



BEDFORD BOROUGH COUNCIL

**NHS**

**Bedfordshire**

Bedford Borough  
Joint Strategic Needs Assessment 2010  
Children and Young People



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for BAL

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# Healthy - Early Years

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## Early Access to Antenatal Care

Ideally, all women should access maternity services for a full health and social care assessment of needs, risks and choices by 12 weeks and 6 days of their pregnancy. This is to give them the full benefit of personalised maternity care, improve outcomes and improve the experience for the mother and the baby. This 'Booking Appointment' is carried out by a Healthcare Professional (usually the Midwife) and allows women to make informed and supported choices in relation to their care during pregnancy, labour and the post natal period.

As part of the Booking Appointment the national choice guarantees are discussed, which include:

- choice of how to access maternity care
- choice of type of antenatal care
- choice of place of birth

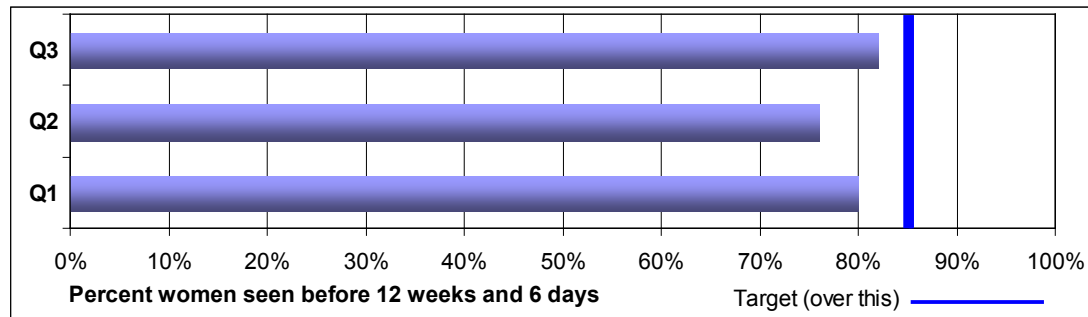
## Key Findings

At the end of 2008/09, 81.9% of pregnant women in Bedfordshire had accessed their antenatal booking appointment within 12 weeks and 6 days of pregnancy against a Vital Signs target (VSB06) of 85%.

For most pregnant women residing in Bedford Borough, their choice of hospital for delivery is predominantly Bedford Hospital, with others opting to deliver at the Luton & Dunstable Hospital or hospitals within neighbouring Counties.

Bedford Hospital Trust is currently in the process of auditing booking appointments which are carried out later than 12 weeks and 6 days to help improve our understanding of the potential barriers that need to be overcome. To date this work has not highlighted specific geographical locations or GP practice populations for which late booking is a particular problem. However this work is ongoing and may be included in the JSNA at a later date.

Figure 1: Early Access to Maternity Services by Quarter in 2009/10



### Best Practice

The Department of Health recently included Early Access to Antenatal Care as one of its Vital Signs indicators (VSB06) against which performance is monitored quarterly. The overarching aim is to achieve an increase in the percentage of women who have seen a midwife or a maternity healthcare professional for assessment of health and social care needs, risks and choices by 12 weeks and 6 days of pregnancy.

The Healthy Child Programme (HCP)<sup>1</sup> is a structured early intervention and prevention public health programme, which offers every family a universal programme of screening, immunisations, developmental reviews, support, information and guidance. The effective implementation of the HCP should assist families to achieve their optimum health and wellbeing, as well as allowing effective identification of those families at greatest risk and in need of progressive services. The HCP strongly supports the need for women to access a full antenatal assessment by 12 weeks of pregnancy.

A survey carried out by the National Perinatal Epidemiology Unit<sup>2</sup> found that four out of five women (80%) realised they were pregnant within the first 6 weeks with smaller proportions taking longer to become aware of their pregnancy (16% at 7-11 weeks and 4% at 12 or more weeks). Little difference in this timing was evident between women who were having their first baby and women who had previously given birth. While women were aware of their pregnancy, not all women contacted a health professional about their pregnancy care immediately. Less than half (43%) had made their first contact with a health professional about their pregnancy by the time they were 6 weeks pregnant, a similar proportion (44%) did so at 7-11 weeks and 14% of women at 12 weeks or more of pregnancy.

Standard 11 of the National Service Framework for children, young people and maternity services<sup>3</sup> requires providers to ensure that the services are equitable and accessible to all, offering choice and individualised care for everyone. It also provides guidance on what an appropriate maternity service should offer for families from specific disadvantage groups such as minority groups, those who do not speak English as their first language, people with disabilities and asylum seekers.

## Service Baseline

Women can now access the midwife directly, in preference to a GP, as the first healthcare contact upon learning of a pregnancy. All women living in Bedford Borough are then offered a Booking Appointment through the Bedford Hospital Trust Midwifery Service, either at Bedford Hospital or a local venue such as a GP Practice or a Children's Centre. Access to Booking Appointments for women in Bedford is being improved through the increase in the availability of appointments and an increase in the use of accessible community based venues. Work is currently underway with Bedford Hospital Trust, through the use of ward level data and internal audit, to identify geographical areas, specific GP practice populations, and specific population groups for whom late antenatal access appears to be a concern. This will help to inform future commissioning of services and targeted work.

## Gaps

Most research data analysing reasons for late antenatal booking have concentrated on Black and Minority Ethnic (BME) women who speak little or no English, are less knowledgeable about the maternity services and had lived in the UK for a shorter period compared to those fluent in English. Women are likely to start antenatal care later and have fewer antenatal visits if they are young or unsupported, from ethnic minorities, refugees, unemployed, in temporary accommodation or live in deprived areas.

## Public / Patient Voice Involvement

Routine service user feedback is collected through the Bedford Hospital Trust Midwifery Department, and is used to inform service development and delivery. The service user feedback tool is currently being revised to comply with the 'Women's Experience of Maternity Care' survey which is recommended by the East of England Strategic Health Authority. It is possible that annual survey results may be included as part of the JSNA in the future. In addition, service users sit on the Maternity Services Liaison Committee for Bedfordshire, to provide both direct service user input and to represent the views of the wider public in regards to issues relating to maternity services delivered at Bedford Hospital.

## Priorities

- Improving our understanding of the reasons for late access of maternity care by mothers living in Bedford Borough
- Ongoing analysis of ward level data, and internal audit will continue to highlight areas of need, although we need to increase our understanding of reasons for late booking out of choice
- Targeting outreach work for vulnerable and socially excluded groups. This will provide a focus on reducing the health inequalities

## Smoking in Pregnancy & Postnatal Period

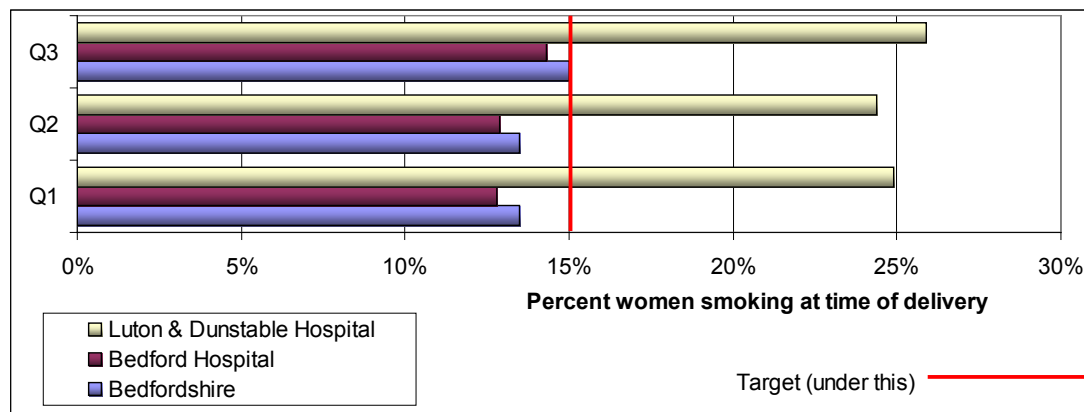
Stopping smoking is the most effective single step a pregnant woman can take to improve her own health and that of her baby. Smoking during pregnancy leads to poorer health outcomes for the unborn child, including smaller airways and low birth weight, as well as increasing the risk of pregnancy related complications, such as bleeding and placental abruption.

Smoking in pregnancy is both a cause and effect of health inequalities. Smoking is a major threat to health across all groups and is the main contributor to the life expectancy gap between those who are least and most well off. Babies born to smoking mothers are more likely to die during the first four weeks of life and stopping smoking at any stage during pregnancy brings proportional health benefits.

### Key Findings

Smoking during pregnancy is monitored at local level by collection of the rates of mothers smoking at time of delivery; a data set which is provided by acute hospital trusts delivering babies to mothers resident in Bedford Borough (primarily Bedford Hospital) (Figure 2).

Figure 2: Smoking at time of delivery by Quarter in 2009/10



## Best Practice

The National Institute for Health and Clinical Excellence recommended in 2008 that Stop Smoking Services be targeted at:

- Women who smoke, that are either pregnant or are planning to become pregnant, as well as their partners and family members who may smoke;
- Mothers of infants and young children, particularly those that are breast feeding, and their partners and family members.

It is the responsibility of a wide range of services to take action to address this important health issue. These include those working in fertility clinics, midwives, GP's, dentists, hospital and community pharmacists and those working in children's centres, voluntary organisations and occupational health services.

## Service Baseline

Bedfordshire NHS Specialist Stop Smoking Service has a Smoking in Pregnancy lead who works closely with Bedford Hospital and a stop smoking specialist advisor that provides dedicated sessions for pregnant women at Bedford hospitals maternity department. Those pregnant women wishing to receive support nearer home can be seen by the Stop Smoking Specialist that covers their local area.

## Gaps

Bedfordshire NHS Specialist Stop Smoking Service together with the Bedford Hospital Midwifery Service provides a high quality support service for women who are ready to stop smoking during pregnancy. Further work needs to be undertaken to ensure that women are motivated to quit smoking upon referral into the service.

It is recognised that the current service provision has the capacity to support women for a relatively short period of time. It has been highlighted that there is a need to develop a holistic long term programme of support, which would see pregnant women being supported throughout the course of the pregnancy and beyond. Similarly, service provision is being expanded to offer support to pregnant women who claim to have recently quit smoking at time of antenatal booking, to prevent relapse during pregnancy and to help prevent women from re-starting smoking after delivery.

Over recent months an upward shift in the number of women smoking at the start of their pregnancy, which is possibly linked to changes in population demography. For this reason pregnant quit targets which are largely static will have little impact on prevalence of smoking at time of delivery, in the presence of an increasing baseline. Therefore it is essential that pregnant quit targets are reviewed and set annually, but also that future work seeks to address the wider tobacco control and prevention agenda.

## Public / Patient Voice Involvement

Service users are provided with a feedback questionnaire prior to discharge from the service. User feedback is then used to inform future service development.

Smoking in pregnancy focus groups are planned with service users.

## Priorities

- Promoting of smoking cessation to women of child bearing age who may be planning a pregnancy
- At the first contact with the woman, discussing her smoking status, providing information about the risks of smoking to the unborn child and the hazards of exposure to second hand smoke
- Providing personalised advice and support throughout pregnancy, through the NHS Stop Smoking Service
- Increasing the number of Midwives trained to provide basic level stop smoking advice to pregnant women, supported by the NHS Stop Smoking Service
- Ensuring clients receive behavioural support from a person who has had training and supervision that complies with the 'Standard for training in smoking cessation treatments' or its updates
- Providing tailored advice, counselling and support, particularly to clients from minority ethnic and disadvantaged groups and wherever possible, provide services in the language chosen by clients
- Ensuring the local NHS Stop Smoking Service aims to treat minority ethnic and disadvantaged groups at least in proportion to their representation in the local population of tobacco users
- Offering and encouraging the participation of partners and household members in stopping smoking
- Increasing the provision of services to support maintenance of post partum cessation
- Where a pregnant woman, or her partner / household contacts, are reluctant to quit smoking, ensuring the promotion of the Smokefree Homes and Cars initiative

## Maternal Mental Health

Mental disorders during pregnancy and the postnatal period can have serious consequences for the mother, her infant and other family members.

Treatment and care should take into account patients' individual needs and preferences. Good communication is essential, supported by evidence-based information, to allow patients to reach informed decisions about their care. Carers and relatives should have the chance to be involved in discussions unless the patient thinks it inappropriate. A key factor in improving mental health and emotional wellbeing outcomes for pregnant women is likely to be improving methods of identification and effective and timely intervention.

### Key Findings

There is no national data available on the incidence of maternal mental health conditions against which comparisons can be made.

Using the epidemiology and assuming an annual birth rate, it is possible to estimate the number of expected cases and referrals to mental health.

**Table 1:** The expected number of women a year presenting with perinatal mental health illness in Bedfordshire<sup>4</sup>

	% of deliveries	No. women*
Major postnatal depression (using research diagnostic criteria)	10%	<b>500</b>
Moderate to severe depressive illness	3-5%	<b>150-250</b>
Referrals to psychiatry – new episodes of postnatal mental health illness	2%	<b>100</b>
Referrals to psychiatry – total pregnancy and child birth related mental health problems	3.5%	<b>175</b>
Admission for puerperal psychosis	0.2%	<b>10</b>

Source: NHS Bedfordshire (2007) Review of Maternity Services

\*Calculations based on an annual birth rate of 5000 deliveries.

Through the implementation of the Healthy Child Programme, routine maternal mental assessments will be carried out in the future by the 0-19 Service. It is possible that results may be compiled for inclusion in this JSNA at a later date.

### Best Practice

Failure to deliver appropriate and timely management of perinatal mental health conditions can pose serious longer term adverse health implications for the mother, child and family. The UK Confidential Enquiry into Maternal Deaths (CEMD) reports that psychiatric disorders contribute to 12% of all maternal deaths, suicide is the second leading cause of maternal death in the UK.

Management of perinatal mental health should be delivered through tailored care pathways which focus on early identification and detection, and incorporate services which are delivered by an appropriately trained and skilled workforce. Questions to identify possible depression should be asked by the healthcare professionals (including midwives, obstetricians, health visitors and GPs) at a woman's first contact with primary care, booking visit and postnatally (usually at 4-6 weeks and 3-4 months). Appropriate questions for use during antenatal and postnatal contacts are outlined in the NICE Guidance<sup>5</sup>.

### Service Baseline

The management and care of mothers with mental illness is undertaken by a variety of primary and secondary care services<sup>6</sup>:

- General Practitioners
- Health visitor, social services, voluntary support organisations
- Midwifery and obstetrics from Bedford Hospital
- Midwifery and obstetrics from Luton and Dunstable Hospital.
- NHS Bedfordshire– mental health commissioning and public health directorate.

A Maternal Mental Health Steering Group has recently been established by NHS Bedfordshire, to lead the review and development of Perinatal mental health service provision.

### Gaps

Comprehensive care pathways for women in Bedford Borough who suffer a perinatal mental health condition.

## Priorities

- Developing comprehensive care pathways for women in Bedford Borough who suffer a perinatal mental health condition
- *Assessing managed perinatal networks.* Evaluating managed perinatal networks should be undertaken to compare the effectiveness of different network models in delivering care. It should cover the degree of integration of services, the establishment of common protocols, the impact on patients' access to specified services and the quality of care, and staff views on the delivery of care. Although only a relatively small number of women have a serious mental disorder during pregnancy and the postnatal period, those who do may need specialist care.
- *Case finding for depression.* A validation study should be undertaken of the 'woolley questions' (for example 'During the past month, have you often been bothered by feeling down, depressed or hopeless?'; 'During the past month, have you often been bothered by having little interest or pleasure in doing things?') in women in the first postnatal year. It should examine the questions' effectiveness when used by midwives and health visitors compared with a psychiatric interview. Depression in the first postnatal year is relatively common and may have a lasting impact on the woman, her baby and other family members.

## Infant Mortality

The infant mortality rate is defined as the death of a baby up to one year per 1,000 live births.

A Neonatal death is the death of a live birth up to 28 days old. The neonatal mortality rate is the number of neonatal deaths per 1,000 live births. A stillbirth is a baby delivered with no signs of life after 24 completed weeks of pregnancy. The stillbirth rate is the number of stillbirths per 1,000 live births and stillbirths.

### Key Findings

Table 2 shows the crude stillbirth, neonatal death and infant mortality for Bedford Borough in 2006-8 (pooled). For infant mortality, Bedford Borough has a higher rate than both East of England and England. These differences are not statistically significant.

**Table 2:** Stillbirth, neonatal death & perinatal death rates for Bedford Borough, East of England and England, 2006-8 (pooled)

	Rate per 1,000 (95% CI)					
	Stillbirth		Neonatal death		Infant mortality	
Bedford Borough	5.5	(3.9, 7.7)	2.2	(1.3, 3.7)	5.0	(3.5, 7.2)
East of England	4.4	(4.1, 4.7)	3.0	(2.7, 3.2)	4.3	(4.0, 4.6)
England	5.2	(5.1, 5.3)	3.3	(3.3, 3.4)	4.8	(4.7, 4.9)

Source: National Centre for Health Outcomes Development.

Bedford Hospital's mortality rates are small and vary year by year. A more reliable figure can be ascertained from the average from a three year period (2005-8) which are:

- stillbirth rate: 3.8 per 1,000 live births
- neonatal deaths rate: 0.6 per 1,000 live births
- perinatal death rate: 4.4 per 1,000 live & still births

Even with an average over three years, the confidence intervals are wide.

