# LEICESTERSHIRE JOINT STRATEGIC NEEDS ASSESSMENT 2018-2021

## BEST START IN LIFE – CHILDREN AGED 0 TO 5 YEARS

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## FOREWORD

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

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

The Local Authority and CCGs have equal and joint statutory responsibility to prepare a Joint Strategic Needs Assessment (JSNA) for Leicestershire, through the Health and Wellbeing Board. The Health and Social Care Act 2012 amended the Local Government and Public Involvement in Health Act 2007 to introduce duties and powers for Health and Wellbeing Boards in relation to JSNAs. The JSNA offers an opportunity for the Local Authority, CCGs and NHS England's plans for commissioning services to be informed by up to date information on the population that use their services. Where commissioning plans are not in line with the JSNA, the Local Authority, CCGs and NHS England must be able to explain why.

The Health and Wellbeing Board has agreed that the JSNA will be published in subject-specific chapters throughout a three-year time period. Chapters will be developed in line with CCG and local authority commissioning cycles. As many of the relationships required for the JSNA in Leicestershire are wide ranging, involving representation from NHS England, CCGs, Leicestershire Partnership Trust, University Hospitals of Leicester, District Councils and the voluntary sector, a JSNA Reference Group has been established. This Reference Group supports the JSNA work across the Health and Wellbeing Board. To examine the detail of the chapters, Task and Finish groups have been established to bring together local professionals, where they can share their expert knowledge on the work area being examined.

The outputs of the JSNA will include:

1. Subject-specific chapters of an assessment of current and future health and social care needs

2. An online infographic summary of each chapter available on the internet

3. An online data dashboard that is updated on a quarterly basis to allow users to self-serve

high level data requests

This JSNA chapter has reviewed the population health needs of the people of Leicestershire aged 0-5 years. This has involved looking at the determinants of poor health in this population, the health needs of the population in Leicestershire, the policy and guidance supporting children aged 0-5 years, existing services and the breadth of services that are currently provided. The unmet needs and recommendations that have arisen from this needs assessment are discussed.

Please note, the majority of indicators presented in this needs assessment are from national sources so are subject to a time lag due to the time required for data collection, data analysis and publication. The data presented deals exclusively with cis women and teenagers, if this does not occur; it will be specified in the narrative. Where possible, comparisons have been made to national averages and local context has been included. The term significance is used throughout the report and refers to statistical significance. This examines if the result presented is different to the national result, due to something other than chance. Most often, this is calculated using 95% confidence intervals.

## EXECUTIVE SUMMARY

This JSNA chapter highlights the importance of giving every child the best start in life. What happens in pregnancy and early childhood impacts on physical and emotional health all the way through to adulthood. It recommends the adoption of the 1001 Critical Days Manifesto which highlights the importance of intervening early in the first 1001 critical days between conception and age 2 to enhance outcomes. It is also important to build on the support in the early years and sustain this across the life course for school-aged children and young people to improve outcomes and reduce inequalities.

Leicestershire is generally more affluent than the England average and performs well for many public health indicators related to children aged 0 to 5 years. However, there are still significant numbers of children living in poverty, at risk of homelessness and exposed to the impacts of domestic violence. Many of these factors affecting the early years are also linked to deprivation. More deprived groups are more likely to engage in multiple unhealthy behaviours, have poorer health and are more likely to need hospital intervention, consequently improving the health of children in the early years will also contribute to reducing health inequalities.

This chapter provides a number of recommendations to improve the health of children aged 0 to 5 years in Leicestershire with specific recommendations focusing on breastfeeding, tackling Adverse Childhood Experiences (ACEs) and ensuring all children achieve a good level of development at age five. The Department of Health recommends exclusive breastfeeding for the first six months of life. The latest breastfeeding initiation data for Leicestershire shows all districts in the county apart from Harborough performed significantly worse than the national average (77.5%), ranging from 65.7% in North West Leicestershire to 71.1% in Charnwood. However, the latest breastfeeding prevalence at 6-8 weeks after birth for the county performs significantly better than England. This infers that although fewer women initiate breastfeeding in Leicestershire, those that do are able to maintain for longer which may be linked to better support.

The importance of addressing ACEs is highlighted in the chapter including the recommendation to develop an agreed trauma informed approach to supporting children and young people who have experienced ACEs build their resilience.

Throughout the early years, a child's health and development is examined to identify children who may require additional support. At the end of reception, all children are assessed across a wide range of developmental areas to see if they are achieving a good level of development and deemed to be "school ready". In Leicestershire a significant improvement in school readiness has been witnessed over the past five years. However, work must continue in this area, particularly in relation to children with free school meal status, as this measure has continued to perform significantly worse than the national average for the past five years.

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# 1. Who is at risk?

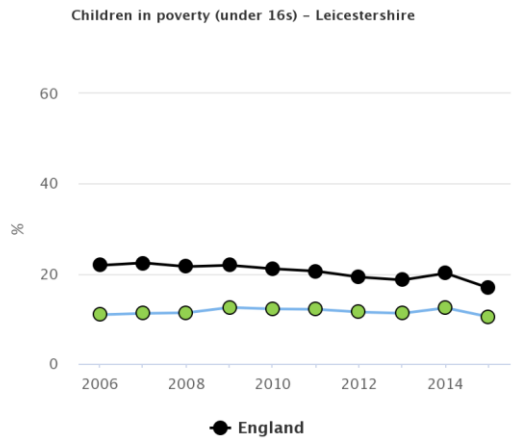
## 1.1. Households and families

### 1.1.1. Poverty and deprivation

The Marmot Review (2010)[1] suggests there is evidence that childhood poverty leads to premature mortality and poor health outcomes for adults. Reducing the numbers of children who experience poverty should improve these adult health outcomes and increase healthy life expectancy.

