

# EDUCATION SCRUTINY COMMITTEE – 17 JULY 2014

## Children's Needs Analysis report to Education Scrutiny

### Context

1. Oxfordshire County Council, working with a range of partners, produce a Joint Strategic Needs Assessment (JSNA), looking at data and information about the population of Oxfordshire, particularly relating to health and wellbeing. This is a statutory responsibility of the Health and Wellbeing Board, which uses the JSNA as an evidence-base in setting its priorities.
2. In 2013 the opportunity to undertake a more detailed piece of work with a specific thematic purpose was recognised, and the benefits of using this to deepen our statistical knowledge of Oxfordshire's Children and Young People was agreed with the CEF Directorate, with the intention that this should also serve as the councils Child Poverty Assessment.
3. The resulting document, appended below, provides a more detailed examination of the factors affecting the lives and life chances of children and young people in Oxfordshire. It is organised into thematic chapters, and where possible includes the relevant data source as well as narrative content.
4. The Children's Needs Analysis is an evolving document, which is held by the Research and Intelligence Team in the Chief Executive's Office. It is intended that rather than a full annual refresh of this document, a different thematic focus will be selected in each year in parallel with the wider JSNA, and key data identified in each round incorporated within the JSNA itself.

### 5. Headlines

- The birth rate is currently at a multi-decade peak, partly driven by larger family size among recent immigrant families. Together with migration patterns this means that ethnic diversity is greater in younger age brackets than overall.
- The national assumption is that this will gradually fall back towards the long-term level as a rate, although the number of children being born in Oxfordshire will, while reducing slightly, remain at a higher level than previously due to the increasing number of women of childbearing age.
- This pattern creates a 'moving peak' of children progressing through the school system resulting in increased, but to some extent temporary, demand for school places.
- Population growth at the younger end of the population is heavily skewed towards urban areas - there are a range of potential explanations for this including the type of housing available/affordable, the pattern of migration into Oxfordshire, and the reclassification of some former rural areas as urban where they have seen significant housebuilding.
- The Income Deprivation Affecting Children Index maps closely to overall Index of Multiple Deprivation across the county. This information suggests that concentrated levels of deprivation are a primarily urban phenomenon in

Oxfordshire, but does not exclude pockets of rural deprivation which are 'disguised' in statistics aggregated across an area. Deprivation as measured by access to services, and housing affordability, shows a much more mixed pattern across the county.

- 30,000 families in Oxfordshire are claiming at least one working-age benefit (excluding housing benefit), although youth unemployment is falling as are the number of young people not in education, employment, or training ('NEETs'). NEETs, as above, primarily appear in urban areas, largely reflecting the location of the relevant population, rather than appreciably higher rates.
- The number of children being born with a low birth weight is rising, although this is not contributing to any increase in infant mortality, which is stable.
- Overall Oxfordshire performs well across most indicators including breastfeeding, immunisation, obesity, under-18 conceptions (though with a higher rate in Oxford City). The main indicator on which Oxfordshire's score is noticeably below average is dental health
- More children are being looked after, or identified as at risk. It is likely that this is as a result of increased investment in child protection services. There are also rising reports to police of domestic violence in situations involving children. Again, increased reporting is actively targeted and therefore an increase in reported levels does not necessarily mean an increased level of such violence.
- Messages on Child Sexual Exploitation in the Children's Needs Analysis directly correspond to those in the JSNA, and wider safety issues are picked up, eg bullying and e-safety.
- Oxfordshire's educational performance continues improve overall, though remains at a level below that which would be expected given Oxfordshire's demography. Following a trend of closing the gap in performance between children who are and are not in receipt of Free School Meals, there has been an increase in the most recent year. Further data will be required to judge whether this is a statistical 'blip', or a reversal of the previous trend.

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# Oxfordshire Children's Needs Analysis

Oxfordshire County Council

Research and Intelligence Unit - Policy Team

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## 1. INTRODUCTION and EXECUTIVE SUMMARY

Over the past year, the needs of children and young people have been central to many of the service planning needs, and future challenges, facing Oxfordshire County Council.

The Director for Children, Education, and Families therefore commissioned a Children's Needs Analysis, to look in more detail at the data and information the Council and partners hold about children and young people, and inform future strategy and decision-making.

This document is the result of that work, and complements the Oxfordshire Joint Strategic Needs Assessment<sup>1</sup>. The JSNA forms a key part of the evidence base around the population of Oxfordshire, and their health and wellbeing, used by Oxfordshire County Council and partners in priority setting and service planning. An annual report based on this information informs the priorities of the Health and Wellbeing Board.

It is also intended that this analysis should serve as the Council's revised Child Poverty Needs Assessment, a requirement of the Child Poverty Act. Information on this theme can be found in various places within the document, but is particularly addressed in Chapter 3.

Overall the analysis which follows suggests that Oxfordshire is well placed to meet the Council's strategic vision of "A Thriving Oxfordshire", for children and young people as well as for the wider population. Qualification and employment rates are high, welfare dependence is low, and health indicators are positive.

Nonetheless there remain significant challenges around areas of deprivation (largely but not solely in the county's urban centres), deprived individuals who may live in areas of overall affluence and therefore not be picked up by data which is simply aggregated across geographies, and thematic challenges, particularly around improving education outcomes, and improving the experience of looked after children.

The document is organised by theme, covering demography (current information, trends, and forecast future population); poverty; public health; vulnerable groups; and education. It remains a developing document, as new data sources are identified, and new data published, and feedback is actively sought.

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<sup>1</sup> <http://insight.oxfordshire.gov.uk/cms/joint-strategic-needs-assessment>

## 2. DEMOGRAPHY

### 2.1. Birth rate.

The UK has seen increases in the Total Fertility Rate\* in recent years, from 1.63 in 2001 to 1.96 in 2008. In 2009 the TFR fell slightly to 1.94, a dip likely to be related to the economic recession. This was short-lived as the longer-term increase resumed in 2010 resulting in the UK TFR reaching 1.98, its highest level since 1973. There was some variation between UK countries during 2009 and 2010, with a stabilisation then strong recovery in England, while in Scotland the TFR fell in both years, and Wales and Northern Ireland both saw small recoveries in 2010.

Fertility rates among women in their thirties and forties in the UK have continued to rise at a fast pace since the turn of the century, reaching levels last seen during the 1960s baby boom<sup>2</sup>.

**Table 1: Actual and assumed\* births per 1,000 women per single year of age, aggregated by broad age groups and year of birth of woman, women born 1950–2010 (reproduced from ONS National Population Series PP2).**

Year	Under 20	20–24	25–29	30–34	35–39	40 and over	Average completed family size (number of children)	Mean age at motherhood (years)
1950	231	699	634	365	132	28	2.09	26.4
1955	221	561	650	403	163	36	2.03	27.1
1960	156	527	630	438	190	43	1.98	27.8
1965	133	457	594	454	216	57	1.91	28.4
1970	152	418	522	466	278	<b>70</b>	<b>1.91</b>	<b>28.9</b>
1975	147	361	471	546	<b>315</b>	<b>72</b>	<b>1.91</b>	<b>29.4</b>
1980	154	349	519	<b>598</b>	<b>309</b>	<b>68</b>	<b>2.00</b>	<b>29.4</b>
1985	135	357	<b>538</b>	<b>591</b>	<b>300</b>	<b>67</b>	<b>1.99</b>	<b>29.4</b>
1990	127	<b>365</b>	<b>524</b>	<b>576</b>	<b>298</b>	<b>68</b>	<b>1.96</b>	<b>29.4</b>
1995	<b>108</b>	<b>347</b>	<b>507</b>	<b>571</b>	<b>300</b>	<b>68</b>	<b>1.90</b>	<b>29.6</b>
2000	<b>101</b>	<b>333</b>	<b>494</b>	<b>571</b>	<b>301</b>	<b>68</b>	<b>1.87</b>	<b>29.8</b>
2005	<b>97</b>	<b>322</b>	<b>490</b>	<b>571</b>	<b>301</b>	<b>68</b>	<b>1.85</b>	<b>29.8</b>
2010 and later	<b>93</b>	<b>319</b>	<b>490</b>	<b>571</b>	<b>301</b>	<b>68</b>	<b>1.84</b>	<b>29.9</b>

\* Figures in bold indicate wholly or partially projected data.

This increasing fertility among older women continued in 2009 and 2010. Since 2002 there have also been smaller increases in fertility among women in their late twenties and a stabilisation among women in their early twenties, following declining fertility in these age groups during the 1990s. However the increases in fertility rates for women in their twenties stalled in 2009 and 2010. The combination of trends in these two age groups has led to the rise in overall fertility over the decade, as well as further small increases in the mean age at childbirth.

<sup>2</sup> Source: ONS

\* Total Fertility Rate is the average number of children born per woman over a lifetime, sometimes expressed as number of births per thousand women.

## **2.2. Expectations for future birth rates – nationally and in Oxfordshire**

When considering future fertility, some factors are likely to constrain and reduce it whilst others are likely to maintain and increase it. Likely constraining/reducing pressures come from: continued increases in female employment and higher education (these raise the opportunity-costs of childbearing); and changes in socio-economic conditions such as housing cost and availability.

Factors tending to raise fertility include the continuing in-migration of women from countries with higher fertility than the UK and perhaps the increased ability of women to realise their fertility intentions, for example by more flexible working patterns for parents. It is not possible to be certain how much impact these, or other unforeseen factors, could have on fertility rates.

ONS assembled an expert panel and asked for their views on the likely level of fertility in 2034: eight out of ten experts thought that the UK TFR would be 1.80 or 1.85 in 2034. This suggests that experts do not believe fertility is likely to maintain its current level in the long-term.

ONS' final projection for the UK is broadly based on a long-term scenario where fertility rates for women in their twenties are somewhat lower than in 2010, fertility rates for women in their thirties are slightly lower than 2010 levels, but fertility among women aged 40 and over is slightly higher than in 2010 – this long-term pattern is achieved by the late 2020s and stabilises from then on. The TFR projection for the UK is shown in figure YXZ.



**Table 2. Forecast fertility for England (ONS) and forecast fertility figures for Oxfordshire districts based on historic relationship between England and district 2008-2011.**

Year	TFR England	Cherwell	Ox City	South Oxon	Vale of White Horse	West Oxfordshire
2008	1.96	2.21	1.59	2.16	2.29	2.29
2009	1.94	2.22	1.58	2.20	2.30	2.30
2010	1.98	2.23	1.57	2.24	2.31	2.31
2011	1.99	2.24	1.58	2.30	2.33	2.33
2012	<b>2.01</b>	<b>2.28</b>	<b>1.62</b>	<b>2.28</b>	<b>2.36</b>	<b>2.36</b>
2013	<b>2.02</b>	<b>2.28</b>	<b>1.62</b>	<b>2.28</b>	<b>2.36</b>	<b>2.36</b>
2014	<b>2.00</b>	<b>2.26</b>	<b>1.61</b>	<b>2.26</b>	<b>2.35</b>	<b>2.35</b>
2015	<b>1.98</b>	<b>2.24</b>	<b>1.59</b>	<b>2.24</b>	<b>2.32</b>	<b>2.32</b>
2016	<b>1.96</b>	<b>2.22</b>	<b>1.58</b>	<b>2.22</b>	<b>2.30</b>	<b>2.30</b>
2017	<b>1.94</b>	<b>2.19</b>	<b>1.56</b>	<b>2.19</b>	<b>2.27</b>	<b>2.27</b>
2018	<b>1.92</b>	<b>2.17</b>	<b>1.54</b>	<b>2.17</b>	<b>2.25</b>	<b>2.25</b>
2019	<b>1.91</b>	<b>2.16</b>	<b>1.53</b>	<b>2.16</b>	<b>2.24</b>	<b>2.24</b>
2020	<b>1.90</b>	<b>2.15</b>	<b>1.52</b>	<b>2.15</b>	<b>2.23</b>	<b>2.23</b>
2021	<b>1.89</b>	<b>2.14</b>	<b>1.52</b>	<b>2.13</b>	<b>2.21</b>	<b>2.21</b>
2022	<b>1.88</b>	<b>2.12</b>	<b>1.51</b>	<b>2.12</b>	<b>2.20</b>	<b>2.20</b>
2023	<b>1.87</b>	<b>2.12</b>	<b>1.50</b>	<b>2.11</b>	<b>2.19</b>	<b>2.19</b>
2024	<b>1.86</b>	<b>2.11</b>	<b>1.50</b>	<b>2.11</b>	<b>2.18</b>	<b>2.18</b>
2025	<b>1.85</b>	<b>2.10</b>	<b>1.49</b>	<b>2.10</b>	<b>2.17</b>	<b>2.17</b>
2026	<b>1.85</b>	<b>2.09</b>	<b>1.48</b>	<b>2.09</b>	<b>2.17</b>	<b>2.17</b>
2027	<b>1.84</b>	<b>2.08</b>	<b>1.48</b>	<b>2.08</b>	<b>2.16</b>	<b>2.16</b>
2028	<b>1.84</b>	<b>2.08</b>	<b>1.48</b>	<b>2.08</b>	<b>2.16</b>	<b>2.16</b>
2029	<b>1.84</b>	<b>2.08</b>	<b>1.48</b>	<b>2.08</b>	<b>2.16</b>	<b>2.16</b>
2030	<b>1.84</b>	<b>2.08</b>	<b>1.48</b>	<b>2.08</b>	<b>2.16</b>	<b>2.16</b>
2031	<b>1.84</b>	<b>2.08</b>	<b>1.48</b>	<b>2.08</b>	<b>2.16</b>	<b>2.16</b>
2032	<b>1.84</b>	<b>2.08</b>	<b>1.48</b>	<b>2.08</b>	<b>2.16</b>	<b>2.16</b>
2033	<b>1.84</b>	<b>2.08</b>	<b>1.48</b>	<b>2.08</b>	<b>2.16</b>	<b>2.16</b>
2034	<b>1.84</b>	<b>2.08</b>	<b>1.48</b>	<b>2.08</b>	<b>2.16</b>	<b>2.16</b>
2035	<b>1.84</b>	<b>2.08</b>	<b>1.48</b>	<b>2.08</b>	<b>2.16</b>	<b>2.16</b>
% of national TFR, 2008-2011	--	<b>113%</b>	<b>80%</b>	<b>113%</b>	<b>117%</b>	<b>117%</b>

\* Figures in bold indicate forecast figures, shaded figures indicate local forecasts vs. ONS national forecasts.

### 2.3. Change in age of parents

Table ABC shows that mean age at motherhood increased steadily during the second half of the twentieth century, and first decade of the twenty first.

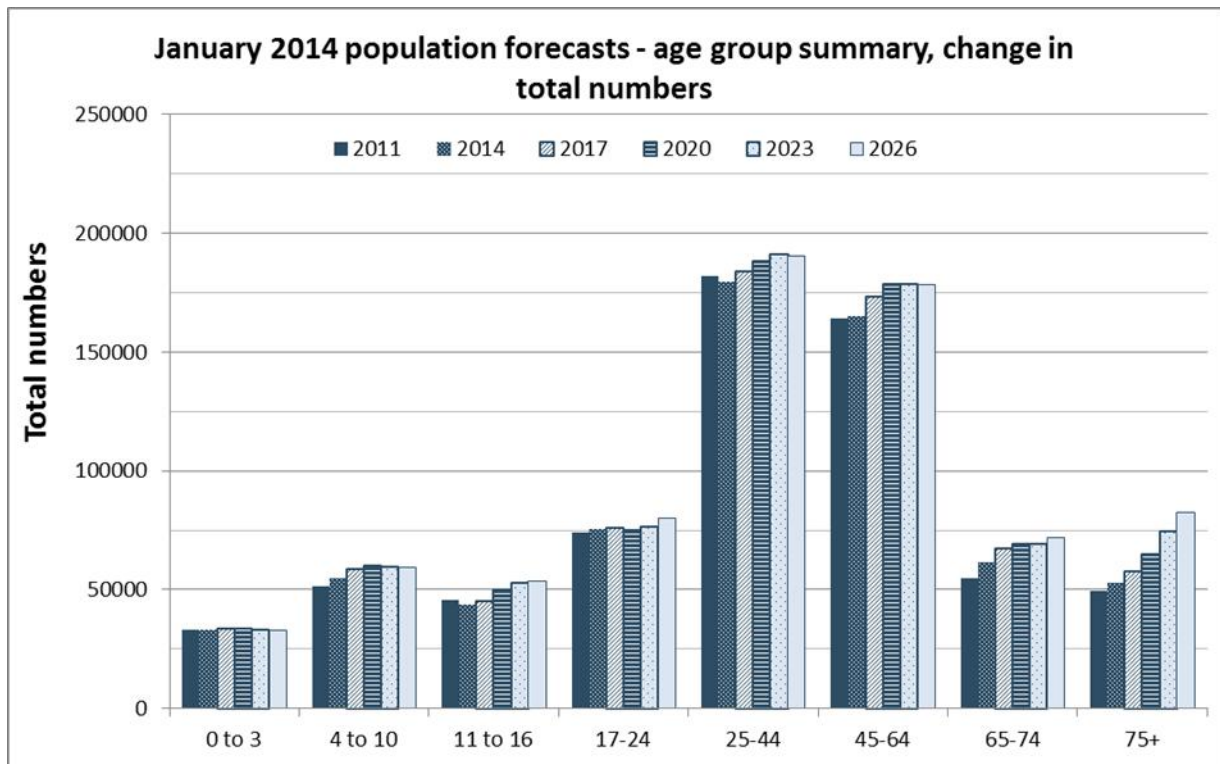
**Table 3. Mean age at motherhood.**

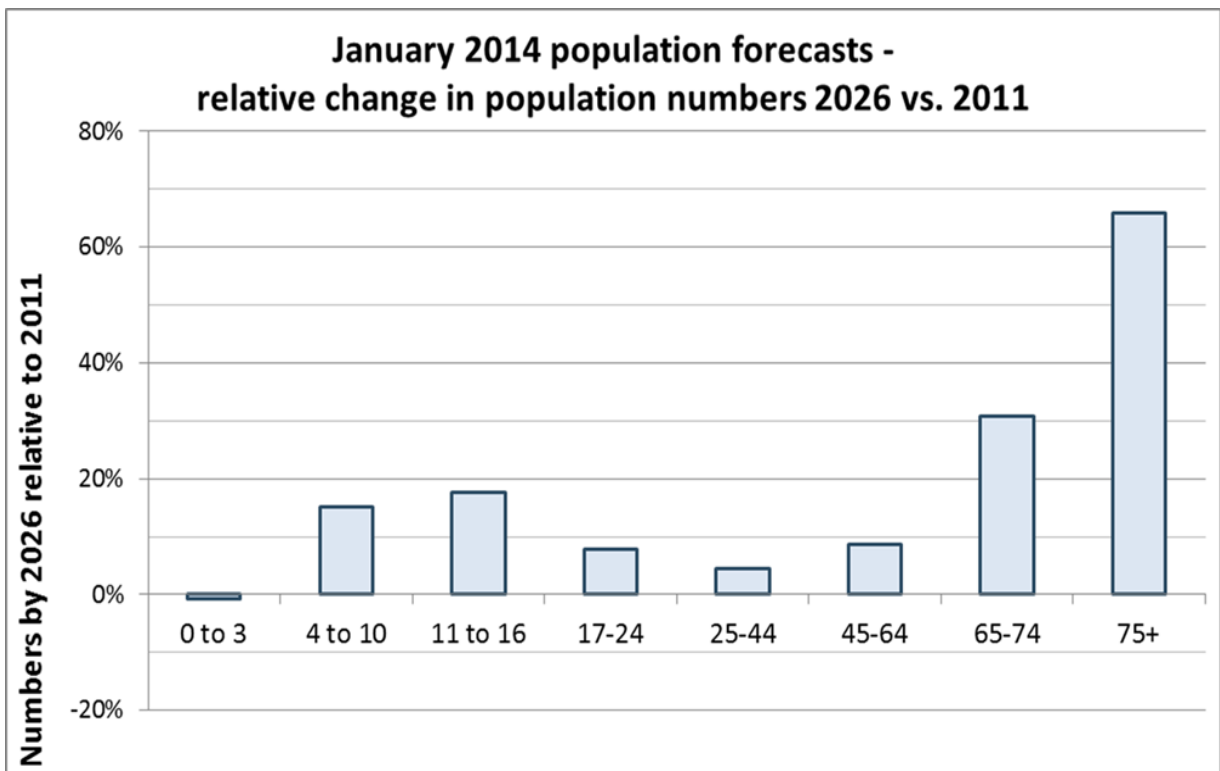
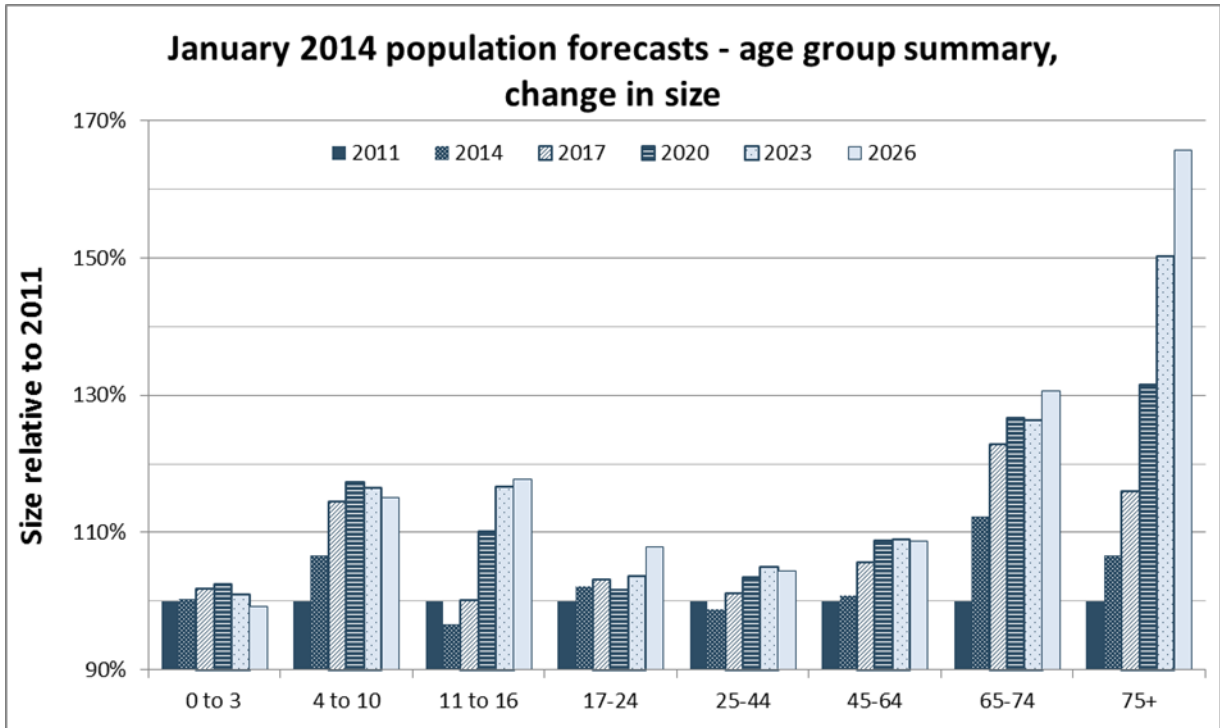
	Mean age at motherhood (years)
1950	26.4
1955	27.1
1960	27.8
1965	28.4
1970	<b>28.9</b>
1975	<b>29.4</b>
1980	<b>29.4</b>
1985	<b>29.4</b>
1990	<b>29.4</b>
1995	<b>29.6</b>
2000	<b>29.8</b>
2005	<b>29.8</b>
2010 and later	<b>29.9</b>

Table ABC. Mean age at motherhood (birth of first child) – source ONS, ONS population series PP2.

