Public Document Pack

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thanet district council

**THANET HEALTH AND WELLBEING BOARD**

**11 JUNE 2015**

A meeting of the Thanet Health and Wellbeing Board will be held at **10.00 am on Thursday, 11 June 2015** in the Council Chamber, Council Offices, Cecil Street, Margate, Kent.

Membership:

Dr Tony Martin (Chairman), Hazel Carpenter, Dominic Carter, Esme Chilton, Councillor Fairbrass, Councillor Gibbens, Madeline Homer, Mark Lobban, Colin Thompson and Councillor Wells

**SUPPLEMENTARY AGENDA No.1**

Item No

11. **THANET HEALTH PROFILE** (Pages 1 - 4)

12. **REPORT ON THE CHILDREN'S BOARD** (Pages 5 - 14)

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Public Health England

Protecting and improving the nation's health

# Thanet

District

This profile was produced on 2 June 2015

# Health Profile 2015

**Health in summary**
The health of people in Thanet is generally worse than the England average. Deprivation is higher than average and about 26.7% (6,800) children live in poverty. Life expectancy for both men and women is lower than the England average.

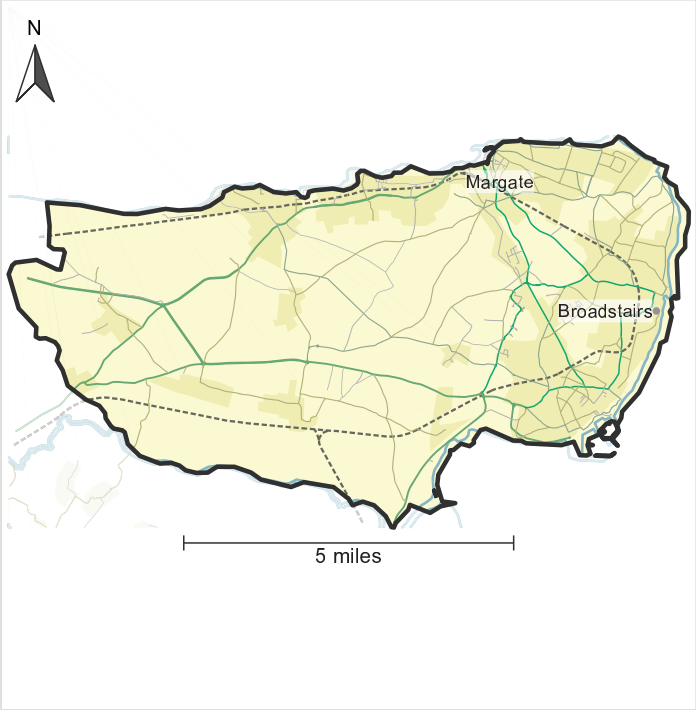
**Living longer**
Life expectancy is 10.9 years lower for men and 6.2 years lower for women in the most deprived areas of Thanet than in the least deprived areas.

**Child health**
In Year 6, 19.1% (251) of children are classified as obese. The rate of alcohol-specific hospital stays among those under 18 was 46.5*. This represents 13 stays per year. Levels of teenage pregnancy, GCSE attainment, breastfeeding and smoking at time of delivery are worse than the England average.

**Adult health**
In 2012, 21.4% of adults are classified as obese. The rate of alcohol related harm hospital stays was 653*. This represents 869 stays per year. The rate of self-harm hospital stays was 326.5*, worse than the average for England. This represents 420 stays per year. The rate of smoking related deaths was 352*, worse than the average for England. This represents 326 deaths per year. Estimated levels of adult excess weight, smoking and physical activity are worse than the England average. Rates of sexually transmitted infections, people killed and seriously injured on roads and TB are better than average.

**Local priorities**
Priorities in Thanet include reducing early deaths from heart disease and stroke and from respiratory disease, reducing alcohol and drug misuse, and improving access to mental health services. For more information see www.thanetccg.nhs.uk or www.kmpho.nhs.uk

* rate per 100,000 population

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**Population: 137,000**
Mid-2013 population estimate. Source: Office for National Statistics.

This profile gives a picture of people's health in Thanet. It is designed to help local government and health services understand their community's needs, so that they can work together to improve people's health and reduce health inequalities.

Visit www.healthprofiles.info for more profiles, more information and interactive maps and tools.

