Agenda – Children, Young People and Education Committee

Meeting Venue:
Committee Room 1 – Senedd
Meeting date: 26 October 2017
Meeting time: 09.15

For further information contact:
Llinos Madeley
Committee Clerk
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Pre-meeting

(09:15 – 09:30)

1 Introductions, apologies, substitutions and declarations of interest

(09:30)

2 Inquiry into Flying Start: outreach

(Pages 1 – 65)

Evidence session 1

(09:30 – 10:30)

Welsh NHS Confederation and Public Health Wales

Lesley Lewis, Head of Nursing Primary Care and Localities – Cwm Taf University Health Board
Alison Cowell, Assistant Area Director Central – Children's Services
Helen James, Head of Children's Public Health Nursing and Paediatric Services – Powys Teaching Health Board
Amy McNaughton, Consultant in Public Health – Public Health Wales

Attached Documents:

Research Brief

CYPE(5)-29 -17 – Paper 1 – Welsh NHS Confederation – Response to First

1,000 days consultation

CYPE(5)-29-17 - Paper 2 - Public Health Wales - Response to First 1,000 days consultation

CYPE(5)-29-17 - Paper 3 - Public Health Wales - Additional evidence for the inquiry

Break

(10:30 - 10:45)

3 Evidence session 2

(10:45 - 11:30) (Pages 66 - 67)

Royal College of Nursing (RCN) and the Welsh Heads of Health Visiting and School Nursing Forum

Alison Davies, Associate Director Professional Practice, RCN Wales

Nicola Milligan, RCN Welsh Board Member, Specialist Health Visitor, Cwm Taf UHB

Sandra Dredge, Senior Nurse for Community Child Health, Cardiff & Vale University Health Board and representing the Welsh Heads of Health Visiting and School Nursing Forum

Attached Documents:

CYPE(5)-29-17 - Paper 4 - RCN - Response to first 1000 days consultation

4 Evidence session 3

(11:30 - 12:45) (Pages 68 - 85)

Flying Start Network

Sarah Mutch, Flying Start Manager, Caerphilly County Borough Council and Chair of all Wales Flying Start Managers' network

Liz Wilson, Flying Start Health and Social Care Manager, Carmarthenshire County Council

Hannah Fleck, Service Manager Community Wellbeing, Conwy County Borough Council

Clair Lister, Head of Integrated Adult and Community Services, Conwy County Borough Council
Sarah Ostler, Flying Start Co-ordinator, Merthyr Tydfil County Borough Council

Attached Documents:
PCYPE(5)-29-17 - Paper 5 - Flying Start Network - Additional evidence for the inquiry

5 Paper(s) to note

(12:45)

5.1 Letter from the Children's Commissioner for Wales to the Minister for Lifelong learning and Welsh Language

(Page 86)

Attached Documents:
CYPE(5)-29-17 - Paper 6 - to note - Letter from the Children's Commissioner for Wales to the Minister for Lifelong learning and Welsh Language

6 Motion under Standing Order 17.42(ix) to resolve to exclude the public from the meeting for the remainder of the meeting.

7 Inquiry into Flying Start: outreach - Consideration of the evidence

(12:45 - 13:00)

Agenda Item 2

Document is Restricted

Y 1,000 diwrnod cyntaf | First 1,000 Days
FTD 22
Ymateb gan: Conffederasiwn GIG Cymru
Response from: Welsh NHS Confederation

Introduction

1. We welcome the opportunity to contribute to the Children, Young People and Education Committee consultation on the First 1,000 Days. The First 1,000 days of a child's life is key to a child's future health and well-being and has the potential of impacting on a person's future intellectual development and lifelong health. The Welsh NHS Confederation and our members are more than happy to provide further information to Members of the Committee if required.

2. The Welsh NHS Confederation represents the seven Health Boards and three NHS Trusts in Wales. The Welsh NHS Confederation supports our members to improve health and well-being by working with them to deliver high standards of care for patients and best value for taxpayers' money. We act as a driving force for positive change through strong representation and our policy, influencing and engagement work.

Overview

3. Improving health outcomes for children, young people and their families, and reducing the health inequalities that exist within our communities, are key priorities for the NHS in Wales. There is clear evidence that one of the most important things we can do to improve the health of our population and reduce inequalities is to ensure children are provided with the best possible start in life.

4. Influencing the development of children to maximise their health, social and educational development is most effective when done as early as possible; the first 1000 days being critical. There is also a strong economic case, as return on investment in the early years is higher than at any other stage of a person's life course.

5. Rates of stillbirth, preterm birth, low birth weight, neonatal deaths, admissions to neonatal units, infant mortality, child mortality, injuries and teenage pregnancy have all been shown to be significantly higher in areas with high levels of deprivation. Across Wales, there are variations in health outcomes and life experiences due to economic deprivation. This includes the unacceptable variation of low birth weights of babies across our communities and the fact that children from the most deprived fifth of the population have a rate of child death 70% higher than those in the least deprived fifth.[i] Giving every child the best start in life is the highest priority recommendation in Professor Sir Michael Marmot's recent strategic review of health inequalities.[ii]

6. Globally, there is an increasing body of evidence purporting to show how experiences during childhood have long-term impacts on a person's health and life chances. In January 2016, Public Health Wales NHS Trust published the first ever study in Wales of Adverse Childhood Experiences (ACE's)[iii] which found that 47% of the Welsh adult population are estimated to have experienced at least one ACE and 14% have experienced four or more ACEs. ACEs are stressful experiences occurring during childhood that directly harm a child (e.g. maltreatment) or affect them through the environment in which they live (e.g. growing up in a household while suffering domestic abuse). A baby's brain grows from 25% to 80% of its adult size during the first 2 years of its life, hence the importance of the first 1000 days in determining a person's life chances simply cannot be emphasised enough.

7. Preventing ACEs can improve health across the whole life course, enhancing individuals' well-being and productivity while reducing pressures and costs on the NHS. Tackling Poverty programmes, such as Flying Start and Families First, promote behaviours which support positive parent child relationships to bring about secure emotional attachments and positive maternal and family emotional health and resilience.

8. The Public Health Wales Observatory report "Health of Children and Young People – Wales Report",[iv] shows that health and behaviour developed during childhood and adolescence is often carried through into adulthood and can affect health later in life. Supporting children to adopt a healthier lifestyle from early years is therefore critical and providing parents with the skills and knowledge around healthy lifestyles is key.

9. NHS strategies and plans therefore have focused on preventing ill health, promoting health and well-being and intervening early by improving access to services. These actions place the child, their family and their carers at the centre of the approach, ensuring that the health, well-being and safety of children and young people are safeguarded.

10. Our response to the inquiry provides an overview of the current programmes, policies and areas of work in relation to the first 1000 days, and recommendations for future key areas of focus and consideration. The following themes are considered to be significant:

- Evidence based programmes;
- Programmes with clearly identified outcomes at the outset;
- A future policy direction to equitable provision based on identified need; and
- A focus on early intervention to improve outcomes and opportunities, to change potential life courses and make long term health improvements.

<u>Terms of Reference</u>

The extent to which Welsh Government policies and programmes support the early parent role, before birth and during the first 2 years of a child's life, how effective these are in supporting children's emotional and social capabilities and development;

11. The policy development and guidance from the Welsh Government, and the implementation of new programmes in recent years, has led to a greater focus on the principles of the first 1000 days. Even though the

first 1,000 days have been a priority for the NHS for some time, there has recently been a significant increase in focus on pre-natal care, as well as the health, well-being, lifestyle choices and significant benefits it has on both the mother and the unborn child.

12. The all-Wales maternity record was revised and the new version introduced in June 2016. The record includes recommendations from Public Health Wales NHS Trust and outlines a significant refocus on healthy lifestyles. The revised version also highlighted a focus on substance misuse, domestic abuse screening and issues associated to health and well-being, including diet and healthy physical activity.

13. The benefit of programmes such as Flying Start and Families First are instrumental to delivering the significant changes required and additional targeting of resources. Flying Start provides a real opportunity to embed health promotion messages to families. For instance, in Blaenau Gwent, Aneurin Bevan University Health Board has established an Antenatal Support Project delivered at Ysbyty Aneurin Bevan. This is a collaboration between Blaenau Gwent Flying Start and wider health staff, Families First, Communities First and the Family Information Service. The project provides health promotion information and advice on the support services available during the pre and post-natal periods. It also signposts mothers to multi-agency services when specific needs are identified.

14. While these programmes have had an impact, they do require complete trust and true partnership working across sectors to ensure effective delivery for all, and outcomes for the future. If the relationships across organisations are not sufficiently strong, then the organisation holding the money often decides on its implementation and usage, which is not always aligned to the areas of greatest impact. However, across Wales, partnerships and commissioning decisions are seeing the significant benefits and outcomes for mothers and children.

The effectiveness of Welsh Government policies and programmes that:

a) **Promote and protect the health and well-being of children from pregnancy (for example through positive parenting, high immunisation rates and tackling smoking in pregnancy).**

15. The effectiveness of policy and new programmes is clear to see when partnership arrangements are clear and consistent with what is expected to be delivered. Over recent years, the combined impact of the Healthy Child Wales programme, Flying Start, Families First, as well as a clear focus on school nursing services and health visiting, has seen an increased emphasis on promoting the health and well-being of children from pregnancy. However, without further resources, pressure is put on the NHS and other partners to deliver on all these areas.

16. All services, not just those provided by healthcare providers within the local community, are starting to consider the real impact and positive outcomes of investing time, support and intervention at the pre-natal stages. By targeting these issues during pregnancy (e.g. promotion of diet nutrition and healthy weight and physical activity, alcohol reduction and positive physical activity) improved health outcomes can be achieved for the mother, the unborn child and the wider family network, which in turn sets the principles of health and well-being for life.

17. The Welsh Ambulance Service NHS Trust (WAST) are in a position to contribute positively to the many and various influences on a child's health and development. WASTs Emergency Medical Services (EMS) provides first line care to patients and families in their homes and communities. This enables unique and valuable opportunities for contact with vulnerable children and their families. The Non-Emergency Patient Transport Service (NEPTS) provides a key service for those children who require transport to hospital appointments, providing another medium of interaction with children and parents. NHS Direct Wales provides frequent contact with parents requiring clinical triage, leading to referrals to the wider NHS in addition to health information and advice.

b) Deliver improved child health outcomes across Wales (for example prevention of obesity and the promotion of health-enhancing behaviours for every child such as eating a well-balanced diet, playing actively, and having an appropriate weight and height for their age and general health).

18. Health Boards recognise the importance of a child's early experiences on future physical and mental health and well-being and they aim to provide all parents with the support they need to be the best parents they can. Core services and new programmes are starting to make a positive impact as well as the targeting of support and awareness raising within core midwifery, health visiting and school nursing services.

19. The Healthy Child Wales Programme has made a positive step in ensuring a universal framework of consistent health promoting messages, of holistic family assessments, standardised assessments of child development and of delivering evidence based interventions.

20. Specific public health interventions have been targeted that align with identified public health priorities, including immunisations and smoking cessation. The programmes have a wider aim, namely to improve the overall health and well-being of children by supporting improved resilience within families. Specific programmes within Health Boards include;

- Baby Buggy Walks, which offers mothers-to-be and new parents the opportunity to get together to exercise and share stories, thereby benefiting not only their physical health, but also their mental health;
- Healthy eating messages begin during the antenatal period, with Health Visitors exploring parental eating habits and food choices;
- Weigh and Play sessions are delivered within communities by Health Visitors and Health Family Support Workers. These encourage and enhance child development and demonstrate to parents how to support their children in order for them to reach their development milestones;

- Through WASTs community engagement and experience work, there has been a demand from the wider public for information around health promotion and health improvement. WAST used to promote 'Birth to Five' in line with Welsh Government/NHS guidance, and since 2014 they have been promoting 'Bump, Baby and Beyond'. Elements of this are linked to Health Challenge Wales, especially the benefits associated with breastfeeding;
- The Designed to Smile programme is considered to have been key in the gradual improvement in oral health and evident reduction in dental caries. It provides a structured framework for practitioners to work within the clear guidance for promoting oral health improvements. The impact of the programme has been significant: the prevalence of dental caries amongst five-year olds between 2008 and 2015 has seen a 12% reduction. This improvement has happened across the social gradient, showing that childhood oral health inequalities are not widening. The Designed to Smile programme is therefore hugely valued and needs to continue and strengthen interventions aimed at the first 1000 days; and
- UNICEFs Baby Friendly Initiative (BFI) has been pivotal in the start of cultural change and attitude with regard to infant feeding and particularly breast feeding. With the unequivocal scientific evidence of the physical and emotional impact of breast feeding and long terms health outcomes, BFI provides clear guidance, a framework for training and quality assurance via audit programmes.

21. The majority of policies and programmes implemented are part of Welsh Government strategies and programmes. However, without effective funding and commissioning arrangements, it is down to local discussions and commissioning to inform opportunities for real change and pilot projects. It is recognised that while Health Boards are delivering a range of interventions to promote and protect the well-being of infants and children, it is often difficult to attribute any impact they make on the

wider public health outcomes. One explanation for this is that data collection has been challenging, but Health Boards are hopeful that improvements to the child health system and implementation of the Welsh Community Care Information System (WCCIS) will provide the mechanism for more robust data collection in the future.

c) Tackle child health inequalities, with a specific focus on child poverty and disabled children.

22. Having a prosperous Wales, where we have strong and economically-resilient communities, is key to health and well-being. As highlighted in the Welsh NHS Confederation's briefing, "*From Rhetoric to Reality – NHS Wales in 10 years' time: Socio-economic Deprivation and Health*",[v] the socio-economic inequalities in life prospects and health are stark. Socio-economic deprivation has a significant impact on a child's survival, development, future health and happiness. Socio-economic deprivation also has an impact on people's lifestyle choices, on healthy life expectancy, including living with an illness or chronic condition, and life expectancy.

23. As the evidence highlights, a child's development and chances of survival are heavily influenced by the social and economic circumstances into which they are born. This is discussed at length in the Royal College of Paediatrics and Child Health's report "*Social and economic inequalities are matters of life and death for children".*[vi] It is important that all sectors work together because children and families need to be empowered with the knowledge, skills and resources for the best start in life.

24. Staff within Flying Start targeted areas actively work with parents where poverty has been identified as impacting upon their child's health and well-being. Health Visitors are uniquely positioned to work alongside parents, using a solution focused approach, to explore and identify areas that may be impinging upon themselves and their family. Each Health

Visitor teams understanding of local health and community resources enables families with children with disabilities to access appropriate and timely support. Staff make use of the Family Information Service and signpost clients to community resources, e.g. Food Banks and Credit Unit. Furthermore, the Healthy Child Wales Programme aims to reduce inequalities through the efficient and effective use of resources and Health Board staff deliver this programme to ensure timely interventions determined by the family's level of need.

