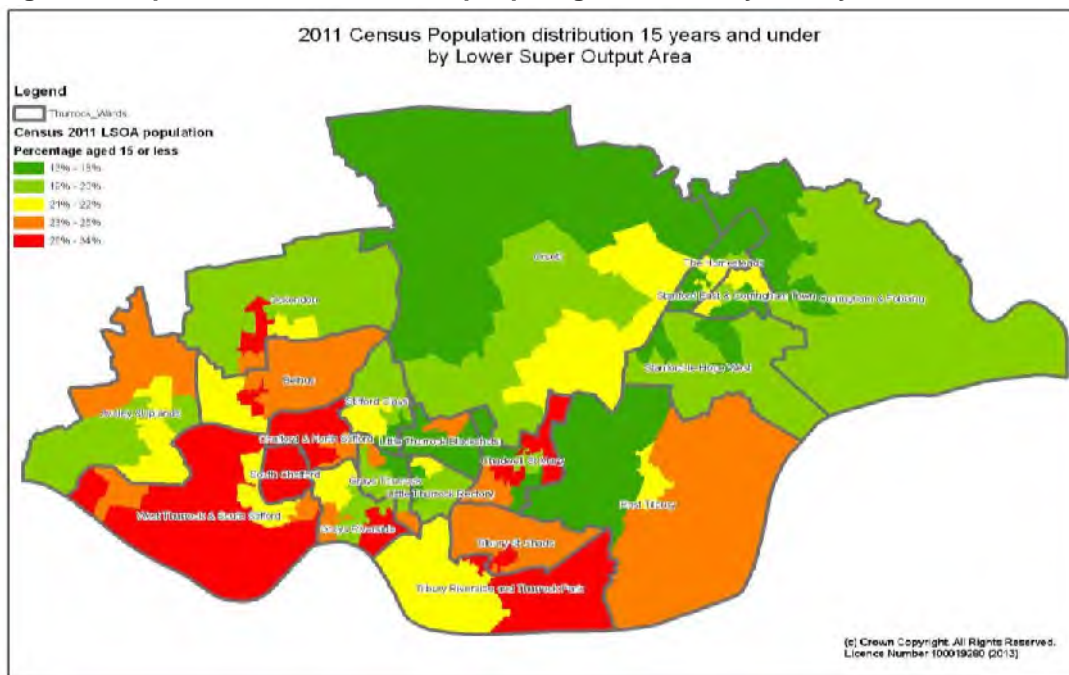
Figure 2: Population projections 2012-2037



Source: ONS, 2012 subnational population projections

Figure 3 illustrates that the areas with the highest percentage of under 15s in Thurrock are heavily clustered around the south and south west of the borough including the wards of Tilbury St. Chads, Chafford and North Stifford, South Chafford and West Thurrock and South Stifford where up to 34% of the population fall within this age group.

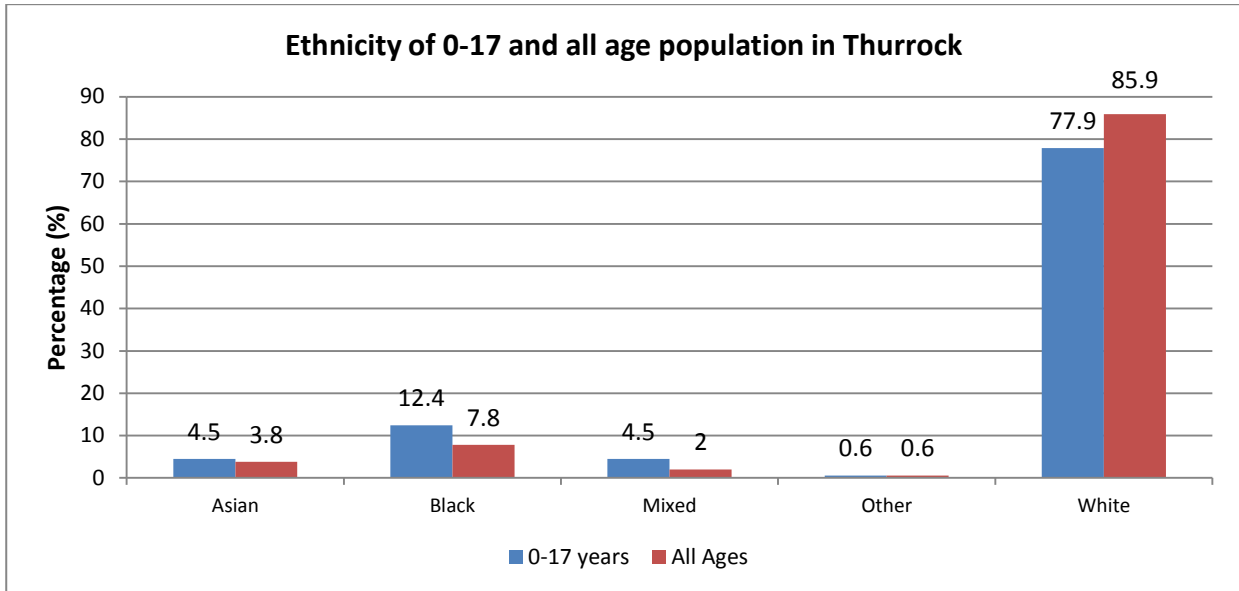
Figure 3: Population Distribution for people aged under 15 years by LSOA



Source: ONS

Our child population in Thurrock is more ethnically diverse than the all age population. Figure 4 below compares the ethnicity of the local population aged 0-17 years with the ethnicity of the total Thurrock population. From this, it can be seen that there is a lower proportion of White residents in the 0-17 population and a higher proportion of Asian, Black and Mixed ethnic groups.

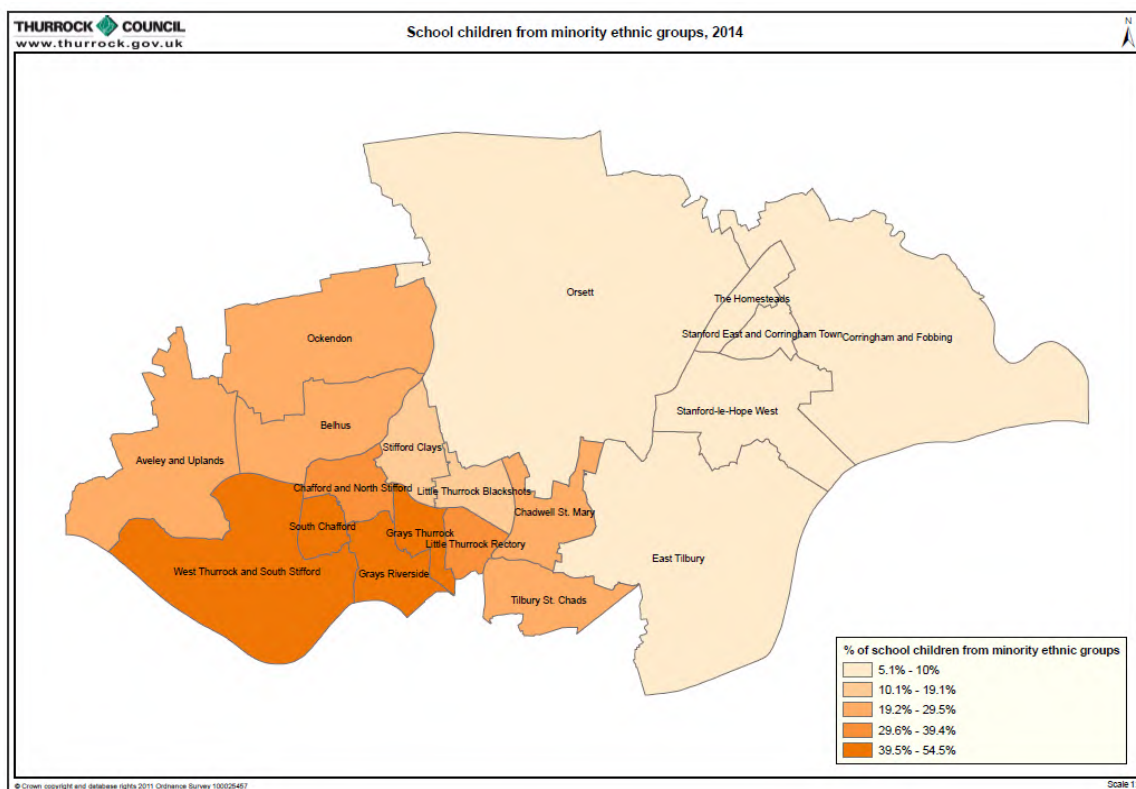
Figure 4: Ethnicity of 0-17 population and all age population in Thurrock



Source: Child and Maternal Health Intelligence Network

The ethnicity of our school aged population is captured within the School Census data, and shows there to be variation across the borough. Wards in the west of the borough have the highest proportion of school children from minority ethnic groups, with the highest proportion residing in Grays Riverside (54.5% of their child population), and the lowest proportion of children from minority ethnic groups living in Corringham and Fobbing (5.1%). There has been substantial inward migration into Thurrock from East London, so the higher proportions of children from minority ethnic groups is consistent with this expectation.

Figure 5: Ethnicity of our school aged population by ward



Source: Spring School Census data, 2014

Information on the variation in deprivation in children and young people in Thurrock can be found in the [Low Income Families and Child Poverty](#) section of the JSNA document.

What do children and young people think about their health?

When considering the provision of services for children and young people that aim to improve their health and wellbeing, it is important to ensure that the views of children and young people are incorporated into the decision-making process. Children and young people often struggle to get their voices heard despite numerous recommendations stating that services provided should reflect children and young people's views. There have been several national studies conducted aiming to highlight children and young people's views of services they receive. Some consistent themes emerge amongst the research:

- Children and young people often feel that professionals do not involve them in decisions about their care and support
- Poor communication or lack of information is often experienced – information needs to be child-friendly and enable them to understand how to access support and what that support will entail
- There is inconsistency in experiences of transition between services – transitions should be more carefully managed and planned in collaboration with young people and their families

In Thurrock, engagement with young people has been integral to shaping many of the services delivered to them. A local survey carried out in 2013 (HealthWatch Thurrock, 2013) with 420 young people aged 11-19 years asked what their biggest health and wellbeing concern was, and the top three answers were:

- Obesity and not getting enough exercise – young people said they would like to have more access to or cheaper exercise facilities.
- Diet - particularly takeaways and junk food were of concern and linked to the lack of affordability of healthy food.
- Idealistic images from magazines and peer pressure to be a certain size; linked to this was dieting at a young age and being underweight.

The Council's Children's Commissioning Team carried out some research in 2011 (Thurrock Council, 2011) with pupils in a selection of schools looking at what areas of help young people would like more of in the borough. They found that pupils in primary schools (Years 3-6) would value more help when they feel upset and aren't able to tell anyone, with boys also valuing additional help with staying healthy, and girls additional help with self-esteem issues. Amongst pupils in secondary schools, the top area was to provide more advice so that young people would not start using drugs, with alcohol prevention and bullying advice ranked highly also.

Another example of feedback gained from engaging with young people followed a survey to 93 pupils by the Public Health team in 2014 (Thurrock Council, 2014) which looked at the current school nursing service and how it might be delivered differently in the future. Young people said that they knew who their school nurse was, but not necessarily the services they offer or how to make an appointment. A large number of young people are aware that they can speak to their school nurse in confidence, and many felt the school nurse was approachable and friendly. This feedback has been used to inform the commissioning of a new school nursing service from September 2015.

Other examples where the views of local children and young people were sought to shape service redesign include:

- Future of pharmacy provision in Thurrock (part of the Pharmaceutical Needs Assessment process)
- Smoke-Free survey – to inform the Tobacco Control Strategy
- User feedback on current Sexual Health service provision

Research with children and young people should be a key point when considering proposals for change, and should form part of an evidence base for any major decision.

2. Being Healthy

Breastfeeding

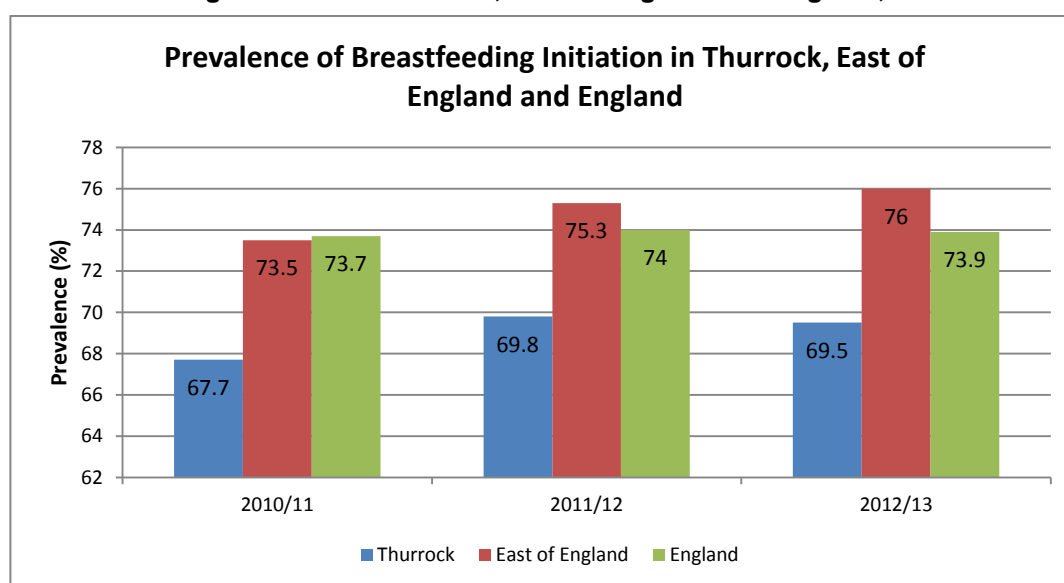
There has been significant reliable evidence produced over recent years to show that breastfeeding is a major contributor to public health and has an important role to play in reducing health inequalities even in the industrialised countries of the world. Breast milk is the best form of nutrition for infants and exclusive breastfeeding is recommended for the first six months (26 weeks) of an infant's life; additionally there is evidence that the longer the duration of breastfeeding, the greater the health benefits in later life. According to a review undertaken by the World Health Organisation in 2007, the available evidence suggests that breastfeeding has long term benefits such as lower blood pressure and lower total cholesterol for breastfed subjects, as well as a reduced prevalence of overweight/obesity and type 2 diabetes. There was also evidence to suggest breastfed subjects performed better in intelligence tests. Another review also looked at evidence for health outcomes for breastfeeding mothers, and found lactation to be associated with reduced risk for type 2 diabetes, breast and ovarian cancer. Early cessation of breastfeeding or not breastfeeding was associated with an increased risk of maternal postpartum depression.

What do we know?

Breastfeeding Initiation

The prevalence of mothers initiating breastfeeding is measured as an indicator on the Public Health Outcomes Framework as an important measure of public health. It is quantified as the percentage of mothers who give their babies' breast milk within 48 hours of delivery. The prevalence of mothers initiating breastfeeding in Thurrock was significantly lower than both the regional and national averages in 2010/11, 2011/12 and 2012/13. This is shown in Figure 6.

Figure 6: Breastfeeding Initiation in Thurrock, East of England and England, 2010/11-2012/13.



Source: Public Health England

There are a number of factors which may affect breastfeeding initiation levels, including:

- Personal choice
- Cultural - a lot of ethnic groups choose not to commence breastfeeding until 'proper milk' comes in
- Extended families can have added pressure, especially where older generations have not breastfed
- Teenagers are not always willing to engage with health professionals and do not always see breastfeeding as 'cool'.
- Peer pressure
- With transient migrant groups, understanding and education around benefits of breastfeeding prior to coming into the area not given
- An area of lower socio-economic groups

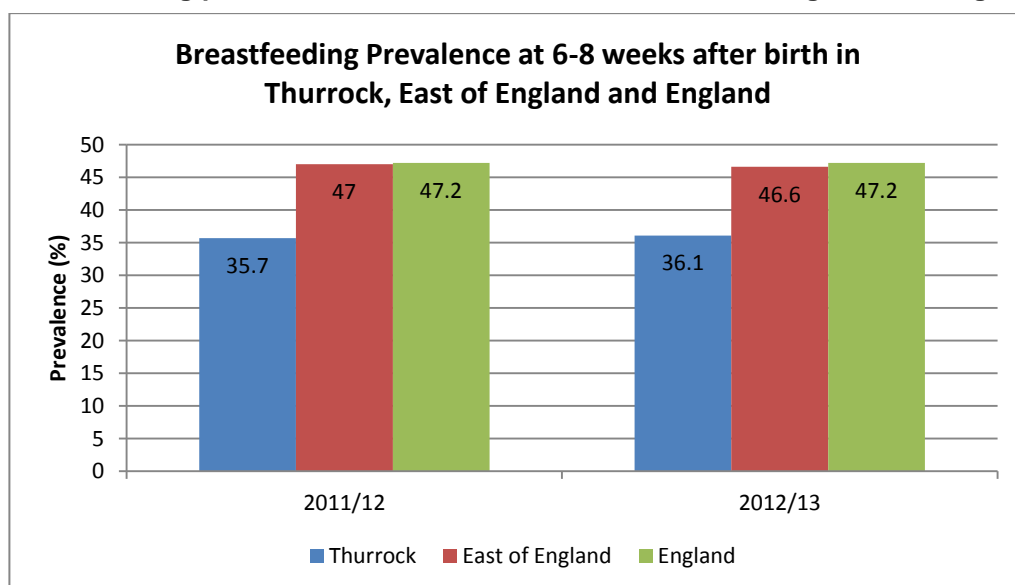
Professionals in Thurrock may benefit from further analysis as to why the local levels of breastfeeding initiation have been historically lower than regional and national averages.

Breastfeeding at 6-8 weeks

The prevalence of mothers' breastfeeding at 6-8 weeks is also measured as an indicator on the Public Health Outcomes Framework as an important measure of public health. It is quantified as the percentage of infants at 6-8 weeks who are totally breastfed – i.e. exclusively receiving breast milk, or partially breastfed – infants who are currently receiving breast milk and formula milk.

The prevalence of mothers' breastfeeding at 6-8 weeks in Thurrock was significantly lower than both the regional and national averages in 2011/12 and 2012/13. This is shown in Figure 7.

Figure 7: Breastfeeding prevalence at 6-8 weeks in Thurrock, East of England and England.



Source: Public Health England

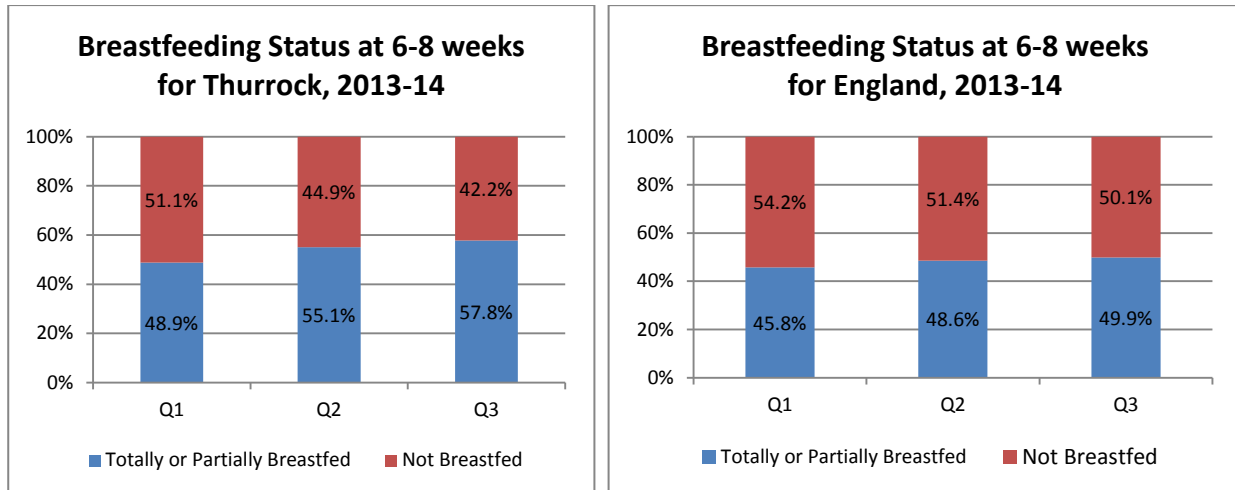
Data from Quarters 1-3 from 2013/14 is available at CCG and practice level, and shows some slight variation throughout the year. When breastfeeding status is viewed per quarter, the prevalence of infants totally or partially breastfed increases between quarter 1 and 3 for both

Thurrock and England. It is of interest to note that this data shows Thurrock to have a higher prevalence of breastfeeding at 6-8 weeks than the national average for all quarters, which is not in line with the trend data displayed above.

Figure 8: Breastfeeding Status at 6-8 weeks for Thurrock

Figure 9: Breastfeeding Status at 6-8 weeks for England

(Percentages are of the infants where breastfeeding status is known.)

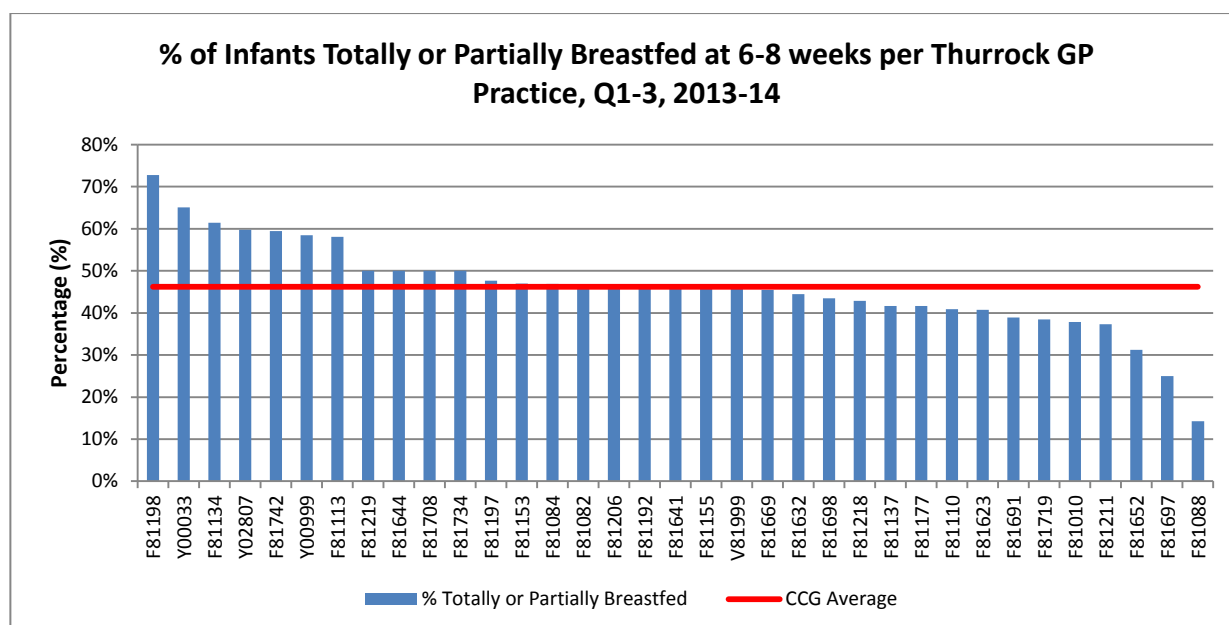


Source: Unify2

There is a large amount of variation in breastfeeding status at 6-8 weeks between GP practices within Thurrock. Practice F81198 had the highest percentage of infants totally or partially breastfeeding across Q1-3 with 72.7%, whilst practice F81088 had the lowest percentage with 14.3%. The mean for Thurrock CCG was 46.2% across the three quarters. Figure 10 shows this below.

Figure 10: % of infants totally or partially breastfed at 6-8 weeks at GP practice level for Quarters 1-3 combined, 2013-14.

Percentages are of the infants where breastfeeding status is known.



Source: Unify2

What are we doing in Thurrock?

There are currently 4 providers in Thurrock that offer a range of programmes to parents; these consist of Community Mums and Dads, Parents 1st, Coram and Family Nurse Partnership. These organisations work with parents with children between the ages of 0-19 years offering a variety of services and support such as:

- Understanding parent and child relationships
- Recognising child and parent behaviours and work on improvement
- Developing parenting skills
- Running informal and formal groups for first time parents
- One to one support
- Home visiting
- Early prevention for mothers in pregnancy, birth and post-birth.
- Supporting and encouraging mums to breastfeed

All of these organisations have strong connections with mothers to encourage and support breastfeeding; this is carried out with home and telephone support, group support discussions and the loan of breast pumps where required. Most develop a relationship with parents at the late stages of pregnancy which is easier to continue their support post-birth. Staff and volunteers are required to work to Baby Friendly Initiatives (BFI) standards. Most of these organisations will work closely with each other sign posting parents into the necessary services available and generally with the children's centres where they can engage with parents and deliver the support groups. Midwives and Health Visitors also support all mothers in early parenthood.

Breastfeeding services are offered to all mothers. 95% of new mothers have a contact attempted within 48 hours (2 working days) of notification of discharge from Basildon and

Thurrock University Hospital (BTUH) where initiation of this will begin for some parents. Key groups that are focussed on include:

- lone parents, and those affected by child poverty,
- mums aged 20 and under,
- parents to be,
- new first time parents and
- those relocating into the defined disadvantaged communities
- those identified by the 0-19 service as requiring additional support

Breastfeeding is actively encouraged at Basildon and Thurrock University Hospital via:

- Informing all mothers prior to discharge of an app created in-house called 'Feeding Together' and all are also encouraged to access website and social media information.
- Having achieved full accreditation as a 'Baby Friendly Accredited Unit', the majority of staff are trained in two full days of Infant Feeding with annual updates
- Paediatricians on their induction are introduced to maternity staff in order to work in partnership to promote breastfeeding
- N.I.C.U./paediatric staff have Unicef Baby Friendly training
- Running *Parentcraft* classes about Infant Feeding
- Participating in local baby related events and at hospital open days

Thurrock's Children's Centres also play an integral role in supporting mothers to breastfeed, and offer a range of supportive services to do this. Two of their 28 outcomes in their Outcomes Framework specifically relate to increasing the number of mothers who breastfeed and ensuring that children are physically healthy.

Future work

The Public Health team have undertaken a review of all services and will be commissioning a new parent and breastfeeding service from July 2015.

Recommendations

- | |
|---|
| <ul style="list-style-type: none">- To promote activities to raise awareness of breastfeeding benefits- Further joint working between professionals- Reducing inequalities and improving access to breastfeeding support for women in low-income groups- Increasing choice, by providing access to a range of services across different settings |
|---|

Low Birth Weight

Birth weight is a good measure of infant health. Low birth weight (defined as births below 2,500g) is strongly associated with poorer health and poorer life chances and is an important predictor of future infant, child and adult health. Low birth weight babies are at greater risk of dying in their first year than heavier babies. Low birth weight is more common for babies born:

- To mothers under the age of 20 and over the age of 40

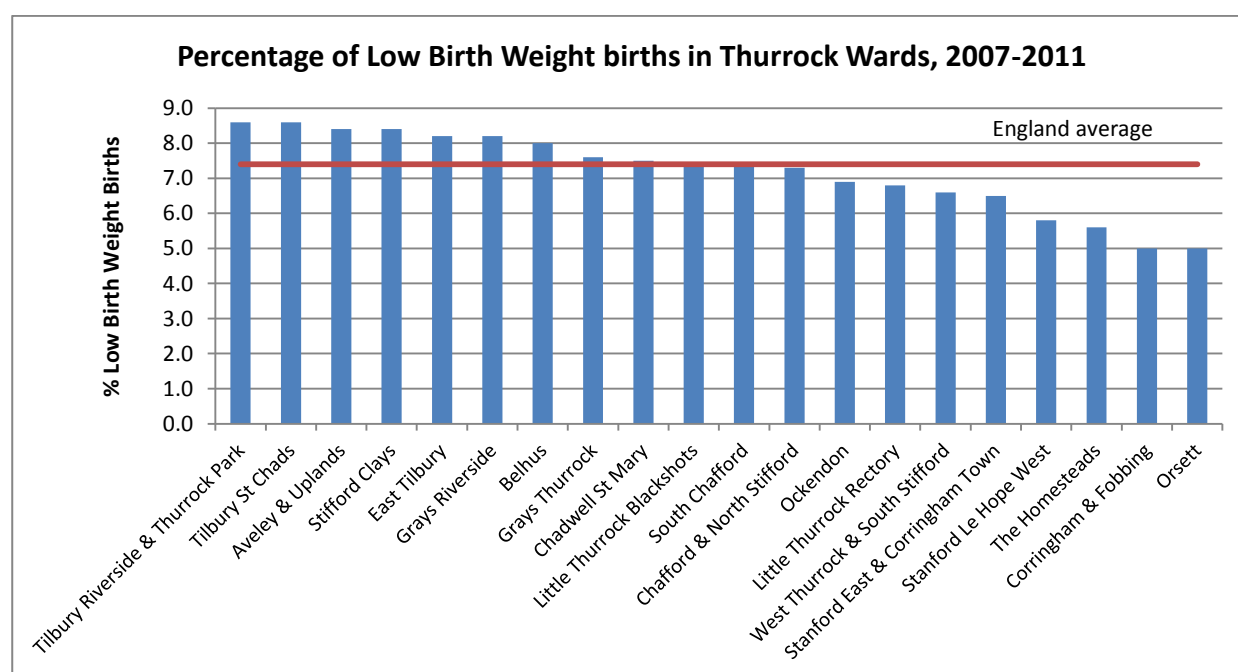
- In deprived areas
- To parents in social class 4 and 5
- To lone mothers
- To mothers born outside the UK

Babies born to mothers who smoked during pregnancy may also be at risk of low birth weight – further information can be found in the [Smoking in Pregnancy](#) section.

What do we know?

The latest data indicates that Thurrock has a similar percentage of low weight births as the national average (7.4% of all live and still births, compared to the national average of 7.3%, 2012). Ward level analysis shows that levels are higher in areas such as Tilbury Riverside and Thurrock Park, and Tilbury St Chads, and lower in areas such as Corringham and Fobbing and Orsett. When considered against the Index of Multiple Deprivation, it can be seen that generally the areas with the highest percentage of low birth weights are more deprived.

Figure 11: Percentage of Low Birth Weight Births (all live and still births) in Thurrock Wards, 2007-11.



Source: Local Health

What are we doing in Thurrock?

Support and delivery to parents in Thurrock focusing on premature babies and low birth weight is delivered through the [Family Nurse Partnership](#) (FNP). The programme aims to:

- improve the outcomes of pregnancy by helping young women aged 19 and under (and their partners) improve their ante-natal health and the health of their unborn baby

- improve children's subsequent health and development by helping parents to provide more consistent, warm and competent care for their children
- improve women's life course by planning subsequent pregnancies, increasing parents aspirations, economic and self-sufficiency through finishing their education and finding employment.

The FNP service operates to reduce inequalities in outcomes across the life course and to ensure a strong focus on prevention, health promotion and early identification of needs, with an aim to improve maternal, child and family functioning. It delivers this by mainly working as a home based visiting programme, however, family nurses are required to offer parents a choice of location, e.g. GP surgeries, children's centres, community health services, extended schools, health centres, cafés, etc.

Thurrock's Children's Centres also play an integral role in supporting parents both before and after the child is born, and offer a range of supportive services to do this. Two of their 28 outcomes in their Outcomes Framework specifically relate to ensuring parents have a greater understanding of how to manage their pregnancy, and ensuring that children are physically healthy.

Recommendations

- Addressing the wider determinants of health, including low income and housing needs
- Reducing smoking in pregnancy targeted particularly within more deprived areas
- Improve family diets and understanding about nutrition and access to more affordable food
- Raise the profile of taking Folate supplements for pregnant women
- Services to promote fewer subsequent pregnancies and greater intervals between births
- Improve awareness of home safety measures
- Maintenance of services that improve parenting skills and techniques
- Increase promotion of opportunities to increase employment and education

Healthy Weight

Childhood obesity is a complex public health issue that is a growing threat to children's health. If the number of obese children continues to rise, today's children and future generations could have shorter life expectancies than their parents. In addition, overweight and obesity has serious economic costs, with the direct costs of treatment to the NHS being estimated at £4.2 billion per year, and the indirect cost to the wider economy at £15.8 billion per year (Butland, et al., 2007). Tackling childhood obesity requires changes in the behaviour of individual children, their parents and of society in general and reflects recent trends across most developing countries to greater fat and sugar consumption and reduced physical activity. There is also evidence to suggest that babies who are breastfed are less likely to be obese in adulthood. The term 'obesogenic environment' refers to the role environmental factors may play in determining both energy intake and expenditure. It has been defined as the 'sum of the influences that the

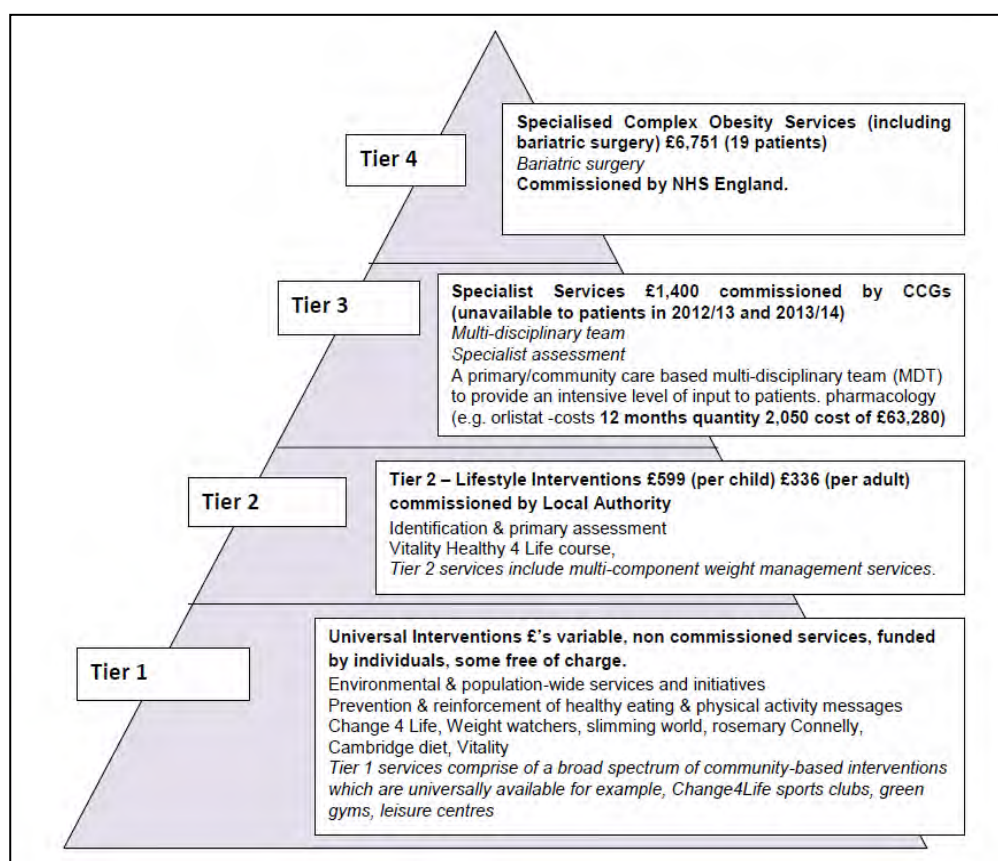
surroundings, opportunities or conditions of life have on promoting obesity in individuals and populations'. Research has also explored the influence maternal weight may have on the prevalence and severity of obesity, in future generations identifying pregnancy as a key time to target weight management. Weight is a sensitive issue, especially for parents and evidence suggests that many parents:

- struggle to assess their children's weight status accurately.
- over-estimate activity levels and underestimate the amount of high-fat, high-sugar foods that the child and family eat.
- make no connection between poor diet and low activity levels in their children and long-term health problems.

The Department of Health reports that by 2020 they want to see "A sustained downward trend in the level of excess weight in children." To achieve the desired outcome, the Department for Health have commissioned the Change4Life programme, and continue to work towards improved labelling requirements on foods and drinks enabling consumers to make better informed choices and similarly encouraging businesses to responsibly advertise the calorie information on all menus. Finally, the Department of Health have been a source of guidance around recommended physically activity levels for adults and children. (Department of Health, 2011) It is recommended that children are active for at least an hour every day.

It is essential to work with the CCG and NHS partners around a whole system approach for healthy weight management and there is work ongoing to change the commissioned services. Figure 12 below shows the costs associated with commissioned tiers of services.

Figure 12: Tier Pathway, costs estimated per person based on commissioned services 2012/13



Source: Thurrock Healthy Weight Strategy, 2014

Defining Childhood obesity

Presently there is debate about the definition of childhood obesity and the best way to measure it in England. For clinical practice the Royal College of Paediatrics and Child Health growth charts are recommended, which include BMI, for children aged 2-18 years (2012). For public health programmes, such as the NCMP and the Health Survey for England, the British 1990 growth reference (UK90) charts are used. Assessing the Body Mass Index (BMI) of children is more complicated than for adults because a child's BMI changes as they mature. Growth patterns differ between boys and girls, so both the age and sex of a child needs to be taken into account when estimating BMI.

Although child obesity is seen as a priority, there is still a proportion of children defined as underweight. Reasons for underweight children can be an illness, malnourishment or more commonly, eating disorders. Eating disorders are typically associated with young girls and has a strong correlation with poor mental health, poor self-image, low self-esteem and a sense of a lack of control. The local CAMHS service offer Cognitive Behavioural Therapy (CBT), nutritional advice and counselling to support young people with an eating disorder; as do a local children's commissioned service provider Catch-22.

Inequalities

Socio-economic status

It has long been known that people from lower socio economic groups have poorer health. The socioeconomic inequalities have increased in the UK since the 1960s leading to a wider gap in regards to both child and adult obesity with differences in prevalence in both age and gender. Evidence from the analysis of data from the National Child Measurement Programme (NCMP) suggests that obesity prevalence among children in both Reception and Year 6 increases with increased socioeconomic deprivation (measured by the 2010 Index of Multiple Deprivation (IMD) score). Nationally obesity prevalence of the most deprived 10% of the population is approximately twice that of the least deprived 10% (Marmot, 2010).

Ethnicity

There are a range of broad and complex factors with minority ethnic communities that could be influencing the proportion of children that are of a healthy weight. There is a lack of evidence to explore these and although there is data available from 2004 including a "boost sample" from minority groups it doesn't effectively reflect the national picture in combination with there being almost non-existent information for many smaller ethnic groups. The National Obesity Observatory does explain that there is an ongoing debate around the validity of information around the definition of obesity within different ethnic groups for adults and children by exploring that different groups are associated with "a range of different body shapes and different physiological responses to fat storage".

Disability

Similarly to ethnicity there is limited data about the link between disabilities and obesity. It is accepted that those people with disabilities are more likely to be obese because of the assumed lower rates of physical activity compared to the general population. However it is also acknowledged that those people with learning difficulties often fall within the underweight or obesity group which suggests a number of other factors may be having an influence here.

Childhood Obesity Surveillance

The National Child Measurement Programme (NCMP) measures the weight and height of children in reception class (aged 4 to 5 years) and year 6 (aged 10 to 11 years) to assess overweight children and obese levels within primary schools. The programme is now recognised internationally as a world-class source of public health intelligence and holds UK National Statistics status. It has been in operation since 2006. The NCMP was set up in line with the Government's strategy to tackle obesity and to:

- inform local planning and delivery of services for children
- gather population-level data to allow analysis of trends in growth patterns and obesity
- increase public and professional understanding of weight issues in children and be a vehicle for engaging with children and families about healthy lifestyles and weight issues.

National policy has recently changed with the introduction of the School Food Plan (Dimbleby & Vincent, 2013), the introduction of universal free school meals for 4-7 year olds, and the return of cookery to the national primary curriculum. In addition, new Ofsted guidance (Ofsted, 2013) states inspectors should 'ask school leaders how they help to ensure a healthy lifestyle for their children'.

Physical Activity

As well as the importance of maintaining a healthy weight, physical activity has an impact on education and academic attainment. Physical activity positively affects cognition in children - being physically active releases hormones, neurotransmitters and a protein responsible for learning, memory and higher thinking. Sport and recreation can also lead to increased self-esteem and the development of motivation and determination – these skills are useful for acquiring new information for passing exams. (Sport and Recreation Alliance, 2012) There is now a wide range of research into this relationship with the consensus that in the majority of instances physical activity enhances school performance. One study that involved 243 school children aged nine to 10 years old found that daily 10 minute physical activity breaks significantly increase on-task behaviour by 8% on average, and that the average was a much higher 20% for the least on-task behaviour pupils, whilst those who took a 10 minute break without being physically active demonstrated a 3% reduction in on-task behaviour (Mahar, et al., 2006).

What do we know?

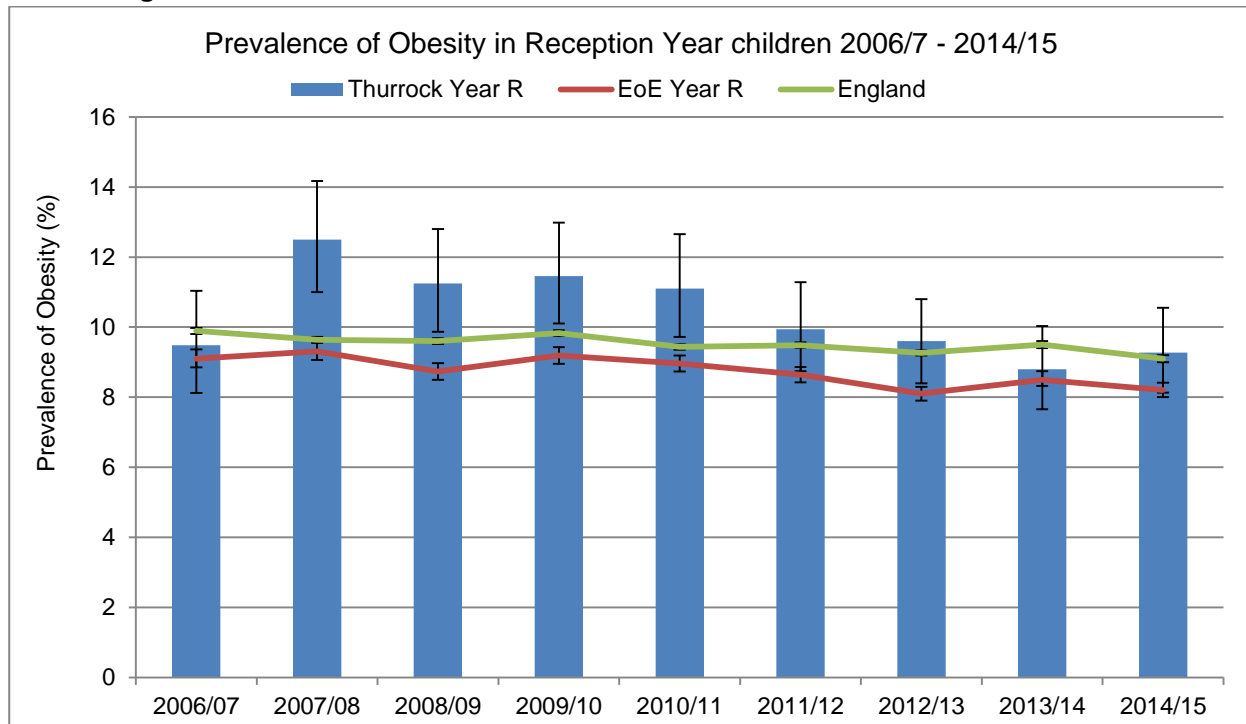
The data below reports on the measurements of children in Reception and Year 6 during the 2014/15 academic year. All data is sourced from the Health and Social Care Information Centre.

Reception Aged Children

The 2014/15 data shows Thurrock to have an obesity prevalence in Reception-aged children of 9.3%, which is significantly higher than the East of England average (8.2%), and is above the

England average of 9.1%, although not significantly so. Upon comparing this to data from previous years, the obesity prevalence has decreased in line with the regional trend – see Figure 13 below. For 2012/13 the Thurrock prevalence is statistically significantly higher than the East of England prevalence, whereas in 2013/14 and 2014/15 there was no significant difference.

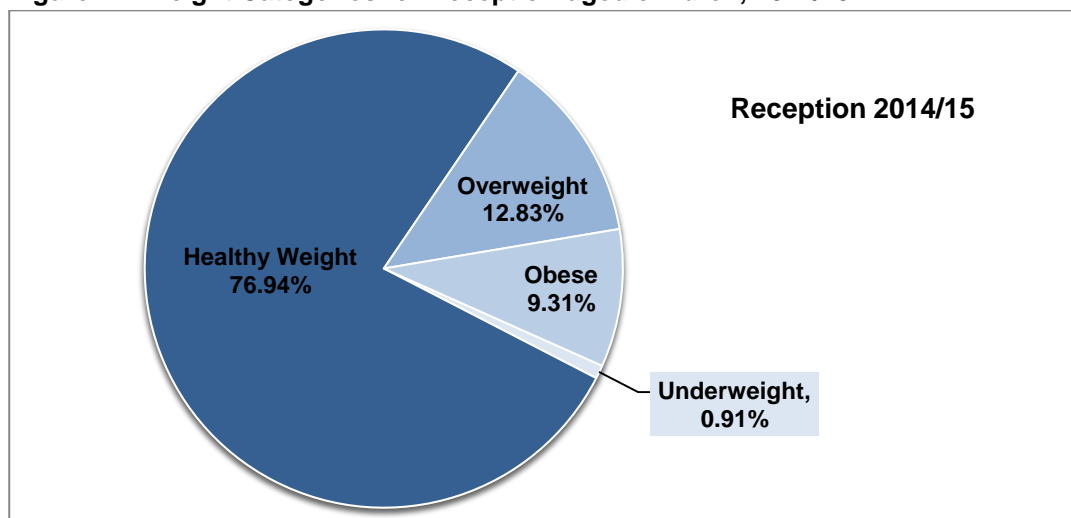
Figure 13: Obesity prevalence in Reception-aged children from 2006/07–2014/15 for Thurrock and East of England.



Source: Health and Social Care Information Centre

The figure below shows the percentage split of weight categories in 2014/15 of Reception year children in Thurrock. It shows that almost a quarter of children were outside of the healthy weight range.

Figure 14: Weight Categories for Reception-aged children, 2014/15

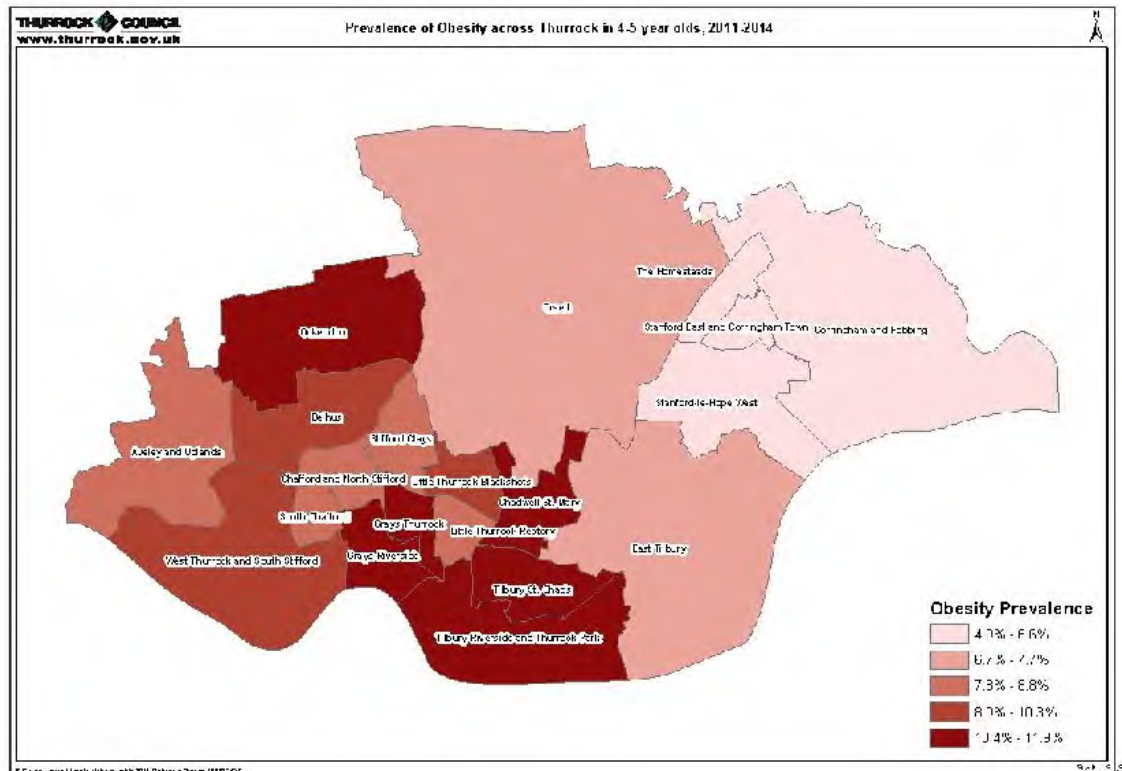


Source: Health and Social Care Information Centre

When Thurrock is compared to its CIPFA comparator sites, its obesity prevalence falls in the middle of the group.

Obesity varies across the borough, with areas within the south and west of Thurrock showing the greatest concentrations. The figure below depicts how obesity in Reception-aged children varies across the borough – it ranges from 4.9% in Stanford East and Corringham Town, to 11.9% in Tilbury St. Chads.

Figure 15: Obesity prevalence across Thurrock in Reception-aged children, 2011-14

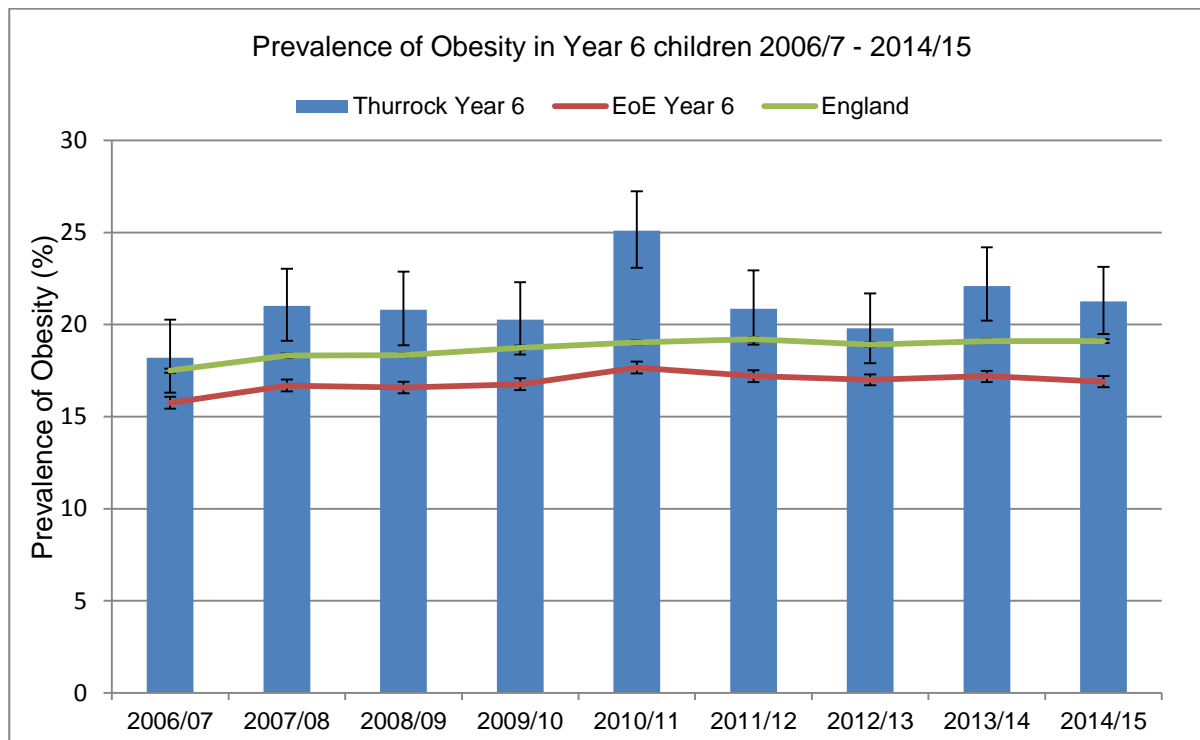


Source: Health and Social Care Information Centre

Year 6 Aged Children

The 2014/15 data shows Thurrock to have an obesity prevalence in Year 6-aged children of 21.3%, which is more than double the local prevalence at Reception Year. Thurrock's prevalence is significantly higher than both the East of England (16.9%) and England (19.1%) average. Upon comparing this to data from previous years, the obesity prevalence has decreased in line with the regional trend – see Figure 16 below. Since 2007/08, the Thurrock prevalence has always been statistically higher than the East of England prevalence and the England prevalence since 2013/14.

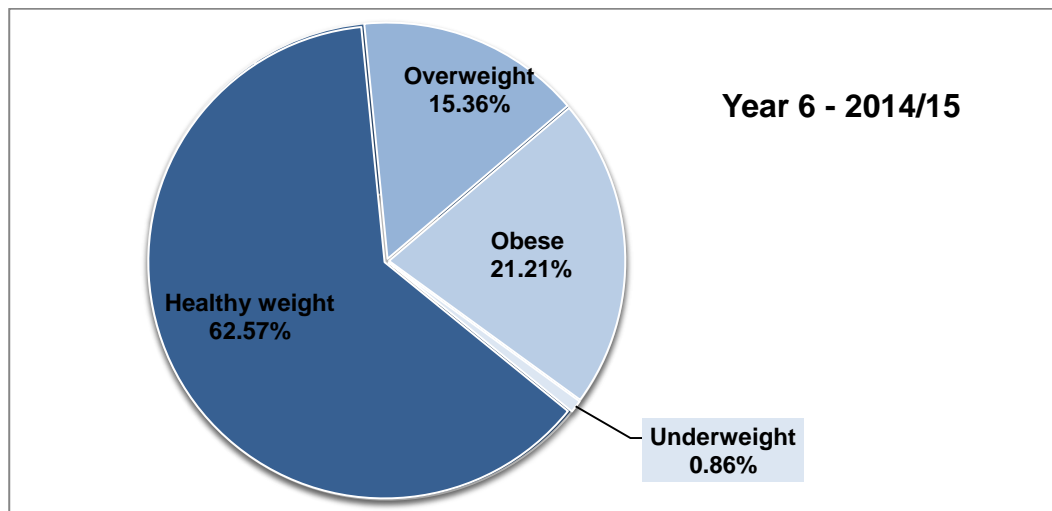
Figure 16: Obesity prevalence in Year 6-aged children from 2006/7–2014/15 for Thurrock and East of England.



Source: Health and Social Care Information Centre

The figure below shows the percentage split of weight categories in 2014/15 of Year 6-aged children in Thurrock. It shows that 37% of children were outside of the healthy weight range.

