

Joint Strategic Needs Assessment:

Children and Young People

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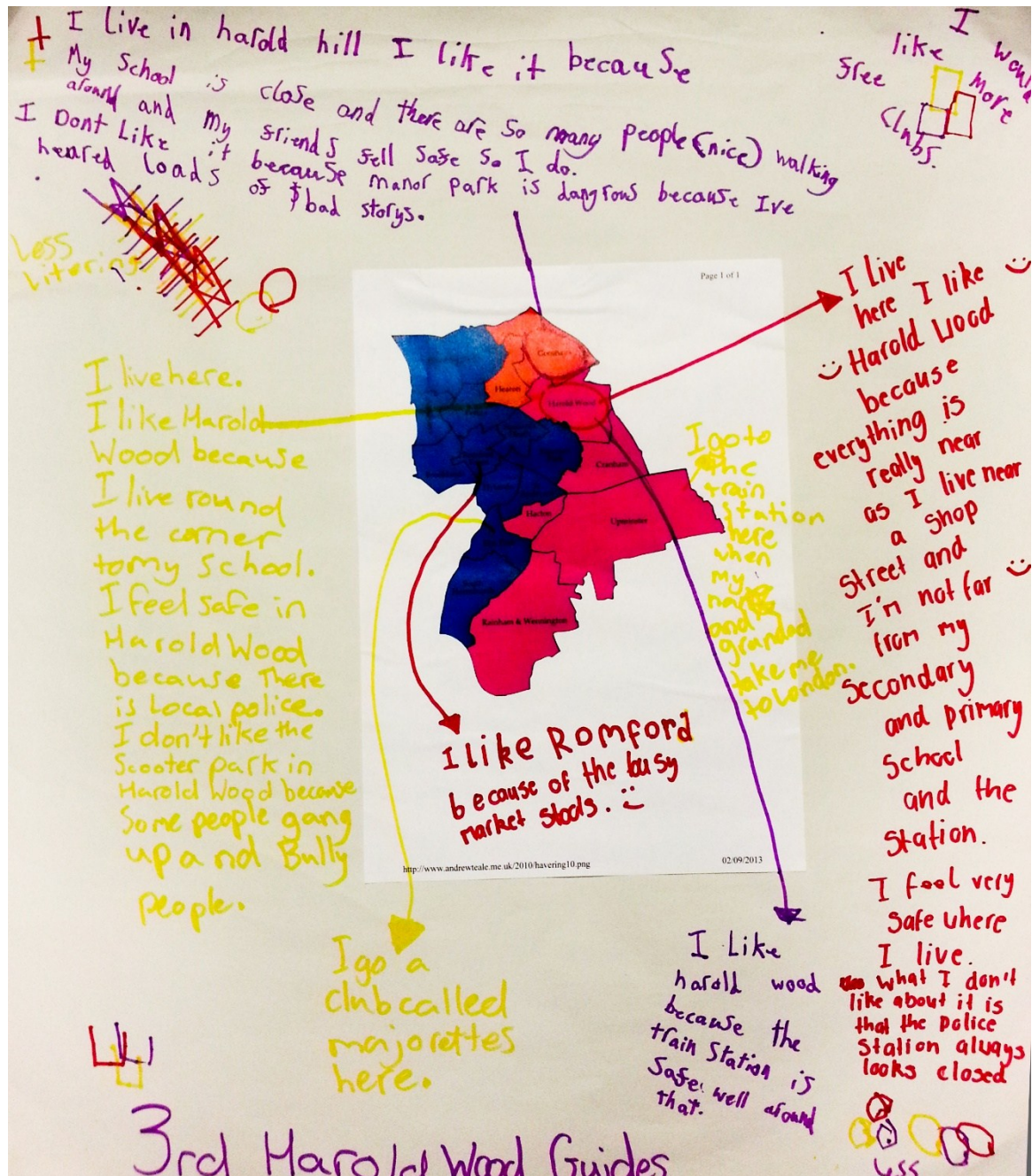
Contents

Executive Summary.....	6
Reader notes	16
Priorities of local children and their families	18
Children and family demographics: headlines from demographics chapter.....	19
Children and families in Havering: where do they live?	20
Household composition	22
Child poverty.....	24
Children and housing	31
Impact of welfare reform on child poverty.....	32
‘Troubled families’	33
Maternity and birth.....	35
Smoking in maternity.....	35
Preterm births.....	36
Multiple births	38
Obesity in maternity	39
Baby birth weight.....	40
Teenage pregnancy and births to teenage mothers.....	42
Breastfeeding.....	48
Infant and child mortality	51
Road safety	53
Healthy weight: children aged 4-5 and 10-11 years	55
Immunisations	60
Oral health	64
Children with special educational need and disabilities (SEND).....	66
Havering’s education provision for children with SEND	66
Current profile of children with SEND	67
Children’s therapy services: client profile.....	78
Hearing impaired advisory teacher services: client profile.....	78
Attainment of pupils with identified SEN: early years foundation stage (EYFS).....	79
Attainment of pupils with identified SEN: KS2.....	79
Attainment of pupils with identified SEN: KS4.....	80
Exclusions, attendance and children with SEN	81

Children’s mental health and relationships	83
Child and adolescent mental health service (NELFT / Havering, tier 2 and 3): client profile	86
Childhood Eating Disorders.....	94
Mental health and hospital admissions	94
Bullying.....	95
Young carers.....	97
Safeguarding children	101
Domestic violence, parental mental illness and substance misuse in Havering: the ‘toxic trio’	101
Domestic violence	102
Parental mental health	105
Parental alcohol and substance misuse.....	105
Perinatal parent infant mental health services	106
Missing children and sexual exploitation.....	107
‘Honour-based’ violence and forced marriage	109
Child Abuse Investigation Command: activity in Havering, Q1 2013	109
Private fostering.....	110
Child protection and children’s social care: service level data	111
Children in care	113
Profile: children for whom Havering is the lead agency.....	113
Profile: children placed in Havering by other local authorities	116
Mental health and children in care.....	126
Children as victims of crime	129
Youth offending	132
Prevalence of gangs and gang-related criminality in Havering.....	135
Substance misuse (alcohol and illegal / controlled drugs)	136
Early Years.....	139
Inequalities in early years development.....	141
What is the current service provision?	144
Primary years (age 5-10).....	146
School place projections	146
Attainment at key stage 2.....	148
Inequalities in key stage 2 attainment.....	149
Exclusions.....	152
Attendance.....	152

Secondary-aged children	155
School place projections	155
Attainment at key stage 4.....	156
Inequalities in attainment at KS4.....	158
Attendance.....	162
Home-schooling	163
Post 16	164
Post 16 attainment	164
Post 16 attainment inequalities.....	165
Appendix one: consultation respondents.....	175
Appendix two: Department for Education statistical releases by subject area.....	176
Appendix three: Department for Education statistical release publication schedule 2014.....	177

3rd Harold Wood Girl Guides: their views on their local area (September 2013)



Executive Summary

The findings of this chapter have commissioning implications across the range of partners working together through the Local Safeguarding Children's Board, the Havering Place Board, the Health and Wellbeing Board and Havering's Children's Trust.

Child population

Over 2001-2011, **Havering's 0-17 population grew by 3.6% to 51,638, with 21% living in Gooshays, Brooklands or South Hornchurch.** Over this period, the numbers of child residents grew substantially in some wards whilst declining in others. **The child population in Brooklands, Heaton, Romford Town and South Hornchurch rose by a total of 1,925 children, or +17.2%, while Hacton, Pettits, Hylands and Upminster saw a decrease of 805 resident children, or -7.2%.** Romford Town and Brooklands in particular had a comparatively high rate of 'young' families (i.e. where the youngest child is aged 0-4 years); those wards with declining numbers of child residents tended to have a higher rate of 'older' families (i.e. where the youngest child is aged 12-18 years). **The age 5-10 population is expected to grow by 24% and the 0-4 age group by 19% over 2011-2021.** Conversely the 11-17 population is projected to dip slightly over 2011-16, before rising back to 2011 levels in 2021.

Child poverty

Poverty and disability are the two risk factors which have a direct association with worse outcomes on all children's outcomes measures, once all other characteristics and behaviours are held constant (Jones, Gutman and Platt (2013)). Family poverty is associated with children having poorer non-verbal, verbal and maths skills, lower KS1 attainment and more behavioural difficulties.

Havering is a borough with a highly varied socio-economic make up; **while the majority of children in Havering are not poor, around 8,800 live in income-deprived households,** as defined by the 'Income Deprivation Affecting Children Index' (2010), and **around 4,861 (11.6%) live in a household where no adult works** (DWP, 2012). As at 2012, the **rate of children living in workless households varied across the borough from 335.6 children per 1,000 in Heaton to 39 per 1,000 in Upminster.** Gooshays and Heaton had both the highest rates of large, young families and the highest rates of children residing in a household where no adult works. At a national level, unemployment is higher amongst lone parents than other family types and consequently, the children of lone parents are more likely to live in poverty than children in a two parent family; **the number of single parent households in Havering rose from 4005 in 2001 to 5079 in 2011.** Compared to outer London and

England, Havering has a relatively low overall rate of pupils eligible for and claiming free school meals; however the proportion of pupils who are entitled to free school meals but not claiming them is comparatively high.

Deprivation and worklessness, childhood obesity, teenage pregnancy, attainment at key stages 2 and the rate of young people not in education, training or employment at age 19 are all known to be associated and linked with inter-generational cycles of deprivation. Local 'heat maps' of each of these factors broadly mirror each other, with children residing in the north and east of Havering less likely to be in education training or employment at age 19, more likely to be a teenage parent and more likely to be obese by age 4-5 than their peers in areas of the west and south west of Havering.

Disability

The second risk factor independently associated with poorer outcomes is longstanding illness / disability in childhood. In line with Ofsted recommendations, Havering has championed a policy that recognises that behavioural difficulties do not necessarily mean that a child or young person has a Special Educational Need (SEN) and should not automatically lead to a pupil being registered as having SEN. Consequently **only children with specific and identified SEN are supported through the special education need framework in Havering; this results comparatively low rates of special educational need (SEN) managed through school action, school action plus or statements, particularly at secondary level.** The rate of children identified through the SEN framework with a learning difficulty, moderate learning difficulty or autistic spectrum disorder is significantly lower than the England rate. The number of children with profound and multiple learning difficulties was the same in 2012 as in 2008 and was comparable to the England rate. Similarly the rate of children with severe learning difficulties is not significantly different to the England rate although the rate has risen from 2008. As only children with specific and identified SEN are supported through the special education need framework, this results in comparatively lower levels of attainment for this cohort as these children often have high levels of need.

2,437 children with a Havering GP accessed a direct service from a NELCS speech and language therapist over Oct 12 – September 2013. 1365 (56%) of these children were aged 5-10, although as at January 2013, only 533 primary-school pupils were identified as having speech, language and communication needs that required support through school action plus or a statement.

Nevertheless, **at primary level, speech, language and communication difficulties are by far the**

most common type of identified SEN, followed by moderate learning difficulties and behaviour, emotional and social difficulties (School Census, January 2013). Together these account for 74% of primary level SEN.

At secondary level, moderate learning difficulties are more prevalent, followed by behaviour, emotional and social difficulties and speech, language and communication needs – these account for 62% of identified secondary level SEN.

Maternity, birth and early years

Children's experiences in their early years strongly influence their outcomes in later life, across a range of areas from health and social behaviour to their employment and educational attainment. The first three years of life are crucial for social, emotional and cognitive development, with **breastfeeding and good maternal mental health key to providing a healthy start in life** and the sensitive and responsive care necessary for children to build secure attachments. **In 2011/12 the rate of initiation of breastfeeding was the second lowest in London** (although this is an improvement on 2010/11 performance). **Smoking in maternity rose over 2005/6-2011/12 but has recently decreased and is currently in line with the England average but as at Q2 2013/14 was the highest rate of all London authorities, and double the London 2012/13 rate.** Local maternity and post-natal services have been subject to an improvement program since 2012 and this has yielded improvements in service delivery and patient experience, with a 2013 Care Quality Commission report finding previously high risks relating to maternity services being mitigated effectively.

The Early Years Foundation Stage (EYFS) is a framework that all early years providers must follow. It helps children learn, develop and helps prepare them for school. In Havering, the proportion of children achieving a good level of development remained relatively static over 2010-2013 at 59-60%. Except for 2012, Havering has consistently performed in line with or better than the England average for this benchmark since 2008. Compared against all England authorities, **Havering is currently ranked 20th for the proportion of children achieving a good level of development at the early years foundation stage (lower is better).** **In 2013 the percentage inequality gap in achievement across all the Early Learning Goals was 27.3% in Havering, compared to 36.6% for England¹.**

¹ This is calculated as the percentage gap in achievement between the lowest 20 per cent of achieving children (mean score), and the score of the median.

Early help for families

Extreme stressful events, such as homelessness, victimisation or abuse, can have long-term effects on children's outcomes. Effective support for children at risk of stressful events focuses on prevention of harm, protection in the event of harm, and sustaining positive change. **Local and external evaluation has demonstrated variability in the effectiveness of screening and assessment for children and families in need of preventative services.** The need for effective screening and identification programs, assessment and whole-family packages of support will increase as the age 0-10 population rises and families are impacted by welfare reform.

Domestic violence, parental mental illness and substance misuse

The term 'toxic trio' is used to describe the comorbidity of domestic abuse, mental ill-health and substance misuse amongst adults with children in their household. **The life chances of a small but significant number of children in Havering are adversely affected by one or a combination of 'toxic trio' factors.** Over quarter 1, 2013, there were 49 domestic violence offences recorded in Havering where the victim or witness was a child. This equates to a prevalence rate of 0.95 per 1000 of the 0-17 population over this period and is similar to the London rate. **Over 2012/13, domestic violence was the 2nd most common reason for a safeguarding referral to children's social care** (most common reason: 'abuse and neglect concerns' – although domestic violence may also feature in these referrals). Less than five domestic violence safeguarding referrals came from Emerson Park, Hacton, Pettits and Upminster in 2012/13, whereas **Gooshays, Heaton, Romford Town and South Hornchurch together accounted for 46% (n=77) of domestic violence-related safeguarding referrals; these four wards account for 26% of the 0-17 population².**

The number of children who are affected by/living with parental alcohol misuse or adults with mental ill-health is largely unknown at both a local and national level. Data on rates of drinking during pregnancy are commonly based on self-reporting and therefore often unreliable as a result of poor estimation, poor recollection and the social stigma associated with heavy drinking during pregnancy. Maternal alcohol consumption levels are therefore often significantly underestimated. However, estimates suggest parental alcohol misuse is far more prevalent than parental drug misuse. As at October 2013, there were 331 children (0.6% age 0-18 population) in Havering living in homes where there is a parent/carer known to be engaging in drug/alcohol treatment. In total, 157

² Some caution is required however as reporting patterns do not always correlate to prevalence; reporting is likely to be inconsistent across socio-economic groups.

parents / carers were receiving drug / alcohol services from our main drug and alcohol service and a further 64 parents / carers were receiving a specialist prescribing service.

Young carers

The number of children resident in Havering who were reported through the census to provide regular and ongoing care to a family member increased from 381 to 443 (+16%) over 2001-2011.

There was a disproportionate increase in those providing very high levels of care although this remains a very small overall number. Over 2012/13, 94 children were supported through Havering's commissioned services as young carers. **Local authority responsibilities to young carers are likely to change over 2014/15.** Amendments to the Children and Families Bill propose to strengthen the right to an assessment of needs for support for all young carers under the age of 18 regardless of who they care for, what type of care they provide or how often they provide it, and link children's and adults' legislation to enable local authorities to align the assessment of a young carer with an assessment of an adult they care for. Consequently, **a greater number of young carer assessments will be carried out in the future and there is likely to be increased demand for young carer support services.**

Protecting children from crime, abuse and substance misuse

Havering has **one of [the lowest overall crime rates](#) in London.** However, survey data from a small unweighted sample of local people suggests the fear of crime is real. 'Supporting children to stay safe and crime free' was ranked the top priority for the 301 children and 308 adults who responded to a Havering survey over July – Sept 2013, with alcohol or drug related violence, theft / robbery and gangs as the top causes for concern. Quantifying the scale of gang activity in Havering is problematic; although some may be arrested for offences typically associated with gang activity, the gang network invariably comprises a far greater number of individuals. Havering, like many outer-London boroughs, is experiencing cross-border migration of gang activity and very small number of young people (approximately 40) are currently identified as at risk of engaging in serious youth violence.

Over 2009/12, the directly standardised rate of hospital admission for substance misuse for persons aged 15-24 years, was 78.2 per 100,000 population (around 23 per year); this is higher than the England directly standardised rate of 69.4, but not significantly so. The crude rate of alcohol specific hospital admissions for under 18 year olds over 2008-10 was 34.2 per 100,000, significantly below the England average rate of 55.8 per 100,000. Very small numbers of young people receive

specialist substance misuse services; 52 in 2010/11 and 63 in 2012/13. Most referrals to specialist substance misuse services came from the youth justice service (n=19), self, family or friends (n=20) or education services (n=17). None came from accident and emergency and <5 came from health and mental health services (excluding accident and emergency).

Children are far more likely to be a victim of crime than a perpetrator³. Over the period 1st July 2012 to 31st March 2013, there were 235 proven offences committed by 127 children aged 0-17 resident in Havering; this represents less than 0.25% of children. Breach of conditions, drug crimes followed by theft and handling stolen goods represented the most common offences. **Re-offending rates for the cohort of young people who offended are broadly in line with national averages, although there has been an increase in re-offending for the most recently reported cohort.** This is due to a small proportion of this cohort who re-offend more than once. The percentage of young people working with the youth offending service and engaging in education, training or employment fell over 2011-12 to 2012-13.

Data relating to Q1 2013/14 suggests that Havering's Child Abuse Investigation Team (CAIT) is proactive (relative to other boroughs' CAITs) in 'flagging' sexual exploitation as a factor in child abuse offences, while the rate per 1,000 children aged 0-17 thought to be at risk of sexual exploitation was middling compared to other London boroughs over this period. The figures for this quarter are not necessarily representative and variations may be reflective of local approaches to tackling child sexual exploitation rather than indicative of prevalence.

Havering has **consistently low comparative rate of children subject to child protection plans, although there is considerable variation by ward**, with 48% of children subject to CPPs in 2013-14 resident in Heaton (19%), Gooshays (17%) and Brooklands (12%). These three wards accounted for 20.6% of the child population in the 2011 census. **Havering also has a low rate of 're-registration'⁴ and a low rate of child protection plans that continue for 18 months or more.**

Children in care

Havering has consistently low rates of children in care and on average there are approximately 190 children in Havering's care at any one time. There were a total of 300 children in care living in the borough as at 31st March 2013; 100 were in Havering's care and 200 were placed in Havering by

³ [Crime Survey for England and Wales, 2013](#)

⁴ Where a child is subject to a child protection plan for a second or subsequent time

other authorities⁵. Consequently, Havering is a net importer of children in care. This is partly a result of increasing numbers of children being placed in Havering by other local authorities (increase from 185 in 2010/11 to 200 in 2012/13) and partly due to less children looked after by Havering being placed outside the borough boundaries (decrease from 85 in 2010/11 to 75 in 2012/13). This has implications for local health services (including CAMHS), schools, and children's safeguarding.

Of the 100 children who came into Havering's care in 2012/13, 30 (30%) did so through police powers of protection. This is an increase from 18% in 2010/11 and 21% in 2011/12. However, in 2012/13, the overall rate of use of police protection per 10K of the age 0-17 population (5.84/10,000) was 'middling' compared to other London authorities. Therefore **the use of powers of police protection are comparable to other London authorities**, but the proportion of children coming into care through this route appears high as comparatively few children enter care.

In 2012/13, 100 children exited Havering's care, with 55 exiting to return to live with their parents or relatives. This is the 2nd highest ratio of exiting care to parents / relatives in England. As at March 2013, the proportion of children in care with up to date annual health assessments was lower than the England and London rate at 68%.

Children in care are far more likely to experience mental ill-health than their peers; **in 2012/2013, screening test results for 95 children in care aged 5 to 16 showed that (56%) were at a high or borderline risk of clinically significant mental health problems.**

Until recently, children in Havering's care were more likely to experience a series a different placements over short periods of time than their peers looked after by other authorities. Extensive analysis and a detailed improvement plan have led to a reduction in the number of times children move placements, and local performance indicators are now closer to the England rate. Following internal and external evaluation, improving how children in care influence the design and delivery of services is a local priority, and in line with national policy, Havering is focusing on improving the timeliness and experience of achieving permanency for children in care.

⁵ Figures rounded to nearest 5 children

Children's mental health

Using national prevalence rates, an estimated 3,275 children aged 0-16 and resident in Havering have a mental health disorder sufficient to cause distress to the child or have a considerable impact on the child's day to day life. Estimates suggest there are 1,947 children with a conduct disorder, 1252 with an emotional disorder and 504 with a hyperkinetic disorder in Havering (some disorders will occur concurrently).

Over 2012-13, NELFT's Child and Adolescent Mental Health Service (CAMHS) provided tier 2 and 3 services to 2065 individuals, with emotional disorders accounting for the majority of primary presentations. Although at a national level conduct disorders are the most prevalent mental health disorder, they accounted for a small number of primary presentations to Havering CAMHS (NELFT) in 2012-13. CAMHS services are heavily skewed towards secondary-aged children, with the 11-17 age group accounting for 64.3% of service users. **Very few referrals to CAMHS were made directly by universal services, with the majority of referrals made by GPs.**

The rate of hospital admissions for self-harm or mental health disorders can be an indication of the effectiveness of local CAMHS provision. In 2011/12, Havering's rate of admissions for mental health disorders per 100,000 residents aged 0-17 was lower than the England rate but higher than Bexley (our closest statistical neighbour). Havering was in the second quintile of performance (lower is better) for admissions due to self-harm, compared to all England authorities.

Healthy weight

In 2012/13, **approximately one in five reception-aged children in Havering were overweight or obese (21%);** this is slightly below the England (22.3%) and London (23%) average. **This figure rises to 35% for children aged 10-11** (above the England (33%) and below the London average (37.4%)). Data available for the first time in 2013 shows that the **rate of obesity increased by 8.7% for children who were reception-aged and measured in the first year of the National Child Measurement Program and who were measured again in 2012/13 as Year 6 pupils.** For children aged 4-5 and 10-11 years, **obesity in Havering is positively correlated with measures of child poverty and child deprivation** (i.e. higher rates of poverty and higher rate of obesity are associated) **and negatively correlated with educational attainment** (i.e. higher rates of obesity and lower rates of educational attainment are associated), particularly at key stage 4.

School attainment

In 2013, rate of attainment for benchmark measures were above national levels in the early years foundation stage and key stage 2. For key stage 4, the rate of children achieving 5 A*- C grade GCSEs fell below the national average, but was above the national average for both the rate of children achieving 5 A*-C GCSEs including English and maths and the rate of children making the expected progress between KS2 and KS4. At KS2 and KS4, children with English as a second language or with mixed, Asian or black heritage were more likely to achieve educational benchmarks than their England peers. However, **good overall rates of achievement mask particular disparities in the attainment of children eligible for free school meals (an indicator of low household income), with an identified SEN and children in care.** Rates of attainment at borough-level mask significant variation in attainment patterns at ward level.

At primary level, the gap between the proportion of children eligible and those not eligible for free school meals achieving level 4 in English and maths increased over 2010-2013 from 14% to 23% points. Compared to other authorities, Havering is now ranked 102/152, a drop from a 2010 ranking of 10/152 (lower is better). This is a consequence of the proportion of pupils who are not eligible for free school meals improving their attainment at a faster rate than the national average and is compounded by the rate of attainment for pupils eligible for FSMs, which while improving year on year, is at a slower rate than other local authorities. The attainment gap is more pronounced for girls; on this measure Havering ranks 130/152 authorities (lower is better) with an attainment gap of 25% points in 2013.

For secondary pupils achieving 5+ A*-C grades including English and maths at GCSE level, the gap between the rate of attainment for those eligible for free school meals and those not eligible narrowed over 2008-2012, but widened in 2013, increasing by 9.5% points to 30.1% points. This is a consequence of the attainment of children not eligible for free school meals increasing by 2.6% and the attainment of child who are eligible for free school meals falling 6.9% points to 35.8% and consequently below the England average for the first time since 2008.

Post 16 outcomes

Overall, **young people in Havering are consistently more likely to have a level 2 or level 3 qualification at age 19 than their peers across England, and are more likely to be in education, employment or training.** However, the historic relatively high rate of pupils eligible for free school meals achieving 5+A*-C GCSEs including English and maths at 16 has not translated to the rate of

young people achieving a level three qualification by the age of 19. However, the two populations measured in each of these benchmark performance measures (i.e. at age 16 and age 19) are different: performance at age 16 is based on pupils attending Havering schools, whilst at age 19 it is based on residency. **Apprenticeship success rates in Havering at both Intermediate and Advanced level have been below the England average since 2009 although the growth rate of apprenticeship starts in Havering has been much higher than that seen nationally in each of the last two years**

Reader notes

A Joint Strategic Needs Assessment (JSNA) is the name given to the process of identifying the health and well-being needs of an area. This draft children and young people's JSNA chapter considers parental, environmental and demographic factors that impact on health and wellbeing needs of children residing in Havering and is jointly owned by the London Borough of Havering (LBH) and Havering Clinical Commissioning Group (HCCG). Each section provides details of outcomes indicators across age ranges (early years, primary, secondary and post-16) and shows data around local inequalities in children's outcomes. Where possible, insights to how local people feel about the issue are included.

Comparative data is referenced throughout in order to provide a relative profile of Havering. Statistical neighbour comparisons have not been used for two reasons. Firstly, statistical neighbours are defined by 2001 census information; new statistical neighbour groupings based on 2011 census data will be made available later in 2014. Secondly, any comparison with statistical neighbours needs to be based on a weighted average in order to account for variations in population between statistical neighbours. Weighted averages are more resource intensive calculations as they require the population for the cohort under consideration to be identified for the year in question. Children's services statistical neighbours are different to the ONS comparators referenced in the demographics chapter. Havering's statistical neighbours are set out in Figure 1

Rank (1=closest)	Local authority	"Closeness"
1	Bexley	Extremely Close
2	Essex	Very Close
3	Medway	Very Close
4	Kent	Very Close
5	Swindon	Very Close
6	Thurrock	Very Close
7	Bury	Very Close
8	Solihull	Very Close
9	Stockport	Very Close
10	Staffordshire	Very Close

Figure 1: Havering's children's services closest demographic neighbours

Public consultation on local priorities was conducted over July – Sept 2013. This involved an online survey both for children and adults and was widely publicised. Accessible group sessions were held with younger children and those with additional needs to help obtain the widest possible range of views. The views of children, young people and local adults on local priorities for children are incorporated throughout this paper, and are briefly summarised overleaf. Professional stakeholder consultation was conducted over 25th November - 16th December 2013. Commentary was received from a range of organisations; these are listed in appendix one.

Where the count of individuals is recorded within a dataset as between 1-5, data is suppressed to maintain confidentiality and marked as 'x'.

Analysis of young people's sexual health is not included here as this will be incorporated into the Sexual Health chapter. Similarly, analysis of accident and emergency attendances and hospital admissions are incorporated within the forthcoming Healthcare chapter.



Priorities of local children and their families

Each year young people around the UK aged 11-18 are asked to vote on a shortlist of fifteen potential priorities for the UK Youth Parliament, with the top five issues being debated at the UK Youth Parliament House of Commons sitting. Over 440,000 young people took part in the 2013 'Make Your Mark' campaign, including **2182** young people from Havering. The top five issues as voted for by young people in Havering are shown to the right, and focus primarily on post 16 employment, education and training opportunities.

In a separate 2013 survey, 301 children and 308 adults told us their top three priorities for local services and the youth council, as follows:

	Children's priorities (sample 301)	Adults priorities (sample 308)
Priority 1	Staying safe and crime free	Staying safe and crime free
Priority 2	Our future – life after year 11	Improving children and young people's education
Priority 3	Access to sport, social and leisure opportunities	Their future - life after year 11

Each of these topics is analysed within this needs assessment, with further detail on the views of children their families as it relates to each of these priorities

'Make Your Mark' 2013 shortlist

1. Every school pupil should have the opportunity to participate in **better work experience** for a minimum of one week in a field of their choice, as well as access to opportunities linking them to professionals to help inspire
2. To **combat youth unemployment** we believe that every local authority that faces youth unemployment rates of 20% or more should have to put into place a strategy for tackling this problem that includes investment in jobs, apprenticeships and internships
3. 16 and 17 year olds are, by law, able to make complex decisions and take on wide ranging responsibilities. It is time to give **votes for 16 & 17 year olds in all public elections and referendums**
4. **16 to 19 bursary fund.** Young people need better financial support to stay in education making sure that funds cover the vital costs
5. The national minimum wage should be raised in line with the **living wage** in order to guarantee workers the decent standard of living they deserve

Children and family demographics: headlines from demographics chapter

A complete analysis of recent and anticipated changes to Havering's demographic is provided within the Havering Joint Strategic Needs Assessment - Demographics Chapter. Key findings from that chapter that relate to children and families are set out below, and developed overleaf.

Pre school children

In 2001, pre-school age infants (aged 0-4 years) accounted for 5.52% (12,415) of the population. This has increased by 10% to make up 5.76% (13,661) of the population in 2011.

The growth in this age group was smaller in Havering than that for London 24% and England 13%.

The Greater London Authority (GLA) **forecasts this age group to increase by 15.2% (additional 2,100) from 2011 to 2016 and by 18.8% (additional 2,600) from 2011 to 2021.**

Primary school age (5-10) children

- The population aged 5-10 years accounted for 7.8% of the population in 2001. This saw a decline in 2011, and accounted for 6.7% of the population.
- The decline in this age cohort is in line with that of England. However, there was an overall increase in London of 5.93%.
- The GLA forecasts this age group to **increase by 10.6% (additional 1,700) from 2011 to 2016 and by 24.4% (additional 3,900) from 2011 to 2021.**

Secondary School age (11-17) children

- The population aged 11-17 years accounted for 8.9% of the population in 2001. There was no proportional change in 2011.
- Although this age group accounts for the same proportion of the population, the numbers increased from 20,161 in 2001 to 21,269 in 2011.
- The increase in this age cohort is in line with that of London, but much higher than that for England
- The GLA forecasts this age group to **decrease by 7.1% (less 1,500) from 2011 to 2016 and increase by 0.5% (additional 100) from 2011 to 2021.**

Details of the changing ethnic profile of children resident in Havering, or attending school in Havering can be found in the demographics chapter.

Children and families in Havering: where do they live?

Over 2001-2011, the 0-17 resident population increased by 3.6% but this was not uniform across wards. Seven wards had declining numbers of child residents, while the numbers of children residing in Brooklands, Heaton, Romford Town and South Hornchurch increased by 17% overall.

Over 2001-2011, the number of children in Havering grew by 1,798 (3.6%) from 49,840 to 51,638. This increase in the number of children was not as great as Havering's overall population growth rate of 6%. A more marked change is in the profile of where children and families live within Havering and the age of the children in those families, as described above.

Headline changes between the 2001 and 2011 census

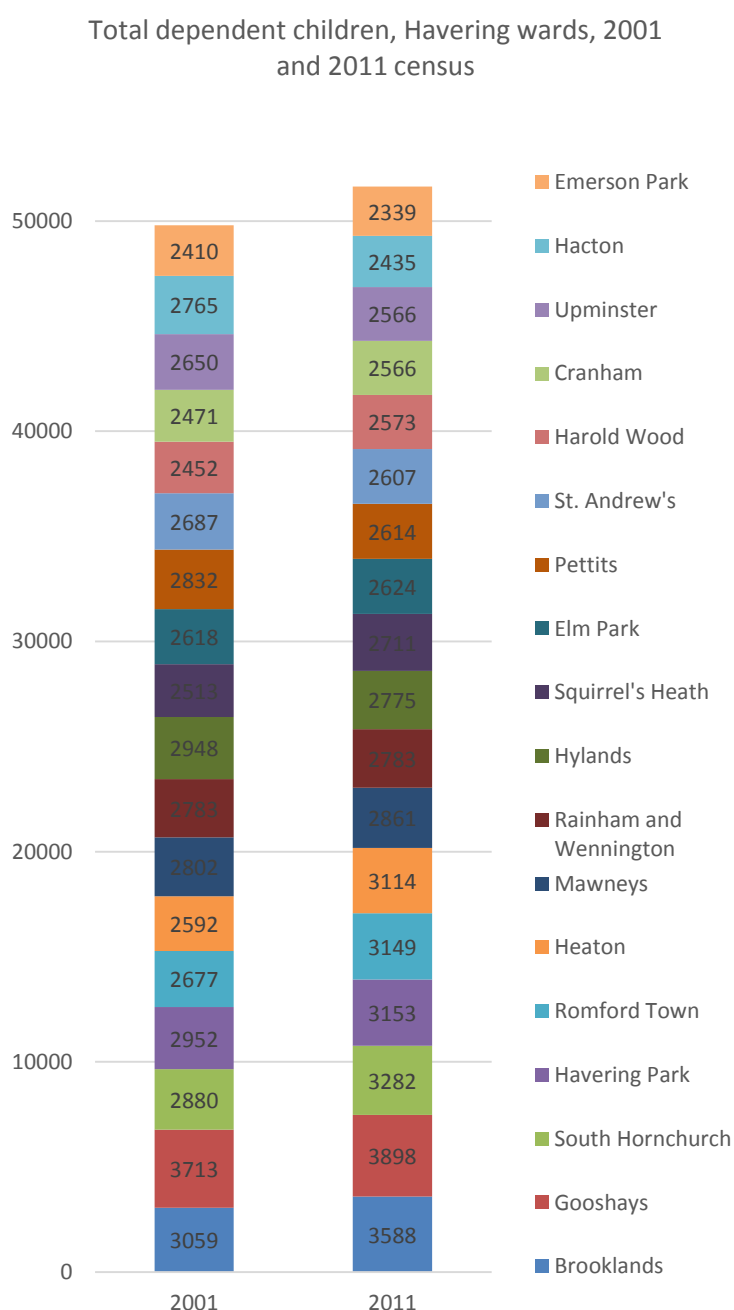
The numbers of children residing in Brooklands, Heaton, Romford Town and South Hornchurch increased by a total of 1,925.

There was a total reduction of 992 children living in Rainham and Wennington, Emerson Park, St. Andrew's, Upminster, Hylands, Pettits and Hacton collectively between the 2001 and 2011 censuses, despite Hacton being the only ward to show a decrease in overall population over this period.

At the time of the 2011 census, Gooshays remained the ward with the highest numbers of children, followed by Brooklands. 21% of all children in Havering live in Gooshays, Brooklands or South Hornchurch.

Although Romford Town has the greatest overall population growth rate (21%), Heaton had the largest growth rate for child residents (20.1%). Romford Town has seen an increase of 17.6% and is now the 5th most child-populated ward (Figure 2).

Children were increasingly concentrated in the far north and east of Havering (Heaton, Brooklands, Romford Town), while reductions in the number of children were focused in the centre of the borough (St Andrew's, Hylands and Hacton).



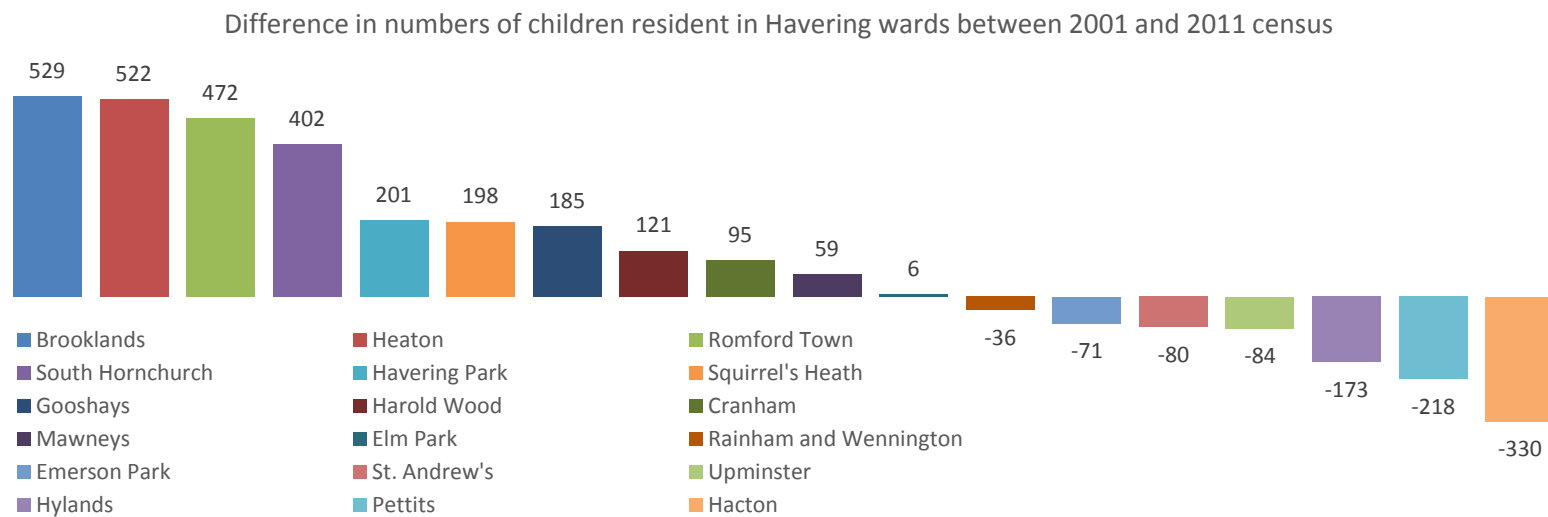


Figure 2: Difference in numbers and percentage of children resident in Havering wards between 2001 and 2011 census

Household composition

At the time of the 2011 Census, 'young' families (i.e. where the youngest child was aged 0-4) were most prevalent in Romford Town and Brooklands; Gooshays and Heaton had a greater proportion of large, young families. Between 2001 and 2011 there was a 26.8% rise in one adult households with children (+1074 households).

Households change rapidly according to migration, births and deaths. The 2011 Census provides the most up-to-date and detailed assessment of the structure of Havering's households. In 2011, there were 5,079 one-parent households in Havering with children under 16; this is an increase of 1,074 (+27%) from 2001. Lone parents experience a diversity of circumstances (including those who had never had a permanent partner and those who were separated, divorced or widowed). However, at a national level, unemployment is higher amongst lone parents than other family types. Consequently, the children of lone parents are more likely to live in poverty than children in a two parent family. The number and proportion of two-parent households has remained broadly similar between the two census dates (Figure 3).

Figure 3: Distribution of household compositions in Havering by census years

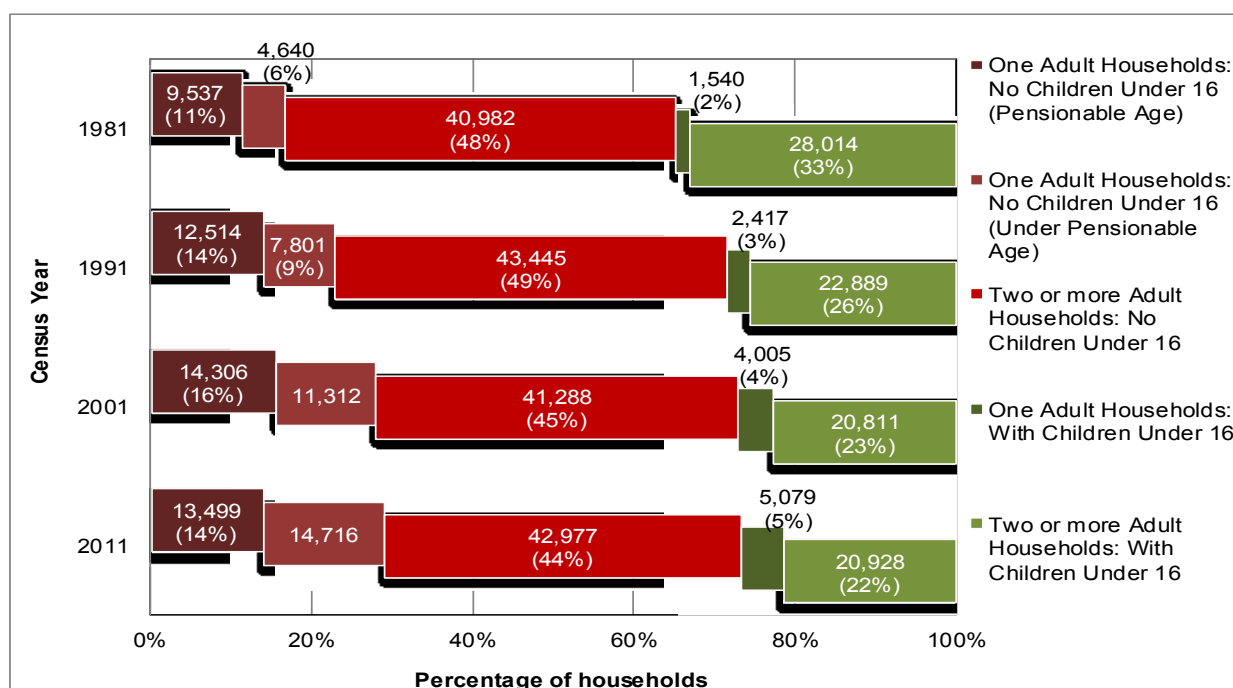
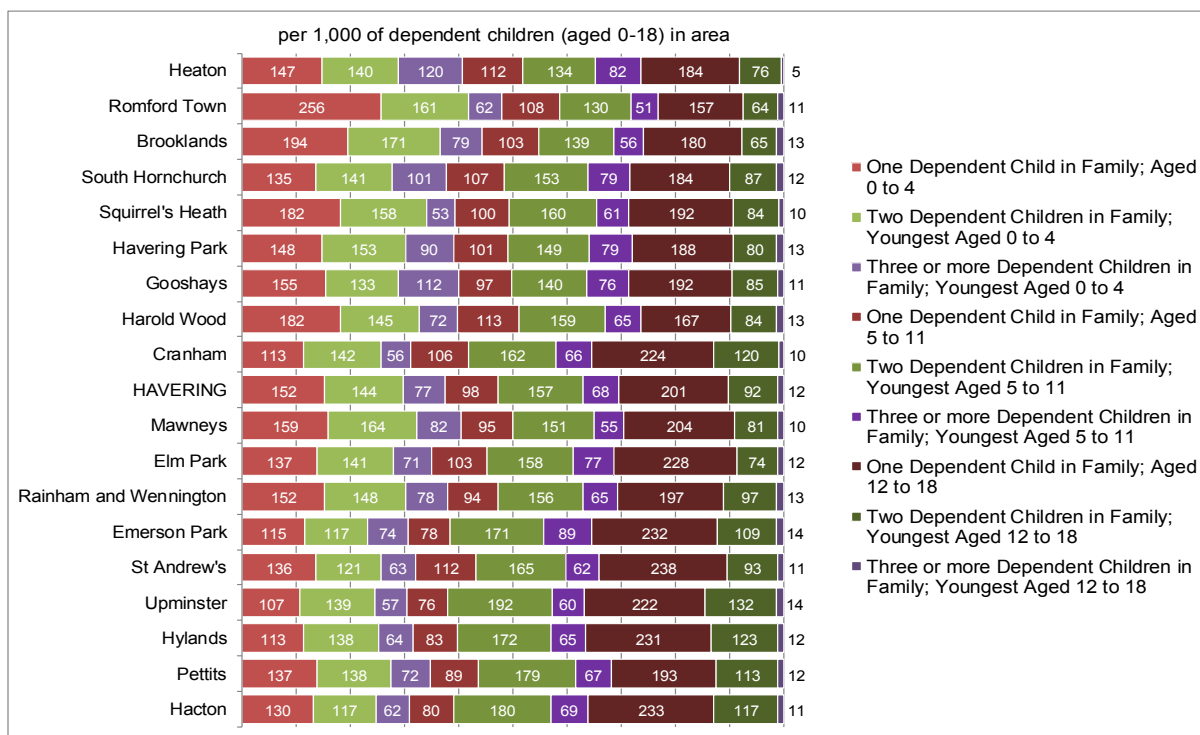


Figure 4 shows the distribution of total dependent children by the youngest age group and number of children in the family at the time of the 2011 Census.

- 'Young' families (i.e. where the youngest child was aged 0-4) were most prevalent in Romford Town and Brooklands. Brooklands also has the highest number of children in the borough.
- Gooshays and Heaton tended to have a greater prevalence of large, young families compared to other wards (i.e. where there are three or more dependent children and the youngest is aged 0-4). Gooshays had the second largest child population in Havering.

Older families (i.e. where the youngest child is aged 12-18) had greater prevalence in Upminster, Hylands, Hacton, Emerson park and Cranham. These wards have the lowest overall numbers of children living there, with the exception of Hylands.

Figure 4: distribution of total dependent children (aged 0-18), by the number and youngest age group of dependent children in their families, Havering and its wards, 2011



Considerations for commissioners and service providers

Increasing numbers of children in the north and east of the borough and decreasing numbers in Rainham and Wennington, Emerson Park, St. Andrew's, Upminster, Hylands, Pettits and Hacton has implications for demand for a range of universal services, including health visitors, school places and early years provision.

To understand how the school population may be changing, analysis of in-year school admissions should consider the rate of children eligible for free school meals within this cohort and the profile of deprivation from the LSOAs from which they are moving.

The increased prevalence of lone parent households is likely to heighten the demand for accessible and affordable childcare to support lone parents into work and reduce child poverty.

As a consequence of associations with poverty, the concentration of large families in particular wards has implications for locality-based service demand, including but not limited to demand for larger family homes, social care and health provision in those areas.

During consultation, some LB Havering service providers reported that access to live birth data by ward (including premature and low weight births) and health visitor screening data would support planning for locality-based early education inclusion services, special educational provision and children's centres.

Child poverty

Compared to all England authorities, Havering has a relatively low rate of children living in workless households and a slightly lower average rate of children entitled to free school meals. However, as measured by the Income Deprivation Affecting Children Index, in 2010 around 8,800 children aged 0-16 and resident in Havering lived in income-deprived households and the pattern of workless households and deprivation affecting children is not uniform across the borough.

At a national level, the following groups of children are more likely to reside in relatively low income households compared to the overall population:

- children in **workless families**
- children living in **single parent households**
- children in families with **three or more children**
- children in households with **no savings**
- children from **certain ethnic minority groups**, particularly Pakistani or Bangladeshi
- children born to **teenage parents**
- children living in **households with disabled children or disabled parents, or where they themselves are disabled**
- children growing up in **social housing or temporary accommodation**
- **traveller and gypsy children**
- children whose **parents are seeking asylum**

Each of these factors can be compounded by local factors, including the sufficiency and adequacy of local childcare and local economic conditions. At the start of the 2000s there were around 630,000 children in poverty in London, which fell slightly to 600,000 ten years later. However, more children in poverty live in working families than before (up from 230,000 to 370,000) and fewer are in workless families (down from 400,000 to 230,000); **across London, over half of all children in poverty live in a household where someone is working.**

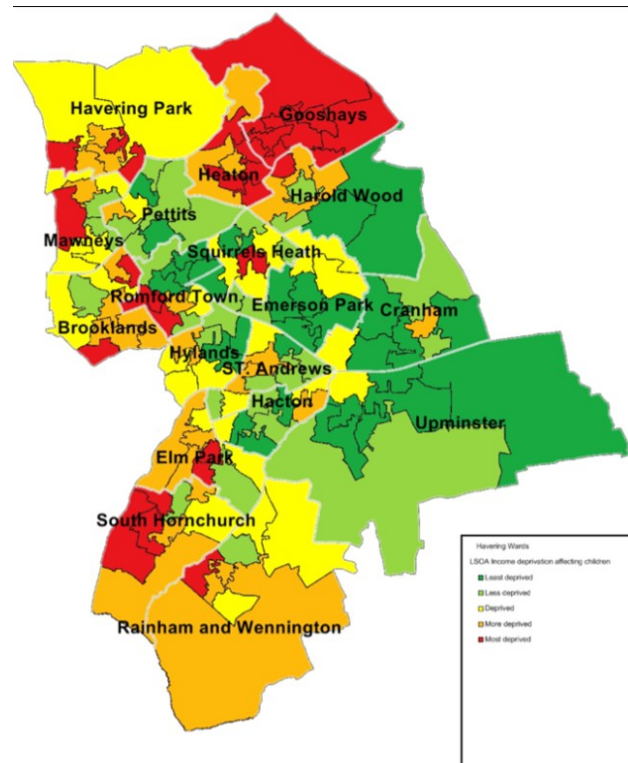


Figure 6: LSOA income deprivation affecting children, (2010)

The most recent accepted measures of poverty are based on 2010 and 2012 data. The Income Deprivation Affecting Children Index (IDACI) measures the proportion of children under the age of 16 that live in low income households⁶. The Index of Multiple Deprivation takes a broader view of deprivation and covers all residents⁷. In 2010, mapping of income deprivation affecting children (

) largely corresponded with the 2011 overall deprivation score (Figure 6) with some exceptions, including increased deprivation affecting children in some LSOAs within Rainham and Wennington, Squirrels Heath, Elm Park Heaton, Havering Park, Romford and South Hornchurch. Some LSOAs in the Harold Wood and Pettits areas had lower levels of children's deprivation against the broader deprivation measure.

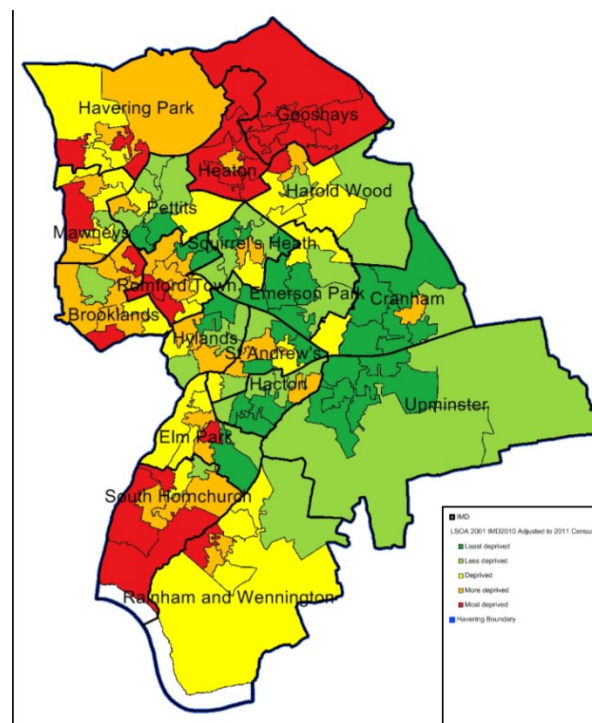


Figure 5: Index of Multiple Deprivation: local quintiles, 2011 census

⁶ Expressed as the proportion of children living in households who are dependent on certain means-tested benefits. The benefits included in the count are Income Support, Income Based Job Seekers Allowance, Pension Credit and Child Tax Credit, along with asylum seekers receiving support.

⁷ Domains include income deprivation; employment deprivation; health deprivation and disability; education deprivation; crime deprivation; barriers to housing and services deprivation; and living environment deprivation.

Central government also publishes the numbers of children in workless households as a proxy indicator of poverty. In 2012, there were 4861 children in Havering living in a household where no adult household member worked (11.6%)⁸. This is a comparatively low figure against all England authorities (Figure 7).

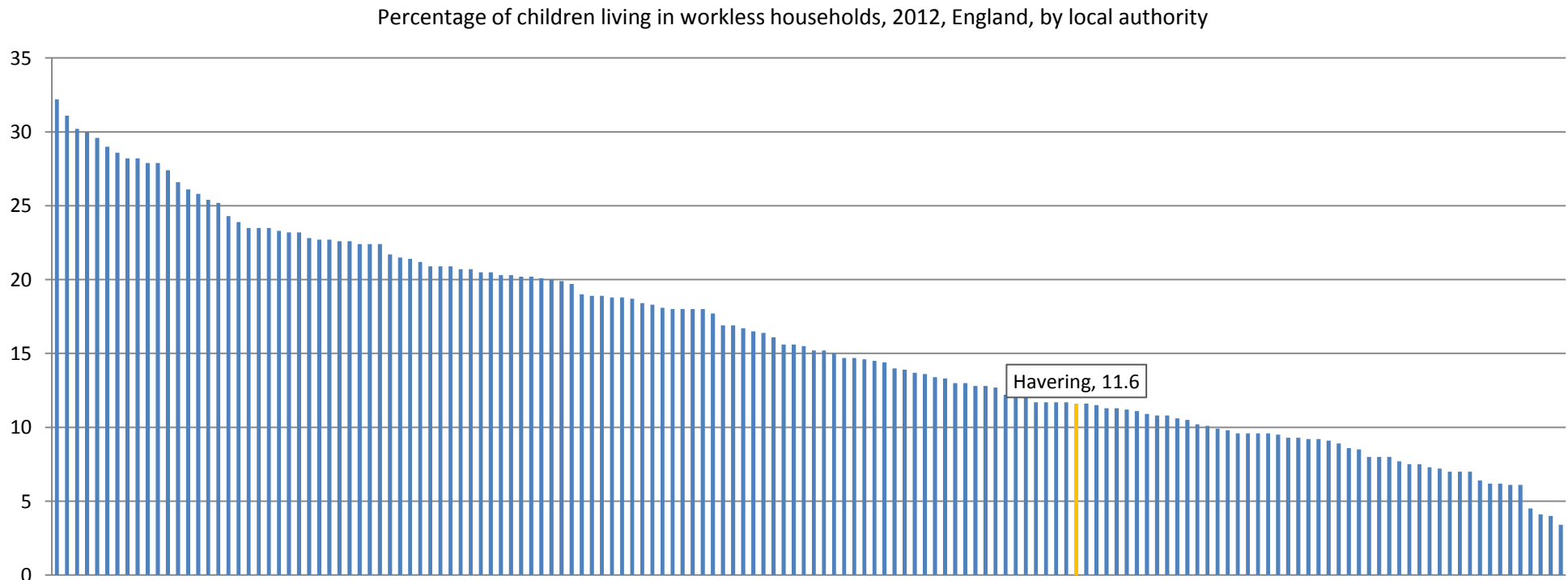
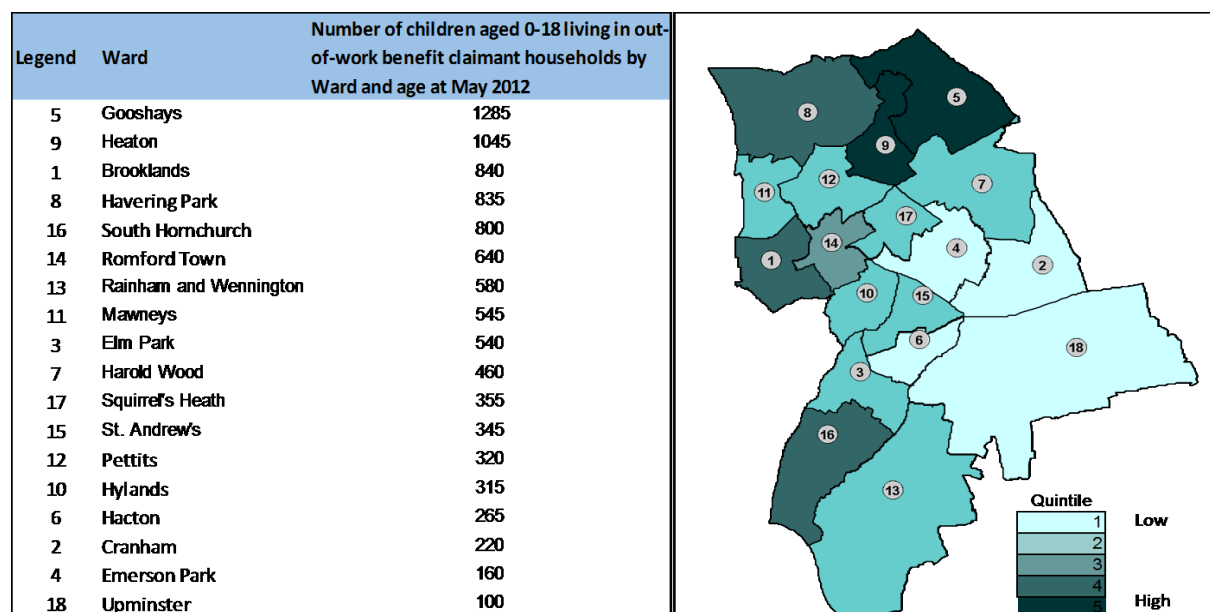


Figure 7: percentage of children living in workless households, 2012, Havering and all England local authorities

⁸ Annual Population Survey Household datasets. Figures should be used with caution, and to illustrate a broader picture; many of the estimates are not considered reliable for practical purposes

Concentrations of children living in workless households vary considerably across Havering. Heaton, Gooshays, Havering Park and South Hornchurch had the highest **rate** of children aged 0-17 living in workless households in 2012⁹, varying between 335.6 and 243.8 children per 1000. Rates in Hacton, Cranham, Emerson Park and Upminster were substantially lower, at between 39 - 108.8 children per 1000 in workless households.