25. Support for siblings of disabled children is also high on the agenda for the NHS as their well-being can suffer in those early days. Families of young children with disabilities benefit hugely from care co-ordination particularly in the early days, particularly if the child has very complex needs.

d) Reduce child deaths and injury prevention, particularly in the most deprived parts of Wales where infant mortality is much higher than the least deprived.

26. There are numerous research reports that highlight how poverty and social inequalities have an important bearing on a child's survival, development, future health and happiness.

27. In relation to child mortality, there is a strong correlation between deprivation and the risk of child death, with child mortality rates higher in the most deprived areas than in the least deprived. The Marmot Review[vii] highlighted how poor health is strongly linked to socio-economic status with children born into poor families more likely to be born premature, have low birth weights and die in their first year of life. Public Health Wales 'Child Death Review Programme Annual Report' evidenced that most child deaths (64%) occur in the first year of life and the death rate among children living in the most deprived fifth of Wales is 70% higher than among children in the least deprived fifth of Wales.[viii]

28. A wide deprivation gap exists in stillbirth rates, with women at higher risk of stillbirth in deprived areas. A study[ix] from 2012 found that women from poorer socio-economic backgrounds are more likely to suffer a stillbirth than those from more affluent families. There were 1,489 stillbirths in the least deprived tenth compared to 3,043 stillbirths in the most deprived tenth. It concludes that a better understanding of these stillbirths is necessary to reduce socio-economic inequalities.

29. Children from more deprived backgrounds are at greater risk of hospital admission and are more likely to experience multiple admissions before the age of three years.[x] There is a higher incidence of acute illnesses among children from more deprived backgrounds, with acute infections such as pneumonia, infections, asthma and bronchiolitis, generally higher for children in the most deprived backgrounds.[xi] Hospital admissions for pedestrian injuries of children from the most deprived fifth of the population is significantly higher than the least deprived. The wider social aspects needs to be considered and initiatives, such as Flying Start, gives the opportunity to provide information on debt and benefit advice services, which helps families to improve their situations and general well-being. It is important that children and families are supported in their early years to mitigate the impact of poverty and also to ensure communities can become more resilient to support local people. The impact of potentially losing Communities First initiatives will therefore need to be considered in this context.

30. In order to identify risks, throughout pregnancy and the pre-school years, Health Board staff continually assess risk and promote safety messages in collaboration with families utilising the Children in Wales - Keep In Mind - Home Safety assessments cards. Health Boards recognise the importance of providing a Health Visitor follow up to all children who attend minor injury unit or hospital to offer further guidance and support around prevention. Furthermore it is important to recognise patterns of frequent attendances and consider whether safeguarding is a concern.

31. Additionally, Health Boards consider how to educate parents regarding preventable death in childhood, include Sudden Infant Death Syndrome (SIDS), drowning, and risky behaviour. Our members acknowledge that this requires good multi-disciplinary relationships and clear pathways of referral from Health Visitors, WAST staff, Social Workers and other members of the Multi-disciplinary team.

32. The benefit of programmes such as Flying Start and Families First are, and could be, instrumental to delivering these significant changes and additional targeting of resources, but this requires complete trust and true partnership working to ensure effective delivery for all. If the relationships across organisations are not strong then the organisation who holds the money often decides on its implementation and usage which is not always aligned to the areas of greatest impact. Greater flexibility is needed to be given locally to use of Flying Start, and other funds. These programmes do not always enable Health Boards to reach the families with the greatest need due to the post code element of the programme, and the significant pressure on other core services.

e) Support effective child development and emotional and social well-being - specifically interventions that are delivered outside the health service which can help to detect and address developmental delays.

33. If we are to meet the growing needs of the population, both now and in the future, it is vital that all sectors work together. The future success of the NHS relies on us all taking a proactive approach to health and ensuring that we create the right conditions to enable people, especially children, to live active and healthy lifestyles. Health Board employees work closely with key partners, including third sector organisation such as Save the Children and Action for Children, who provide one-to-one family support and facilitate group work with families. Furthermore, working and training in partnership with other agencies allows the

pooling of skills, knowledge, experience and resource which can be further promoted outside of the health arena.

34. Flying Start initiatives have also been vital in relation to supporting children's psychological and mental health needs. Psychological and mental health needs of young children and their families has been raised as a key theme by many Health Boards. In Blaenau Gwent, Aneurin Bevan UHB has a Flying Start Community Psychiatric Nurse, who plays a key role in supporting families. Also, there is a particular programme at Aneurin Bevan's Serennu Centre in Newport, the Helping Hands programme. It provides clinical psychology services to parents and carers of children with disabilities or development difficulties aged 0-18, to support their well-being and resilience. The programme is a partnership between the Big Lottery, the Sparkle Appeal and the Health Board and is funded until 2019.

f) Focus on improving learning and speech and language development through the home learning environment and access to early years' provision (including childminders, preschools and day nurseries).

35. The years from birth to 2 are critical in helping babies learn all the foundation skills for talking, and parents and carers have a vital role to play as a baby and young child's first teacher. Early language skills play a crucial role in literacy, a child's ability to achieve their educational potential, their social mobility, and their life chances. Beyond academic attainment, well-developed speech, language and communication skills are fundamental to the ability to form and maintain social relationships with family, peers and friends.

36. There is an increasing focus on children's speech, language and communication skills within early years' policy in Wales. The recently launched Healthy Child Wales programme has a specific focus on speech and language development, and the 15 month health visitor family health

review, the 'Parenting – Give it Time' campaign incorporates key learning to talk messages throughout the website content. Speech and Language Therapists have also linked into the drafting of the Foundation Phase Profile.

37. Given the strong correlation between disadvantage and early language delay, the Flying Start programme has prioritised speech, language and communication, both with regard to supporting parents and carers, and within the childcare entitlement. The Flying Start programme has notably prioritised this area by publishing guidance and employing a speech, language and therapist in each Flying Start project in a consultative role to support parents and early year's practitioners. Evidence of the huge impact of the profession within the Flying Start programme is starting to become clear. Part of the role of the therapist is both to up skill the early year's workforce in these areas and to improve parents' knowledge and skills to support children's early language development.

38. While the role of speech of language therapist is clear, there is a shortfall in access to speech and language therapy provision. Whilst acquisition of language development can be reinforced by staff who have been trained it is imperative that the quality of the service model has been assured by the speech and language therapist. Health Board health visiting teams are closely supported by speech and language colleagues who offer regular updates, as well as supervision and joint visiting opportunities as and when they are required.

g) Reduce the adverse impact on the child of psychosocial issues such as poor parenting, disruptive family relationships, domestic violence, mental health issues and substance misuse through effective safeguarding.

39. Health Boards across Wales are ensuring that they are making every contact count" across all service areas. This involves midwives, health visitors, other professionals and the third sector offering and encouraging positive life choices, healthy behaviours throughout a woman's pregnancy, through to early years, early childhood, into schooling and adolescence.

40. Health Boards recognises the importance of the Public Health Wales NHS Trust ACE report[xii] as a platform on which to better understand the prevalence of children experiencing ACEs in their area and the adverse impact ACEs are having on children in their area. Once this has been established, the next steps will be for Health Boards to use this information to re-design services that start to address the issues and break perpetual cycles of destructive parental behaviours or identify children earlier who are in need of safeguarding. However for those parents who have experienced ACEs themselves, whilst some joint working with outside agencies begins to enable and empower them to be better parents, further input in the form of additional services that work to support the parent-infant relationship may need to be considered. It is thought that a screening tool would be helpful in understanding the prevalence of ACEs which staff may need training to implement.

41. Health Boards understand the impact of ACEs during the Early Years which informs their Safeguarding Role. All staff across Health Boards are skilled in recognising when children are suffering or are at risk of suffering significant harm and will work within the All Wales Child protection guidelines. 'Together for Mental Health' and the Well-being of Future Generations (Wales) Act 2015 are seen as platforms for collaborative initiatives to prevent ACEs in the future. The Welsh ACE survey identified that the prevalence of low mental well-being in adults is strongly related to the number of ACEs individuals reported experiencing as children. Health Boards acknowledge the key role our frontline staff play in identifying safeguarding concerns and we need to strengthen the

links between identifying safeguarding children issues and vulnerable adults who are parents of young children with the ACEs and their impact not just on the individual's health but on wider society.

42. The Flying Start programme is an example of early intervention services that the Welsh Government has invested in to address the issues in the first 1,000 days of life. The positive impact of this initiative is becoming clearer, as highlighted in the recent evaluation[xiii] of Flying Start and the difference it makes in early years. The challenge however is for practitioners working in the areas outside of Flying Start, where need is still identified but the level of support and intervention is significantly less than for those residing in the Flying Start areas.

43. The MAMMS and Bump Start pilots are showing early gains in areas relating to smoking cessation in pregnancy, healthy weight gain and impact on low birth weight babies, all of which impact on this area and enable a greater and more supportive and positive outcome for babies and pregnant women. As a result of the need to reduce low birth weight babies, smoking and BMI in pregnancy local projects are proving successful and audits are identifying positive impacts in reducing LBW babies in these areas, and increased uptake in MAMMS programme.

44. The concern is that funding for these is not secure long term as it is provided via external partnership grants, as funding does not always follow Welsh Government policies and programmes, and so when funding does come via eternal grants, as outlined above this can sometimes be lost in clarity as to who holds the budget lines and what local commissioning processes are in place. Very often when grant funding changes direction then only the budget holders are asked for input relating to future direction Health play a significant role and also need opportunity to influence service and strategy direction as language across organisations often differ significantly.

Evaluation of Welsh Government programmes

45. It is emphasised that Welsh Government and local programmes, such as those outlined above, need to be continually well evaluated and good information must be collected to assist with prioritisation and sustainability for future years, particularly where funding is provided from a range of sources. There will need to be considerations for the developing Local Partnership Boards in relation to a focus on future generations as part of the Well-being of Future Generations Act 2015 and also to ensure that there is equity of provision based on needs across all geographical areas.

Conclusion

46. The NHS in Wales, with our partners, are working hard to improve the health outcomes for children, young people and their families and to bring about a reduction in the health inequalities that exist within our communities. There is clear evidence that one of the most important things we can do to improve the health of our population and reduce inequalities is to support children to have the best start in life and the NHS will continue to prioritise this.

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[i] Royal College of Paediatrics and Child Health, January 2017. State of Child Health: 2017 Recommendations for Wales

[ii] The Marmot Review Team. February 2010. Fair Society, Healthy Lives: Strategic Review of the Health Inequalities in England post-2010: The Marmot Review. London 2010.

[iii] Public Health Wales, January 2016. Welsh Adverse Childhood Experience (ACE) study

[iv] Public Health Wales Observatory, November 2013. Health of Children and Young People – Wales Report

[v] Welsh NHS Confederation, June 2015. From Rhetoric to Reality – NHS Wales in 10 years' time: Socio-economic Deprivation and Health.

[vi] Royal College of Paediatrics and Child Health, May 2014. Why children die: death in infants, children and young people in the UK.

[vii] The Marmot Review Team. February 2010. Fair Society, Healthy Lives: Strategic Review of the Health Inequalities in England post-2010: The Marmot Review. London 2010.

[viii] Public Health Wales, September 2014. Child Death Review Programme Annual Report.

[ix] Sarah E Seaton, David J Field, Elizabeth S Draper, Bradley N Manktelow, Gordon C S Smith, Anna Springett, Lucy K Smith, June 2012. Socioeconomic inequalities in the rate of stillbirths by cause: a population-based study.

[x] Professor Nick Spencer published by End Child Poverty, Health Consequences of Poverty for Children.

[xi] R Reading, Sociology of Health and Illness 19, 1997, pp395-414. Social Disadvantage and Infection in Childhood.

[xii] Public Health Wales, January 2016. Welsh Adverse Childhood Experience (ACE) study

[xiii] IPSO Mori, October 2013. Flying Start: Qualitative research with high need families

Y 1,000 diwrnod cyntaf | First 1,000 Days
FTD 24
Ymateb gan: Iechyd Cyhoeddus Cymru
Response from: Public Health Wales

1 Introduction

Public Health Wales welcomes the focus being given to this critical part of the life-course through this Consultation and the opportunity to provide evidence for consideration by the Committee.

The Committee will be aware that the First 1000 Days Collaborative Programme was the first initiative of Cymru Well Wales a cross sectoral partnership of organisations committed to working different to improve health and wellbeing outcomes. A separate response to the Consultation will be provided by Cymru Well Wales and more information on the work being done through the First 1000 Days programme will be provided through that route.

Public Health Wales identified the Early Years as a priority area within its strategic plan in 2014. This prioritisation acknowledged the growing body of international evidence that investment in action in the early years of a child's life would bring life-long benefits[1].

The origins of many of the inequalities in health lie in early childhood and before birth. The early years –from pre-birth to seven years of age – is a critical part of childhood when they grow, develop, play and learn. It is a key factor in determining future health and well-being. There are long lasting and positive effects from early years programmes.

In 2015, Public Health Wales ran the Adverse Childhood Experiences (ACEs) study. ACEs are stressful events occurring in childhood such as suffering neglect and child abuse (physical, sexual and/or emotional) or growing up in a household in which there are adults experiencing alcohol and drug use problems, mental health conditions, domestic violence or criminal behaviour resulting in incarceration. The Welsh ACE survey, the first of its kind in Wales, collected anonymous information from just over 2000 residents from across Wales (aged 18-69 years) about their adverse experiences during childhood and their current health and lifestyle behaviours. Evidence from the Welsh

survey and ACE surveys internationally has demonstrated a strong and cumulative association between exposure to ACEs and the adoption of health harming behaviours such as smoking, excessive alcohol consumption and violence (which are often adopted as coping mechanisms), poor mental health, early diagnosis of chronic disease and high levels of health service use across the life course[1]. Evidence from Wales and internationally has demonstrated a strong and cumulative association between exposure to them and the adoption of health harming behaviours (which are often adopted as inappropriate coping mechanisms) as well as poor mental health across the life course.

International evidence has demonstrated a range of cost effective approaches to preventing and mitigating ACEs. While ACE exposure can happen throughout childhood and have lasting impact across the life course, the critical period of brain development in the first 1000 days can mean that exposure to multiple ACEs in this period is particularly damaging. Evidence demonstrates that ACEs experienced from birth, and even adverse experiences experienced by the mother whilst baby is still in the womb e.g. maternal use of drugs or alcohol and chronic and severe mental stress, matter significantly to children's long-term emotional and psychological health. The stress hormone Cortisol can be passed to the developing foetus in the womb and can have a toxic and detrimental effect upon its brain.

