Public Health England

Protecting and improving the nation's health

Improving health outcomes for vulnerable children and young people
Report for Trafford

1.   Purpose

This report presents local data alongside evidence for use by local authorities. It begins with general information making the case for addressing the risk factors which make children and young people more vulnerable to poorer health and other outcomes. The report describes the work of the Children's Commissioner for England in identifying the numbers of children who might be experiencing these vulnerabilities. The report also presents evidence on the impact of adverse childhood experiences.

The report then gives an overview of relevant local data on risk factors and protective factors which can be used to prioritise activity with the aim of improving outcomes and reducing inequalities. Data on the numbers of children and young people in your area who are experiencing these vulnerabilities at any one time are estimated.

The report should be read in conjunction with No child left behind: a public health informed approach to improving outcomes for vulnerable children and No child left behind: understanding and quantifying vulnerability. These reports summarise the extent and nature of vulnerability in childhood; the evidence of increased risk and impact associated with factors at individual, family and community levels; the protective factors which, where present, can mean that children go on to prosper even where they experience may have increased vulnerability or experience adversity; and PHE actions and resources to improve outcomes for children, young people and their families and how the work of public health and its partners can help children realise their full potential.

2. Using this report

Health and social needs are inherently complex; it is unlikely that there will be a single factor which is responsible for the particular situation in your local area. For this reason, it is important that no single item of information is treated in isolation. Instead the various pieces of data and evidence should be used as pieces of a jigsaw which when linked together give you a picture of the needs of your local community.

As with all health data and intelligence, it is important to 'sense check' the findings with colleagues and triangulate the data with other sources available locally such as from children's social care, community health services and Child Death Overview Panel reviews. Is the picture given by the data what you would expect? There can sometimes be anomalies in data which have resulted in atypical results, for example a new housing development. The data may not be wrong but you should be sure that you understand the reasons why something is not as you might expect.

Contact your local PHE knowledge and intelligence service (see next steps section) if you need further advice.

This report is intended for you to cut and paste text, tables and charts and include them in your own local documents. Please acknowledge Public Health England as the source and state the date on which you accessed the report. If cutting and pasting sections that quote from or reference other sources, please make sure you also reference the original source.

3. Approaches to understanding factors which can make a child vulnerable

Benefits of addressing vulnerability

What happens during pregnancy and the first few years of life influences physical, cognitive and emotional development in childhood and may affect health and wellbeing outcomes in later life (1). A focus on these early years is important to avoid the development of such issues and improve the health of the whole population (2,3,4).

This requires taking a life course approach where action to reduce health inequalities starts before birth and continues through to old age (5). There are overlaps and interdependencies across these life stages (for example teenage pregnancy) which highlight the need to take a life course and intergenerational approach. Intervention should be based on place and that, at its heart, improving outcomes for vulnerable children includes addressing underlying health inequalities. To do this effectively, local areas may wish to create 'place-based systems of planning' using the 'Population Intervention Triangle', which combines civil-level, community-based and service-based interventions for greater impact (5, 6). They may also wish to take a public health informed approach as outlined in No child left behind: a public health informed approach to improving outcomes for vulnerable children.

While the risk factors discussed are intended to give an idea of the magnitude of the problems within Trafford, it should be noted that many parents facing challenging circumstances successfully raise healthy and happy children.

The COVID-19 pandemic raises specific considerations which can be usefully placed in the broader context of childhood vulnerability discussed in this report. The potential way in which the COVID-19 pandemic may have affected the vulnerability of children can be categorised

into three groups:

1. A group of children who may be more clinically vulnerable to COVID-19 because they have underlying health conditions, or the pandemic has in some way delayed or curtailed their access to health services.
2. Children and families who are at increased risk due to family and socially circumstances where there is a statutory entitlement for care and support (education, health and care plan and those with a social worker)
3. Children who may be at higher risk due to being negatively impacted through wider determinants of health and/or family stressors family and social circumstances and may not be known to services

Children may be in more than one group and children not previously identified as vulnerable may have become so as the economic and social impact of the pandemic are felt in the family. More generally, the underlying wider community and social conditions which can make children more vulnerable which existed before the pandemic are likely to remain; these are the focus of this report.

Defining vulnerability

In recent years various organisations have attempted to define and measure vulnerability in children. For the purposes of this report, 'vulnerable children' are taken to be any children at greater risk of experiencing physical and/or emotional harm and experiencing poor outcomes because of one or more factors in their lives. A wide range of risk factors may make a child more vulnerable. Conversely protective factors may make a child less likely to experience a poor outcome even when risk factors are present.