The ward map below shows the **number** of children living in workless households; 50% live in Gooshays, Heaton, Brooklands, Havering Park or South Hornchurch. These areas account for 32% of the overall 0-18 population¹⁰. The highest numbers of children aged 0-4 living in workless households live in Gooshays, Brooklands and Heaton, whereas for ages 5-10, Brooklands, Rainham and Wellington and Gooshays have the highest numbers.



Children living in workless households: <u>rate</u> per 1000 children aged 0-17	
Heaton	335.6
Gooshays	329.7
Havering Park	264.8
South Hornchurch	243.8
Brooklands	234.1
Rainham and Wennington	208.4
Elm Park	205.8
Romford Town	203.2
Mawneys	190.5
Harold Wood	178.8
St. Andrew's	132.3
Squirrel's Heath	130.9
Pettits	122.4
Hylands	113.5
Hacton	108.8
Cranham	85.7
Emerson Park	68.4
Upminster	39.0

⁹ Based on 2011 census figures for those wards

¹⁰ Published by DWP Information Governance and Security Directorate, October 2013.

Child poverty and the pupil population

Children receive free school meals (FSMs) if their parent(s) claim some types of state support payments¹¹ and have registered for FSMs. The prevalence of children eligible for and claiming FSMs in Havering schools provides an indication of how many children in Havering schools come from low income households. This population is different to the resident population.

In January 2013, 14% (n=5084) of pupils in Havering schools were eligible for and claiming free school meals. This rate varies considerably across provision. For every type of school listed (below), the proportion of pupils eligible for and claiming free school meals is lower in Havering than in Outer London or England. At both a national level and in Havering, pupils attending special schools or pupil referral units are more likely to belong to families where income is low.

	Number known to be eligible for and claiming free school meals in Havering (January 2013)	Havering: % pupil population known to be eligible for and claiming FSMs	Outer London: % pupil population known to be eligible for and claiming FSMs	England: % pupil population known to be eligible for and claiming FSMs
Maintained nursery and state-funded primary schools	3,071	15.4%	19.2%	18.1%
State-funded secondary schools	1,890	11.5%	17.8%	15.1%
Pupil Referral Units	37	33.9%	34.6%	39.6%
Special Schools	86	33.7%	38.1%	36.7%
TOTAL	5,084	14%	19%	17%

A DfE report on '[Pupils not claiming free school meals](#)' (2012) used HMRC benefits (December 2011) and School Census (January 2012) data and identified 1300 Havering pupils who were entitled to free school meals but not claiming them. At local authority level under-registration rates (i.e. pupils not claiming FSM as a proportion of entitled pupils) ranged between 0% and 33%. Havering had a comparatively high rate at 22%; this is higher than the England (14%), Inner London (9%) and Outer London (17%) averages. Analysis at a national level has shown that pupils with the following characteristics have a lower likelihood of claiming FSMs:

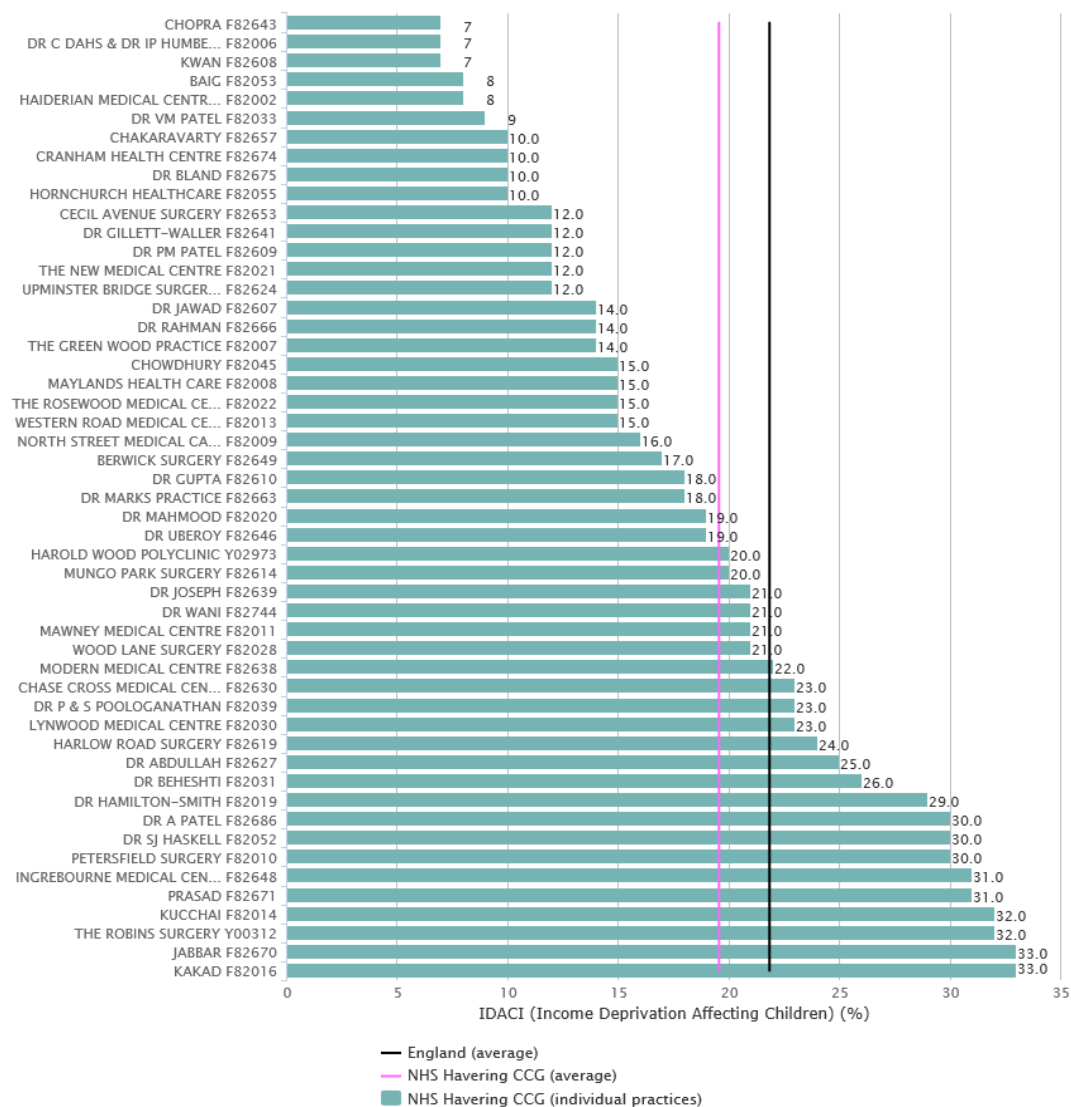
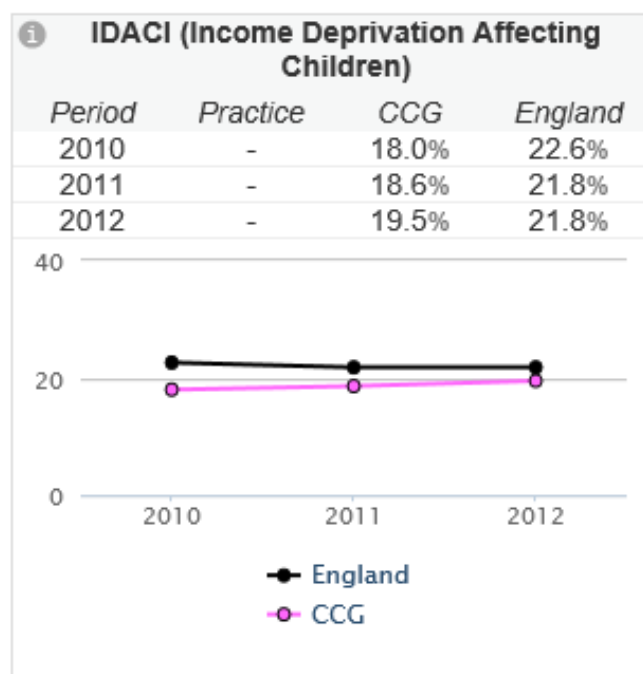
¹¹ Including universal credit, job seekers allowance and some forms of tax credit

- pupils living in a less deprived area
- pupils attending schools with a lower FSM rate
- pupils from families with higher status occupations
- pupils living in a family with higher parental qualifications; and
- pupils of Chinese ethnic origin

In addition there is some evidence to suggest that families entitled to FSMs while in part time work are less likely to claim FSMs than those on out-of-work benefits. National-level data also shows that the under-registration rate for primary and secondary aged pupils is the same, therefore demonstrating that there is not a FSM issue in terms of older pupils not wanting to claim FSM. The exception to this is pupils aged 15, where there is a bigger disparity between entitled and claiming FSM pupils, with 20% of pupils entitled to FSM not registering to claim, the highest amongst all age groups.

Child poverty and the GP registered population

Children registered with Havering GPs are not necessarily Havering residents (although the vast majority are); Havering's Clinical Commissioning Group is responsible for commissioning services to the GP registered population. Applying LSOA level IDACI 2010 data proportionally to Havering's GP practice gives a deprivation rate of 19.5% for 2012, but with a wide range across practices, from 7%-33%. There will be large variances in the patient age profile for across GP practices, therefore small numbers may cause large proportional variations.



Children and housing

Overcrowded and unsuitable houses are linked with poorer outcomes for children, including increased risk of accidents, respiratory problems, increased risk of certain infection and limited space to complete homework. Two UK studies focusing on children under the age of five found a correlation between overcrowded housing conditions and heightened risk of contracting meningitis, and children living in damp, mouldy homes are more prone to asthma attacks and other respiratory conditions than children living in dry homes. However these correlations are not necessarily causal and may be related to poverty and other socio-economic factors. Homeless children can be particularly disadvantaged because of the disruption to their schooling.

In Havering, an average of 214 homelessness decisions were taken over 2011/12 and 2012/13 on households that include one or more dependent child. This does not include homeless 'approaches' to the Council, rather cases where an investigation has been carried out and a formal homelessness decision reached. Decisions include whether the household is 'intentionally' or 'unintentionally' homeless. In Havering, the number of families being found intentionally homeless increased from 37 (17%) to 55 (25%) over 2011/12 - 2012/13, although small numbers will cause large fluctuations in proportions.

As at 30th September 2013, there were 683 households in Havering with dependent children who said they lacked one or more rooms to meet their needs, based on housing applications where the applicant claims to require one or more additional rooms. This includes only households with a current housing application and therefore the actual figure will be higher¹³.

Homelessness decisions on households that include a child or children, Havering			
	2011-12	2012-13	2013-14 (Q1 & Q2)
Intentionally homeless	37 (17%)	55 (25%)	16 (26%)
Unintentionally homeless	175 (83%)	162 (75%)	45 (74%)
Total	212 (100%)	217 (100%)	61 (100%)

Overcrowded households containing one or more under 18 dependents, based on housing applications where the applicant claims to require one or more additional rooms				
	Council	Private Housing Solutions	Other ¹²	Total
Lacking 1 room	299	69	147	515
Lacking 2 or more	8	1	159	168
Total	307	70	306	683

¹³ There are a further 120 cases where the number of bedrooms in the applicant's current property is unknown. Applicants are currently residing in private rented, housing association or family and friends accommodation

Impact of welfare reform on child poverty

Many households with children have had their income from benefits and tax credits reduced through welfare reform measures, including the recovery of payments on a sliding scale via income tax from people earning over £50,000, and the cessation of the Child Trust Fund, Health in Pregnancy Grant, Sure Start maternity Grant and the baby element of child tax credit. The amount of childcare costs covered by working tax credit has also been reduced from 80% to 70% and most couples with children now required to work at least 24 hours a week (previously 16) to qualify for working tax credit. The uprating of many benefits has been limited to 1%. This applies to Local Housing Allowance, Employment Support Allowance, Income Support, Child Benefit, Child Tax Credits and Working Tax Credits. However, disability benefits and Carers Allowance continue to be uprated in line with inflation. More recent or imminent key changes impacting on the amount of benefit payments households with children receive include:

Benefit capping: this restricts the total amount of support received by any one household to £500 a week for families with children. The cap is administered via changes in Housing Benefit payments until claimants move to Universal Credit (UC). Exemptions include pensioners, anyone in receipt of Disability Living Allowance (DLA), and anyone working over 16 hours per week. Nationally, of the 25,508 households subject to a benefit cap as at October 2013, 96% (24,550) include children, with single parent with child dependant households accounting for 60.5% of all households affected by the benefit cap¹⁴. 75% of households were capped by £100 or less.

Under occupation charges: the extension of size eligibility criteria to social housing reduces the level of support for families in social rented housing if they are deemed to have an extra bedroom. One bedroom is allowed per couple, adult or young person (aged 16+), two children of the same gender, or two children of a different gender if under 10 years old, and per resident carer. The rent reduction impact is 14% if under-occupying by one bedroom and 25% if under-occupying by two bedrooms or more. Approved foster carers are exempt from this policy so long as they have fostered a child, or become an approved foster carer in the last 12 months.

Universal credit (UC): rollout has been delayed but its impact on families could be significant. This restricts the total amount of six common benefits received by any one household to £500 a week for families with children and £350 for single people. UC is payable on a monthly basis, in arrears, directly to people both in and out of work. It will be paid to just one person in a household. UC is to be 'digital by design' with the government aiming for 80% of applications to be made online. However, phone and face-to-face services will be available to those who need them.

Changes to community care grants, crisis loans and council tax benefit: in April 2013, funding for Community Care Grants, Crisis Loans for living expenses and Council Tax benefit transferred to local authorities to establish local schemes of provision. This results in different levels and types of support, as well as eligibility criteria, between areas. Havering was one of 11 London boroughs who chose not cut council tax benefit for workless households.

¹⁴ Department for Work and Pensions, [Benefit Cap – number of households capped, data to October 2013, GB](#)

Disability Living Allowance (DLA): DLA is to be gradually replaced by the Personal Independence Payment (PIP). The budget for PIP will be 20% less than DLA. Government impact assessments with regard to current claimants of DLA estimate that 30% of these will not receive an award, 28% will receive a reduced award and 41% will remain either unaffected or will receive an increased award. Pensioners and children are to retain their DLA at existing rates. However, children in households where there is an adult claimant of DLA will be affected.

‘Troubled families’

The Troubled Families (TF) programme is a national initiative that recognises that there are households with complex and multiple needs that require significant resources from central and local government to address them. Families that receive targeted support as part of the TF cohort are those with a combination of risk factors, including children with a high level of school absence, children who have been excluded from school or who attend a pupil referral unit, families showing anti-social or offensive behaviour, and those with unemployed parents. In addition, councils are allowed to add local criteria based on local issues, and in Havering these include domestic violence, substance abuse and mental health issues. Although housing issues and the impact of the Welfare Reform Act 2012 do not form part of the national suite of the Government’s TF criteria, 159 (51%) of households who meet TF criteria reside in some form of social housing. For this reason, Havering’s Family Intervention Project works closely with housing services and the housing benefit team to ensure that they have early intelligence of the build-up of arrears and action being taken to recover properties, especially where large number of children are involved, in order to put effective support measures into place.

Considerations for commissioners and service providers

The benefit cap is expected to disproportionately impact on families with children with larger families as a consequence of the impact on Child Tax Credits. As Gooshays and Heaton have a comparatively high number of children live in workless households and a higher proportion of larger families, children in these boroughs are likely to be disproportionately affected.

Welfare reform may have implications for increased levels of homeless families. The benefit cap, restricting families’ benefits to £500 a week, has no exemption for temporary accommodation. If families are accepted by Havering as homeless, the dilemma of finding affordable accommodation below the cap falls to the authority.

There is potential for increases in rent arrears and personal debt as benefits are reduced and future uprating is pegged lower than inflation. Families at risk will need information, advice and guidance on how to make applications for discretionary housing payments and Havering’s local welfare assistance schemes and of the risks associated with the use of loan sharks / payday lenders. LB Havering actively supports the Liberty Credit Union, a community-based savings and loans organisation, open to anyone who lives or works in the boroughs of Havering or Barking & Dagenham. The union is authorised and regulated by the Financial Services Authority and offers a savings account and low-cost loans to members.

Some areas, particularly those within Inner London, are likely see to lower-income families move out as families attempt to find affordable rents. Havering has the second lowest median and average private rent rates across Greater London. Families who move to Havering seeking more affordable housing may be further away from their established support network; their children may have longer school journeys, or will apply for a place at a local school; and parents may have to travel further to get to work. This movement may prove challenging to services, such as school admissions, and services that work direct with clients with already chaotic lives. It will also potentially see a concentration of low earners/benefits claimants in what are already relatively deprived areas, with high unemployment and few job opportunities. Increased demand for private-rented accommodation in Havering may affect limit the availability and affordability of privately-rented family homes. More detailed local analysis of the impact of welfare reform of local children and families is underway.

Havering's child poverty strategy is due to be refreshed; this strategy will need to be built on the assessment of drivers of child poverty as identified within this chapter and the wider JSNA, including parental worklessness, low paid work, affordable childcare, levels of adult education and housing need. In common with most local authorities, there is a lack of reliable data on overcrowding in the housing stock in the private rented sector and up-to-date data on child poverty proxy measures is limited. Havering's revised child poverty strategy will need to develop a multi-agency approach to supporting families to manage and maximise their income (for those both not in work and in work); raise aspirations; access flexible and appropriate employment opportunities, and childcare.

Maternity and birth

Readers should refer to the demographics chapter for detail on historical and projected fertility rates.

Smoking in maternity

In Q1 and Q2 2013/14, 11.5% of pregnant women in Havering were smokers. This is the highest rate in London but broadly in line with the England average. The proportion of women who smoke in pregnancy in Havering increased over 2005/6-2011/12 but declined to 11.5% for both Q1 and Q2, 2013/14.

Smoking during pregnancy increases the risk of complications during pregnancy and labour, including miscarriage. Women who smoke, or who are exposed to second-hand smoke, while pregnant are more likely to have a baby with a [low birth weight](#) than non-smoking mothers.

Smoking during, and after, pregnancy also increases the risk of sudden infant death ('cot death'). Smoking in pregnancy is a major contributor to higher [infant mortality](#) in the routine and manual socio-economic group in many regions of England compared with all (couple) births in England and Wales. It has been estimated that 57% of the gap in infant mortality between the routine and manual group in the East of England and all couple births in England in 2008/09 was due to smoking in pregnancy.

In Havering, the proportion of women who smoked during pregnancy rose steadily over 2005/6 – 2011/12 and dropped by 1.8% in 2012/13. The most recently available data indicates that Havering has a higher proportion of women smoking during pregnancy than the London and Bexley Care trust averages but is broadly in line with England and on target for the 'national ambition' rate of 11% by 2015. For both these quarters, Havering had the highest rate of smoking in maternity in London. Coverage rates are high (at least 98.3% for Havering and all comparators since 2007/8).

Smokers as % of all maternities, 2005/6 – 2012/13 (Q3) ¹⁵										
	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	
									Q1	Q2
Havering	6.6%	6.9%	10.2%	11.9%	13.5%	13.6%	14.8%	13%	11.5%	11.5%
England	X	15.1%	14.4%	14.4%	14.0%	13.5%	13.2%	12.7%	12%	11.8%
London	X	8.2%	7.1%	7.5%	7.3%	6.3%	6.0%	5.7%	4.7%	5%
London Suburbs	X	X	8.5%	8.1%	8.3%	7.3%	6.5%	6.3%	X	X
Bexley Care Trust	16.4%	15.7%	13.7%	15.2%	12.4%	12.5%	10.2%	9.8%	9.9%	9.4%

¹⁵ [Health and Social Care Information Centre](#), Lifestyle Statistics / Omnibus, benchmarking tool

Considerations for commissioners and service providers

Public health programmes work best when they are developed with a detailed understanding of the target population. The demographics of Havering women who smoking in maternity in Havering needs further analysis. Data on smoking in maternity by age, ethnicity and LSOA / ward of residency were not available for inclusion in this analysis but is needed to develop effective, targeted interventions.

Recent data on low [birth weight](#) was not available for inclusion in this analysis, but over 2006-2011 there does not seem to be a relationship between the increased proportion of women smoking in maternity over this period, and the proportion of low weight births¹⁶. Similarly, [infant mortality](#) rates are in line with comparators.

Preterm births

Access to local data on preterm births will support the commissioning and delivery of Havering's education, health and social care services to support children with additional needs. Nationally the rate of babies delivered and surviving preterm is rising.

Preterm birth is birth that occurs before 37 weeks of pregnancy. It usually follows spontaneous preterm labour. However, around 25% of women have a planned preterm birth induction of labour or planned caesarean section to avoid continuing risk to the mother or baby from complications of pregnancy.

Preterm birth is associated with a range of adverse outcomes for the baby. These include increased rates of perinatal death (see infant and child mortality), neonatal morbidity (including respiratory distress syndrome, intra-DRAFT ventricular haemorrhage and necrotising enterocolitis (an infection that can cause parts of the bowel to die) and long-term compromise. Long-term compromise tends to affect the neurological system (for example, cerebral palsy, lower educational attainment) and the respiratory system (for example, bronchopulmonary dysplasia). The risk of adverse outcomes occurring is inversely proportional to length of gestation. Therefore, infants born extremely premature (before 28 weeks) have significantly worse outcomes than those born moderately premature (34–37 weeks)¹⁷.

Spontaneous preterm birth has several possible causes. It is associated with intrauterine infection and in some women, preterm labour is associated with a known pregnancy-related risk factor such as antepartum haemorrhage, or multiple pregnancy. However, the mechanisms by which preterm labour and birth occur are not clearly understood. In the majority of women, there is no obvious cause. Maternal disease (for example, pre-eclampsia and diabetes) or fetal conditions (such as intrauterine growth restriction) can also prompt planned preterm birth (by induction of labour or planned caesarean section). The two strongest risk factors for preterm labour are low socio-economic status and previous preterm delivery.

¹⁶ Over 2006-2011 the percentage of low weight births fluctuated between 6.9%-7.6%

¹⁷ NICE (2013). Preterm labour and birth: draft scope for consultation. Available at: <http://www.nice.org.uk/nicemedia/pdf/IPCNICEGuidance.pdf>

In England there are around 54,000 preterm births each year, which represents approximately 8% of all live births. Most of these preterm births occur between 32 and 36 weeks, with around 13,500 (2%) births occurring before 32 weeks.

The EPICure2 study and the comparison with the EPICure1995 study are in press with the British Medical Journal. [Summary findings](#) published in advance of full publication show:

- Rates of preterm birth are rising in many European countries and are particularly high in the UK;
- That although more babies survived shortly after extreme preterm birth in England in 2006 compared with 1995, the number with major conditions on leaving hospital remained largely unchanged;
- Some improvement in the number of extremely preterm children who survived without disability at 3 years of age, but no change in the rate of serious health and developmental problems over the same 10-year period.

Considerations for commissioner and service providers

Data on preterm births was not available for inclusion in this analysis, but is needed to understand local trends and impact.

Extremely low birthweight children have more hospital readmissions and other health problems in the early years after discharge than do normal birthweight children. Respiratory illnesses, including lower respiratory infections, are the dominant cause for hospital readmission.

The survival rate of preterm babies is increasing and services should consider the prevention and management of likely risk factors in pregnant women, including:

- Genital tract infection
- Preterm rupture of the membranes
- Antepartum haemorrhage
- Cervical incompetence
- Congenital uterine abnormalities
- Antiphospholipid syndrome
- Diabetes mellitus

The associated complications of preterm delivery has service demand implications for education, health and social care services, in particular services to support children and adults with cerebral palsy and sight and hearing impairment.

Multiple births

Access to local data on multiple births will support the commissioning and delivery of Havering's education, health and social care services. The rate of multiple births in Havering is likely to be rising in light of the increased national rate.

Multiple pregnancy is associated with higher risks for the mother and babies. Women with multiple pregnancies have an increased risk of miscarriage, anaemia, hypertensive disorders, haemorrhage, operative delivery and postnatal illness. Maternal mortality associated with multiple births is 2.5 times that for singleton births.

Risks to babies depend partly on the chorionicity and amnionicity of the pregnancy. Across England, the overall stillbirth rate in multiple pregnancies is higher than in singleton pregnancies: in 2009 the stillbirth rate was 12.3 per 1,000 twin births and 31.1 per 1,000 triplet and higher-order multiple births, compared with 5 per 1,000 singleton births. The risk of preterm birth is also considerably higher in multiple pregnancies than in singleton pregnancies, occurring in 50% of twin pregnancies (10% of twin births take place before 32 weeks of gestation). Feto-fetal transfusion syndrome, most commonly occurring in twin pregnancies, is a condition associated with a shared placenta and accounts for about 20% of stillbirths in multiple pregnancies. Additional risks to the babies include intrauterine growth restriction and congenital abnormalities. In multiple pregnancies, 66% of unexplained stillbirths are associated with a birth-weight of less than the tenth centile, compared with 39% for singleton births. Major congenital abnormalities are 4.9% more common in multiple pregnancies than in singleton pregnancies¹⁸.

In England and Wales, the rising multiple birth rate is attributed mainly to increasing use of assisted reproduction techniques, including in vitro fertilisation (IVF). Up to 24% of successful IVF procedures result in multiple pregnancies. However in Nigerian women, multiple births tend to arise from spontaneous pregnancies.

The incidence of multiple births has risen in the last 30 years. In 2009, 16 women per 1000 giving birth in England and Wales had multiple births compared with 10 per 1000 in 1980.

Considerations for commissioner and service providers

Data on multiple births was not available for inclusion in this analysis, but is needed to understand trends and impact.

Because of the increased risk of complications, women with multiple pregnancies need more monitoring and increased contact with healthcare professionals during their pregnancy than women with singleton pregnancies. An awareness of the increased risks may also have a psychosocial and economic impact on women and their families, resulting in an increased need for psychological support.

¹⁸ NICE (2011). Clinical guideline 129, Multiple pregnancy: The management of twin and triplet pregnancies in the antenatal period. Available at: <http://www.nice.org.uk/nicemedia/live/13571/56422/56422.pdf>

Obesity in maternity

Obesity in pregnant women increases the risk of complications both for the woman and her unborn child. These effects can last into adulthood.

The Centre for Maternal and Child Enquiries (CMACE) highlighted that obesity in pregnancy carries significant risks and identified that over half the women who died either directly or indirectly from pregnancy related causes were overweight or obese.

Babies born to obese women face increased risk of fetal death, stillbirth, congenital abnormality, shoulder dystocia, macrosomia and subsequent obesity.

A number of studies have demonstrated a link between maternal gestational weight gain and later obesity in childhood^{12, 13}. High maternal BMI was more strongly related to the risk of giving birth to a large-for-gestational-age (LGA) baby¹⁹.

Above normal range weight gain during pregnancy is associated with increased risk to both mother and fetus. Increasing BMI is associated with increased incidence of pre-eclampsia, gestational hypertension, macrosomia, induction of labour and caesarean delivery⁵.

Considerations for commissioners and service providers

The Department of Health's best practice guidance for developing tier 2 weight management services²⁰ provides 'Best Practice Examples' in which pregnancy or breastfeeding should be considered as an exclusion criteria. This is because weight loss during pregnancy is not recommended as it may harm the health of the unborn child⁴. However, the period before, during and after pregnancy provides an opportunity to give women practical advice to help them to eat healthily, become more physically active and to help them manage their weight effectively.

Pregnant women should be offered advice on lifestyle support by their midwife, GP and other health professionals, but referrals to physical activity and/or weight management services, such as Exercise on Referral or Weight Watchers, are not an optional referral route. Other than advice and sign-posting, there is no local NHS or Local Authority service to support pregnant women with an above normal BMI.

¹⁹ Barbara Heude, Olivier Thiébauges, Valérie Goua, Anne Forhan, Monique Kaminski, Bernard Foligué, Michel Schweitzer, Guillaume Magnin, Marie-Aline Charles, *Pre-pregnancy body mass index and weight gain during pregnancy: relations with gestational diabetes and hypertension, and birth outcomes*; *Matern Child Health J.* 2012 February; 16(2): 355–363.

Baby birth weight

Low birth weight is strongly associated with infant mortality. Macrosomia (high birth weight) is associated with higher mortality risk in the first year of life, as well as higher prevalence of premature mortality in adult-hood.

Low birth weight is defined as a birth weight of a liveborn infant of less than 2,500 g (5.5 pounds) regardless of gestational age. Macrosomia, also known as big baby syndrome, is sometimes used synonymously with Large for Gestational Age (LGA), or is otherwise defined as a fetus or infant that weighs above 4000 grams (8lb 13oz) or 4500 grams (9lb 15oz) regardless of gestational age.

Birth weight is governed by two major processes: duration of gestation and intrauterine growth rate. Low birth weight is thus caused by either a short gestation period or retarded intrauterine growth (or a combination of both). The relationships between these processes and the outcome of low birth weight are complex; not all preterm births result in low birth weight babies, nor does intrauterine growth restriction directly correlate to birth weight.

Birth weight is an important predictor of new-born health and survival. Babies born weighing less than 2,500g are at risk of severe neuro-cognitive and pulmonary morbidity and other long-term health difficulties, including deficits in growth, cognitive development, diabetes and heart disease²⁰.

Birth weight and mortality

- Birth weight between 3500-4500g seems to be the optimal range for survival in the first year of life.
- Risk of stillbirth, neonatal death and infant death is inversely related to birth weight apart from a slight upturn in the risk in the small number of babies born ≥ 4500 g.
- Although gestational age is the more powerful determinant of mortality among infants < 2500 g, birth weight, even below 2500g, has an effect on mortality independent of gestational age.
- A number of studies report an inverse relationship of birth weight to mortality in childhood beyond the age of 1 year independent of gestational age.
- Risk of death from cancer in childhood may be associated with high birth weight.

Infant mortality rates by ethnic group were highest for babies in the Pakistani group at 8.9 deaths per 1,000 live births.

In 2011 the infant mortality rates for very low birth weight babies (under 1,500 grams) and low birth weight babies (under 2,500 grams) were 172.6 and 36.5 deaths per 1,000 live births respectively.

The Barker Hypothesis²¹ (1995) demonstrated that people who had low birth weight are at greater risk of developing coronary heart disease. Fetal undernutrition leads to small size at

²⁰ Bull, J., Mulvihill C., and Quigley, R. (2003). Prevention of low birth weight: assessing the effectiveness of smoking cessation and nutritional interventions: Evidence briefing. NHS Development Agency.

²¹ Barker DJP, *Fetal origins of coronary heart disease*, British Medical Journal 1995;311:171-174

birth and cardiovascular disorders, including hypertension, in later life²². This is because abdominal obesity appears in malnourished offspring and is subsequently aggravated by early catch-up growth⁹.

The [ONS Birth cohort tables for infant deaths, England and Wales, 2010](#), are the most recent birth cohort tables. There is a far greater rate of infant mortality in low birth weight babies. However, LGA babies have higher mortality risk in their first year and are increased risk of poor health during their life due to higher adiposity (fat mass) and possible gene alterations.

	Singleton		Multiple		All	
Total No.	700,785		22,380		723,165	
Birth weight >4,000gr	81,974	11.7%	19	0.09%	81,993	11.34%
Birth weight <2,500gr	38,266	5.46%	11,957	53.43%	50,223	6.95%

Considerations for commissioner and service providers

Data on birth weight was not available for inclusion in this analysis, but is needed to understand trends and impact. There are implications for services to men and women whose birth weights were towards the lower end of the normal range as they are at increased risk of cardiovascular disease.

Infant mortality was highest in 2010 in babies born to Pakistani mothers, at 8.9 per 1,000 live births (more than double the overall rate). This relates to increased low birth weight incidence in this group; commissioners and service providers should consider this in light of the increased rate of the Pakistani population in Havering (99 per 100K , 2001; 275 per 100K, 2011).

Identification of Havering's SGA (small for gestational age) and LGA (large for gestational age) babies coupled with follow up monitoring through the National Child Measurement Program in Reception and Year 6 would enable identification of links between SGA, LGA and childhood weight / health status.

The associated complications of low birth weight has service demand implications for education, health and social care services, in particular services to support children and adults with cerebral palsy and sight and hearing impairment.

²² Eriksson JG, Kajantie E, Osmond C, Thornburg K, Barker DJP, *Boys Live Dangerously In The Womb*. American Journal of Human Biology, 2009; 22: 330-335

Teenage pregnancy and births to teenage mothers

In 2011, both the age 15-17 and age 13-15 conception and maternity rate was below the average rate across England, London and statistical neighbours. Havering had a higher percentage of age 15-17 conceptions leading to abortion than England, London and statistical neighbours. Borough-level data masks considerable variation at ward level; aggregated data over 2008-10 shows ward in the far north of Havering, and Brooklands, recorded statistically significant higher rates of under 18 conceptions.

Action to reduce teenage pregnancy has been a long-standing governmental priority and remains a key indicator on the Public Health Outcomes Framework. The health and social effects highlighted in the Social Exclusion Unit Report on Teenage Pregnancy (1999) and the high rates relative to the rest of Europe supported the launch of a national Teenage Pregnancy Strategy and the adoption of national targets to reduce teenage pregnancy by 50% by 2010²³. Most teenage pregnancies are unplanned and approximately half end in a termination²⁴. The challenges of bringing up a child can be difficult for teenagers and can impact on outcomes for both the parent and child in terms of the baby's health, the emotional well-being of the mother and the long term likelihood of the child living in poverty²⁵. The impact of poverty on health and life chances was highlighted within the [Marmot Review](#). Teenage pregnancy is a complex issue and assessing the impact of intervention is difficult, as there is an unavoidable delay in the Department of Health's release of conception rates, and the most effective interventions are those that impact over the medium to long-term.

Groups who are more vulnerable to becoming teenage parents include young people who are: in or leaving care, homeless, underachieving at school, children of teenage parents, members of some ethnic groups, involved in crime, living in areas with higher social deprivation.

At a national level, Caribbean, Pakistani and Bangladeshi women have higher teenage birth rates than white young women. In contrast, Indian young women have lower rates than white young women. Fertility rates in all South Asian groups have fallen substantially over the past 25 years, but have remained stable in white and black Caribbean young women²⁶. Areas of high deprivation typically correlate with high teenage pregnancy rates.

Note: Abortion and conception statistics are prone to fluctuations due to small numbers.

²³ Department of Health. Public Health Outcomes Framework 2012

²⁴ [Department of Health. Sexual Health Improvement Framework 2013](#)

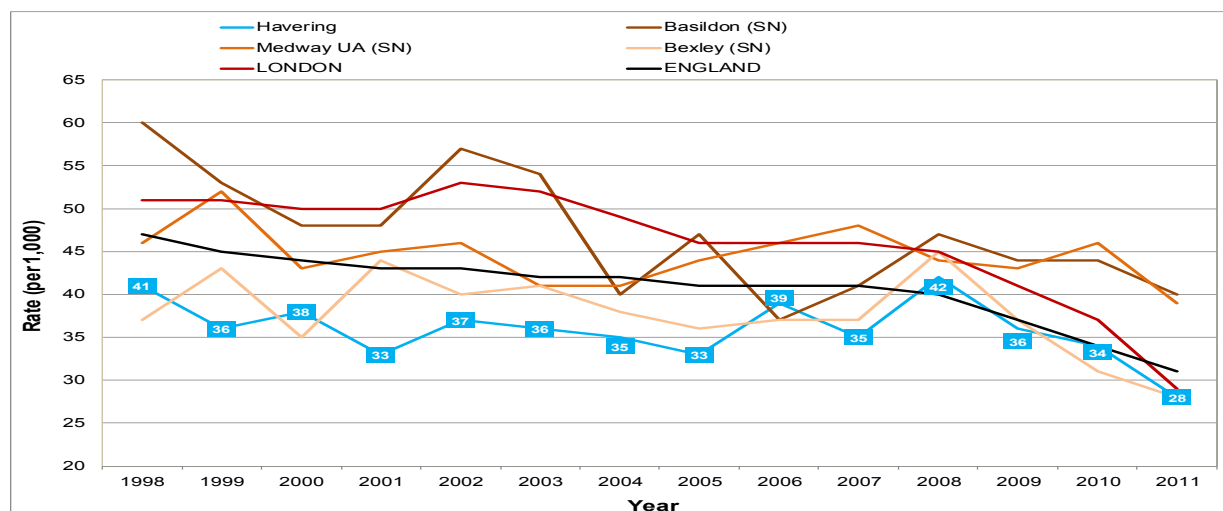
²⁵ Department for Children, Schools and Families. Teenage Pregnancy: Beyond 2010 2010; Department for Children, Schools and Families.

²⁶ Berthoud, R. (2001). Teenage births to ethnic minority women. Population Trends 104: 12-17.

Under 18 conceptions, maternities and abortions

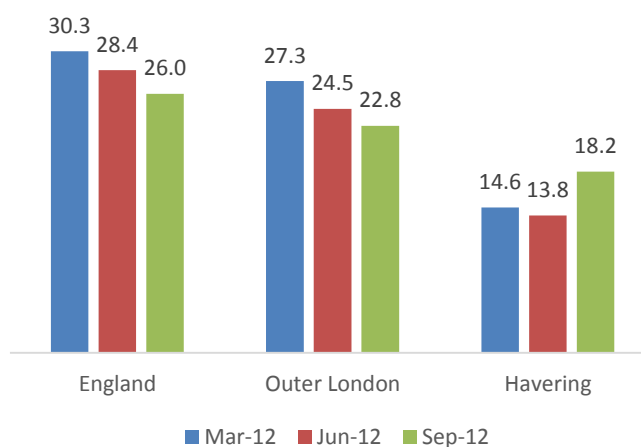
In Havering, the 2011 age 15-17 conception rate was 28 per 1,000, which was below that of London and England. There was an overall reduction in teenage conceptions since the 1998 rate of 41 per 1,000 and this is now in line with comparator, national and regional trends (Figure 8).

Figure 8: Under 18 conception rate (per 1,000 females aged 15-17 years), Havering compared to Statistical Neighbours (SN), London and England



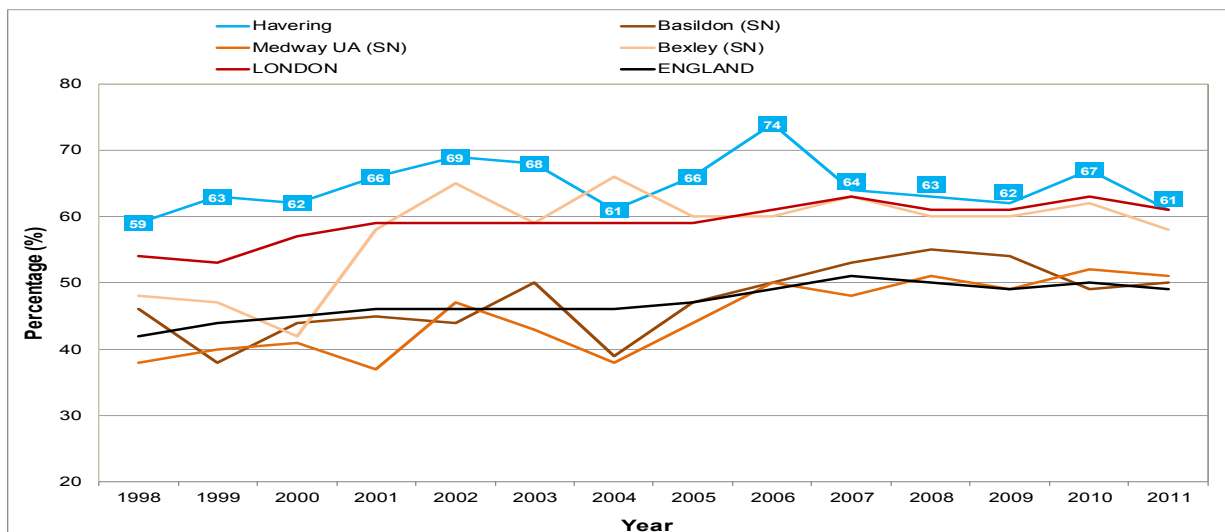
The most recent (provisional) data shows Havering had an under 18s conception rate below the England and London averages in 2012.

Quarterly conceptions per 1000 women aged 15-17, England, outer London and Havering, 2012



The percentage of under 18 conceptions leading to abortion in Havering fluctuated between 59-74% over 1998 - 2011 (Figure 9). In 2011, Havering had a higher percentage of age 15-17 conceptions leading to abortion than England, London and statistical neighbours (Figure 9). There were 1,041 abortions in Havering in 2012, of these 86 (8.3%) were in the in the under 18 age group.

Figure 9: Percentage of under 18 conceptions leading to abortion, Havering compared to Statistical Neighbours (SN), London and England



As a consequence of the above, the age 15-17 maternity rate is comparatively low (Figure 10).

Figure 10: Under 18 maternity rate (per 1,000 females aged 15-17 years), Havering compared to Statistical Neighbours (SN), London and England

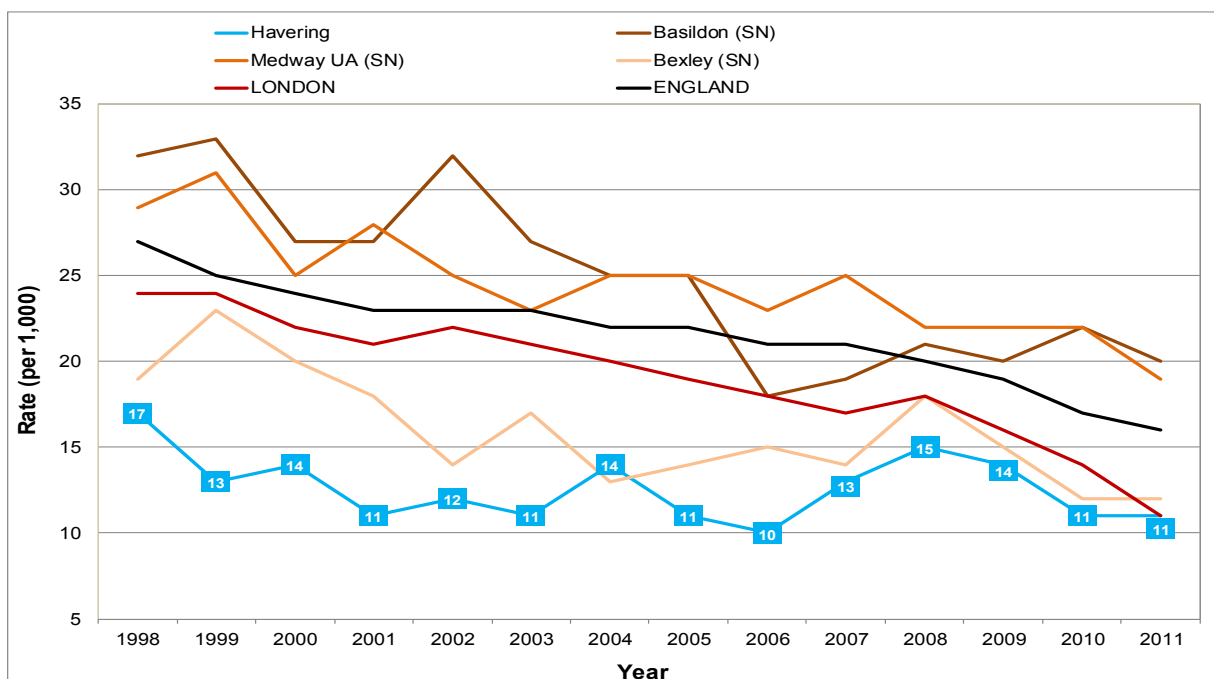


Figure 11 shows the variation in under 18 conceptions across Havering. Significance levels are compared to the England rate and are based on aggregated data over 2008-10. While wards in the far north of the borough and Brooklands recorded statistically significant higher rates of under 18 conceptions over this period, wards in the centre of the authority had significantly lower rates. Ward level data is not available for conception rates amongst 13-15 year olds.

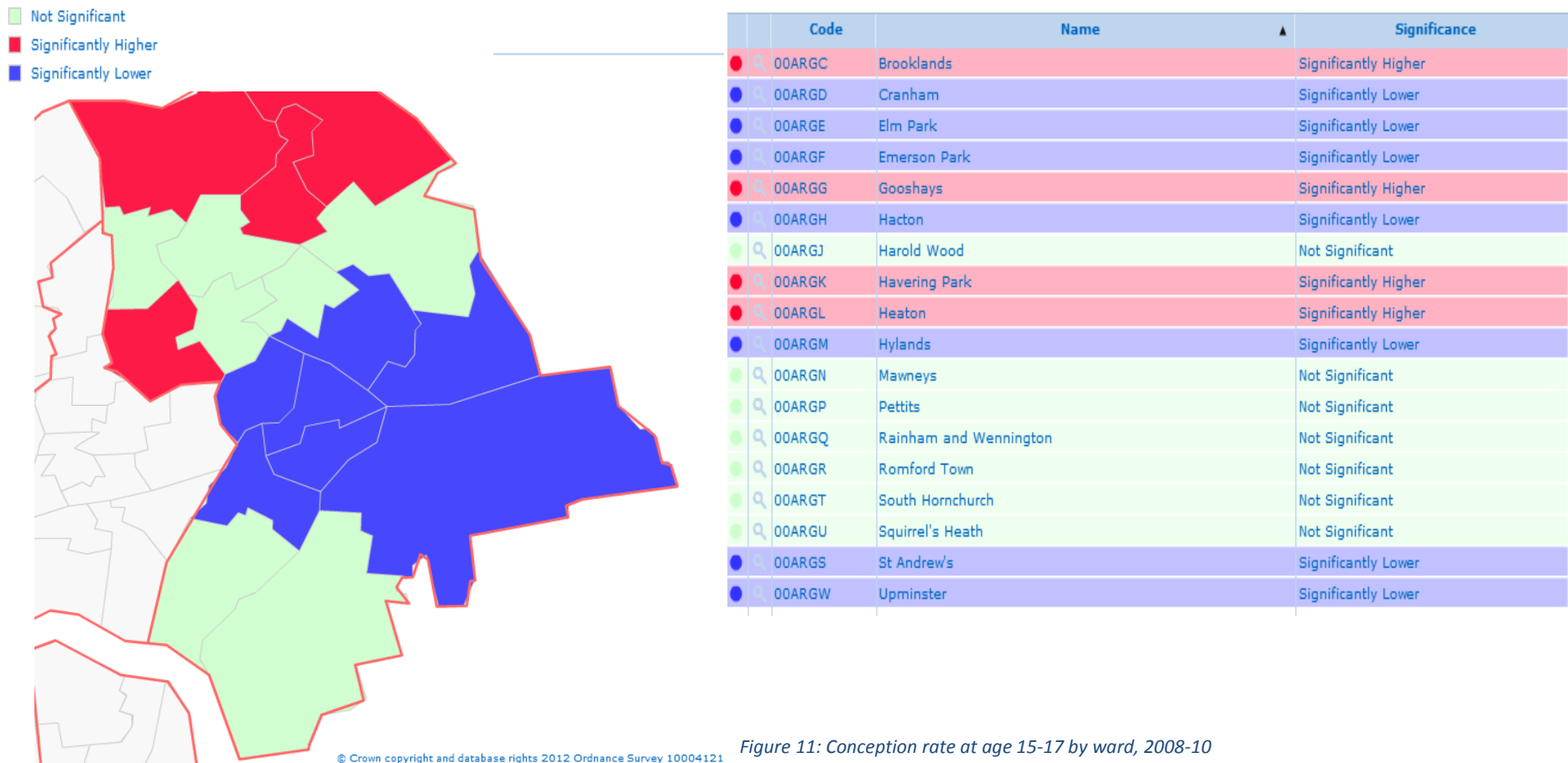
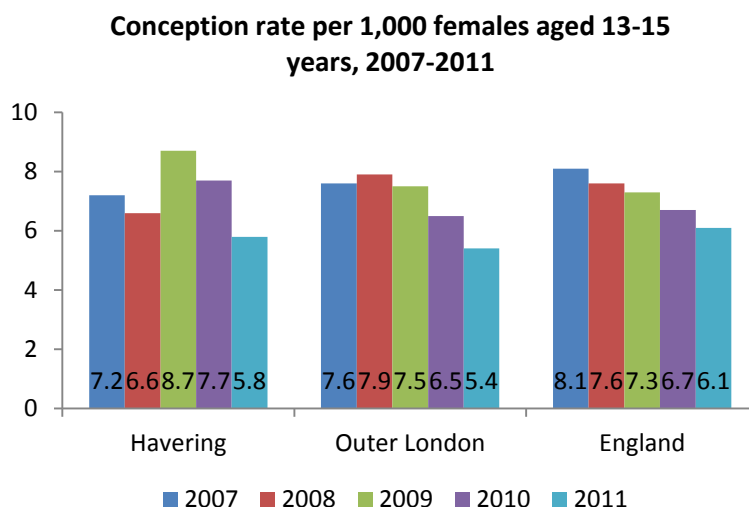


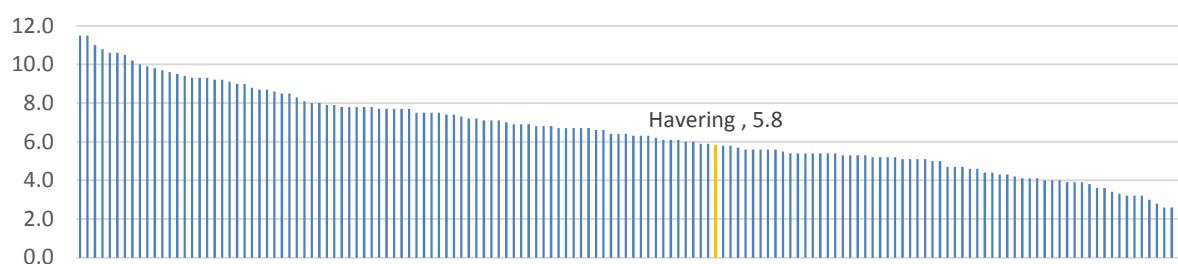
Figure 11: Conception rate at age 15-17 by ward, 2008-10

Under 16 conceptions and abortions

Over 2009-11, the conception rate per 1000 females aged 13-15 declined in Havering from 8.7 to 5.8. This equates to 39 conceptions in 2009 and 26 in 2011. In 2011, the rate was slightly higher than outer London but lower than England; overall the Havering rate fell within the lowest 40% across England.

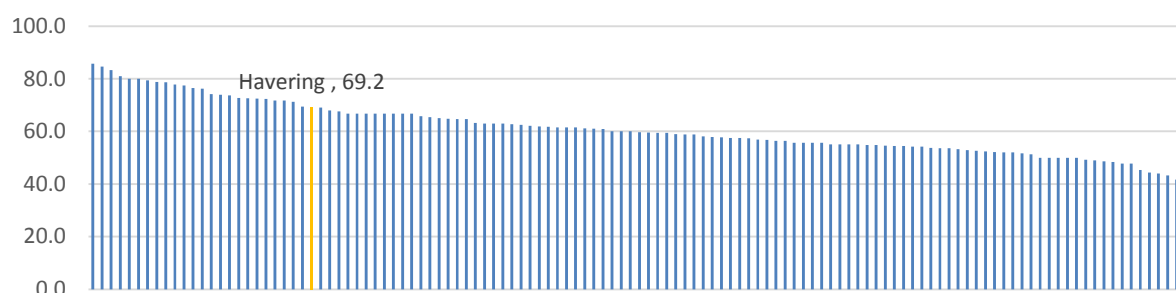


Conception rate per 1,000 females aged 13-15 years, all England authorities, 2011



In 2011, compared to all other England authorities, Havering had a relatively high rate of age 13-15 conceptions that led to abortion at (69.2%). This means a total of 18 of the 26 age 13-15 conceptions in 2011 ended in abortion. This number fluctuates over time due to small numbers.

Percentage of conceptions leading to abortion for females aged 13-15 years, all England authorities, 2011



What are the implications through the life course?²⁷

- The primary consequence for mothers is that women having a teen-birth are more likely to partner with men who are poorly qualified and more likely to suffer unemployment. This is related to higher levels of poverty for this group.
- Teenage mothers suffer from poorer [mental health](#) in the three years after their birth compared with other mothers—they have 30% higher levels of mental illness 2 years after the birth, after which they start to converge to the population average.
- Children of teenage mothers suffer as young adults in terms of lower educational attainment, a higher risk of economic inactivity and of becoming a teenage mother themselves. This may result because of the lower standard of living experienced by many teenage mothers, owing in part to the poorer earning partners that they pair with.

Considerations for commissioners and service providers

The teenage pregnancy strategy is currently under review and will consider how best to target approaches to reducing teenage conceptions, given the wide disparities in the under 18 conception rate across the borough.

²⁷ DoH (2004). Teenage Pregnancy Research Programme Research Briefing: long term consequences of teenage births for parents and their children.

Breastfeeding

Compared to all other London authorities, Havering had the second lowest rate of breastfeeding initiation in 2011/12, and low levels of infants who are totally or partially breastfed at 6-8 weeks (39.5%, 2010/11)

Breast milk is the best form of nutrition for infants, and exclusive breastfeeding is recommended for the first six months (26 weeks) of an infant's life²⁸. Breastfed babies have:

- less chance of diarrhoea and vomiting and having to go to hospital as a result
- fewer chest and ear infections and having to go to hospital as a result
- less chance of being constipated
- less likelihood of becoming obese and therefore developing type 2 diabetes and other illnesses later in life
- less chance of developing eczema

For mothers, breastfeeding is associated with a reduction in the risk of breast and ovarian cancers. A recent study also suggests a positive association between breastfeeding and parenting capability, particularly among single and low-income mothers.