Locally we also expect to see this change in ASFRs, bounded by the projections for district TFRs derived from historic relationship to national TFRs.

#### 2.4. Forecast changes in numbers of CYPP by age





Fertility rates (the average number of children born to a woman over a whole lifetime) rose across England throughout the 2000s and early 2010s and are expected to reach a forty-year high-point in 2013. International migration into Oxfordshire was shown by the 2011 Census to have been higher than previously expected, which increased the number of women of childbearing age. These two factors have caused a recent “baby-boom”.

As the “boom” cohort ages, numbers in age groups will rise and then fall again. For the next ten to fifteen years, this means that the number of school age children will increase. For the 4-16 age group, the latest forecasts are for growth from a total of 97,000 in 2011 to 127,000 in 2026 (16% growth). Whilst the 4-10 group will peak in 2020, the 11-16 group will peak in 2026: this will occur as people born in the late 2000s and early 2010s fertility boom move through these age groups.

However, numbers of pre-school children are forecast not to change significantly over the next 15 years. This is because, while fertility rates are expected to fall over this period, the population base will continue increasing: the two effects will broadly cancel one another out.

## 2.5. Forecast changes in numbers CYPP by area (rural urban, specific wards)

Comparison of the 2011 and 2001 census data on population by ONS Urban/Rural classification showed that most population growth was in urban settlement areas, within overall growth of about 8% across Oxfordshire. There was modest growth in the number of under 14s over the same period (3%). However, the average for the county hides a large disparity between the urban and rural areas: the numbers of young people rose 42% in urban areas yet declined significantly in rural ones.

**Table 4. Forecast changes in numbers CYPP by area**

	Total population 2011 vs. 2001	0-14 years 2011 vs. 2001	65+ 2011 vs. 2001
Urban > 10k	11.0%	42.0%	12.5%
Town and Fringe	4.0%	-21.1%	24.6%
Village, Hamlet & Isolated Dwellings	2.7%	-35.7%	25.6%
Oxfordshire average	8.0%	3.0%	18.0%

Source: 2001 Census and 2011 Census tables, ONS.

Explanations for why this pattern of change occurred are twofold:

- Newly built property tends to attract people with young families or about to start them, and has typically been located on the edge of existing urban settlements (for example, Langford Village and Bure Park areas in Bicester, which saw 10-50% increases in the number of 0-14s from 2001 and 2011).
- There has been greater population turnover in Oxford City, and a consistent level of net international in-migration which brings lowers the average age of the Oxford City population, resulting in more people in the most fertile age groups, which also helps explain why the urban areas saw the largest growth in the numbers of children.

## 2.6. Country of birth and ethnicity

The 2011 Census provides the most up-to-date and detailed data currently available about the ethnic composition of Oxfordshire, and numbers of people born overseas.

There are no forecasts of country of birth, or forecasts by ethnic group. However, for country of birth, if past international migration patterns continue, similar rates of change in numbers of people born overseas will be seen in the short term as occurred 2001 to 2011. Future changes in numbers of people by ethnicity are much less easy to predict: aside from migration, estimates of birth rates for different ethnic groups in local populations would be needed, and ethnic categorisation is a less objectively measurable characteristic than country of birth.

It should be noted that whereas country of origin is a discrete, objective measure, ethnicity data is usually self-reported. This means that people may be influenced by politics, history, and other factors affecting self-identity, and may also be influenced by the choice of categories offered to them, since these are to some extent arbitrary and some change across surveys over time.

The ethnic composition of Oxfordshire, as captured from Census questions, changed significantly 2001 to 2011: all of the county's Black and minority ethnic communities grew, and now account for 9.2% of the population, just under double the 2001 figure of 4.9%.

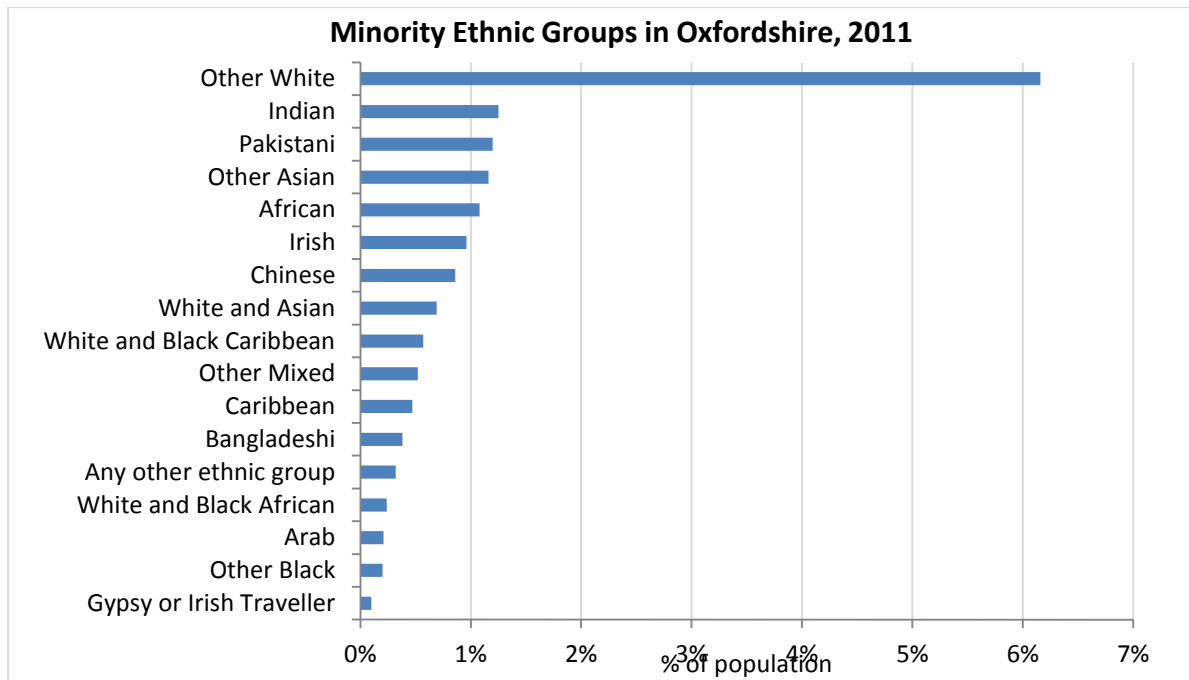
There has been a growth in people from White backgrounds other than British or Irish, who now account for 6.3% of the population (up from 4% in 2001). Much of this increase is explained by a movement of people from the countries which joined the EU in 2004 and 2007. In 2011, 13,000 residents in Oxfordshire were born in these countries, with more than half born in Poland (7,500 people, 2,700 resident in Oxford and 2,300 in Banbury).

People from White Gypsy and White Irish Traveller backgrounds make up 0.1% of the county, and this is the same proportion across all the districts aside from West Oxfordshire, where 0.2% of the population classify themselves as such.

4.8% of the population are from Asian backgrounds, twice the 2001 figure of 2.4%. People from Asian communities form the largest minority ethnic group in the county, and most come from Indian or Pakistani backgrounds (2.45%)

The proportion from all Black backgrounds has more than doubled, from 0.8% to 1.75% of the county's population.

People from mixed ethnic backgrounds account for 2% of the population (up from 1.2% in 2001).



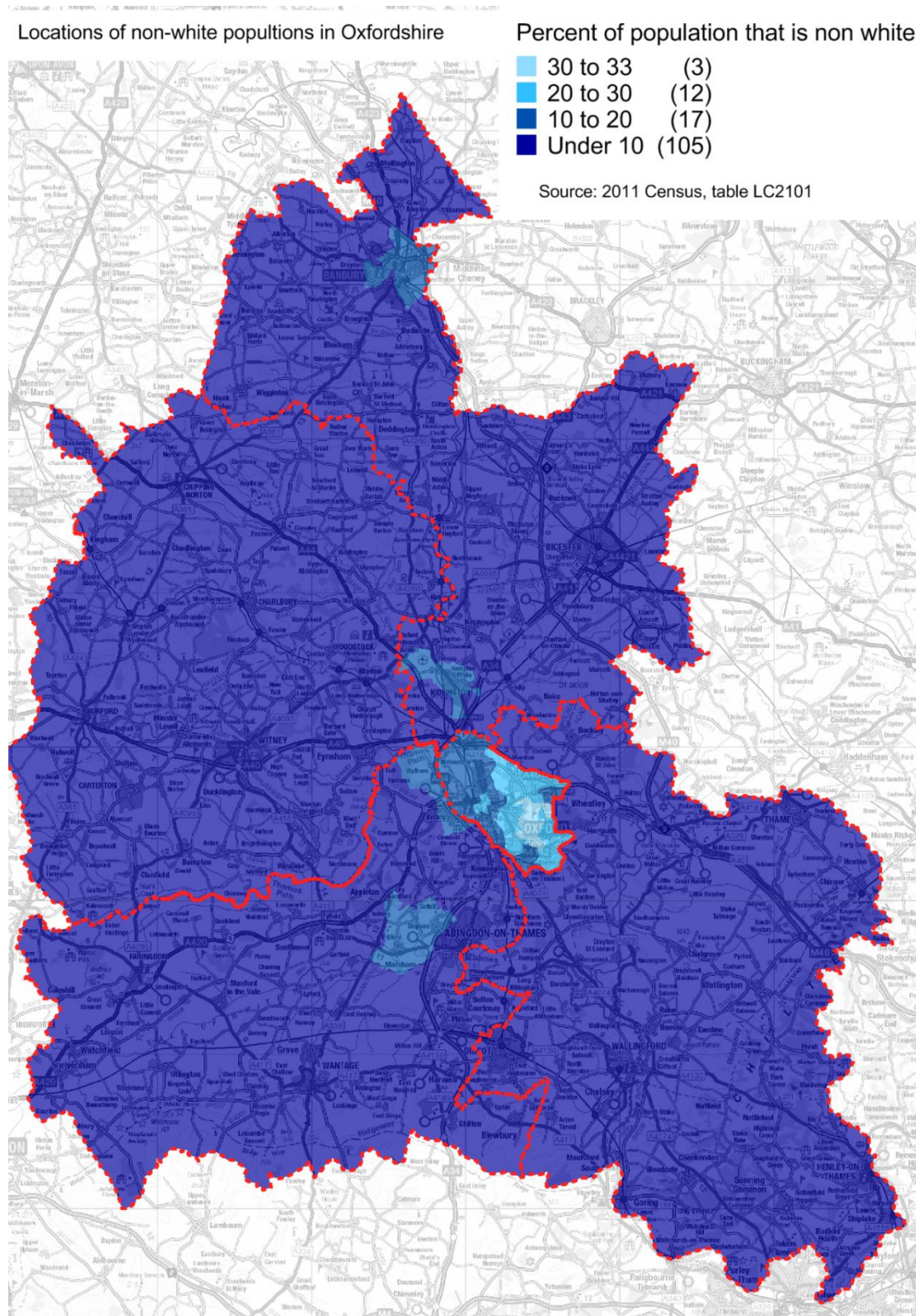
Source: ONS. Please note, to display minority groups on a chart, the category of 'White British' (83.6% of the population) is not shown.

**Table 5. Ethnic groups by district, 2011 (% of resident population)**

High level grouping	Lower level	Cherwell	Oxford	South Oxfordshire	Vale of White Horse	West Oxfordshire
<b>White</b>	English/Welsh/Scottish/Northern Irish/British	86.3	63.6	90.9	89.8	92.6
	Irish	0.8	1.6	0.8	0.8	0.7
	Gypsy or Irish Traveller	0.1	0.1	0.1	0.1	0.2
	Other White	5	12.4	4.2	4.3	3.4
<b>Mixed/multiple ethnic group</b>	White and Black Caribbean	0.6	1.1	0.4	0.3	0.3
	White and Black African	0.3	0.5	0.1	0.1	0.1
	White and Asian	0.5	1.3	0.5	0.5	0.5
	Other Mixed	0.4	1.1	0.3	0.3	0.3
<b>Asian/Asian British</b>	Indian	1.2	2.9	0.6	0.7	0.3
	Pakistani	1.7	3.2	0.1	0.3	0.1
	Bangladeshi	0.1	1.2	0.1	0.2	0.1
	Chinese	0.5	2.3	0.3	0.5	0.3
	Other Asian	0.8	2.8	0.6	0.8	0.5
<b>Black/African/Caribbean/Black British</b>	African	0.7	2.9	0.3	0.7	0.3
	Caribbean	0.4	1.2	0.2	0.2	0.1
	Other Black	0.2	0.5	0.1	0.1	0.1
<b>Other ethnic group</b>	Arab	0.1	0.6	0.1	0.1	0.1
	Any other ethnic group	0.3	0.7	0.1	0.2	0.1

Source: ONS, 2011 Census

Oxfordshire's distribution of people of non-white ethnic groupings shows that Oxford City is far more ethnically diverse than the other four districts (using proportion of people who are non-white as a proxy for ethnic diversity).



Children of non-white ethnicity follow the same pattern of distribution in the county as adults, predominantly living in Oxford City. However, whilst the highest proportion of adults of non-white ethnicity recorded in the 2011 Census was 33%, the highest proportion for children was 58%.

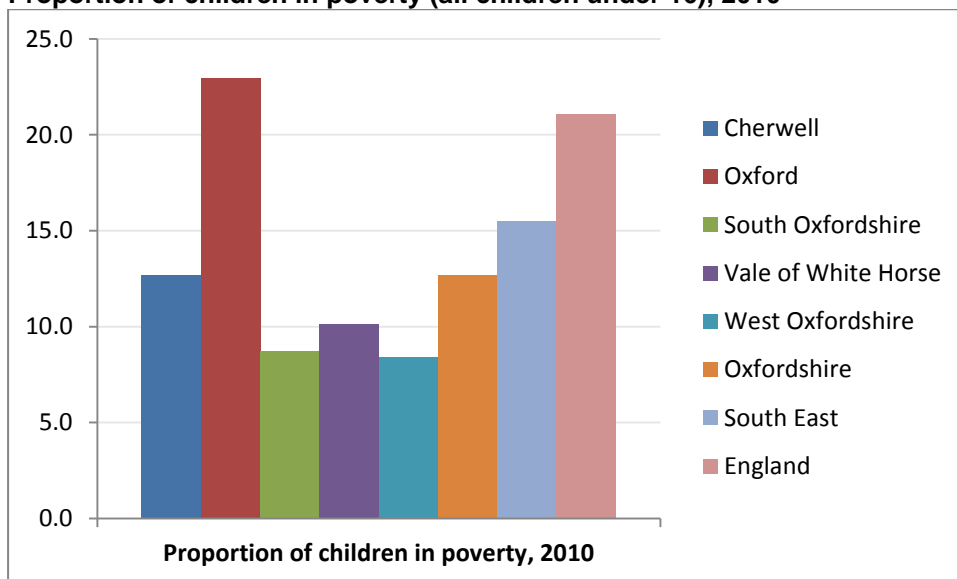
### 3. POVERTY

The Child Poverty Act requires local authorities to prepare and publish an assessment of the needs of children living in poverty in its area. The Child Poverty Needs Assessment is an opportunity to highlight what child poverty looks like in Oxfordshire, to identify who is in poverty, where they live, why they are in poverty.

Poverty is about a lack of resources. Poor people lack capital but they can also be resource-poor in other ways: they may lack human capital, such as education or good health as well as a social capital such as positive and trustful communities. Child Poverty is defined as growing up in a household with low income, and there are several indicators which can be used to measure it. Certain groups of people face a much higher risk of living in poverty than others<sup>3</sup>:

- Families with children are more likely to be poor than people without children.
- Lone parents are more likely to experience poverty than those in a couple.
- Disability is strongly connected to poverty. Parents with disabilities often face multiple barriers to work; children with disabilities place additional demands on the family.
- Households where only one adult works are at a much higher risk of poverty than average.

**Proportion of children in poverty (all children under 16), 2010<sup>4</sup>**



Source: Proportion of children in poverty, 2010, [www.apho.org](http://www.apho.org)

<sup>3</sup> Child Poverty Action Group, [www.cpag.org.uk](http://www.cpag.org.uk)

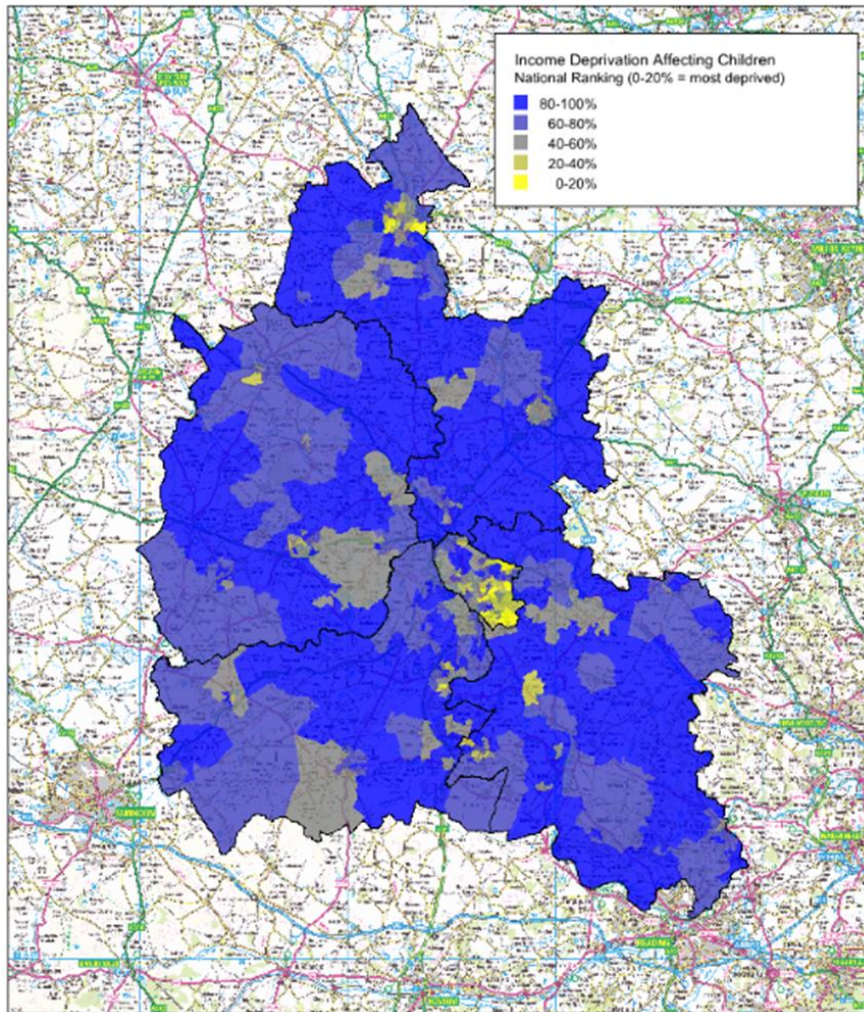
<sup>4</sup> % of children in poverty in an area as a percentage of child benefit claims



### 3.1. Income deprivation

The Income Deprivation Affecting Children Index (IDACI) is a national measure of poverty affecting children and identifies the proportion of families with children aged under 16, which are income deprived. Of the 152 local authorities with social care responsibilities in England, Oxfordshire is the 12<sup>th</sup> least deprived.

Map 1: Children in Most Income Deprived Households, 2010.



Source: The English Indices of Deprivation 2010: The Income Deprivation Affecting Children Index, <http://data.gov.uk/dataset/income-deprivation-affecting-children-index>

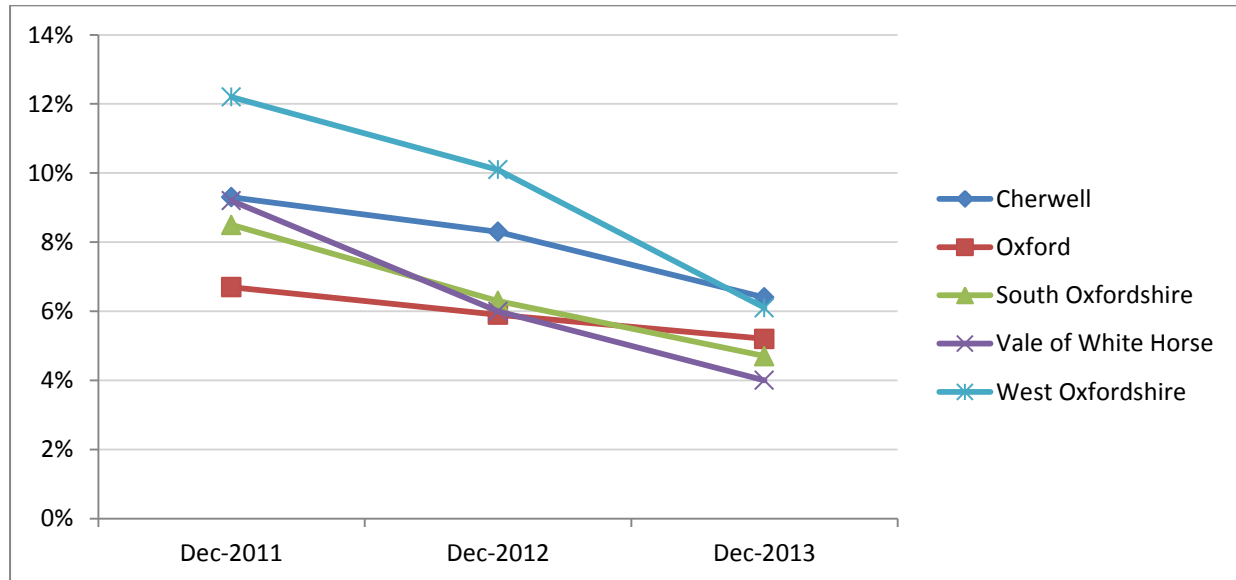
The map shows areas with a low IDACI ranking (high levels of deprivation) in yellow. The most deprived areas are predominantly, but not exclusively, in the urban centres of Oxford and Banbury.

At the more local level of lower super output areas (LSOAs) the following areas of deprivation can be identified:

- 18 LSOAs in Oxfordshire out of 404 are identified as being among the most deprived 20% nationally
- The percentages in West and South Oxfordshire and the Vale are respectively 10%, 11%, 12%.

- However it should be noted that 83 LSOAs in the county are among the least deprived 10% nationally, of which 24% are in Cherwell, 7% in Oxford City, 26% in South Oxfordshire, 21% in Vale of White Horse and 20% in West Oxfordshire.

**Claimant Count\*: Job Seekers Allowance aged 19 and under, December 2011 to December 2013**



Source: NOMIS

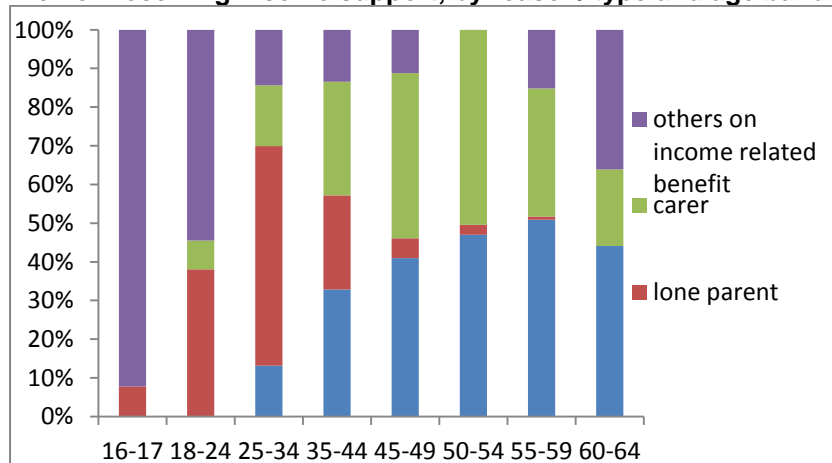
\*Claimant count figures do not yet include claimants of Universal Credit.