The Office of the Children's Commissioner has developed a framework of 37 categories, with the children who fall into each being vulnerable to a greater risk of harm or of not reaching their full potential (7). Estimates of the number of vulnerable children are:

- Children receiving statutory support – estimated 723,000 children (7). This includes children in care, children in secure settings and children subject to child protection plans among others
- Children living with risk because of a vulnerable family background – estimated 2.3 million children (7). This includes children in low-income families, young carers, children exposed to domestic violence and abuse and children with parental mental ill-health among others.

For both, the Children's Commissioner sought to estimate the number of vulnerable children but this is difficult as while some individual risk factors are quantified, others are not (8). A further complicating factor is that many children have multiple risk factors so establishing a single estimate of the overall number of vulnerable children is difficult as indicators are gathered in different ways from different sources with little to no data linkage (8). Nevertheless, estimates have been developed of the likely number of children falling into each category and are given above. In considering these, it is important to note that a child may fall into more than one type and so be counted more than once in these estimates.

Children may have a combination of risk factors which make them vulnerable but may experience these with no adverse consequences. Research, however, suggests that being exposed to two or more risks in the first years of life is likely to affect a child's cognitive and behavioural development as they grow up (9).

The absence of prevalence estimates for the total number of children who might be

considered vulnerable within these parameters means that this report instead presents what is known about a local area for individual factors. In doing so, it encounters the same difficulties in that many children are likely to experience more than one risk factor or protective factor and so may well be counted in more than one estimate, though where known, these are discussed.

Promoting resilience

When looking at vulnerability, it is important also to consider the other side of the coin: resilience, which can be defined as the ability to adapt to stress and adversity (10). Resilience does not imply that those who are resilient are unharmed. Instead resilient individuals, families and communities are more able to deal with difficulties and adversities when they arise than those with less resilience (10, 11).

Many children will encounter challenge to a greater or less degree and so taking steps to improve resilience is important. A public health approach to resilience does not just seek to improve young people's personal coping skills, but ensures that conditions are in place to support relationships in the family and strengthen local community resilience, and that services are available and appropriate for when they are needed.

Adverse childhood experiences

In recent years, there has been considerable interest in a specific set of childhood experiences and how these can be associated with negative outcomes later in life (12):

Adverse childhood experiences directly relating to the child:
- psychological, physical or sexual abuse

Adverse childhood experiences relating to the child's household:
- parental separation
- domestic violence
- mental illness
- high risk and dependent alcohol use
- substance misuse
- incarceration

The body of research on adverse childhood experiences has galvanised action to address vulnerability in childhood and enabled collaboration at a local level. It should, however, be considered in the wider context of childhood vulnerability more generally discussed elsewhere in this report.

The concept of tackling adverse childhood experiences originally developed from a study in the United States which showed that those who experienced four or more of these specific categories of childhood exposure, compared to those who had experienced none, had a four to twelve-fold increased health risk of alcohol and drug dependence, depression, and suicide attempt; a two to four-fold increase in smoking, poor self-rated health, fifty or more sexual intercourse partners, and sexually transmitted disease; and a 1.4- to 1.6-fold increase in physical inactivity and severe obesity (12).

An evidence review has been published by Public Health Wales and Cardiff and Bangor Universities (13) which identifies 110 interventions to prevent and mitigate the harms relating

to adverse childhood experiences.
These are summarised into four approaches:
- supporting parents
- building relationships and resilience
- early identification of adversity
- responding to trauma and specific adverse childhood experiences

Early Help and the Troubled Families Programme

Early Help describes an approach for total support that improves a family's resilience and outcomes or reduces the chances of a problem getting worse, offering community support, universal services and acute and targeted services which are combined in different ways depending on the local area. The Troubled Families Programme has formed part of how local areas have sought to take a whole family approach.

The first Troubled Families Programme ran from 2012 to 2015, with a new programme running from 2015 to 2020 (14). The current programme is similar to the first but, this time, aims to achieve significant and sustained progress with 400,000 families with multiple, high-cost problems (14). All families in the programme must have at least two problems from worklessness and financial exclusion; poor school attendance; crime and anti-social behaviour; children who need help (including children in need and children with special educational needs); physical and mental health problems; and domestic violence (14). Similarities can be seen between these factors and those identified elsewhere in this report as making children and young people more vulnerable. For this reason, an area is likely to want to consider the work of the Troubled Families Programme in their local area alongside planning services for vulnerable children more generally.

