APPENDIX C

RUTLAND JOINT STRATEGIC NEEDS ASSESSMENT 2018

CHILDREN AND YOUNG PEOPLE - STAYING SAFE AND HEALTHY

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FOREWORD

The purpose of the Joint Strategic Needs Assessment (JSNA) is to:

- To improve the health and wellbeing of the local community and reduce inequalities for all ages.
- To determine what actions the local authority, the local NHS and other partners need to take to meet health and social care needs, and to address the wider determinants that impact on health and wellbeing.
- To provide a source of relevant reference to the Local Authority, Clinical Commissioning Groups (CCGs) and NHS England for the commissioning of any future services.

The Local Authority and CCGs have equal and joint statutory responsibility to prepare a Joint Strategic Needs Assessment (JSNA) for Rutland, through the Health and Wellbeing Board. The Health and Social Care Act 2012 amended the Local Government and Public Involvement in Health Act 2007 to introduce duties and powers for Health and Wellbeing Boards in relation to JSNAs.

The JSNA has reviewed the population health needs for the people of Rutland in respective of a person's child and teenage years. This has involved looking at the determinants of health, the health needs of this population in Rutland, the impact of services, the policy and guidance supporting young children, and the existing services and the breadth of services that are currently provided. The unmet needs and recommendations that have arisen from this needs assessment are discussed.

The JSNA offers an opportunity for the Local Authority, CCG and NHS England's plans for commissioning services to be informed by up to date information on the population that use their services. Where commissioning plans are not in line with the JSNA, the Local Authority, CCG and NHS England must be able to explain why.

EXECUTIVE SUMMARY

- In 2016/17, the proportion of pupils residing in Rutland with excess weight (classified as overweight or obese) in Year 6 (aged 10-11 years) (25.4%) was better than the national percentage (34.2%); this has been the case for four of the last six years. In contrast, the prevalence of overweight and obese Reception pupils in Rutland (24.0%) is similar to the England average (22.6%), and has increased each year for the last three years.

- Compared to last year, the prevalence of excess weight in Year 6 children in Rutland improved from 31.4% to 25.4%; this equates to a reduction in 20 pupils in the authority classified with excess weight. Whilst the proportions of both overweight and the obese categories fell between 2015/16 and 2016/17, the statistical significance of overweight pupils has remained similar to England, whereas the statistical significance of obese pupils became significantly better than the national average. The proportion of obese pupils in Year 6 in Rutland is 11.3%; this is the best performing percentage nationally.

- The rate of under 18 conceptions in Rutland has shown a significant decline in line with national and since 2013, has remained significantly better than the national rate.

- Rutland continues to perform significantly worse than the national percentage for proportion of the population aged 15-24 screened for chlamydia. Meanwhile in 2017, Rutland continues to perform significantly worse than the benchmarked goal rate of 1,900-2,300 per 100,000 population for chlamydia detection rate for 15-24 years olds but has seen a year on year increase since 2015.

- Regular drinking is defined as consuming an alcoholic drinking at least once a week. 7.0% of 15 year olds in Rutland said they were drinking regularly, similar to the England value of 6.2%. Meanwhile, 20.6% of 15 year olds in Rutland said they had been drunk in the last 4 weeks. This is worse than the England value of 14.6%.

- Rutland has a lower level of estimated prevalence of mental health disorders in children aged 5-16 years compared to England. In 2015, the estimated prevalence in Rutland was 8.2%, compared to 9.2% nationally.

CONTENTS

List of Tables

List of Figures

1. Who is at risk?

There are many factors that influence the health and care needs of a child during their pre-school years. This is a vital time for development of a child whether that be physically, emotionally or socially, and many of the factors influencing a child's health at this time can have an impact on their later life.

1.1 Children in poverty

The Marmot Review (2010) suggests there is evidence that childhood poverty leads to premature mortality and poor health outcomes for adults. It therefore follows that reducing the numbers of children who experience poverty should improve adult health outcomes and increase healthy life expectancy.**Error! Bookmark not defined.**

Under the Child Poverty Act 2010, a household is said to be in relative poverty when their income is less than 60% of the current median income. This figure stands at 18.4% before housing costs have been considered.

Rutland are positioned within the 25 local authorities with the lowest levels of child poverty across the UK.

Table 1: Top 25 local authorities with the lowest levels of child poverty across the UK[1]

Local authority	% of children in poverty 2017 (after housing costs)
Isles of Scilly	5.17%
Shetland Islands	9.39%
Wokingham	10.76%
Hart	11.17%
South Northamptonshire	11.79%
Mole Valley	12.08%
Waverley	12.49%
South Oxfordshire	12.50%
Aberdeenshire	12.59%
Rushcliffe	12.89%
Ribble Valley	12.90%
South Cambridgeshire	13.07%
Uttlesford	13.17%
Harborough	13.34%
Mid Sussex	13.37%
West Oxfordshire	13.39%
Elmbridge	13.44%
Rutland	13.52%
Epsom and Ewell	13.56%

Surrey Heath	13.56%
Horsham	13.94%
Chiltern	14.06%
Winchester	14.08%
West Berkshire	14.27%
Fareham	14.27%

1.1.1 Homelessness

Homelessness often equates to severe poverty which is a social determinant of health. As a result, homeless children are often the most vulnerable in society.

Family homelessness (applicant households eligible for assistance (1996 Housing Act) unintentionally homeless and in priority need) in 2016/17 was 1.9 per 1,000 households for England, and 1.6 per 1,000 households for the East Midlands. Rutland's rate was 1.2 per 1,000 households (19 households) which is significantly better than the England value.[2]

1.1.2 Low income families

Low income families are those in receipt of out of work benefits or tax credits where the families' reported income is less than 60% median income.

In 2015, 7.2% of children under 16 years were in low income families (430 children). This is better than the England value of 16.8%.[3] In 2017, 4.6% of children attending state-funded schools in Rutland were eligible and claiming free school meals (256 children). This value is better than the England value of 13.9%. [2]

1.2 Children in Need

In Rutland in 2016/17, 504 children under the age of 18 were classified as children in need. This equates to a rate of 573 per 10,000 population. This is significantly better than the England average value of 612 per 10,000 population.[4]

Of those in need 71.7% were defined as in need due to abuse/neglect or family dysfunction. This is significantly worse than the England average value of 68.3%.[4]

Of those children in need, 21 children (a rate of 27.2 per 10,000 population) were defined as in need due to child disability or illness in Rutland in 2017. This is similar to the England value of 31.2 per 10,000 population.[4]

Self-harm was identified as risk in 4.5% of assessments of children in need, slightly higher than the national average of 4.1% during 2016/17.[4]

1.3 Special Educational Needs

In Rutland in 2017, there were 347 pupils of primary school age with special educational needs (SEN). This is 11.9% of the total number of pupils and is lower than the East Midlands proportion of 12.7% and the England proportion of 13.8%.[4]

For secondary schools, there were 374 pupils with special educational needs. This is 14.0% of the total number of pupils and is higher than the East Midlands proportion of 11.7% and the England proportion of 12.3%.[4]

Percentages of children receiving SEN support in Rutland have risen significantly from 8.5% in 2015 to 13% in 2018. The rate of SEN support is now ranked third in the East Midlands (of 9 authorities) having been lowest from 2009 to 2015.[4]

1.4 Children Looked After

In Rutland on 31 March 2017, 40 children under the age of 18 were classified as looked after. This equates to a rate of 51.8 per 10,000 population. This is significantly better than the England average value of 62.0 per 10,000 population. The rate of Children Looked After (CLA) per 10,000 children for Rutland has increased over the last five years from 40 per 10,000 in 2012 to 52 per 10,000 in 2017. The increase in the rate over the last five years has been greater for Rutland than for the national and regional comparators, with only a small increase regionally and the national figure remaining static over the last four years. This means that the increase over the last six years has brought Rutland's rate of CLA proportionate to its local population much closer to the regional and national pictures.

Rutland has the lowest number of CLA of any local authority in England; no other local authority has fewer than 100 CLA – Wokingham is the next smallest with 110 – and the average for a local authority is 649 children (average for all authorities over the last 5 years).

