Bath & North East Somerset Council

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Date: 1st July 2016
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To: All Members of the Children and Young People Policy Development and Scrutiny Panel

Councillors: Lisa Brett, Matt Cochrane, Karen Warrington, Peter Turner, Sally Davis, Alison Millar and Liz Hardman

Co-opted Voting Members: David Williams and Andrew Tarrant

Co-opted Non-Voting Members: Chris Batten and Rebecca Thompson

Chief Executive and other appropriate officers
Press and Public

Dear Member

Children and Young People Policy Development and Scrutiny Panel: Tuesday, 12th July, 2016

You are invited to attend a meeting of the **Children and Young People Policy Development and Scrutiny Panel**, to be held on **Tuesday, 12th July, 2016** at **10.00 am** in the **Kaposvar Room - Guildhall, Bath.**

The agenda is set out overleaf.

Yours sincerely

Mark Durnford
for Chief Executive

If you need to access this agenda or any of the supporting reports in an alternative accessible format please contact Democratic Services or the relevant report author whose details are listed at the end of each report.

This Agenda and all accompanying reports are printed on recycled paper

NOTES:

1. **Inspection of Papers:** Any person wishing to inspect minutes, reports, or a list of the background papers relating to any item on this Agenda should contact Mark Durnford who is available by telephoning Bath 01225 394458 or by calling in at the Guildhall, Bath (during normal office hours).

2. **Public Speaking at Meetings:** The Council has a scheme to encourage the public to make their views known at meetings. They may make a statement relevant to what the meeting has power to do. They may also present a petition or a deputation on behalf of a group. Advance notice is required not less than two full working days before the meeting (this means that for meetings held on Wednesdays notice must be received in Democratic Services by 4.30pm the previous Friday)

   The public may also ask a question to which a written answer will be given. Questions must be submitted in writing to Democratic Services at least two full working days in advance of the meeting (this means that for meetings held on Wednesdays, notice must be received in Democratic Services by 4.30pm the previous Friday). If an answer cannot be prepared in time for the meeting it will be sent out within five days afterwards. Further details of the scheme can be obtained by contacting Mark Durnford as above.

3. **Details of Decisions taken at this meeting** can be found in the minutes which will be published as soon as possible after the meeting, and also circulated with the agenda for the next meeting. In the meantime details can be obtained by contacting Mark Durnford as above.

   Appendices to reports are available for inspection as follows:-

   Public Access points - Reception: Civic Centre - Keynsham, Guildhall - Bath, The Hollies - Midsomer Norton. Bath Central and Midsomer Norton public libraries.

   For Councillors and Officers papers may be inspected via Political Group Research Assistants and Group Rooms/Members' Rooms.

4. **Recording at Meetings**:-

   The Openness of Local Government Bodies Regulations 2014 now allows filming and recording by anyone attending a meeting. This is not within the Council's control.

   Some of our meetings are webcast. At the start of the meeting, the Chair will confirm if all or part of the meeting is to be filmed. If you would prefer not to be filmed for the webcast, please make yourself known to the camera operators.

   To comply with the Data Protection Act 1998, we require the consent of parents or guardians before filming children or young people. For more information, please speak to the camera operator

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5. **Attendance Register:** Members should sign the Register which will be circulated at the meeting.

6. THE APPENDED SUPPORTING DOCUMENTS ARE IDENTIFIED BY AGENDA ITEM NUMBER.

7. Emergency Evacuation Procedure

When the continuous alarm sounds, you must evacuate the building by one of the designated exits and proceed to the named assembly point. The designated exits are sign-posted.

Arrangements are in place for the safe evacuation of disabled people.

Children and Young People Policy Development and Scrutiny Panel - Tuesday, 12th July, 2016

at 10.00 am in the Kaposvar Room - Guildhall, Bath

A G E N D A

1. WELCOME AND INTRODUCTIONS

2. EMERGENCY EVACUATION PROCEDURE

   The Chair will draw attention to the emergency evacuation procedure as set out under Note 6.

3. APOLOGIES FOR ABSENCE AND SUBSTITUTIONS

4. DECLARATIONS OF INTEREST

   At this point in the meeting declarations of interest are received from Members in any of the agenda items under consideration at the meeting. Members are asked to indicate:

   (a) The agenda item number in which they have an interest to declare.

   (b) The nature of their interest.

   (c) Whether their interest is a **disclosable pecuniary interest** *or* an **other interest**, (as defined in Part 2, A and B of the Code of Conduct and Rules for Registration of Interests)

   Any Member who needs to clarify any matters relating to the declaration of interests is recommended to seek advice from the Council's Monitoring Officer or a member of his staff before the meeting to expedite dealing with the item during the meeting.

5. TO ANNOUNCE ANY URGENT BUSINESS AGREED BY THE CHAIRMAN

6. ITEMS FROM THE PUBLIC OR COUNCILLORS - TO RECEIVE DEPUTATIONS, STATEMENTS, PETITIONS OR QUESTIONS RELATING TO THE BUSINESS OF THIS MEETING

   At the time of publication no notifications had been received.

7. MINUTES - 17TH MAY 2016 (Pages 9 - 16)

8. CABINET MEMBER UPDATE

The Cabinet Member will update the Panel on any relevant issues. Panel members may ask questions on the update provided.

9. PRIMARY PARLIAMENT FEEDBACK

The Panel will receive a presentation regarding this item.

10. YOUNG PEOPLE PARLIAMENT FEEDBACK (Pages 17 - 20)

This report provides the Panel with feedback of the B&NES Young Parliament that took place at Broadlands Academy on Thursday February 11th 2016.

11. CHILDREN'S MENTAL HEALTH (Pages 21 - 52)

This report provides an update on the mental health services for children and young people in Bath and North East Somerset, an update on commissioning and strategic progress and a request for further support from the Local Authority to continue to prioritize mental health services for children and young people in Bath and North East Somerset.

12. CHILDHOOD OBESITY (Pages 53 - 88)

13. CHILDREN'S HEALTH (GENERAL) (Pages 89 - 132)

This report introduces and identifies some highlights from three sources of recent and local information.

14. CARE ACT - IMPLICATIONS FOR CHILDREN (Pages 133 - 146)

This report sets out to inform the Panel about the Care Act 2014 and the interface and implications for children and young people.

15. PEOPLE AND COMMUNITIES STRATEGIC DIRECTOR'S BRIEFING

The Panel will receive a verbal update on this item from the People and Communities Strategic Director.

16. PANEL WORKPLAN (Pages 147 - 152)

This report presents the latest workplan for the Panel. Any suggestions for further items or amendments to the current programme will be logged and scheduled in consultation with the Panel’s Chair and supporting officers.

The Committee Administrator for this meeting is Mark Durnford who can be contacted on 01225 394458.

BATH AND NORTH EAST SOMERSET

CHILDREN AND YOUNG PEOPLE POLICY DEVELOPMENT AND SCRUTINY PANEL

Tuesday, 17th May, 2016

Present:- Councillors Lisa Brett (Chair), Matt Cochrane (Vice-Chair), Karen Warrington, Colin Barrett (in place of Sally Davis), Alison Millar and Liz Hardman

Also in attendance: Ashley Ayre (Strategic Director, People and Communities), Richard Baldwin (Divisional Director for Children and Young People, Specialist and Targeted Division), Mike Bowden (Director, Children & Young People, Strategy and Commissioning) and Deborah Forward (Senior Commissioning Manager - Preventative Services)

Cabinet Member for Children's Services: Councillor Michael Evans

1 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting.

2 EMERGENCY EVACUATION PROCEDURE

The Chair drew attention to the emergency evacuation procedure.

3 APOLOGIES FOR ABSENCE AND SUBSTITUTIONS

Councillors Sally Davis and Peter Turner had sent their apologies to the Panel. Councillor Colin Barrett was present as a substitute for Councillor Davis for the duration of the meeting.

Andrew Tarrant, Diocese of Clifton, Co-opted Panel Member had sent his apologies to the Panel.

4 DECLARATIONS OF INTEREST

Councillor Colin Barrett declared an interest in agenda item 13 (Education White Paper: Educational Excellence Everywhere) as he is a Governor at Weston All Saints Primary School.

5 TO ANNOUNCE ANY URGENT BUSINESS AGREED BY THE CHAIRMAN

There was none.

6 ITEMS FROM THE PUBLIC OR COUNCILLORS - TO RECEIVE DEPUTATIONS, STATEMENTS, PETITIONS OR QUESTIONS RELATING TO THE BUSINESS OF THIS MEETING

Councillor Eleanor Jackson addressed the Panel. She said that she had recently attended the Standing Agreed Syllabus Conference for Bath & North East Somerset

SACRE (Standing Advisory Council on Religious Education) where the proposed new syllabus was discussed.

She stated that the Bath & North East Somerset SACRE had unanimously approved an agreed syllabus for use in local authority schools from 1st September 2016 and she wished to commend it to the Panel for their approval prior to being approved by the Council.

The Chair stated on behalf of the Panel that they note and recommend the approval of the new RE syllabus.

Councillor Michael Evans, Cabinet Member for Children's Services said that he endorsed the syllabus and expected coverage of religions and beliefs to be followed up at a classroom level.

7 MINUTES - 22ND MARCH 2016

The Cabinet Member for Children's Services, Councillor Michael Evans said that an amendment was required to the fifth paragraph on page 59 of the minutes relating to the Youth Justice Plan.

The sentence within that paragraph should read 'She added that the local *custodial* rate is currently zero….'

With that amendment, the Panel confirmed the minutes of the previous meeting as a true record and they were signed by the Chair.

8 CABINET MEMBER UPDATE

Councillor Michael Evans, Cabinet Member for Children's Services addressed the Panel.

First Steps Moorlands Children's Centre: B&NES is willing to grant land for the much-needed rebuilding of this centre. He said that First Steps would finance the build. During the rebuild, temporary use of land at Moorlands School is needed and that negotiations are ongoing with the head and the governing body. He hoped that this could be resolved quickly so that work could start to give the young children of the area a healthy, dry building.

Academy of Trinity: He said that the Ofsted classification relating to this school required updating following its latest findings. He added that the B&NES Local Authority Designated Officer, responsible for Safeguarding, has sent the findings of the B&NES Safeguarding Review of Trinity to the Midsomer Norton Partnership Trust (Alun Williams) and the South West Regional Schools Commissioner (Rebecca Clark).

St. Martin's Garden Primary School: The school is becoming an Academy and joining the Palladium Trust (Ralph Allen). Negotiations are ongoing between B&NES and Ralph Allen about the terms of the transfer. He added that ageing play equipment at the Margaret Coates Centre, which is part of St. Martin's Garden had been put out of use. The equipment is 15 years old and had been supplied through a

government grant. The school has appealed for donations to replace it, and B&NES is looking to help, though it cannot cover the complete cost.

Health & Wellbeing Board – Inequalities Day Workshop: This was a very well attended day that brought together many partner organisations in the field of Public Health. He said that early intervention was key to reducing the troubling inequalities in longevity and healthy life which we have in B&NES as elsewhere.

IKB Studio School: He attended the opening ceremony of the IKB Studio School at Wellsway School. He said that it was significant that the guest of honour was Dame Glynis Breakwell, Vice Chancellor of Bath University, and shows the interest in which the university is taking in promoting vocational subjects and apprenticeships.

Councillor Liz Hardman asked when the Safeguarding Review of Trinity would be published.

The Strategic Director for People & Communities replied that a summary report would be published in due course and that Political Group Leaders would receive a briefing. He added that the full report would be sent to the Department for Education, the Regional Schools Commissioner and local Diocese.

Councillor Liz Hardman commented that the recent White Paper indicates possible changes for the roles of the Cabinet Member and Strategic Director. She asked if he had any thoughts on this at this stage.

Councillor Michael Evans replied that he had no comment to make at this time as the White Paper was in its relatively early stages.

The Chair thanked him for his update on behalf of the Panel.

9 UPDATE ON COMMISSIONED FAMILY SUPPORT SERVICES

The Chair said that she was pleased to see that there had been no decrease in targeted support following the remodelling of Children's Centre Services that had taken place. She asked what steps have been taken to ensure that the errors in the first tendering of Family Support and Play Services are not repeated.

The Senior Commissioning Manager for Preventative Services replied that officers now have more clarity of the procurement process and have been working with the Information Governance team.

Councillor Matt Cochrane asked if this would lead to any impact on service delivery.

The Senior Commissioning Manager for Preventative Services replied that services were not affected by this process taking place.

Councillor Liz Hardman asked if there was a danger that some of the centres could still be closed in the future.

The Senior Commissioning Manager for Preventative Services replied that a range of partners now use the centres including voluntary groups and health teams and

that work was ongoing to look at how their costs associated with the centres can be incorporated into future budgets.

The Chair asked how the charges for the Council run universal groups compare with other toddler groups.

The Senior Commissioning Manager for Preventative Services replied that the charges were set at a competitive rate.

Councillor Colin Barrett asked why there was such an increase in the percentage of families accessing targeted support 10 months pre and post 1st June 2015 in Keynsham / Chew Valley.

The Senior Commissioning Manager for Preventative Services replied that this was likely to be as a result of more effective targeting.

Councillor Liz Hardman asked if families from rural areas were entitled to any financial assistance in relation to transport costs to attend centres.

The Service Manager for 0-11 Outcomes replied that when there are targeted services running that restrict certain families from attending we will do all we can to enable a family to access the group and sometimes this might involve support with transport costs. She added that they now run groups in a number of rural areas such as Timsbury, Cameley, Longvernal so that families are served in some of our remoter parts.

Councillor Liz Hardman commented that there were no universal services currently available within Paulton.

The Senior Commissioning Manager for Preventative Services replied that some targeted services were still available and that 1-2-1 work was ongoing.

Councillor Alison Millar asked how Health Visitors felt about the changes that have occurred.

The Senior Commissioning Manager for Preventative Services replied that it was a culture shock for some to be based within the centres. She added that the levels of early support and interventions have improved from this form of partnership working.

The Panel **RESOLVED** to:

(i) Note the updates provided in this paper.
(ii) Receive an update on the new Family Support and Play Service one year on.
(iii) Receive a paper on the evolving performance framework for Early Help Services in due course.

10 NEETS - YOUNG PEOPLE NOT IN EDUCATION, EMPLOYMENT OR TRAINING

Councillor Liz Hardman asked what the percentage of NEETs was in relation to Looked After Children.

The Divisional Director for Children and Young People, Specialist and Targeted Division replied that 66% of care leavers were in Education, Employment or Training compared with 56% in 2015.

Councillor Liz Hardman asked what work was being done with regard to the remaining 34%.

The Divisional Director for Children and Young People, Specialist and Targeted Division replied that it can take time to build relationships and that it was likely that this cohort would have had some previous issues relating to education. He added that he was proud of their current record

The Strategic Director for People & Communities added that the young people can opt not to work with us as other life events take priority. He added that research indicates that if a young person is not in Education, Employment or Training when they are 16 / 17 then they are likely to be in and out of casual employment by the time they are 18.

The Chair thanked the Divisional Director for Children and Young People, Specialist and Targeted Division for his update on behalf of the Panel.

11 EDUCATION WHITE PAPER: EDUCATIONAL EXCELLENCE EVERYWHERE

The Chair stated that B&NES has a good record on running schools and a dedicated, talented workforce that provides excellent support to our local schools. She said however, as more schools are incentivized to convert to academies it is inevitable that eventually a critical mass will be reached when it is no longer considered viable for the Council to support the remaining Primary schools.

She said that the Panel do not want to lose the high quality experience and expertise of B&NES Council staff from its local educational service provision.

She added that Councillor Evans is also keen to ensure healthy competition exists between Multi Academy Trusts (MAT) and to avoid a local monopoly forming.

She explained that as an outcome of their pre-meeting the Panel would like help scope the setting up of a partner organisation, similar to Sirona, to act as a MAT for all B&NES primary schools who want to join.

She stated that in order to ensure the scheme is impartially compared against alternatives, she would like to ask officers to begin the process by conducting a SWAT analysis of creating a partner ‘Sirona style’ MAT, a SWAT of undertaking a ‘do nothing’ approach and a SWAT for facilitating a co-operative MAT.

She added that concurrently, she would like officers to sound out the level of interest amongst non-faith based Primary School Heads.

The Director for Children & Young People, Strategy & Commissioning replied that constructive conversations have taken place with some Primary Heads along these lines and that it was envisaged that they would disseminate this information to colleagues within the area.

Councillor Liz Hardman said that she felt it was wrong for schools to be forced into becoming an Academy especially as there was no evidence to support that standards would improve. She added that she remained concerned over lack of local accountability that leaves the Council powerless to intervene when problems are observed.

The Strategic Director for People & Communities said that a series of meetings with Head Teachers and Governors began last summer. He said that if a school decided to become either a Co-operative Trust or a Charitable Trust this would not be prevent them from joining a MAT.

He urged schools to not get sucked into the marketing behind academisation and to make choices on behalf of their pupils. He said that officers were available to discuss their options.

He added that the team involved with the Chew Valley Educational Trust were doing a fantastic job.

Councillor Karen Warrington asked if it were possible for the Panel to see any documents relating to the Chew Valley Educational Trust.

The Strategic Director for People & Communities replied that he would check and circulate if possible.

Councillor Matt Cochrane asked if officers had any figures to hand relating to schools having become or considering becoming an Academy.

The Strategic Director for People & Communities replied that 11 had already become academies and that 9 were in the process of doing so.

The Chair asked that the Panel meet informally in one month's time to discuss the matter further and receive the requested analysis from officers.

12 PEOPLE AND COMMUNITIES STRATEGIC DIRECTOR'S BRIEFING

The Strategic Director for People & Communities addressed the Panel, a summary of his briefing is set out below.

Social Work Recruitment: He said that following a recent question from the Chair that a report relating to Social Work recruitment could be prepared for a future meeting. He thought though that it would be helpful at this stage to outline the current position.

- 'Rolling' adverts in the professional press for Social Workers, Deputy Team Managers (DTMs) and Team Managers (TMs).

- Provision of a bursary / “golden hello” for new recruits and newly qualified Social Workers (£2k - £3k).
- Extensive professional and practice support for newly qualified Social Workers during their first year of practice.
- Support for accredited training to reach advanced practitioner levels with the opportunity to study to MSC/MA level.
- Opportunities to progress to Senior Practitioner level prior to or as an alternative to managerial promotion.

Councillor Matt Cochrane asked if the bursary was a suitable incentive.

The Strategic Director for People & Communities replied that it was in line with offers of other local authorities.

Councillor Matt Cochrane asked if the Council had considered offering a second year bursary.

The Strategic Director for People & Communities replied that he would be willing to examine that option.

Councillor Karen Warrington commented that she would like to see schools encouraged to provide more information on this career to pupils.

The Strategic Director for People & Communities replied that the Council is involved with Step Up to Social Work which is an intensive full-time training programme that covers everything trainee social workers need to know in 14 months. He added that we also work with the UWE and the universities in Bath, Bristol and Cheltenham.

Adoption Services: The Government have legislated to develop a series of regional or sub-regional Adoption Agencies that will incorporate the Adoption functions of the Local Authorities within a region.

B&NES has been working with North Somerset, South Gloucestershire, City of Bristol, Wiltshire and Gloucestershire on a proposal for a single Adoption Agency working in partnership with the Voluntary Adoption Agencies (all charities) that operate across the joint administrative area.

A report will be submitted to the Cabinet in July across all six Local Authorities requesting permission to develop a proposed single agency to become operational from April 1st 2018. A further report for decision will then come to Cabinet in late Autumn 2016. The Panel may wish to receive a report on this at their September meeting.

Councillor Alison Millar asked how many adoptions took place within the last year in B&NES.

The Divisional Director for Children and Young People, Specialist and Targeted Division replied that it was 12, which was a lot for a Council the size of B&NES.

The Strategic Director for People & Communities added that it is so important to find the right permanent solution for the child concerned.

Councillor Liz Hardman asked if support is provided to adoptive parents.

The Strategic Director for People & Communities replied that it was and as such there has not been a breakdown of relationships over the past ten years.

The Chair thanked him for his update on behalf of the Panel.

13 PANEL WORKPLAN

The Chair introduced this item to the Panel. She suggested that as it would fit well with other items that the Healthy Weight Forum Presentation be scheduled for July 2016.

The Divisional Director for Children and Young People, Specialist and Targeted Division said that as requested he had spoken to the Senior In Care Council about them addressing the Panel at a future meeting. He said that they would be happy to attend the next scheduled evening meeting in November.

Councillor Eleanor Jackson suggested that the Panel receive a report in September regarding Youth Work Development.

The Strategic Director for People & Communities said that the Panel could receive a report in the autumn on the issue of Unaccompanied Asylum Seeking Children.

The Panel **RESOLVED** to approve all of the above proposals.

The meeting ended at 7.30 pm

Chair(person) .....

Date Confirmed and Signed .....

Prepared by Democratic Services

Bath & North East Somerset Council

Report of the Young Parliament

The B&NES Young Parliament took place at Broadlands Academy on Thursday February 11th 2016. Over 80 young people attended from 11 different secondary schools, one special school and from a range of settings including Project 28, the CAMHS Young People's Participation Group, the Youth Forum, Off the Record, SPACE (LGBT Group) and prospective candidates for the B&NES Member of Youth Parliament. There were 20 accompanying staff and workshop facilitators and 15 guests, including the Chair of the Council, Cllr Ian Gilchrist.

The event was organised by staff and students of Broadlands School Council in collaboration with the Local Authority.

Introductory Speeches

After short welcoming comments by Broadlands students and the Headteacher, Dean Anderson, there were keynote speeches by members of the Youth Forum and members of Chew Valley Mental Health Team, who discussed the inspirational work they were undertaking to make a difference to the lives of young people locally.

Workshops

There were 4 workshops, co-facilitated by Broadlands students and adults from the Local Authority, Public Health, Off the Record and CAMHS. Following workshop discussion and debate in the morning, students presented their recommendations and action points in the afternoon as follows:-

A. Social media and its impact on mental health

What to do if you are a victim of online abuse/harassment

- Depending on the situation, not responding might be an appropriate course of action
- Speak to someone – friend or adult (teacher, parent or police) depending on the circumstances
- Use online reporting tools
- Challenging the behaviour directly with the person if known – "I don't like it when you….., it makes me feel….."

What actions we can take as an individual / group / school to improve things

- Raise awareness of what tools and courses of actions are available to everyone
- Set up a Cyber Mentoring scheme as they have done in Norton Hill
- Take part in Safer Internet Day
- Encourage all to know the affect online communication can have
- Help people to develop better online communication skills (be aware of how things may be interpreted)
- Raise awareness of the Bystander effect

Sexual Health & Social Media

One group also discussed the impact that sex can have on mental health and that the following should be covered in PSHE. Anxieties around:-

- Sexually transmitted infections
- Peer pressure / anxiety about having sex , (feeling their friends have done it and they don't want to feel left out)
- Getting it right (pornography paints a very unreal picture of the reality of sex)
- Issues of diversity (ensuring that LGBT issues are covered in Sex and Relationships Education)
- Issues related to pornography and sexual coercion and violence
- General emotional guidance re sexual relationships (not rushing into it and doing it with the wrong person)

B. Keeping mentally healthy and reducing stigma

This group decided on the following recommendations :

- All schools (staff and students) to sign up to a pledge which covers confidentiality (nothing will be shared unless someone is at risk of significant harm)
- Slurs of any type are not acceptable - students and staff will challenge this when they occur - there will be consequences for not following this.
- Diversity will be actively celebrated and each young person's individual needs catered for.

C. Ways to increase self esteem

This group wanted schools to promote kindness and compassion both to fellow students and towards themselves as they believe this leads to better mental health and improved self-esteem. They would like these issues to be included within PSHE but would also like students to be involved in deciding how their school can promote kindness and compassion. They discussed and identified a range of ways to promote kindness towards themselves and others, such as:-

- Random acts of kindness
- Doing something nice for someone new every day
- Smiling at people
- Having a happiness book for people to write things to make them happy
- Doing activities which make you / your friends happy
- Getting outside
-

D. Where to get help and support on mental health issues

Suggestions were:-

- All schools to have PSHE Lessons to address what to do if you are worried about a range of issues
- Access to a safe, peaceful space to go if they feel stressed and anxious. This place could be staffed with a counsellor or someone that has the time to listen to what they are feeling. Or it could be run by young people

themselves. It should be able to signpost to leaflets posters or websites for further support and be a comfortable space to relax in. This could inform the Secondary resilience hubs being piloted in our schools. The transformation plan talks about having such hubs in all BANES secondary schools and the college.

- Schools to provide ideas on self-help. Have posters and/or lessons with lots of ideas to support you if you are feeling down.
- We mentioned music, pictures, text messages or emails to yourself, having a happiness book to go and read (or make your own).
- School planners as a source of information for websites and phone numbers etc.
- Website links on school websites for them and for parents and schools helping them with strategies for helping themselves etc.
- Assemblies from people who have mental health problems and or work in services like CAMHS

Taking action points back to schools / settings

Delegates were reminded to take the list of action points back to their schools and settings and arrange a meeting with the School Leadership Teams to discuss the issues that had been raised at the Parliament. A follow-up meeting of young people representatives will be held in the near future.

Member of Youth Parliament Elections

The afternoon session also provided an opportunity for the 6 prospective MYP candidates to give short presentations based on their manifestos and for Becky, the current MYP, to explain about the process and importance of the election.

Questions to the Expert Panel of adults

The final session was a question and answer session: delegates to the Parliament had decided on questions to ask the adult panel during their workshops. The panel consisted of Kate Murphy and Judy Allies (School Improvement), Clare Laker (Public Health) , Gill Welsh (CAMHS) , Lisa Benham (Off The Record) and Mike Bowden (Deputy Director , Children and Young People Strategy) . Questions ranged from issues of funding for mental health services , ensuring the reduction of stigma, how to ensure that Sex and Relationships Education takes account of the diversity of relationships (LGBT), providing mental health resources to schools and ensuring that we promote the idea of being kind to yourself (self-compassion) in all settings. There were also questions from the floor about support for parents / carers and CSMHS services.

Closing Words

The Chair of the Council closed the Parliament and thanked all who had attended but especially Broadlands for their excellent organisation and hospitality.

K. Murphy
February 2016

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Bath & North East Somerset Council		
MEETING/ DECISION MAKER:	**Children and Young People Policy Development & Scrutiny Panel**	
MEETING/ DECISION DATE:	**12th July 2016**	EXECUTIVE FORWARD PLAN REFERENCE:
TITLE:	**Update on the provision Mental Health Services for Children and Young People in Bath and North East Somerset**	
WARD:	All	

AN OPEN PUBLIC ITEM

List of attachments to this report:

- CAMHS Transformation Plan 2015/16: http://www.bathnes.gov.uk/sites/default/files/sitedocuments/Children-and-Young-People/banes_transformation_plan_oct15.docx
- For you, by you- call for young people's engagement in the re-procurement of PCAMHS/CAMHS- (poster attached as Appendix 1)
- KOOTH- on-line support and counselling for young people- poster (Attached as Appendix 2)

1 THE ISSUE

1.1 This report provides an update on the mental health services for children and young people in Bath and North East Somerset, an update on commissioning and strategic progress and a request for further support from the Local Authority to continue to prioritize mental health services for children and young people in Bath and North East Somerset.

2 RECOMMENDATION

2.1 To note the progress of the 15/16 CAMHS Transformation Plan

2.2 To note that targeted and specialist Children and Adolescent Mental Health Services (CAMHS), currently provided by Oxford Health NHS Foundation Trust (OHFT) are being re-commissioned jointly with Wiltshire and Swindon CCGs/LAs in 2017.

2.3 To note the invitation to young people to engage with the re-procurement

2.4 To support the priorities being progressed within the CAMHS Transformation Plan for 2016/17

3 RESOURCE IMPLICATIONS (FINANCE, PROPERTY, PEOPLE)

3.1 Continuing re-design of mental health services for children and young people is taking place, in the context of the overarching savings requirements of the Council and the CCG. NHS England has committed additional funding for children's mental health services and the CAMHS Transformation Plan 2016-2017 details the priority areas that have been agreed for the allocated funding.

3.2 The annual cost of this contract with Oxford Health NHS Foundation Trust (local CAMHS provider) is about £2.1m for the NHS and Local Authority in Bath and North East Somerset. This represents just under a third of the overall current and planned joint contract with Wiltshire

4 STATUTORY CONSIDERATIONS AND BASIS FOR PROPOSAL

4.1 Statutory duties of the NHS and Council for the provision of Health and Social Care Services

5 THE REPORT

5.1 CAMHS Transformation Plan – update on 15/16 and plans for 16/17

In August 2015 NHS England announced additional funding and guidance to implement the **Future in Mind** report's recommendations to improve CAMHS services. To "draw down" these funds, each CCG was required to submit an agreed CAMHS Transformation Plan by October 2015.

