KENT PUBLIC HEALTH OBSERVATORY

Health Needs Assessment

0-4 year olds in Kent

September 2022

Produced by

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We spoke to a range of stakeholders across Kent working in various sectors who are listed by general role.

- Clinical Commissioning Group [CCG] commissioners particularly those working in children's commissioning
- Professionals working in early help, ACEs, and children's social work
- GPs
- Managers for clinical children's services, SEND, child health, and continuing health care
- Area Partnership Managers
- Professionals working in children's mental health, early years and childcare
- Commissioners of public health services for children
- Safeguarding leads
- Kent Public Health Observatory Team
- Children's data analysts and information officers in KCC and the NHS
- Health Visitors including heads of service and those working in the family partnership programme
- Third sector organisations including Save the Children

Contents

Abbreviations

A&E	Accident & Emergency
ACEs	Adverse childhood experiences
EYFS	The Early Years Foundation Stage
GP	General Practice/Practitioner
HES	Hospital episode statistics
HNA	Health needs assessment
HV	Health Visitor / Health Visiting
IDACI	Income deprivation affecting children index
KCHFT	Kent Community Health Foundation Trust
LSCB	Local Safeguarding Children Board
LSOA	Lower super output area
MMR	Measles, mumps, and rubella
NBBS	Newborn blood spot
NHS	National Health Service
ONS	Office of National Statistics
PHE	Public Health England
SEN	Special education needs
SIDS	Sudden Infant Death Syndrome
SLC	Speech, language, and communication
UK	United Kingdom

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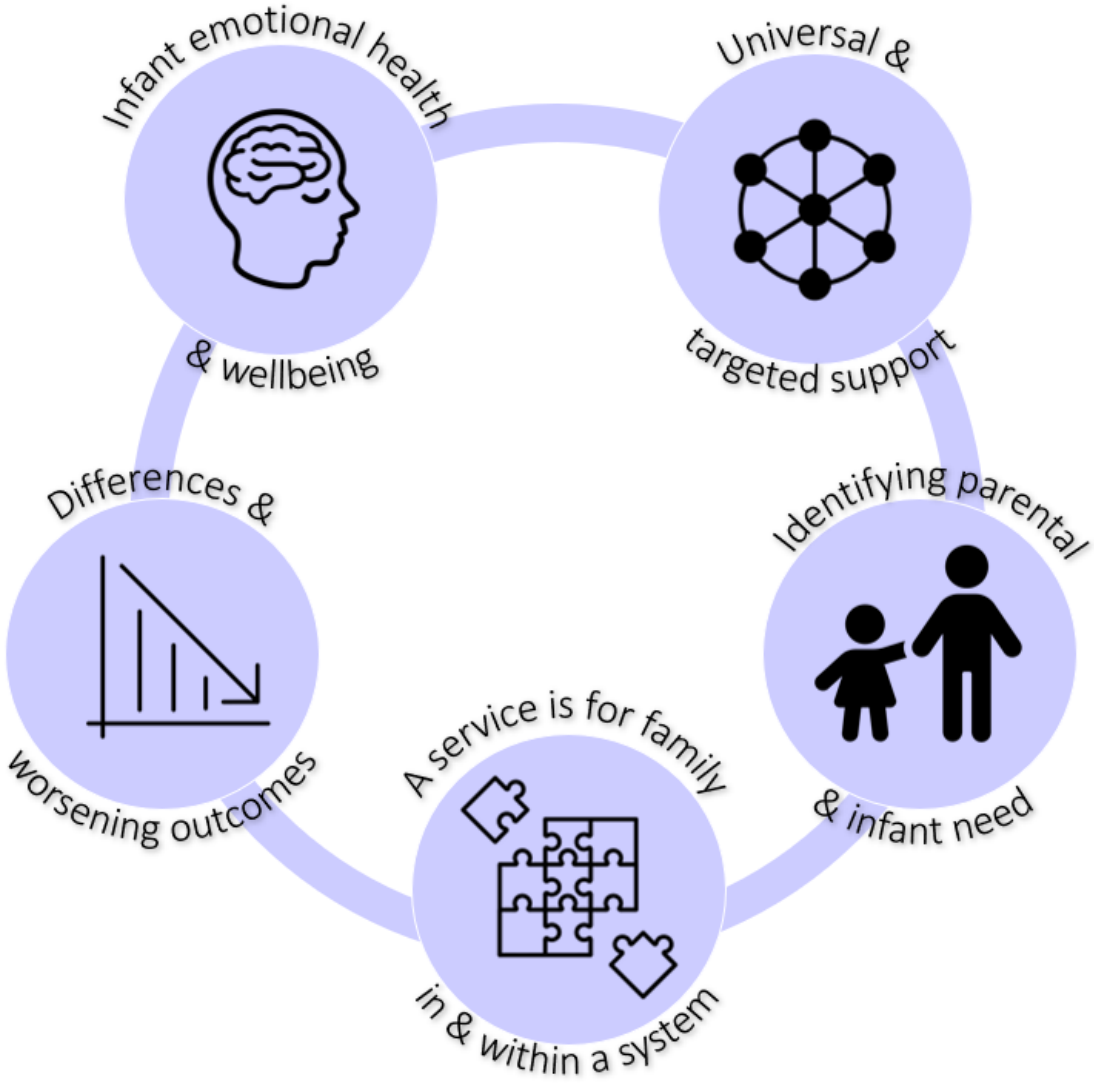
Executive summary

The summaries of the key findings are presented at the end of chapters 5,6,7 and 8. The key themes are presented below.

Figure 1: Infographic illustrating the key strategic findings of the Health Needs Assessment



Differences and worsening outcomes

- The social gradient in health is being accentuated in Kent. There is a changing picture of need and indicative measures of poor future health status are being observed.

A service is for the family, in and within a system

- Children aged 0-4 years are mostly seen in isolation, by a range of individuals and services, without their peers, but when their family is present.
- The approach to prevention of poor health outcomes is inconsistent and not helped by reduced workforce capacities.

Identifying infant and parental need

- Changes to the support infrastructures have impacted most negatively in areas where there was greater dependency upon them.

Infant emotional health and wellbeing

- Infant mental health is not prioritised and understanding of the impacts misplaced.

Universal and targeted support

- The provision and levels of support is variable and children with more complex needs are needing to be managed.

In responding what do the findings mean for the whole system in Kent to improve future outcomes of 0-4 year olds recommendations include:

- Identification of a lead to audit and explore the opportunities to establish a programme whereby the system can learn collaboratively, to **embed preventative** work into all contacts with children and their families, and not just for those who may be working in family hubs.
- Establishment of a system wide approach to **preventing** poor health outcomes, utilising technologies to ensure provision and levels of support are flexible and responsive to meet needs.
- Shared agreement to develop, embed and monitor a system which ensures real time sharing of d**ata** between services.
- Shared commitment to **redistributing** services and professionals so that the highest needs are met, and inequalities are reduced, in the context of a changing population and fiscal landslide.
- Shared agreement to having a shared responsibility and commitment to improving the start of life for all children.

1. Introduction

This Health Needs Assessment (HNA) provides a focus on the health and wellbeing of all children aged 0-4 years (0-4s) living in Kent. This includes exploration of the current service provision, and identification of gaps in support or service provision.

When considering the health and wellbeing of 0-4s, it is important to consider the myriad of pre-birth factors, such as health in pregnancy, that impact the newborn and their development. Including an in-depth HNA of pre-conception and pregnancy health which is beyond the scope of this work, however, 0-4s data will be supplemented with context and narrative around pregnancy and the life course and this will be responded to in a forthcoming pre-conception strategy. This aspect of 0–4-year-olds health and wellbeing was highlighted by the majority of stakeholders which has led to an additional section focused on parents and parenting.

Despite continual decrease over the last few decades in babies born with a low birth weight and reduced infant deaths, the improvements have started to slow down, and inequalities are widening. (1) (2)The most deprived families are 2.2 times more likely to have a low birth weight term baby and are 2.3 times more likely to have a child die under the age of one. Stillbirth and Neonatal mortality rates are highest for babies of Black and Black British ethnicity and Asian and Asian British ethnicity. (3) The rates of neonatal mortality and stillbirth are observed to be higher in younger and older mothers and where there is higher level of deprivation. (3)

About a third of children in England living in vulnerable families (around 829,000) are not receiving any support and are therefore 'invisible'. (4) For very vulnerable families, home visits have been shown to effectively reduce the chance of child abuse in infancy, (5) yet the pandemic has seen significant reductions in physical face-to-face services. Some feedback from stakeholders noted concerns that online support is not adequate and is too fragmented. One stakeholder notes you *"**can't be a child's advocate if you only talk to the parent over the phone.**"* The system to target disadvantaged children has been deemed by the Children's Commissioner as 'disjointed' and 'failing' those who need early help, with many children in England already behind their expected milestones by the time they start school. (6) Only 62% of eligible two-year-olds registered for funded early years provision (reduced from 69% in 2020). This fell by 13% in 2021, however it is difficult to determine to what extent this is a consequence of COVID-19. (7)

Health is a complex phenomenon with wide ranging interpretations and factors that can impact it, thus we acknowledge the wider determinants of health (8) through the document. Though 0-4s have been seen as the forgotten population (9) (10) (11) we continue to see this population group as a priority.

1.1 Purpose of this HNA

The purpose of this HNA is to establish the health and wellbeing needs among 0-4s in Kent, building on previous HNAs undertaken in Kent, and in the context of COVID-19. National and local policies relating to 0-4 year olds' health and wellbeing, as well as relevant published literature, have been reviewed to better understand the evidence around the health needs of 0-4 year olds.

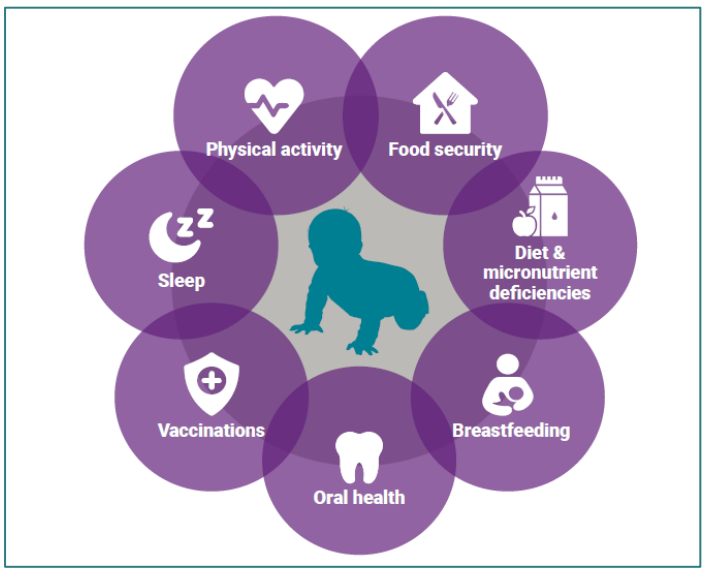
This HNA will provide an epidemiological overview of the needs of 0-4 year olds, describing the population by age, sex, deprivation, and other key measures. The objectives are:

- to identify opportunities to improve, re-organise, or re-locate local provision to better meet the needs of this population
- to make recommendations to commissioners and policy makers based on the findings.

1.2 COVID-19

The COVID-19 pandemic has had a major impact on many areas of health and wellbeing, healthcare, and community life. Despite a lack of UK evidence, global studies have highlighted the negative impact COVID-19 has had on 0-4 year olds including food security, oral healthcare, routine vaccinations, and physical activity. (12) The Early Intervention Foundation [EIF] (13) reviewed seven factors negatively influencing children's physical development related to the pandemic, particularly in the case of vulnerable groups. However, little evidence specifically examined this impact on 0-4 year olds.

Figure 2: Seven factors affecting children's physical development in the Early Years relating to the COVID-19 pandemic



Source: Early Intervention Foundation

The EIF review reports that having inadequate space to play at home, such as living in flats, as well as having an adult or siblings working/schooling from home, was associated with worse physical activity levels. Evidence suggests there have been substantial changes to children's lifestyle and behavior because of the pandemic, as well as increased exposure to other risk factors for poor health such as food insecurity, socioeconomic deprivation, and lack of access to safe outdoor spaces. This puts children at increased risk of poor physical health outcomes and exacerbates existing health inequalities. Importantly, changes to attitudes and behaviours that started during the pandemic, such as attitudes to physical activity, may be long-lasting which could have a cumulative adverse impact on child health and development over time. The lockdown period also impacted on existing mental health and new issues emerged for children and their parents. (14) Furthermore, the indirect impacts of COVID-19 on young children have been extensive and multi layered but are not yet fully understood.

COVID-19 has impacted vulnerable children (15), particularly those from low-income or ethnic minority families and these children remain disproportionately at higher risk of poor outcomes. The national lockdowns placed additional strain on families who were reliant on both financial and social support offered by schools, nurseries, and children's centres, whilst also making it difficult for many to maintain budgeting or manage on a low income. For families with young children, isolation, and reduced contact with those outside the home was particularly difficult.

The COVID-19 pandemic has caused delays and disruptions to many services. On 20th March 2020, the government asked education and childcare settings to close to all children except those of critical workers and those classified as vulnerable. Childcare settings could reopen to all children from June 2021, with safety measures in place.

Speech, language, and communication (SLC) services have been impacted and more concerns have been raised about preschool children's social and emotional interaction with their peers, behaviour self-regulation, and anxiety levels. This may be partly due to fewer opportunities for communicating with a wide variety of people during lockdowns by increased time spent at home, and not able to access opportunities to play and learn with others.

Nationally, there have been temporary and permanent setting closures, reduced demand for early years places and workforce challenges (16). Recently, a significant proportion of early childhood education and care settings have reported much lower occupancy than in previous years. A study of local authorities in England, in Spring 2021 found that 54% of local authorities reported that levels of childcare use were low. (17). Low occupancy was reported to be exacerbated by parents' employment arrangements and status including furlough, unemployment and working from home (17), as well as parental anxiety regarding the risks of COVID-19 transmission (18).

Before the pandemic there were long standing, national issues about the recruitment and retention of qualified and skilled early years practitioners, which have since been exacerbated (16). Some providers are still experiencing challenges with staffing levels due to staff sickness, self-isolation, or high attrition rates. In addition to low levels of demand, many settings report full, partial, or temporary closures, and some permanent closures (19). Despite a range of government measures to support the early childhood education and care sector, the impact of COVID-19 has exacerbated many providers' concerns of financial sustainability (18).

During the pandemic, the Kent Health Visiting [HV] service redeployed a proportion of HV service colleagues to support Tier 1 services as part of the COVID-19 response. Service provision was also adapted, including the introduction of virtual contacts, in line with the national guidance (20) (21) (22). Virtual contacts were introduced across all five mandated contacts, however the duration of which the virtual contacts were in place for each contact varied in line with the national guidance and capacity of the service.

Virtual contacts were risk assessed for the requirement for a face-to-face review. Virtual and face-to-face provision also varied dependant on the level of need. Families receiving targeted and specialist levels of support, were risk assessed for face-to-face contacts, to either take place in a clinic or in the family home, in line with need.

During the recovery stage, children centres started to reopen and now all centres which closed due to the COVID-19 pandemic have been reopened. Measures implemented in response to COVID-19 have resulted in some provision, such as group activities, being restricted when compared to provision pre-COVID-19, the service are therefore targeting provision to those with the greatest need.

2. Methods

2.1 Literature review

A literature review of national and local evidence was performed to inform this HNA. This was carried out by a public health specialist librarian and a public health registrar. The following databases were included in the search: NICE Evidence, Social Care Online, LAPH, Cochrane database, Trip database, and the British Nursing Index. National policies, guidance, and strategies on the health and wellbeing of 0-4 year olds were reviewed as well as evidence of effectiveness of different public health interventions. Findings of the literature review are summarised in section 4 and referenced through the document.

2.2 Stakeholder engagement

A range of professionals were interviewed to help inform the HNA. Of the 38 identified individuals who were contacted, semi-structured interviews were conducted with 31 respondents. Subsequent thematic analysis was undertaken. See Acknowledgments on page 2 for a list of stakeholders by role.

2.3 Sources of data

A wide variety of data sources have been utilised to inform this HNA. To understand population data, screening, and various health indicators, the Office for National Statistics (ONS) and Public Health England (PHE) Fingertips data were used for comparisons with national and regional figures. To understand service use such as A&E attendances and hospital admissions, Hospital Episode Statistics (HES) and Medi tool were used.

Modelled estimated data has been used to present the ethnicity profiling from the 2011 national census. There will be an opportunity to update this once the 2021 census analysis is published.

The data utilised from the public domain has enabled analysis and exploration of trends over a five year period and comparison with the England average. Where there was available data, presentation at district or ward level has been presented. Where numbers were too small to present at district level, data has been combined over a three to five year period. The data presented is the most up to date available at the time of analysis.

To make comparisons and to show differences in information relating to either geographical areas or age bands the authors have calculated information into rates, using the population data from the estimated ONS population figures or the published birth figures.

2.4 Data limitations

In the absence of local data for some aspects of this HNA, national data was used. Much of the published data presented was collected before the COVID-19 pandemic, yet as COVID-19 has impacted most areas of health and wellbeing, including services, it is hard to ascertain the truest and most current picture of under 5 year olds health and wellbeing. Lastly, different time frames may have been used for different datasets due to data availability at the time of analysis.

3. National Context

This section presents the national policy context of 0-4s health and wellbeing with key updates from the literature, as well as an overview of the statutory services provided in England for this age cohort.

Ensuring every child has the best start in life is one of ten key priorities within Public Health England's 5 year strategy, '*PHE Strategy 2020-25*', (23) and part of the NHS Long Term Plan. (24) This compliments the plethora of national guidance and reports around 0-4s' health and wellbeing. The UK Government has set out priorities for 0-4 year olds, from maternity care recommendations to the child development reviews led by the health visiting service, and the importance of investing in early years services. (25) (26)

There is more emphasis now on prevention of poor emotional and physical health, starting in pregnancy to two years of infancy. (27) (28) (29) However, the mental wellbeing of infants is under-researched and so poorly understood. The Leadsom review '*The Best Start for Life*' (27) recommends focusing policy on the first 1001 days of life, from conception to age two, introducing family hubs, strong leadership, as well as information and support available for families when needed. Family hubs are recommended as a platform to deliver high quality advice and support, (30) and "*allows families to access face-to-face and digital support from public, private and voluntary organisations at a single place*". (27) [7:2021]

Safeguarding is of paramount importance in children aged 0-4 years as they are some of the most vulnerable in our society. Safeguarding is an essential aspect of professionals working in services focused on maternity and children. The guidance '*Working together to safeguard children*' reinforces safeguarding is everyone's responsibility through early help assessments, provision of effective early health services, and data sharing guidance (31).

The pressure on the health visiting service, including around safeguarding, has been increasing nationally partly due to redeployment during the pandemic. (32) A national HV survey conducted in 2020 (33) found over three quarters of respondents reported increases in domestic violence, perinatal mental illness, poverty, food bank use, speech and communication delay. 65% of HVs said that "*focusing solely on those most at risk leaves limited capacity to deliver prevention/ early intervention*".

3.1 Statutory services

There are various services that are mandated by the UK Government to support the needs of 0-4 year olds and their families. See appendix 1 for a matrix of the workforces.

3.1.1 Maternity services

Midwives, GPs, obstetricians, and other healthcare professionals will see women and their families throughout pregnancy, birth, and the postnatal period to provide care, treatment, and health advice.

Ideally a booking appointment will take place before 10 weeks of pregnancy and regular contacts [four weekly] with maternity services for the remaining months. During this time there will be observation of foetal growth via symphysis-fundal height measurements and ultrasound, monitoring of maternal mental health, and conducting physiological and biochemical tests such as blood pressure, blood tests, and urinalysis to screen for certain conditions that may affect the mother or growing baby.

Six high impact areas in maternity are public health priorities given the impact these can have on the growing foetus and babies:

1. Improving planning and preparation for pregnancy
2. Supporting good parental mental health
3. Supporting healthy weight before and between pregnancies
4. Reducing the incidence of harms caused by alcohol in pregnancy
5. Supporting parents to have a smokefree pregnancy
6. Reducing the inequality of outcomes for women from Black, Asian, and Minority Ethnic communities and their babies (34)

3.1.2 Healthy Child Programme

The Healthy Child Programme [HCP] (35), launched in 2009. This remains the national evidence based universal programme for children aged 0-19. The HCP for the early life stages focuses on a universal preventative service, providing families with a programme of screening, immunisation, health and development reviews, supplemented by advice around health, wellbeing and parenting. The Healthy Child Programme aims to bring together health, education, and other key partners to deliver an effective programme for prevention and support. Health Visitors lead the 0 to 5 elements of this programme.

The Health and Social Care Act 2012, introduced in April 2013, moved the responsibility for commissioning of public health services from the NHS to local government. The transfer of responsibility for health visitor services to local authorities was deferred to October 2015, including relevant aspects of the 0-5 years Healthy Child Programme, to allow time to complete the National Health Visiting Programme (NHVP). The NHVP was a five-year investment in health visitor services to increase the workforce and transform the way in which the service was delivered. Regulations were introduced mandating the delivery of five universal health visitor reviews for 18 months (to March 2017), after which time they would automatically expire. A review undertaken by Public Health England in 2016 found widespread support for the regulation of these services to continue, and for future arrangements to be considered alongside other regulated public health services. (36)

The HCP has been supplemented by additional evidence over the last decade and there is national commitment to modernise the programme over the next few years, to ensure the programme is both current in terms of evidence and context. PHE's report *No Child Left Behind* published in 2021 highlights the need for a focus on reducing vulnerabilities and addressing inequalities. (37)

In 2021, Public Health England published the revised Health Visiting model, commissioning guidance and high impact areas, updated with new evidence and emerging policy developments, based on feedback from service users, professionals working in this space and commissioners. (38) The revised Health Visiting Model replaces the previous "456" model, to focus further on needs assessment so that interventions are personalised to respond to children and families' needs across time. The new 'Universal in Reach – Personalised in Response' model, is based on 4 levels of service depending on individual and family needs: community, universal, targeted and specialist levels of support. The universal, targeted and specialist levels replace the previous universal, universal plus and universal partnership plus levels. Safeguarding children is embedded through the model because the health visiting service have a vital role in keeping children safe and supporting local safeguarding arrangements. (39)

In addition to the five mandated contacts, the amended model suggests opportunities for further contacts for consideration where health visitors, or a member of their team, could respond to a family's identified needs. These are two additional contacts suggested at three to four months and six months, to enable support with infant feeding, growth and development, maternal mental health, Minor illness and accident prevention, speech, language, and communication development (38).

The High Impact Areas provide an evidence-based framework for those delivering maternal and child public health services and are central to the health visitor delivery model. These have been refreshed and contain new evidence, policy and suggested additional material to support implementation. (39) These High Impact Areas do not describe the entirety of the role of Health Visiting services. The 6 early years high impact areas are listed below:

1. supporting transition to parenthood and the early weeks
2. supporting maternal and infant mental health
3. supporting breastfeeding (initiation and duration)
4. supporting healthy weight and healthy nutrition
5. improving health literacy; reducing accidents and minor illnesses
6. supporting health, wellbeing and development: Ready to learn, narrowing the 'word gap'

See appendix 2 for an overview.

As part of the modernisation Public Health England have committed to extending the programme to include preconceptual care. The modernisation will also include developing suites of resources to address key priority areas, this includes preconceptual care, maternity, effective care continuity between midwifery and health visiting, and narrowing the word gap (speech and language skills) to address inequalities. (37)

3.1.3 Children's social care

Local authorities, working with partner organisations and agencies, have specific duties to safeguard and promote the welfare of all children in their area (40). The Children Acts of 1989 (41) and 2004 (42) set out specific duties; Section 17 of the Children Act 1989 puts a duty on the local authority to provide services to children in need in their area, working closely within a multi-agency team.

Each district in Kent has at least two teams made up of a team manager, two senior practitioners, 4 or 5 social workers, a social work assistant and admin support.

These teams:

- carry out children and family assessments, which may lead to a Child in Need plan, a 'step down' to early help services or no further action
- carry out Section 47 assessments on new referrals, and any resulting initial Child Protection Conferences
- initiate care proceedings where necessary.

A safeguarding partner in relation to a local authority area in England is defined under the Children Act 2004 (as amended by the Children and Social Work Act, 2017) (43) as:

- The local authority.
- A clinical commissioning group for an area any part of which falls within the local authority area.
- The chief officer of police for an area any part of which falls within the local authority area.

These three safeguarding partners should agree on ways to co-ordinate their safeguarding services; act as a strategic leadership group in supporting and engaging others; and implement local and national learning including from serious child safeguarding incidents. The Act mandates the regular inspection of children's services, including early years provision as well as setting out fostering responsibilities.

The responsibility for ensuring that child death reviews are carried out is held by 'child death review partners'. Child death review partners, in relation to a local authority area in England, are defined as the local authority for that area and any clinical commissioning groups operating in the local authority area. (43)

3.1.4 Safeguarding

In 2018, the government issued 'Working Together to Safeguard Children' (44), Statutory guidance on inter-agency working to safeguard and promote the welfare of children. The guidance set out new duties for local safeguarding partners including how they work together and in collaboration with others to improve safeguarding practice locally. The statutory framework was designed to allow for greater flexibility in the reviewing of serious child safeguarding cases.

In September 2019, the Kent Safeguarding Children Multi-Agency Partnership (KSCMP) arrangements were implemented, in line with the statutory guidance and legislation (45). These arrangements have recently been updated and are expected to be reissued in Spring 2022.

Serious incident notifications

Serious Incident Notifications relate to serious child safeguarding cases, where a child has died or been significantly injured as a result of abuse or neglect. In the latest KSCMP Annual Report (46), the KSCMP reported a 41% increase in the number of Serious Incident Notifications (SINs) received, **for children of all ages**, between October 2020 and September 2021 (24 SINs), compared to October 2019 to September 2020 (17 SINs).

Rapid reviews

Local Safeguarding Children Partnerships are required to promptly undertake a rapid review on all serious incidents notified by the Local Authority to the National Panel. There is a fifteen working day timescale for the completion of rapid reviews. '*Rapid reviews should assemble the facts of the case as quickly as possible in order to establish whether there is any immediate action needed to ensure a child's safety and the potential for practice learning*.' (47) [14:2019]

The Child Safeguarding Practice Review Panel note that *'rigorous and comprehensive rapid reviews can offer a new mechanism through which the key learning may be identified and disseminated quickly within a matter of weeks'*. (47) [14:2019]

The latest KSCMP Annual Report noted the finding from a review of Rapid Reviews over an 18-month period.

'The majority of children were under 1 and an emerging theme was that information sharing, particularly between midwives, health visitors and GPs was presenting as a barrier to effective safeguarding of children. This finding is in line with a similar theme which emerged in the national review of Non-Accidental Injury in under 1s published in September 2021. This is an area for development which the partnership has acknowledge and will be progressing further in its workplan for 2022.'

Rory Patterson, Independent Scrutineer of KSCMP, (46) [7:2021]

Safeguarding practice reviews

The safeguarding practice review process provides opportunity for reflection and learning, to improve practice. The national Child Safeguarding Practice Review Panel identify and oversee the review of serious child safeguarding cases, which, in its view, raise issues of complex or national importance. The panel work with local safeguarding partners to identify such cases and maintain oversight of the system of national and local reviews (47).

3.1.5 Primary care

Primary care services, which include general practice [GP], community pharmacy, dental, and optometry (eye health) services provide a first point of contact in the healthcare system.

There is no cost to register with a GP and anyone in England can register with a GP surgery. 'There is no contractual duty to seek evidence of identity, immigration status or proof of address. Practices should not refuse registration on the grounds that a patient is unable to produce such evidence.' (49)

All children including newborns, should be registered with a GP. This will enable the newborn screen at 6-8weeks (50) to be undertaken and immunisations to be delivered.

Dental services through the NHS are free and children should be given opportunity to access dental care before the age of one year and seen regularly as their primary teeth develop and are more susceptible to damage from bacteria.

3.1.6 Statutory framework for the early years foundation stage

The Statutory framework for the early years foundation stage is mandatory for all early years providers in England. This includes maintained schools; non-maintained schools; independent schools (including free schools and academies); all providers on the Early Years Register; and all providers registered with an early years childminder agency.

The Early Years Foundation Stage [EYFS] sets the standards to ensure that children from birth to 5 years of age are learning and developing well and are kept healthy and safe. 'It promotes teaching and learning to ensure children's 'school readiness' and gives children the broad range of knowledge and skills that provide the right foundation for good future progress through school and life'. (51)

Government funding for early childhood education and care provision comprises of supply-side funding through the free entitlements, discussed in section 6.41, paid directly to early childhood education and care providers, and demand-side funding paid directly to parents through the benefit system or through tax-free childcare and employer childcare vouchers,

to support parents to pay for childcare fees. (19) Stewart and Reader (2021) reported a change to the pattern of demand-side funding, with a fall in spending through benefits targeted at low-income families and a rise in spending through tax-free childcare and employer childcare vouchers, targeted at middle and higher income families, (2011/12 – 2018/19). In the 2018/19, support for middle- and higher-earners overtook support for low-income families for the first time (48).

3.2 Early help and preventative services

Early Help and Preventative Services [EHPS] is not a statutory service but a key service delivery in Kent which aims to target early help services for the most vulnerable children, young people, and families with a focus on delivering better outcomes.

Children, young people, and families should be able to access the right services at the right time in the right place. The aim of the service is to work in an integrated way and avoiding, where possible, lack of coordination or wasteful duplication.

EHPS offer a wide range of support services to children, young people, and families across different levels of need. Most children and young people may have a few basic needs that are well supported through a range of universal services. However, some children have more additional or complex needs and may require access to additional, intensive or specialist services to support them. These levels of need are defined by the Kent support level guidance sheet. (49) Request for support can be submitted by partners and by individuals/families themselves. The support is offered at different levels. (See appendix 3)

Universal services - level 1. Universal services are provided to or are routinely available to all children and families. These services are accessed in the local community and delivered by partners including schools, early years education and childcare, health, GPs, hospitals, community health services, children's centres, youth hubs, police, fire service, voluntary and community groups.

Additional Support - Level 2. Children, young people, and families with additional needs who require extra help to improve education, parenting, behaviours, or to meet specific health needs. These needs can be met by universal services working together or with the addition of some targeted services such as Open access Early Help support.

Intensive Support - Level 3. Intensive support can be offered to children, young people, and families where they have complex or multiple needs requiring local authority services to work together to assess, plan and work with the family to bring about positive change. This would be worked by intensive early help and child in need services.

Specialist Support - Level 4. Children who are considered to have been harmed or are likely to suffer significant harm as a result of abuse, neglect, removal from home, or will suffer serious lasting impairment without the intervention of local authority statutory services, under high level concern Child in Need (CIN) or high-risk Child Protection (CP) services and specialist justice youth work. Children whose disability affects all aspects of development. Level 4 support would be provided by the Children social work team (CSWT).

The Front Door service is available to give access to support for children, young people and families requiring intensive or specialist support at levels 3 and 4. Any referrals that do not meet the criteria should be referred to the appropriate service for additional or universal services or consideration given as to whether the identified needs can be met within the referrer's own service.

The Support Levels Guidance (49) has been developed in a way which will better assist partner agencies when considering where children, young people and families sit within the continuum of need.

Partners should have a discussion with the parents or carers; and with the children and young people where appropriate, before making any request for support. If there are concerns that a child may be suffering significant harm, the Request for Support Form should be completed and immediately submitted to the Front Door.

The Request for Support Form will be used to determine the most appropriate advice and support for the family. The quality of the information received will enable the Front Door team to direct the request to the most appropriate service where the criteria is met - an Early Help Unit or Children's Social Work Team. If the request for support does not meet level 3 or 4, the referrer or parent (if self-referred), will be contacted and advised to have a district conversation with open access. Alternatively request just for open access support can be submitted directly to open access.

Following a District Conversation, the support that can be offered is low level bespoke 1:1 single piece of support of up to 4 sessions, or signposting to local services, referrals to parenting programmes, engaging in groups and services, where additional support can be accessed. The aim is that the family will have the bespoke short piece of work and when this ends, they continue to access support universally via the children's centres.

3.3 Primary care and children's centre locations

There are various ways information on current services are collected and shared with multi-agency partners and parents in Kent. Some areas in Kent have a directory or bulletin which is updated or a regular newsletter that is sent out to partners with information on new services. Many stakeholders mentioned the issue of collating information on children's

We ‘struggle as a system to meet the needs’ / Eligibility thresholds are too high as resources are stretched / Services are less embedded in the community / There is a lack of venues / The opening times are restricted – what about working parents?

Source: Stakeholder interviews

services in one place for parents to access, such as an online information hub. A full list of the GPs and Children’s Centres mapped below are included in appendix 4.

Figure 3: Kent GPs and Children’s Centres map by deprivation by LSOA

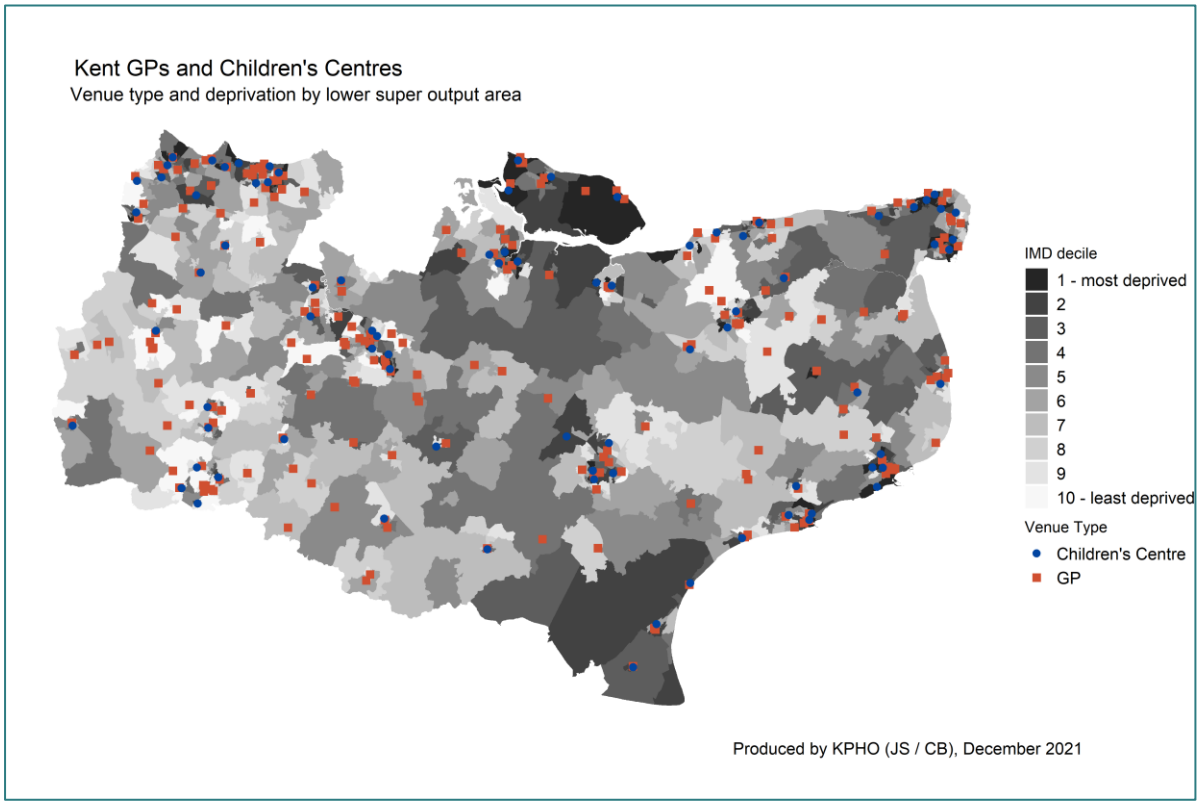
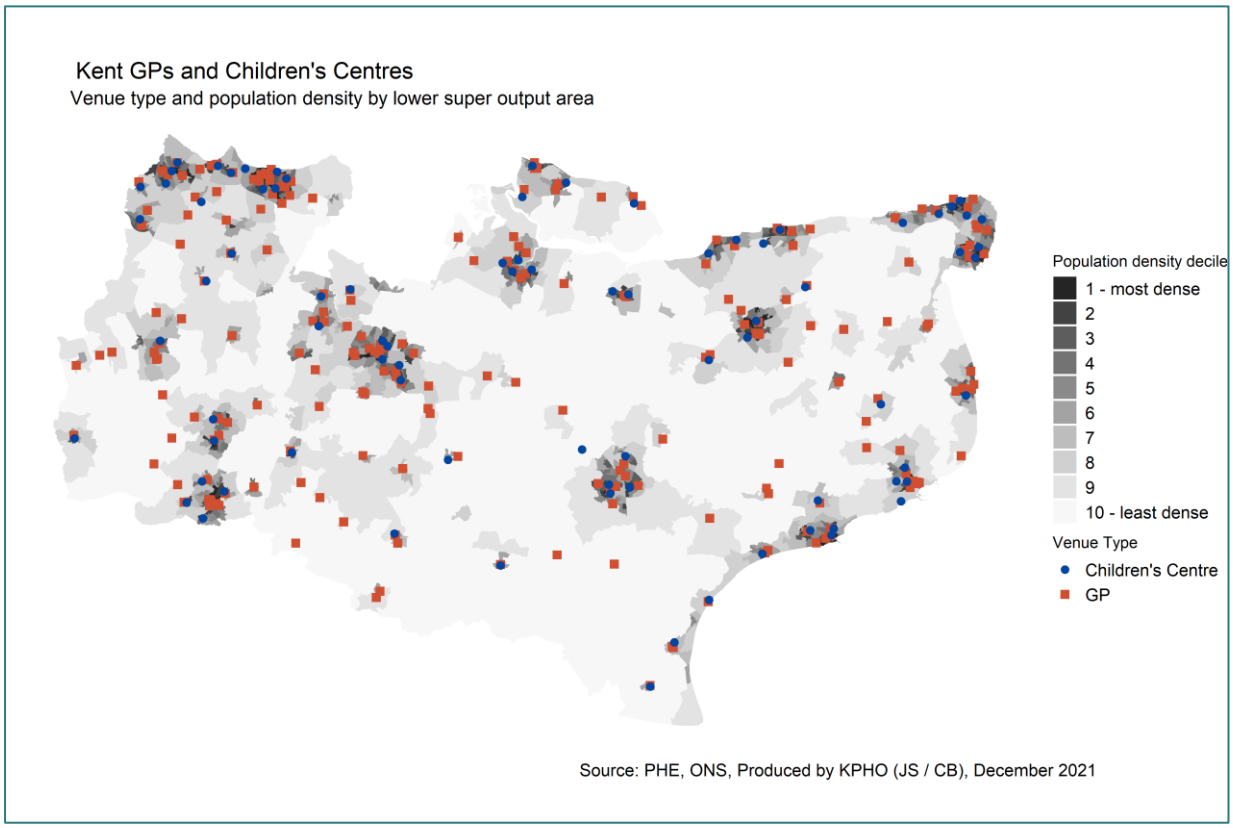


Figure 4: Kent GPs and Children's Centres map by population density and LSOA



4. Parenting

Whilst assessing the health needs of 0-4 year olds, it is vital to acknowledge the context within which they are born, grow, and develop. Parents, carers, and guardians play the most important part in this journey and their unique parenting role has been acknowledged many times during stakeholder interviews, with stakeholders repeatedly saying parents need to be seen as "*part of the workforce*" and "*need to feel empowered to make decisions*", while also reporting a notable lack of confidence in parenting abilities and an increase in parental stress and anxiety. The word 'parent' is used throughout to include carers and guardians.

Mental health problems during the perinatal period (from conception to 1 year after birth) affect between 10 to 20% of mothers and 10 to 15% of fathers. If left unresolved, mental health issues can have significant long-term impacts on parents, their child, and the wider family. (50) Moreover, those experiencing poverty or social exclusion have higher rates of perinatal depression. Parental anxiety has worsened during the COVID-19 pandemic, particularly for families of low socio-economic status or ethnic minority background who are not always as able to access the support or services they need. (10) However, as Kent's ethnic and cultural profile is varying more due to migration, there is a risk that inequalities will keep widening if counselling and therapy services for parents are not available in other languages, possibly contributing to the worsening of outcomes.

Parental conflict can have damaging effects on children's cognitive and behavioural development, as well as their mental health, causing psychological distress. Conflict can be expressed in different ways including aggression, domestic abuse, and emotional control, and can be present in all types of parental relationships. There is strong evidence to show parental conflict can impact children's long-term outcomes including academic achievement, employability, and future relationships. (51) In the UK in 2019, 12% of children in couple-parent families reported relationship distress. When focusing only on couples where both parents do not work, this rose to 21%, and this difference has been consistent since 2011. (52) However, these figures are likely to be underreported.

Parental conflict is closely linked to adverse childhood experiences (ACEs). Furthermore, parents (particularly fathers) who are themselves affected by ACEs from their childhood, may not have the emotional skills to nurture their own children, unless they receive support and education, thus perpetuating the cycle of some adversities. Attachment-based interventions targeted at parents who are at an increased risk of attachment difficulties, have been shown to improve child outcomes. (53)

There has been an increase in the awareness of adversities in childhood and the protective and risk factors which may be in an individual's life. Moving towards embedding trauma

informed principles and approach will help to further improve outcomes for children and adults.

4.1 Supporting parents to parent

Various parent support programmes were spoken of highly during stakeholder interviews, namely: 'families support families' programme, Solihull parenting programme, the 'easy-peasy app', the first 1000 days programme in Ramsgate, open access children's centres and hubs, as well as the reducing parental conflict programme. A literature review of parenting programmes was undertaken by Kent Public Health observatory in 2020, available: https://www.kpho.org.uk .

Due to the success of the #readyforpregnancy campaign in the South East of England which sought to prepare expectant parents and raise awareness about specific health topics during pregnancy, a follow-on campaign commenced in November 2021, #readyforparenthood which seeks to address key parenting topics such as attachment, sleep, how to deal with a crying baby, and mental health. Furthermore, a perinatal mental health service focusing on birth loss and trauma is currently being implemented as an early adopter programme in East Kent Hospitals University NHS Foundation Trust, and due to be available across Kent by 2023/24. This will offer support to fathers/partners.

5. Starting life – the under 5-year-old population in Kent

The health and wellbeing needs of 0-4 year olds in Kent are varied, differences are driven by population by ethnicity, sex, health condition, pregnancy/birth outcomes, feeding and nutrition, nurturing, living environment and vaccination status. Facts and figures are presented below comparing Kent or Kent districts to national data where possible. It is important to understand the demography of Kent and its districts in order to help with planning of appropriate and differing levels of services.

5.1 Population of under 5-year-olds in Kent

This figure below illustrates children aged 0-4 years in Kent constitute a very similar proportion [2.8%] of the population when compared to national proportions. Please note delays in birth registrations because of the coronavirus pandemic may have affected 2020 data.

Figure 5: Population age profile of resident population in Kent by five-year age bands, 2020

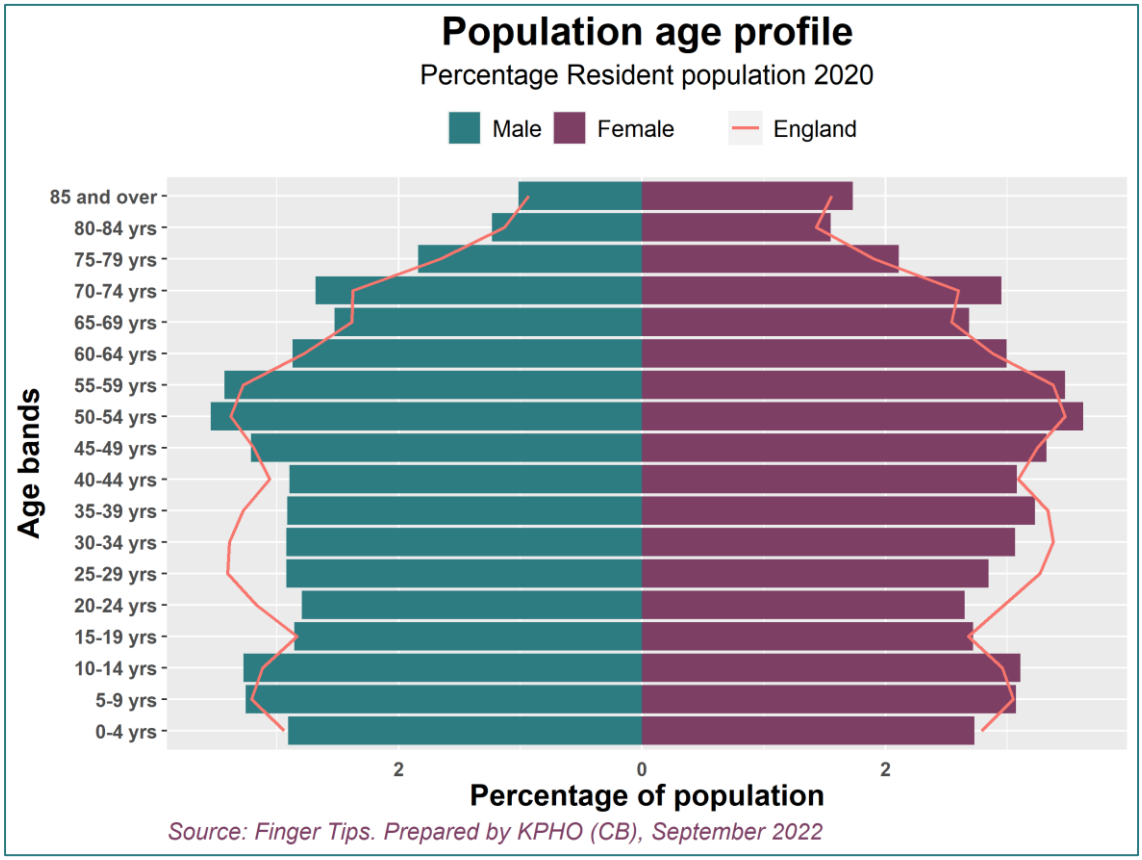


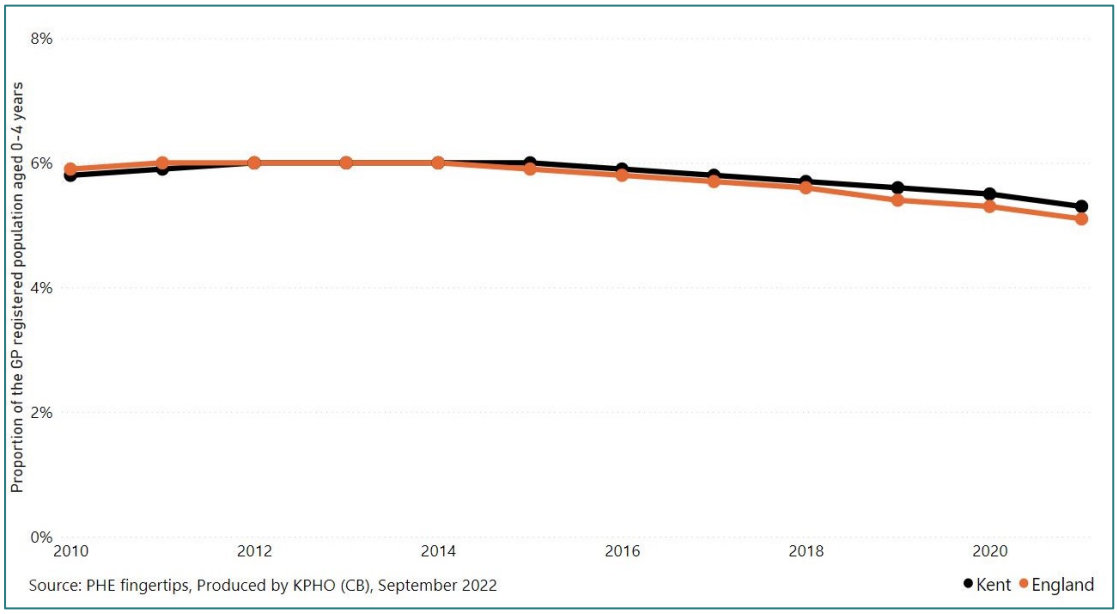
Table 1: Proportion and number of the population of under 5-year-olds by district, Kent, 2020

Districts	Proportion of under 5s population in the district population	Number of under 5's
Ashford	5.9%	7800
Canterbury	4.3%	7200
Dartford	7.4%	8400
Dover	4.9%	5800
Folkestone & Hythe	4.7%	5300
Gravesham	6.5%	6900
Maidstone	6.0%	10500
Sevenoaks	5.6%	6800
Swale	6.1%	9200
Thanet	5.4%	7600
Tonbridge and Malling	5.8%	7700
Tunbridge Wells	5.3%	6300
Kent	**5.6%**	**89500**

Source: ONS

In 2020 there were 89,537 children aged 0-4 years registered with a GP in Kent and Medway CCG. Children in temporary accommodation or rehomed from another authority area may not be registered with a GP. Kent's registered population of 0-4 year olds has generally followed the national average since 2010 but in recent years been slightly higher.

Figure 6: Proportion of the GP registered population aged 0-4 years in Kent and Medway CCG and England, 2010-2021

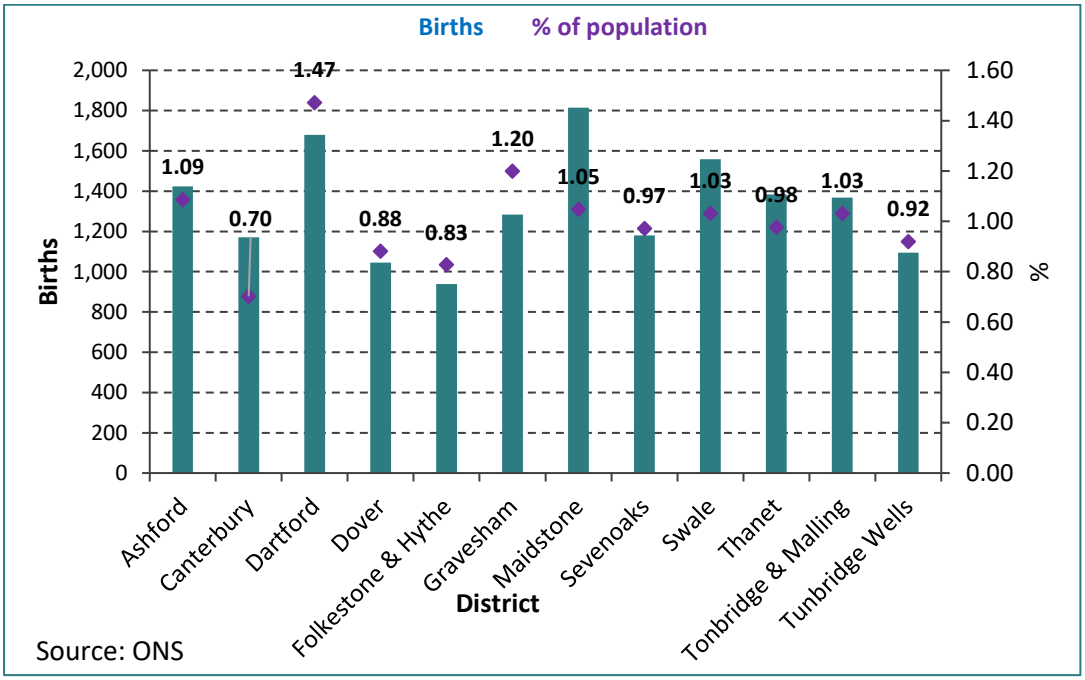


Between mid-2018 and 2028, the total population of Kent is estimated to increase by 7.6% (compared to 5.0% in England), though migration accounts for the majority of this. The largest increase over the 10 year period is expected in Dartford (15.5% = 17,000 people), and the lowest in Gravesham (1.5% = 1,600 people).

During 2020 there were 15,940 births in Kent. Maidstone district had the largest number of live births in 2020 with a total of 1,815. Mid and West Kent districts tend to have a younger age profile and for this reason the number of births in these districts, such as Gravesham, Maidstone, Dartford, and Tonbridge and Malling are typically much higher than the number of deaths, leading to a higher population growth due to natural change.

