report

meeting	HEALTH AND WELLBEING BOARD		
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REPORT OF THE CORPORATE DIRECTOR FOR CHILDREN, FAMILIES AND CULTURAL SERVICES AND THE DIRECTOR OF PUBLIC HEALTH

Child and Adolescent Health Behaviours

Purpose of the Report

1. This report outlines health behaviours of children and adolescents in Nottinghamshire and their impact on health. The report considers local data, information on national policy drivers and provides an overview of current priority areas for the Nottinghamshire Children's Trust[1]. Recommendations for action for members of the Health and Wellbeing Board are outlined for consideration.

Information and Advice

Background

2. The physical, mental and emotional health of a child has a crucial influence on the future of that child, in addition to being an important outcome in its own right.

   "*Nothing can be more important than getting it right for children and young people. We know the importance of health services and healthy behaviours in childhood and teenage years in setting patterns for later life*[2]".

3. Previous international reports have indicated that the wellbeing of children in the UK is poor when compared to that in other industrialised countries[3]. Improving the health and well being of children, young people and families is a key priority for the Nottinghamshire Children's Trust.

[1] The Nottinghamshire Children's Trust is a partnership of local organisations working with children, young people and families across Nottinghamshire.
[2] DH (2010) 'Achieving equity and excellence for children – how liberating the NHS will help us meet the needs of children and young people'
[3] Unicef (2007) An overview of child wellbeing in rich countries. A comprehensive assessment of the lives and well-being of children and adolescents in economically advanced countries.

How child and adolescent health behaviours impact on outcomes

4. It is widely acknowledged that particular behaviours have an impact on a range of health outcomes. During both childhood and adolescence, individuals may engage in behaviours which carry long-term risks for their health. Younger children usually have less choice in relation to health behaviours, since they are dependent on parents and families. Thus a poor diet and lack of opportunity to exercise may lead to obesity or a lack of supervision may result in accidental injury. Young people may engage in behaviours that put their health at risk, for example through excessive alcohol consumption, other substance misuse or dangerous activities.

5. When considering why children and young people engage in behaviours which put their health at risk, it is important to consider the child's environment and influences on their behaviour. Children are members of families, schools, friendship groups and the wider community. It is well established that socio-economic status impacts on health behaviours and outcomes. Children growing up in poverty are more likely to suffer emotional and behavioural problems early in childhood[4]. Socio-economic disadvantage can compound chronic stress, family instabilities and parental mental health issues which in turn can impair parenting. A young person who was a child of a teenage mother is more likely to become a teenage parent themselves, to leave school at 16 with no qualifications, to experience domestic violence, to smoke and, to experience poor mental health.

6. Clearly not all young people engage in harmful behaviours and most seek advice and make sensible decisions in relation to their health. In addition, parents, carers and service providers can do much to mitigate any harm that may result from these behaviours. In seeking to improve health and wellbeing and reduce harmful behaviours, good quality health education and access to appropriate health and other services will support children and young people in achieving and maintaining good health[5]. Early intervention to minimise poor outcomes is both beneficial in terms of health and is cost effective.

7. More information in relation to health behaviours and factors associated with poorer health outcomes is presented in **Appendix One** of this report. Further detailed analysis is available in the Joint Strategic Needs Assessment (JSNA) and specific issue based needs assessments.

Local Data – what do we know about health behaviours and outcomes?

8. The Nottinghamshire Children's Trust updated the children and young people's chapter of the JSNA in September 2010. The JSNA is available at www.nottinghamshire.gov.uk/cypjsna100908.pdf, on the Nottinghamshire County Council website. Key messages from the health section appear in **Appendix Two** of this report.

9. The JSNA highlights the issue of health inequalities. There is a direct correlation between poor health outcomes, child poverty, and localities

[4] N Spencer Health Consequences of Poverty for Children. End Child Poverty 2008
[5] Coleman J et al (2007) 'Adolescence and Health' Wiley Blackwell, Oxford

experiencing deprivation. Within Nottinghamshire, localities with higher levels of deprivation have higher levels of infant mortality, smoking in pregnancy, low birth weight births, reduced levels of breastfeeding, childhood obesity, teenage conception and substance/alcohol misuse.

10. Health outcomes for certain groups are of particular concern. For example, children looked after by the local authority are more likely than other groups to adopt risk taking behaviours which lead to poor outcomes. National data indicates that looked after children and young people have a worse level of health than their peers, in part due to the impact of poverty, abuse and neglect to which they have been subjected.

National Policy Drivers

11. There are a number of national policy documents which articulate the Government's vision for children and young people's health services. These span a range of health issues, age groups and settings. It is important to note that many policy documents were published by the previous government, so it is unclear which national policy drivers will continue in the longer term.