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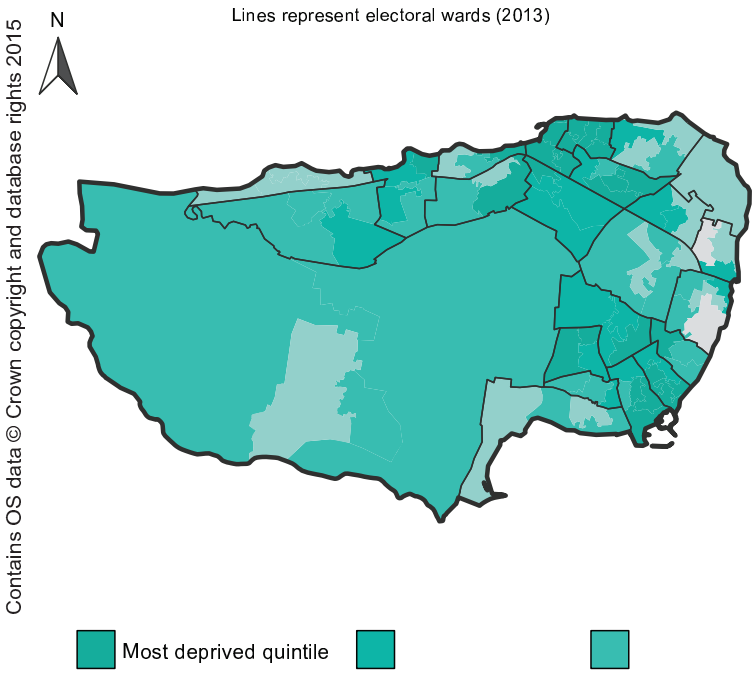
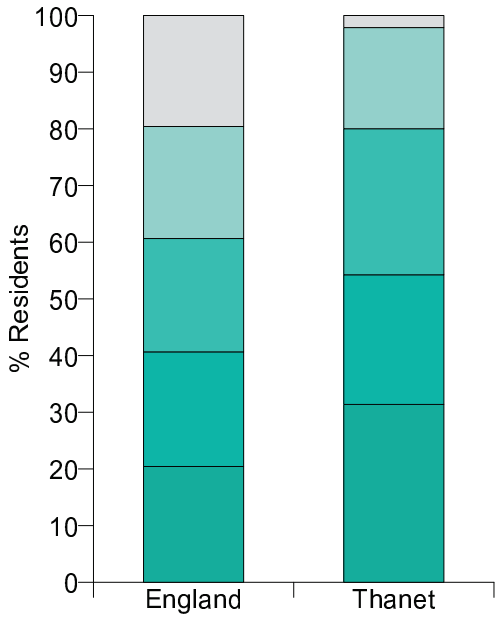
# Deprivation: a national view

The map shows differences in deprivation in this area based on national comparisons, using quintiles (fifths) of the Index of Multiple Deprivation 2010, shown by lower super output area. The darkest coloured areas are some of the most deprived neighbourhoods in England.




This chart shows the percentage of the population who live in areas at each level of deprivation.

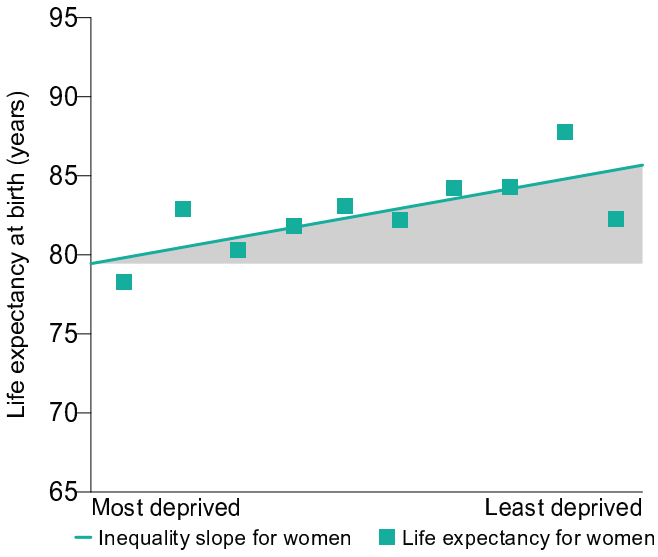



# Life expectancy: inequalities in this local authority

The charts below show life expectancy for men and women in this local authority for 2011-2013. Each chart is divided into deciles (tenths) by deprivation, from the most deprived decile on the left of the chart to the least deprived decile on the right. The steepness of the slope represents the inequality in life expectancy that is related to deprivation in this local area. If there were no inequality in life expectancy as a result of deprivation, the line would be horizontal.

