UNDERSTANDING THE NEEDS OF SCHOOL AGED CHILDREN AND YOUNG PEOPLE IN BIRMINGHAM

December 2017

1. INTRODUCTION TO PURPOSE

The factors which enhance or undermine children and young people's health and wellbeing, particularly in the school setting is the strategic question to be addressed in this assessment and review. It is intended to support the procurement of the school based support in these areas.

2. BIRMINGHAM DEMOGRAPHICS

Birmingham is a growing city, between the census years of 2001 and 2011 the city's population grew by 96,000 (9%) to 1,074,300. The most recent population estimate (2016) puts the city population at 1,124,569. The population increase over the last decade is associated with more births, fewer deaths and international migration. Birmingham has more people in the younger age groups, while England as a whole has a greater proportion of older people - 46% of Birmingham residents are under 30, compared with 37% for England[1].

In December 2017, there are 298 Primary, 80 Secondary and 7 All through state-funded mainstream schools in Birmingham. In addition there are 27 special schools and 7 pupil referral units and alternate provision establishments which are state-funded. According to the school census (January 2017), within the mainstream schools there are 111,381 primary aged children and 64,418 secondary aged (Year 7 to Year 11) children. Within the special and alternate schools there are 1870 primary and 2289 secondary aged children

The largest ethnic group in Birmingham in 2011 was White British with 570,217 (53.1%). This proportion has decreased since 2001 (65.6%) and lower than the average in England (79.8%). Other large groups include Pakistani (144,627, 13.5%) and Indian (64,621, 6.0%) which have grown since 2001, while people defining themselves as Black Caribbean (47,641, 4.4%) have declined. More recent trends see people arriving from many different parts of the world, including Eastern Europe, Africa and the Middle East.

238,313 Birmingham residents were born outside the UK. Of these around 45% arrived during the last decade. 46.1% of residents said they were Christian, 21.8% Muslim and 19.3% no religion.

[1] Mid-year estimates, Office of National Statistics 2016

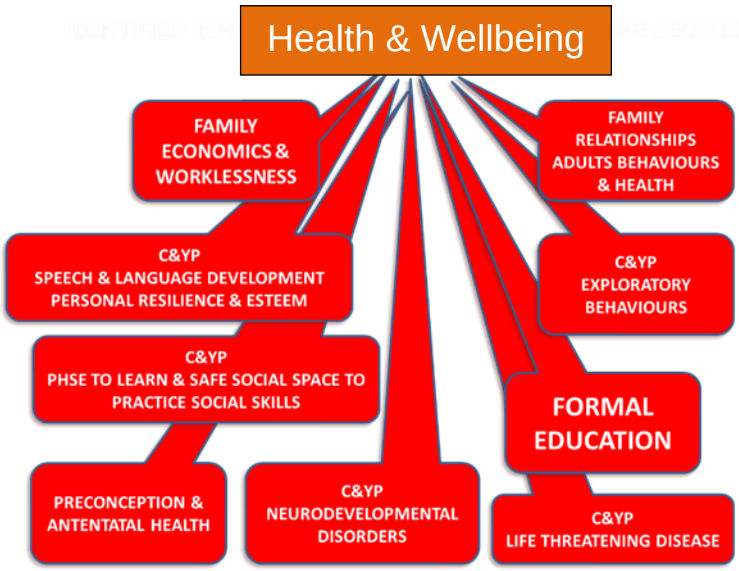
3. THE RANGE AND SCOPE OF INFLUENCES UPON CHILDREN AND YOUNG PEOPLE'S HEALTH & WELLBEING

The relationship between Children & Young People's health & wellbeing and their educational achievement is well documented[2] [3]. In order to achieve their full potential Children & Young People have to be capable of engaging in the activities at school and therefore must be present at school. The summary outcome therefore becomes:

Children & Young People can Attend, Engage, and Achieve

There are important factors which enhance and/or undermine the health & wellbeing of Children & Young People (Figure 3.1). The two most influential factors are family poverty and family/peer relationships. Both of these undermine their health & wellbeing and make it more likely that a cycle of intergenerational disadvantage continues. There are also other specific adverse experiences in childhood (Table 3.1) which further contribute to this cycle of poor achievement and disadvantage. Improving family poverty and reducing the opportunities for the adverse experiences to arise, and hence adverse impact, improves children & young people's health & wellbeing. Emotionally warm but strong relationships with trusted adults in childhood are protective factors in improving and academic achievement.