12. The Health and Social Care Bill 2011 has created a situation of instability in terms of long term strategic planning, policy arrangements and clarity regarding future expectations and commissioning responsibilities. There is some uncertainty about what must be done and what interventions are optional. Currently, however, there are a number of core activities and programmes included in the NHS Operating Framework 2011/12 for Primary Care Trusts. For example PCTs are required to increase the health visiting workforce substantially (though where the longer term responsibility for this will lie remains unclear).

13. A summary list of key national policy drivers is included in **Appendix Three** of this report.

Local Policy Drivers and Priorities

14. The identified needs of children and young people in Nottinghamshire, together with national policy drivers, have led to the development of a range of improvement programmes and strategies to address local health related issues for children and young people.

15. **Children, Young People's and Families Plan 2011-12 –** Within the plan, improving health and well being is a key theme with priorities including improving emotional health and well being and improving services for disabled children and young people. The plan is due to be launched in summer 2011.

16. **Safeguarding Improvement Programme –** The annual Ofsted assessment of children's services is derived from the performance profile of the quality of services and outcomes for children and young people in each local area. In March 2010, a full Ofsted inspection identified that safeguarding services were inadequate within Nottinghamshire. Since then, the Safeguarding Improvement Programme has overseen action to address identified

shortcomings and significant progress has been made, including the launch of the Pathway to Provision initiative (which provides a means of clearly identifying thresholds and referral routes for access to key children's services) and clarity on use of the Common Assessment Framework to assess need. A recent peer review exercise identified noteworthy improvements.

17. **Nottinghamshire Early Intervention and Prevention Strategy –** This strategy will be launched in July 2011, at a time of reducing resources across the public sector and rising demand for specialist services. Effective early intervention and prevention services will result in children, young people and their families receiving the support required much earlier, at a reduced cost with reduced demand for specialist services. Development of health visiting services and the Family Nurse Partnership (FNP) programme are referred to in the strategy (refer to Appendix Three), as key components of an integrated approach to early intervention.

18. **Participation Strategy 2009-12 -** The strategy is primarily focussed on the participation of children and young people in service design, delivery and evaluation, in some instances it also includes the need to engage parents and carers. The Nottinghamshire Children's Trust is committed to promoting the active participation of children and young people wherever possible and plans are under way to ensure that children and young people are included in the commissioning of HealthWatch.

19. **The Nottinghamshire Joint Commissioning Framework –** reinforces the benefits of joint work and commissioning across both PCTs and Nottinghamshire County Council. Children and young people are a priority commissioning theme within the framework, and joint commissioning continues to be a key driver locally with the expectation of increased partnership working and working towards more aligning of budgets to reduce duplication and streamline processes and outcomes.

20. The Framework has highlighted a number of joint commissioning priorities which if tackled and commissioned together will improve progress and outcomes for children and young people. These are set out below.

Nottinghamshire's Joint Commissioning Framework Priorities	**Local Response**
Improving outcomes for disabled children and young people	• A joint commissioning group has been established and a needs assessment and strategy are currently being developed. The strategy will inform local priorities and commissioning intentions. • There are a range of services in place for children and young people with disabilities and or special educational needs led by health providers, the Local Authority and the voluntary and community sector.
Reducing childhood obesity	• Nottinghamshire has a well established strategic partnership to tackle obesity amongst children and adults. This partnership has prepared a strategy and brings together local providers in ensuring service interventions are in place, are effective and target the groups most in

	need. • Services and interventions are being implemented by health providers, Nottinghamshire County Council, District Councils and the voluntary and community sector. • The National Child Measurement Programme is delivered annually in nearly all primary schools in Nottinghamshire; this data is invaluable in ensuring service interventions are targeted appropriately and there is greater understanding of local need and projections.
Improving emotional health and well being	• The Child and Adolescent Mental Health Service (CAMHS) is well established with clear pathways to access support including specialist services for complex issues. • A CAMHS partnership group is established and a strategy is in place for 2011-12. The commissioners for the service include both PCTs and Nottinghamshire County Council.
Reducing substance and alcohol misuse amongst young people	• A young people's substance use strategy for Nottinghamshire is in place and lists local priorities. The strategy is the responsibility of the Joint Commissioning Group for Young People's substance use. • There are a range of services available in Nottinghamshire including a service for children and young people affected by parental substance use. • Substance use is currently being led by Targeted Youth Support Services within Nottinghamshire County Council to ensure a comprehensive package for young people at risk of poor outcomes.
Reducing teenage conceptions	• The Teenage Pregnancy Strategy ended in 2010/11 and was led by a local partnership group. The work of the strategy has been successfully embedded into mainstream service delivery including sex and relationships education in schools. • There are a range of contraception and sexual health services across Nottinghamshire and the C-Card Condom scheme is led by Nottinghamshire's Youth Support Service.