Research from Hamlyn et al (2000) found factors associated with continuation or early cessation of breastfeeding included:

- Lower socio-economic group of the mother and of her partner was associated with lower initiation and continuation rates
- Younger mothers were least likely to breastfeed, and most likely to discontinue early
- Mothers of second or later babies breastfeed for longer than mothers of first babies
- Mothers who breastfed their previous child for longer than six weeks continue to breastfeed their later child for longer
- Duration of breastfeeding was longest among those who left full-time education after the age of 18, and shortest among those who left school at age 16 or younger
- In the UK, white mothers were less likely to initiate breastfeeding and those who do so then continue for a shorter duration than mothers from other ethnic groups.
- Breastfeeding mothers who were entirely bottlefed themselves were more likely to stop in the first two weeks after birth
- Since epidural anaesthetic became common for caesarean section there were no significant differences in breastfeeding according to mode of birth. Women who received a general anaesthetic, however, were less likely to breastfeed
- The shortest duration of breastfeeding was among women who go back to work when the baby is between six weeks and four months old

²⁸ *National Institute for Health and Clinical Excellence (2008). Improving the nutrition of pregnant and breastfeeding mothers and children in low-income households. London.*

In 2011/12, 71.1% of mothers in Havering gave their babies breast milk in the first 48 hours after delivery, an increase of 2.4% from 2010/11 rates. This puts Havering at the bottom of the third quintile when compared to all England local authorities (Figure 12).

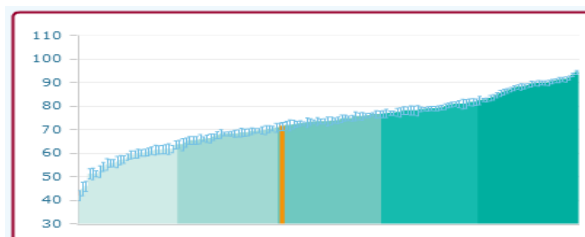


Figure 12: percentage of mothers in Havering who gave their babies breast milk in the first 48 hours after delivery, 2011/12, England quintiles

When compared to all London authorities, Havering had the lowest rate of breastfeeding initiation, bar one (Figure 13); this translated to low levels of infants who were totally or partially breastfed at 6-8 weeks (39.5%, 2010/11). This rate was the lowest in London and within the second lowest quintile across England.

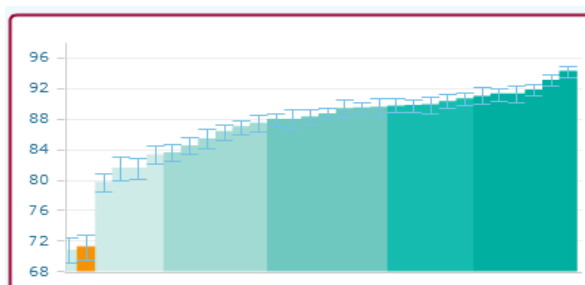


Figure 13: percentage of mothers in Havering gave their babies breast milk in the first 48 hours after delivery, 2011/12, London quintiles

Considerations for commissioner and service providers²⁹

Ongoing monitoring of rates of variation in infant feeding combined with socio-demographic data would help develop a targeted programme of change.

Programmes should consider interventions that are intended to have a supportive effect (eg training health professionals in breastfeeding support skills), but also those that may have a detrimental effect (eg healthcare practices such as separating mothers and babies for routine procedures and the care given to women experiencing problems).

Breastfeeding-specific support from both peers and professionals has been shown to be effective at increasing breastfeeding among women who plan to breastfeed, as long as that support is offered to women soon after the birth. Such support has been shown to be effective at increasing exclusive breastfeeding among women from relatively advantaged backgrounds but has not been shown to be effective at increasing exclusive breastfeeding among women from disadvantaged backgrounds

Additional general postnatal support offered to women regardless of infant feeding intention or practice is unlikely to affect breastfeeding duration

²⁹ NICE (2005). [The effectiveness of public health interventions to promote the duration of breastfeeding.](#)

For disadvantaged groups, there is some evidence to suggest that tailored antenatal education, combined with proactive postnatal support in hospital and community is effective in enhancing breastfeeding duration

Combining antenatal education with partner support, postnatal support and incentives for women in low-income groups is regarded as promising practice.

In relation to the training and preparation required there is no evidence that professionals without additional, breastfeeding-specific training have been effective in supporting women to breastfeed.

Infant and child mortality

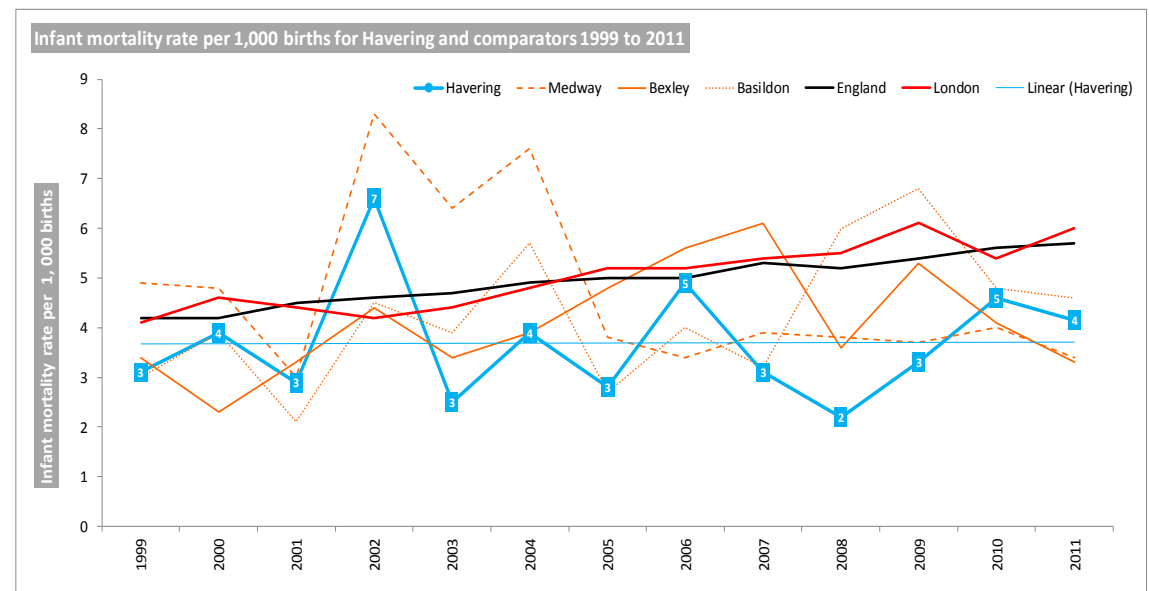
In 2011, Havering's infant mortality rate was below that of regional and national comparators and was similar to comparators. With a standardised death of 13.4 per over 2002-2011, child mortality in Havering was in the lowest quintile of death rates compared to all England authorities, and when compared to all London authorities.

Infant mortality refers to the death of a child less than one year of age. The infant mortality rate (IMR) is the number of babies born alive, who die in the first year of life per 1,000 live births. There is a clear link between high levels of infant mortality, deprivation and poor health outcomes. It is therefore often used as a comparative measure of a nation's health as well as a predictor of health inequalities.

Gestation-specific infant mortality in England and Wales, 2010

- In 2010, the overall infant mortality rate was 4.1 deaths per 1,000 live births.
- For babies born at term, the infant mortality rate was 1.6 deaths per 1,000 live births.
- For pre-term babies, the infant mortality rate was 24.3 deaths per 1,000 live births.
- The infant mortality rate for babies of mothers aged 40 years and over was 5.9 deaths per 1,000 live births. For babies of mothers under 20 years, the infant mortality rate was 5.1 deaths per 1,000 live births.
- The pre-term infant mortality rate was higher for singletons than for multiples (25.4 and 20.8 deaths per 1,000 live births respectively).

In Havering, from 1999-2011 approximately 2-5 infants in every 1,000 live births died. Except for in 2002, this rate was consistent over 1999-2011. In 2011, Havering's infant mortality rate was below that of regional and national comparators and is similar to borough comparators.



Over 2009-2011 there were 4 deaths for every 1,000 live births of infants aged less than one in Havering. In this period this fell into the second quintile compared to other London boroughs and in the third quintile nationally.

Child Mortality refers to the death of a child aged 1-17 years. National evidence demonstrates that there is a substantial difference in death rates between social classes and that social deprivation is strongly linked to mortality rates even after the neonatal period. Evidence from birth and death registration in England and Wales has been used to examine the associations between social and biological factors and mortality in children. This has shown that many of the well-established risk factors for death in infancy persist into older ages. These include the association between birth weight and

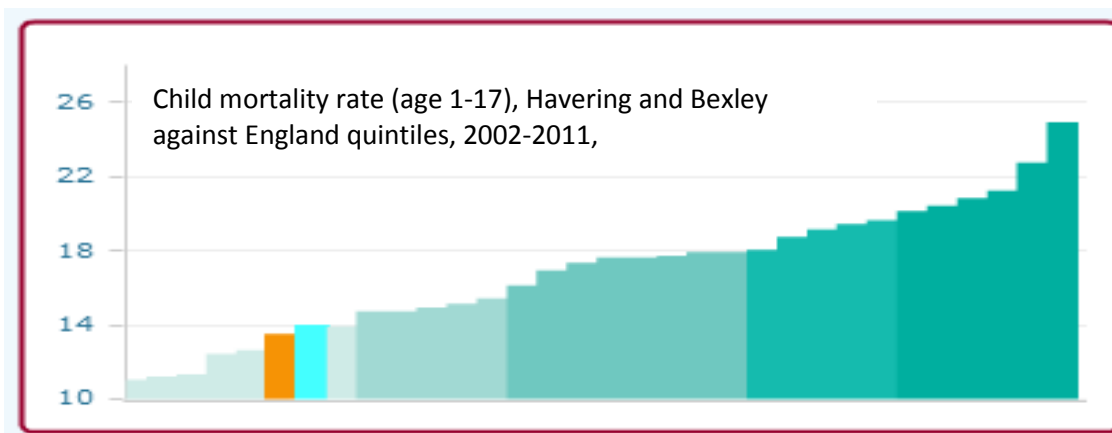
mortality, the differential between those children of fathers in manual occupations and those children of fathers in non-manual occupations, and the age, country of birth and marital status of the mother. The differential between these groups reduces in the older age-groups.

- With a standardised rate of death rate of 13.4 per over 2002-2011, child mortality in Havering was in the in the lowest quintile of performance compared to all England authorities and when compared to all London authorities (lower is better).
- The standardised child mortality rate in Havering for 2009-2011 was higher than the national and regional average (but not significantly). The numbers of deaths at a local level are too few to demonstrate differences.

Reducing the variation in child and infant mortality rate remain key national targets for tackling inequality and requires initiatives to improve maternal health, child health and the wider determinants of health, such as education and housing.

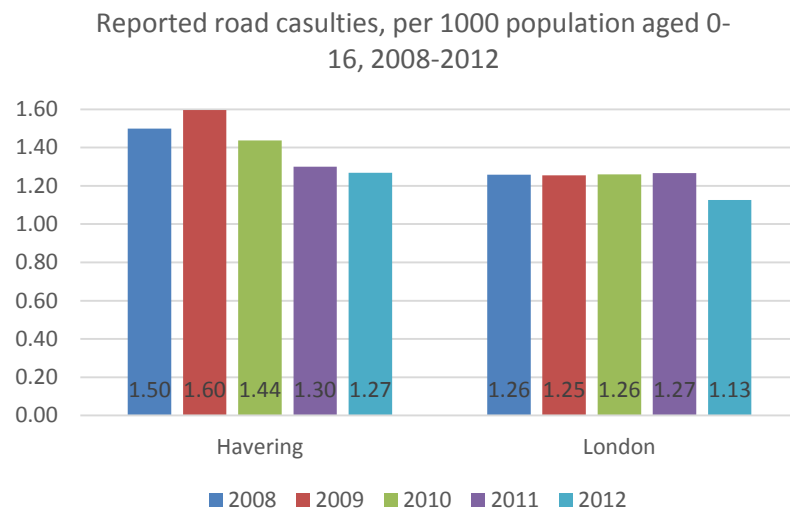
Considerations for commissioners and service providers

- Improving the quality and accessibility of antenatal care and support during the first year of life, particularly in disadvantaged areas
- Reducing smoking in pregnancy
- Improving nutrition in pregnancy and infancy, including increasing the number of mothers who breastfe



Road safety

Over 2009 to 2012, the prevalence of road casualties³⁰ involving children aged 0-16 in Havering declined. However, the prevalence of road casualties for this cohort is higher than for London as a whole.



Considerations for commissioners and service providers

Developing an understanding the travel patterns of children and the associated pattern of road casualties will help plan effective road safety programmes. Further analysis of road casualties should consider children as pedestrians, passengers and cyclists as well as those with additional support needs.

³⁰ A casualty is defined as a person killed or injured in an accident.



Healthy weight: children aged 4-5 and 10-11 years

In 2012/13, one in five reception-aged children and 35% of 10-11 year olds in Havering were overweight or obese. Pooled data over 2009/10 - 2011/12 shows that reception-aged obesity varies across the borough, ranging from 15.1% in Hacton to 6.9% in Hylands.

Being overweight or obese in childhood and adolescence has consequences for health in both the short and long term. Once established, obesity is difficult to treat, so prevention and early intervention are very important.

Overweight and obese children are more likely to become obese adults, and have a higher risk of morbidity, disability and premature mortality in adulthood. Although many of the most serious consequences may not become apparent until adulthood, the effects of obesity - for example, raised blood pressure, fatty changes to the arterial linings and hormonal and chemical changes (such as raised cholesterol and metabolic syndrome) can be identified in obese children and adolescents.

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

Research shows the emotional and psychological effects of being overweight are often seen as the most immediate and most serious by children and young people themselves. These include discrimination and teasing by peers; low self-esteem; anxiety and depression. This can impact on educational attainment.



Reception-aged children

In 2012/13, one in five (21%) reception-aged children in Havering were overweight or obese (right). This is slightly below the England average of 22% and the London average of 23%. The rate of underweight 4-5 year olds remained static at 1% over 2007/8 – 2012/13, while the rate of overweight and obese children fluctuated between 23%-27%, stabilising at 24% for 2010/11 and 2011/12 before dropping 3% points in 2012/13.

Children aged 10-11

In 2012/13, 35% of children aged 10-11 in Havering were overweight or obese. This is above the England average (33%) and below the London average (37%). The rate of obesity for children aged 10-11 in Havering is markedly higher than for younger children.

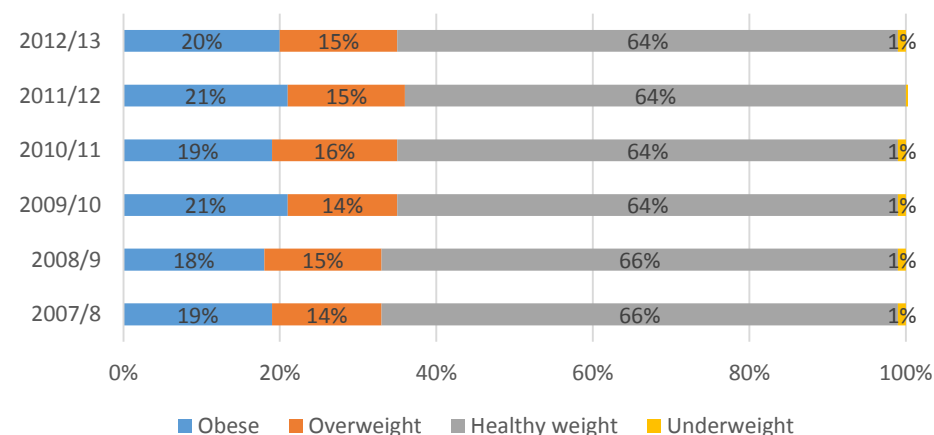
The National Obesity Observatory has analysed correlations between Havering's Middle Layer Super Output Areas (MSOAs), obesity and other socio-economic factors. For both age groups (4-5 and 10-11 years), correlations have been found between:

- % of household below 60% of median income after housing costs ($r = .41$ age 4-5. $r = .84$, age 10-11)
- Income deprivation affecting children index score 2010 ($r = .41$ age 4-5. $r = .78$, age 10-11)
- Educational attainment³¹. The correlation is much stronger for older children ($r = -.77$)

Proportion of measured children in Havering aged 4-5 years by weight category, 2007/8 - 2012/13



Proportion of measured children in Havering aged 10-11 by weight category, 2007/8 - 2012/13



³¹ Measured as average point score of pupils eligible for KS assessments in 2010/11 ($r = -.33$, age 4-5).

There was a weak or no correlation between the % of children who were obese and the percentage of % land that was domestic garden ($r = -0.4$, age 4-5. $r = -0.23$, age 10-11) or the percentage of land that was green space in 2005 ($r = -0.09$ age 4-5. $r = -0.01$, age 10-11). At a national level, reception-aged children from Indian and mixed ethnic groups have similar prevalence of obesity to white ethnic groups, while obesity prevalence among boys in reception is highest in the black African, black other, and Bangladeshi groups. Nationally, for girls in reception obesity prevalence is highest among those from black African, and black other ethnic groups³².

Obesity at age 4-5, by Havering wards, 2009/10-2011/12			
Ward		95% confidence limits	
	% children	Lower	Upper
Hacton	15.1%	11.7%	19.3%
Heaton	14.6%	11.7%	18.1%
Mawneys	13.1%	10.3%	16.5%
Brooklands	12.7%	10.2%	15.6%
Rainham and	12.2%	9.4%	15.7%
Havering Park	11.9%	9.4%	15%
Gooshays	11.4%	9%	14.3%
South Hornchurch	10.2%	7.8%	13.2%
Emerson Park	10.1%	7.1%	14.3%
Pettits	10%	7.4%	13.5%
Squirrel's Heath	9.9%	7.2%	13.5%
Elm Park	9.8%	7.2%	13.3%
Cranham	9.6%	6.9%	13.3%
Harold Wood	8.6%	6.1%	12.1%
Romford Town	8.4%	6.3%	11.1%
Upminster	7.4%	5.1%	10.7%
St Andrew's	7.3%	5%	10.5%
Hylands	6.9%	4.8%	10%

Pooled data (left) over 2009/10-2011/12 shows the prevalence of obesity at age 4-5 varied considerably across the borough. Hacton (15.1%) and Heaton (14.6%) had the highest prevalence of reception-aged obesity in the borough with rates significantly higher than the Havering average rate of 10.7%.

Conversely, Hylands had the lowest rate of obesity (6.9%); this is significantly lower than the Havering average. Nationally, the highest incidence of children who are underweight is in the most deprived areas and follows an upward trend from the least deprived areas. Local mapping of children who are underweight by area of deprivation is not possible as numbers are too low to publish. However, it is reasonable to assume that Havering follows the national trend.

The 2007 [Report of the Children and Young People with Diabetes Working Group](#) states that local authorities and primary care trusts (PCTs) might expect between 100 and 150 children with diabetes to live in their area. As at 28th October 2013, there were 120 children with diabetes registered with a Havering GP with 114 residing in Havering. Virtually all cases are type 1 diabetes, and most of those diagnosed are aged 11+, although 31 children with diabetes are aged 0-10 (registered with Havering GP). This is broadly in line with England ratio of type 1 to type 2 diabetes³³.

³² National Child Measurement Programme 2011/12

³³ There are almost 23,000 people under the age of 17 with diabetes in England. 97 per cent have Type 1 diabetes, 1.5 per cent have Type 2 and 1.5 per cent are recorded as 'other'. Source: [Diabetes in the UK 2012 – key statistics on diabetes](#).

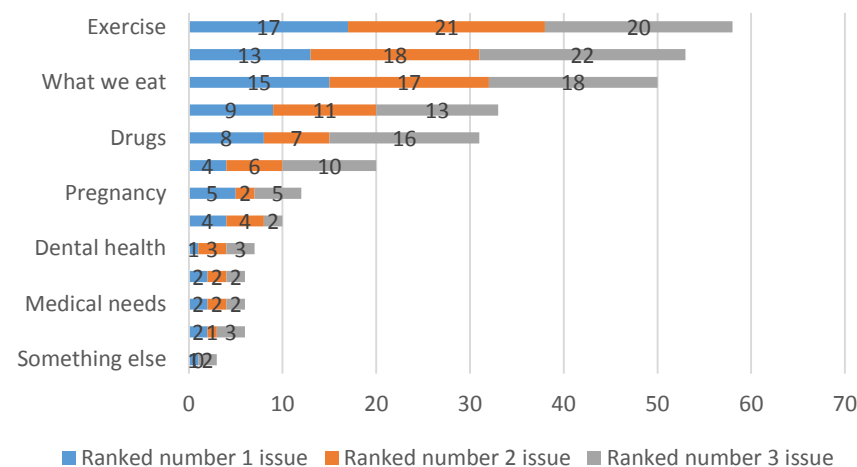
Healthy schools programme

[Healthy Schools London](#) is a programme to support schools to help their pupils be healthier. An associated award scheme recognises the achievements of schools in supporting the health and wellbeing of their pupils. There are three levels of award (bronze, silver and gold). More than 22% of schools in London are registered with the healthy schools programme. Havering had two schools registered as at November 2011, and no awards.

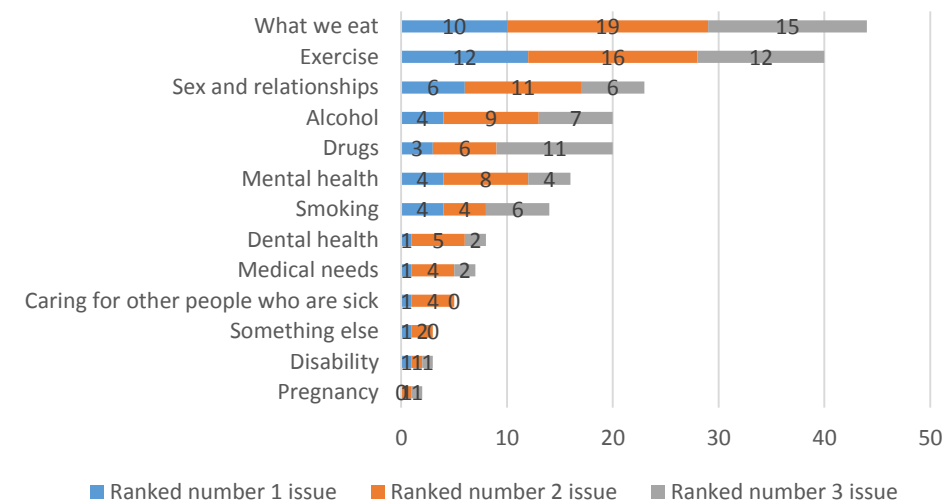
What do local people think?

As part of a survey of children resident and / or attending school in Havering, 108 children and young people responded to the question 'what are the 3 most important health issues for young people in Havering'. 'Exercise' was the most commonly cited response, followed by 'smoking' and then 'what we eat'. The same question was asked in a parallel survey of adults and of the 73 respondents, 'what they eat' was the top response, followed by 'exercise'.

Young people: what are the 3 most important health issues for children and young people in Havering? (108 responses)



Adults: what are the 3 most important health issues for young people in Havering? (73 responses)



Considerations for commissioners and service providers

Use the National Child Measurement Programme to build local intelligence in order to inform service planning through analysis of childhood obesity 'hotspots'. This evidence can be shared with schools, Children's Centres and other providers of services to children to enable them to make the best decisions to improve the health of the children in their care.

Work with schools to support them to register and work through the Healthy Schools London programme.

Use local media to raise awareness of childhood obesity and healthy lifestyle information with the general population.

Consider the approval of new fast food outlets in light of childhood obesity 'hotspots', particularly near schools.

Work with fast food outlets to support them in reducing the salt, fat and sugar content in their menus

Immunisations

Vaccine coverage in Havering is generally in line with comparators, although is lower for Hib / MenC (exp. booster), Hib, MMR (1st dose) and DTaP at age 2. Low numbers of requests for phlebotomy lab tests for MMR suggest that current provision and uptake of MMR immunisations in Havering are suitable to meet the population level need.

- The **DTaP/IPV/Hib vaccine** protects against diphtheria, tetanus, whooping cough, polio and Hib (haemophilus influenza type B). It is also known as the 5-in-1 vaccine and is given at two, three and four months of age.
- The **MMR vaccine** protects against measles, mumps and rubella (MMR) and is given at 12-13 months and at 3 years and 4 months of age, or sometime thereafter.
- The **Meningococcal C conjugate (MenC) vaccine** protects against meningitis C (meningococcal type C) and is given at three months of age and as a teenage booster at age 13-15 (from September 2013).
- The **PCV vaccine** protects against some types of pneumococcal infection and is given at two, four and 12-13 months of age.
- The **HPV vaccine** protects against the two virus types that cause over 70% of cervical cancer and against two types of HPV that cause about 90% of cases of genital warts.

Low vaccine uptake can put children and others at risk, particularly unvaccinated pregnant women, those with compromised immune function and any non-immune person (who has not been vaccinated or was vaccinated but did not develop immunity). Where there are high rates of migration from countries experiencing a resurgence of certain diseases, low vaccine uptake carries additional risks.

In the charts below, coverage rates for childhood immunisations in Havering are compared against Bexley, London and England using the following red / amber / green ratings. Note that children immunised after the precise target age (i.e. 2nd birthday) are not included in returns; this means the potential for local variations in the timeliness of vaccinations may affect reported coverage rates.

Havering performs better than comparator by 0.6% or more	
Havering performs within - / + 0.5% of comparator	
Havering performs worse than comparator by 0.6% or more	

In 2011/12, there was a comparatively good rate of coverage for immunisations due before children's first birthdays.

Coverage by the 2nd birthday was more of a mixed picture. While Havering had comparatively good coverage rates for the Hib / MenC (Booster), coverage for all other vaccinations at this age were below the England rates. Havering performs well against London for all 2nd birthday vaccinations, but coverage for MenC and DTaP/IPV/Hib is lower than in Bexley.

Coverage by the 5th birthday was better than London rates for all vaccinations for this cohort, and is better than or in line with Bexley and England for Hib / MenC (exp. booster), MMR (1st and 2nd dose) and the DtaP/IPV (Booster). Havering's coverage rates for MMR (1st dose) and DTaP were lower than rates for Bexley and England.

However, Havering and all comparators all fall short of the World Health Organisation's 95% target coverage rate.

Percentage coverage of immunisations before 1st birthday, 2011/12				
	Havering	Bexley	London	England
MenC	94.5%	93.4	89.9	93.9
PCV	94.1%	93.4%	90.4%	94.2%
DTaP/IPV/Hib	94.5%	93.4%	91.3%	94.7%

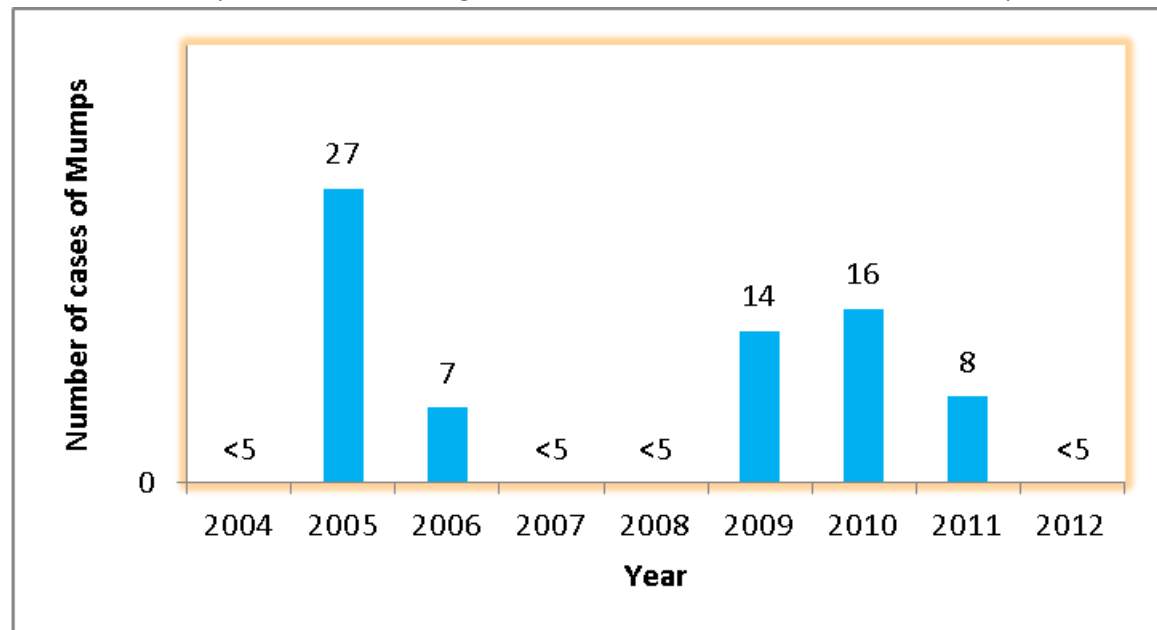
Percentage coverage of immunisations before 2nd birthday, 2011/12				
	Havering	Bexley	London	England
Hib / MenC (Booster)	93.2%	89.2%	86.8%	92.3%
PCV (Booster)	90.8%	86%	85.3%	91.5%
MMR (1st dose)	89.9%	85.4%	86.1%	91.2%
MenC	91.6%	95.6%	90.2%	94.9%
DTaP/IPV/Hib	94.4%	95.7%	93.3%	96.1%

Percentage coverage of immunisations before 5th birthday, 2011/12				
	Havering	Bexley	London	England
DtaP/IPV (Booster)	88.5%	82.1%	78.8%	87.4%
MMR (1st and 2nd dose)	85.5%	84.9%	80.2%	86%
Hib / MenC (exp. booster)	88.6%	88.5%	81.5%	88.9%
Hib	94.4%	95.8%	91.5%	94.9%
MMR (1st dose)	90.3%	92.3%	89.7%	92.9%
DTaP	93.8%	95.8%	92%	95.4%

Cases of MMR in children

MMR data is collected by government regions and based on phlebotomy laboratory confirmed cases. Historical data has been collected by postcode of the testing requestor so it does not mean that the patient is resident in the same area where he/she sought medical advice. The data is solely a reflection of phlebotomy lab requests resulting from people accessing primary or acute care services in Havering.

In Havering between 2002 and 2012 the annual number of lab confirmed cases of Measles and Rubella was too low to report (<5 individuals). Low numbers of cases suggest that current provision and uptake of immunisations in Havering are suitable to meet the population level need. Most cases of mumps affect children between two to fourteen years of age, therefore we would expect to see a time lag between missed MMR vaccinations and the presentation of Mumps in teenagers. The figure below shows that the number of confirmed cases of mumps was highest in 2005, 2009 and 2010, suggesting that there were lower vaccination rates two to fourteen years prior. These trends may therefore be linked to the media dispute resulting from the controversial paper published in the Lancet in 1998 which raised concerns about a link between the MMR vaccination and autism. Concern in parents impacted on the uptake of MMR, resulting in a higher number of cases in unvaccinated teens. This report has since been comprehensively discredited and the 2012 [Cochrane Collaboration mega-review](#) brought together evidence from 54 different scientific studies in 2012 to allay parent's fears. In 2012 the number of cases in Havering was too small to report and continued efforts will ensure MMR vaccination uptake continues to be high in the borough to offer maximum protection for all from measles, mumps and rubella.



HPV uptake (Year 8 girls)

- 89.3% of year 8 girls completed all 3 doses of the HPV vaccine in Havering in 2011/12. This is higher than England, London and Bexley.
- Havering has one of the highest coverage rates in London (quintile 5).
- Coverage has increased since 2009/2010.

Considerations for commissioners and service providers³⁴

Pearce et al explored the factors associated with MMR vaccine take up for group of children born in the UK over 2000-2002. These children were more likely to be unimmunised against MMR if:

- They lived in a household with other children or a lone parent or
- Their mother was under 20 or over 34 at the time of the child's birth, more highly educated, not employed, or self-employed.

They found the use of single vaccines increased with household income, maternal age, and education. Children were less likely to have received single vaccines if they lived with other children, had mothers who were Indian, Pakistani or Bangladeshi, or black, or aged under 25. Nearly three quarters (74.4%, 1110) of parents who did not immunise with MMR made a 'conscious decision' not to immunise.

These social differentials in uptake could be used to inform targeted interventions to promote uptake.

³⁴ Pearce, A., Law, C., Elliman, D., Cole, T., and Bedford, H. (2008). Factors associated with uptake of measles, mumps, and rubella vaccine (MMR) and use of single antigen vaccines in a contemporary UK cohort: prospective cohort study. British Medical Journal: 336, 754

Oral health

Oral health at age 5 is good compared to England levels. However, children in Havering who have dental decay are less likely to have their teeth filled and more likely to have sepsis present. Havering has the lowest 'care index' in London.

Children's oral health in Havering at age 5 is comparatively good against England, although children who have dental decay are less likely to have their teeth filled and more likely to have sepsis present. The sum of decayed, missing and filled teeth is a measure of the decay experience of the average child. It theoretically could have been prevented and is therefore key data for evaluation of efforts to prevent decay. Children resident in Havering on average have less obviously decayed, missing or filled teeth compared to their England peers (Figure 14).

The 'care index' is the proportion of teeth with caries that have been filled. Opinions differ regarding the appropriateness and benefit of filling decayed deciduous teeth. The care index was 11.2% across England, showing just over a tenth of decayed teeth are treated by filling them. Within London, Havering had the lowest index at 6.2% compared to 29.5% in Kingston upon Thames. The Havering rate is significantly lower than the England rate. The care index should be interpreted alongside other intelligence such as deprivation, disease prevalence and the provision of dental services³⁵.

The study also found a comparatively higher percentage of children with sepsis³⁶ present, although this is not statistically significant. Among five-year-olds, nearly all sepsis will be the result of the dental decay process rather than originating from gum problems.

³⁵ Public Health England (2013). National Dental Epidemiology Programme for England: oral health survey of five-year-old children 2012: A report on the prevalence and severity of dental decay.

³⁶ Sepsis was defined as the presence of a dental abscess or sinus recorded by visual examination of the soft tissues.

Figure 14 Key results summary from National Dental Epidemiology Programme for England, Oral Health Survey of five-year-old children 2012³⁷

	Havering	England	Statistically significant	Better / worse than England
Average number of obviously decayed, missing (due to decay) and filled teeth per child	0.54 (CL 0.37-0.96)	0.94 (CL 0.93-0.96)	No	Better
Percentage of children with decay experience (ie: with one or more obviously decayed, missing (due to decay) and filled teeth)	19.8% (CL 12.8%-22.2%)	27.9% (CL 24.2%-24.7%)	Yes	Better
For those children with decay experience, the average number of obviously decayed, missing (due to decay) and filled teeth per child	2.73 (CL 2.2-3.26)	3.38 (CL 3.36-3.41)	Yes	Better
Percentage of children with current/active decay (ie: with one or more obviously decayed teeth)	17.5% (CL 14.9%-24.7%)	24.5% (27.7%-28.1%)	Yes	Better
Percentage of children with one or more missing (due to decay) teeth	2.3% (CL 0.5%-4.1%)	3.1% (CL 3%-3.2%)	No	Better
Proportion of teeth with decay experience which have been filled ('care index')	6.2% (5.1% - 7.6%)	11.2% (CL 11.1%-11.3%)	Yes	Worse
Percentage of children recorded with sepsis present	2.7% (CL 0.6%-4.8%)	1.7% (CL 1.7%-1.8%)	No	Worse

³⁷ 418 Havering children were approached to take part in the National Dental Epidemiology Programme for England, [Oral Health Survey of five-year-old children 2012](#). Of these, 253 were examined.

Children with special educational need and disabilities (SEND)

Support for children with SEND is undergoing radical reform. The Children and Families Bill proposes to extend the SEND system from birth to 25; replace statements of special educational need with a new birth-to-25 education, health and care plan; and offer families personal budgets. In particular, Havering's Clinical Commissioning Group (CCG) and the National Health Service Commissioning Board will be required to make joint commissioning arrangements to secure education, health and care provision for children and young people for whom the authority is responsible and who have special educational needs. The [Draft Special Educational Needs Code of Practice: for 0-25 years](#) requires Health and Wellbeing boards to consider the needs of vulnerable groups, including those with SEN and disabled children and young people, those needing palliative care and looked after children.

Much of the data referenced below differentiates between children supported at three tiers, as defined by the SEN code of practice 2001, shortly to be succeeded by a new code of practice. Levels of SEN support are currently defined as follows:

- **School action:** When a class teacher or the SENCO identifies a child with SEN the teacher should provide interventions that are additional to, or different from, those provided as part of the school's usual differentiated curriculum offer and strategies.
- **School action plus:** external support services will usually be consulted so that they can provide more specialist assessments, advise teachers and in some cases provide support for particular activities
- **Statement of special educational need:** a statement describes a child's special educational needs and the help the child should receive. The local authority will usually make a statement if they decide that all the help the child needs cannot be provided from within the school's resources. These resources could include money, staff time and special equipment.

Havering's education provision for children with SEND

Havering seeks to meet the needs of pupils with special needs in their local mainstream schools. For children whose needs cannot be met in their local school there are eight schools who are specially resourced to meet particular needs, described below.

Special educational need specialism	Havering school
Hearing impairment	Hacton Primary School
Language difficulties	Mead Primary School
Behaviour, emotional and social difficulties	Hilldene Primary School
Autism spectrum disorder	RJ Mitchell Primary School
Visual impairment	Crownfield Junior School
Hearing impairment	Sanders Draper School
Autism spectrum disorder	Hall Mead Academy
Language difficulties	Redden Court Academy

For children with more profound needs, Havering has three special schools.

Special educational need specialism	Havering School	Number of 0-16 funded places
Severe learning difficulties	Ravensbourne	71
Moderate learning difficulties	Corbets Tey	110 (from April 2014)
Moderate learning difficulties	Dycorts	80

Ravensbourne has an additional 23 places for post-16 students and at the other end of the age spectrum, accepts pupils from age two upwards. In addition, Bridge Nursery offers up to sixteen places (mornings or afternoons) for children in the year prior to Reception who have social communication difficulties.

Current profile of children with SEND

There are two different groups of children considered in this analysis.

- 1) **Children for whom LB Havering is responsible for the provision of resources to meet the child's statement of special educational needs:** the responsible authority is dependent on the child's borough of residence, which may be different to where they attend school.
- 2) **Children whom attend Havering schools:** these children may reside in any borough.

The best source of evidence on the current prevalence of SEND amongst children in Havering is local data on special educational need derived from the School Census³⁸ and demand for children's therapy services. GP records of children's learning disabilities indicate substantial under-recording³⁹.

³⁸ The school census is a statutory return which takes place during the autumn, spring, and summer terms. The most recent data reported here is taken from the January 2013 school census.

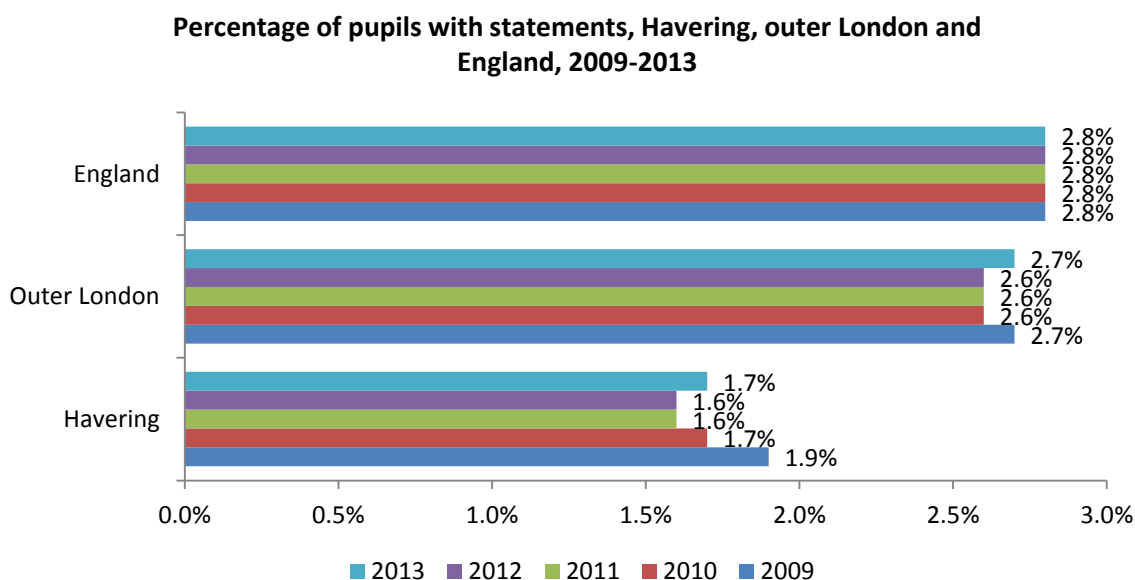
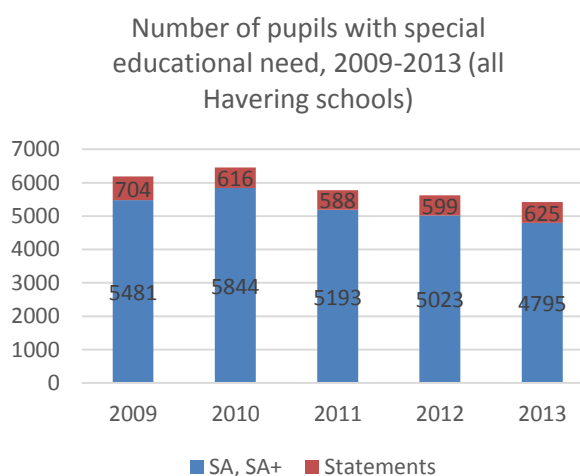
³⁹ As at 28th October 2013, just 72 children who were registered with a Havering GP were recorded as having a learning disability. Five were recorded as having mental ill-health.

Profile of resident and pupil population

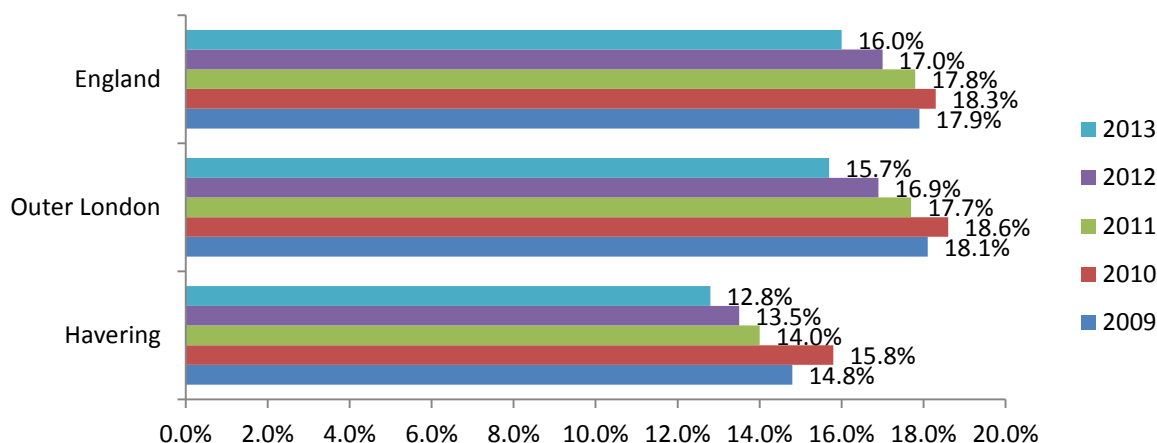
Pupil population: the proportion of Havering pupils with statements fluctuated between 1.6-1.7% over 2010-2013, while over 2010-2013 the SA / SA+ rate declined from 15.8% to 12.8%. This is a consequence of changes in local policy following recommendations from Ofsted's '[special educational needs and disability review](#)'.

Resident population: from 2009-2011, the numbers of pupils for whom Havering was responsible for their statement declined from 700 to 660, and then increased over 2011-2013 by 8.6% (+55 children). In January 2013, LB Havering was responsible for maintaining statements of SEN for 690 pupils; this is higher than the number of pupils in Havering schools with statements.

Pupil population: As at January 2013, there were 5,420 children attending Havering schools who were recorded as having a special educational need (14.5%). The proportion of those supported at SA and SA+ declined over 2010-2013, a trend also seen in outer London and England. There has been a recent upward trend in the number of children with statements in Havering schools; a 4.2% increase between 2012-2013; however the proportion of pupils with a statement has remained broadly consistent over 2010-2013.

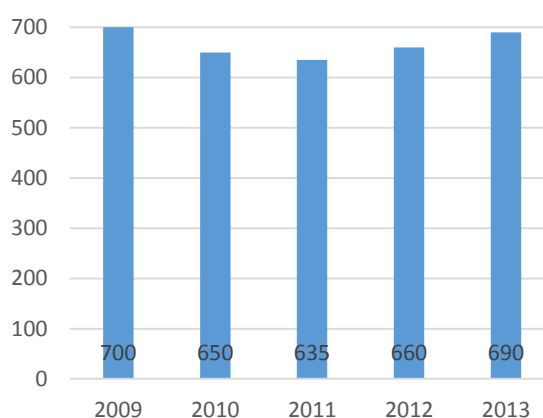


**Percentage of pupils supported at school action or school action plus,
Havering, outer London and England, 2009-2013**



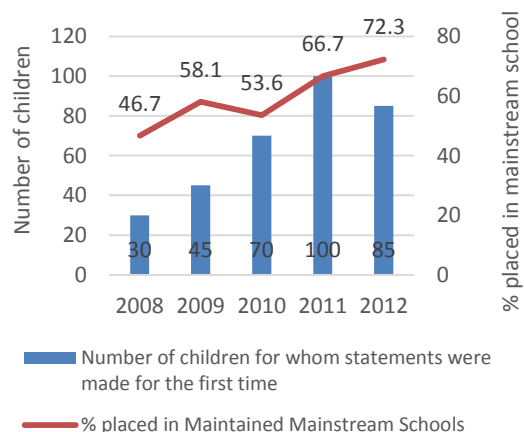
Resident population: Not all children who are supported through a LB Havering statement of SEN attend Havering schools. From 2009-2011, the numbers and rate of pupils for whom Havering was responsible for their statement declined. This then increased over 2011-2013 (+55 children). In January 2013, LB Havering was responsible for maintaining statements of SEN for 690 pupils; this is higher than the number of pupils in Havering schools (including direct grant nursery schools) with statements.

Number of children with a statement maintained by LB Havering, 2009-2013



Over 2008 -2011, Havering issued an increasing number of 'first time' statements of special education need, and these children were increasingly educated in mainstream schools. However, the number of statements issued in 2012 dropped by 15% compared to 2011. In 2012, Havering placed a higher percentage of children with 'new' statements in mainstream provision (72.3%) than outer London authorities (62.3%) and England (60.1%).

Number of 'first time' statements made and % educated in mainstream schools



Comparative profile

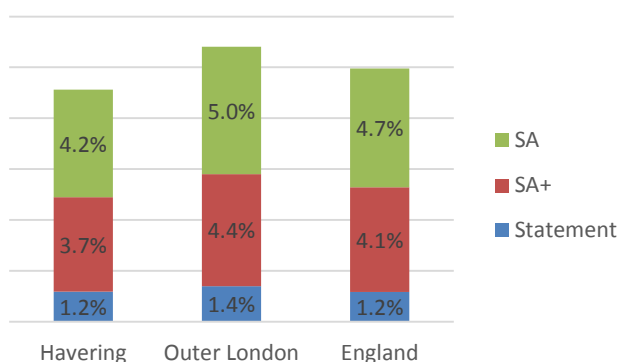
In January 2012, the overall proportion of pupils with identified SEN in Havering schools was lower than outer London and England, with features of Havering's SEN profile that make it markedly different to that of outer London and England, including a significantly lower rate of children with a moderate learning difficulty or autistic spectrum disorder. Data from January 2013 shows lower proportions of SEN pupils with behaviour, emotional and social difficulties (all types of schools) and higher proportions of SEND pupils with moderate learning difficulties in secondary and special schools, compared to England and outer London averages.

In line with Ofsted recommendations, Havering has championed a policy that recognises that behavioural difficulties do not necessarily mean that a child or young person has a SEN and should not automatically lead to a pupil being registered as having SEN. The Havering approach recognises that consistent disruptive or withdrawn behaviours can be an indication of unmet SEN, and these are assessed to determine whether there are any causal factors such as undiagnosed learning difficulties, difficulties with communication or mental health issues. If it is thought housing, family or other domestic circumstances may be contributing to the presenting behaviour a multi-agency approach, supported by the use of the Common Assessment Framework (CAF) may be the appropriate tool.

Early years: comparative profile

In Havering early years provision, 9.1% of children were identified as having a SEN in 2012. The rate supported through a statement was in line with outer London and England, but was lower for support through school action and school action plus.

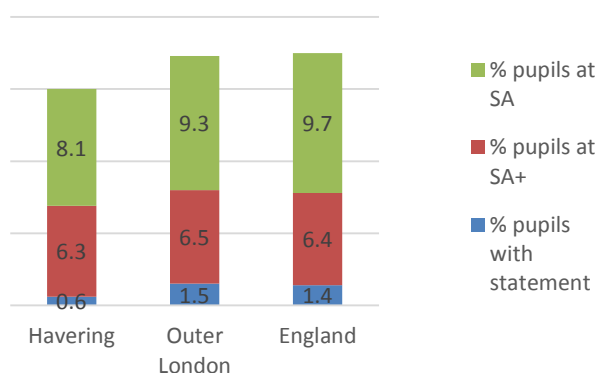
Percentage of children identified with SEN, 2012 (**early years** foundation stage)



Primary age: comparative profile

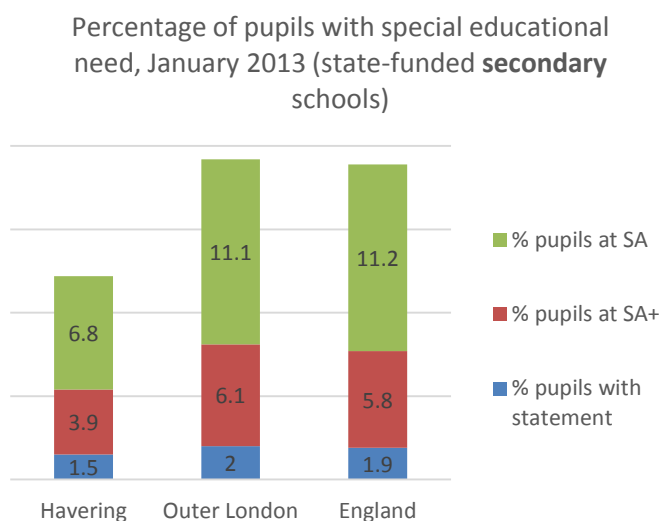
In Havering primary schools, 15% of children were identified as having a SEN in January 2013. The proportion of children supported at SA+ (6.3%) was broadly similar to outer London (6.5%) and England (6.4%) rates. Rates are markedly lower for children supported through statements in Havering (0.6%) and through SA compared to England and outer London.

Percentage of pupils with special educational need, January 2013 (state funded **primary** schools)



Secondary age: comparative profile

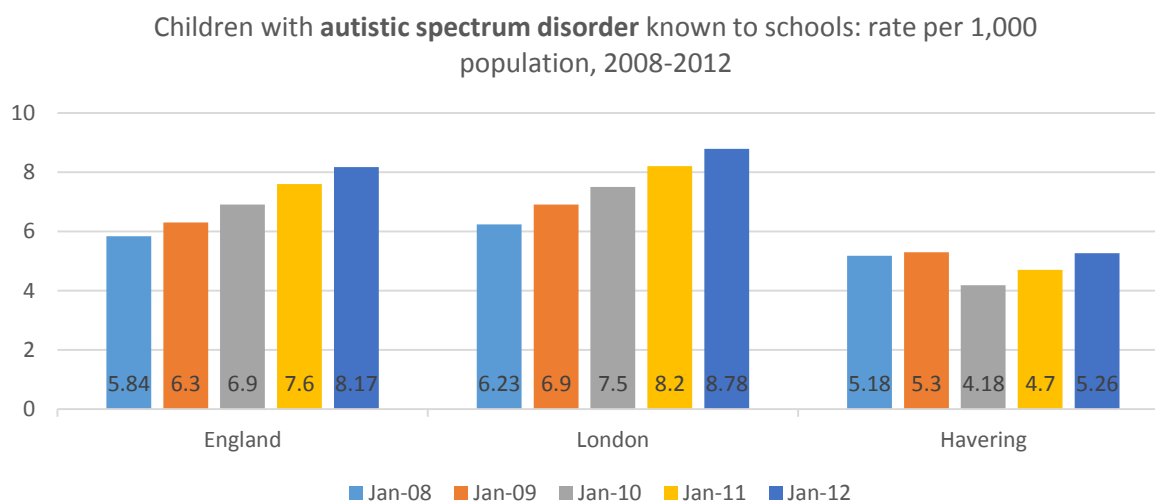
The difference is starkest at secondary level, where the rate of children supported through SA is 6.8% in Havering, compared to 11.1% in outer London and 11.2% across England. The proportion of children supported at SA+ in Havering secondary schools (3.9%) is also considerably lower than outer London (6.1%) and England (5.8%). A total of 12.2% secondary pupils have identified SEN.



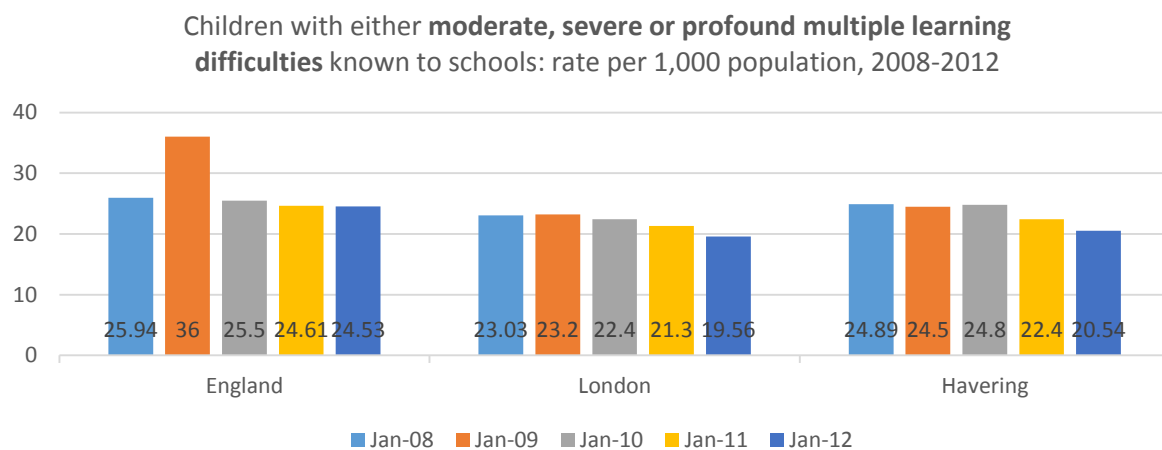
Type of disability: comparative profile

The January 2012 data below is drawn from the [Public Health England: Havering Learning Disabilities Profile 2013](#).

