

Children and Young People: the Leicester picture

Leicester has a young population and the city is seeing major increases in the number of children and young people living here. The city is home to 130,726 children and young people aged up to 24 years, an increase of 12.5% since 2015, which is more than double the increase seen in England as a whole. This growth includes a big increase in the number of young children aged 0-4 years which rose by nearly 25% from 20,726 in 2005 to 25,884 in 2015.

Set against this backdrop, the Joint Strategic Needs Assessment (JSNA) looks at the health picture for children in the city. Life expectancy in Leicester is below the England average, with significant differences in how long people live according to where they live: many of the patterns for this are laid down in childhood. Children's health and well-being is therefore not only important as a goal in itself but is a key priority to improving the overall health of the entire city.

Children's health and well-being is affected by a huge number of influences: as well as some of the genetic building blocks for health, their family, friends, schools, the environment they live in and wider societal factors are all key influences. Childhood is also changing with influences such as new technologies having a potential impact on health and well-being that we do not yet fully understand.

The JSNA summarises in one place what we do know about children's health and well-being and some of the factors that influence this. It is based on available data held locally and nationally that helps us to build up a city-wide picture. This inevitably means that there are gaps in what we know where data is not collected or cannot be accurately collated. The JSNA also highlights where we do not have robust information to give us a true picture of health across the population and in specific groups who are likely to experience poor health.

Crucially, the JSNA does not include children and young people's views about their health and well-being and what could improve this: the forthcoming Leicester Children's Health and Wellbeing Survey and work with the City's Young Advisors, Young People's Council and others will give vital information to shape the findings of the JSNA. This work will be supported by the City's Health and Well-being Board and the Board's regular meetings with children and young people and through the Children's Trust Board.

This JSNA highlights a number of key challenges for children's health and well-being:

- The city's age profile contributes to its vibrancy and in the medium-term may mean that some of the challenges of an aging population take effect less rapidly than in other parts of the country. But it has also required the city to respond rapidly to meet this need, including additional demands for maternity services, health visiting and expanding school places. Although the birth rate is stabilising, forecasts show that by 2025, the population of young people aged 0-24 will increase by a further 138,100 (an increase of 7.4% from 2014). This has been – and will continue to be – factored early into local planning.
- There are around 5,100 births in Leicester each year, and the city's birth rate is higher than for England as a whole. Although infant mortality rates are not significantly different from the England average, this varies across the city and rates are highest in the most deprived parts of Leicester. Supporting women to be healthy during in pregnancy is also a key issue

for the city as Leicester has higher obesity and smoking rates in pregnancy than the England average, with important consequences for both maternal and child health.

- Deprivation has an important impact on children's lives both in the short and long-term and there is a clear link between how long people live – and how good their health is – and deprivation. Leicester is ranked 21st out of 326 local authorities in England and 41% of Leicester's population aged 0-15 years live within the 20% most deprived areas nationally. Continuing to tackle child poverty, improve educational attainment, boost jobs and the local economy will be crucial to improving the health of this generation's children.
- Like other cities with a similar socio-economic profile, Leicester faces significant challenges in effectively protecting children who experience neglect, family breakdown or crisis. This has been a major focus of attention within the city, overseen by the city's Improvement Board and with the City's Children's Trust Board and Local Safeguarding Children's Board. Child sexual exploitation and female genital mutilation are also key priorities locally: understanding the extent of these issues in the city as well as continuing to embed effective identification and management across agencies will be important to support a particularly vulnerable group of children.
- High rates of childhood obesity and poor oral health demonstrate the need for focused work to improve children's diet and levels of physical activity across the city. This work will also help to reduce rising levels of Type II diabetes and other chronic diseases associated with obesity. Equally, parts of the city have high rates of children who are underweight which needs to be a local priority.
- Mental wellbeing is important for healthy development, and it is influenced by social and economic circumstances, the wider environment, individual and family characteristics. As a city with high rates of deprivation, inequality and variable attainment in school, the risk factors for poor mental health in Leicester's children are high. The multi-agency work to better understand and address mental wellbeing for children in Leicester is a priority.
- Children and young people at risk of offending or within the youth justice system often have more unmet health and social care needs than other children. It is therefore important that the needs of vulnerable children and young people (aged 10-17) at risk of offending are included in mainstream planning and commissioning. Improvement work to better understand the health and wellbeing needs of Young Offenders has been a focus a priority overseen by the Young Offending Management Board.
- Gypsies and travellers are a vulnerable group with the lowest life expectancy of any group in the UK. Leicester has a small population of Gypsies and travellers, but their access to and uptake of important health services is poor. Some barriers include communication difficulties, stigma and discrimination. The local specialist approach to this population has improved their access to healthcare, but more work is needed to improve engagement with the communities and ultimately reduce their burden of disease.
- Services for children in the city are undergoing a period of change. This has included substantial reconfiguration and restructuring of many services provided by both local

government and the NHS. Further changes are planned over the next few years, including proposed changes to maternity services. Although the JSNA does not make specific recommendations for service change, the JSNA provides important evidence about key health outcomes for children. Understanding the impact of changes on health outcomes and identifying how some of the measures outlined in the JSNA can be implemented or accelerated during this period of change will be an important challenge for local public services and for the Health and Well-being Board locally.

What is the Children's Joint Strategic Needs Assessment (JSNA)?

Local authorities and Clinical Commissioning Groups (CCGs) have a joint duty to prepare JSNAs through their Health and Wellbeing Boards. The aim of the children's JSNA is to present a picture of health needs across the city, coordinating information that is often fragmented and held by a range of different organisations. It describes what we know about a range of factors that influence children's health and well-being now and in the future, and describes what is being done locally to address these. This can then be used to understand current and future need locally, to identify gaps or areas for improvement and to shape local services.

JSNAs rely on routinely collected data: one of the purposes of the JSNA is therefore to highlight where there are important gaps in data which need to be addressed locally or nationally to understand and improve children's health. The JSNA uses the most up to date available data: in some cases, data may not be collected annually and in this case, the most recent data has been used. In other cases, particularly where data is being used to compare the city to other areas, older data may be used for comparative purposes only.

The JSNA has a specific focus on what needs to be done to improve health across the city. It therefore does not look in detail at specific healthcare needs or individual clinical conditions unless these have a major impact across the city as a whole. It does however, look at some particularly vulnerable groups of children whose health needs require a particular focus, including looked after children, gypsy and traveller children and young offenders. It also considers the health impacts of some major challenges including female genital mutilation and child sexual exploitation. Importantly, it includes a chapter on children and young people's mental health which has been included as part of wider work to give parity of esteem – or equal treatment- to mental health and physical health issues.

In line with 'Fair Society, Healthy Lives' (2010)¹, the JSNA follows a life course approach which maps out how children's health needs change as they grow and develop at different stage of their lives and includes the following chapters:

1. Demographic profile of CYP in Leicester
2. Pre-birth to early life
3. Early years (0-4 years)
4. School years (5-19 years)
5. Young Adulthood (20-24 years)
6. Mental Health of Children and Young People
7. Looked After Children
8. Youth Offenders
9. Vulnerable groups

This CYP JSNA has been led by a local partnership steering group including young advisors, the NHS and local authority, led by the Division of Public Health. The Young Advisors who advise community leaders on how to engage young people in community life, were commissioned to assist the JSNA process. Two stakeholder events were held to get a wider range of view on the JSNA during its development. Data collection and analysis was carried out by subject specialists within the council and NHS, coordinated by the Division of Public Health.

CYP Benchmarking Overview

The Children and Young People's Benchmarking spine-chart below provides an overview of the outcome data from the Public Health Outcomes Framework², the NHS Outcomes Framework³ and other sources. This allows for a comparison of Leicester's position to the rest of the country but time-lags in the national collation of data mean that our current local picture may have changed. This is identified in more detail in each section of the JSNA.

Interpreting the spine-chart

The spine chart below is a data visualisation technique presenting an overview for a number of indicators for CYP. The spine-chart summarises Leicester's position compared to England as a whole. On the spine, the light grey bar shows the range of values found in England. The dark grey sections mark out the range within which the middle half of the values lie (25th to 75th percentile). The England value for each indicator is represented by the central red-line on the chart. Leicester's value for each indicator is presented as a circle.

¹ <http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review>

² <http://www.phoutcomes.info/>

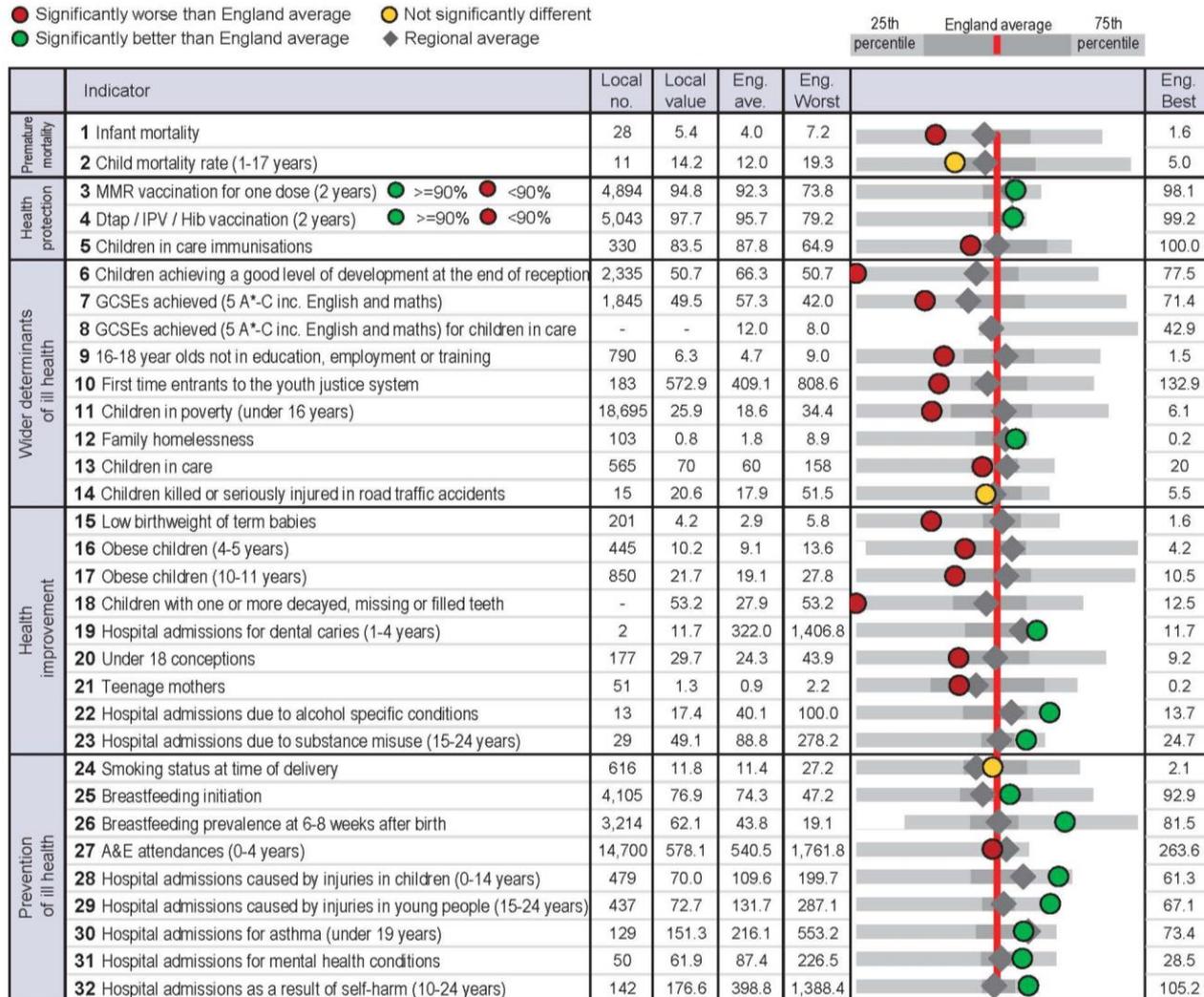
³ <http://www.england.nhs.uk/resources/resources-for-ccgs/out-frwrk/>

Where possible 95% confidence limits were calculated and the values are used to identify if an indicator is significantly higher or lower than the England value. Where possible, significantly higher and lower indicators are determined to be better or worse than England dependent on whether a low value is desirable or not. In some instances, it is not possible to determine whether a high value is better or worse. The indicator value circles are coloured to represent the significance⁴ in comparison to the England value:

- significantly worse = red (these are presented on the left of the spine chart)
- significantly better = green (these are presented on the right of the spine chart)
- not significantly different = Blue
- significance could not be calculated = Black

Leicester's Children and Young People's Health Profile

- Significantly worse than England average
- Significantly better than England average
- Not significantly different
- ◆ Regional average



⁴ It is not possible to calculate statistical significance

Setting the context – Leicester’s demographic profile

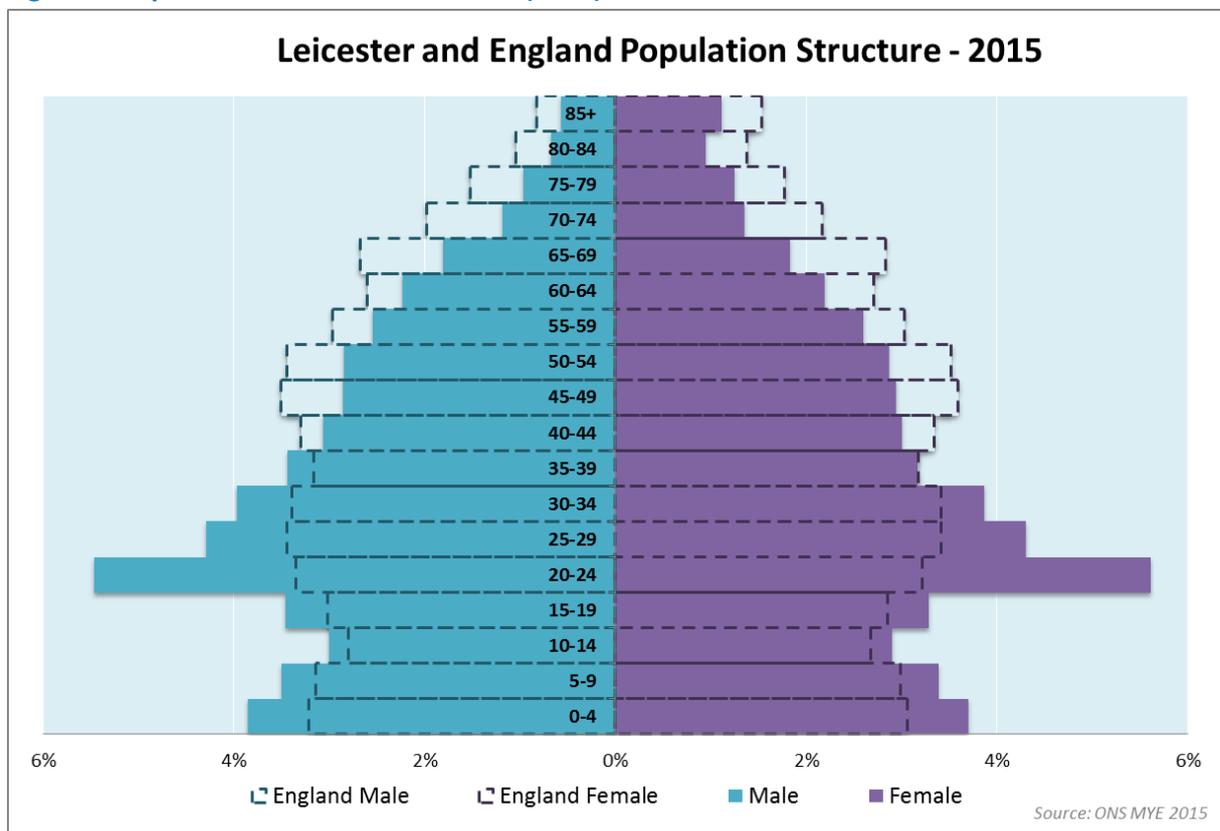
Chapter 1

Population and CYP in Leicester

The population of Leicester is currently 342,627⁵, and the birth rate appears to be falling (further information is contained in Chapter 4 -pre-birth to early life). A boy born in the city today can expect to live to aged 77 years compared with 82 years for a girl born on the same day. Life expectancy at birth for boys and girls in Leicester is significantly worse than the England averages⁶.

38.2% (n=130,726) of the city’s population are aged between 0 and 24 years. Of these, 50.5% are male (n=66,066) and 49.5% are female (n=64,660) with a significantly higher proportion aged between 20 and 24 years in comparison to the England average (Figure 1).

Figure 1: Population structure in Leicester (2015)



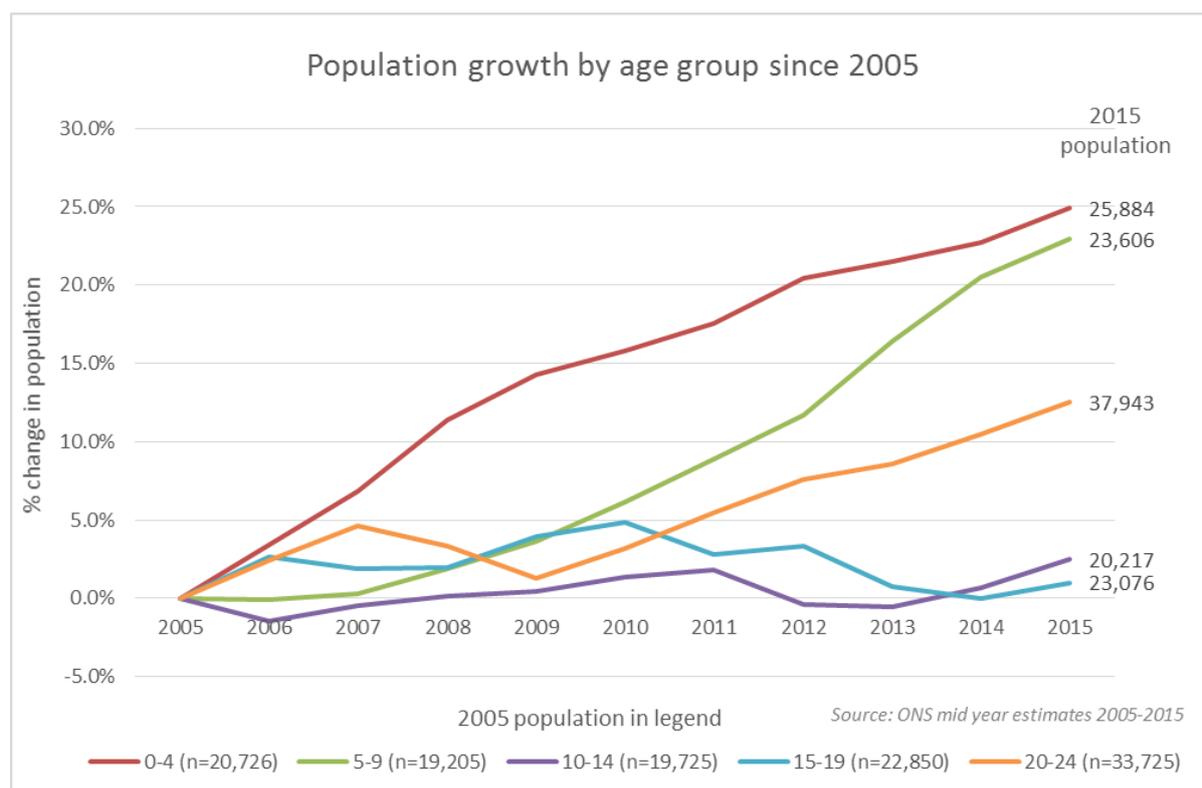
⁵ 2015 figures sourced from ONS mid-2015 population estimates

⁶ Figures 2013-15 sourced from office of national Statistics. England average life expectancy for boys 79.5years & 83.1 years for girls

Population growth of CYP in Leicester (trend)

The proportion of 0-24 year olds living in Leicester increased by 12.5% between 2005 (n=116,231) and 2015 (n=130,726). This is a significant increase when compared against the East Midlands (5.8%) and England (5.7%). Leicester's 0 to 4 population increased from 20,726 in 2005 to 25,884 in 2015, an increase of 5,158 or 25%. The 10-14 and 15-19 age groups have experienced a slower rate of percentage growth over the same period, 10-14 population was 19,725 in 2005 and in 2015 reached 20,217.

Figure 2: Population growth by age group in Leicester since 2005 (2005 – 15)



The proportion of the population in each age group has remained similar since 2005. In 2015 the breakdown by age group in Leicester is as follows:

- 0-4 years: 7.6%
- 5-9 years: 6.9%
- 10-14 years: 5.9%
- 15-19 years: 6.7%
- 20-24 years: 1.1%

Projected population of CYP in Leicester

Population projections are a vital source of information for future service planning as changes in the population age structure affect the need for services, particularly in terms of health and social care.

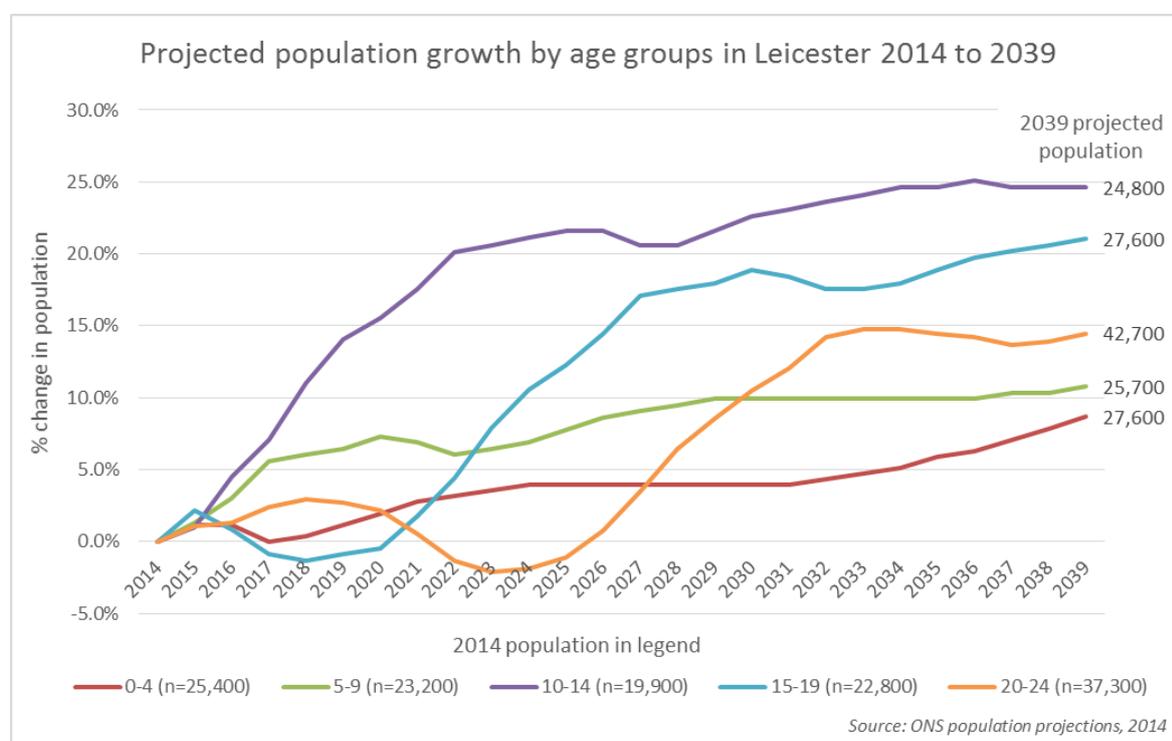
For Leicester, the Office of National Statistics (ONS) 2014 based population projections suggest that:

- The total population of Leicester is projected to grow to 371,100 by 2025 (an increase of 9.9% from 2014)
- The number of CYP (aged 0 to 24 years) is projected to grow to 138,100 by 2025 (an increase of 7.4% from 2014)

Not all age groups of CYP are expected to change in the same way. Figure 3 shows the projected population growth by age groups in Leicester. The estimated percentage change from 2014 to 2025 by age groups in Leicester is as follows:

- 0-4 years: 3.9%
- 5-9 years: 7.8%
- 10-14 years: 21.6%
- 15-19 years: 12.3%
- 20-24 years: -1.1%

Figure 3: Projected population growth by age groups in Leicester (2015-2039)



The proportion of the population in each age group is projected to remain similar over the period 2014 to 2039. It is projected that in 2039 the age breakdown for Leicester will be as follows:

- 0-4 years: 6.8%
- 5-9 years: 6.3%
- 10-14 years: 6.1%
- 15-19 years: 6.8%
- 20-24 years: 10.5%

Ethnicity of CYP in Leicester

Figure 4 shows a breakdown of ethnic⁷ groups for CYP aged 0-24 years in Leicester. The proportion of BME population (n=74,300) is significantly greater when compared against the England average.

Figure 4: Ethnic groups for 0-24 year olds in Leicester (2011)

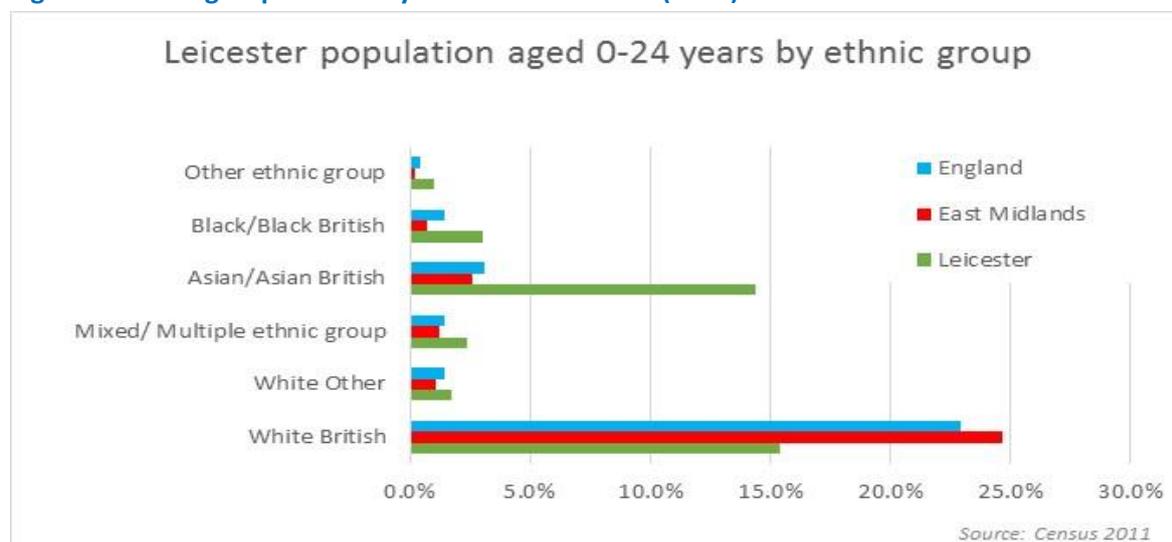
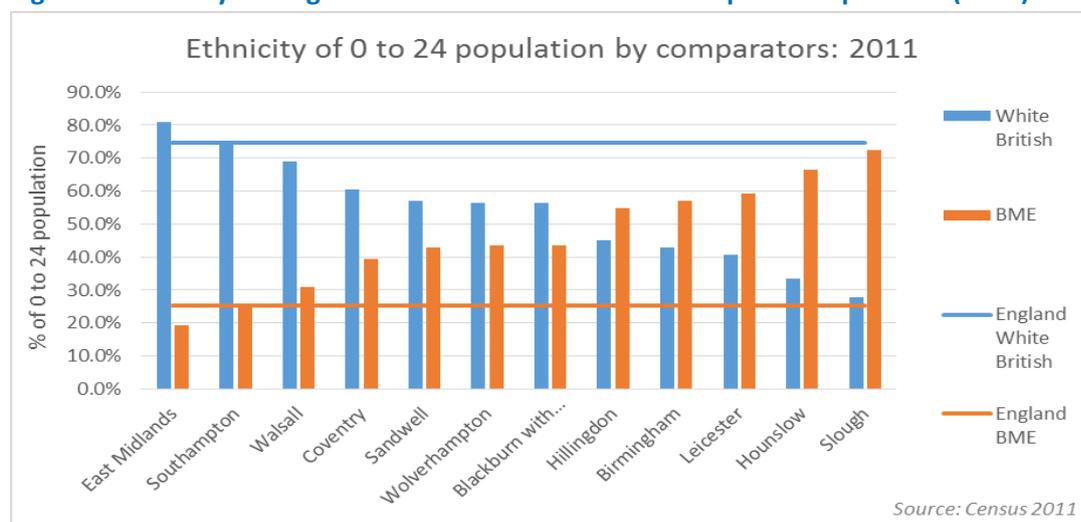


Figure 5 depicts the White British and BME proportions of CYP in Leicester against peer comparators, East Midlands and England. Leicester has the third highest proportion of BME and the third lowest proportion of White CYP amongst its peer comparators.

Figure 5: Ethnicity amongst CYP in Leicester and children’s peer comparators (2011)

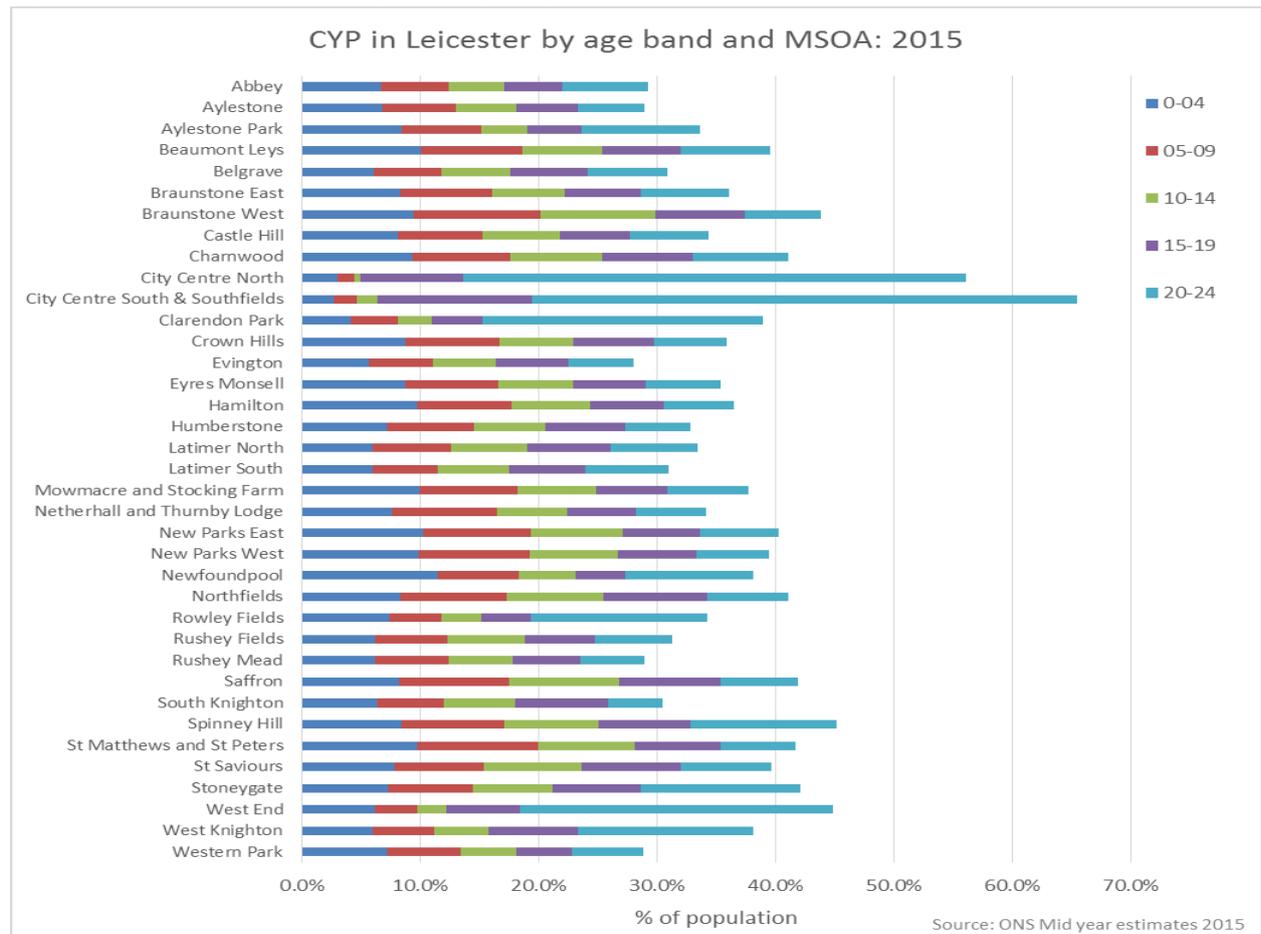


⁷ As per the census (2011) definitions ‘White’ incorporates English, Welsh, Scottish, and Northern Irish. ‘BME’ (Black, Minority and Ethnic groups refers to all other groups including White Irish, White Gypsy, Irish Traveller and White Other (including eastern Europeans).

CYP population groups by Mid-Layer Super Output Area (MSOA)⁸

Figure 6 shows the proportion of CYP by age bands living in each MSOA in Leicester. It illustrates that high proportions of 20-24 year olds are located in the two city centre MSOAs (n=8601), West End (n=3643), and Clarendon Park (n=2785). This is most likely due to the student populations from the city centre universities and to migrant populations settling in Leicester. These MSOAs also have the smallest proportion of 0-14 year olds. The largest proportion of 0-4 year olds reside in MSOAs in the west, and also Hamilton in the north east and St Matthews & St Peters, and Charnwood just east of the centre. Otherwise the distribution of ages appears to be proportionate across the city wards. Further details about age group distribution can be found in subsequent chapters.

Figure 6: CYP in Leicester by age band (2015)



⁸ There are 37 Mid-Layer Super Output Areas (MSOAs) in Leicester. These statistical geographies are less prone to change and share more similar characteristics when compared to electoral wards. MSOAs in Leicester have populations ranging from 6,000 to 14,000 and an average of about 9,250.

Deprivation

Index of Multiple Deprivation (IMD)

The IMD 2015⁹ provides a relative measure of deprivation at lower super output areas (LSOA) across England. Areas are ranked from least deprived to most deprived on seven different dimensions of deprivation and an overall composite measure of multiple deprivation¹⁰. The higher the IMD score, the more deprived an area¹¹. All the scores for each LSOA have been ranked both in England and in Leicester. Ranking works in an opposite direction to the score, as the lower the rank, the more deprived an area.

The IMD 2015 indicates that Leicester has an average score of 33.1; this means that Leicester is ranked 21st out of 326 local authorities in England, with 1 indicating the most deprived. Figure 7 shows the deprivation quintile for each Leicester LSOA. 76% of Leicester's population, compared with 40% of England's, live in the 40% most deprived LSOAs in the country.

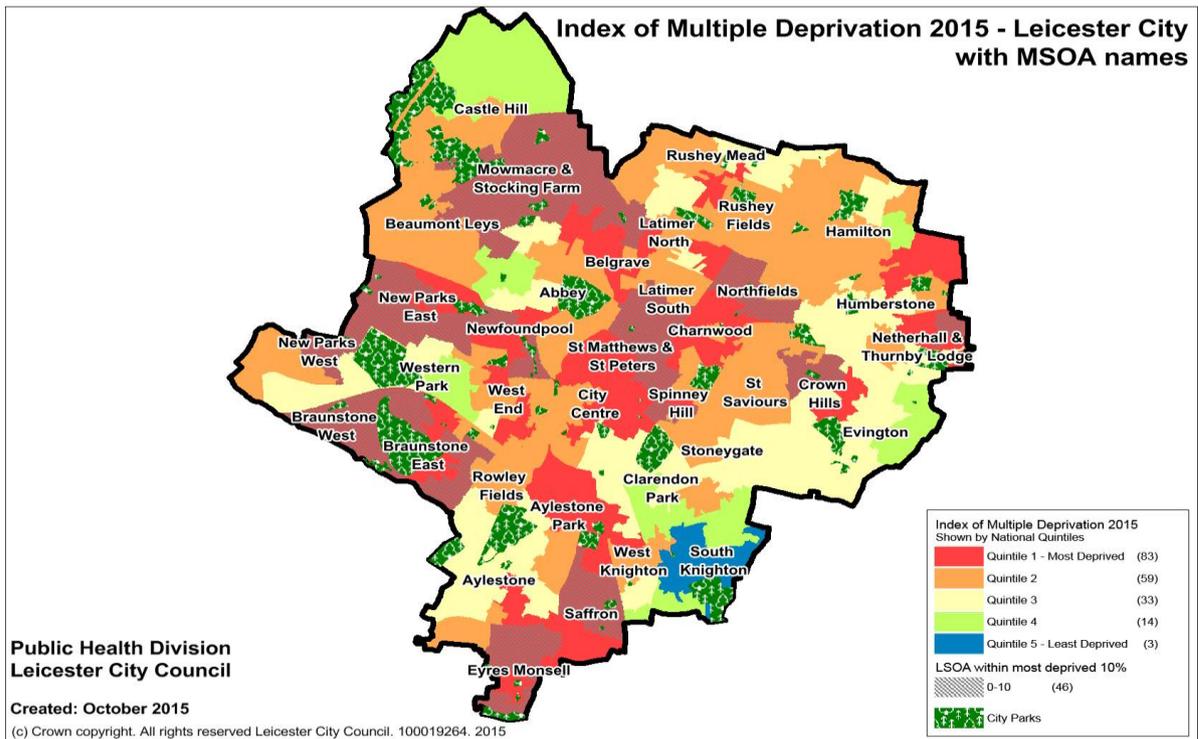
Figure 7: IMD 2015 in Leicester

⁹ A full briefing on the implications of the Index of Multiple Deprivation 2015 for Leicester is available here:

<http://www.leicester.gov.uk/media/181190/indices-of-deprivation-in-leicester.pdf>

¹⁰ The domains used in the Indices of Deprivation 2015 are: income deprivation; employment deprivation; health deprivation and disability; education deprivation; crime deprivation; barriers to housing and services deprivation; and living environment deprivation. Each of these domains has its own scores and ranks, allowing users to focus on specific aspects of deprivation. Most of the data underlying the 2015 Indices are for the year 2013.

¹¹ As with all the deprivation indices, it is important to note that not all deprived people live in deprived areas and conversely, not everyone living in a deprived area is deprived. The indices highlight areas with high levels of deprivation. It should be noted that areas of the city which are not classed as 'deprived' are not necessarily 'affluent' either, they fall somewhere between the two categories.



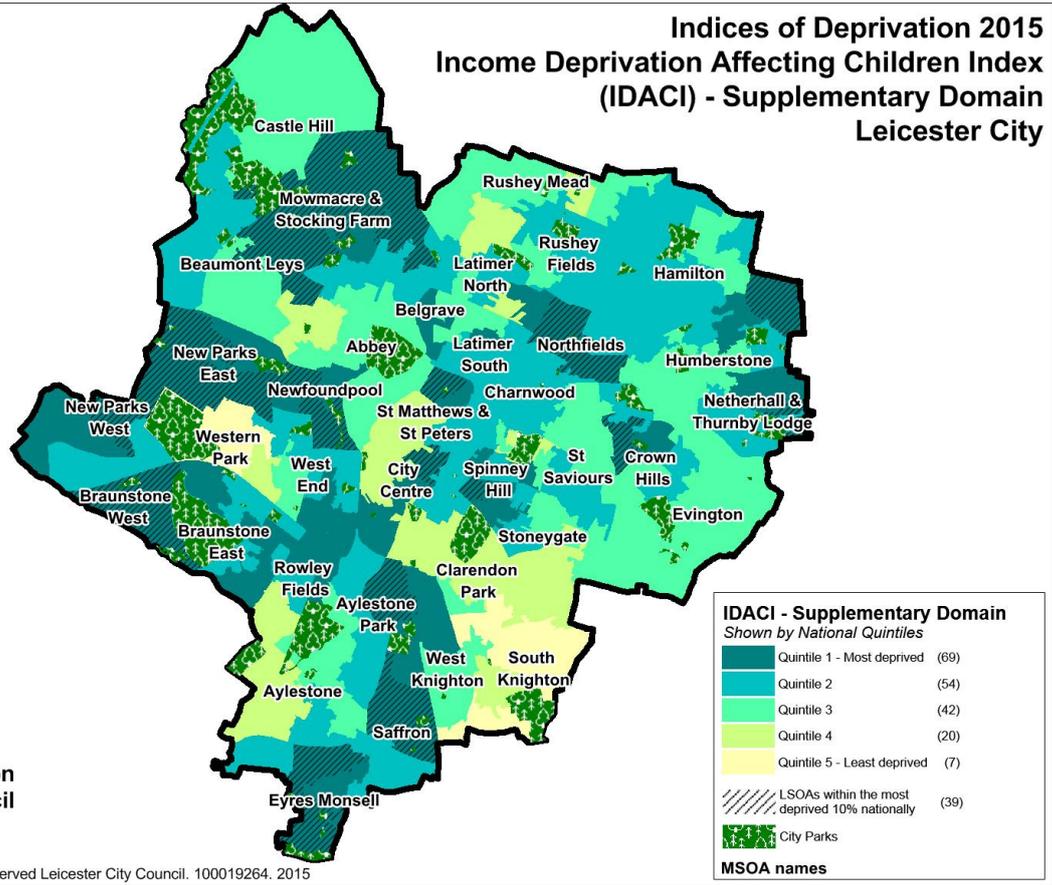
Income Deprivation Affecting Children Index (IDACI) 2015

The IDACI measure is part of IMD 20150 which looks at the percentage of children aged under-16 years old living in income deprived households. This is based on families receiving one of the following means tested benefits - Income Support, Income Based Job Seekers Allowance, Income-based Employment and Support Allowance, Pension Credit (Guarantee), Working Tax Credit or Child Tax Credit.