Figure 17: Weight Categories for Year 6-aged children, 2014/15

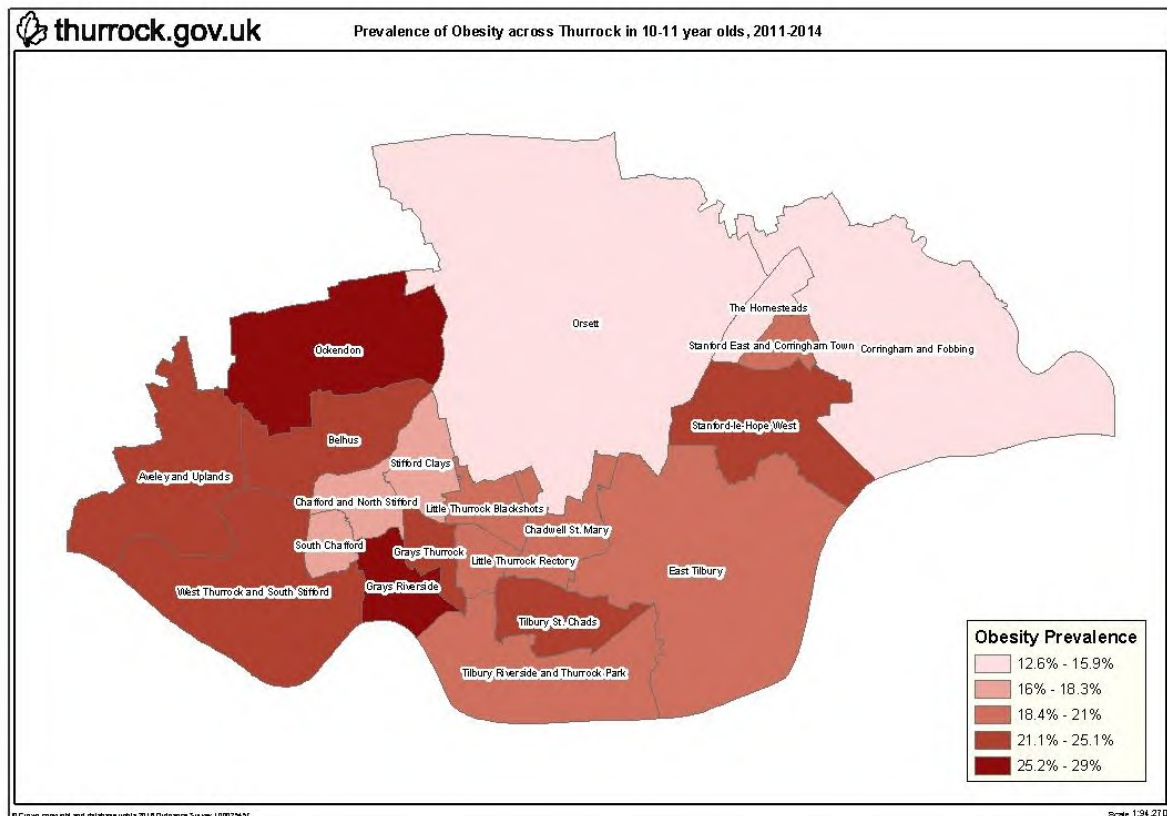


Source: Health and Social Care Information Centre

When Thurrock is compared to its CIPFA comparator sites, it has one of the highest obesity prevalence rates in the group; however it has one of the lowest prevalence rates of underweight children. This is an important positive statistic to note alongside the less positive generally high prevalence of obesity and overweight children in this age range.

Obesity varies across the borough, with wards within the south and north-west of Thurrock showing the greatest concentrations. The figure below depicts how obesity in Year 6-aged children varies across the borough – it ranges from 12.6% in Corringham and Fobbing to 29% in Grays Riverside.

Figure 18: Obesity prevalence across Thurrock in Year 6-aged children, 2011-14



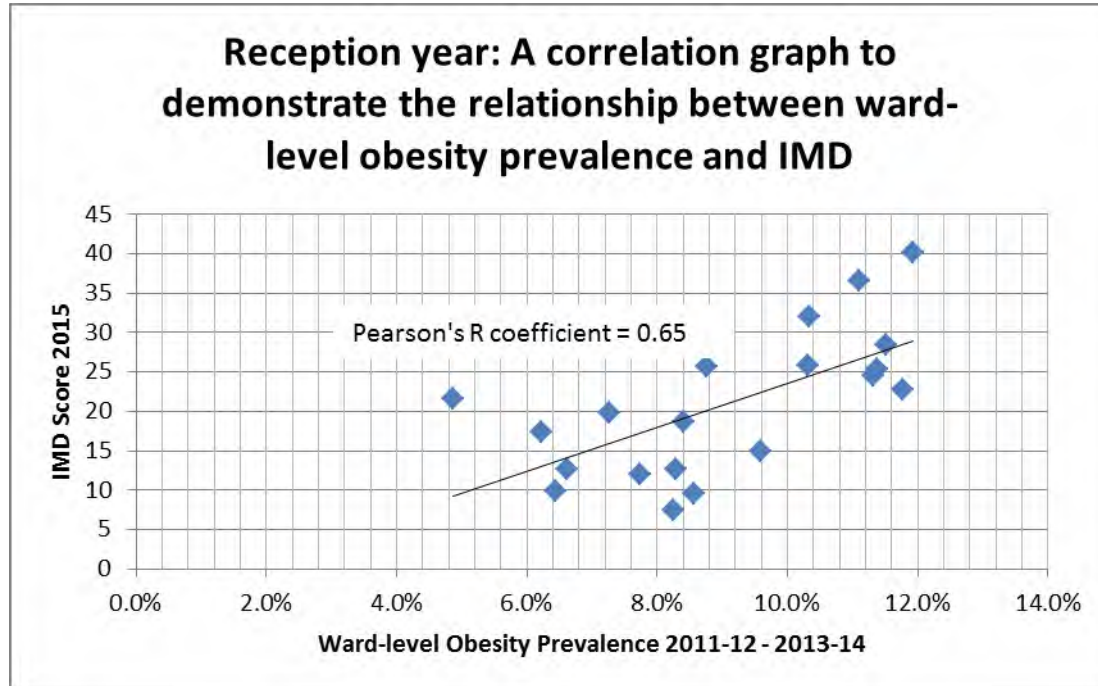
Source: Health and Social Care Information Centre

Association with Deprivation

An association between high obesity prevalence and areas of high deprivation can be observed for both Reception-aged and Year 6-aged children in Thurrock. The two figures below show the correlation between percentage of obesity prevalence and deprivation by ward level in Thurrock for 2011-2014 for both Reception year and Year 6 children (each blue dot is one ward).

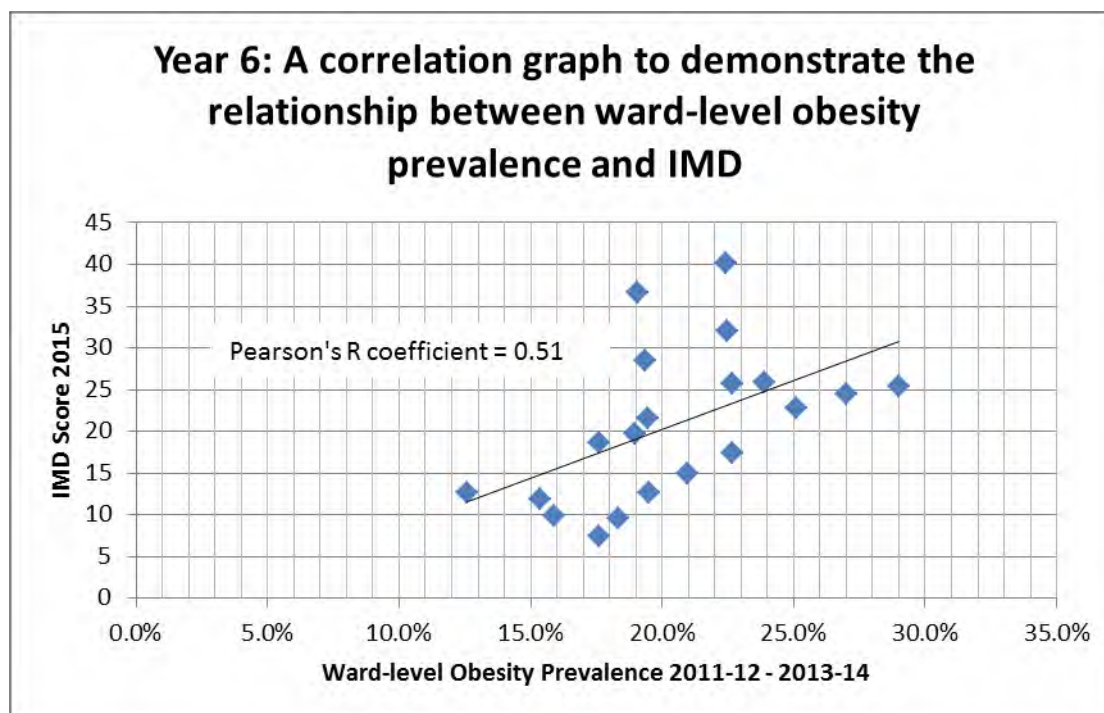
[The Pearson product-moment correlation coefficient is a measure of the correlation (linear dependence) of two variables where the r value = 1 it denotes a perfect correlation and where $r = 0$ it denotes no correlation.] Both figures show a positive correlation between the percentage of obese children and level of deprivation.

Figure 19: Correlation between obesity prevalence and IMD in Reception-aged children



Source: Health and Social Care Information Centre and DCLG

Figure 20: Correlation between obesity prevalence and IMD in Year 6-aged children



Source: Health and Social Care Information Centre and DCLG

This is important data for commissioning health services as it indicates a health inequality and shows that services to tackle childhood obesity need to be focused towards areas of higher deprivation within Thurrock.

Physical Activity

Although not graphically depicted, Thurrock has relatively low levels of physical activity levels for children in school compared to CIPFA comparators. Levels of physical activity are statistically lower than 12 out of 15 CIPFA comparator Local Authorities and regional and national rates.

What are we doing in Thurrock?

These statistics highlight a need to tackle obesity in Reception age children and preschool children as the levels of obesity are already very high by the time children start school.

Children's Centres

Thurrock's Children's Centres also play an integral role in supporting parents and children maintain a healthy weight, and offer a range of supportive services to do this. Two of their 28 outcomes in their Outcomes Framework specifically relate to encouraging mothers to breastfeed, and ensuring that children are physically healthy.

Transport

Over the last 50 years or so, there has been an increase in car use and decrease in cycling, walking and active travel. We aim to maximise the potential to encourage these forms of active travel. This also contributes to objectives in relation to sustainability and congestion. The Road Safety team/Local Sustainability Transport Fund are also supporting initiatives which affect child weight and promote active travel, such as Walk to School Week. Partnerships have developed with the Local Sustainable Transport team and initiatives such as 'Bike it', health walks, and cycle pit stops have evolved. Beat the Street Thurrock was a joint-funded project rolled out in Thurrock in June and July 2014 encouraging people to walk more. Over 100 boxes were placed around the whole of Thurrock and players were given pre allocated fobs to allow them to track walks as part of the challenge raising money for charity (inactive adults and school children were targeted in different ways). The programme was very well taken up with in excess of 14,000 people registering to play. More information on projects run by the LSTF which also increase physical activity can be found in the '[Accidental Injuries and Deaths](#)' section].

Planning and Environment

Work has progressed looking at the close proximity of takeaways to schools in Thurrock and a paper was taken to Overview and Scrutiny Committee in collaboration with the Planning team. A number of local authority areas have already taken steps to limit the growth of fast food takeaways through supplementary planning policies which Thurrock can explore further. The development of links between the Public Health and Planning teams will allow closer collaboration on projects of joint interest; for example working together to create a healthier built environment that allows people more opportunity to be physically active in the way buildings and spaces are designed.

Sports and Physical Activity

Thurrock Sports and Physical Activity Partnership Group which has a wide membership including local leisure centres, school sports co-ordinators, Active Essex, providers of weight management services, Council members and officers, including Public Health as well as

volunteers of sporting, exercise and physical activities in Thurrock. The partnership identifies funding opportunities and works with other organisations in identifying and initiating sporting/activity projects. The partnership will develop and secured a 'Physical Activity connector' post on a part time basis to shape the work of the partnership and facilitate more joined up working. This partnership is ideally placed to drive forward projects that increase physical activity and sports in Thurrock and the members to be ambassadors for projects in their workplace and communities.

County Sports Partnership

Through the Thurrock Sports and Physical Activity Partnership the relationship with the County Sports Partnership 'Active Essex' has been strengthened. Through active engagement with Active Essex Thurrock can benefit from taking a joined up approach to projects, support and shared learning with other areas around sports and physical activity as well as opportunities to access Sport England funding such as 'Sportivate'. A directory has also been piloted in partnership with Active Essex to co-ordinate local sports clubs and activities in a user friendly and accessible place. This was an action following the Healthy Weight workshop facilitated by the Public Health team in December 2013.

Parks and green spaces

Parks and green space are important for communities and provide people the opportunity to be active in their leisure time. Maintenance and improved quality results in increased use of these facilities. Through the Healthy Weight Strategy delivery, the Sports and Physical Activity action plan will look to improve signage and facilities. A pilot of the 'playing out' project is aspired to as part of this delivery which involves encouraging children to play outside more through coordinated temporary road closures in residential areas. We have seen a significant amount of children using our spaces due to limited funds for holidays now having an impact on local households. The Friends of Parks groups have been able to change people's perceptions of certain key parks without the need for equipment just utilising the space.

Education and learning

The NCMP is delivered in schools by the provider school health teams providing a method of surveillance for child obesity prevalence. The current services use this programme to identify children that would benefit from weight management programmes which can then be offered to them and their family. There is potential to build upon this service model and to create a closer link with schools and weight management services. Working together with schools can only benefit pupil's health and wellbeing with the potential to influence educational attainment. The school sports premium allows schools the opportunity to direct funds towards local solution around sport and physical activity. Working together with school games organisers could benefit this and an offer designed to allow schools control to shape programmes to suit children's needs.

Programmes that link schools on an area wide basis such as 'Beat the Street' offer the opportunity not only to increase activity in school age children and their families but allow the opportunity for pupils to work together towards a shared goal, allowing social inclusivity with the added benefit of decreasing traffic around the school and thereby improving pupil safety.

Programmes around healthy eating can be explored with schools alongside physical activities to commission evidence based programmes that will engage schools and pupils and promote achieving a healthy weight.

The Public Health team have worked with the Learning and Skills team to deliver the 'Eat Better, Start Better' programme in Thurrock, a two-year programme to improve food provision for children aged 1-5 in early years settings. The project aims are: Improved, healthier food provision, including increasing nutrition and cooking skills knowledge in the workforce and parents, for children aged 1-5 in early year's settings and at home. Following on from an evaluation, work continues to ensure the programme's sustainability.

Recommendations

- All healthy weight initiatives and programmes will have defined priorities, key action points and reporting methods in line with the Healthy Weight Delivery Plan.
- Activity Directory to be provided to GP's and Primary Care Professionals to support them in undertaking brief interventions around healthy weight and referring into the relevant tier of weight management services and physical activity programmes.
- School activities and family programmes around healthy weight will be an important element in combating the rise in obesity between Reception and Year six children and these should be evaluated to measure success.
- In response to the engagement to date, specific programmes/projects will be commissioned with the objective of working to reduce the obesogenic environment in Thurrock.
- Continue to develop the partnership working that has started with the Healthy Weight strategy delivery group following the workshop held in December 2013
- Using local leadership such as Hubs and the Local Area Coordinators (LAC's) and the Asset Based Community Development (ABCD) principles, communities will have played an important role in identifying and developing physical activity and healthy eating opportunities that are relevant to their local areas and resources.
- Communities should be involved in physical activity challenges such as 'Beat the Street'.
- Looking at the close proximity of takeaways to schools in Thurrock and work with food outlets within close proximity to schools to promote healthier options.
- A new tier 1 to tier 4 weight management pathway should be developed alongside health and CCG colleagues.
- Monitor the take up of the new school meal premium across primary schools and health professionals to have the opportunity to influence school menus.
- Develop a sustainable follow on programme/offer following the Eat Better Start Better programme completed in 2013 with pre-school settings to tackle healthy weight in 0-5 year olds
- Review the provision of nutritional and weaning advice within Health Visiting services
- Work more closely with dental services around oral health and the link between sugar decay and healthy diets.
- Work with schools to educate children on portion sizes.

Obesity remains one of the biggest public health risks nationally and will continue to be a priority in Thurrock which is reflected in the Thurrock Health and Wellbeing Strategy.

Oral Health

Oral health refers to the condition of gums, teeth, surrounding bone and soft tissues of the mouth enabling function and being free of disease and pain. Oral health problems for children include dental caries, gum disease, and facial and dental injuries. Although the oral health of children in England has been improving over the last 30 years – improvements attributed to advances in medical science, use of fluoride toothpaste, better nutrition and increased awareness of dental health issues, inequalities are still observed which are strongly associated with deprivation and social background. Some vulnerable groups, e.g. minority ethnic groups, may encounter language and cultural barriers to accessing dental services, increasing their risk of oral disease, and adolescents have been identified as a group in which there is a large reduction in dental visits, also increasing their risk of developing poor oral health. If tooth decay in children is not treated, the consequences can include pain and discomfort on chewing, abscesses and extractions, which may affect children's growth and development. Poor oral health can lead to difficulties in eating, sleeping and socialising, thereby affecting health-related quality of life.

Advice in *Delivering Better Oral Health* (2014), the evidence based guidance for dentists and their teams, recommends that a person should visit a dentist for routine care at a time interval agreed between the patient and the dentist dependant on the risk of developing dental disease. This may be three monthly, six monthly, annually or once every two years. Tooth decay in children is largely preventable, with a large body of evidence advocating regular brushing and reduction of sugar intake. The availability of topical fluoride such as in toothpastes, varnishes and mouthwashes also helps to prevent tooth decay.

Local authorities improving oral health: commissioning better oral health for children and young people (2014) evidences ways for local authorities to champion oral health and address inequality across the life course, using universal or targeted interventions working closely with NHS, Public Health England and other partners. Training in oral health and hygiene for all staff who work with children and young people is one example. Improving the oral health of children is also identified as a priority within the *NHS Operating Framework 2011/12*, as well as in *Equity and Excellence: Liberating the NHS* (2010) and *Healthy Lives, Healthy People – Our Strategy for Public Health in England* (2010). Tooth decay in 5 year olds is now included in the list of public health outcomes measures (Department of Health, 2012). The Department of Health's Oral Health Strategy for England (1994) set national dental health targets for the country's children:

- Five year old children are to have no more than 1 decayed, missing or filled first tooth (on average); and
- 70% of five year olds should have no experience of tooth decay.

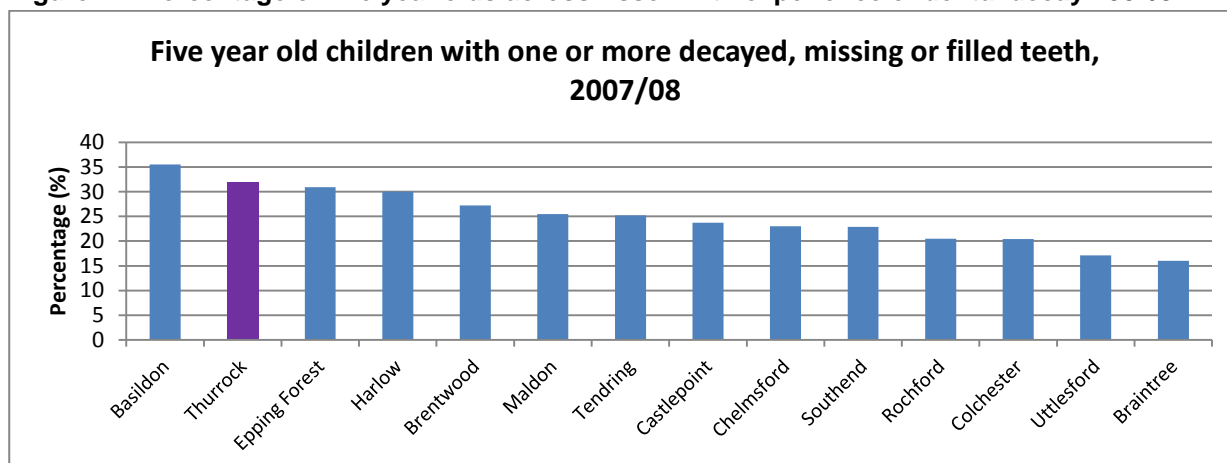
What do we know?

The level of dental need may be estimated from national dental health surveys of 5 and 12-year-olds, and data detailing the percentage of children aged 0-19 years admitted to hospital for dental extractions.

5 year old children

Data from the 2007/08 oral health survey of 5 year old children showed that 31.8% of Thurrock children had decay experience (one or more decayed, missing or filled teeth), which was the second highest local authority in the county and also above the national average of 30.9%. This indicates that only 68.2% of five year olds in Thurrock had no experience of tooth decay, which was lower than the Department of Health target (70%). Figure 21 below shows the geographical distribution across Essex.

Figure 21: Percentage of five year olds across Essex with experience of dental decay 2007/8



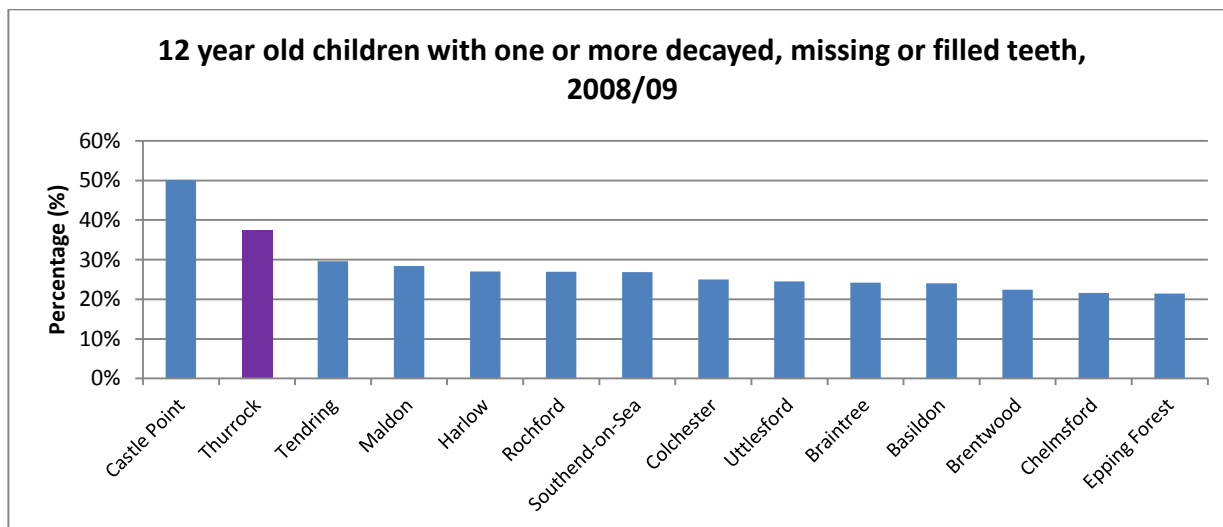
Source: NHS Information Centre

Although this survey is repeated every two years, unfortunately the data for Thurrock was not collected for the subsequent survey relating to data collected in 2009/10. This data, nationwide, showed an overall drop in rates since 2007/08, but there were local exceptions, and so it would be unwise to draw conclusions about changes in rate amongst the children of Thurrock. The survey was repeated in 2013/14 and results are expected in the near future.

12 year old children

Data from the 2008/09 oral health survey of 12 year old children showed that 37.5% of Thurrock children had decay experience, which was the second highest local authority in the county and also above the national average of 33.4%. Figure 22 below shows the geographical distribution across Essex.

Figure 22: Percentage of 12 year olds across Essex with experience of dental decay 2008/09

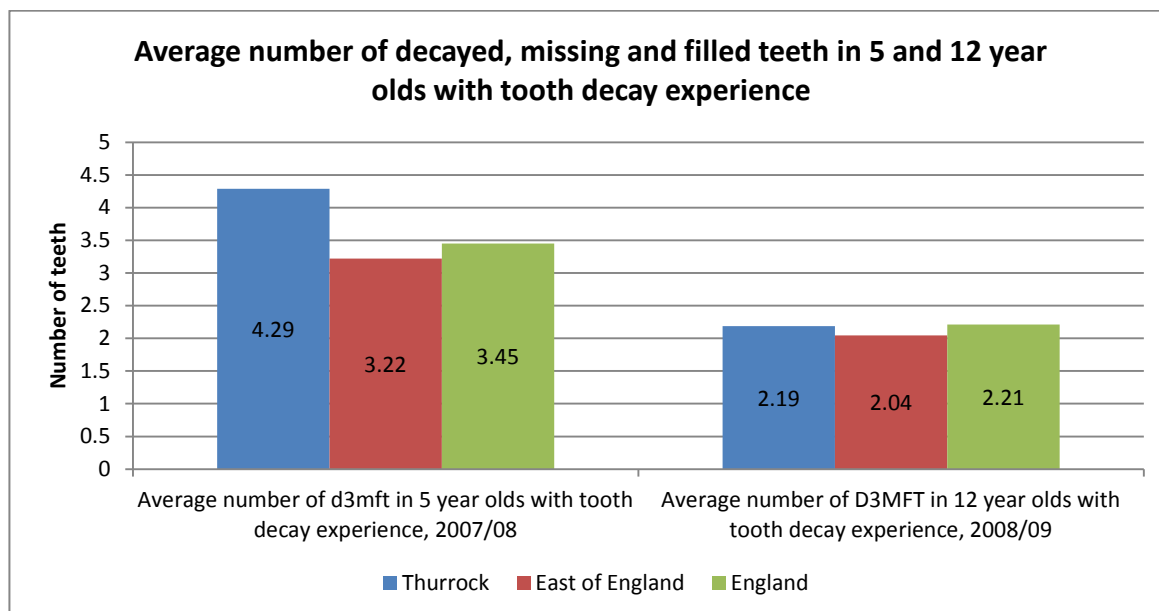


Source: NHS Dental Epidemiology Programme, 2008/09

Children with tooth decay

For those children who have experience of tooth decay, an average of 4.29 decayed, missing and filled teeth (d3mft) was reported for 5 year olds in Thurrock, which is greater than the regional and national averages. An average of 2.19 decayed, missing and filled teeth (D3MFT) was reported for 12 year olds in Thurrock, which was similar to the regional and national averages. This is shown in Figure 23 below.

Figure 23: Average number of decayed, missing and filled deciduous teeth (d3mft) in 5-year-olds and permanent teeth (D3MFT) in 12-year-olds, 2007/08 and 2008/09.

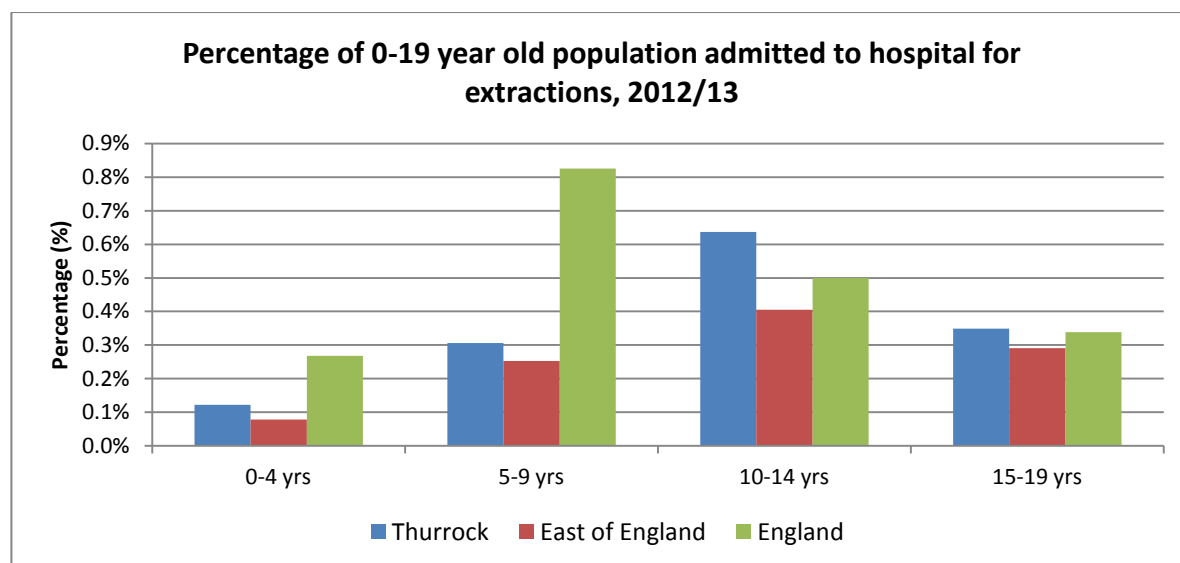


Source: NHS Dental Epidemiology Programme, 2007/08 and 2008/09

Dental Extractions

Cases of advanced tooth decay may result in extraction. The latest data shows that 0.3% of children aged 0-19 years in Thurrock were admitted to hospital for a dental extraction during 2012/13, which is the same as the regional average and less than the national average of 0.5%. Figure 24 below shows the admissions broken down by age group, and it can be seen that, when compared to the national average, Thurrock had a lower percentage of children aged 0-4 and 5-9 years admitted but a higher percentage of children aged 10-14 and 15-19 years admitted.

Figure 24: Percentage of 0-19 year old children admitted to hospital for extractions in Thurrock, East of England and England, 2012/13.



Source: Hospital Episode Statistics

In summary, it is likely that about 30% of children and young people in Thurrock have experience of tooth decay that can lead to pain and costly NHS procedures. Children with decay are likely to have more than one tooth affected.

What are we doing in Thurrock?

It is currently recommended that regular dental attendance for all children is promoted by early years staff so that 1:1 advice can be given to parents and carers by dental care professionals. A dentist is likely to start recording a child's attendance at the surgery from the age of 2 years even though they will start seeing a child younger than this informally at the appointment of the parent or carer.

The data denotes that 7985 different children from Thurrock aged 3-5 years were seen in the two years up to February 2014. Between them they had 10,099 courses of treatment of which 7,916 were for a check-up and preventive advice only.

1,465 different children had a 'band 2' course of treatment, denoting that this was more than just a check-up and preventive advice, probably for treatment for tooth decay. It is good that the disease was being treated rather than neglected, but bad in that the treatment is needed at all. If there are high levels of disease in a population, then there should be high levels of dental service use. 1,754 courses of 'band 2' treatment were undertaken on the 3 – 5 age group over the two years which means that some of the 1,465 children had more than one course of

restorative care such that their problems weren't solved the first time. This may have been because of poor compliance, because of continuing disease progression or because the disease was extensive and it was practical to deal with it in stages within the child's capability. 382 children had urgent dental care in the two year period, and all together there were 407 such episodes, denoting that up to 25 children had more than one urgent episode.

However it should be noted that access information alone does not tell us much about oral health – higher access rates may be due to children with toothache seeking treatment or due to children with good oral health going for a check-up and preventive advice. Additionally, in affluent areas, low access rates may be due to patients visiting a private dentist (which is not included in the NHS information reported).

Children's centres are well placed to provide information and support for families to improve oral health and to establish links with local dental services. There are some examples in Thurrock where this is already taking place. One of their 28 outcomes in their Outcomes Framework specifically relates to ensuring that children are physically healthy.

Recommendations

The evidence base provided by Public Health England in their evidence-informed toolkit for local authorities (2014) indicates that local authorities should be looking to ensure that oral health is integrated within broader Public Health and Children's Services initiatives that aim to address the underlying causes of health inequalities and the causes of poor general and oral health.

Practical ways to address this might include:

- Promotion of regular dental attendance for all children
- Ensure consistent oral health messages (e.g. around the use of fluoride toothpaste, smoking cessation and diet) are delivered by health professionals and those working with children in children's centres and schools
- Care should be taken to ensure that oral health care is accessible to all, particularly those in vulnerable groups of the population such as looked after children, children with disabilities and traveller children
- Ensure Thurrock's participation in the National Dental Epidemiological Programme to establish a more accurate picture of the local need
- Review oral health training needs for the wider health, social care and education workforce to support oral health improvement in their daily role.

Immunisations and Screening

Immunisation is one of the most effective public health interventions in the world in terms of saving lives and protecting health. A given percentage of the population (the World Health Organisation recommends this to be 95%) needs to have been immunised against a specific disease in order to prevent its spread and outbreaks; this concept is known as herd immunity. The routine childhood immunisation programme for the UK includes immunisations as defined by the Department of Health in Immunisation against infectious diseases (the Green Book). The

new schedule for the programme is shown in Figure 25 below. Information on the programme for adults will be covered in the Adults chapter of the JSNA.

Screening is a process of identifying apparently healthy people who may be at increased risk of a disease or condition. They can then be offered information, further tests and appropriate treatment to reduce their risk and/or any complications arising from the disease or condition. Whilst the majority of screening programmes are targeted at adults, there are antenatal and newborn screening programmes offered nationally.

Figure 25: Routine Childhood Immunisations from summer 2014

When to immunise	Diseases protected against	Vaccine given	Immunisation site ¹
Two months old	Diphtheria, tetanus, pertussis (whooping cough), polio and <i>Haemophilus influenzae</i> type b (Hib)	DTaP/IPV/Hib (Pediactel or Infanrix IPV Hib) ²	Thigh
	Pneumococcal disease	PCV (Prevenar 13)	Thigh
	Rotavirus	Rotavirus (Rotarix)	By mouth
Three months old	Diphtheria, tetanus, pertussis, polio and Hib	DTaP/IPV/Hib (Pediactel or Infanrix IPV Hib)	Thigh
	Meningococcal group C disease (MenC)	Men C (NeisVac-C or Menjugate) ²	Thigh
	Rotavirus	Rotavirus (Rotarix)	By mouth
Four months old	Diphtheria, tetanus, pertussis, polio and Hib	DTaP/IPV/Hib (Pediactel or Infanrix IPV Hib)	Thigh
	Pneumococcal disease	PCV (Prevenar 13)	Thigh
Between 12 and 13 months old – within a month of the first birthday	Hib/MenC	Hib/MenC (Menitorix)	Upper arm/thigh
	Pneumococcal disease	PCV (Prevenar 13)	Upper arm/thigh
	Measles, mumps and rubella (German measles)	MMR (Priorix or MMR VaxPRO) ²	Upper arm/thigh
Two, three and four years old ³	Influenza ⁴ (from September)	Flu nasal spray (Fluenz Tetra) (annual) (if Fluenz unsuitable, use inactivated flu vaccine)	Nostrils Upper arm
Three years four months old or soon after	Diphtheria, tetanus, pertussis and polio	DTaP/IPV (Infanrix IPV or Repevax) ²	Upper arm
	Measles, mumps and rubella	MMR (Priorix or MMR VaxPRO) (check first dose has been given) ²	Upper arm
Girls aged 12 to 13 years old	Cervical cancer caused by human papillomavirus types 16 and 18 (and genital warts caused by types 6 and 11)	HPV (Gardasil)	Upper arm
Around 14 years old	Tetanus, diphtheria and polio	Td/IPV (Revaxis), and check MMR status	Upper arm
	MenC ⁵	MenC (Meningitec, Menjugate or NeisVac-C) ⁵	Upper arm
65 years old	Pneumococcal disease	PPV Pneumococcal polysaccharide vaccine (Pneumovax II)	Upper arm
65 years of age and older	Influenza ⁴	Flu injection (annual)	Upper arm
70 years old	Shingles (from September)	Shingles (Zostavax)	Upper arm (subcutaneous)

Immunisations for those at risk ⁶			
At birth, 1 month old, 2 months old and 12 months old	Hepatitis B	Hep B	Thigh
At birth	Tuberculosis	BCG	Upper arm (intradermal)
Six months up to two years	Influenza ⁴	Inactivated flu vaccine (annual)	Upper arm/thigh
Two years up to under 65 years	Pneumococcal disease	PPV Pneumococcal polysaccharide vaccine (Pneumovax II)	Upper arm
Over two up to less than 18 years	Influenza ⁴ (from September)	Flu nasal spray (Fluenz Tetra) (annual) (if Fluenz unsuitable, use inactivated flu vaccine)	Nostrils Upper arm
18 up to under 65 years	Influenza ⁴	Inactivated flu vaccine (annual)	Upper arm
From 28 weeks of pregnancy ⁷	Pertussis	dTaP/IPV (Boostrix-IPV) ⁸	Upper arm

Source: Public Health England

What do we know?

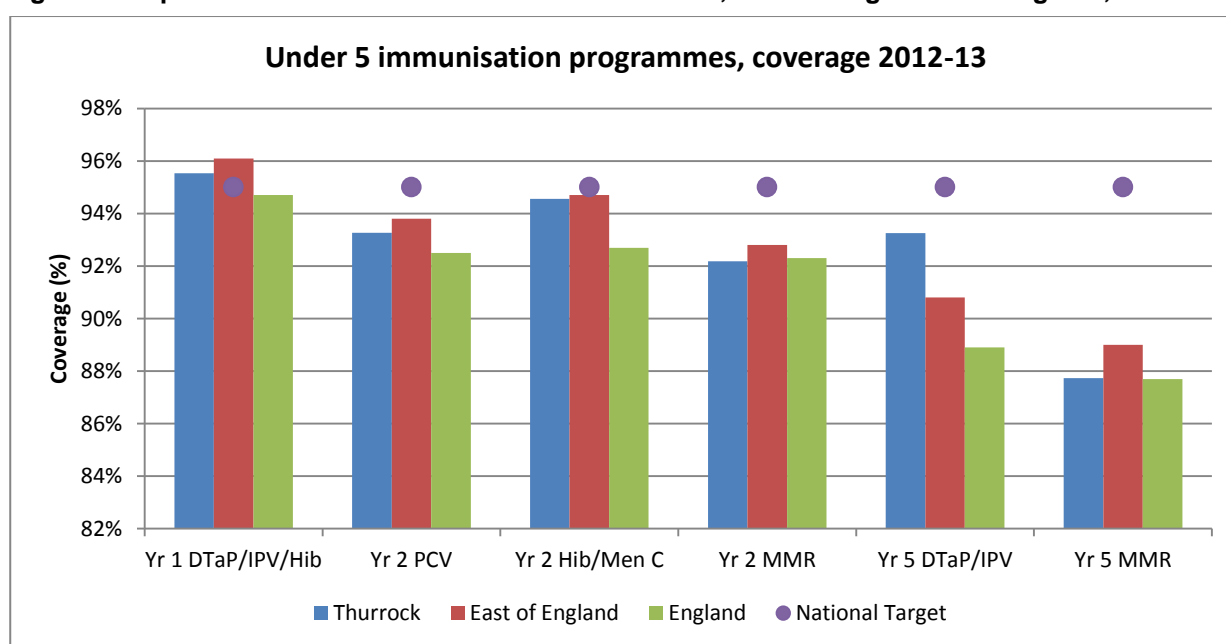
Under 5s vaccination programmes

The delivery of the national childhood routine immunisation programme is carefully monitored by Public Health England through COVER (cover of vaccination evaluated rapidly) data, which measures the percentage of the eligible population that has received each vaccination by 1,2 and 5 years within certain timeframes. The uptake target for all of the childhood vaccinations for children under 5 years was set by the World Health Organisation (WHO) and the Green Book as 95% in 2012-13. The vaccinations measured are:

- Diphtheria, tetanus, pertussis, polio and Haemophilus influenza type b at Year 1 (abbreviated as DTaP/IPV/Hib)
- Pneumococcal conjugate vaccine at Year 2 (abbreviated as PCV)
- Haemophilus influenza type b and Meningococcal group C disease at Year 2 (abbreviated as Hib/Men C)
- Measles, mumps and rubella at Year 2 (abbreviated as MMR)
- Diphtheria, tetanus, pertussis and polio at Year 5 (abbreviated as DTaP/IPV)
- Measles, mumps and rubella at Year 5 (abbreviated as MMR)

Figure 26 below shows the uptake of childhood vaccinations for Thurrock, East of England and England in 2012-13. It can be seen that Thurrock exceeds the national target for Year 1 DTaP/IPV/Hib and mirrors the regional and national coverage for several of the vaccinations; however uptake is considerably lower than the national targets for Year 2 PCV, Year 2 MMR and Year 5 MMR. It is worth noting however that in most cases the national average does not meet the national target, and whilst Thurrock may have fallen short of the 95% target, the national, and often regional, average was exceeded for almost all under 5s vaccinations.

Figure 26: Uptake of childhood vaccinations in Thurrock, East of England and England, 2012-13

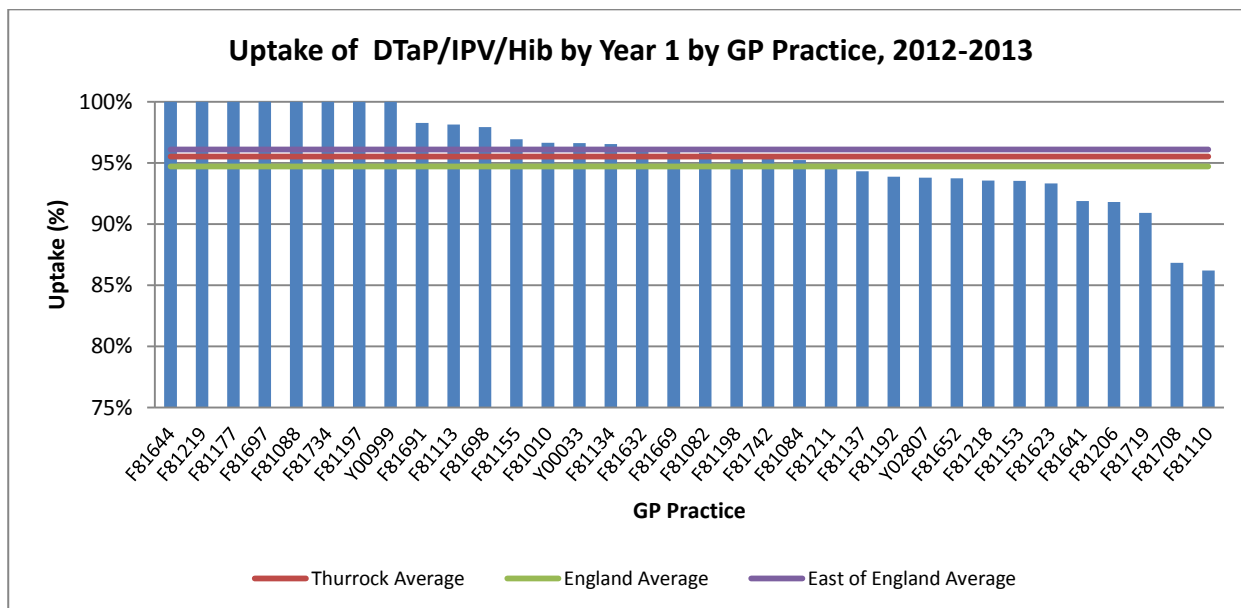


Source: Health and Social Care Information Centre

DTaP/IPV/Hib Year 1 Uptake

Figure 27 depicts the percentage of children aged one who have completed immunisations for diphtheria, tetanus, polio, pertussis, Haemophilus influenza type b (Hib) – (i.e. all three doses of DTaP/IPV/Hib) per GP practice in Thurrock from 2012-2013.

Figure 27: DTaP/IPV/Hib Year 1 Uptake by Thurrock GP practice for 2012-2013



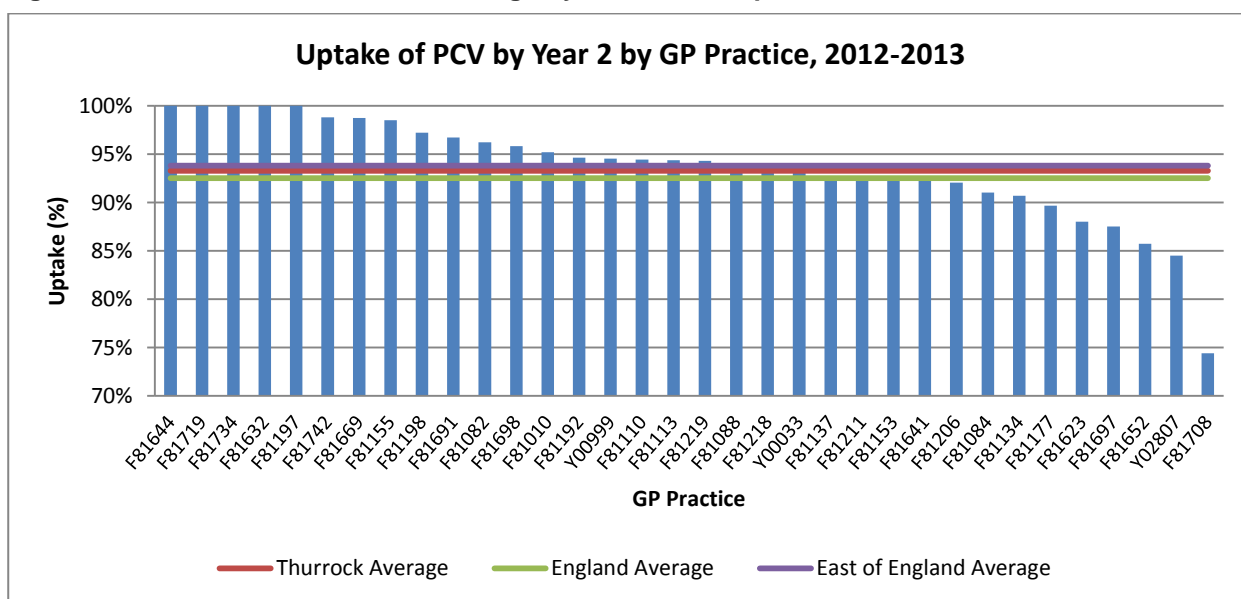
Source: Child Health SystmOne Körner data

Of the GP practices depicted, almost two thirds achieved the WHO target of 95%, and the same number exceeded the England average (94.7%). The Thurrock coverage for 2012-13 (95.53%) had increased from 2011-12 (94.5%).

Pneumococcal Conjugate Vaccine (PCV) Year 2 uptake

Figure 28 depicts the percentage of children aged two who have completed immunisations for pneumococcal infection (i.e. received pneumococcal booster) per GP practice in Thurrock from 2012-2013.

Figure 28: Year 2 Pneumococcal coverage by Thurrock GP practice for 2012-2013



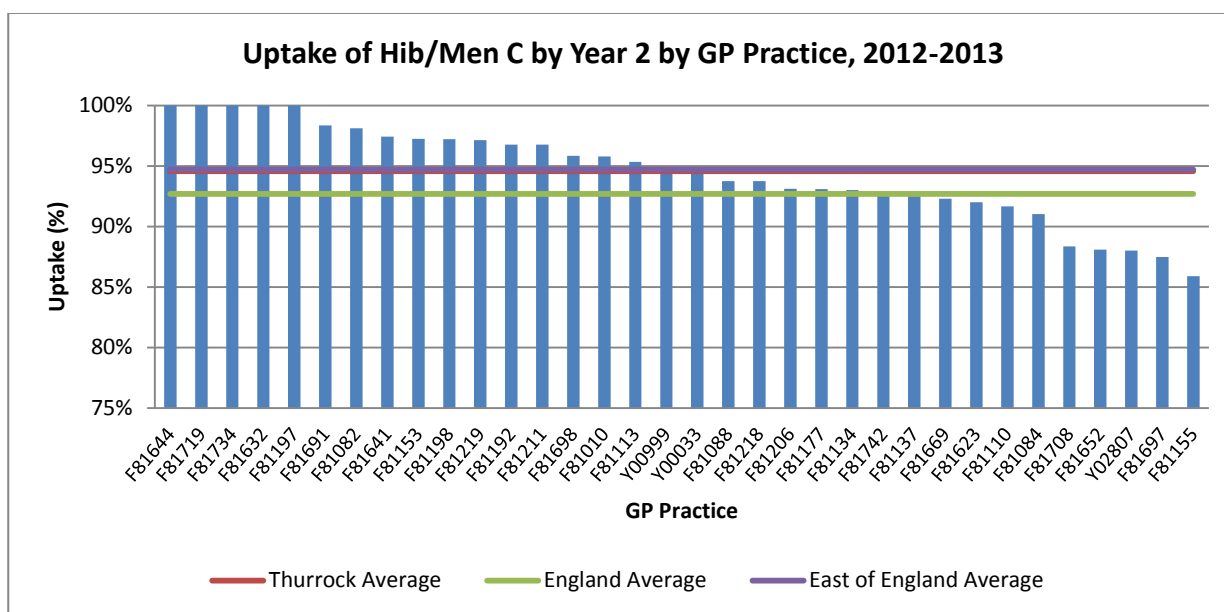
Source: Child Health SystmOne Körner data

Of the GP practices depicted, more than a third achieved the WHO target of 95%, and over half exceeded the England average (92.5%) and the East of England average (93.8%). The Thurrock coverage for 2012-2013 (93.3%) had increased from 2011-12 (89.6%).

Hib/Men C Year 2 uptake

Figure 29 depicts the percentage of children aged two who have completed immunisations for Haemophilus influenza type b (Hib) and Meningococcal C (Men C) – (i.e. received Hib/MenC booster) per GP practice in Thurrock from 2012- 2013.

Figure 29: Hib/MenC Year 2 uptake by Thurrock GP practice for 2012-2013



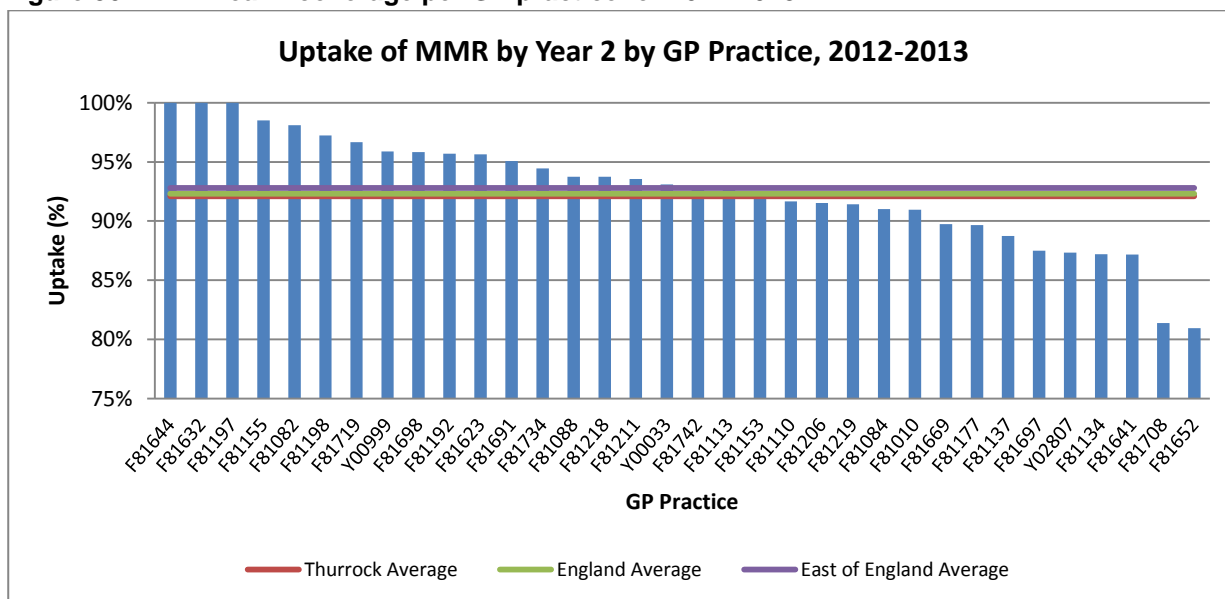
Source: Child Health SystmOne Körner data

Of the GP practices depicted, almost half met the WHO target of 95% and exceeded the East of England average (94.7%), while two thirds exceeded the England average (92.7%). The Thurrock coverage average for 2012- 2013 (94.6%) had increased from 2011-12 (93.6%).

MMR Year 2 uptake

Figure 30 depicts the percentage of children aged two who have completed immunisations for measles, mumps and rubella (MMR) – (i.e. one dose of MMR) per GP practice in Thurrock from 2012-2013.

Figure 30: MMR Year 2 coverage per GP practice for 2012-2013



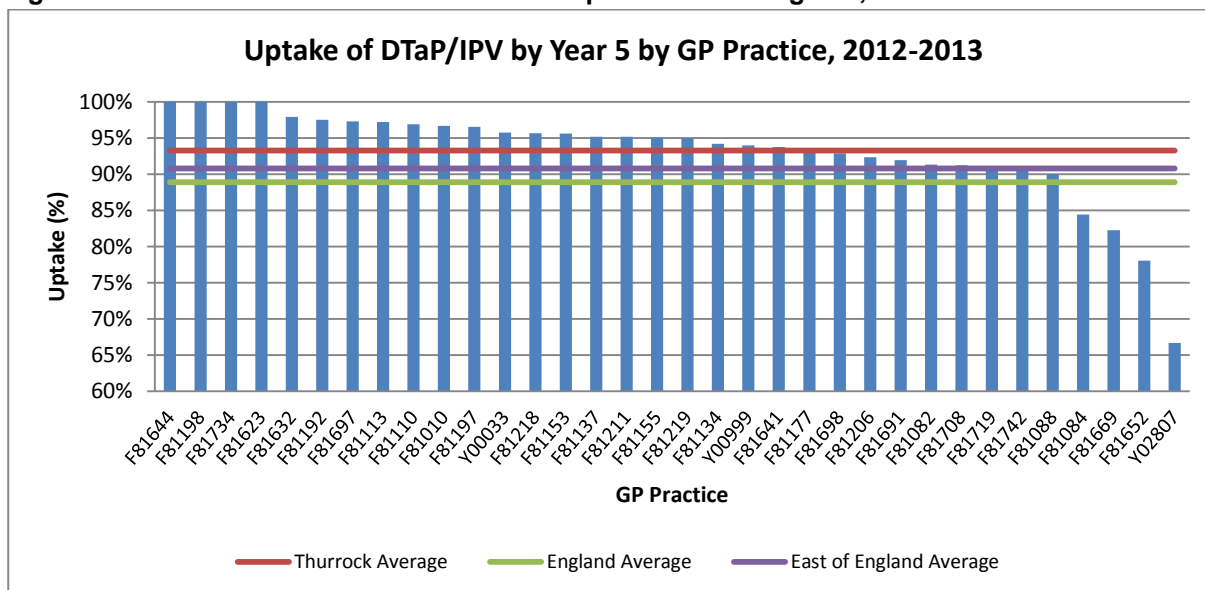
Source: Child Health SystmOne Körner data

Of the GP practices depicted, more than a third achieved the WHO target of 95%, and over half exceeded the England average (92.3%) and the East of England average (92.8%). The Thurrock coverage for 2012-2013 (92.18%) had increased from 2011-12 (89.26%).

Pre-school booster Year 5 uptake

Figure 31 depicts the percentage of children aged five who have completed immunisations (i.e. all four doses) for diphtheria, tetanus, polio, pertussis (DTaP/IPV) per GP practice in Thurrock from 2012-2013.

Figure 31: Pre-school booster Immunisation uptake children aged 5, 2012-13



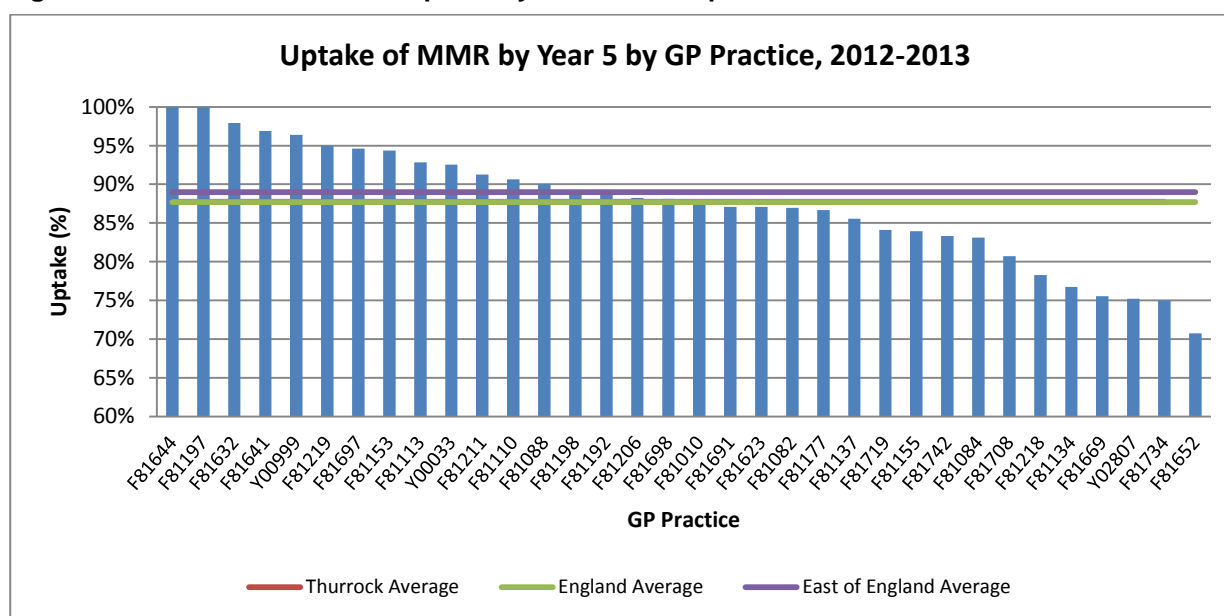
Source: Child Health SystmOne Körner data

Of the GP practices depicted, more than half achieved the WHO target of 95% and the majority exceeded the England (88.9%) and East of England averages (90.8%). The Thurrock coverage for 2012-13 (93.3%) had increased since 2011-12 (87.6%).

MMR Booster Year 5 uptake

Figure 32 depicts the percentage of children aged 5 who have completed immunisations for measles, mumps and rubella (MMR booster) (i.e. two doses of MMR) per GP practice in Thurrock from 2012-2013.