The most recent evaluation of the programme found that individuals on the programme were considerably more complex than individuals in the general population (15). Compared to the general population the children of families in the programme were nearly three times more likely to be persistently absent from school, and over nine times more likely to be classified as a child in need (15). Over two fifths of troubled families had a family member with a mental health problem and over a fifth had a family member affected by an incident of domestic abuse or violence (15).

In the two years following joining the programme, the proportion of children in need fell, and the proportion of looked after children rose (15). A smaller proportion of juveniles on the programme received a custodial sentence compared to a comparison group (15).

Serious case reviews

Serious case reviews are carried out when abuse and neglect are known or suspected factors when a child dies or is seriously injured or harmed (16). Since 2008 the Department for Education has carried out a study into serious case reviews (SCRs) to establish what improvements can be made to the ways in which professionals and agencies work together to safeguard children (16). The fifth such study covered the years 2011-2014 and considered a total of 293 SCRs (16). Previous analysis listed domestic violence, parental mental health problems and parental substance misuse (including alcohol) as important factors which can increase risk of harm to a child (16). The most recent edition added to this list adverse

experiences in the parents' own childhoods, a history of violent crime, a pattern of multiple consecutive partners, acrimonious separation, and social isolation (16). Many of these risk factors will be discussed later in the report in the context of wider vulnerability, but it is important to note that these may be indicators of risk of serious harm.

Children in need

A child in need is defined under the Children Act 1989 as a child who is unlikely to achieve or maintain a reasonable level of health or development, or whose health and development is likely to be significantly or further impaired, without the provision of services; or a child who is disabled (17). Local authorities are required to provide services for children assessed as in need for the purposes of safeguarding and promoting their welfare. These assessments will be referenced in this report.

4.   Looking at the picture for Trafford

The picture in a local area is likely to be complicated. A detailed understanding will be essential in order to prioritise interventions as effectively as possible. This report has been produced at a population level and as such cannot be used to infer that individuals with particular characteristics will necessarily have particular outcomes as a result. However, a local area may wish to balance interventions which make a small improvement for many children with those which have a major impact on improving the life chances of smaller groups of children. The interactions between risk and protective factors is also something which should be considered. The following two sections provide data and evidence on these factors. It should be noted that, in many cases, the absence of a protective factor can be considered a risk factor so the section should be considered as a whole.

In looking at the factors in a population, it may be of value to consider those which affect children at the individual level or within a family context, together with the role played by the wider school and local community in making children more or less vulnerable.

Risk factors

This section describes risk factors which may increase vulnerability in more detail and displays local data where available.

Children in care

There are many reasons why children go into the care of the local authority or become looked after. It may be that a parent is unable to look after a child because he or she is ill or has a disability or the child may be an unaccompanied asylum seeker (18). In some cases, children's social services may have intervened because a child is thought to be at risk of harm, in which case, some form of court process is likely to have been involved (18).

While it is not the case for all children in care, many are likely to have had experiences which make them more vulnerable, leaving them at risk of poorer outcomes than children who are not. Children in care have been found to have lower educational attainment across all age groups as well as poorer mental and physical health (19). They are almost four times more likely to have a special education need than the child population overall (20). There is also an association between children in care and offending, with 38% of children in Young Offender Institutions and 52% in Secure Training Centres having previously been in care (21).

Looking at children in care shows the complexity of issues which may make a child vulnerable as there are often connections between risk factors, with many children being vulnerable as the result of more than one factor. For example, violence and abuse is something which a child in care may have experienced which in turn are associated with difficulties forming relationships with others and behavioural problems (18). Working with families intensively through schemes such as the Troubled Families Programme may help to reduce the number of children in care and experiencing multiple problems (22).

In Trafford in 2019 415 children were looked after, a rate of 74 for every 10,000 children. This is lower than North West region (94 per 10,000) and is higher than England (65 per 10,000).

Homelessness

Children from homeless households are often the most vulnerable in society. In Trafford in 2017/18 126 households with dependent children or pregnant women were regarded as unintentionally homeless and eligible for assistance, a rate of 1.3 per 1,000 households. This is similar to North West region (1 per 1,000) and is better than England (1.7 per 1,000).