Figure 3.1: Identified Influences upon School Aged Children and Young People's Health & Wellbeing



The influences upon children's health and wellbeing are wider than the school environment in their cause and impact and differ over the life course of childhood. Tackling these influences is not just the responsibility of schools neither are they all amenable to intervention in the school environment. The factors identified in the research literature are shown in Figure 3.1 and described below.

a) **Family poverty**, leading to impoverished childhoods, is a major determinant of health, wellbeing, and achievement in childhood. Marmot and others have articulated this in

[2] Department of Health *Healthy Child Programme: From 5-19 years* October 2009 http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_108866.pdf

[3] Lightfoot J, Bines W *Working to Keep School Children Healthy: The Complementary Roles of School Staff and School Nurses* Journal of Public Health Medicine 2000 20(1) 74-80

great detail. The remedy of child poverty is multifaceted and requires more strategically joined up actions than has hitherto been achieved in Birmingham or most communities. The Birmingham Child Poverty Commission and the resultant Child Poverty Action Forum is the most focused response in Birmingham in recent times[4]. This work continues and is a cross cutting theme in the Council Plan 2018+.

b) **Family relationships** are the early foundation of emotional and social resilience with opportunities for early acquisition of speech, language, and cognitive functions. This influence is sustained through the primary education setting. In the secondary education setting family relationships can disturb the emotional resilience and reduce the engagement of students with consequent reduction in achievement.

c) **Adults' behaviours & health** can be directly harmful from abuse and neglect due to parents experiences of abuse, mental illness, substance misuse, or physical illness. Violent parents, involving only adults or including children, exert a particularly strong adverse impact upon children in the family at all ages.

d) **Personal resilience & esteem** is the foundation of much of the impulse and emotional controls we acquire during childhood. Factors or events that undermine the personal resilience and esteem result in conduct disorders in early years and Primary Education or the more extreme use of exploratory behaviours in Secondary School students.

e) **Speech & language development** is a significant factor in the development of social and intellectual skills in Early Years and Primary education settings. Delay in these attributes reduces the development of communication and reading skills which in turn reduces social and educational attainment over the rest of childhood and adulthood.

f) **Personal, Health, & Social Education** is an opportunity for Children and Young People to develop understanding of the importance of social and emotional attitudes and behaviours. This might be through a course of study but it also greatly influenced by the attitudes and behaviours of peers and adults with whom they meet and relate. Ofsted has consistently found the quality of Personal, Health, and & Social Education in schools unsatisfactory.

   A **Safe social space** in which to practice the acquired learning of Personal, Health, and & Social Education is fundamental to the acquisition of the life skills required to live in a family and community. Some of the Primary School active play, playground leadership, and circle time initiatives help develop this. There is less obvious development, beyond school councils and vertical tutor groups, in secondary school settings to nurture these opportunities to practice the skills. A greater challenge is to develop safe social spaces outside the school gates. Council run Youth Clubs may have declined but many Faith communities have thriving groups which may not be restricted to families of their own faith. A balance between a one-size fits all universal approach and a community sensitive/initiated movement is required

g) **Formal education** is acknowledged by Marmot[5] as an important precursor to child hood achievement and the foundation for improved socio-economic prospects in adulthood with improved health and wellbeing outcomes. Ofsted attempts to quantify the quality of the formal educative processes but the only outcome that is taken seriously is the aggregated performance of students in public examinations. There is

[4] Birmingham Child Poverty Commission *A Fairer Start for ALL our children* Birmingham City Council 2016

[5] Marmot *Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England Post 2010* February 2010 www.ucl.ac.uk/marmotreview

no attempt to track individual's progress and capture any sense of personalised achievement against the odds to demonstrate appropriate preparation for adult life.

h) There are fewer **physical health** issues which impact upon childhood health & wellbeing in population terms. At an individual and family level however, the impact can be significant and includes:

   i. **Preconception parental health:** This is important to the healthy growth of a baby during pregnancy. International research links preconception health, particularly vitamin deficiency; drug therapies; smoking; alcohol; and mental illness, with poor infant outcomes and some future health and development adverse impacts.