The number of infant deaths for Bedford Hospital in 2008 are relatively small. The primary causes of death are listed in Table 18.

**Table 3:** Causes of infant mortality at Bedford Hospital in 2008

Cause of death	Number of deaths
Disorders related to length of gestation and fetal growth	9
Respiratory and cardiovascular disorders specific to the perinatal period	3
Ill-defined and unknown causes of mortality	3
Congenital malformations of the circulatory system	2

Source: NHS Bedfordshire

## Best Practice

### Hospital-to-Hospital Transfers

For the first time in 2007, Confidential Enquiry into Maternal and Child Health (CEMACH) has provided information on hospital-to-hospital transfer patterns for neonatal deaths born at 22 weeks gestation onwards. A fifth of babies dying in the neonatal period whose mothers initially booked at level 1 or level 2 units, were not transferred to level 3 units until after birth; the median gestation of these babies was 30 and 26 weeks respectively. In-utero transfer of preterm babies may not always be appropriate or feasible, however it is important that review of non-transfers is carried out at unit and network levels.

### Low Maternal Age

Teenage mothers (aged less than 20 years at delivery) had the highest neonatal mortality rate of 4.4 per 1,000 live births compared to other maternal age groups. This may be due to a number of associated factors such as social deprivation and a higher rate of preterm delivery in this age group. In 2007, teenage pregnancies contributed 9.6% to overall neonatal mortality in England, Wales and Northern Ireland.

### Maternal Risk Factors

Extremes of maternal age, smoking, non-White ethnicity, and maternal social deprivation continue to be risk factors for stillbirth and neonatal death, and maternal obesity is also likely to be associated with these adverse outcomes. The increase in ethnic diversity, obesity and the proportion of older mothers within the UK maternity population suggests that achieving optimal pregnancy outcomes may become more challenging in the future.

## Post Mortem Examinations

The proportion of stillbirths and neonatal deaths where a post mortem examination was offered to parents has increased substantially from 2005. This is an encouraging finding and is likely to reflect the uptake by local maternity services of national-level guidance on post mortem examination and consent. There were fewer post mortems carried out for stillbirths and neonatal deaths born to Asian mothers.

## Service Baseline

The majority of maternity services for women in Bedford are provided by Bedford Hospital Trust these include community midwifery in addition to hospital based services such as outpatient clinics, delivery suite, postnatal ward and a Neonatal level 1 unit. A co-located midwifery led unit opened in late 2009.

Women are encouraged to see a midwife within 12 weeks of pregnancy so that the midwife can take a detailed history and give information and advice as early as possible to promote the woman's health and that of her baby. The majority of Bedford women choose to deliver at Bedford Hospital Trust with a small proportion choosing to deliver at home or at an alternative hospital.

The midwife is normally responsible for the providing care for the baby up to ten days when the Healthy Child Team takes over responsibility as part of the Bedfordshire 0-19 service.

## Gaps

Recruitment of Midwives to achieve optimum staffing levels is a national problem.  
Accessible integrated antenatal parenting education.

## Public/Patient Voice Involvement

The Bedford Maternity Services Liaison Committee has a lay chair and user representation. Also focus groups have been carried out and the National Patient Survey will include maternity services in 2010.

## Priorities

- Addressing maternity workforce issues
- Reducing maternal social deprivation, for example reducing poverty and unemployment, improving housing, improving nutrition including breastfeeding
- Reducing maternal smoking as it is associated with neonatal deaths
- Reviewing Hospital-to-hospital transfers
- Developing maternal mental health pathways
- Reducing teenage pregnancy and provide more support to pregnant teenagers or teenage parents
- Minimising maternal risk factors -the increase in ethnic diversity, obesity and the proportion of older mothers within the UK maternity population suggests that achieving optimal pregnancy outcomes may become more challenging in the future
- Increasing the number of women that book with a midwife within 12 weeks and five days of pregnancy
- There were fewer post mortems carried out for stillbirths and neonatal deaths born to Asian mothers - ensure post mortem examinations are carried out wherever possible, including tackling cultural issues and barriers

## Breastfeeding Initiation & Continuation

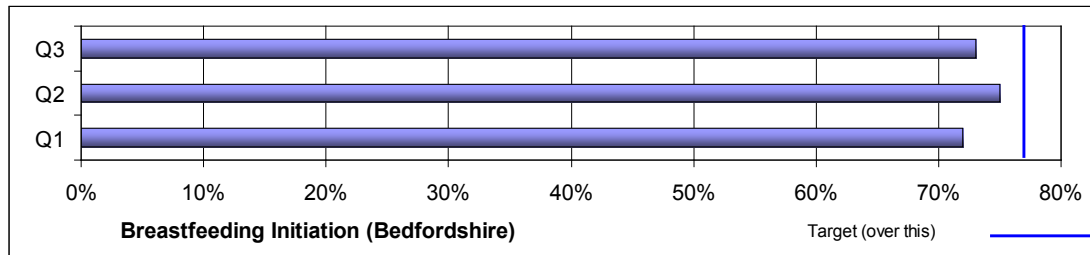
Breastmilk is the optimal form of nutrition for infants, and exclusive breastfeeding is recommended for the first six months (26 weeks) of an infant’s life. Thereafter, breastfeeding should continue for as long as the mother and baby wish, while gradually introducing the baby to a more varied diet<sup>7</sup>.

### Key Findings

Data on breastfeeding initiation is collected and reported to NHS Bedfordshire by acute hospital trusts, in line with the Department of Health definition for breastfeeding initiation (see Figure 3).

The annual target for breastfeeding initiation, set by the Department of Health, is to achieve a 2% annual increase in breastfeeding rates. In addition to the national target, which is being achieved, NHS Bedfordshire also chose to set an aspirational target of 75% in 2008/09, rising to 77% in 2009/10.

Figure 3: Breastfeeding Initiation rates in Bedfordshire

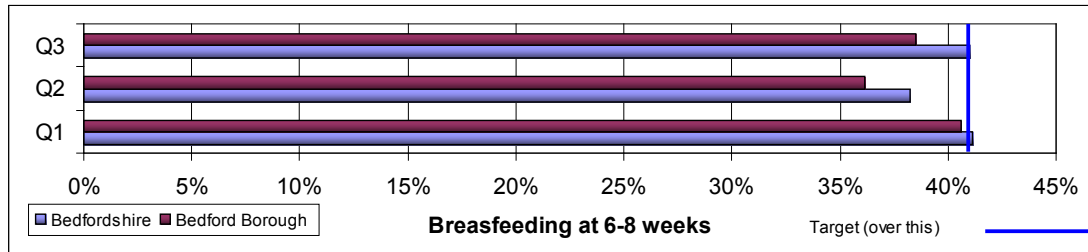


Source: NHS Bedfordshire

Bedford Hospital Trust has now started to provide ward level data on breastfeeding initiation for Bedford Borough women who deliver there. Ward level analysis of rates will be available in 2010/11.

Data on rates of breastfeeding at 6-8 weeks after birth are collected by General Practitioners at the 6-8 week infant developmental check, and is reported to NHS Bedfordshire quarterly by Primary Care practices (see Figure 4). The vital signs target for 2008/09 was 39%, rising to 41% in 2009/10 (VSB11\_05).

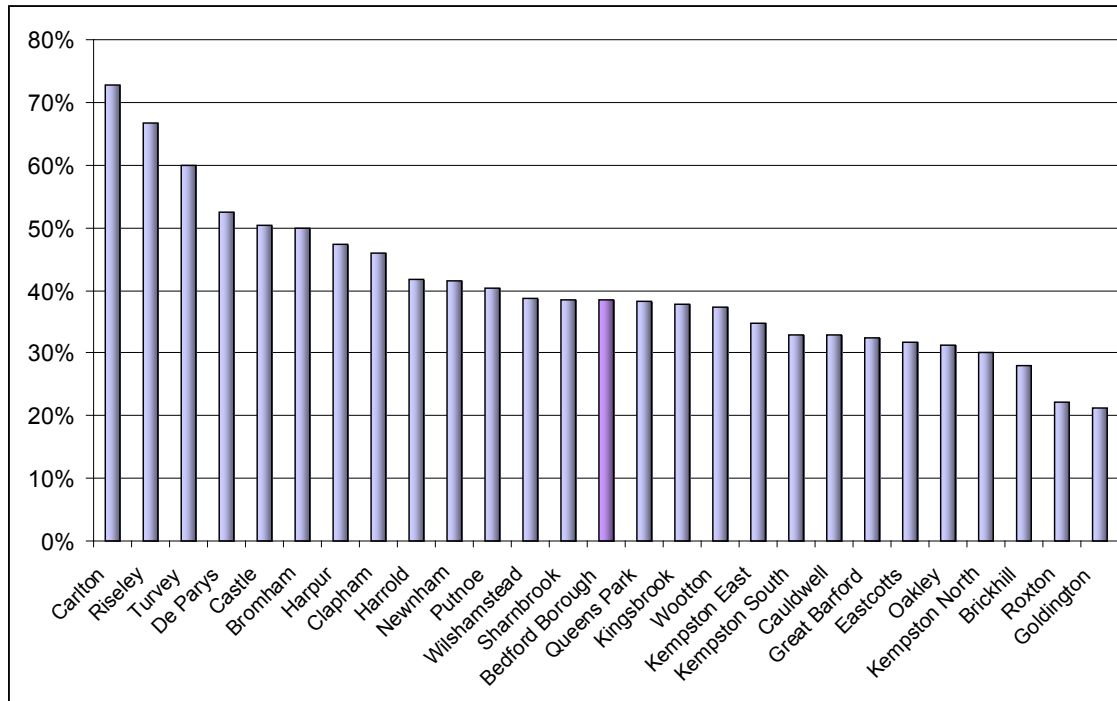
Figure 4: Breastfeeding rates at 6-8 weeks after birth 2008/9



Source: NHS Bedfordshire

Data is stored on the Child Health Information System, meaning that the analysis of data to ward level is also possible (see Figure 5).

Figure 5: Breastfeeding rates at 6-8 weeks after birth by ward in Bedford Borough



## Best Practice

Breastfeeding brings significant health benefits for both mother and child. Infants who are not breastfed appear more likely to suffer with conditions such as gastroenteritis and respiratory disease requiring hospitalisation. In the longer term the child could be at greater risk of having higher levels of blood pressure and blood cholesterol in adulthood and at greater risk of type 2 diabetes. In addition, breastfeeding is associated with a reduction in the risk of breast and ovarian cancers for mothers<sup>8</sup>.

Increasing rates of breastfeeding is considered to be a vital component of improving the health of the population, and in particular that of children and young people. For this reason the Department of Health monitors rates of breastfeeding initiation and rates of breastfeeding at 6-8 weeks after birth (vital signs target VSB11\_05).

The Healthy Child Programme (HCP)<sup>9</sup> places great emphasis on the achievement of increased rates of breastfeeding initiation and continuation, which will contribute to the delivery of the 2008–11 PSAs<sup>10</sup> for improving the health and wellbeing of children – specifically the indicators for breastfeeding and obesity prevention.

## Service Baseline

Both Bedford Hospital and Bedfordshire Community Health Services, which incorporates the new 0-19 Service (previously health visiting and school nursing services), have committed to achieving UNICEF Baby Friendly Status. This commitment sets out the intention of healthcare services to achieve Baby Friendly accreditation, to ensure the ongoing implementation of best practice and standards related to supporting breastfeeding.

Bedford Hospital Trust Midwifery Department has recently dedicated midwifery time specifically to the purpose of improving levels of breastfeeding initiation at Bedford Hospital. The ongoing implementation of the Healthy Child Programme is also seeing the introduction of a Health Visitor contact for pregnant women during the antenatal period, which is a valuable opportunity to reinforce the benefits of breastfeeding and to ensure that parents are suitably informed in relation to breastfeeding support.

Bedfordshire Community Health Services are taking a number of positive steps to improve the continuation of breastfeeding in the community, which include:

- The roll out of a peer support programme, where breastfeeding mothers are trained and supported by health professionals to support other new mothers to breastfeed
- Progression towards stage 1 accreditation of UNICEF Baby Friendly status has seen a comprehensive audit of skills across a range of healthcare professionals
- Training to a range of healthcare professionals, including those in Primary Care Practice, to improve support for breastfeeding mothers
- Development of community based breastfeeding support programmes through Children's Centres.

## Gaps

Whilst the overall prevalence and duration of breastfeeding has increased across the UK, the greatest increases have been seen among older mothers, mothers from higher socio-economic groups and mothers with higher educational levels. Young women in low-income areas with lower educational levels are least likely to initiate and continue breastfeeding. Many young mothers lack access to key sources of advice and information, such as antenatal classes, peer support programmes, friends, family and other support networks<sup>17</sup>.

Increasing rates of breastfeeding will not only secure the best start in life for more newborn infants in Bedford Borough, it will also play a vital role in reducing health inequalities.

## Public / Patient Voice Involvement

Routine service user feedback is collected through the Bedford Hospital Trust Midwifery Department, and is used to inform service development and delivery. The service user feedback tool is currently being revised to comply with the 'Women's Experience of Maternity Care' survey which is recommended by the East of England Strategic Health Authority. It is possible that annual survey results may be included as part of the JSNA in the future.

In addition, service users sit on the Maternity Services Liaison Committee for Bedfordshire, to provide both direct service user input and to represent the views of the wider public in regards to issues relating to maternity services delivered at Bedford Hospital.

## Priorities

- Adopting UNICEF's Baby Friendly Initiative<sup>12</sup> (or similar) in all hospital and community providers. Certificates of commitment have already been acquired by Bedford Hospital Trust, Luton & Dunstable Hospital Trust and Bedfordshire Community Health Services
- Raising awareness of the health benefits of breastfeeding – as well as the risks of not breastfeeding
- Developing the skills of health professionals so that they are able to support mothers to breastfeed
- Providing timely and easy access to professional advice for mothers at times of need
- Providing peer support – especially during the early weeks – to establish and continue breastfeeding. A peer support programme is currently being piloted in Bedfordshire, supported by NHS Bedfordshire and Bedfordshire Community Health Services
- Routinely informing fathers about the health benefits of breastfeeding, giving them advice and encouraging them to be supportive about breastfeeding – the father's involvement is a key predictor of breastfeeding initiation and maintenance
- Using children's centres to make antenatal and postnatal services more accessible to hard-to-reach groups
- Increasing awareness of breastfeeding among young and low-income mothers by discussing breastfeeding during pregnancy and providing support to tackle the barriers
- Raising the profile of the Healthy Start initiative, whereby mothers receive advice on healthy eating and breastfeeding
- Avoiding the use of inappropriate commercially sponsored promotional material
- Embedding the promotion of breastfeeding into local public health campaigns and work streams, such as the Change 4 Life obesity prevention programme.

## Childhood Immunisation & Vaccination

Vaccines produce their protective effect by inducing active immunity and providing immunological memory. Immunological memory enables the immune system to recognise and respond rapidly to exposure to natural infection at a later date and thus to prevent or modify the disease. The primary aim of vaccination is to protect the individual who receives the vaccine.

Vaccinated individuals are also less likely to be a source of infection to others. This reduces the risk of unvaccinated individuals being exposed to infection, meaning that individuals who cannot be vaccinated will still benefit from the routine vaccination programme. This concept is called population (or 'herd') immunity. For example, babies below the age of two months, who are too young to be immunised, are at greatest risk of dying if they catch whooping cough. Such babies are protected from whooping cough because older siblings and other children have been routinely immunised as part of the childhood programme.

When vaccine coverage is high enough to induce high levels of population immunity, infections may even be eliminated from the country, e.g. diphtheria. But if high vaccination coverage were not maintained, it would be possible for the disease to return.

### Key Findings

Of the childhood immunisations, only the vaccination covering diphtheria, tetanus, pertussis (whooping cough), polio and Hib by age 1 and measles, mumps & rubella aged 2 achieved the target in Bedford Borough in quarter 4 of 2009-10 (Table 4). However, the vaccinations are all increasing their uptake with time.

Table 4: Vaccination Uptake

	Achieved	Target	Difference
Dtap/IPV/Hib* (aged 1)	95.3%	95%	0.3%
Pneumococcus (aged 2)	88.0%	95%	-7.0%
Hib & Hepatitis C (aged 2)	90.4%	95%	-4.6%
Measles, mumps & rubella (aged 2)	90.6%	90%	0.6%
Dtap/IPV/Hib (aged 5)	89.8%	95%	-5.2%
Measles, mumps & rubella (aged 5)	86.5%	90%	-3.5%

\*Dtap: Diphtheria, tetanus, pertussis (whooping cough), IPV: polio and Hib: Haemophilus influenzae type B

## Best Practice

The National Institute for Health and Clinical Excellence Public Health Guidance 21<sup>13</sup> focuses on the reduction of differences in immunisation uptake among children, and provides recommendations for improving immunisation uptake.

The Healthy Child Programme (HCP), reinforces the importance of childhood immunisation and recommends that immunisations be offered to all children and their parents. In particular it calls for local planning to target excluded or at-risk families (including refugees, the homeless, travelling families, very young mothers, those not registered with a GP and those who are new to an area). At every scheduled contact, members of the HCP team should identify the immunisation status of the child, and parents or carers should be provided with good-quality, evidence-based information and advice on immunisations, and the importance of childhood immunisation should be promoted.

## Service Baseline

Childhood immunisations for children living in Bedford Borough are delivered by the following healthcare services:

- Primary Care Practices deliver the full range of childhood immunisations up to age 5 years
- Primary Care Practices have also been responsible for delivering the Human Papillomavirus (HPV) vaccination programme to young women aged 16-18 years old
- The 0-19 Service (incorporating Health Visiting and School Nursing) delivers the HPV vaccination programme to young women aged 12-13 years and the Diphtheria, Tetanus and Polio booster to young people aged between 13-18 years. Both are delivered through school based programmes.