The percentage of children in low income families (children living in families in receipt of out of work benefits or tax credits where their reported income is less than 60% median income) for under 16s has remained significantly lower (better) than the national average since data recording (in 2006). The latest data shows in 2015 there were 11,795 children aged under 16 living in families in receipt of Child Tax Credit whose reported income is less than 60% of the median income or in receipt of Income Support or (Income-Based) Job Seeker's Allowance. This represents 10.4% of all children aged under 16 in Leicestershire.[23]

**Figure 1: Trend in children in poverty in Leicestershire[23]**




For further information on the population and deprivation that exists throughout Leicestershire, please visit the Demographics JSNA chapter, available here: http://www.lsr-online.org/leicestershire-2018-2021-jsna.html

### 1.1.2. Housing

Poor quality of housing is associated with poverty and is a social determinant of health. It is also associated with adverse health, education and social outcomes, particularly for

children. To understand more about the housing situation in Leicestershire, please visit the Housing JSNA chapter, available here: http://www.lsr-online.org/leicestershire-2018-2021-jsna.html

### 1.1.3. Homelessness

Babies and toddlers that live in families that are homeless are vulnerable to poor social and emotional wellbeing.[2] The NSPCC explains the effects of homelessness on babies in their report 'An unstable start': "Babies living in homeless families can be extremely vulnerable. This is because babies' development is reliant on the quality of the care their parents are able to provide and for some parents who are homeless, providing this care can be difficult.[2]"

"The limited research on the specific impact of homelessness on babies shows that homeless infants experience a significant decline in general developmental function between 4 and 30 months.[2]"

Table 1 shows the rate of family homelessness in Leicestershire has remained lower than the national average over the last five years.

**Table 1: Family homelessness: households containing children or a pregnant woman per 1,000 households[3]**

| | 2012/13 | 2013/14 | 2014/15 | 2015/16 | 2016/17 |
|---|---|---|---|---|---|
| England | 1.7 | 1.7 | 1.8 | 1.9 | 1.9 |
| East Midlands | 1.4 | 1.3 | 1.3 | 1.3 | 1.6 |
| Leicestershire | 1.0 | 1.1 | 1.0 | 1.1 | 1.0 |

### 1.1.4. Unemployment

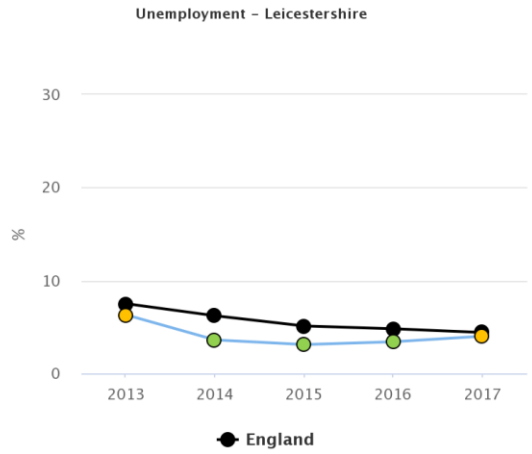
Unemployment is associated with an increased risk of ill health and mortality. There are relationships between unemployment and poor mental health and suicide, higher self-reported ill health and limiting long term illness and a higher prevalence of risky health behaviours including alcohol use and smoking, all which can impact on children.

Model-based estimates of unemployment are taken from the Labour Force Survey. These are based on a model which utilises Annual Population Survey estimates of unemployment along with the number of people claiming Jobseekers Allowance (JSA) averaged over 12 months, from claimant count data. The model-based estimates are considered to be

generally more reliable then estimates based on Labour Force Survey data and confidence intervals are tighter.[4]

The data shows approximately 14,000 adults aged 16+ were unemployed in Leicestershire in 2017, equivalent to 4.0% of the adult population. This is similar to the national average of 4.4%. The unemployment rate for the previous three years in Leicestershire, between 2014 to 2016, performed significantly better than the national average.[4] Please note, data solely examining parents or carers who are unemployed or economically inactive is not available.

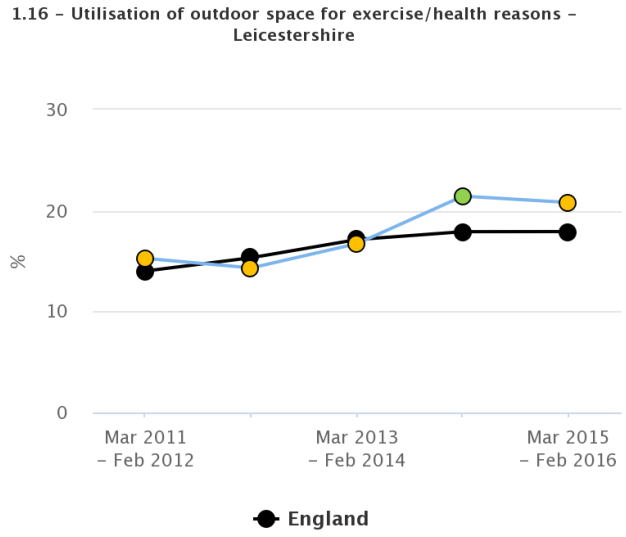
**Figure 2: Trend of unemployment in Leicestershire[4]**




### 1.1.1. Access to outdoor space for exercise/health reasons

There is strong evidence to suggest that green spaces have a beneficial impact on physical and mental wellbeing and cognitive function through both physical access and usage, across the life course. In Leicestershire, an estimated 20.8% of people were using outdoor space for exercise/health reasons in the period March 2015 – Feb 2016. This is similar to the national percentage of 17.9%. Locally the percentage has declined from 21.4% in the previous time period.[23]