Figure 8 presents the distribution of income deprivation affecting children within Leicester. 69 of Leicester's 192 LSOAs were within the most deprived quintile in England for income deprivation affecting children. 41.1% of Leicester's population aged 0-15 years live within these 20% most deprived areas.

Figure 8: Distribution of Income Deprivation Affecting Children within Leicester (2015)

**Indices of Deprivation 2015
Income Deprivation Affecting Children Index
(IDACI) - Supplementary Domain
Leicester City**



Public Health Division
Leicester City Council

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Chapter 2

1. Introduction

The pre-birth to antenatal period is paramount to providing each child a 'best start in life'. Investments targeted to the pre-birth and antenatal period influence a child's readiness for school, educational attainment, economic participation and long term health. The right support at this stage is therefore key to children's long-term health and well-being.

This chapter covers the pre-birth to antenatal period of the life course. Issues on which this chapter focuses are preconception, pregnancy, the perinatal period (around childbirth), the neonatal period (until the infant is 28 days old), infant mortality (up to a year) and breastfeeding.

2. Who's at risk and why?

The main factors which can adversely affect health outcomes at this stage are:^{12, 13, 14}

- **Deprivation:** Poor social and economic circumstances adversely affect lifetime health and wellbeing.
- **Ethnicity:** An interplay of factors affects health and wellbeing for people from some minority ethnic backgrounds in the UK.
- **Low birth weight (LBW):** Birth weight less than 2,500gm increases the risks of childhood mortality and developmental problems which can lead to poorer health in later life.
- **Maternal age:** Mothers aged younger than 20 and older than 35 years, experience higher infant death rates and poorer pregnancy outcomes.
- **Maternal obesity:** Increases health risks for both mother and child during and after pregnancy.

¹² Marmot (2010). Fair society, healthy lives. Retrieved from <http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review>. 2 December 2015

¹³ Public Health England. Maternal Obesity Information page. Retrieved from http://www.noo.org.uk/NOO_about_obesity/maternal_obesity_2015. 2 December 2015

¹⁴ Centers for Disease Control. Tobacco use and pregnancy information page. Retrieved from <http://www.cdc.gov/reproductivehealth/maternalinfanthealth/tobaccousepregnancy/index.htm>. 2 December 2015

- Maternal mental health: Childbirth increases the risk to women’s mental health, which can have longstanding effects on a child’s emotional, social and cognitive development.
- Lifestyle: Lifestyle and behaviour choices such as smoking, alcohol, poor diet and substance misuse contribute to low birth weight and infant mortality.
- Poor parenting: Poor parenting can have a detrimental effect on a child’s early cognitive development, emotional wellbeing, social competence, physical and mental health.
- Consanguinity:¹⁵ Genetic diseases and conditions can cause an increase in morbidity and mortality.
- Access to quality services: Timely access to appropriate care can affect the survival of babies born with life threatening conditions. For example, low birth weight babies have better outcomes when delivered at specialist centres. Early access to antenatal care can ensure effective management of pregnancy and improve outcomes.

3. Demographic Summary

3.1 Population profile

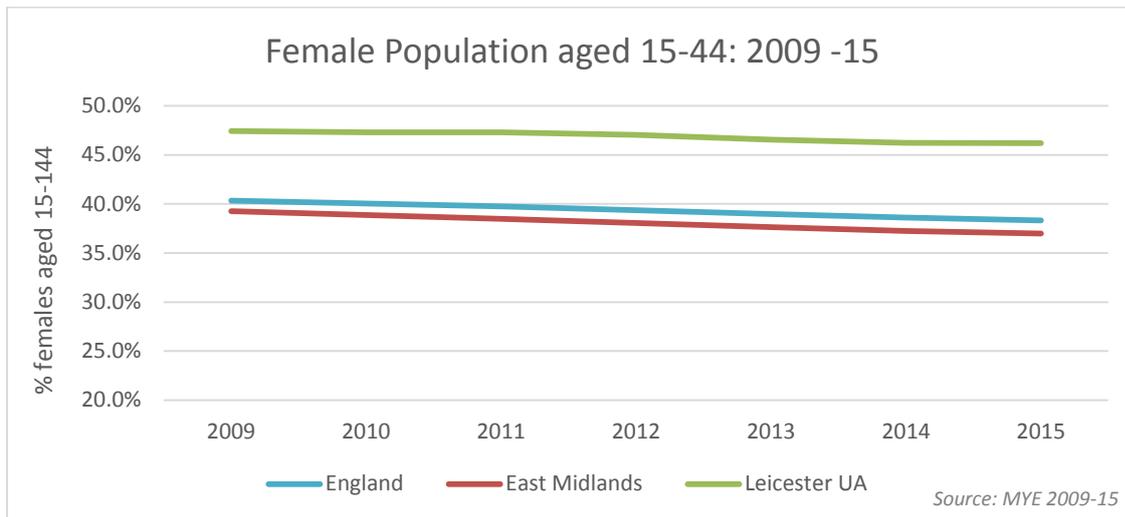
The population of females in Leicester who are of child bearing age (15 to 44 years) is detailed in this section.

Figure 1 shows that:

- In 2015, about 46% (n=79,566) of all females in Leicester were of child bearing age, that is aged 15 to 44 years. This was a significantly higher proportion than the England average, which was 38%.
- Between 2009 and 2015 there was a decrease of 1% in the proportion of women of child bearing age in Leicester. This was similar to the regional and national trends (2%).

Figure 1: Female population aged 15 to 44 years old (2009-15)

¹⁵ Relating to or denoting people descended from the same ancestor



3.2 Life expectancy

Life expectancy (the average lifespan a person is expected to live at birth) has increased over the last 20 years. However, life expectancy for both males and females is significantly lower in Leicester compared to England. Life expectancy is impacted by a wide variety of factors including deprivation, access to health services, education, mental wellbeing, communicable and non-communicable diseases and attainment.

From 2000 to 2015 the gap in average life expectancy for Leicester compared to England widened (worsened) in males from 1.8 to 2.4 years (Figure 2). For females the life expectancy gap remained roughly the same going from 1.4 to 1.5 years during the same time period (Figure 3).

In 2015, life expectancy at birth in Leicester was 81.6 years for females compared to the England average of 83.1 years, and for males 77.1 years compared to the England average of 79.5 years. Life expectancy is lower in Leicester than most peer comparators.

Figure 2: Life expectancy at birth (females) 2000-15

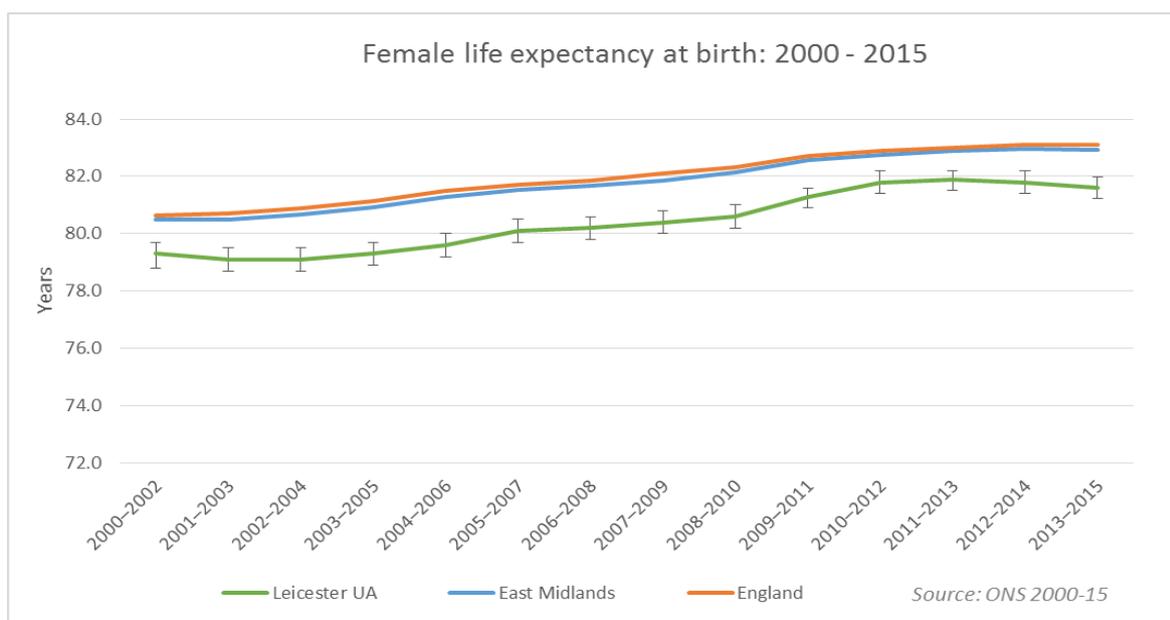
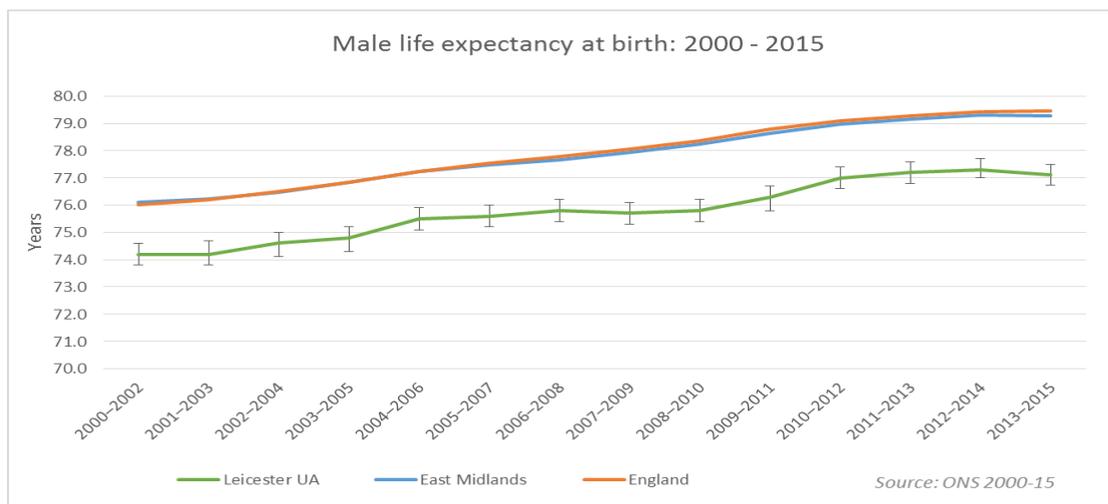


Figure 3: Life expectancy at birth (males) 2000-15



There is variation in life expectancy between different areas in Leicester. The areas of Leicester where life expectancy for females is worse than England are in the East, West and South of Leicester (Figure 4). For males, life expectancy in Leicester is significantly worse than England for 20 of the 37 MSOAs for Leicester (Figure 5). These areas are distributed across the city.

Figure 4: Life expectancy at birth for females in Leicester by MSOA (2009-2013)

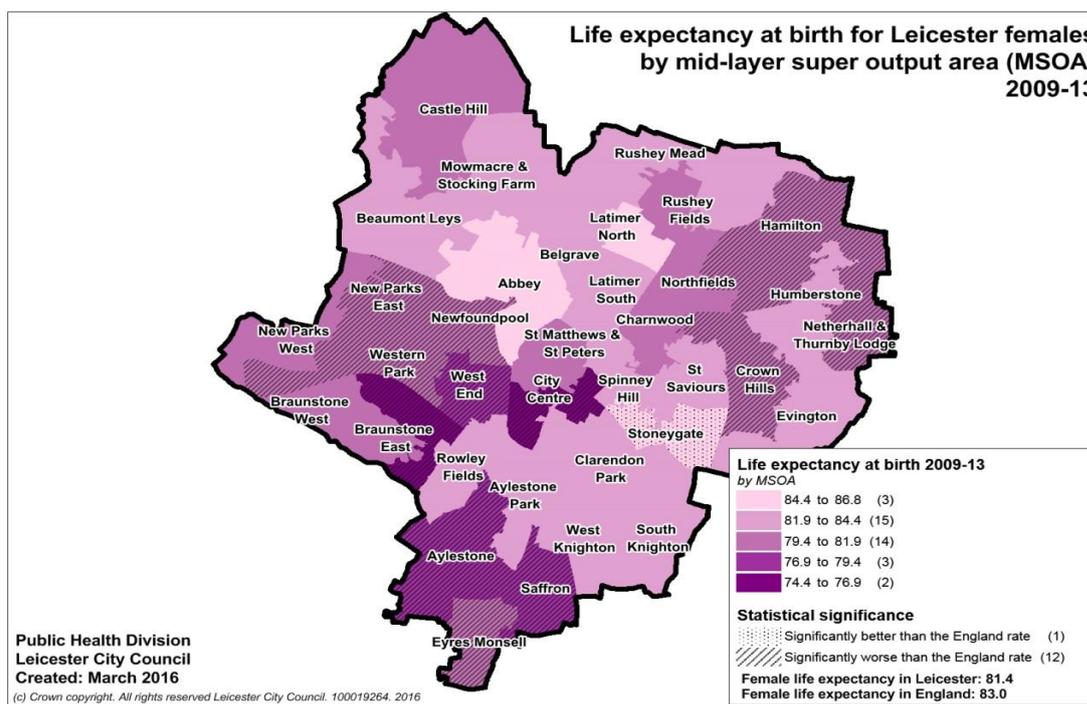
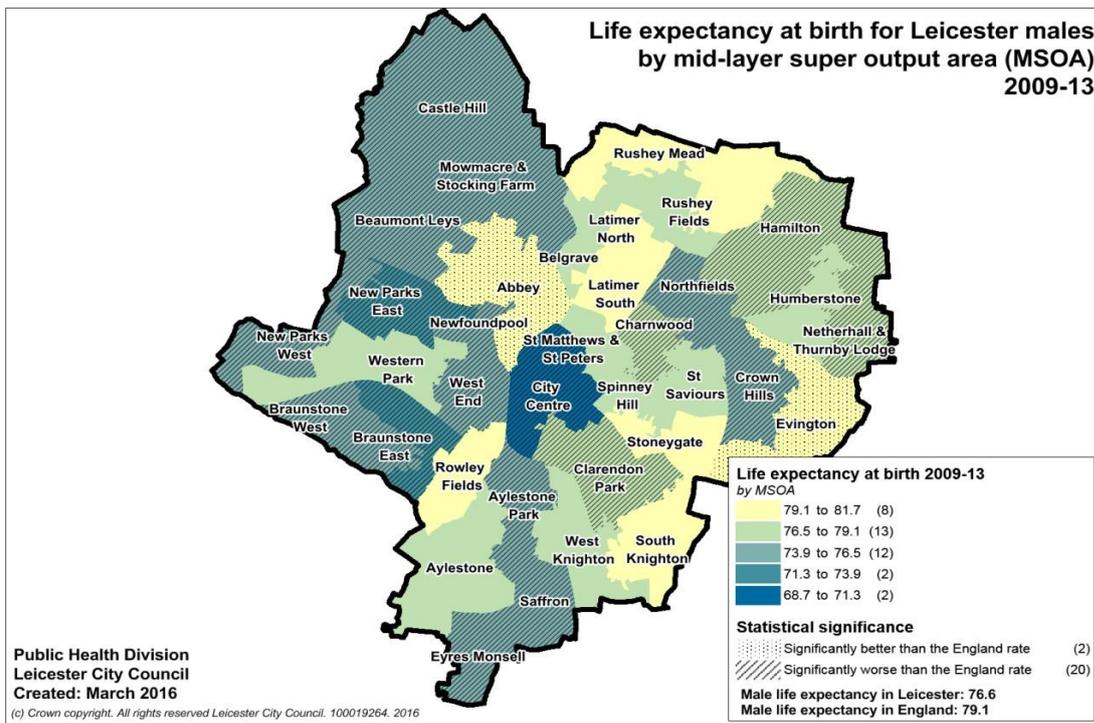


Figure 5: Life expectancy at birth for males in Leicester by MSOA (2009-2013)



3.3 Births

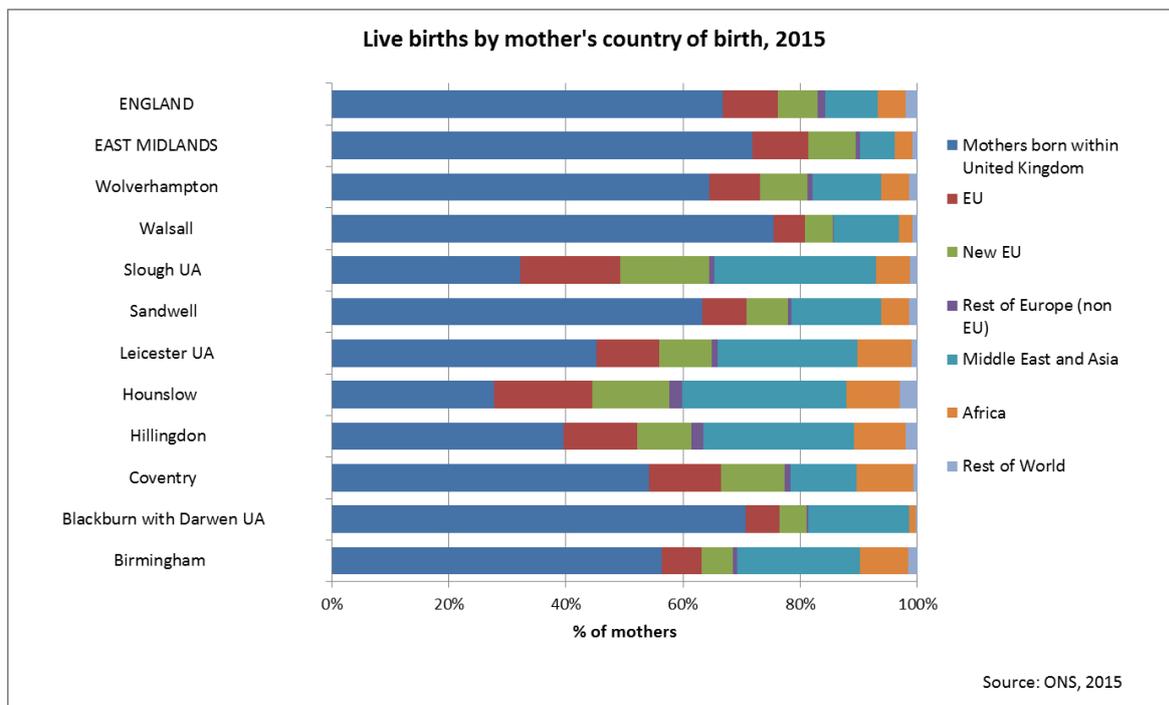
3.3.1 General Fertility Rate (GFR)

The GFR is the total number of live births per 1,000 females of child bearing age. There were 5,156 babies born to women in Leicester in 2015, giving a GFR of 64.8 per 1,000 women aged 15 to 44 years. Although there was a decrease from 68.3 per 1,000 in 2006, the GFR in 2015 was significantly higher than the averages for the East Midlands (61.3 per 1,000) and for England (62.5 per 1,000).

3.3.2 Mother's country of birth

Approximately 50% of births in Leicester in 2015 were to women born outside the UK. This is significantly higher than the England and the East Midlands averages (Figure 6). Countries in the Middle East and Asia are where 26% of Leicester's mothers were born.

Figure 6: Births in Leicester by mother's country of birth (2015)



4. The level of need in the population

4.1 Outcomes

4.1.1 Maternal mortality

Maternal deaths are those which occur during pregnancy or within 42 days of termination of pregnancy. They can be from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.

Cases of maternal death are relatively rare.¹⁶ The Confidential Enquiry into Maternal and Child Health¹⁷ showed that women living in situations where both partners were unemployed were up to 20 times more likely to die from a pregnancy related complication than those from more advantaged groups. Single mothers were found to be 3 times more likely to die than those in stable relationships. Women living in the most deprived areas of England had a 45% higher death rate compared to those living in more affluent areas.

¹⁶ They are documented triannually by Mothers and Babies - Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK), which replaced Centre for Maternal and Child Enquiries (CMACE)

¹⁷ A. M. Weindling (2003). The confidential enquiry into maternal and child health (CEMACH) Archives of diseases in childhood. Arch Dis Child.;88:1034-1037

Two thirds of maternal deaths in the UK are from medical and mental health problems in pregnancy. The remainder are from direct complications of pregnancy such as bleeding and other causes such as influenza. Heart disease is the leading cause of maternal death during or up to six weeks after the end of pregnancy.

The overall maternal mortality rate for England for 2012-14 was 0.39 per 100,000 women aged 15 to 44 years. There were no maternal deaths in Leicester in the same period.

4.1.2 Infant Mortality

Deaths that occur during the first year of life are a key indicator of the health of a population and are a measure of inequality. Infant mortality is linked to deprivation.

Various causal factors can contribute to deaths in the first year, so infant mortality rates are a crude indicator. The Marmot Review (2010) noted that factors such as births outside marriage, maternal age under 20 years old and deprivation were independently associated with an increased risk of infant mortality. Other factors associated with infant mortality include access to health services, consanguinity and substance misuse. The Marmot Review went further to say that 'low birthweight in particular is associated with poorer long-term health outcomes and the evidence...suggests that maternal health is related to socio-economic status.' Pregnancy is a key time for intervention to reduce infant deaths.

There are several measures of infant mortality used: stillbirth rate, perinatal death rate, neonatal death rate and post neonatal death rate.

- Stillbirths include foetal deaths occurring after 24 weeks' gestation
- Perinatal deaths include stillbirths plus deaths up to 7 completed days of life
- Neonatal deaths include deaths between birth and the 28th day of life
- Infant deaths include deaths up to age 1 year.

Perinatal and infant mortality rates in Leicester have not changed over the last 10 years, and these remain higher compared to England, the East Midlands and peer comparator authorities.

4.1.2.1 Stillbirths and perinatal deaths

Perinatal mortality includes stillbirths and deaths of all children from birth up to 7 days old. Stillbirths are defined as a baby delivered with no signs of life after 24 completed weeks of pregnancy.

Over the last 60 years perinatal death rates have fallen across the UK, but variation still exists between regions and localities. Much of the reduction in perinatal mortality has been associated with an overall improvement in the health and nutrition of the population and the major technological advances in the care of pregnant women and newborns.

Risk factors for stillbirths and perinatal deaths include maternal obesity, maternal age, smoking, ethnicity, diabetes, influenza, socioeconomic status and diabetes.

The perinatal mortality rate is the number of deaths per 1,000 births. Figure 7 shows that the perinatal mortality rate for Leicester has not significantly changed over the past 11 years. The

current rate (9.3 per 1000 births) is significantly higher than the England (6.8 per 1000 births) and East Midlands (6.9 per 1000 births) rates.

Figure 7: Trend in perinatal mortality rates for Leicester and peer comparators (2003-2014)

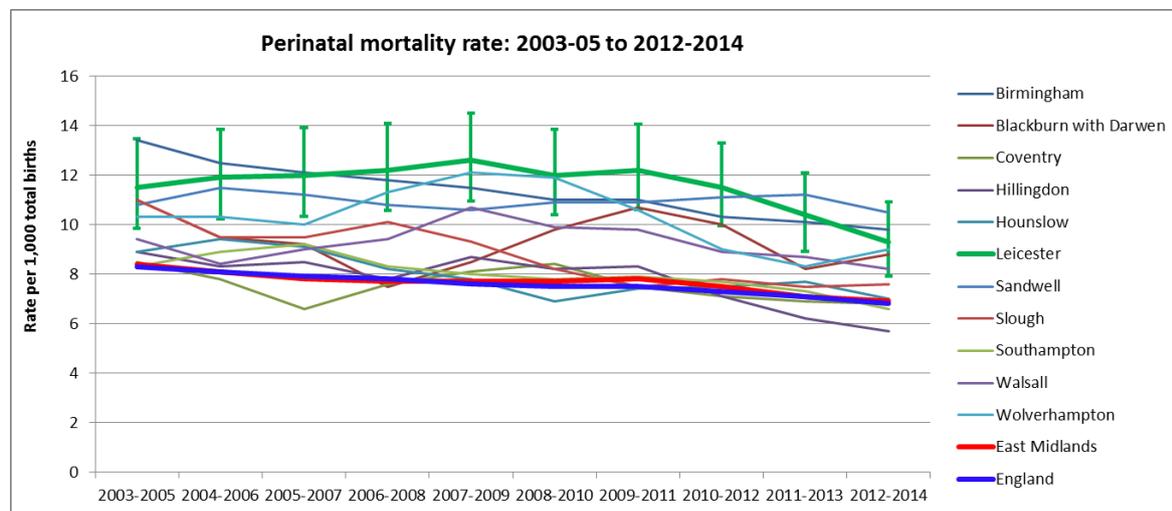
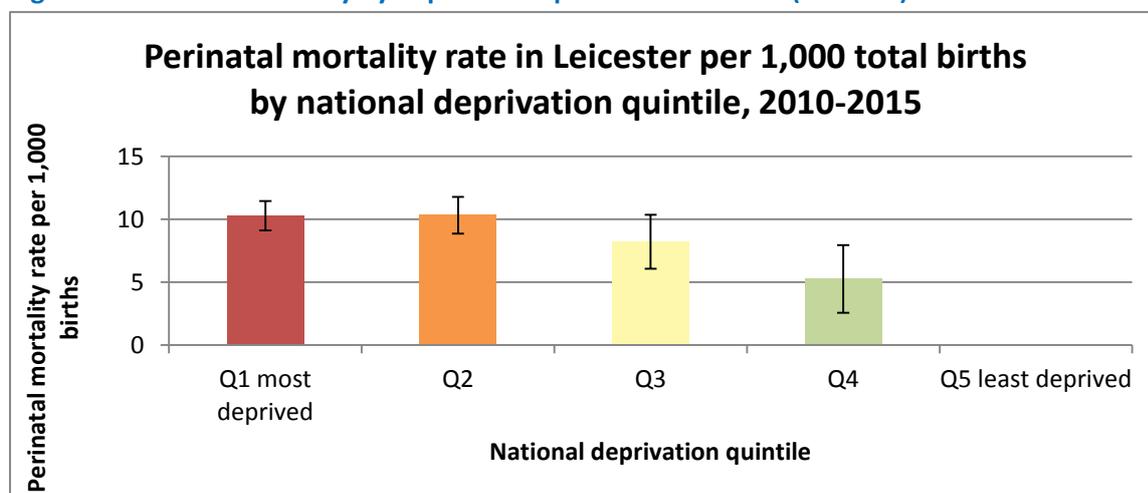


Figure 8 shows that there is a significantly higher rate of perinatal mortality in the most deprived quintiles of the Leicester population.

Figure 8: Perinatal mortality by deprivation quintile in Leicester (2010-15)



* Note Data suppressed for Q5 as number of deaths is less than 5

4.1.2.2 Infant deaths

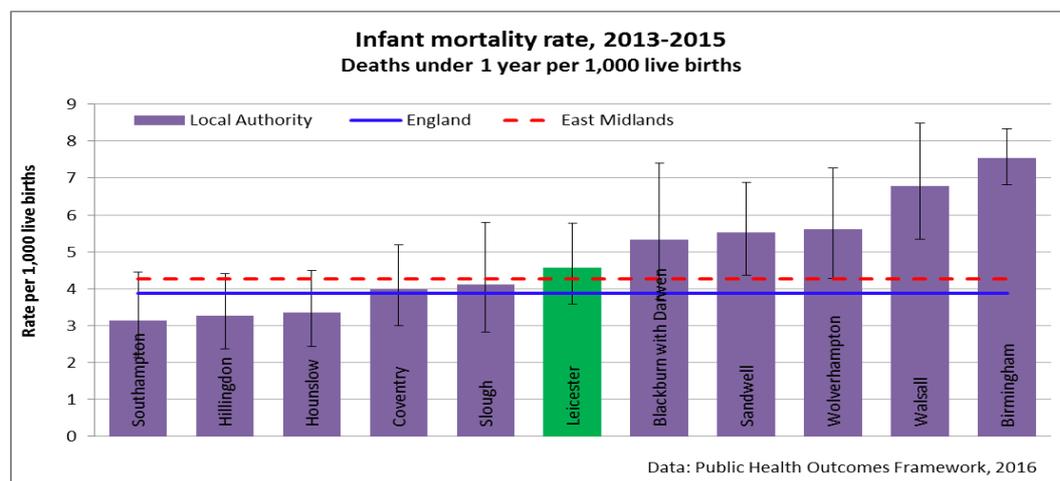
Infant mortality refers to the number of deaths in children under 1 year old. The Infant Mortality Rate (IMR) is the number of infant deaths (under 1 year old) per 1,000 live births; it is measured on a 3 year rolling average.

The IMR includes deaths for Sudden Infant Death Syndrome (SIDs). These deaths are sudden and unexplained deaths of apparently healthy infants. While the rates of SIDs have decreased nationally

SIDs remains a significant cause of death in this age group. Some factors that are thought to increase the risk of SIDs are putting the child to sleep on their front, exposing the child to passive smoke and smoking during pregnancy.

For 2013-15, the infant mortality rate for Leicester was statistically similar to the England and East Midlands averages (Figure 9). Leicester is statistically similar to all but one of its peer comparators. The IMR for Leicester has not changed significantly over the past 10 years.

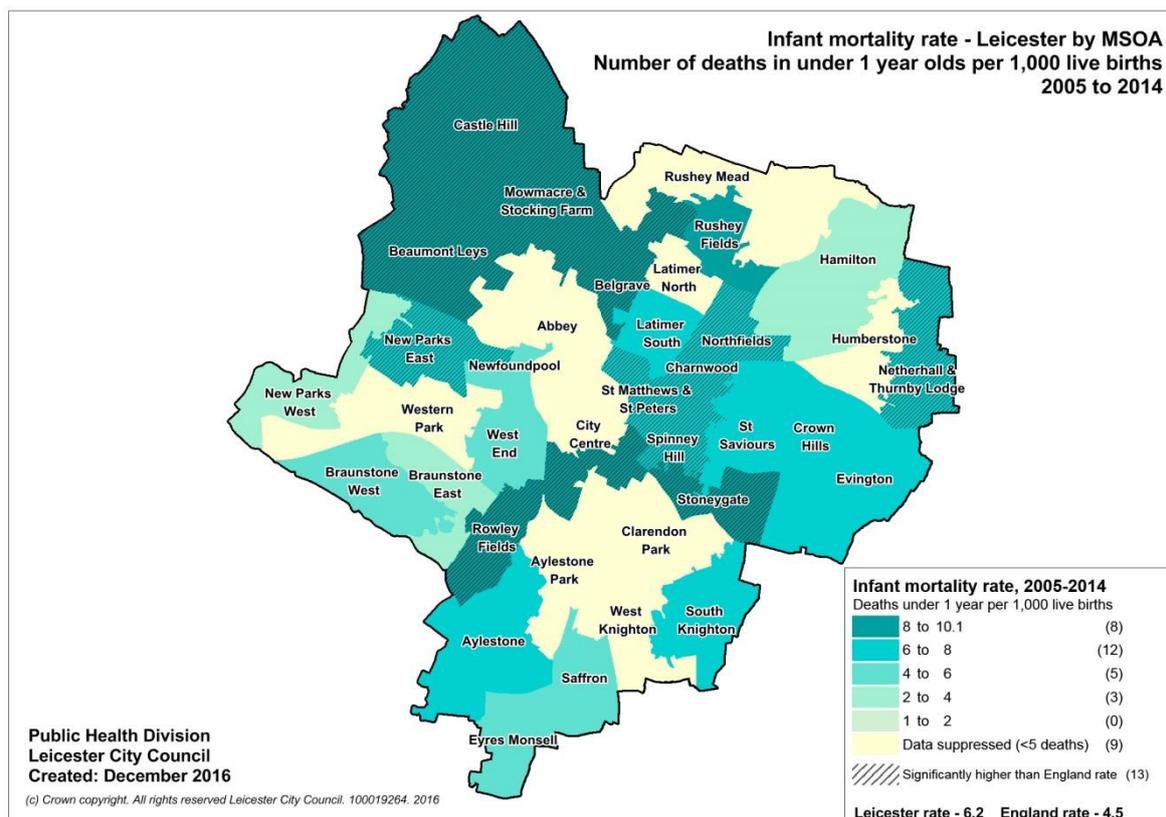
Figure 9: IMR for Leicester and peer comparators (2013-15)



As highlighted in the Marmot Review, deprivation is one of many factors contributing to IMR. Nationally the IMR has been reducing overall. While both lower and higher socioeconomic groups have seen reductions in IMRs, a gap remains between the two groups.

The IMR for specific areas of Leicester vary. There are 13 middle super output areas (MSOA) in Leicester that have significantly higher IMRs compared to England. These are primarily in the north west, centre and east of the city (Figure 10).

Figure 10: Infant mortality rate by Leicester Ward, 2005-14



4.1.3 Low Birth Weight (LBW)

The World Health Organisation defines LBW as a birth weight of a live born infant of less than 2,500g regardless of gestational age.¹⁸ It can have serious consequences for health in later life, and it is a factor in childhood morbidity and infant mortality, as mentioned above.

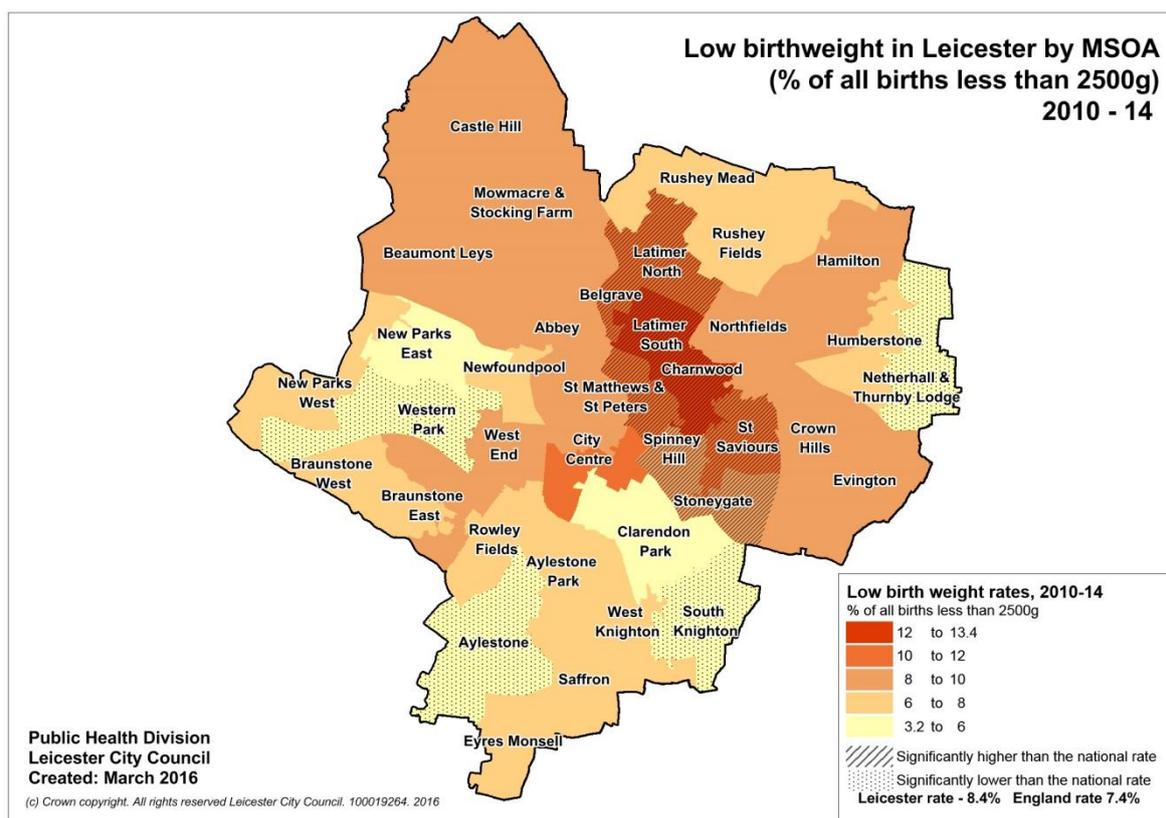
Mothers resident in areas of high deprivation are at greater risk of delivering a baby with LBW.¹⁹ Other factors that are associated with LBW are access to early antenatal, mother's age, general health, smoking status, nutrition and substance use during pregnancy. Ethnicity also plays a part with Pakistani, Indian, Bangladeshi, Black African and Black Caribbean women experiencing greater rates of LBW.

The areas of the city with a significantly higher proportions of births that are less than 2500g are the Eastern and Central areas of Leicester (Figure 11).

¹⁸ Global Nutrition targets 2025. Low Birth Weight policy brief. Retrieved from: http://www.who.int/nutrition/publications/globaltargets2025_policybrief_lb/en/ on 3 December 2015

¹⁹ R.,; Raybould S.; Jarvis S. (1993) **Deprivation, low birth weight, and children's height: a comparison between rural and urban areas.** BMJ 307:1458–1462

Figure 11: Map of low birth weight rates in Leicester wards: 2010-14



4.1.4 Teenage pregnancy

Conceptions by teenage females are generally unplanned, and both mother and child are more likely to have poor outcomes compared to other mothers and babies. Some of the poor outcomes for mother and baby include poor health (physical and emotional) and long-term poverty. Physical health complications for children of teenage mothers can be linked to biological immaturity or poor preconception health. Teenage mothers are at greater risk of having a baby with LBW, which can lead to increased health concerns for the child.

Teenage pregnancy refers to women who are aged less than 20 years when the pregnancy ends. The National Teenage Pregnancy Strategy²⁰ set a national target to halve the under-18 conception rate by 2010, as compared to the 1998 rate. Historically, Leicester has a higher than average rate of teenage pregnancy. By 2010 the Leicester rate had reduced by 40%. Although this did not meet the national target, the downward trend in Leicester has continued.

²⁰ The National Teenage Pregnancy Strategy (2010 retrieved from <http://webarchive.nationalarchives.gov.uk/20130401151715/https://www.education.gov.uk/publications/standard/publicationdetail/page1/DCSF-00224-2010> on 12 January 2015

The under-18 conception rate for Leicester in 2012/2014 was 29.3 per 1000 females aged 15 to 17 years old. The rate for England was 24.9 per 1000, and the rate for the East Midlands was 24.8 per 1000 15 to 17 year old females.

There were 8 wards in 2012/2014 that had teenage conception rates significantly higher than the England average. These wards were primarily located in the west and south of the city (Figure 13). This data is produced nationally and pre-dates changes to local ward boundaries.