## Priorities

- Monitoring vaccination status as part of a wider assessment of children and young people's health, through the implementation of the Healthy Child Programme
- Improving access to immunisation services. This could be achieved by extending clinic times, ensuring children and young people are seen promptly and by making sure clinics are child and family friendly
- Improving local call and recall systems, in conjunction with the Child Health Information System
- Ensuring up-to-date information on vaccination coverage is available and disseminated to all those responsible for the immunisation of children and young people
- Taking responsibility for reviewing immunisation status at school entry as part of the Healthy Child Programme the 0-19 Service and ensuring missed vaccinations are caught up
- Nurseries, schools and higher education settings should play an active role in promoting immunisations
- Improving access to immunisation services for those with transport, language or communication difficulties, and those with physical or learning disabilities -for example, provide longer appointment times, walk-in vaccination clinics, services offering extended hours and mobile or outreach services. The latter might include home visits or vaccinations at children's centres
- Developing and implementing a clear process for the local infant hepatitis B vaccination programme
- Tailoring support for Primary Care practices which displays low uptake of childhood immunisations.

# School Age Children

## Oral Health

The dental health of children in Bedfordshire is relatively good. This has been evidenced in the recent national BASCD survey (British Association for the Study of Community Dentistry) of five-year-olds for 2007/08. The BASCD survey shows the percentage of children with no decay experience to be 75.9% whilst the average national figure is 69.1%.

However, there are still substantial improvements to be made, as these figures mask oral health inequalities. Socially disadvantaged children experience disproportionately high levels of dental disease.

Improvements in oral health should focus on reducing oral health inequalities by reducing the decay experience of 5 year old children, providing better access to dental services for young infants and for looked after children.

## Key Findings

Nationally the prevalence of dental caries in young children has decreased substantially over the past 40 years. The greatest improvement in the decay experience of five-year-olds was seen between 1973 and 1983, during which time the mean number of decayed, missing and filled teeth (dmft) per child halved and the percentage of children without any caries (caries free) doubled. However trend data suggest that caries disease levels are now static.

Locally the results have shown a decline in dental caries as noted by BASCD surveys. The results of the national dental survey of five-year-old children carried out in 2007-2008 have been published recently.

Although the results show an overall improvement in oral health it is important to note that this was the first survey that used positive consent. This survey should not therefore be used as 'trend data' but as a 'stand alone' survey and should be triangulated with other available data eg levels of deprivation. This is because there were smaller numbers of children taking part in the survey when compared to previous surveys. A more detailed dental survey of five year old children was also carried out in the East of England and the results of this will be published in the near future. It is hoped that the results of this bigger survey will provide accurate results of the inequalities and localities where dental decay is highest so that oral health promotion activities are more targeted in reducing inequalities.

Socially disadvantaged children experience disproportionately high levels of dental disease. This is reflected in the table below (Table 5) comparing the former PCT areas of Bedford, which has more social deprivation, and Bedfordshire Heartlands. There are still substantial improvements to be made, as these averages mask oral health inequalities.

Table 5 compares the mean dmft for Bedfordshire for all five year olds compared to the dmft in children who have had decay experience. The figures show that there are inequalities as the children who have decay experience have three teeth affected more than the average five year old child.

**Table 5: Dental Disease in Children**

Mean Decayed, Missing and Filled Teeth (dmft) in all Children aged 5 years (low is good) YEAR	Bedfordshire Heartlands	Bedford	Bedfordshire	Mean dmft only in children who have experienced decay
2001/02	0.73	1.04		
2003/04	0.90	1.21		
2005/06	0.87	0.95	0.90	3.37
2007/08*	-	-	0.78*	3.02

\*BASCD 2007/08 data cannot be used as part of trend data as this survey used positive consent

### Best Practice

The British Fluoridation Society states that fluoridating drinking water as part of a wider health strategy has proven links to improved dental health in children and adults and can reduce oral health inequalities between the most and least deprived areas<sup>14</sup>. Water fluoridation in the former Bedford PCT covers 100% of the population (unusual on a national level), whilst 22% of people in the former Heartlands PCT area live in an area where water is fluoridated. Dental health in areas of Bedfordshire where water has been fluoridated is better than in non-fluoridated areas.

To reduce the inequalities in dental decay experience further, targeted oral health promotion interventions must be used with mix skilled workforce. Targeted interventions to be implemented include application of fluoride varnish, tooth-brushing programmes in schools, fissure sealants and oral health education<sup>15</sup>.

Current oral health promotion activities must be evaluated with input from the public to provide more information and an understanding of how best to deliver the interventions and which settings would be best.

## Priorities

- Evaluate the effectiveness of current oral health promotion programmes with public involvement and amend programmes to provide better outcomes, measured in the longer term by BASCD surveys.
- To commission services to provide better robust epidemiology data for all future BASCD surveys.
- To implement oral health promotion interventions targeting populations experiencing the highest level of dental decay within dental practices as noted in 'Delivering better oral health'.
- To commission dental practices to deliver evidenced based caries prevention treatments in areas of highest deprivation and ensure contracts are monitored.

## Childhood Obesity

Nationally, there has been a rapid increase in the prevalence of overweight and obesity in recent years. The last verified data pool identified 10.4% of boys and 8.8% of girls (average 9.6%) in Reception year (aged 4-5 years) and 20% of boys and 16.6% of girls (average 18.3%) in Year 6 (aged 10-11 years) are classified as obese according to the British 1990 population monitoring definition of obesity ( $\geq 95^{\text{th}}$  centile)<sup>16</sup>.

Projections for the future are based on a range of models and subject to variation. Whilst some models<sup>17</sup> project a continued rise, other interpretations suggest a much lower rise<sup>18</sup>. Nevertheless, forecasters and health professionals are unanimous in considering current levels too high for healthy outcomes. Obesity in children is a primary predictor of obesity in adulthood. The health outcomes of sustained obesity are numerous and include increased incidence of: Type 2 Diabetes, CHD, Stroke, Depression, some cancers and Back Pain. Being obese throughout adulthood decreases life expectancy by up to 9 years.

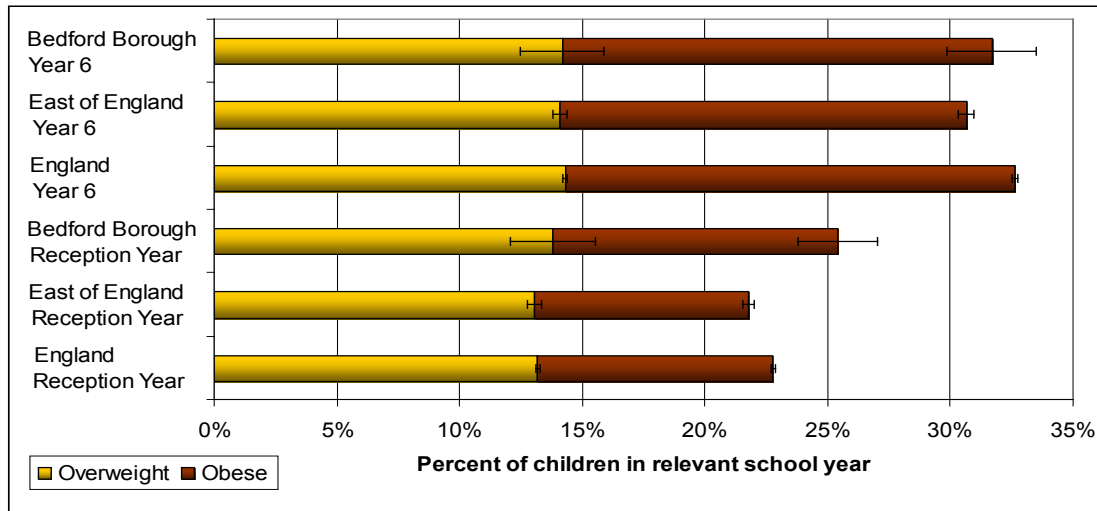
### Key Findings

While Bedford Borough is projected to have an ageing population, there remains a significant number of people in the 0-19 year age range of 39,000 (2008, mid year estimate) rising to 40,000 (2021 forecast)<sup>19</sup>.

Verified childhood obesity data for Bedford Borough is not available for school year 2007/8 as the unitary did not exist at this time and there was no requirement to disaggregate the data.

Figure 6 shows verified data for the school year 2008/9 separated by Bedford Borough with East of England as a comparison. The rise in levels of obesity at year 6 over previous years are, in part, associated with the increase in number of children measured, these children typically being in the most reluctant and more overweight/obese groups.

Figure 6: Obesity in School Age Children in 2008/9



Source: [http://www.ic.nhs.uk/webfiles/publications/ncmp0809/NCMP\\_2008\\_09\\_Online\\_Tables2](http://www.ic.nhs.uk/webfiles/publications/ncmp0809/NCMP_2008_09_Online_Tables2). [accessed 10/02/10]

### Best Practice

The Government's Office for Science released a comprehensive evidence and modelling document reviewing obesity<sup>17</sup> across all ages in 2007. This document recognised the lack of cohesive, unequivocal evidence surrounding childhood obesity interventions stating "It is likely that action will be needed when evidence is neither complete nor perfect".

Notwithstanding the above there are some evidence based guidelines in national and peer reviewed documents:

- NICE CG 43 Obesity guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children (2006)
- Healthy Weight Healthy Lives (2008)
- Be active, be healthy: a plan for getting the nation moving (2009)
- Promoting physical activity, active play and sport for pre-school and school-age children and young people in family, pre-school, school and community settings (2009).

The majority of evidence supports whole family and population level interventions aimed at modifying behaviours from less healthy to more healthy, with specific interventions based in identified geographical areas (such as lower socio-demographic areas) and for those already in the obese categories.

There is presently a bespoke programme running in Bedford called BeeZee Bodies based on recognised best practice which has the following key features:

- 1 x 2 hour session per week for 17 weeks
- Community based (Pilgrim School)
- Nutrition and dietary advice
- Physical activity programmes using local coaches
- Adult (parent or carer) education including sociological intervention
- Clinical oversight from Bedford Hospital Dietetics
- Pre and post measurement
- Free to the user

This programme is being reviewed by University of Hertfordshire to comply with NICE recommendations on evidence gathering.

Other evidence leads towards education regarding healthy food choices for children. Change 4 Life (C4L) seeks to promote behaviour change at a nation level while other programmes are more targeted. Healthy eating behaviour change programmes such as HENRY, Food Dudes, and Phunky Foods have a range of evidence level supporting them. Food Dudes has been delivered in three Bedford Borough Primary Schools with NHS Bedfordshire funding, the outcomes are being reviewed by the University of Bangor at the time this document was created.

The programme has the following key features:

- School based delivered by teachers and support staff trusted by the children
- Encourages children to eat fruit and vegetables both at school and at home
- Helps children develop a liking for fruit and vegetables
- Encourages children to become proud to think of themselves as healthy eaters
- Changes the 'culture' of a school to one that strongly supports healthy eating
- Free to the user

## Service Baseline

- Beezee Bodies runs once per year and is scheduled to increase in capacity
- Food Dudes has been running in 3 Primary Schools with positive initial output, decisions regarding future funding will be based on validated outcome
- Change 4 Life (C4L) runs in the community and there is a programme of evolution from specific cluster centres (i.e. Kempston) to the wider population
- NHS Bedfordshire funds additional capacity in Bedford Borough physical activity programmes

## Gaps

### Capacity needs to impact behavioural change

There is a need to increase capacity on the C4L programmes to a point where it is sufficient to modify behaviours and thoughts around healthy lifestyle choices

Capacity on intervention programmes (i.e. Beezee Bodies, physical activity provision)

Engagement from retail sector to remove promotion of high fat, sugar and salt foods around schools and the wider community

## Public / Patient Voice Involvement

Public/Patient engagement through commercial Social Marketing organisation, selected parental feedback:

- 88% believed happiness reflected health status
- 84% of parents stated that they use visual signs to check on their children (in fact it is known that  $\approx 70\%$  of parents are unable to visually identify obesity in children).
- 35% recognised they did something different as a result of seeing C4L material
- "Fast food is cheaper than healthy food"
- "peer pressure such as other children eating at MacDonald's"

Patient / service user voice and public views addressing inequalities and vulnerable groups

Programmes are adapted through a feedback cycle with engaged groups and health champions

## Priorities

Bedford Borough in conjunction with partner organisations should continue to deliver a comprehensive a range of prevention and intervention programmes based in the community and schools. Specifically there is a need to:

- Increase uptake of existing programmes
- Improve public awareness of health issues associated with childhood obesity
- Engage community groups and provide support for healthy living initiatives
- Use population feedback to develop additional services around:
  - Children's centres
  - Schools

Small geographical areas identified as having greater need Additionally, they should seek to:

- Build physical activity into all new build and refurbishment projects. Specifically, so that where given a choice the natural choice is to be active rather than passive in areas such as transport and play.
- Engage with Chambers of Commerce partners to encourage food retailers to provide healthy options at competitive prices and with equal or greater promotion than other foods, especially where the retailers are close to schools.

Develop and deliver an internal system of physical activity at the workplace to become an exemplar organisation.

## Mental Health

Mental health problems are an important health issue for children in Bedford Borough. An estimated 2,220 school age children (5-16 years old) suffer from a diagnosable mental health disorder. This represents approximately 10% of children<sup>20</sup>.

The recently launched New Horizons, (cross governmental programme to improve mental health and mental health services), highlighted unidentified and untreated mental health problems in childhood and adolescence as potentially resulting in high social and financial costs<sup>21</sup>.

There is a widespread recognition of the importance of early intervention and prevention. This is leading to a focus on tier 2 services. These are services which sit between generalist services such as general practices and schools and specialist services such as mental health trust expert teams.

### Key Findings

Conduct disorders are estimated to affect 5.8% of 5-16 year olds which means 1,340 children in Bedford Borough would be expected to have these problems in 2010. Conduct disorders are thought to be increasing with time<sup>22</sup>. The highest prevalence is expected in areas of highest social deprivation<sup>23</sup> so in the wards of Castle, Harpur, Cauldwell, and Kingsbrook.

Emotional disorders are estimated to affect 3.7% of 5-16 year olds which means that 860 children would be expected to have these problems in 2010. Emotional disorders are thought to be increasing with time. The highest prevalence is expected in the areas of highest social deprivation.

Eating disorders are estimated to affect 0.3% of 5-16 year olds which means that 80 children would be expected to have these problems in 2010. The prevalence of anorexia nervosa is thought to be stable with time but for bulimia the trend is unclear<sup>24</sup>. These disorders are not thought to be associated with social deprivation so may be evenly spread across the area. However there may be higher rates in private girls schools.

Hyperkinetic disorders (including attention deficit hyperactivity disorder (ADHD)) are estimated to affect 1.5% of 5-16 year olds which means that 350 children would be expected to have these problems in 2010. Time trends in hyperkinetic disorders are difficult to establish due to increasing case ascertainment. These disorders are thought to be associated with psycho-social adversity so would be expected to have higher prevalence in the areas of higher social deprivation listed above<sup>25</sup>.

Autistic spectrum disorders are estimated to affect 0.9% of 5-16 year olds which means that 210 children would be expected to have these problems in 2010. Time trends in hyperkinetic disorders are difficult to establish due to changing case definition and ascertainment. Autistic spectrum disorders are likely to be evenly spread across the area.

Self harming behaviour is estimated to have affected 1.3 % of 5-15 year olds but is much commoner in 15-16 year olds with 13% estimated to have a history of self harm<sup>26</sup>. Approximately half of those with a history of self harm are likely to have self harmed in the last year. So in 1 year it would be expected that approximately 265 children would have self harmed. It may be that self harming behaviour is no longer increasing with time<sup>27</sup>. It would be expected to be highest in the most deprived areas listed above.

### Best Practice

Conduct disorders: NICE guidance recommends parenting programmes for parents of children under 12 years old. These should be evidence based and ideally last 8-12 sessions<sup>28</sup>. For adolescents there is some evidence for individual interventions to help with coping skills and problems solving<sup>29</sup>.

Emotional disorders: NICE guidance recommends that mild depression can be treated at tier 1 or 2 with psychological interventions for 2-3 months (if not improved after 4 weeks of watchful waiting). These may include individual non-directive supportive therapy, group cognitive behavioural therapy (CBT) or guided self-help (GSH)<sup>30</sup>. After this referral to specialist services is suggested if not improved. Psychological therapies are also appropriate therapy for anxiety problems<sup>31</sup>.

Eating disorders: NICE guidance recommends that people with suspected anorexia nervosa should be referred to specialist care immediately but that those with suspected bulimia can be managed with an evidence-based self help programme. Adolescents can be appropriately managed with cognitive behavioural therapy but will normally need 16-20 sessions over 4-5 months<sup>32</sup>.

Hyperkinetic disorders: NICE guidance recommends a period of watchful waiting of up to 10 weeks or offering parents or carers a referral to a parent-training/education programme should be considered if suspected ADHD is having an adverse impact on development or family life. For young people with moderate levels of impairment a group parent-training/education programme, either on its own or together with a group treatment programme, Cognitive Behavioural Therapy (CBT) and/or social skills training, for the child or young person is recommended<sup>33</sup>.