In 2017, 96.0% of eligible looked after school aged children (22 children) had an emotional and behavioural health assessment. This is higher than the England average value of 76.0%. The proportion of eligible children considered 'of concern' in 2016/17 was 59.0% (13 children). This is worse than the England value of 38.0%.[4]

In 2016/17, the rate of children leaving care for Rutland was 25.9 per 10,000 population. This is significantly lower than the England average value of 26.5 per 10,000 population.

1.4.1 Health Assessments

Under the performance assessment framework, local authorities in England are monitored on the uptake of annual health checks for children who were being 'looked after'. Children who have been

looked after for 12 or more months are expected to have a health assessment. The health checks are a key tool in ensuring the health needs of all looked after children are identified. Initial and annual health assessments are important to ensure prompt identification of pre-existing, emerging and changing health needs.

In 2017, 96.0% of eligible looked after school aged children (22 children) had an emotional and behavioural health assessment. This is higher than the England average value of 76.0%. The proportion of eligible children considered 'of concern' in 2016/17 was 59.0% (13 children). This is worse than the England value of 38.0%.[4]

In 2017, 100.0% of looked after children under the age of 5 in Rutland (6 children) had up-to-date development assessments, and 100.0% of looked after children under the age of 18 (29 children) had an annual health assessment.[4]

1.5 Safeguarding of children

In Rutland at the end of March 2017, 20 children were subject to a child protection plan. This equates to a rate of 25.9 per 10,000 population. This is lower than the England average value of 43.3 per 10,000 population.

In Rutland during 2016/17, there were 32 new child protection cases for children aged less than 18 years of age. This is a rate of 46.6 per 10,000 population. This is similar to the England rate of 56.3 per 10,000 population. Meanwhile, in Rutland, 36.1% of children aged under 18 years of age (13 children) became subject of a child protection plan for a second or subsequent time. This is higher than the England value of 18.7%.[4]

1.6 Trilogy of Risk (aka Toxic Trio)

The term 'Trilogy of Risk' has been used to describe the issues of domestic abuse, mental ill-health and substance misuse which have been identified as common features of families where harm to adults and children has occurred. They are viewed as indicators of increased risk of harm to children and young people.

For detailed data on the Trilogy of Risk and its impact for Rutland children and young people please refer to the previous Toxic Trio Needs Assessment (2016), which will be updated in the latter part of 2018.[5]

1.7 Child Sexual Exploitation

Child sexual exploitation (CSE) is a type of sexual abuse. Children in exploitative situations and relationships receive something such as gifts, money or affection as a result of performing sexual

activities or others performing sexual activities on them.

Rutland has clear processes in place for addressing CSE aligned to the Local Safeguarding Children's Board and led locally by Children's Social Care.

There is no specific crime of child sexual exploitation. Offenders are often convicted for associated offences such as sexual activity with a child, and therefore it is not possible to obtain specific figures from statistics of sexual exploitation offences. National data suggests that almost 560 children were trafficked for sexual exploitation in 2017 under the National Referral Mechanism of the National Crime Agency.

The National Referral Mechanism is a victim identification and support process that is designed to make it easier for all the different agencies involved in a modern slavery case (for example, the police, UK Visa and Immigration, local authorities and non govermental organisations) to cooperate, share information about potential victims and facilitate their access to advice, accommodation and support.

In 2017 the National Referral Mechanism (NRM) received a total of 5,145 referrals of potential victims of trafficking. 2,118 (41%) were children under the age of 18. The most prevalent exploitation types for children believed to have been trafficked were labour exploitation (1,026, 48% of all children believed to have been trafficked) and sexual exploitation (559, 26%). The exploitation type of 414 (20%) of children believed to have been trafficked was recorded as unknown.[6]

These figures are likely to be under-estimates due to the difficulties in recognising and understanding that individuals have been victims of trafficking. It is also not mandatory for a professional to make a referral to the NRM.[6]

1.8 Education

A child's performance in school is a key indicator of their development. In addition to exam-related performance, engagement in other activities can provide opportunities to enhance a pupil's mental wellbeing. For more information on education, please refer to the 'Achieving Educational Potential' JSNA Chapter.

1.9 Youth Justice

It is common for children and young people who enter the youth justice system to have more unmet health needs than other children.

The combined figure for Leicestershire and Rutland for children who have formally entered the youth justice system was 2.5 per 1,000 children aged 10-18 years in 2016/17. This is better than the England value of 4.8 per 1,000 children.[7]

Meanwhile, the combined figure for Leicestershire and Rutland for first time entrants in the youth justice system was 163.4 per 100,000 children aged 10-17 years in 2016. This is better than the England value of 327.1 per 100,000 children.[7]

Numbers of children and young people from Rutland who access the Youth Offending Service are extremely low and consequently the data is suppressed. The numbers have remained consistent over the past three years.

1.10 Young Carers

In 2011, 60 children aged less than 15 years in Rutland provided 1 or more hours of unpaid care per week. This is 0.9% of the total number of children aged less than 15 years. This is similar to the England proportion of 1.11%.[7]

Three children aged less than 15 years in Rutland provided 20 or more hours of unpaid care per week. This is 0.04% of the total number of children aged less than 15 years. This is better than the England proportion of 0.21%.[2]

In 2011, 146 young people aged 16-24 years in Rutland provided 1 or more hours of unpaid care per week. This is 3.6% of the total number of children aged 16-24 years. This is better than the England proportion of 4.8%.[2]

Meanwhile, 19 young people aged 16-24 years in Rutland provided 20 or more hours of unpaid care per week. This is 0.5% of the total number of children aged less than 16-24 years. This is better than the England proportion of 1.3%.[2]

The number of new young carers referred for assessment to children's social care was 9 in 2015-16, 26 in 2016-17 and 21 in 2017-18. The total number of young carers receiving support was 42 in 2015-16, 56 in 2016-17 and 65 in 2017-18.[4]

1.11 Household Issues

Households experiencing issues may have a negative impact on the quality of a child's housing and health.

1.11.1 Lone parent households

714 households in Rutland in 2011 had a lone parent with dependant children. This is 4.8% of the total number of households and is lower than the England proportion of 7.1%.[8]

1.11.2 No parents in employment

235 households in Rutland in 2011 had dependent children but no adult in employment. This is 1.6% of the total number of households and is lower than the England proportion of 4.2%.[7]

1.11.3 Long-term health problem

In 2011 there were 456 households in Rutland which had dependent children and at least one person (which could be an adult or a child) with a long-term health problem or disability. This is 3.04% of the total number of households and is lower than the England proportion of 4.62%.[7]

1.12 Risky Behaviours

Risky behaviours are those behaviours that are unhealthy as well as some which are illegal. As part of the 'What About YOUth' survey, 15 year olds were surveyed with respect to their lifestyle behaviours. The survey took place in 2014/15 and the unweighted base was 137 respondents in Rutland.

In Rutland, 17.9% of 15 years olds reported having undertaken at least three of the following unhealthy behaviours: smoking, drinking, smoked cannabis, took other drugs, consumed fewer than five portions of fruit and vegetables, not active for 60 minutes or more in the week prior to the survey. Rutland's value is similar to the England proportion of 15.9%. [9]

2. Level of need in Rutland

In 2016, Rutland's population of 5-19 year olds was estimated to be a total of 6,752 (3,205 females and 3,547 males). This is projected to increase by 6.6% to around 7,200 by 2039.[10]

Further information regarding Rutland's population can be seen in the JSNA Population chapter here: **Add link once published**

2.1. Child mortality

Deaths in children after their first birthday are mostly due to injuries and are therefore usually preventable. The mortality rate for children aged 1-17 years cannot be calculated for Rutland as there were only 3 deaths in this age group during 2014-16.[2] Since 2010-12, the highest number of child deaths in a three year time period was 3.

2.2. Excess Weight

Excess weight in children can lead to excess weight into adulthood. Childhood obesity can lead to health problems such as: 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.