Figure 32: MMR Booster Year 5 uptake by Thurrock GP practice for 2012-2013



Source: Child Health SystmOne Körner data

Of the GP practices depicted, only six met the WHO target of 95%. Nevertheless, less than half fell below the England average (87.7%) and half below the East of England average (89%). The Thurrock coverage for 2012-2013 (87.7%) had increased since 2011-12 (85.7%).

Changes to the routine vaccination schedule in 2013/14

Public Health England announced a series of changes to the existing national vaccination schedule during 2013/14 which are described in detail in the 'Green Book' *Immunisation against Infectious Disease*. Table 1 below summarises these changes:

Table 1: Summary of changes to national immunisation programmes for children in 2013/14

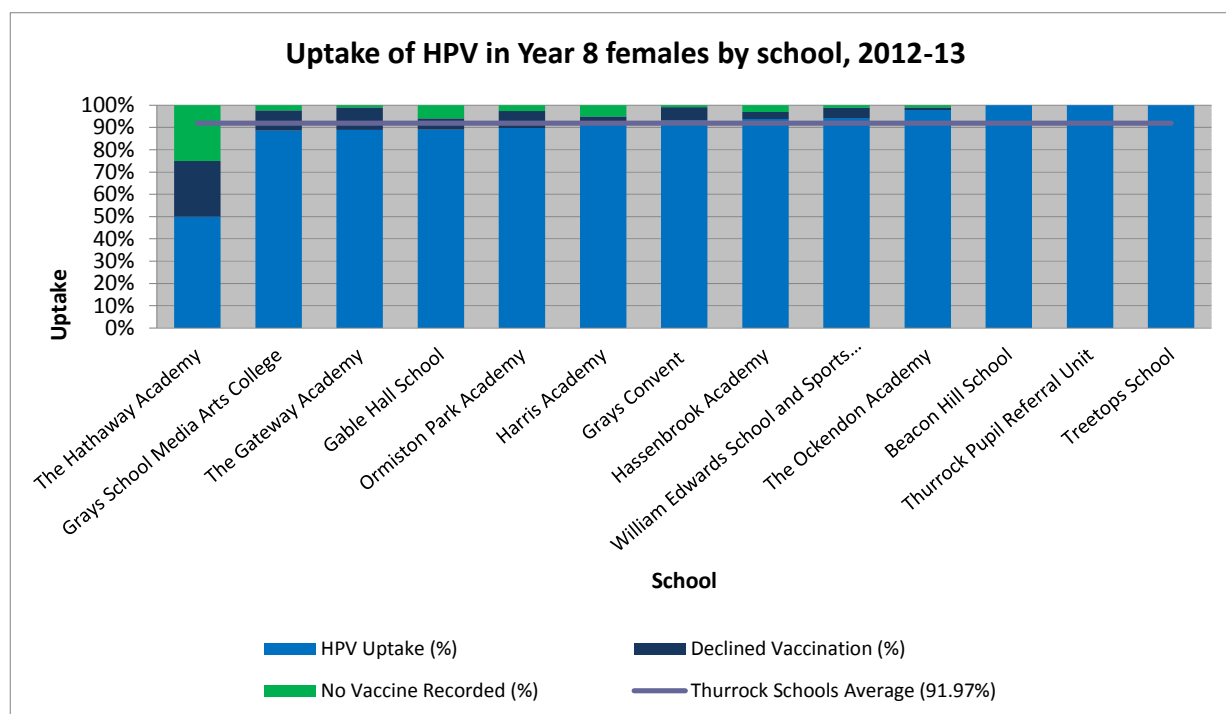
Date	Change	Rationale
June 2013	Meningococcal C (Men C) vaccine: removal of one primary dose	Second primary dose is being replaced by booster dose in adolescence.
July 2013	Rotavirus vaccine: introduced at 2 months and 3 months	Protects infants against rotavirus infection – common cause of gastrointestinal infection in infants.

September 2013	Men C vaccine: adolescent dose introduced via school-based programme	Protects children and young people against illnesses caused by meningococcal (group C) infection.
	Flu vaccine: introduced for 2 and 3 year olds	Protects children against flu, and reduces circulating flu in the community.
	Flu vaccine: pilot for 4 to 10 year olds in 7 areas in the country	Protects children against flu, and reduces circulating flu in the community.

School-age vaccinations

The Human Papillomavirus (HPV) vaccine is generally given to girls around 12-13 years in Year 8. Figure 33 below depicts coverage of the third dose of HPV by school.

Figure 33: HPV coverage of all three doses for 2012-2013 for 12 to 13 year old females by school.



Source: NHS England Local Area Team

The average coverage for girls attending Thurrock schools in 2012-13 was 91.97%, which is higher than the national target of **90%**. It must be noted that this cohort includes students who live outside the Thurrock area and commute in for schooling, plus omits girls who reside in Thurrock and are educated outside of the locality. Declined rates remain low, with a small proportion of patients refusing the HPV vaccination. In the case of the Hathaway Academy, there were a small number of girls recorded which has affected the proportions shown. Following up of students who are not presenting should be a priority so that they are offered the HPV vaccine in future clinics.

The **Bacillus Calmette-Guérin (BCG)** vaccine is routinely given to children in areas with a high rate of TB or who have a parent or grandparent from a country with a high rate of TB. Thurrock does not routinely give this vaccine.

What are we doing in Thurrock?

The Screening and Immunisations team within the Essex Area Team (part of NHS England) have held the commissioning responsibilities in Thurrock for these programmes since 1st April 2013. The Area Team has a programme of visits planned to the practices in Essex with the poorest performance against a range of indicators including immunisations and screening, in order to investigate the reasons for poor performance. A local plan was also implemented as part of the national catch up programme for the MMR vaccine in 2013.

Recommendations

All of the infections that are in the childhood immunisation programme can develop into serious illnesses and have the potential to cause disability or death. Immunising children means that they are protected from these serious diseases and their potentially devastating effects. Many of these diseases have no cure so vaccination can prevent any unnecessary illness. Immunisation is complex and various factors should be consistent across GP practices in the borough. To improve the offer of childhood immunisations and screening in Thurrock, emphasis should be placed on strengthening the following:

- Patient reminder and recall systems in GP practices
- High quality patient education and information resources in a variety of formats to ensure access to hard-to-reach groups
- Ensuring accurate data is held on the immunisation status of the population
- Maintenance of staff knowledge and awareness with regard to immunisations and screening to ensure accurate and consistent advice is provided to patients
- Partnership working to promote and deliver immunisation programmes
- Effective performance management of the commissioned service provided, to ensure it meets the requirements of the area

Focus for future improvements will look to improve uptake where Thurrock is below the regional and national averages or the WHO target – particularly for Year 2 MMR and Year 5 MMR.

When planning services, consideration should also be given to the projected increase in the local child population within the next few years to ensure there is sufficient provision to meet the increasing demand.

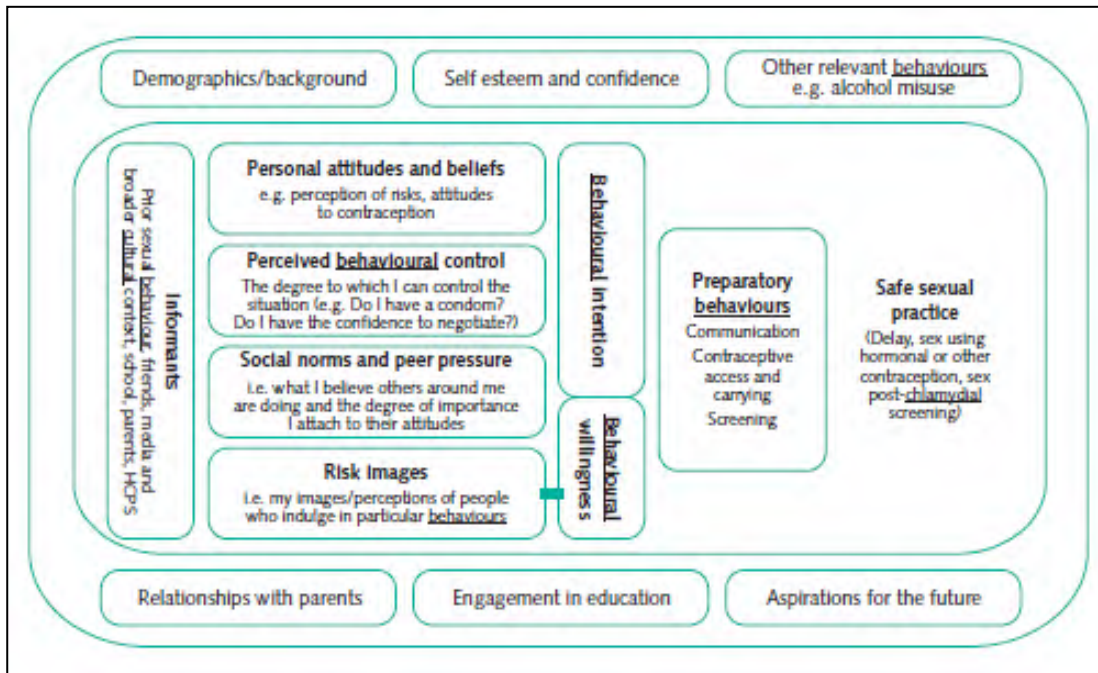
Sexual Health

Sexual health covers the provision of advice and services around contraception, relationships, sexually transmitted infections (STIs) (including human immunodeficiency virus (HIV) testing) and abortion. Provision of sexual health services is complex and there is a wide range of providers, including general practice, community services, acute hospitals, pharmacies and the voluntary, charitable and independent sector. The consequences of poor sexual health can be serious. Unintended pregnancies and STIs can have a long lasting impact on people's lives, and the latter are the main preventable cause of infertility particularly in women. Untreated STIs can facilitate HIV transmission and increase susceptibility to HIV. The number of visits to genito-

urinary medicine (GUM) clinics has been increasing steadily since the 1960s, and now stands at over a million a year (Department of Health, 2001).

Groups known to be at risk of worse sexual health outcomes include those living in deprived areas, gay and bisexual men and certain minority ethnic groups (HIV). However there are a number of other factors that can influence sexual health outcomes. Figure 34 below depicts some of the key influences on safer sex practice.

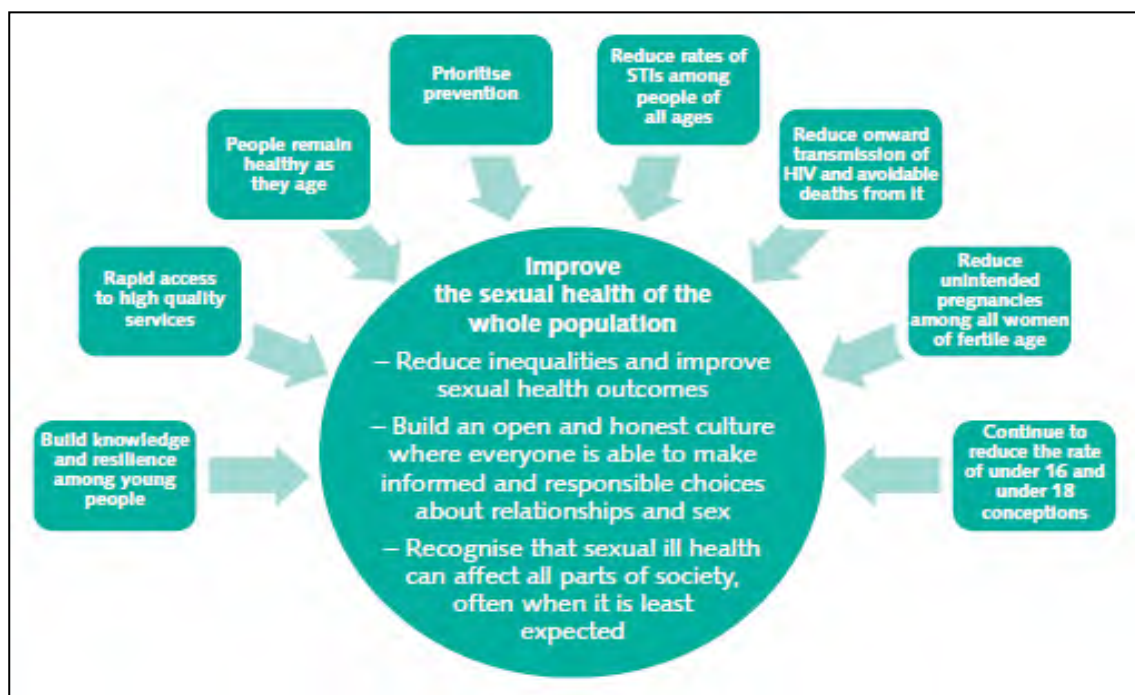
Figure 34: Influences on Safer Sex Practice



Source: Department of Health, 2013

The importance of improving sexual health is acknowledged by the inclusion of three indicators in the Public Health Outcomes Framework (PHOF): under-18 conceptions, Chlamydia diagnoses (15–24 year-olds), and people presenting with HIV at a late stage of infection. The Department of Health have set out some key objectives within their latest best practice guidance for sexual health services (Department of Health, 2013), which look to reduce inequalities and improve the sexual health of the population. These are shown in Figure 35 below.

Figure 35: Key Objectives: A Framework for Sexual Health Improvement in England, 2013



Source: Department of Health, 2013

For the minority of young people aged under 16 who are sexually active, it is important that they have confidence to attend free and open access sexual health services, thus giving early access to professional advice, support and treatment to prevent pregnancy and STIs. In addition, sexual health service providers should be aware of child protection and safeguarding issues and take very seriously the possibility of abuse and/or exploitation. [Information on children and young people at risk of exploitation, abuse and sexual violence can be found in other sections of the JSNA].

What do we know?

Rates of Chlamydia are substantially higher in young adults than in any other age group. Launched in 2003, the National Chlamydia Screening Programme (NCSP) aims to test all sexually active people under the age of 25 annually or with each change of sexual partner as a routine part of primary care and sexual health consultations. There were 1,529 per 100,000 diagnoses of Chlamydia to young people aged 15-24 years in Thurrock in 2013, which has decreased since 2012 (1,606 per 100,000). Thurrock has a significantly lower rate of Chlamydia diagnoses than the national (2,016 per 100,000) and regional (1,719 per 100,000) averages. [Chlamydia data before 2012 cannot be compared to 2012 or 2013 figures due to changes made to the surveillance system].

It should be noted however that data showing the rate of positive screens may not show the full picture of Chlamydia in Thurrock, this could be because a large number of young people who have the disease may not be being screened at all. The latest data on the proportion of young people aged 15-24 years being screened for Chlamydia indicate that there were a statistically lower number of young people being tested in Thurrock than nationally or regionally (18.0% of the eligible population of 15-24 year olds were screened in Thurrock in 2013, compared to 24.9% nationally and 22.4% regionally).

Data on the diagnosis rates of other sexually transmitted diseases and the rates of teenage conceptions can be found elsewhere in the JSNA.

What are we doing in Thurrock?

Thurrock Council commissions North East London Foundation Trust (NELFT) to offer a comprehensive community based service that includes advice and guidance on relationships and safer sex, contraception, pregnancy testing, testing and treatment for STIs and testing for HIV. Services provided are highly accessible to the population groups most in need of them and are non-discriminatory.

The current service provision includes:

- **Early diagnosis of HIV infection and Genito-Urinary Medicine service (GUM):** GUM services support sexual and reproductive healthcare needs. The service offers screening for STIs and HIV, distributing condoms and delivering health education on sexual health and general health issues. Some clinics offer psychosexual counselling and specialist HIV treatment and care which is commissioned by the CCG.
- **C-Card** The c-card scheme provides free condoms, sexual health advice and routine Chlamydia screening to under 25 year olds. Young people are required to visit a c-card assessor to get a c-card, which can then be presented at outlets across Thurrock to receive free condoms.
- **Sexual and reproductive healthcare:** These are community based contraceptive services delivering focused, holistic care for women and men. They provide training and advice to primary care practitioners, contribute to the reduction of sexually transmitted infections, and contribute to the reduction of unplanned pregnancies. The emergency contraception scheme offers free emergency contraception to under 19s from a range of service providers across Thurrock.
- **Training to professionals:** Our provider offers a suite of sexual health training to multi-agency professionals who work with young people:
 - *Sexual Health Awareness Foundation Training (SHAFT)* - a one day course which enables participants to consider approaches to sexual health and learn about sexual health of young people in Essex, the services that are available and the initiatives which are in place to support good sexual health for young people.
 - *Go Girls* – a one day course which provides practical strategies for emotional development and building self-esteem in girls and young women.
 - *Delay training* - to ensure that young people feel equipped to resist peer pressure and other influences, and encourage young people to make healthy and responsible decisions about relationships and sexual health.

It should be noted that the current sexual health service in Thurrock is undergoing a full service review with a consultation and benchmarking exercise, with the aim to have a comprehensive integrated sexual health service in place by April 2015. Part of this involves consultation with schools, colleges, primary and secondary care providers, other stakeholders and service users to fully engage with them around this process. The future model proposes to offer a full GUM level one service within the Contraceptive and Sexual Health (CASH) clinic in Grays Health Centre which proved successful in a recent pilot. A review of current workforce will be undertaken.

Recommendations

- The population in Thurrock has been subject to many changes over recent years, and is set to increase. In addition, the opening of the new South Essex College campus in Grays is likely to increase demand on our open access sexual health services. Services should ensure that they can meet the changing needs – which will be more fully understood following the full service review.
- Prevention strategies to improve STI screening coverage should be sustained and continue to focus on groups at highest risk. However, promotion campaigns should fully encapsulate as wide an audience as possible and involve all relevant stakeholders and providers. Many STIs do not have any symptoms, and so raising awareness of the risks of infection may be the only way to ensure people understand the risks and how these can be reduced.
- Continuation of sexual health training to professionals, and continued promotion of these courses amongst all professionals who work with young people will ensure young people are able to be supported to experience good sexual health.
- Future services will be commissioned to ensure our young people are safe from sexual exploitation.

Teenage Pregnancy

Teenage pregnancy is a complex issue affected by a wide range of factors, and is a cause of health inequalities. It is an issue that is monitored at a national level - as well as being included in the Public Health Outcomes Framework, teenage pregnancy has also been included as an indicator to be monitored within the “A New Approach to Child Poverty: Tackling the Causes of Disadvantage and Transforming Families’ Lives” document, published by the Department for Work and Pensions and Department for Education in 2011.

The evidence shows that children born to teenage mothers are more likely to experience a range of negative outcomes in later life and are more likely, in time, to become teenage parents themselves – perpetuating the disadvantages that young parenthood brings from one generation to the next. The Department for Children, Schools and Families (2010) identified several socio-economic risk factors associated with teenage pregnancy:

- Living in a deprived area - measures such as housing, income, employment and benefits are often closely related to the teenage pregnancy rate
- Limited knowledge regarding contraception and sexual health advice – some young people still do not fully understand risk associated with sex, how the body works or how to use contraception. There also may be a reduced awareness with regard to the social and economic consequences of pregnancy.
- Family structure – children living in care or those from lone parent backgrounds may be more likely to become teenage parents. Additionally, those whose mothers were teenage parents are also more likely to become teenage parents.
- Educational attainment - on average, deprived wards with poor levels of educational attainment have under-18 conception rates twice as high as similarly deprived wards with better levels of educational attainment (Department for Education and Skills, 2006).

In addition, research found that those leaving school with no qualifications were more likely to use no contraception when having sex, compared to those with higher levels of educational attainment (Department for Education and Skills, 2006).

- Disengagement from school – the Department for Education and Skills found that among the most deprived 20% of local authorities, areas with higher rates of absenteeism have higher under-18 conception rates.
- Participation in early and risky behaviours – including early onset of sexual activity, and substance misuse
- Mental health problems – particularly self-esteem and confidence levels, which can impact on their choices
- Some ethnic groups are more likely to experience teenage pregnancy than others – however it is unclear whether this is an independent factor.

Where young women choose to go ahead with the pregnancy, they can be at greater risk of experiencing a range of poor outcomes, which include:

- Teenage mothers are less likely to finish their education, and more likely to bring up their child alone and in poverty
- The infant mortality rate for babies born to teenage mothers is 60 per cent higher than for babies born to older mothers
- Teenage mothers have three times the rate of post-natal depression of older mothers and a higher risk of poor mental health for three years after the birth
- Children of teenage mothers are generally at increased risk of poverty, low educational attainment, poor housing and poor health, and have lower rates of economic activity in adult life. Sons of teenage mothers are more likely to be imprisoned when compared to their peers born to older mothers.

It is likely that when identifying teenage parents locally, it will emerge that many will have more than one of the identified risk factors, as the link with deprivation for many of these factors is widely known. Services within local areas should work together and invest in actions to maintain the preventative services offered to potential teenage parents, particularly in the current climate of reducing public spend, in order to improve outcomes for teenage parents and their children.

What do we know?

Under 18 conceptions

The data shows that Thurrock had 93 conceptions in females aged under 18 years in 2012. This equates to a conception rate of 30.5 per 1,000, which is higher than the England average. Thurrock has a lower percentage of conceptions ending in abortion than the England average. When comparing the 2012 and 2011 data, Thurrock has 11 fewer under 18 conceptions in 2012 than 2011 and the rate is therefore lower. The percentage of conceptions ending in abortion has reduced in Thurrock in 2012. These key figures can be seen in Table 2 below.

Table 2: Headline under 18 conception figures for Thurrock, East of England and England

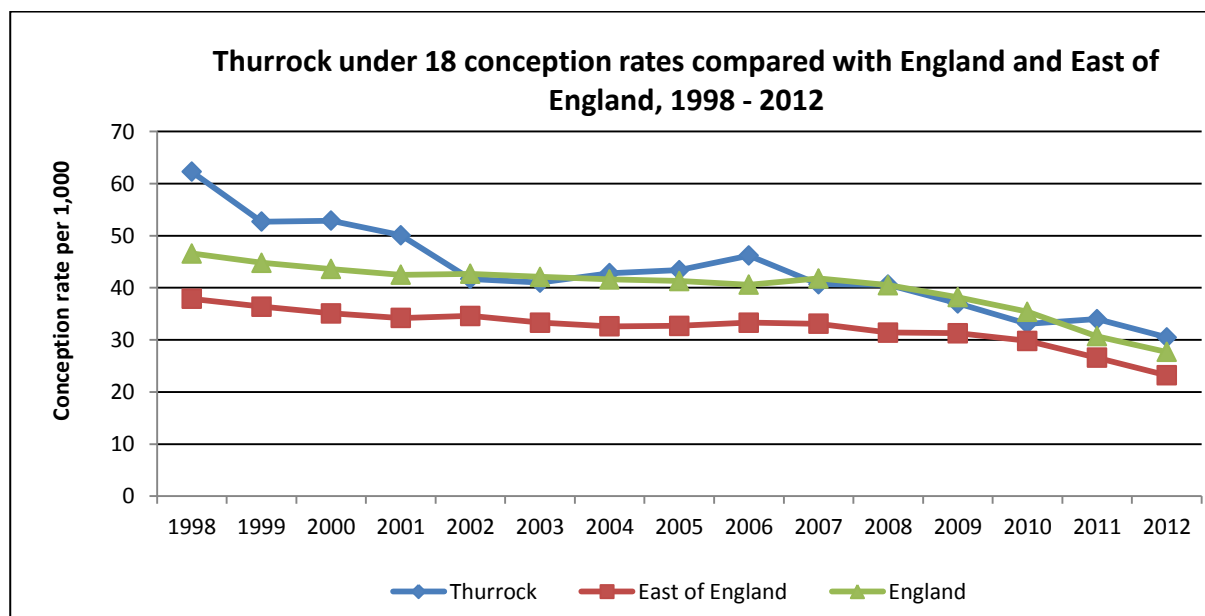
	2012 conceptions (number and rate	2011 conceptions (number and rate	2012 conceptions	2011 conceptions

	per 1,000)	per 1,000)	leading to abortions	leading to abortions
Thurrock	93 – equates to 30.5 per 1,000	104 – equates to 34.0 per 1,000	41.9%	54.8%
East of England	2,467 – equates to 23.2 per 1,000	2,860 – equates to 26.6 per 1,000	49.2%	50.2%
England	26,157 – equates to 27.7 per 1,000	29,166 – equates to 30.7 per 1,000	49.1%	49.3%

Source: ONS

It should be noted that Thurrock's reduction in under 18 conceptions is in line with the national trend – this can be seen graphically in Figure 36. Thurrock has dramatically decreased its rate of under 18 conceptions by 51% since the national teenage pregnancy strategy was launched in 1998. This impact is far greater in comparison to national and regional figures that have decreased by 40.6% and 38.8% respectively and is the 6th biggest reduction by a council outside of London. No single factor can be entirely credited with this achievement since the interdependencies are complex. Instead it is a series of marginal gains that are the likely cause, including but not limited to the availability of free and open access community contraceptive services for young people and having dedicated staff to support teenage parents and strategically plan the service provision.

Figure 36: Under 18 conception rates in Thurrock, East of England and England, 1998-2012

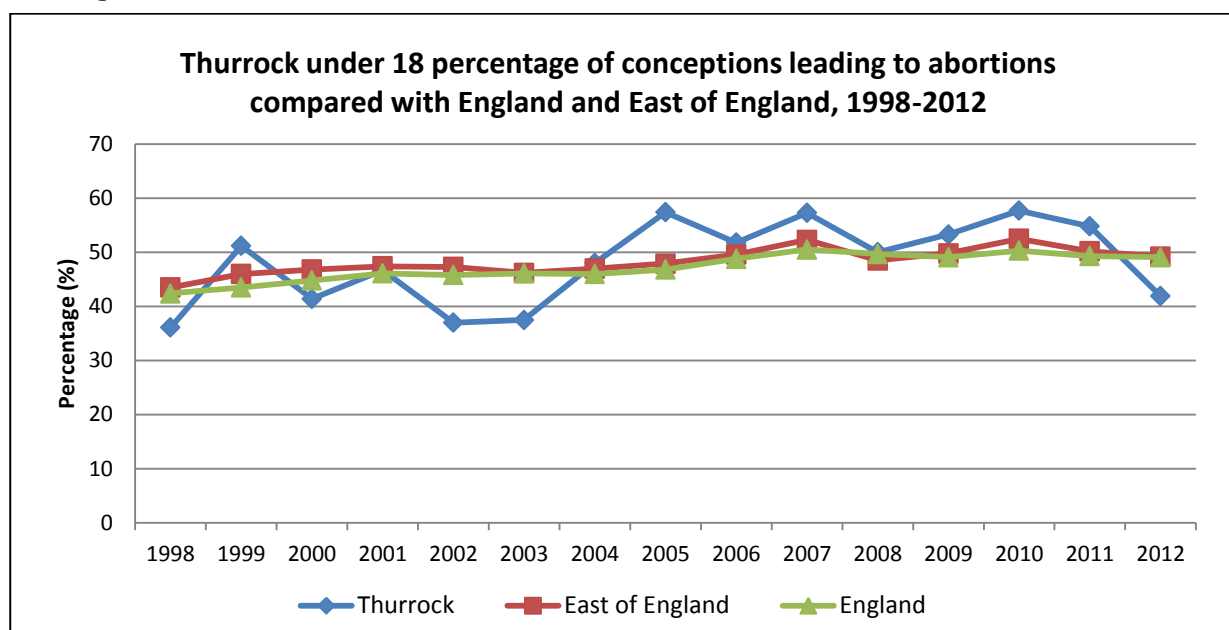


Source: ONS

In Figure 36 above it is possible to see how on a number of occasions Thurrock's conception rate has dropped below that of the national rate and in 2010 was very close to the regional rate.

Figure 37 below shows the percentage of under 18 conceptions that led to abortion from 1998-2012, and depict that whilst the national and regional percentages have been relatively stable, the Thurrock percentages have more variation between years. The smaller numbers involved should be considered when reviewing this data.

Figure 37: Percentage of under 18 conceptions leading to abortions in Thurrock, East of England and England, 1998-2012



Source: ONS

It should be noted that the most recent abortion data from the Department of Health showed that Thurrock had a higher rate per 1,000 of abortions in 2013 to females aged under 18 than the national and regional averages (18 per 1,000 compared to 11.7 per 1,000 and 10 per 1,000 respectively).

Ward-level data

Ward-level data on numbers and rates of conceptions to females aged under 18 is produced by the ONS as an aggregation of three years' data. The most recent data (2010-12) shows that the wards with the highest rates of conceptions are Tilbury St Chads, Stanford Le Hope West and Tilbury Riverside and Thurrock Park. In 2009-11, the top three wards were Tilbury Riverside and Thurrock Park, Tilbury St Chads and Belhus. These wards contain some of the most deprived LSOAs in England, showing an association between increased teenage conceptions and poverty at a local level.

Under 16 conceptions

The data shows that Thurrock had 19 conceptions in females aged under 16 years in 2012. This equates to a conception rate of 6.3 per 1,000, which is higher than the England average. Thurrock also has a higher percentage of conceptions ending in abortion than the England average. When comparing the 2012 and 2011 data, Thurrock has four fewer under 16 conceptions in 2012 than 2011 and the rate is therefore lower. The percentage of conceptions ending in abortion has been suppressed for 2011 and is unavailable for comparison. These key figures can be seen in Table 3 below.

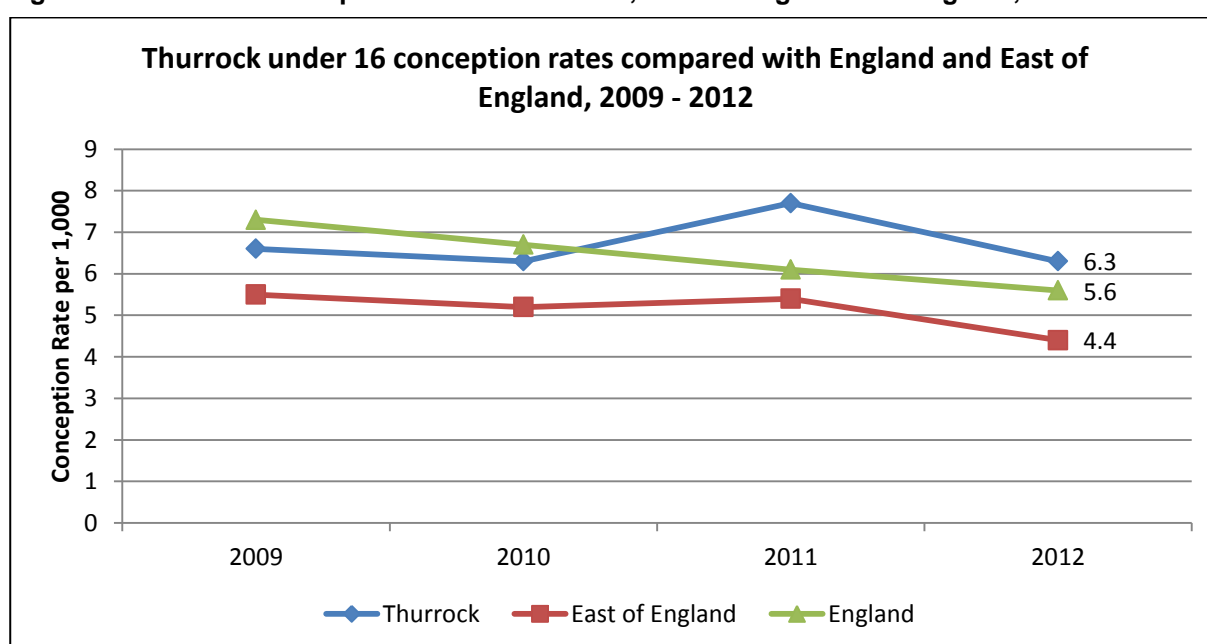
It should be noted that Thurrock's reduction in under 16 conceptions is in line with the national trend – this can be seen graphically in Figure 38.

Table 3: Headline under 16 conception figures for Thurrock, East of England and England

	2012 conceptions (number and rate per 1,000)	2011 conceptions (number and rate per 1,000)	2012 conceptions leading to abortions	2011 conceptions leading to abortions
Thurrock	19 – equates to 6.3 per 1,000	23 – equates to 7.7 per 1,000	63.2%	Suppressed
East of England	459 – equates to 4.4 per 1,000	569 – equates to 5.4 per 1,000	58.0%	58.3%
England	5,131 – equates to 5.6 per 1,000	5,661 – equates to 6.1 per 1,000	60.1%	60.5%

Source: ONS

Figure 38: Under 16 conception rates in Thurrock, East of England and England, 2009-2012



Source: ONS

What are we doing in Thurrock?

North East London Foundation Trust (NELFT) provide community contraceptive services in Thurrock via sexual health clinics and services available through GP surgeries and pharmacies, including a specialist genitourinary medicine (GUM) clinic in Orsett. NELFT also provide our school nursing service that promote and provide aspects of the sexual health service and support Personal, Social and Health Education (PSHE) and Sex and Relationships Education (SRE) in schools where possible. Children's centres also have capacity to deliver some sexual health services such as C-card in addition to midwifery services, and offer support to parents to ensure they have a greater understanding in how to manage their pregnancy (which is one of their 28 outcomes under their Outcomes Framework).

The Family Nurse Partnership is now established in Thurrock with 44 places for teenage mothers and partners on an intense programme of support over 3 years (further information can be found in the [Low Birth Weight](#) section).

For teenage parents, there are currently two teenage parent-supported housing schemes able to support 16 people. There are also some flats specifically for young parents to move into once they have completed a period of support in either of the two schemes. Once they have demonstrated that they can sustain independent living, they are supported to move into the local community. In addition, there is a floating support service that supports 7 young women at a time in the local community, either to support them to remain living with parents or to support women moving on from the housing scheme.

Recommendations

- Future commissioning of any interrelated service across the council should include consideration for the impact on teenage conceptions and have this as a target within the service specification e.g. school nursing, sexual health services, residential foster placements
- Staff working in related fields should be able to demonstrate their understanding of and ability to effectively engage vulnerable young people who are at risk of becoming a teenage parent and provide or signpost to services for appropriate support. Such staff might include GPs, teachers, social workers, school nurses, Local Area Coordinators, Troubled Families team staff and associated outreach workers that may come into contact with children and young people from time to time. Spotting the risk factors and effectively responding to these early is key to the success of the prevention agenda where shared targets need to be the norm; improved school attendance and attainment of our young people is everyone's business. Legislation to raise the participation age for education, training or work-based learning makes getting this right ever more important.
- Work should continue to support and engage all secondary schools in offering the full range of services available from the school nursing service including flexible confidential drop-in services, specialist and up-to-date advice on sexual health for PSHE and SRE lesson plans including cross-cutting subjects such as the sciences, and supporting teaching staff with the delivery of such lessons. Our staff and services need to remain responsive to the changing needs of our communities such as population growth in some parts of the borough due to regeneration and the likely increase in demand on local services that the new college campus will have in Grays. For example, the GUM clinic is preparing to offer a permanent satellite service in Grays to respond to such impending demand.
- Appropriate early education delivered at all primary schools
- Sexual health service training should continue to be offered to frontline staff across social care, education and health such as C-card, Go Girls and Speakeasy.
- Young males should not be overlooked when planning services.
- You're Welcome is a health-based audit to measure how young-person friendly a service is. NELFT have been targeted with achieving the standard and work is under way to ensure all of our Children's Centres achieve the standard too.

Smoking

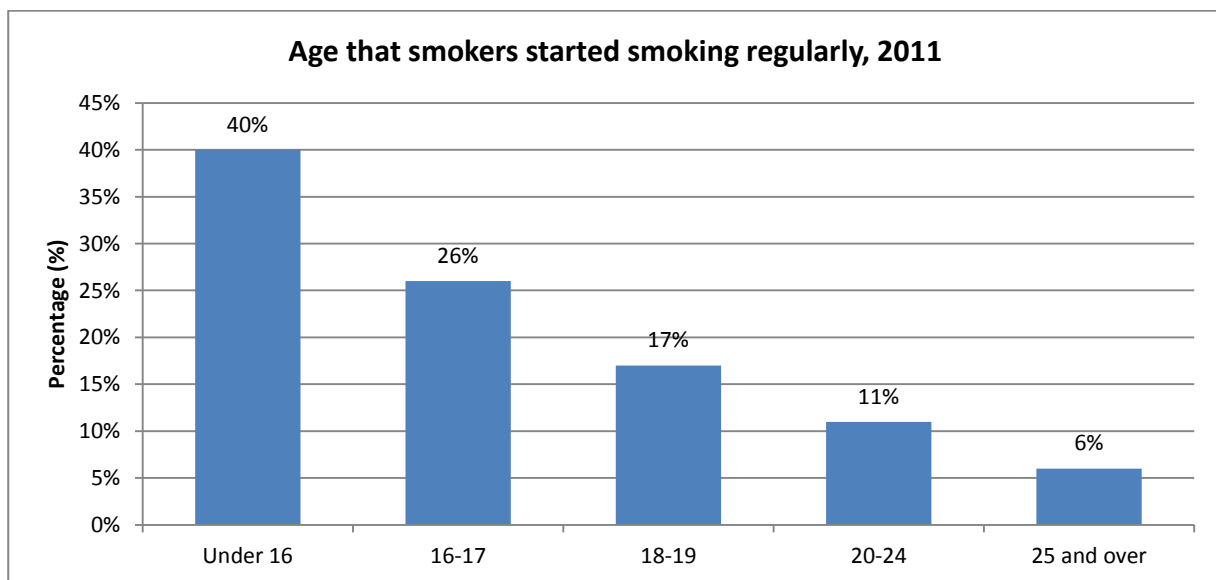
Smoking in Children and Young People

Child and adolescent smoking causes serious risks to respiratory health both in the short and long term. Children who smoke are two to six times more susceptible to coughs and increased phlegm, wheeziness and shortness of breath than those who do not smoke. They are also more likely to continue smoking during their adult lives and have a lower chance of quitting. Smokers who start smoking at an early age have a higher risk of developing lung cancer or heart disease. In addition, there are enormous economic costs to society associated with smoking. Research by Action on Smoking and Health (ASH) estimated that smoking costs the UK economy £13.1 billion per year, including £2 billion in direct treatment costs to the NHS. (Action on Smoking and Health, 2014)

Children and young people are also more susceptible to the effects of passive smoking, particularly if there is a parent at home who smokes. They are at higher risk of respiratory infections, asthma, bacterial meningitis and cot death. Second-hand smoke has been linked to around 165,000 new cases of disease among children in the UK each year (Cancer Research UK). Passive smoking is particularly dangerous in cars, as just one cigarette smoked in a car can create pollution levels 35 times greater than those deemed safe by the World Health Organisation. More than 430,000 children are exposed to second hand smoke in the family car each week. (British Lung Foundation, 2013)

Cancer Research UK (2011) found that over 200,000 children aged between 11 and 15 start smoking in the UK every year. Research by the Office of National Statistics (2011) found that almost two thirds of adult smokers started smoking before the age of 18 – the figure below depicts smoking uptake by age.

Figure 39: Age at which smokers started smoking regularly, 2011



Source: General Lifestyle Survey, 2011

In their factsheet, Action on Smoking and Health (2014) wrote that initiation of smoking is associated with risk factors which include:

- Parental or sibling smoking – children who live with parents or siblings who smoke are up to 3 times more likely to become smokers themselves than children of non-smoking households.
- The ease of obtaining cigarettes
- Smoking by friends and peer group members
- Socioeconomic status
- Exposure to tobacco marketing
- Depictions of smoking in the media

Surveys undertaken by the Health and Social Care Information Centre have found that smoking in children and young people is associated with other substance abuse - the 2013 survey found that of the 6% of pupils who reported smoking in the week before the survey, most (4%) had also drunk alcohol or taken drugs recently, or had done both. It is also associated with truancy or exclusion from school - the 2012 survey found that young people who played truant from school or who had been excluded from school in the previous 12 months were almost twice as likely to smoke regularly compared to those who had never been truant or excluded.

Effective interventions

Research suggests that knowledge about smoking is a necessary component of anti-smoking campaigns but by itself does not affect smoking rates. It may, however, result in a postponement of initiation. Young people may be deterred from smoking due to high prices if they do not possess a large disposable income; however this alone is not sufficient as a deterrent. In fact the existence of an illegal trade in tobacco products reduces the effectiveness of tobacco control measures as it is often available at cheaper prices and is available from a range of sources (Tackling Illicit Tobacco for Better Health, 2014). The National Institute for Health and Clinical Excellence (NICE) has issued guidance on school-based interventions to prevent the uptake of smoking amongst children, and has recommended that a combination of community-based activity, mass media campaigns and systematic tobacco education in schools is an effective approach in reducing smoking uptake in children and young people.

There is clear evidence that the most effective tobacco control strategies involve taking a multi-faceted and comprehensive approach at both national and local level. There are other national tobacco control initiatives in place; these include:

- Standardised cigarette packaging – evidence shows that removing all branding and design from the packs makes cigarettes less attractive, particularly to children and young people.
- Outlawing smoking in cars – Parliament have spoken in favour of a ban to outlaw smoking in cars carrying children, which is likely to be introduced before the next election in 2015.
- Removing tobacco products from display in large stores - research by the Centre for Tobacco Control Research (2008) shows that Point of Sale (PoS) display has a direct impact in young people's smoking, stating that almost half (46%) of UK teenagers were aware of tobacco display at PoS and those expressing an intention to smoke were more likely to recall brands that they had seen at the point of sale.

- Legislation around the sale of tobacco - updated regulations came into force on 1st October 2007 which makes it illegal to sell tobacco to anyone under the age of 18 and authorities may confiscate tobacco from anybody under the age of 16.

The rise of e-cigarettes has meant that it is now unknown how many children and young people are using them as they can legally be sold to children. The lack of restrictions on advertising strategies have led to a range of flavours and colours available which are likely to appeal to young people. Although they are perceived as a better option than smoking and a helpful aid for quitting, concerns have been raised as it is not yet known what harm the tobacco-free devices could inflict on young people's health. However it is likely that at least one e-cigarette product may be licensed as a prescription medicine for nicotine replacement therapy (NRT) in the near future.

What do we know?

Data collected by the Health and Social Care Information Centre (2013) indicates that 3% of pupils in England reported that they smoked at least one cigarette per week. When results were broken down by age, it can be seen that the prevalence of smoking increased with age: less than 0.5% of 11 and 12 year olds said that they smoked at least one cigarette per week, compared with 4% of 14 year olds and 8% of 15 year olds.

Research undertaken by Essex County Council's Research and Analysis Unit (2013) found that pupils receiving Free School Meals, with poor emotional wellbeing or have received a police warning are significantly more likely to smoke, demonstrating clear socioeconomic differences from an early age.

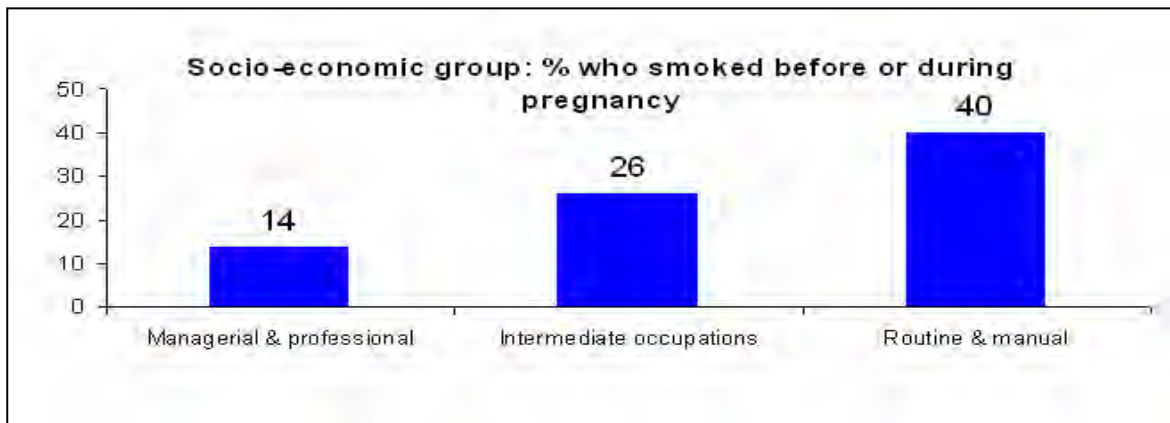
Accurate local data is limited. The most recent data on smoking habits in children and young people originates from the TellUs4 survey (2009), which indicates that 4% of Thurrock children in years 6, 8 and 10 usually smoke at least one cigarette per week, which was the same as the national average but higher than the regional average (3.4%).

There has been a general decline in recent years in the number of smokers engaging with a quit attempt with a recognised stop smoking service. At the same time there has been a sharp rise in the sales of electronic cigarettes due to the increasing range of products available. Even though not all the evidence suggests these smokers are quitting with the help of an e-cigarette and many are simply switching products or dual-using, this has a large impact on quit rates both locally and nationally.

Smoking in pregnancy

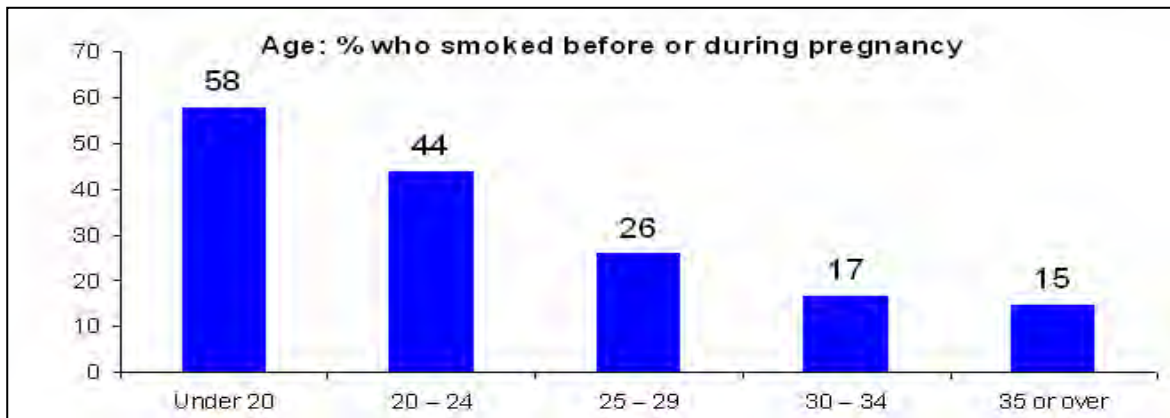
Smoking during pregnancy can cause serious pregnancy-related health problems, complications during labour and an increased risk of miscarriage, premature birth, still birth low birth-weight and sudden unexpected death in infancy. It has been found to increase the risk of infant mortality by 40% (National Institute for Health and Clinical Excellence, 2010). Results from the Infant Feeding Survey (2005) indicate that more than 1 in 6 mothers smoke during pregnancy. Evidence has shown that smoking prevalence during pregnancy is much higher among lower socioeconomic groups (Gray, et al., 2009) and teenage mothers – this can be seen in the two figures below (40 and 41):

Figure 40: Women who smoked before or during pregnancy, by socio-economic group



Source: Infant Feeding Survey, 2005

Figure 41: Women who smoked before or during pregnancy, by age group



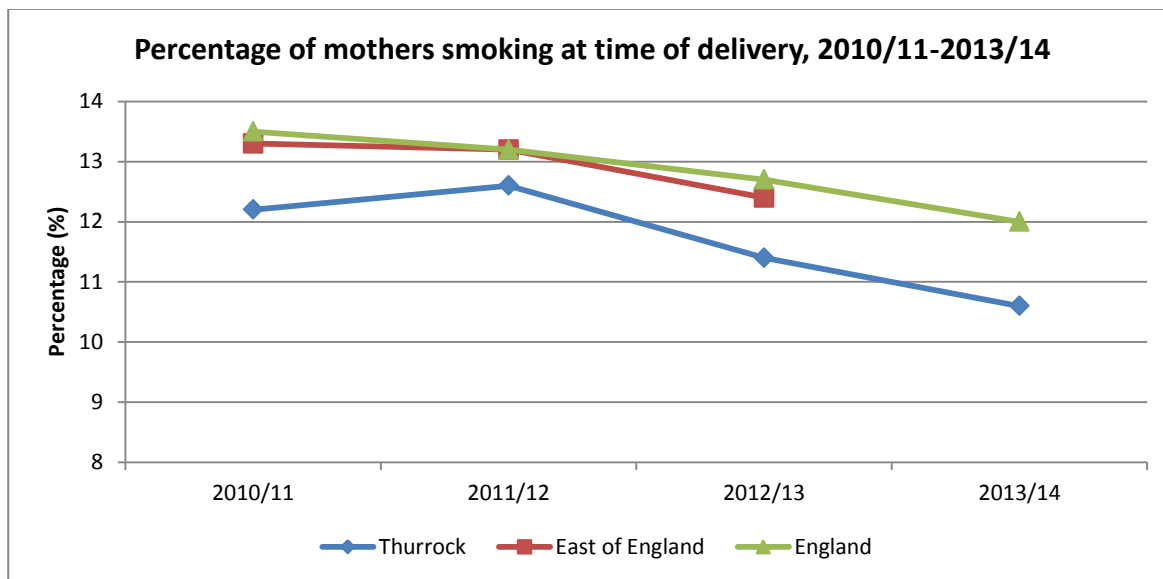
Source: Infant Feeding Survey, 2005

Reducing smoking during pregnancy is one of the three national ambitions in the [Tobacco Control Plan](#) – the aim is to reduce the proportion of women smoking throughout pregnancy to 11% or less by the end of 2015 (measured at time of giving birth).

What do we know?

The latest information shows that 10.6% of women in Thurrock were smoking at the time of delivery in 2013/14, which is lower than the previous two years. Comparing the data to East of England and England, Thurrock's figures do appear to be consistently lower; however confidence intervals mean that the authority is statistically similar to the national average.

Figure 42: Percentage of mothers smoking at time of delivery in Thurrock, East of England and England, 2010/11-2013/14



Source: Public Health England / Health and Social Care Information Centre

What are we doing in Thurrock?

The Government's tobacco control plan target is to reduce the number of 15 year olds smoking in England to 12% by 2015. In 2013 Thurrock Council signed up to the Local Government Declaration on Tobacco Control and is listed on the [Smokefree Action](#) website. A key tenet of this includes developing plans with partners and local communities to address the causes and impacts of tobacco usage.

Thurrock is also in the process of writing a Tobacco Control Strategy and has an aspiration to reduce the number of under 20 year olds that smoke by half before 2020. There is currently a shortage of local statistical data quantifying smoking prevalence in the under-17 age group and more evidence based research is needed within this group to support future strategies.

Thurrock commission local stop smoking services (LSSS) which look to raise awareness of the harms of tobacco, help to prevent young people from starting smoking, and make sure that people who want to quit have as much support as they need. The 5-19 service also works with young people who smoke and provide advice to support young people to stop smoking. Pregnant women are all routinely screened for smoking status and given specialist support and advice to help them stop smoking. Children's Centres actively work with parents to reduce the number of parents who smoke (which is one of their 28 outcomes under their Outcomes Framework).

Recommendations

- More school based interventions and prevention tools with further support and education within Thurrock schools themselves (in accordance with NICE guidelines). NICE recommend information on smoking to be included in the curriculum – classroom discussions could be relevant when teaching Biology, Chemistry, Citizenship and Maths.
- Targeting our LSSS to deliver preventative interventions in schools such as ASSIST or KickAsh as an integral part of service delivery.
- Targeting smokers from disadvantaged groups by developing decision making skills and include strategies for enhancing self-esteem such as the UK Resilience Programme in schools.
- Ensure adequate provision for compliance and enforcement to support new and existing government legislation on:
 - The sale of cigarettes to under 18's (both in shops and via other people)
 - The ban on cigarette displays in retail outlets
 - Passive smoking such as in cars when children are present
 - The existing ban on smoking in public places
 - The use of e-cigarettes particularly in children and young people.
- Closely monitor research and evidence on the use of e-cigarettes amongst children and young people and actively ensure that young people recognise the smoking-related behaviours and risks associated with these products.
- More frequent collection and analysis of smoking data amongst children and young adults in schools.
- Particular focus should be given in secondary schools to ensure pupils know how to access advice and support about smoking and to ensure this service is accessible and approachable.

Smoking remains one of the biggest public health risks and reducing levels of smoking in Thurrock will remain a top priority in improving the health of the local population.

Substance Misuse

Substance misuse is often a symptom rather than a cause of vulnerability among young people. Many have broader difficulties in their lives that are compounded by drugs and alcohol and that need addressing at the same time. Young people's substance misuse services engage vulnerable young people and intervene early to stop escalating risk and harm from substance misuse. Evidence shows that young people's lives can improve when they have access to substance misuse services alongside support to address their wider health and wellbeing needs. This means that the commissioning and delivery of specialist drug and alcohol interventions should take place within wider service structures that meet a range of needs. A Department for Education cost-benefit analysis found that every £1 invested in specialist substance misuse interventions delivered up to £8 in long-term savings and almost £2 within two years, meaning that this can be a cost-effective way of reducing future demand on health and social care services. A life course approach to drug prevention that covers early years,

family support, universal drug education, and targeted and specialist support for young people is one of the key aims of the Government's 2010 Drug Strategy.

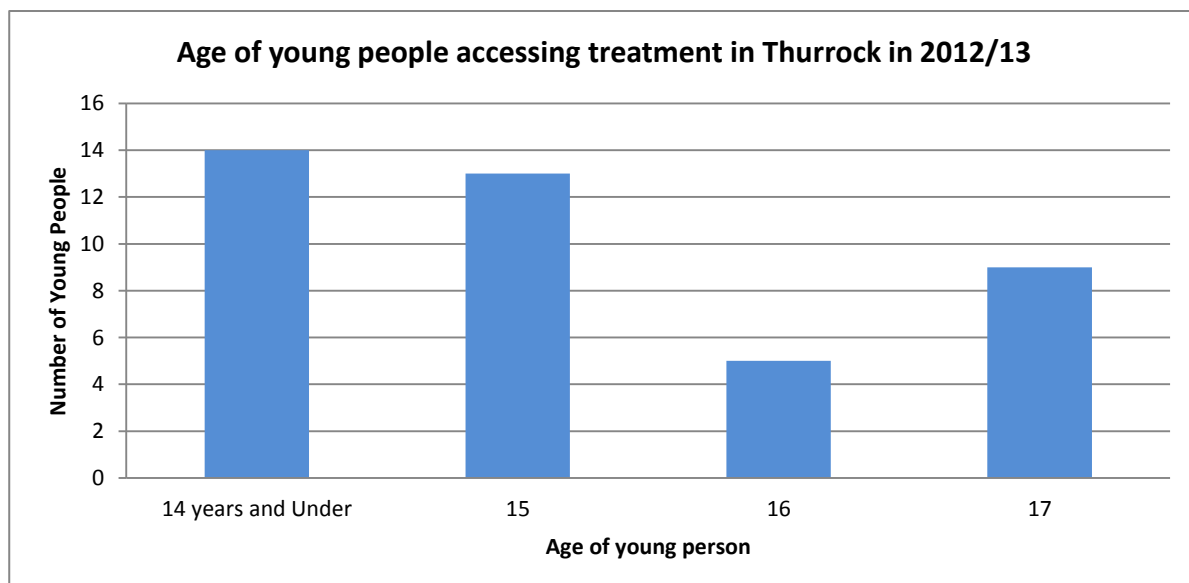
Parental drug use can compromise children's health and development, as well as impact on parenting capacity. Research cited in the Government's Hidden Harm report (2004) estimated that there are between 200,000 and 300,000 children in England and Wales where one or both parents have serious drug problems – representing 2-3% of children under 16. Children of parental drinkers are also at risk of Foetal Alcohol Syndrome (FAS) or Foetal Alcohol Spectrum Disorder (FASD) – which is a series of preventable birth defects caused entirely by a woman drinking alcohol at any time during her pregnancy, often even before she knows that she is pregnant. Estimates by Alcohol Concern suggest that there were 7,317 children born in England in 2012 with FASD. The lifetime cost to the economy for a child born with FAS was estimated at £1,500,000, and the adverse consequences experienced by children can include: weakened immune systems, a wide range of emotional, cognitive, behavioural and other psychological problems; early substance misuse and offending behaviour; and poor educational attainment.

What do we know?

Entering Treatment

In Thurrock, there were 39 new entrants to treatment services in 2012/13, which was lower than the number of new entrants for 2011/12 (59). Age of initiation is often the strongest predictor of the length and severity of substance misuse problems – the younger the age they start to use, the greater the likelihood of them becoming adult problematic drug users. (It is noted that this does not necessarily indicate the age of initiation).