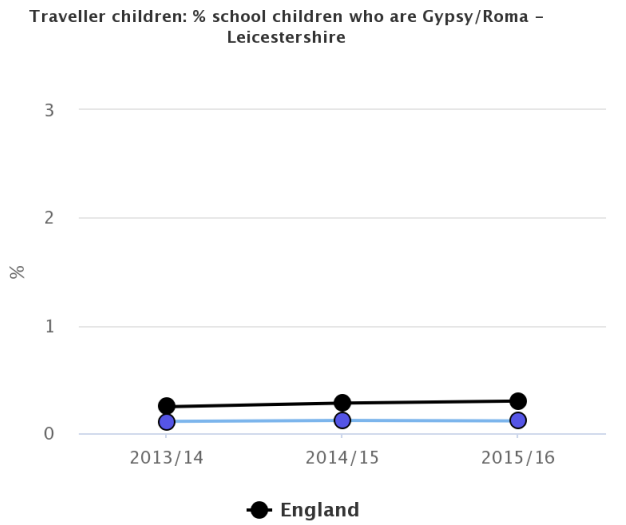
**Figure 3: Trend in utilisation of outdoor space for exercise/health reasons in Leicestershire**




### 1.1.2. Traveller children

The percentage of state primary and secondary school children whose ethnic group is Gypsy/Roma, of all children whose ethnic group is classified, in Leicestershire has remained significantly below the national average for the past three years. The latest data for 2015/16 shows 97 children in Leicestershire were Gypsy/Roma, equating to 0.1% of all state primary and secondary school children in the county. Nationally the percentage was 0.3%.[40]

**Figure 4: Trend of school children who are Gypsy/Roma in Leicestershire[40]**

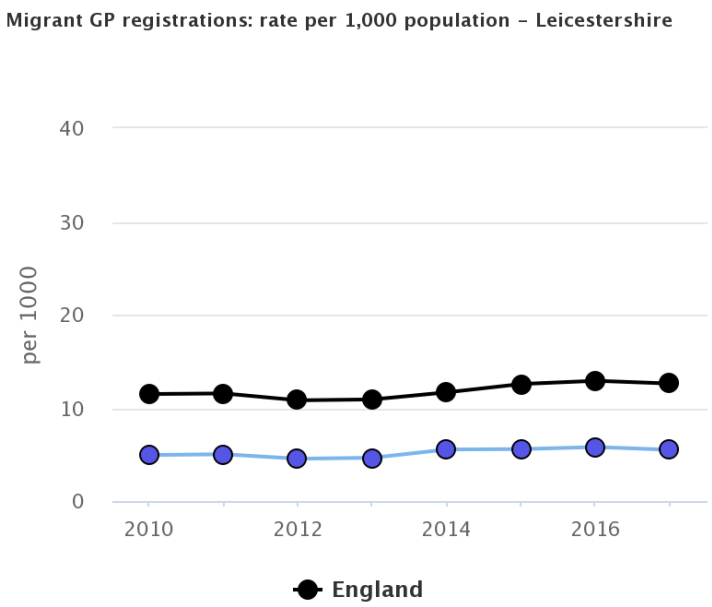


### 1.1.3. Refugees

High levels of migration into an area can impact on existing health care provisions. New arrivals into areas may include UK-based migration, economic migrants seeking employment in the UK, or refugees arriving from areas of conflict. Reviews have found these groups are exposed to risk factors before, during and after migration. The pre-migration risks include traumatic events, exposure to conflicts and persecution. Post-migration risks include the uncertainty of asylum status, detention and reduced social integration.[5]

Figure 5 shows the trend of migrant GP registration in Leicestershire. Locally there has been a significant increase in migrant GP registrations over the last five years despite continuing to perform significantly lower than the national rate since recording (in 2010). In 2017, there were 3,794 GP registrations from someone that was previously living overseas.[9]

**Figure 5: Trend of migrant GP registrations in Leicestershire[9]**




## 1.2. Factors affecting family resilience

### 1.2.1. Age of pregnancy

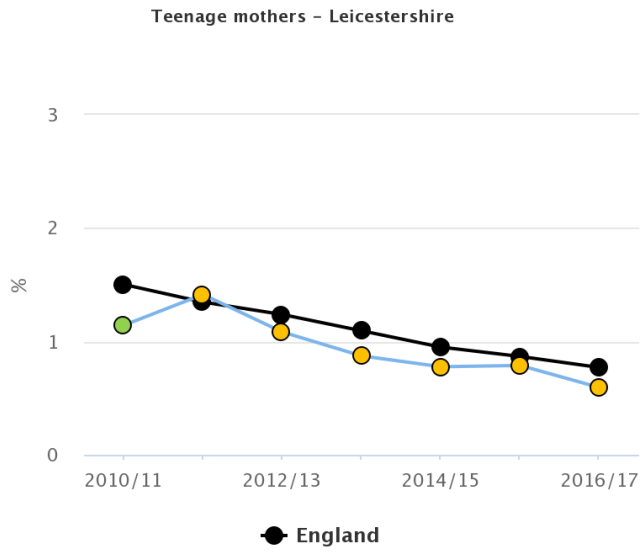
NICE guidelines states that pregnancy in under 18 year olds can lead to "poor health and social outcomes for both the mother and child[6]" for example: "…resulting children are at greater risk of low educational attainment, emotional and behavioural problems, maltreatment or harm, and illness, accidents and injuries[7]".

The NICE guidance on social and emotional wellbeing in the early years[29] lists being born to

parents aged under 18 years as a factor that can make children vulnerable to poor wellbeing. Young mothers are also more at risk of developing postnatal depression than average.[8]

Figure 6 shows the trend of deliveries to mothers aged under 18 years in Leicestershire. Both nationally and locally there has been a significant decline in teenage mothers over the last five years.[40] In 2017, there were 39 deliveries to teenage mothers in Leicestershire and Rutland. It is important to note that not all babies born to teenage parents will be brought up by them. Also, although a high number of teenage parents in a population is a risk factor for higher levels of poor infant mental health, on an individual level many teenage parents will parent effectively and raise healthy children. In addition, it is worth considering whether younger adult parents (those in their late teens or early twenties) may require extra support, especially those who are vulnerable or lack family support.