**Table 6.**

Claimant stock and flows by age (18-24) and duration	Cherwell	Oxford	South Oxfordshire	Vale of White Horse	West Oxfordshire
Total	-16%	-26%	-40%	-39%	-32%
13 weeks or less	-21%	-21%	-33%	-46%	-37%
over 13 and up to 26 weeks	22%	-43%	-42%	-28%	-33%

**3.2. Other benefits**

**Women receiving income support, by reason/ type and age band<sup>5</sup>**



<sup>5</sup> Source: DWP Statistics via NOMIS (August 2013 figures)

Child Tax Credit (CTC) brings together income-related support for children and for qualifying young people aged 16-19 who are in full time non-advanced education or approved training, into a single tax credit, payable to the main carer. Families can claim whether or not the adults are in-work. This measure provides a broad proxy for relative low-income child poverty as set out in the Child Poverty Act 2010 and enables analysis at a local level.

Working Tax Credit (WTC) provides in-work support for people on low incomes, with or without children. A family will normally be eligible for WTC if it contains one of the following;

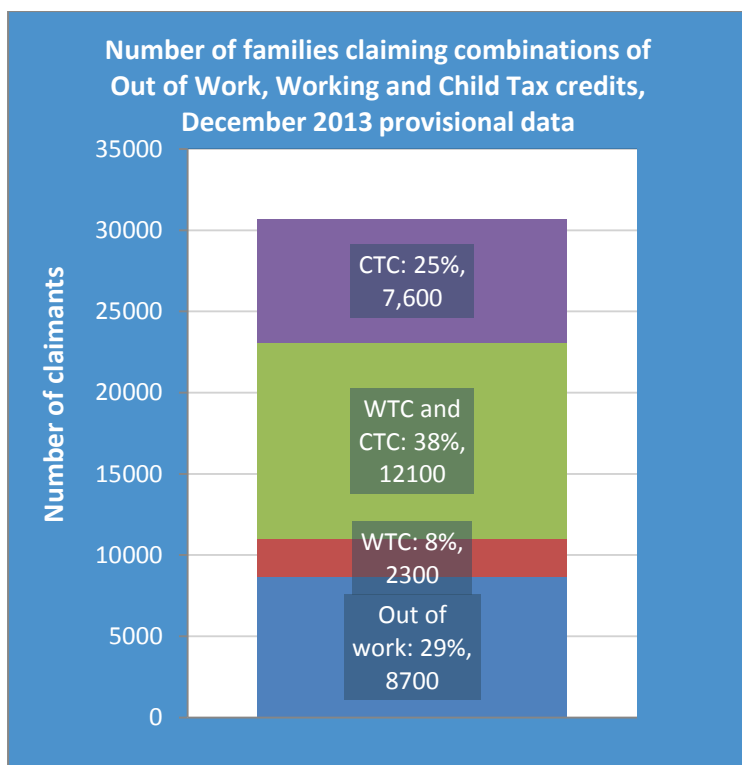
- a single person who is responsible for a child or young person and works at least 16 hours a week, or
- a couple that is responsible for a child or young person, and who jointly work 24 hours or more per week (NB. one adult must be working at least 16 hours).
- a person who is receiving or has recently received a qualifying sickness or disability related benefit and has a disability that puts them at a disadvantage of getting a job, and who works at least 16 hours per week, or
- a person is aged 60 or over and works at least 16 hours per week.

If none of the above applies, then a person will still be eligible for WTC if they are aged 25 and over and work 30 hours or more a week.

An estimated 30,700 families\* in Oxfordshire claimed one or both of Child Tax Credit and Working Tax Credit in December 2013 which is a 4.6% decrease since April 2013. (\*Families figure includes single people qualifying for Working Tax Credit)<sup>6</sup>. These results are likely to be the evidence that more families with children are moving into work and are less dependent on state support.

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<sup>6</sup> Welfare Reform Briefing Note, March 2014 Update, Research & Intelligence Team, Oxfordshire County Council



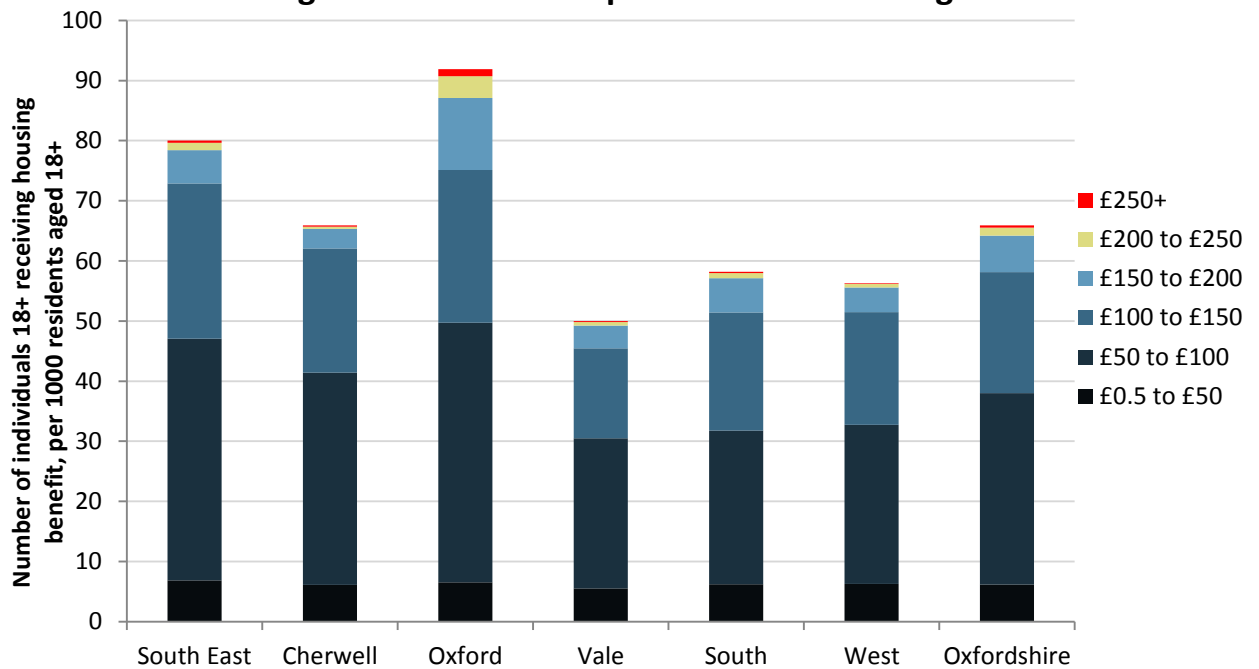
Source: HM Revenue & Customs

Except for Oxford City which is significantly worse than the England average all districts are significantly better in terms of proportion of children in poverty.

In Oxfordshire, there are 66 housing benefit claimants for every 1000 persons aged 18+, which is below the national average. However, the number of persons per 1000 population receiving payments in the top two tiers (£200 to £250, and £250+ per week) is slightly above the South East average. Oxford stands out from the rest of Oxfordshire for the total number of housing benefit claimants, with 92 claimants per 1000 residents aged 18+, and 1.13 receiving £250+ per week, figures which are both well above the South East averages of 80.0 and 0.39 respectively<sup>7</sup>.

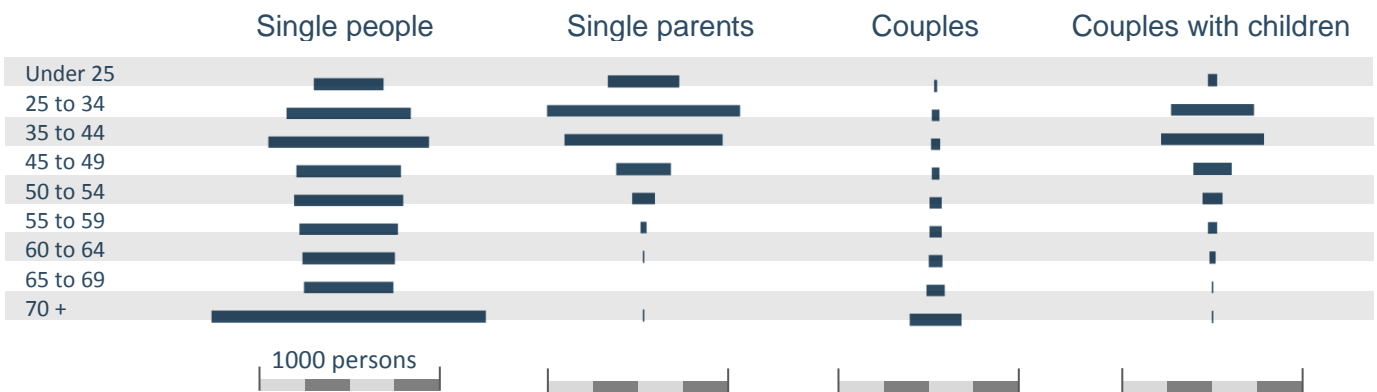
<sup>7</sup> Welfare Reform Briefing Note, March 2014 Update, Research & Intelligence Team, Oxfordshire County Council

### Housing Benefit Claimants per 1000 residents aged 18+



Source: DWP data, via Stat-Xplore website (November 2013 figures)

Most claimants of Housing Benefit are single people, followed by single parents. Within a given age band, the number of single people claiming housing benefit greatly exceeds the number of people living as a couple that claim it.



Source: DWP data, via Stat-Xplore website (November 2013 figures)

One factor in child poverty is level of debt compared to the income of household they live in. The financial Inclusion Centre has published a report on debt and household incomes. The findings are that while higher income households have more debt outstanding, lower income households' debts are much greater as a proportion of their incomes. For example, households on incomes of £13,500 or less had total debts worth 6.4 times income (as at end 2009). In comparison, households with incomes between £30,000- £50,000 had total debts worth just under two times income.

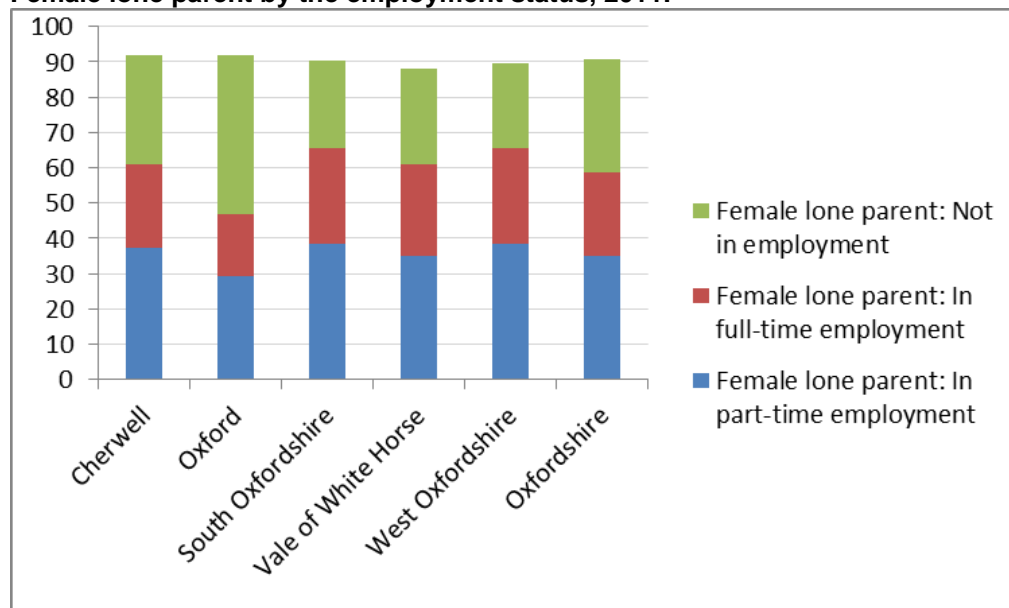
### 3.3. Risk factors for deprivation.

Some groups were at a higher risk of living in low-income households than average, these included: children in families with three or more children; children in lone-parent families rather than those in families with two adults.

There were nearly 2 million lone parents with dependent children in the UK in 2011, a figure which has grown significantly from 1.7 million in 2001.

In 2011 in Oxfordshire, women accounted for 91% of lone parents with dependent children and men accounted for 9 %. These percentages have changed little since 2001 Census. Women are more likely to take the main caring responsibilities for any children when relationships break down, and therefore become lone parents.

**Female lone parent by the employment status, 2011.**



Source: 2011 Census data via NOMIS (table QS119EW)

The 2011 Census introduced a new measure of household poverty. The dimensions of deprivation used to classify households are indicators based on the four selected household characteristics.

A household is deprived in a dimension if they meet one or more of the following conditions<sup>8</sup>:

<sup>8</sup> Source: 2011 Census data via NOMIS (table QS119EW)

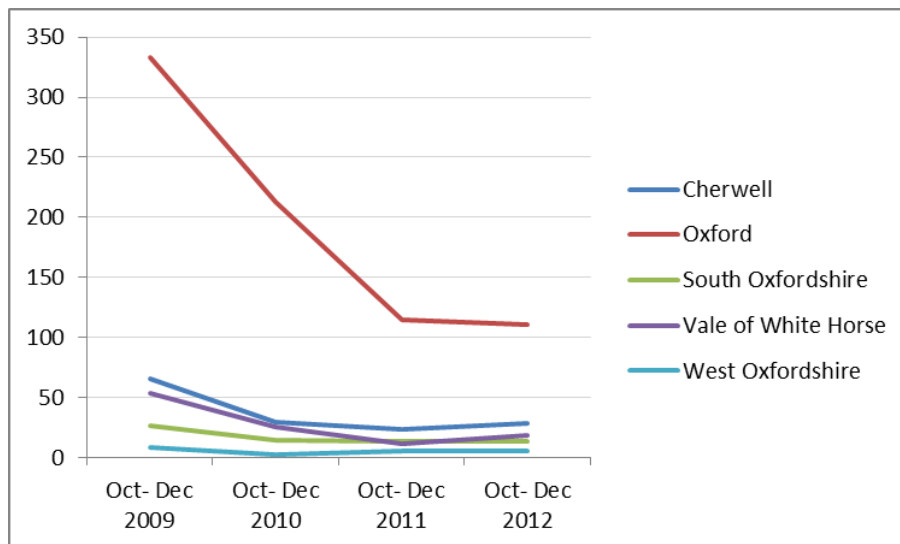
- Employment: any member of a household not a full-time student is either unemployed or long-term sick,
- Education: no person in the household has at least level 2 education (see highest level of qualification), and no person aged 16-18 is a fulltime student,
- Health and disability: any person in the household has general health 'bad or very bad' or has a long term health problem,
- Housing: Household's accommodation is ether overcrowded, with an occupancy rating -1 or less, or is in a shared dwelling, or has no central heating.
- A household is classified as being deprived in none, or one to four of these dimensions in any combination.

**Table 8. Households by the deprivation dimensions**

Household Deprivation	Cherwell	Oxford	South Oxfordshire	Vale of White Horse	West Oxfordshire
deprived in 1 dimension	32%	32%	30%	31%	31%
deprived in 2 dimensions	30%	31%	24%	23%	24%
deprived in 3 dimensions	10%	14%	7%	8%	7%
deprived in 4 dimensions	2%	3%	1%	2%	1%

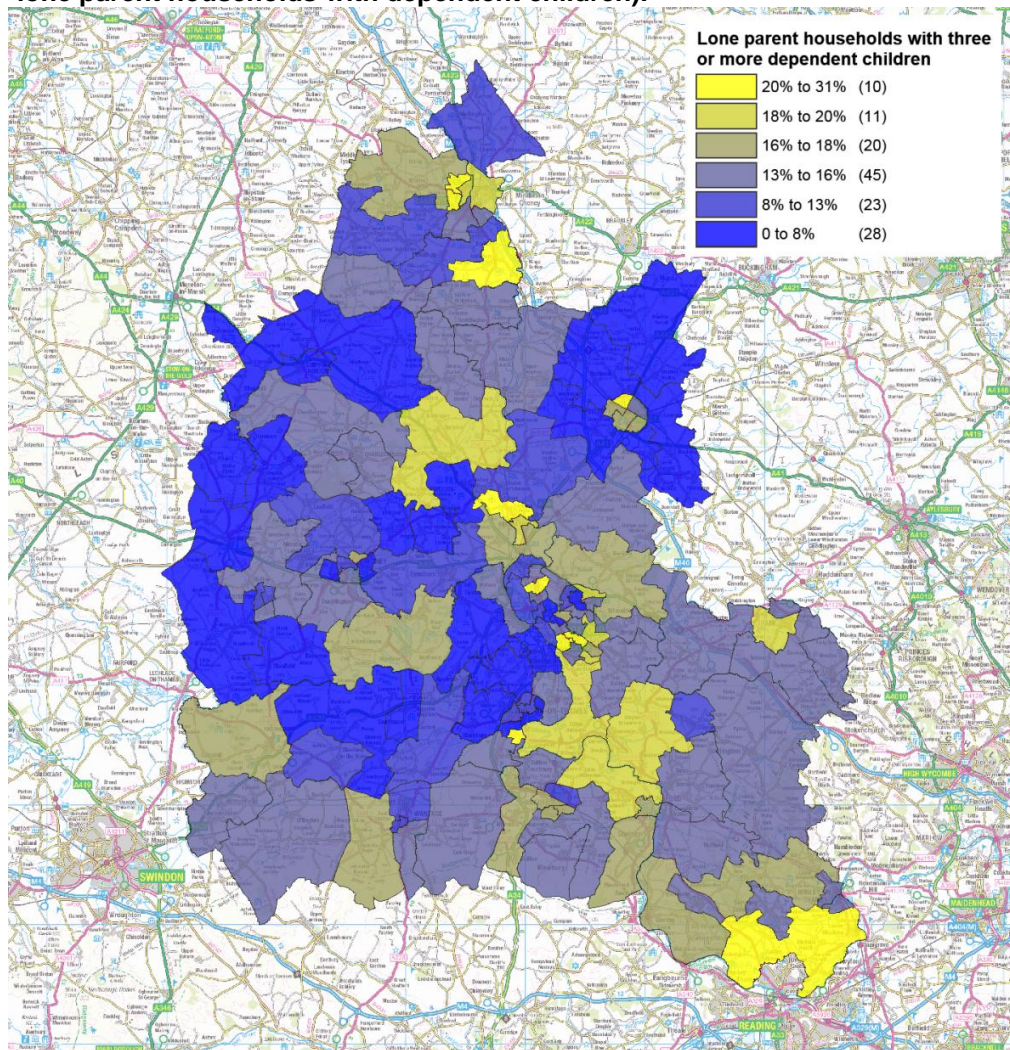
Over the last three years the number of households in temporary accommodation with dependent children and/or pregnant women saw a significant decrease in Oxford City. West Oxfordshire has the lowest amount of temporary accommodation of this type and remains stable since 2009.

**Total number of households in Temporary Accommodation of which Households with dep. Children and/or pregnant woman with no other dependants, 2009- 2012**



Source: Health and Social Care Information Center

**Lone parent households with three or more dependent children, 2011 Census (% of all lone parent households with dependent children).**



In Oxfordshire families with three or more children are between 15 and 18% of the total number of families with dependent children. The total numbers of lone parent families with three or more children for all five districts are as follows.

**Table 9. Families with three or more dependent children.**

	<b>Three or more dependent children in family</b>
Cherwell	490
Oxford	752
South Oxfordshire	356
Vale of White Horse	317
West Oxfordshire	236

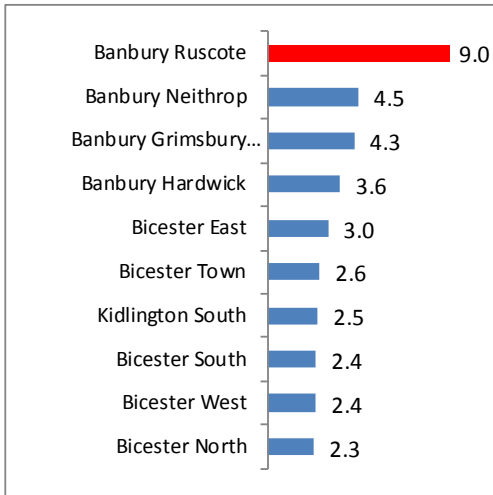
Source: ONS (Table LLC1114EW)

In terms of unemployed adults in workless household with dependent children Oxfordshire's rate is significantly lower than the national and the South East

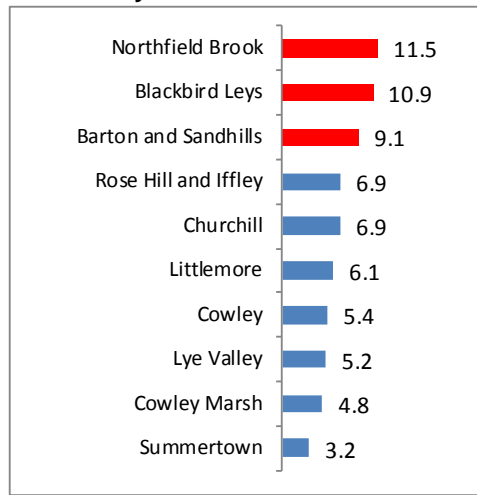


average. However there are four wards exceeding the average by three to four times.