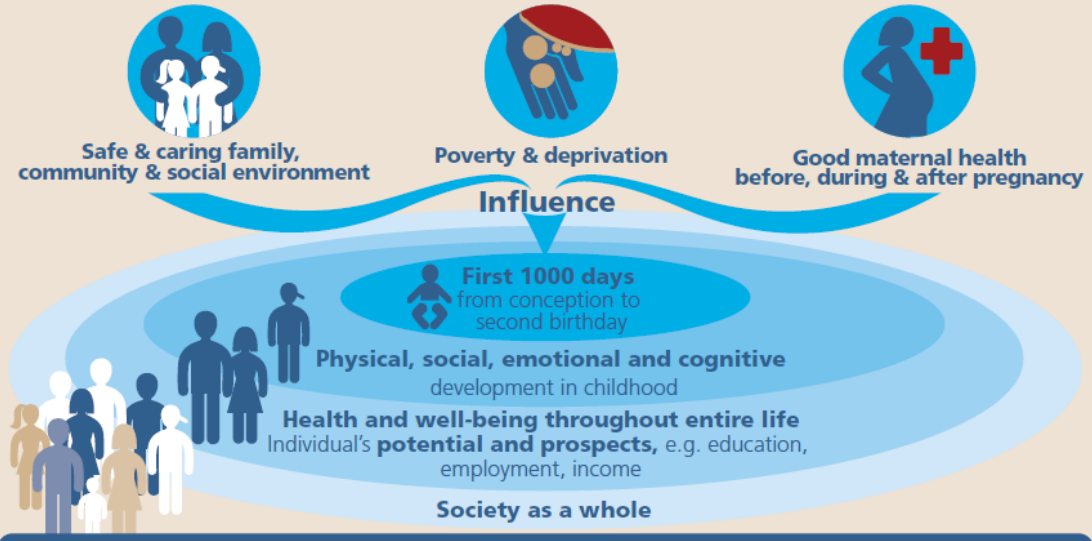
Inequalities are already evident in child health outcomes, such as childhood obesity and oral health at the age of five. The Making a Difference Report published by Public Health Wales in 2016 has highlighted the substantial economic evidence for early intervention in reducing inequalities and in improving outcomes. This work will continue to inform future work within this priority.

We have responded to each of the areas highlighted within the consultation below, outlining the current position in Wales; evidence where it is available on the effectiveness of current programmes and where appropriate making suggestions for future improvement.

Investing in Early Years for a Sustainable Future in Wales

GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales

Early childhood experiences, including before birth, can have a lifelong impact



Children who live in poverty and deprivation are at higher risk of dying early, developing obesity or experiencing ill health

Infants (0-28 days) in the most deprived areas in Wales are **one and a half times more likely** to die compared to those in the least deprived

Less than ¼ (22.5%) of the babies in the most deprived areas in Wales are **exclusively breastfed at 10 days after birth** compared to **nearly ½** (46.8%) of those in the least deprived

Obese children (age 4 - 5) in the most deprived areas in Wales (14.7%) are **two times more** than those in the least deprived (7.3%)

Adverse Childhood Experiences

are associated with

nearly **¼** of current adult smoking

over **⅓** of teenage pregnancies

more than **½** of the violence and drugs use

The Solutions

Investing in Early Years for a Sustainable Future in Wales

Investing in the first 1000 days from conception to the second birthday is cost-effective and has the most potential for action

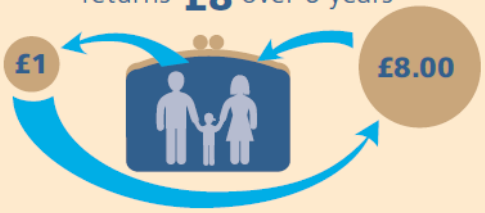
Effective early child development interventions can include:

- support to mothers before & after birth
- breastfeeding and nutrition support
- parenting support
- access to health services and childcare
- access to early education

Investing in universal (accessible to all) interventions along with additional resource proportionate to need for vulnerable children works and it is cost-effective

Every **£1** invested in **early years interventions** returns **£1.30 - £16.80**

Every **£1** invested in **parenting programmes to prevent conduct disorder** returns **£8** over 6 years



from health care, education and criminal justice costs

Investing in **targeted interventions + universal child care + paid parental leave** in Wales

could save **£72 billion** over 20 years

from the costs of social problems

Note: This infographic is part of the 'Making a Difference: Investing in Sustainable Health and Well-being for the People of Wales' report. The methods and sources of information are available in the 'Supporting Evidence' document on the Public Health Wales website. Where possible, latest figures for Wales are presented. Where unavailable, figures for Wales have been estimated from the latest UK/England/other data on unadjusted per capita basis.

1.1 Promote and protect the health and wellbeing of children from pregnancy (for example through positive parenting, high immunisation rates and tackling smoking in pregnancy).

Pregnancy is recognised as an opportunity for intervention. Prospective parents are more receptive to health messages as they want to give their children the best possible start in life.

The NHS is the universal service provider in this critical period. All expectant parents will have access to a midwife who will usually be the primary provider of care, supported where necessary by more specialist services and by primary care practitioners. The Pregnancy and Early Years Surveillance Tool[2] developed by Public Health Wales Observatory in conjunction with Welsh Government and a range of other partners collates and tracks a range of key indicators on child health and wellbeing.

1.1.1 Neural Tube Defects (NTD)

International comparisons by EUROCAT suggest an overall rate of neural tube defects in Europe of 9.1 cases per 10,000 births over approximately the past two decades (in press). In this analysis, Wales has the second highest rate in Europe, at 15.1 cases per 10,000 births (1998 to 2011). These analyses take no account of maternal age and the time periods vary for data submitted by different registers. Different national policies for termination of affected pregnancies and completeness of reporting of cases lost in early pregnancy are also likely to have a significant effect on rates. Despite these caveats, the rates in Wales appear high compared to many other areas of Europe. There are approximately 50 cases of neural tube defects in Wales each year with around nine live births.

Evidence has been available since the early 1991 that taking folic acid before conception and in the early stage of pregnancy could reduce the risk of NTD by 72%. After the guidance was produced there was a slight fall in NTD rates but there has been no further decline. A study published in December 2015 based on data from the Welsh and English Regional Congenital Anomaly Registers found that implementation of a mandatory fortification scheme e.g. flour, such as that adopted in the USA would have resulted in a 21% reduction

[2] http://www.wales.nhs.uk/sitesplus/922/page/84657

in NTDs. The UK-wide Healthy Start Scheme, introduced in 2006, includes the provision of folic acid supplements low-income pregnant women and anyone pregnant under the age of 18 years. Data on uptake in Wales is not available however studies undertaken elsewhere in the UK report the uptake of the supplement via the scheme to be below 10%. There is potential for Wales to consider introduction of mandatory fortification of flour to reduce the rate of NTDs. If similar results were achieved in Wales it could lead to 10 fewer affected pregnancies a year and two fewer live births with an NTD a year.

1.1.2 Smoking in Pregnancy

Wales has one of the highest rates of smoking in pregnancy in the United Kingdom. From 2013 to 2014, Public Health Wales in collaboration with four Health Boards and Stop Smoking Wales carried out a study to evaluate the effectiveness of different service delivery models for smoking cessation support to pregnant women. The study showed that using a specially trained maternity support worker increased the proportion of pregnant women who received quit support by 34%. This approach to support led to 35% (CI 29%-43%) of pregnant smokers setting a quit date and attending at least one treatment session compared with just 1% (CI 0%-3%) with the 'usual care' approach. The cost of implementing this model was estimated at £500 per engaged smoker. The specialist maternity support worker model therefore has the potential to reduce rates of smoking prevalence during pregnancy and improve future health outcomes for mothers and babies across Wales. Implementing the model across Wales is estimated to lead to around 200 avoidable adverse pregnancy outcomes a year, ranging from stillbirth to low birth weight.

1.1.3 Parenting Support

There is a strong international evidence base for the effectiveness of parenting support interventions in improving a whole range of outcomes for children.[2,3] However, uptake of parenting support, particularly the more intensive evidence based programmes can be sub-optimal. There is some evidence that there is a stigma associated with targeted parenting support and it is likely that increased population impact might be achieved through a more universal approach to all parents which then offers more intensive

support according to parent need for support. (A proportionate universalism approach)

A universal population approach to parenting has been tested in Ireland using the Triple P programme. The Triple P – Positive Parenting Programme (Triple P) is a multi-level, public health approach to parenting.
It was implemented in Longford and Westmeath by the Longford Westmeath Parenting Partnership (LWPP). The programme delivers support to all parents of children aged 3-7 through four modes of delivery: a universal media strategy, seminars, workshops and groups. The Parenting Study used a quasi-experimental (pre-test – post-test within-groups) design to evaluate child and parent outcomes associated with participation in Triple P.

The Population Study used a quasi-experimental (non-randomised between-groups) design, with treatment and comparison areas, to analyse the population-level impact of Triple P. There was a population-level impact on children's emotional and behavioural problems, parental distress, parental discipline and parents' relationships with their children, and also the number of children categorised as 'borderline/abnormal' for emotional and behavioural problems[4].

Testing a similar approach, potentially implemented through our existing Flying Start and Families First programmes may have benefits in Wales.

1.1.4 Immunisation

The WHO considers that immunisation is the most effective public health intervention after clean water. Pregnant women in Wales are actively offered immunisation against influenza (flu) and pertussis (whooping cough). Flu vaccination is safe and effective and reduces both the incidence of flu and its complications in pregnant women, including reducing foetal loss. It also protects the infant during the first six months of life. Pertussis vaccination in pregnancy was introduced in 2012 in response to a national increase in cases and deaths in young infants. The UK was the first country to vaccinate against pertussis in pregnancy, and cases of pertussis in infants born to vaccinated mothers have reduced by over 90% as a result. Maternal rubella infection and congenital rubella syndrome have been eliminated in Wales through the MMR programme, with no cases in the last 10 years, and so

screening in pregnancy for rubella antigen ceased in Wales in 2016. Uptake of flu and whooping cough vaccines among pregnant women is high in Wales, 75.6% and 72.4% respectively in 2015/16. Efforts to further improve infant and pregnancy vaccination uptake will continue.

Many diseases which were once common causes of childhood disability and deaths in Wales, including polio, whooping cough, diphtheria and measles, have been largely eliminated though immunisation. Other infant diseases, including pneumococcal disease, Hib and meningococcal group C meningitis have been reduced to low levels by programmes introduced in the last 15 years, with several new programmes in the last few years. Children from two years of age have been offered nasal spray flu vaccine since 2013, and rotavirus vaccine was also added then. In 2015 Wales, along with the rest of the UK, became the first country in the world to routinely offer the meningococcal group B (MenB) vaccine to all infants.

In 2015/16, uptake of all established routine vaccinations in one year old children was over 95% in Wales for the eighth consecutive year, and in two year old infants vaccine national uptake ranged from 94.7% to 97.0%. This was 0.1-0.8% lower than the previous year, and mirrors falls in vaccine uptake in older children over the last two years.

The safety and effectiveness of immunisation programmes is kept under constant review. The MenC vaccine programme has reduced cases of meningococcal group C meningitis and septicaemia by over 90%. Following introduction of the rotavirus immunisation programme in Wales in 2013 there has been an 88% reduction in confirmed rotavirus infections in children aged younger than one year, and also a reduction in older unimmunised cohorts demonstrating 'herd protection'. The children's nasal spray flu programme has significantly reduced GP attendances and hospital admissions for flu in pilot programme areas not only in children but also in adults, a trend seen in Scotland and Northern Ireland which fully implemented flu vaccination for all children age 2-11 years in 2014/15. Similar benefits are expected in Wales when the programme is fully implemented in 2019/20.

The need for new vaccine programmes is regularly reviewed, and Public Health Wales participates in the UK Joint Committee for Vaccination and Immunisation. Public Health Wales will continue to work with HBs and

practices to maintain uptake of infant immunisations above the 95% target. Over the last year PHW has worked with WG and NHS partners to support the role of health visitors and clarify actions they can take to follow up children missing immunisation, and also define responsibilities in Flying Start programmes. NICE considered evidence that such follow up activities involving uptake of MMR vaccine were cost saving. We will monitor the ongoing impact of these interventions.

1.1.5 Parent and Infant Mental Health

Parental mental health can have a significant impact on children's health and development, even relatively mild or moderate mental health problems can impact on a parent's ability to parent, particularly their ability to develop a strong bond and ensure optimal attachment to the infant.

Currently, maternal mental health is discussed routinely in pregnancy but the focus is on identifying those with a diagnosis of a serious mental health problem rather than establishing general well-being. Routine assessment of mental wellbeing in line with NICE guidance should be a core part of early ante-natal assessment.

The Healthy Child Wales surveillance programme includes routine assessment of 'attachment' and infant mental health; which if fully implemented should offer opportunities for early intervention using evidence based interventions. It is not clear currently whether the full range of interventions to address poor attachment are in place in each local area. There has been investment in perinatal mental health services which is to be welcomed, however, this is likely to support only the most serious of cases and further investment and a more co-ordinated and strategic approach is needed. Public Health Wales is working with the Together for Children and Young people Programme and the First 1000 Days Programme, to identify actions to address this important area and considers this area as the greatest priority for action.

1.1.6 Stillbirth and Neonatal Deaths

There were 697,852 live births in England and Wales in 2015, an increase of 0.4% from 2014. In 2015, the stillbirth rate decreased to 4.5 per 1,000 total births, the lowest rate since 1992. This equates to 1:200 of UK births are stillborn. In Wales, the stillbirth rate in 2015 was 4.7 per 1,000 total births,

down from 5.2 in 2014. Due to the small number of stillbirths in Wales, the stillbirth rate is more prone to random fluctuations. MBRRACE-UK report is a stark reminder of the tragically avoidable burden of stillbirth for families living in the UK. Among the world's 35 richest nations, the UKs stillbirth rate is the third highest – over one-and-a-half times greater than in neighbouring countries like Denmark, Norway, and Finland. Or, to put it another way, of the nine British families who each day must face the devastating loss of their baby, three would instead be celebrating a healthy live-born child if they'd been living in any of several neighbouring Scandinavian countries. Please follow the link for the latest MBRACCE report on perinatal mortality in the UK[3]

In February 2013, the Health and Social Care Committee of the National Assembly for Wales held a One Day Inquiry into Stillbirths in Wales. This remains an open enquiry. The Governments response to this report was that the nine recommendations would inform the work of the National Stillbirth Working Group. The multidisciplinary Maternity Network and the National Stillbirth Working Group, chaired by the Chief Nursing Officer for Wales, Professor Jean White, have been developing work streams based the nine recommendations to tackle patient safety in reducing stillbirth in Wales, year on year, by raising public awareness.