Life expectancy gap for men: 10.9 years

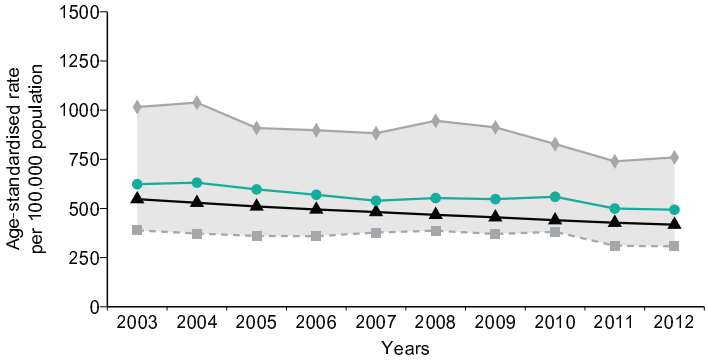

Life expectancy gap for women: 6.2 years



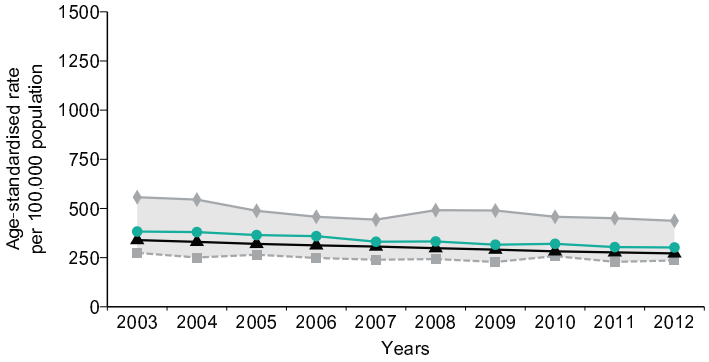
# Health inequalities: changes over time

These charts provide a comparison of the changes in early death rates (in people under 75) between this area and all of England. Early deaths from all causes also show the differences between the most and least deprived quintile in this area. (Data points are the midpoints of 3 year averages of annual rates, for example 2005 represents the period 2004 to 2006).