Autistic spectrum disorders: SIGN guidance (2007) recommends behavioural interventions should be considered to address a wide range of specific behaviours in children and young people with ASD, both to reduce symptom frequency and severity and to increase development of adaptive skills<sup>34</sup>.

Self harming behaviours: NICE recommends that the decision about referral for further treatment and help should be based upon a comprehensive psychiatric, psychological and social assessment, including an assessment of risk, and should not be determined solely on the basis of having self-harmed.

### Service Baseline

Bedford Borough council offers a range of parenting support. These have the following strengths:

- Several programmes are group based.
- Several of the programmes offer 8-12 sessions.
- The services cover the age range recommended.
- The Strengthening Families 10-14 programme includes young people as well as parents.

Conduct disorders are rarely seen by core specialist CAMHS teams. It is estimated that only 1% of those with conduct disorders are seen by specialist CAMHS in one month.

Most psychological services are only accessible through tier 3 specialist CAMHS referral. Educational psychologists and/or counsellors both work with schools in Bedford Borough. An estimated 10-25% of children with emotional disorders are seen by specialist CAMHS core teams.

For eating disorders some initial support will be given at tier 1 and also from some tier 2 services such as counselling. An estimated 10-25% of children with eating disorders are seen by specialist CAMHS core teams.

An ADHD pathway is being developed currently. Typically school nurses and GPs refer to community paediatricians. The community paediatrics team will refer complex cases on to specialist CAMHS. Currently there are insufficient links between this referral pathway and parenting classes. There is a lack of social skills training.

Autistic spectrum disorders are developmental disorders which are often seen by paediatricians as well as psychiatrists. Specialist CAMHS core teams are estimated to see an estimated 5-15% of children with these problems. Educational support is given by educational psychology teams.

Young people who self harm will currently be seen across the wide range of services available with the most severe seeing specialist CAMHS. Those with self injury or poisoning which results in hospital attendance will result in a specialist CAMHS review.

The Targeted Mental Health in Schools Project (TAMHS) is being rolled out and is focused on improving mental health and emotional wellbeing of children aged 5-13 within targeted schools. TaMHS is based on two school clusters: Goldington/Newnham/Woodside Middle cluster and Beauchamp Middle cluster. The selected schools rank highly in terms of deprivation indices.

## Gaps

Parenting services may not have sufficient capacity to meet need with respect to conduct disorders, ADHD and autistic spectrum disorders.

Psychological services are not currently widely accessible from the community.

This is important for emotional disorders and bulimia in particular.

Pathways for ADHD and autistic spectrum disorders need to be better linked to parenting support.

Sharing of risk assessment, particularly of children who self harm, needs to work better across the range of services working with children.

## Public / Patient Voice Involvement

Consultation with stakeholders emphasised the following issues:

- Insufficient mapping of current services.
- Gaps in provision of family therapies, evidence based psychological therapies and peer mentoring programmes among others.
- Poor communication across the many service providers involved in children's care.
- Difficulties with the demand required in making a multi-agency allocation group referral and the lack of an easily accessible referral pathway.

Views of service users have been gathered by the Children & Young People Department (CYPD) of Bedfordshire and Luton Partnership Trust (BLPT), 2008-09. The main areas highlighted for improvement were the standards of the waiting areas and also more convenient appointment times.

## Priorities

- Availability of parenting classes should be reviewed and is likely to need to be increased.
- Availability and access of psychological therapies should be reviewed to examine the possibilities for increasing access at tier 2 level.
- Services for behavioural and emotional disorders, such as parenting and psychological services should be focused on the areas of highest social deprivation (listed within this report).
- For suspected bulimia, evidence based self help programmes and CBT sessions should be made available.
- For autistic spectrum disorders, behavioural interventions focused on adaptive skills should be provided across different settings.
- For young people who self harm, effective psychosocial and risk assessment should be better supported at tier 1.
- A forum for improving local children's mental health data should be established.
- Detailed mapping of current services and establishment of clear referral pathways and lines of communication should be carried out.
- Multi-agency allocation group systems and the use of the common assessment framework need to be reviewed.
- Further work needs to be done on the needs of the most vulnerable groups.

# Healthy Lifestyles

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## Healthy Schools

The Healthy Schools Programme (NHSP) is a joint initiative between Department for Children, Schools and Families (DCSF) and Department of Health (DH). This promotes a whole school / whole child approach to health. The programme has existed since 1999.

Healthy Schools is intended to deliver real benefits with respect to:

- Improvement in health and reduced health inequalities;
- Raised pupil achievement;
- More social inclusion;
- Closer working between health promotion providers and education establishments.

The programme is intended to support children and young people to be healthy and achieve at school and in life, by providing opportunities at school for enhancing emotional and physical aspects of health. In the longer term, this will lead to improved health, reduced health inequalities, increased social inclusion and raise achievement for all.

A broad range of activity is being undertaken across Bedford Borough schools, supported by the Bedfordshire Healthy Schools Team. Workstreams focus on improvements in diet and nutrition, increasing levels of physical activity, improving sexual health and reducing harmful and risky behaviours.

## Key Findings

The target for 75% of schools to achieve National Healthy School Status by December 2009 was exceeded in Bedford Borough, with 92% of schools having achieved National Healthy School status.

To ensure the maintenance of standards, schools which achieved National Healthy School Status in 2006, (13 schools) are now required to complete an online Annual Review to maintain their National Healthy School Status. To further improve standards, schools which achieved National Healthy School Status in either 2006 (13 schools) or 2009 (8 schools) are now also eligible to embark on the new Enhancement Model for Healthy schools.

The remaining 6 schools without National Healthy School Status are currently being supported to achieve this.

## Best Practice

Healthy Schools Bedfordshire is delivered against best practice evidence through the National Healthy Schools Programme (NHSP), jointly led by the Department of Health (DH) and the Department for Children, Schools & Families (DCSF).

## Service Baseline

77 maintained schools in Bedford Borough (including PRU), excluding Nurseries and Independent Schools.

## Public / Patient Voice Involvement

All schools are involved in on-going evaluation and feedback as part of the Validation and Enhancement processes. The Healthy Schools Advisory Group, comprising of broad representation from a wide range of schools, meets termly to ensure full participation from school staff in the ongoing development of Healthy Schools Bedfordshire.

## Priorities

- Support remaining 6 schools within Bedford Borough to achieve National Healthy School Status;
- Ensure ongoing commitment to the support and delivery of wider Public Health programmes, such as the Change 4 Life (obesity prevention and physical activity promotion);
- Provide support to schools to guide parents and pupils with concerns around weight (both over and under weight), particularly those identified through the National Child Measuring Programme (NCMP);
- Continue to work closely with the School Sports Partnerships in order to ensure effective collaborative working to support the delivery of high quality Physical Activity provision for children and young people;
- Support improvement in the consistency and quality of Personal, Social and Health Education (PSHE), including Sex and Relationship Education (SRE), particularly in the teenage pregnancy hot spot areas;
- Continue to develop and support the Emotional Health and Well-being Essential Guide website.

## Smoking - Children & Young People

Smoking remains the main cause of preventable morbidity and premature death in England and beyond the well-recognised effects on health; tobacco also plays a role in perpetuating poverty, deprivation and health inequalities.

### Key Findings

Nationally some 80% of people start smoking as teenagers and it can be presumed that this will be the same for smokers that live within Bedford Borough. Smoking prevalence has declined in the last few decades, although this is not the case for young smokers. One in seven 15 year-olds are regular smokers, with girls being more likely to smoke than boys. Those young people who do experiment run the risk of addiction and of becoming long term smokers. The earlier young people become regular smokers, the greater their risk of developing lung cancer or heart disease if they continue smoking into adulthood.

In Bedford Borough, 47% of Year 8 pupils (aged 12-13) reported that they have a parent, sibling or friend who smokes on most days and 2% of boys and 4% of girls reported that they smoke occasionally or regularly. 3% of pupils said that they used to smoke but don't now<sup>35</sup>.

This contrasts with Year 10 (aged 14-15) in Bedford Borough where 66% of pupils reported that they have a parent, sibling or friend who smokes on most days, 6% of boys reported that they smoke occasionally or regularly and 25% of girls reported that they smoke occasionally or regularly.

A range of factors can increase the risk of becoming a regular smoker. These include gender, being older, alcohol or drug use, a history of truancy or exclusion from school and lack of educational aspirations beyond age 16.

### Best Practice

The National Institute for Clinical Excellence (NICE) mass-media and point-of-sales measures<sup>36</sup> to prevent the uptake of smoking by children and young people recommends:

- The use of Mass media campaigns and the enforcement of existing legislation. These interventions should be combined with other prevention activities as part of a comprehensive tobacco control strategy.
- NICE will be publishing guidance on School-based interventions to prevent smoking uptake among children in February 2010.
- There is currently no NICE Guidance around best practice for supporting young people to quit smoking.

In 2008 the DH published Excellence in tobacco control: 10 High Impact Changes to achieve tobacco Control. It stated that although de-normalising smoking across the wider population is the key to youth prevention, there are other steps that local Smokefree Alliances take to support tobacco control.

### **Service Baseline**

NHS Bedfordshire Stop Smoking Service currently provide support for young people that wish to quit and with 'Healthy Schools' have worked in partnership with local schools to train student support workers to provide interventions within school settings.

Bedfordshire has a smokefree homes scheme that encourages parents that do not wish to quit, to smoke outside away from their children. However, promotion of this scheme by front line staff has been limited.

Family is a key influence on whether or not children and young people take up smoking, those that live with adult smokers are almost three times more likely to start smoking than those that live in smokefree homes and those with an older sibling who smokes are themselves five times more likely to smoke. Therefore reducing adult prevalence is essential to stopping young people starting.

### **Public / Patient Voice Involvement**

All service users are invited to return a completed feedback questionnaire, which is used to inform future service development.

## Priorities

- Help all smokers to quit by providing high quality NHS Stop Smoking Services and ensuring their promotion at local level
- Reducing exposure to secondhand smoke by promoting smokefree homes and cars
- Support the use of mass media campaigns
- Support the work of Bedfordshire and Luton multi agency Smokefree Alliance around the following as stated in Excellence in tobacco control
- Working in partnership with schools colleges, trading standards, young people's services, local communities and the voluntary sector
- Encourage the role of youth advocacy
- Work with trading standards to educate retailers, reduce underage sales and increase test purchasing in retail environments
- Support local action to stem the flow of illegal tobacco imports and educate the general public on illicit sales to further reduce access 'on streets'
- Work with the Healthy Schools coordinator to ensure that there is an evidence base approach in place to undertake tobacco education across each of the four key stages of the curriculum
- Reinforce the message that adults at work or in a position of authority should not smoke in front of children and young people
- Treatment services should be promoted to young people and the quality should be the same as that for adult stop smoking services
- Brief interventions should be part of school nurse targets, at the very least they should be delivering messages about where and how to access support
- Professionals working with parents should be trained to pass on the messages about secondhand smoke.

## Sexual Health

Sexually transmitted infections (STIs) disproportionately affect young people. Research shows that young people are more likely to have higher numbers of sexual partners, use barrier contraception inconsistently and are more likely to become re-infected after being diagnosed with and treated for an initial STI.

Chlamydia is the most common STI and left untreated can lead to pelvic inflammatory disease, ectopic pregnancy, and infertility.

### Key Findings

The incidence of sexually transmitted infections (STIs) in Bedfordshire is in line with the national average. However, infection with chlamydia (diagnosed in clinics of genito-urinary medicine) is increasing. Some of this increase is due to increased testing but the high proportion of positive tests is of concern. By the end of March 2009 around 16.6% of 15-24 year olds in Bedfordshire had been tested for Chlamydia.

1 out of 12 young people screened opportunistically (that is to say without symptoms) for chlamydia were found to be infected.

Infection with gonorrhoea is decreasing in the Eastern Region since it peaked in 2003/4. Local figures show such variability that interpretation of short term trends is problematic. Data is currently clinic based, so only a proportion of patients at the clinics shown will be from Bedford Borough.

**Table 6:** Number of Chlamydia screens by settings

#### Education Settings

Setting	Actual Number of Screens	% of 51, 000 Total YP Pop	% of our 25% 12775 target
Schools	452	0.89%	3.5% of target
Colleges	103	0.2%	0.8% of target
Universities	57	0.1%	0.45% of target
TOTALS	612	1.2%	4.8% of target

## Primary care settings

Setting	Actual Number of Screens	% of 51, 000 Total YP Pop	% of our 25% 12775 target
GPs	559	1.09%	4.38%
Pharmacies	1	0.001%	0.0001%
CASH	225	0.4%	1.76%
TOTALS	785	1.5%	6.1%

## Children's Under 5s Services

Setting	Actual Number of Screens	% of 51, 000 Total YP Pop	% of our 25% 12775 target
Children's Centre	4	0.008%	0.03%

## Hard to reach young people

Setting	Actual Number of Screens	% of 51, 000 Total YP Pop	% of our 25% 12775 target
Hostels	90	0.18%	0.70%
Youth Groups	77	0.15%	1.0%

## Workplace, Sports and Leisure Settings

Setting	Actual Number of Screens	% of 51, 000 Total YP Pop	% of our 25% 12775 target
Sports & Leisure	5	0.01%	0.05%
Workplace	6	0.01%	0.05%

Source: CASH: Contraceptive & Sexual Health

## Best Practice

Sexual health advice and treatment should be available through a range of providers and venues to meet young people's needs. These include:

- Condom distribution needs to be available in a variety of settings including schools, colleges, hostels, youth organisations, children's centres, GP practices, pharmacies
- Chlamydia Screening should be offered to all Young People between the age of 15 and 24 years old, regardless of whether they describe themselves as sexually active or not. This allows those who are at risk but unwilling or uncomfortable about disclosing this to be tested and subsequently treated in complete confidence. Young People should be screened at least annually and after each change of partner
- Sexual Health/Teenage Pregnancy training programme for professionals working directly with young people. The training programme, which commenced in September 2009, has been completed by 73 staff to date
- Brook Bedfordshire will be running two clinics in Bedford Borough. These clinics will run on a Tuesday and a Saturday. They offer a range of services including Chlamydia testing and treatment, choice of contraception, emergency contraception, pregnancy testing, free condoms, STI testing and treatment, support around sexuality and orientation and referral for abortions. Brook will also be providing clinics in youth settings, in schools and in further education colleges, as well as specific work with boys and young men
- Five Sphere clinics running across Bedford Borough delivering Integrated Sexual Health Services to Registered and Non Registered patients. Sphere clinics offer a variety of services including: sexual health information and advice, various contraception methods, chlamydia screening, HIV testing and screening and treatment for sexually transmitted infections.

## Service Baseline

See Sexual Health Needs Assessment – conducted to inform the redesign of the Bedfordshire Sexual Health Services for 2009/2010.

## Gaps

Increased provision of accessible, young-people friendly sexual health services that meet in full, the 'You're Welcome' quality standards. e.g. services based in:

- Schools
- Pharmacies
- GPs
- Children's Centres
- Informal Youth Settings
- Colleges
- Need for improved systems and processes for young people's involvement networks to provide evidence of impact, and inform service development.

## Public / Patient Voice Involvement

See final point above.

## Priorities

- Increase school based sexual health services including condom distribution, by fully trained pastoral or student support services staff – specifically in the three Teenage Pregnancy Hotspot Cluster Upper Schools;
- Improve the quality and consistency of Personal, Social and Health Education (PSHE including Sex and Relationship Education- SRE) in schools – particularly those in the most vulnerable areas;
- Increase the number of young people's sexual health service sessions available;
- Increase the number of Sphere clinics running;
- Increase in the number of Pharmacies participating in the distribution of Emergency Hormonal Contraception, Chlamydia Screening Programme and distributing condoms;
- Improve access to up-to-date data around STIs and young people's risky behaviour;
- Chlamydia screening should be normalised and offered to all young people in the age range as an opt out;
- Engage a Bedford Borough GP champion for Chlamydia screening to assist in the increased uptake of testing within Primary Care;
- Expand routine Chlamydia screening age range within educational settings.

## Teenage Pregnancy

There are a number of negative outcomes associated with teenage pregnancy that make it a key concern for public health:

- At age 30, teenage mothers are 22% more likely to be living in poverty than mothers giving birth aged 24 or over, and are much less likely to be employed or living with a partner
- Teenage mothers are 20% more likely to have no qualifications at age 30 than mothers giving birth aged 24 or over
- Teenage mothers have three times the rate of post-natal depression of older mothers and a higher risk of poor mental health for three years after the birth
- The infant mortality rate for babies born to teenage mothers is 60% higher than for babies born to older mothers
- Teenage mothers are three times more likely to smoke throughout their pregnancy, and 50% less likely to breastfeed, than older mothers - both of which have negative health consequences for the child
- Children of teenage mothers have a 63% increased risk of being born into poverty compared to babies born to mothers in their twenties and are more likely to have accidents and behavioural problems
- Among the most vulnerable girls, the risk of becoming a teenage mother before the age of 20 is nearly one in three

### Key Findings

Teenage pregnancy is a public health issue within Bedford Borough. There are wards such as Cauldwell, Kingsbrook, Goldington, Newnham and Kempston East where teenage pregnancy rates are much higher than the National, Regional and Bedford Borough average. This clearly demonstrates why there is a need for targeted work within these areas, involving all frontline professionals working with young people.

In Bedford Borough we are targeting our resources to tackle these higher rate areas. This has been achieved through the commissioning arrangements, where three local organisations have been chosen to undertake targeted programmes of work to address the underlying causes of teenage pregnancy.