21. Improving the health of children looked after (LAC) by the Local Authority is also a shared priority for PCTs and Nottinghamshire County Council. The health of LAC is of great importance during Ofsted inspections of safeguarding and looked after children's services. National data clearly indicates that looked after children and young people have a worse level of health than their peers, in part due to the impact of poverty, abuse and neglect that they have been subjected to. Further information is included in Appendix one.

Challenges

22. **Complexity -** Improving health outcomes for children and young people is inherently complex, since outcomes are influenced by range of factors including socio economic status, community networks, attitudes to children and young people, access to services, the behaviour of parents and carers

and that of children and young people themselves. In addition, current structural changes within the education system (such as the Academies programme) mean that there is less clarity on how to effectively engage schools in improving the health and wellbeing of children and young people.

23. **Measuring the impact of what we commission** – It is essential to commission interventions that are based on national and international evidence of what works. Likewise, that the impact of interventions and services on health and well being outcomes should be monitored. This will inform decisions on future commissioning and decommissioning, recognising that cost-effectiveness of various health programmes and public health interventions frequently depends on long term commitment and investment.

24. **Funding –** With restricted budgets there is a need to refocus services within limited resources and capacity. The Department of Health still expects PCTs to commission key programmes and make substantial in-year savings, and the County Council continues to operate within a difficult financial climate.

25. **New NHS Providers** – Following the reorganisation of NHS community services, there are now a wider range of providers of children's services operating across Nottinghamshire, with an associated risk of increased fragmentation of services. PCTs and Nottinghamshire County Council are working to engage all new providers through the Children's Trust.

26. **Data and information sharing -** The refreshed JSNA identified a number of challenges in relation to data; without key datasets we are unable to assess needs and priorities fully. For example, it is problematic to collate accurate, timely data in relation to disabled children and young people both locally and nationally. Such information is collected by different agencies, is often out-of-date and is not shared routinely. Obstacles around information sharing can make commissioning services based on local needs challenging.

Summary

27. Health behaviours of children and young people are associated with the environment in which they live, generally influenced significantly by their own or their parents status and experiences. Some children and young people are at greater risk of poor health outcomes and health problems than others.

28. In order to improve the health and wellbeing of children and young people and reduce inequalities, the Nottinghamshire Children's Trust has identified key priorities for action and joint commissioning, underpinned by early intervention, a focus on early years and appropriate targeting. However, there are considerable challenges to be faced currently and the Health Well Being Board and GP Commissioning Groups have an important role in supporting progress in this area.

Statutory and policy implications

29. This report has been compiled after consideration of implications in respect of finance, equal opportunities, personnel, crime and disorder and those using

the service. Where such implications are material, they have been described in the text of the report.

RECOMMENDATION

30. That:

(1) Members of the Health and Wellbeing Board are invited to comment on the current approach summarised in this paper to improving health and wellbeing of children and young people.

(2) Board members consider the health of children, young people and families when developing the Health and Wellbeing Strategy for Nottinghamshire, recognising the importance of reducing health inequalities and the value of early intervention and prevention.

(3) The Board considers the inclusion of a chapter in the Health and Wellbeing Strategy for children and young people, or alternatively the development of a stand alone Health and Wellbeing Strategy for Children and Young People.

(4) In light of NHS reforms and changes in commissioning arrangements, the Board considers how Nottinghamshire County Council and PCTs engage with GP Commissioning groups to ensure the health needs of children and young people are effectively addressed.

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ANTHONY MAY

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Legal Services' comments (LM/21.06.11)

31. The Health and Wellbeing Board has delegated authority to approve the recommendations in the report.

Financial comments of the Service Director – Finance (NDR)

32. Nil.

Background papers available for inspection

Nil.

Electoral division(s) affected

Nottinghamshire

M19C2824

APPENDIX ONE

How do health behaviours impact on health outcomes for children and young people?

Behaviour / Status	Outcomes and links with other risk factors
Socio Economic Status	• Women from poor families are more likely to have poor health and significant psychological problems during pregnancy. They are more likely to have poor nutrition, genital infections and smoke. These are important determinants of the outcome of pregnancy, including birth weight, which is itself an important determinant of infant mortality[6]. • Birth weight has consistently been shown to decrease with lower social status[7]. • All causes of neonatal death show a socio-economic gradient. There is a marked gap between infant mortality rates in the most deprived groups and the least deprived groups in the population[8] • In the UK, the 20% - 25% of people who are obese or smoke are concentrated among the 26% of the population living in poverty, measured in terms of low income and multiple deprivation of necessities. This is also the population with the highest prevalence of anxiety and depression[9]. • Poor children have increased rates of disability and ill health. Nationally 29% of disabled children live in poverty. • Acute illnesses are more likely to affect poor children, they are at greater risk of hospital admission and they are more likely to experience multiple admissions before the age of three[10]. • Among poor children, those with higher levels of emotional wellbeing have better educational outcomes than their equally poor peers.[11] • Among poor children, those with higher levels of emotional wellbeing have better educational outcomes than their equally poor peers.[12] • The prevalence of obesity increases with deprivation. There is a positive relationship between obese and overweight children and deprivation in Nottinghamshire for both sexes, especially in Year 6[13]. • Respiratory illness in early childhood is a risk factor for developing chronic obstructive lung disease in adulthood. Since respiratory illnesses are more common in children who live in poverty, this illustrates how poverty in childhood can affect health outcomes for adults[14].