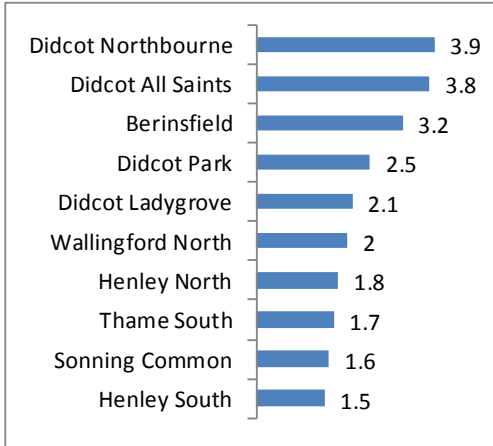
**Cherwell**



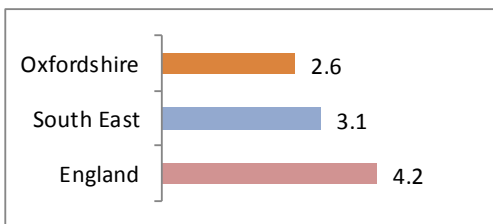
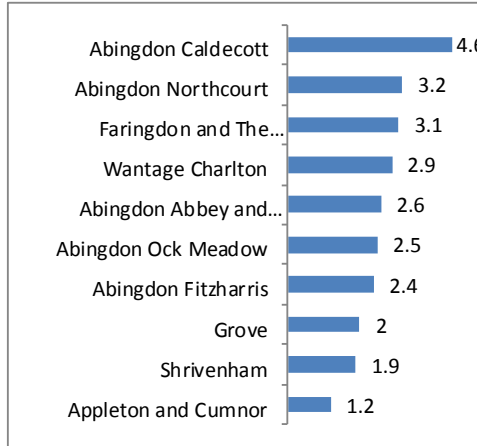
**Oxford City**



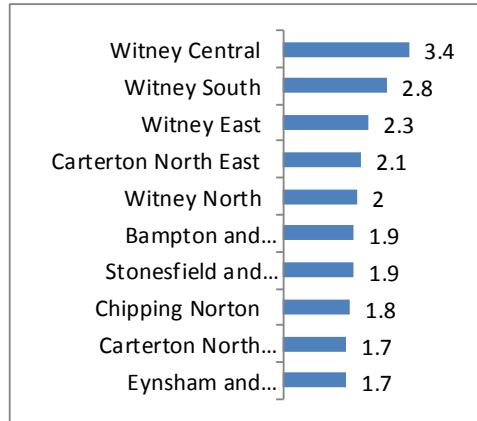
**South Oxfordshire**



**Vale of White Horse**



**West Oxfordshire**



**No adults in employment in household:  
With dependent children**  
% of all households

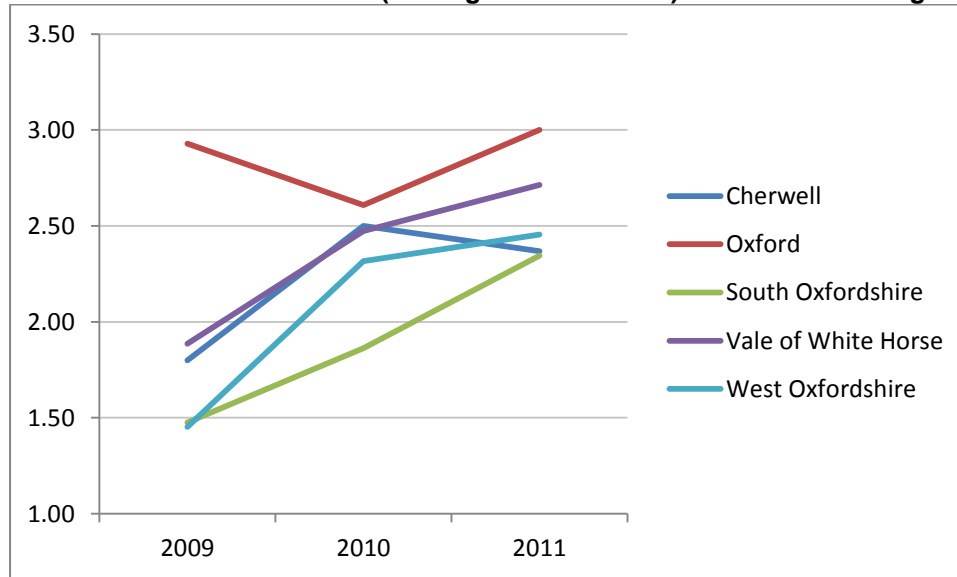
Source: NOMIS, KS106EW

## 4. PUBLIC HEALTH

### 4.1. Low birth weight

Low birth weight increases the risk of childhood mortality and of developmental problems for the child and is associated with poorer health in later life. At a population level there are inequalities in low birth weight and a high proportion of low birth weight births could indicate lifestyle issues of the mothers and/or issues with the maternity services<sup>9</sup>.

**Number of live births at term (>= 37 gestation weeks) with low birth weight (<2500g)<sup>10</sup>**



Source: Public Health England, [fingertips.phe.org.uk](http://fingertips.phe.org.uk)

In 2011, 2.6% of all births in Oxfordshire were classified as low birth weight<sup>11</sup> compared to 2.3% for South East and 2.8% for England as a whole England as a whole.

### 4.2. Infant mortality

Recent infant mortality rates (Infant deaths under 1 year of age per 1000 live births) in Oxfordshire are not significantly different from the England wide or South East averages, when looking at crude rates 2009-2011.

<sup>9</sup> Source: Public Health England

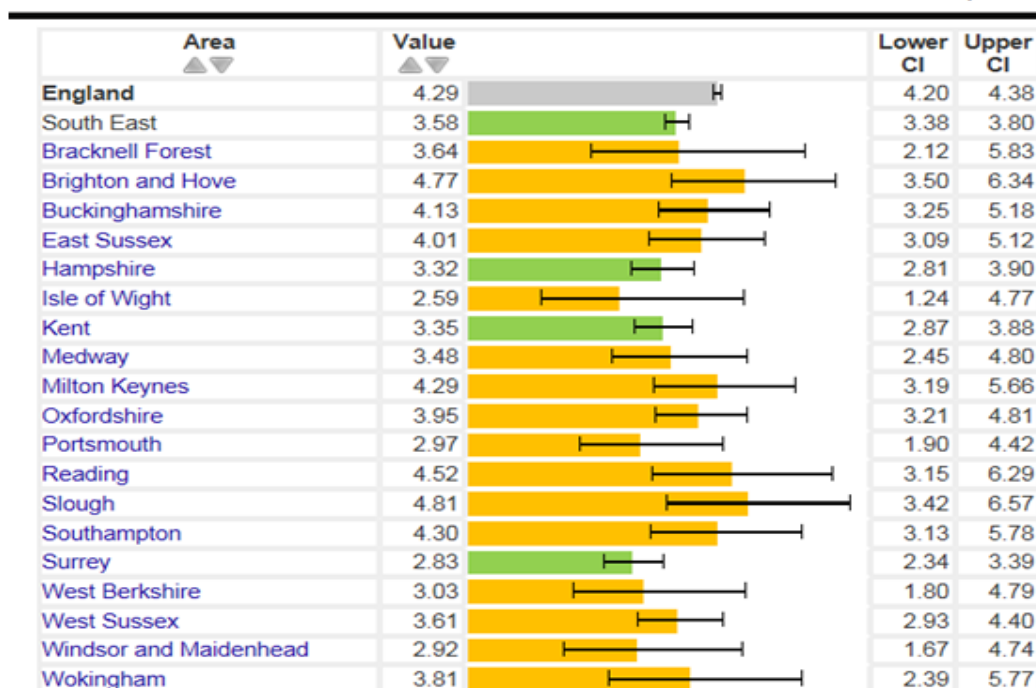
<sup>10</sup> Low birth weight full term live births as a percentage of all full term live births. Births without a recorded birth weight are excluded.

<sup>11</sup> Live births with a recorded birth weight under 2500g and a gestational age of at least 37 complete weeks as a percentage of all live births with recorded birth weight and a gestational age of at least 37 complete weeks.

## Infant Mortality, 2009- 2011

Compared with benchmark: Better Similar Worse Lower Similar Higher Not compared

Crude rate - per 1000



Source: Public Health England website, Children and Young People's Health Benchmarking Tool

With a mortality rate of about a third of one percent (or 4 per thousand live births) in recent years, small changes year-on-year can have large relatively changes in the very small rate: this makes it impossible to reliably determine any recent local trends in infant mortality rates specific to the Oxfordshire area or sub-areas.

**Table 10. Infant mortality rates.**

	Deaths at age <1	Live births	Infant mortality rate (deaths age <1 / live births)
2007	25	8148	0.31%
2008	29	8307	0.35%
2009	25	8134	0.31%
2010	34	8439	0.40%
2011	31	8502	0.36%

### 4.3. Maternal mental health

Maternal Postnatal Depression (PND) is a major public health issue: it affects around 13% of mothers<sup>12</sup>, and compared to children of non-depressed mothers, the children of mothers with PND are more likely to have learning, behavioural and attachment problems.

<sup>12</sup> *Oxford Postnatal Treatment Study: treatment for mothers with postnatal depression to improve child outcome*, Department of Psychiatry, Warneford Hospital, Oxford, 2010.

There is a strong link between teenage pregnancy and PND occurrence. Teenage pregnancy is currently at its lowest level over three decades. However, England still has the highest rate of teenage pregnancy in Western Europe.

The most common problems associated with teenage pregnancy are<sup>13</sup>:

- teenage mothers are three times more likely to develop PND than older mothers
- they are at a higher risk of poor mental health for three years after the birth
- three times more likely to smoke during pregnancy than mothers over 35
- one third less likely to breastfeed
- likely to struggle to complete their education and find it difficult to gain employment

Teenage pregnancy is a cause and consequence of child poverty:

- children of teenage mothers have a 63% increased risk of being born into poverty
- half of all under 18 conceptions occur in the 20% deprived wards
- over one third of teenage mothers have no qualifications and 70% are not in education, training or employment
- teenage mothers, young fathers and their children are more likely to be in poor health and to live in poor housing.

#### **4.4. Physical activity**

In Oxfordshire in 2013 about 90% of children aged 5-16 in Oxfordshire spend at least 2 hours a week doing sport or physical activity at school. This is in line with the national figures<sup>14</sup>:

88% of children and young people aged 4 to 19 years play outside at home, and 87% do sports related activity out of school / college. This compares with much lower percentages among children and young people in temporary accommodation: of these only 53% play out, and 69% who do sports related activities out-of-school).

#### **4.4. Breastfeeding**

Breast milk provides the ideal nutrition for infants in the first stages of life. There is evidence that babies who are breast fed experience lower levels of gastro-intestinal and respiratory infection. Observational studies have shown that breastfeeding is associated with lower levels of child obesity. Benefits to the mother include a faster return to pre-pregnancy weight and possibly lower risk of breast and ovarian cancer<sup>15</sup>.

Increases in breastfeeding are expected to reduce illness in young children, have health benefits for the infant and the mother and result in cost savings to the NHS

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<sup>13</sup> *Teenage Pregnancy: The Evidence*, Teenage Pregnancy Associates, London, July 2011.

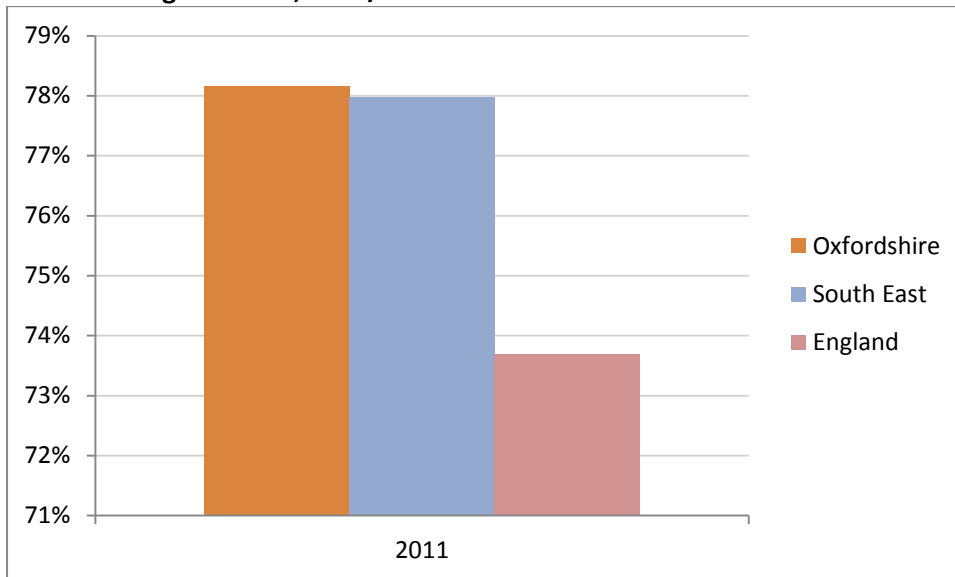
<sup>14</sup> Source: *Oxfordshire NHS Risky Behaviours Needs analysis*, 2011, [chimat.org.uk](http://chimat.org.uk).

<sup>15</sup> Source: Public Health England, BMA Board of Science, 2009

<http://www.derbyshirelmc.org.uk/Guidance/Early%20Life%20Nutrition%20and%20Lifelong%20Health.pdf>

through reduced hospital admission for the treatment of infection in infants<sup>16</sup>. Current national and international guidance recommends exclusive breastfeeding for newborns and for the first six months of infancy<sup>17</sup>.

**Breastfeeding initiation, 2011/12\***

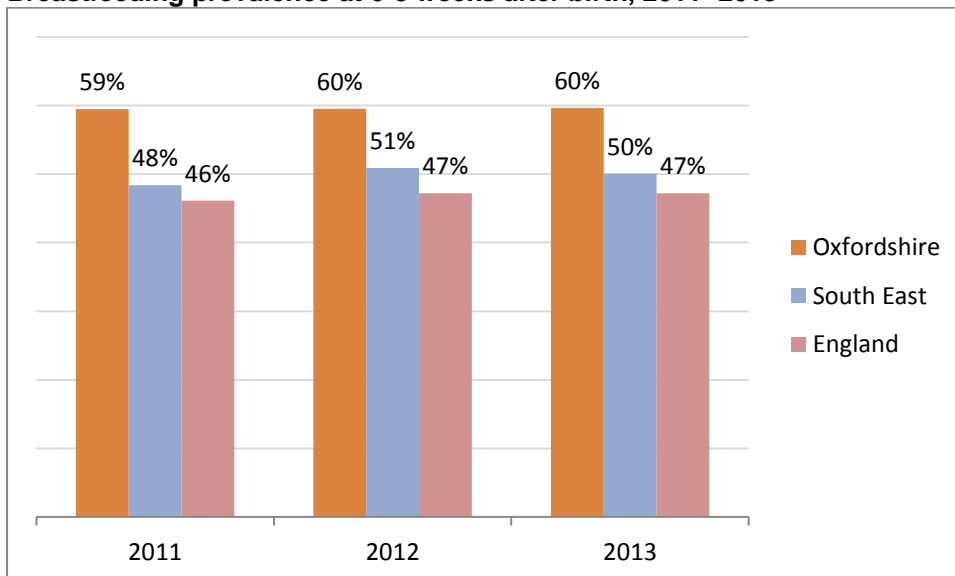


Source: Public Health England, [www.fingertips.phe.org.uk](http://www.fingertips.phe.org.uk)

\*Measures the proportion of mothers who give their babies breast milk in the first 48 hours after delivery. (The number of mothers initiating breast feeding divided by the total number of maternities). 2012/13 value for Oxfordshire not published for data quality reasons.

The County's breastfeeding initiation rate is 78.1%, compared with a national figure of 73.6%. For breastfeeding at 6-8 weeks the Oxfordshire rate is 59.6% and is again higher than the national rate of 47.2%.

**Breastfeeding prevalence at 6-8 weeks after birth, 2011- 2013**



Source: Public Health England, [www.fingertips.phe.org.uk](http://www.fingertips.phe.org.uk)

<sup>16</sup> <http://pediatrics.aappublications.org/content/119/4/e837.long>

<sup>17</sup> [http://www.who.int/nutrition/topics/infantfeeding\\_recommendation/en/index.html](http://www.who.int/nutrition/topics/infantfeeding_recommendation/en/index.html)

## 4.5. Immunisation

Vaccination coverage is the best indicator of the level of protection a population will have against vaccine preventable communicable diseases. Coverage is closely correlated with levels of disease. Monitoring coverage identifies possible drops in immunity before levels of disease rise.

Since April 2000 it has been recommended that all pregnant women in England and Wales should be offered testing for hepatitis B through screening for HBsAg, and that all babies of HBsAg seropositive women should be immunised. A dose of paediatric hepatitis B vaccine is recommended for all infants born to an HBV infected mother as soon as possible after birth, then at 1 and 2, and 12 months of age.

All children at age 12 months who have received the complete course (4 doses) of hepatitis B vaccine within each reporting area as a percentage of all the eligible population as defined in the hepatitis B chapter of the immunisation against infectious diseases "Green Book" (have maternal Hep B positive status).

In 2012-2013 the percentage of children in Oxfordshire immunised by their first birthday was as follows:

- 96.9% were immunised for diphtheria, tetanus, polio, pertussis (whooping cough) and Haemophilus influenzae type b (DTaP/IPV/Hib). Significantly better compared with 94.4% South East and 94.7% of England as a whole.
- 93.9% were immunised for meningitis C (MenC).
- 94.4% were immunised for pneumococcal disease (PCV)
- 99.8% were immunised for Hepatitis B
- 93.9% were immunised for meningitis C (MenC).
- 94.4% were immunised for pneumococcal disease (PCV)

The percentage of children in Oxfordshire immunised by their second birthday was as follows:

- 97.5% were immunised for diphtheria, tetanus, polio, pertussis (whooping cough) and Haemophilus influenzae type b (DTaP/IPV/Hib).
- 95.1% were immunised for measles, mumps, and rubella (MMR).
- 95.2% were immunised for diphtheria, tetanus, polio, pertussis and Hib.
- 95.2% were immunised for Hib/ MenC booster.
- 99.4% were immunised for Hepatitis B

The percentage of children in Oxfordshire immunised by their fifth birthday was as follows:

- 95 % were immunised for Hib/ MenC booster.
- 95.1% were immunised for MMR for one dose and 93.1% for two doses.

The HPV vaccine protects against the two high-risk HPV types – 16 and 18 – that cause over 70% of cervical cancers.

In Oxfordshire 91.2% of all girls aged 12 to 13 years have received all three doses of the HPV vaccine within each reporting area as a percentage of all girls aged 12 to 13 years within each area<sup>18</sup>.

#### 4.6. Obesity

The UK is experiencing an epidemic of obesity affecting both adults and children. Among boys and girls aged 2 to 15, the proportion of children who were classified as obese increased from 11.7 per cent in 1995 to 16.0 per cent in 2010, peaking at 18.9 per cent in 2004<sup>19</sup>.

The health consequences of childhood obesity include: increased blood lipids, glucose intolerance, Type 2 diabetes, hypertension, increases in liver enzymes associated with fatty liver, exacerbation of conditions such as asthma and psychological problems such as social isolation, low self-esteem, teasing and bullying.

There is concern about the rise of childhood obesity and the implications of such obesity persisting into adulthood. The risk of obesity in adulthood and risk of future obesity-related ill health are greater as children get older. Studies tracking child obesity into adulthood have found that the probability of overweight and obese children becoming overweight or obese adults increases with age 1, 2, and 3.

**Excess weight in 4-5 year olds<sup>20</sup>**



Source: Public Health England, [www.fingertips.phe.org.uk](http://www.fingertips.phe.org.uk)

The percentages of children overweight or obese are lower in Oxfordshire than overall in England or the South East, but there are still a significant number of children in Oxfordshire who are obese. Oxford City is slightly above the South East

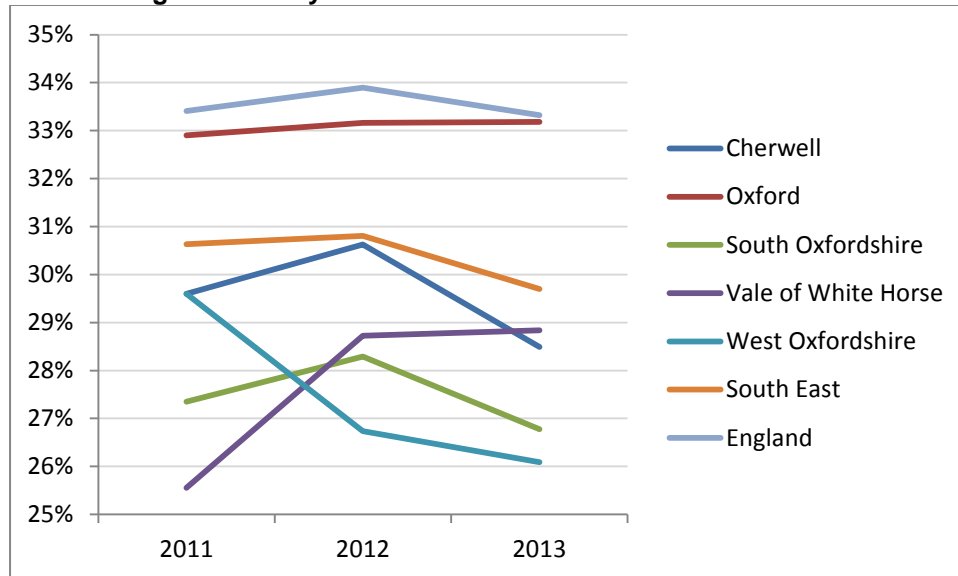
<sup>18</sup> Source: Public Health England, [www.fingertips.phe.org.uk](http://www.fingertips.phe.org.uk)

<sup>19</sup> Health Survey for England (HSE), 2010.

<sup>20</sup> Proportion of children aged 4-5 classified as overweight or obese. Children are classified as overweight (including obese) if their BMI is on or above the 85th centile of the British 1990 growth reference (UK90) according to age and sex.

average and remained stable in past three years. There is a slight growth in numbers of obese children in Vale of White Horse in 4-5 year olds which continues in those aged 10-11.

**Excess weight in 10-11 year olds 2011- 2013**

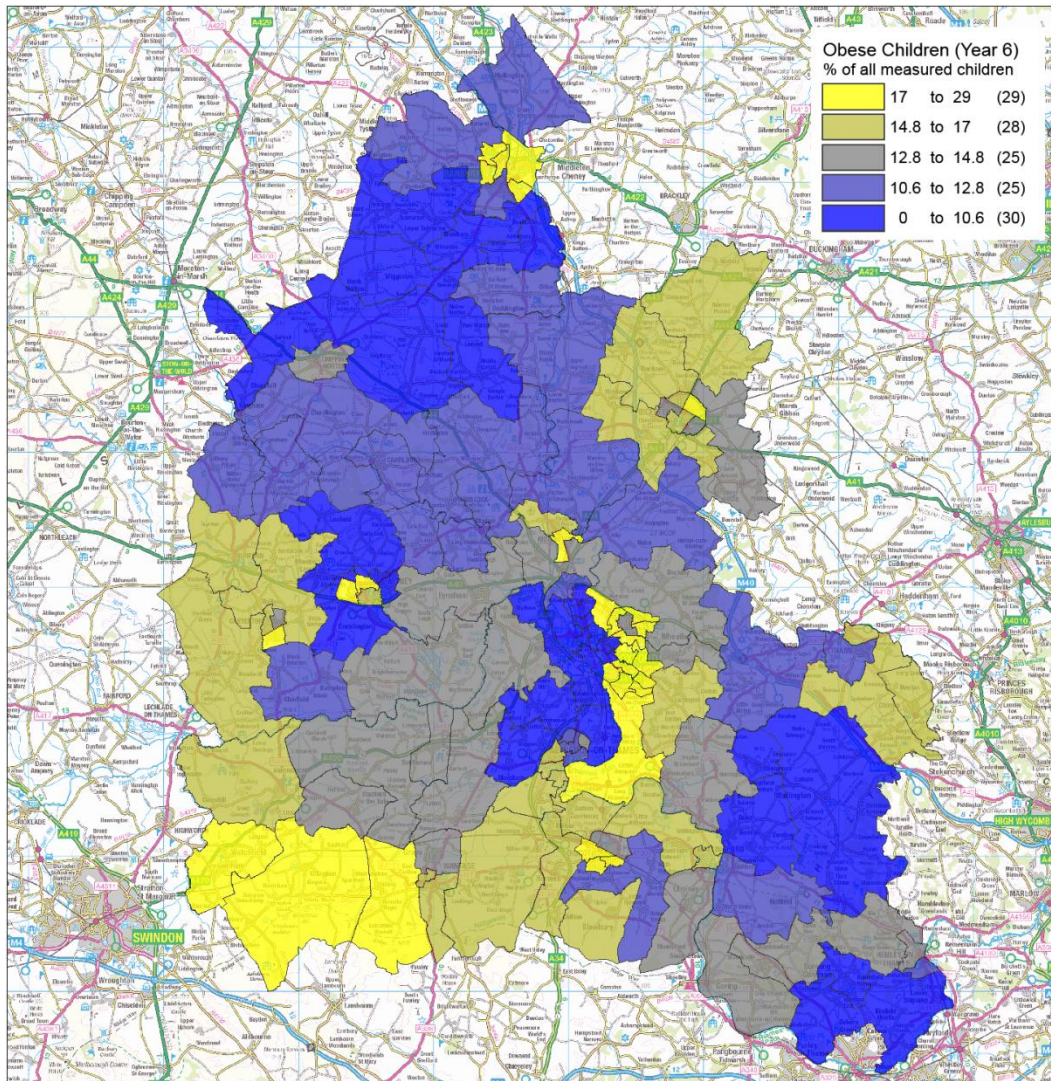


Source: Public Health England, [www.fingertips.phe.org](http://www.fingertips.phe.org).