Figure 43: The age of young people entering treatment services in Thurrock in 2012/13

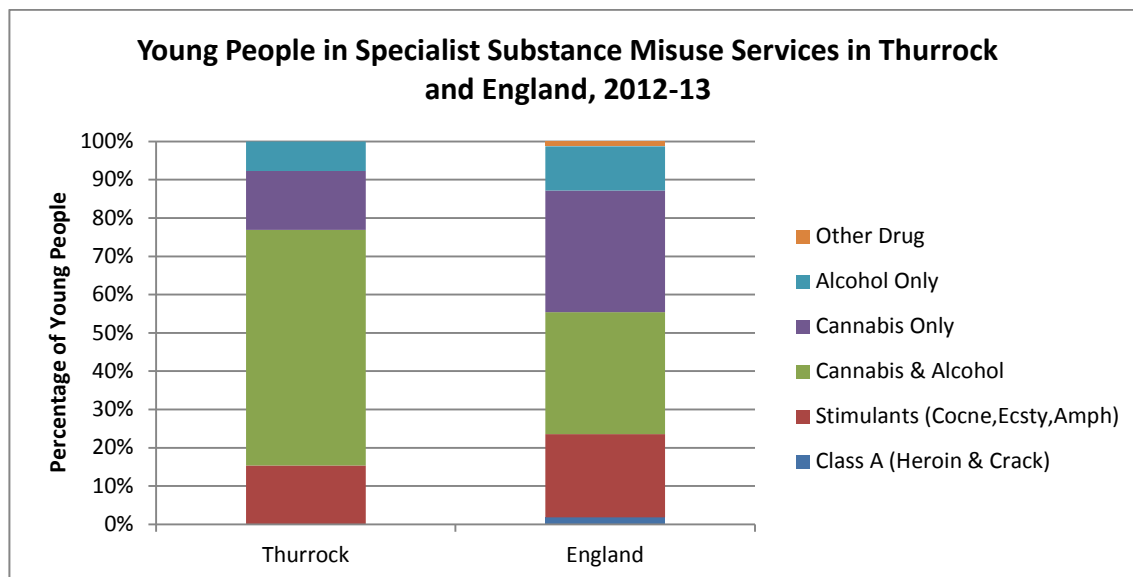


Source: NDTMS

The main type of substance misuse service offered in Thurrock in 2012/13 was for Cannabis and Alcohol combined – 24 out of the 39 entrants were in this category, equating to 61.5%. When compared to the national average, Thurrock had more young people presenting for

Cannabis and Alcohol combined, but reduced proportions presenting for Cannabis and Alcohol separately, and none for Class A drugs.

Figure 44: Young people entering treatment services in 2012/13 in Thurrock and England by substance type.



Source: NDTMS

When categorising the 39 young people by referral source, it can be seen that the largest number of referrals were received from universal sources – these might include GPs, hospitals, school nurses or family members, or specialist sources – e.g. social care or youth offending services. No referrals were received from targeted sources – e.g. Targeted Youth Support services.

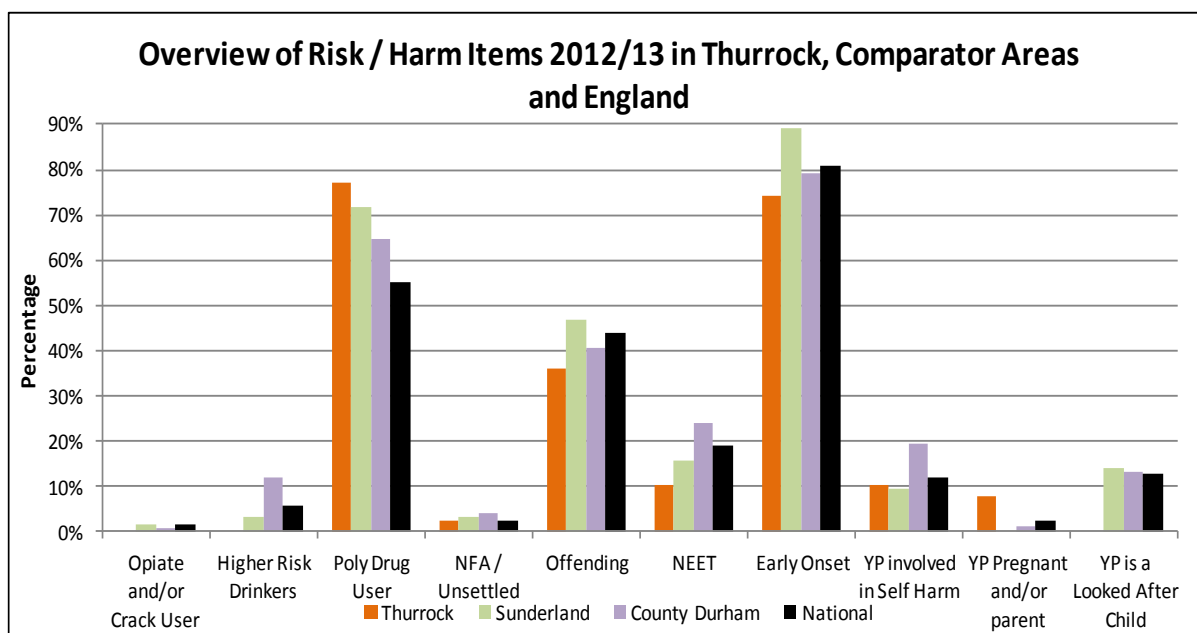
Table 4: Entrants into Thurrock treatment services in 2012/13 by source of referral.

	Specialist	Targeted	Universal/Other
All Substance Types	18	0	21

Source: NDTMS

In order to better understand and inform the commissioning of services, information is captured from each young person at the start of their treatment to identify if they have any of 10 key risks or harms that may lead to adult dependencies. The figure below outlines the percentage of entrants to treatment services which have the identified vulnerabilities in Thurrock, England and the two most similar authorities to Thurrock in the Child Wellbeing Index. From this, it can be seen that although there were no young people identified as higher risk drinkers, opiate users or Looked After Children, 77% of Thurrock entrants to services were classified as poly drug users and 74% as early onset. Overall Thurrock has a similar risk harm profile to those of similar partnerships. below outlines the percentage of entrants to treatment services which have the identified vulnerabilities in Thurrock, England and the two most similar authorities to Thurrock in the Child Wellbeing Index.

Figure 45: Risk Harm Profile of young people entering treatment in Thurrock, Comparator Areas and England, 2012/13.



Source: NDTMS

In Treatment

The table below outlines the length of time that young people were in treatment services in Thurrock in 2012/13. It should be noted that this figure includes not only those starting treatment within the year but also anyone who started treatment prior to 1st April 2012 but were still accessing structured treatment at the start of the year. Young people generally spend less time in specialist interventions than adults because their substance misuse is not entrenched; however those with complex care needs often require support for longer.

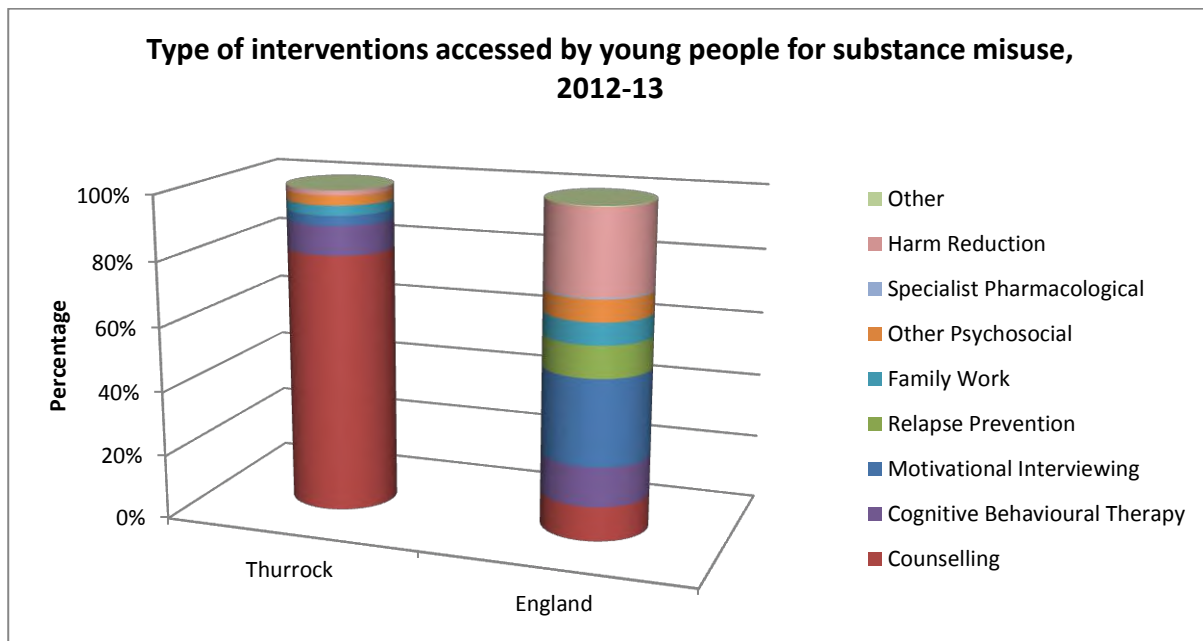
Table 5: The length of time young people were in treatment services in Thurrock, 2012/13.

Total	0-12 weeks	13-26 weeks	27 weeks or more
All Substance Types	36	9	14

Source: NDTMS

Young people have better outcomes when they receive a range of interventions as part of their personalised package of care. The figure below outlines the percentage of young people accessing different types of interventions in Thurrock and England. The majority of young people in Thurrock access counselling as an intervention whereas Motivational Interviewing and Harm Reduction are more common interventions accessed nationally. 6 of the 59 young people in Thurrock accessing treatment in 2012-13 were accessing multiple interventions.

Figure 46: Types of substance misuse interventions accessed by young people in Thurrock and England, 2012-13.



Source: NDTMS

Foetal Alcohol Spectrum Disorder

Data supplied by Alcohol Concern estimated that there is likely to have been approximately 22 children born with FASD in Thurrock in 2012. Whilst this is a crude estimate based on the prevalence of 9.1 per 1,000 births calculated by Sampson *et al* (1997), it gives an indication of likely need in the borough. Alcohol Concern estimated that the lifetime cost to Thurrock from children born in 2012 with FAS to be in the region of £7,500,000.

What are we doing in Thurrock?

The Thurrock Drug and Alcohol Action Team commission a young person's service which contributes to the following aim:

'Putting Thurrock young people in the best position to resist, recover and move on from substance misuse to provide the potential of positive, healthy and fulfilling lives' (Thurrock Council, 2013)

This service is known as *Wize-Up*, and is an integrated service offering universal, targeted and specialist substance misuse interventions to young people in Thurrock. Targeted provision is accessible by young people who are considered to be vulnerable or who have been identified as having needs that require some low intensity intervention and monitoring. Thurrock DAAT has identified the following groups of young people in Thurrock as highly vulnerable to substance misuse:

- Those who are homeless and/or 'runaways';
- Those engaged in offending

- Those engaged or being inducted into sex work;
- Those who have been 'Looked After' by the local authority;
- Those who live with parents and/or siblings who are substance misusers
- Those who truant from school or who have been excluded;
- Those who are experiencing mental health problems;
- Domestic abuse and/or sexual violence.

There is also an element of partnership working with Thurrock Youth Offending Service by means of an agency Substance Misuse Worker when this is required. This is to ensure that the specific substance related issues of young offenders are met.

Recommendations

- Preventative work in schools was a key focus of the outgoing young people substance misuse service and the new provider of this service (since 1st April 2014) has been working to ensure this legacy is built upon.
- The number of young people in treatment recorded as being a parent or pregnant in figure 45 is less than 10%, yet this number is high in relation to comparator areas. Work should be conducted by commissioners to better understand this data.
- Counselling support in Thurrock is utilised far more when compared to national trends where the two prominent interventions are Motivational Interviewing and Harm Reduction. A deeper analysis of this intervention should be conducted by commissioners to understand whether our new service provider should use a broad or narrow suite of interventions on our clients.
- Our Stop Smoking Service has been tasked with ensuring effective partnership working with our substance misuse services since the latest evidence shows that this can be a mutually beneficial investment.
- Novel Psychoactive Substances (NPS's, AKA Legal Highs or Club Drugs) can have devastating and sometimes fatal consequences for users and we know the Internet makes these substances readily available. This will be reviewed locally.
- Reaching treatment naive parents who require treatment for substance misuse, due to children experiencing hidden harm, is a challenge for treatment services and something they must maintain a focus on.
- Ensure that appropriate links are being made locally between services for domestic and sexual violence, young people and substance misuse.
- Initiatives to raise awareness of FAS and FASD amongst all professionals working with pregnant women or women who may be planning a family.

Long Term Conditions

The World Health Organisation defines long term conditions as health problems that require ongoing management over a period of years or decades. Long term conditions (LTCs) can also be defined as conditions that cannot currently be cured but can be controlled with the use of medication and/or other therapies (WHO 2002). This includes a very broad range of conditions which can be classified as:

- Cerebral conditions

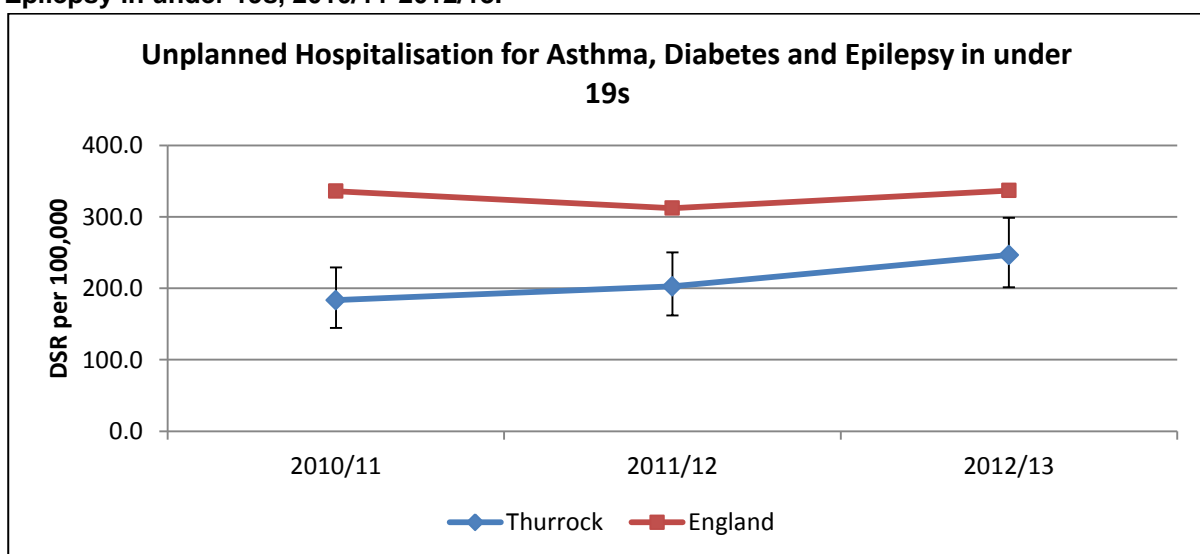
- Respiratory conditions, of which asthma is the most common in children
- Cardiac conditions
- Metabolic conditions, including diabetes
- Neurological conditions, including epilepsy
- Haematological conditions
- Gastrointestinal conditions
- Genito-urinary conditions
- Structural impairments, including hearing or sight impairments, bone and joint disorders
- Communicable diseases, including HIV/AIDS
- Neoplasia, including benign and malignant tumours and conditions such as leukaemia

Long term conditions have become a priority because of the increasing prevalence of conditions such as asthma, diabetes, cancer and epilepsy which account for a significant and growing proportion of our health and social care resources (DH 2008).

What do we know?

Asthma, epilepsy and diabetes account for approximately 94% of emergency hospital admissions for children under 19 years with long-term conditions. Providing effective ambulatory care for these conditions will lead to better patient care and case-management, as well as a reduction in preventable emergency admissions which are costly and expose patients to otherwise avoidable clinical risks such as health care acquired infections. Data for unplanned hospitalisation for the three conditions shows that Thurrock has had a significantly lower rate of admissions than the national average (local rate was 246.5 per 100,000 in 2012/13 compared to the national average of 336.9). However this rate has been increasing over the last three years and commissioners should remain mindful of this to ensure appropriate resources are available. Figure 47 shows this trend below.

Figure 47: Unplanned Hospitalisation in Thurrock CCG and England for Asthma, Diabetes and Epilepsy in under 19s, 2010/11-2012/13.



Source: NHS Indicators

When the rate of admissions is separated by gender, it can be seen that at the national level, the rate has remained higher in males compared with females. However in Thurrock in 2012/13, the rate was higher in females (263.8 compared to 230.0 per 100,000 in males); although still lower than national rates.

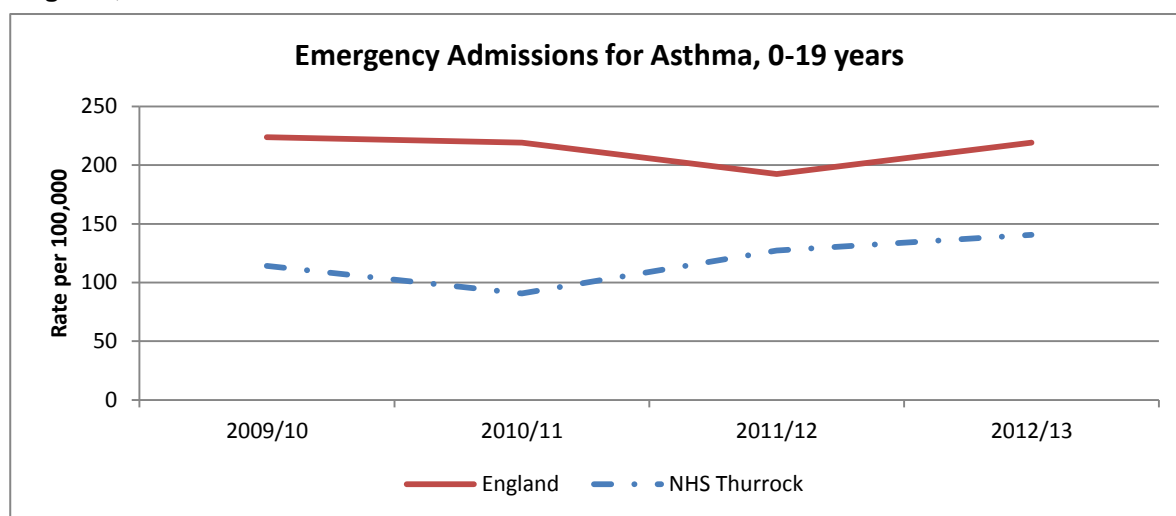
Asthma

According to www.asthma.org.uk, asthma is the most common long-term medical condition, affecting 1.1 million children in the UK – one in 11. The usual symptoms of asthma in children are:

- wheezing, or a whistling noise in the chest
- getting short of breath
- coughing, particularly at night and after exercise
- feeling tight in the chest

In some circumstances, asthma can lead to unplanned hospital admissions, or even death. There were 25,073 emergency hospital admissions for children in the UK in 2011-2012 – which is 69 per day. In Thurrock, emergency hospital admissions for asthma for children under 19 are lower than the national average. Figure 48 displays this below.

Figure 48: Emergency hospital admissions for asthma for children under 19 in Thurrock and England, 2009/10-2012/13.



Source: Hospital Episode Statistics

Local data indicates that there were 31 admissions of Thurrock residents aged 0-19 years due to asthma between April 2013 and March 2014, with over 75% aged 0-9 years. This is a large decrease from the admissions between April 2012 and March 2013, when there were 62 admissions for asthma – 71% of these were aged 0-9 years. When the average length of stay is considered, Thurrock has a higher average length of stay following emergency admission for asthma, with 1.52 days during 2012/13 (England average = 1.25 days).

Although Thurrock is performing well with respect to asthma, asthma has been identified as a priority area in children and young people's healthcare both regionally and nationally, with the commissioned report "Why Asthma Still Kills" focussing on prevention of asthma deaths and the East of England Paediatric Asthma forum looking to standardise and improve care across the region.

Epilepsy

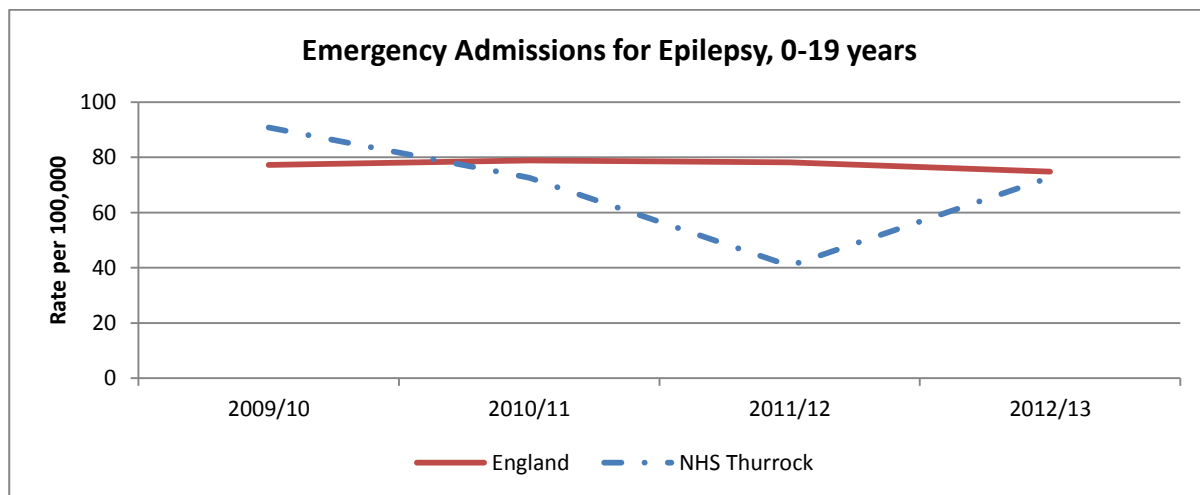
Epilepsy is a neurological condition that can affect people of any age group. However there are a number of issues specific to the management of epilepsy in children. These include the following:

- epilepsy may have a significant impact on a child's ability to learn and participate fully in educational activities, so it is vital that good links are forged with educational services. Up to 50% of children with epilepsy require some additional support in school.
- children with epilepsy may be more psychologically vulnerable and more likely to develop psychiatric disorders.
- an estimated 15% of children with mild learning disabilities and 30% with severe learning disabilities have epilepsy
- Some forms of treatment may affect fertility and contraception – this should be considered particularly when treating teenage patients

Source: Epilepsy UK

It is estimated that there are 51,500 children in the UK under the age of 16 living with epilepsy (Epilepsy UK). Hospital admissions data capturing the rate per 100,000 of children aged 0-19 years admitted for epilepsy indicates that there were 73 admissions per 100,000 in 2012/13, which is similar to the national average of 75 per 100,000. This is shown in Figure 49 below. Local intelligence indicates that as of September 2014, there were 240 children in Thurrock on the GP register for all degrees of epilepsy.

Figure 49: Emergency hospital admissions for epilepsy for children under 19 in Thurrock and England, 2009/10-2012/13.



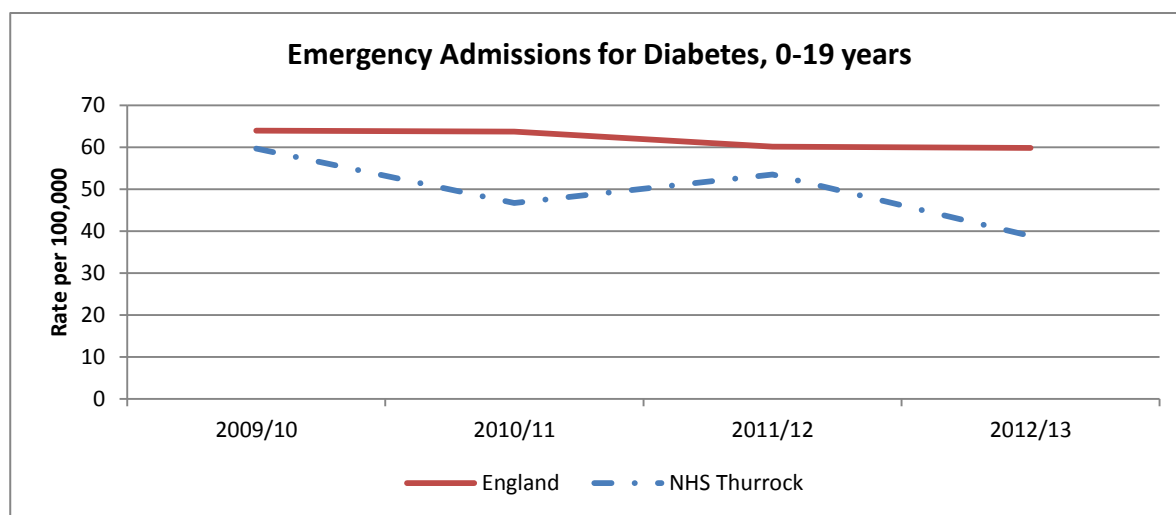
Source: Hospital Episode Statistics

Local data indicates that there were 23 admissions of Thurrock residents aged 0-19 years due to epilepsy between April 2013 and March 2014, with almost 70% aged 0-9 years. This is a decrease from the admissions between April 2012 and March 2013, when there were 30 admissions for epilepsy – 70% were aged 0-9 years. When the average length of stay is considered, Thurrock has decreased markedly in recent years from 4.37 days in 2009/10 to 1.9 days in 2012/13, which is similar to the national average of 1.91 days.

Diabetes

According to estimates by Diabetes UK, there are about 29,000 children and young people with diabetes in the UK. About 26,500 of them have Type 1 diabetes and about 500 have Type 2 diabetes. There are a further 2,000 children and young people in the UK with diabetes whose diagnosis is not known. The risk of developing diabetes is higher in children of south east Asian origin, who are up to 13 times more likely to develop type 2 diabetes than white children (Source: Diabetes UK). It should be noted that type 2 diabetes is associated with obesity and the prevalence in the national population has increased in recent years. Hospital admissions data capturing the rate per 100,000 children aged 0-19 years admitted for diabetes indicates that there were 39 admissions per 100,000 in 2012/13, which is lower than the national average of 60 per 100,000. This is shown in Figure 50 below. Local intelligence indicates that as of September 2014, there were 75 children in Thurrock on the GP register for diabetes.

Figure 50: Emergency hospital admissions for diabetes for children under 19 in Thurrock and England, 2009/10-2012/13.



Source: Hospital Episode Statistics

Local data indicates that there were 26 admissions of Thurrock residents aged 0-19 years due to diabetes between April 2013 and March 2014, with almost 70% for children aged 10-19 years. This is a slight increase from the previous year – 19 admissions for diabetes were seen between April 2012 and March 2013, and only 37% of those were for children aged 10-19 years. When the average length of stay is considered, Thurrock has a similar length of stay to the national average (2.0 days, compared to 2.04 days).

Sickle Cell disease

Sickle cell disease affects approximately one in every 2,000 births in England. It is estimated that there are 380,000 healthy carriers of unusual haemoglobin variants, most of which are sickle. According to data captured by the National Sickle Cell and Thalassaemia programme (available via www.sct.screening.nhs.uk), the highest prevalence of sickle cell disease is among Black Africans and Black Caribbean ethnic groups, with 63% of positive screens being for newborn babies within these ethnic groups in 2012/13. The 2012/13 screening programme identified a national rate of 0.46 per 1,000 as having a significant condition. In Thurrock, local

admissions data indicates that there were 26 admissions for sickle cell disease in children between April 2013 and March 2014, which is much lower than the 87 admissions observed between April 2012 and March 2013. In 2013/14 the age group with the largest proportion of admissions was 15-19 years (38%) whereas in 2012/13 there was a larger proportion of 5-9 year olds (45%). The average length of stay in hospital was 1.27 days in 2013/14, compared to 0.74 days in 2012/13 – indicating that although the number of admissions has dropped, the patients are spending longer in treatment.

South West Essex has the highest number of children with sickle cell disorders in Essex, with an estimated 66.5% of all children with these disorders living in the South West of the county. This equates to in excess of 145 children living in South West Essex with sickle cell disorders, all of whom will need to access services on at least an annual basis.

What are we doing in Thurrock?

Thurrock's priorities around these long term conditions include:

Sickle Cell disorders

Work is focusing on repatriating the large number of patients from South West Essex who travel to London for their clinics back to a localised service. As there is currently no complete sickle cell pathway in Essex, work is underway to consider extending the existing service (currently offered to those aged 0-1 years and their families) to cover a wider age range. It is hoped that this work will reduce untimely admissions – i.e. children and young people not waiting for extended time periods whilst in A&E whilst experiencing a crisis, and also prevent unnecessary hospital admissions for management of less serious sickle cell crises. If children and their families can gain increased education, and consequently increased confidence, in the ability to manage their condition, there should be a reduction in inappropriate hospital admissions for all but the most serious of crises. This also increases quality and meets the care closer to home agenda. By offering a joined-up acute and community approach, too, patients' care will be better integrated and holistic, meaning the patient will only have to tell 'their story' once, and feel more comfortable with consistent practitioners. Equally, by including such best practice elements as the patient passport, patients' voice will be heard in their care.

Asthma

Asthma is one of the High Impact Pathways to be launched in Thurrock. These pathways are aimed at empowering parents/ families / carers to manage common conditions at home and develop pathways to ensure care is delivered at the most appropriate setting. As part of this work, there is a regional focus on Asthma from the East of England Strategic Clinical Network, which covers off the clinical pathway, ensuring information technology and systems are in place, and education.

Recommendations

Work in Thurrock around Long Term Conditions needs to focus on a variety of aspects:

- Management within the Community
 - As level of need increases and acute settings become increasingly busy, the community has a key part to play in the management of Long Term Conditions. This includes ensuring primary care and community-providers are enabled to offer support to families who need it, and begin to play a role in managing those more complex conditions within the community, while also ensuring basic work such as inhaler technique for asthma sufferers is delivered correctly. Work needs to focus on education, capacity building, and confidence-building, to ensure both patient quality of life improves, and unnecessary hospital admissions and attendances reduce.
- Patient-focus and voice of the patient
 - SEND reforms will focus partners on this increasingly. It is essential to ensure the patient comes first in all our decision making and scoping, particularly those most vulnerable children.

Mental Health

Mental health has been defined as ‘the strength and capacity of our minds to grow and develop, to be able to overcome difficulties and challenges and to make the most of our abilities and opportunities (Young Minds, 2006). Young people’s emotional health and wellbeing is important, both for the impact that it has on their present quality of life, and also for the implications it has for their future social and emotional development, academic experience and achievement. National research highlights that good emotional and mental health is fundamental to the quality of life and productivity of individuals, families, communities and nations. Positive mental health is associated with enhanced psychosocial functioning, improved learning, increased participation in community life, reduced risk-taking behaviour, improved physical health, reduced mortality and reduced health inequality. Poor emotional well-being and mental health can lead to negative outcomes for children, including educational failure, family disruption, poverty, disability and offending.

Although children and young people are healthier now than ever, inequalities persist and evidence suggests that mental ill health affects one in ten of 5-16 year olds (Green, et al., 2004). There is also a sizeable economic burden associated with mental health, with the Department of Health estimating that mental illness costs approximately £105.2 billion per year (Department of Health, 2011).

The Department of Health publication *No Health Without Mental Health* (2011) emphasised the importance of promoting good mental health and intervening early, particularly in the childhood and teenage years, in order to prevent mental illness from developing and mitigate its effects when it does. This should begin with health promotion programmes delivered during pregnancy, in order to reduce the impact of maternal stress and promote attachment, as it is known that this phase strongly influences outcomes in later life. A child’s experience in their first two years sets the foundation for their future years, with inappropriate child-rearing practices potentially leading to language delay and emotional or behavioural disorders. Professionals working in schools

also have an important role to play in promoting emotional health and wellbeing, recognising potential problems and intervening appropriately. There are large economic benefits associated with early intervention into mental health problems – NICE estimated the potential long-term savings from each case of severe conduct disorder prevented to be £150,000 (National Institute for Health and Care Excellence, 2013). School-based interventions have also been shown to provide large amounts of savings, with bullying-prevention programmes estimated to generate savings of £1,080 per school pupil, and violence-prevention programmes for 6 year old children saving £829 per child at age 6 and increasing to £8,223 at age 15 (Department of Health, 2011).

The Thurrock CAMHS (Child and Adolescent Mental Health Service) Strategy for 2014 – 2017 identifies four specific groups who have a greater risk of developing mental health problems.

These are children:

- with learning difficulties & disabilities, developmental disorders & in residential schools
- in short stay schools
- on a child protection plan
- who are looked after

Thurrock Council has also determined that a range of other factors known to put certain groups of children more at risk of mental health problems should also be monitored.

The identified groups are children:

- living in poverty
- With behavioural, emotional and social difficulties
- With ADHD
- Who self harm
- At risk of suicide
- Who are bullied (often or very often)
- With substance misuse problems
- Teenage parents
- Excluded from school
- Young offenders
- 16-17 year olds and young people in transition
- With physical disabilities
- From BME background
- Witnessed domestic violence
- Attachment disorders

Half of lifetime mental illness arises by the age of 14, and widespread research has shown that early intervention and preventative strategies are effective and crucial to improve the emotional wellbeing and mental health of populations. Resilience to poor psychological health can be developed at individual, family and community levels and interventions are most effective when they take a holistic, family centred approach.

What do we know?

There are a multitude of estimates of the numbers of children and young people with mental health problems. These come from a variety of sources, with different sample sizes and definitions of mental health conditions. This all contributes to potential confusion over which would be the most representative figures to use as a basis for service planning. When discussing mental health, two terms are useful.

“Mental health disorder” - describes a clinically recognisable onset of symptoms or behaviours.

“Mental health problems” - is used to describe a broad range of emotional and the behavioural difficulties that may cause concern or distress. These problems are relatively common and encompass mental disorders which are more severe and/or persistent mental health conditions.

Prevalence of mental health disorders

There is relatively little data about the prevalence of mental health disorders in pre-school children. A literature review of four studies looking at 1,021 children aged 2 to 5 years inclusive, found that the average prevalence rate of any mental health disorder was 19.6% (Egger, H *et al*, 2006, cited by CHiMat). Applying this average prevalence rate to the estimated population within the area gives a figure of 1,890 children aged 2 to 5 years inclusive living in Thurrock who may have a mental health disorder.

The research referred to previously by Green *et al* (2004) for the Office of National Statistics estimated the national prevalence of any clinically diagnosed mental disorder in 5-16 year olds to be almost 10%; of these:

- 4% had an emotional disorder (such as anxiety or depression),
- 6% had a conduct disorder,
- 2% had a hyperkinetic disorder; and
- 1% had a less common disorder (such as autism, ticks, eating disorders and selective mutism).

Prevalence rates were shown to vary by age and by gender – in both age groups boys were found to have a higher prevalence of mental health disorders than girls and were highest in boys aged 11-16 years.

Table 6: Variation in prevalence of mental health disorders observed by Green *et al* (2004)

Age Group	Prevalence in boys	Prevalence in girls	Prevalence for both genders
5 – 10	10.2%	5.1%	7.7%
11 – 16	12.6%	10.3%	11.5%
All (5 – 16)	11.4%	7.8%	9.6%

Source: Green *et al*, 2004

Applying these prevalence rates to the 2012 estimate of Thurrock’s population means that approximately 2375 children aged 5-16 years in the borough have a diagnosable mental health condition. The table below shows the estimated number of children in Thurrock with mental health disorders by age and sex, calculated using Green *et al* (2004) prevalence rates.

Table 7: Estimated number of children with mental health disorders in Thurrock by age and gender

Age Group	Estimated number of boys	Estimated number of girls	Estimated number of both genders
5 – 10	660	320	980
11 – 16	780	610	1390
All (5 – 16)	1440	950	2375

Source: ChiMat – produced using ONS Mid Year Estimates 2012 and Green *et al*, 2004

These prevalence rates of mental health disorders have been further broken down by prevalence of conduct, emotional, hyperkinetic and less common disorders. The following table shows estimates of the numbers of children aged 5-16 with conduct, emotional, hyperkinetic and less common disorders, and neurotic disorders for those aged 16-19, calculated using ONS 2012 population estimates and Green *et al* (2004) prevalence rates.

Table 8: Expected number of children in Thurrock with mental health disorders by type, 2012

	Estimated no. with conduct disorders aged 5-16 years	Estimated no. with emotional disorders aged 5-16 years	Estimated no. with hyperkinetic disorders aged 5-16 years	Estimated no. with less common disorders aged 5-16 years	Estimated no. with neurotic disorders aged 16-19 years
Thurrock	1,381	886	361	324	1,088

Source – ChiMat – produced using ONS Mid Year Estimates 2012 and Green *et al*, 2004

Green *et al* (2004) also found that one in five of the children with a mental disorder were diagnosed with more than one of the main categories of mental disorder. This figure represented 1.9% of all children. The most common combinations were conduct and emotional disorder, and conduct and hyperkinetic disorder. Applying the 1.9% prevalence to the local population would equate to approximately 799 children in Thurrock who may have more than one type of mental health disorder.

Children at risk of developing mental health problems across Thurrock

The section above focused upon those children and adolescents with mental health *disorders* and not individuals with less serious mental health *problems*. The possible extent of mental health *problems* is obviously far larger, and estimates of the numbers of children and young people with mental health problems vary between 10 and 14%.

In order to target services and resources more effectively, it is useful to estimate the number of children in groups who have specific needs which makes them at greater risk of developing a mental health problem. Only a minority of young people with mental health problems receive professional help, and social factors and mental health can often have a reciprocal effect upon each other. Existing UK statistics do not separate mental health causes/factors from non-mental health factors.

The following section provides an estimate of the number of children and young people in each of the categories identified as high risk by Thurrock CAMHS Strategy 2014-2017 and Thurrock Council. It should be noted that many children will be in more than one of these groups.

Children with a learning disability

It is known that people with learning disabilities are more likely to experience mental health problems. Estimation of the population with learning disabilities with mental health problems was undertaken by applying prevalence rates researched by Emerson *et al*, (2008) and Foundation for People with Learning Disabilities (2002) – referenced by CHiMat, to the local population. The research undertaken by the Foundation for People with Learning Disabilities (2002) estimated that up to 40% of those with learning disabilities might have mental health problems, and this is applied to the Thurrock population in the table below.

Table 9: Estimated number of children with learning disabilities who might experience mental health problems in Thurrock

Age group	Number estimated to have a learning disability	Number estimated to have a learning disability with mental health problems
5 – 9 years	105	45
10 – 14 years	220	90
15 – 19 years	270	110

Source: CHiMat – produced using research by Emerson *et al* (2008), ONS Mid Year Estimates 2012 and Foundation for People with Learning Disabilities (2002).

When the ChiMat estimates were compared to local data, it was of interest to observe that actual numbers of children known to have learning disabilities was higher than the ChiMat estimates, resulting in a higher estimated number with mental health needs when the 40% prevalence was applied.

Table 10: Estimated number of children with learning disabilities with mental health needs

	Number of fully statemented children	Number of children on School Action	Number of children on School Action Plus	Number of children in residential schools	Total number of children with learning disabilities	Estimated number with MH needs (40%)	% of 5-19 population
Thurrock	892	2,396	1,611	22	4,921	1,968	6.55%

Source: Thurrock Council, 2013

Children in short stay schools (Pupil Referral Units)

Data provided by Thurrock Council shows that there were 88 children in short stay schools in 2011/12. It is expected that all of these children and young people will require some mental health intervention.

Children on a Child Protection Plan

Children on a child protection plan who have been subjected to abuse and neglect are likely to experience a wide range of debilitating emotional and behavioural problems, and could lead to serious impairment of health and development – all of which may persist into adulthood.

Data provided by Thurrock Council (2013) shows that there were 200 children subject to a Child Protection Plan which equates to 0.48% of the local 0-19 year old population.

Children in Care

Looked after children are more likely to experience mental health problems (Ford, T. *et al*, 2007 – referenced by Essex Joint Strategic Needs Assessment, 2013). It has been found that among children aged 5 to 17 years who are looked after by local authorities in England, 45% had a mental health disorder. Results from the Strengths and Difficulties Questionnaire (SDQ) completed by children in care can indicate mental health needs, and the table below estimates the number of children in care in 2012 that might have had mental health needs.

Table 11: Estimated number of children in care who might have had mental health needs in Thurrock, 2012.

	Number	% of 0-19 population	% of children in care with SDQ score considered to be a concern	Expected number with MH needs
Thurrock	260	0.62%	48%	125

Source: Essex Joint Strategic Needs Assessment for Children's Emotional Well-Being and Mental Health, 2013.

Other groups of children at risk of developing mental health problems

The table below outlines the vulnerable groups suggested by Thurrock Council who have a higher risk of developing mental health problems.

Vulnerable Group	Rationale	Estimated Local Need	Data source
Children living in poverty	It is estimated that children living in poverty are three times more likely to suffer mental health problems.	20.0% of children are estimated to live in low income families – which equates to 7,950 children in Thurrock. As deprivation is a risk factor for mental ill health, consideration should be given to ensure service provision is targeted in areas of high deprivation. Further information on deprivation can be found in the Child Poverty section.	HMRC
Children with behavioural, emotional and social difficulties	Children with a SEN are more likely to develop a mental health problem, or to have their mental health needs overlooked. In addition, they are more likely to be excluded from school (resulting in lower educational attainment) and to become known to the young offenders' service.	Based on an estimate of 6.9% of pupils in Essex, this would be approximately 2,072 children in Thurrock.	Schools Health Education Unit (SHEU)
Children with Attention Deficit Hyperactivity Disorder (ADHD)	There is some evidence that children who are diagnosed with attention deficit hyperactivity disorder at an early age are at greater risk of depression and suicide than other teens. Conduct disorder was also the primary reason for referral to the Thurrock Tier 2 service.	The expected prevalence of ADHD is included as part of the ChiMat estimates for all hyperkinetic disorders No current data on the number of children with ADHD with mental health problems.	
Children at risk	Self-harming is usually triggered by		NHS

of self-harm or suicide	a set of circumstances that leave young people feeling overwhelmed and can be a sign of emotional difficulties. It is estimated that 90% of people who attempt or die by suicide have one or more mental health conditions. In addition, Looked After Children and care leavers are between four and five times more likely to attempt suicide in adulthood	Further information on children who were admitted to hospital for self-harm and estimated number of suicides can be found in the Staying Safe chapter.	Choices
Children who are bullied	Bullying can have significant impact on the mental health of children and young people resulting in depression, low self-esteem, and anxiety.	10.4% of pupils reported that they were currently being bullied.	Tell Us survey (2010)
Children with substance misuse problems	Substance abuse may sharply increase symptoms of mental illness or trigger new symptoms. Alcohol and drug abuse also interact with medications such as antidepressants, anti-anxiety pills, and mood stabilizers, making them less effective. The mental health problems that most commonly occur with substance misuse are depression, anxiety and bipolar disorder.	Further information on children with substance misuse problems can be found in the children's Substance Misuse section.	
Teenage parents	National data shows teenage mothers are three times more likely to develop post natal depression and experience poor mental health for up to 3 years after the birth of their child.	Further information on teenage conceptions in Thurrock can be found in the Teenage Pregnancy section.	
Young offenders	Findings have indicated a high prevalence of complex and persistent mental health and social care needs among children and young people in contact with the youth justice system. One quoted study reported that one third of these children and young people have mental health needs, often undiagnosed and untreated.	One third of the Thurrock Youth Offending Service would equate to 135 children with mental health needs.	Centre for Mental Health / Thurrock Council
Children with physical disabilities	Physical health problems significantly increase the risk of poor mental health, and vice versa.	There are 850 children known to the CWD team – but only 427 on the disability register (2013)	Thurrock Council
Children from a BME background	Research shows that children from BME backgrounds are under-represented in CAMHS services, and that it is more likely that their problem will reach a crisis point before they come into contact with services.	Further information on the ethnicity of children in Thurrock can be found in the children's Demography section.	
16-17 year olds and young people in transition	The prevalence of mental health disorders is known to increase throughout adolescence, and young people in transition are	Applying the prevalence of 21.5% would equate to 885 16 and 17 year olds in Thurrock with mental health disorders.	(McManus, et al., 2009)

	<p>additionally at risk of having their mental health needs overlooked. One survey indicated that as many as 21.5% of women aged 16-24 years have a mental health disorder.</p>		
Children with parents who have mental health issues	<p>Poor parental mental health is significantly associated with children's social and emotional development and their mental health, as it affects the upbringing of a child. Children with parents who have mental health issues are twice as likely to experience a childhood psychiatric disorder. National research indicates that 17.8% of parents have a mental health issue.</p>	<p>Figures from the CAMHS service in Essex show that 50% of those attending CAMHS had at least one parent who had had contact with adult mental health services.</p>	
Children with parents with substance misuse problems	<p>The misuse of drugs and/or alcohol may adversely affect the ability of parents to attend to the emotional, physical and developmental needs of their children. Research indicates that children are twice as likely to use alcohol and/or drugs at an earlier age, and have higher rates of psychiatric disorder. They are also at high risk of being put onto a Child Protection Plan.</p>	<p>Figures from the CAMHS service in Essex show that 25% had a substance misusing parent.</p>	
Children who have witnessed domestic violence	<p>It is now well accepted that witnessing abuse in childhood is a significant factor in the development of depression, anxiety and other mental health disorders, and may lead to sleep disturbances, self-harm, suicide and attempted suicide, eating disorders and substance misuse.</p>		Women's aid
Attachment disorders	<p>There is a sizeable body of literature on the relationship between types of early childhood attachment and a variety of negative health and mental health consequences</p>		Bowlby – Ethological Theory of Attachment

What are we doing in Thurrock?

In 1995, the document *Together We Stand* laid out a strategy to improve mental health services for children, young people and families. *Together We Stand* laid out a tiered service structure to clarify this and better deliver the care pathways. This covers four tiers of provision for emotional wellbeing and mental health:

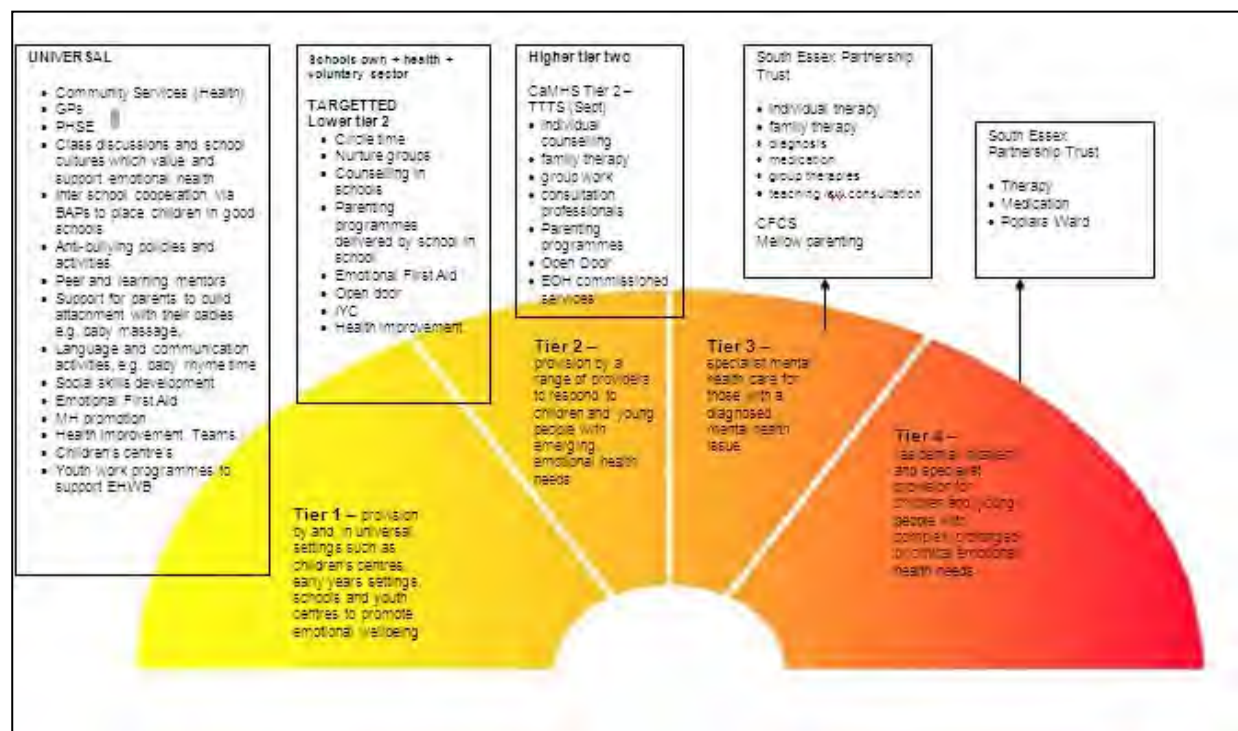
Tier 1: provided by practitioners who are not mental health specialists working in universal settings such as schools and early years settings, offering general advice and support aimed at promoting emotional wellbeing and preventing mental illness.

Tier 2: a service provided by specialist individual practitioners in primary and community settings including assessment, care and interventions for children and young people with emerging emotional health needs.

Tier 3: a specialised multi-disciplinary service for more severe, complex or persistent mental health problems.

Tier 4: essential tertiary level services for children and young people with the most serious problems, such as day units, highly specialised out-patient teams and in-patient units providing 24 hour nursing care.

Figure 51: The range of CAMHS services delivered in Thurrock, 2014



Source: Adapted from Thurrock Multi agency assessment and responses to children.

Children's centres

Thurrock's children's centres play an integral role in promoting positive mental health and emotional wellbeing in both children and their parents, and offer a range of supportive services to do this. Two of their 28 outcomes in their Outcomes Framework specifically relate to ensuring parents feel adequately supported and that they have good mental wellbeing and self-esteem.

Family Nurse Partnership

The recently launched Family Nurse Partnership (FNP) programme aims to provide ongoing intensive support to new teenage parents and their babies. As the programme helps first-time parents to adapt to parenthood, it also provides support with mental health needs. Further information on the FNP can be found [here](#).

Estimated need for services

Data from ChiMat estimated the below numbers of Thurrock children aged 17 and under who may require a service from CAMHS:

Table 12: Estimated need for CAMHS services in Thurrock

	Tier 1	Tier 2	Tier 3	Tier 4
Thurrock	5,855	2,735	725	30

Source: ChiMat – produced using Office for National Statistics mid-year population estimates for 2012 and research by Kurtz, Z. (1996).

CAMHS Crisis Team

The Crisis teams across Essex provide emergency assessments, and where appropriate, home treatment to avoid the admission of a child or young person. These services are currently delivered from within CAMHS Tier 3 provision and act as the gateway into Tier 4 inpatient services. An assessment by the crisis team could result in a complete discharge from CAMHS services, a referral to CAMHS Tier 3 community service, or an inpatient admission.

Access for children and young people with a learning disability

South Essex Partnership Trust (SEPT) has a specialist CAMHS LD service which works with children with mental health needs aged 5 to 12 who have a severe and profound learning disability and a statement of special educational needs. In addition, individuals with a less severe learning disability may receive interventions from generic CAMHS teams. The 2012/13 contract monitoring data reports that between 60 and 70 individuals with a diagnosed learning disability are recorded as being on CAMHS caseloads each month in South Essex.

Tier 4 services

Nationally NHS England commissions a variety of beds that Thurrock can access, including general inpatient adolescent beds, Psychiatric Intensive Care Unit (PICU), Eating Disorder beds, and low and medium secure adolescent beds. Where a young person's needs cannot be met within the region, other national providers will be considered and these include specialist provision for complex, high risk or dual diagnosis. As of November 2014, there were 9 Thurrock children known to the NHS England East Anglian Mental Health team, and the majority of these were treated within the Thurrock area. Treating needs within tier 4 services can incur high costs – the average cost for the patients referred from South Essex Partnership Trust was £7,123.18. In 2011, the Department of Health estimated that improvements to the acute care pathway for mental health could result in national savings of around £224 million per annum by 2014/15 (Department of Health, 2011) and sets out a number of suggested approaches that may help to achieve this reduction.

Identifying unmet needs

Partners across Southend, Essex and Thurrock have been engaged since 2011 in reviewing the response to children and young people's emotional wellbeing and mental health needs. It has been recognised that the current model of emotional wellbeing and mental health provision for children, young people, their families and carers is not providing sufficient integration. Consultations with partners, children and young people and their parents/carers during 2011,

2012 and 2013 focused on the experience of CAMHS Tier 2 and Tier 3 and what a good service would consist of.

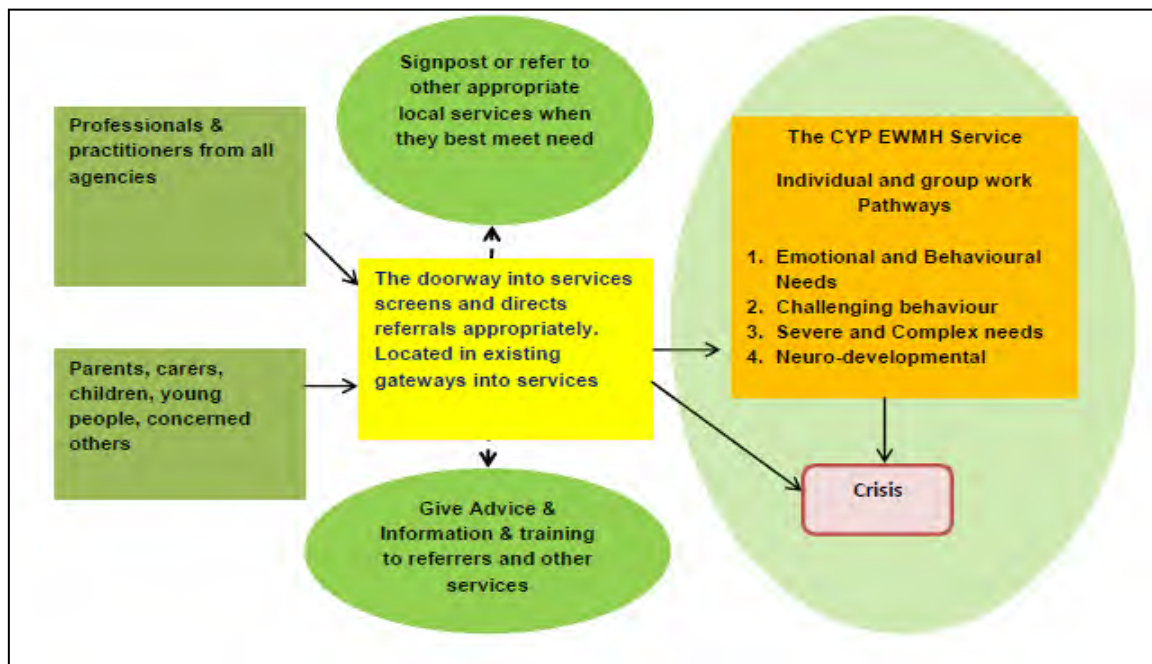
The key emerging themes were:

- Supporting parents/carers and the whole family
- Having local or community based services and engaging with young people
- Improved access to support, advice with quick and easy access/referral to appropriate services.
- Workforce training (including universal staff)

The Essex Joint Strategic Needs Assessment of Child and Adolescent Emotional Wellbeing and Mental Health completed in summer 2013 concluded that there is no overall coherent integrated strategy within which services are commissioned and there is a complex, fragmented and poorly understood and accessed set of services in place. The Health and Social Care reforms together with the current financial climate have given added impetus for an integrated commissioning approach. A desktop analysis of good practice was also undertaken.

A wide range of stakeholders have been working in partnership during 2013 to develop a service model that integrates the Tier 2 and Tier 3 Services (which are currently separate), to reflect good practice and address the gaps and approaches identified in these consultations and the 2013 Essex Joint Strategic Needs Assessment. The redesigned model consists of a Single Point of Access and a service providing direct interventions to children and young people with emotional wellbeing and mental health needs. It eliminates the separation between Tiers 2 & 3 CAMHS, collapsing them to deliver an integrated service known as the Children and Young People's Emotional Wellbeing and Mental Health Service (The CYP EWMH Service). The new service will provide a comprehensive, outcomes based and innovative approach using targeted and specialist, evidence based interventions and an integrated pathway approach across health, social care, education and the voluntary and community sector to respond to the varying emotional wellbeing and mental health needs of children and young people. It will advise, inform and support universal services and provide training to maximise capacity to build resilience and provide appropriate early intervention to children and young people with emotional wellbeing and mental health needs. It will work closely with a wide range of partners to ensure an integrated, effective service.