In 2016/17, the proportion of pupils residing in Rutland with excess weight (classified as overweight or obese) in Year 6 (aged 10-11 years) (25.4%) was better than the national percentage (34.2%); this has been the case for four of the last six years. In contrast, the prevalence of overweight and obese Reception pupils in Rutland (24.0%) is similar to the England average (22.6%), and has increased each year for the last three years.[11]

Compared to last year, the prevalence of excess weight in Reception children in Rutland has increased from 22.9% to 24.0%; this equates to an increase in four pupils in the authority classified with excess weight. This is mainly due to the increase in the prevalence of obese Reception pupils from 7.7% to 8.8%. However, the prevalence of overweight pupils in Reception remained reasonably stable at 15.2%.[11]

In contrast, the prevalence of excess weight in Year 6 children in Rutland improved from 31.4% to 25.4%; this equates to a reduction in 20 pupils in the authority classified with excess weight. Whilst the proportions of both of the overweight and the obese categories fell between 2015/16 and 2016/17, the statistical significance of overweight pupils remained similar to England, whereas the statistical significance of obese pupils became significantly better than the national average. The proportion of obese pupils in Year 6 in Rutland is 11.3%, this is the best performing percentage nationally.[11]

Compared to the national picture in 2016/17, the gap narrowed between the difference in prevalence of excess weight in Reception and Year 6 children in Rutland, and currently stands at +0.9 percentage points. In 2014/15 to 2015/16, this gap increased (+2.1, +8.4).

Most demographic groups demonstrated a higher proportion to England with regards to excess weight amongst Reception pupils in 2016/17. Whilst the biggest differences between the authority and the national average were found in the overweight category rather than the obese category, the proportion of obese Reception pupils appears to have been rising over the last three years at a quicker rate than the proportion of overweight pupils. In contrast, the corresponding proportions of overweight pupils in Year 6 were similar to the England average across different demographic groups, and the proportion of excess weight was significantly lower amongst a number of Year 6 demographic groups.

Although there was little evidence of an association between level of deprivation and prevalence of excess weight in either Reception or Year 6, the prevalence of excess weight in Reception in the least deprived areas of Rutland (IMD decile 10) has increased year on year since 2013/14, and has been (non-significantly) higher than the England average and Rutland average for the last three years.

2.2.1. Body perception

In Rutland in 2014/15, the percentage of 15 year olds who thought their body was the right size was 52.5%. This is similar to the England value of 52.4%.[9] Over a third (35.9%) of respondents from Rutland felt they were too fat and 11.6% felt they were too thin. This is similar to the national percentages of 34.4% and 13.2% respectively.[9]

2.3. Physical activity

Regular exercise is beneficial to health. In addition to physical benefits, there are psychological benefits, such as reduced anxiety and depression. Over two-thirds (68.7%) of 15 year olds said they had about 7 or more hours of sedentary behaviours in their free time on a weekday in the previous week. This is better than the England value of 70.1%.[9] Furthermore, 8.6% of 15 year olds said they were physically active for at least an hour per day, 7 days a week. This is worse than the England value of 13.9%.[9]

2.4. Smoking

Smoking in early adulthood is likely to impact on the health and health behaviours later in life. Smoking is known to cause preventable morbidity and premature death.

As part of the 'What About YOUth' survey, 15 year olds were surveyed with respect to their lifestyle behaviours. The survey took place in 2014/15. Regular smokers are those that said they smoked at least one cigarette a week. 4.5% of 15 years in Rutland said they were regular smokers. This is similar to the England value of 5.5%.[9]

Occasional smokers are those that said they sometimes smoked, but not as many as one a week. 5.0% of 15 year olds in Rutland said they were occasional smokers. This is statistically similar to the England value of 2.7%.[9]

13.1% of 15 year olds said they had tried other tobacco products. This is similar to the England value of 15.2%.[9] 15.2% of 15 year olds said they had tried e-cigarettes. This is similar to the England value of 18.4%.[9]

2.5. Tooth decay

Oral health problems in children are largely preventable. Oral health is an important aspect of a child's overall health status and is seen as a marker of wider health and social care issues, including poor nutrition and obesity. A combination of healthy diet and practising good dental hygiene can help to ensure a child has healthy teeth and gums.

2.5.1. Five year olds

In England, 23.3% of five-year-old children had experience of obvious dental decay (caries), having one or more teeth that were decayed to dentinal level, extracted or filled because of caries (%d3mft>0) in 2016/17. d3mft is the standard measure of dental decay and refers to teeth that are decayed, missing and/or teeth with fillings. In Rutland, the percentage of children with obvious dental decay is significantly better than the national average at 15.6%. From 2014/15 to 2016/17 there has been a significant improvement in the percentage of children with obvious dental decay (%d3mft>0) in Rutland (28.8% to 15.6%).[12]

In England, the average (mean) number of teeth per child affected by decay (decayed, missing or filled teeth (d3mft)) was 0.8. In Rutland, the average number of teeth per child affected by d3mft was 0.4, half the national average. From 2014/15 to 2016/17 there has been a significant improvement in the average number of decayed teeth per child in Rutland (0.7 to 0.4).[12]

Among the children with decay experience, the average number of decayed, missing (due to decay) or filled teeth (mean d3mft (% d3mft>0)) in England is 3.4. At upper-tier local authority level there is clear variation of this measure with affected children in Rutland and Wiltshire having only 2.3 teeth affected on average, while those in Harrow had 4.8.[12]

The presence of substantial amounts of plaque compared with 'visible' or no plaque provides a proxy measure of children who do not brush their teeth, or brush them rarely. Such children cannot benefit from the protective effects of fluoride in toothpaste on dental decay. A 'substantial amount of plaque' was recorded for 1.5% of volunteers in England compared to 0.0% in Rutland.[12]

At the age of five-years, nearly all oral sepsis will be the result of the dental decay process rather than originating from gum problems. A small number of cases will be linked to traumatic injury of teeth, but no diagnosis of cause was recorded during this survey. Oral sepsis was defined in the protocol as the presence of a dental abscess or sinus recorded by visual examination of the soft tissues. Oral sepsis was recorded for 1.1% of volunteers in England and 0.0% of volunteers in Rutland.[12]

It is useful to know what proportion of children had dental decay affecting one or more of their incisor (front) teeth. This type of decay is usually associated with long term bottle use with sugar-sweetened drinks, especially when these are given overnight or for long periods during the day. Overall, the national prevalence of incisor decay was 5.1%. In Rutland the percentage was 1.3%.[12]

2.5.2. Twelve year olds

The latest data available for 12 year olds was compiled in 2008/9: 12 year olds in Leicestershire and Rutland had an average of 0.85 decayed, missing or filled teeth. This is similar to the England value

of 0.74. For the same time period, 58.1% of 12 years olds in Leicestershire and Rutland were free from dental decay. This is worse than the England proportion of 66.4%.[13]

2.6. NHS Dentistry

2.6.1. Access

A 12 month time period is used for access reporting to reflect National Institute for Health and Care Excellence (NICE) guidelines which recommend that the longest interval between oral reviews for children should be 12 months.[14] In Rutland, 5,324 children saw an NHS dentist in the 12 months to 30 June 2017, representing 69.0% of all children resident in the county. Nationally the percentage was 58.2%.[15]

When examining by five year age bands, Rutland has a higher access percentage than the national average for 0-4 and 5-9 years. At 10-14 and 15-19 years, Rutland has a lower access percentage than the national average.[16]

2.6.2. Activity

NHS dental treatment is divided into patient charge bands depending on the level and complexity of treatment provided. Patient charge bands are associated with a Course of Treatment (CoT) as stated in Part 5 Treatment Category of the FP17. Dental care providers submit details of their activity on an FP17 form. There are three standard charge bands for all NHS dental treatments:

- Band 1 course of treatment: covers an examination, diagnosis (including X-rays), advice on how to prevent future problems, a scale and polish if needed, and application of fluoride varnish or fissure sealant.

- Band 2 course of treatment: covers everything listed in Band 1 above, plus any further treatment such as fillings, root canal work or removal of teeth.

- Band 3 course of treatment: covers everything listed in Bands 1 and 2 above, plus crowns, dentures and bridges.

- Urgent care is a separate Band 1 category.