#### Ward level data

Under-18 conception *rates* allow comparisons between areas and over time as they account for differences in population size. 'Hotspot' wards with a rate among the highest 20% in England have a 2005-07 under-18 conception rate equal or higher than **53.3** per 1000 females aged 15-17.

High rates of teenage pregnancy in Bedford Borough are concentrated within the following wards:

**Table 7:** 2005-2007 Under 18 conception rates per 1000 females

Ward	Area	U18 conception rate per 1000 females 15-17yrs
Goldington	Bedford Borough	<b>70.7</b>
Kingsbrook	Bedford Borough	<b>67.9</b>
Newnham	Bedford Borough	<b>60.2</b>
Kempston East	Bedford Borough	<b>54.3</b>
Cauldwell	Bedford Borough	<b>53.5</b>
Castle	Bedford Borough	<b>52.5</b>

**Table 8:** England, East of England & Bedford Borough under 18 conception data

	England (ONS 2008 Provisional figures)	East of England (ONS 2008 Provisional figures)	Bedford Borough (ONS 2008 Provisional figures)
U18 Provisional Rate	40.5	31.4	42.2
% Leading to Abortion	-*	-*	46%
% Change in rate from 1998 Baseline (47.1)	13%	17.2%	10%
2010 target	23.3	-*	23.6

\*Data not available at time of this document being produced

Source: Office for National Statistics, 2010 and the Teenage Pregnancy Unit, 2010

**Table 9:** Risk Factors associated with Teenage Pregnancy

Risky Behaviour	Education Related Factors	Family and Social Circumstances
<ul style="list-style-type: none"> <li>• Early onset of sexual activity</li> <li>• Poor contraceptive use</li> <li>• Mental health/conduct disorder/ involvement in crime</li> <li>• Alcohol and substance misuse</li> <li>• Teenage motherhood</li> <li>• Repeat abortions</li> </ul>	<ul style="list-style-type: none"> <li>• Low educational attainment</li> <li>• Disengagement from school</li> <li>• Leaving school at 16 with no qualifications</li> </ul>	<ul style="list-style-type: none"> <li>• Living in care</li> <li>• Daughter of a teenage mother</li> <li>• Ethnicity</li> <li>• Parental aspirations</li> </ul>

**Best Practice**

The Teenage Pregnancy Strategy for Bedford Borough provides a comprehensive plan to achieve a reduction in the teenage conception rate within Bedford Borough. An annual Self Assessment Toolkit is submitted to the Teenage Pregnancy Unit, which ensure that local strategy follows best practice, incorporates review of local service provision, and compares the local picture with that of its statistical neighbours.

## Service Baseline

Current local activity, structured around evidence based practice, includes the following (see Table 10)

**Table 10:** Evidence based practice to reduce teenage pregnancy

Strategic	<ul style="list-style-type: none"> <li>• A local Strategy Group has been established to ensure that specific gaps in strategy are addressed</li> <li>• The Assistant Director for Integrated Services 0-19 and the Director of Public Health are the high level accountable leads to the Children’s Trust.</li> </ul>
Data	<ul style="list-style-type: none"> <li>• Ward level data is used to target local areas of high and increasing rates.</li> <li>• Ward level data has influenced the mainstreaming of Connexions Teenage Parent posts.</li> </ul>
Strong Delivery of Personal, Social and Health Education/Sex and Relationship Education	<ul style="list-style-type: none"> <li>• Audit completed in all Upper Schools</li> <li>• Healthy Schools Bedfordshire is developing the new Enhancement Model in schools with students vulnerable to a range of negative outcomes.</li> <li>• Teenage Pregnancy Hotspot Cluster Support group established to support delivery with external agency input and strong partnership working.</li> <li>• Chlamydia Screening Programme is running in all Upper Schools for Years 12 &amp; 13 and currently in 2 schools for Year 11.</li> </ul>
Access to Young People Friendly Contraceptive and sexual health services	<ul style="list-style-type: none"> <li>• Brook are delivering new Sexual Health Services to young people in Bedford Borough and are working towards the You’re Welcome Quality Standards.</li> <li>• Sphere clinics delivering integrated sexual health and contraceptive services in 5 GP Practices in Bedford Borough.</li> <li>• The number of Undercover Condom Distribution sites has now reached 47 in Bedford Borough.</li> <li>• The Emergency Hormonal Contraception (EHC) Scheme is available from two pharmacies in Bedford Borough.</li> </ul>
	<ul style="list-style-type: none"> <li>• 1 x 0.5 Whole Time Employee (WTE) Teenage Pregnancy Prevention Youth Worker funded to deliver preventative work in high under-18 conception wards in Bedford Borough– Cauldwell, Kingsbrook, Goldington, Castle and Kempston East</li> </ul>
Targeted work with at risk young people	<ul style="list-style-type: none"> <li>• Commissioned projects delivered by Prevention, Understanding, Knowledge and Education (PUKE) on drinking and risky behaviours and Woodenhill, developing self esteem, communication and tackling SRE issues with looked after children and alternative education groups.</li> <li>• Cluster Support group established to support delivery with external agency input and strong partnership working.</li> </ul>

Communication	<ul style="list-style-type: none"> <li>Comprehensive Communications Strategy being developed through the Risk &amp; Resilience Group for 2010 onwards</li> </ul>
Raising Aspirations	<ul style="list-style-type: none"> <li>Systems and processes for the monitoring and evaluation of specific programmes to raise aspirations and self-esteem to be developed and confirmed by the Risk &amp; Resilience Group for 2010/2011.</li> </ul>
Workforce Development	<ul style="list-style-type: none"> <li>Comprehensive and evaluated TP &amp; Sexual Health Training Programme delivered to all partner organisations e.g. Youth Service; Connexions; YOT; Foster Carers</li> </ul>

### Gaps

Areas for improvement have been highlighted through the completion of the Teenage Pregnancy Self Assessment and they make up the priorities as stated in the Priority Section.

### Public / Patient Voice Involvement

In 2009, a teenage parent's needs assessment was completed for Bedfordshire. As part of this assessment, focus groups and one to one interviews were held with teenage mothers and fathers across the county to get their views on the current service provision for young parents. The feedback gained will be used to shape future services for teenage parents in 2010/11.

The three commissioned projects continually gain feedback and evaluation from the young people they work with. This ensures that services are flexible in their approach and provide support that meets the needs of young people.

## Priorities

Completion of the annual Teenage Pregnancy Unit Self Assessment Toolkit, and a Review of the local Strategy, has identified a number of key areas to be addressed.

### **RED** (Require SMART actions within 3-6 months)

- Ensure clear and effective strategic co-ordination, incorporating effective use of data.
- Ensure that the consistency and quality of PSHE (including SRE) is improved – specifically in identified teenage pregnancy 'hotspot' areas.

### **AMBER** (Considered of high importance for improvement within 12 months)

- Clarify local commissioning arrangements
- Improve provider data provision
- Review improvements to the effectiveness of Young People's CASH and abortion services
- Ensure consistent and regular monitoring of services
- Execute a full training needs assessment
- Improve promotion of positive activities
- Improve sign-posting to specialist services
- Ensure further targeted support for young people at risk
- Agree accountability for a Parenting Strategy
- Improve provision of training, support and supervision for young parents
- Develop and implement a clear Teenage Pregnancy Care Pathway
- Support the development of parenting programmes to support parents of teenagers in discussing sex, relationships and drugs and alcohol issues.

## Physical Activity

Physical inactivity is a serious and increasing public health problem.

The estimated costs of physical inactivity in England are £8.2 billion annually – and this does not take into account the contribution of inactivity to obesity which is estimated at £2.5 billion annually. Adults who are physically active have 20-30% reduced risk of premature death and up to 50% reduced risk of developing the major chronic diseases such as coronary heart disease, stroke, diabetes and cancers.

Although children are generally more active than adults, approximately one-third of boys and one-third to a half of girls report activity levels that may compromise their health.

### Key Findings

In Bedford, children are more likely to be physically active at school compared to the national average however fewer than 1 adult in 9 is physically active. Activity in adults is in line with the England and regional average at 10.8%. 96.5% of children are reported to be physically active which is significantly better than the England average of 90.0% and the regional average.

### Best Practice

Physical activity is defined as 'Any force exerted by skeletal muscles that results in energy expenditure above resting level'. Moderate physical activity can be defined as activities with an energy cost of at least 5 kcal/min but less than 7.5 kcal/min. For most people this is equivalent to a brisk walk.

*Be Active, Be Healthy* establishes a framework for the delivery of physical activity aligned with sport for the period leading up to the London 2012 Olympic Games, Paralympic Games and beyond. It also sets out new ideas for local authorities and primary care trusts (PCTs) to help determine and respond to the needs of their local populations, providing and encouraging more physical activity, which will benefit individuals and communities, as well as delivering overall cost savings.

Change4Life, launched in January 2009, is a society wide movement that will help families in England to "eat well, move more and live longer" by supporting them to change their behaviour. Although the programme is starting with at-risk families initially, it will ultimately be extended to everyone. Go to [www.nhs.uk/change4life](http://www.nhs.uk/change4life) for more information.

The Department of Health recommends that children and young people should achieve at least 60 minutes of moderate intensity physical activity each day. The recommended levels can be achieved either by doing all the daily activity in one session, or through several shorter bouts of 10 minutes or more. For most people, the easiest and most acceptable forms of physical activity are those that can be incorporated into everyday life however it can be structured exercise or sport, or a combination of these.

**Be Active, Be Healthy (2009)** identifies four overriding principles to increasing levels of physical activity:

- Informing choice and promoting activity – the majority of adults fail to exercise at a level that brings the full range of health benefits. Messages need to communicate the facts, dispel myths and be tailored to specific population groups, taking into account their priorities and any barriers they face
- Creating an 'active' environment – the quality of the environment has a direct influence upon levels of physical activity. Good urban designs take into account the needs of cyclists and pedestrians and exercising in the natural environment has been shown to reduce chronic stress, enhance a sense of well-being and have a restorative effect on adults suffering from depression or anxiety
- Supporting those most at risk – in accordance with their specific needs
- Strengthening delivery – following the establishment of County Sports Partnerships, PCTs are more able to support physical activity programmes, often under match funding arrangements, that are outcome-led and sustainable.

NICE guidance on the promotion and creation of physical environments that support increased levels of physical activity offers the first evidence-based recommendations on how to improve the physical environment to encourage physical activity. They include:

- Ensure planning applications for new developments always prioritise the need for people (including those whose mobility is impaired) to be physically active as a routine part of their daily life
- Ensure pedestrians, cyclists and users of other modes of transport that involve physical activity are given the highest priority when developing or maintaining streets and roads
- Plan and provide a comprehensive network of routes for walking, cycling and using other modes of transport involving physical activity
- Ensure public open spaces and public paths can be reached on foot, by bicycle and using other modes of transport involving physical activity

NICE guidance for those involved in promoting physical activity among children and young people, including parents and carers, advises on:

- Promoting the benefits of physical activity and encouraging participation
- Consulting with children and young people
- Planning and providing spaces, facilities and opportunities
- Training people to run programmes and activities
- Promoting physically active travel e.g. cycling and walking<sup>37</sup>

### Service Baseline

#### BeeZee Bodies:

A family weight management programme which is designed for overweight and obese children aged between 7 and 15 years and their families. BeeZee Bodies is comprised of 4 elements: physical activity, healthy eating (theory and practical sessions), specialist speakers and the 'Do Something Different' programme.

#### InterACTIVE:

InterACTIVE is a school based physical activity programme which targets inactive children aged 7-13 and provides a positive physical activity experience. The programme offers outdoor education experiences followed by taster sessions with local physical activity and sports coaches, with the aim of improving self efficacy and self esteem.

#### School Sports Partnerships:

Bedford Borough has four School Sports Partnerships, each with their own development plan.

### Priorities

- Contribute to a reduction in inequalities in health, by increasing physical activity opportunities for those in the 20% most deprived wards
- Contribute to halting the rise in childhood obesity and thereafter seeking to reduce it
- Develop and establish interventions to promote the inclusion and increase physical activity levels in the general population.

## Substance Misuse

The national drugs/alcohol agenda for children, young people & families is set within the overall framework of cross government Public Service Agreements (PSA) for 2008-2011.

The agreements that highlight the agenda are two fold:

- Reduce the harm caused by alcohol & drugs (including the numbers of users in treatment & drug related offending)
- Increase the number of children & young people on the path to success (including the proportion of young people using substances)

The national drugs/alcohol strategy for children, young people & families is outlined in the new 10-year document 'Drugs: Protecting Families & Communities' (February 2008)<sup>38</sup>. With respect to alcohol, 'Safe Sensible Social - the next steps in the national alcohol strategy' (June 2007)<sup>39</sup> builds upon the national harm reduction strategy (2004). Overall, the Department for Children, Schools & Families (DCSF) carries primary responsibility for the delivery of the children, young people & families' strand of the national drugs strategy with support in relation to specialist drugs & alcohol treatment from the National Treatment Agency (NTA).

### Key Findings

Excessive alcohol consumption can lead to liver disease, many cancers, cardiovascular disease, and increases the risk of accidents. Britain has one of the highest percentages of children consuming alcohol in the world. The average weekly amount of alcohol consumed by children who drink regularly has more than doubled since 1990. Alcohol use in childhood is associated with mental health problems and addictive behaviours (smoking and other substance misuse) and predicts heavier alcohol use in young adulthood. The rise in teenage male suicides has been attributed to a rise in alcohol consumption. Young people aged 16-24 are more likely than older groups to binge drink.

The Health Survey for England 2001-2 reported that more than a quarter of 13-15 year olds consumed an alcoholic drink in the last week, 2.5 units on average. The Health Survey for England reported that 13% of 13-15 year olds in the East of England had consumed 7 or more units of alcohol in the previous week compared to a national average of 8%.

In a local survey in 2004, 47% of 14-15 year olds in Bedfordshire reported having at least one alcoholic drink in the previous week. In 2006, a similar survey found the percentage of 14-15 year olds in Bedfordshire reporting having at least one alcoholic drink in the previous week had increased to 53%.

Findings from the recent Balding Survey (2008) highlight;

- In Bedford Borough, the 2008 survey highlights that 2% of Girls in Year 10 reported drinking more than 21 units in the week prior to the research. This has fallen from 5% in 2006
- Overall, males tend to drink higher volumes of alcohol more frequently than females across the county.
- The health related behaviour 'Balding Survey' (2004, 2006 & 2008) highlights specific issues in terms of prevalence and trends across Bedford Borough. The overall trend for those using drugs recorded in both the last year and last month prior to the survey is a downward one. For example, those in Year 10 who have taken drugs in the last month have fallen from 19% in 2004 to 10% in 2008.
- The overall trends re alcohol use are more varied when compared to drug use. For example, those who used alcohol on two or more days prior to the survey was recorded at 22% in 2004, increased to 24% in 2006 and has now dropped to 20% in 2008. However, those drinking between 4-20 units in Bedford Borough have shown a 6% reduction over the same time period.

Pupils from Bedford Borough tend to use alcohol less frequently and in smaller volumes than pupils in Central Bedfordshire. Estimates for Bedfordshire suggest that there are locally nearly 1,900 young people aged under 19 who are dependent drinkers and over 7,700 drinking at hazardous/harmful levels.

It has been possible to use evidence from local health related behaviour 'Balding' Survey' (2008) and ONS mid year estimates (2006) to help estimate an overall demand for specific drugs/alcohol interventions. The survey was undertaken by a broad cross-section of schools, including those that serve communities that experience higher levels of deprivation.

### Drugs

The results demonstrate when compared to 2006, the estimate of those having taken drugs in the last year has fallen 5% across Bedfordshire from 1,420 young people to 1,340. The estimate for those having taken drugs in the last month has also fallen 5% from 900 young people to 850. It could therefore be estimated that approximately 300 young people per year in Bedford Borough would benefit from targeted intervention services.

The prevalence of drug use amongst young people in Bedfordshire is falling in line with the national picture. The overall trend for those using drugs recorded in the last year is a downward one. For example, those in year 10 who have taken drugs in the last month have fallen from 19% in 2004 to 10% in 2008 Hospital admissions linked to drug misuse (aged 15-24) are also lower than the regional average.

The Health Related Behaviour Survey of 2008 in Bedford Borough schools reported that 4% of Year 8 pupils and 16% of Year 10 pupils had taken an illegal drug in the past year. 3% of Year 8 and 10% of Year 10 pupils had taken an illegal drug in the past month.

The 19% of Year 10 pupils who indicated that they were 'fairly sure' or 'certain' that they knew someone who takes illegal drugs represents a significant reduction from the 30% in 2006. Similarly the 15% of Year 10 boys and 25% of Year 10 girls who reported having been offered cannabis was a reduction on the 28% and 27% in 2006. The primary substances being used by young people were cannabis and alcohol; often in conjunction (e.g. in 2008/09 alcohol and cannabis were used together in at least 62 (43%) of cases, with cocaine as a primary drug dropping.

## Alcohol

When compared to 2006, the results demonstrate the estimate of those having consumed between 4-20 units a week prior to the survey has fallen 13% from 2,050 young people to 1,785. The estimate for those having consumed 21+ units has fallen by 26% from 500 young people to 370. In Bedford Borough, it is therefore estimated that approximately 70 young people would benefit from treatment specialist services.

Excessive alcohol consumption can lead to liver disease, many cancers, cardiovascular disease, and increases the risk of accidents. Britain has one of the highest rates of children consuming alcohol in the world. The average weekly amount of alcohol consumed by children who drink regularly has more than doubled since 1990. Alcohol use in childhood is associated with mental health problems and addictive behaviours (smoking and other substance misuse) and predicts heavier alcohol use in young adulthood. The rise in teenage male suicides has been attributed to a rise in alcohol consumption. Young people aged 16-24 are more likely to binge drink than older age groups.

