

# **Somerset: Our County**

Joint Strategic Needs Assessment

## **Summary 2016 Vulnerable Children and Young People**



**Somerset Health and Wellbeing Board**



# FOREWORD

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SOMERSET: OUR COUNTY

Joint Strategic Needs Assessment (JSNA) 2016 Summary

**Councillor Ann Bown**

**Chair of Somerset's Health and Wellbeing Board**

Welcome to this year's JSNA.

"Somerset: Our County", is a summary of the Joint Strategic Needs Assessment (JSNA) for Somerset 2015/16. This year the JSNA focuses specifically on the needs of vulnerable children and young people in our county.

The JSNA is a statutory responsibility for all Health and Wellbeing Boards. It brings together information about the place, the people and their social and health status to give us a well-rounded picture of what it is like to live in Somerset. This information will be used to inform the development of services according to need and to give a longer-term view of what Somerset could be like in the future, so we can shape the way we want our county to develop.

For the purposes of this work the term "children and young people" includes from pre-birth to 18 years in the most part but, in line with local authority responsibilities, the upper age has been extended to include those under 25 where appropriate.

The term "vulnerability" is also used very broadly for this report and refers to those young people suffering harm or ill-health, or who are at risk of doing so. This can include sexual exploitation and under-achievement at school as well as disease or unintentional injury. Ofsted refers to vulnerable children and families as "target groups with additional needs."

Most of the information assembled and analysed in the JSNA is held on the web at [www.somersetintelligence.org.uk](http://www.somersetintelligence.org.uk). Far more detailed data is held there than can be included in this summary and this report contains links to pages holding more information and discussion of the themes covered, to make it easier for the reader to access more detail if required.

We hope you find this JSNA interesting and informative. We all have a role to play in using this evidence to improve the health, safety and wellbeing of children in Somerset.

Best wishes

A handwritten signature in black ink that reads "Ann Bown".



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# NOTE FROM THE AUTHORS

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We hope you find this JSNA interesting and informative. We recognise that this is a quite long, and in places, technical document but to help with its use we have concluded each section with recommendations for commissioning.

Also back by popular demand is the JSNA “Snippet” – watch out for him throughout the document! He will provide you with some useful facts and figures.

We are always grateful for any comments and feedback you might have on the JSNA in order to improve it in future years.



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# EXECUTIVE SUMMARY

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This JSNA tells us an important story about the population of vulnerable children and young people in our county; how they live, how well they reach their potential and what their health and social needs are.

The Office of National Statistics (ONS) mid-year 2014 population estimates show that there are 540,000 people living in Somerset. Of these, 110,000 are children under the age of eighteen and 30,000 are young children and infants aged 0-4. There are 56,000 boys and 53,000 girls under the age of eighteen.

Overall, Somerset is relatively affluent and enjoys lower than average levels of deprivation. There are, however, 25 neighbourhoods within the 20% most deprived in England; the highest intensity of deprivation is found within the county's larger urban areas<sup>1</sup>. According to the supplementary Income Deprivation Affecting Children Index (IDACI) Somerset has 10 neighbourhoods within the most deprived 10% and 19 within the most deprived 20% in England. All 19 areas are urban.

Because children and young people live in families and communities and there are many complex influences on vulnerability, we have considered the information in this JSNA within a framework of "*Think Individuals, Think Families, Think Communities*". Considering vulnerability in this way helps to give us a more rounded picture of the issues that have an influence on children and young people.

## **So what does the JSNA tell us?**

**For individuals**, the overriding message from this assessment is the need for us to tackle the inequalities that exist for children and young people. It is important that high-level population level data is not presented without looking specifically at particular groups who experience different outcomes than the average, where numbers are big enough to do this. Looking behind the headline figures shows significant inequalities, particularly in relation to educational attainment, but also other issues such as smoking in pregnancy, breastfeeding and tooth decay.

All the evidence is consistent with a pattern of the majority of children having safe and healthy lives; a minority having higher risk, which may be temporary; and a much smaller number having a far greater intensity and complexity of need. Raising the conditions for vulnerable children across the county is best achieved by improving the life chances of the most vulnerable fastest, as they have been shown to hold a strongly disproportionate burden of issues, both in terms of number and severity, through this JSNA.

## **Key findings:**

- Between 5,000 and 10,000 children are in particular need, with the majority of those living in the most deprived wards in the county's towns.
- Those children in need living in rural areas face particularly difficult issues with less contact with existing services.
- Evidence shows us that a renewed focus centred on these deprived areas would benefit those in need.

- The more that information and signposting is made easily accessible, the more individuals, families and communities can help themselves.

**For families**, the best and most complete information we have is from the Troubled Families (Family Focus) Programme. This national programme identifies Somerset as having 2,790 families that have three or more of the eligible areas of need. Looking at the data from this programme in detail gives us a more comprehensive understanding of the “layering” effect of issues that children can experience. Looking at the combination of issues that arise for these families shows a distinction between those that live more chaotic lifestyles and those where harm to children can be more serious. There is a trend for families experiencing more abusive or criminal issues to be grouped together geographically, whereas the more generally chaotic families are more widely dispersed across the county. This provides us with very useful information regarding the capacity of services needed in particular areas of the county.

The vulnerabilities of parents are known to have an impact on children. In particular, households with issues associated with domestic abuse, mental health problems and substance misuse have been found to cause harm to children. A recent Hidden Harm Needs Assessment has identified that improvements are required in adults’ services relating to these issues to be able to identify vulnerable children early.

We have a huge amount of information on different issues impacting on vulnerability at a family and individual level but we are currently unable to connect this information together. By way of an example, we know 1,400 reception age children and young people in the county are overweight or obese; we also know that 1,550 of this group have decayed teeth. Whilst it would be logical to say these issues are linked and they are largely the same children, we cannot say this for definite as we are not currently able to connect information on an individual level. This is just one simple example; the issue stretches right across concerns that impact on the vulnerability of children and young people, making it very difficult to get a more complete picture on the extent and depth of vulnerability in the county.

A greater integration and sharing of information, possibly using a unique identifier such as the NHS number, would enable us to identify vulnerability to a greater extent and provide more appropriate support at an earlier stage.

### **Key findings:**

- Somerset has 2,790 families that have three or more of the eligible areas of need.
- Improvements have been instigated across services for adults, where families are at risk of developing problems, to identify vulnerable children.
- Investing in early help services will deliver a high return for children’s development.
- Families with chaotic lives or who are suffering temporary setbacks can “drift” into further need – this can strengthen the case for universal services.
- Potential to use the NHS number and Unique Pupil Reference Number has worked in other parts of the country and should be looked at again for Somerset.



- Services continue to need to “join-up” and to work together. The Somerset picture is improving but more can be done.

**For communities**, most of the analysis at a community level in this JSNA has used the Index of Multiple Deprivation (IMD)<sup>1</sup> to describe patterns of need, in particular the IDACI. This identifies about 14,300 children in low income households; although not all are necessarily “vulnerable” we know that poverty is a strong indicator of wellbeing and opportunity. What is most striking is the geographical concentration of these children and young people, with 10% being in only 0.07% of the county’s area, in Taunton, Bridgwater and Yeovil; half live in only 5% of the area, meaning that another 50% are dispersed over 95% of the county.

The information contained in this JSNA can give a clear steer to a more strategic approach to supporting vulnerable children. Given the high proportion of vulnerable children living in a relatively small number of communities, it is important that public services are concentrated and well-coordinated in these areas. Similarly, as a county which is split between rural and urban residents, we need to recognise that life is very different in different parts of the county. To support vulnerable children and young people who live in these different areas, we need to work in different ways. We shouldn’t assume that “one size fits all.”

#### **Key findings:**

- There is a continued need for skilled face-to-face delivery of services in homes, community buildings and shared public sector hubs, amongst others.
- Further investment in self-help and better signposting and information for individuals, families and communities is a growing priority.
- There is no “one size fits all” solution for individuals or groups; each has particular needs.
- Building community capacity to support vulnerable people close to home is ever more important.
- Linking information about families and communities can help target services more effectively.

**Table 1: Benchmarks - Based on the Public Health England Child Health Profile April 2016**

Where Somerset does better	Where Somerset does worse
Children in poverty (14.1%; England 18.6%)	Hospital admissions due to substance misuse (15-24 years) (118.5/100k; England 88.8)
Homeless families (1.4%; England 1.8%)	Smoking at delivery (14.1%; England 11.4%)
Children in Care (45/10k children <18; England 60/10k)	A&E attendances (0-4 years) (557.6/1000; England 540.5/1000)
Children killed/seriously injured in road traffic collisions (7.4/10k population; England 17.9)	Hospital admissions – injuries (age 0-14 years - 124.4/10k; England 109.6) (age 15-24 years - (172.6/10k; England 131.7)
MMR Vaccination, one dose (2 years) (94.7%; England 92.3%)	Hospital admissions as a result of self-harm (10-24 years) 605.8/10k; England 398.8)
Dtap / IPV / Hib vaccination (2 years) (97.2%; England 95.7%)	The Somerset Children and Young People's Survey found 29% of primary aged children reported high self-esteem (38% nationally)
Low birth weight babies (2.1%/<2500g; England 2.9%)	
Obese children (10-11 years) (17.0%; England 19.1%)	
Breastfeeding initiation (80.8%; England 74.3%)	
Breastfeeding prevalence at 6-8 weeks (49.4%; England 43.8%)	
Hospital asthma admissions under 19 years (106.5/100k; England 216.1)	

# BACKGROUND AND CONTEXT

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## About the Joint Strategic Needs Assessment (JSNA)

The JSNA provides a broad overview of needs and resources within Somerset. It exists principally within the [Somerset Intelligence website](#), where there is more information on every topic covered in this report. Even at this length, this is merely a summary. This summary uses the latest data available at the end of 2015; the website will contain more up to date information where it becomes available. The website includes more historical information and trends than could be included here.

The JSNA shows broad patterns and types of need. It describes broad numbers, locations and types of vulnerability and associations of disadvantage with each other. It is important to state the boundaries of the JSNA:

- The JSNA is a public document. It does not include statistical information about individuals and suppresses any data where there is a risk of identifying individuals.
- The JSNA derives some information from national sources which is apportioned or modelled to the Somerset scale. Whilst imprecise, this may give a valid indication of need that is not already identified in the county.
- The JSNA derives some information from local administrative sources, but is in no way a substitute for the information which deals with individual or family cases within different agencies.

There are innumerable influences on children's wellbeing and there is often no clear distinction between cause and effect. However, protective factors such as secure attachment to a parent are well-established and can mitigate against a number of influences on poorer outcomes.

Evidence is typically collected for individuals, families and communities and this classification will be used in the remainder of the report.

## Data Sources

### Qualitative

Where possible this report tries to include the "voice" of vulnerable young people. There are numerous groups in Somerset that represent young people and they have been very helpful in providing reference to existing reports and events. Amongst others, the Youth Parliament, Young Healthwatch, the In-Care Council and Leaving Care Council have provided insights, as has a recently formed group for young people with special educational need and disabilities – "The Unstoppables".

Qualitative sources allow young people to raise issues that closed, quantitative questions may miss out entirely. A national survey by the Girl Guides<sup>2</sup> found that their members felt that adults often fail to keep pace with new threats to girls' wellbeing. For instance, 82% of girls aged 11 to 21 said adults don't recognise the pressure they are under, and while girls aged 13 to 21 think their parents' biggest concerns remain drug use, alcohol and smoking, they themselves say that mental health issues, cyber bullying and getting a job are the top

overall concerns facing young people today. Qualitative data gives a richer picture which can explore more fully the complexities faced by children and young people.

## Quantitative

Much statistical data is published on the subject of young people and it has a powerful use in measuring the scale of action needed and in comparing Somerset with the national picture. However, this data suffers from two particular disadvantages:

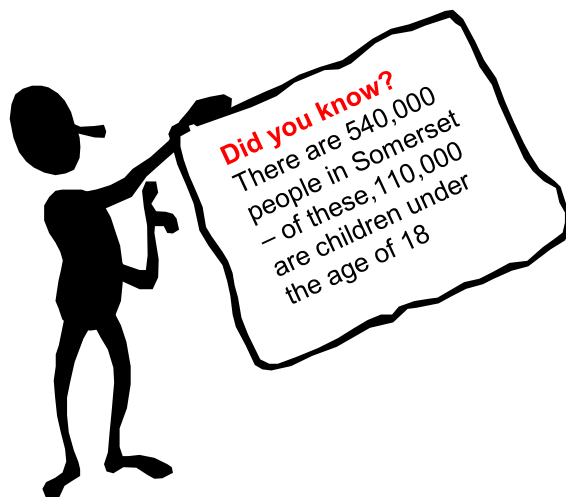
- Firstly, most statistics are derived from the systems that administer services – social services, for instance. This means that they use “providing help” as a proxy for “needing help”; this is often, but not necessarily, the same thing and runs the risk of overlooking those with unidentified need.
- It is unlikely that the observed patterns are wholly different from reality, but the concentration of deprivation in a small number of areas may be self-reinforcing, as services are more focused on these areas and become better at identifying needy children and families.
- The second disadvantage is that the statistics, like the services, often exist in silos. So, for example, it is possible to say that Somerset has about 1,400 overweight and obese children of reception age, and about 1,550 with decayed and missing teeth of a similar age. We cannot, though, say that there is a single cohort of about 1,500 whose diet, exercise and dental hygiene need attention, or two entirely separate groups who need different approaches. We generally suspect the former, and the report includes analysis of “troubled families” data which, unusually, enable such joining up.

*These caveats about data quality are not minor considerations. They reflect the frequent tendency to think about children and young people’s vulnerability in silos and to address them in the same way. Improving data quality is essential to “Think individual” and “Think family”.*

## About Somerset

Somerset covers an area of 1,333 square miles (3,452 square kilometres) and is the 12th largest geographical county in England. According to the ONS 48% of Somerset’s population is classified as living in a rural area compared with 52% in urban areas. This makes it one of the 10 most rural local authorities in England<sup>3</sup>.

ONS mid-year 2014 population estimates show there are 540,000 people resident in Somerset. 110,000 residents are children under the age of eighteen and 30,000 of these are young children and infants aged 0-4. There are 56,000 boys aged under the age of eighteen which is slightly more than the 53,000 girls in Somerset. Overall there were 6,000 live births in Somerset during 2014<sup>4</sup>.



At the time of the 2011 census there were nearly 150,000 young people aged 0-24 in Somerset: 94% were White British and 3% were Other White, while 2% were from mixed ethnic backgrounds and 1% were Asian or Asian British. This was different from the England picture in which 75% of people had a White British ethnicity, 4% Other White, 10% Asian or Asian British and 5% Black, African, Caribbean or Black British ethnicity. The remainder is of mixed ethnicity<sup>5</sup>.

The rural population continues to increase at around half the rate of the county's urban population. The proportion of people aged below 35 in rural areas is lower than in urban areas<sup>3</sup>. There are around 44,000 children (aged 0-15) living in rural Somerset and around 23,000 young people aged 16-24<sup>3</sup>.

Somerset has one of the highest ratios of rural to urban schools of any local authority in England. The Department for Education (DfE) classifies 70% of state-funded primary and 54% of state-funded secondary schools in Somerset as rural<sup>3</sup>.

The 2015 Somerset School Population Forecast for the total mainstream roll (pupils aged 4-17) is 67,187. This is 472 pupils higher than in 2014 and there is expected to be an increase of 2,568 (3.8%) by the end of the forecast period in 2019<sup>6</sup>.

The IMD<sup>1</sup> 2015 shows that Somerset is generally better than the national average in terms of overall levels of deprivation. However, the number of neighbourhoods within the 20% most deprived in England increased to 25 in IMD 2015. The highest extent and, in general, intensity of deprivation are found within the county's larger urban areas<sup>1</sup>. According to the supplementary IDACI, Somerset has 10 neighbourhoods within the most deprived 10%, and 19 within the most deprived 20%, in England. All 19 areas are urban.



# SECTION 1 – THINK INDIVIDUALS

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All children are likely to face difficulties and setbacks as they grow up, but all vary in their ability to “bounce back” when “knocked down”. This ability to bounce back is a crucial part of personal wellbeing throughout life. Children and young people typically develop personal resilience in a supportive family environment.

Much information is collected at the level of the individual child rather than the family and this information is an important part of the analysis here. It is also almost impossible to separate causes and effects: for example, is a child overeating because of bullying, or being bullied because of being overweight? The answer to such a question is likely to vary from child to child and even where an answer is possible it is unlikely to be very meaningful.

This section will consider a range of factors that are associated with good health and wellbeing and attempt to use them to indicate the numbers and locations of vulnerable children.

## The Lifestyles of Children and Young People

### Physical Activity

The 2014 Somerset Children and Young People Survey<sup>7</sup> (SCYP Survey) found that enjoyment of physical activity generally declined as pupils progressed through the school system: 83% of Year 6 pupils said they enjoyed physical activities, compared to 73% in Year 8, and 66% in Year 10.



In Year 6, 27% of girls had exercised hard at least five times in the last week. However, just 9% of Year 8 and Year 10 girls said this for at least five days in the last week. Activity improved slightly in Further Education (FE): 13% of girls in the FE sector said they had exercised at least five times in the last week.

Levels of activity were higher for boys: 43% of Year 6 boys had exercised hard at least five times in the last week. 16% of Year 8 and 20% of Year 10 boys said this for at least five days in the last week. 26% of boys in the FE sector said they had exercised at least five times in the last week.

When asked about barriers to exercise, 29% of pupils in Years 8 and 10 said that they didn't have time. 10% of pupils said transport was a problem and 14% said they weren't comfortable about how they looked. Girls were much more likely to cite how they looked as a barrier (23% compared to 8% of boys).

The value of physical exercise was noted by one of the participants in the Somerset Children and Young People’s Health and Wellbeing focus groups:

*“If you’re eating healthier and taking I think its sixty minutes of exercise a day, that makes you feel better and release endorphins. If you’re just eating junk everyday it will have an effect on your brain.”*

## Overweight and Obesity

<http://www.somersetintelligence.org.uk/>

Established in 2005/06, the National Child Measurement Programme (NCMP) for England records the height and weight measurements of children in Reception (typically aged 4-5 years) and Year 6 (aged 10-11 years) and enables detailed analysis of child weight.

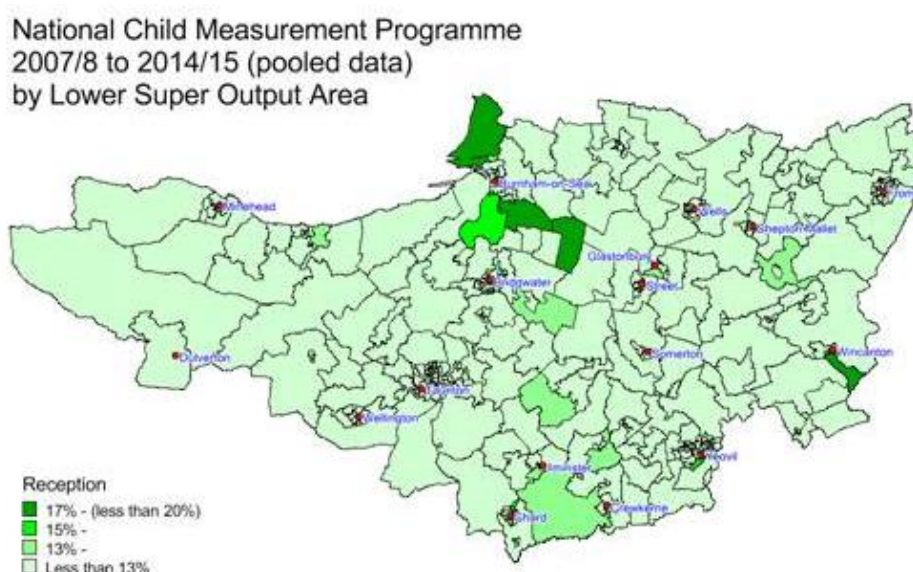
In Reception, over a fifth (23.2%) of children measured were either overweight or obese, which is higher than the South West regional average (22.3%) and the national average (21.9%) but similar to statistical neighbours for 2013-14.

In Year 6 this proportion increases to three in ten (31.4%), which is higher than the South West regional average (30.5%), but below the national average (33.2%) and was better than statistical neighbours for 2013-14.

The percentage of obese children in Year 6 (17.0%) is well above that of Reception age children (9.0%).

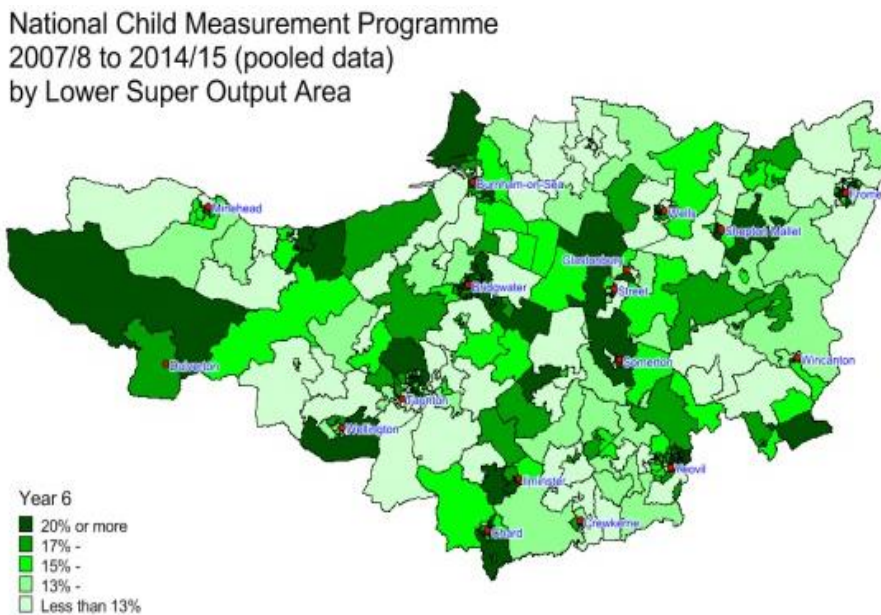
The maps in Figure 1 and Figure 2 show an increase in the proportions of overweight and obese children at Reception and Year 6.

**Figure 1: Overweight and Obesity in Reception Age Children**





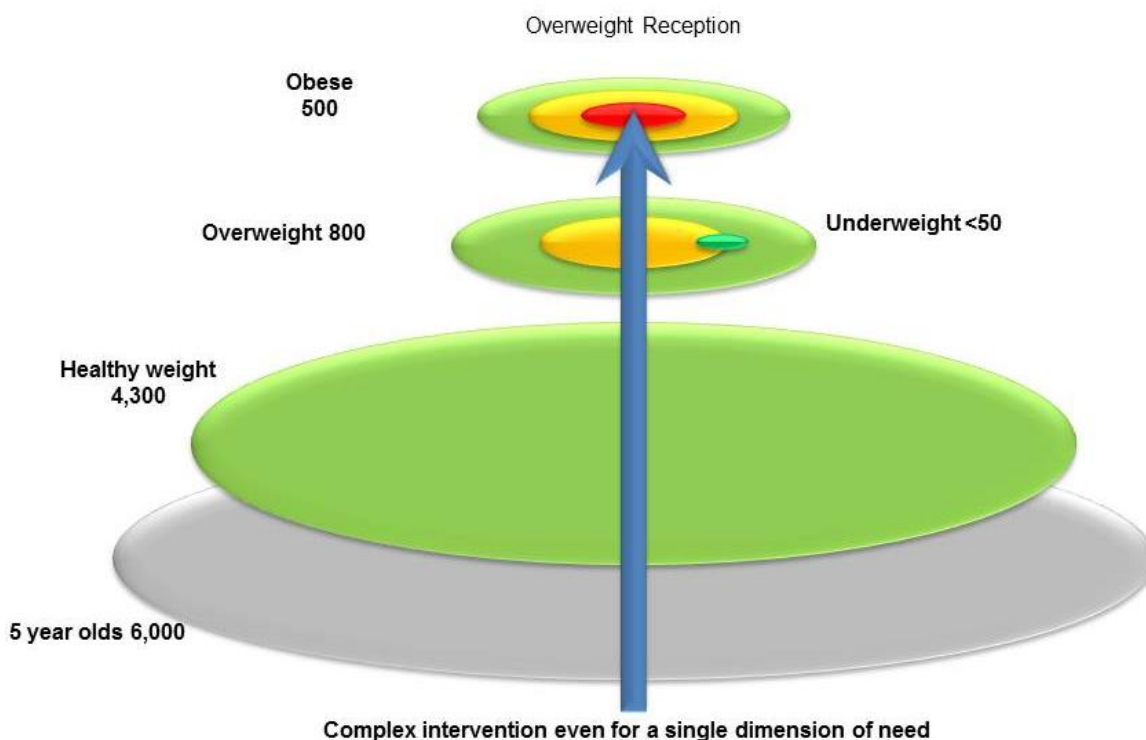
**Figure 2: Overweight and Obesity in Year 6 children**



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These maps show there is a very strong association between the increase in overweight and obesity of the two age bands and deprivation, as shown later in Figure 22 (p.61).