[6] M S Kramer, L Séguin, J Lydon and L Goulet, 'Socioeconomic Disparities in Pregnancy Outcome: why do the poor fare so poorly?', Paediatric and Perinatal Epidemiology 14, 2000, pp194-210
[7] N Spencer *Health Consequences of Poverty for Children*. End Child Poverty 2008
[8] Implementation Plan for Reducing Health Inequalities in Infant Mortality: A Good Practice Guide. DH 2007
[9] World Health Organisation (2009) *Mental health, resilience and inequalities* Dr Lynne Friedli
[10] N J Spencer, M A Lewis and S Logan, 'Multiple Admission and Deprivation', Archives of Disease in Childhood 68, 1993, pp760-62).
[11] World Health Organisation (2009) *Mental health, resilience and inequalities* Dr Lynne Friedli
[12] World Health Organisation (2009) *Mental health, resilience and inequalities* Dr Lynne Friedli
[13] Nottinghamshire JSNA September 2010
[14] N Spencer *Childhood Poverty and Adult Health*. End Child Poverty 2008

	• Research suggests that adults are 50% more likely to self-report a long-standing illness if they were economically disadvantaged during childhood[15]. • Prevalence rates of mental disorders are greater among children[16]: o In lone parent families compared with two parent families (16% compared with 8%) o In families with five or more children compared with two children (18% compared with 8%) o If the parent had no educational qualifications compared with a degree level or equivalent qualification (15% compared with 6%) o In families where neither parent works compared with both parents in employment (20% compared with 8%) o In families with a gross weekly household income of less than £200 compared with £500 or more (16% compared with 6%)
Age of Mother	• Nationally, low birth weight (LBW) babies are associated with both very young mothers and mothers over 40 years[17]. • The infant mortality rate for babies born to teenage mothers is 60% higher than for babies born to older mothers. • A significant proportion of teenage mothers have more than one child when still a teenager. Nationally, around 20% of births conceived under-18 are second or subsequent births. • Research shows that being the daughter of a teenage mother is the strongest predictor of teenage motherhood. • At age 30, teenage mothers are 22% more likely to be living in poverty than mothers giving birth aged 24 or over, and are much less likely to be employed or living with a partner. • Teenage mothers are 20% more likely to have no qualifications at age 30 than mothers giving birth aged 24 or over. • Teenage mothers are three times more likely to smoke throughout their pregnancy, and 50% less likely to breastfeed, than older mothers - both of which have negative health consequences for the child. • Children of teenage mothers have a 63% increased risk of being born into poverty compared to babies born to mothers in their twenties and are more likely to have accidents and behavioural problems. • Among the most vulnerable girls, the risk of becoming a teenage mother before the age of 20 is nearly one in three. • Teenage mothers are three times more likely than older mothers to suffer postnatal depression and mental health problems in the first three years of their baby's life[18].
Disability	• Disabled children and young people currently face multiple barriers which make it more difficult for them to achieve their potential, to achieve the outcomes their peers expect and to succeed in education. • The educational attainment of disabled children is unacceptably lower than that of non-disabled children and fewer than 50% of schools have

[15] N Spencer *Childhood Poverty and Adult Health*. End Child Poverty 2008
[16] Joint Health Surveys Unit, Health Survey for England: The health of young people 1995-97. University College London, 1998
[17] N Spencer *Health Consequences of Poverty for Children*. End Child Poverty 2008
[18] Ermisch. 2003. Does a 'Teen-Birth' Have Longer-Term Impacts on the Mother? Suggestive evidence from the British Household Panel Survey. Colchester: Institute for Social and Economic Research.

	accessibility plans. • Disabled young people aged 16-24 are less satisfied with their lives than their peers and there is a tendency for support to fall away at key transition points as young people move from child to adult services. • Families with disabled children report particularly high levels of unmet needs, isolation and stress. • The prevalence of severe disability is increasing. • Over a third of children and young people with an identified learning disability also have a diagnosable psychiatric disorder[19]. • Children and young people with physical disabilities are twice as likely to develop psychological problems as those without, 13 as are those who experience serious or chronic illness[20].
Children and Young People Looked After by the Local Authority	• Looked After Children (LAC) are more likely than their peers to experience problems, including speech and language difficulties, bedwetting, co-ordination, vision and or hearing difficulties[21],[22]. • About 60% of looked-after children and young people have mental health and emotional problems. Frequent placement changes can severely lessen the sense of identity and self-esteem of a child or young person, and can also adversely affect their experience of, and access to, education and health services[23]. • Nearly 50% of children in local authority care have a clinically diagnosable mental health disorder, compared with 10% in the general population. This increases to nearly 70% among children living in residential care[24]. • Being looked after is an important predictor of social exclusion in adulthood. Higher than average rates of poor mental health, drug use, behaviour problems and poor educational attainment reduce prospects of employment, with significant cost to the individual and the state[25].
Parental mental health	• Households with a chronically ill person are among those with the highest levels of deprivation[26]. • Children and young people are likely to be carers for a parent with a mental health issue[27].
Parental substance/ alcohol use	• Those in our society with a background of childhood abuse, neglect, trauma or poverty are disproportionately likely to be affected by substance or alcohol misuse. In turn, the children of those dependent on drugs have to cope with the impact on their own lives and some may end up in state care[28].