Teenage drinking was linked to 12 specific under 18 hospital admissions in Bedford over a two year period, which is significantly better than the regional incidence.

The Health Related Behaviour Survey of 2008 in Bedford Borough schools reported that 48% of Year 8 pupils and 44% of Year 10 pupils correctly identified alcohol as the drug that kills the most people in this country. The 42% of Year 10 girls who correctly identified alcohol as the drug that kills the most people represented a significant improvement over the 28% in 2006.

17% of Year 8 and 35% of Year 10 pupils had at least one alcoholic drink in the week before the survey, a reduction on the 23% and 47% respectively reported in the 2006 survey. 3% of Year 10 boys and 2% of Year 10 girls said they drank 21 or more units of alcohol in the seven days before the survey, a reduction from the 6% and 5% reported in the 2006 survey. 14% of Year 10 girls were able to purchase alcohol from an off-licence that should sell only to over-eighteens.

However, the 70% of boys and 61% of girls in Year 10 who stated that they had not consumed alcohol in the previous week was an improvement on the 59% and 48% reported in the 2006 survey.

## Best Practice

The annual drugs/alcohol strategic summary outlines the direction and purpose of services to address substance misuse issues amongst children, young people and families.

An Alcohol Strategy for Bedford Borough addresses the reduction of alcohol related harm in relation to three key themes:

1. Children and Young People;
2. Health;
3. Community Safety.

## Service Baseline

There are a range of services in place to address substance misuse issues amongst children, young people and families. This includes support for schools to improve drugs/alcohol education, targeted work with vulnerable groups of children and young people and treatment for those experiencing the harms caused by substances. Indications suggest our services generally perform well when compared to other authorities.

## Gaps

The following list represents the current unmet need in relation to substance misuse:

- It is unclear whether services are targeting the right localities below the unitary level (i.e. locality level)
- More work is required to focus on alcohol and cannabis issues amongst young people
- A higher percentage of Looked After Children are refusing substance misuse interventions
- An increase in drugs & alcohol related exclusions from mainstream education.

## Public / Patient Voice Involvement

Extensive consultation with young people in early 2009 highlighted the following issues;

- Taking crack is the worse thing that you can do
- Alcohol use is normal - just part of growing up
- Cannabis is the main drug of choice for young people
- There is a lot of peer pressure
- Mistakes are made when using drugs/alcohol
- Your family can determine you taking drugs and family breakdown has a big impact
- They can make you look good and feel more confident
- Drugs and alcohol are easy to get hold of sometimes.

## Priorities

- To develop mechanisms to collect and analyse drug and alcohol related data and information at a local level
- To focus the work of early intervention and treatment services on alcohol and cannabis
- To enhance pathways with services that work with our most vulnerable young people
- To safeguard children by embedding a think family approach across all drug and alcohol services
- To embed robust systems for clinical governance across treatment services.

# Safe

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## Introduction

The Children Act 2004, as well as ensuring that partners work together in a Children's Trust, also placed a duty on all partners to co-operate to safeguard and promote the welfare of children and young people. In Bedford Borough, partners are committed to improving the safety of **all** children and young people.

*Safety is fundamental – if children are not safe, they cannot be happy, healthy, achieve or reach their full potential. It is the responsibility of us all to keep children and young people safe.*

Rt. Hon Ed Balls, MP  
Previous Secretary of State for Children, Schools and Families

It is a "bigger agenda" than might be considered as traditional 'safe' work, which might have been thought of as child protection. In many ways, children and young people are safer today than in previous generations and have many more opportunities afforded to them, through, for example, new technologies, leisure and travel. Rates of sudden infant deaths have fallen and rates of accidents are reduced.

However, children and young people today also live in a much more complex world; there are choices, but also challenges. Family structures are changing, communities are more diverse, and there are less family support networks available. The development of technology that brought new opportunities can also bring potential for exploitation and harm.

Crime levels in Bedford Borough have been falling over the last five years. Total crime was just under 12,000 in 2008/09, which was a 25% decrease from 16,000 in 2003/04. However, incidents of domestic burglary have increased. It is known that this level of crime is important to the residents of Bedford Borough, and 'crime levels' was ranked as their most important quality of life factor in surveys carried out in 2006 and 2008.

It is recognised that bullying, wherever and whenever it occurs, has a negative effect on everyone involved; especially for victims who are left feeling distressed and can adversely effect concentration, achievement, attainment and health. Those who bully are more likely to be victims of bullying themselves. Those who witness bullying can also suffer harm, and it does have an effect on the community and the extent to which people feel safe. It is certainly not just an issue within schools and it is an intention of Bedford Borough partners to reduce the number and affects of incidents of bullying, wherever and whenever they occur.

Being a victim of crime can lead to all kinds of problems, for children, young people and their families. Some of these can be very difficult to deal with, and the effects may cause problems later in life. Partner organisations are working together with families and young people to reduce levels of crime across the Borough, but also to ensure that where there is a victim of crime, each receives the appropriate support.

## Key Findings

Referrals in Bedford Borough are roughly in proportion to its statistical neighbours although more referrals lead to initial assessments, and then to further core assessments, and ultimately to Child Protection Plans. All of these levels have risen and are above statistical neighbours. All levels of assessment were completed within timescales either better or in line with our statistical neighbours.

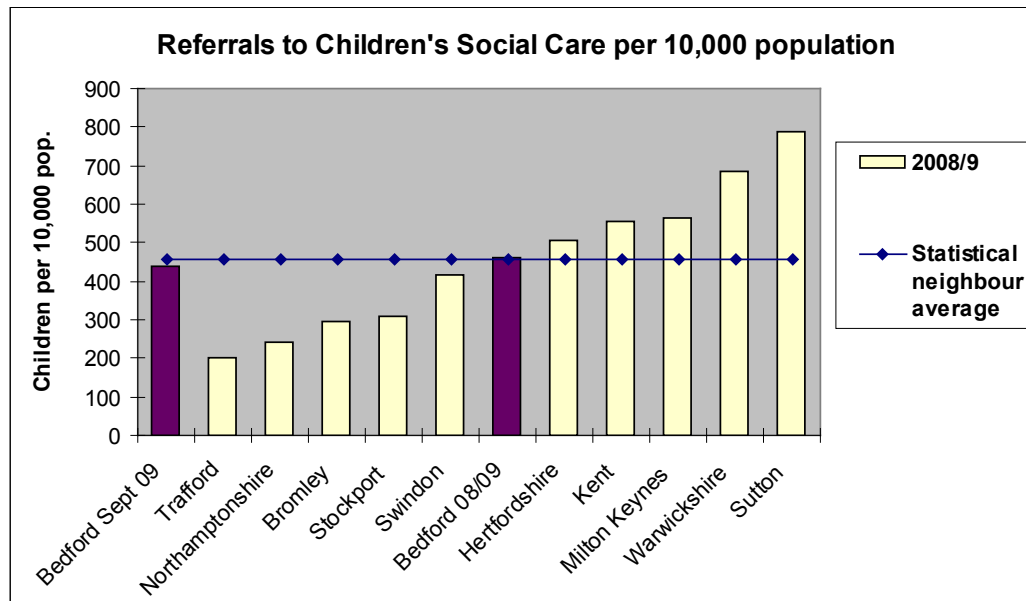
Child road deaths in Bedford are low, but a third of all car accidents result in a young driver aged 17-24 being killed or seriously injured.

The vast majority of pupils feel safe in their schools and see them as happy and caring places. Bullying levels appear to be in line with national trends.

## Referrals and Assessments of Children in Need

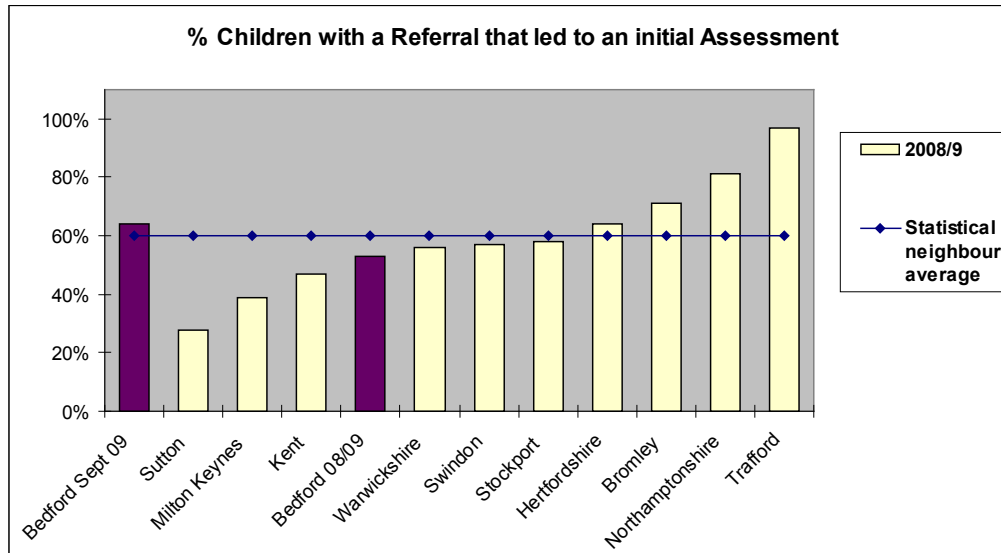
Children's social care received 459 referrals per 10 000 population as at Sept 2009 which is in line with the statistical neighbour average of 457 (Figure 7). This rate has not changed significantly since 2008-09. Referral rates vary widely across individual local authorities and often reflect differing thresholds for referral.

Figure 7: Referrals to Children's Social Care



The percentage of referrals of children in need that led to an initial assessment has increased from 53% (2008/9) to 64.2% (Sept 09). This is higher than the statistical neighbour average of 59.8% (2008/9). An initial assessment is where a social worker gathers information about the issues affecting a family to help them decide if there is any support required. The assessment is completed within 7 working days of the referral.

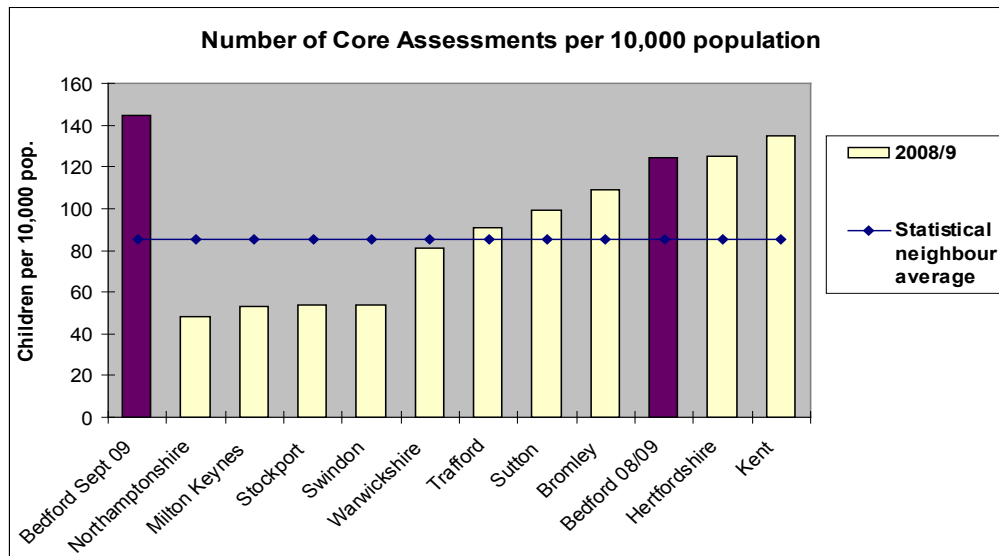
Figure 8: Children Referrals Leading to Initial Assessment



90% of initial assessments were completed within 7 working days as expected, which is considerably higher than the statistical neighbour average of 77.6%. 83.9% of Core assessments were completed within 35 working days as expected which is in line with the statistical neighbour average of 84%. A Core assessment is a more in-depth look at the needs of the child and family, building on the information gathered in the initial assessment.

The number of Core assessments per 10,000 population has increased from 124.2 per 10,000 population (2008/9) to 144.7 (Sept 09). This is significantly higher than the statistical neighbour average of 85 (2008/9).

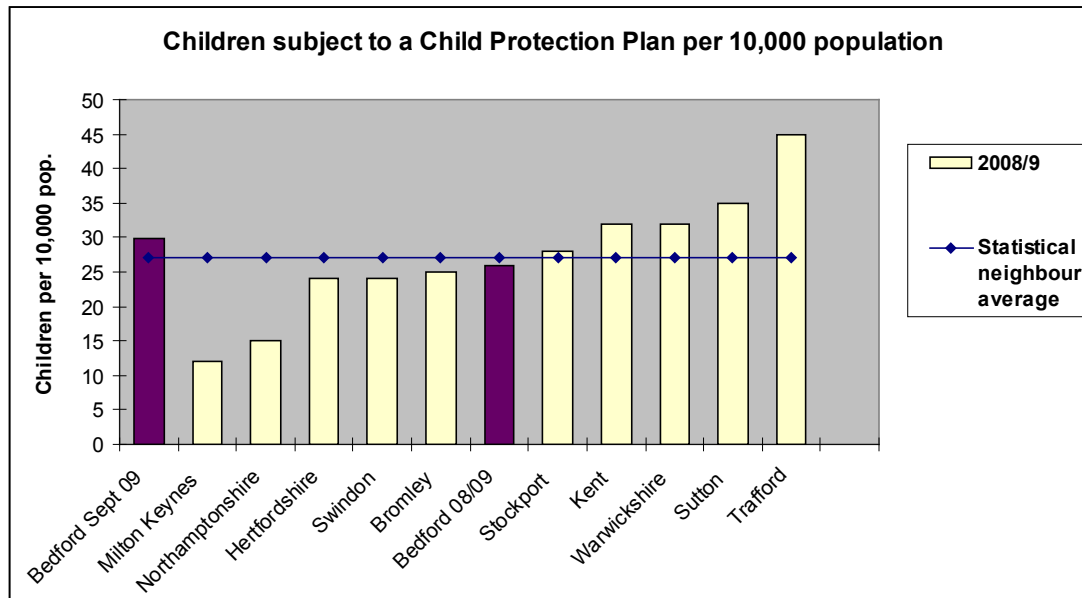
Figure 9: Core Assessments



## Child Protection

Where concerns are raised about the safety of a child on physical, sexual or emotional neglect or harm, a Child Protection Plan is developed. The number of children subject to such a Plan in Bedford Borough has risen from 25.9 per 10,000 population (2008/9) to 30 (Sept 09). (Figure 10). This is higher than the statistical neighbour average of 27 (2008/9) although there is wide variation across different authorities.

Figure 10: Children Subject to CPP

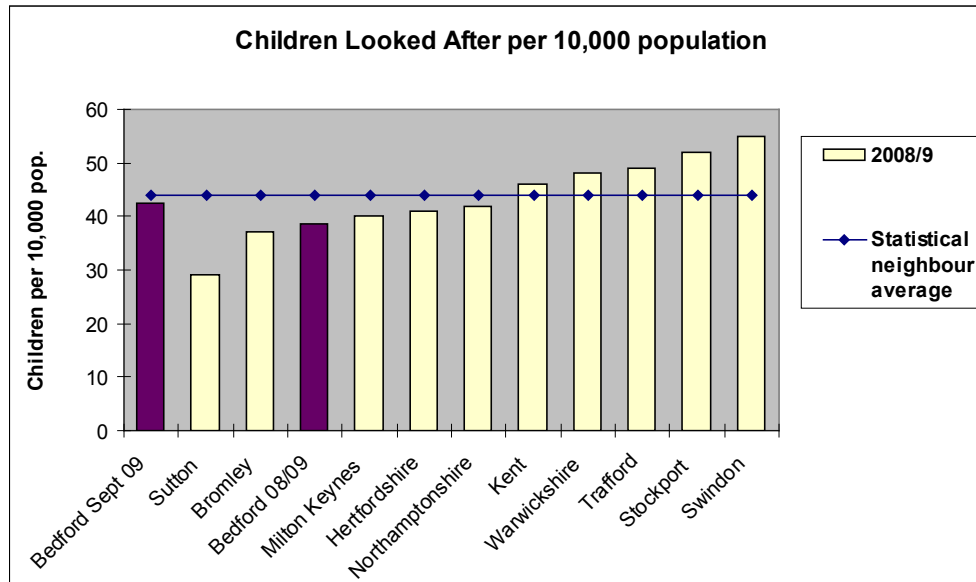


If concerns about a child re-merge, a subsequent Child Protection Plan can be implemented. In Bedford Borough the rate of this happening has decreased from 22.3% (2008/9) to 10.7% (Sept 09). This is now more in line with the statistical neighbour average of 13.6% (2008/9). All children subject to a child protection plan had their reviews held to timescale during 2008/9. This is slightly higher than the statistical neighbour average of 99%.

## Looked After Children

Bedford has 149 children looked after by the Council. This is similar to our statistical neighbours (42.5 per 10,000 population in Bedford as compared to 44 per 10,000 population).(Figure 11). The term 'looked after' was introduced in the Children Act (1989) and is used to describe when a child or young person is being cared for by the Local Authority, when the birth parents are unable to provide ongoing care in either a temporary or permanent capacity.