**Figure 3: Overweight and obesity in reception-age children in Somerset 2014/15. Figures show numbers of children; the weight of about 200 children was not recorded (figures do not sum due to rounding)**



The numbers in each of the weight categories for Reception-aged children and examples of the services appropriate for each level are shown in Figure 3. The diagram shows the need for strong universal services such as primary schools, playgrounds and public health nursing in preventing increases in weight at Year 6.

Additionally, if the pattern of multiple need evident in the troubled families database applies, it might be expected that these children also have additional needs that will complicate the type of need still further.

In the academic year 2014/15, 57 primary schools prioritised healthy weight by engaging in projects and investing in resources that increased children’s understanding of the importance of regular physical activity and a balanced diet. This equates to 12,090 pupils who have increased access to cooking, growing food, farm visits, outdoor learning and dynamic play opportunities.



### Substance misuse by young people

In the 2014-15 financial year, the Somerset Drug and Alcohol Service (SDAS) recorded 1,475 individuals in structured treatment (Tier 3 specialist drug and alcohol interventions).

Of these 62 were 17 or under and 99 were between the ages of 18 and 24 (at the end of March 2015). Opiate use in the 17 and under cohort in treatment is very small and this has been the case for some years, whereas alcohol and non-opiates (especially cannabis use) are the two significant substances of young people in treatment.

Numbers of opiate users in the 17 year old and under cohort in treatment are very small and this has been the case for some years, even though *any* opiate use would put a young person in this category.

Non-opiates (especially cannabis) are, along with alcohol, the most significant substance of young people in treatment. These are, of course, the numbers *in treatment* and this will inevitably be only a proportion of the total users.

The 2014 SCYP Survey<sup>7</sup> found that rural pupils were more likely to have been offered cannabis and to know someone who took drugs than urban pupils.

**Table 2: Young People in Treatment 2015** Numbers rounded to nearest five; \* is less than five

AGE	Alcohol & other illicit (includes opiates)	Alcohol & non-opiates	Alcohol only	Non-opiates only	Opiates
17 and under	20	20	10	30	*
18 - 24	40	30	10	30	30
Total	60	50	20	60	30

## **Novel Psychoactive Substances - NPS (Legal Highs)**

NPS are drugs which are designed to replicate the effects of illegal substances. People may refer to these drugs as “legal highs”, but many of the NPS products can also contain illegal substances even if advertised as a “legal high”. In the Queen’s Speech on 27 May 2015, it was announced that new legislation will ban the new generation of psychoactive drugs.

The Psychoactive Substances Act<sup>8</sup> received Royal Assent on 28 January 2016. The Act applies across the UK and makes it an offence to produce, supply, offer to supply, possess with intent to supply, possess on custodial premises, import or export psychoactive substances; that is, any substance intended for human consumption that is capable of producing a psychoactive effect. The maximum sentence will be seven years imprisonment.

Data from services that deliver interventions to address drug use indicates that the use of NPS is limited even when identifying the range of substances in young people’s profiles.

Data on those young people in treatment, for example aged 17 and under from April 2014 to September 2015, recorded 13 instances of young people using NPS as a first, second or third drug. The data, however, does not undermine the personal and community impact NPS use has. On-going data monitoring is critical to better understand the use and prevalence of NPS in Somerset.

The ONS reported that there were 60 deaths in England and Wales registered as related to legal highs, with half having this mentioned as the only contributing factor.

The Somerset rate of hospital admissions due to substance misuse (age 15-24 years) for 2011/2012-2013/2014 was 118.5 per 100,000 (standardised rate), significantly higher than the England figure of 81.3 per 100,000.

Substance abuse is considered separately in this report, using information on young people in contact with services. The significantly high rate of hospital admissions is included here as a health indicator and one which can be related to injuries and self-harm, both of which are also significantly high for the county.

## **Alcohol**

The 2014 SCYP Survey<sup>7</sup> indicated that the proportion of young people who drink alcohol in a week rises rapidly with age from 6% of Year 6 pupils (aged 9-11) to 43% of Year 12s (aged 17-18).

As with adults, drinking alcohol is not restricted to the most vulnerable groups but those 14-15 year olds who do drink alcohol are more likely than other young people to have smoked, had sex or taken drugs.

The most common location for drinking alcohol in the past week was at home (27%), followed by at a friend’s home (17%) and in a pub or bar (16%). Almost half of 44% of 14-15 year old drinkers said their parents don’t always know that they are drinking alcohol; however, national and local evidence shows the clear relationship between parental use of alcohol and the impact and influence on young people’s use of alcohol.

## Tobacco

Figures published by Public Health England (PHE) in January 2015 estimate smoking rates among young people in local areas for the first time. The figures are modelled estimates of youth smoking rates for every local authority, ward and local NHS, based on factors known to predict smoking in young people.

In Somerset, the wards with the highest estimated prevalence are in Bridgwater (Westover, Eastover, Victoria and Hamp) and Taunton (Halcon and Eastgate)<sup>9</sup>. Further details are available<sup>9</sup>. 1,641 children are estimated to start smoking in the county each year; that's around 32 a week.



National survey data has shown continuing falls in smoking amongst school-age young people, to the lowest levels ever recorded. A national survey of 15 year olds in 2014 found that 24% had ever smoked, with 8% (10% female, 7% male) being current smokers.

This was also reflected in the 2014 SCYP Survey<sup>7</sup>: 1% of Year 6 pupils, and 4% of secondary pupils reported smoking in the last seven days. Smoking among college students was higher at 18%, over half of whom expressed a wish to quit. This suggests that the combined effects of tobacco control measures, for example age of sale and tax increases raising retail prices, has led to a delay in uptake of regular smoking amongst young people. It also suggests a need to address uptake in the transition from school to college or workplace.

The 2014 SCYP Survey<sup>7</sup> showed that very few young people were using E-cigarettes. In Year 10, 4% of never smokers had tried E-cigarettes, but there were no current users. By contrast around half of smokers had tried them, with regular smokers who want to quit being the most common users (30%). The local evidence to date would suggest that E-cigarettes are not attracting young people who do not already smoke.

Smokefree Homes campaigns have been running in the county now for six years. Currently the campaigns are led by Smokefree Southwest.



Across the region the number of people allowing smoking inside the home has fallen sharply during this period. In Somerset, the survey showed that about 12% of children reported that smoking takes place inside the home, with a further 6% reporting that smoking took place on the doorstep.

DECIPHer-ASSIST is an evidence-based smoking prevention programme which aims to reduce adolescent smoking prevalence, by training influential Year 8 students to work as "peer supporters", informing their peers about the risks of smoking and the benefits of being smokefree.

## Teenage Conception and Birth

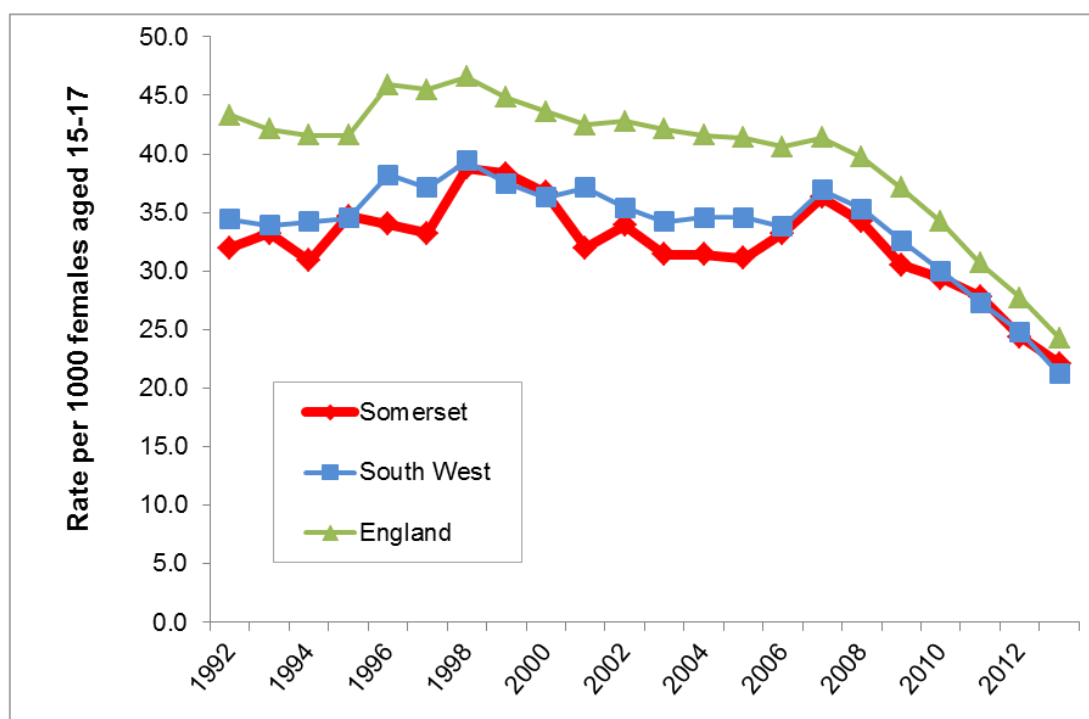
<http://www.somersetintelligence.org.uk/sexual-health.html>

Teenage pregnancy is strongly associated with the most deprived and socially excluded young people. Difficulties in young people's lives, such as poor family relationships, low self-esteem and unhappiness at school, also put them at greater risk. Rates of teenage pregnancy are far higher among deprived communities, so the negative consequences of teenage pregnancy are disproportionately concentrated among those who are already disadvantaged. The poorer outcomes associated with teenage motherhood also mean the effects of deprivation and social exclusion are passed from one generation to the next.

- There were 746 conceptions amongst 15-17 year-old females recorded in Somerset in the three year-period 2011-13. The conception rate was 24.8 per 1000 females in the age group, below the England average and in line with the South West rates. Since 2008, there has been a steady decrease in teenage conception rates in Somerset and nationally (see Figure 4).
- In 2013, the maternity rate per 1000 women in Somerset was 10.9, slightly below the England average of 11.9. The abortion rate was 11.1, below the national figure of 12.9. 51% of conceptions led to abortion, in line with the regional and national proportions but slightly higher than in recent years.

Evidence shows that having children at a young age can damage young women's health and wellbeing and severely limit their education and career prospects. Whilst young people can be competent parents, studies show that children born to teenagers are more likely to experience a range of negative outcomes in later life and are up to three times more likely to become a teenage parent themselves.

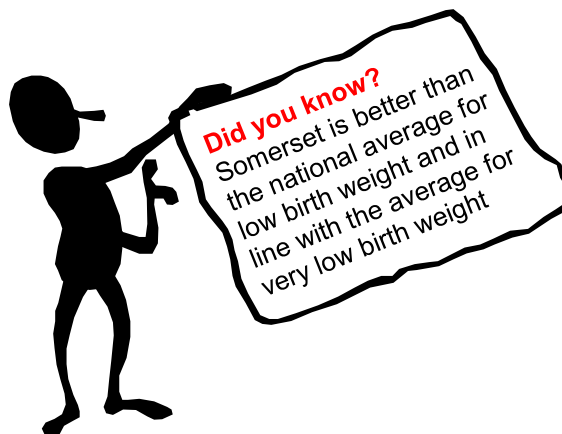
**Figure 4: Trends in Teenage Conception Rate**



The Somerset Health Visiting Team provides a dedicated service to teenage or young parents up to 25 years of age. The Young Parents' Programme offers ante-natal and post-natal support to any young parent and offers a bespoke parenting support programme, delivered one-to-one or in a group setting. The team continues to offer support and advice to the young person until their child's two year integrated review.

### Low birth weight

Low birth weight is defined as a weight under 2,500 grams. Many factors are associated with low birth weight including multiple pregnancy, maternal country of birth, poor maternal nutrition, lower socio-economic status and maternal smoking and drinking. Low birth weight is also associated with premature delivery.



Somerset is better than the national average rate for low birth weight (<2500g) and in line with the average for very low birth weight (<1500 grams).

The proportion of all births which were of low weight has changed little in the past four years, across Somerset, the South West region and England.

**Table 3: Births of Low Weight 2012 and 2013 (%)**

	<1500g/53oz		<2500g/88oz	
	2012	2013	2012	2013
<b>England</b>	1.3	1.3	7.3	7.4
<b>South West</b>	1.0	1.0	6.4	6.2
<b>Somerset</b>	1.1	1.1	6.6	6.4

### Perinatal and Infant Mortality

<http://www.somersetintelligence.org.uk/pregnancy-maternity.html>

Perinatal mortality is defined as a death within the first seven days of life. Infant mortality is defined as a death in the first year of life. These mortalities have reduced steadily over decades, in response to improved sanitation, diet and the availability and quality of healthcare. However, inequalities remain and one of the major determinants of infant mortality is social deprivation. Low income groups have higher rates of children born with low birth weight and infant mortality compared with higher income groups.

There were 111 perinatal mortalities in Somerset for 2011-13. The perinatal mortality rate in Somerset for 2011-13 is 6.5 per 1000 total births, not significantly different from the regional and national rates of 6.4 per 1000 and 7.1 per 1000 births, respectively.

There were 68 deaths in infants under one year in Somerset in the 2011-13 period. Somerset's infant mortality rate of 4.0 per 1000 is in line with both regional and national averages.

A Health and Wellbeing Event, through Healthwatch Somerset and The Care Forum held at Yeovil College in 2015, gathered the views and experiences of health and social care students. They were asked:

### **When you hear the word ‘healthy’ what do you think of?**

- *Eating decent foods and not being overweight*
- *Being in the best state, physically, mentally and emotionally*
- *When an individual is obtaining the right balance of food, drink and exercise*
- *Food/diet – running up the stairs and not being out of breath*

### **When you hear the word ‘wellbeing’ what do you think of?**

- *How you feel as a whole; physical, emotional etc*
- *Keeping yourself healthy and under control, looking after yourself*
- *Emotional problems – good and bad*
- *Feeling OK*

### **What are the biggest issues, problems or difficulties that face you and your friends?**

- *Financial and mental; the stress of life ahead*
- *Communication being one-sided; attitude; not being honest*
- *Cheap food; alcohol; not being able to drive*
- *University: stress of money – living; not knowing what will happen each day*
- *Stress from college and work, managing my own time and finding time for ourselves*

### **Mental health – self-care and resilience<sup>i</sup>**

- *Making plans with friends, things to look forward to*
- *Distractions. I have a list of things I can do if I’m feeling down that make me feel better, like playing sport or listening to music...being able to think about it more, then going and finding help from someone and talking about it more.....*
- *I find being with other people who are a good influence, good friends, people who actually make you feel like they care.*
- *Take a step back; it’s probably not such a big deal as you think it is*

## **Health**

### **Immunisation**

<http://www.somersetintelligence.org.uk/infectious-diseases.html>

Immunisation is a universal service that provides protection at both the individual level and at the community level through so-called “herd immunity”, when the proportion of those immunised is so high that any infection brought into a community will be unable to establish itself.

<sup>i</sup> Somerset Focus Groups with young people – ideas and experiences around mental health 2015 – commissioned by Public Health, Somerset County Council

Herd immunity is normally achieved when 95% of the eligible population are immunised for a particular antigen. Somerset rates are higher for almost all categories than England, although only a minority exceed the 95% level.

**Table 4: Immunisation rates for Somerset<sup>10</sup>**

Vaccination			Somerset	England
By 1 <sup>st</sup> birthday	DTaP/IPV/Hib	Primary	94.7%	94.2%
	PCV	Primary	95.3%	93.9%
By 2 <sup>nd</sup> birthday	DTaP/IPV/Hib	Primary	97.2%	95.7%
	MMR	1st dose	94.7%	92.3%
	Hib/Men C	booster	93.6%	92.1%
	PCV	booster	94.8%	92.2%
By 5 <sup>th</sup> birthday	DTaP/IPV/Hib	primary	97.4%	95.6%
	DTaP/IPV	booster	93.0%	88.5%
	MMR	1st dose	96.6%	94.4%
	MMR	1st and 2nd dose	92.1%	88.6%
	Hib/MenC	booster	92.0%	92.4%

### Immunisation for Children in Care

The percentage of children in care who have age appropriately completed immunisations as at the end of Q3 2015/16 was 81.2%, below the (self-imposed) target of 90%.

Children in care are often very mobile, in addition to their other needs and immunisation rates are typically lower than that of the general population. The value of herd immunity is considerable for such groups who are less likely to achieve personal protection from disease.

### Oral Health

<http://www.somersetintelligence.org.uk/oral-health.html>

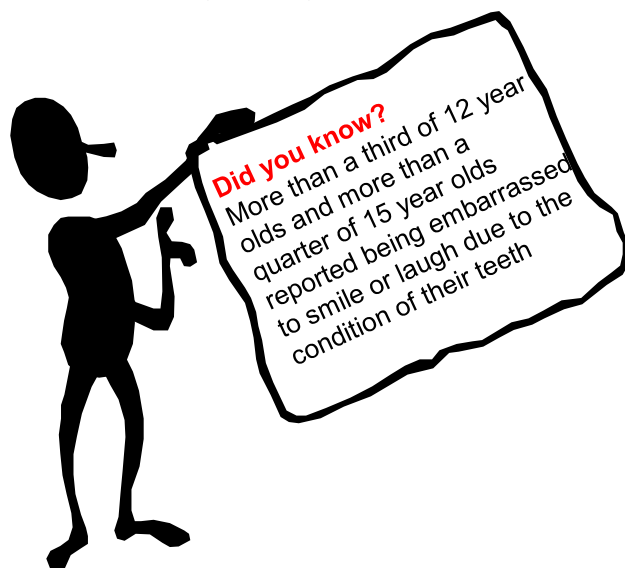
Dental extractions were the leading cause of admissions to hospital for children in England aged 5- 9 in 2013/14. At a district level the proportion admitted for dental extraction in this age group ranges from 0.9% in Sedgemoor to 0.2% in South Somerset. When explored by “getset” catchment area, rates are highest in Sedgemoor South, Taunton North and East and Quantock West.

Although decay in five year olds has reduced over time, the prevalence of decay in this age group is still 30.9% nationally. In Somerset the prevalence of tooth decay experienced is 25.8%; however, it is evident that there is inequality in the severity of decay seen across the county. Children in Sedgemoor are more likely to have multiple decayed teeth and children in Sedgemoor/West Somerset have higher rates of abscess and/or sepsis.



The prevalence of tooth decay in 12 year olds in Somerset is slightly higher than that seen nationally (36.6% as opposed to 33.4%). At a district level this higher prevalence is evident in Sedgemoor, Taunton Deane and West Somerset. Greater severity of decay is also evident in West Somerset and Sedgemoor.

Nationally, in a 2013 survey, a fifth of 12 and 15 year olds reported difficulty eating in the previous three months. More than a third of 12 year olds and more than a quarter of 15 year olds reported being embarrassed to smile or laugh due to the condition of their teeth.



## Injuries

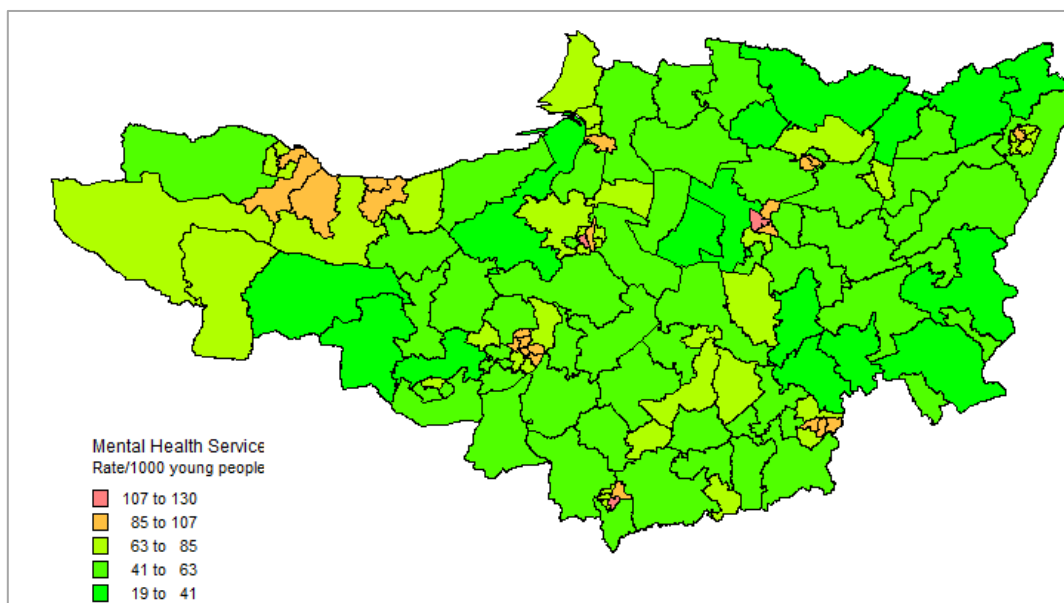
Injuries are a leading cause of hospitalisation and represent a major cause of premature mortality for children and young people. They are also a source of long-term health issues, including mental health related to experience(s). Whilst this is a “health” indicator, its inclusion is key for cross-sectoral and partnership working to reduce injuries, including child safeguarding. Even though some are undoubtedly “accidents” and largely unavoidable, injuries can be linked to substance abuse, for example, and addressing this indicator requires a broad, child and family-centred approach.



## Mental Health

The chances of a full and lasting recovery from mental illness are maximised by identifying young people in the early stages of emotional and mental distress and putting in place preventative measures, support and treatment packages. This in turn reduces the burden on services through transition to adulthood and creates lifelong benefits for the young person, their family and for statutory health and social services. Half of all lifetime mental ill health begins before the age of 14<sup>11</sup>.

**Figure 5: Somerset Young People's Mental Health Service – rate of young people receiving services**



The pattern of mental health service users (shown in Figure 5) is very concentrated in a relatively few, largely urban, communities in Somerset.

Whilst it is important to remember that this is a map of *treatment* – and may reflect lower incidence of mental illness in rural areas or lower rates of detection, or both – it is very striking that more than 11% of young people in three wards (Bridgwater Westover, Chard Jocelyn and Glastonbury St Benedict's) are in contact with young people's mental health services.

As an indicator of potential poor mental health, as well as other risks described here, the 2014 SCYP Survey<sup>7</sup> found 29% of primary age children reported good self-esteem, compared to 38% in the national reference sample.

### **Child and Adolescent Mental Health Service (CAMHS)**

Somerset CAMHS provides a specialist mental health service for children and young people aged 0-18 (up to 19 for young people with additional needs), who may be experiencing a range of mental health problems. The overall goal of the service is to enable children and young people to achieve a fulfilling, meaningful life and a positive sense of belonging in their community.