In March 2017 a National Campaign will launch at the 1000 Lives National Learning Conference. The campaign is designed to increase public awareness of risk associated with stillbirth.

Future work includes developing a national framework of review and investigation following the loss of a baby by developing an Integrated Care Bundle. This will be an All Wales concise document to include all legal requirements for care and investigation for women and families. Accompanying this is scoping work to establish what good bereavement care looks like to formulate a recommendation to Welsh Government of the requirements for Health Boards.

[3] MBRRACE-UK-PMS-Report-2014.

1.1.7 Ante-natal screening

Antenatal screening is undertaken to detect defined serious conditions present in either the mother or baby that are likely to have an adverse effect on the health of either and for which an effective intervention is available and warranted. Antenatal Screening Wales hosts the antenatal screening clinical network and is responsible for establishing policies, standards and protocols and the health boards are responsible for delivering the service. Having agreed standards across Wales ensures there is equity of access and service for our pregnant population. All women resident in Wales should be offered screening in every pregnancy for blood group and antibodies, hepatitis B, syphilis, HIV, Down's Syndrome, early pregnancy ultrasound scan (dating) and fetal anomaly ultrasound scan. Antenatal screening for sickle cell disease and thalassaemia should be offered to all pregnant women at increased risk of having a child affected by one of the conditions.

It is important to review the evidence base for screening programmes and in line with England and Scotland antenatal screening for rubella ceased to be offered in Wales from October 2016 due to the success of the MMR vaccination campaign.

1.1.8 Breastfeeding

The UK has one of the most entrenched bottle feeding cultures in the world, and despite overwhelming evidence that breastfeeding saves lives, improves health and cuts costs, there continues to be a general belief that formula milk is almost as good as breast milk.[4] Wales like the rest of the UK, has some of the lowest breastfeeding rates in the world and these have not changed significantly in more than a decade despite our best efforts. A different approach is needed which helps to create a society where breastfeeding is seen as the norm. This involves a move away from interventions which focus solely on breastfeeding being the responsibility of the woman, to a more societal approach to ensure population level improvement. This requires a concerted effort by society as a whole to enable mothers to breast feed wherever they choose to do so.

[4] UNICEF UK Call to Action 2016

Currently strategic action focuses on acute and community settings achieving UNICEF UK Baby Friendly status. Across Wales there is a variable picture within and across Health Boards and for those that have achieved positive results, sufficient resource is needed to sustainably maintain and progress beyond the set of minimum standards.

A recent in-depth, comprehensive review of breast feeding showed that the health benefits are substantial, lasting well beyond the period of breastfeeding and affecting high and low-income populations alike[5,6]. Evidence indicates that the biggest improvements in breastfeeding rates come when a multi-faceted approach is taken that considers the parents' whole journey from pregnancy to new parenthood. Sensitive conversations during pregnancy, skilled support in the immediate post-birth period, ongoing guidance and social support are all needed to enable mothers to feel confident and breastfeed successfully for as long as they wish. In addition, the wider community needs to welcome and support breastfeeding. Supporting women to make better informed choices about how they feed their infant in the first 6 months of life remains a priority for Public Health Wales. We are working closely with academic partners; infant feeding leads within Health Boards and the third sector to develop a renewed approach to improving breastfeeding rates that draws on the best available international evidence and where necessary develops innovative solutions supported by evaluation. Ultimately, our collective success is judged on whether we have made any improvements in the outcomes for mothers, infants and families.

1.2 Deliver improved child health outcomes across Wales (for example prevention of obesity and the promotion of health-enhancing behaviours for every child such as eating a well-balanced diet, playing actively, and having an appropriate weight and height for their age and general health).

Public Health Wales has responsibility, in partnership with Health Boards, for delivering the Child Measurement Programme in Wales. This provides surveillance of weight for children as they start school aged 4 – 5 years of age. The most recent findings indicate that just over seven in every ten Welsh children have a healthy weight. This is an area in which there are significant inequalities with reception-age children living in areas of higher deprivation significantly more likely to be obese. The local authority area

with the highest prevalence of obesity at this age is Merthyr Tydfil with 14.7% of children aged 4-5 being obese. This is more than double that of the local authority area with the lowest prevalence – the Vale of Glamorgan at 7.3%. Across the last three years there appears to have been a significant increase in the prevalence of overweight or obesity in reception year in Hywel Dda UHB (26.4% to 30.1%), and a significant fall in Cardiff and Vale UHB (23.7% to 20.9%) but we are not yet able to say whether this is a longer term trend. Unfortunately Wales compares unfavourable to England with 26.2% of children in Wales are overweight or obese, compared to 21.9% in England in this age group.

1.2.1 10 Steps to a Healthy Weight

In response to the findings of the Child Measurement Programme Public Health Wales reviewed the scientific evidence for the factors which were associated with healthy weight/overweight in children. These have been used to develop the 10 Steps to a Healthy Weight. The intention of the 10 Steps is to align action across Wales to encourage all agencies that have a role to play to support action on one or more of the 10 Steps.

Public Health Wales has also been working with parents to identify how best to motivate them to support their children to be a healthy weight when they start school. This has lead to the Every Child programme which will be launched shortly. Every Child will include a range of programmes relating to child health in the Early Years rather than just a focus on overweight and obesity. One strand will be 'Every Child ... a Healthy Weight' which incorporates the 10 Steps.

Public Health Wales has also been disseminating information about the 10 Steps to professionals and partner organisations and undertaking a series of evidence reviews so that we can encourage and support effective action on each of the 10 Steps.

Public Health Wales has also reviewed the impact of the Change for Life programme in Wales and has found little evidence of any impact on outcomes at a population level. We have proposed that the Every Child Programme becomes the umbrella initiative within Wales, supported by a programme of social marketing that is linked more directly to wider programmes of work in Wales.

1.2.2 Oral Health

Tooth decay (dental caries) is a preventable disease caused by the breakdown of sugars by bacteria existing in the plaque around teeth. The disease process can begin as soon as baby teeth appear in the mouth, and childhood caries affects 14.5% of 3 year old children in Wales, rising to 20.2% in the most disadvantaged areas[7]. Child dental health surveys in Wales show that a large proportion of the decay found at age 5 is already present by age 3[8]. The immediate impacts of decay are distress, pain and an increased risk of infection, and longer term poor oral health can negatively affect well-being, quality of life, daily activities, speech, self-esteem, school attendance and performance[9, 10, 11, 12, 13]. The ability to eat a well-balanced diet, and subsequently growth and development can be affected[14, 15]. Treatment for severe caries is one of the most common reasons for childhood hospitalisation, with 7855 children in Wales having a dental general anaesthetic operation in 2014/15[16].

Childhood oral health is a predictor of oral health throughout adulthood[17]. The impact of poor oral health increases with age[18], and may affect quality of life[19], and social and economic well-being[20], as well as impacting on other health conditions[21, 22].

The Welsh Government funded Designed to Smile programme, which is a national childhood oral health improvement programme, targets children in the most deprived postcodes. It was launched in January 2009 as a pilot and rolled out in 2011. In Wales, we have seen a 12% reduction in the prevalence of caries amongst five-year olds between 2008 and 2015, the first significant improvement since the surveys began[23]. This improvement has happened across the social gradient, showing that childhood oral health inequalities are not widening. The Designed to Smile programme is beginning a re-focus in 2017, to strengthen the interventions aimed at the first 1000 days in order to realise the benefits to this population.

Improving family oral health and reducing the transmission of bacteria to a baby's mouth is one of the actions that can contribute to prevention. Bacterial colonisation frequently occurs due to parents passing on mouth bacteria to their child through sharing of spoons, dummies etc. Improving a mother's oral health in pregnancy and in the post-natal period can reduce

her bacterial load[24]. Welsh Government policy to offer women free NHS dental care from pregnancy through to 12 months after birth can enable improvement of the oral health of mothers, and therefore have a positive effect on their baby. Also, the policy enables establishment of a relationship between the mother and child with a dental practice. Welsh Government policy to provide free NHS dental care to all children under 18 years of age enables universal coverage of young children to receive evidence-based preventive services from birth.

Delivering fluoride to teeth and promoting good oral hygiene is a second key strand in prevention. Designed to Smile complements NHS dental practice care, by providing preventive interventions aimed at young children and their families in targeted areas. When a baby is six months of age, families receive a toothbrushing pack from their health visitor. This is timed at when the first baby teeth usually appear, to promote the establishment of good toothbrushing habits i.e. parents brushing their children's teeth with fluoride toothpaste. For children in some Flying Start areas, additional toothbrushing packs are regularly provided at the home visits. Provision of toothbrushing packs has shown to be effective at preventing dental caries and to give a good return on investment[25, 26].

Once children enter nursery, those living in targeted areas can participate in the Designed to Smile supervised toothbrushing and fluoride varnish programmes. These interventions are clinically effective and have demonstrated a good return on investment[27, 28,].

1.2.3 Healthy Start Vitamins

The UK-wide government welfare scheme Healthy Start includes the provision of Healthy Start vitamins to improve the health of low-income families. Pregnant women and children from six months to four years (unless they are having 500ml or more of infant formula daily) from low income families are eligible to receive free Healthy Start vitamins. Healthy Start women vitamin supplements containing folic acid and vitamin C and D and the children vitamins containing vitamin A, C and D are specifically designed to meet the Department of Health recommendations.

Despite studies to encourage beneficiaries to take the recommended daily vitamin allowance and the widespread availability of Healthy Start vitamins, uptake has been reported to be below 10% in many areas. Data on uptake in Wales is not available however a recent audit has indicated that the volume of vitamins for children ordered in Wales would only reach 4% of those eligible.

This would suggest that the scheme is not reaching those at risk and that the potential population impact is not being realised. Public Health Wales is currently reviewing the potential for further work in Wales to assess the impact of the scheme on improving health outcomes and reducing inequalities amongst those eligible.

1.2.4 Newborn Screening Programmes

To improve health outcomes for children who have a disease or condition that cannot be prevented needs to be identified early to enable the disease or condition to be managed.

The aim of newborn bloodspot screening is to identify rare, but serious diseases, which respond to early intervention to reduce risk of death and/or disability. In Wales the conditions screened for are congenital hypothyroidism, cystic fibrosis, sickle cell disorders, and six inherited metabolic disorders. A small sample of blood is taken from the baby's heel on day 5 to 8 of life. The programme is managed by Public Health Wales and the sample is taken as part of routine postnatal care. There have been significant improvements in the quality and timeliness of the samples but there is further improvement needed to meet the high standards set by the programme

Newborn Hearing Screening Wales aims to identify babies with significant hearing impairment which is of sufficient severity to cause or potentially cause a disability. Finding out early means that support can be offered before there is a problem identified. The programme performs to a very high standard with 99.5% of babies screened. Uptake is not affected by deprivation which means the this programme addressed inequity in our population and ensure that all of the babies affected are identified

1.3 Tackle child health inequalities, with a specific focus on child poverty and disabled children.

Inequalities in child health and wellbeing outcomes are well documented and to date there has not been the progress that we would have wished in reducing the health gap between the most and least disadvantaged communities and families.

The Tackling Poverty Programmes have some evidence of impact among families but this lacks the scale that is needed to deliver impact at a population level. We have considered how the current programmes of work could be adapted or further developed to achieve greater population and family impact as part of our work in developing the First 1000 Days; Early Years and ACE programmes of work.

The association between poverty and poorer outcomes is well described but the mechanisms through which poverty impacts on poor outcomes are less well understood. Clearly, in some cases, simple material disadvantage has an impact; this is most likely in the provision of a healthy diet; for many families it is much more difficult to provide a healthy diet and ensuring that children receive some food is the priority.

In other situations, it is more complex, poverty and disadvantage do not always lead to poorer outcomes, it is important that we understand why some families have the personal assets to overcome these challenges and others find it more difficult. The work on Adverse Childhood Experiences is helping to provide an explanation for one of the mechanisms through which poverty and disadvantage might lead to longer term inequalities. The interventions and actions that are required to prevent or mitigate the impact of ACEs are less well understood but will be a focus on Public Health Wales work with its partners over the coming years.

We have also reflected on the approach taken in targeting interventions at key population groups, largely defined by place. While the rates of poorer outcomes are higher in certain populations; individuals and families with the same level of disadvantage will also be present outside of those communities and often in larger numbers. Targeting of support such as the Flying Start Programme at geographical communities has the potential to create a

different sort of inequality, where families in high need do not get the same access to support because they live in the wrong area.

Evidence suggests that universal service provision should be the starting point for action to address inequalities. In the first 1000 days of life the universal service is the NHS through its midwifery and health visiting services. While we would not advocate that all action needs to be delivered by health professionals, they are uniquely placed to identify need for additional support and to co-ordinate care.

Currently, the Healthy Child Wales programme is being implemented and Health Boards are challenged to resource the minimum universal contacts and assessment. Enabling Health Visitors and Midwives to make additional visits (enhanced universal provision) can often result in early intervention and prevent problems developing. Outside of Flying Start areas this kind of enhanced universal service is not possible within current resources. We would propose that Flying Start and similar programmes would have a greater impact at population level if the additional NHS services funded through these programmes were flexible enough to provide more intensive preventative interventions to all families where this level of need has been identified regardless of where they live.

It is difficult to measure the impact of programmes and initiatives designed to improve outcomes if insufficient focus has been given to evaluation from the outset or where evaluation approaches have not included a comparison group. This has been a challenge with the Flying Start Programme. Analysis of immunisation uptake, an outcome measure for Flying Start services, found that national differences in uptake between the most and least deprived area had narrowed since the introduction of the service, although official data show similar improvement in areas receiving usual care.[29] The other weakness of many of the programme evaluations is that data on which children and families have received what intervention or service is not available in a sufficiently standardised way to draw conclusions. We would wish to see a greater emphasis given to rigorous evaluation mechanisms as part of any new policy or programme.

1.4 Reduce child deaths and injury prevention, particularly in the most deprived parts of Wales where infant mortality is much higher than the least deprived.

Article 6 of the UN convention on the Rights of the Child states that all children and young people have the right to survive and the right to develop and that Governments should work to prevent the deaths of children and young people.

There are numerous programmes and processes within Wales which have an interest in ensuring that child deaths are reported and reviewed. These include the Child Death Review Programme, All Wales Perinatal Survey, morbidity and mortality meetings in health boards and MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK). There would be benefit in co-ordinating and rationalising these. There are also multi-agency processes including PRUDiC (Procedural response to unexpected deaths in childhood) and child practice reviews.