From April 2015 a number of developments to support the transformation plan began:

1. ***Pilot - Extended CAMHS support: for > 18 y/o's*** who were receiving CAMHS interventions when they turned 18 and, although they are particularly vulnerable; do not meet the referral criteria for adult mental health services. This cohort will include, but is not restricted to, Care Leavers and will provide intensive emotional support.
2. ***Pilot - Early Intervention in Psychosis:*** Pilot to improve fidelity to the early intervention in psychosis model by building links with CYP substance misuse, developmental disorder, CAMHS, schools and other services.
3. ***Pilot - School Based Counselling****:* Independent counsellors have been commissioned to provide individual 'drop in' advice sessions and formal counselling sessions at seven secondary schools from September.
4. ***Pilot - Resilience Hubs****: (*See above) These complement school based counselling and have also started in the new academic year.
5. ***Pilot - Mindfulness Pilot:*** 32 members of staff from *2* secondary schools have undertaken an 8 week Mindfulness course. 2 staff from each school will now be trained to deliver Mindfulness in Schools sessions/resources directly to young

people.

6. ***KS4 resource packs****:* Mental Health PSHE Resource packs for Key stages 3&4 are being developed in partnership between School Improvement and the CAMHS participation group.
7. ***Specialist Family Support and Play re-procurement****:* A review has resulted in a new combined service model being procured to provide early intervention with 5-13 years olds with a range of emotional and social issues.
8. ***Protocol between CAMHS and police****:* has been implemented to reduce inappropriate attendances at the S136 suite.
9. ***Pilot - CAMHS self-referral for 16 and 17 y/o's:*** is being trialled by provider
10. ***ASD support service****:* Additional SLT sessions have been commissioned to 'speed' up ASD diagnosis and a new parent support worker will visit families whose children with ASD refuse to attend school.
11. ***Eating Disorder Specialist service****:* Agreeing new service model with provider and neighbouring CCGs

Did things go according to the 15/16 CAMHS Transformation Plan?

The majority of the identified priorities and developments were delivered as planned. The only exceptions were as follows;

- "The consideration and development of a single point of access or 'single front door' to enable practitioners, parents/carers and CYP to contact and thereafter receive, at the earliest opportunity, the most appropriate help." The scope and implications of a 'single front door' was discussed with social care, Early Help services and health commissioners. Discussions concluded that no independent review could be commissioned and concluded within the necessary six month timescale. Hence the budget planned for this (£10,000) was reallocated. Nevertheless the idea remains aspirational but would require a phased implementation over a number of years.

- The plan to scope support for parent/carers whose children do not engage with services being offered to them. Due to parallel reviews of both the LA's Parenting strategy and Behaviour strategy, it was decided to await the outcome of these reviews to inform any gap analysis for those parents/carers who can feel very powerless when their children, for whatever reason, choose not to engage with services.

- Three developments were delayed due to recruitment difficulties and/or legal commissioning requirements. As a result the therapeutic support for social care, college hubs and the on-line counselling service were 'under budget' and some of the underspend was used to contribute towards the infant mental health service.

- The specialist family support and play re-procurement was not completed during 15/16 but is now underway again.

- Although useful digital EHWB websites have been identified, final decisions about where and how to host these have not been taken. The new on-line support service (KOOTH) has the facility to offer a tailored webpage to direct B&NES CYP and this is being explored, together with the option of a page hosted on B&NES LA website.

5.2 Planning for 16/17 CAMHS Transformation Plan

B&NES Clinical Commissioning Group (CCG) has received £380,000 allocation for the 16/17 CAMHS Transformation Plan with an additional £96,000 for specialist eating disorder services.

The 2016/17 CAMHS Transformation Plan continues to deliver against priority areas identified in the Future in Mind report.

Discussions with GPs, the Director of People & Communities, Behaviour & Attendance Panels, School Nurses, Specialist CAMHS (OHFT), Your Care Your Voice and EHWB Strategy group members has resulted in the following commissioning priorities being identified.

- More direct interventions for CYP who do not meet the referral criteria for CAMHS but who do require additional support from trained staff who can provide evidenced based interventions and who have access to consultation and supervision themselves.

- As a consequence we are proposing to spend some of the 16/17 funding on independent counselling services. These have proved to be popular and effective interventions both within the school setting and the wider community. (There has been a lack of equity around access to these services, some of which have received funding from Schools Forum and CAMHS TP funding. A further request will be going to Schools Forum to contribute more funding for school-based counsellors at those schools who have not yet benefitted.)

- The implementation of the secondary school Emotional Resilience Hubs has been variable and reflects challenges identified in a similar national pilot. Due to practical complexities and the cultural shifts required it has been decided to continue funding the pilot for another academic year and to review the service again before committing any more local future funding.

- The flexible transition service is a small but important service for very vulnerable young people approaching their 18th birthday. This offer will continue but may be a different service offer at a reduced cost.

- Perinatal services for mothers with anxiety and depression and their infants will be reviewed.

- The individuals and institutions that support CYP – midwives, health visitors, primary and secondary school teachers, pastoral support staff etc. – often require training in attachment, behaviour and how they can create environments that develop resilience. Training needs to be more collaborative, co-ordinated and should adopt the principles and practices used by the national CYP IAPT collaborative. Digital training resources should be widely promoted. A small working group (with a small budget) will progress this priority.

5.3 Re-procurement of CAMHS after 31 March 2017

The current CAMHS contract runs to March 2017 and the service is provided by Oxford Health NHS Foundation Trust. The joint contract is led by Wiltshire CCG,

and both CCGs benefit from the commissioning of specialist services across a greater population, (e.g. Eating Disorder and Learning Difficulties Services) as well as 'out-of-hours' cover which would not be viable on a B&NES-only basis.

Given the timing of this process relative to development of the Your Care Your Way model, in February 2016 B&NES CCG committed to a further joint contract with Wiltshire, whilst signalling that this is a service we would wish to explore bringing within the umbrella of the prime provider arrangement in due course.

Proposal

The intention is to jointly recommission both primary (PCAMHS) and specialist CAMHS for a 5 (+2) year period across Wiltshire and B&NES.

The annual values of B&NES CCG's current contract with OHFT are as follows:-
CAMHS Contract Baseline 15/16: £1,924,680 (this includes a £317,000 contribution from B&NES council)
PCAMHS Contract Baseline 15/16: £245,712
These figures *do not* include 15/16 or 16/17 contract variations for investments and CAMHS Transformation Plan funding).

This involves aligning CAMHS and PCAMHS budgets from across Wiltshire CCG, Wiltshire Council and B&NES CCG and funding the new service under one contract, with Wiltshire CCG being the Lead Commissioner. Swindon CCG is also actively considering becoming a joint commissioner in this process. There are efficiencies in having a service that works across a wider geographical footprint and this joint commissioning model is in line with the local Bath, Swindon and Wiltshire Sustainability and Transformation Plan (STP).

Commissioners aim to develop a new service delivery model which will improve the quality of service and experience for children, young people and their families. This will be achieved by removing tiers; encouraging improved coordination between mental health services, GPs, schools, the local authority and the voluntary and community sector; and providing evidence based interventions and treatment that works in non-stigmatised community settings, close to home. These changes should provide children and their families with faster access to the right help they need, at the right time and in the right place.

A range of stakeholders will be involved in the development of a new service delivery model for CAMHS (covering Wiltshire, Swindon and B&NES). Importantly this will include children, young people and their families. Professionals who work with children will also be involved from across health, education, social care and the voluntary and community sector.

6 RATIONALE

6.1 The priorities in the Transformation Plan have been developed in consultation with stakeholders and represent the agreed view of priorities guided by the national criteria for the funding and our EHWB Strategy.

6.2 The rationale for re-commissioning jointly with Wiltshire is described in para 5.3 above.

7 OTHER OPTIONS CONSIDERED

7.1 Various options for the Transformation Plan were considered in consultation with stakeholders and the priorities were agreed by the EHWB Strategic Group.

8 CONSULTATION

8.1 This report has been prepared by the CAMHS Commissioner and the chair of the Emotional Health and Wellbeing Strategy Group: the planned re-procurement of the PCAMHS/CAMHS service has been endorsed by the CCG in B&NES and Wiltshire. Priorities identified by children and young people through a number of participation processes- SHEU, Primary and Pupil Parliaments , Your Care Your Voice and the Member of Youth Parliament have been incorporated into the development of the CAMHS Transformation Plan and the PCAMHS/CAMHS re-procurement.

9 RISK MANAGEMENT

9.1 A risk assessment related to the issue and recommendations has been undertaken, in compliance with the Council's decision making risk management guidance.

9.2 Appropriate risk management in place for the procurement.

Contact person	Margaret Fairbairn, Health Project Manager Mary Kearney-Knowles, Senior Commissioning Manger Specialist Services Mike Bowden, Director for Children and Young People - Strategy and Commissioning
Background papers	*List here any background papers not included with this report, and where/how they are available for inspection.*
Please contact the report author if you need to access this report in an alternative format	

Appendix One

Bath & North East Somerset, Swindon & Wiltshire Clinical Commissioning Groups

'Working together for the future'

Supporting children and young people's emotional wellbeing and mental health

WE NEED YOUR HELP

We are looking for young people from across the Bath and North East Somerset, Swindon and Wiltshire areas to help us choose the right organisation to deliver a new mental health service for children and young people.

Could you be one of those people?

Are you interested in child and adolescent mental health?	Do you have an opinion on how to stay emotionally well?	Are you confident to say what you think and to ask difficult questions?

If you can answer yes to the above, are available to give some time during July and August 2016, and would like to find out more please contact us.

voiceandinfluenceteam@wiltshire.gov.uk

01225 713712

Appropriate expenses will be paid and young people will be fully supported in this process

Appendix 2


GOT A PROBLEM?
NEED ADVICE?
FEELING LOW
WWW.KOOTH.COM
Self harm
RELATIONSHIPS
Being abused
BULLYING
Sexuality; gay, lesbian or just confused
Eating disorder
Award-winning counselling services for young people
KOOTH.COM is a FREE, ANONYMOUS, CONFIDENTIAL website where young people can go for help.
> Drop-in chats
> Booked 1:1 sessions
> Themed message forums and lots more
87% of our users prefer online counselling so visit www.kooth.com
help
KOOTH.COM
FREE ONLINE SUPPORT FOR YOUNG PEOPLE

Bath & North East Somerset Council

NHS
Bath and North East Somerset Clinical Commissioning Group

Children & Young People's CAMHS Transformation Plan

Version 2 16/10/15

The purpose of the Transformation Plan is to help improve the emotional wellbeing and mental health of children and young people (aged < 18) living in Bath & North East Somerset (B&NES). This plan evidences the strong partnership approach and commitment to emotional health and wellbeing; that is well established in B&NES. It aims to further transform local provision with greater co-production with schools, colleges and service users; with the intended outcome of B&NES "families" having improved resilience and positive emotional wellbeing. The Plan co-ordinates the planning and commissioning of services to ensure that resources in all partner agencies are used in the most effective way to improve children and young people's emotional health.

1. National Context

DoH evidence[1] confirmed that

- The cost of mental health problems to the economy in England has recently been estimated at £105bn, with treatment costs expecting to double in the next 20 years.
- 50% of lifetime diagnosed cases of mental illness start by the age of 14
- Poor mental health in childhood is associated with poor childhood and poor adult outcomes.
- 10% of children at any one time have mental health problems

The 2010 national public health strategy[2] gave equal weight to both mental and physical health and focused on tackling the underlying causes of mental ill-health. The strategy noted;

- Intervening early for children with mental health problems has been shown not only to reduce health costs but also realise larger savings such as improved educational outcomes, reduced unemployment and less crime.
- 25-50% of mental health problems are preventable through interventions in the early years.

[1] *Healthy Lives, Healthy People (Nov 2010) and No Health Without Mental Health (Feb 2011)*
[2] *Healthy Lives, Healthy People (Nov 2010),*

National strategy expects early intervention and preventative services to be provided by partnership working between the NHS, local government and the third sector.

A number of documents have been published since 2011 which illustrate the government's commitment to improve mental health for all age groups.

The most recent and important one for children and young people, published in 2015 is: *Future in Mind*
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf

Others relevant documents are listed in Appendix 1:

2. Links with Children and Young People's Plan (CYPP)

a) The CYPP 2014-2017 - the commissioning and delivery plan to improve the general health and wellbeing of children and young people across B&NES - outlines the Children's Trust Board's vision and priorities for the period 2014-17.

The vision is:

'We want all children and young people to enjoy childhood and to be well prepared for adult life.'

The CYPP's 3 key outcomes are:

Children and Young People are Safe
Children and Young People are Healthy
Children and Young People have Equal Life Chances

The vision for good mental health for children and young people is**:**

'All children and young people, from birth to their eighteenth birthday, are supported to develop and maintain good mental health, a sense of well-being and emotional resilience. Any children and young people with emotional difficulties and mental health disorders have access to timely, integrated, high quality, multi-disciplinary mental health services to ensure effective assessment, treatment and support, for them and their families.'

Bath & North East Somerset commissioners aim to commission and develop services which:

- Help children & young people learn the skills they need to stay emotionally healthy
- Ensure the delivery of a comprehensive range of services to tackle mental health problems before they become entrenched

- Work with adult mental health services to minimise the impact of parental mental ill-health on children and young people
- Identify children & young people who need extra support and provide it as early as possible for as long as it is needed
- Meet children & young people in the most accessible place possible
- Periodically review services to ensure resources are being used in the best possible way

b) The following commissioning principles are promoted:

Multi-agency working: a key principle of the strategy is that mental health is the 'business' of all agencies, and a joint approach is required to improve children & young people's mental health. There is a commitment to an integrated care pathway for children & young people with emotional and behavioural difficulties which addresses how universal, targeted and specialist services work together to best meet the needs of children, young people and their families. Children & young people may have a 'lead professional' to help coordinate services.

Early Intervention: There is a focus on early intervention; in terms of early in the life cycle, early identification of difficulties and early intervention. Hence multi-agency services that promote the mental health of all children & young people (including building resilience) and provide early identification and preventative interventions are commissioned alongside services to meet the needs of children & young people with established or complex problems. Interventions are best provided 'nearest' the child or young person i.e. provided by practitioners with the 'lowest level of specialism' (but nevertheless with the necessary skills and competencies).

Evidence-based practice: Services should provide mental health care which is based upon the best available evidence, including relevant NICE guidelines.

Addressing inequalities: Services must be provided to children & young people regardless of their ethnicity, gender, sexual orientation and/or religion. All services should pro-actively consider the specific needs of children and young people

- from black and minority ethnic groups (including migrant families),
- with physical and learning disabilities
- who are - or are at risk of becoming - young offenders
- who are - or are at risk of entering - the care system
- who are lesbian, gay, bisexual, transgender or questioning their sexuality
- who are being bullied or discriminated against for other reasons e.g the way they look or their economic circumstances

Service User involvement: All services should have a commitment to increasing the participation of service users, parents and carers in the planning and evaluation of services to ensure that services are designed around the needs of children, young people and their carers as opposed to the needs of individual agencies.

Clear service expectations and outcomes: Services will be commissioned against clear expectations, outputs & outcomes, detailed in service specifications and monitored to ensure compliance and quality.

c) Links with other strategic work;

- There are links to the Suicide Prevention Strategy Group and the Self-Harm Steering Group via the Mental Health representative from Public Health. Some actions from the Suicide Prevention Strategy Action Plan form part of the Action Plan for the EHWB Strategy.
  The current Suicide Prevention Strategic Plan and Action Plan can be viewed here: http://www.bathnes.gov.uk/services/public-health/guide-programmes-strategies-and-policies/suicide-prevention-strategy-2012

- Perinatal Mental Health.
  B&NES is working towards creating a perinatal mental health strategy. The working group consists of commissioners and providers from maternity, adult mental health, children and adolescent mental health and health visiting and primary care services.

3. Promoting and protecting good Mental Health

The Mental Health Foundation[3] believes that good mental health is characterised by a child's ability to fulfil a number of key functions and activities, including:

- The ability to learn
- The ability to feel, express and manage a range of positive and negative emotions
- The ability to form and maintain good relationships with others
- The ability to cope with and manage change and uncertainty

There are a number of 'protective' and 'risk' factors known to be associated with good emotional health. These are reproduced in Appendix 2.

4. Prevalence of emotional and mental ill-health in Bath and North East Somerset

[3] **http://www.mentalhealth.org.uk/**

Symptoms of poor emotional health may differ according to a child's personality, personal history, community and environmental factors. Symptoms include behavioural problems, substance misuse, self-harm, suicide attempts, eating disorders, depression, anxiety, obsessions and episodes of psychosis.

Local Profile of CYP

- 2013 population estimates for the 0-17 population living in households in B&NES was 34,214. This is 19% of the total population. ONS mid-year population estimates)
- Planned housing: The Core Strategy 2014 cites an increase in housing of 13,000 with the main areas for development being: Bath (7,020); Keynsham (2,150) and Somer Valley (2,470).
- 6,273 (25%) are lone parent households. Lone parents with dependent children rose by 17% between the 2001 and 2011 census.
- 2013 school census data suggests that B&NES school population (4-18 years) is 21,408 in total (January 2013), of which 10.72% classify themselves as BME (i.e. non-white British). In 2015 the population of BME under 5's was 14.6% (1,307) with the highest density in Central Bath (Parkside Children's Centre area – at 24.5%, or 255 children; Moorlands CC area 21%; Weston 19% and St. Martin's 18.7%).
- The growing under 5 y/o BME population is further evidenced by looking at the % of new-born BME children born in the last year. This was 20.2% compared with 13.6% of current 4 year olds.
- The 2011 Census showed the population of Bath & North East Somerset to be 90% White British and 10% other ethnicities.
- In 2014, 1.70% of primary school children and 1.30% of secondary school children and young people had statements of special educational needs compare with the national English average of 2.8%. (DfE National Statistics: Special Educational Needs in England: January 2015).
- • 2013-14, only 19.6% of SEND children attained 5+A*-C grades at GCSE compared to 69.2% of 'non SEND' children in B&NES. This gap is wider than the national England gap of 43.9%.
- According to the 2011 Census:
    - 1.09% of children aged 15 and under in B&NES were providing some (1+ hours) unpaid care per week, similar to the South West (1.21%) and England (1.11%).
    - 3.0% of young people aged 16-24 in B&NES were providing some (1+ hours) unpaid care per week, significantly lower than the South West (4.2%) and England (4.8%).
    - 0.21% of children aged 15 and under in B&NES were providing considerable (20+ hours) unpaid care per week, the same as the South West and England.
    - 0.6% of young people aged 16-24 in B&NES were providing considerable (20+ hours) unpaid care per week, significantly lower than the South West (4.2%) and England (1.0%).

- In addition, in the 2015 SHEU survey of school pupils (see later), 186 pupils (6% of respondents) said they cared for family members after school on the day before the survey, suggesting caring roles may be unreported in the Census.
- The JSNA in Bath and North East Somerset is a “live” document that is updated on ongoing bases, as new data/feedback becomes available.

Local intelligence regarding emotional health and wellbeing

Intelligence on the emotional health and wellbeing of children and young people B&NES, alongside mental health problems, comes from a number of sources. The following data is predominately drawn from Bath and North East Somerset’s Joint Strategic Needs Assessment, Public Health England (2014) CYP MH profile, National Child and Maternal Health Intelligence Network, CAMHS Needs Assessment Tool and the Authority’s Schools Health Related Behaviour Survey.

a. Self reported difficulties

B&NES Public Health, commission The Schools Health Education Unit (SHEU) to complete a Health Related Behaviour Survey in both primary and secondary schools on a biennial basis. The surveys have been developed by health and education professionals, and cover a wide range of topics. The SHEU Surveys in B&NES in 2015, 2013 and 2011 asked school children in B&NES a number of questions linked to their wellbeing in terms of satisfaction with life, the extent to which they worry about things and their self-esteem.

Data from this survey can inform planning and discussion on the basis that a large number of B&NES’ pupils complete it. At time of writing only secondary school data for 2015 is available with year 8 (1,648) and 10 students (1,487) having participated. It should be noted, however, that those completing the survey do not represent a random sample of young people in the authority and excludes those attending non-participating schools (2 out of 14 secondary schools), young people absent on the day due to illness or exclusion, those with limited access to computers, those attending schools elsewhere and those who opted out. Primary school data will be analysed, summarised and reported by December 2015. Each school has additional access to its ‘own’ data and, in conjunction with public health colleagues, can think about addressing specific issues pertinent to their individual school e.g. revising PHSE programmes.

The survey asks a number of questions relating to emotional health and wellbeing. When it is stated that something is significantly higher/lower it means that the difference is statistically significant

Satisfaction with life
When rating how satisfied they felt with their life using a scale of 1 to 10, of the pupils surveyed, a significantly higher proportion of girls (19%) rated their satisfaction as low (0-4) compared to boys (8%). A significant proportion of those who were eligible for a free school meal in the last six years also scored their satisfaction lower compared to those non-free school meal pupils (13%)

Bullying
A quarter of young people surveyed said they felt afraid to go to school sometimes because of bullying. This was significantly higher for girls (33%) than boys (16%) and significantly higher for pupils who had been eligible for free school meals in the last six years (32%), compared to those who hadn't (24%). Appearance, size and weight were the main reasons pupils cited for having been picked on or bullied.

Self-esteem
The survey generated self-esteem scores based on the pupils' responses to a set of ten statements taken from a standard self-esteem enquiry method. The scale is based on social confidence and relationships with friends. The scores range from 0-18. A significantly higher proportion of girls (28%) had a med-low self-esteem score (9 or less) compared to boys (15%). The proportion of pupils that stated that they had been eligible for free school meal in last six years that had a med-low self-esteem score was significantly higher (29%) than non-free school meals pupils (20%).

Worries
The survey asked pupils how much they worried about a range of issues. A significantly higher proportion of girls (64%) said they worried a lot about at least one of the issues than boys (48%). The issues girls most worried about were: exams and tests (70%), the way they look (57%), family (49%) and career (48%). Boys also worried about these issues, though to a lesser extent, with over half worrying about exams and over 40% family and career.

Coping with low self-esteem and worries
When surveyed pupils were asked what they were likely to do when they had a problem that worried them. Over two third of boys (66%) and nearly two thirds of girls (58%) said that they would talk to an adult. Over two thirds (65%) of girls and nearly a half (48%) of boys said they would talk to a friend. A significant of proportion of girls (37%) and boys (26%) however said that they would keep worries to themselves. 20% of girls and 12% of boys said they eat when they are worried and 15% of girls and 12% of boys turn to the internet or social media. 10% of girls and 3% of boys said they self-harm.

94% of boys and 88% of girls said that they have at least one adult they can trust.

b. Seeking support at school

In 2014/15, School Nurses (including 2 FE College nurses) in B&NES had 1869 contacts with young people which related to emotional or mental health.

In quarter one of 2015/16, the majority of School Nurse face-to-face contact time was spent supporting children and young people with their mental health, predominantly with anxiety but also a significant proportion with issues around self-harm. The data recording is currently limited to just the number of contacts, so it is not possible to indicate how many children and young people this equates to.

The school nursing service allocates its capacity by reference to a matrix which reflects local inequalities e.g. free school meals, indices of income deprivation etc. Access to the service is also monitored by pupils home postcode place in Index of Multiple deprivation. A pilot school nurse health review of vulnerable Year 9 pupils is being undertaken in two secondary schools.

Reports from the recent 2015 School Parliaments also highlighted pupils' attitudes to the importance of mental health

Final Young Parliament Me Myself

Final Primary Parliament Me Myself

c. Estimating prevalence of mental ill health

The prevalence of mental health problems in children and adolescents (aged 5 – 16 years) was last surveyed over 10 years ago in 2004. This study (Green et al 1.) estimated that at any one time, almost 1 in 10 children aged 5-16 years old had a clinically diagnosable mental disorder, causing distress to the child or having a considerable impact on their daily life. More recently Public Health England (2014) estimated that 8.4% of children and young people aged between 5 – 16 years in B&NES have a mental health disorder. This is similar to estimates for England (9.6%) as a whole and the South West (8.9%). Boys are more likely (11.4%) to experience mental health problems than girls (7.8%). Based on the same rates, the table below shows the **estimated** prevalence (note the true figure could vary from this) of mental health disorders by age group, gender and condition for B&NES' population aged 5 – 16 years (2014).

***Table 1**: Estimated prevalence of mental health disorders by age group, gender and condition (2014). Total population 5-16 years of age (inclusive) = 22,853*

NUMBERS	5 to 10			11 to 16		
	Male	Female	All	Male	Female	All
All disorders	510	250	760	665	500	1160
Conduct disorder	355	135	490	404	235	640
Emotional disorder	105	125	230	225	305	525
Hyperkinetic disorder	140	150		125	30	150

Less common e.g. ASD, eating disorders	110	40	145	95	45	135

Source: Local authority mid-year resident population estimates for 2014 from Office for National Statistics. CCG population estimates aggregated from GP registered populations (Oct 2014).

Public Health England also estimated the number of children and young people who may experience mental health problems appropriate to a response from CAMHS at Tiers 1, 2, 3 and 4 based on rates provided by Kurtz (1996 [3]). The following table shows these estimates for the population aged 17 and under in B&NES, 2014. It is important to note that these estimates do not make any adjustment for local characteristics which may impact on need for services.

Table 2: *Estimated number of children / young people who may experience mental health problems appropriate to a response from CAMHS per year in B&NES.*

CAMHS Tier	Tier 1 (2014)	Tier 2 (2014)	Tier 3 (2014	Tier 4 (2014)
BANES	5,165	2,410	640	30

Source: Office for National Statistics mid-year population estimates for 2014. CCG population estimates aggregated from GP registered populations (Oct 2014).
Kurtz, Z. (1996).

d. Local specialist child and adolescent service (CAMHS)

Specialist CAMHS services in B&NES have been provided by Oxford Health NHS Foundation Trust (OHFT) since 2010. Additional services (PCAMHS), delivering lower level interventions, were commissioned from the same Trust in 2011. The funding, and hence the caseloads, for both services have remained fairly static since then. Approximately 550 children and young people are receiving P/CAMHS services at any one time. During 2014/15 there were 1239 discharges from P/CAMHS.

An approximate breakdown by referral agency is given below:

GPs	50%
Community Paediatricians	20%
School Nurses/Schools	15%
Social Care	7%
Other	8%

There is a single point of access to primary and specialist CAMHS. In 2014/15 the percentage of referrals not accepted by the CAMHS averaged 17%, although this ranged from 6% - 30% in different months.

During 14/15 the percentage of referrals assessed within 4 weeks was 95% for referrals to the Outreach service (which include urgent cases), 72% for more routine CAMHS referrals and 73% for PCAMHS. There is an ambition for 90% of accepted routine referrals to be assessed within 4 weeks.

The primary CAMHS service is currently commissioned by NHS B&NES CCG and costs £245,712 per year. The specialist CAMHS service, commissioned by NHS B&NES CCG for £1,924,680, includes a £392,000 contribution from the local authority. OHFT employs 24 (16.7 WTE) practitioners in specialist CAMHS, and a further 18 (16.1 WTE) in PCAMHS and the Outreach team.

The OHFT CAMHS service forms part of the Oxford and Reading CYP IAPT collaboration which formed in 2012. The Children and Young People's Improving Access to Psychological Therapies programme (CYP IAPT) is a service transformation programme delivered by NHS England that **aims to improve existing** CAMHS working in the community.
More detail is available here:


CYP IAPT Key Facts Document Sept 14 (1

Part of the CYP IAPT programme is training for CAMHS practitioners. To date, in B&NES the following numbers of staff have been trained:

Year 1, 2012/13	5 therapists trained in CBT, 1 in parenting.
Year 2, 2013/14	4 therapists trained in CBT, 1 in parenting.
Year 3, 2014/15	4 therapists trained in SFP, 1 in IPT-A.

A key part of IAPT has been the introduction of goal based measures to all patients in CAMHS and to introduce session by session Reported Outcomes Measures by all clinicians.

Eating Disorders

At least 1.1 million people in the UK are affected by an Eating Disorder (ED), with young people in the age-group 14-25 being most at risk of developing this type of illness. Based on the 2007 Adult Psychiatric Morbidity Survey and the BANES 16-24 resident population, it is estimated that in 2013 there were 3,879 young people aged 16-24 in the authority area with an eating disorder. Highest prevalence is in 16-24 year old girls.

The number of admissions for eating disorders in B&NES has increased although this may be due to changes in diagnosis rather than an actual increase in prevalence.

The local specialist ED service, provided by OHFT, meets latest NICE Guidance


ed nice audit.docx

But there are new access and waiting times which must be implemented:

cyp-eating-disorders
-access-waiting-time-

And the CAMHS provider, OHFT has developed a new specialist eating disorder service to meet these standards which will be part funded by new Transformation Plan funding:

SWB CAMHS ED
proposal final 02.09.

e. Inpatient (Tier 4) care

During 2014-15 there were 8 admissions to CAMHS beds for B&NES CYP, 5 of these to the 'local' beds at Marlborough House, 3 to more specialist provision out of area. The average length of stay as an inpatient was 164 days, although the median stay was x days, reflecting the complex needs of a very small number of CYP.

Between 2009 and 2012 OHFT were jointly commissioned by Wiltshire CCG and B&NES CCG to provide generic CAMHS beds and specialist community CAMHS (Tier 3). Since 2012 NHS England specialists have commissioned all CAMHS inpatient beds on behalf of CCGs.

The community Outreach Service for Children and Adolescents (OSCA) works particularly closely with inpatient facilities at Marlborough House, Swindon and Highfield Unit, Oxford to ensure that admissions are appropriate and timely, and that CYP are discharged as soon as they can be supported in their own homes.

