Bath & North East Somerset Council

B&NES Early Help

Early Help Needs Assessment

May 2020

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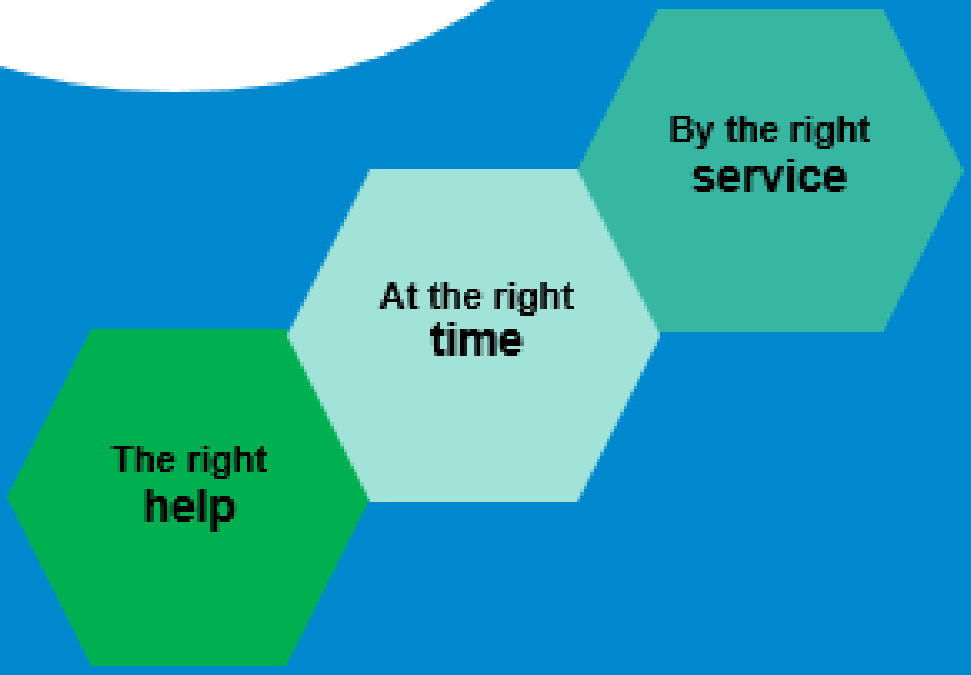

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Forward

The central importance of Early Help in enabling children, young people and families to reach their full potential has been a common theme in a number of reviews that have been commissioned by successive governments (Working Together; the Munro Review; Allen Review; Field Review and the Marmot Review). They have all independently reached the same conclusion and stress the need for preventative Early Help in order to improve outcomes for children and young people. Ofsted published a thematic inspection of how local partnerships are delivering Early Help in March 2015. It estimated that over two million children in the UK today are living in difficult family circumstances. These include children whose family lives are affected by parental drug and alcohol dependency, domestic abuse and poor mental health. It is crucial that these children and their families benefit from the best quality professional help at the earliest opportunity. For some families without Early Help, difficulties escalate, family circumstances deteriorate, and children are more at risk of suffering significant harm.

The purpose of the Needs Assessment is to ascertain unmet need, trends and gaps in the provision of Early Help for children, young people and their families. It provides information as to the level of need for Early Help services and to identify actionable solutions to meet the needs through understanding what is available, and where service gaps may exist. It will be used to inform the refresh of the Early Help strategy, commissioning priorities and for service planning.

The needs assessment will enhance the existing Joint Strategic Needs Assessment (JSNA) which offers context to the more detailed Early Help needs assessment that focuses on the key vulnerabilities contributing to families requiring early support and timely intervention.

Within B&NES, the governance for Early Help has recently been restructured with the formation of a new Early Help and Intervention subgroup of the Banes Community Safety and Safeguarding partnership BCSSP. This subgroup now brings together children's and adult's areas of Early Help and intervention. However, this needs assessment only covers the children and family aspect of the Early Help offer in B&NES. It will be used to inform the Early Help and Intervention subgroup on its strategic direction going forward.

1.1 What is Early Help (EH) and what does this look like in B&NES?

Early help in Bath and North East Somerset is about children, young people and families getting **The right help, At the right time, By the right service**.[1] It is essential in ensuring that families can reach their full potential. The 2015-2018 Multi-Agency Early Help strategy focused on achieving three main outcomes. These were that children and young people:

- Are safe
- Are healthy
- Have equal life chances

Achieving this requires a multiagency approach and an understanding of the complex nature of the accumulation of risk factors and mitigating factors that contribute to the need for Early Help. Recognising these complexities and the need to "Think Family", the Bath and North East Somerset Community Safeguarding Partnership has committed to ensuring that the voice of children, adults and families is strengthened and improved. The Early Help and Intervention Subgroup has prioritised engaging with key stakeholders to positively promote learning and messages of "Think Family, Think Community".

The infographic below is taken from the Early Intervention Foundation[2] and demonstrates the many factors that contribute to the trajectory of a child's life.

FIGURE 1: RISK FACTORS OCCURRING IN A CHILD'S LIFE

[1] B&NES Multi-Agency Early Help Strategy for Children, Young People and Families (2016), available at https://www.bathnes.gov.uk/sites/default/files/sitedocuments/Children-and-Young-People/ChildProtection/early_help_strategy_jan_2016_final.pdf

[2] Early intervention foundation (2018) Realising the Potential of Early Intervention, available at https://www.eif.org.uk/report/realising-the-potential-of-early-intervention

1.2 Early Help and the spectrum of prevention

Early Help is not about the prevention of needs arising, but rather the recognition of additional needs which cannot be met by the universal services and thus require the input of EH services. The hope is that by providing an EH offer, the escalation of needs can be mitigated. Early Help may also be used in the context of stepping down from social care or acute services. It is utilised to prevent the re-escalation of needs back to a threshold which requires social care or acute service input.

The Early Help offer in Bath and North East Somerset recognises the complex nature of this area of work which involves individuals and families, in the context of their personal and material resources, living in different environments and experiencing varying challenges. Therefore, the processes involved in providing Early Help are underpinned by the empowerment of professionals to understand family's needs and facilitate access to appropriate resources.

1.3 Levels of need within the Early Help system

To aid the understanding and assessment of levels of need, B&NES has a local threshold document.[3]

It describes specific domains and examples of impacts that might be seen at each level of risk. The domains covered are listed below:

[3] B&NES LSCB Threshold Document (2019) available at https://www.safeguarding-bathnes.org.uk/sites/default/files/threshold_for_assessment_1.pdf

- Food
- Quality of housing
- Stability of housing
- Child's clothing
- Animals
- Hygiene
- Safe sleeping arrangements and co-sleeping for babies
- Seeking advice and intervention
- Disability and illness
- Safety awareness and features
- Supervision of the child
- Handling of baby/ response to baby
- Care by other adults
- Responding to adolescents
- Parent/ carer's attitude to child, warmth and care
- The child's emotional wellbeing
- Sexual relationships
- Boundaries
- Adult arguments and violence
- Physical abuse
- Positive values
- Substance misuse

How an assessment of needs should translate into service referral is illustrated in the table below.

Need / Risk	Assessment	Impact / Response
Level 1 — Child, YP or family whose needs are being met, or whose needs can be met by universal services	**Universal Services**	At this level, needs are met by parents, carers, communities and universal services for example GP, HV, SN, Education etc. Please visit One Big Database Bathnes and/or Wellbeing Options for further information regarding universal services.
Level 2 Universal + — Child, YP or family with additional needs that can be met by a single agency or by signposting to an additional agency	**Consider an (Early Help Assessment EHA)**	Consider using the EHA as a way to identify needs and plan a response, either single agency or with the support of another agency. Details of which can be found via the Early Help App. You may consider contacting your safeguarding lead within your agency for further support and guidance at this level. Signpost to Rainbow Resource / SEND local offer or the NHS Safeguarding APP to identify types of support including local resources.
Level 3 — Child, YP or Family that needs a co-ordinated programme of support from more than one agency	**Complete an Early Help Assessment (EHA)**	Undertake an EHA to identify evidence of the level of need and to plan a holistic multi-agency response. This should be done with parental consent via a Team Around the Family (TAF) meeting co-ordinated by the nominated lead professional. This should be done in partnership with the family so they fully understand the purpose and benefits of engaging and that the aim is to be supportive. You may wish to discuss with your safeguarding lead if the family refuse consent.
Level 4 — Child, YP or family who require intensive and co-ordinated support for complex issues via targeted services/ Early Help and /or where support at Level 3 has not improved outcomes	**An Early Help Assessment has been completed but outcomes have not improved**	The need/risks have not been met / addressed by the multi-agency action plan in place following EHA. The child, YP or family may require long term intervention from statutory and specialist services.
S.17 Child / Level 5 — Child or Young Person at risk of /or suffering significant harm due to compromised parenting, or whose needs require acute services or care away from their home	**Statutory / Specialist Assessment**	**If a child is in immediate danger, ring the Police.** Otherwise refer urgently to the Duty Team on **01225 396312** or **01225 396313**, or, outside office hours, the Emergency Duty Team on **01454 615165.** You should follow up the referral in writing within 48 hours.

1.4 Pathways of Early Help in B&NES

Initial recognition of needs can result in several different pathways through the system depending on the complexity and the risk of significant harm. These pathways are outlined in more detail in section 9.

1.5 Working in complex adaptive systems

The above describes the processes and pathways through Early Help in B&NES based on how the EH system was set up and intended to operate. It has been noted anecdotally that this complex system has adapted to accommodate pressures within the system. The headline adaptations are highlighted below.

- Reduced numbers of multi-agency Early Help Assessments (EHA formerly known as CAF)
- Agency assessments evolved to be similar to the EHA
- High numbers of referrals to social care which are not **level 5**

Understanding the local offer for Early Help is important in framing future direction. This should be understood in the context of the Early Help resource pack released by the Local Government Association in conjunction with the Early Intervention Foundation and Bright Futures. This document outlines the legislative roots of Early Help and points to evidence sources for further informing local Early Help offers.[4]

2 National Trends that affect the need for early help

2.1 Child Poverty

Child poverty is increasing in the UK and at a rate disproportionate to that explained by population growth. The Joseph Rowntree Foundation, an independent social change organisation, report that 4.1 million children live in poverty in the UK. They suggest that whilst the total number of children grew between 2011/12- 2017/18 by 3%, the number of children living in poverty increased by 15%. Driving this increase are factors associated with lone-parent families, who experience both high rates and persistent poverty when compared to couple families.[5]

The relationship between poverty and child abuse and neglect has been articulated through an evidence review.[6] Whilst the evidence from the UK is limited, drawing on a wider body of literature allows an understanding of the association between poverty and the chances of experiencing child abuse and neglect. Not all children who live in poverty will experience child abuse and neglect. However, the direct and indirect effects of poverty on families and children contribute to the overall picture of abuse and neglect. Therefore, when rates of child poverty are increasing, we can

[4] Local Government Association/ Early Intervention/ Bright Futures (2019) Early help resource pack available at https://local.gov.uk/sites/default/files/documents/15.66%20Early%20Help%20resource%20pack_May%202019.pdf

[5] Joseph Rowntree Foundation (2018), UK Poverty 2018 available at https://www.jrf.org.uk/report/uk-poverty-2018

[6] Joseph Rowntree Foundation (2016) , The relationship between poverty, child abuse and neglect: an evidence review, available at https://www.jrf.org.uk/report/relationship-between-poverty-child-abuse-and-neglect-evidence-review

anticipate that child abuse and neglect will also increase and thus the need for Early Help services will increase.

2.2 National changes to the benefits system

The UK is currently in the process of a phased change to the benefits system. This is the system by which, as a country, we support people to ensure they have enough financial means to live. Whenever there is a change in a system there are inevitable impacts both immediate and long term. The Institute for Fiscal Studies has considered these following the change to Universal Credit and reported key findings. These help us understand the national narrative around implementation of the policy.[7]

Firstly, it is suggested that those in the lowest decile of population income experience the greatest losses from Universal Credit. The study highlights how short-term losses may be temporary and over longer timeframes, fluctuations in income flatten out. Whilst this may provide some reassurance of the system, the impact of even temporary reductions in income for those already struggling is significant. This process of change to Universal Credit is likely to result in increased financial insecurity affecting those already experiencing income hardship. It also highlights the vulnerability of those families experiencing worklessness who rely solely on the benefits system. Direct and indirect impacts of this, in terms of ability to provide for material needs, and the stress of changing processes of financial support are likely to increase the need nationally for Early Help services.

The above is only part of the picture. Whilst it describes a perspective on income, it does not consider income in the context of cost of living. Research has suggested that it is getting more expensive to raise children.[8] It could be suggested that it is factors such as an increase in living costs that have driven the use of food banks. As families grapple with poverty and closing the gap between income and living costs, alternative support is sought.

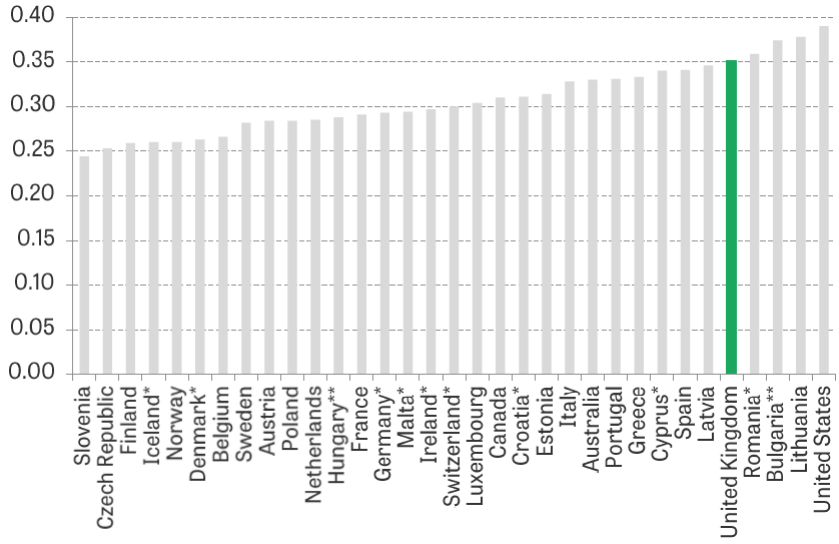
2.3 Inequalities

Where there is inequality, social cohesion can be negatively affected. The UK remains an unequal country as evidenced through the Gini coefficient.

[7]Mike Brewer et al (2019) Universal credit and its impact on household income: the long and the sort of it. Available at https://www.ifs.org.uk/publications/14083

[8] Child Poverty Action Group (2019), The coist of a child, available at https://cpag.org.uk/sites/default/files/files/policypost/CostofaChild2019_web.pdf

Gini coefficient of equivalised net household incomes in selected countries, 2016



If income was completely equal across society the coefficient here would be 0. If all a country's wealth was held by one household the coefficient would be 1. This graph is most usefully understood as a comparator to other countries. It shows us that the UK has a high level of income inequality when compared to our European neighbours, although not quite as unequal as the United States.

This becomes important when understanding our local data. Indicators that take an average across an area, for examples B&NES, could appear to be favourable when compared to averages in other areas. But when we understand the spread of the data within an area, we begin to see how this national picture of income inequality is reflected locally. This also shapes the need and demand for Early Help services seen locally in B&NES.

2.4 Pressure on resources

Years of austerity have resulted in cuts to public sector budgets, whilst demands for support have increased catalysed by the impact of austerity on families' lives. Early Help has been shown to be cost effective[9] and underpins an approach to spending that focuses on prevention. If needs are not addressed early they may escalate with negative impacts on families thus increasing the need for, already stretched, acute or statutory social services. Various evidence reviews on interventions have been undertaken[10] with the Early Intervention Foundation providing different evidence reviews for specific groups. It also provides a guidebook with information about early intervention programmes that have been evaluated and shown to improve outcomes.[11]

2.5 A Trauma informed approach

[9] https://www.eif.org.uk/report/realising-the-potential-of-early-intervention

[10] C4EO Grasping the nettle: early intervention for children, families and communities, available at https://www.family-action.org.uk/content/uploads/2014/07/Early-Intervention-Grasping-the-Nettle-Full-Report.pdf

[11] Early Intervention Foundation Guidebook, available at https://guidebook.eif.org.uk/

Our understanding of childhood trauma and its negative impacts is ever growing, yet how common trauma is in the general population has been a difficult question to answer. In 2019 a large epidemiological twin study (2232 children) found that 31.1% of the study population reported exposure to trauma by the age of 18 years old. In this group higher rates of major depressive episodes, conduct disorders and alcohol dependency were seen along with increased risk events, including self-harm, suicide attempts and violent offences.[12] Further to this, the important role of experiencing direct interpersonal trauma, such as maltreatment by adults or bullying by peers, and the development of post-traumatic stress disorder (PTSD) was noted. This evidence provides insight into both why Early Help is needed, and why an understanding of trauma remains a dominant narrative in working to improve outcomes for children and families.

STOP PRESS- The world is currently experiencing a pandemic- COVID 19. Whilst the impact of this will be under review for many years there are already national trends emerging which will impact the need for Early Help across the country such as:

- Increases in domestic violence noted in the media measured by calls to charities supporting victims
- Increased food insecurity as a result of financial pressure as jobs are lost, and to the impact of the social isolation required to control the virus spread
- Increased family tensions due to lock down within family units
- Impacts on education due to missed time at school

3 B&NES Population

3.1 Summary of population in B&NES

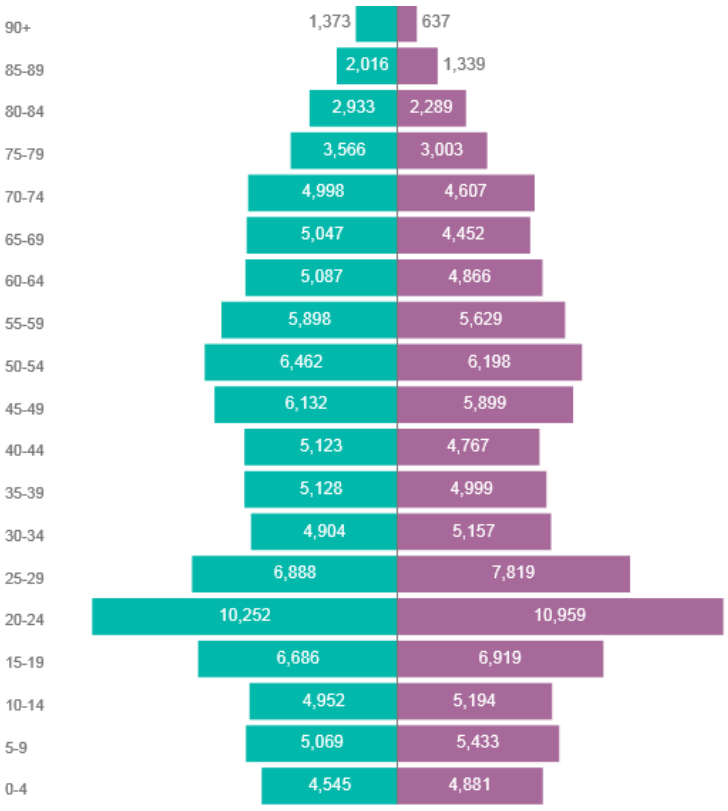
In 2018 mid-year the population in B&NES was estimated to be 192,106.[13] The GP registered population in February 2019 reflected a higher population of 211,454 however this was felt to be reflective of GP registration of people living outside the B&NES geographical border. When understanding the need for Early Help there are some key elements of population distribution that allow us to understand where needs may arise.

3.2 Population structure

Below is a population pyramid from 2018

[12] S. J. Lewis et al (2019). *The epidemiology of trauma and post-traumatic stress disorder in a representative cohort on young people in England and Wales*. Lancet, available at https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(19)30031-8/fulltext

[13] B&NES JSNA Population pages, available at https://www.bathnes.gov.uk/services/your-council-and-democracy/local-research-and-statistics/wiki/population



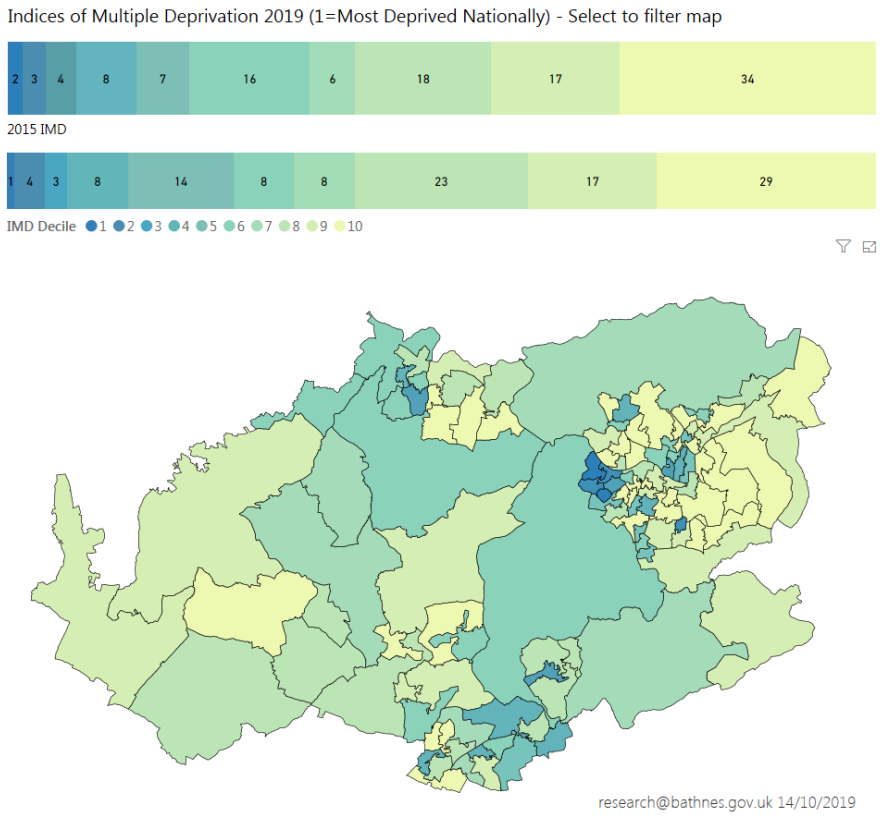
The need for Early Help described in this document arises from the population of children and families. In B&NES there are 43,679 children aged 19 and under. At the time of the 2011 Census there were 19,111 households in B&NES with dependent children (including single parent households).[14] For specific vulnerable groups this is extended to aged 24 and under and will be described in more detail later in the report. The proportionally large population size for this age group is due to the significant university student population in B&NES.

3.3 Deprivation and the narrative of inequality across B&NES

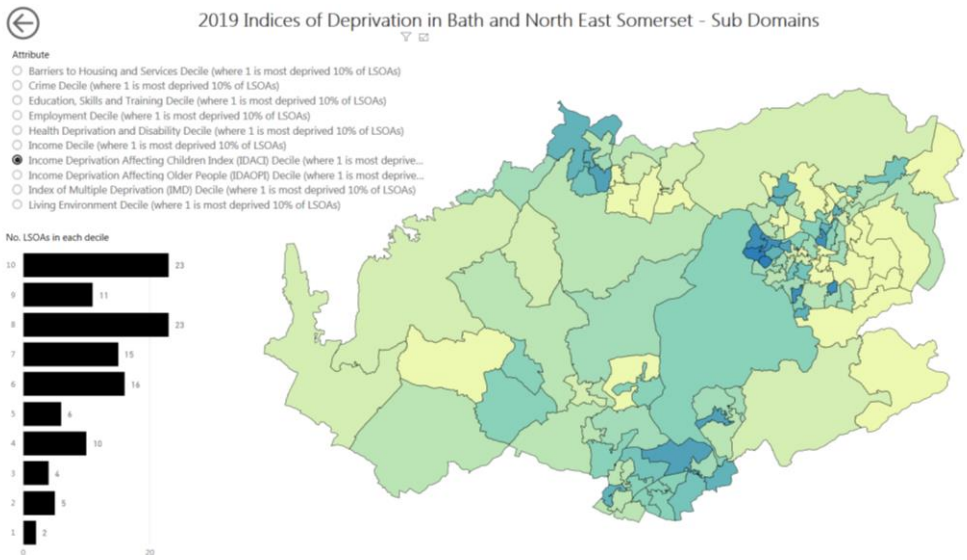
According to the 2019 Indicies of Deprivation (IMD) B&NES remains one of the least deprived local authorities. It ranks 269 out of 317. However across B&NES there are significant pockets of deprivation. This variation describes both the inequalites seen across B&NES and the patterning of need. If we accept that deprivation is a prerequisite to health, social and educational needs and that inequality negatively impacts social cohesion,[15] we begin to build a picture of where Early Help needs are likely to arise.

[14] ONS (2011), 2011 Census: Household composition, local authorities in the United Kingdom, Table KS105UK available from http://ons.gov.uk/census/2011census

[15] Indices of Deprivation 2019 interactive tool, available at https://app.powerbi.com/view?r=eyJrIjoiYWZlMzk5ZWUtNjgzOS00Y2U4LTk4Y2QtMGQ0NDZlOTAxOWNmIiwidCI6ImM1NjJjMGNlLWQ5MjUtNGRmZC04ZDk5LWM5NDE2ZWIwM2ViOSIsImMiOjh9



The graph above shows the IMD ranks of LSOAs in B&NES. Each section represents a Lower-level super output area. B&NES has 5 areas that fall into the bottom two deciles of deprivation nationally, compared to 46 areas in the top 2 deciles.



Income deprivation affecting children, which is a measure of the proportion of all children aged 0-15 living in income deprived families.