The Child Death Review Programme produce thematic reviews on deaths of children between 0-18 years and identifies evidence-based opportunities for prevention. Many of the past reviews are relevant to the first 1,000 days including those on meningitis and drowning. However, the thematic review on Sudden Unexpected Death in Infancy (see http://www.wales.nhs.uk/sitesplus/888/page/84342 for thematic reviews) may be the most pertinent, and includes evidence of the impact of factors such as smoking in pregnancy and smoking and alcohol in families with very young children that are associated with these tragic deaths.

The statutory function of the Local Safeguarding Children Boards Regulations 2006 in England includes the responsibility to collect and analyse information about every child death with a view to identifying public health or safety concerns and putting in place procedures for prevention. Similar regulations do not exist in Wales but would be of benefit by enabling sharing of information.

Although there are many programmes working in this area, improved co-ordination would

- avoid duplication of effort
- allow for better shared learning
- identify overlap and gaps

to maximise opportunities for prevention of future child deaths.

1.4.1 Injuries

Information on unintentional injuries to children aged 0 – 2 years of age is not readily available. Generally injuries to children in this age group will occur within the home. Analysis of UK death registration data from 1980 – 2010 found that 31% of deaths in children aged 1 – 4 years of age were from unintentional injuries.

Public Health Wales recognises that co-ordination to prevent unintentional injuries among children in Wales has been very limited.

1.5 Support effective child development and emotional and social well-being – specifically interventions that are delivered outside the health service which can help to detect and address developmental delays.

Many of the interventions which have the potential to improve outcomes can be delivered by non-specialist services and these may often be best placed to support families if they have already established a relationship with that family. The following, is a list of evidence based interventions that focus on improving the parent child relationship and are associated with better outcomes. None of these require specialist professionals to provide them:

- Responsiveness from the parent or adult to a child; responding to what a child does immediately after it takes place such as smiling back at a child
- Sensitivity and emotional warmth
- Household routines, reduced chaos
- Shared reading and talking to children
- Authoritative but not harsh discipline, setting clear and consistent boundaries

There needs to be a whole system approach at a local level where all local services whether they are in the statutory or voluntary sector understand the evidence; understand how improvements can be made; understand their contribution and that of other agencies and are supported by a common measurement system.

Our work with Cymru Well Wales and the First 1000 Days programme has highlighted that there is often a great deal of activity around the first 1000 days in any local area but the connections and links between services is very limited. They do not function as a collective system.

1.6 Focus on improving learning and speech and language development through the home learning environment and access to early years' provision (including childminders, preschools and day nurseries).

Language development requires relatively simple action by parents and other adults, in talking to children from birth; reading together and learning songs and nursery rhymes etc. This work can be supported by early years provision such a nurseries and play groups, particularly to support those families which may struggle to provide consistent interaction for children. We are aware that the work in Bridgend through Flying Start has made a significant difference to language development by working with early years provision. Ensuring that learning such as this is shared and adopted across Wales would help to ensure a population level impact across Wales.

1.6.1 Newborn Hearing Screening

Newborn hearing screening is offered to identify babies with a significant hearing loss that will impact on early language development. The sooner that interventions can be in place the better the outcomes are for language and development of the child.

In the annual report published for April 2014-March 2015 showed that 99.9% eligible babies were identified for screening and 99.5% were tested.

The mean age of babies identified with a significant hearing loss was 9.7 weeks with mean age of hearing aid fitting 15.9 weeks. This means that of the 1.3 per 1000 babies screened identified with a hearing loss that these

babies have early access to amplification and early support for speech and language development.

1.7 Reduce the adverse impact on the child of psychosocial issues such as poor parenting, disruptive family relationships, domestic violence, mental health issues and substance misuse through effective safeguarding.

Research tells us that relationships with caring, responsive adults and early positive experiences promote a child's healthy development. Significant stress from ongoing hardship or threat disrupts the biological foundations of learning, behaviour, and health, with lifelong consequences. Providing the right ingredients for healthy development, including where necessary protective factors that can counterbalance the ill effects of adversity, from preconception onwards produces the best outcomes for children.

1.7.1 Safeguarding Children

The Welsh Government has legislated to enable effective safeguarding. The Social Services and Well-being (Wales) Act 2014 established multiagency Regional Safeguarding Boards to work together to safeguard people across Wales. The same Act established the National Independent Safeguarding Board to provide support and advice to Safeguarding Boards in Wales with a view to ensuring that they are effective, to report on the adequacy and effectiveness of arrangements to safeguard children and adults in Wales, and to make recommendations to the Welsh Ministers as to how those arrangements could be improved.

The NHS in Wales is committed to protecting and safeguarding the welfare of children and young people. As a result of the universal nature of the provision of health services health professionals are often the first to be aware that families are experiencing difficulties in looking after their children. In his report, Safeguarding and Protecting Children in NHS Wales (Cardiff University, 2010), Professor Sir Mansel Aylward identified the need for robust monitoring and evaluation in order to improve and develop services. This led to the following recommendation:

'Evaluation of the efficiency and efficacy of child protection and safeguarding arrangements and interventions must rest on outcome-based monitoring. This is an area that requires further attention. Consideration should be given to the inauguration of a National outcomes development and quality assurance group to establish standards, to set tangible objectives and to drive improvement on an all-Wales basis.'

In response the Chief Nursing Officer for Wales, Professor Jean White, established the NHS Wales Safeguarding Network which first met in October 2013. The Network was established to provide a vital bridge between strategies and arrangements at local level and national policy developments to support NHS Wales Health Boards and Trusts in discharging their responsibilities for safeguarding people. The membership of the Network includes the Designated Professionals and National Role GP of the National Safeguarding Team, Public Health Wales, Executive Leads for safeguarding in Health Boards and Trusts, Assistant/Associate Directors of Nursing, with safeguarding responsibilities in Health Boards and Trusts, Named Professionals for safeguarding in Boards and Trusts and Health Board GP Safeguarding Leads. Senior Medical and Senior Nursing Officers Welsh Government are included as observers. The Network has a work plan through which it develops and agrees national standards, policy and practice guidelines relevant to safeguarding, and promotes best practice. Member organisations contribute to All Wales audits of safeguarding practice. The Network shares the learning from multiagency safeguarding reviews, domestic homicide reviews and relevant research. It supports systems and processes to ensure the agreed guidance on safeguarding training is delivered across NHS Wales. It provides oversight of barriers, where progress in safeguarding people have been recognised, and collaborates on solutions.

It must be remembered that neglect is by far the most prevalent form of child maltreatment. Severe neglect appears to be at least as great a threat to health and development as physical abuse—possibly even greater. When compared with children who have suffered physical abuse, young children who experience chronic neglect exhibit more serious cognitive impairments, attention problems, language deficits, educational difficulties, behavioural difficulties, and problems with peer interaction as they get older.

Initiatives such as Flying Start and Families First have ensured a focus and additional support and investment for some of Wales' most vulnerable children in the crucial early stages of development however there remains work to be done to integrate neglect more fully into the Welsh Government's overall approach to the early years. In 2013 Welsh Government funded a twin-phased two-year project from Action for Children – Gweithredu drs Blant and NSPCC (Cymru/Wales) to scope, with partners, key areas for multiagency action to tackle child neglect. The Welsh Neglect Project report strongly promotes the idea of an All Wales Child Neglect protocol that will clearly embed a shared responsibility for identifying and tackling neglect, including the use of evidence-based assessment tools, the role of preventive services in addressing neglect, training and reviews, information sharing and referral processes, and designated neglect specialists in key agencies. This has yet to be delivered.

1.7.2 Adverse Childhood Experiences

In order to tackle ACEs at a population level, Public Health Wales has work through *Cymru Well Wales* is taking a whole-system approach to preventing and mitigating their ongoing effects. International evidence has demonstrated a range of cost effective approaches to preventing and mitigating the effects of ACEs, some of which are currently being trialled within Wales. For example, the programme of work for Early Intervention and Prevention with the Police, the work with Primary Care to routinely enquire about ACEs and the work with schools to develop an ACE informed whole school approach.

The *ACE Prevention and Support Hub* is being established to drive the achievement of the collective vision for Wales as a world leader in ACE-free childhoods. It will help create the environment for change, enable and support individuals, communities and organisations to achieve their local ambitions around the ACEs agenda. It will do this by:

- Bringing the voice of affected children and families to the table to co-design solutions that will work for them
- Providing targeted evidence about what different organisations can do differently to help prevent and mitigate ACEs

- Training professionals to be experts in ACEs for their organisations and using a workforce development model to support them to grow their internal and external networks to change practice
- Pulling learning from individuals, organisations and the wider system and sharing it through a range of action learning sets and communities of practice
- Driving change and system transformation at local and national levels.

The ACE Prevention and Support Hub will commence operation in April 2017. The proposal is for an initial three year transformation funding in order to support organisations to change their ways of working that we collectively believe is required to support, sustain and embed changes in policy and practice across Wales. The long term success of the approach will depend upon buy in from organisations, networks and agencies to embed the changes and continue the new ways of working beyond the three years. The office of the Future Generations Commissioner can support this long term change.

The Hub will work alongside existing networks and programmes through bringing into the team people for relevant agencies, organisations and networks that are doing work in the ACE prevention space already or could deliver rapid change in practice by bringing an ACE lens to services and programmes in their system/sector. Working through and alongside these system "activators" the Hub staff will support local system level change through innovative test and learn pilots, awareness raising, training, facilitation, action learning, evaluation and innovation support. In addition the Hub will deliver a dedicated ACE prevention and support website, a social media presence around how to prevent ACEs and respond if you have experienced them together with telephone support help lines for both the public and professionals (utilising existing help lines such as the Samaritans and NSPCC).

2 Conclusions

Public Health Wales welcomes that this critical period of child development is gaining greater attention and focus. There are a number of positive policy initiatives and programmes on which to build. However, when the strength

of the international evidence base for action in this area is considered and the potential from emerging research in genetics and neuroscience is considered we have not yet fully grasped the potential or invested sufficient resources in prevention to achieve improved population outcomes. Failure to invest in prevention in the First 1000 Days will result in long term costs to Health and Social Care, Criminal Justice Agencies, Education and out of work benefits in addition to the impact on children and families.

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Dechrau'n Deg | Flying Start
FS 01
Ymateb gan: Iechyd Cyhoeddus Cymru
Response from: Public Health Wales

1 Introduction

1.1.1 Public Health Wales welcomes the focus being given to the First 1000 Days through this series of Consultations and the opportunity to provide evidence for consideration by the Committee.

1.1.2 The Early Years is a priority area for Public Health Wales acknowledging the growing body of international evidence that investment in action in the early years of a child's life brings life-long benefits[1]. The First 1000 Days Programme led by Public Health Wales on behalf of CymruWellWales is a response to this prioritisation. The programme is taking a whole system approach to improving outcomes and reducing inequalities in the period from conception to a child's second birthday.

1.1.3 The origins of many of the inequalities we see in physical and mental health lie in early childhood and before birth. The early years – from pre-birth to seven years of age – is a critical part of childhood when children grow, develop, play and learn. Children's experiences in this time are a key factor in determining future health and well-being. There are proven long lasting and positive effects from early years programmes. Central among these important influencing factors is the potential to reduce or prevent exposure to adverse childhood experiences in the early years and to take steps to reduce the lifelong impact of childhood trauma when it does occur.

1.1.4 The core Flying Start offer to families living in eligible areas provides services that are evidenced to support improved outcomes in the early years including access to; free 'quality' part time childcare for all eligible 2 to 3 year olds; enhanced health visiting contact; parenting support programmes and support for early language development and play[2]. Public Health Wales considers the provision of these types of services to be key in reducing inequalities and improving outcomes for children in the first 1000 days and beyond. The impact of such services is however likely to be greatest where provision is based on individual/family rather than geographically measures of need.

1.1.5 We have responded to each of the areas highlighted within the consultation below, outlining the current position in Wales; evidence

where it is available on the effectiveness of current programmes and where appropriate making suggestions for future improvement.

1.2 The outreach element of Flying Start requiring Local Authorities to identify children living outside defined Flying Start areas who would benefit from Flying Start services.

1.2.1 There is strong evidence that giving every child the best start in life is key to reducing inequalities. The most effective approach to achieving this is through the provision of universal services which can be supplemented by higher intensity support as individual's and families' needs or vulnerability increases[3].

1.2.2 In Wales midwifery and health visiting services represent the universal service in pregnancy and the early years. Flying Start currently provides targeted support in some of the most disadvantaged geographical areas of Wales and represents the more intensive support offer funded by Welsh Government to families living in these areas.

1.2.3 The First 1000 Days Programme works through a collaborative model in localities across Wales, as defined by the boundaries of Public Services Boards. Together we are engaging the local workforce across a wide range of services and settings in the public and voluntary sectors, and this process begins with a System Engagement Event. There have been four held to date and a summary of the early themes coming from these events has been produced for the First 1000 Days Programme Board.

1.2.4 A key theme identified by areas working with the First 1000 Days Collaborative is that services should be proportionate to the needs of families irrespective of geography. There are currently significant differences in the level and range of services available to families between Flying Start and non-Flying Start areas, even though the level of need might be the same. There is a common feeling across First 1000 Days Collaborative areas that a more widely available enhanced service, particularly for midwifery and health visiting, would improve childhood outcomes. There is also consistent feedback that the way in which funding is organised and administered is a barrier to innovation and service development.

1.2.5 One argument often made for the geographical basis of Flying Start is the fact that making services available to everyone in a defined geographical area reduces the risk of families feeling stigmatised, as no one family is singled out for special support. There are a range of approaches that can be taken to reducing the risk of stigma, including embedding tiers of enhanced provision within

universal services. In the first 1000 days the universal service is the NHS through its midwifery and health visiting services. While we would not advocate that all action needs to be delivered by health professionals, they are uniquely placed to identify need for additional support and to co-ordinate enhanced care.

1.2.6 There may be value in considering a mixed model for the future provision of Flying Start with some elements retaining a geographical focus, but others becoming more focussed on individual need. We would propose that Flying Start and similar programmes would have a greater impact at population level if the additional NHS services funded through these programmes were flexible enough to provide more intensive preventative interventions to all families where a defined level of need has been identified regardless of where they live. However Health Boards are challenged to resource the minimum universal contacts and assessments set out in the Healthy Child Wales Programme within existing resources. Enabling Health Visitors and Midwives to make additional visits (enhanced universal provision) can often result in early intervention and prevent problems developing, but requires investment.