The new Transformation Plan investment in specialist Eating Disorder Services may reduce both the need for some inpatient admissions associated with EDs and the length of stay required for those who are admitted. In addition, by 'in reaching' into acute hospitals the ED Service should also be able to reduce the length of stay in acute hospitals to those CYP with EDs who present with advanced physical deterioration.

In the near future there may be a national re-procurement of CAMHS beds, and local CCG commissioners are committed to working closely with NHS England to ensure that appropriate provision is secured for CYP from B&NES. The SW Strategic Clinical Network (SWSCN) facilitates discussions between NHS England, CCG commissioners and local CAMHS providers, and local children's health commissioners attend regularly and contribute to SWSCN's work.

In addition, there is a joint NHS England and CCG Co-Commissioning group which meets monthly. CAMHS is one of the top 5 key priorities on the co-commissioning agenda

f. Liaison and Diversion Services, also known as Court Assessment and Referral Service (CARS)

CYP from B&NES have been in receipt of the nationally specified and commissioned all-age Liaison and Diversion (L&D) services. L&D practitioners are based at the local custody suite (Keynsham) and aim to improve early identification of a range of vulnerabilities, (including but not limited to mental health, substance misuse, personality disorder and learning disabilities), in people coming into contact with the youth or criminal justice systems. Further to identification and assessment, individuals can be referred to appropriate treatment services so contributing to an improvement in health and social care outcomes, which may in turn positively impact on offending and re-offending rates. At the same time, the information gained from the intervention can improve fairness of the justice process to the individual, improve the efficiency of the criminal justice system, and ensure that charging, prosecuting and disposal decisions are fully informed. If offenders receive non custodial sentences then this may be on condition that they agree to engage with relevant support services. The L&D service may offer support to their first appointment and the capturing of outcomes.

Due to the possibility of some young offenders already 'being known' to CAMHS, the local CAMHS provider, OHFT has created a Memorandum of Understanding with AWP, to local L&D service. This clarifies working arrangements when the L&D service has concerns about a young person in custody or at the court or when CAMHS are contacted about someone who they think would benefit from an L&D assessment.

MOU Oxford Health CAMHS -final.docx

In September 2015 a review of the Memorandum of Understanding concluded that arrangements were working well.

g. Crisis Concordat

The Crisis Concordat review and action plan is a joint plan between statutory public, community and third sector organisations in B&NES. The B&NES Mental Health Crisis Care Concordat sets out how organisations will work together better to make sure that people get the help they need when they are having a mental health crisis.

The Concordat focuses on four main areas: Access to support before crisis point, urgent and emergency access to crisis care , quality of treatment and care when in crisis, recovery and staying well.

Oversight of the B&NES plan is via a Crisis Concordat Task Group with all agencies represented by senior local staff (this includes children's and adults mental health commissioners, substance misuse commissioner, police, acute trust, CAMHS, AWP, community services, ambulance service). The plan includes consideration for children and young people in mental health crisis and was commended for its strong partnership approach.

The latest copy of the review and action plan is here

BNES MH Crisis Concordat Review an

The CAMHS service forms part of the Crisis Concordat within B&NES. Regarding urgent and emergency access to crisis care, all young people up to the age of 18 who present at the local acute hospital (Royal United Hospital Bath) following an act of deliberate self-harm and who are admitted to either the Paediatric ward or the Observation Ward are assessed the following day by a clinician from the CAMHS Team. A full assessment of their mental health needs and mental state is undertaken and follow up assessment / intervention offered as appropriate to their needs.

There is a national determination to ensure that no young person is inappropriately detained in police cells by ensuring that there is sufficient provision of Place of Safety facilities for young people to be assessed under Section 136 of the Mental Health Act. Children and young people who are detained by the police under the Mental Health Act, are currently taken to a Place of Safety at Southmead Hospital in Bristol. To reduce the risk of children and young people being taken the Southmead unnecessarily, the Police Service and the CAMHS service have recently implemented a protocol in which the police consult the local CAMHS service before deciding to transport the CYP to Southmead.

S136 MoU tween OHFT and police.pdf

5. Commissioning

B&NES CCG and LA have had integrated commissioning for a number of years, across a number of children and young people services. This has been further enhanced with Public Health becoming part to the Local Authority commissioning arrangements in 2014. More recently, the LA/CCG are working with other partners , including schools to maximize the use of resources, and a number the more recent pilots identified in Table 4 are being co-produced with schools.

Responsibility for commissioning local EHWB services lies with a number of agencies; CCG, Early Years (LA), Youth Service (LA), Schools and Colleges (LA and academies), Specialist Commissioning (National Commissioning Board), Public Health (LA) and Voluntary Sector funding. A model of comprehensive service provision is reproduced in Appendix 3.

Table 4: Services currently (October 15) commissioned to support the Emotional Health of Children and Young People

EHWB support commissions Sept15.›

Previously there have been 7 EHWB strategic action plans for Bath and North East Somerset, the latest one dated 2014-2017. Significant progress has been made in the priorities identified within the previous strategies.

a. During the current year 2015/16, the following developments have been prioritised:

1. The consideration and development of a single point of access or 'single front door' to enable practitioners, parents/carers and CYP to contact and thereafter receive, at the earliest opportunity, the most appropriate help.
2. To improve school/college/CAMHS liaison by introducing 'Resilience Hubs' at each school and college. These Hubs will provide opportunities for monthly face-to-face meetings where CAMHS link workers, selected school/college staff, school/college nurses and independent counsellors can meet for consultation, training and mutual support.
3. To increase the level of therapeutic support offered to statutory social workers and parents/carers who are struggling to prevent the breakdown of fostering and adoptive placements. This will take the form of a CAMHS psychologist being seconded to the LA placements team. This additional service is being introduced as an attempt to readdress the inequality of Looked after Children who frequently suffer a higher incidence of mental ill-health.
4. To further increase the skills of a number of practitioners who work directly with families and schools whose younger children/pupils display behaviours which present barriers to learning
5. To improve the digital guidance for national and local EHWB services. This will include the published Transformation Plan, suggestions for CYP self-care, guidance for referrers etc. all presented in an informative and accessible manner.
6. To pilot a children and young people's on-line counselling service.
7. Ensure that transitions to adults services for all CYP, including those with EHCP plans, are well managed.

b. Since April 2015 a number of developments to support the transformation plan have begun:

1. *Pilot - Extended CAMHS support: for > 18 y/o's* who were receiving CAMHS interventions when they turned 18 and, although they are particularly vulnerable, do not meet the referral criteria for adult mental health services. This cohort will include, but is not restricted to, Care Leavers and will provide intensive emotional support.
2. *Pilot - Early Intervention in Psychosis:* Pilot to improve fidelity to the early intervention in psychosis model by building links with CYP substance misuse, developmental disorder, CAMHS, schools and other services.
3. *Pilot - School Based Counselling:* Independent counsellors have been commissioned to provide individual 'drop in' advice sessions and formal counselling sessions at seven secondary schools from September.
4. *Pilot - Resilience Hubs: (*See above) These complement school based counselling and have also started in the new academic year.
5. *Pilot - Mindfulness Pilot:* 32 members of staff from *2* secondary schools have undertaken an 8 week Mindfulness course. 2 staff from each school will now be trained to deliver Mindfulness in Schools sessions/resources directly to young people.
6. *KS4 resource packs:* Mental Health PSHE Resource packs for Key stages 3&4 are being developed in partnership between School Improvement and the CAMHS participation group.
7. *Specialist Family Support and Play re-procurement:* A review has resulted in a new combined service model being procured to provide early intervention with 5-13 years olds with a range of emotional and social issues.
8. *Protocol between CAMHS and police:* has been implemented to reduce inappropriate attendances at the S136 suite.
9. *Pilot - CAMHS self-referral for 16 and 17 y/o's:* is being trialled by provider
10. *ASD support service:* Additional SLT sessions have been commissioned to 'speed' up ASD diagnosis and a new parent support worker will visit families whose children with ASD refuse to attend school.
11. *Eating Disorder Specialist service:* Agreeing new service model with provider and neighbouring CCGs

Some of these developments are included in the tracker spreadsheet.
NOTE The strategic group are still currently working at conceptualising and describing services and pathways using the outcomes suggested by the Liverpool model (as opposed to Tiers), i.e.

- *Improved environments so that C&YP can thrive*
- *Increased identification of C&YP with early indicators of distress and risks*

- *Reduction in mild to moderate distress*
- *Reduction in the development of moderate to severe distress*
- *Reduction in life long distress*

6. Children and Young People participation

In B&NES, children and young people's views are used effectively and consistently to influence change, shape services, improve practice and service delivery and have so for a number of years. Children and young people contribute through models of co-production as set out in the Service User Engagement Framework (Commissioning Framework), Children In Care Councils, democratic processes, strategic development, the Children and Young People's Plan, the Early Help Strategy and through the groups that have been set up to hear the voices of seldom heard minorities.

The framework which provides guidance to help involve children and young people in the commissioning of services is currently being re-drafted. The greatest challenge is to engage young people who are not existing or potential users of a new commission.

CYP Commiss Framework 2015.doc

The local 2014-2017 Participation Strategy sets out the locally agreed definition of participation and identifies the benefits of participation not only to children and young people but also to the adults who work with them, the organisation and services that are provided, and society as a whole. LINK

OHFT CAMHS service, having been the lead provider in the regional CYIAPT collaborative for the last 3 years, has developed effective CYP participation in line with the principles outlined in *Delivering With, Delivering Well* (reproduced in Appendix 4). The CAMHS participation group is usually consulted about pilot developments and is particularly key in suggesting and approving written and digital resources.

A very recent consultation by the local Youth Forum suggests that CYP

- do not always comprehend the range of services available,
- still perceive a stigma around mental health problems and
- would prefer to be informed of self care and further information in a variety of ways.

Further consultation is planned to determine the most appropriate website to host the Transformation Plan and to signpost useful digital resources.

7. Transformational Funding

B&NES is served by all elements of the model outlined in Appendix 3. Children's services are detailed above (Table 4) and are provided by a range of organisations including the LA, Sirona Care and Health, Oxford Health NHS Foundation Trust and smaller voluntary organisations.

Some of the proposals for driving improvement within the Transformation Plan will be cost-neutral, requiring a different way of helping C&YP within existing resources. However, the Government has committed additional monies to local areas based on the standard CCG allocation formula. For B&NES this is £333,463 per year. £95,191 has already been received by the CCG and this must be spent on improving the C&YP Eating Disorders Service. Pending approval of the Transformation Plan, the CCG will receive another £238,272 for 15/16 and thereafter £333,462 per year.

The proposed distribution for 15/16 funding is as follows:

1	Eating Disorder (includes training)	95,191
2	Therapeutic support for social care (6 months)	32,500
3	development of digital resources incl TP publishing, incl map of medicine	10,000
4	workforce capacity building (Theraplay,Thrive, Attachment Aware etc)	55,000
5	college resilience hubs (includes staff training)	5,000
6	school resilience hubs (includes staff training)	41,000
7	online counselling	16,000
8	school counsellors attending school Hubs	10,500
9	nuture outreach service in primary schools	40,000
10	commissioning capacity (7 months)	6,021
11	CYP/parent/carer consultation/coproduction/	5,000
12	stakeholder event -launch of resources and co-production of 16/17 plans	2,250
13	support for parents of 'non-engaging' children (scoping)	5,000
14	independent evaluation and consideration of 'single point of access'	10,000
		333,462

Funding (once agreed) to implement the plan will be monitored via the national Transformation Plan tracker excel spreadsheet.

8. Governance

- The EHWB Strategy Group acts as a sub-group for the Children's Trust Board and are required to produce 6 monthly reports to the Children's

Trust Board, LSCB and Health and Wellbeing Board as well as an annual review of performance.

- Formal monitoring of the Transformation Plan will be via a subgroup of the EHWB Strategy Group. Although this group does not include a CYP representative, the CYP Equalities Group will also receive the same 6 monthly report for scrutiny and comment. (This group includes representatives from the various children and young people participation groups and school equalities teams across B&NES including CAMHS service users, Children in Care, Youth Forum and the Member of Youth Parliament)
- There are strong links to the Local Safeguarding Children's Board (LSCB) with the EHWB group's social care representative also being a member of the LSCB.
- The CCG Children's Health Commissioning Project Manager engages with mental health events facilitated by the SW Strategic Clinical Network and the SW CAMHS Operational Delivery Network and contributed to the *Commissioning better CAMHS in the South West*, Oct 2014. This forum will continue to be used to give/receive national guidance and to share ideas, experiences and good practice.

Appendix 1

Chief Medical Officer's Annual Report: Our children deserve better: Prevention pays, October 2013
https://www.gov.uk/government/publications/chief-medical-officers-annual-report-2012-our-children-deserve-better-prevention-pays

NSPCC - Prevention in mind, All babies count: spotlight on Perinatal Mental Health, June 2013
http://www.nspcc.org.uk/Inform/resourcesforprofessionals/underones/spotlight-mental-health-landing_wda96578.html

Public Health England – How healthy behaviour supports children's wellbeing, August 2013
https://www.gov.uk/government/publications/how-healthy-behaviour-supports-childrens-wellbeing

Children and Young People's Mental Health Coalition report 'Overlooked and Forgotten', December 2013
http://www.cypmhc.org.uk/resources/overlooked_and_forgotten_full_report/

Mental health sub-group report of the children's outcomes forum, May 2013
https://www.gov.uk/government/publications/independent-experts-set-out-recommendations-to-improve-children-and-young-people-s-health-results
Closing the Gap, Priorities for essential change in mental health, January 2014 https://www.gov.uk/government/publications/mental-health-priorities-for-change

Baby Bonds, Parenting, attachment and a secure base for children, The Sutton Trust, March 2014
http://www.suttontrust.com/researcharchive/baby-bonds/

Green, H., McGinnity, A., Meltzer, H., Ford, T. and Goodman, R. (2004) Mental health of children and young people in Great Britain, 2004. Office for National Statistics. London, HMSO

Egger, H. L. and Angold, A. (2006) Common emotional and behavioral disorders in preschool children: presentation, nosology, and epidemiology. Journal of Child Psychology and Psychiatry, 47 (3-4), 313–37.

Kurtz, Z. (1996) Treating children well: a guide to using the evidence base in commissioning and managing services for the mental health of children and young people. London. Mental Health Foundation

Appendix 2

Table 1: Protective factors potentially influencing the development of mental health problems and mental disorders in individuals (particularly children)

Individual factors	Family factors	School context	Life events and situations	Community and cultural factors
Easy Temperament adequate nutrition attachment to family above average intelligence school achievement problem solving skills internal locus of control social competence social skills good coping style optimism moral beliefs values positive self-related cognitions physical activity	supportive caring parent family harmony secure and stable family small family size more than two years between siblings responsibility within the family (for child or adult) supportive relationship with other adult (for a child or adult) strong family norms and morality	sense of belonging positive school climate pro-social peer group required responsibility and helpfulness opportunities for some success and recognition of achievement school norms against violence	involvement with significant other person (partner/mentor) availability of opportunities at critical turning points or major life transitions economic security good physical health	sense of connectedness attachment to and networks within the community participation in church or other community group strong cultural identity and ethnic pride access to support services community/cultural norms against violence

Table 2: Risk factors potentially influencing the development of mental health problems and mental disorders in individuals (particularly children)
NB: the following tables list *influences* on the development of mental health problems not the *causes*.

Individual Factors	Family/social factors	School context	Life events and situations	Community and cultural factors
Prenatal brain damage Prematurity birth injury	having a teenage mother having a single parent	Bullying peer rejection poor attachment to	physical, sexual and emotional abuse school transitions	socio-economic disadvantage social or cultural discrimination

low birth weight, birth complications physical and intellectual disability poor health in infancy insecure attachment in infant/child low intelligence difficult temperament chronic illness poor social skills low self-esteem alienation impulsivity alcohol misuse	absence of father in childhood large family size antisocial role models (in childhood) family violence and disharmony marital discord in parents poor supervision and monitoring of child low parental involvement in child's activities neglect in childhood long-term parental unemployment criminality in parent parental substance misuse parental mental disorder harsh or inconsistent discipline style social isolation experiencing rejection lack of warmth and affection	school inadequate behaviour management deviant peer group school failure	divorce and family break up death of family member physical illness unemployment, homelessness incarceration poverty/ economic insecurity job insecurity unsatisfactory workplace relationships workplace accident/ injury caring for someone with an illness/ disability living in nursing home or aged care hostel war or natural disasters	isolation neighbourhood violence and crime population density and housing conditions lack of support service including transport, shopping, recreational facilities

Reproduced from: Commonwealth Department of Health and Aged Care 2000, Promotion, Prevention and early intervention for mental health-a Monograph, Mental Health and Special Programs branch, Commonwealth Department of Health and Aged Care, Canberra. Quoted in Making it Happen (DH 2001).

Appendix 3

Appendix 4

Delivering With Delivering Well.pdf

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Bath & North East Somerset Council		
MEETING/ DECISION MAKER:	**Children's Policy Development & Scrutiny Panel**	
MEETING/ DECISION DATE:	**12th July 2016**	EXECUTIVE FORWARD PLAN REFERENCE:
TITLE:	**Childhood Obesity**	
WARD:	All	
AN OPEN PUBLIC ITEM		
List of attachments to this report: **Shaping Up! Healthy Weight Strategy 2015 - 2020**		

1 THE ISSUE

1.1 The evidence is very clear. Significant action is required to prevent obesity at a population level to avoid creating "obesity promoting" environments as well as improving healthy eating and physical activity in individuals. Trends in childhood overweight and obesity are of particular concern. Obesity has been rising rapidly in children in England over the past 20 years - the proportion of children classified as obese has nearly doubled for children aged 4- 5 years and increased more than threefold for 10 -11 year olds.

1.2 There is a rather persistent finding over a number of years in B&NES that our obesity figures for children in reception year are a little worse than national and regional averages but that our year 6 children have lower rates of obesity and overweight than their peers. Although the rate of obesity in children and young people is slowing down, further action is needed to address this issue.

2 RECOMMENDATION

2.1 The scrutiny panel is asked to note the Shaping Up! Healthy Weight Strategy and its relevance to Children and Young People's health.

2.2 The panel is asked to note that while B&NES compares reasonably well for children's obesity rates in comparison with similar areas we still have significant numbers of children whose health will be adversely affected as a result of their weight.

2.3 The panel is asked to endorse the importance of addressing obesity at a population level though creating health promoting environments and maintaining adequate health improvement services, including universal services, targeted

support and specialist services through this period of intense pressure on local government finances.

3 RESOURCE IMPLICATIONS (FINANCE, PROPERTY, PEOPLE)

3.1 No specific requests are being made and so there are no direct resource implications. The scrutiny panel is asked to note that children's healthy weight in B&NES is underpinned by a wide range of services commissioned or provided by the council together with a range of interventions to reduce obesogenic environments such as active transport, provision of leisure and outdoor spaces, planning for the built environments and so forth.

4 STATUTORY CONSIDERATIONS AND BASIS FOR PROPOSAL

4.1 Nil specific

5 THE REPORT

Why is Childhood obesity an issue?

5.1 Around 1 in 4 (23.2% reception aged children (4 – 5 yr olds) in B&NES are an unhealthy weight (either overweight or obese). Around 1 in 11 (8.9%) reception aged children are obese.

Around 3 in 10 (29.5%) year 6 children (10 – 11 yr olds) in B&NES are an unhealthy weight . Around 1 in 6 (16%) year 6 aged children are obese.

Deprivation and ethnicity are significant factors in the levels of obesity amongst year 6 children in B&NES. Parental obesity is a significant risk factor for childhood obesity and half of parents do not recognise that their children are overweight or obese.

5.1 Being overweight or obese in pregnancy, childhood or adolescence has consequences for health in both the short and long term. Maternal obesity significantly increases the risk of foetal congenital abnormality, prematurity, still birth and neonatal death. Overweight and obese children are more likely to become obese adults and will have a higher risk of morbidity, disability and premature mortality in adulthood. Although many of the most serious consequences will not be apparent until adulthood, the effects of obesity e.g raised blood pressure, fatty changes, raised cholesterol and metabolic syndrome can be identified in obese children and adolescents. Some obesity related conditions and health risks can develop during childhood such as type 2 diabetes, early puberty, eating disorders, asthma, and skin disorders. There is strong evidence to link obesity with poor mental health in teenagers as a result of bullying, stigmatisation and low self esteem.

5.2 Achieving a healthy weight for children and young people is a complex issue and depends on factors in every part of life: the environment, our schools, social life and the families and people around us. The evidence is clear that policies aimed solely at individuals will be inadequate and that simply increasing the number of small scale interventions will not be sufficient to reverse the trend. We need significant effective action at a population level targeting elements of the obesogenic environment as well as improving nutrition and physical activity in individuals. Addressing these factors is dependent upon partnership working with local residents and a range of agencies if we are to have a lasting effect.

5.3 The Shaping Up! Healthy Weight Strategy for B&NES describes our partnership approach to promote healthy weight and tackle the rise in obesity. The strategy provides an overview of the current issues relating to healthy weight and focusses on what will achieve sustainable change. It draws on the main themes from the national Healthy Lives, Healthy People: A Call to Action on Obesity in England. At the time of writing the strategy a new national childhood obesity strategy was being drafted and was due for publication in spring 2016. This has been delayed due to the recent EU referendum. The local strategy will be reviewed to reflect any changes in policy once the national strategy is published.

Eating well and being physically active go hand in hand so this strategy should be read together with the B&NES Fit for Life physical activity strategy and the Local Food strategy.

5.4 The implementation of the Shaping up! Healthy Weight strategy is coordinated via a multi agency partnership which reports to the Health and Wellbeing Board.

5.5 The key objectives in the strategy which relate to children are to :

i Coordinate weight management pathways for pregnant women, children and young people.

ii Increase opportunities for physical activity in our daily lives (delivered via the fit for life strategy and partnership)

iii Promote a healthy and sustainable food culture enabling people to access affordable good food (delivered via the local food strategy and partnership)

iv Develop a workforce that is confident and competent in promoting healthy weight.

5.6 Achievement of these objectives will involve action across all stages of life including from conception with a particular focus on families. Action will be at three levels : universal (for the whole population) , targeted (for those at risk) and specialist (for those who are already above a healthy weight)

6 RATIONALE

6.1 No new course of action is being suggested in this paper.

7 OTHER OPTIONS CONSIDERED

7.1 Children and young people's public health services are constantly being reviewed and updated according to new policy and guidance and in response to budgetary opportunities and pressures. Some of the relevant services come within the scope of "your care your way" and so are currently being reviewed through that process.

8 CONSULTATION

8.1 The Shaping Up! Healthy Weight strategy was subjected to full consultation processes during the development phase.

8.2 Issues and barriers that were raised during the consultation were lack of good facilities and activities for preschool children , need for improved activities (indoor and outdoor) for young people, improved transport for disabled children, cost of activities, lack of awareness of services, fear of being judged as a parent, reacting badly to being told their child is overweight.

9 RISK MANAGEMENT

9.1 A risk assessment related to the issue and recommendations has been undertaken, in compliance with the Council's decision making risk management guidance.

Contact person	*Denice Burton Assistant Director Health Improvement 01225 394061*
Background papers	*Shaping Up! Healthy Weight Strategy 2015 -2020 (attached)* *Fit for Life strategy 2014 – 19* *Local Food strategy 2014 – 17*
Please contact the report author if you need to access this report in an alternative format	

Bath & North East Somerset Council

Shaping Up!
Healthy Weight Strategy
2015-2020

Foreword

Our Vision for Bath and North East Somerset is for all residents to have the opportunity to have a healthy lifestyle and every child and adult is informed and supported to eat healthily and be physically active.

A healthy weight is about much more than an individual's weight or body shape. It can so often be an essential foundation for physical, emotional and social wellbeing. Like a good education or living in a strong community it can help an individual to reach their full potential in many aspects of life.

Helping people to achieve and maintain a healthy weight is a complex issue and is dependent upon partnership working with local residents and a range of agencies if we are to have a lasting impact.

Achieving a healthy weight depends on factors in every part of life: the environment we live in, our workplace, school, social life and the people around us. In Bath and North East Somerset we want to build on the good work to date, to create an environment where people have the opportunity and are supported to be a healthy weight. We also know that these influences are not the same for everyone therefore this strategy aims to prioritise those most at need.

Eating well and being physically active go hand in hand so this strategy should be read together with the Fit for Life Physical Activity Strategy and the Local Food Strategy.

We recognise that obesity is a complex issue and therefore it is essential that we continue to build on the success of the last few years if we are to make eating healthily and being active a reality for everyone.

Councillor Vic Pritchard
Joint Chair of Health and Wellbeing Board

Dr Ian Orpen
Clinical Chair NHS Bath and North East Somerset Clinical Commissioning Group
Joint Chair of Health and Wellbeing Board

Contents

Introduction

The evidence is very clear. Significant action is required to prevent obesity at a population level to avoid creating 'obesity promoting' environments as well as improving nutrition and physical activity in individuals. This strategy recognises the contributions and combined efforts of all partners to increase the number and proportion of children and adults who are a healthy weight.

"We know that for people at risk of obesity, losing just 5-7% of your weight can cut your chance of diabetes by nearly 60%. If this was a pill we'd be popping it – instead its a well designed programme of exercise, eating well and making smart health choices."
Simon Stevens, CEO NHS England

Executive Summary

This document describes our partnership plans to promote healthy weight and tackle unprecedented levels of obesity. A strategy was initially developed in Bath and North East Somerset in 2005 and subsequently refreshed in 2007 and 2011. Since then, obesity has climbed the national public health agenda.

In terms of obesity, the government has made its intention clear: it wants to see the rising rates reversed. Its obesity strategy, '*Healthy Lives, Healthy People: A call to action on obesity in England*', which was published in October 2011, set a new target for a downward trend in excess weight for children and adults by 2020:

- **a sustained downward trend in the level of excess weight in children by 2020**

- **a downward trend in the level of excess weight averaged across all adults by 2020.**

This strategy is a high-level overview of current issues relating to healthy weight and focuses on what will achieve sustainable change. It draws on the main themes from the national Healthy Lives, Healthy People: A Call to Action on Obesity in England as a clear vision for where action can be taken. It also takes into consideration the best practice recommendations as outlined in National Institute for Clinical Excellence (NICE) guidance and briefings relating to diet, nutrition, obesity and physical activity.

At the time of writing this strategy Public Health England has drafted a new national childhood obesity strategy which is due for publication in Spring 2016. This strategy will be refreshed to reflect any changes in policy once the national strategy is published.

Achieving a higher proportion of healthy weight in the population is a complex social and public health issue. The evidence is very clear that policies aimed solely at individuals will be inadequate and that simply increasing the number or type of small-scale interventions will not be sufficient to reverse the trend. We need significant effective action to prevent obesity at a population level targeting elements of the obesogenic environment as well as improving nutrition and physical activity in individuals.

Our key objectives will be to:

1. Coordinate a weight management pathway for everyone which includes prevention, self care and treatment
2. Increase opportunities for physical activity in our daily lives, reducing sedentary behaviour – (delivered through fit for life strategy and partnership)
3. Promote a healthy and sustainable food culture, enabling people to access affordable good food (delivered through Local Food Strategy and partnership)
4. Support organisations to promote the health and wellbeing of their employees
5. Develop a workforce that is confident and competent in promoting healthy weight

Vision and Strategic Targets

In B&NES all residents have the opportunity to have a healthy lifestyle and every child and adult is informed and supported to eat healthily and be physically active.

Aim

To focus our combined efforts on lasting societal and environmental changes that enable people to maintain a healthy weight; while informing and empowering people to make healthy choices.

Outcome:

- All people in B&NES are a healthy weight
- All residents and their families can experience the benefits of being a healthy weight.

To tackle overweight and obesity effectively we need to adopt a life course approach – from pre-conception through pregnancy to preparing for older age.

Action is needed at all ages across to prevent the short- and long-term consequences of excess weight and to ensure that health inequalities are addressed.

Action needs to be a balance of investment and effort between prevention and, for those who are overweight or obese, treatment and support.

Prioritising local need

The strategy will focus on the following priority groups:

Geographical areas of inequalities:

- Areas of B&NES with the highest child obesity prevalence, as measured through the child measurement programme
- Areas of B&NES with the highest estimated adult obesity prevalence.

Points across the life course where people are more at risk of obesity:

- Women during and after pregnancy
- Early years (0-5years)
- Children aged between 6 and 9 years
- Young People aged 14-19
- Prevention in adults aged less than 35 years
- Weight management in adults aged over 35 years
- Women following the menopause
- People stopping smoking
- Adults following retirement

People are more likely to be a risk of obesity:

- Looked After Children
- Children and adults living in the most disadvantaged areas of B&NES
- Children and adults with a learning disability
- Black and Minority Ethnic Children
- Adults with depression or other common mental health problems

Bringing together a coalition of partners

Effective local action on obesity requires wide collaboration of partners to work together in order to create an environment that supports and facilitates healthy choices by individuals and families.

The Council already performs a vital leadership role by bringing together partners who can stimulate action on local issues through the Health and Wellbeing Board.

The local Health and Wellbeing Board has set a framework for action.

Priorities have been identified under 3 key themes:

- Theme one: Helping people to stay healthy
- Theme two: Improving the quality of people's lives
- Theme three: Creating fairer life chances

Helping children to be a healthy weight and creating healthy and sustainable places have been identified as local priorities within theme one .