Local Authority level statistics from End Child Poverty suggested that 12% of children in B&NES were living in poverty in 2017/18.[16]

The wider determinants of health are also important to understand in the context of Early Help. Where families experience poor accommodation, food poverty, fuel poverty or factors such as poor air quaity, their basic needs may not be being met. When basic needs are not met the ability to achieve in other areas of life could be affected, resulting in non achievement of school readiness, antisocial behaviour or risk taking behvaiour.

Family Poverty in Bath and North East Somerset	
Overall proportion of children living in poverty	Estimated 12 % of children in B&NES living in poverty
Food poverty in B&NES	The published School Census figures from Jan 2019 show that there were 3,184 children in B&NES schools claiming free school meals[17]. This represents 11.7% of the children on a school roll in B&NES at that time. The percentage of children claiming free school meals in B&NES schools ranges from 1% - 53.8%.
Fuel poverty	In 2012 15.7% of all households were expereincing fuel poverty in Bath and North East Somerset (under the 10% definitions), slightly higher than the England average of 14.7%
Workessness	Nomis offical labour market statistics (ONS) [18] provide insight into the percentage of children who are in households that are workless. Across the South West 8.1% of children are thought to be in such households. The figure in B&NES is likely to be lower than this.

[16] End Child Poverty (2019) published figure on level of child poverty by local authority http://www.endchildpoverty.org.uk/poverty-in-your-area-2019/

[17] Schools pupils and their characteristics (2019) ONS available at https://www.gov.uk/government/statistics/schools-pupils-and-their-characteristics-january-2019

[18] Nomis Labour Market Profile Bath and North East Somerset (2018) available at https://www.nomisweb.co.uk/reports/lmp/la/1946157346/report.aspx#workless

4 Identifying specific groups within B&NES who would benefit from Early Help

The document Working Together to Safeguard Children 2018 highlights specific groups that would benefit from Early Help.[19] A description of the prevalence of these groups in B&NES informs the assessment of need for Early Help.

- Those with additional needs due to disability
- Those with special educational needs
- Young carers
- Those showing signs of engaging in anti-social or criminal behaviour
- Those in a family circumstance presenting challenges for the child, such as substance misuse, adult mental health, domestic violence
- Those showing signs of neglect

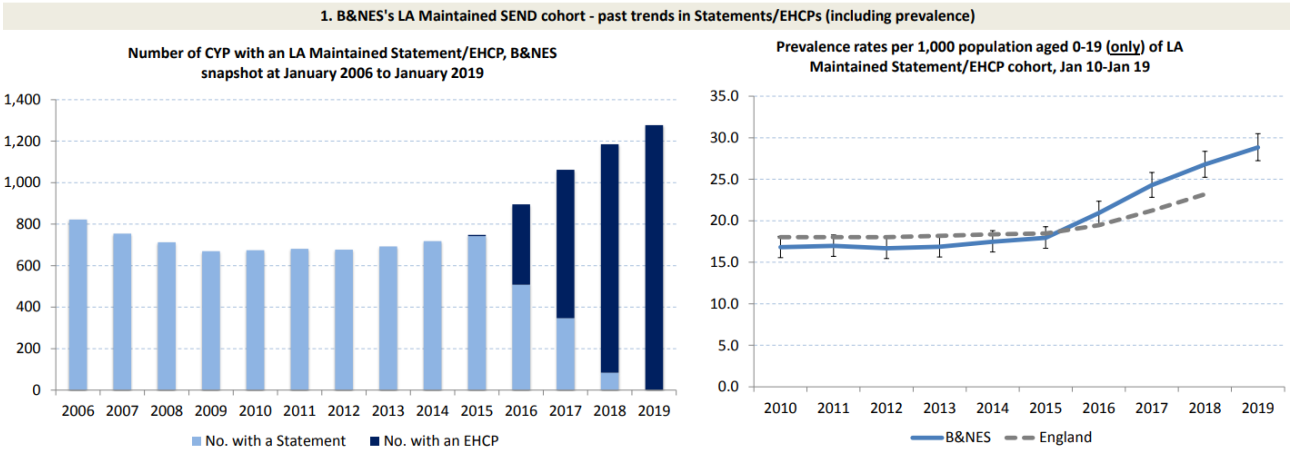
4.1 Those with additional needs due to disability and those with special educational needs (SEND)

Understanding this group of the population is challenging. The local data sources that provide an indication of the prevalence of childhood disability in B&NES includes the SEND data and the Schools Health Education Unit (SHEU) survey where children self-report disability. Further to this, synthetic estimates are used based on disability prevalence calculated at a national level through research. All these sources are underpinned by definitions of disability that vary and with limitations, such as differing population structures in the synthetic estimates.

As of January 2019, there were 1,277 children with an Educational Health Care Plan (EHCP). Over time this number has been increasing. This trend is illustrated through the graph showing the total number of children with a maintained LA Statement/ EHCP from 2006 through to 2019. This translates to a prevalence rate of 27 per 1000 children (aged 0-19) per year in 2019.[20] The B&NES Special Educational Needs and Disability Needs Assessment, Data and performance review (2019) provides a detailed analysis and can be found via the link below (18).

[19] Government Statutory Guidance (updated 2019). Working together to safeguard children. Available at https://www.gov.uk/government/publications/working-together-to-safeguard-children--2

[20] B&NES Special Education Needs and Disability Needs Assessment, Data and performance review (2019) https://www.bathnes.gov.uk/sites/default/files/siteimages/Your-Council/Local-Research-Statistics/draft_2019_banes_annual_send_performance_report.v5xupdated.pdf



In June 2019 B&NES undertook the Health-Related Behaviour Survey. Young people self-reported answers to several questions including:

"Do you have a long-standing illness, disability or special need?"

Twelve percent of year 8 children who answered the question (n= 1748) and 10% of year 10 children (n=1615) answered yes to this question. Whilst this question is open to interpretation by young people, it speaks of a level of perceived disability in this sample.

Using the Disability Discrimination Act (DDA) definition of disability, a UK based study used the Family Resource Survey of 2004/05 to estimate the prevalence of childhood disability in the UK. They estimated a prevalence of 7.3% (CI 6.9, 7.7).[21]

Using the ONS mid-year 2018 population estimates and applying the prevalence estimates from the BMJ paper we can estimate that 2782 children in B&NES have a disability (as defined by the DDA). This estimate could be as low as 2501 or as high as 3106 once 95% confidence intervals are applied. This is a synthetic estimate based on a UK level prevalence described in research literature and therefore must be interpreted with caution.

Age in years	Population	Prevalence	Count	Count Lower CI	Count Upper CI
0-4	9,426	3.7 (3.2, 4.3)	348.76	301.63	405.32
05-11	14,745	8.2 (7.6, 8.9)	1209.09	1120.62	1312.305
12-15	7,852	9.5 (8.6, 10.5)	745.94	675.272	824.46
16-18	6,505	8.5 (7.2, 10.0)	552.925	468.36	650.5
Totals	**38,528**		**2856.715**	**2565.88**	**3192.59**

[21] C.M. Blackburn, N. J Spencer, J. M. Read (2010) Prevalence of childhood disability and the characteristics and circumstances of disabled children in the UK: secondary analysis of the Family Resource Survey, available at https://bmcpediatr.biomedcentral.com/articles/10.1186/1471-2431-10-21

4.2 Young carers

Being a young carer has inevitable impacts on a young person's life. These may be direct, such as learning new skills to enable caring responsibilities (cooking, cleaning, washing, how to aid someone in personal care) or indirect. The time young people spend giving care may also have negative impacts on their education. Indirect effects could include adverse effects on wellbeing, for example due to reduced opportunities to socialise and resultant isolation.

2011 census data was used to estimate the proportion of young people aged 16-24 providing 1+ hours of unpaid care a week. It was estimated that 3% of all residents in this age groups in B&NES (95% confidence interval 2.8- 3.2) are young carers (data from 2015), this represents 817 young people. This data is derived from census data of 2011 and will be affected by the large number of university students that contribute to the 16-24 age population.[22] A further 323 under 15-year-olds were estimated to be providing 1+ hr of care a week.

In 2019 a survey of primary and secondary school children in B&NES showed that 6% of year 8 students and 5% of year 10 students identified as young carers. Whilst this is a sample of the B&NES population it identifies a significant number of children as young carers.

The impacts of being a young carer are such that this group of children and young people would benefit from an early help offer. Whilst accurately quantifying this need is not possible, it is likely that in B&NES there are around 1000 children and young people who identify as carers.

4.3 Those showings signs of engaging in anti-social or criminal behaviour

Those that enter the criminal justice system need support. Whilst we can quantify this number, those at **risk of entering** requires a broader understanding of the factors which contribute to the young people committing offences. Some of these factors have already been outlined, for example childhood trauma. In 2018, 30 young people aged 10-17 entered the criminal justice system. This represents a rate of entrance of 190.4 per 100,000 young people aged 10-17 based on mid-year population estimates (95% confidence interval 128.4 to 271.4).[23] The latest statistics from 2019 suggest a slight decrease to a rate of 153 per 100,000.[24]

In B&NES the total number of young people in contact with the justice system is relatively low with variation across years, making assessment of significant differences between groups and over time difficult to quantify.

[22] Public Health Profiles available at https://fingertips.phe.org.uk/search/care#page/1/gid/1/pat/6/par/E12000009/ati/102/are/E06000022/iid/91156/age/264/sex/4/cid/4/page-options/ovw-do-0_car-do-0

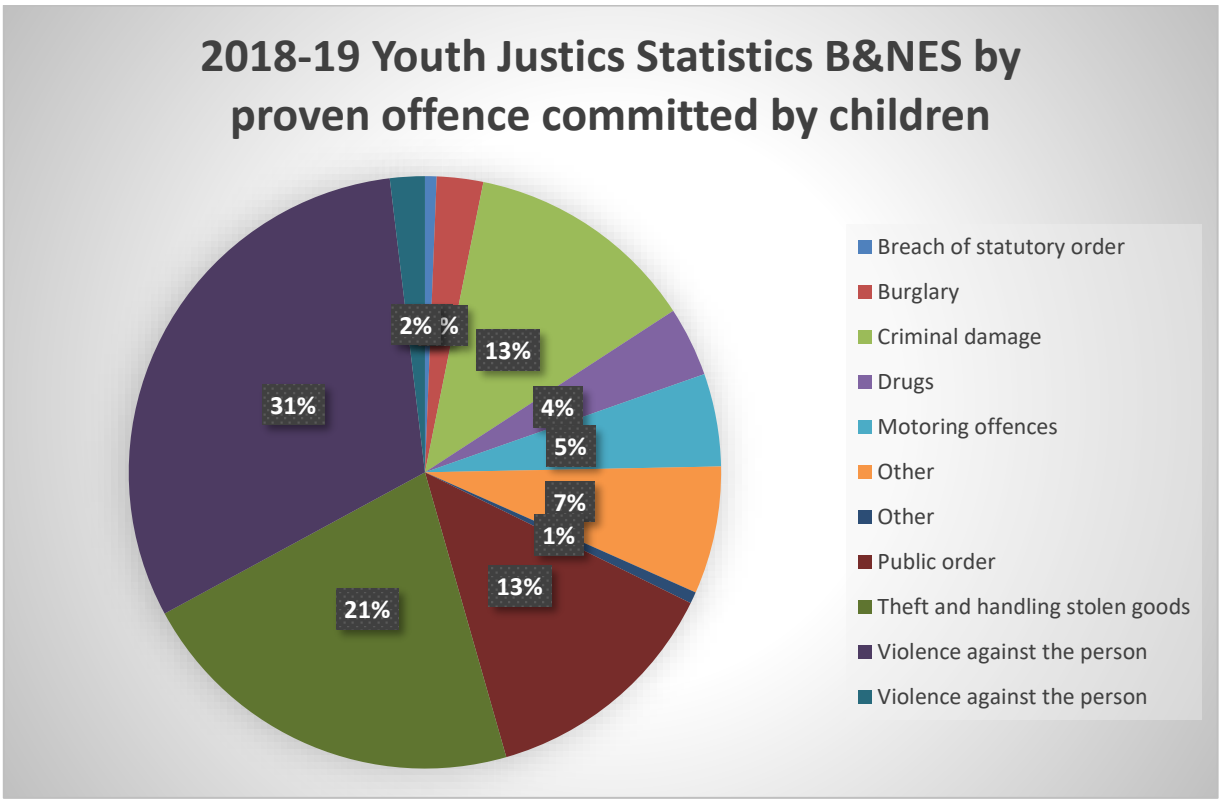
[23] Public Health Profiles https://fingertips.phe.org.uk/profile/public-health-outcomes framework/data#page/3/gid/1000041/pat/10039/par/cat-39-10/ati/102/are/E06000022/iid/10401/age/211/sex/4

[24] Youth Offending Team Data Summary April- December 2019

The latest Youth Justice statistics for 2018/19 are shown in the table and pie chart below.

Offence group	Gravity score	Number of offences
Breach of statutory order	1-4	1
Burglary	1-4	4
Criminal damage	1-4	20
Drugs	1-4	6
Motoring offences	1-4	8
Other	1-4	11
Other	5-8	1
Public order	1-4	21
Theft and handling stolen goods	1-4	34
Violence against the person	1-4	49
Violence against the person	5-8	3
	Total	**158**

An offence's seriousness, or 'gravity score' is scored out of eight, ranging from one (less serious) up to eight (most serious).
Gravity scores have been grouped in this tool; 1-4 (less serious) and 5-8 (most serious)



Pivot table showing the number of offences in B&NES over time (of note there was a change in methodology in this time which may affect direct comparison)

Sum of Number of Offences	Column Labels						
Row Labels	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	Grand Total
1-4				229	288	154	671
5-8				12	25	4	41
Not available	358	252	294				904
Grand Total	**358**	**252**	**294**	**241**	**313**	**158**	**1616**

Local data from the Youth Justice Board on proven offences shows that in B&NES between March 2017-2018, in a cohort of 75 young people with proven offences, 31 reoffended contributing to 77 reoffences. This meant that 41.3% of the original cohort went on to reoffend[25] this is compared to a nation figure (England) of 38.2% during the same time period.[26] Please note this data is based on offence location not offender place of residence. Difference in case definition means local youth offending data will present slightly differing statistics.

A recent publication of the problem profile for serious violence in B&NES[24] give some insight into the Youth Offending Services cohort. This profiling suggests that, in line with national averages, 77 per cent of children in the youth justice system receiving a youth caution or sentence in the year ending March 2019 were aged between 15 and 17+. 81 per cent of violent offences over the last six years were committed by White British individuals (351 / 432 offences). Black and minority ethnic (BME) individuals are over-represented - for example, the 2011 census records 90.1 per cent of residents as White British, rising further in wards such as Keynsham North (95.2 per cent White British). Males were responsible for most violent offences during 2014-2019 (violence, knife crime, robbery and sexual offences) and all robbery and sexual offences. [27]

If we consider this in the wider context and compare B&NES to local authorities that rank similarly to B&NES in terms of the IMD 2015, we see that B&NES crude rates of first time entrants into the youth justice system are similar to the England Average, whereas many other local authorities with similar IMD scores are below the national average. However, with such small numbers the conversion to population rates comes with a high level of uncertainty and so this should not be overinterpreted.[28]

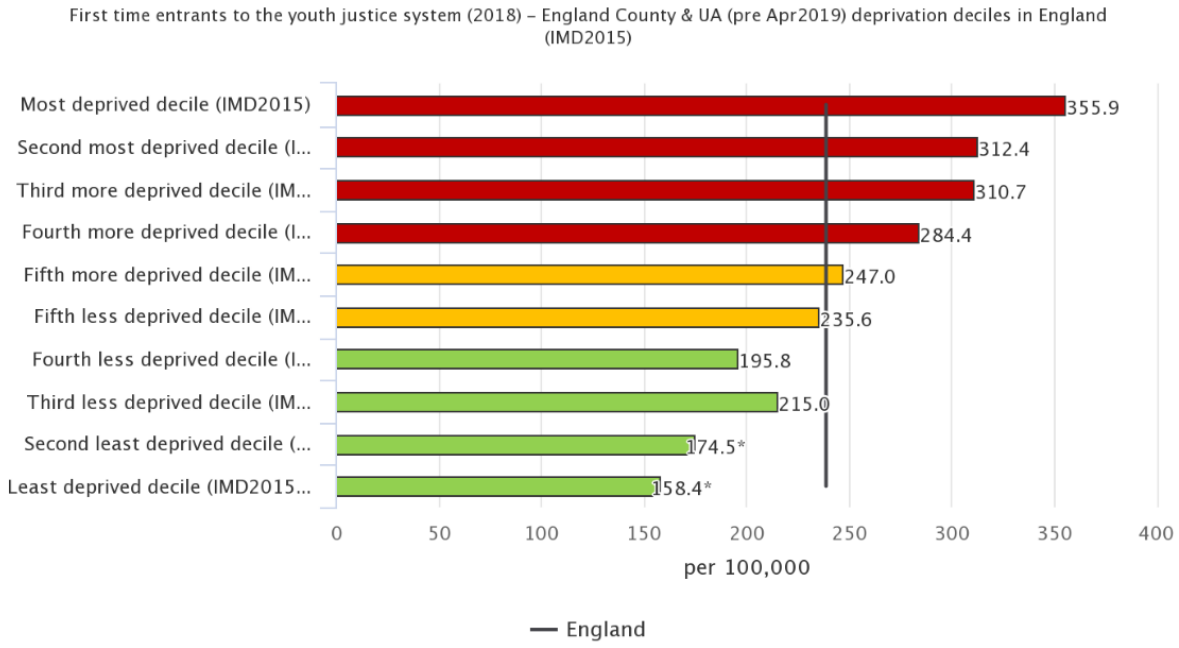
[25] Youth Offending Team Data Summary April- December 2019

[26] ONS (2019) Youth Justice Statistics England and Wales, available at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/862078/youth-justice-statistics-bulletin-march-2019.pdf

[27] Crest (March 2020), Problem profile: Serious violence in B&NES

[28] Public Health Profiles available at https://fingertips.phe.org.uk/search/youth%20justic#page/4/gid/1/pat/10039/par/cat-39-10/ati/102/are/E06000022/iid/10401/age/211/sex/4

When considering first time entrance into the Youth Justice System by IMD 2015 deciles across England, there is patterning[29]; with higher rates of first entrance into the youth justice system being seen across the gradient of IMD deciles. Whilst this represents a national picture, it provides further evidence for how deprivation may impact and increase the need for Early Help.



4.4 Those whose family circumstances present challenges

Evidence such as that undertaken in Wales looking at adverse childhood experiences (ACEs) and the toxic trio (mental health, substance misuse and domestic violence) suggests that, where family circumstances are challenging, outcomes for children and families are worse.[30] [31] These groups have, by definition, a need for Early Help to mitigate the adverse factors they are exposed to. This mitigation may be through building resilience or providing support that is missing from the home environment, such as role modelling. The challenges that have been identified through toxic trio and adverse childhood experiences work include parental mental health, substance misuse and domestic abuse.

[29] Public Health Profiles https://fingertips.phe.org.uk/search/youth%20justic#page/7/gid/1/pat/10039/par/cat-39-10/ati/102/are/E06000022/iid/10401/age/211/sex/4

[30] Public Health Wales NHS Trust (2015) Welsh Adverse Childhood Experiences Study available at http://www2.nphs.wales.nhs.uk:8080/PRIDDocs.nsf/7c21215d6d0c613e80256f490030c05a/d488a3852491bc1d80257f370038919e/$FILE/ACE%20Report%20FINAL%20(E).pdf

[31] Hampshire County Council (2015) Rapid Evidnece Review, Working with Familes where there is Domestic Violence, Parent Substance Misuse and/ or Parental Mental Health Problems https://innovationcsc.co.uk/wp-content/uploads/2018/01/Rapid-Research-Review-relating-to-FIT-July-2015-KB-1.pdf

4.4.1 Parental substance misuse

Alcohol dependence

Information from the 2019 Adult Substance Misuse Treatment health needs assessment provided a modelled estimate for alcohol dependence in B&NES. In 2016/17 it was estimated that 1,732 adults aged 18 or over were dependant on alcohol.[32]

Using the University of Sheffield and Kings college modelling estimates, it was suggested that in 2014/15 there were 621 children in B&NES who were living with an adult with alcohol dependency.[33]

Drug dependency

The Liverpool John Moores University modelled estimates for 2014/2015 suggests that there were 305 adults with opiate dependency, living with 543 children in B&NES.[34]

Adults substance misuse treatment needs assessment 2019

The adult substance misuse treatment health needs assessment in B&NES provides some information regarding adults in services and entering services who are parents of children. Throughout the period of 1st Jan to 31st December 2018 there were 226 clients in drug and alcohol treatment who were living with children under the age of 18.

There was an unmet need of an estimated 133 opiate dependant parents in B&NES in 2016/17 who were not treated but would have potentially benefited from treatment services. Further to this there was an estimated 284 alcohol dependent parents in B&NES in 2016/17 who would potentially benefit from treatment, but who were not in treatment.

4.4.2 Parental mental health

Common mental health conditions include depression and anxiety. These pose a significant challenge to daily functioning through the distress they cause. Common mental health problems were estimated to affect 18.9% of the working age population in B&NES in 2019 (22, 308 people). Whilst these are synthetic projected estimates, they suggest the burden of common mental health conditions which affect our population and impact on family life. [35]

In 2016/17 B&NES undertook a piece of primary research looking specifically at parents from the cohorts of adults using mental health, domestic abuse and/ or substance misuse services. It was

[32] B&NES Adult Substance Misuse Treatment Needs Assessment (2019) available at https://docs.google.com/document

[33] Local intelligence. Wider determinants spread sheet. Natalie Urry

[34] B&NES Adult Substance Misuse Treatment Needs Assessment (2019) available at https://docs.google.com/document

[35] B&NES JSNA Mental Health and Illness pages, available at https://www.bathnes.gov.uk/services/your-council-and-democracy/local-research-and-statistics/wiki/mental-health-and-illness

found that 72% (802) parents in these services had experienced mental health problems (as defined by individual services).[36]

Public Health England produce area-based assessments providing estimates of maternal mental health problems during pregnancy and around birth. The table below illustrates this data. [37]

In B&NES 1682 women gave birth in 2017 data source HES data via NHS digital	
Estimated number of women with postpartum psychosis	5
Estimated number of women with chronic SMI	5
Estimated number of women with severe depressive illness	55
Estimated number of women with mild-moderate depressive illness and anxiety (lower estimate)	170
Estimated number of women with mild-moderate depressive illness and anxiety (upper estimate)	255
Estimated number of women with PTSD	55
Estimated number of women with adjustment disorders and distress (lower estimate)	255
Estimated number of women with adjustment disorders and distress (upper estimate)	505

Whilst this gives some suggestion of the burden of mental health illness during the perinatal period, need cannot be quantified by simply adding the counts together as women may experience multiple mental health challenges. Also, this is looking specifically at the population of women giving birth in 2017. Childbirth is a time of risk for experiencing mental health problems. It highlights the need for Early Help in the antenatal and post-natal period to enable rapid detection of concerns, and implementation of support for families. Whilst no information on the wellbeing of fathers during pregnancy and early years is presented, a father's mental health will impact the family need for Early Help.

During the formation of the B&NES, Swindon and Wiltshire (BSW) All Age Mental Health Strategy pathways into services were reviewed and a greater understanding of the lower level mental health issues around the time of pregnancy were understood. The birth rate for the B&NES area is approximately 1800 per year suggesting that up to 90 women per year may need support from the specialist community perinatal mental health service (AWP), whilst a further 270 may have mild to moderate needs. Many of these women will be adequately supported by family, friends, midwives and health visitors.

During the Maternity Pathway review, commissioners and B&NES CCG clinical leads identified a gap in terms of responding to mild and moderate perinatal mental health needs. Women who were unable to access specialist community service were often referred 'back' to their GPs. On 15th March 2018, B&NES CCG agreed to pilot a perinatal service to increase access to mental health support. The pilot created a coherent and coordinated service offer delivered by a collaboration of voluntary sector providers, including Bluebell Care, in partnership with Health Visiting, Maternity and

[36] Natalie Urry-Mackay (2017) Toxic/ Complex Trio Profile, available at https://www.bathnes.gov.uk/sites/default/files/siteimages/Your-Council/Local-Research-Statistics/v3_-toxiccomplex_trio_profile_exectuve_summary_for_the_jsna.pdf

[37] Public Health Profiles, B&NES Mental Health in health in pregnancy and infant file:///C:/Users/wattleS/AppData/Local/temp/chimat-Mental_health_in_pregnancy_and_infants-E06000022.pdf

Children's Centre Services. This illustrates the interaction between the Early Help offer, and services provided by other services such as mental health.