**% of measured children in Year 6 who were classified as obese, 2009/10-2011/12<sup>21</sup>**

<sup>21</sup>Proportion of children in Year 6 classified as overweight or obese in the academic year. Children are classified as overweight (including obese) if their BMI is on or above the 85th centile of the British 1990 growth reference (UK90) according to age and sex.





Source: Public Health England, Local Health, [www.apho.org.uk](http://www.apho.org.uk)

The strong relationship between deprivation and childhood obesity, and the higher prevalence among some ethnic groups, indicate areas where efforts need to be particularly concentrated.

According to the National Obesity Observatory here are growing indications that the previous upwards trend in child obesity may now be flattening out. However it is still too early to be certain that this represents a long-term change in the trend. Future HSE data will confirm whether this is a persistent pattern, or just a short-term blip in a long-term upwards trend<sup>22</sup>.

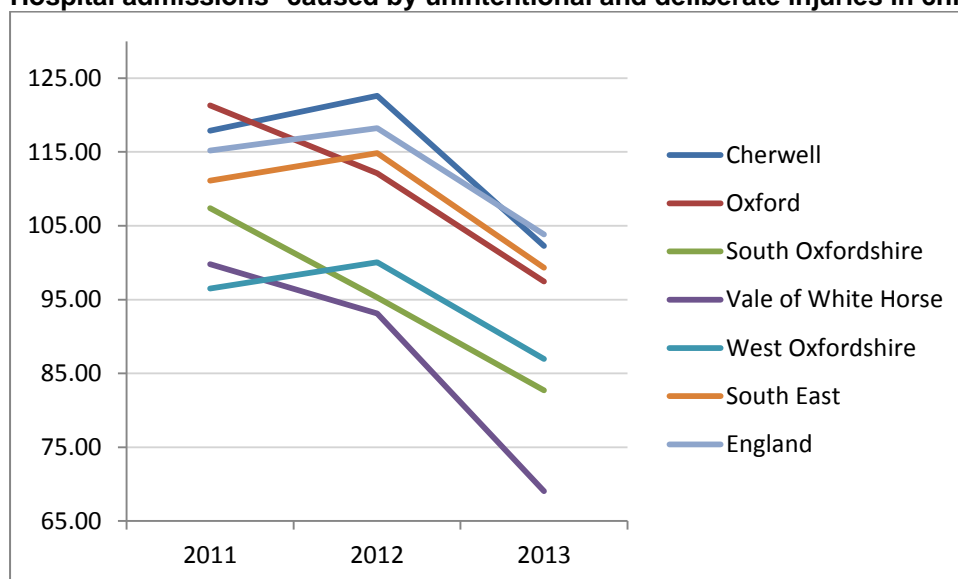
#### 4.7. Hospital admissions

Injuries are a leading cause of hospitalisation and represent a major cause of premature mortality for children and young people. They are also a source of long-term health issues, including mental health related to these experience(s)<sup>23</sup>.

<sup>22</sup> National Obesity Observatory, [www.noo.co.uk](http://www.noo.co.uk), February 2013

<sup>23</sup> Public Health England

**Hospital admissions\* caused by unintentional and deliberate injuries in children (aged 0- 14)**

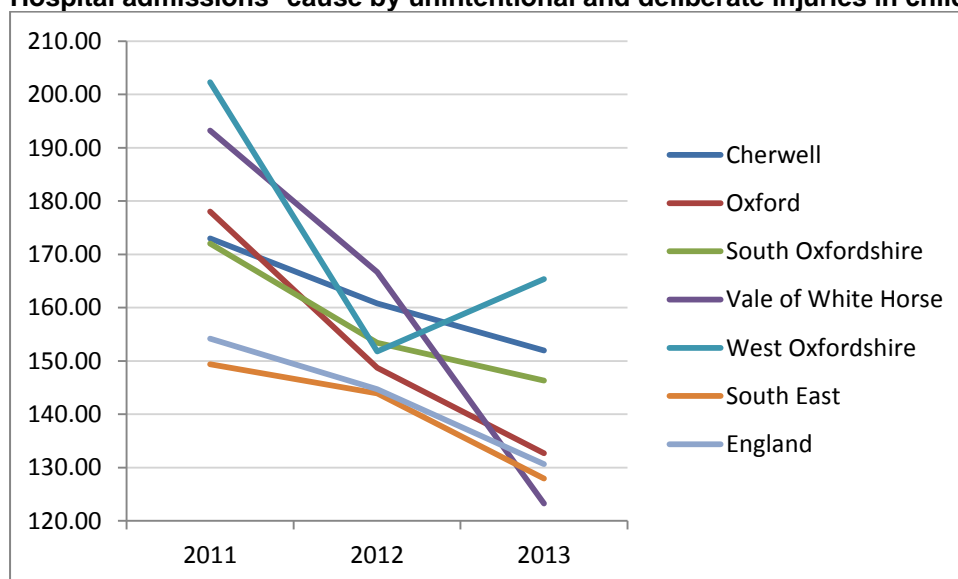


Source: Public Health England, [www.fingertips.phe.org.uk](http://www.fingertips.phe.org.uk)

\*Crude rate per 10 000 population.

The rate for hospital admissions in Oxfordshire due to self-harm has averaged around 12 per 10,000 young people in recent years, but has fallen in 2012/13 to just over 9 per 10,000. There were 165 such admissions in 2011/12.

**Hospital admissions\* cause by unintentional and deliberate injuries in children (aged 15-24)**

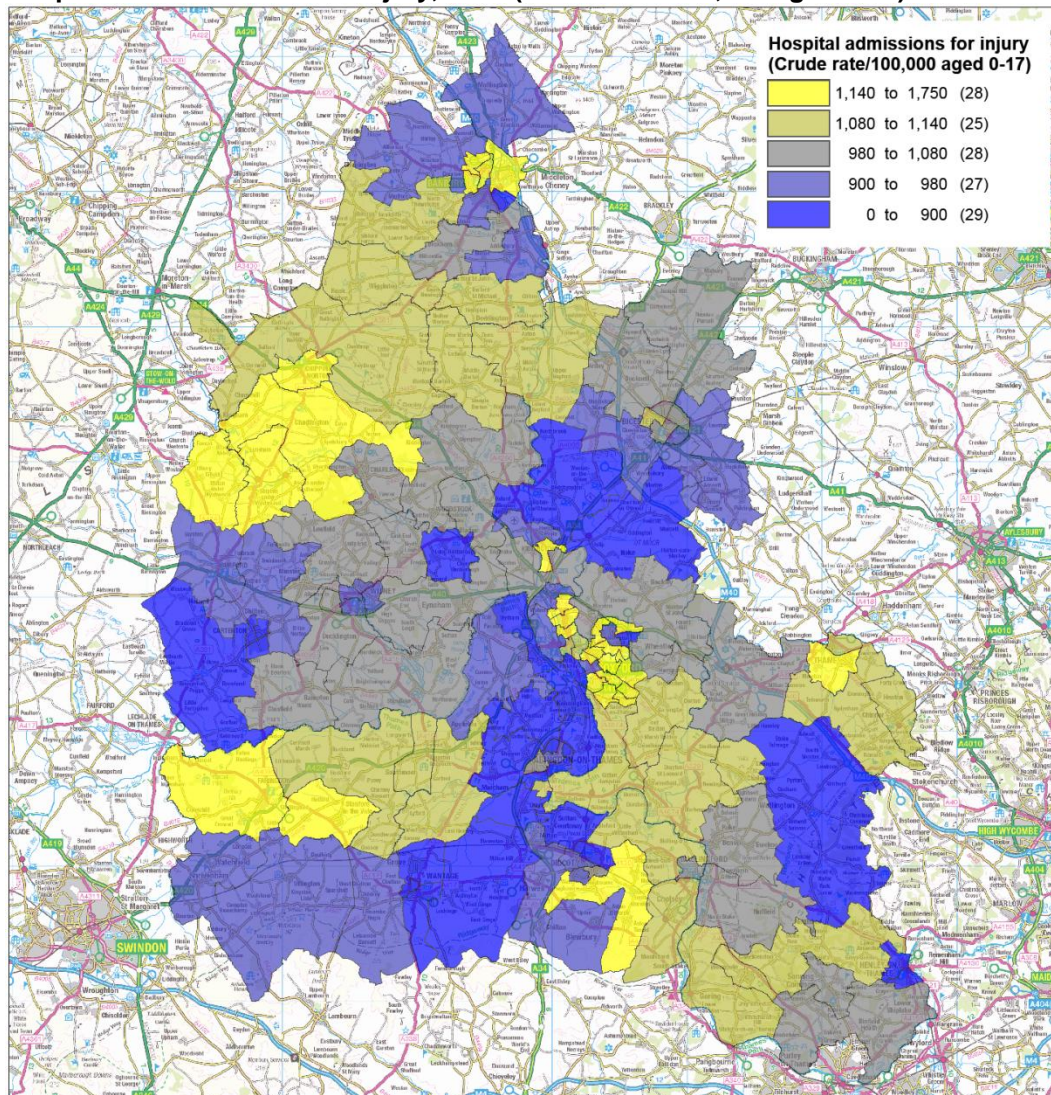


Source: Public Health England, [www.fingertips.phe.org.uk](http://www.fingertips.phe.org.uk)

\*Crude rate per 10 000 population.

Hospital admissions due to injury, 2011

## Hospital admissions due to injury, 2011 (Crude rate/ 100,000 aged 0-17)



Source: Public Health England, [www.apho.org.uk](http://www.apho.org.uk)

According to Socioeconomic variation in injury in children and older people *for all admissions, and admissions related to self-harm, assaults, falls, pedestrian injuries, poisoning and burns, there are socioeconomic gradients with higher rates in more deprived communities for all younger age groups (...) this should be considered when developing area-based preventative interventions or monitoring the effectiveness of policies to reduce inequalities or injury occurrence*<sup>24</sup>.

Between 2000 and 2009, researchers found that hospital admission rates in 5-19 year olds for total obesity-related diagnoses increased more than fourfold from 93 to 414 per million in the United Kingdom. Obesity was a secondary diagnosis contributing to the condition for which children and young people were admitted.

In Oxfordshire there was a significant increase in unplanned hospitalisation for asthma, diabetes and epilepsy with levels above the England average. Other districts noted a significant decrease and remain below the average.

<sup>24</sup>Lyons R A, Jones S J, Deacon T, Heaven M, *Socioeconomic variation in injury in children and older people: a population based study*, Injury Prevention 2003; 9: 33-37 from <http://www.ncbi.nlm.nih.gov/>

According to the World Health Organisation Childhood asthma accounts for *many lost school days and may deprive the affected children of both academic achievement and social interaction, in particular in underserved populations and minorities. The economic cost of asthma is considerable both in terms of direct medical costs (such as hospital admissions and the cost of pharmaceuticals) and indirect medical costs (such as time lost from work and premature death)*<sup>25</sup>.

**Table 11. Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s<sup>26</sup>**

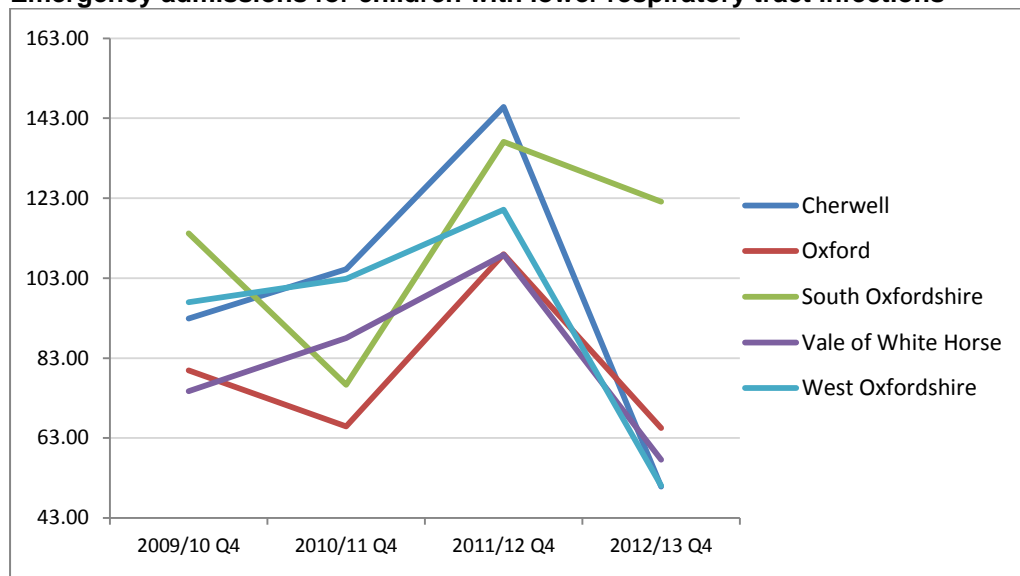
	2011/12 Q4	2012/13 Q4
<b>Cherwell</b>	53.10	79.30
<b>Oxford</b>	65.50	38.20
<b>South Oxfordshire</b>	35.90	-
<b>Vale of White Horse</b>	58.20	36.10
<b>West Oxfordshire</b>	47.50	42.40
<b>South East</b>	-	-
<b>England</b>	-	77.00

Source: Source: Public Health England, [www.fingertips.phe.org.uk](http://www.fingertips.phe.org.uk)

- Figures are nil or negligible

The number of emergency admissions for children with lower respiratory tract infections declined in the fourth quarter of the 2012/13 financial year and is significantly better than the England average of 89.6.

#### Emergency admissions for children with lower respiratory tract infections



Source: Public Health England, [www.fingertips.phe.org.uk](http://www.fingertips.phe.org.uk)

<sup>25</sup> Chronic Respiratory Diseases, World Health Organisation, [www.who.int](http://www.who.int)

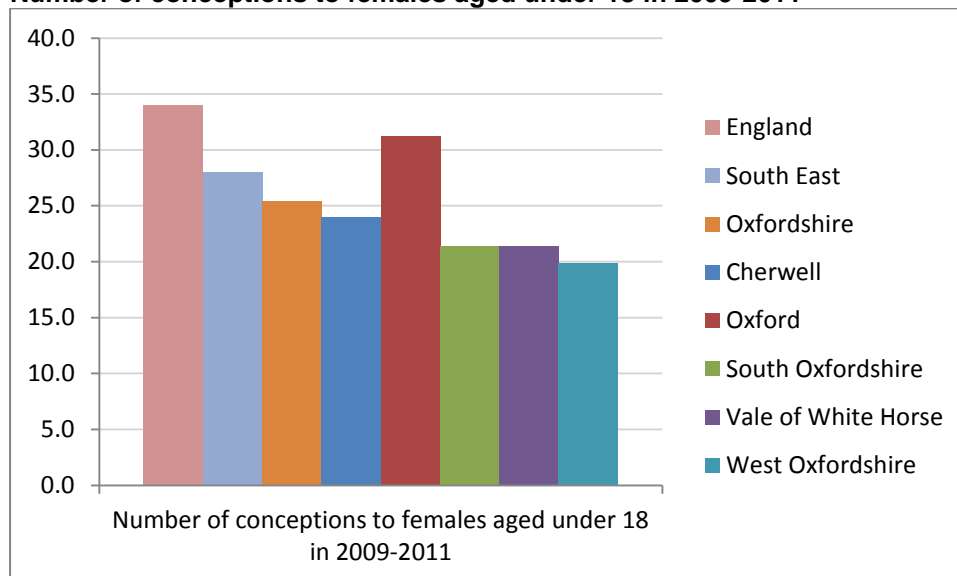
<sup>26</sup> The rate per 100,000 population aged under 19 (0 to 18 years), with asthma, diabetes or epilepsy, admitted to hospital as an emergency admission in the respective quarter of the financial year.

#### 4.8. Under 18 conceptions and sexual health

According to Public Health England most teenage pregnancies are unplanned and around half end in an abortion. For many teenagers bringing up a child is extremely difficult and often results in poor outcomes for both the teenage parent and the child, in terms of the baby's health, the mother's emotional health and well-being and the likelihood of both the parent and child living in long-term poverty. Children born to teenage mothers are 63% cent more likely to live in poverty than children born to mothers in their twenties, and are themselves more likely to become teenage parents<sup>27</sup>.

Research evidence, particularly from longitudinal studies, shows that teenage pregnancy on average is associated with poorer outcomes for both young parents and their children. Teenage mothers are less likely to finish their education, are more likely to bring up their child alone and in poverty and have a higher risk of poor mental health than older mothers. Infant mortality rates for babies born to teenage mothers are around 60% higher than for babies born to older mothers<sup>28</sup>.

**Number of conceptions to females aged under 18 in 2009-2011**



Source: Public Health England, [www.apho.org.uk](http://www.apho.org.uk)

The under-18 conception rate in Oxfordshire was 25.4 per 1,000. The rates in all five districts have been significantly lower than the national ones for same year, and are decreasing broadly in line with the trend for England.

Nationally young people experience the highest STI rates. Changes to data collection make it difficult to compare historical data but generally numbers have risen in the last 10 years. Geographic analysis shows that most deprived areas generally have higher rates. Prevention efforts, such as greater STI screening coverage (i.e. National Chlamydia Screening Programme) and easier access to sexual health services continue to focus on groups at highest risk – these are known

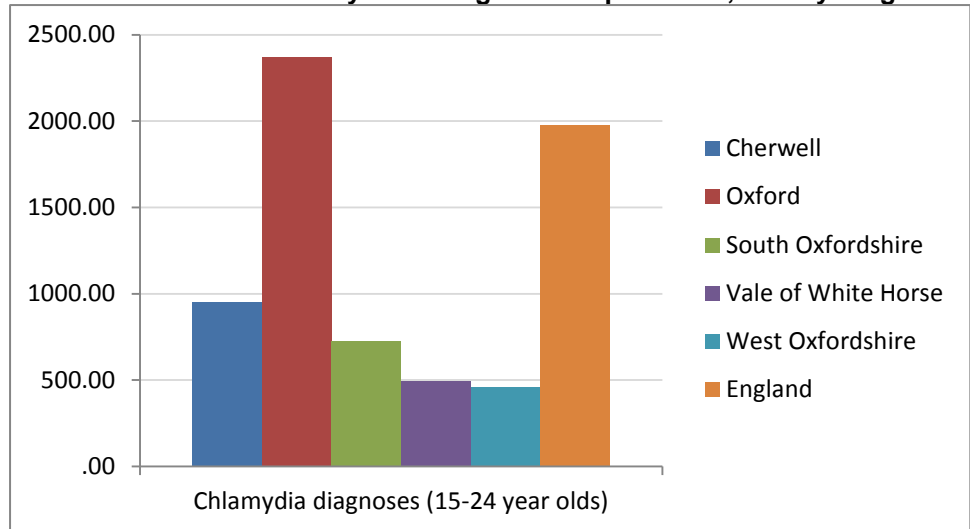
<sup>27</sup> Department for Work and Pensions, Department for Education, *A New Approach to Child Poverty: Tackling the Causes of Disadvantage and Transforming Families' Lives*, April 2011

<sup>28</sup> Public Health England

to be under 25s, men who have sex with men and Black African and Black Caribbean groups..

Chlamydia is the most commonly diagnosed sexually transmitted infection. It causes avoidable sexual and reproductive ill-health, including symptomatic acute infections and complications such as pelvic inflammatory disease (PID), ectopic pregnancy and tubal-factor infertility. It represents infections identified. Increasing diagnostic rates indicates increased control activity: it is not a measure of morbidity<sup>29</sup>.

**Crude rate of chlamydia diagnoses per 100,000 young adults aged 15-24**



Source: Public Health England, [www.fingertips.phe.org.uk](http://www.fingertips.phe.org.uk)

<sup>30</sup>Chlamydia diagnosis is provided for the wide age band because a substantial proportion of young adults (15-24 years)\* become infected with chlamydia each year and many of these infections remain undetected. However, as it can easily be diagnosed and effectively treated. The Department of Health included an indicator in the Public Health Outcomes Framework to assess progress in controlling chlamydia in this age group.

<sup>29</sup> Public Health England

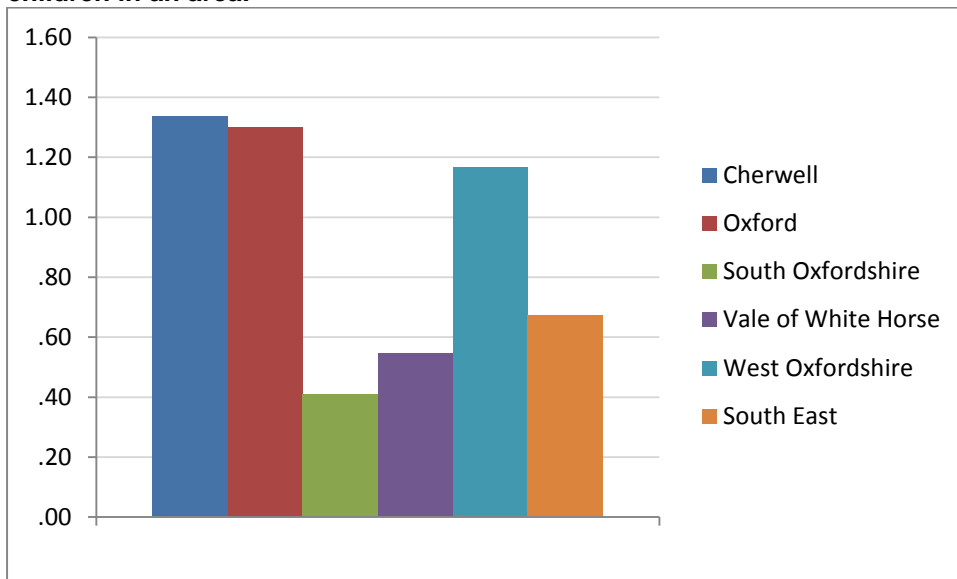
\* In 2012, several changes were made to the collection and reporting of chlamydia activity data, to deliver a simpler and more representative national surveillance system. It is important to note that as a result of the revisions, chlamydia data for 2012 onwards are not directly comparable, Public Health England. .

#### 4.9. Tooth decay in children aged 5.

Tooth decay in children is preventable disease. In severe cases it might result in pain, sleep loss, time off school and sometimes requires treatment under general anaesthetic.