The figure below shows that though Dartford had fewer births in 2020 compared to Maidstone, those births made up a higher percentage of the total population in that district, highlighting the importance of equity in service provision. Equally, Dover and Folkestone and Hythe had the least number of births throughout Kent, however their smaller population means those births made up a higher proportion of the total population in those districts.

Figure 7: Births by district and % of total district population, Kent 2020



The general fertility rate [GFR] provides an indication of population growth. The GFR represents the number of live births per 1,000 females aged 15 – 44 years and is a measure of current fertility levels. Understanding the demography of the area will help with planning of appropriate services. Fertility rates are closely tied to growth rates for an area and can be used as an indicator of future population growth or decline in that area.

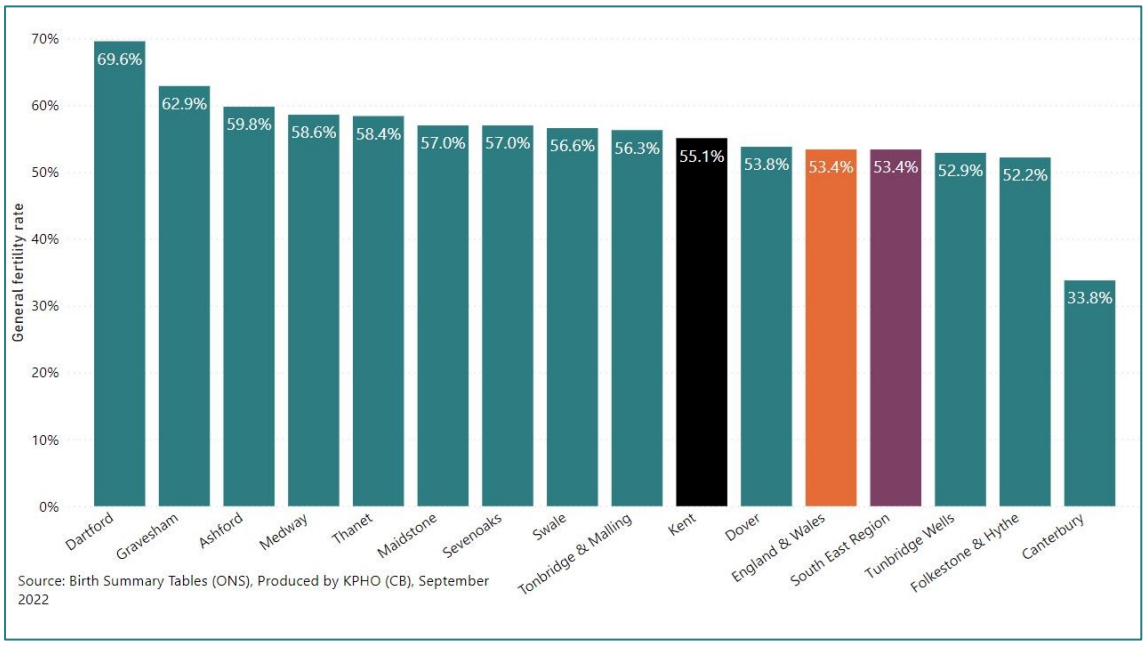
In 2020, Dartford had the highest GFR of Kent districts at 71.9, higher than the England average 55.3 (54) Overall, the GFR in Kent and England has reduced since 2016.

Table 2: General fertility rate (GFR): live births per 1,000 women aged 15-44 years in 2016-2019 and five year pooled 2015-2019

Region	2016	2017	2018	2019	Five year pooled 2015-2019
Kent	62.5	63.0	61.4	59.4	60.6
England	62.5	-	-	57.5	60.6

Source: Public Health Profiles - PHE / ONS

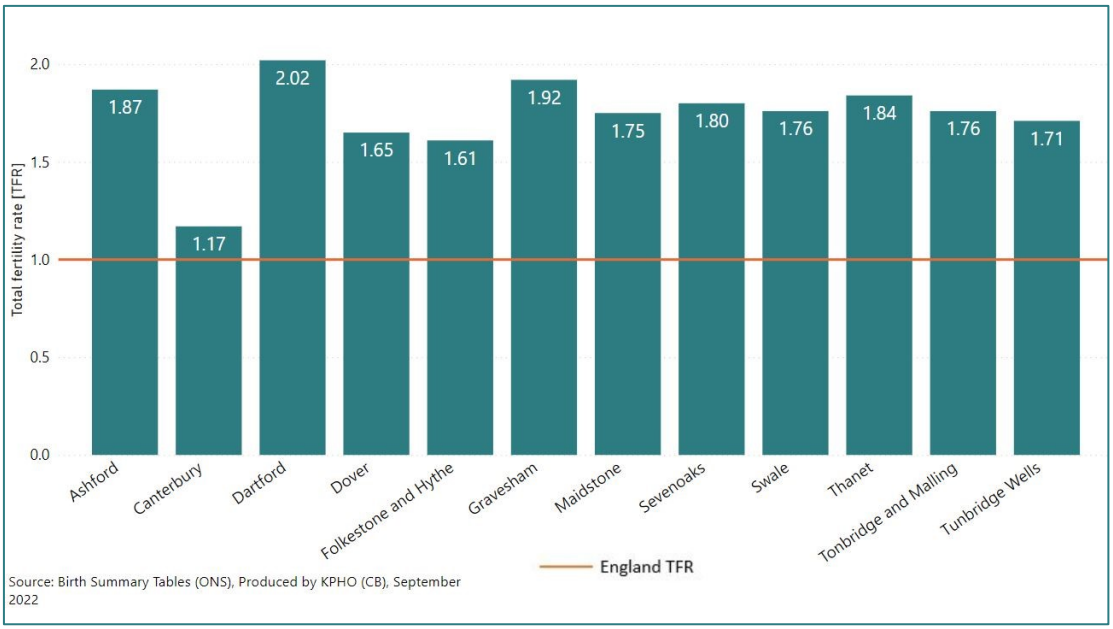
Figure 8: General fertility rate by districts in Kent, 2020



Another way to look at changes in population growth is to explore the total period fertility rate [TFR]. The TFR is the average number of children a woman would have if she experienced current age-specific fertility rates for the calendar year referred to throughout her reproductive life span.

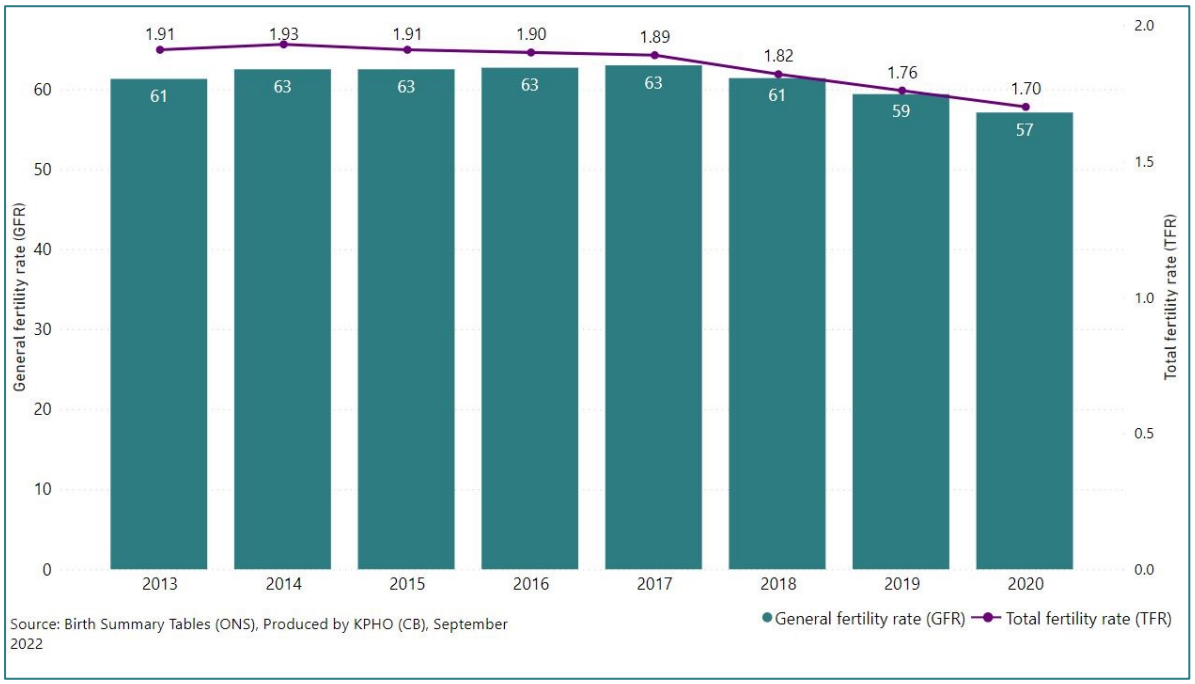
The TFR for England was 1.59 children per woman in 2020, decreasing from 1.66 children per woman in 2019. For Kent the TFR was 1.74, well above the England average. Dartford had the highest TFR, 2.02, and Canterbury had the lowest, 1.17. Canterbury has a large student population which will skew their figures. The higher TFR seen in Kent may be related to changing demographics such as increases in migration.

Figure 9: Total fertility rate [TFR] by district in Kent, 2020



The figure below shows the relationship between the TFR and GFR over the last seven years in Kent, which are steadily declining, but remain consistently higher than the England and Wales averages.

Figure 10: Birth rates in Kent, 2013 to 2020



5.1.1 Infant mortality

Infant mortality is a good indicator of general population health. The crude rate of infant deaths in Kent has been similar to the national average of 3.9 per 1,000 live births over the timeframe presented below.

Table 3: Crude rate of infant deaths in those aged under one year per 1,000 live births, Kent and England 2014/16- 2018/20

Region	2014/16	2015/17	2016/18	2017/19	2018/20
	Rate (95% CI)	Rate (95% CI)	Rate (95% CI)	Rate (95% CI)	Rate (95% CI)
Kent	3.5 (3.0–4.0)	3.9 (3.3–4.4)	4.0 (3.4–4.5)	3.9 (3.4–4.5)	3.7 (3.1–4.2)
England	3.9 (3.8–4.0)	3.9 (3.8–4.0)	3.9 (3.8–4.0)	3.9 (3.9–4.0)	3.9 (3.8–4.0)

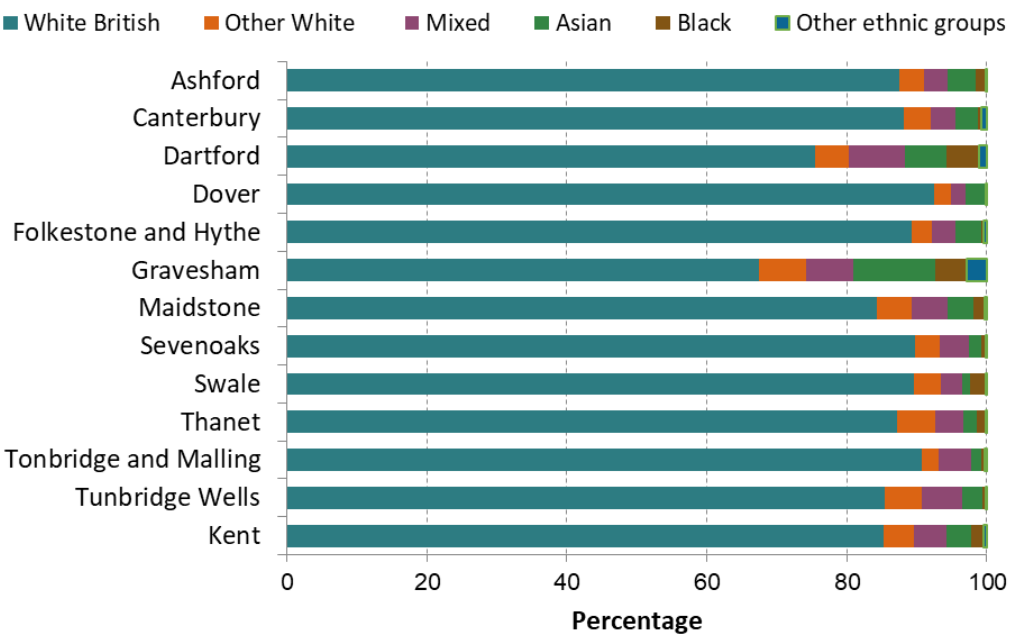
Source: Fingertips PHE

5.1.2 Ethnicity

Ethnicity varies across the districts in Kent. Gravesham and Dartford have the highest proportion of different ethnic profiles. Approximately a third of the 0-4 year old population in Gravesham and a quarter of Dartford district are not White British. This highlights the

importance of providing health information and advice in multiple languages, as well as acknowledging the increased likelihood of inequalities, inequities, and presence of barriers to health services in these areas. The proportion of white other is an increasing ethnic group and not necessarily born in Kent.

Figure 11: Estimated broad ethnic group populations for children aged 0-4 by district in Kent, 2019*



Source: Population denominators by broad ethnic group and for White British, local authorities in England and Wales: 2011 to 2019, ONS, prepared by KPHO(SR / CB), June 2022

*Note: As these are estimates based on the 2011 census there are some caveats to the data, such as becoming less reliable the further they are from 2011, and caution with small population subgroups for local authorities.

The most recent national report on perinatal surveillance for births from January to December 2019 (55) identified that:

- Mortality rates remain exceptionally high for babies of Black and Black British ethnicity: stillbirth rates are over twice those for babies of White ethnicity and neonatal mortality rates are 43% higher.
- Similarly, mortality rates remain high for babies of Asian and Asian British ethnicity: stillbirth and neonatal mortality rates are both around 60% higher than for babies of White ethnicity.
- Despite the reduction in both stillbirth and neonatal mortality rates over time across most groups, these reductions have not been the same across all ethnicities. As a

result, there has been a small increase in the ratio of stillbirth rates for babies of Black or Black British ethnicity compared to babies of White ethnicity.

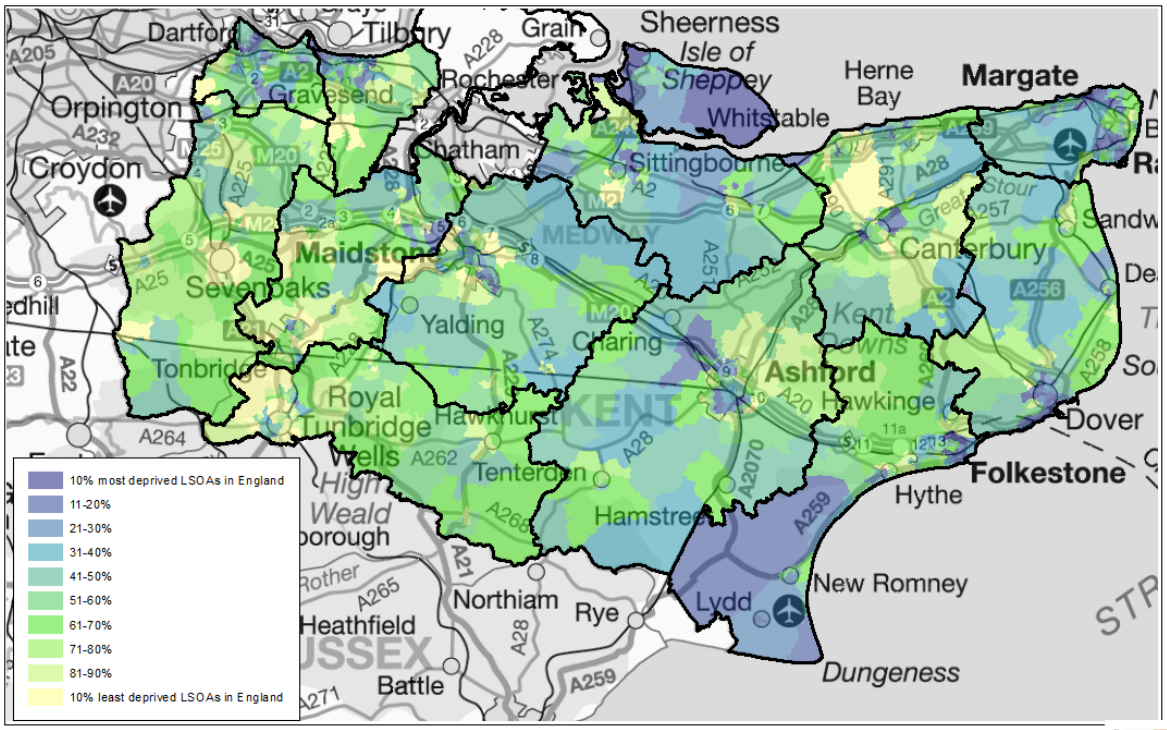
5.2 Social determinants of health

5.2.1 Poverty and deprivation

This section highlights the different experiences of and outcomes for children under 5 years of age who live across Kent, and where the impact of social determinants are most apparent. Despite Kent's affluence, it has areas with significant deprivation such as Thanet and Swale. These districts have over 30% of their wards within the top 10% of most deprived wards in the country (2019). (56)

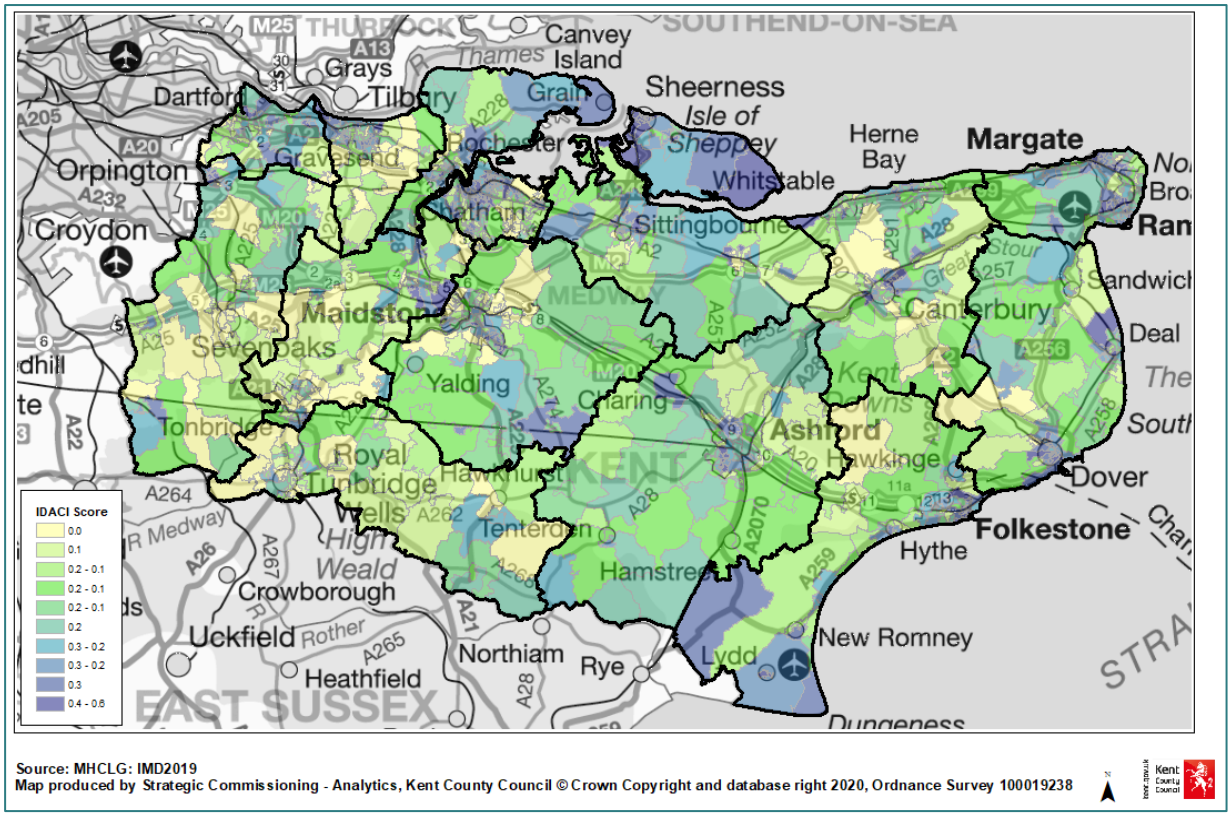
In 2019, Kent had an income deprivation affecting children index score (IDACI) of 0.158, [15.8%] amongst children aged 0-15 years compared to the England average IDACI of 0.171 [17.1%]. (57) This indicator is a measure of child poverty.

Figure 12: Overall IMD 2019: National rank of LSOAs, Kent



Source: The English Indices of Deprivation 2019 (IoD2019): The Ministry of Housing, Communities & Local Government (MHCLG)
Map produced by Strategic Commissioning - Analytics, Kent County Council © Crown Copyright and database right 2019, Ordnance Survey 100019238

Figure 13: Income deprivation affecting children, Kent 2019



According to the Income Deprivation Affecting Children Index, all of the top 20 most deprived areas in Kent are in coastal areas. Cliftonville West in Thanet is the 5th most deprived in the country for the IMD 2019 indicator, measuring children and young people's education, skills and training. (57)

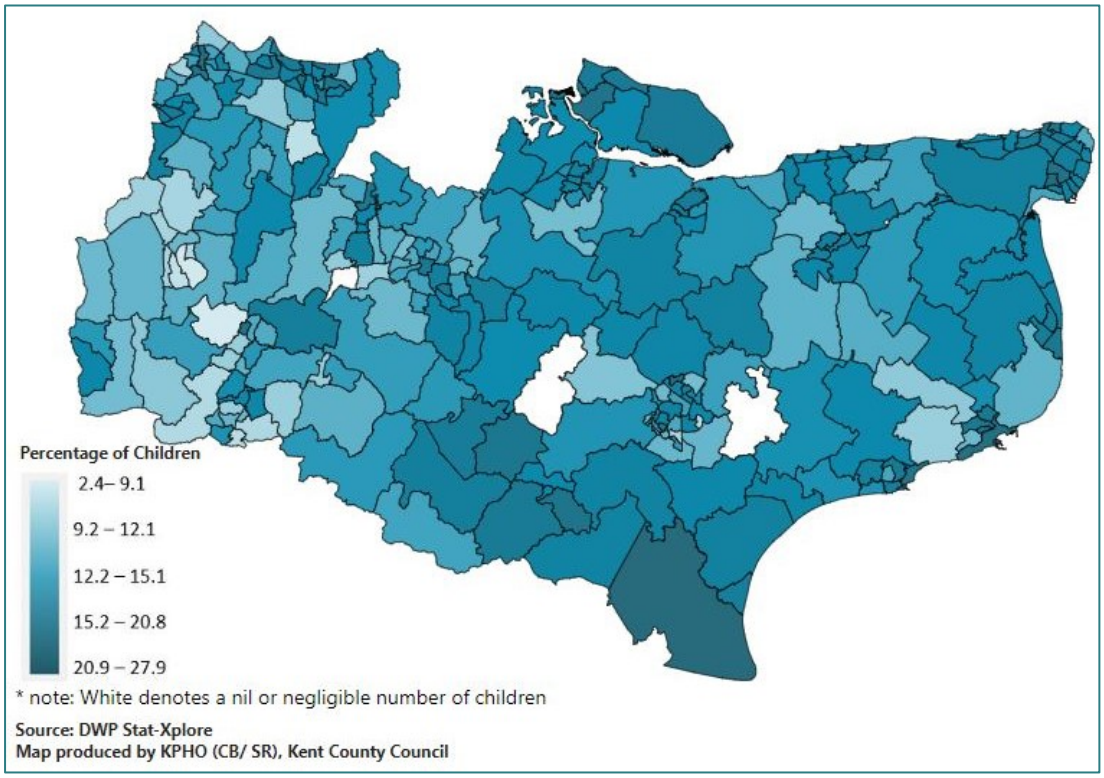
Children **born into poverty** are more likely to suffer from greater health and social inequalities and experience a wide range of health problems including poor nutrition, chronic disease, and mental health issues. Poverty has a significant impact on children's life chances.

Children **living in poverty** are more likely to: die in the first year of life, breathe secondhand smoke, be bottle fed, become overweight, suffer from asthma, have tooth decay, perform poorly at school, and die in an accident.

Whilst there is no single definitive measure of child poverty, The Child in Poverty Bulletin (April 2022) looks at several measures. The children in low-income families [CiLIF] statistics provide information on the number and proportion of children living in Relative and Absolute low income before Housing Costs by local area across Great Britain. The CiLIF measure looks at the number of children in families (not households), where the income is less than 60% of median income before housing costs in both absolute and relative terms which makes it difficult for them to meet their basic needs. For both measures a family must have claimed one or more of Universal Credit, Tax Credits or Housing Benefit at any point in the year to be classed as low income in these statistics. (58)

Absolute low income is defined as a family in low income before housing costs in the reference year, in comparison with incomes in 2010/11. (58)

Figure 14: Proportion of children aged 0-4 years living in absolute low-income families by ward in Kent, 2020/21



In 2020/21 in Kent 14.3% of all children aged 0-4 years were living in absolute low-income families. This is below the national average of 15.1%. Districts with the highest proportion of all children aged 0-4 years old in low-income families include Thanet (18.7%), Folkestone and Hythe (17.9%), Gravesham (17.7%), Dover (16.9%) and Swale (16.5%). Tunbridge Wells (10%) and Sevenoaks (10.5%) have the lowest proportion of all children aged 0-4 years living in absolute low-income families. The number of children aged 0-4 years living in absolute low-income families fell in all Kent local authorities in 2020/21 compared to 2019/20. (58)

Relative low income is defined as a family in low income before housing costs in the reference year. (58)

In 2020/21 in Kent 17.3% of all children aged 0-4 years were living in relative low-income families. This is below the national average of 18.1%. Districts with the highest proportion of all children aged 0-4 years old in relative low-income families include Thanet (23.6%), Folkestone and Hythe (21.3%), Gravesham (21.1%), Dover (21.1%) and Swale (20%). Sevenoaks (11.9%) had the lowest proportion of all children aged 0-4 years living in relative low-income families. (58)

In 2020/21, Canterbury, Dover, Gravesham, Maidstone, Swale and Tunbridge Wells, had a higher proportion of 0–4-year-olds who lived in relative low-income households than the

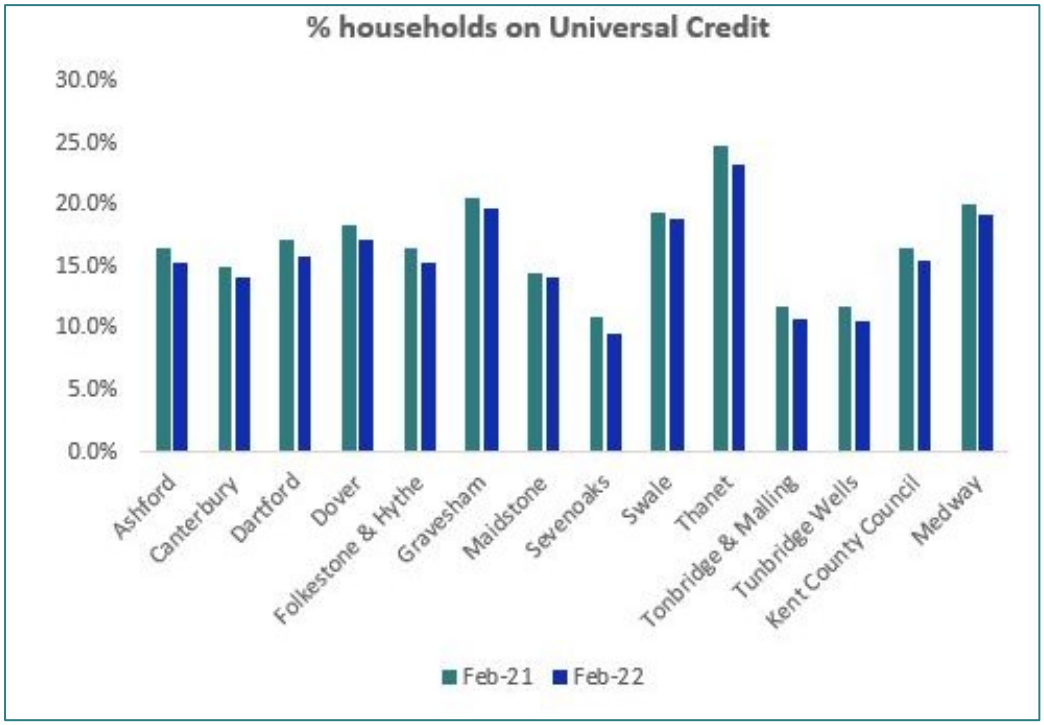
older age groups. Thanet has the highest proportion of children living in relative low-income families. Almost a quarter of 0–4-year-olds in Thanet live in relative low-income families. The number of children aged 0-4 years living in relative low-income families fell in 2020/21 compared to 2019/20, in all Kent local authorities, except for Tonbridge and Malling. Thanet saw the biggest reduction with 303 fewer 0–4-year-olds living in relative low-income households than in 2019/20. (58)

Although not specific to the lives of children under 5 years of age, it was estimated that in 2020 5.7% of households with dependent children had no adult in work, up from 4.6% the year before. An estimated 23,000 children were living in workless households in 2020. This equates to 6.4% of all children. (58)

This is partly illustrated through presentation of the changes observed in the unemployment rate across the districts in two time periods during the last two years. A consequence of the measures put in place to manage Covid 19, including the introduction of furlough and for some subsequent job loss or the closing of businesses may have led to changes in opportunities for short term employment and management of childcare as these may have been dependent on family or other infrastructures.

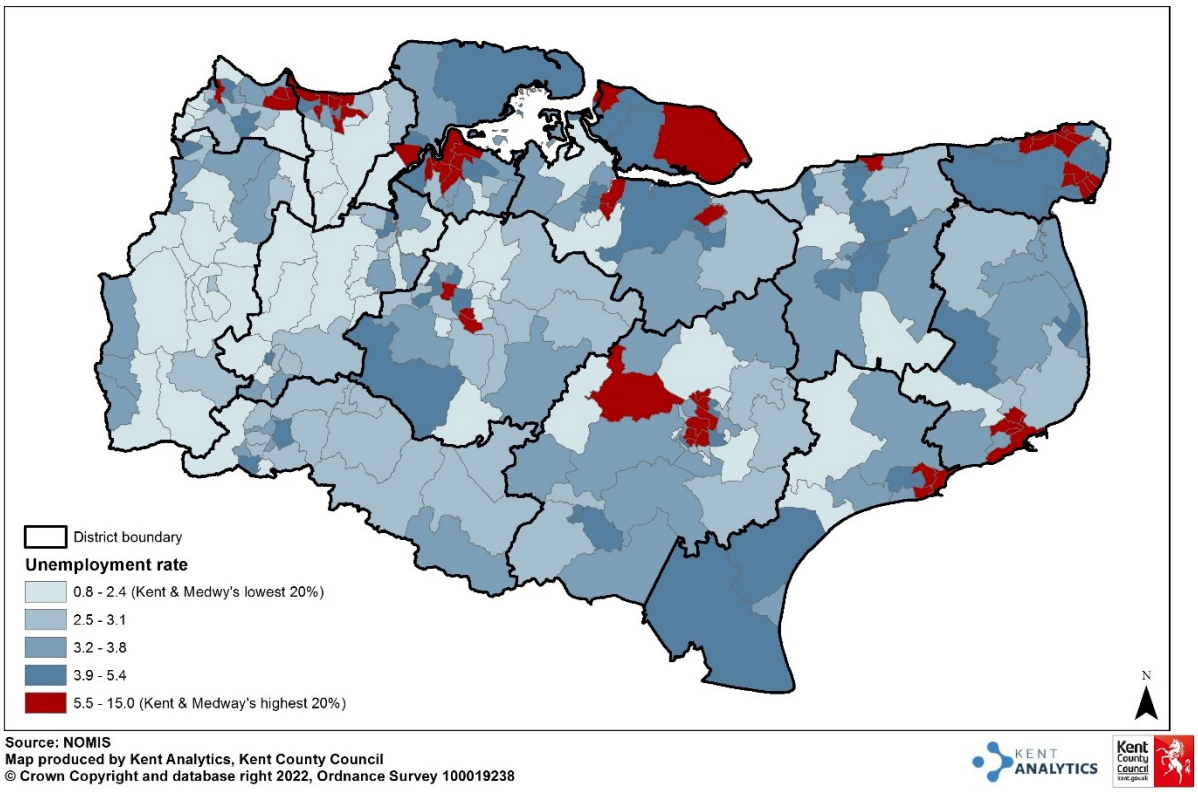
Universal credit is a payment to help with living costs for those who are on low income or unemployed. To be eligible to claim, you must live in the UK, be aged 18 or over, under the state pension age and have £16,000 or less in savings. You can claim if you live with your partner, are in full time education and if you are responsible for a child either as a single person or couple (59)

Figure 15: Percentage of households on universal credit, by district in Kent, February 2021, and February 2022



Source: financial hardship toolkit Version date: 18/05/2022

Figure 16: Unemployment rates of 18-64 year olds by wards in Kent, November 2021



Source: NOMIS, Produced by Kent Analytics, KCC

The different measures presented in this section have illustrated the levels of poverty across the county and highlighted Thanet district.

5.2.2 Healthy start programme

The national Healthy Start scheme offers vitamins and food vouchers that can be used to buy healthy foods. Pregnant women from 10 weeks' gestation or parents of a child under 4 years may be entitled to get help to buy healthy food such as:

- Plain liquid cow's milk
- Fresh, frozen and tinned fruit and vegetables
- Fresh, dried and tinned pulses
- Infant formula milk based on cow's milk

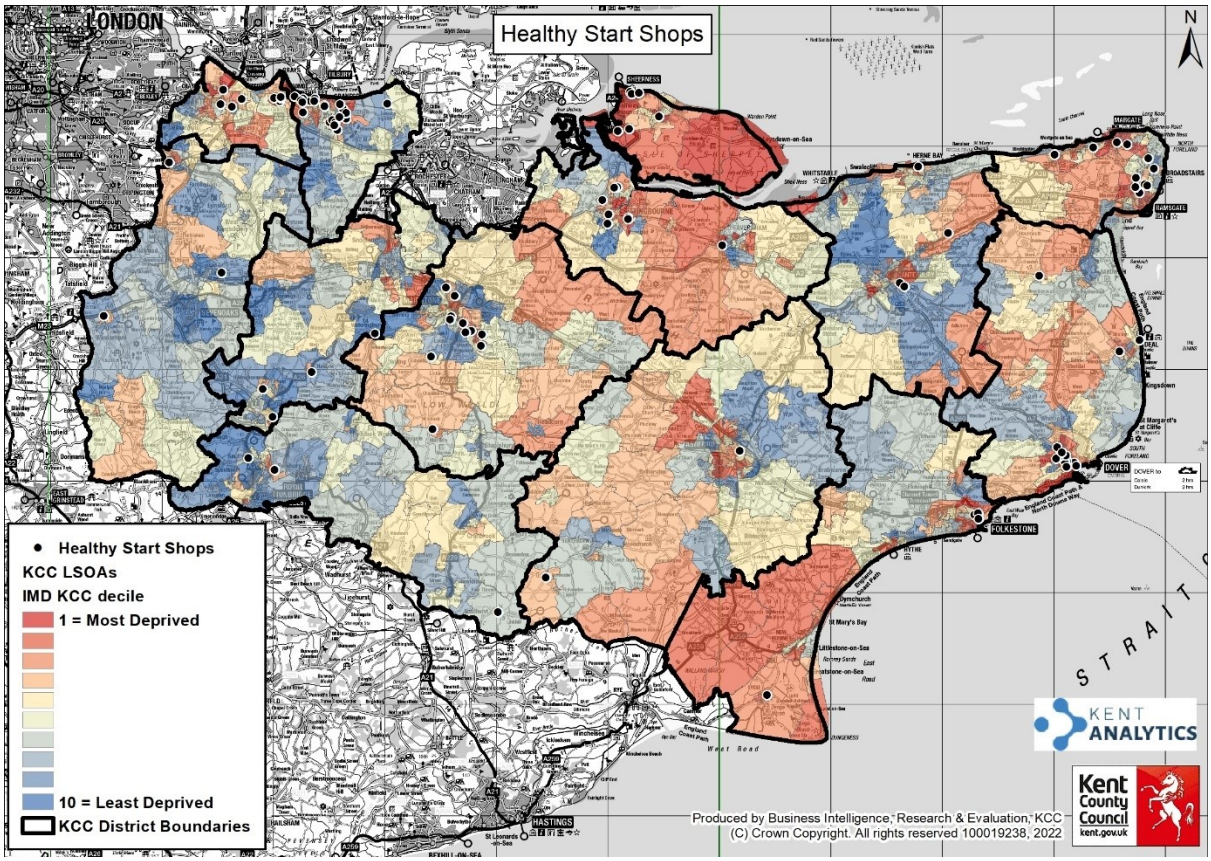
In addition, there is opportunity to access:

- Healthy start vitamins to support during pregnancy and breastfeeding
- Vitamin drops for babies and young children- from birth to 4 years old. (60)

5.2.3 Access and uptake of the Healthy start voucher

The limitation in access to retailers who accept healthy start vouchers has most likely been impacting on the take up and use of this programme in Kent. Individuals can register online to be in receipt of the programme and if they are eligible in terms of age, [under 18 years] or are in receipt of benefits, for example universal credit, they will have access to the programme.

Figure 17: Locations to utilise healthy start voucher by deprivation decile Kent 2021



The healthy start programme is currently transitioning into a digital model which will provide opportunity to utilise a pre-paid MasterCard rather than paper vouchers.

The programme which provides payment towards food and milk as well as access to vitamins for pregnant women and infants under 4 years of age will, under the digital offer, be acceptable at any retailer who has the correct merchant category code (used to classify a business by the types of goods or services it provides). This will help break the barrier to access by stopping the need for retailers to register to accept the paper vouchers.

5.2.4 Food Banks

The Trussell Trust provides emergency food and support to people locked in poverty, while also campaigning for change to end the need for food banks in the future. They support a network of food banks across the UK. Each provides emergency food to people in crisis, and additional support to help tackle the root causes that sweep people into poverty and build people's resilience, so they are less likely to need a food bank in the future. (61) In Kent, The Trussell Trust have distribution centres in 7 districts and most have multiple distribution centres in Dover, Folkestone and Hythe, Gravesham, Sevenoaks, Tunbridge Wells and Tonbridge and Malling. District councils, churches, schools, companies, pubs, and other food outlets have contributed to help support families in greatest need to receive food parcels and meals during the pandemic. Service providers working with families make referrals to access food banks.

There is currently work being undertaken by Policy in Practice who have created a dashboard for all districts in Kent. The dashboard consolidates information from benefits, council tax support, worklessness and poverty and housing affordability. Not all elements of the dashboard are fully functioning, yet and some district data has yet to be published, however this could be informative going forward.

5.2.5 Food insecurity

Food insecurity has been linked to several adverse medical and psychosocial outcomes, including obesity. Food security is achieved when 'all members of a household have access to adequate food at all times for a healthy, active lifestyle'. A UNICEF report in 2017 estimated that 10% of children in the UK lived in households affected by severe food insecurity. Children from food insecure households are more likely to eat past satiation. (62)

A YouGov poll commissioned by the Food Foundation found that 2.4 million (17%) children are living in food insecure households, and two million (14%) children have received smaller portions, a reduced number of meals and/or low-cost, less nutritious meals because their parents have run out of food. Households struggling to access enough food has meant more than 350,000 (2%) children have had times when they've not eaten enough, because there wasn't enough food since lockdown started. (63)

Food insecurity driven by isolation and economic hardship in households with children has doubled since lockdown (5.7%-11%), with parents in 2.8 million (37%) households with children reporting a loss of income. (62)

There are three main health effects of food poverty in children:

- Food insecure children are at increased risk of growing up to be obese adults. Obesity carries with it serious health risks, including heart disease, arthritic problems, cancer, and most recently, COVID-19 complications.
- Obese children will grow up with behavioural effects that are likely to make it harder for them to lose weight, because they've had this experience of food scarcity and a sense of not having enough to eat.
- These children are also at increased of dental decay. While we do not tend to worry about this condition, it has a pernicious effect on children living in poverty. If the permanent teeth are damaged in childhood, children will spend the rest of their lives with dental damage and pain. (64)

Chapter 5 key findings

Population: Between mid-2018 and 2028, the total population of Kent is estimated to increase by 7.6% (compared to 5.0% in England). The largest increase over the 10 year period is expected in Dartford (15.5% = 17,000 people). Overall, the GFR in Kent and England has reduced since 2016. In 2020, Dartford had the highest GFR of Kent districts at 71.9, higher than the England average 55.3. For Kent in 2020 the TFR was 1.74, well above the England average. Dartford had the highest TFR, 2.02.

Ethnicity: Ethnicity varies across the districts in Kent. Approximately a third of Gravesham's population and a quarter of Dartford's population are not White British. Mortality rates remain exceptionally high for babies of Black and Black British ethnicity: stillbirth rates are over twice those for babies of White ethnicity and neonatal mortality rates are 43% higher. Similarly, mortality rates remain high for babies of Asian and Asian British ethnicity: stillbirth and neonatal mortality rates are both around 60% higher than for babies of White ethnicity. Despite the reduction in both stillbirth and neonatal mortality rates over time across most groups, these reductions have not been the same across all ethnicities. As a result, there has been a small increase in the ratio of stillbirth rates for babies of Black or Black British ethnicity compared to babies of White ethnicity.

Social determinants of health: Social determinants of health: Social determinants of health: Kent has an IDACI score of 0.158, amongst children aged 0-15, compared to the national average which is 0.171. According to IDACI, all the top 20 most deprived areas in Kent are in coastal areas. Thanet, Folkestone and Hythe, Gravesham, Dover, and Swale districts have the highest proportion of all children aged 0-4 years old living in absolute low-income families and the proportion of all children aged 0-4 years old living in relative low-income families. Almost a quarter of children aged 0-4 years in Thanet are living in relative low-income families.

In summary, this chapter has reiterated and demonstrated the stark inequalities experienced from those children under 5 years old living in poverty and deprivation. This is a running theme through the health needs assessment as seen in uptake of different service provision, service need and health outcomes. There needs to be acknowledgement that proportionate universalism is required, whilst targeting where need is greatest. As highlighted in the Marmot review, disadvantage starts before birth.

6. Supporting the preschool population to thrive

'Disparities in child development are recognisable in the second year of life and have an impact by the time children enter school. If left unsupported, these children are more likely to fail to achieve their full potential.' (65)

6.1 Health visiting

The health visiting universal offer includes around 71,000 mandated developmental reviews per annum. This includes an antenatal, new birth, 6 to 8-week, 1 year and a 2-2½ year health and wellbeing reviews. The HCP's universal reach provides an invaluable opportunity to identify families that are in need of additional support and safeguarding concerns. There has been increased identification in the need for mental health support for pregnant and post-natal women and their partners over the last two years. Poor mental health in parents/carers can reduce their capacity to attach with and nurture their child. If the parent[s] are left unsupported, there will be an impact on the health of the infant, as the ways infants develop and build relationships is important to brain development. In turn these impact on emotional, social, intellectual, and psychological development.

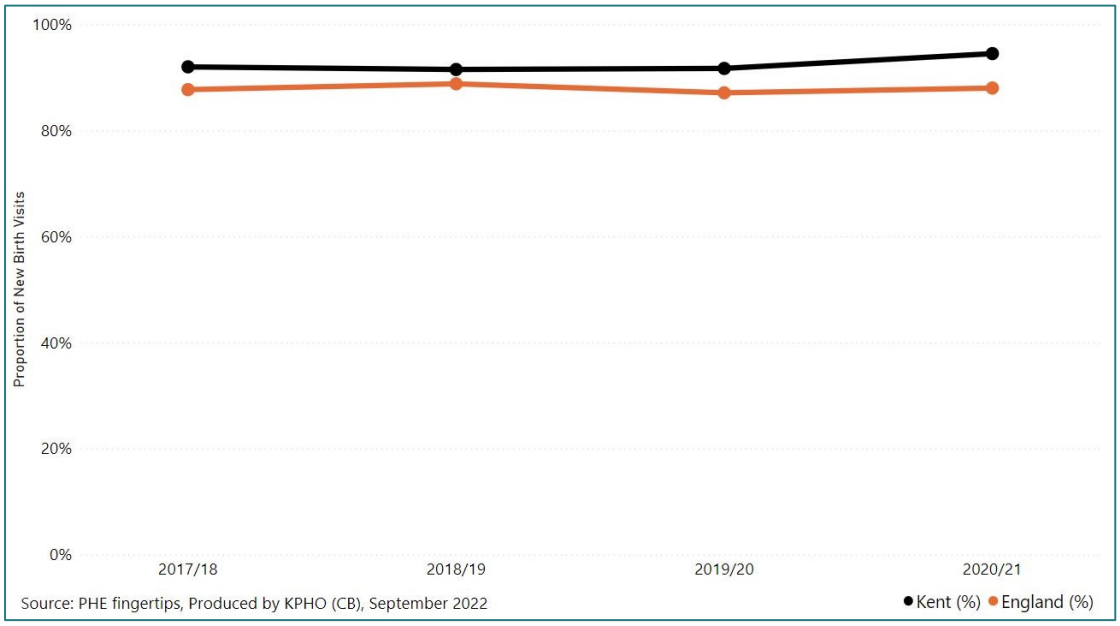
6.1.1 Antenatal health and wellbeing review

The Health Visiting Service make contact with families from 28 weeks of pregnancy. An antenatal health promoting contact delivers a comprehensive and holistic assessment of the family's needs (38). The prevalence of antenatal visits has varied by year. The variance has been influenced by local action and prioritisation plans, as well as national guidance. For example, from quarter 3 2018/19 in Kent, prioritisation of face to face contacts were given to first time mothers and vulnerable families and contact with universal families was made via an introduction letter, in line with the local service business continuity plans.

6.1.2 New birth visit

The new birth health and development review ideally takes place within 10 to 14 days of the birth. The proportion of new birth contacts completed within 14 days in Kent has been higher than the England aggregate since 2017/18. There was an increase of around 2.5% in 2020/21, when compared to previous years, to 94.5%.

Figure 18: Proportion of New Birth Visits (NBVs) completed within 14 days, Kent and England[1], 2017/18 to 2020/21



6.1.3 Six - eight week health and wellbeing review

The 6-8 week review includes an assessment of progress from birth to 8 weeks. The table below shows the proportion of infants who received a 6-8 week review by the time they were 8 weeks old in Kent. The proportion has been higher in Kent compared to the England aggregate for each of the four years presented.

Table 4: Proportion and number of infants who received a 6-8 week review by the time they were 8 weeks old, Kent, 2017/18 to 2020/21

Years	Numbers	Proportion
2017/18	15,836	90.4%
2018/19	14,785	87.9%
2019/20	14,732	89.2%
2020/21	14,317	90.3%

Source: PHE fingertips

[1] Aggregate value of local authorities passing Stage 1 validation.

6.1.4 One year health and wellbeing review

The Health Visiting Service carry out the 12 month health and development review between 9 and 15 months. The ages and stages questionnaire is used to support the developmental review in line with best practice. The table below shows that the prevalence of the 12 month review by 15 months in Kent has been consistent at around 87% since 2017/18. The proportion has been higher in Kent compared to the England aggregate for each of the four years presented.

Table 5: Proportion and number of infants who received a 9-12 month review before 15 months of age, Kent, 2017/18 to 2020/21

Years	Numbers	Proportion
2017/18	15,018	87.5%
2018/19	15,445	86.9%
2019/20	15,425	87.7%
2020/21	14,845	87.4%

Source: PHE fingertips

6.1.5 Two to two and a half year health and wellbeing review

The 2 to 2.5 years contact includes a holistic review of child health, development, and growth, to identify children who are not developing as expected and/or in need of additional support. The use of the ASQ-3 and ASQ:SE2 tool is mandated for the developmental review. The table below shows the proportion of children who received a 2-2½ year review by the time they turned 2½ years old, in Kent.

Table 6: Proportion and number of infants who received a 2- 2 ½ year review, Kent, 2017/18 to 2020/21

Years	Numbers	Proportion
2017/18	14,319	82.8%
2018/19	14,417	80.6%
2019/20	14,835	82.6%
2020/21	13,962	78.3%

Source: PHE fingertips

6.1.6 Child development outcomes at 2 to 2 and a half years

It is mandated that a recognised tool for the developmental review is used at 2 to 2 and a half year review. The Ages and Stages questionnaires (ASQ), ASQ-3 is to be used at 2–2½ year developmental reviews. (66)

The ASQ-3 is not a screening tool, but it does provide an objective measure of development at a population level. It allows comparisons to be made which help to identify children who are not developing as expected and supports decisions on closer monitoring of progress or targeting of services. (67)

ASQ-3 questionnaires are completed by parents and cover five domains of child development: communication, gross motor skills, fine motor skills, problem solving and personal-social development, to monitor child development.

In 2020/21, 77.9% of children in Kent aged 2-2½ years were at or above the expected level of development in all five areas of development (communication, gross motor, fine motor, problem-solving and personal-social skills). This is lower than the England average as it had been for the preceding two years. However, it is noted that there are concerns about the quality of the data for the indicators regarding child development at 2-2.5 years, due to an 'unspecified reason' and that these statistics should be interpreted with extreme caution.

6.1.7 Duty Line

The Health Visiting Service provide the duty line, from 9am and 5pm between Monday and Friday. Each district has a duty line, to provide advice to families including Infant feeding support, triage issues, instigate appropriate follow up and signpost to other organisations. Professionals can also use the duty line to contact the service.

KCC and Kent Community Health NHS Foundation Trust are looking at a range of digital solutions to reduce demand on the duty lines, to provide choice for parents and reduce wait times for a response to simpler queries.

6.1.8 Workforce

The latest annual institute of health visiting [iHV] Health Visiting survey, completed in Autumn 2021, reported that health visitors have seen widening health inequalities with an increase in vulnerability and safeguarding risks. The survey also reported that there are not enough health visitors to meet the rising level of need. The survey found that, 49% of health visitors in England have a caseload of over 500 children per FTE, the recommended ratio of 250 children aged 0-5, or less, per full time equivalent health visitor (68). This is in line with local stakeholder feedback, in which one stakeholder noted health visiting caseloads are over the recommended caseload numbers at around 570 families.

> 'We don't get to do what we were trained to do: help families reach their potential'

Source: Stakeholder interviews

Nationally, a steady decline in the number of health visitors since 2015 has been reported, largely due to qualified nurses retiring and moving to other roles, and insufficient trainees entering the profession (69). In 2021, The Institute of Health Visiting called for an additional 5,000 health visitors with the specialist community public health nursing (SCPHN) skills to support families and their 'escalating' levels of need and vulnerability (33).

In the context of limited resources, it has been noted that "a balance is needed between providing universal services to all children while also focusing additional resources on the most vulnerable children and marginalised groups" (69). In response to these challenges, some areas have implemented new delivery models and staffing arrangements. In Kent over recent years, a skill mix has been introduced to the workforce and the Family Partnership Programme has been implemented in place of the Family Nurse Partnership model.

6.2 Speech, language, and communication

The first years of life are vital in giving every child the best start, with speech, language, and communication (SLC) skills an important indicator of child wellbeing (see appendix 5). These skills shape a child's ability to learn, develop friendships and their future life chances.

Every child, regardless of circumstance should be able to develop and thrive. There is increasing concern about the numbers of children starting school with poor speech, language, and communication skills, with unacceptable differences in outcomes in different areas of the country. Inequalities in early language development are recognisable in the second year of life and have an impact by the time children enter school. (70)

In Kent, stakeholders have reported that SLC referrals have doubled for children under 5 years old in multiple areas across the county, including Canterbury, Dartford, Gravesham, Thanet, and Swale districts. SLC referrals include speech and language therapy, which provides treatment, support and care for children and young people who have difficulties with communication, or with eating, drinking, and swallowing.

The ability to communicate is fundamental to all of us. It is a set of skills that starts early in life and continues across the life course. Whilst we each develop at a different pace, there are key milestones in SLC development. When these are not reached, they indicate that additional support may need to be offered to a young child and their carers. Many children do not get this support early enough, leading them to start school with SLC levels behind that of other children. **The Early Years Foundation Stage (EYFS) profile results highlight**

that too many children currently start school with poor communication skills and personal care skills, such as not being toilet trained, and are not emotionally ready to learn, with avoidable national variations.