Children with autistic spectrum disorder: 191 pupils in 2008, 196 pupils in 2012 and significantly lower than the England rate in 2012

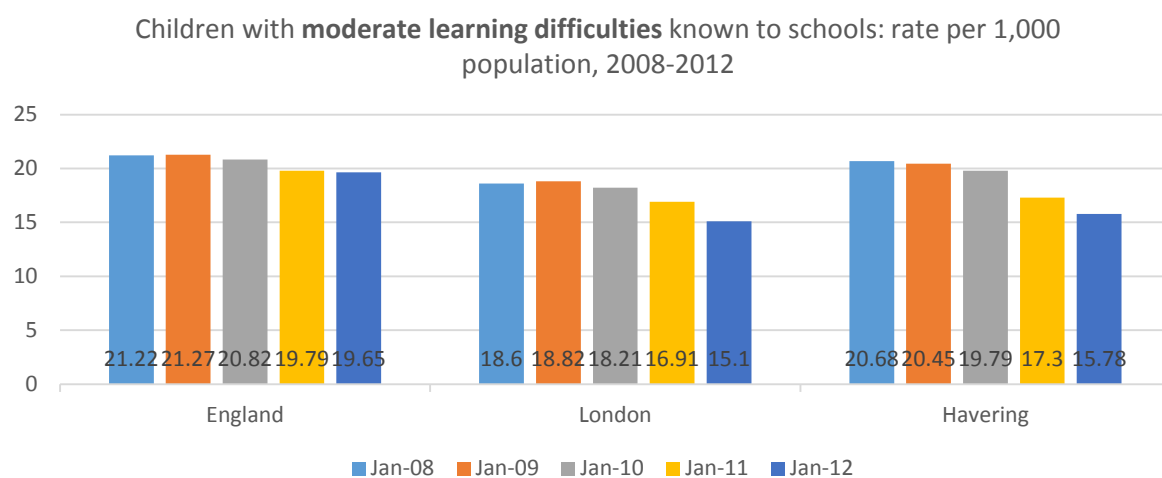


Children with a learning disability (moderate, severe or profound): 917 pupils in 2008, 765 pupils in



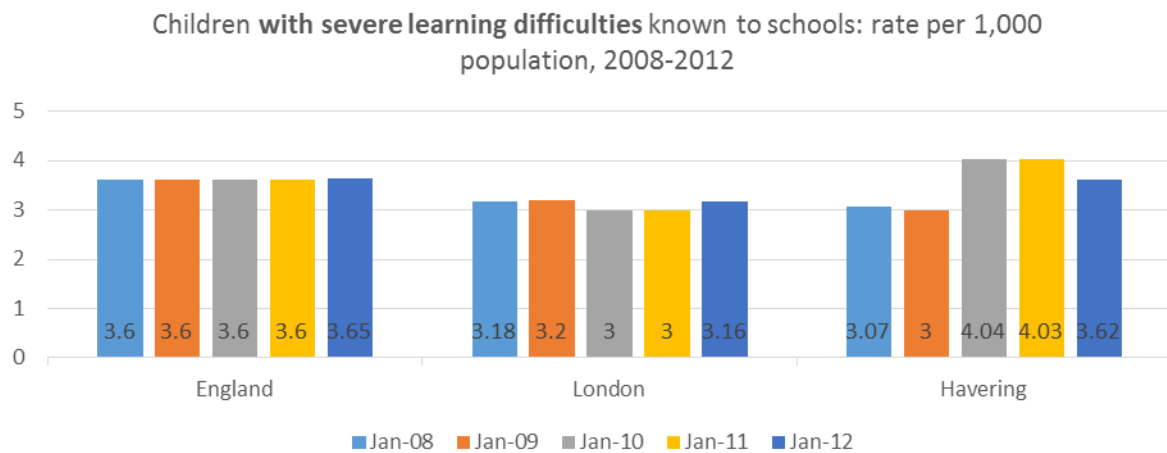
2012 and significantly lower than the England rate

Children with moderate learning difficulties: 762 pupils in 2008, 588 pupils in 2012 and significantly

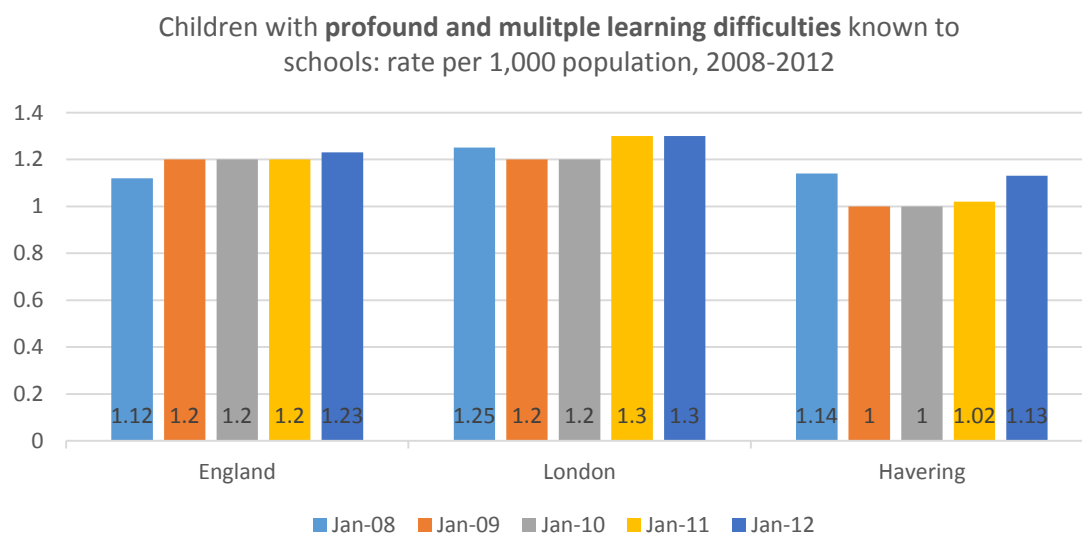


lower than the England rate

Children with severe learning difficulties: 113 pupils in 2008, 135 pupils in 2012 and no significant difference to England



Children with profound and multiple learning difficulties: 42 pupils in 2008, 42 pupils in 2012 and no significant difference to the England rate



The profile of types of SEN varies between Havering's primary, secondary and special schools (Figure 15).

- **At primary level**, speech, language and communication difficulties are by far the most common type of identified SEN, followed by moderate learning difficulties and behaviour, emotional and social difficulties. Together these account for 74% of primary level SEN.
- **At secondary level**, moderate learning difficulties are more prevalent, followed by behaviour, emotional and social difficulties and speech, language and communication needs – these account for 62% of identified secondary level SEN.
- **Special schools** have a very different profile with most children having a severe, moderate or profound and multiple learning difficulties – these account for 79% of SEN in Havering's special schools.

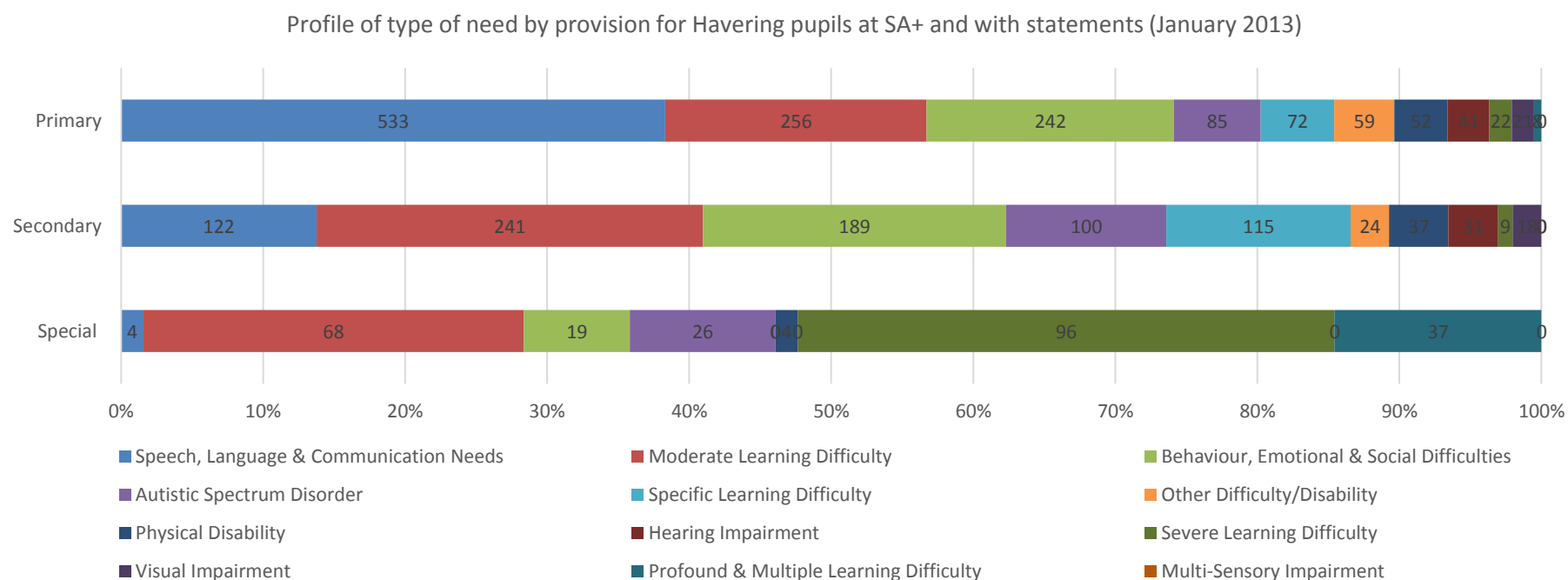
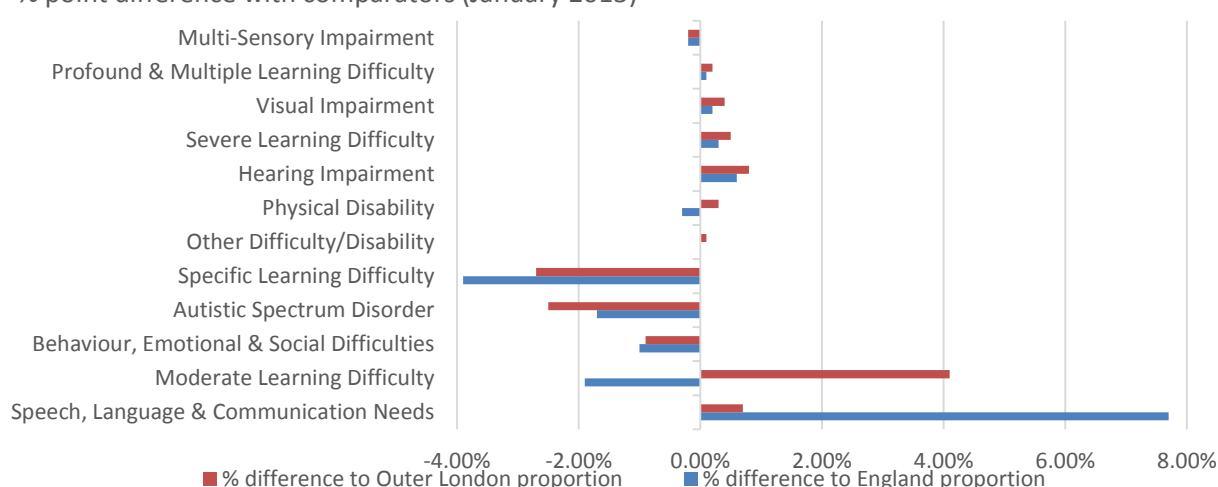


Figure 15: Number and percentage of pupils with statements of special educational needs or at school action plus, by type of need (state-funded primary, secondary and special schools, January 2013)

The profile of SEN amongst primary pupils is broadly similar to outer London and England. **Standout features of the SEN profile in Havering primary schools include:**

- a lower proportion of children with identified **behaviour, emotional and social difficulties, specific learning difficulty and autistic spectrum disorder** compared to England and outer London.
- a higher proportion of children with identified **moderate learning difficulties (MLD)** compared to outer London peers but lower than England.
- a higher proportion of children with identified **speech, language and communication needs** compared to England

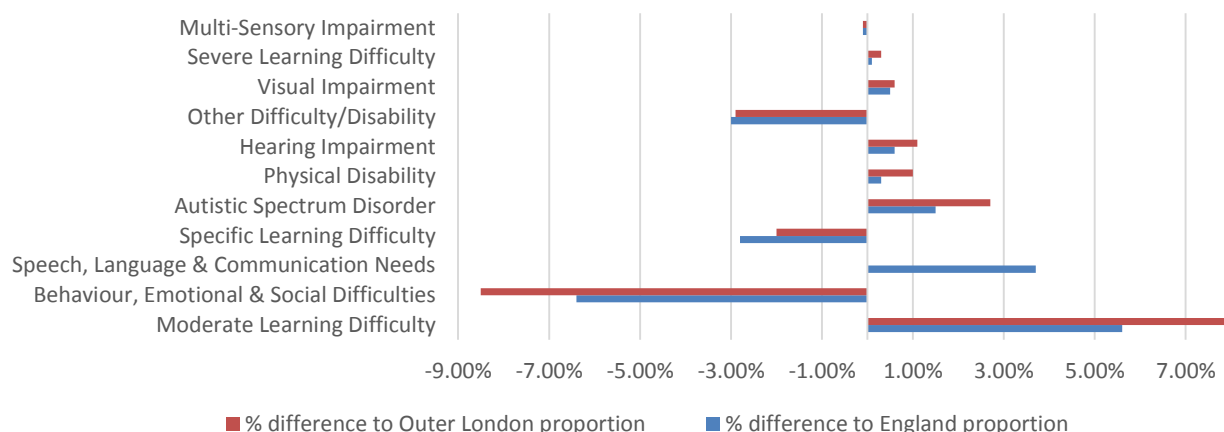
Type of SEN for primary pupils at school action plus and with statements:
% point difference with comparators (January 2013)



The profile of SEN amongst secondary pupils has greater variation against outer London and England. **Standout features of the SEN profile in Havering secondary schools include:**

- a higher proportion of children with **moderate learning difficulties** compared to England and outer London
- a lower proportion of children with **behaviour, emotional and social difficulties, specific learning difficulty or 'other' difficulties / disabilities** compared to outer London and England

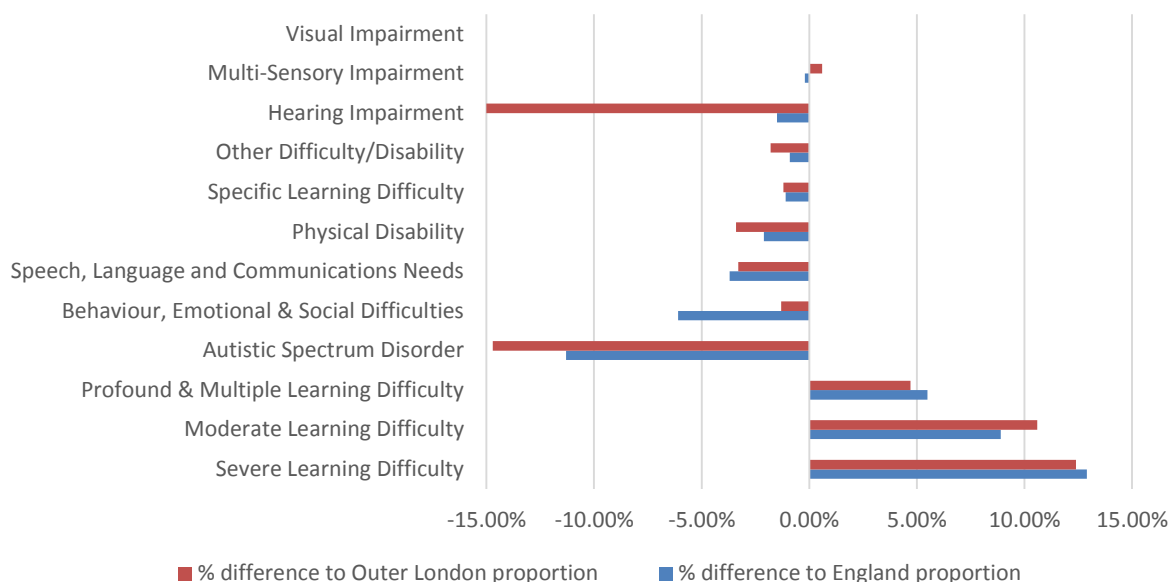
Type of SEN for secondary pupils at school action plus or with a statement: % point difference with comparators (January 2013)



The profile of SEN amongst special school pupils is markedly different to outer London and England. Note small numbers can cause substantial variations in comparative rates. **Key features of the SEN profile in Havering special schools include:**

- a higher proportion of children with identified **severe, moderate, profound or multiple learning difficulty** compared to outer London and England
- lower proportions of **all other types of identified SEN**, particularly autistic spectrum disorder, compared with outer London and England peers

Type of SEN for special school pupils at school action plus or with a statement: % point difference with comparators (January 2013)



Havering pupils supported through school action plus or statements are less likely to attend some form of special educational provision than their outer London and England peers at both primary and secondary level. This difference is more pronounced for secondary pupils.

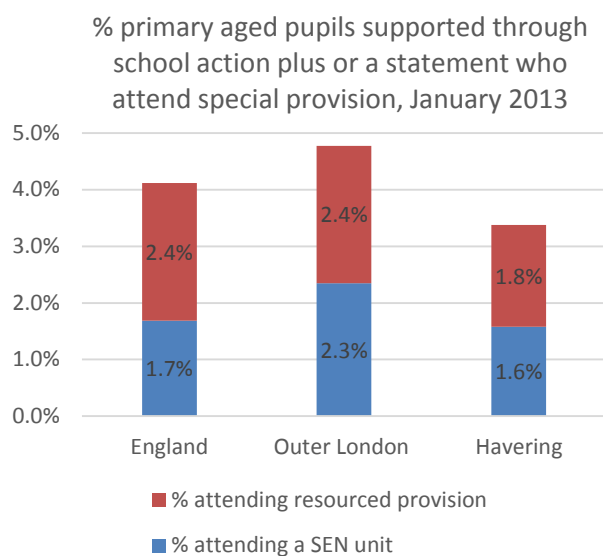


Figure 16: % primary aged pupils supported through school action plus or a statement who attend special provision, January 2013

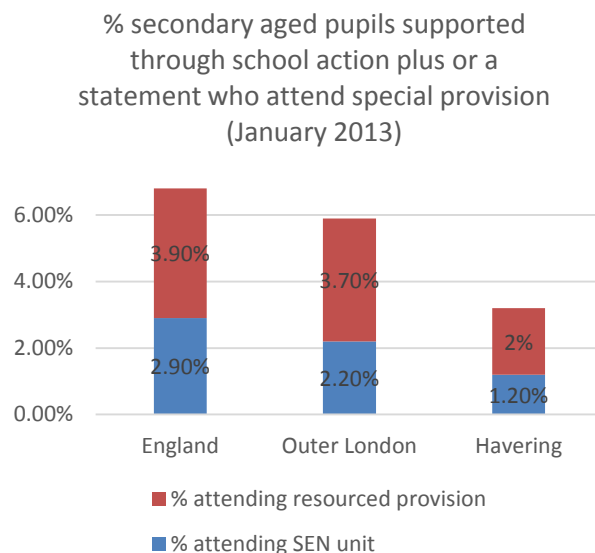


Figure 17: % secondary aged pupils supported through school action plus or a statement who attend special provision, January 2013

Children's therapy services: client profile

North East London Community Services (NELCS) provides therapy services to children aged 0-19 with a Havering GP in a variety of settings including home, clinics, early years and education.

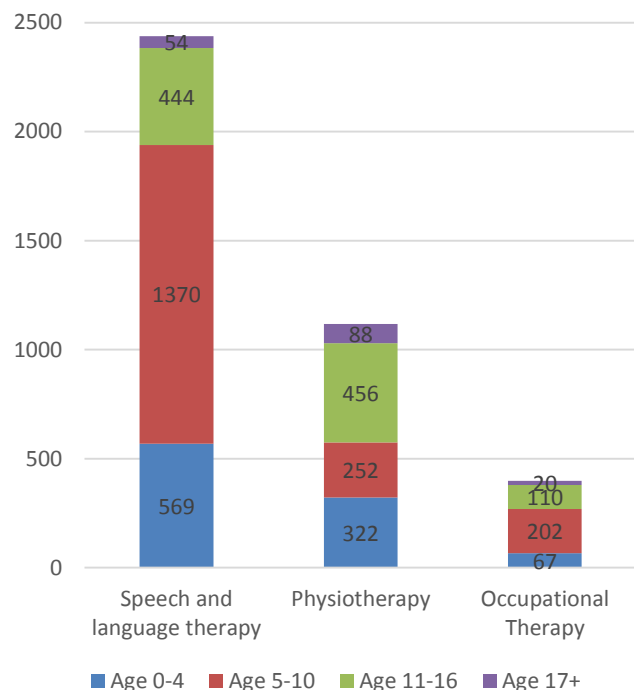
Therapies include:

- Speech and Language
- Occupational Therapy
- Physiotherapy divided into muscular-skeletal and neurology

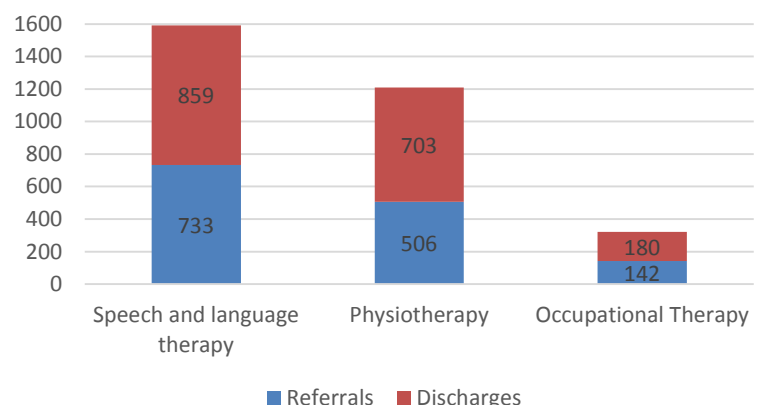
Over the course of Oct 12 to Sept 13:

- 2437 individual children received a direct service from a speech and language therapist. The majority were aged 5-10 (1370). A further 348 children were monitored but did not receive a direct service
- 1118 individual children received a direct service from a physiotherapist. 40% were aged 11-16 years and 29% aged 0-4
- 399 individual children received a direct service from an occupational therapist. 17% were aged 0-4 and 51% were aged 5-10
- There was a high rate of churn for all children's therapies, although the number of children discharged outnumbered children referred for speech and language therapy, physiotherapy and occupational therapy.

Numbers of children receiving a direct service from a therapist, Oct 12 - Sept 13



Children's therapies: numbers of referrals and discharges, Oct 12 - Sept 13



Hearing impaired advisory teacher services: client profile

Babies who do not pass the 'newborn hearing screen' are recorded onto the newborn hearing screening database, which includes a Permanent Childhood Hearing Impairment (PCHI) register. At

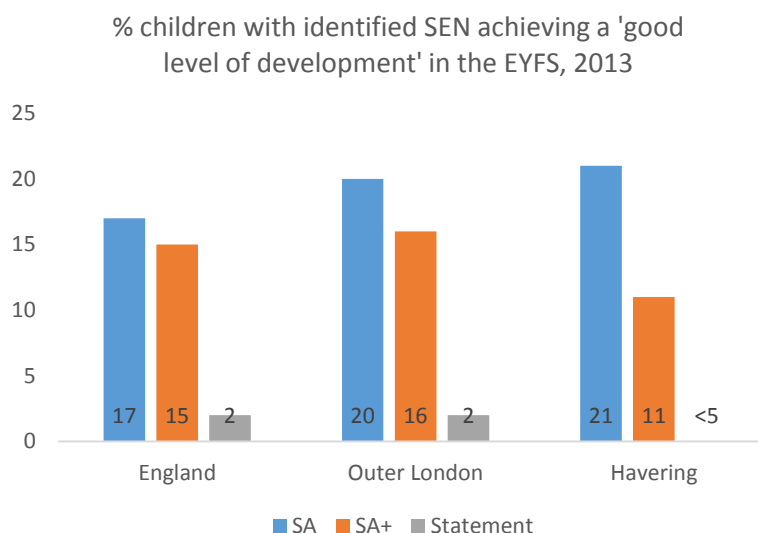
present this register does not separate babies resident in Havering from those resident in other boroughs (i.e. Barking and Dagenham, Redbridge) and therefore it is not been possible to identify, over time, the numbers of babies in Havering who have PCHI.

As at 26th September 2013, there were 215 hearing impaired babies and children seen by the advisory teacher for hearing impaired children, all of whom were Havering residents. Hearing loss for the cohort ranges from mild to profound. The majority of children are hearing aid users or have cochlear implants; a small number with Central Auditory Processing Disorder use an amplification device.

Hearing impaired babies and children seen by the advisory teacher for hearing impaired children (Sept 13)	Number
Babies and pre-schoolers	16
Children attending mainstream primary settings	74
Children attending the primary resource at Hacton Primary	25
Children attending mainstream secondary settings	59
Children attending the secondary resource at Sanders	10
Children attending Special Schools	25
Others (inc, young people at Sixth Form, educated out-of-borough or home tutored)	6
TOTAL	215

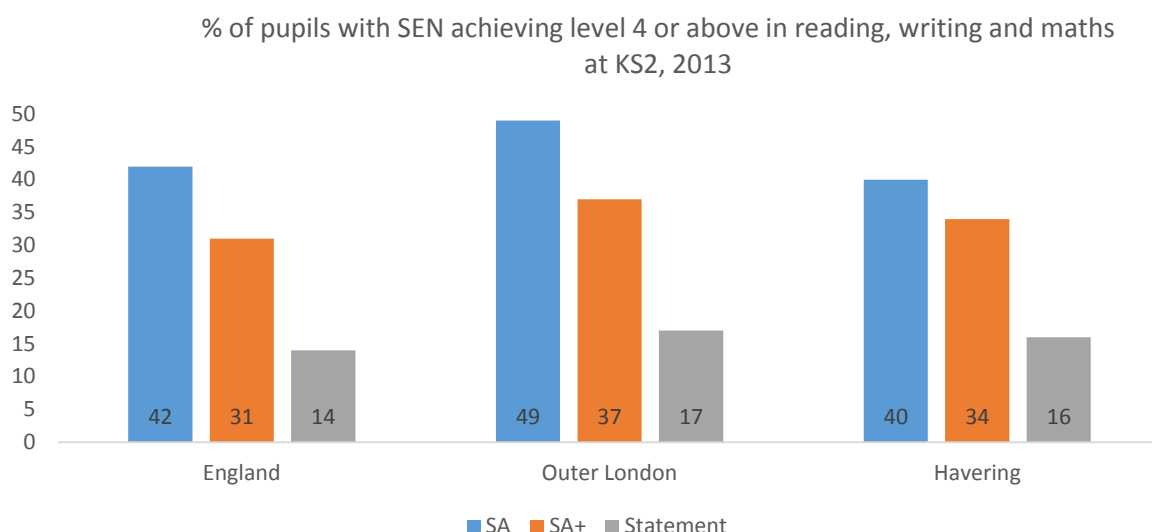
Attainment of pupils with identified SEN: early years foundation stage (EYFS)

At the EYFS, the rate of children supported through SA who achieved a good level of development in 2013 was above the England and outer London average, but below the average at SA+. The small numbers of children in the Havering cohort will cause large fluctuations in proportional rates.



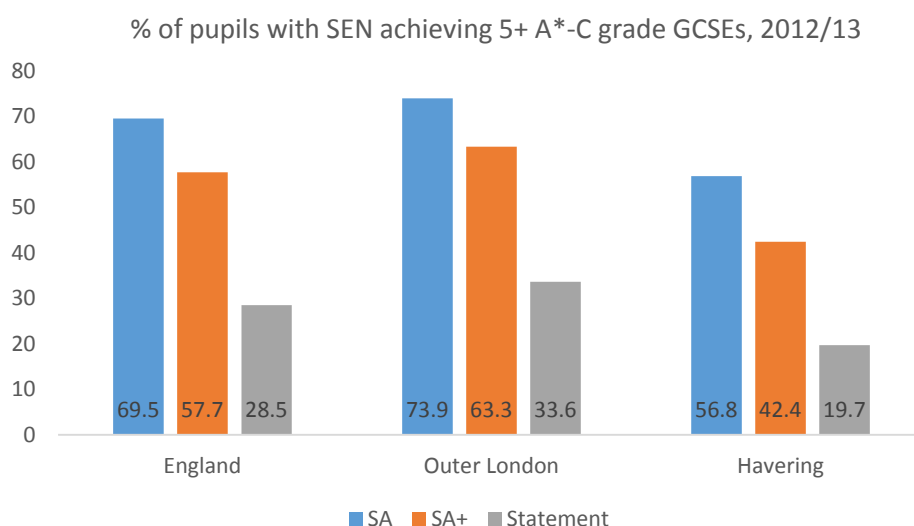
Attainment of pupils with identified SEN: KS2

At KS2 in 2013, the rate pupils with identified SEN achieving level 4 or above in reading, writing and maths was broadly in line with England and outer London averages; again, small numbers within the Havering cohort will cause large fluctuations in proportional rates.



Attainment of pupils with identified SEN: KS4

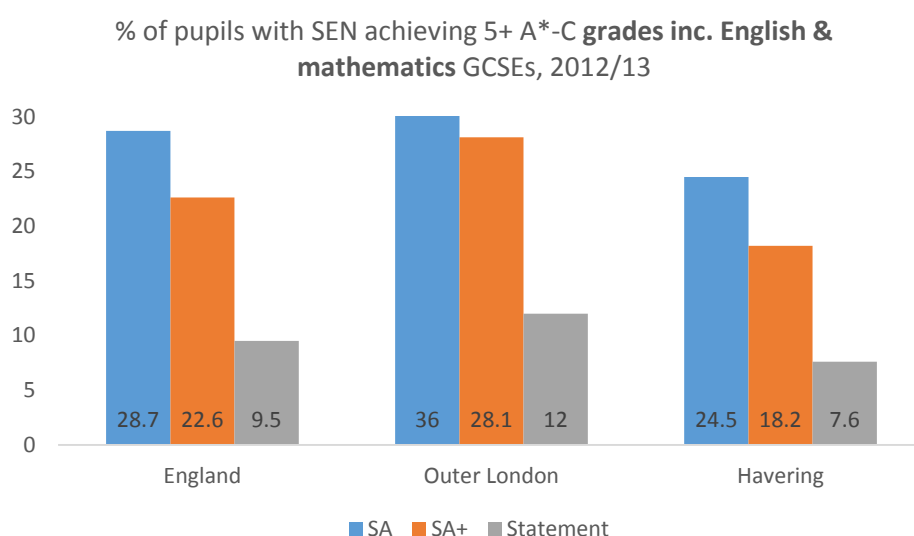
The profile of children supported through the SEN framework in Havering's secondary schools is different to that of outer London and England, with lower proportions of the SEN cohort experiencing emotional and behavioural disorders and higher proportions with moderate learning disabilities. Hence the rate of KS2 benchmark attainment for children with SEN is lower than the average rate across England and outer London and Havering ranked in the lower quintile of national performance for SEN attainment on the 5+ A*-C grade GCSEs measure, and in the bottom 40% of



performance for SEN attainment on the 5+ A*-C grade GCSEs including English and maths measure.

Overall, for the attainment of pupils supported through school action or school action plus, Havering ranked

141/152 authorities on this measure in 2012/13.



Overall, for the attainment of pupils supported through school action or school action plus, Havering ranked 112/152 authorities on this measure in 2012/13.

Exclusions, attendance and children with SEN

Compared to England, Havering had a lower rate of exclusion for pupils with SEN in 2012.

Permanent and fixed term exclusions by provision for SEN, all state funded schools (inc Academies and CTCS), 2012

	SA		SA+		Statement	
	% receiving at least one fixed term exclusion	% receiving a permanent exclusion	% receiving at least one fixed term exclusion	% receiving a permanent exclusion	% receiving at least one fixed term exclusion	% receiving a permanent exclusion
England	4.6%	0.1%	9.5%	0.5%	8.2%	0.2%
Havering	2.8%	Suppressed	6.8%	Suppressed	3.3%	0%
Difference	-1.8%	NA	-2.7%	NA	-4.9%	-0.2%

Absence rates and persistent absenteeism were below the England rate for all types of SEN in 2012.

Absence rates and persistent absenteeism by provision for SEN, all state funded schools (inc Academies and CTCS), 2012

	SA		SA+		Statement	
	% half days missed	% persistent absentees	% half days missed	% persistent absentees	% half days missed	% persistent absentees
England	6.4%	8.4%	7.7%	11.9%	8.2%	13.4%
Havering	6.3%	7.8%	7.3%	10.9	7.6%	11.4%
Difference	-0.1%	-0.6%	-0.4%	-1%	-0.6%	-2%

Considerations for commissioners and service providers

As a consequence of Havering's 'no statement' policy, support for social and emotional difficulties being provided predominantly outside the SEN framework, and with a lack of data available on premature, multiple and low weight births, it is difficult to accurately assess how the local profile of children with special educational need is changing in Havering. Given rising pupil rolls, the national increase in multiple, premature and low weight births, the increased child population in some of Havering's most deprived wards and the link between poverty and disability, it is likely that the number of children with special educational or complex needs will increase. However, improved data collection is needed to support SEN planning.

Individual support for children with complex needs often requires years of advance planning; for example, the lead time for specialist training in sensory impairment is approximately two years, and is required for both for teaching and portage⁴⁰ staff who work with sensory impaired children.

Forthcoming reforms to the legislative SEND framework will require education, health and social care services to work in a number of radically different ways and are too extensive to detail here; this work is currently underway through Havering's SEND project group.

⁴⁰ Portage is a home-visiting educational service for pre-school children with additional support needs and their families.

Children's mental health and relationships

The government strategy for mental health⁴¹ recognises that mental health problems contribute to perpetuating cycles of inequality through generations. Early interventions, particularly with vulnerable children and young people, can improve lifetime health and wellbeing, prevent mental illness and reduce costs incurred by ill health, unemployment and crime.

Improved mental health and wellbeing is associated with a range of better outcomes for people of all ages and backgrounds. These include improved physical health and life expectancy, better educational achievement, increased skills, reduced health risk behaviours such as smoking (over 40% of children who smoke have conduct and emotional disorders⁴²) and alcohol misuse, reduced risk of mental health problems and suicide, improved employment rates and productivity, reduced anti-social behaviour and criminality, and higher levels of social interaction and participation. Children with a long term physical illness are twice as likely to suffer from emotional or conduct disorders.

Stigma and experiences of discrimination continue to affect significant numbers of people with mental health problems. For all groups of people with mental health disorders, including children, this can:

- stop people from seeking help;
- keep people isolated, and therefore unable to engage in ordinary life, including activities that would improve their wellbeing;
- mean that support services have low expectations of people with mental health problems, for example their ability to do well at school; and
- stop people being educated, realising their potential and taking part in society

Risk factors for mental illness in childhood can be grouped as child, parental and household factors. Regarding parental factors, alcohol, tobacco and drug use during pregnancy increase the likelihood of a wide range of poor outcomes that include long-term neurological and cognitive–emotional development problems. Maternal stress during pregnancy is associated with increased risk of child behavioural problems, low birth weight is associated with impaired cognitive and language development, poor parental mental health with four- to five-fold increased risk of emotional/conduct disorder and parental unemployment with two- to three-fold increased risk of emotional/conduct disorder in childhood. Child abuse and adverse childhood experiences result in increased risk of mental illness and substance misuse/dependence later in life. Looked-after children, those with intellectual disability and young offenders are at particularly high risk⁴³. In addition, teenage parents, young carers, children living in households affected by domestic violence those with a physical disability and those not in education, training or employment tend to have higher rates of mental ill-health than their peers.

⁴¹ HM Government. (2011). [No Health without Mental Health: a cross government mental health outcomes strategy for people of all ages](#)

⁴² Green, H., et al. (2005). *Mental Health of Children and Young People in Great Britain, 2004*. Basingstoke: Palgrave Macmillan.

⁴³ Royal College of Psychiatrists. (2010). [No health without public mental health: the case for action](#). Position Statement PS4/2010.

Conduct disorders are characterised by repetitive and persistent patterns of antisocial, aggressive or defiant behaviour that amounts to significant and persistent violations of age-appropriate social expectations. They are associated with increased risk of personality disorder, with 40–70% of children with conduct disorder developing antisocial personality disorder as adults⁴⁴. Overall, children who had conduct disorder or sub-threshold conduct problems in childhood and adolescence and whose problems are not treated contribute disproportionately to all criminal activity. Nearly half of children with early-onset conduct problems experience persistent, serious, life-course problems including also crime, violence, drug misuse and unemployment⁴⁵.

Pre-school children

There is relatively little data about prevalence rates for mental health disorders in pre-school age children. A literature review of four studies looking at 1,021 children aged 2 to 5 years inclusive, found that the average prevalence rate of any mental health disorder was 19.6% (Egger et al, 2006)⁴⁶. According to the Child and Maternal Health Intelligence Network, in 2013, there are 2,230 children aged 2 to 5 years inclusive living in Havering who have a mental health disorder⁴⁷.

School-age children

Current and projected numbers of children with mental health issues are based on prevalence rates identified by Green et al⁴⁸; these are set out in Figure 19. The work of Green et al is used by the Child and Maternal Health Intelligence Network to produce an [Annual CAMHS Needs Assessment](#) for all local authorities. Their work used the ICD-10 Classification of Mental and Behavioural Disorders with strict impairment criteria i.e. the disorder was sufficient to be causing distress to the child or having a considerable impact on the child's day to day life. Prevalence varies by age and sex, with boys more likely to experience a mental health problem than girls. Children aged 11 to 16 years olds

	Boys aged 5-10	Girls aged 5-10	Boys aged 11-16	Girls aged 11-16
Conduct disorders	6.9%	2.8%	8.1%	5.1%
Emotional disorders	2.2%	2.5%	4.0%	6.1%
Hyperkinetic disorders	2.7%	0.4%	2.4%	0.4%
Less common disorders	2.2%	0.4%	1.6%	1.1%

are also more likely than 5 to 10 year olds to experience mental health problems.

Figure 18: Estimated prevalence rates of mental health disorders at a national level, Green et al, 2004

⁴⁴ National Institute for Health and Clinical Excellence (2009) [Antisocial Personality Disorder, Treatment, Management and Prevention](#).

⁴⁵ Fergusson DM, Horwood LJ, Ridder EM (2005) Show me the child at seven: the consequences of conduct problems in childhood for psychosocial functioning in adulthood. *Journal of Child Psychology*, 46, 837–849.

⁴⁶ Egger, H. L. and Angold, A. (2006) Common emotional and behavioural disorders in preschool children: presentation, nosology, and epidemiology. *Journal of Child Psychology and Psychiatry*, 47 (3-4), 313–37.

⁴⁷ [Child and maternal health intelligence network](#). Accessed 1st November 2013.

⁴⁸ Green, H., McGinnity, A., Meltzer, H., Ford, T. and Goodman, R. (2004) Mental health of children and young people in Great Britain, 2004. Office for National Statistics. London, HMSO.

Based on the prevalence rates identified by Green et al, Figure 19, shows the estimated number of children resident in Havering with a mental health disorder by age and sex.

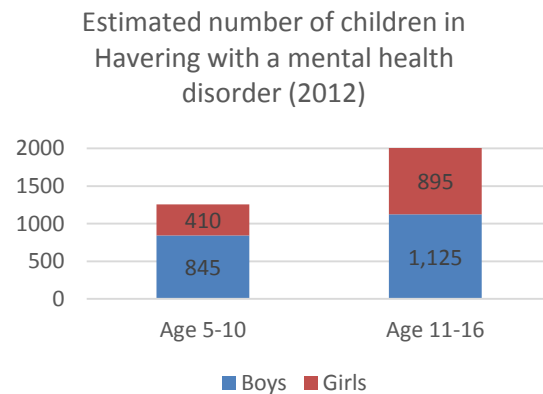


Figure 19: estimated number of children in Havering with a mental health disorder 2012, by age and sex

Based on the assumption that prevalence rates in Havering are in line with the CHIMAT annual needs assessment and the work of Green et al, Figure 20 shows the expected numbers of children with a mental health disorder by age group and sex in Havering⁴⁹ in 2013. The numbers cited in Figure 20 will not add to the same as those in Figure 19 as some disorders will be concurrent. The skewed profile of childhood deprivation across Havering means it is likely that the prevalence of mental health disorders are not uniform across the borough.

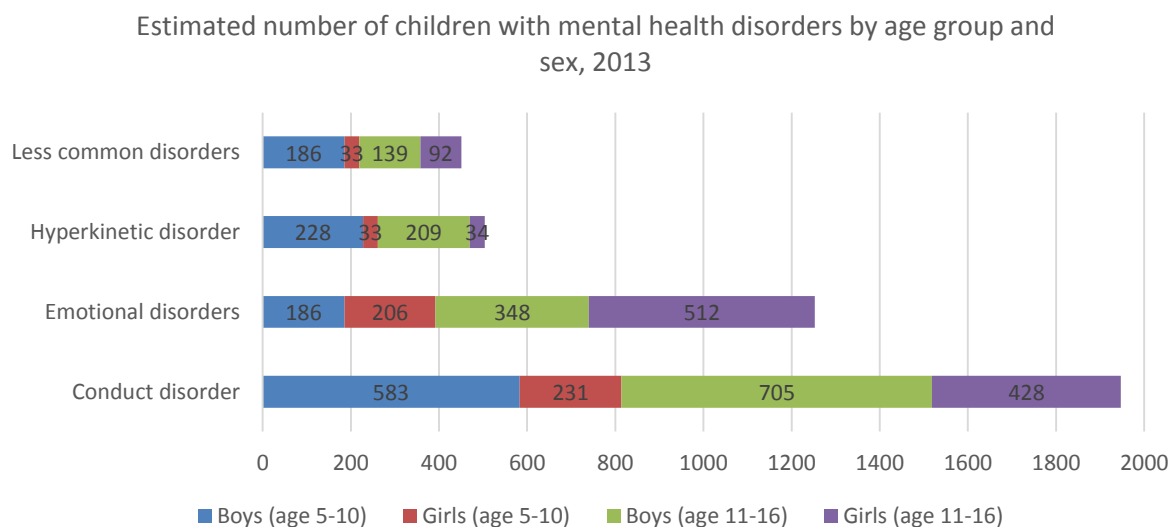


Figure 20: estimated number of children with mental health disorders by age and sex, 2013 (based on estimated national prevalence rates)

⁴⁹ Source: Office for National Statistics mid-year population estimates for 2012

Child and adolescent mental health service (NELFT / Havering, tier 2 and 3): client profile

The profile of current NELFT / Havering CAMHS service provision is shown to the right. Services included here are:

- **Havering specialist CAMHS** (tier 2 primary mental health and tier 3);
- **INTERACT** (works between tier 3 and 4 as a bridging service and carries out adolescent outreach work to prevent escalation to tier 4).
- **Perinatal services.** These are part of adult mental health services, supporting mothers with mental health issues in the early stages of post-partum.
- **PIMHS** is part of the perinatal provision provided through CAMHS and working with mothers who are vulnerable to emotional/mental health problems, with young children. They are supported to manage issues such as bonding.

From the data provided, it has not been possible to separate out those services provided directly to children and young people, as opposed to services to support their mothers in parenting.

The majority of CAMHS service users were white British (84.2%), 4.3% were of

unknown ethnic origin and the remaining 11.5% are from a range of ethnic minority backgrounds. Services are heavily skewed towards adolescents, in line with the estimated mental health profile in Figure 19. The profile in Figure 20 is markedly different to the profile of CAMHS service provision (above), with

Presentation	Numbers of individuals receiving a Tier 2 or 3 Havering CAMHS, 2012-13
Emotional Disorders, includes OCD, PTSD	542
Hyperkinetic Disorders, includes ADHD	237
Autism Spectrum Disorders	169
Conduct Disorders, including anti-social behaviour	124
Deliberate Self Harm, includes overdose	116
Not Possible to State	73
Developmental Disorders	45
Other	40
Habit Disorders, includes tics, soiling	34
Learning disabilities, moderate - severe	32
Eating Disorders, includes preschool problems	12
Substance Abuse, drug and alcohol misuse	10
Psychotic Disorders	8
NULL	623
Total	2065

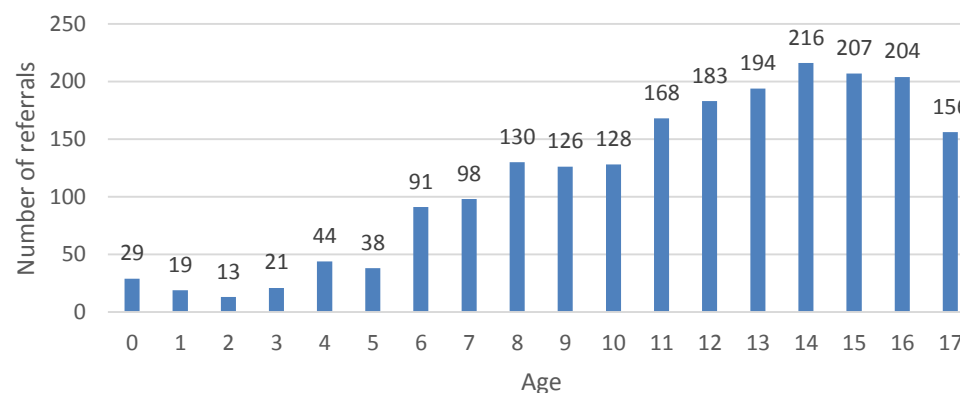
the majority of CAMHS tier 2 and 3 service provision⁵⁰ focused on emotional disorders. This needs to be considered in light of the inclusion of data for two services that provide support to mothers, rather than directly to children.

Assuming the 124 individuals listed in the table are children receiving a direct service (i.e. are not mothers aged 18+), CAMHS services for conduct disorders as the primary presentation are currently provided to 0.2% of the 0-17 population and accounts for 8.6% CAMHS service provision set out here, excluding 'null' presentations from calculations (6% with null presentations included).

Over 2012-13, Havering's CAMHS provided tier 2 and 3 services to 2065 individuals⁵¹. Not all those supported through Havering's CAMHS live in Havering, and not all are registered with a Havering GP; 1956 individuals were registered with a Havering GP and 105 were registered with a GP out of the area⁵².

The majority of children receiving a CAMHS service are recorded as living in RM1 (47.8% / 987 individuals) or RM3 (22.9% / 473 individuals). These postcodes cover Romford town, Harold Wood, Harold Hill, Noak Hill and Harold Park. 11.7% of referrals are for children living in RM7, which includes Rush Green, Mawneys and Romford.

Number of children receiving a CAMHS by age of child, 2012/13



⁵⁰ Services include: ADHD Management, CAMHS Triage, INTERACT, Paediatric Liaison Team, Parent Infant Mental Health, Perinatal Team, Primary Mental Health Team and Tier 3 CAMHS

⁵² An additional four children do not have their GP recorded

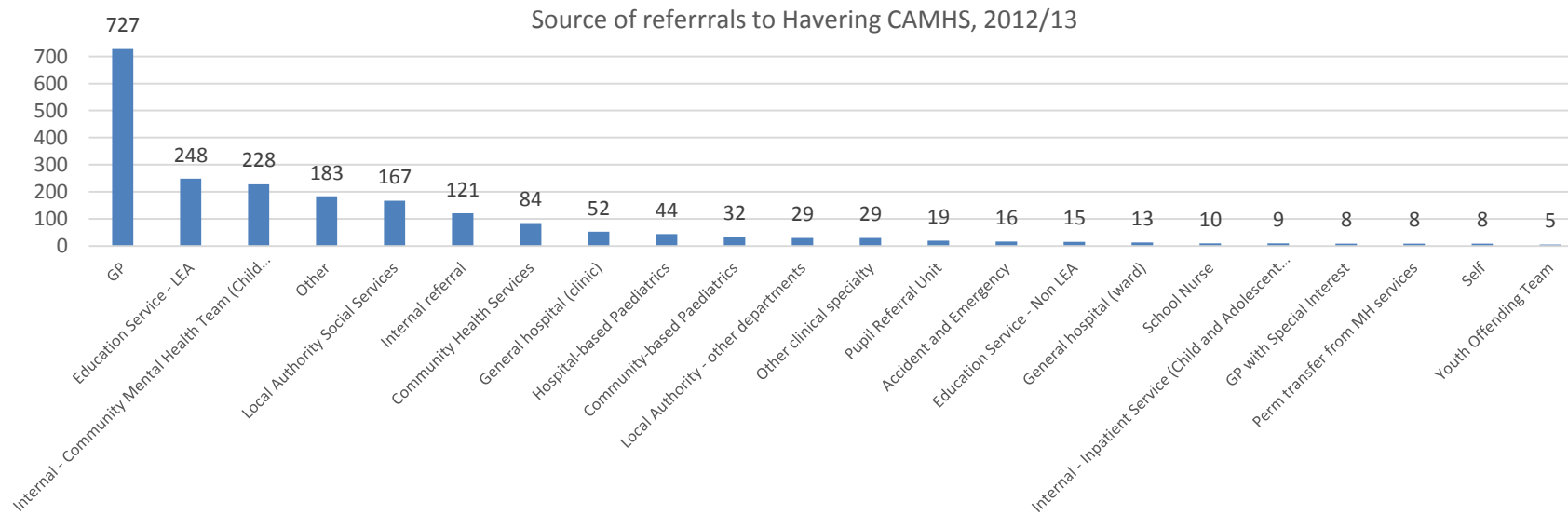
NEFLT / Havering CAMHS: client profile

- More males than females received a CAMHS service in 2012/13 (56% males, 44% females). The profile of presentation was markedly different based on sex.
- 542 individuals received services for emotional disorders: 313 (57%) were female and 333 (61%) were aged 12-17 years. 388 (72%) of these individuals resided in RM1 or RM3
- 237 individuals received services for hyperkinetic disorders: 199 (84%) were male and 107 (45%) were aged 7-11 years. 167 (70%) of these individuals resided in RM1 or RM3; and 50 (21%) in RM5 or RM7
- 169 individuals received services for autistic spectrum disorders: 139 (82%) were male and 79 (48%) were aged 5-11 years. 122 (72%) of these individuals resided in RM1 or RM3
- 124 individuals received services for conduct disorder: 104 (84%) were male and 88 (71%) were aged 10-15 years. 90 (73%) of these individuals resided in RM1 or RM3
- 116 individuals received services for deliberate self-harm: 90 (78%) were female and 83 (72%) were aged 14- 16 years. 79 (68%) of these individuals resided in RM1 or RM3

FEMALES Most common primary need for CAMHS (as a % of age cohort)			
Age band	1	2	3
0-4	Emotional Disorders, including OCD, PTSD 29%	Figures are suppressed	Figures are suppressed
5-10	Emotional Disorders, including OCD, PTSD 33%	Autism Spectrum Disorders 7%	Hyperkinetic Disorders including ADHD 6%
11-15	Emotional Disorders, including OCD, PTSD 36%	Deliberate Self Harm, including overdose 12%	Hyperkinetic Disorders including ADHD 5%
16-17	Emotional Disorders, including OCD, PTSD 36%	Deliberate Self Harm, including overdose 18%	Figures are suppressed

MALES Most common primary need for CAMHS (as a % of age cohort)			
Age band	1	2	3
0-4	Emotional Disorders, including OCD, PTSD 21%	Figures are suppressed	Figures are suppressed
5-10	Hyperkinetic Disorders including ADHD 20%	Emotional Disorders, including OCD, PTSD 15%	Autism Spectrum Disorders 13%
11-15	Emotional Disorders, including OCD, PTSD 22%	Hyperkinetic Disorders including ADHD 18%	Autism Spectrum Disorders 14%
16-17	Emotional Disorders, including OCD, PTSD 23%	Hyperkinetic Disorder, including ADHD 10%	Autism Spectrum Disorders 8% Conduct Disorders, inc anti-social behaviour, 8%

Most individuals are referred through their GP. Very few referrals are made directly by universal services such as school nurses (although some referrals may have been included within the community health service count) or youth services. However, a review of Havering GP records showed just five children with a mental health diagnosis. Figures from other referral sources (i.e. drugs services, family / friends / neighbour) are suppressed due to low numbers.



Estimates of the number of children and young people who may experience mental health problems appropriate to a response from CAMHS at tiers 1, 2, 3 are based on estimates from Kurtz (1996)⁵³. These are the **standard rates** used to inform the Child and Maternal Health Intelligence Observatory's Annual CAMHS Needs Assessment for all England local authorities.

Estimates are based on national estimates of prevalence; other socio-economic factors have not been taken into account.

NELFT / Havering CAMHS currently provides tier 2 and 3 services to a significantly lower number of individuals than set out in Figure 21. This could be due to lower prevalence rates in the local community, under-identification of mental health disorders in children, barriers to accessing the CAMHS, because locals are accessing service through other providers, or a number of other factors.

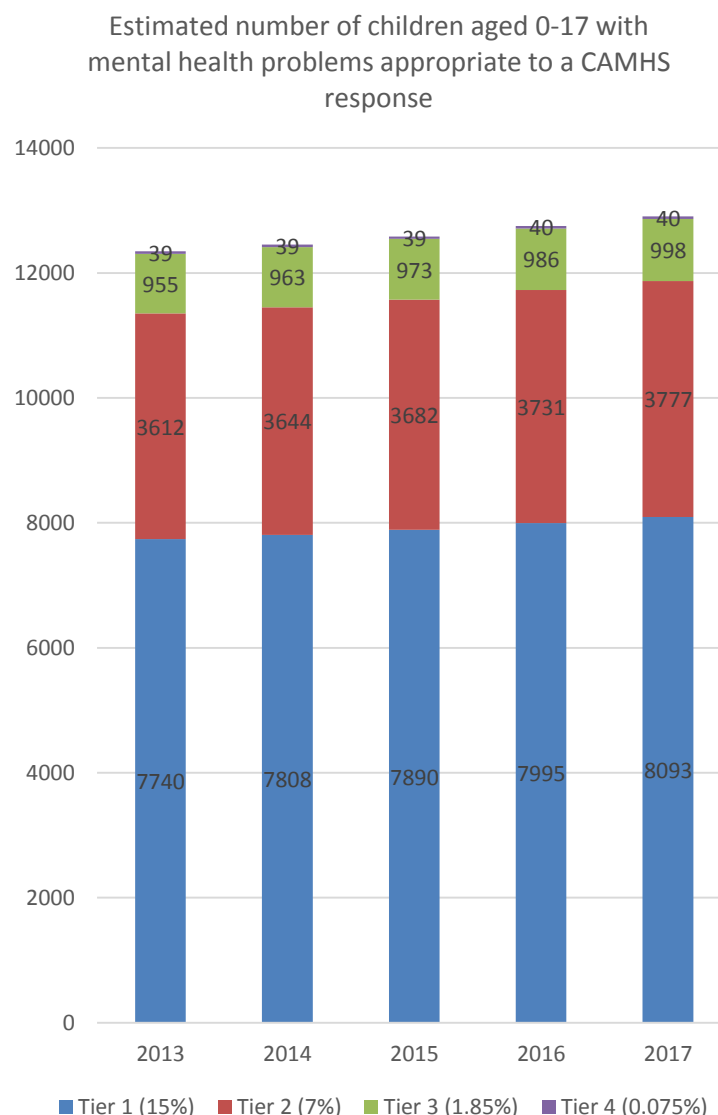
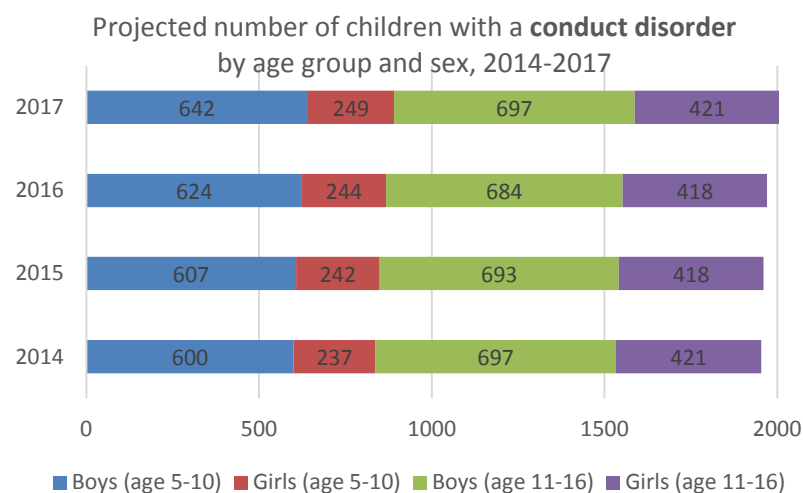


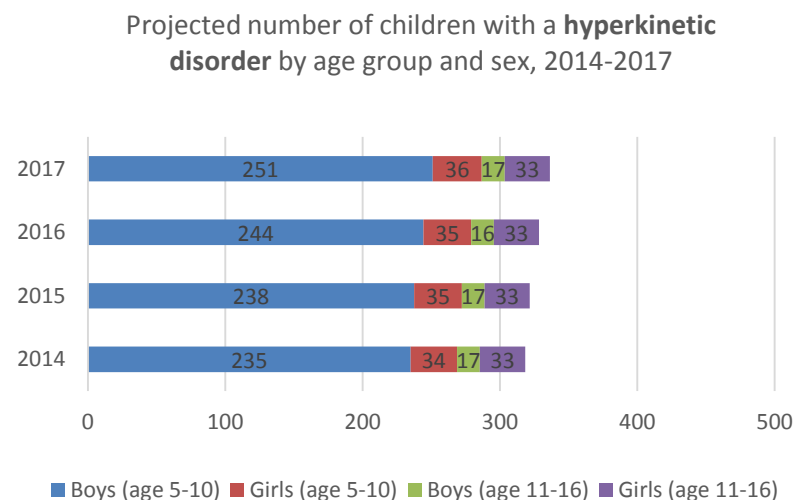
Figure 21: estimated number of children aged 0-17 with mental health problems appropriate to a CAMHS response, 2013-2017

⁵³ Kurtz, Z. (1996) Treating children well: a guide to using the evidence base in commissioning and managing services for the mental health of children and young people. London. Mental Health Foundation.