As advised by Public Health England: *Inclusion of this indicator in the Public Health Outcomes Framework will encourage local authorities to focus on and prioritise oral health and oral health improvement initiatives to reduce tooth decay.*

**Total number of obviously decayed, missing (due to decay) and filled teeth in five year old children in an area.**

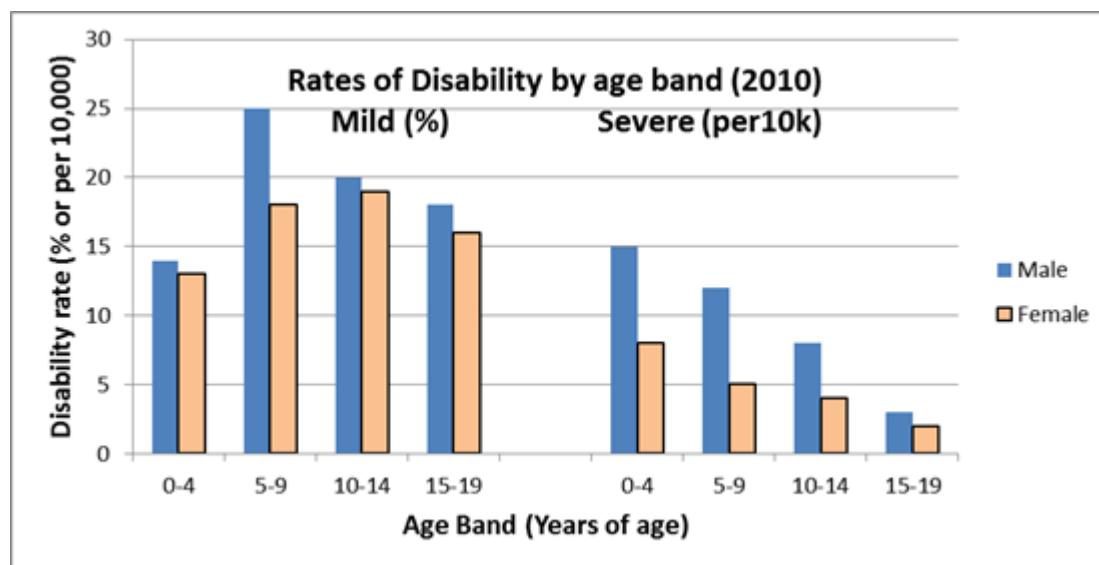


Source: Public Health England, [www.fingertips.phe.org.uk](http://www.fingertips.phe.org.uk)

## 5. VULNERABLE GROUPS/ RISKY BEHAVIOURS

### 5.1. Disabilities

The mean percentage of disabled children in English local authorities has been estimated to be between 3% and 5.4%. If applied to the population of Oxfordshire this would equate to between 3,946 and 7,102 children experiencing some form of disability (Chimat, 2013). The table below shows estimated numbers for 0-19 with disabilities in Oxfordshire.



Source: Chimat Disability Service Snapshot for Oxfordshire

- According to the Foundation for People with Learning Disabilities incidence of learning disabilities are most common amongst young boys. Children from poorer families are more likely to have a learning disability
- Moderate and severe learning difficulties are more common among 'Traveller' and 'Gypsy/Romany' children. Profound multiple learning difficulties are more common among 'Pakistani' and 'Bangladeshi' children
- Overall, 89% of children with moderate learning difficulty, 24% of children with severe learning difficulty and 18% of children with profound multiple learning difficulty are educated in mainstream schools<sup>31</sup>.
- Approximately 200,000 children in England are at the School Action Plus stage of assessment of SEN or have a Statement of SEN and have a primary Special Educational Need (SEN) associated with a learning disability.

<sup>31</sup> Public Health England: *People with Learning Disabilities in England, 2011*, <http://www.improvinghealthandlives.org.uk/>



**Table 12. P=Primary school, S=Secondary school**

<b>Pupils in schools at School Action Plus or with a statement of special education need: rate per 1,000 pupils in Oxfordshire</b>	<b>P</b>	<b>S</b>
Specific learning difficulty	5.4	14.2
Moderate learning difficulty	23.6	28
Severe learning difficulty	1	0.4
Profound and multiple learning difficulty	0.5	N/A
Behaviour, emotional and social difficulties	13.9	20
Speech, language and communications needs	13.8	6.6
Hearing impairment	1	1.1
Visual impairment	0.5	0.5
Multi-sensory impairment	0.1	0
Physical disability	2.4	2.6
Autistic Spectrum Disorder	6.2	9.5
Other difficulty / disability	0.7	0.5

Source: chimat.org.uk

## **5.2. Emotional wellbeing, self-harm<sup>32</sup> and suicide**

1 in 10 children and young people aged 5-16 suffer from a diagnosable mental health disorder – that is around three in every class at school. About half of these (5.8%) have a conduct disorder, whilst others have an emotional disorder (anxiety, depression) and Attention Deficit Hyperactivity Disorder (ADHD).

The most deprived communities have the poorest mental and physical health and wellbeing. Children from the poorest 20% of households have a three-fold greater risk of mental health problems than children from the wealthiest 20%. Parental unemployment is also associated with a two- to three-fold greater risk of emotional or conduct disorder in childhood

Looked After Children (LAC) experience significantly worse mental health than their peers, and a high proportion experience poor health, educational and social outcomes after leaving care. An estimated that between 45 and 60% of Looked After Children aged 5 to 17 have mental health difficulties: over four times higher than all children. Young carers are also more likely to have mental health problems than their non-carer peers.

1% of children are thought to have Autistic Spectrum Disorder (ASD) (including Asperger's Syndrome). This equates to 1500 children and young people in Oxfordshire. Recent studies have shown that approximately 70% of people with ASD also meet diagnostic criteria for at least one other (often unrecognised) psychiatric disorder that is further impairing their psychosocial functioning.

<sup>32</sup> Self- Harm in Oxford 2010, K. Hawton, D. Casey, E. Bale, D. Rutherford, H. Bergen, S. Simkin, F. Brand, K. Lascelles, Centre for Suicide Research, Department of Psychiatry, Warneford Hospital, Oxford

95% of imprisoned young offenders have a mental health disorder, and young people in prison are 18 times more likely to take their own lives than others of the same age.

Self-harming in young people is not uncommon (10–13% of 15–16-year-olds have self-harmed) but only a fraction of cases are seen in hospital settings. There are about 150 admissions to hospital for self-harm each year – but this is only the tip of the iceberg with many more engaging in self-harm but never being admitted.

For children and young people, the prevalence rate of a diagnosable psychiatric disorder is 36% in children and adolescents with learning disabilities. These young people were also 33 times more likely to be on the autistic spectrum and were much more likely than others to have emotional and conduct disorders<sup>33</sup>.

Applying some national prevalence figures to the Oxfordshire population it is likely that approximately

- 14,000 children experience a mental health problem at some time in childhood
- 2600 14-17 year olds self-harm to some degree.

In 2010, 58.5% of patients reporting mental health problems were under 35 years of age. The largest numbers of females were in the 15-19 (148 cases) and 20-24 (131 cases) year age groups. 58.5% of patients were under 35 years of age. There were 60 under-16 year olds. The youngest patients were aged 11 years.

Problem drug use in young females was associated with higher suicide intent scale scores. During the study period, problem drug use and drug misuse increased in females, but not in males<sup>34</sup>.

In Oxfordshire the proportion of overdoses involving paracetamol (including compounds) in 2010 was 42.8%. In under-16-year-olds, two-thirds (68.5%) of overdoses involved paracetamol. In 2010, 19 overdoses by under-18 year-olds (17 persons) involved antidepressants, compared with 25 in 2009 and an annual average of 30 during 2001-2003. 10 of the 19 antidepressant overdoses in this age group involved fluoxetine, compared with 23 out of 91 (25.3%) overdoses during 2001-2003, and 2 involved sertraline. Of the assessed self-harm patients 93 were students (including school students)<sup>35</sup>.

Urban self-harm rates were substantially higher than rural rates amongst both males and females aged between 15 and 64 years. This relationship was sustained even when socioeconomic deprivation and social fragmentation were taken into account. Urban self-harm patients were more likely to be younger, non-white in ethnic origin, unemployed, living alone, to have a criminal record, to have previously engaged in self-harm.

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<sup>33</sup> Public Health England: *People with Learning Disabilities in England, 2011*

<sup>34</sup> Self-Harm in Oxford 2010, K. Hawton, D. Casey, E. Bale, D. Rutherford, H. Bergen, S. Simkin, F. Brand, K. Lascelles, Centre for Suicide Research, Department of Psychiatry, Warneford Hospital, Oxford

The Department for Education publishes annual statistics on looked after children in England. For the purpose of this year's publication 'looked after' child is a child who has been continuously looked after for at least 12 months up to and including 31 March 2013.

Emotional and behavioural health is measured by using The Strengths and Difficulties Questionnaire (SDQ)\* which is a behavioural screening questionnaire about 3-16 year olds. There are various types available each to meet the needs of the different research groups. All of them ask about 25 attributes, some positive and others negative, divided between 5 scales:

- emotional symptoms
- conduct problems
- hyperactivity/ inattention
- peer relationship problems
- pro- social behaviour

The year ending at 31 April 2013 Oxfordshire's average score of 16.6 is classified as borderline but leaning towards 'cause for concern'. This figure remains the same as in the previous years while the regional score has decreased slightly. Ranked 124 of 154 LAs, Oxfordshire's score is on a par with Medway and Milton Keynes.

**Table 13. Emotional and behavioural health of children looked after continuously for 12 months at 31 March for whom a Strengths and Difficulties Questionnaire (SDQ) was completed, by Local Authority**

Area	Average score per child	Banded SDQ Score*		
		Percentage		
		Normal	Borderline	Concern
England	14.0	50	12	38
South East	14.8	45	14	41
<b>Oxfordshire</b>	<b>16.9</b>	<b>37</b>	<b>12</b>	<b>51</b>

Source: Outcomes for Children Looked After for Local Authorities, Table LA7, Department for Education, 2 April 2014 release

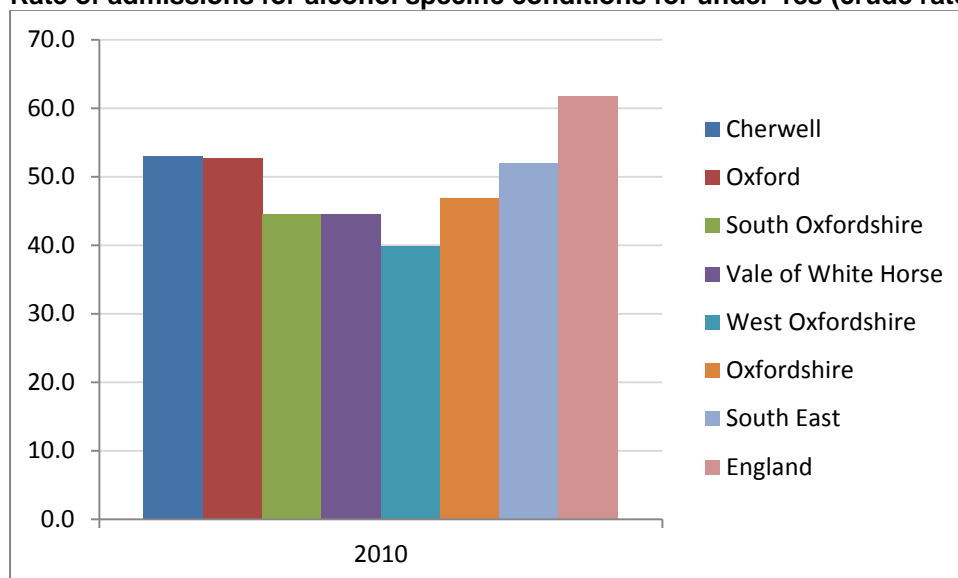
\* Scores have been banded in the following way: a score of fewer than 14 is considered normal, 14-16 is borderline cause for concern and 17 or over is a cause for concern.

### 5.3. Substance misuse

Multiple risk behaviour in adolescence such as smoking, hazardous alcohol consumption and unprotected sexual intercourse are associated with increased risk of poor educational attainment, future morbidity and premature mortality. People who engage in any one risk behaviour are likely to engage others. Engagement in these types of activities is likely to persist into the adulthood<sup>36</sup>.

The National Youth Survey results show that *a large minority of young people in their early teens take part in heavy 'binge' drinking even though they are well below the age when they can legally buy alcohol. A quarter of 13- and 14-year-old students in Year 9 at school admit they have recently downed five or more alcoholic drinks in a single session, rising to more than half of all 15- and 16-year-old pupils in Year 11*<sup>37</sup>.

**Rate of admissions for alcohol specific conditions for under 18s (crude rate per 100,000)**



Source: Public Health England, [www.apho.org.uk](http://www.apho.org.uk)

\*Does not include attendance at A&E

The 2012/13 Government Alcohol strategy advice was advised to focus on a different types of drinking down the local level as they differ in the same way as the population and type of the alcohol related injuries in certain areas<sup>38</sup>.

In 2013 6.7% of children looked after were identified as having a substance misuse problem, almost double the South East Average of 3.5%. During this year no child refused an offer of help or intervention<sup>39</sup>.

<sup>36</sup> Multiple risk behaviour in adolescence, Journal of Public Health, Volume 34, Oxford University Press

<sup>37</sup> A National Survey of Problem Behaviour and Associated Risk and Protective Factors Among Young People, April 2002, [www.jrf.org.uk](http://www.jrf.org.uk).

<sup>38</sup> Government's alcohol strategy: third report 2012-13, Volume 1, Health Committee, House of Commons.

<sup>39</sup> Outcomes for Children Looked After for Local Authorities, Table LA5, Department for Education, 2 April 2014 release

## 5.4. Safeguarding and looked after children

Between April and November 2013 levels of referrals moving to assessments were comparatively very low (124<sup>th</sup> of 151 authorities). The number of children on caseloads remain stable but still significantly above the national average of 2%.

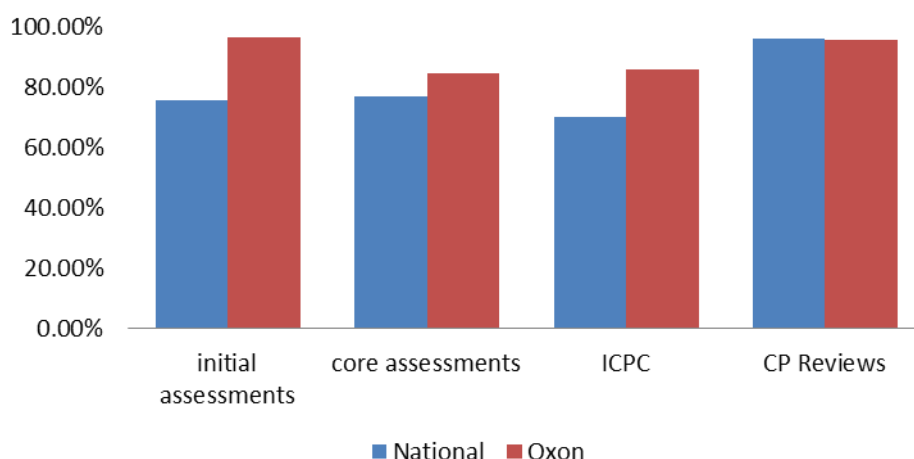
Table 14.

	2012/13		Apr - Nov 13-14 (Oxon)		
	National	Oxon	2012	2013	Change
Referral	-2%	1%	3799	3705	-2.5%
S47 investigation	2%	8%	598	750	25.4%
Initial CP Case Conference	7%	-4%	324	402	24.0%
Children placed on a plan	1%	-6%	300	381	27.0%
Became looked after	2%	-5%	148	191	29.0%
Case lists					
On caseloads	2%	6%	3471	3481	0.2%
On a plan	0.3%	17%	430	477	10.9%
Looked after	1.7%	- 7.6%	416	463	11.3%

Source: OCC Joint Commissioning Performance Team

There has been an improvement in numbers of the initial and core assessments within 10 days as well as number of days between entering care and moving in with adoptive family and Days between court authority & matching to an adoptive family.

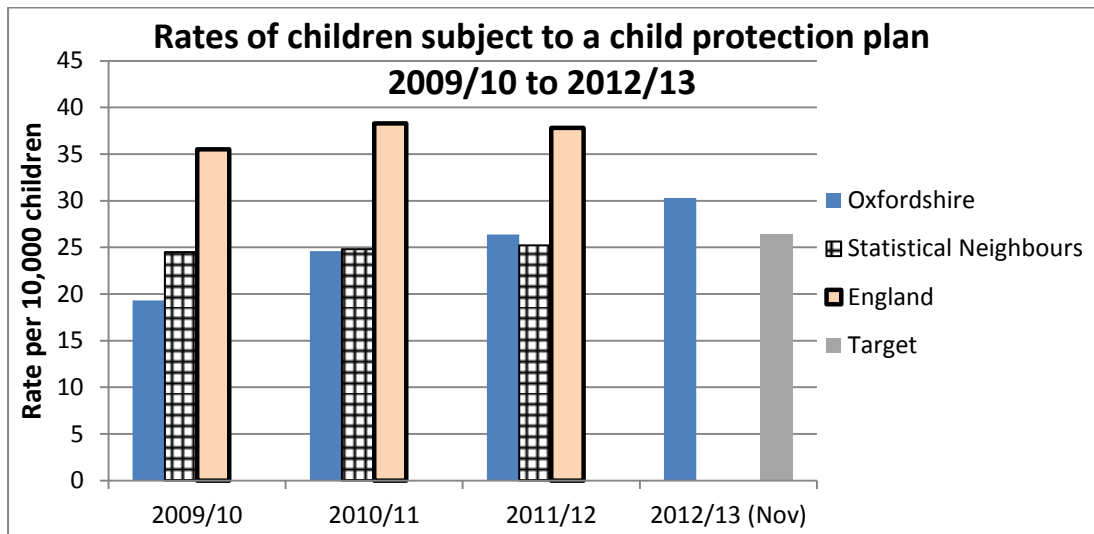
### National timeliness measures



Source: OCC Joint Commissioning Performance Team

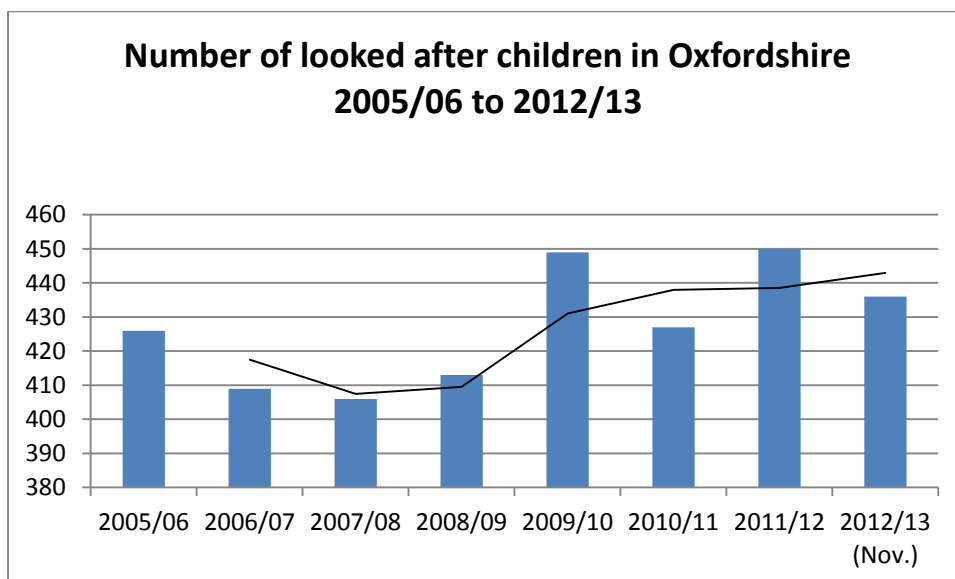
Compared to others, percentage of Looked After reviews Child Protection reviews completed on time remain significantly worse.

The number of children subject to a child protection plan in Oxfordshire is rising year on year, with a particularly steep increase so far in 2012/13.



Source: OCC Joint Commissioning Performance Team

The number of looked after children in Oxfordshire has averaged 440 over the past 4 years. This is in line with the County target, slightly below statistical neighbour rates, and well below the national figure.



Source: OCC Joint Commissioning Performance Team

The majority (68%) of Looked After Children are placed in a foster placement (foster care or friends/family).

The number of Oxfordshire children in children's homes has increased, but stabilised in recent years at around 45. At the end of November 2012 there were 23 in Oxfordshire and 22 out of County (5 in neighboring counties, 17 further afield).

Nearly 50% of looked after children are looked after under the Need Code of Abuse or Neglect. Family Dysfunction is the next highest need category at 17% of those looked after.

## 5.6. Young carers<sup>40</sup>

Of the 1469 identified young carers (data up to January 2014), 648 (44.1%) were male and 821 (55.9%) were female. The number of young carers identified has increased by 34% since November 2012, when 1096 young carers were identified.

The most common cause of caring is parental mental health (23.4%) followed by Sibling Learning Difficulties (18.0%) and Parental Physical Disabilities (15.5%). 15.1% care for a parent with a physical illness, 13.6% for a parent with multiple conditions and 8.8% for siblings with physical disabilities. 4.3% care for parents with substance misuse issues.

In the academic year 2012/13 of 742 students, 244 have had at least 1 term where their attendance fell below 85%. This represents a percentage of 32.88% (lower than the 2011/12 figure of 39%).

Table 15.

Level 4 and above in English and Maths	Young Carers	Oxfordshire Average
2009	55.4%	72.8%
2010	62.2%	75%
2012	64.2%	82%
2013	59.6%	77%

Source: Oxfordshire Young Carers Data Headlines, Children, Oxfordshire County Council Education and Families, January 2014

The 2013 cohort of 89 (for whom data could be matched):

- 52.8% (44.2% in 2012) were Free School Meal eligible (FSM)
- 46.1% (53.7% in 2012) were identified as having Special Educational Needs (SEN)
- 18% (18.9% in 2012) were of non-white British ethnicity

Table 16. Attainment - Key Stage 4 including English and Math

5 A* - C GCSEs	Young Carers	Oxfordshire Average
2009	13.5%	52.9%
2010	29.9%	57.3%
2011	30.4%	57.4%
2012	40.0%	57.2%
2013	34.0%	60.3% (Provisional)

Source: Oxfordshire Young Carers Data Headlines, Children, Oxfordshire County Council Education and Families, January 2014

The 2013 cohort of 101 (for whom data could be matched):

- 46.2% (60% in 2012) were Free School Meal eligible (FSM)

<sup>40</sup> Oxfordshire Young Carers Data Headlines, Children, Oxfordshire County Council Education and Families, January 2014.

- 40.4% (47% in 2012) were identified as having Special Educational Needs
- 10% (8.2% in 2012) were of non-white British ethnicity

In November 2013 the percentage of known young carers in the age range 16 to 19 who were NEET was 34.5% (5% of Oxfordshire young people aged 16 -19 are NEET in November 2013).

### 5.7. Domestic violence and its effect on children

Children and youth who are exposed to domestic violence experience emotional, mental and social damage that can affect their developmental growth.

As for the nature of this type of abuse *children who witness family violence is a special case of counting the hard-to-count and measuring the hard-to measure*<sup>41</sup> and for that only careful estimation is possible.

**Table 16. Reported incidents to the Police, 2012/13**

Local Police Area	Crime	Crime related Incident (CRI)	All Domestic Incidents 2012/13
Cherwell	542	1741	2283
Oxford	586	1995	2581
South & Vale	633	2022	2655
West Oxfordshire	336	784	1120
<b>Oxfordshire</b>	<b>2097</b>	<b>6542</b>	<b>8639</b>

Source: Oxfordshire's Integrated Strategy Report and Evaluation 2013, Domestic Abuse Oxfordshire, Reducing the Risk

One in four women experience domestic abuse or domestic violence at some point in their lives. This may be physical, sexual, emotional or psychological abuse. 30% of this abuse starts in pregnancy, and existing abuse may get worse during pregnancy or after giving birth.