Table 7: EYFSP attainment in Communication and Language and Literacy Areas of Learning, by sex, in Kent and England 2019

LA code	Region name	Number of children			Percentage achieving the expected level of development in communication & language & literacy			
		All	Girls	Boys	All	Girls	Boys	Gap
E10000016	Kent	17,932	8,766	9,160	74.8	83.1	68.7	11.3
E92000001	England	638,995	311,553	327,442	72.6	79.1	66.4	12.7

Source: www.gov.uk

Approximately 10% of all children have long-term speech, language, and communication needs (SLCN). In some areas of deprivation, more than 50% of children start school with SLCN. Meeting the needs of children, and reducing inequality, requires a system-wide approach as currently needs are frequently unidentified.

The increased awareness of the importance of early language has led to national and local initiatives to ensure that every child is supported to achieve their potential. The pre-school years are an important stage in a child's language development. It ensures foundations are in place for later learning, literacy and forming relationships. Children will learn to communicate, understand, and use language at different rates and stages.

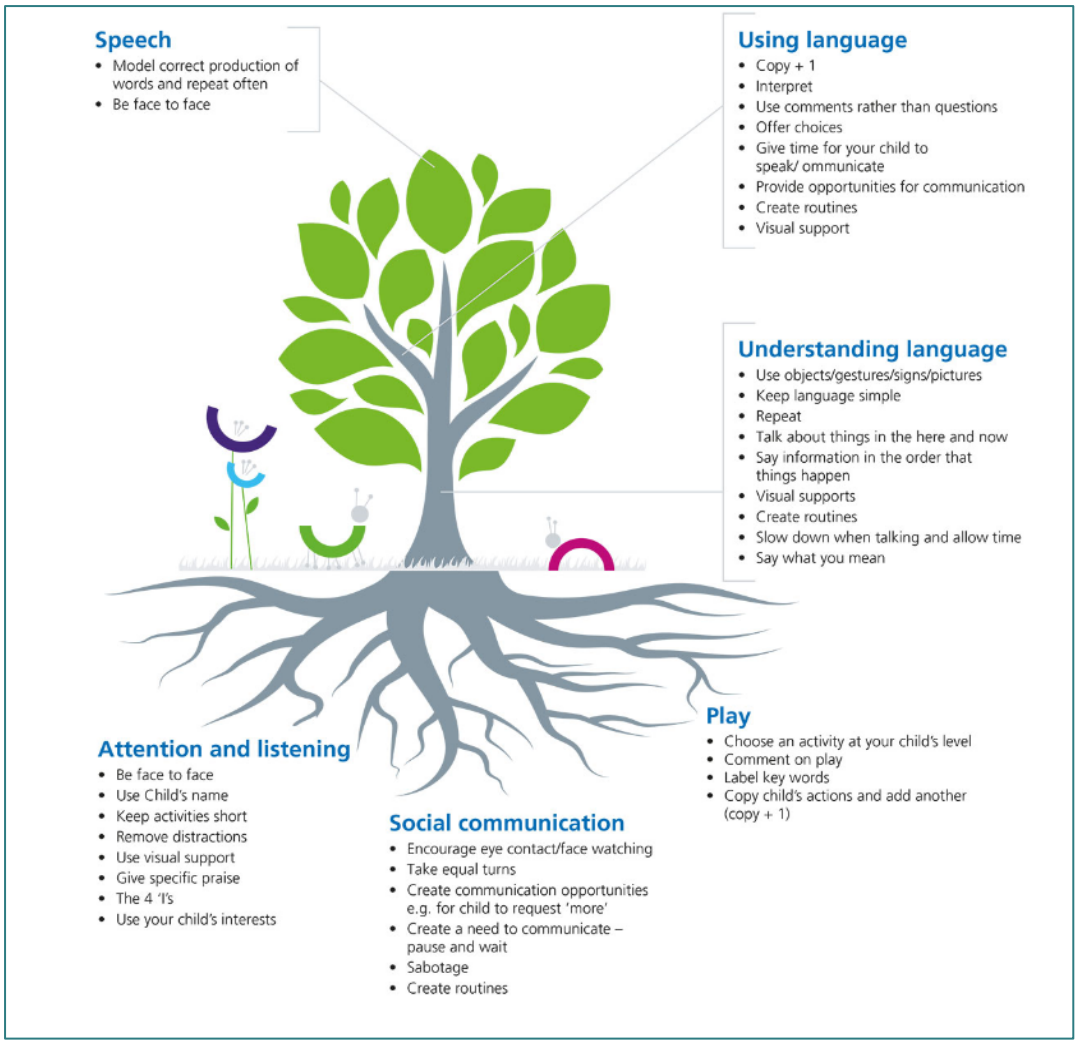
Early Years Providers have voiced that there has been an increase in referrals to LIFT with Specialist Teachers seeing children earlier. Appendix 6 includes data on the referrals to LIFT and Specialist Teaching Service in Kent. They report of an increase from parents making requests for an Education Healthcare Plan (EHCP) with increase in the proportion of children with an EHCP at age 4 years from 1.7% in 2016 – 5.5% in 2018. Providers believe this is due to parental confidence in what the school can provide without an EHCP. Comments in response to the increase in EHCP's from Specialist Teacher and Learning Services included:

- Parents believing that they need an EHCP to access support
- Complex levels of needs of pupils increasing, including attachment issues and Foetal Alcohol Spectrum Disorder (FASD), which are hard to diagnose.
- Higher levels of children with the communication and interaction as their main need type, resulting in increased diagnostic levels for ASD, and higher numbers of requests for statutory assessment.

- Early identification of children at 2 levels or below.

Communication starts in the very early days of a child's life. From looking at others, to communicating their needs through vocalisations such as crying and babbling, to later using words and having conversations. The pre-school years are an important stage in a child's language development. It ensures the foundations are in place for later learning, literacy and forming relationships. Children will learn to communicate, understand, and use language at different rates and stages. There are many different areas and skills that need to develop for a child's language to grow. Parents play a key role in supporting their child's language and communication skills in everyday life. Children learn about the world through their experiences and interests particularly within their play. The evidence highlights the importance of joining children in their play and following their interests, to provide them with opportunities to develop their ability to understand, use words and later sentences.

Figure 19: Key roots and foundation to communication



Source: Kent Community Health NHS Foundation Trust

The figure above highlights the importance of early speech and language development that comes from the roots and through growth to the top of the tree. This includes encouraging eye contact, being face to face with a child to develop social communication, attention and listening which are all important factors to develop. As this becomes established so does the understanding of language, once a child understands words, they are likely to begin to use words. (71)

6.3 Children's centres

The core purpose of children's centres as set out in the statutory guidance for children's centres is to 'improve outcomes for young children and their families, with a particular focus on families in greatest need of support in order to reduce inequalities in: child development and school readiness; parenting aspirations, self-esteem and parenting skills; and child and family health and life chances' (72).

In Kent, Children's Centres are located across Kent as illustrated in the map included in section 3.3 and support is also delivered to families via outreach. Other services deliver and work from children's Centres, including Midwifery, Health Visiting, Early Help Units and Domestic Abuse One Stop Shop Services.

The Evaluation of Children's Centres in England took place from 2009 to 2015 (73), funded by national government. The evaluation identified positive effects, including improvement to family outcomes linked to family engagement with children's centres and service use (74).

Across England there has been considerable variation of approaches for Children's Centres and hubs, including how they have been organised and delivered, as local authorities respond to changes in population need and public funding. This has made it challenging to evaluate their impact (75).

There has been no national evaluation of children's centre approaches since the final Evaluating Children's Centres in England impact report in 2016. Ofsted inspections of children's centres were suspended in September 2015, and there has been no independent inspection since that point (75).

There is no official national data available on the use and reach of children's centres. However, Action for Children undertook a survey of 152 local authorities in 2019 (76). From the survey findings Action for Children estimated that the number of children using a children centre in England fell by almost a fifth between 2014/15 and 2017/18. It found that the majority of children using children's centres are in their pre-school years. It estimated that the proportion of children aged 5 years and under using a children's centre dropped from 50% to 41%, between 2014/15 and 2017/18. A reduction in visits to children's centres amongst the under 5-year-olds is replicated from 2015 – 2017 in Kent but most markedly in the districts of Swale and Thanet, as shown in the figure below, which would appear inverse to the observed needs of these populations.

The Action for Children report notes the national context, including findings from the Sutton Trust, which identified financial pressures experienced by local authorities being a 'principal driver' for changes (77). These changes included centre closures, reduced opening hours and the reduced or restricted number of open access services offered by centres, with a greater focus on more targeted work, resulting in centres gradually reaching fewer children and a smaller percentage of the total population (76).

Between 2017 and 2019, the number of children registered **at any setting in Kent** were highest in 2017 and decreased in 2018 and 2019[1]. Over the 3 year period, the number of children registered at any setting were lowest in Folkstone and Hythe and Dover districts. Presentation through calculation of the rates provides comparable information for 2019 as shown in the next table which is the most recent data available for this type of analysis.

Table 8: Crude rate of registered or active at any setting per 1,000 0-4 year old population by district 2019

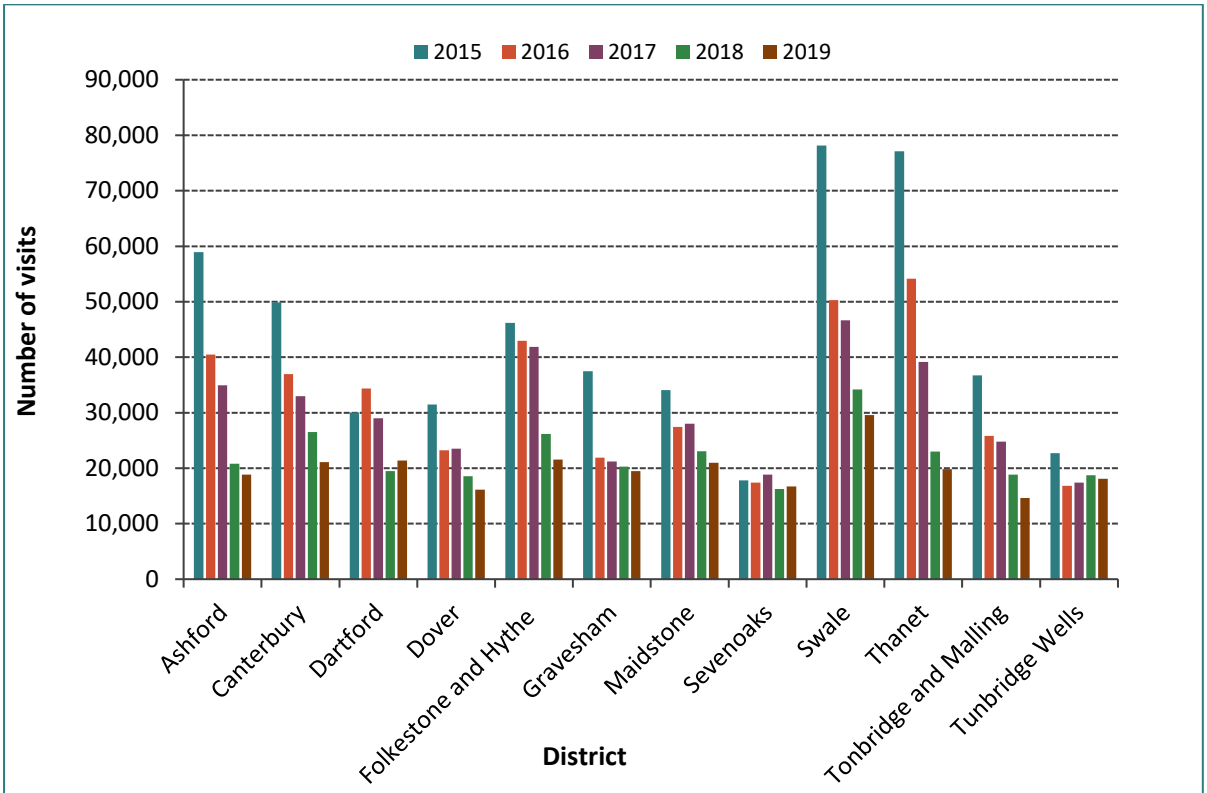
Districts	0-4 population 2019	Number of children registered or active at any setting	Rate per 1,000 0-4 population registered or active at any setting	Rank
Ashford	7,924	1,255	158.3	7
Canterbury	7,232	1,175	162.4	6
Dartford	8,349	1,569	187.9	1
Dover	5,934	850	143.2	11
Folkestone & Hythe	5,378	757	140.0	12
Gravesham	7,088	1,316	186.0	2
Maidstone	10,694	1,765	164.8	5
Sevenoaks	6,978	1,255	179.8	3
Swale	9,188	1,538	167.3	4
Thanet	7,877	1,155	146.6	10
Tonbridge & Malling	7,882	1,182	149.9	9
Tunbridge wells	6,388	971	152.0	8

Source: Management Information, Children, Young People & Education, KCC

The total number of visits of children aged 0 to 4 years old seen in Kent[2] to any children centre setting between 2015 and 2019 has reduced each year from 2015. Over the 5 year period the total number of visits were highest in Swale and Thanet, but these districts have seen the most significant reduction in the number of visits from 2015 to 2019. There may be

different interpretations as to why this change took place including provision of more focus on targeted work for vulnerable families, which may be recorded separately. However, data to evidence this level of interpretation was not accessed or reviewed by the authors for inclusion in this assessment.

Figure 20: Total Number of Visits to any Children's Centre Setting, 0–4-year-old population, by district, 2015 -2019



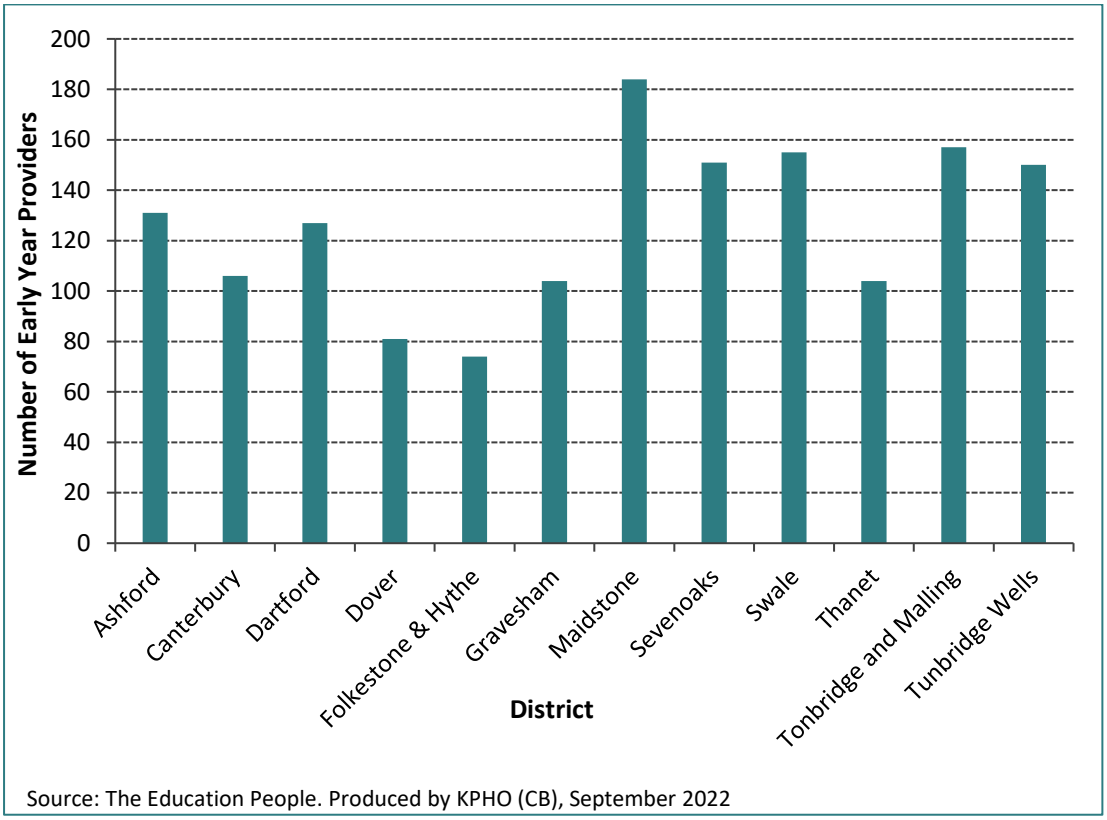
Source: Management Information, Children, Young People & Education, KCC. Produced by KPHO (CB), September 2022

6.4 Early Years Education

"*An essential part of reducing the number of children who are vulnerable to poorer outcomes is investing in early years and early intervention support... Interventions should focus on supporting positive, nurturing relationships, reducing the sources of stress in a child's life, promoting resilient and stable families, and taking into account the social determinants that impact on families*". (28) [7:2020]

There is a large body of research that supports the positive impact on children's outcomes when they attend high quality childcare, especially those from vulnerable backgrounds (78). In Kent, there are around 1,500 childcare providers, this includes childminders, academy, FE college, independent, private school run voluntary and maintained nursery settings.

Figure 21: Number of Early Year Providers by district, Summer Term 2021.



Source: The Education People. Produced by KPHO (CB), September 2022

As reported in the summer term of 2021, the division of childcare providers by provider type across Kent identified: Childminders made up over 50% of all providers, followed by private providers at 27% and voluntary providers at 13%. The prevalence of provider type varied by district, for example in Gravesham 60% of providers were childminders, 17% private and 12% voluntary providers. Whereas, in Dover district 35% of providers were childminders, 41% private and 21% voluntary providers.

6.4.1 Funding

In England, there are three government-funded 'supply-side' early education schemes that offer free childcare for children aged two, three and four years old.

Two year olds who meet the Government's eligibility criteria can receive up to 15 hours of free childcare per week for 38 weeks of the year, (up to 570 hours). In Kent, the national funding scheme is called 'Free for 2'. Families who are eligible can apply online or speak with their local children centre or preferred childcare provider who can help apply (79).

All 3 and 4 year olds can have up to 15 hours of free childcare a week for 38 weeks of the year, known as Free Early Education (FEE), a total of 570 hours per year. This is a national scheme every child in England is entitled to. There is no application process for the funding (79).

Eligible working families with 3 and 4 year olds can receive up to 30 hours of free childcare a week. This is an extra 15 hours of free childcare, in addition to the universal entitlement and

is known as Extended Free Entitlement (EFE). This equates to a total of 1,140 hours per year. To receive the additional hours, families need to sign up online to get an eligibility code. Families need to reconfirm their eligibility every 3 months. (79)

The following two figures show the supply of places, take up of places and percentage take-up over supply of the free for 2 funding (two-year-old free entitlement) in Kent, between the Autumn 2018 and Summer 2021 term.

The supply of places are based on what the childcare providers advised they would be able to accept with regards to free for 2 places, in the term concerned. Places are not left vacant or held for free for 2 children but would be taken up by other children requiring a place. Take up of places includes the number of children who have taken a free for 2 places in Kent.

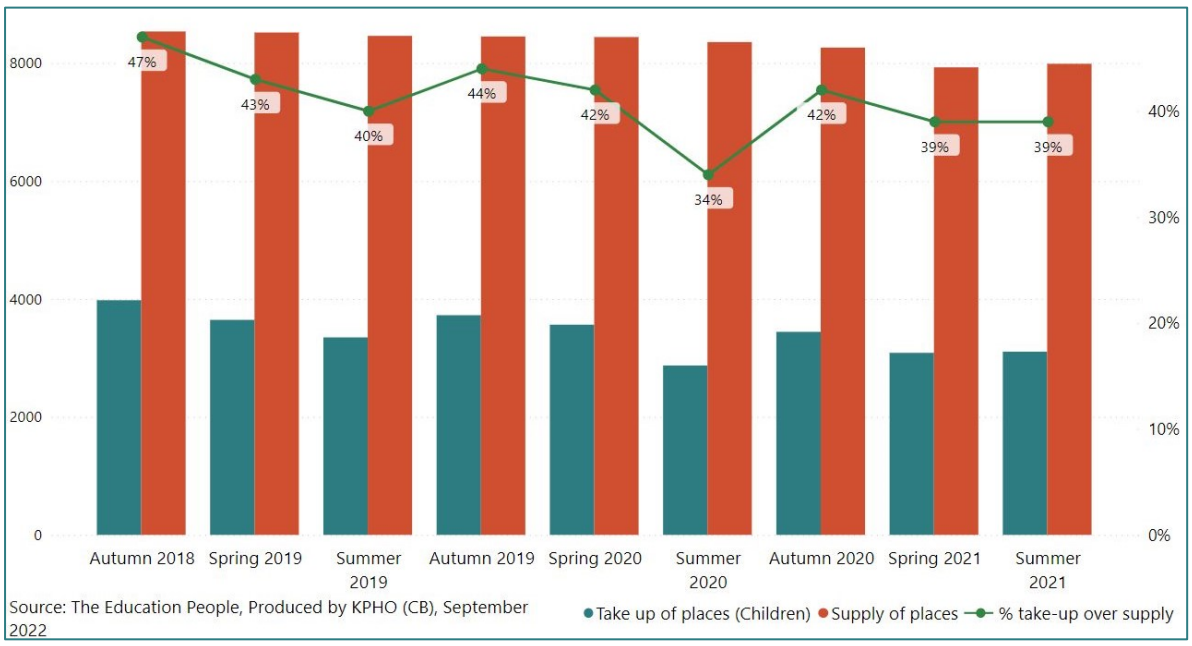
The percentage take-up over supply, has been calculated using the take up of places (number of children), divided by the supply figure. It is important to note the figure below does not show uptake of free for 2 funding against eligibility. This data was not available for inclusion in this report.

As illustrated below, the availability of places often increases in the Autumn term, where children leave Early Years to start school and their places in the setting come available. Over the 9 terms there has been a reduction in the number of free for 2 places in Kent. Overall, the percentage take up of places against supply and take up of places has decreased over the same period in Kent. There is reduction in the take up (number of children) and percentage take up of places against supply observed in the Summer 2020 term. It is thought that the decline observed for this term was attributed to the COVID-19 pandemic, including the national guidance affecting the opening of settings to all children between the 20th March to June 2021, discussed in section 1.2.

Nationally, the number of two-year-olds using the funded early education entitlements in 2021[2] had fallen by around 20% since 2018. The Department of Health report that this change is partially due to a 7% fall in the estimated number of eligible two-year-olds since 2018 and a decline in take-up amongst eligible families in 2021, which may have been a consequence of the COVID-19 pandemic (80).

[2] The data reports on the provision during the week commencing 18 January 2021. Early years provision was expected to remain open during the national lockdown in January 2021. Open providers and providers who were closed due to government advice were asked to return data on the expected attendance of their registered children.

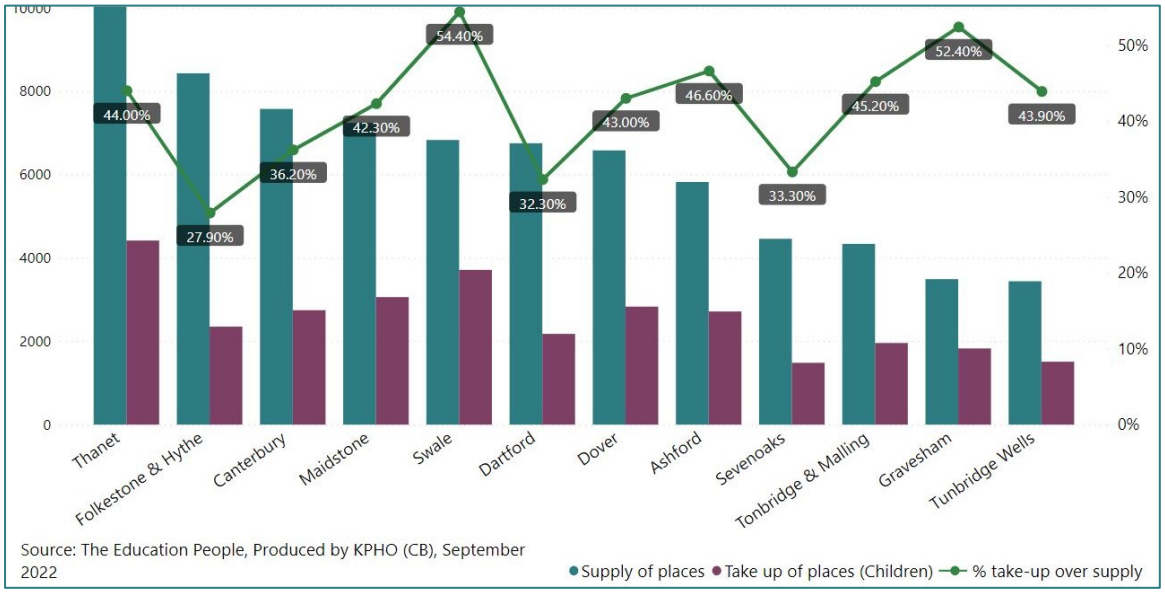
Figure 22: Supply of places, take up (number of children) and % take-up over supply for free for 2, Kent, Autumn 2018 to Summer 2021 term[3]



Between the Autumn 2018 and Summer 2021 term, Tunbridge Wells and Gravesham districts had the lowest supply of free for 2 places, whilst Thanet and Folkestone and Hythe districts had the highest supply of places. The highest number of free for 2 funded places taken up are in Thanet and Swale. The lowest number was in the districts of Sevenoaks, Tunbridge Wells, Gravesham and Tonbridge and Malling.

[3] Summer term; April – July (including August if funding is stretched or fee paying), Autumn term; September – December, Spring term; January – April

Figure 23: Supply of places, take up (number of children) and % take-up over supply for free for 2, by district, Autumn 2018 to Summer 2021

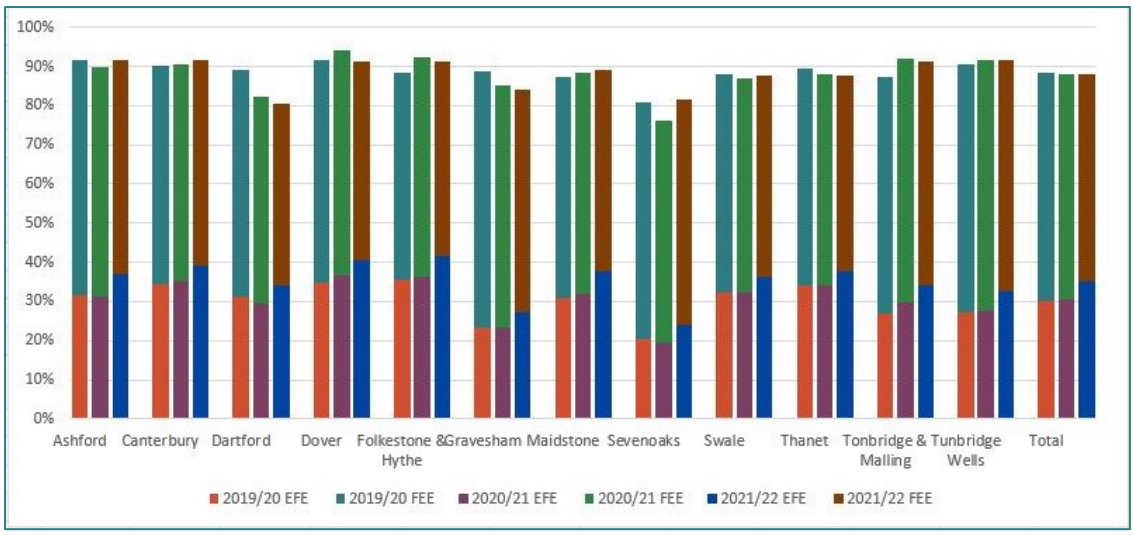


The Department for Education uses data from the Department of Work and Pensions to measure local authority take up. In 2021, Kent became one of twenty local authorities that were part of a national project to increase take up of the two-year-old free entitlement. A Free for 2 subgroup made up of key partners was established to support this work and will continue until the end of 2022.

The Kent Childcare Sufficiency Assessment, assess the variations in the take up of formal childcare across Kent for 3 and 4 years olds, by comparing the number of children taking up a place with the population forecasts (78).

The overall take up of the free early education take up of 3 and 4 year olds in Kent, between 2019 -2021, has remained around 88%. However, there is considerable variance across the districts, with the lowest uptake of the funding in Sevenoaks and Tunbridge Wells districts and the highest uptake in Thanet and Swale districts, over the three-year period presented. The number of children aged under 5 years in each district is variable with nearly twice the number in Maidstone district compared to Folkestone and Hythe district – figures which will also impact demand.

Figure 24: The percentage of Free Early Education amongst 3 & 4 year olds accessing Extended Free Entitlement (EFE) or Free Early Education (FEE) hour places, by district, Kent -Summer term (2019 – 2021)[4]



Source: The Kent Childcare Sufficiency Assessment

Research undertaken by Campbell et al, found that children from the most disadvantaged families were least likely to access their funded entitlements (81). The Nuffield Foundation's report in 2021 notes that, "policies designed to increase provision for working parents have inadvertently accentuated disadvantage, such as the 30-hour policy, which effectively gives children of higher-earning parents double the amount of funded early education than many disadvantaged children" (18). For childcare sufficiency in Kent please see the KCC Childcare Sufficiency Assessment (78).

6.4.2 The early years foundation stage - Assessments

The Statutory framework for the early years foundation stage [EYFS] (82), includes assessment of a child's progress, this includes assessments between 2 and 3 years and at the end of the school year when they are 5 years old.

6.4.3 The Integrated Review at Two

The Health Visiting Service carry out the Healthy Child Programme, Health and Development review of the child aged 2-2 ½ years (discussed in section 6.1.5). In line with recommendations from Ofsted and Care Quality Commission, KCC, The Education People and Kent Community Health Foundation Trust [KCHFT] have worked together to develop an Integrated Review at Two process for Kent.

[4] Due to COVID-19, an interim sufficiency assessment was completed for the Autumn Term in the 2020/2021 academic year. The take up rate for the summer term of 2020/2021 academic year is forecasted, based on the headcount data on the number of 3 and 4 year olds accessing childcare in the autumn term of the 2020/2021 academic year.

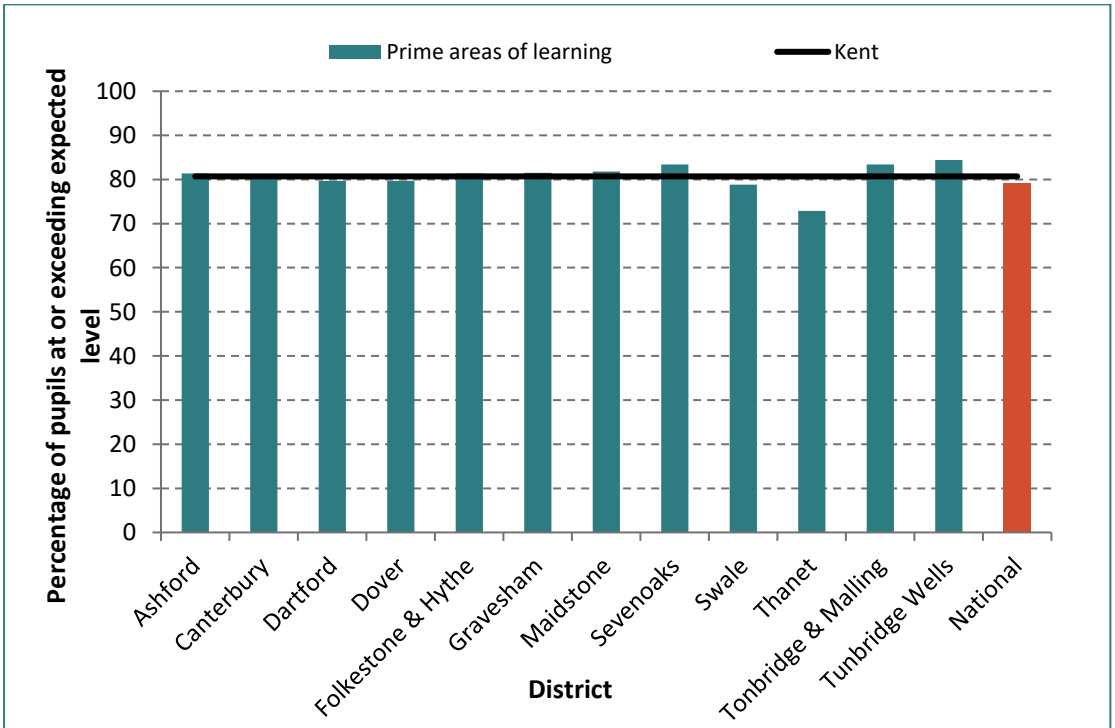
The 'Integrated Review at Two' process brings together the Healthy Child Programme Health and Development Review at age two to two and a half and the EYFS Progress Check at age two. The aim of the integrated process is to support a 'tell it once' approach, early identification, and support. This includes pathways for Early Years providers and Health Visiting Practitioners, to support universal information sharing, referral processes and the integrated review meeting (between the parents/carers, Early Years provider and Health Visiting practitioner) for children identified with concerns. The integrated review at 2 process was fully implemented, across Kent in March 2021.

6.4.4 Early years foundation stage profile results, 2019

The Early Years Foundation Stage (EYFS) profile is a statutory assessment of children's development at the end of the EYFS (the end of the academic year in which the child turns five). The EYFS consists of 17 early learning goals in seven areas of learning. These are grouped into prime areas of learning (personal, social, and emotional development; physical development; and communication and language) and specific areas of learning (mathematics, literacy understanding the world and expressive arts, designing and making) (83).

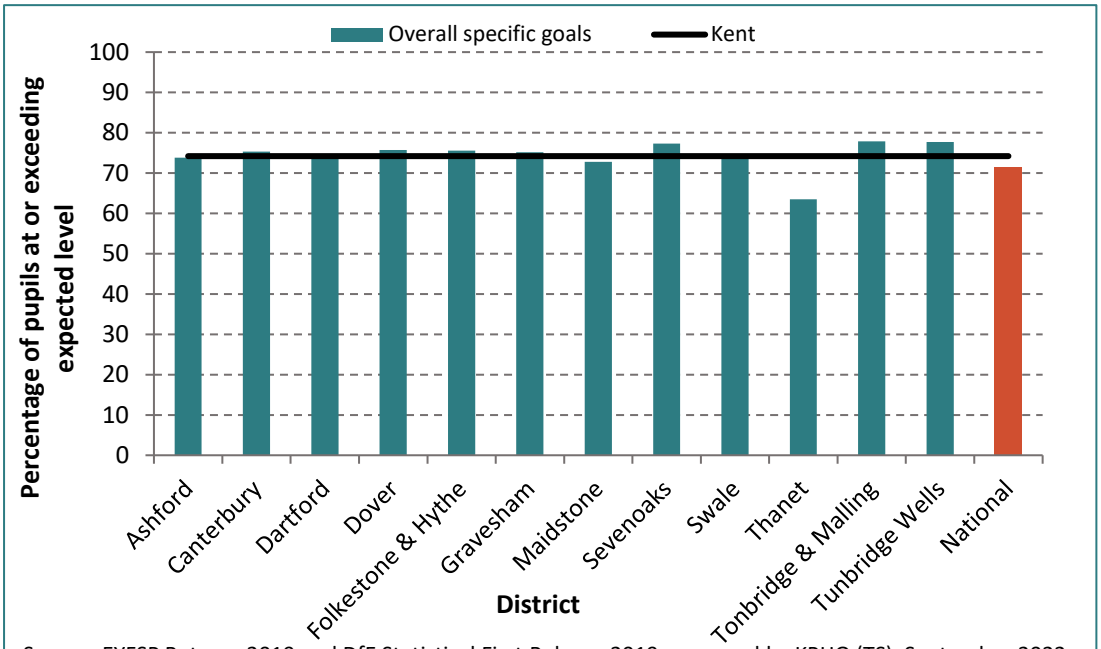
The following four figures provides Early Years Foundation Stage Profile attainment data, by District, for 2019. These illustrate the variance in the percentage of pupils at Expected Level or Exceeding Expected Level by district.

Figure 25: The percentage of pupils achieving at least the expected level in all prime areas of learning (communication and language, physical development, and personal, social and emotional development), by district in Kent 2019.



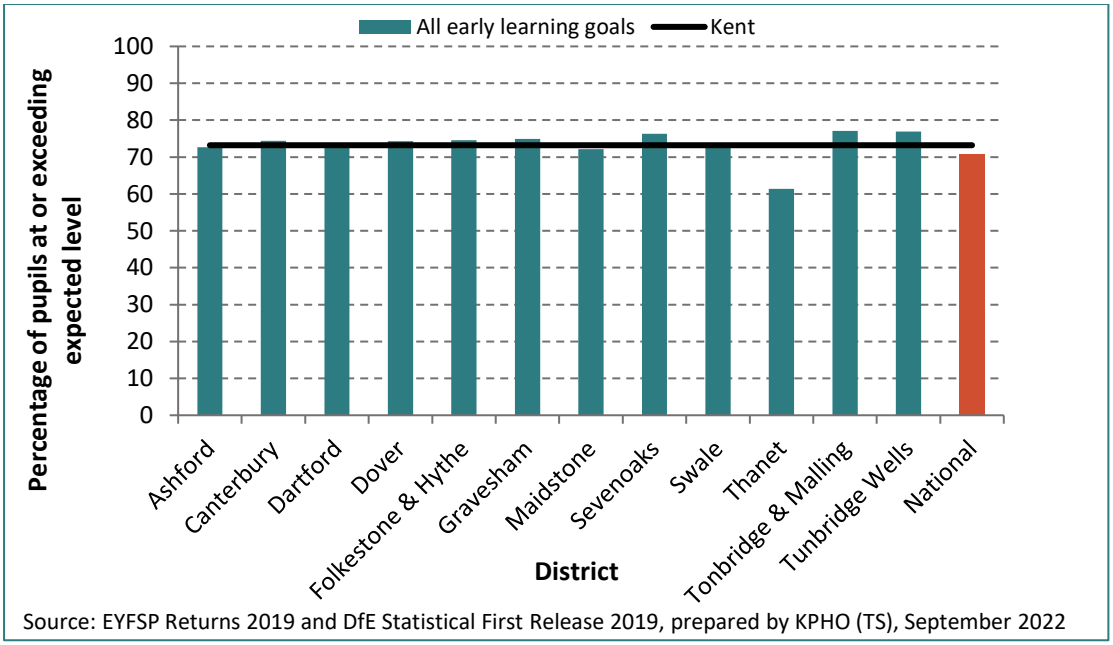
Source: EYFSP Returns 2019 and DfE Statistical First Release 2019, prepared by KPHO (TS), September 2022

Figure 26: The percentage of pupils achieving at least the expected level in all specific areas of learning (literacy, mathematics, understanding the world and expressive arts and design), by district in Kent 2019



Source: EYFSP Returns 2019 and DfE Statistical First Release 2019, prepared by KPHO (TS), September 2022

Figure 27: The percentage of pupils achieving at least the expected level in all Early Learning Goals, by district in Kent 2019

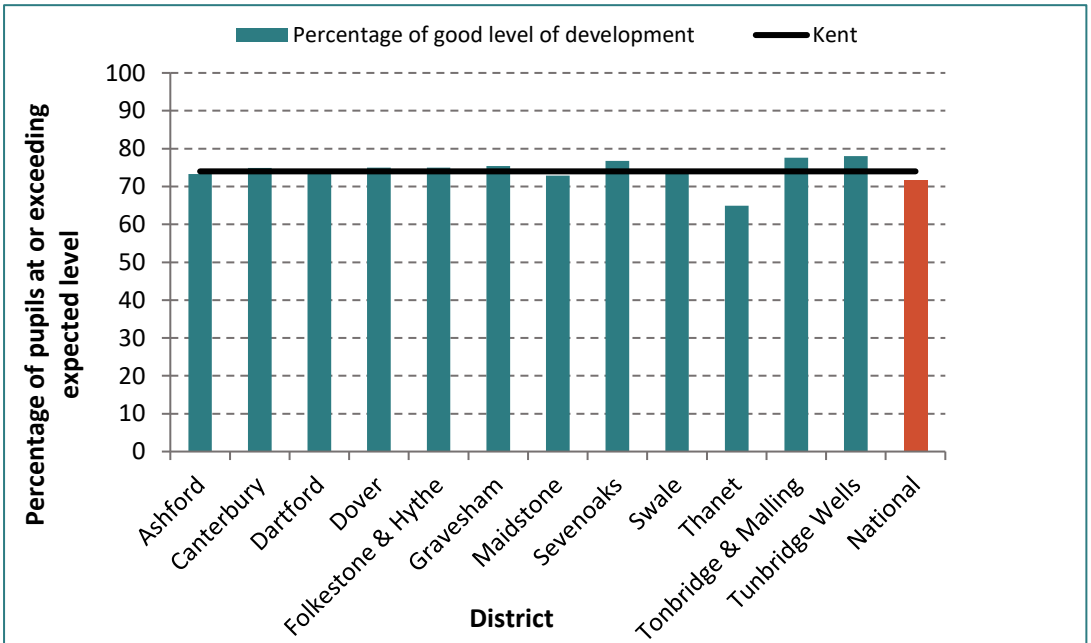


Source: EYFSP Returns 2019 and DfE Statistical First Release 2019, prepared by KPHO (TS), September 2022

Children are defined as having reached a Good Level of Development as shown in the figure below, if they have achieved at least the expected level for the early learning goals in the prime areas of learning and the specific areas of mathematics and literacy (83).

In Thanet, the percentage of pupils at expected level or exceeding expected level are below the national percentage across all learning goals and percentage achieving a good level of development. All other districts exceed the national percentages.

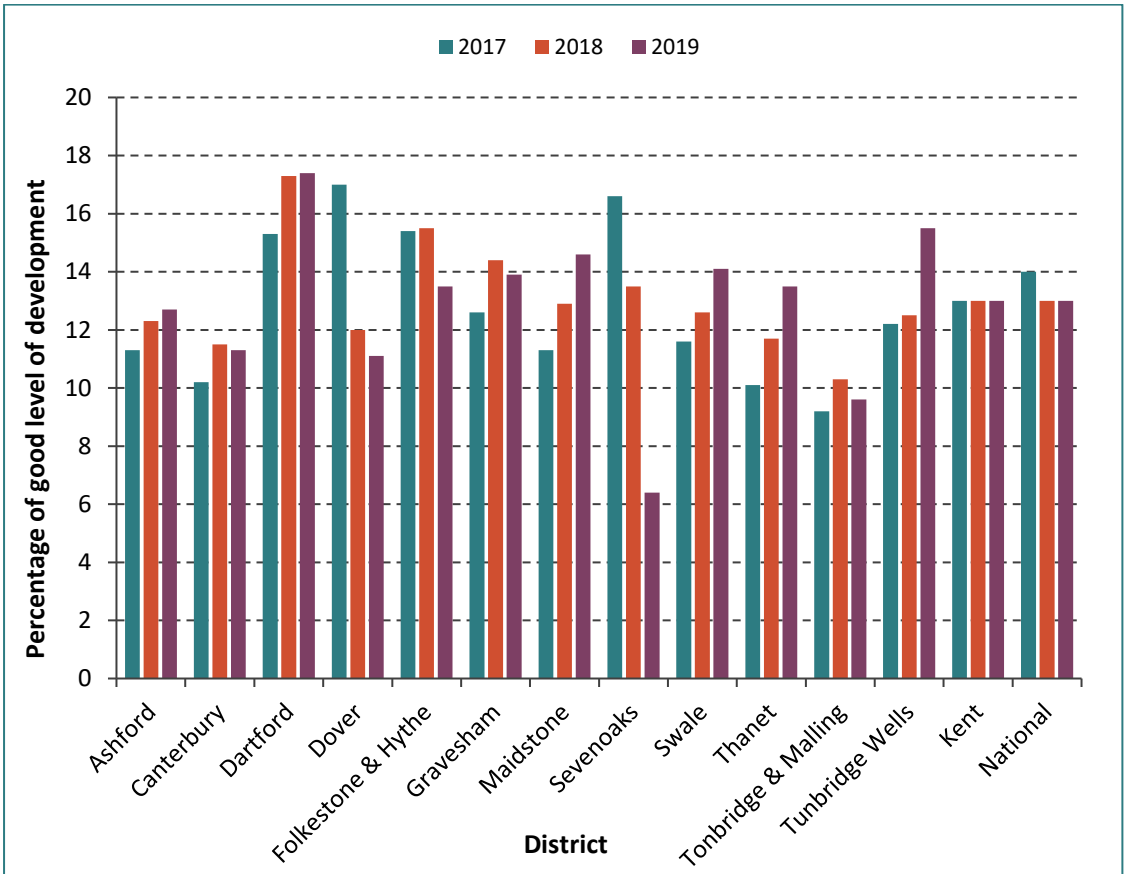
Figure 28: The percentage of pupils achieving a good level of development, by district in Kent 2019



Source: EYFSP Returns 2019 and DfE Statistical First Release 2019, prepared by KPHO (TS), September 2022

Girls continue to do better than boys in England and Kent. Kent has remained consistent with a 13% attainment gap across the 3-year period, between 2017 to 2019, in line with the National gap. The figure below indicates that the percentage attainment gap between girls and boys with a good level of development, between 2017 and 2019, varied by district, by year. For example, the percentage gap significantly reduced over the three-year period in the Sevenoaks district, from 16.6% to 6.4%, whereas in the Dartford district this increased from 15.3% to 17.4% in the same period.

Figure 29: The percentage attainment gap between Girls and Boys, Good Level of Development, by district in Kent 2017 - 2019



Source: EYFSP Returns 2019 and D of E Statistical First Release 2019, prepared by KPHO (TS), September 2022

6.5 'School ready'

"*Children should start school healthy, happy, communicative, sociable, curious, active and ready equipped for the next phase of life and learning*". (84)

School readiness is a term often used to describe how ready children are socially, physically, and intellectually to start formal schooling. School readiness not only refers to the attributes of a child but also the key roles and responsibilities of families, teachers, and practitioners in ensuring children are ready and able to access learning as they enter Key Stage 1 and beyond. In Kent, children are considered to be 'School Ready' if they have achieved a Good Level of Development at the end of the Early Years Foundation Stage (EYFS) and are confident and resilient with a keen, enthusiastic thirst for learning (85)

Every child deserves the best possible start in life and the support that enables them to fulfil their potential. Children develop quickly in the early years and a child's experiences between birth and age five have a major impact on their future life chances. A secure, safe, and happy childhood is important in its own right. Good parenting and high-quality early learning together provide the foundation children need to make the most of their abilities and talents as they grow up.

Kent's definition of school readiness is in agreement and supportive of UNICEF's description of 'School Readiness' which states that three elements together bolster children's likelihood of success:

- Children's readiness for school affects their learning and development
- Early Years settings and Schools' readiness for children ensures learning environments are child friendly and adapt to the diverse needs of young learners and their families
- Families' readiness for school promotes a positive and supportive approach to education, their children's learning, and the transition from home to school.

It is these three aspects which Kent believe will maximise each child's likelihood of success as they progress through their time in school. What School Readiness is not about is compliant behaviour, such as the ability to sit still and to line up. Nor is it about embarking too early on a formal approach to learning. (85) PHE's ambition, 'ready to learn at 2, ready for school by 5', means that by school entry, every child will have reached a level of holistic development which enables them to:

- communicate their needs with a good vocabulary and understand others
- get dressed and go to the toilet independently
- eat independently
- take turns, sit still, listen and play
- socialise with peers, form friendships, and separate from parent(s)
- enjoy good physical health or have disabilities and complex health needs identified and managed appropriately to maximise access to education.
- have a healthy weight for height range and be well nourished and physically active
- attend the dentist regularly and have good oral health
- benefit from protection against infectious illness, having received all childhood immunisations (86)

Some evidence suggests that the pandemic may have negatively impacted on young children's development (87). Research commissioned by the Education Endowment Foundation found that 76% of schools reported that children who started Reception in autumn 2020 needed more support than children in previous cohorts, with children struggling with communication and language, personal, social, and emotional development, and literacy (88).

Stakeholders reported that many children were anxious about starting school and this has been associated at this time with the impact of the pandemic, children having spent significant periods of time at home with their parent(s)/carers; insufficient transitional work being completed due to lock down; lack of socialism with peers; parental anxiety over the COVID-19 pandemic impacting on them, and parent/carer reluctance for their child to attend an educational setting with other children and adults present during this time.

A survey, by the Anna Freud Foundation, found that 42% of nursery staff said that children's emotional wellbeing had been affected by the pandemic (89).

In 2020 a significant number of children in England had a difficult start, without the essential building blocks in place for a happy life. The Children's Commissioner reported that there are 560,000 children under five living in households where a parent or carer is experiencing severe mental ill health, substance misuse or domestic abuse. 42,000 under-fives are living in homes where a parent has experienced all of these in the last year. Modelled data estimated that in 2019/2020, 18,800 children aged 0-4 years lived in households with parents suffering severe mental health, substance misuse or domestic abuse in Kent (90). These are children who do not have the vital foundation of a stress and anxiety free home, and whose parents may be less able to give them the loving attention they need. Over two million families with children under five are living in poverty, and poverty is rising fastest for the youngest children. (6)

A child experiencing hardship and trauma is more likely to have long-term repercussions throughout their childhood and later life. Many children who have grown up in families like those described above are already behind by the time they start formal education.

Available evidence suggests that changes in access to early childhood, education, and care (ECEC) has impacted pre-school children in a number of ways, including social, emotional, and behavioural development and mental health, physical development and school readiness. However, evidence also suggests that children and families have experienced the pandemic in very different ways, which has shaped any impacts on development, both positive and negative. Negative impacts on children's development and mental health from changes in access to ECEC are more likely for disadvantaged children and children with Special Educational Needs and Disabilities [SEND], as well as vulnerable children. (19)

One of the objectives of Government ECEC policy is to improve school readiness. Some research has focused on the impact of the pandemic on the extent to which children are ready for school as evaluated at entry to Reception. The Education Endowment Foundation published the interim report of the School Starters Study in April 2021, with the final report expected in Spring 2022. (91) The survey of 58 schools in England found that 76% of schools reported children needed more support when entering school in the Autumn Term 2020 than previously. Communication and language development; personal, social, and emotional development; and literacy were all cited as particular areas of concern by schools. However, once the school year had started most parents reported that children had settled well and were not concerned about their child's ability to cope.

Stakeholders have reported that more attention is given to emotional wellbeing and nurturing this year by teachers, as many pupils face more separation anxiety from parents, and are less independent. The lack of interaction with other children and not attending nursery has affected social skills for many. Some pupils missed out on vital pre-school development and the final nursery term is important for reception preparation (for example

learning phonics, names, numbers). Overall, it appears that there is a widened gap between children, depending on lockdown experiences.

Kent County Council Early Years and Childcare Strategy 2020-23 builds on success in the early years and childcare sector in Kent over the past decade. The strategy details further priorities and targets for improvement in early years provision and outcomes for children by age 5, by ensuring better continuity of provision and services across the 0-4 year age range, and increasing the number to be school ready at the end of the Early Years Foundation Stage (92)

Importantly the learning experiences of early years stays with pupils throughout their school experience. For non- 'school ready' pupils, this can impact self-esteem long-term; some suggest a mindset of not being able to achieve as well as peers can develop amongst these children. Many acknowledge that this can lead to gaps widening between peers. For non-'school ready' children who struggle to catch up, it may lead to behavioural and engagement problems.

> "Vulnerable and hard-to-reach families are so easy to slip through the cracks".

Source: Stakeholder interviews

6.6 Vulnerable children under 5 years of age and targeted support for families

6.6.1 Early help services

The Early Help service supports children, young people, and their family, early in the life of a problem or as soon as it emerges. The help can be required at any stage in a child's life, whether it is from pre-birth to adulthood. It applies equally to safeguarding or complex needs that the family cannot deal with or meet on their own. The support requires agencies to work together to ensure a child and their family receives support in a timely and responsive way, so that children are safeguarded educational, social, and emotional needs are met and outcomes are good.