Figure 12: Under-18 conception rate per 1,000 females aged 15-17 years

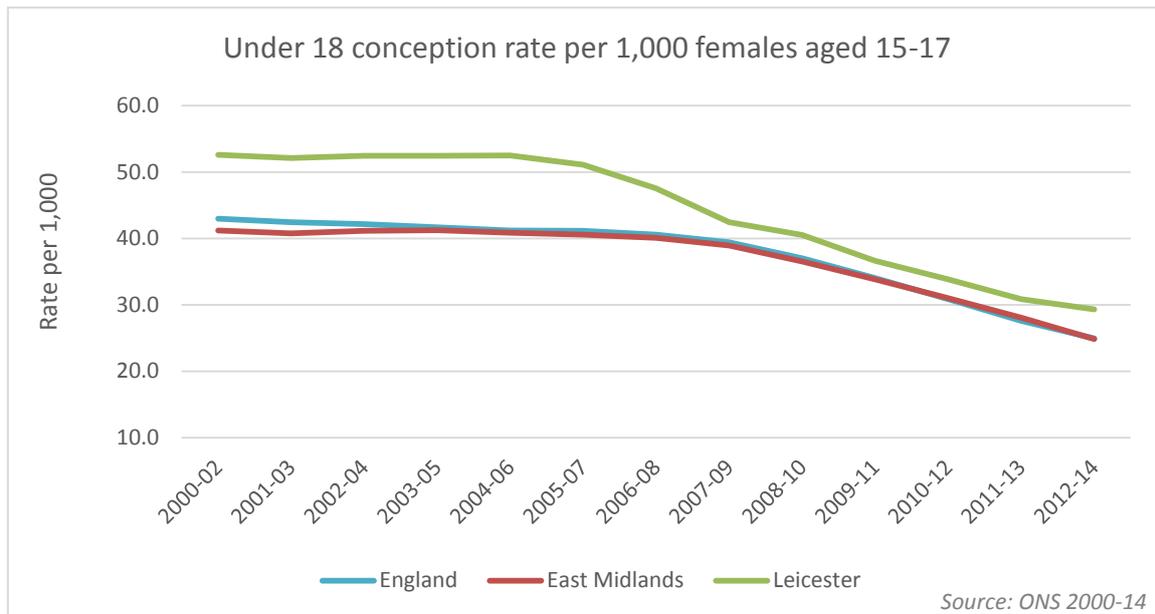
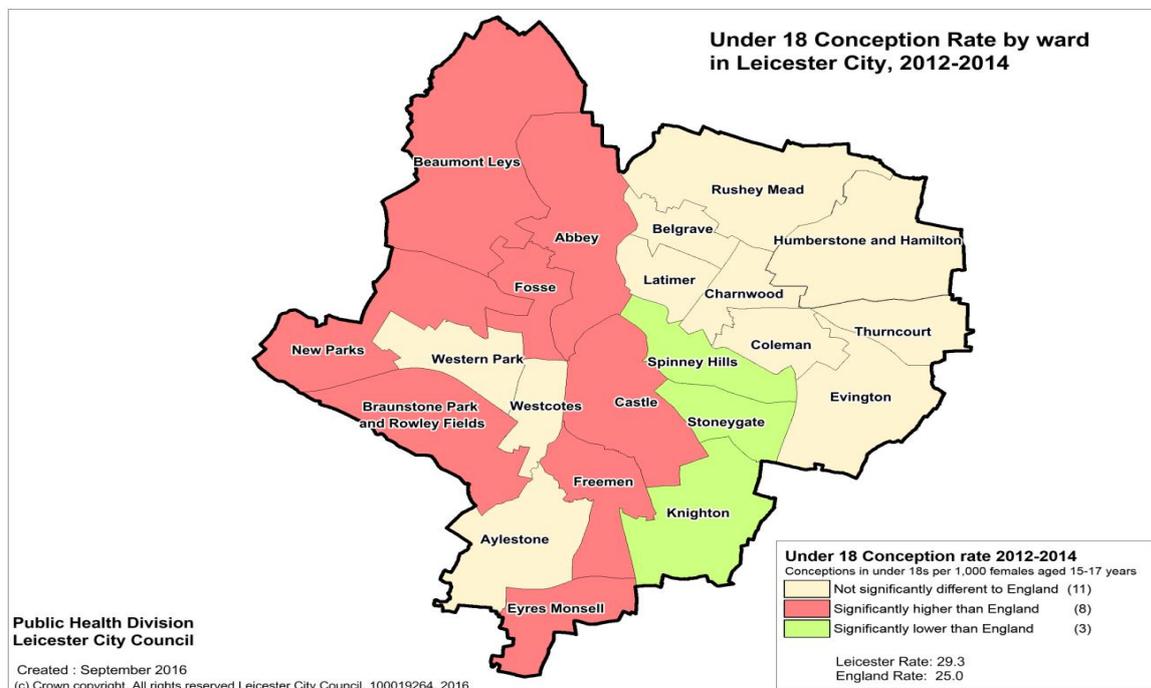


Figure 13: Under-18 conception rates (per 1,000) in Leicester by wards (2012-2014)



4.2 Determinants of Health

4.2.1 Substance misuse in pregnancy

4.2.1.1 Smoking during pregnancy

Smoking during pregnancy can have detrimental health impacts for mother and child. Research has shown some of the poor outcomes include:

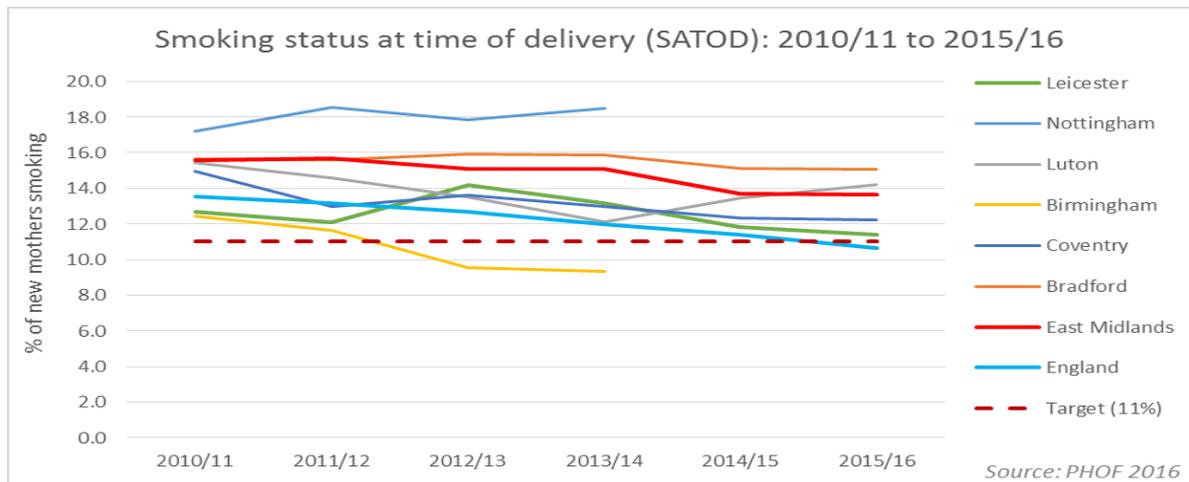
- Lower oxygen available to the mother and baby
- Increase the baby's heart rate
- Increase the risk of miscarriage and stillbirth
- Increase the risk of premature birth and low birth rate
- Increase the baby's risk of developing respiratory problems
- Increase the risks of birth defects
- Increase the risk of Sudden Infant Death Syndrome

The more cigarettes a pregnant woman smokes per day, the greater the baby's chances of developing these and other health problems. There is no safe level of smoking while pregnant. Stopping smoking in pregnancy can reverse and reduce some of the risks to both the mother and baby. Smoking in pregnancy varies by age and area of residence; younger women in the most deprived areas are more likely to smoke.

In 2011 the Department of Health (DH) set the national goal to reduce rates of smoking in pregnancy to 11% or less by the end of 2015.²¹ The relevant data is called Smoking at Time Of Delivery (SATOD). Figure 14 below shows that between 2010/11 and 2015/16 SATOD did not significantly decrease in Leicester, but the 2015/16 SATOD (11.8%) was close to the National Ambition.

Figure 14: Smoking Status at the time of delivery (2010/11 to 2015/16)

²¹ HM Government (2011). Healthy lives, healthy people A tobacco control plan for England. Retrieved from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/21. On 2.December 2015.



After birth exposure to smoke is a significant health risks for both mother and baby. Smoking causes harm to children through second hand or passive smoking. Some of the poor outcomes for children associated with second-hand smoking are an increased risk of asthma, of ear infections and deafness, and of SIDs.

4.2.1.2 Alcohol Consumption during Pregnancy

Alcohol consumption during pregnancy can cause premature birth, LBW and some congenital anomalies. It can also lead to preventable medical conditions described as Foetal Alcohol Spectrum Disorder (FASD).²² These conditions include abnormal head and facial development, growth failure, and neuro-developmental delay. The highest risk period for foetal damage is the first three weeks of pregnancy.

It is a difficult period to influence women’s drinking behaviour during the first three weeks of pregnancy because many women may be unaware that they are pregnant. The Department of Health advises pregnant women to abstain from drinking alcohol.

At present it is not known which groups are most at risk of having a child with FASD. This is partly because some symptoms associated with FASD may be caused by other factors: this means there are no local data available on the incidence or prevalence of FASD.

Locally there are also no data on the number of women who drink in pregnancy or the quantity they consume.

²²What is Foetal alcohol spectrum disorder? (2013) accessed from <http://www.fasdnetwork.org/what-is-fasd.html> on 2 December 2015.

4.2.2 Perinatal Mental Health

Women's health and wellbeing before, during and after childbirth are risk factors for whether or not a child has a healthy start in life. Perinatal mental health problems are mental health conditions which complicate pregnancy and the year that follows childbirth. Evidence shows the incidence of new onset mental illness is not elevated in pregnancy but the risk is higher following delivery.

In contrast, recurrences of severe depressive conditions do occur in pregnancy. Non-psychotic conditions such as depressive illness and anxiety are common during pregnancy and after delivery. Psychotic illness in pregnancy is associated with poorer pregnancy outcomes, such as premature birth, stillbirth, perinatal death and neurodevelopmental disorder.²³ These conditions cause distress, affect adjustment to motherhood and the care of the new baby and any existing children.

Acute serious perinatal mental illness can present as an emergency and may result in inpatient care. Separation at this crucial time can have a detrimental impact on mother and child attachment, a cause of further distress which prevents important processes such as breastfeeding.²⁴

Non-psychotic depression and anxiety, especially that which is associated with social adversity, can affect the child's emotional health and social and cognitive development.^{25,26} Prevention, early identification, diagnosis and effective treatment of perinatal mental illness can reduce the number of children with short and long term mental health problems.²⁷ Serious perinatal psychotic disorder is associated with an increased risk of suicide.²⁸

Data on perinatal maternal mental illness are not routinely collected, so it is not possible to report the actual local prevalence of various types of perinatal poor mental health in Leicester.

²³ Howard, L., et al, 2003, Medical outcome of pregnancy in women with psychotic disorders and their infants in the first year after birth. *Br J Psychiatry* 182: 63-7

²⁴ Henderson, J. J., Evans, S., Straton, J., Priest, S. R., & Hagan, R. (2003). Impact of Postnatal Depression on Breastfeeding Duration. *Birth*, 30(September), 175-180.

²⁵ Murray, L., et al, (1996). The cognitive development of 5 year old children of postnatally depressed mothers. *Journal of child Psychology and Psychiatry* 37: 927-35

²⁶ Pearson R.M., Evans J. & Kounali, D. et al. (2013). Maternal depression during pregnancy and the postnatal period: risks and possible mechanisms for off spring depression at age 18 years. *JAMA Psychiatry*, 70: 1312-19.

²⁷ Pearson R.M., Evans J. & Kounali D. et al. (2013). Maternal depression during pregnancy and the postnatal period: risks and possible mechanisms for off spring depression at age 18 years. *JAMA Psychiatry*.70: 1312-19.

²⁸ Oates, M.& Cantwell, R. (2011). Deaths from psychiatric causes in Saving Mother's Lives. Reviewing maternal deaths to make motherhood safer 2006-2008. *British Journal of Obstetrics and Gynaecology*: 118 (Sup 1)

4.2.3 Long Term Conditions and Illnesses

4.2.3.1 Overweight or Obesity in Pregnancy

In England, approximately half of all women of childbearing age are overweight or obese. Obesity and overweight can impact the health of women and their babies in a variety of ways. Women who are obese when they become pregnant have an increased risk of complications during pregnancy and childbirth.²⁹ These complications include impaired glucose tolerance, gestational diabetes, miscarriage, pre-eclampsia, thromboembolism and maternal death. Obese women giving birth are likely to stay in hospital 4 to 6.5 days longer than women of normal weight. In addition, babies born to obese women have a higher risk of foetal death, stillbirth, congenital abnormality and obesity later in life.³⁰

The risks associated with obesity for particular ethnic groups are heightened during pregnancy. Women from Asian/Asian British ethnic backgrounds are at a greater risk of increased insulin resistance in late pregnancy. Pre-pregnancy Body Mass Index (BMI) has a much greater effect on insulin resistance during pregnancy in Asian/Asian British women compared to White/White British women. Asian/Asian British women are 11 times more likely to develop gestational diabetes than White British women.³¹

The most recently available UHL maternity data shows that 25% of pregnant women in Leicester who booked with University Hospitals of Leicester were recorded as being overweight with 19%³² being obese. This is significantly higher than the England average.

4.2.3.2 Diabetes in Pregnancy (Pre-existing and Gestational)

Diabetes is the most common pre-existing condition complicating pregnancy in the UK. Approximately one in 250 pregnant women has pre-existing diabetes.³³ Both pre-existing and gestational diabetes are associated with increased risk of stillbirth, congenital malformations and perinatal mortality. Babies affected by maternal gestational diabetes may also be at risk of diabetes in later life.

²⁹ NHS Choices. Pregnancy and baby. Retrieved from <http://www.nhs.uk/conditions/pregnancy-and-baby/pages/overweight-pregnant.aspx#close> on 2 December 2015

³⁰ Isaacs, J.D., Magann, E.F., Martin, R.W., Chauhan, S.P. & Morrison, J.C. (1994). Obstetric challenges of massive obesity complicating pregnancy. *J Perinatol*, 14:10–14

³¹ Dornhorst A, Paterson CM, Nicholls JSD et al. (1992). High prevalence of gestational diabetes in women from ethnic minority groups. *Diabetic Medicine*

³² Sourced from UHL maternity data

³³ Department of Health. Diabetes in pregnancy retrieved from: http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/browsable/DH_4915754 on 2 December 2015.

The risk of type-2 diabetes is increased 4 to 6 fold in people from Asian/Asian British ethnic backgrounds compared to those from a White British background.³⁴ Women from ethnic backgrounds other than white may also have elevated diabetes risks associated with obesity during pregnancy. For example pre-pregnancy Body Mass Index (BMI) has a greater effect on insulin resistance during pregnancy in Asian/Asian British women, such that they are 11 times more likely to develop gestational diabetes compared to women from White British ethnic backgrounds.³⁵

Gestational diabetes usually occurs during the second or third trimester, usually because the body may not be able to produce enough insulin to meet the extra demands of later pregnancy. Women diagnosed with gestational diabetes are 30% more at risk of developing type 2 diabetes later in life.³⁶ UHL data indicates that 4.8% of pregnant women in Leicester developed gestational diabetes in 2014/15.

4.2.4 Domestic Violence (DV) in pregnancy

DV is “any incident of threatening behaviour, violence or abuse between adults who are, or who have been, in a relationship, or between family members. It can affect anyone regardless of his or her gender or sexuality. The violence can be psychological, physical, sexual, or emotional.”³⁷ DV includes issues of concern that may affect specific BME communities, such as ‘honour based violence’, FGM and forced marriage.

About a third of DV cases start or escalate during pregnancy. This is associated with increased rates of miscarriage, LBW, premature birth, foetal injury and foetal death.³⁸ Woman who experience DV may have difficulties using antenatal care services; for example, the perpetrator may prevent her from attending appointments. These situations are complicated by fears that disclosure will worsen rather than alleviate the situation, and anxieties about the response of healthcare professionals.

³⁴ Barnet, A., Raymond, N.T., Kumar, S. (2006). Type 2 diabetes and cardiovascular risk in the UK South Asian community. *Diabetologia* 49: 2234–46

³⁵ Dornhorst, A., Paterson, C.M. & Nicholls, J.S.D, et al. (1992). High prevalence of gestational diabetes in women from ethnic minority groups. *Diabetic Medicine*

³⁶ NHS choices. Diabetes. Retrieved from: <http://www.nhs.uk/conditions/diabetes-type2/Pages/Introduction.aspx> on 2 December 2015

³⁷ New definition of domestic violence to include 16-17 year olds. HM Government press release. Retrieved from: <https://www.gov.uk/government/news/new-definition-of-domestic-violence-and-abuse-to-include-16-and-17-year-olds>

³⁸ National service framework for children, young people and maternity services. Maternity services (2004). Department of health. Retrieved from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/199957/National_Service_Framework_for_Children_Young_People_and_Maternity_Services_-_Maternity_Services.pdf

The NICE guidance on pregnancy and complex social needs includes domestic abuse³⁹. This guidance details what commissioners and practitioners should do to enable these women to be fully supported and receive adequate antenatal care.

In Leicester, the SAFE Project (See Services Section for more information) supported 1609 victims between April 2013 and November 2015. 67% of the victim-survivors had children, and approximately 7% were pregnant at the time of entry to the service. Around 20% of victim-survivors with children were noted as being known to the LCC Children's and Young People's services. Women under 19 years of age constituted approximately 4% of victim-survivors supported by the project.

There are a large number of local organisations who hold information about domestic violence and who are taking action to support victims of DV. Improving the consistency of how this data is collected and coordinated will be key to making sure that there is an accurate picture of need across the whole city.

4.2.5 Antenatal screening and immunisations

4.2.5.1 Antenatal screening

All pregnant women in Leicester are routinely offered antenatal screening for HIV, Hepatitis B and Syphilis, and susceptibility to Rubella. The screening programme aims to ensure that women with positive screens are offered appropriate assessment and management of their condition and to reduce the risk of mother-to-child transmission.

4.2.5.2 Immunisations in pregnancy

Influenza

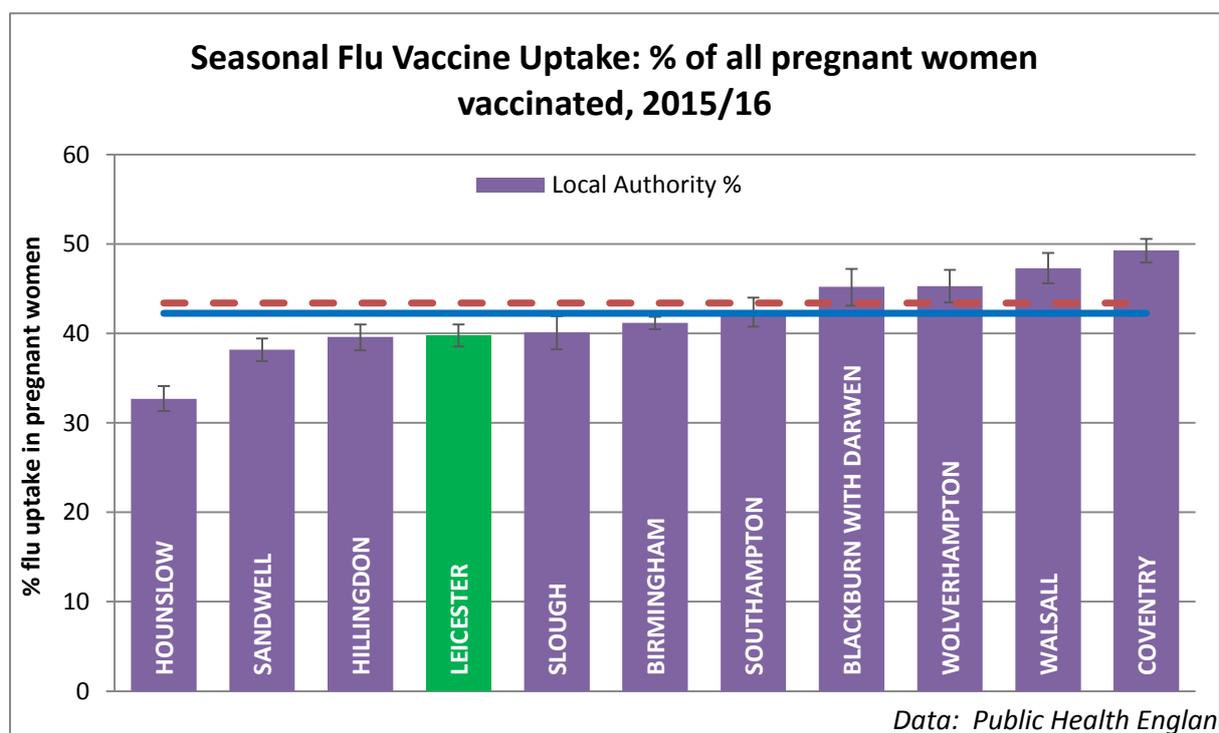
The H1N1 (Swine Flu) pandemic in 2009/10 resulted in an increase in complications from influenza in pregnant women. As a consequence of the pandemic, pregnant women were added to the list of those considered to be at high risk from seasonal flu.

Strong evidence shows that contracting influenza in pregnancy affects the unborn baby. Babies born to women who have had flu while pregnant are more likely to be born prematurely and to have LBW. This may be due to an inflammatory response from influenza which can trigger premature labour. Influenza in pregnancy can lead to stillbirth or death in the first week of life.

³⁹ <https://www.nice.org.uk/guidance/cg110/chapter/1-Guidance#pregnant-women-who-experience-domestic-abuse>

The uptake of the seasonal influenza vaccine by Leicester’s pregnant women was significantly lower than the England and East Midlands averages (Figure 15) and should be kept under review by the local Health Protection Board.

Figure 15: Uptake of seasonal flu vaccine by pregnant women (2015/16)



Whooping Cough

Whooping cough (pertussis) is a serious bacterial respiratory infection which can be severe in young babies. Following an increase in the number of whooping cough cases, a national vaccination programme against pertussis was introduced for all pregnant women in 2012.⁴⁰ By vaccinating pregnant women, unborn babies are protected from developing whooping cough in the first few weeks of life. Current data on uptake of this vaccine is not available.

Mortality Review Bodies

4.3 Maternal mortality reviews

All maternal deaths are ‘Serious Incidents’ and are investigated and reported as such by the UHL Quality and Safety teams.

⁴⁰ NHS choices. Whooping cough in pregnancy retrieved from: <http://www.nhs.uk/conditions/pregnancy-and-baby/pages/whooping-cough-vaccination-pregnant.aspx> on 2 December 2015.

4.3.1 Perinatal and infant mortality reviews

Since April 2008 Local Safeguarding Children Boards (LSCB) are required to review the death of every child normally resident in a locality. The Leicester, Leicestershire and Rutland Child Death Overview Panel (CDOP) is a subgroup of the three LSCBs. The main purpose of the CDOP is to identify factors that might have prevented a child's death.

The University Hospitals Leicester (UHL) Perinatal Mortality Review (PMR) group is a multi-disciplinary group which reviews all perinatal deaths, including those born at less than 23 weeks gestation and stillbirths. Cases are reviewed at the PMR before consideration by CDOP. The main purpose of the PMR is to identify factors which could have contributed to the death of a child. The Child Death Review Manager attends both the PMR and CDOP meetings. Cases are presented to the CDOP by a consultant neonatologist, who is also a member of the PMR group.

4.3.2 Infant mortality strategy

Given the higher than average rate of infant mortality in Leicester, the Infant Mortality Strategy Group (IMSG) is developing a strategy setting out actions to address infant mortality risk.

5. Current Services

There are a number of services that are particularly relevant to this age group.

5.1 Midwifery services

There are two medical and midwife led units in Leicester; at Leicester Royal Infirmary and Leicester General Hospital. This service has specialist midwives who focus on teenage parents, substance misuse, homeless, asylum seekers, mental ill health and safeguarding concerns.

5.1.1 Early access to maternity services

Access to midwifery services by the twelfth week of pregnancy is associated with better outcomes, lower rates of complications in pregnancy and labour and fewer maternal and perinatal deaths.

In 2010/11 the proportion of Leicester's pregnant women (<80%) who had early access to maternity services was significantly lower than England, the East Midlands and some peer comparators. Currently no data are available to compare Leicester to its peers but local data show that 87% of bookings in Leicester were made within 12 weeks or less in 2015/16. Continuing to improve this needs to be an important priority for local health services.

5.1.2 Home births

The type of delivery, method, venue and the lead professional can influence outcomes for mother and child. With appropriate care and support most healthy women, assessed as low risk of complications, can give birth with minimal medical intervention. All pregnant women should be offered evidence-based information to enable informed decisions about childbirth options, such as home births, midwife-led births or consultant-led births.

5.2 Services and initiatives to support and promote breastfeeding

5.2.1 UNICEF Baby Friendly Initiative

UNICEF has developed standards to promote and support breastfeeding. The implementation of the standards will help to improve care and support for women and families; enabling women to build strong and healthy relationships with their babies. Organisations which meet the UNICEF standards can receive the Baby Friendly accreditation. This suggests that the organisation has demonstrated a welcoming breastfeeding culture and that all staff members are confident, competent and consistent in supporting breastfeeding. UHL has achieved Stage 2 of the 'Baby Friendly' assessment and is currently working towards Stage 3, the final stage. Leicestershire Partnership Trust (LPT) has achieved Stage 3.

5.2.2 Breastfeeding peer support

NICE recommends a co-ordinated breastfeeding peer support programme to help women initiate and continue breastfeeding. In Leicester the National Childbirth Trust (NCT) supports breastfeeding groups in Children, Young People and Families Centres, offering hospital ward-based support and home visits to eligible women.

5.3 Substance misuse in pregnancy services

5.3.1 Alcohol and drugs

UHL provides specialist midwifery for women who misuse substances, through to 28 days after birth. The midwife assesses need, initiates appropriate support and refers to other services. The specialist midwife for substance misuse works in partnership with the criminal justice system, New Futures, Inclusion Health Care and Turning Point to deliver care packages with the aim of supporting both mother and baby and keeping them together. The specialist midwife carries out brief interventions, provides weekly clinics at UHL and conducts home visits.

5.3.2 Smoking

The Leicester Stop Smoking service has two dedicated practitioners who specialise in smoking cessation in pregnancy. Smoking cessation is a core component of midwifery work, and 3 midwives have a special interest in this topic area. Leicester's Stop Smoking Service has a significantly higher rate of pregnant women quitting smoking compared to the national average and peer comparator areas.

The Leicester City Stop Smoking Service also works with agencies, including Community Midwives and Midwifery Support Workers, to deliver the 'Step Right Out' programme. This aims to raise awareness about the dangers of second hand smoke and to encourage people to sign a 'Step Right Out' pledge to keep their home smoke free for the benefit of their families' health. Research has shown that making a commitment to keep the home smoke free can be important in addressing smoking behaviour and moving towards quitting. Since 2012, the number of pregnant women signing up to the pledge from Community Midwives and Midwifery Support Workers has been increasing.

5.4 Mental health services

In Leicester, women see obstetricians and midwives regularly throughout their pregnancy and at 28 weeks, they have their first contact with a health visitor. All midwives and health visitors receive training for the detection of mental illness in pregnancy and following childbirth.

Maternal mental health is assessed at various stages in the perinatal period. Women with mental health problems are seen by health visitors, services in Children, Young People and Families Centres or referred to specialist mental health services, such as Open Mind Improving Access to Psychological Therapies (IAPT) or the Specialist Perinatal Outreach Mental Health Service.

The LLR Specialist Perinatal Outreach Mental Health Service is provided by LPT. Specialist inpatient care is delivered regionally at inpatient units which are compliant with NICE and Royal College of Psychiatry guidance.

The outreach service is staffed by a Consultant Liaison Psychiatrist and community psychiatric nurses. The service holds outpatient clinics at the Leicester Royal Infirmary and LPT. Patient surveys show reduced levels of stigma associated with mental illness and higher levels of acceptance when clinics are held in the maternity units. The service liaises with obstetrics, offers second opinions, advises on medication, contributes to safeguarding and trains other clinicians.

Community based perinatal psychiatry includes home support for women with serious mental illness, working closely with the mental health crisis care team. The service assesses and manages significant mental illnesses that complicate pregnancy and the postpartum period which cannot be managed effectively and safely by primary care services. The majority of referrals come from primary care.

5.5 Maternal Obesity and Diabetes Service

In line with NICE guidance, midwives will offer the following to pregnant women who are obese or overweight:

- Offer practical and tailored information on weight management.
- Dispel any myths about what and how much to eat while pregnant.
- Advise that moderate-intensity physical activity will not harm her or her unborn child. At least 30 minutes of moderate-intensity activity per day is recommended.
- Give specific and practical advice about being physically active.
- Offer women with a BMI of 30 or more at the booking appointment a referral to a dietitian or appropriately trained health professional for assessment and personalised advice on healthy eating and how to be physically active.
- Encourage mothers to lose weight after pregnancy.

Women with pre-existing diabetes should be referred to the multi-disciplinary (MDT) clinic as early as possible when pregnant. Referrals can be made by GP, Diabetes Specialist Nurse (DSN), Community Midwife or the woman herself. A weekly clinic runs at both LRI and LGH. The pathway is likely to include regular blood glucose monitoring and insulin dose adjustment if necessary. Scan appointments are booked for 12, 20, 28, 32, and 36 weeks of pregnancy. Retinal screening is performed in the first and third trimester. Women are followed up in the MDT clinic as often as is

clinically indicated to maintain good glucose control but at least monthly. An individual plan for delivery is discussed at 36 weeks.

There is a monthly pre-conception clinic, run by a Consultant Obstetrician and Consultant Diabetologist, at LGH. UHL closely follows the NICE guidance for Diabetes in Pregnancy (NG3) published February 2015.

5.6 Teenage Pregnancy Services

Reducing the number of teenage pregnancies will contribute to improved outcomes for children. A co-ordinated approach to the issue, including close working with young people, has seen a significant reduction in number of teenage pregnancies in Leicester. Young people are provided with free condoms from a variety of community-based sites such as pharmacies and youth services. There is also an emphasis on young people receiving advice and information about relationships and sexual health and in encouraging them to discuss these issues with their family.

There are two specific services aimed at teenage mothers; this includes dedicated support through the Family Nurse Partnership service and the specialist teenage midwife, who assesses cases and provides more intensive care and support as required. Support from midwifery can be extended up to 28 days after.

5.7 Services for New Arrivals

ASSIST provides care and support for all pregnant women who are asylum seekers and refugees. There is also a partnership group which discusses a co-ordinated response for new arrivals in Leicester.

5.8 Family Nurse Partnership (FNP) Service

The FNP is a licenced, evidenced-based, targeted, preventative programme for vulnerable first time mothers (under 19 years) with voluntary participation. The scheme runs from the antenatal period (preferably before 16 weeks of pregnancy) until the child is 2 years old. The family nurse practitioner visits the families on a weekly or fortnightly basis according to the prescription of the programme. The focus of FNP is the future health and well-being of the child and mother. There are 7 WTE FNPs in Leicester; all are health visitors. The service can take up to 150 clients at maximum capacity. The programme accepts self-referrals and referrals from all professionals. Approximately 10% of clients have been or are currently looked after children (LAC). FNP was launched in Leicester at the end of 2011 and as of July 2015, 185 mothers have been recruited, 75 have graduated, 35 have dropped out and 75 continue to participate. This programme has recently been recommissioned as part of the city's 0-19 Healthy Child Programme.

5.9 Children, Young People and Family Centres

Children, Young People and Family Centres (CYPFs) are core to the Early Help offer with a renewed focus on the most disadvantaged families. CYPFs have a role in promoting parenting and nurturing skills. As community based services they are accessible to all families with young children and have an important role in identifying and supporting families with greatest need.

The CYPFs offer a range of universal and targeted programmes with the aim to ensure good health and wellbeing in all children under 5 years of age and to support parents in ensuring their children develop well and are ready for school. There is a strong focus on promoting help when needs are first identified and particularly for children from hard to reach families.

5.10 Antenatal Parenting Education Service

There are different antenatal parenting education classes available in Leicester. Since April 2015 an antenatal programme has been developed with Midwifery Support Workers, Health visitors and Children, Young People and Families Centre staff called Bumps to Babies. Beyond this basic provision paid sessions are also available.

The Bump to Babies programme is delivered by Children, Young People and Families Centre staff, health visiting and midwifery teams through CYPF centres across the city. First time mothers and those with additional needs are particularly encouraged to attend. The programme provides a forum to raise concerns, share experiences and develop relationships with other group members. Early contact with the CYPF centres should encourage parents to access other services and enable timely identification of parents who need additional services. The programme is based on the DH resource pack Preparation for Birth and Beyond⁴¹.

5.11 Early Help Service

EH services in Leicester are for children, young people and families whose needs are not being met by routine services but who do not need specialist services. The services are for children of all ages and not just the very young. LCC leads on the EH offer, but there is now greater emphasis on staff in all agencies working with children to provide direct support, signposting and a co-ordination of agencies working with the family. EH services can be provided at any point of need and can be very effective in supporting a child, young person and/or their family to step down from statutory services as well as preventing the escalation of issues.

More information may be found at www.leicester.gov.uk/earlyhelp

Midwives are involved in Early Help. They work with partners such as Border House and refer into Children, Young People and Family Centres, Early Help and a number of local charities including SAFE, NSPCC and Open Hand.

⁴¹ Department of Health (2011). Preparation for birth and beyond: a resource pack for leaders of community groups and activities (2011). Retrieved from <https://www.gov.uk/government/publications/preparation-for-birth-and-beyond-a-resource-pack-for-leaders-of-community-groups-and-activities> on 3 December 2015

5.12 DV Services in Pregnancy

Specialist midwives and other key professionals from voluntary and statutory agencies are involved in Multi Agency Risk Assessment Conference (MARAC) for women with children who are experiencing the highest risk of domestic violence and abuse. During these victim-focused meetings, all professionals work together to share information and ensure the right support and care is put in place for the woman and her children.

There are four specialist services commissioned by Leicester City Council for DV. The services include the DV Family Service, Safe Home Service, the SAFE Project and the DV Perpetrator Intervention Service.

The DV Family Service provides individual and group support (and awareness work) to children and young people on domestic violence. This includes individual and group work with parents and carers of those children and young people. The contract includes respite and practical activities such as crèche provision and play groups as well as emotional support to deal with the impact of domestic violence. The service also includes specific interventions for young people who have started to use abusive behaviour following their exposure to domestic violence between their parents/ caregivers.

The Safe Home Service includes women only (with or without children) refuge accommodation. They also provide other accommodation related support such as security measures for homes, general housing related advice and emergency temporary accommodation for men fleeing domestic violence.

The Victim-Survivor Service (The SAFE project) is the main pathway for accessing support and information for people affected by domestic violence. It is a service for concerned friends and family members, local practitioners and those who have been victim of domestic violence or those concerned about their own behaviour. There is a helpline service, website, individual and group support. This includes crisis and court support and longer term emotional support. It also includes an element of counselling service.

DV Perpetrator Intervention Service (the Jenkins Centre) provides voluntary services for men and women concerned about their own abusive behaviour and motivated to change. The service is Respect accredited and involves individual and group work. The service includes contact and support of partners and ex-partners of those perpetrators.

6 Projected service use

6.1 Fertile Population Projection

The fertile population (15 to 44 year female population) in Leicester is predicted to decrease by 2.15% by 2021 and therefore there will be a slightly reduced burden on maternity services.

6.2 Maternal Mental Health

The table below shows that the number of births in Leicester is projected to decrease slightly over the next 10 to 15 years from an estimated 5,400 to 5,200 in 2030. As the birth rate is projected to decrease over the next decade, the maximum number of cases per year of perinatal mental illness is expected to drop from 2,776 in 2015 to 2,674 by 2030. However, the table below shows that the number of cases of serious perinatal maternal mental illness is not expected to decrease. The largest decrease is expected in the number of cases of depression, anxiety and adjustment disorders.

Table 3: Estimated rates of Perinatal Mental Illness for Leicester (2015-2030)

Births and disorders	Rate of Perinatal Psychiatric Disorder per 1,000 maternities	2015	2020	2025	2030
Projected Births		5,400	5,300	5,200	5,200
Postpartum psychosis	2/1,000	10.8	10.6	10.4	10.4
Chronic serious mental illness	2/1,000	10.8	10.6	10.4	10.4
Severe depressive illness	30/1,000	162	159	156	156
Mild to moderate depressive illness and anxiety	100-150/1,000	540-810	530-795	520-780	520-780
Post-traumatic stress disorder	30/1,000	162	159	156	156
Adjustment disorders and distress	150-300/1,000	810-1,620	795-1,590	780-1,560	780-1,560

Chapter 3

1 Introduction

A child's experience during the early years is critical to their physical, cognitive and social development. During this development phase the groundwork is laid for the rest of the child's life. During the early years it is important that every child has the optimum conditions for success. According to Marmot (2010) and Allen (2011), this period of life influences school readiness, educational attainment, economic participation and long term health. During these years important milestones and tasks for children's physical development, social and emotional development and language and cognitive development occur⁴².

Evidence shows that poor development in the early years frequently results in continuing cycles of poverty and deprivation throughout life⁴³. The Marmot review of health inequalities⁴⁴ provides evidence of the long-lasting effects of child poverty leading to lower life expectancy and poor health outcomes as an adult.

During the early years there are a variety of factors that are important for long term health and wellbeing. Breastfeeding is a key determinant of health for both the child and the mother. Nutrition behaviours and habits are established during the early years and are likely to influence eating patterns into adulthood. Deprivation plays a role in dental decay which is a largely preventable burden on children. Many of the issues facing young children are influenced to some degree by deprivation.

42 Barlow J and Blair M (2012).. Life stage: early years. Annual Report of the Chief Medical Officer 2012, Our Children Deserve Better: Prevention Pays. Available at: <https://www.gov.uk/government/publications/chief-medical-officers-annual-report-2012-our-children-deserve-better-prevention-pays>

43 Field, F. (2010) "The Foundation Years: preventing poor children becoming poor adults - The report of the Independent Review on Poverty and Life Chances", HM Government

<http://webarchive.nationalarchives.gov.uk/20110120090128/http://povertyreview.independent.gov.uk>

44 Marmot, M. (2008), "Review of Health Inequalities – Fair Society, Healthy Lives", Institute of Health Equity <http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review>

2. Who is at Risk, and Why

The main risk factors that can adversely affect longer term health and wellbeing outcomes for children aged 0-4 years are as follows^{1,45,46,47,48,49,50}.

- **Deprivation:** Poor social and economic circumstances affect health and wellbeing throughout life. Death rates amongst 0-4 year olds from families with 'manual' or routine occupations are three times higher than children from families with occupations 'classed as 'managerial' or 'professional'. Child poverty is also a significant barrier to improving outcomes for children (e.g. chronic illness and infant mortality).
- **Ethnicity:** There is a complex interplay of factors affecting health and wellbeing in some minority ethnic communities in the UK.
- **Area of residence:** Children living in urban areas can have higher rates of emergency hospital admission compared to those in rural areas.
- **Obesity:** Obese and overweight children are more likely to become obese adults. They also have a higher risk of morbidity, disability and premature mortality in adulthood.
- **Readiness for school:** The development score a child attains at age 22 months has been found to accurately predict their educational outcomes at age 26 years. These educational outcomes are related to long-term health outcomes and are a major contributing factor to patterns of social mobility.
- **Lifestyle:** Parental lifestyle choices such as smoking, alcohol and substance misuse can negatively affect children's health in different ways.
- **Parenting:** Poor parenting can have a detrimental effect on a child's early development of cognitive skills, emotional wellbeing, social competence, physical and mental health.

45 http://www.barnardos.org.uk/what_we_do/our_work/child_poverty/child_poverty_what_is_poverty/child_poverty_statistics_facts.htm

46 Watt, R. & Sheiham, A. (1999) "Inequalities in oral health: a review of the evidence and recommendations for action", *British Dental Journal* Jul 10; 187(1):6-12

47 Nuttall, N. & Harker, R. (2004) "Impact of Oral Health: Children's Dental Health in the United Kingdom, 2003"

48 Clarke, M. & Et al. (2006) "Malnourishment in a population of young children with severe early childhood caries", *Paediatr. Dent.* 28, 254-259

49 *Child and adolescent mental health: A guide for healthcare professionals* (2006) BMA Board of Science

<http://www.familieslink.co.uk/download/jan07/ChildAdolescentMentalHealth%202006.pdf>

50 Feinstein, L. "How early can we predict future educational achievement? Very early?" *Centrepiece* (2003)

<http://cep.lse.ac.uk/pubs/download/CP146.pdf>

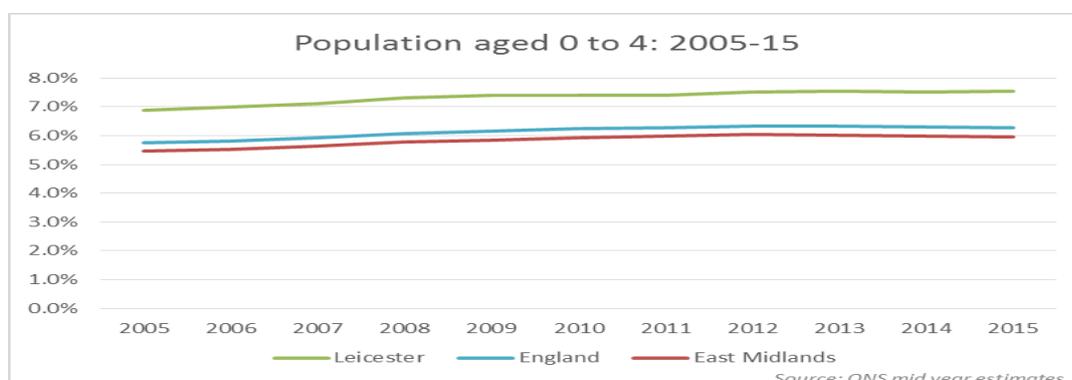
3. Summary

3.1 Population Profile

The population of children in Leicester who are aged 0 to 4 years old is detailed in this section.