Figure 52: Proposed model of the Children and Young People's Emotional Wellbeing and Mental Health Service for Southend, Essex and Thurrock



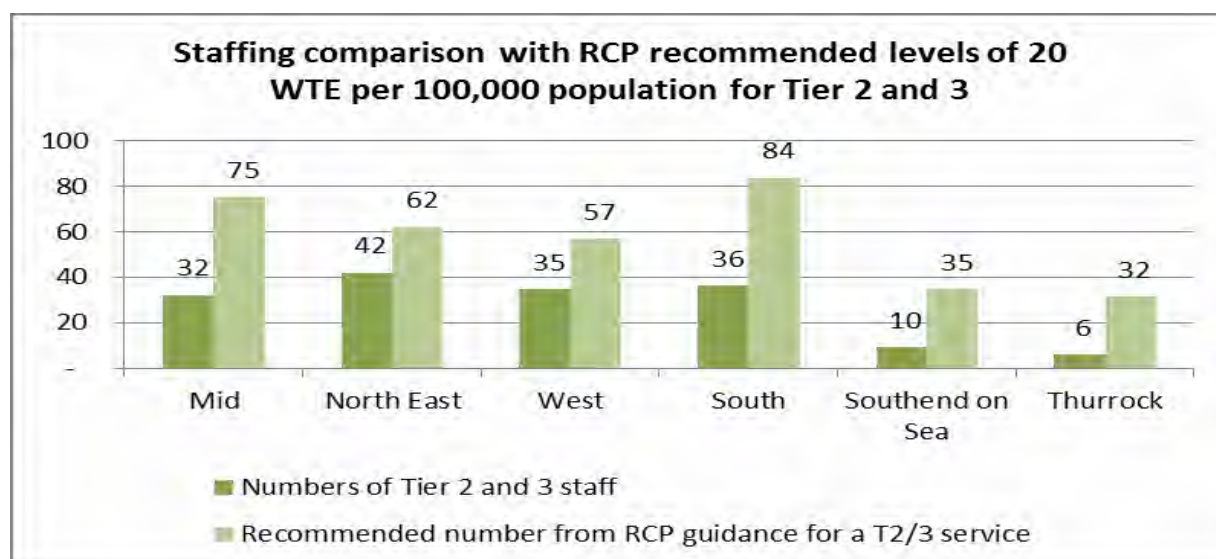
Source: Southend, Essex and Thurrock Children and Young People Emotional Wellbeing and Mental Health Service Model, 2014

The CAMHS workforce

Work was undertaken as part of the Essex Joint Strategic Needs Assessment for Children's Emotional Well-Being and Mental Health (2013) to review staffing numbers across the county. The National Service Framework (2007) recommendations state that a Tier 3 service with teaching responsibilities for 0-17 year olds would need a minimum of 20 whole time equivalents (WTEs) per 100,000 total population, or 15 per 100,000 for a non-teaching service. The Royal College of Psychiatry put forward a recommended staffing level of 20 WTEs per 100,000 for an integrated Tier 2 and 3 service for 0-16 year olds, of which 5 WTE should be primary mental health workers.

Whilst it is known there are variations in staffing across the county, and it is difficult to directly compare to these recommendations as services are currently delivered in Essex to 0-18 year olds, calculations show that the known numbers of Tier 2 staff, together with those in SEPT Tier 3 services represent 47% of the numbers recommended by the Royal College of Psychiatry.

Figure 53: Royal College of Psychiatry workforce recommendations and actual numbers of Tier 2 and 3 staff



Source: Essex Joint Strategic Needs Assessment for Children's Emotional Well-Being and Mental Health, 2013.

Future Public Health Preventative Mental Health Service

The Public Health team are working with school nursing teams in primary schools to develop a one year pilot to support emotional health and mental wellbeing in children aged 4-11 years. This approach will improve health and reduce health inequalities by working with individuals and families building on the child-centred approach within the 5-19 healthy child programme (HCP).

Recommendations

- Planning and commissioning of services should take account of the predicted population changes.
- Robust contract management with Commissioning partners to ensure the ambitions and outcomes are achieved to the agreed timescales.
- Commissioners should consider increasing prevention and early intervention capacity particularly to the at risk groups identified via the local CAMHS consultation work in 2011-2013
- Parents and carers need information on child development, the causes of emotional distress and signs of mental ill health so that they can support their children and build resilience
- Raise the profile of good mental health with children and young people to reduce stigma and health inequalities.
- Staffing levels and workforce training are featured strongly in the new model of service delivery and detailed within the service specification
- Referral criteria for the new model of integrated provision are clear and account for co morbidities
- Further work should be undertaken to ensure the new service meets the needs of young people in transition between children's and adult's mental health services.

3. Staying Safe

Vulnerable Groups

It is noted that particular groups of children may be considered more vulnerable to poor outcomes. The sections below describe some of these.

Children In Need

A general duty is placed on every local authority to safeguard and promote the welfare of children who are in need within their area. This duty is set by:

1. Section 17 of the Children Act 1989
2. Section 10/11 of the Children Act 2004
3. recommendations in the Munro Review of Child Protection, 2011
4. the Working together to safeguard children statutory guidance 2013

Children's social care must, so far as is consistent with this duty, promote the upbringing of children in need by their families, through provision of a range and level of services appropriate to the child's needs.

The Children Act 1989 states that a child shall be considered "in need" if:

1. s/he is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision of services by a local authority
2. their health or development is likely to be significantly impaired, or further impaired, without the provision of such services
3. s/he is disabled

If children in need are not identified early and referred onto appropriate support they may be at risk of experiencing poor outcomes (Department for Children, Schools and Families, 2010).

These may include:

1. **Health** – their physical health might deteriorate or they may develop mental health disorders.
2. **Safety** – they may become more at risk of serious harm.
3. **Development** – their learning, social and emotional development may suffer as a result of not having appropriate educational support and inadequate opportunities to socialise with their peers.
4. **Behaviour** – they may participate in risk taking activities such as anti-social or criminal behaviour, or take risks with their health, experimenting with dangerous substances or risky sexual behaviours.
5. **Employment** – ultimately, poor outcomes may impact on a young person's ability to acquire the key skills for employment and find a decent job.

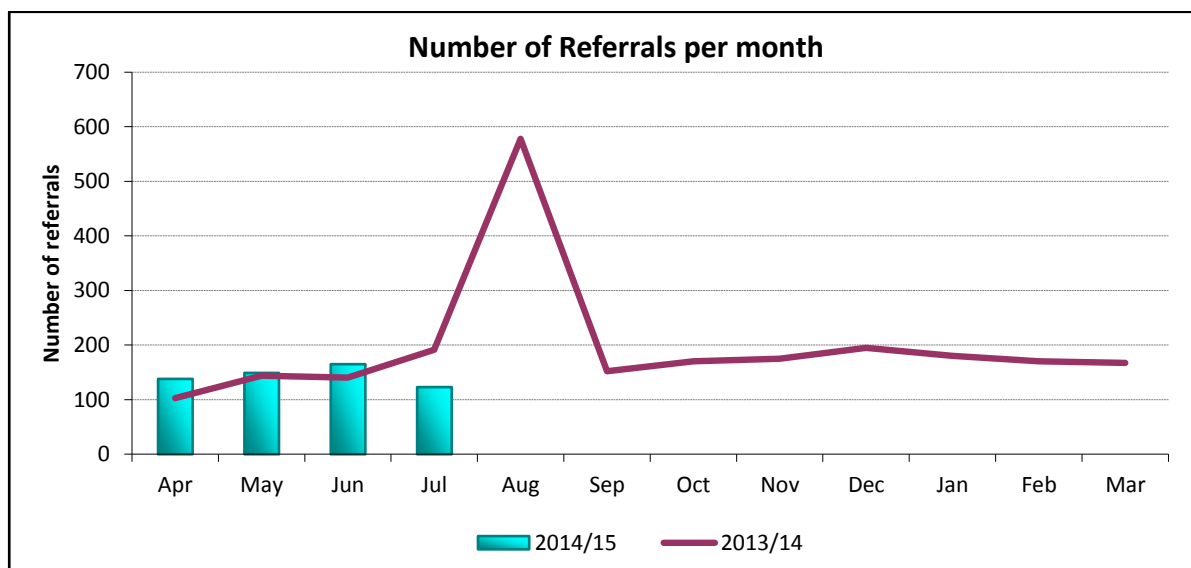
If the problems faced by children in need are not effectively addressed, they may escalate and the child or young person may become subject to a Child Protection Plan or a Looked After Child (LAC).

What do we know?

Referrals

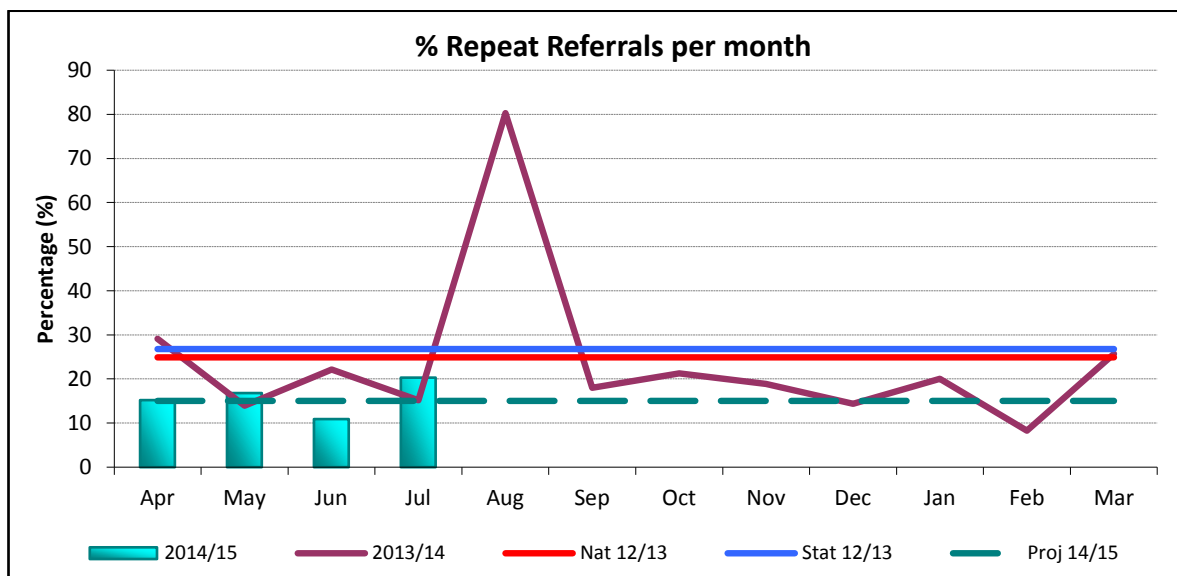
There have been 575 referrals between April 2014 and July 2014, which remains consistent with the 578 during the same period in 2013. The proportion of repeat referrals is currently 15.5% which is lower than the proportion of 18.9% in 2013/14. There is a dip in referrals in July – however it is too early to consider a trend or pattern. In addition, the service has recently introduced the MASH and the impact on referrals will be monitored. Figure 54 and Figure 55 show the volume of referrals received per month, and the proportion of referrals that are repeat referrals.

Figure 54: Referrals per month in Thurrock in 2014/15 and 2013/14



Source: Thurrock Council

Figure 55: % of referrals that are repeat referrals per month in Thurrock in 2014/15 and 2013/14

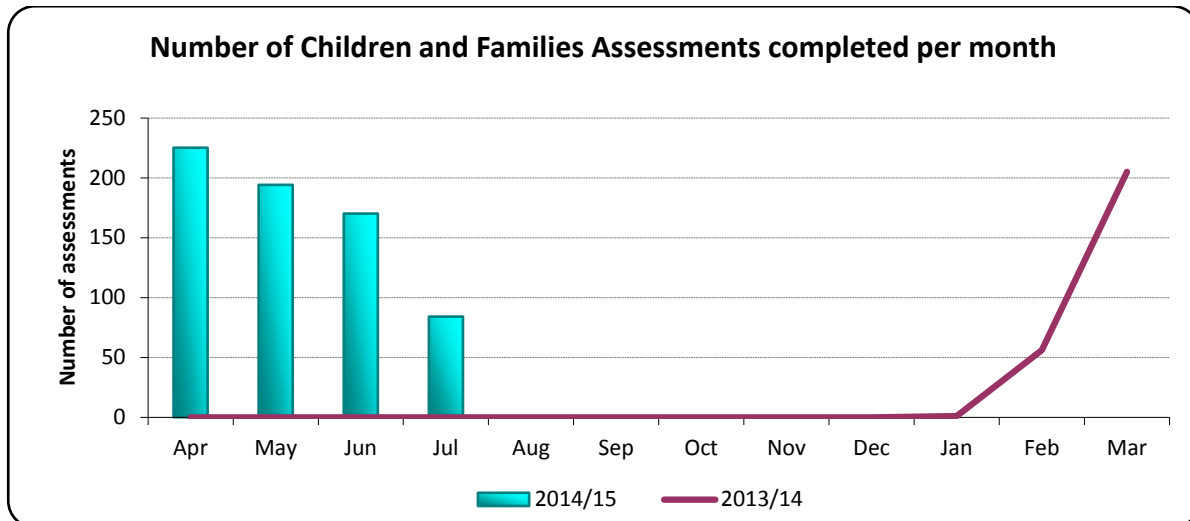


Source: Thurrock Council

Children and Family Assessments

673 Children and Family assessments have been completed between April and July 2014. July appears to show a dip in the number of assessments completed (84); however it is too early to identify a trend. Figure 56 shows this below.

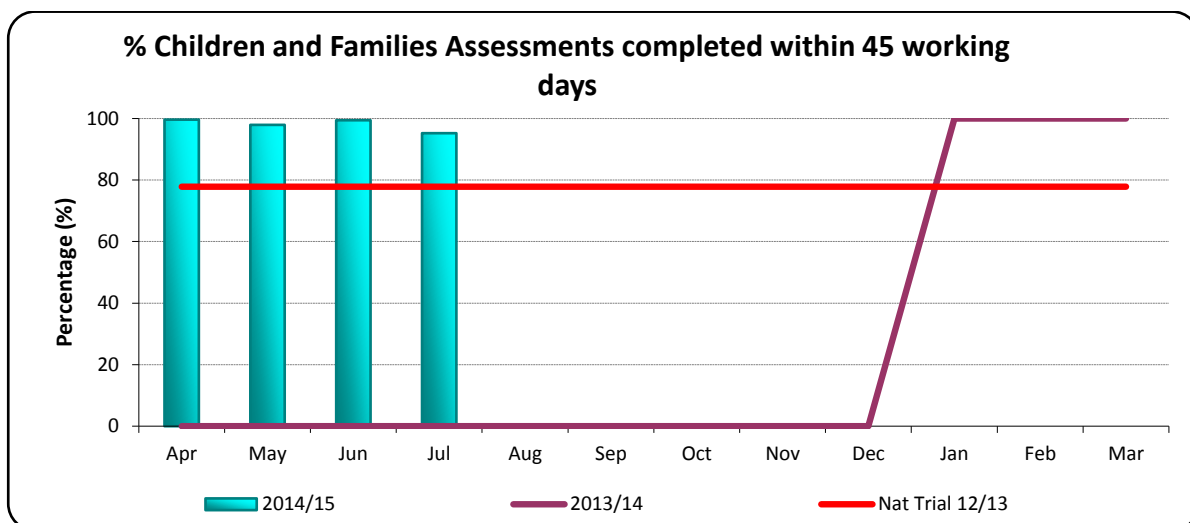
Figure 56: Volume of assessments completed per month



Source: Thurrock Council

As of July 2014, 98.5% of assessments are completed within the 45 day timescale. However, it is important to note that timeliness performance shows a declining trend month on month since April, and was 95.2% in July. There are no national or comparator council performance averages to compare our performance with, and the release of national 2013/14 data will provide the first set of data for benchmarking in this area. However, we are able to provide an indicative comparison against the 2012/13 national Children and Families assessment trial average which was 77.8%. Thurrock therefore remains significantly better.

Figure 57: Proportion of assessments completed within 45 working days



Source: Thurrock Council

What are we doing in Thurrock?

A new multi-agency model for delivering services to children and families in Thurrock was introduced in July 2014. This model incorporates the MASH (Multi agency safeguarding hub) and enhances the Early Offer of Help.

Multi Agency Safeguarding Hub (MASH)

The MASH is a single point of entry for all referral, notifications and police reports in Thurrock and where there is a need for support or where there is a specific concern about the welfare of a child or a young person. It brings together a variety of agencies into an integrated co-located multi agency team; where information is shared appropriately and securely on children, families and adults around the child or young person in order to make timely and appropriate decisions. By working closely together across professional boundaries MASH will help to ensure early identification of concerns and provisions of help to families; which is vital in promoting children and young people's wellbeing.

MASH core agencies include:

1. Children Social Care (MASH screening desk)
2. Essex Police
3. Health
4. Troubled Families Programme Manager
5. Probation
6. Housing
7. Education Welfare (EWO)
8. Youth offending service (YOS)
9. Independent domestic violence advocate (IDVA)

MASH satellite agencies include:

10. Adult services (Community solutions team linked to the Adult Safeguarding team)
11. Link to SEPT - Community mental health services (CMHT and CAMHS)
12. Link to Education Psychologist (EP)
13. Link to children missing from education
14. Basildon hospital

Confidentiality:

MASH acts as an intelligence hub, in which each agency identifies what information they hold on a child/ young person and the adults around them. This process is initiated when the MASH Team Manager identifies the need for a MASH enquiry to commence. Each agency then assesses whether it is appropriate for their information to be shared (in line with the information sharing arrangement) with partners in the hub as well as outside of the hub. A risk assessment is undertaken on those cases where there are concerns about child sexual exploitation, and an

agreement will be made collectively on the best course of action for that referral. The [information sharing document](#) is published on the Thurrock council website.

Thurrock's Early Offer of Help:

Linked as a function to the MASH is the Early Offer of Help, which is designed to ensure that children and families receive support if they do not meet the threshold criteria for support through statutory social work services, (i.e. section 17 or 47) or are stepped down from children's social care services. Situated in the hub but with a very specific early intervention role is a Locality senior practitioner (x3 in post and who will be rotating on a weekly basis connected to both the MASH and area Localities) and a CAF coordinator. The aim of the early offer of help is to offer appropriate help, which ranges from offering advice and information to parents, carers and partner agencies, signposting families to appropriate services, including parenting support services. The link with a senior practitioner in the MASH and within the Early offer of help service will not only make it easier to get the right help for a child or young person but ensures the help they receive is holistic, well-coordinated and efficiently delivered so that everyone involved has the best possible experience of getting' and 'receiving' help from Thurrock partners.

The [ethos of early intervention](#) has been given greater impetus due to the Graham Allen MP report into it. This is also supported by Munro.

Locality based services

Locality teams are multi-disciplinary teams providing early intervention and prevention services for children, young people and families across Thurrock. There are three locality teams in Thurrock East, Central & West. These teams support families where they do not meet the threshold for statutory intervention but require support or where cases are stepped down from Social Care to provide ongoing support to families. This aspect of the Early Offer of Help Strategy is key to delivering earlier intervention and avoiding costly interventions with Children's Social Care. A multi-agency approach is adopted with a senior practitioner heading the teams providing a crucial social work input to the area. The teams are positioned strategically across the area to offer a wide range of services through a single point of contact and have multi-agency management including Health and Social Care. Work in the service area is focused on whole family engagement, assessment and intervention for children and young people aged up to 19 years. It works to promote collaboration with families and a range of partners to give support when it can make the most difference.

Locality teams include:

1. **Evidence-based parenting** - These parenting programmes have been extensively researched and have a solid international reputation. They are proven to have positive outcomes for families.
2. **Funded day care** - This provides support for families, so they are able to access other services. Places are requested by a professional working with the family and provision is purchased from providers with whom there is already a contract.

3. **Children's centres** - Children's centres will link closely to the Locality based services. They are places where children up to 19 years of age and their families can receive seamless integrated services and information, and where they can access help from multi-disciplinary teams of professionals. The Outcomes Framework for children's centres specifically focuses on supporting both parenting practices and child development.

Data for the new locality teams is not yet available since they only became operational recently. However data is available for 2013/14 in respect of the previous MAGS service:

- In 2013/14 there were 283 new referrals
- 153 cases were open as at March 2014
- The largest number of referrals came from the Lakeside and Central localities, however this is not necessarily representative of need since Tilbury and Chadwell saw the lowest number of referrals. There can be issues around effective use of these pre-statutory interventions and willingness for families to engage in what is a voluntary service.
- The largest volume of referrals was from schools with the next largest from Health Visitors
- Referrals were predominantly White British and not representative of the demography of Thurrock. Again there may be issues with some communities not willing to engage in voluntary interventions, despite considerable effort having gone in to increasing referrals.
- Two thirds of referrals were boys

A recent small sample of cases that has successfully closed evidenced that 90% of those cases were not re-referred to either the MAGS service or to statutory services.

Child and Family Assessment teams /Family support teams/ Adolescent support teams

The child and family assessment team now receives its work directly from the MASH and undertakes assessments and S47 enquiries. The Adolescent support team also receives work from MASH where the issue involves a young person who has specific problems due to their behaviour. These teams undertake a child and family assessment and decide whether further social work is needed with the family and whether to progress the case if it requires a response as a Child in need or if there are safeguarding concerns whether there is a need for a multiagency child protection plan. Nationally published data about Children in Need shows that the rate per 10,000 0-17 population in England increased by 26% between 2008/09 and 2013/14, with over two thirds of local authorities experiencing an increase in numbers of CIN.

Troubled Families

The national Troubled Families programme focuses on families with worklessness, poor school attendance and anti-social behaviour as problem features. This is operated locally under the national descriptor and uses Programme Managers to work to support the lead professional for each family, as is identified in the early help model of delivery. Thurrock Council is committed to working with their partners to help those identified as meeting the criteria to turn their lives around with the appropriate intervention, advice and signposting of services. We want to ensure the children in these families have the chance of a better life.

As part of the Troubled Families programme, we will work to:

1. get children back into school
2. reduce youth crime and anti-social behaviour
3. put adults on a path back to work
4. reduce the high costs these families place on the public sector each year

Troubled families workers are also located in the MASH to pick up families that meet their criteria. This is a “payment by results” programme and as at August 2014 Thurrock has claimed for 136 families. Thurrock's Troubled Families are currently working with their 3rd year cohort and the programme is becoming fully embedded into services within the local authority. This government has extended the programme from 2015 for 5 years with initial funding agreed for 2015/16.

Targeted youth work

The youth work team delivers a number of targeted projects aimed at reaching those young people deemed with the most need. The team works with internal and external partners such as:

- MASH
- Troubled Families
- YOT
- Social Care
- Thurrock Careers
- Catch 22
- Alternative Education Centres
- Schools and Academies
- Young Carers

to identify young people who need further support in their personal and social development. A referral is then made to the team identifying the young person's areas of development, and a young person is then referred onto a youth work project that aims to achieve the required outcomes. If for instance a particular need is identified, a project targeting specific issues will be delivered and young people are referred onto this project through the team's links with internal and external partners. The youth work team also makes its own referrals to its targeted projects.

The team's targeted provision includes:

- *The Goal Project* – this is a 12 project aimed at developing the personal and social skills of disengaged young people by using football as a learning tool. This project had a weekly slot at the PSS as well as being delivered at The Gateway Academy, Hassenbrook Academy and to Thurrock Young Carers.
- *Street Football Project* – this project is aimed at engaging young people into positive activity and steering them towards positive pathways. The project delivers 9 hours a week of football to young people in targeted areas in Thurrock. The sessions take place in ball courts, parks and school fields.
- *Re:Cycle* - the re:cycle project is a 12 week project aimed at developing transferable skills to young people. Young people learn the basics of bike mechanics whilst stripping

down and building back up a recycled bike. At the end of the project young people get to keep their bike which they can use as a form of transport as well as a means of keeping fit and healthy.

- *ID Project* – this is aimed at developing the self-esteem of young people through exploring different communities and values in a youth work setting.
- *Girls Group* – this is a 12 week project aimed at developing the awareness of the social issues young woman may face.
- *Extreme 360* – The E360 project is a project that uses extreme sports to develop young people's personal and social skills.
- *Project ME* – A 12 week project for 16-19's who are currently NEET. This project will support young people's next steps into employment or training by breaking down barriers and building skills to use in the workplace.

The team also delivers targeted provision in the school holidays; for example the summer holiday activity project provided activities to over 100 targeted young people. The activities included white water rafting, laser tag, grangewaters, and the Royal Opera House. *Soccability* sessions are also offered at the special schools in the borough and summer holiday provision at the Sunshine Centre.

Recommendations

- Review the implementation of MASH and monitor impact on children and families
- Review the provision of services to families and ensure they meet local need and demand following the JSNA.
- Further work to take place to evidence the reduction of demand on statutory services and impact on numbers of open CIN, CP and Looked after children

Children subject to a Child Protection Plan

Children and young people that become subject to Child Protection Plans do so because they are considered to be, or likely to be, suffering significant harm. Any child or young person under the age of 18 can be subject to a child protection plan in order to safeguard them from significant harm. The *Children Act 1989* introduced the concept of significant harm as the threshold that justifies compulsory intervention in family life in the best interests of children, and gives local authorities a duty to make enquiries to decide whether they should take action to safeguard or promote the welfare of a child who is suffering, or likely to suffer, significant harm.

Working Together to Safeguard Children (2010) describes four broad categories of abuse:

- **Emotional abuse** - persistent emotional maltreatment of a child which is likely to adversely affect their emotional development
- **Physical abuse** – any treatment of a child or young person which causes physical harm to them.
- **Sexual abuse** - involves forcing or enticing a child or young person to take part in sexual activities, whether or not the child is aware of what is happening
- **Neglect** - persistent failure to meet a child's basic physical and/or psychological needs

It should be noted that some level of emotional abuse is involved in most types of ill treatment of children.

There are some key factors that are often found in cases of abuse and/or neglect, and whilst their presence is not proof abuse has occurred, they must be regarded as indicators of possible significant harm. These include:

- **Deprivation** – many families face unemployment, financial hardship, social isolation, and other problems associated with living in disadvantaged areas. Children and young people from deprived backgrounds are at greater risk of experiencing poorer health, development and educational outcomes than their peers
- **Family circumstances presenting challenges for children, such as substance abuse, mental health problems or domestic violence** – poor parental health may affect parents' ability to look after both themselves and their children. **Parenting experiences** – some adults have negative childhood experiences which may impact on their parenting skills.
- **Parental learning disability** – parents with learning disabilities may impact on their ability to care for their child, depending on their cognitive ability. This could manifest itself in poor decision making and lack of awareness around issues such as child safety, diet, hygiene and learning.
- **Unaccompanied Asylum Seeking Children and Trafficked children** - Many of these children will have suffered physical abuse on their way to the United Kingdom. The process of identifying these children and keeping them safe presents difficult challenges, especially as many of them will have complex needs.
- **Disabled children at residential special schools**
- **Children who have been privately fostered**

Working Together to Safeguard Children (2013) also outlines that professionals should be alert to the potential need for early help for children who:

- are disabled and have specific additional needs;
- have special educational needs;
- are young carers;
- are showing signs of engaging in anti-social or criminal behaviour;
- are showing early signs of abuse and/or neglect.

As a result of abuse and neglect, children and young people are at risk of a number of poor outcomes. *Working Together to Safeguard Children* (2010) includes a summary of the known impacts of abuse on children's health and development. These include:

- Poor mental health including disorders such as anxiety, depression, and eating disorders
- Participation in risk-taking behaviours such as substance abuse, youth offending and anti-social behaviour
- Impaired growth, poor emotional and intellectual development and poor social functioning
- Physical injury leading to neurological damage, disability or in extreme cases death

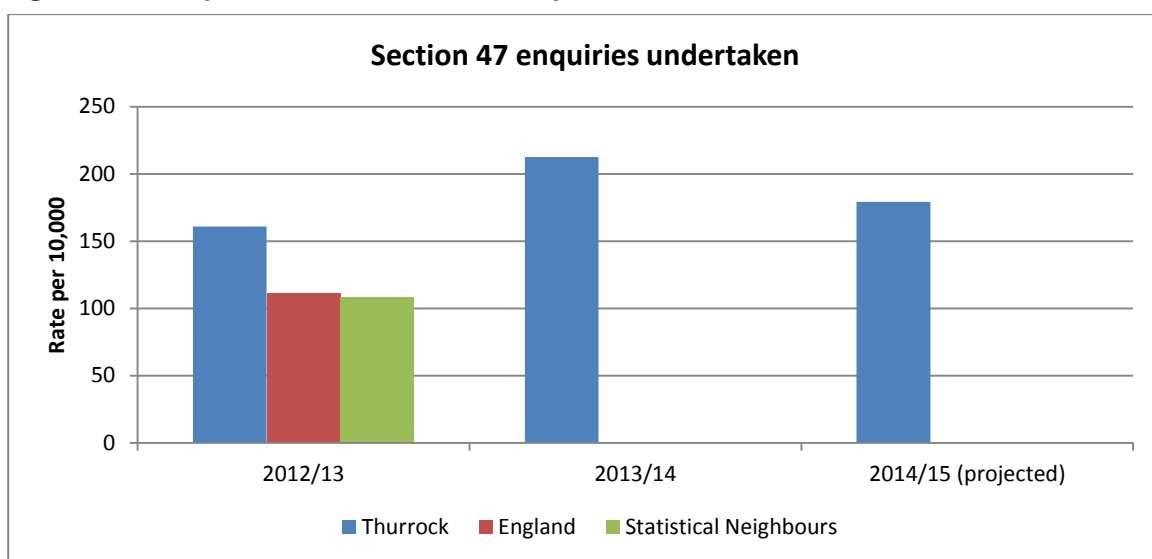
The Local Authority has a lead role as an investigating agency, statutory holder of cases for children who are subject to child protection plans and the agency responsible for initiating care proceedings whereby the court has considered the need for the Local Authority to share parental responsibility.

What do we know?

Section 47 investigations

The projected year end rate for 2014/15 of section 47 investigations per 10,000 population is 179.3. This would be below the rate of 212.6 in 2013/14 though remaining above the latest data for both national (111.5) and statistical neighbour areas (108.2).

Figure 58: Rate per 10,000 of section 47 enquiries undertaken

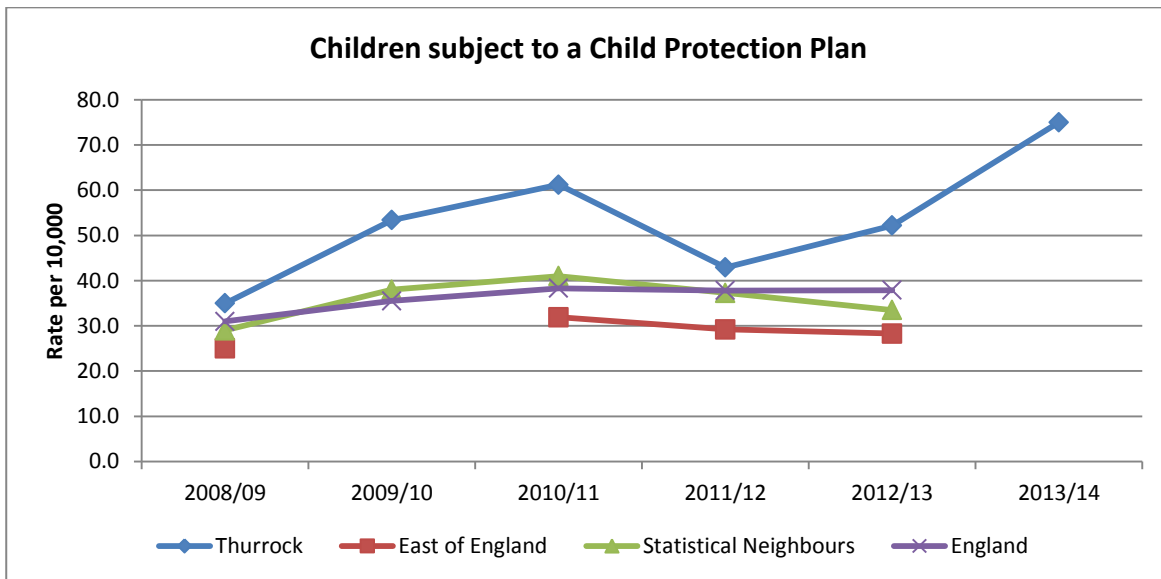


Source: Thurrock Council

Children subject to a Child Protection Plan

The rate of children subject to child protection plans had been on an upwards curve in Thurrock and continued to rise through 2013/14. The rate per 10,000 children in 2013/14 was 75 (288 children). This compared to a rate of 53 in 2012/13 – an increase of 41%. The rate also placed Thurrock significantly above both 2012/13 national (38) and statistical neighbours (34) averages. The trend can be seen in Figure 59 below.

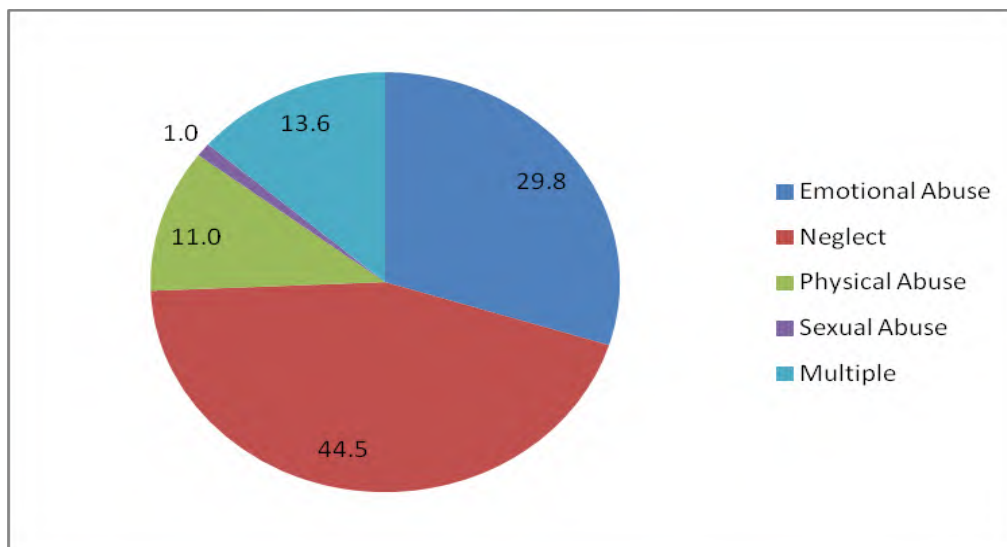
Figure 59: Rate per 10,000 of children subject to a Child Protection Plan



Source: Thurrock Council

When analysed by category of abuse, it can be seen that the most prevalent category of abuse is neglect (44.5%) followed by emotional abuse (29.8%).

Figure 60: Children subject to a Child Protection plan in Thurrock by category of abuse, 2014



Source: Thurrock Council

The gender split in 2014 is broadly even with 49% being males and 50% being females. Analysis of the age profile shows that the majority of children subject to plans are aged between 0-4 (45%) and 5-11 (43%).

What are we doing in Thurrock?

There has been considerable focus has been made on understanding why Thurrock has a higher level of S47 enquiries and children subject of a child protection plan and to explain the considerable rise in children being subject of plans. There has been a national rise in numbers

but this has been higher in Thurrock than in other areas. External scrutiny and internal auditing has been undertaken to review thresholds and evaluate decisions for s47 enquiries. These have generally found that thresholds are sound and enquiries undertaken appropriately. This work has specially considered those cases that have been on a plan for more than two years. This has resulted in a significant reduction in numbers of children subject of a plan in the last 6 months (April – Sept 14) This work is intended in the future to have partnership engagement to monitor children on plans for over 12 months to prevent drift and ensure effective multi agency working.

Thurrock had an inspection of its Youth Offending Service (YOS) in 2012, an Ofsted inspection of Safeguarding and looked after services (SLAC) in June 2012 and more recently an inspection of Fostering Services in March 2013. The YOS inspection rated the service as creditable, while the other two inspections found the service to be rated as Good.

Child protection and Child in need plans continue to be an area for further development to ensure that they are SMART and fully responsive to the family's needs to ensure positive outcomes. Work is underway to review the current Child protection conferencing style, taking advantage of the Transformation Programme to ensure that conference facilities are family-friendly and lend themselves to a Strengths-based approach to conferencing.

Thurrock has implemented a multi-agency Missing Children Panel which will incorporate those at risk of sexual exploitation. The panel tracks individual cases but has also contributed to identifying patterns of absconding and behaviour to minimise the impact of child sexual exploitation. The panel also monitors those missing from education and regular absconders. The multi-agency approach to this work has been seen as successful is being considered as a model across Greater Essex.

The E-Safety sub group from the LSCB has recently embarked on a series of "Roadshows" in partnership with Essex Police, reaching an audience of almost 5,000 students aged 9-11 across the Borough giving clear messages about the dangers of the on-line world. The roadshows have been well received and have generated further debate within the community, following some of the findings generated by a questionnaire completed by the students about their on-line habits. The proposal is to develop this forum further to include parents and carers.

Child Sexual exploitation has also been a significant focus, a county wide strategy has been developed with training being rolled out across the borough to 5,000 staff, making them aware of the signs of exploitation and how best to respond. A local strategy needs to be developed.

Parents of Children in Need, children on Child Protection Plans and those who do not met the threshold for statutory intervention and receive a locality based service (previously known as MAGS) have access to a wide range of services. This is primarily delivered through the Early Offer of Help (EOH) strategy which has a suite of commissioned services central to it. These include the following:

- Domestic violence perpetrators programme
- for women including a targeted 10 week programme and a universal drop-in service
- Sexual violence support for women who have suffered any form of sexual violence

- Drug and alcohol support programme – an intensive package of support that takes a whole family approach
- A range of parenting programmes
- Family Intervention Project (FIP) – an intensive package of support for families with multiple complex issues

These services were commissioned following a local needs analysis and using the 2012 JSNA. They are currently all well-utilised with some of the services slightly under capacity, partly due to awareness rather than need. Services are subject to continual review and a full analysis of impact will be conducted prior to any re-commissioning exercise.

In addition other support services exist:

- The current re-commissioning of the pan-Essex CAMHS service will see emotional well-being provision more widely available to children in need and those not known to statutory services. The current service only works primarily with looked after children.
- Mentoring and awareness programmes are in place for young people who are exhibiting risky behaviours or at risk of doing so.
- All children's centres across Thurrock support families via a range of support for parents and their children through early intervention and to avoid families escalating to statutory services. They also play a crucial role in supporting families that have been closed to Social Care but require ongoing support to avoid issues escalating in the future.
- The provision of a Substance misuse and mental health and a domestic violence worker within Children's social care ensures advice / assessment and referral on to appropriate services.

Recommendations

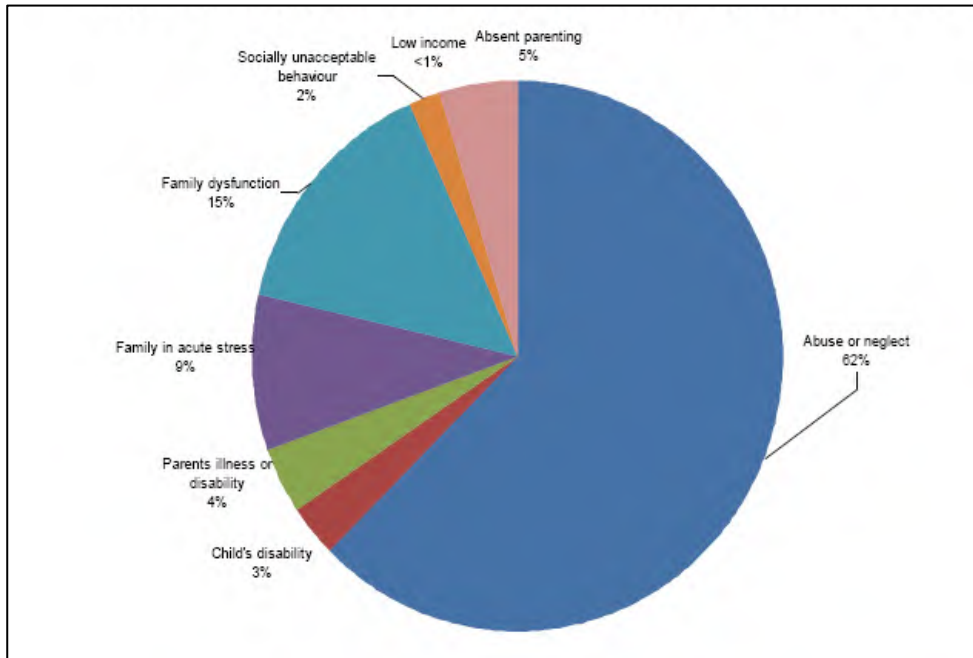
- Implement strengthening families approach to child protection conference process
- Develop a local CSE strategy and ensure the incidents of CSE are known and addressed across Thurrock
- Develop and implement a neglect strategy through the LSCB, especially addressing adolescent neglect
- Children subject of plans for over 2 years are monitored closely by a multiagency group.

Looked After Children

Looked after children and young people are particularly vulnerable by virtue of the fact that they are no longer living with birth family for a number of reasons. The majority of looked after children are provided with a service due to abuse or neglect. Some may be in care because of the illness or death of a parent. Others may have disabilities and complex needs. Most young people in care come from families who experience hardship and are separated from them because their family was unable to provide adequate care. Unaccompanied minors seeking asylum in the UK may also become looked after. In addition, a minority are in care because of offences they have committed. The reasons why looked after children are provided with a

service have been relatively stable since 2009. The chart below shows the reasons for a child to be provided with a service and the proportions of children looked after recorded in each category as of 31 March 2013.

Figure 61: Primary Need for a service, England as of 31st March 2013.



Source: Department for Education, 2013

In England as of March 2013 there were 68,110 looked after children, an increase of 2% compared to 31 March 2012 and an increase of 12% compared to March 2009.

Placement of Looked After Children

National data from the Department for Education indicates that the number of looked after children placed in foster care has increased by 16% since 2009. The percentage of looked after children cared for in foster placements was 72% in 2009, in 2013 it increased to 75%. There were 3,350 looked after children placed for adoption at 31 March 2013. This is an increase of 16% from 2012 and an increase of 25% from 2009.

Care Leavers (18+)

All local authorities have a duty to provide services to young people who were previously looked after and are leaving care. This is governed by legislation, such as the Children (Leaving Care) Act 2000 and subsequent legislation.

All local authorities have to provide information to the Government in respect to those young people who are not in education, employment or training (NEET) and their living arrangements as at the age of 19. As of 31st March 2013, there were 6,930 young people aged 19 who were looked after when aged 16. Of these young people, 2,360 (34%) are NEET. This is a decrease of 1% since 2012, reversing the upward trend seen in previous years.

According to the Department for Education, most young people now aged 19 who were looked after at 16 are in independent living arrangements (37%). This percentage has decreased over the last 5 years – in 2009 the percentage in independent living arrangements was 43%. The majority (88%) of young people are classed as being in suitable accommodation. There were 330 young people living with their former foster carers, this represents 5% of this cohort of young people and is a similar figure to that of 2012.

What do we know?

Since its creation as a Unitary Authority Thurrock Council historically had relatively low numbers of Looked After Children. However this profile has changed radically over the last few years, with a significant year on year rise, as can be seen below.

Table 13: Children in Care in Thurrock and England, 2009-2015. Data as of 31st March each year.

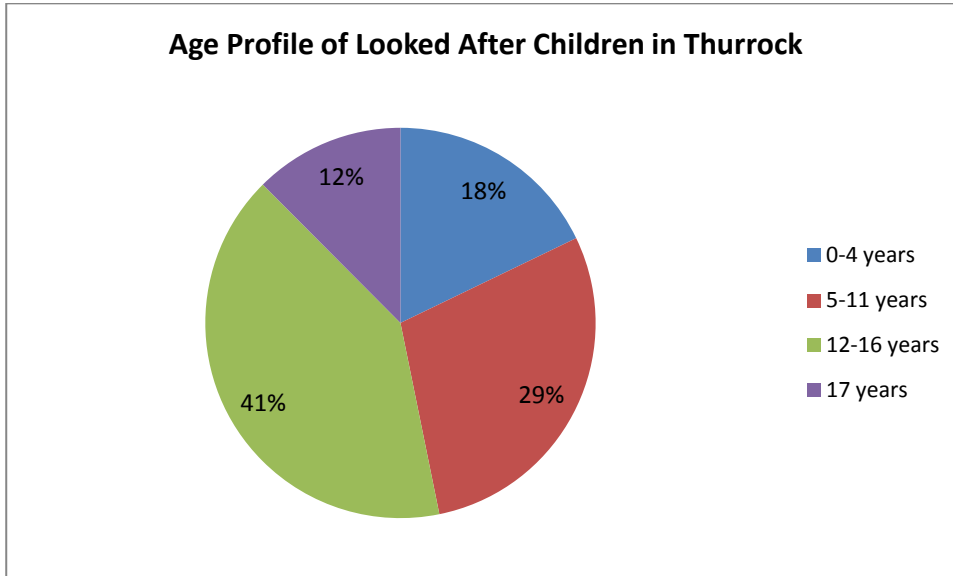
	2009	2010	2011	2012	2013	'14 proj	'15 proj
Total children in care (under 18)	220	235	210	240	264	291	297
Thurrock Unaccompanied Asylum Seeking Children (under 18)	25	35	20	24	19	17	18
Thurrock other (under 18)	195	200	190	216	245	274	279
Thurrock (per 10,000) (under 18)	60	63	56	62	68	75	76
England (per 10,000)	55	59	59	59	60		
Statistical neighbours (per 10,000)	58	62	63	65	67		

Source: Thurrock Council

Whilst it is anticipated that the ongoing development of our strategies for early intervention will begin to reduce the rate of looked after children per 10,000, which is currently well above the national average, this may to an extent be offset by the projected overall rise in numbers of children and young people.

As of 10th June 2014, there were 297 looked after children in Thurrock. The age groups of this population are shown in Figure 62 below:

Figure 62: Age Profile of Looked After Children in Thurrock, June 2014

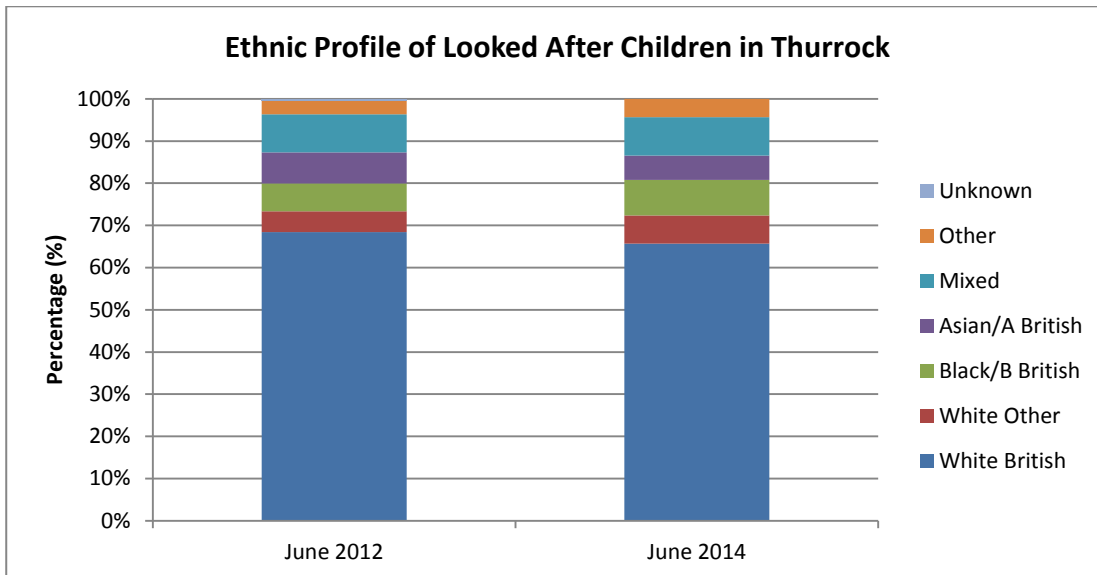


Source: Thurrock Council

Of the 297 children, 179 (60%) were male and 118 (40%) female.

The ethnicity of current children is as follows, and shows a relatively stable profile over the last two years:

Figure 63: Ethnicity of Looked After Children in Thurrock, 2012 and 2014.



Source: Thurrock Council

This suggests that at present there is reasonable consistency regarding the ethnic profile of Looked After Children in Thurrock. However the overall population profile has changed over recent years with a growth particularly in Black African and East European families. It is therefore reasonable to presume that these groups will become more heavily represented in the Looked After population in years to come.

Placement of Looked After Children

Of the 297 looked after children in Thurrock cited above, the spread of placements was as follows:

Table 14: Age of Looked After Children in Thurrock and type of placement.

Age of child	In house fostering	Independent Fostering	Residential	Other	Total by age
Under 1	7	3		5	15
1-5	19	20		10	49
6-11	30	35	6	2	73
12-15	30	39	21	1	91
16+	28	16	15	10	69
Total by provision type	114	113	42	28	297

Source: Thurrock Council

In total therefore 227 children (or almost 77%), were living in foster placements, 42 (or just over 14%) were living in a variety of residential provision, and 28 (9%) had other arrangements, such as living with someone with parental responsibility or currently placed for adoption. The total for in-house foster care includes 23 Family and Friends Foster Carers, some of whom were currently Temporarily Approved and undergoing assessment as Connected Persons.

Thurrock has been consistent in our relatively high use of foster placements over time; our performance has regularly been above the national average, which for 2012-2013 was 75%. However we have fared less well in our capacity to place within the boundaries of Thurrock Unitary Authority. Of the 297 placements, only 101 were within our boundaries and 196 were outside. However this needs to be seen in the context of our relatively small geographic area, and in fact of those outside, 127 were placed in the neighbouring or nearby authorities of Essex, Havering, Barking and Dagenham and Southend. It is also the case that a number of these placements were with in-house carers who have chosen to foster for Thurrock but live outside the Thurrock boundaries. 72% of Looked After Children in Thurrock were placed within 20 miles of the child's home address, which is slightly below the national average of 76% for 2012/13 but above the regional average of 67%.

Currently we have 42 young people in a variety of residential provision, such as Children's Homes and Residential Special Schools. However the cases of around 33% of these children are held within the Team for Disabled Children, although this team hold only 8% of all looked after children. This reflects their high levels of need, and consequent costs which arise in trying to meet them. Interestingly the average age of this group at 15.2 years is slightly above the average for all children in residential provision, which is 14.5 years. Recently published data by the Department for Education (Children's Homes Data Pack June 2014 Update) reports that the average age nationally for 2012-2013 was 14.6 years and that around 75% of young people in residential homes are between 14-17. Thurrock's profile at 78.5% is thus broadly in line with the national picture.

Given Thurrock's size and levels of demand it has not been considered economically viable to maintain our own directly managed residential resources and therefore the last remaining

children's home closed a few years ago. In this Thurrock is not unique and 51 other authorities are reported to have no provision of their own, although most do have at least one independent provider within their boundaries. This clearly increases the possibility that a child in a residential placement will be placed outside the authority, although we have some placements with local providers.

Care Leavers (18+)

Out of the 110 young people in Thurrock aged 19, 20 and 21 leaving care, 41% are NEET. 75% of the 110 young people are reported to be in suitable accommodation, which is lower than the national average cited above of 88%.

What are we doing in Thurrock?

Whilst it is anticipated that the ongoing development of our strategies for early intervention will begin to reduce the rate of looked after children per 10,000, which is currently well above the national average, this may to an extent be offset by the overall rise in numbers of children and young people.

At a time of significantly diminishing budgets, this will clearly place serious demands on the resources of the Council, and poses a major challenge in endeavouring to ensure that children are found appropriate placements when they are needed. The role of the Corporate Parenting Committee, which consists of Councillors, senior offices and other key people, oversee the work of the department's looked after children, through scrutiny and challenge.

A Placement Panel chaired by senior managers oversees the placements of all looked after children to again provide challenge and ensure that children are placed in the right placements for their needs, and a new Threshold to Care Panel began in September 2014 to ensure the best use of available resources to keep children in the community and out of the care system. The Panel will be chaired by the Head of Service.

A Looked After Children's Surgery has also been set up to look at all care plans for looked after children to ensure they are appropriate and robust.

Placements for Looked After Children

Thurrock's in-house foster care continues to be at the heart of our provision of placements, as reflected in the current distribution of placements. The service is made up of a number of constituent parts:

- Foster Care Support Team
- Therapeutic Foster Care Team
- Supported Lodgings Team
- Recruitment and Assessment Team
- Shared Care

As of 31st March 2014, Thurrock had a total of 98 fostering households, with a potential occupancy of 181 children. However it is recognised that because of needing to avoid

inappropriate combinations of children, or because carers are on temporary hold because of personal circumstances there will never be 100% occupancy. Nevertheless we attempt to make use of in-house foster carers wherever possible. At any given point a proportion of in-house carers will be from Friends and Family placements, sometimes still temporarily approved pending full assessment. These numbers can fluctuate significantly but represent a significant resource which reduces the demands on other carers.

Overall numbers of in-house carers have remained relatively stable, increasing only slightly, as although we have continued to bring in new foster carers through our Recruitment and Assessment Team, the age profile of our existing carers means that a proportion each year will decide to retire or otherwise resign because of changed personal circumstances. Our aim is to increase the pool of in-house carers for our children, identifying areas of specific needs and focusing recruitment activity in these areas.

Care Leavers (18+)

There is a specific team called the After Care Team that works with those young people who have left care and are entitled to a service under the current legislation. The team liaises and works in partnership with a number of organisations such as Education, Health (including Mental Health Services), Adults, Home Office, DWP, Housing and other local authority departments. Within the team there is a member of staff who has sole responsibility for accommodation, which means that he manages a range of accommodation that is used for this cohort of young people. He liaises with the Housing Department, attends a Panel that allocates supported housing, which is a partnership between Social Care, Housing and the Voluntary Sector, and is involved in the current changes with the benefit system and supporting young people to ensure they receive their entitlement.

The role of this service is to ensure that young people have a smooth transition to adulthood through attending reviews of looked after children from the age of 15 and over, advising social workers and carers about independent living and young people's entitlements once they reach 18.

The Council's Learning and Skills team provide 1:1 support for care leavers (16-24 years) to move into full time education or apprenticeships. Further information on this can be found in the [Further Education, Employment and Training](#) section.

Recommendations

In order to ensure we are targeting our placement resources most effectively towards those children who need to be in the care system, we need to develop more assistance to children and young people on the “edge of care”. This includes reviewing the effectiveness of our work in returning children to their birth families where appropriate. For teenagers this may be channelled through our Adolescent Team, but for younger children we need to consider whether the services currently operating under our Early Offer of Help provision are being sufficiently effective. We also need to consider whether some work could be more successfully channelled through alternative providers, who may have an advantage of appearing more independent of the local authority, and we are piloting the use of an external organisation to facilitate the return home of a looked after child. Ultimately this could prove to be an *invest to save* opportunity. Similarly we should explore alternative opportunities such as Volunteers in Child Protection, which could be brought into the Early Offer Strategy.

Placements for Looked After Children

As in-house fostering will continue to be at the heart of our provision it is vital that we continue to expand our numbers through our marketing strategy. Our Thurrock Fostering Marketing Strategy 2012-2015 set out the following objectives:

- To increase the ratio of enquiry to approval to 7% in 2012/13 and 8.5% in 2013/14 and 10% in 2014/15.
- Identify which types of foster carers are specifically needed and target advertisements and information accordingly
- Increase fostering awareness to BME communities.
- To ensure the provision of foster carers matches the needs and diversity of the children and young people in care and increase the stability of placements (This includes therapeutic and supported lodgings placements).

These general objectives still hold good. However in terms of our specific needs we are clear that the issue of finding carers with capacity for sibling groups must be a priority, as is expanding our capacity in house to provide Parent and Child Placements which can support the authority’s work in developing Community Based Assessments. We need to develop greater market management strategies, particularly in relation to 16+s. This applies both to new late entrants to the system, and those who have been with us some time and may need assistance to prepare for independence post 18. Aligned with this is the need to explore options for young people remanded into the care of the local authority, and developing some specific capacity within the in-house fostering service might be an option.

In addition Thurrock has a particular challenge in finding placements for Unaccompanied Asylum Seeking Young People. At the time these young people come to our attention there will usually have been only limited scope to complete the full age assessment, and we will have no real information about their background or circumstances. As a consequence we need to avoid placement with younger children, and have therefore identified some providers of semi-supported accommodation who can provide an immediate response. Although these work reasonably well we are often placing some distance away from Thurrock, making follow up work by Social Workers more difficult and time-consuming. A more local resource would therefore be valuable.