The Principles of the Early Help service mean:

- Building on families' existing resources with a culture of high aspiration and empathy
- Building family wellbeing and resilience that leads to sustainable change
- Listening to the voice of children, young people and families and using their voice to shape our support
- Joining up services to support families at the right time and in the right place, with a focus on reducing transitions

Early Help reflects the widespread evidence base that it is better to identify and deal with problems early rather than respond when difficulties have emerged, when intervention can be less effective and often more expensive. The Early Help Assessment is part of Kent's Early Help Strategy to provide help to families at the earliest point of identification, and to reduce the need for more specialist or statutory service interventions at a later stage. Early Help assessments and intensive support is currently offered through the Early Help Units (intensive support), whilst the Open Access services provide universal, targeted, and additional support. The 27 intensive Early Help units in Kent comprise of a Unit Lead, senior Early Help Workers, and Early Help Workers.

Table 9: Early help units by district, Kent

Districts	Number of early help units
Ashford	2
Canterbury	2
Dartford	2
Dover	2
Folkestone & Hythe	2
Gravesham	2
Maidstone	3
Sevenoaks North/ Tonbridge & Malling	3
Sevenoaks South/ Tunbridge wells	2
Swale	3
Thanet	4

Source: Early Help and Preventative Services

Requests for support are submitted by partners or by individual self-referrals via the front door. These requests are then triaged to establish the best level of support for children, young people and families requiring intensive or specialist support at levels 3 and 4. When a request for support is submitted, the primary reason for contact is recorded. There are a possible 73 primary reasons for contact including: parenting support, parental disability, no recourse to public funds, homelessness, domestic abuse, neglect, mental health of adult. Once the request is triaged by the Front Door and support is required, it is then transferred to the appropriate level of support service in the required district.

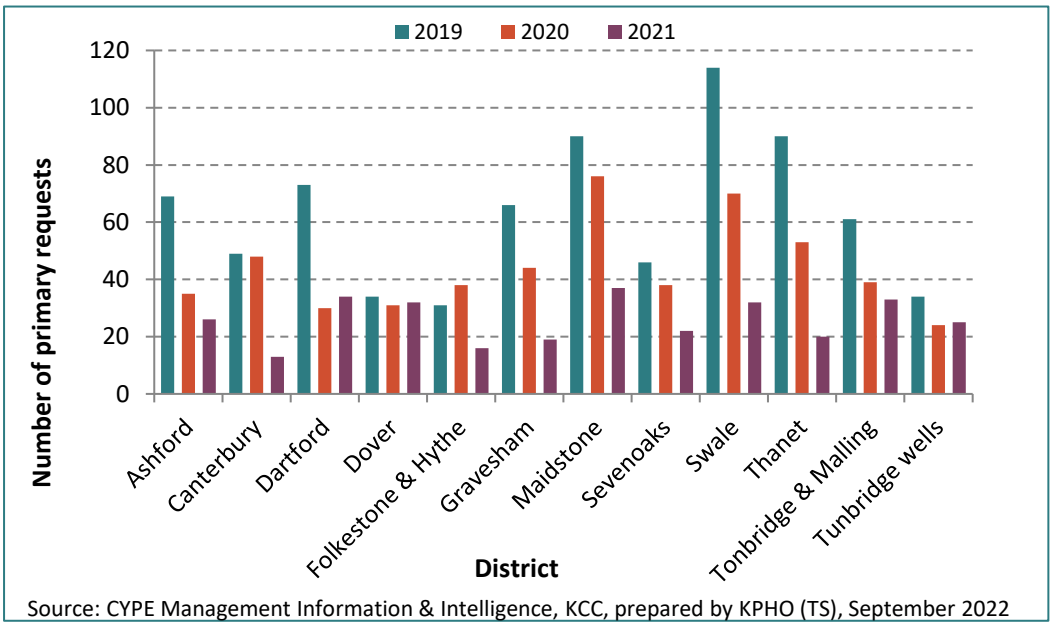
Once cases from the front door have been triaged and re assigned to the correct district, the Unit lead in each specific district on duty will look at the cases and allocate these to an early help worker. Allocations are completed within 2 days and first contact with a family takes place within 24 hours. Early Help complete a whole family assessment and plan. They review the plan and progress every 6 weeks and will work with a family for up to 20 weeks (or longer if concern is still apparent).

6.6.2 Domestic abuse

A recent government report (93) highlighted the significant effect on children's wellbeing when exposed to violence or abuse. Living in a household with Domestic Abuse (DA) can impact on a child's physical and mental health, as well as social, behavioural, and cognitive development. Moreover, the Children's Commissioner reported that '*despite their increased vulnerability, they can be invisible to professionals'*, (94) [2:2018] which was also emphasised during stakeholder interviews. In Kent, DA referrals come through the Front Door service

The next figure illustrates a substantial drop in the number of referrals of under 5-year-olds through the front door for domestic abuse support from 2019. This may be a consequence of change for the level of reporting of domestic abuse notifications [DANs] in March 2020 to services and subsequent management of covid 19 which meant there was less visibility of under 5s across the system. From 2021, domestic abuse notifications are presented directly from the police to maternity services and health visiting services where there are pregnant women or children under 5 years.

Figure 30: Number of Primary Requests through the front door for Domestic Abuse (DA) support in districts where contacts had children under 5 years old in the household 2019-2021



Source: CYPE Management Information & Intelligence, KCC, prepared by KPHO (TS), September 2022

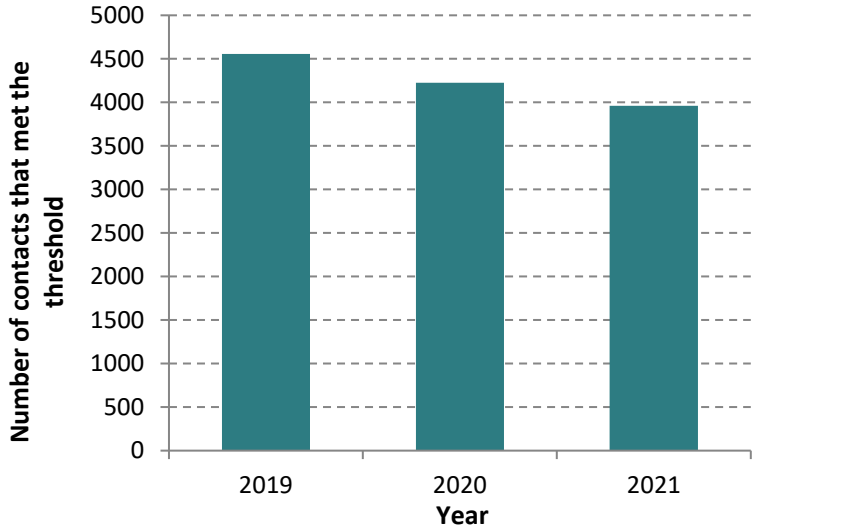
When Police are called to a DA incident all children are checked at the address regardless of age. Officers will check if the children were present or witnessed any DA and include whether there are any children under 5 years who are/were present at the address (even if they are not part of the family group). The voice of the child is gained, and observations made of babies and young children. If the voice of the child is not gained at the time, officers will try and go back and speak to them.

If there are safeguarding concerns at level 3 or 4, Police will complete a Front Door notification (request for support) and the case will be allocated to Early Help or Children's Social work team (CSWT). (95) Some DA incidents are reported historically or at another location such as at the police station and victims do not always report who was present or the full extent of the DA.

6.6.3 Children's services

The data presented below includes contacts which went through the Front Door between 2019 – 2021 for 0–4 year olds, with an outcome that the threshold had been met for Children's Social Work Services[5]. This outcome indicates that the contact will result in a new children's social work referral. The figure below shows that the number of contacts has declined over the 3-year period. This reflects the trend for the number of referrals to Children's Social Care reported for children of all ages in England (96).

Figure 31: Number of front door contacts which met the threshold for the Kent Children's Social Work Services, 0-4 year olds, 2019-2021

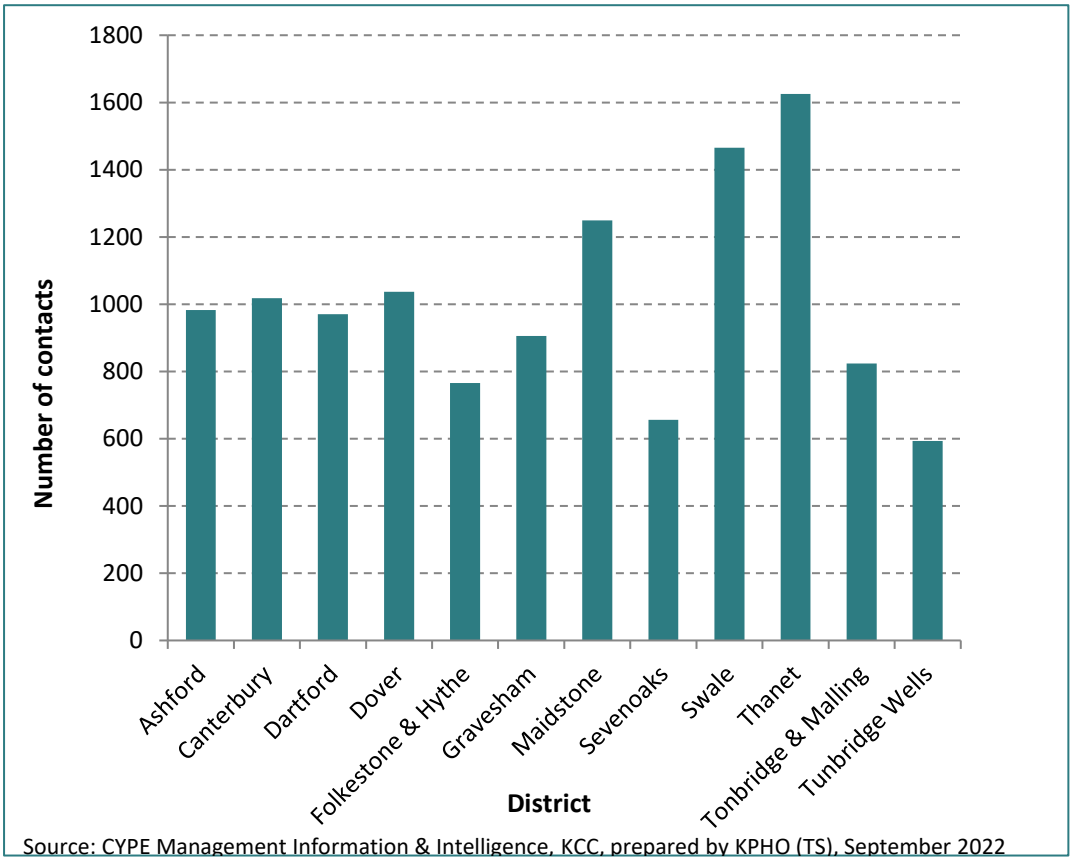


Source: CYPE Management Information & Intelligence, KCC, prepared by KPHO (TS), September 2022

[5] Step Downs, Step Across, and contacts where Early Help teams added in extra children the Front Door were not aware about have been excluded. Contacts where the case was open to Children's Social Work Services at the time of the contact are not recorded as a new contact (unless they came through the Children's Portal) and so have been excluded. Instances where the case was open to Early Help at the time of the contact but have now met the threshold for CSWS intervention have been included.

The next figure shows that Thanet, Swale and Maidstone had the highest number of contacts to the front door with an outcome that the threshold has been met for Children's Social Work Services. The number of contacts were lowest in Tunbridge Wells, followed by Sevenoaks.

Figure 32: Number of contacts which met the threshold for the Kent Children's Social Work Team, by district in Kent, 0-4 year olds, 2019 - 2021



Source: CYPE Management Information & Intelligence, KCC, prepared by KPHO (TS), September 2022

To understand the differences in need across the district populations the information is presented in rates. This is shown in the table below and shows the contacts which met the threshold for the Kent Children's Social Work Team by rate per 1,000 0-4 year old population. This illustrates that Thanet, Dover, and Swale districts had the highest rate of contacts that meet the threshold per 1,000 0–4 year old population, whereas Sevenoaks and Tunbridge Wells had the lowest rate.

Table 10: Contacts which met the threshold for the Kent Children's Social Work Team, rate per 1,000 0–4 year old population, by district in Kent, 2019 – 2021

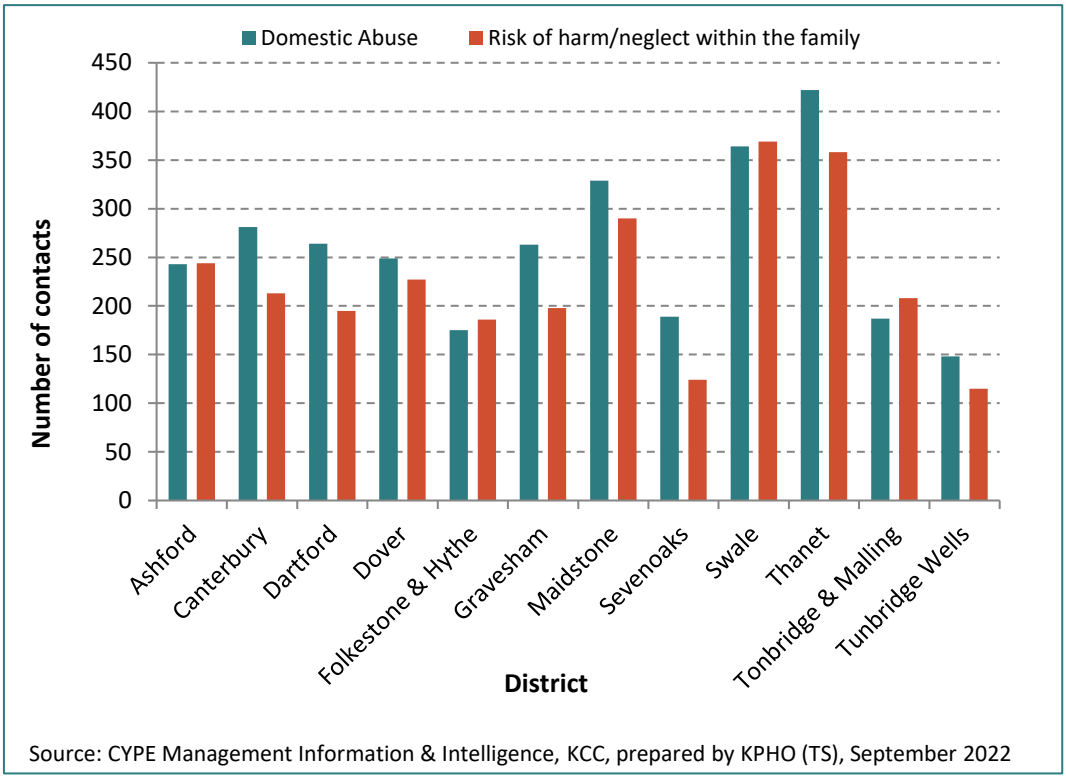
Districts	2019	2020	2021
Ashford	46.8	40.5	38.7
Canterbury	47.2	51.9	42.2
Dartford	42.6	39.5	33.3
Dover	61.7	62.8	54.3
Folkestone & Hythe	50.8	49.1	44.7
Gravesham	49.3	45.2	36.8
Maidstone	41.3	39.3	38.3
Sevenoaks	32.2	33.4	30.9
Swale	55.5	53.0	50.7
Thanet	75.5	70.8	67.5
Tonbridge & Malling	38.4	34.4	34.2
Tunbridge wells	35.7	30.2	28.3
Kent	**47.9**	**45.6**	**41.6**

Source: CYPE Management Information & Intelligence

Between 2019 and 2021, the most common primary reason for contact recorded, included 'domestic abuse' and 'risk of harm/ neglect within the family'. Across the districts, the primary contact reason 'domestic abuse' has been highest in terms of numbers in Thanet, Swale and Maidstone districts. The primary contact reason 'risk of harm/ neglect within the family' was highest in terms of numbers in Thanet and Swale districts.

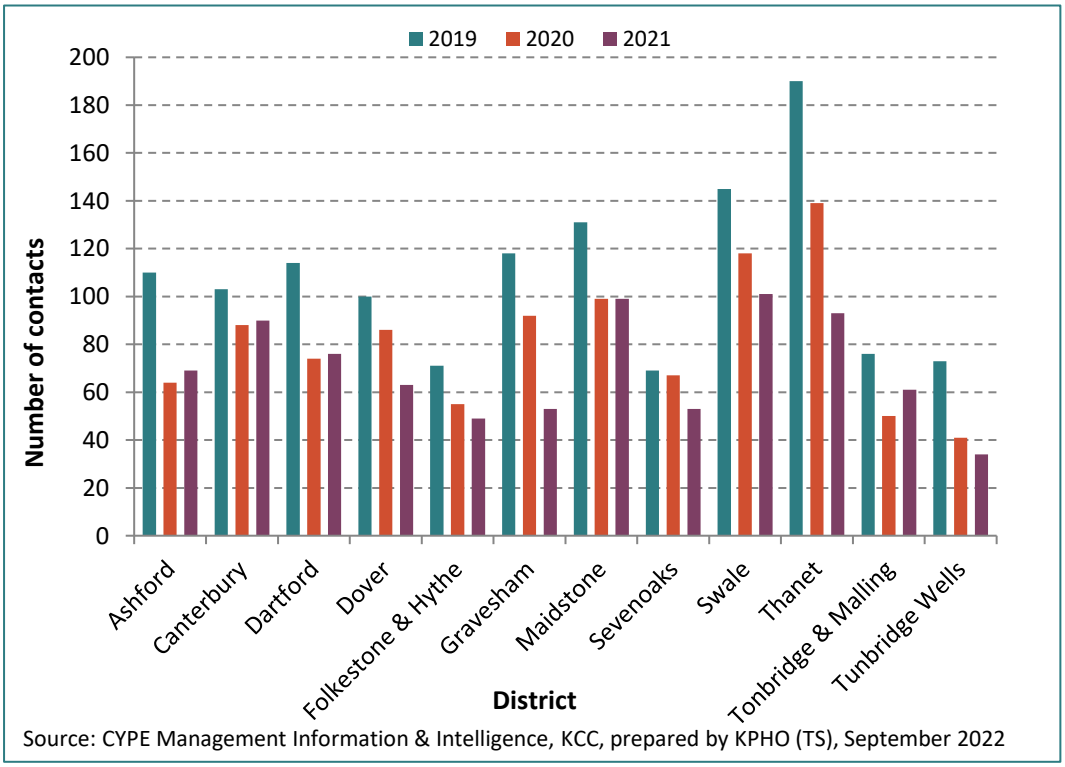
It should, be noted that the following five figures which relate to 0–4-year-olds are presenting information as numbers. The information is presented by age or district but the districts or age cohorts are not comparable when shown numerically.

Figure 33: Number of front door contacts which met the threshold for the Kent Children's Social Work Team with 'domestic abuse' and 'risk of harm/neglect within the family' as the primary contact reason, 0-4 year olds, by district, 2019-2021



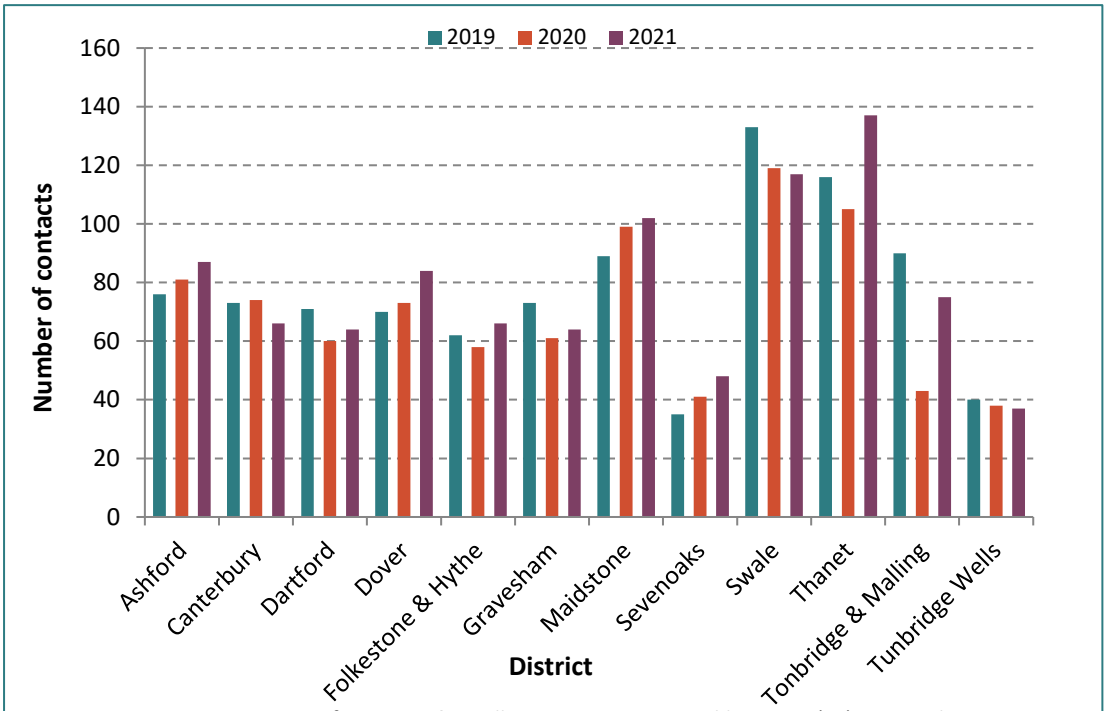
Source: CYPE Management Information & Intelligence, KCC, prepared by KPHO (TS), September 2022

Figure 34: Number of front door contacts which met the threshold for the Kent Children's Social Work Team with 'domestic abuse' as the primary contact reason, 0-4 year olds, by district, by year 2019-2021



Source: CYPE Management Information & Intelligence, KCC, prepared by KPHO (TS), September 2022

Figure 35: Number of front door contacts which met the threshold for the Kent Children's Social Work Team with 'risk of harm/neglect within the family' as the primary contact reason, 0-4 year olds, by district, 2019-2021

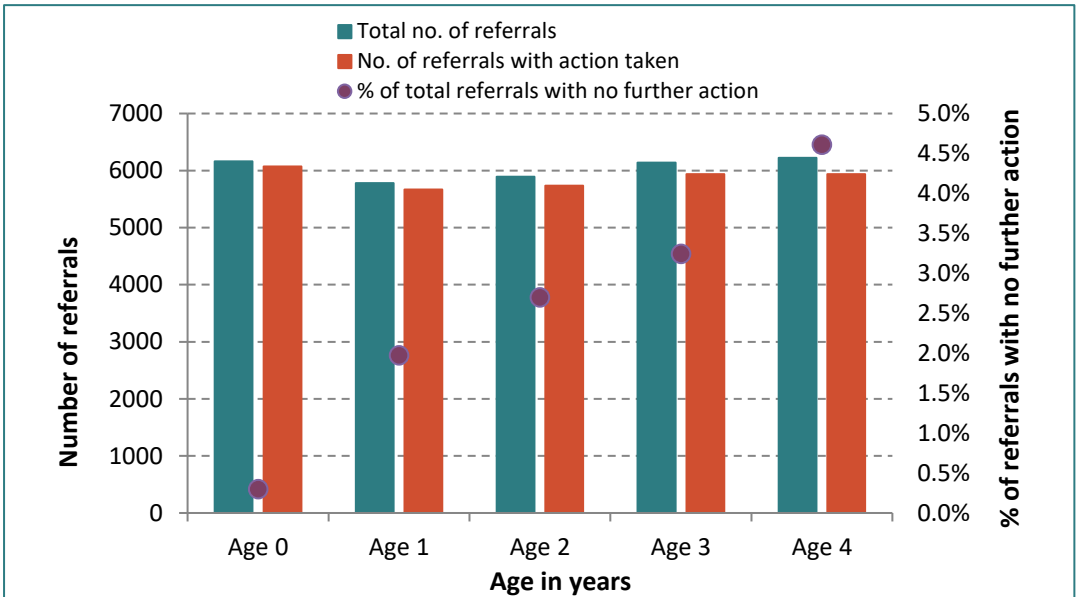


Source: CYPE Management Information & Intelligence, KCC, prepared by KPHO (TS), September 2022

The following presentations are a slightly different timeframe. These are presentation of the activity required for national reporting to the DfE. The front door data above, is not dictated to by the DfE and is used by KCC to give a greater level of clarity regarding the issues presenting and to identify if there are trends regarding certain types of cases. In Kent, between 1st April 2016 – 19th January 2022, 30,202 referrals were made to the children's social care service for children aged 0-4 years old [6]. Of the 30,302 referrals received during the timeframe, 2.81% were assessed as requiring no further action. The percentage of referrals that were assessed as requiring no further action increased with age with the highest proportion for children aged 4 years at 4.6% which is presented in the next figure.

[6] This data shows the number of referrals, therefore if more than one referral has been received for a child, each referral will be counted in the data.

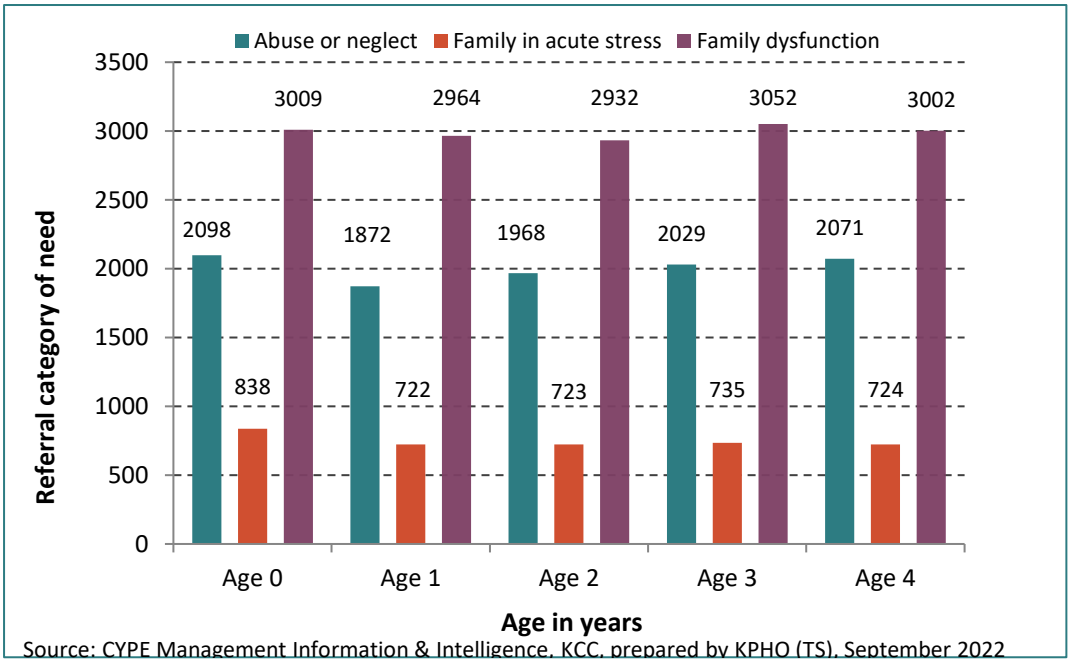
Figure 36: Number of referrals into children's social care for 0-4 year olds, including the number and percentage that were assessed as no further action required, in Kent, 1st April 2016 – 19th January 2022[7].



Source: CYPE Management Information & Intelligence, KCC, prepared by KPHO (TS), September 2022

In Kent, across all 0-4 age groups, over the time period presented, family dysfunction, abuse or neglect and family in acute stress were the most common referral category of need.

Figure 37: The most common referral categories of need, 0-4 years, by age, Kent, 1st April 2016 – 19th January 2022



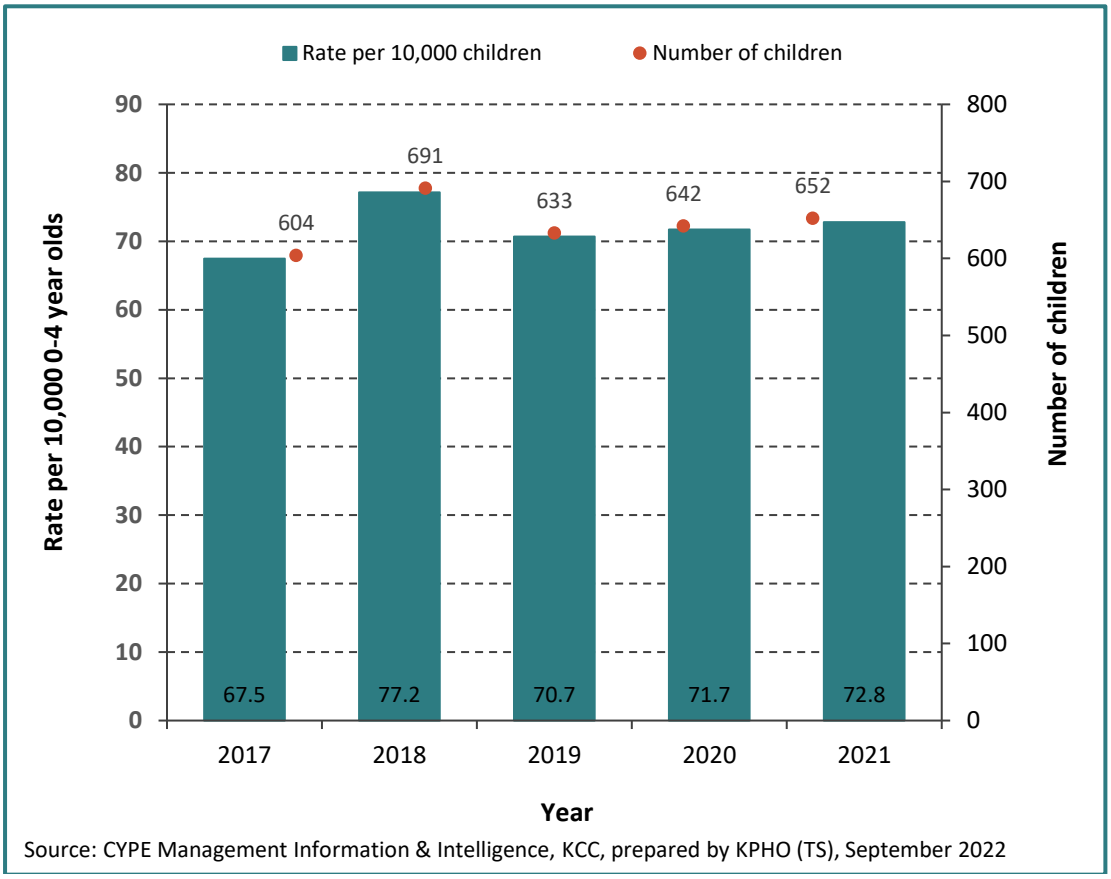
Source: CYPE Management Information & Intelligence, KCC, prepared by KPHO (TS), September 2022

[7] This data shows the number of referrals, therefore if more than one referral has been received for a child, each referral will be counted in the data.

A child in need is defined under Section 17 of the Children Act 1989 (41) 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.

In Kent the number and rate of children in need, under 0-4 years old peaked in 2018 and fell in 2019. Between 2017 and 2021, the rate (per 10,000 children aged 0-4 years) and number of children in need aged 0-4 years has been highest for children aged 0 years. The second highest rate (per 10,000 children aged 0-4 years) and number is for children aged 1 years old, in which the rate has increased by 16.89 per 10,000 children over the 5 year period.

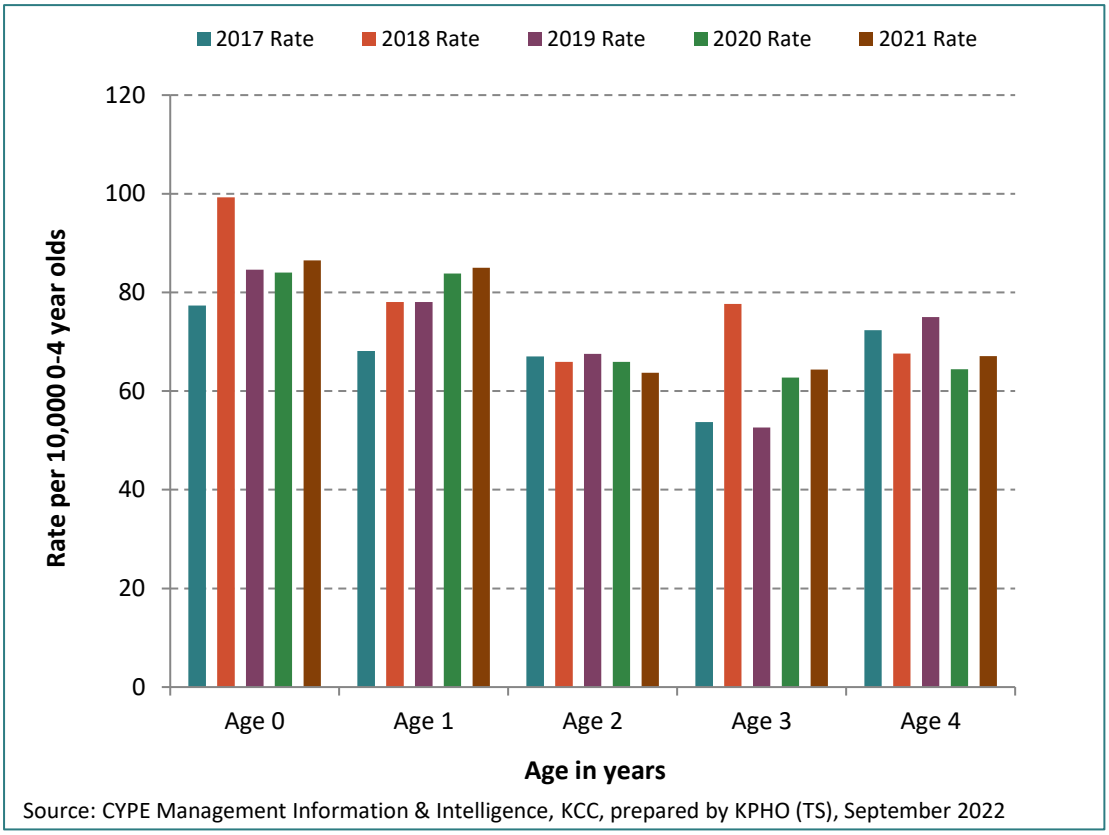
Figure 38: Rate (per 10,000 children aged 0-4 years) and number of children aged 0-4 years in need, in Kent, 2017 -2021[8]



Source: CYPE Management Information & Intelligence, KCC, prepared by KPHO (TS), September 2022

[8] The figures are a snapshot as at the 31st March of each year. The figures exclude unborn children.

Figure 39: Rate (per 10,000 of children aged 0-4 years) in need, by age, in Kent, 2017 -2021[9]



Source: CYPE Management Information & Intelligence, KCC, prepared by KPHO (TS), September 2022

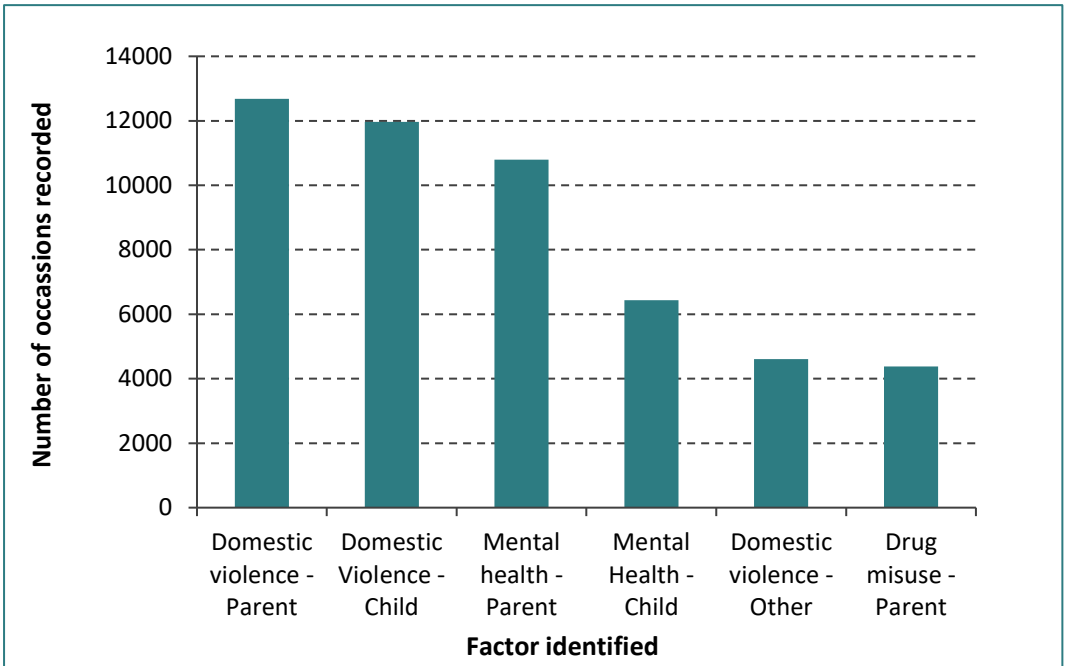
When a child is referred to children's social care, a child and family assessment is carried out (usually within 45 working days of a referral) to understand the child's needs and make decisions on what intervention or support is necessary, and whether the child meets the criteria for ongoing services as a 'Child in Need' (97). Factors identified at the end of assessment are additional factors that social workers record as being relevant in a case.

The figure below shows the six factors with the highest number of occasions recorded at the end of the child and family assessments authorised from 1st April 2016 – 19th January 2022, for children under 5 years old (excluding unborn children)[10]. This shows that 'domestic abuse – parent' has been recorded the most, followed by 'domestic abuse – child' and 'mental health of the parent'.

[9] The figures are a snapshot as at the 31st March of each year. The figures exclude unborn children.

[10] A child may have more than one factor recorded in the child and family assessment. A child may have had more than one child and family assessment completed across the period. The data excludes unborn children.

Figure 40: Factors recorded at the end of the child and family assessments with the highest number of occasions for children under 5 years old, 1st April 2016 – 19th January 2022[11]



Source: CYPE Management Information & Intelligence, KCC, prepared by KPHO (TS), September 2022

In England (as of 31st March) 2021, for children of all ages, concerns about the child's parent/carer being the victim of domestic violence remained the most common factor, identified in one third of episodes with assessment factor information. The next most common factor was concerns about the mental health of the child's parent/carer. This pattern has remained unchanged since 2018 (96).

Child protection

Under Section 47 of the Children Act 1989 (41), where a local authority have reasonable cause to suspect that a child is suffering, or is likely to suffer, significant harm, the authority must make enquiries and decide if any action must be taken to safeguard and promote the welfare of the child.

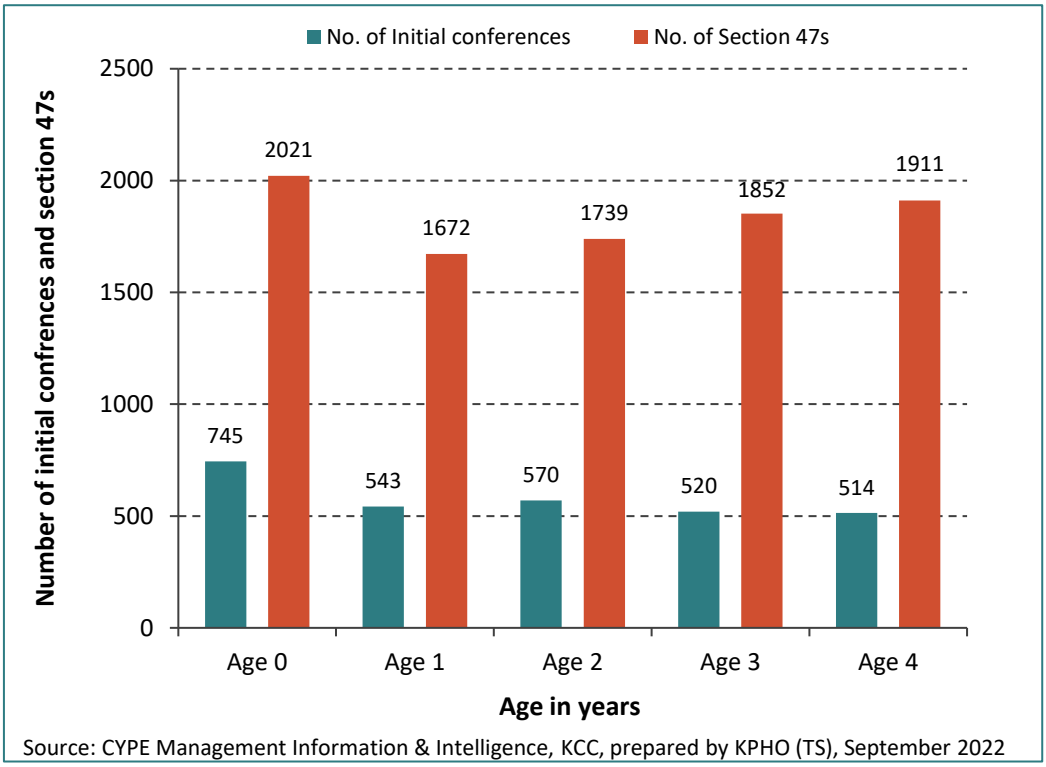
Child protection refers to the activity that is undertaken to protect specific children who are suffering, or are likely to suffer, significant harm. If concerns are substantiated and the child is judged to be at continuing risk of harm, then an initial child protection conference (ICPC) should be convened within 15 working days.

In Kent, between 1st April 2016 – 19th January 2022, there have been 9,195 section 47

[11] A child may have more than one factor recorded in the child and family assessment. A child may have had more than one child and family assessment completed across the period. The data excludes unborn children.

enquires for children aged 0-4 years old (excluding unborn children)[12]. As a result of these section 47 enquires there were 2,892 initial conferences for children aged 0-4 years. Over this time period and by age band, the highest number of section 47 enquires, and initial conferences took place for children aged 0 years.

Figure 41: Number of section 47 enquires and initial child protection conferences in Kent, 0-4 years, by age, 1st April 2016 – 19th January 2022[13]



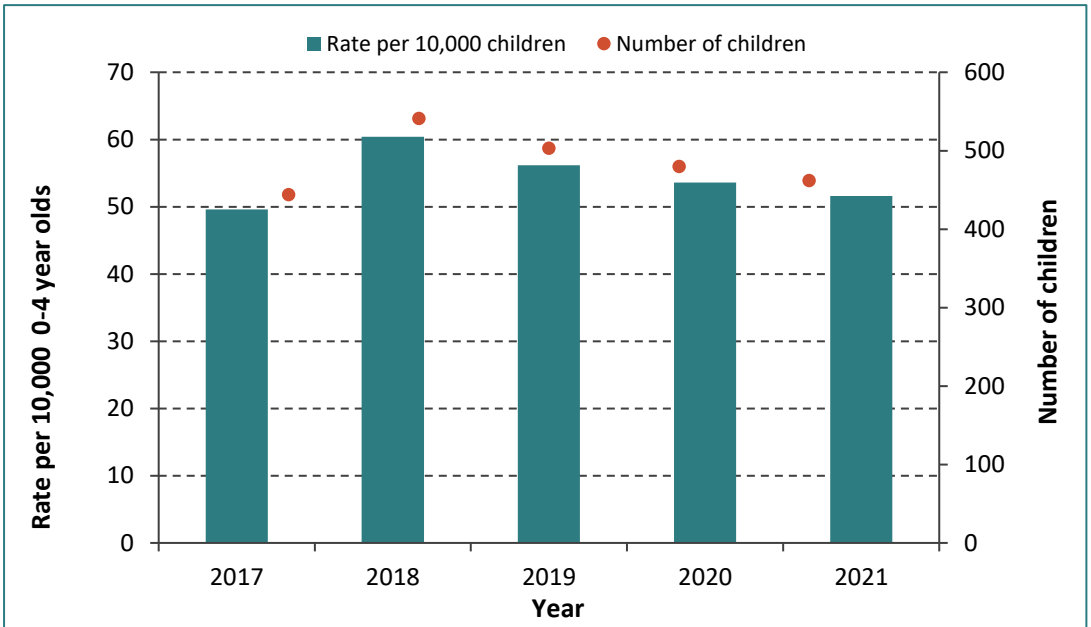
Source: CYPE Management Information & Intelligence, KCC, prepared by KPHO (TS), September 2022

Where a Child Protection Conference determines that a child is at continuing risk of significant harm, a multi-agency Child Protection Plan is formulated to protect the child. A Core Group of professionals, including the Lead Social Worker, are responsible for keeping the Child Protection Plan up to date and co-ordinating inter-agency activities within it (98).

In Kent, the number and rate (per 10,000 children) of children aged 0-4 years on a child protection plan peaked in 2018 and has since fallen for a third consecutive year to a rate of 51.60 per 10,000 children in 2021. This pattern has also been observed nationally for children of all ages (96). By age band, children aged 0 years had the highest number and rate (per 10,000 children) in the 5 year period.

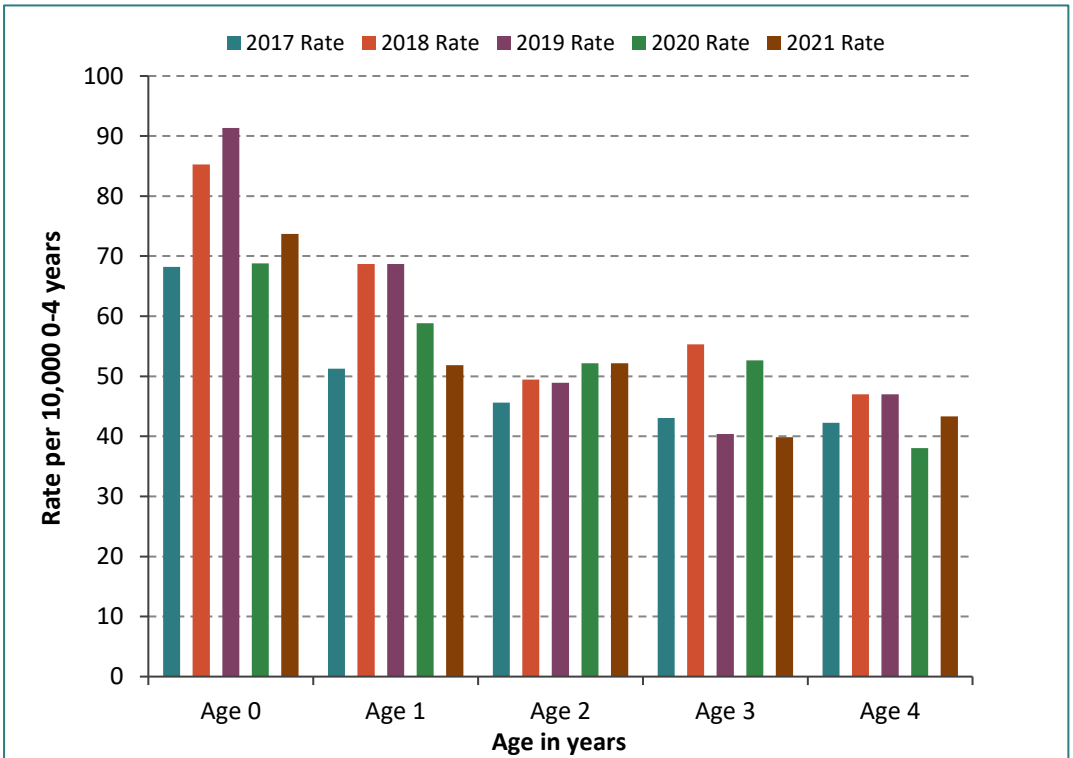
[12] This data shows the number of section 47 enquires, therefore if more than one section 47 enquiry is completed for a child, each enquiry will be counted in the data. The figures exclude unborn children.
[13] This data shows the number of section 47 enquires, therefore if more than one section 47 enquiry is completed for a child, each enquiry will be counted in the data. The figures exclude unborn children.

Figure 42: Number and rate (per 10,000 children aged 0-4) of children aged 0-4 years on a Child Protection Plan in Kent[14] 2017-2021



Source: CYPE Management Information & Intelligence, KCC, prepared by KPHO (TS), September 2022

Figure 43: Rate (per 10,000 0-4 year olds) on a Child Protection Plan, by age in Kent, 2017-2021[15]



Source: CYPE Management Information & Intelligence, KCC, prepared by KPHO (TS), September 2022

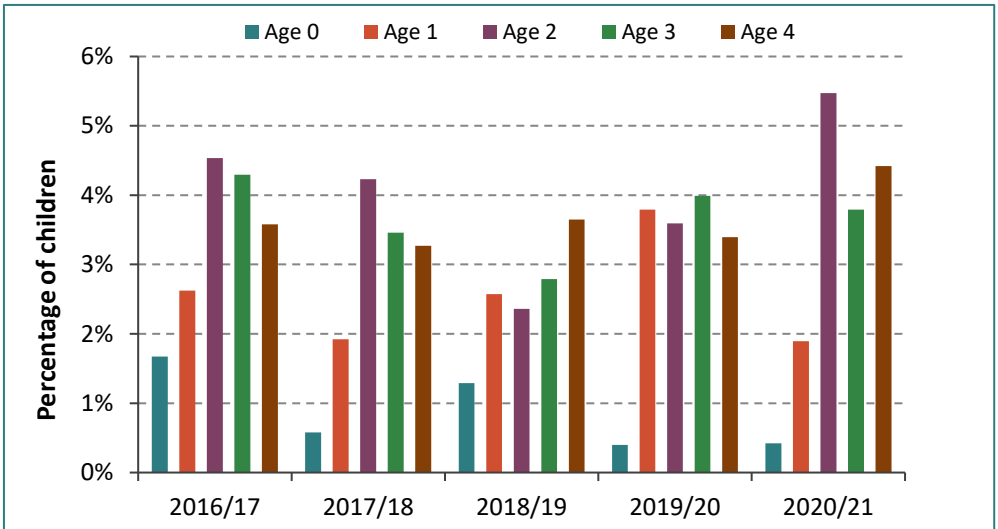
[14] The figures are a snapshot as at the 31st March of each year. The figures exclude unborn children.

[15] The figures are a snapshot as at the 31st March of each year. The figures exclude unborn children.

The next figure shows that the percentage of children by age subject to a child protection plan for a second or subsequent time has varied by age across the timeframe 2016/17 and 2020/21 in Kent.

Between April 2016 and December 2021, 14.7% of children aged 0-4 years who had previously been the subject of a child protection plan, became subject to a Child Protection Plan (CPP) for a second or subsequent time.

Figure 44: Percentage of children aged 0-4 years who had become subject to a Child Protection Plan (CPP) for a second or subsequent time, by age and year, Kent, 2016/17 – 2020/21[16]



Source: CYPE Management Information & Intelligence, prepared by KPHO (LS), Sept 22

Looked After Children

Under the Children Act 1989, A child is looked after by a local authority if he or she is in their care or is provided with accommodation for more than 24 hours by the authority (41). The act sets out the legal statuses for a looked after child.

The figure below shows that between 2017 and 2021, the number and rate (per 10,000 0-4 year olds) of children looked after in Kent, dropped in 2019 and has increased in the last 2 consecutive years to its highest in the 5 year period. Across the 5 year period, the rate and number of children who are looked after is substantially higher for children aged 0 years, when compared to the other 0-4 age groups.

[16] The figures are based on the total number of CPP plans across each financial year. The figures exclude unborn children. Data below the value of 5 has been supressed.