Figure 11: Looked After Children



## Emotional and Behavioural Health of Looked After Children

Looked After Children experience significantly worse mental health than other children in the general population. An estimated 45% of looked after children nationally aged 5 to 17 have mental health problems, over 4 times higher than all children.

Foster Carers are required to complete a 'Strengths and Difficulties' Questionnaire (SDQ) for children looked after. The total is added together to give an overall SDQ score (0 – 40) for each child. A higher point score indicates greater complex needs. Bedford's looked after children scored an average of 15.8 points during 2008/9. This is higher than the statistical neighbour average of 14.4.

84.6% of Looked After Children had an annual health assessment in the 12 month period ending 30<sup>th</sup> September 2009. Looked after children aged under 5 are required to have six-monthly visits.

## Stability of Placements

Research clearly links instability of placements and multiple placement moves with poor outcomes for Looked After children. Children with 3 or more placement moves in the last 12 months improved from 14.1% (2008/9) to 10.1% (Sept 09). This is slightly better than the statistical neighbour average of 11.3% (2008/9).

The number of children in a long term stable placement (for two years or more) dropped slightly from 64.3% (2008/9) to 63.0% (Sept 09). This is below the statistical neighbour average of 68% (2008/9).

The number of Unallocated Cases of Children in Need has dropped from 35 in 2008/9 to 1 at the end of Sept 09. An unallocated case is where a case is held by duty workers without being assigned to a specific social worker.

## Road Safety

The number of Children Killed or Seriously Injured (KSI) in road traffic accidents in Bedfordshire is low. In 1994-98, on average, 398 people were killed or seriously injured (KSI) in road traffic collisions in Bedfordshire and Luton, including 53 children per year. In 2007, KSI were reduced by 31% overall, and child KSI were reduced by 60%, with one child being killed in 2007 and 20 seriously injured. Car drivers account for 28% of all KSI casualties, with young drivers aged 17 to 24 representing one third of these. 1 in 5 casualties are pedestrians, with 80% as a result of their own error.

## Bullying

Bullying, wherever and whenever it occurs, and whatever form it takes, has a negative effect on everyone involved; especially for victims who are left feeling distressed and can adversely affect concentration, achievement, and health.

In line with national findings, young people within Bedford Borough have consistently identified bullying as an issue that concerns them. New requirements of schools to log bullying episodes will help us gather harder data on the actual prevalence of bullying in schools\*. In the academic year 2008-09, 352 bullying incidents (or behavioural incidents with a bullying element) were logged by 27 schools. The most common forms that bullying took were aggressive behaviour, verbal and physical abuse. Boys were involved in 4 times as many bullying incidents than girls.

The 2008 Tellus Survey of young people in school years 6, 8 and 10 showed that bullying levels in Bedfordshire were largely in line with national trends. 49% of pupils said they had never been bullied (compared to the national average of 56%) while 10% reported that they were bullied at least once a week, sometimes most days. An in-depth bullying survey of pupils in 4 of Borough middle schools in 2008 showed that 60% had not been bullied in the 12 months prior to the survey.

91% of our pupils felt safe in their schools and 84% described their school as a happy and caring place. 11% of pupils surveyed felt that bullying was not a problem in their school, and 30% felt that their school dealt with bullying very well or quite well. However, 46% felt that their school could deal with bullying better than currently. In a local survey 46% of bullied pupils who had informed someone felt that no action was taken as a result. In 31% of cases, action taken after bullying was reported had been successful in stopping the bullying. Boys are most likely to not tell anyone they are being bullied.

## Domestic Violence

Domestic violence accounts for 25% of all violent crime. It will affect one in four women and one in six men. On average, a person will be assaulted 35 times before reporting it to the police. Victims are mostly female (over 70%), White and aged between 20-39 years. In 90% of domestic violence incidents, children are said to be in the same or adjacent room.

From April 2010 252 cases have been referred to the MARAC (Multi-Agency Risk Assessment Conference) but this also involves many children as well who are family members. The 252 cases had a parental responsibility for 426 children all of whom must be affected by what is happening within their own home.

Currently, Bedfordshire MARAC is operating on a re-referral rate (repeat victimisation) of 24% (the national average is 33%). Alcohol is a major contributory factor in domestic incidents, where 27% of incidents over a six month period involved alcohol or drugs. Honour based Violence is on the increase within the Borough with 13 incidents recorded in 2008 and 8 in the first six months of 2009.

\*The Tellus survey, Bedford Borough's Anti-Bullying Pupil Perception Survey, the Behaviour Management System and a survey of schools' Anti-Bullying Champions

## Crime and Offending Behaviour

Bedford Borough is one of the safer places in the country and crime levels in the Borough have been falling over the last five years. Total crime was just under 12,000 in 2008/09, down from just over 16,000 in 2003/04, with an overall 18% fall in serious acquisitive crime. However, rates of domestic burglary, theft from a person and being a victim of crime is going up.

According to the Place Survey, nearly half of the Bedford Borough respondents said they felt safe when outside in their local area after dark, which is slightly above the national average. Also in line with national trends, teenagers hanging around the streets are perceived as the greatest problem (36% of respondents), followed by litter (30%), vandalism and graffiti (28%) and drugs issues (28%).

Neighbourhood policing surveys also show that nuisance youths are a significant concern for local people, as is drugs and alcohol misuse. Domestic violence also figures highly with knife crime as a lesser issue.

When young people are surveyed as to their concerns around crime, the following were identified:

- Safety on public transport, especially waiting for buses in villages due to lack of lighting, safety in schools and using buses in Bedford town after dark
- Fear of crime
- Perception that there isn't enough for young people to do in their local area
- Safety of belongings at school
- Bullying
- Worry about being a victim of violence, theft or assault.

Residents consistently rank levels of crime as their most important quality of life factor in surveys in 2006 and 2008. Anti-social behaviour in particular can have a significant impact on people's fear of crime and their perception of personal safety. Evidence shows that a small number of families can generate a large proportion of the antisocial behaviour in an area. Respondents identified the main causes of crime as lack of discipline from parents (30%) and drugs (26%).

Nearly three-quarters of those convicted of disorder offences were identified as hazardous drinkers and alcohol was identified as a factor in over half of these arrests.

## Victims of Crime

Being a victim of crime can lead to all kinds of problems, for children, young people and their families. Some of these can be very difficult to deal with, and the effects cause problems later in life.

Although overall risk of being a victim of crime has fallen from 40% in 1995, to 22% in 2008, this has shown a slight increase over the last year. As you would expect, risk of victimisation varies by personal and household characteristics and by crime type. Men are twice as likely as women to have been victims of crime with young men aged 16-24 having the highest risk.

Of the actual victims of robbery in Bedford Borough in 2008/09, 59% were in the age group 10-25 years, with 34% being under 18 years old. Just over half the total incidents involved some form of physical assault on the victim. For victims in the 10-25 year age group, robbery of mobile phones and MP3s occurred in nearly half the incidents. Theft of a mobile phone is a likely first offence for many young offenders.

However, people consistently overestimate the likelihood of being a victim of crime. For instance, 16% of people thought they were likely to be a victim of burglary, compared with an actual risk of 2%.

## Geographical Location

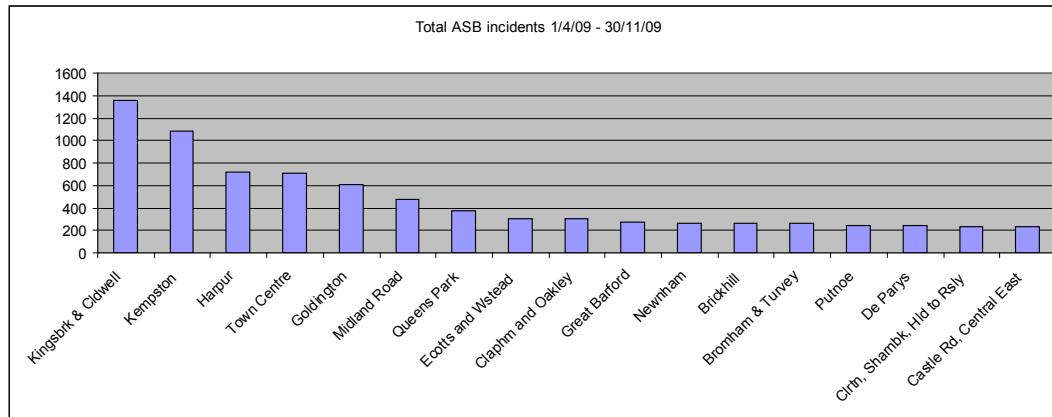
Crime statistics vary enormously across the Borough. Bedford Town Centre, where crime reduction has been most evident, continues to have a vibrant night time economy with approximately 40 premises with a combined capacity to entertain over 11,000 people. The main antisocial behaviour hotspots in the Borough are consistently in the Bedford-Kempston urban areas.

Figure 12 shows that during 2008/09 480 antisocial behaviour incidents were logged in the town centre, with 65% occurring within just 5 streets. Around 10% of antisocial incidents involved alcohol or pubs and clubs.

Rural villages can suffer from antisocial behaviour caused by abandoned and burnt out vehicles, vehicle nuisance (such as motorbikes and mopeds) and young people hanging around causing a nuisance by intimidating others or throwing stones, for instance. These can tend to be concentrated in the summer months.

Youth related antisocial behaviour accounts for around 20% of all reported incidents of ASB each month.

Figure 12: Total ASB



13% of robberies occurred in parks or recreation areas such as Russell or Bedford Park, or Goldington Green. Of 17 of this type of incident, 12 (70%) involved victims in the 10-18 age group.

Although robberies peak in the very late evening, 15% (19) were committed between 15:15h and 18:30h – the times after the close of the school day.

There were 585 first time entrants to the Youth Justice system in 2006-07, which is lower than the regional average. There has been an 18% reduction in Bedford Borough. Numbers of young people in custody have also been reducing.

Bedfordshire Youth Offending Service identified that 88% of the young people with whom it worked were in education or employment which is well above than the national average.

Young people in the Looked After system are more likely to be involved in offending behaviour. 13.9% of Looked After Children in Bedford were given final warnings during 2008/09 compared to 3.1% of all other children (in Bedfordshire). Although fewer children overall were given final warnings in Bedford Borough (3.1% as opposed to 4.3%), Looked After children were far more likely to be in receipt of a final warning (14% in Bedford as opposed to 8% nationally).

The drugs & alcohol data from Bedfordshire Youth Offending Service (BYOS) highlights that the number of young people who have offended with drugs and/or alcohol needs fell from 71 in 2006/07 to 47 in 2007/08. The overall figure has risen slightly again in 2008/09 to 63.

## Best Practice

STATUTORY – Children Act 1989, 2004 and associated legislation.

Provision of services for children in need, their families and others:

- to safeguard and promote the welfare of children within their area who are in need; and
- so far as is consistent with that duty, to promote the upbringing of such children by their families.
- provide accommodation for any child in need within their area who appears to them to require accommodation to safeguard and promote their welfare<sup>40</sup>.

It is a Local Authority's duty to investigate for child protection concerns (S47) where they have reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer significant harm to enable them to decide whether they should take any action to safeguard or promote a child's welfare.

## Public / Patient Voice Involvement

The development of priorities in this area was subject to extensive consultation with children, young people, families / carers and other stakeholders across Bedford Borough.

## Priorities

- To ensure that children, young people and their families feel safe and happy at home, in school and in their local community;
- To make our services easy to understand, easy to access and more responsive;
- To minimise the impact that poverty has on child safety;
- To understand the impact of crime on children who are victims of it;
- To understand more about how young people in the Borough are affected by self harm, to understand the causes and to work together to address these.

# Aspire

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## Introduction

Aspire brings together the three Every Child Matters (ECM) outcomes;

- Enjoy and Achieve,
- Making a Positive Contribution and
- Achieve Economic Well Being.

It is not just in school that children and young people learn and that it is not just qualifications that lead to being ready for work. This Joint Strategic Needs Assessment looks at these three ECM outcomes together, to enable partners to make the biggest difference possible for children and young people.

*Aspire, noun; 'directing hopes towards achieving something special.'*

Educational attainment has risen over the last five years; however, there are still significant inequalities and in 2008, the number of pupils achieving five A\* - C grades in GCSE, including English and Maths, varies from 20% to 70%. In 2009, around half of our 16 years olds left schools with fewer than five GCSEs at this grade.

It is recognised GCSE results in the Borough could be better and the nursery schools, pre-statutory providers, the schools across all three phases and the Local Authority School Improvement team are working hard to deliver the Borough Council's aim to achieve a 'step change in attainment'. In the Bedford Borough Children's Trust Children and Young People's Plan there are priorities and work stream identified to support this, as well as how all partners will work together to help children and young people to:

- Enjoy their childhood and young adulthood
- Achieve both academically and personally
- Have fantastic opportunities for employment and training
- Help them to play a really positive part in their local community

Attainment levels at Bedford Borough schools are improving but are still below statistical neighbours at GCSE level. Bedford Borough schools are achieving some success in narrowing the gap between the highest and lowest achievers in the Foundation Stage where girls outperform boys across all indicators. Key Stage 1 assessments place the borough above the national average but this is not sustained at Key Stage 2 with a fall below national levels. Efforts at Key Stage 3 seem to be coming in line with national levels (although these are based on teacher assessments as the government no longer publishes result for this key stage).

Looked After Children perform particularly poorly at GCSE level.

Levels of permanent and fixed term exclusion have fallen significantly and are more in line with national averages (which are also falling).

Attendance at Bedford Borough schools is better than is the case nationally, and fewer of our pupils are identified as persistent absentees.

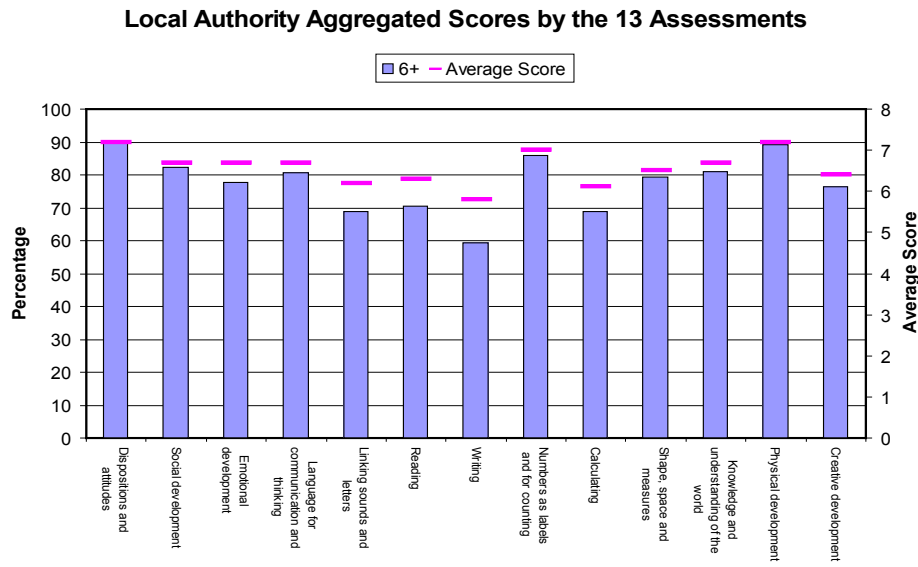
## Key Findings

### Academic Achievement

Although levels of educational attainment have risen in each of the last five years, pupil performance in Bedford Borough is well below the average of its statistical neighbours at Key Stage 4 with GCSE and equivalent qualifications.

The Foundation Stage profile measures children in the Reception year when they turn 5 against 13 assessment areas (Figure 13). The target nationally is for the average achievement to be 78 points out of a maximum of 117 – Bedford Borough is currently achieving an average of 72.7 points, which is a slight improvement on previous years.

Figure 13: Aggregated Scores



The gap is narrowing between the lowest 20% of achievers faster than Bedford Boroughs targets – this means that the lowest achievers are improving faster than the rest of pupils in the Foundation Stage.

In the Foundation Stage, girls outperform boys across all 13 indicators, particularly in writing. This is in line with national trends for children of this age.

Performance at Key Stage 1 (School years 1 and 2) is above both the national average and that of statistical neighbours. In 2008-09, 87% of Bedford children achieved level 2 and above in reading compared with a national average of 84% and a statistical neighbour average of 86%. For writing, the Bedford Borough figure was 84% compared with a national average of 81% and statistical neighbour average of 83% and for mathematics, the equivalent figure was 91% compared with 89% nationally and 91% among statistical neighbours.

At Key Stage 2 the percentage of pupils achieving level 4 at both English and mathematics in 2008-09 was 67% which was both below the national average of 72% and the average for statistical neighbours of 73%.

Performance at Key Stage 3 provisional teacher assessment figures indicate that the percentage of pupils achieving level 5 and above in English in 2008-09 was 78% which was in line with the national average. For mathematics the percentage of pupils achieving level 5 was 77% which was below the national figure of 79%. These figures will remain provisional as the government no longer publishes Key Stage 3 achievement and attainment performance tables.

At the end of Key Stage 4, when students sit their GCSE examinations, the gap between Bedford Borough and the statistical neighbours has widened. The percentage of students obtaining five or more A\*-C grades in Bedford Borough (67.5%) is further below both the statistical neighbour average (71.6%) and the national average (69.7%) (2008-09 figures). Similarly, the percentage of students in Bedford Borough achieving five or more A\*-C grades at GCSE including English and mathematics was 47.8% in 2009, compared with a national average of 49.7% and an average among statistical neighbours of 54.6%.

Post-16, Bedford Borough students perform below both the national and statistical neighbour averages. In 2008-09 the average point score per student was 695.6 whilst the national average was 713.0 and the statistical neighbour average was 747.3.