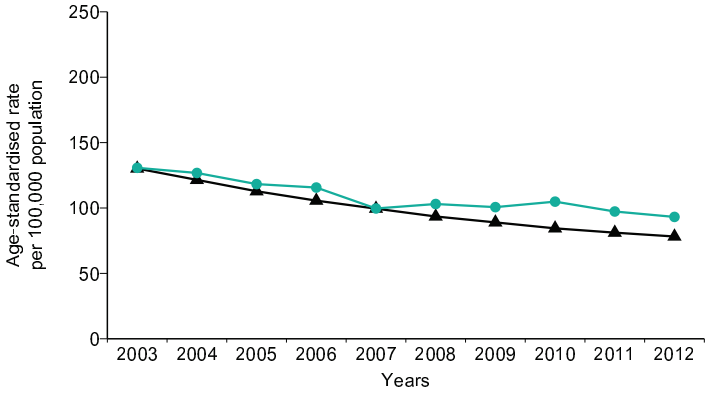
Early deaths from all causes: MEN



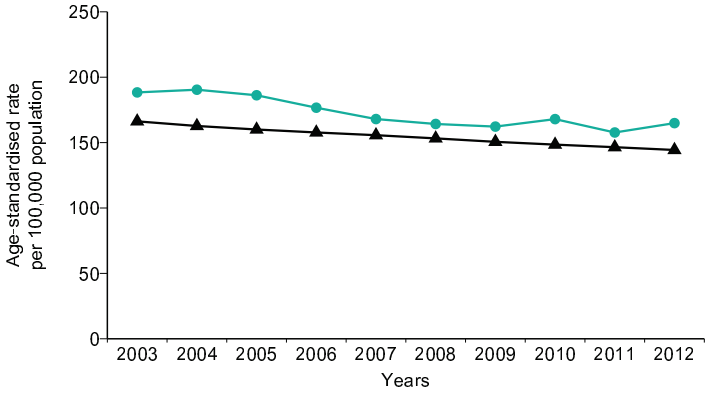

Early deaths from all causes: WOMEN

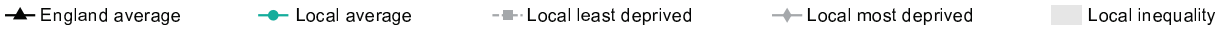



Early deaths from heart disease and stroke



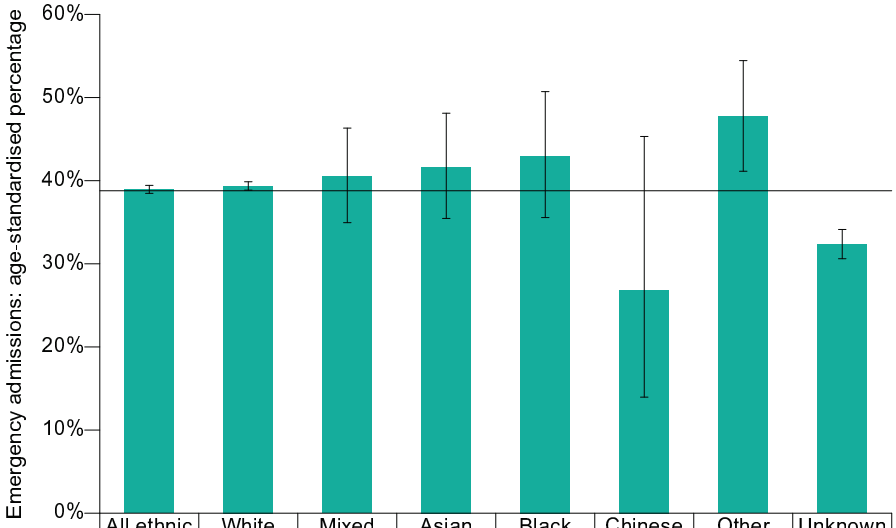

Early deaths from cancer




# Health inequalities: ethnicity

Percentage of hospital admissions that were emergencies, by ethnic group, 2013




This chart shows the percentage of hospital admissions for each ethnic group that were emergencies, rather than planned. A higher percentage of emergency admissions may be caused by higher levels of urgent need for hospital services or lower use of services in the community. Comparing percentages for each ethnic group may help identify inequalities.

Thanet

England average (all ethnic groups)

95% confidence interval

Figures based on small numbers of admissions have been suppressed to avoid any potential disclosure of information about individuals.

| All ethnic groups | White | Mixed | Asian | Black | Chinese | Other | Unknown | |
|---|---|---|---|---|---|---|---|---|
| 15,570 | 14,316 | 119 | 94 | 66 | 7 | 100 | 868 | Local number of emergency admissions |
| 39.0 | 39.4 | 40.5 | 41.6 | 43.0 | 26.8 | 47.7 | 32.3 | Local value % |
| 38.8 | 39.2 | 38.3 | 43.0 | 42.5 | 35.2 | 44.9 | 30.1 | England value % |

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# Health summary for Thanet

The chart below shows how the health of people in this area compares with the rest of England. This area's result for each indicator is shown as a circle. The average rate for England is shown by the black line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means that this area is significantly worse than England for that indicator; however, a green circle may still indicate an important public health problem.

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average

Regional average^ | England Average | England Worst | England Best | 25th Percentile | 75th Percentile | England Range