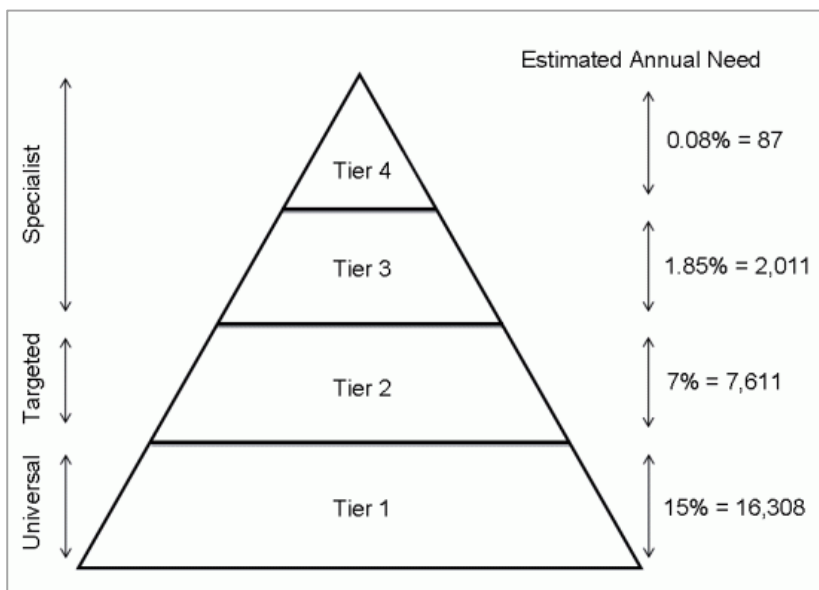
Between April 2014 and March 2015, Somerset Partnership NHS Foundation Trust recorded a total of 1,601 CAMHS open referrals (note that all such activity is Tier 3). Inpatient activity (Tier 4) is very small.

#### *CAMHS 'Pyramid of Need' in Somerset*

The numbers of young people locally who may be expected to require CAMHS services at different levels of need are conventionally calculated using prevalence rates from the 2004 Mental Health of Children and Young People in Great Britain survey<sup>12</sup>. This prevalence

survey is being repeated in 2016 and so it is likely this pyramid of need will need to be recalibrated. For more details of the service, please visit the [CAMHS website](#).

**Figure 6: CAMHS Pyramid of Need**



### CAMHS Case Study 2016



*"I was first referred to CAMHS was when I was 14 years old. This was after an emergency hospital admission for extreme low weight, blood pressure and heart rate due to anorexia nervosa.*

*I was also referred to CAMHS when I was 16, after two overdoses and when I was 17, due to my behaviour which was high risk and impulsive.*

*I had therapy with additional family therapy. I also had help with social anxiety from a support worker and twice weekly outreach visits.*

*My needs at the time were management of my eating disorder, therapy, help with social anxiety and help with suicidal ideation.*

*The things I found most helpful were outings and chats with my support worker, one to one therapy, text contact with my workers (within working hours) and being able to talk to someone without judgement.*

*The things that I found unhelpful were not being allowed to go to school because my weight was too low, the waiting times for therapy, too much focus on my weight, no CAMHS dietician, no out of hours help."*

<http://www.somersetintelligence.org.uk/mental-health-cyp.html>

## Self-Harm

Hospital admissions for self-harm in children have increased in recent years; the rate for Somerset in 2012/13 was 497.7. Nationally, admissions for young women are much higher than admissions for young men. It is clearly an indicator of poor mental health and may be linked to substance misuse. Self-harm may also be associated with potential suicide. However, suicide is very rarely recorded as a cause of death in those under 16 years.

The Somerset rate of hospital admissions as a result of self-harm in 2013/14 was 624.4 per 100,000 (standardised rate), significantly higher than the England figure of 412.1 per 100,000.

## Bullying

<http://www.somersetintelligence.org.uk/feeling-safe-cyp.html>

Bullying, be it physical or psychological (for instance, using social media) can have a seriously detrimental effect on a child's health and wellbeing. This, in turn, can adversely affect attainment in school and consequently opportunities for higher education or employment later in life.

The 2014 SCYP survey<sup>7</sup> found that more than two in five (41%) Year 6 pupils (aged 10-11) said they felt afraid of going to school at least "sometimes" because of bullying and half of 8-10 year-old girls feel afraid of going to school because of bullying at least "sometimes". More than one in four primary and secondary pupils said they had been bullied at or near school or college in the past year. Girls were more likely than boys to have been bullied, contrary to the TellUs 4 survey of 2009. Amongst Year 10 pupils (aged 14-15), young carers, pupils with Special Educational Needs (SEN) and those with long-term illnesses/conditions were more likely than the average to have been bullied. Pupils in rural areas were more likely to have experienced teasing, pushing, name-calling or other bullying.

The way people looked was the most common reason for being picked on or bullied, especially amongst older girls. Amongst Year 12 and 13 students, 11% of girls and 2% of boys had experienced sexual harassment. Almost one in five secondary aged boys admitted deliberately hurting someone else at school in the past year. Most pupils thought their school took bullying seriously but one in three secondary pupils thought their school dealt with bullying "badly" or "not well".

The "What about YOUth" survey suggested that the rates of bullying amongst 15 year olds were less in Somerset than nationally. Whilst this may be at a slightly lower rate than nationally, that does not diminish its importance for the wellbeing of Somerset children and young people collectively and individually.



From the SCC Young Carers' Consultation 2012:

Young carers as a group identified themselves as being bullied in the last year (45%). This number was the highest compared with other children and vulnerable groups taking part in the survey (for instance, children in care, children of ethnic minority backgrounds).



### Cyber bullying

Social media, text messages, instant messaging, email and on-line games offer new opportunities for bullying and surveys of young people highlight this as an area they are concerned about.

Nationally, a survey by the Girl Guides<sup>2</sup> found that this was one of several issues overlooked by adults who were still concerned about older but declining problems, such as drugs and teenage conception. About nine in ten primary and secondary pupils responding to the 2014 SCYP Survey<sup>7</sup> had been told how to stay safe online, mainly at school. However, almost one in three secondary pupils (and almost half of Year 10 boys) responded that they did not always follow the advice they have been given. More than one in three (37%) Year 10 girls said that someone online who they didn't know has asked to see pictures of them and 6% had actually sent sexual pictures of themselves to someone they didn't know.

From the Somerset Rural Youth Project focus groups – JSNA 2015



*“No one can see online bullying - people say things they wouldn't normally. People are more concerned about short internet “fame” than anything real.”*

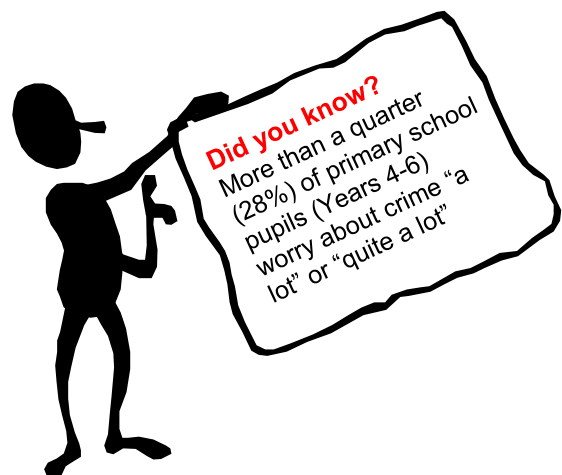
The sexual crime element for young women and girls has been clearly stated in the Police and Crime Assessment for Avon and Somerset:

*“The recorded crime picture indicates that victims of these offences are most likely to be young females between the ages of 10 and 30, with risk increasing markedly from the age of 14.*

*Around 78% of victims of recorded sexual-related cybercrime offences over the last two years were under the age of 16 and 87% were female. It should be noted, however, that this may only represent those most likely to report victimisation. The increase in children using and having access to social media via mobile devices also continues to present challenges in terms of safeguarding and law enforcement.”*

### Crime, Offending and Community Safety

More than a quarter (28%) of primary school pupils (Years 4-6) worry about crime “quite a lot” or “a lot”. For boys this is the second most



common worry (from a series of possible options), after SATs/tests.

For girls, crime was the fourth most common concern, after SATs/tests, problems with family and problems with friends. Only half (50%) of secondary pupils (Years 8 and 10) rated their safety when going out after dark as “good” or “very good”, while 17% rated their safety as “poor” or “very poor”.

In the year to August 2015, there were 2,186 child victims of crime recorded by Avon and Somerset Constabulary in Somerset, up from 2,032 crimes in the previous 12 months (up 7.6%).

## Hate Crime

The number of hate crimes (committed against someone because of their race, religion, sexuality, disability or gender) in the Avon and Somerset police force area increased by 21% in the period from 2013 to 2014 according to figures from the Home Office. This is not broken down by age.



There were 1,566 hate crimes in the police force area during 2013/14, three quarters (75%) of which related to race. In the year to August 2015, Avon and Somerset Constabulary recorded 18 child victims of race hate crimes, compared with 24 in the previous 12 months.

Other pretexts for hate crime in 2013/14 were: 11% sexual orientation; 6% disability, including Learning Disability; 5% religion and 2% transgender. There is some evidence that Travellers can end up being excluded from schools due to fighting back following racial incidents.

## Violence

The Avon and Somerset Police and Crime Needs Assessment 2015 (consultation draft) (ASPCNA) wrote about young people and crime, nationally, as follows:

*“Young people are also at disproportionately high risk of experiencing most crime types, including serious crime. Those aged 17 to 24 account for 19% of police recorded victims of crime and only 8.5% of the resident population.*

*The Crime Survey for England and Wales (CSEW) has reported nationally that around 12% of children aged 10 to 15 are victims of crime each year – a proportion which has remained relatively stable over the last three years.*

*While young people remain disproportionately affected by violent crime, both the CSEW and Violence and Society Research Group at Cardiff University estimate that levels of violent crime experienced by 10 to 17 year olds has fallen by between 16% and 18% in the last year.”*

Young people’s interpersonal violence includes violence in relationships, which may be the result of an inability to understand the boundaries in a healthy relationship.

The mental health issues referred to in the ASPCNA are frequently linked to low self-esteem, making the young people easily drawn in by movements that seem to give them

worth and purpose, reinforcing the importance of personal resilience in keeping vulnerable young people safe.

## Radicalisation

Young people often explore new ideas as they grow up and for a small number that may lead them into extreme groups who are strongly at odds with wider society.

Most prominent are animal rights, far right wing and Islamic extremism. The internet has enabled isolated individuals to become aware of others with similar views far more easily than in the past and such contact can be mutually reinforcing; the web and social media give existing extremists new means to promulgate their views to vulnerable young people.

The ASPCNA notes that:

*“Individuals from the South West region are known to have travelled or expressed a desire to travel to support ISIL (Islamic State in Iraq and the Levant) in Syria. Some of these individuals are highly vulnerable or socially isolated and early identification is vital to ensure safeguarding and investigative opportunities are realised.*

*While the threat remains considerable, most of those identified as being at risk are deemed to either not have the intent or the capability of carrying out attacks and often have safeguarding and/or mental health issues.”*

The small numbers of young people referred to Channel<sup>13</sup> (part of the Prevent programme) for multi-agency investigation are small; this and the sensitivity of the subject means that little detail can be given here. That said, radicalisation does exist in Somerset and agencies need to be aware that this is the case.

## Child Sexual Exploitation (CSE)

<http://www.somersetintelligence.org.uk/cse.html>

The National Working Group for Sexually Exploited Children and Young People defines CSE as:

*“The sexual exploitation of children and young people under the age of 18 involves exploitative situations, contexts and relationships where young people (or a third person or persons) receive ‘something’ (e.g. food, accommodation, drugs, alcohol, cigarettes, affection, gifts, money) as a result of performing, and/ or others performing on them, sexual activities. In all cases, those exploiting the child/young person have power over them by virtue of their age, gender, intellect, physical strength and/or economic or other resources.”*



Recorded CSE tagged crimes in Somerset increased to 76 in the year to August 2015, compared to 50 in the previous 12 months. The rise is similar to the increase (+53%) in the number of recorded CSE tagged crimes across the Avon and Somerset force as a

whole. The likelihood is that officers, police staff and partner agencies are getting better at recognising the warning signs that a child might be at risk of, or is being, sexually exploited and have an improved understanding of the action to take.

The [Somerset Local Safeguarding Children Board](#) (LSCB) has adopted a strategy setting out its commitment to prevent CSE and tackling it when it occurs. Under the auspices of the LSCB, a Child Sexual Exploitation Strategic Group (CSEG) has responsibility to ensure a robust multi-agency response to CSE in Somerset. A victim-centred supportive approach will be an overriding principle.

This strategy is aimed at anyone who engages with children and young people. It builds on work already undertaken in the county since 2008 and is informed by lessons learnt. The overriding aim is to safeguard and protect children in Somerset. The LSCB recognises that only a proactive, co-ordinated, multi-agency approach will be effective in preventing and disrupting CSE and in pursuing, disrupting and prosecuting perpetrators.

### **Female Genital Mutilation (FGM)**

<http://www.somersetintelligence.org.uk/sexual-health.html#FGM>

When practised, FGM is usually inflicted on girls younger than 16. Communities in the Avon area predominantly affected by this practice include Somali, Sudanese and Sierra Leonean / West African communities. There were 28 maternities in the period 2005-13 to women with FGM and of these, 16 were female babies.

The distribution of affected communities in the region would suggest that the large majority of cases would be in the City of Bristol area. There have been no prosecutions in the Avon and Somerset area and no reported cases by either of the two hospital trusts in Somerset; however, there may be instances not known to either the police or NHS.

From 1 October 2015, all regulated health care professionals and teachers have a responsibility to report “first-hand” accounts of FGM to the police. It is likely this will result in better detection locally, as this remains hidden in families.

### **Youth offending**

The numbers of first-time entrants (aged 10-17) to the youth justice system in Somerset have been falling (mirroring downward national and regional trends) but show signs of levelling off.

In 2013, there were 255 first-time entrants in Somerset recorded on the Police National Computer, down from 365 in 2012 and 482 in 2011. As a rate per 100,000 of the population aged 10 to 17, Somerset remains above national and regional averages (see Table 5).

During 2014, the Youth Offending Team in Somerset received 1,497 referrals, of which the great majority (88%) came from the police. These referrals related to a total of 1,073 individual clients. Higher rates of referrals were generally found within the county's urban areas such as parts of Bridgwater, Chard, Minehead, Taunton, Wincanton and Yeovil.

For the Avon and Somerset area, the main offence types among young offenders are violence (22%), theft (20%), drug offences (13%) and criminal damage (12%). Reductions



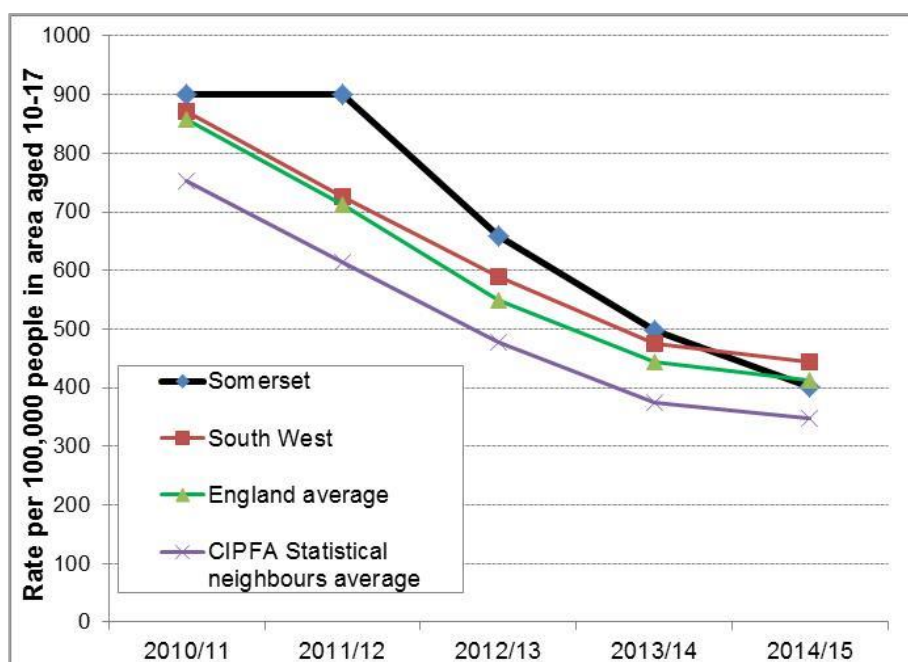
in overall youth offending have been most notable in the areas of burglary (-33%) and theft and handling stolen goods (-20%). Violent offending has also reduced (-14%).

Evidence indicates that the average age of perpetrators of sexual offending is getting younger, while local Youth Offending Teams have identified increases in low threshold Harmful Sexual Behaviour amongst their caseloads.

**Table 5: First time entrants to the Youth Justice System aged 10-17 (Raw values) (from 2012/13 to 2014/15)**

Period	Somerset	South West	England average	CIPFA Statistical neighbours average
2012/13	658	589	548	477
2013/14	498	475	444	374
2014/15	402	444	412	347

**Figure 7: Chart showing Five Year Trends**



Source: [http://lginform.local.gov.uk/reports/lqastandard?mod-metric=123&mod-period=3&mod-area=E10000027&mod-group=Somerset\\_AllGeographicalNeighbours&modify-report=Apply](http://lginform.local.gov.uk/reports/lqastandard?mod-metric=123&mod-period=3&mod-area=E10000027&mod-group=Somerset_AllGeographicalNeighbours&modify-report=Apply)

2014/15 data shows that 7% of children looked after (CLA) (who had been looked after continuously for at least 12 months) received a conviction or a final warning or reprimand during the year ending 31 March 2015.

Although comparisons need to be treated with care because of definitional differences, this was lower than the 2013/14 figure of 12.2% but slightly above 2014/15 regional (6%), national (5%) and statistical neighbour (5.4%) averages.

All crime data related to young people should be considered in the knowledge that young people tend to under-report crime, often due to a feeling that they will not be believed, fear of retaliation or a lack of awareness of the services available. Findings from the Crime Survey of England and Wales 2012 indicate that while only 15% of 10-17 year olds report crime to the police, around 60% report incidents to teachers.<sup>14</sup>

## Education and Attainment

<http://www.somersetintelligence.org.uk/attainment.html>

### Early Years Foundation Stage (EYFS)

In Somerset overall 66.7% of children achieved a “Good” Level of Development (GLD). This is an improvement from 61.4% in 2014. Somerset is now in line with national (66.3%) and statistical neighbour (67.3%) averages.

### Key Stage 1 (KS1) – Age 7

Results in Reading, Writing and Maths for 7 year olds improved in 2015. The percentage of 7 year olds achieving the national benchmark of Level 2b or above was 82.9% in Reading, 74.3% in Writing and 82.1% in Maths. Figures were above the national average in each subject.

### Key Stage 2 (KS2) – Age 11

2015 Level 4 or above (combined) results show 78.4% of pupils achieved this level of attainment. This was a 0.8% increase on 2014, which was 77.6%. The national average is 80% and the statistical neighbour average is 79%.

### Key Stage 4 (KS4) / GCSE

Results at Key Stage 4 show that Somerset’s performance at five or more GCSE A\*-C grades including English and Maths improved to 58.6%, compared to 53.9% in 2014. The national average is 53.8% and the statistical neighbour average is 57.4%.

### Key Stage 5 (KS5) / A Level

The percentage of students achieving two or more A level passes decreased to 90.8%, compared to 93% in 2014.

### Gender

Gender differences are significant, opening up markedly in the EYFS and continuing to be an issue at all Key Stages. At the EYFS, girls continue to out-perform boys, with 73.3% of girls and 60.2% of boys achieving a GLD.

The gender gap at Key Stage 1 continues to show girls doing better than boys in all three areas. In 2015, at Level 2b or above in Reading the gap was 8%, in Writing it was 14.3%, and Maths 3.3%. The gap narrowed in Reading and Maths in 2015 compared to 2014.

At Key Stage 2, girls at Level 4+ in Reading, Writing and Maths combined, continue to outperform boys. Attainment for girls remained the same in 2015 as in 2014 (80.8%). Boys improved their performance by 1.5% on 2014. The gap between the attainment outcomes for girls and boys in 2015 was 4.7%.

At Key Stage 4, the gender gap was 12% in 2015 (52% of boys and 64% of girls attained five good GCSEs including English and Maths).

Boys are over-represented in figures for SEN, CLA, school exclusions and NEETs (Not In Education, Employment or Training).

## **Children Looked After**

In 2015, outcomes for CLA were broadly in line with 2014 outcomes at both Key Stages 2 and 4. Of CLA who were looked after for more than 12 months, 33% achieved Level 4 or above in Reading, Writing and Maths at Key Stage 2, compared to 30% who achieved Level 4+ in 2014; 13% of CLA achieved five or more A\* to C grades including English and Maths compared to 14% in 2014. This means that the CLA Key Stage 2 attainment “gap” (comparing CLA and non-CLA pupils) decreased by 3%, down to 45% in 2015 from 48% in 2014. The CLA Key Stage 4 attainment gap is to be confirmed.

## **Pupils in receipt of Free School Meals (FSM)**

Attainment gaps between pupils from low income families and their more affluent peers persist through all key stages of education. At the EYFS, the achievement gap between those in receipt of FSM and their peers was 23% in 2015, the same as in 2014. For Key Stage 1 Level 2b or above in Reading the achievement gap was 18.5% in 2015, in Writing it was 20.3% and in Maths it was 17%.

All three gaps widened compared to 2014. For Key Stage 2 Level 4+ Reading, Writing and Maths combined, the attainment gap between FSM pupils and their peers was 23.8% in 2015. This gap widened from 2014, when it was 20.4%. These gaps are in line with the national average. However, whilst this gap persists as an average, it does not apply to all schools. In a minority of cases those eligible for FSM outperform those who are not.

Data at the individual level of each school is not published, but the performance of FSM pupils appears to be broadly better in the more prosperous catchments. There are a number of possible explanations – better resourced schools or a more supportive culture amongst parents, perhaps, as well as the quality of schools themselves and their leadership.

It could be because of the relative intensity of need in those areas. National evidence suggests that FSM pupils fare best in the most prosperous areas or the most deprived; only six of Somerset’s 327 Lower Super Output Areas (LSOAs) are classified within the 5% most deprived in England.

Clearly, all FSM pupils will not have the same level of need and it may be that those in the poorer areas have more hurdles to overcome to achieve. This would suggest that whilst their role is crucial, the schools need to work with other services to help bridge the gap.

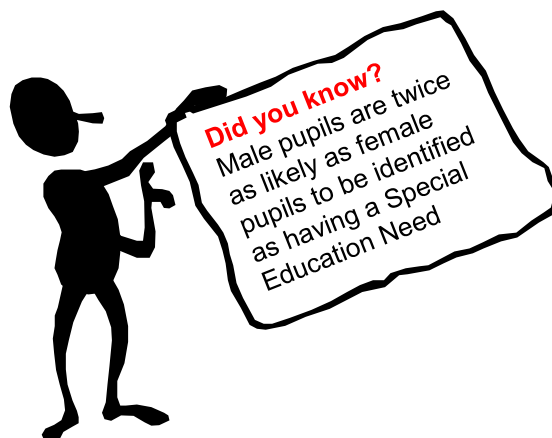
## Pupils with Special Educational Needs



### Special Educational Need and Disability (SEND)

<http://www.somersetintelligence.org.uk/sen.html>

The School Census identifies pupils with Special Educational Needs (SEN). In 2015 such pupils made up over 14% of the school population. Of these 9,836 (fewer than 10%, or 910) were designated as such, giving them entitlement to special support. This designation is now an Education, Health and Care (EHC) Plan, having previously been a Statement of SEN.



**Table 6: Breakdown of SEN by Primary Need**

	Number	% of total
Learning Difficulty (LD)	3,196	38.9
Speech, language and communications needs	1,647	20.1
Social, Emotional and Mental Health	1,625	19.8
Autistic Spectrum Disorder	496	6.0
Sensory Impairment (visual and hearing)	237	2.9
Physical disability	239	2.9
Other difficulty/disability	439	5.3
No specialist assessment of need	331	4.0

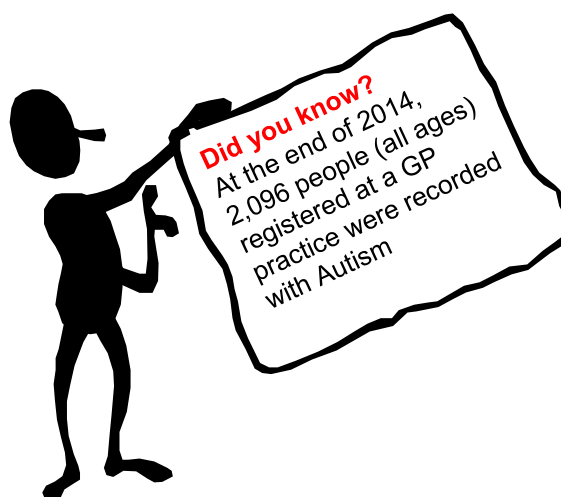
The largest category of SEN is Learning Difficulty, making up nearly four fifths of the total, with Speech, Language and Communications Needs, and Social, Emotional and Mental Health making up a further two fifths each. Sensory impairment and physical disability made up less than 6% of the numbers.