Figure 45: Number and rate per 10,000 children aged 0-4 years, who are looked after, in Kent,2017 - 2021[17]

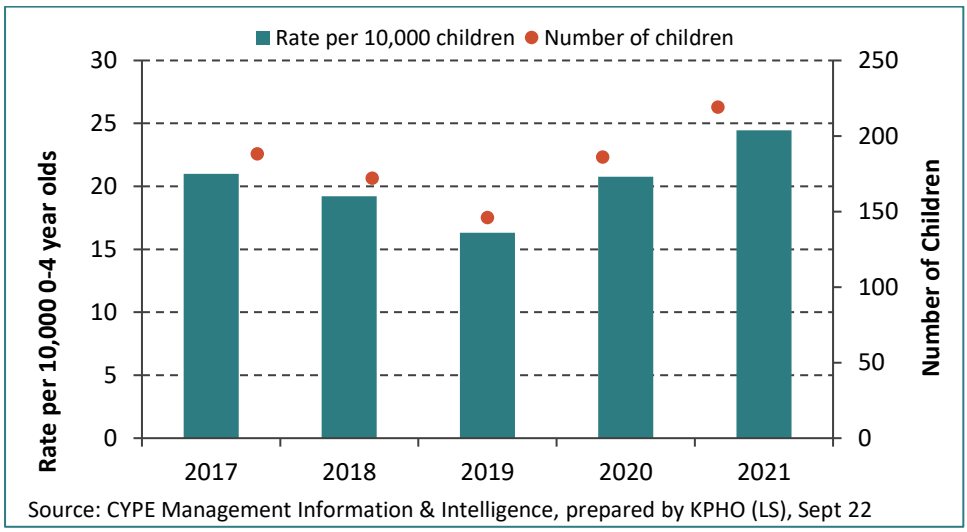
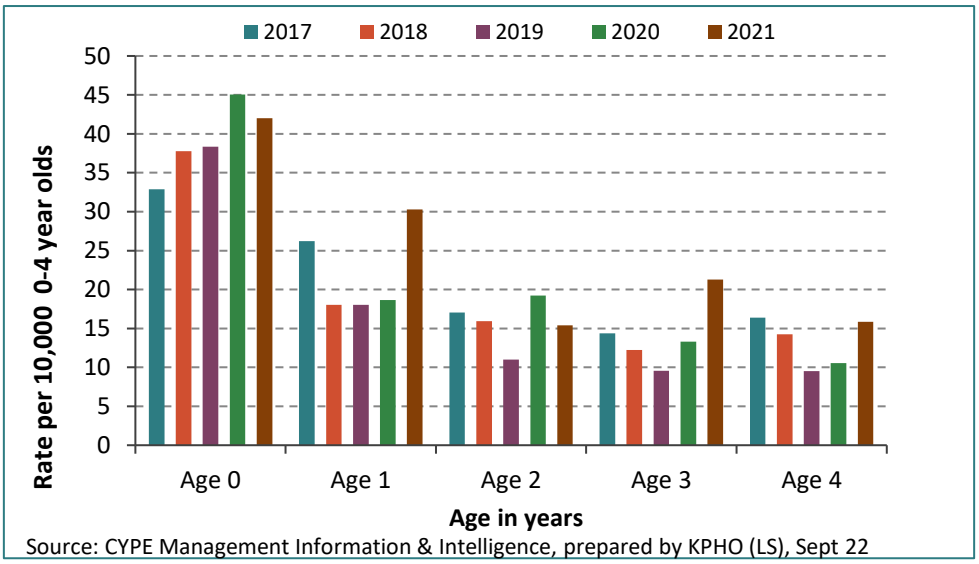


Figure 46: Rate per 10,000 0-4 year olds, who are looked after, by age, in Kent, 2017 - 2021[18]



6.6.4 Troubled families programme

The Troubled Families Programme (TFP) is a programme in England administered by the Ministry of Housing, Communities and Local Government (MHCLG). The TFP conducts targeted interventions for families experiencing multiple problems, including crime, anti-social behaviour, truancy, unemployment, mental health problems and domestic abuse.

[17] The figures are a snapshot as at the 31st March of each year.
[18] The figures are a snapshot as at the 31st March of each year.

Since its launch in 2011, up to £1.533 billion of funding through the Troubled Families Programme has helped families and local areas to achieve a huge amount. The programme has supported over 400,000 families to achieve positive outcomes between 2015-2021. Each one of these outcomes means a family's life changed for the better, whether it has meant improving a child's school attendance so they get the best start in life, supporting a parent to overcome their substance misuse and keep their family together, or supporting victims of domestic abuse so they can build a more positive future for themselves and their family.

The programme has also benefitted many more by driving widespread transformation in how family services are delivered in local areas, making them more coordinated, family-centered and data driven. The programme has championed whole family and multi-agency working to support vulnerable families, which is those experiencing multiple disadvantages such as worklessness, domestic abuse, and poor mental health.

In Kent the government's Troubled Families programme is now fully integrated into Early Help and Preventative Services, and families receive intensive support through the work of the Early Help Units.

There are 6 headline problems, and a family would need to meet 2 of these eligibility criteria as laid out by Troubled Families Outcome Plan to be worked with under this programme:

1. Staying safe in the community: parents or children involved in crime or anti-social behaviour
2. Getting a good education and skills for life
3. Improving children's life chances: children who need additional support, from the earliest years to adulthood
4. Improving living standards: families experiencing or at risk of homelessness, worklessness or financial difficulties (part 1, 2, 3)
5. Staying safe in relationships: families affected by domestic abuse
6. Living well, improving physical and mental health and wellbeing: parents and children with a range of health needs (part 1, 2)

Families must meet the following 4 principles to be considered as 'worked with' under the Troubled Families programme:

- there will have been an assessment that considers the needs of the whole family
- there is an action plan that takes account of all (relevant) family members
- there is a lead worker for the family that is recognised by the family and other professionals involved with the family
- the objectives in the family action plan are aligned to those in the area's Troubled Families Outcomes plan.

The family will be deemed 'turned around' when all the criteria have significantly improved for a sustained period, and at this point a claim can be submitted. The programme required

Kent to turn around 9,200 families by March 2020. To achieve this target, the programme must identify substantially more than 9,200 families (99). All families known to Early Help Units and family support commissioned services are assessed against these 6 criteria. Kent achieved this target and was one of only a few local authorities to hit 100%. A reduced target of 1,541 was put in place for the 2020 to 2021 year, which recognized the challenges of engaging families during the COVID-19 pandemic.

6.6.5 Family Partnership Programme

The Family Partnership Programme is an evidence based early intervention intensive visiting service for families experiencing a range of vulnerabilities. The service is delivered by Family Partnership Programme Leads, integrated in each Health Visiting District across Kent. The strengths-based partnership programme is designed to empower parents and help them achieve the very best outcomes for their children, their families and themselves. The programme was developed by the Centre for Child and Parent Support at the South London and Maudsley NHS Foundation Trust, utilising the Family Partnership Model (FPM). The programme was implemented in Kent in June 2019.

Families who may benefit from the service can be identified for the service by midwives and other health or social care professionals. In the antenatal period, midwives complete a form if there are any concerns or vulnerabilities for a family and send this to their Health Visiting District Team. There are different forms used across the Kent and Medway Trusts, including the Maternity Support Form (MSF) or Concerns and Vulnerabilities (C&V) form. Each MSF and C&V form received is assessed by the district Family Partnership Programme Lead for inclusion in the programme. The programme is flexible, with 22 contacts starting from 28 weeks of gestation until the child is one year old. Following completion, the family will be supported by the universal Health Visiting Service.

A review carried out in October 2021, identified that between February 2020 to August 2021, 82% of those assessed were offered the programme and 63% of those offered accepted the programme. In this period, 300 individuals were recruited onto the programme[19]. Demand for the programme was greatest in the districts of Maidstone, Dartford, and Canterbury. Of those recruited, 71.8% completed the programme (up to their child's first birthday). Families may leave the programme before completion for several reasons, including moving out of area, their goals have been met or they no longer wish to engage with the programme.

The service supports families who have experienced adversities and therefore have more complex needs than the general population. Of those being supported 2 in 5 of the cohort are from those aged 19- 24 years old. Outcomes recorded at 6 months for those on the

[19] Recruitment of families onto the Family Partnership Programme was temporarily suspended between April 2020 and September 2020 due to the COVID-19 pandemic.

programme shows that a high proportion of children had received their immunisations as scheduled at 94.8%.

Chapter 6 key findings

Health visiting: It has been reported that the health visiting service have seen widening health inequalities with an increase in vulnerability and safeguarding risks.

Speech, language, and communication (SLC): The COVID-19 lockdowns have significantly impacted children's language and development. Kent, stakeholders have reported that SLC referrals have doubled for under 5 year olds in multiple areas across the county. Early Years Providers have also voiced that there has been an increase in referrals to LIFT with Specialist Teachers seeing children earlier. The Early years foundation stage (EYFS) profile results highlight that too many children currently start school with poor communication skills and personal care skills, such as not being toilet trained, and are not emotionally ready to learn, with avoidable national variations.

Children's centres: A national survey estimated that the proportion of children aged 5 years and under using a children's centre dropped from 50% to 41%, between 2014/15 and 2017/18. In Kent, the number of children registered at any setting were highest in 2017 and decreased in 2018 and 2019 The number of individual children aged 0-4 years old seen in Kent, between 2015 and 2019 peaked in 2017 and reduced in 2018 and 2019. The total number of visits for children aged 0-4 years old in Kent, to any setting between 2015 and 2019 have reduced each year from 2015.

Early years education: The number of two-year-olds using the funded early education entitlements have fallen since 2018 both locally and nationally. The overall take up of the free early education for 3 and 4 year olds between 2019 -2021 has remained around 88% in Kent, however, there is considerable variance across the districts. Thanet has the lowest percentage of children achieving 'at least the expected level in all prime areas of learning' in the Early Years Foundation Stage profile.

'**School ready'**: School readiness has been impacted greatly by the pandemic, with decreasing levels nationally. Communication and language development; personal, social, and emotional development; and literacy are cited as particular areas of concern.

Safeguarding & vulnerability: Between 2019 and 2021, Thanet, Dover and Swale district had the highest rate of front door contacts which met the threshold for the Kent Children's Social Work Services per 1,000 of the 0-4 year old population. **The most common primary reason for contact recorded in this period included 'domestic abuse' and 'risk of harm/ neglect within the family'. Children aged 0 years had the highest rate (per 10,000 children)** and number of children in need number, children on a child protection plan and looked after children, and the highest number of section 47 enquires and initial conferences when compared to the other 0-4 age groups. In 2021, the number and rate (per 10,000 children) of looked after children aged 0-4 years old in Kent, was at its highest of the 5 year period.

Family Partnership Programme: The programme supports vulnerable families with a recent review identifying that 44.8% of the clients recruited onto the programme had 4 or more adverse childhood experiences (ACEs) and 24.9% with 6 or more ACEs. 43% had 4 or more risk factors identified, with 78% of mothers reporting current or previous mental health, 54% parents with limited support and 49% with previous or current domestic abuse.

In summary the take up of service provision across the system is changing and presenting needs are more complex. Infants under 1 year of age are among the most vulnerable.

7. Development of and health outcomes amongst children 0-4 years

This section will set out the short and long-term physical, mental, and social needs of 0-4 year olds with a focus on those in Kent.

7.1 Pregnancy and early infancy

A Kent and Medway perinatal equity and equality audit was undertaken in November 2021 (100) which details various behavioural risk factors in pregnancy such as smoking and alcohol use, as well as key areas of perinatal care such as foetal growth, birth, and breastfeeding.

7.1.1 Smoking in pregnancy

Smoking in pregnancy can cause premature birth (which is associated with many complications), low birth weight, miscarriage, and perinatal death. Babies living in households with a smoking parent are more at risk of sudden infant death syndrome [SIDS] and respiratory conditions from second hand smoke. This emphasizes that there is no safe level of exposure to tobacco smoke for the foetus, (101) yet in England 9.6% of women were smoking during pregnancy in 2020/21. (102) Pregnant women are offered carbon monoxide screening at their booking and 36 week appointment to provide better quality support to women who smoke, as well as ensuring women and their families are safe from poisonous gas exposure.

One of the key ambitions of the Tobacco Control Plan (2017) (103) is to reduce smoking in pregnancy (as recorded at time of delivery), to 6% or less. This would achieve significant reductions in poor health outcomes, approximately:

- 45 – 73 fewer babies stillborn
- 11 – 25 fewer neonatal deaths
- 7 – 11 fewer sudden infant deaths
- 482 – 796 fewer preterm babies
- 1455 – 2407 fewer babies born at a low birth weight (104)

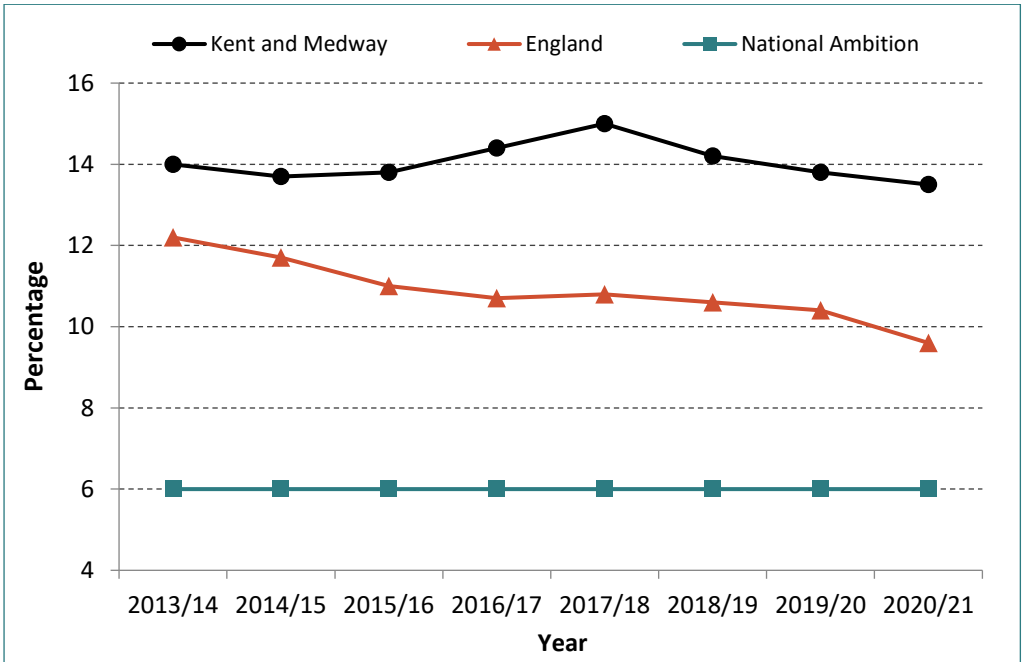
Although the national rate is decreasing, it is decreasing more slowly in women of lower socioeconomic status, with women who are younger, single, or live with a partner who smokes being more likely to smoke, thus contributing to health inequalities. (101) Furthermore, treating mothers and their infants with problems caused by smoking during pregnancy is estimated to cost the NHS between £20 million and £87.5 million each year. (105)

Despite investment and various smoking cessation interventions throughout the county, including a smoking cessation midwife post, smoking at time of delivery [SATOD] in Kent and Medway in 2020/21 is 13.5%, higher than the national average. In the last decade, the

proportion of smokers at the time of delivery in Kent and Medway has been statistically significantly higher than the England average.

Though national prevalence has declined steadily since 2013/14, the prevalence in Kent is remaining relatively stable, see the figure below. Children growing up in homes with parents who smoke are around three times more likely to smoke themselves and, similar to pregnancy, there is no safe level of exposure to second-hand smoke.

Figure 47: Percentage (%) of women who report to smoke at time of delivery, Kent & Medway and England, 2013/14 to 2020/21



Source: NHS Digital, prepared by KPHO (LS), September 2022

The SATOD data published by NHS Digital is reported by the Kent and Medway CCG at CCG level and therefore does not enable the authors to report SATOD rates for Kent and Medway separately. The authors have not been able to include SATOD data at a trust level, as the published data available suggests that there are data quality issues which have caused inaccuracies and gaps in the data.

Smoking in pregnancy is one of many factors linked to prematurity (birth before 37 weeks' gestation) and low birth weight. For information on low birth weight, see section 7.6, 'healthy infant growth'.

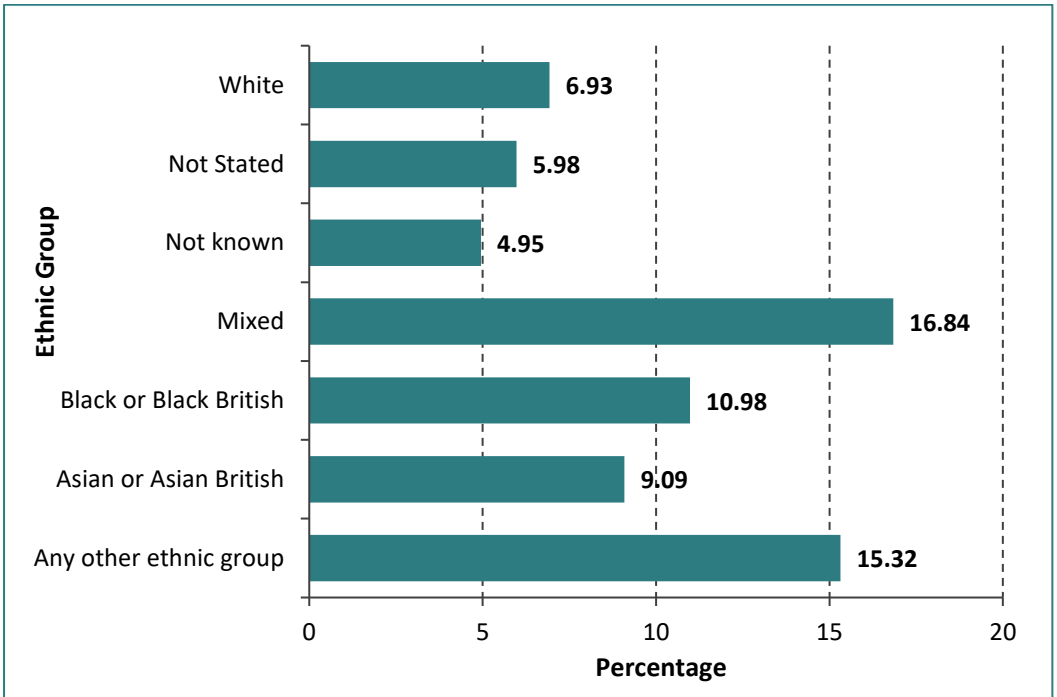
7.1.2 Prematurity

Depending on the level of prematurity, babies can be more at risk of severe developmental, behavioural, physical, and mental health needs. Premature babies are also more at risk of prolonged hospital admission, sudden infant death syndrome [SIDS], and neonatal death. It is the leading cause of death in children under 5 worldwide. Two prominent risk factors for prematurity are non-white ethnicity, and deprivation. These factors are becoming more

prevalent in Kent, with increasing variation in ethnicity due to migration as well as increasing deprivation in some districts.

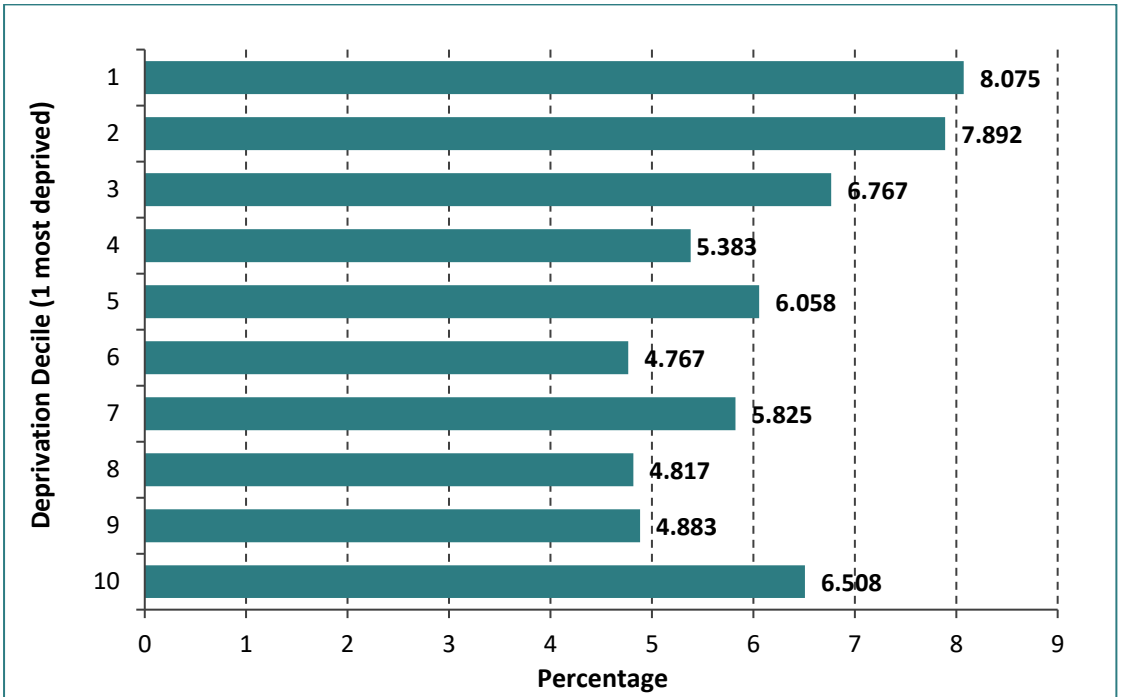
Premature births in Kent and Medway vary widely by ethnicity, deprivation, and age, as shown below. In Kent and Medway, premature births are more common in mothers of mixed, Black, or any other ethnic group, in mothers from the three most deprived deciles, and young mothers under 20 (as well as mothers over 40 years old). Often premature infants require more support with feeding, and parents require more support with infant care in the early weeks and months after birth. Support for families should be targeted at those most at risk, as well as prioritising health promotion activities such as smoking cessation, and focusing on the wider determinants of health such as deprivation. This is best achieved with a multi-agency approach.

Figure 48: Births under 37 weeks' gestation by ethnic group, Kent and Medway 2020/21



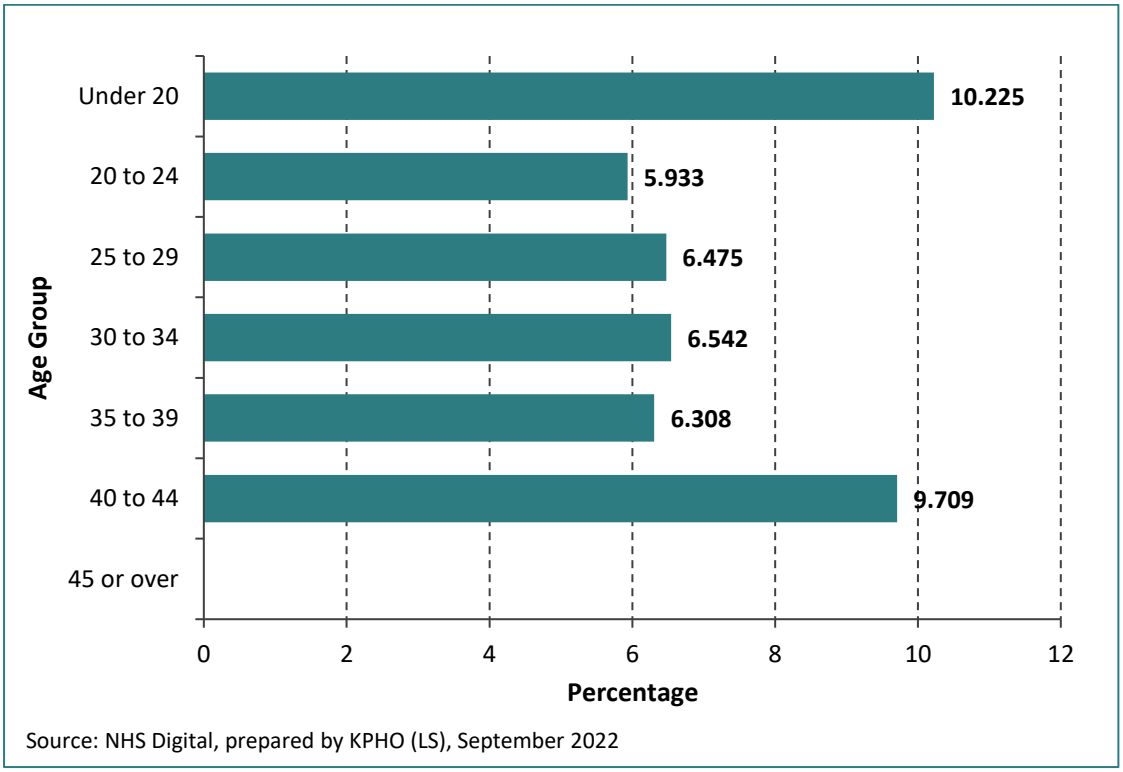
Source: NHS Digital, prepared by KPHO (LS), September 2022

Figure 49: Births under 37 weeks' gestation by deprivation decile, Kent and Medway 2020/21



Source: NHS DIgital, prepared by KPHO (LS), September 2022

Figure 50: Births under 37 weeks' gestation by maternal age band, Kent and Medway 2020/21



Source: NHS Digital, prepared by KPHO (LS), September 2022

The trust with the highest rate of premature births is Medway Foundation trust [MFT], (67.7 per 1,000, six-month rolling average, October 2021) which serves districts including Swale, with higher levels of deprivation compared to the Kent average. However, contribution to

this higher rate is likely to be the specialism provided, as MFT is a tertiary neonatal unit and receives referrals from across and outside Kent.

7.1.3 Unexplained infant deaths

Unexplained infant deaths are deaths from sudden infant death syndrome [SIDS], plus unascertained deaths. Unexplained infant deaths have been steadily decreasing since 2005. In 2019 there were 170 unexplained infant deaths accounting for 7.1% of all infant deaths in England and Wales. SIDS is the unexplained death of an infant under 12 months during sleep. Known risk factors include low birthweight, prone sleeping, second-hand smoke exposure, co-sleeping, and increased room temperature (106) and is also associated with deprivation and young maternal age. (107) (108) (109) Mothers under 20 years are over five times more likely to experience unexplained infant deaths than mothers over 40 years.

Male infants have a consistently higher rate of unexplained infant death than females and four times higher in babies of low birth weight (under 2500g). In 2018, the proportion of low-birth-weight babies, as a percentage of all live births with stated birth weight in Kent was 5%, lower than the England average 7.4%, which equated to 792 babies in Kent. The difference when looking at low birth weight in term babies is reduced. In 2020, the proportion of low-birth-weight babies as a percentage of all full-term live births in Kent was 2.42%, slightly lower than the England average 2.86%, which equated to 329 babies in Kent.

The report, '*Out of Routine: A Review of Sudden Unexpected Death in Infancy in Families Where the Children are Considered at Risk of Significant Harm*', published by the Child Safeguarding Practice Review Panel in July 2020, recommends co-producing information with parents, and a deeper understanding on the factors that may contribute to SIDS within the multi-agency team. (110)

Table 11: Unexplained infant mortality rates (per 1000 live births) 2009/18 to 2010/19, Kent, South East and England

Region	2009-2018	2010-2019
England	0.33	0.31
South East	0.27	0.27
Kent	0.43	0.43

Source: ONS

Co-sleeping has been identified in serious case reviews in Kent, highlighting the need for consistent messaging, clear communication, and training for healthcare professionals and parents. Public health in Kent have redesigned their thermometer card for parents and guardians with advice around safe sleeping and room temperature which is being disseminated through social care, maternity, and health visiting.

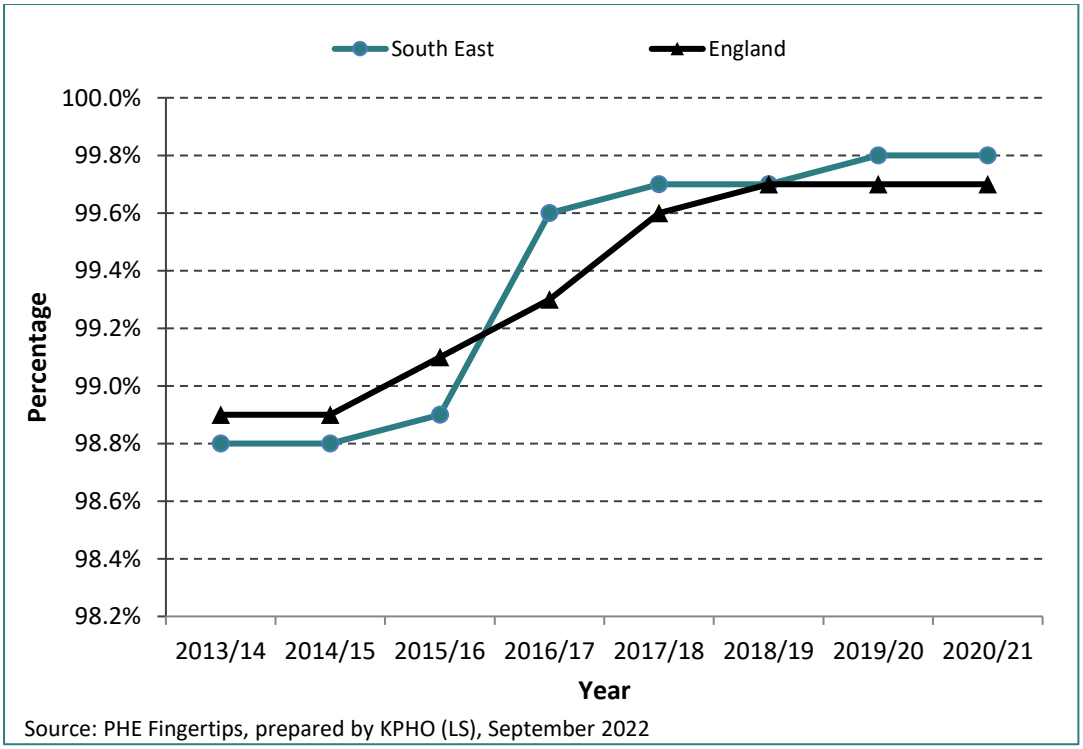
7.2 Pregnancy and newborn blood spot screening

7.2.1 Screening in pregnancy

Sickle cell and thalassaemia disease are inherited blood disorders (haemoglobinopathies) that can be life-threatening if not properly managed and treated. Sickle cell disease and thalassaemia disease are more common in people with family origins in Africa, the Caribbean, the Mediterranean, parts of Asia and the Middle East. Therefore, a family origins questionnaire is completed at booking, at around 10 weeks' gestation, to decide whether a pregnant woman requires testing or not. If a mother has the trait, the partner will be offered a test to see how likely the baby will be born with the trait (and be a healthy 'carrier') or have the disease. This is important to note as the ethnic profile of Kent is becoming more varied, with increasing migration, and so may have an impact on the number who screen positive for haemoglobinopathies.

Screening coverage for sickle cell and thalassemia in the South East and England are 99.8% and 99.7% respectively and have been steadily increasing since 2013/14.

Figure 51: Sickle cell and Thalassaemia screening coverage, South East and England 2013/14 to 2019/20



Source: PHE Fingertips, prepared by KPHO (LS), September 2022

There are between 260 to 350 babies born with sickle cell disease each year in England. Beta thalassaemia major is the most common and severe form of the disease, however only around 20 babies born in the UK each year have the condition.

7.2.2. Newborn blood spot

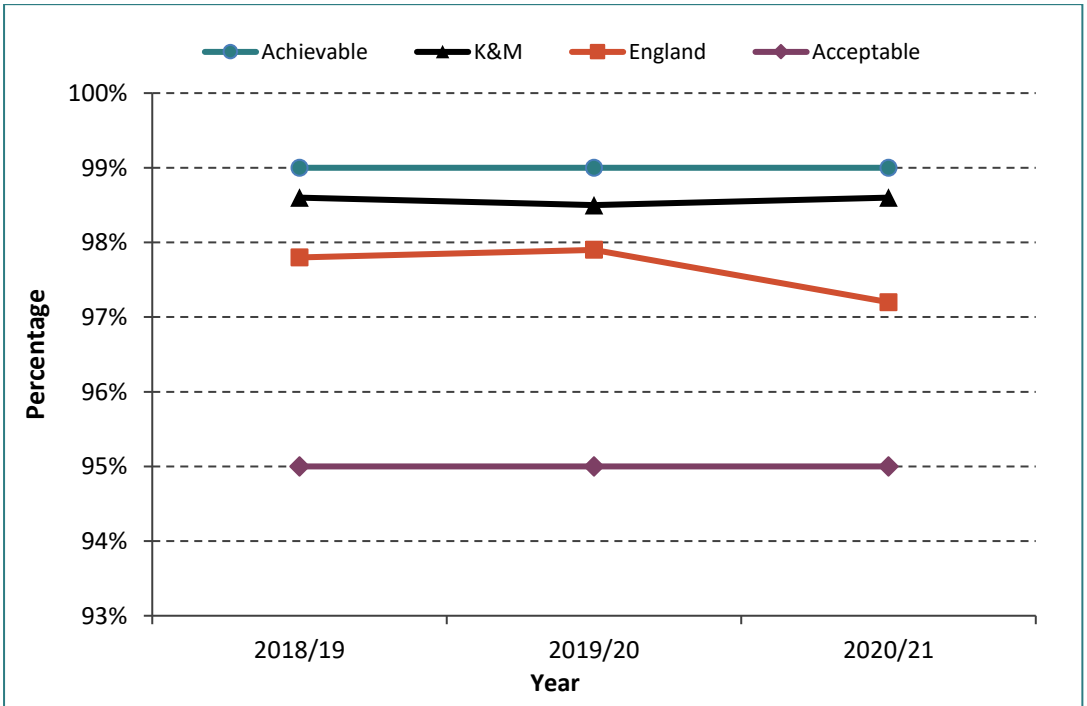
The newborn blood spot [NBBS], also known as the 'heel-prick test', is a screening test offered to all babies between day 5 and 8 of life, though preferably on day 5, and is part of the Healthy Child Programme. The NBBS screens for a variety of genetic and metabolic conditions to enable early detection and treatment of life-threatening and debilitating conditions: sickle cell disease, cystic fibrosis, congenital hypothyroidism, phenylketonuria, and MCADD. The following 4 additional disorders have recently been added to the screening list:

- Homocystinuria
- Maple Syrup Urine Disease
- Glutaric Aciduria type 1
- Isovaleric Aciduria

Screening coverage in the UK remains high, above the 95% 'acceptable' target, but still below the 99% 'achievable' target. Occasionally other medical conditions such as beta thalassaemia major will be detected by the NBBS. (116) When looking for data on Medi tool for sickle cell disease and thalassaemia hospital admissions, very small numbers in Kent were found for 0-4 year olds. Hospital episode data shows there were 35 admissions in the last 5 years amongst this age cohort in Kent.

The figure below shows the national screening coverage of the NBBS, and Kent and Medway have performed higher than England every year since 2018/19.

Figure 52: NBBS screening coverage (%) in Kent & Medway and England, 2018/19 to 2020/21



Source: PHE Antenatal and Newborn Screening KPI Data, prepared by KPHO (LS), September 2022

Since 2008, the rate of declined NBBS tests for babies has increased with the largest increases seen in 2018 and 2019. This poses an added challenge for maternity and health visiting services, to counsel parents and encourage screening uptake for the health of their baby. (111)

7.3 Immunisations

Immunisations (the process of vaccination and then developing partial or total immunity) are a safe and effective way of protecting children from many communicable diseases (112) and so are a vital part of public health programmes. However, this is also an area of growing concern: the World Health Organisation [WHO] stated vaccine hesitancy as one of the greatest threats to global health (113) however, variations in immunisation coverage could also be impacted by service provision particularly in the context of COVID-19, and deprivation. Early findings indicate that the COVID-19 pandemic has led to a reduction in early vaccination coverage for children. (114) The Royal College of Paediatrics and Child Health [RCPCH] recommend addressing concerns and misinformation by dispelling misconceptions and contradictions about vaccinations. (115) A report from the RCPCH found early immunisation rates have steadily fallen since 2014 for measles, mumps, and rubella [MMR] and since 2012 for the 6-in-1 vaccine given at twelve months. (115) Though this is a national issue, Kent is under the WHO global target of 95% vaccination coverage to achieve herd immunity, and frequently under the England average, 87%.

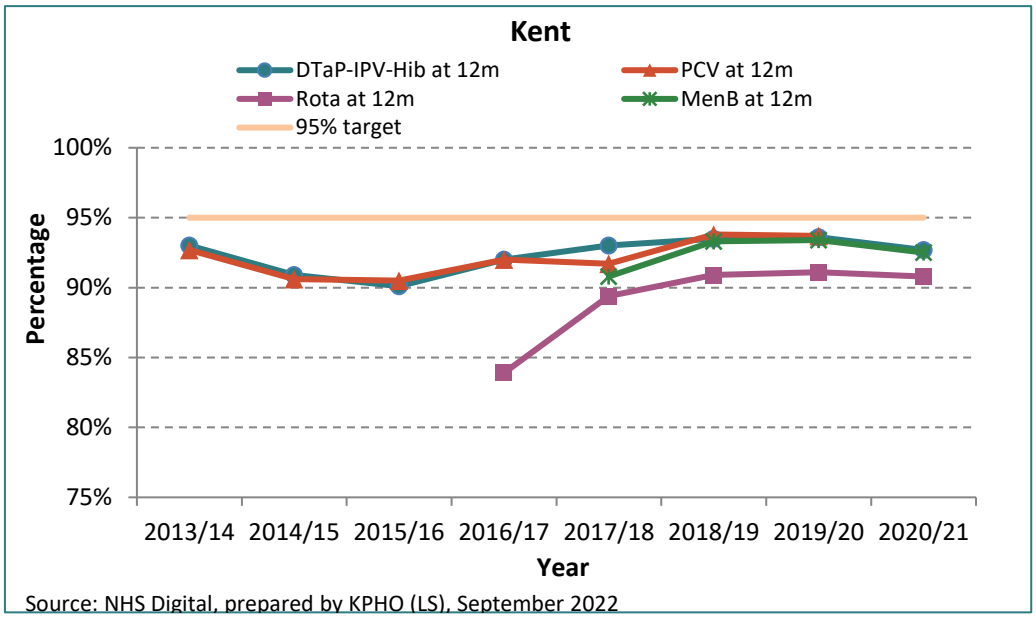
Childhood immunisations are part of the statutory service provision for children in England, provided through General Practice. These are offered at 8, 12 and 16 weeks old, at 1 year, and then 3 years and 4 months. Selective childhood immunisations are for:

- Babies born to mothers infected with hepatitis B: HepB immunisation
- Infants in areas of the country with Tuberculosis incidence over 40/100,000 (Kent is 5.6/100,000 (116)) or those with a parent/grandparent born in a high incidence country: BCG
- At risk children between 6 months and 2 years of age: influenza (117)

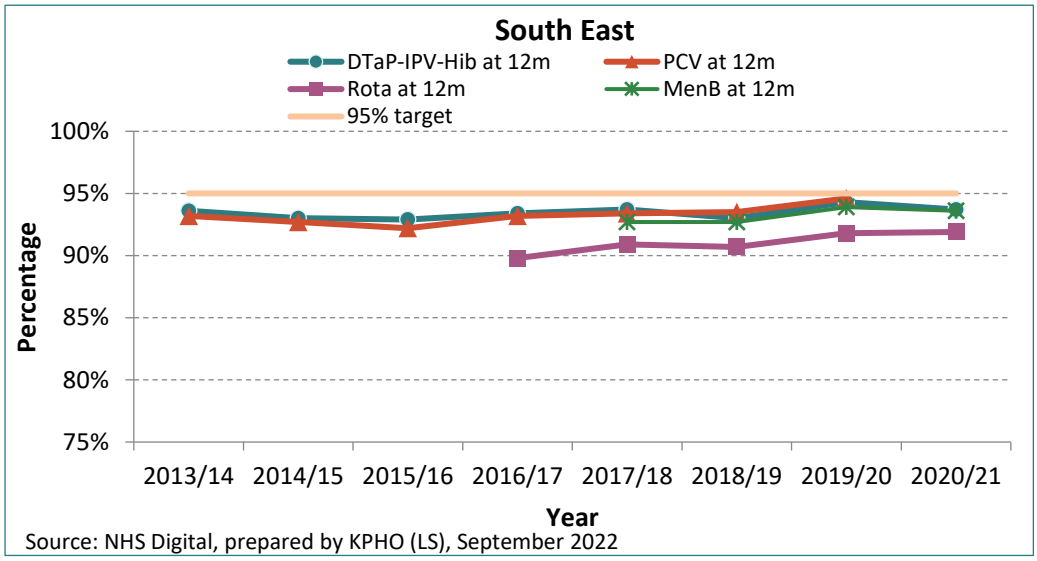
In Kent, vaccination coverage at 12 months has fluctuated since 2013/14 but has been decreasing since 2018/19. DTaP-IPV-HiB vaccination at 12 months by district showed very little variation in 2016-2018.

The oral rotavirus immunisation was introduced nationally in July 2013 to protect against the highly infectious virus, but coverage is not yet in line with other vaccinations.

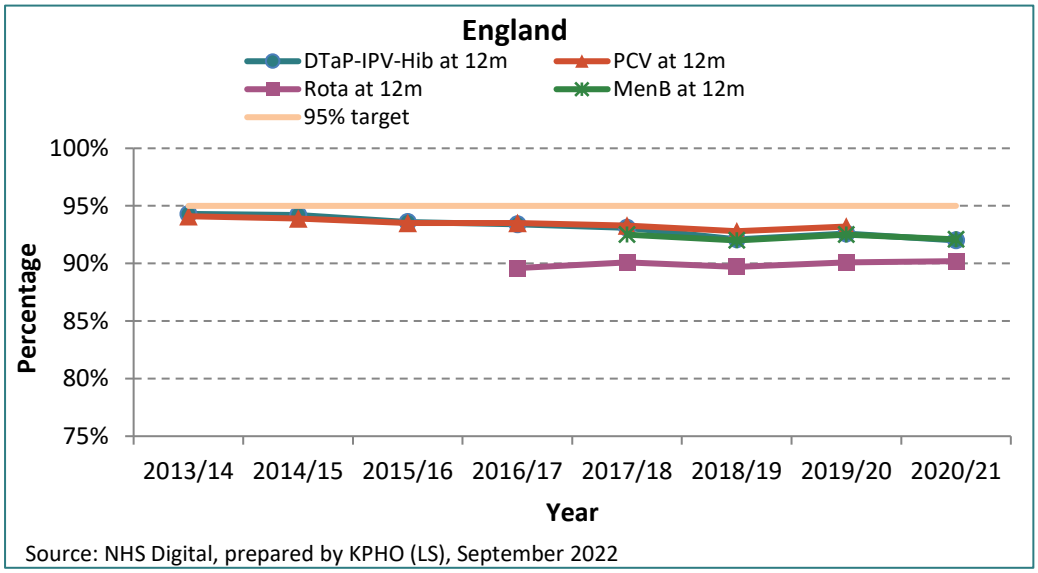
Figure 53: Percentages of childhood vaccination coverage at 12 months, Kent, South East and England 2013/14 to 2020/21



Source: NHS Digital, prepared by KPHO (LS), September 2022



Source: NHS Digital, prepared by KPHO (LS), September 2022



Source: NHS Digital, prepared by KPHO (LS), September 2022

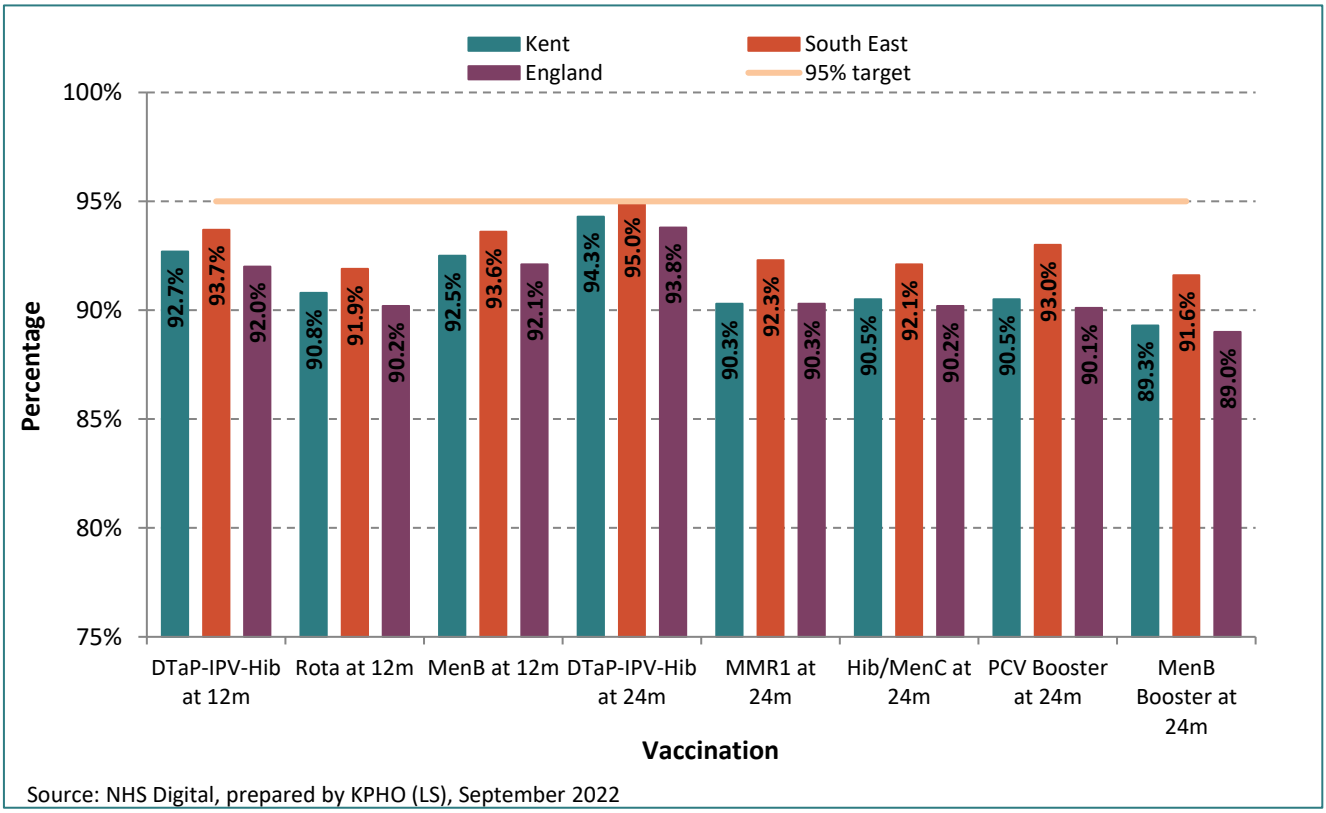
Since 2013/14, vaccination coverage at 2 years has fluctuated in Kent. DTaP-IPV-HiB has remained steady for the last 3 years, but the other vaccines given at 2 years have slowly been declining over the last 2 years.

Table 12: Population vaccination coverage at 2 years old, Kent and England 2020/21

Vaccination	Kent (%)	England (%)
Dtap / IPV / Hib	94.3%	93.8%
Hib / MenC booster	90.5%	89.8%
HepB	79.5%	-

Source: Child and Maternal Health - Data - PHE

Figure 54: Percentage coverage of all childhood vaccinations up to 2 years of age, by Kent, South East and England, 2020-2021



Source: NHS Digital, prepared by KPHO (LS), September 2022

In 2020/21, Kent fell below the regional average for coverage of childhood vaccinations up to 2 years which mirrors the national average. which illustrates that vaccination coverage remains below the recommended 95% target level, required for herd immunity.

Coverage of the MMR vaccination nationally remains below the 95% target and is declining. In Kent, there is little variation across districts in **MMR coverage for 2 doses**, **apart from**

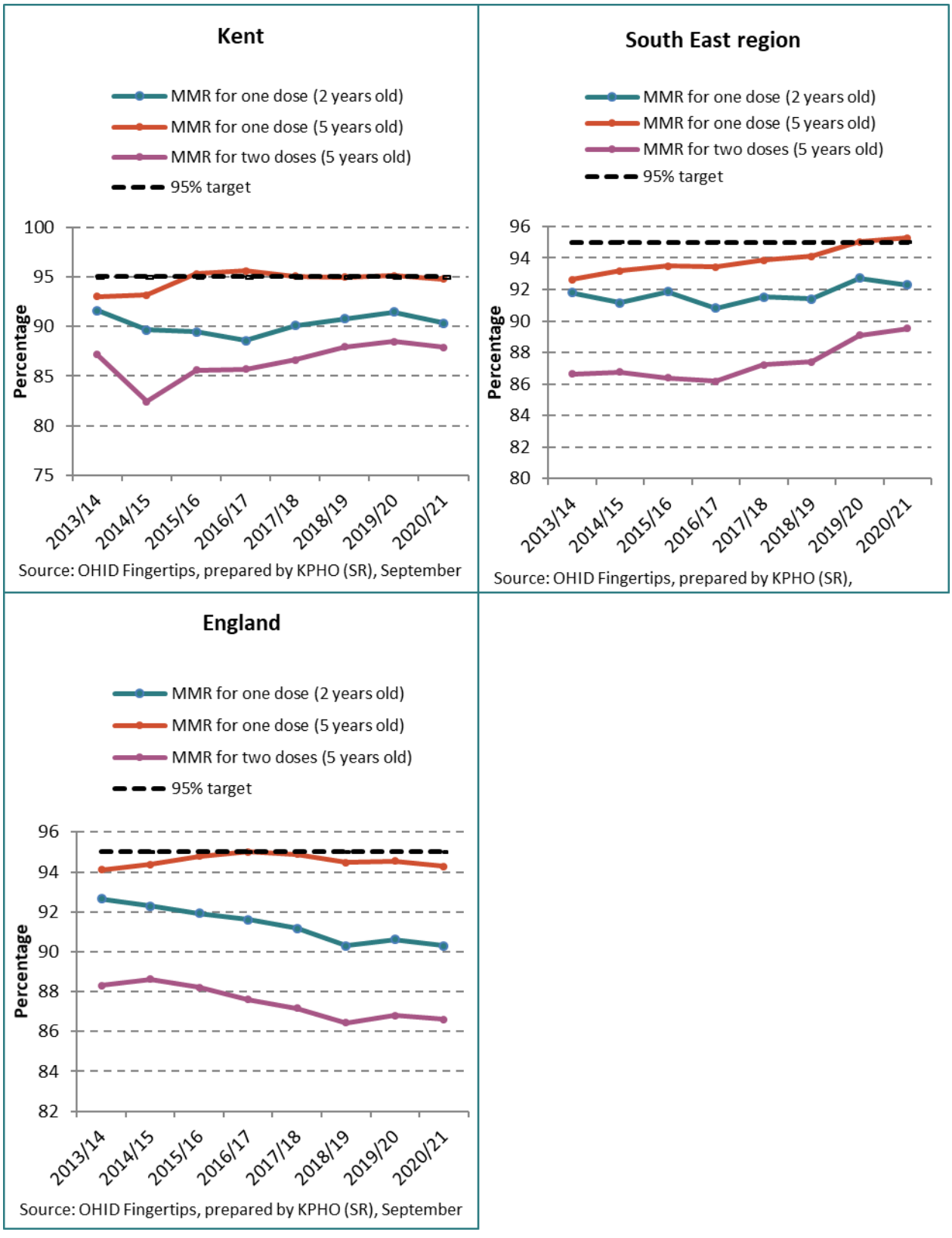
Dartford which is significantly below the county average. (118) In Kent, MMR coverage (one dose) at 5 years is steady, however MMR at 2 years and MMR (2 doses) at 5 years are falling gradually and below the 95% target.

Table 13: Population vaccination coverage of MMR, Kent and England, 2020/21

Vaccination	Kent (%)	England (%)
MMR for one dose (2 years old)	90.3%	90.3%
MMR for one dose (5 years old)	94.8%	94.3%
MMR for two doses (5 years old)	87.9%	86.6%

Source: Fingertips PHE

Figure 55: Proportion of MMR vaccination coverage, by Kent, South East and England 2013/14 to 2020/21



7.3.1 Influenza

The influenza vaccine is offered to preschool children over the age of 2. Compared to England, Kent had a higher percentage of children aged two and three vaccinated against influenza between September 2020 and February 2021.

Table 14 A: Provisional data - Percentage of children aged 2 years vaccinated against Influenza (seasonal flu), Kent and England 2020-21*

Region	All 2 year olds	Aged 2 and in a clinical risk group	Aged 2 and not in a clinical risk group
England	55.3	61.2	55.2
Kent	58.2	69.5	58.0

Table 14 B: Provisional data - Percentage of children aged 3 years vaccinated against Influenza (seasonal flu), Kent and England 2020-21*

Region	All 3 year olds	Aged 3 and in a clinical risk group	Aged 3 and not in a clinical risk group
England	58.0	65.7	57.8
Kent	61.0	75.5	60.6

Source: UK Government vaccination programme, quarterly data 2019/20

* Data is provisional and represents 97.2% of all GP practices in England responding to the February 2021 Child GP Flu Survey compared with 99.3% of practices in the same survey month in 2020-21.