1.3 The extent to which sufficient Flying Start funding is provided to reflect the outreach element of Flying Start delivery plans and whether the workforce capacity is sufficient to deliver the programme and its outreach elements

1.3.1 Despite the growing evidence that a greater prioritisation of our resources in the very early years would bring both additional lifelong benefits and a better return on investment for society and public services there is currently proportionally less financial investment made in the early years than across the rest of the lifecourse[3].

1.3.2 Funding for Flying Start outreach is set at 2.5% of the uplift from the 2012 funding levels[4] with guidance stating that these funds should be used to deliver elements of Flying Start to children, with an identified need, across the wider local authority.

1.3.3 Analysis carried out by Public Health Wales has shown that 37.5% of poor or income deprived people live within the geographical areas that are within the most deprived quintile in Wales. This means that nearly two thirds of people who are income deprived live outside of geographical areas that are defined as deprived. It is therefore highly unlikely that the relatively small proportion of Flying Start funding available for outreach work is sufficient to meet the needs of families living outside of Flying Start areas.

1.3.4 A further theme identified through the First 1000 Days System Engagement Events held to date has been that Collaborative areas have found that services within a single PSB area can be working to different thresholds and criteria of need. More generally, the Programme has also found that assessments are not based on an assessment of overall risk, which is an essential underpinning to a focus on prevention. Whilst a great deal of information is gathered, it is not routine practice to holistically assess the combined factors in an individual's situation. This has implications for the effective identification of those families that would benefit most from the limited outreach capacity currently available through Flying Start.

1.3.5 It is also worth noting that many interventions that could improve outcomes for children at a population level not only provide good return on investment but are also relatively low cost. Language development requires relatively simple action by parents and other adults, in talking to children from birth; reading together and learning songs and nursery rhymes etc. This work can be supported by early year's provision such as nurseries and play groups, particularly to support those families which may struggle to provide consistent interaction for children. We are aware that the work in Bridgend through Flying Start has made a significant difference to language development by working with early year's provision. Ensuring that learning such as this is shared and adopted throughout Wales would help to ensure a population level impact across the country.

1.4 The evidence on outcomes for parents and children in Flying Start areas compared to the outcomes for parents and children in areas that are most similar in terms of deprivation levels but are not Flying Start areas.

1.4.1 This question highlights the inherent limitation in the current delivery model of Flying Start. The geographical model of provision means that there are children in Wales who are likely to be experiencing equal levels of need but are not able to access the same support as a result of where they live.

1.4.2 There are a number of factors that make evidencing the impact of Flying Start difficult. There is a great deal of activity and a number of services working with families in the first 1000 days, offering a wide range of provision. When families access a range of services and support it can be difficult to provide evidence of the causal links between specific interventions and improvements in outcomes. Further work could be undertaken to ensure consistency in recording interventions across areas through the development of a common taxonomy.

1.4.3 It is also difficult to measure the impact of programmes and initiatives designed to improve outcomes if insufficient focus has been given to evaluation from the outset or where evaluation approaches have not included a comparison group. This has been a challenge with the Flying Start Programme and we are aware of very little analysis that has been able to compare outcomes for families in Flying Start areas with outcomes in areas experiencing similar levels of deprivation which are not Flying Start areas[5]. Any adaptations to the future delivery of Flying Start should build in consideration of the evaluation of impact from the beginning.

1.4.4 Currently, the Healthy Child Wales programme is being implemented and this will see an increase in the quality, consistency and availability of outcomes data for families receiving health visiting services outside of Flying Start areas. There would be benefit in ensuring that the metrics recorded across both Flying Start and health visiting services are aligned to allow for a more effective measurement of impact across these services in the future.

2 Conclusions

2.1.1 Public Health Wales welcomes the greater attention and focus that this critical period of child development is gaining.

2.1.2 Evidence suggests that universal service provision should be the starting point for action to address inequalities. In Wales our midwifery and health visiting services, delivered through the NHS, provide the core universal service during pregnancy and the early years.

2.1.3 While the rates of poorer outcomes are higher in certain populations; individuals and families with the same level of disadvantage will also be present outside of those communities and often in larger numbers. Targeting of support such as Flying Start at geographical communities has the potential to create a different sort of inequality, where families in high need do not get the same access to support because they live in the wrong area. Ensuring that universal Health Visiting and Midwifery services have the capacity to provide enhanced services according to need; building on the current Healthy Child Wales Programme offer could improve our ability to intervene early and prevent problems developing, but would require investment.

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Agenda Item 3

Y 1,000 diwrnod cyntaf | First 1,000 Days
FTD 15
Ymateb gan: Coleg Nyrsio Brenhinol Cymru
Response from: Royal College of Nursing Wales

3 February 2017

Response from the Royal College of Nursing Wales to the Children, Young People and Education Committee's Inquiry into First 1,000 Days

The inquiry is looking at a number of specific areas, not all of which are relevant to the Royal College of Nursing. As such, we are submitting a number of general comments and observations below:

Health visiting services and Flying Start

I. Health visiting services provide a vital level of support to young children and their families, both pre and postnatally and through working with midwives. The evaluations of Flying Start and Adverse Childhood Experiences show that investment and development in these areas should continue.

II. However, whilst Flying Start and the enhanced health visiting programme has been shown to improve outcomes and have excellent results in some areas, there is also the risk that it creates health inequalities, with those not lucky enough to live in the appropriate postcode unable to access the support.

III. Provision of speech and language support in the early years in areas that fall outside of the Flying Start areas can be patchy and inconsistent, with the additional support which some families require not always being made available. This also applies more generally to other areas in which families may need support and access to specialist services, but are not fortunate enough to live in Flying Start areas. A form of referral system by health visitors for those families who would benefit from the scheme might be one option worth investigating.

Accessing services and service availability

IV. While targeted interventions are an essential component in supporting children and families with specified risk or need during the first 1000 days, it is also important to consider the needs of the wider population. For instance, those who either live outside of geographically targeted services, or those who fall below the criteria set for accessing targeted services despite having unmet needs.

V. Housing can be a particular issue, especially when working with some of the poorest and most vulnerable families. Poor living conditions have a negative impact on mental health which can impact on parenting capacity which in turn can have a negative effect on child development and attachment, all of which can have long-term detrimental effects on the child and family.

VI. Providing appropriate support for children and young adults with disabilities is vital, and greater levels of co-production are required to ensure services are designed to meet needs. As such, the level of support available to children with

disabilities and their families is in need of review, along with the workforce development and planning requirements to meet the needs of the population.

VII. It is also essential that all public services relating to health and children, recognise the factors that adversely affect a child's well-being, and take children's needs into consideration when decision making and designing services.

VIII. The availability of Welsh language services is key, particularly in areas such as speech and language therapies where provision in Welsh is not always available, and there is a definite need for improvement in this area.

Prevention & early intervention

IX. The Royal College of Nursing would like to see full delivery of the aims in the Healthy Child Wales Programme. The importance of regular health visits and checks, particularly in the first 2 years of life, is crucial. Not only does this assist with instigating early help and intervention where necessary, but it also assists with school readiness so that a child is able to learn in the school environment from the outset. For instance, ensuring that a child will be able to see the blackboard, hear the teacher, and speak and communicate with peers.

X. Young people are the parents of the future, and it is important that childhood and early life experiences help prepare them for this responsibility. The role of school nurses is critical in terms of helping build the resilience of young people so that their preparedness for adulthood and its responsibilities is enhanced. However, the workload of school nurses is often focussed on immunisation and other targeted interventions which, whilst being an important part of school nursing services, often means that there is little opportunity to undertake longer term, preventative and enabling work with young people.

XI. The benefits of a fully enabled school nursing service, designed and predicated on the needs of the school aged population should be recognised. Examples where school nursing services have been developed through external funding streams can demonstrate positive results, and this supports the need to invest in young people ahead of parenthood.

About the Royal College of Nursing

The RCN is the world's largest professional union of nurses, representing over 430,000 nurses, midwives, health visitors and nursing students, including over 25,000 members in Wales. The majority of RCN members work in the NHS with around a quarter working in the independent sector. The RCN works locally, nationally and internationally to promote standards of care and the interests of patients and nurses, and of nursing as a profession. The RCN is a UK-wide organisation, with its own National Boards for Wales, Scotland and Northern Ireland. The RCN is a major contributor to nursing practice, standards of care, and public policy as it affects health and nursing. The RCN represents nurses and nursing, promotes excellence in practice and shapes health policies.

Agenda Item 4

Dechrau'n Deg: allgymorth | Flying Start: outreach
FS 03
Ymateb gan: Aelodau o Rwydwaith Rheolwyr Dechrau'n Deg Cymru Gyfan
Response from: Members of the all Wales Flying Start Managers' network

October 6th 2017

Thank you for the opportunity to contribute to the National Assembly's Children, Young People and Education Committee inquiry into Flying Start. The members of the all Wales Flying Start Managers' network have worked with Children in Wales to gather evidence for submission. Representatives from Merthyr, Conwy and Carmarthenshire will attend the formal meeting on October 26th as will the Caerphilly Flying Start Manager who is the Chair of the network.

Children in Wales is the national umbrella organisation in Wales for children, young people's and their family issues, bringing organisations and individuals from all disciplines and sectors together to speak with one voice, to exchange knowledge and practice, and to provide opportunities to enhance policy and practice through shared learning.

We understand that the Committee's inquiry will give consideration to the following areas. This document contains collated comments provided by a number of Flying Start Managers in regards to the outreach and alignment elements of local Flying Start plans. We have not collated information regarding outcomes for parents and children but the four representatives will be happy to discuss at the formal meeting.

The outreach element of Flying Start requiring Local Authorities to identify children living outside defined Flying Start areas who would benefit from Flying Start services.

- The extent to which sufficient Flying Start funding is provided to reflect the outreach element of Flying Start delivery plans and whether the workforce capacity is sufficient to deliver the programme and its outreach elements.

- The evidence on outcomes for parents and children in Flying Start areas compared to the outcomes for parents and children in areas that are most similar in terms of deprivation levels but are not Flying Start areas.

Submission to Committee

This document sets out a sample of the approaches taken to delivering a Flying Start Outreach service in nine counties.

Key issues to consider

1. Outreach is a very small element of the Programme e.g. only about 30 or so for Swansea out of 3,000.
2. Local authorities were given flexibility to define Outreach in their areas as circumstances and models of FS delivery vary from area to area.
3. FS has a very clear evidence base, however, the Outreach element principles don't fit the evidence base.
4. Outreach provision is very diverse, although remains within basic principles, across all 22 Local Authority areas, and can be challenging to nationally prescribe due to the needs in the different communities, size of programmes, rurality and spread of small communities or conversely the density of urban populations, as well as the diversity of the communities' demographics including ethnicity, language, vulnerabilities.
5. The Outreach element has to be very carefully managed so as to not raise family expectations unrealistically due to the numbers being small nationally and targeted at the most vulnerable.
6. There is a concern that spreading services too thinly within the same funding level could build unrealistic expectations for professionals and families, as well as potentially dilute the impact for the targeted population and remove the ability to change outcomes significantly.

Swansea

Outreach in Swansea is used as follows:

- To meet identified and agreed anomalies in postcodes. (i.e. where there are gaps within existing areas)
- To provide services for children from Flying Start areas that become LAC during their entitlement.

This outreach criteria reflects the limitations of the funding available for outreach – if we were to open it up as a referral based criteria, it would be unmanageable & closed for most of the time; opening only when one of the 37 spaces becomes available over a 4 year period (as eligibility would be up to the child's 4th birthday).

General Comments on Outreach

- In Swansea our Outreach is purely on postcode anomalies and LAC for both practical reasons due to the FS model but also it would simply be unworkable to open up some sort of referral system.
- From 2012 local authorities were provided with additional funding ('the uplift') to support the expansion of Flying Start. Local authorities were expected to use 2.5% of this 2012 uplift funds for Outreach activities. This was stipulated in the original guidance for Outreach provided within the 'Flying Start Strategic Guidance 2012'.
- As there is a set amount of budget per child (WG currently allocate £2,100 per child per year), in Swansea we have translated financial cost into number of children to enable monitoring and make the services provided equitable. In Swansea our 2.5% uplift equates to 37 children.
- Each Authority has a different approach depending on the need for the area
- For the whole FS programme the outreach element is extremely small – in Swansea 37 out of a cap of 2,903 = 1.27%.
- It is a requirement in the guidance that the full provision of FS entitlements (all 4 elements) is available for all outreach prior to the Service being offered and therefore due consideration has to be given to capacity and proximity. Childcare is the most costly with a year's childcare costing more than the annual £2,100 allocation per child.
- The funded childcare element is what most parents seek and that is probably the most difficult component to achieve outside FS areas without additional dedicated funds. For this to be more widely available the FS Programme would need to be formally expanded with additional WG resources
- The Childcare is very difficult to achieve for additional unplanned numbers as settings have been established to reflect typical numbers of children in each age cohort living in each area.
- Other funds and programmes are available to ensure that most elements of the Flying Start Programme can be offered in some form outside FS target areas. It depends on each Authority's priority to Early Years as to whether this has/is being done
- Outreach is not necessarily aligned to the evidence base and fidelity of the Programme.

Gwynedd

Outreach work is offered to areas on the outskirts of Flying Start areas by working closely with the present Generic Health Visitor to assess and utilise a Gyda'n Gilydd referral or FS Generic Referral.

This is restricted to the following Generic HV's:

- Caernarfon Generic HV's – Caernarfon Town postcodes only
- Bangor Generic HV's – Bangor City - Hirael postcodes only
- Blaenau Ffestiniog Generic HV – Llan Ffestiniog,Tanygrisiau and Manod
- Bethesda Generic HV – Bethesda Town postcodes only
- Penygroes Generic HV's – Penygroes village postcodes only.
- Dolgellau Generic HV's – Dolgellau Town postcodes only.

The consented referral from Gyda'n Gilydd will be sent to the FS Referral Panel to authorise access and set work plan for family. Only high need families have access to the outreach service. For transfers out of the programme the FS HV refers directly to the FS Referral Panel.

The specific criteria for referral are the following:

- Children noted as high need in the above areas or moving out of the FS area The Children will be in need of 3 or 4 of the Flying Start entitlements.
- Children under 8 months old will have priority
- Statutory Child Protection
- Claimants of benefits
- Parents under 25 years of age and parents whom have been under the care system
- Children placed in temporary housing such as psl.
- Parents suffering with postnatal depression

FS also works closely with the Gyda'n Gilydd Team, Families First and relevant generic HV's to identify possible outreach. The Gyda'n Gilydd allocation meeting is held fortnightly the same day as the Flying Start referral panel with some panel members sitting on both panels which allow the information to flow effectively in between panels. Flying Start also refers back to the Gyda'n Gilydd team if a family moves out of the FS area or if the child is too old for Flying Start.
During 2013-14 FS offered outreach service to 2 children and during 2014-15 the outreach numbers increased to 10. The number at 29.1.16 was 13 children. Numbers will increase further in 2016-17/ 2017-18 up to 26.