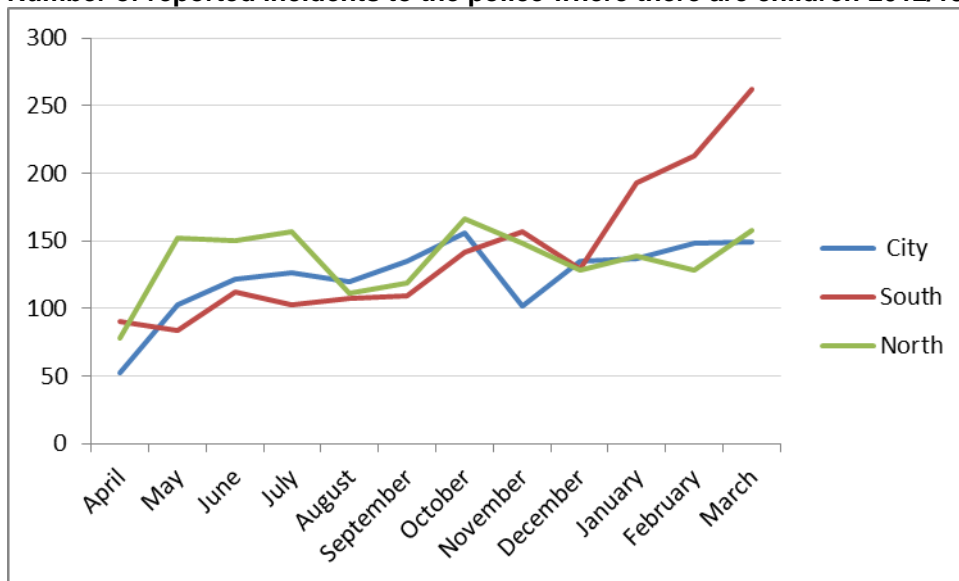
Domestic abuse during pregnancy puts the mother and her unborn child in danger. It increases the risk of miscarriage, infection, premature birth, and injury or death to the baby<sup>42</sup>.

<sup>41</sup> Domestic Violence and its Impact on Children's Development, [www.community.nsw.gov.au](http://www.community.nsw.gov.au)

<sup>42</sup> Domestic abuse, [www.nhs.uk](http://www.nhs.uk)



**Number of reported incidents to the police where there are children 2012/13**



Source: Oxfordshire’s Integrated Strategy Report and Evaluation 2013

Altogether there were 4820 incidents of domestic abuse reported to the police in 2012-13 where there were children. While some may be repeat incidents affecting the same children, many incidents will affect more than one child and domestic abuse is under reported to the police. This is therefore only a partial picture of the number of children affected in Oxfordshire<sup>43</sup>.

The increase of reported incidents of the domestic abuse can’t be an indication of this problem arising. It can only indicate the fact that victims feel more comfortable about reporting the violent crime to the third party.

### 5.8. Child sexual exploitation.

The prevalence of Child Sexual Exploitation has been an emerging national issue of concern over recent years. Operation Bullfinch was a joint surveillance operation by Police and Social Workers within Oxfordshire which commenced in 2010 due to growing concerns about possible street grooming of vulnerable girls by a gang of men acting together. This resulted in the successful prosecution and conviction of 7 men for a range of serious sexual offences against these girls and young women.

The Oxfordshire Safeguarding Children Board has instigated a Serious Case Review into this matter and commissioned a special task group to identify and action improvements into how agencies can better work together in combatting this horrific form of abuse. A formal strategy to address this abuse has been agreed by all statutory agencies, procedures reviewed and training undertaken for key professionals involved in this area.

The Kingfisher team has been established as a multi-agency professional group charged with the responsibility of investigating all referrals where Child Sexual

<sup>43</sup> Source: Oxfordshire’s Integrated Strategy Report and Evaluation 2013

Exploitation is suspected. The Team has handled over 90 referrals in the last 12 months, as a result of work by all agencies to pro-actively identify children who present risk factors for CSE using the CSE screening tool. Following referral these children receive preventative support, protection and further investigation as appropriate to their individual circumstances. All these children have multi-agency plans in place to ensure all risks are assessed and addressed.

### **5.9. Bullying and e-safety**

Bullying is repeated verbal, physical, social or psychological behaviour that is harmful and involves the misuse of power by an individual or group towards one or more persons. Cyberbullying refers to bullying through information and communication technologies.

Bullying can involve humiliation, domination, intimidation, victimisation and all forms of harassment including that based on sex, race, disability or sexual orientation. Bullying of any form or for any reason can have long-term effects on those involved including bystanders<sup>44</sup>.

Statistics on bullying collated from government reports and research by NSPCC<sup>45</sup> say that:

- Almost half (46%) of children and young people say they have been bullied at school at some point in their lives.
- 38% of disabled children worried about being bullied.
- 18% of children and young people who worried about bullying said they would not talk to their parents about it.
- 38% of young people have been affected by cyber-bullying, with abusive emails (26%) and text messages (24%) being the most common methods.

Bullying was chosen by 18% of parents who took a part in a survey conducted by the Centre for Social Research as one of the main reasons of a persistent school absence of their children<sup>46</sup>. Previous experience of bullying was also in the top three reasons for choosing home education .

Oxfordshire Children, Education and Families directorate views the tackling or bullying as a crucial priority to safeguard the well-being of Oxfordshire's children and young people. A total of 3874 young people took part in the pilot survey<sup>47</sup> from 8 secondary and 6 primary schools. The results are as follows:

- 14% of pupils that have been bullied every month or more frequently (10% every week or more frequently, 6% most days). This is a significant minority and for 40% of all those bullied the impact was considerable with vulnerable groups likely to experience increased impact of bullying.

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<sup>44</sup> Source:www.stopbullying.gov

<sup>45</sup> Statistics on bullying, National Society for the Prevention of Cruelty to Children, March 2013.

<sup>46</sup> Estimating the prevalence of young people absent from school due to bullying, Centre for Social Research, May 2011.

<sup>47</sup> Oxfordshire Pilot Bullying Survey 2012/13, Children, Education and Families Directorate

- The most common type of bullying is verbal bullying (51%) and this far more common than emotional and indirect bullying (22%), physical bullying (16%) and cyberbullying (10%).
- Prejudice-related name calling is common, reflecting national trends and a very high proportion of young people are hearing insults and name calling in relation to 'being gay' with 39% hearing these insults most days and the word 'gay' being heard as a derogatory term by 47% of pupils most days.
- 16% admit to bullying someone else (3% a lot, 13% a little, 18% don't know).
- 55% of the pupils said their school handled bullying quite well or better, 33% not very well or worse. As children and young people get older they are less satisfied and those belonging to 'vulnerable groups' are also likely to be less satisfied.
- When bullied 17% told a teacher, 31% told a family member, 24% told a friend and 17% did not tell anyone. Telling someone does appear to be effective but as children get older they are less likely to tell someone.
- Bullying impacts differently in terms of age and gender.
- The data indicates that there is no one method that children and young people feel confident works to address bullying and as they get older they have less faith in the methods used.

## 5.10. Thriving families

The Thriving Families Programme aims to make a real and lasting impact to the lives of some of the most vulnerable families in the county. The aim is to *fight the problems of poverty, disadvantage and disconnection from the mainstream of society, which persist through generations and are experienced by a group of our most troubled and troubling families*<sup>48</sup>.

The Thriving Families team have to date identified a list of 711 families within Oxfordshire who meet at least two of the national criteria and which are tracked as part of the Troubled Families programme. Overall it is estimated that Oxfordshire has 810 such families. The criteria are:

- children not attending school regularly or behaving well in school
- parents in receipt of age -related working benefits
- anti-social behaviour/ offending within the family

It was estimated that the Thriving Families team would be working with 100 families by the end of March 2014<sup>49</sup>.

In Oxfordshire 57% of all Thriving Families were living in a single parent household which is way above the national average of 26%. Only 3% owns their own property

<sup>48</sup> Oxfordshire Thriving Families Bulletin, October 2012, Edition 1.

<sup>49</sup> Thriving Families Programme Update, June 2013.

followed by the 15% private and 85% socially rented. 12% is at a risk of eviction and 8% at risk of homelessness<sup>50</sup>.

96% of Thriving Families in Oxfordshire is registered with GP:

- 66% adults diagnosed with mental health issues (within which 16% has a learning difficulties)
- 39% adults diagnosed with physical disability
- 41% of families attended a hospital in last year

50% of families had a child excluded from school:

- 18% had more than one child excluded
- 80% had a child who was a persistent absentee, 40% had more than one child who was a persistent absentee
- 76% of children on SEN register
- 61% of children are in alternative provision

Children and Parents:

- 76% had poor parenting as an issue
- 23% had children identified as Children in Need
- 11% had children on a Child Protection plan
- 14% had a child in care
- 30% adults in employment, the rest remaining on work related benefits

Crime incidents:

- 28% suffering domestic abuse
- 46% subject to Anti Social Behaviour sanction
- 42% conviction in last year
- 57% repeat police call outs

### **5.11. Vulnerable adults and effect on children.**

It is estimated that parental drug misuse affects between 2,340 and 3,510 children in Oxfordshire<sup>51</sup>. Furthermore there are children who live with parental solvent misuse and a much higher number who live with parental alcohol misuse. Nationally, the official figure for children living with alcohol misusing parents is 1.3million<sup>52</sup>. Four times the number of children living with parental drug misuse.

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<sup>50</sup> Thriving Families Programme Update, January 2014.

<sup>51</sup> Oxfordshire DAAT

<sup>52</sup> Prime minister's strategy unit, 2003

## 5.12. Young offenders.

Mapping relevant risk factors associated with youth crime can maximise the life chances of vulnerable children and improve outcomes for them.

*"A lack of focus in this area could result in greater unmet health needs, increased health inequalities and potentially an increase in offending and re-offending rates, including new entrants to the system. The impact of incorporating these vulnerable children into mainstream commissioning also has the potential benefit of impacting on a young person's wider family now and in the future"<sup>53</sup>.*

- First-time entrants rates lower than elsewhere - 324 Oxfordshire children per 100,000 aged 10-17 entered the justice system in 2012 compared with 537 nationally.
- 3.6% of LAC children convicted or subject to a final warning or reprimand during 2012/13 compared with 6.2% nationally
- Custody rates dropped to 0.12 per 100,000 in 2012/13 compared with 0.55 nationally.
- Reoffending is in line with national levels at 33% but higher than statistical neighbours<sup>54</sup>.

Between April 2012 and March 2013 there were 761 young people aged under 18 who were involved in some sort of offence 86% of which were White or White British.

**Table 17. Young offenders by the ethnic origin.**

<b>ETHNICITY</b>	<b>Central</b>	<b>North</b>	<b>South</b>
<b>Asian or Asian British</b>	<b>14</b>	<b>7</b>	<b>0</b>
<b>Black or Black British</b>	<b>16</b>	<b>21</b>	<b>2</b>
<b>Chinese or other ethnic group</b>	<b>2</b>	<b>0</b>	<b>2</b>
<b>Mixed</b>	<b>20</b>	<b>5</b>	<b>6</b>
<b>Unknown</b>	<b>4</b>	<b>6</b>	<b>1</b>
<b>White/ White British</b>	<b>170</b>	<b>250</b>	<b>235</b>
<b>Grand Total</b>	<b>226</b>	<b>289</b>	<b>246</b>

Source: Joint Commissioning, Oxfordshire County **Council**

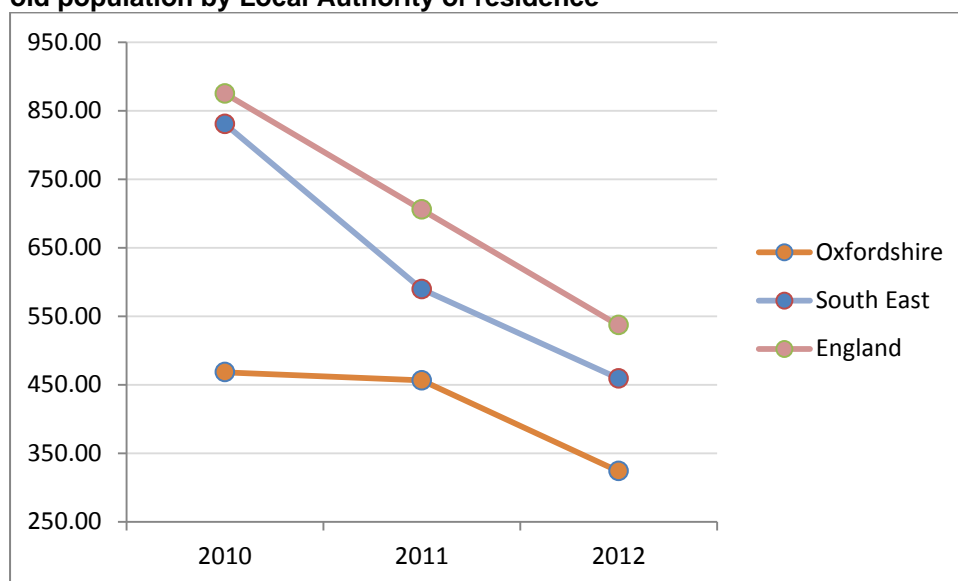
In 2013, 3.6% of 190 looked after children aged 10 or above were convicted or subject to a final warning or reprimand. This is lower than the regional average of 7.6% and England average of 6.2%<sup>55</sup>.

<sup>53</sup> Source: Public Health England.

<sup>54</sup> Source: OCC Joint Commissioning Performance Team

<sup>55</sup> Outcomes for Children Looked After for Local Authorities, Table LA4, Department for Education, 2 April 2014 release

**Rates of juveniles receiving their first reprimand, warning or conviction per 100,000 10-17 year old population by Local Authority of residence**



Source: Public Health England, [www.fingertips.phe.org.uk](http://www.fingertips.phe.org.uk)

Amongst all young offenders aged 11-17, 84% were boys. Over a half of all offences in this group was committed by 16 and 17 year olds. The most common offences were theft and violence against the person.

**Table 18.**

OFFENCES BY TYPE AND AREA	Central	North	South	All
ARSON	7	1	1	9
BREACH OF BAIL	3	8	3	14
BREACH OF CONDITIONAL DISCHARGE	2	7	2	11
BREACH OF STATUTORY ORDER	8	0	2	10
CRIMINAL DAMAGE	19	36	73	128
DEATH OR INJURY BY RECKLESS DRIVING	1	1	0	2
DOMESTIC BURGLARY	5	2	13	20
DRUGS OFFENCE	24	27	16	67
FRAUD AND FORGERY	1	5	1	7
MOTORING OFFENCES	14	14	11	39
NON DOMESTIC BURGLARY	6	3	4	13
OTHER	5	4	4	13
PUBLIC ORDER	19	26	6	51
RACIALLY AGGRAVATED	2	1	4	7
ROBBERY	6	7	7	20
SEXUAL OFFENCE	4	4	8	16
THEFT AND HANDLING	48	70	36	154
VEHICLE THEFT	5	2	12	19
VIOLENCE AGAINST THE PERSON	47	71	43	161
Grand Total	226	289	246	761

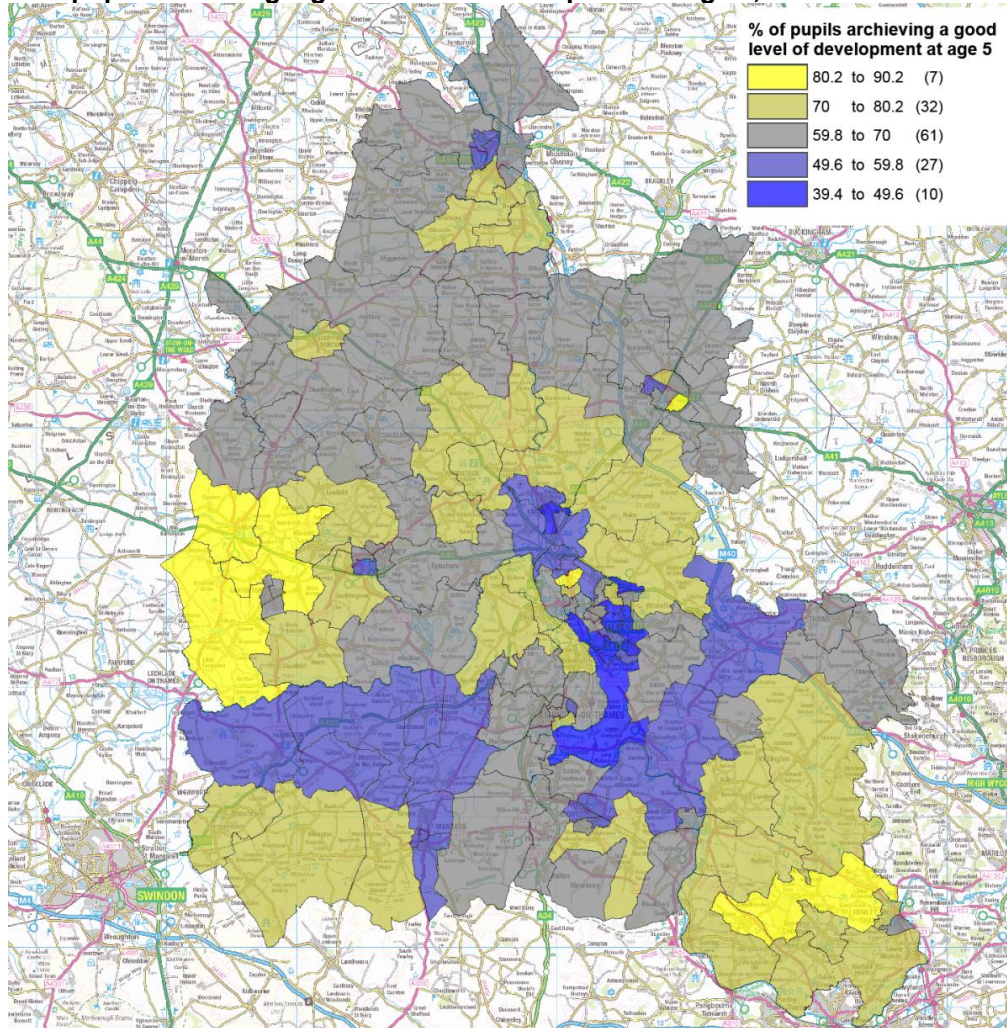
Source: Joint Commissioning, Oxfordshire County Council

## 6. EDUCATION

### 6.1. Early years

Research conducted by Oxford University points out the importance of early education in children aged 0-3. During these early years, babies and young children experience phenomenal growth in brain development, and in their understanding of themselves and the world around them<sup>56</sup>.

#### % of pupils achieving a good level of development at age 5, 2011/2012

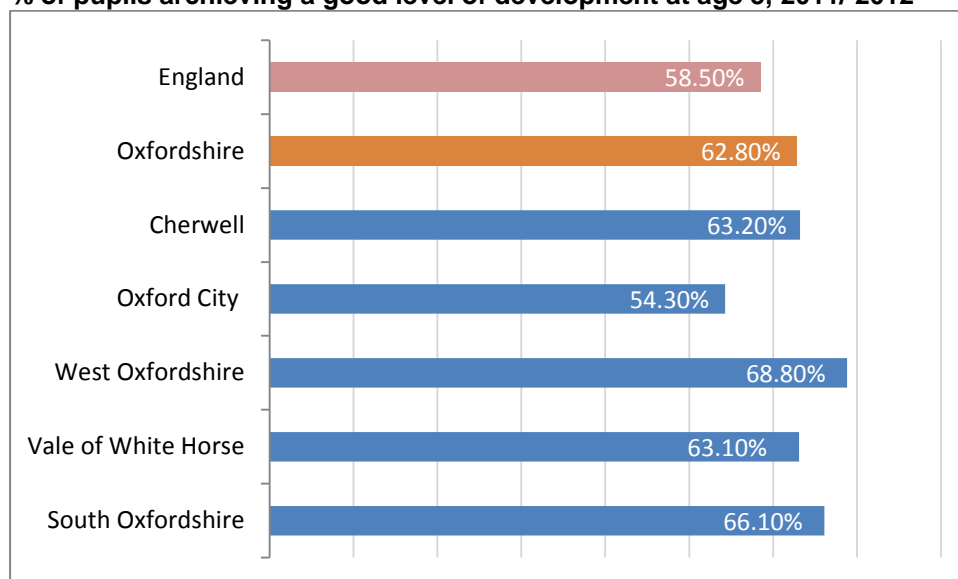


Source: Public Health England, [www.apho.org.uk](http://www.apho.org.uk)

As of 2011/12, in Oxfordshire 62.8% of pupils were achieving a good level of development at the age of 5, significantly above the England average of 58.5%.

<sup>56</sup> A Review of the Research Evidence on Quality of Early Childhood Education and Care for Children Under Three Implications for Policy and Practice, University of Oxford, January 2014.

### % of pupils achieving a good level of development at age 5, 2011/ 2012



Source: Public Health England, [www.apho.org.uk](http://www.apho.org.uk)

## 6.2. Attainment at key stages

Research shows high-quality early learning and care is important because children who attend higher quality preschool provision tend to do better throughout primary school, particularly in reading. Evaluation of the two-year-old free entitlement to childcare backs this up. It showed that those children who had attended a high-quality setting had a significant improvement to their vocabulary.

Quality early learning and childcare can make a real difference to children's future success in school and later life, and help them to fulfil their full potential<sup>57</sup>.

For many pupils, progress during Key Stages 2 and 3 is not linear and continuous. Episodes of regression to an earlier level of attainment, or remaining at the same level for a period, are part of the norm. More progress is made per year in Key Stage 2 than Key Stage 3 in all three subjects, but especially in reading and writing.

Boys are less likely to make progress than girls in all three subjects. The differences are larger during Key Stage 3, when the probability of progressing each year decreases more for boys than for girls. Maths has the smallest gender progress differences, and reading has the largest<sup>58</sup>.

The gaps in attainment widen between pupils known to be eligible for Free School Meals (FSM) and their peers, as there are greater differences in progress in years 4 and 5 during Key Stage 2, although pupils with FSM also make less progress during Key Stage 3. Reading has the smallest FSM progress differences, and maths has the largest.

<sup>57</sup> Department for Education.

<sup>58</sup> *How do pupils progress during Key Stage 2 and 3?* Education Standards Analysis and Education Division, Department for Education.