In Rutland, there were 9,136 CoT delivered to children in 2016/17. Of these CoTs, 79.0% (7,221) were Band 1 treatments indicating children are more likely to receive a general check-up than correctional treatments. Aside from examinations, fluoride varnish was the most common Band 1 treatment provided to children, with 2,343 CoTs delivered. This represents a 66.3% increase (1,409) from 2015/16.[1517] Between 2014/15-2015/16 a quarter (25.0%) of FP17 claims for children in Rutland included fluoride varnish. Nationally, fluoride varnish represents a third of all treatment

types in this time period.[16]

The most common Band 2 treatment provided to children was permanent fillings and sealant restorations with 1,181 CoTs delivered. This represents a 7.9% decrease (1,282) from 2015/16. 'Other treatment' accounted for the most common Band 3 treatment for children in Rutland with 24 CoTs delivered.[1517]

2.7. Road traffic accidents

Vehicle speed and traffic volumes are seen as reasons why parents are wary of their children walking and cycling. By limiting walking and cycling, physical activity is limited.

During 2014-16, one child aged 6-10 years was killed or seriously injured in a road traffic accident in Rutland. This equates to a rate of 16.9 per 100,000 population and is similar to the England rate of 14.8 per 100,000 population.[2]

The crude rate of children aged 0-15 years killed or seriously injured in a road traffic accident during 2014-16 was 5.1 per 100,000 population (1 child). This is similar to the England rate of 17.1 per 100,000 population.[2] In the previous time period of 2013-15, one child was also killed or seriously injured in a road traffic accident.

2.8. Sexual Health

2.8.1. HPV Vaccination

Vaccination to protect against the main cause of cervical cancer is offered as part of the human papillomavirus (HPV) immunisation programme. It is a two dose programme that is given to females in Year 8 and Year 9 of school.

The population vaccination coverage for females having received one dose of the HPV vaccine at 12 or 13 years old was 88.8% in 2016/17. This is similar to the benchmarked target range of 80% to 90%. Rutland has shown an increase when compared to the previous year, where the coverage was 86.6%. The national coverage increased slightly compared to the previous year to 87.0%.[3]

Meanwhile, the population vaccination coverage for females having received two doses of the HPV vaccine at 13 or 14 years old was 75.8% for in 2016/17. This is worse than the benchmarked target range of 80% to 90%. Rutland has shown a decrease since the previous year where the coverage was 85.2%, which was similar to the national benchmark (80%-90%).[3]**Error! Bookmark not defined.**

2.8.2. Teenage pregnancy

Teenage pregnancies are largely unplanned and about half end in an abortion. Having a child at an

early age can be detrimental to both the teenage parent and child – in terms of the baby's health, the mother's emotional health and wellbeing and the likelihood of parent and child living in long-term poverty.

2.8.2.1. Conceptions

The rate of under 18 conceptions in Rutland has shown a significant decline in line with national, and since 2013, has remained significantly better than the national rate. In 2016, there were 4 conceptions for girls aged 15-17 years in Rutland. This equates to a rate of 4.7 per 1,000 females aged 15-17 years. This is better than the England rate of 18.8 per 1,000 females aged 15-17 years.[18]**Error! Bookmark not defined.**

2.8.2.2. Deliveries

Factors relating to the mother and method of delivery of a newborn child can have an influence on the health needs of a child.

A child's long-term health can be impacted on as follows: children born to teenage mothers have 60% higher rates of infant mortality and are at increased risk of low birthweight. The mental health effects for a teenage mother are that they are three times more likely to suffer from post-natal depression and experience poor mental health for up to three years after the birth – this may impact on the child's health and development. Living in poverty, is also an increased risk for teenage parents and their children.

In 2015, the number of births to mothers aged 15-17 years of age in Rutland was 3, a rate of 3.4 per 1,000 females aged 15-17 years of age. This is similar to the England value of 6.3 per 1,000 females aged 15-17 years of age.[18]

2.8.3. Chlamydia

Chlamydia is known to cause avoidable sexual problems – such as infections, pelvic inflammatory disease, ectopic pregnancy and tubal-factor infertility. The National Chlamydia Screening Programme recommends annual screening or on change of partner, whichever is more frequent.

Rutland continues to perform significantly worse than the national percentage for proportion of the population aged 15-24 screened for chlamydia. The percentage has decreased from 18.6% in 2016 to 16.2% in 2017, which equates to a decrease of 109 screenings in Rutland in 2017. Nationally the percentage screened has also decreased from 21.0% in 2016 and 19.3% in 2017. [18]

Meanwhile, in 2017 Rutland continues to perform significantly worse than the benchmarked goal rate of 1,900-2,300 per 100,000 population for chlamydia detection rate for 15-24 years olds, but has seen a year on year increase since 2015. In Rutland the chlamydia detection rate increased

(improved) from a rate of 1,461 per 100,000 population aged 15-24 years in 2016 to 1,614 per 100,000 population aged 15-24 years in 2017.[18]

Like nationally, the chlamydia detection rate in females in Rutland is higher than in males, however, the difference in rate between males and females in Rutland is much smaller compared to nationally. Locally, males have seen a year on year increase in the detection rate since 2015 whereas in females, the rate has been declining throughout this time.

2.9. Substance misuse

2.9.1. Alcohol

Alcohol consumption in teenagers is associated with risky behaviour, particularly in respect of sexual activity and the likelihood of teenage pregnancy and contracting a sexually transmitted infection. Research has also suggested that people drinking at an early age drink more frequently and more in total. They are therefore more likely to develop alcohol problems in adolescence and adulthood. For this reason, the Chief Medical Officer for England recommended that under 15s should not drink alcohol at all.

As part of the 'What About YOUth' survey, 15 year olds were surveyed with respect to their lifestyle behaviours. The survey took place in 2014/15. In Rutland, 74.4% of 15 years olds said they had had an alcoholic drink. This is worse than the England value of 62.4%.[9]**Error! Bookmark not defined.**

Regular drinking is defined as consuming an alcoholic drinking at least once a week. 7.0% of 15 year olds in Rutland said they were drinking regularly. This is similar to the England value of 6.2%.[9]**Error! Bookmark not defined.** Meanwhile, 20.6% of 15 year olds in Rutland said they had been drunk in the last 4 weeks. This is worse than the England value of 14.6%.[9]**Error! Bookmark not defined.**

The rate of hospital admissions for people aged under 18 years due to alcohol-specific conditions during 2014/15 - 16/17 are not available for Rutland as the numbers are too small.[19]

2.9.2. Drugs

The usage of recreational drugs by young people can lead to mental health issues such as suicide, depression and disruptive behaviour disorders.

As part of the 'What About YOUth' survey, 15 year olds were surveyed with respect to their lifestyle behaviours. The survey took place in 2014/15. In Rutland, 10.8% of 15 year olds had tried cannabis; this is similar to the England value of 10.7%. In comparison, 2.7% had taken cannabis in the last month. This is also similar to the England value of 4.6%.[9] 0.9% of 15 year olds in Rutland had taken other drugs in the last month. This is similar to the England value of 0.9%.[20]

The rate of hospital admissions for people aged 15-24 years due to substance misuse for the past three time periods has remained similar to the national average, with a constant count on 10 admissions. During 2014/15 - 16/17 for Rutland was 68.1 per 100,000 population. This is statistically similar to the England rate of 89.8 per 100,000 population.[19]

2.10. Mental health

The emotional health and wellbeing of young people can impact on their development and learning, in addition to their physical and social health.

As part of the 'What About YOUth' survey, 15 year olds were surveyed with respect to their lifestyle behaviours. The survey took place in 2014/15. The proportion of 15 year olds with low life satisfaction in Rutland in 2014/15 was 9.5%, this is better than the England value of 13.7%.[20]

Bullying in any form can impact on a person's physical and mental health. It can also impact on educational attainment and can pose a suicide risk.[9] The proportion of 15 year olds in Rutland in 2014/15 who said they had been bullied in the past couple of months was 60.2%, this is similar to the England value of 55.0%.[9]

Rutland has a lower level of estimated prevalence of any mental health disorders in children aged 5-16 years compared to England. In 2015, the estimated prevalence in Rutland was 8.2%, compared to 9.2% nationally.[21] The estimated prevalence of emotional disorders (anxiety disorders and depression) in children aged 5-16 years in Rutland in 2015 was 3.3%, lower than the England value of 3.6%.[1]

2.10.1. Eating disorders

The estimated prevalence of potential eating disorders in young people aged 16-24 years in Rutland in 2015 was 1.2%. The England value was 1.5%.[21]

2.10.2. Admissions for self-harm

Between 2012/13 and 2015/16, the rate in hospital admissions as a result of self-harm in Rutland increased year on year, peaking in 2015/16, where there were 27 admissions. In 2016/17 the rate declined and 15 young adults aged 10-24 years old in Rutland were admitted to hospital as a result of self-harm. This equates to a rate of 230.9 per 100,000 population which is better than the England rate of 404.6 per 100,000 population.[19]

2.11. Hospital attendances

Many emergency hospital admissions for children are preventable. Emergency hospital activity can be an indicator of other issues such as housing and transport, or mental health problems for the

child or their parent.