Homelessness is often linked to other risk factors such as family breakdown or children who are leaving care (23). Over a third of young homeless people have poor physical or mental health and potentially abuse substances (23). Many young homeless people are also affected by gang crime (23). In Trafford in 2017/18 34 homeless households had a young person aged 16 to 24 at its head (0.4 per 1,000 households), which is similar to North West region (0.4 per 1,000) and is better than England (0.5 per 1,000).

Children in low income families

There is evidence that childhood poverty, in addition to being linked to higher rates of offending, may also lead to premature mortality and poor health outcomes in adulthood (4). In Trafford in the latest year, 11.6% of under 16s were living in low income families, which is better than North West region (18%) and is better than England (17%). The 2015 Index of Multiple Deprivation (IMD) is a commonly accepted measure of deprivation. Upper tier local authorities are ranked out of the 152 upper tier local authorities in England, with a rank of 1 indicating the most deprived. Trafford, with a score of 15.4, is in the third less deprived decile, though it is important to recognise that local variation across the authority will exist, with some wards being more deprived than others.

Family disharmony or parental breakup

Parental arguments and separation can cause emotional and behavioural problems in children and they may find it harder to concentrate in school, with feelings of insecurity sometimes leading older children to misbehave or withdraw (24). Families with multiple problems who are taking part in the Troubled Families Programme are more likely to be lone parent families (25). In 2017 there were an estimated 2.8 million lone parent families in the UK (26) although these will not all be due to separation. It is important to note that lone parent families are not a risk factor on their own, and having at least one positive parent-child relationship or another supportive adult in a child's life is seen to be a protective factor in terms of mental health outcomes (27).

As might be expected, issues to do with work can be associated with tensions in a relationship. Children living in workless couple-parent families were almost three times more

likely (27.6%) to have a parent reporting a distressed relationship as those where both parents worked (9.7%) (28). This may lead to parental separation (28).

Domestic violence and abuse within the household

Domestic abuse can take many forms. In England, the Home Office defines domestic abuse as "any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality" (29). It can include psychological, physical, sexual, financial and emotional abuse (29). Children can witness domestic abuse either directly, such as by seeing kicking or punching, but also indirectly, such as hearing such events behind a closed door or seeing injuries or upset afterwards (30). Domestic abuse can also place strain on the relationship between a child and parent, creating distance, worry that parents will separate and fear (30).

There were over 200,000 child protection referrals in England and Wales in the year ending March 2018 for domestic abuse related incidents (31). In Trafford in 2018 603 children identified as 'in need' had abuse or neglect identified as the primary reason which represents 108.4 in 10,000 children. This is lower than North West region (238.2 per 10,000) and is lower than England (181.4 per 10,000).

The Children's Commissioner has also published local maps which include projected proportions of children living in households where an adult has experienced violence or abuse from a partner in the past year.

Parental substance use

Most parents who drink alcohol or take drugs do not cause harm to or neglect their children but it is important to recognise that children living with parents with problem alcohol or drug use can be at greater risk (34). Parents who misuse drugs or alcohol often lead less settled lives and have difficulties in understanding and responding to their children's needs, placing them at increased risk of neglect (32). People who are dependent on alcohol are also more likely to have problems with their mental and physical health (33). Children may also be exposed to crime if parents or carers use this to pay for their dependency (32). Partnerships between children's services and alcohol and drug services, combined with effective interventions can contribute to improved outcomes (34).

Drug and alcohol misuse is more common in socially deprived areas (36). It is estimated that around 220,000 children lived with an adult who was dependent on alcohol in 2014-15 (35).

While parental substance use is not usually identified as a reason why children are referred for assessment by children's services as a potential child in need, nationally 18.3% of children in need had alcohol misuse identified as a factor at the end of assessment in 2018/19, with 21.0% having drug misuse identified (37). Local data for this is available from the Department for Education in Table C3.

Public Health England's Problem parental drug and alcohol use: a toolkit for local authorities contains further guidance and data for local areas to identify problematic parental substance use to help commission services to reduce and prevent harm to children and families.

The Children's Commissioner has also published local maps which include projected

proportions of children living in households where an adult has a drug or alcohol dependence.

Parental mental health issues

Poor parental mental health is associated with an increased risk of subsequent behavioural and emotional difficulties in children (38). Around a quarter of children in the UK live with at least one parent reporting symptoms of emotional distress (26.5% in 2015 to 2016) (39). If this percentage were applied to the population of Trafford then approximately 15,000 children might be expected to have at least one parent reporting symptoms of emotional distress, indicative of mental health problems such as anxiety or depression. This measure varies depending on whether parents are working. Children in couple-parent families where at least one parent is working have a slightly lower likelihood of at least one parent reporting symptoms of emotional distress (24.7%) than the UK average, while those in workless families have a far higher chance (49.8%) (39).