[19] Emerson and Hatton. 2007. The Mental Health of Children and Adolescents with Learning Disabilities in Great Britain. Lancaster: Institute for Health Research, Lancaster University.
[20] Parry-Langdon (ed.). 2008. Three Years On: Survey of the development and emotional well-being of children and young people. Cardiff: ONS.
[21] Meltzer H., Corbin T., Gatward R., Goodman R. and Ford T. (2003) 'The mental health of young people looked after by local authorities in England'. London: The Stationery Office
[22] National Children's Bureau (2008) Promoting the health of young people leaving care. Healthy Care Briefing. www.ncb.org.uk/healthycare
[23] NICE & SCIE (2010) Promoting the quality of life of looked-after children and young people
[24] Meltzer, Gatward, Corbin et al. 2003.The Mental Health of Young People Looked After by Local Authorities in England. London: TSO.
[25] NICE & SCIE (2010) Promoting the quality of life of looked-after children and young people
[26] *Poverty and Social Exclusion in Britain*, Joseph Rowntree Foundation, 2000
[27] survey commissioned by the Supporting Disabled Parents Working Panel in August 2009
[28] HM Government 'Drug Strategy 2010. Reducing demand, restricting supply, building recovery: supporting people to live a drug free life. Dec 2010

Smoking in pregnancy	• Smoking in pregnancy is a key cause of ill health for both mother and baby. Babies born to women who smoke are 27% more likely to be born prematurely and have an 82% increase in risk of being of low birth weight compared to babies born to non smoking mothers. • Babies born to mothers who smoke are up to three times as likely to die from sudden unexpected deaths in infancy (SUDI) and smoking in pregnancy increases infant mortality by approximately 40%[29].
Uptake and maintaining breastfeeding	• Breast feeding has substantial health benefits for both mothers and infants. Breastfed babies are less likely to suffer from conditions such as gastroenteritis, chest, urinary tract or ear infections, diabetes in childhood, and childhood obesity. Mothers who breastfeed have a reduced risk in later life of some cancers (ovarian and breast) and of osteoporosis[30].
Diet and nutrition	• Cohort studies suggest that children who increase calorie intake, increase fat intake, consume "junk food", "takeaways" and "carbonated drinks" and/or do not eat breakfast, tend to gain weight[31]. • Studies have identified that children of normal weight, who do not eat breakfast, increase calorie intake, increase fat intake and eat more 'fast foods' appear to gain more weight than their peers[32]. • A study undertaken in Newcastle[33] found that knowledge and awareness about healthy eating were the most important predictors of achieving a healthy diet. Nevertheless, the same study found that poorer communities did not have adequate access to private or public transport and shopped mainly in their local area where availability of fruit and vegetables is more limited, and this was also reported as being a strong predictor of a healthy diet. This is backed up by the Nottinghamshire's Food Initiative Group, which found that deprived areas such as Ashfield had poorer access to fresh fruit and vegetables[34].
Participation in physical exercise and sport	• Cohort studies suggest that children who do not participate in sport outside school and who are the least active appear to gain more weight than their more active peers[35] • In children the persistence of obesity into adulthood is the most important concern; the risk of persistence increases with increasing age of the child and the severity of obesity, but obesity also causes significant morbidity in childhood, as indicated[36].
Early onset of sexual activity	• Girls having sex under-16 are three times more likely to become pregnant than those who first have sex over 16[37]. • Around 60% of boys and 47% of girls leaving school at 16 with no qualifications had sex before 16, compared with around 20% for both males