7.3.2 Pertussis vaccination

Pregnant women are offered the pertussis vaccine from 16 weeks' gestation to protect their child against whooping cough after birth. The annual vaccine coverage for 2020/21 was 2.7% lower compared to 2019/2020. (119) Vaccination in pregnancy could be declining generally due to vaccine hesitancy observed in relation to COVID-19. (120)

Table 15: Pertussis vaccination coverage in pregnant women, Kent and Medway and England, 2020/21

Region	Coverage (%)
Kent and Medway	75.00%
England	67.78%

Source: PHE

7.4 Hearing loss

A newborn hearing screen is universally commissioned and offered to newborn infants within the first 30 days of life.[20] This is one of the national screening programmes (121) which commenced in 2006. The group which has oversight for national screening programmes seeks to lead on 'high-quality, uniform screening, providing accessible information to both the public and health care professionals and developing and monitoring standards. It is also responsible for the delivery of national quality assurance and for ensuring training and education for all those providing screening is developed, commissioned and delivered through appropriate partner organisations.' (122)

Longitudinal monitoring illustrates that the newborn hearing screening programme is effective and of those screened 3% have referral to audiology in the first 3-6 months of life. (123) A report conducted in 2017 concluded that *Prompt referral, diagnosis and treatment of babies who do not get a clear response at their screening test has given these children a better chance of developing speech, language and communication skills from an early age.* (123)

Although a universal programme, four groups of babies are excluded from the screening programme. The rationale for these exclusions is available through PHE. (124) These are infants with:

- microtia/external ear canal atresia
- Neonatal bacterial meningitis or meningococcal septicaemia
- Programmable ventricular peritonea shunts in place
- Confirmed cytomegalovirus [cCMV]

Microtia affects approximately 1 in 6,000 births (125) and causes hearing loss. This would equate to approximately 3 births in Kent each year.

The incidence of neonatal bacterial meningitis or meningococcal septicaemia is unclear. A hearing test should be offered four weeks after recovery from these infections, because one of the most common complications associated with meningitis is hearing loss and the most common cause of acquired childhood deafness.

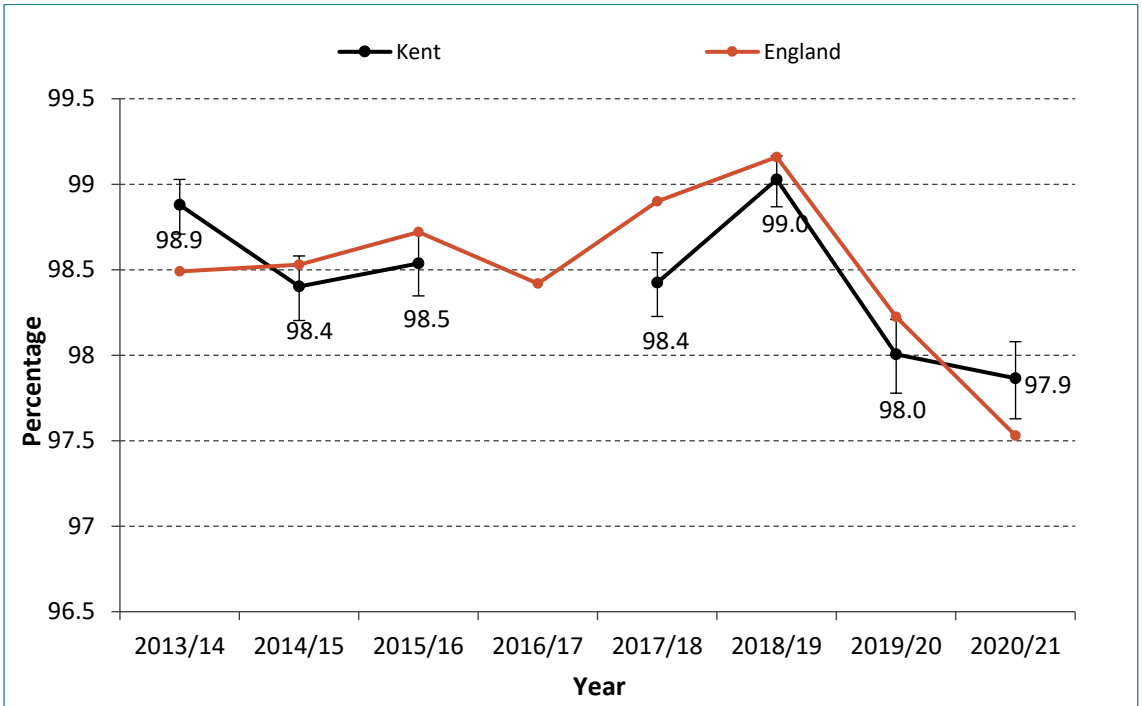
[20] Eligible babies (denominator) is the total number of babies born within the reporting period whose mother was registered with a GP practice within the CCG, or (if not registered with any practice) resident within the area covered by the provider NHSP site or CCG area, excluding:
• any baby who died before screening could be completed
• babies that have not reached 4 weeks corrected age (hospital programmes – well babies, NICU babies) or 5 weeks corrected age (community programmes – well babies) at the time of the report
• babies born in England and have had their record transferred electronically to Wales
Corrected age is used for babies born at <40 weeks gestation.

Congenital cytomegalovirus (cCMV) is the most common non-genetic cause of childhood sensorineural hearing loss. Approximately 6 per 1,000 babies are born with cCMV each year. This would indicate in the region 90 – 100 babies affected each year in Kent. cCMV is responsible for around 25% of childhood hearing loss. (126) These infants should be monitored through audiology and managed with prompt anti-viral treatment will help reduce the level of hearing loss.

Babies born with hydrocephalus may require insertion of a ventriculoperitoneal shunt and whilst hearing loss following neurosurgical procedures have been reported there is limited evidence related to these shunts. PHE have advised that infants requiring this procedure should be referred for audiology assessment not the hearing screening programme. (124)

Of those eligible, the proportion of infants who receive the new-born hearing screening programme in Kent has been consistently high as shown in the next figure.

Figure 56: Proportion of infants receiving a new-born hearing screen in Kent 2013/14 - 2020/21



Source: OHID Fingertips, prepared by KPHO (SR), September 2022

PHE undertook analysis of the new-born hearing screening programme in 2017/18. This analysis (127) did not identify detail of local population need but provides an overview of East and West Kent. This is presented as hospital activity, although it does not identify trusts or indicate whether Medway are included. The analysis indicates that the referral rate to diagnostic audiological assessment was 2.9% and 4.6% respectively in West and East Kent. Further work to understand this difference would be useful.

Evidence suggests that the prevalence of permanent hearing loss will increase with age amongst children through acquired hearing loss, which is estimated to be a minimum of 1.65/1,000 live births by the age of nine (128). However, this maybe a conservative estimate, given the more recent overview of hearing loss at birth which is 1-2 per 1,000 live births. It strengthens the need to utilise other opportunities where hearing can be measured, which the universal Year R hearing screening programme helps to provide.

'Between one and two babies in every 1,000 are born with permanent hearing loss in one or both ears.' (129) However, estimates of rates of hearing impairment in children are not routinely reported at local, regional or national level. Kent Public Health Observatory attempted to replicate published methodologies for estimating the prevalence of hearing impairment using locally available GP records from Kent and Medway. Their estimates, however, were significantly different from benchmarks in published literature and therefore insufficient confidence to report here.

One retrospective review (130) from the millennium cohort study population to identify the risk factors for permanent hearing loss in childhood has identified, that risk increased in those with neonatal illness whether or not neonatal care was required. Risk was also increased in those born to younger women and concurred with other earlier research that that there is increased risk amongst those of Pakistani or Bangladeshi ethnicity.

Importantly the review found that the risk of permanent childhood hearing impairment was highest between birth and nine months of age.

National data suggests that '8 out of 10 children will experience glue ear before the age of 10 years.' (131) A common condition particularly in those under 5 years, it can cause temporary deafness.

According to NHSE 'in a population of 500,000, there will be about ten new cases of permanent childhood hearing impairment per year, with about 50 pre-school and 200 school age deaf children in the population. In some areas, where there are large numbers of children who enter the UK after the age for new-born screening, this can be expected to be two to three times the national prevalence, due to population variations (deprivation and ethnicity).' (132) This may suggest that Kent could be expected to have a higher prevalence detected given the migrant population.

7.5 Oral health

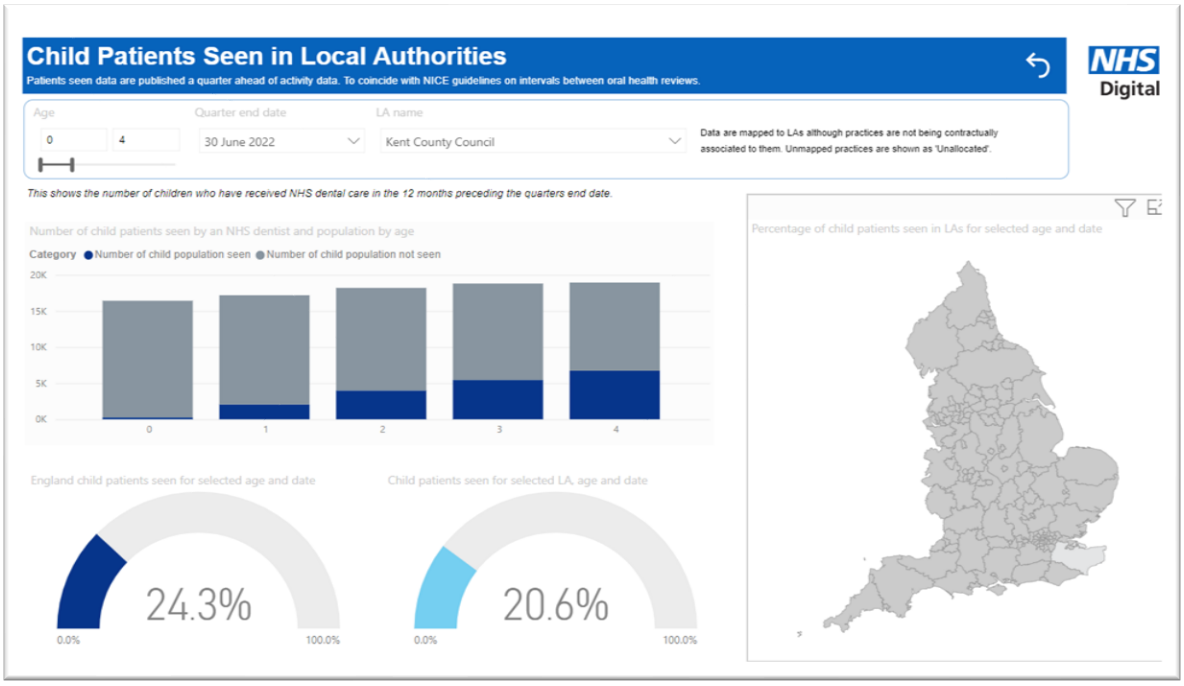
Tooth decay is preventable but continues to be the most common oral disease in children.

There are differences in primary and permanent teeth, including the composition of the enamel in primary teeth, which is less resilient and not able to provide the same level of protection from bacteria. Decay of primary teeth in the upper front teeth is associated with

the recurrent consumption of sugary drinks through bottles or supping cups. This decay can easily spread to other teeth.

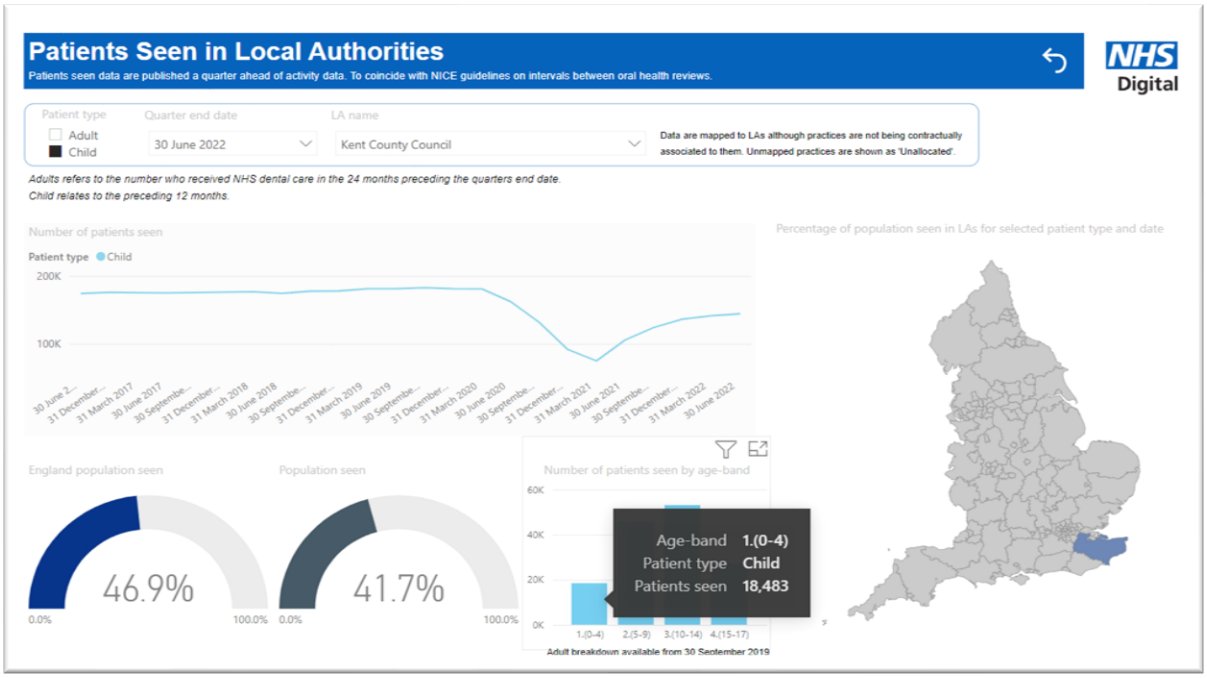
Effective oral health alongside early access to primary dental health care is important.

Figure 57: Access to primary dental care: 12 months to June 30th, 2022, by age 0-4 years, in Kent



Source: NHS digital

Figure 58: Numbers 0–4-year-olds seen by primary dental care: 12 months to June 30th 2022, Kent



Source: NHS digital

Tooth decay is more evident when a mouth receives a steady supply of sugar. The recurrent exposure to teeth from free sugars, is the main cause of dental decay. Toothache can cause difficulties with speaking, smiling, socialising, sleeping and eating.

A survey of dental health in a sample of children aged 3 years in two districts in Kent, took place in 2019/20. Based on the methodology utilised, teeth were examined, and the following key areas were identified:

- 14.5% of 3 year olds in Gravesham district compared to 10.7% of 3 year olds in England (whose parents gave consent for this survey) had experienced tooth decay whereas in Thanet district it was 4.2%
- Of these children 7.2% in England compared to 18.5% in Gravesham district and 10.4% in Thanet district had one or more teeth extracted.
- In England and Gravesham district, children had on average 3 teeth that were decayed, missing or filled (at age 3 most children have all 20 primary teeth) compared to Thanet district where children had on average 5 teeth that were decayed, missing or filled.

This suggests that there are differing needs based on the cohorts examined in Thanet and Gravesham districts, with less children identified with decay in Thanet but who experience significantly more decay compared to Gravesham and England. The findings from this cohort suggested that Gravesham district had more children who experienced tooth decay.

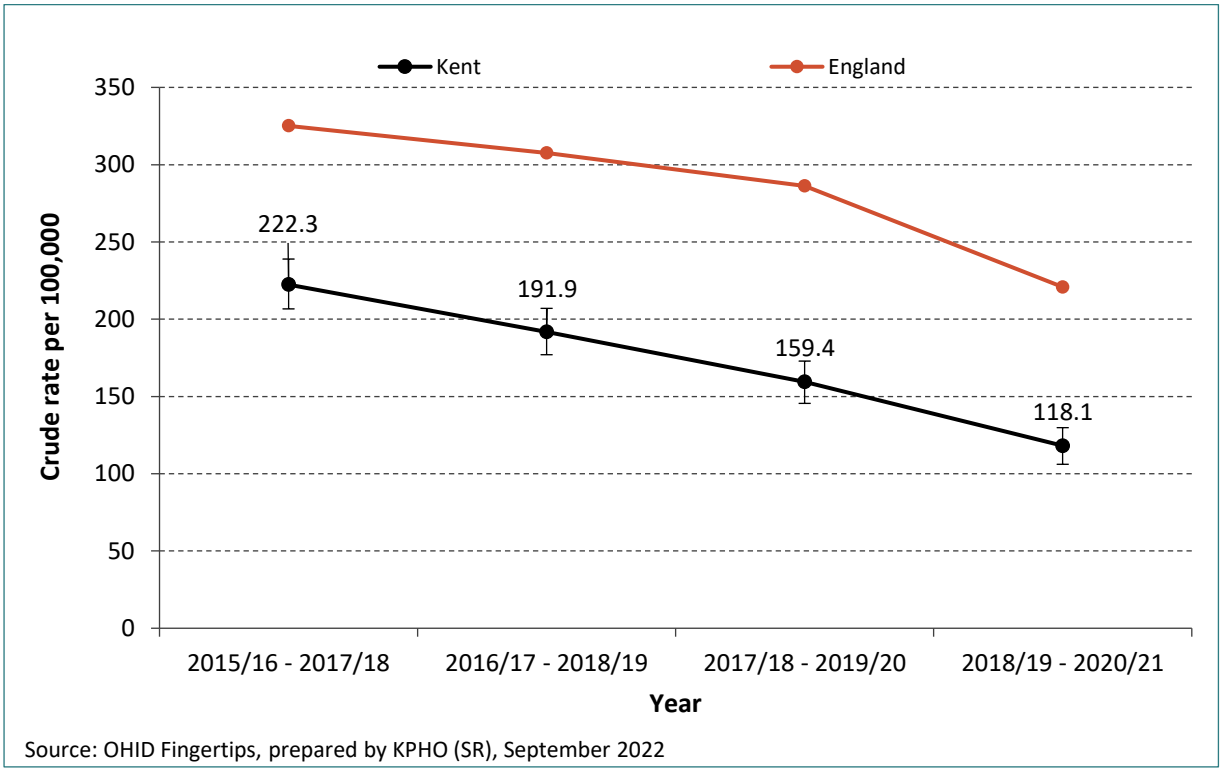
Decayed teeth are likely to be experienced and identified through pain. The subsequent removal of decayed teeth is most likely to be undertaken in hospital under general anaesthetic.

The published data for the finished consultant episodes [FCEs] for children 0-19 is presented in age bands, 0-5, 6-10, 11-14 and 15-19 years so are able to present information relating to 0-5 year olds. The proportion of finished consultant episodes (FCEs) for children aged 0-5 year for hospital dental extractions (surgical removal or simple extraction of tooth), as a % of population [all diagnoses] in Kent was 0.31%, with a range in districts from 0.2%-0.5% in 2018/19. In 2019/20 this was 0.27% in Kent, with a range in districts from 0.1%-0.4%.

There was very limited activity in Kent compared to other local authority areas in 2020/21 so it is not presented here as a proportion. Instead, it is shown as the extraction rate per 100,000 population 0-5 year olds. In 2020/21 the FCE hospital tooth extractions [all diagnoses] rate in Kent was 18.34 per 100,000 population aged 0-5 years.

One study (139) refers to the significant emotional and psychological issues of these dental extractions and the wait time to have the procedure undertaken.

Figure 59: Hospital admissions for dental caries among children aged 0-5 years in Kent 2015/16-2017/18 to 2018/19-2020/21



Source: OHID Fingertips, prepared by KPHO (SR), September 2022

Limited dental care and reduced access for dental extractions during the covid pandemic and potentially less focus on oral hygiene will have exacerbated inequalities in oral health of 0–4 year olds.

Supporting families to embed good oral hygiene practice when teeth start to appear, taking a child to the dentist before one year of age, making toothbrushing a regular activity and being mindful of the damage that free sugars have on teeth, will help ensure that infants and young children have good oral health. There are a range of written and visual resources on oral health to support families.

16% signposted to dentist / particularly Roma health & dentists no longer coming into schools

Source: Stakeholder interviews

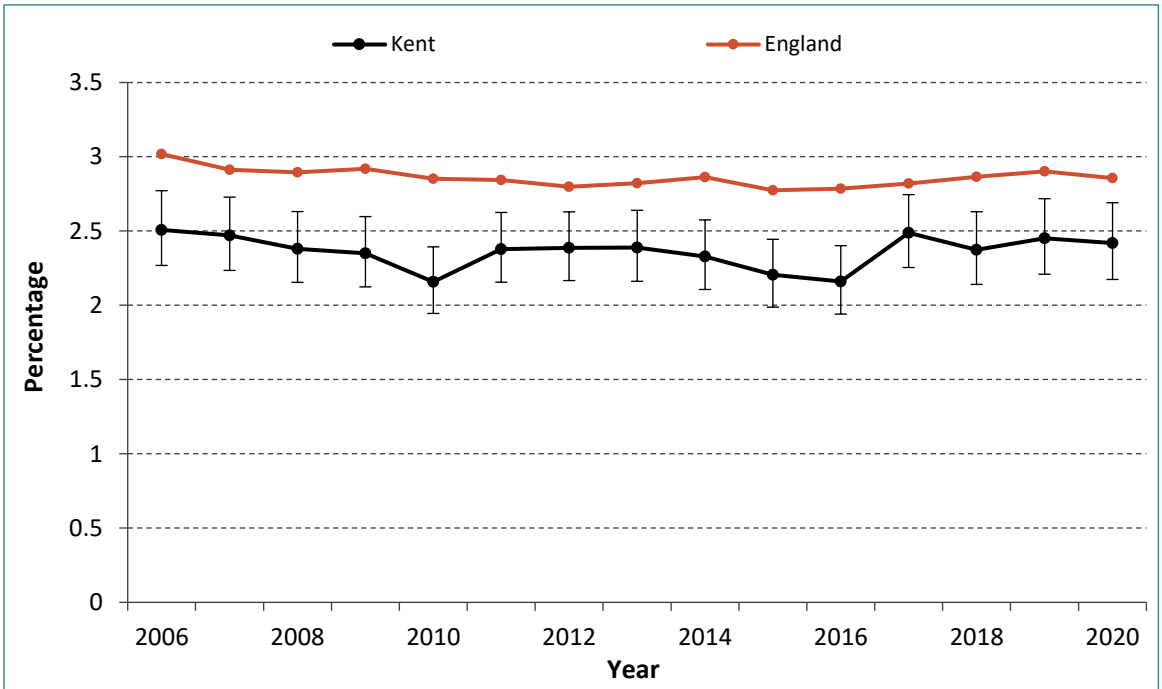
The RCPCH recommend the following oral health interventions:

- brush with fluoride toothpaste as soon as teeth erupt
- minimise sugary foods and drinks
- attend the dentist regularly for preventive advice and care
- Remember that poor oral health may be an indication of child neglect (133)

7.6 Healthy infant growth

Birth weight trends are difficult to identify at a local level as some reporting of ONS analysis has changed. Term babies refers to those reaching gestation of 37 weeks and over.

Figure 60: The proportion of live births at 37 weeks and over gestation with a low birth weight in Kent and England, 2006 - 2020



Source: OHID Fingertips, prepared by KPHO (SR), September 2022

Lower level analyse show that the trend in the number of live births at 37 weeks gestation and over with a low birth weight in Kent has been stable over a long period from 2006-2018. Importantly low birth weight per say is associated with increased risks of infant mortality, problems with childhood development and poorer health outcomes. Current data reporting of low birth weight is incomplete and therefore not included here.

One study (134) suggests that the birth weight in England and Wales has increased over recent decades which reflects the changes in age at which women give birth. This maybe a reflection of and contributing factor of higher BMI seen in more pregnant women and the associated risk of gestational diabetes.

Analysis of 2018 ONS birth weight suggests that the proportions of infants with a higher birth weight are seen in the South East compared to England, with slightly higher proportions of birth weight greater than 4kg [8.8lb]. This is likely to reflect the socio demographics in the South East, but to note the weight not being recorded may skew these observations.

Table 16: Proportions of birth weight across weight ranges in England and South East, 2018

Birth weight in grams	under 1500g	1500-1999g	2000-2499g	2500-2999g	3000-3499g	3500-3999g	4000-4499g	4500-4999g	5000g +	Weight not stated
England	0.94%	1.26%	4.74%	16.62%	35.52%	28.73%	8.74%	1.15%	0.10%	2.16%
South East	0.84%	1.06%	4.11%	14.94%	34.88%	29.82%	9.56%	1.33%	0.11%	3.29%

Source: ONS

The first days of life have an emphasis on weight which helps in part to identify that a baby is thriving. This does not necessarily involve weighing the baby although facilities are available in children centres.

There is evidence (135) which suggests that breast feeding can help prevent excess weight and obesity with greatest protection for babies breast fed for 6 months. The prevalence of breastfeeding is recorded through collection of the feeding status at the 6-8 weeks mandated health visiting service health and wellbeing review. Analysis of this data is provided in the next section, 'Infant Feeding'.

A breastfed baby is less likely to overfeed, but rather be satisfied and end feeding. Formula feeding guidance provided by the manufacturer includes volume of feed to be prepared by age. Over concentration of feed could lead to dehydration and excess weight. Recommendation is to formula feed on demand and not encourage the finishing of the bottle. (136) A study in Chicago (137) looked at the number of times a full-term baby was overfed [more than 30 ml] formula feed on the first day of life and the weight of these children at age four. This study showed that 'overfeeding on the first day of life is an independent risk factor for the development of overweight and obesity.' This reflects the suggestion that early overfeeding damages the development of the brain to understand when the stomach is full.

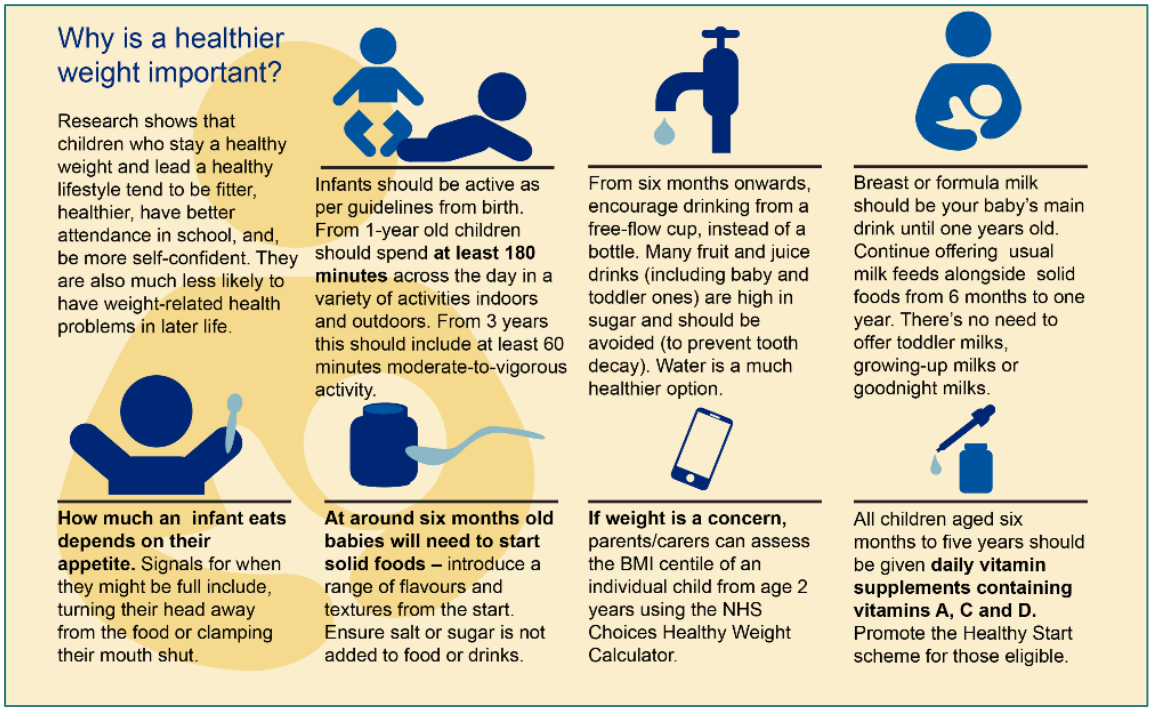
Universal healthy weight interventions for 0-4 year olds are provided by the Health Visiting Service. This offer is developing and includes health promotion messages given at the 5 mandated contacts, information and support on infant feeding, including introduction to solids, portion size and at other opportunities where they arise. The provision of advice on safe eating is also recommended to avoid difficulties which may impact a small child's airway. A local resource is being produced.

A published study (138) by a local health visitor which explored use of a healthy weight discussion tool, reiterates the challenges of addressing infant weight with families, but illustrated its potential benefits to reduce weight centiles in overweight infants.

The CMO report 'Time to solve childhood obesity' (139) highlighted that **1 in 4 babies gain too much weight in the first 18 months of life**. This was identified through a study completed in 2016 but indicates the importance of supporting families to develop their

awareness about the role of food in early child development. A study (140) in the USA reports that over the last three decades there has been a 60% increase in the prevalence of obesity in infants less than 2 years old.

Figure 61: Illustration of why a healthy weight in early childhood is important



Source: PHE

There are recommended levels of activity for 1-5 year olds: to aim for at least 180 minutes of physical activity every day – including activities such as dance, games, messy play, jumping, and swimming. It is recommended under 1s have 30 minutes of tummy time across the day. This level of physical activity for under 5s helps maintain a healthy weight, develop motor skills, encourage brain development, improve sleep and build relationships. (141) A systematic review found physical activity of at least moderate to vigorous intensity in 0-4 year olds is associated with better health indicators, and particularly found using varying types of exercise beneficial, including tummy time for under 1 year olds. (142)

7.6.1 Infant Feeding

"Breastfeeding is one of the most effective ways to ensure child health and survival." (143) [1:2021]

The World Health Organization (WHO) and UNICEF recommend "exclusive breastfeeding for newborns and for the first six months of infancy; and introduction of nutritionally-adequate and safe complementary (solid) foods at 6 months, together with continued breastfeeding up to 2 years of age or beyond" (144).

A number of benefits have been identified for infants who are breastfed (145) (146). This includes a lower risk of sudden infant death syndrome, diabetes, obesity (discussed in section 7.6), infectious diseases in infancy such as gastrointestinal and respiratory infection and allergies including asthma.

A number of sociodemographic factors have been associated with breastfeeding, including maternal age, socioeconomic background, maternal education and ethnicity, both in the UK and other high income countries (147) (148) (149) (150) (151) (152). The UK Infant Feeding Survey in 2010 (147), found that the highest incidences of breastfeeding were among those from minority ethnic groups, those who were in full-time education until the age of 18 and those in managerial and professional occupations. Rates were higher for those living in the least deprived areas and the incidence of breastfeeding decreased as deprivation levels increased. The survey also found that rates were highest among mothers aged 30 or over and lowest among mothers under the age of 20.

Breast milk at first feed

Data on the percentage of babies who had a first feed status recorded with a first feed of maternal or donor breast milk has been published by NHS Digital since 2017/18. The experiences of labour, the mode of delivery, maternal choice and other factors will impact on the timing and success of a first feed of breast milk.

The requirement on the maternity dashboard is reporting of first feed, however anecdotally it has been articulated that the definition and reporting is inconsistent across the trusts in Kent and Medway. The table below presents the breast milk at first feed data available for Kent and England. Published data at a county level is not available for 2019/20 and 2020/21.

Table 17: Percentage of babies whose first feed is breastmilk, Kent, 2017/18-2018/19

Region	2017/18	2018/19
Kent	66.0%	65.2%
England	-	67.4%

Source: Maternity Services Dataset (MSDS)

The following table presents the breast milk at first feed data available by NHS Trust and England. Data at a trust level was not available for 2019/20.

Table 18: First feed status, babies who received maternal or donor breast milk, Maternity trusts, Kent and Medway LMNS and England 2017/18-2020/21

NHS Trusts	2017/18	2018/19	2019/20	2020/21*
Dartford & Gravesham NHS Trust	65%	66%	-	66%
East Kent Hospitals University Foundation NHS Trust	63%	59%	-	66%
Maidstone & Tunbridge Wells NHS Trust	70%	72%	-	74%
Medway Foundation NHS Trust	68%	71%	-	33%
England/ All submitters	58%	67%	60%	62%

Source: NHS digital maternity statistics

*This is the data the authors observed suggesting there are data reporting issues or the detail was incomplete.

Feeding at 6-8 weeks [21]

A set of three validation rules are applied to the 6-8 week breastfeeding measure. The next table shows that over the last four-year period Kent has not meet the stage 3 validation test, which requires knowing the breastfeeding status of 95% or more infants at 6-8 weeks.

Table 19: Percentage of infants whose breastfeeding status was known at 6-8 weeks, Kent and England 2016/17 -2020/21

Region	17/18	18/19	19/20	20/21
Kent	93.7%	91.3%	93.2%	89.4%
England	87.6%	87.5%	89.3%	87.1%

Source: PHE Gov breastfeeding data

The next table shows that the percentage of infants who are totally or partially breastfed at the 6-8 week contact in Kent between 2017/18 and 2020/21 has increased slightly and remained above the England (aggregated) prevalence.[22]

Table 20: Percentage of infants who are totally or partially breastfed at 6-8 weeks (of those with a breastfeeding status completed), Kent and England, 2016/17 -2020/21

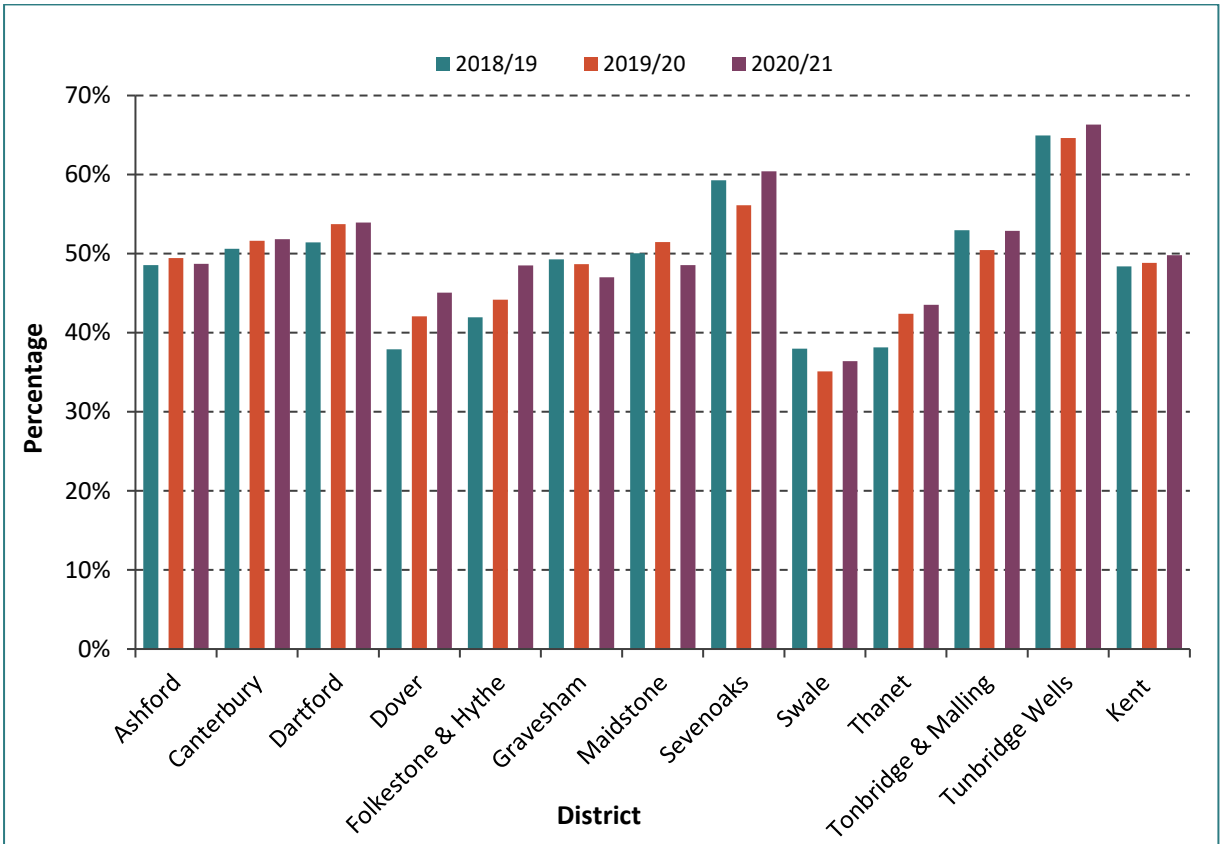
Region	17/18	18/19	19/20	20/21
Kent	48.3%	48.4%	48.8%	49.8%
England	43.1%	46.2%	48.0%	47.6%

Source: Kent data - Kent Community Healthcare Foundation Trust and England data - PHE Gov Breastfeeding data

[21] Please treat the figures with caution: where totals are presented for England, these are aggregate totals of the local authorities that submitted information and passed initial validation.
[22] Please treat the figures with caution: where totals are presented for England, these are aggregate totals of the local authorities that submitted information and passed initial validation.

Looking at the data at district level suggests that the percentage of infants who are totally or partially breastfed at 6-8 weeks varies considerably highlighting the correlation between lower prevalence of breastfeeding and levels of deprivation.

Figure 62: Percentage of infants who are totally or partially breastfed at the 6-8 week visit, by district and Kent, 2018/19, 2019/20, 2020/21



Source: Kent Community Health Foundation Trust, prepared by KPHO (SR), September 2022

7.6.2 Infant Feeding Service

The Kent Infant Feeding Service, delivered by KCHFT, provides universal and specialist infant feeding support to families across Kent.

Universal support includes the provision of breastfeeding groups delivered by Breastfeeding Champions (from the Health Visiting Team) and Breastfeeding Volunteers (peer to peer support). The COVID-19 pandemic did impact the provision of the breastfeeding support groups, however the lactation consultants/specialist infant feeding service developed virtual support with live and recorded support on videos, through social media and virtual groups.

The service also provides specialist support, delivered by the Specialist Breastfeeding Practitioners, including specialist infant feeding leads and qualified lactation consultants. The Specialist Breastfeeding Service can deliver support virtually or face to face, either in the home or in a specialist breastfeeding clinic. The voluntary sector provides additional offers of infant feeding support in the county.

Tongue Tie

Tongue tie [TT] is a congenital anomaly caused by a tight or short frenulum which may inhibit the mobility of the tongue. The frenulum is a membrane that secures the tongue to the floor of the mouth. The frenulum normally thins and recedes before birth. However, where this fails to happen the frenulum may affect the shape of the palate and restrict tongue mobility which impacts on the baby's ability to latch on most effectively. Studies have found that tongue tie is more common in male babies.

Some babies with TT can breastfeed well from the start and others when there is improvement in positioning and attachment, for example, when the breast is not engorged. Poor attachment may affect milk supply and subsequently weight gain. Maternal nipple pain and damage may be caused by the babies' inability to suck effectively creating difficulty with feeding.

Published research (155) presents different findings suggesting that tongue tie affects between 3-11% of babies. Kent and Medway CCG commission acute providers, to complete frenulum division procedures in line with NICE guidelines for infants under 12 weeks with a diagnosed restricted frenulum. This is a fluctuating service provision which requires stability to address local need. To help facilitate this challenge KCHFT have established a tongue-tie co-ordination and support function role, as an extension to the current Specialist Infant Feeding Service. This is to support a system-wide approach to referrals, clinical triage and support for babies and their parent/carers awaiting a frenulotomy procedure.

Other support

The We Are Beside You website (www.wearebesideyou.co.uk) and social media (#wearebesideyou) supports breastfeeding across Kent and Medway, with information for pregnant and breastfeeding women and their supporters. There are also many local voluntary groups and national helplines which can provide infant feeding support to families, information on which is available on We Are Beside You website.

Baby Friendly Initiative

The UNICEF UK Baby Friendly Initiative provides a framework for the implementation of best practice by NHS trusts, other health care facilities and higher education institutions. Implementing Baby Friendly standards is a proven way of increasing breastfeeding rates. It also means health professionals can give mothers the support, information and encouragement they need. The following organsiations in Kent have either achieved or are working towards differing levels of Baby Friendly accreditation.

Table 21: UNICEF baby friendly accreditation status by organisation, Kent and Medway, January 2022

Organisation	Accreditation status
Darent Valley Hospital, Dartford and Gravesham NHS Trust	Maternity - Further assessment required [1]
	Neonatal - No current information
Maidstone Hospital, Maidstone Tunbridge Wells NHS Trust	Maternity - Stage 2
	Neonatal - Not applicable
Medway Hospital, Medway Foundation NHS Trust	Maternity - Full accreditation
	Neonatal - Stage 1
Queen Elizabeth Queen Mother Hospital, East Kent University Hospital NHS Foundation Trust	Maternity - Stage 1
	Neonatal - Certificate of commitment
Tunbridge Wells Hospital, Maidstone Tunbridge Wells NHS Trust	Maternity - Stage 2
	Neonatal - Stage 2
William Harvey Hospital, East Kent University Hospital NHS Foundation Trust	Maternity - Stage 1
	Neonatal - Certificate of commitment
Kent Community Health NHS Foundation Trust	Full accreditation
Children's Centres in Kent run by KCC	Full accreditation

Source: UNICEF Awards

7.7 Mental health and wellbeing

In 2015, PHE reported that 'the mental wellbeing is of particular importance in younger age groups **as childhood experiences in infancy and the first five years of life have been found to have a lasting impact upon a child's mental wellbeing**.' (153) [6:2015]

The publication of 'The best start for life start for life: a vision for the 1001 critical days', (27) raises the importance of maternal wellbeing during pregnancy and the environment in which the pregnancy progresses which impacts on the development of the growing foetus.

The impact of perinatal mental health of parents will impact the emotional health and wellbeing of infants in the first 1001 days and beyond which illustrates that the mental

health and wellbeing of mums, dads, partners and carers is crucial to the development of the baby.

Poor mental health can impact a parent's ability to bond with their baby, to develop that invaluable attachment and have the capacity to nurture them. NICE (154) defines attachment as 'a secure relationship with a main caregiver, usually a parent, allowing a baby or child to grow and develop physically, emotionally and intellectually. Babies and children need to feel safe, protected and nurtured by caregivers who identify and respond appropriately to their needs.' This reiterates the importance of meeting the needs of parents and carers so they are better equipped to meet the needs of their baby.

Poignantly other reports advise that despite wide political and evidentiary support for the first 1,001 days of a child's life, there are few opportunities for health and social care services to notice, identify and support infants under 5 years of age. (155)

In 2017, NHS Digital found that two to four year olds were 2.7 times more likely to develop a mental disorder if they have a parent who also has poor mental health.' (156)

It is recognised that the way infants develop and build relationships is important to brain development. In turn these impact on emotional, social, intellectual and psychological development.

One recent study (157) which has looked at sleep deprivation in early childhood has found that that there are correlations between early infancy sleep problems such as short sleep direction/difficulty falling asleep, frequent night waking and specific behavioural and mental problems at 2 years. These sleep problems were clearly associated with daytime behavioural problems including over activity, anxiety, defiance, and aggression.

A small study by Ofsted (158) of children in early years during October 2020 identified in response to the question 'overall, would you say that children's learning and development has improved, fallen behind or stayed the same in the following areas' that the development area which had fallen behind most was social and emotional development. 'EY providers were most concerned about the effect of COVID-19 restrictions on children's personal, social and emotional development. This was most frequently cited when we asked providers to identify one area of learning that had declined the most.' [6:2020]

Opportunities for play and social interaction with peers help to lay the foundations for emotional health and wellbeing. Reduced access to or uptake of early year provision has been observed in Kent (see section 6.4).

There is no data which quantifies the breadth of the mental health needs of children aged 0-4 years, but there is a review of children's development, including personal social skills, through the Ages and Stages Questionnaire (ASQ-3) undertaken by the health visiting service when a child is 2-2 ½ years old, which have been used since 2015. This provides a measure of development and helps to identify children who are not developing as expected. This could lead to closer monitoring of progress or early intervention services.

Understanding and identifying the range of risk factors to which 0-4 years olds are exposed, will help the system better support those at risk. Recognising that:

> 'Children express mental health differently at a young age - anger and behaviour issues are often picked up as autism'

Source: Stakeholder interviews

7.8 Long-term illness

This section focuses on three long term conditions. A report in 2017 (159) looked at the relationships between the use of emergency hospital services and deprivation in England, amongst children and young people, over the previous 10-year period.

The study found that those children and young people consistently most likely to attend A & E and need emergency hospital treatment were from the most deprived areas. In 2015/16 the researcher observed that of those preschool aged children attending accident and emergency, the portion was 50% higher amongst those in the most deprived areas compared to the least deprived areas. Whilst the study found hospital attendances for epilepsy and diabetes amongst children and young people had reduced over the time period, they suggested that this may have been as a result of the audits designed and findings acted upon for both of these conditions. This may suggest timelier and more effective primary, community or outpatient care could prevent admissions.

7.8.1 Diabetes

Type 1 diabetes is where the body does not produce sufficient insulin and is the most common type seen amongst children. This can be seen through first presentation when a child presents and is admitted with diabetic ketoacidosis [DKA]. This presentation is seen more in areas of deprivation.

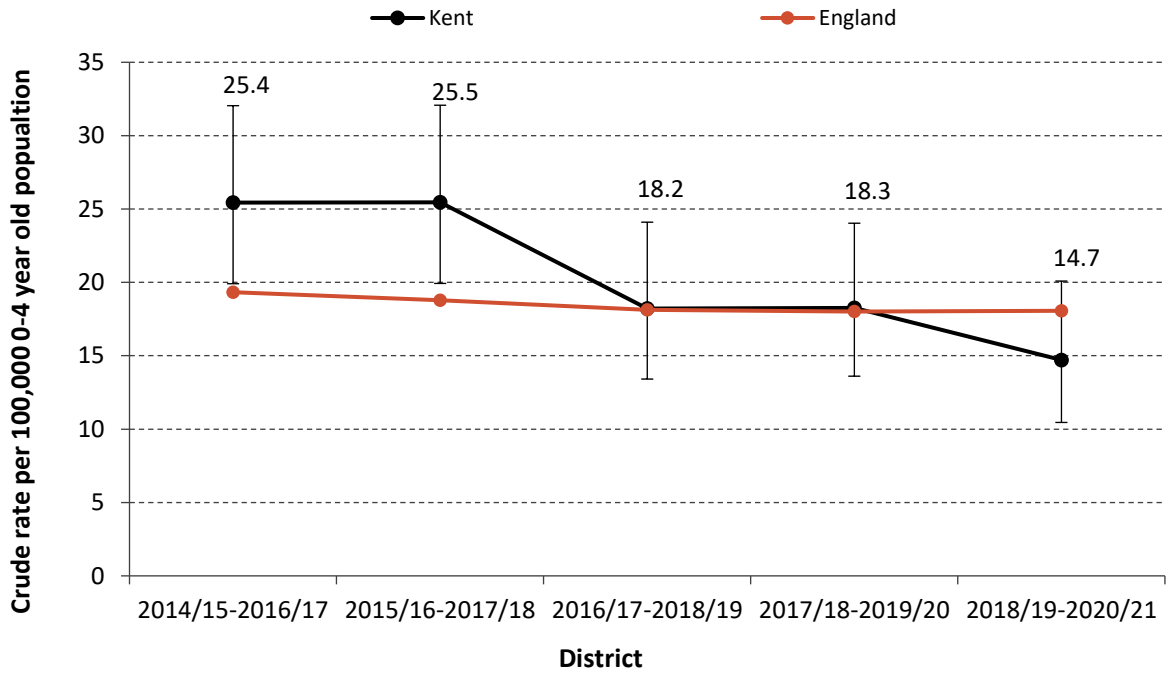
Type 2 diabetes is where the body does not produce sufficient insulin, or the body is resistant to insulin. This type is most common in those of south Asian or Afro-Caribbean ethnicity, obese or overweight individuals and observed to be highest in areas of deprivation.

The national paediatric diabetes audit, which is undertaken annually, provides some understanding of the needs of CYP and the impact of diabetes, particularly of older children who, for example, need support from mental health services. 90% of diabetes in children and young people under 19 years is type 1.

The most recent paediatric diabetes audit conducted suggests that 0.94% of the 0–4 year old population in Kent and Medway were included in the audit, and therefore known to be

receiving paediatric diabetes services. This is a small increase [0.05%] from the audit in 2016/17, which indicated 0.89% of the 0–4-year-old population in Kent and Medway were included in the paediatric diabetes audit. 'In children under five, the incidence of type 1 diabetes **is rising by five per cent** each year.' (160)

Figure 63: Emergency hospital admissions for diabetes among children aged 0-4 years in Kent, ICD 10: E10, 2014/15-2016/17 to 2018/19-2020/21



Source: Hospital Episode Statistics NHS Digital, prepared by KPHO (SR), June 2022

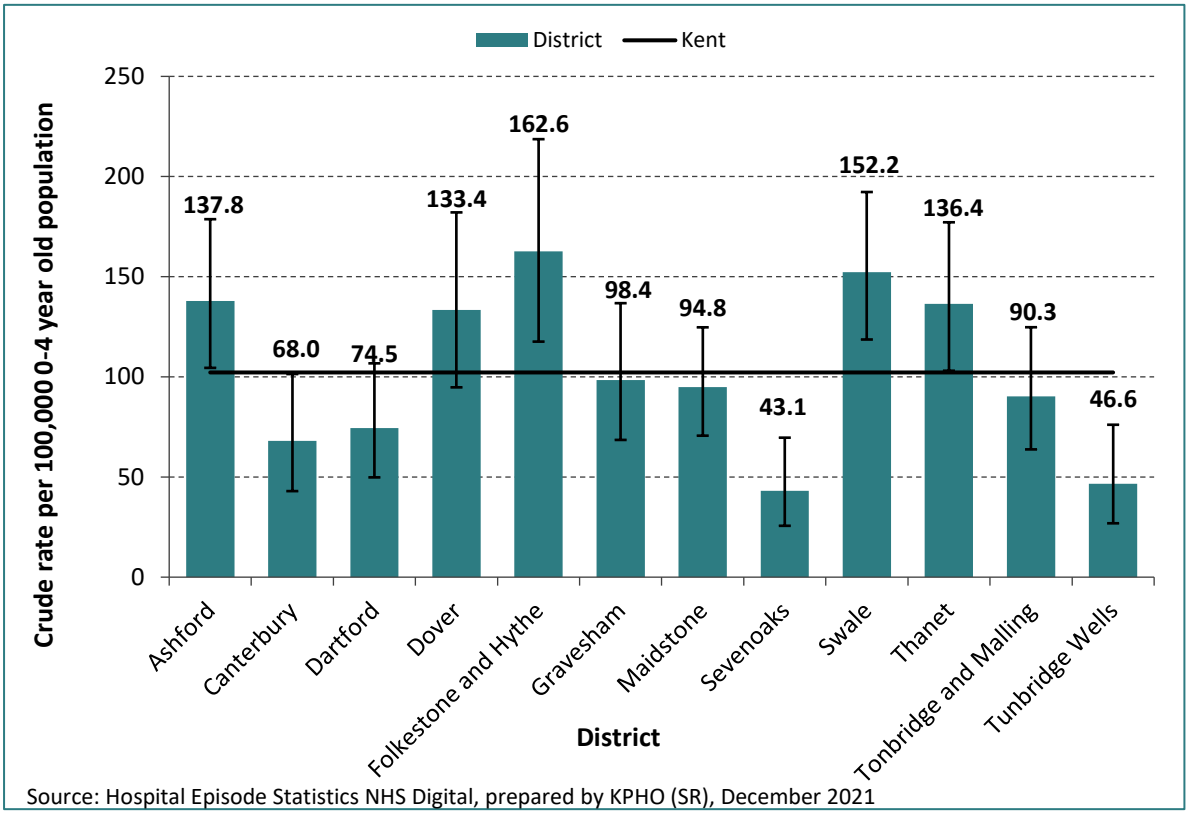
7.8.2 Epilepsy

Epilepsy can affect anyone and can start at any age. However, it is most commonly diagnosed amongst those aged under 20 years. Factors that might cause epilepsy are difficulties at birth, infections in childhood or following accidents.