| Domain | | Indicator | Local No Per Year | Local value | Eng value | Eng worst | Eng best |
|---|---|---|---|---|---|---|---|
| Our communities | 1 | Deprivation | 42,917 | 31.4 | 20.4 | 83.8 | 0.0 |
| | 2 | Children in poverty (under 16s) | 6,800 | 26.7 | 19.2 | 37.9 | 5.8 |
| | 3 | Statutory homelessness | 112 | 1.8 | 2.3 | 12.5 | 0.0 |
| | 4 | GCSE achieved (5A*-C inc. Eng & Maths)† | 689 | 44.9 | 56.8 | 35.4 | 79.9 |
| | 5 | Violent crime (violence offences) | 3,040 | 22.4 | 11.1 | 27.8 | 2.8 |
| | 6 | Long term unemployment | 1,213 | 15.1 | 7.1 | 23.5 | 0.9 |
| Children's and young people's health | 7 | Smoking status at time of delivery | 269 | 17.0 | 12.0 | 27.5 | 1.9 |
| | 8 | Breastfeeding initiation | 1,047 | 67.4 | 73.9 | | |
| | 9 | Obese children (Year 6) | 251 | 19.1 | 19.1 | 27.1 | 9.4 |
| | 10 | Alcohol-specific hospital stays (under 18)† | 13.3 | 46.5 | 40.1 | 105.8 | 11.2 |
| | 11 | Under 18 conceptions | 94 | 35.6 | 24.3 | 44.0 | 7.6 |
| Adults' health and lifestyle | 12 | Smoking prevalence | n/a | 24.8 | 18.4 | 30.0 | 9.0 |
| | 13 | Percentage of physically active adults | 231 | 48.4 | 56.0 | 43.5 | 69.7 |
| | 14 | Obese adults | n/a | 21.4 | 23.0 | 35.2 | 11.2 |
| | 15 | Excess weight in adults | 233 | 68.4 | 63.8 | 75.9 | 45.9 |
| Disease and poor health | 16 | Incidence of malignant melanoma† | 24.0 | 20.4 | 18.4 | 38.0 | 4.8 |
| | 17 | Hospital stays for self-harm | 420 | 326.5 | 203.2 | 682.7 | 60.9 |
| | 18 | Hospital stays for alcohol related harm† | 869 | 653 | 645 | 1231 | 366 |
| | 19 | Prevalence of opiate and/or crack use | 875 | 10.7 | 8.4 | 25.0 | 1.4 |
| | 20 | Recorded diabetes | 8,232 | 7.2 | 6.2 | 9.0 | 3.4 |
| | 21 | Incidence of TB† | 10.3 | 7.6 | 14.8 | 113.7 | 0.0 |
| | 22 | New STI (exc Chlamydia aged under 25) | 588 | 718 | 832 | 3269 | 172 |
| | 23 | Hip fractures in people aged 65 and over | 211 | 595 | 580 | 838 | 354 |
| Life expectancy and causes of death | 24 | Excess winter deaths (three year) | 113.7 | 21.9 | 17.4 | 34.3 | 3.9 |
| | 25 | Life expectancy at birth (Male) | n/a | 77.8 | 79.4 | 74.3 | 83.0 |
| | 26 | Life expectancy at birth (Female) | n/a | 82.6 | 83.1 | 80.0 | 86.4 |
| | 27 | Infant mortality | 4 | 2.6 | 4.0 | 7.6 | 1.1 |
| | 28 | Smoking related deaths | 326 | 351.7 | 288.7 | 471.6 | 167.4 |
| | 29 | Suicide rate | 13 | 9.9 | 8.8 | | |
| | 30 | Under 75 mortality rate: cardiovascular | 118 | 93.2 | 78.2 | 137.0 | 37.1 |
| | 31 | Under 75 mortality rate: cancer | 211 | 164.9 | 144.4 | 202.9 | 104.0 |
| | 32 | Killed and seriously injured on roads | 42 | 31.0 | 39.7 | 119.6 | 7.8 |

**Indicator notes**

1 % people in this area living in 20% most deprived areas in England, 2013 2 % children (under 16) in families receiving means-tested benefits & low income, 2012 3 Crude rate per 1,000 households, 2013/14 4 % key stage 4, 2013/14 5 Recorded violence against the person crimes, crude rate per 1,000 population, 2013/14 6 Crude rate per 1,000 population aged 16-64, 2014 7 % of women who smoke at time of delivery, 2013/14 8 % of all mothers who breastfeed their babies in the first 48hrs after delivery, 2013/14 9 % school children in Year 6 (age 10-11), 2013/14 10 Persons under 18 admitted to hospital due to alcohol-specific conditions, crude rate per 100,000 population, 2011/12 to 2013/14 (pooled) 11 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2013 12 % adults aged 18 and over who smoke, 2013 13 % adults achieving at least 150 mins physical activity per week, 2013 14 % adults classified as obese, Active People Survey 2012 15 % adults classified as overweight or obese, Active People Survey 2012 16 Directly age standardised rate per 100,000 population, aged under 75, 2010-12 17 Directly age sex standardised rate per 100,000 population, 2013/14 18 The number of admissions involving an alcohol-related primary diagnosis or an alcohol-related external cause, directly age standardised rate per 100,000 population, 2013/14 19 Estimated users of opiate and/or crack cocaine aged 15-64, crude rate per 1,000 population, 2011/12 20 % people on GP registers with a recorded diagnosis of diabetes 2013/14 21 Crude rate per 100,000 population, 2011-13, local number per year figure is the average count 22 All new STI diagnoses (excluding Chlamydia under age 25), crude rate per 100,000 population, 2013 23 Directly age and sex standardised rate of emergency admissions, per 100,000 population aged 65 and over, 2013/14 24 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 01.08.10-31.07.13 25, 26 At birth, 2011-13 27 Rate per 1,000 live births, 2011-13 28 Directly age standardised rate per 100,000 population aged 35 and over, 2011-13 29 Directly age standardised mortality rate from suicide and injury of undetermined intent per 100,000 population, 2011-13 30 Directly age standardised rate per 100,000 population aged under 75, 2011-13 31 Directly age standardised rate per 100,000 population aged under 75, 2011-13 32 Rate per 100,000 population, 2011-13

† Indicator has had methodological changes so is not directly comparable with previously released values. ^ "Regional" refers to the former government regions.