[29] Passive smoking and children, Royal College of Physicians 2010
[30] Nottinghamshire JSNA September 2010
[31] NICE (2006) Obesity - Guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children
[32] NICE (2006) Obesity - Guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children
[33] University of Newcastle. Do food deserts exist? A multi-level, geographical analysis of the relationship between retail food access, socio-economic position and dietary intake. London: Food Standards Agency, 2004.
[34] Ward M & Kenning M (2007) 'Access to Healthy Food in Ashfield' Food Initiatives Group, Groundwork Trust Nottinghamshire.
[35] NICE (2006) Obesity - Guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children
[36] NICE (2006) Obesity - Guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children
[37] Wellings K, et al (2001) *Sexual Health in Britain: early heterosexual experience.* The Lancet vol.358: p1834-1850

	and leaving school at 17 or over with qualifications.
Alcohol and substance misuse	• Early drug and alcohol use is related to a host of educational, health and social problems[38]. • Regular smoking, drinking and experimenting with drugs increases the risk of starting sex under-16 for both young men and women. Teenagers who report having sex under the influence of alcohol are less likely to use contraception and more likely to regret the experience[39]. • Homeless young people, young people abused through prostitution, children looked after, teenage mothers and young people not in education, employment or training are just some of the groups identified as being at risk of problematic substance use. Persistent non-attenders and school excludees are also at particular risk of substance misuse. • Young people in contact with the criminal justice system are at particular risk of substance use. Nationally, over 50% of young offenders in custody reported Class A drug use in the past year, among the highest for any at risk group. • In England, an estimated 80% of heroin or crack cocaine users are on benefits, often for many years, and their drug use presents a significant barrier to employment[40].
Emotional Health and Well being	• There are associations between mental health outcomes and poor educational attainment, absence from school, exclusion from school and lack of friendship networks. • Children in special schools for behavioural, emotional and social difficulties or Pupil Referral Units (PRU) are significantly more likely to experience mental health difficulties than the general population. • A high proportion (approx 40%) of children and young people in contact with the youth justice system has a mental health problem. This rises to more than 90% for those in custody. These children and young people are vulnerable for many reasons, for example, they tend to be exposed to multiple risk factors; frequently have more than one disorder (including more 'stigmatised' disorders such as emerging personality disorder or inappropriate sexual behaviour); frequently miss out on universal promotion and preventive services; and engage with the system at a point that does not offer the most appropriate treatment and placement solutions for mental health problems[41].

[38] HM Government 'Drug Strategy 2010. Reducing demand, restricting supply, building recovery: supporting people to live a drug free life. Dec 2010

[39] Alcohol Concern (2002) *Alcohol & Teenage Pregnancy.* London: Alcohol Concern

[40] Hay, G. and Bauld, L. (2008) Population estimates of problematic drug users in England who access DWP benefits: a feasibility study. DWP Working Paper No. 46. Department for Work and Pensions; and Hay, G. and Bauld, L. (forthcoming in 2010) Population estimates of alcohol misusers who access DWP benefits. DWP Working Paper No. 94. Department for Work and Pensions

[41] Healthcare Commission. 2006. A Review of Healthcare in the Community for Young People who offend. London: Commission for Healthcare Audit and Inspection.

APPENDIX TWO

Children and Adolescent Health - the picture for Nottinghamshire

Source: Nottinghamshire Joint Strategic Needs Assessment 2010

Chapter 1 'Children, young people and families'

www.nottinghamshire.gov.uk/jointstrategicneedsassessment

1.1 Maternity and early years

1. The birth rate in Nottinghamshire is significantly lower than both the England and the East Midlands average. However, there is projected to be a 9% increase in the under-5 population over the next 20 years.
2. 24% of mothers giving birth in hospitals providing care in the north of the county smoke at the time of delivery. This is well above the national and regional average of around 15%. Smoking in pregnancy is associated with low birth weight and higher infant mortality rates.
3. In 2007, 621 babies were born with a low birth weight, representing 7.2% of all live births. Mansfield and Ashfield have a significantly higher proportion of low birth weight births (9.2% and 8.3% respectively) than, for example, Broxtowe (5.6%). The proportion of low birth weight babies increases with deprivation across Nottinghamshire. Birth weight is a strong predictor of health outcomes in childhood and adulthood. 64% of infant deaths in England and Wales in 2003 were of low birth weight babies and other adverse health outcomes include poor development of cognitive skills in children and diseases such as diabetes, stroke and lung disease in adulthood[42].
4. The numbers of women who initiate breastfeeding is high (over 75% in NHS Nottinghamshire County, approximately 63% in NHS Bassetlaw) but a high proportion of mothers stop breastfeeding within 6 – 8 weeks of the birth of their child, with less than 40% continuing at this stage.
5. There is very low uptake of available vouchers to buy fresh fruit and vegetables and free vitamin supplements (for mother and baby) by those who are eligible as part of the Healthy Start Programme. It is well established that poor maternal and infant nutrition affects long term health outcomes.

1.2 Disability

1. The national picture indicates that more children and young people with profound disabilities and long-term conditions are living longer and surviving into adulthood[43].
2. The detail on the numbers of children and young people with specific disabilities/long-term conditions can be difficult to access as it is collected and held by individual services and practitioners, is often out of date and is not routinely shared.