**Figure 6: Trend of percentage of delivery episodes where the mother is aged under 18 years in Leicestershire[40]**




### 1.2.2. Long-term health problem or disability

The 2011 Census examined the proportion of the population that have a health problem or disability that limits their day-to-day activities and has lasted, or is expected to last, at least 12 months. In Leicestershire over 105,000 residents reported to have a long-term health problem or disability equating to 16.2% of the population. This is significantly lower than the national percentage of 17.6%.[9]

For information on mental health of adults in Leicestershire, please visit the published JSNA

chapter, available here: http://www.lsr-online.org/leicestershire-2018-2021-jsna.html

### 1.2.3. Domestic abuse

An association has been found between domestic abuse and antenatal depression, postnatal depression, anxiety and post-traumatic stress disorder (PTSD).[10] A systematic review and meta-analysis found that: "… high levels of symptoms of all types of perinatal mental disorders included in studies to date (i.e., antenatal and postnatal anxiety, depression, and PTSD) were associated with having experienced domestic violence, although causality cannot be inferred.[10]" A high level of domestic violence in an area indicates the population is more at risk of mental health problems in pregnancy and the year after childbirth.

Living in a household where domestic violence is occurring is also a risk factor for poor mental health in babies and toddlers: "The impact of living in a household where there is a regime of intimidation, control and violence differs by children's developmental age. However, whatever their age, it has an impact on their mental, emotional and psychological health and their social and educational development.[11]"

In 2016 there were 18.7 domestic abuse incidents per 1,000 population reported to the police force area which covers Leicestershire, Leicester and Rutland compared to 22.5 per 1,000 nationally. Please note these rates relate to all incidents and are not restricted to those involving households containing children or pregnant women.

### 1.2.4. Drug and alcohol misuse

If a parent or caregiver misuses alcohol or drugs, there can be an impact on a baby or toddler's development, often due to parenting problems: "Research has shown that parents misusing substances are at risk of a wide range of difficulties associated with their role as a parent. These may include a lack of understanding about child development issues, ambivalent feelings about having and keeping children and lower capacities to reflect on their children's emotional and cognitive experience.[12]"

In terms of alcohol misuse, NICE guidance stresses the importance of taking account of "the impact of the parent's drinking on the parent–child relationship and the child's development, education, mental and physical health, own alcohol use, safety, and social network[13]".

The NSPCC report 'All babies count: spotlight on drugs and alcohol' highlights the effect of alcohol misuse on parenting: "Problematic drinking by parents is associated with negative parenting practice…and parenting capacity can be compromised when parents become

increasingly focused on drinking and as a result become less loving, caring, nurturing, consistent or predictable.[12]"

In 2000, the Advisory Council on the Misuse of Drugs launched an inquiry into the children of problem drug users. It found that "parental problem drug use can and often does compromise children's health and development at every stage from conception onwards.[14]"

Looking at the impact at different stages of a child's life, the inquiry found that from birth to age two: "The foundation of a child's normal development is a good relationship with a well parent or primary care giver…who is consistently able to provide nourishment, stimulation and protection from danger and give the child a sense of well-being and security. Much of the potential for parental drug use to damage the child in these early months lies in the way it can obstruct or corrupt this relationship.[14]"

At 3-4 years of age "parental problem drug use can continue to jeopardise the child's development in many ways[14]", including being left unsupervised or neglected, physical violence or emotional abuse and less time stimulated through play or reading.[14]

The National Treatment Agency for Substance Misuse[15] found that during 2011/12, one third of adults in treatment lived in a household containing children (this includes parents living with their own children and adults living in a house with children who are not theirs, for example step-children or grandchildren). Parents who live with their own children tend to have fewer drug-related problems than others in treatment, are less likely to use the most addictive drugs, and are less likely to inject drugs when compared to non-parents in treatment.[15] They are also less likely to be homeless or arrive in treatment via the criminal justice system.[15]

In 2011/12, the rate of parents in alcohol treatment rate in Leicestershire was 139.9 per 100,000 children aged 0-15 years, similar to the national rate of 147.2 per 100,000 children aged 0-15 years. In the same year, the rate of parents in drug treatment rate in Leicestershire was 62.3 per 100,000 children aged 0-15 years, significantly lower than the national rate of 110.4 per 100,000 children aged 0-15 years.[16]

Local data from the National Drug Treatment Monitoring System (NDTMS) presents information on alcohol and drug treatment services, hospital admissions and drug/alcohol related deaths. The data shows in Leicestershire there were 91 drug users who entered treatment who lived with a total of 151 children in 2017-18. These drug users represented 18% of new presentations to treatment services in the year, an identical percentage to the national average.[17] In the same time period in Leicestershire, there were 111 alcohol clients who entered treatment who lived with a total of 182 children in 2017-18. These alcohol

clients represented a quarter (25%) of new presentations to treatment services in the year, a higher percentage than the national average (24%).[18]

#### 1.2.5. Parental separation

According to the 2011 Census, the percentage of adults whose current marital status is separated or divorced in Leicestershire was 11.0%. This accounts for over 58,000 adults in the county. The local percentage is significantly lower than the national average of 11.6%.[9]

#### 1.2.6. Family support

Women who lack social support have been found to be at increased risk of antenatal and postnatal depression.[19] Having a poor relationship with a partner is also a risk factor for postnatal depression.[19] ONS statistics show that infant mortality rates are higher among babies that are registered by just one parent than for other registration types.[20]

The number of births which were registered by just one parent potentially gives a rough indication of the number of women that are likely to lack the support of the father during pregnancy and as a new mother. In 2016 in Leicestershire, 4.0% of births were registered by just one parent which is lower than the national average of 5.1%.[21]

### 1.3. Healthy pregnancy

#### 1.3.1. Smoking in pregnancy

Smoking in pregnancy has well known detrimental effects for the growth and development of the baby and health of the mother. Smoking during pregnancy can cause serious pregnancy-related health problems. These include complications during labour and an increased risk of miscarriage, premature birth, stillbirth, low birth-weight and sudden unexpected death in infancy.