4.4.3 Domestic abuse

Exposure to domestic abuse causes harm. This is illustrated later through domestic abuse information from the JSNA. 66% of child protection cases in B&NES in 2014-15 cited domestic violence as a risk factor.[38]

The data in the graph below demonstrates the number of 18-year olds in B&NES recorded by the police as either being a victim, offender or witness of domestic violence.[39]

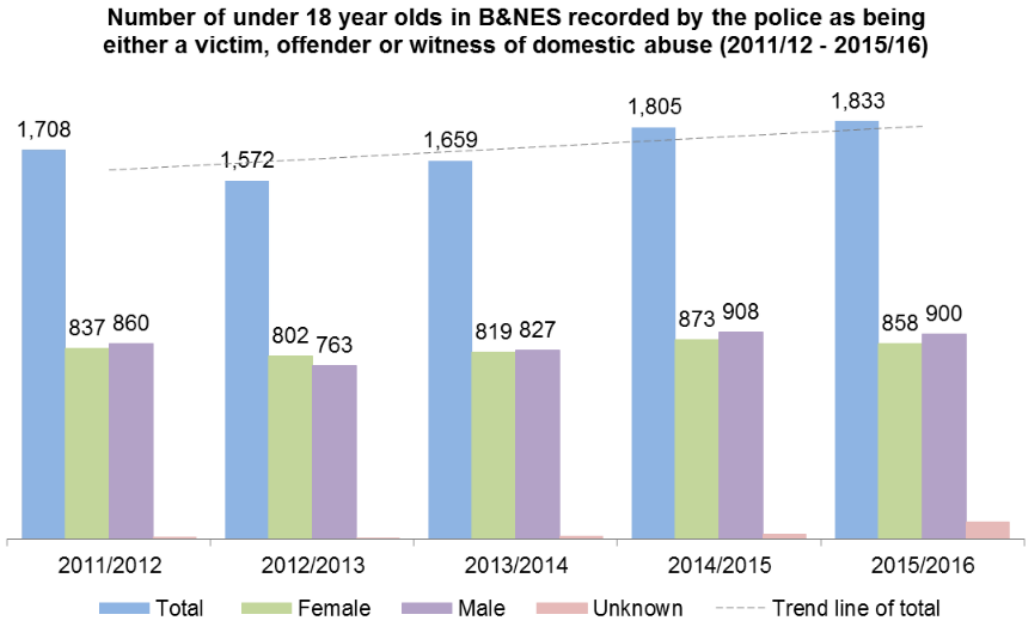


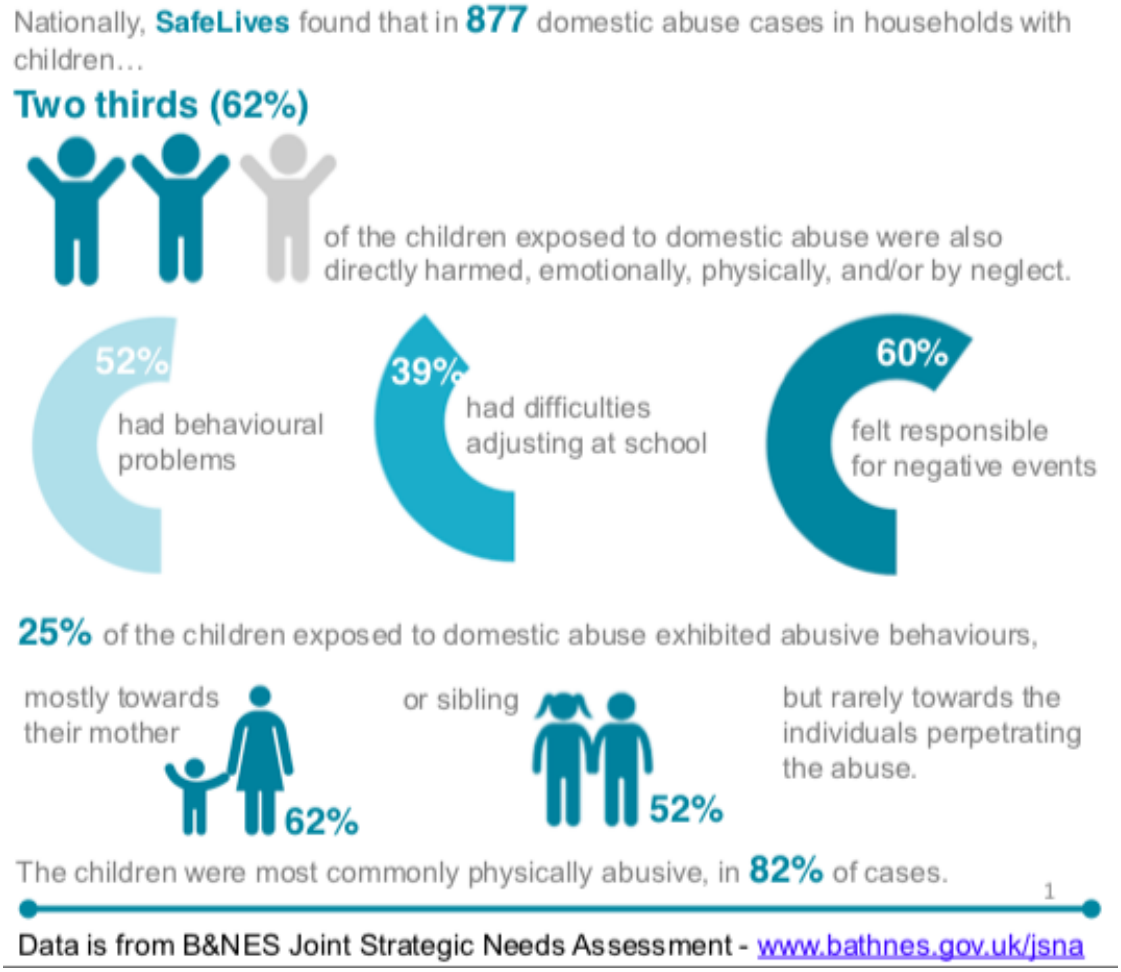
Figure 1: Number of under 18 year olds in B&NES recorded by the police as being either a victim, offender or witness of domestic abuse (2011/12 - 2015/16)* [12]

*Please note - Caution needs to be applied to these figures as the police have recently gone through a change of system and are still working on data quality.

Being exposed to domestic abuse is detrimental to children's health and wellbeing. We know that children who are exposed to domestic abuse are at increased risk of being harmed as a result of this. This exposure also impacts children's functioning in the wider context such as at school, and can present as behavioural problems, difficulty adjusting and a sense of responsibility for negative events. Below illustrates national data from SafeLives looking at the impact of domestic abuse in a sample of 877 domestic abuse cases.

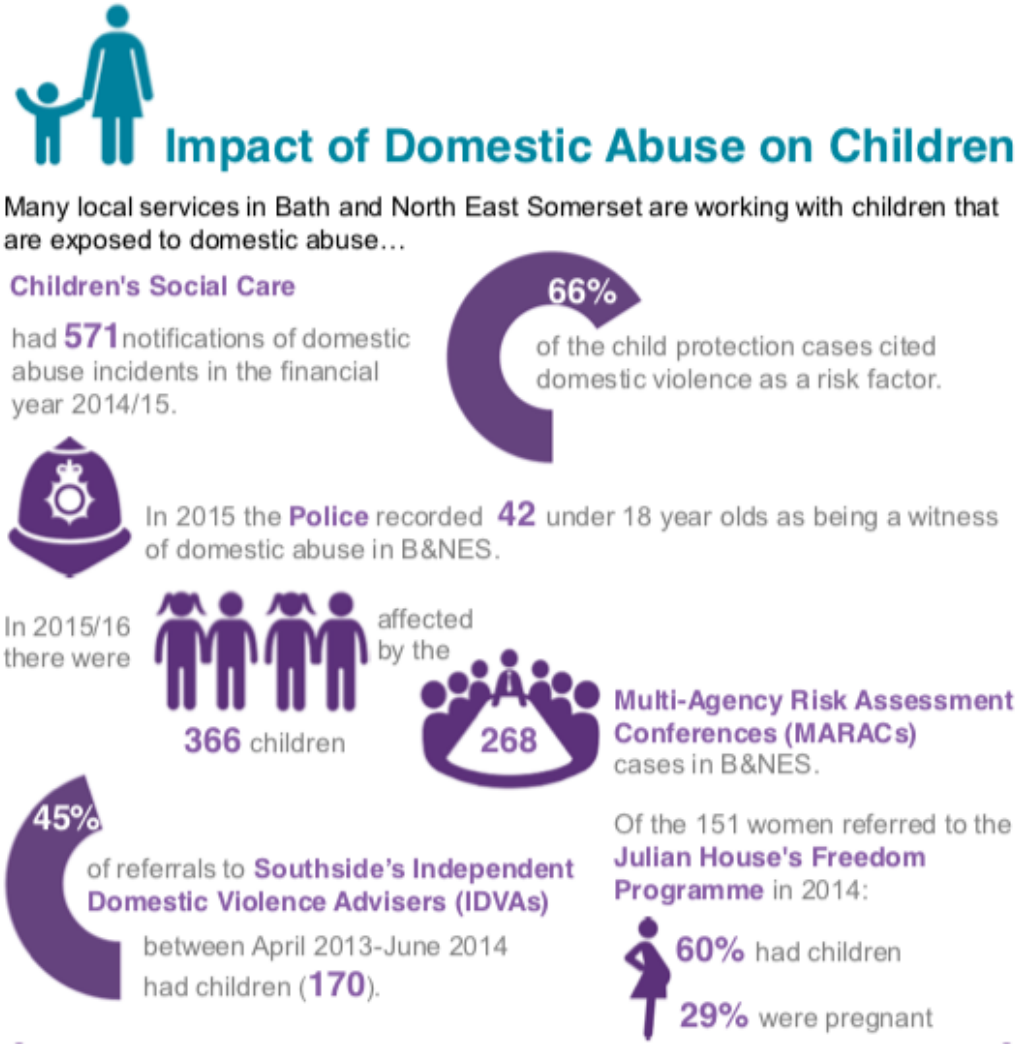
[38] B&NES JSNA Children Exposed to Domestic Abuse, available at https://www.bathnes.gov.uk/services/your-council-and-democracy/local-research-and-statistics/wiki/children-exposed-domestic

[39] B&NES JSNA Children Exposed to Domestic Abuse, available at https://www.bathnes.gov.uk/services/your-council-and-democracy/local-research-and-statistics/wiki/children-exposed-domestic



In B&NES there are several services that work with victims of domestic abuse. The infographic below provides an insight into the number of children this affects. It is important to recognise that this is the tip of the iceberg. Social care, the police and services for victims often see the worst cases, where risk of harm has become so great that crisis intervention is needed. Within the population there will be many more children exposed to lower levels of domestic abuse with associated negative impacts.

Domestic abuse across B&NES represents an area where more up to date data would support this work. However, within the timeframe and scope of this need assessment, gaining more data has not been possible.



Domestic abuse is a key factor in the need for Early Help. Where parents experience the interpersonal trauma of domestic abuse impacts will be seen across areas of their lives. Children and young witnessing domestic abuse may themselves be traumatised with the results of trauma shaping their development. In the B&NES problem profile for serious violence it states that,

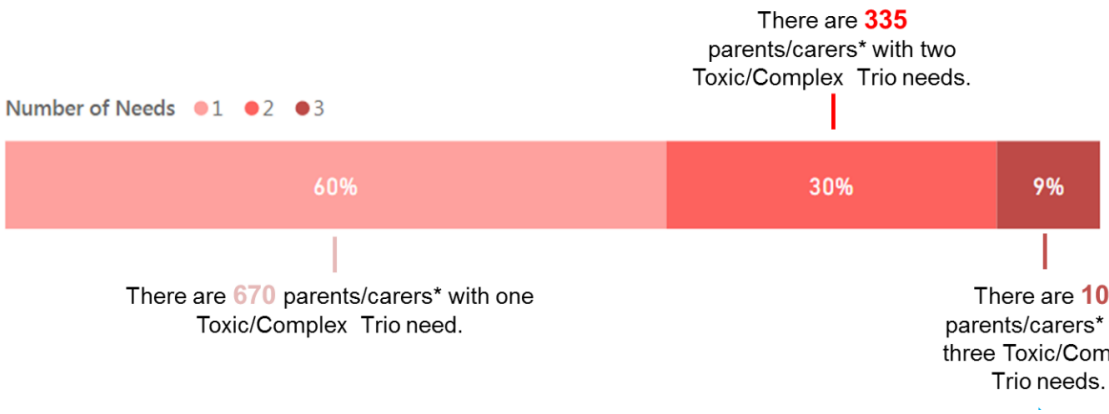
"Domestic abuse is **the most common circumstantial flag** for serious violent offences, and domestic violent offences have a particular profile requiring attention".[40]

This report also highlights that domestic abuse incidents are highly concentrated in areas of socioeconomic deprivation, which strengthens the narrative of needs concentrating in areas of deprivation.

4.4.4 Toxic Trio

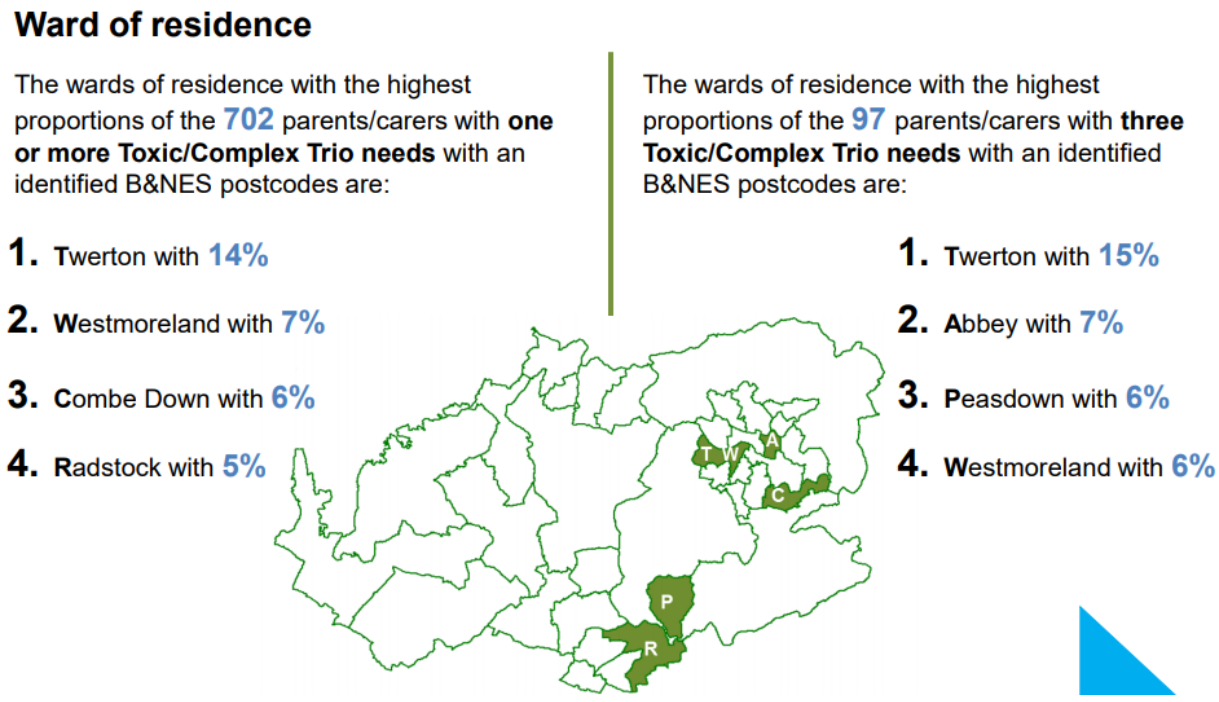
In 2016/17 primary research was carried out in B&NES which involved contacting 22 services from whom data was collected on toxic trio prevalence, among services users, who were parents.[41]

[40] Crest (March 2020), Problem profile: Serious violence in B&NES



Evidence suggests that children living exposed to the toxic trio are much more likely to require social care input.

The toxic trio work can be further understood through the distribution of needs across B&NES. The infographic below supports the earlier narrative that deprivation is associated with need and, whilst needs can emerge across the population, those who experience deprivation often experience more, or higher levels.



[41] Natalie Urry-Mackay (2017) Toxic/ Complex Trio Profile, available at https://www.bathnes.gov.uk/sites/default/files/siteimages/Your-Council/Local-Research-Statistics/v3_-toxiccomplex_trio_profile_exectuve_summary_for_the_jsna.pdf

4.5 Those showing early signs of neglect

When families are struggling, for whatever reason, neglect of children's needs is a sign that help is required. Within this term 'neglect' is a spectrum of severity. In B&NES there is multi-agency acknowledgement of the impact of neglect on children. Local data allows us to understand the number of children being referred to statutory services due to neglect. In 2017/18 neglect was given as the reason for a request for service to Council's Social Care on 495 occasions. What is lacking is data on the prevalence of neglect that does not reach the threshold for social care but reaches the threshold for early help. The reinstatement of the early help audit group may provide an opportunity in the future to address this data gap.

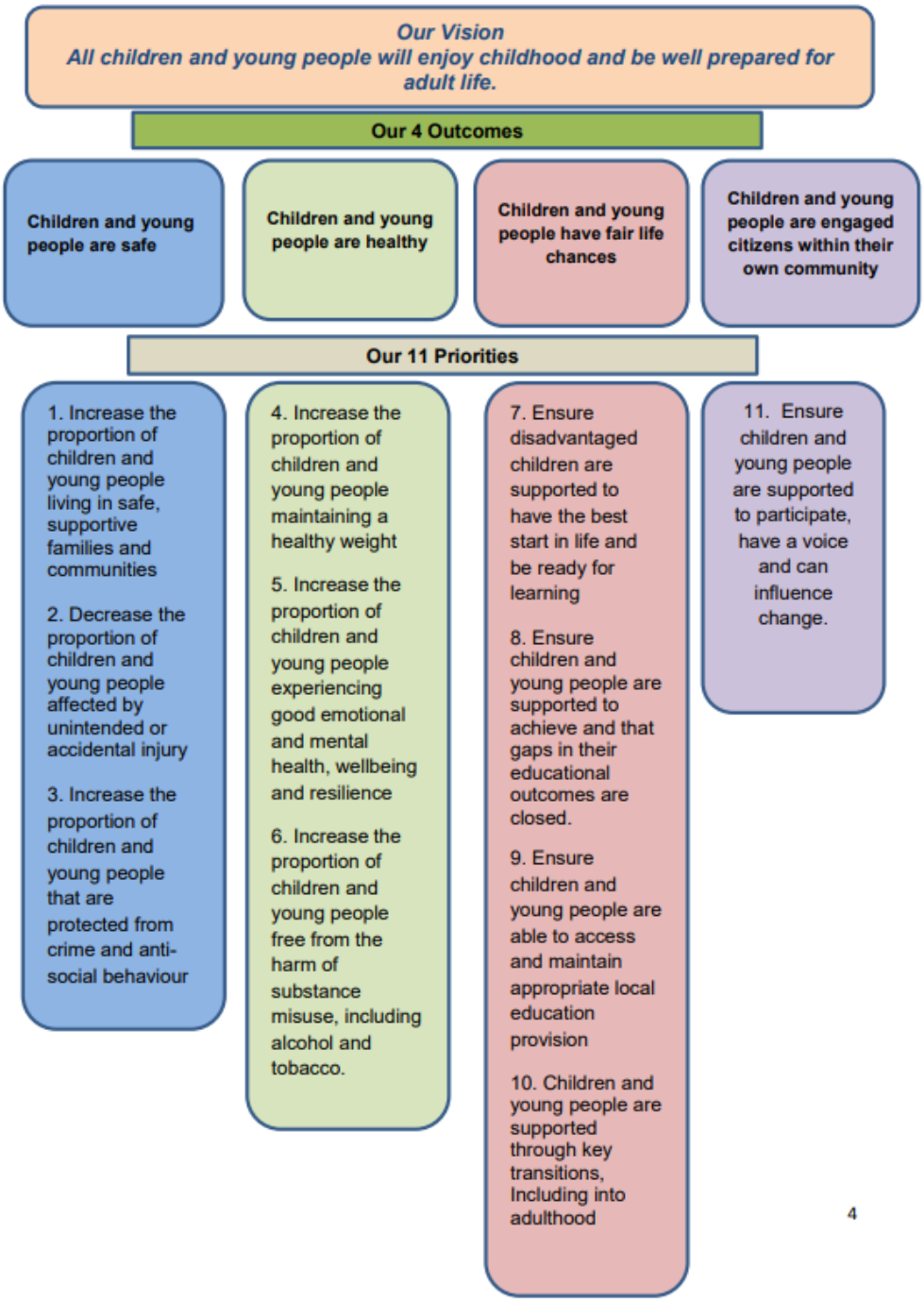
Within the B&NES Multi Agency Neglect Strategy the following regarding the prevalence of neglect is noted:[42]

- Since 2002 neglect has consistently been the most common reason for being subject to a child protection plan (CPP) in England and Wales as reported by the NSPCC (How safe are our children, 2016). For 2015, 45% of CPPs in England were under the category of neglect, this has shown a general upward trend from approximately 35% since 2002.
- In 2015-16 59% of child protection plans in Bath & North East Somerset were due to neglect. Similarly, at the end of Oct 2016, 55% of CPPs were due to neglect.
- Neglect is also commonly seen as a feature of children's serious case reviews (SCRs); there was evidence of neglect in 62% of recent SCRs (Pathways to harm, pathways to protection: A triennial analysis of serious case reviews 2011 to 2014, 2016). In a small number of these SCRs, extreme neglect can be directly linked to the death of children.

[42]B&NES Multi Agency Neglect Strategy available at https://www.bathnes.gov.uk/sites/default/files/sitedocuments/Children-and-Young-People/ChildProtection/lscb_neglect_strategy_v5.pdf

5 Local Strategic Context

5.1 B&NES has a Children and Young People's (CYP) Plan[43] which outlines the vision, outcomes and priority areas to implement when working with children and young people. Strategies that relate to children and young people have embedded these priorities to ensure a coherent approach across work undertaken within the council and partner agencies.



[43]B&NES Children and Young People's Plan available at https://beta.bathnes.gov.uk/sites/default/files/2020-01/children_and_young_peoples_plan_2018-2021.pdf

5.2 B&NES Multi Agency Neglect strategy 2017[44]

Neglect describes a persistent failure to meet a child's needs. It can occur in domains of physical or emotional health and has significant impacts on a child's ability to develop and flourish. Neglect has consistently been the most common reason for child protection plans (CPPs) in B&NES with 55% of CPPs occurring as a result of neglect in 2016. The Neglect Strategy outlines key priority areas and provides a coordinated approach to addressing neglect. These are underpinned by the vision of children and young people having safe, healthy lives with equal life chances.

Risk factors in the strategy are categorised into three areas as outlined in the table below.

Child risk factors	Parental risk factors	Wider risk factors
Special educational needs and disability	Poor mental health	Poverty
Behavioural problems	Drug and alcohol substance misuse	Unemployment
Chronic ill health	Domestic abuse	Poor social support
Young carers	Parents' own exposure to maltreatment	
	Lack of experience of positive parenting	

Early Help is one of the six guiding principles in the strategy. Early identification of signs and symptoms of neglect facilitates the implementation of the right help, at the right time for individuals and families.

5.3 B&NES Shaping Up! Healthy Weight Strategy 2015-2020[45]

The Shaping Up strategy identified priorities under three themes

- Helping people stay healthy
- Improving the quality of people's lives
- Creating fairer life chances

The strategy describes the groups most likely to be at risk of obesity including looked after children, those living in the most deprived areas, children and adults with learning disabilities and adults with depression and other common mental health problems.

Both prevention and targeted help are outlined in the strategy as ways of improving healthy weight. These are described across the life course.

[44] B&ES Multi Agency Neglect strategy, available at https://www.bathnes.gov.uk/sites/default/files/sitedocuments/Children-and-Young-People/ChildProtection/lscb_neglect_strategy_v5.pdf

[45] B&NES Shaping Up! Healthy Weight Strategy, available at https://www.bathnes.gov.uk/sites/default/files/siteimages/PublicHealth/shaping_up_healthy_weight_strategy_2015_-_2020.pdf

The effects of obesity on children and young people include:

- Emotional and behavioural
- Stigmatisation
- Bullying
- Low self esteem
- Impacts on school attendance
- Educational attainment

5.4 B&NES Parenting strategy 2016-2018[46]

The vision for children and young people in B&NES is that they are safe, healthy and have equal life chances. In the Parenting Strategy this is translated into an ambition that,

"Parents take responsibility for understanding and meeting their children's needs, enjoying their childhood with them and preparing them for adult life"

The strategy was underpinned by a needs assessment which highlights a range of factors that contribute to pressure felt by parents.

- Parental mental health
- Domestic abuse
- Parental drug and alcohol misuse
- Family offending or antisocial behaviour
- Housing
- Family debt
- Parent's own experiences as children

Many of these factors are described in other sections of this needs assessment. Parents own experiences in childhood are not described at a local level. However, research of an adult cohort in Wales suggested that 23% of adults had experienced verbal abuse by the age of 18, 17% had experienced physical abuse and 10% had experienced sexual abuse.[47] Whilst cohorts vary and thus these proportions may not be directly applicable to adults in B&NES, it provides an insight into how childhood trauma can influence parenting capacity.

In B&NES there has been an increasing focus on ensuring the whole voice of the family is heard including fathers.

[46] B&NES Parenting Strategy available at https://www.bathnes.gov.uk/sites/default/files/sitedocuments/Children-and-Young-People/StrategiesPoliciesPlanning/bnes_parenting_strategy_2016-18.pdf

[47] Public Health Wales NHS Trust (2015), Adverse Childhood Experiences available at http://www2.nphs.wales.nhs.uk:8080/PRIDDocs.nsf/7c21215d6d0c613e80256f490030c05a/d488a3852491bc1d80257f370038919e/$FILE/ACE%20Report%20FINAL%20(E).pdf

5.5 B&NES Homelessness Strategy 2014-2018 [48]

B&NES Homelessness Strategy outlines key priorities relating to the prevention of homelessness. Those that relate to children and families include:

- Identifying people most at risk of domestic violence as this is the third most common reason for women with children to become homeless
- Improving housing advice and support for those living in rural areas
- Provide suitable temporary accommodation and stop using bed and breakfasts

Having a safe and stable place to live is vital for children and families. A lack of stability can be a constant source of stress for parents and families, affecting their ability to function and flourish. Further to this, poor standards of housing can negatively impact the health of children making them more at risk of certain infections and conditions such as asthma.