More information is available at www.healthprofiles.info and http://fingertips.phe.org.uk/profile/health-profiles Please send any enquiries to healthprofiles@phe.gov.uk

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# Thanet Children's Board Priorities – Overview

- The Thanet Children's Board (COG) held its inaugural meeting on 25 September 2014.
- Historically it has been challenging for the Board to co-ordinate representation from Social Care, Education, Schools and Health to get the right people around the table and hold people to account. However the TCB has reinvigorated membership, not least because of re-structures now in place across the county and a re-focus on what is needed. Membership includes, CCG Clinical Lead, TDC Leader, Early Help Area Manager, 0-25 Early Help Manager for Thanet, KCC Public Health, TDC and Community Safety, KCC Specialist Children's Services and Kent Safeguarding Children.
- At its second meeting in December 2014 the Board decided to hold an Extraordinary Meeting on 24 February 2015 specifically to look at identifying key priorities and resolve 'quick' issues.
- At the Extraordinary Meeting it became clear that tackling absence/exclusion is a cross cutting issue for Education, Kent Police, Health, Specialist Children's Services, and Public Health. Gang crime, child sexual exploitation is a major issue and young people on the streets are vulnerable to be exploited and targeted by gangs.
- The Thanet Children's Board at its meeting on 19 March agreed to target as its key priority, Exclusions and Absenteeism, and set up a Task and Finish group to further explore the Thanet Exclusion Project led by Rob Comber to develop the Programme Ideation.

| **Thanet Children's Board – Identified Key Priorities** | **Partnerships / organisations leading delivery** | **Current data (if available/applicable)** | **Interventions/Performance Measures** |
|---|---|---|---|
| **1. Increase levels of safeguarding across all areas.** | Kent Safeguarding Children's Board plus all providers | | |
| **2. Reduce absenteeism and the number of exclusions in Thanet** | KCC Education, KCC Specialist Children's Services, Early Help & Prevention, Kent Police, Public Health and CCG | Permanent exclusions in Thanet have increased over the last three years and account for 46% of all permanent exclusions in Kent.<br>There has also been an increase in the number of young pupils (5-7) being excluded from Thanet primary schools. | Thanet Exclusion Project. Thematic, cross-cutting, multi-disciplinary approach, using Theory of Change Model.<br>Programmes and interventions that have the greatest impact in reducing exclusions and improving outcomes for children. |

Updated: April 2015

| | | | | |
|---|---|---|---|---|
| | | | | Programmes and strategies which increase capacity of schools to manage behaviour.<br>Reduction in number of exclusions across primary schools at a rate greater than recent trends. |
| **3.** | **Reduce the number of missing children in Thanet** | KCC Education, KCC Specialist Children's Services, Early Help Help & Prevention, Kent Police, Public Health and CCG, TDC and Community Safety Partnership | A total of 235 Looked after Children (LAC) were recorded as being placed in Thanet in 2013-14 out of a total for Kent of 1842 (13%). Of these there were 167 missing LAC incidents | |
| **4.** | **Reduce number of vulnerable young people at risk, including those at risk of Child Sexual Exploitation and Gang involvement** | TDC, Community Safety Partnership, KCC Education, KCC Specialist Children's Services, Early Help & Prevention, Kent Police, Public Health and CCG | | Margate Task Force EOI to the Social Care and Innovation Fund for funding to work with Children in Social Care and at risk from gangs and going missing |
| **5.** | **Improve the child and adolescent mental health services (CAMHS)** | Clinical Commissioning Group, Public Health | | Public Health is monitoring the effect changes to the CAF process may have on CAMHS |
| **6.** | **Increase breastfeeding initiation rates and prevalence at 6-8 weeks** | Children's Centres District Advisory Board (DAB) + GPs + commissioned by Public Health. Health Visitors and Midwives also lead. | Breastfeeding initiation rates for Thanet are 71.4% compared to national average of 73.9%(Public Health England Health Profile 2014) | Breastfeeding initiation and prevalence at 6-8 weeks after birth |
| **7.** | **Reduce smoking prevalence of smoking mothers** | Midwives + Children's Centres DAB + Public Health | In Thanet 17.6% of pregnant women continuing to smoke, compared with the England average of 12.7% (Public Health England Health Profile August | Smoking status at time of delivery |