[42] Indications of Public Health in the English Regions: Child Health (2009), Association of Public Health Observatories
[43] Contact a Family (2006) 'About Families with Disabled Children – UK'

3. Applying prevalence data from national studies and elsewhere to local populations in Nottinghamshire, it is estimated that at any one time there will be:
    - 70 children/young people with Cystic Fibrosis
    - 70 children/young people with Sickle Cell Disease
    - 240 children/young people with Crohn's disease
    - 360 children/young people with Diabetes Mellitus
    - 280 children/young people with a neoplasm such as leukaemia
    - 10,690 with asthma characterised by persistent episodes of wheezing
4. Many of these children and young people have complex needs that require support from a range of professionals from diverse disciplines in order to achieve their potential.
5. Transition to adult services can be particularly challenging for these children and young people.
6. Parental satisfaction with services for disabled children in Nottinghamshire is good overall (National Indicator 54). The lowest area of satisfaction is with accessible feedback and complaints procedures.

1.3 Health of looked after children

1. In line with national data, looked after children in Nottinghamshire experience higher levels of physical, emotional and mental ill-health. High rates of substance misuse are reported, but pregnancy rates are low for looked after children and young people.
2. Immunisation rates are lower than the average for Nottinghamshire but access to primary care services is good.
3. It is difficult to assess whether a range of health outcomes are improving for looked after children since there is a lack of robust trend data.

1.4 Childhood vaccination and immunisation

1. Nottinghamshire's rates of immunisation are above the national average but some, including first year vaccination levels, are below the average for the East Midlands region.
2. There is variation in uptake within Nottinghamshire, between the six GP Commissioning Consortia.
3. Uptake of MMR (measles/mumps/rubella) vaccine needs to improve from the current level of 85% to 95% to provide 'herd immunity'.
4. There is strong evidence that some groups of children are at risk of not being fully immunised.

1.5 Child oral health

1. In Nottinghamshire the levels of dental caries in five year olds are lower than the national average in all areas except Broxtowe and Gedling.

2. There is strong evidence of the positive impact of water fluoridation on the decay levels in young children in Nottinghamshire. The levels of dental decay in the three areas with water fluoridation – Ashfield, Bassetlaw and Mansfield - are significantly lower than the national average, despite high levels of deprivation in those areas.

1.6 Obesity in children

1. Obese children are more likely to become obese adults. Obesity shortens life expectancy by 9 years (National Audit Office, 2002) and is estimated to be responsible for about 30,000 deaths per year nationally. If we do nothing to prevent the projected growth in obesity levels, the costs to the NHS and indirect costs will increase substantially.
2. Participation in the National Child Measurement Programme in Nottinghamshire has grown over the past three years and remains above the 85% Department of Health target.
3. In Reception year, over one in five children are either overweight or obese. By Year 6, the rate is almost one in three, similar to the national figure.
4. In Year 6 aged children, the prevalence of obesity is significantly higher in boys than girls (19.6% and 15.5% respectively). Nationally, 20% of boys and 16.5% of girls are obese at this age.
5. Obesity prevalence is significantly higher than the national average for children in both school years in the ethnic groups: ‘Asian or Asian British', ‘Any Other Ethnic Group', ‘Black or Black British' and ‘Mixed'
6. Twenty-one percent of young people aged 11-18 years say they never play sport or do any physical activity. In Ashfield, this figure is 33%, the highest in the county.
7. 22% of local children and young people eat five or more portions of fruit and vegetables a day, above statistical neighbours (18%) and the national average (19%) (Tellus 4 Survey).

1.7 Emotional health and well-being

1. “…If you do just one thing, get those who know what they are doing to work better together.’’ Parent - National Child & Adolescent Mental Health Review, 2009.
2. There is significant evidence that the emotional health & well-being of children and young people has deteriorated over the past 25 years.
3. Risk factors affecting emotional health include physical illness or disability, family circumstances, environmental issues (such as poverty) and traumatic life events.
4. Environmental issues across the county result in clearly differentiated levels of need and prevalence, with more deprived areas generally having higher risk factors such as unemployment and substance misuse.

5. The estimated prevalence of mental illness in children and young people aged between 5 and 16 years of age in Nottinghamshire is estimated at around 10,760 children, or 9.6% of this population.