5.6 B&NES Suicide Prevention Strategy 2020-2023[49]

The Suicide Prevention Strategy has a vision which covers the following areas:

- Reducing suicide and self-harm
- Ensuring that no resident will think that suicide is their only option
- Tackling the stigma associated with suicide and developing community conversations about suicide
- Building community resilience
- Supporting those who are affected by suicide

Within this work there are high risk groups identified. The strategy also highlights where efforts should be targeted in terms of improving mental health and include:

- Children and young people
- Users of drug and alcohol services
- Women around the time of childbirth
- People in receipt of benefits

5.7 B&NES Local Safeguarding Board Youth @ Risk Strategy 2019-2022[50]

The Youth @ Risk strategy is founded on a vision for all children and young people and their families and communities to be safe from criminal exploitation. This strategy considers exploitation

[48] B&NES Homeless Strategy available at https://democracy.bathnes.gov.uk/documents/s28282/Appx%201%20Draft%20Homelessness%20Strategy%202014-2018.pdf

[49] B&NES Suicide Prevention Strategy available at https://www.bathnes.gov.uk/services/public-health/guide-programmes-strategies-and-policies/suicide-prevention-strategy-2012

[50] B&NES Youth @ Risk strategy available at https://www.safeguarding-bathnes.org.uk/sites/default/files/youth_risk_strategy_2019-22.pdf

'in the round' whilst being underpinned by six individual protocols addressing each area in more detail.

1. Child Sexual Exploitation

2. Radicalisation

3. Child Criminal Exploitation, including involvement in county lines, gangs, human trafficking, modern slavery and labour exploitation

4. Serious Youth Violence

5. (Going) Missing from Home, Care or School

6. Harmful Sexual Behaviour

5.8 B&NES Domestic Abuse Strategy 2018-2021

The B&NES Domestic Abuse Strategy has a vision of seeing B&NES free of domestic abuse through a robust, coordinated response in breaking the cycle of relationship violence and abuse. The abuse includes, but is not limited to:

- Psychological
- Physical
- Sexual
- Financial
- Emotional

The strategy outlines national and local data which helps inform the strategy and can be found following by following the link in the footnotes.[51]

5.9 BSW CCG All Age Mental Health Strategy

A B&NES, Swindon and Wiltshire (BSW) all age mental health strategy has been co-produced to transform how we deliver mental health support to better meet the needs of local people. There is a shared enthusiasm to enhance lives and wellbeing with a shared commitment that no-one should be left in need. Regardless of personal circumstances, age or individual need, our strategic commitment is to deliver the best mental health care and support. Local people should be confident that the challenges they face will be heard and that they will be offered appropriate help and support within their local communities with timely access to more specialist provision if required.

The draft strategy has been co-created with people with lived experience, their families, carers and supporters along with our partners including third sector and statutory organisations.

[51] B&NES Domestic Abuse Strategy 2018-2021 available at https://www.bathnes.gov.uk/services/neighbourhoods-and-community-safety/crime-prevention-and-community-safety/domestic-violence

6 Indicators of need

Population level data provides some indication of outcomes for children and families in B&NES and facilitates a comparison to similar local authorities and a comparison to England. A table of these indicators is included in appendix 1. Many of these measures could be considered proxy indicators of the need for Early Help, for example in B&NES, in 2017/18 there were 549 episodes of people aged 10-24 presenting to A&E with self-harm. This was higher than similar areas, 442 and the England value of 421. Other indicators have already been referred to earlier in this document.

These population level indicators are perhaps most useful when they can be shown across areas within B&NES as this allows an understanding of inequalities. The table on page 32 shows the indicator of child poverty (IMD 15) across areas in Bath.[52] Note the distribution with 32.2% of children 0-15 in Twerton thought to be living in poverty, compared to 2.9% in Bathwick.

The Income Deprivation Affecting Children Index (IDACI) measures the proportion of all children aged 0 to 15 living in income deprived families. It is a subset of the Income Deprivation Domain which measures the proportion of the population in an area experiencing deprivation relating to low income.

Table: Child Poverty, English Indices of Deprivation 2015, IDACI 2015

[52] Public Health England Local Health available at https://fingertips.phe.org.uk/profile/local-health/data#page/6/gid/1938133180/pat/101/par/E06000022/ati/8/are/E05001935/iid/93094/age/169/sex/4/cid/4/page-options/ovw-tdo-0_car-do-0

Area	Count	Value	95% Lower CI	95% Upper CI
England	2,016,120	19.9	19.9	19.9
Bath and North East Somerset	3,607	12.1	11.7	12.5
Twerton	386	32.4	29.8	35.1
Southdown	242	23.7	21.2	26.4
Radstock	267	21.7	19.5	24.1
Keynsham South	168	18.4	16.0	21.0
Combe Down	196	18.1	16.0	20.6
Odd Down	185	17.7	15.5	20.1
Weston	174	17.2	15.0	19.6
Keynsham North	161	16.6	14.4	19.0
Kingsmead	87	14.4	11.8	17.4
Abbey	47	13.2	10.0	17.1
Oldfield	102	13.0	10.8	15.6
Bathavon West	47	12.8	9.8	16.6
Midsomer Norton Redfield	110	12.3	10.3	14.6
Westfield	149	12.1	10.4	14.0
Peasedown	153	11.4	9.8	13.2
Midsomer Norton North	133	11.1	9.4	13.0
Paulton	110	10.4	8.7	12.4
Walcot	99	9.9	8.2	11.9
Farmborough	35	9.6	7.0	13.0
Westmoreland	60	9.6	7.5	12.1
Timsbury	40	9.1	6.8	12.2
Mendip	45	8.9	6.7	11.6
Lambridge	87	8.3	6.8	10.2
Lansdown	53	7.3	5.6	9.4
Publow and Whitchurch	27	7.2	4.9	10.2
Bathavon North	84	6.8	5.5	8.3
High Littleton	35	6.3	4.6	8.7
Keynsham East	52	5.9	4.5	7.6
Widcombe	41	5.8	4.3	7.7
Newbridge	63	5.7	4.5	7.3
Clutton	27	5.7	3.9	8.1
Lyncombe	52	5.2	4.0	6.8
Chew Valley North	19	4.6	3.0	7.1
Chew Valley South	18	4.0	2.5	6.3
Saltford	22	3.4	2.2	5.0
Bathavon South	19	3.1	2.0	4.8
Bathwick	11	2.9	1.6	5.2

Population indicators as area profiles

Appendix 2 shows area profiles for Twerton, Southdown, Radstock and Lansdown to help contextualise indicators across employment, health and education. A snapshot of these indicators is demonstrated in the table below. All these indicators were taken from the most recent data on the Public Health England Local Health tool where the exact methodology behind measure is reported.[53]

	Child Poverty	Unemployment (JSA claimants)	Children with excess weight in reception (%)	Child development aged 5 (%)	GCSE achievement (%)
Bath	12.1%	1.6%	22.7%	62.7%	62.1%
England	14.6%	1.9%	22.4%	60.4%	56.6%
Twerton	32.4%	4.7%	26.4%	55.4%	29.5%
Southdown	23.7%	2.6%	29.2%	43.5%	44%
Radstock	21.7%	2.7%	30%	53.5%	47.5%
Bathwick	2.9%	0.3%	20.3%	66%	90%

In B&NES there is a significant attainment gap between those who live in the most affluent and most deprived areas. This is articulated in B&NES JSNA in the below points:[54]

- In 2015 in B&NES 83% of socio-economically disadvantage key stage 2 pupils achieved level 4+ in reading, compared to 94% of other pupils, 76% achieved this in writing compared to 91% of other pupils, and 77% in mathematics compared to 92% of other pupils.
- The key stage 2 level 5 + attainment gap between socio-economically disadvantage pupils and others in B&NES in 2015 widened compared to 2014 in all three subjects, from 24% to 27% in reading, 19% to 24% in writing and 17% to 20% in mathematics.

[53] Public Health England Local Data tool available at https://www.localhealth.org.uk/#bbox=370781,169025,12172,8972&c=indicator&i=t1.child_dev_age_5&selcodgeo=E05001939&view=map15

[54] B&NES JSNA Educational Attainment, available at https://www.bathnes.gov.uk/services/your-council-and-democracy/local-research-and-statistics/wiki/education-attainment

- In 2015, overall the proportion of pupils who achieved 5A* - C GCSEs including English and mathematics in B&NES (62%) remained above the South West (57%) and national (56%) averages.
- In B&NES in 2015 36% of socio-economically disadvantage pupils achieved 5A* - C GCSEs including English and mathematics compared to 69% of other pupils. However, the gap between socio-economically disadvantaged pupils and other pupils had narrowed in 2015 by 8% compared to 2013.
- In B&NES in 2015 74.2% of the A-Level students achieved 3 or more A-Levels at A*-E, this was lower than the national achievement level of 78.7%.

7. Local needs across the life course for children and families

The table below illustrates the identified needs across the life course which can be addressed by the early help offer

Type of Needs	First 1001 Days (pre-birth – age 2) and pre-school ages 3/4	Ages 5 – 11	11-19 (up to 25 with SEND)	Parents/Carers
Access to mental wellbeing information and support		√	√	√
Access to substance misuse identification and support			√	√
Access for support for living with domestic abuse			√	√
Access to support for living with parental conflict		√	√	√
Access to support for family breakdown	√	√	√	√
Access to support for bereavement/ loss	√	√	√	√
Access to housing / homelessness / At risk of eviction advice and support	√	√	√	√
Access to debt and financial advice	√	√	√	√
Access to support to minimise impact of poverty	√	√	√	√
Access to support to get into Education, Employment or Training (NEET)			√	√
Access to support to address worklessness				√
Access to information advice and support for Special Educational Needs and Disabilities	√	√	√	√

Access to support to avoid or address poor transitions	√	√	√	
Access to support for carers		√	√	√
Access to opportunities to reduce social isolation		√	√	√
Access to services to prevent avoidable poor health – e. g stop smoking, weight management, exercise on prescription	√	√	√	√
Access to services to reduce risk taking behaviour		√	√	√
Access to support for those missing from education	√	√	√	
Access to opportunities to reduce Anti-social behaviour / criminal activity / radicalisation	√	√	√	√

8. Local services mapped to needs – see Appendix 3

Appendix 3 illustrates the current provision of early help services to meet the identified needs which were mapped by the Early Help and Intervention Sub-group. These include services commissioned and directly delivered but does not reflect a complete picture of the additional support available from the wider third sector.

9. Early Help / Social Care Thresholds, Processes and Pathways

1. The Early Help Offer in Bath and North East Somerset

Early Help is underpinned by the principle of "the right help, at the right time, by the right service".

The B&NES Community Safety and Safeguarding Partnership Threshold for Assessment guidance explains the different levels below through examples of needs, risks and impact and should be consulted when deciding what level of support is needed to meet emerging needs to prevent them escalating.

Examples of needs are across levels 1 – 5, with 1 being where needs are met by universal services and 5 being at risk of significant harm and the need for statutory services.

Level 1 – Universal Provision: Whilst every child and family has needs, much of this need within the population is met through the provision of universal services such as maternity, health visiting, schools and primary care.

Levels 2 – Additional Needs: Early Help services should be considered when a need emerges that cannot be met through universal services alone and additional single agency support is needed

Level 3 – Needs requiring support from more than one agency: where needs are likely to require a multi-agency response and need a co-ordinated programme of support through an early help assessment.

Level 4 – Complex needs and risks that require intensive and co-ordinated support: where needs are becoming more complex and require intensive support to prevent risks.

Level 5 – Statutory Provision: When needs are very complex and risks to the child and family are significant, social care intervention may be required. This may include ongoing or new support from early help services alongside social care to support a reduction in risk and to enable step down from social care.

2. Assessment of need

The needs of children and families can appear in different ways. It may be that something is noted physically, for example, a child appears dirty or hungry and shows concerning behaviour. Other factors that might trigger a concern include knowledge of a difficult circumstance, such as a parent with mental health or addiction problems. Therefore, at the point at which a need becomes apparent, an assessment is required to ascertain what the main needs are, and which agencies could help to address these. Assessments help to identify the wider context of the needs which in turn helps to determine which level of the Early Help and Social Care pathway should be followed and which agencies should be involved.

2a) Agency Assessments

Many agencies working with children and families have their own assessment. Agency assessments are the most common method particularly when only a single agency response is necessary though commissioned targeted support services often undertake their own assessments to explore and determine need across levels 2, 3 and 4.

2b) Early Help Assessments

Where needs appear more complex requiring multiple agency input then an Early Help Assessment has the potential to gather a detailed description of need. The Early Help Assessment replaced the previous Common Assessment (CAF) and enables a thorough review of needs to determine Levels 3 and 4 support required.

3. Integrated Working Team

The Council's Integrated Working Team provides support for agencies completing an Early Help Assessment (EHA). EHAs are sent to the team to be logged. The team also provide advice on which agencies may be best placed to support the needs identified but do not make onward referrals, rather they advise on the assessment process and coordinate an audit group to quality assure the assessments. If needs are identified that require another service/ agency involvement the onward referral is made from those producing the EHA.

4. Request for Service

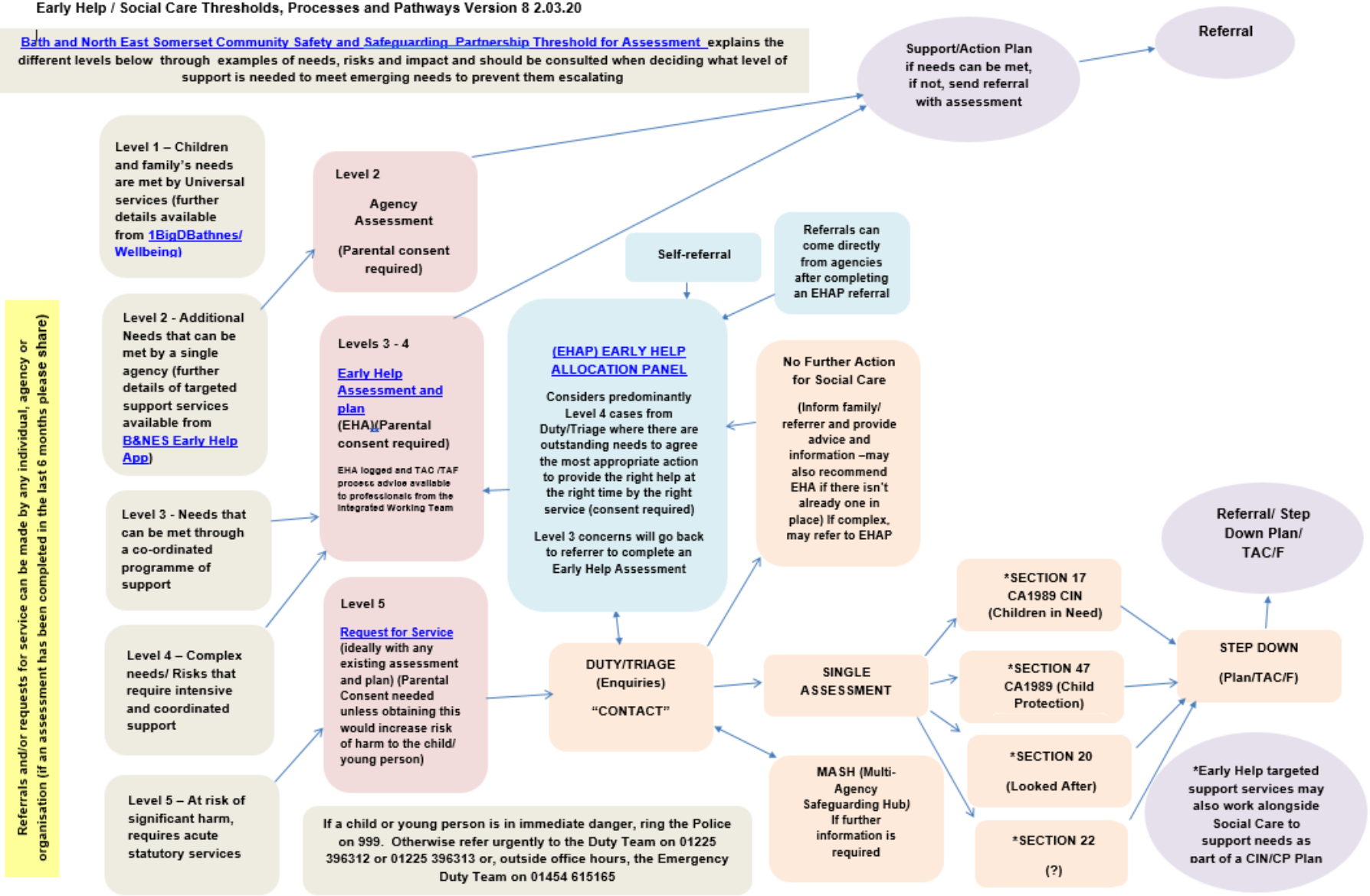
When there is concern of significant risk to the child (level 5) then a request for service can be made and sent to the Council's Social Care Duty Team. Request for service forms also include an Early Help option which can be selected if consent is obtained from families. These requests go via the Social Care Duty team directly to the Early Help Allocation Panel.

5. Early Help Allocation Panel

In addition to receiving a request for service where early help has been requested, the Social Care Duty Team may also forward any request for service that does not meet the threshold for Level 5 intervention, but where there are outstanding needs, (following consent from families) to the Early Help Allocation Panel which meets to discuss cases on a fortnightly basis to decide which services are best placed to meet the needs. The panel includes representatives from Early Help Targeted Support services and Social Care Duty.

Early Help / Social Care Thresholds, Processes and Pathways Version 8 2.03.20

Bath and North East Somerset Community Safety and Safeguarding Partnership Threshold for Assessment explains the different levels below through examples of needs, risks and impact and should be consulted when deciding what level of support is needed to meet emerging needs to prevent them escalating



10. Analysis of Early Help in B&NES

Although own agency assessments or multi agency assessments are conducted in most cases it has been challenging to use them to identify needs for early help for two reasons:

- agency assessments are held with the various individual agencies on different data collection systems so there is no centralised collection of this data
- Early help assessments have reduced greatly in number and the audit group reviews the quality of the assessments rather than collates a summary of the presenting needs

Therefore to gain a better understanding of the needs and offer of Early Help in B&NES two pieces of work have been undertaken.

1) A thematic analysis of a sample of case studies of families using early help services
2) A survey completed by referers and providers of Early Help to understand the needs, to identify perceived service gaps and gain insight into how the system is working.

10.1 Thematic analysis of case studies in early help

Providers of commissioned services produce case studies quarterly. A sample of 13 case studies from across the services were reviewed. The case studies were first read then general themes noted. Preliminary codes were applied and themes were reviewed. The analysis is presented as a logic model.

The logic model adds a valuable perspective to Early Help in the absence of quantitative data to assess needs. It also illuminates the complex nature of why Early Help is needed, and the way in which Early Help works to prevent adverse outcomes and improve the trajectory of families' and individuals lives. These outcomes are often preventative and thus no metric exists to measure them.

Of note these case studies were not collected for the purpose of this analysis, rather this was an opportunistic piece of analysis at a time where participatory work was restricted (due to Covid 19).

Tahe table below summarises the findings from a review of 13 early help case studies

Predisposing factors	Triggering factors for entrance into Early Help	Activities	Additional activities- Surrounding support	Outputs	Outcome
Changing environments (moving, going between separated parents) Relationship breakdown Parental ACE's Domestic abuse Physical illness or additional needs (child or parents) Addiction Exposure to risks such as drugs/ alcohol Social isolation Incarceration of a parent Witnessing conflict Low income Chaotic busy lifestyles Bereavement	Emotional dysregulation resulting in behavioural problems Parents feeling unable to cope Parents unable to meet child's needs Non-attendance at school Risk taking behaviour Delay in development- speech and physical Parental anxiety Acknowledgement of isolation (this could be children isolating themselves at school or parents with young children being isolated from wider social networks)	All activities started with understanding the family, their history and current situation from the perspectives of all involved Identifying the individual needs and their hopes for the future (sometimes with the trajectory if no change to help families/ individuals understand where they are) Equipping individuals/ families to create sustained change through helping them process the predisposing factors and the links between these and the trigger factors. For example, how giving children boundaries helps them know what is expected and enables them to see you as a trusted adult resulting in improved behaviour and empowered parents. This is framed by each of the services core offer	Building rapport to facilitate trust and empower families to access help Professionalism in helping people understand complex issues and gain skills Support to undertake normal activities which present challenges due to complex circumstances Providing tailored support, such as help accessing funding such as sourcing grants for school shoes Liaising with other organisations to ensure that all needs are addressed as far as possible	Improved physical markers such as improved speech or improved development. Also, skills like healthy eating supported Improved ability to cope Children feel able to engage with school/ education Parents/ individuals feel empowered and upskilled; therefore, they have not just received a service, they have been helped to make lasting change for them and their families The value of social networking is enhanced, and individuals feel more able to access support AND evidence that they feel able to facilitate peer support for others in the community	Improved social networking Improved educational outcomes Improved health and wellbeing of vulnerable groups Changed trajectory of children who may have entered the care system, with subsequent reduced pressure of social care Intergenerational benefits as children experiencing positive parenting will improve their ability to parent in the future

This analysis demonstrates the holisitc nature of Early Help in B&NES. The founding principles of Early Help are understanding families needs. These are often complex and multifaceted even in what may appear the most simple cases. When trying to describe the value of preventative services it can be a struggle to find measures that demonstrate this. The above analysis shows clear positive impacts including those related to:

- Physical and emotional deveopment
- Educational engagement
- Parenting skills
- Social networking
- Improved resilience

Further to this, individual commissioned Early Help services in B&NES have been undertaking a Theory of Change exercise which involves reflecting on and developing their own service specific logic models.

10.2 Early Help Survey

In addition to the thematic analysis a survey was designed and sent to professionals working across the Early Help system. This was focused on the providers of Early Help services and universal services who refer in. Attempts were made to also include the wider system such as those working in housing and those in the voluntary sector.

Method

A survey was developed and piloted within the Early Help Network group to refine questions and in conjunction with the councils research team. Once amendments had been made the 24 question survey monkey was cascaded out across the Early Help system to gain insight into both needs and processes. The table below demonstrates the demographics of responses.

- The survey was an opportunity to give those within the system a chance to feedback on needs, gaps and ideas for service improvement
- The survey was not intended to identify prevalence of need

Results

93 people responded and the survey had an overall completion rate of 66%.

ANSWER CHOICES	RESPONSES	
Health visiting services	6.45%	6
School nursing services	2.15%	2
Schools	30.11%	28
Police (EHAP agency)	3.23%	3
Children's centre services	3.23%	3
Family Support and Play Service	11.83%	11
Connecting families	2.15%	2
Youth connect	3.23%	3
Mentoring plus	8.60%	8
Compass	2.15%	2
Family nurse partnership	1.08%	1
Child and adolescent mental health services (CAMHS)	1.08%	1
Project 28	1.08%	1
Health visiting service UP/UPP	1.08%	1
Youth carers service	1.08%	1
other	21.51%	20
TOTAL		93

Twenty eight of the the responses were from schools. Therefore a analysis of these 28 responses was undertaken separately to gain insight into the specific experiences of this sector. This does not include school nurses.

Early Help survey results from schools

Question 2- What is your job title within the agency? Of those responding from schools 8 were head teachers, 6 were SENCOs, 5 were deputy heads, 5 were teachers and 4 had other roles.

Question 3- Which of the following do you consider yourself to be (please tick one response)? When asked if they considered themselves referrers, referrer providers or providers, 75% of respondants (21) responded they were referrers to Early Help services, 25% (7) identified themselves a referrer to, and provider of Early Help services. None identified themselves purely as providers of Early Help.

Question 4- In your role do you ever act as the Lead Practitioner (Lead Professional)? (please tick) 64% (18) answered yes, with 36% (10) answering no.

Question 5- What are the three most common presenting needs of the children you refer to Early Help Services/ provide Early Help services to?

Please note that the word clouds are all a summary of the free text responses, they do not include all verbatim response and the size of the words do not directly correlate to frequency of response.

Question 6- What are the three most common presenting needs of parents and carers you refer to Early Help services/ provide Early Help services for?

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Question 7- When you identify needs, are there services available to address these needs? 24% responded that yes there were services available to address these needs all the time. Those who did not respond "yes, all the time" were asked to select reasons for their answers.

Question 8- For any answer other than 'Yes, all the time' (please select from reasons below or use the free text box)

ANSWER CHOICES	RESPONSES	
No service for identified need	25.00%	3
No service for age of child	25.00%	3
No service in this geographical area	16.67%	2
Services exist but I cannot access them	33.33%	4
No services that meet all the needs	33.33%	4
Other (please specify)	50.00%	6
Total Respondents: 12		

Comments

"Long waiting lists"

“Schools are asking to hold TAF/TAC and services not available”

“We have received referral response that states needs can be met as part of EHCP but if concerns are raised due to home support (care) there isn’t a huge amount of intervention service available at present”

“Financial constraints”

“Cost can make it difficult to access”

“Services are available, but often frustrating. Most vulnerable families (i.e. those who struggle with engagement) tend to end in a ‘circle’ of support, being re-referred to support structures that they’ve struggled to engage with previously. This can be very off-putting for the referrer, as it can feel like you are chasing your tail, with little result at the end”

Question 9- What need(s) have you identified where there is no service to meet this need? (please write in free text box below) The answers to this question hightlighted a number of issues including safeguarding, parenting capacity and financial constraints. It was also highlighted that sometimes there is a need to extend longer term support which may not be available.
One respondent highlighted that the childs needs may stem from a parent struggling with issues such as substance misuse. In these cases the parent needs support for their issues to allow them to support their child. “Often these parent’s do not meet the criteria involved for accessing family support, leaving the school stuggling to support them themsleves, in order to support their children”.