The four mental health disorders listed in Figure 20 are the key disorders that account for behavioural, emotional and social SEN in school. Havering has relatively low rates of identified SEN associated with behaviour, social and emotional difficulties at secondary level when compared to outer London and England as a consequence of local policy to support these children through other forms of multi-agency assessment and support, such as the common assessment framework. Therefore it might be expected that CAMHS service level data would reflect this. Yet CAMHS tier 2 and 3 service level data for 2012/13 shows rates of service provision rates below what would be expected, even if Havering was identifying and supporting children with EBD through the SEN framework, with rates in line with comparators. **The projections provided below are based on local population projections and assume current levels of need reflect national prevalence rates; they do not account for existing local variations in prevalence, local changes in socio-economic determinants or the potential for current under-identification.** As the aged 11-16 population is expected to remain static between 2014 and 2017, rises in prevalence of mental health disorders are not anticipated using this model; however, service demand for this group may rise as a consequence of shifts in local socio-economic factors.

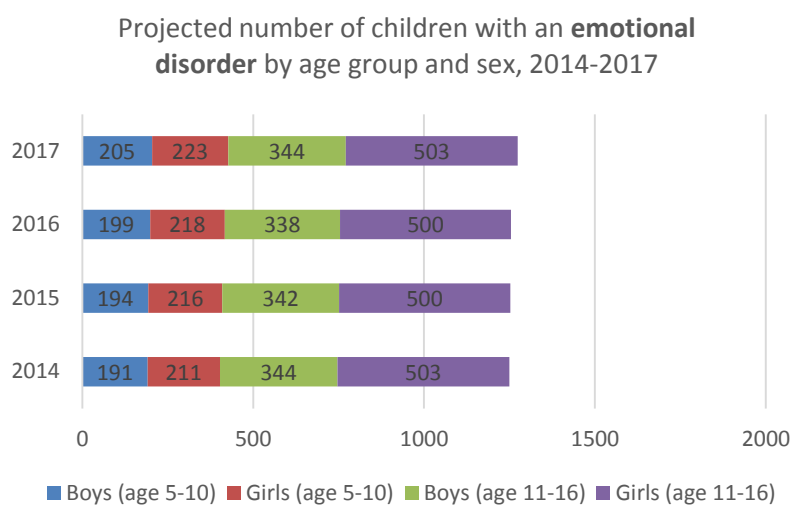


Conduct disorders: the number of children aged 5-10 with a conduct disorder is expected to rise by 54 between 2014 and 2017. Most of this rise is accounted for by boys.

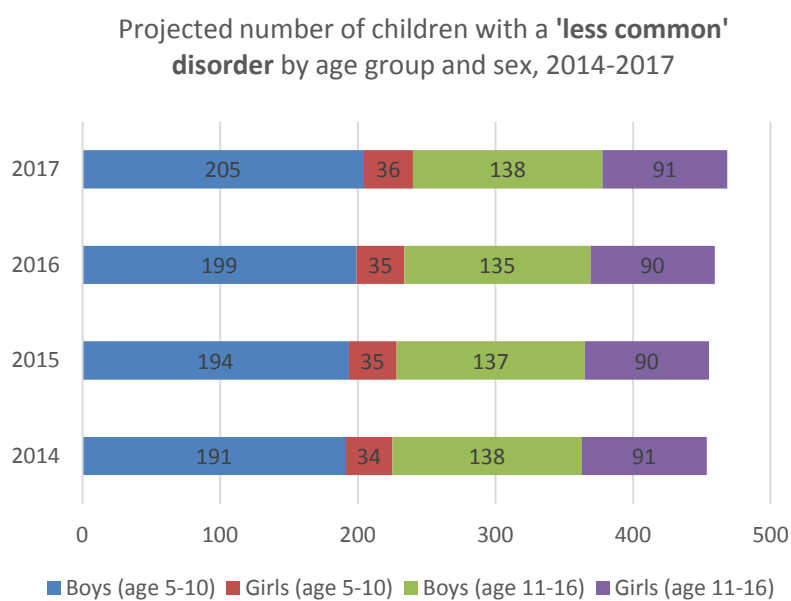


Hyperkinetic disorders: the number of children aged 5-10 with a hyperkinetic disorder is expected to rise by 18 between 2014 and 2017. This is accounted for almost exclusively by boys.

Emotional disorders: the number of children aged 5-10 with an emotional disorder is expected to rise by 26 between 2014 and 2017. This rise is approximately equal for boys and girls.

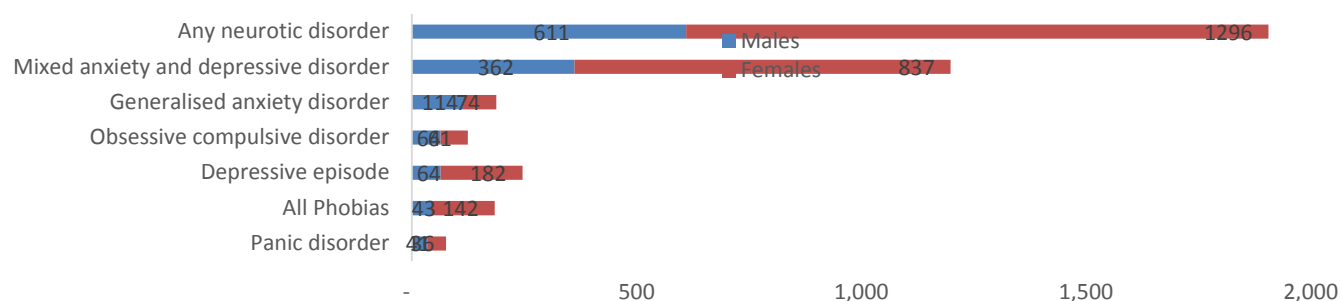


Less common disorders: the number of children aged 5-10 with an emotional disorder is expected to rise by 16 between 2014 and 2017. This is accounted for almost exclusively by boys.



Research by Singleton et al (2001)⁵⁴ estimates prevalence rates for neurotic disorders in young people aged 16 to 19 inclusive living in private households. The chart below shows how many 15 to 19 year olds would be expected to have a neurotic disorder when these prevalence rates are applied to the age 15-19 Havering population of Havering⁵⁵.

Estimated number of young people aged 15 to 19 with neurotic disorders, 2017
(based on research from Singleton et al (2001) and used to inform the annual CHIMAT Havering CAMHS needs assessment)



⁵⁴ Singleton, N., Bumpstead, R., O'Brien, M., Lee, A. and Meltzer, H. (2001) Psychiatric morbidity among adults living in private households, 2000. Office for National Statistics. London. HMSO

⁵⁵ Unable to source population estimates on residents aged 16-19 only, hence prevalence figures have been applied to the 15-19 population

Childhood Eating Disorders

According to a report from Micali et al (2013)⁵⁶, eating disorders have the highest death rates of all mental disorders. Micali et al found that adolescent girls aged 15–19 had the highest incidence of eating disorders at 2 per 1000, and that eating disorders are probably the most common new onset mental health disorder in adolescent girls after depression. On this basis, there are an estimated 14–15 girls aged 15–19 with an eating disorder in Havering. No females of this age were supported by Havering CAMHS tier 2 and 3 services for eating disorders in 2012/13. Overall, Havering CAMHS provided services to 12 children with eating disorders, 9 of whom were aged between 4–14 years.

Epidemiological studies suggest that although the incidence of eating disorders has been fairly static over the last few decades, individuals with anorexia nervosa are presenting at an earlier age. Researchers estimate that this gives an overall incidence rate of 3.01 cases in every 100,000 children.

Mental health and hospital admissions

Higher rates of admission to hospital for mental health disorders can indicate that universal services are not identifying children in need of support early enough, or that CAMHS are not making effective enough interventions.

There were 39 admissions for mental health disorders amongst 0–17 year olds in Havering in 2011–2012. This equates to 76.7 admissions per 100,000 residents aged 0–17 (lower than England at 91.3 per 100,000 but higher than Bexley).

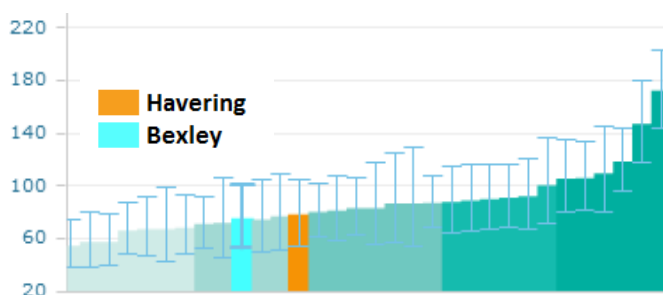


Figure 22 Inpatient admission rate for mental health disorders per 100,000 population aged 0–17 years, 2011/12

Over the same period (2011/12), there were 61.9 admissions for self-harm for every 100,000 0–17 year olds in Havering. This was lower than England (115.5 per 100,000) and Bexley (75.7 per 100,000). Havering ranked in the second lowest quintile in London.

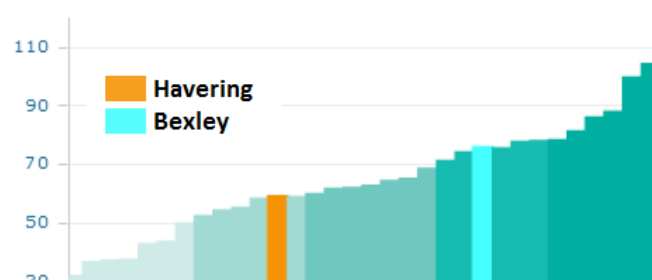


Figure 23 Crude rate of emergency admissions for self-harm (0–17 years) per 100,000 population aged 0–17 years, 2011/12

⁵⁶ Micali, N., Hagberg, KW., Petersen, I, and Treasure, JL. (2013). The incidence of eating disorders in the UK in 2000–2009: findings from the General Practice Research Database. *BMJ Open* 2013;3

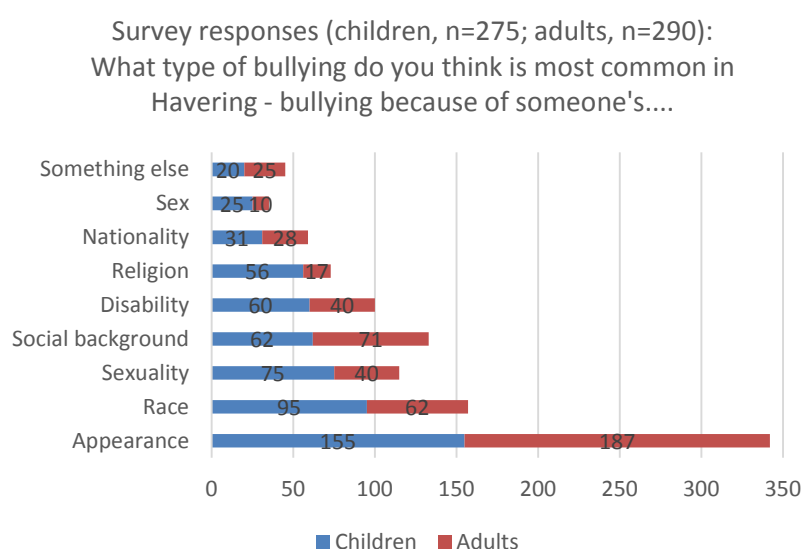
Bullying

Bullying is defined by the Department of Education as 'behaviour by an individual or group, repeated over time, that intentionally hurts another individual or group either physically or emotionally.

Bullying can take many forms (for instance, cyber-bullying via text messages or the internet), and is often motivated by prejudice against particular groups, for example on grounds of race, religion, gender, sexual orientation, or because a child is adopted or has caring responsibilities. It might be motivated by actual differences between children, or perceived differences. Stopping violence and ensuring immediate physical safety is obviously a first priority but emotional bullying can be more damaging than physical⁵⁷.

In 2013, 28% (n=403) children and young people who responded to LB Havering's annual Children and Young People's Survey said they had been bullied over the past 12 months⁵⁸. As part of a more recent survey of children resident and / or attending Havering schools⁵⁹, 275 young people responded to the question 'what type of bullying do you think is most common in Havering'. The same question was answered by 290 respondents in a parallel survey of adults.

Respondents were able to pick multiple answers. For both children and adults, by far the most commonly cited 'type' of bullying was bullying because of someone's appearance. For children, this was followed by bullying because of someone's race, their sexuality and social background. Adults reported bullying on the basis of social background to be more common, followed by race and the sexuality and disability. It may be that adults more readily conflate appearance and social background than children do.



There are an estimated 750 16-24 year olds living in Havering who identify as Gay, Lesbian or Bisexual⁶⁰. Between November 2011 and February 2012, 1,614 lesbian, gay and bisexual young people aged between 11 and 19 completed an online national survey as part of a collaboration between Stonewall and the University of Cambridge. Of these respondents, more than half (55%) reported experiencing homophobic bullying. Bullying was most often verbal, but cyber bullying was also common and one in six (16%) respondents reported physical abuse, with 6% reporting having been

⁵⁷ Department for Education. (2013). [Preventing and tackling bullying: Advice for headteachers, staff and governing bodies](#)

⁵⁸ 78% of respondents were from primary schools

⁵⁹ June – October 2013

⁶⁰ Havering estimates are based on The Integrated Household Survey, produced by the Office of National Statistics and carried out over April 2011 to March 2012, which reported that 2.7% of 16-24 year olds in the UK identified themselves as Gay, Lesbian or Bisexual.

subjected to death threats⁶¹. Nearly one in four (23%) lesbian, gay and bisexual young people reported trying to take their own life at some point.

Most children who experience bullying do not experience any long-term negative consequences. There is evidence to suggest that children who are subject to chronic bullying to over a number of years at primary school are significantly more likely to self-harm six to seven years later in adolescence, even when controlling for previous exposure to an adverse family environment (domestic violence, maladaptive parenting); concurrent internalizing and externalizing behaviour; and psychopathology (borderline personality disorder and depression symptoms)⁶². There is some evidence to suggest a relationship between children who bully at school and those who have increased conduct problems and hyperactivity symptoms on the Strengths and Difficulties Questionnaire⁶³.

Considerations for commissioners and service providers

- In light of the increasing numbers of pre-school and primary aged children residing in Havering, commissioners of mental health services should consider how to meet rising demand for services, particularly for younger children.
- Commissioner and service providers should consider early years screening provision and how this can be used to support preventative interventions and service planning
- Commissioners may wish to explore how best to ensure that children with behaviour, emotional and social difficulties are being identified at the earliest possible opportunity, and provided with the appropriate support.
- In light of the changing demographic of resident population, commissioners may wish to consider the continuing and increasing need for accessible services.
- Havering's clinical commissioning group has prioritised a wide-ranging review of CAMHS provision across all tiers over 2014/15.

⁶¹ Guasp, A. (2012). The School Report: the experiences of gay young people in Britain's schools in 2012. Centre for Family Research, University of Cambridge.

⁶² Lereya, S., Winsper, C., Heron, J., Lewis, G., Gunnell, G., Fisher, H. and Wolk, D. (2013) Being Bullied During Childhood and the Prospective Pathways to Self-Harm in Late Adolescence. *Journal of the American Academy of Child & Adolescent Psychiatry*. Vol. 52, 6, 608-618.

⁶³ Gini, G. (2008). Associations between bullying behaviour, psychosomatic complaints, emotional and behavioural problems. *Journal of Paediatrics and Child Health*, 44, 492-497

Young carers

There is an under reporting of children providing regular and on-going care to adults both at a national level and in Havering. LB Havering is likely to carry out a greater number of young carer assessments in the future and will provide support services to a greater number of young carers.

Young carers are children and young persons under 18 who provide regular and ongoing care and emotional support to a family member who is physically or mentally ill, disabled or misuses substances⁶⁴. They carry out caring tasks and assume a level of responsibility which would usually be associated with an adult. The term does not apply to the everyday and occasional help around the home that may often be expected of or given by children in families. The key features are that the caring responsibilities persist over time and are important in maintaining the health, safety or day to day well-being of the person cared for and/ or the wider family. The person receiving care is often a parent but can be a sibling, grandparent or other relative.

Inappropriate or excessive levels of caring by children may prevent them from enjoying their childhood in the same way as other children. Young carers are particularly vulnerable to educational underachievement. It is estimated that, at a national level, 27% of all young carers of secondary school age are missing school or experiencing educational difficulties. This figure rises to 40% for young carers specifically caring for someone who misuses drugs or alcohol⁶⁵.

Local authority responsibilities to young carers are likely to change over 2014. Amendments to the Children and Families Bill propose to:

- strengthen the right to an assessment of needs for support for all young carers under the age of 18 regardless of who they care for, what type of care they provide or how often they provide it, and
- link children's and adults' legislation to enable local authorities to align the assessment of a young carer with an assessment of an adult they care for.

In addition, the [Care Bill 2013-14](#) sets out a requirement whereby if a young carer is likely to have needs for support after becoming 18, the local authority must, if it is satisfied that it would be of significant benefit to do so and if the consent given, provide an assessment of their support needs and make a decision on the appropriate level of service provision.

⁶⁴ ADCS / ADASS (2009). [Working together to support young carers: a model local memorandum of understanding between statutory directors for children's services and adult social services.](#)

⁶⁵ Dearden, C. & Becker, S. (2004). Young Carers in the UK: The 2004 Report.

What is the current service provision?

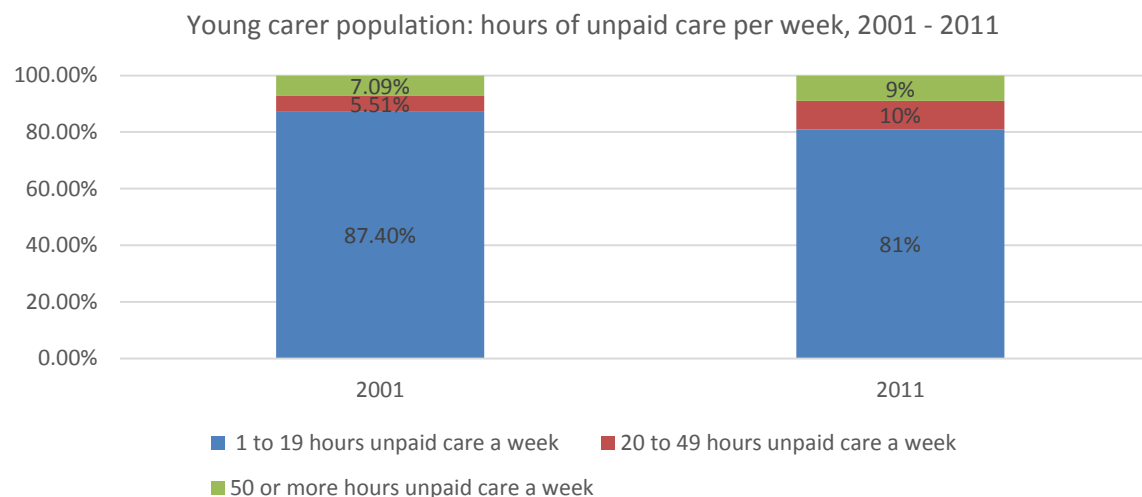
LB Havering commissions a Young Carers Service. Over 2012-13, the service assessed 43 young people who had been clearly identified as young carers. In addition, a further 133 children and young people were identified as siblings of disabled children, or young people who could be young carers. Of these children, further 51 had assessments over 2012-13. Therefore a total of 94 children are currently supported as young carers in Havering.

How many young carers live in Havering?

The best source of evidence to estimate how many young carers reside in Havering is the 2011 census. At this point, around 443 children aged 0-15 in Havering were providing some level of unpaid care. This represents around 1.00% of the 0-15 year old Havering population and is slightly lower than the England rate (1.11%), but represents a rise on the rate of 0.86% at the time of the 2001 census.

	2001	2011	
	Number of children aged 0-15	Number of children aged 0-15	% difference over time
Provides 1 to 19 hours unpaid care a week	333	358	+7.5%
Provides 20 to 49 hours unpaid care a week	21	44	+ 110%
Provides 50 or more hours unpaid care a week	27	41	+74%
Total	381	443	+16%

Over 2001-2011, the profile of unpaid care provided by children aged 0-15 changed. In 2011, 19% of Havering's young carer population provided 20+ hours of unpaid care per week, compared with 12% in 2001. This is in line with the England average.



Data provided from the Department of Work and Pensions through a Freedom of Information request shows that as at August 2012, there were 640 adults in Havering, with a simultaneous claim for both Disability Living Allowance (DLA) and Child Benefit. The rate of DLA is made up of two components and is awarded according to how the individual's disability or health condition affects their mobility and / or the amount of care they require.

130 claimants of both DLA and child benefit required help or supervision throughout both the day and night, or were terminally ill, and a further 180

needed frequent help or constant supervision during the day, supervision at night or someone to help while on dialysis. These figures do not tell us how many children reside with the adult, nor do we know how many children live in households where DLA is claimed but that claimant is not the child benefit claimant (i.e. where the mother claims child benefit but the father is the DLA claimant).

Not all children living with an adult with care and / or mobility needs will provide regular and ongoing care and emotional support to that individual, and there is a lack of consensus on how parental illness or disability impacts on children's outcomes. However, it is reasonable to expect that long-term ill or disabled parents might face greater challenges in supporting their children's development and that in some cases, those children may take on a caring responsibilities.

There are likely to be many young carers in Havering who have not received an assessment of their needs; this is in line with the national profile of underreporting and indicated by local data. Reasons for this include a lack of awareness among many professional groups of young carers' needs and concerns; young carers' own lack of awareness of their entitlements, and their reluctance to seek formal help. Work is underway to improve our

Number of <u>concurrent</u> adult claimants of child benefit and disability living allowance (DLA), by the components of DLA claimed				
Mobility Award Type				
Care Award Type	Higher Any other, more severe, walking difficulty	Lower Guidance or supervision outdoors	None	Total
Highest Help or supervision throughout both day and night, or terminally ill	100	30	-	130
Middle Frequent help or constant supervision during the day, supervision at night or someone to help while on dialysis	80	80	20	180
Lowest Help for some of the day or with preparing cooked meals	110	50	90	250
None	60	20	-	80
Total	350	180	110	640

understanding of Havering's young carers. Our annual children and young people's survey has been amended for 2013 to help identify the prevalence of young people providing care in Havering and LB Havering's new Children's Care Management System (CCM) will support the improvement of local recording when a young carer is identified.

What do young people think?

Social workers and teachers are recognised as the people potentially most capable of identifying and supporting young carers, but national level research from the Social Care Institute of Excellence found that young carers' consider themselves stigmatised by teachers and their peers, and feel little support is forthcoming from schools. Research consistently reports positive feedback from young carers about young carers' projects. They prefer support that is non-intrusive and provided by individuals and organisations other than statutory services⁶⁶.

Considerations for commissioners and service providers

LB Havering is likely to carry out a greater number of young carer assessments in the future and will provide support services to a greater number of young carers. Services to this cohort are under review at the time of writing.

⁶⁶ Social Care Institute for Excellence (2005). SCIE Research briefing 11: The health and well-being of young carers.

Safeguarding children

Domestic violence, parental mental illness and substance misuse in Havering: the 'toxic trio'

While almost all parents want to do the best they can for their child, many find this very difficult, especially when there is interplay in the family between such factors as poverty, mental ill health (including postnatal depression), addiction and violence.

Graham Allen MP (2011). Early Intervention: the next steps. An Independent Report to Her Majesty's Government

The term 'toxic trio' is used to describe the comorbidity of domestic abuse, mental ill-health and substance misuse. National level biennial reports reviewing the learning from serious case reviews (SCRs)⁶⁷ note the prevalence of domestic violence, misuse of alcohol and/or drugs, and parental mental health problems in the lives of the families at the centre of SCRs. The last biannual report, drawn from 139 overview reports, finds 'evidence that about two-thirds of cases featured domestic violence, and mental ill health of one or both parents was identified in nearly 60% of the families.

Parental substance misuse was mentioned for 42% of families, with a context of drug misuse in 29% of families, and alcohol misuse in 27% of the cases. In some families there was misuse of both substances. In many families it appears that it was the presence of more than one of these factors which posed a particular risk to the child's safety⁶⁸. The number of children in Havering who die in these circumstances is extremely small; since 2009, six SCRs have been conducted. The Venn diagram in Figure 24 shows how many Havering SCRs noted that the child(ren) lived in an environment where one or more of these factors was present. Although

deaths in these circumstances are rare, the life chances of a small but significant number of children in Havering are adversely effected by one or a combination of 'toxic trio' factors.

**None indicated:
one**

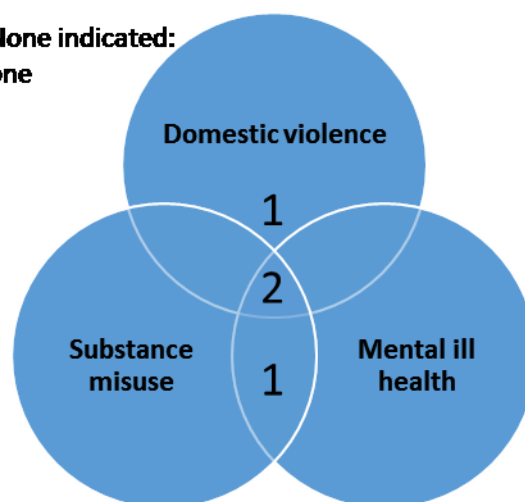


Figure 24: Serious case reviews 2009-13, Havering, Venn diagram of adverse parental circumstances

⁶⁷ The Local Safeguarding Children Board must undertake a SCR when abuse or neglect of a child is known or suspected; and either - (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child. SCRs should also be undertaken when a child dies in custody, including where the child was detained under the Mental Health Act 1983, as well as cases where a child died by suspected suicide.

⁶⁸ Brandon, M., Sidebotham, P., Bailey, S., Belderson, P., Hawley, C., Ellis, C. and Megson, M. (2012) *New Learning from Serious Case Reviews: a two year report for 2009-2011*. Department for Education, DFE-RR226, London.

Domestic violence

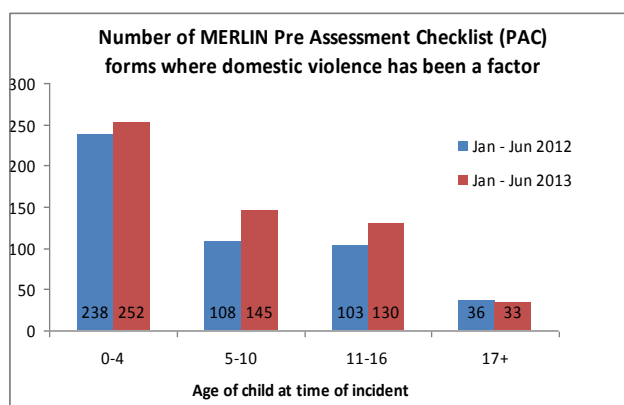
The government recently amended the definition of domestic violence and abuse to mean:

“Any incident, or pattern of incidents, of controlling⁶⁹, coercive⁷⁰ or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the psychological, physical, sexual, financial or emotional abuse”.

This definition includes so called ‘honour’ based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group. Domestic violence often goes under-reported and variations in local policing practice may influence the figures below.

Over quarter 1, 2013, there were 49 domestic violence offences recorded in Havering where the victim or witness was a child. This equates to a prevalence rate of 0.95 per 1000 of the 0-17 population over this period. For London as a whole, the prevalence rate was 0.98 for the same population (Figure 25). The Havering sanctioned detection rate⁷¹ over this period was 28.6%, lower than the London average of 45.5%. However, in the equivalent quarter last year, the Havering SD rate was 70.6% while the London average was 55.3%. The figures for this quarter are not necessarily representative.

All instances of a child or young person who comes to the attention of a police officer, where it is believed there are concerns about the child's well-being or safety, must be recorded onto a MERLIN PAC form by the attending officer. Jan – June 2013 saw an overall 15.5% (from 485 to 560) increase in the number of police Merlin reports where domestic violence was a factor, compared to the same time period in 2012⁷².



⁶⁹ Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

⁷⁰ Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim

⁷¹ A sanctioned detection occurs when (1) a notifiable offence (crime) has been committed and recorded; (2) a suspect has been identified and is aware of the detection; (3) the CPS evidential test is satisfied; (4) the victim has been informed that the offence has been detected, and; (5) the suspect has been charged, reported for summons, or cautioned, been issued With a penalty notice for disorder or the offence has been taken into consideration when an offender is sentenced.

⁷² 485 reports Jan-Jun 2012, 560 reports Jan – Jun 2013

Recorded domestic violence offences where the victim or witness was a child: rate per 1000 0-17 population (quarter 1, 2013)

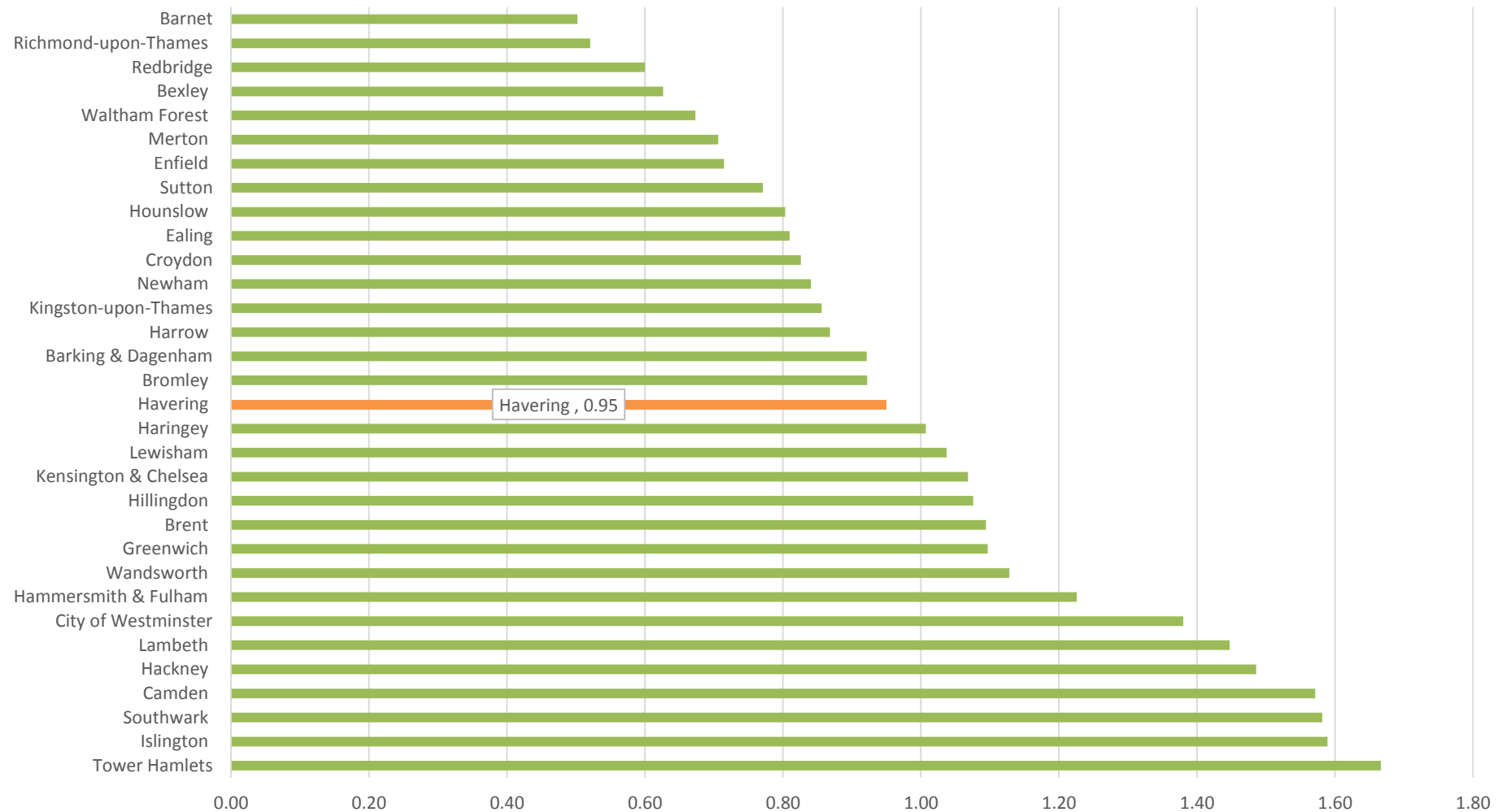


Figure 25: recorded domestic violence offences where the victim or witness was a child: rate per 1000 0-17 population (Q1, 2013)

Note small numbers account for considerable fluctuation in these figures and an increase in reporting does not necessarily correlate with an increase in incidence.

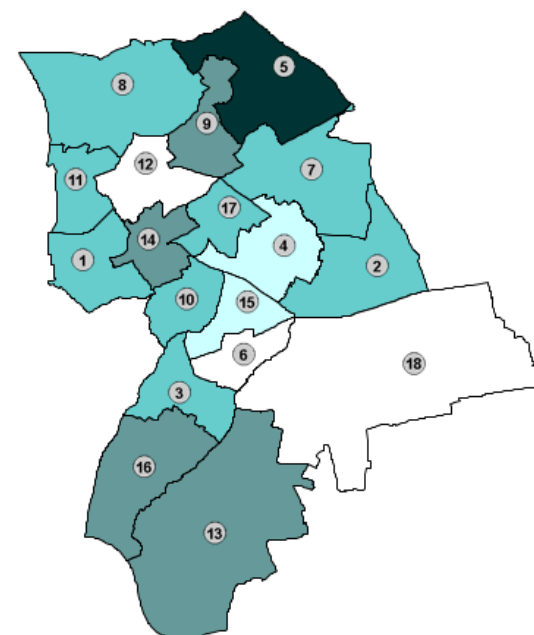
Referrals to children's social care are made when someone believes that a child may be at risk of significant harm. In 2012/13, 168 referrals were made to Havering's children's social care where domestic violence was recorded as the primary need. **Domestic violence is likely to be a factor in many more referrals, but it will not always be recorded as the primary issue.**

Referrals relating to children being at risk of significant harm as a consequence of domestic violence vary significantly by ward. Less than five domestic violence safeguarding referrals came from Emerson Park, Hacton, Pettits and

Upminster in 2012/13, whereas Gooshays, Heaton, Romford Town and South Hornchurch together accounted for 46% of this type of safeguarding referral; these four wards account for 26% of the 0-17 population. Domestic violence is associated with deprivation and Heaton, Gooshays, and South Hornchurch have a comparatively high prevalence of children aged 0-18 in workless households.

Some caution is required however as reporting patterns do not always correlate to prevalence; reporting is likely to be inconsistent across socio-economic groups.

Legend	Ward	Number of referrals to children's social care where the reason for referral is cited as domestic violence (2012-13)
1	Brooklands	11.0
2	Cranham	7.0
3	Elm Park	7.0
4	Emerson Park	0.0
5	Gooshays	30.0
6	Hacton	x
7	Harold Wood	6.0
8	Havering Park	9.0
9	Heaton	17.0
10	Hylands	9.0
11	Mawneys	9.0
12	Pettits	x
13	Rainham and Wenningtor	13.0
14	Romford Town	16.0
15	St. Andrew's	5.0
16	South Hornchurch	14.0
17	Squirrel's Heath	6.0
18	Upminster	x



Parental mental health

A review of Havering inpatient records indicates that 10,924 women gave birth between 1st April 2009 and 1st April 2013. Cross referencing the NHS numbers of these women with Havering GP records returns just 14 records of women giving birth who also had a diagnosed mental health condition over this period. Overall, Havering GP records show 412 females registered with a mental health condition over 1st April 2009 to 26th October 2013. The estimated point prevalence just for major depression (and not accounting for post-natal factors) among 16 to 65 year females in the UK is 25 cases per 1,000. The numbers returned through this exercise suggest a very significant under recording of mental health conditions in females by Havering GPs.

Data on the numbers of adult mental health service users with a child resident in the household was not available at the time of writing.

Parental alcohol and substance misuse

Parental alcohol misuse can impact upon children in a wide range of ways. Although there is uncertainty regarding a safe level of alcohol consumption in pregnancy, at low levels there is no evidence of harm to the unborn baby. However, drinking alcohol in the first 3 months of pregnancy may be associated with an increased risk of miscarriage and consuming more than 5 standard drinks or 7.5 UK units on a single occasion may be harmful to the unborn baby throughout pregnancy. Fetal alcohol syndrome (FAS) is a pattern of mental and physical defects that can develop in a fetus in association with high levels of alcohol consumption during pregnancy. There is currently no reliable evidence on the incidence of FASD in the UK. The most at risk populations are those that experience high degrees of social deprivation and poverty.

We do not understand in detail how the level, frequency and severity of alcohol consumption and its consequences affect children, nor how natural recovery processes in some families may influence the experiences and needs of children. However, parental alcohol misuse is correlated with violence, abuse and conflict and evidence suggests that it is not just children of those defined as dependent drinkers who experience negative repercussions of parental alcohol misuse⁷³.

The number of children who are affected by/living with parental alcohol misuse at a local and national level is largely unknown. Data on rates of drinking during pregnancy are commonly based on self-reporting and therefore often unreliable as a result of poor estimation, poor recollection and the social stigma associated with heavy drinking during pregnancy. Maternal alcohol consumption levels are therefore often significantly underestimated. However, estimates suggest parental alcohol misuse is far more prevalent than parental drug misuse. Manning et al (2009)⁷⁴ carried out secondary analysis of five UK national household surveys. From this, they estimate that:

⁷³ Office of the Children's Commissioner (2012). [Silent Voices: Supporting children and young people affected by parental alcohol misuse](#)

⁷⁴ Manning, V., Best, D., Faulkner, N & Titherington, E. (2009). [New estimates of the number of children living with substance misusing parents: results from UK national household surveys](#). BMC Public Health 9: 377.

- In 2004, around 30% of children under-16 years in the UK lived with at least one binge drinking parent, 8% with at least two binge drinkers and 4% with a lone (binge drinking) parent⁷⁵.
- In 2000, 22% lived with a hazardous drinker⁷⁶ and 6% with a dependent drinker⁷⁷.

As at October 2013, there were 331 children in Havering living in homes where there is a parent/carer known to be engaging in drug/alcohol treatment. In total, 157 parents / carers were receiving drug / alcohol services from our main drug and alcohol service and a further 64 parents / carers were receiving a specialist prescribing service.

Perinatal parent infant mental health services

The perinatal parent infant mental health services (PPIMHS) is a specialist psychiatric and psychological service. The psychiatric component of the service works with women with mental health problems during pregnancy and up to a year postnatally. The psychological component of the service works with parents and children up until the age of three to address attachment difficulties to prevent complex mental health problems when the babies and toddlers become older. The Parent-Infant Mental Health Service aims to:

- provide a comprehensive, specialist clinical/therapeutic service to parents and babies who breakdown emotionally in the perinatal period.
- prevent the formation of a diagnosable attachment disorder in the baby.
- provide parents with the opportunity to work through unresolved trauma, loss and insecurity from their own childhoods and to prevent the repetition of traumatic relationships being passed onto the new baby.
- provide consultation and training about perinatal mental health to Tier 1 and 2 professionals.
- work closely with social care in relation to high risk cases where safeguarding concerns are paramount.

The PPIMHS is delivered by the NELFT and provides services to residents of Barking and Dagenham, Havering, Redbridge and Waltham Forest. Since 2009/10, Havering residents have consistently accounted for 21-25% of all referrals to the service.

NELFT Perinatal Parent Infant Mental Health Service: patients referred and discharged (Havering)			
	Referrals received	Discharged	Churn
2009-10	243	68	28%
2010-11	301	239	79%
2011-12	251	209	83%
2012-13	238	116	49%
Apr 2013 – Aug 2013	110	23	21%

⁷⁵ Binge drinking at least once in the week before interview and measured as per the UK Government definition (i.e. 6 or more units in a single drinking occasion for women and 8 or more units for men)

⁷⁶ Hazardous drinking: a pattern that increases the risk of harmful consequences to the user or others

⁷⁷ Identified using the Severity of Alcohol Dependence Questionnaire

Missing children and sexual exploitation

Missing children: The Department for Education describes a young runaway or a missing child as ‘children and young people up to the age of 18 who have run away from their home or care placement, have been forced to leave, or whose whereabouts is unknown’. Statutory guidance states that children’s homes and foster carers must report any missing incidents to local police, the authority responsible for the child’s placement and the child’s parents. Evidence presented to a 2012 All-Party Parliamentary Group inquiry⁷⁸ suggested a strong link between children in care who go missing and those being groomed or sexually exploited.

Number of missing children: over 2011/12-2012/13, police records indicate that between 393 and 409 children were reported as missing each year. Of these children, 11-12 were in care, 11-12 were on child protection plans, 11-12 were residing in Havering but receiving a service from another authority’s children’s social care team and 11-12 were receiving another LB Havering children’s social care service (i.e. child in need).

Sexual exploitation: the sexual exploitation of children and young people under 18 involves exploitative situations, contexts and relationships where a young person (or a third person) receives ‘something’ in return for involvement in some form of sexual activity (DSCF 2009). Sexual violence incorporates any behaviour that is perceived to be of a sexual nature, which is unwanted or takes place without consent or understanding. The majority of children who are sexually exploited are living in their family home with a disproportionate number of victims living in care homes⁷⁹.

The Child Abuse Investigation Command (Specialist Crime Directorate 5) investigates allegations of abuse against children under 18 years of age, involving family members, carers or people in a position of trust, Sudden Unexpected Death in Infancy (SUDI) and historical allegations where the victim, now an adult, reports being abused as a child. In addition to the 18 Child Abuse Investigation Teams (CAITs) that cover London, the command has central units that address matters outside the CAIT capability or capacity:

- **The Serious Case Team** deal with complex linked abuse cases and other high profile proactive investigations.
- **Operation Paladin** is a joint MPS/UKBA safeguarding team based at Heathrow.
- **The Paedophile Unit** tackles child abuse online and offline by targeting predatory paedophiles. This includes grooming offences and the distribution of indecent images
- **The Partnership Team** lead on specialist child abuse issues within distinct communities

Data referenced below relates specifically to that of London’s Child Abuse Investigation Teams.

⁷⁸ [The APPG for Runaway and Missing Children and Adults and the APPG for Looked After Children and Care Leavers \(2012\)](#)

⁷⁹ [Accelerated report on the emerging findings of the OCC’s Inquiry into Child Sexual Exploitation in Gangs and Groups, with a special focus on children in care](#)

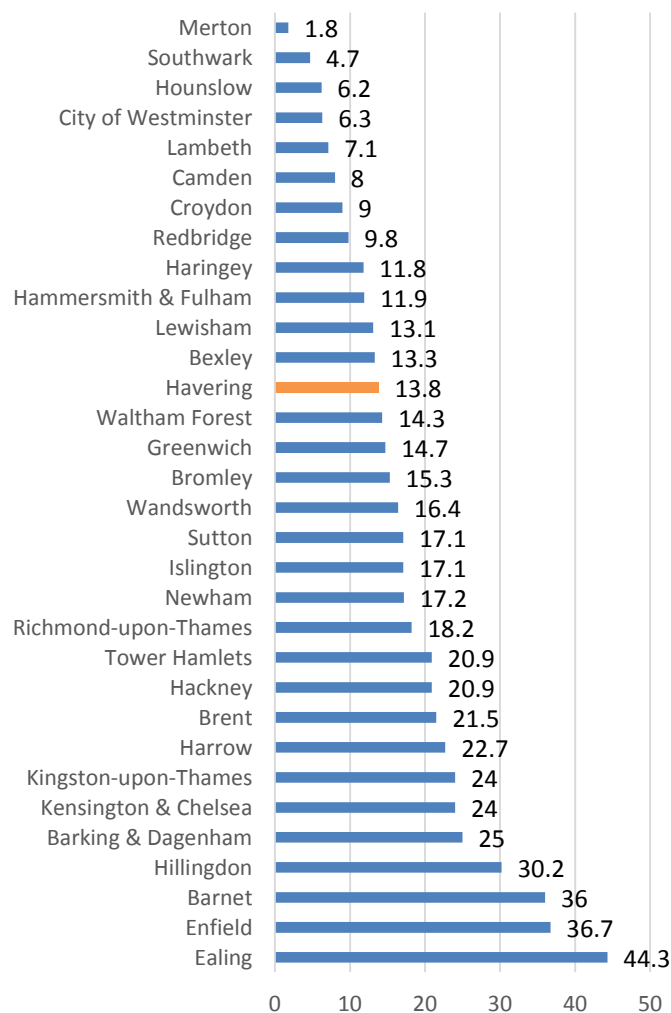
In Q1 2013, 0.16 per 1000 of the age 0-17 population in Havering were recorded by CAIT as the victim of an offence with a sexual exploitation 'flag'.

Over the same period, the proportion of all offences recorded by CAIT that had a sexual exploitation 'flag' was 13.8%.

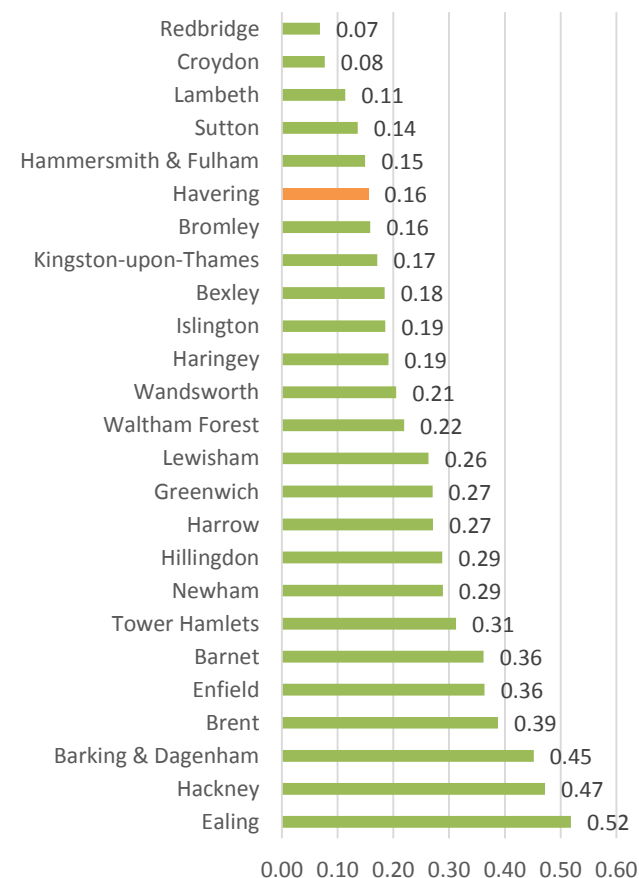
The combination of these two figures suggests that Havering CAIT are relatively proactive in 'flagging' sexual exploitation while the rate of recorded sexual exploitation was middling compared to other London boroughs over this period.

The figures for this quarter are not necessarily representative and variations may be reflective of local approaches to tackling child sexual exploitation rather than indicative of prevalence.

Proportion of offences recorded by the Child Abuse Investigation Command with a sexual exploitation 'flag', Q1 2013, London authorities



All offences recorded by the Child Abuse Investigation Command with a sexual exploitation 'flag': rate per 1000 of age 0-17 population, London authorities (**NOTE: data suppressed for seven authorities due to low numbers**)



‘Honour-based’ violence and forced marriage

As at September 2013, the Metropolitan Police Continuous Improvement Team have not recorded any honour-based violence or forced marriage crimes within Havering. Children’s social care report <5 children currently in care following attempted forced marriage and <5 cases of children known to them who have been subjected to or at risk of honour based violence.

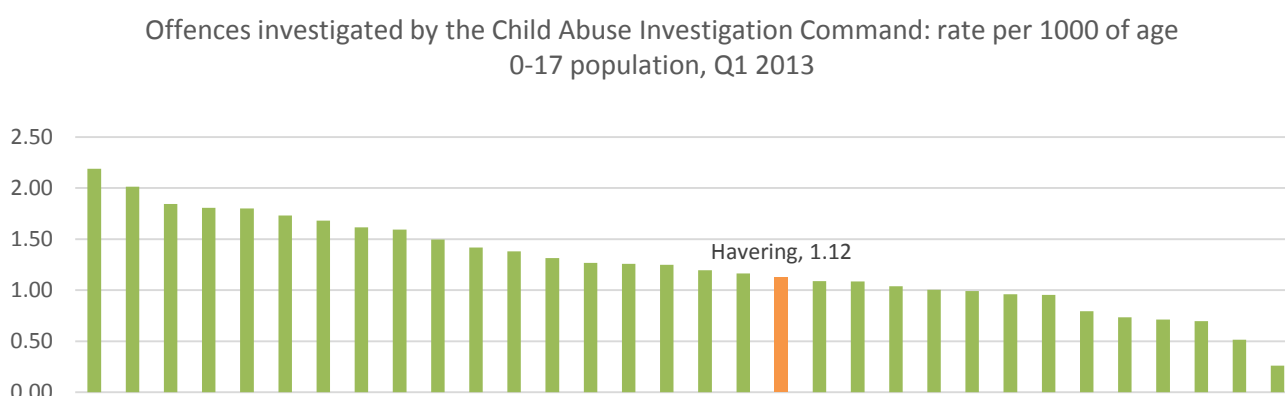
Honour is a fluid concept which has been widely interpreted by different societies, cultures and classes throughout history to promote behaviour which is seen as beneficial to the community. The concept of sexual honour arises from ideas that the reputation and social standing of an individual, a family or a community is based on the behaviour and perceived morality of its female members. To avoid the serious consequences that can result from losing one’s honour, individuals, families and communities may take drastic steps to preserve, protect or avenge their honour. This can lead to serious abuses including forced marriage, domestic violence, honour killing and female genital mutilation. It is difficult to estimate the prevalence of so-called ‘honour-based’ violence and forced marriage, but we do know that nationally, the incidences of both are under-reported. Forced marriages tend to occur in communities governed by honour, pride and shame. Such communities include South Asians, Kurds, Arabs, Iranians, Turks and in some cases, ultra-orthodox Jewish communities, amongst others⁸⁰.

Child Abuse Investigation Command: activity in Havering, Q1 2013

The figures for this quarter are not necessarily representative and variations may be reflective of local approaches to tackling sexual offences against children rather than indicative of prevalence.

In quarter 1 2013, Havering’s Child Abuse investigation Command investigated 58 offences; this equates to a rate of 1.12 offences investigated per 1000 of the 0-17 population (although more than one crime may be committed against one child). Havering’s sanctioned detection⁸¹ rate of 32.8% was higher than that London average of 25.1%.

The rate of serious sexual offences recorded by CAIT and occurring against Havering children was 0.2 per 1000 of 0-17 population and broadly in line with other London boroughs.⁸²



⁸⁰ Brandon, J. and Hafez, S. (2008). [Crimes of the Community: Honour-based violence in the UK](#). Centre for Social Cohesion.

⁸² Data is suppressed for two London authorities due to low numbers

Private fostering

Private fostering is when a child or young person aged 16 (or under 18 if they are disabled), is cared for and provided with accommodation for 28 days or more by an adult who is not a close relative. A close relative is an aunt, uncle, step-parent, grandparent or sibling, but not a cousin, grand aunt/uncle or a family friend. Statistic releases are believed to be an underestimate of the total number of children in private fostering arrangements. This is because there is doubt over whether all parents, carers and other relevant third parties currently report the existence of these arrangements to their Local Authority. Therefore any change in the number of arrangements seen may be due to a change in activity in private fostering or due to a change in the reporting of such arrangements.

Private Fostering data is used to monitor how Local Authorities discharge their duty to promote and encourage notification of private fostering arrangements. Havering received 12 notifications of new Private Fostering Arrangements in 2012/13 and 13 in the previous year (2011/12).

Child protection and children's social care: service level data

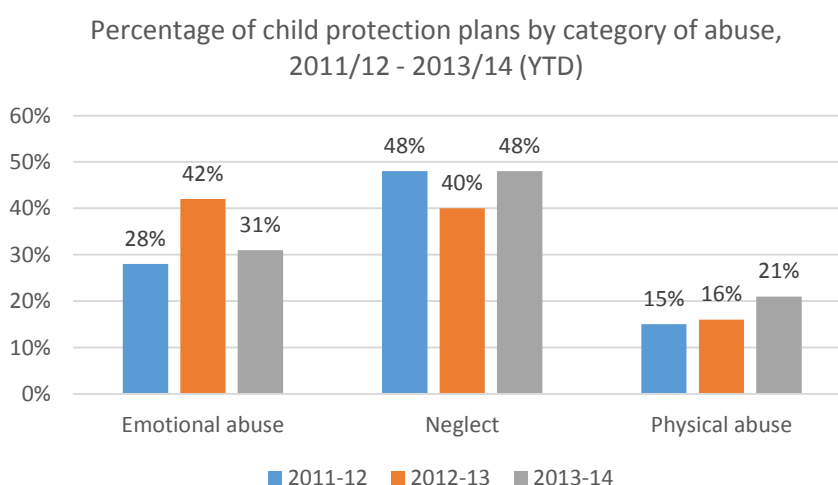
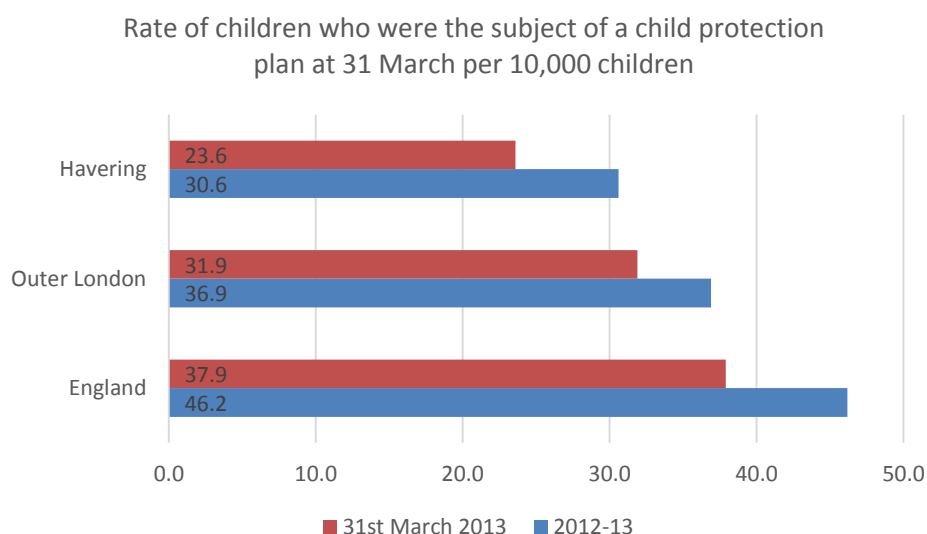
Much of the data below is drawn from the Children in Need Census 2013; note that local variations in recording practices, recording error and small numbers may skew comparative rates.