Care Leavers (18+)

- To continue to develop links with other agencies that provide services to care leavers, such as the DWP and Housing
- To develop and ensure there is a range of accommodation to suit the needs of our care leavers
- To provide training to others in respect to the needs of care leavers

Children With Disabilities

Children and young people with disabilities are a particularly vulnerable group in society. To reach their potential to make a positive contribution, children and young people with disabilities and their families need effective support from statutory health, education, social care and the voluntary services at the appropriate stages of their lives. Current financial pressures and the new national SEND reforms call for a more integrated, joint agency approach to ensure the best use of resources in commissioning these services.

Projections suggest the volume and prevalence of children and young people with disabilities may rise over the next 10 years. It is therefore important to ensure that the correct services are in place at an early stage to support those that are disabled and their families.

The primary equalities issue in relation to children with disabilities is the overrepresentation of families from more disadvantaged socio-economic groups amongst those affected by disabilities. Some of the causes of low birth weight, prematurity and perinatal complications leading to childhood disabilities are more frequent among economically disadvantaged families, even in a nation with well- developed welfare systems. Disability can also be a major contributor to material disadvantage and poverty. Families with disabled children are likely to have low incomes because caring for disabled children limits parents' earning capacity. In addition the costs for caring for a disabled child are greater compared with a non-disabled child.

What do we know?

1399 disabled children and young people have been known to the Team for Disabled Children in Thurrock since recording began in 1992, and 773 have been registered as disabled. As of August 2014, there are 233 disabled children currently open to the Team for Disabled Children in Thurrock. Of these children, the ward where the largest number live is Grays Riverside (21). When considering the nature of disabilities experienced by all 1399 children, it can be seen that the most prevalent types (where a type was recorded) are Autism/Aspergers (338), and Learning Disability (234).

Table 15: Nature of disabilities experienced by the 1399 previously known or open cases to Social Care, 1992-2014.

Category of Disability	Number
Behaviour or Conduct Disorder	53
ADHD	28
Emotional/Behavioural Difficulties	9
Sensory Disabilities	29
Communication	52
Consciousness	8
Diagnosed with Autism/Aspergers	338
Hand Function	11
Hearing	37
Incontinence	13
Learning	234
Mobility	139
Other DDA	102

Personal Care	31
Profound Physical and Learning Disabilities.	27
Vision	65
Not recorded	223

Source: Thurrock Council

What are we doing in Thurrock?

Early Years Services

There are a number of services for pre-school children with disabilities, including the Early Support Programme, Educational Psychology, Sensory Support, Portage, Sunshine Centre and School for Parents at Beacon Hill School. Early Support meetings and the identification of a Lead Professional ensure that Multi agency plans are developed and reviewed at the earliest point. Educational Psychologists play a key role in ensuring the needs of children are identified and assessed. Portage provides a range of home- based teaching services for children with significant developmental delays or complex needs. Sensory Support is provided via specialist teachers. The Sunshine Centre provides an opportunity for Pre School children to have access to additional stimulation via group work. The School for Parents supports carers of young children with complex physical needs.

Early Offer of Help

This is the provision of universal and targeted support that meets the needs of all children. However the Sunshine Centre offers targeted, early intervention and prevention via group work, befriending and support to access mainstream and universal social and leisure activities.

Social Care Services

Children and young people with disabilities between birth and 18 years are eligible to receive support from children's social care services. If their development is significantly impaired and they need to receive more personal care and supervision than a child without disabilities of similar age and circumstances. Parents and the Government have emphasised the importance of Education, Health and Social Care being joined up.

Short Breaks

Daytime, evening, weekend and overnight activities that provide a break for parents and an activity for children and young people are available via a number of organisations. These services provide sitting and befriending, group activities, individual support and residential stays. Engagement with parents has highlighted how much value is placed upon the short breaks provision and the role it can play in preventing family breakdown.

NHS Continuing Care Packages

Children and young people receive continuing care health packages to meet complex health needs including those with congenital conditions, those with conditions acquired as a result of accidents or illnesses and those that are approaching the end of their lives. These children and

young people often also have complex social and learning needs, which require additional social care resources and SEN provision.

Direct Payments/ Personal Budgets

Thurrock Council continues to promote the take up of Direct Payments. Since the introduction of Direct Payments to children in 2000, the number of families in receipt of them has increased.

In 2008/2009 there were 48 families in Thurrock in receipt of Direct Payments; the current total as of August 2014 is 82. The uptake of Direct Payments is concentrated in children and young people over 6 years of age. Proportionally few families with children under 5 years chose direct payments.

As Direct Payments are offered to all families who are eligible to receive support in this way, the numbers of families receiving them are likely to increase, particularly with the implementation of Personal Budgets via the Education, Health and Care Plans from September 2014.

Transition

The Thurrock Transition service sits within Adult Social Care. There is a team of 3 social workers and one deputy manager, and they are based within the Social Work Intervention and Transition Team. The Transition service supports all young people between 14 and 25 with eligible special educational needs.

The Team works with different agencies to plan and provide young people with the support they need. They:

- Attend school reviews if required to help young people at the age of 14 to start considering their long term ambitions and goals
- At 16 work closely with the Children With Disabilities Team to identify those young people with more complex needs and jointly plan for their future
- At 17 a transitions worker will be allocated and will assess using the adult social care eligibility criteria, ensuring smooth transitions across the services

The Team aims to:

- help young people to make the right choices and decisions with the support of their families
- provide young people with support and assistance to help them to maximise their education, training and employment potential
- help young people with impairments to live as independently as possible
- help young people to use leisure and recreation facilities
- Signpost families and carers and young people to local support services

Recommendations

Best practice suggests the following factors are important for the successful delivery of services for children with disabilities:

- Support that is tailored to the child and family.
- Early intervention and prevention of family breakdown
- Seamless and coordinated services across all agencies.
- Having a well-trained and confident workforce.
- Effective data collection and data sharing protocols across agencies
- Service users, individual agencies and providers treated as equal partners.
- Parents and Carers to influence strategy via co production.
- Ongoing Joint commissioning of short break services.

Children with Special Educational Needs

Children with Special Educational Needs and Disabilities (SEND) are children or young people who have a learning difficulty or disability which calls for special educational provision to be made for them. Their needs may include:

- Profound and multiple learning difficulty
- Behaviour, emotional and social difficulty
- Speech, language and communication needs

Children with SEN may experience a number of educational inequalities when compared with their peers; including lower levels of attainment, lower rates of sustained education, and higher rates of absence or exclusion (Department for Education, 2014). Evidence has shown that lower educational attainment can affect future achievements [further detail can be found in the [Educational Attainment](#) section]. Children who are not receiving adequate educational provision risk impairing their academic, personal and social development, which shape their life-chances and the contribution that they are capable of making to society. In addition, children who do not experience proper inclusion amongst their peers during school age risk longer-term difficulties within inclusion in society. Other outcomes that children with SEN are at higher risk of experiencing include: increased likelihood of teenage pregnancy, poorer mental health and increased risk of familial economic hardship – often a loss of income due to caring requirements is experienced (Boyle & Burton, 2004).

The prevalence of children with Special Educational Needs is not uniform across the whole child population. Findings from the Department of Education (2014) indicated that:

- **Boys are much more likely to have SEN than girls** (two and a half times more likely to have statements in primary school, and nearly three times more likely in secondary school)
- **Older age groups are more likely to have statements**
- **Pupils with SEN are more than twice as likely to be eligible for free school meals**

- **Black pupils are more likely and Chinese pupils are least likely to have SEN**
- **Almost 70% of looked after children have SEN** (compared with 17.9% of all pupils in January 2014)

The statutory processes for identifying and meeting the needs of children and young people with SEND has undergone significant changes with the introduction of the Children and Families Act 2014. (Department for Education, 2014)

The key changes in the way in which children and young people with SEND are supported in the new systems of SEND are:

- A unified Education Health and Care Plan (EHCP) bringing together support for all children and young people with SEND aged 0-25 years.
- A clear focus on the participation of children and young people and their parents in decision making at both an individual and strategic level.
- New duties on the joint commissioning of services bringing together Education, Health and Social Care commissioning to provide clearly joined up services based on the current and predicted future needs of the local population.
- A clear system of planning, identifying and disseminating information on services for all children and young people with SEND known as the Local Offer
- New arrangements for Personal Budgets allowing young people and parents of children with SEND to hold a personal budget to secure provision in the Education, Health and Care Plan.
- A clear focus on high aspirations and outcomes for children and young people with SEND ensuring a successful transition to adulthood.

What do we know?

As of 1st September 2014 there are 1,176 children and young people with Statements of Special Educational Need in Thurrock. The children and young people range in age from 3 to 19 years of age. The data showing the categories of Primary Need as identified on the child or young person's statement is shown in the table below.

Table 16: Statement of SEN by category of need

Category of Need	Number
Autism	243
Behaviour Emotional Social Difficulties	205
Hearing Impairment	22
Moderate Learning Difficulties	233
Multi-sensory impairment	3
Other	21
Physical Difficulties	83
Profound and Multiple Learning Difficulties	19
Speech Language and Communication Needs	212
Severe Learning Difficulties	29
Specific Learning Difficulties	28

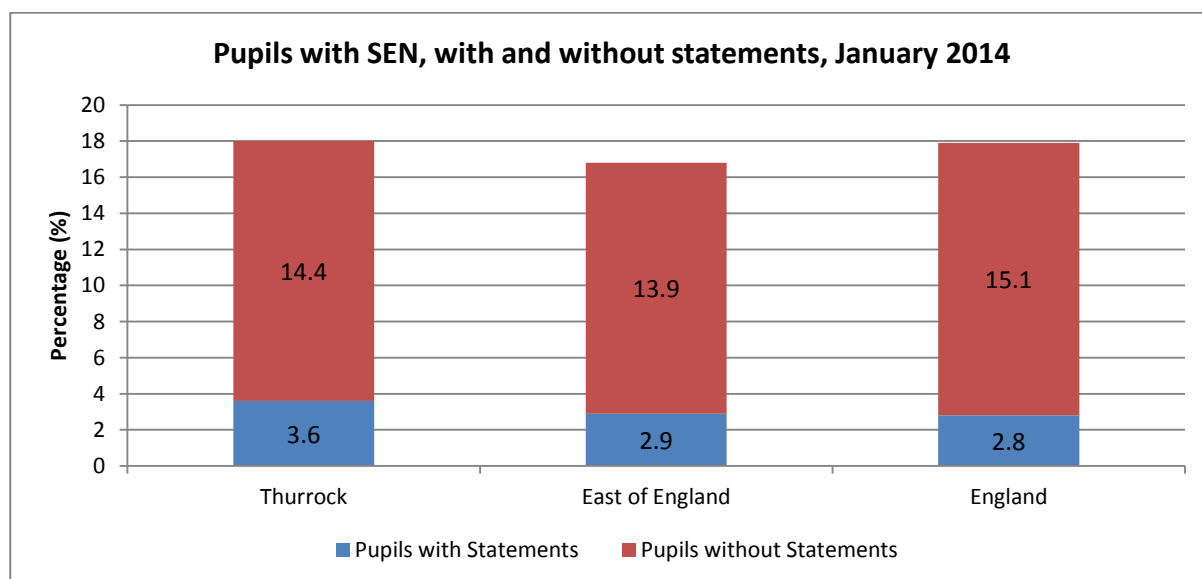
Visual Impairment	14
Not Specified	64

Source: Thurrock Council

The above table does not include young people who previously had statements for SEND but have left full time school education and transferred to a mainstream or specialist college. The statements for these young people would have ceased at this time under the previous SEND Code of Practice. These young people would have had a Post-16 Learning Difficulties assessment and support needs identified through this. The above table includes pupils who are over the age of 16 but have remained in schools such as special school post 16 bases.

When all pupils with SEN are considered, it can be seen that Thurrock has a higher proportion of pupils with SEN having Statements than the regional or national averages. This can be seen in Figure 64 below. On a national level, the proportion of pupils who have an SEN has been decreasing since 2010 (21.1%) and is largely due to a decrease in SEN without a statement. The continued decline in the number of children with SEN could be as the result of better identification of those children who have SEN and those who do not. This may have been as a consequence of the 2010 Ofsted Special Educational Needs and Disability review which found that a quarter of all children identified with SEN, and half of the children at School Action, did not have SEN.

Figure 64: Percentage of pupils with SEN in Thurrock, East of England and England, 2014



Source: Department for Education

What are we doing in Thurrock?

Mainstream Schools/ Settings / Colleges

Mainstream schools, settings and colleges have significant numbers of children and young people with SEND attending these facilities and being supported through their SEN services. Mainstream resources have worked closely with the Local Authority on the development of the new SEND arrangements and there are significant demands being placed on these mainstream services during the transfer of the SEN Statements to the new EHC Plans and the introduction

of new EHC Plans. Mainstream schools have identified particular challenges on ensuring that there is good communication and contact between Health services and schools in relation to planning support for children and young people's SEND.

It is anticipated that with the introduction of EHC plans for young people attending college and the continuation of these plans in college where needed, (as opposed to the ceasing of statements) there is likely to be a significant increase in demand for assessment and support services across Education, Health and Social Care agencies from September 2014.

Special Schools

Thurrock has two special schools, Treetops School for children with autism, and moderate learning difficulties and Beacon Hill School for children with severe learning difficulties and profound and multiple learning difficulties. Both of these schools are outstanding schools and have strong regional and national reputations for expertise in the education of pupils with particular Special Educational Needs.

There has been an exceptionally high demand for places in Treetops school for children with Autism whose parents wish to access the Applied Behavioural Analysis / Verbal Behaviour programmes run in the school. This has included families moving into Thurrock from other areas in the UK and from abroad. The very high level of demand for places has led to an increase in the number of places offered in the school in recent years and additional demands for all other services supporting these pupils and their families.

Beacon Hill School has experienced a significant change in the complexity and severity of complex needs of the pupil population. There is a significant increase in the number of children who have very complex health needs requiring a high level of nursing care, and exceptional vulnerability.

Resource Bases

Thurrock has the following resource bases located within mainstream schools for children with special educational needs:

Primary	Places
Dilkes Base for children with Emotional Social and Behavioural Difficulties	10
Lansdowne Base for children with Learning difficulties/ social communication difficulties	10
Stanford Le Hope Primary Base for children with Visual Impairment	5
Warren Primary Base for children with Hearing Impairment	14
Corringham Base for children with speech and language difficulties	
Secondary Age	
St Clere's Base for Hearing Impairment	11
St Clere's Base for Visual Impairment	6
Harris Base for Speech and Language/Autistic Spectrum Disorder	20
Ormiston Park ASCEND Base for Behavioural, Emotional and Social difficulties	15

In addition to the above resource bases there are a significant number of children and young people attending the Primary or Secondary Pupil Referral Units who have special educational needs and require access to services particularly with regard to emotional and mental health services.

Preschool Services

Thurrock has a well-established pre-school home visiting service, the Portage Service which supports parents of children with SEND both at home and with support activities hosted through the two special schools. The Early Support Programme also involves staff from both special schools and supports the identification and co-ordination of support for children with SEND and their parents. There are additional support services for children with Speech and Language needs through the ICAN Nursery at Chafford Hundred Primary school and additional designated nursery places at Stanford Le Hope Nursery. A significant number of pre-school children with SEND are supported in mainstream pre-school settings.

There has been a significant rise in the number and complexity of medical referrals (332 Notifications) to the Local Authority in recent years. The data for this is shown below.

Table 17: Medical Referrals by year

Year	Referrals
July 2006 – June 2007	55
July 2007 – June 2008	65
July 2008 – June 2009	73
July 2009 – June 2010	77
Jan 2011 – Dec 2011	77
Jan 2012 – Dec 2012	115
Jan 2013 – Dec 2013	92
Jan 2014 – Dec 2014	110 (predicted)

Source: Thurrock Council

Recommendations

- There is a need to ensure that all services supporting children and young people with SEND in Thurrock are clearly co-ordinated across Health, Social Care and Education in line with the joint commissioning arrangements set out in the SEND Code of Practice and developed in close partnership with parents and young people to ensure they meet the changing needs of the local population.
- It is important that services for children and young people of all ages work in co-production with parents and young people to identify gaps and key areas of service to ensure local needs are being met fully. The Local Parent Carer Forum can support this alongside agencies such as HealthWatch and other groups across the borough.
- The significant growth in numbers and complexity of young children with SEND will need to be addressed through ongoing support for services such as the Early Support Programme and close joint working arrangements such as the joint professional multi agency assessment work for pre-school children.
- The need for family-centred approaches and joint agency work as part of the new Education and Health Care Assessments will need to be taken into account in the delivery of all Health services to ensure full engagement of all staff in this.
- The significant need for access to timely support in the area of mental health needs of children with SEND will need to be addressed as part of the delivery of CAMHS services.
- The growth in the numbers of children with autistic spectrum disorders in Thurrock due to the outstanding local services and the increase in the complexity of medical needs at Beacon Hill school needs to be taken into account in the provision of local Health services both with regard to assessment and diagnostic services, nursing services and specific areas of service such as speech and language therapy services.

Young Carers

Young carers are children and young people under 18 who provide, or intend to provide, care, assistance or support to another family member who is disabled, physically or mentally ill or has a substance misuse problem. Young carers carry out both practical and emotional tasks on a regular basis, taking on a level of responsibility that is inappropriate to their age or development. It is also recognised that young carers are likely to be providing care or assistance that is not formally recognised by them, their carers, or professionals involved.

The 2011 Census identified that there were 166,363 young carers in England; however it is widely accepted that this is an underestimate. Many young carers remain hidden from official sight for numerous reasons, including family loyalty, stigma, bullying and lack of knowledge around support services. The Children's Society (2013) found that young carers are 1.5 times more likely than their peers to be from BME communities, and twice as likely not to speak English as their first language. They also found that young carers are 1.5 times more likely than their peers to have a Special Educational Need or a disability. Other characteristics identified by this research to be associated with young carers include a reduced median family income, increased likelihood to live in a household with no working adults, and increased likelihood to live in a household with three or more other children.

Although being a young carer can offer many positive experiences for young people and their family, it has been reported in national research and surveys that it can also result in negative outcomes. These could include:

- Mental health problems – these could arise due to anxiety for their loved one or due to neglect of their own needs
- Risk of isolation and bullying – young carers may find difficulties building and maintaining friendships, and could find themselves stigmatised
- Physical health problems – these could arise due to inappropriate lifting, or the following of an unhealthy lifestyle including poor diet and lack of exercise
- Risk of lower educational attainment – this could be due to absence due to their caring responsibilities, difficulties in completing homework outside of school, or anxiety. The Children's Society (2013) found that young carers have significantly lower educational attainment at GCSE level equating to 9 grades lower overall than their peers. This could impact on future achievement: the same research found that young carers are more likely than the national average to be not in education, employment or training (NEET) between the ages of 16 and 19.

Young carers who are well supported are likely to build resilience, build support networks and develop skills that will support them into adulthood.

What do we know?

The 2011 Census identified that there were 1,126 children and young people aged 0-24 years providing unpaid care in Thurrock, which corresponds to 2.17% of children in that age group. This is lower than the regional (2.28%) and national (2.54%) proportions. However, as highlighted above, this is likely to be a large underestimation.

Data supplied by the Young Carers services in Thurrock indicate that there are 50 Young Carers known to them that are between the ages of 4 and 8, and 412 between the ages of 8 and 18 (correct as of June 2014). Of those aged between 8 and 18 years, 305 are attending respite activities with the service.

What are we doing in Thurrock?

Thurrock has produced a [Young Carers Strategy](#) (2012) which highlights the need to recognise our young carers and include them in the services offered.

The Carers of Barking and Dagenham offer support to carers in Thurrock aged 8 and above. Services provided are:

- **Home Visit-** A home visit to the Young Carer and their family is arranged for every new referral made to get to know the young person and get an idea of their caring role. At this visit they are given the option to attend the respite activities.
- **One to One Support (ongoing)**
- **Respite Activities-** Activities run on two weekday evenings, Saturdays and throughout the school holidays. These can range from cooking, bowling, rolla disco, games & quiz night, jewellery making and many more.

- **Residential-** Depending on funding one or more residential stays a year may be arranged for Young Carers with a high caring role.
- **Opportunity to meet new friends (within activities)**
- **Training/Workshops-** Workshops are run such as stress & anger management training, Face 2 Face training (understanding their caring role), self-esteem training and many more.
- **Newsletter & Information Updates**
- **Volunteer Opportunities-** Some young carers feel they have grown out of the activities or have reached 18 but still want to be involved so they volunteer their time either in the office or on activities with the younger group.

Thurrock is one of very few authorities who also offer a separate service to Young Carers between the ages of 4-8, which is based at the Sunshine Centre in Tilbury. Two sessions are run each week on a booking-in system with up to 30 children attending. There is no formal structure to the sessions, as they are designed as opportunities for children to come and play and just have fun in the centre; however staff are available for any children wishing to speak about their home situation. The sessions also promote children to talk to each other, and often they open up and realise that they are not the only one in their position. The service runs occasional trips, such as a trip to a local farm, and also has good links with local charities and the rotary club who have donated funds to pay for taxis to transport children to the centre.

Recommendations

The provision of support to Young Carers aged under 8 years should be continued to give young children the opportunity for time away from their caring responsibilities and access to extra support should they need it. In addition, the service is seeking additional funding to enhance their offer of support to Young Carers who care for parents with mental health issues or substance misuse problems. The new Care Bill puts a focus on young adult carers (aged 18-25 years), and this group should be a priority going forward to ensure they have access to their own Carers Assessments.

Gypsy, Roma and Traveller Children

Children and young people from Gypsy, Roma and Traveller (GRT) communities have been acknowledged in multiple sources as a population experiencing inequalities in their health. Research (Parry, et al., 2004) has suggested that, when compared to the national child population, GRT children may experience:

- Reduced access to primary care services
- Higher rates of perinatal and infant mortality
- An increased likelihood of having conditions such as asthma or cystic fibrosis
- A lower life expectancy – national research has shown life expectancy for Gypsies, Roma and Travellers to be 10 years lower than the rest of the population
- Lower educational attainment and reduced school attendance, particularly at secondary level – linked to the culture of educating children outside of school (Wilkin, et al., 2010)

- Increased levels of stress and anxiety – potentially linked to a feeling of social isolation and stigmatisation, and also may result from repeated evictions
- Living in deprivation – often the GRT sites are situated in hostile environments deemed unsuitable for other development, and are situated away from local amenities or play facilities.

What do we know?

The latest data indicates that there are over 1,290 gypsy and traveller residents in Thurrock, living in 13 private sites, 2 showman sites and 3 council-run sites. Distribution is not uniform across the borough, with the majority of families residing in sites in the west of the borough. The largest site is Buckles Lane in South Ockendon, which is home to approximately 1,000 residents.

It is difficult to gain current information about the number of children registered with schools in the borough, as GRT is not listed as an ethnic category in the most recent school census figures. Data from the 2012 school census showed Thurrock to have 68 children with an ethnic group of Gypsy/Roma, which equates to 0.3% of all children for whom an ethnic group is known. This is above the national figure of 0.2%. However it should be noted that ethnicity is not recorded for all pupils, and the ethnicity for some GRT children may not have been recorded correctly.

What are we doing in Thurrock?

Thurrock Council runs the Thurrock Traveller Achievement Service (TTAS), which aims to work directly with the GRT community to address their needs. Their services include:

- supporting pupils that are highly mobile to secure access to school
- transfer to secondary school
- assessing pupil need and providing support
- sign-posting support agencies and offering to act as intermediaries

The TTAS bus travels between known traveller sites in the borough looking to engage with the GRT community, promoting initiatives and working with residents to address their issues. Some of the recent health campaigns that TTAS have been actively promoting within the GRT community include the SMILE campaign (oral health), Stoptober, flu immunisation and diabetes awareness. Feedback received indicates that these generated a lot of interest in the sites and resulted in numerous referrals to services and an increase in flu immunisations.

Recommendations

- Improved joint working between public sector organisations, voluntary organisations and GRT families to assist identification and addressing of community issues
- To ensure that local policies look to address the inequalities experienced in educational attainment
- Services should continue to seek and listen to the voices of GRT children and incorporate these into their future planning.
- Development of staff within education, health and social care organisations to ensure full awareness of the cultural barriers faced by the GRT community
- Supporting of an improved information collection system to ensure data held on the local GRT community is accurate and robust. GRT should be included as a category in all health records.
- To consider commissioning a Specialist Health Visitor with a clear remit for Gypsy, Roma and Traveller families
- To consider training of GRT Health Ambassadors sourced from within the communities who are able to teach health and social care skills to their community, and who can also work with the Traveller Achievement Service to ensure their needs are recognised.

Young Offenders

Young offenders (or those at risk of offending) are a highly marginalised group and often have greater health needs than the non-offending population, experiencing exposure to inequalities in health that persist into adult life, including a higher incidence of physical and mental ill health, sexually-transmitted disease, injuries, and early pregnancy in females.

The Crime & Disorder Act 1998 puts a statutory duty on local authorities and its partners to form Youth Offending Teams (YOT)/Services whose primary task is to reduce offending and re-offending by young people. Teams consist of professionals from Social Care, Probation, the police, Health & education. They work with young people aged 10-17 who have been either convicted in the Courts or have been made subject to a pre-Court outcome. Interventions can take place in the community or in the secure estate and are designed and implemented to address the risk factors that each young person presents. They also work with the victims of Youth Crime and manage restorative justice processes.

YOT prevention work focuses upon young people aged 8 to 17 years before they enter the criminal justice system but are presenting offending or anti-social behaviour.

The Youth Justice Board for England and Wales have established the following strategic priorities for 2014-2017:

- prevent offending
- reduce reoffending
- protect the public and support victims
- promote the safety and welfare of children and young people in the criminal justice system.

Research by the NSPCC has highlighted a range of risk factors that could lead to a young person becoming involved in crime and anti-social behaviour. These include:

- peer influence
- poverty and social exclusion
- parenting and family environment
- experience of abuse or neglect
- substance misuse
- mental health issues
- exclusion from school/poor educational attainment

Further research by the Youth Justice Board also indicates that unemployment and poor physical health could be risk factors for future offending.

What do we know?

There were 207 offences committed in Thurrock in 2013/14 that were known to the Youth Offending Team – 174 were committed by males and 33 by females. This is in line with national and adult data. The number of offences increases by age – this is shown in Table 18 below.

Table 18: Offences in Thurrock in 2013/14 by age of offender

	Number of offences
10-13 years	23
14 years	33
15 years	37
16 years	42
17 years	72
All ages	207

Source: Thurrock Youth Offending Service

The most common type of offence committed was Violence against a person, with 53 of the 207 offences falling into this category. This is in line with national and adult data.

Table 19: Offences in Thurrock in 2013/14 by type of offence

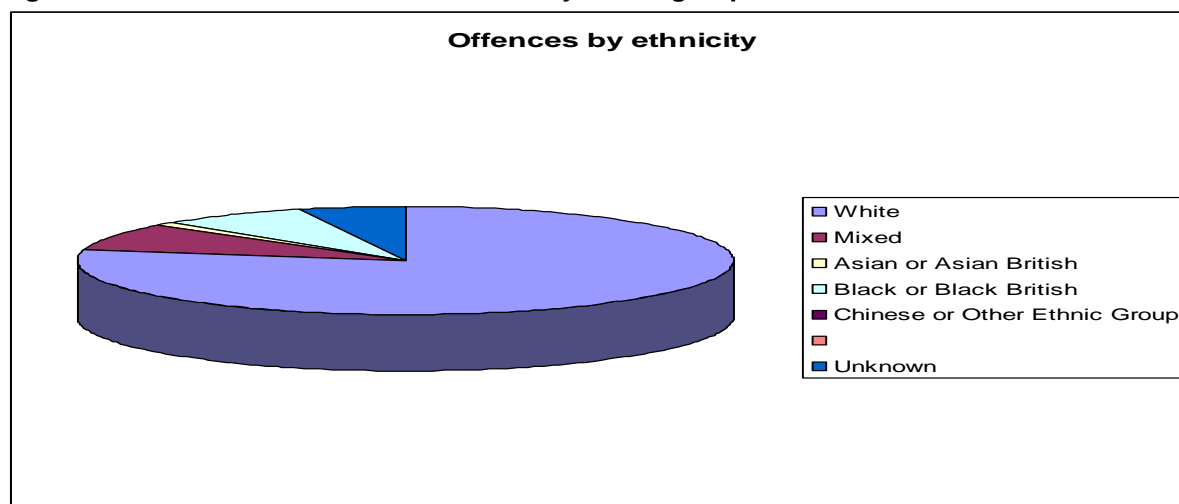
Offence	Number of offences (* Data has been suppressed)
Violence Against Person	53
Theft & Handling	39
Criminal Damage	21
Domestic Burglary	19
Drugs Offence	18
Breach of Statutory Order	13
Robbery	11
Vehicle Theft	7
Motoring Offences	6
Public Order	6
Fraud & Forgery	*
Racially Aggravated	*
Non Domestic Burglary	*

Other	*
Breach of Bail	*
Sexual Offences	0
Death or Injury by Reckless Driving	0
Arson	0
Breach of Conditional Discharge	0

Source: Thurrock Youth Offending Service

Figure 65 below shows the offences committed by ethnic group in Thurrock – this is in line with national and adult data.

Figure 65: Offences in Thurrock in 2013/14 by ethnic group



Source: Thurrock Youth Offending Service

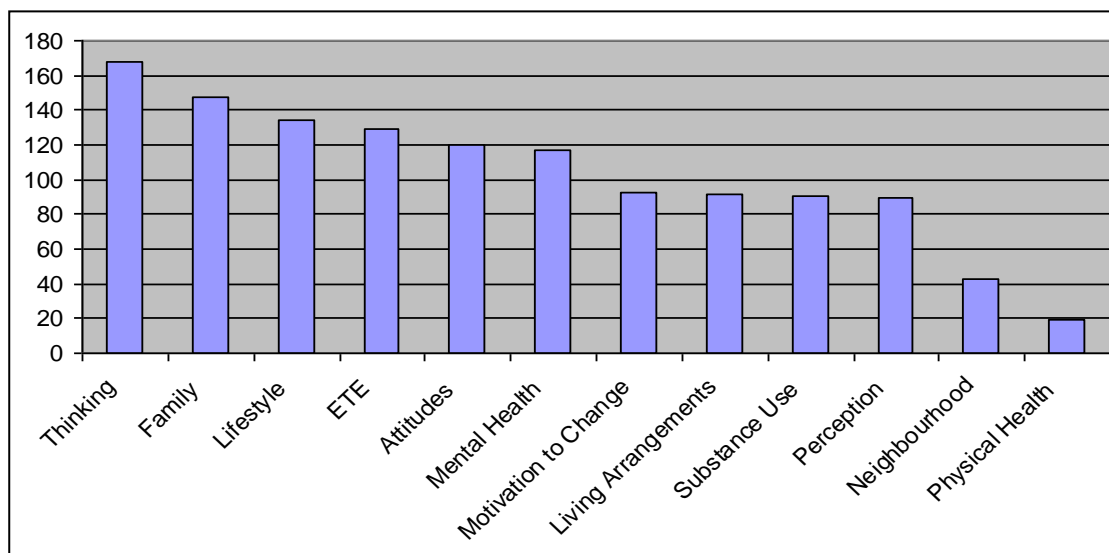
On average **29%** of young people who are subject to Court Orders in Thurrock are assessed as vulnerable and consequently are subject to Vulnerability Management plans. These vulnerabilities include issues concerning alcohol & substance misuse, self-harm, sexual exploitation, at risk of harm from others or their own behaviour and mental health. Additionally, **45%** of young people who are subject to Court Orders in Thurrock are assessed as presenting a risk of serious harm and consequently are subject to Risk Management plans. The identified risk factors include connections to serious youth violence and gangs, possession of offensive weapons, sexual offences and anger management issues. Some young people are assessed as both vulnerable and a risk of serious harm.

Education, Training & Employment (ETE) remains an issue with over **35%** of our client base not being in fulltime ETE. A high majority have identified behavioural or learning difficulties and are, or were, subject to Statements of Special Educational Needs as a result, with Attention Deficit, Hyper-activity Disorder being the most common.

The assessed generic risk factors for young people offending and re-offending in Thurrock indicate that the most common risk factor is thinking & behaviour, followed by family and personal relationships, emotional and mental health, education training and employment and attitudes to offending. The least common is physical health. An increase has been observed in young people presenting Emotional & Mental Health issues linked to their offending. However,

this may be due to the increase of increasingly robust services within the YOS which is ensuring that issues are identified and managed. There also may be a link to the increase of young people being supervised who have been involved in serious youth violence and the emotional issues it can instigate. This can be seen in Figure 66 below.

Figure 66: Assessed Risk Factors in Young Offenders in Thurrock, 2013-14



Source: ASSET Management Tool and Thurrock Youth Offending Service

Due to high migration from the London Boroughs Thurrock YOS is supervising a number of young people who have links to serious youth violence and gangs.

Thurrock Youth Offending Service report performance against a number of indicators, with comparisons to 'family' areas (YOTs within England and Wales of a similar size and budget) and national data. These enable a rounded picture of the service performance to be ascertained and areas of concern to be highlighted. Below are the indicators reported to Thurrock Council:

First Time Entrants			
	2011-12	2012-13	2013-14
Thurrock	-35% (69)	- 34% (67)	44
Family	-23%	-24%	Not available
National	-19%	-33%	Not available

Annually Thurrock continues to perform well in the reduction of first time offenders compared to the baseline figure (10-11), we are performing above the national and family average. The figure for 13-14 is the lowest we have ever had and could be a result of the extension and promotion of YOS preventative service. However only the final PNC outrun for 13-14 will fully evidence this (this will result in the percentage reduction on the baseline and is yet to be published).

Source: Thurrock Youth Offending Service

Prevention			
	2011-12	2012-13	2013-14
Thurrock	91	40	44
Recidivism	28%	26%	0%*
Reduction %	+ 28%	-2%	N/A

** Please remember that this data has a 3 month drag.*

The year 12-13 saw a significant reduction in those referred for prevention services, this was as a result of the reduction of TRIAGE (referred by the police). Consequently in March 13 YOS re-introduced the Youth Inclusion & Support Programme – YISP). From a resource point of view it should be noted that TRIAGE is a short 28 day intervention, whereas YISP interventions can last up to 12 months, are more intensive & address specific identified risk factors.

Source: Thurrock Youth Offending Service

Re-Offending			
	2011-12	2012-13	2013-14
Thurrock	46%	43%	27%
Family	Not available	Not available	Not available
National	Not available	Not available	Not available

The final figure for 12-13 (reported on in Q1 13-14) shows a marginal reduction in offending on the previous year. Due to the reduction in FTE's & young people receiving outcomes in court the cohort for the 12-13 data was the smallest in Thurrock's history (42 as opposed to 61 in 10-11 and 138 in 9-10). As mentioned, this is a result of the prevention agenda from both the YOS and the police. Therefore, by the time young people meet the criteria for the cohort their offending has often become entrenched and they are at high risk of offending.

Source: Thurrock Youth Offending Service

Court Disposal			
	2011-12	2012-13	2013-14
Thurrock	201	184	158

Despite the initial drop in the number of Court disposals as a result of TRIAGE, Community Resolutions and the political change (in 10-11 the annual figure was 369), numbers now seemed to have bottomed out and the outrun at three quarters through the reporting period 13-14 is in line with the previous two years. The YOS has adapted it's service to address this with the reduction in core case managers and an increase in prevention services.

Source: Thurrock Youth Offending Service

Use of Custody			
	2011-12	2012-13	2013-14
Thurrock	11%(18)	10%(14)	6%(8)
Family	Not available	Not available	Not available
National	Not available	Not available	Not available

*As a result of community solutions and the success of TRIAGE in greatly reducing the first time entrants to the youth justice system in Thurrock (a reduction of 40% on the 2010 cohort), the reduction in those appearing before the Courts & undergoing sentencing has greatly reduced (see below) & those that are appearing for sentencing are therefore the more serious & persistent offenders and at higher risk of a custodial sentence. Additionally the lesser crimes are now being dealt with by the prevention/pre-Court disposal and can no longer be used to counter balance custodial sentences. This is reflected in the figures above (*young people v percentage).*

Source: Thurrock Youth Offending Service

Education, Training and Employment			
	2011-12	2012-13	2013-14
Thurrock	65%	64%	65%
Family	70.9%	Not available	Not available
National	72.8%	Not available	Not available

Young people completing orders who are in full time Education, Training & Employment has been relatively static for a number years, despite numerous interventions by the YOS to address it..

Thurrock has the smallest YOS in the country and enjoys good value for money indicators. The most recent inspections in January 2012 from the Care Quality Commission and HMI Probation had positive outcomes, with the subsequent action plan having been fully implemented. Feedback from the Youth Justice Board has suggested that they are pleased with the current performance of Thurrock YOS.

What are we doing in Thurrock?

Mental Health: Thurrock YOS has two fulltime practitioners from the Children & Adolescent Mental Health Service who work with young people sentenced through the Courts and those subject to prevention interventions. Every young person's emotional & mental health is screened by a YOS case manager and if they present as medium risk or above they are referred to the CAMHs practitioners for a full assessment and then an intervention if deemed necessary. CAMHs practitioners will also oversee every initial assessment and give advice in respect of core interventions.

Substance Misuse: Despite previously employing a full time substance misuse worker in YOS, we now refer and facilitate interventions by Thurrock YP substance misuse service – *Wize-Up*. In 2013-14 over 8% of convictions were in relation to possession or possession with intent to supply of illegal substances but the use amongst our clients base is far bigger. However, whilst this can increase other risk factors it is rarely the sole reason for their offending. The use of class A drugs is rare in young people in Thurrock, but there were a number of convictions of young people dealing crack & heroin in 13-14.

Serious Youth Violence: Since the appointment of a Senior Officer with a specific responsibility for Serious Youth Violence and high risk cases, there have been low levels of re-offending and thus far no serious incidents. Thurrock are also part of the Serious Youth Violence Group with partners in Community Safety and the police. Local programmes such as *The Prison group* and *Streetwise* look to address high risk offenders, serious youth violence and weapons awareness.

Prevention work in respect of Youth Inclusion and Support takes all of its referrals from schools via the MAGS panel. We also link closely with the Thurrock Schools Police Officer (now called a Youth Officer). Additionally we have extended our prevention service to offer interventions within local schools.

Recommendations

The major issues and future risk factors for Thurrock are the continued increase in migration from the London boroughs, especially in relation to the management of young people who have been involved in serious youth violence. The increasingly diverse population and consequent increase in the BME population will result in changing risk factors and a change in interventions and supervision will be needed to meet these. With the increase of young people involved in gangs comes the increased risk of sexual exploitation and the increase in vulnerability and safeguarding which has been evident over the preceding years. The strategy to manage this risk is more partnership working and form working relationships with the London boroughs which are the sources of the migration. Additionally, although it is not yet presenting itself, there may be an increase in substance misuse issues specifically related to Class A addiction in young people.

Children experiencing sexual violence

Sexual violence can take many forms, mainly: rape, sexual assault (including intimate partner violence), childhood sexual abuse, sexual harassment, stalking, female genital mutilation (FGM) and sexual exploitation, which is increasingly becoming focussed on grooming children and young people on-line. National research by the NSPCC (2014) and (2013) shows that 34% of children under the age of 18 who experienced contact sexual abuse by an adult did not tell anyone about this, and 82.7% who experienced contact sexual abuse from a peer did not tell anyone. The issue is therefore significantly under reported across the UK. Based on national research, where young people had experienced a positive disclosure there were three key elements: a.) the young person felt believed; b.) the young person had some kind of emotional support; c.) young people wanted someone to notice when something was not right, someone to ask when they have concerns and someone to hear them when they do disclose.

There is no nationally comparable data for access to specialist sexual violence services; however it is recognised that there are significant shortfalls in sexual violence services for both children and for adults across the UK.

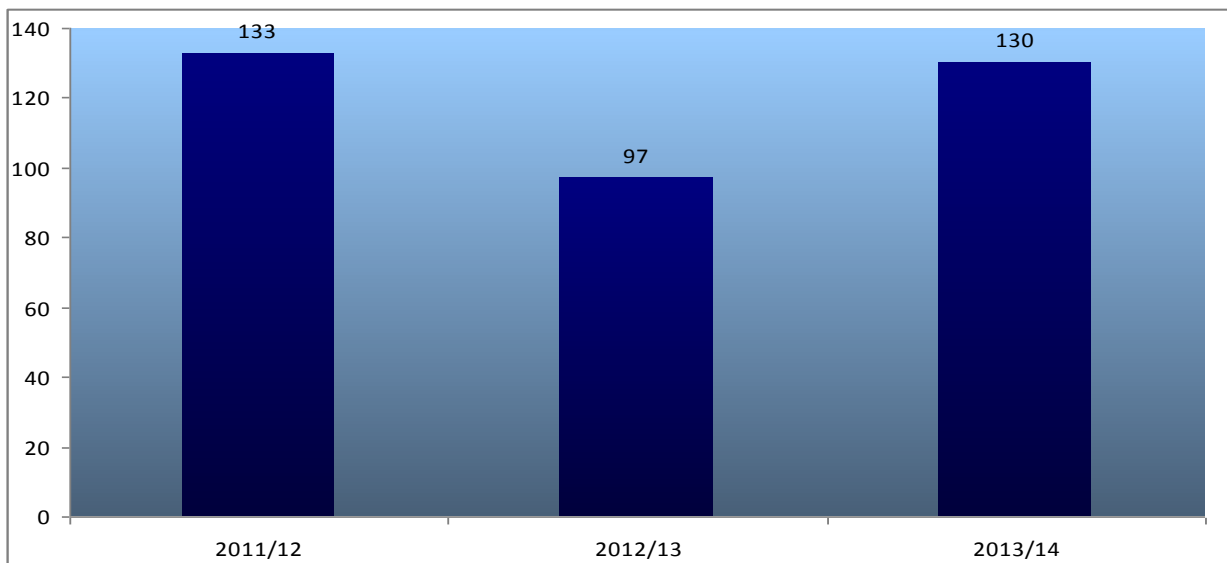
What do we know?

Data from South Essex Rape and Incest Crisis Centre (SERICC) shows that the breakdown of perpetrator relationship is: 35.2% male relative; 6.8% partner or ex-partner; 8.0% friend; 9.1% friend of family; 15.9% acquaintance; 12.5% stranger; 4.5% professional; 8.0% multiple (i.e. gang rape) in 2012/13.

It should be noted that there is currently no collection of local data for FGM prevalence.

SERICC reported that 130 young people accessed services in 2013/14, which is an increase from 2012/13. However, taking the national research into consideration, the actual need for services could be as high as 751 young people, based on the fact that 82.7% of those experiencing sexual abuse nationally did not report it to anyone. Figure 67 shows the number of young people accessing services in Thurrock by year.

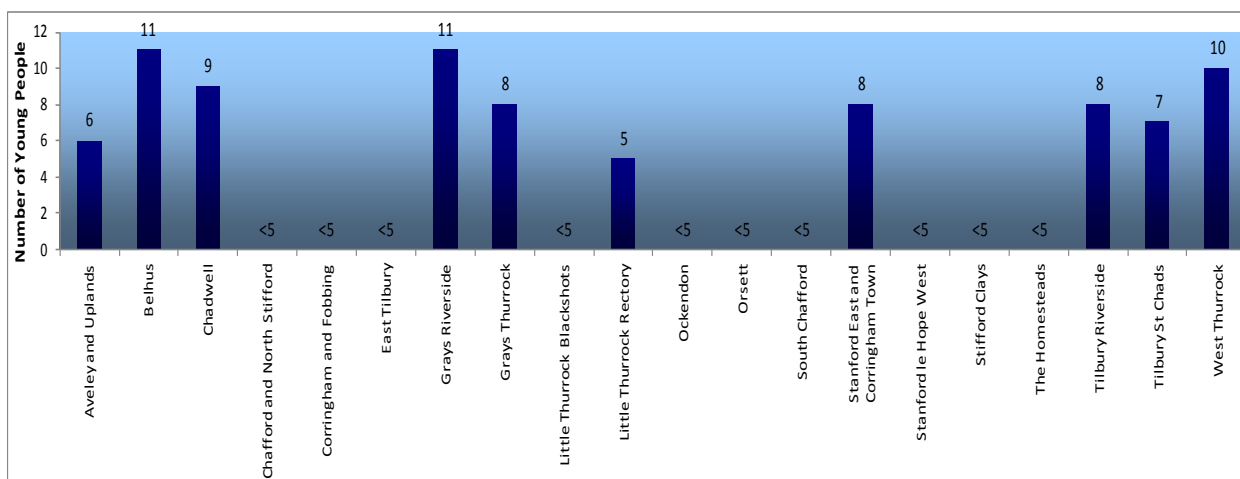
Figure 67: Number of young people (13-21 or <25 with learning disabilities) accessing specialist sexual violence services in Thurrock, 2011/12 to 2013/14.



Source - South Essex Rape and Incest Crisis Centre (SERICC)

Locally there is a relatively equal distribution of referrals by ward, although there are seven wards where prevalence (based on access to services and not necessarily need) is slightly more prominent: Grays Riverside, Belhus, West Thurrock, Chadwell St Mary, Tilbury Riverside, Grays Thurrock and Stanford East & Corringham Town.

Figure 68: Breakdown of young people (13-21 or <25 with learning disabilities) accessing specialist sexual violence services in Thurrock by ward 2013/14



Source: South Essex Rape and Incest Crisis Centre (SERICC)

The primary ethnic group is White British at 91%; however this may not be representative of need.

Over three quarters of under 18's that local services work with are where there has been childhood sexual abuse with the next significant category being rape. From the 18-21 (25 if young person has learning disabilities) years olds around half of young people that local services work with are where rape has taken place. The current trend demonstrates a decrease in the age group for referrals for the local 'young person's sexual violence counsellor service'.

What are we doing in Thurrock?

The local response is delivered primarily via a charitable organisation, SERICC (South Essex Rape and Incest Crisis Centre). The organisation works with young people through a counselling and advocacy service. Services are however usually at capacity, and whilst service users are never refused access, the continued increase in demand will inevitably see waiting times lengthen. The organisation also works to raise the issue with professionals and within schools, when funding permits.

The Local Safeguarding Children's Board (LSCB) has delivered child sexual exploitation sessions to years 5 and 6 primary schools in Thurrock. This work is helping to raise awareness for young people and is continuing need, rather than a one off exercise.

Recommendations

- Further community awareness raising - young women who are asylum-seeking, migrant, not eligible and have no recourse to public funds, BME communities, disabled or who have mental health issues, all face additional and sometimes significant barriers to accessing services.
- Awareness raising and training for agencies such as police, health and schools with the desired outcome that more cases are reported and young people are believed and supported when they disclose.
- Increased capacity in therapeutic services to support young people.
- Improved data collection and sharing procedures

Accidental Injury and Death

Infant and Child Mortality

Infant mortality is defined as the death of a child in the first year of life, and is quantified as the number of babies born alive, who die in the first year of life per 1,000 live births. There is a clear link between high levels of infant mortality, deprivation and poor health outcomes. It is therefore often used as a comparative measure of a nation's health as well as a predictor of health inequalities. Low Birth Weight is also linked with premature death or poorer life outcomes. On a national level, there are large inequalities in infant mortality rates between ethnic groups – Caribbean and Pakistani babies are more than twice as likely to die before the age of one as White British or Bangladeshi babies. This may be due to a higher prevalence of preterm birth and congenital anomalies in these groups; however more research is needed into this area. Deaths in childhood are very rare but can be used as an indicator of child health. Nationally,

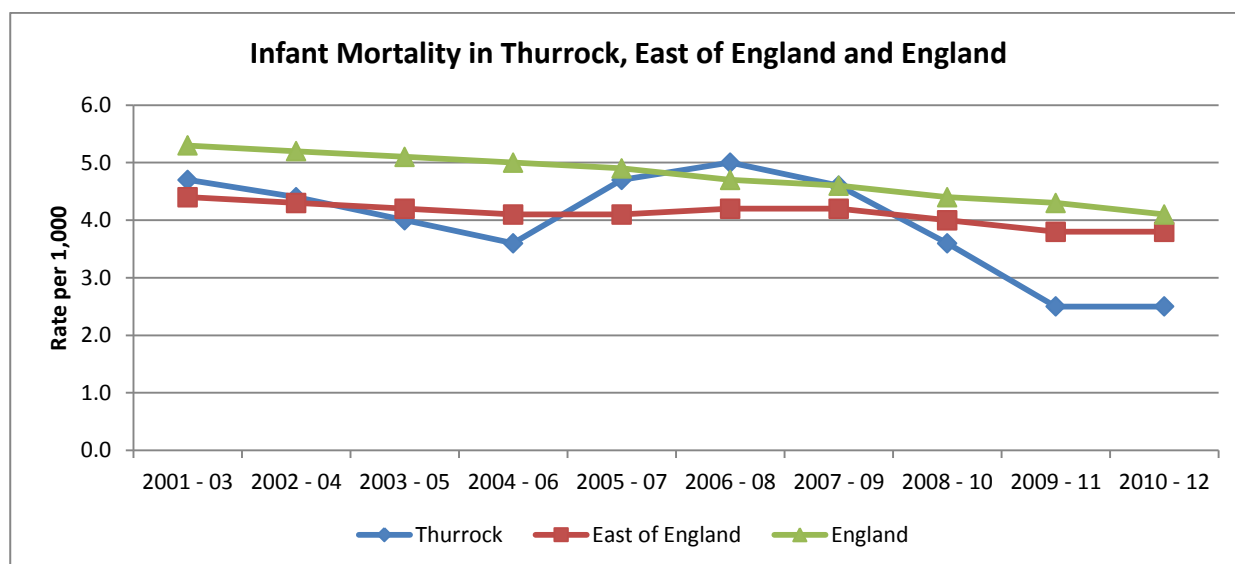
numbers and rates of death among children aged under five years have been falling, but despite this reduction nationally, deprivation is still linked with higher mortality for deaths after the neonatal period. Beyond the 5-9 age group, male mortality exceeds female mortality, with the difference becoming greater in later childhood and young adulthood.

According to the Office for National Statistics, the leading cause of death for children aged 1-4 years was congenital malformations, deformations and chromosomal abnormalities (14% of boys, 16% of girls). These conditions are usually present at birth or develop shortly after, and include congenital heart defects. These conditions were also the leading cause of death for girls aged between 5 and 19, accounting for 7% of deaths. Brain cancers, lymphoid cancers (including leukaemia) and land transport accidents each accounted for 6% of deaths to 5-19 year old girls, while the leading cause of death for boys of the same age was land transport accidents.

What do we know?

Figure 69 shows the infant mortality rates for Thurrock since 2001-03, compared with the regional and national rates, and shows that Thurrock's current infant mortality rate is 2.5 per 1,000, which is significantly lower than regional and national rates. However it should be noted that Thurrock's figures are very low and small changes in the numbers of deaths each year will have a large impact on the rates.

Figure 69: Infant Mortality in Thurrock, East of England and England, 2001-03 – 2010-12



Source: Public Health England

The rate of child mortality in Thurrock is statistically similar to the national average, with a rate of 14.2 per 100,000 in 2010-12 for children aged 1-17 years, compared to the national average of 12.5 per 100,000. The local rate has increased since 2009-11 (17.0 per 100,000); however the small numbers involved should be considered.

Child Death Review Panel Activity

The local Child Death Review Panel (CDRP) reviews childhood deaths in Southend, Essex and Thurrock, particularly considering any modifiable factors contributing to each death and lessons to be learnt. The table below summarises the main activity and conclusions reached by the CDRP from 2008/09-2013/14. It should be noted that not all child deaths that occurred in each year had their completed review within the same year as some may take many months to complete.

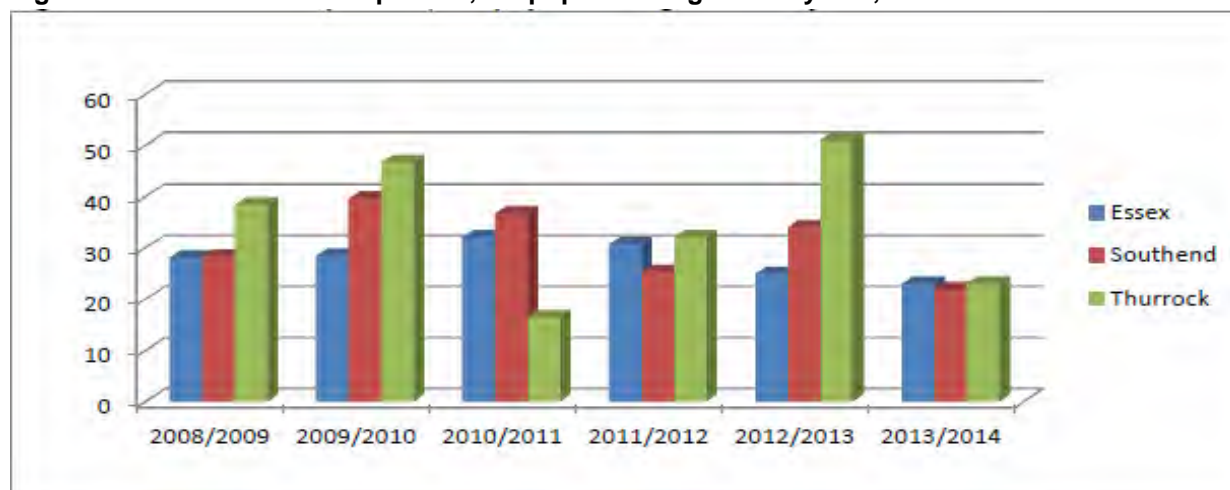
Table 20: Summary of SET Local Child Death Review Activity 1st April 2008 – 31st March 2014

Child Death Review Activity	08/09	09/10	10/11	11/12	12/13	13/14
Total child death notifications received for Essex resident child deaths	108	116	115	112	106	96
Total child deaths discussed at review meetings	76	100	115	86	86	82
Child Death Review Findings <i>(Deaths reviewed at panel meetings rather than death notifications - findings may not be presented against the year in which the death occurred)</i>	08/09	09/10	10/11	11/12	12/13	13/14
Total cases adopted as a Serious Case Review	0	<5	0	<5	0	0
Total deaths due to external causes	9	11	7	6	5	12
Total deaths classified as having modifiable factors	9	20	29	22	24	29
Total child deaths classified as not preventable	64	80	95	64	62	53

Source: Southend Essex and Thurrock Child Death Review Annual Report, 2014

Of the 96 deaths notified for review for SET residents, 10 of these occurred in Thurrock children. When converting these numbers to rates, it can be seen that Thurrock has a similar rate per 100,000 population aged 0-17 years for 2013/14 when compared with Essex and Southend; however in previous years the rate in Thurrock has been considerably higher than both Essex and Southend. Care should be given however to the small numbers involved.

Figure 70: Crude Death Rate per 100,000 population aged 0-17 years, 2008-2014



Source: Southend Essex and Thurrock Child Death Review Annual Report, 2014

Since April 2010, CDR Panels have identified where modifiable factors were present which may have contributed to the death. These factors are defined as those which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths. Modifiable risk factors were identified in 35% of the completed reviews in 2013-14 for the SET area – this is a small increase on the proportion for 2012-13, when 28% of deaths reviewed had modifiable risk factors.

Modifiable factors were found in each of the deaths in the trauma and external events category (11% of deaths were in this category), and factors identified included:

- Unfenced residential swimming pools
- Prior surgical intervention
- Alcohol/substance misuse by a child
- Emotional/behavioural and mental health of the child

Modifiable factors found in other categories of death included:

- Factors related to service provision
- Vitamin D deficiency in pregnancy
- Parental smoking during pregnancy or in the household
- Housing conditions
- Parenting capacity
- Co-sleeping

What are we doing in Thurrock?

Over the last year, some changes have been made to practice in order to look to reducing deaths. These have included:

- Ensuring midwives emphasise the importance of vitamin D and good nutrition during pregnancy
- Lullaby Trust Safer Sleeping Advice cards are now given out to all new mothers along with the Personal Child Health Record (red book)
- Rapid Response training rolled out to relevant professionals
- Increased use of the Essex Safeguarding Children's Board website and twitter feed to disseminate information

Recommendations

Although Thurrock's current position is good, work should continue to improve factors that are known to increase the risk of infant mortality. Maternal age at time of delivery may have an impact on risk of infant mortality, and work to reduce teenage conceptions and support older mothers who may have more complications will help to reduce the risk. It is also imperative to promote the health of the mother, reducing smoking prevalence, alcohol intake and obesity, and supporting them in breastfeeding and immunisations to help protect their children. Targeted approaches should also focus on the more deprived areas of the borough in order to improve health outcomes.