Question 10- What would your service deliver if additional resources were available? The answers in this section varied from suggestions of practical resources that could be used for multi-agency work, to a sense that there is nothing extra that could be delivered to support parents due to no capacity.

Question 11- Which of these Early Help services do you regularly refer to?

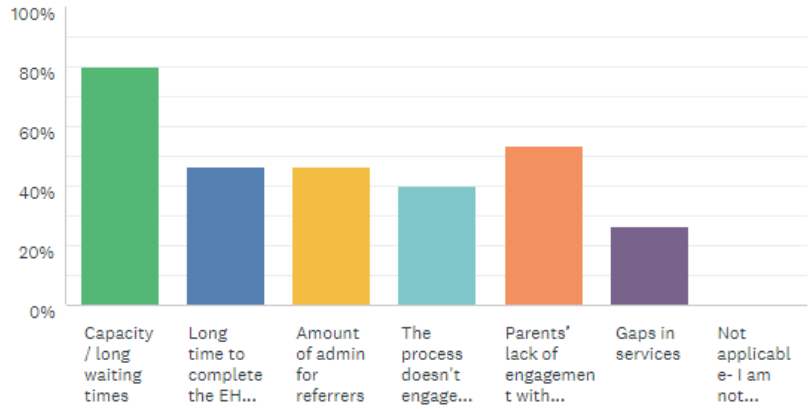
ANSWER CHOICES	RESPONSES	
Children's centre services (Bright Start and Action for Children)	33.33%	5
Family support and play service (Southside and Bath Area Play Project)	73.33%	11
Connecting Families	33.33%	5
Mentoring service for young people (Mentoring Plus)	46.67%	7
Targeted youth support (Youth Connect)	6.67%	1
Risk of offending service (Compass)	20.00%	3
Family Nurse Partnership	60.00%	9
Not applicable (provider of service only, no onward referrals)	0.00%	0
Health Visiting Service Universal Plus /Universal Partnership Plus	26.67%	4
Total Respondents: 15		

Question 13- Which of these specialist services do you regularly refer to?

ANSWER CHOICES	RESPONSES	
Not applicable (provider of service only, no onward referrals)	0.00%	0
Children and adolescent mental health services (CAMHS)	70.59%	12
Young peoples substance misuse service (Project 28)	0.00%	0
Speech and language service	100.00%	17
Young Carers Service	41.18%	7
Other	0.00%	0
Counselling and advocacy service (Off the record)	23.53%	4
Perinatal infant and mental health service	0.00%	0
Total Respondents: 17		

Question 14- Have you experienced any issues when trying to refer to Early Help services?

Answered: 15 Skipped: 13



ANSWER CHOICES	RESPONSES	
Capacity / long waiting times	80.00%	12
Long time to complete the EHA process	46.67%	7
Amount of admin for referrers	46.67%	7
The process doesn't engage parents	40.00%	6
Parents' lack of engagement with process	53.33%	8
Gaps in services	26.67%	4
Not applicable- I am not involved in referring	0.00%	0
Total Respondents: 15		

The analysis that now follows is of all the survey results and therefore represents a wider, systems view on Early Help.

Results across all respondents

Question 5- What are the three most common presenting needs of the children you refer to Early Help Services/ provide Early Help services to?

Please note that the word clouds are all a summary of the free text responses, they do not include all verbatim response and the size of the words do not directly correlate to frequency of response.

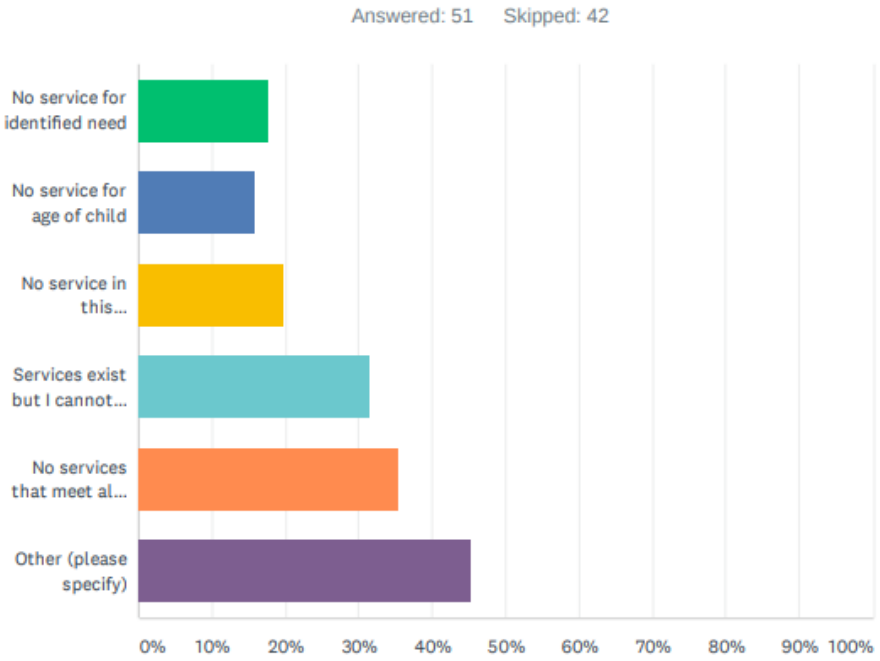
The above represents a word cloud of the codes applied to the free text responses to this question by all respondants. The most commonly occuring themes were needs relating to **behaviour**, **mental health**, **safeguarding** (often described as not meeting thresholds), **parenting** (capacity, support and skills) and **speech and language**. The breadth of the needs observed across the system span those relating to practical needs such as those stemming from finances and poverty, and needs that are quite specific such as toileting.

Question 6- What are the three most common presenting needs of parents and carers you refer to Early Help Services/ provide Early Help services to?

The same question was asked in relation to the needs of parents and carers. Whilst the themes are similar there is more of a slant towards factors that impact the whole family but may originate with the parents. For example the three aspects of the **toxic trio, mental health, domestic abuse** and **substance misuse** appeared frequently. **Poverty/ finances** and **housing** were also reported as commonly observed needs. **Parenting** and **behaviour** also remained a key feature of needs of the parents and carers.

Question 7- When you identify needs, are there services available to address these needs? Of the 63 responses received for this question just over 22% answered “yes, all the time”.

Question 8- For any answer other than "Yes, all the time" please select form the reasons below or use the free text box.



ANSWER CHOICES	RESPONSES	
No service for identified need	17.65%	9
No service for age of child	15.69%	8
No service in this geographical area	19.61%	10
Services exist but I cannot access them	31.37%	16
No services that meet all the needs	35.29%	18
Other (please specify)	45.10%	23
Total Respondents: 51		

Comments highlighted the following issues

- Services closed to referrals, long waiting lists, services at capacity
- No service that meets all the needs
- Lack of timeliness
- Access difficulties due to costs or times of day
- Safe spaces for young people to go
- Service capacity to attend multiagency meetings
- Thresholds as a barrier to accessing support or perceptions that other service should be meeting the need
- Parental engagement, including non engagement which results in the "circle of support"
- Need for therapeutically informed workers to work with parents and young people

Question 9- What need(s) have you identified where there is no service to meet this need?

In these responses specific groups were identified including:

- Dads
- Grandparents

Specific needs were identified such as:

- Support to move beyond trauma
- Autistic spectrum support
- Support with housing and welfare
- Parental mental health (considering thresholds for specialist services)
- Whole family support
- Bereavement support
- Support specifically relating to parental incarceration
- Support for unemployed young people
- Navigating parental separation

Services related issues:

- No all encompassing service
- Service capacity to help enough (unmet need remains)
- Physical spaces for services- children's centres, safe spaces for young people
- Services to provide 1 to 1 sessions particularly for children
- Services for whole family support
- Long term support
- Long waiting times
- Services at capacity
- Navigating services and referral processes
- Reduced access to services such as educational psychologists
- Access issues for parents due to cost, location or times of day
- Engagement of parents

Question 10- What could your service deliver if additional resources were available? There were 52 responses to this question many responding to the issues highlighted question 9. It was clear from the responses here that there is an appetite across the system to address the issues that have been highlighted if there were resources to do so.

Question 11 and 12 - Which of these Early Help services do you regularly refer to? Which of these Specialist services do you regularly refer to?

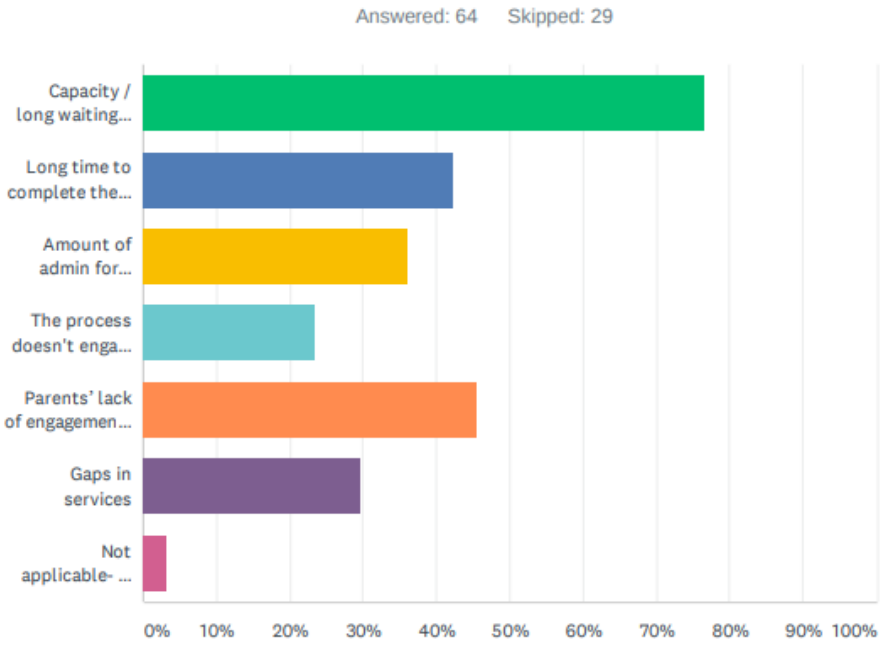
Services that are regularly referred to include:

- Children's centre services
- Family support and play services
- Connecting families
- Mentoring services (Mentoring Plus)
- Targeted youth support (Youth Connect)
- Risk of offending services (Compass)
- Family nurse partership

- Health visiting services (Universal Plus and Universal Partnership Plus)
- Children and adolescent mental health services CAMHS
- Young peoples substance misuse service (Project 28)
- Young carers services
- Counselling and advocay services (Off the Record)
- Perinatal mental health services
- Speech and language services
- School nurses
- Paediatricains
- Occupational therapy
- Educational psychology
- Dietician
- Wellbeing House
- Citizens Advice Bureau
- Trauma Recovery Centre
- Autistic Spectrum Disordersupport service
- Conciliation in CURO
- YMCA
- Bath Youth For Christ
- Independent Domestic Violence and Abuse Advisers (IDVA)
- Welfare support
- Carers Centre Blue Ice
- Bath City Farm
- Home Search
- Housing Options
- Continence service
- Separated Parents Information Programme (SPIP)
- ADDers
- Kooth
- Talking Teens
- Stepping Stones
- SEND Partnership
- Developing Health and Independence (DHI)
- REACH
- Saplings
- Black Families
- Education Support
- MIND
- Re-Ablement
- Freedom Programme
- NEST project
- Local charities for furniture and white goods
- St Johns Funding
- Future Bright
- Genesis trust

- Brighter Futures
- HENRY course
- Carers Network
- Make a Move
- Bluebell
- Willow
- Counselling
- Listening support
- Inclusion and transition funding for nursery
- Play schemes
- BOOST therapy
- Audiology
- Opthamology

Question 14- Have you experienced any issues when trying to refer to Early Help services?



ANSWER CHOICES	RESPONSES	
Capacity / long waiting times	76.56%	49
Long time to complete the EHA process	42.19%	27
Amount of admin for referrers	35.94%	23
The process doesn't engage parents	23.44%	15
Parents' lack of engagement with process	45.31%	29
Gaps in services	29.69%	19
Not applicable- I am not involved in referring	3.13%	2
Total Respondents: 64		

Themes included:

- Age limitations on some services

- Breaks in provision of interventions
- Families being turned away because they don't meet the threshold
- Capacity for certain sectors (schools particularly) to complete paperwork
- Early Help assessments take a long time (6hrs quoted in one response) and felt a waste of time
- The voluntary aspect of the process means some families don't engage

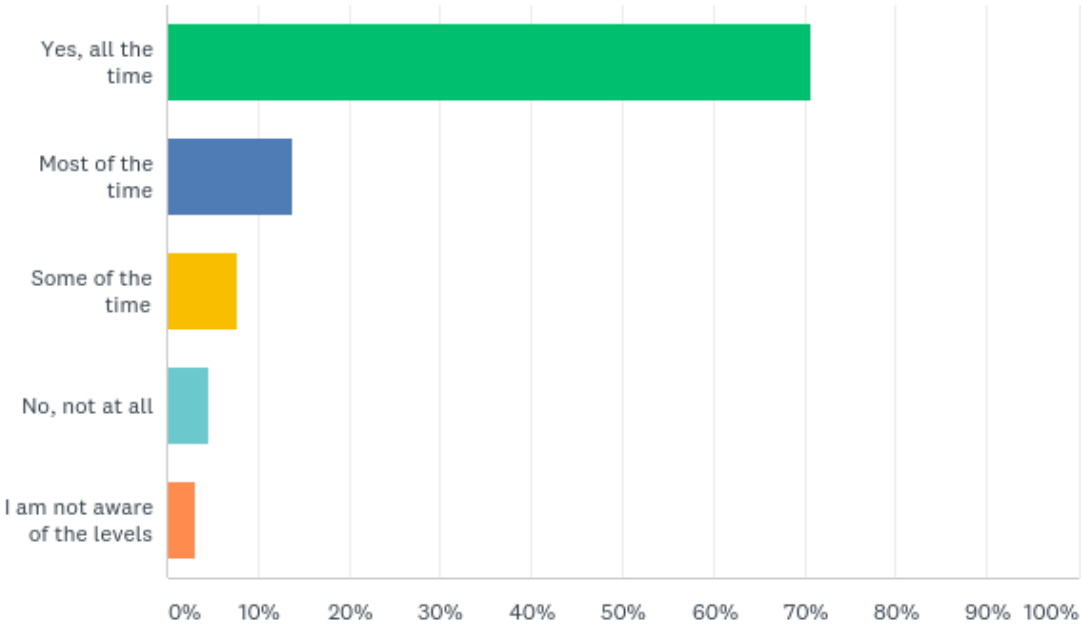
Question 15- Do you use the Early Help App to find out about local services? Of the 65 responses to this question 47% (31) people said yes, whilst 53% (35) answered no.

Question 16- What assessment does your agency use to assess need?

ANSWER CHOICES	RESPONSES	
Own agency assessment	29.23%	19
Early Help Assessment (EHA)	35.38%	23
Both an agency assessment and an EHA	29.23%	19
Assessment undertaken by another agency	6.15%	4
TOTAL		65

Question 17- Are you aware of the B&NES Community Safety and Safeguarding Partnership CSSP (previously LSCB) threshold document for level of need? Of the 64 responses to this question 81% answered yes with 19% responding no.

Question 18- Are there regular opportunities to disucss level of need with a manager or supervisor? Of the 64 responses



It was noted in a comment elsewhere in the survey that not all those involved in the Early Help process have the opportunity to discuss levels of need with a manager or supervisor, for example a head teacher in a school feels they have no formal supervision.

Question 19- Do you think your service has the resources to meet the needs of those referred to you? 51% of respondents who answered this question chose yes (33), 24% (16) answered no, and a further 24% (16) stated this question was not applicable as they were referrers. The comments highlight the expressed needs for further resources of those within the system.

“We need more funding to increase the availability”

“More desks needed in the office; more pool cars needed”

“Ideally staff would offer support to children and families at weekends; we would have a budget to run activities.”

“We now need a 'safe' room but do not have a suitable space in our mainstream school for very dysregulated children.”

“We struggle without a base”

“No space in school that is not used at all times, no spare adults, no funds for training or release of staff for training.”

“Difficult to find venues in rural areas”

“We are a 2 person team serving a community of 100's of young carers. It is unmanageable and unrealistic to expect that the needs of young carers can be fully met on this level of resource.”

“….it would be great to be able to reach more young people.”

“Yes, but it is hard to keep up with the amount of families needing our support and we would benefit from more workers to help with this.”

“There is a lot we can offer but could always support more.”

“We have volunteers who could be paid members of staff if we had the funds. This would stop waiting list or having to close due to capacity.”

“Re question 18 as a headteacher I do not have anyone to discuss referrals to - there is not supervision in education. We do end up giving early help services, dealing with Curo, getting carpets, furniture, food vouchers, providing therapy all the time but it is not what we should be doing but families would fall apart if we didn’t.”

“Lack of capacity is an ongoing issue.”

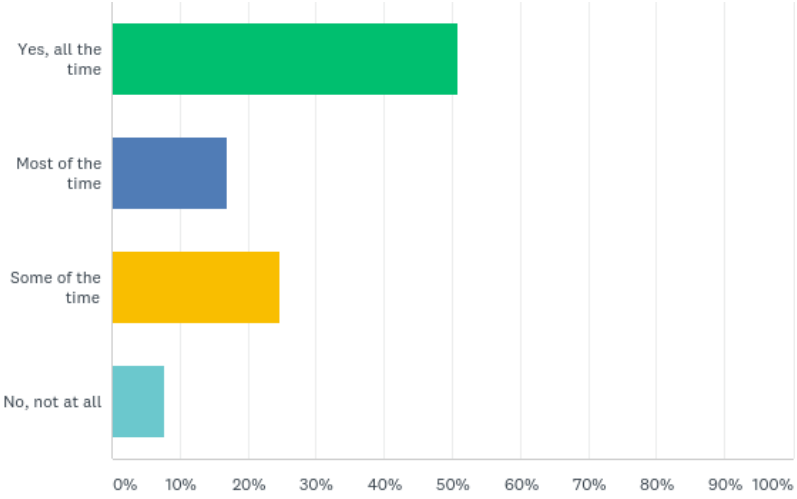
“Funding in schools has meant our SEND coordinator has less time to support teachers and we have less funding to support those who do not meet the threshold for an EHCP.”

“We buy in services such as speech and language, yoga and music therapy and so they come at a cost to the business.”

“We do our best given limited capacity, time etc”

“Yes, although better quality provided if working alongside other agencies.”

Question 20- Are you involved in the Team Around the Family TAF or Team Around the Child TAC meetings? 65 respondents



Question 21- Do you think these meetings are effective in understanding the family’s needs to inform appropriate support? 65 respondents

ANSWER CHOICES	RESPONSES	
Yes, all the time	24.62%	16
Most of the time	55.38%	36
Some of the time	15.38%	10
No, not at all	4.62%	3
TOTAL		65

Question 22- Is it clear from these meetings what the goals and outcomes will be going forward, and what difference these will make to families? Of the 65 responses to this question 74% (48) responded either “yes, all the time” or “most of the time”.

Question 23- Is there a clear plan for meeting these goals?

ANSWER CHOICES	RESPONSES	
Yes, all the time	27.69%	18
Most of the time	53.85%	35
Some of the time	10.77%	7
No, not at all	1.54%	1
Not applicable- I am not involved	6.15%	4
TOTAL		65

Question 24- Do you think you have any unmet training need that would strengthen your role in Early Help? Of the 62 responses 35% (22) answered yes to having unmet training needs. These needs fitted broadly into the following categories.

- Training on process, systems and services available (managing waiting lists and demand, threshold training, referal processes and completing paperwork)
- Training on a trauma informed approach (ACEs)
- Specific training needs (including domestic abuse training, toileting, baby massage)

There is also a wider issue of understanding the roles and responsibilities across the system which may in term facilitate multi-agency work.

Question 25- How could we further strengthen the delivery of Early Help? There were 38 free text responses to this question. The themes that emerged included the following.

Processes

- Clear processes
- Simpler paperwork that engages famlies and considers the capacity of agencies across the system
- Shorter waiting times
- Timely assistance
- Strengthen the focus on outcomes
- Strengthen multi-agency communication, including feedback and next steps
- Consider how to make the process more parent/ carer friendly

Resources

- More resources to enable the provision of more support from existing services and new services to support needs not supported currently.

Commisioning

- Longer contracts for commissioned services
- Review age range of commissioned services
- Increase capacity of existing services

Training

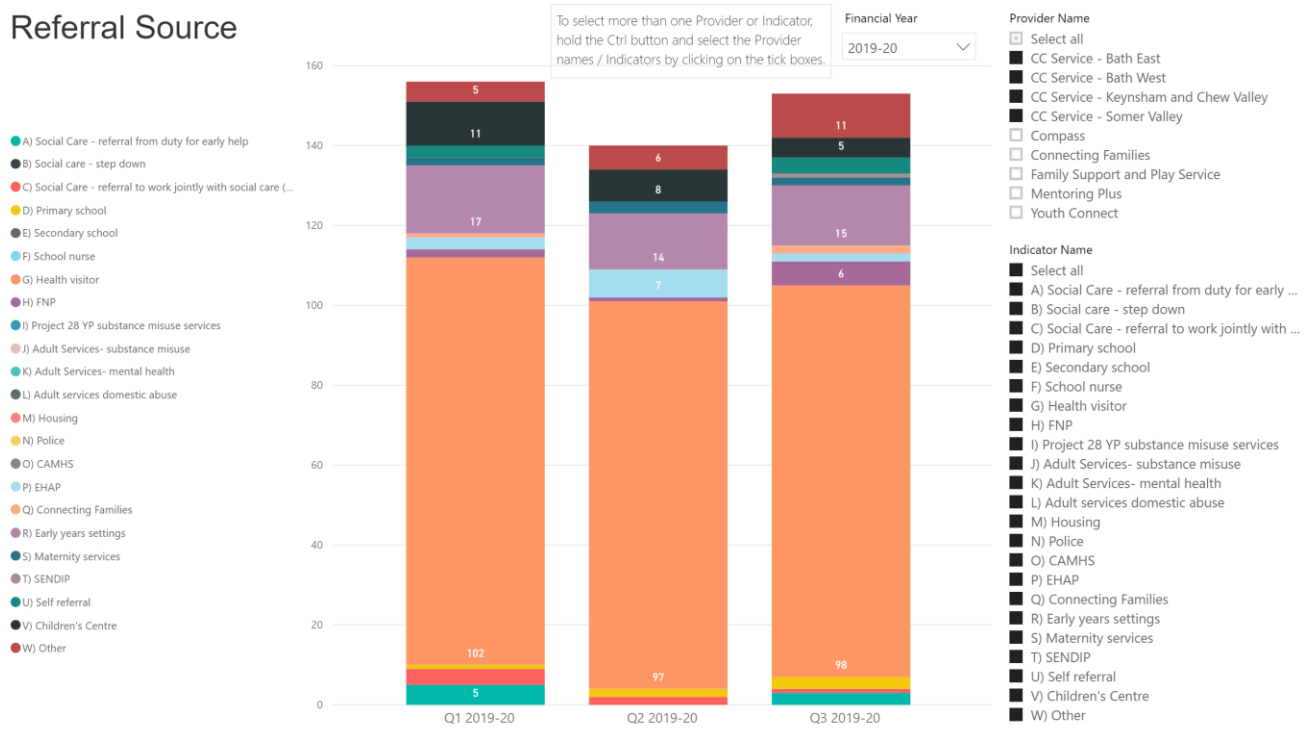
- Regular updates to professionals
- Threshold training

10.3 Targeted Early Help Services Power BI data

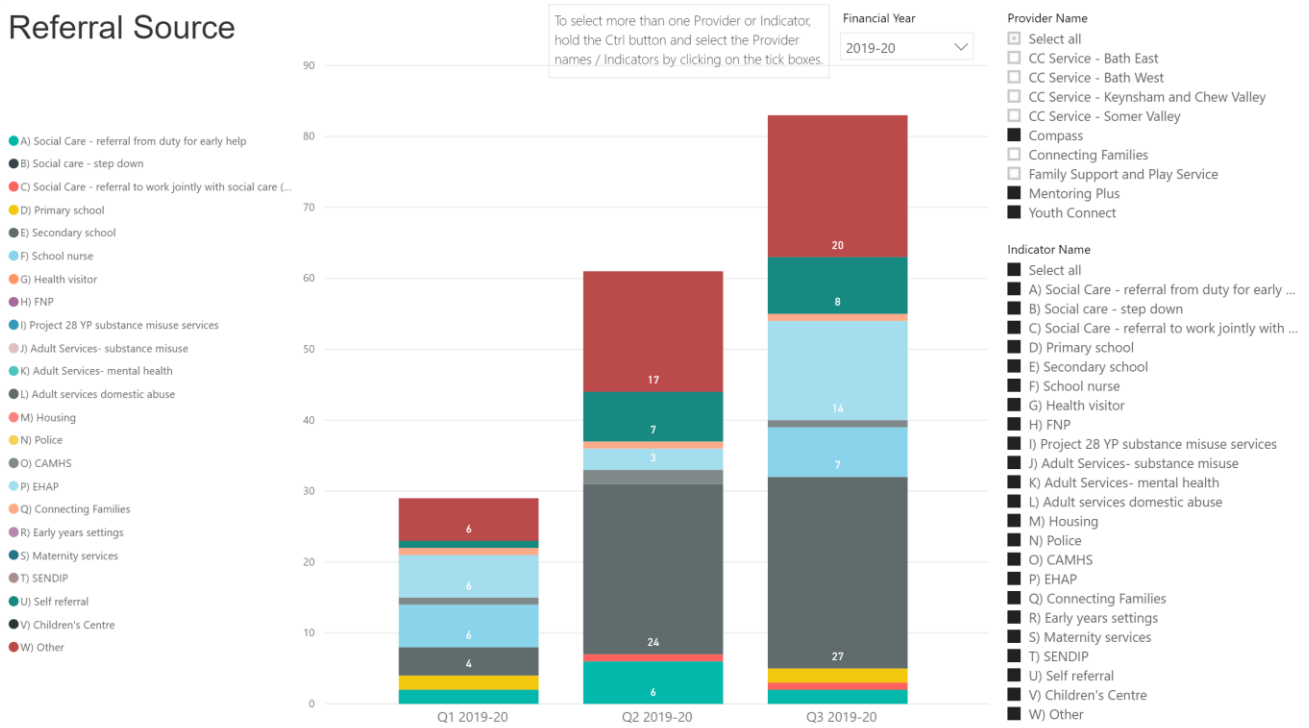
For the purpose of looking at the service data services have been grouped into three groups, Children's Centre Services (provided by Bright Start and Action for Children), Youth Services (Compass, Youth Connect and Mentoring Plus) and Family Services (Connecting Families and the Family Support and Play service provided by Southside and Bath Area Play Project - BAPP). The data has been taken from Power BI which is the data platform now being used. This is a new system and some data quality issues are still being addressed. Therefore, whilst this data can be used to describe and generate hypothesis, some caution must be applied. Where there are known data concerns this will be highlighted in the text.