A budget has been allocated for the 2 yrs. old childcare entitlement for outreach children. The four elements are available for the families by the Flying Start team, and are opened as a case for the nearest team. If the

child moves area within the period and still attends the child care, then on this occasion the child will be able to attend until end of term.

Cardiff

The following is the Cardiff Flying Start eligibility criteria;

Cardiff has approximately 55 outreach places available for children not resident in Flying Start areas, at any one time. The following is used as the eligibility criteria;

a. Families with 0-3's temporary housed in a designated Homeless Hostel which is outside of our current catchments and LSOA's. These families are offered the full Flying Start entitlement for the time they are resident in the Hostel

b. Families in (a) above who are subsequently re-housed will continue to receive their parenting; childcare or ELD entitlement if they have already started to receive a service, and will continue to have a Flying Start health visitor until transfer to generic;

c. Any family that transfers out of a Flying Start catchment/LSOA during receipt of specific Parenting; Childcare or ELD intervention will continue to benefit until the end of the term in which they move out, and retain their Flying Start health visitor until transferred to generic;

d. Families assessed as 'high risk/vulnerable' who move out of a Flying Start area will be considered on a case by case basis for any or all Flying Start core services, alongside opportunities to benefit from the TAF; Families First; IFST and Communities First services;

e. Vulnerable mothers with 0-3s in Ty Hafan Supported Housing for Lone parents; and consideration of referrals from Ty Enfys Mother and baby Supported Project will be offered the full Flying Start entitlement, as far as it is practicable.

f. Gypsy Traveller families with 0-3's resident in Rover Way, Cardiff, will be offered the full Flying Start entitlement as far as it is practicable.

In more detail:

Health: Homelessness creates significant additional difficulties for already

vulnerable families. The Health Visitor; CNN's and the wider Parenting and Early Language Development teams across Flying Start continue to work within Nightingale House, (Homeless Hostel outside of Flying Start) as well as other homeless hostels within designated LSOA's. Detailed discussions with support staff at Hafan Flats has led to new provision for young, vulnerable families becoming incorporated into the Outreach programme.

As a result of joint working and collaboration with the Taff Housing SHINE project, a draft protocol has been agreed between this organisation and Flying Start. This is with the purpose of avoiding duplication and taking practical steps towards joint working e.g. planning for transition for families out of hostels into local communities.

Gypsy Traveller provision has changed from an identified Health Visitor working within the community, to a sensitively delivered service by a new working group of Health Visitors, supported by managers. The Team leader co-ordinates the joint working from each element of the Flying Start Health, Childcare & Parenting teams as well as education. This provides continuity and "familiar faces" for potential clients to engage with.

The team works with the wider health and parenting teams to engage with the Rover Way Gypsy & Traveller community. To support our more targeted communities, the dietetic service delivers at least one cooking course on the Shirenewton Gypsy & Travellers site (April 2017 to March 2018). This is delivered using a more informal approach allowing children to be involved in the cooking and a drop in session. This suits the needs of the families on site. A bespoke entry level 3 Agored Cymru unit is being piloted. The sessions are delivered in partnership with Families First, the Flying Start Play Team and Shirenewton FS childcare setting. The dietetics team support 2 courses over 2017-2018 delivered in Nightingale House and Ty Greenfarm Homeless Hostels. (mentioned previously)

Over 2017-2018, the dietetics team are delivering an accredited *Get Cooking* course in Nightingale House Hostel and another in Ty Greenfarm Hostel. Women living in the Hafon flats in Ely are supported to attend the Ty Greenfarm course. These are delivered by a Dietetics Support Worker and *Get Cooking* trained homeless service CNN.

Parenting: Within the homeless hostels and in conjunction with health professionals, parenting provision is targeted through regular drop-in

Stay & Play sessions, individualised *Parents Plus* interventions and ensuring access to PNP, Get Cooking and other parent groups. Due to Shine (TAFF Housing) delivery of play sessions and parenting programmes, regular meetings have been arranged to ensure staff and parents are clear about services available and where possible duplication has been avoided as more joined up working is evident.
Gypsy Traveller families are offered parenting provision individualised *Parents Plus* interventions and ensuring access to PNP, Get Cooking and other parent groups.

Flintshire

A review of the processes for Outreach is being undertaken, ensuring compliance with the multi-agency formal review process and a review of outcomes for families in receipt of outreach funding.

Due to the funding constraints, Flintshire's outreach programme has been limited to high need children and families with a focus on continuation of childcare for children with additional needs.

Changes to the Families First programme in Flintshire and notably TAF have implications for the management of outreach, therefore a scaling back was necessary in this context also. Flintshire will continue to use the same model of outreach for 2017/18 as new developments in Flintshire mean it is likely to be extremely effective. The creation of the '*Early Help Hub'* (EHH) means that any family in need of outreach support can be supported to transition to universal services via a single referral to a multi-agency panel with a particular focus on ACE's (adverse childhood experiences). It is anticipated that transition will be managed in a timely and ultimately cost-effective manner. Established partnerships between Flying Start and some of the Families First organisations who will form part of the EHH will continue to work with Flying Start families as part of a co-ordinated approach to ensuring the right support for families and children. Work on mutually beneficial referral processes, ISPs and transition periods began in July 2017.

Carmarthenshire

The 2.5% of uplift of funds to support the expansion of Flying Start in 2012, which was agreed for Outreach activities as per Flying Start Guidance (2012) equates to 23 children in Carmarthenshire.

Outreach in Carmarthenshire can be accessed via a referral criteria which has been devised looking at vulnerability indicators and the assessment

processes used in the Flying Start Team, which are based on the Assessment Framework for Children in Need.

This is aligned to the Families First JAFF process and will continue through 2017/18: Indicators of Vulnerability that we work to and offer services around include: unemployment, housing, qualifications, mental health, illness/disability, low income, material deprivation (Families at Risk, 2008).

These indicators were used by the Welsh Government in 2011 when discussing 'troubled' families'. Taking into account all the above, the criteria list below was agreed at the Flying Start Management Board in 2012. In 2017/18 the list has been updated to incorporate the Social Services and Well Being Act 2014 and to take into account the reduction in the Midwifery strand. Through organisational change, antenatal parents have routinely been removed as a criteria. However if local need determines it, a further review of processes will be carried out.
In order to access Outreach the families need to be residing in an area next to an existing Flying Start area to enable services to be delivered.

Criteria List for Outreach Work in Flying Start Carmarthenshire

The following criteria are used to assess and determine access to the Flying Start Outreach Service, for families and children, in order to offer packages of care and support:

·Children on the Child Protection Register who have transferred out of a Flying Start area.
·Children whose names have been removed from the Child Protection Register (deregistered) within the last six months and have ongoing need for care and support.
·Children and Families that have ongoing, complex welfare needs, requiring additional interventions e.g. families where there are substance misuse issues, domestic abuse, identified learning disability, parental mental health issues and housing issues which impact on the health and wellbeing of the child. In addition to this these families would have been assessed as having low resilience using the FRAIT.
·Children and Families that have been open cases to the IFSS team and are requiring ongoing additional targeted interventions in phase 2, to maintain ongoing change processes.
·Children with disabilities, where the family require additional welfare support on top of an agreed package of care and support.

·Children who have become Looked After Children and have already been receiving a Flying Start service, to support this transition period, until longer term plans have been established. (This is not an exhaustive criteria list; each case should be looked at on an individual basis and will be determined through a multi –agency panel which involves receiving of a completed referral form and joint decision making from a budgetary and needs perspective).
Rhondda Cynon Taf The FS Outreach service is a provision for non-FS children, 2-3 years who have complex and persistent needs. This falls within the category, 'communities of interest'. Children are offered assisted childcare in Flying Start childcare settings with additional support, as per their assessed need. The children are closely supported by the FS settings. The overarching outcome of the service is to give children the very best opportunities to reach their potential. For some children this may mean securing a place at a special school or attending mainstream education with support or attending mainstream education without support. (Supporting flyer attached)
Torfaen Outreach funding is used to ensure continuity of service and necessary support to children who are moving out of Flying Start areas that are identified (evidenced by the family assessment tool) as medium-high need. These children should be identified via the Multi-Professional Panel Meeting either prior to or within six weeks of them moving out of a Flying Start area. Outreach funding is limited therefore consideration is made as to whether the services can be commissioned through Families First strategic projects, Communities First projects or other third sector organisation initiatives if Flying Start funding is not available. It is at the discretion of the Flying Start Coordinator, or nominated representative, as to whether to commit the funds and resources to provide the support required. N.B. Funding can only support up to 12 children.
Caerphilly The Outreach element for Caerphilly equates to 24 children and as such is under immense pressure. Therefore strict criteria for needs and evidence are applied including considering if the needs can be met through the joint contracts for complimentary early years' projects in Families First.

These are our elements / criteria for Outreach:

- On moving out of a Flying Start area the provision they are already accessing is continued until the end of that term and then the family is transitioned into generic health visiting, Families First parenting and Families First speech and language groups. Information is given regarding community based childcare provision with the different government support mechanisms information is given to the parent as this is the element most wanted but limited funding is available and so parent usually has to pay.
- If following a movement out, the intervention has not yet started then consideration for outreach is based on family need.
    - If the child is temporarily LAC and their resident postcode remains their FS postcode they are offered the closest relevant provision to the child.
    - If the family are high needs and therefore most vulnerable their needs are identified and a package offered which may include 1 to 4 elements of FS and this is reviewed termly with an aim to transition the family to Families First targeted services and support or universal provision.
- FS outreach enables a family worker as part of their FS caseload to work intensively in the family homeless unit on the outskirts of one of our most vulnerable FS areas. The families are often eventually homed in one of our FS areas and so this work often prevents the family reaching crisis when they are at their most vulnerable. The family worker works with the family alongside the health visitor for vulnerability and health nursery nurse to offer a relevant bespoke package. This often includes working with services offered through Families First and Supporting People to ensure the family are supported to move on. This package rarely involves childcare as often the families have very young children / babies and parents are young themselves.
- Working alongside the Families First Targeted Youth and Family Engagement project, one of our Family Support Workers works intensively with young pregnant teenagers to deliver antenatal programmes and outreach packages with the most vulnerable young people. The intensive antenatal support including support to housing services, supported accommodation, preparing for parenting, relationship guidance, healthy pregnancy information etc. enables the young people to have healthy pregnancies and reduces the risk of safeguarding proceedings to the point of removal at birth which was happening more frequently prior to this intervention

being put in place. Although some babies are put on the Child Protection Register at birth and some continue to be removed these are now the minority as the young people are supported to make the behaviour changes required to meet their child's needs. Many of these young people are homed in FS areas so they would transfer to the normal entitlement and we work with both Supporting People and housing to try to ensure this happens. If not they are considered for outreach support and if not required are transferred to Families First or universal interventions.

Working closely with both Families First and Supporting People has allowed families access appropriately across the right provision to meet their needs and stemmed the pressures on FS outreach.

Ceredigion

Ceredigion Flying Start is using the WG guidance published in 2014 to shape services in Ceredigion as follows:

1. Flying Start provides all 4 entitlements to 3 **'Communities of Interest'** within Flying Start catchment areas – 2 Women's Refuges and one Homeless Hostel at a cost of @£6,500 per year. @40% of families settle in FS areas; 9.5 children benefit during their stay which on average lasts 4 months (2013 figures).

2. ***Families transferring out of FS areas with high needs***. Flying Start staff who have concerns about the high level of need of families transferring out of a Flying Start area complete a JAFF form and refer the family to the Team Around the Family Co-ordinator. If the family are high need and are transferring to an area within 5km of an existing FS area, then the FS staff member may inform the TAF co-ordinator that they intend to continue to support the family or if be more appropriate, be part of a transition plan. They would also inform the FS office for monitoring purposes.

3. ***Families referred to FS from non-FS areas.*** These families are referred to TAF with a completed JAFF in the first instance. The Team Around the Family Coordinator monitors JAFFs being submitted and where she feels families could benefit from FS funding, an application form is completed which states the reason for the application and the entitlement requested. The FS manager then signs paperwork and the delivery is monitored to keep a track of cost.

Funding for outreach for 2017-18 amounts to a total of £12,215. This sum divided by £2,100 per child equates to 6 children receiving their full Flying Start entitlement

Alignment

Flying Start plans include details of how LAs are ensuring alignment in delivery of services/provision across the range of anti-poverty programmes, particularly with regard to Flying Start, Families First, Communities First, and Supporting People. They also describe how LAs plan to increase the level of alignment and delivery in 2016-17.

Swansea

- Flying Start and Families First are led and managed by Early Intervention Services in Swansea. This has enabled a strategic approach to elements of the Programmes that are relevant to both.
- This has included many services working across both Programmes to ensure consistency and city wide coverage as much as possible. This has been the case specifically in relation to Parenting, Language Development, Young and First time parents, ALN support for pre-school children, the ethos of TAF and the linkages with primary schools including effective transition into school and beyond.
- Both Programmes are developed within the broader Education, Health and Well-being agendas for children, young people and their families to ensure that they are complementary and provide effective pathways of early intervention.
- There are no services within Flying Start or Families First that duplicate in any way with each other. Supporting People is focused primarily in Swansea on Older People's services and Housing and is as such very different in nature, focus and targeting and there are limited cross overs between the Programmes.
- The current arrangements provide sufficient opportunity and flexibility to achieve alignment whilst at the same time ensuring that the individual uniqueness of each Programme is retained including the fidelity of Flying Start to the evidence base.
- It's difficult to see, even just with Families First and Flying Start which are managed together, how further alignment would be helpful or achieve greater outcomes or indeed efficiencies.

Gwynedd

Flying Start, Families First and Communities First work closely in Gwynedd. Three of the FS areas are also Community First areas being Marchog 1/2, Bangor; Talysarn and Cadnant and Peblig, Caernarfon. The teams are co-located in Ty Cegin Bangor and in Talysarn Centre therefore are able to collaborate on many operational projects.

Also some of the Families First packages are managed by the Early Years Unit therefore the teams share managers etc. This promotes a cohesive way of working, the ability to share good practice, share resources and conduct joint training. The Early Years project within Families First has been designed with the FS model in mind therefore FS expertise is shared within Families First. Referrals for FS outreach come through the FF TAF referral meeting and FS refer in to Families First when children leave the programme or when older siblings require the FF service.