- Children aged 0-4 years old living in Leicester made up 7.6% (25,884) of the total population in 2015. This is significantly greater than the East Midlands and England averages.
- There is a larger proportion of males in Leicester’s 0 to 4 years population compared to females (51% and 49%, respectively).
- There has been a faster growth in the proportion of 0-4 year old children in Leicester when compared against the East Midlands and England (Figure 1).

Figure 1: Population trend for 0-4 year olds (2005-2015)

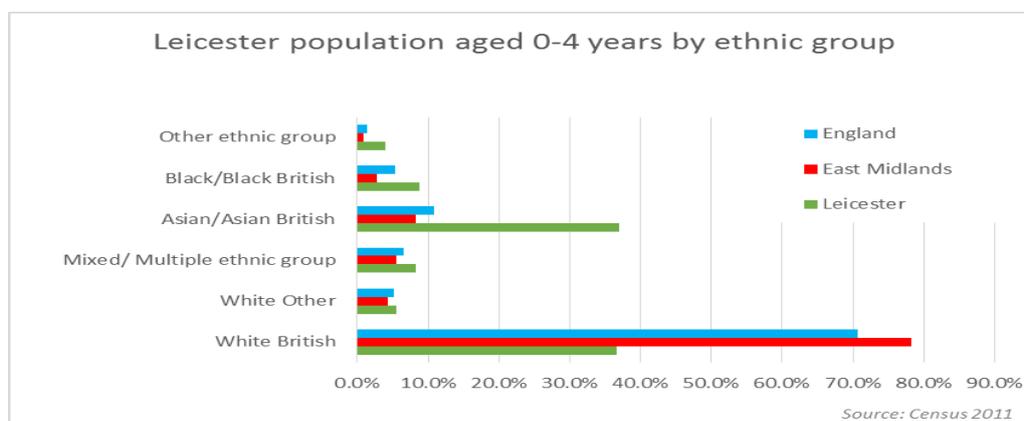


4.3.2 Ethnicity

Leicester is a diverse city with Black Minority Ethnic (BME) and White ethnic groups each comprising 49.5% of the whole local population.

The proportions of the different ethnic groups of the 0-4 years old population in Leicester are shown in Figure 2. Asian/Asian British children aged 0 to 4 years constitute a significantly larger proportion (36.9%) of this age group compared to the East Midlands (8.3%) and England (10.8%) averages.

Figure 2: Leicester’s 0 to 4 years old population by ethnic group (2011)



4. The level of need in the population

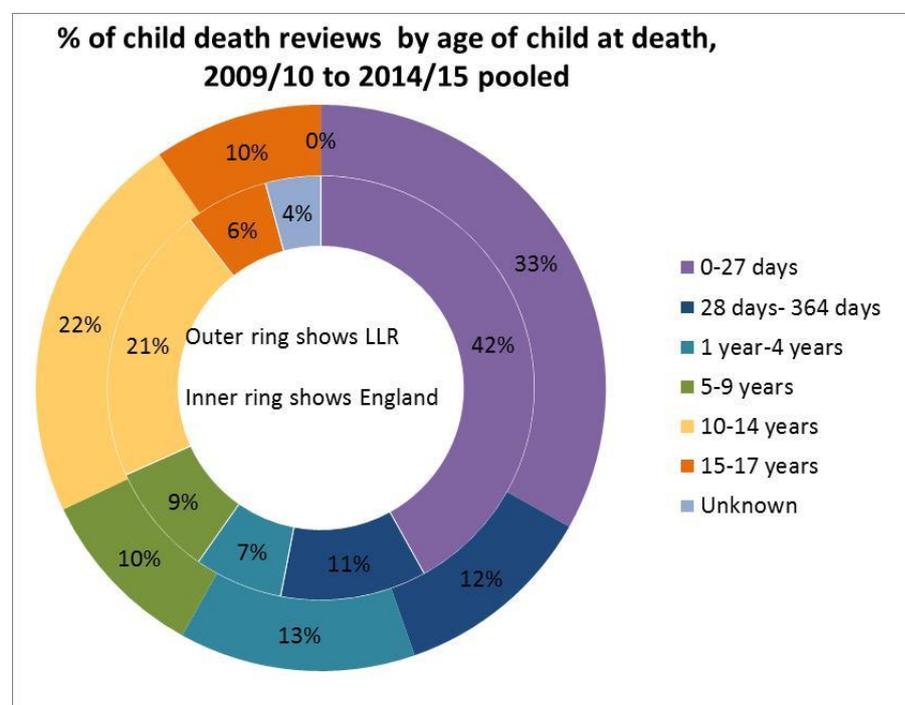
4.1 Outcomes

4.1.1 Child Mortality

For information regarding 'infant mortality' (deaths of infants from birth to the age of 1) please refer to the 'Pre-birth to antenatal' chapter.

The Child Death Overview Panel (CDOP) for Leicester, Leicestershire and Rutland undertook a thorough review of cases reported to them between 2009/10 and 2014/15. Due to small numbers of child deaths, it is not possible to separate Leicester for every aspect of the report.

Figure 3: CDOP Child Death Reviews by Age, 2009/10 to 2014/15



CDOP found that children aged 1 to 4 years contributed 13% of all child deaths between 2009/10 and 2014/15. This is significantly more deaths in this age group when compared to England (7%).

The detailed findings of that review may be found here <http://lrsb.org.uk/uploads/llr-child-death-review-analysis.pdf>. Continued monitoring and taking action to reduce child deaths through the City's Safeguarding Children's Board will remain a priority.

4.1.2 Healthy Weight and Nutrition

During the early years a child's diet and physical activity are determinants for short and long term health and wellbeing. Nutrition and dietary behaviours and habits are established during the early years and are likely to influence eating patterns into adulthood. Local data about diet and obesity

are covered in the next chapter which assesses how healthy weight patterns change through the primary school years.

Breastfeeding and deprivation are key determinants of health for both the child and the mother. Breastfeeding can help reduce some inequalities between the least and most deprived children.

4.1.2.1 Breastfeeding

Breastfeeding is a key early intervention that improves the health of infants and mothers. Current UK policy is to promote feeding only breastmilk for the first 6 months before gradually introducing a more varied diet.

The risk of illness during infancy and childhood are reduced for breastfed babies. Breastfed babies are at a lower risk for gastrointestinal infections, SIDS, ear infections and insulin-dependent diabetes.

With respect to maternal health, breastfeeding confers benefits in re-gaining their pre-pregnancy weight and protection against certain types of cancer. Mothers who breastfed also have a lower risk of breast cancer and ovarian cancer.

By increasing breastfeeding rates in lower socioeconomic groups, some inequalities between the least and most deprived can be reduced. For example, breastfed babies born into lower socioeconomic groups have better health outcomes than formula fed infants born into higher socioeconomic groups.⁵¹

Breastfeeding levels are reported at initiation and at 6 to 8 weeks after giving birth. Breastfeeding initiation is assessed as the proportion of babies who are put to the breast compared to the total of babies born during a specified period. It measures the proportion of babies who received colostrum; the first milk produced during pregnancy. It does not measure the proportion of babies for whom breastfeeding has been established. Current levels in England are amongst the lowest in Europe.

The proportion of women in Leicester initiating breastfeeding at time of delivery is better than the England average, but the areas with the highest level of deprivation have the lowest rates of breastfeeding initiation. National data for 2014/15 show the breastfeeding initiation rate in Leicester was 76.9% which was significantly higher than the England average of 74.3%.⁵² Lower rates of breastfeeding initiation are found in areas of greatest deprivation in Leicester.

⁵¹ Forsyth S (2004). *Influence of infant feeding practice on health inequalities during childhood*.

⁵² There is a discrepancy in the data, as the local provider indicates that Leicester's breastfeeding rates for 2014/15 was 74.8%.

Breastfeeding rates at 6 to 8 weeks after birth in Leicester are reported as 62.1%. This is significantly higher than the England average (43.8%).⁵³

4.1.3 Injuries

Intentional injuries are a major cause of morbidity and mortality during the early years of life. Intentional injuries have increased in the UK over the last 10 years which is linked to violence and stress in society. For example, high levels of domestic conflict, lack of basic resources and unemployment contribute to an increase in abuse. Such incidents can negatively impact the health and wellbeing of both the child and the family.

Leicester has a rate of 78.7 per 1000 children aged 0 to 4 years (2014/15) who are admitted to hospital due to accidental and deliberate injuries. This rate is significantly lower than the England average.

4.1.4 Oral Health

Dental decay for young children in Leicester is significantly higher than the average for England. In addition to the risk of dental diseases for the general population of children, children taken into the care system are at an increased risk of poor dental health.

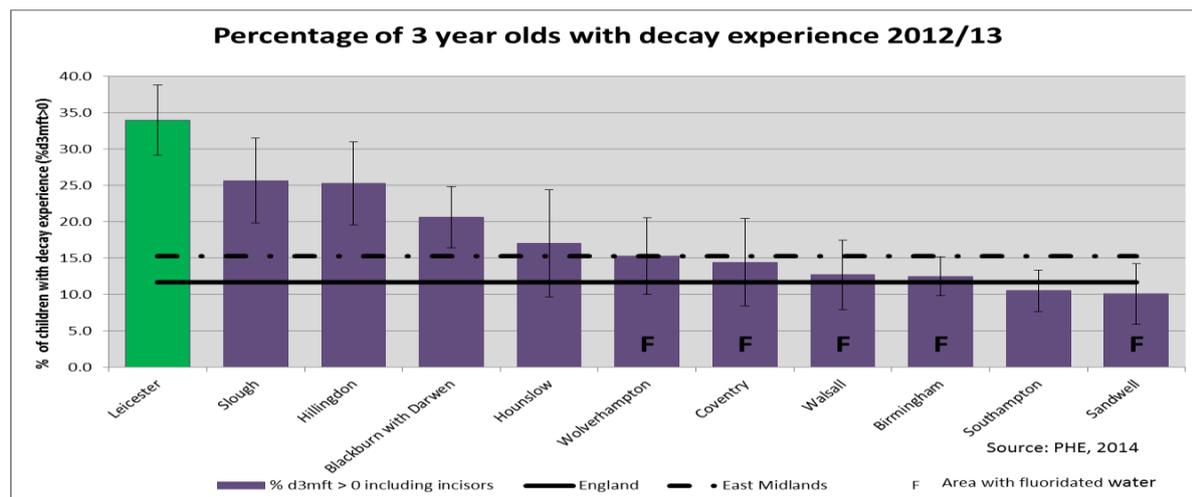
Long-term dental disease can result in severe acute and chronic infection. For young children whose milk teeth are affected, dental disease may also cause damage and consequential loss to the underlying permanent teeth. Additionally, older children with dental disease are also at risk of losing their permanent/adult teeth due to extensive dental decay. Treatment of extensive symptomatic disease, both with and without general anaesthesia, which may distress the child has risks for morbidity and mortality⁵⁴ and is also a significant avoidable cost to the NHS.

Three year old children living in Leicester have the highest experience of dental decay observed in England, with 34% of them having had experience of obvious dental decay. These are the most recent data available. These data should not be confused with the more recent data for decay in 5 year olds. Those data are available in the School Years chapter.

⁵³ NHS England Statistical Release: Breastfeeding Initiation & Breastfeeding Prevalence 6-8 weeks, 2014/15

⁵⁴ Flick RP, Katusic SK, et al (2011) Cognitive and behavioural outcomes after early exposure to anesthesia and surgery. *Pediatrics* 128(5): e1053-61.

Figure 4: Percentage of children with decay experience (2012/13)



*Delivering Better Oral Health*⁵⁵ recommends the application of fluoride varnish twice a year for all children from age 3 years (with increased applications for those with higher need) for preventative purposes. Although the national guidance states that fluoride varnish should be applied from 3 years, only 6% of eligible children in England and 14.4% of eligible children in Leicester received fluoride varnish applications in 2014/15.

4.1.5 Children with Disabilities or Special Educational Needs

Children with disabilities or special educational needs are a vulnerable group in society. Their disabilities and needs have a large impact on their health and wellbeing. Appropriate care for such disabilities and needs may require regular visits to hospital, a requirement to adhere to all medical and pharmaceutical regimen, consideration of diet and what types of activities may be done. Children in this age group are not fully able to understand what is happening to them.

Disability may limit the amount of time a child can attend early education and begin to prepare for attending school and building social relationships with peers; both of which are determinants of long term achievement and wellbeing.

4.2 Children with Disabilities

Many children and young people who have SEN may also have a disability. A disability is described in law (the Equality Act 2010⁵⁶) as ‘a physical or mental impairment which has a long-term (i.e. a year or more) and substantial adverse effect on their ability to carry out normal day-to-day activities.’

⁵⁵ Public Health England (2014): *Delivering Better Oral Health – an evidence based toolkit for prevention*; available at <https://www.gov.uk/government/publications/delivering-better-oral-health-an-evidence-based-toolkit-for-prevention>

⁵⁶ Source: <https://www.gov.uk/definition-of-disability-under-equality-act-2010>

This includes, for example, sensory impairments such as those that affect sight and hearing, and long-term health conditions such as asthma, diabetes or epilepsy.

There are no local data on the number of disabled children aged 0-4 years living in Leicester. It has been estimated that between 3 and 5.4% of all children experience some form of disability⁵⁷.84.1.5.2 Children with Special Educational Needs

The Children and Families Act (2014)⁵⁸ sets out the matters to which Local Authorities must have regard when they are supporting children and young people with Special Educational Needs and/or disabilities (SEND) including the importance of their participation in decisions about services and the provision of information to facilitate the best possible outcomes for the child.

The [SEN Code of Practice](#) refers to the different types of educational support available for children with SEN⁵⁹ to replace the old code. The new code of practice provided new guidance for education and training settings on taking a graduated approach to identify and support pupils with SEN to replace School Action and School Action Plus.

Also, for children with more complex needs a co-ordinated assessment process and the new 0-25 Education, Health and Care plan (EHC plan) replace statements and Learning Difficulty Assessments (LDAs).

4.3 School Readiness

School readiness is a determinant of a child's future health and well-being across the life course. Improved school readiness and better educational attainment influence one's physical and mental health, positive peer relations, confidence, and ability to earn a high wage.⁶⁰

The transition to school is a stressful and challenging time for children and their parents or carers. Concerns about expectations, new environments and social relationships can be difficult. Figure 5 illustrates the wide variety of factors that affect the success of pupils transitioning to school. School transitions also offer the opportunity to build resilience, and resilience is a key life skill that enables individuals to deal with adversity and difficulty. Therefore, ensuring children are ready for school is important for ensuring they have the best start to their educations and future careers.

⁵⁷ Thomas Coram Research Unit (TCRU)

⁵⁸ Source: http://www.legislation.gov.uk/ukpga/2014/6/pdfs/ukpga_20140006_en.pdf

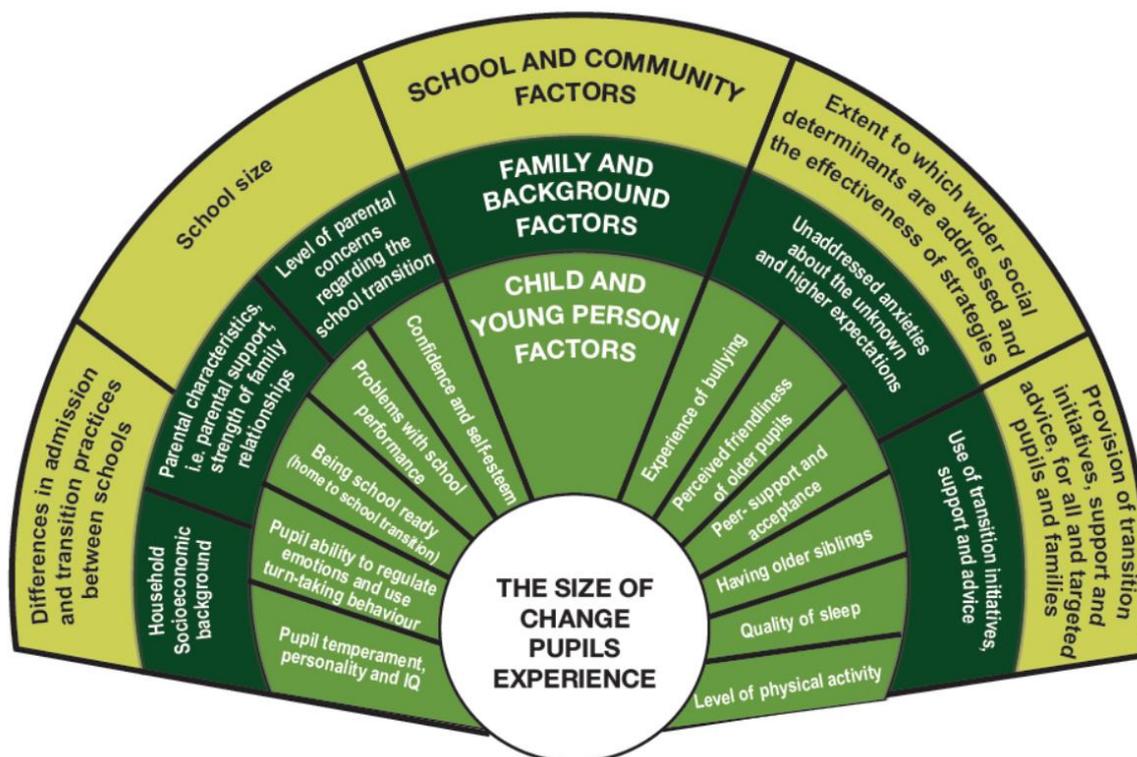
⁵⁹ Source:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/398815/SEND_Code_of_Practice_January_2015.pdf

⁶⁰ Roberts, Jill (2015). *Improving School Transitions for Health Equity*. Available at:

<http://www.instituteoftheequity.org/projects/improving-school-transitions-for-health-equity>

Figure 5: Factors affecting the success of school transitions



Taken from: Roberts (Improving School Transitions For Health Equity)

Children who are ready for school should have the basic minimum skills and knowledge to enable them to succeed in school. A broader definition of school readiness includes domains such as physical well-being, motor development, social and emotional development, learning approaches, language development and general knowledge.

This section includes information on continence, Early Education provision, language development and emotional health and well-being which are key building blocks to a successful start in education. Other aspects of physical health for children aged 0 to 4 years are covered through this chapter.

4.3.1 Continence

The ability to use the toilet on one's own is a vital self-care skill that provides some independence and confidence to young children. Continence problems include bedwetting, daytime urinary incontinence, or constipation and faecal incontinence, or a combination of these. On the absence of local data on this issue, local estimations have been undertaken from reported national prevalence.

Local estimates suggest that around 1,900 children aged 4 ½ will experience significant problems with bed-wetting, with around 700 of these having problems during the day. Around 145 boys and 90 girls in Leicester will have more serious problems with faecal incontinence with implications for their self-esteem, socialisation and ability to learn and play. In most cases, through the support of parents or carers, these problems will resolve with age but for a small number of children, more specialist support or advice may be needed through the city's 0-19 Healthy Child Programme.

4.3.2 Early Education

Access to good quality early education programmes is a determinant for longer term educational attainment and wages. Attendance to nursery and preschool allows children to learn some of the necessary skills for school success such as social interactions, following instructions, engaging in activities, and language development. According to UNICEF, the return on investment of for early childhood programmes is higher than for any other 'human capital development programmes'.

The number of Leicester's 2 year olds that are eligible to access a Funded Early Education Entitlement (FEEE) place will vary depending upon the numbers of families living in the city meeting the criteria. LCC receives regular lists of potentially eligible families from the Department for Work and Pensions. The average number of eligible children is 2,500 which equates to 50% of the total population of 2 year olds in the city. Nationally, the 2 year old FEEE offer is accessible by the 40% most disadvantaged low income families and so Leicester's higher percentage of the 2 year old cohort being eligible reflects the relative levels of deprivation in the city.

All 3 and 4 year olds are entitled to access a FEEE place. Take up of this offer by three year olds in Leicester is fairly high, but is lower than the England average. The delivery of places for three year olds is split between the private/voluntary/independent sector and nurseries in local schools. Take up of the offer for 4 year olds is higher in Leicester than the England average. The majority of 4 year olds access their place through their local school foundation stage.

4.3.3 Language Development

A child's ability to communicate verbally is important for his/her confidence and success at school. Poor language development can impact school performance, social inclusion and self esteem. Children who do not speak English as their first language are less likely to be school ready. Children's understanding and use of vocabulary and their use of two-three word sentences at 24 months is very strongly associated with their later performance on the school entry assessment when adjusted for social class. Therefore a child's language improves a child's development irrespective of their social background.

Children's Speech and Language Therapy (SALT) is provided by Leicestershire Partnership Trust to work in settings across the city clinics, CYPFCs, nurseries and schools. The caseload in 2014/15 was 1,055 (of children aged 0-4 years). The breakdown of boys to girls in this age group mirrors the England statistics (approximately 3:1).

4.3.4 Emotional Health

Children with poor socio-emotional skills, low self-esteem or low confidence are more likely to find transition to school very difficult. Children with good socio-emotional health can form close relationships with others (e.g. parents, teachers and peers), express and manage their emotions and

confidently explore new environments. All three of these domains are important for being ready for and succeeding at school.

There are relatively little data about prevalence rates for mental health disorders in pre-school age children. A literature review⁶¹ of four studies looking at 1,021 children aged 2 to 5 years inclusive found that the average prevalence rate of any mental health disorder was 19.6%. When this average prevalence rate is applied to Leicester, a figure of 3,740 children aged 2 to 5 years are estimated to have a mental health disorder. National estimates show that the number of children who experience lower level mental health issues is rising with significant differences across the social gradient pointing to an emerging health issue.

4.4 Neglect

Child maltreatment is both a human rights violation and a complex public health issue, likely caused by a myriad of factors that involve the individual, the family and the community. Aside from the serious physical and health consequences of child maltreatment, several emotional and behavioural consequences for children have been noted in the literature. Neglected children do not usually have a good relationship or attachment with their parent/carer. Persistent neglect can lead to serious impairment of health and development, and long term difficulties with social functioning, relationships and educational progress. In extreme cases, neglect can also result in death.

Amongst children aged 0 to 4 years old in Leicester, there were 223 Child Protection Plans started between 1 April 2015 and 31 March 2016. This data is monitored and reported on a continuing basis. Neglect was documented as the initial category of abuse for 111 children (49%) aged 0 to 4 years old during this time period in Leicester.

In Leicester there have been a number of serious case reviews which featured aspects of neglect, and the Local Safeguarding Children's Boards have therefore made neglect a priority. The LSCB recently launched a Neglect Toolkit and Strategy for practitioners to use when working with children and families suspected of neglect.

4.5 Determinants of health

4.5.1 Deprivation

Deprivation is a key determinant for life long health and wellbeing. Deprivation covers a broad range of issues that may affect an individual's health and wellbeing because they have unmet needs caused by a lack of resources, not just financial. More information on the level of deprivation and child poverty in Leicester is available in Chapter 3.

⁶¹ Egger H.L., Kondo D. & Angold A. (2006) "The epidemiology and diagnostic issues in preschool attention-deficit/hyperactivity disorder: A review", *Infants & Young Children*. 2006b;19:109–122.

4.5.2 Immunisations

Vaccinations are the most effective method for preventing disease and maintaining the public's health. Children are protected against diseases that can kill or result in long term poor health. As a result of the UK's Immunisations Programme, the numbers of deaths due to vaccine-preventable deaths is low. The costs to the NHS and other local services to treat and support children who suffer from such illnesses is considerable.

The proportion of coverage for childhood immunisations to age 5 years for 2015/16 in Leicester, East Midlands and England are depicted in Table 1. The World Health Organisation (WHO)⁶² recommends a threshold of 95% for all vaccinations, and Leicester achieves this threshold except for the 1st and 2nd doses of MMR and the 5 year Hib/MenC booster. However, Leicester's overall performance is above (or comparable to) the regional and England averages.

The schedule of vaccinations is primarily completed between the ages of 0 and 5 years old, however there are three vaccines given to adolescents. These vaccines are for Human Papillomavirus (HPV); tetanus, polio and diphtheria (Td/IPV); and Meningitis C.

⁶² 'Herd' immunity is the immunity that occurs when the vaccination of a significant proportion of the population provides a measure of protection and reduces the probability of infection for the whole population, including individuals who have not developed immunity

Table 1 – Percentage of coverage for childhood immunisations (2015/16)

	1 year olds:		2 year olds				5 year olds				
	Diphtheria, Tetanus, Polio, Pertussis, Hib: primary	PCV: primary	Diphtheria, Tetanus, Polio, Pertussis, Hib: primary	MMR: dose 1	Hib/MenC: booster	PCV: booster	Diphtheria, Tetanus, Polio, Pertussis, Hib: primary	Diphtheria, Tetanus, Polio, Pertussis: booster	MMR: dose 1	MMR: dose 2	Hib/MenC: booster
				1st dose	Booster	Booster		Booster	1st dose	2nd dose	Booster
England	93.6	93.5	95.2	91.9	91.6	91.5	95.6	86.3	94.8	88.2	92.6
East Midlands	95.6	95.5	97.0	94.1	94.0	94.0	97.0	89.2	96.5	90.5	93.4
Leicester	95.8	95.4	97.1	94.5	94.0	94.1	96.9	88.3	96.5	90.3	91.6
95%	95.0	95.0	95.0	95.0	95.0	95.0	95.0	95.0	95.0	95.0	95.0

DTap/IPV/Hib: Diphtheria, tetanus, pertussis (whooping cough), polio and Haemophilus influenza B

MenC: Meningococcal Group C disease

PCV: Pneumococcal conjugate vaccination

MMR: Measles, Mumps, Rubella (German Measles)

4.5.3 Safeguarding

Safeguarding is everyone's responsibility. Safeguarding is defined as "protecting children from maltreatment, preventing impairment of children's health or development, ensuring that children are growing up in circumstances consistent with the provision of safe and effective care, and taking action to enable all children to have the best life chances" (Working Together to Safeguard Children). The maltreatment of children – physically, emotionally, sexually or through neglect – can have major longterm effects on all aspects of a child's health, development and wellbeing.

Some safeguarding risks to children aged 0 to 4 years include poor life chances, compromised care, bullying and mental health problems. Poor life chances include social and economic circumstances that shape a child's life course for example his/her life expectancy. A child lives in a home with domestic abuse, illegal behaviour, parental substance misuse and/or parent mental illness will most likely have compromised care.

Children, Young People and Family Centres (CYPFCs) work with families to provide a range of services aimed at ensuring the best start for children. Families may also access targeted Early Help provision to meet their needs at an earlier stage and prevent any issues from escalating. Approximately 55.1% of families with children aged 0-4 years who were registered with CYPFCs accessed services provided by CYPFCs across a 12 month period (2015/16).

The Local Safeguarding Children Boards (LSCB) works to coordinate local work to safeguard and promote the welfare of children and to ensure the effectiveness of member organisations' work individually and together. The LSCBs participate in the planning of services for children in the local authority area, monitor the effectiveness of what is done to safeguard and promote the welfare of children, and collect and analyse information about child deaths.

5. Current services

5.1 General Practice (GP) Registration

All children are eligible to register with a General Practice to receive health care. New arrivals are provided information that recommends registering with a GP.

5.2 Oral Health

Children under-18 in Leicester are entitled to free dental treatment by an NHS dentist. There are currently 62 dental practices within the Leicester city boundary.

It is recommended that children see the dentist as a minimum once per year. The recommended recall interval for children is between 4 and 12 months, compared to adults where it is 6-24 months⁶³.

Leicester City Council is focused on improving oral health for children in Leicester. The Oral Health Promotion Partnership Board was created in September 2013 to further this agenda. The Healthy Teeth, Happy Smiles! programme is currently running in the city to promote good oral health. Some work being done by the programme includes: providing oral health training to frontline staff, raising awareness of the Healthy Teeth, Happy Smiles! programme and supporting a variety of national oral health initiatives.

5.3 Services for New Arrivals

ASSIST provides care and support asylum seekers and refugees. There is also a partnership group which meets 4 times a year which discusses a co-ordinated response for new arrivals in Leicester. At any one time there are about 1,000 asylum seekers in Leicester, many of whom will be children.

5.4 Children, Young People and Family Centres

CYPFCs are at the centre of the early help (EH) offer, with a renewed focus on the most disadvantaged families. CYPFCs are also expected to be a hub of the local community and enhance their role in promoting parenting and nurturing skills. They are accessible to all families with young children and have an important role in identifying and supporting families in greatest need.

The EH offer includes the provision of integrated education, care, family support, family learning and health services which are crucial to increasing the wellbeing of children and their parents. There are a number of CYPF buildings spread across the city in a hub and spoke model linked to 6 geographical clusters. Each cluster has one registered CYPFC which is identified as the registered centre with Ofsted.

An integral part of Leicester's CYPFC delivery is its offer for 0-4 year olds, working in partnership with statutory as well as community and voluntary agencies. This enables the CYPFC universal offer to include health, early education and information services across a range of determinants of health. This co-delivery of a range of core services across the CYPFCs includes activities and programmes focused on learning, development and engagement of families delivered at the cluster level and include the following:

- Specific support for dads and male carers
- Breastfeeding support and support of breast feeding peer support
- Welfare Rights Advice sessions
- Drop-in access to family support workers to provide advice and guidance as required
- Parenting programmes
- Ante-natal and post-natal services
- Speech and language advice, guidance and early support

63 NICE Dental Recall Clinical Guideline 2004

- Housing advice
- Co-ordinated support for children with lower level SEND (special educational needs and disabilities) in settings and the home
- Access to targeted and specialist services, such as mental health, 0-5s Supporting Families Team, CAMHS
- Advice/access to funded early education
- Domestic violence support - one stop shop

5.5 Childcare and Funded Early Education Entitlement (FEEE)

Leicester City Council (LCC) has a statutory duty to secure sufficient childcare to enable parents to work or to undertake training leading to employment under the Childcare Act 2006. LCC also has a statutory duty to secure a free minimum amount of early learning and care for all 3 and 4 year olds whose parents want it. FEEE is available for 15 hours per week up to 38 weeks per year.

Childcare sufficiency requires there to be enough childcare provision to meet parental demand. LCC has a statutory duty to produce a Childcare Sufficiency Assessment (CSA) which analyses and reviews the childcare market across the city to ensure that there is sufficient, sustainable, good quality provision to meet parental demand. The last full CSA was completed in November 2016; this showed that overall there is sufficient childcare provision in place to meet demand.

5.6 Early Help (EH)

EH services in Leicester are for children, young people and families whose needs are not being met by routine services but who do not need specialist services. The services are for children of all ages and not just the very young. LCC leads on the EH offer, but there is now greater emphasis on staff in all agencies working with children to provide direct support, signposting and a co-ordination of agencies working with the family. EH services can be provided at any point of need and can be very effective in supporting a child, young person and/or their family to step down from statutory services as well as preventing the escalation of issues.

More information may be found at www.leicester.gov.uk/earlyhelp

5.7 Voluntary Sector

The voluntary sector provides a large number of pre-schools, play groups and family support services such as parent and toddler groups. Voluntary groups also provide information, advice and support to new mothers on issues such as breastfeeding. These voluntary groups are well placed to provide school readiness, new parent support and recreational activities to the youngest children.

6. Projected service use for 0-4 years olds

The 0-4 year- old population in Leicester has increased by 16.3% over the last 10 years, which is significantly higher than the national and regional averages. The latest population projections from the Office of National Statistics predict that by 2037 the 0 to 4 year- old population will increase by an additional 13.6%.

The increase in the 0-4 year- old population will impact on future demand for health, education and care services. Services must take into account not only the number of children but also the composition of the ethnic groups to reflect the educational, care and health need for services now and in the future.

Leicester also has a range of recently arrived communities to the city with new families arriving that have an impact on service planning and provision, as well as on the outcomes for young children who have language needs or may experience difficulties settling in to their new environments.



Chapter 4

1. Introduction

Between the ages of 5 years and 19 years old children will experience many transitions in all aspects of their lives, and their experiences will shape their future. Their start in life during the pre-birth and early years periods will influence how well they manage and cope with important transitions in their social lives, education and relationships during school years.

At age 5 children are still mostly dependent on their caregivers to provide their needs, but by age 19 young people are more independent in their choices and behaviours. Therefore the school years are important for the health and wellbeing of children young people in the short and long term.

During the primary school years (5 to 9 years old) education has an increasing influence in addition to their family and home life. Children also experience physical development, acquisition of cognitive skills and exploring environments, developing independence and experimenting with risk.

The behavioural patterns established during the early adolescent phase (10 to 14 years) help to determine young people's health status and their risk for developing chronic diseases in adulthood⁶⁴. Although early adolescence is generally a healthy time of life, several important public health and social problems either peak or start during these years.

Because adolescents are in developmental transition, early adolescents are particularly sensitive to environmental—that is, contextual or surrounding—influences⁶⁵. Environmental factors, including their family, peer group, school, neighbourhood, and societal cues, can either support or challenge young people's

64 National Research Council and Institute of Medicine. Committee on Adolescent Health Care Services and Models of Care for Treatment, Prevention and Healthy Development. Adolescent health services: Missing opportunities. (2009). Lawrence, R.S., Gootman, J.A., Sim, L.J., editors. Washington: National Academies Press. Retrieved from: http://books.nap.edu/openbook.php?record_id=12063&page=1 On 2 December 2015.

65 Mulye, T.P., Park, M.J. & Nelson, C.D., et al. (2009). Trends in adolescent and young adult health in the United States. *Journal of Adolescent Health*.;45(1):8-24. Retrieved from: <http://download.journals.elsevierhealth.com/pdfs/journals/1054-139X/PIIS1054139X09001244.pdf>

health and well-being⁶⁶. Addressing the positive development of young people facilitates their adoption of healthy behaviours and helps to ensure a healthy and productive future adult population⁶⁷.

Later adolescence (15 to 19 years) is another crucial period for children and young people as they start making important decisions in terms of their education, employment and relationships. They will also become increasingly responsible for their health behaviours and their lifestyles. All of these issues will have an impact upon their adult lives.

The school years population in Leicester is larger and has higher need relative to its peer areas, the East Midlands and England. Overall, these young people experience a wide range of risk factors of poor health and well-being when compared to other areas and nationally. There has been improvement in the health and wellbeing of children and young people locally, but for many indicators gaps remain between Leicester and its peers, the East Midlands and England.

2. Who is at risk, and why

As well as risks that apply at earlier ages, there are specific factors that affect health outcomes for 5 to 19 year olds are:

- Access to quality services: Timely access to appropriate care can affect the health and well-being of children and young people. This is particularly relevant for services such as dentists, GPs and school nurses and, during adolescence, services such as sexual health.
- Educational achievement: Academic success and achievement are strong predictors of overall adult health outcomes. Proficient academic skills are associated with lower rates of risky behaviours and higher rates of healthy behaviours.^{68,69}
- School environment: The school social environment affects students' attendance, academic achievement and behaviour. A safe and healthy school environment promotes student engagement and protects against risky behaviours and dropping out⁷⁰.

66 National Research Council, Panel on High-Risk Youth, Commission on Behavioral and Social Sciences and Education. Losing generations: Adolescents in high-risk settings. (1993). Washington: National Academies Press. Retrieved from: http://www.nap.edu/openbook.php?record_id=2113&page=1 On 2 December 2015

67 Mc. Neely C. & Blanchard J. (2009). The teen years explained: A guide to healthy adolescent development. Baltimore: Johns Hopkins Bloomberg School of Public Health, Center for Adolescent Health; Retrieved from: <http://www.jhsph.edu/adolescenthealth> On 2 December 2015

68 Srabstein, J. & Piazza, T. (2008). Public health, safety and educational risks associated with bullying behaviours in American adolescents. *International Journal of Adolescent Medicine and Health*;20(2):223–233.

69 Public Health England (2014). The link between pupil health and wellbeing and attainment. A briefing for head teachers, governors and staff in education settings. Retrieved from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/370686/HT_briefing_layoutvFINALvii.pdf on 2 December 2015

- Family socialisation: Children and young people who perceive that they have good communication and are bonded with an adult are less likely to engage in risky behaviours. Parents who provide supervision and are involved with their adolescents' activities are promoting a safe environment in which to explore opportunities.⁷¹
- Media exposure: Adolescents who are exposed to media portrayals of violence, sexual content, smoking, and drinking are at risk for adopting these behaviours⁷².

3. Demographic Summary

3.1 Population profile

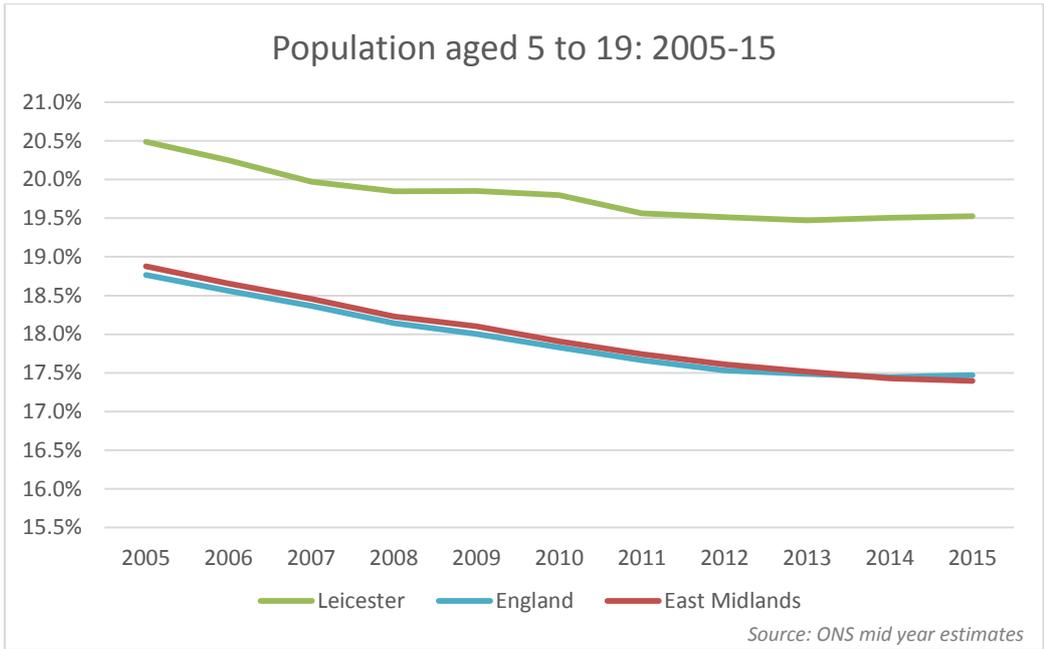
- In 2015 there were an estimated 66,899 children aged 5 to 19 years old living in Leicester.
- Leicester has more males (34,128, 51%) than females (32,771, 49%) in this age group.
- Figure 1 shows there was a decrease of 1% in the proportion of 5 to 19 year olds in Leicester from 2005 to 2015. England and the East Midlands show a similar decrease for this age group in the same time frame (1.3% and 1.5%, respectively).