During pregnancy and the year after birth, many women experience common mild mood changes. Some women can be affected by common mental health problems, including anxiety disorders (13%) and depression (12%) (40). The risk of developing a severe mental health condition such as postpartum psychosis (which affects between 1 and 2 in 1000 women who have recently given birth (41)), severe depressive illness, schizophrenia and bipolar illness is low but increases after childbirth. The impact of poor mental health can be greater during this period, particularly if left untreated (42). Young mothers also have higher rates of poor mental health up to three years after birth (43,44).

Based on the number of women giving birth in Trafford, PHE's Perinatal Mental Health tool presents estimates of the prevalence of specific conditions. Details of how the estimates were calculated are available in the indicator definitions section, and definitions of the conditions can be found in the glossary at the end of this report.

Adding all these estimates together will not give an overall estimate of the number of women with antenatal or postnatal mental health conditions in your area, as some women will have more than one of these conditions. It is believed that overall between 10% and 20% of women are affected by mental health problems at some point during pregnancy or the first year after childbirth (45-47).

43.5% of all children in need assessments in 2018/19 included mental health as an identified factor (37). Local data for this is available from the Department for Education in Table C3.

The Children's Commissioner has also published local maps which include projected proportions of children living in households where an adult has a clinically diagnosable mental health condition.

Young people in contact with the youth justice system

Children who offend or are at risk of offending have been identified as a subgroup experiencing disadvantage, often at multiple levels (48). Children and young people who offend are also more likely not to be in education, employment or training (49). There is also an association between young people who have difficulties with communication and youth offending; 60% of young offenders have communication difficulties (50). The health and wellbeing needs of children and young people tend to be particularly severe by the time that they are at the risk of receiving a community sentence and more so when they receive

custodial sentences (51).

Children with learning difficulties and neuro-disability are overrepresented in the youth justice system. Having these conditions can make it more difficult to cope with justice processes, such as police interviews, court proceedings or compliance with the requirements of a community sentence (52). As young people are admitted to custody their needs (including health needs) are assessed. Through this process, young people entering youth custody have been found to have disproportionate health needs (often undiagnosed or untreated) when compared to the general population, including mental health (33%), substance misuse (including alcohol) (45%), and learning difficulties or disabilities (32%) (53). PHE's evidence review: smoking, drinking and drug use among hard to reach children and young people (54) offers further information about this topic.

In Trafford in 2018, 44 10-to-17 year-olds received their first conviction or youth caution, a rate of 183.1 in every 100,000. This is similar to North West region (243.3 per 100,000) and is similar to England (238.5 per 100,000) overall.

School absence

Persistent absence from school can be more common in children from families with multiple problems such as those taking part in the Troubled Families Programme (25). Addressing the wider issues within the family may make it more likely for children to attend school and achieve the education and training which will make them less vulnerable to worklessness themselves as young adults (25). In Trafford in 2018/19, 10% children in state-funded secondary schools were persistent absentees which is better than North West region (14%) and is better than England (13.7%).

School exclusions

Additionally, the rate (per 100) of fixed period exclusions in primary and secondary schools in England in 2016/17are shown below.

	Primary school fixed period exclusions: rate per 100 pupils	Secondary school fixed period exclusions: rate per 100 pupils
Trafford	0.7 (161)	5.2 (902)
North West	1.2 (7,655)	9.4 (39,190)
England	1.4 (64,340)	9.4 (302,890)

Source: Exclusions, Department for Education. www.gov.uk/government/collections/statistics-exclusions

Teenage pregnancy

Although a high number of teenage parents in a population may mean that more children are vulnerable, at an individual level many teenage parents will parent effectively and raise healthy children, without negative outcomes. At a population level, teenage pregnancy can make both the young parents and their children more vulnerable to poorer health and other outcomes. Teenage mothers are more likely than other young people not to be in education, employment or training; and by the age of 30, are 22% more likely to be living in poverty than

mothers giving birth aged 24 or over (55). Young fathers are twice as likely to be unemployed aged 30, even after taking account of deprivation (55). Children born to teenage mothers have a 63% higher risk of living in poverty (55), and mothers under 20 have a 30% higher risk of poor mental health up to three years after giving birth (55). At an individual level the strongest associated risk factors for pregnancy before 18 include family poverty, slower than expected academic progress between ages 11-14, persistent school absence by age 14 and being in care. It is estimated that preventing adverse childhood experiences in future generations would reduce levels of unintended teenage pregnancy by 44% (56).