   ii. **Variation in neuro-development:** Overcoming these variations are challenges of prevention and management. Preventing these conditions occurring includes paying attention to preconceptual parental health, but many have no known cause. Identifying individuals developing signs of delay and clearly assessing the needs which are the focus of a care management plan are very important to parents and families, including if possible a diagnostic label.

   iii. **The development of life threatening disease:**, Although relatively rare at a population level this will disrupt the health and wellbeing of individuals and families. The natural history and prognosis will influence the size of the impact of any serious illness in childhood. The NHS Healthcare service response to these events ought to include an assessment of the impact, including an attempt at prognosis and length of impact, with some mitigating emotional and physical support to the individual and family, and a partnership with public and voluntary providers, including schools, of additional supports.

i) A range of **Adverse Experiences in Childhood** (Table 3.1) results in serious adverse impacts upon health & wellbeing in children, young people, young adults, and mature adults (Table 3.2, Figures 3.2 and 3.3)[6] [7] [8]. Recognising these experiences are a powerful driver in the difficulties of Children & Young People opens the way for the effects of these traumas and the restoration/repair of the Children & Young People's attachment difficulties with other people. This can break the well documented cycle of intergenerational abuse and violence with further beneficial outcomes for others and especially the children of the future.

Table 3.1: The Range of Adverse Childhood Experiences

DIRECT EXPERIENCES	PARENTAL CONDITIONS IMPACTING ON THE CHILDREN
PHYSICAL ABUSE	MENTAL ILLNESS
SEXUAL ABUSE	ALCOHOL ABUSE
VERBAL ABUSE	DRUG ABUSE
PARENTAL SEPARATION	INCARCERATION
DOMESTIC VIOLENCE	

[6] Fellitti et al Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults, The Adverse Childhood Experiences Study American Journal of Preventative Medicine 1998: 14(4): 245-58

[7] Bellis MA, Ashton K, Hughes K, Ford K, Bishop J, Paranjothy S. Adverse childhood experiences and their impact on health-harming behaviours in the Welsh adult population. Cardiff: Public Health Wales, 2015

[8] Lowry et al ACEs in Blackburn with Darwen Blackburn with Darwen Council and Liverpool John Moores University 2014

Table 3.2: Health Harming Behaviours

Figure 3.2: The Impact of Adverse Experiences in Childhood (Aged 18-70)

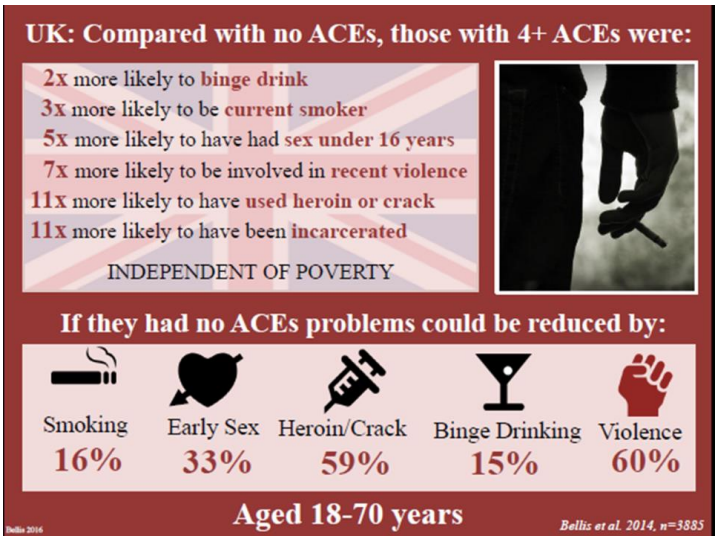
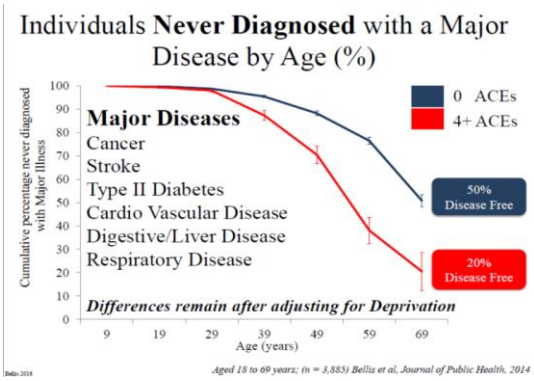