2.11.1. Accident & Emergency (A&E)

Since 2010/11, the rate of A&E attendances for children and young people in Rutland has remained significantly better (lower) than the national average. In 2015/16, there were 2,719 attendances at Accident & Emergency for children and young adults in Rutland aged 0-19 years old. This equates to a rate of 315.2 per 1,000 population and is better than the England rate of 408.5 per 1,000 population.[19]

2.11.2. Emergency admissions

In 2015/16, nationally, the highest rate of emergency admissions in children and young people were seen in the 15-19 age group, followed by the 5-9s and the 10-14s. In Rutland, the 5-9s have the highest rate, followed jointly by the 10-14s and 15-19s.

Across all age bands in 2015/16, Rutland has a significantly better (lower) rate than nationally. This equates to 58 emergency admissions for children in Rutland aged 5-9 years old, 61 emergency admissions for children in Rutland aged 10-14 years old and 77 emergency admissions for children and young adults in Rutland aged 15-19 years old.[19]

2.11.3. Admissions for injuries

In addition to being a cause of premature mortality, injuries can cause long-term health and mental health issues.

Between 2013/14 and 2015/16, the rate of admissions due to unintentional and deliberate injuries in children aged 0-14 years was significantly better (lower) than the national average. In 2016/17, the rate increased to 101.0 per 10,000 population to perform similar to the England rate of 101.5 per 10,000. This equates to 60 children aged 0-14 years in Rutland admitted to hospital due to unintentional and deliberate injuries.[19]

2.11.4. Admissions for asthma

The rate for hospital admissions for asthma has remained similar to national since 2013/14. The latest data shows in 2016/17, 10 people aged under 19 years in Rutland were admitted for asthma. This is a rate of 120.6 per 100,000 population and is statistically similar to the England rate of 202.8 per 100,000 population.[19]

3. How does this impact?

People's health and emotional wellbeing have their roots in early childhood, by providing the right level of nurture and support, where needed, at an early stage we can enable children to thrive

throughout school and into their adult lives. Caring and supportive environments that promote optimal early childhood development greatly increase children's chances of a successful transition to school. This, in turn, promotes children's chances of achieving better learning outcomes while at school and better education, employment and health after they have finished school.

£7.300 million per 10,000 children aged 0-17 years was spent on Local Authority children and young people's services (excluding education) in Rutland during 2016/17. This is lower than the England rate of £7.789 million per 10,000 children.

Of the above, £2.369 million per 10,000 children aged 0-17 years was spent on looked after children in Rutland during 2016/17. The England rate was £3.527 million per 10,000 children.

£2.310 million per 10,000 children aged 0-17 years was spent on safeguarding children and young people's services (excluding education) in Rutland during 2016/17. The England rate was £1.981 million per 10,000 children.

The planned spend on special schools in Rutland during 2017/18 was £1.282 million per 100,000 children. The England rate was £9.978 million per 100,000 children.

The expenditure on youth justice for children aged 0-17 years in Rutland during 2016/17 was £107,000 per 10,000. The England rate was £230,000 per 10,000 children.

4. Policy and Guidance

4.1. The Children and Families Act 2014

The Children and Families Act 2014 puts a much greater emphasis on bringing together support for children and young people up to the age of 25, focusing on outcomes beyond school or college. The Act also introduced major changes to support for children and young people with special educational needs (SEN), creating education, health and care (EHC) plans to replace SEN statements. Families with EHC plans are offered personal budgets for elements of their care. The Act also places a duty on local authorities to identify all children in their area who have SEN or disabilities.

The overall aim is to give families a greater involvement in decisions about their support and to encourage social care, education and health services to work more closely together in supporting those with special needs or disabilities. As part of the changes local authorities are required to publish a 'local offer' setting out what support is available to families with children who have disabilities or SEN. The local offer should also explain how families can request personal budgets, make complaints and access more specialist help. Details of Rutland's local offer can be found here: https://www.rutland.gov.uk/my-services/schools-education-and-learning/send-local-offer/

4.2. Rutland SEND and Inclusion Strategy 2017

The Council's SEND and Inclusion Strategy provides an opportunity to create a shared view of the challenges faced by children and young people. This Strategy enables the Council and other stakeholders together to identify the gaps in services, and challenge what needs to change and improve to achieve better outcomes for children and young people.

This Strategy sets out clear expectations of the Council and Clinical Commissioning Groups (CCGs), and other partners especially health and education providers, which reflects the statutory requirement under primary legislation, regulation and case law as set out in the SEND Code of Practice (2015), Section 28 Duty to Co-operate and the Local Safeguarding Board safeguarding procedures.

4.3. Future in Mind (2015)

The Department of Health and NHS England published 'Future in Mind: Promoting, protecting and improving children and young people's mental health and wellbeing' in 2015. Future in Mind sets out the Government's vision for children and young people's mental health.[22] The themes of Future in Mind include:

- Promoting resilience, prevention and early intervention
- Improving access to effective support – a system without tiers
- Care for the most vulnerable
- Accountability and transparency
- Developing the workforce

4.4. The Green Paper[23]

A Green Paper 'Transforming Children and Young People's Mental Health Provision': was published in December 2017. It builds on the government's vision for children and young people's mental health set out in Future in Mind in 2015, and provides the joint response of the Department for Health and Social Care and the Department for Education.The Paper contains three key announcements:

- To provide an incentive for every school and college to have a designated senior lead for mental health. All children and young people's mental health services should have a link for schools and colleges to better support them in delivering on child and young people mental health and wellbeing needs. They will do this through advice, consultation and signposting for children who need it.

- Funding for new mental health support teams, which will be supervised by NHS children and young people's mental health staff, to provide extra capacity for early intervention and

ongoing help.

- A four week waiting time for access to specialist NHS children and young people's mental health services will be trialled.

4.5. The Five Year Forward View for Mental Health (2016)[24]

In order to deliver on the vision set out in 2015's Future in Mind and 2016's Five Year Forward View for Mental Health, the government have:

- Legislated for parity of esteem between physical and mental health.
- Committed to make an additional £1.4 billion available for children and young people's mental health over five years.
- Committed to recruit 1,700 more therapists and supervisors, and to train 3,400 staff already working in services to deliver evidence-based treatments by 2020/21.
- Improved services for eating disorders, with, 70 new or enhanced Community Eating Disorder Teams, and the first ever waiting times for eating disorders and psychosis.
- Funded eight areas to test different crisis approaches for children and young people's mental health.

4.6. Prevention Concordat for Better Mental Health[25]

The Prevention Concordat for Better Mental Health is underpinned by an understanding that taking a prevention-focused approach to improving the public's mental health is shown to make a valuable contribution to achieving a fairer and more equitable society. The concordat promotes evidence based planning and commissioning to increase the impact on reducing health inequalities.

It represents a public mental health informed approach to prevention, as outlined in the NHS Five Year forward view and promotes relevant NICE guidance and existing evidence based interventions and delivery approaches, such as 'making every contact count'.

The Concordat seeks to prevent mental health problems from developing and to promote good health through local and national action including addressing the wider determinants of mental health and focusing on prevention. It recognises the need to build capacity and capability of the workforce to prevent mental health problems and promote good mental health. A Prevention Concordant has been adopted for the East Midlands.

4.7. Suicide Prevention: Policy and Strategy (2018)[26]

The Five Year Forward View for Mental Health recommends that all local authorities have multi-agency suicide prevention plans in place in 2017. These should target high-risk locations and support

high-risk groups, including men and people in contact with mental health services. The local plans should be reviewed annually and supported by new investment.