Child protection plans (CPPs) are not a measure of the incidence of maltreatment but do give some indication of the scale of the problem by providing figures for the number of children who are judged to be at risk of significant harm. However, research indicates that abuse and neglect are both under-reported and under-recorded.

As at September 2013, 110 children in Havering were identified as being at risk of significant harm and therefore supported via the statutory intervention of a CPP; this equates to a rate of 22 per 10k 0-17 population, while the national average as at 31st March 2013 was 37.8. This rate is higher than the rate of offences investigated by the CAIT (1.12 incidences of offences per 1000 of the 0-17 population) as not all children on a CPP will have had a criminal offence committed against them.

The September figure marks a decline to levels last seen in July 2012 (average for 2012-13 was 126). The average number of new CPPs each month is ten, consistent with 2012-13 (12 per calendar month; 2011-12 10 per calendar month). Over 2010/11-2012-13, between 9-12% of all children on a CPP are unborn and a further 35-40% were aged 0-5. Historically Havering has had a low rate of re-registration (children subject to a child protection plan for a second or subsequent time); this will impact on the overall comparative rate of children subject to CPPs.

The proportions of CPP category (i.e. physical, sexual, emotional abuse or neglect) vary over time and are based on small numbers; over 2011/12-2013-14, there has been an increase from a low base in CPPs where the primary concern is physical abuse.



48% of children subject to CPPs in 2013-14 were resident in Heaton (19%), Gooshays (17%) and Brooklands (12%).

If a child remains subject to a child protection plan for an extended period of time, this can be an indication that the risk to the child is not reducing sufficiently enough to put them below the threshold of risk of significant harm. Conversely, if a child protection plan ceases prematurely, parents may not sustain their improved childcare and the child may subsequently become at risk of significant harm and potentially subject to a further CPP. In September 2013, the majority of CPPs lasted between 0 and 6 months. Five children had been subject to a CPP for more than 18 months. Despite the increasing number of child protection plans in 2012-13 compared to previous years, the duration of those plans was relatively low. The year-end result of 3.7% (5 children) on a child protection plan for two or more years was a decrease on the previous year. The Children's Services Quality Assurance Group completed an audit of 28 CPPs which ceased between January and June 2013. Although the audit identified some challenges and areas for improvement, the Group received assurance that the decisions to end the CPPs were generally sound.

High rates of re-registration can suggest that the decision to cease a CPP was premature and that the child was not actually safer. If re-registration were to increase alongside an increase in the proportion of children leaving CPPs after a short period of time, it may be reasonable to question whether children were being taken off plans before necessary safeguards have been put in place. In Havering, the percentage of children who became the subject of a child protection plan during the year ending 31 March 2013 who became the subject of a plan for a second or subsequent time was 5.7%; this is low compared to the England rate of 14.9% and outer London rate of 12.8%. Bexley had a rate of 6.3%. This may indicate step down services are effective in helping families to sustain change.

Children in care

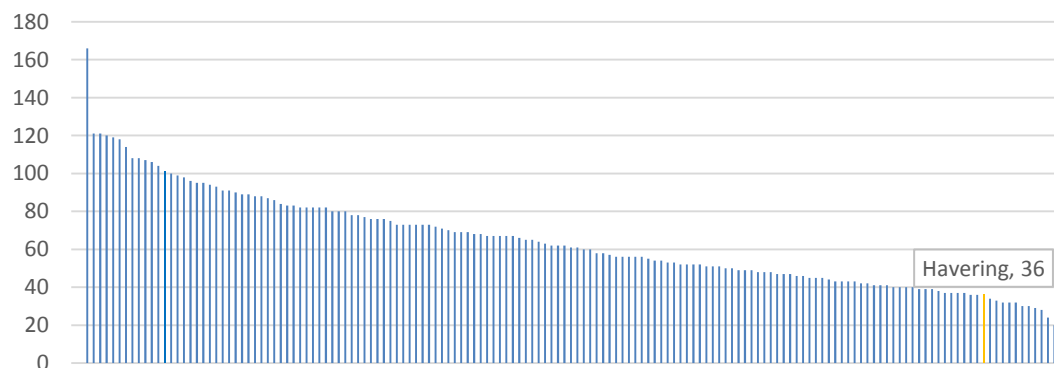
There are two populations of children in care described below.

- 1) **Children for whom LB Havering is the lead agency.** These children entered care whilst residing in Havering, but may or not be placed in Havering; however it is increasingly common for children to be placed within NELFT boundaries even if not within the borough.
- 2) **Children whom are looked after and resident in Havering, but LB Havering social care are not the lead agency.** These children will have been resident in another local authority at the time they entered care, and are now placed within Havering by that authority.

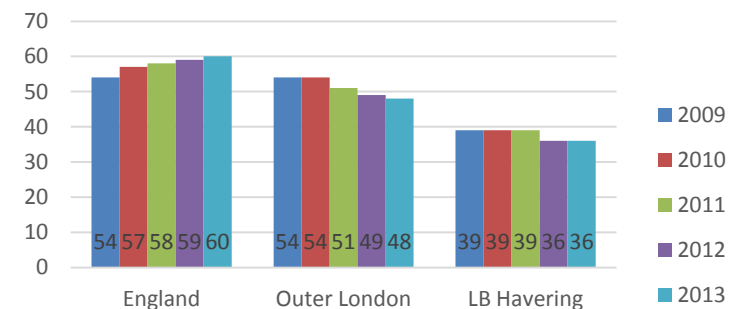
Profile: children for whom Havering is the lead agency

There are on average between 180-190 children in care at any one time. LB Havering's Sufficiency Statement for Looked After Children 2013 contains detailed year-on-year projections, and states that overall numbers of children in care are not expected to increase significantly over the next three years (forecast average for 2016/17 - 195 children). The rate of children in care to Havering is consistently below the outer London and England average rates and was one of the lowest rates across England in 2012/13.

Children looked after as at 31st March 2013: rates per 10K children aged 0-18, all England authorities



Children looked after as at 31st March: rates per 10,000 of children aged under 18 years, 2009-13



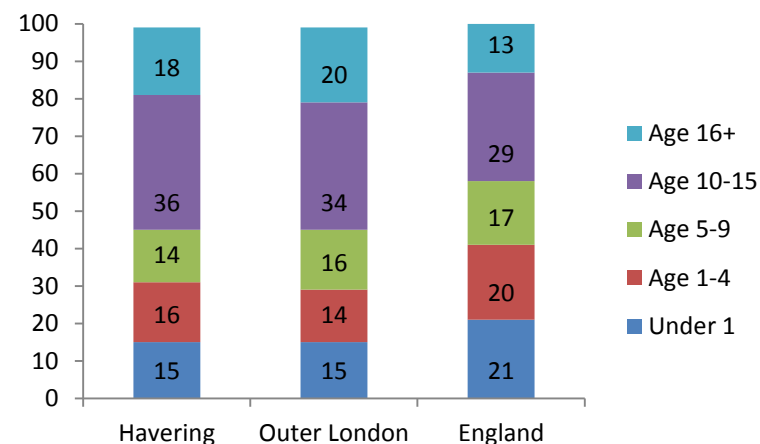
Figures exclude children looked after under an agreed series of short term placements

Havering has proportionately more males than females in care (2013/14 average, 53% male, 47% female). This is slightly above the 0-17 male / female ratio for Havering (51% male, 49% female) but not significantly so and is in line with comparators. One third of children in Havering's care are originally from the RM3 postcode area, which includes Harold Wood, Harold Hill, Noak Hill and Harold Park. Nearly a quarter of Havering's children in care lived in RM13 (Rainham, South Hornchurch, Wennington) prior to entering care.

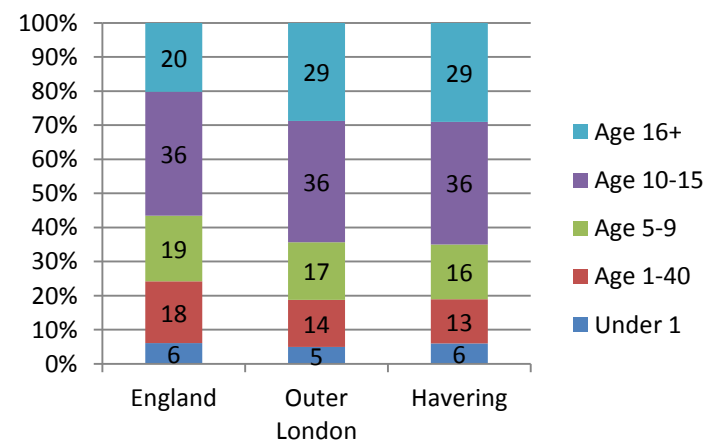
The age profile children who started to be looked after during 2012/13 broadly mirrored that of other outer London authorities, as did the age profile of all children in care as at 31st March 2013.

Havering has very few unaccompanied asylum seeking children in care (<5), with numbers declining from 2009. As at 31st March 2013, 80% of Havering's children in care were white and 12% were black or black British; the remaining figures are suppressed due to low numbers. The proportion of white children in care is in line with the overall age 0-17 Havering population at the time of the 2011 census (white, 82%).

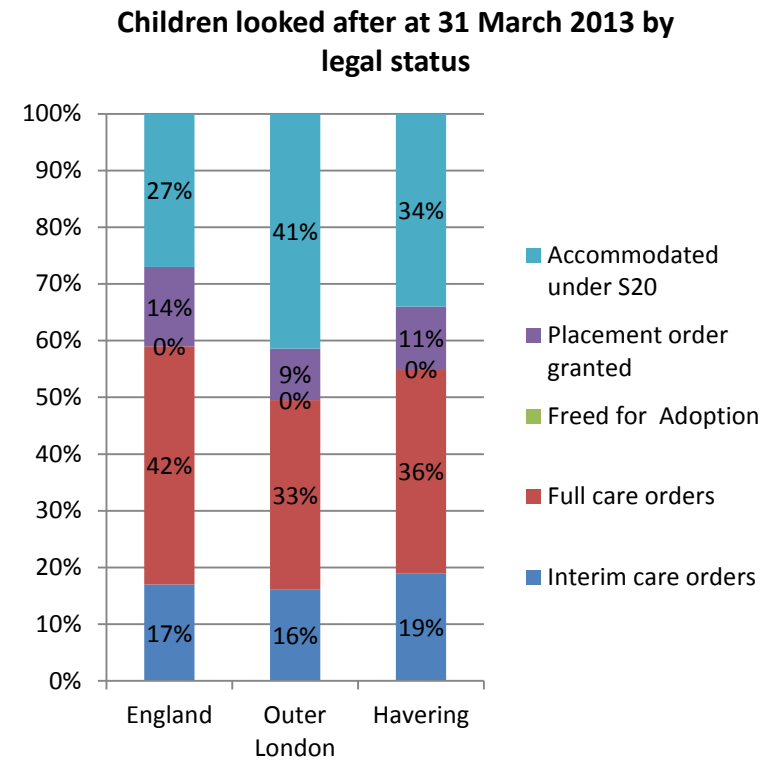
Percentage of children who started to be looked after during the year, by age on starting, 2012/13



All children looked after at 31st March 2013: proportions by age bracket

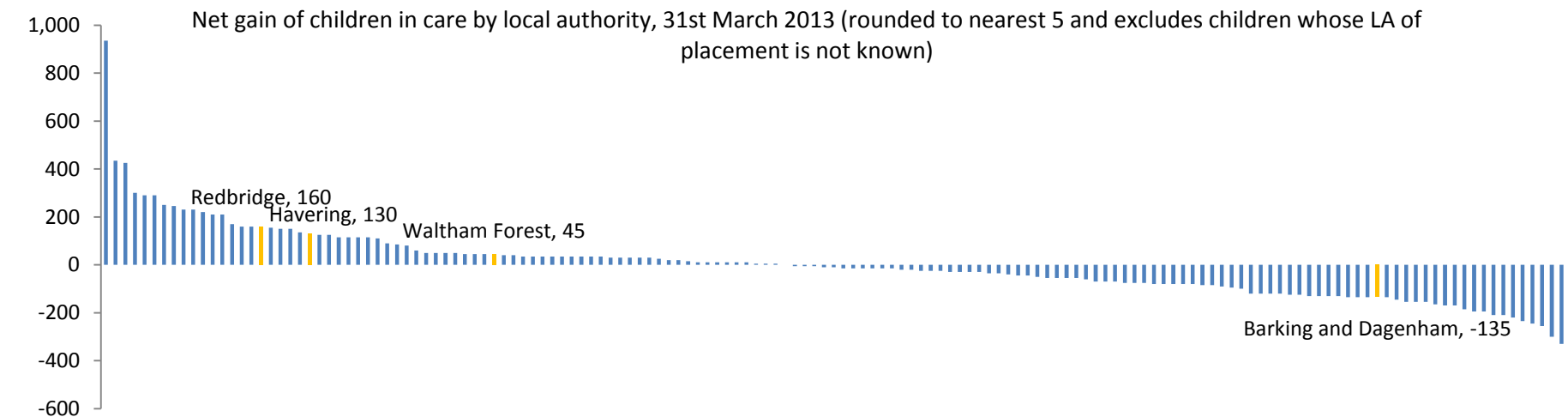


The profile of legal statuses of children looked after by Havering as at 31 March 2013 was broadly similar to the Outer London profile, with 19% looked after under an interim care order, 11% with a placement order and the remainder voluntarily accommodated or under a full care order. Small numbers of children in care in Havering can cause large fluctuations in prevalence rates and that there is considerable churn in the looked after children cohort, which means rates can vary markedly over time.



Profile: children placed in Havering by other local authorities

There were a total of 300 children in care living in the borough as at 31st March 2013; 100 were in Havering's care and 200 were placed in Havering by other authorities. Consequently, Havering had a net gain of 130 children in care within its geographical boundaries⁸³. This is the second highest net gain in London and a 30% increase from 2011. This is partly a consequence of increasing numbers of children being placed in Havering by other local authorities (increase from 185 in 2010/11 to 200 in 2012/13) and partly due to less children looked after by Havering being placed outside the borough boundaries (decrease from 85 in 2010/11 to 75 in 2012/13). Overall, there was a net gain of 200 children within the NEFLT boundaries of Redbridge, Havering, Waltham Forest and Barking and Dagenham as at 31st March 2013. These children are likely to attend schools and access health services within the borough, and may be vulnerable and require safeguarding services.

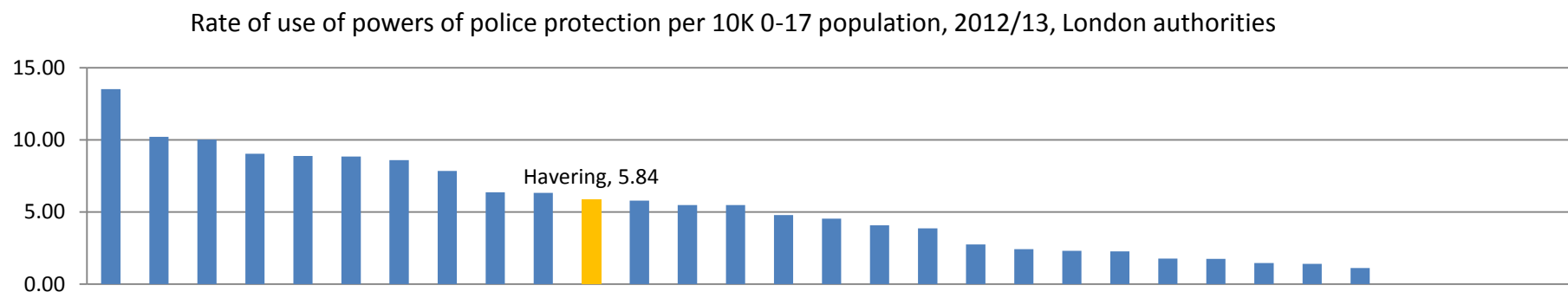


⁸³ 200 children placed in Havering by other local authorities, minus 75 children that Havering placed outside of the authority. Figures are rounded to the nearest 5 and exclude 10 (rounded figure) children looked after by Havering whose local authority area of placement is not cited in the statistical return, hence rounding will cause figures to not sum accurately.

How do children enter care?

Police protection: Police have powers of protection and are able to remove a child to a place of safety if they believe there are sufficient grounds for this. A high rate of the use of the powers of police protection can indicate that universal services are not identifying children in need of help and protection early enough, or that children's social care services are not making effective enough interventions to protect children.

Of the 100 children who came into Havering's care in 2012/13, 30 (30%) did so through police powers of protection. Figures are suppressed for 32 authorities due to low numbers. This is an increase from 18% in 2010/11 and 21% in 2011/12. However, in 2012/13, the overall rate of use of police protection per 10K of the age 0-17 population (5.84/10,000) was 'middling' compared to other London authorities. Therefore the use of powers of police protection are comparable to other London authorities, but the rate of children coming into care through this route appears high as comparatively few children enter care.



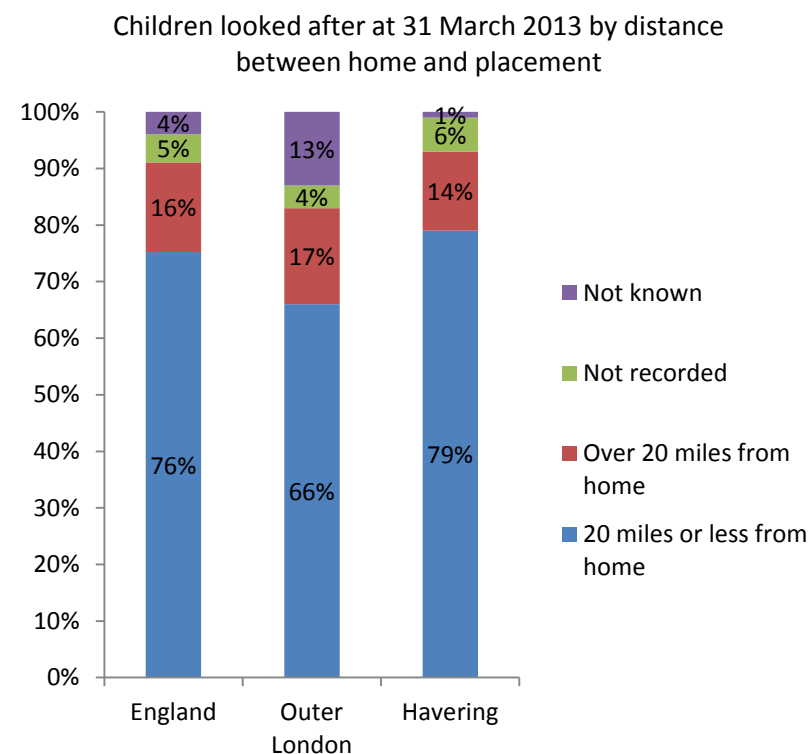
Voluntary accommodation: 55 children (55%) came into care as part of a voluntary arrangement (S.20, CA 1989) between Havering and those with parental responsibility for the child. Taking account of small numbers, this is broadly in line with England (59%) and outer London averages (60%). The remaining 15 children came into care either through a placement or interim care order. According to official statistics, none entered care through the youth justice route (i.e. remand, the Police and Criminal Evidence Act 1984 (PACE) or a supervision order with a residence requirement). Similarly none were subject to an Emergency Protection Order.

Care Orders: No children entered Havering's care through a Full Care Order in 2012/13 and <5 did so through an Interim Care Order. While nationally very few children enter care through a full order, the rate of children entering care through an interim care order is lower than all other outer London boroughs except one (England average, 23%; Outer London average, 14%, range 1% - 27%)⁸⁴.

Placements

As at 31st March 2013, the profile of placement type in Havering broadly mirrored that of England and outer London, although the proportion of children placed in secure units, children's homes and hostels was slightly higher (Havering 15%; outer London, 11%; England 9% - note small numbers will cause large fluctuations and this is a snapshot in time).

Of the 79% children placed within 20 miles of their home, 54% were placed within the borough boundary and 25% were placed outside the borough. Overall 40% of children were placed outside the borough boundary; this is lower than the 2010/11 (43%) and 2011/12 (44%) rates. 14% were placed outside the Havering boundary and more than 20 miles from where they used to live (England, 12%; outer London, 17%).



⁸⁴ Raw figures are rounded to the nearest 5 therefore the true average will be different.

Once in care, children generally benefit from stability in the adults around them. In previous years, Havering had comparatively high rates of children in care moving between placements. Detailed work was undertaken in 2011/12 to understand the causes of placement stability and to inform a service improvement plan. The proportion of children moving placements three or more times has lowered since 2012 and is now closer to comparator rates. However, placement stability does not always mean the

relationship between the child and carer is happy or that the carers are satisfied. Sometimes, especially for younger children who are more likely than teenagers to have stable placements but less able to express their views, this is not the case. This data needs to be looked at in the context of children's self-reports about their happiness in their placement and is regularly reported on through the children's social care quality assurance group.

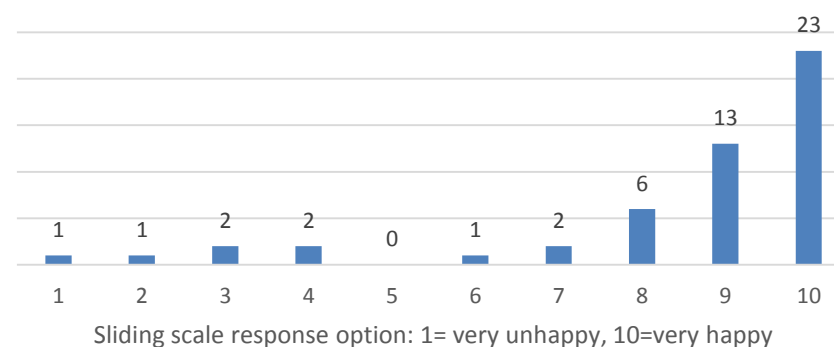
Over Jan-Dec 2013, 51 different children in care answered the question 'how happy are you living with your carer'; the majority gave a score of 8, 9 or 10, indicating that most of these children are content with their placement arrangements.

As at 31st March 2013, 20 / 25 children aged 19 years old who were looked after when aged 16 were living in suitable accommodation⁸⁵.

Percentage of children looked after with three or more placements during the year ending 31 March



Responses from 51 children in care to the question 'how happy are you living with your carer' (Jan - Dec 2013)

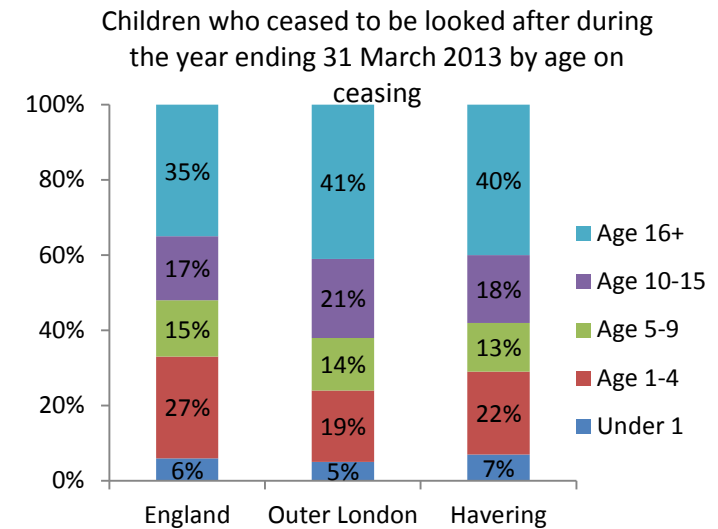


⁸⁵ 'Suitable accommodation' is defined in [Schedule 2, Care Leavers \(England\) Regulations 2010](#). Broadly accommodation is regarded as suitable if it provides safe, secure and affordable provision for young people. Local authorities are required to report on this as part of their annual SSDA903 return.

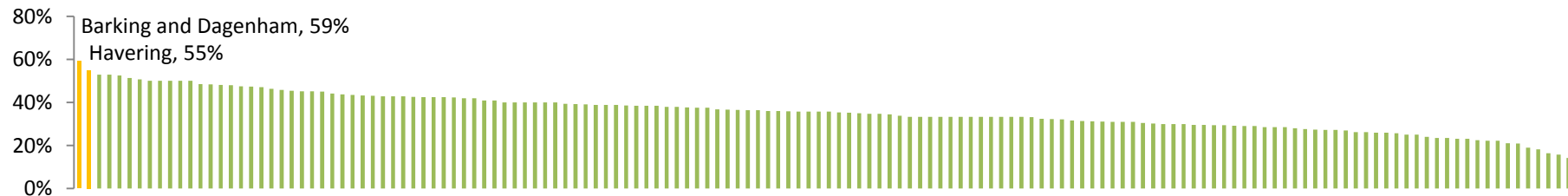
Routes to permanency: exiting care (2012/13)

Numbers of children starting or ceasing to be looked after within each of the last 3 years is relatively constant and over half the population of children in care 'turnover' each year (54%, 2012/13). The number of children in care that *both* started and ceased to be looked after with the same year is also relatively constant and represented 19% of the total care population in 2012/13.

In 2012/13, 100 children exited Havering's care. Taking account of small numbers, the age profile of these children is broadly in line with the England and outer London profile. 55 (55%) of these children exited care to return to live with their parents or relatives. This is the 2nd highest ratio of exiting care to parents / relatives in England.

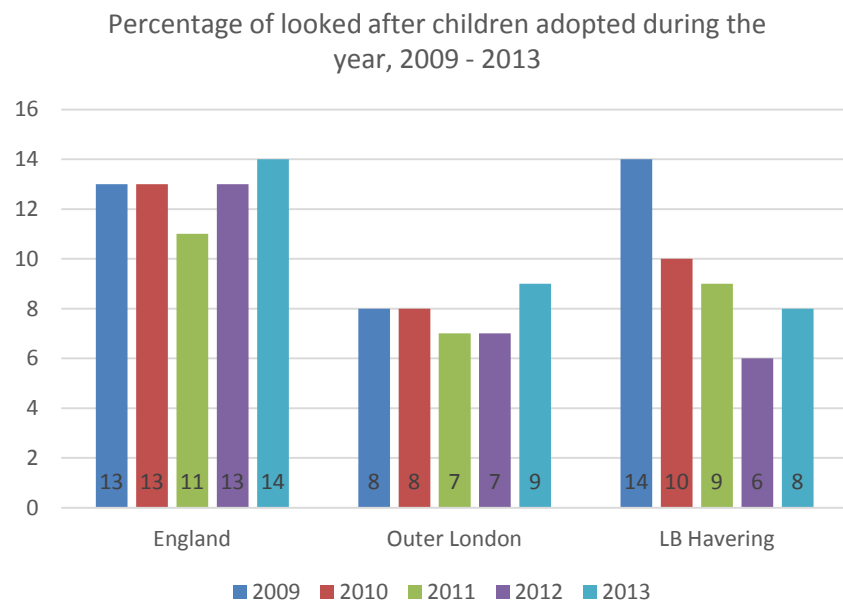


Number of children who ceased to be looked after as they returned home to live with parents or relatives, as a proportion of all children who ceased to be looked after, all England local authorities, 2012/13



Adoption

The adoption of children from care is a central government priority. The Adoption Scorecard is the main tool by which local authorities' performance in securing permanency for looked after children through adoption is measured by the Department for Education (DfE). Released annually, it reports on moving three-year cycles against a series of time-based and outcome-based measures. DfE introduced the Scorecards as part of a new approach to address delays in the adoption system, as set out in ['An action plan for adoption: tackling delay'](#). These scorecards allow local authorities and other adoption agencies to monitor their own performance and compare it with that of others.



Children			
	Average time between a child entering care and moving in with its adoptive family, for children who have been adopted (days)	Average time between a local authority receiving court authority to place a child and the local authority deciding on a match to an adoptive family (days)	Children who wait less than 20 months between entering care and moving in with their adoptive family (number and %)
LA's 3 year average (2010-13)	759	249	20 (44%)
1 year trend - Improvement from 2012 to 2013	n/a	n/a	n/a
3 year trend - Improvement from 2009-12 to 2010-13	Average time in 2010-13 was longer than in 2009-12	Average time in 2010-13 was shorter than in 2009-12	n/a
England 3 year average (2010-13)	647	210	11,360 (55%)
Distance from 2010-13 performance threshold	151 days	67 days	n/a

The average time between a child entering care and moving in with its adoptive family, for children who have been adopted

Although the 2010-13 average of 759 days is +13% points higher than the 2009-12 average of 673 days, there was a reduction in the average over 2011/12 to 2012/13 from 778 days to 673 days.

Of the 12 children that had ceased to be looked after due to the granting of an adoption order over Apr 13 – Dec 13, the average number of days between a children becoming looked after and moving in with their prospective adopters is 648, which means Havering is currently in line to achieve the 2013/14 target of 650 days.

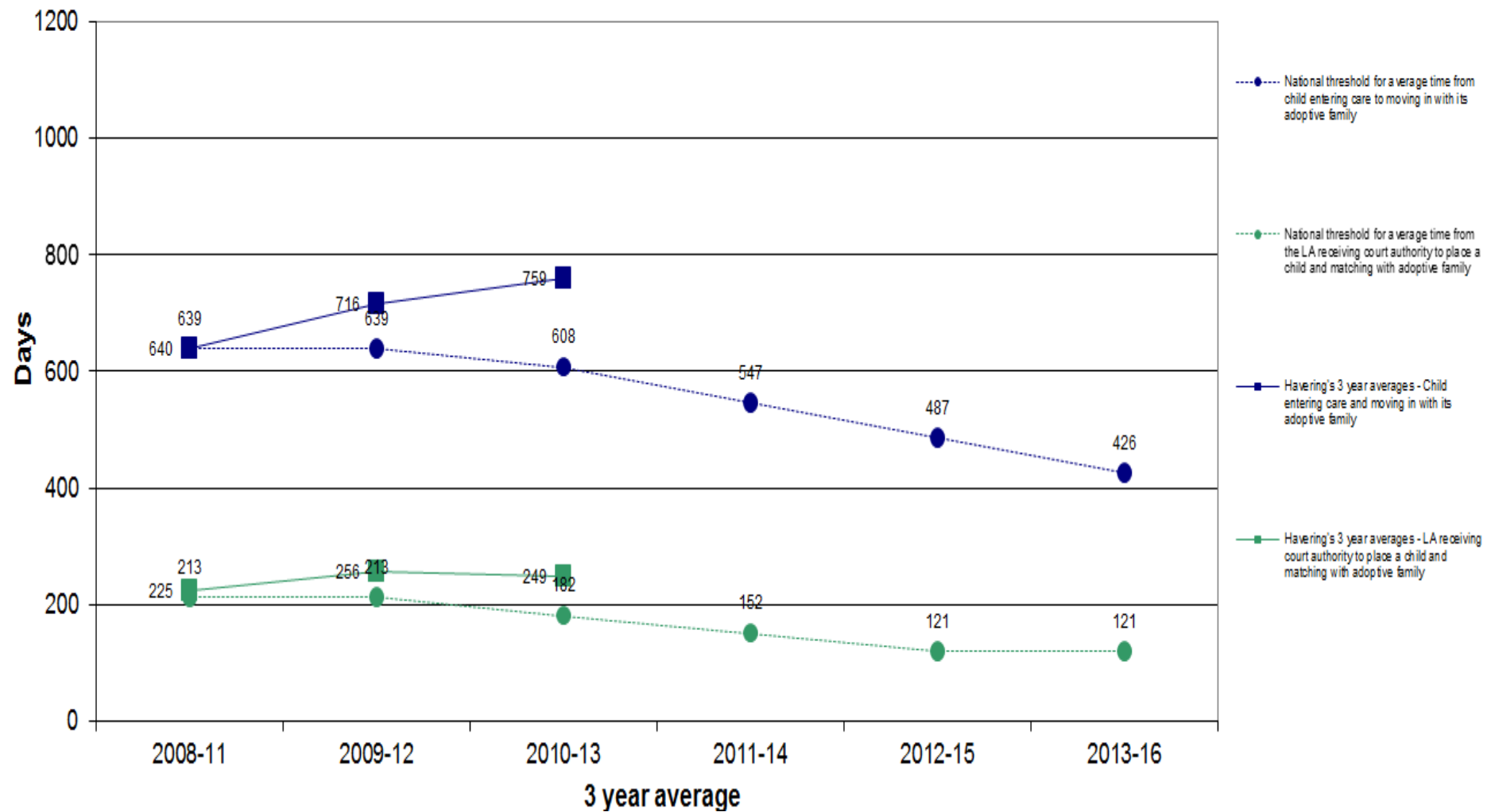
The average time between a local authority receiving court authority to place a child and the local authority deciding on a match to an adoptive family

The 3-year average for this indicator improved from 256 days (2009-12) to 249 days (2010-13). Of the 12 children that had ceased to be looked after due to the granting of an adoption order over Apr 13 – Dec 13, the average number of days between the court decision and the child being matched with prospective adopters was 222 days.

Percentage of children who wait less than 21 months between entering care and moving in with their adoptive family

There was a drop in performance on this indicator from 40% 2011/12, to 35% 2012/13. However, over April 13-Dec 13, 12 children ceased to be looked after upon the granting of an adoption order, and a further 10 were placed with their prospective adopters (as at Dec 13). Of those, 12 (54.5%) waited less than 21 months between entering care and moving in with their adoptive family.

Average Time Indicators



Leaving care

An important factor in successfully exiting care and transitioning to independent living is the age at which this occurs. Looked after young people tend to be much younger than their peers when they move to independent living. For some young people this can be a positive step, but it is normally better for young people to remain looked after for longer. The general principle is that young people should continue to be looked after until their 18th birthday, if it is in their best interests. The rate of children ceasing to be looked

after aged 16 or 17 has fluctuated in Havering over 2009-2013; this is likely to be as a consequence of very low numbers. At present, around 40% of children who cease to be looked after are aged 16 or 17, although this group accounts for 23% of the looked after cohort. However, older children in care tend to be looked after for shorter periods of time; a brief period of care can support family reconciliation work. [Havering's Sufficiency Statement 2013](#) contains further detail.

% of children ceasing to be LAC who are also aged 16 years or over, 2009 - 2013



The 2009 'Southwark Judgement' confirmed responsibilities lie with local authorities under Section 20 of the Children Act 1989 to provide accommodation for the majority of 16 and 17 year olds who are homeless (with some exceptions). Over Jan 2013 - 27th Sept 2013, internal records show that 22 16-17 year old children approached LB Havering as homeless. The vast majority of these were female⁸⁶ and half were originally residing in RM3 (Harold Wood, Harold Hill, Noak Hill, Harold Park) or RM7 (Rush Green, Mawneys, Romford). Following assessment, 15 of these approaches resulted in no further action.

In 2012, at a national level, 88% of young people who have left care were classed as being in suitable accommodation⁸⁷, compared to 81% in Havering. 20 young people were including in the Havering cohort in 2012; note that small numbers can account for large variations in performance.

⁸⁶ Numbers suppressed to prevent identification

⁸⁷ Accommodation is to be regarded as suitable if it provides safe, secure and affordable provision for young people. It would generally include short-term accommodation designed to move young people on to stable long-term accommodation, but would exclude emergency accommodation used in a crisis.

Education of children looked after by Havering continuously for at least 12 months

Local authorities have a statutory duty to promote the educational achievement of the children they look after, regardless of where they are placed. The figures below relate to children in the care of LB Havering; these children are not necessarily attending Havering schools. Similarly, there will be children in care who are educated in Havering but whose attainment is not included in these figures as another local authority is responsible for their care.

Key stage 1 and key stage 2: five children were eligible for KS1 and five were eligible for KS2 assessments in 2013 and therefore results are not reportable.

Key stage 4: 25 children were eligible to sit GCSEs in 2013 (provisional data)⁸⁸; of these, 32% achieved 5+ GCSEs A*-C or equivalent (England rate, 36.6%; outer London, 34%). Other benchmark KPIs are not reportable due to small numbers.

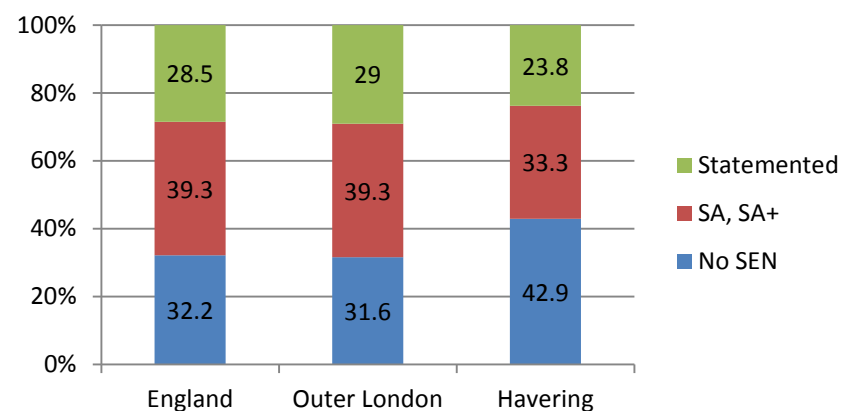
Care leavers and education, training and employment: as at 31st March 2013, 15 / 25 (60%) children aged 19 years old who were looked after when aged 16 were in education, training or employment. None were in higher education.

Special educational need: As at 31st October 2013, 20 children in care were supported by Havering's children with disabilities team. At a national level, children in care are far more likely to have SENs than their non-care experienced peers. Although this is also true in Havering, as at 31st March 2013⁸⁹, the proportion of children in care recorded as not having SEN was 10.7% higher than the England average. Children in care in Havering are less likely to be identified as needing support through school action (SA), school action plus (SA+) or statements than their England or outer London peers.

⁸⁸ This is the number of looked after children at the end of KS 4 in all educational settings. If a child is recorded as at the end of KS 4 (in year group 11) more than once, then the same child may appear in local authority results in more than one year. Nationally, this affects around 3% of looked after children each year.

⁸⁹ Based on 85 children looked after at 31 March 2013 who had been continuously looked after for at least 12 months and who were matched to school census data.

SEN profile of children looked after continuously for at least 12 months as at 31st March 2013



Offending by children who have been looked after continuously for at least 12 months

There were 90 children looked after aged 10+ as at 31st March 2013; of these 10 (9%) were convicted or subject to a final warning or reprimand during 2013 (England, 6.2%; Outer London, 5.7%)

Substance misuse by children who have been looked after continuously for at least 12 months

There were 125 children looked after for at least 12 months as at 31st March 2013; 7 (5.6%) were identified as having a substance misuse problem during the year (England, 3.5%; outer London, 5%). All seven were aged 15+.

Health care and development assessments of children who have been looked after continuously for at least 12 months

There were 125 children looked after for at least 12 months as at 31st March 2013. Of these:

- 110 (88%) had up-to-date immunisations (England, 83%; outer London, 80%)
- 110 (88%) had their teeth checked by a dentist (England, 82%; outer London, 88%)
- 85 (68%) had their annual health assessment during the year ending 31 March 2013 (England, 87%; outer London, 88%)
- 20 children were aged 5 or younger at 31 March 2013 and had been looked after for at least 12 months. Of these, 15 (75%) had up-to-date development assessments⁹⁰ (England, 84%; outer London 86%).
- Havering has <5 young people in care who are mothers; this has been consistent since 2010/11. Data on unwanted conceptions is not available.

Mental health and children in care

Metzger et al (2003)⁹¹ carried out the most authoritative study to date of the mental health needs of children in care. They found that among young people aged 5–17 years and looked after by local authorities:

- 45% were assessed as having a mental health disorder
- 37% had clinically significant conduct disorders
- 12% were assessed as having emotional disorders, and

⁹⁰ This measures whether the child's Health Surveillance or Health Promotion Checks were up-to-date

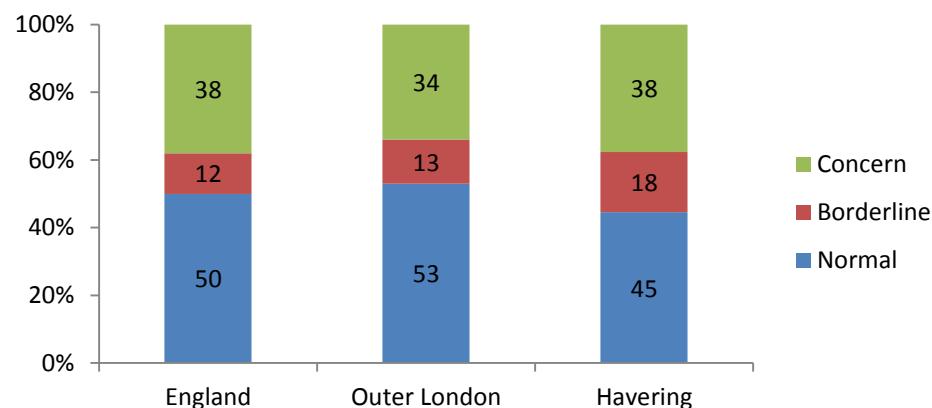
⁹¹ Meltzer, H., Gatward, R., Corbin, T., Goodman, R. and Ford, T (2003). The mental health of young people looked after by local authorities in England. National Statistics. London TSO.

- 7% were assessed as hyperactive.

The Strengths and Difficulties Questionnaire (SDQ) is a brief behavioural screening questionnaire about 3-16 year olds and is routinely used to assess the mental well-being of children in care. In 12/2013, there were 95 children aged 5 to 16 who were looked after continuously for at least 12 months and for whom a SDQ score was submitted. The average score was 14.6 (England, 14; outer London, 13.5). 53 (56%) of these children had scores that indicate a high or borderline risk of clinically significant problems.

In Havering, there are 24 children with SDQ carer-rated SDQ scores recorded from 2008/9 through to 2012/13. These children will have spent at least five years in care. Over this time, SDQ 'total difficulties' scores decreased for about half of the children, scores increased for around one third and scores stayed the same for 17% of this group. This suggests for around half of these children, their mental health improved over this period, and for half it stayed the same or deteriorated. It is common however for trauma experienced in early childhood to not manifest until adolescence.

Proportions of banded SDQ score for children aged 5-12 and looked after continuously for 12 months as at 31st March 2013



As at December 2014, there were 38 children receiving a NELFT CAMHS service who are either looked after by Havering (30 children) or who have been adopted, are subject to a Special Guardianship Order or are recorded are in a 'kinship care' arrangement (this could be a private or looked after arrangement). Of those 38 children, 21 were referred in or before 2011; 8 were referred in 2012 and 8 in 2013 (the referral date for one case was unrecorded). Of the 30 children in care currently receiving a CAMHS service, 21 of these referrals came from social workers and the remainder came from health services, education or foster carers. Over half of these children (17) were referred in or before 2011.

Considerations for commissioners and service providers

- There has been no significant change in the number of children aged 0-5 on child protection plans since 2009/10 and the rate of children in care has reduced slightly since 2011. Over the same period, there have been increasing numbers of children, particularly aged 0-5, residing in Havering. The increase in child-residents has been most marked in areas of deprivation. Commissioners and service providers should consider if this is a consequence of a) effective early help b) under identification of need or c) some other factor.
- Projections indicate numbers of children in care are not expected to rise substantially over the next five years and children are increasingly less likely to be placed out-of-area. SDQ scores for children in care indicate substantial risk of clinically significant mental health problems for children in care, particularly in relation to conduct issues and peer problems. Consideration should be given to using the profile of SDQ scores to inform workforce development, including for foster carers.
- Private fostering was rated as inadequate by Ofsted in November 2012, although a subsequent safeguarding inspection recognised that prompt was action to ensure that arrangements were improved. However, numbers of children who are known to be privately fostered remain low and there is a continued need to raise awareness of the service amongst the public and professionals. GPs, education and other health providers are key to identifying these arrangements.
- 'Hidden harm': children and young people who are missing from home, care or full time school education, those placed in residential care and those placed a long way from home are often very vulnerable and some will be at increased risk of sexual exploitation. As communities in which honour-based violence, forced marriage and FGM become more prevalent in Havering, those with safeguarding responsibilities need to be aware of the risk and resilience factors associated with protecting children from these crimes.
- Implementing and sustaining change arising from the recommendations within [Ofsted's 'What about the children' report](#) is a local priority to help support the identification, assessment and support for children and young people who live in households where a parent or carer misuses substances or suffers from mental ill-health, or where there is domestic violence.
- Although the rate of children looked after by Havering is consistently low, numbers of children in care residing within borough boundaries increased by 8% over 2010/11 – 2012/13 and is likely to continue to rise. This has implications for commissioners and providers of health care services (including mental health) and schools.
- Foster carer recruitment and retention is key to effective matching, reducing placement instability and supporting children in care to live nearer to their home communities, where appropriate.
- Health assessment completion rates for children in care are currently below expected levels. Results from audits of health assessments will be used to inform improvement planning, including consideration of foster carers training on the health needs of children in care.
- Educational achievement of children in care is key to improving outcomes for this group.

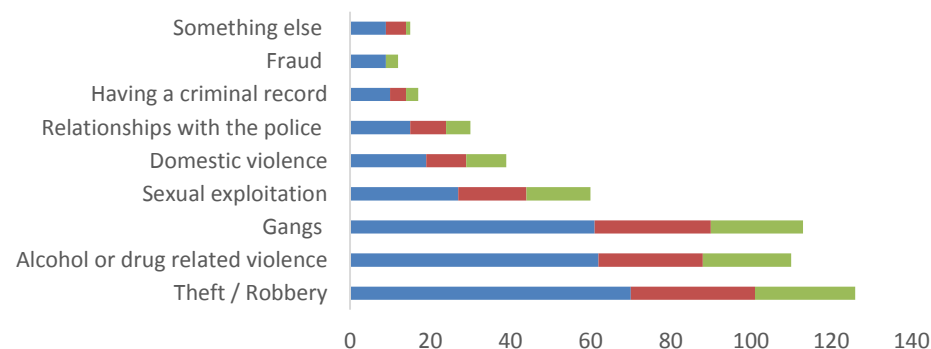
Children as victims of crime

What do local people think?

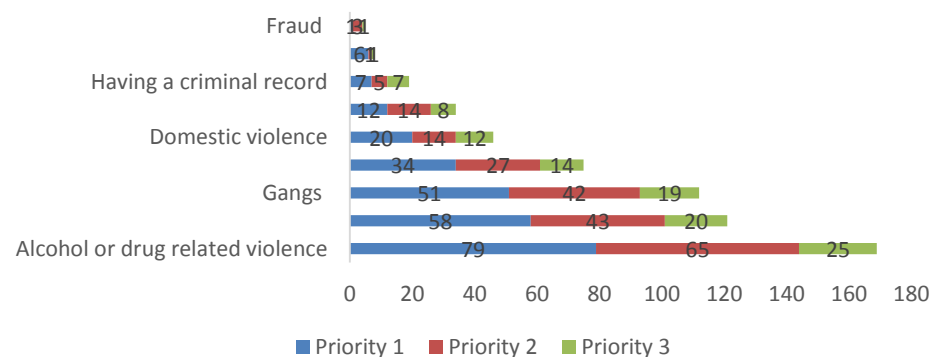
‘Supporting us to stay safe and crime free’ was the top priority for the children who responded to LB Havering’s ‘pick your priorities survey over July – Sept 2013. Children and young people who selected ‘supporting us to stay safe and crime free’ as their 1st, 2nd or 3rd priority were also asked to say what they thought the ‘3 most important crime and safety issues are for children and young people in Havering’. Theft and robbery, followed by gangs and alcohol / related violence were the top responses⁹².

When adults were asked ‘what are the three most important crime and safety issues for children and young people in Havering, their responses broadly concurred with the views of the child respondents⁹³, although the adults were more concerned about alcohol or drug related violence.

Children: What are the 3 most important crime & safety issues for children / young people in Havering? (172 responses)



Adults: What are the three most important crime and safety issues for children and young people in Havering? (205 responses)

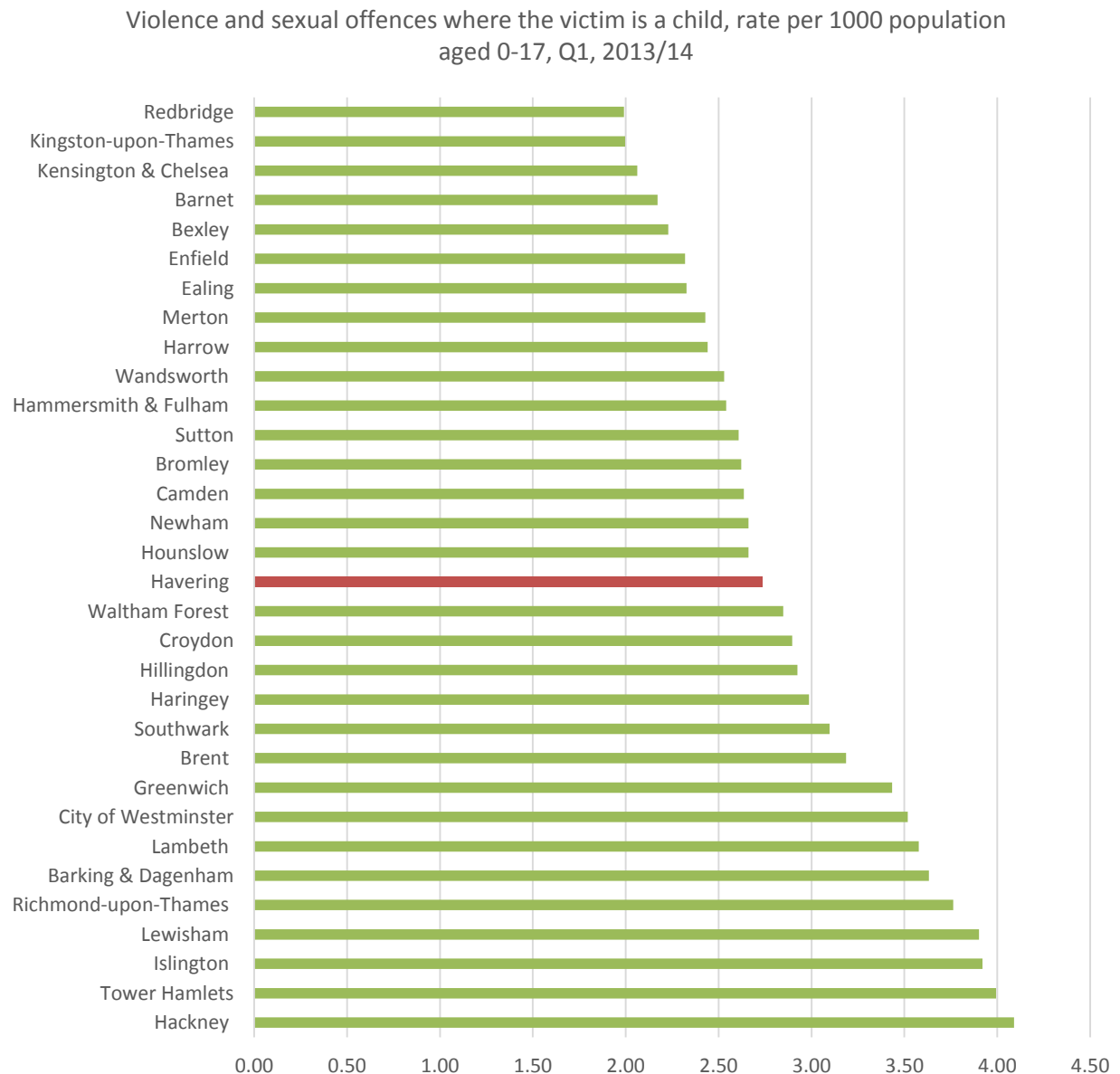


⁹² Of the children who chose crime and safety as a priority in the earlier question, a total of 172 went on to answer this question.

⁹³ Of the adults who chose crime and safety as a priority in the earlier question, a total of 205 went on the answer this question

Violent and sexual offences where the victim is child

For all violence and sexual offences, where the victim is a child, for the first quarter of 2013/14, Havering had an offence rate of 2.73 per 1000, compared to 2.88 per 1000 for London. In the same period the sanctioned detection rate for these crimes (24%) was better than the London average (19%).



Youth offending

Data from the Youth Justice Board shows that over the period 1st July 2012 to 31st March 2013, there were 235 proven offences committed by 127 children aged 0-17 resident in Havering. This represents less than 0.25% of children. Of these offences, 14 involved a breach of bail, conditional discharge or of a statutory order. Figure 27 show that drugs offences represented the most common of the remaining 113 offences (18.6%), followed by theft and handling stolen goods (16%)⁹⁴.

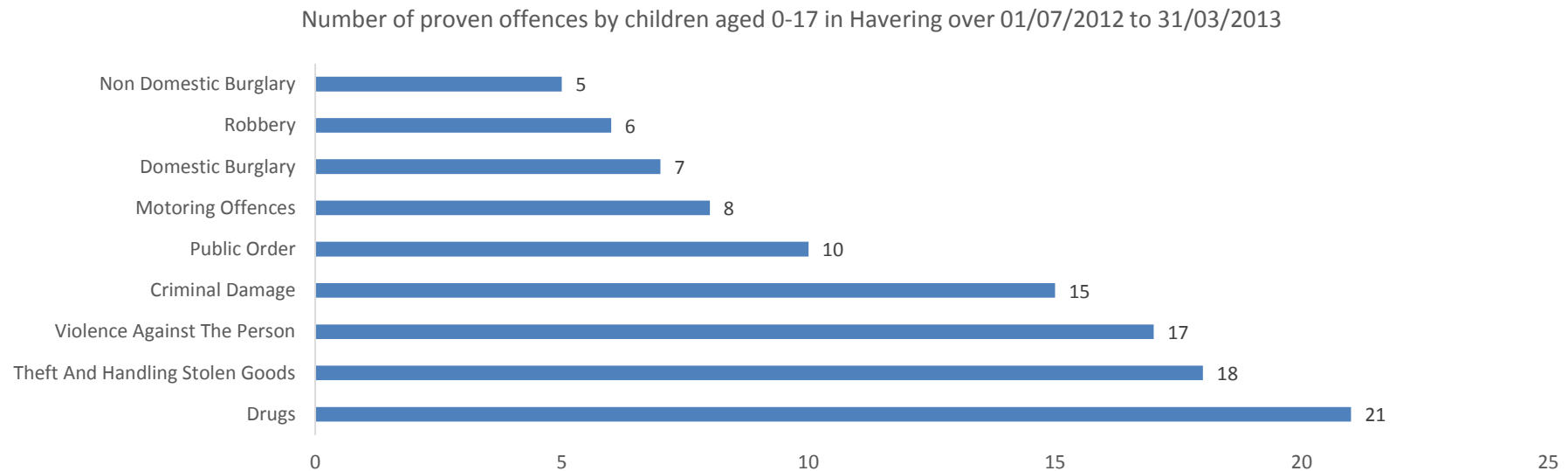
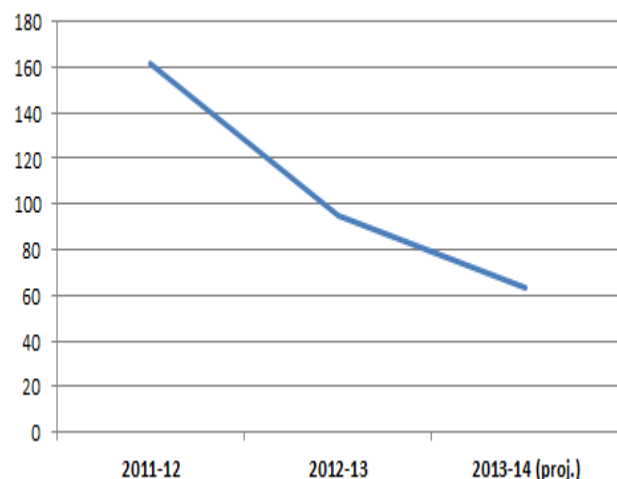


Figure 27: Number of proven offences by children aged 0-17 in Havering over 1st July 2012- 31st March 2013

Of the 127 young offenders, 77% were male (n=98) and 71% were white. Asian, black and mixed accounted for the remaining 23% of offenders. 8 did not have their ethnicity recorded.