Figure 3.3: The Impact of Adverse Experiences in Childhood on Physical Health (Aged 18-70)



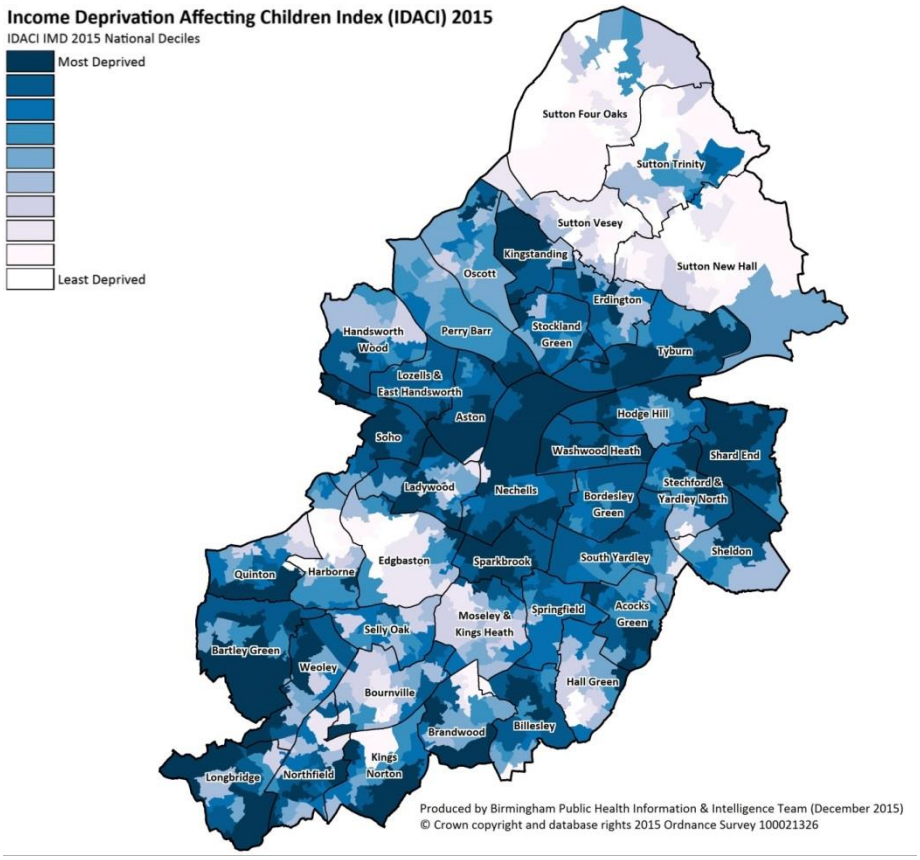
4. WHAT IS IT LIKE LIVING IN THE UK AND BIRMINGHAM AS A CHILD?

It was noted earlier that a major influence and impact upon children's health and wellbeing is child and family poverty. Birmingham has more families and children in poverty than the national norm[i] with 75,501 children under 16 in poverty (30.5% compared with England's 19.9% and the lowest area of 1.3%).

Child poverty measured by the income deprivation affecting children index (IDACI) is not shared equally across the City (Figure 4.1). It is interesting to note that over time (2010-2015), which includes the recent financial crisis; more families in households in affluent areas (quintile 5) have experienced poverty.

Poverty is an important feature of undermined health and wellbeing in children and Young People and will require action across a number of sectors of City life. The announcement of a Child Poverty Commission in 2015 was a significant first step to securing that action. The Commission reported in 2016 and initial recommendations have been actioned. Further actions will be directed by a multi-sector Child Poverty Action Forum. Reversing the trends and impacts however will take some time. In the meantime service provision to Children, Young People, and families must take this factor into account when planning the distribution of resources and effort.