Figure 1: Population trend (5-19 years old), 2005-15

70 Public Health England (2014). The link between pupil health and wellbeing and attainment. A briefing for head teachers, governors and staff in education settings. Retrieved from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/370686/HT_briefing_layoutvFINALvii.pdf on 2 December 2015

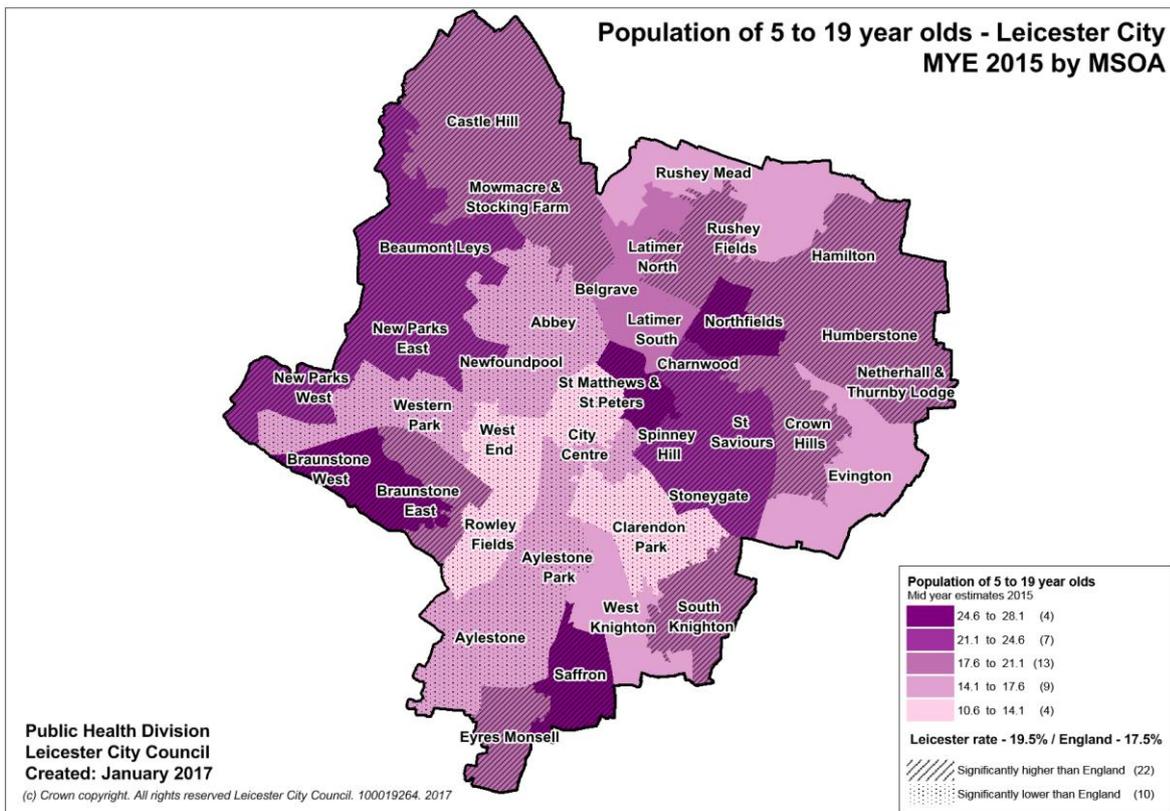
71 Roche, K. M., Ahmed, S. & Blum, R. W. (2008). Enduring consequences of parenting for risk behaviors from adolescence into early adulthood. *Social science & medicine*

72 Roberts DF, Henriksen L, Foehr UG. Adolescents and media. Chapter 16 in *Handbook of Adolescent Psychology* (pp 487-521), 2nd ed. Lerner RM, Steinberg L, editors. Hoboken, NJ: John Wiley & Sons, Inc.; 2004.



The areas of Leicester with the largest proportion of children aged 5 to 19 years are primarily in the Northwest and Northeast parts of the city (Figure 2). The Central areas of Leicester have significantly smaller populations of 5 to 19 year olds compared to England.

Figure 2: Population of 10 to 14 years old by Leicester City MSA, 2015



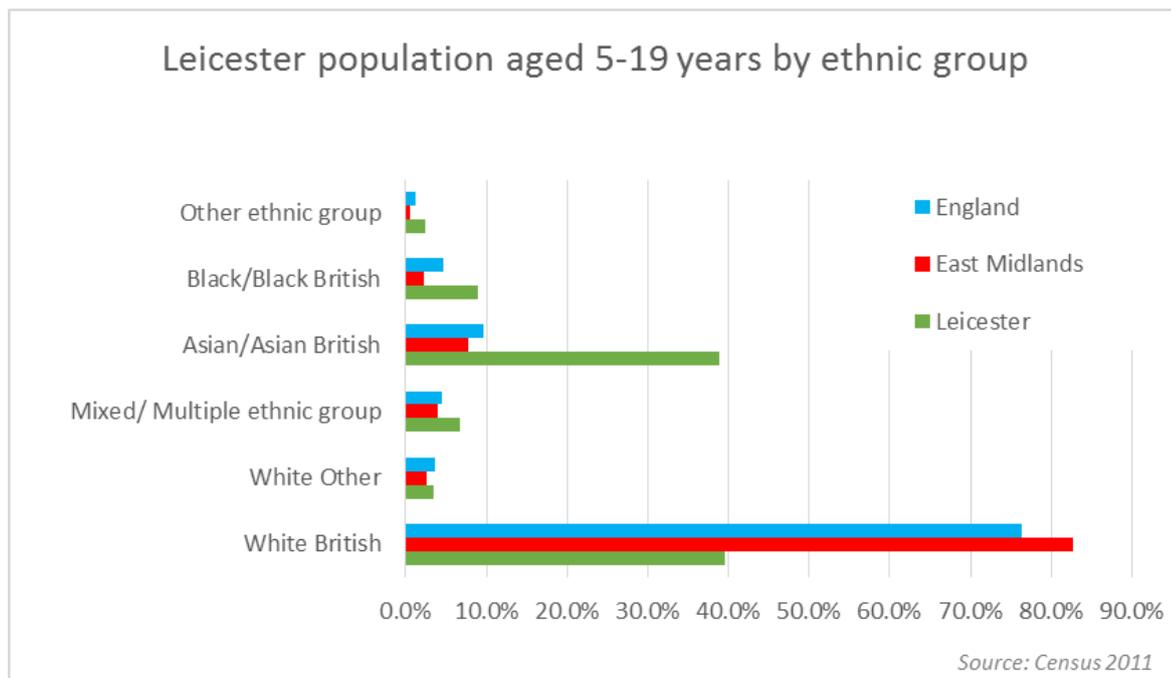
3.2 Ethnicity

In Leicester, the ethnicities of children aged 5 to 19 years (as per census 2011) are as follows:

- 43% White⁷³
- 39% Asian/Asian British
- 9% Black/ African/ Caribbean / Black British
- 7% Mixed/multiple ethnic group
- 2% Other ethnic group

Compared to the England and East Midland averages, Leicester has a smaller proportion of white children aged 5 to 19 years (Figure 3). For all other ethnic groups, Leicester has significantly more children in these groups compared to the England and East Midlands averages.

Figure 3: Proportions of 5 to 19 year olds by Ethnic Group compared to England and East Midlands



4. The level of need in the population

⁷³ Includes 'White Other'.

4.1 Outcomes

4.1.1 Children with Long Term Illness or Disability

Chronic and long term illnesses and disability have a large impact on the health and wellbeing of children and young people. Care for such illnesses and disability may require regular visits to hospital, a requirement to adhere to all medical and pharmaceutical regimens, consideration of diet and what types of activities may be done. Illness and disability may limit the amount of time a child can attend school and build social relationships with peers; both of which are determinants of long term achievement and wellbeing.

Immediate and ongoing medical investigations may be invasive, uncomfortable or painful, with treatment regimens requiring medication, injections, blood measurements, brain or body scans. One in ten children will have a chronic illness that is severe enough to substantially limit their daily life and demand extended care and supervision (Yeo & Sawyer, 2005).

Long-term self-management behaviours for diabetes, asthma, epilepsy and other chronic conditions are largely initiated in adolescence. It is in early and mid-adolescence that individuals take over the management of their chronic conditions from their parents, and there is strong evidence that the self-management behaviours initiated in adolescence remain with them throughout life⁷⁴. Adolescence therefore provides an important window of opportunity to influence the trajectories of non-communicable diseases and physical health throughout later life.

4.1.1.1 Disability

It is difficult to estimate accurately the number of children with a disability. Official datasets only capture children whose disability meets the agreed criteria for extra funding and support (e.g. Disability Living Allowance). Children under 5 will not normally receive DLA because their needs may not be significantly outside the range of 'normal' compared to other children in this age group.

The 2011 Census, which relied on parental reporting, estimated there were 4,500 children aged 5 to 9 years old in Leicester with a disability. In the same year the Department for Work and Pensions reported 980 children in the age group were in receipt of Disability Living Allowance. This demonstrates that the perceived need of parents is frequently greater than those who meet the DLA thresholds for support.

The latest DLA data (May 2016) is broken down into individuals under age 16 and those 16 to 24 years old. There were 2310 children under 16 in receipt of DLA, and 640 young people aged 16 to 24 years old receiving DLA.

⁷⁴ Sawyer S.M., Drew, S., Yeo, M.S.& Britto, M,T, (2007). Adolescents with a chronic condition: challenges living, challenges treating. *Lancet*; 369(9571): 1481–9.

4.1.1.2 Diabetes

Type 1 diabetes and many other auto-immune conditions have their peak incidence in early adolescence⁷⁵. The National Paediatric Diabetes Audit showed that 70% of the childhood diabetes population is aged 12–19, and the great majority of emergency hospital admissions nationally for diabetes are in this age group⁷⁶.

Diabetics may suffer from long term poor mental health. This is due to the overwhelming burden of their illness on their lives. Some feel like a burden, misunderstood, lonely and frustrated. Poor mental health in the school years is linked to poor achievement and lifelong wages. Over the course of their lives they may experience problems with their eye sight, circulation, and kidneys. Their life expectancy may also be cut short.

The NCMP data shows obesity is a concern for Leicester's children. The dietary and physical activity habits of children influence their weight in adulthood. Because obesity is linked to the increase in Type 2 diabetes, an increase in Type 2 diabetes for both young people and adults is expected in Leicester over the next 5 years.

Markers of diabetes control such as the HbA1c (glycated haemoglobin) level are worse in adolescence than in childhood or adulthood in type 1 diabetes⁷⁷. Given poorer outcomes for diabetes in Britain than in other European countries, this places British adolescents at the bottom of the outcome leagues.

Currently the data for the 5 to 19 years age group are unavailable.

4.1.1.3 Asthma

Asthma is the most common symptomatic long term condition in children. It can start at any age, but it is most common between ages 5 and 15. It is a respiratory condition⁷⁸, which can cause breathlessness, tightness in the chest, coughing and wheezing. For most children asthma can be controlled, but at present there is no cure. Like diabetics, asthmatics may suffer from long term poor mental health which ultimately impacts their overall health and wellbeing, school performance,

In Leicester, 8% (n=1,731) of 5 to 9 year olds have been diagnosed with asthma. Prevalence is higher in males. Figure 4 shows that children in the Asian/Asian British (34%) and White (37%) ethnic groups in Leicester contribute a larger proportion of asthma cases in comparison to other ethnic groups.

Figure 4: Ethnicity of 5 to 9 year olds in Leicester with Asthma, February 2015

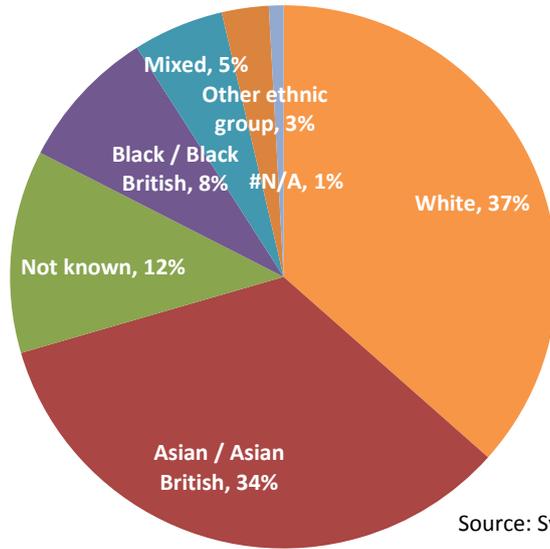
75 Patton GC, Viner R. Pubertal transitions in health. *Lancet* 2007; 369(9567): 1130–9.

76 National Paediatric Diabetes Audit Report 2010-11. London: Royal College of Paediatrics and Child Health & HQIP (Healthcare Quality Improvement Partnership) UK, 2012.

77 National Paediatric Diabetes Audit Report 2010-11. London: Royal College of Paediatrics and Child Health & HQIP (Healthcare Quality Improvement Partnership) UK, 2012.

78 British Thoracic Society (2008). BTS guidelines: British Guideline on the Management of Asthma 63:iv1-iv121 accessed from <https://www.brit-thoracic.org.uk/document-library/clinical-information/asthma/btssign-guideline-on-the-management-of-asthma/> on 5 January 2016

Asthma prevalence in 5-9 year olds, by ethnic group (Feb 2015)

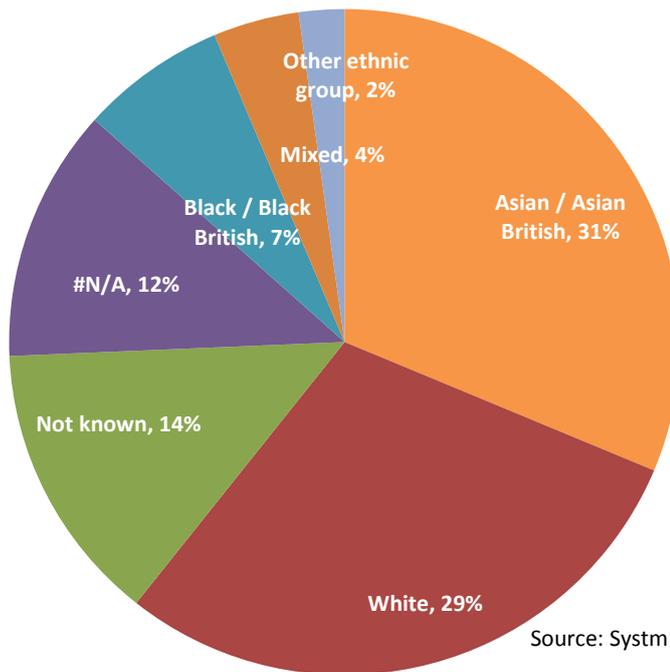


Source: System1, Feb 2015

Asthma is most common between 5-15 years old. The prevalence then declines until 55-64 years, when it starts to rise again. In Leicester, 12% (n=2,415) of 10 to 14 year olds have been diagnosed with asthma. The majority of these (61%) are male. Figure 5 shows Asian/Asian British children in this age group constitute 31% of those with asthma while 30% of 10 to 14 years old in Leicester are White (Source: system1).

Figure 5: Ethnicity of 10 to 14 year olds in Leicester with Asthma, February 2015

Asthma prevalence in 10-14 year olds, by ethnic group (Feb 2015)



Source: System1, Feb 2015

4.1.2 Healthy weight and eating

Poor diet is responsible for over half of all coronary heart disease and also contributes to stroke, hypertension, obesity, diabetes and some cancers. It is estimated that 70,000 premature deaths in the UK could be avoided each year if UK diets matched nutritional guidelines. Healthy eating and being physically active are particularly important for children and adolescents. This is because their nutrition and lifestyle at this age influence their wellbeing, growth and development for the rest of their lives.

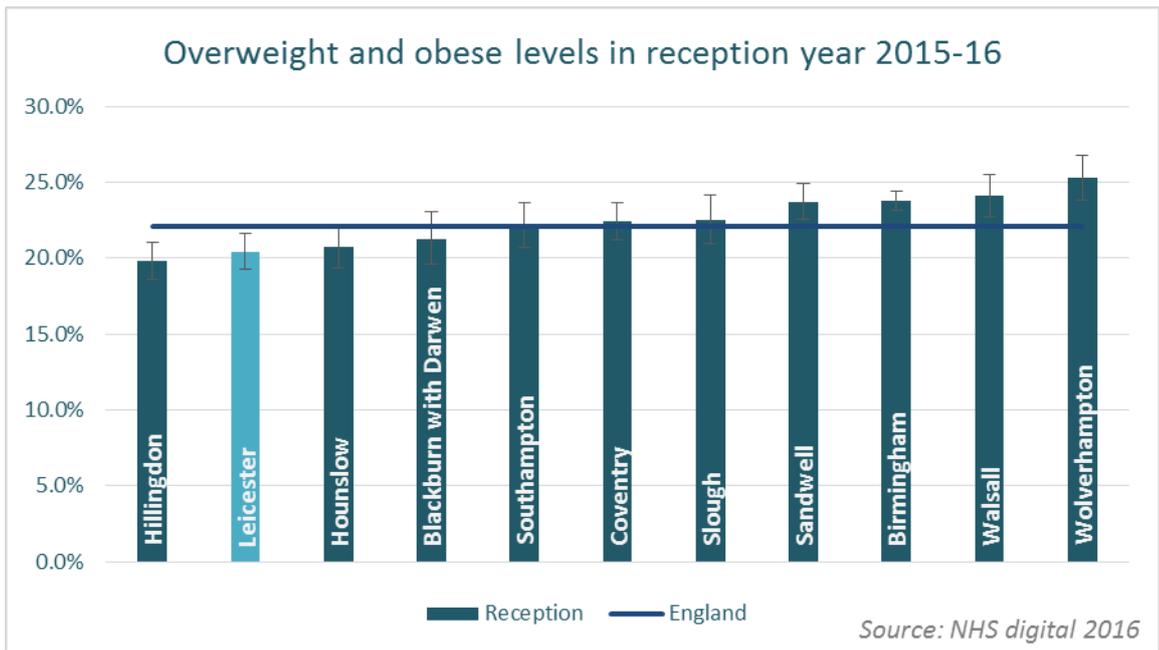
4.1.2.1 National Child Measurement Programme

The National Child Measurement Programme (NCMP) is a surveillance programme, introduced by the Department of Health in 2006 to measure obesity levels in the population. School nurses measure the height and weight of all children in reception (aged 4-5) and year 6 (aged 10-11) annually. Using these measurements the child's BMI (Body Mass Index) is calculated. The BMI provides a measure of the proportion of children who are overweight, obese or underweight in these year groups.

Obesity and overweight in Reception

The proportion of Leicester's Reception Year pupils who are obese and overweight (20.4%) is statistically lower compared to England (22.1%). Compared to its peer comparators, Leicester has a similar or smaller proportion of obesity and overweight in Reception pupils (Figure 6).

Figure 6: Prevalence of overweight and obese (combined) children in reception year, 2015/16

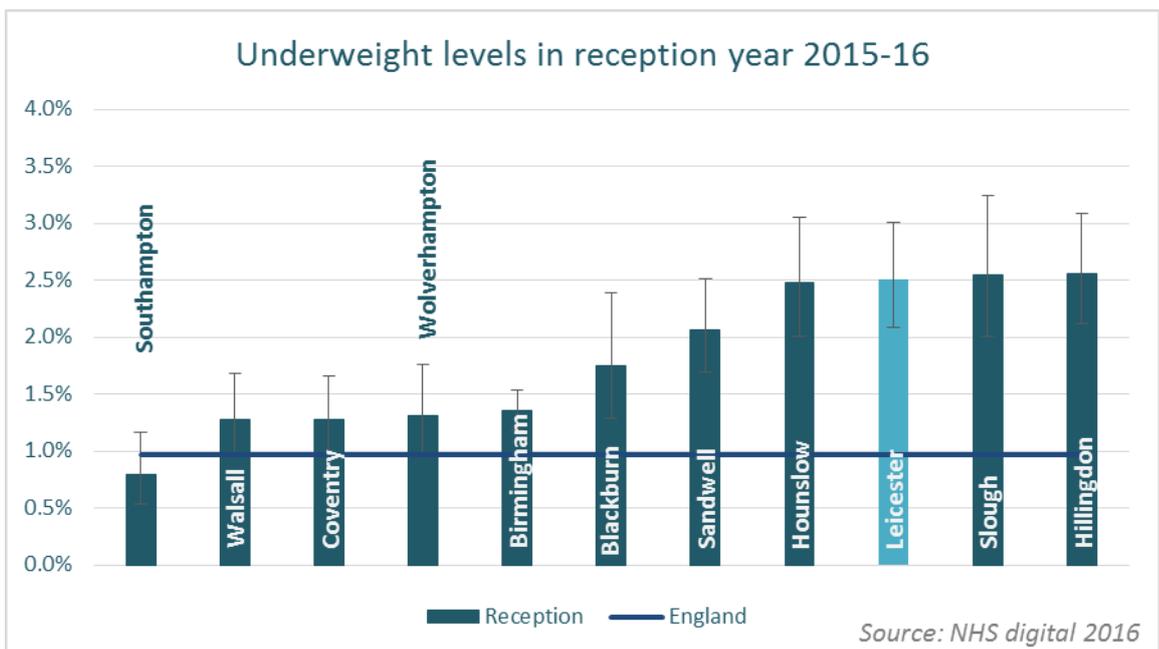


Underweight in Reception

In addition to whether or not children are overweight or obese, the NCMP measures if children are underweight. There are a variety of factors that influence whether or not a child is underweight. Some of the factors include: poor diet, malabsorption due to illness, ethnicity and neglect.

The proportion of Leicester’s Reception Year pupils who are underweight (2.5%) is statistically higher compared to England (1.0%). Compared to all but five of its peer comparators, Leicester has a statistically higher proportion of underweight reception pupils (Figure 7).

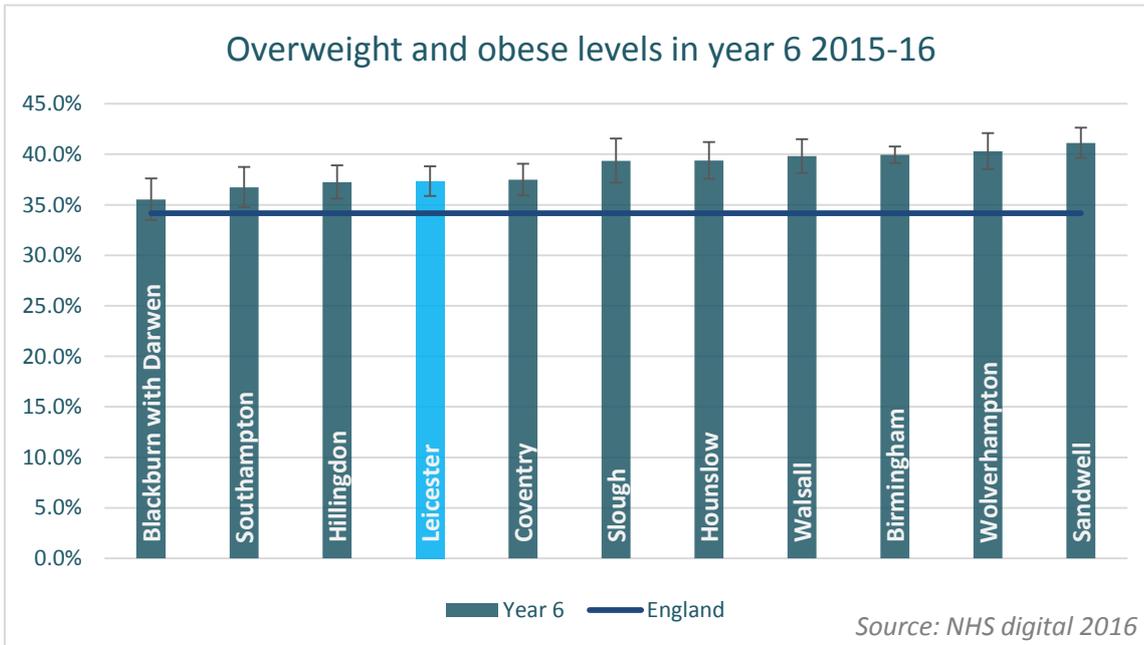
Figure 7: Underweight Levels in Reception Year, 2015/16



Obesity and overweight in Year 6

The proportion of Leicester’s Year 6 pupils who are obese and overweight (37.3%) is statistically higher compared to England (34.2%). Compared to its peer comparators, Leicester has a similar proportion of obesity and overweight (Figure 8).

Figure 8: Overweight and Obese Levels in Year 6, 2015/16

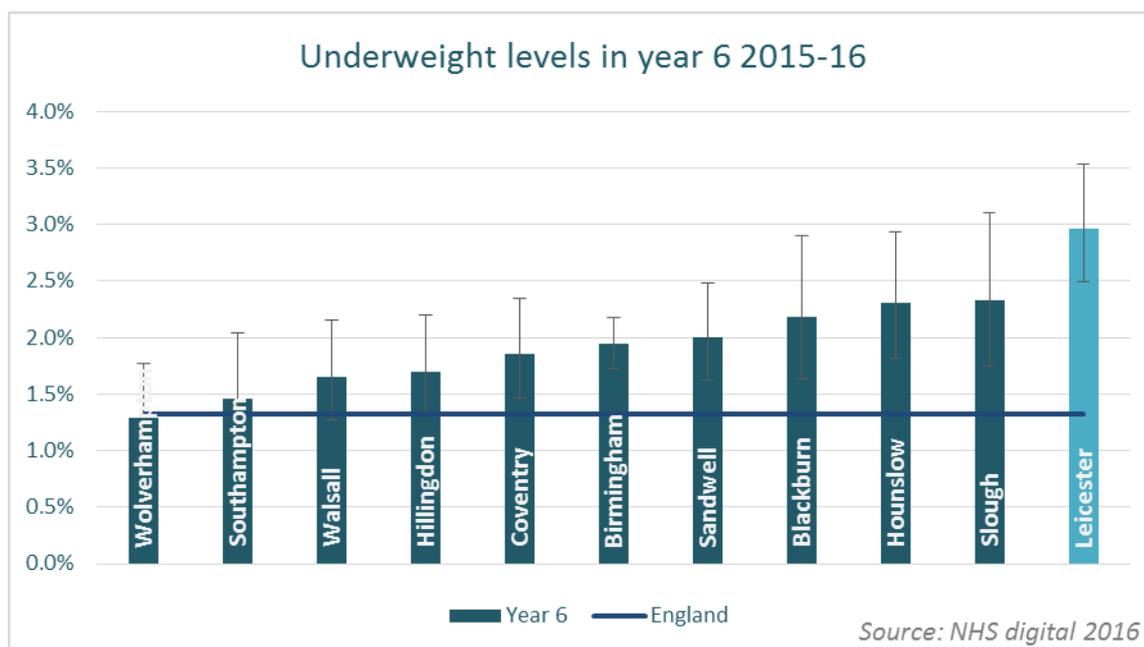


Underweight in Year 6

In addition to whether or not children are overweight or obese, the NCMP measures if children are underweight. There are a variety of factors that influence whether or not a child is underweight. Some of the factors include: poor diet, malabsorption due to illness, ethnicity and neglect.

The proportion of Leicester’s Year 6 pupils who are underweight (3.0%) is statistically higher compared to England (1.3%). Compared to all but three of its peer comparators, Leicester has a statistically higher proportion of underweight Year 6 pupils (Figure 9).

Figure 9: Underweight Levels in Year 6, 2015/16



4.1.3 Oral Health

Dental decay for children in Leicester is significantly higher than the average for England. In addition to the risk of dental diseases for the general population of children, children taken into the care system are at an increased risk of poor dental health.

Long-term dental disease can result in severe acute and chronic infection. For young children whose milk teeth are affected, dental disease may also cause damage and consequential loss to the underlying permanent teeth. Additionally, older children with dental disease are also at risk of losing their permanent/adult teeth due to extensive dental decay. Treatment of extensive symptomatic disease, both with and without general anaesthesia, may distress the child and does in itself have the risk of morbidity and mortality⁷⁹

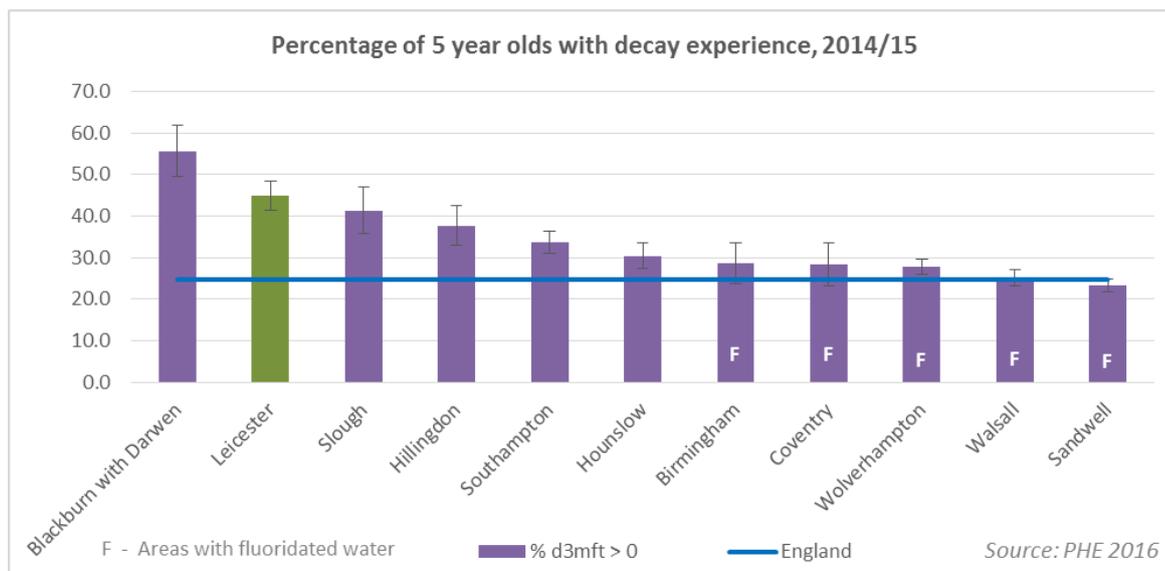
4.1.3.1 Tooth Decay

Dental caries (tooth decay) can occur at any age but can occur more frequently in earlier years of life particularly in lower socio-economic groups. Tooth decay affects physical and psychological wellbeing and quality of life; it can result in days off school or work due to the pain.

In Leicester, 48.4% of five year olds had experience of dental decay in 2014/15 (Figure 10). This proportion of decay is higher than the England average.

⁷⁹ Flick RP, Katusic SK, et al (2011) Cognitive and behavioural outcomes after early exposure to anesthesia and surgery. *Pediatrics* 128(5): e1053-61.

Figure 10: Percentage of children aged 5 years old experienced tooth decay in 2014/15



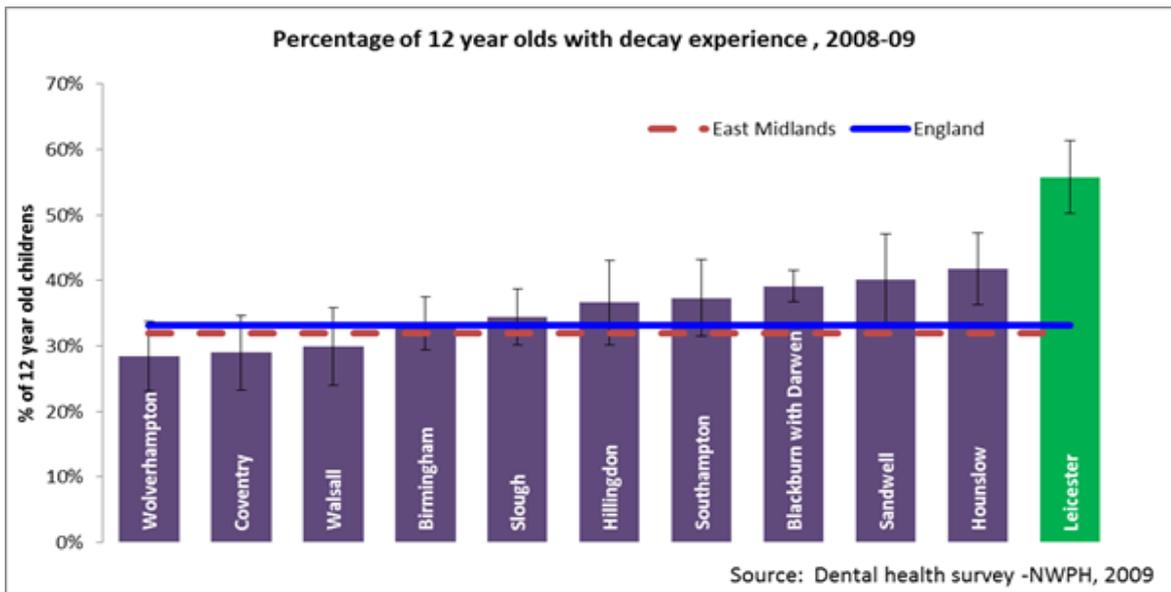
By age 12, children in Leicester have the highest burden of dental disease when compared against similar local authorities (Figure 11). The proportion of Leicester’s 12 year olds with dental decay experience (having one or more teeth decayed, missing or filled) is 55.7%. It should be noted that children living in Birmingham, Wolverhampton, Coventry, and Walsall all benefit from water fluoridation with much reduced levels of dental decay experience⁸⁰.

These are the latest available data due to the survey cycle for oral health.

Figure 11: Proportion of 12 year olds with decay experience, 2008-09⁸¹

⁸⁰ Leicester does not have an artificially fluoridated water supply.

⁸¹ Due to the survey cycle, this is the latest available local data for 12 year olds.



4.1.3.2 Fluoride Varnish

Fluoride varnish (FV) is a treatment which may be used to prevent tooth decay. It is a key public health intervention. 42,000 children Leicester children aged 6 to 12 years had FV treatment in 2015. This equates to 18.4% which is significantly lower than the England figure of 38%. Children living in southern ward areas had higher FV treatment rates.

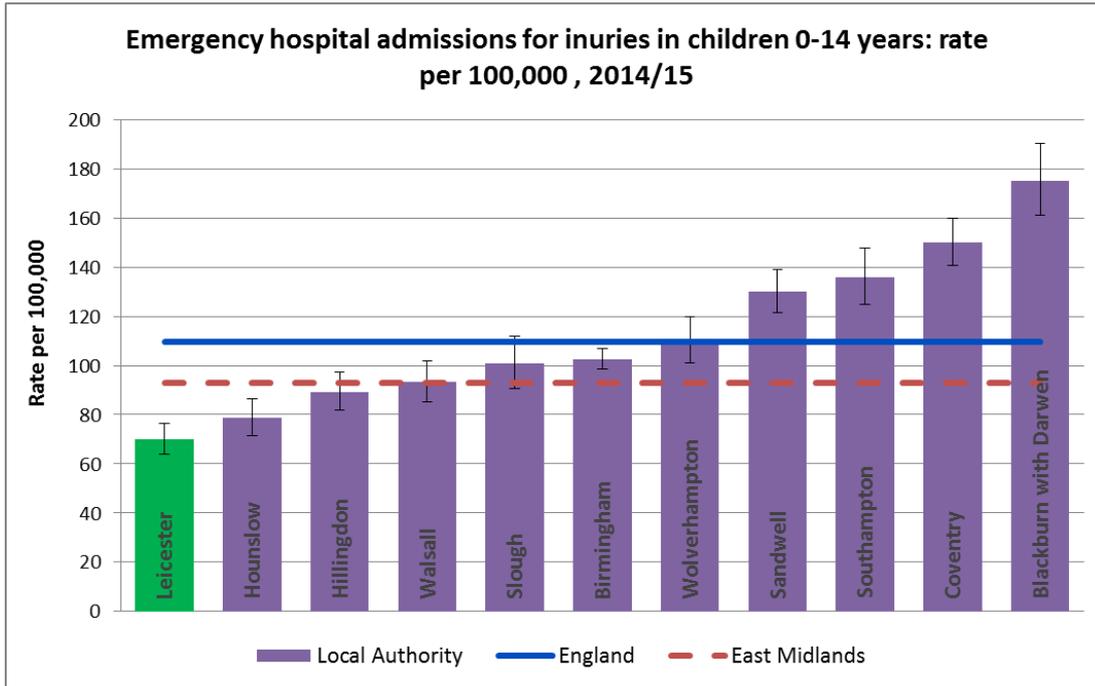
4.1.4 Unintentional and deliberate injuries

Rates of childhood injury (both unintentional and intentional) are higher among socioeconomically disadvantaged families. Based on the data below, Leicester does not fit this trend. However, it is not possible to breakdown the below data based on deprivation. There may also be factors such as a lower local threshold at which families take a child to the emergency department or the injuries may be less severe.

Income-related family factors often cited to explain differences in injuries between the least and most deprived include family functioning, family structure, parenting practices, maternal age, health and educational attainment. Families under stress due to chronic deprivation may contribute to greater risk of injury through lack of supervision and poor mental health. Inequities in injuries may also be attributed to differences in exposure to risk. There are also a number of potential neighbourhood influences, including substandard housing that lacks proper safety features, crime, violence, as well as unsuitability of the built environment for safe activities of young children.

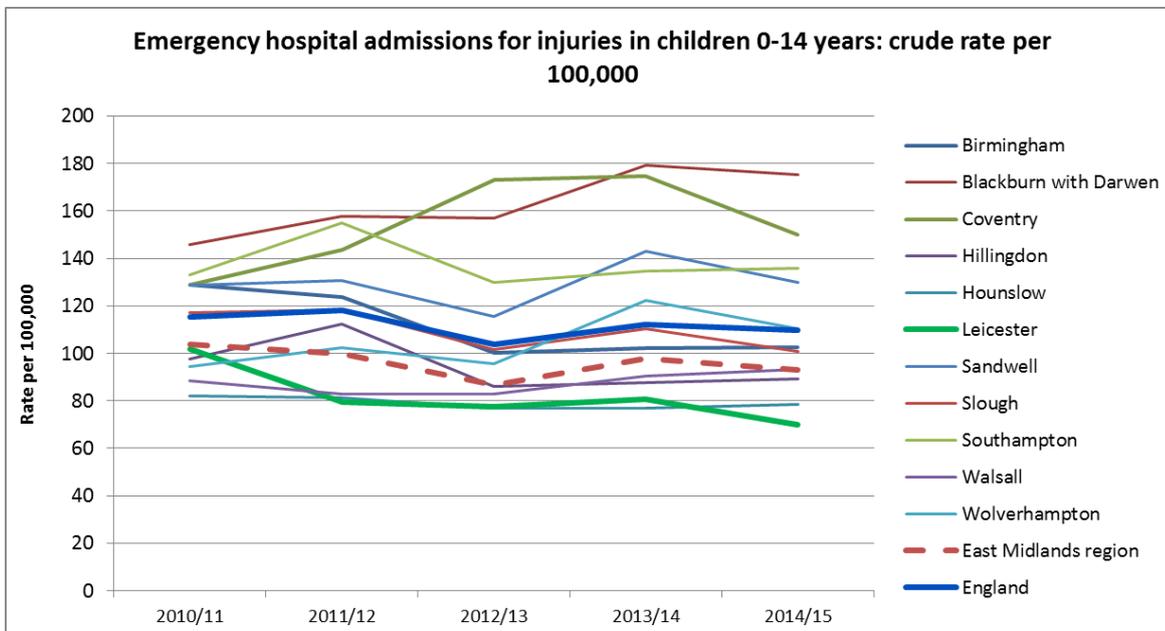
Hospital admissions caused by unintentional and deliberate injuries in the 0-14 year age group is an indicator in the Public Health Outcomes Framework for England, 2013 – 2016. Compared to its peer comparators, Leicester had a lower rate of emergency hospital admissions for injuries per 100,000 children aged 0 to 14 in 2014/15. The rate in Leicester was 70 per 100,000 compared to the England average of 109.6 per 100,000.

Figure 12: Emergency Hospital Admissions for Injuries, 2014/15



There is a decreasing trend in the rate of hospital admissions for children aged 0 to 14 years olds caused by unintentional and deliberate injury in Leicester. Between 2010 and 2015, Leicester’s rate reduced from 101.6 per 100,000 to 70.0 per 100,000. Many of Leicester’s peer comparators have either remained roughly the same or increased over the same time period.