The LLR Suicide Audit and Prevention Group (LLR SAPG) has been brought together to tackle the cause and the impact of suicide across LLR and has developed the LLR Suicide Prevention Strategy and Plan 2017-20. This plan includes the STOP Suicide Prevention Campaign, and the development of a Suicide Prevention website.

4.8. NICE Guidance

4.8.1. Social and Emotional Wellbeing in Primary Education PH 12

This guideline covers approaches to promoting social and emotional wellbeing in children aged 4 to 11 years in primary education. It includes planning and delivering programmes and activities to help children develop social and emotional skills and wellbeing. It also covers identifying signs of anxiety or social and emotional problems in children and how to address them.[27]

4.8.2. Social and Emotional Wellbeing in Secondary Education PH20

This guideline covers interventions to support social and emotional wellbeing among young people aged 11–19 years who are in full-time education. It aims to promote good social, emotional and psychological health to protect young people against behavioural and health problems.[28]

4.8.3. Social and emotional Wellbeing Early years PH40

This guideline covers supporting the social and emotional wellbeing of vulnerable children under 5 through home visiting, childcare and early education. It aims to optimise care for young children who need extra support because they have or are at risk of social or emotional problems.[29]

4.8.4. Young People's Mental Health coalition Guidance[30]

Published in 2015 'Promoting Children and Young People's emotional health and wellbeing: a Whole School and College Approach guidance has also been included in the green paper. It includes a designated lead for mental health in a school or college who will have oversight of the whole school approach.

5. Current Services

5.1. Local Safeguarding Children's Board

Under the auspices of the Local Safeguarding Children's Board, Rutland has a clearly set out thresholds document which sets the level of type of interventions to be provided to children and young people depending on their level of need. It breaks down risk factors into developmental;

family and Environmental; and parent and carers.

5.2. "Front door" of services

The Council provides the 'front door' through which parents and professionals can access additional support at any level, including early help advice and support. This includes a multi-disciplinary holistic approach that brings a range of professional skills and expertise to bear through a "Team Around The Family" approach; a relationship with a trusted Lead Professional who can engage the child and their family, and/or co-ordinate the support needed from other agencies

The critical features of an effective Early Help Offer which have been identified nationally and on which Rutland's early help process is founded are:

The Early Help Offer recognises the crucial role that all family members – not just mothers and fathers, but step parents, grandparents, siblings and other extended family members and carers – play in influencing what children experience and achieve as well as the consequences when families are in difficulty.

The provision of early help services covers for levels of need:

Universal need - Services working with children and families, to promote positive outcomes for everyone; midwives, health visitors, schools and early year's settings, adult learning and community voluntary groups. Practitioners working in these services identify where children and families would benefit from extra help at an early stage.

Early Help and Targeted need - Services focus on children, young people and families who may need support either through a single service or through an integrated multi-agency response, for example, housing, youth options, and community safety. They work with families where there are signs that without support a child may not achieve good outcomes and fulfil their potential.

Specialist need - Services, such as social care, adult mental health services, focus on families with individual or multiple complex needs, who are at risk of significant harm or significant impairment to their health or development, including where help has been requested through Section 17 - a child in need or where a specific disability or condition is diagnosed, and Section 47 – where there is a need to investigate a significant safeguarding concern.

By law, Children's Social Care has to give priority of service to children with specific categories of need:

- Those at risk of serious harm and who may need a protection plan

- Those who are, or may need to be, looked after by Children's Social Care and are unable to remain living at home (birth to 18 years including unaccompanied asylum seeking children and young people)
- Private Fostering - such arrangements have to be notified to the local authority (Children's Social Care)
- Those aged 16 or over who are leaving the care of Children's Social Care or have previously left care and are eligible for Leaving Care services
- Where Children's Social Care involvement is required by the courts

Specialist services include:

- The recruitment, assessment and supervision of foster carers
- Placing and supporting children with foster carers
- Placing children in residential care for children who are no longer able to live at home and where that is the appropriate option
- Supervising children who are privately fostered
- Supporting young carers Adoption services are provided on Rutland's behalf by Leicestershire County Council.

5.3. Social Care teams and partners

The Social Care teams work in partnership with, and may refer to, other services, including education, health, housing, and the police to provide interventions and support on a multi-agency basis. Social Care provision is delivered by three teams:

Referral, Assessment and Intervention Service who provide the front door service including; advice and guidance, screening of contacts made to the service and recommendations as to appropriate support for families, complete reports requested by the courts for families in Private Family Law matters, complete assessments under section 17 and initial child protection investigations under section 47.

Permanency and Protection Service – this service is split in to two teams, one working with the complex child in need work under section 17 and families subject to child protection plans, the other working with children looked after by the Local Authority and any other court work required of the Local Authority.

Fostering, Adoption and Care Leavers Service who provide support to current foster carers and recruitment of new carers, care leavers, children in care who require a Personal Advisor, and matters relating to adoption.

The Local Offer sets out information about services for children and young people with Special Educational Needs and Disabilities (SEND) with information for parents/carers, children and young

people as well as for professionals. https://www.rutland.gov.uk/my-services/schools-education-and-learning/send-local-offer/

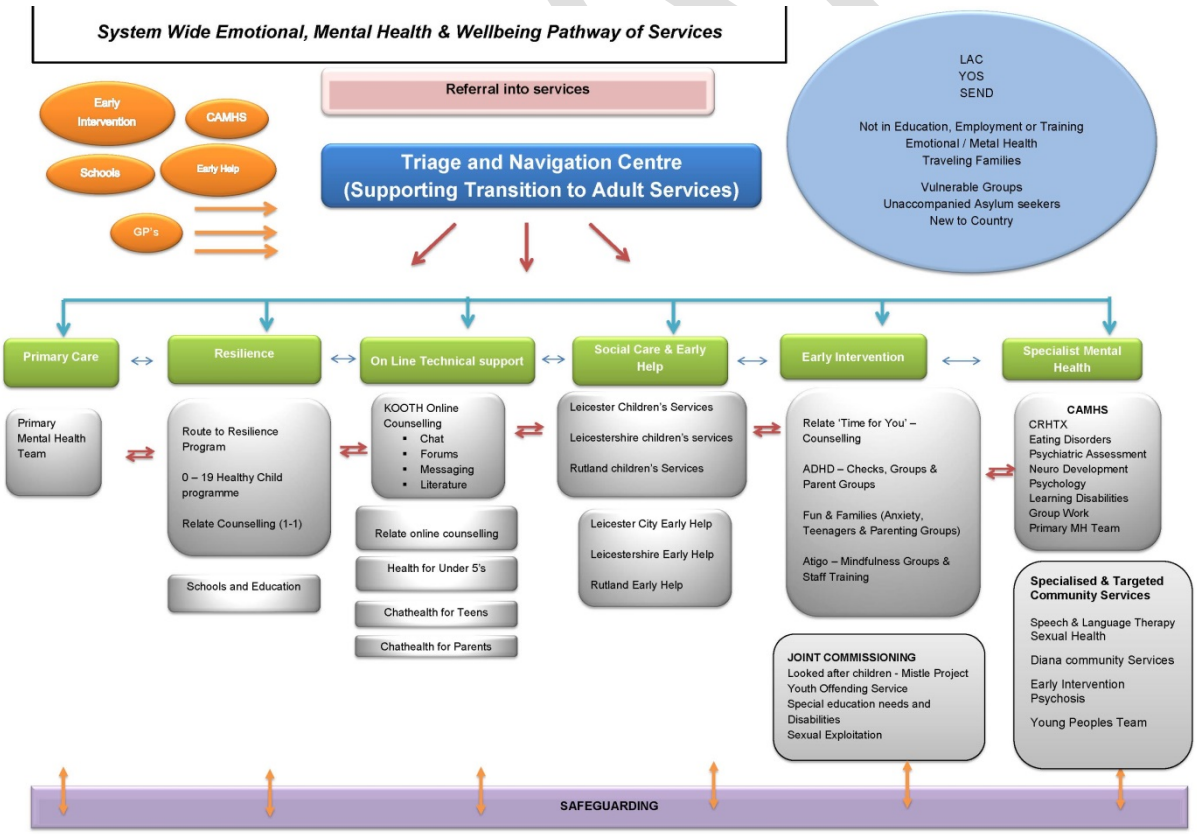
5.4. Promotion of Mental Health and Wellbeing

Services to promote mental health and wellbeing and to identify and support those who are experiencing mental health problems need to be co-ordinated and integrated. Locally this has been described as a whole system pathway across Leicester, Leicestershire and Rutland, called the Social, Emotional, Mental Health and Wellbeing pathway.