Whilst the CDR Panel has identified a number of modifiable factors that have been present in deaths of our local children, priorities for the future should include raising awareness of these and working to prevent future deaths caused by these factors.

Childhood Injuries and Accidents

According to the National Child Bureau, unintentional injuries are the major cause of death for children under the age of 19 years in England. It is a major cause of avoidable ill health, disability and death and has a disproportionately large effect on people in deprived communities. The most common types include road traffic injuries, drowning, poisoning, burns and falls. In their guidance on preventing unintentional injuries in the under 15s, the National Institute for Health and Clinical Excellence highlight specific groups of children that are more vulnerable in terms of having increased risk of injury (NICE 2010). These include children:

- 1) under the age of 5 years (generally, under-5s are more vulnerable to unintentional injuries in the home)
- 2) over the age of 11 (generally, over-11s are more vulnerable to unintentional injuries on the road)
- 3) who have a disability or impairment (physical or learning)
- 4) from some minority ethnic groups
- 5) who live with a family on a low income
- 6) who live in accommodation which potentially puts them more at risk (this could include multiple-occupied housing and social and privately rented housing).

There is a body of evidence to show that many accidents are preventable and the impact of those that do occur can be reduced. Avoiding injury requires a collective effort across all sectors of society and this needs to take place at all levels, from individuals being aware of risk and adjusting their behaviour accordingly to governmental legislation aimed at pre-empting risk.

What do we know?

Hospital Admissions

- Thurrock has a significantly lower rate of hospital admissions for injury when compared with the national average for both the 0-14 years and 15-24 years age groups.
- Thurrock has a statistically similar rate of hospital admissions for mental health conditions when compared with the national average
- Thurrock has a significantly lower rate of hospital admissions for self-harm when compared with the national average

Table 21: Hospital Admissions in Thurrock and England

	Thurrock	England
Hospital Admissions for Injury (0-14 years) (rate per 10,000) 2012/13	78.1	103.8
Hospital Admissions for Injury (15-24 years) (rate per 10,000) 2012/13	88.0	130.7
Hospital Admissions for Mental Health Conditions (0-17 years) (rate per 100,000) 2012/13	64.1	87.6

Hospital Admissions for Self-Harm (10-24 years) (rate per 100,000) 2012/13	82.4	346.3
---	------	-------

Source: CHiMat

Emergency Hospital Admissions

There were 11,566 A & E admissions for Thurrock residents aged 0-19 years in 2013/14, which is an 18.9% increase from 2012/13 (9,731 admissions). When the primary diagnosis was considered, it can be seen that the three highest categories of diagnosis (where diagnosis was known/recorded) in both 2012/13 and 2013/14 were respiratory conditions, gastrointestinal conditions and admissions for dislocation/fracture/joint injury/amputation. However it should be considered that multiple diagnoses are often recorded for patients, so this only records the first diagnosis. The largest increases between 2012/13 and 2013/14 can be seen for infectious diseases, allergies and gastrointestinal conditions. Table 22 below shows admissions for children aged 0-19 years in 2012/13 and 2013/14 by primary diagnosis.

Table 22: Emergency admissions to children aged 0–19 years shown by primary diagnosis, 2012/13 and 2013/14

Primary Diagnosis	2012/13	2013/14	Difference	% change
Diagnosis not classifiable	1457	1856	399	27.39
NONE	1364	1657	293	21.48
Respiratory conditions	734	955	221	30.11
Gastrointestinal conditions	670	951	281	41.94
Dislocation/fracture/joint injury/amputation	706	802	96	13.60
Sprain/ligament injury	528	660	132	25.00
Head injury	516	590	74	14.34
ENT conditions	438	556	118	26.94
Soft tissue inflammation	557	463	-94	-16.88
Laceration	362	410	48	13.26
Infectious disease	207	345	138	66.67
Contusion/abrasion	232	231	-1	-0.43
Nothing abnormal detected	176	222	46	26.14
Other	138	90	-48	-34.78
Muscle/tendon injury	195	187	-8	-4.10
Urological conditions (including cystitis)	174	184	10	5.75
Central Nervous System conditions	200	179	-21	-10.50
Dermatological conditions	136	150	14	10.29
Local infection	145	145	0	0.00
Allergy (including anaphylaxis)	95	136	41	43.16
Foreign body	128	134	6	4.69
Poisoning	118	124	6	5.08
Ophthalmological conditions	108	106	-2	-1.85
Cardiac conditions	80	100	20	25.00
Psychiatric conditions	61	71	10	16.39
Gynaecological conditions	73	64	-9	-12.33
Burns and scalds	68	54	-14	-20.59
Bites/stings	53	40	-13	-24.53

Source: NHS Thurrock CCG Performance Team

When categorised by incident location, the majority of incidents occurred in the home (68.70%) and this was true for all age groups, although highest in the 0-4 year old age group (82.86% of their incidents took place in the home). Incidents in educational establishments, public places, work and other locations were higher in older age groups. Table 23 below shows the percentage of incidents that resulted in an A & E admission for children aged 0–19 years in Thurrock by location of incident in 2012/13 and 2013/14 combined.

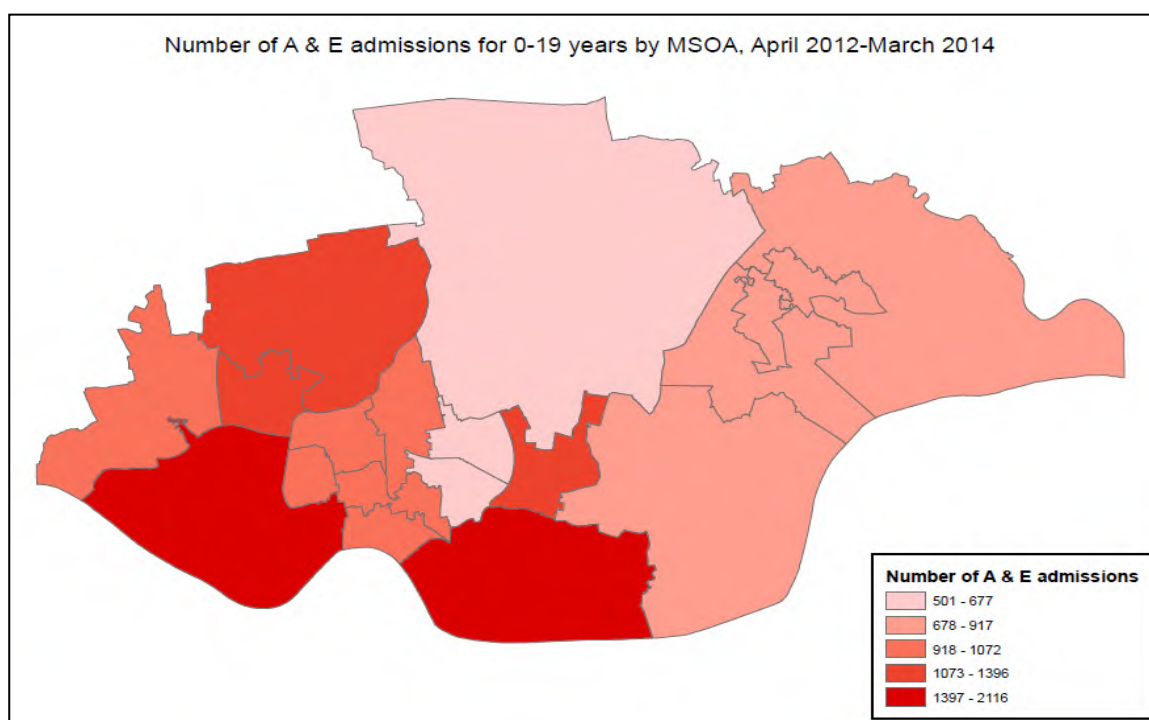
Table 23: Emergency admissions to children aged 0–19 years shown by incident location and age group, April 2012-March 2014

Location	0-19 years	0-4 years	5-9 years	10-14 years	15-19 years
Educational establishment	5.81%	1.29%	9.52%	14.91%	4.35%
Home	68.70%	82.86%	66.30%	50.65%	56.44%
Other	15.19%	11.42%	12.88%	19.59%	21.29%
Public place	8.70%	3.58%	10.28%	13.66%	13.88%
Work	0.74%	0.02%	0.03%	0.06%	3.44%
Not recorded	0.86%	0.83%	0.99%	1.14%	0.60%

Source: NHS Thurrock CCG Performance Team

A & E attendance by Thurrock children was not resident across the borough between 2012/13 and 2013/14. Figure 71 shows A & E attendance between April 2012 – March 2014 by MSOA of residence, and it can be seen that the highest number of admissions came from the Tilbury Riverside and Tilbury St Chads, and West Thurrock and South Stifford areas. When considering the proportion of 0 – 19 year olds that live in these areas, whilst West Thurrock and South Stifford does have a high number of 0–19 year olds, Tilbury Riverside and Thurrock Park, and Tilbury St Chads have 0 – 19 populations that fall in the middle of the Thurrock wards, and it would therefore not be expected for them to present with such a high number of admissions when considering this alone.

Figure 71: Number of A & E admissions for 0 – 19 years by MSOA in Thurrock, April 2012-March 2014



Source: NHS Thurrock CCG Performance Team

Children Killed or Seriously Injured in Road Traffic Accidents

Road traffic collisions are a major cause of deaths in children, and comprise higher proportions of accidental deaths as children get older. Parents cite vehicle speed and volume as reasons why they do not allow their children to walk or cycle, thereby reducing opportunities for physical activity. A large proportion of childhood injuries occur as a pedestrian or on bicycle, and incidence increases with age, which could be due to increased unsupervised exposure. Children from lower socioeconomic groups are at higher risk of serious injury. In 2010-12, 17.5 per 100,000 children aged 0-15 years in Thurrock were killed or seriously injured in road traffic accidents, which is similar to the regional and national rates.

What are we doing in Thurrock?

Whilst the rate of children killed or seriously injured in road traffic accidents is not significantly different from the regional or national rates, focus should not be removed from services to reduce the number of these largely preventable accidents. Thurrock Council's Road Safety team has been successful at securing funding to deliver Level 2 *Bikeability* training, which provides children with the skills to cycle safely and with confidence on the local transport network. In addition funding has also been secured to deliver Level 1 *Bikeability* and Scooter training until March 2015. Pedestrian training is delivered to parents of reception pupils and to Year 3 and 6 pupils, including the use of a speed gun for pupils to judge the speed of vehicles. *Kerbcraft* (a prescriptive form of pedestrian training) is delivered to Year 2 pupils and the Young Driver programme is delivered to Year 10/11 students. *Cyclicious*, a cycling project specifically for female students is undertaken in secondary schools.

To support the training programmes, the council organises events and activities to embed positive walking and cycling behaviours, including Walk Once a Week (WoW), the Zig Zag scheme for key stage 1 pupils, Walk to School Week, Park and Stride, Theatre in Education (TIE), and Crucial Crew, a multi-agency initiative reaching 1,800 Year 6 pupils. A Bike It Officer is employed to provide intensive cycling support at 15 primary schools. A budget is also allocated to ensure walking and cycling infrastructure is adequate in and around school sites. Infrastructure measures include installing cycle parking, upgrading footpaths and improving parking restrictions.

Recommendations

In order to reduce A&E admissions:

- Work on culture shift to ensure parents, carers, families feel confident and enabled to manage CYP's condition at home
- Work to increase community's role in managing conditions

4. Enjoying and Achieving

School Readiness

Too many children start schools without the range of skills they need. The quality of a child's early life experience is shaped by a number of factors, including socio-economic status, access to high-quality early education and care, and the influence of 'good parenting' (Ofsted, 2014). The gap between those eligible for free school meals and their peers is clearly established by the age of 5, and this has serious implications for future development. Research cited by the Department for Education (2011) found that vocabulary at age 5 is the best predictor of later social mobility for children from deprived backgrounds. Children who start school as confident speakers with good language skills are more likely to become successful learners and achieve in life.

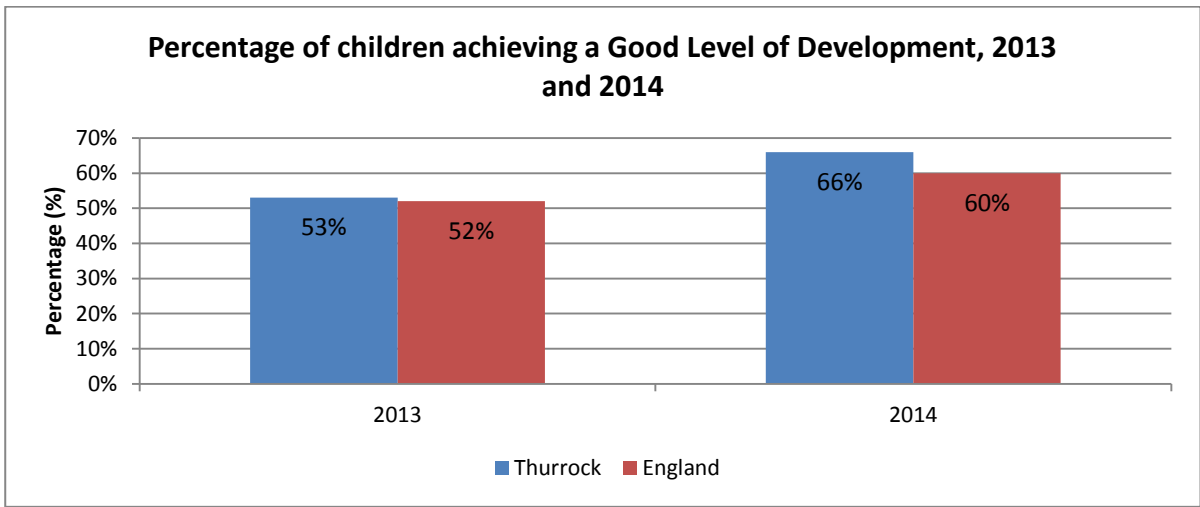
High-quality early education is crucial in supporting children to have the best start in life. The period before entering into primary school education is vital in providing children with the broad range of knowledge and skills that provide the right foundation for good future progress through school. The former Children and Families Minister Sarah Teather said of school readiness in 2011: "This isn't just about making sure they can hold a pencil - children need the resilience, confidence and personal skills to be able to learn."

The term "school readiness" does not yet have a nationally agreed definition, despite its appearance in many reviews of education and statutory guidance. A recent report by Ofsted (2014) identified in a survey that it is interpreted differently by providers across the country, and calls for a definition to be agreed. From 2016 there will be a new indicator which will support measuring of school readiness.

What do we know?

School readiness can currently be measured by the percentage of children achieving a "Good Level of Development" (GLD) in the Early Years Foundation Stage (EYFS). According to the Department of Education, children will be defined as having reached a GLD at the end of the EYFS if they achieve at least the expected level in the early learning goals in the prime areas of learning (personal, social and emotional development; physical development; and communication and language) and in the specific areas of mathematics and literacy. From the below it can be seen that Thurrock is 6% above the national average in 2014 for children achieving a GLD.

Figure 72: Percentage of children achieving a Good Level of Development in Thurrock and England

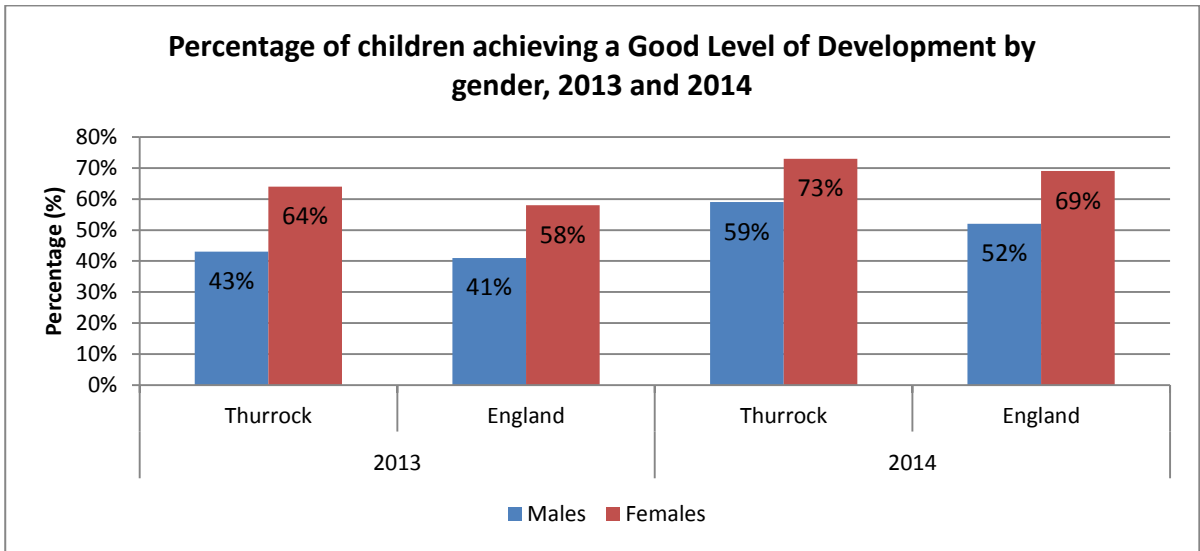


Source: Thurrock Council

It should be noted that data prior to 2013 was measured differently and cannot be directly compared to the above.

Vast inequalities can be seen between achievements of GLD by gender, as even by the age of 5, females are performing better than males. Locally in 2014, only 59% of males achieved a GLD, compared with 73% of females. This is a smaller difference than in 2013, when 43% of males and 64% of females achieved a GLD. This gender inequality is also present nationally, and can be seen graphically in **Error! Reference source not found.** below.

Figure 73: Percentage of children achieving a Good Level of Development in Thurrock and England by gender



Source: Thurrock Council

The Two Year Old Early Entitlement provides funded childcare for children whose parents/carers meet the required eligibility criteria. Up to 15 hours per week of free Ofsted registered childcare may be accessed per week during term time, or over a longer period of

time for fewer hours per week. The aim is to improve outcomes for eligible disadvantaged two year olds, benefitting their social, physical and mental development and helping them to prepare for school. Early education is also available for all 3 and 4 year olds but must be provided by Ofsted registered providers. Take up of early education and childcare fluctuates throughout the year, but taking Spring 2013 data as a snapshot in time, it can be seen that there were 422 children aged 2, 3 and 4 years in Thurrock who were eligible but who did not take up any early education. A break down by age can be found below in Table 24.

Table 24: Eligible children and children accessing early education in Thurrock, Spring 2013

	2 year olds	3 year olds	4 year olds	Total
Children accessing Early Education	369	2144	2285	4798
Eligible Children	443	2360	2417	5220
Number of Eligible Children NOT accessing early education	74	216	132	422

Source: Thurrock Childcare Sufficiency Assessment, 2014 [Data based on ONS mid year estimates 2012, DWP 2013 data and Spring Census data 2013]

Thurrock's [Childcare Sufficiency Assessment](#) (2014) outlines the early education and childcare provision in the borough, and determined that there was sufficient provision in Thurrock, albeit with individual ward pressures. The table below outlines the number of providers by type of provision with the number of registered places. Of the 8414 Ofsted registered places, 7822 can deliver early education (15 hour) places, indicating that there is a surplus supply of 2602 places if all the eligible children had taken them up. The take up of fee paying childcare accessed by working parents does impact on place availability for early education.

Table 25: Summary of early education and childcare in Thurrock

Type of provision	Total Number of Providers	Total Ofsted Registered places per session	Early Education (15 hour) places
Accredited Childminders (can deliver early education)	13	66	24
After school club	21	635	0
Breakfast club	23	697	0
Childminders	187	863	0
Day Nursery	25	1264	2985
Holiday Club	15	541	0
Preschool	25	720	1185
School nursery	22	1334	1334
School reception class	37	2294	2294
Total	368	8414	7822

Source: Thurrock Childcare Sufficiency Assessment, 2014

What are we doing in Thurrock?

Thurrock has 9 Children's Centres, which aim to *improve outcomes for young children and their families and to reduce inequalities*. Five are run by the council directly, and four are commissioned to *4children*. The overall outcomes framework for those run by the Local Authority has 28 statements; 8 of which look to shape the work that Children's Centres do with regard to child development and school readiness:

1. To increase the level to which children pay attention to activities and people around them (PSE)
2. Children show increasing enjoyment of looking at books
3. Children are read to at home more often.
4. Children are learning to share and take turns with friends.
5. Children have age-appropriate self-management skills and self-control (behaviour)
6. Children develop and improve their listening skills
7. Children develop and improve their speaking skills.
8. Children develop age-appropriate early drawing and writing skills.

The centres run a range of universal and targeted services (which are based on data showing needs relevant to vulnerable groups in each area) to support school readiness; these include:

- Three *Stay and Play* sessions (0-12 months, 12-36 months, 36-60 months)
- *Bookstart*
- *Speech and Language Drop In*
- *Parent Outreach Worker*
- *Two year old offer*
- *Early Offer of Help Commissioned Services*

Recommendations

- It is a priority to encourage parents of eligible two year olds to take up the offer of free childcare and early education.
- Ensure parents are informed about choices and provision in the area
- Targeted work to ensure needs of vulnerable groups in each area should be maintained
- Ensure appropriate data monitoring in order to demonstrate good progress of two year olds
- Good partnership working with schools/parents/other agencies working with vulnerable children

School Attendance

Poor attendance can disrupt a pupil's learning and mean they fall behind their peers academically. Persistent absence (measured by the percentage of pupils with less than 85% attendance) can also have an impact beyond educational attainment of a pupil at school, as evidence has found persistently absent pupils are more likely to be NEET (not in education, employment or training), less likely to attend university, more likely to claim state benefits, and more likely to be in temporary rather than permanent employment. (Department for Education, 2011) The same research also found:

- Pupils eligible for Free School Meals (FSM) have over twice the odds of being a persistent absentee as similar pupils who are not eligible for FSM.
- Pupils with Special Education Needs (SEN) have greater odds of being persistently absent than pupils without SEN.
- Girls are more likely to have absences due to illness than boys; boys however, are more likely to have absences due to exclusions than girls.
- Persistent absentees are more likely to come from lone parent households or households with no parents, compared to their non-PA peers.
- Almost a third of persistent absentees come from households where the principal adult/s are not in any form of current employment – this compares to just over a tenth of non-PAs
- Evidence suggests that persistent absentees are more likely to be bullied, excluded from school and be involved in risky behaviours (experiment with drugs, alcohol etc.) than non-PAs.

The Department for Education published a separate report profiling school exclusions in England (2012), and found that:

- Boys are more likely to be excluded (both permanently and for a fixed period) at all ages than girls, with very few girls being excluded during the primary years. The most common time for both boys and girls to be excluded is at ages 13 and 14.
- Pupils with a statement of Special Educational Needs (SEN) were almost seven times more likely to receive a permanent exclusion than pupils with no SEN, and were nine times more likely to receive a fixed period exclusion.
- Pupils who were known to be eligible for Free School Meals were around four times more likely to receive a permanent exclusion, and were around three times more likely to receive a fixed period exclusion than children who were not eligible for Free School Meals.
- The rate of exclusions was highest for Traveller of Irish Heritage, Black Caribbean and Gypsy/Roma ethnic groups. Black Caribbean pupils were nearly four times more likely to receive a permanent exclusion than the school population as a whole and were twice as likely to receive a fixed period exclusion.

Both pupil attendance and behaviour are analysed by Ofsted under their Framework for School Inspection (updated July 2014).

What do we know?

Attendance levels at primary school continue to improve in Thurrock with total primary absences remaining constant at 4.7%, which is in line with both regional and national averages. Persistent Absence has been improving from 4.4% in 2010/11 to 3.1% in 2012/13, reducing the gap with the regional and national average to 0.1%.

Table 26: Percentage of Total and Persistent Absences at primary schools in Thurrock and comparators, 2008/09 – 2012/13.

Total Primary Absence (%)					
	08/09	09/10	10/11	11/12	12/13

Thurrock	5.6	5.5	5.1	4.7	4.7
England	5.3	5.2	5.0	4.4	4.7
East of England	5.1	5.1	5.0	4.5	4.7
Statistical Neighbours (<i>correct as of August 2014</i>)	5.2	5.1	4.9	4.3	4.6
Total Primary Persistent Absence (%)					
	10/11	11/12	12/13		
Thurrock	4.4	3.5	3.1		
England	3.9	3.1	3.0		
East of England	3.8	3.3	3.0		
Statistical Neighbours (<i>correct as of August 2014</i>)	3.8	3.1	2.9		

Source: Thurrock Council

Attendance levels at secondary school have also been improving in recent years, with Thurrock's percentage of total secondary absences reducing over the last four years to 5.7%, which is statistically similar to the regional and national averages, and our statistical neighbours. The percentage of Persistent Absence in secondary schools has also decreased since 2011/12 to 6.5%, which is statistically similar to the regional and national averages, and our statistical neighbours.

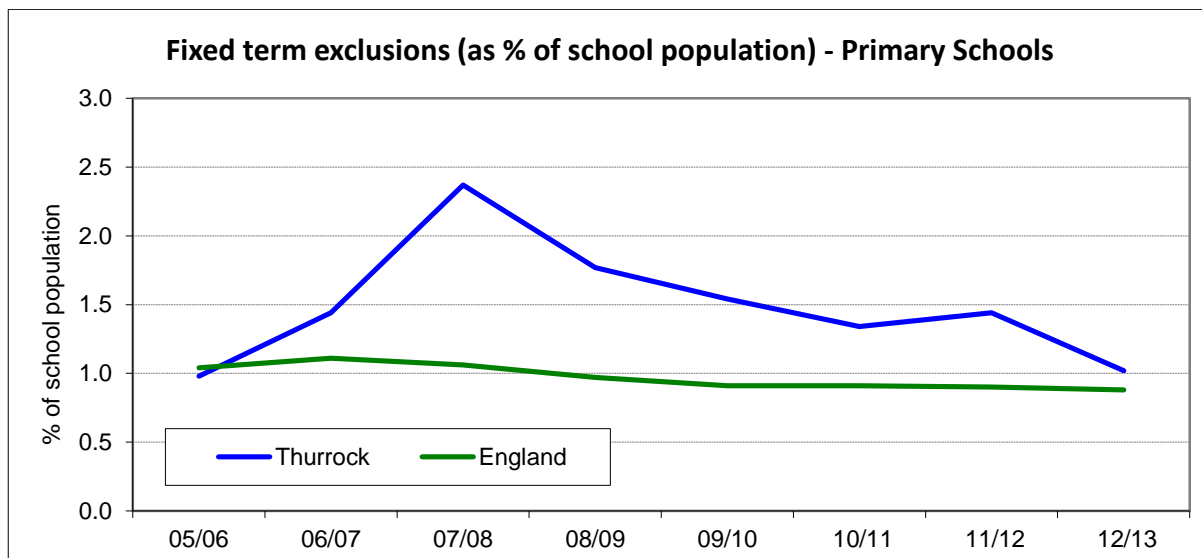
Table 27: Percentage of Total and Persistent Absences at secondary schools in Thurrock and comparators, 2009/10 – 2012/13.

Total Secondary Absence (%)				
	09/10	10/11	11/12	12/13
Thurrock	6.5	6.0	6.0	5.7
England	6.9	6.5	5.9	5.9
East of England	6.8	6.6	6.0	5.8
Statistical Neighbours (<i>correct as of August 2014</i>)	6.6	6.3	5.8	5.8
Total Secondary Persistent Absence (%)				
	10/11	11/12	12/13	
Thurrock	7.5	8.3	6.5	
England	8.4	7.4	6.2	
East of England	8.3	7.4	6.4	
Statistical Neighbours (<i>correct as of August 2014</i>)	8.0	7.4	6.5	

Source: Thurrock Council

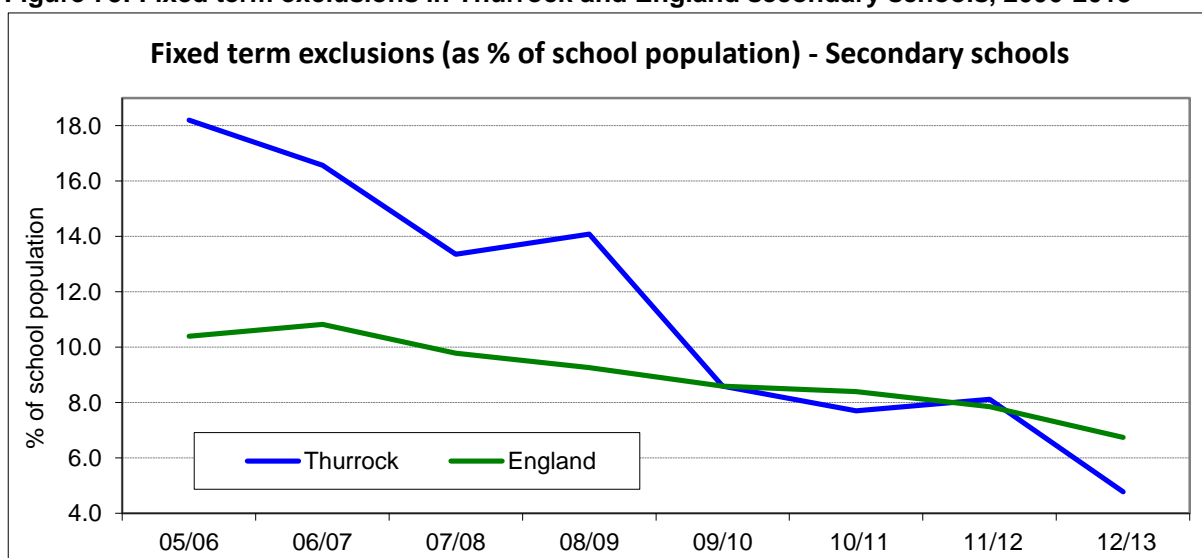
Data showing the proportion of fixed term exclusions in Thurrock highlights that exclusions have decreased dramatically over recent years. Fixed term exclusions in primary schools decreased from a peak of 2.4% in 2008 to 1.0% in 2013, bringing them closer to the national average, which remained fairly constant during this period showing just a slight decrease. In secondary schools there has been an even more dramatic decrease in fixed term exclusions, from a peak of 18.2% in 2006 to 4.8% in 2013. Figure 74 and Figure 75 show exclusions in primary and secondary schools against the national average.

Figure 74: Fixed term exclusions in Thurrock and England primary schools, 2006-2013



Source: Department for Education and Thurrock Council

Figure 75: Fixed term exclusions in Thurrock and England secondary schools, 2006-2013



Source: Department for Education and Thurrock Council

What are we doing in Thurrock?

School attendance is a key focus for the officer led Schools Standards and Progress Board meetings where individual school attendance is scrutinised and strategies to support improvement are agreed as part of the overall school improvement function supported by the Education Welfare Service. Links between the Education Welfare and School Improvement Officers have become more clearly focused since 2011 in relation to how attendance affects pupil outcomes.

Arrangements have been introduced locally to improve access to school for pupils who have experienced difficulties in schooling or who have moved into the area. This has been through a renewed Fair Access Protocol and Access Panel. This has led to significant improvements in

access to mainstream schools for these pupils and the utilisations of managed moves to prevent exclusion.

Fixed Term Exclusions in primary schools is a priority for Thurrock with ongoing support to key schools through work from a behaviour worker including training for teachers and teaching assistants. A new audit of behaviour approaches was carried out in key schools in the summer term of 2013 which has been used to inform a new programme of behaviour support for these schools.

Thurrock's Children's Centres also play an integral role in supporting parents and children with behaviour management, and offer a range of supportive services to do this. Many of their 28 outcomes in their Outcomes Framework specifically relate to giving parents confidence in their parenting ability and supporting them to set and reinforce boundaries at home.

Recommendations

Thurrock Council's Behaviour Strategy outlines a number of recommendations for the Local Authority to help manage pupil behaviour:

- Relevant teams and services are coordinated and managed so as to provide effective support for pupils' social, emotional and behavioural development in schools and other settings
- Effective partnerships are created and maintained with schools, other agencies and organisations to support implementation
- Effective challenge to and support for schools is provided in order to ensure continuous improvement in both policy and practice for improving pupils' social, emotional and behavioural skills
- Regular audits of the range of provision available to schools to support positive pupil behaviour for learning are carried out
- Exemplars of good practice are identified and widely disseminated
- Clarity for schools around sustainable funding sources for improving behaviour for learning is established and maintained

Educational Attainment

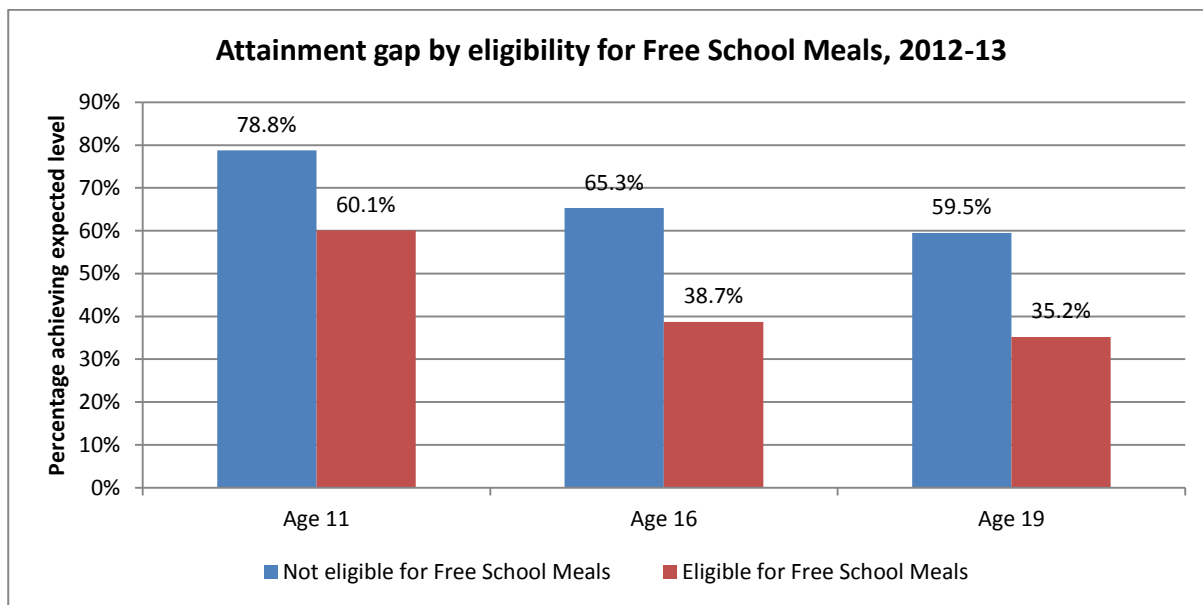
There is a strong association between educational attainment and good health and wellbeing outcomes. The Fair Society, Healthy Lives paper (2010) showed that a range of interacting factors impact on educational outcomes:

- Distal factors – socio-demographic features such as income and parental education
- Proximal factors – parental support and parent-child relationships
- School-peer factors - the nature of the school and its population
- Individual factors of the child – prior educational attainment of the child

It is a complex relationship which connects these factors to educational attainment, with some being stronger predictors of attainment than others.

Educational attainment is lower in deprived areas, and this can affect future life chances – young people with fewer qualifications are more likely not to be in education, employment or training (NEET) after leaving school and find it more difficult to secure employment as they get older. Eligibility for free school meals provides a broad indicator of **deprivation** for pupils attending a school – Figure 76 below shows the association between eligibility for free school meals and educational performance nationally. It has been identified as a leading Government priority to narrow the attainment gaps between disadvantaged pupils and their peers.

Figure 76: Attainment gap from age 11 to age 19 by eligibility for free school meals, 2012-13



Source: Department for Education

Gender has also been demonstrated to affect attainment. Research undertaken by the Department for Education and Skills (2007) shows that the gender gap is wide in English and narrower in Maths, with girls performing better than boys on average. The gender gap in the Sciences has been traditionally very small. Girls are more likely to gain an A* grade at GCSE, whereas boys are a little more likely to gain a G grade or to gain no GCSEs at all. The differences at A-Level are smaller, but girls are still more likely to perform better than boys in terms of those attaining an A grade (for the majority of subjects), which is a significant change over the last ten years. Some reasons behind the gender gap were suggested:

- Girls and boys tend to use different styles of learning
- Girls find it easier to succeed in school settings
- Boys are more likely to be influenced by their male peer group which might devalue schoolwork and so put them at odds with academic achievement.
- The use of coursework in examinations may advantage girls, but analysis does not find that this alone accounts for the gender gap

The latest information also indicates that there is variation in educational attainment between different **ethnic groups**. GCSE A*-C data from 2012/13 indicate that Chinese and Indian students have much higher levels of attainment compared to the national level, whereas Pakistani, Black Caribbean and Gypsies, Roma and Travellers. Black Caribbean boys in particular are 37 times more likely to be excluded from school than girls of Indian origin, which would have a large impact on attainment and future employment.

The Government have committed to raising the achievement of disadvantaged pupils by providing Pupil Premium funding to schools and monitoring use and impact of this funding, utilising Ofsted inspections and performance tables to hold schools to account for achievement of disadvantaged pupils, and investing in funding streams such as the Education Endowment Foundation to help schools raise attainment levels. Moreover, by increasing the autonomy and flexibility of schools, the Academies programme has offered schools considerable opportunity to improve education for their pupils. In particular, academy chains which can share experience and expertise are delivering considerable improvement to schools which have long suffered disadvantage. Likewise, Free Schools are also bringing greater innovation in the sector (Centre for Social Justice, 2014).

Educational outcomes are normally considered alongside the performance of schools in Ofsted inspections. Schools are normally assessed under four key judgement areas: achievement, teaching, behaviour and leadership, and given an overall rating of *Outstanding*, *Good*, *Requires Improvement* or *Inadequate*. Local authorities monitor the proportion of schools in their areas receiving *Good* or *Outstanding* results as an indicator of schools that are performing well.

What do we know?

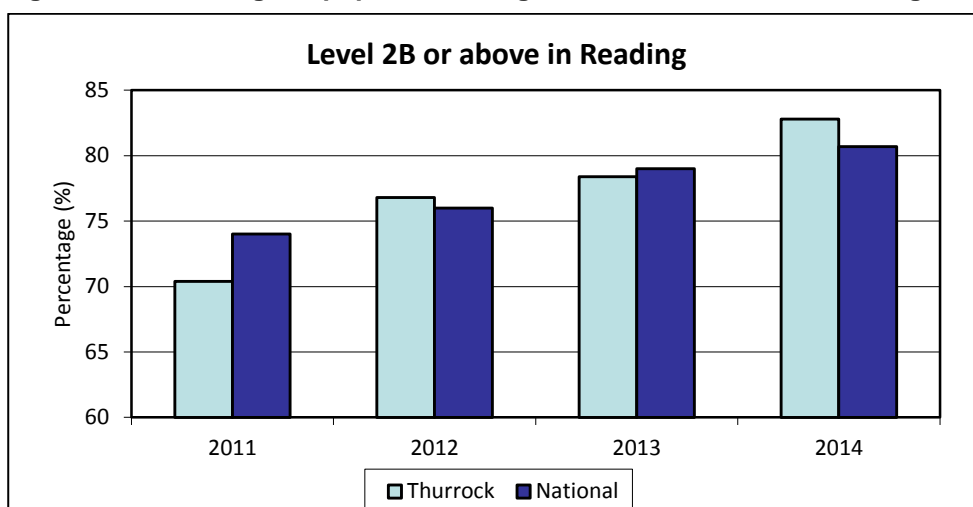
Early Years Foundation Stage

The Early Years Foundation Stage (EYFS) is used as a common measure for school readiness for pupils in Reception Year aged 4-5 years. This data can be found in the [School Readiness](#) section.

Key Stage 1

Key Stage 1 is the term for the period of schooling up to Year 2 for pupils aged 5-7 years. Attainment in Thurrock can be seen broken down by subject and year in Figure 77, Figure 78 and Figure 79 below.

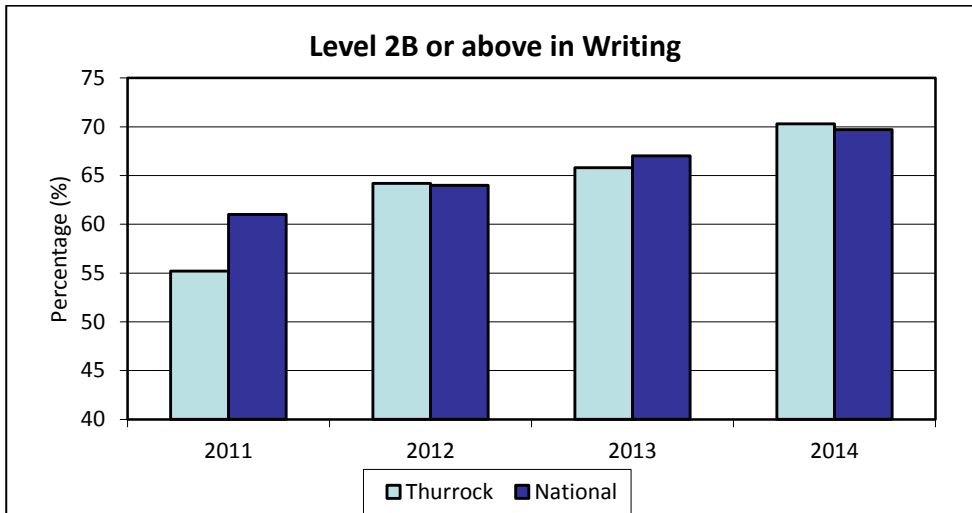
Figure 77: Percentage of pupils achieving a level 2B or above in Reading, 2011-2014



Source: Department of Education and Thurrock Council

Reading: Performance has improved by 12% from 2011 with 82.4% of children in Thurrock achieving a Level 2B or above in reading. Attainment has continued to increase each year, and it is now above the national average by 2%.

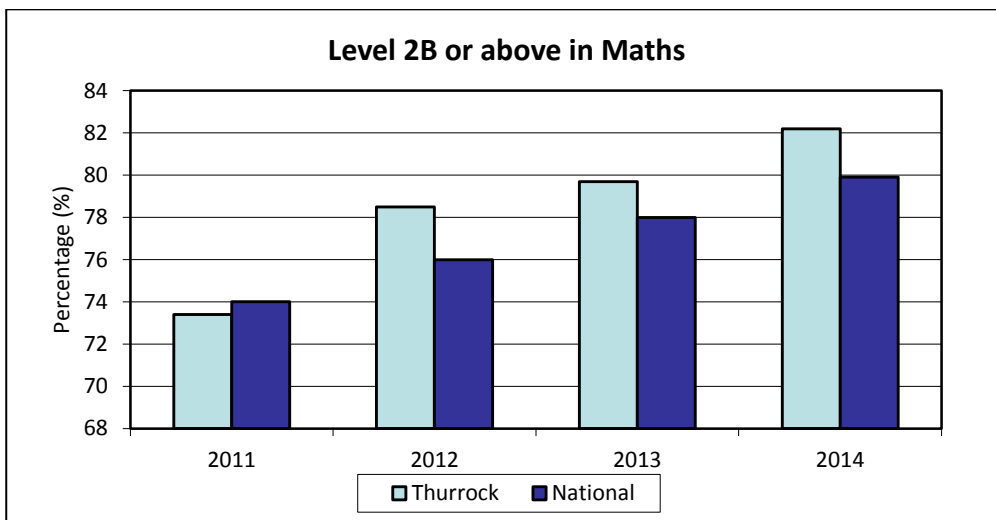
Figure 78: Percentage of pupils achieving a level 2B or above in Writing, 2011-2014



Source: Department of Education and Thurrock Council

Writing: Performance has improved by 15% from 2011 with 70.3% of children in Thurrock achieving a Level 2B or above in writing. This is slightly higher than the national average by 0.6%.

Figure 79: Percentage of pupils achieving a level 2B or above in Maths, 2011-2014



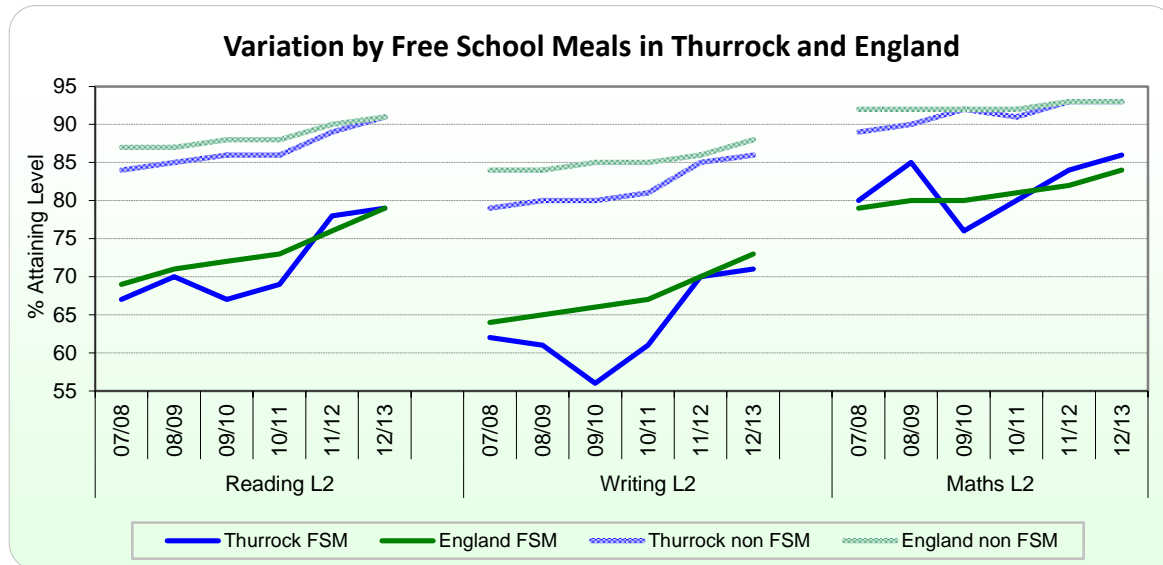
Source: Department of Education and Thurrock Council

Maths: Performance has improved by 9% from 2011 with 82% of children in Thurrock achieving a Level 2B or above in maths. Attainment remains higher than the national average, with a gap of 2.3%.

Variation by Free School Meals

As mentioned above, eligibility for free school meals is an indicator for deprivation and impacts on educational attainment. Figure 80 below depicts the variation between those eligible and not eligible for free school meals for each subject.

Figure 80: Variation by Free School Meal eligibility in Thurrock and England, 2008-2013



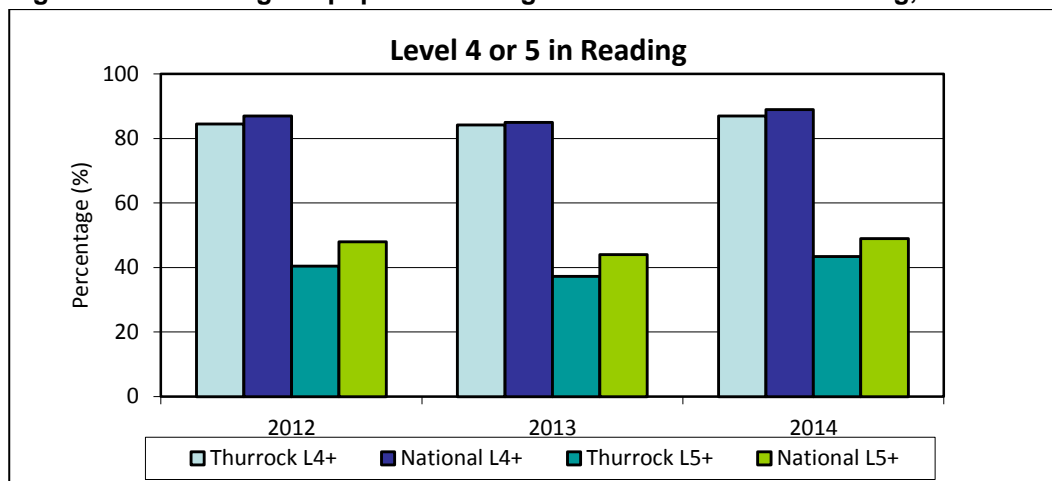
Source: Department of Education and Thurrock Council

The percentage achieving Level 2B or above is lower for all subjects for those eligible for free school meals both locally and nationally. However it can be seen that performance has been increasing in Thurrock over recent years, with attainment for reading and maths scoring above or equal to the national average in 2012/13.

Key Stage 2

Key Stage 2 is the term for the period of schooling up to Year 6 for pupils aged 7-11 years. Attainment in Thurrock can be seen broken down by subject and year in Figure 81, Figure 82 and Figure 83 below.

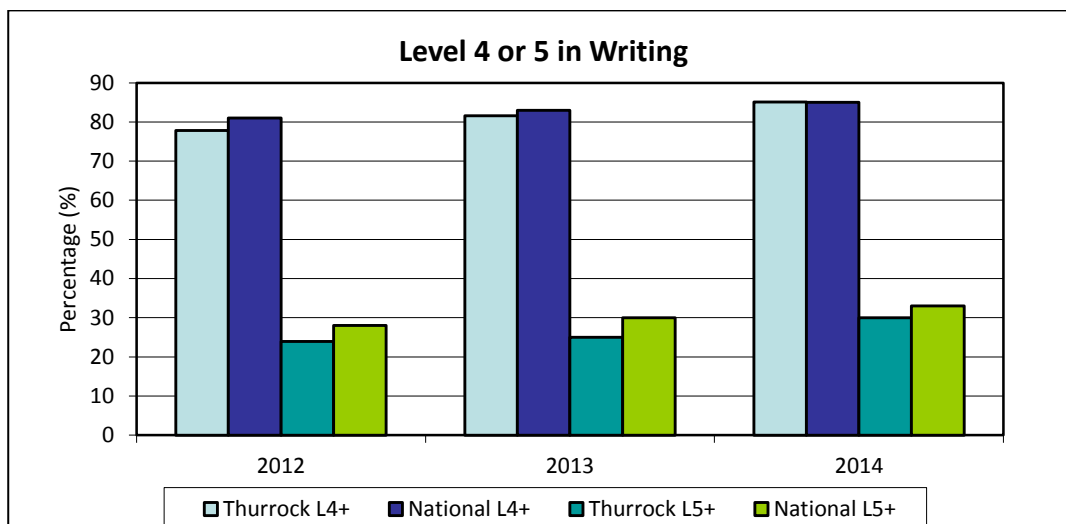
Figure 81: Percentage of pupils achieving a level 4 or above in Reading, 2012-2014



Source: Department for Education and Thurrock Council

Reading: Performance has improved from 2013 with 87% of children in Thurrock achieving a Level 4 or above in reading and 43.4% achieving a Level 5 or above. Performance is broadly in line with the national average.

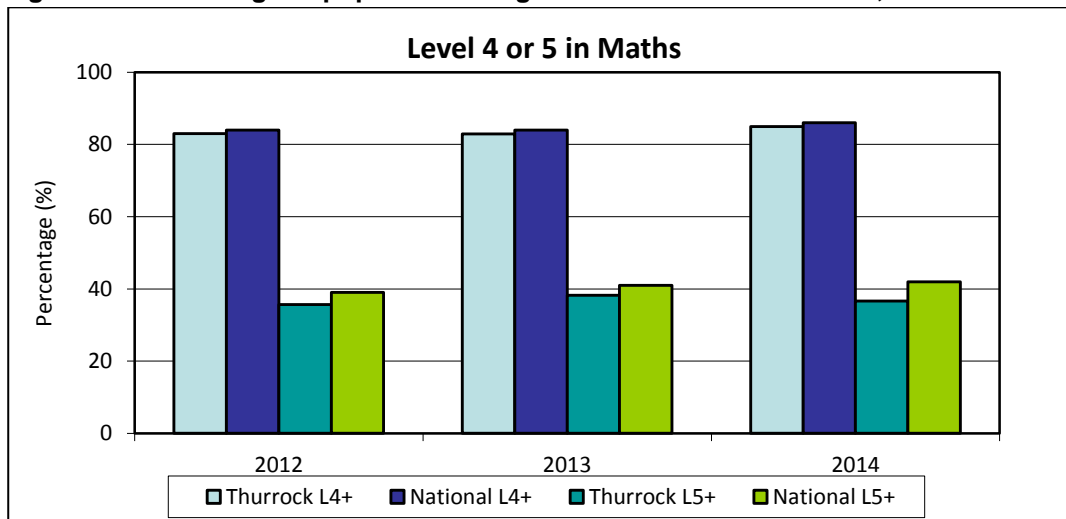
Figure 82: Percentage of pupils achieving a level 4 or above in Writing, 2012-2014



Source: Department for Education and Thurrock Council

Writing: Performance has improved from 2012 with 85.1% of children in Thurrock achieving a Level 4 or above in writing and 30% achieving a Level 5 or above. In 2014, the percentage achieving level 4 or above was equal to the national average.

Figure 83: Percentage of pupils achieving a level 4 or above in Maths, 2012-2014



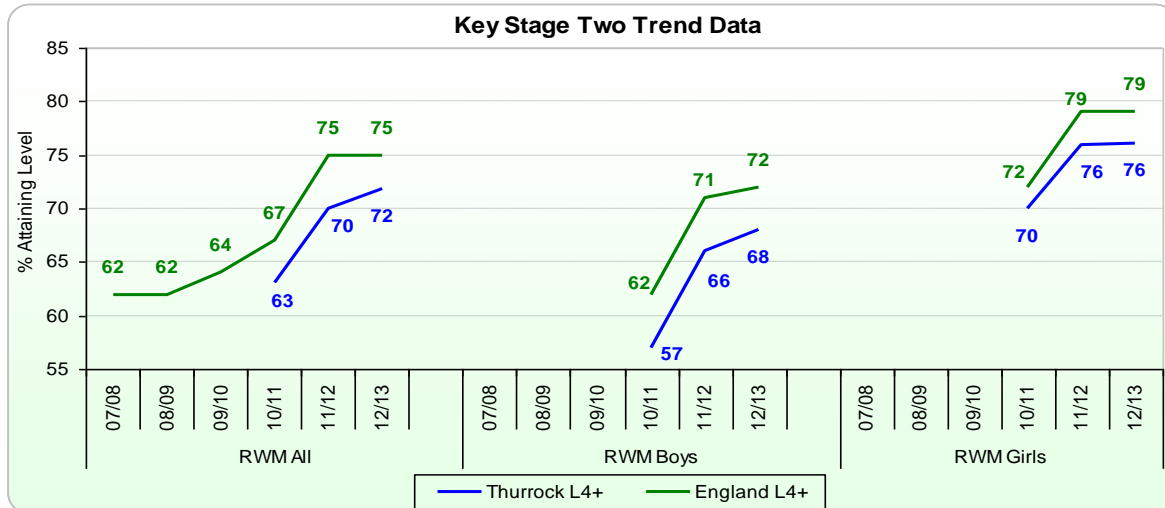
Source: Department for Education and Thurrock Council

Maths: Performance has improved from 2012 with 85% of children in Thurrock achieving a Level 4 or above in maths; however the proportion of children achieving a level 5 or above has decreased since 2013 (36.6% achieved level 5 or above in Thurrock in 2014, compared to 38.2% in 2013). Performance is broadly in line with the national average.

Variation by Gender

Looking at the Key Stage 2 data for all subjects by gender, it can be seen that boys have had lower attainment both locally and nationally over the last few years than girls. Performance has been increasing in Thurrock over recent years; however still is lower than the national average.