The three projects are all strategically led from the Children, Young People and Family Support Partnership Board which meet on a quarterly basis led by the Strategic Director of the Council. The Supporting People programme will need to be included in this partnership working.

Following the 2016-17 guidance the managers from the four programmes meet up regularly to discuss collaboration and working together to plan and identify opportunities for the potential to jointly commission activities/projects.

Flying Start will give a contribution towards the Gyda'n Gilydd TAF team in order to co-ordinate families between both programmes. Gyda'n Gilydd provides a framework for bringing the Families First and Flying Start closer together by offering a co-ordinated approach to families.

Flintshire

- Alignment with the 3-4 year old childcare offer, linking sustainable provision for the 'early implementers' with Flying Start childcare.

- Alignment with Healthy Child Wales Scheme and working closely with generic services to support best practice with in Flying Start and the local authority.

- Monitoring developments in Families First procurement process to ensure service continues to benefit Flying Start Families and that appropriate links with existing and new services are maintained.

- Continuing to work with Communities First through the transition period and the new Community Zones.

- Working with Supporting People and the funded projects. Ensuring Flying Start families can gain access to information, advice and support around welfare changes and universal credits, to help them into employment or education.

RCT

In RCT Council a new Commissioning Team has been established within a new 'Community and Prosperity Service. The focus of this team is to bring together the activities of the grant funded services through a Single Outcomes Framework. Much work has focused on Communities First, due to the change in national direction of this programme. Currently the Team is focusing on Families First, also due to the new guidance which has come from WG. This has prompted more focused discussions around integrated parenting programme delivery, which was an area of development that was key for collaboration. The discussions are currently in their infancy

Torfaen

The Flying Start Coordinator is part of the Tackling Poverty Leads Group which looks at the alignment of all of the Tackling Poverty Programmes with a view to working towards a 'Single Plan'.

During 2017/18 Torfaen is reviewing the family assessment tool undertaken across all programmes as part of the Don't Walk on By Strategy. Assessments are also been reviewed as part of the First 1000 days programme and in line with the new Health Child Wales delivery.

Work will be ongoing in 2017/18 to build shared database across the tackling poverty groups.

Families First and Communities First are represented at the Flying Start Management Group Meetings. Here the annual delivery plans are shared and discussed prior to submission, accounting for how the teams can support each other.

The Flying Start Coordinator attends the Families First Panel Meetings.

Some Flying Start staff are also co-located with Early Years Families First team and managed by the same team leaders. We continue to co-facilitate Parenting and Early Language Development groups with Families First.

Carmarthenshire.

Flying Start and Families First are managed by the Family Support Services Manager, which assists in a collaborative, integrated approach to family support and early intervention within the county.

Carmarthenshire after a long consultation period has developed a Family Support Strategy and action plan which underpins and drives the alignment and delivery of the 'Tackling Poverty' programmes.

As part of this collaborative approach a strategic planning group, the Alignment Working Group has been established to include the four 'Tackling Poverty' programmes. The Alignment Working Group has further developed a joint action plan for 2017/18 focusing on the following 6 areas:

Collaboration and Smarter Planning: This has involved reviewing collaborative working arrangements to create effective joint commissioning and planning arrangements. This includes the progression on the development of joint contacts/SLAs and joint planning and delivery of services such as parenting groups.

Information: Development of a clear and accessible pathway for families to get help, information and guidance, linking in with the IAA implementation Board

Needs Assessment: In Carmarthenshire two significant needs assessments have been carried out to date –SSWBA and population assessment. These are used, along with local programme data to form the basis for commissioning services jointly that are fit for purpose to meet the identified family and service user needs and also identifying any gaps in service provision.

Team Around the Family and Joint Assessment Family Framework: In Carmarthenshire the TAF approach has been shared and utilised by other Tackling Poverty Programmes, this has been done through training and supporting its usage as an assessment tool.

The Flying Start Programme in Carmarthenshire has an internal TAF approach using the new All Wales Health Visiting Assessment Tool / Instrument, FRAIT. Work is currently being undertaken to look at how FRAIT translates into/aligns with a JAFF on transition of families from Flying Start into Families First.

Work Force Development: a programme of multiagency training, a core competency framework and skill mix options are being explored between the Tackling Poverty programmes.

Participation and Involvement: Exploration of wider opportunities to engage with service users in an inclusive and participatory approach is being undertaken.

Carmarthenshire has also been chosen to pilot the Children's First Zones using a collaborative approach to family support.

The Flying Start Health and Support Services have aligned to the Healthy Child Wales Programme and are working closely with Generic Health Visiting services in Hywel Dda University Health Board to deliver the programme.

Progress reports on services are fed into the Anti-Poverty and Local Service

Board (LSB).

Caerphilly

Flying Start, Families First, Communities First and Supporting People continue to work and strategically plan programme delivery very closely. We meet monthly through the Programme Collaboration Group to ensure we are aware of any current strategic developments across the directorates which adds strength and a wider perspective to our programme strategic planning. The four programmes are represented on the Families First Board and regularly report to Education Scrutiny Committee, Public Service Board and Anti Poverty Board to ensure the strategic fit with Wellbeing Plan and objectives.

The programme jointly commission a significant number of projects already and programme delivery has been shaped in each programme to prevent duplication and maximise reach across the borough. CF areas had synergy with FS areas and the revised legacy programme will continue this, with legacy projects being developed to fit the gaps between programmes including employment based programmes.

We have maximised the reach of the Flying Start programme through jointly or complementary commissioning with Families First the Speech Language and Communication groups, Health intervention groups, antenatal support, parenting programmes, developmental support packages in the home for children with developmental delays, Childcare placement packages for children with additional learning needs, etc. Families First is based on a referral process which means those outside of Flying Start areas in the early years have access to provision depending on their family needs. Therefore the only element which has a significantly reduced offer is the childcare which is targeted for those with developmental delays to identify support needs prior to Foundation Phase. Supporting People has also linked into the commissioning process and equally joint commissions with Families First for wider reach of other projects from single person to the whole family perspective including younger children. As a result this commissioning strategic planning process has maximised the accessibility for families in need across the borough. However, there will be continue to be families outside of Flying Start who do not wish to access any support other than the funded Flying Start Childcare provision and who do not have any identified needs including economic so this continues to be a criticism / complaint area for the public. In addition workforce planning through the Programme Collaboration Group has allowed for sharing of training being delivered and places being maximised as well as shared key messages and common language being developed.

The JAFF has been developed to allow for referrals across all programmes and has a central referral point through the IAA team. Although this single point of contact is in its early stages this has been well received by both

families and professionals who no longer need to decide which services to refer to, fill in multiple referral forms and families who have to tell their story multiple times to different organisations. Development of the cohesive range of services and the linkages between programmes has also been received well by practitioners. This continues to be monitored as inevitably with the complexity of families' lives new gaps in provision will emerge.

Supporting Family Change as the TAF approach in Caerphilly continue to work with all programmes to ensure our most vulnerable families access the range of services needed.

In the Wellbeing Plan there is a Public Services Board commitment to ensure there is a quality early years' interventions programme and as such we are working with Public Health Wales to use the Early Pathfinder tools (1000 day pilots) to identify any further gaps and consider how to address them.

Ceredigion

Ceredigion has no Communities First funding.

Flying Start and Families First share a line manager and are therefore part of the same business unit and contribute to a single business plan within the local Authority. Contact has been made with the Supporting People manager and information shared on programmes and outcomes with a view to developing this work further in 2017-18.

The programme leaders for each programme meet on a regular basis at Ceredigion County Council's Work stream Groups (see diagram below). Families First and Flying Start also meet at the Children and Young People's Service Provider's Forum.

At the end of 2014-15, Ceredigion Flying Start and Families First Steering Groups were combined and in 2015-16, the Terms of Reference were revised to reflect the increased emphasis on alignment.

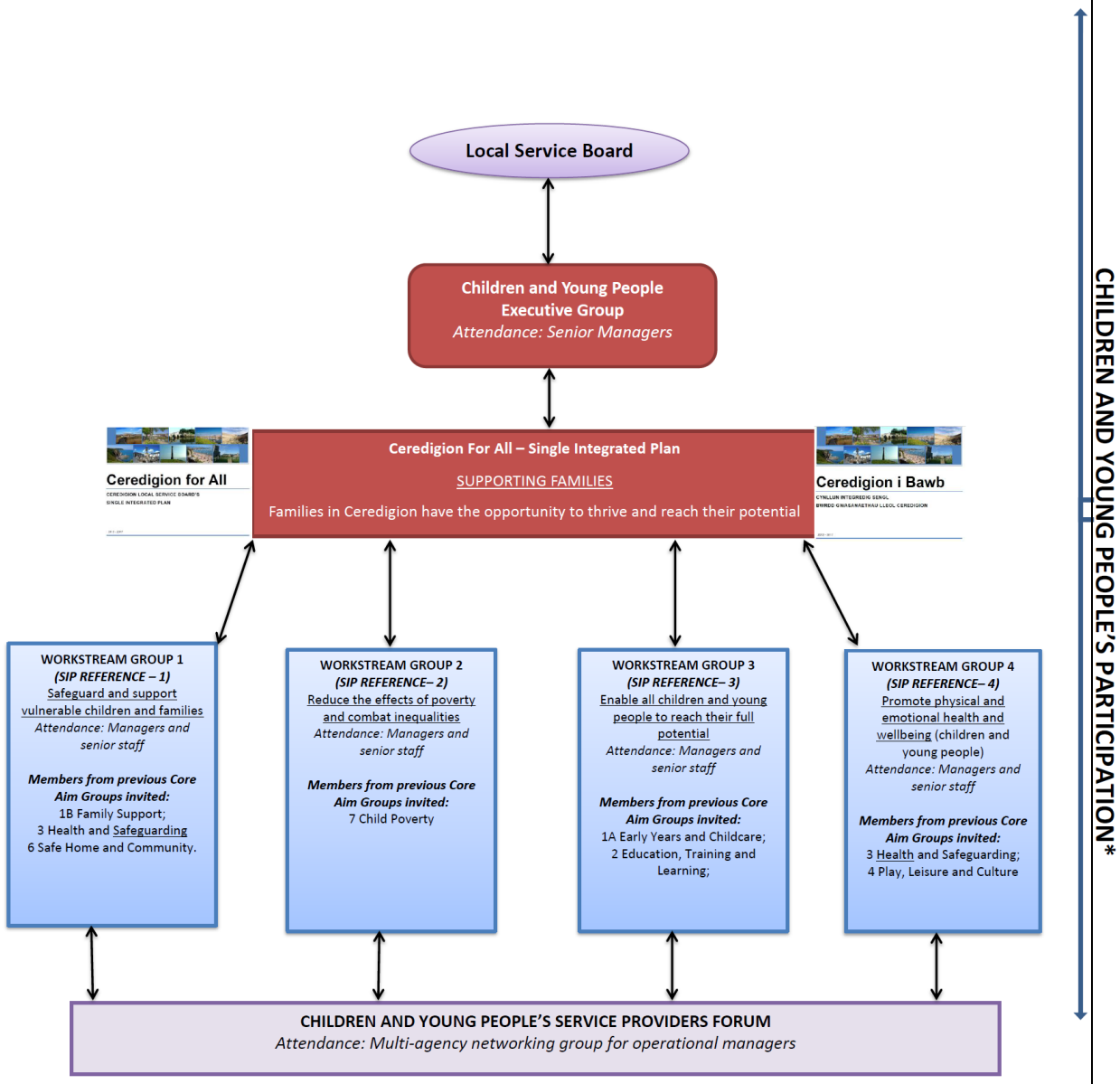
The work of developing Parenting Support across the county , sharing good practice and developing common tools such as the Workforce Audit tool is ongoing. There has been a focus more recently on making sure that services reflect and address 'The Social Services and Well Being Act (2014)' as well as Families First, Flying Start and local desired outcomes. Work is set to continue in 2017-18.

Families First and Flying Start have a number of shared Service Level Agreements. These are reviewed and re-negotiated annually. Performance measures for these services are jointly agreed between Flying Start and Families First to support the delivery of an aligned service.

The above takes place against the background of Ceredigion's Single Integrated plan which ensures the coordinated delivery of family support

across the whole county and between LSB partners. Flying Start and Families First both contribute to Family Support priorities within the SIP and report to the LSB via the LSB Executive group for Children and Young People (formerly the Children and Young People's partnership).

Structure Summary - Ceredigion Local Service Board Executive Group for Children and Young People



In 2017-18 a bid to vie money was submitted with the intention of increasing the reach of support for victims of Domestic Abuse. Our figures show that this is a growing problem. A number of meetings were held with FF, FS and a range of professionals across agencies to address this issue and these have been submitted to WG for their consideration.

Agenda Item 5.1

Comisiynydd Plant Cymru
Children's Commissioner for Wales
Sally Holland

By e-mail only

To: Alun Davies AM, Minister for Lifelong Learning and Welsh Language
CC: Lynne Neagle, Chair of the Children, Young People and Education Committee, National Assembly for Wales

16 October 2017

Dear Minister,

I write further to the session of the Children, Young People and Education (CYPE) Committee on 4th October 2017, under Stage 2 of the Additional Learning Needs and Education Tribunal (Wales) Bill (hereafter the ALN Bill). I have also seen a copy of the letter from the Welsh Local Government Association dated 3rd October 2017, which was referred to during that session.

I was pleased during the session to hear your explicit commitment to placing due regard to the United Nations Convention on the Rights of the Child (UNCRC) onto the face of the Bill, and your firm undertaking to work with all members of the CYPE Committee in order to bring forward a Government amendment to give effect to that at Stage 3.

There was much discussion in the Committee session on 4th October 2017 around whether or not it was appropriate for the duty to sit with "a person" rather than with "relevant bodies". I understand that there was concern about pressure on frontline practitioners and how they would record and evidence their observance of the due regard duty.

My primary objective is to ensure that learners with additional needs have the support that they need to reach their full potential through education. I firmly believe that placing a due regard duty on the face of the ALN Bill has the legitimate and proportionate aim of helping learners with additional needs to be the best that they can be and would like to work you, your officials, and members of the CYPE Committee to find a consensual way forward in order to achieve this. I would be pleased to meet with you and/or your officials prior to the drafting of amendments for Stage 3 of the Bill, in order that the considerations from my evidence, the CYPE Committee's stage 1 report and the discussions at stage 2 can be worked through as part of that process.

You will see that I have copied this letter to Lynne Neagle as Chair of the CYPE Committee.

Yours sincerely,

Sally Holland
Children's Commissioner for Wales

Croesawn ohebiaeth yn y Gymraeg yn ogystal â'r Saesneg ac mewn amryw o fformatau/We welcome correspondence in the medium of Welsh and English as well as alternative formats.

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