| | | | |
|---|---|---|---|
| | | 2014) | |
| **8. Reduce risk-taking behaviour in Children and Young People, e.g. smoking, sexual health, teenage conception, drugs alcohol specific stays in hospital for the under 18s** | KCC Early Help and Preventative Service 0-25, Public Health, Schools | Alcohol-specific hospital stays (under 18) in Thanet are 58.3% compared to the national average of 44.9% | Full suite of measures set out on Early Help and Prevention 0-25 Scorecard.<br><br>Focus in Thanet on alcohol and then drugs |
| **9. Reduce teenage under 18 conception rates** | KCC Early Help and Preventative Service 0-25,Public Health, School Nurses | Teenage conception rates for 2014 are significantly higher in Thanet than the rest of Kent at 36.1% compared to the national average of 27.7% (although significant reduction compared to 2010 at 59.6%).(Public Health England Health Profile August 2014) | Full suite of measures set out in KCC Early Help and Preventative Services 0-25 scorecard. |
| **10. Deliver the universal child health promotion programme to all Thanet children** | Public Health, GPs, Health Visitors and School Nurses | | |

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**Education & Young People's Services**

Early Help &
Preventative Services

# A Holistic Approach to Improved Pupil Outcomes in Primary Schools

# Update Report: **Programme Ideation**

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## Introduction

An initial review of data and performance indicators within the Education & Young People's Services directorate identified the potential for services to be developed to support schools and families in reducing the number of pupils in primary schools in Thanet being excluded. Further insight and analysis was completed to identify the scale of the problem.

This project (A Holistic Approach to Improved Pupil Outcomes in Primary Schools) has been established with the following aims;

- Gain a greater understanding of the reasons attributing to high levels of exclusion amongst some primary schools
- Gain a greater understanding of which initiatives, programmes and interventions have the greatest impact in reducing exclusions and improving outcomes for children.
- Design, test and implement programmes and strategies which have an impact in improving outcomes for pupils

The project will embed a Theory f Change approach within the methodology ensuring that any work has a causality focus.

Workshops have been delivered with multi-disciplinary groups which have; supported the interpretation of the insight and analysis; completed causality modelling activities; identified the programme structure; and agreed the principles of programme generation.

The below information is a summary of information gathered through analysis and workshop delivery.

## The Problem

In recent years too many children have been either directly or indirectly excluded from primary schools in Thanet.

Exclusion from school often exacerbates other disadvantage experienced by a child. Whilst the experience of a single disadvantage can create difficulties for young people, multiple disadvantages can often interact and exacerbate one another, leading to more harmful and costly outcomes for both the young person and society as a whole.

The impact of exclusion has a substantial cost to an individual and society. The total lifetime cost of permanent exclusions from school in Kent totals approximately £117 million in the last 8 years (New Philanthropy Capital).

A survey conducted by HM Inspectorate of Prisons and the Youth Justice Board of 15-18 year olds held in custody revealed that:

- 40 per cent of the young men and 53 per cent of the young women reported that they were aged 14 or under when they were last in school. This figure rose to 100 per cent in one of the female establishments

- 90 per cent of the young men and 75 per cent of the young women had been excluded from school

Exclusion from school is statistically linked to deprivation. The likelihood of a child being excluded from school is increased within communities where there are higher levels of deprivation. Some of the most deprived communities in Kent are located within Thanet.

## The Vision for the Future

Every child and young person achieves their potential in life, whatever their background. Every child and young person will be safe; their education, social and emotional needs will be met and their outcomes will be good. They will be able to contribute positively to their communities and those around them, now and in the future, including active engagement in learning and employment.

The needs of the family will be identified as potential risks to a child and young person's positive engagement in school and community and exposure to risk will be reduced through strong family bonds.

The school is the driver to developing a strong, engaging and connected community where the most vulnerable have an identity. Services work together to achieve the best possible outcomes for the family, the child, the school and the community.

## The Outcomes

Through the successful delivery of a multi-family community led prevention programme based within the school the following outcomes are anticipated;

- Improved academic performance
- Improvement in the child's prosocial interactions and behaviours
- Reduced child aggression and inappropriate behaviour
- Improvement in parental pro-school attitudes
- Improvement in the connectedness of the community
- Improvement in positive family functioning
- Improvement in the efficacy of parents

## The Theory of Change

Theory of Change is a process used to enable us to describe theories and assumptions, and the required evidence, supporting the rationale for change.