Approximately one in 509 children aged four years and under in England and Wales has epilepsy (161), and this has stayed constant over recent decades. (162)

The episodes of epileptic seizures are influenced by a range of causes, including neuropathic disorders, high temperature, poor treatment adherence or management of treatment. Ethnicity has been found to be an early-onset epilepsy risk factor, but socioeconomic status has not. (162)

Figure 64: Emergency admissions for epilepsy amongst children aged 0-4 years by Kent district, crude rate per 100,000 0- 4 year olds, ICD 10: G40, G41, 2016/17-2020/21



Source: Hospital Episode Statistics NHS Digital, prepared by KPHO (SR), December 2021

Given the difference in emergency admission amongst 0–4 year olds across the county, exploration and differentiation of febrile convulsions may be beneficial with health messaging to reduce the likelihood of febrile convulsions taking place.

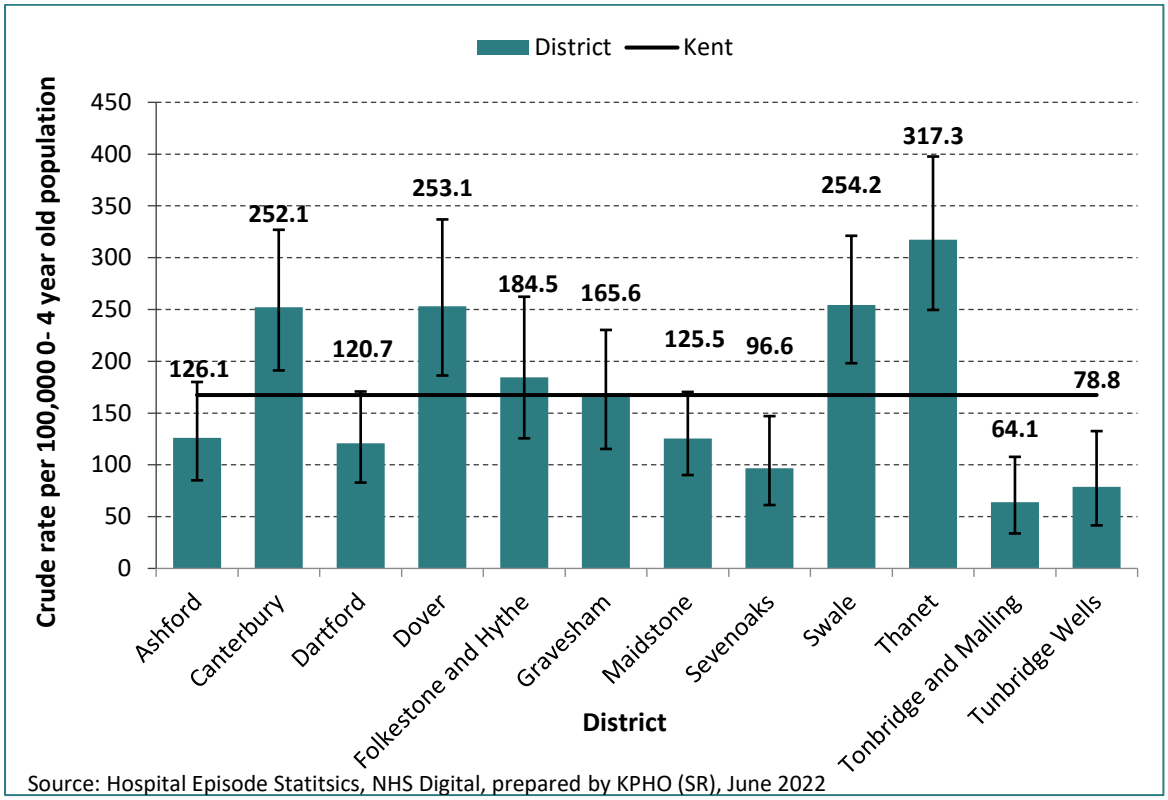
7.8.3 Asthma

A disease of the airways, currently one in 11 children in the UK are receiving treatment for asthma. The condition can be well managed but allergies, the environment or emotional changes can affect the control of asthma.

Previous national surveys in primary care have found variance in the basic care of individuals with asthma. The findings of the national audits will help inform practice.

NHS England states that 'asthma is the most common long-term medical condition among children and young people in the UK. It is the most common reason for urgent admissions to hospital in children and young people in England.' (163)

Figure 65: Emergency hospital admissions for asthma amongst children aged 0-4 years by district in Kent. Crude rate per 100,000 0-4 year olds. ICD 10: J45-J46 (primary diagnosis) [aggregated 3 years 2018/19 – 2020/21]



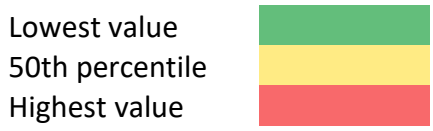
Source: Hospital Episode Statitsics, NHS Digital, prepared by KPHO (SR), June 2022

Analysis of emergency readmission of 0-4 year olds with asthma has occurred amongst 1 in 5 of the 0-4 year olds over the previous three years or the most recent year with 21.4% having had at least one emergency admission. **Emergency admissions for asthma amongst 0-4 year olds are consistently higher in the districts in the east of Kent and Swale.**

A national audit (164) of children and young people with asthma was published in August 2021. This found that more boys [60%] than girls [40%] were admitted to hospital and that the average age of admitted children and young people were 6 years old. The arrival at hospital by children and young people with asthma was found to be highest in the afternoon and early evening. One of the significant triggers of an asthma attack is inhalation of cigarette smoke. **The audit found that approximately 6 out of 10 children and young people with asthma did not have exposure to cigarette smoke status reported in their medical record.**

Table 22: Emergency hospital admissions for asthma in children aged 0-4 years: district trend. Crude rate per 100,000 children aged 0-4, ICD 10: J45-J46 (primary diagnosis), 2014/15-2016/17 to 2018/19-2020/21

District	2014/15-2016/17	2015/16-2017/18	2016/17-2018/19	2017/18-2019/20	2018/19-2020/21
Ashford	314.8	291.2	248.0	228.3	126.1
Canterbury	262.8	288.0	312.7	317.2	252.1
Dartford	242.7	217.2	170.2	144.3	120.7
Dover	326.5	299.6	329.2	277.1	253.1
Folkestone and Hythe	315.3	261.8	206.1	211.0	184.5
Gravesham	229.1	138.0	162.0	140.5	165.6
Maidstone	113.7	96.0	110.9	125.1	125.5
Sevenoaks	160.7	117.0	142.8	120.1	96.6
Swale	364.0	290.5	325.5	289.8	254.2
Thanet	455.0	477.5	403.1	412.7	317.3
Tonbridge and Malling	176.6	175.0	129.7	106.8	64.1
Tunbridge Wells	122.9	100.3	51.2	77.8	78.8
Kent	**256.1**	**229.1**	**214.9**	**206.4**	**167.4**



Source: Hospital Episode Statistics, NHS Digital, prepared by KPHO (SR), June 2022

NICE (165) recommends observation and advice given on improving technique in inhaler use. This should be carried out at every consultation relating to an asthma attack, in all care settings, when there is deterioration in asthma control, when the inhaler device is changed, and at every annual review.

7.9 Additional needs

Identifying neurodivergence is complex. It may manifest to others in terms of challenging behaviours or mental health needs. Whether this is autism, ADHD, dyspraxia or dyslexia, these will be present from birth, impacting on the way individuals view the world and negotiate the environments in which they develop.

Foetal alcohol spectrum disorder [FASD] can be detected at birth but often is not diagnosed. FASD is a diagnostic term used to describe impacts on the brain and body of individuals prenatally exposed to alcohol during pregnancy. Individuals with FASD have their own

unique areas of difficulties and may experience challenges in their daily living and need support with motor skills, physical health, learning, memory, attention, emotional regulation, and social skills. It has been estimated that between 6%-17% of births are impacted by FASD in the UK (166). A recent UK based study showed that up to 17% of children screened had symptoms consistent with FASD. The UK has the fourth highest level of prenatal alcohol use in the world. FASD is a disability which often remains hidden or misunderstood by the wider population.

The impact on brain development from poor attachment or adversities will create further disabilities as individuals are impacted socially, emotionally, cognitively, and physically. These in turn will be reflected and observed in early childhood developmental milestones.

> There is confusion between attachment, autism, and behaviour, an increase in referrals, and gaps in low level SEND support while waiting for referral.
>
> Autism assessments used to be 15-18 months wait, now it is 2.5 years.

Source: Stakeholder interviews

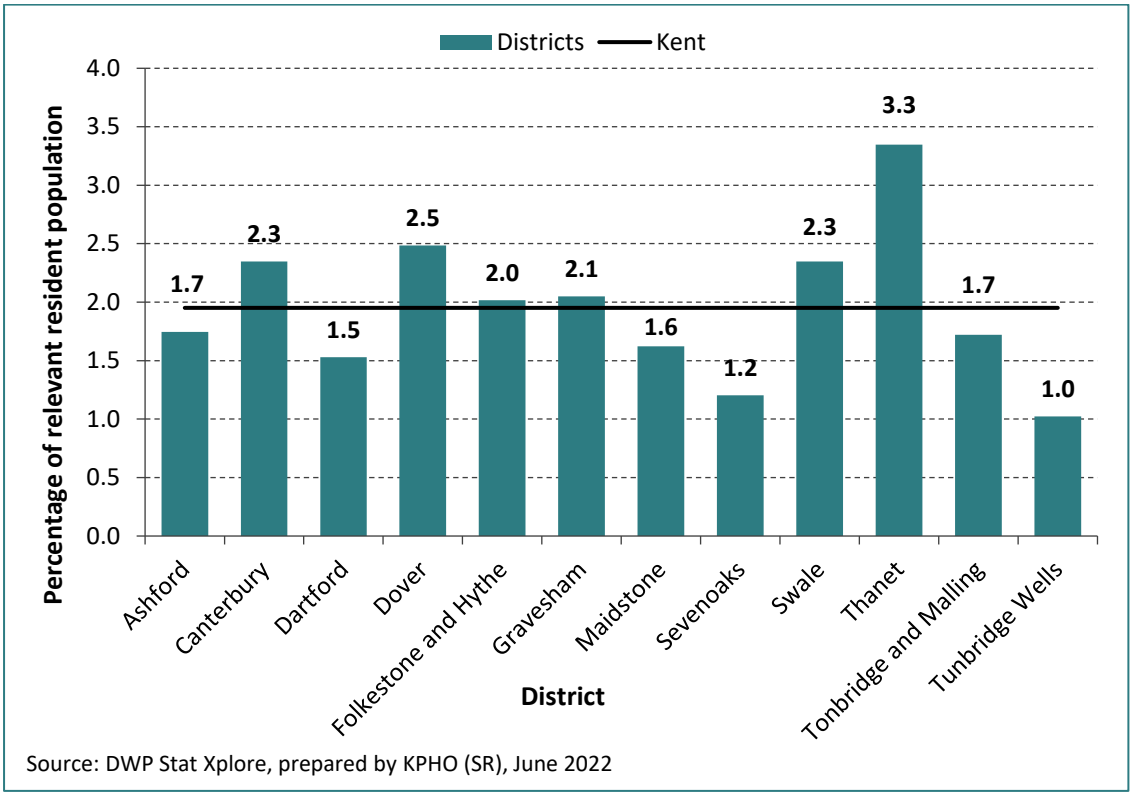
As more is learnt and understood about brain development and differences in the brain amongst those who are neurodiverse, so too will be increased awareness about movement disorders, or non-communicable diseases in this population. Those experiencing disability are often invisible, so presentation of data is limited and especially for those not accessing pre-school provision.

The diagnosis of a learning disability is usually identified in early life through a pediatrician. The figures amongst under 5 year olds in Kent are not collated in published data sets.

One measure seen is access to the disability living allowance. [23] This does not indicate the prevalence of learning disability but provides an indication of some needs.

[23] Usual eligibility: aged under 16 years, habitually resident in the UK, lived for at least 6 of the last 12 months in GB if over 3 years of age, need extra looking after or have walking difficulties

Figure 66: Children aged 0-4 years entitled to disability living allowance, by Kent district. Percentage of population aged 0-4, quarter November 2021



Source: DWP Stat Xplore, prepared by KPHO (SR), June 2022

Table 23: All children aged 0-4 who are entitled to Disability Living Allowance (DLA) not split by condition, by districts in Kent, November 2016-November 2021

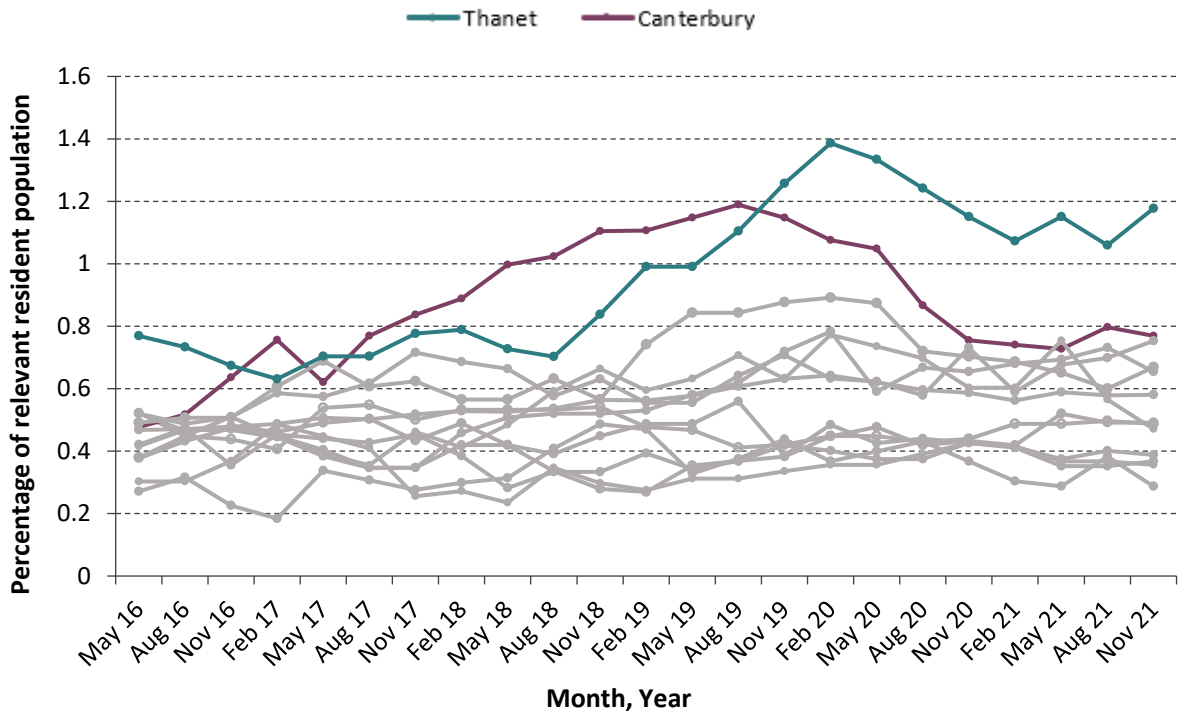
Percentage of children aged 0-4	Nov 16	Nov 17	Nov 18	Nov 19	Nov 20	Nov 21
Ashford	1.3	1.3	1.6	2.0	1.8	1.7
Canterbury	1.6	1.8	2.0	2.1	2.0	2.3
Dartford	1.2	1.1	1.3	1.5	1.6	1.5
Dover	1.8	2.2	2.1	2.5	2.3	2.5
Folkestone and Hythe	2.0	2.2	2.4	2.2	2.0	2.0
Gravesham	1.4	1.5	1.5	1.6	1.7	2.1
Maidstone	1.3	1.5	1.6	1.4	1.4	1.6
Sevenoaks	1.2	1.1	1.2	1.2	1.3	1.2
Swale	1.6	1.8	1.9	1.9	2.2	2.3
Thanet	2.1	2.2	2.4	3.1	3.1	3.3
Tonbridge and Malling	1.3	1.3	1.3	1.3	1.5	1.7
Tunbridge Wells	0.8	0.9	1.1	1.1	1.1	1.0
Total	**1.5**	**1.6**	**1.7**	**1.8**	**1.8**	**2.0**

Lowest value	Green
50th percentile	Amber
Highest value	Red

Source: DWP Stat Xplore, prepared by KPHO (SR), June 2022

The following figure provides presentation of the entitlement of the disability living allowance for those with a learning difficulty, by quarter, which illustrates a stark and increased trend in one district. This needs to be better understood to plan health and care services and school placement.

Figure 67: Children aged 0-4 who are entitled to Disability Living Allowance (DLA) for a learning difficulty, Kent district trend, by quarter May 2016-November 2021



Source: DWP Stat Xplore, prepared by KPHO (SR), June 2022

Chapter 7 key findings

Pregnancy and early infancy: smoking at time of delivery in Kent and Medway is 13.5%, consistently higher than the national average, 9.6%. Premature birth varies widely across Kent and Medway by ethnicity, deprivation, and age. Premature births are more common in non-white mothers, from the three most deprived deciles, and under 20 years old.

Unexplained infant deaths: Kent has higher mortality rates than England and the South East. Unexplained infant deaths are closely linked to co-sleeping, temperature control, and second-hand smoke.

Pregnancy and newborn screening: Screening for haemoglobinopathies in pregnancy has been increasing since 2013/14 and is over 99% in the South East and England. NBBS screening in Kent and Medway remains above the 95% target.

Immunisations: Kent is below the WHO target (95%) to achieve herd immunity for almost all childhood vaccinations. MMR vaccination rates are falling nationally, however rates of the second MMR dose given by the age of 5 are lowest out of all MMR vaccinations. Rates fell in Kent between 2019/20 (88.5) and 2020/21 (87.9).

Hearing loss: Newborn hearing screening in Kent is similar to the England average. Approximately 90 – 100 babies are affected by congenital cytomegalovirus each year in Kent, the most common non-genetic cause of childhood hearing loss.

Oral health: Tooth decay is a major concern in Kent, particularly in districts such as Gravesham and Thanet.

Healthy infant growth: The trend in the number of low birth weight babies born at term has remained stable since 2006, around 2.5%. However, approximately 1 in 4 babies gain too much weight before the age of 2.

Infant Feeding: There are gaps in the data available on baby's first feed nationally and locally. The percentage of infants who are totally or partially breastfed at the 6-8 week visit in Kent between 2017/18 and 2020/21 has increased and remained above the England (aggregated) prevalence. Swale and Thanet have had the lowest percentage of breastfeeding infants compared to other districts, since 2018/19 at the 6-8 week visits.

The Kent Infant Feeding Service: KCHFT, Children's centres run by KCC, and Medway Hospital (maternity) are the only services in Kent and Medway with full Baby Friendly accreditation status.

Mental health and wellbeing of under 5 year olds: It is reported that 'the mental wellbeing is of particular importance in younger age groups as childhood experiences in infancy and the first five years of life have been found to have a lasting impact upon a child's mental wellbeing.' However, the Mental health and wellbeing of under 5 year olds is largely unknown. A recent study identified correlations between early infancy sleep problems, such

as short sleep direction, difficulty falling asleep, frequent night waking and specific behavioural and mental problems at 2 years.

Long-term illness: 0.94% of under 5s in Kent are receiving paediatric diabetes services. The incidence of type 1 diabetes in children under 5 is rising by 5% each year. Emergency admissions for epilepsy and asthma vary across districts. Between 2018/19-2020/21, the crude rate (per 100,000 children aged 0-4) of emergency hospital admissions for asthma in children was highest in Thanet. Between 2016/17-2020/21, the crude rate (per 100,000 children aged 0-4) of emergency admissions for epilepsy for children was highest in Folkestone & Hythe district.

Actual and potential additional needs: Thanet has the highest percentage of children entitled to disability living allowance.

In summary, poor health status of under 5-year-olds can be prevented through a more robust approach to prevention and improvements to pathways of care, as well as improving understanding of and response to presenting behaviours.

8. Utilisation of the system wide health care services

8.1 General Practice

There are 0.45 qualified General Practitioners [GPs] per 1000 patients in England which has decreased from 0.52 in 2015. This means the average number of patients a GP is responsible for has increased by 16% since 2015. The British Medical Association surveyed over 2,050 GPs in 2021 and found over half are currently suffering from poor mental health, including burnout, and almost half are planning to work fewer hours after the pandemic. (167) Stakeholders mentioned GP paediatric referrals are increasing particularly in the last two years, however the reason for referrals is unclear.

> Stakeholders frequently mentioned the benefit of having GPs with a special interest in paediatrics

Source: Stakeholder interviews

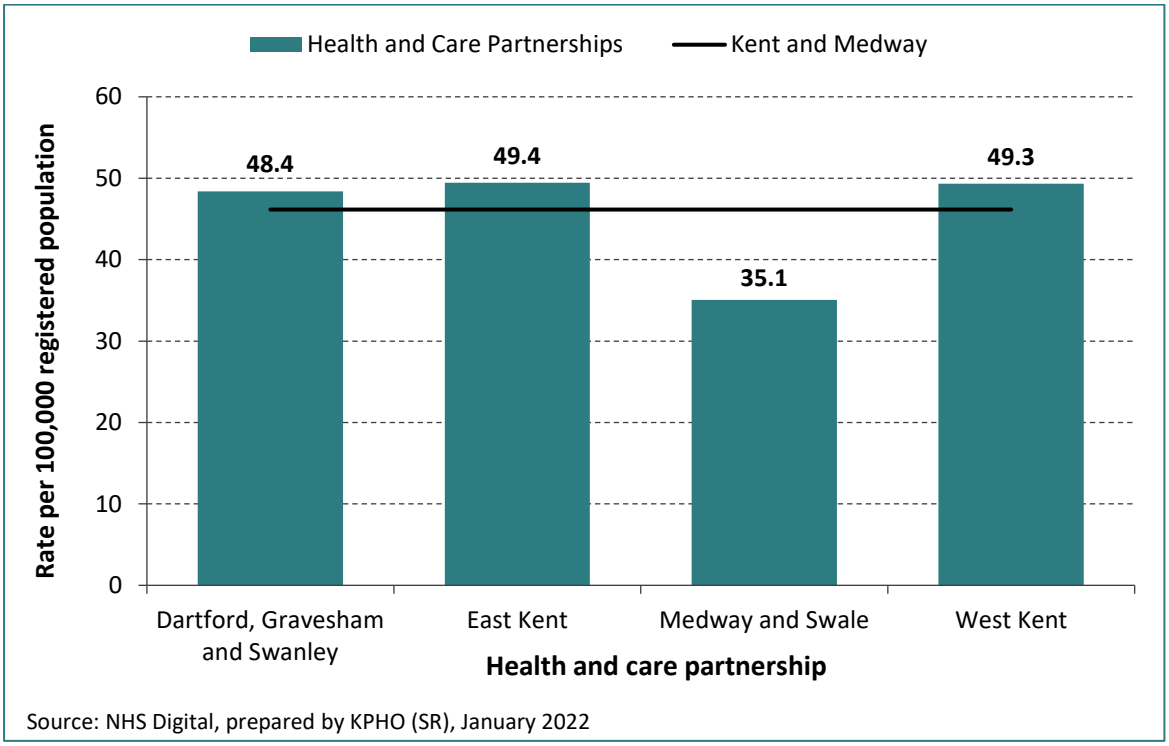
Some population groups are less likely to register at a GP, for example Roma families, asylum seekers, and non-English speakers. The implications for this are far reaching, particularly for those with young children in their families, increasing the risk of missing important vaccinations or health advice, monitoring or treatment of long-term conditions, or identifying safeguarding issues. However, there are barriers to registering, from documentation required (in English), to transport and language barriers, particularly for those on low-income or unemployed. For example, some may be unable to call for an appointment due to lack of phone credit. Despite physical access being a potential barrier, in 2019, the average time to travel to a GP by public transport or walking was 14 minutes in Kent, 2 minutes less than the national average. (168) Other communities may not seek help from their GP as often, due to cultural practices and would prefer to seek help from their own community first.

In 2020, 0-4 year olds made up 5.6% of the Kent population, but 5.3% [n = 103,565] of the GP registered population in Kent and Medway in 2021.[24]

There are significantly fewer full time equivalent [FTE] GPs per 100,000 population in Medway and Swale than the average for Kent and Medway, despite Swale being a highly populous area, with significant deprivation, which is linked to higher health needs. Swale is also the district in Kent with the third highest number of births.

[24] GP data is only available for Kent and Medway combined

Figure 68: Full time equivalent GPs per 100,000 population by health and care partnership, November 2021



Source: NHS Digital, prepared by KPHO (SR), January 2022

Note: no GP data was provided for two practices in Medway and Swale and two practices in East Kent.

The majority of GP practices in Swale district have below the Kent and Medway average of FTE GPs per 100,000 population.

8.2 NHS 111

NHS 111 is a non-emergency national helpline seen as a way of potentially reducing unnecessary visits to accident and emergency [A&E]. In 2020, the NHS piloted employing paediatricians to enhance paediatric support. Due to its success, paediatricians and advanced nurse practitioners are now being recruited for NHS 111 shifts. Parents can call 111 for advice 24/7 however, if their child is under 12 months, the child would be referred to A&E. Calls to NHS 111 have increased dramatically during the pandemic, alongside increases in calls to the health visiting service duty line, raising questions around service capacity to deal with the demand.

Stakeholders reported parents often do not seek help unless there is a critical event and are often unable to access a GP. Research shows approximately 5% of calls made to NHS 111 still result in unnecessary attendance at A&E within 24 hours, against medical advice, and that women and those calling on behalf of children under 5 years were more likely to visit A&E in these circumstances. (169) This highlights the importance of parental support, timely access to GPs, and building confidence in parents, as highlighted in multiple stakeholder interviews.

8.3 Accident and emergency [A&E] attendances

Families with young children attend A&E via various routes. There are five A&E departments in Kent and one in Medway namely:

- *William Harvey Hospital, Ashford*
- *Darent Valley Hospital, Dartford*
- *Medway Maritime Hospital, Gillingham*
- *Maidstone Hospital, Maidstone*
- *Tunbridge Wells Hospital, Tunbridge Wells*
- *Queen Elizabeth The Queen Mother Hospital, Margate*

The Health Foundation reported a 63.6% decrease in A&E attendances of children under 5 years in 2020 (compared to a 45% reduction for the whole population). (170) This reduction is attributed to the COVID-19 pandemic and periods of lockdown. Many hospitals reported a similarly large reduction in A&E attendance for children (171) and one hospital in London reported a 90% decrease in attendances at the start of the first lockdown. (172) The RCPCH also report a small but significant number of delayed presentations at the start of the pandemic of certain conditions, such as diabetes and sepsis, perhaps due to worried parents wanting to avoid hospitals. Non-urgent attendances appear to be more common in children under 5 year olds, particularly under 1s, and are more likely to present out of hours (173), highlighting the need for appropriate community care, which is also available outside of usual opening hours.

Compared to England, Kent has had a lower rate of A&E attendance for 0-4 year olds over the last 10 years. However, the rate in Kent is steadily increasing each year as illustrated when looking at this by district, with the exception of 2020/21. A&E attendances include both attendances to a 24-hour consultant-led unit, as well as a minor injuries unit [MIU]. When looking at the severity of attendances and the proportion of attendances that were admitted, it was difficult to compare districts due to differences in coding and so this was not included in the analysis.

Table 24: A&E attendances crude rate per 1,000 children aged 0-4 years, by districts in Kent, 2016/17 – 2020/21

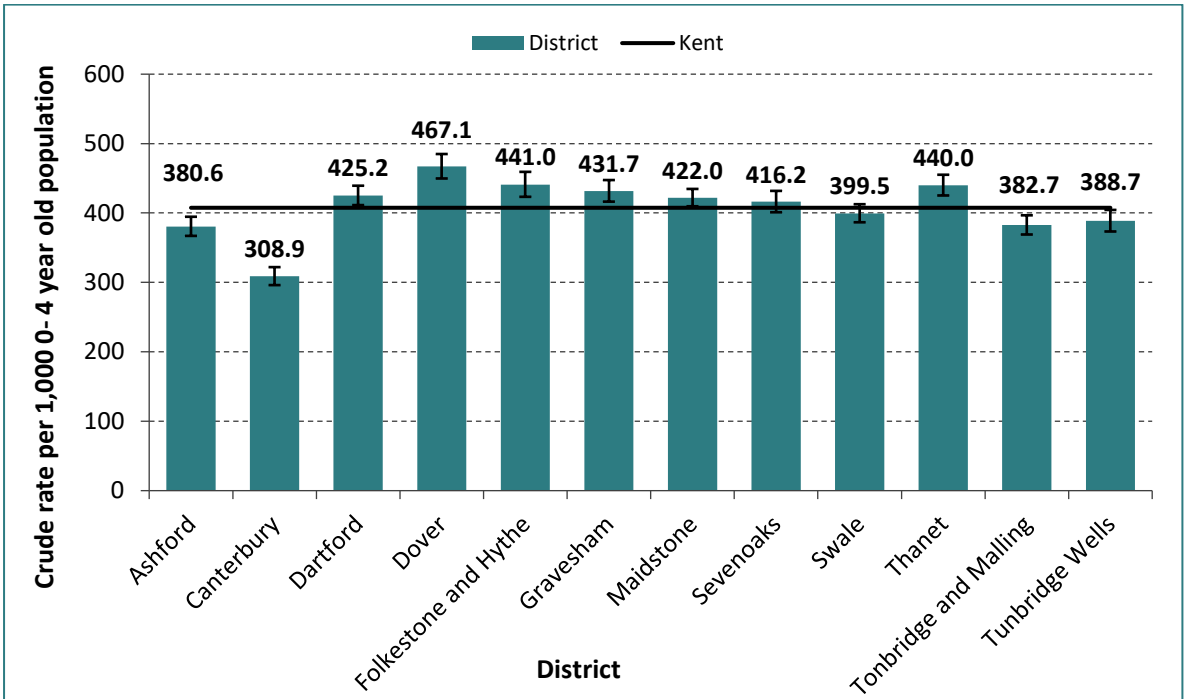
Districts	2016/17	2017/18	2018/19	2019/20	2020/21
Ashford	428.7	464.4	536.1	589.3	380.6
Canterbury	371.1	382.0	447.0	508.2	308.9
Dartford	638.6	697.7	796.5	770.8	425.2
Dover	578.2	632.3	688.3	694.3	467.1
Folkestone and Hythe	522.9	552.1	619.7	701.9	441.0
Gravesham	589.7	615.1	655.8	669.0	431.7
Maidstone	474.2	510.3	554.3	595.7	422.0
Sevenoaks	520.7	593.9	635.0	764.5	416.2
Swale	479.9	519.7	577.9	594.8	399.5
Thanet	538.1	540.0	635.9	698.9	440.0
Tonbridge and Malling	465.4	508.7	574.4	612.2	382.7
Tunbridge Wells	419.9	480.3	553.3	572.2	388.7
Kent	**500.0**	**538.5**	**603.4**	**644.3**	**407.5**

Lowest value
50th percentile
Highest value

Source: Hospital Episode Statistics, NHS Digital, prepared by KPHO (SR), June 2022

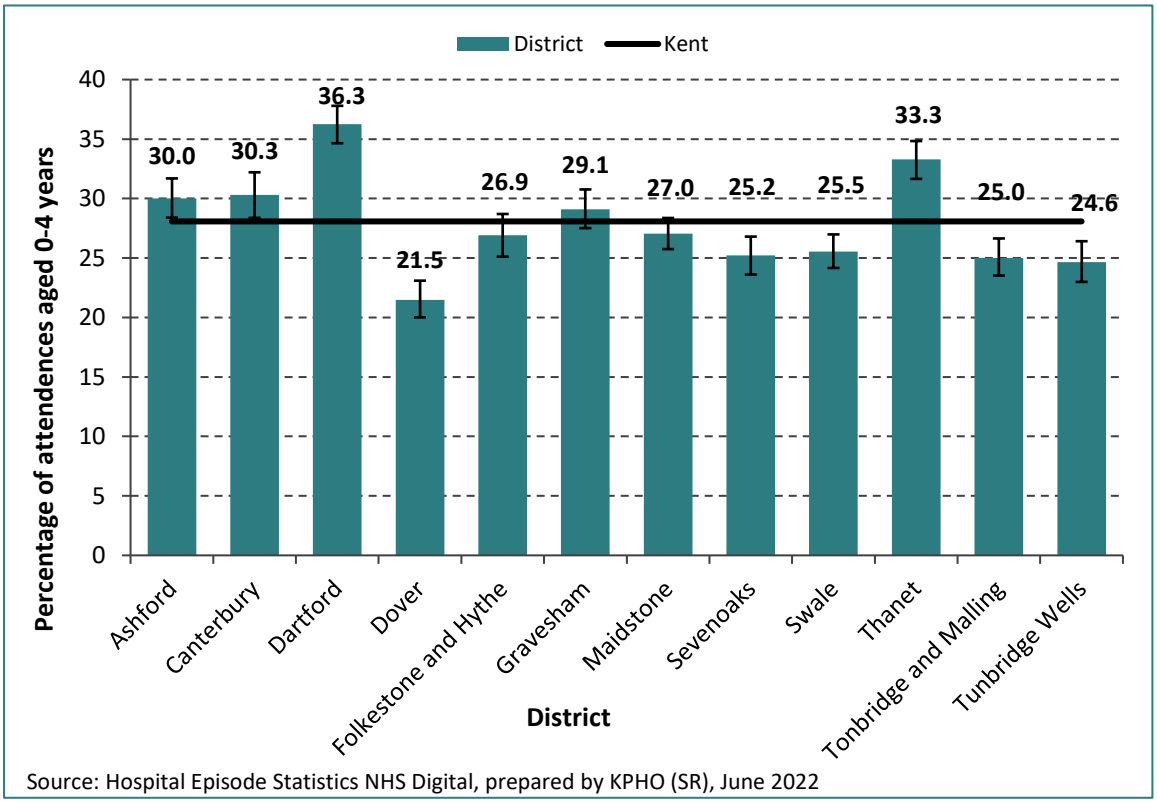
All districts saw a decrease in attendance rate in 2020/21, Analysis of A & E attendances of 0-4 year olds in Dover district which had higher attendance than other districts found 39.4% of attendances were to a 24-hour consultant led A&E and 60.6% were to another type of A&E/minor injury activity.

Figure 69: A&E attendances in children aged 0-4 years, crude rate per 1,000 children aged 0-4 years, by Kent districts 2020/21



Source: Hospital Episode Statistics NHS Digital, prepared by KPHO (SR), June 2022

Figure 70: Percentage of A&E attendances in children under 1 year as a proportion of under 5 A&E attendances by district in Kent, 2020/21



Source: Hospital Episode Statistics NHS Digital, prepared by KPHO (SR), June 2022

8.4 A&E admissions

Emergency admission rates have been increasing nationally for children under five years and particularly for infants under one year, more so than other age group. (174) Most of the increase in hospital admissions among infants has been in the early neonatal period (during the first week of life) for three conditions: physiological jaundice, feeding difficulties, and gastroenteritis. (175) Furthermore, emergency admissions have been higher among infants from the most deprived areas of England. (176) As mortality and morbidity rates are not changing significantly, investigation is needed as to why this is happening, whether parents are able to access their GP in a timely manner, or whether they are self-referring directly to A&E. However, evidence on reducing unplanned hospital admissions is weak. (177)

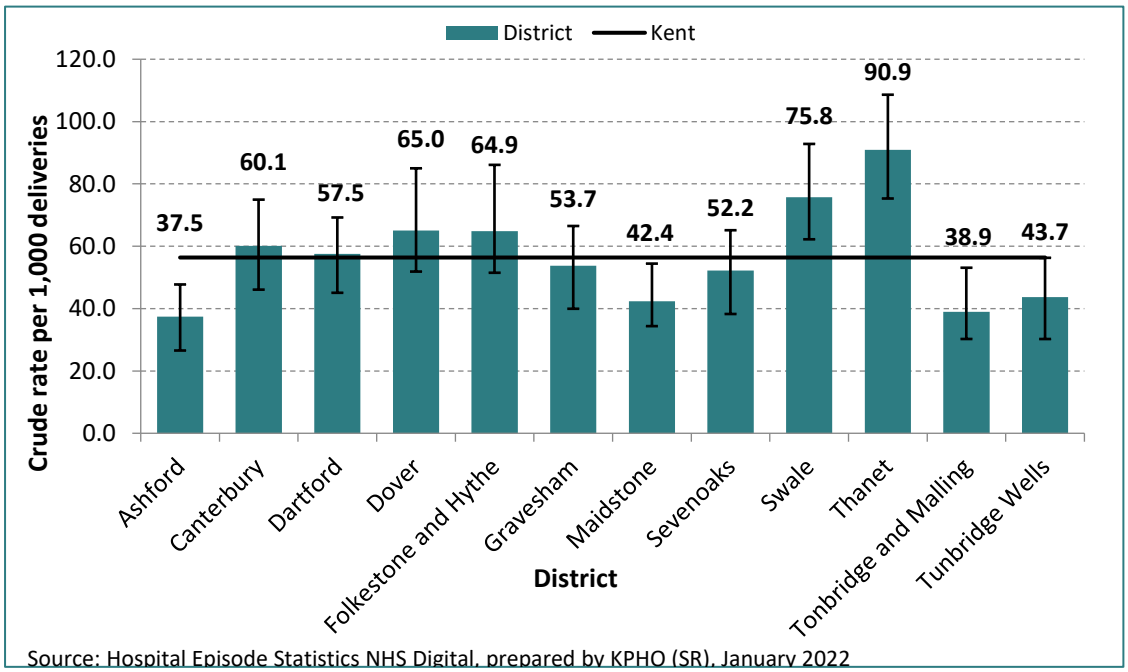
Emergency admissions across Kent were analysed for babies under 14 days and for children under 5 years old.

8.4.1 Admissions of babies under 14 days

The Healthcare Commission reports: '*High levels of re-admissions of either mother or babies soon after birth can suggest problems with either the timing or quality of health assessments before the initial transfer or with the postnatal care once the mother is home. Dehydration and jaundice are two common reasons for re-admission of babies and are often linked to problems with feeding*.' (178)

The next figure presents the rate of emergency admissions of infants before 14 days of age. In 2020/21 the highest rate presented was in Thanet district. Of the admissions in Thanet, 58.3% had a diagnosis (in any diagnosis position) of jaundice or dehydration (ICD10 codes: P58, P59, P57.9, P55.0, P55.1, P55.9, P74.1). This highlights the importance of infant feeding advice and breastfeeding support antenatally and in the early postnatal period. As previously reported over the last three years Thanet has had one of the lowest breastfeeding prevalence as measured through the health visiting service 6-8 week contact following birth.

Figure 71: Emergency admissions of babies under 14 days, Crude rate per 1,000 deliveries, by district, Kent 2020/21



Source: Hospital Episode Statistics NHS Digital, prepared by KPHO (SR), January 2022

Table 25: Emergency admissions of babies under 14 days, Crude rate per 1,000 deliveries, by district, Kent, 2016/17 – 2020/21

Districts	2016/17	2017/18	2018/19	2019/20	2020/21
Ashford	64.8	54.1	70.9	51.5	37.5
Canterbury	87.3	75.2	63	61.7	60.1
Dartford	56.5	60.6	53.6	57.7	57.5
Dover	76.2	54.8	67	73.5	65
Folkestone and Hythe	60	58.3	52.4	56.4	64.9
Gravesham	40.6	54.9	44.9	46.7	53.7
Maidstone	26.2	28.3	20.7	37.8	42.4
Sevenoaks	43.7	44.8	38.8	44.4	52.2
Swale	82.1	85.5	86.3	78.6	75.8
Thanet	98.4	81.3	96.6	77.8	90.9
Tonbridge and Malling	28.9	33.5	35.2	29.1	38.9
Tunbridge Wells	26.8	31.3	30.7	37.2	43.7
Kent	**57.2**	**56**	**54.7**	**54.5**	**56.4**

Lowest value
50th percentile
Highest value

Source: Hospital Episode Statistics, NHS Digital, prepared by KPHO (SR), January 2022

8.4.2 Admissions of children to hospital aged 0-4 years

Admission rates have been relatively stable since 2016/17, until 2020/21, where there was almost a decrease of 50%. Presentation of admission is observed to be highest where the levels of deprivation are greater. Nevertheless, over the last 5 years, Dartford has had the highest crude rate of emergency admissions for children aged 0-4 years.

Table 26: Crude rate of emergency hospital admissions per 1,000 children aged 0-4, by district, Kent 2016/17 – 2020/21

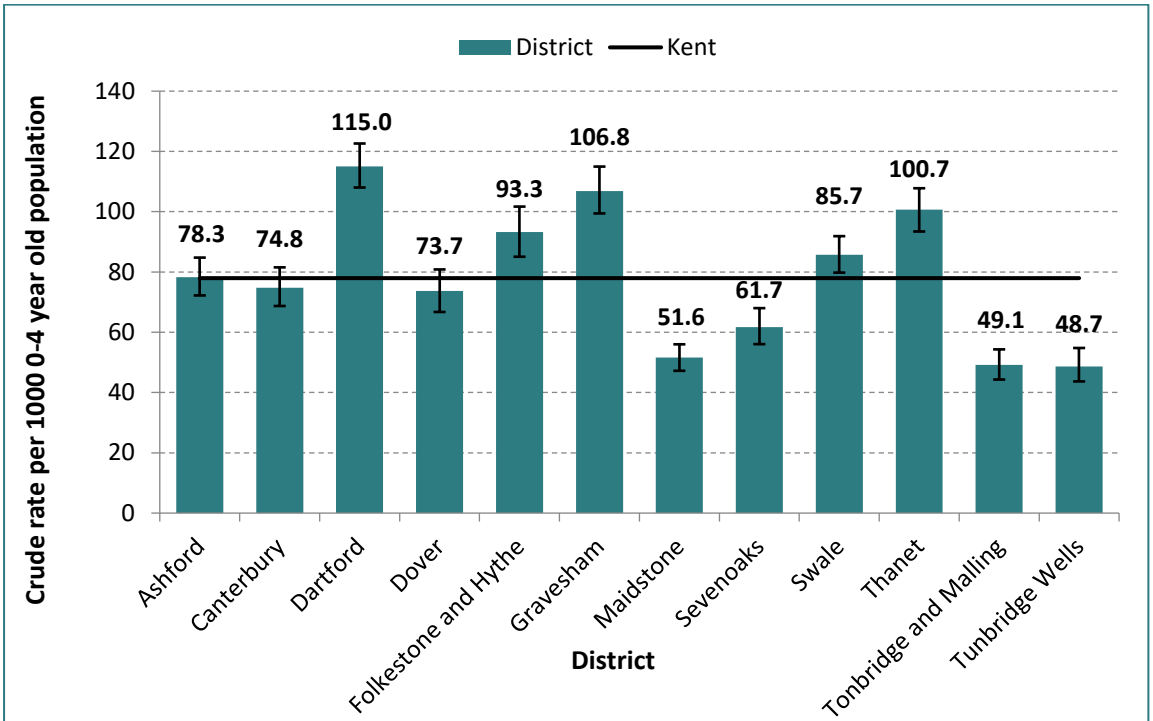
Districts	2016/17	2017/18	2018/19	2019/20	2020/21
Ashford	187.3	197.3	226.0	155.9	78.3
Canterbury	174.3	166.0	161.6	148.0	74.8
Dartford	217.0	212.3	242.0	233.0	115.0
Dover	174.2	168.9	180.4	136.5	73.7
Folkestone and Hythe	192.2	207.7	207.2	178.5	93.3
Gravesham	176.7	167.2	170.4	172.9	106.8
Maidstone	85.1	89.8	82.2	85.1	51.6
Sevenoaks	112.9	122.8	128.0	130.4	61.7
Swale	170.6	153.4	166.5	155.1	85.7
Thanet	198.1	193.0	194.1	179.0	100.7
Tonbridge and Malling	91.4	85.4	94.2	89.4	49.1
Tunbridge Wells	79.0	75.2	76.9	72.0	48.7
Kent	**153.5**	**151.4**	**159.0**	**143.7**	**78.0**

Lowest value
50th percentile
Highest value

Source: Hospital Episode Statistics, NHS Digital, prepared by KPHO (SR), June 2022

Paediatric units which are open daily for a 12 hour period can observe children who may have come into A&E, which may be coded as an admission. Hospitals in Ashford, Maidstone, Tunbridge Wells, and Margate have access to a unit.

Figure 72: Crude rate emergency hospital admission per 1,000 children aged 0-4 years, by district, Kent 2020/21

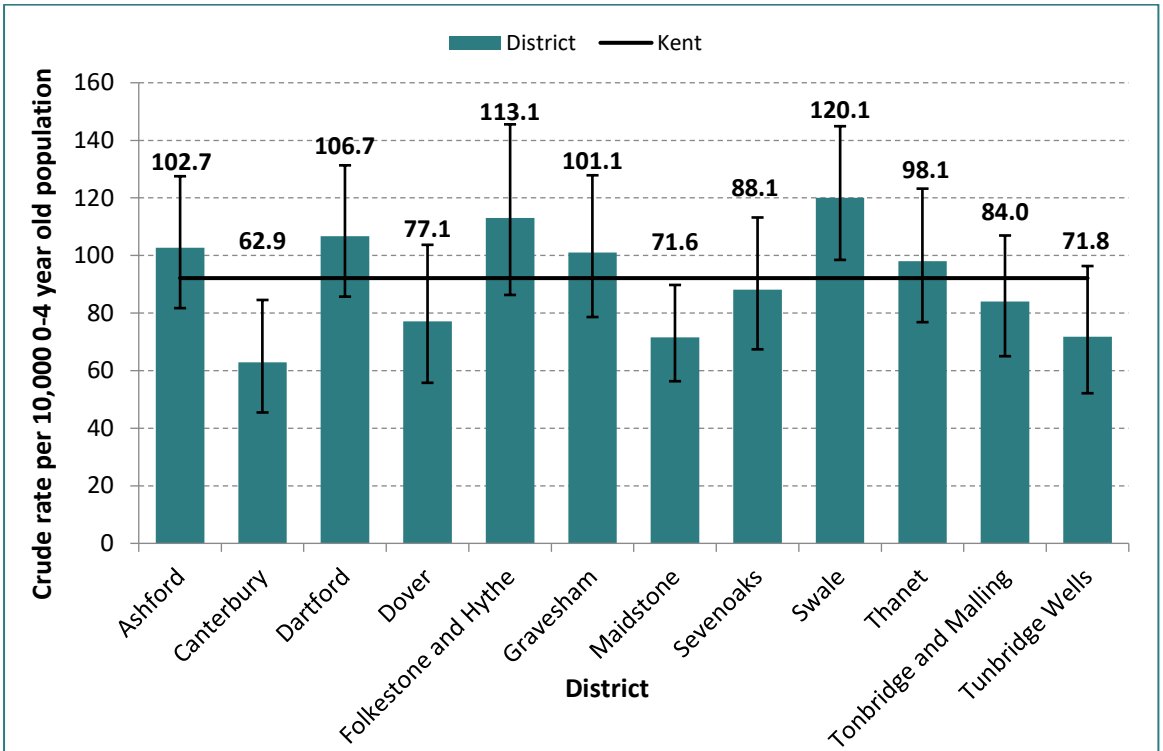


Source: Hospital Episode Statistics NHS Digital, prepared by KPHO (SR), June 2022

8.4.3 Unintentional and deliberate injury hospital admissions

Unintentional injuries such as poisonings, scalds, or falls from stairs can indicate safeguarding issues (179) as they are largely preventable, occurring at or near the home. The cost to the system is high, with a single serious home accident for a child under 5 years estimated to be £2,494 to healthcare and wider costs of £33,200. (180). Injuries are associated with parental knowledge and behaviour, as well as overcrowding and low socio-economic status. (181) There is good evidence showing that home safety equipment schemes increase parents' knowledge of home safety as well as being associated with a reduction in injury-related hospital admissions. (182) The PHE report "Reducing unintentional injuries in and around the home among children under five years" (180), recommends various preventative measures with an overall approach of reducing inequalities.

Figure 73: Crude rate of hospital admissions caused by unintentional and deliberate injuries per 10,000 children aged 0-4 years, by Kent district. ICD10: S00-T79, V01-Y36, 2020/21



Source: Hospital Episode Statistics NHS Digital, prepared by KPHO (SR), June 2022

Across Kent, the rate of hospital admissions caused by unintentional and deliberate injuries amongst 0-4 year olds has decreased over the last 5 years, but the picture when looked at by district is more variable. **Notably Swale district has shown an increase in 2020/21 from the previous three years, 2017/18 -2019/20**, as seen in the following table.

Table 27: Crude rate of hospital admissions caused by unintentional and deliberate injuries per 10,000 children aged 0-4 years, by district, Kent, 2016/17 – 2020/21

Districts	2016/17	2017/18	2018/19	2019/20	2020/21
Ashford	136.9	123.7	123.8	113.6	102.7
Canterbury	106.0	108.0	107.7	76.1	62.9
Dartford	184.2	127.9	105.2	107.8	106.7
Dover	122.7	98.4	124.7	75.8	77.1
Folkestone and Hythe	121.2	142.0	125.6	139.5	113.1
Gravesham	143.8	112.0	125.7	127.6	101.1
Maidstone	77.8	94.5	79.4	79.5	71.6
Sevenoaks	90.6	115.6	115.7	78.8	88.1
Swale	135.4	92.1	108.8	92.5	120.1
Thanet	141.9	121.4	123.2	120.6	98.1
Tonbridge and Malling	118.3	97.1	83.3	88.8	84.0
Tunbridge Wells	112.9	99.7	102.0	62.6	71.8
Kent	**124.8**	**109.4**	**107.7**	**95.7**	**92.1**

Lowest value
50th percentile
Highest value

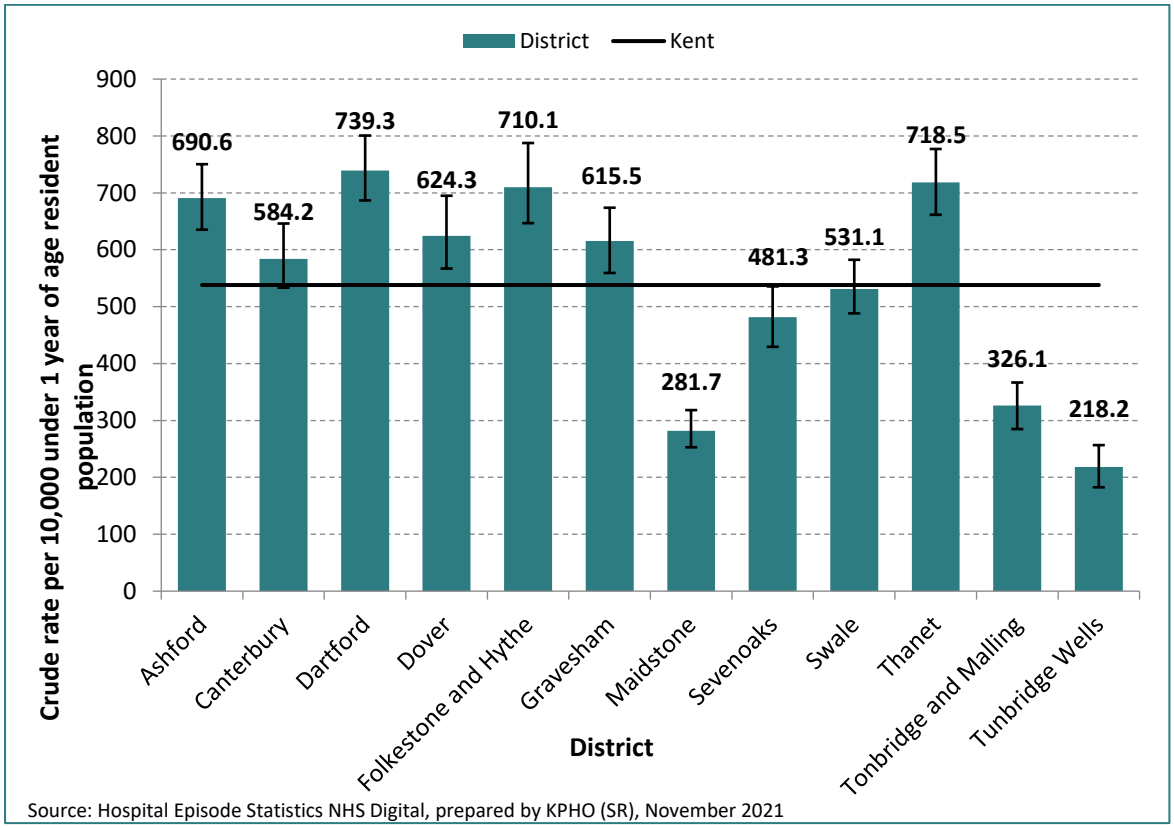
Source: Hospital Episode Statistics, NHS Digital, prepared by KPHO (SR), June 2022

8.5 Respiratory infections hospital admissions

Respiratory syncytial virus [RSV] is a common viral infection in children causing bronchiolitis, spread by coughs or sneezes, and a common cause of hospital admission. Almost all children are infected with it within the first 2 years of life. As babies and young children have underdeveloped airways, they are more likely to get bronchiolitis compared to older children. Children who are more at risk are those who are less than 2 months old, born prematurely and have other conditions such as congenital heart disease. Children are more likely to get infected if they have parents who smoke, are not breastfed or breastfed for less than 2 months or have siblings attending nursery/school.