In 2018 in Trafford 0.4% of women giving birth were aged under 18 years. This rate is similar to North West region (0.8%) and is similar to England (0.6%).

Special educational needs

Children are defined as having special educational needs (SEN) if they have a learning difficulty or disability which calls for special educational provision to be made for them (57). Nationally in 2017/18, 24.2% of children receiving SEN support achieved a good level of development at the end of reception compared to 77% of children with no identified SEN. In Trafford in 2018, 12.6% of school children had special educational needs, which is lower than North West region (14.6%) and is lower than England (14.4%).

Protective factors

By contrast, some factors can mean that children are less vulnerable to poor outcomes, guarding against the negative impact of the risk factors listed above. These factors can contribute to the resilience of a child, though it should be noted that these factors are not exhaustive, and that the absence of these does not mean that a child cannot be resilient. In many cases sources of resilience are difficult to quantify.

Community engagement

Children who live in a supportive community are more likely to be resilient to the harmful impact of vulnerability such as mental health problems in their adult lives (58). Taking part in community activities can take many forms.

Social inclusion

Loneliness has been shown to affect an individual's wellbeing and has been linked to poor physical and mental health (59). Young people aged 16-24 are significantly more likely than most other age groups to report feeling lonely often or always (32.7%), and are the least likely age group to report never experiencing loneliness (11.4%) (59). The Office for National Statistics have recently published national measures of loneliness to explore this further (59).

Access to outdoor play areas and green spaces

There is good evidence for the benefits of physical activity on wellbeing (60) and that participating in sport can build resilience in both adults and children (58). In 2014/15, 11.4% of fifteen-year-olds were physically active for at least one hour per day seven days a week, which is similar to North West region (13.2%) and is worse than England (13.9%).

Access to green spaces has also been found to be beneficial for both physical and mental

health (61,62). In Trafford in 2015/16, 18.7 % of people of all ages make use of the outdoors for exercise and health reasons, which is similar to North West region (17.5%) and is similar to England (17.9%). Nationally, 70% of children under 16 report spending time outside at least once a week, falling to 64% of 16 to 24-year-olds (63).

Working families

Children are likely to be less vulnerable where both they and their families have had a good education and are in work. There is an established link between outcomes for children who grow up in working families and those who are workless; those in workless families are almost twice as likely not to reach expected levels at all stages of education (28). While the number of children in workless families has declined nationally, approximately 1.2 million children in the UK lived in workless families in the final quarter of 2018 (64). About 80% of these were long-term workless families (64).

The impact of work or its absence on health and wellbeing as a child enters young adulthood is also a factor in his or her overall vulnerability. Children and young people who are out of work and education are at greater risk of a range of negative outcomes including poor health, (65) depression (65) or early parenthood (55). On the other hand, having a stable job or being in education can build resilience in young people, give them access to peer support and mentoring, as well improve wellbeing by helping to build a sense of self-worth (11). In Trafford in 2019 5% of children and young people are not in education, employment or training, which is similar to North West region (5.4%) and is similar to England (5.5%).

Children in less affluent families are more likely to report lower Warwick-Edinburgh Wellbeing Score (WEMWBS) scores whereby the higher the score, the higher the respondent's self-reported wellbeing (66). A proxy measure for family affluence is the percentage of children eligible for free school meals. In 2018 in Trafford, 8.6% of children are eligible for and receive free school meals, which is lower than North West region (16%) and is lower than England (13.5%).

Positive relationships with parents, other trusted adults and peers

When protected by supportive relationships with adults, a child is better placed to learn how to cope with everyday challenges (67). Adults who could provide a supportive relationship include parents, grandparents or members of the extended family but equally could be a teacher, support worker or other role model in the wider community.

In addition to the support of adults, children and young people who have a reliable circle of friends have been found to be less badly affected should they have multiple adverse childhood experiences. Where supportive relationships with parents, other adults and peers are in place, the chance of poor childhood health as a result of such experiences has been found to reduce from 60% of children to 21% (69).

The *Health Behaviours in School-aged Children* study has found that in England 77% of young people agreed that when they talk someone always listens to them and 59% agreed that they got emotional support from their family, though both figures decrease as children get older (69).