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Through the delivery of a causality modelling workshop involving representative agencies of the Thanet Childrens Board an assumption has been made that family issues, which are often complex, are associated to the existence of risks to the child, family, community and school.

Through supporting and enabling parents to more effectively protect their families against risks by strengthening relationships with their child, their peers, their school and their community;

- the family will become stronger and reduce exposure to risk;
- children will develop better, be more supported to cope with issues of disadvantage and be able to self-regulate;
- the family will become more engaged in their child's school and education;
- children will be less likely to engage in anti-social and harmful behaviour;
- children will thrive in their school and community.

## The Programme Structure

The Thanet Childrens Board agree to commit to the delivery of a programme of 2 to 3 years which can be effectively evaluated for impact in order to determine the benefits of a programme.

The programme will have three inter-connected domains of focus identified to achieve optimum impact; parental engagement, whole school support; and pupil activity. The programme will be delivered across 3 schools identified as having one or more of the following characteristics;

1. community has higher rates than average of deprivation
2. the school has higher than average rates of exclusion
3. the school has higher than average rates of absence
4. the school has a willingness to engage with the programme

Governance of the programme will be provided through Early Help & Preventative Services and the Thanet Childrens Board. Progress reports will be provided to each at an agreed frequency.

The programme will be evaluated to identify impact and to determine whether the programme could be scaled up and rolled out to other areas.

Programme design will be completed by a multi-disciplinary group emphasising the need to co-design and co-deliver activities. Wherever possible activities should be community led and consider the sustainability and fidelity of work.

## Programme Concepts – Parental Engagement

Determined through delivery of workshop activities and research from national What Works Centres the following concepts should be considered within the Parental Engagement domain of programme activity.

***Who is this programme aimed at?***

Parents and carers of children identified as at risk and aged between 5 and 10, and who wish to support their child's development and engagement in their school and community.

***Where could this programme be delivered?***

Within schools engaged in the programme.

***How could this programme work?***

- Engagement in the programme is incentivised
- A fixed period programme is delivered to a group of parents and children within a school after school hours once a week (for 8-12 weeks)
- A fixed period programme focusses on developing communication skills; the ability to manage stress; parent and child play activities; budgeting; meal preparation and cooking; and the skills to organise and manage group activities
- The fixed period programme is co-delivered by school staff and community based practitioners with a degree of group led agenda setting.
- At the end of the fixed period programme parents pass/qualify based on engagement with the programme and an event is held.
- The group of parents who pass/qualify are provided with a resource/budget to maintain the delivery of the group for 2 years (with minimal support) with a focus on community led peer to peer development which can be delivered during the school day outside of the school. These parents can also be used to deliver a following wave of the programme.

## Programme Concepts – Whole School Support

Determined through delivery of workshop activities and research from national What Works Centres the following concepts should be considered within the Whole School Support domain of programme activity;

***Who is this programme aimed at?***

School teaching and non-teaching staff.

***Where could this programme be delivered?***

Within the school and utilising training days/

***How could this programme work?***

- A training package will be delivered to provide tools and strategies to develop the early identification of neglect and the actions that should be taken including awareness of signs of escalation leading to neglect.
- The training package will include coping strategies for school staff who are exposed to signs of neglect within their pupils.

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- It will also include tools and strategies to encourage appropriate information sharing from children. The package will include ideas and strategies on how to improve the school environment to allow space and time for staff to be mindful and implement coping strategies.

## Programme Concepts – Pupil Activity

Determined through delivery of workshop activities and research from national What Works Centres the following concepts should be considered within the Pupil Activity domain of programme activity;

***Who is this programme aimed at?***

All primary school pupils

***Where could this programme be delivered?***

Within a primary school and classroom

***How could this programme work?***

- Activities are delivered that help children feel better about themselves
- Activities are built into the curriculum within the school
- Co-delivered by teachers and community based practitioners in group sessions for all pupils.
- Additional counselling support is available for children when more complex needs are identified.
- Programme principles are: doing good things makes you feel good about yourself, making good choices helps you create a cycle of positivity
- Pupils learn about nutrition, exercise and good hygiene and sleep habits.
- Pupils learn about treating other people in a manner in which you would like to be treated - Pupils learn about empathy and respect for others.
- Pupils learn about goal setting and persistence.
- Creative sessions are delivered to help pupils explore coping strategies.

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