One of the data issues identified is the definition used by different services for a 'case'. Organisations that work with families define a 'case' as one family with multiple individuals. In other services a "case" is an individual.

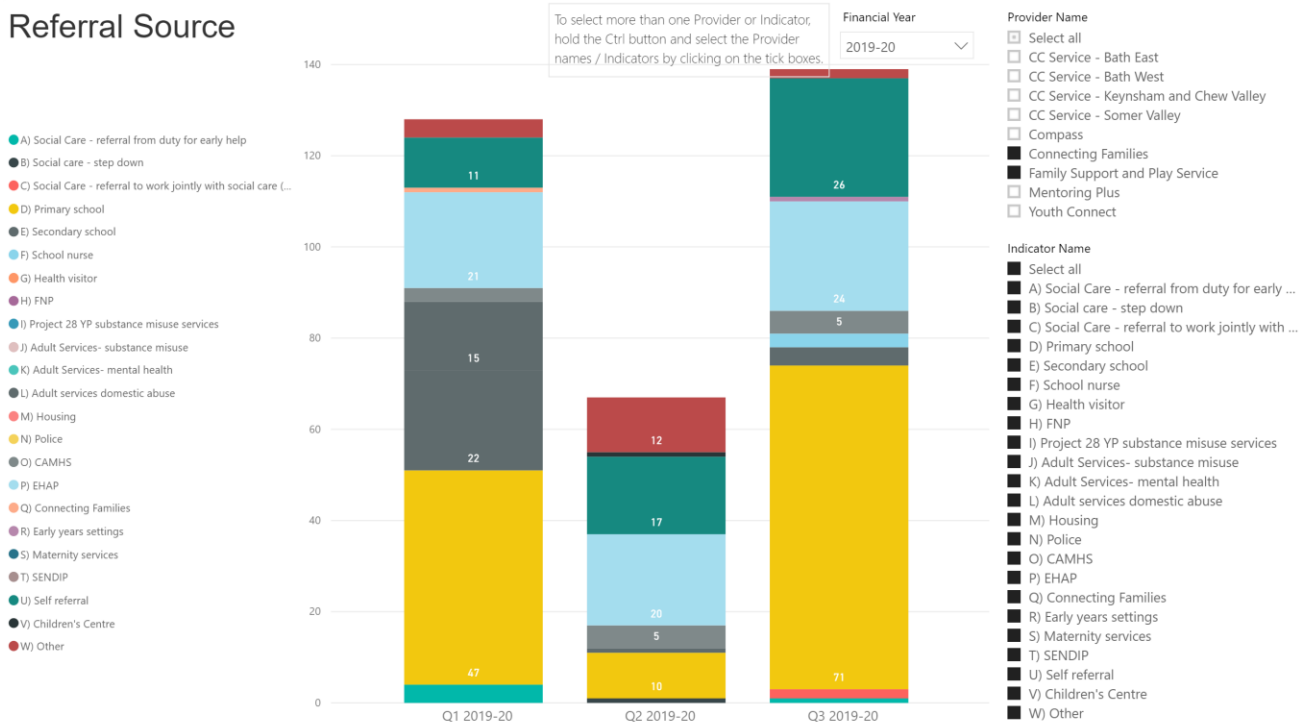
10.3.1 Referral source



The main referral source to Children's Centre Services are Health Visitors followed by Early Years settings.

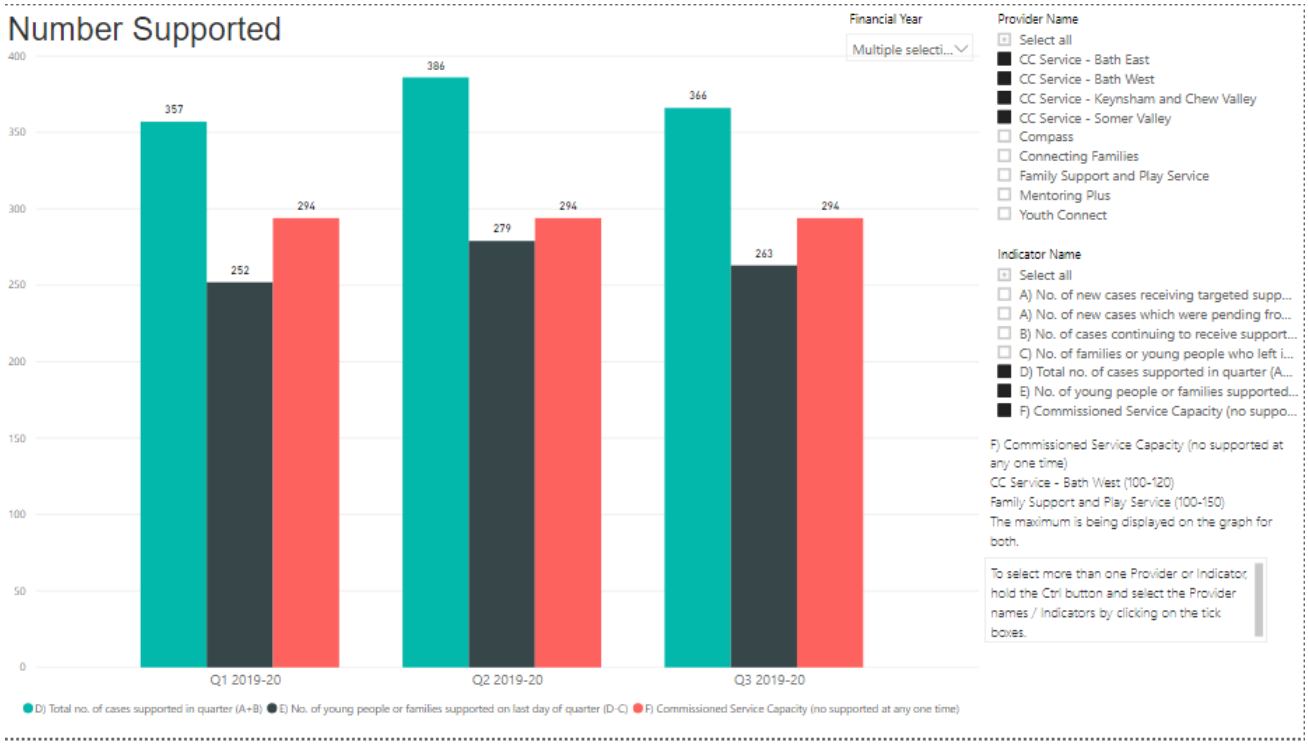


For the three youth support services the main source of referrals are secondary schools. For these services a self referral is a referral by the the young person themselves. The “other” category includes referrals made by parents and carers of young people. Mentoring Plus provides a year long programme and is sometimes closed to new referrals. This will be seen in the data as a quarter as fewer referrals.

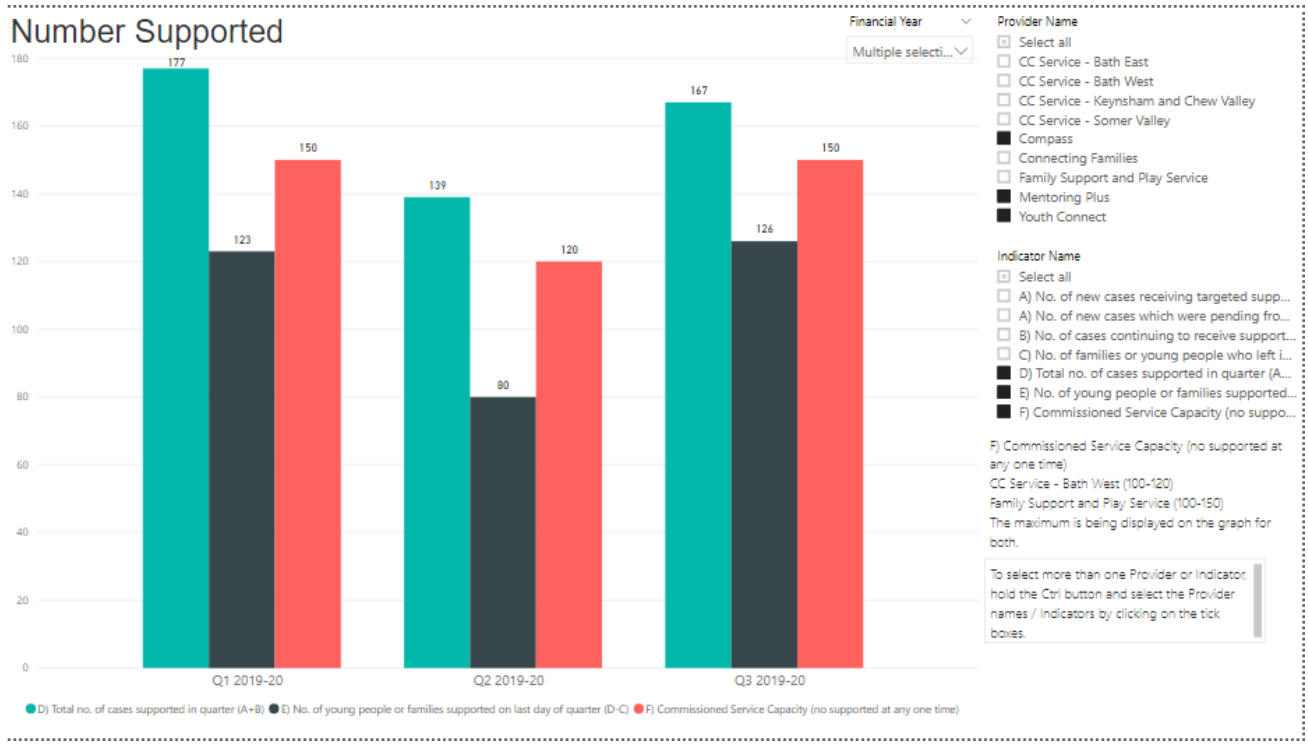


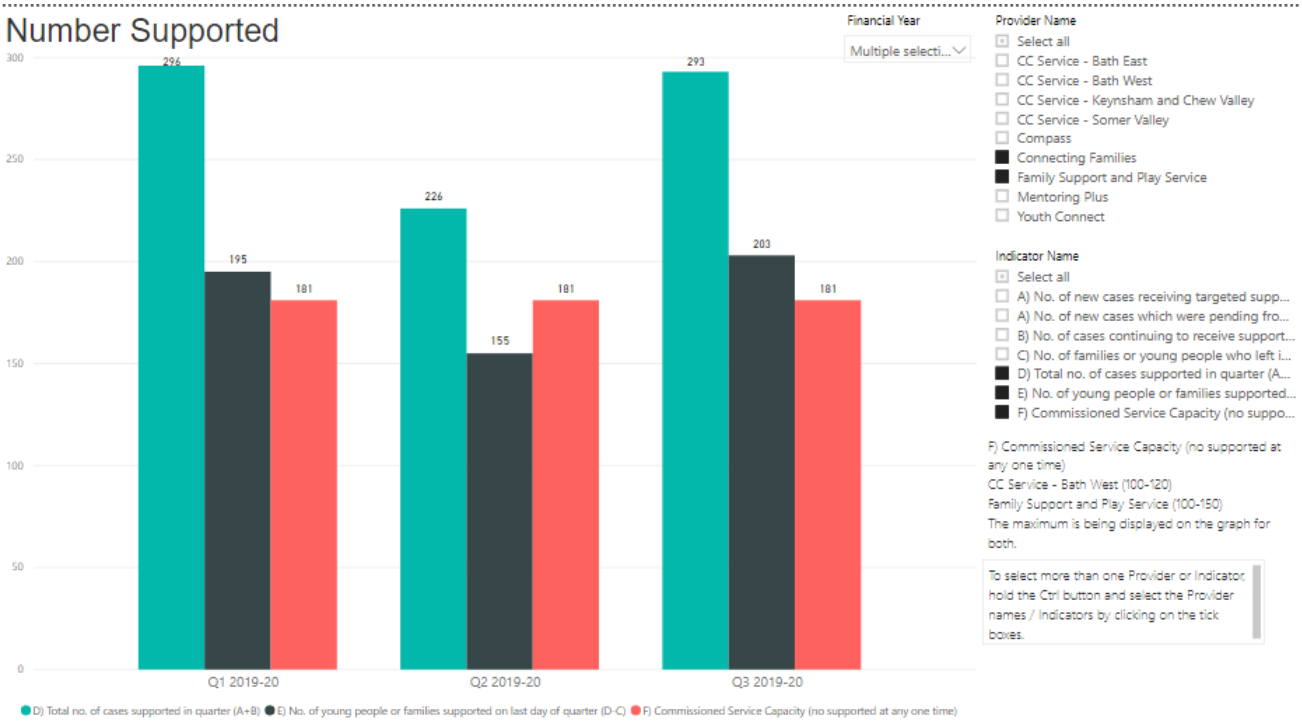
The main souces of referral for connecting families and family support and play services are primary schools, the Early Help Allocation Panel and self referrals.

13.3.2.Demand and capacity



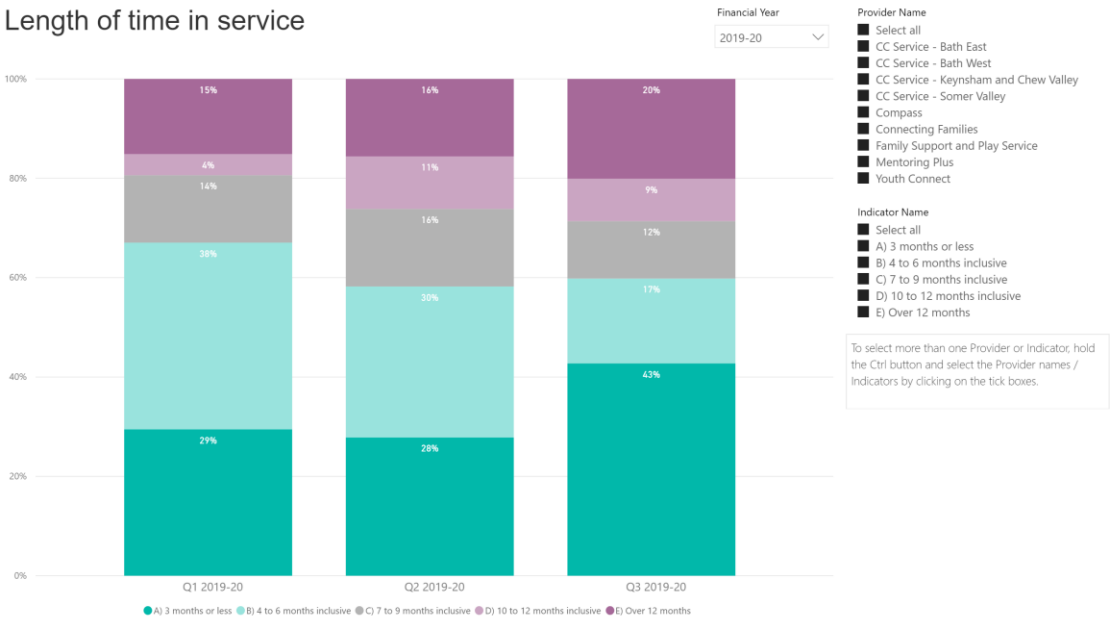
The graph above shows the commissioned service capacity (orange), alongside the number supported on the last day of the quarter (grey) and the total number of cases supported in quarter (green). This shows that across the Children's Center Services the total number supported in quarter is above the commissioned capacity, yet on the last day of the quarter they are below capacity and therefore able to maintain flow through the service whilst generally working above capacity.





The Youth and Family Support services follow a similar pattern as Children's Centre Services. Family Support services have been over capacity on the last day of the month in two out of the three quarters shown here suggesting particularly high demand for family support. In the Early Help survey undertaken, whole family support was a need that was identified as a potential gap. Whilst there are services for whole family work this data suggests that the demand for them is greater than the capacity within the current services.

10.3.3 Length of time in services



Across the commissioned services support is provided for varying durations. This is based on the specific interventions provided by services as well as families needs and ability to engage. Around 40% of Early Help in this data was provided for a period of time of 7 months or more.

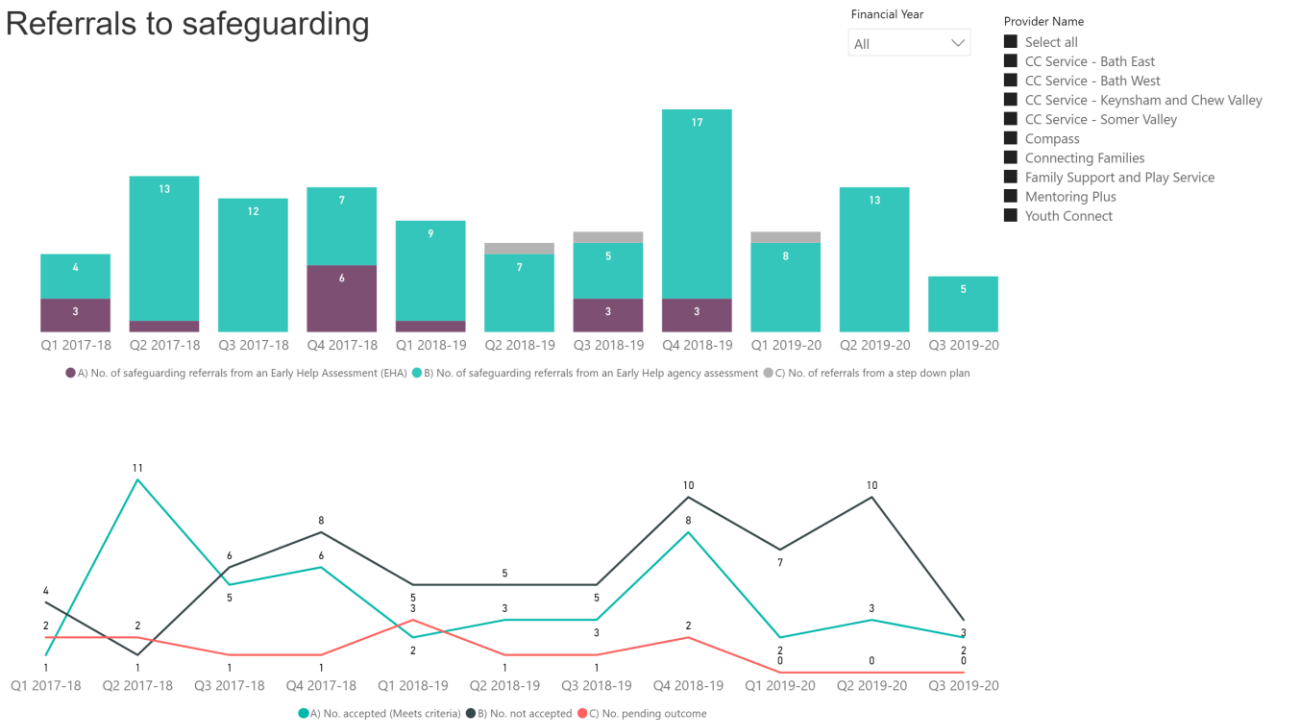
10.3.4 Assessment type

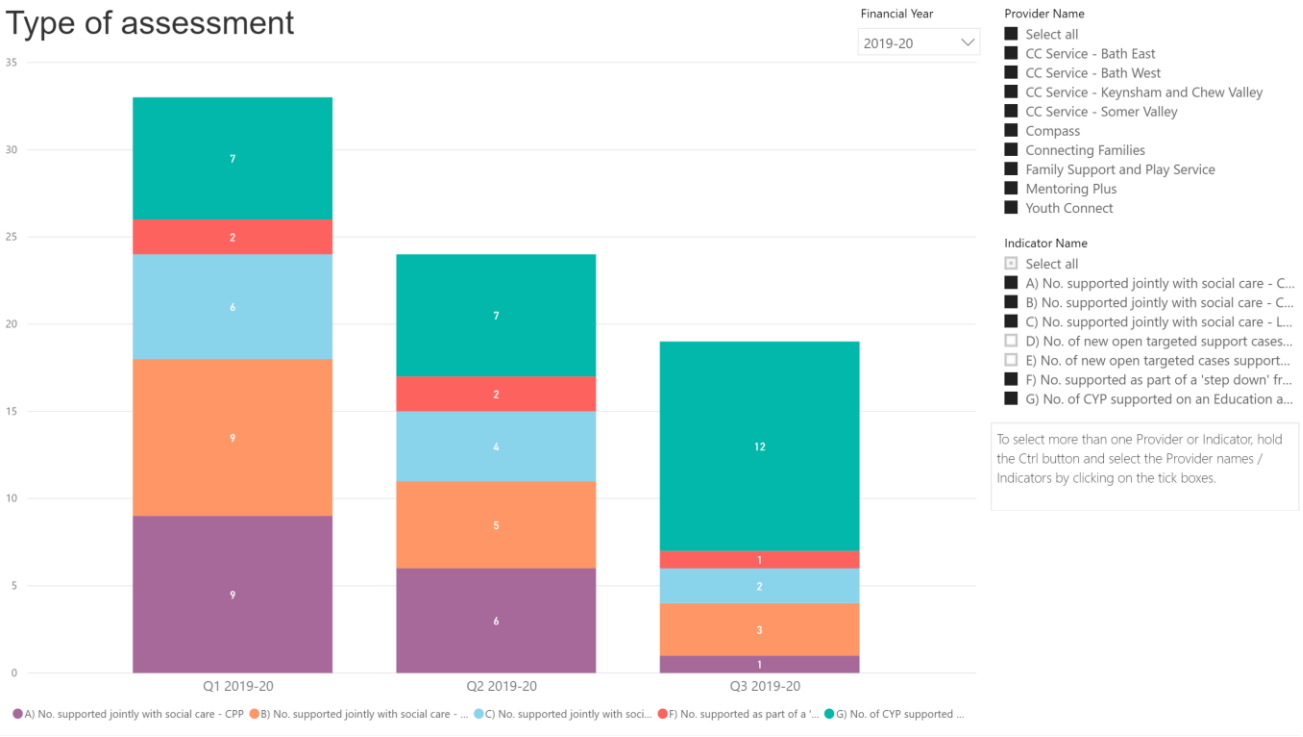
The vast majoirty of assessments across the Early Help system are own agency assessments. The power BI data suggests that in quarter 2 of 2019/20 187 own agency assessents were completed compared to 13 Early Help Assessments. In quarter 3, 2019/20, 233 own agency assessments were recorded on Power BI and 17 Early Help Assessments. The qualitative data from the survey along with the evidence of small numbers of Early Help Assessments suggests that this as an aspect of the Early Help offer process that requires further review.

10.3.5 Interaction with social care

The interaction between Early Help and Children's Social Care is one that is currently under review. Social Care experience significant demand and understanding how much of this demand is actually more appropriate for Early Help support that has been innappropriately directed to Social Care, remains an unanswered question. There are processes within Early Help, such as access to the Early Help Allocation Panel, which also mean referrals come through Children's Social Care Duty. It could be hypothesised that processes within the Early Help system have inadvertantly resulted in an increased pressure on the Social Care Duty team due to this means of accessing the Early Help Allocation Panel.

One aspect of the interaction between Early Help and Social Care that we can understand through the Power BI data is the referrals to Social Care from Early Help services. The trend graph below illustrates the absolute numbers of referrals to safeguarding, stratified as accepted (green line), not accepted (black line) and pending (red line). The first thing to note is that in absolute terms these trends represent very small numbers. So whilst it is true to say that 77% (10 out of 13) of referrals to safeguarding in Q2 were not accepted, the actual number during that quarter was 10 across all the commissioned services. It is therefore unlikely that any one service is repeatedly making inappropriate referrals for safeguarding. Furthermore through the routine contract management process it has become apparent that some of the cases recorded as referrals were actually "new information" on existing requests sometimes made by other agencies. The relationship between Social Care Duty and Early Help Targeted Support Services has become increasingly collaborative ensuring that thresholds have been understood and communication channels have been positive.