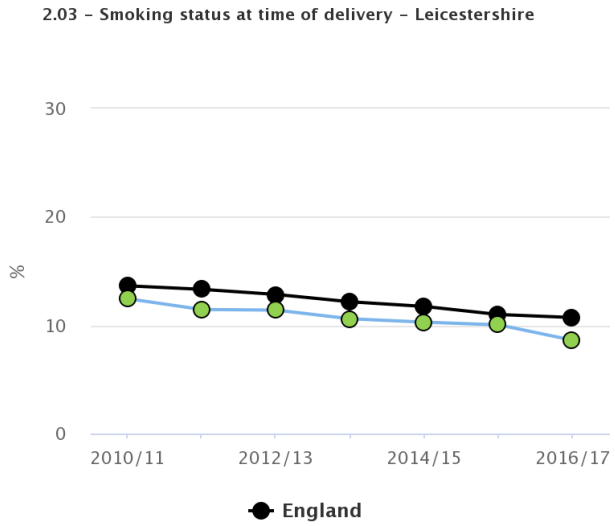
Encouraging pregnant women to stop smoking during pregnancy may also help them to become non-smokers, and so provide health benefits for the mother and reduce exposure to second-hand smoke for the infant. Leicester, Leicestershire and Rutland Child Death Overview Panel (LLR CDOP) undertakes a comprehensive and multi-agency review of all child deaths. Of the 425 cases reviewed by CDOP between 1st April 2011 and 31st March 2017, parental smoking was thought to have contributed to the ill–health, vulnerability or death of the child in 25 cases (6% of cases)[55].

The Tobacco Control Plan[22] contained a national ambition to reduce the rate of smoking throughout pregnancy to 11% or less by the end of 2015 (measured at time of giving birth). Nationally (11.0%) and locally this was met (10.0%), however in Leicestershire and Rutland

(combined) 705 women still smoked at the time of delivery in 2015/16.[23]

In July 2017 the Department of Health published an updated Tobacco Control Plan[24] which contained a national ambition to reduce the rate of smoking throughout pregnancy to 6% or less by the end of 2022. Latest trend analysis has shown the proportion of women smoking at time of delivery has reduced significantly in Leicestershire and Rutland (combined) since 2010/11, from 12.4% to 8.6%, equating to 313 fewer women in 2016/17.[23]

**Figure 7: Trend of Smoking Status at Time of Delivery in Leicestershire**




Examining the latest data in 2016/17 by Leicestershire districts shows the highest rate of smoking throughout pregnancy was witnessed in North West Leicestershire (9.9%) and Hinckley and Bosworth (9.9%). Melton and Oadby and Wigston had the lowest rates in Leicestershire at 7.0% in both districts. Harborough and Blaby also had a significantly better rate than nationally at 7.3% and 7.4% respectively.[23]

According to the most recent data at CCG level (Quarter 1, 2018/19) there is variation within Leicestershire and Rutland, ranging from 6.0% of women smoking at the time of delivery in NHS East Leicestershire and Rutland to 10.2% in NHS West Leicestershire.[25]

### 1.3.2. Maternal obesity

The Maternity Services Data Set (MSDS) has been developed to help achieve better outcomes of care for mothers, babies and children using NHS-funded maternity services in England. It provides comparative data that will be used to improve clinical quality and reduce health inequalities. One indicator examined is the Body Mass Index (BMI) of women attending booking appointments. Height and weight are required data items which are submitted to the MSDS if they are locally recorded.

In 2017/18, the percentage of women attending University Hospitals of Leicester NHS Trust with an overweight and obese BMI at the time of their booking appointment was 29% and 22% respectively (excluding missing values). Nationally, the percentage with an overweight and obese BMI at the time of their booking appointment was lower at 26% and 21% respectively.[26]

Healthy eating and physical activity are considered to be important during pregnancy. Therefore, pregnant women with a body mass index of 30 or more at the booking appointment should be offered personalised advice from an appropriately trained person on healthy eating and physical activity.

### 1.3.3. Perinatal mental health

The social and emotional wellbeing of a baby or toddler can be affected by whether the mother has a mental health problem herself, often due to the effect on the mother-baby relationship[272829]: "…. emotional distress and problems during pregnancy, childbirth and the postnatal period warrant particular attention because of the longitudinal impact these difficulties have on the developing foetus and newborn baby, effects which are often mediated through the woman's disrupted relationship with her infant.[28]"

It is believed that between 10% and 20% of women will be affected by mental health problems at some point during their pregnancy or the first year after childbirth.[30] Perinatal mental health is defined as the antenatal period (during pregnancy) and the postnatal period (up to one year after childbirth). Mental health issues that arise during the perinatal period can vary in severity from anxiety and depression through to post traumatic stress disorder (PTSD) and postpartum psychosis. For women who have had a history of bipolar disorder, there is an increased risk of a relapse at this time. Although these conditions can affect anyone with mental health problems, the concern with mental health problems in perinatal women is that it can affect the foetus, baby, family and the mother's physical health.[30]

Table 2 shows in 2015/16, the most prevalent disorder affecting postpartum women in Leicestershire was adjustment disorders and distress, affecting between 15.1% - 30.0% of mothers in Leicestershire. This equates to between 955 and 1905 mothers in the county. Mild-moderate depressive illness and anxiety was the second most prevalent condition affecting between 10.0% - 15.1% of mothers in Leicestershire. It is estimated that severe depressive illness affected 3.1% of postpartum woman (195) in Leicestershire. It is important to remember that failure to treat perinatal depression can result in a prolonged and harmful effect on the relationship between the mother and baby. Evidence suggests that postnatal depression "may be associated with lower cognitive and language

achievements" in young children.[31]

**Table 2: Estimated number and percentage of mental health conditions of postpartum women in Leicestershire in 2015/16[32]**

In Leicestershire, 6,344 women gave birth in 2015/16[33]:

| | *Count | *Percentage |
|---|---|---|
| Estimated number of women with adjustment disorders and distress (upper estimate) | 1905 | 30.0% |
| Estimated number of women with mild-moderate depressive illness and anxiety (upper estimate) | 955 | 15.1% |
| Estimated number of women with adjustment disorders and distress (lower estimate) | 955 | 15.1% |
| Estimated number of women with mild-moderate depressive illness and anxiety (lower estimate) | 635 | 10.0% |
| Estimated number of women with severe depressive illness | 195 | 3.1% |
| Estimated number of women with PTSD | 195 | 3.1% |
| Estimated number of women with postpartum psychosis | 15 | 0.2% |
| Estimated number of women with chronic SMI | 15 | 0.2% |

Please note, figures are based on national estimates and must not be added together to give an overall estimate as some women may suffer from more than one condition.