Figure 4.1: Child Poverty by Electoral Ward in Birmingham (2010)



Evidence in the UK[9] of suggests a mixture of challenges to children's health & wellbeing. Personal wellbeing is rated favourably. Family relationships are a little more

[9] Office for National Statistics *Children's Wellbeing 2014* March 2014

mixed with children talking about things that matter to Mothers more than fathers and 57% of children eating together as a family frequently. However quarrels with parents (28% Mother and 20% Father) are quite common and more so than bullying at school.

Children also seem to be engaged in sport or cultural activities. Social Networking sites are clearly a common feature of children's lives now (80%). They like living in their neighbourhoods and are relatively happy with their school. Almost half feel a bit or very unsafe walking alone after dark and a small proportion have been a victim of crime or are worried about becoming a victim of crime.

There is an annual sample survey of students aged 7-18 years in Birmingham[10]. Each year schools across Birmingham are invited to participate in the survey (since 2006/7). The school then arranges for pupils in the school to complete the survey online. The survey was designed the Social Research Unit (Dartington) to cover the main areas of the Every Child Matters Outcomes Framework and show:

a) Over the past five years children have reported similar levels of physical health.

b) 2% of 12-18s said they drink at least once a week 2% of 12-18s said they smoke and 3% of 12-18s said they had used drugs in the last month.

c) 8% of children identified they had emotional problems (7-11 year olds).

d) In addition 7% of 7-11s and 14% of 12-18s have significant problems with pro-social skills (e.g. being considerate of others feelings, sharing, being helpful if someone is hurt, being kind and volunteering to help etc.) and 9% of 7-11s and 6% of 12-18s have significant problems with peer relations (e.g. preferring to play alone, not having at least one good friend, being picked on by other children etc.).

e) On average over the past 5 years 70% of 7-11 year old and 50% of 12-18 year old children report enjoying going to school with 78% and 58% always getting on well with their teachers. Interestingly bullying is reported more often in 7-11 year olds (16%) than 12-18 year olds (11%).

f) Over the past five years children's expressions about their future aspirations have remained stable, with the exception of 12-18year olds view on the importance of a College qualification (varies between 69 and 79% but without any time related pattern). 72% of 7-11 year olds and 65% of 12-18 years olds considering it important to go to university but 78% of both age groups consider it important to have a job that is well paid.

g) Only a third of children reported feeling safe in their neighbourhood at all time, This means that 60+% feel unsafe *at any time* compared to the national picture where almost half feel *a bit or very unsafe walking alone after dark.*

It would seem that for children living in Birmingham results in similar experiences and impacts to the national experience except for feeling safe in the streets and household family poverty.

[10] Syed Z *Child Wellbeing Survey 2016-17* Birmingham City Council April 2017

5. HOW SHOULD WE RISE TO THE CHALLENGES?

Table 5.1 illustrates Birmingham's performance for key indicators compared to England averages in the Child Health Profile and therefore the scope of the challenge. A school based support service would contribute to the following City wide Public Health Outcomes.

a) Improved Pupil attendance

b) NEETs reduction.

c) Fewer self-harm.

d) Fewer entrances to Youth Justice.

An engagement exercise to determine the principles for School Health Support was undertaken in December 2017. This has provided a useful insight into the needs of the children this service would be addressing. The findings from this engagement exercise build on the findings from a previous consultation to inform the commissioning intentions related to the current service, This was conducted between 8th December 2014 and 16th February 2015. It included a Be heard Survey to all members of the public and a children and Young people's consultation with MOO MOO marketing.

In total 3424 questionnaires were completed (75% of this response represented young people under 15). The consultation focussed on the overall aim of a support service and associated priorities. The priorities which were proposed were:

a) Helping children to attend school even if they have medical problems
b) Helping to find health problems early
c) Giving early help to children with health problems
d) Safeguarding children
e) Helping children who may need special help
f) Helping children to be a healthy weight
g) Helping children with emotional problems
h) Helping children who may have a problem with drugs, alcohol or smoking
i) Helping growing children with relationships, including sexual health

Overall, the priorities were well received. However, several priorities sparked debate and were felt less of a priority than others (Figure 5.1).