Self-esteem

Building resilience and establishing positive mental wellbeing can make it less likely that a child who has experienced one or more of the risks listed above has poorer outcomes as a result(11). In 2015 a lifestyle survey of 15 year-olds in England asked respondents to answer a series of questions to establish how satisfied they were with their lives currently (70). It also established a wellbeing score based on WEMWBS (66, 70). Children who report higher WEMWBS scores are less likely to engage in risky behaviours such as drinking or smoking and more likely to state that their general health is excellent (60).

	Mean score of the 14 WEMWBS statements at age 15	Percentage reporting low life satisfaction at age 15
Trafford	47.6	13.9
North West	47.8	13.3
England	47.6	13.7

Source: Health and Wellbeing of 15-year-olds in England - Main findings from the What About YOUth? Survey 2014 NHS Digital. https://digital.nhs.uk/data-and-information/publications/statistical/health-and-wellbeing-of-15-year-olds-in-england/main-findings---2014

Educational attainment

It is important that all children reach their academic potential through education and training, ensuring that a child's background does not determine his or her future outcomes, and encouraging social mobility (71). Unfortunately, socio-economic factors mean that not all children currently reach their potential and so action to tackle these underlying factors is needed (71).

Children are assessed at various points, data from which can help inform both the education of individual children but also the planning of services which bring benefit to larger groups in the community.

As children come to the end of reception, their readiness for school is assessed. In Trafford in 2018/19, 74.7% of children achieved a good level of development at the end of reception which is better than North West region (68.9%) and is better than England (71.8%). 56% of children with free school meal status achieved this level which is similar to North West region (54.4%) and is similar to England (56.5%).

Attainment 8 measures the achievement of a pupil at the end of Key Stage 4 (age 15 to 16) and replaced previous indicators based solely on GCSE results in 2017. Further details about the measure are available from the Department for Education. The most recent attainment 8 scores (2019/20) are shown in the table below, where higher scores represent better average achievement.

	Average Attainment 8 score	Average Attainment 8 score of children in care
Trafford	54.3	19.4
North West	45.6	18.8
England	46.9	19.2

Source: Department for Education

Academic achievement is not the only benefit of education, with connectedness to school

having been shown to have direct positive outcomes in terms of reduction of violence, substance misuse and teenage pregnancy rates (72). In England 32% of young people (aged 11 to 15) reported liking school 'a lot' (69).

Language development

Children who do not develop good oral language in early life are at greater risk of experiencing problems with literacy later on, potentially impairing their ability to reach their academic potential (73). As the National Institute for Health and Care Excellence (NICE) explains: "Children and young people with communication difficulties are at increased risk of social, emotional and behavioural difficulties and mental health problems. So identifying their speech and language needs early is crucial for their health and wellbeing. Many young children whose needs are identified early do catch up with their peers" (74).

Early prevention can ensure that all children start school in a position to flourish and avoid the development of gaps which can have a lasting detrimental impact on social mobility (71). Research has shown that "children who had poor language skills at age five were about six times less likely to reach the expected standard in English and about 11 times less likely to reach the expected standard in maths at age 11" (75). In addition, 15% of pupils with identified speech, language and communication needs achieve the expected standard in reading, writing and maths at the end of primary school, compared with 61% of all pupils (76). As the government's national plan to improve social mobility through education states: "Children who arrive at school in a strong position will find it easier to learn, while those already behind will face a growing challenge: early advantage accumulates, but so too does early disadvantage" (71).

In 2018/19, data on communication skills development between the ages of 2 and 2 ½ years is not available for Trafford and cannot be compared with England (90% reaching the expected level) overall and cannot be compared with North West region (86.9% reaching the expected level). At the end of reception 2,542 children in Trafford had reached the expected level of development in communication and language skills. This represents 85.5% children reaching the expected standard in communication and language at this age, which is better than England (82.2%) overall and is better than North West region (79.2%).

5. Next steps

Combined with local knowledge and data, the data and evidence in this report should help to set priorities for interventions in a local area to support vulnerable children and young people. The list below sets out other resources and sources of information to look at to help do this and to move on to the next stage of planning for services which meet the needs of a local population.

- Find out more about the general population in your area, including child poverty, by looking at the child and maternal health section on PHE's Fingertips tool.
- There may also be local data and intelligence which could be compared with other sources.
- Considering the views of local children and families when commissioning services is valuable. Local Healthwatch has more information on ensuring the voice of service users is included in the commissioning and delivery of health and care services.