Post-traumatic stress disorder is a mental health disorder that can occur after birth related traumas, stillbirth, the death of a baby or sometimes from an uncomplicated delivery.[34] It is estimated there are 195 women in Leicestershire (3.1%) who suffered from PTSD in the perinatal period in 2015/16.[35]

It is recognised that some fathers may also suffer from mental health issues over this period however there is very little data available to examine this.

## 1.4. Issues affecting life journey

### 1.4.1. Adverse Childhood Experiences

Adverse childhood experiences (ACEs) are very traumatic and stressful experiences that occur in childhood and can lead on to suffering from physical and mental health conditions in adulthood. ACEs can cover a multitude of events (many described earlier in this chapter) from maltreatment, violence (including sexual assault and domestic violence), coercion and prejudice through to inhumane treatment, adult responsibilities (being a young carer), bereavement and surviving an accident or illness. They can impact upon a child's development and their relationships with others which could result in social isolation and mental health problems.[36]

There are many protective factors to assist in keeping children safe and well. This includes having positive and supporting family environments, safe and mutual relationships with peers and compassionate and supportive responses from professionals including early

intervention and support from safeguarding services.[36]

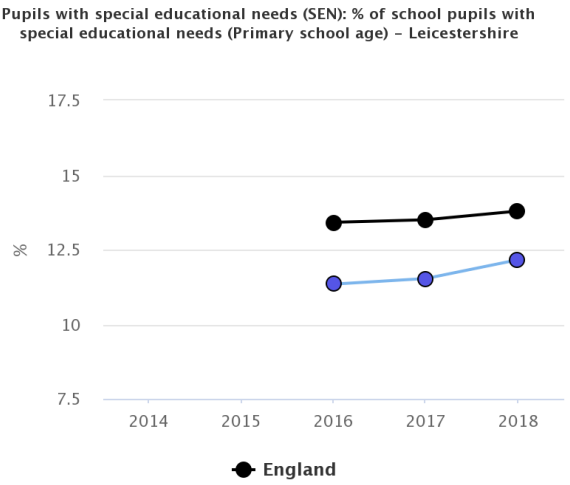
People with four or more ACEs are more likely to engage in risky behaviour. They are twice as likely to binge drink, five times more likely to have under age sex, and 11 times more likely to have been incarcerated and/or to have used illicit drugs.[36]

## 1.5. Vulnerable Children

### 1.5.1. Special Educational Needs

In Leicestershire the percentage of pupils with special educational needs (SEN) in primary school age has remained significantly lower than the national percentage for the past three years. However, locally the percentage has increased at a faster rate compared to nationally over the past three years. In 2018, 6,585 primary school pupils in Leicestershire were identified as having special educational needs, 12.2% of all primary school pupils.[40]

**Figure 8: Trend in primary school pupils with special educational needs in Leicestershire[40]**




### 1.5.2. Looked After Children

There are risks to babies' and toddlers' mental health associated with the experience of being in care, as mentioned in the NICE guidance on looked after children and young people:

"Evidence suggests that frequent moves…can adversely affect the ability of babies and very young children to form healthy attachments that lead to healthy emotional and physical development.[37]"

"The absence of a permanent carer at such a young age can jeopardise children's chances of developing meaningful attachments and have adverse consequences for their long-term

wellbeing.[37]"

"Very young children can become closely attached to foster care families and can experience great distress if moved to a new placement.[37]"

In Leicestershire the numbers and rates for looked after children (LAC) aged under 18 have been increasing over the last four years, from 435 in 2012/13 to 470 in 2015/16. There has been an increase in the rates for looked after children aged 10-15 years between 2014 to 2016 across the local authority and nationally, whilst there has been a decrease in the rate of looked after children under 5 for Leicestershire between 2014/15 to 2016/17.[40] Although Leicestershire has a significantly lower rate of looked after children across all ages compared to national (Figure 9), LAC in Leicestershire have a higher average difficulties score and a significantly higher percentage of looked after children with a cause for concern compared to nationally (Figure 10 and Figure 11).[23]

**Figure 9: Trend of Looked After Children in Leicestershire by Age[40]**

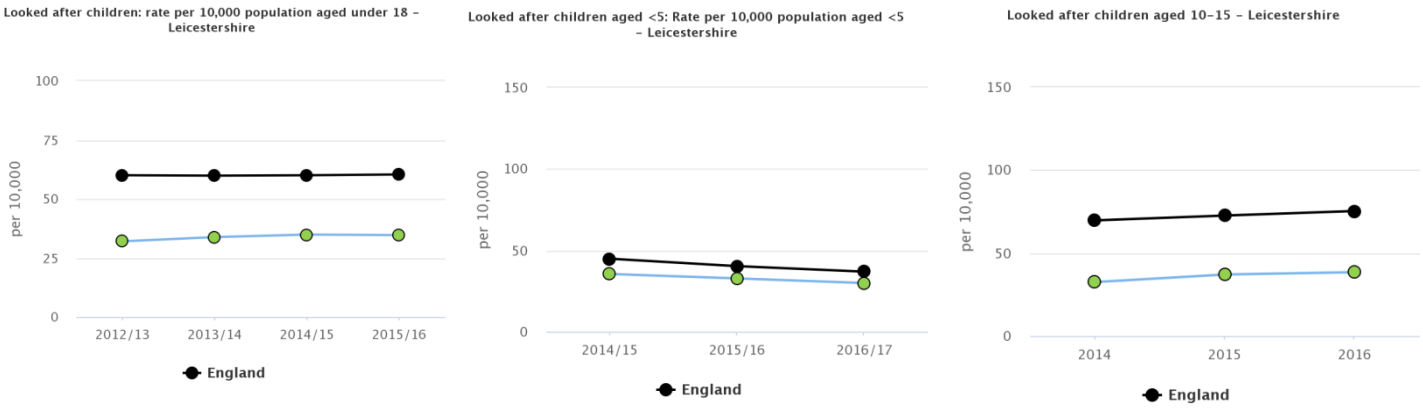


**Figure 10: Trend of average difficulties score for all looked after children aged 5-16 who have been in care for at least 12 months on 31st March in Leicestershire[23]**