Although this graph is labeled Type of Assessment in Power BI the selected indicators represent the number supported jointly with social care, as step downs from social care or alongside an education plan. Again the numbers in these categories are low compared to the overall caseload across the Early Help commissioned services.

10.4.Early Help Allocation Panel (EHAP)

Between 1st April 2019 and 31st March 2020 372 applications were taken to EHAP. Of these 90 went back to referrers but with an offer of support. As well as those that went back to referrers 17 direct request for agencies to complete an Early Help Assessment were made.

During the time period between 1st July 2019 and the 31st March 2020, 256 (91.1%) of referrals came through Duty with 25 (8.9) coming through Connecting Families. Of those that came though Connecting Families, the original source of referral is demonstrated in the table below.

Referral Sources	
Total	25
Primary School	4
Secondary School	7
School Nurse	1
Project 28	1
Housing	1
CAMHS	1
Self-Referral	4
Other	4
Other – GP	1
DWP	1

11. Understanding limitations of data collection within the Early Help system

Within the wider system there are multiple ways in which data is captured. However most reported data is activity data. Own agency assessments, which provide details of needs, are kept within agencies. This has impacted the ability to gain an overview of the needs across services within the time and resources of this project. Early Help Assessments are collected centrally but are too few in number to draw population level conclusions from. The data capture within the Early Help system is outlined in appendix 4.

12. Conclusions and recommendations

Early Help describes a complex system. Whilst the Early Help targeted support services provide a core offer, the voluntary sector, universal services and specialist services are all providers of Early Help.

The need for Early Help in B&NES is evident and demonstrated through both population and service level data. There are some areas, such as the understanding of domestic abuse, which would benefit from supplementary information to inform actions going forward. It is clear that domestic abuse is a significant factor contributing to the need for Early Help, through both the direct and indirect impacts it has on children and families. It is also apparent through engagment with stakeholders that being able to understand and support families who have experienced domestic abuse (but may present because of other needs) is an important aspect of their role. Understanding domestic absue forms part of our understanding of trauma, which provides the broader context to working in Early Help. This is likely why training relating to this was highlighted in the participatory work.

Also within the narrative of trauma is an understanding of those experiencing, and at risk of, exploitation. There are six key protocols in B&NES that are covered in the @ Risk strategy on exploitation. Early Help also needs to work across these areas with a prevention perspective.

There is a demand for Early Help and this is predicted to increase as the impacts of covid 19 compounds existing vulnerabilities and creates adverse life circumstances for many more.

Through qualitative and quantitative work it has been possible to identify the range of needs, however providing an exact quantitative picture of unmet needs is not possible. Key areas of need that emerged from the questionnaire relating to children and young people included themes of behaviour, mental health, safeguarding, parenting and speech and language. Needs for parents and carers included the toxic trio (mental health, domestic abuse and substance misuse) along with poverty/ finances and housing needs.

Some key priorities for ongoing work are based on the following findings:

- The burden of needs is not uniform across B&NES, with high needs likely to be experienced in areas of highest deprivation as evidenced by gaps in empoloyent, educational attainment and health

Gaps in the system have been identifed through consultation and include:

- Provision of Early Help for specific groups
- Specific needs where no services exist (or are not known about)
- Service related issues

This assessment has highlighted aspects within the current processes that require further review. These include the Early Help Assessment which has been identified in the participatory work as a potential barrier to accessing services. Whilst it replaced the CAF it appears to have been rejected by the system and replaced with own agency assessements. Own agency assessments provide a robust and quality assessment; however the processing of these means data is no longer being captured centrally. Consequently an understanding of overall patterns and levels of need is not possible without analysis of individual agency assessments.

Clear pathways to facilitate access to services are needed. This would facilitate appropriate referrals. Some aspects of the Early Help pathway have evolved due to pressures within the system. The EHAP receives 91.1% of its referrals through Duty. It is not clear if all these referrals came to the panel following a referral due to high levels of concern (level 5), or whether this has been perceived as the route into the panel which acts as a gatekeeper into services. Further to this, practitioners within the system are calling for training and clarity around how the system works. There is a desire from within the system for processes to be simple, clear and responsive.

There should be a focus on strengthening the Think Family agenda as many of the parental needs identified including mental health, addiction or domestic abuse should be supported by adult services. This would triangulate the support given through children and family services and hopefully reduce some of the burden of needs experienced. Therefore, building strong relationships with adult services would help ensure a holistic Think Family approach is seen going forward to address the needs in B&NES.

Limitations

Data is a significant issue within the Early Help system with some thought needed regarding:

- Definitions across the system such as what constitues a 'case' in activity data
- Recording and reporting of needs across the system
- Sharing of core data across agencies including feedback of outcomes
- Understanding terms such an 'non engagement' and how this term is used in a system that aims to provide The right help, **At the right time**, By the right service
- A common understanding of when interventions start i.e. at assessment or at the point of delivery of a specific intervention, this influences how waiting lists are recorded

Where there isn't a common understanding it is not appropriate to combine data from different sources, as they are not comparable across the system.

When considering outcomes, the current system is measured primarily through activity data. The development of core outcomes across the system would enable Early Help to evidence the impact which is clearly visible when you review case study data.

The practitioner survey facilitated insight into needs seen by those working in the system. This was not a representative sample and as such those working with particular age groups, in geographical areas and on addressing particular needs, are not equally represented. The survey was not designed to be an exact replication of the truth across the system, but to produce useful insight and to generate hypotheses for future work. Due to the limitations of the survey, where possible, results have been reported as themes to provide an overview.

The service mapping was undertaken by the Early Help and Intervention Subgroup. It represents a snap shot in time and is not a complete picture of Early Help provision in B&NES. It follows a life course approach rather than geographical mapping of services. Whilst it provides a good overview of services it does not tell you about provision by geographical location.

Recommendations

- Gain further insight from the Social Care prespective as this data is missing from this needs assessment

- As data becomes available fill in the intelligence gap around domestic abuse
- Explore how to gain data to inform when parent/carer needs impact on the child(ren) and vice versa
- Review the current pathways and consider if adaptations are required in response to the pressure points in the system, these could include:
    - A hub model could be considered as has been implemented in other areas such as Cornwall.
    - Continue ongoing work with the Social Care front door to reduce demand on Social Care and appropriately direct people to Early Help
- Review the Early Help Assessment process and consider how data capture could be achieved with a view of providing an overview of needs across the system. This could be achieved by:
    - Creating a simple form for capture of needs which is collected centrally such as a one-page matrix of needs in addition to and informed by the Early Help Assessment and own agency assessments
    - Review the early help assessment and agency assessments to identify the most appropriate mechanism to capture both needs and outcomes across the system possibly developing a toolbox model and provide a clear policy steer
    - Continue work to explore the ability for Early Help Assessments to be put on Liquid Logic
    - Continue work to investigate whether own agency assessments can be audited for quality in the same way as Early Help Assessments
- Address service gaps
    - Undertake further work to review and understand commonalities and differences between services working to support the same needs identified in Appendix 3
    - Map services within a wider system against gaps (groups and specific needs) identified. Currently there are ongoing pieces of work relating to bereavement support which could be considered in the Early Help system
    - Further mapping of Early Help support by location, starting with areas of highest need, would help strengthen the understanding of support available and barriers to support based on geography
    - Consider commissioning new services or re-focussing services where gaps exist
- Consider an Early Help summit where practitioners can come together
    - To consult on development of an outcomes framework which could be used across the system
    - To gain deeper appreciation of each others roles through appreciative inquiry, led by leaders in the system
    - To be trained on the system pathways
    - To consider how capacity in the system could be raised through collaborative working
    - To consider how to embed a Think Family Think Community approach across the early help system
- Review Data flows and reporting to facilitatie:
    - Harmonising terminology across the system to make reporting more consistent
    - Considering how data platforms can be best used

In February 2020 the Governement released an Early Help System Guide. This is a toolkit which aims to assist the local strategic partnerhsip responsible for their Early Help System. This guide, in conjunction with this needs assessment will help inform the Early Help strategy going forward.[55]

There is clear need and demand for Early Help, as evidenced through this report and this is likely to increase as a result of covid 19. One of the biggest challenges going forward will be how to navigate the unprecedented impacts of covid 19 on children and families. All of this must be done in a context of scarce resources and savings. This highlights the need to consider the wider system of Early Help, including community based assets, and to review how the system can understand and respond to arising needs in a dynamic way.

[55] Early Help Systems Guide, available at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/878994/TF_Early_Help_System_April_2020.pdf

Appendix 1 Public Health Outcomes Framework area profile available at https://fingertips.phe.org.uk/

Indicator	Period	Bath & NESom			Deprivation decile	England	England		
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Infant mortality rate	2015 - 17	–	15	2.8	3.1	3.9	8.1		1.7
Child mortality rate (1-17 years)	2015 - 17	–	7	*	-	11.2	24.3		7.5
Population vaccination coverage - MMR for one dose (2 years old) <90% 90% to 95% ≥95%	2018/19	↑	1,866	94.6%	91.5%*	90.3%	74.3%		97.1%
Population vaccination coverage - Dtap / IPV / Hib (2 years old) <90% 90% to 95% ≥95%	2018/19	↓	1,906	96.7%	93.8%*	94.2%	81.6%		98.8%
Children in care immunisations	2018	→	110	93.3%	81.4%	85.3%	5.7%		100%
School readiness: percentage of children achieving a good level of development at the end of Reception	2017/18	↑	1,388	72.6%	75.4%	71.5%	63.9%		80.5%
Average Attainment 8 score	2017/18	–	-	48.3	-	46.7	39.8		55.8
Average Attainment 8 score of children in care	2017/18	–	-	33.9	-	19.3	0.0		33.9
16-17 year olds not in education, employment or training (NEET) or whose activity is not known	2017	–	180	5.4%	5.5%*	6.0%	24.4%		1.9%
First time entrants to the youth justice system	2018	↓	30	190.4	158.4*	238.5	554.3		72.3
Children in low income families (under 16s)	2016	↓	2,795	9.8%	10.1%	17.0%	31.8%		6.4%
Family homelessness	2017/18	→	56	0.7	1.1	1.7	7.7		0.1
Children in care	2018	↓	170	48	41	64	185		23
Children killed and seriously injured (KSI) on England's roads	2015 - 17	–	4	4.3	12.4	17.4	41.7		2.6
Low birth weight of term babies	2017	→	43	2.75%	2.23%	2.82%	5.30%		1.57%
Reception: Prevalence of obesity (including severe obesity) New data	2018/19	→	141	8.3%	-	9.7%	14.2%		5.4%
Year 6: Prevalence of obesity (including severe obesity) New data	2018/19	↓	223	13.5%	-	20.2%	29.6%		10.7%
Children with one or more decayed, missing or filled teeth	2016/17	–	-	25.8%	-	23.3%	47.1%		12.9%
Hospital admissions for dental caries (0-5 years)	2015/16 - 17/18	–	164	472.0	199.7*	325.1	10.8		1,612.1
Under 18s conception rate / 1,000	2017	↓	38	13.1	10.7	17.8	43.8		6.1
Teenage mothers	2017/18	–	8	0.5%	0.4%*	0.7%	2.1%		0.2%
Admission episodes for alcohol-specific conditions - Under 18s	2015/16 - 17/18	–	50	47.4	*	32.9	106.5		7.4
Hospital admissions due to substance misuse (15-24 years)	2015/16 - 17/18	–	71	71.5	72.4*	87.9	329.3		33.1
Smoking status at time of delivery	2018/19	↓	105	6.8%	-	10.6%	25.7%		1.6%
Breastfeeding initiation	2016/17	↑	1,605	85.8%	81.2%*	74.5%	37.9%		96.7%
Breastfeeding prevalence at 6-8 weeks after birth - current method	2018/19	–	969	60.4%	-	46.2%*	-	*Insufficient number of values for a spine chart*	-
A&E attendances (0-4 years)	2017/18	↑	3,906	411.8	531.8*	619.0	2,011.3		321.3
Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-14 years)	2017/18	→	337	113.8	*	96.4	203.7		46.5
Hospital admissions caused by unintentional and deliberate injuries in young people (aged 15-24 years)	2017/18	↓	398	116.0	*	132.7	284.4		69.0
Hospital admissions for asthma (under 19 years)	2017/18	↓	32	84.0	*	186.4	511.7		82.5
Hospital admissions for mental health conditions	2017/18	→	34	95.6	90.4*	84.7	187.6		14.5
Hospital admissions as a result of self-harm (10-24 years)	2017/18	–	241	549.5	442.2*	421.2	1,009.6		116.9

Data quality: Significant concerns | Some concerns | Robust

Compared with benchmark: Better | Similar | Worse | Not compared

Recent trends: Could not be calculated | No significant change | Increasing / Getting worse | Increasing / Getting better | Decreasing / Getting worse | Decreasing / Getting better | Increasing | Decreasing

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

Indicator	Period	Bath & NESom			Region	England	England		
		Recent Trend	Count	Value	Value	Value	Worst	Range	Best
Children in low income families (under 16s)	2016	↓	2,795	9.8%	14.0%	17.0%	31.8%		6.4%
Free school meals: % uptake among all pupils	2018	→	2,807	10.4%	11.0%	13.5%	33.6%		4.7%
Reception: Prevalence of obesity (including severe obesity) New data	2018/19	→	141	8.3%	8.7%	9.7%	14.2%		5.4%
Year 6: Prevalence of obesity (including severe obesity) New data	2018/19	↓	223	13.5%	16.5%	20.2%	29.6%		10.7%
Under 18s conception rate / 1,000	2017	↓	38	13.1	14.9	17.8	43.8		6.1
Children with one or more decayed, missing or filled teeth	2016/17	–	-	25.8%	20.2%	23.3%	47.1%		12.9%
Population vaccination coverage - HPV vaccination coverage for one dose (females 12-13 years old) <80% 80% to 90% ≥90%	2017/18	–	1,161	90.7%	85.4%	86.9%	67.8%		95.3%
Children killed and seriously injured (KSI) on England's roads	2015 - 17	–	4	4.3	13.2	17.4	41.7		2.6
Children in low income families aged 5 to 10	2013	–	1,165	10.5%	14.3%	18.0%	33.9%		5.6%
Admissions for asthma for children aged 0 to 9	2016/17	↓	16	80.9	211.6	255.8	625.7		80.9
Admissions for diabetes for children aged 0 to 9	2016/17	–	-	*	28.1	28.2	63.2		12.4
Admissions for epilepsy for children aged 0 to 9	2016/17	↑	30	151.7	101.1	87.6	201.5		31.9
Children aged 6-10 killed or seriously injured in road traffic accidents	2014 - 16	–	0	0.0	11.1	14.8	64.7		0.0
Persistent absentees - Primary school	2017/18	–	934	8.0%	8.2%	8.7%	12.8%		3.5%
Persistent absentees - Secondary school	2017/18	–	1,676	15.2%	14.9%	13.9%	22.0%		6.7%
Key stage 2 pupils meeting the expected standard in reading, writing and maths	2018	–	1,256	66.1%	62.9%	64.9%	48.0%		80.6%
Key stage 1 pupils meeting the expected standard in reading	2019	–	1,469	77.6%	74.9%	74.9%	66.9%		83.3%
Key stage 1 pupils meeting the expected standard in writing	2019	–	1,344	71.0%	68.7%	69.2%	60.8%		76.4%
Key stage 1 pupils meeting the expected standard in maths	2019	–	1,454	76.8%	75.1%	75.6%	69.8%		82.0%
Key stage 1 pupils meeting the expected standard in science	2019	–	1,631	86.2%	83.4%	82.3%	75.1%		90.7%

Appendix 2 All areas profile data was taken from the Public Health England Local Health tool available at https://fingertips.phe.org.uk/profile/local-health

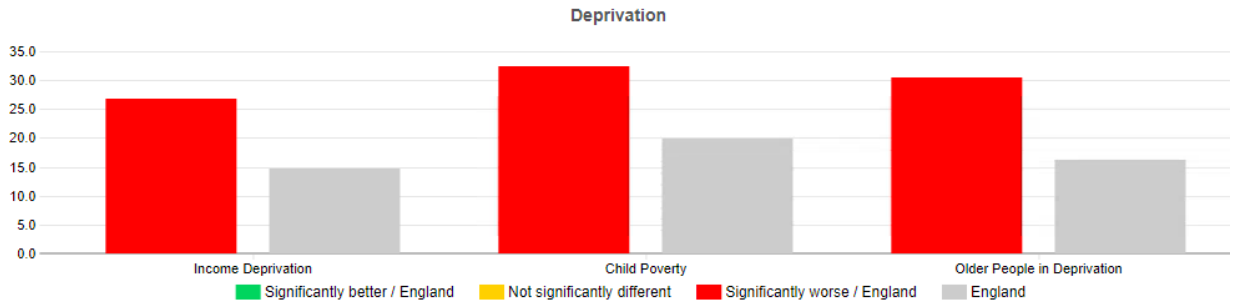
Index of Multiple Deprivation data for B&NES is available at the Lower-layer Super Output Area (LSOA) level and places 5 areas in B&NES in the bottom quartile nationally. However, local level indicators are not available at this level. A new tool produced by Public Health England allows some indicators to be understood at ward level. The indicators below are taken from the three wards in B&NES with the highest IMD scores of deprivation in B&NES from 2015 based on Middle Layer Super Output Areas (MSOA) ranking.

Twerton

Indices of Deprivation, 2015, %

Indicators	Twerton	Bath and North East Somerset (LTLA 2013)	Bath and North East Somerset (UTLA 2013)	England
Income Deprivation (%)	26.7	9.1	9.1	14.6
Child Poverty (%)	32.4	12.1	12.1	19.9
Older People in Deprivation (%)	30.5	11.5	11.5	16.2

Source: DCLG © Copyright 2015

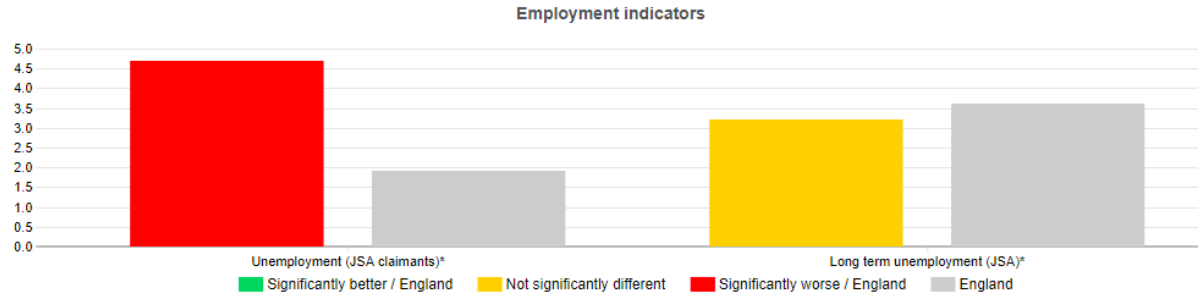


Source: DCLG © Copyright 2015

Employment Indicators, 2017/18, %

Indicators	Twerton	Bath and North East Somerset (LTLA 2013)	Bath and North East Somerset (UTLA 2013)	England
Unemployment (JSA claimants)* (%)	4.7	1.6	1.6	1.9
Long term unemployment (JSA)* (Rate/1,000 working age population)	3.2	1.0	1.0	3.6

*Source: NOMIS *Monthly average*



*Source: NOMIS *Monthly average*

Child poverty in Twerton is more than the B&NES average. Unemployment is significantly worse that the England average. Long term employment is not significantly different from the UK average.

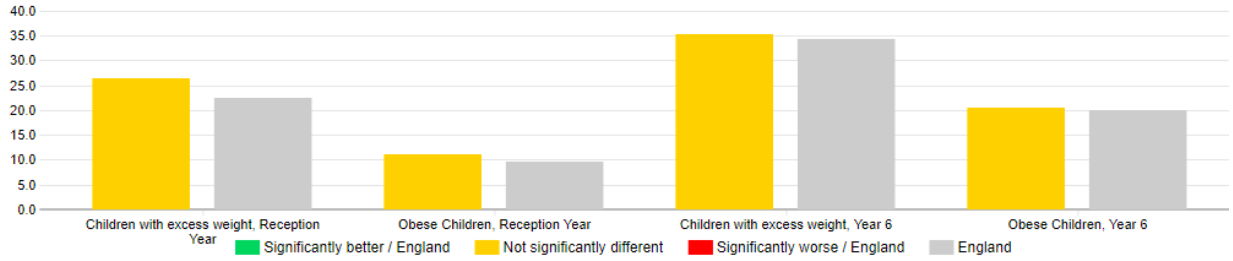
The below indicators link to health (obesity), and child development/ education (percentage of children reaching good development at age 5 and percentage of pupils achieving 5 GCSE grades of A star to C including English and Maths, at the end of the academic year). Areas where these outcomes are worse are likely to need more Early Help provision to address some of the causes and effects.

Children's weight indicators, 2015/16-2017/18, %

Indicators	Twerton	Bath and North East Somerset (LTLA 2013)	Bath and North East Somerset (UTLA 2013)	England
Children with excess weight, Reception Year (%)	26.4	22.7	22.7	22.4
Obese Children, Reception Year (%)	11.2	8.0	8.0	9.5
Children with excess weight, Year 6 (%)	35.2	26.8	26.8	34.2
Obese Children, Year 6 (%)	20.4	13.3	13.3	20.0

Source: National Child Measurement Programme, NHS Digital © 2018

Children's weight indicators, %



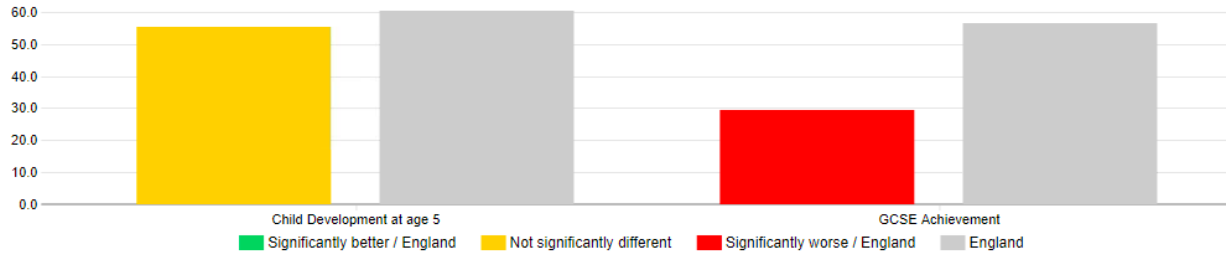
Source: National Child Measurement Programme, NHS Digital © 2018

Child development, and education indicators, values

Indicators	Twerton	Bath and North East Somerset (LTLA 2013)	Bath and North East Somerset (UTLA 2013)	England
Child Development at age 5 (%)	55.4	62.7	62.7	60.4
GCSE Achievement (%)	29.5	62.1	62.1	56.6

Source: Public Health England, ONS, DfE

Child development, and education indicators



Source: Public Health England, ONS, DfE

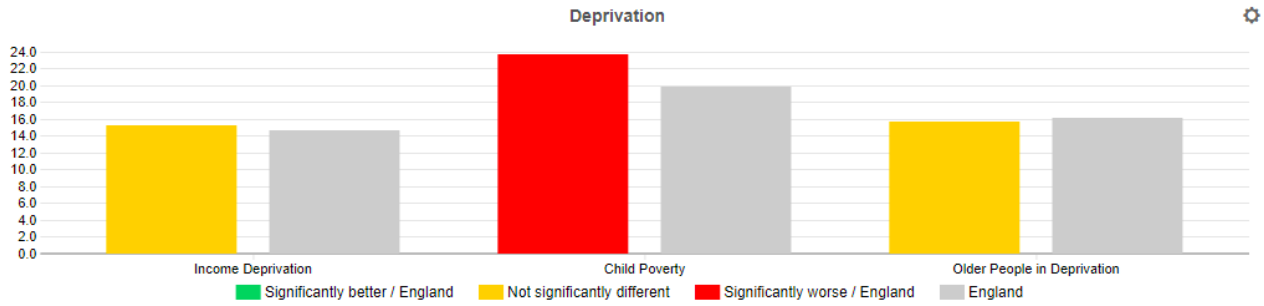
Indicators related to child obesity and child development also illustrate that outcomes in Twerton are worse than average in B&NES and England.

Southdown

Indices of Deprivation, 2015, %

Indicators	Southdown	Bath and North East Somerset (LTLA 2013)	Bath and North East Somerset (UTLA 2013)	England
Income Deprivation (%)	15.2	9.1	9.1	14.6
Child Poverty (%)	23.7	12.1	12.1	19.9
Older People in Deprivation (%)	15.7	11.5	11.5	16.2

Source: DCLG © Copyright 2015

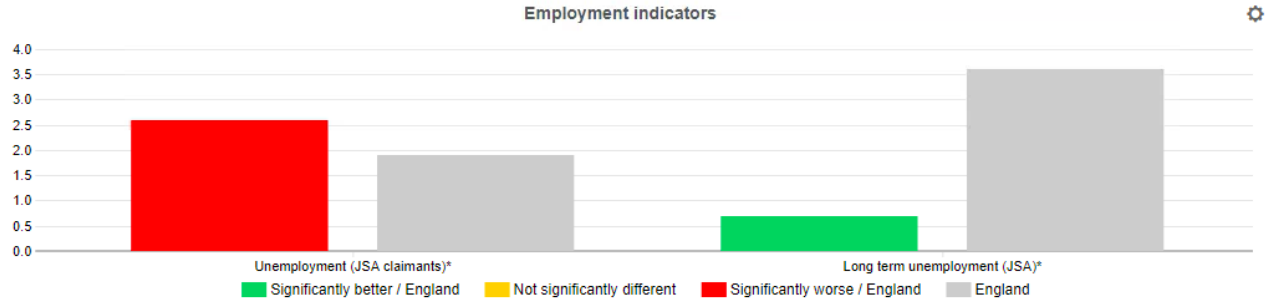


Source: DCLG © Copyright 2015

Employment Indicators, 2017/18, %

Indicators	Southdown	Bath and North East Somerset (LTLA 2013)	Bath and North East Somerset (UTLA 2013)	England
Unemployment (JSA claimants)* (%)	2.6	1.6	1.6	1.9
Long term unemployment (JSA)* (Rate/1,000 working age population)	0.7	1.0	1.0	3.6

*Source: NOMIS *Monthly average*



*Source: NOMIS *Monthly average*

Child poverty in Southdown is nearly twice that of the B&NES average. Unemployment in Southdown in significantly higher than the England average. Long term unemployment is recorded as significantly better. It is also important to consider the type of employment, which is not noted here.