5.5. Future in Mind commissioned services

A number of services have been commissioned directly as part of the Future in Mind programme. These services have been designed to augment and improve pre-existing mainstream services. This is the list of the **Future in Mind commissioned services** (Commissioned by Leicester City Clinical commissioning Groups on behalf of all 3 CCGs across Leicester, Leicestershire and Rutland):

Figure 1: System wide pathway of services



- Targeted Early Intervention Emotional health and wellbeing Service for LLR

- Route to Resilience in Schools - a whole school approach to resilience in schools programme
- Xenzone - Kooth deliver an Online Counselling service
- Enhanced Access to Childhood and Adolescent Mental Health Service (CAMHS)
- Eating Disorders Service
- Crisis and Home Treatment Service
- Place of safety
- CAMH Service
- Primary Mental Health Team

5.6. Child and Adolescent Mental Health Service (CAMHS)

The CAMHS service is an LLR wide service and links with the Future in Mind services described above. CAMHS help children and young people who have been referred by another healthcare professional. CAMHS website: http://www.leicspart.nhs.uk/_OurServicesAZ-ChildandAdolescentMentalHealthServiceCAMHS.aspx

Referrals are made if it's thought the child or young person has emotional and/or behavioural difficulties at a level which requires specialist support. The range of services includes initial assessments, therapy, group work, emergency assessments and in-patient care. CAMHS also links with other children's services to offer a multi-agency approach. The team is made up of doctors, nurses and therapists who specialise in child mental health. The support we provide varies according to need, from a one-off appointment to a programme of on-going care which lasts until the child or young person feels better and is felt to be safe.

- **CAMHS Crisis Resolution and Home Treatment team** provides rapid assessment and treatment at home for children and young people in mental health crisis and support for their families, providing no physical medical intervention is required. Once a referral is received, the team aims to make telephone contact with a family within two hours and to assess the child or young person within 24 hours. The service is operational from 8am until 10pm. Outside of these times, support is provided by the adult crisis team.

- The **Primary Mental Health Team** works between primary care - for example GPs and public health (school) nurses - and specialist CAMHS outpatient teams. The team treats young people having difficulties with their mental health or emotional wellbeing, and who may be at risk of developing a mental health disorder.

- The **Young Peoples Team** works particularly with vulnerable young people in care and those who are involved with the youth offending service.

- The **CAMHS Learning Disability Team** provide services for children with a moderate to profound learning disability as defined in International Classification of Disease 10 presenting with mental health and or associated behavioural problems.

- The **CAMHS Eating Disorders Team**, based at Mawson House in Leicester, offers specialist outpatient assessment and treatment to young people and their parents affected by eating disorders, and manages around 100 new referrals each year. Treatment usually lasts between 12 and 18 months, though early intervention is crucial to recovery.

- The **Paediatric Psychology Team**, based at Artemis House, offers specialist psychological assessment and treatment to children, young people and their families who are psychologically affected by living with physical health conditions or disabilities. Referrals are from Consultant Paediatricians only

5.7. Healthy Child Programme

The programme helps to build resilience and support emotional health and wellbeing of children and young people and maternal mental health. Children's mental health has been included as high impact areas in the delivery of the 0-19 Healthy Child Programme. In this context, Public Health nurses (Health Visitors and School Nurses) provide brief interventions, advice, and support for children, young people and their families on emotional health and wellbeing.

0-19 Healthy Child Programme have also developed a number of packages of care and support and pathways in response to need including: anxiety, emotional health and self -harm, emotional health, behaviour management 0-5/5-19, domestic violence safeguarding, child sexual exploitation referral pathways.

Public health nurses provide face to face support through drop in clinics for young people in secondary schools and for parents in primary schools

Young people can also text a public health nurse to access confidential advice via a secure messaging service, ChatHealth. In Leicestershire and Rutland, young people can text 07520 615387

The ChatHealth service is also available for parents and carers if they have concerns about their child's health, and would like to contact a health professional. In Leicestershire and Rutland: 07520 615382

5.7.1. Early Start Programme

The Early Start Programme provides intensive early intervention and support for vulnerable first time parents with an infant 0-2 years. Informed by an outreach health visiting model, ESP is delivered by health visitors, early childhood practitioners and family nursing support staff and provides families with bespoke support. Support can start from 16 weeks pregnancy until the child's second birthday.

The Aim of the Programme is to ensure all children have the best start to life and prepare and equip vulnerable parents for parenthood providing them with skills, knowledge, confidence and capability to enable them to give their children the best possible start.

There is information on Emotional health and wellbeing and mental health issues on the 3 Healthy Together websites including:

Health for under 5's: https://healthforunder5s.co.uk/

Health For Kids: https://www.healthforkids.co.uk/

Health for Teens: https://www.healthforteens.co.uk/

6. Unmet needs/Gaps

6.1. Needs of children and young people

The evidence of local needs, current and emerging indicates:

- There are increasing numbers of referrals to early intervention services and CAMHS for children and young people with mental health and emotional health and wellbeing problems e.g. self-harm, anxiety.
- There are increasing numbers of children and young people who are exposed to domestic violence and other adverse childhood experiences. Research states that children who experience domestic violence have a fourfold increased risk of experiencing mental and emotional health issues. Therefore, there are a significant number of children in Leicestershire who may be experiencing and/or witnessing domestic violence; however their emotional and mental health needs are not necessarily being catered for[31].
- Public health nurses (school nurses) are also seeing an increasing number of children who are self-harming and experiencing anxiety.
- The age at which children and young people are presenting to services with emotional and mental health problems has lowered to primary school age.

- A significant number of referrals to CAMHS are related to behaviour which is taking up significant time and resources. It is hoped that the new system wide emotional, mental health and wellbeing pathway will help to divert these referrals away from CAMHS, if appropriate. The care of children and young people with behavioural issues is better served if it is multidisciplinary and focused on the child's needs rather than a medical diagnosis.

- There is also emerging recognition that many of the referrals to services are caused by attachment issues, therefore there should be an increased focus on parenting programmes through the 0-19 healthy child programme the Children and Family Service's early help service and voluntary sector programmes.

- A recent national 'Time to change' survey[32] revealed that 90% of young people said that they have experienced stigma and discrimination as a result of their mental health issues. This has prevented them in some cases, from doing every day activities that they enjoy. Stigma and discrimination can also stop people from seeking help and socialising with friends and discussing their problems with family or friends because they fear a negative reaction.

6.2. Mental Health Promotion and Prevention of Mental Health problems and Early Intervention

- Across the system there is recognition that there needs to be a greater emphasis on mental health promotion, prevention of mental health problems and early intervention, identifying emotional and mental health problems early in order to 'break the cycle'.

- Resilience also needs to be systematically promoted within all schools through the route to resilience programme and through the delivery of personal social health education (PSHE) including how to build mental resilience and wellbeing. All schools will have to deliver compulsory health education from September 2020.

- Self Help: There may be scope and potential to help and support young people to manage emotional health and wellbeing issues themselves.

- There needs to be more emotional and mental health training and support provided to universal services (e.g. Schools, Primary Care (GPs), Health Visiting and School Nursing Services) due to sheer numbers of children and young people accessing these services.

- It is recognised that schools need to be helped to take on a greater role in promoting emotional health and wellbeing as well identifying children who are at risk of emotional and mental health problems. However, in order to do this they need training and support to feel competent and confident. Part of compulsory health education (from September 2020) will include the need to ensure that children and young people will know how to recognise when

they and others are struggling with mental health issues and how to respond

6.3. Provision of CAMHS Services

There are still significant blockages in terms of access to treatment at every level of CAMHS. However, it is also recognised that there have been recent improvements.