⁹⁴ Data for 'other', 'racially aggravated' and 'vehicle theft / unauthorised taking' crimes are suppressed due to low numbers

First-time entrants to criminal justice system



The latest available data shows that children who received their first reprimand, warning, caution or conviction between ages 10-17, continues to fall in Havering. It is thought this is in part due to the Triage Programme in the Youth Offending Service (YOS), which identifies low-level offenders who plead guilty to an offence and avoid a criminal record if they consent to work with non-statutory elements of YOS.

Young people receiving a custodial sentence

The number (and percentage of those sentenced) of young people (aged <18) who receive a custodial sentence is projected to be lower in 2013-14 than in the previous two years. Notably, fewer young people are projected to receive any form of sentence.

	2011-12	2012-13	2013-14 (proj.)
Number of young people who receive a custodial sentence	12	13	6
Number of young people sentenced	303	213	153
% young people who receive a custodial sentence	3.96%	6.10%	3.92%

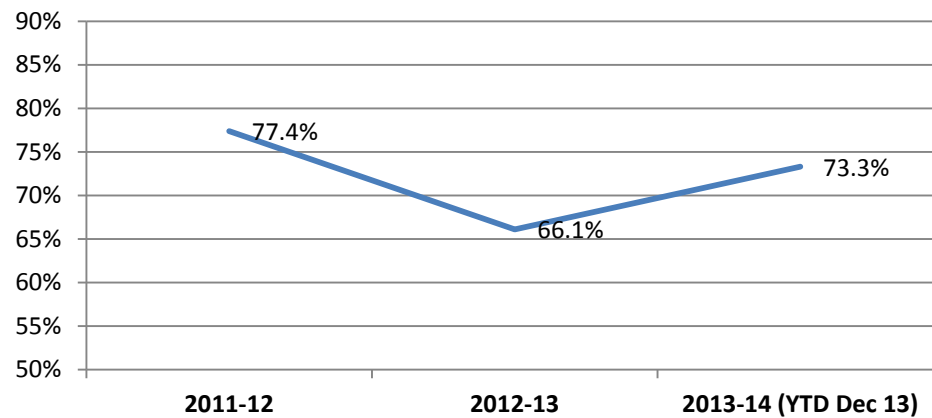
Re-offending rates

To establish the re-offending rate, a cohort of young offenders is tracked for a year following any type of conviction. The reported data is consequently subject to a time lag. For the cohort tracked from 2010 Havering performs broadly comparably to national averages, although there has been a notable increase in re-offending for the most recently reported cohort. This is due to a small proportion of this cohort who re-offend more than once. Performance is not anticipated to improve due to the effectiveness of the Triage service (active since 2012), which ensures that low-level offenders (i.e. those least likely to reoffend) do not enter the criminal justice system and are not tracked in the re-offending cohort; the tracked cohort consequently comprises offenders who are

Jan-Dec 2008	Jan-Dec 2009	Jan-Dec 2010	National average Jan-Dec 2010
32.9	31.2	40.2	35.3

more likely to re-offend. Havering YOS has developed closer working relationships with Police and Probation services. In addition to supporting the welfare of young offenders, YOS is adopting a stronger stance around enforcement, e.g. of missed appointments, so that appropriate intervention is made to prevent drift and minimise risk of the young person committing further offences.

% of young people 'linked' into education, employment and training programme by their Yoth Offender worker, of the total who required it



Young people are more at risk of reoffending if they are not engaged in education, employment or training. The Youth Justice Board monitors the number of young people on an order who were not in education training or employment and who were then 'linked' into education, employment and training programmes by the youth offending team. Small numbers cause large variations in proportional rates. In 2011/12, 130/168 young people were linked into EET through the YOS (77.4%); in 2012/13 this figure dropped to 119/180 (66.1%). Year-to-date figures for 2013/14 (Dec 13) showed an improvement at 77/105 (77.3%).

Prevalence of gangs and gang-related criminality in Havering

Following the August 2011 riots, 13 London boroughs were identified as part of the Ending Gang and Youth Violence work programme, on the basis of high rates of serious violence, high rates of admissions to hospital for assault using sharp objects, and a significant known local gang problem. Despite local concerns over cross-border migration of gang activity, Havering was not part of this programme, although London Borough of Barking and Dagenham, with whom Havering shares a Youth Offending Service (YOS), are.

The Havering Community Safety Partnership (HCSP) is leading work to understand and address gang and youth violence in Havering. Quantifying the scale of gang activity in Havering is problematic; although some may be arrested for offences typically associated with gang activity, the gang network invariably comprises a far greater number of individuals. Havering, like many outer-London boroughs, is experiencing cross-border migration of gang activity, with 11 gangs from neighbouring boroughs actively operating within Havering borders.

As at the end of October 2013, 40 individuals had been identified as potentially at risk of engaging in serious youth violence. Key features of this group were as follows⁹⁵:

- The vast majority were male
- Around one third were on roll at a pupil referral unit
- 31 were from families known to the Troubled Families programme
- 26 were involved with Havering YOS
- Nine lived in Council or Housing association accommodation; most were living in some form of private accommodation within Havering.
- Eight were in the care of children's social care due to threats of violence arising from drug-related debts.

⁹⁵ Numbers are suppressed where less than 5 to maintain confidentiality

Substance misuse (alcohol and illegal / controlled drugs)

National profile of self-reported substance misuse amongst 11-15 year olds

The *Smoking, drinking and drug use among young people in England* survey (NHS, 2013) is the latest in a series designed to monitor smoking, drinking and drug use among secondary school pupils across England aged 11 to 15. A similar annual survey is run within Havering and can provide insight into local young people's attitude to drugs and alcohol. As respondent numbers are small, the national survey is a better indicator of prevalence. Key findings from the **national survey** include:

- The prevalence of illegal drug use was at its lowest since 2001 (when 29% reported that they had ever taken drugs), when the current method of measurement was first used. 17% of pupils had ever taken drugs, 12% had taken them in the last year and 6% in the last month.
- The prevalence of ever having taken drugs increased with age from 7% of 11 year olds to 31% of 15 year olds. There were similar patterns for drug use in the last year (from 4% to 24%) and in the last month (from 2% to 13%).
- Of those pupils who had taken drugs in the last year, 75% reported only having taken one type of drug, and 25% had taken two or more.
- As in previous years, cannabis was the most widely used drug among 11 to 15 year olds; 7.5% of pupils reported taking it in the last year. This figure is similar to that seen in 2011 (7.6%), but continues the overall downward trend in prevalence of cannabis use since 2001.
- Class A drug use remained relatively rare among pupils; 2.2% reported taking one of the eight Class A drugs asked about in the last year. From 2001 to 2009, this proportion was around 4% but fell to 2.4% in 2010 and has remained at a similar level since.
- Use of volatile substances, such as glues, gases, aerosols and solvents, was reported by 3.6% of pupils in 2012, a similar proportion to 2011 (3.5%).
- 28% of pupils reported ever being offered any drug, a similar proportion as in 2011 (29%). Boys were more likely than girls to say they had been offered any drugs (30% of boys compared with 27% of girls).
- Pupils who had ever truanted or had been excluded from school were more likely to report usually taking drugs at least once a month than those who had never truanted or had never been excluded (10% compared with 1%). Also, pupils who had ever played truant or been excluded were more likely to report taking Class A drugs in the last year (9%) than those who had never truanted or been excluded (1%).
- Pupils who said they had taken drugs in the last year were asked on how many occasions they had taken drugs and how often, if at all, they usually did so. Figures for 2012 were broadly similar to those reported in previous years; 3% of all pupils said they had only ever taken drugs on one occasion, 3% said they had taken them on two to five occasions, 1% reported they had taken them on six to ten occasions, and 2% reported having taken drugs on more than ten occasions.
- Pupils were most likely to get helpful information from teachers (66%), parents (63%) or TV (60%). As in previous years, helplines were the source least likely to be found helpful by pupils (15%).

Havering specialist substance misuse services: client profile⁹⁶

The National Drug Treatment Monitoring System (NDTMS) provides data on specialist treatment for young people under the age of 18 with problems around both alcohol and drug misuse.

- The number of young people receiving specialist substance misuse services rose from 52 in 2010/11 to 63 in 2012/13. Over half (55.5%, n=35) of these young people were aged 16-17. Of all adults and young people in treatment, the proportion of which were young people was between 9-10% over 2011/12-2012/13 and was in line with the national profile. <5 young people were in a secure estate receiving treatment.
- In 2012/13, most referrals to specialist substance misuse services came from the youth justice service (n=19), self, family or friends (n=20) or education services (n=17). None came from accident and emergency and <5 came from health and mental health services (excluding accident and emergency)
- The majority of specialist interventions are psychosocial only⁹⁷ (95%). 95% of interventions last 52 weeks or less and 68% are 26 weeks or less.

Many young people receiving specialist interventions have a range of vulnerabilities. They are more likely to be not in education, employment or training (NEET), have contracted a sexually transmitted infection (STI), have a child, be in contact with the youth justice system, be receiving benefit by the time they are 18, and half as likely to be in full-time employment. The risk-harm profile identifies 10 key items to gauge the vulnerability of young people entering specialist substance misuse services. The higher the score, the more complex the need.

- 69% of young person receiving a specialist substance misuse service in Havering identify themselves as have 2-4 risks / vulnerabilities; this is exactly in line with the national profile
- The most frequently cited risk factors cited by young people accessing specialist substance misuse services in Havering are that they are using two or more substances⁹⁸ (64% Havering; 55% national) or that they began using the main problem substance under the age of 15 (83% Havering; 81% national).
- Six young people using substance misuse services in 2012-13 stated that they were involved in sexual exploitation either at the start or end of their treatment⁹⁹
- In 2012/13, 80% of young people exited the service in a planned way (as a proportion of all exits and in line with national profile)

⁹⁶ Public Health England (2013). Alcohol and drugs: JSNA support pack. Key data to support planning for effective young people's substance misuse interventions.

⁹⁷ Psychosocial interventions are a range of talking therapies designed to encourage behaviour change and include family interventions and harm reduction as well as other specific psychosocial intervention types.

⁹⁸ Includes alcohol

⁹⁹ Readers should refer to page 108 for a definition and further detail on child sexual exploitation

The profile of substance misuse amongst specialist service users in Havering and nationally for 2012/13 is set out below.

Profile of substance misuse, young people's specialist substance misuse service users, 2012/13		
	Havering	National
Stimulants (Cocaine, Ecstasy, Amph. Not Crack)	36.5% (n=23)	21%
Cannabis & Alcohol	32% (n=20)	34%
Cannabis Only	22% (n=14)	30%
Class A (Heroin & Crack)	X (n=<5)	2%
Alcohol only	X (n=<5)	12%
Other Drug	0	1%

Hospital admissions due to substance or alcohol misuse

Over 2009/12, the directly standardised rate of hospital admission for substance misuse for persons aged 15-24 years, was 78.2 per 100,000 population (around 23 per year); this is higher than the England directly standardised rate of 69.4, but not significantly so.

The crude rate of alcohol specific hospital admissions for under 18 year olds over 2008-10 was 34.2 per 100,000, significantly below the England average rate of 55.8 per 100,000.

Early Years

"The evidence is clear that children's experiences in their early years strongly influence their outcomes in later life, across a range of areas from health and social behaviour to their employment and educational attainment. The most recent neuro-scientific evidence highlights the particular importance of the first three years of a child's life. A strong start in the early years increases the probability of positive outcomes in later life; a weak foundation significantly increases the risk of later difficulties"

Dame Claire Tickell, 2011

The Early Years Foundation Stage (EYFS) is a framework that all early years providers must follow. It helps children learn, develop and helps prepare them for school. In Havering, the proportion of children achieving a good level of development increased over 2008-2010 and has remained relatively static over 2011-2013 at 59-60%. Except for 2012, Havering has performed consistently in line with or better than England since 2008. Compared against all England authorities, Havering is currently ranked 20th for the proportion of children achieving a good level of development at the early years foundation stage.

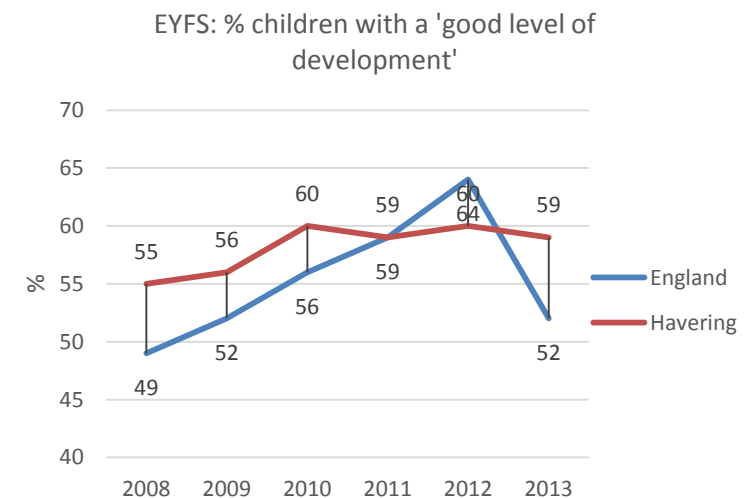
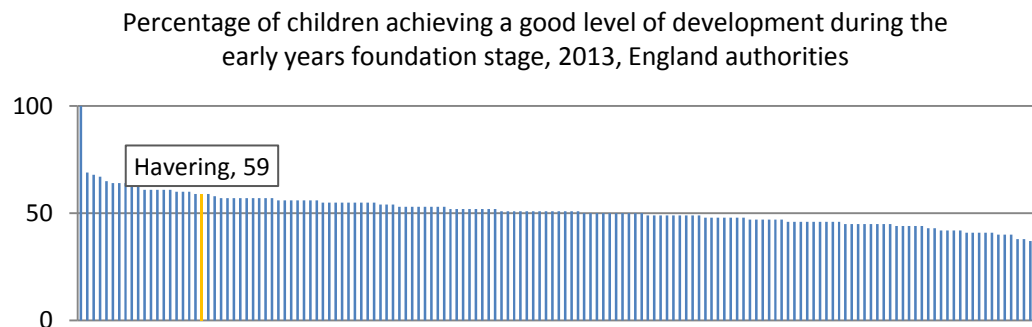


Figure 28: percentage of children achieving a good level of development during the early years foundation stage, 2008-13, England and Havering

All 3 and 4-year-olds in England are entitled to 15 hours of free early education each week for 38 weeks of the year. Some 2-year-olds are also eligible on the basis of their parents' benefit or tax credit status. From September 2014 more 2-year-olds in England will be eligible for free early education. As well as the current rules, a child will then also be eligible if any of the following apply:

- Parent claims Working Tax Credits and earns no more than £16,190 a year
- Child has a current statement of special educational needs (SEN) or an education, health and care plan
- Child receives Disability Living Allowance
- Child has left care through special guardianship or an adoption or residence order

2 year old offer

The current eligibility criteria extends to 20% of all 2 year olds, rising to 40% from September 2014. The Department of Education estimated that 506 children would be eligible for the statutory two year old offer in September 2013. During the summer and autumn terms of 2013, 646 2 year olds accessed the free early education entitlement¹⁰⁰. Numbers accessing each term vary; as at January 2014, there was a net "drop-out" of children expected to start in the spring term 2014 although more applications were expected once the term started. In December 2013, the DfE estimated that 716 children would be eligible for the offer from April 2014, and 1128 eligible from September 2014 when eligibility criteria is extended. The DfE has supplied numbers within general post code areas (e.g. RM1 1) of children expected to be eligible in Havering from September 2014, which will enable targeted promotion.

3 and 4 year old offer

In the Summer Term 2013 (13 weeks) 4,275 children accessed the universal early education entitlement in private, voluntary, independent and maintained settings. As with the 2 year old offer not all children take-up the full 15 hours per week entitlement. The summer term generally has the highest number of accessing children.

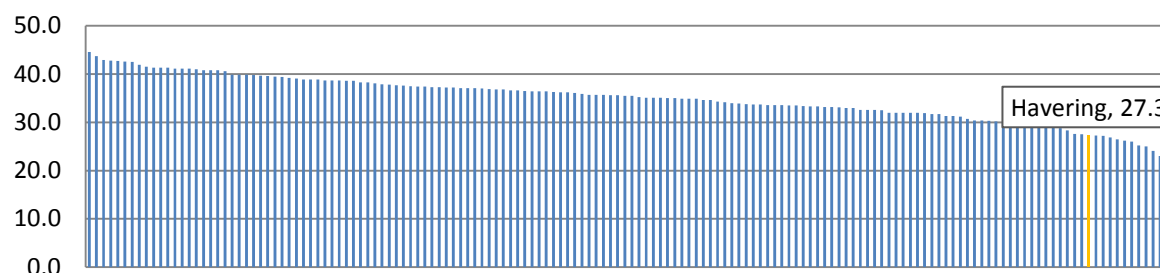
¹⁰⁰ Some children do not access the full 15 hours per week entitlement so these are not necessarily full time equivalents.

In the autumn term 2013 (14 weeks) 2,985 children accessed the universal early education entitlement in private, voluntary, independent and maintained settings. As with the 2 year old offer not all children take-up the full 15 hours per week entitlement. The autumn term generally has the lowest number of accessing children.

Inequalities in early years development

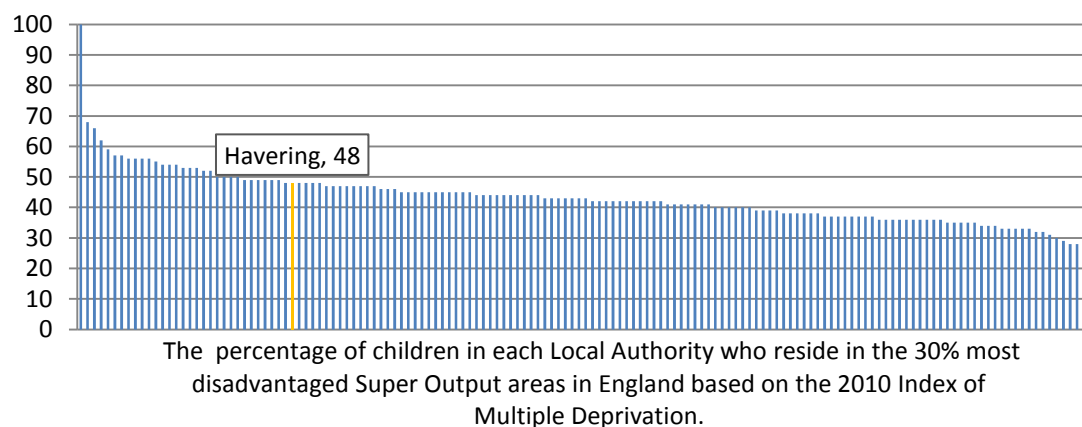
In 2013 the percentage inequality gap in achievement across all the Early Learning Goals was 27.3% in Havering, compared to 36.6% for England¹⁰¹.

Percentage inequality gap in achievement across all the Early Learning Goals by all England Local Authorities, 2013 (lower is better)



Similarly, the percentage of children achieving at least the expected level in 'the areas of learning' by deprivation status of child residency was comparative high at 48% in Havering and 44% across England in 2013. However, both the Havering and England rate of achievement for this cohort dropped from 2012 levels (England 56%; Havering 51%)

Percentage of children achieving at least the expected level in the Areas of Learning by national deprivation status of child residency for each England Local Authority, 2013 (higher is better)



¹⁰¹ This is calculated as the percentage gap in achievement between the lowest 20 per cent of achieving children (mean score), and the score of the median.

Percentage point gender gap of children achieving a good level of development, by all England Local Authorities, 2013 (lower is better)

The chart displays the percentage point gender gap for 321 Local Authorities. The y-axis represents the percentage point gap, ranging from 0 to 30. The x-axis lists the Local Authorities. Havering, London is highlighted with a yellow bar, indicating a value of 12.

Local Authority	Percentage point gender gap
Havering, London	12

- Children who were eligible for free school meals were far less likely to achieve a good level of development than those who are not eligible (Havering, 48% v 63%; England, 48% v 67%). There was a substantial difference in the rate of boys versus girls who were eligible for free school meals who achieved a good level of development, (Havering, 37% v 59%, England, 39% v 58%)
- Children who spoke English as a second language were less likely to achieve a good level of development than those with English as a first language (Havering, 53% v 61%; England 56% v 65%). Over the last five years the number of children in the early years foundation stage with English as a second language rose from 196 to 357.
- In Havering, children from a black or minority ethnic background and white children were equally likely to achieve a good level of development (Havering, 59% v 60%; England, 61% v 65)

142 | Page

Over 2010-2012, the rate of children achieving a good level of development relative to the England average declined for virtually all cohorts. Overall performance has improved for 2013, but detail on the achievement of vulnerable groups has not yet been published. In 2010, all cohorts listed in Figure 29 outperformed the England average. In 2012, the only group that performed favourably to the England average was girls eligible for free school meals. The starkest differential in performance was for White children, boys, children with English as a first language and children not eligible for free school meals.

Figure 29: Children achieving a good level of development during the early years foundation stage, compared to the England average for the same cohort

(figures in brackets show the percentage difference in performance between the Havering and England cohort)

	2010	2011	2012	2013 ¹⁰³
White children	Better (+4%)	Worse (-1%)	Worse (-5%)	
Boys	Better (+2%)	Worse (-3%)	Worse (-4%)	Better (+8)
Children with English as a first language	Better (+3%)	Worse (-1%)	Worse (-4%)	
Children not eligible for free school meals	Better (+3%)	Same (0%)	Worse (-4%)	
Children with English as a second language	Better (+5%)	Better (+5%)	Worse (-3%)	
Girls	Better (+5%)	Better (+4%)	Worse (-3%)	Better (+5%)
Boys eligible for free school meals	Better (+5%)	Worse (-5%)	Worse (-2%)	
Black and ethnic minority children	Better (+4%)	Better (+1%)	Worse (-2%)	
All children eligible for free schools meals	Better (+6%)	Worse (-1%)	Same (0%)	
Girls eligible for free school meals	Better (+7%)	Better (+6%)	Better (+1%)	
Child resides in 30% most deprived national area			Worse (-5%)	Better (+4%)
Pupils with SEN but without a statement			Better (+1%)	

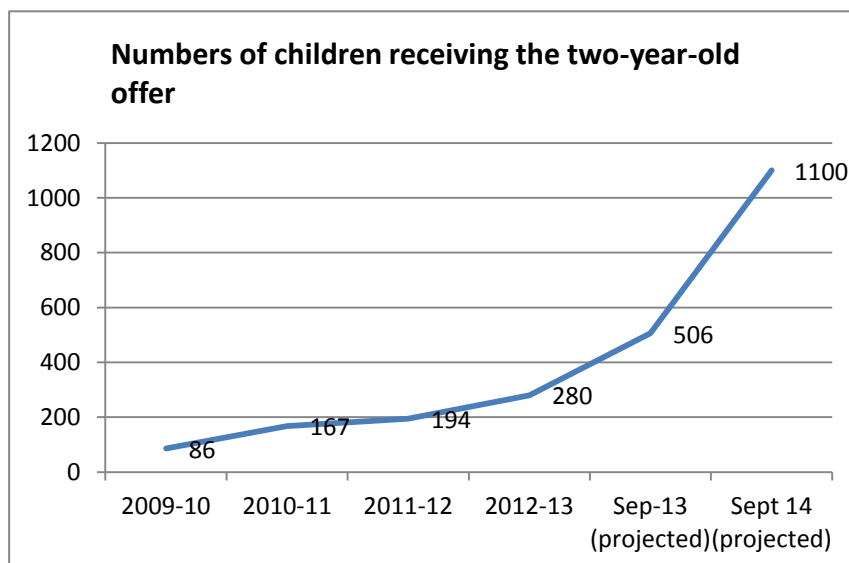
¹⁰³ A pupil achieving at least the expected level in the ELGs within the three prime areas of learning and within literacy and numeracy is classed as having "a good level of development". This is a different definition to that used for 2010, 2011 and 2012.

What is the current service provision?

Early years providers are subject to inspection by Ofsted, who provide a grade for the 'overall effectiveness' of the provision. As at June 2012, the overall effectiveness of early years registered providers at their most recent inspection was as follows:

	Outstanding	Good	Satisfactory	Inadequate
Havering	14% (41) ¹⁰⁴	61% (181)	24% (70)	1% (3)
London	11%	62%	26%	1%
England	12%	62%	26%	1%

The two-year-old offer is due to be extended from 1 September 2014 to 40% of two year olds nationally. Qualifying children include those entitled to free school meals and looked after by the Local Authority. Those who qualify are entitled to 570 hours of early education in any year and for no fewer than 38 weeks. The current estimate of



qualifying two year olds in Havering as notified by the DfE is 1,100. However, as the DfE has reduced the estimate for two year olds qualifying from 1 September 2013, this figure may well reduce. The qualifications for the extended offer from September 2014 are expected to include children with special educational needs or disabilities and those who have left care but are unable to return home

The Local Authority is meeting its childcare sufficiency duty as the availability of childcare on a Borough wide basis continues to outstrip the number of 3 and 4 year olds in Havering.

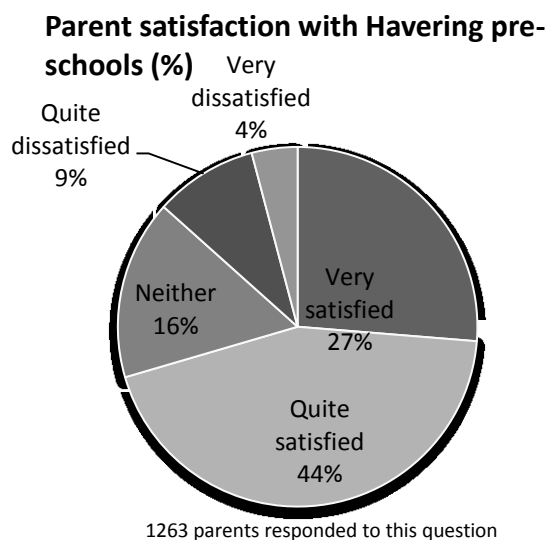
Since 2011, private, independent and voluntary sector early years providers have led in the development of five Common Assessment Frameworks, although have contributed to others. Training is planned for 2013 on early help assessments.

Havering has six children's centres. The centres work are paired into locality hubs, providing universal and early help services to three reach areas (north, central and southern). Four children's centres were rated as having good overall effectiveness and two were graded as requiring improvement by Ofsted as at February 2014.

¹⁰⁴ Numbers in brackets represent the actual number of providers inspected

What do local people think?

71% (n=897) of parents who responded to a survey about schools and school places said they were very or quite satisfied with pre-school provision in LB Havering. 13% (n=164) said they were quite or very dissatisfied. The most commonly cited reasons for dissatisfaction with pre-schools include a perceived lack of availability of pre-school places and a lack of pre-school provision attached to primary schools¹⁰⁵.



Considerations for commissioners and service providers

To provide effective early years support to improve health and reduce inequalities, local authorities can (Hallam 2008):

- target the most disadvantaged children and their families with intensive support, supplementing specific interventions with mainstream universal family support services. Successful interventions tend to be behaviour-focused – for example, coaching parents during play sessions with children – rather than simply providing information. Staff should be adequately trained to provide specialist, intensive support;
- focus on vulnerable mothers, from pregnancy until the child reaches the age of two. Programmes that involve health visitors and specialist nurses undertaking home visits have had successful outcomes, including improvements in prenatal health, fewer childhood injuries, fewer subsequent unplanned pregnancies, and increases in maternal employment and children's school readiness.
- The local authority may wish to consider how settings can ensure that children receive the best start possible as part of its review of its childcare sufficiency statement.

¹⁰⁵ Data is drawn from a LB Havering survey of parent's views of schools and school places, carried out over April-18 May 2012. The survey was circulated via Havering schools and received a total of 1447 responses.

Primary years (age 5-10)

School place projections

Current projections for reception and primary school places through to 2022/23 are set out below. Over July- October 2013, there was a larger than expected rise in the number of applications for school places. Further analysis is underway to understand the outflow of children and on-going monitoring will determine whether this spike becomes a trend that impacts on school place and other projections.

PROJECTED RECEPTION PUPIL POPULATION 2013-14 TO 2022-23											
	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
Total Birth	3,039	3,090	3,139	3,164	3,172	3,193	3,214	3,242	3,258	3,247	3,228
Total Reception	2,906	3,130	3,196	3,283	3,417	3,468	3,551	3,603	3,639	3,675	3,707
Projected Reception Total inc. housing	2,906	3,170	3,276	3,381	3,523	3,566	3,628	3,646	3,656	3,681	3,711
<i>Total Reception with housing plus target (not yet planned)</i>		3,170	3,276	3,382	3,533	3,595	3,677	3,714	3,742	3,778	3,809
<i>Total Reception with housing plus target (not yet planned) PLUS 5%</i>		3,329	3,440	3,551	3,710	3,775	3,861	3,900	3,929	3,967	4,000
BY ADMISSION NUMBER (AN)											
Reception Capacity (AN)	2,799	3,084	3,174	3,174	3,174	3,174	3,174	3,174	3,174	3,174	3,174
Reception Surplus/Deficit	-107	-46	-22	-109	-243	-294	-377	-429	-465	-501	-533
Reception % Surplus/Deficit	-3.8%	-1.5%	-0.7%	-3.4%	-7.6%	-9.3%	-11.9%	-13.5%	-14.7%	-15.8%	-16.8%
Reception % Surplus/Deficit inc.housing		-2.8%	-3.2%	-6.5%	-11.0%	-12.3%	-14.3%	-14.9%	-15.2%	-16.0%	-16.9%
Reception % Surplus/Deficit inc.housing + target		-2.8%	-3.2%	-6.6%	-11.3%	-13.3%	-15.9%	-17.0%	-17.9%	-19.0%	-20.0%
Additional places needed to maintain 5% surplus		245	266	377	536	601	687	726	755	793	826

PROJECTED PRIMARY PUPIL POPULATION 2013-14 TO 2022-23											
	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
Total Primary	19,078	19,839	20,492	21,195	21,910	22,738	23,472	24,190	24,713	25,206	25,642
Total Primary with housing	19,078	19,919	20,651	21,390	22,123	22,935	23,627	24,276	24,747	25,218	25,650
Total Primary with housing plus target (not yet planned)		19,919	20,651	21,393	22,143	22,994	23,725	24,412	24,918	25,410	25,847
Total Primary with housing plus target (not yet planned) PLUS 5%		20,915	21,684	22,463	23,250	24,143	24,911	25,633	26,164	26,681	27,139
BY ADMISSION NUMBER											
Primary Capacity (AN)	19,578	19,863	20,268	20,673	21,078	21,498	21,843	22,128	22,218	22,218	22,218
Primary Surplus/Deficit (no additional housing)	500	24	-224	-522	-832	-1,240	-1,629	-2,062	-2,495	-2,988	-3,424
Primary % Surplus/Deficit	2.6%	0.1%	-1.1%	-2.5%	-3.9%	-5.8%	-7.5%	-9.3%	-11.2%	-13.4%	-15.4%
Primary % Surplus/Deficit inc.housing		-0.3%	-1.9%	-3.5%	-5.0%	-6.7%	-8.2%	-9.7%	-11.4%	-13.5%	-15.4%
Primary % Surplus/Deficit inc.housing + target		-0.3%	-1.9%	-3.5%	-5.1%	-7.0%	-8.6%	-10.3%	-12.2%	-14.4%	-16.3%
Additional places needed to maintain 5% surplus		1,052	1,416	1,790	2,172	2,645	3,068	3,505	3,946	4,463	4,921

Attainment at key stage 2

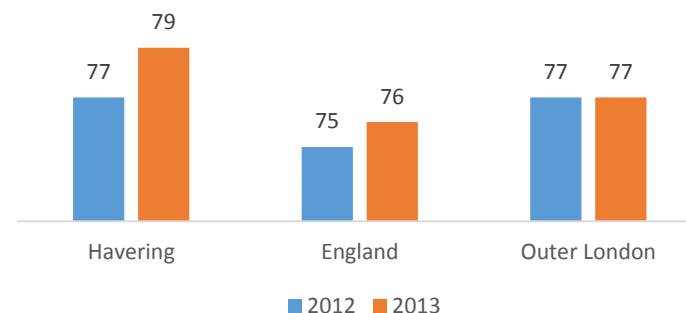
Key stage 2 (KS2) is the term for the four years of schooling in maintained schools in England and Wales normally known as Year 3, Year 4, Year 5 and Year 6, when pupils are aged between 7 and 11. At the end of each key stage, children are expected to reach certain levels of knowledge, skills and understanding in each subject. The expected attainment level for children at the end of KS2 (i.e. age 11) is level 4.

In 2012 and 2013, the Havering rate of pupils achieving level 4 or above in reading, writing and maths at KS2 was on par with or above the England and outer London average rates¹⁰⁶.

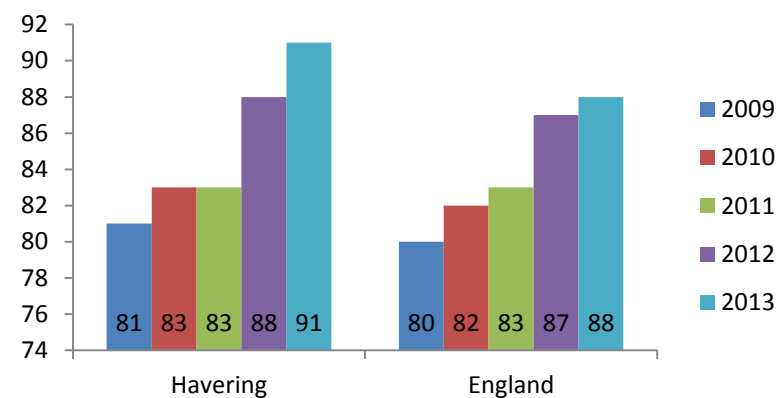
Over 2009-2013, the proportion of pupils making the expected progress between KS1 and KS2 was consistently the same or higher than the England average¹⁰⁷.

Within the overall figures for achievement at the end of KS2, there are differences in outcomes for particular groups of children.

% of pupils achieving level 4 or above in reading, writing and maths at KS2



Percentage of pupils making expected progress in maths between KS1 and KS2, 2009-2013



¹⁰⁶ Measurements changed in 2012 and therefore earlier data on English and math achievement is not directly comparable with 2012 and 2013 figures.

¹⁰⁷ Havering data for 2010 may not be representative due to limited coverage for this year.

Inequalities in key stage 2 attainment

Attainment by ward

Rates of attainment at borough-level mask significant variation in KS2 attainment patterns at ward level. KS2 attainment data is not available for all wards, and is not yet available for any wards for 2012/13.

- The rate of attainment for both benchmark measures is consistently above the Havering average in Cranham, Emerson Park, Hacton, Romford Town, South Hornchurch, Squirrel's Heath, St Andrew's and Upminster.
- The rate of attainment for both benchmark measures is consistently below the Havering average in Gooshays, Harold Wood and Havering Park. In Gooshays, the rate of attainment has fluctuated over time, but reduced on both measures by -10% (English) and -8% (maths) over 2010/11-2011/12.

Ward	% of pupils achieving level 4 or above in English at KS2					% of pupils achieving level 4 or above in maths at KS2					% points difference in overall rate of attainment between 2010/11 and 2011-2012	
	2007/08	2008/09	2009/10	2010/11	2011/12	2007/08	2008/09	2009/10	2010/11	2011/12	% of pupils achieving level 4 English	% of pupils gaining -achieving level 4 maths
Brooklands	✗ 79	✗ 76	✓ 84	✗ 85	✓ 89	✗ 62	✗ 70	✓ 85	✗ 79	✓ 89	4	10
Cranham	✓ 88	✗ 80	~	✓ 91	✓ 93	✓ 89	✓ 88	~	✓ 91	✓ 91	2	0
Elm Park	✓ 92	✓ 85	~	✗ 85	✓ 91	✓ 88	✗ 81	~	✗ 79	✓ 90	6	11
Emerson Park	✓ 94	✓ 92	~	✓ 96	✓ 92	✓ 91	✓ 87	~	✓ 92	✓ 90	-4	-2
Gooshays	✗ 61	✗ 72	✗ 65	✓ 86	✗ 76	✗ 68	✗ 64	✗ 58	✗ 80	✗ 72	-10	-8
Hacton	✓ 89	✓ 94	~	✓ 90	✓ 93	✓ 87	✓ 90	~	✓ 90	✓ 93	3	3
Harold Wood	✗ 74	✗ 74	~	✗ 76	✗ 85	✗ 72	✗ 78	~	✗ 75	✗ 83	9	8
Havering Park	✗ 82	✗ 78	~	✗ 83	✗ 83	✗ 76	✗ 75	~	✗ 76	✗ 78	0	2
Heaton	✗ 75	✗ 73	✗ 68	✗ 83	✗ 83	✗ 75	✗ 72	✗ 69	✓ 85	✗ 77	0	-8
Hylands	✗ 84	✓ 89	~	✓ 91	✓ 88	✗ 80	✓ 87	~	✗ 76	✓ 86	-3	10
Mawneys	✓ 87	✓ 94	✓ 83	✗ 84	✓ 90	✓ 92	✓ 91	✓ 86	✓ 83	✓ 88	6	5
Pettits	✓ 90	✓ 87	~	✓ 86	✓ 88	✓ 84	✓ 82	~	✓ 83	✗ 82	2	-1
Rainham and Wennington	✗ 78	✗ 77	~	✗ 76	✗ 82	✗ 79	✗ 78	~	✓ 82	✗ 85	6	3
Romford Town	✓ 92	✓ 94	~	✓ 86	✓ 92	✓ 83	✓ 92	~	✓ 83	✓ 91	6	8
South Hornchurch	✓ 87	✗ 82	~	✓ 87	✓ 88	✓ 85	✓ 88	~	✓ 86	✓ 86	1	0
Squirrel's Heath	✓ 91	✓ 92	~	✓ 91	✓ 90	✓ 86	✓ 87	~	✓ 87	✓ 86	-1	-1
St Andrew's	✓ 94	✓ 94	~	✗ 82	✗ 84	✓ 90	✓ 87	~	✓ 83	✓ 87	2	4
Upminster	✓ 90	✓ 86	~	✓ 87	✓ 91	✓ 87	✓ 82	~	✓ 82	✓ 90	4	8
Havering average	85	85	81	86	88	82	82	82	82	86	2	4

Key: Comparison with Havering average

- ✓ Above
- ✗ Equal to
- ✗ Below

Attainment by free school meal status

The gap between the proportion of children eligible and those not eligible for free school meals achieving level 4 in English and maths increased over 2010-2013 from 14% to 23% points. Compared to other authorities, Havering is now ranked 102/152 on this measure, a drop from a 2010 ranking of 10/152 (lower is better). This is a consequence of the proportion of pupils who are not eligible for free school meals improving their attainment at a faster rate than the national average, and is compounded by the rate of attainment for pupils eligible for FSMs, which while improving year on year, is at a slower rate than other local authorities.

The attainment gap is even more pronounced for girls; Havering ranks 130/152 authorities (lower is better) with an attainment gap of 25% points in 2013

Attainment by first language and ethnic background

- Children who spoke English as a second language were slightly less likely to achieve level 4 or above in both English and maths than those with English as a first language (Havering, 78% v 82%; England 78% v 80%), but rates were in line with England averages (2012).
- In 2012, Havering pupils from a BME background and white children were equally likely to achieve level 4 or above in both English and maths (Havering, 83% v 82%; England, 79% v 80%)

Over 2011-2012, most groups of children achieved in line with or better than the England average for their cohort (Figure 30).

Figure 30: Percentage of pupils achieving level 4 or above in both English and maths at key stage two, compared to the England average for the same cohort, 2011-2012
(figures in brackets show the percentage difference in performance between the Havering and England cohort)

	2011	2012	2013
Black and ethnic minority children	Better (+3%)	Better (+4%)	
Boys	Better (+5%)	Better (+3%)	
Boys eligible for free school meals	Better (+5%)	Better (+3%)	
White children	Better (+2%)	Better (+2%)	
Children with English as a first language	Better (+2%)	Better (+2%)	
Children not eligible for free school meals	Better (+2%)	Better (+2%)	
Girls	Better (+1%)	Better (+2%)	
All children eligible for free schools meals	Better (4%)	Same (0%)	Worse (-1%)
Children with English as a second language	Better (+3%)	Same (0%)	
Girls eligible for free school meals	Better (+3%)	Worse (-3%)	
Children supported through school action plus	Worse (-8%)	Worse (-3%)	
Children supported through school action	Worse (-1%)	Worse (-4%)	
Children with a Statement of Special Educational Need	Same (0%)	Worse (-6%)	

The starkest differential in performance was for children who were identified as having a special educational need. Commentary on the [attainment of children with special educational need](#) is made earlier in this document; the Havering profile of pupils with SEN is markedly different to the England profile and therefore are not directly comparable.

Exclusions

The raw number of **primary fixed term exclusions** (FTEs) has fluctuated between 68 and 86 over 2009/10-2011/12. Although the number of FTEs rose from 2010-2011/12, the Havering rate was (0.44%) less than half the England rate (0.9%)¹⁰⁸.

	2009/10	2010/11	2011/12
Primary	86	68	85
Secondary	1012	1021	962
Special	0	14	x

The most common reason for a FTE in primary and special schools in Havering is 'physical assault against a pupil' followed by 'persistent disruptive behaviour' (2011/12). At a national level, data is broken down by pupil characteristics. This information is not provided at local level. Permanent exclusions were made at primary level in 2011/12, but were <5 and therefore not reportable.

Attendance

Research from the Department of Education shows a correlation between children who are persistently absent from school and those who are bullied, excluded from school or involved in risky behaviours. Unsurprisingly, there is also a link between school absence and attainment. In England during 2009/10, pupils who have never been classified as persistent absentees over the Key Stage 2 period were twice as likely to achieve level 4 or above (including English and maths) as pupils who were persistently absent for each of the four Key Stage 2 years.

At a national level, a review of absence data over 1996 – 2010 by the Department of Education found that:

- Pupils eligible for Free School Meals (FSM) have over twice the odds of being a persistent absentee as similar pupils who are not eligible for FSM;
- Pupils with Special Education Needs (SEN) have greater odds of being persistently absent than pupils without SEN. Those at School Action Plus have the highest odds of being persistently absent (almost three times that of pupils without SEN) followed by statemented pupils (2.8 times the odds) and pupils at School Action (almost twice the odds of being persistently absent than pupils without SEN)¹⁰⁹
- Pakistani, Bangladeshi, African, Indian and pupils of Mixed White and Asian ethnicity report higher proportions of absences due to religious observance compared to all other ethnic groups;

¹⁰⁸ Local figures for fixed period exclusions (FPE) from the school census are available 2 terms in arrears and have been used historically; however these figures cannot be used at present as academies were not required to supply FPE data to LB Havering and therefore are not included in the data set. From September 2013 academies will be required to supply this information.

¹⁰⁹ Department for Education (2011). A profile of pupil absence in England. Research Report DFE-RR17.

- Persistent absentees are more likely to come from lone parent households or households with no parents, compared to their non-PA peers.
- Almost a third of persistent absentees come from households where the principal adult/s are not in any form of current employment – this compares to just over a tenth of non-PAs

What do local people think?

As part of a survey of children resident and / or attending school in Havering, 98 children and young people responded to the question ‘what are the 3 most important education issues for young people in Havering’. ‘Attendance’ was the second most commonly cited response. The same question was asked in a parallel survey of adults and of the 142 respondents, attendance was also the second most common response.

What does the data tell us?

In 2011/12, Havering had a comparatively high rate of persistent absenteeism¹¹⁰ at primary level (3.6%). This put Havering in the bottom 20% of performance against all London authorities (range 2.2% - 4.1%) and in the bottom 25% for England authorities (range 2.7% - 5.3%).



Figure 31: percentage of persistent absentees at primary level, 2011/12, **England** quintiles

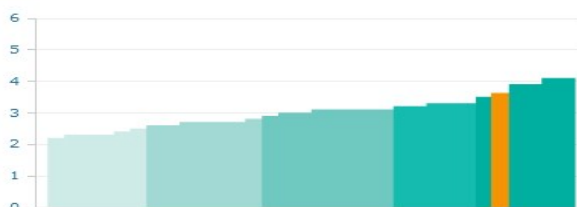


Figure 32: percentage of persistent absentees at primary level, 2011/12, **London** quintiles

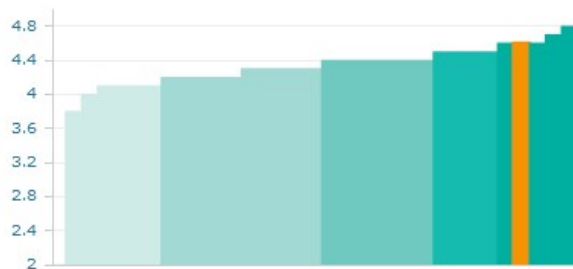
The percentage of primary school half day absences for the same period was also comparatively high at 4.6%. Again, this put Havering in the bottom 20% of poorest performance when compared to all London authorities and bottom 30% for England, although the overall England average was 4.4%. Provisional data for 2012/13 indicates that the rate of primary half day absences (including authorised and unauthorised) has risen to 4.9%. Authorised absence¹¹¹ for primary-aged children was the joint

¹¹⁰ Persistent absentees are defined as having 46 or more sessions of absence (authorised or unauthorised) during the academic year, around 15 per cent of overall absence.

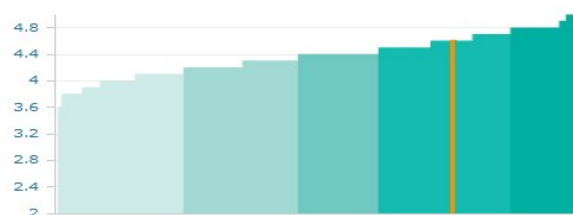
¹¹¹ Authorised absence is absence with permission from a teacher or other authorised representative of the school. This includes instances of absences for which a satisfactory explanation has been provided (for example, illness).

poorest rate in London at 4% in 2011/12 whereas unauthorised absence¹¹² was comparatively low at 0.6%.

*Figure 33: percentage half days missed at primary level, 2011/12, **London** quintiles*



*Figure 34: percentage half days missed at primary level, 2011/12, **England** quintiles*



¹¹² Unauthorised absence is absence without permission from a teacher or other authorised representative of the school. This includes all unexplained or unjustified absences. Arriving late for school, after the register has closed, is recorded as unauthorised absence.

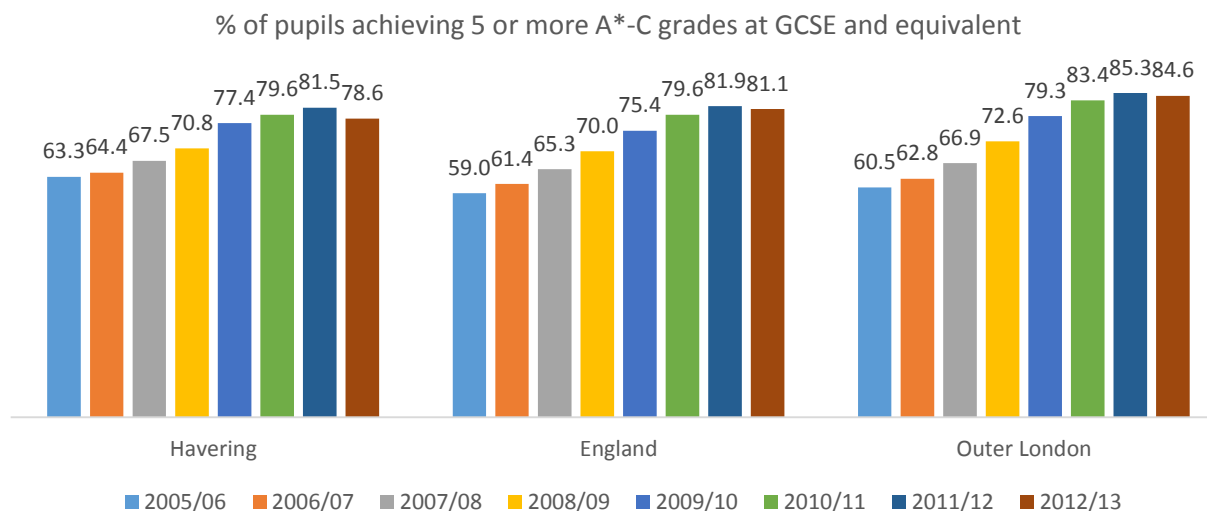
Secondary-aged children

School place projections

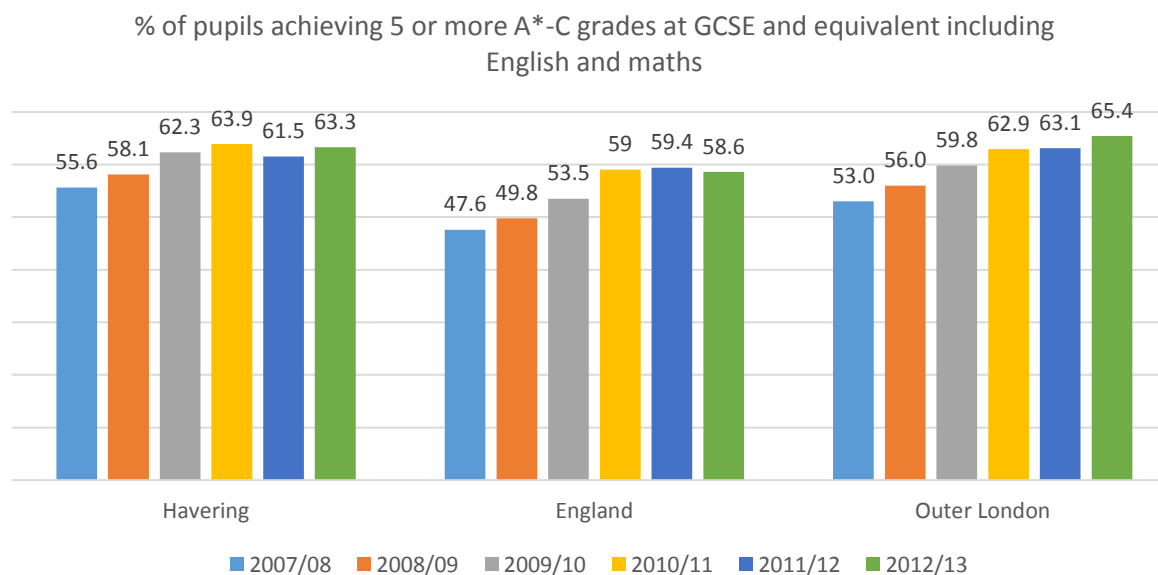
PROJECTED YEAR 7 TO 11 PUPIL POPULATION 2013-14 TO 2022-23											
	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
Total Secondary Year 7-Year 11	15,029	14,725	14,629	14,577	14,803	15,017	15,540	15,948	16,570	17,133	17,855
Total Secondary Y7-Y11with housing		14,782	14,743	14,716	14,955	15,157	15,651	16,010	16,594	17,141	17,860
Total Secondary Y7-Y11with housing plus target		14,782	14,743	14,718	14,970	15,200	15,720	16,107	16,716	17,279	18,001
<i>Total Secondary with housing plus target (not yet planned) PLUS 5%</i>		<i>15,521</i>	<i>15,480</i>	<i>15,454</i>	<i>15,718</i>	<i>15,959</i>	<i>16,506</i>	<i>16,912</i>	<i>17,552</i>	<i>18,143</i>	<i>18,901</i>
BY ADMISSION NUMBER (AN)											
Secondary Capacity (AN)	15,953	16,057	16,146	16,170	16,160	16,140	16,140	16,140	16,140	16,140	16,140
Secondary Surplus/Deficit	924	1,332	1,517	1,593	1,357	1,123	600	192	-430	-993	-1,715
Secondary % Surplus/Deficit	5.8%	8.3%	9.4%	9.9%	8.4%	7.0%	3.7%	1.2%	-2.7%	-6.2%	-10.6%
Secondary % Surplus/Deficit inc.housing		7.9%	8.7%	9.0%	7.5%	6.1%	3.0%	0.8%	-2.8%	-6.2%	-10.7%
Secondary % Surplus/Deficit inc.housing + target		7.9%	8.7%	9.0%	7.4%	5.8%	2.6%	0.2%	-3.6%	-7.1%	-11.5%
Additional places needed to maintain 5% surplus		-596	-785	-865	-617	-181	366	772	1,412	2,003	2,761

Attainment at key stage 4

In 2011/12 and 2012/13, the proportion of Havering pupils who achieved **5 or more A*-C grade GCSEs or equivalent** (78.6%) was lower than the England and outer London average, with the Havering rate declining in 2012/13 for the first time in many years. **Consequently, Havering ranked 130th / 152 authorities for performance on this measure in 2012/13.**



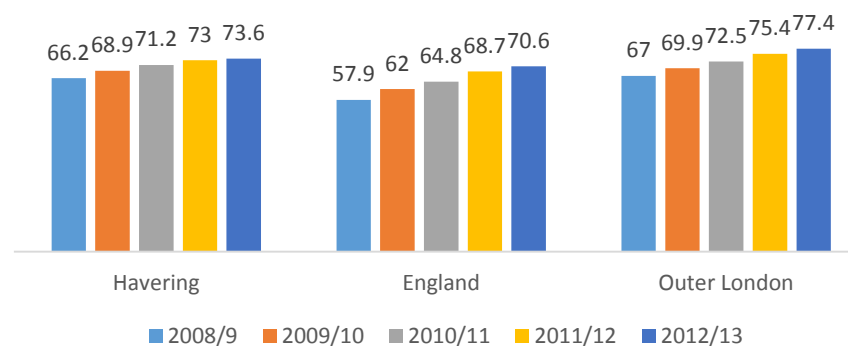
However, the proportion of pupils achieving 5 or more **A*-C grade GCSEs or equivalent including English and maths** was consistently higher than England over 2004/5-2012/13 and stood at 63.3 % in 2012/13. **Havering's 2012/13 rank on this measure was 38th / 152 authorities.**



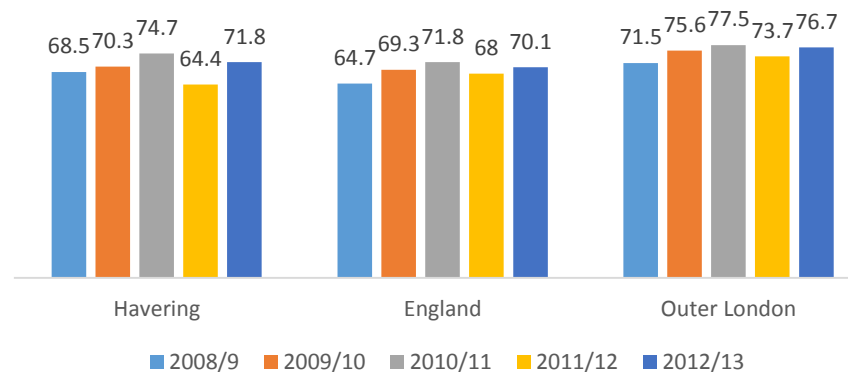
The rate of pupils making expected progress in maths over 2008/9-2012/13 steadily increased across England, outer London and within Havering. In 2012/13, the Havering rate remained above the England average for this measure, but was below the outer London average by 3.8%. **Havering's 2012/13 rank on this measure was 45th / 151 authorities.**

Similarly, for the expected progress in English measure, the Havering rate in 2012/13 was slightly higher than the England average but lower than outer London by 4.9%. **Havering's 2012/13 rank on this measure was 59th / 151 authorities.**

Percentage of pupils in state-funded schools **making expected progress in maths** between key stage 2 and key stage 4



Percentage of pupils in state-funded schools **making expected progress in English** between key stage 2 and key stage 4



Inequalities in attainment at KS4

Rates of attainment at borough-level mask significant variation in KS4 attainment patterns at ward level. KS4 attainment data is not available for all wards, and is not yet available for any wards for 2012/13.