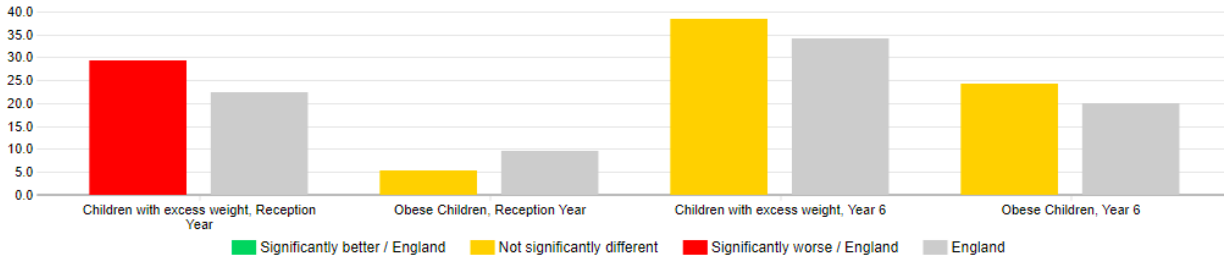
The below indicators link to health (obesity), and child development/ education (percentage of children reaching good development at age 5 and percentage of pupils achieving 5 GCSE grades of A star to C including English and Maths, at the end of the academic year). Areas where these outcomes are worse are likely to need more Early Help provision to address some of the causes and effects

Children's weight indicators, 2015/16-2017/18, %

Indicators	Southdown	Bath and North East Somerset (LTLA 2013)	Bath and North East Somerset (UTLA 2013)	England
Children with excess weight, Reception Year (%)	29.2	22.7	22.7	22.4
Obese Children, Reception Year (%)	5.3	8.0	8.0	9.5
Children with excess weight, Year 6 (%)	38.4	26.8	26.8	34.2
Obese Children, Year 6 (%)	24.3	13.3	13.3	20.0

Source: National Child Measurement Programme, NHS Digital © 2018

Children's weight indicators, %



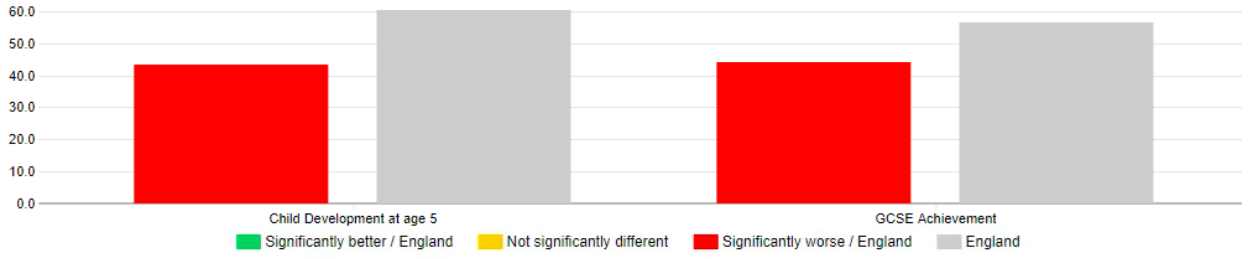
Source: National Child Measurement Programme, NHS Digital © 2018

Child development, and education indicators, values

Indicators	Southdown	Bath and North East Somerset (LTLA 2013)	Bath and North East Somerset (UTLA 2013)	England
Child Development at age 5 (%)	43.5	62.7	62.7	60.4
GCSE Achievement (%)	44.0	62.1	62.1	56.6

Source: Public Health England, ONS, DfE

Child development, and education indicators



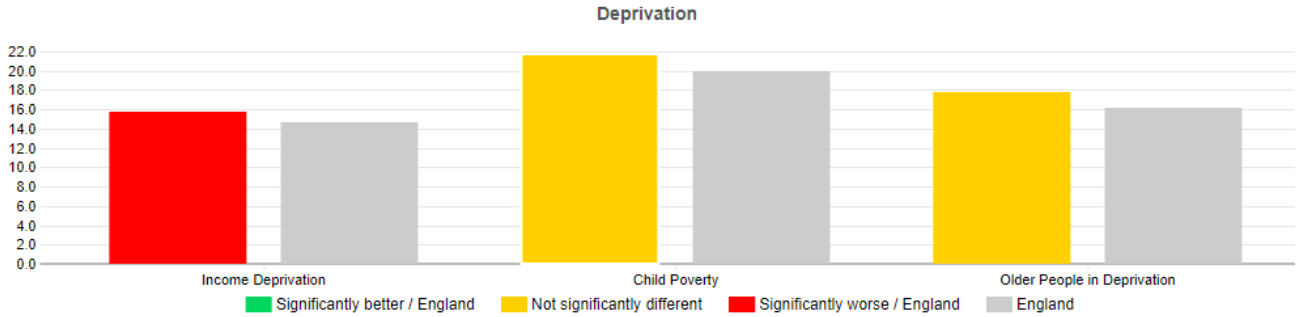
Source: Public Health England, ONS, DfE

Radstock

Indices of Deprivation, 2015, %

Indicators	Radstock	Bath and North East Somerset (LTLA 2013)	Bath and North East Somerset (UTLA 2013)	England
Income Deprivation (%)	15.8	9.1	9.1	14.6
Child Poverty (%)	21.7	12.1	12.1	19.9
Older People in Deprivation (%)	17.8	11.5	11.5	16.2

Source: DCLG © Copyright 2015

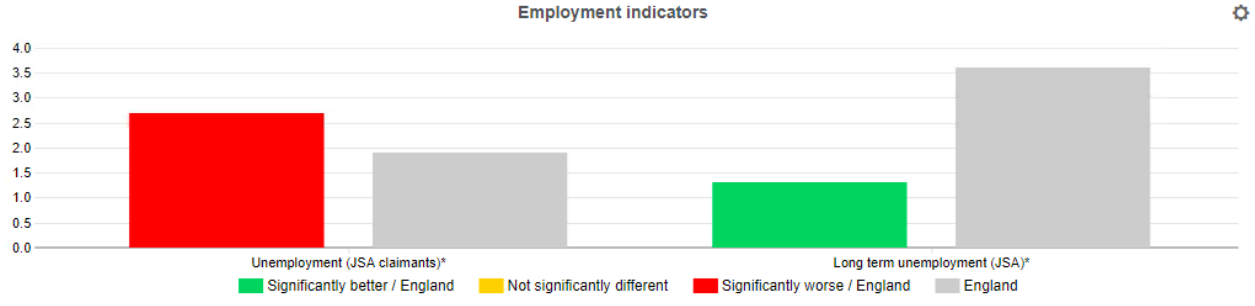


Source: DCLG © Copyright 2015

Employment Indicators, 2017/18, %

Indicators	Radstock	Bath and North East Somerset (LTLA 2013)	Bath and North East Somerset (UTLA 2013)	England
Unemployment (JSA claimants)* (%)	2.7	1.6	1.6	1.9
Long term unemployment (JSA)* (Rate/1,000 working age population)	1.3	1.0	1.0	3.6

*Source: NOMIS *Monthly average*



*Source: NOMIS *Monthly average*

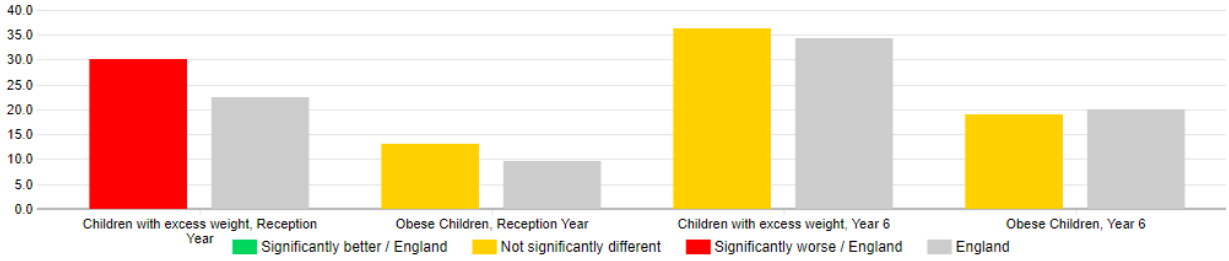
The below indicators link to health (obesity), and child development/ education (percentage of children reaching good development at age 5 and percentage of pupils achieving 5 GCSE grades of A star to C including English and Maths, at the end of the academic year). Areas where these outcomes are worse are likely to need more Early Help provision to address some of the causes and effects

Children's weight indicators, 2015/16-2017/18, %

Indicators	Radstock	Bath and North East Somerset (LTLA 2013)	Bath and North East Somerset (UTLA 2013)	England
Children with excess weight, Reception Year (%)	30.0	22.7	22.7	22.4
Obese Children, Reception Year (%)	13.2	8.0	8.0	9.5
Children with excess weight, Year 6 (%)	36.4	26.8	26.8	34.2
Obese Children, Year 6 (%)	19.1	13.3	13.3	20.0

Source: National Child Measurement Programme, NHS Digital © 2018

Children's weight indicators, %



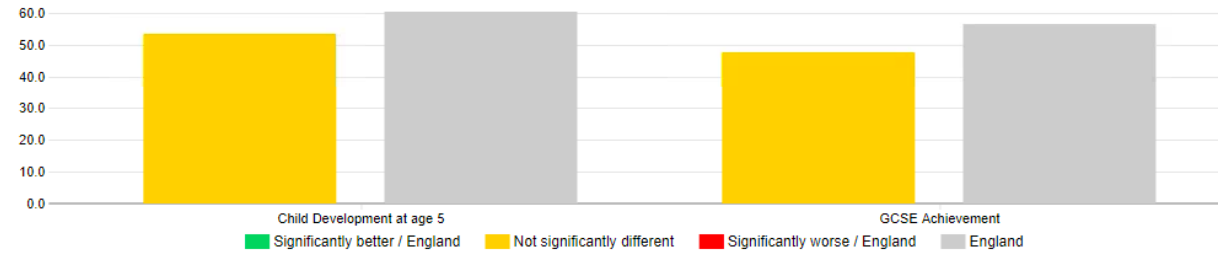
Source: National Child Measurement Programme, NHS Digital © 2018

Child development, and education indicators, values

Indicators	Radstock	Bath and North East Somerset (LTLA 2013)	Bath and North East Somerset (UTLA 2013)	England
Child Development at age 5 (%)	53.5	62.7	62.7	60.4
GCSE Achievement (%)	47.5	62.1	62.1	56.6

Source: Public Health England, ONS, DfE

Child development, and education indicators



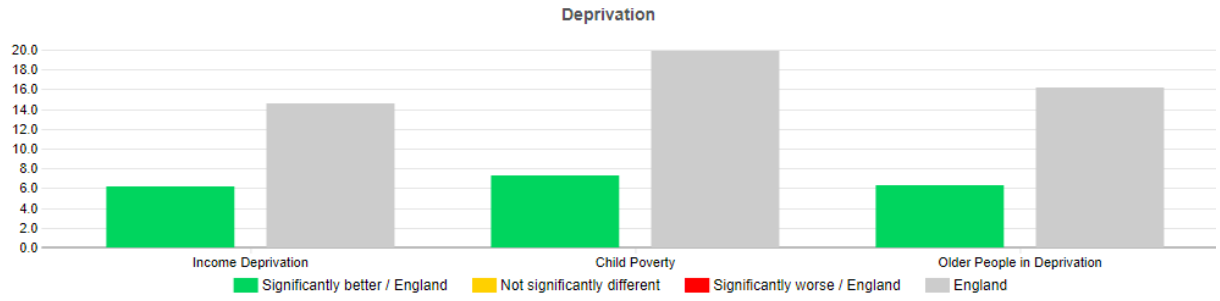
Source: Public Health England, ONS, DfE

Lansdown MSOA

Indices of Deprivation, 2015, %

Indicators	Lansdown	Bath and North East Somerset (LTLA 2013)	Bath and North East Somerset (UTLA 2013)	England
Income Deprivation (%)	6.2	9.1	9.1	14.6
Child Poverty (%)	7.3	12.1	12.1	19.9
Older People in Deprivation (%)	6.3	11.5	11.5	16.2

Source: DCLG © Copyright 2015

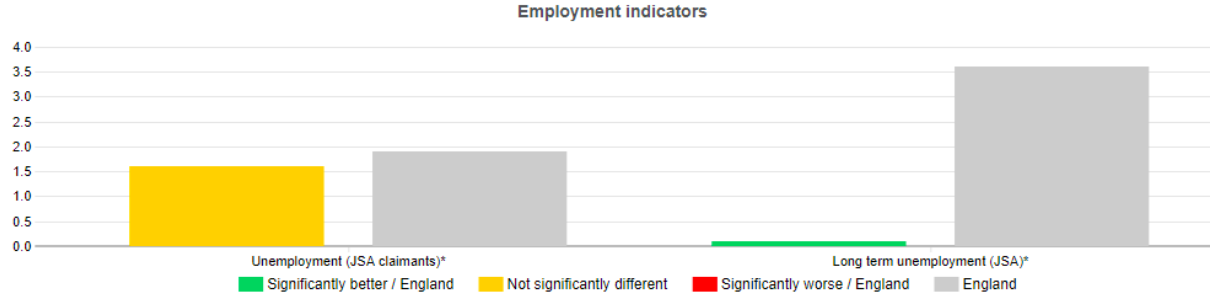


Source: DCLG © Copyright 2015

Employment Indicators, 2017/18, %

Indicators	Lansdown	Bath and North East Somerset (LTLA 2013)	Bath and North East Somerset (UTLA 2013)	England
Unemployment (JSA claimants)* (%)	1.6	1.6	1.6	1.9
Long term unemployment (JSA)* (Rate/1,000 working age population)	0.1	1.0	1.0	3.6

*Source: NOMIS *Monthly average*



*Source: NOMIS *Monthly average*

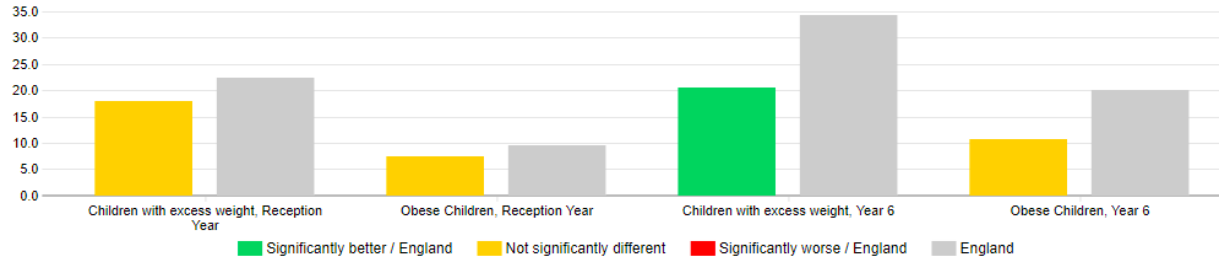
The first three area profiles showed indicators that were worse than the B&NES averages. Lansdown shows the opposite. This demonstrates how averages can skew the impression of need and why average across B&NES hide a narrative of deprivation and need that must be consdiered.

Children's weight indicators, 2015/16-2017/18, %

Indicators	Lansdown	Bath and North East Somerset (LTLA 2013)	Bath and North East Somerset (UTLA 2013)	England
Children with excess weight, Reception Year (%)	18.0	22.7	22.7	22.4
Obese Children, Reception Year (%)	7.4	8.0	8.0	9.5
Children with excess weight, Year 6 (%)	20.5	26.8	26.8	34.2
Obese Children, Year 6 (%)	10.7	13.3	13.3	20.0

Source: National Child Measurement Programme, NHS Digital © 2018

Children's weight indicators, %



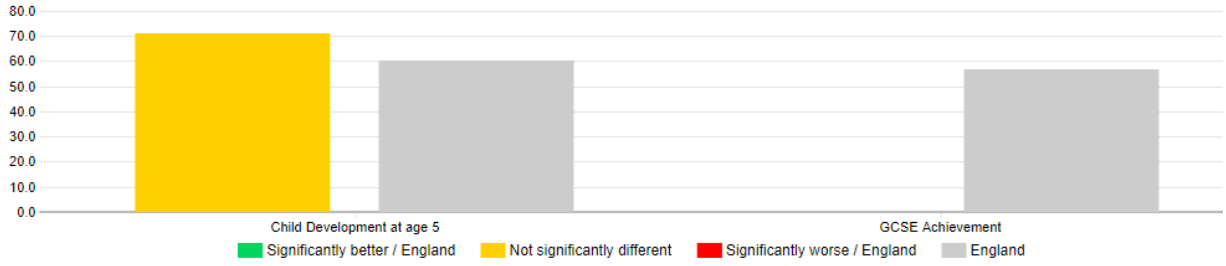
Source: National Child Measurement Programme, NHS Digital © 2018

REPORT PART 1 - CHILD DEVELOPMENT AND EDUCATION

Indicators	Lansdown	Bath and North East Somerset (LTLA 2013)	Bath and North East Somerset (UTLA 2013)	England
Child Development at age 5 (%)	71.2	62.7	62.7	60.4
GCSE Achievement (%)	N/A	62.1	62.1	56.6

Source: Public Health England, ONS, DfE

Child development, and education indicators



Source: Public Health England, ONS, DfE

Health and education outcomes are also better in Lansdown showing the same patterning as poverty and employment.

Appendix 3

Needs	First 1001 Days (pre-birth – age 2) and pre-school ages 3/4	Ages 5 – 11	11-19 (up to 25 with SEND)	Parents/Carers
Support for mental wellbeing	Infant mental health support (delivered by AWP) Health Visiting (universal plus/ universal partnership plus) * Family Nurse Partnership (for young parents) * Children's Centre services (delivered by Bright Start and Action for	Family Support and Play Service (delivered by Southside and BAPP) * School Nursing Service* Trauma Recovery Centre	Family Support and Play Service (delivered by Southside and BAPP) * Targeted Youth Support (delivered by Targeted Youth Support (delivered by Targeted Youth Support (delivered by Youth Connect SW))) Mentoring Service (delivered by Mentoring Plus) * School Nursing Service Trauma Recovery Centre	Maternity Services (Lotus Team) Peri-natal mental health support (delivered by AWP) Infant mental health support (delivered by AWP) Bluebell Service for parents experiencing or at risk of postnatal depression) * Health Visiting (universal plus/ universal partnership plus) Family Nurse Partnership (for young parents) Children's Centre services (delivered by Bright Start and Action for Children) IDVA delivered by Southside Freedom Programme (delivered by Julian House and Children's Centre Services) Family Support and Play Service (delivered by Southside and BAPP) * Connecting Families Trauma Recovery Centre
Support for those living with Substance			Project 28	DHI

misuse	Children) * IDVA delivered by Southside Freedom Programme (delivered by Julian House and Children's Centre Services) * Family Support and Play Service (delivered by Southside and BAPP) *			
Support for those living with Domestic abuse		Family Support and Play Service (delivered by Southside and BAPP) * Connecting Families *	Targeted Youth Support (delivered by Targeted Youth Support (delivered by Targeted Youth Support (delivered by Youth Connect SW) * Mentoring Service (delivered by Mentoring Plus) * Family Support and Play Service (delivered by Southside and BAPP) *	Southside
Support for Parental conflict		Family Support and Play Service (delivered by Southside and BAPP) * Connecting	Family Support and Play Service (delivered by Southside and BAPP) * Connecting	Separated Parents Information Programme (SPIP delivered by Action for Children) Family Support and Play Service (delivered by Southside and BAPP) * Connecting Families*

		Families *	Families*	
support for Family Breakdown			Family Support and Play Service (delivered by Southside and BAPP) * Connecting Families	Separated Parents Information Programme (SPIP delivered by Action for Children)
support for Bereavement/ loss	Bereavement Services (CRUISE)			
Support for Housing/ Homelessness / At risk of eviction	Curo Knightstone Housing Options Team – Bath and North East Somerset Council Citizens Advice Bureau			
Support to mitigate the impact of and reduce Poverty/ Debt	Citizens Advice Bureau			
Support to get into Education, Employment or Training (NEET)		Family Support and Play Service (delivered by Southside and BAPP) * Mentoring Plus – primary	Targeted Youth Support (delivered by Targeted Youth Support (delivered by Youth Connect SW) *	Targeted Youth Support (delivered by Targeted Youth Support (delivered by Youth Connect SW) (for young parents) * Connecting Families* Children's Centre Services (delivered by Bright Start and Action for Children) * Family Support and Play Service (delivered by Southside and BAPP) *

		mentoring service * Nurture Outreach Service (delivered by Brighter Futures) *		
Support to get people out of worklessness				
Support and information for families with Special Educational Needs and Disabilities Support to address poor transitions	Children's Centre Services (delivered by Bright Start and Action for Children) * Specialist Nursery (delivered by First Steps Bath) * SEND team	Nurture Outreach Service (delivered by Brighter Futures) * Bath Area Play Project SEND team	SEND Team Targeted Youth Support (delivered by Targeted Youth Support (delivered by Youth Connect SW))	
Support for Carers		Young Carers Service		Carers Centre
Support to address Social isolation	Children's Centre Services (delivered	Family Support and Play Service	Targeted Youth Support (delivered by Targeted Youth Support (delivered	Children's Centre Services (delivered by Bright Start and Action for Children) * Family Nurse Partnership*

	by Bright Start and Action for Children) * Family Nurse Partnership* Health Visitor (universal plus/ universal partnership plus) *	(delivered by Southside and BAPP) * Connecting Families*	by Youth Connect SW) * Mentoring Service (delivered by Mentoring Plus) * Connecting Families* Family Support and Play Service (delivered by Southside and BAPP) *	Health Visitor (universal plus/ universal partnership plus) * Connecting Families*
Support to reduce risks to poor Physical health	Children's Centre Services (delivered by Bright Start and Action for Children) * Family Nurse Partnership* Health Visitor (universal plus/ universal partnership	Family Support and Play Service (delivered by Southside and BAPP) *	Family Support and Play Service (delivered by Southside and BAPP) * Targeted Youth Support (delivered by Targeted Youth Support (delivered by Youth Connect SW) *	Children's Centre Services (delivered by Bright Start and Action for Children) * Health Visitor (universal plus/ universal partnership plus) * Connecting Families *

	plus) *			
Support to reduce risk taking behaviour		Compass (aged 8+) Family Support and Play Service (delivered by Southside and BAPP) * Project 28 *	Targeted Youth Support (delivered by Targeted Youth Support (delivered by Youth Connect SW) * Mentoring Service (delivered by Mentoring Plus) * Connecting Families* Family Support and Play Service (delivered by Southside and BAPP) * Project 28 * Compass *	Children's Centre Services (delivered by Bright Start and Action for Children) * Health Visitor (universal plus/ universal partnership plus) * Connecting Families* Developing Health and Independence (DHI) *
Support to prevent children missing from education		Compass (aged 8+) Family Support and Play Service (delivered by Southside and BAPP)	Compass (aged 8+) * Family Support and Play Service (delivered by Southside and BAPP) * Mentoring Service (delivered by	

		* Children Missing Education Service	Mentoring Plus) * Targeted Youth Support (delivered by Targeted Youth Support (delivered by Youth Connect SW) * Children Missing Education Service	
Support to address Anti-social behaviour / criminal activity / radicalisation		√		Children's Centre Services (delivered by Bright Start and Action for Children) * Connecting Families* Family Support and Play Service (delivered by Southside and BAPP) * Police (neighbourhood teams, PCSOs)

Appendix 4

	What is captured	Where it is captured	Is it shared
Universal services	Activity data	System 1 reported via Tableau	Reported to Public Health
Universal services	Individual case data including details of assessments		Not shared
Externally commissioned targeted early help services	Activity data	Power Bi	Reported to Public Health
Externally commissioned targeted early help services	Own agency assessments of needs and care plans	Connecting Families- Early Help Module Bright Start- Early Help Module Action for Children- e-Aspire Connecting families- liquid logic	Not shared (early help module reporting function not currently available but does connect with liquid logic)
Externally commissioned targeted early help services	Early Help Assessments	Paper form	Integrated Working Team and Early Help audit group
Externally commissioned targeted early services	Case studies	Quality assurance monitoring	Reported
Other Early Help services Compass	Early Help Assessment	Paper form	Integrated Working Team
EHAP	Activity data, source of referral, outcome of panel	Spreadsheet	Reported to Public Health
EHAP	Case data/ referral data Outcomes/ letters	Within EHAP team	Not shared
Statutory Service	Referrers Results of contact Case notes	Liquid logic Annex A	Not a shared system but reports produced