Figure 13: Emergency hospital admissions for injuries, Trend 2010/11 to 2014/15



4.2 Determinants of health

Within this age group, in addition to the socio-economic factors that apply across all ages, there are a number of additional influences:

4.2.1 Immunisations

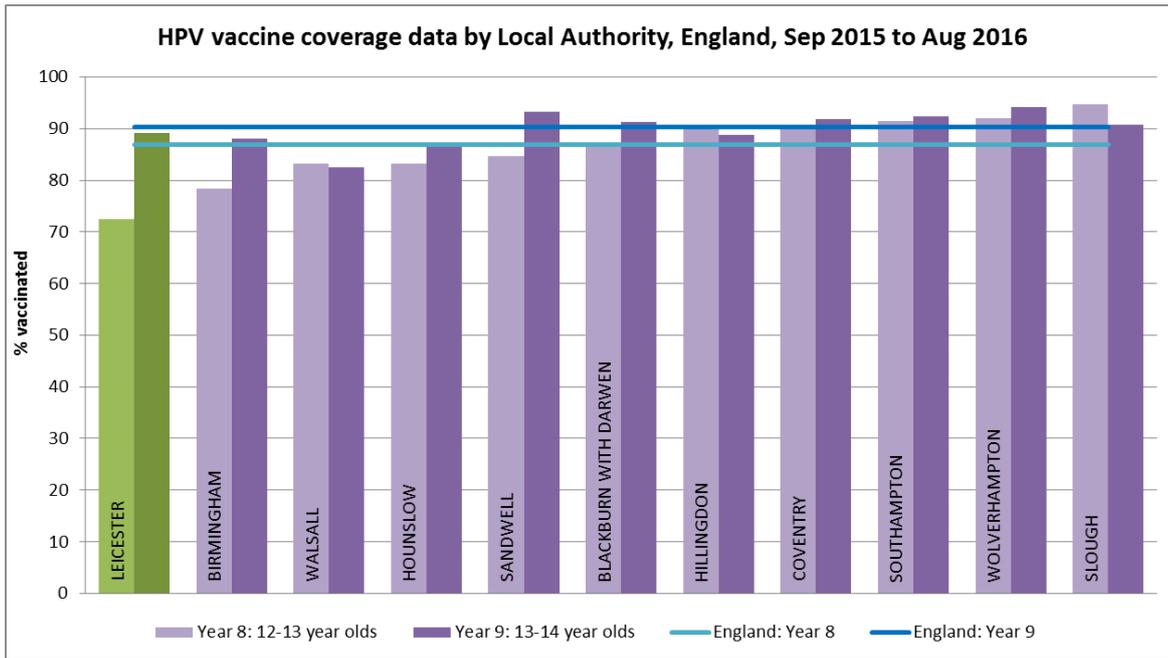
Much of the routine childhood immunisation programme is completed by age 5, but there are a number of important programmes that target adolescents:

4.2.1.1 HPV Vaccine

Human Papillomavirus (HPV) is known to be associated with an increased risk of cervical cancer. The national campaign to vaccinate girls aged 12 to 13 years was rolled out in 2008. Locally a vaccination team is responsible for delivering the vaccines, and this team is supported by the school nursing team. Leicester has achieved an uptake for 2015/16 of 72.5% in Year 8 girls and 89.1% of Year 9 girls.

Leicester has only achieved over the 90% target for one of the last five years (2012/13). However, Leicester's HPV vaccine uptake is similar to the uptake in comparator local authorities in Year 9 (Figure 14). Leicester's uptake in Year 9 is also similar to the England average, but uptake for Year 8 is low.

Figure 14: HPV Vaccine Uptake for Year 8 and 9 Girls: 2015/16



4.2.1.2 Td/IPV (Tetanus, Diphtheria, and Polio) Booster

As part of the national vaccination schedule, children aged 13 to 18 years are entitled to receive the Td/IPV booster. It is recommended that the booster is received around age 14 years, and this can be obtained from the child’s General Practitioner (GP). This vaccination is a single injection into the upper arm that protects children against three separate diseases: tetanus, diphtheria and polio.

Table1 shows that of the 62 GP practices in Leicester, only 37% achieved the target of 90% of all eligible children receiving the booster. Almost 30% of Leicester’s GP practices achieved less than 80% uptake.

The data below are the latest available due to data collection for this vaccine being suspended nationally.

NHS England has implemented new data reporting mechanisms through school nurses for 2016/17. Therefore data should be available later in 2017.

Table 1: Td/IPV Booster Uptake in Leicester, 2013-14

Immunisation	Target	Number of practices achieving target	Number achieving 85-89.9 %	Number under 80 %
Td/IPV Booster 13-18 yrs	90%	23	21	18

4.2.1.3 Meningitis C and Meningitis W

Children in England are eligible to receive the MenACWY vaccine around the age of 14 years, but it is particularly important for children aged 17 to 18 years and those attending university. Recently there has been an increase in Meningitis W cases. A single injection is given into the upper arm to protect the child against meningitis C and meningitis W. This vaccine is available from the child's GP.

Currently there are no data available nationally on the uptake of this vaccine.

4.2.2 Education

Pupils with better health and wellbeing are likely to achieve better academically.⁸² Effective social and emotional competencies are associated with greater health and wellbeing, and better achievement. Education is a key determinant for lifelong wellbeing, and continues to be important in this age group as they prepare to transition from primary to secondary to post-education.

School education in England is categorised into the Foundation Years followed by Key Stages (KS) 1 to 5. Expected attainment is assessed during each Key Stage. KS1 is relevant to this age group; it covers Years 1 and 2 and tests reading, writing and maths. Pupils are expected to improve by at least 2 levels for each tested topic area.

4.2.2.1 Educational attainment

The National Curriculum is divided into four Key Stages during children's school life. Targets defined in the National Curriculum are assessed at the end of each Key Stage. Data are not available for Key Stage 3 data as these are no longer collected following changes nationally.

Results for Leicester's Key Stages have continued to improve. For more detailed information, see <http://www.cabinet.leicester.gov.uk/documents/s76854/Annual%20Education%20Performance%20ReportFIN.pdf> and

<http://www.cabinet.leicester.gov.uk/documents/s73129/Early%20Years%20Foundation%20Stage%20Outcomes.pdf>

4.2.2.2 Special Education Needs (SEN)

Local data show that in 2015 there were over 7,700 children aged 5 to 19 years old with a Special Educational Need (SEN). This equates to 11.5% of all children in this age group.

Table 2: Children aged 5 to 14 years old with a SEN Stage for 2015/16

⁸² See https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/370686/HT_briefing_layoutvFINALvii.pdf

	Education Health and Care Plan	SEN Support	Statement
Totals	410	6351	942

Source: Leicester City Council, 2016

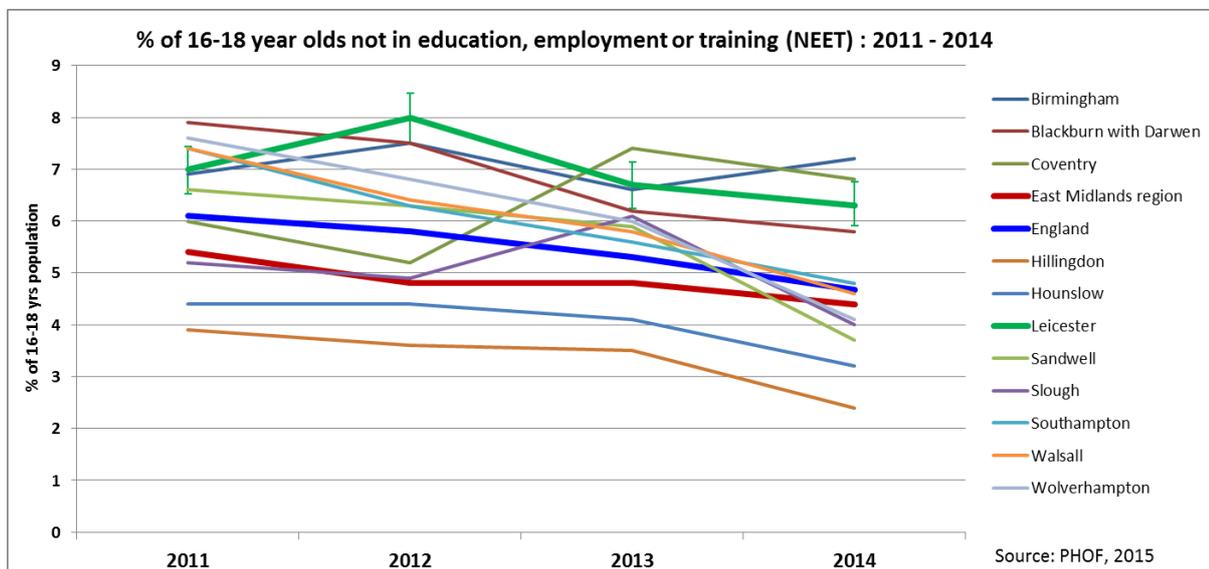
4.2.3 Not in Education, Employment or Training (NEET)

Spending time not in employment, education or training (NEET) has been shown to have a detrimental effect on physical and mental health. This effect is greater when time spent NEET is at a younger age and when a longer amount of time is spent NEET. The link between time spent NEET and poor health is partially due to an increased likelihood of unemployment, low wages, or low quality work later on in life. Being NEET can also have an impact on unhealthy behaviours and involvement in crime.

These negative health effects do not occur equally across the population. The risk of being NEET is affected by area deprivation, socio-economic position, parental factors (such as employment, education, or attitudes), growing up in care, prior academic achievement and school experiences. Being NEET therefore occurs disproportionately among those already experiencing other sources of disadvantage.

Figure 15 shows that although Leicester is currently the third highest amongst peer comparators, and significantly higher than both the East Midlands and England averages, the proportion of young people classed as NEET has fallen significantly from 2012 to 2014 in Leicester..

Figure 15: Percentage of 16-18 year olds who are NEET



4.2.4 Smoking

Smoking and its negative impact on health is a major burden on the NHS and other health services. Smoking in early adolescence is a risk factor for smoking as an adult. For children whose parents smoke, second-hand smoke can cause severe respiratory health problems such as asthma and reduced lung function.

Currently there are no local data on the levels of smoking in children and young people. More information will become available with the release of the Children and Young People's Survey data in May 2017.

4.2.5 Teenage Pregnancy

Teenage pregnancy (under-18 conception) refers to all conceptions in females aged 15-17 years in a calendar year. This includes termination of pregnancy, still birth and miscarriage and live births. It does not include prevention by emergency contraception.

Teenage pregnancy is a complex issue with many reasons for concern. Risk factors for under-18 conceptions include being a looked after child, poor school performance and attendance, economic disadvantage, substance misuse, older male partner and single or teen parents and poor access to contraception. Teenagers as a group tend to have higher rates of complications during pregnancy and delivery; these complications may be due to factors such as biological immaturity or poor preconception health. Teenage mothers are also at greater risk of having a baby with Low Birth Weight (LBW) which can predispose the baby to increased health concerns. Ongoing maternal health can be poor and result in poor mental health and postnatal depression.

Pregnant teenagers were found to be nearly three times more likely to have insecure attachment compared with adults. They may also experience poor support from their partner. These have been found to be associated with depression, and insecure attachment style should be addressed in prevention and intervention strategies with teenage mothers.⁸³

The data for under-18 conceptions is located in the PreBirth chapter of this JSNA. This shows a significant fall in teenage conception rates, following a national trend.

5. Current services

There are a number of additional services that are particularly relevant to this age group, particularly older adolescents, in addition to the services outlined in previous chapters.

5.1 Weight Management Services

Schools which participate in the National Child Measurement Programme weigh and measure children in Reception and Year 6 to inform local planning and delivery of children's services. Leicester is engaged in the Change4Life⁸⁴ programme to promote healthy eating and exercise.

⁸³ Figueiredo, B., et al., Teenage pregnancy, attachment style, and depression: a comparison of teenage and adult pregnant women in a Portuguese series. *Attachment and Human Development*, 8(2), June 2006, pp.123-138.at <http://www.scie-socialcareonline.org.uk/teenage-pregnancy-attachment-style-and-depression-a-comparison-of-teenage-and-adult-pregnant-women-in-a-portuguese-series/r/a1CG000000GTbMMAW>

⁸⁴ The Change4Life programme is a national scheme driven by Public Health England.

As part of the Food Plan for Leicester there are healthy eating projects, in schools and early years' settings. These increase awareness about the benefits of eating fresh fruit and vegetables and support schools to encourage healthy and sustainable eating behaviours, and increased cooking and growing skills.

5.2 Sexual Health Services

The Integrated Sexual Health Service (ISHS) is commissioned by the local authorities (Leicester City, Leicestershire County and Rutland County) and is provided by Staffordshire and Stoke on Trent NHS Partnership Trust (SSOTP). ISHS provides open access contraception, STI testing and treatment, outreach work, psychosexual counselling and a young people's service that includes a C card scheme.

The aim of the ISHS is to provide a range of accessible, high-quality, responsive, cost-effective, confidential services across LLR. The service provides an open access hub and spoke model of sexual health provision meeting all the sexual health needs of an individual in one visit.

In addition to the ISHS, other services which deliver elements of sexual health services in Leicester as follows:

- General Practice
- Pharmacies
- Pregnancy termination services
- HIV treatment and care
- Sexual Assault and Rape Centres
- Relationship and Sex Education

5.3 Substance Misuse

5.3.1 Smoking Cessation Services

Leicester's Stop Smoking service has played a key part in helping to lower smoking rates amongst adults and young people in Leicester. The service- adheres to national Guidance⁸⁵ and as such does not have services aimed specifically at the 15-19 year old age group but rather focuses on adult smoking, as this will be the greatest influence over youth uptake. This approach is more appropriate, rather than spending a disproportionate sum on prevention, when youth smoking levels are lower than they have ever been, both nationally and locally.

However, the service acknowledges that in some communities, and in particular vulnerable groups, smoking among teens remains an issue, and so stop smoking treatment is offered to any young person who will attend appointments. Additionally, the service has helped to develop a network of pharmacies who will make extra effort with young people, and have shared the list with Leicester City schools.

⁸⁵ National centre for smoking cessation and training (NCSCT) (2015). <http://www.ncsct.co.uk/usr/pub/NCSCT%20briefing-effectiveness%20of%20local%20cessation%20and%20prevention.pdf>. Accessed from on 11 December 2015

Data obtained from service indicates that of those aged 18 and under (an exact 15-19 breakdown is unavailable) who set a quit date in 2013-14, 49% actually quit. In 2014-15, the equivalent figure was 27%.

5.3.2 Drugs and Alcohol

Substance misuse services for young people and adults will be changed on 1st July 2016 and are jointly commissioned across Leicester and Leicestershire. Turning Point is the provider of these services. Young Person's provision is directed towards under-21 year olds with a tailored approach to adults under 25.

5.4 Voluntary Sector

The voluntary sector offers a wide range of different services for the late teenage demographic in particular. These include groups tackling issues on sexuality and LGBT issues, youth mental health groups, and training and employability services for the most vulnerable young people furthest from the labour market. Additionally there are voluntary groups that support those who are homeless, suffering from substance misuse and young offenders.

6. Projected service use

ONS estimates suggest that there will be a significant growth in the number of 5-19 year olds in Leicester over the next few years.

6.1 Education Services

Schools are required to provide school places for every child in the City. In 2015 the School roll was 19,613 places. As the numbers of children attending schools will increase so will issues such as SEN and the need for additional support. Furthermore from the diversity of the residents, school commissioners should infer that there will be increasing need to support children for whom English is a second language.

6.2 Health Services

The increasing numbers of children and young people will mean an increase in the need for GP registrations and the childhood immunisation programme. There will be a need to improve understanding of the health system, self-care and the need for immunisations in a culturally sensitive way. Current trends in childhood obesity and the associated impact on diabetes are also likely to have consequences for health services in the medium term.

6.3 Children's Services

Similar pressures are expected to be felt on social services in the future with the increase in the child population in Leicester City. This is predominantly expected in the west side of the City.

Chapter 5

1. Introduction

The transition from adolescence to young adulthood is a time of major changes for most young people. Unlike the childhood transitions described in other chapters of this JSNA, the transition to adulthood for many will include a move away from family and friends. A successful transition to young adulthood forms a foundation for young adults in their future stages of development and transitions. Young adults who are less likely to make this transition well are those who are not in employment education or training, those with special educational needs and those suffering a mental illness.

For public services, young adulthood is the 'last' opportunity to help young people secure a stable foundation for their future lives. Late adolescence and young adulthood transition's significance is reflected in the Children and Families Act 2014, the Care Act 2014, and in 'Special educational needs and disability code of practice: 0 to 25 years'. This guidance is designed to ensure that when young people reach the legal age of adulthood at 18 they do not fall through gaps in the health and education system.

The Care Act frames this as 'preparing for adulthood', referring to the key lifetime domains of:

- Employment and/or purposeful activity
- Independent living
- Community participation
- Health

2. Who's at risk and why?

In addition to the risks that apply across all age-groups, some young people face specific new risks at this point:

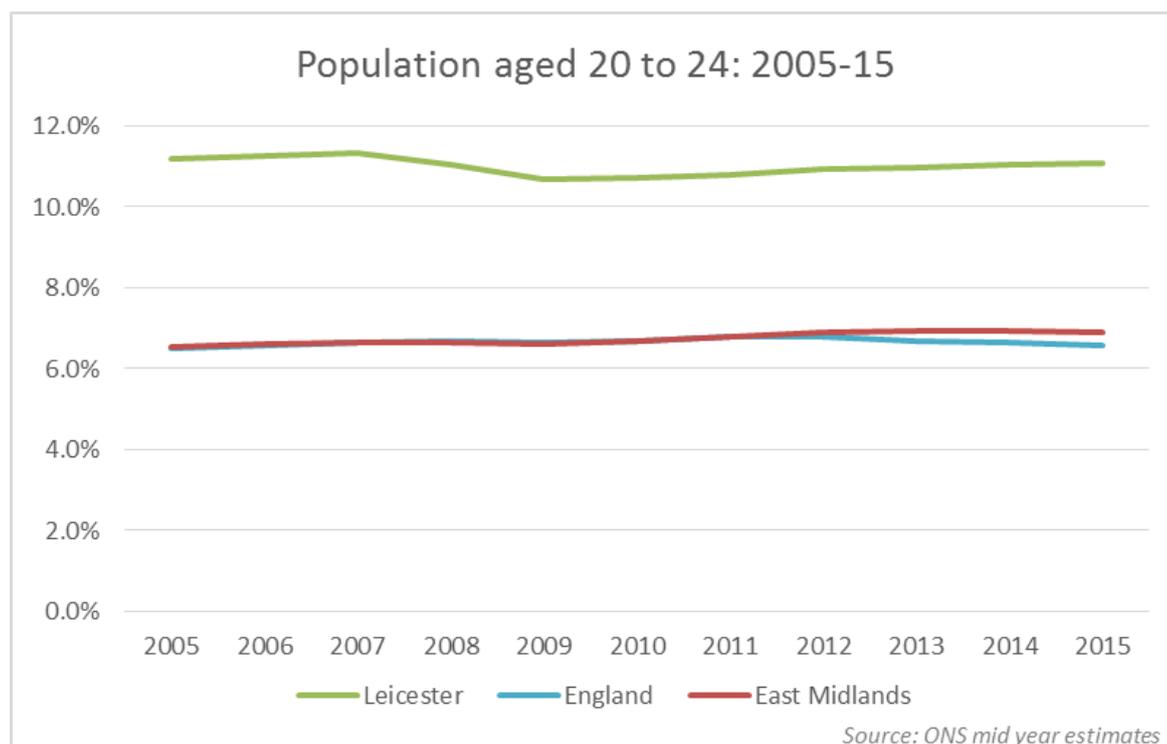
- Lifestyle: Behaviour choices around healthy diets and risk-taking behaviour contribute to the mortality and morbidity in this group.
- Transition to Adulthood & adult services: Poor transitions can have a negative effect on health outcomes. Approximately 75% of adult mental health problems begin before 18, so transitions are very significant for many young people's health and well-being. This is a particular issue for young people with special educational needs and disabilities who may have had significant support from their parents and carers and their education setting. Getting this support right at as young people move into adult services is key.
- Looked after children and care leavers: Looked-after children and care leavers are between four and five times more likely to self-harm in adulthood. They are also have a five-fold increased risk of all mental, emotional and behavioural problems.

3. Demographic Summary

3.1 Population profile:

- In 2015 there were an estimated 37,943 people aged 20-24 years living in Leicester. The population trend between 200 and 2015 is shown in Figure 1. Over the last 10 years the 20 to 24 year old population of Leicester has remained relatively constant, but Leicester has a significantly higher proportion of the population in this age group compared to England and the East Midlands.
- Of these, 49% were male and 51% female.
- This age group made up approximately 11% of the total population, making them the single largest age group and helping to define Leicester as a “young” city.
- Leicester is home to two universities, De Montfort and Leicester. The students of both contribute to the 20 to 24 year old population cohort.

Figure 1: Leicester’s population aged 20 to 24 years old (2005-15)



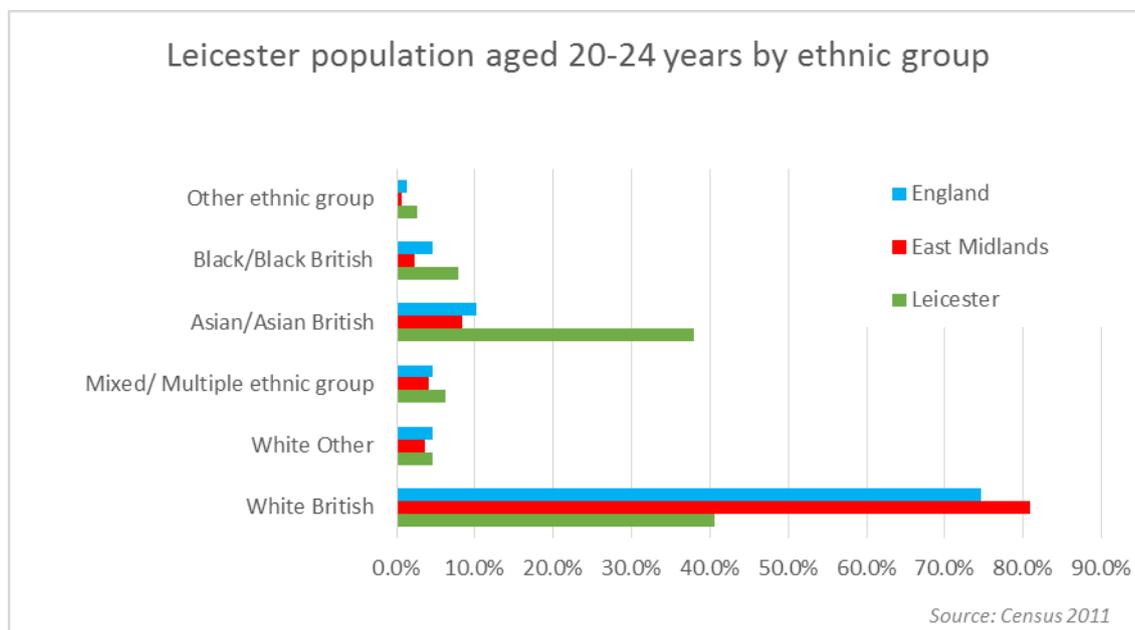
3.2 Ethnicity

In Leicester, the ethnicities of young adults (as per census 2011) are as follows:

- 45% White⁸⁶
- 38% Asian/Asian British
- 8% Black/ African/ Caribbean / Black British
- 6% Mixed/multiple ethnic group
- 3% Other ethnic group

Compared to the England and East Midland averages, Leicester has a smaller proportion of young adults (Figure 2). For all other ethnic groups, Leicester has significantly more children in these groups compared to the England and East Midlands averages.

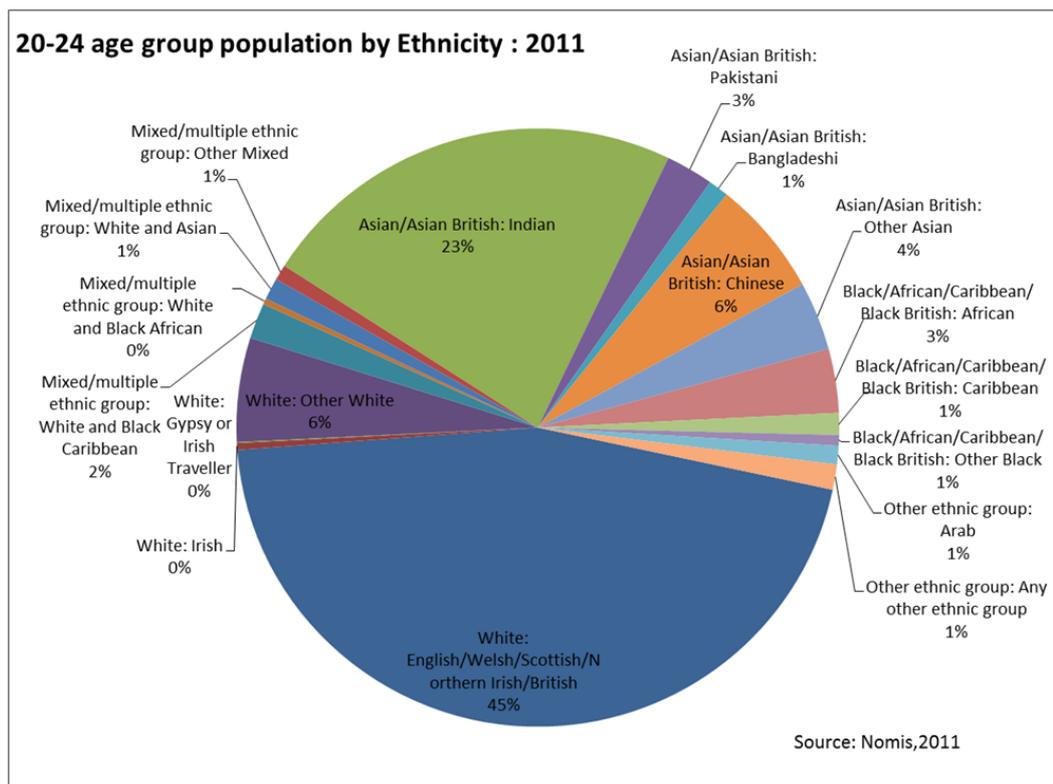
Figure 2: Leicester’s population of young adults aged 20-24 years by ethnic group



The detailed review of ethnicity in Figure 3 shows the wide range of ethnic groups that are masked when only divided by broad ethnic categories. This shows that in this age group there is a significantly higher proportion of Chinese and lower proportion of Asian Indian people than the Leicester population as a whole.

⁸⁶ Includes 'White Other'.

Figure 3: Leicester's 20-24 year old population by ethnicity



4. The level of need in the population

4.1 Severe and Multiple Disadvantage

The Hard Edges research provides a statistical profile of the manifestation of ‘severe and multiple disadvantage’ (SMD) across 153 local authority areas in England. SMD is the shorthand term used to signify the problems faced by adults involved in the homelessness, substance misuse and criminal justice systems, with poverty an almost universal, and mental ill-health a common, complicating, factor.

Hard Edges estimates that the ‘average’ local authority might expect to have about 1,470 adult (aged 18 upwards) SMD cases over the course of a year, as defined by involvement in two out of the three relevant service systems. In relation to the incidence of individuals experiencing two or three of the SMD domains, Hard Edges also reports that the 24 authorities with the highest incidence were likely to experience between two-three times the prevalence rate of SMD overall than the average authority. Leicester appears as number 11 in the ‘top 24’ of all 153 authorities, putting it in the top (worst) 7% of authorities.

4.2 Employment

Adolescents transition from school/college to university and/or the workforce during the early adult years. Similar to the transitions discussed in the Early Years chapter, disadvantaged children may find the transitions more difficult. They may be disadvantaged due to deprivation, a lack of necessary skills, mental illness or lack of support. Young people from deprived backgrounds are more likely to not be in education,

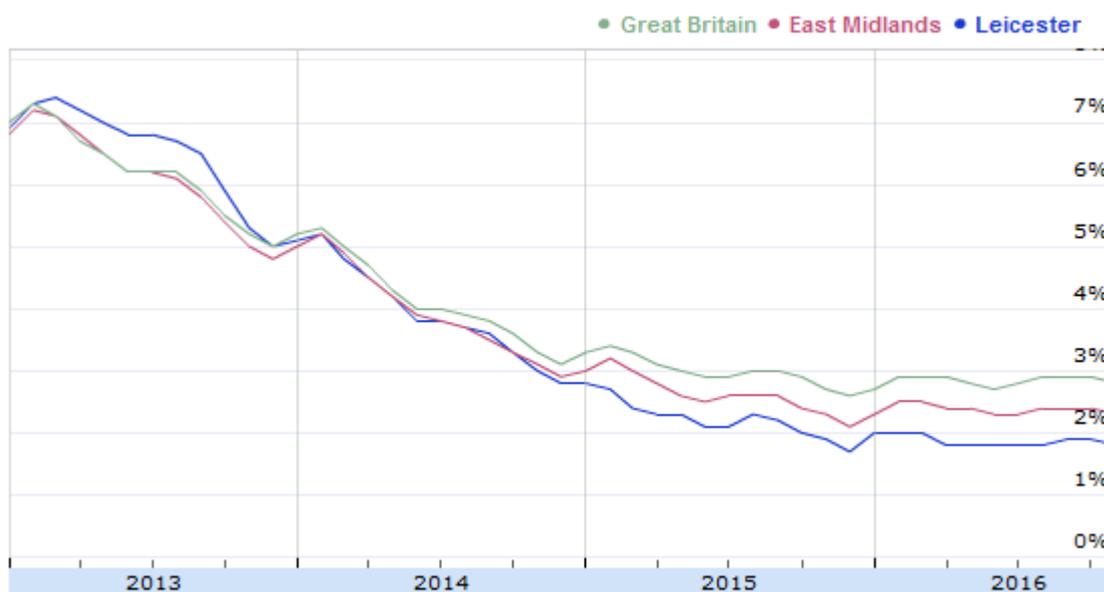
employment or training when aged 20 to 24 years old. These individuals are also more likely to experience other disadvantage such as difficult family relationships, substance misuse or mental illness.

Young adulthood is a time when your education or employment becomes even more important for your life trajectory. Having insufficient money to lead a healthy life is a highly significant cause of health inequalities; there is a clear relationship between wealth and health according to Marmot (2010). The less deprived you are the healthier you are likely to be. As life expectancy is based on early child development, education, employment, living wage, environmental factors and lifestyle factors (e.g. smoking, diet, activity), whether or not you are employed or training during ages 20 to 24 years are key factors to your long term health.

4.2.1 Out of Work Benefits

By the age of 24 years the majority of young people will have entered the employment market. During 2013 the proportion of 15-19 year-olds who were NEET in the UK was 9%, while the proportion of 20-24 year-olds was more than twice as high at 19%. Over the past three years the proportion of young people claiming out of work benefits has fallen and in 2016 stabilised at just under 2% in Leicester.

Figure 4: Proportion of 18 to 24 year olds Claiming Out of Work Benefits (2013 to 2016)



The majority of young people (83%) who claim job seekers allowance do so for less than 1 year. This is less than 1% of the total cohort of this age group.

4.3 Learning Disabilities

Young adults with learning disabilities are particularly vulnerable during this transition to adulthood. The research indicates that people with moderate to serious learning disabilities are three times as likely to die early compared to the general population. Individuals with learning disabilities are also more likely to experience poor general health, and to have high levels of unmet physical and mental health needs. People with learning disabilities face serious health inequalities, partly arising from difficulties they

encounter in using health and social services. Currently there are no data available on the ability of Leicester’s young adults to access services.

Emerson et al⁸⁷ identified five key determinants of health inequalities for individuals with learning disabilities:

- They are at a greater risk of exposure to social determinants of poorer health such as poverty, poor housing, unemployment and social disconnectedness.
- They have an increased risk of health problems associated with specific genetic and biological causes of learning disabilities.
- They experience difficulty communicating and have reduced health literacy.
- They have higher personal health risks and behaviours such as poor diet and lack of physical activity.
- They experience difficulty accessing to healthcare provision.

In Leicester there is a lack of detailed and easily accessible data on the health needs of 20 to 24 year olds with learning disabilities and Special Educational Needs (SEND). A more detailed specific needs assessment is needed for this population of vulnerable young adults.

Data from PANSI project the numbers of adults aged 18-24 in Leicester who are predicted to have a learning disability and those predicted to have a moderate physical disability, 2014-2030. Over the next 15 years the numbers of young adults with learning disabilities is expected to grow in Leicester.

Table 1: People aged 18-24 years predicted to have a learning disability

	Baseline estimates	Moderate /Severe	Severe	Living with parent	Downs Syndrome	Challenging behaviour	Autistic spectrum disorders
2014	1299	298	98	195	30	22	470
2015	1298	298	98	195	30	22	472
2020	1243	287	95	187	29	21	454
2025	1232	288	95	189	29	21	448

⁸⁷ Emerson, E., Baines, S., Allerton, L. and Welch, V. (2011) Health Inequalities & People with Learning Disabilities in the UK: 2011.

2030	1357	319	105	209	32	23	494
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Table 2: People aged 18-24 predicted to have a moderate physical disability

	Moderate disability	Serious disability	Moderate personal care disability	Serious personal care disability	Diabetes	Serious visual impairment	Moderate or severe hearing impairment
2014	1968	384	288	192	409	31	79
2015	1968	384	288	192	408	31	78
2020	1886	368	276	184	391	30	76
2025	1874	366	274	183	389	30	73
2030	2066	403	302	202	429	33	81

4.4 Homelessness

As well as the young adults who continue to live with a parent(s) between the ages of 20-24, there are those who cannot do so and some will become homeless as a result. Among these, only those who meet the criteria for the ‘priority’ categories of young people, namely those with children and those considered ‘vulnerable’ under homeless legislation, are entitled to rehousing by their local authority.

There are many and complex causes of homelessness for young adults. The reasons may be economic, social, structural or emotional. Structural issues such as poverty, unemployment and a lack of affordable housing magnify the needs of individuals. Social relationships with friends and family may both cause homelessness and/or extend the time a young adult is homeless. Financial strain is a risk factor for a young person becoming homeless, and therefore young adults from more deprived backgrounds are more at risk of homelessness⁸⁸.

⁸⁸ Youth Homelessness in the UK report.

During childhood and adolescence the attachment and bond with families is important for building their resilience and confidence. For young people without strong bonds with their families, homelessness is even more difficult. Relationship breakdown has historically been and continues to be a primary trigger for homelessness across the UK. During 2014/15 young adults who were accepted as statutorily homeless, the reason given for a quarter of them was that relatives/friends were no longer able or willing to accommodate them.

The Hard Edges⁸⁹ report found that homeless young people are increasingly unable to look after themselves properly. Some of the skills they lack include eating healthy food, being physically, maintaining emotional stability or focus on education, training and employment. Their mental health needs are increasing, and undiagnosed learning difficulties were often reported.

There has been a significant decline in the levels of official statutory youth homelessness as measured by the number of young people owed the rehousing duty by local authorities. However, there is also a wider group of young people are living on sofas or spare rooms of their friends and family. The impact of the removal of automatic Housing Benefit from April 2017 for 18 to 21 year olds and any impact on homelessness levels will need to be reviewed.

4.5 Health

The health of young adults is influenced by behaviours and habits that started during childhood and adolescence. These behaviours and habits include nutrition, physical activity, substance misuse and educational achievement.

During early adulthood, several behavioural and mental disorders begin to emerge. Some of the new freedoms during young adulthood encourage exploration and experimentation and have been found to be associated with increased substance use and health-risking behaviours. Because there is variability in the timing of transitions into adult roles (e.g. romantic relationships, having children), some young adults will be more vulnerable to health and wellbeing risks than others and at different times in their life course. This variability is important to consider when planning preventive services targeting young adults.

The Leicester Health and Well-being Survey 2015 provides a summary of the self-reported health and well-being of adults living in Leicester. The survey found that 89% of 20 to 24 year olds feel their health is 'good' compared to 71% of all adults aged 16+ years. This age group is more likely to want to eat healthily and exercise compared to other age groups. However, they are also more likely to not have visited a dentist in the last 12 months. More information on the self-reported health and well-being of adults in Leicester is available at: <https://www.leicester.gov.uk/your-council/policies-plans-and-strategies/health-and-social-care/data-reports-information/leicester-health-and-wellbeing-survey-2015/>

⁸⁹ The Hard Edges Report. Available at: <http://lankellychase.org.uk/multiple-disadvantage/publications/hard-edges/>

More information on the health needs of adults in Leicester is available in the 2016 Adults JSNA which is available at <https://www.leicester.gov.uk/your-council/policies-plans-and-strategies/health-and-social-care/data-reports-information/jsna/jsna-2016/adults-older-people/>

More detailed information about mental health in Leicester can be found at “Mental Health in Leicester: a Joint Specific Needs Assessment”. Available at: <http://www.leicester.gov.uk/media/178811/mental-health-jsna.pdf> The mental health of adults is also covered in the most recent ‘Adults JSNA’. Available at: <https://www.leicester.gov.uk/your-council/policies-plans-and-strategies/health-and-social-care/data-reports-information/jsna/jsna-2016/adults-older-people/conditions-populations-and-services/mental-health-and-wellbeing/>

4.6 Smoking

Experimentation with cigarettes and the developing a habit of smoking typically occur during adolescence. The evidence shows that almost 90% of adult smokers tried their first cigarette before the age of 18, and the peak age to start smoking is between 12 and 14 years old. Therefore 20 to 24 year old who smoke are most likely already addicted to nicotine. According to the Health and Well-being Survey, approximately 70% of 16 to 24 year olds reported they have never smoked a cigarette or e-cigarette.

Smoking is correlated with the socioeconomic level of adults, and the evidence suggests social inequalities in adults who smoke are based on social patterns of initiation and quitting smoking⁹⁰. Therefore smoking prevention work that occurs during adolescence should work to break this social split. Such programmes are important to the health and wellbeing of young adults in the short and long term.

4.7 Substance Misuse

In Leicester, those who report they have misused drugs and alcohol are more likely to be male, white and aged 16 to 24 years.⁹¹ There is a correlation between age and drug-related criminal offending in Leicester, with a far greater prevalence in the age range 16-24 years than across other age groups. Similarly, rates of alcohol related offences for drunkenness, assault, disorder and other attributable offences were highest among 16-24 year-olds and decreased with increasing age, indicating that younger people are at the greatest risk of alcohol-related crime.⁹²

⁹⁰ <http://journals.sagepub.com/doi/pdf/10.1177/1403494810395989>

⁹¹ “Joint Specific Needs Assessment (JSNA): Drugs and Alcohol”, June 2012. Available at <https://www.leicester.gov.uk/media/178815/drugs-and-alcohol-health-health-needs-assessment.pdf>

⁹² Ibid

Substance misuse in adults is also included in the 2016 Adults JSNA. For more detailed data please visit: <https://www.leicester.gov.uk/your-council/policies-plans-and-strategies/health-and-social-care/data-reports-information/jsna/jsna-2016/adults-older-people/lifestyle-factors/>

5. Current services in relation to need

5.1 GP registration

Residents of the United Kingdom, including asylum seekers, are entitled to register with a local NHS General Practitioner (Doctor/GP), and must do so before they can qualify for any free medical treatment, other than emergency treatment. Individuals can register by contacting a GP's surgery in their local area. Some GPs may not be able to accept new patients as their lists may be full. The Health and Well-being Survey shows that 94% of this age group are registered with a GP, below the average across all ages (98%)

5.2 Sexual Health Services

There are a variety of sexual health providers within Leicester, covering various levels of service provision. The community of sexual health providers across Leicester, Leicestershire and Rutland (LLR) is supported by the Sexual Health and HIV network which meets twice a year in order to share developments and good practice.

The Integrated Sexual Health Services (ISHS) is commissioned by the local authorities (Leicester City, Leicestershire County and Rutland County) and is provided by Staffordshire and Stoke on Trent NHS Partnership Trust (SSOTP). It commenced on the 1st January 2014 and provides open access contraception, STI testing and treatment, outreach work, psychosexual counselling and a young people's service that includes a C card scheme. The aim of the ISHS is to provide a range of accessible, high-quality, responsive, cost-effective, confidential services across LLR. The service provides an open access hub and spoke model of sexual health provision meeting all the sexual health needs of an individual in one visit.

5.3 Smoking cessation services

Leicester's Stop Smoking service has played a key part in helping to lower smoking rates amongst adults and young people in Leicester. The service adheres to national Guidance⁹³ and focuses on adult smoking, as this will be the greatest influence over youth uptake. Young people aged 20 to 24 years old may access the service.