Partnership: the key to success

Scope of the Strategy

The scope of this strategy is to provide a strategic framework for working collaboratively across B&NES focussing on actions to achieve sustainable changes in unprecedented levels of obesity.

The strategy will not consider those who are underweight or recommend actions at a national level.

Local Governance

The successful delivery of the this strategy will be dependent upon collaboration with other key partnerships and the delivery of the other key strategies:

1. Fit for Life – getting more people, more active, more often. The strategy with leads on local priorities which encourage people to be more active as well as looking at changes to the physical environment, transport and planning.

2. Local Food Strategy - working with local organisations who lead on environmental sustainability to encourage people to eat more local food, improve access to affordable healthy food as well as helping people to have the right knowledge and skills to be able to have a healthy diet.

3. It will also have links to the local **NHS Clinical Commissioning Group 5 year plan** which highlights the need for prevention and self care, the redesign of diabetes services as well as contributing to the reduction in falls in older people.

This strategy is governed by the Health and Wellbeing Board and reports also to the Children's Trust Board.

Various groups (including task and finish groups) will be involved in the implementation of the different aspects of the strategy e.g. the School Food Forum, Fit for Life Partnership – Subgroups etc.

Principles underpinning the strategy

1 Leadership – Has strong local leadership supporting people to embrace change

2 Partnerships – effective partnership working to optimise the use of resources

3 Intelligent Interventions - developments are needs led, making best use of available market insight

4 Advocacy – ensuring local people & key stakeholders understand the benefits of healthy weight

5 Value for Money – ensuring we deliver our priorities in the most effective way

6 Innovative – uses technology to better engage and connect with people

7 High quality and Best Practice – Development that meets local need, learning from & improving on the best practice

8 Holistic – a cross sector commitment contributing to improved health and wellbeing of local people

9 Targeted – focuses on the inactive, addressing inequalities for underrepresented groups, creating opportunities which are fun, tailored and inclusive

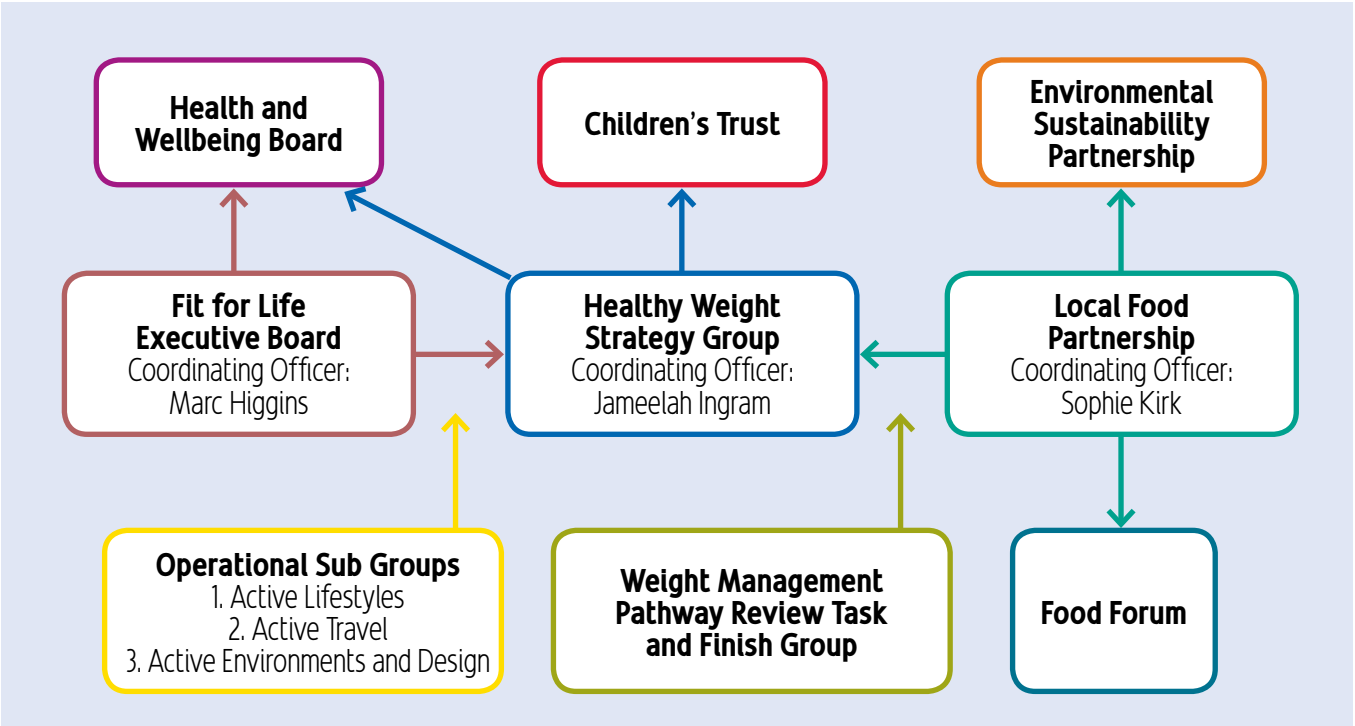
10 Sustainability - ensuring exit routes are in place for participants to ensure impacts and measures are sustained and long lasting and that work is built from the bottom up creating an asset based community development approach

Implementation and monitoring of the strategy

The strategy will be supported by an annual action plan. Reporting of outcomes will be via the Healthy Weight Strategy Group to the Health and Wellbeing Board and Childrens Trust Board.

Monitoring the prevalence of healthy weight in children and adults is a requirement of the national Public Health Outcomes Framework as highlighted by the following key performance indicators:

- Excess weight in 4-5 and 10-11 year olds (PHOF 2.6)
- Diet (placeholder) (PHOF 2.11)
- Utilisation of green space for exercise/health reasons (PHOF 1.16)

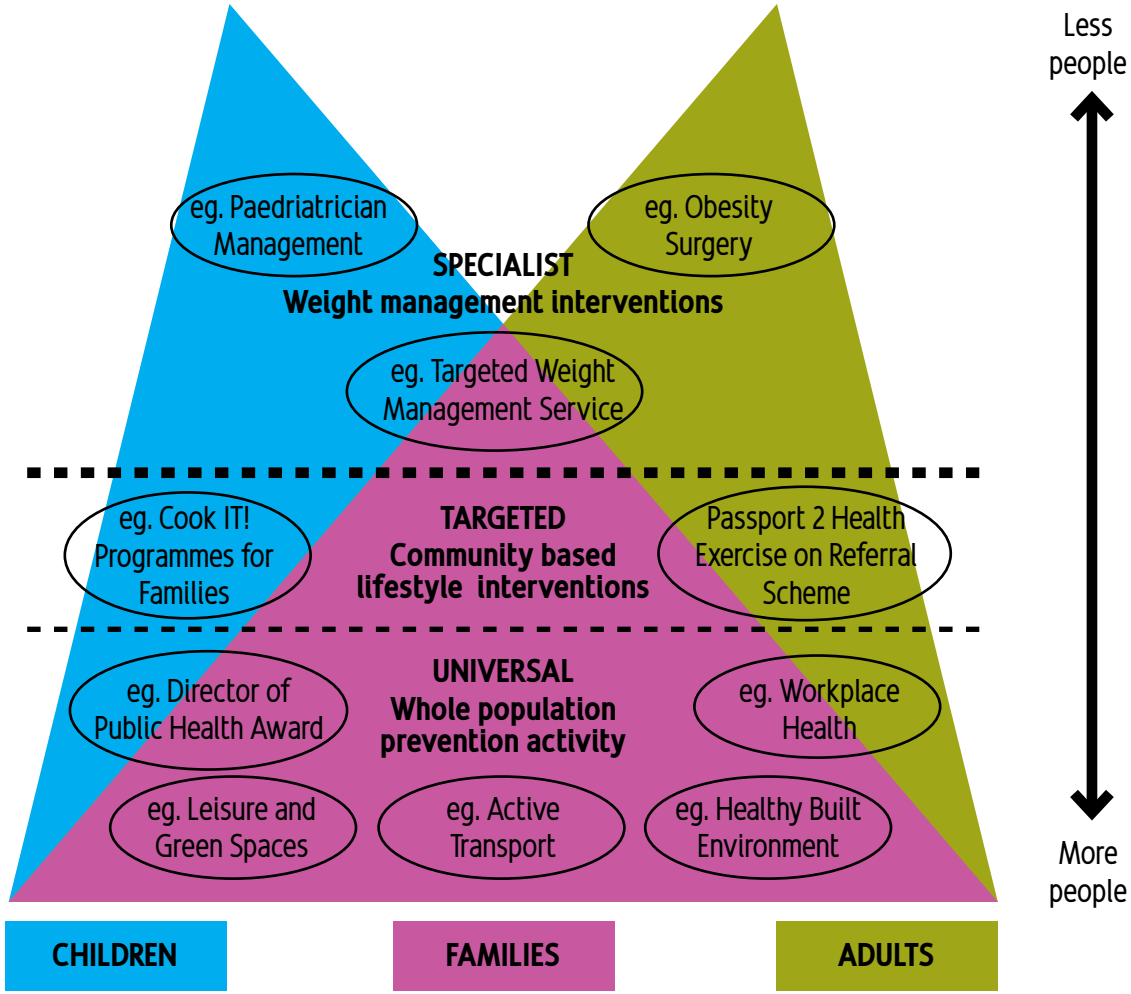


Pathway

Achievement of our strategic objectives requires action across the life course from childhood to adulthood, with a particular focus on families. Basing the framework on our objectives allows us to check that we have sufficient action in each area: universal interventions aimed at helping us all to maintain a healthy weight; and targeted lifestyle interventions to intervene early for those who need support to achieve a healthy weight. In this way, we can match our activities to our strategy and highlight gaps in our approach.

The triangles overlap because some interventions benefit both adults and children – whole families are often influenced by a targeted approach as seen in the middle of the diagram. See Appendix 2 for complete list of the current interventions at the time of writing this strategy.

Strategic Framework for Development (with some examples)



How B&NES will promote a healthy weight

Achieving a higher proportion of healthy weight in the population is a complex social and public health issue. The evidence is very clear that policies aimed solely at individuals will be inadequate and that simply increasing the number or type of small-scale interventions will not be sufficient to reverse the trend. We need significant effective action to prevent obesity at a population level targeting elements of the obesogenic environment as well as improving nutrition and physical activity in individuals.

Our key Objectives will be to:

1. Coordinate a weight management pathway for everyone which includes prevention, self care and treatment

2. Increase opportunities for physical activity in our daily lives, reducing sedentary behaviour – (delivered through Fit for Life strategy and partnership)

3. Promote a healthy and sustainable food culture, enabling people to access affordable good food (delivered through Local Food Strategy and partnership)

4. Support organisations to promote the health and wellbeing of their employees

5. Develop a workforce that is confident and competent in promoting healthy weight

Achievement of these objectives will involve action across the stages of life through pregnancy to older age with a particular focus on families. Action will be at three levels; universal (for whole population), targeted (for those at risk) and specialist (for those who are above a healthy weight).

1. Universal: Whole population prevention activity

We will work collaboratively with the Fit for Life Partnership and the Local Food steering group to create positive environments which actively promote and encourage a healthy weight in B&NES. This involves transport, the built environment, parks and open space and promoting access to affordable healthy food; as well as interventions such as the Healthy Child Programme, Director of Public Health Award in educational settings and Eat Out Eat Well award accreditation scheme with food retailers.

2. Targeted: Community based lifestyle interventions

We will maintain and develop interventions to support individuals and communities most at risk of obesity to intervene earlier and reduce inequalities in obesity. This will include interventions to support individuals and families becoming more active and eating more healthily.

3. Specialist Weight management services

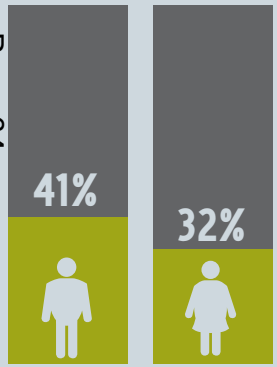
Working together with the NHS to develop and deliver high quality specialist treatment and support to for local residents who are severely obese and have additional complex health needs and where conventional lifestyle support has been unsuccessful. This level of support may include drug therapy, specialist clinical support and in some cases surgery.

The local picture

BASELINE

Obesity Key Facts:

Over half (58.7%)
of adults in B&NES are estimated to be overweight or obese, although this is significantly lower than regional and national figures.



Nationally, men and women have a similar prevalence of obesity, but **men are more likely to be overweight** (41%m compared to 32%f) (2008)[7]

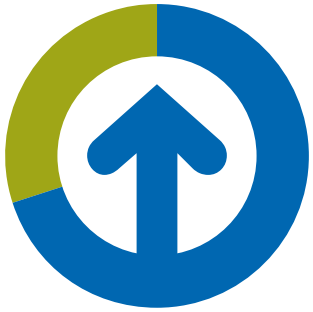
Rates of recorded obesity are **rising in adults** in B&NES but are lower than national rates.

What causes obesity?

The UK diet has changed significantly since the 1950s. Both the types and amount of food consumed have changed and there is an increased availability of energy dense convenience foods and an increase in food eaten outside the home with people unconsciously consuming more calories than the body needs. A typical fast food meal contains more than double the calories of an average British meal. Unhealthy foods are often cheaper and heavily marketed to be more appealing to the consumer. Consuming high sugar foods and drinks have shown to lead to increased weight gain. Portion size is also increasing. Evidence from several research studies how that when people are faced with bigger portions, they eat more.

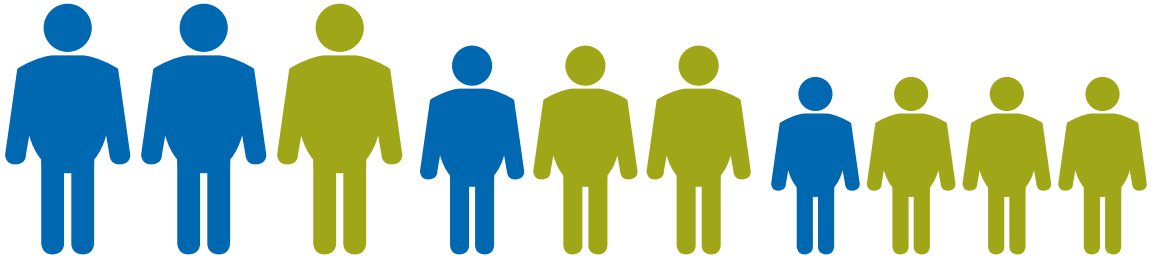
Our environment plays an important role in our ability to be physically active. Nowadays fewer people have a job which enables them to be physically active with more people working in offices or sitting for long periods.

We benefit from labour saving devices in the home and rely heavily on cars to get around. This increase in car usage over the past 50 years has led to a major decline in walking and cycling.



Prevalence is rising
Overweight and obesity in adults is predicted to reach 70% by 2034. More adults and children are now severely obese

Consequences are costly
A high BMI
- is costly to health and social care
- has wider economic and societal impacts



Obesity is widespread
A quarter of 2-10 year olds, a quarter of 2–10 year olds, one third of 10–15 year olds and two thirds of adults are overweight or obese

Concerns about safety, anti-social behaviour and crime may also deter people from being physically active in their local area and parents are wary of letting children walk or cycle to school.

Environmental factors affecting our weight include how local housing estates are designed, how we travel to destinations, the accessibility of shops and public services and the availability of good quality sport and leisure opportunities, including parks and open spaces.

Low mood has also been linked to obesity. There are also links between social inclusion, wellbeing, physical activity and people not feeling fully in control of the food they eat. Social issues are important determinants of obesity in children and adults. Economic factors also play a role in an individual's ability to choose a healthy diet or access opportunities to be more active.

Why is obesity an issue?

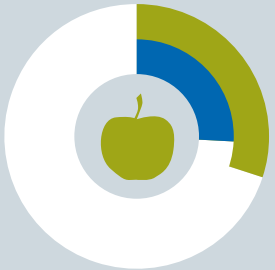
The prevalence of obesity in the UK has increased dramatically over the last 25 years with Britain now being the most obese nation in Europe.

The majority of the adult population 61.9% and 28% of children aged 2- 15 are either overweight or obese and it is estimated that, without clear action, these figures will rise to almost nine in ten adults and two-thirds of children by 2050. While there is some indication that it may be starting to level off among children in England, prevalence remains very high among this group.

Adults

In England 24.7% of adults are obese (BMI 30 and over, including 2.4% who are severely obese (BMI over 40) (Health Survey for England 2012)[2].

Diet Key Facts

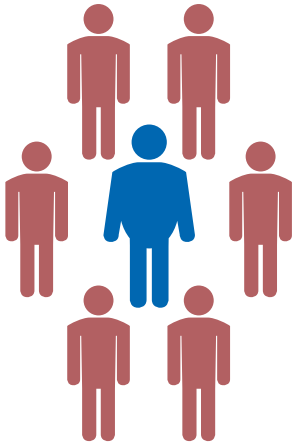


B&NES has a higher than national known level of fruit and vegetable consumption (**30% compared to 26%**)

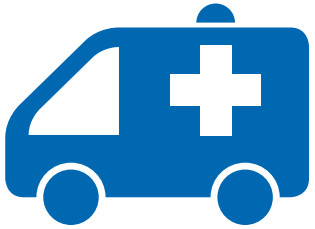
Lyncombe has the highest model based estimate percentage of 38% consumption of fruit and veg and of those that are known, Twerton has the lowest at 19% consumption of 5 pieces of fruit and veg a day

Obesity affects adults

Less likely to be in employment

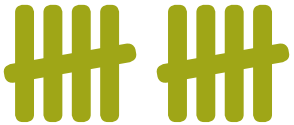


Discrimination and stigmatisation



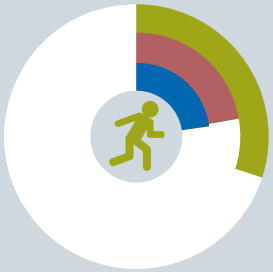
Increased risk of hospitalisation

Obesity reduces life expectancy by an average of 3 years



Severe obesity reduces life expectancy by 8–10 years

Physical Activity - Key Facts



27% of Bath and North East Somerset population undertake 30 minutes of moderate intensity exercise on 3 or more days a week (**22.3% national**, **South West 22.9%**).

43.7% of adults do no sport or active recreation in Bath and North East Somerset

Health costs in Bath and North East Somerset due to inactivity comes to £2.9 million per year.

National research suggests that over half of people living in deprived areas would take more exercise if green spaces were improved

The cost of inactivity in B&NES is estimated at £15m.

Risk to health

Obesity can lead to reduced life expectancy. Adults with moderate obesity levels (BMI 30-35) have a reduced life expectancy of 3 years, while severe obesity (BMI 40-50) reduces life expectancy by eight to ten years.

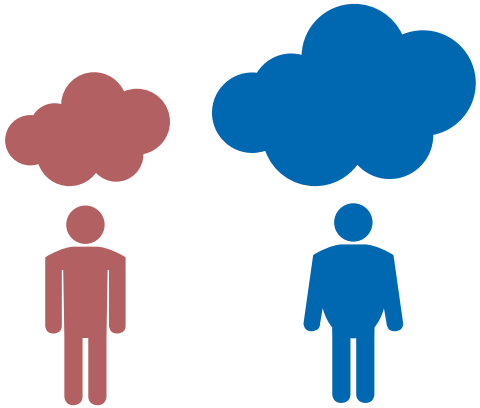
People who are overweight have a higher risk of getting type 2 diabetes, heart disease and certain cancers. Excess weight can also make it more difficult for people to find and keep work, and it can affect self-esteem and mental health. Health problems associated with being overweight or obese cost the NHS more than £5 billion every year.

Mental health and obesity

Depression, anxiety and other forms of mental illness are more common in obese individuals than in the general population. Obesity may trigger psychological issues such as eating disorders, distorted body image, and low self-esteem.

Other mental health effects of obesity include social discrimination – people often judge and mistreat individuals who are overweight. Depression may also lead to reduced physical activity and increased appetite including binge eating. Activity limitations due to obesity or related chronic illnesses may also increase the risk of depression by reducing involvement in physically rewarding activities.

Obese persons had a 55% increased risk of developing depression over time, whereas depressed persons have a 58% increased risk of becoming obese' The mental health of women is more closely affected by overweight and obesity than that of men. There is also strong evidence to suggest an association between obesity and poor mental health in teenagers and adults. This evidence is weaker for younger children.



Obese persons had a 55% increased risk of developing depression over time

depressed persons had a 58% increased risk of becoming obese

Economic impact of obesity

Independent research undertaken in 2015 found that obesity now costs the British taxpayer more than police, prisons and fire service combined. It is clear that, as a society, if we are going to continue to deliver world class public services and look after the health of the population as a whole, we are going to have to do more to address this.

The associated costs to society and business could reach £45.5 billion per year by 2050, with a 7 fold increase in NHS costs alone.

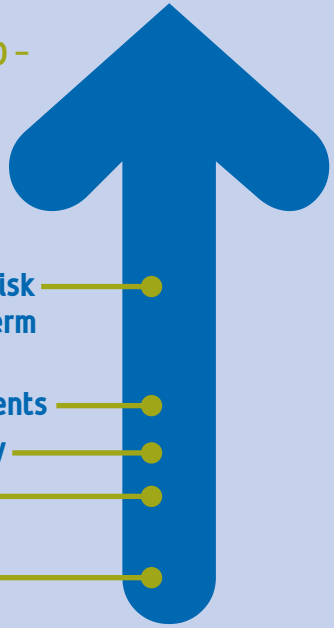
Obesity can impact on the workplace in a number of ways. Obese employees take more short and long term sickness absence than workers of a healthy weight. In addition to the impact on individual health and increased business costs due to time off work through associated illnesses, obese people frequently suffer other issues in the workplace including prejudice and discrimination.

There are significant workplace costs associated with obesity. For an organisation employing 1,000 people, this could equate to more than £126,000 a year in lost productivity due to a range of issues including back problems and sleep apnoea.

On current projections costs are likely to increase

Between 2010 and 2030 – health costs are up by

£2bn



- **Obesity increases the risk of many serious long term conditions**
- **More advanced treatments**
- **Greater life expectancy**
- **Increasing obesity prevalence**
- **More people than ever living in ill health**

The annual cost of obesity

Cost to wider economy

£27bn

- **Obesity attributed days sickness £16m**
- **Obesity medication £13.3bn**
- **Cost to NHS £55.1bn**
- **Social care £352m**

Obesity and inequalities

The prevalence of overweight and obesity has increased in all communities, demonstrating that the whole population is at risk and a population preventative approach is required. However some sectors of the population are more at risk of developing obesity and its associated complications, contributing to inequalities in health.

Children

Trends in child obesity are a particular cause for concern. Obesity has been rising rapidly in children in England over the past 20 years – the proportion of children classified as obese has nearly doubled for children aged 4-5 years and increased more than threefold for children aged 10-11 years. Although the rate of obesity in children and young people is slowing down, further action is needed to address this issue.

Being overweight or obese in pregnancy, childhood and adolescence has consequences for health in both the short term and longer term. Maternal obesity significantly increases risk of foetal congenital anomaly, prematurity, stillbirth and neonatal death. Once established, obesity is notoriously difficult to treat, so prevention and early intervention are very important. Overweight and obese children are more likely to become obese adults, and have a higher risk of morbidity, disability and premature mortality in adulthood. Although many of the most serious consequences may not become apparent until adulthood, the effects of obesity – for example, raised blood pressure, fatty changes to the arterial linings and hormonal and chemical changes (such as raised cholesterol and metabolic syndrome) can be identified in obese children and adolescents.

Some obesity-related conditions can develop during childhood. Type 2 diabetes has increased in overweight children. Other health risks of childhood obesity include early puberty, eating disorders such as anorexia and bulimia, skin infections, asthma and other respiratory problems. Some musculoskeletal disorders are also more common, including slipped capital femoral epiphysis (SCFE) and tibia vara (Blount disease).

Around 1 in 4 (23.2%) **Reception aged children (4 to 5 years old)** in B&NES are an unhealthy weight, i.e. either overweight or obese. Around 1 in 11 (8.9%) Reception aged children in B&NES are obese.

Around 3 in 10 (29.5%) **Year 6 aged children (10 to 11 years old)** in B&NES are an unhealthy weight, i.e. either overweight or obese. Around 1 in 6 (16.0%) Year 6 aged children in B&NES are obese.

Research shows that 3 year olds are now experiencing tooth decay – with sugary drinks being a key factor.

75%

There is a 75% uptake of healthy start vouchers by eligible families in Bath and North East Somerset.

Age is a significant factor in the levels of obesity among children in B&NES, i.e. increasing with age. **Deprivation and ethnicity** are significant factors in the level of obesity among Year 6 aged children in B&NES.

Parental obesity is a significant risk factor for childhood obesity. Therefore, areas with high levels of childhood unhealthy weight and obesity are also likely to have more adult obesity. 1

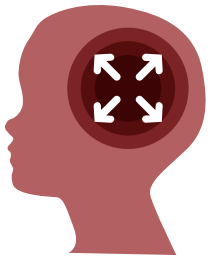
84% of babies in B&NES are breastfed at birth, higher than regionally (78%) and nationally (74%). At the 6-8 week check this rate has dropped to 65% as of Q2 2013/14, although this is still higher than regional (49%) and national (47%) rates. These rates have been relatively flat over the past few years, but seem to be rising locally.

Within B&NES there is considerable variation in rates of breastfeeding between different areas, with 9 wards having 6-8 week rates of less than 50%, the lowest being 29%. It is difficult to distinguish the influence of geographical deprivation from age of mother from the data in B&NES as some of the most deprived areas, with the lowest rates of breastfeeding, also have the highest numbers of teenage mothers.

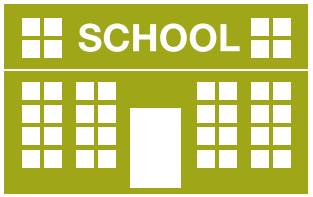
Disabilities and obesity

Children and young people with disabilities are more likely to be obese than children without disabilities and this risk increases with age.

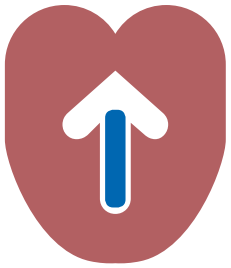
Obesity affects children and young people



- Emotional and behavioural
- Stigmatisation
- Bullying
- Low self-esteem



- School absence
- Educational attainment



- High cholesterol
- High blood pressure
- Pre-diabetes
- Bone and joint problems
- Breathing difficulties

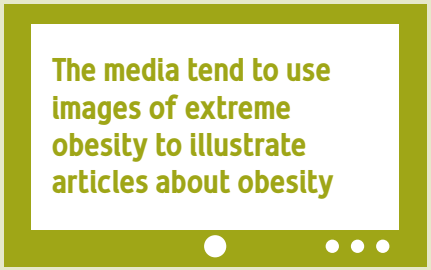
- Increased risk of becoming overweight adults
- Risk of ill-health and premature mortality in adult life

You highlighted:

- Lack of good facilities and activities for preschool aged children
- Lack of crèche facilities whilst exercising for parents
- Need for improved activities (indoor and outdoor) for young people
- Transport is the main barrier to participating in activities for older people and disabled children
- Barriers which prevent parents from encouraging physical activity in children include: fear of being judged on parenting skills, not knowing other parents or workers, cost of activities, lack of awareness of services, reacting badly to being told that their child is overweight.

Causes of obesity

- Adults tend to underestimate their own weight
- Half of parents do not recognise their children are overweight or obese



The media tend to use images of extreme obesity to illustrate articles about obesity

GPs may underestimate their patients' BMI

If we do not recognise obesity we are less likely to prioritise tackling it

Strategic Objective 1: Review and coordinate a weight management pathway for everyone which includes prevention, self care and treatment and is person centred

What we are doing now

Maternal health

Tier 2 - community based Healthy Weight service

Specialist Service - Health in Pregnancy Support Service

Early Years 0-5

Universal Services

Free Healthy Start vitamins, fruit and vegetable vouchers for families on low incomes

Brief intervention for families delivered by Health Visiting

Director of Public Health Award in early years settings

Maternal child nutritional guidance for practitioners

Start4Life campaigns

Baby Feeding Hubs across the local community

Unicef Baby Friendly Breastfeeding accreditation scheme for health visiting service

Targeted Services

Healthy Eating and Nutrition for the Really Young (HENRY) Healthy Weight Programme for Parents and core skills training for Health Visitors

6 week cookery courses for families with overweight/obese children aged 0-19

What else we will do

Maternal Health

Review commissioning and service provision of maternity and Early Years Services, providing family based parenting programmes which equip families with the skills to maintain a healthy weight

Contribute to the commissioning of maternity services ensuring healthy weight standards are incorporated

Early Years 0-5

Universal Services

Contribute to a healthy weight offer for connecting families programme

Develop a healthy weight programme of support for families postnatally

Develop targeted social marketing campaigns for specific at risk groups

Incorporate healthy lifestyle standards into all commissioned parenting programmes and 0-5 services

Review, update and disseminate maternal health and early years nutritional guidance to all professionals working in children's services

Develop and disseminate a framework of key messages for all children's services and relevant council wide departments to promote key messages on healthy weight and infant feeding

Targeted Services

Review Specialist Infant Feeding Support Services

Review and improve provision of Healthy Weight programmes (Tier 1 and Tier 2) for families, ensuring they are effective and value for money

What we are doing now

5-19 Years

Universal Services

Support and promote healthy schools through the delivery of the Director of Public Health Award Scheme for educational settings

Healthy Child Programme delivered by school nurse programme

Change4Life campaigns

Targeted Services

Telephone support offered to families participating in National Child Measurement Programme who have a child who is obese

6 week cookery courses for families with overweight/obese children aged 0-19

HENRY Healthy Lifestyle parenting programme for under 5 year olds

Specialist Weight Management

SHINE community based weight management programme for children and young people aged 10-17 year olds including psychological support

Paediatric dietetic support

Adults

Universal Services

Telephone lifestyle service offering 1-1 weight management support and signposting to local services

Targeted Services

Community based cookery programmes for example:

Bath City Farm cookery programme for mental health service users

Cookery programmes for young adults and older people in supported housing

Volunteering projects to improve cooking and food growing skills

Recipe food box scheme for adults with learning difficulties

Health check for adults aged 40-74

What else we will do

5-19 Years

Universal Services

Raise awareness and increase use of care pathways

Targeted Services

Develop a school ambassador programme to promote healthy weight

Specialist Services

Improve access and availability of weight management provision for school aged children

Involve schools in the design and delivery of family based weight management programmes.