### Autistic Spectrum Conditions

<http://www.somersetintelligence.org.uk/autism.html>

In total, 334 children (113 in state primary, 157 in state secondary and 64 in special schools) were considered in January 2012 to be in “high need” - with either SEN statements or School Action Plus (SAP) - where Autistic Spectrum Disorder was a primary need.

As a proportion of all SEN/SAP pupils in each type of school in Somerset, these figures represent 6.9%, 9.0% and 14%, respectively. These



proportions are similar to regional and national averages.

In January 2013, about one in four (26%) of those in “high need” had a secondary need, of which Speech, Language and Communication Needs and Behaviour, Emotional and Social Difficulties were the main ones (7% and 6% respectively).

At the end of 2014, 2,096 people (all ages) registered at a Somerset GP Practice were recorded with Autism. This represents an increase of 26% since the end of 2012, which could reflect more intensive efforts to identify and record the condition.

The SEN gap continues to be significant. At Key Stage 2, the gap also continues to be significant, with only 34.8% of pupils receiving SEN support gaining Level 4 or above in Reading, Writing and Maths. Non-SEN pupils achieved 88.6%, a gap of 53.8%.

### **Minority Ethnic Groups**

Overall, pupils of “White British” ethnicity outperform those of non-White British ethnicity.

At Key Stage 1 in 2015, the overall percentage of pupils achieving the national benchmark of Level 2b or above in Reading, Writing, and Maths was higher for White British pupils than for non-White British pupils. The achievement “gap” was 5.8% in Reading, 5.0% in Writing and 5.4% in Maths.

At Key Stage 2, provisional 2015 results indicate 77.6% of non-White British pupils achieved the benchmark of Level 4 or above in Reading, Writing and Maths (compared to 78.5% of White British pupils). This gap narrowed in each of the last two years.

It may be noted that several individual ethnic groups outperform the White British group overall in some or all of the benchmark measures. In addition, with relatively small groups of pupils – as is the case with individual ethnic groups in Somerset - the validity of the data can be questionable and subject to variation from year to year depending on the cohort.

### **Attendance**

The most recent available information is for the autumn term 2014. For primary schools, the average time missed was 3.8 sessions, of which 3.3 were authorised. For secondary schools the equivalent figures were 5.0 and 4.0. In all cases the rates are broadly similar to the region and national rates. The percentage of pupils missing 22 or more sessions was 3.3 for primary schools and 5.8 for secondary, both below the national rate.

Persistent absence rates for Somerset’s Pupil Referral Units (PRUs) (with 69% of pupils missing 14 or more sessions) were significantly worse than the national figures, making Somerset the worst performing local authority in the South West in the autumn of 2014.

Attendance for pupils with SEN is the worst for the region, with between 9.0% and 14.4% (based on categories of SEN) missing 56 sessions or more.

Attendance of CLA is also the worst for the South West, with 7.3% likely to be persistent absentees.

## School exclusions

The latest figures for Somerset that can be compared with national data give a mixed picture, with the number of fixed period exclusions for primary (1.63% of school population) being higher than the national (1.02%). Secondary exclusions were at 6.16% compared to 6.62% nationally, and for special schools the rate was 38.98% compared to 13.86%. For 2013, Somerset had the highest rate of fixed term exclusions for CLA of all English local authorities (18.6% of cohort; 9.8% national).

Permanent exclusions were low, in line with national rates, being 0.02% of primary pupils and 0.10% of secondary. No special school pupils were permanently excluded in 2013/14. However, the number of permanent exclusions rose from 25 in 2012/13 to 46 in 2014/15.

For those with SEN, the numbers of Somerset pupils categorised at SAP, and those with SEN, with and without a statement, who had at least one fixed period exclusion in 2012/13 were significantly higher than regionally or nationally.

## Employment and Income

### Social mobility

The Social Mobility Index compares the chances that a child from a disadvantaged background will do well at school and get a good job, across each of the local authority district areas of England.

It examines a range of measures of the educational outcomes achieved by young people from disadvantaged backgrounds and the local labour and housing markets, to shed light on which are the best and worst places in England in terms of the opportunities young people have to succeed, when they are from poorer backgrounds.

**Table 7: Social Mobility Index<sup>15</sup> Social Mobility for Somerset Districts, rank out of 324 lower tier local authorities**

	Overall	Early Years	School	Youth	Adult
Mendip	161	201	144	<i>69</i>	203
Sedgemoor	238	204	<b>257</b>	135	237
Taunton Deane	218	243	129	242	199
South Somerset	150	189	243	<i>44</i>	180
West Somerset	<b>324</b>	<b>323</b>	212	<i>71</i>	<b>324</b>

*Green italic = upper quartile; Red bold = lower quartile*

The small size of the West Somerset population means that the figures for the district need to be treated with caution, but its position at the bottom of the national league table is striking and a cause for concern.

**“NEETS” (Not in Employment, Education or Training) and “EETS”** <http://www.somersetintelligence.org.uk/eet-neet.html>

The majority of young people succeed in education and make a positive transition to adult life and the world of work. But there remains a small proportion who do not, and who become Not in Education, Employment or Training (NEET<sup>16</sup>).

Department for Education (DfE) annual estimates of young people aged 16-18 who are NEETs<sup>16</sup> reveal that, at the end of 2014, an estimated 789 young people in Somerset were NEET<sup>16</sup>, representing 4.4% of the 16-18 population.

There are wide variations with age: 1.5% of 16 year olds were NEET<sup>16</sup>, increasing to 4.0% of 17 year olds, and 7.9% of 18 year olds. Nationally, 4.7% of the 16-18 year old population are NEET<sup>16</sup>, while the average for Somerset's statistical neighbours is 4.2%.

Various risk factors associated with young people who become NEET<sup>16</sup> have been identified by national and international studies, particularly those for whom it can be more prolonged. These include educational attainment at school, truancy and exclusion and a lack of information about employment, education and training opportunities post-16.

Some of these issues are themselves associated with factors such as lack of parental support, low self-esteem and deprivation levels. Understanding these and addressing them early can reduce the likelihood of young people becoming NEET<sup>16</sup>.

DfE data on destinations of pupils after Key Stage 4 and Key Stage 5 indicate that 92% of pupils were in sustained education or training/employment the year after GCSE and that 76% of pupils were in sustained education or training/employment the year after A-level.

It is worth noting that for the remainder of the above cohort who drop out, a proportion of pupils' whereabouts (particularly post A-level) are not known and therefore it is also not known whether these fall into the category of NEETS<sup>16</sup>.

## Implications for Commissioning

- Perhaps most striking in this section is the inequality between the educational outcomes - including attainment, attendance and exclusions – between the majority of the population and disadvantaged groups. The attendance and exclusion figures for CLA and children with SEN are particularly large and explain Somerset's education outcomes overall, not matching what would be expected of a county where “wider determinants of health” are good.
- More broadly, this section has given a range of numbers of children and young people in different types of need. It is not possible to add these together to give an overall total because the nature and degree of overlap between the categories cannot be determined. The analysis of troubled families data and much more anecdotal evidence suggests that the overlap is considerable.
- This implies that many children and young people have a complex set of needs, each of which probably exacerbates the other. This means that a child-centred approach is essential. A simple focus on the most prominent symptoms may well fail to address the causes.
- Where data can be mapped, it suggests that there is a concentration of needy young people in deprived communities, just as is the case for needy families. This further justifies a focus of effort on locating services in those most deprived areas, particularly in the main towns of Taunton, Bridgwater and Yeovil. However, there are vulnerable children across the county; all agencies such as schools, health visitors, GPs and police have a role in identifying and sharing information about these children.

# SECTION 2 – THINK FAMILIES

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There are approximately 60,000 families with dependent children in Somerset.

The immediate home environment and family have profound effects on children's wellbeing and resilience from before birth. This includes the condition of housing itself, but in particular a stable and supportive family, especially in the first two years, can bring benefits that last for life.

## Family Structure

Just over one in four households (26%) contained at least one dependent child, rising to 35% in the Hamp and Victoria wards of Bridgwater.

Almost 6% (12,709) of households consisted of a lone parent with dependent children, slightly below the England and Wales figure of 7.2%. In Taunton Halcon, the proportion was more than twice the Somerset average, at 12.7%.

## Births and parental age

There were 5,538 births to mothers usually resident in Somerset in 2013. The birth rate of 62.4 per 1000 women (aged 15-44) is slightly below that for England (62.4). Of these births, 352 were to mothers under 20, of whom 69 were under 18; at 1.2% and 5.1% these proportions are slightly higher than for England (1.1% and 4.1%).



Very young parents can be vulnerable in themselves and may lack the experience and resources to provide well for their children. Teenage pregnancy rates are, however, lower than the national average, as described later in the report. The proportion of births to mothers aged 40 and over (4.4%) is slightly higher than that for England (4.2%).

Evidence shows that young mothers and their babies experience poorer health outcomes in comparison to general maternal health. Young mothers are more likely to smoke during pregnancy, are more likely to have post-natal depression and are less likely to breastfeed. This is often compounded by the fact that many young parents come from the most deprived areas.

Young parenthood can result in a failure to complete education, which further disadvantages both the parent(s) and the child, as the education level of the parent is known to be protective for long-term health.

## Young carers

The term "young carer" refers to children and young people under 18 who provide regular and continuing care and emotional support to a family member who is physically or mentally ill, has a disability or misuses substances. The term does not apply to everyday and occasional help around the home.



According to the 2011 Census, the number of unpaid young carers (aged 5 to 17) has increased by more than a third since 2001 in South West England. If Somerset is typical of the region there are an estimated 1,750 such carers in the county.

A young carer's consultation carried out by Somerset County Council in 2012 yielded the following key results:

- Young carer groups are highly valued by young carers in the county and give them "something to look forward to" and the chance to "be kids".
- Many young carers said if they didn't access the Somerset Young Carers Service, they would feel like they were alone. Young carers reported feeling stressed, anxious and worried, with their parents reporting that their children are socially isolated because of their role as a carer. Having someone to talk to is very important to young people.
- Many young carers experience difficulties in school and often need additional time to complete work because of their responsibilities at home.
- 81% felt that schools could play a more active role in identifying and supporting young carers, although a large number do not wish school staff and friends to know about their home situation.
- School is a sanctuary for many children, a place where they can get away from some of the anxieties they face at home.
- A large number of young carers reported having experienced bullying because of their family circumstances, with young carers stating that other people don't understand what they are going through. Awareness raising must be handled sensitively so they don't feel singled out or embarrassed by the attention.
- Young carers value consistency of support from staff and do not wish to explain their situation over and over to a number of different workers.
- Young carers as a group had the lowest percentage of self-esteem (30%) compared to other children and children from other vulnerable groups.
- Young carers are more worried about money (39%) compared with other children and children from other vulnerable groups.

### **Children of prisoners**

Parental absence may be the result of imprisonment. People who are imprisoned are not routinely asked about dependent children. Those in contact with children and young people – schools, for example - are not necessarily aware that a child's parent is in prison, making this a dimension of vulnerability potentially overlooked.

It is thought that, nationally, 7% of children will be affected by the imprisonment of their father during their school life. If the national rate applies in Somerset then about 1,800 children will be affected every year. Children of prisoners are twice as likely to suffer from mental health problems and research into boys whose father is imprisoned suggested that 65% of will go on to offend.

The Arrest Intervention Referral Service (AIRS) assessed 213 men arrested in one month in Somerset in 2015, of whom 65 identified themselves as having children. In 20 of these cases the child or children were residing with them; of these 16 were referred to the Multi-Agency Safeguarding Hub. It should be noted that these figures do not include women.

The rural nature of Somerset, and absence of a prison in the county, means that distance and poor access may exacerbate the separation of children and imprisoned parents. That said, in cases such as parental imprisonment, particularly involving domestic abuse and violence, the *presence* of a parent may also bring issues for the child.

## Parents

### Breastfeeding

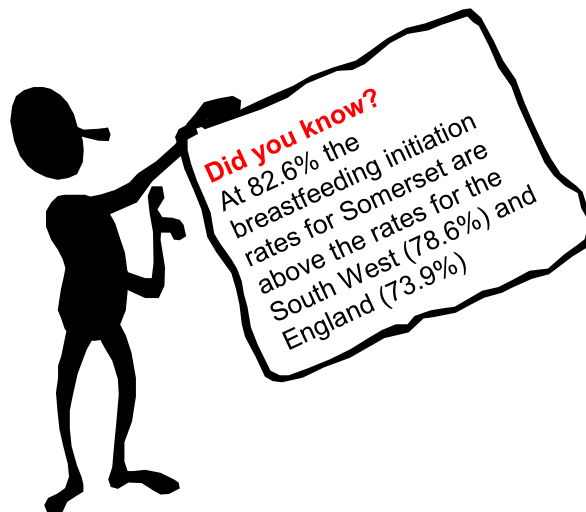
<http://www.somersetintelligence.org.uk/pregnancy-maternity.html>

Breastfeeding prevalence increases with maternal age and decreases with greater deprivation. (Somerset Breastfeeding Health Equity Audit<sup>17</sup>). Young mothers under 24 years and teenage parents are less likely to breastfeed and more likely to discontinue breastfeeding soon after initiation, as shown in Figure 8.

At 82.6% the breastfeeding initiation rates for Somerset are above the rates for the South West (78.6%) and England (73.9%).

At the 6-8 week check, breastfeeding prevalence for Somerset was 48.5%, compared to 49.3% for the South West and 43.8% for England.

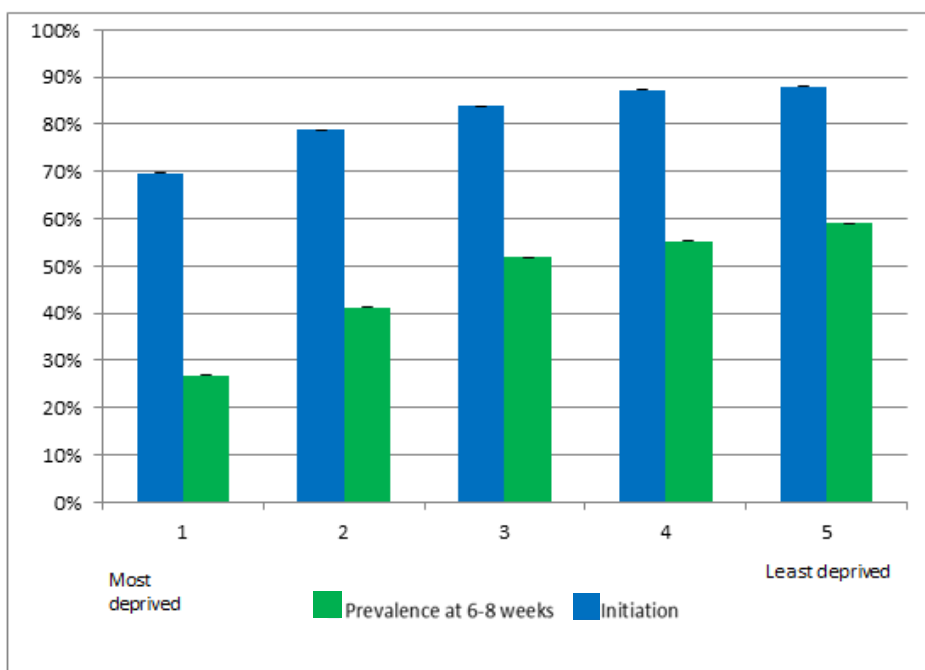
The London breastfeeding services mapping project noted the following:



“There is clear evidence that *not* breastfeeding has health disadvantages for both mothers and babies in the short and longer term. For this reason, exclusive breastfeeding is recommended for the first six months of the infant’s life.

Babies who are not breastfed are many times more likely to acquire illnesses such as gastroenteritis and respiratory infections, to become obese in later childhood and suffer Type II diabetes, impaired cognitive development, high blood pressure and total cholesterol. In addition mothers who have not breastfed are at greater risk of breast and ovarian cancer and Type II diabetes.”<sup>18</sup>

**Figure 8: Breastfeeding Initiation and Prevalence at 6-8 weeks by deprivation quintile**



## Hidden Harm

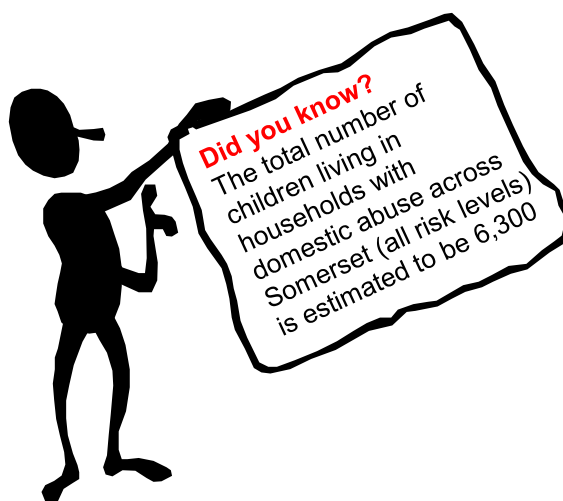
<http://www.somersetintelligence.org.uk/hidden-harm.html>

To safeguard and promote the welfare of children, parents must provide basic care, safety, emotional warmth, appropriate stimulation, guidance, boundaries and stability. Mental illness, learning disability, substance misuse and domestic abuse can affect parents' capacity to adequately address these issues. A single disorder can negatively affect parents' capacity to meet their children's needs, but the co-existence of these types of problems has a much greater impact on parenting capacity.

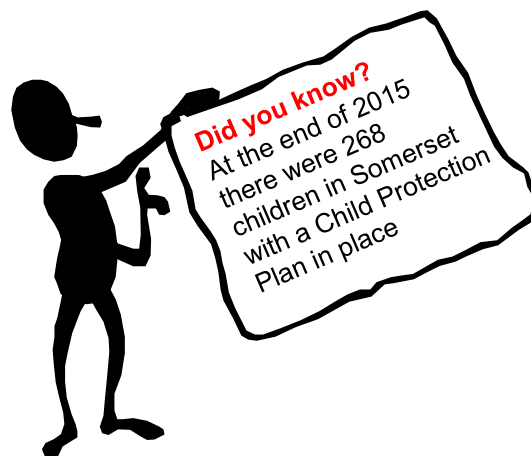
Three elements of parental behaviour can be particularly detrimental to children. These are substance misuse, mental illness and domestic abuse. They are often considered together as "hidden harm" and were the subject of a Hidden Harm Needs Assessment<sup>19</sup> (HHNA) by Somerset County Council Public Health in January 2015.

Between April and September 2014, the total number of children whose parents were in contact with the Somerset Drugs and Alcohol Service (SDAS) was 2,118. The number of children with parents in structured treatment with SDAS was 1,426. The total number of children living in households with domestic abuse across Somerset (all risk levels) is estimated to be 6,300.

Contact with mental health services is more likely in adults living in urban areas.



At the end of 2015 there were 268 children in Somerset with a Child Protection Plan (CPP) in place. Earlier analysis, of the 465 cases in January 2015, suggested that 18% had all three hidden harm factors.



The HHNA stated that:

*“When considering hidden harm the aim is to intervene early with vulnerable children and young people in order to improve lifetime health and wellbeing, prevent mental illness and reduce costs incurred by ill health, unemployment and crime.*

*It is anticipated early intervention will bring benefits not only to the individual during childhood and into adulthood, but also improve his or her capacity to parent.”*

It went on to say:

*“Consideration of the needs of all members of the family and extended family (where appropriate) are important for all factors which can contribute to hidden harm.*

*This “Think Family” approach can be incorporated into service design, service delivery and staff training.”*

It is essential that professionals who work with a specific client group consider the needs of all family members, particularly the children. The extent to which parents experience a number of different disorders means that it is imperative that protocols for information sharing and joint working are developed between agencies providing different types of services.<sup>20</sup>

The importance of early intervention and the need to understand the family as a whole emerge elsewhere in this JSNA.

### **Substance misuse by parents**

<http://www.somersetintelligence.org.uk/alcohol.html>

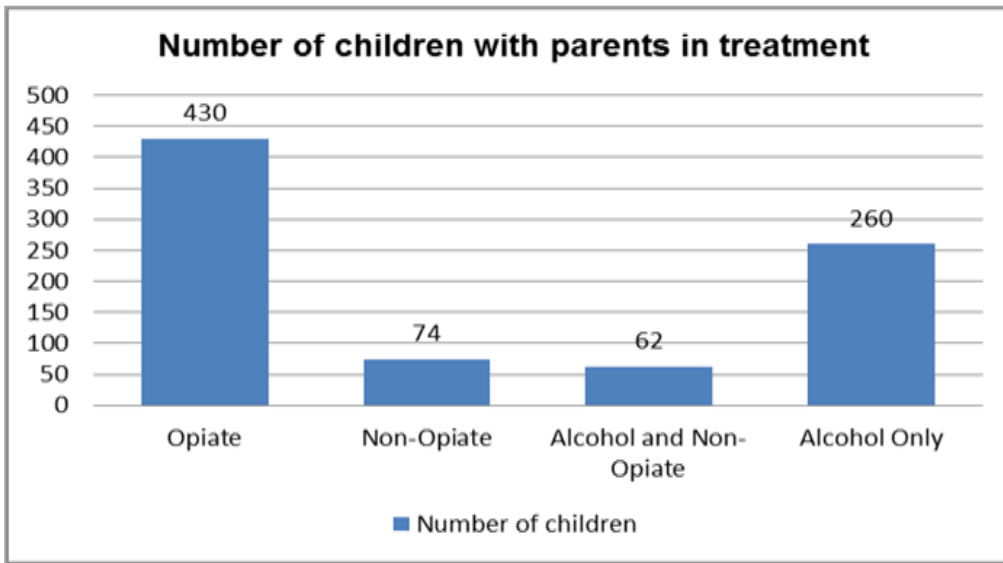
It is hard to know with any certainty how many children in Somerset are living with parents who are using illicit drugs as such behaviour is, by definition, illegal. However, knowledge and profiling of those parents who are in treatment has successfully informed re-commissioning locally to ensure that services understand and continually develop their understanding of harm.

During the 18 month period 1 April 2014 to 30 September 2015 there were:

- 552 individual parents in treatment with SDAS.
- 475 parents in treatment with SDAS who had children living with them.
- 826 children whose parents were in treatment with SDAS.
- 107 children with a parent in treatment had a CPP or were CLA.

The number of children with parents in treatment by their substance use can be seen in Figure 9.

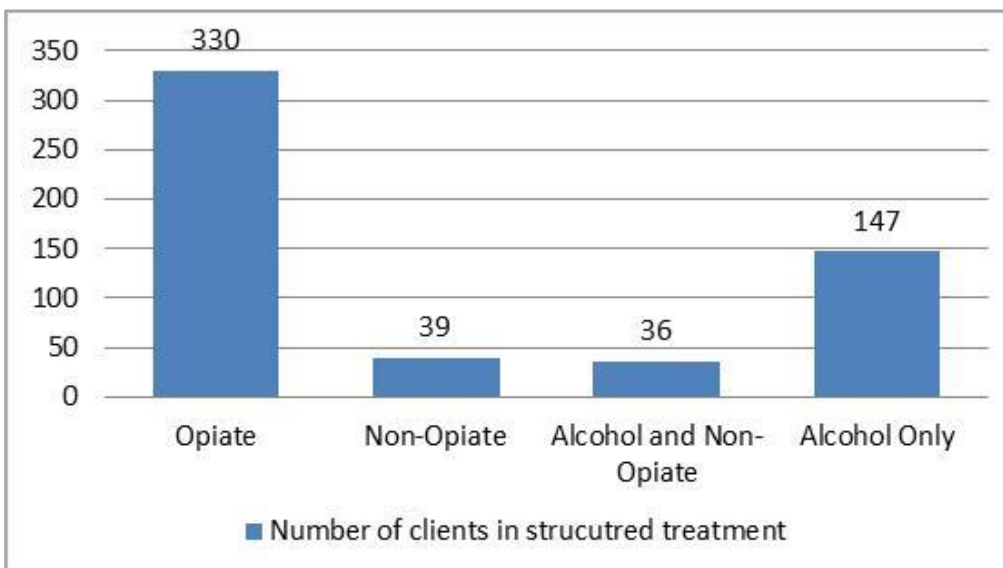
**Figure 9: Number of children with parents in treatment**



The substance split is a reflection of our current “in treatment” population. Opiate users and alcohol users are more likely to have the most complex profiles, often associated with longer histories of use and more chaotic lifestyles.