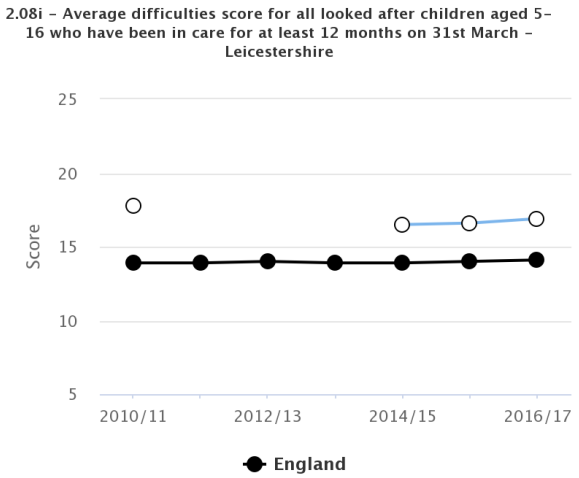
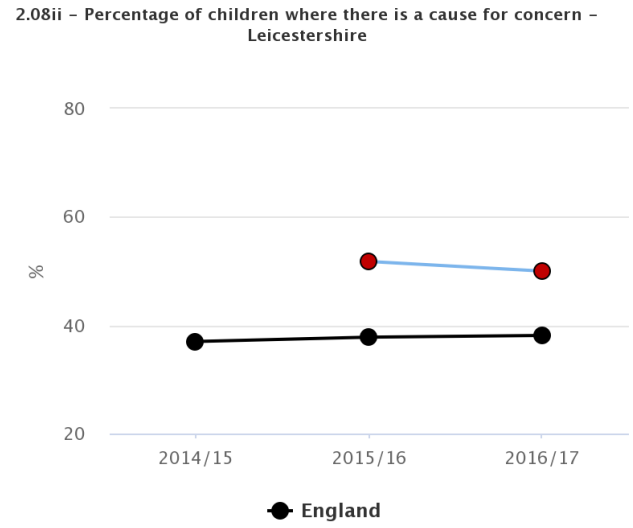



**Figure 11: Trend of percentage of children where there is a cause for concern in Leicestershire[23]**




## 2. Level of need in Leicestershire

### 2.1. Children in Leicestershire

#### 2.1.1. Population

In 2017 the total population of Leicestershire was 690,212. There were 44,784 persons aged 0-5 years in the county, equating to 6.5% of the total population. This is lower than the national proportion of 7.4%. Throughout the Leicestershire districts, the highest proportion of 0-5s were found in Blaby (7.0%) and the lowest in Harborough (6.1%), whereas the

highest absolute numbers were found in Charnwood (11,468) and the lowest in Melton (3,173).[38]

For more information on the Leicestershire population, please see the Demography Report, available here: http://www.lsr-online.org/leicestershire-2018-2021-jsna.html

### 2.1.2. Births

There were 6,946 live births in Leicestershire in 2017, a decrease of 2.4% from 2016 and the lowest number of live births for the last three years.[39]

The Total Fertility Rate (TFR) examines the average number of live children that a group of women would bear if they experienced the age-specific fertility rates of the calendar year throughout their childbearing lifespan. In 2017, the TFR declined to 1.70 children per woman, the lowest rate in five years following a gradual increase from 1.72 in 2013 to 1.77 in 2016.[39]

The general fertility rate (GFR) examines the live births occurring to females aged 11 years and over divided by females aged 15-44 years in the population. In Leicestershire the GFR has remained significantly lower than the national rate since 2010 (since recording). In the Leicestershire districts, Blaby has the highest GFR at 62.4 per 1,000 females aged 15 to 44 years and Charnwood the lowest at 49.9 per 1,000 females aged 15 to 44 years in 2017.[39]

Both nationally and locally, the fertility rate was highest for mothers aged 30-34, with this age grouphaving the highest birth rate over the last five years. Those aged 25-29 have the second highest birth rate, followed by those aged 35-39 years. In Leicestershire compared to the previous year, fertility rates decreased for all age groups in 2017, except for women in the youngest and oldest age groups. However please be aware the number of live births in these age groups are low. For women aged under 18, the rate increased by 8.1% to 4.0 births per 1,000 women and for women aged 40 years and over, the rate increased by 16.7% to 0.7 births per 1,000 women.[39]

The average age of mothers in Leicestershire in 2017 increased to 30.6 years from 30.4 years in 2016. In England, the average age has remained constant over the last two years at 30.5 years.[39]

### 2.1.3. Stillbirth

Stillbirth refers to a death in the womb of a baby over 24 week's gestation.

As numbers per Local Authority are small it is useful to pool several years' worth of data in order to better understand the information. Between 2014-16 there were 95 stillbirths in

Leicestershire and Rutland (combined), this equates to over two per month and a rate of 4.3 per 1,000 total births which is similar to the national rate of 4.5 per 1,000 total births.[40]

Between 2010-12 and 2014-16, the national rate of stillbirths has fallen over the last four time periods. In Leicestershire, although the rate fluctuates due to small numbers, for the latest three time periods, the rate has remained similar to the national average.