Figure 5.1: The Outcome of the Online Consultation (2017)

PRIORITIES IDENTIFIED BY SCHOOL SETTING	
PRIMARY	**SECONDARY**
Healthy weight	Healthy weight
Learning support	Disability & other health issues
Behaviour support	Learning support
Bullying	Alcohol/smoking/drugs
Disability	Relationships
Keeping safe	Home problems
	Depression
	Feelings

Table 5.1: Child Health Profile – Birmingham (2017)[11]

Compared with benchmark Better Similar Worse Not Compared

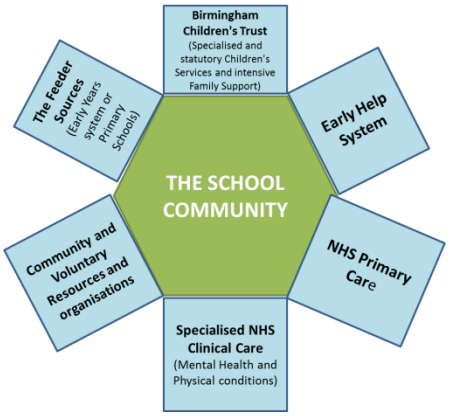
Benchmark Value: Worst | 25th Percentile | 75th Percentile | Best

Indicator	Period	Birmingham			Region	England	England		
		Recent Trend	Count	Value	Value	Value	Worst	Range	Best
Infant mortality	2014 - 16	–	402	7.9	6.0	3.9	7.9		1.6
Child mortality rate (1-17 years)	2013 - 15	–	136	16.8	13.0	11.9	20.7		6.5
MMR vaccination for one dose (2 years) <90% 90% to 95% ≥95%	2016/17	↓	15,372	88.0%	93.2%	91.6%	69.8%		97.5%
Dtap / IPV / Hib vaccination (2 years) <90% 90% to 95% ≥95%	2016/17	↓	16,263	93.1%	96.0%	95.1%	74.7%		98.6%
Children in care immunisations	2016	↑	1,325	95.0%*	85.9%*	87.2%*	26.7%		100%
Children achieving a good level of development at the end of reception	2016/17	↑	10,921	65.9%	68.6%	70.7%	60.9%		78.9%
GCSEs achieved (5A*-C including English & Maths)	2015/16	–	6,560	52.3%	54.8%	57.8%	44.8%		74.6%
GCSEs achieved (5 A*-C inc. English and maths) for children in care	2015	–	22	16.7%	14.3%	13.8%	6.4%		34.6%
16-17 year olds not in education, employment or training (NEET) or whose activity is not known - current method	2016	–	2,560	10.2%	7.3%	6.0%	44.8%		2.1%
16-18 year olds not in education, employment or training - previous method	2015	↓	2,030	5.2%*	4.3%	4.2%	7.9%		1.5%
First time entrants to the youth justice system	2016	↓	662	564.2	398.5	327.1	739.6		97.5
Children in low income families (under 16s)	2014	↓	81,845	32.9%	23.5%	20.1%	39.2%		7.0%
Family homelessness	2015/16	↓	2,897	6.8	2.6*	1.9	10.0		0.1
Children in care	2017	↓	1,840	64	75	62	184		20
Children killed and seriously injured (KSI) on England's roads	2014 - 16	–	189	24.8	19.1	17.1	46.8		1.3
Low birth weight of term babies	2016	↓	603	3.8%	3.2%	2.8%	5.2%		1.3%
Obese children (4-5 years)	2016/17	→	1,854	11.5%	10.7%	9.6%	13.5%		4.8%
Obese children (10-11 years)	2016/17	↑	3,647	25.2%	22.4%	20.0%	29.2%		11.3%
Children with one or more decayed, missing or filled teeth	2014/15	–	-	28.7%	23.4%	24.8%	56.1%		14.1%
Hospital admissions for dental caries (0-4 years)	2013/14 - 15/16	–	174	68.2	*	241.4	9.2		1,143.2
Under 18 conceptions	2015	↓	545	25.4	23.7	20.8	43.8		5.7
Teenage mothers	2015/16	↓	173	1.1%	1.0%	0.9%	2.2%		0.2%
Hospital admissions due to substance misuse (15-24 years)	2013/14 - 15/16	–	341	63.1	79.4	95.4	345.3		34.1
Smoking status at time of delivery (current method)	2016/17	↓	1,322	8.1%	11.8%	10.7%	28.1%		2.3%
Breastfeeding initiation	2016/17	–	12,253	71.1%	68.9%	74.5%	37.9%		96.7%
Breastfeeding prevalence at 6-8 weeks after birth - current method	2016/17	–	8,815	*	*	44.4%*	19.3%		75.6%
A&E attendances (0-4 years)	2015/16	↑	53,147	622.1	538.4	588.1	1,836.1		335.0
Hospital admissions caused by injuries in children (0-14 years)	2016/17	↓	2,334	96.4	106.7	101.5	190.5		43.3
Hospital admissions caused by injuries in young people (15-24 years)	2016/17	↓	1,861	101.5	120.0	129.2	254.8		64.0
Hospital admissions for asthma (under 19 years)	2016/17	↓	969	320.8	259.2	202.8	497.5		63.6
Hospital admissions for mental health conditions	2015/16	↓	278	97.9	89.8	85.9	179.8		33.8
Hospital admissions as a result of self-harm (10-24 years)	2015/16	–	883	344.8	443.3	430.5	1,444.7		102.5
Admission episodes for alcohol-specific conditions - Under 18s	2014/15 - 16/17	–	129	15.1	28.5	34.2	100.0		6.5