The number of individuals in structured treatment with SDAS at any time between 1 April 2014 to 30 September 2015 is shown in Figure 10.

**Figure 10: Number of parents in structured treatment by substance type between 1 April 2014 to 30 September 2015**



Parental misuse of drugs or alcohol, or both, is found in more than half of parents who neglect their children<sup>21</sup>. Adults with alcohol problems are more likely than those without to experience poor mental health. It is estimated that up to 85% of users of alcohol services experience mental health problems<sup>22</sup>.

In pregnancy, alcohol can cause a range of harms to the foetus, including miscarriage, low birth weight, cognitive deficiencies and foetal alcohol spectrum disorders.

Up to 1.3 million children in the UK are adversely affected by family drinking; around a quarter of child protection cases involve alcohol ([Chief Medical Officer Report \(2008\) Collateral Damage from Alcohol](#)).

Alcohol-related harm includes a link with sexual violence and grooming.

## Parental smoking

<http://www.somersetintelligence.org.uk/smoking.html>

It is known that maternal smoking during pregnancy is a key cause of underdeveloped babies at birth, resulting in low birth weight as well as miscarriage and stillbirth. Furthermore, the smoking of any household member after birth prejudices a child's health, increasing the risk of Sudden Infant Death (SID) amongst other conditions.



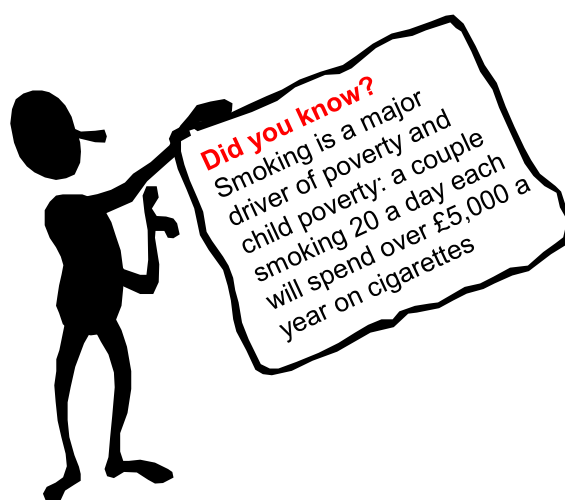
Smoking remains one of the few modifiable risk factors in pregnancy. Smoking in pregnancy remains relatively high in Somerset, although work started in 2013 is showing good results.

The proportion of mothers recorded as "still smoking" at the time of giving birth has been reduced from 17.4% to 14.1% over the two years to March 2015. In 2014/15, 395 pregnant women set a quit date with the NHS Stop Smoking service, up from 251 in 2013/14, of whom 211 quit (53.4%) as opposed to 109 (43.4%) the previous year.

Nationally, figures demonstrate links between smoking and deprivation. There appears to be a slower decline among women in deprived areas who need the most help to give up smoking.

Babies from deprived backgrounds are also more likely to have much greater exposure to secondhand smoke in childhood. It is important that midwives and Stop Smoking Services offer targeted support and services to these women, appropriate to the context of their lives and their socio-economic circumstances.

Smoking is a major driver of both poverty and child poverty: a couple smoking 20 a day each will spend over £5,000 a year on cigarettes.



Babies born to mothers who smoke:

- Are more likely to be born prematurely and with a low birth weight (below 2.5kg).
- Have a birth weight on average 200g less than those born to non-smokers. This effect increases proportionally - the more the mother smokes, the less the child weighs.
- Have organs that are smaller on average than babies born to non-smokers.

- Have poorer lung function.
- Are twice as likely to die from SID (previously known as cot death).
- Are ill more frequently. Babies born to women who smoked 15 cigarettes or more a day during pregnancy are taken into hospital twice as often during their first eight months of life.
- Get painful diseases such as inflammation of the middle ear and asthmatic bronchitis more frequently in early childhood.
- Are more likely to become smokers themselves in later years.

In addition, pregnant women who smoke increase their risk of early miscarriage.

### **Domestic abuse**

<http://www.somersetintelligence.org.uk/domestic-violence-cyp.html>

The total number of children living in households with domestic abuse across Somerset (all risk levels) is estimated to be 6,300.

A total of 704 children were linked to cases discussed by Somerset Multi-Agency Risk Assessment Conferences (MARACs) during 2014/15. MARAC consider cases where an individual has been identified as being at high risk of domestic abuse. The level of cases linked to children has remained broadly steady in recent years.

In the six months from April to September 2014, two-thirds of referrals to the Somerset Integrated Domestic Abuse Service (SIDAS) Accommodation Service for domestic violence were for victims with children. Of these children, 38% were aged five years or under. There were a total of 157 referrals to the Accommodation Service in the period.

Somerset police recorded 4,474 incidents of domestic violence in which a child was present during 2012/13. A total of 4,925 individual children (aged 0-17) experienced at least one domestic violence incident in this way. The figures suggest that domestic violence and abuse affects around 5% of Somerset's child population. The highest concentrations of incidents were in parts of Taunton, Yeovil and Bridgwater.

### **Parental mental health**

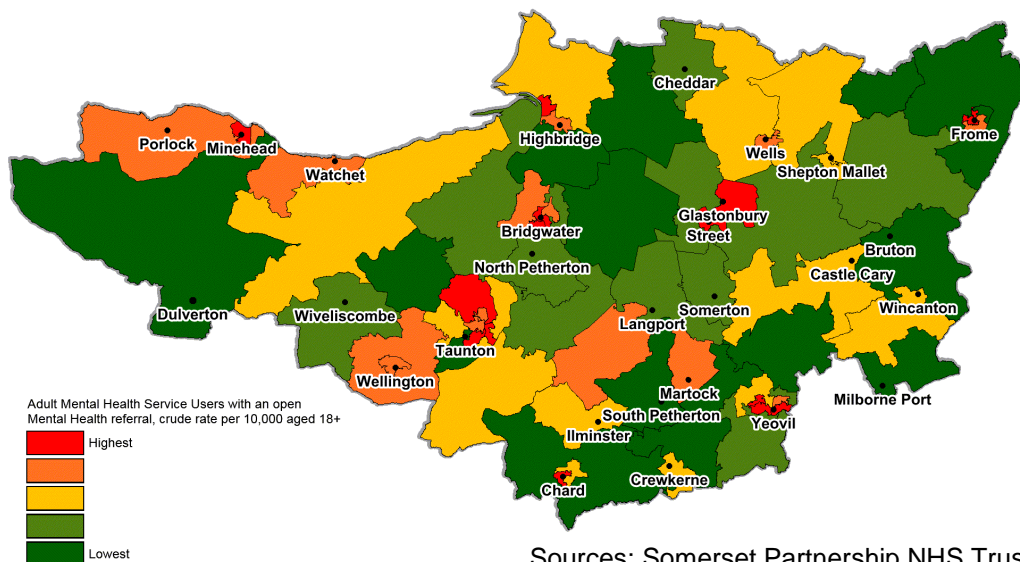
<http://www.somersetintelligence.org.uk/hidden-harm.html>

Parental mental illness is associated with increased rates of mental health problems in children and young people, with an estimated one to two-thirds of children and young people whose parents have a mental health problem experiencing difficulties themselves.

Based on national estimates, one in six (or 88,000) people in Somerset could be suffering from a common mental health problem at any one time and 80% of these will not be receiving treatment. Mental health referral data indicated that contact with mental health services is more likely in the major towns, as shown in Figure 11.

However, given that only 20% of people with such conditions are likely to be in treatment, great care should be taken in treating this as a map of incidence. The data does not record whether people with mental health problems are also parents; therefore this is currently a gap in information.

**Figure 11: Map of contact with Mental Health Service Users with an open Mental Health referral by MSOA, between April and December 2014**



Sources: Somerset Partnership NHS Trust; ONS Mid Year Population Estimates by MSOA

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## Housing, Poverty and Financial Inclusion

<http://www.somersetintelligence.org.uk/housing.html>

Based on the “rooms” definition, there were about 14,000 under-25s living in overcrowded accommodation and 3,400 in households without central heating. Almost 600 under-25s lived in overcrowded homes without central heating.



### Housing and health

Poor housing can have a direct impact on the health and wellbeing of young people. Outcomes of poor housing conditions such as overcrowding, damp, indoor pollutants and cold have all been shown to be associated with illnesses including eczema, hypothermia, heart disease and, in particular, respiratory ill-health.

Children living in overcrowded homes are up to 10 times more likely to contract meningitis and three times more likely to have respiratory problems. Children under five years old are particularly vulnerable to gastro-intestinal illness and skin infections in housing with poor sanitation.



Children are more likely to live in overcrowded housing than working age adults and pensioners. Nationally about 15% of social housing and about 30% of privately rented housing would fail the Decent Homes Standard<sup>23</sup>. Older figures suggest that in Somerset, more than 40% of privately rented homes would fail to meet the standard.

The association between poor housing and poor mental health is less established than for physical health. However, living in poor housing conditions has been shown to increase stress and reduce empowerment and control, each of which has clear links with mental health.

There is a growing base of evidence to indicate that children under school age are very susceptible to long-term mental health issues, such as anxiety and depression, if they are in substandard housing.

The harmful aspects of substandard housing include noise and overcrowding. The latter also has an impact on school performance if there is a shortage of space to do homework. Housing quality is an element in the IMD<sup>1</sup>, so it is unsurprising that poor housing is most often found in communities that are deprived on other measures.

### **Housing availability and homelessness**

<http://www.somersetintelligence.org.uk/youth-housing.html>

Housing availability has impacts on housing quality, as parents may discover that the only accommodation they can find is of a lower quality than they would like. A further critical point for young people is when they start to look for their own accommodation independent of their parents. For some, with parental support, this can be a comparatively smooth transition. Others, especially those leaving care, with particular needs of their own or with a difficult relationship with their parents, require additional support.

In Somerset this additional support is provided by P2i (Pathways to Independence) in which a range of agencies work together to support young people at risk of homelessness into housing. Nearly 750 young people aged 16-24 *needed* help with access to housing in 2015, using the P2i service. The P2i internal needs analysis in 2015 found that 662 people *received* support from P2i services in 2014/15.

Table 8 shows the needs of young people accessing P2i services in Somerset.

**Table 8: Young people (excluding care leavers) accessing P2i services and support received**

<b>Client Group</b>	<b>Percentage</b>
Homelessness (single homelessness)	61% (30%)
Mental Health	10%
Substance Misuse	8%
Rough Sleeping	5%
Offending	4%
Learning Difficulty	3%
Harassment or Domestic Abuse	2%
Disability	2%
Other	5%
Total	100%

Between April 2013 and March 2015 there were 525 unique Leaving Care records. Some duplicates exist for people who are supported by multiple teams and different areas of the county.

Table 9 shows how many moves were experienced by care leavers on the caseload within this period. Half the young people had no more than one move; however over a third moved at least three times.

**Table 9: Accommodation moves for young people on the Leaving Care caseload between April 2013 and March 2015**

Number of Moves	People	Percentage
None	133	25%
One	125	24%
Two	82	16%
Three to Five	110	21%
Six to Ten	59	11%
Eleven Plus	13	2%

There were nine care leavers who were of no fixed address and/or homeless on 31 March 2015.

Consultation to support the P2i Needs Analysis, with the Leaving Care Council members, found that young people said:



“..... they are concerned about managing their finances, understanding their responsibilities, loneliness and keeping themselves safe. Generally they would like to live in shared accommodation with people they know and trust or return to live with their families or move into an independent flat. They would like information and advice on managing their finances, independent living skills (such as cooking), accessing employment, tenancy issues and access to good quality accommodation with good landlords.”

Most young people continue to live with parents until they are prepared to set up on their own and housing support may involve helping them to live with parents or other family.

As one client reported in the P2i needs analysis:



*“Living in supported housing is good. They have helped me get back in contact with my family.”*

However, in some cases, notably where there is domestic abuse or other elements of “hidden harm”, young people may be safer and require support away from the family home.

## Low Income

<http://www.somersetintelligence.org.uk/child-poverty.html>

In Somerset 13,085 children (aged under 16) were considered to be living in poverty in 2013, equating to 14.1% of all children, as defined by the Children in Low-Income Families Local Measure (CLIFLM). This proportion was the same as in 2012, and down from a peak of 15.6% in 2009 during the economic recession.



The CLIFLM is the proportion of children living in families either in receipt of out of work benefits or in receipt of tax credits, with a reported income which is less than 60% of national median income. This measure provides a broad proxy for the relative low-income measure as used in the Child Poverty Act 2010<sup>24</sup> and enables analysis at a local level.

Nationally, poverty is the strongest predictor of a child's future life-chance. The highest early achievers from poorer backgrounds are overtaken by lower achieving children from advantaged backgrounds by age seven; by the end of Key Stage 1 the odds of a pupil eligible for FSM achieving Level 2 in Reading, Writing and Maths are one third those of a non-FSM pupil.

The gap widens further during secondary education and persists into Higher Education. The odds of an FSM pupil achieving five or more GCSEs at A\*-C including English and Maths are less than one third those of a non-FSM pupil. A pupil from a non-deprived background is more than twice as likely to go on to study at university as their deprived peers. Attainment gaps have proved to be persistent and slow at narrowing despite investment.

Not only do poor families have less money than the rich, they also face the so-called "poverty premium". National research has shown that a typical low-income family could pay over £1,200 a year more than better-off families for their basic goods and services. Those lacking a bank account or who have no internet access are especially affected, for example, by being unable to shop around for cheaper household utility prices.

Levels of child poverty in Somerset are consistently below south west and national averages, as shown in Table 10, but mask significant variations at lower geographical levels.

**Table 10: Children under 16 in poverty, 2006-2013 (%)**

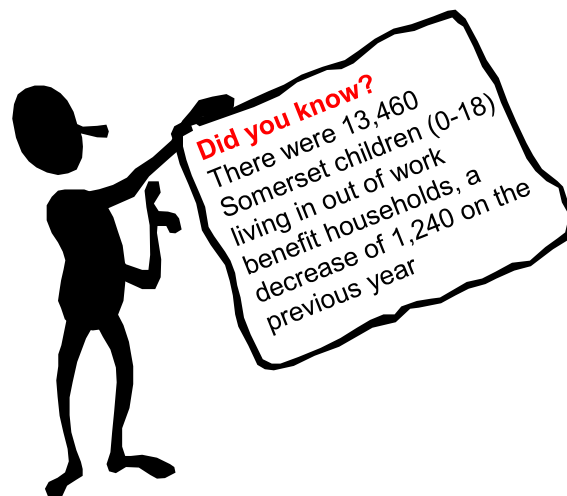
	2006	2007	2008	2009	2010	2011	2012	2013
<b>England</b>	21.8	22.4	21.6	21.9	21.1	20.6	19.2	18.6
<b>South West</b>	16.6	16.9	16.5	17.2	16.6	16.2	15.1	14.8
<b>Somerset</b>	15.2	15.5	14.8	15.6	14.9	14.9	14.1	14.1

At a district level, the highest percentages of children in poverty in 2013 were in Sedgemoor (17.2%) and the lowest were in West Somerset (15.0%). Taunton Halcon Ward had the highest proportion of children under 16 living in poverty (30.6%). This is consistent with other data and anecdotal evidence showing an intensity of need in Taunton Halcon that is not matched elsewhere in the county, even though the extent of poverty in Bridgwater may be greater in general.

### Out of work benefits

There were 13,460 Somerset children (aged 0-18) living in households in receipt of out of work benefits, a decrease of 1,240 children on the previous year.

There were a total of 7,240 households claiming at least one out of work benefit, a decrease of 630 on the previous year. These falls mirrored national downward trends. At a local (ward) level, the largest annual falls in numbers of children in out of work benefit households were in Taunton Halcon and in Bridgwater Sydenham. Meanwhile, increases were seen in Frome Keyford, Crewkerne and in Taunton Blackbrook and Holway (based on pre-2013 ward boundaries).



### Troubled Families

The Troubled Families Programme is a national initiative that seeks to “turn around” the lives of 120,000 households, who were estimated to cost the public purse £9bn per year at the start of the project. This cost includes policing, health and benefits. 20,400 families have been identified as having one or more of the “troubles” in question. The implementation of the programme is by local authorities, who have selected families who meet three of the following four criteria:

- Are involved in youth crime or anti-social behaviour.
- Have children who are regularly truanting or not in school.
- Have an adult receiving out of work benefits.
- Cause high costs to the taxpayer.

In Somerset, 2,790 have been identified for the Troubled Families Programme, with three or more eligible areas of need.

This means that there is local data about particular families which is useful for understanding the overlap between different categories of need. This is because the programme records how many “troubles” a family has, rather than the more usual classification of how many families have a particular trouble.

This allows us to find out whether problems are spread randomly in the population, or whether some families have a concentration of need. Figure 12 shows that of those identified, school truancy is the most prevalent, followed by worklessness.

Least prevalent appears to be long-term ill health (causing high costs to the taxpayer); this is deceptive and merely reflects limited access to data. This domain will be not be shown in subsequent graphs.

**Figure 12: “Troubles” in Somerset families**

**Key:** Work=worklessness, School=school absence, CiN=Child(ren) in Need, DV=Domestic Violence and Abuse, Crime=Criminal offending, Health=long-term, high-cost ill health

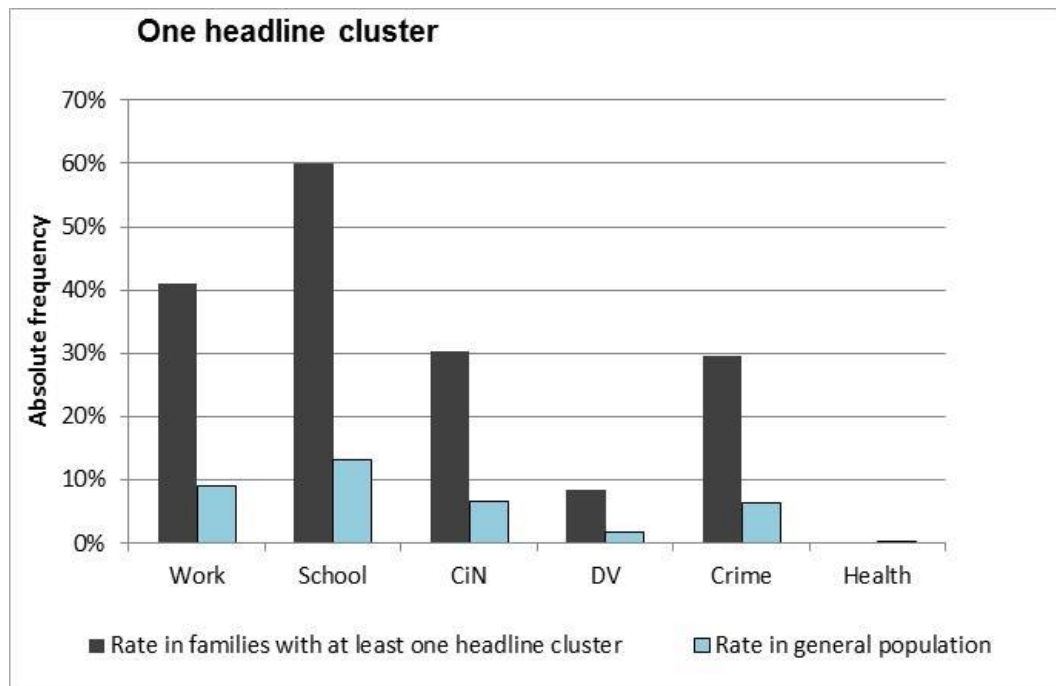


Figure 13 and Figure 14 show maps of school absence and domestic violence. Truancy is more prevalent and widely dispersed in the county, whereas domestic violence and abuse is notably concentrated, largely in the most deprived communities described in the previous section.

This widespread pattern of school absence fits with more qualitative evidence, suggesting that this can be the result of “chaotic” family circumstances rather than more immediately serious, malign, harm.

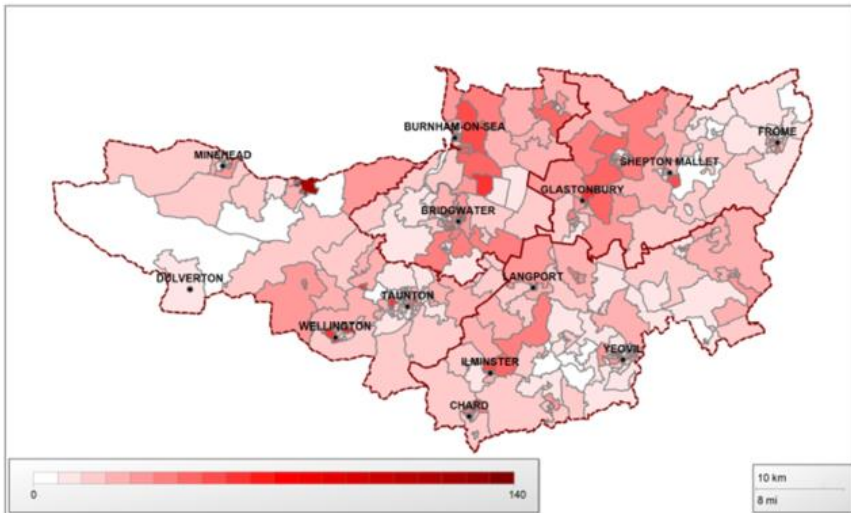
On the other hand, the case studies from Taunton Learning showed a very different dimension of need.