- The rate of attainment for both benchmark measures is consistently above the Havering average in Cranham, Emerson Park, St Andrew's and Upminster
- The rate of attainment for both benchmark measures is consistently below the Havering average in Gooshays, although the 5+ A*-C rate rose from 41.4% in 2007/8 to 78.6% in 2011/12. The 5+A*-G rate in Gooshays has fluctuated between 81.1% - 88.1% over the same period.
- The rate of children achieving 5+ A*-C in Brooklands has fallen from 79.9% in 2008/9 to 69.4% in 2011/12; the A*-G rate has remained broadly consistent.
- Rates of pupils achieving 5+ A*-G in Gooshays, Havering Park, Heaton, Pettits and Squirrel's Heath have all been below the Havering average for both 2010/11 and 2011/12. The rate has fallen in Squirrel's Heath over 2009/10-2011/12.

Key: Comparison with Havering average

- Above
- Equal to
- Below

Ward	GCSE and equivalent results, % of pupils achieving 5+ A*-C					GCSE and equivalent results, % of pupils achieving 5+ A*-G					% points difference in overall rate of attainment between 2010/11 and 2011-12	
	2007/08	2008/09	2009/10	2010/11	2011/12	2007/08	2008/09	2009/10	2010/11	2011/12	% of pupils gaining - achieving 5+ A*-C	% of pupils gaining - achieving 5+ A*-G
Brooklands	75.6	79.9	76.2	75.4	69.4	98.6	x	98.1	98.6	98.6	-6	0
Cranham	76.3	78.4	85.4	83.3	85.4	97.8	x	99.5	99.5	99.5	2.1	0
Elm Park	.	.	.	.	.	.	.	.	.	.	NA	NA
Emerson Park	69	72.8	84.9	90.2	91.4	95.9	96.3	96.6	98.3	99.8	1.2	1.5
Gooshays	41.4	46	60.2	62.9	78.6	82.8	81.7	85.8	81.1	88.1	15.7	7
Hacton	64.2	64.4	69.8	76.6	77.5	95.2	98.4	97.4	97.8	97.3	0.9	-0.5
Harold Wood	.	.	.	.	.	.	.	.	.	.	NA	NA
Havering Park	42.7	63.5	79	82.2	86.5	90.3	89.9	94	95.9	95.3	4.3	-0.6
Heaton	.	.	x	0	0	.	.	x	0	0	0	NA
Hylands	58.2	62.8	72	78.8	77	89.8	93.9	97.3	99.5	96.6	-1.8	-2.9
Mawneys	.	.	.	.	.	.	.	.	.	.	NA	NA
Pettits	67.8	60.4	68.2	70.5	77.4	98.7	94	94.7	96.8	96.8	6.9	0
Rainham and Wennington	67.7	69.5	82	72.3	75.6	95.5	97	98.4	100	100	3.3	0
Romford Town	77.6	78.8	80.3	80.8	79.6	94.3	95.8	99.5	99.1	97.7	-1.2	-1.4
South Hornchurch	52.4	53.8	65.1	71.8	70.7	93	x	95.8	97.1	97.6	-1.1	0.5
Squirrel's Heath	50	58.9	69.3	73.1	70	95.1	x	97.4	92.4	87.3	-3.1	-5.1
St Andrew's	62.3	74.4	81.1	88	91	95.8	96.3	98.2	98.2	99.4	3	1.2
Upminster	84.8	85.2	82.7	83.4	86.1	96.6	97.2	97.1	97.8	98.4	2.7	0.6
Havering average	67.5	70.8	77.4	79.6	81.50	94.8	96	96.6	97	97.4	1.9	0.4

Attainment by English as a second language (EAL) status

The proportion of children in Havering with EAL who achieve a good level of attainment at KS4 has slowly increased over the last three years, whereas the England average has increased more rapidly. The gap between pupils with EAL / without EAL in Havering is small and comparable to the national gap.

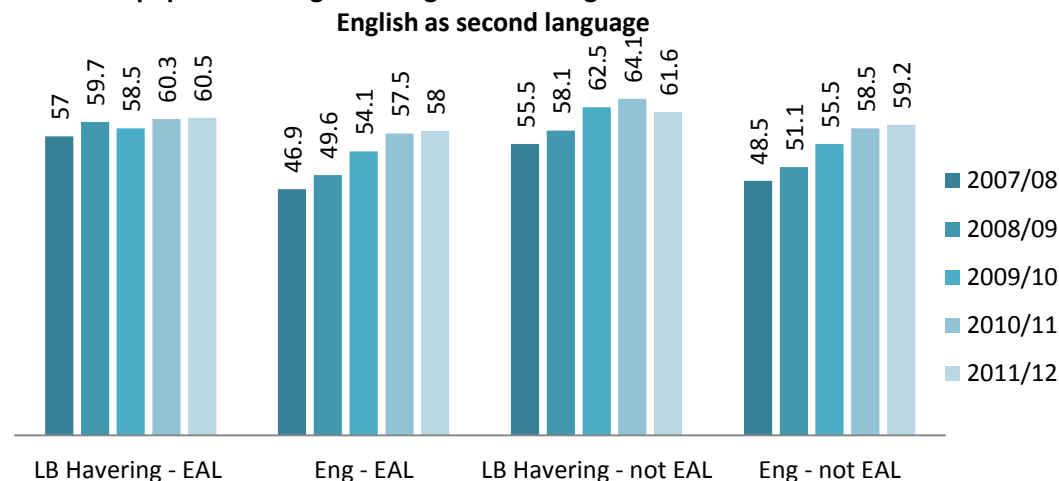
Attainment by gender

At a national and local level, the rate of girls achieving 5+ A*-C grade GCSEs or equivalent inc England and maths is consistently higher than that for boys. Since 2008/9, the rate for Havering boys and Havering girls is consistently higher than for their respective cohort of peers at a national level.

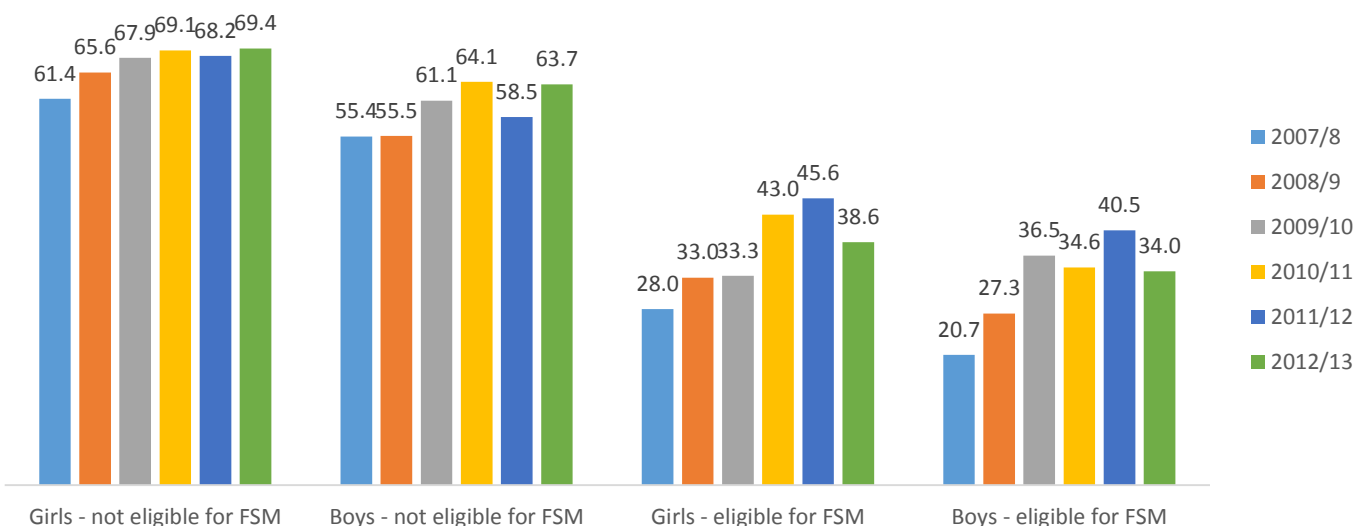
Attainment by free school meal (FSM) status

For children achieving 5+ A*-C grades inc. English & mathematics at GCSE level, the gap between the rate of attainment for pupils eligible for FSMs and those not eligible narrowed over 2007/8-2011/12, but widened in 2012/13, increasing

% of pupils achieving 5+ A*-C grades inc. English & mathematics GCSEs:

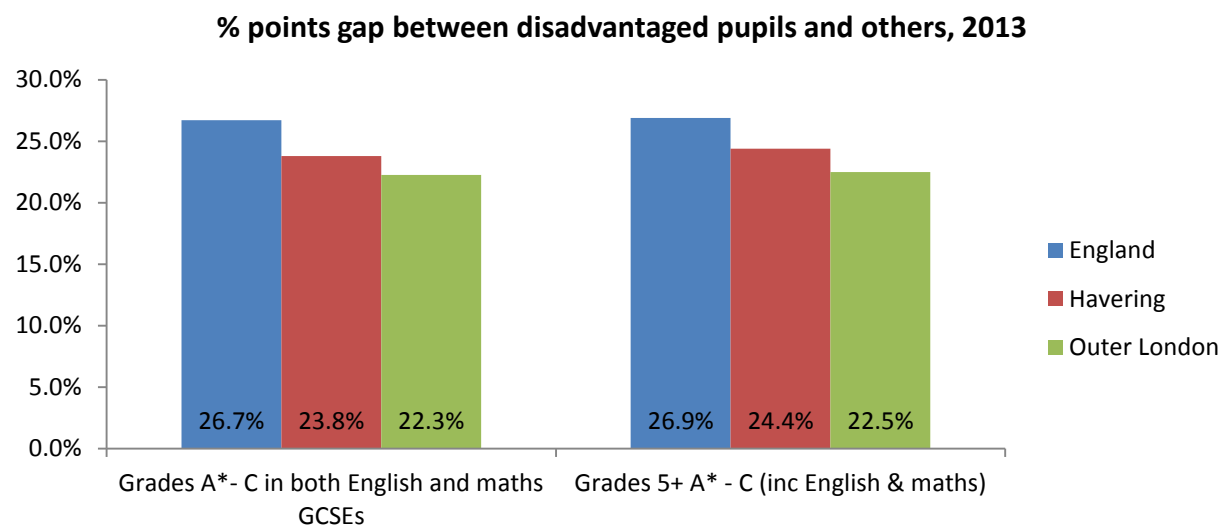


% of pupils achieving 5+ A*-C grade GCSEs including English and maths, Havering, by gender and FSM status



by 9.5% points from 20.6% to 30.1%. This is a consequence of the rate of children not in receipt of FSMs reaching this benchmark increasing by 2.6% points, and the **attainment rate of pupils in receipt of FSMs falling by 6.9% points to 35.8% and consequently below the England average for the first time since 2008.**

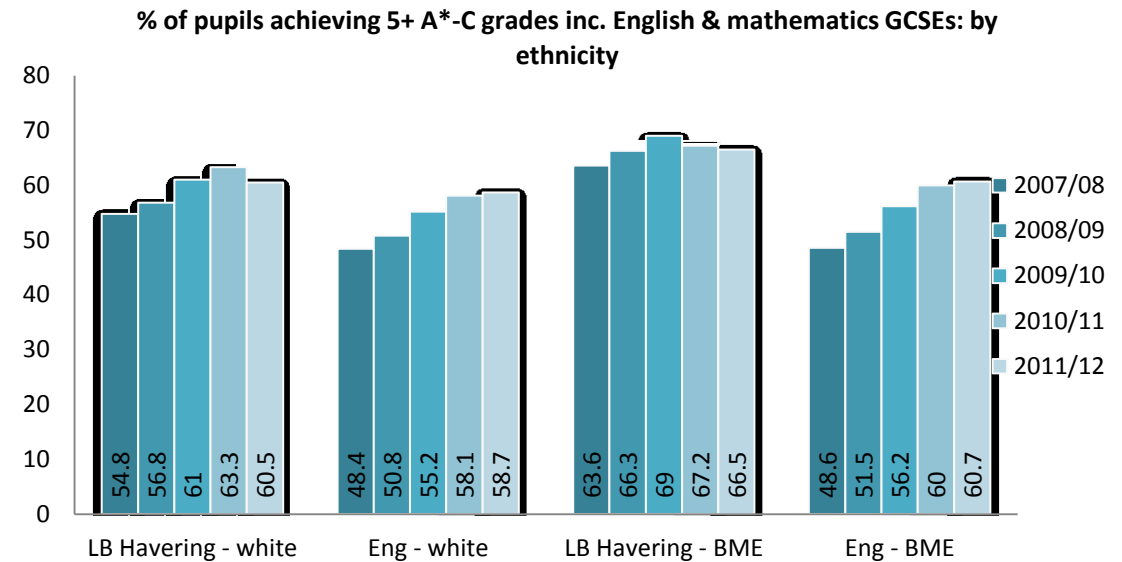
The disadvantaged pupils category includes pupils who were eligible for FSM at any point during the last six years and children looked after (CLA). CLA are pupils who have been looked after continuously for 6 months (≥ 183 days) during the year and are aged between five and fifteen. In 2013, the gap between disadvantaged pupils and non-disadvantaged pupils in Havering was smaller than the England average, but slightly larger than the outer London average.



However in the previous year (2011/12), Havering's ranking for the attainment of pupils not in receipt of FSMs fell from a previous position of 23rd / 24th over 2007/8-2010/11 to 71st, against all England authorities. Conversely, the 5+ A*-C inc English and maths rate of attainment for pupils eligible for FSMs steadily improved over 2007/8-2011/12, with Havering ranking 27th nationally on this benchmark; however, as the rate of attainment dropped to 35.8% in 2012/13, Havering's comparative ranking is likely to have dropped significantly.

Attainment by ethnic group

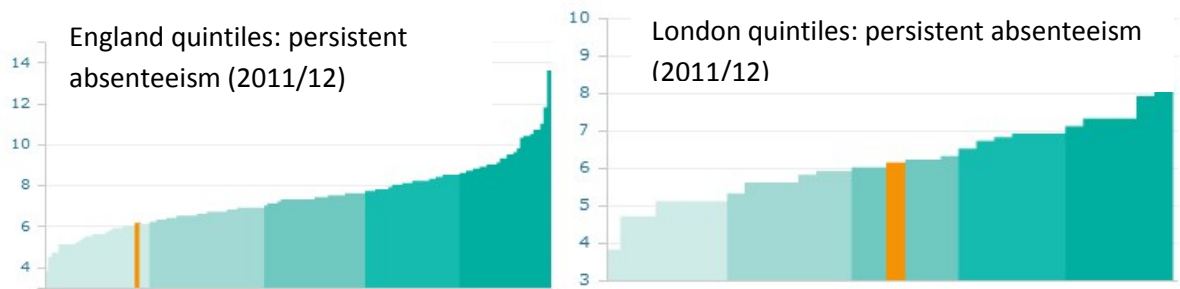
In Havering, children from black and minority ethnic (BME¹¹³) backgrounds had a higher rate of achieving GCSEs (5+ or equiv. 5+A*-C incl. Eng. and maths) than white children over 2007/8-2011/12. However, the rate of attainment for the BME cohort has fallen over 2009/10-2011/12, while the England average rate has increased over the same period.



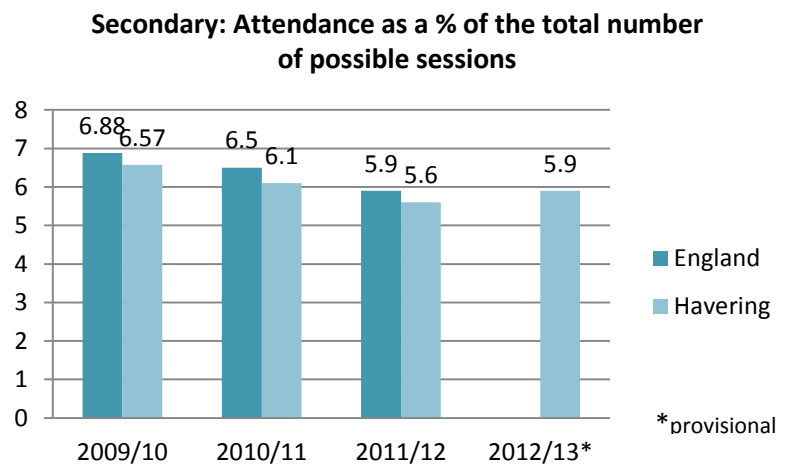
¹¹³ Black and minority ethnic group scores are a weighted average of scores for pupils of mixed, Black, Asian and Chinese heritage. Pupils from 'any other ethnic group' and pupils for whom ethnicity was not obtained, was refused or could not be determined are not included.

Attendance

In 2011/12, persistent absenteeism at secondary level in the bottom quintile of performance compared to all England authorities and in the third quintile of London authorities (lower is better).



Pupil absence (right) is defined as the % of half days missed by pupils due to overall absence (including authorised and unauthorised absence). Over 2009/10-2011/12 this was lower than England; provisional figures suggest the rate rose slightly in 2012/13



Home-schooling

Parents have the right to educate their children at home; education is compulsory, but school is not. The Local Authority has a responsibility to make arrangements to establish the identities, so far as it is possible to do so, of children in their area who are not receiving a suitable education. The duty applies in relation to children of compulsory school age who are not on a school roll, and who are not receiving a suitable education otherwise than being at school (for example, at home, privately, or in alternative provision). Local authorities have no statutory duties in relation to monitoring the quality of home education on a routine basis. From a safeguarding perspective, it is important for the Local Authority to have an accurate understanding of how many children are being home educated at any one time, where they are and where they have come from.

There were 81 children electively home educated and resident in Havering in September 2013. Of these, 29 were primary-aged and 52 were of secondary-age. There are more females (44) home-educated than boys (37).

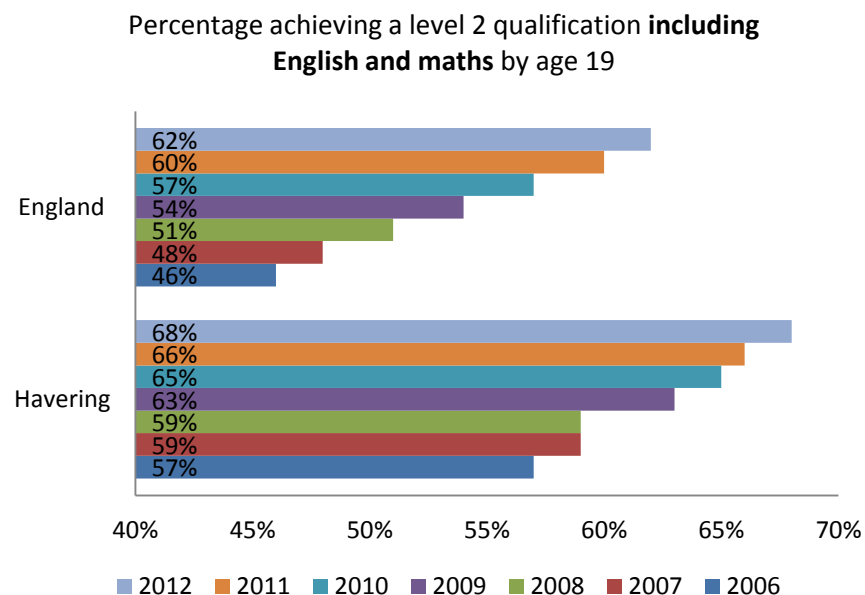
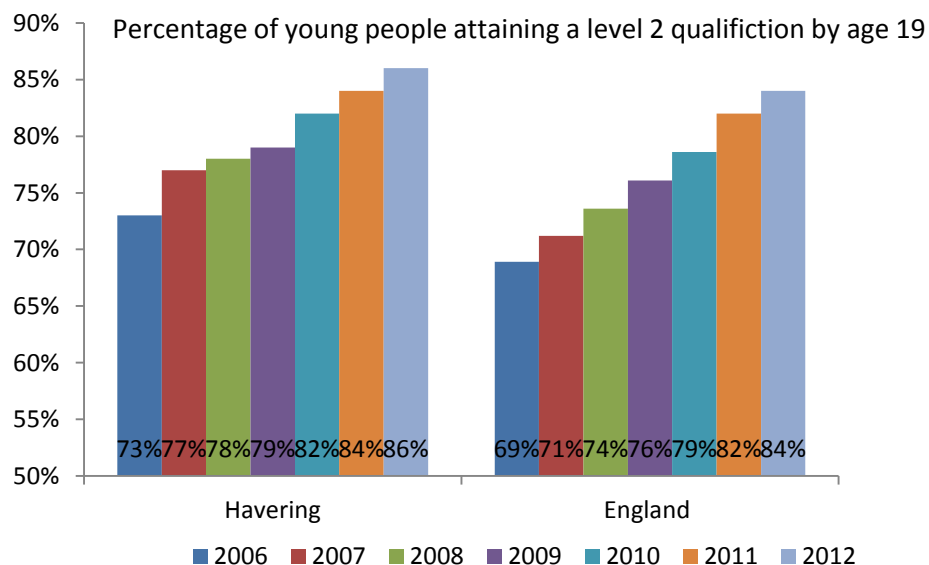
Post 16

Overall, young people in Havering are consistently more likely to have a level 2 or level 3 qualification at age 19 than their peers across England, and are more likely to be in education, employment or training. However, the historic relatively high rate of pupils eligible for free school meals achieving 5+A*-C GCSEs including English and maths at 16 has not translated to the rate of young people achieving a level three qualification by the age of 19. However, the two populations measured in each of these benchmark performance measures (i.e. at age 16 and age 19) are different: performance at age 16 is based on pupils attending Havering schools, whilst at age 19 it is based on residency. Apprenticeship success rates in Havering at both Intermediate and Advanced level have been below the England average since 2009 although the growth rate of apprenticeship starts in Havering has been much higher than that seen nationally in each of the last two years.

Post 16 attainment

The data below shows the proportion of young people attaining a Level 2 qualification by age 19. The Havering average has been consistently above the England rate with both the Havering and England averages increasing fairly consistently between 2006 and 2012, the Havering average by 13% and the England average by 15%.

The proportion of young people in Havering achieving a Level 2 including

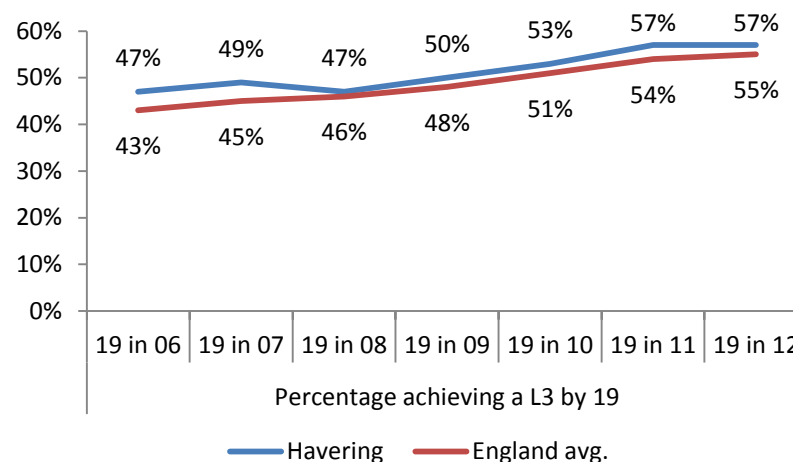


English & Maths by age 19 has also been consistently above the England average; more than 65% of students had achieved a Level 2 by 19 in 2012. Both the Havering and England averages have increased between 2006 and 2012, the Havering average by 11% and the England average by 16%. Similarly, the percentage of young people achieving a level 3 qualification by age 19 remained above the England average in 2012 at 57%.

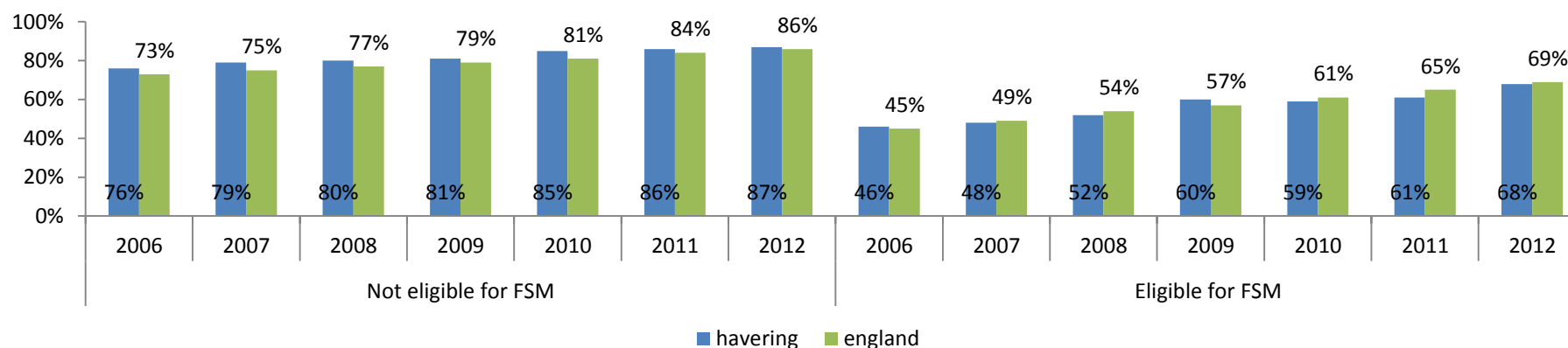
Post 16 attainment inequalities

Young people in Havering achieving a level 2 qualification at age 19 by free school meal status

Over 2006-2012, the percentage of young people not eligible for free school meals who achieve a level 2 qualification by age 19 in Havering has risen and has remained consistently slightly above the England average. Conversely, the proportion of young people eligible for free school meals attaining a level 2 qualification by age 19 in Havering was slightly below the England average over 2010, 2011 and 2012.



Percentage of young people in Havering achieving a level 2 qualification at age 19 by free school meal status



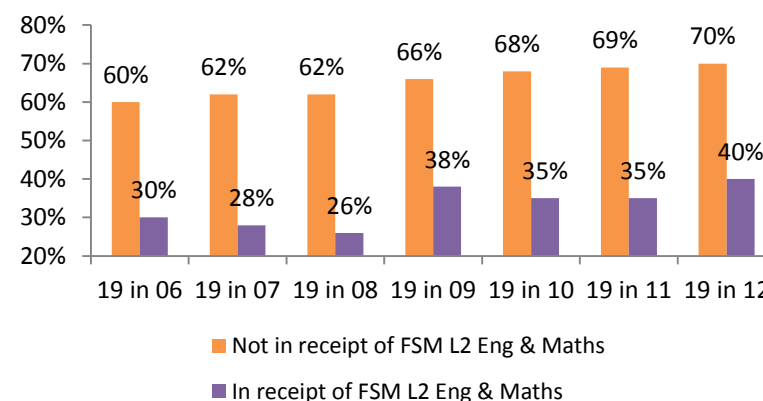
At a national level, the attainment gap between those young people eligible for free school meals and those not eligible has steadily reduced over 2006-2012 from 27% to 17% points difference. In Havering, the gap was higher than the England average from 2010-2012 but has reduced from 26% to 20% points difference, the lowest gap since 2006 and the closest to the national average since 2009.

Attainment gap between young people eligible and not eligible for free school meals (ppts)							
	19 in 06	19 in 07	19 in 08	19 in 09	19 in 10	19 in 11	19 in 12
Havering	30%	31%	28%	21%	26%	25%	20%
Eng. avg	27%	26%	24%	22%	20%	19%	17%

Young people in Havering achieving a level 2 qualification including English and maths at age 19 by free school meal status

The proportion of young people eligible for free school meals who also hold a level 2 qualification at age 19 including English and maths was at 40% in 2012, the highest it has ever been in Havering. However, this cohort of young people are far less likely to reach this attainment benchmark than their peers who are not eligible for free school meals; the percentage point attainment gap between those young people eligible for free school meals and those not eligible fluctuated between 2006-2009, with a net increase since of 4 % from 2006 to 2011. The gap closed by 4% in 2012 to 30%, although this remains above the England average gap of 27% points difference.

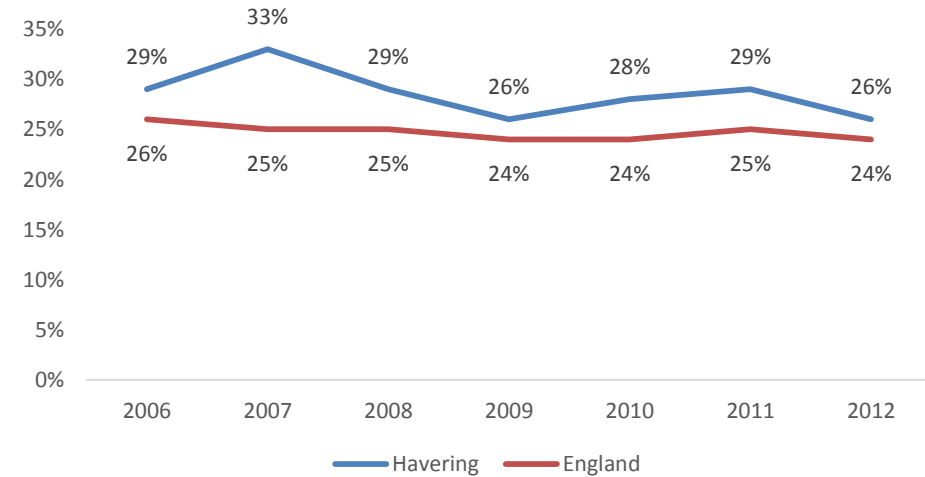
Percentage of young people in Havering achieving a level 2 qualification including English and maths at age 19 by free school meal status



Young people in Havering achieving a level 3 qualification at age 19 by free school meal status

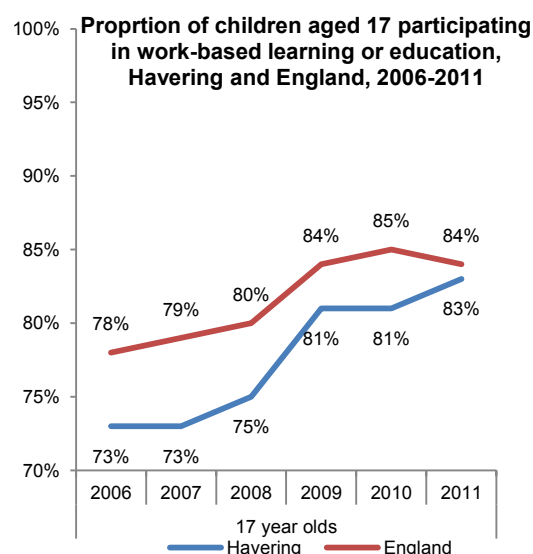
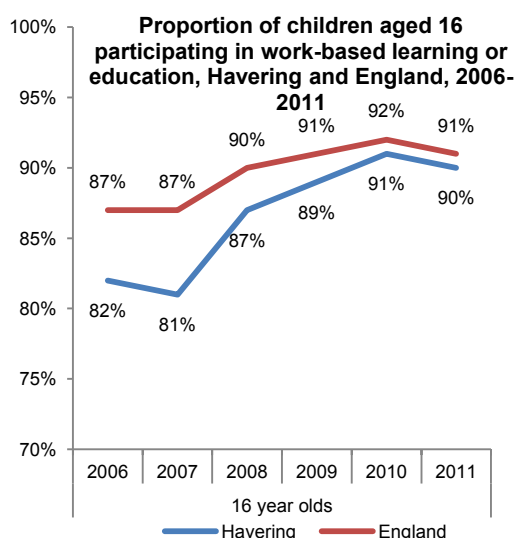
The proportion of young people not in receipt of free school meals who attained a level 3 by age 19 has remained above the England average except for a slight dip in 2008. The attainment gap in Havering has remained above the England average over 2006-2012, but reduced to 26% points difference in 2012, still above the England average of 24% points difference.

Percentage points difference between the rate young people eligible for free school meals achieve a level 3 qualification at age 19, and those not eligible for free school meals, Havering and England, 2006-2012



Participation in post 16 education, training and employment

Both the proportion of young people aged 16 and the proportion aged 17 who participate in either work-based learning or education has remained below the England average over 2006-2011, albeit to varying degrees. Over 2007-2010, the proportion of 16 year olds engaged increased from 81% to 91% and dropped slightly in 2011 to 90%, almost in line with the England average. Similarly, the proportion of 17 year olds engaged increased from 73% in 2007 to 83% in 2011 and also falls marginally below the England rate.



Data source: DFE SFR Participation by 16 and 17 year olds by Local Authority 2013 Final

Small numbers of young people aged 16 or 17 participate in work-based learning, with the majority staying on in education. Nationally the proportion decreased over 2006-2011, while in Havering the proportion participating in work-based learning (WBL) at age 16 dropped from 5% to 3% over the same period, those participating at age 17 increasing slightly from 5%-6% and is in line with the national rate.

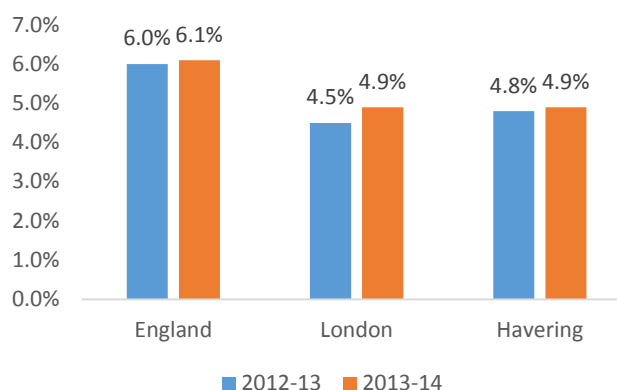
Participation in work based learning of young people aged 16 & 17 year olds				
	Havering		England	
Year	age 16	age 17	age 16	age 17
2006	5%	5%	6%	8%
2007	4%	7%	6%	8%
2008	4%	6%	5%	7%
2009	3%	5%	5%	7%
2010	3%	5%	4%	6%
2011	3%	6%	5%	6%

Young people not in education, employment or training (NEET)

The three month average NEET rate from November to January is the national measure for NEET used by the Department for Education. The rate of young people NEET is fluid and hence the most recently available local data is cited here.

The proportion of young people aged 16-18 who were NEET for three months in Havering was relatively static over May-July 2012 and May – July 2013, falling 1.2% below the national average in the 2013 period but in line with the London rate.

Proportion of young people aged 16-18 who were NEET for the previous three months (May-July averages)



The NEET rates should be considered in the

context of the rate of young people whose education, employment or training status is not known. Some of these young people may be disengaged from services and a high rate of 'unknown' participation status usually indicates more proactive work is needed to make sure all young people who need support to access education, employment and training are identified and offered appropriate services. In Havering, the 'unknown' rate over 2012 to 2013 was markedly below the London and England average.

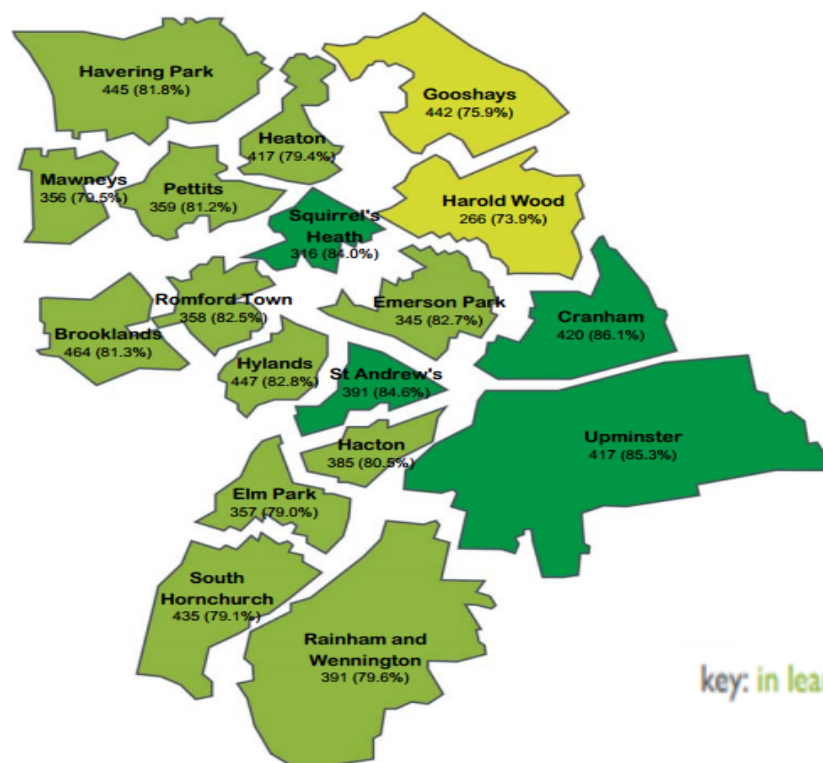
Proportion of 16-18 year olds whose participation status was 'not known' for the past three months, May-June averages, 2012 and 2013



The rate of young people in education, training and employment varies markedly throughout the year, coinciding with enrolment dates. Snapshot data should not be interpreted as indicative of long-term trends; however, the latest available ward level data shows variation in the proportion of year 12, 13 and 14 young people who are engaged in learning, varying from 73.9% in Harold Wood to 86.1% in Cranham. In addition to ward level variation, young parents, care leavers and young people with learning disabilities are at disproportionate risk of being NEET.

havering • in learning cohort • november 2013

in learning YP by ward
(as a % of ward residents)



key: in learning total = 80.8%

>2% > 82.8%

+/- 2% 78.8% to 82.8%

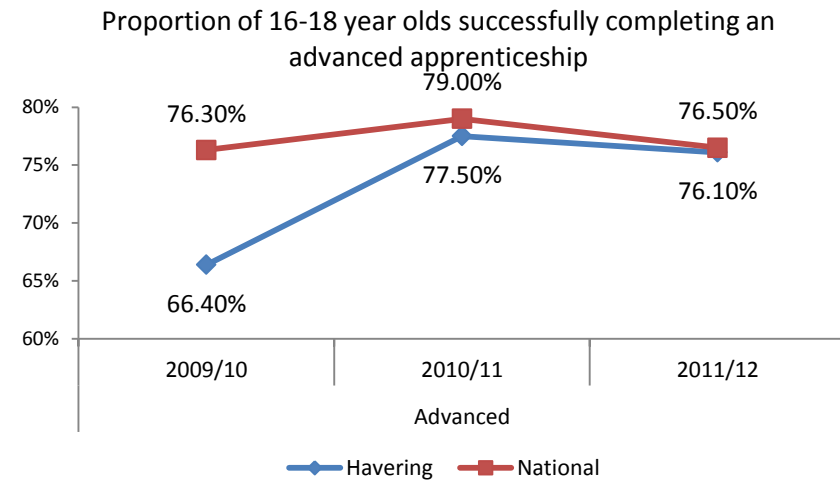
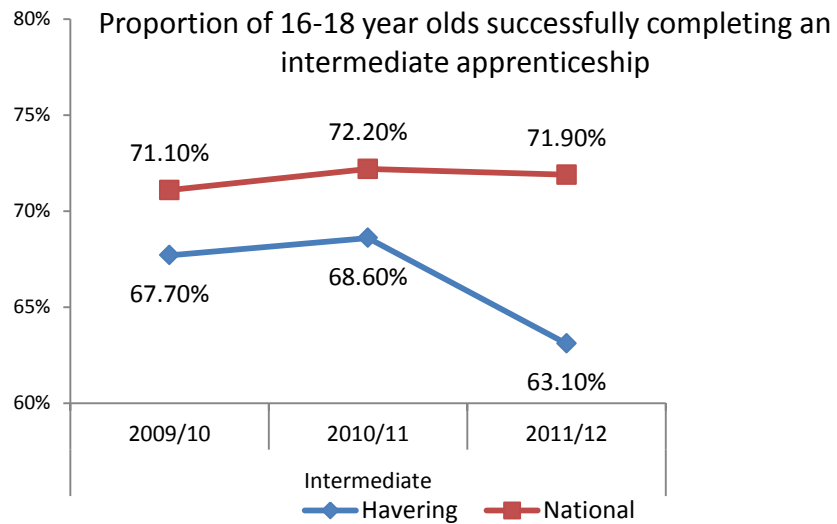
<2% < 78.8%

in learning YP by ward / locality

		total resident YP	in learning YP	in learning%	year 12	year 13	year 14
Wk	*Unknown Ward	25	9	36.0%	3	5	1
		25	9	36.0%	3	5	1
Havering	Brooklands	571	464	81.3%	183	162	119
	Cranham	488	420	86.1%	166	148	106
	Elm Park	452	357	79.0%	139	125	93
	Emerson Park	417	345	82.7%	135	118	92
	Gooshays	582	442	75.9%	186	148	108
	Hacton	478	385	80.5%	146	140	99
	Harold Wood	360	266	73.9%	92	109	65
	Havering Park	544	445	81.8%	181	180	84
	Heaton	525	417	79.4%	171	143	103
	Hylands	540	447	82.8%	164	154	129
	Mawneys	448	356	79.5%	147	115	94
	Pettits	442	359	81.2%	129	134	96
	Rainham and Wennington	491	391	79.6%	158	138	95
	Romford Town	496	395	79.6%	151	153	91
	South Hornchurch	550	435	79.1%	172	151	112
	Squirrel's Heath	376	316	84.0%	113	110	93
	St Andrew's	462	391	84.6%	149	143	99
Upminster	489	417	85.3%	169	149	99	
	8,711	7,048	80.9%	2,751	2,520	1,777	
	total resident YP	8,736	7,057	80.8%	2,754	2,525	1,778

Apprenticeships

The data below shows the Havering and England success rate for 16-18 year olds engaged in intermediate and advanced apprenticeships over 2009/10-2011/12. At advanced level rates are broadly in line with England, but at an intermediate level success rates are considerably lower than the England average.



The table below shows data on the numbers of young people starting and participating in apprenticeships during the last three years in Havering and the comparative regional and national figures. Whilst the numbers provide a clear indication of the volumes at each level without the corresponding total numbers of 16-18 year-olds in each of the four areas they are clearly not comparable. The proportional differences year on year provide an indication of the growth rates. Both the national and regional rate of young people starting apprenticeships declined markedly over 2011/12-2012/13, the rate in Havering rose by 11.3%.

Starts and continuing participation in apprenticeships at the end of the second quarter, young people aged 16-18									
		Starts			% Difference		Participation		
		2010/11	2011/12	2012/13	10/11-11/12	11/12-12/13	2010/11	2011/12	2012/13
Havering	Intermediate	200	212	225	6.0%	6.1%	425	448	504
	Advanced	95	107	126	12.6%	17.8%	169	173	212
	Higher	<5	<5	5	NA	NA	<5	<5	6
	Total	296	320	356	8.1%	11.3%	595	623	722
Regional	Intermediate	3,619	4,358	3,454	20.4%	-20.7%	7,145	8,398	7,277
	Advanced	1,596	1,866	1,605	16.9%	-14.0%	2,648	3,143	3,110
	Higher	5	10	35	100.0%	250.0%	6	10	40
	Total	5,220	6,234	5,094	19.4%	-18.3%	9,799	11,551	10,427
National	Intermediate	54,796	56,668	47,736	3.4%	-15.8%	109,298	106,656	98,077
	Advanced	20,937	22,309	21,523	6.6%	-3.5%	37,407	38,073	39,370
	Higher	119	170	370	42.9%	117.6%	151	195	457
	Total	75,852	79,147	69,629	4.3%	-12.0%	146,856	144,924	137,904

Destination Measures

In July 2012, the Department for Education (DfE) released new 'Education Destination Measures' as 'experimental statistics' which show the proportion of students progressing to further learning in schools, Further Education or Sixth Form Colleges, apprenticeships, work based learning providers or higher education institutions. Two measures have been introduced to show the destinations of young people the year after they finish compulsory schooling - Key Stage 4 (KS4), and the year after taking A level or equivalent qualifications - Key Stage 5 (KS5).

To be included in the destination measure, young people have to show *sustained* participation in an education destination in all of the first two terms of the year (October to March) after they completed KS4 or KS5. In Havering, 87 % of young people were recorded as being in a sustained education destination in the year after KS4, which compares to 88 % in London and 86 % nationally:

- Sixth Form College was the most popular destination for Havering residents with 33 % studying in this destination compared to 12 % nationally, and 11 % in London.
- School Sixth Form was the most popular destination for young Londoners with 50 % studying in this destination. This was also the most popular destination nationally although a lower %age (37 %) studied there. School Sixth Forms were also popular in Havering with 23 % studying in this destination.
- The second most popular destination for young people in Havering was Further Education (FE) College with 27 % of young people studying at FE Colleges, compared to 25 % in London and 33 % nationally.
- In Havering, 5 % were studying for an Apprenticeship in an FE College, other FE provider, School Sixth Form and Sixth Form College which compares to 3 % in London and the same as nationally.
- In Havering, 3 % were studying in an 'other FE provider', which is just below the national figure of 4 %.

In Havering, 6 % of young people did not fulfil the two term criteria for sustained participation in an education destination, this is the same as London and compares to 7 % nationally.

6% of young people were not captured in the education destination data (which is just below the national figure). These young people may have been in employment, not in employment, education, or training (NEET), on a gap year, left the country or were attending a Scottish or Welsh college or school.

Destinations in the year after taking A Level or equivalent qualifications – KS5 (2010/11)

In Havering, 65 % of young people were recorded as being in a sustained education destination in the year after they took their A Level or equivalent qualification/s (KS5), which compares to 71% in London and 64 % nationally:

- 6 % were studying in a FE College, the same as London and 8 % nationally, with a further 3% studying in a Sixth Form college, compared to 1 % in London and nationally.
- 1% were studying in an 'other FE provider', compared to 3 % nationally,
- 1% of young people were taking an Apprenticeship in a FE College, other FE provider, School Sixth Form and Sixth Form College, compared to 2 % in London and 3 % nationally.

- 55% went to a Higher Education Institution, compared to 56 % in London and 48 % nationally.

15% of young people did not fulfil the two term criteria for sustained participation in an education destination (9% increase over the last year). This compares to 7% in London and 8 % nationally.

14% of young people were not captured in the education destination data, which is less than the national average. These young people may have been in employment, NEET, on a gap year, left the country, or were attending a Scottish or Welsh college or school. This compares to 20 % in London and nationally.

Appendix one: consultation respondents

Responses to the consultation on Havering's children's JSNA were received by representatives from the following organisations:

- The Children's Society
- Havering's Child and Adolescent Mental Health Steering Group
- Havering's Children's Trust
- Havering's Clinical Commissioning Group
- Havering's Education Strategic Partnership
- Havering's Safeguarding Children Board
- Havering's Strategic Disability and SEN Steering Group
- JSNA Steering Group
- LB Havering Business and Performance
- LB Havering Children and Young People Services
- LB Havering Corporate Management Team
- LB Havering Housing
- LB Havering Learning and Achievement
- LB Havering Legal Services
- LB Havering Public Health
- Metropolitan Police Service, Havering Borough
- North East London Foundation Trust (NELFT)

Appendix two: Department for Education statistical releases by subject area

The links below provide the most recent statistical release from the Department for Education for the following subject areas.

- [14 to 19 diploma](#)
- [16 to 19 attainment](#)
- [A/AS levels \(key stage 5\)](#)
- [Admission appeals](#)
- [Behaviour in schools](#)
- [Childcare and early years](#)
- [Child death reviews](#)
- [Child protection](#)
- [Children's social care workforce](#)
- [Children in need](#)
- [Destinations](#)
- [Exclusions](#)
- [Early years foundation stage profile](#)
- [Fostering](#)
- [GCSEs \(key stage 4\)](#)
- [Key stage 1](#)
- [Key stage 2](#)
- [Key stage 3](#)
- [Local authority/school finance data](#)
- [Looked-after children](#)
- [NEET](#)
- [Neighbourhood \(absence and attainment\)](#)
- [Phonics check](#)
- [Pupil absence](#)
- [Pupil projections](#)
- [School and pupil numbers](#)
- [School applications](#)
- [School capacity](#)
- [School workforce](#)
- [Secure children's homes](#)
- [Special educational needs \(SEN\)](#)
- [Sure Start children's centres](#)
- [Teacher training](#)
- [Youth cohort study](#)
- [Bulletins](#)
- [Performance tables](#)
- [Publication schedule](#)
- [Volumes](#)

Appendix three: Department for Education statistical release publication schedule 2014.

This schedule shows the planned publication dates of all of the Department for Education's statistical first releases for 2014. Readers may wish to refer to the relevant links where more recent data has become available.

Publication date	Release title
30 January 2014	Childcare and early years survey of parents, 2012 Childcare and early years series
27 February 2014	Characteristics of children in need in England: 2012 to 2013 - additional analysis Children in need series
27 February 2014	NEET statistics quarterly brief: October to December 2013 NEET series
March 2014	Pupil absence in schools in England, including pupil characteristics: 2012 to 2013 Pupil absence series
March 2014	The local authority children's social care services workforce in England, 30 September 2013 Children's social care workforce series
March 2014	Attainment by young people in England measured using matched administrative data: attainment by age 19 in 2013 16 to 19 attainment
March 2014	Participation in education and work based learning: 16- and 17-year-olds in England, end 2012 (sub-national data) NEET series
April 2014	Outcomes for children looked after by local authorities in England, as at 31 March 2013 - additional tables Looked-after children series
April 2014	School workforce in England, November 2013 School workforce series
May 2014	Pupil absence in schools in England: autumn term, 2013 Pupil absence series
May 2014	NEET statistics quarterly brief: January to March 2014 NEET series
May 2014	Qualification success rates for English school sixth forms, academic year 2012 to 2013 A/AS levels (key stage 5) series
June 2014	Neighbourhood statistics: small area pupil attainment and absence by pupil characteristics in England - academic year 2012 to 2013 Neighbourhood (absence and attainment) series
June 2014	Secondary and primary school applications and offers: March to April 2014 School applications series
June 2014	Destinations of key stage 4 and key stage 5 students in 2011 to 2012 Destinations series
June 2014	Schools, pupils and their characteristics: January 2014 School and pupil numbers series
June 2014	Participation in education, training and employment by 16- to 18-year-olds in England, end 2013 NEET series
June 2014	Provision for children under 5 years of age in England: January 2014 Childcare and early years series
June 2014	Children accommodated in secure children's homes, England and Wales: year ending 31 March 2014 Secure children's homes series
July 2014	Income and expenditure in academies in England: 2012 to 2013 Local

Publication date	Release title
	authority/school finance data series
July 2014	School workforce in England: November 2013 - additional tables School workforce series
July 2014	Notifications of private fostering arrangements in England: year ending 31 March 2014 Fostering series
July 2014	Child death reviews completed in England: year ending 31 March 2014 Child death reviews series
July 2014	Admission appeals for maintained primary and secondary schools in England: 2013 to 2014 Admission appeals series
July 2014	Permanent and fixed period exclusions from schools in England 2012 to 2013 Exclusions series
July 2014	Special educational needs in England: January 2014 Special educational needs (SEN) series
July 2014	National pupil projections; future trends in pupil numbers - December 2014 update Pupil projections series
August 2014	Initial teacher training allocations for academic year 2014 to 2015: final Teacher training series
August 2014	NEET statistics quarterly brief: April to June 2014 NEET series
September 2014	National curriculum assessments at key stage 2 in England 2013 to 2014 (provisional) Key stage 2 series
September 2014	Planned expenditure of local authorities on education and children's social care functions (section 251 data) Local authority/school finance data series
September 2014	Children looked after by local authorities in England (including adoption and care leavers) - year ending 31 March 2014 Looked-after children
September 2014	Childcare and early years providers survey 2013 Childcare and early years series
September / October 2014	Phonics screening check and national curriculum assessments at key stage 1 in England 2014 Phonics check series
October 2014	Level 1 and 2 attainment in English and mathematics by 16 to 19 students, academic year 2012 to 2013 16 to 19 attainment series
October 2014	Pupil absence in schools in England: autumn term 2013 and spring 2014 Pupil absence series
October 2014	Provisional GCSE and equivalent results and national curriculum teacher assessments at key stage 3 in England , academic year 2013 to 2014 Key stage 3 series
October 2014	A level and other level 3 results in England, academic year 2013 to 2014 (provisional) A/AS levels (key stage 5) series
October 2014	Children with special educational needs: an analysis - 2014 Special educational needs (SEN) series
October 2014	Early years foundation stage profile results in England, academic year 2013 to 2014 Early years foundation profile series
October 2014	Characteristics of children in need in England , 2013 to 2014 Children in need series

Publication date	Release title
October 2014	2014 key stage 2 national curriculum tests review outcomes (provisional) Key stage 2 series
November 2014	Education and training statistics for the United Kingdom: 2014 Volumes series
November 2014	Early years foundation stage profile attainment by pupil characteristics in schools in England 2013 to 2014 Early years foundation profiles series
November 2014	NEET statistics quarterly brief - July to September 2014 NEET series
November 2014	Initial teacher training trainee number census Teacher training series
December 2014	Outcomes for children looked after by local authorities in England, as at 31 March 2014 Looked-after children series
December 2014	Children looked after by local authorities in England including adoption and care leavers) : year ending 31 March 2014 - additional tables Looked-after children series
December 2014	National curriculum assessments at key stage 2 in England 2013 to 2014 (revised) Key stage 2 series
December 2014	2014 primary school performance tables Performance table series
December 2014	Income and expenditure in local authority maintained schools – 2013 to 2014 Local authority/school finance data series