Improve access and provision for children who are severely obese with complex needs

Review access and provision of paediatric dietetic support

Adults

Universal Services

Incorporate weight management standards into commissioned service specifications for long term conditions

Explore use of new technologies and social marketing to raise the issue of healthy weight initiatives

Strengthen communications and marketing work, increasing greater awareness with specific communities

Targeted Services

Identify and work with religious leaders and community groups to ensure they have access to appropriate healthy weight information and can signpost to local support services

What we are doing now

Targeted Services

Diabetes education programmes

6 week support with a lifestyle advisor

Specialist Services

Slimming on referral scheme - 12 week group based
Commercial weight loss programme (Weight Watchers, Slimming World), Counterweight)

Counterweight online weight management pilot with Council and NHS Staff

6 Counterweight programme delivered in selected GP surgeries

Dietetic support

Specialist weight management support for severely obese clients with complex health needs - provided by the Royal United Hospitals NHS Trust Bath

Specialist Bariatic Surgery service funded by NHS England

Post-operative weight management service

What else we will do

Universal Services

Engage pharmacies in the healthy weight agenda including ensuring that local support services information be given with weight management drugs

Targeted Services

Develop healthy weight package of support for public sector workforce

Develop a healthy weight package of support for health check programme

Review weight management support for newly diagnosed diabetic patients

Improve access and availability of community based weight management programmes for:

- Adults aged 20-25
- People suffering from poor mental health
- Those with a physical or learning difficulty
- Residents who are from a Black or minority ethnic background or origin

Specialist Services

Review weight management support within existing social care pathways

Improve psychosocial component of commissioned specialist weight management services

Develop a strategy for supporting overweight/obese clients who have disordered eating

Review and revise specialist weight management offer for obese clients with complex health needs

Review and revise post operative weight management support for patients who have undergone NHS funded weight loss surgery

Strategic Objective 2: Increase opportunities for physical activity in our daily lives, reducing sedentary behaviour

A new multiagency 5 year Fit for Life Physical Activity Strategy was launched in Summer 2015. The local Fit for Life Executive Board and 4 subgroups (Active Lifestyles, Active Design, Active Environments and Active Travel) will lead on the implementation of this strategic objective.

For the purpose of this strategy key priorities which are most relevant in achieving healthy weight outcomes have been included. For a copy of the full strategy and action plan please visit: http://www.bathnes.gov.uk/services/sport-leisure-and-parks/health-and-fitness/fit-life

The Local Authority has awarded a new leisure contract to Greenwich Leisure Ltd to lead on a £17 million modernisation and refurbishment of the Council's local leisure facilities. Sites include: Bath Sport and Leisure Centre, Keynsham Leisure Centre, Culverhay Leisure Centre, Chew Valley Leisure Centre, Odd Down Playing Fields and the Bath Pavilion.

What we are doing now

Maternal Health

Through the Active Lifestyles Subgroup:

Moving on Up project , 12 week postnatal dance programme for women

Early Years 0-5 Years

Through the Active Lifestyles Subgroup:

Targeted Healthy Lifestyle Parenting Programme (HENRY) promoting play for 0-5s

Through the Active Environments Group:

Director of Public Health award in Early Years settings

Through the delivery of the Active Travel Sub Group to:

Go By Bike: community based preschool cycling activities delivered in children centres

What else we will do

Maternal Health

Through the Active Lifestyles Subgroup:

Review and improve provision of opportunity for physical activity available for pregnant women and parents/ carers of small babies / pre-schoolers

Early Years 0-5 Years

Through the delivery of the Active Environments Group:

Refresh the Council's play strategy and ensure promoting the opportunity for active play is embedded in all other relevant children's service specifications

Ensure there is more focus in the community on outdoor play

Through the delivery of the Active Travel Sub Group to:

Work with early years and educational settings to continue to encourage a culture of physically active travel, supporting them to provide cycle and road safety training for all children

Active Lifestyles

Promote activities which children can do independently and those they can enjoy with their family and friends

What we are doing now

5-19 Years

Through the Active Lifestyles Group:

Open Access Community play sessions run in areas of highest need

Family play inclusion workers offering tailored play support for children aged 5 to 13 and their families, SEN/disabled families prioritised

Healthy lifestyle activities delivered by Connecting Families Team for parents and children

Sport England funded try active programme to increase cycling, walking/running and outdoor fitness for 14-19 year olds

Schools Sports Partnership delivering everyday active programme of activities in primary and secondary schools

Community based weight management programme (SHINE) for 10-17 offers ongoing rolling physical activity offer for children and young people

University of Bristol commissioned dance research project to engage Year 7 girls in dance activities after school

Director of Public Health Award

Wheels for All cycling club for adults and children with disabilities and differing needs

Through the delivery of the Active Travel Sub Group:

Go By Bike programme: delivering cycling proficiency and sporting events in partnership with schools

What else we will do

5-19 Years

The Active Environments Group will:

Support schools to be community hubs providing access to their facilities in their local community to raise awareness and encourage families to be more active

The Active Lifestyles Group will:

Work across sectors to increase opportunities for everyday activity and opportunities for play in children, young people and families. Prioritise:

- Families in low socioeconomic groups (targeting families with children aged 0-5)
- Children with disabilities and/or who have parents with a disability and
- BME children
- Girls aged 12 upwards
- NEETS

Incorporate physical activity standards in educational setting's policies and plans.

Support children and young people's settings to promote physical activity and play in and out of school hours.

Continue to ensure high quality sport and physical activity in schools

Develop effective strategies for increasing activity levels in the key transition points for young people (between primary and secondary school and secondary and further education)

Strengthen partnership with schools and clubs to increase participation

The Active Travel Group will:

Introduce an active travel scheme for schools

Increase opportunities for active travel for families

Increase range of community based activities for families with children with a learning or physical difficulty

What we are doing now

Adults

Through the Active Lifestyles Group:

- Group led wellbeing walks delivered by Sirona Care and Health
- Mass Participation sporting events for example, sport relief mile, half marathon, Tour of Britain, Parkrun

AGE UK funded chair based seated exercise, Tai Chi, guided walks, Fit for the future physical activity Programme

Lottery funded wellbeing community activator programmes for older people and/or their carers

Commissioned twelve week exercise on referral scheme offering subsidised access to local leisure facilities for inactive residents who are at risk of heart disease or experiencing low mood and low self-esteem

Macmillan funded structured exercise programme for cancer survivors

Through the delivery of the Active Travel Group:

- Free cycle training is offered for Adults commissioned by council

Active Environments:

- Development of the Odd Down Cycle Circuit to increase community activities
- Sport England funded Tryactive programme – free activities for adults to increase walking, cycling and improve outdoor fitness

University of West of England mapping current physical activity provision for older people

Bath University published Promoting physical activity in older adults: A guide for local decision makers

What else we will do

Adults

The Active Lifestyles Group will:

Increase mass participation events aimed at engaging inactive adults

Promote activities which are holistic and combine improved mental wellbeing and exercise

Improve opportunities and access to sport and physical activity for those with disabilities

Bath University will deliver a research study to develop a 12 month intervention to reduce sedentary behaviour in older people (REACT)

Review and improve provision of physical activity programmes delivered in residential homes and day centres

Increase walking based activities

Develop falls prevention pathway to include physical activity

Promote Change4Life campaigns

Invest in additional marketing campaigns that will inform, support, empower people to make changes to their activity levels.

Increase opportunities for low level structured activity needed for obese or those with long term conditions

Review and increase provision of community based activities which attract adults aged 20-25 year olds,women, people with learning/physical difficulties and those who have a different ethnic origin than white.

Increase participation in local sports clubs

Active Environments Group will:

Review and improve availability of green spaces and playing pitches as well as safeguard against the loss of open space and recreational facilities.

Work with local housing providers to utilise and optimise their access to residents to increase options for healthy eating

What we are doing now

Adults

Active Environments:

Contribution to the development of the River Strategy

Update the green space strategy standards

Active Design

Contribution to the development of the master plan for Bath and the Placemaking through Health Impact Assessment

What else we will do

Active Environments Group will:

Increase participation in people being active in the natural environment

Protect playing pitches and outdoor opportunities for physical activity from development

Improve open spaces and play areas so they are safe stimulating and challenging for all children

Develop a well-connected multifunctional network of green infrastructure

The Active Travel Group will:

Increase the opportunities for active travel for individuals/families

Support development of residential travel plans that promote sustainable/active travel.

Active Design

Utlise active design criteria to assess pre-planning and planning applications for major developments

Incorporate active design principles in Council/NHS Strategies

Invest in training for planners (urban, rural and transport), architects and designers on the health implications of local plans

Strategic Objective 3: Promote a healthy and sustainable food culture, enabling people to access affordable good food

A new 5 year local Food Strategy was launched in Spring 2015. The local food partnership will play the lead role in coordinating the implementation of this objective.

For the purpose of this strategy key priorities which are most relevant in achieving healthy weight outcomes have been included. For a copy of the full strategy and action plan please visit: http://www.bathnes.gov.uk/sites/default/files/bath_and_north_east_somerset_local_food_strategy_0.pdf

What we are doing now

Food Provision and Access

National Healthy Start Voucher Scheme providing free milk, fruit and vegetables and vitamin supplements for low income families with children under 5

A 'Baby Welcome' scheme promoting breastfeeding in cafes and community venues

Bronze Council Catering Service Food for Life Partnership Award achieved in 61 primary schools

Local Educational Setting Food Forum supporting implementation of School Food Plan

Public Health Award scheme to support educational settings to deliver healthy eating, and food growing initiatives.

Delivery of a healthy eating accreditation scheme to support food outlets and businesses to provide healthier options

Workplace wellbeing charter to support workplaces promote healthy eating practices

What else we will do

Food Provision and Access

Increase uptake of healthy start vouchers by eligible families

Increase acceptance of food welfare vouchers at fruit and veg market stalls

Provide training opportunities for low income groups to develop skills in cookery, food growing and healthy eating

Include healthy eating criteria in all public sector food contracts

Support public sector organisations to serve food which is healthy and nutritious through healthy eating accreditation scheme

Promote healthy eating across all settings (workplace/health/commercial organisations)

Increase support to food-outlets and public environments to welcome breast-feeding

Reduce the number of outlets which offer unhealthy snack and drink in areas close to educational settings and family leisure facilities

Improve the nutritional quality of food provision in local hospitals and residential care settings

Reduce the number of new fast food outlets near educational settings

Increase the availability of affordable fruit and vegetables in neighbourhoods of high need.

Work with local housing providers to utilise and optimise their access to residents to increase options for healthy eating

Review and create a sustainable model for cooking skills for social housing tenants

What we are doing now

Support everyone to afford good quality food

Family cookery programmes delivered in educational and community venues for 0-19s

Pilot between Age UK and Chew Valley secondary school to engage older people in sharing knowledge about cooking and food skills

What else we will do

Food provision and access

Engage more people in communal activities associated with food such as cooking and growing can contribute to community cohesion and social engagement

Encourage local workplaces and business to sign up to the Responsibility Deal

Work with partners to install healthy vending machines in public buildings

Work with job centres to investigate providing appropriate information on healthy lifestyles and the services available to clients

Optimise the use of empty green spaces and provide more allotment spaces to residents for food

Support everyone to afford good quality food

Continue to support educational settings to embed healthy eating skills and education into the curriculum using whole school approach

Seek further training opportunities for residents to develop cooking and food growing skills

Co-ordinate and provide healthy eating and nutrition advice to local residents

Promote national Change4Life programme

Deliver key messaging on the dangers of sugary and caffeinated drinks and portion sizes/ oversnacking locally

Reduce diet-related inequality for families, prioritising

Children from Black and Minority Ethnic Backgrounds as well as children with a physical or learning difficulty and young Families on a low income

Ensure that those residents receiving meals in inpatients or in residential settings/facilities have healthy meals in line with Food Standard's Agency guidance

Strategic Objective 4: Support organisations to promote the health and wellbeing of their employees

What we are doing now

Adults:

NHS health checks for residents aged 40-74

Commissioned service to deliver Workplace Wellbeing Charter to local businesses

Online workplace weight management pilot

Active Travel incentives for employees including:

- Roadshows
- Cycling training
- Pool Bikes
- Individualised travel plans
- Electric cars
- Improved washing facilities
- Improved cycle storage facilities

Wellbeing walks

Access to integrated lifestyles hub for weight management and physical activity support. For example:

Slimming on Referral

Exercise on referral

What else we will do

Adults:

Through development of the Workplace Wellbeing Charter, support workplaces to provide opportunities for staff to eat a healthy diet and be physically active, through:

- active and continuous promotion of healthy choices in restaurants, hospitality, vending machines and shops for staff and clients, in line with existing national guidance
- working practices and policies, such as active travel policies for staff and visitors
- a supportive physical environment, such as improvements to stairwells and providing showers and secure cycle parking
- recreational opportunities, such as supporting out of-hours social activities, lunchtime walks and use of local leisure facilities.

Workplaces providing health checks for staff should ensure that they address weight, diet and activity, and provide ongoing support to employees.

Increase the opportunities for workplace weight management programmes

Strategic Objective 5: Develop a workforce that is confident and competent in promoting healthy weight

What we are doing now

Maternal and children and young people

Investment in commissioned evidence based training programmes for professionals

Specialist Health in Pregnancy midwives and support staff trained in SHINE weight management programme for pregnant women

All Health Visitors and some children centre staff trained in HENRY solution focussed approach to enable them to raise the issue of weight with families and support them to make positive changes to their diet and activity levels

Sirona Health Improvement Specialists and School Nurses trained in SHINE weight management training for 10-17 year olds

Adults

Investment in training Health Check Practitioners in raising the issue of weight

'Making Every Contact Count' training pilot with public sector and voluntary staff and volunteers

Local Authority training license holder for Counterweight programme Counterweight to enable practice staff to raise the issue of weight with patients and provide weight management support.

RSPPH Level 2 and Level 3 Nutrition training on offer to Businesses

What else we will do

Maternal and children and young people

Secure investment and deliver a coordinated training programme of 'making every contact count' for frontline staff working in the public and voluntary sector

Enable all staff to have increased confidence in:

- raising the issue of weight
- Promoting Baby Friendly key messages
- competencies to deliver/refer to weight management interventions where appropriate.

Adults

Secure investment and deliver a coordinated training programme of 'making every contact count' for frontline staff working in the public and voluntary sector

Review and develop and coordinate training opportunities for staff to improve their knowledge and skills in promoting healthy weight

Measuring success and evaluation

The successful delivery of this strategy is dependent upon good data quality to be able to measure success. We will continue to collect, analyse and disseminate local, regional and national data to understand local need to inform future provision of local services accordingly.

What do we mean by the terms Healthy Weight and Obesity?

The term 'healthy weight' is used to describe when an individual's body weight is appropriate for their height and benefits their health. Above the healthy weight range there are increasingly adverse effects on health and wellbeing. Weight gain can occur gradually over time when energy intake from food and drink is slightly greater than energy used through the body's metabolism and physical activity.

Obesity is defined as a significant excess of body fat which occurs when energy intake exceeds expenditure over a long period of time. Obesity is known to increase the risk of a range of health problems particularly type 2 diabetes, stroke and coronary heart disease, cancer and arthritis. It is also important to note the immense impact of overweight and obesity on emotional health and quality of life.

Measurement of Healthy Weight, Overweight and Obesity

The recommended measure of overweight and obesity within a population is body mass index (BMI)3. BMI is calculated by dividing body weight (kilograms) by height (metres) squared. In children this is adjusted for a child's age and gender to allow for growth and development. Although it does not directly measure body fat, having a higher than recommended BMI in adulthood increases risk of chronic diseases. Children with BMI in the overweight and obese range are more likely to become overweight or obese adults. BMI is an indicator of health and should be used with caution when exercised when used for individuals as waist circumference is also used a predictor of obesity. Clinical judgement is necessary to assess individual's weight where there is concern.

Table 1: BMI classifications for adults

Classification	BMI Centile
Underweight	>18.5
Healthy Weight	18.5 – 24.9
Overweight	25.0 – 29.9
Obese	30.0 – 39.9
Morbidly Obese	>40

Source: Nice 2006

Presently there is some debate about the definition of childhood obesity and the best way to measure it. The National Childhood Measurement Programme (NCMP) uses BMI reference charts to classify children which take into account children's weight and height for their age and sex. Children over the 85th centile are considered overweight and those over the 95th centile, obese.

Table 2: UK National Body Mass Index (BMI) percentile classification or child

Classification	BMI Centile
Underweight	≤ 2nd centile
Healthy Weight	2nd centile – 84.9th centile
Overweight	85th centile – 94.5th centile
Obese	≥95th centile

Source: Nice 2006

Pathway of current programmes as at January 2016

Level	Intervention	Maternal Health and Early Years 0-5s	Children and Young People 5-19	Adults
UNIVERSAL	Transport – improving infrastructure and promotion of walking and cycling	●	●	●
	Built Environment – creating environments conducive to health	●	●	●
	Cycling Proficiency in schools		●	
	Improving parks, open spaces and playing fields	●	●	●
	Healthy Child Programme: 0-5 and 5-19	●	●	
	Unicef baby friendly breastfeeding scheme	●		
	Director of Public Health Award	●		
	Parenting strategy	●	●	
	School Sport and PE programme		●	
	School Food Plan		●	
	School travel plans			
	Oral Health Promotion	●	●	●
	National Child Measurement Programme		●	
	Social marketing campaigns: e.g. Change4life, One You	●	●	●
	Brief Advice: Making Every Contact Counts	●	●	●
	Raising the issue of weight training	●	●	
	Hello baby – antenatal programme	●		
	Accredited nutrition training	●		
	Infant feeding hubs	●		

Pathway of current programmes as at January 2016

Level	Intervention	Maternal Health and Early Years 0-5s	Children and Young People 5-19	Adults
TARGETED	Healthy Start	●		
	Community Play/Family Support and Play workers	●	●	
	Cook It! Family based cooking skills programme	●		
	Grow it and Cook it programmes	●		
	NHS Health Check Programme			●
	Lifestyle Advisors			●
	Feel Good Foods Recipe Box Scheme	●		
	Wheels for All inclusive cycling		●	●
	Lets get healthy with HENRY: parenting and lifestyle programme	●		
SPECIALIST	Health in Pregnancy Support Service – SHINE	●		
	Teen Weight management Service (1-17 years) – SHINE		●	
	Fit Club for Families with Learning difficulties			
	Slimming on Referral – adult weight management			●
	Counterweight weight management			●
	Passport to Health: Exercise on Referral		●	●
	Specialist Dietetics		●	●
	Specialist Weight Management Clinic			●
	Anti Obesity Drug Therapy			●
	Bariatric Surgery and follow up			●

Modelling life course timeline & opportunities for making the healthy choice the easy choice

Personal Behaviour Knowledge, skills, attitude & lifestlye	Cooking skills	5 fruit & veg per day	Daily exercise	Adult education	Physical activity groups
Self Care Information, skill, development & support	Food choices		Maternal diet		Expert patient groups
Family & Friends	Parental skills	Active families	Walking school bus schemes		Sport & hobbies
Local Community	School playing fields	Community centres	Workplace canteens	Commercial slimming organisations	Community group lifestyle activities
Environment	Community safety	Supervised play spaces	Traffic schemes	Cycle ways	Available plublic transport
Health Services Targeted prevention & weight management	Health visitors, midwives School nurses, health trainers Children centres	GPs & Primary Care Teams Healthy workplace	Obesity drugs Dieticians Leisure services	Gastric surgery Hospital Staff Adult education	Care workers Community nurses Healthy living centres
Public Policy Making the healthy choice the easy choice	Food advertising to children	Food labelling	Integrated public transport	Food safety	NSFs, NICE guidance

References

For more information on local statistics quoted in this report please visit the

Bath and North East Somerset Joint Strategic Needs Assessment Wiki page at www.bathnes.gov.uk/jsna

1. Foresight (2007) Tackling obesities: Future Choices- project report. Government Office for Science.
2. Craig R, Mindell J (eds) (2013) Health Survey for England 2012, London: The Health and Social Care Information Centre.
3. http://www.bathnes.gov.uk/services/your-council-and-democracy/local-research-and-statistics/wiki/obesity
4. Gatineau M, Dent M (2011) Mental Health and Obesity London: National Obesity Observatory (NOO)
5. Gatineau M, Mathrani S (2012) Alcohol and Obesity: an overview London: NOO
6. http://www.alzheimers.org.uk/site/scripts/news_article.php?newsID=2150

All the national infographics statistics
https://www.noo.org.uk/securefiles/150225_1335//Making_the_case_for_tackling_obesity_reference_sheet_factsheet.pdf

Local Statistics
http://www.bathnes.gov.uk/services/your-council-and-democracy/local-research-and-statistics/wiki/obesity

Bath & North East Somerset Council		
MEETING	**Children and Young People Policy Development & Scrutiny Panel**	
MEETING	**12th July 2016**	EXECUTIVE FORWARD PLAN REFERENCE:
TITLE:	**Bath and North East Somerset Children's Health Profile**	
WARD:	All wards	
AN OPEN PUBLIC ITEM		
List of attachments to this report: 2016 Children's Health Profile for B&NES 2015 Health Behaviours in Young People summary for B&NES. A presentation based on the 2015 B&NES Child Health Related Behaviours survey.		

1 THE ISSUE

1.1 The children's scrutiny committee has asked for a paper on children's health and wellbeing for this themed meeting. This short report introduces and identifies some highlights from three sources of recent and local information.

1.2 The National Child and Maternal Health Intelligence Network (CHIMAT), now part of Public Health England, produces annual children's health profiles which cover a wide range of indicators of physical and mental health and wellbeing and provide a good overall snapshot of children and young people's health.

1.3 A companion report on health behaviours in young people is also produced and has been attached.

1.4 A more detailed primary and secondary school-based survey is done locally on child health related behaviours often referred to as the SHEU survey. A presentation based on this concerning "children's sense of safety" was presented to the scrutiny panel earlier this year but a more general presentation is attached to this report to complete an overview of children and young people's health and challenges that they and our services face.

2 RECOMMENDATION

2.1 The scrutiny panel is asked to note the contents of these profiles and the presentation on child health related behaviours survey.

2.2 The panel is asked to note that while children and young people in B&NES are generally healthy in comparison to their peers across the county, they nevertheless face many challenges to both their physical and mental health particularly in relation to adopting and maintaining healthy lifestyles and behaviours and in dealing with the stresses that they face at school and at home.

2.3 The panel is asked to endorse the importance of maintaining adequate services, including universal services such as health visiting and school nursing, through this period of intense pressure on local government finances.

3 RESOURCE IMPLICATIONS (FINANCE, PROPERTY, PEOPLE)

3.1 No specific requests are being made and so there are no direct resource implications. The scrutiny panel is asked to note that the generally good children's health in B&NES is underpinned by a wide range of services commissioned by the council and the NHS, including universal health visiting and school nursing services and a range of targeted services for health promotion and children's social wellbeing and mental health.

3.2 The panel is reminded that the budget and the commissioning responsibility for 0-5 public health services, these being the health visiting and family nurse partnership, has sat with the council since October 2015 following a transfer from NHS England.

4 STATUTORY CONSIDERATIONS AND BASIS FOR PROPOSAL

4.1 Nil specific

5 THE REPORT

5.1 The profiles enclosed demonstrate a range of children and young people's health and wellbeing indicators benchmarked against national and, in some cases, regional averages.

5.2 Overall the health profile demonstrates that the health and wellbeing of children and young people in B&NES is significantly above the national average for 20 out of 32 indicators and is not significantly below the national average for any. This is an improvement on the 2015 profile in which we were significantly worse than the national average for three indicators:

(1) First time entrants to the youth justice system

(2) Hospital admissions for self-harm in children age 10-24

(3) Hospital admissions for injuries in children age 0-14

5.3 We remain slightly, but not statistically significantly, below national average for some indicators, notably alcohol related hospital admissions. Although this may partly reflect admissions policies as much as an actual alcohol problem, there is one finding in the second profile that suggests that some young people in B&NES might be consuming more alcohol than their peers.

5.4 There is a rather persistent finding over a number of years in B&NES that our obesity figures for children in reception year are a little worse than national and regional averages but that our year 6 children have lower rates of obesity and overweight than their peers. This will be covered in a companion paper on childhood obesity.

5.5 The Health Behaviour Profile shows that B&NES children are similar in many ways to others in the region and nationally. In benchmarking terms, our children are significantly above the national average for consumption of fruit and veg and in the numbers who meet physical activity recommendations, while they are significantly worse on the numbers who have been drunk in the last month. But good benchmarking should not be confused with a good absolute position and so, for example even though we benchmark well for physical activity, only 18.8% of young people actually meet the target and this is only "good" in relation to a very poor national average of 13.9%. Much work is going into improving this picture but we are struggling against a background culture that is far too sedentary.

5.6 The school-based child health related behaviours survey (often known as the SHEU survey) has been partially presented already to the panel in a topic on children's sense of safety". Since this is the most detailed source of information on a wide range of important topics a more general presentation based on the survey is attached to this report covering a selection from both primary and secondary school findings.

5.7 This presents a mixed picture with many areas of strength but also significant concerns and challenges. Among the concerns it is notable that a lot fewer girls have high self-esteem than boys, particularly in secondary school, and that children and young people entitled to free school meals show a number of areas where they differ from the average to their disadvantage.

5.8 The "free school meals gap" is illustrative of the wider issue of health inequalities, which are present in B&NES as elsewhere. While inequalities in the main health outcomes in terms of overt disease and mortality more often manifest in later life, the causes of inequalities begin before birth and develop through all stages of life and differences in health related behaviour s certainly show from earliest years. It is known that the way children are reared in these earliest years – "the first thousand days" – is particularly critical for attachment and neural development and so the importance of good support to all children and families is given particular emphasis.

5.9 More recently neuroscientists have also demonstrated that during the teenage years there is also intensive brain development affecting cognitive skills and the emergency of the adult personality, and so the importance of good support in these years is also emphasized.

6 RATIONALE

6.1 No new course of action is being suggested in this paper.

7 OTHER OPTIONS CONSIDERED

7.1 Children and young people's public health and mental health services are constantly being reviewed and updated according to new policy and guidance and in response to budgetary opportunities and pressures. Many of the relevant services come within the scope of "your care your way" and so are currently being reviewed through that process.

8 CONSULTATION

8.1 The two statistical reports are collated by Public Health England. The exact source of each item of data is referenced at the end of the profiles.

8.2 The child health related behaviours survey has been widely presented to different stakeholder groups including schools, the LSCB and the children's trust board.

9 RISK MANAGEMENT

9.1 A risk assessment related to the issue and recommendations has been undertaken, in compliance with the Council's decision making risk management guidance.

Contact person	*Dr. Bruce Laurence 01225394075* *bruce_laurence@bathnes.gov.uk*
Background papers	*PHE Child and Maternal Health Intelligence Network Child Health Profile for B&NES* *PHE Child and Maternal Health Intelligence Network Health Behaviours in Young People Summary* *Child health related behaviours survey presentation*
Please contact the report author if you need to access this report in an alternative format	

Public Health England

Child Health Profile
March 2016

Bath and North East Somerset

This profile provides a snapshot of child health in this area. It is designed to help the local authority and health services improve the health and wellbeing of children and tackle health inequalities.

The child population in this area

	Local	South West	England
Live births in 2014			
	1,702	58,403	661,496
Children (age 0 to 4 years), 2014			
	9,500 (5.2%)	307,400 (5.7%)	3,431,000 (6.3%)
Children (age 0 to 19 years), 2014			
	41,100 (22.6%)	1,208,600 (22.3%)	12,907,300 (23.8%)
Children (age 0 to 19 years) in 2025 (projected)			
	43,900 (23.3%)	1,300,800 (22.4%)	13,865,500 (23.7%)
School children from minority ethnic groups, 2015			
	2,546 (11.3%)	76,043 (12.0%)	1,931,855 (28.9%)
Children living in poverty (age under 16 years), 2013			
	11.7%	14.8%	18.6%
Life expectancy at birth, 2012-2014			
Boys	81.3	80.2	79.5
Girls	84.7	83.9	83.2

Children living in poverty

Map of the South West, with Bath and North East Somerset outlined, showing the relative levels of children living in poverty.