**Case studies**

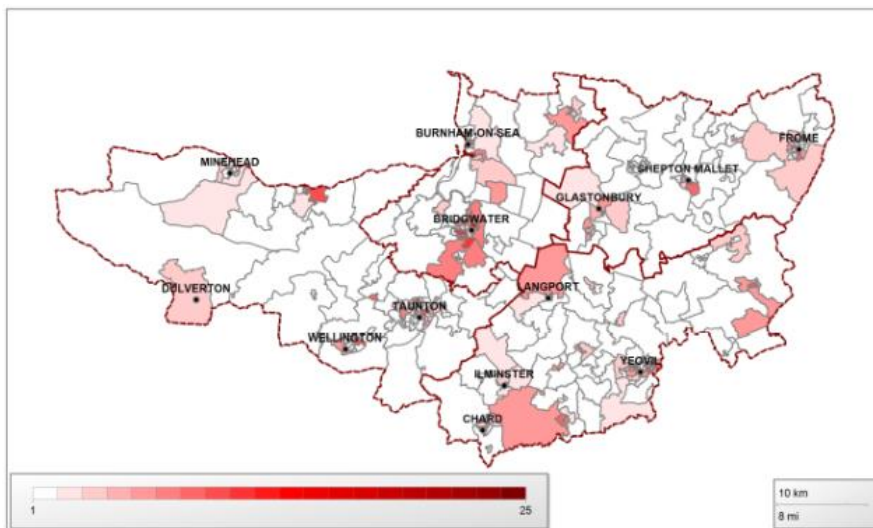
*A six year old is at risk of permanent exclusion. His parents are very young and separated, with the father not present. The mother is refusing to medicate the child for ADHD in the hope that he will be sent to a special school.*

*A five year old child – her mother’s seventh child, each by different fathers – had been at nursery and without parental support almost since birth. She arrived at school biting, spitting and eating excrement.*

**Figure 13: Troubled Families – school absence (numbers per LSOA)**



**Figure 14: Troubled Families – Domestic Violence (number per LSOA)**



**Figure 15: Troubled Families – children in need (number per LSOA)**

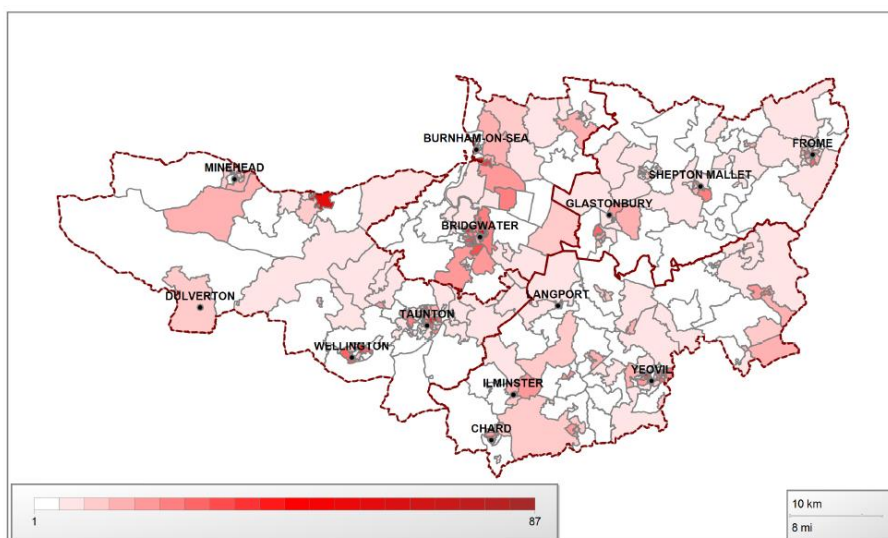
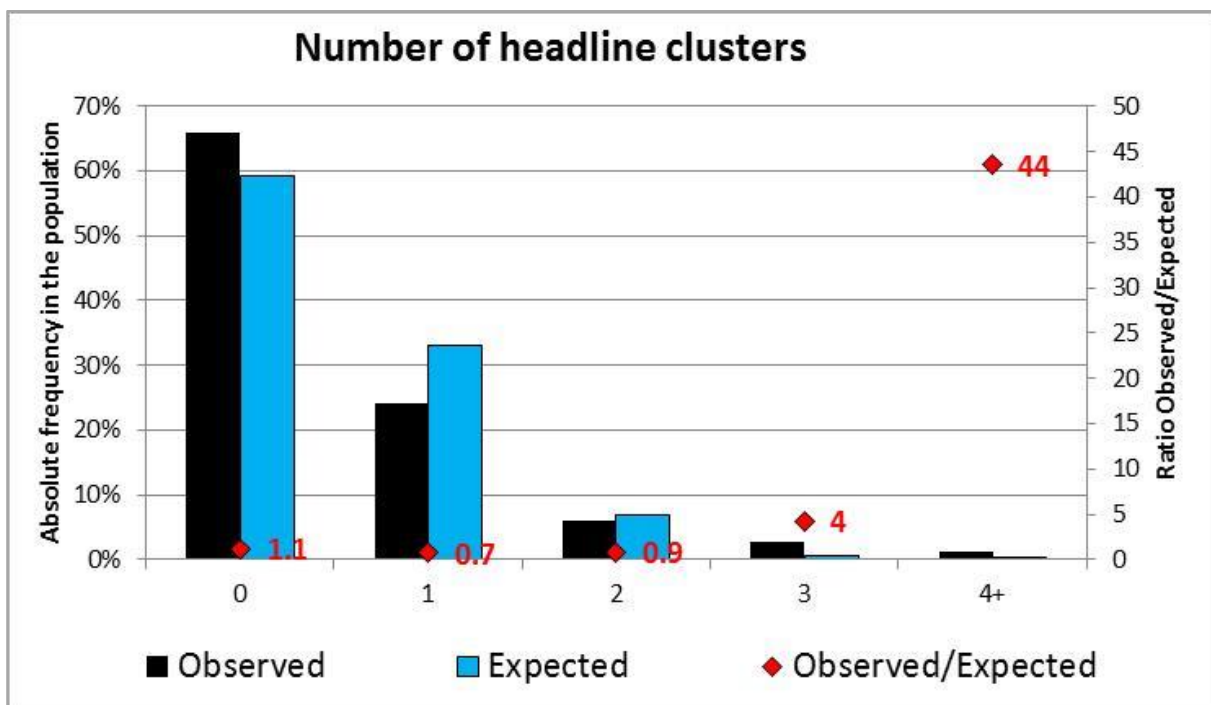


Figure 14 and Figure 15 show a strong relationship between communities with high rates of recorded domestic abuse and deprivation, as shown also shown in Figure 22, later on in this report. Whilst a degree of caution needs to be exercised, as the data is *recorded* rather than *actual* domestic abuse, the degree of association reinforces the case for a general focus of efforts on the most deprived communities to address inequalities.

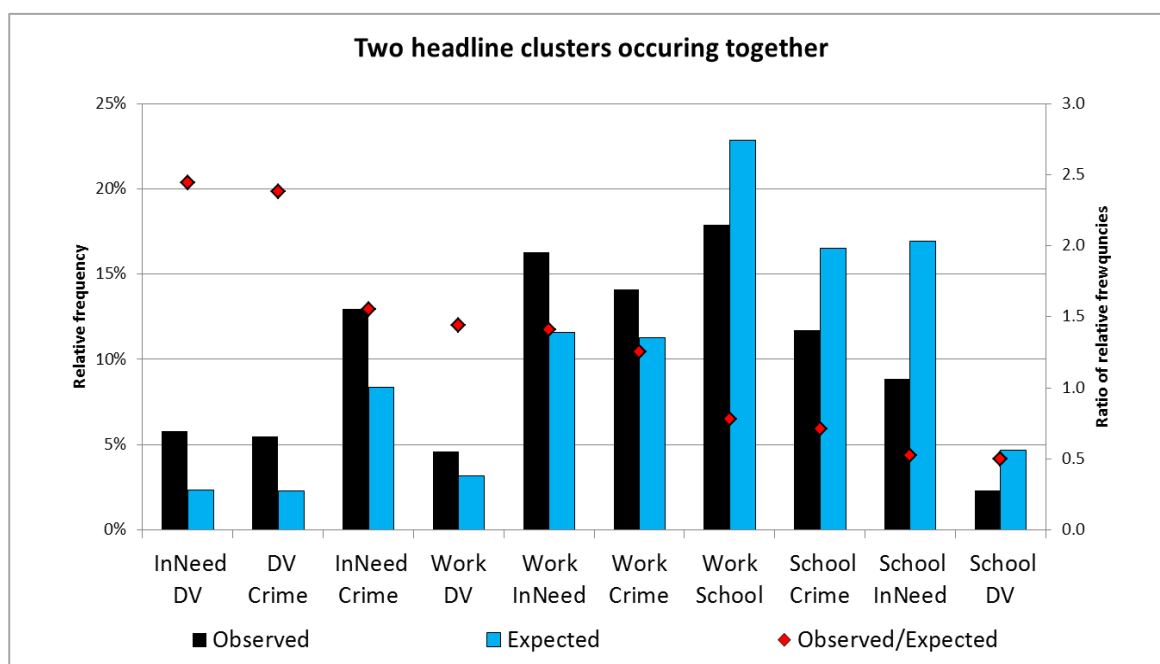
The great value of the troubled families database is that we can study how different “troubles” are related to each other. Figure 16 shows how more families than we might expect have no apparent problems at all and fewer than we would expect have one or even two, but for three or more the figures are considerably higher, suggesting that there is a strong tendency for troubles to come “in battalions”.

**Figure 16: Proportions of Families with numbers of “troubles” – actuals compared to the expected values in a random distribution**



Even more valuable is the ability to see which problems tend to be associated together, as shown for two headline clusters in Figure 17. Unsurprisingly, the combination of worklessness and truancy (which are the most frequent single categories) is the most common, but it is noticeable that the two combine less frequently than might be expected. Children in need and domestic violence, and domestic violence and crime, are found together about two and a half times more than might be expected. Conversely, the combinations involving truancy are less common than expected.

**Figure 17: Observed, expected and relative frequency of two troubles from the Troubled Families database**



This broad pattern is also found in combinations of three and four dimensions of need. This confirms the assertion that vulnerable children, especially the *most* vulnerable, are at multiple risk.

The more criminal or abusive factors tend to be found disproportionately together, whilst worklessness and school absence, which may be more transitory or associated with “chaotic” families, are more dispersed geographically and less likely to be associated with other dimensions of need.

The troubled families database enables a type of analysis that is not possible with other data that cannot – at the moment - be joined up in the same way. This reinforces the need to use a common identifier, such as the NHS number, between agencies to understand need in a child-centred way, although that is not enough in itself to show family relationships.

Analysis of this sort is dependent on the quality of the data and it may be that inclusion of meaningful health data, or other factors, might affect the results considerably. Nevertheless, what this shows is consistent with other research findings which distinguish between broadly chaotic families and those where harm to children may be more serious and intentional.<sup>25</sup>

This concentration of multiple need in the most troubled families is often implicit in analysis but is difficult to demonstrate at the local level. It has important implications for commissioning services.



## Safeguarding

### Children in need

When a child is referred to children's social care, an assessment is carried out to identify whether the child is in need of services which local authorities have an obligation to provide, under Section 17 of the Children Act 1989<sup>26</sup>. These services can include family support, leaving care support, adoption support or disabled children's services.



- There were 4,264 children assessed as being in need in Somerset as at 31 March 2015, equating to 392 per 10,000 population. This represents an increase of 6%, from 4,037 the previous year.
- There were 5,591 referrals to Somerset Children's Services in 2014/15 compared to 7,338 in 2013/14. Anecdotal evidence from local authorities across the country suggests that increased media attention on child protection led to an increase in the number of referrals in 2013/14. There were 6,170 referrals during 2012/13. At a rate per 10,000 population, referrals to Children's Social Services in Somerset in 2014/15 (513.4 per 10,000) were below national (548.3 per 10,000) and statistical neighbour (535.3 per 10,000) averages.
- The police and schools continue to be the most common referral sources (each accounting for 21% of all referrals), followed by health services (18%) and local authority services (14%).
- There were 1,508 re-referrals (within 12 months) in the year to March 2015, accounting for 27% of all referrals. This proportion was above the averages for the South West (25%), national (24%) and statistical neighbour (24%).

### Child Protection Plans (CPP)

There has been a strong recent decline in the number of children with a CPP, down to 268 children in December 2015, from 522 in March 2015. This is a rate of 25.3 per 10,000, lower than both the statistical neighbour rate of 39.2 per 10,000 and the England rate of 42.9 per 10,000. This welcome decline is the result of a review and greater clarity on thresholds and the consequent closure of a number of cases that no longer meet the threshold for a CPP.

The percentage of children becoming subject to a CPP for a second time during the previous 12 months was, at January 2016, 25.1%, (120 out of 478 in the period). This is higher than the statistical neighbour average (19.3%) and the national average (16.6%).

At the end of March 2015 in Somerset, children were the subjects of CPPs for the following reasons:

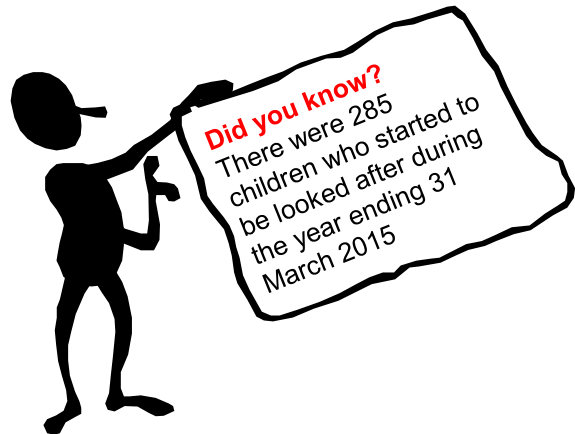
- Emotional abuse – 245 plans 46.9% (39.6% the previous year).
- Neglect – 180 plans 34.5% (30.1%).

- Physical abuse – 13 plans 2.5% (5.1%).
- Sexual abuse – 22 plans 4.2% (4.4%).
- Multiple factors – 62 plans 11.9% (20.8%).

A total of 511 children ceased to be the subject of a plan during 2014/15. Approximately 28% of plans lasted a year or more, including 3% (17 plans) which lasted two years or more. These plans ended for reasons which included no being longer at risk of harm, reaching 18 years old, leaving the country or death. In some cases the plan may have been ended in Somerset but another started in a new county if the child moves.

### Children Looked After (CLA)

Under the Children Act 1989<sup>26</sup>, a child is legally defined as “looked after” by a local authority if he or she is provided with accommodation for a continuous period of more than 24 hours, is subject to a care order, or is subject to a placement order.

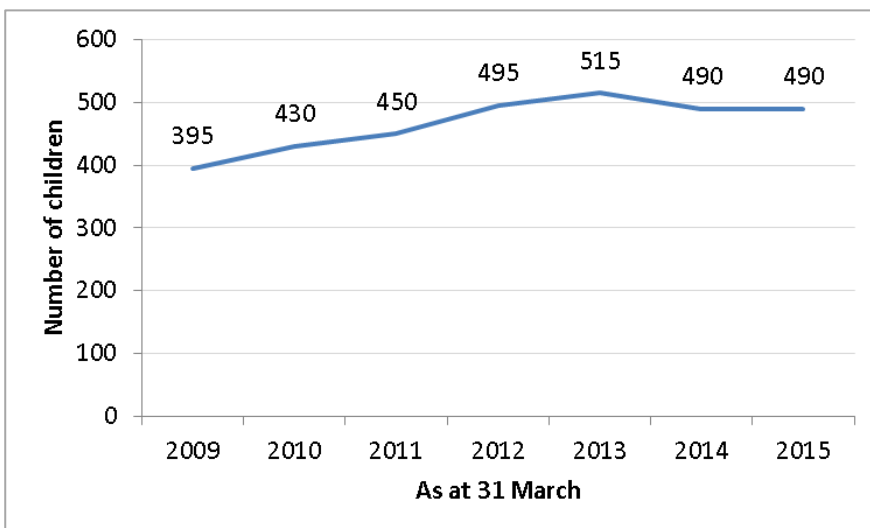


As of 31 March 2015, there were a total of 490 CLA in Somerset, the same number as at the equivalent time in 2014; however, rates of CLA in Somerset remain lower than the England average. Adoptions of CLA continue to rise.

There were 285 children who started to be looked after in Somerset during the year ending 31 March 2015, an increase of 10% (25 children) on the previous year’s figure. There was a slight fall in the number of children ceasing to be looked after, meaning that the total number was stable, after a fall in the previous year.

Nationally, there was a 2% increase between 2014 and 2015. In Somerset, there were 295 children who ceased to be looked after during the year ending 31 March 2015, marginally lower than the figure for 2014 (2%). There were 55 CLA adopted during the year ending 31 March 2015, up from 50 children in 2014 and 30 in 2013.

**Figure 18: Numbers of CLA in Somerset, 2009 to 2015**



## The Voice of Children Looked After

As part of an engagement event with CLA in 2015, solutions were sought to barriers to doing well at school. Being able to stay at the same school played an important role.

- *Make sure I have the correct uniform for when I start.*
- *Better planning, no unnecessary placement changes.*
- *Social worker tries and keeps you in one place.*
- *Try to stop changes happening, find solutions, ways around it.*
- *Help schools to better understand the difficulties/stresses CLA experience - help them to understand why I am stressed.*
- *Let schools know of any changes in placement before I get there, so I don't have to explain myself and they understand.*

## Children leaving care

There were 519 young people aged 16-25 supported by the Leaving Care Service between April 2013 and March 2015<sup>ii</sup>. Of these, 119 were aged 16-17 and 400 were aged 18-25.

Somerset County Council has undertaken work to ensure that all care leavers have a Pathway Plan which they can contribute to and understand, with specific actions and timescales. These plans must be in place by the time the young person is aged 16½. A new Pathway Plan format has been introduced which is more holistic and better promotes the involvement of young people.

At the time of writing, 100% of all care leavers aged over 18 have a Pathway Plan, of which 95% are current. Over 72% of young people were involved in formulating those plans. By the age of 16½, 83% of young people have a Pathway Plan in place.

## Needs and difficulties experienced by Somerset care leavers

An exercise was undertaken by the Leaving Care Service in 2007, to identify the level and types of need of care leavers, to aid understanding and seek funding for improvements in services.

A snapshot was taken of those experiencing significant difficulties in a range of areas, to the extent that it impinged on their everyday lives, by the four area Leaving Care Service team leaders. The exercise was repeated in March 2012 and since then the situation has been monitored annually.

The overall number of care leavers has increased significantly since 2007 and those reported on increased from 304 in 2007 to 423 in 2014 (482 in 2013). The percentage of those thought to be experiencing significant difficulties has more than doubled to 68%.

<sup>ii</sup> This figure can be higher due to a duplication of records where a young person is supported by multiple teams and areas

The majority of care leavers are resident in the major towns of Taunton, Bridgwater and Yeovil, although some also leave for towns outside the county.

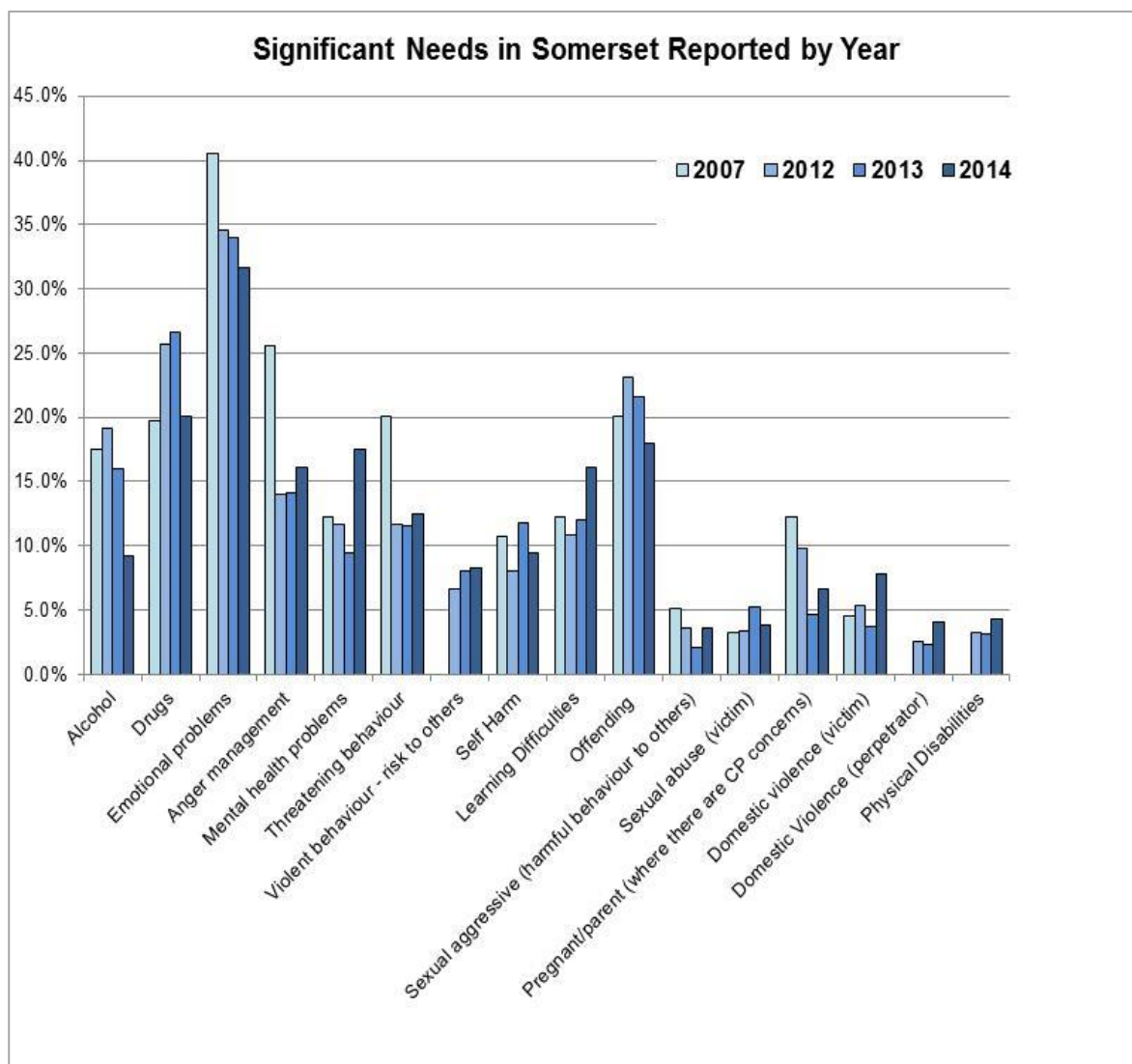
**Table 11: Self-identified areas of concern for Somerset Care Leavers (numbers)**

Area of concern	2014	2013
Alcohol	39	77
Drugs	85	128
Emotional problems	134	164
Anger management	68	68
Mental health problems	74	46
Threatening behaviour	53	56
Violent behaviour - risk to others	35	39
Self-Harm	40	57
Learning Difficulties	68	58
Offending	76	104
Sexually aggressive (harmful behaviour to others)	15	10
Sexual abuse (victim)	16	25
Pregnant/parent (where there are CP concerns)	28	22
Domestic Violence (victim)	33	18
Domestic Violence (perpetrator)	17	11
Physical Disabilities	18	15
<b>Number of YP with Significant Needs</b>	<b>289</b>	<b>295</b>
<b>Number of YP without Significant Needs</b>	<b>134</b>	<b>187</b>
<b>Total no. of young people</b>	<b>423</b>	<b>482</b>

The highest single category reported is emotional issues which, at 30.9% is concerning but is decreasing. The highest issue, if figures for drugs and alcohol are combined, is also declining, with alcohol following the trend for the past two years. Offending has shown a decline in the last two years from a high in 2012.

Mental health problems, Learning Difficulties and domestic violence (victim) have all increased substantially.

**Figure 19: Trends in self-reported areas of concern for Somerset Care Leavers (numbers)**



Pregnancy/parenting, where there are safeguarding concerns, had reduced by over a half from a high in 2007, but has increased again since 2013. About half of care leavers are parents, more than half of whom have either had children removed or who have safeguarding concerns regarding their children. It is thought that many of these parents may go on to have further children. The leaving care cohort might benefit from parenting advice, in pre-pregnancy, in pre-birth assessments and in early years services such as health visiting.

Housing is not considered here, but is discussed in the **housing section** of this report on page 43.

## Implications for Commissioning

- Raising the conditions for vulnerable children across the county is best achieved by improving the lot of the most in need fastest, as they have a strongly disproportionate burden.
- The “second tier” of need may have a number of families who are described here as “chaotic”, or suffering from temporary difficulty, such as short-term unemployment. Lack of parental care or attention may constitute neglect and lead to such children falling into more serious trouble.
- Families with few needs nevertheless require universal services, such as schools and immunisation. For some, such services may prevent more serious consequences and should be valued for their cost effectiveness, as well as contributing to wellbeing.
- The families with most significant need appear to be concentrated in the most deprived communities, reinforcing the importance of providing services very locally in these areas.
- This analysis is consistent with the recommendation of the Marmot Review<sup>27</sup> to adopt “proportionate universalism” – focusing services on those most in need, whilst maintaining some provision for all.
- The incompleteness of analysis because of incomplete data-sharing is an important implication in its own right. It affects both strategic planning and practical support to families.



# SECTION 3 – THINK COMMUNITIES

## Population

<http://www.somersetintelligence.org.uk/population-estimates-and-projections.html>

The ONS 2014 mid-year population estimates for Somerset put the total population of those aged under 25 at 148,017, consisting of 75,927 males (51.3% of the total) and 72,090 females (48.7%). Age band estimates are provided in Table 12.