⁹³ National centre for smoking cessation and training (NCSCT) (2015). <http://www.ncsct.co.uk/usr/pub/NCSCT%20briefing-effectiveness%20of%20local%20cessation%20and%20prevention.pdf>. Accessed from on 11 December 2015

5.4 Substance misuse service

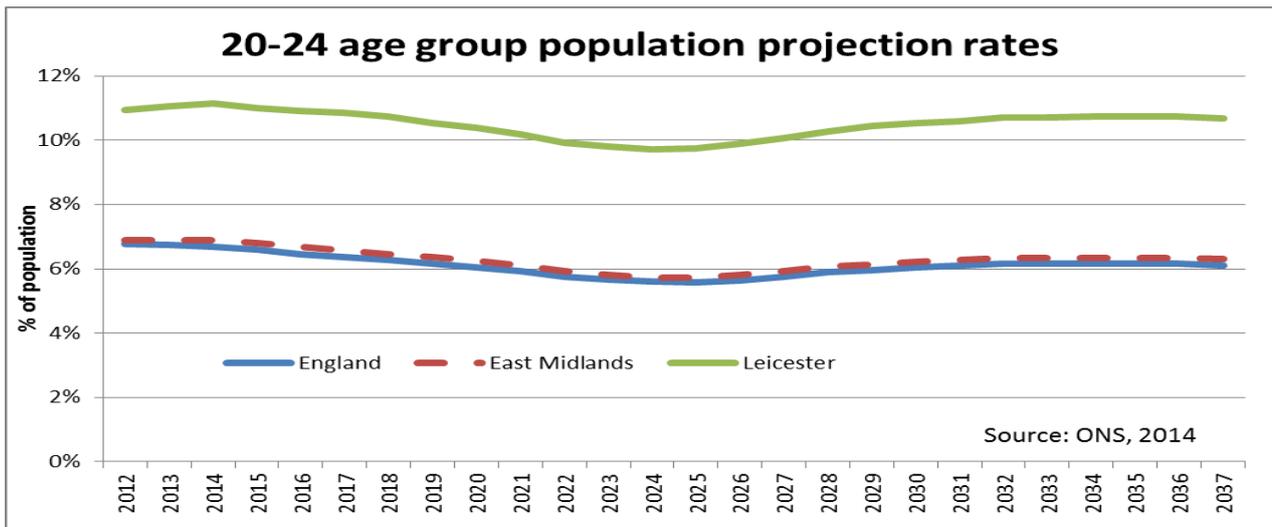
Substance misuse services for young people and adults changed on 1st July 2016 and are jointly commissioned across Leicester and Leicestershire. Turning Point is the provider of these services. Young Person’s provision is directed towards under-21 year olds with a tailored approach to adults under 25.

6. Projected service use for 20-24 years olds

Based on population projections, this age group will remain relatively constant in its size.

Work is needed to have a better understanding of how those within this age group transition from child to adult services. The impact of childhood and adolescent health and wellbeing improvement programmes are important for ensuring young people develop the appropriate life skills to be healthy young adults.

Figure 5: Population project for Leicester’s 20 to 24 year old age group



Chapter 6

1. Introduction

Mental health problems in children and young people are common and a significant burden of illness.⁹⁴ They can have wide-ranging and lasting effects; for example most lifelong mental illness begins by age 14.⁹⁵ Childhood mental illness can lead to significant distress and poor outcomes in educational attainment, employment prospects, social relationships and long term physical health problems.

Mental wellbeing is important for healthy development. It is influenced by social and economic circumstances, the wider environment, individual and family characteristics. As a city with high rates of deprivation, inequality and variable attainment at school, the risk factors for poor mental health in Leicester children are high.

2. Policy Drivers for Young People's Mental Health

The story of the causes, effects and impact of mental illness in young people is well known. It underpins a number of policy initiatives to protect and promote mental wellbeing in children and young people. These are especially important at a time of challenging economic outlook and increasingly disproportionate social disadvantage.

The report of the Chief Medical Officer 2012, which placed prevention of childhood illnesses at the centre of health policy, was a call to arms to tackle the vulnerabilities and risk factors which have an impact on childhood wellbeing. For mental wellbeing this was reinforced by Future in Mind, which sets out a strategic approach by which health and social care, and the wider resources involved in looking after children and young people, can work together to protect mental wellbeing.

3. The level of need in the population

⁹⁴ Chief Medical Officer (CMO), 2012, Our Children Deserve Better: Prevention Pays

⁹⁵ Kessler, R et al., 2007, Age of onset of mental disorders: a review of recent literature. *Current Opinion in Psychiatry* 20(4) p 359-64

3.1 Population profile⁹⁶

There are high rates of mental health problems in boys and girls across England. The Office of National Statistics estimates that 10% of children have a clinically diagnosable mental disorder; that is a problem with significant impairment. There is some variation according to age group and gender.

Among 5 to 10 year olds, 10% of boys and 5% of girls have a mental disorder; in Leicester that would be equivalent to more than 2,000 children. In the 11 to 16 year age group the prevalence is 13% for boys (n = 1,015 in Leicester) and 10% for girls (n = 955). The prevalence of conduct disorder is 4.5-5% (n = 886-985); anxiety disorders 2-3% (n = 394-591); depression 0.9% (n = 200); ADHD 1.5% (n = 295) and autism spectrum disorders 0.9% (n = 200).⁹⁷ Conduct disorders and autism spectrum disorders are more common in boys and emotional disorders more common in girls.⁹⁸

For people aged 16-24 years 2.2% (n = 1,234) experience a depressive episode, 4.7% were screened for post-traumatic stress disorder, 16.4% experienced anxiety disorder, 0.2% a psychotic illness and 1.9% a diagnosable personality disorder.⁹⁹

Self-harm is a concern among young people. The rate in children aged 5-10 years with no diagnosed mental health disorder was 0.8%, rising to 6.2% in children with anxiety and 7.5% in those with conduct or hyperkinetic disorder. The prevalence is higher in adolescence where the prevalence was 1.25% in young people with no diagnosed mental health disorder, 9.4% with anxiety and 18.8% depression.

The Household Survey found that 6.2% of 16-24 year olds had attempted suicide and 8.9% had self-harmed in their lifetime. Nationally, suicide is the leading cause of death in young people. The suicide rate among 10-19 year olds is 2.2 per 100,000; it is higher in males (3.14) than females (1.3), and in older adolescents (4.04 among 15-19 year olds).

3.2 Families, Parenting and Early Years

Individual mental health can be influenced by events or circumstances occurring before birth. Unwanted pregnancy or those which occur in teenage years can increase the chance of childhood mental health problems.¹⁰⁰ Use of tobacco, alcohol and drugs in pregnancy, and low birth weight increases the risk to brain development.¹⁰¹

⁹⁶ Based on 2014 mid-year estimates 10% boys aged 5-10 years in Leicester is 1,400 and 5% of girls is 670

⁹⁷ All numbers which refer to Leicester are mid-year estimates 2014 based on the proportions in the evidence. 2014 mid-year estimate totals for Leicester are: 5-10 years: Male (M) 13,926; Female (F) 13,398; 11-16 years: M 10,149; F 9,549; 16-24 years: M 27,726; F 28,377.

⁹⁸ CMO, 2012, *ibid*

⁹⁹ Meltzer, S., et al., 2009, *Adult psychiatric morbidity in England 2007: Results of a Household Survey*. Leeds, The health and social care information centre

¹⁰⁰ Kieling, C., et al. *Child and adolescent mental health worldwide: evidence for action. Lancet*, 378 pp 1515-25

¹⁰¹ WHO, 2005, *Promoting Mental Health: concepts, emerging evidence, practice*. World Health organisation, Geneva

Neonatal attachment is important for social and emotional development.¹⁰² It lays the foundations for social and emotional development and protect against stress, anxiety and insecurity. Through early interactions young children learn how to recognise and regulate their own emotions, and build the foundations for later relationships.

Perinatal mental health problems compromise the health, emotional, cognitive and physical development of the child, with serious long term consequences.¹⁰³ Paternal depression has been shown to have a negative impact on children.¹⁰⁴ Between 10% and 20% of women develop a mental health problem in pregnancy or in the first year of having a baby. The exact number of men having mental health problems in the same period is not known.

There are large differences between lone parents and those who are in couples. Both lone mothers and lone fathers are more likely to have mental health problems than are mothers or fathers who live in couples. Evidence also points towards younger mothers being more likely to have a mental health problem than older ones.

3.3 School Aged Children

Childhood years are vital for developing life skills. Negative experiences at home or school, linked for instance to conflict or bullying, can damage cognitive and emotional development.¹⁰⁵

Meltzer et al¹⁰⁶ found that:

- 10% of children aged 5 -15 years had a mental disorder: 5% had clinically significant conduct disorders; 4% were assessed as having emotional disorders (anxiety and depression), and 1% was rated as hyperactive.
- Less common disorders (such as autistic disorders, tics and eating disorders) were attributed to half of one per-cent of the sampled population.
- Among 5-10 year olds, 10% of boys and 6% of girls had a mental disorder. In the older age group, the 11-15 year olds, the proportions of children with any mental disorder were 13% for boys and 10% for girls.

The prevalence rates of mental disorders were greater among children in the following circumstances:

- In lone parent compared with two parent families (16% compared with 8%)
- In reconstituted families rather than those with no step-children (15% compared with 9%)

¹⁰² Walker, S., et al 2011, Inequality in early childhood: risk and protective factors for early child development. *Lancet*

¹⁰³ Bauer, A., et al., 2014, The costs of perinatal mental health problems. Centre for Mental Health and London School of Economics at <https://www.centreformentalhealth.org.uk/costs-of-perinatal-mh-problems>

¹⁰⁴ Paulson, J. et al, 2006, Individual and combined effects of postpartum depression in mothers and fathers on parenting behaviour. *Paediatrics*, 118 pp 659-68

¹⁰⁵ Kieling, C. et al *ibid*

¹⁰⁶ Melzer, H., et al., 2000, *The mental health of children and adolescents in great Britain*. London, ONS

- In families with five or more children compared with two-children (18% compared with 8%)
- Parent with no educational qualifications compared with a degree level or equivalent qualification (15% compared with 6%)
- In families with neither parent working compared with both parents at work (20% compared with 8%)
- In families of social class V compared with social class I (14% compared with 5%) whose parents are social sector tenants compared with owner occupiers (17% compared with 6%)
- In household with a striving rather than a thriving geo-demographic classification (13% compared with 5%)

Risks to mental health include family violence or conflict, negative life events, low sense of connection to learning environments. Socio-economic conditions and poor living conditions may reduce opportunities for learning and social interaction, increasing a child's exposure to disease and injury.

Children with a parent who has mental illness or substance use disorder are at high risk of mental health problems.¹⁰⁷ Depression and anxiety account for most cases of parental mental illness. A small proportion will have a psychotic disorder such as schizophrenia. According to SCIE Guide 30¹⁰⁸ it is probable that, among the working age adult population 9 -10% of women and 5-6% of men in Britain will be parents with mental health problems. It is possible that up to 25% of children aged between 5 and 16 years have mothers who would be classed as at risk for common mental health problems. Other estimates suggest that 25% of children aged 5 to 16 has a mother who is at risk of a common mental health problem such as depression or anxiety.

In an average primary school class this might mean six or seven children living with a mother with a mental health problem. In classes where there are a high proportion of children living with lone mothers, the numbers are likely to be even higher. At least one in four adults in contact with mental health services is likely to be a parent.

3.4 Adolescence

Adolescence is the period when mental disorder is more likely to become apparent. Adverse experiences, conditions or environments that apply to children apply at this stage with the emergence of other risks such as tobacco, drug and alcohol use. Adolescents who are exposed to family unrest or those who exhibit behavioural problems are more likely to engage in psychoactive substance use.¹⁰⁹ Adolescents may also be susceptible to peer pressure and media influences which may encourage risk taking behaviour.

¹⁰⁷ Hetherington, R., et al, 2001, *The welfare of children with mentally ill parent: Learning from inter-country comparisons*. Wiley et al, Chichester

¹⁰⁸ Think child, think parent, think family: a guide to parental mental health and Child Welfare, Social Care Institute for Excellence Families' and Children's Services Guide 30 at <https://www.scie.org.uk/publications/guides/guide30/files/guide30.pdf>

¹⁰⁹ Fisher, J., et al, 2011, Adolescent Mental Health in Resource-Constrained Settings: a Review of the Evidence of the nature, prevalence and determinants of common mental health problems and their management in primary health care. *International Journal of Social Psychiatry* 57 Supplement 1

Some specific severe mental health problems are common among young people, such as worries about weight, shape and eating and hyperactivity disorders.

Concerns with eating happen in young people of all backgrounds and cultures. They may be more prevalent among young girls, but anecdotal evidence from local colleges suggests that boys are increasingly affected. Being very overweight can cause a lot of problems, particularly with physical health. Some young people, many of whom are not overweight in the first place, want to be thinner; this can evolve into a serious eating disorder, such as anorexia nervosa and bulimia nervosa.

The incidence of anorexia nervosa in the general population has been calculated from 12 cumulative studies at 19 per 100,000 per year in females and 2 per 100,000 per year in males. In community-based studies, the prevalence of bulimia nervosa has been estimated as 0.5-1.0% in young women with an even social class distribution. About 90% of people diagnosed with bulimia nervosa are female.

Attention Deficit Hyperactivity Disorder (ADHD) is a disorder characterised by poor concentration, which includes a combination of additional symptoms including impulsiveness and over activity. Another medical term for ADHD is hyperkinetic disorder. ADHD affects 2-5% of UK school-aged children, with rates being higher in boys than in girls.

The most vulnerable children are likely to be at higher risk of mental health problems. Meltzer found that the rate of mental ill health disorder amongst looked after children to be significantly higher than that in the general population. This is likely to be because they may not have access to stable education, experience a difficult transition to adulthood, and are disproportionately associated with crime, homelessness and unemployment. Some looked after children may have particular needs, such as those from black and minority ethnic backgrounds, unaccompanied asylum seekers or those who are gay or lesbian.

3.5 Young Adults

Individuals who have a secure and supportive childhood and adolescence are generally better equipped to exercise control and react to challenging adult circumstances. Generally young adults who are not in employment or education are more vulnerable to mental health problems. However, there are increasing numbers of students presenting with mental health problems. This perhaps reflects growing rates of mental health problems among young people generally, the rapidly increasing access of young people to higher education and the concomitant growth in student numbers.

The Student Psychological Health Project at Leicester University¹¹⁰ surveyed more than a thousand second-year students and found that 13% of undergraduates recorded scores suggesting they were moderately distressed by feelings of depression. Females scored significantly higher than males. This study also showed that 12–14% of the undergraduate population recording had self-assessed symptoms suggestive of

¹¹⁰ Leicester University (2002) *Student Psychological Health Project*. <http://www.le.ac.uk/edsc/sphp>.

moderate obsessive–compulsive distress (trouble remembering things, trouble concentrating, difficulty making decisions, checking). Eating disorders were also a problem, with 4% of undergraduates reporting self-induced vomiting and 2% the use of diuretics and laxatives.

Alcohol and substance misuse increases the risk of mental illness and mental ill health increases the risk of increased intake of alcohol and substance misuse. In Leicester¹¹¹, 14% male and 31% female undergraduates admitted harmful levels of alcohol consumption; but 50% and 25% respectively also admitted binge drinking at least once per week.

Females are more likely to show increased evidence of emotional problems during the course of higher education with female students demonstrating increased levels of depression, anxiety and phobias compared with their male counterparts. With regard to homesickness, there was no significant difference between males and females. In the UK and elsewhere, female students have been found to be more likely to demonstrate increased levels of psychological symptoms. The University of Leicester study¹¹² showed that students from ethnic minorities were also at higher risk.

3.6 Prevalence of Mental Health Problems for Leicester’s Children and Young People

27% of the population of Leicester is aged below 20 years. 66.4% of school children in Leicester are from BME backgrounds. General health and wellbeing of children in Leicester is mixed compared with the England average. The infant mortality rate is worse and the child mortality rate is worse than the England average. The level of child poverty in Leicester is worse than the England average, with 30% of children aged below 16 years live in poverty; the distribution of poverty in Leicester is wide.

Childhood educational attainment is correlated to socio-economic circumstances in adult life. Given the distribution of poverty and deprivation in Leicester, education provides an opportunity to tackle disadvantage. The Child Health Profile suggests that Leicester has the worst value for the level of child development at the end of reception year at school. It also indicates that Leicester has a significantly worse proportion of attainment at GCSE than the national average.

In terms of wider activity, the 2009-10 Tell Us Survey found that young people in Leicester were less likely than to participate in a group activity outside school. The rates of obesity in children aged 4-5 and 10-11 are significantly higher in Leicester than the national average. Tell Us Surveys showed that bullying in Leicester was slightly higher than the national average.

If 9-10% women and 5-6% of men are likely to be parents with a mental health problem, then this is equivalent to 9,700 women and 6,400 men in Leicester. If 25% of children aged 5-16 years have mothers at risk of common mental health problems then this is equivalent to 12,000 children in Leicester. 10-15% of

¹¹¹ Grant, A. (2002) Identifying students’ concerns: taking a whole institutional approach. In *StudentMental Health Needs: Problems and Responses* (eds N. Stanley & J. Manthorpe). London: Jessica Kingsley.

¹¹² Grant *ibid*

children and adolescents in the general population suffer from mental ill health, equivalent to a range of approximately 3,500 to 5,250 for a city the size of Leicester. In Leicester 3 in every 1,000 residents under the age of 20 are registered with mental health services, a figure which reaches 5 in every 1,000 in the most deprived areas. In Leicester cases of suicides registered amongst people aged 18 or under are rare. The self-harm admissions for 15-19 years olds vary roughly between 200 and 300 per year (based on 2004/5-2006/7 data) for the Leicester, Leicestershire and Rutland area. In 2011/12 the Leicester rate of inpatient admissions for children because of self-harm was lower than the England average.

4. Current services in relation to need

The integrated approach between mental health services, social services, education, offender management services and adult mental health is crucial to enable children and adolescents to reach their full potential. Only a small proportion of the mental health needs of children will be met by specialist mental health services.

The local Future in Mind Transformational Plan will influence commissioning so that children and young people will get timely access to specialist services, and ensure that universal and specialist services are more joined up, with shared frameworks to enable integrated working.

The resources available, in addition to Children’s Centres, include Health visitors, School Nurses, GPs, Educational Psychologists, Schools, Community Paediatricians, as well as the range of specialist mental health services for children and young people. Better use of universal services, escalating to the more specialist CAMHS tiers when appropriate, may contribute to more effective prevention of mental health problems and better treatment. This improvement should be underpinned by prevention and earlier intervention, developing the workforce and tackling stigma.

The table below shows that there are opportunities to develop public mental health approaches at different levels and in different groups to protect mental wellbeing in children and young people in Leicester.

Table 1: Key opportunities for childhood mental health promotion and protection¹¹³

Strategic direction	Key interventions
Developing and protecting individual attributes	Enable early attachment, provide appropriate parent training and natal care (including protecting perinatal mental wellbeing; develop safe, stable, nurturing relationships between children and care givers Ensure sufficient diet and stimulation, regular physical activity,

¹¹³ Adapted from WHO, 2012, Risks to Mental Health: an overview of vulnerabilities and risk factors World Health Organisation

	discourage tobacco, alcohol and drug use
Supporting households and communities	Ensure secure living conditions for children and adolescents; target prevention on those with behavioural disorders and those with parents with mental illness; prevent domestic violence Support increased employment opportunities and promote safe working conditions Improved living conditions, including social and financial protection Make neighbourhoods safe, social networks, restrict availability of drugs, alcohol and tobacco
Supporting vulnerable groups	Develop and implement social inclusion policies Tackle stigma and discrimination, including gender equalities Awareness raising campaigns

5. Projected service use for Mental Health

The population of children and young people, aged 5 to 24 years, in Leicester is projected to increase from 104,700 to 120,100 a rise of 14.7%. A crude estimate of the prevalence of mental illness based on this increase suggests that up to 6,400 children in Leicester could have a diagnosed mental illness by 2035, the current estimate is 5,250.¹¹⁴

¹¹⁴ See section 3.6 of Mental Health Chapter

Chapter 7

1. Introduction

The children most impacted by health inequalities are also affected by other inequalities such as living in areas of deprivation, poor childhood experiences, living apart from their parents, suffering abuse, neglect or exploitation, young carers, refugees, those with a parent in prison and those in the youth justice system. These issues disproportionately affect Looked After Children. Looked-after children (LAC), compared with their peers, have significantly more educational and mental health problems, and on leaving care have worse outcomes as adults.

The term 'looked after' applies to children or young people up to the age of 18¹¹⁵ for whom the local authority provides care and accommodation on behalf of their parent(s), or for whom the local authority has either sole or shared parental responsibility by virtue of a court order.

Children and young people become looked after under a range of circumstances, often, but not solely, due either to the risk or occurrence of abuse or neglect. Nationally, and compared with their peers, looked after children (LAC) are a vulnerable group. They are more at risk for the following compared to non-LAC children:

- Increased incidence of educational and mental health difficulties
- Increased likelihood of childhood mental health, emotional and behavioural problems¹¹⁶
- Greater likelihood of experiencing poor health, educational and social outcomes after leaving care¹¹⁷
- Increased incidence of teenage pregnancy for LAC - over twice that of peers not in the care system¹¹⁸.
- Estimates suggest that almost half of female care leavers become mothers between the ages of 18 and 24¹¹⁹.
- Increased likelihood of self-harm as care leavers aged 16+ are between four and five times more likely to self-harm into adulthood¹²⁰
- More likely to attempt suicide in adulthood¹²¹

¹¹⁵ Between the ages of 16 and 17, subject to statutory guidance, young people may make their own agreement with the local authority about being looked after.

¹¹⁶ NICE: Promoting the quality of life of looked-after children and young people. NICE public health guidance 28. 2010.

¹¹⁷ DCSF: Children looked after in England (including adoption and care leavers) year ending 31 March 2009.

¹¹⁸ Social Exclusion Unit. (1999). Teenage Pregnancy retrieved from <http://www.socialexclusion.gov.uk/page.asp?id=227> on 10 December 2015.

¹¹⁹ Biehal N., Clayden J., Stein M., Wade J. (1995). Moving on. Young people and leaving care schemes. London, HMSO.

¹²⁰ Piggot J, Williams C, McLeod S et al (2004) A qualitative study of support for young people who self-harm in residential care in Glasgow, *Scottish Journal of Residential Child Care*, 3 (2), 45-54

- More like to be in contact with the criminal justice system.

This chapter details the health and attainment data specific to LAC in Leicester compared to England and peer comparators. Data about LAC are produced by the Department of Education (DfE) and are captured annually on 31st March. The DfE reports on the number of LAC in each local authority on this date and the rate of LAC per 10,000 within each local authority's 0-18 years old population.

Leicester City Council and the NHS have signed up to the recommendations from a Health Needs Assessment of Looked after Children conducted by Leicestershire County Council. All relevant agencies are working together to action the recommendations. Therefore most of the issues highlighted in this JSNA are already under consideration, have an action plan and are being improved.

2. Demographic Summary

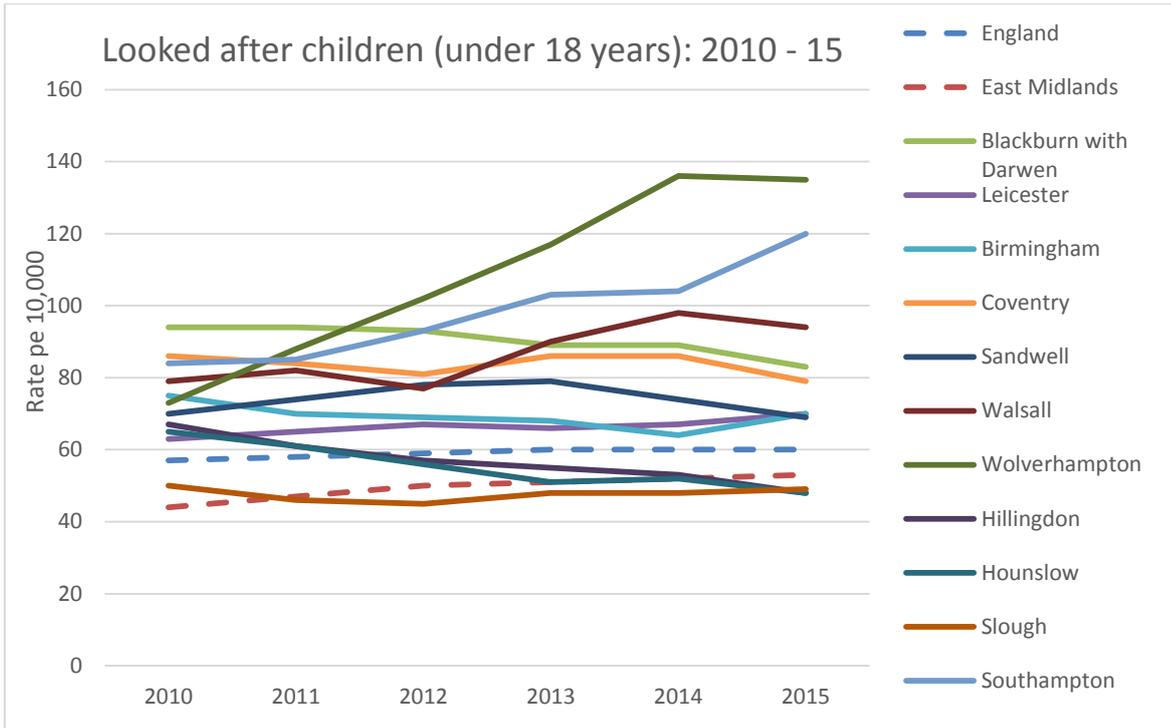
2.1 Key facts about Leicester's looked after population

The rate of LAC in Leicester has increased from 63 per 10,000 children in 2010 to 70 per 10,000 children in 2015 (Figure 1). The rate of LAC in Leicester has been consistently higher than England and the East Midlands, it has been lower than some of its peer comparators.

The rate of LAC as per 31st March 2015 was 70 per 10,000 (n=565) which is an increase of 4%. During the year 2014-2015, 220 children started to be looked after, an increase of 7% on the number of starters the previous year (205). Further, 190 ceased to be looked after, a decrease of 3% on the previous year (195). The net result, therefore, is a cumulative overall rise in the looked after population of plus 30 as at 31st March 2015, compared to plus 10 as at 31st March 2014.

Figure 1: Leicester and peer comparator LAC population – rate per 10,000 under 18

¹²¹ Children and young people's health outcomes forum. Report of the children and young people's health outcomes forum –mental health sub-group. retrieved from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216853/CYP-Mental-Health.pdf on 9 December 2015

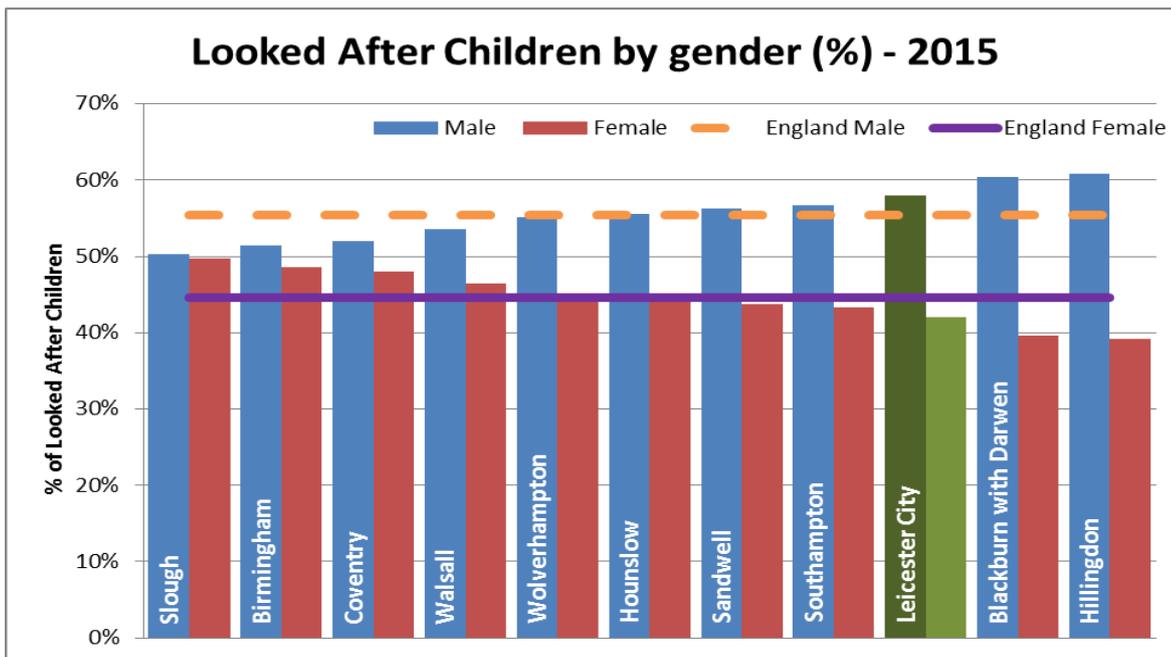


Source: DfE, 2015

2.1.1 LAC by Gender

Leicester has a higher proportion (58%) of male LAC which has been consistent over time and is similar to the picture for England. Figure 2 shows the proportions of LAC by gender for Leicester and its comparator authorities.

Figure 2: LAC by gender (%) - 2015



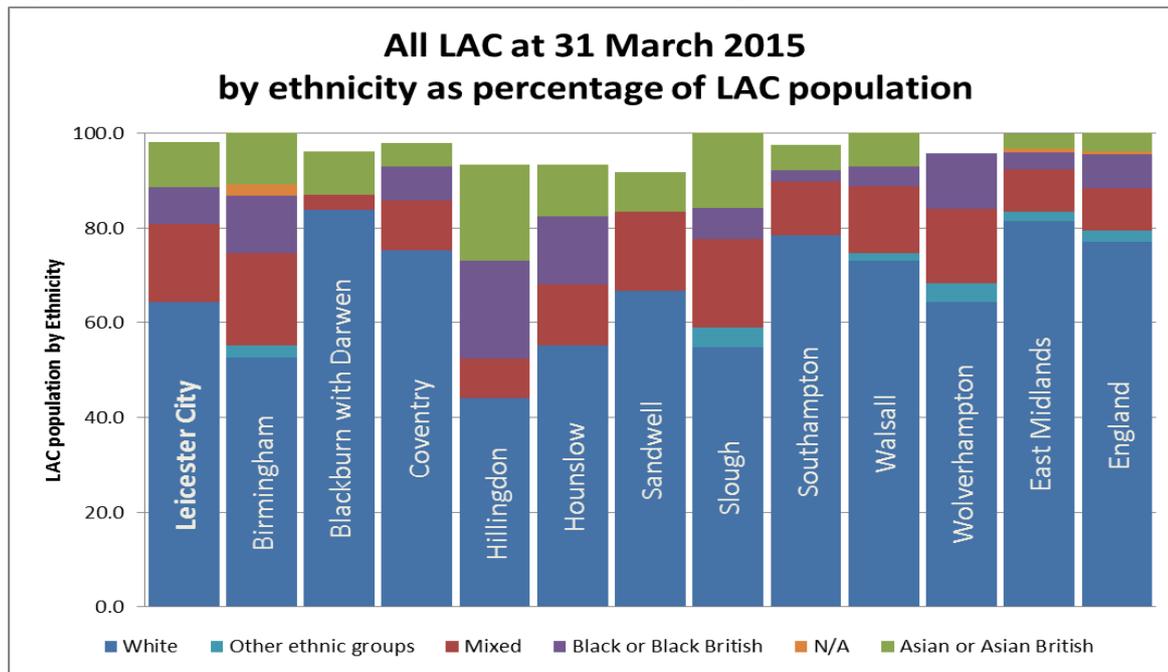
Source: DfE, 2015

2.1.2 LAC by Ethnicity

Of the 565 children in care in Leicester on 31st March 2015: 365 (65%) were white; 95 (17%) were of Mixed ethnic origin; 55 (10%) were Asian/Asian British; 45 (8%) were Black/Black British.

The ethnic make-up of the city’s LAC population does not reflect the distribution of ethnic groups within the 0-18 years old population of Leicester. Figure 3 shows the proportions as at 31st March 2015 of Leicester’s looked after population, and those of comparator authorities, by ethnic group.

Figure 3: Leicester and peer comparator LAC by ethnicity (%)



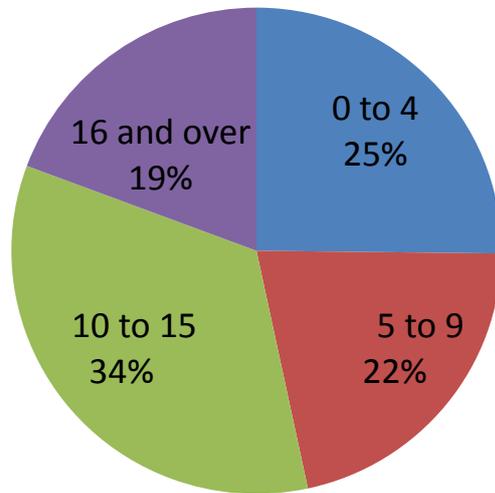
Source: DfE, 2016

2.1.3 LAC by Age Group

The majority of LAC children in Leicester are aged between 10 and 15 years old (Figure 4). The second largest group is the 0 to 4 years old group.

Figure 4: Leicester City LAC by age group

Looked After Children by Age Group: Leicester City 2015



Source: DfE, 2016

3. The level of need in the population

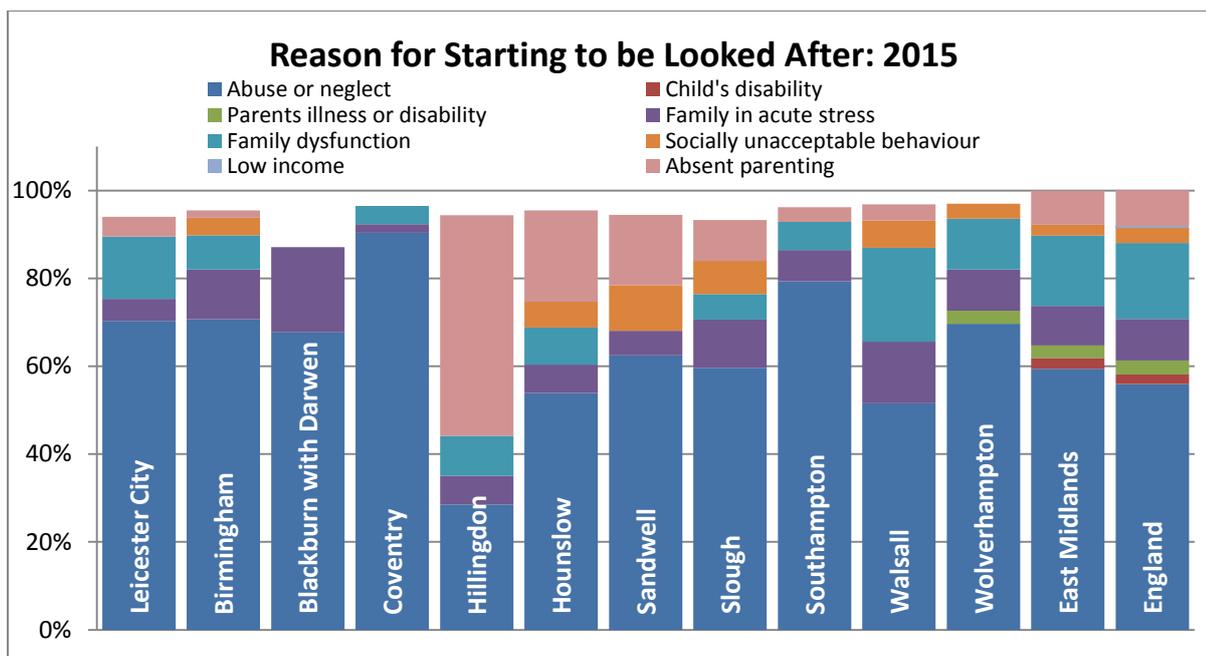
3.1 Why children enter care

Children enter care under various sections of the Children’s Act (1989)¹²², and their legal status may change during their time in care. The reasons for their entry to care are selected and coded against a national DfE list and criteria.

The primary reason (70%) children entered care during the year ending 31st March 2015 was due to Abuse or Neglect. Family dysfunction was the second most prevalent reason for children entering care in Leicester.

Figure 5: Leicester and peer comparators for LAC Reasons for entering care

¹²² This is the primary legislation for LAC



Source: DfE, 2016

3.2 Outcomes for looked after children and young people

Looked after children and young people do not fare as well as their peers along several dimensions of health and overall well-being. Annual statistical information is available about children and young people who have been looked after continuously for at least 12 months by DfE¹²³, and the data are briefly summarised below. The full data set is available at: <https://www.gov.uk/government/statistics/children-looked-after-in-england-including-adoption-2014-to-2015>

3.2.1 Educational attainment

Educational attainment is low amongst children who have been looked after continuously for at least 12 months. Compared to non-LAC children and Leicester's comparators, this is also true. Educational attainment for LAC is a priority previously identified through needs assessments and service reviews, and work is underway to improve LAC attainment.

A smaller proportion of LAC children in Leicester are achieving at least level 2 at KS1 in reading (60%), writing (53%) and mathematics (60%) compared to England, the East Midlands and all peer comparators.

¹²³ These measures therefore relate to children and young people for whom a local authority has been 'parent' for a significant proportion of their childhood

In reading (58%), grammar, punctuation & spelling (46%) and reading, writing & mathematics (27%) a lower percentage of LAC children in Leicester achieve Level 4 for Key Stage 2 (ages 7 to 11 years). This level of attainment is lower than the England and East Midlands averages. Leicester is particularly low for the 'reading, writing and mathematics' combined measure with only 27% achieving a Level 4.

The data for Leicester's LAC aged are not reported in the national data set, it is not possible to compare Leicester to England, the East Midlands or its comparators for Key Stage 4 performance.

3.2.2 Levels of offending

Children who are looked after are more likely to be known to the criminal justice system. The levels of offending by children by LAC children who have been looked after continuously for at least 12 months are provided. Approximately 5.2% of LAC children in Leicester aged 10 and above are known to the youth offending system having been given a reprimand, final warning or conviction. This average is similar to the East Midlands (5.5%) and England (5.2%) averages.

3.2.3 Substance misuse by LAC children

The data for Leicester were suppressed due to low number, so it is not possible to compare Leicester to England, the East Midlands or its peer comparators.

3.3 Statutory health checks for LAC

Although most looked after children have the same health issues as their peers, the extent of these is often greater, exacerbated by their past experiences. For example, almost half of children in care have a diagnosable mental health disorder. The majority of LAC have suffered abuse or neglect, and it is recognised that children in care have significantly higher levels of health needs than children and young people from comparable socio-economic backgrounds who have not been looked after. Past experiences, a poor start in life, care processes, placement moves and many transitions mean that these children are often at risk of having inequitable access to health services, both universal and specialist.

Statutory health assessments must be carried out for looked after children, including routine dental checks and preventative measures such as immunisation.

Information on the statutory health checks for LAC in Leicester and its comparators were provided by DfE. Table 10 shows the Health care and development assessments of children who have been looked after continuously for at least 12 months.

Other population level data on issues such as teenage pregnancy are not available for this cohort due to the current methods of data collection locally. Work is currently underway to address this data gap by utilising different data management tools.

Leicester has a higher proportion of completed annual health checks (90%) compared to the East Midlands (87%) and it is the same as the England proportion (90%).

The proportion of LAC receiving dental checks (78%) is lower than England (86%), the East Midlands (83%) and all peer comparators except Southampton.

When compared to England (89%) and the East Midlands (78%), Leicester (93%) had a higher proportion of children aged 5 years or younger who had up-to-date development assessments.

In 2015 84% of LAC children in Leicester had up to date immunisations which is similar to the East Midlands and lower than the England average. Leicester is similar to the majority of its peer comparators.

3.3.1 Emotional Health and wellbeing of LAC

The SDQ is a standardised and validated mental health assessment tool used to assess looked after children's emotional health. The higher scores demonstrate there are more difficulties for the child.

Only 21% of Leicester LAC children aged 5 to 16 years old who were looked after continuously for at least 12 months had an SDQ score. Leicester is significantly lower than the majority of its peers, the East Midlands and England.

The average SDQ score that Leicester's LAC children received (15.1) was similar to the East Midlands (15.5) and its peers. Leicester was higher than the England average (13.9). Almost half of Leicester's children with an SDQ score were of 'concern' on the SDQ score bands. This is the same as the East Midlands and higher than England.