Contains Ordnance Survey data

Data sources: Live births, Office for National Statistics (ONS); population estimates, ONS mid-year estimates; population projections, ONS interim 2012-based subnational population projections; black/ethnic minority maintained school population, Department for Education; children living in poverty, HM Revenue & Customs (HMRC); life expectancy, ONS.

Key findings

Children and young people under the age of 20 years make up 22.6% of the population of Bath and North East Somerset. 11.3% of school children are from a minority ethnic group.

The health and wellbeing of children in Bath and North East Somerset is generally better than the England average. The infant mortality rate is better than and the child mortality rate is similar to the England average.

The level of child poverty is better than the England average with 11.7% of children aged under 16 years living in poverty. The rate of family homelessness is better than the England average.

9.6% of children aged 4-5 years and 13.9% of children aged 10-11 years are classified as obese.

The hospital admission rate for alcohol specific conditions is similar to the England average. The hospital admission rate for substance misuse is lower than the England average.

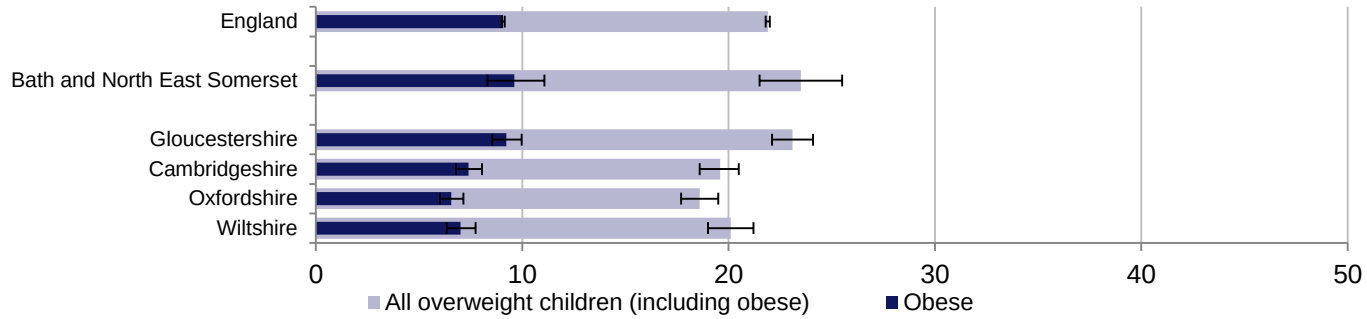
In 2014, 72 children entered the youth justice system for the first time. This gives a similar rate to the England average for young people receiving their first reprimand, warning or conviction. The percentage of young people aged 16 to 18 not in education, employment or training is lower than the England average.

Any enquiries regarding this publication should be sent to info@chimat.org.uk.

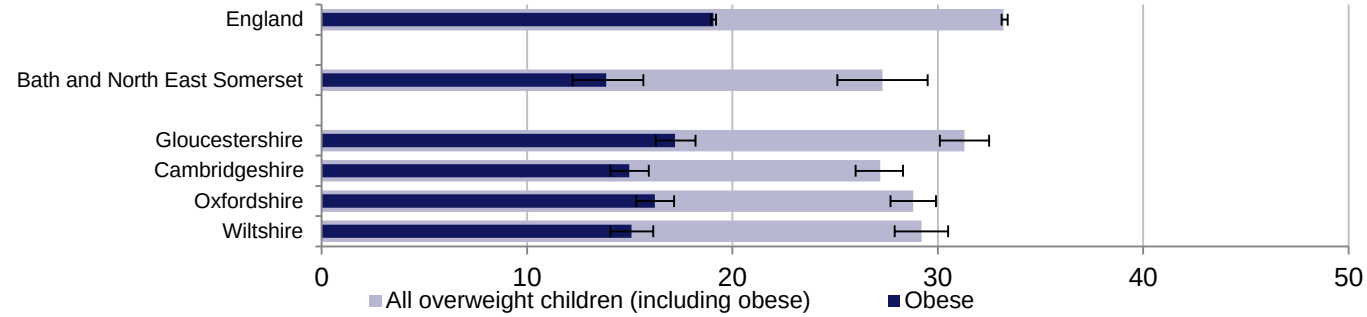
Childhood obesity

These charts show the percentage of children classified as obese or overweight in Reception (aged 4-5 years) and Year 6 (aged 10-11 years) by local authority compared with their statistical neighbours. Compared with the England average, this area has a similar percentage in Reception and a better percentage in Year 6 classified as obese or overweight.

Children aged 4-5 years classified as obese or overweight, 2014/15 (percentage)



Children aged 10-11 years classified as obese or overweight, 2014/15 (percentage)



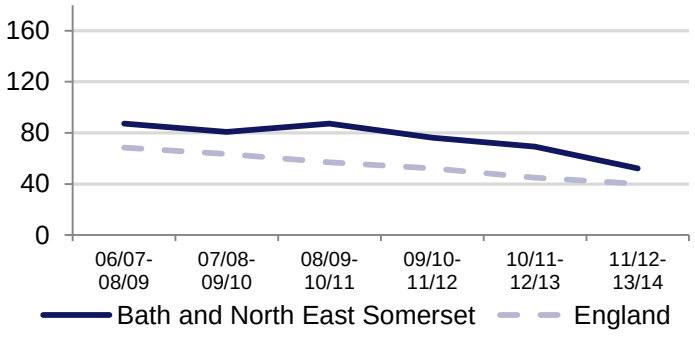
Note: This analysis uses the 85th and 95th centiles of the British 1990 growth reference (UK90) for BMI to classify children as overweight and obese.

I indicates 95% confidence interval. Data source: Public Health Outcomes Framework

Young people and alcohol

In comparison with the 2006/07-2008/09 period, the rate of young people under 18 who are admitted to hospital because they have a condition wholly related to alcohol such as alcohol overdose is lower in the 2011/12-2013/14 period. The admission rate in the 2011/12-2013/14 period is similar to the England average.

Young people aged under 18 admitted to hospital with alcohol specific conditions (rate per 100,000 population aged 0-17 years)

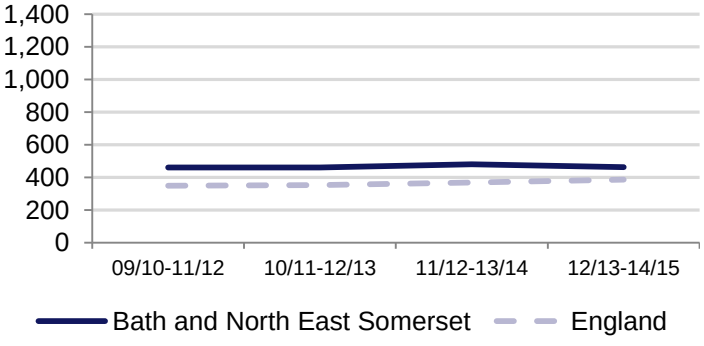


Data source: Public Health England (PHE)

Young people's mental health

In comparison with the 2009/10-2011/12 period, the rate of young people aged 10 to 24 years who are admitted to hospital as a result of self-harm is similar in the 2012/13-2014/15 period. The admission rate in the 2012/13-2014/15 period is higher than the England average*. Nationally, levels of self-harm are higher among young women than young men.

Young people aged 10 to 24 years admitted to hospital as a result of self-harm (rate per 100,000 population aged 10 to 24 years)

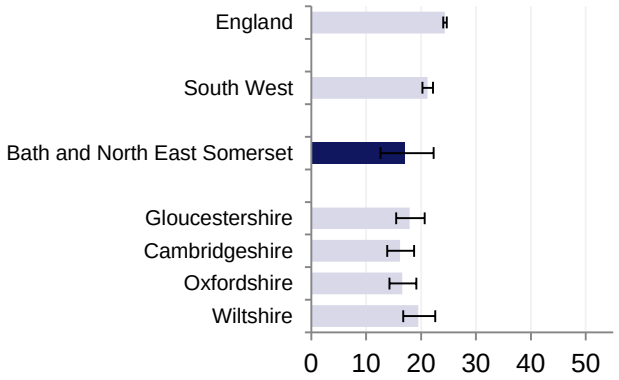


*Information about admissions in the single year 2014/15 can be found on page 4

Data source: Hospital Episode Statistics, Health and Social Care Information Centre

These charts compare Bath and North East Somerset with its statistical neighbours, the England and regional average and, where available, the European average.

Teenage conceptions in girls aged under 18 years, 2013 (rate per 1,000 female population aged 15-17 years)



In 2013, approximately 17 girls aged under 18 conceived for every 1,000 females aged 15-17 years in this area. This is similar to the regional average. The area has a lower teenage conception rate compared with the England average.

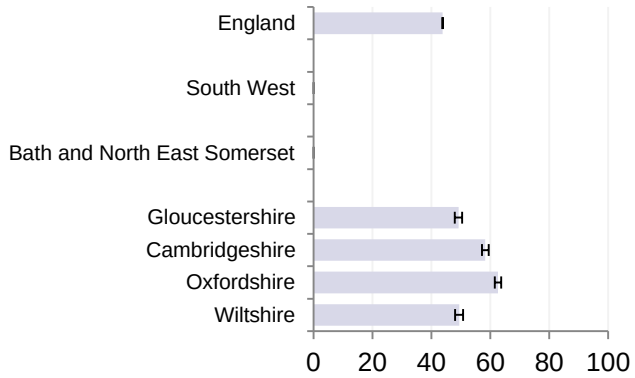
Source: Conceptions in England and Wales, ONS

Chlamydia detection, 2014 (rate per 100,000 young people aged 15 - 24 years)

Chlamydia screening is recommended for all sexually active 15-24 year olds. Increasing detection rates indicates better targeting of screening activity; it is not a measure of prevalence. Areas should work towards a detection rate of at least 2,300 per 100,000 population. In 2014, the detection rate in this area was 1,377 which is lower than the minimum recommended rate.

Source: Public Health Outcomes Framework. The shaded area from 1,900 shows the range of values approaching the minimum recommended rate of 2,300 (the black line).

Breastfeeding at 6 to 8 weeks, 2014/15 (percentage of infants due 6 to 8 week checks)

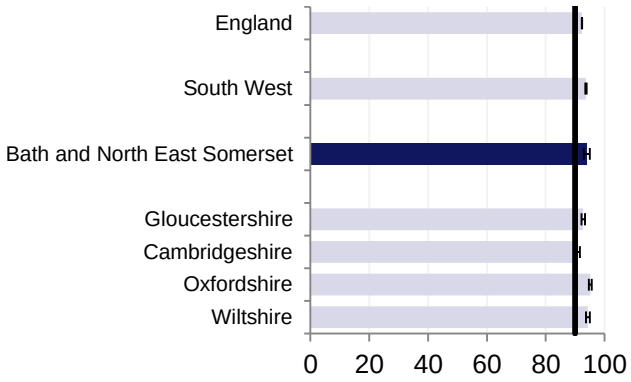


84.1% of mothers in this area initiate breastfeeding when their baby is born. This area has a lower percentage of babies who have ever been breastfed compared with the European average of 89.1%*. There is no data for breastfeeding at six to eight weeks.

* European Union 21 average, 2005. Source: Organisation for Economic Co-operation and Development (OECD) Social Policy Division

Source: Public Health Outcomes Framework

Measles, mumps and rubella (MMR) immunisation by age 2 years, 2014/15 (percentage of children age 2 years)



More than 90% (the minimum recommended coverage level, shown as a vertical black line on the chart above) of children have received their first dose of immunisation by the age of two in this area (94.1%). By the age of five, 90.5% of children have received their second dose of MMR immunisation. In the South West, there were 2 laboratory confirmed cases of measles in young people aged 19 and under in the past year.

Sources: Public Health Outcomes Framework; Public Health England

Note: Where data is not available or figures have been suppressed, no bar will appear in the chart for that area.

Bath and North East Somerset Child Health Profile March 2016

The chart below shows how children's health and wellbeing in this area compares with the rest of England. The local result for each indicator is shown as a circle, against the range of results for England which are shown as a grey bar. The red line indicates the England average. The key to the colour of the circles is shown below.

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

	Indicator	Local no.	Local value	Eng. ave.	Eng. Worst	Eng. Best
Premature mortality	**1** Infant mortality	3	1.7	4.0	7.2	1.6
	2 Child mortality rate (1-17 years)	3	10.0	12.0	19.3	5.0
Health protection	**3** MMR vaccination for one dose (2 years) >=90% <90%	1,873	94.1	92.3	73.8	98.1
	4 Dtap / IPV / Hib vaccination (2 years) >=90% <90%	1,937	97.3	95.7	79.2	99.2
	5 Children in care immunisations	100	95.2	87.8	64.9	100.0
Wider determinants of ill health	**6** Children achieving a good level of development at the end of reception	1,330	69.6	66.3	50.7	77.5
	7 GCSEs achieved (5 A*-C inc. English and maths)	1,006	62.1	57.3	42.0	71.4
	8 GCSEs achieved (5 A*-C inc. English and maths) for children in care	-	-	12.0	8.0	42.9
	9 16-18 year olds not in education, employment or training	170	3.5	4.7	9.0	1.5
	10 First time entrants to the youth justice system	72	463.2	409.1	808.6	132.9
	11 Children in poverty (under 16 years)	3,345	11.7	18.6	34.4	6.1
	12 Family homelessness	35	0.5	1.8	8.9	0.2
	13 Children in care	130	38	60	158	20
	14 Children killed or seriously injured in road traffic accidents	3	8.9	17.9	51.5	5.5
Health improvement	**15** Low birthweight of term babies	24	1.6	2.9	5.8	1.6
	16 Obese children (4-5 years)	170	9.6	9.1	13.6	4.2
	17 Obese children (10-11 years)	215	13.9	19.1	27.8	10.5
	18 Children with one or more decayed, missing or filled teeth	-	20.1	27.9	53.2	12.5
	19 Hospital admissions for dental caries (1-4 years)	23	303.0	322.0	1,406.8	11.7
	20 Under 18 conceptions	51	17.0	24.3	43.9	9.2
	21 Teenage mothers	9	0.5	0.9	2.2	0.2
	22 Hospital admissions due to alcohol specific conditions	18	52.1	40.1	100.0	13.7
	23 Hospital admissions due to substance misuse (15-24 years)	17	53.4	88.8	278.2	24.7
Prevention of ill health	**24** Smoking status at time of delivery	160	10.0	11.4	27.2	2.1
	25 Breastfeeding initiation	1,508	84.1	74.3	47.2	92.9
	26 Breastfeeding prevalence at 6-8 weeks after birth	-	-	43.8	19.1	81.5
	27 A&E attendances (0-4 years)	3,745	395.4	540.5	1,761.8	263.6
	28 Hospital admissions caused by injuries in children (0-14 years)	313	110.6	109.6	199.7	61.3
	29 Hospital admissions caused by injuries in young people (15-24 years)	364	113.3	131.7	287.1	67.1
	30 Hospital admissions for asthma (under 19 years)	37	100.3	216.1	553.2	73.4
	31 Hospital admissions for mental health conditions	31	90.1	87.4	226.5	28.5
	32 Hospital admissions as a result of self-harm (10-24 years)	183	422.0	398.8	1,388.4	105.2

Notes and definitions - Where data is not available or figures have been suppressed, this is indicated by a dash in the appropriate box.

1 Mortality rate per 1,000 live births (age under 1 year), 2012-2014
2 Directly standardised rate per 100,000 children age 1-17 years, 2012-2014
3 % children immunised against measles, mumps and rubella (first dose by age 2 years), 2014/15
4 % children completing a course of immunisation against diphtheria, tetanus, polio, pertussis and Hib by age 2 years, 2014/15
5 % children in care with up-to-date immunisations, 2015
6 % children achieving a good level of development within Early Years Foundation Stage Profile, 2014/15
7 % pupils achieving 5 or more GCSEs or equivalent including maths and English, 2014/15
8 % children looked after achieving 5 or more GCSEs or equivalent including maths and English, 2014 (provisional)
9 % not in education, employment or training as a proportion of total age 16-18 year olds known to local authority, 2014
10 Rate per 100,000 of 10-17 year olds receiving their first reprimand, warning or conviction, 2014
11 % of children aged under 16 living in families in receipt of out of work benefits or tax credits where their reported income is less than 60% median income, 2013
12 Statutory homeless households with dependent children or pregnant women per 1,000 households, 2014/15
13 Rate of children looked after at 31 March per 10,000 population aged under 18, 2015
14 Crude rate of children age 0-15 years who were killed or seriously injured in road traffic accidents per 100,000 population, 2012-2014
15 Percentage of live-born babies, born at term, weighing less than 2,500 grams, 2014
16 % school children in Reception year classified as obese, 2014/15
17 % school children in Year 6 classified as obese, 2014/15
18 % children aged 5 years with one or more decayed, missing or filled teeth, 2011/12
19 Crude rate per 100,000 (age 1-4 years) for hospital admissions for dental caries, 2012/13-2014/15
20 Under 18 conception rate per 1,000 females age 15-17 years, 2013
21 % of delivery episodes where the mother is aged less than 18 years, 2014/15
22 Crude rate per 100,000 under 18 year olds for alcohol specific hospital admissions, 2011/12-2013/14
23 Directly standardised rate per 100,000 (age 15-24 years) for hospital admissions for substance misuse, 2012/13-2014/15
24 % of mothers smoking at time of delivery, 2014/15
25 % of mothers initiating breastfeeding, 2014/15
26 % of mothers breastfeeding at 6-8 weeks, 2014/15
27 Crude rate per 1,000 (age 0-4 years) of A&E attendances, 2014/15
28 Crude rate per 10,000 (age 0-14 years) for emergency hospital admissions following injury, 2014/15
29 Crude rate per 10,000 (age 15-24 years) for emergency hospital admissions following injury, 2014/15
30 Crude rate per 100,000 (age 0-18 years) for emergency hospital admissions for asthma, 2014/15
31 Crude rate per 100,000 (age 0-17 years) for hospital admissions for mental health, 2014/15
32 Directly standardised rate per 100,000 (age 10-24 years) for emergency hospital admissions for self-harm, 2014/15

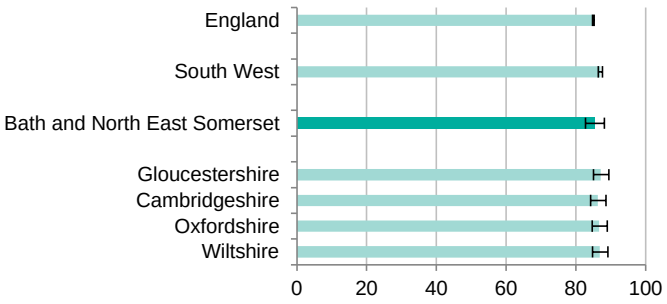
Bath and North East Somerset

The What About YOUth? (WAY) survey is a lifestyle study of 15-year-olds in England, collecting data on risky behaviours, health and wellbeing. The survey was produced by the Health and Social Care Information Centre (HSCIC) with an accompanying profile published on Public Health England's Fingertips platform. All WAY data is taken from the 2014 survey responses, all other sources are stated.

General health

In this area, 85.3% of children reported their general health as excellent or good, which is similar to the England average of 85.0%. The proportion of children who have a long term illness, disability or condition is similar to the England average. 18.1% engage in three or more of the risky behaviours they were asked about, which is similar to the England average of 15.9%.

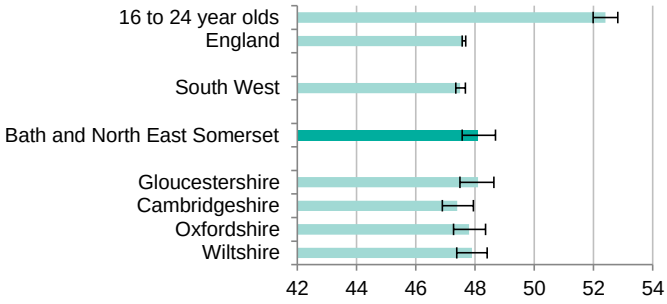
Children reporting their general health as good or excellent



Wellbeing

The Warwick-Edinburgh Mental Wellbeing scale (WEMWBS) measures wellbeing using responses to 14 positive statements to give a score between 14 and 70, where positive answers result in a higher score. In Bath and North East Somerset the mean score is 48.1 which is similar to the England mean score of 47.6. The average WEMWBS score for 16 to 24 year olds in 2012 was higher, at 52.4 (Health Survey for England).

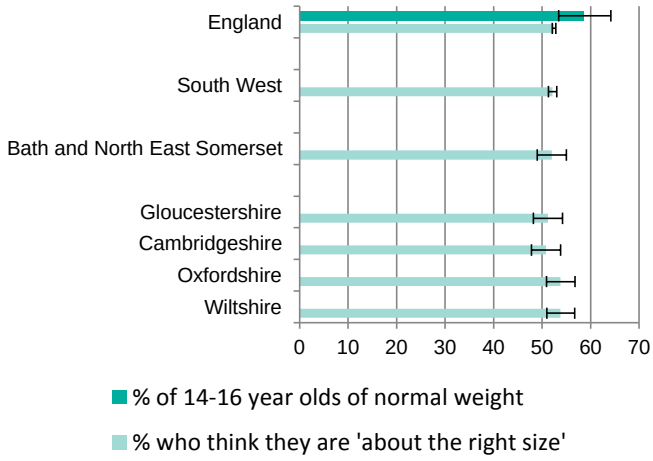
Mean score of the 14 WEMWBS statements



Data source: Health Survey for England 2012

Body image and BMI

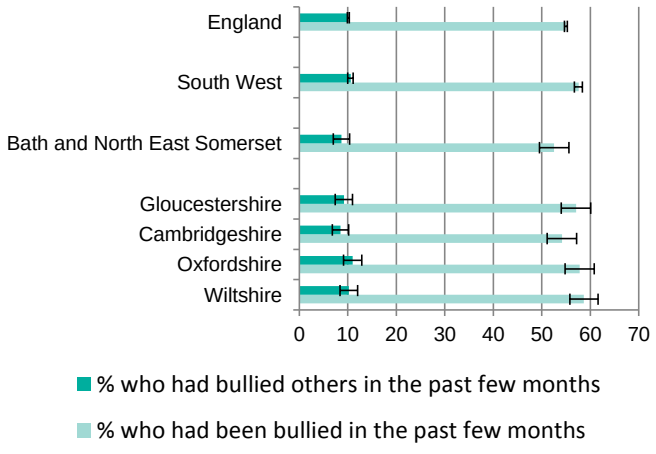
In Bath and North East Somerset, 52.0% of children reported that they felt their body was 'about the right size', which is similar to the England value of 52.4%. In the Health Survey for England 2013 data 58.7% of 14-16 year olds in England were recorded as having a healthy weight.



Data source: Health Survey for England 2013

Bullying

Bullying in schools can negatively impact health, educational attainment and can pose a suicide risk. In Bath and North East Somerset 52.5% of children reported they had been bullied in the past couple of months, and 8.7% had bullied others. This survey's definition of bullying included physical and verbal bullying, as well as text messages and online activity.

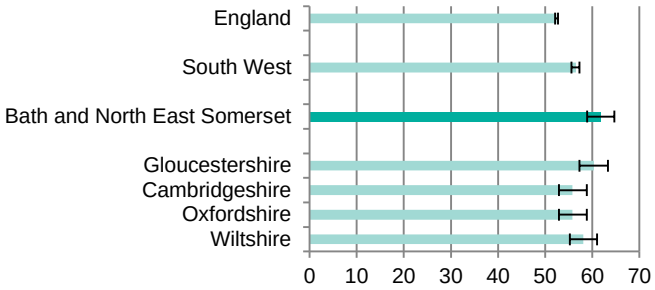


These charts compare this area with its statistical neighbours and the England and regional average.

Diet

Poor diet is a major risk factor for ill-health and premature death. In Bath and North East Somerset, 61.8% of children reported that they ate the recommended amount of fruit and vegetables each day; at least five portions. This compares to 56.5% in South West and 52.4% in England.

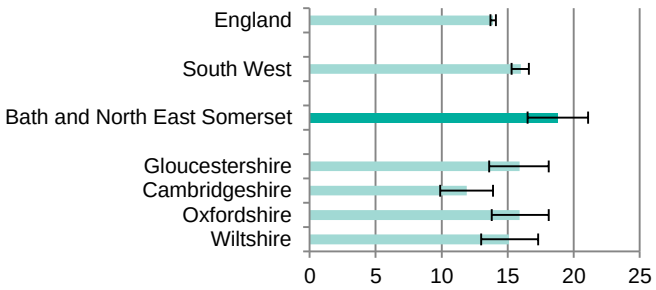
Percentage of children reporting that they eat five portions of fruit and vegetables per day



Physical activity

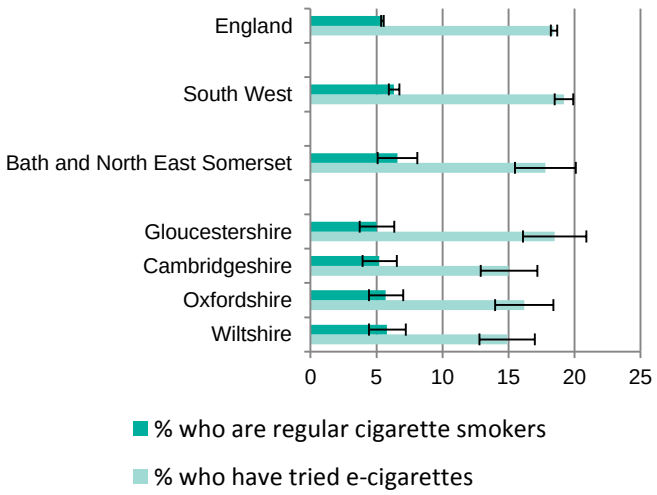
The World Health Organization's guideline of an hour of moderate-to-vigorous physical activity per day is met by 18.8% of young people, higher than the England average of 13.9%. Good physical activity habits in childhood and adolescence are likely to be carried into adulthood, while lower levels of activity are associated with obesity.

Percentage of children reporting that they meet the physical activity guideline



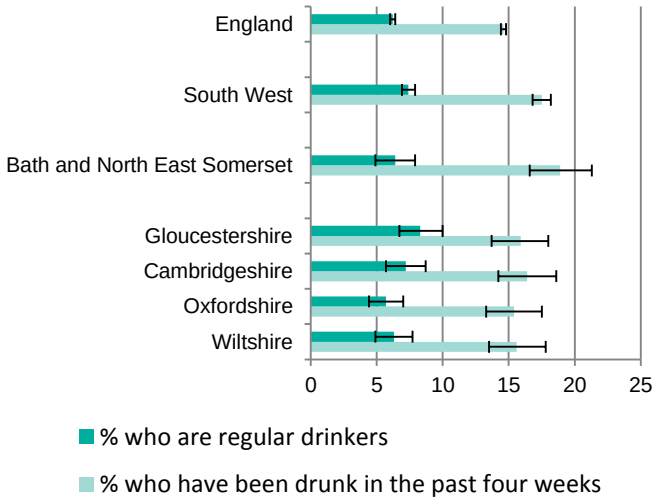
E-cigarettes and smoking

In Bath and North East Somerset 6.6% of 15-year-olds are regular smokers, which is similar to the England average of 5.5%. E-cigarettes have been tried at least once by 17.8% of 15-year-olds which is similar to to the England value of 18.4%. Please note these indicators are shown together for illustrative purposes and definitions are different.



Drinking

Research has shown that young people who start drinking at an early age are more likely to drink more frequently and in higher quantities than those who start later in life. In Bath and North East Somerset 6.4% of 15-year-olds are regular drinkers, similar to the England average of 6.2%. In the last four weeks 18.9% have been drunk, higher than 14.6% for England.