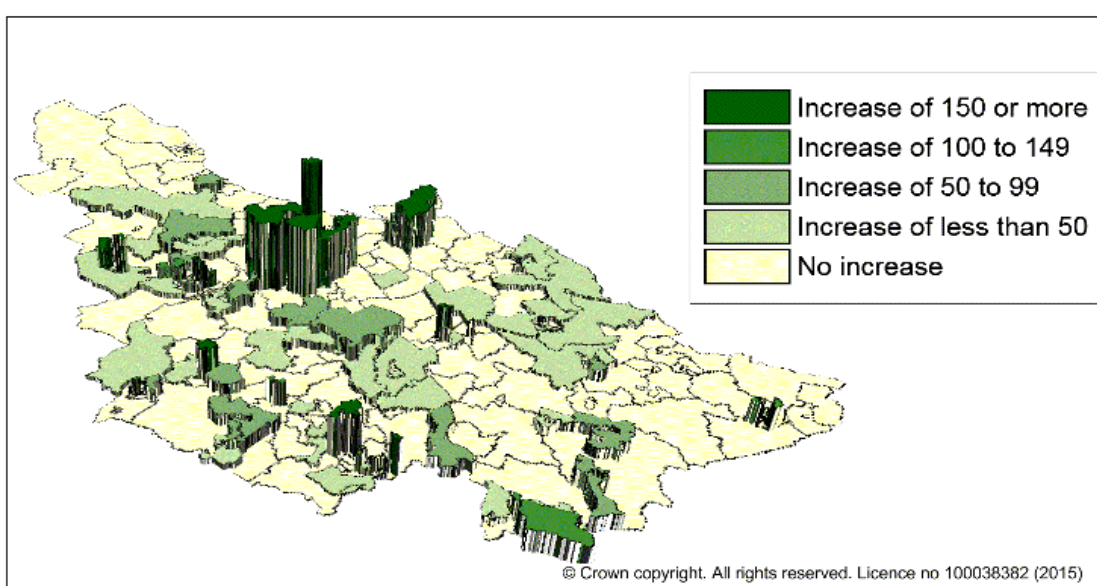
**Table 12: Selected age bands, 2014 mid-year population estimates**

Somerset Age Bands under-25s	Number	% of Somerset population
0-4	29,628	5.5%
5-10	35,535	6.6%
11-15	30,076	5.6%
16-17	13,660	2.5%
18-24	39,118	7.2%
0-24	148,017	27.3%
All ages	541,609	100%

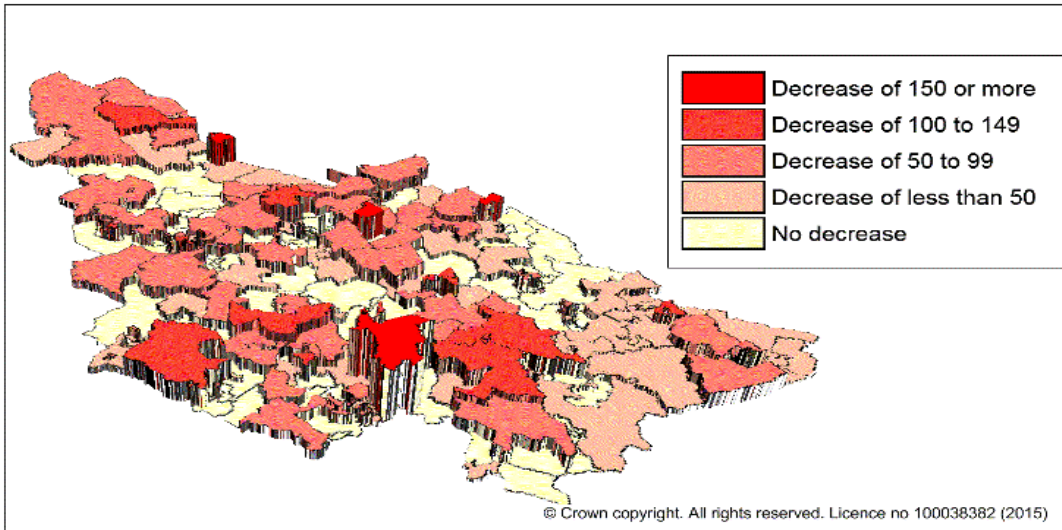
Whilst the population of those aged over 75 in the county is expected to more than double in the 2012-based population projections to 2037 (from 55,600 to 112,200), the number of young people is expected to grow only slowly.

The number of people aged under 16 is expected to grow from 94,800 to 101,600 in the same period. The changes in population are not, of course, consistent across the county. Figure 20 and Figure 21 show areas of expected growth and decline in the numbers of young people from 2014-24.

**Figure 20 and Figure 21: Projected change in population aged 16 and under, 2014-2014**







Just over half of the population of Somerset live in the 11 large towns classified as urban by the Office for National Statistics; Taunton, Yeovil, Bridgwater and Frome are the four largest towns with a third of the county's population. The rural town and dispersed population makes up 48% of the population, with population density particularly low in the upland of West Somerset and the Mendips, and in the lowland Levels and Moors.

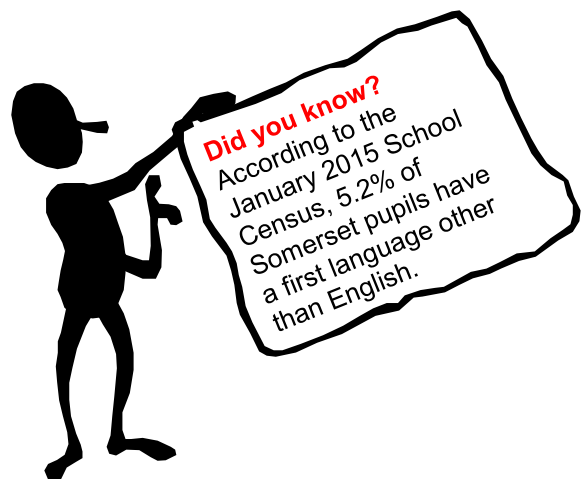
Whilst small area projections should always be treated with caution, especially when broken down further to segments of the population (such as young people), the broad pattern of expected change is clear. The most significant growth is in the largest towns along the M5 and to a lesser extent Yeovil, and decline in many rural areas especially in the west and east of the county.

These rural areas tend to have the most elderly population structure already. This reinforces the importance of providing services for young people in urban areas, and exacerbates the difficulties of providing them to young people in rural areas where these services are likely to become even more dispersed.

### Ethnicity and language of young people

<http://www.somersetintelligence.org.uk/school-pupil-ethnicity.html>

The large majority of young people in Somerset are, as with the adult population, white British. According to the January 2015 School Census, 91.5% of Somerset pupils are of White British ethnicity. The next most common broad ethnic group is White Other (encompassing White European ethnicity) at 4.0%.



Pupils of mixed ethnicity make up 2.2% of the school population, Asian ethnicity 1.2% and Black ethnicity, 0.2%. The 2011 census suggested that the mixed ethnicity population group is strikingly younger than the population overall, with half of people being aged under 20. Gypsy or Irish Travellers comprise 0.4% of Somerset's school population (282 pupils).

According to the January 2015 School Census, 5.2% of Somerset pupils have a first language other than English. The most common non-English language in schools is Polish (1.9% of pupils), followed by Portuguese (0.5%) and Lithuanian (0.2%).

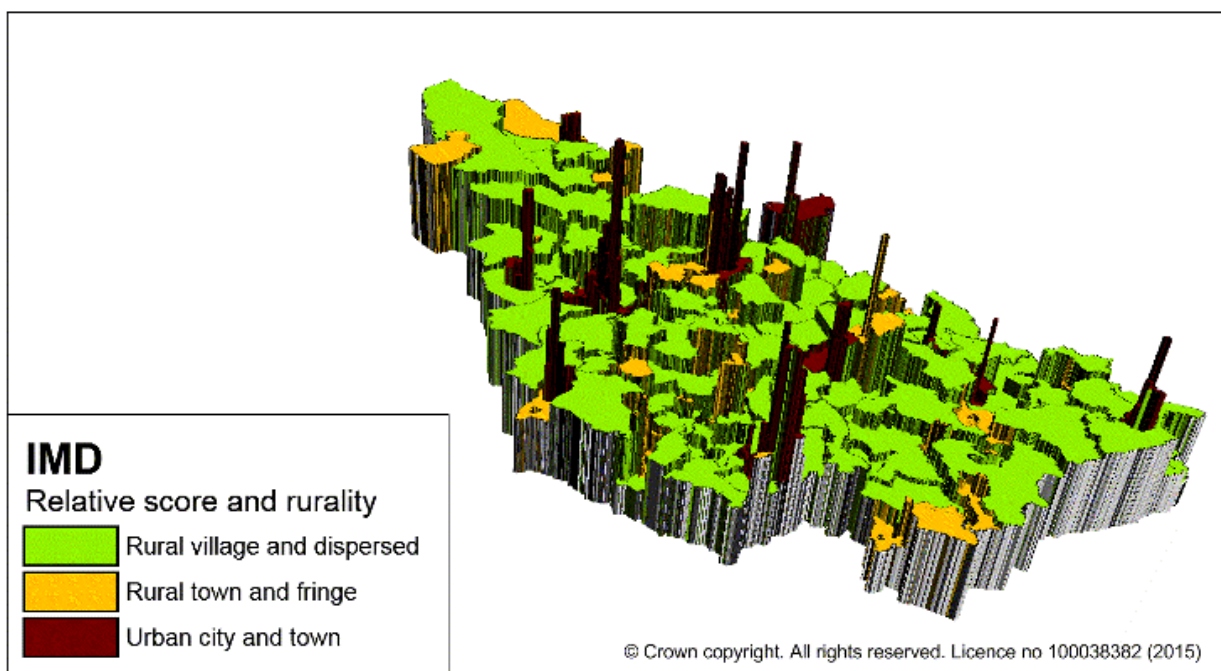
## Deprivation

At the community level, the IMD<sup>1</sup> is well established as a broad measure of need, made up of measures of income, health, education, environment and access to services at the neighbourhood level using LSOAs, a census-based geography with about 1,500 residents.

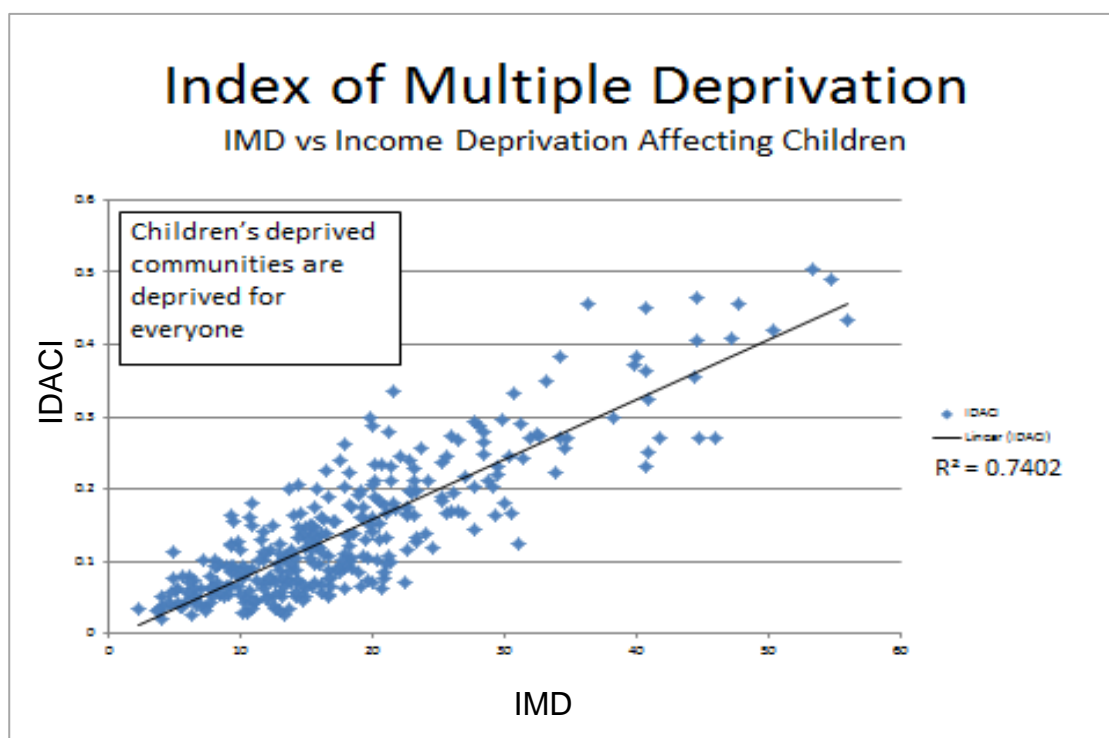
Figure 22 shows the pattern of deprivation in Somerset, with the most intense deprivation in urban areas. Rural areas, especially in West Somerset, also appear prominently. This is because of their high deprivation scores on “geographical access to services” and their large geographical area.

Figure 23 shows how the IMD<sup>1</sup> (overall) correlates strongly with the specific IDACI with 74% of the variation being explained. The latter is used preferentially in this report, but the graph shows how the use of the IMD<sup>1</sup> is a good proxy for children, and indeed may pick up elements of deprivation that undoubtedly affect children.

**Figure 22: Index of Multiple Deprivation in Somerset**



**Figure 23: Index of Multiple Deprivation (main index) compared to Income Deprivation Affecting Children Index for LSOAs in Somerset**



**Table 13: Inequality between communities**

<b>Somerset Lower Super Output areas in most deprived national 10%</b>			
<b>Description</b>	<b>IDACI Score</b>	<b>National Rank</b>	<b>Somerset Rank</b>
Bridgwater Sydenham Central	0.505	722	1
Taunton Roman Road	0.489	947	2
Bridgwater Hamp East	0.466	1,320	3
Bridgwater Hamp South West	0.457	1,484	4
Yeovil Westfield	0.456	1,503	5
Bridgwater Parkway South	0.450	1,613	6
Taunton Lambrook	0.434	1,973	7
Taunton Lyngford East	0.420	2,287	8
Highbridge South West	0.408	2,609	9
Bridgwater West Street	0.406	2,679	10

These are the ten Somerset LSOAs in the 10% most deprived nationally.

The 26 most deprived LSOAs (out of 327) on the IDACI measure are all urban. This concentration of deprived areas is shown clearly in Figure 24 and Figure 25 and means that 50% of income-deprived children live in 5% of the county’s geographical area and 10% live in less than 0.1% of the area, all within Taunton, Bridgwater and Yeovil.

The three most deprived LSOAs in the “rural town and fringe” ONS category are:

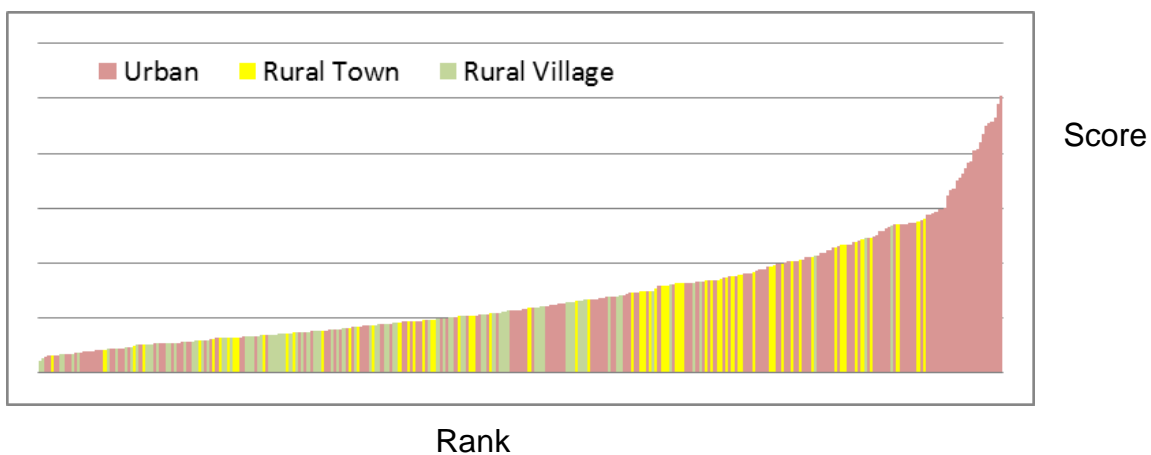
- Woolavington (Somerset rank = 27) - Sedgemoor
- Williton North (29) – West Somerset
- Glastonbury Central (36) - Mendip

The three most deprived LSOAs in “rural village and dispersed” are:

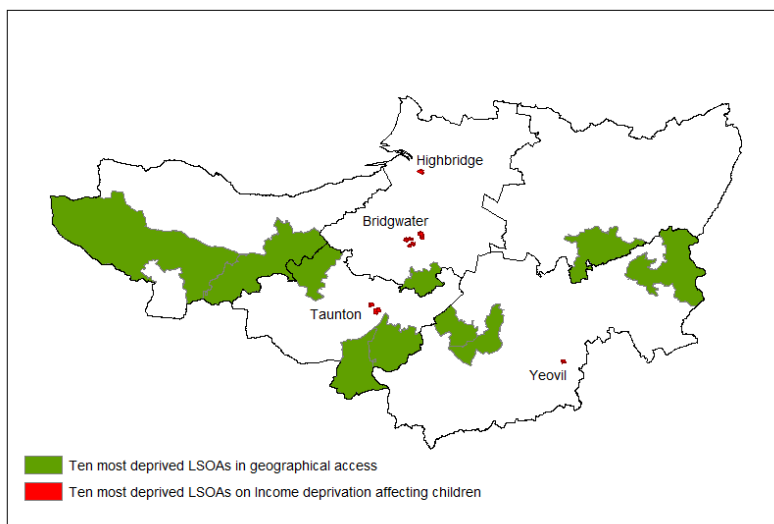
- Old Cleeve (38)
- Carhampton & Withycombe (47) – both West Somerset
- Chilton Polden (119) – Sedgemoor.

Figure 24 shows the location of the LSOAs with the highest rate of child poverty, which can be taken as a good proxy for identified need. Of these, nine are in the three largest towns in Somerset – Taunton, Yeovil and Bridgwater, with one other in Highbridge.

**Figure 24: Slope chart of urban, small town and rural LSOAs on IDACI**



**Figure 25: Map showing the 10 most deprived LSOAs on IDACI score and 10 most deprived on the “access to services” domain**



These areas undoubtedly show the highest levels of community deprivation in the county, and many measures in this report show a broad level of correspondence between this and need at the family or individual child level. These ten are in the most deprived 10% in England on this measure.

The map also shows the most deprived LSOAs in terms of their distance to services. This indicates the areas where rurality poses the greatest difficulties in delivering services, and where evidence of child need will be particularly “diluted” by diversity within the area. As many statistics use provision of services as a proxy for need, this may imply some under-identification of need in these areas.

In Somerset, there are 78 LSOAs in the most deprived 10% in England on this measure.

### **Inequality between groups**

Just as there are geographical inequalities in wellbeing, there are also different social groups and communities which show inequality:

- Breastfeeding initiation rates in the least deprived social groups in Somerset are 88% compared to 69% in the most deprived groups.
- Breastfeeding prevalence at 6-8 weeks is 59% for the least deprived social groups in Somerset compared to 26% in the most deprived.
- Recorded CSE tagged crimes in Somerset increased to 76 in the year to August 2015, compared to 50 in the previous 12 months, similar to the rise across Avon and Somerset Constabulary Area. National research shows that CLA are more likely to be at risk of CSE and involvement in crime than their peers.
- At December 2015 there were 268 children in Somerset with a CPP in place. Analysis in January 2015 suggested that 18% had all three hidden harm factors: substance misuse, mental illness and domestic abuse.
- For the Early Years Foundation Stage (EYFS), girls continue to out-perform boys with 73.3% of girls, and 60.2% of boys achieving a Good Level of Development. The 13.1% gap is narrower than the South West regional (15.7%) and national (15.6%) averages.
- For those eligible for FSM, at Key Stage 1 Level 2b+, the already significant gap between FSM pupils and their peers widened in all three subject areas in 2015:
  - the gap in Reading at Level 2b+ has widened by 3.4% to 18.5%
  - in Writing it has widened by 1.5% to 20.3%
  - in Maths it has widened by 0.9% to 17%.
- At Key Stage 2, provisional 2015 results indicate 77.6% of “non-White” British pupils achieved the benchmark of Level 4 or above in Reading, Writing and Maths (compared to 78.5% of White British pupils). The gap narrowed in each of the last two years.
- At Key Stage 4, the gap between students with SEN and the rest has narrowed by 1.9% to reach 45.6% less than their non-SEN Somerset peers; that is 1.8% wider than the national figures.

- Attendance of pupils with SEN and at PRUs is the worst in the South West region (69.3% of pupils missing 14 or more sessions; 50.1% regional).
- For 2013, Somerset had the highest rate of fixed term exclusions for CLA of all English local authorities (18.6% of cohort; 9.8% national).

The lower self-esteem noted in the 2014 SCYP Survey<sup>7</sup> for primary school age children, compared to the national rate, is important as children and young people with lower self-esteem are known to engage in more risky behaviours.

It is frequent for children and young people to experience a range of disadvantages rather than just one. There are innumerable influences on children's wellbeing and there is often no clear distinction between cause and effect. However, protective factors such as secure attachment to a parent are well-established and can mitigate a number of influences on poorer outcomes. This reinforces the need to "Think child" and "Think family".

Disadvantage or under-attainment can exist for families or individuals in any social group or geographical community. These inequalities can help in focusing efforts but do not preclude the existence of disadvantage elsewhere, or the need for universal services.

### **Case study – The One Team Approach**

The "One Team" approach is now being adopted in a number of the county's most deprived communities, including Halcon and Priorswood (both Taunton), Wellington, Sydenham (Bridgwater) and central Yeovil.

This neighbourhood approach recognises that the problems experienced by residents can be multidimensional and connected. The "layering" of issues can result in greater deprivation due to the issues exacerbating each other.

Joint working between the police, drug and alcohol team, "getset" services, health visiting, housing, school and local voluntary sector organisations and many more, acting together as "one team", is key to addressing issues together rather than in silos.

This means sharing information at regular meetings about crime or anti-social behaviour, or families with particular risks – such as children getting into trouble, exposure to drugs or threats of domestic abuse. It enables the best-placed agency, which may be because of a good personal relationship with the family, to intervene.

It also means that any member of "the team" is trained to notice risk factors when they visit residents. Halcon has already seen significant falls in crime and poverty during the period of the scheme.

## **Rurality**

<http://www.somersetintelligence.org.uk/profile-of-rural-somerset-from-the-2011-census.html>

The IMD<sup>1</sup> shows large areas of rural Somerset (especially West Somerset) as deprived. These areas are still generally less deprived than those in the urban housing estates. These areas are particularly deprived in their distance to services, which has implications for young people.

Although not included in the IMD<sup>1</sup>, the speed or even existence of broadband access is a particular element that affects young people's lives. In other respects, many countryside dwellers are comparatively well off and many outcomes for children also reflect that.



The importance of digital access was made very evident by young people in rural Somerset in research conducted by the Somerset Rural Youth Project<sup>28</sup> for the 2015 JSNA. The research found that whilst many young people wanted face to face contact – for financial advice, for instance - digital connectivity had a major social impact.

*“There’s no broadband at home so my phone is my lifeline.”*

*“We use technology more in rural areas because we’re more isolated.”<sup>28</sup>*



Young people in the Somerset Children and Young People's Health and Wellbeing focus groups reported they felt more comfortable engaging online and this could be a valuable source of support for them.

There was lots of enthusiasm for receiving more support online (by instant chat or email) and it seemed to be the more vulnerable students who were most keen on this approach.

## Environment

Children are affected by the physical environment in which they are brought up. For example, some communities have been described as “obesogenic” – encouraging obesity and overweight in people who live there. This can be because exercise is difficult, with limited open space and sports facilities, including in schools.

It may be difficult to incorporate exercise into daily life in these communities; walking or cycling to school or playing in the street are far less attractive when traffic is busy and the infrastructure for pedestrians and cyclists is poor.

Roads which are busy with traffic also reduce contact between neighbours and so social support is also reduced. These conditions are typical of poorer urban neighbourhoods. They may also apply in rural areas with narrow lanes and long distances to sports fields and formal exercise but opportunities for less formal exercise in the open air is usually greater.

An association has also been found between deprived areas and the type of food available, with poor quality, energy-dense, “fast food” typical in takeaways and local shops.

Contact with green spaces has been demonstrated to have a positive impact on mental health and wellbeing by the Faculty of Public Health.

## Access

Getting children and young people onto local bus services increases their self-reliance and independence, gets them used to travelling by bus, increases activity levels (which decreases childhood obesity), reduces congestion and encourages young people to think about the bus as a sustainable future source of transport.