3.4 LAC children by Special Educational Need

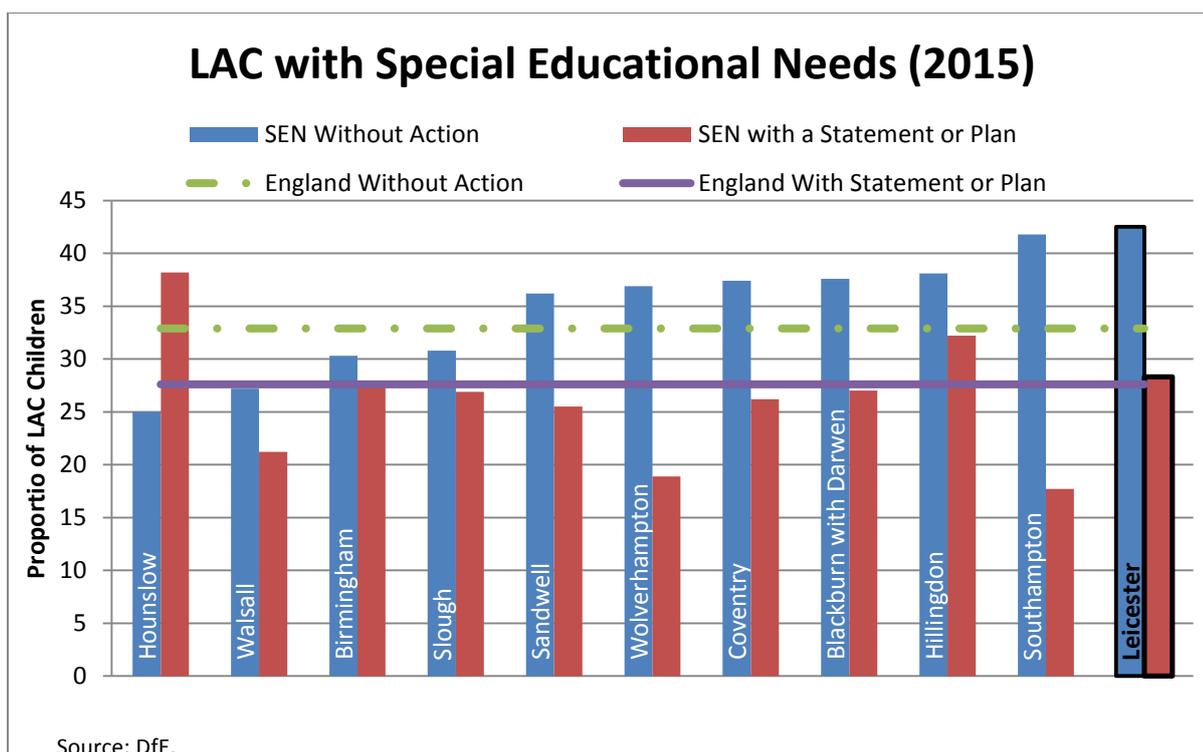
Closing the gap between the educational attainment of looked after children and all young people is a high priority in Leicester. Almost 70% of LAC in Leicester had a special educational need (SEN). This is a factor which is likely to contribute to holding attainment of looked after children below that for all pupils.

Data on LAC children with Special Educational Need (SEN) are provided broken down into those without a SEN, those with a Statement or Plan and those without a Statement or Plan. The data is for children who have been looked after continuously for at least 12 months.

The data show that 29.1% of LAC children in Leicester have no SEN. This proportion is lower than England, the East Midlands and peer comparators.

Over 40% of Leicester's LAC children have a SEN without a statement or plan (Figure 6). This proportion is higher than the England and East Midland's averages.

Figure 6: Looked after children with Special Educational Needs (2015)



4. Current Services in Relation to Need

4.1 Leicester City Council’s Looked after Children Services

Leicester’s Looked after Children Services include a wide variety of services to address the needs of LAC. The city council complies with all statutory requirements for LAC. Some services available to local LAC include the following.

- Five residential care homes
- Education while in care
- Contact services so children may stay in touch with their family and friends
- Children and Family Support Team to provide support and therapeutic interventions for LAC to be maintained in their placements
- Placement commission to secure placements for LAC in foster home, secure welfare facilities, residential care, hostels, and parent and baby placements
- Fostering and adoption service
- The 16+ team that provides for LAC and care leavers in the city aged 16 to 21 years old
- Leaving care service assists older children who will not be returning home.

4.2 Health Services

4.2.1 LPT Specialist Looked After Children Health Team

Leicestershire Partnership Trust (LPT) is commissioned by the local CCG to undertake statutory health assessments and provide support for children looked after in Leicester, Leicestershire and Rutland. This includes an initial assessment (IHA) by a doctor at the time of becoming looked after, followed by an annual review health assessment (RHA) by a specialist nurse for 5- to 16-year-olds. RHAs for under-5s are carried

out by health visitors every 6 months. Health assessments remain a priority for improvement for Social Care and Health.

LPT remain responsible for ensuring the health assessments of LAC are undertaken even if a child or young person from Leicester City is living outside the Leicester, Leicestershire and Rutland (LLR) area. The CCG may commission other providers in that area to complete the assessment but the Designated doctor or nurse for LAC ensures that it is of good quality.

The team also support and provide training to foster carers, health visitors and student health visitors. The specialist nurses provide an ongoing source of support and advice to LAC, including “packages of care” to meet needs identified at health assessments, including improving understanding of healthy eating, healthy relationships, sexual health and contraception, hygiene and self-care, dental care, smoking, drugs and alcohol.

They also support young people to transition to adult services and have developed a Leaving Care health summary to provide young people with important information about their health from birth. This Leaving Care Health Summary should be rolled out to all Care leavers.

4.2.2 CAMHS

Leicestershire Partnership Trust is also commissioned to provide a dedicated CAMHS Young People’s Team for looked after children, adopted and homeless children and young offenders across Leicester, Leicestershire and Rutland. It is partially funded by the local authorities and partially by local CCGs.

It has a 13 week target for assessment in routine cases and a 4 week target for assessment of urgent cases. These targets are currently being met and waiting times are not as long as general CAMHS services. There are thresholds for access to the service, which are primarily based on the severity of the mental health problem, its impact on the child or young person’s functioning and the levels of distress caused.

Wider support and training for staff and carers is also part of the team’s remit. There are two primary mental health workers who work with the local authority children’s homes, run groups for young people and for staff and carers. This may be important where young people are not willing to directly see a mental health worker, so training for social workers and carers to support the young person is an alternative approach. Primary mental health care workers also play an important role in supporting young people and carers when things have improved and they no longer need to be seen by the specialist service (and hence increasing capacity for new referrals).

4.2.3 School Nursing and Health Visiting

In addition to the universal service provided to all children and young people. LAC nurses may consult with school nurses for LAC with complex needs to ensure the review health assessments are accurate. This service is provided to Leicester LAC who are placed in city and for LAC from other areas that are placed in Leicester. Leicester LAC who are placed out of city receive this service from local primary health care providers.

4.2.4 Other health care services

LAC are able to access universal health care services such as GPs, dentists, sexual health and substance misuse services in the area in which they are placed.

5. Projected service use for LAC

The LAC population in Leicester has increased each year, and it is expected to continue to increase over time. A forecast for LAC in Leicester is not available.

The increase in the size and complexity of this cohort will impact on the future demand for health, education and social care services. Services must take into account the complexities and unique situations faced by these children and young people.

The LAC population is likely to increase significantly when unaccompanied asylum seekers come into the authority in 2016. This is based on 0.07% of the population and is around 50 young people on a rolling programme. As they leave care at 18 years old another place will be filled. All unaccompanied asylum seekers become LAC.

Version 2 - by David Thrussell on 9 May 2017

1. Introduction

Children and young people at risk of offending or within the youth justice system often have more unmet health and social care needs than other children. The 2013 Young Minds Report¹²⁴ states that 95% of imprisoned young offenders had a mental health disorder. In addition, 80% had between 1 and 5 vulnerabilities including mental health issues, behavioural issues and social problems.

It is therefore important that the needs of vulnerable children and young people (aged 10-17) at risk of offending are included in mainstream planning and commissioning. The Public Health Outcomes Framework states that a lack of focus in youth offending 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. By incorporating vulnerable young offenders into mainstream commissioning this has the potential benefit of impacting on the young person's wider family in the short and long term. This is particularly true when the young person may already be a parent.

Leicester's Youth Offending Service (YOS) work with young people aged 10 to 17 years who are convicted of criminal offences. For those young people who are involved in the criminal justice system the majority do not re-offend following their conviction. The re-offending rate for Leicester is 39.2% which is slightly higher than the national average of 37.9%¹²⁵.

Young people known to the YOS may experience a range of risks associated with their offending behaviour which can include school absence, not being in formal education training or employment, negative peer influences, special educational needs and poor mental health and wellbeing. There is a disproportionate number of children in need, looked after children, young people at risk of sexual exploitation who are known to the YOS.

Demographic Summary

The YOS cohort ranges from ages 10 to 17 years with a small number of 18 year olds.

- 278 young people were supervised by Leicester City in 2015/16
- 84% (n=234) of young people supervised by Leicester City YOS in 2015/16 were male
- 72% of the YOS cohort were aged 15 and above in 2015/16 which was similar to the England average.

¹²⁴ Young Minds report. Available at: http://www.youngminds.org.uk/assets/0000/9472/Barrow_Cadbury_Report.pdf

¹²⁵ Ministry of Justice

- White young people make up the majority of Leicester’s youth offending population (approximately 60%).

The level of need in the population

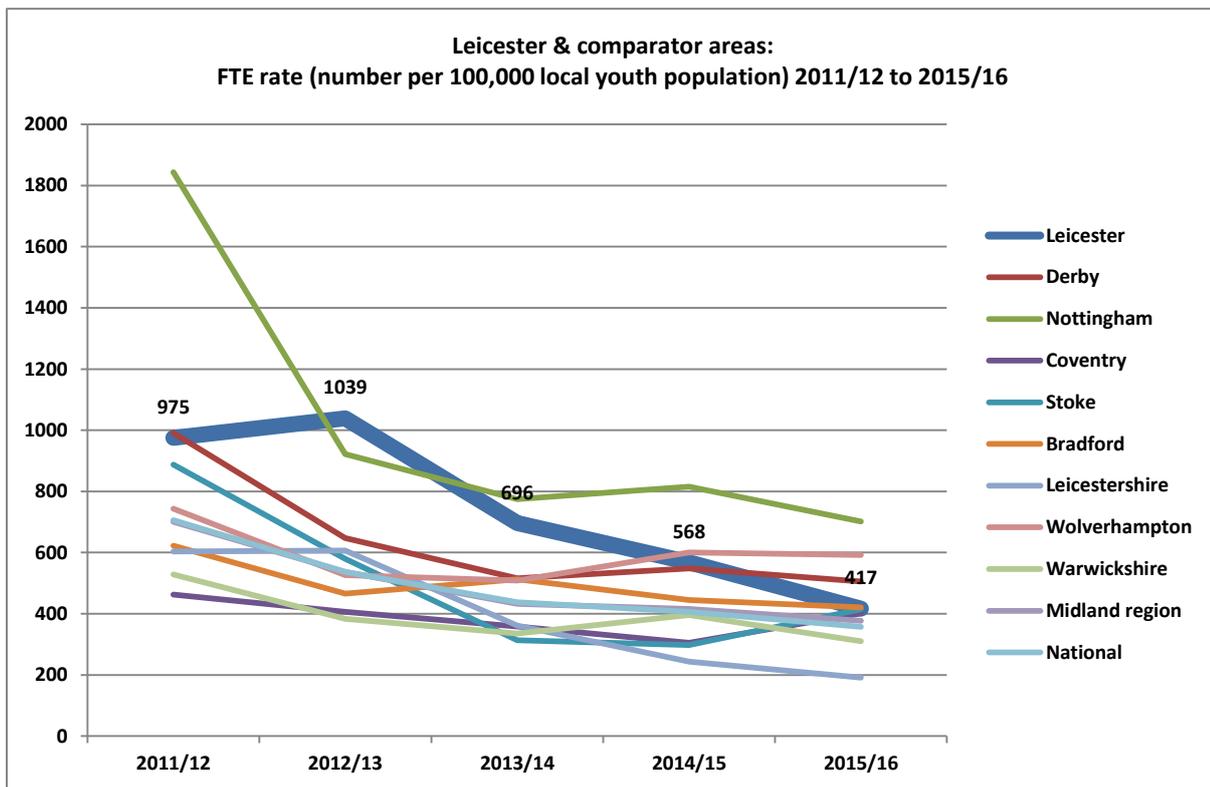
3.1 Youth Offenders in Leicester

3.1.1 First Time Entrants

Data on First Time Entrants to the youth justice system is reported by the Ministry of Justice, but it is also included in the Public Health Outcomes Framework.

The rate per 100,000 local youth of first time entrants (FTE) to the Youth Offending Service has been declining in Leicester since 2011/12. The overall reduction over the period for Leicester was 57%. The FTE rate in Leicester is similar to the Midland region and England.

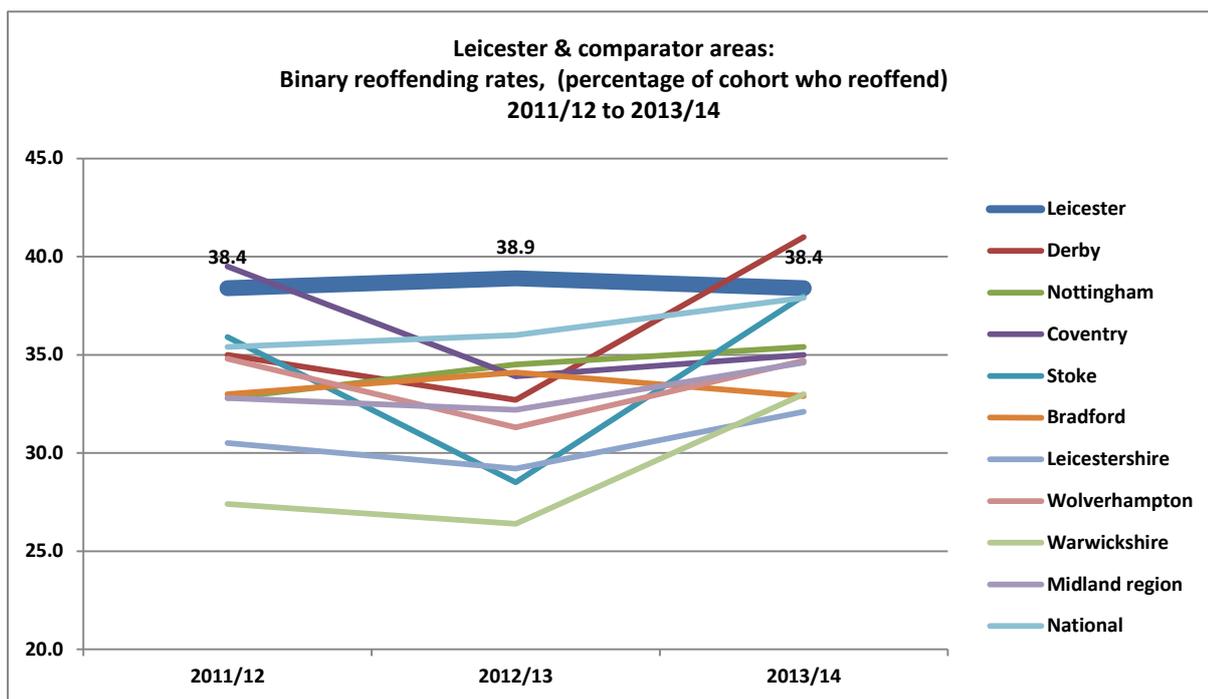
Figure 1: FTE Rate (per 100,000) between 2011/12 to 2015/16



3.1.2 Reoffending

The proportion of young offenders who reoffend has remained fairly constant between 2011/12 and 2013/14. This trend is similar to other areas, although Leicester has a higher proportion of reoffenders compared with peer comparators, the Midlands region and England.

Figure 2: Proportion of young offenders who reoffend: 2011/12 to 2013/14



Leicester’s rate has remained static over the period. Nationally reoffending rates have been increasing in recent years as the size of the cohort has reduced.

3.2 Education, Training and Employment

According to the ‘Review of the Youth Justice System in England and Wales’¹²⁶ (The Review) many young offenders have poor records of school attendance and educational achievement. Learning and communication difficulties are also common in this population of young people. These children require a carefully considered and coordinated response from a number of partners, making the link between youth offending, children’s services, health and education all the more critical if the root causes of offending are to be addressed.

In Leicester, the proportion of young people in receipt of 25 hours or more of education, training or employment at the end of their court order is similar to peer comparators, the Midlands region and England.

¹²⁶ Published in December 2016. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/577103/youth-justice-review-final-report.pdf

3.3 Health Needs

Young people involved in the criminal justice system are disproportionately likely to experience poor health and wellbeing outcomes. They are more likely to have more unmet health and social needs compared to other children and are at a greater risk of social exclusion.

According to the 'Review of the Youth Justice System in England and Wales'¹²⁷ approximately one third of young offenders across England and Wales have a diagnosed mental health disorder. Health services therefore play a vital role in preventing youth offending. For children who offend and have a mental disorder or behavioural or learning difficulties, many times these conditions have gone undiagnosed. These problems then can be at the root of a child's offending, and frequently are a barrier to engagement or progress in education. Tackling these problems through multi-agency working as quickly as possible is therefore essential.

The Review also found that many young offenders come from very dysfunctional families where drug and alcohol misuse, physical abuse, emotional abuse and offending are common. As has been discussed in other chapters of this JSNA, the behaviours learned and experienced at home and from an early age are heavy influences on a child's future trajectory.

As a consequence of the health needs for young offenders, all young people known to Leicester's Youth Offending Service (YOS) are subject to a generic screening assessment tool (ASSET Plus) which addresses a range of known risk factors including emotional health and wellbeing.

The recent Full Joint Inspection (FJI) by HM Inspectorate of Probation and the Inspection of Youth Offending Work found there was room for improvement by the YOS regarding the health of young offenders. The FJI particularly found there should be better identification and management of young offenders' physical health, sexual health and speech, language and communication needs.

The Leicester Youth Offending Management Board has accelerated this priority and is currently addressing these gaps and improving the health of local young offenders. Work is ongoing between relevant service commissioners to ensure the specific needs of this sub-population are fully considered and integrated into service planning and provision.

As this work has recently begun, there is no health data currently available on their overall health and wellbeing.

¹²⁷ Published in December 2016. Available at:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/577103/youth-justice-review-final-report.pdf

Current services in relation to need

Young offenders have access to all services open to children and young people of the same age. However, young offenders may have special needs or may not be able to easily access the same services.

Consideration by commissioners is needed during planning and commissioning to ensure these specific needs are addressed including services for young people in secure detention returning to the community.

4.1 Youth Offending Service

The YOS provides services for young people aged 10-17 years who have offended and are sentenced by the Youth or Crown Court, to be supervised under a range of Youth Justice Court Orders. The service is provided with due regard for the victims of these offences.

The YOS also has a prevention service for those young people who are at risk of offending and entering the youth justice system for the first time.

The YOS assessment tool (ASSET Plus) draws on a range of information across agencies as well as in-depth screenings with service users and their families or carers. The YOS practitioners are required to assess likelihood of reoffending, risk of harm to self and others and safety and wellbeing (vulnerability) and ensure that the intervention planning stages reflect the risk domains identified.

4.2 Mental Health Services

Young offenders have access to the mental health services offered to non-offenders. Considering the large proportion of young offenders who have diagnosed mental health illnesses, further work is required in Leicester identify the emotional health and wellbeing needs of young people known to the YOS. Work is being undertaken to better understand the needs of this cohort as part of the current joint work with child and adolescent mental health commissioners and providers.

4.3 Early Help and Prevention

The majority of young people who commit offences for the first time are successfully diverted away from the criminal justice system through a range of non-court disposals including police cautions and restorative justice interventions.

A small number of first time entrants are identified as having more complex needs and these young people may be offered Early Help support through the YOS or other relevant services including targeted youth support and the education welfare service.

The number numbers of young people referred by the YOS for Early Help services remains low and there needs to be a better understanding of the needs of vulnerable young people who require additional support outside of the criminal justice system including first time entrants, young people completing their community sentences and young people completing custodial sentences.

Chapter 9

Female Genital Mutilation

1. Introduction

Female genital mutilation (FGM), sometimes known as female circumcision, is the practice of cutting away part or all of a female's external genitalia. FGM has no health benefits, but it can result in severe, sometimes irreversible, physical and psychological injuries and later health problems. Complications include bleeding and urinary problems, cysts, infections, infertility and complications of childbirth with an increased risk of new-born deaths. The impact of FGM on the mental wellbeing of women and girls can heavily influence their overall health and wellbeing. Individuals may suffer the symptoms of Post Traumatic Stress Disorder, particularly during vaginal exams or childbirth.

FGM is a human rights abuse as recognised by the World Health Organisation. The Female Genital Mutilation Act 2003 makes it illegal to help, support or arrange for FGM to be performed on a girl in the UK. It also forbids taking a girl outside the UK to have FGM.

From October 2015 the Serious Crime Act for England and Wales requires teachers and regulated health and social care professionals to report to the police cases of FGM in females aged less than 18 years. In addition, data collection and submission of a new FGM Enhanced Dataset became mandatory for all acute trusts from July 2015, and all Mental Health Trusts and General Practices from October 2015. This will improve the NHS response to FGM and facilitate better commissioned services to safeguard and support women and girls.

The Local Safeguarding Children Board's recently revised its procedures for FGM reporting . Despite the requirement for social workers, teachers, doctors, nurses and midwives to report FGM, many cases are continuing to go unnoticed because FGM happened at a young age and/or abroad. The local procedures may be found at: <http://lrsb.org.uk/fgm-female-genital-mutilation>.

2.The level of need in the population

2.1 Population Profile

In the UK FGM is more common among communities from Kenya, Somalia, northern Nigeria, Sierra Leone, and Egypt. Over 100,000 women are living with the consequences of FGM in the UK, with 60,000 girls at risk.¹²⁸ Although FGM is illegal in the UK,¹²⁹ it is unlikely to be reported to the Police.

A report¹³⁰ on FGM prevalence in England and Wales showed the highest rates in London boroughs, for example, 4.7% of women in Southwark, compared to 0.5% in England and Wales as a whole. Other areas, such as Manchester, Slough, Bristol, Leicester and Birmingham had rates ranging from 1.2 to 1.6%. Experimental statistics released by the Health and Social Care Information Centre on 21 July 2016 show 30 newly identified FGM cases in Leicester City. 25 of the 30 were advised of the health implications and the illegality of FGM. This is likely to be an under-estimate of the true local picture.

2.2 Risk Factors

The most significant risk factor for whether or not a girl will be circumcised is whether or not her family has a history of FGM practice. Other risk factors include

- family indicate that there are strong levels of influence held by elders and/or elders are involved in bringing up female children;
- a woman/family believe FGM is integral to cultural or religious identity;
- a girl/family has limited level of integration within UK community;
- parents have limited access to information about FGM and do not know about the harmful effects of FGM or UK law;

As FGM is illegal in the UK, girls may be taken abroad during summer holidays for FGM to be performed.

Not all girls from FGM affected countries have undergone FGM. In Leicester and across the world, there is growing awareness that FGM is a negative practice. Many communities are therefore stopping FGM, but some communities and individuals are reluctant to say so.

2.3 Audit of Compliance with FGM Safeguarding Procedures

A recent audit on compliance with the Leicester Safeguarding Children Board FGM Procedures was conducted in 2016 and the results of this are being followed up locally. This showed that evidence that GPs

¹²⁸ Female Genital Mutilation in England and Wales: Updated statistical estimates of the numbers of affected women living in England and Wales and girls at risk Interim report on provisional estimates, City University London, 2013

¹²⁹ Female Genital Mutilation Act (2003) <http://www.legislation.gov.uk/ukpga/2003/31/contents>

¹³⁰ MacFarlane et al. (2015). Prevalence of Female Genital Mutilation in England and Wales. National and Local estimates retrieved from: <http://www.trustforlondon.org.uk/wp-content/uploads/2015/07/FGM-statistics-final-report-21-07-15-released-text.pdf> on 2 December 2015

are identifying and recording FGM on mother's and child's case notes and that women are now more commonly routinely asked appropriate questions about FGM locally. Further embedding this through local training, improving the use of interpreters and continuing to develop effective communication between agencies where referrals have been made will all help to strengthen local action to tackle FGM.

3. Current services in relation to need

Due to the uncertainty as to the true scale of burden by FGM in Leicester, it is not clear what services victims utilise and/or require. All health, social care and education professionals should ensure they are aware of and familiar with the FGM reporting guidance and processes.

The Obstetrics and Gynaecology department at UHL have a pivotal responsibility in providing accessible advice, treatment and support to women affected by FGM whilst ensuring that children are protected. Clinical guidelines are in place to ensure that healthcare professionals know how to manage FGM, as well as organise services for women with FGM. The service also provides a FGM clinic for women who wish to reverse the mutilation to some extent.

Mental health services should be improving their ability to cope with the needs of FGM. The Department of Health is running training sessions for mental health professionals to better improve their knowledge of FGM, how to ensure services are appropriate and to manage patients' needs appropriately.

A community engagement group is currently being set up to address FGM in Leicester through community capacity building and information sharing. This work is building up on the work of a previous task and finish group at the LSCB.

Local voluntary and community groups are heavily involved in campaigning against FGM and supporting victims and communities.

Child Sexual Exploitation

1. Child Sexual Exploitation Introduction

Child Sexual Exploitation (CSE) is defined as 'a form of child abuse [which] involved children and young people receiving something...as a result of them performing sexual activities, or having others perform sexual activities on them'¹³¹. It can also occur without physical contact, when children are groomed to post sexual images on the internet. In all cases those exploiting the child have power over them, perhaps by

¹³¹ Department for Education

virtue of their age or physical strength. These relationships are characterised by being exploitative and relying on ‘fear, deception, coercion and violence.

There are many forms of CSE. These may be within a community, intra- and inter-familial, or with people less well known to children and young people. CSE crosses boundaries of culture, disability, social class, and gender and other diverse issues. This means it is often under reported and misunderstood.

The impact on children and young people is significant. CSE effects physical, emotional and mental health both in the short and long term. Specific issues include self-harm, attempted suicide, pregnancy, injuries, sexually transmitted infection, substance misuse and impairing educational attainment.

CSE is considered a form of child abuse and, because there is no specific crime of CSE, official police statistics cannot be obtained; where perpetrators are convicted, it is for offences such as ‘grooming’ or ‘sexual activity with a child’. It is also not possible to ascertain figures through children protection proceedings as there is not recognised category of abuse for CSE. CSE data recording is often incomplete or goes unrecorded.

2. The level of need in the population

2.1 Population profile

For a variety of reasons it cannot be fully determined how many children and young people are survivors of CSE. The abuse can be described as ‘hidden’, with survivors not included to disclose to what has happened to them. But some may not recognise it as abuse if the perpetrator has led them to believe they are in a relationship or if they are reliant on the protection of their abuser.

In the UK, the Office of the Children’s Commissioner’s Inquiry into Child Sexual Exploitation in Gangs and Groups (CSEGG) found that at least 16,500 children were at risk of CSE in one year. It also found that 2,409 children were confirmed victims of sexual exploitation in gangs during a 14 month period, but this is thought

In Leicester, the number of cases of children and young people at risk of CSE or subject to CSE between April and December 2016 are reported in Table 1.

Metric	April to June 2016	July to September 2016	October to December 2016
Number of children/young people referred in period	40	26	40
Number of children/young people assessed as medium and high risk of CSE in	31	16	26

2.2 Risk Factors

The Office of the Children’s Commissioner’s Inquiry into Child Sexual Exploitation in Gangs and Groups (CSEGG) identified 11 indicators of CSE risk in children aged 10+ that can be measured using education, police or other public service datasets, to identify children at risk locally¹³²:

- Child in Need or Children Looked After
- Children persistently absent from education
- Children permanently excluded from school
- Children misusing drugs and/or alcohol
- Children engaged in offending
- Children reported missing, or Children reported to be ‘absconding’ or ‘breaching’
- Children reported as victims of rape
- Children lacking friends of similar age
- Children putting their health at risk
- Children displaying sexually inappropriate behaviour
- Children who are self-harming or showing suicidal intent.

2.3 Audit of Compliance with Safeguarding Procedures

A recent audit on compliance with the Leicester Safeguarding Children Board Multiagency Safeguarding Procedures was conducted in 2016 and the results of this are being followed up locally. This showed evidence that there is a lack of compliance for the multi-agency procedures across agencies, and the CSE Risk Assessment Tool is not be completed by all agencies.

Further improvement for CSE safeguarding is needed through local training, improving the use of assessment tools and continuing to develop effective communication between agencies where referrals have been made will all help to strengthen local action to tackle CSE.

3. Current services in relation to need

In September 2016, Leicester City Council established a CSE, Missing and Trafficked Children team. The team is located at a Leicestershire police station in the Multi-agency CSE hub. The team works alongside Leicestershire County Council colleagues, health and police partners to ensure a systematic approach is taken to understanding the issues for young people at risk. The coordination and sharing of key information is proving critical to creating a better understanding of the prevalence of CSE and how it is being tackled.

¹³² Office of the Children’s Commissioner (2012) “I thought I was the only one. The only one in the world.” Inquiry into Child Sexual Exploitation in Gangs and Groups - Interim Report, Nov 2012

From 5 December 2016, the Leicester City CSE, Missing and Trafficked Children team took responsibility for undertaking return interviews (when these are required) for children and young people who go missing from education, home or care. This should help to identify any additional children and young people at risk that would otherwise not be identified.

In April 2016, a Regional Child Sexual Exploitation Framework was agreed by agencies across the East Midlands, aiming to raise standards, promote good practice and improve the quality and consistency of service delivery across the region. It has been informed by reference to key questions posed by Ofsted during their thematic inspection of CSE 'the sexual exploitation of children: it couldn't happen here, could it?' (Ofsted 2014) in addition to the NWG summary of recommendations from a range of reports, inquiries, serious case reviews and research.

Gypsy and Traveller Children

1. Gypsies and Travellers Introduction

Gypsies and Travellers¹³³ have the lowest life expectancy of any group in the UK, and experience high infant mortality rates. 18% of Gypsy and Traveller women have experienced the death of a child.¹³⁴ They experience, and are being held back by, some of the worst outcomes of any group across a range of social indicators. For instance

- In 2011 12% of Gypsy, Roma and Traveller pupils achieved for or more GCSEs over grade C, compared with 58.2% of all pupils
- There is excess prevalence of miscarriage, stillbirth and neonatal death in Gypsy and Traveller communities
- About 20% of traveller caravans are on unauthorised sites
- Gypsy and Traveller communities are subjected to hostility and discrimination and often lead separate lives to the wider community.

Gypsy, Roma and Traveller people are not homogenous. The terms may cover English and Welsh Gypsies, Irish and Scottish Travellers, and Roma from Eastern Europe. Roma people may encompass different groups too. There are other groups too, who may be seen in Leicester, such as New (Age) Travellers, barges or boat dwellers, circus people or showmen.

2. The level of need in the population

2.1 Population profile

Leicester has a small population of Gypsy, Roma and Traveller people. Gypsy and Traveller people generally live on the 3 sites across the city. Most Roma people live in houses in the East Park Road and Narborough Road areas.

Some services have evolved, such as Babington College which specialises in education for Roma people. The Gypsy and Traveller Healthcare service is based at New Parks Health Centre. This has improved access to primary care, with higher registration rates and overcome barriers to care.

There are about 100 children and young people from Gypsy and Traveller backgrounds in Leicester. There are lower rates of take up of childhood immunisations, poor diet and dental health in young children. Rates

133 Ministerial Working Group on tackling inequalities experienced by Gypsies and Travellers at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/6287/2124046.pdf

134 Parry, G., et al, 2004, the Health Status of Gypsies and Travellers in England. Report of Department of Health Inequalities in Health Research Initiative Project 121/7500

of teenage pregnancy, domestic violence and drug taking in young males are reported to be higher than in the general population. These have an impact on the mental wellbeing of people in the community.

2.2 Health Status of Gypsy and Traveller People in the UK

Gypsies and Travellers have poorer health status than non-travellers and more self-reported symptoms than all other UK residents. However, they are less likely to access services.

As with the general population, the health status of Gypsies and Travellers is affected by age, education and smoking. Rates of smoking are generally higher, educational attainment lower and life expectancy shorter than average for Gypsies and Travellers.

The most marked inequality is found in self-reported anxiety and respiratory problems. Trauma, mental and physical health problems endured by Gypsy, Roma and Traveller young people often result from inadequate accommodation, and experiences of eviction and discrimination. These were highlighted for instance in the Dale Farm evictions and arguments about the right to respect for private and family life, home and correspondence. The mental wellbeing of children and young people may be affected by lack of privacy, overcrowding and domestic violence.

Parry et al¹³⁵ found that Travellers' health beliefs and attitudes to health services demonstrate cultural pride in self-reliance, tolerance of chronic disease and avoidance of screening, possibly linked to fatalistic and nihilistic views on illness.

The health status of Gypsy, Roma and Traveller people is not helped by poor access to care, communication difficulties and stigma and discrimination. Barriers to health care in the past have included reluctance in general practice to register Gypsies and Travellers, expectations of service providers and Gypsies about the service to be provided.

Wilkin et al¹³⁶ found that levels of educational attainment in Gypsy, Roma and Traveller pupils are lower than that for people from minority ethnic backgrounds at all key stages. This is due to a complex range of factors, including barriers that prevent them from fully accessing the curriculum, such as lack of engagement, interrupted education and negative experiences of school. The educational disadvantage of Gypsy, Roma and Traveller families is the most marked difference between this group and other socially deprived and minority ethnic populations.

135 Parry, G., et al, 2004, The Health Status of Gypsies and Travellers in England. University of Sheffield

136 Wilkin, A., et al., 2010, Improving the outcomes for Gypsy, Roma and Traveller pupils: final report London, DfE
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/181669/DFE-RR043.pdf

2.3 Health of Gypsy, Roma and Traveller Children and Young People in Leicester

Defining the Gypsy, Roma and Traveller community is as much an issue in Leicester as it is nationally. The Roma community, which is from Eastern Europe, is generally housed, and accesses primary care, health visiting, schools and school nursing as part of the general population. There has been some interest in a specialist approach to Roma needs in some services, such as in education, where Babington College has developed expertise in looking after needs of young people from the Roma community. However, because most Roma people in Leicester are resident in houses they are most likely to access all services in the same way as the general population.

For Gypsies and Travelers though, almost by definition, housing is insecure compared to the general population. The majority will live on sites. Some Travellers have always lived in houses but have a heritage of moving from place to place and may travel for long periods during the summer months. Others are mobile all the time, some use specific sites in Leicester at Meynalls Gorse, Redhill and Greengate Lane. Some people use a site on Bath Lane in Belgrave. There may be different attitudes between those who live in houses and those who constantly travel.

Clinicians at the Gypsies and Travellers Health Service estimate there are about 100 young people aged 0 to 24 years known in Leicester. Young Gypsy and Traveller people are likely to experience high rates of trauma, accidents and lower rates of take up of immunisations and poor dental health. There are higher than average rates of drug taking in young males and teenage pregnancy. Primary school education for Gypsies and Travellers is common, but education beyond age 11 is rare and levels of literacy are low.

The local specialist approach has improved access to healthcare, with higher rates of registration with primary care. However, there may be higher than average rates of attendance at the accident and emergency department, and lower access to secondary care.

Older Gypsy and Traveller people have a traditional view of society; often this prevails in local communities. This may result in outcomes which are different to the general population; such as traditional gender roles, early marriage and teenage pregnancy. With regard to health and wellbeing, the view of older people can be influenced by their own experience or family history. Clinicians note that Gypsy and Traveller people are often stoical in their outlook on chronic disease, that males may appear less receptive to health advice than in the general population, that children may not access all vaccines which are part of the Childhood Immunisation Programme.

The local Gypsies and Travellers Health Service find that young males are less forthcoming about health need. There are also high rates of accidents among younger males and young people who have experienced bereavement.

Local clinicians agree that Gypsy, Roma and Traveller people are becoming increasingly proactive in seeking health and social care for their communities. This will need to be sustained by continued Gypsy and Traveller engagement in the design and delivery of services, confidence building through trusted practitioners and flexibility and capacity to further develop therapeutic relationships with vulnerable people.

Draft recommendations

- Partners in the city, including the Health and Well-being Board & Children's Trust Board should ensure that service planning for children and young people continues to reflect the growing numbers of children living in the city. [HWB/CTB]

0 to 19 years old Children

- Take action to reduce infant mortality and low birth weight, particularly in the most deprived parts of the city, by continuing to improve early access to high quality universal maternity services including the number of women booking into maternity care by 12 weeks of pregnancy. [CCG/ UHL/ LA]
- Routine antenatal visits should be used to raise awareness of the impact of alcohol and smoking during pregnancy, improve the uptake of smoking in pregnancy services and provide evidence-based advice and support on healthy weight in pregnancy. [CCG/UHL/ LA]
- Breastfeeding initiatives including peer support, through the city's 0-19 Healthy Child Programme and in maternity services need to be maintained and developed. This should include a specific focus on supporting women living in areas with the highest levels of deprivation. [LA/ UHL/LPT]
- Maintaining high coverage of immunisation and vaccination against infectious disease in pregnancy and childhood remain important ways of protecting children's health and reducing avoidable demand for health services. This should continue to be closely monitored locally by the Leicester, Leicestershire & Rutland Health Protection Board in conjunction with NHS England. [LLRHP/NHSE]
- Intelligence from the National Child Measurement Programme should be used to identify and work with schools to promote healthy weight, reduce obesity and tackle underweight. This should be done by continuing to support the Food for Life programme, local growing schemes and by working with partners to engage children and their families in physical activity. Schools in more deprived areas and where obesity or underweight levels are high should be targeted. [LA]
- Increase the uptake of funded early year's education for 2 and 3 years olds in high quality facilities. [LA]
- Schools, colleges, the local authority and health services should continue to collaborate and build upon on current momentum to enable all children to achieve good educational and personal outcomes that prepare them for adulthood.
- Continue to reduce the incidence of poor oral health and reduce the number of children who required tooth extractions under general anaesthetic in Leicester, by expanding the uptake of fluoride varnish application and through the city's Healthy Teeth, Happy Smiles programme [LA/NHSE]
- Determine ways to increase the school readiness of Leicester's children by targeting the factors that affect their transition (e.g. language development, motor development, and social/emotional development) through the city's 0-19 Healthy Child Programme [LA/NHS]

20 to 24 Year Old Young People

- The circumstances and economic and emotional pressures on young people are complex. Therefore more work is needed to understand the specific needs of young people in Leicester not living independently and not in employment, education or training.
- In light of the automatic housing benefits for 18 to 21 year olds ending in April 2017, a review of the types of local housing available to young people should be conducted to ensure there is an adequate supply of affordable housing.
- A specific needs assessment is needed to better plan and resource services for young adults with SEND and their transition to adult services.

Mental Health

- Ensure the integrated approach between mental health services, social services, education, offender management services and adult mental health continues to be strengthened. [NHS/YOS/LA]
- Ensure that the results of the local Children's Survey are used to better understand & intervene early to improve the mental health of children and young people to reduce preventable mental illness and improve children's well-being [LA/NHS/HWB]
- Promote resilience to mental illness in schools, by working with schools to develop whole-school approaches to enabling good mental health & well-being. [LA/NHS]

Looked After Children

- Commissioners of health services for children and young people should consider requiring client information to be recorded in an electronic format that is easily interrogated to facilitate understanding of population health needs and monitoring of performance beyond statutory assessments. [CCG/LPT]
- Accelerate the work with the Youth Offending Service to reduce the proportion of LAC being convicted, having a final warning or reprimand during the year. [YOS/LA/Police]
- Continue work through the Local Children Safeguarding Board on Neglect to address this issue at a population level. [LA/ NHS/other partners]

Youth Offending

- In line with the Full Joint Inspection's recommendation, a reporting system that allows for easy identification of the health needs for young people known to YOS should be implemented. These health needs include the physical and sexual health needs and speech, language and communication needs. [YOM]
- Improve the multi-agency Health and Social Care pathways and planning for young offenders to manage risks (to health and wellbeing and for reoffending). [YOS/YOM/NHS]

- Provide a more streamlined approach to client care through a shared YOS Health Care Plan for young people. These Health Care Plans should involve parents to ensure that parents receive appropriate support before the young person reaches a state of crisis. [YOM/YOS/other partners]

Female Genital Mutilation

- Increase community engagement on FGM to ensure proper safeguarding and to better educate communities on the health impacts of FGM. [LA/CTB/LSCB]
- Ensure that the care of FGM victims is integrated between mental health services, social services and physical health services. [LA/NHS]
- Promote training on the risk factors and signs of FGM to health, social care and education [LA/NHS]
- Continue the monitoring and auditing of compliance with FGM safeguarding procedures across all partners and relevant agencies. [LA/ LSCB/NHS]

Child Sexual Exploitation

- The use of CSE assessment tools across agencies should be improved to ensure all children at risk or subjected to CSE are identified in a timely fashion.
- Improve communication between agencies where CSE referrals have been made. Additional multi-agency training is needed to further facilitate this.
- The CSE Hub should continue to build upon the coordination and sharing of key information to provide a better understanding of CSE, its prevalence and how to continue tackling this issue.

Gypsies and Travellers

- Health and social services should continue to improve community engagement with these communities to determine the best ways to improve their health and well-being. While we have some understanding of their needs, how to improve their care and their health is not clear.
- More understanding and flexibility by health and social care agencies is necessary to allow for effective community involvement and improved care. This may include ensuring staff and commissioners have a better understanding of Gypsy and Traveller communities, their health literacy, social structures and their behaviours.