Contact local PHE knowledge and intelligence service for further advice and support:

North East	LKISNorthEast@phe.gov.uk
North West	LKISNorthWest@phe.gov.uk
Yorkshire and the Humber	LKISYorkshireandHumber@phe.gov.uk
East Midlands	LKISEastMidlands@phe.gov.uk
East of England	LKISEast@phe.gov.uk
West Midlands	LKISWestMidlands@phe.gov.uk
London	LKISLondon@phe.gov.uk
South East	LKISSouthEast@phe.gov.uk
South West	LKISSouthWest@phe.gov.uk

6. Glossary

Adjustment disorders
Adjustment disorder is a state of mixed emotions such as depression and anxiety which occurs as a reaction to major life events or when having to face major life changes such as illness or relationship breakdown.
Source: Royal College of Psychiatrists (77)

Adverse childhood experiences
A specific set of childhood experiences associated with negative outcomes in later life.

Child abuse
Child abuse is when "a person – adult or child – harms a child. It can be physical, sexual or emotional, but can also involve a lack of love, care and attention."
Source: NSPCC (78)

Community
The term is used as shorthand for the relationships, bonds, identities and interests that join people together or give them a shared stake in a place, service, culture or activity.
Source: PHE (79)

Health inequality
Avoidable and unfair differences in health status between groups of people or communities. (5)

Life course
Instead of focusing on a single condition at a single life stage, a life course approach considers the critical stages, transitions and settings where large differences can be made in promoting or restoring health and wellbeing. In doing so, it emphasises minimising risk factors and enhancing protective factors through evidence-based interventions at important life stages (80).

Mild-moderate depression and anxiety
The main symptoms of depression are losing pleasure in things that were once enjoyable and losing interest in other people and usual activities. A person with depression may also commonly experience some of the following: feeling tearful, irritable or tired most of the time, changes in appetite, and problems with sleep, concentration and memory. People with depression typically have lots of negative thoughts and feelings of guilt and worthlessness. Sometimes people with depression harm themselves, have thoughts about suicide, or may even attempt suicide.

Mild depression is when a person has a small number of symptoms that have a limited effect on their daily life. Moderate depression is when a person has more symptoms that can make their daily life much more difficult than usual. Mild anxiety is experienced as feelings of being overwhelmed by responsibilities and unable to cope. People with depression may have feelings of anxiety as well.
Source: NICE,(81) Best Beginnings,(82)

Perinatal
The period of time coming both before (antenatal) and after (postnatal) birth. The

term is often used when talking about mental health.

Place-based
Place-based working is a person-centred, bottom-up approach used to meet the unique needs of people in one given location by working together to use the best available resources and collaborate to gain local knowledge and insight. By working collaboratively with the people who live and work locally, it aims to build a picture of the system from a local perspective, taking an asset-based approach that seeks to highlight the strengths, capacity and knowledge of all those involved (83).

Postpartum psychosis
Postpartum psychosis (or puerperal psychosis) is a severe episode of mental illness which begins suddenly in the days or weeks after having a baby. Symptoms vary and can change rapidly. They can include high mood (mania), depression, confusion, hallucinations and delusions.
Source: Royal College of Psychiatrists (84)

Post-traumatic stress disorder
Postnatal Post Traumatic Stress Disorder (PTSD) is experienced as nightmares, flashbacks, anger, and difficulty concentrating and sleeping. It may be a pre-existing condition or be triggered by a traumatic labour.
Source: Best Beginnings (82)

Resilience
The ability to manage and recover from adversity in a way that strengthens wellbeing in the long term.
Source: PHE (10)

Serious mental illness (severe mental illness)
Serious mental illness includes diagnoses which involve psychosis. The most common disorders which are associated with psychotic symptoms are schizophrenia, bipolar disorder and psychotic depression. Psychosis is used to describe symptoms or experiences that happen together. Each person will have different symptoms, but the common feature is that they do not experience reality like most people. A person with psychosis may have: hallucinations, delusions, muddled thinking, lack of insight.
Source: Mental Health Wales (85) Royal College of Psychiatrists (86)

Severe depressive illness
Severe depression is when a person has many symptoms that can make their daily life extremely difficult. Sometimes a person with severe depression may have hallucinations and delusions (psychotic symptoms).
Source: NICE (81)

Vulnerable children and vulnerability
For the purposes of this report, vulnerable children are taken to be any children at greater risk of experiencing physical or emotional harm and experiencing poor outcomes because of one or more factors in their lives when compared with children who do not have such factors.

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