*"I use the bus regularly to get to college. Without this service it would be impossible for me to get to college to complete my education."*<sup>28</sup>

**YOUR  
OPINION**

As many schools and colleges become specialised academies, students need to be able to travel to different sites in order to study their field of interest. The distance between educational establishments means that the choice available to rural students may well be more limited than that available to those in more urban areas, especially the large cities.

A general lack of transport in some rural areas also impacts on other areas of life for young people, such as opportunities to volunteer and time to attend health appointments.

*"I would love to volunteer but I don't get home from college until late on the bus – how would I get back to anywhere to volunteer – and then home again."*<sup>28</sup>

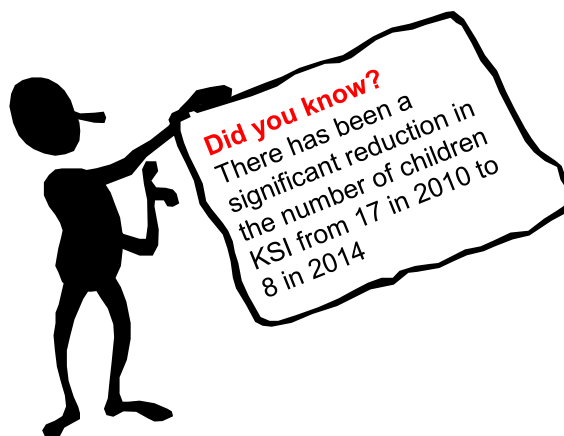
**YOUR  
OPINION**

*"I can't get to the surgery in time before it closes – so I have to miss college (work)."*<sup>28</sup>

## Road traffic casualties (children aged 0-15)

<http://www.somersetintelligence.org.uk/road-safety/>

During 2014, there were a total of 117 child casualties as a result of road traffic collisions in Somerset, of which one was fatal, seven were serious and 109 were slight. There has been a significant reduction in the number of children killed or seriously injured (KSI) in recent years, from a total of 17 in 2010 to eight in 2014.



Child casualties tend to be concentrated in and around urban areas. Children can be vulnerable outside schools and are increasingly at risk as they become older and more likely to be using the road unaccompanied. In 2014, 35% of all children injured in road traffic collisions were aged 12 to 15 years; 27% were aged 8 to 11 years; 17% were four to seven years; and 11% were 0 to three years of age.

Child pedestrian casualties have declined from 40 in 2010 to 28 in 2014. The number of children KSI as pedestrians, whilst remaining relatively low, has fluctuated between four and six in the last five years, with a figure of four KSI casualties in 2014.

A perceived danger of the risk of cycling may lead to a reduction in children and young people taking it up in the first place, which in itself has implications for their physical health and wellbeing. The number of child cyclists injured in road traffic collisions has fallen gradually over the last five years. There were 12 casualties in 2014, which was 40% below the number in 2010. KSI child cyclist casualty figures fell from four in 2010 and 2011 to zero in 2014. Numbers of children injured as car passengers have decreased over the last five years from 82 to 62. The number of children KSI as car passengers decreased from nine in 2010 to three in 2014.



## Road traffic casualties (young people aged 16-24)

<http://www.somersetintelligence.org.uk/road-safety/>

During 2014, there were a total of 375 casualties as a result of road traffic collisions in Somerset in the 16 to 24 age group, of which seven were fatal, 39 serious and 329 slight. The number of KSI casualties in the 16 to 24 group has fluctuated over the last five years. Between 2010 and 2014 there were an average of 59 KSI casualties per year, with a peak of 76 in 2013 and a low of 46 in 2014. This age group is disproportionate and is over represented in overall KSI figures.

Although numbers are relatively low, there has been a steady increase in the percentage of KSI casualties aged 16 to 24 who are motorcyclists and a reduction in the proportion who are car users.

## Community Services and Buildings

### Early years

<http://www.somersetintelligence.org.uk/pre-school-cyp.html>

Research has shown that good quality early years education can have a positive effect on the educational, cognitive, behavioural and social outcomes of children, both in the short and long term. The DfE has carried out a Study of Early Education and Development<sup>29</sup> (SEED – July 2015).

Somerset County Council has worked with partners and produced a Strategy for Achieving Excellence for All – 2016-2019. Within this there is a strategy for early years which sets out objectives and includes a trajectory for improvement.

Childcare is also needed to enable parents to work. Employment is recognised as the most sustainable way to lift parents out of persistent poverty.

The extent to which children start school ready and able to learn can have a long-term impact on their likelihood of success in education and employment. There are significant gaps by social background in the level of school readiness. Key drivers include:

- Family factors, for example: parental education, maternal age, material deprivation, maternal/child health.
- Parental engagement and early home learning environment.
- Quality of early years settings.

The Childcare Sufficiency Assessment 2015<sup>30</sup> looks at the supply and demand of childcare in Somerset. Somerset's early years and childcare provision is delivered by a wide range of providers, of which 99% are independent of the local authority and lie in the private, voluntary and independent sector:

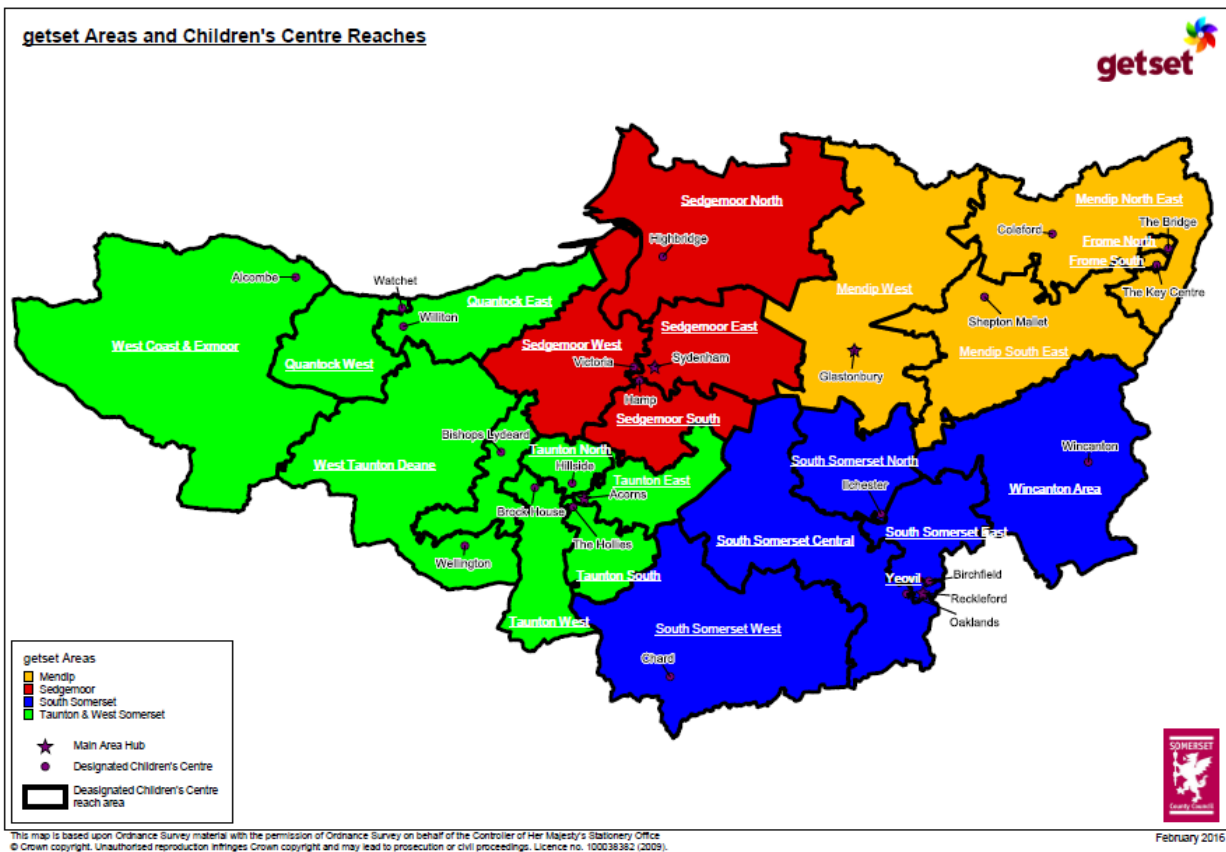
- 14 run by LA or maintained schools
- 14 run by independent schools
- 175 voluntary run

- Six childcare on domestic premises<sup>iii</sup>
- 359 child minders
- 111 privately owned nurseries

At the end of August 2015, 82% of Somerset’s early years providers were judged as “good” or “outstanding”, an improvement of 21% since 2013.

Figure 26 The “getset” areas and children’s centres are shown in Figure 26. Children’s centres are broadly distributed across the county reflecting the distribution of the population. Within towns they are located in the areas of need. This inevitably means, though, that some children in rural areas, especially in West Somerset, can be some distance from a children’s centre.

**Figure 26: Children’s Centres and getset Areas in Somerset**



## Schools

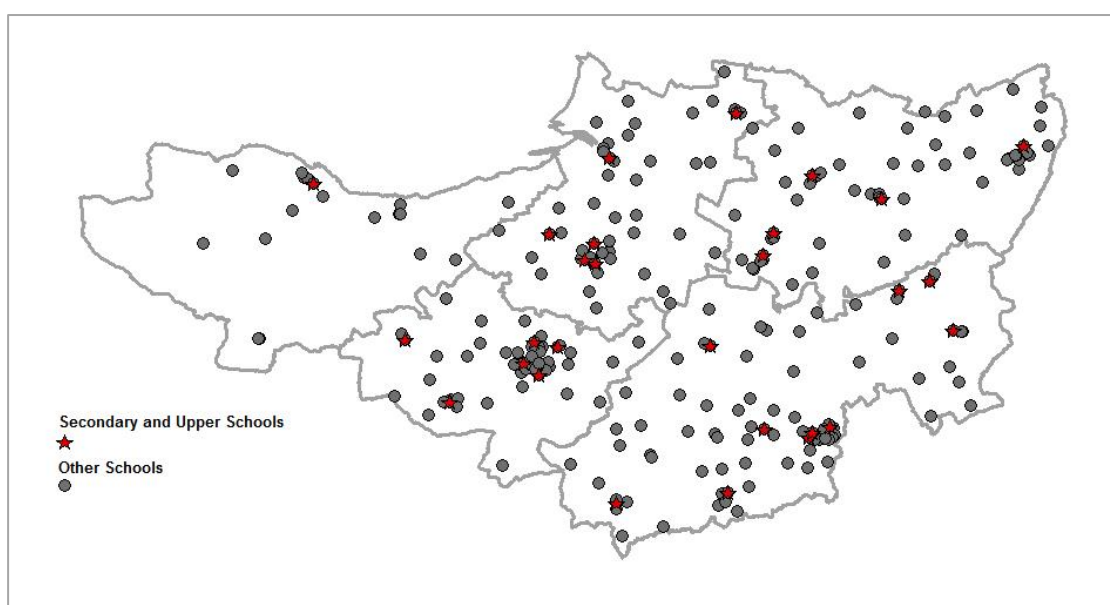
Somerset currently has 263 state-funded schools, including academies, free and special schools. There are 68,125 pupils in state-funded education and 8,557 in 34 independent schools (as at January 2015). There are four PRUs, four Further Education (FE) colleges, one sixth form college and no university. Schools are linked into clusters and in the future there is an aim that services will form a team around these learning clusters.

<sup>iii</sup> Where two or more childminders work together on the same premises

At April 2016, 88% of pupils were in outstanding or good schools. In Somerset, 91% of all schools were judged to be good or better, higher than the South West (89%) and national (84%) averages.

- In terms of pupil numbers at secondary schools as at April 2016, 86% are in outstanding or good schools. 84% of Secondary Schools in Somerset were judged to be good or better (as at 30<sup>th</sup> April 2016). This was above the regional and national averages of 83% and 72%, respectively. For Primary Schools, 91% were judged to be good or better (as at 30 April 2016), superior to the figures of 88% in the South West region and 84% nationally. All Special Schools in Somerset were judged to be good or better as of end of April 2016.

**Figure 27: Schools in Somerset**



### **Youth clubs**

There are four youth clubs in Taunton, three in Bridgwater and one each in 11 other Somerset market towns. These are all run by voluntary groups.

The rural nature of the county and limited public transport mean that many young people are too distant to attend such clubs regularly. Physical distance is even more isolating for people in minority groups.

An example of addressing this minority group isolation is the charity 2BU, which not only holds youth groups for Lesbian, Gay, Bisexual, Transgender (LGBT) people, but also provides taxis to bring them to and from the events; the young people may be too self-conscious to ask their parents for a lift.

Whilst access to youth clubs is difficult, they are valued by those who can attend. Participants in the Somerset Children and Young People's Health and Wellbeing focus groups were very vocal in their disappointment about the loss of their youth groups. They said there were youth workers who "got it because they'd been there", which made a real difference in relation to mental health.

They asked for:

*“Groups where you can meet up and talk about issues and have fun.”*

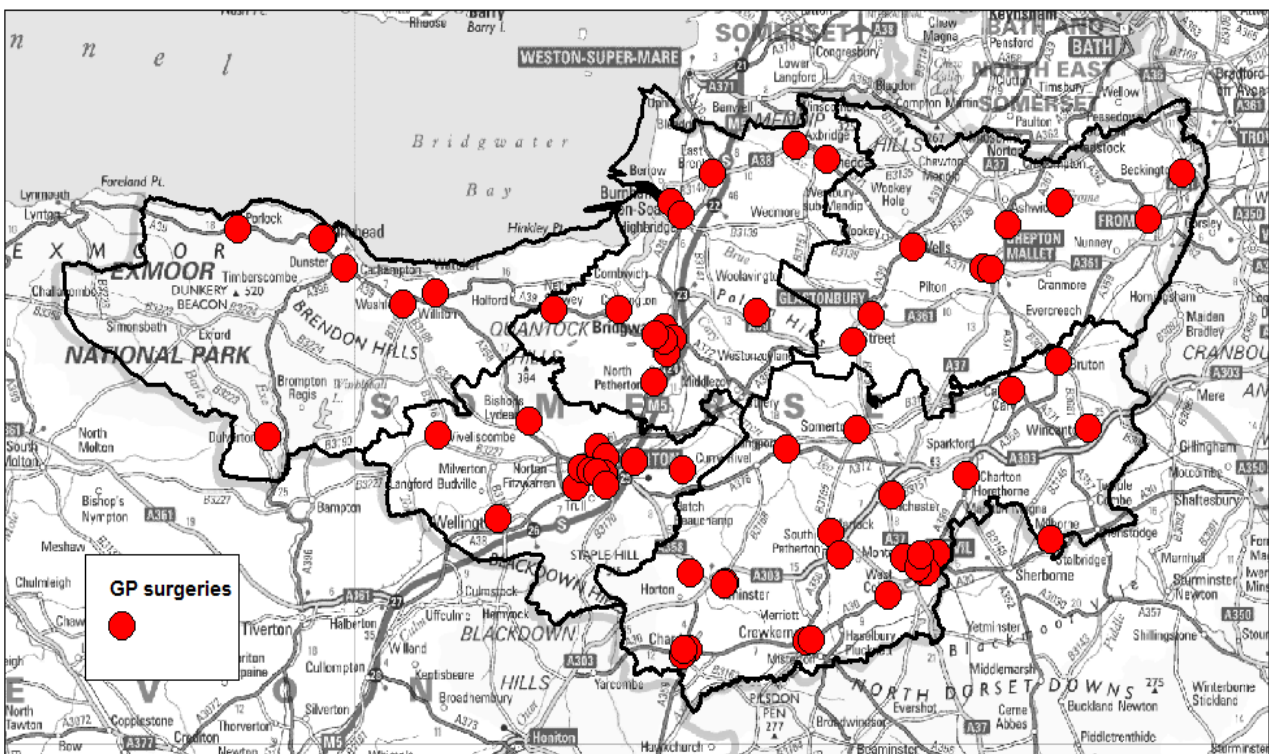


### GPs and pharmacies

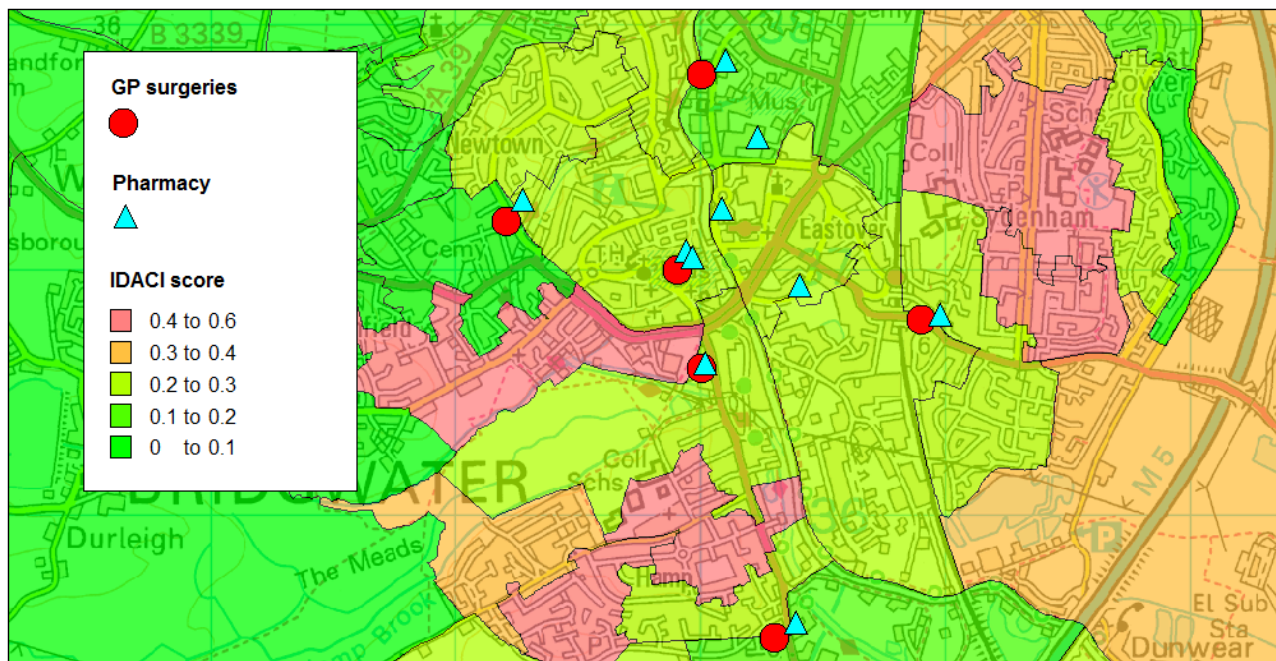
Family doctors are often the first point of contact for parents with concerns about the health of their children and are one source of advice for young people regarding drugs and sexual health.

There are 75 GP practices in Somerset, and as shown in Figure 28, their distribution broadly reflects the population distribution. However, as shown in Figure 29 for Bridgwater, they tend not to be located in the most deprived communities. Only Oaklands Surgery in Yeovil is in the 10% most deprived of Somerset’s LSOAs on the IDACI measure, and only two more (Glastonbury Medical Practice and Penn Hill in Yeovil) are in the 20% most deprived. The distribution of pharmacies in the same figure shows a similar pattern.

**Figure 28: Distribution of GP surgeries in Somerset**



**Figure 29: GP practices and Pharmacies in Bridgwater plotted over index of multiple deprivation IDACI**



## Implications for Commissioning

- There is a concentration of community need in the most deprived urban estates in Somerset, and these areas also have a high proportion of children in low income households. We heard that many residents rarely leave these estates so providing services within these areas is important.
- The “One Team” approach that is being applied in several deprived communities in the county offers opportunities to share resources and information locally to support early intervention for vulnerable children.
- Vulnerable children exist right across Somerset, even in more prosperous or dispersed rural areas and are as deserving of support as those in poor communities. In some ways, these children offer the greatest challenge to service providers as the focused attention possible in towns is harder to achieve in rural areas.

# CONCLUSIONS

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The JSNA is intended to inform the strategic direction of health and social care in Somerset. Its evidence and implications inform the Somerset Health and Wellbeing Strategy 2013-2018 and in this specific case also inform the Children and Young People's Plan 2016-2019.

The following summary draws conclusions from the evidence presented under the five themes which follow.

## **Helping the worst off first**

All the evidence is consistent with a pattern of the majority of children having safe and healthy lives; a minority having higher risk, which may be temporary; and a much smaller number having a far greater intensity and complexity of need.

Defining the cohort with the greatest need is difficult and data silos mean that we cannot assess the extent of double counting. That said, a figure of 5-10,000 children in particular need would be broadly consistent with the evidence available. The majority live in the most deprived wards in the county's urban areas. The remainder live in wealthier parts of large towns, smaller urban areas and more dispersed rural areas. The latter group is likely to be more "hidden" in the averages and perhaps have less contact with services.

We have used the number of children living in income deprived households as an approximate – and available - indicator of vulnerability. On this measure there are 14,300 Somerset children in poverty: many of these will only be temporarily poor or not suffer other disadvantage, and children in wealthier households are not immune, of course. The 10% most deprived LSOAs have 30% of the income deprived children, and the 20% most deprived have 46%.

The intensity of need for those in deprived urban areas and their geographical proximity to each other would suggest that focused efforts in these communities would yield a good return in human welfare and effective use of resources.

Children with the most complex and intense need clearly exist away from the deprived urban centres and have an equal right to public services. Difficulties of physical access means that many services, such as health visiting, will have to be provided by visiting children's dwellings. Equally schools, which are well distributed across the county, will also have an important role.

Different ways of delivering services, which are not based around buildings and which will require even more involvement of the community and voluntary sector, will have to be adopted in such areas.

## **Focus on the child and family**

The complexity of need for the most vulnerable is very evident in this report and this requires a focus on the child and family. “All happy families are alike; each unhappy family is unhappy in its own way.”<sup>31</sup> Only understanding the nature of risk and vulnerability at this level of refinement can be expected to yield significant results. This includes, but goes beyond, understanding issues of diversity and equality.

Without thinking this way there is at least a risk of dealing with symptoms rather than causes and for most families it is unlikely that a single, simple cause exists.

Communities can be treated more generally, for example with issues of poor housing common to urban areas and distance from services in the countryside. Nevertheless, any local action requires understanding of the particular needs of the areas concerned.

## **Prevention and Early Help**

The importance of a good start in life – indeed from even before conception - for children is evident throughout this report. A healthy, supportive environment in the first two years is vital and harm at this stage may leave permanent damage to a child’s health and prospects.

The Marmot Review<sup>27</sup> clearly demonstrated that returns on investment in early childhood are higher than in adolescence. And, self-evidently, no child should suffer unnecessary harm.

The idea of a range or pyramid of need has been a common feature of many of the subjects covered here. It is clear that those away from the most intense levels may be at risk of falling into greater need without the right support.

Families with chaotic lives or suffering temporary setbacks may drift towards neglecting their children, leaving them vulnerable to real harm. Preventing such a drift should be a concern of services at all levels of support, meaning that universal services are still required.

This “proportionate universalism” was strongly advocated by the Marmot Review<sup>27</sup>. Creating the right balance between focused support for those most in need, and preventative services for the rest, is a challenge but a necessity for the public sector, especially in a time of austerity. It also helps to create community capacity which generates resilience amongst community members to support those who are more vulnerable.

## **Better, joined-up information**

The analysis of the “troubled families” database here has shown how joined-up information can give far greater insights into the nature of need. It is unfortunate that such analysis cannot be undertaken on far more of the available information.

Our understanding of how diet affects children's health would be greatly improved if we could say with certainty whether overweight children tend to be those with tooth decay, rather than being, perhaps, two entirely separate groups.

The NHS number is the obvious candidate as an identifier to link individuals across data sets. A link to the Unique Pupil Reference Number would also be clearly significant. This would hugely improve our understanding. However, linking individuals' data does not go far enough and we need to find effective ways of joining information about families and their relationships too.

### **Better integration of services**

All the themes here highlight the importance of services working together. This is at the level of analysis – simply joining up information will achieve nothing if it is not used – and in contacts with children and families. This is not just co-operation; it is not letting administrative boundaries get in the way of providing services so that they benefit the most vulnerable.





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