Figure 84: Variation by gender in Thurrock and England, 2008-2013



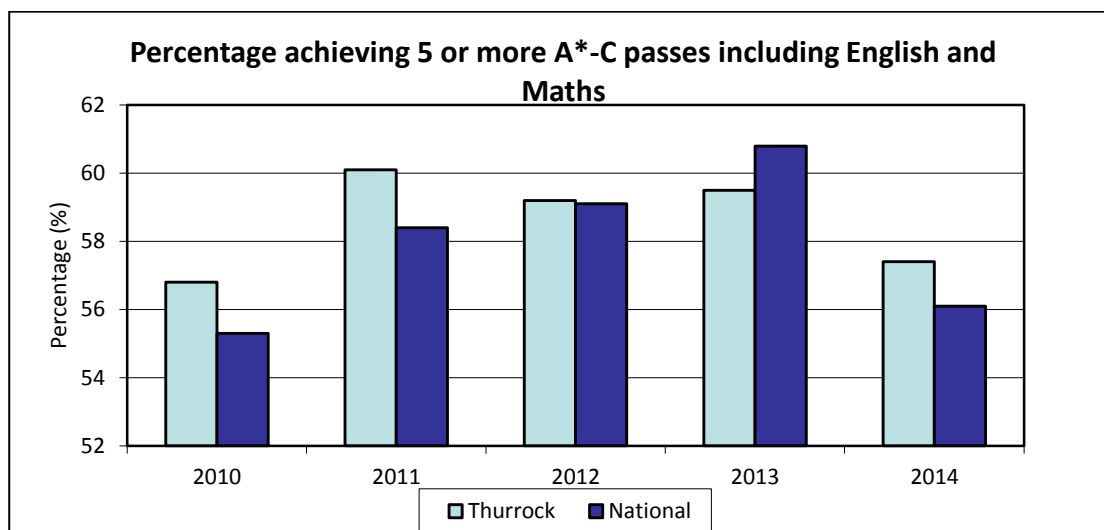
Source: Department for Education and Thurrock Council

It should be considered that the gender inequality gap has narrowed considerably since the EYFS data (which can be viewed in the School Readiness section) – the gap at EYFS between boys and girls was 14 percentage points in 2014 (boys = 59% and girls = 73%), whilst at Key Stage 2 in 2013 the gap was only 8 percentage points.

Key Stage 4

Key Stage 4 is the term for education for pupils who complete this stage in the year of their 16th birthday. The percentage of pupils achieving 5 or more GCSEs at grades A*-C (including English and Maths) is a measure included by Public Health England on its Children and Young People's Benchmarking Tool as an indicator of educational attainment.

Figure 85: Percentage of pupils achieving 5 or more GCSE's at grades A*-C including English and Maths, 2010-2014



Source: Department for Education and Thurrock Council

In Thurrock, 57.4% of pupils at the end of Key Stage 4 achieved five or more GCSEs at grade A*-C or equivalent including English and Maths in 2013/14. Thurrock is ranked 59th out of 151 authorities and is currently above the national average of 56.1%. When all subjects are considered, 65.7% of Thurrock pupils achieved five or more A*-C grades in 2013/14, which is slightly higher than the national average of 65.3%.

Variation by Free School Meals

The percentage achieving five or more GCSEs at grade A*-C or equivalent including English and Maths is lower for those eligible for free school meals both locally and nationally. Pupils eligible for free school meals in Thurrock have seen a drop in performance in 2013 of almost 9.7% compared to national levels which increased by 1.6%. Performance for FSM pupils in Thurrock was high in 2012 so this decrease has resulted in a gap with national of 7.1%. Pupils not eligible for FSM improved in 2013 in line with national performance with the gap remaining around 1%.

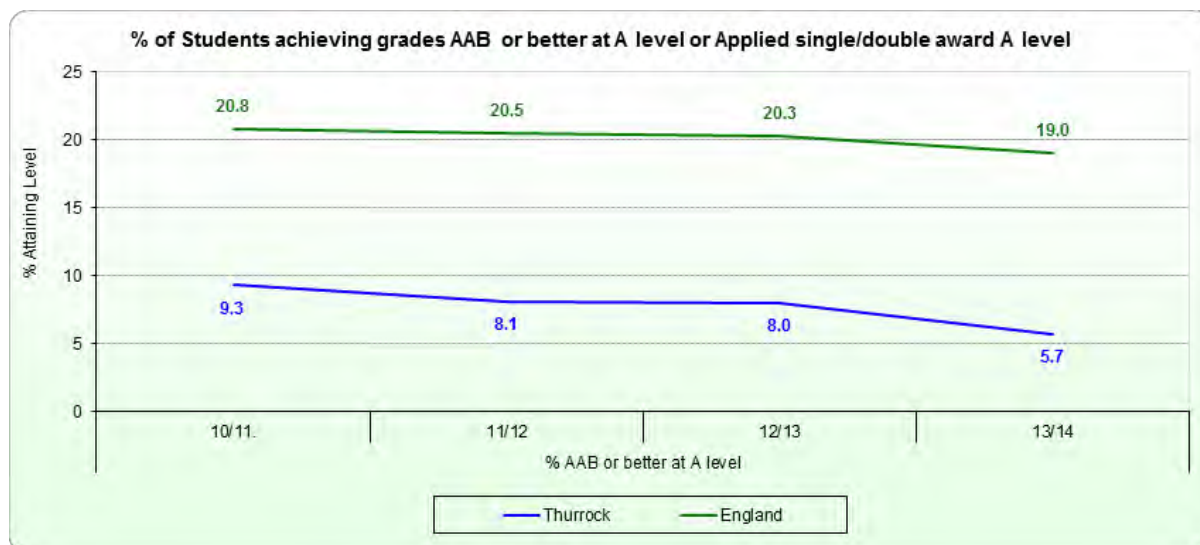
Variation by Gender

There are gender differences in the level of achievement at both a national and local level. The percentage of boys in both Thurrock and England achieving five or more GCSEs at A*-C or equivalent including English and Maths is consistently lower than the percentage of girls over the same period – only 51.7% of boys achieved this target compared to 63.1% of girls in Thurrock in 2014. Whilst in 2013 the gender gap was, at 6.6, the lowest it has been in nine years and was a much smaller gap than the national average, in 2014 it is now larger than the national average.

Key Stage 5

Key Stage 5 (KS5) is the two years of education for students aged 16-18. Young people study Level 3 qualifications including AS/A Level, NVQ at Level 3 and BTEC award.

Figure 86: Percentage of pupils achieving AAB or above at A Level in Thurrock and England



Source: Department for Education and Thurrock Council

In Thurrock, the percentage of pupils achieving AAB grades or higher has followed a decreasing trend since 2010/11 and is now 5.7%, which is below the national average of 19.0%.

What are we doing in Thurrock?

The School Improvement Team works with the Thurrock Teaching Schools, 0-11 Strategy Group and the 11-19 Strategy Group to identify current needs through data analysis, school improvement consultant visits and Ofsted reports. Recommendations have been made to Thurrock Education Alliance who commission Thurrock Excellence Network to commission and deliver continuous professional development through courses, bespoke training and Specialist Leaders in Education deployment. Targeted training is commissioned to meet the needs of the Thurrock schools and academies. A comprehensive brochure has been collated and sent to all schools and included training in all the focus areas.

TEN has commissioned a successful Head Teacher to develop a recruitment and retention strategy. Alongside this work Thurrock has developed a high quality induction programme and mentoring programme for each new Head Teacher or Deputy Head.

We have commissioned SEND and Governance reviews in schools where these are a priority. Early Excellence was also commissioned to develop practice in schools where Early Years was a priority. This has had a positive impact on Early Years provision in those schools, as Thurrock EYFS data now exceeds national data. KS1 and KS2 data for age-related expectations is in line or exceeds national with the exception of level 5+ maths.

Work is underway to refresh the current 0-19 Education Improvement Strategy, which has identified the following key areas upon which to focus future work:

- SEN outcomes

- EAL – a growing community
- Attainment of Higher levels (EY to KS5)
- Closing the gap – particularly around boys and girls
- Transition and continuity of effective provision
- Recruitment and retention high quality teachers and leaders
- A level average points score and challenge for more able young people at KS5
- Achievement of Level 2 and 4 by the age of 19

Thurrock's Children's Centres also play an integral role in supporting parents and children in enjoying and achieving well, and offer a range of supportive services to do this. Two of their 28 outcomes in their Outcomes Framework specifically relate to encouraging parents to support their children's learning at home, and encouraging parents to read to their children.

Recommendations

The *Ambition, Achievement and Aspiration in Thurrock* Strategy (June 2014) outlines a number of suggested ways to drive improvement in educational outcomes for local children and young people, with the aspiration for Thurrock's children to be the best performers in the region and for every school to have a *good* or *better* Ofsted rating by 2016. In order to achieve this, Thurrock should:

- Work with a range of partners to ensure that all Thurrock's children have the best possible start in life to enable them to progress successfully in their education
- Continue to support parents and carers to engage positively in their children's education
- Drive practice to narrow the identified gaps in attainment, particularly for children and young people who are vulnerable
- Look to minimise variation between schools to ensure all children and young people have access to high quality education
- Ensuring that the benefits of schools becoming academies are realised to support rapid improvement, e.g. making best use of the capacity of academy chains and partnerships and the use of teaching schools
- Work in partnership to help Thurrock become an attractive and successful place to train, develop and retain teachers and leaders of effective schools and settings
- Ensure that young people aged 14-19 years benefit from expert careers education information and guidance in order to meet their interests, aspirations and needs
- Look to raise awareness in schools and colleges of the career opportunities opened up by the recent investments within the borough to support young people onto the necessary progression pathways

5. Making a Positive Contribution

Volunteering is generally considered an altruistic activity and is intended to promote goodness or improve human quality of life. Central Government is committed to getting younger people involved in public decision making and wants all young people to have a positive and active role in their communities and the wider society. The government looks towards local authorities to identify and resource arrangements to ensure young people are involved in influencing the designing of the policies that concern them. Volunteering also has wider social aspects and, as well as being fun, you can also choose to, do the things that are of interest to you, meet new people in the process or volunteer with friends.

Volunteering is...

- giving up your time and energy;
- for the benefit of society, the community, the environment or individuals outside of your immediate family;
- unpaid;
- your choice!

Some important themes in youth volunteering include increasing social inclusion and community participation, creating ownership through youth-led opportunities and recognising young volunteers through specific awards and accreditation. Volunteering is not only about what you can give back to your community, but also what you get out of it - many young people who volunteer find that their experience increases their confidence and self-esteem, teaches them new skills and gives a boost to their education and employment opportunities through building new skills/ training and additional qualifications that can be used on CV's and UCAS applications. Volunteering can also improve health and wellbeing through such opportunities as sporting activities and being part of a team.

Many young people are already involved in volunteering either through their school, local youth groups or their faith groups; some of these voluntary roles are:

- Faith based activities
- Sports clubs
- Uniformed groups such as scouting/ cadets/ first aid
- Youth club
- Supervision/prefect duties at schools
- Bands
- Peer mentoring
- Helping out at school events

What do we know?

Through Ngage, the Thurrock Volunteer Centre, there are many varied opportunities for young people to be able to take an active part in their community. As of 22nd October 2014, Ngage is working with:

- 3 volunteers under 15 years
- 297 volunteers between 15-18 years

- 617 volunteers between 19-25 years

Information collected in Thurrock Council's activity report indicated that in November 2013, there were 0.4% of 16-19 year olds volunteering in Thurrock, which is lower than the national average.

What are we doing in Thurrock?

Thurrock has a long history of proactive volunteering and a thriving and robust programme of youth opportunities ranging from more formal volunteering such as Young Leader programmes within uniformed groups to informal volunteering at local riding stables. In line with the Governments wish to involve young people in local democracy, Thurrock has two opportunities which provide this for young people:

1. Youth Cabinet

This group enables young people to get actively involved in local decision making. 31 members (11-19 years) from various schools and community groups sit on the Youth Cabinet. Some of the examples of young people's involvement are as follows:

Make Your Mark Ballot: Every year there is a national youth ballot named Make Your Mark which gives an opportunity for every young person (11-18 years) in the UK to vote on their top issue. Youth Cabinet members go out and about in their local areas encouraging young people to get involved and vote. In 2014 there were 4,326 Thurrock young people that voted in Make Your Mark. This is up from 1,735 (2013) and 698 (2012). The Youth Cabinet will now look at what issues received the top votes locally and see what work/campaigns can be run from this.

Interviewing commissioned providers: The Youth Cabinet work in partnership with the Council's Children's Commissioning Team to get young people involved in the commissioning process. Youth Cabinet members have carried out a number of interviews/service reviews with different commissioned providers. Their findings are then written up and passed back to the Council.

Interviewing new staff: Youth Cabinet members have sat on interview panels for new members of staff that come to work within Children's Services at the Council. These have included officer posts right up to director level.

Young people scrutinising decisions: The Youth Cabinet has 2 representatives on the Council's Children's Overview & Scrutiny Committee. These young people play an active role in the meetings and ensure young people's voices are heard at the committee.

Monthly youth cabinet meetings: The Youth Cabinet meet every month and as part of this a range of guest speakers engage with them to seek their views and opinions. These guest speakers include a range of officers and councillors at Thurrock Council covering areas such as safety, public health, regeneration and youth services.

2. Children in Care Council (CICC)

The CICC is a group of young people in care aged 11-21 who meet monthly to discuss issues that matter to them and their peers. They take part in consultations about services provided to them. They inform Thurrock directors, the corporate parent panel and local councillors of their wishes and feelings about the topics they have discussed. Professionals such as health and education also meet with the CICC to consult and obtain their feedback on current affairs affecting young people in Thurrock. In July 2014 the CICC facilitated a workshop for the social work interview day which allowed the CICC to be part of the recruitment process for new social workers who would like to join Thurrock. The CICC have also been involved in the commissioning process in regards to foster care recruitment and have framed questions for 2 tender evaluations. Health, education, team managers for social care and Thurrock's commissioning team have also visited the CICC to consult with them. They have recently taken part in the local youth debate and support other young people with their campaigns. The CICC are currently reviewing the Pledge (promises Thurrock make to those young people in care). They are also taking the lead in supporting young people to completing the annual national survey for children in care and care leavers.

Future work

Ngage volunteering centre are in the process of developing a new one year project for young people aged 16-24 with the aim of recruiting 200 volunteers to the programme.

Recommendations

- Opportunities identified through commissioning and providers processes to increase the inclusion of NEET's into volunteering opportunities to improve their employment chances.
- Commissioners and providers to enhance the promotion of volunteering opportunities for young people.
- Local Authority to closer align the different youth voice mechanisms enabling the Youth Parliament to have a greater understanding of the views and needs of young people and the ability to inform the commissioning process.
- Timebanking and Carebanking information and opportunities to be cascaded out to young people.

6. Achieving Economic Wellbeing

Low Income Families and Child Poverty

Although the greatest factor for childhood poverty is growing up in a workless family or a family with low income, there are often a complex interplay of influences involving factors in individual families, the local economy and low levels of attainment. Children who grow up in poverty are often at risk of social exclusion and there are clear links between poverty and lower educational attainment, poorer health outcomes and intergenerational disadvantage.

Children living in areas of high deprivation:

- Experience a higher risk of infant mortality
- Are at higher risk of acute illnesses requiring hospital admission
- May be more likely to experience emotional and behavioural problems
- Are less likely to maintain a healthy weight
- Are more likely to experience problems with oral health
- Are more likely to achieve lower levels of educational attainment

In addition, young people growing up in areas of high deprivation:

- Are more likely to conceive and become teenage parents
- Are more likely to enter the youth justice system
- Are more likely to smoke
- Are at higher risk of becoming NEET
- May experience lower earnings and poorer qualifications in adulthood

There are some factors known to influence child poverty, which include family size and structure, the age and educational qualifications of parents, low earnings, ethnicity and lack of employment. Lone parent families are particularly vulnerable to poverty and teenage mothers are three times as likely to suffer poverty compared with older mothers. Disabled adults of working age are twice as likely as non-disabled adults to live in poor households and more than half of families with disabled children live on low incomes. In all parts of the country, people from ethnic minorities are, on average, more likely to live in low income households than white British people.

The Government is focussed on breaking the cycle of disadvantage and ending child poverty and remains committed to the goal of ending child poverty in the UK by 2020. The [Child Poverty Strategy 2014-17](#) (HM Government, 2014) focuses on three key areas:

- Supporting families into work and increasing earnings
- Improving living standards
- Preventing poor children becoming poor adults through raising their educational attainment

The Child Poverty Act 2010 set four challenging targets to be met by 2020. The targets are:

- *Relative poverty* – to reduce the proportion of children who live in relative low income (in families with income below 60% of the median) to less than 10%
- *Material deprivation* – to reduce the proportion of children who live in material deprivation and have a low income to less than 5%
- *Persistent poverty* – to reduce the proportion of children that experience long periods of relative poverty, with the specific target to be set at a later date
- *Absolute poverty* – to reduce the proportion of children who live below an income threshold fixed in real terms to less than 5%

The Act also tasked local authorities with producing local child poverty needs assessments and strategies to improve understanding of drivers of child poverty, and to set out measures that can be undertaken to reduce child poverty in their local area.

Defining and measuring Child Poverty

Child poverty is defined by the national child poverty indicator (NI 116) as the percentage of children who live in families in receipt of out-of-work benefits or in working families with income less than 60% of the median national income (taking account of differences in household size and composition).

However, when considering levels of child poverty, low income families should also be considered – these are defined as working households (where at least one adult works more than 16 hours per week) which are receiving both Child Tax Credit and Working Tax Credit. Many of these families will be above the 60% income threshold used and are not counted within child poverty statistics, but the Government considers their income to be low enough to qualify for additional support.

What do we know?

The National Child Poverty Unit provides information on a [range of indicators](#) including the proportion of children living in low income families. This shows that 20.0% of children in Thurrock live in low income families, which is slightly higher than the national figure of 18.6% and shows an improvement of 1.4% from 2011.

Table 28: Children living in low income families, 2006-2012

	Thurrock		East of England		England	
	Number	Percentage	Number	Percentage	Number	Percentage
2006	7,335	20.1%	191,885	15.8%	2,298,385	20.8%
2007	7,485	20.4%	200,435	16.4%	2,397,645	21.6%
2008	7,335	19.8%	199,060	16.1%	2,341,975	20.9%
2009	8,040	21.1%	212,645	16.9%	2,429,305	21.3%
2010	8,160	21.1%	209,255	17.1%	2,367,335	20.6%
2011	8,385	21.4%	206,280	16.2%	2,319,450	20.1%
2012	7,950	20.0%	194,380	15.1%	2,153,985	18.6%

Source: HMRC

This data also shows a 74% employment rate in Thurrock with 47% of children living in working households. This is slightly lower than the regional and national averages. This can be seen in Table 29.

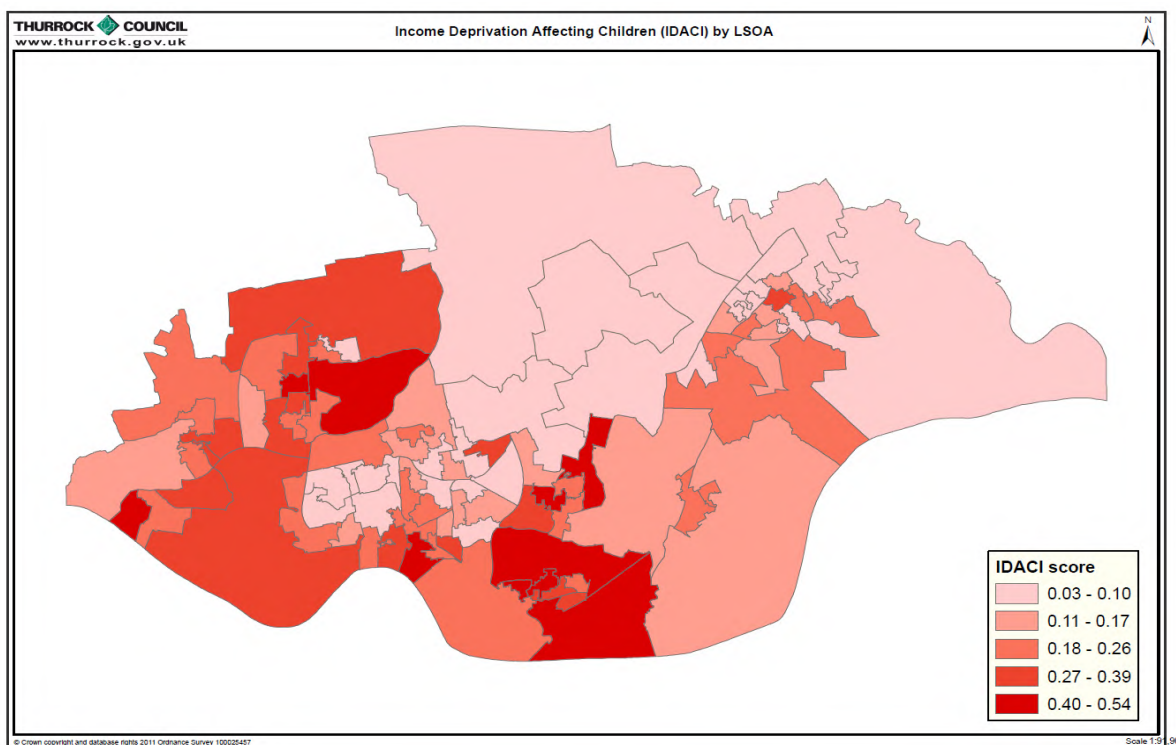
Table 29: Employment Profile, 2012

	Thurrock	East of England	England
Children in Workless Households (2012)	14%	12%	15%
Children in Working Households (2012)	47%	56%	51%
Overall employment rate (2013)	74%	76%	72%
Average earnings of employees (2013)	£552.10	£542.70	£520.70

Source: ONS

Child poverty exists everywhere in Thurrock but is most concentrated in the deprived parts of the borough. The Income Deprivation Affecting Children Index (IDACI) measures the proportion of children in each Lower Super Output Area (LSOA) aged under 16 years that live in income-deprived households. This can be viewed in Figure 87 below, and shows that there is wide variation across the borough – 3% of children in one LSOA in Corringham and Fobbing live in low income households, compared with one LSOA in West Thurrock and South Stifford, where 54% of children live in low income households.

Figure 87: Income Deprivation Affecting Children (IDACI) across Thurrock by LSOA, 2010



Source: Department for Communities and Local Government, Indices of Deprivation 2010

In Thurrock, the areas that have the highest levels of child poverty in most cases have the lowest educational attainment, more people in poor health or with disabilities that prevent them

from working, higher proportions of workless families, more families who lack bank accounts or home insurance, fewer car owners and higher proportions of adults who have poor basic skills or who lack qualifications.

What are we doing in Thurrock?

The [Thurrock Child Poverty Strategy 2011-2014](#) has set the following strategic priorities:

- To increase parental employment and skills by providing access to adult training and skills development through the Wishes Adult Skills Programme and progression to adult learning opportunities.
- To increase benefit take up by improving providing high quality advice and guidance targeted to areas where there is a high prevalence of poverty and workless households.
- To reduce attainment gaps between children living in poverty and those who don't by targeting school improvement to those areas and supporting parents to be able to support their children through, for example, adult learning opportunities.
- To reduce the health inequalities faced by some families by developing a targeted, integrated approach to local delivery of services.
- To support the need to prevent homelessness from occurring by addressing the underlying causes of homelessness through effective partnerships, collaboration and the co-ordination of services.

The reduction of child poverty remains a key focus and the strategy for 2015 onwards will continue to reflect the national strategic priorities.

Since the introduction of a child poverty strategy locally there has been:

- A reduction in the number of children living in workless households from 19% in 2010 to 14% in 2012, this compares to the England average of 16% in 2010 and 15% in 2012.
- A reduction in the number of young people who are not in education, employment or training to 5% with a broader offer of training and employment opportunities linked to sector based skills linked to local regeneration.
- The continuation of the Wishes entry into adult learning programme which has supported on average 40 learners per year with low or no qualifications into level one and two training programmes.
- The development of joint working with Job Centre Plus as a part of the Troubled Families Programme
- The provision of support to families through partnership working with the [Citizens Advice Bureau](#)
- An increased supply of early education and childcare places, particularly for two year olds from low income families, with approximately 800 two year old children now accessing funded early education.
- A narrowing of the gap in attainment between those children living in areas of deprivation and others.
- The introduction of multi-agency planning of services and co-location to improve access for families to support.

- The introduction of a service targeted at preventing homelessness in young people

Thurrock's Children's Centres also play an integral role in supporting parents and children within low income families, and offer a range of supportive services to do this. Five of their 28 outcomes in their Outcomes Framework specifically relate to improving parent aspirations and focus on supporting parents to improve their basic literacy and numeracy skills, to ensure they have sufficient skills to access work, to help parents in managing their financial situation, helping parents enrol onto further training, and giving volunteers more confidence in progressing onto training or work.

Recommendations

- To further develop partnership working to reduce child poverty
- To develop the next stage of Thurrock's response to child poverty by writing the new strategy for 2015-2018
- To continue to embed child poverty reduction across the council and its partners

Further Education, Employment or Training

Young people over the age of 16 years who are not in education, employment or training (NEET) are at a greater risk of a range of negative outcomes. These include increased risk of living in areas of high deprivation, social exclusion and isolation, poor mental health and an increase in unhealthy behaviours such as substance misuse and smoking.

According to Allen (2014), almost half of those who are NEET at age 17-18 are still NEET one year later, and those who are NEET at age 18-19 are 28% more likely than others to be unemployed 5 years later. There are numerous other reasons why unemployment early on in life is particularly damaging; these include the increased likelihood of developing a mental health problem such as depression which could ultimately result in suicide – a large killer of young men in the UK. Allen (2014) also found that young men who are NEET were 5 times more likely to have a criminal record than their peers, citing that it could be necessity-driven. There is also evidence that when those who were NEET do move into work, they are more likely to be in low-paid jobs or receive no further training.

The Audit Commission (2010) produced a report which examined factors that increased young people's risks of becoming and remaining NEET. They found that being NEET at least once increased the chance of becoming NEET again for 6 months or more by almost 8 times. The full list can be seen in the table below.

Table 30: Factors leading to an increased chance of becoming NEET for 6 months or more

Factor	Increase in chance of being NEET for 6 months or more
Being NEET at least once before	7.9 times more likely
Pregnancy or parenthood	2.8 times more likely

Supervision by youth offending team	2.6 times more likely
Fewer than three months post-16 education	2.3 times more likely
Disclosed substance abuse	2.1 times more likely
Responsibilities as a carer	2.0 times more likely

Source: Audit Commission, analysis of Connexions data from fieldwork areas (approximately 24,000 young people), 2010

Other population groups associated with increased risk of becoming NEET include young people with special educational needs, learning difficulties or disabilities, care leavers, those with existing health problems, and those being classed as 'gifted and talented' but bored by school.

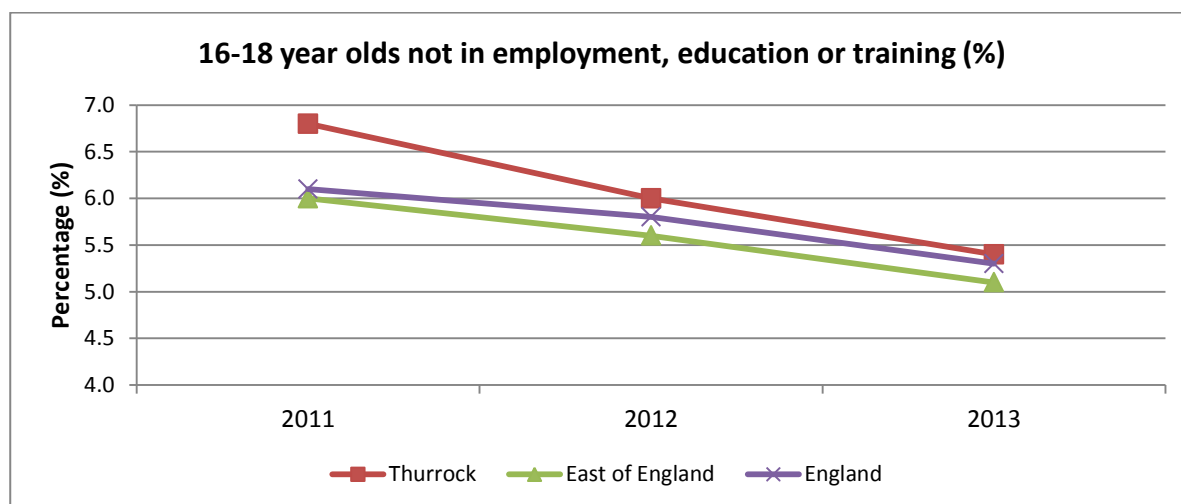
Allen (2014) indicates that remaining in education has a protective effect on health, concluding that four more years of schooling relates to up to a 16% reduction in mortality rates and reduces risk of heart disease and diabetes. The UK government has several schemes in process which aim to reduce the number of young people who are NEET, including:

- Raising of the Participation Age (from 2015, young people will be required to continue in education or training until they turn 18)
- the Youth Contract (package of schemes aimed at helping young people into sustained employment),
- the Work Programme (offering support to groups of long-term unemployed people).

What do we know?

Data showing the percentage of 16-18 year olds who are NEET is returned to the Department for Education on an annual basis. The most recent data (covering the period between November 2013 and January 2014) indicates that 5.4% of 16-18 year olds in Thurrock are NEET, which is similar to the regional average of 5.1% and the national average of 5.3%. As can be seen from the figure below, the Thurrock proportion has been decreasing in recent years in line with regional and national averages.

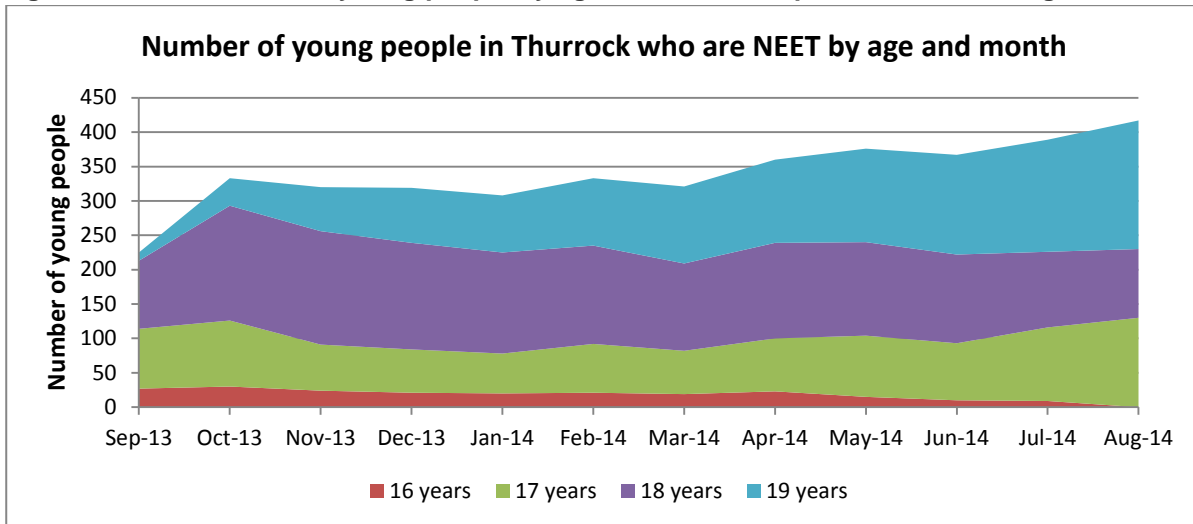
Figure 88: The percentage of 16-18 year olds who are not in education, employment or training in Thurrock, East of England and England, 2011-2013



Source: Public Health England

When this percentage is further analysed in terms of age and distribution over the course of an academic year, it can be seen that the numbers of NEET young people fluctuate throughout the year. Figure 89 below shows how the number of 16, 17, 18 and 19 year old NEETs in Thurrock change over 12 months, and it can be seen that the highest number of NEETs were seen in August 2014.

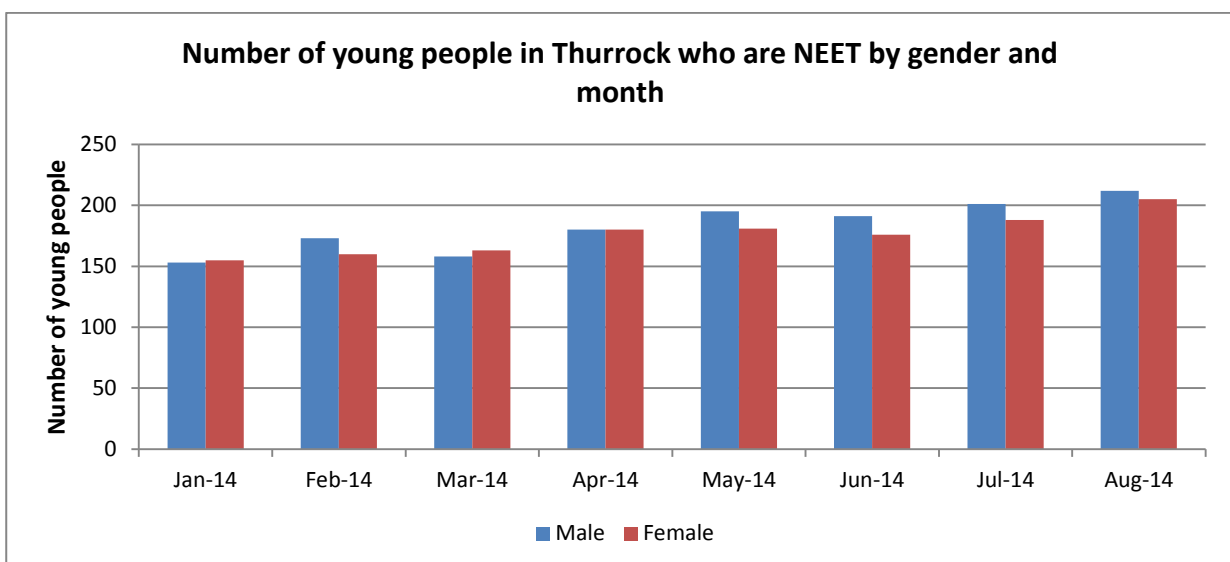
Figure 89: Thurrock NEET young people by age and month, September 2013 to August 2014



Source: Thurrock Council

With regards to gender, it can be seen from the figure below that for most months there are more NEET males than females, and that the numbers of both genders increase throughout the year up to August.

Figure 90: Thurrock NEET young people by gender and month, January to August 2014

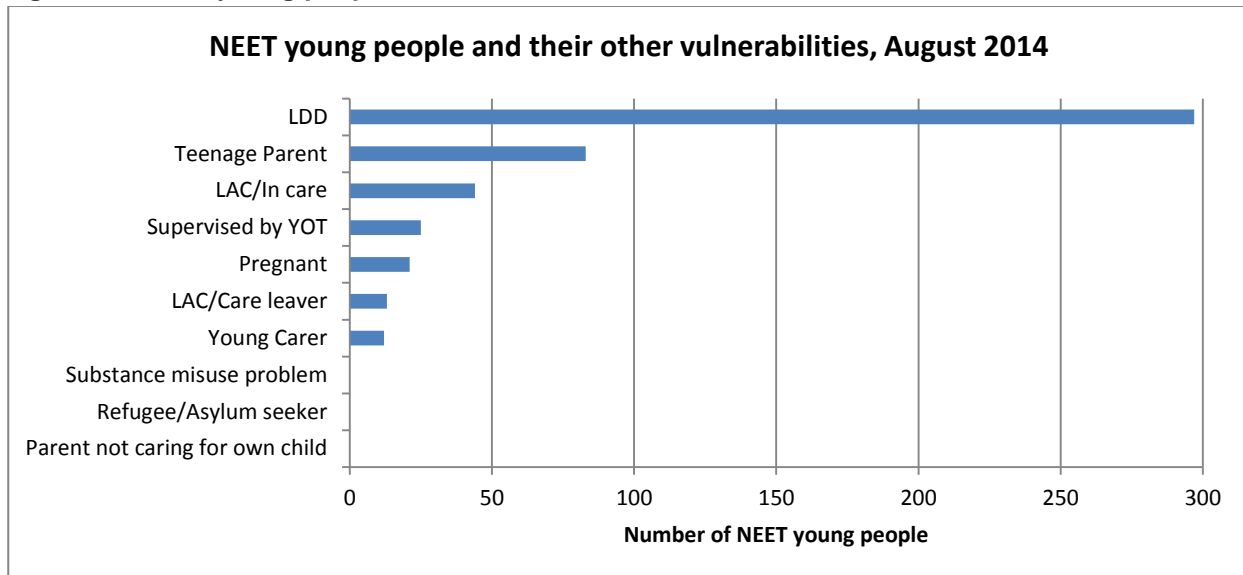


Source: Thurrock Council

The figure below outlines some of the other vulnerabilities recorded for the NEET population of Thurrock as of August 2014. It can be seen that a high number (297) of NEET young people have a learning difficulty or disability, which is one of the risk factors for becoming NEET.

Teenage parents and girls who are pregnant also represent a large proportion of the Thurrock NEET population (104). (It should be noted that one young person could be recorded in several groups).

Figure 91: NEET young people and other vulnerabilities



Source: Thurrock Council

What are we doing in Thurrock?

The Council's Learning and Skills team provides a service to residents of all ages, working with partners to develop skills and promote opportunities for further education, employment or training. Their work in supporting young people includes:

- Working with partners in the design and delivery of short 2-12 week programmes, comprising of sector specific training, employability skills training and work placement that should lead to employment. The programmes delivered have focused on Thurrock's key priority sectors and others: Construction, Logistics, Health and Social Care (elderly and childcare), Hospitality, Retail, Public Services, Creative and Cultural, Horticulture, Engineering. Following feedback from NEET young people that they are unable to afford transport and food costs associated with the programmes, we secured payment of transport and food on some of the programmes which slightly increased participation and outcomes.
- Providing 1:1 support to young people with the delivery of employability skills training. This includes support with CVs, job applications and interview skills, until they secure employment with training or volunteering.
- Working with schools and employers to create meaningful work experience placements. A suite of documents is provided to each school/academy to enable robust documentation for Ofsted to measure quality of the experience.
- Working with employers to create apprenticeship placements. The team facilitate this in a number of ways, including completing recruitment paperwork, advising on apprenticeship issues and supporting interview processes. Thurrock Council has 54 Apprentices in post; 13 of these are appointed Ambassadors who will promote the benefits of their route into employment in schools from September 2014.

- Providing 1:1 support for care leavers (16-24 years) to move into full time education or apprenticeships. This includes a *personalised package of learning* that can include literacy, numeracy, employability and life skills training before work experience placements/volunteering and ultimately secure employment. An effective cross directorate partnership reviews progress/services being accessed every two weeks. Since April 2014, 5 care leavers have secured employment (and they continue to receive ongoing support).
- Working closely with partners to create internships for local LDD residents (16-24 years) that are keen to be employed.

Future initiatives that will impact on local young people include:

- A new approach to employer engagement is emerging with a partnership collaborative comprising Thurrock Council, South Essex College, JobCentre Plus, Reed NCFE, National Apprenticeship Service and others to share vacancies and improve the recruitment of local people by local employers. Thurrock Council's employer engagement strategy will be updated to reflect the changes.
- The piloting of a job shop for one day a week in Tilbury library that is staffed by representatives from Thurrock Council and its partners to give high quality advice on how to access services and employment. It is envisaged that training courses will be delivered from the library in the future.
- The recent Partnership Agreement with JobCentre Plus which looks to reduce NEET in Thurrock as a priority.

Recommendations

Allen (2014) put forward a number of suggestions outlining what works in terms of reducing the proportion of NEET young people. These include:

- The need to focus on early intervention – strategies aimed at young people before the age of 16 years to prevent them from becoming NEET are likely to have the largest impact.
- Tackling barriers faced by NEET young people – such as housing provision, debt and health problems.
- Working across organisations – whilst this is already happening in Thurrock, this should be continued to ensure young people's needs are considered in a holistic way.
- Working with local employers – the current work and future approach that Thurrock will roll out should enhance these relationships and help ensure young people have the right skills and opportunities to enter the workplace.
- Track and monitor progress – Thurrock should continue to collect and maintain accurate data and intelligence around our NEET population, and also undertake effective monitoring and evaluation of initiatives aiming to reduce the level of NEET.
- Base interventions on features of other successful programmes – future initiatives should ensure they are based on sound evidence and best practice.

Appendix 1: References

- Action on Smoking and Health, 2014. *ASH Fact Sheet on young people and smoking*, s.l.: Action on Smoking and Health.
- Action on Smoking and Health, 2014. *The economics of tobacco*. s.l.:Action on Smoking and Health.
- Advisory Council on the Misuse of Drugs, 2004. *Hidden harm: responding to the needs of children and problem drug users.* , London: s.n.
- Allen, M., 2014. *Local action on health inequalities: reducing the number of young people not in employment, education or training (NEET)*, London: Public Health England and UCL Institute of Health Equity.
- Anon., 2013. *Essex Joint Strategic Needs Assessment for Children's Emotional Well-Being and Mental Health*, s.l.: s.n.
- Anon., 2014. *Southend, Essex and Thurrock Children and Young People Emotional Wellbeing and Mental Health Service Model, v0.5*. s.l.:s.n.
- Audit Commission, 2010. *Against the odds: re-engaging young people in education, employment or training.*, London: Audit Commission.
- Boyle, D. & Burton, E., 2004. *Making sense of SEN (special educational needs): a guide for donors and grant-makers.*, s.l.: New Philanthropy Capital.
- Butland, B., Jebb, S., Kopelman, P. & al, e., 2007. *Tackling obesities: future choices – project report (2nd Ed)*, London: Foresight Programme of the Government Office for Science.
- Centre for Social Justice, 2014. *Closing the divide: tackling educational inequality in England.* , London: Centre for Social Justice.
- Centre for Tobacco Control Research, 2008. *Point of Sale Display of Tobacco Products*. Stirling: University of Stirling.
- Child and Maternal Health Intelligence Network, 2014. *CAMHS Needs Assessment*, s.l.: s.n.
- Department for Children, Schools and Families, 2010. *Teenage Pregnancy Strategy: Beyond 2010.* , Nottingham: Department for Children, Schools and Families.
- Department for Children, Schools and Families, 2010. *Working Together to Safeguard Children*. [Online] Available at:
<http://webarchive.nationalarchives.gov.uk/20130401151715/https://www.education.gov.uk/publications/eorderingdownload/00305-2010dom-en-v3.pdf>
[Accessed 8 October 2014].
- Department for Children, Schools and Families, 2013. *Working Together to Safeguard Children*. [Online] Available at:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281368/Working_together_to_safeguard_children.pdf

[ether_to_safeguard_children.pdf](#)

[Accessed 8 October 2014].

Department for Education and Skills, 2006. *Teenage Pregnancy Next Steps: Guidance for Local Authorities and Primary Care Trusts on Effective Delivery of Local Strategies.* , Nottingham: Department for Education and Skills.

Department for Education and Skills, 2007. *Gender and education: the evidence on pupils in England.*, Nottingham: Department for Education and Skills.

Department for Education, 2011. *A profile of pupil absence in England*, London: Department for Education.

Department for Education, 2011. *Supporting families in the foundation years*, s.l.: Department for Education.

Department for Education, 2014. *Children with Special Educational Needs 2014: An Analysis.* , London: Department for Education.

Department for Education, 2014. *Special educational needs and disability code of practice: 0 to 25 years.* [Online]

Available at:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/342440/SEND_Code_of_Practice_approved_by_Parliament_29.07.14.pdf

[Accessed 9 October 2014].

Department of Health BASCD, 2014. *Delivering Better Oral Health - An evidence-based toolkit for prevention.*, London: Department of Health.

Department of Health, 1994. *An Oral Health Strategy for England.*, London: Department of Health.

Department of Health, 2001. *The national strategy for sexual health and HIV*, London: Department of Health.

Department of Health, 2010. *The Operating Framework for the NHS in England 2011/12.*, London: Department of Health.

Department of Health, 2011. *No health without mental health: A cross government mental health outcomes strategy for people of all ages*, London: Department of Health.

Department of Health, 2011. *No health without mental health: Supporting document - the economic case for improving efficiency and quality in mental health*, London: Department of Health.

Department of Health, 2011. *Start Active, Stay Active: A report on physical activity for health from the four home countries' Chief Medical Officers*, London: Department of Health.

Department of Health, 2012. *Improving Outcomes and Supporting Transparency. Part 1: A Public Health Outcomes framework for England, 2013-2016.* , London: Department of Health.

- Department of Health, 2013. *A framework for sexual health improvement in England.* , London: Department of Health.
- Dimbleby, H. & Vincent, J., 2013. *School Food Plan.* [Online]
Available at: www.schoolfoodplan.com
- ECC Research and Analysis Unit, 2013. *Essex Schools Health Education Survey.* Chelmsford: Essex County Council.
- Essex CAMHS Joint Commissioning Committee, 2012. *CAMHS consultation - Report on findings from consultation with stakeholders, young people and parents.*, s.l.: Essex CAMHS Joint Commissioning Committee.
- Gray, R., Boneillie, S. R., Chalmers, J. & al, e., 2009. Socio-economic disparities in pregnancy outcome: why do the poor fare so poorly?. *Paediatric and Perinatal Epidemiology*, 14(3), pp. 194-210.
- Green, H. et al., 2004. *Mental Health of Children and Young people in Great Britain.*, London: Office for National Statistics on behalf of the Department of Health and Scottish Executive..
- Health and Social Care Information Centre, 2013. *Smoking, Drinking and Drug use amongst young people in England 2012*, s.l.: Health and Social Care Information Centre.
- Health and Social Care Information Centre, 2014. *Smoking, Drinking and Drug use amongst young people in England 2013*, s.l.: Health and Social Care Information Centre.
- HealthWatch Thurrock, 2013. *Children and Young People's Consultation Report: smoking and obesity.* Thurrock: HealthWatch.
- HM Government, 2014. *Child Poverty Strategy 2014-17*, London: s.n.
- Horta, B. L. e. a., 2007. *Evidence on the long-term effects of breastfeeding.*, s.l.: World Health Organisation.
- Ip, S. e. a., 2007. *Breastfeeding and Maternal Health Outcomes in Developed Countries.* , Rockville: Agency for Healthcare Research and Quality.
- La Valle, I. & Payne, L., 2012. *Listening to children's views on health provision: A rapid review of the evidence.*, London: National Childrens Bureau.
- Mahar, M. T., Murphy, S. K. & Rowe, D. A. e. a., 2006. Effects of a Classroom-Based Program on Physical Activity and on-task Behaviour. *Medicine and Science in Sport and Exercise*, Volume 38, pp. 2086-2094.
- Mainey, A., Ellis, A. & Lewis, J., 2009. *Children's views of services: A rapid review.*, London: National Children's Bureau.
- Marmot, M., 2010. *Fair Society, Healthy Lives: A Strategic Review of Inequalities in England.* , London: University College London.
- Marmot, M., 2010. *Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England post-2010*, s.l.: s.n.

- McManus, S. et al., 2009. *Adult Psychiatric Morbidity in England, 2007: Results of a Household Survey.*, London: NHS Information Centre for Health and Social Care.
- Mirza-Davies, J., 2014. *NEET: Young People Not in Education, Employment or Training.* , London: House of Commons.
- National Institute for Health and Care Excellence, 2013. *Social and emotional wellbeing for children and young people*, s.l.: NICE.
- National Institute for Health and Clinical Excellence, 2010. *Quitting smoking in pregnancy and following childbirth: Guidance.*. London: NICE.
- NHS Health Advisory Service, 1995. *Together we stand*, London: HM Stationery Office.
- NHS Information Centre, 2006. *Infant Feeding Survey*. [Online]
Available at: www.ic.nhs.uk/pubs/breastfeed2005
- NSPCC, 2013. *No one noticed no one heard - a study of disclosures of childhood abuse - October 2013*. [Online]
Available at: http://www.nspcc.org.uk/Inform/research/findings/no-one-noticed-no-one-heard-pdf_wdf98744.pdf
- NSPCC, 2014. *A compilation of the key statistics on child sexual abuse from research and official publications*. [Online]
Available at:
http://www.nspcc.org.uk/Inform/resourcesforprofessionals/sexualabuse/statistics_wda87833.html
- Ofsted, 2013. *Subsidiary guidance supporting the inspection of maintained schools and academies*. s.l.:s.n.
- Ofsted, 2014. *Are you ready? Good practice in school readiness*, Manchester: Ofsted.
- Parry, G. et al., 2004. *The Health Status of Gypsies and Travellers in England: Report of Department of Health Inequalities in Health Research Initiative.*, Sheffield: University of Sheffield.
- Public Health England, 2014. *Local authorities improving oral health: commissioning better oral health for children and young people. An evidence-informed toolkit for local authorities.* , London: Public Health England.
- Sampson, P. D. et al., 1997. Incidence of FAS and prevalence of ARND. *Teratology*, Volume 56, pp. 317-326.
- Secretary of State for Health, 2010. *Equity and Excellence: Liberating the NHS.* , London: Department of Health.
- Secretary of State for Health, 2010. *Healthy Lives, Healthy People – Our Strategy for Public Health in England.* , London: Department of Health.

Sport and Recreation Alliance, 2012. *Sport and Recreation Alliance*. [Online]
Available at: <http://www.sportandrecreation.org.uk/>
[Accessed 2014].

Tackling Illicit Tobacco for Better Health, 2014. *Undermining efforts to cut smoking*. [Online]
Available at: <http://www.illegal-tobacco.co.uk/problem/undermining-tobacco-control/>
[Accessed 10 October 2014].

The Children's Society, 2013. *Hidden from view: the experiences of young carers in England*, s.l.: The Children's Society.

Thurrock Council, 2011. *Summary of Young People's views*.. Thurrock: Thurrock Council.

Thurrock Council, 2013. *Young People's Integrated Substance Misuse Service Specification*.. s.l.:Thurrock Council.

Thurrock Council, 2014. *School Nursing Survey Feedback report*.. Thurrock: Thurrock Council.

Thurrock Council, 2014. *Thurrock CAMHS Strategy for 2014-2017*. Thurrock: Thurrock Council.

Wilkin, A. et al., 2010. *Improving the outcomes for Gypsy, Roma and Traveller pupils: final report: Report of Department for Education*., London: Department for Education.

Young Minds, 2006. *Looking after your mental health*. London: Young Minds.

Appendix 2: Glossary of Terms

Term	Definition
A&E	Accident and Emergency
ALS	Alcohol Liaison Service
ASD	Autistic spectrum disorder
BCG	Bacillus Calmette-Guérin (vaccine)
BME	Black and minority ethnic
BMI	Body mass index
BTUH	Basildon and Thurrock University Hospital
CAMHS	Child and Adolescent Mental Health Services
CCG	Clinical Commissioning Group
Chimat	National Child and Maternal Health Intelligence Network - part of Public Health England
CIN	Child In Need
CIPFA	Chartered Institute for Public Finance and Accountancy
Commissioning	A continuous cycle of activities that contribute to the securing of services, including the specification of services to be delivered, contract negotiations, target setting, monitoring and managing performance.
Confidence Interval (CI)	A 95% confidence interval is a range within which the true population would fall for 95 per cent of the times the sample survey was repeated. It depends on the amount of variation in the underlying population and the sample size, and is a standard way of expressing the statistical accuracy of a survey-based estimate.
CP	Child Protection
CSE	Child Sexual Exploitation
CVS	Councils for Voluntary Services
DAAT	Drug and Alcohol Action Team
Dental caries	A disease that damages tooth structures, resulting in what is commonly called tooth decay or cavities, which are holes in the teeth.
DH / DoH	Department of Health
DSR	Directly Standardised Rate
DTaP	Diphtheria, Tetanus and Pertussis (vaccine)
EAL	English as an Additional Language
Elective admission	A planned admission
Emergency admission	An unplanned admission
FNP	Family Nurse Partnership - a voluntary home visiting programme for first time young mums aged 19 or under (and dads)
GP	General Practitioner
GUM	Genito-urinary medicine
Hib	Haemophilus influenza type b
HIV	Human immunodeficiency virus
HPA	Health Protection Agency
HPV	Human Papilloma Virus
HWB	Health and Wellbeing Board

IMD	Index of Multiple Deprivation - Combines a range of indicators into a single deprivation score, including social and economic measures and a measure for "Health Deprivation and Disability". These measures may be used individually, or can be combined to rank areas relative to each other so that comparisons can be made.
Incidence	The rate at which new cases of a disease occur.
IPV	Injectable polio vaccine
JSNA	Joint Strategic Needs Assessment
Key Stage	Educational assessment stage
KSI	Killed or seriously injured
LA	Local authority
LAC	Looked after Child - a child is looked after when in the care of the local authority
LD	Learning difficulties
LSCB	Local Safeguarding Children Board. An authority-wide forum involving all agencies participating in child protection, used to set and monitor procedures and promote inter-agency co-operation.
LSOA	Lower level super output area - a geographic hierarchy designed to improve the reporting of small area statistics
MAGS	Multi Agency Groups
MASH	Multi Agency Safeguarding Hub
MECC	Making Every Contact Count
MMR	Measles, mumps and rubella (vaccine)
Mortality	The condition of being mortal, or susceptible to death
MSOA	Middle level super output area - a geographic hierarchy designed to improve the reporting of small area statistics
NCMP	National Child Measurement Programme
NCSP	National Chlamydia Screening Programme
NEET	Young people not in education, employment and training
NELFT	North East London Foundation Trust
Net migration	Inward migration minus outward migration
NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence
NICU	Neonatal Intensive Care Unit - an intensive care unit specialising in the care of ill or premature newborn infants
Obese	Body mass index of over 30
ONS	Office for National Statistics
Overweight	Body mass index 25-30
PCT	Primary Care Trust
PCV	Pneumococcal disease
PHE	Public Health England
PHOF	Public Health Outcomes Framework - sets out a vision for public health, desired outcomes and the indicators that will help us understand how well public health is being improved and protected.
Prevalence	The proportion of a population who have a disease.
QOF	Quality Outcomes Framework (indicator)
Section 47 Enquiry	Investigation legally required of a local authority for any child considered at risk of harm

SEN	Special educational needs
SEPT	South Essex Partnership Trust
STI	Sexually transmitted infection
TTAS	Thurrock Traveller Achievement Service
Ward	Electoral and administrative boundary.
WHO	World Health Organisation
YOS	Youth Offending Service

Appendix 3: Document Contributors

Key Contributors:

Name	Team	Organisation
Beth Capps	Public Health Team	Thurrock Council
Clare Moore	Children's Care and Targeted Outcomes	Thurrock Council
Damon Last	Performance, Quality and Business Support	Thurrock Council
Daniel Stoten	Children, Young People, Maternity & CAMHS Commissioning Team	NHS Thurrock CCG
Jason Read	Children's Care and Targeted Outcomes	Thurrock Council
Kevin Malone	Public Health Team	Thurrock Council
Linda Hillman	Dental Public Health	Public Health England
Liz Morrison	School Improvement Team	Thurrock Council
Malcolm Taylor	Learning and Universal Outcomes	Thurrock Council
Maria Payne	Public Health Team	Thurrock Council
Mark Livermore	Children's Commissioning	Thurrock Council
Nicky Pace	Children's Care and Targeted Outcomes	Thurrock Council
Paul Coke	Children's Care and Targeted Outcomes	Thurrock Council
Paula McCullough	Children's Commissioning	Thurrock Council
Ruth Brock	School Improvement Team	Thurrock Council
Tracey Finn	Public Health Team	Thurrock Council

Also thanks to:

Name	Organisation	Name	Organisation
Alan Cotgrove	Thurrock Council	Kim Stevens	Thurrock Council
Andrea Winstone	Thurrock Council	Laura Burroughs	Thurrock Council
Andrea Winterflood	Thurrock Council	Laura Hudson	Ngage
Anne Brewer	NHS Central Eastern Commissioning Support Unit	Louise McCarthy-Martin	Thurrock Council
Carmel Littleton	Thurrock Council	Mikaela Burns	Thurrock Council
Charlotte May	Carers of Barking and Dagenham	Natalie Carter	Open Door Services
Chris Evans	Thurrock Council	Natasha Harmsworth-Blyth	Thurrock Council
Colin Jones	Thurrock Council	Neale Laurie	Thurrock Council
Debbie Maynard	Thurrock Council	Pam Hall	NHS England
Debbie Saban	NHS England	Pat Kielty	Thurrock Council
Denise Langan	Thurrock Council	Rhodri Rowlands	Thurrock Council
Frances Leddra	Thurrock Council	Roland Minto	Thurrock

			Council
Gail Clayton	Thurrock Council	Sarah Allen	Thurrock Council
Helen Forster	NHS Central Eastern Commissioning Support Unit	Sharon Cumberbatch	Carers of Barking and Dagenham
Ian Badman	Thurrock Council	Sue Bradish	Thurrock Council
Joanne Pitt	Thurrock Council	Sue Matthews	Thurrock Council
Kate Kozlova	Thurrock Council	Sue Wellard	Thurrock Council
Kelly Clarke	Thurrock Council	Tiffany Bright	Thurrock Council
Khurram Jamal	NHS Thurrock CCG	Tom Hopkins	Thurrock Council

Appendix 4: Version Control

Version Number	Date Released	Editor	Summary of amendments
1.0	12/03/15	Maria Payne	First full version of document
1.1	12/02/16	Maria Payne/Kelly Clarke	Update to NCMP data
1.2	23/05/16	Maria Payne	Update to NCMP data