6.4. Emerging gap between children with ADHD and autism with mental health services

A gap in the current commissioned services around children and young people with a diagnosis of Autism has been identified. The gap focusses specifically on those children and young people with a diagnosis of Autism, but do not also have a diagnosis of a mild to moderate learning disability. The children with Autism with mild learning disability are not picked up until situations escalate i.e. in:

- Care and Treatment reviews
- Children with medical need (education meeting)
- Not in education, employment or training (NEET)
- Youth offending Services

6.5. Children in Care (Looked after Children)

Children in care have particular emotional needs, related to their earlier experiences before they were looked after. These earlier experiences have an influence on brain development and attachment behaviour. Rates of: emotional, behavioural and mental health difficulties are at four to five times higher amongst children in care (looked after children) than the wider population.

A Whole System Approach to promoting good emotional health of children in care (looked after children) is needed (see NSPCC's 'Achieving Emotional Wellbeing for Looked after Children' (2015)[33] the priorities for change within the system should include:

- Embed an emphasis on emotional wellbeing throughout the system
- Take a proactive and preventative approach
- Give children and young people a voice and influence
- Support and sustaining children's relationships
- Support care leavers' emotional needs

7. Recommendations

- Target resources in proportion to need to address the needs of any children living in poverty and those most vulnerable.
- Increase numbers of children being active, and encouraging them to be active for longer

- Promote child visits to dentists and increase levels of fluoride varnish treatments to prevent tooth decay.

- Work with NHS England, commissioners of human papillomavirus (HPV) vaccination programme, to improve uptake of second dose.

- Better promote the range and availability of Tier 1 and 2 support available in Rutland to professionals, young people and parents via the Rutland Information Service, School websites and parent training.

- Support training for school staff to assist them with compulsory requirements for all schools to provide: relationship education (primary school) and sexual health and relationship education (secondary schools) from 2019, and to enable them to deliver health education which becomes compulsory from September 2020.

- Adversity and trauma informed care for children and young people should be prioritised for those who have Adverse Childhood Experiences (ACEs). ACEs include: parental separation, domestic violence, mental illness, alcohol misuse/ drug use. This should form part of an overarching partnership strategy and cover both primary and secondary prevention. The ACEs model should be used to identify young people and families who perhaps do not reach the threshold for a referral into statutory services.

GLOSSARY OF TERMS

A&E	Accident & Emergency
ACEs	Adverse Childhood Experiences
CAMHS	Child and Adolescent Mental Health Service
CCG	Clinical Commissioning Group

CLA	Children Looked After
CoT	Course of Treatment
CSE	Child Sexual Exploitation
d3mft	decayed, missing or filled teeth
EHC	Education, Health and Care
HPV	Human Papilloma Virus
JSNA	Joint Strategic Needs Assessment
LLR	Leicester, Leicestershire and Rutland
LSOA	Lower Super Output Area
NEET	Not in education, employment or training
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
NRM	National Referral Mechanism
PHE	Public Health England
SEN	Special Educational Needs
SEND	Special Educational Needs and Disabilities

REFERENCES

[1] Child Poverty Action Group 2015. End Child Poverty. At: http://www.endchildpoverty.org.uk/

[2] Public Health England. Overview of Child Health (2018) At https://fingertips.phe.org.uk/child-health-overview#gid/1938132992/ati/102

[3] Public Health England. Public Health Outcomes Framework (2018) At https://fingertips.phe.org.uk/profile/public-health-outcomes-framework

[4] Rutland County Council. Liquidlogic Children's Social Care System (2018).

[5] Rutland County Council. Toxic Trio Health Needs Assessment (2016). https://www.rutland.gov.uk/my-services/health-and-family/health-and-nhs/joint-strategic-needs-assessment/

[6] NSPCC. Child sexual exploitation. Facts and statistics. At https://www.nspcc.org.uk/preventing-abuse/child-abuse-and-neglect/child-sexual-exploitation/child-sexual-exploitation-facts-and-statistics/

[7] Public Health England, Crisis Care Profiles (2018). At https://fingertips.phe.org.uk/profile-group/mental-health/profile/crisis-care

[8] Public Health England. Perinatal Mental Health Profiles (2018) https://fingertips.phe.org.uk/profile-group/child-health/profile/perinatal-mental-health

[9] Public Health England. Child and Maternal Health. Young People (2018) At https://fingertips.phe.org.uk/profile-group/child-health

[10] Office for National Statistics, Revised population estimates for England and Wales: mid-2012 to mid-2016 (2018). At https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/bulletins/annualmidyearpopulationestimates/mid2012tomid2016

[11] Public Health England. NCMP and Child Obesity Profile (2018) At https://fingertips.phe.org.uk/profile/national-child-measurement-programme

[12] Public Health England. NHS Dental Epidemiological Oral Health Survey of 5-year-old children in England 2016/17. (2018). at http://www.nwph.net/dentalhealth/survey-results%205(16_17).aspx

[13] Dental Public Health Epidemiology Programme for England: oral health survey of twelve year old children (2009). At http://www.nwph.net/dentalhealth/survey-results-12.aspx

[14] National Institute for Health and Care Excellence. Dental checks: intervals between oral health reviews. Clinical guidance [CC19]. (2004). at https://www.nice.org.uk/guidance/cg19/chapter/1-guidance

[15] NHS Digital. NHS Dental Statistics for England, 2016-17. (2017). at http://digital.nhs.uk/catalogue/PUB30069

[16] NHS Business Services Authority and the PHE Dental Public Health Intelligence Team. NHS Dental Statistics - Access and Activity 2014/15 – 2015/16. (2018).

[17] NHS Digital. NHS Dental Statistics for England, 2015-16. (2016). at https://digital.nhs.uk/catalogue/PUB21701

[18] Public Health England. Sexual and Reproductive Health Profiles (2018). At https://fingertips.phe.org.uk/profile/SEXUALHEALTH

[19] Public Health England. Overview of Child Health (2018). At https://fingertips.phe.org.uk/profile-group/child-health/profile/child-health-overview

[20] Public Health England. Young People (2018). At https://fingertips.phe.org.uk/profile-group/child-health/profile/child-

health-young-people/data#page/1/gid/1938132999/pat/6/par/E12000004/ati/102/are/E06000017

[21] Public Health England. Children and Young People's Mental Health and Wellbeing (2018). At https://fingertips.phe.org.uk/profile-group/child-health/profile/cypmh

[22] Department of Health (2015) Future in mind: promoting, protecting and improving our children and young people's mental health and wellbeing, NHS England at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf

[23] Department of Health and Social care, Department for Education (2017) Transforming Children and Young People's Mental health provision : a green paper, DH at https://www.gov.uk/government/consultations/transforming-children-and-young-peoples-mental-health-provision-a-green-paper

[24] NHS England (2014) Five Year forward view , NHSE at https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

[25] Public Health England (2017) Prevention Concordat for better mental health planning resource, PHE at https://www.gov.uk/government/publications/prevention-concordat-for-better-mental-health-planning-resource

26 Department of Health & social care (2017) Preventing suicide in England: third progress report of the cross government outcomes strategy to save lives, HM Government at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/582117/Suicide_report_2016_A.pdf

27 National Institute for Health and Care Excellence (2008) Social and emotional wellbeing in primary education, public health guideline 12 at https://www.nice.org.uk/guidance/ph12

28 National Institute for Health and Care Excellence (2009) Social and emotional wellbeing in secondary education, public health guideline 20 at https://www.nice.org.uk/guidance/ph20

29 National Institute for Health and Care Excellence (2012) Social and emotional wellbeing : early year settings, public health guideline 40 at https://www.nice.org.uk/guidance/ph40

30 Public Health England & Children & Young People's Mental Health Coalition (2015) Promoting Children and Young People's emotional health & wellbeing: a Whole School and College Approach, PHE at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/414908/Final_EHWB_draft_20_03_15.pdf

[31] NSPCC. Child abuse and neglect in the UK today. At: https://www.nspcc.org.uk/services-and-resources/research-and-resources/pre-2013/child-abuse-and-neglect-in-the-uk-today/

[32] Time to Change. Stigma Shout (2008). At: https://www.time-to-change.org.uk/resources

[33] NSPCC. Achieving Emotional Wellbeing for Looked after Children (2015) at: https://www.nspcc.org.uk/globalassets/documents/research-reports/achieving-emotional-wellbeing-for-looked-after-children.pdf