[11] Public Health England, Overview of Child Health

School is the only universal setting common to all children. Students spend 55% of the days in their year (200/365 days) and 30% of their waking year (200 x 7 hour days is 1,400 of a total 4,745 waking hours/year) at school.

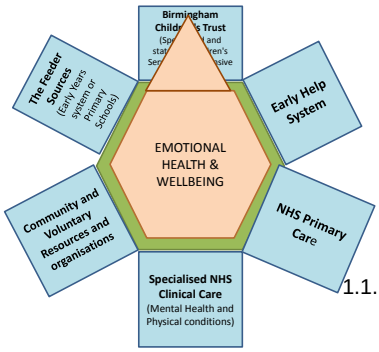
Figure 5.2



School therefore contributes a significant opportunity to develop skills for life and resilience in relationships, as well as knowledge to work with. However school is not an isolated community and it's members (the children) may have relationships with other settings, agencies, organisations, &/or communities (Figure 5.2) The school, as an organisation, should also relate to and partner with these for the benefit of the individual child and collective community of children.

The feature of children's wellbeing and skills for life, reported locally as the most important and challenging, is emotional health and wellbeing (Figure 5.3). Preparing children to live with other human beings in productive relationships requires the development of the individual's resilience and emotional understanding. It is not an intellectual exercise, like learning how the body works in Biology, but a learned experience requiring good role models and trusted relationships with adults. It builds upon the quality of the child's experience of attachment in early childhood.

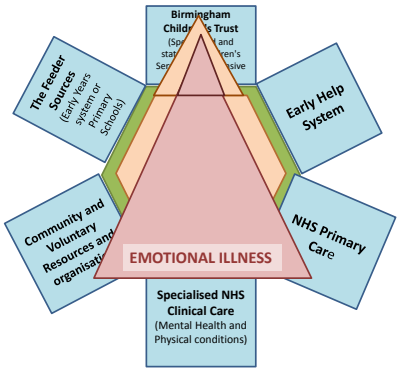
Figure 5.3



The NewStart programme is collaboration between Birmingham Educational Partnership, Forward Thinking Birmingham, and schools. It uses attachment theory and the evidence of the impact of Adverse Childhood Experiences in a programme of whole school development, based on Academic Resilience, to develop individual resilience in productive relationships.

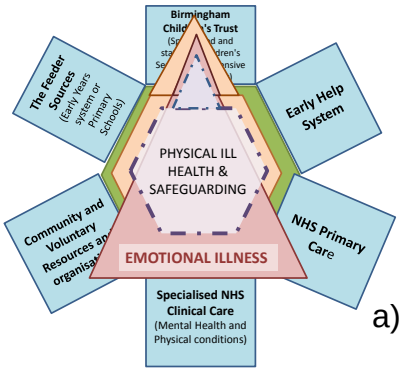
1.1. The Virtual School for Children in Care and the City of Birmingham School are also using similar principles to enhance the resilience and outcome for children in Care and those excluded from mainstream school with an aim of reducing that exclusion experience.