1.8 Tobacco control

1. There is no smoking prevalence data for children and young people.
2. Nationally, about two million children currently live in a household where they are exposed to cigarette smoke, and many more are exposed outside the home.
3. Evidence suggests that long-term smokers start before the age of 18 and that children and young people are more likely to smoke if their parents do.
4. Nottinghamshire based projects show smoking prevalence increases as children and young people got older, most markedly at around the age of 14 years. Among young people, more girls smoke than boys.
5. In under-18 year olds accessing smoking cessation services, quit rates are lower than for adults

1.9 Substance misuse

1. There were a total of 500 young people in specialist substance misuse treatment across the year (2008/09) – an increase of 15% from the previous year.
2. The primary substances that young people are receiving specialist treatment for continue to be alcohol and cannabis. Whilst alcohol referrals have significantly increased between 2007/08 and 2008/09 (42% to 53% of clients), there has been a slight decrease in cannabis referrals (45% to 41%).
3. It is estimated that up to 4,266 children and young people are affected by parents illicit drug use and between 13,271 and 21,565 are affected by parental problematic alcohol use.
4. Alcohol related admissions in under-18 year olds have decreased by over 20% between 2005/06 and 2008/09. however, across Nottinghamshire there has been an increase in young women being admitted to hospital for alcohol related conditions, contrary to decreases in young men's alcohol related admissions.
5. The majority of young people attending A&E for alcohol related accidents are aged between 12 and 15 years.
6. The majority of referrals to local drug treatment services are still through the criminal justice route and evidence suggests that more young people would benefit from and should be receiving earlier interventions.

1.10 Young people's sexual health

1. Nottinghamshire has achieved an overall reduction in teenage conceptions of 25.5% from the 1998 baseline. However, this masks variances in reduction across wards and districts in Nottinghamshire (2009 data).

2. There are 26 wards with over 53.2 conceptions per 1000 15-17 year old females, and one ward has a teenage conception rate of 160.4 conceptions per 1000 15-17 year old females. 14 of these wards have teenage conception rates in the top 20% of wards nationally (2007-09 data).
3. Ashfield (30.4%) and Gedling (26.3%) have had the greatest reductions in under-18 conceptions since the 1998 baseline. Ashfield is the only district that has had a significant reduction in under-16 conceptions.
4. Mansfield district has the highest under-18 conception rate (48.8 per 1000 15-17 year old females) and the most hotspot wards (six).
5. Terminations of pregnancy rates are similar in Nottinghamshire to other comparative areas.
6. The percentage of NHS funded terminations at under-10 weeks is 57% in Nottinghamshire, compared to 72.2% nationally.
7. Take up of Chlamydia screening across the county is varied - coverage from 18.1% in Mansfield to 10.5% in Rushcliffe.
8. Nottinghamshire has a higher percentage of positive test results than the national average.

1.11 Hospital admissions

1. The emergency admission rate is significantly lower than the national average for NHS Nottinghamshire County and is significantly higher for NHS Bassetlaw. Compared to PCT peers, Nottinghamshire County PCT has one of the lowest emergency admission rates.
2. Within Nottinghamshire, emergency admission rates are significantly higher than the national average for Bassetlaw and Mansfield. Gedling has the lowest rate.
3. There is a clear relationship between deprivation and emergency admissions, with more deprived areas showing higher rates of admission. This reflects differences in health need, the quality of existing services, knowledge of services and access to primary care.
4. For elective admissions, there are high rates of admission for young people aged 15-19. There is no clear relationship between elective admissions and deprivation.

APPENDIX THREE

Key National Policy Drivers

Achieving Equity and Excellence for Children (DH 2010) - sets out what the NHS White Paper will mean for children, young people and families**.** This includes:

- arrangements so that children and young people's voices are fed into local commissioning
- the option of registering with a practice which has developed particular expertise and knowledge in caring for children and young people
- individual budgets for disabled children and their families
- improved information for children and young people while maintaining confidentiality and support to navigate the system, for example through health visitors and children's centres
- in a discussion of the proposed central role of GP commissioning, suggestions that one way in which GP consortia might pool expertise and risk would be to delegate commissioning of children's services to local authorities

Healthy lives, healthy people: our strategy for public health in England 2010 - promotes an evidence-based approach to public health with a focus on a life stages approach including: children and young people (starting well, developing well) and the integration of physical and mental health.

NHS Operating Framework 2011-2012 - details new commitments in relation to health visitors and the Family Nurse Partnership Programme (see below), in addition to outlining performance measures that relate to children and young people.

Health Visiting Implementation Plan 2011 – 2015 - sets out the expanded, strengthened health visiting services needed to deliver the Healthy Child Programme[44], provide greater support to families and develop local community capacity, working closely with Children Centres. Commissioning organisations are asked to commission an enhanced service model with increased capacity. There is an expectation that NHS Nottinghamshire County will need to increase their Health Visiting team by 73% (i.e. an extra 57 full time health visitors) and NHS Bassetlaw to increase by 60% (i.e. an extra 9 health visitors) by 2015.

Family Nurse Partnership Programme – The Operating Framework 2010-11 outlines the expectations that the NHS will offer the Family Nurse Partnership programme to improve outcomes for the most vulnerable first time young mothers and their children. This evidence based licensed programme offers intensive preventative support from early in pregnancy until children are two years old and is shown to improve outcomes and to be cost effective.

a) [44] **Healthy Child Programme 2009 sets** out a framework of universal and progressive services for children and young people to promote optimal health and well-being, with a key aim of reducing health inequalities**.**