There is significant inequalities in attainment across the Borough. In 2007-08 individual school performance varied from 72% to 20% of pupils achieving 5 A-C grade GCSEs (including English and Mathematics).

### Attainment of Looked After Children

There are significant issues regarding the under-performance of Looked After Children at GCSE level. In 2009, 9 Looked After Children took GCSEs (out of a possible 16 who were eligible. Of these 9, only 56.3% achieved 1 GCSE at A\* - G and 6.3 % achieved 5 GCSEs at grades A\* - C. This compares to rates of 97% and 64% for the total population taking GCSEs. Although this is a national trend with poor attainment being reported for Looked After Children, Bedford Borough is well below the national levels of 66% of LAC gaining at least 1 GCSE and 14% gaining 5 GCSEs at grades A\*-C.

### School Exclusions

During the 2008-09 academic year, there were a total of 29 permanent exclusions. This equates to a rate of 1.2 per thousand pupils (12 exclusions per 10,000 pupils). This is down from 1.6 per thousand in 2007/08. Although there are no comparative figures nationally for the current period, the national rate for 2007/08 was 1.1 per thousand (11 exclusions per 10,000).

Permanent exclusions in Bedford Borough have reduced by 24% (9) in 2008/09. The most significant reduction has occurred in upper schools where exclusions have fallen from 22 to 13, a 41% reduction. It is also worth noting that there have been no exclusions of pupils from lower schools in this academic year.

Nationally there was a 6.4% reduction in permanent exclusions in 2007/08.

97% (28) of the pupils permanently excluded were male and only one female pupil was permanently excluded from Bedford Borough in this academic year.

Overall there is still a peak in year 10 with 24% of all exclusions in Bedford Borough.

Permanent exclusions in year 7 represent 21% of the total exclusions in Bedford Borough. 79% (23) of pupils excluded were known to have special educational needs.

In the 2008/09 academic year, the single biggest reason for permanent exclusion was persistent disruptive behaviour accounting for 38% (11) of all permanent exclusions.

31% (9) of pupils permanently excluded in Bedford Borough were eligible for free school meals. Children who are eligible for free school meals are three times more likely to be permanently excluded than those who are not.

During the academic year 2008/2009, there were a total of 806 fixed term exclusions, which is a 17% reduction on last year (974). Nationally in 2007/08, the number of fixed term exclusions decreased by 9.8%. 490 pupils (2% of Bedford Borough's school population) were excluded for a fixed period.

The majority (67%) of these pupils were excluded only once

The actual total days lost due to fixed term exclusions has reduced by 19.5% from 2834 in 2007/08 to 2280 in this academic year. The average length of a fixed term exclusion in Bedford Borough is 2.8 days. Nationally this figure was 2.7 days lost per exclusion in the 2007/08 academic year. More than 97% of all fixed term exclusions in Bedford Borough lasted one school week or less, with 51% being one or two days. Less than 1% of exclusions lasted longer than two school weeks

### Drugs and Alcohol Related Exclusions

Over the last three years there have been increases in both the number of drugs/alcohol related permanent exclusions from schools from 4% of all permanent exclusions in 2006-07 to 15% of all exclusions in 2008-09.

There has been a gradual increase in the numbers of drugs/alcohol related fixed term exclusions over the last three years, but due to the overall increase in fixed term exclusions, the proportion has remained steady at around 3% or 4% of overall exclusions in Bedford Borough schools.

## School Attendance

Children and young people attending Bedford Borough schools miss fewer half days through absence at both primary and secondary level than children nationally. Our attendance figures at secondary level are amongst the best in the country.

Overall attendance in Bedford Borough secondary schools during 2008-09 was registered as 94% with only 0.8% of the absences of secondary age pupils being unauthorised (ie. without the school's knowledge or permission) and 0.5% of primary aged pupils.

While illness and other circumstances account for a proportion of absence, holidays in term time continue to be a factor across all school phases.

A persistent absentee is defined as any pupil with less than 80% attendance at school, regardless of the reason. We had a slightly higher number of persistent absentees in primary (lower) schools than our statistical neighbours (2.2%, compared to 2.0%) but were much better than average when considering secondary (middle and upper school) pupils (4.4% compared to 5.3%)

Although below the thresholds levels for national concern, 6 of our middle and upper schools have over 6% of pupils as persistent absentees and 7 lower schools have over 2.5% of their pupils in this category.

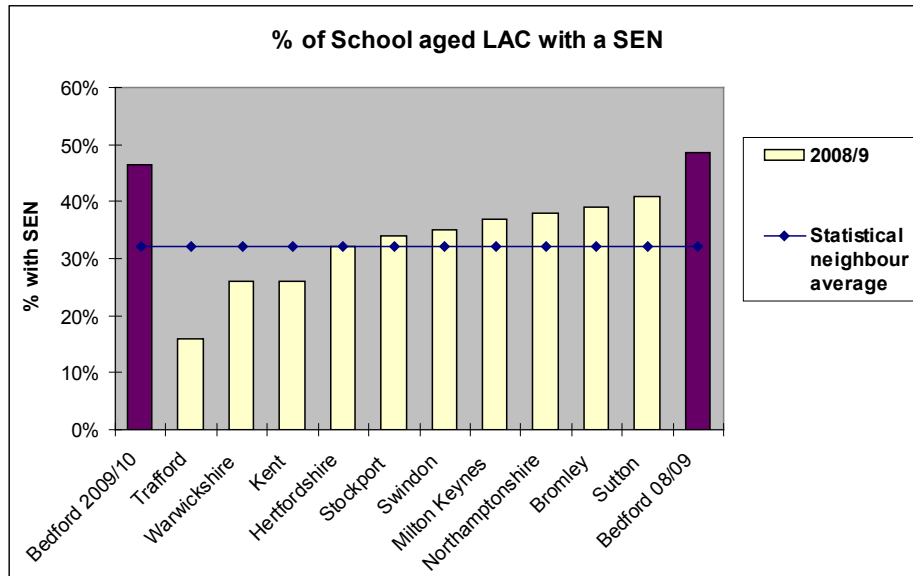
## Special Educational Need and Disability

674 children in Bedford Borough have Statements of Special Educational Need. 75% of these are boys (506). The authority has previously had higher than average levels of pupils with a statement.

334 pupils currently attend our 3 special schools, although approximately a third of these children reside in the areas now part of Central Bedfordshire or other counties. A further 55 children attend 9 specialist provisions within mainstream schools. 69 pupils attend specialist provisions in other counties (including 13 who are placed in the BESD special school in Central Bedfordshire). We have had higher than average numbers of pupils in special schools.

The number of Looked After Children with a statement of special educational needs has reduced slightly from 48.5% to 46.5% (Figure 14). However this is still considerably higher than all of Bedford's statistical neighbours. In fact of the 150 authorities in England during 2008/9 only one council (Richmond-upon-Thames) had a higher percentage of Looked After Children with a statement of Special Educational Need.

Figure 14: LAC with SEN



### Social

Bedford Borough is a small authority, with a diverse population, spread across rural and urban wards. Children and young people in some urban wards experience high levels of deprivation while those in rural areas struggle with access to services. Urban areas have high levels of ethnic minorities although this is not concentrated in any one particular group. The population is growing, supplemented by a significant number of arrivals from new EU states.

## Cultural and Leisure Opportunities

Access to and participation in the arts, culture and sports gives young people a sense of purpose, allows them to develop their potential and enriches their lives. There is also evidence that providing sports and arts activities specially for young people promotes physical and mental health and well being, addresses the complaint of “nowhere to go, nothing to do”, and reduces youth crime.

Last year Bedfordshire Music Service engaged with over 50 000 children, young people and adults providing musical enrichment opportunities to a wide range of communities, as well as instrumental tuition to about 11 000 pupils – about 18% of the total school population county wide.

The council runs summer play schemes for 5-13 year olds with over 8000 attendees in 2008-09.

## Physical Activity

5-16 years olds in Bedford Borough are significantly more active than national levels, and the levels of participation in sports in schools are near the top in the region. Clusters of schools are formed into School Sport Partnerships comprising all school phases and engaging virtually all schools. 92% of Bedford Borough pupils in these partnerships do 2 hours or more of quality PE (in 2009) compared to national averages of 81% and regional averages of 86%. The Borough scored particularly well (100% or 99%) in all years apart from years 10 and 11 (63%). More pupils than the national or regional average do 3 hours or more per week of physical education, and participate in regular intra and inter school competition. 29% of the pupils are involved in leadership and volunteering in their sports compared to the national average of 19%.

## Housing

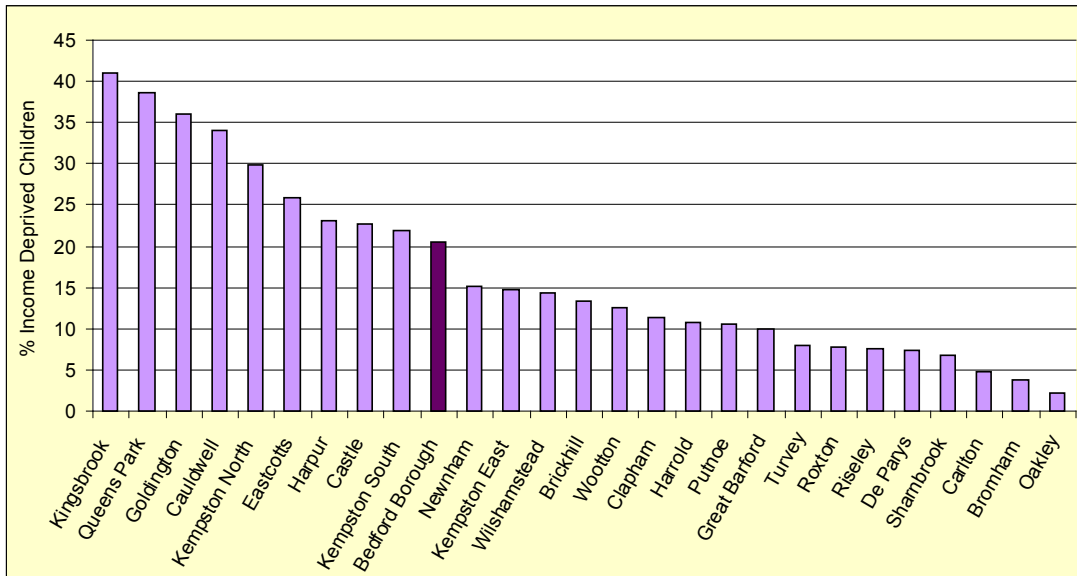
Bedford Borough is at the heart of the Milton Keynes and South Midlands growth areas and has been identified for significant housing growth. As a result of this housing growth, the Borough’s population is forecast to rise to 172,500 by 2021, an increase of 10.5% from 2008. Over 16 000 new houses are planned in the Kempston, Bedford and Marston Vale areas before 2021. The population aged 0-19 is estimated to reach 41 800 by 2020, which will be 23.2% of the total population.

In 2007 there were 210 households with pregnant women or dependent children who were statutorily homeless.

## Deprivation

Overall, almost 20% of children in the Borough live in income deprived households according to the IDACI measures in 2007, but rates in some wards are much higher. (Figure 15). The highest rates of child poverty are in Kingsbrook (41%) and Queens Park (38.7%) wards: Bedford Borough has 9 areas among the 10% most deprived in England and a further 9 among the 20% most deprived. All 18 are located in either Bedford or Kempston.

Figure 15: Children in Income Deprived Households (IDACI) by Ward, 2007

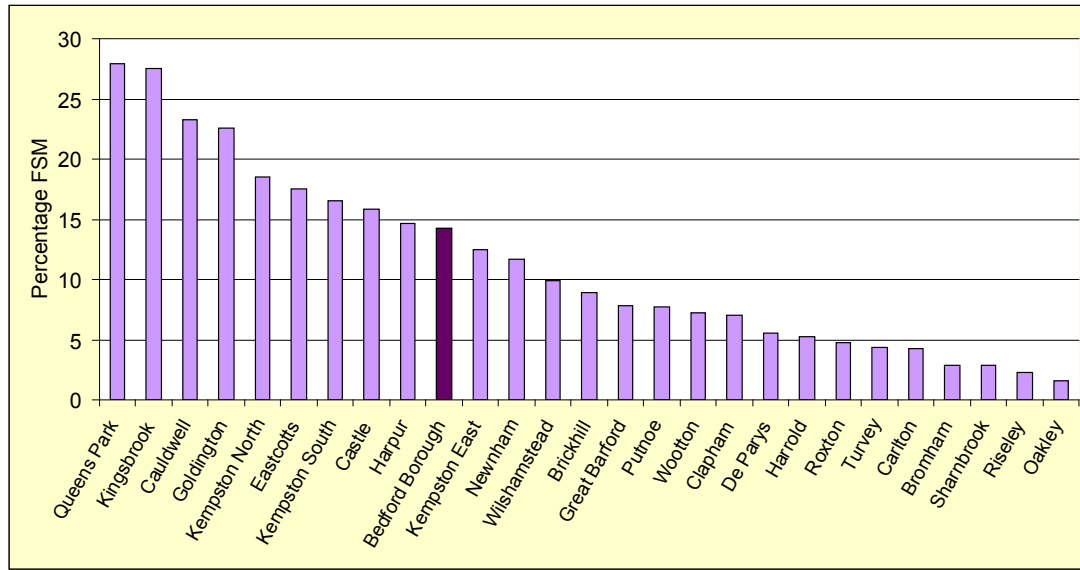


In the most deprived areas within Castle, Harpur and Kingsbrook two-thirds of children live in income deprived households, and a further four areas in Goldington, Queens Park, Caudwell and Kempston North have rates of 50%.

According to Child Tax credit data, 39% of children in Bedford Borough live in low income families. Across the whole Borough, 19% of children live in workless families although in some wards this is as high as 30%. Nationally the majority of children living in poverty have at least one parent in work but their earning is so low that the family is unable to rise above the poverty line.

Around 15% of pupils in state schools across the country are entitled to free school meals. In Bedford Borough this figure averages 13.4% of pupils were eligible to receive free school meals, and 78.2% of pupils who were eligible received a free school meal.(Figure 16). There has been an overall decrease of 0.41% in the number of pupils entitled to free school meals since 2008. The proportion of children eligible for Free School Meals varies greatly by ward and exceeds 25% in Queens Park and Kingsbrook.

Figure 16: Proportion of Children in Maintained Schools Eligible for Free School Meals, 2009



### Rural Deprivation

The rural areas of the Borough (roughly a third of the total) do not generally suffer from significant deprivation. Of the 35 most deprived areas in the Borough, only 1 is rural.

However, many of the Borough's rural areas do suffer from inaccessibility to such essential services as a GP, primary school, post office and supermarket. When considering geographical barriers, 14 areas in the Borough are among the 10% most deprived in England in access to services (areas in Riseley, Roxton, Bromham and Turvey being most affected), and a further 16 are among the Top 20%. Indeed, 70% of the Borough's 55,000 rural residents live in areas which are among the 20% most deprived areas in England in access to services.

Access to services and to leisure opportunities can be a considerable problem for children in rural areas, particularly those living in households without a car or wishing to travel at times when public transport is unavailable or inconvenient. Rural areas also have to contend with the growing cost pressures on the provision of public transport, and the reduction in services which some

## School Leaver Destination

The Borough has been negatively impacted by the national recession with the claimant count unemployment rate rising from 2.1% of the working age population in April 2008 to 4.2% in October 2009, and the rate in Bedford/Kempston exceeding 5%. On a broader measure of worklessness, almost 12% of the working age population in the Borough claims out of work benefits, and the rate is between 15-20% in Castle, Cauldwell, Goldington, Harpur, Kingsbrook and Queens Park wards.

Between 5 and 6% of young people in Bedford Borough aged 16-18 are not in education, employment or training.

Government figures show that young people who were not in employment, education or training (NEET) when aged between 16 and 18 were three times more likely to be involved in crime in their late teens and throughout their twenties, while females NEETs were 22 times more likely to be teenage mothers than the average. With little or no experience, young people are often disproportionately affected by recession. Those looking for their first job are hard hit by recruitment squeezes, while those lucky enough to have obtained employment are often the last in, and so the first out. Government records suggest that youth unemployment is costing more than £500m a year in benefits.

In October 2009, Bedford Borough had 8060 young people aged 16 – 19 who had completed their compulsory education. 76% (6144) are in education, training or employment, nearly 90% of who are in education or training. 395 young people in this age group have been identified as not in Education, training or employment. Of these, 90 young people are not available to the labour market for reasons such as pregnancy, being teenage parents, illness or caring responsibilities. The current situation of a further 1509 young people is not known (18%).

More males than females are in training and employment, rather than education. The NEET cohort is exactly balanced on gender grounds although more young men are in the labour market with 90% of those not available for employment being young women (often on the grounds of being teenage parents, pregnant or young carers).

50% of care leavers (young people aged around 16 or 17 who have been Looked After) in Bedford Borough are not in employment, education or training (2008-09) which is a better situation than is the case regionally (56%) and nationally (63%).

## Public / Patient Voice Involvement

The development of priorities in this area was subject to extensive consultation with children, young people, families / carers and other stakeholders across Bedford Borough.

### Priorities

- To develop learning opportunities at school, within the home and within the community and increase choice for children and young people;
- To provide a full range of play, leisure, sport and cultural activities to support young people in achieving their full potential;
- To focus on narrowing the achievement gap for our most vulnerable children and young people;
- To support those young people most at risk of not being in education, employment and training.

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