Further indicators, metadata and visualisations of this data are available including a spine chart for each area at PHE's Fingertips site, while the full report is published on the HSCIC website.

http://fingertips.phe.org.uk/profile/what-about-youth http://www.hscic.gov.uk/catalogue/PUB19244

PHE publications gateway number 2015724

Bath & North East Somerset Council

NHS
Bath and
North East Somerset

Working together for health & wellbeing

Children & Young People Health & Wellbeing Survey 2015 (SHEU)

SHEU Health & Well-being Survey

- Schools Health Education Unit
- Public Health funded
- Information /evidence about pupil health and well-being outcomes
- Compares schools with local B&NES and national data
- Free School Meal comparative data
- Trend data

SHEU in B&NES (2015)

- 29 Primary Schools
- 1653 pupils from years 4 (77% participation rate) and 6 (87%)

- 12 Secondary Schools
- 3048 pupils from years 8 (88% participation rate)and 10 (81%)

Asked questions about

- Healthy Eating
- Physical Activity
- Relationships
- Mental Health
- Smoking, Alcohol, Drugs
- Staying safe
- Enjoying and achieving
- Views and opinions

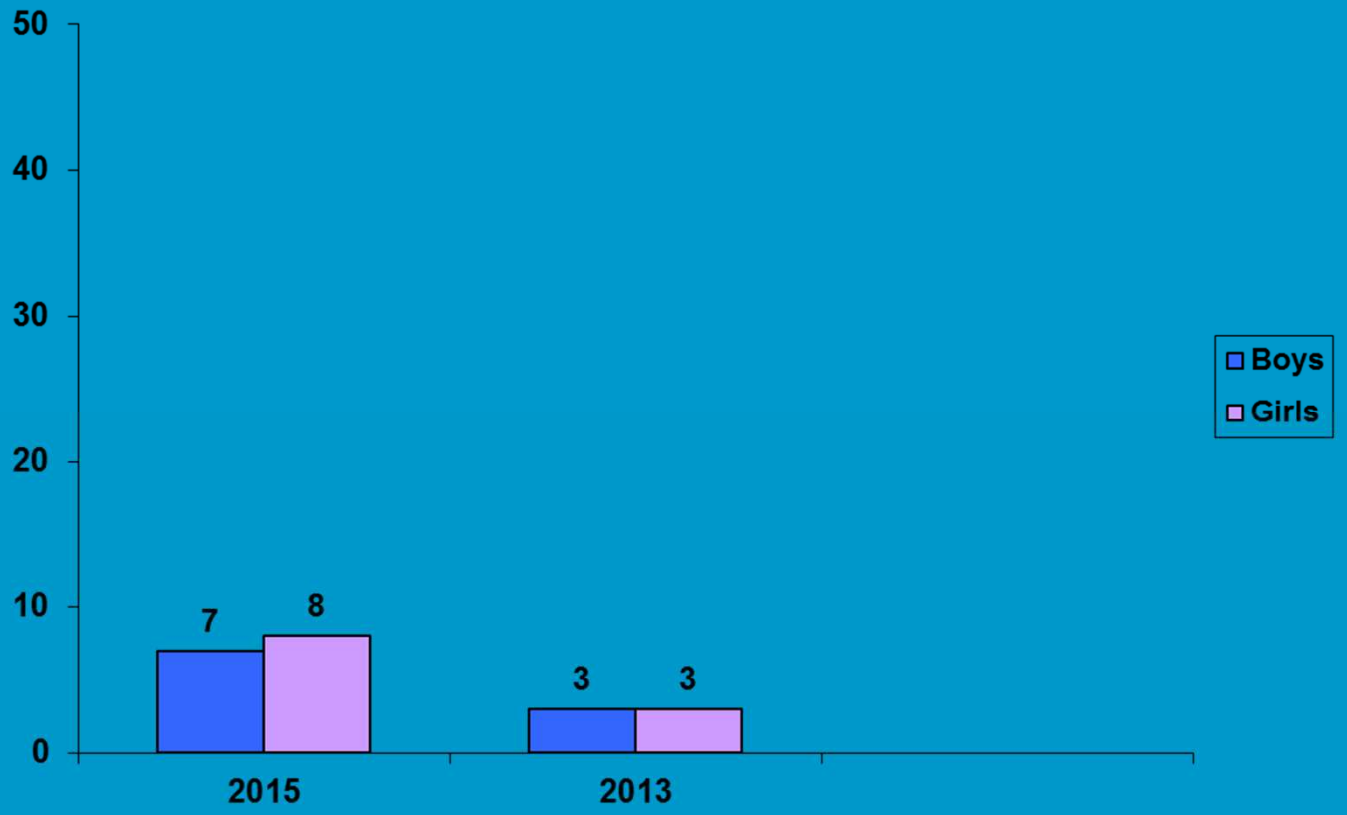
B&NES Primary sample sizes

School Year	2015	2013	2011
Boys	875	633	687
Girls	767	589	672
Total	1653	1222	1359

Food and drink Primary

- **8** % didn't eat or drink anything before lessons

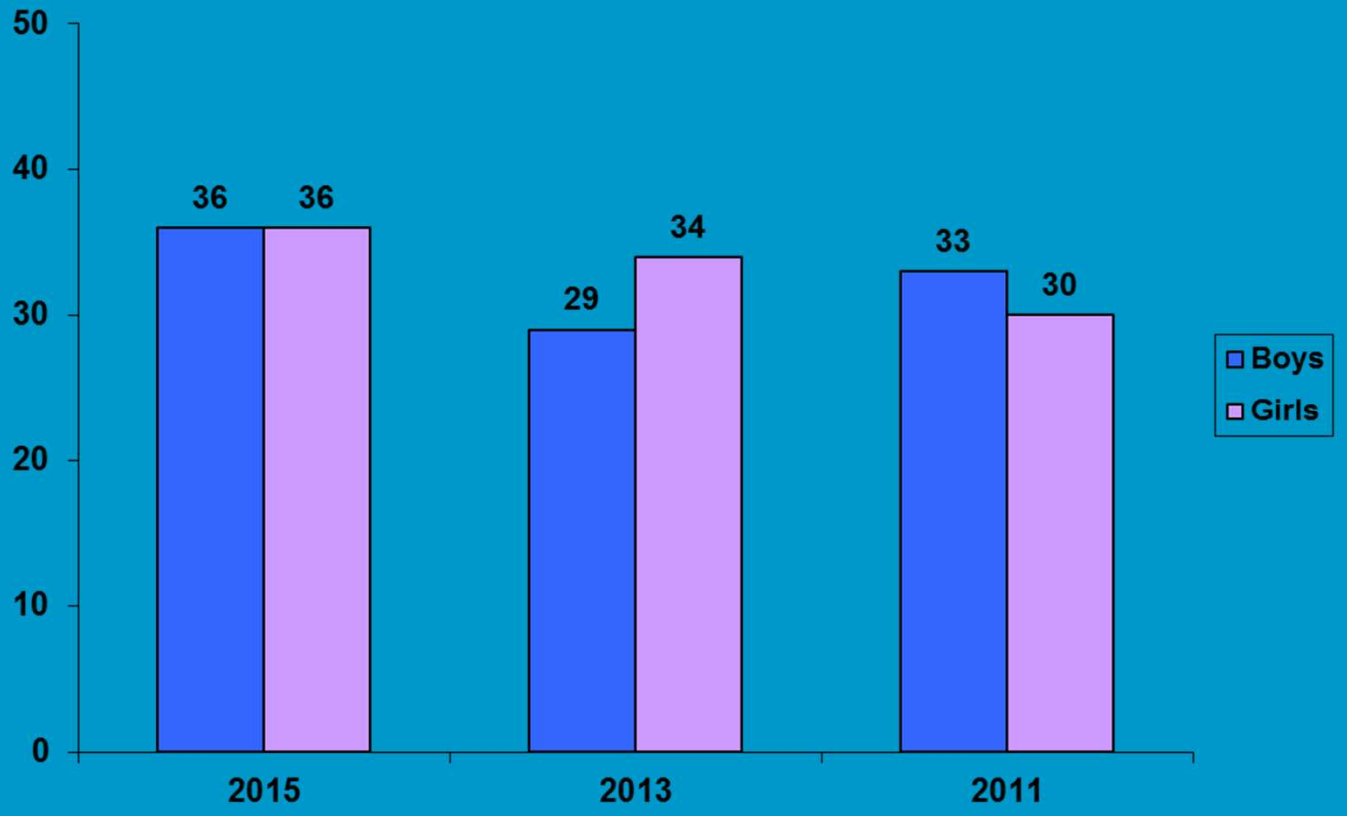
Nothing for Breakfast (%)



Food and Drink Primary

- **36 %** ate at least 5 portions of fruit and veg the day before

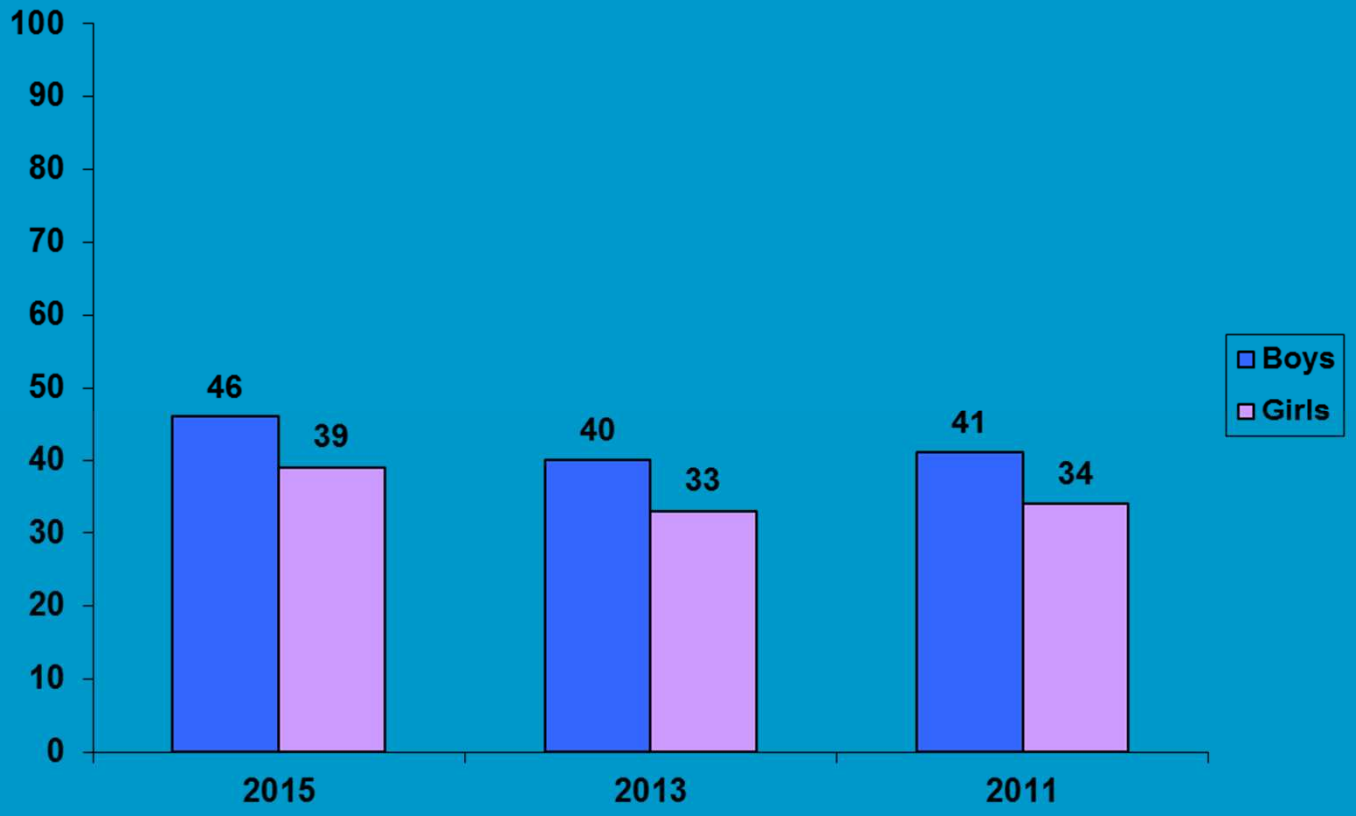
At least five-a-day (%)



Self-esteem Primary

- **43** % had a high self esteem score

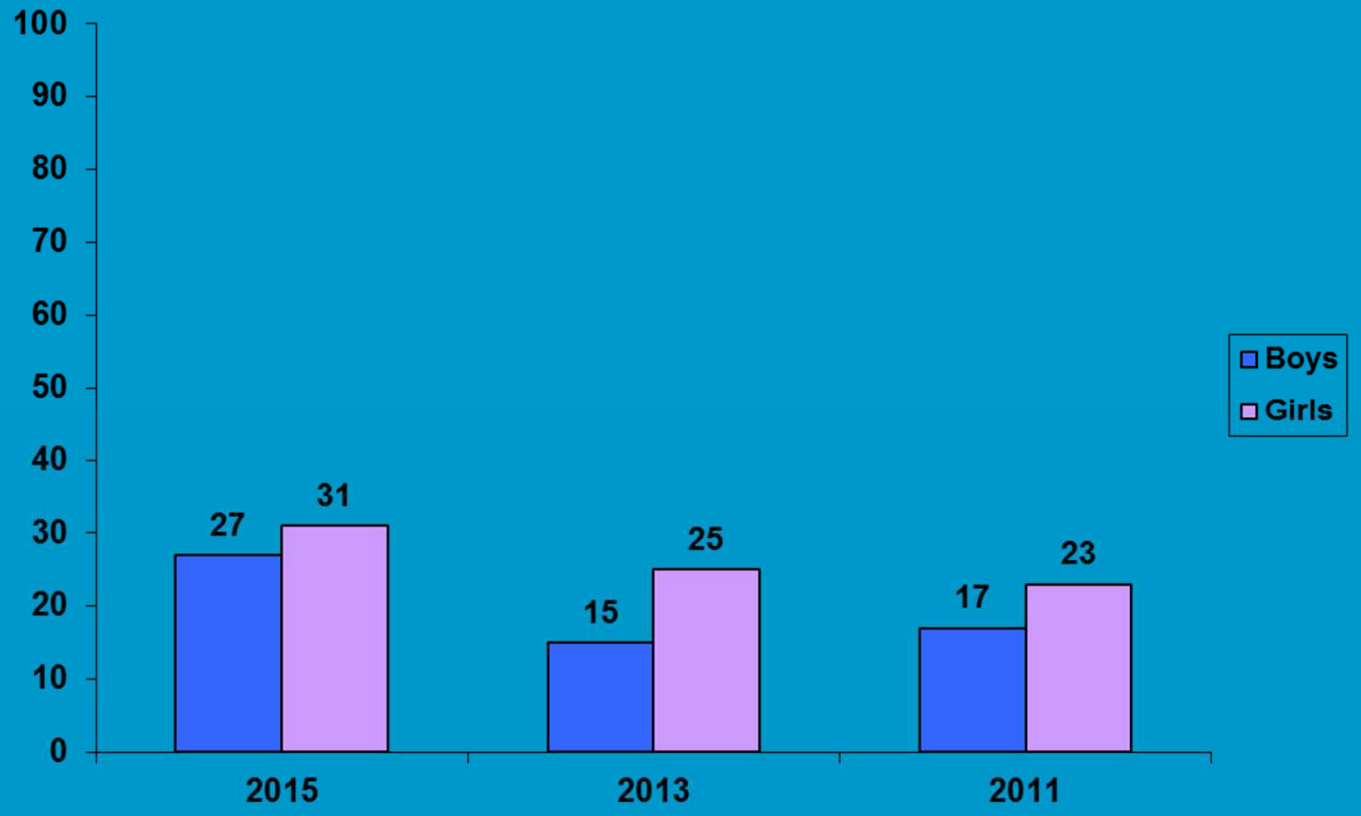
High self-esteem (%)



Internet Safety Primary

- **29 %** of year 6 pupils saying they have seen upsetting images on-line

Seen upsetting images online (%)



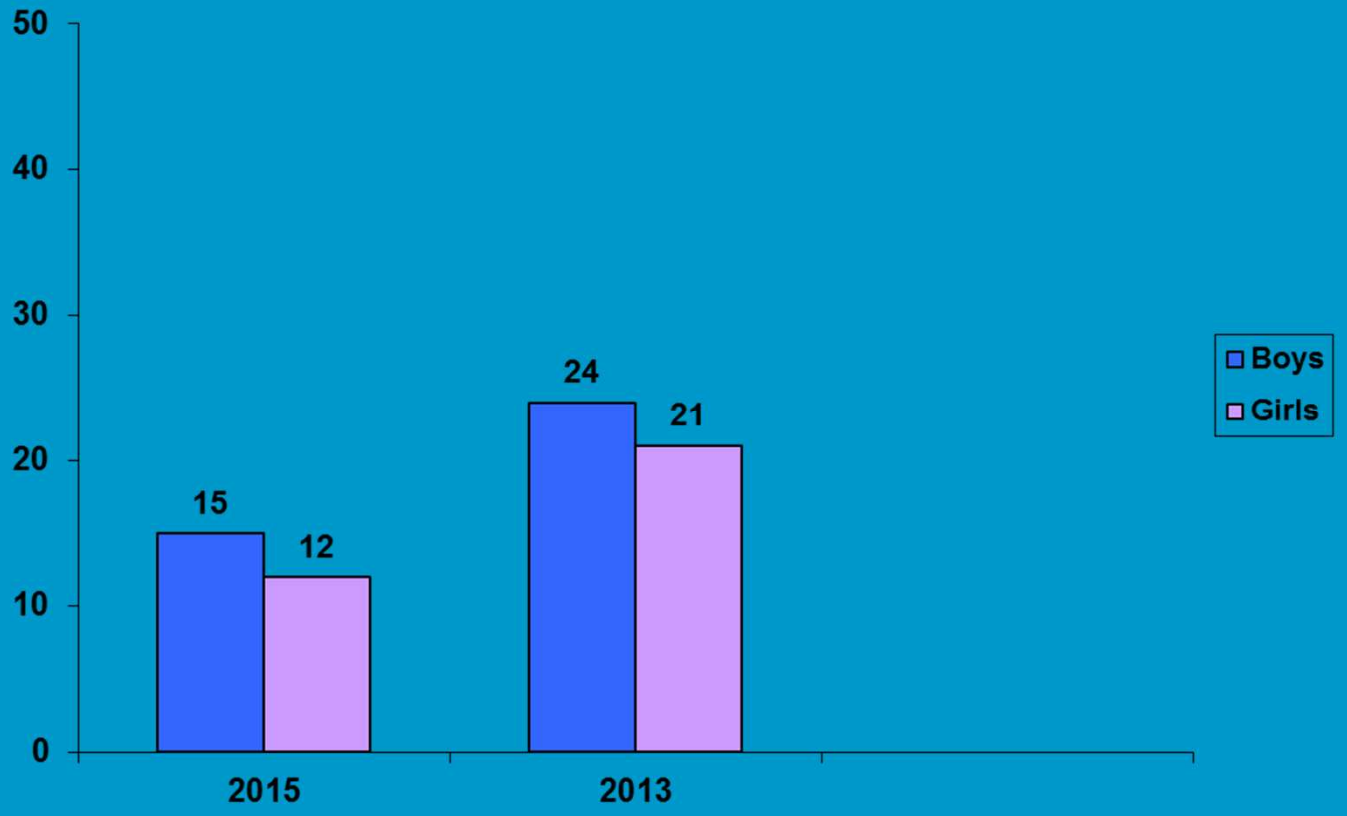
B&NES Secondary sample sizes

School Year	2015	2013	2011
Boys	1472	1351	1264
Girls	1576	1266	905
Total	3130	2617	2169

Drinking Secondary

- **13** % who drank alcohol in the last week

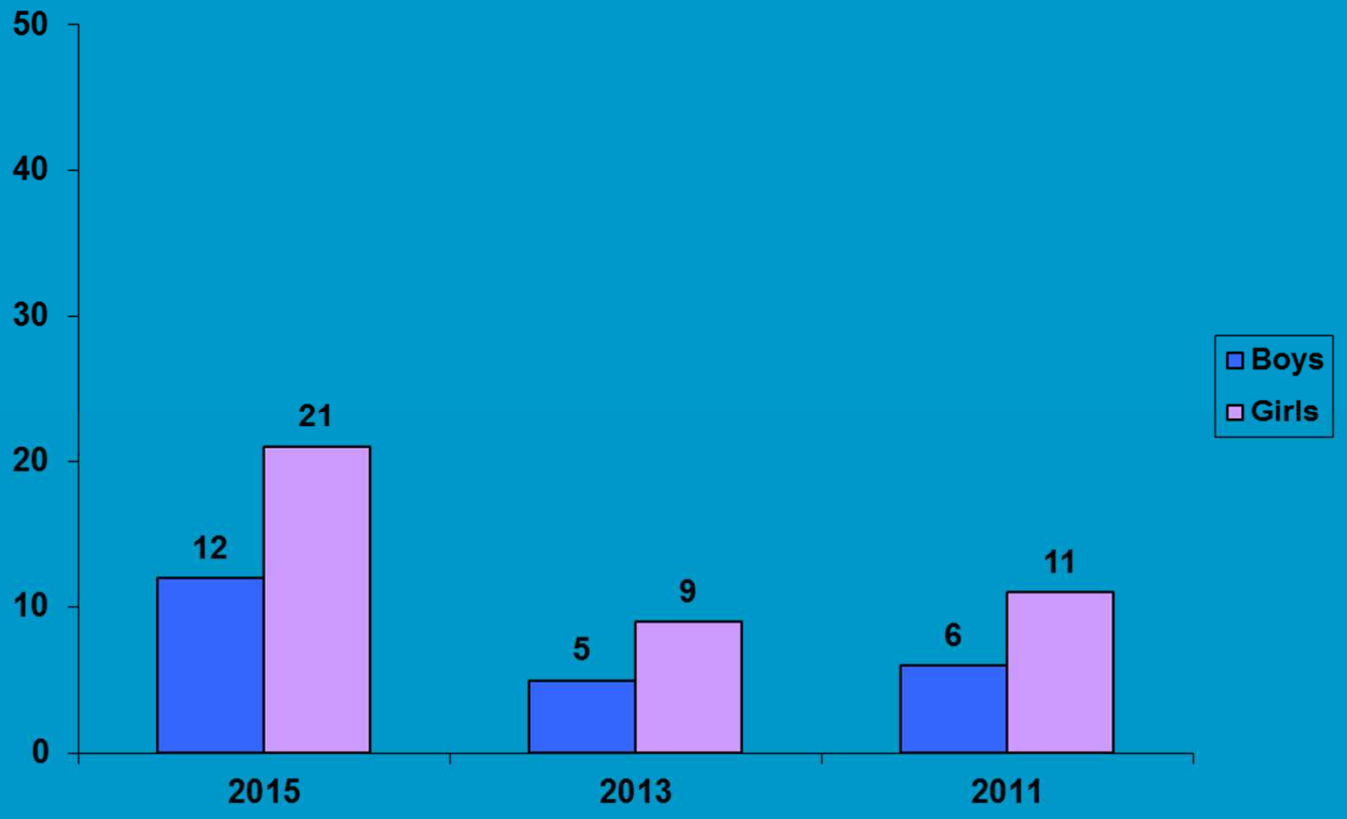
Drank alcohol last week (%)



Breakfast Secondary

- **17 %** didn't eat or drink anything before lessons

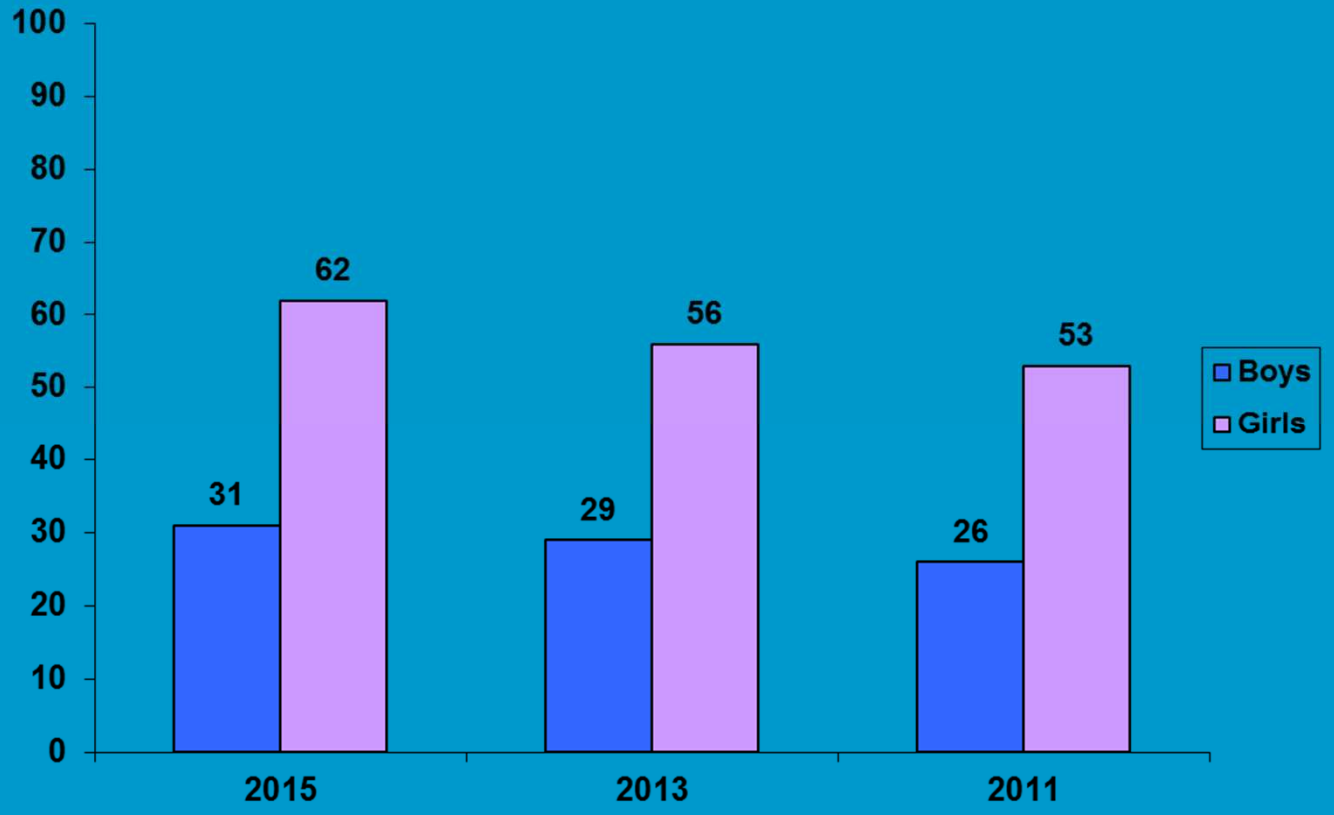
Nothing for Breakfast (%)



Losing Weight Secondary

- **47** **%** saying they would like to lose weight

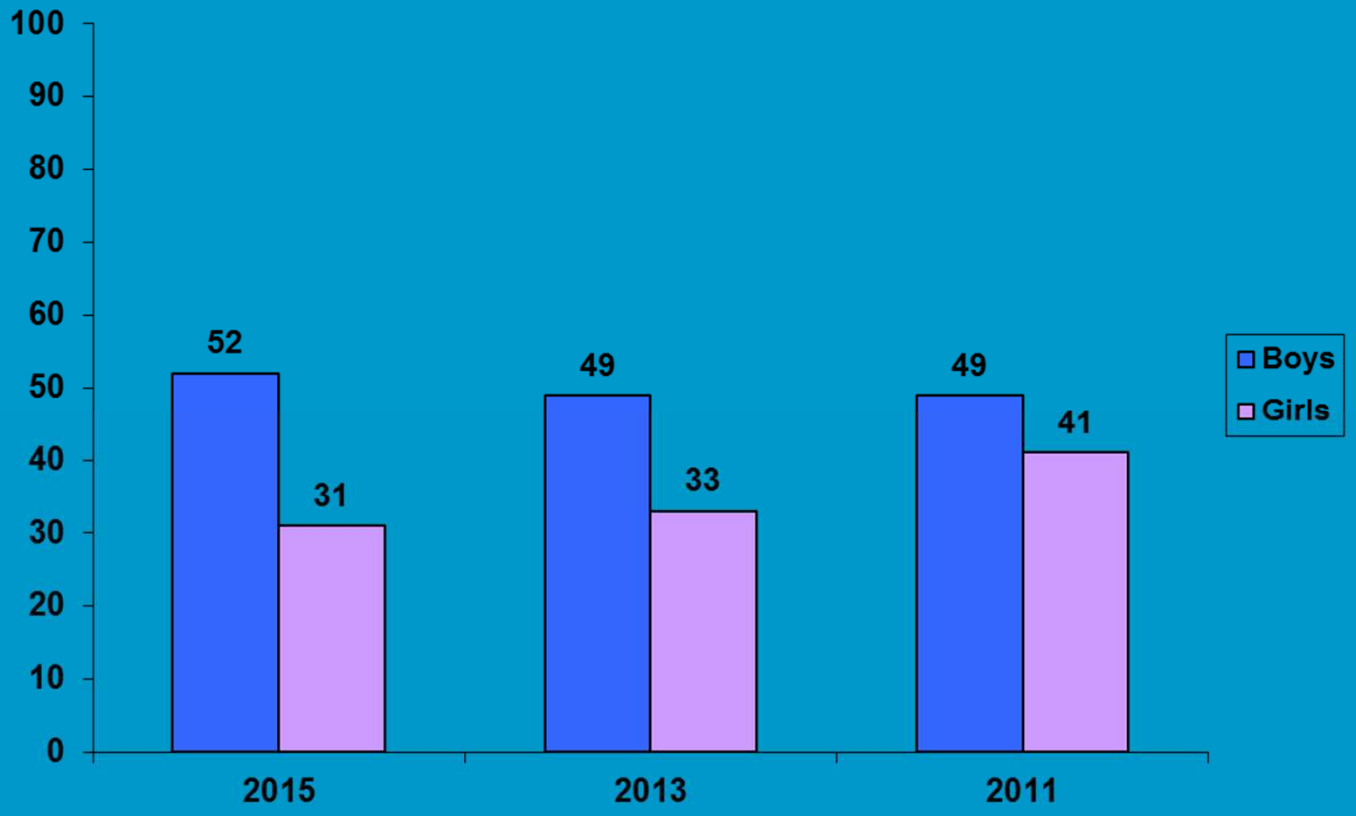
Want to lose weight (%)



Self-esteem Secondary

- **40** % had a high self esteem score

High self-esteem (%)



What Year 8s and 10s worry about (GIRLS)

- Exams and tests (70%)
- The Way they look (57%)
- Family (49%)

What they do :-

- Talk to friends (64%)
- Talk to adults (58%)
- Relax (e.g music (48%)
- Eat (20%)
- Self harm (10%)

What Year 8s and 10s worry about (BOYS)

- Exams and tests (52%)
- Career (45%)
- Family (43%)

What they do :-

- Talk to adults (66%)
- Talk to friends (48%)
- Relax (e.g music (43%)
- Eat (12%)
- Self harm (3%)

Other Positives : Primary

- Walking to school
- Cycle Safety
- School taking bullying seriously
- Alcohol
- Smoking

Areas for development Primary (2015)

- Body image
- Sun safety
- Peer pressure
- Information about body changes as they grow up *
- E-safety

* dependent on when survey conducted

Ever 6 FSM : Primary (2015)

- More living in single parent households
- Fewer happy with their weight
- Lower self esteem
- Less attention to sun safety
- Fewer taking part in physical activity
- Less cycle safety

Positive trends: Secondary

- More eating fruit and vegetables
- More pupils reporting they are LGB or questioning
- Fewer drinking alcohol & smoking
- More doing physical activity after school
- Better dental care
- Higher aspiration (to go to University)
- Views and opinions making a difference

Secondary : Areas for development

- Having lunch
- Sun safety
- Viewing upsetting images on-line
- Enjoyment of lessons
- Body Image
- Thinking school doesn’t take bullying seriously (22%)
- Self harm (girls)

Ever 6 FSM : Secondary (2015)

- More likely to live with single parent
- More likely to be a young carer
- Fewer expect to do well in GCSEs
- More likely to smoke (including E cigs)
- Fewer eat fruit and veg
- More likely to have bullied and been bullied

FSM : Secondary

- Lower self esteem
- Fewer enjoy school lessons
- Fewer want to continue in full time education
- More have looked on-line for violent images , films or games

What we're doing

- Meetings with key staff in schools to identify strengths and areas for development
- Schools to share key points with and involve pupils, governors, parents
- DPHA / PSHE work
- Narrowing the Gap work around FSM continues
- E safety – whole school approach

What we're doing with wider partners

- Sharing this data widely with key strategic groups (e.g. EHWB Strategy Group etc.)
- Using the data to inform priorities / strategies / resources (e.g. mental health)

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Bath & North East Somerset Council		
MEETING/ DECISION MAKER:	**Children & Young People Policy Development & Scrutiny Panel**	
MEETING/ DECISION DATE:	**12th July 2016**	EXECUTIVE FORWARD PLAN REFERENCE: N/A
TITLE:	**Care Act - Implications for Children and Carer's**	
WARD:	All	
AN OPEN PUBLIC ITEM		
List of attachments to this report: Appendix 1 included at the end of the report Appendix 2 attached – Lifetime Healthcare Pathway Appendix 3 attached - Social Care Pathway Appendix 4 attached - Young Carers Pathway		

THE ISSUE

This report sets out to inform the Panel about the Care Act 2014 and the interface and implications for children and young people.