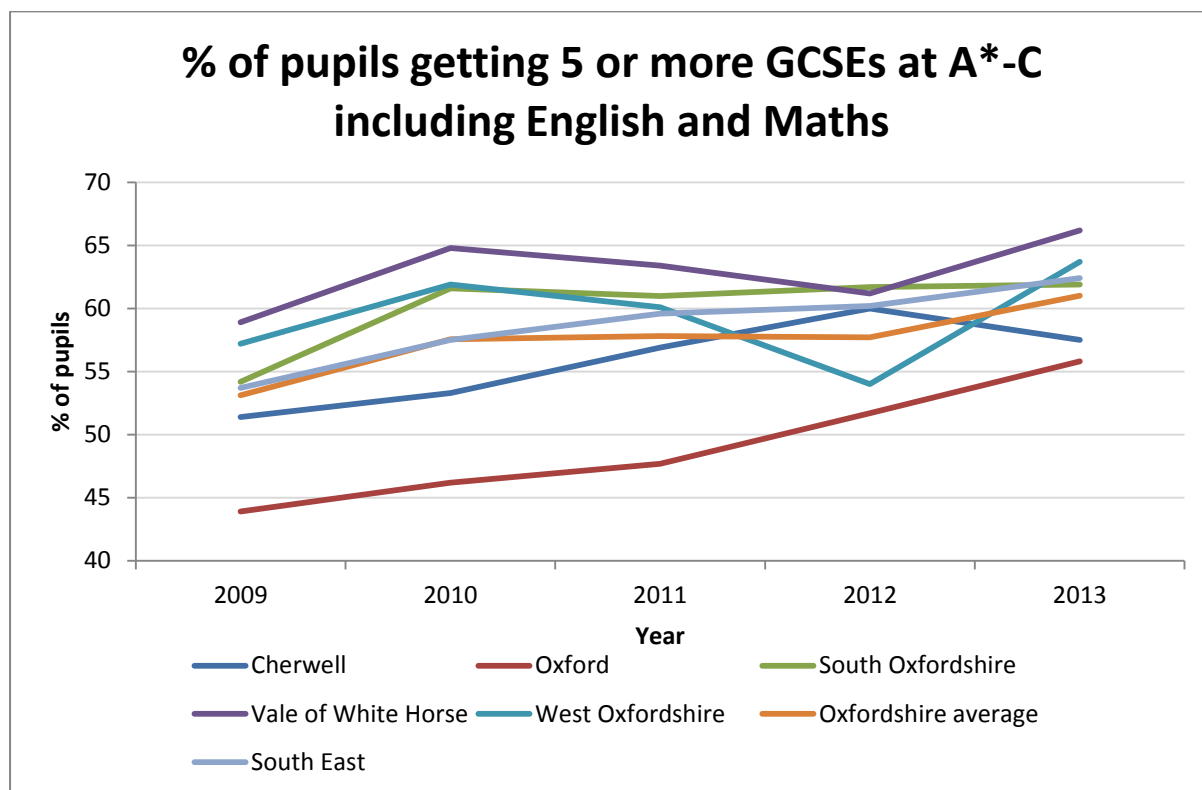


**Table 20. Percentage of pupils achieving level 4 or above at Key Stage 2, 2013<sup>59</sup>**

	Reading		Writing		Mathematics		Grammar, punctuation & spelling		Reading, writing & mathematics	
	Number of eligible pupils	Percentage achieving level 4 or above <sup>1</sup>	Number of eligible pupils	Percentage achieving level 4 or above <sup>1</sup>	Number of eligible pupils	Percentage achieving level 4 or above <sup>1</sup>	Number of eligible pupils	Percentage achieving level 4 or above <sup>1</sup>	Number of eligible pupils	Percentage achieving level 4 or above <sup>1</sup>
<b>Oxfordshire</b>										
Cherwell	1,414	90	1,414	86	1,414	89	1,414	75	1,414	81
Oxford	1,108	82	1,108	81	1,108	81	1,108	69	1,108	71
South Oxfordshire	1,283	88	1,283	87	1,283	86	1,283	76	1,283	79
Vale of White Horse	1,137	90	1,137	84	1,137	88	1,137	75	1,137	79
West Oxfordshire	1,020	88	1,020	87	1,020	87	1,020	76	1,020	79

Source: Department for Education

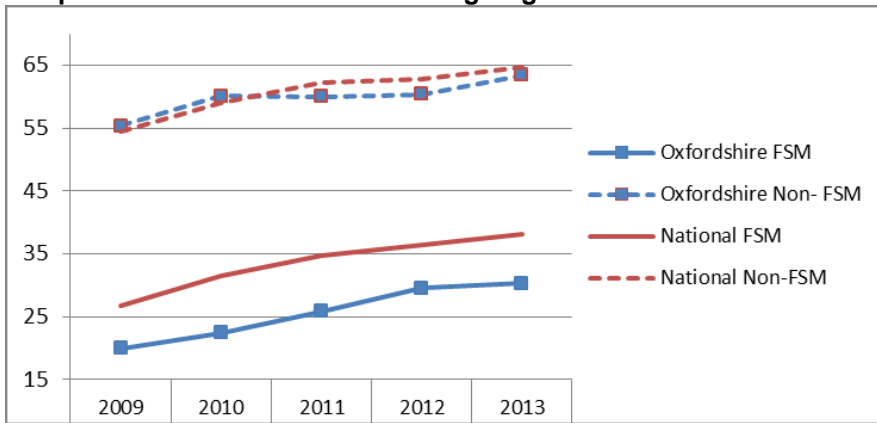
Overall the percentage of pupils achieving 5 or more GCSEs at A\*- C including English and Maths has been growing in line with South East average for all five districts and county as a whole. Girls are slightly more successful than boys in terms of GCSE attainment (51.6% vs. 48.4% respectively for Oxfordshire). Despite a steady improvement over the last five years, attainment Oxford City is still significantly below the regional average.



Source: Department for Education

<sup>59</sup> School type: state-funded schools (including academies and CTCs)

**Graph 1: % 5+ A\*-C GCSEs including English & Maths – Free School Meals**



Source: Oxfordshire County Council, Education and Intervention

Free School Meal Gap (%pts)					
	2009	2010	2011	2012	2013
<b>Oxfordshire</b>	36	38	34	31	33
<b>National</b>	28	28	28	26	27

Source: Oxfordshire County Council, Education and Intervention

- 70% of pupils known to be eligible for Free School Meals in Oxfordshire leave school without 5 GCSEs at A\*-C including English and maths. Nationally this proportion is 62%.
- Oxfordshire’s FSM attainment at GCSE ranks 125th out of 152 LAs.
- The FSM gap relates to the difference in attainment between those eligible for free school meals and the rest of the cohort.
- Oxfordshire’s non-FSM attainment is in line with national but that of Oxfordshire’s FSM pupils falls below that nationally, resulting in a wider attainment gap.
- The FSM gap in Oxfordshire had been decreasing since 2010 but it widened again in 2013. The cohort has increased from 450 in 2009 to 540 in 2013, with a significant increase between 2012 and 2013 which corresponds to the period in which the gap widened.
- Oxfordshire FSM pupils are broadly in line with national for the proportion achieving 5+ GCSEs at any grade. However the county falls significantly below the national average for the proportion achieving at least 5 GCSEs at A\*-C. This indicates that it is achieving the higher grades is the potential challenge for this group of children.
- A similar pattern is shown for pupil premium (for those pupils eligible for FSM at any point in the last 6 years) – although only 2 years data is available<sup>60</sup>.

<sup>60</sup> Education Scrutiny Committee- 3 April 2014, Educational Attainment of vulnerable groups, 2012/2013 academic year, Report by Deputy Director for Education and Intervention, Oxfordshire County Council

Table 21.

Key Stage 2	% level 4 + Reading, Writing and Maths					
	2012			2013		
	FSM	not FSM	FSM gap (%pts)	FSM	not FSM	FSM gap (%pts)
<b>Oxfordshire</b>	56	79	23	58	80	20
<b>National</b>	59	78	19	60	79	19

Source: Oxfordshire County Council, Education and Intervention

- Only 58% of key stage 2 pupils eligible for free school meals in Oxfordshire achieve the expected level 4 in reading, writing and maths compared to 80% of those not eligible for free school meals.
- The FSM attainment gap at key stage 2 in Oxfordshire (22%points) is again wider than that nationally (19%points). In a similar pattern to key stage 4 this is because the attainment of non FSM pupils in Oxfordshire is above that nationally but the attainment of FSM pupils is slightly lower than that of the same cohort nationally.
- The FSM attainment gap in Oxfordshire decreased very slightly this year.
- Attainment by FSM and gender shows that girls who are eligible for FSM outperform the boys, both in Oxfordshire and nationally. Only half (50%) of boys in Oxfordshire eligible for FSM achieve level 4 or above compared with 67% of girls eligible for FSM<sup>61</sup>.

### 6.3. School absences and exclusions

Persistent absence is a serious problem for pupils. Much of the work children miss when they are off school is never made up, leaving these pupils at a considerable disadvantage for the remainder of their school career. There is also clear evidence of a link between poor attendance at school and low levels of achievement<sup>62</sup>:

- Of pupils who miss more than 50% of school, only 3% manage to achieve five A\* to Cs including English and maths.
- Of pupils who miss between 10% and 20% of school, only 35% manage to achieve five A\* to C GCSEs including English and maths.
- Of pupils who miss less than 5% of school, 73% achieve five A\* to Cs including English and maths.

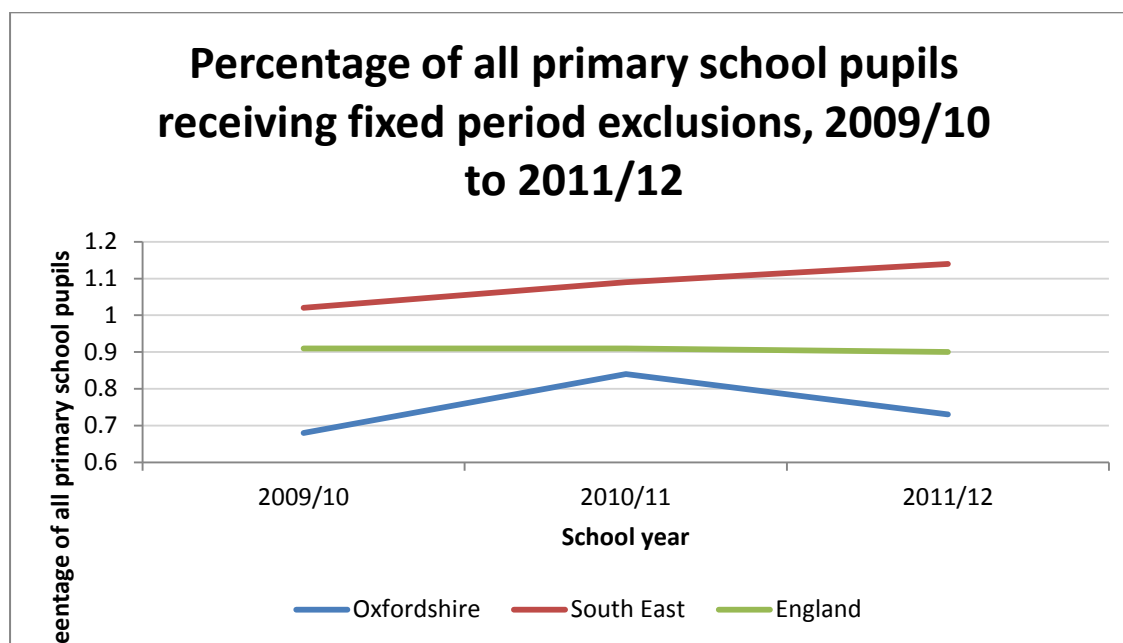
Children with low attendance in the early years are more likely to come from the poorest backgrounds. These children are likely to start school already behind their peers, particularly in their acquisition of language and their social development<sup>63</sup>.

<sup>61</sup>Education Scrutiny Comitee- 3 April 2014, Educational Attainment of vulnerable groups, 2012/2013 academic year, Report by Deputy Director for Education and Intervention, Oxfordshire County Council

<sup>62</sup> *Persistent absence: government changes definition to deal with reality of pupil absenteeism in schools*, Department for Education, July 2011.

<sup>63</sup> *Improving attendance at school*, Department for Education, 2012.

In a 2011/12 school year 9 primary school children received permanent exclusion from school. Fixed period exclusions have fallen after peaking in 2010/11 and remain below both the South East and England average.



Source: Department for Education

Evidence shows that pupils who are persistently absent in secondary schools have had poor attendance levels in primary school<sup>64</sup>.

The overall absence rate of looked after children has been falling since 2009 (7.6% and fell to 4.2% in 2013).

**Table 22. Absence from school of children who have been looked after continuously for at least 12 months**

Area	Percentage of school-aged children with UPN <sup>66</sup>	Number of looked after children matched to absence data <sup>67</sup>	2013 (6 terms) <sup>65</sup>			Percentage of looked after children classed as persistent absentees <sup>8</sup>
			Authorised absence	Unauthorised absence	Overall absence	
<b>England</b>	90-99	26,820	3.3	1.1	4.4	5.0
<b>South East</b>	.	3,410	3.6	1.1	4.8	5.7
<b>Oxfordshire</b>	<b>100</b>	<b>145</b>	<b>3.3</b>	<b>1.2</b>	<b>4.6</b>	<b>4.2</b>

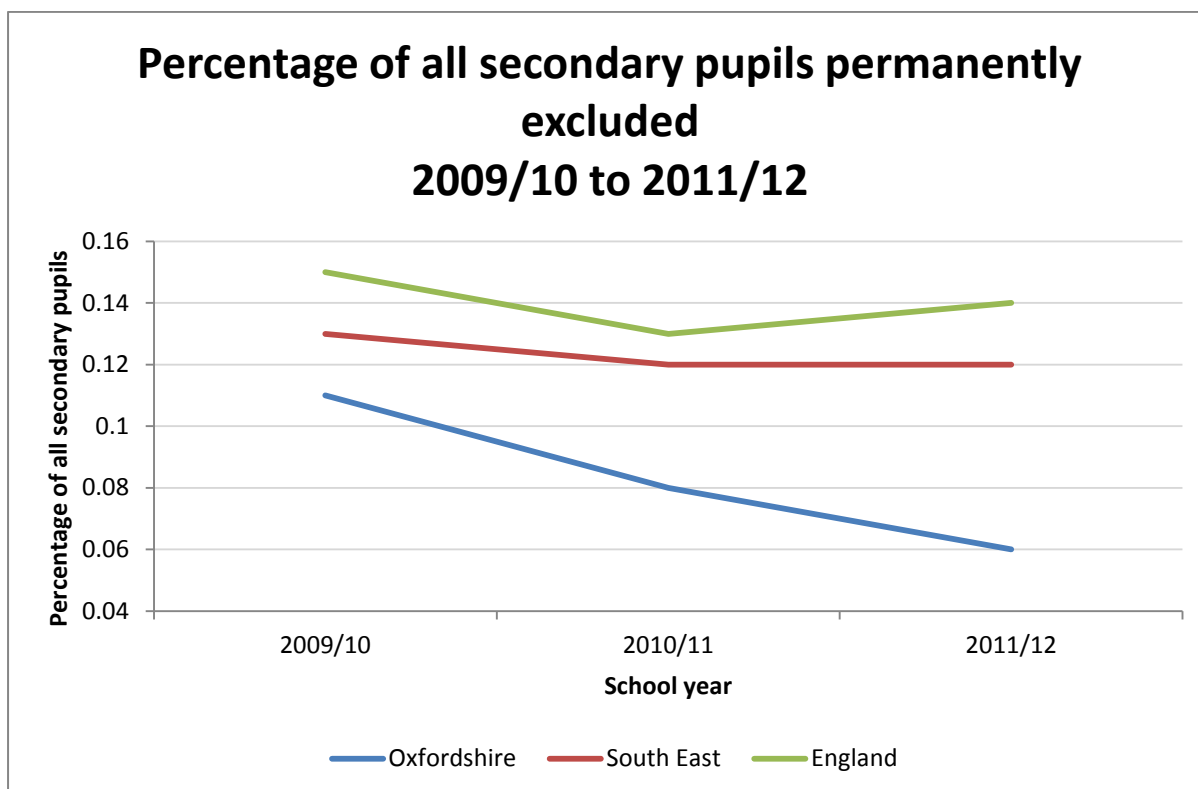
Source: Outcomes for Children Looked After for Local Authorities, Table LA10, Department for Education, 2 April 2014 release

<sup>64</sup> *Persistent absence: government changes definition to deal with reality of pupil absenteeism in schools*, Department for Education, July 2011.

<sup>65</sup> For 2009 to 2012 (academic years 2008/09 to 2011/12) absence data was only collected for 5 half terms. In 2013 (academic year 2012/13) absence data started to be collected for the 6th half term

<sup>66</sup> This is the percentage of children looked after continuously for at least 12 months at 31 March, aged 5-15 at the start of the academic year (31 August) and had a valid Unique Pupil Number (UPN) recorded in the SSDA903 return

<sup>67</sup> The number of children looked after continuously for at least 12 months at 31 March who were aged 5-15 at the start of the academic year (31 August) and were matched to absence data in the School Census. This is the denominator for persistent absentees



Source: Department for Education

\*In 2011 The Department for Education reduced the threshold at which a pupil is defined as “persistently absent” to 15%, down from 20%.

Pupils with special educational needs missed more school through absence compared to those without special educational needs.

Nationally at primary schools, pupils with statements of special educational needs had the highest overall absence rate (7.3%), while at secondary schools, pupils at School Action Plus had the highest rate (11.5%)<sup>68</sup>.

Pupils eligible for Free School Meals (FSM) have consistently had higher rates of authorised and unauthorised levels of absence than pupils not eligible for FSM. Persistent absentee rates among FSM pupils are 2.5 times that seen in non-FSM pupils<sup>69</sup>.

#### 6.4. Young People not in Education or Employment

The majority of young people succeed in education and make a positive transition into adult life and the job market. Unfortunately a small proportion do not make this transition successfully, and become NEET (Not in Education or Employment).

As of end December 2013 4.8% of year 12-14s in Oxfordshire that were classed as being NEET. There are several reasons why young person is being classified as a

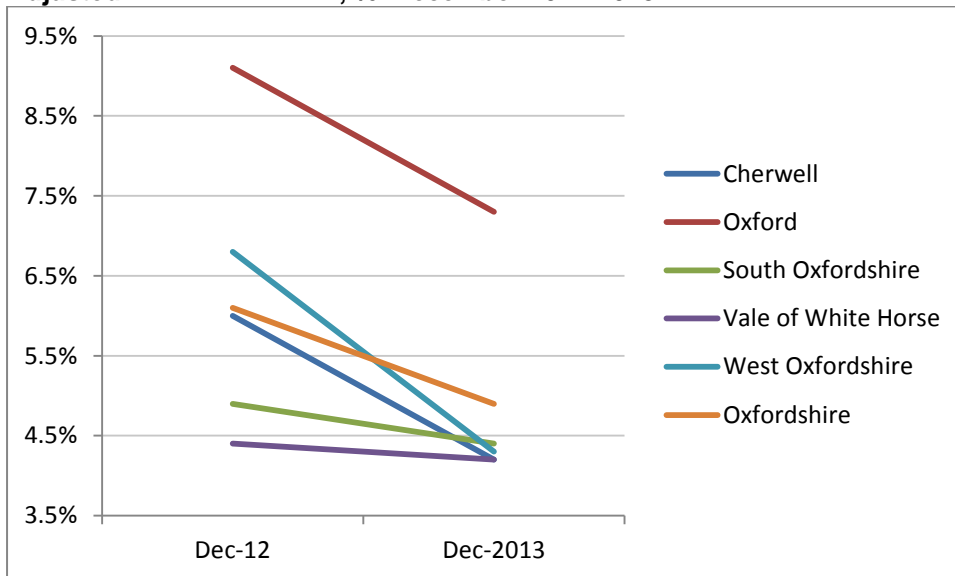
<sup>68</sup> *Children with Special Educational Needs 2012: An Analysis*, www.gov.uk.

<sup>69</sup> *A profile of pupil absence in England*, Education Standards Analysis and Research Division, Department for Education,

NEET. As for the December 2013 the most common reasons in Oxfordshire were as follows:

- Seeking employment, education or training, of which 17% live in Cherwell, 31% in Oxford City, 22% in South Oxfordshire, 21% in Vale and 9% in West Oxfordshire).
- Not available to labour market/learning – illness/pregnancy/parent/ unlikely ever to be economically active make 10% of NEETs.

**Adjusted NEET Yr. 12 – 14, %, December 2012-2013.**

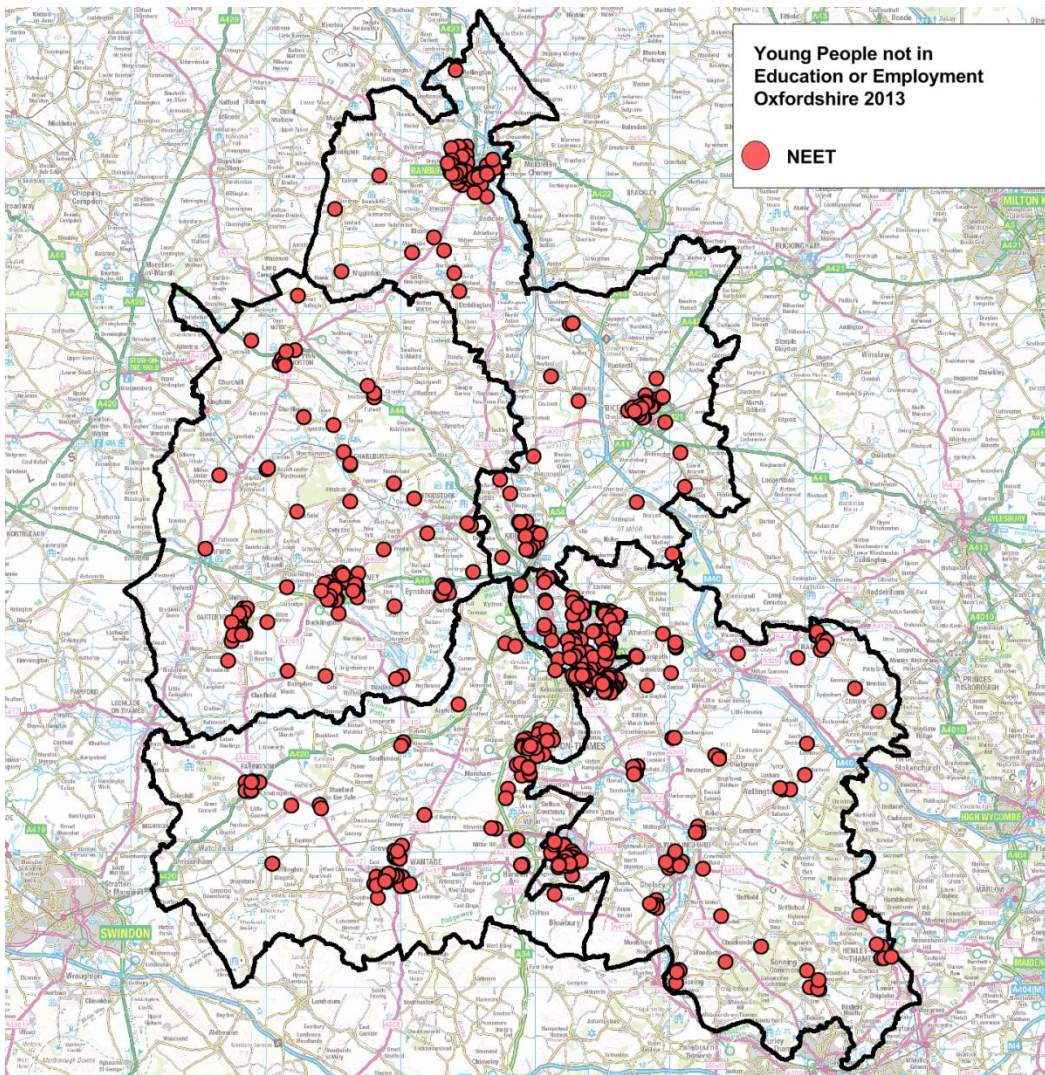


Source: Oxfordshire County Council, Education and Early Intervention Team

**Table 23.**

Actual Not In Learning Yr. 12 - 14 %		
	Dec-12	Dec-13
Oxfordshire	24.3%	13.0%
Cherwell	26.9%	14.0%
Oxford	30.6%	14.4%
South Oxfordshire	22.2%	11.9%
Vale of White Horse	14.7%	11.9%
West Oxfordshire	27.1%	12.6%

Source: Oxfordshire County Council, Education and Early Intervention Team



Source: Oxfordshire County Council, Education and Early Intervention Team

The above map represents the location of NEETs, mainly clustering around Banbury and South-East Oxford (in line with the largest centres of young people in the population), but present across the county. Some areas experiencing the highest numbers of NEETs are also in top 20% the most deprived LSOAs in the country.

## 7. INFORMATION SOURCES AND CONTACT

### Information Sources

Where possible the sources of data contained within this document have been referenced at the appropriate point. There are a number of significant repositories of data for those wishing to seek specific data points and check the most recent figures. These include:

Oxfordshire Insight: <http://insight.oxfordshire.gov.uk>

Public Health Outcomes Framework: <http://www.phoutcomes.info/public-health-outcomes-framework>

Neighbourhood Statistics: <http://www.neighbourhood.statistics.gov.uk/dissemination/>

The Oxfordshire County Council Research and Intelligence Team also provide an enquiry service for council staff and local partners seeking data and analysis. Queries can be submitted by e-mail to [observatory@oxfordshire.gov.uk](mailto:observatory@oxfordshire.gov.uk).

### Contact

The Children's Needs Analysis is held by the Research and Intelligence Team. Suggested revisions, updates to data, and requests for clarification, should be submitted to

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01865 896163