Figure 5.4



Although the previously described programmes will improve emotional health resilience, with a reduction in subsequent emotional illness, there will continue to be those who develop emotional illness (Figure 5.4). Improving the outcomes for these children should be a partnership between schools and providers of specialist and complex care. Schools should not be expected to deliver specialist mental health care but Forward Thinking Birmingham is developing the partnership with schools to improve the responses to emotional distress and/or illness in the school setting.

Figure 5.5

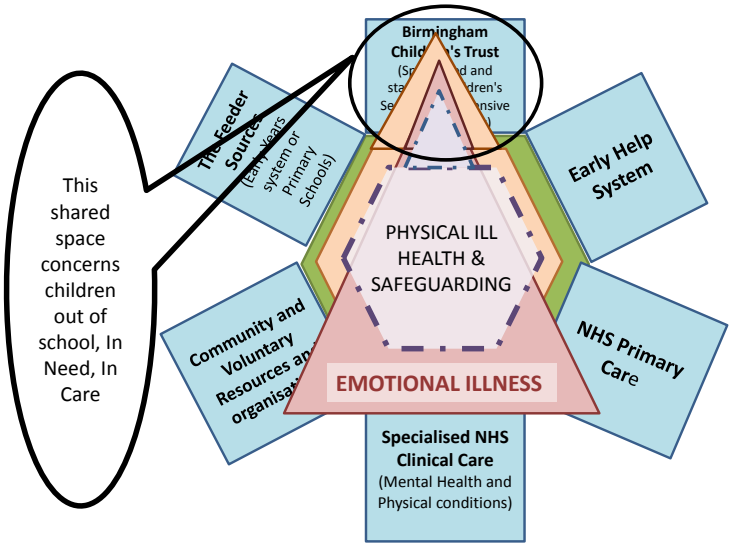


A student developing a physical health condition results in the need for the school to be prepared to adapt to the child's changed circumstances and to be prepared to respond to a sudden change in the child's health status. This is seen commonly in asthma, diabetes, and epilepsy but other less common conditions do present, such as cancer, for which schools will also need to prepare plan on a more individual basis (Figure 5.5).

a) In addition to these groups of students there are also the needs of children with disabilities, with or without the need for special educational arrangements that may require additional planning or advice from health, education, and social care colleagues. The students whose needs are assessed to be most complex are more likely to be in Special Schools, supported by a special school nursing service and the disability social care team. This support is less consistently available in mainstream school settings at present (Figure 5.5).

Because of the universal setting described previously, schools are a key partner in the development and delivery of plans for children in need and children in need of protection (Figure 5.6).

Figure 5.6



The NHS contribution to these processes and plans is less frequent and should be more focused and specialised in school aged children. Some co-ordinated responses may be needed between schools and the contributing NHS agency. It is a co-ordinating role that school nurses and more recently School Health Advisers have undertaken rather than any therapeutic role (Figure 5.6).

This co-ordination role was required because of an historical separation between the NHS and school contributions. In the realm of emotional distress and /or illness this separation is diminishing as NewStart and Forward Thinking Birmingham continue to develop the programmes and partnership approach. The development in this proposal of a more focussed physical health approach would also diminish this separation and enhance the outcomes for the children and families involved.

Both approaches will support the school and students by contributing to safeguarding assessment and plans where appropriate and there is no presumption that this will be a person/people/discrete service of any particular skill or professional group.

The principles outlined here could refocus the use of a smaller Public Health allocation in school aged children to support:

a) supporting pupils with medical needs, including SEND, schools' health planning, and Education Health & Care Plans;

b) Enabling the healthcare components of plans for Child Protection, children in Need, and edge of exclusion to be realised in the school setting; and

6. END PIECE

This analysis focuses upon the needs of the majority of the school aged children and young people of Birmingham. It does not address the additional needs of that children and young people might need for special educational, health or social care. There are more detailed strategic assessments of the need for Children and young people with Special Educational Needs and Disability and children vulnerable to complex or specialist health and/or social care.

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