RECOMMENDATION

The Panel are asked to note to content of the report.

RESOURCE IMPLICATIONS (FINANCE, PROPERTY, PEOPLE)

None identified.

STATUTORY CONSIDERATIONS AND BASIS FOR PROPOSAL

The Care Act 2014 has placed new duties on Local Authorities – this report sets out the duties that relate to children and young people.

THE REPORT

1. Background

The Care Act 2014 (the Act) received Royal Assent on 14th May 2014. It came into force in April 2015 and abolishes most adult community care statutes (38 in total) including the National Assistance Act 1948, the NHS and Community Care Act 1990, the Carers (Recognition and Services) Act 1995 and the Community Care (Direct

Payments) Act 1996. It does not replace the Mental Health Act 1983 (amended in 2007 and 2009) or the Mental Capacity Act 2005. The Act deals with adult social care for anyone over the age of 18 years and puts a duty on Adult Care Services to ensure that services are available at 18 years. It therefore requires clear planning between Adults and Children Services prior to that age.

The Act is in three parts:
1. Care and Support
2. Care Standards
3. Health

Part 1 of the Act consolidates and modernises the framework of care and support law, including making the provision for new duties for Local Authorities and new rights for service users and carers.

The Act sets out to:
- Promote peoples wellbeing
- Enable people to prevent and delay the need for care and support, and for carers to maintain their caring role
- Give people more choice and control of their lives

It embeds the interface with children and families legislation, particularly in relation to transitions and caring roles and special educational needs and disability (SEND) reform.

New entitlements have been established by way of the duty to undertake a transition assessment for young people and their carers in advance of transition from Children to Adult Services and changes introduced by the Children and Families Act 2014 with regard to SEN, which introduced the system of support extending from birth to 25 years of age – thereby meaning that there will be a group of young people aged between 18 and 25 years who will be entitled to support through both the Children and Families Act 2014 and the Act.

The Act also replaces the Chronically Sick and Disabled Persons Act 1970 with the exception of Section 2 (Appendix 1) which remains in force for children (up to 18 years).

2. Interface and New Requirements

2.1 Preparing Children for Adulthood – new duties around transition

Sections 58-66 of the Act relates to the new duties around **transition:**

- Section 58-59 relates specifically to the **assessment of a child's need for care and support.** Where a child is likely to have need for care and support after the age of 18 the Local Authority MUST, if it believes there would be of 'significant benefit' to the child, assess their needs and consider what they are likely to be when 18. This is known as a 'child's needs assessment' (Sec 58 (2)). Gaining consent (the consent condition) is a significant issue here as is the determination of capacity in accordance with the Mental Capacity Act 2005. If the child does not consent the Local Authority MUST carry out the assessment if the child is 'experiencing, or is at risk of, abuse or neglect'

(Sec 58 (4)). If consent is not received and the child has capacity this must be respected and information and advice provided.
However…*'For young people below the age of 16, local authorities will need to establish a young person's competence using the test of 'Gillick competence' (whether they are able to understand a proposed treatment or procedure). Where the young person is not competent, a person with parental responsibility will need to be involved in their transition assessment, – or an independent advocate provided if there is no one appropriate to act on their behalf (either with or without parental responsibility).* ' Care and Support Statutory Guidance for the Care Act 2014, DH, 16.38.

The assessment itself must include: details of the care and support needs likely after the child becomes 18, details of the outcomes they wish to achieve for day-to-day life and how the provision of care and support could help achieve these outcomes (Sec 59 (1) (a) (b) (c). It must involve the child, parents and carers and any person the child or parents and carers request. The assessment should consider whether any other mechanism can be used to achieve the outcomes other than 'provisions'. The assessment must indicate whether the care and support needs are likely to meet the 'eligibility criteria' (Sec 59 (4) (a) set out in the National Eligibility Framework.

The Act does not set out what age the child's needs assessment needs to be undertaken.

The Act makes the provision for independent advocacy for children being assessed for support from Adult Services as is the case for all people supported through the Act. (Care and Support Statutory Guidance issued under the Care Act 2014, DH, 7.2).

A care and support plan must be developed.

- Section 60 – 61 relates to the **assessment of a child's carer's needs for support.** The Local Authority MUST assess the carer of a child (who is likely to have care and support needs when they become 18) if it believes that it would be of 'significant benefit' to the carer. This is known as the 'child's carer's assessment' (Sec 60 (2)). If the carer refuses the assessment the Local Authority is not required to carry one out, however it must provide information and advice in writing about how to prevent the carer's need for support developing in the future.

  Similar to the child's needs assessment, the child's carer's assessment must consider: whether the carer is able to continue to support the child upon becoming 18, whether they are willing to continue to do so, the impact it will have on them and what their care and support needs might be when the child is 18, the outcomes they want to achieve in their day-to-day life and whether provision of support can help this. The assessment must consider if the carer works or wishes to do so or whether they wish to undertake education, training or recreation. The carer and any person the carer would like to involve should be involved in the assessment. Like the child's needs assessment the child's carer's assessment must indicate whether the carer's care and support needs are likely to meet the 'eligibility criteria' set out in the National Eligibility Framework.

- Section 62 sets out the **Power to meet child's carer's needs for support.** The Local Authority can meet the identified carer's care and support needs as it 'considers appropriate.'

  Regard must be given to the Care and Support (Children's Carers) Regulations 2014 and Section 17 of the Children Act 1989 when deciding the provision for carers.

- Section 63-64 relates to **assessments of young carer's care and support needs.** Again for this to take place the 'consent condition' must be met and the Local Authority must be satisfied that support (after becoming 18) would be of 'significant benefit.' Where this is the case the young carer's care and support will be assessed as a 'young carer's assessment (Sec 63 (2)). If the young carer can't consent but the Local Authority is satisfied this assessment would be of benefit, it will be undertaken in their 'best interests'. Again where the young carer refuses consent and has capacity to do so, the Local Authority MUST only carry out the 'young carer's assessment' if the young carer 'is experiencing, or is at risk of, abuse and neglect.' (Sec 63 (4)), otherwise the Local Authority MUST provide in writing information and advice about how to prevent the care and support needs building.
  Section 64 details what the assessment requirements are and these are the same as for the child's carer as set out above.

  The Care and Support Statutory Guidance issued under the Care Act 2014, DH, (2.49) states that *'the Local Authority must undertake a young carer's assessment under part 3 of the Children Act 1989.'* The guidance makes it clear that young carer's MUST be identified and makes reference to a 'whole family approach' (6.68). It also makes reference to 'unsuitable' tasks that need consideration *'in light of the child's circumstances and may include:*
    - *Personal care such as bathing and toileting;*
    - *Carrying out strenuous physical tasks such as lifting;*
    - *Administering medication;*
    - *Maintaining the family budget;*
    - *Emotional support to the adult.* (6.72)

- Section 65 sets out how the assessments above (Section 58 – 64) can be carried out and makes reference to the potential for combination assessments, however again regard must be given to the 'consent condition'. The Care and Support Statutory Guidance issued under the Care Act 2014, DH, (6.3) states *'A combined assessment, where an adult's assessment is combined with a carer's assessment and / or an assessment relating to a child so that interrelated needs are properly captured…'*

- Section 66 refers to **continuity of services under other legislation** and sets out the interface with Section 17 of the Children Act 1989 (Section 17 relates to a child in need). The Local Authority must *'continue to comply with Section 17 after the child reaches the age of 18 until they reach a conclusion in his case.'* (Sec 66 (2)).

  A new clause has been inserted into the Children Act 1989 to ensure that Children Services continue to provide services post 18 until Care Act

assessment(s) are completed. The Act does not state when the assessments needs to be completed by but refer to them being negotiated with Children Services.

In relation to Education, Health and Care (EHC) plans – where this plan is no longer maintained and the Local Authority hasn't reached its conclusion for Section 17 as set out above it must continue to comply with the Children Act 1989 until this conclusion is reached. The Act sets out to put in place mechanisms to prepare children and carers appropriately and in a timely way without their being a gap in assessment or provision – described in the Government Fact Sheet 11 as 'no "cliff-edge" '.

In relation to the Chronically Sick and Disabled Persons Act 1970 a new section the same as above has also been inserted in 2A.

2.2. The aim of the Act is to promote independence and reduce long term needs for care and support.

The Care and Support Statutory Guidance issued under the Care Act 2014, DH, also recommends one 'designated' person coordinates the transition and this person is referred to in the guidance as a Personal Advisor (16.49).

The Act does not set a blanket rule of what age everyone has to be assessed it is flexible in recognition that the best time to plan the move to Adult Services will be different for each person. (Government Care Act Fact Sheet). However regard must be given to start the preparation in year 9 if there is a EHC plan in place (see 2.3 below).

The Act also makes it explicit that Local Authorities have a legal responsibility to cooperate and consider other assessments being carried out – provided all parties agree. The Local Authority can carry out joint assessments with other organisations or on behalf of other organisations. The Care and Support Statutory Guidance issued under the Care Act 2014 states that:

'…a holistic approach to assessment which aims to bring together all of the person's needs may need the input of different professionals, such as adult care and support, children's services housing, experts in the voluntary sector, relevant professionals in the criminal justice system, health or mental health professionals.' (6.75).

The Act (as for all people over the age of 18) introduces means-testing and charging for services which the child and carers will need to be aware of. (Care and Support Statutory Guidance issued under the Care Act 2014, DH, 16.51).

2.3 The **interface with the Children and Families Act 2014.**
The Care and Support Statutory Guidance issued under the Care Act 2014, DH, (1.23) makes specific reference to the fact that the Act is designed to work in

partnership with the Children and Families Act 2014. The Children and Families Act 2014 created the new birth- to-25 EHC plans for children and young people with special educational needs and disabilities (SEND) and offers families personal budgets so they can have choice and control over the type of support they get – in some cases the 'care' part of the EHC plan will be provided for by the Act.

The EHC plan must set out the care and support which is reasonably required by the young person's SEND. For people over 18 with a care and support plan this needs to be incorporated into the EHC plan rather than be developed separately. Whilst the Act itself does not set a specific age for which planning transitions should start both the Care and Support Statutory Guidance issued under the Care Act 2014, DH (16.34) and the Children and Families Act 2014 says preparation for adulthood must start no later than from school year 9 (approximately 14 years of age). However the Guidance also states:
'For some people with complex SEN and care needs, local authorities and their partners may decide that children's services are the best way to meet a person's needs – even after they have turned 18. Both the Care Act 2014 and the Children and Families Act 2014 allow for this.' (16.70)

Both Acts place an emphasis on outcomes focused, person-centred practice when considering assessments, planning and support as well as co-production.

Regard must be given in both Acts to the wellbeing duty rather than waiting for crisis. *'Children should not undertake inappropriate or excessive caring roles that may impact on their development. A young carer becomes vulnerable when their caring role risks impacting upon their emotional or physical wellbeing and their prospects in education and life.'* (Care and Support Statutory Guidance issued under the Care Act 2014, DH, 2.49). In order for planning to be effective with the interface joint commissioning arrangements across children and adult services are required. Significant focus has been given to this in B&NES.

Both Acts set out the duty to assess a parent carer or young carer.

Both Acts place a duty of the provision of accessible, good quality information, advice and support.

2.4 A multi-agency Transitions Planning Group is in place which meets bi monthly. The main objective of the group is to ensure that all the key partners involved in supporting young people and young carers in transition are working together effectively. The groups aim is to facilitate the seamless transition from children services to adult services.

2.5 There is also a Transitions Operational Panel which meets three times a year and receives referrals / identifies young people who are likely to be in need of care and support into adulthood. The Operational Panel ensure the pathways are followed once the young person is identified. Examples of the pathways are included as Appendix 2 Lifetime Healthcare Pathway, Appendix 3 Social Care Pathway and Appendix 4 Young Carers Pathway. These pathways ensure that the Council meets its statutory duty for young people and young carers in need of transitional care and support as set out in the Act and in accordance with the Children and Families Act 2014.

RATIONALE

N/A

CONSULTATION

N/A

RISK MANAGEMENT

A risk assessment related to the issue and recommendations has been undertaken, in compliance with the Council's decision making risk management guidance.

Contact person	*Lesley Hutchinson – Head of Safeguarding Quality Assurance* *Lesley_Hutchinson@bathnes.gov.uk 01225 396339* *Mike MacCallam – Senior Commissioning Manager* *Mike_MacCallam@bathnes.gov.uk 01225 396054*
Background papers	*None*
Please contact the report author if you need to access this report in an alternative format	

Appendix 1

Chronically Sick and Disabled Persons Act 1970 Section 2

2. Provision of welfare services.
(1)Where a local authority having functions under section 29 of the National Assistance Act 1948 are satisfied in the case of any person to whom that section applies who is ordinarily resident in their area that it is necessary in order to meet the needs of that person for that authority to make arrangements for all or any of the following matters, namely—

(a)the provision of practical assistance for that person in his home;

(b)the provision for that person of, or assistance to that person in obtaining, wireless, television, library or similar recreational facilities;

(c)the provision for that person of lectures, games, outings or other recreational facilities outside his home or assistance to that person in taking advantage of educational facilities available to him;

(d)the provision for that person of facilities for, or assistance in, travelling to and from his home for the purpose of participating in any services provided under arrangements made by the authority under the said section 29 or, with the approval of the authority, in any

services provided otherwise than as aforesaid which are similar to services which could be provided under such arrangements;

(e)the provision of assistance for that person in arranging for the carrying out of any works of adaptation in his home or the provision of any additional facilities designed to secure his greater safety, comfort or convenience;

(f)facilitating the taking of holidays by that person, whether at holiday homes or otherwise and whether provided under arrangements made by the authority or otherwise;

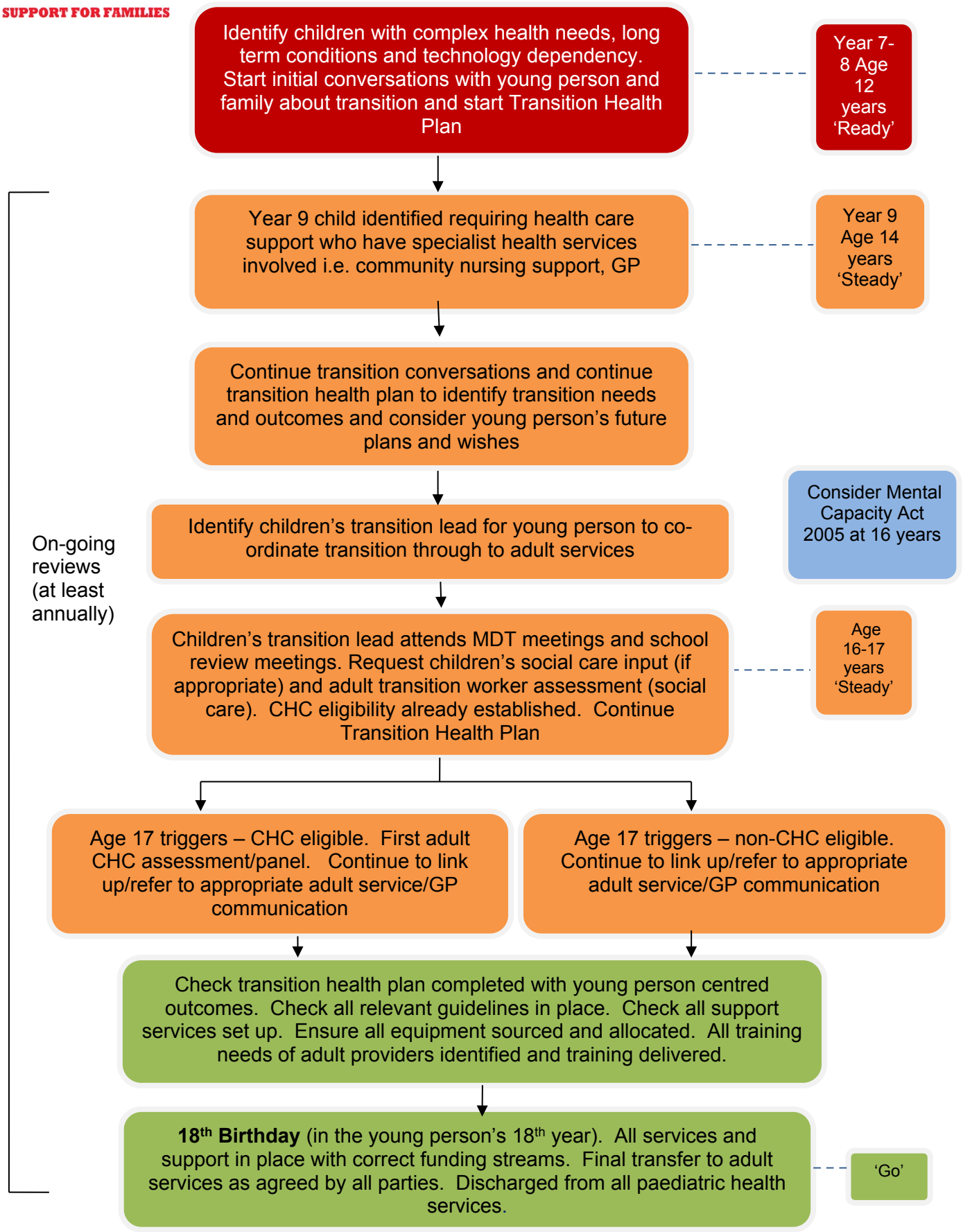
(g)the provision of meals for that person whether in his home or elsewhere;

(h)the provision for that person of, or assistance to that person in obtaining, a telephone and any special equipment necessary to enable him to use a telephone.

SUPPORT FOR FAMILIES

Bath and North East Somerset

Lifetime Healthcare Pathway



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Bath and North East Somerset Social Care Pathway

All agencies review young people who may require support

All agencies to gain consent before presenting to panel

Schools | SEND | Disabled Childrens Team | Youth Connect | Looked After Children | Lifetime | Young Carers

Transitions Operational Panel – meet 3 x per year – using agreed criteria will identify young people who are likely to need social care support into adulthood and determine at what time it would be of significant benefit for them to have a Transitions Assessment under the Care Act

Usually between 14–16 years

If eligible

If not eligible

- Signpost to local offer
- Set out why
- Clarify next steps i.e. if to be re-assessed

Young person's details entered onto Transitions Database

Admin email adult transitions worker for allocation

Children's worker meets adult worker

Introductions to be made by children's support if available

Transitions Assessment - Complete initial contact and leave information

Adult worker and health care make contact with young person and family. Check if CHCs reviewing required

Adult transitions worker attends school reviews, MDT meetings as co-worker and for advice

Usually between1 6-17

If required Adult Transitions worker refers to relevant adult service, health, employment, day services etc

17 for looked after children

Adult transitions worker completes first full community care assessment

17.5 all other young people

Complete support plan, check all relevant referrals actioned; check all support services set up; take to panel if over £650

V3.20 April 2016

18th Birthday – all support in place with correct funding

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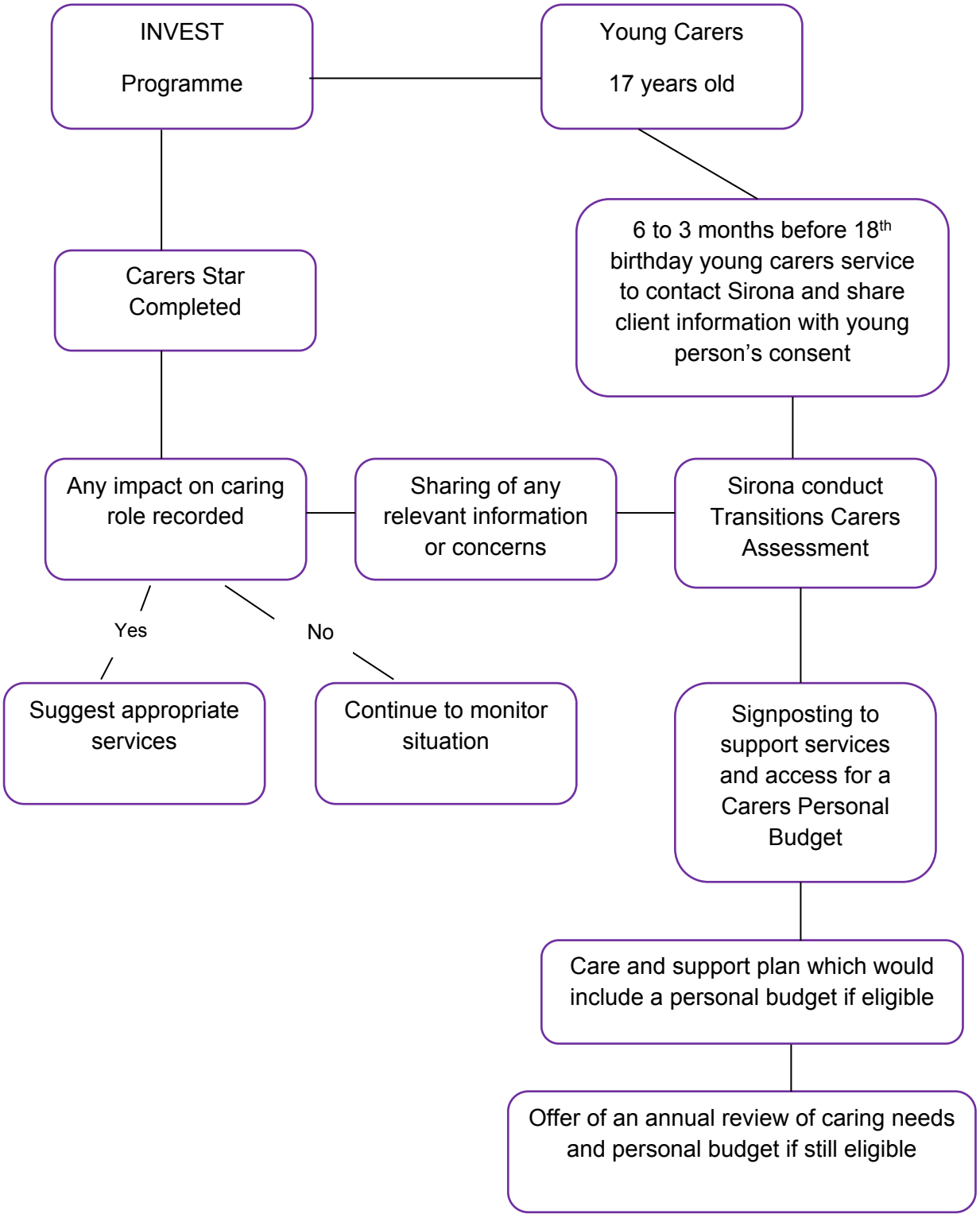
Bath and North East Somerset

Young Carers Pathway



v1 8 March 2016

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Bath & North East Somerset Council

CHILDREN AND YOUNG PEOPLE POLICY DEVELOPMENT AND SCRUTINY PANEL

This Forward Plan lists all the items coming to the Panel over the next few months.

Inevitably, some of the published information may change; Government guidance recognises that the plan is a best assessment, at the time of publication, of anticipated decision making. The online Forward Plan is updated regularly and can be seen on the Council's website at:

http://democracy.bathnes.gov.uk/mgPlansHome.aspx?bcr=1

The Forward Plan demonstrates the Council's commitment to openness and participation in decision making. It assists the Panel in planning their input to policy formulation and development, and in reviewing the work of the Cabinet.

Should you wish to make representations, please contact the report author or Mark Durnford, Democratic Services (01225 394458). A formal agenda will be issued 5 clear working days before the meeting.

Agenda papers can be inspected on the Council's website and at the Guildhall (Bath), Hollies (Midsomer Norton), Civic Centre (Keynsham) and at Bath Central, Keynsham and Midsomer Norton public libraries.

Ref Date	Decision Maker/s	Title	Report Author Contact	Strategic Director Lead
12TH JULY 2016				
12 Jul 2016	**CYP PDS**	**Young People Parliament Feedback**	Kate Murphy Tel: 01225 394502	Strategic Director - People
12 Jul 2016	**CYP PDS**	**Primary Parliament Feedback**	Sarah McCluskey, Kate Murphy Tel: 01225 394464, Tel: 01225 394502	Strategic Director - People
12 Jul 2016	**CYP PDS**	**Children's Mental Health**	Mary Kearney-Knowles Tel: 01225 394412	Strategic Director - People
12 Jul 2016	**CYP PDS**	**Childhood Obesity**	Bruce Laurence Tel: 01225 39 4075	Strategic Director - People
12 Jul 2016	**CYP PDS**	**Children's Health (General)**	Bruce Laurence Tel: 01225 39 4075	Strategic Director - People
12 Jul 2016	**CYP PDS**	**Care Act - Implications for Children**	Lesley Hutchinson Tel: 01225 396339	Strategic Director - People
13TH SEPTEMBER 2016				

Ref Date	Decision Maker/s	Title	Report Author Contact	Strategic Director Lead
13 Jul 2016 13 Sep 2016 **E2859**	**Cabinet** **CYP PDS**	**Future Provision of Adoption Services**	Richard Baldwin Tel: 01225 396289	Strategic Director - People
13 Sep 2016	**CYP PDS**	**Multi Academy Trusts**	Mike Bowden Tel: 01225 395610	Strategic Director - People
13 Sep 2016	**CYP PDS**	**Independent Reviewing Officer's Annual Report**	Jackie Deas Tel: 01225 396959	Strategic Director - People
13 Sep 2016	**CYP PDS**	**Local Safeguarding Children's Board Annual Report**	Lesley Hutchinson Tel: 01225 396339	Strategic Director - People
13 Sep 2016	**CYP PDS**	**Unaccompanied Asylum Seeking Children**	Ashley Ayre Tel: 01225 394200	Strategic Director - People
13 Sep 2016	**CYP PDS**	**Youth Work Development**	Tracey Pike, Sam Plummer Tel: 01225 396988, Tel: 01225 395032	Strategic Director - People
15TH NOVEMBER 2016				
15 Nov 2016	**CYP PDS**	**Senior In Care Council**	Richard Baldwin Tel: 01225 396289	Strategic Director - People
17TH JANUARY 2017				

Ref Date	Decision Maker/s	Title	Report Author Contact	Strategic Director Lead
14TH MARCH 2017				
ITEMS YET TO BE SCHEDULED				
The Forward Plan is administered by **DEMOCRATIC SERVICES**: Mark Durnford 01225 394458 Democratic_Services@bathnes.gov.uk				

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