The next figure provides presentation of the crude rate of hospital admissions with respiratory infections per 10,000 resident population under 1 year of age by district in Kent using five years of combined data from 2016/17- 2020/21. This illustrates significant differences in rates.

Figure 74: Crude rate of hospital admissions with respiratory tract infections per 10,000 resident population under 1 year of age by district, Kent. ICD10: J10, J110-1, J12-16, J180-1, J189, J21 (primary diagnosis) 2016/17- 2020/21



Source: Hospital Episode Statistics NHS Digital, prepared by KPHO (SR), November 2021

Hospital admissions rates for respiratory tract infections [RTIs] in under 1 year olds are presented in the next figure as three-year combined data which suggest an increased rate of admission in Kent from 2014/15-2016/17 until the combined period 2018/19 -2020/21.

Table 28: Crude rate of hospital admissions with respiratory tract infections per 10,000 resident population under 1 year of age, by district, Kent, 2014/15–2016/17 to 2018/19 -2020/21

District	2014/15-2016/17	2015/16-2017/18	2016/17-2018/19	2017/18-2019/20	2018/19-2020/21
Ashford	557.2	680.2	875.9	896.8	630.3
Canterbury	541.8	604.2	684.1	699	521.6
Dartford	654.8	763.9	904.9	920.5	693.8
Dover	742.6	743.9	779	758.5	524.4
Folkestone and Hythe	646.4	823.8	867.8	933.8	634.8
Gravesham	597.9	665.1	689.9	734.4	567.9
Maidstone	295	302.8	334.1	336.8	246.5
Sevenoaks	459.4	475.1	529.1	594	458.6
Swale	478.9	550.1	593.1	681	539.9
Thanet	867.8	867.7	831.6	829.5	589.8
Tonbridge and Malling	263.1	281.4	352.8	395.5	323.1
Tunbridge Wells	217.7	232.1	261.9	276.1	198.3
Kent	**521.6**	**574.5**	**632.6**	**662.6**	**492.4**

Lowest value
50th percentile
Highest value

Source: Hospital Episode Statistics, NHS Digital, prepared by KPHO (SR), November 2021

Chapter 8 key findings

Utilisation of health care services: Swale [and Medway] have the least number of full time equivalent GPs per 100,000 population. Thanet had the highest rate of emergency admission of babies under 14 days, over twice the rate of four other districts. In Thanet, 58.3% of those admissions had a diagnosis of jaundice or dehydration. Over the last 5 years there has been some fluctuation in emergency A & E attendance rates for children aged 0-4 years with increases in rates with the understandable exception of the most recent year 2020/21. Over the five-year time period, consistently higher rates of A & E attendance than the Kent average have been observed in Dartford, Dover, Folkstone & Hythe, Gravesham and Thanet districts and over the last four years this has included Sevenoaks district. Dartford district has seen the highest rates.

Differences in usage of health care: primary and secondary, are illustrated through this section with consistently higher rates of service use in the districts of Thanet, and Dartford.

9. Stakeholder insights

Semi structures interviews with 31 respondents from a range of professionals provided a richness of data which has helped triangulate information and influenced the presentation of some insights. There are quotes from stakeholders embedded into chapters of the health needs assessment. See Acknowledgments on page 2 for a list of stakeholders by role.

There were seven main themes identified from stakeholder interviews:

1. Data and knowledge

   Health and wellbeing of 0-4 year olds is largely not well known and there is a lack of data to highlight gaps. It is also challenging to access some data held by certain services e.g. Health visiting service, paediatrics, nurseries, for example data regarding DNA appointments. There is a lack of public information for families and no standardised and updated central directory of services for them, meaning *"families have to hunt for information"* and *"sometimes we make it difficult for people".*

2. Systems thinking

   Many stakeholders reported the need for more integrated services, focusing on the family unit, with a consistent resource in the community for families such as a peer supporter or care navigator. Stakeholders reported this requires strategic leadership and buy-in from all service providers to prioritise a preventative approach to care and to reduce referrals.

3. Service challenges

   Many services are stretched beyond capacity, evidenced by long waiting times, inundated duty lines, and an increase in 111 calls. There is also a lack of specialists such as community paediatricians, specialist nurses, therapists, and specialists in mental health and neurodevelopment. Services are less embedded in the community causing access challenges for vulnerable families.

4. Physical needs

   Complex care is increasing. Obesity is also worsening, and parents are not willing to have the conversation with healthcare professionals, sugary drinks are becoming increasingly common. Oral health is a concern and dentists are no longer visiting schools.

5. Social and emotional wellbeing needs, including neurodevelopment

   Young children's social skills and speech, language and communication skills have been adversely affected by the COVID pandemic, partly due to lack of face-to-face services, and this has impacted school readiness. The emotional needs of children

under 5 years are increasing and poorly understood: social anxiety is being seen at younger ages, and mental health referrals (for children of all ages) almost tripled during the pandemic. Stakeholders highlighted the need for good early years support, including emotional wellbeing services for families. Neurodevelopmental concerns were voiced as there is confusion between attachment, autism and behaviour. SEND referrals are increasing and there is a gap in low level SEND support while waiting for a referral. There is a need for parental support and provision of clear information.

6. Safeguarding needs

   The frequency and severity of domestic abuse is increasing, and stakeholders questioned what can be done to intervene for children if mothers decline early intervention. Safeguarding referrals (and re-referrals) are also increasing, seeing the impact of parental drug and alcohol use on children. Stakeholders reported parents often prefer an early help worker compared to a social worker. Vulnerable families are often hidden and hard-to-reach, they are *"so easy to slip through the cracks"* and one stakeholder mentioned *"we don't get to do what we were trained to do: help families reach their potential".*

7. Parents

   Most stakeholders voiced the need for support for both parents, particularly due to the increase in parental stress and anxiety and the consequential effects this has on children. The pandemic has impacted parents in many ways such as illness, unemployment, economic pressures and lower resilience, which have directly impacted children.

Most stakeholders reported an appetite and readiness to contribute to change.

10. Recommendations

System wide actions are presented in the executive summary (page 15) of this health needs assessment and presented in further detail below.

1. **Invest to ensure early identification of and support for poor perinatal mental health amongst pregnant women and postnatally for women and their partners**
    - Develop a robust system wide pathway for low to moderate perinatal mental health support.
    - Provide a sustained programme of workforce development on low to moderate perinatal mental health awareness and of the support available for all staff who work with families where there are pregnant women and/or children under 2 years.
      (KCC, KCHFT, ICB, third & private sector)

2. **Review and monitor the provision of support for parents and carers**
    - Acknowledge and provide the support parents and carers need in order to parent their children well.
    - Involve families in the design and development of future services, seeing them as "part of the workforce".
    - Consider the impact of traditional opening times for services on working parents.
      (KCC, KCHFT, ICB, TEP)

3. **Establish a system wide approach to preventing poor health outcomes, ensuring provision and levels of support are flexible and responsive to meet needs**
    - Redistribute service provision with a focus on services for 0-4 year olds in areas with worsening health outcomes.
    - Ensure services are culturally appropriate with information available in other languages, particular to the local communities.
      (KCC, KCHFT, ICB)

4. **Utilize all opportunities to provide preventive interventions or messaging**
    - Embed preventative work into all contacts with pregnant women and/or families with children under 5 years of age.
    - Target support in districts with high levels of A&E attendance to empower families and reduce non-emergency attendances.
      (KCC, ICB)

5. **Ensure the provision of consistent information across the system on: infant feeding, introduction to solid foods and portion sizes, with additional levels of support in response to need, to enable the healthy growth of all infants and children.**
   (KCC, KCHFT, ICB, TEP)

6. **Embed data sharing and linkage**
   - Ensure data sharing and linkage is consistently being improved particularly between maternity care, early help, health visiting, social care, and early years education.
     (KCC, KCHFT, ICB, TEP)

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Appendices

Appendix 1: Matrix of the workforces

1. Maternity service
    - Midwives
    - GPs
    - Obstetricians
    - Specialists e.g. obstetric medicine
    - Sonographers
    - Health care assistants / maternity support workers
    - Infant feeding specialists & lactation consultants
    - Neonatologists

2. Health visiting service
    - Health visitors
    - Community Public Health Nurses
    - Community Nursery Nurses
    - Family Partnership Programme Leads
    - Infant feeding specialists and lactation consultants

3. Early years service
    - Broad provision type: childminder agency, childcare on domestic premises, childcare on non-domestic premises, childminder
    - Type of provision: day nursery, family/combined/integrated centre, nursery school, playgroup/preschool, other
    - Type of offer: full day care, sessional day care, other
    - Sector: Childminder, Local Authority day nursery, private, registered independent school, state-funded governor-run, voluntary or other

Appendix 2: Early Years summary - High Impact Areas, Kent

High impact area	Key performance indicator	Current performance	Current trend	Trend icon
Transition to parenthood and the early weeks	Teenage pregnancy, 15 - 17 years	17.1 per 1,000 (2019)	No significant change	
	Smoking at time of delivery	13.5% (2020/21)	No significant change	
	Smoking at booking	14.1% (2018/19)	Too early to say (new indicator)	
	Maternal obesity at booking	24.0% (2018/19)	Too early to say (new indicator)	
	Low birth weight of term babies	2.5% (2019)	No significant change	
	Infant mortality rate	3.7 per 1,000 (2018 - 20)	No significant trend	
Maternal mental health (perinatal)	Maternal mental health	Metric in development	Not applicable	
Breastfeeding	Breastfeeding at 6 - 8 weeks	Not available (2020/21)	Cannot be calculated (missing data)	
Healthy weight	Excess weight 4 - 5 years	25.2% (2019/20)	Increasing and getting worse	
Managing minor illnesses and reducing accidents	A&E attendance rates, under 5 years	603.5 per 1,000 (2018/19)	Increasing and getting worse	
	Emergency hospital admissions, under 5 years	143.7 per 1,000 (2019/20)	No significant change	

	Hospital admissions for injuries, under 5 years	96.3 per 10,000 (2019/20)	Decreasing and getting better	
Health, wellbeing and development	Tooth decay, at 5 years	19.9% (2018/19)	Cannot be calculated (missing data)	
	MMR immunisation coverage, 2 doses at 5 years	87.9% (2020/21)	Increasing and getting better	
	Child development outcomes at 2 - 2½ years, all areas	77.9% (2020/21)	Too early to say (new indicator)	
	Child development outcomes at 2 - 2½ years, communication skills	91.5% (2020/21)	Too early to say (new indicator)	
	Child development outcomes at 2 - 2½ years, gross motor skills	93.9% (2020/21)	Too early to say (new indicator)	
	Child development outcomes at 2 - 2½ years, fine motor skills	84.7% (2020/21)	Too early to say (new indicator)	
	Child development outcomes at 2 - 2½ years, problem solving skills	95.4% (2020/21)	Too early to say (new indicator)	
	Child development outcomes at 2 - 2½ years, personal-social skills	93.9% (2020/21)	Too early to say (new indicator)	
	School readiness, good level of development at end of reception, all areas	74.0% (2018/19)	No significant change	
	School readiness, good level of development at end of reception, communication and language skills	83.5% (2018/19)	Decreasing and getting worse	

Source – PHE fingertips https://fingertips.phe.org.uk/static-reports/child-health-early-years-high-impact/E10000016.html?area-name=Kent

Appendix 3: Kent support levels guidance

Kent Safeguarding Children multi-agency partnership | Kent County Council

KENT SUPPORT LEVELS GUIDANCE SHEET PROFESSIONALS — 1

This form is designed as a quick reference guide and should be used in conjunction with the online Kent Support Level Guidance www.kscmp.org.uk

The following examples and key indicators are for professional guidance only, these should always be considered in respect of the impact they are having on the child or young person

UNIVERSAL SUPPORT LEVEL 1

Child or Young Person—Indicators

- My attendance at school/college/training is above 90%
- There are no concerns about my home/school link
- There are no barriers to my learning and no concerns about my cognitive development
- There are no concerns about my behaviour
- I am able to discriminate between 'safe' and 'unsafe'
- I am able to understand right from wrong and act appropriately
- I have a positive sense of self, with no concerns about me forming relationships
- I have stable and affectionate relationships with my parents/carers
- I am physically healthy and my development checks are up to date
- I have an adequate and nutritious diet, regular dental and optical checks
- There are no concerns about my mental health
- There are no concerns about my attitude to drugs or alcohol
- There are no concerns about my use of technology
- I live in adequate housing and in a safe and secure environment
- I have a positive sense of my abilities
- I have positive relationships with my peers
- I have good core relationships with my siblings

Parents / Carers

- My parents/carers can meet my needs, including taking me to school and all my health appointments
- My parents/carers provide me with guidance and boundaries to support my development
- My parents/carers provide me with secure and caring parenting
- My parents/carers are able to manage my behaviours

Risks to me outside my home

- I am safe at home and outside in my community

ADDITIONAL SUPPORT LEVEL 2

Child or Young Person—Indicators

- I occasionally truant or have absences from school
- I have had some fixed term exclusions
- I have started to go missing, or been absent from school or home
- I have not developed good attachments/relationships
- I am a young carer with some responsibilities at home
- I am a teenage parent and I require some low level support
- I am not reaching my developmental milestones
- I have language/communication difficulties
- I need some low level support due to a diagnosed disability or sensory impairment
- I am showing early signs of associating with peers who are involved in crime or anti-social behaviour
- I am showing early signs of instigating or experiencing problematic sexual behaviour and language
- I have low level mental health or emotional issues or self harm
- I am saying I want to 'run away'
- I have disruptive/challenging behaviours
- I am at risk due to low level/emerging neglect
- I am home educated and there are concerns about my welfare
- I am negatively affected by difficult adult/family relationships

Parents / Carers

- My family is impacted by poverty affecting their access to appropriate services/affecting my development
- My family home is in a poor state of repair, impacting on my health/development, or there is serious level of overcrowding
- My family are facing eviction/statutory homelessness
- My parents/carers struggle to meet my needs, or they place their own needs above mine
- My parents/carers struggle to provide me with good supervision or behaviour management
- My parents/carers often do not take me to my appointments which impacts negatively on my health or development
- My parents/carers health including physical/mental/learning disability or substance misuse, impacts negatively on my health or development
- My parents/carers require support to understand my disability or sensory impairment, and lack strategies to manage
- My parents/carers are at risk of entering the Criminal Justice System due to low level offending/anti-social behaviours
- My parents/carers used to be a Child in Care

Risks to me outside my home

- I am being encouraged to use substances
- I am being encouraged to truant from school
- I am being encouraged to commit low level crimes or become involved in anti-social behaviour
- I may be at risk due to content, conduct or contact online

INTENSIVE SUPPORT LEVEL 3

Child or Young Person—Indicators

- I have persistent unauthorised absence from school/NEET
- I am at risk of, or I have been permanently excluded from school
- There is serious delay in me achieving my developmental milestones creating significant concerns
- I regularly go missing from home or school with no explanation
- I am a pregnant teenager and there are serious concerns about me and my unborn baby
- I am vulnerable to being sexually abused or exploited
- I am vulnerable to/exhibiting intimate partner abuse/violence
- I am vulnerable due to my drugs and/or alcohol use
- I have significant disabilities and require professional support
- I am a homeless child in need, including 16-17 years old
- I am a young carer whose caring duties are affecting my outcomes
- I have significant dental decay that has not been treated
- I am a child subject of a Court Ordered Report under s7 or s37 being completed by children's social care
- I am a child placed under an Education Supervision Order under Section 36 of the Children Act
- I am home educated, there are significant concerns for my welfare

Parents / Carers

- I am unborn, where the level of concern for me requires a pre-birth risk assessment to be completed
- I am being chronically neglected. Food, warmth and other basics are often not available. I live in very poor home conditions
- I am at risk due to the levels of domestic abuse in my family home
- I am at risk due to my parents/carers inability to parent consistently, and this is impacting negatively on my development
- I am at risk due to inappropriate child care arrangements
- I am at risk due to my parents/carers health or disability, or learning difficulty, or substance misuse, or their offending behaviour having a direct negative impact on me
- I am at risk due to my parents/carers own emotional or mental health difficulties, impacting on my health or development
- My family needs support to meet my disability needs
- I am Privately Fostered
- My family are being evicted despite professional/agency support
- I am at serious risk because my family may breakdown and I will be homeless, or I may have to be looked after outside my family net-work

Risks to me outside my home

- I am being encouraged to become involved in a gang
- I am being encouraged to carry drugs/weapons
- I am at risk due to having contact with people who pose a risk of physical or sexual harm to children
- I am in a peer group that regularly goes missing
- I am at risk due to improper content, contact or conduct online
- I am vulnerable to criminal/sexual exploitation or radicalisation

SPECIALIST SUPPORT LEVEL 4

Child or Young Person—Indicators

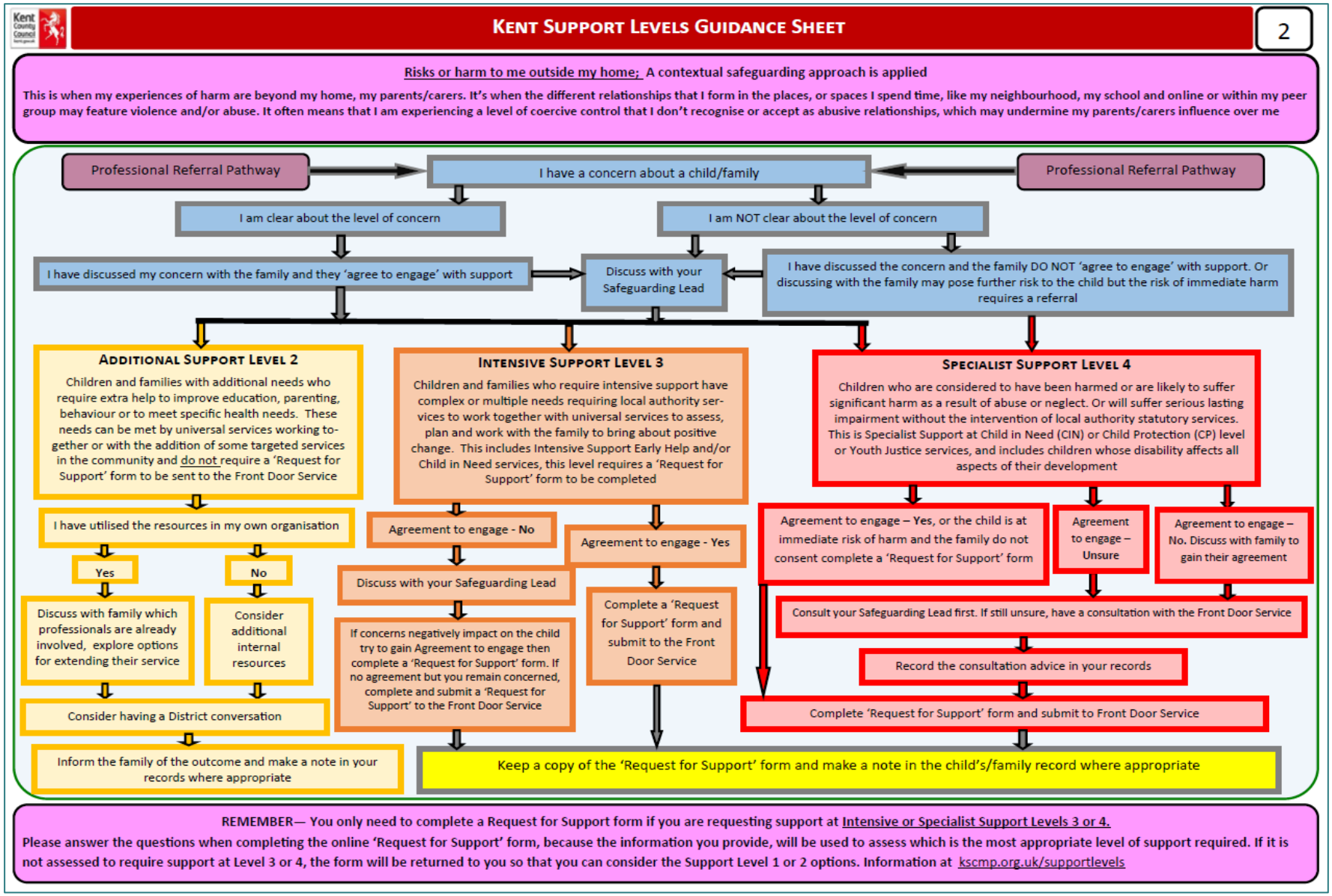
- I am not growing or developing properly with no medical reasons for this
- I am a non-mobile baby or non-mobile child with a bruise or an injury
- I am under 13 years of age and sexually active/have an STI/pregnant
- I am subject to a Youth Justice Court Order
- I have been physically/sexually abused, including child sexual assault
- I have been kicked out of home, or I have left home as I am not safe there
- I have retreated socially, or I am struggling with my emotional/mental health and this is having a significant impact on me
- I have suicidal ideations/plans
- I have been abandoned or severely neglected by my parent/carer
- I am being significantly emotionally abused by my parent/carer/partner
- Others have significant concerns about my reliance on drugs or alcohol
- I am home educated, there are serious concerns for my safety

Parents / Carers

- Meeting my needs as a severely disabled child has a significant impact on my family/parents/carers
- I am at significant risk because my carer cannot parent me properly
- I am at significant risk because my parents/carers are not supporting my medical or development needs
- I am at significant risk because my parents/carers are not able to protect me from known abusers in, or coming to, our family home
- I am at significant risk due to being left at home alone without adequate supervision or support
- I am at high risk due to my parents/carers mental health/substance abuse
- I am at high risk due to the level of domestic abuse in my family home
- I am an unborn at risk due to the pregnancy being concealed
- I am at risk because my parent/carer has abused/neglected another child
- A previous child has been removed from my parents/carers care
- I am at risk, my carer is exaggerating or causing symptoms/illness in me
- I am at high risk due to my parents/carers learning or physical disability
- I am at high risk due to my parents/carers cultural customs regarding Female Genital Mutilation (FGM)
- I am being forced to marry someone I don't want to
- I am at high risk due to my family's honour/cultural customs
- My parents may be benefitting from the risks to me outside my home

Risks to me outside my home

- I am being trafficked
- I am experiencing peer on peer abuse which may involve use of/or being forced to carry weapons in a group setting, i.e. gangs/county lines
- I am at high risk of harm due to illegal or inappropriate content, conduct or contact online
- I am high risk of harm of being radicalised, abused or exploited through technology or inappropriate relationships, in person, or online
- I am being criminally/sexually exploited in a group setting, i.e. Gangs
- I am instigating or experiencing intimate partner abuse or violence
- I am at high risk of significant harm when I go missing from home



Source: SLG Sheet - April 2020 v16 - Copy.pub (kscmp.org.uk)

Appendix 4: Kent GPs and Children's Centres, including postcode

Name	Area	Postcode	Type
The Cedars Surgery	Swanley	BR8 7AH	General practice
Swanley Children's Centre	Swanley	BR8 7BT	Children's Centre
Hextable Surgery	Swanley	BR8 7RB	General practice
The Oaks Partnership	Swanley	BR8 7UP	General practice
Northgate Medical Practice	Canterbury	CT1 1WL	General practice
New Dover Road Surgery	Canterbury	CT1 3AP	General practice
Canterbury Medical Practice: Cossington House	Canterbury	CT1 3HX	General practice
Canterbury Health Centre	Canterbury	CT1 3JH	General practice
Sturry Surgery: Molony	Canterbury	CT1 3JH	General practice
Little Hands Children's Centre	Canterbury	CT1 3SD	Children's Centre
Broadstairs Medical Practice	Broadstairs	CT10 2AJ	General practice
St Peter's Surgery	Broadstairs	CT10 2SQ	General practice
Mocketts Wood Surgery	Broadstairs	CT10 2TR	General practice
Callis Grange Children's Centre	Broadstairs	CT10 3DG	Children's Centre
Newlands Children's Centre	Ramsgate	CT11 7AJ	Children's Centre
East Cliff Medical Practice	Ramsgate	CT11 8AD	General practice
The Grange Practice	Ramsgate	CT11 8AD	General practice
Dashwood Medical Centre	Ramsgate	CT11 9PR	General practice
Priory Children's Centre	Ramsgate	CT11 9XT	Children's Centre
Minster Surgery	Ramsgate	CT12 4AB	General practice
Newington Road Surgery	Ramsgate	CT12 6EW	General practice
Newington Children's Centre	Ramsgate	CT12 6HX	Children's Centre
Summerhill Surgery	Ramsgate	CT12 6SU	General practice
Sandwich Medical Practice: Butchery Surgery	Sandwich	CT13 9DL	General practice
Sandwich Medical Practice	Sandwich	CT13 9ET	General practice
St Richards Road Surgery: Golf Road	Deal	CT14 6PY	General practice

Surgery			
The Cedars Surgery	Deal	CT14 7DN	General practice
Balmoral Surgery	Deal	CT14 7EQ	General practice
Blossom Children's Centre	Deal	CT14 7TL	Children's Centre
Manor Road Surgery	Deal	CT14 9BX	General practice
St Richards Road Surgery	Deal	CT14 9LF	General practice
The Sunflower Children's Centre	Dover	CT15 4AN	Children's Centre
White Cliffs Medical Centre: Premnath: Elvington	Dover	CT15 4DZ	General practice
Buckland Medical Practice: Bahadur: Tara	Dover	CT15 6BT	General practice
Lydden Surgery	Dover	CT15 7ET	General practice
White Cliffs Medical Centre: Premnath: Shepherdswell	Dover	CT15 7QQ	General practice
Pencester Surgery	Dover	CT16 1BW	General practice
Buckland Medical Practice: Peter Street Surgery	Dover	CT16 1EF	General practice
Peter Street Surgery	Dover	CT16 1EF	General practice
High Street Surgery	Dover	CT16 1EQ	General practice
Pencester Surgery: Pencester Health	Dover	CT16 1RH	General practice
St James' Surgery	Dover	CT16 1SF	General practice
Buckland Medical Practice	Dover	CT16 2AE	General practice
Buckland & Whitfield Children's Centre	Dover	CT16 2BT	Children's Centre
High Street Surgery: The Whitfield Surgery	Dover	CT16 3LT	General practice
The Daisy Children's Centre	Dover	CT17 0BX	Children's Centre
Snowdrop Children's Centre	Dover	CT17 0HL	Children's Centre
The Buttercup Children's Centre	Dover	CT17 0HL	Children's Centre
The Samphire Children's Centre	Dover	CT17 9HJ	Children's Centre
White Cliffs Medical Centre	Dover	CT17 9SG	General practice

Beaton Hawkinge: Hawkinge Health Centre	Folkestone	CT18 7BP	General practice
Hawkinge and Rural Children's Centre	Folkestone	CT18 7BS	Children's Centre
Church Road Surgery	Folkestone	CT18 8HY	General practice
New Lyminge Surgery	Folkestone	CT18 8NS	General practice
Caterpillars Children's Centre	Folkestone	CT19 4PN	Children's Centre
White House Surgery	Folkestone	CT19 4PU	General practice
The New Surgery	Folkestone	CT19 5SR	General practice
The Village Children's Centre	Folkestone	CT19 6EQ	Children's Centre
Sturry Surgery	Canterbury	CT2 0EF	General practice
University Medical Centre	Canterbury	CT2 7PB	General practice
Riverside Children's Centre (Canterbury)	Canterbury	CT2 7PH	Children's Centre
Canterbury Medical Practice: London Road Surgery	Canterbury	CT2 8SG	General practice
Northgate Medical Practice: Blean Surgery	Canterbury	CT2 9HP	General practice
Guildhall Street Surgery	Folkestone	CT20 1EJ	General practice
Harbour Medical Practice (Central Surgery)	Folkestone	CT20 1JY	General practice
Folkestone Early Years Centre	Folkestone	CT20 1QF	Children's Centre
Sandgate Road	Folkestone	CT20 2HN	General practice
Manor Clinic	Folkestone	CT20 2SE	General practice
Sun Lane	Hythe	CT21 5JX	General practice
Oaklands Health Centre	Hythe	CT21 6BD	General practice
Hythe Bay Children's Centre	Hythe	CT21 6HS	Children's Centre
Aylesham Medical Practice: Wingham Surgery	Canterbury	CT3 1BN	General practice
Canterbury Medical Practice: Littlebourne Surgery	Canterbury	CT3 1TX	General practice
Ash Surgery	Canterbury	CT3 2HD	General practice

Aylesham Medical Practice	Canterbury	CT3 3BB	General practice
Heron Medical Practice: Hersden Surgery	Canterbury	CT3 4EX	General practice
The Tina Rintoul Children's Centre	Canterbury	CT3 4HS	Children's Centre
Canterbury Medical Practice	Canterbury	CT4 5BL	General practice
Beaton Hawkinge: Hawkinge and Elham	Canterbury	CT4 6UH	General practice
Northgate Medical Practice: Chartham Surgery	Canterbury	CT4 7JU	General practice
Old School Surgery	Canterbury	CT4 7JY	General practice
Old School Surgery: Dr Kinnersley	Canterbury	CT4 7JY	General practice
Apple Tree Children's Centre	Canterbury	CT4 7QN	Children's Centre
Whitstable Medical Practice: Whitstable Health Centre	Whitstable	CT5 1BZ	General practice
Swalecliffe Children's Centre	Whitstable	CT5 2PH	Children's Centre
Whitstable Medical Practice: Chestfield Medical Centre	Whitstable	CT5 3QU	General practice
Whitstable Medical Practice	Whitstable	CT5 3SE	General practice
Joy Lane Children's Centre	Whitstable	CT5 4LT	Children's Centre
Heron Medical Practice	Herne Bay	CT6 5NF	General practice
Park Surgery	Herne Bay	CT6 5RE	General practice
The Poppy Children's Centre	Herne Bay	CT6 5RE	Children's Centre
Herne Bay Integrated Care Ltd	Sheerness	CT6 6EB	General practice
Heron Medical Practice: Beltinge Surgery	Herne Bay	CT6 6SR	General practice
Park Surgery: Broomfield Surgery	Herne Bay	CT6 7LY	General practice
Briary Children's Centre	Herne Bay	CT6 7RS	Children's Centre
Birchington Children's Centre	Margate	CT7 0AS	Children's Centre
Birchington Medical Centre	Birchington	CT7 9HQ	General practice
Westgate Surgery	Westgate-on-Sea	CT8 8SN	General practice
The Limes Medical Centre	Margate	CT9 1QY	General practice

Six Bells Children's Centre	Margate	CT9 1WH	Children's Centre
Cliftonville Children's Centre	Margate	CT9 2DB	Children's Centre
Northdown Surgery	Margate	CT9 2TR	General practice
Bethesda Medical Centre	Margate	CT9 3NR	General practice
Millmead Children's Centre	Margate	CT9 3RU	Children's Centre
The Limes Medical Centre: Garlinge	Margate	CT9 5DD	General practice
Garlinge Children's Centre	Margate	CT9 5NR	Children's Centre
Lowfield Medical Centre	Dartford	DA1 1HP	General practice
Dartford East Health Centre	Dartford	DA1 1QY	General practice
Pilgrims Way Surgery	Dartford	DA1 1QY	General practice
Brent Children's Centre	Dartford	DA1 1UP	Children's Centre
Dartford West Health Centre	Dartford	DA1 2HA	General practice
Maple Practice	Dartford	DA1 2HA	General practice
The Orchard Practice	Dartford	DA1 2HA	General practice
Horsman's Place Surgery	Dartford	DA1 2JP	General practice
Oakfield Children's Centre	Dartford	DA1 2SW	Children's Centre
Temple Hill Children's Centre	Dartford	DA1 5ND	Children's Centre
Temple Hill Surgery	Dartford	DA1 5ND	General practice
Swanscombe Health Centre	Dartford	DA10 0BF	General practice
Swanscombe Children's Centre	Swanscombe	DA10 0BU	Children's Centre
Pelham Medical Practice	Gravesend	DA11 0HN	General practice
Old Road West Surgery	Gravesend	DA11 0LL	General practice
Bright Futures Children's Centre	Gravesend	DA11 7JF	Children's Centre
Springhead Health	Gravesend	DA11 8BZ	General practice
Shrubbery Surgery	Gravesend	DA11 8RD	General practice
Little Gems Children's Centre	Northfleet	DA11 9HB	Children's Centre
Rochester Road Surgery: Beaumont Drive Surgery	Gravesend	DA11 9NY	General practice
Parrock Street Surgery	Gravesend	DA12 1EN	General practice
Gravesend Medical Centre	Gravesend	DA12 2EN	General practice

Rochester Road Surgery	Gravesend	DA12 2HU	General practice
Riverside Children's Centre (Gravesend)	Gravesend	DA12 2JY	Children's Centre
Lower Higham Road Surgery	Gravesend	DA12 2NG	General practice
Little Pebbles Children's Centre	Gravesend	DA12 2RL	Children's Centre
Downs Way Medical Practice: Shorne Village Surgery	Gravesend	DA12 3DY	General practice
Pelham Medical Practice: St Gregory's Crescent	Gravesend	DA12 4JW	General practice
Shrubbery Surgery: Riverview Park Surgery	Gravesend	DA12 4RX	General practice
Oakfield Health Centre, Practice 2	Gravesend	DA12 5BW	General practice
Kings Farm Children's Centre	Gravesend	DA12 5JD	Children's Centre
Swanscombe Health Centre: Lamorna Surgery	Gravesend	DA12 5PY	General practice
Old Road West Surgery: Mackenzie Way Surgery	Gravesend	DA12 5TY	General practice
Meopham Medical Centre	Meopham	DA13 0AH	General practice
Downs Way Medical Practice	Gravesend	DA13 9LB	General practice
Swanscombe Health Centre: Bennett Way Surgery	Dartford	DA2 7JT	General practice
Maypole Children's Centre	Dartford	DA2 7UZ	Children's Centre
Swanscombe Health Centre: Bean Village Surgery	Dartford	DA2 8BS	General practice
Greenlands at Darenth Children's Centre	Dartford	DA2 8DH	Children's Centre
Jubilee Medical Centre	Longfield	DA3 7QD	General practice
New Ash Green Children's Centre	Longfield	DA3 8JH	Children's Centre
Jubilee Medical Centre: Meadow Green Surgery	Gravesend	DA3 8RH	General practice
Braeside Surgery	Dartford	DA4 0JU	General practice
Devon Road Surgery	Dartford	DA4 9AB	General practice

Downs Way Medical Practice: Summerhouse Surgery	Bexley	DA5 2AE	General practice
Swanscombe Health Centre: Elmdene	Greenhithe	DA9 9DB	General practice
Swanscombe Health Centre: Greenhithe Surgery	Greenhithe	DA9 9EJ	General practice
Knockhall Children's Centre	Greenhithe	DA9 9HD	Children's Centre
Temple Hill Surgery: Ivy Bower Surgery	Greenhithe	DA9 9NF	General practice
Burham Children's Centre	Burham	ME1 3SY	Children's Centre
Woodgrove Children's Centre	Sittingbourne	ME10 1JS	Children's Centre
London Road Medical Centre	Sittingbourne	ME10 1ND	General practice
Grove Park Children's Centre	Sittingbourne	ME10 1PT	Children's Centre
Milton Court Children's Centre	Sittingbourne	ME10 2EE	Children's Centre
Grovehurst Surgery	Sittingbourne	ME10 2ST	General practice
Green Porch Medical Partnership	Sittingbourne	ME10 2TZ	General practice
Lake Medical Centre	Sittingbourne	ME10 2TZ	General practice
Murston Children's Centre	Sittingbourne	ME10 3RU	Children's Centre
The Chestnuts Surgery	Sittingbourne	ME10 4RU	General practice
Memorial Medical Centre	Sittingbourne	ME10 4XX	General practice
The Meads Medical Practice	Sittingbourne	ME10 5AA	General practice
Dr S J Witts Practice: Mill House	Queenborough	ME11 5AQ	General practice
Ladybird Children's Centre	Queenborough	ME11 5JF	Children's Centre
Seashells Children's Centre	Sheerness	ME12 1AW	Children's Centre
Sheppey Healthy Living Centre	Sheerness	ME12 1HH	General practice
St Georges Medical Centre	Sheerness	ME12 1QU	General practice
OM Medical Centre	Isle of Sheppey	ME12 1UA	General practice
Dr S J Witts Practice	Sheerness	ME12 1UP	General practice
Sheerness Health Centre	Sheerness	ME12 1UP	General practice
OM Medical Centre: Shiva Medical Centre	Isle of Sheppey	ME12 2RL	General practice

Sheppey Healthy Living Centre: Minster Medical Centre	Sheerness	ME12 3LT	General practice
Sheppey NHS Healthcare Centre	Sheerness	ME12 3LT	General practice
Lilypad Children's Centre	Sheerness	ME12 3NZ	Children's Centre
St Georges Medical Centre: Eastchurch	Sheerness	ME12 4BN	General practice
Beaches Children's Centre	Sheerness	ME12 4NA	Children's Centre
St Georges Medical Centre: Warden Bay	Sheerness	ME12 4PS	General practice
St Georges Medical Centre: Leysdown	Sheerness	ME12 4RE	General practice
Bysing Wood Children's Centre	Faversham	ME13 7NU	Children's Centre
St Mary's Children's Centre	Faversham	ME13 8AP	Children's Centre
Newton Place Surgery	Faversham	ME13 8FH	General practice
Faversham Medical Practice	Faversham	ME13 8QR	General practice
Brewer Street Surgery	Maidstone	ME14 1RU	General practice
Howard de Walden Children's Centre	Maidstone	ME14 2UG	Children's Centre
Bearsted Medical Practice	Maidstone	ME14 4DS	General practice
East Borough Children's Centre	Maidstone	ME14 5DX	Children's Centre
Albion Place Medical Practice	Maidstone	ME14 5DY	General practice
The Medical Centre Group: Grove Green Medical Centre	Maidstone	ME14 5TQ	General practice
College Practice	Maidstone	ME15 6SB	General practice
Sunshine Children's Centre	Maidstone	ME15 6TL	Children's Centre
The Medical Centre Group	Maidstone	ME15 7LN	General practice
Greenfields Children's Centre	Maidstone	ME15 8DR	Children's Centre
Mote Medical Practice	Maidstone	ME15 9FL	General practice
Wallis Avenue	Maidstone	ME15 9JJ	General practice
The Meadow Children's Centre	Maidstone	ME15 9JR	Children's Centre
Mote Medical Practice: The Loose Medical Centre	Maidstone	ME15 9QJ	General practice

College Practice: Allington	Maidstone	ME16 0RY	General practice
College Practice: Barming	Maidstone	ME16 0ZJ	General practice
Bower Mount Medical Practice	Maidstone	ME16 8AX	General practice
The Vine Medical Centre	Maidstone	ME16 8RL	General practice
Blackthorn Medical Centre	Maidstone	ME16 9AN	General practice
Len Valley Practice: Glebe Medical Centre	Maidstone	ME17 1AP	General practice
Len Valley Practice	Maidstone	ME17 2QF	General practice
Sutton Valence Group Practice	Maidstone	ME17 3BD	General practice
Sutton Valence Group Practice: Southways	Maidstone	ME17 3HT	General practice
Langley	Maidstone	ME17 3JY	General practice
Greensands: The Orchard Medical Centre	Maidstone	ME17 4PL	General practice
Greensands	Maidstone	ME17 4PS	General practice
Wateringbury Surgery	Maidstone	ME18 5SS	General practice
Yalding	Maidstone	ME18 6ES	General practice
West Malling Group Practice	West Malling	ME19 4JF	General practice
West Malling Group Practice: Avicenna Medical Centre	West Malling	ME19 5PU	General practice
Woodlands Children's Centre	West Malling	ME19 6SH	Children's Centre
Thornhills Medical Practice	Aylesford	ME20 6QJ	General practice
Wateringbury Surgery: Larkfield	Aylesford	ME20 6SS	General practice
Phoenix Medical Practice: The White House	Aylesford	ME20 7HX	General practice
Aylesford Medical Centre	Maidstone	ME20 7SE	General practice
Borough Green Children's Centre	Snodland	ME6 5HS	Children's Centre
Snodland Youth and Children's Centre	Snodland	ME6 5HS	Children's Centre
Snodland Medical Practice	Snodland	ME6 5SN	General practice
Lake Medical Centre: Lakeside	Sittingbourne	ME9 7JR	General practice

Medical Centre			
Iwade Health Centre	Sittingbourne	ME9 8TY	General practice
Dr RB Kumar Practice	Sittingbourne	ME9 9QL	General practice
Lonsdale Medical Centre	Tunbridge Wells	TN1 1PE	General practice
Grosvenor & St James Medical Centre	Tunbridge Wells	TN1 2DX	General practice
Grosvenor & St James Medical Centre: St James	Tunbridge Wells	TN1 2HW	General practice
Hildenborough Medical Group: Trenchwood Medical Centre	Tonbridge	TN10 3ET	General practice
Little Foxes Children's Centre	Tonbridge	TN10 3JU	Children's Centre
Tonbridge Medical Group: Dunorlan Medical Group	Tonbridge	TN10 4JB	General practice
Hadlow Medical Centre	Hadlow	TN11 0ET	General practice
Warders Medical Centre: Penshurst Surgery	Tonbridge	TN11 8BP	General practice
Hildenborough Medical Group: Leigh Surgery	Tonbridge	TN11 8RW	General practice
Hildenborough Medical Group	Hildenborough	TN11 9HL	General practice
Malling Health Four	Tonbridge	TN12 0LB	General practice
Woodlands Health Centre	Paddock Wood	TN12 6AX	General practice
Paddock Wood Children's Centre	Paddock Wood	TN12 6DS	Children's Centre
Howell Surgery	Brenchley	TN12 7NQ	General practice
Howell Surgery: Horsmonden	Tonbridge	TN12 8LP	General practice
Marden Medical Centre	Tonbridge	TN12 9HP	General practice
Town Medical Centre	Sevenoaks	TN13 1AR	General practice
South Park Medical Practice	Sevenoaks	TN13 1ED	General practice
Amherst Medical Practice	Sevenoaks	TN13 3AQ	General practice
St John's Medical Practice	Sevenoaks	TN13 3NT	General practice
Spring House Children's Centre	Sevenoaks	TN13 3PT	Children's Centre
Otford Medical Practice	Sevenoaks	TN14 5RB	General practice

Westerham Practice: Dr AJ Skinner & Partners	Sevenoaks	TN14 6EH	General practice
Hildenborough Medical Group: Weald Surgery	Sevenoaks	TN14 6QX	General practice
Temple Hill Surgery: West Kingsdown Medical Centre	Sevenoaks	TN15 6EJ	General practice
West Kingsdown Children's Centre	West Kingsdown	TN15 6JP	Children's Centre
Otford Medical Practice: Kemsing Village Surgery	Sevenoaks	TN15 6PU	General practice
Borough Green Medical Practice	Borough Green	TN15 8RQ	General practice
Amherst Medical Practice: Brasted Surgery	Westerham	TN16 1HU	General practice
Westerham Practice	Sevenoaks	TN16 1RB	General practice
Old Parsonage Surgery	Goudhurst	TN17 1AN	General practice
Orchard End	Cranbrook	TN17 3AY	General practice
Old School Surgery	Cranbrook	TN17 3JB	General practice
The Crane Surgery	Cranbrook	TN17 3JB	General practice
Cranbrook Children's Centre	Cranbrook	TN17 3JZ	Children's Centre
Weald View Medical Practice: Hawkhurst	Cranbrook	TN18 4EX	General practice
Wish Valley Surgery	Hawkhurst	TN18 4NB	General practice
Speldhurst & Greggswood Medical Group	Tunbridge Wells	TN2 3JL	General practice
Little Forest Children's Centre	Tunbridge Wells	TN2 3UA	Children's Centre
Waterfield House Surgery	Tunbridge Wells	TN2 4LR	General practice
Kingswood Surgery	Tunbridge Wells	TN2 4UH	General practice
The Ark Children's Centre	Tunbridge Wells	TN2 5RP	Children's Centre
Kingsnorth Medical Practice	Ashford	TN23 3ED	General practice
The Willow Children's Centre	Ashford	TN23 4EY	Children's Centre
Ashford Medical Partnership: St Stephens Health Centre	Ashford	TN23 5AQ	General practice

Ashford Medical Partnership: Singleton Health Centre	Ashford	TN23 5GR	General practice
Ray Allen Children's Centre	Ashford	TN23 5RN	Children's Centre
Sydenham House Medical Centre: Musgrove Park Medical Centre	Ashford	TN23 7SP	General practice
Ashford Medical Partnership: Willsborough	Ashford	TN24 0HZ	General practice
Waterside Children's Centre	Ashford	TN24 0PQ	Children's Centre
Sydenham House Medical Centre	Ashford	TN24 8DN	General practice
Hollington Surgery	Ashford	TN24 8UN	General practice
New Hayesbank Surgery	Ashford	TN24 9JZ	General practice
Sure Steps Children's Centre	Ashford	TN24 9LS	Children's Centre
Wye Surgery	Ashford	TN25 5AY	General practice
Sellindge Surgery	Ashford	TN25 6JX	General practice
Bluebells Children's Centre	Ashford	TN26 1HA	Children's Centre
Hamstreet Surgery	Ashford	TN26 2NJ	General practice
Woodchurch Surgery	Ashford	TN26 3SF	General practice
Charing Surgery	Ashford	TN27 0AW	General practice
Headcorn Surgery	Headcorn	TN27 9AA	General practice
Headcorn Children's Centre	Ashford	TN27 9NR	Children's Centre
New Romney Children's Centre	New Romney	TN28 8BL	Children's Centre
Oak Hall	New Romney	TN28 8BW	General practice
Church Lane Health Centre	New Romney	TN28 8ER	General practice
Dymchurch Children's Centre	Romney Marsh	TN29 0NQ	Children's Centre
Martello Health Centre	Romney Marsh	TN29 0TD	General practice
Orchard House	Lydd	TN29 9AE	General practice
Lydd'le Stars Children's Centre	Romney Marsh	TN29 9HW	Children's Centre
Speldhurst & Greggswood Medical Group: The Old Bakery	Tunbridge Wells	TN3 0PQ	General practice
Lamberhurst Surgery	Tunbridge Wells	TN3 8EX	General practice

Little Explorers Children's Centre	Tenterden	TN30 6RA	Children's Centre
Ivy Court Surgery	Tenterden	TN30 6RB	General practice
Ivy Court Surgery: Temporary Cabin	Tenterden	TN30 6RB	General practice
Southborough Children's Centre	Tunbridge Wells	TN4 0JY	Children's Centre
St Andrews Medical Centre	Tunbridge Wells	TN4 0NA	General practice
Harmony Children's Centre	Rusthall, Tunbridge Wells	TN4 8RZ	Children's Centre
Rusthall Medical Practice	Tunbridge Wells	TN4 8UW	General practice
Abbey Court	Tunbridge Wells	TN4 9TF	General practice
The Wells Medical Practice	Tunbridge Wells	TN4 9TF	General practice
Edenbridge Children's Centre	Edenbridge	TN8 5AB	Children's Centre
Edenbridge Medical Practice	Edenbridge	TN8 5ND	General practice
Tonbridge Medical Group	Tonbridge	TN9 1EP	General practice
Warders Medical Centre	Tonbridge	TN9 1LA	General practice
Warders Medical Centre: Little Warders	Tonbridge	TN9 1LA	General practice
South Tonbridge Children's Centre	Tonbridge	TN9 1TG	Children's Centre

Source: SHAPE Atlas

Appendix 5: Definition of speech, language and communication.

The Royal College of Speech and Language Therapists (RCSLT) defines the terms speech, language and communication:

Speech refers to:

- saying sounds accurately and in the right places in words
- speaking fluently, without hesitation, prolonging or repeating words or sounds
- speaking with expression in a clear voice, using pitch, volume and intonation to add meaning

Language refers to:

- understanding and making sense of what people say
- using words to build up sentences which are used in longer stretches or spoken language and to build conversations
- putting information in the right order to make sense

Communication refers to:

- being able to communicate to people and take turns as well as change language/communication to suit the situation; in effect, how we interact with others
- non-verbal communication, for example eye contact, gestures, and facial expressions
- being able to consider another person's perspective, intentions, and the wider context.

The term 'speech, language and communication needs' (SLCN) encompass a wide range of difficulties related to aspects of communication in children and young people. These can include difficulties with fluency, forming sounds and words, formulating sentences, understanding what others say, or using language socially.

The following skills are also important to the development of SLC:

Attention and listening skills – this refers to the ability to pay attention and listen carefully to what is being said. This skill is required in order to have, and to follow, a conversation, as well as retaining information.

Social interaction – this refers to the capacity to relate to others in a socially appropriate manner and plays a pivotal role in promoting social integration. This also involves expressing emotions and using and decoding non-verbal communication. (183)

Appendix 6: Number of referrals to LIFT and specialist teaching service, Kent

West Kent	2016-17 TOTALS	2017-18 TOTALS	2018-19 TOTALS	2019-20 TOTALS
Maidstone				
Number of Referrals to LIFT	90	104	98	96
Number referrals allocated to Specialist Teacher	90	104	98	96
Tunbridge Wells				
Number of Referrals to LIFT	73	0	0	113
Number referrals allocated to Specialist Teacher	59	0	0	113
Tonbridge & Malling				
Number of Referrals to LIFT	52	69	60	65
Number referrals allocated to Specialist Teacher	40	49	44	45
North Kent	**2016-17 TOTALS**	**2017-18 TOTALS**	**2018-19 TOTALS**	**2019-20 TOTALS**
Gravesham				
Number of Referrals to LIFT	0	0	77	61
Number referrals allocated to Specialist Teacher	0	0	73	55
Sevenoaks				
Number of Referrals to LIFT	0	0	0	0
Number referrals allocated to Specialist Teacher	0	0	0	0
Dartford				
Number of Referrals to LIFT	0	77	80	0
Number referrals allocated to Specialist Teacher	0	71	67	0

East Kent	2016-17 TOTALS	2017-18 TOTALS	2018-19 TOTALS	2019-20 TOTALS
Swale				
Number of Referrals to LIFT	0	0	145	88
Number referrals allocated to Specialist Teacher	0	0	127	81
Canterbury				
Number of Referrals to LIFT	54	59	70	78
Number referrals allocated to Specialist Teacher	40	53	70	61
Thanet				
Number of Referrals to LIFT	0	0	0	0
Number referrals allocated to Specialist Teacher	0	0	0	0
South Kent	**2016-17 TOTALS**	**2017-18 TOTALS**	**2018-19 TOTALS**	**2019-20 TOTALS**
Dover				
Number of Referrals to LIFT	0	97	63	85
Number referrals allocated to Specialist Teacher	0	78	51	64
Ashford				
Number of Referrals to LIFT	0	96	0	0
Number referrals allocated to Specialist Teacher	0	37	0	0
Folkestone & Hythe				
Number of Referrals to LIFT	67	84	125	0
Number referrals allocated to Specialist Teacher	34	58	79	0

Source: Early Years Provider