## 2.2. Development

### 2.2.1. Development progress at aged 2

All children in England are eligible for a development review around their second birthday, led by the local health visiting service. This is an opportunity to identify children who are not developing as expected and who may require additional support in order to maximise their learning and development so that they are ready for school by age 5. This development review is currently assessed using the Ages and Stages Questionnaire (ASQ-3$^{TM}$).[41]

In 2017/18 the proportion of children aged 2-2½yrs receiving ASQ-3 as part of the Healthy Child Programme or integrated review in Leicestershire was 93.8%. This is significantly better than the national average of 90.2%.[23]

During the review health professionals work with parents to complete the ASQ-3 questionnaire, to measure the development of children at specific ages across five domains: Communication, Gross Motor, Fine Motor, Personal/Social and Problem Solving. Each domain has a minimum score threshold, indicating that a child's development appears to be on schedule.[41]

The data on child development outcomes reported here are from supplementary metrics for the number of health visitor reviews completed at 2-2½ years using ASQ-3. The data for ASQ-3$^{TM}$ outcomes in Leicestershire only began being reported in 2018/19. The Q1 2018/19 data showed[41]:

- The total number of children who received a 2-2½ year review in the quarter for whom the ASQ-3$^{TM}$ was completed was 1,540.
- The percentage of children who were at or above the expected level in communication skills was 97.5%
- The percentage of children who were at or above the expected level in gross motor skills was 97.5%.
- The percentage of children who were at or above the expected level in fine motor

skills was 99.7%.

- The percentage of children who were at or above the expected level in problem solving skills was 98.7%.
- The percentage of children who were at or above the expected level in personal-social skills was 99.1%.
- The percentage of children who were at or above the expected level in all five areas of development was 93.4%.

### 2.2.2. Early years entitlement

All 4 year olds have been entitled to a funded early education place since 1998 and in 2004 this was extended to all 3 year olds. Since September 2010, all 3 and 4 year olds have been entitled to 570 hours a year of funded early education over no fewer than 38 weeks of the year (which equates to 15 hours a week for 38 weeks of the year). This is referred to as the **universal funded early education entitlement**.[42]

From September 2013, the entitlement to 15 hours of funded early education per week for 38 weeks of the year was extended to 2 year olds from families in receipt of specified benefits and 2 year olds who were looked after by the local authority. The entitlement for 2 year olds was further extended in September 2014 to children in low income families, children with a statement of SEN or an Education, Health and Care Plan, children in receipt of Disability Living Allowance and children who are no longer looked after by a local authority as a result of an adoption order, a special guardianship order or a child arrangements order which specifies with whom the child is to live. In April 2018 the eligibility criteria for 2 year olds to benefit from a funded early education place were changed to reflect the introduction of Universal Credit.[42]

In September 2017, the government doubled the funded early education entitlement for 3 and 4 year olds from working families who meet the eligibility criteria to 30 hours a week for 38 weeks of the year (or 1,140 hours a year over no fewer than 38 weeks of the year). This is referred to in this publication as the **extended funded early education entitlement**. The entitlement was extended to 30 hours free childcare for families where both parents are working (or the sole parent is working in a lone parent family), and each parent earns a weekly minimum equivalent to 16 hours at national minimum wage or living wage, and less than £100,000 per year.[42]

#### 2.2.2.1. Universal funded early education entitlement

In 2018 in Leicestershire[42]:

- 75% of 2 year olds benefitted from universal funded early education, the same as in 2017 and higher than 59% in 2015.
- 98% of 3 year olds benefitted from universal funded early education, this has gradually increased from 92% in 2011.
- 103%* of the 4 year old population benefitted from universal funded early education, an increase from 102%* in 2017.
- 101%* of the 3 and 4 year old population benefitted from universal funded early education, the highest percentage since recordings began.

#### 2.2.2.2. Extended funded early education entitlement

In January 2018, 4,536 3 and 4 year old children in Leicestershire benefitted from the extended early entitlement (up to an additional 15 hours – meaning a total of up to 30 hours entitlement). All (100%) of 3 and 4 year olds benefitting from the extended entitlement did so in a private, voluntary or independent provider. Almost all (96%) of all 3 and 4 year olds benefitted from the extended entitlement at a setting rated good or outstanding by Ofsted.[42]

### 2.2.3. Early Years Foundation Stage Profile (EYFSP)

The Early Years Foundation Stage Profile (EYFSP) is a teacher assessment of children's development at the end of the EYFS (the end of the academic year in which the child turns five). It should support a smooth transition to key stage 1 (KS1) by informing the professional dialogue between EYFS and KS1 teachers. This information should help Year 1 teachers plan an effective, responsive and appropriate curriculum that will meet the needs of all children. The profile is also designed to inform parents or carers about their child's development against the early learning goals (ELGs).[43]

* Population estimates at local authority, for example, are subject to a greater degree of error. In some cases, local authority take-up rates can exceed 100%. Therefore, take-up rates at local authority level should be treated with more caution than national take-up rates. The sources used in the calculation of take-up rates for 3- and 4-year-olds are consistent over time, allowing users to see any change in local authority level take-up rates over time.

The EYFS framework contains 17 early learning goals in seven areas of learning covering children's physical, intellectual, emotional and social development:

**Table 3: Early Years Foundation Stage Framework[43]**

| Area of learning | | Early learning goal | Part of the good level of development measure |
|---|---|---|---|
| Prime areas of learning | Communication and language | 1: Listening and attention | Yes |
| | | 2: Understanding | Yes |
| | | 3: Speaking | Yes |
| | Physical development | 4: Moving and handling | Yes |
| | | 5: Health and self-care | Yes |
| | Personal, social and emotional development | 6: Self-confidence and self-awareness | Yes |
| | | 7: Managing feelings and behaviour | Yes |
| | | 8: Making relationships | Yes |
| Specific areas of learning | Literacy | 9: Reading | Yes |
| | | 10: Writing | Yes |
| | Mathematics | 11: Numbers | Yes |
| | | 12: Shape, space and measures | Yes |
| | Understanding the world | 13: People and communities | No |
| | | 14: The World | No |
| | | 15: Technology | No |
| | Expressive arts, designing and making | 16: Exploring and using media and materials | No |
| | | 17: Being imaginative | No |

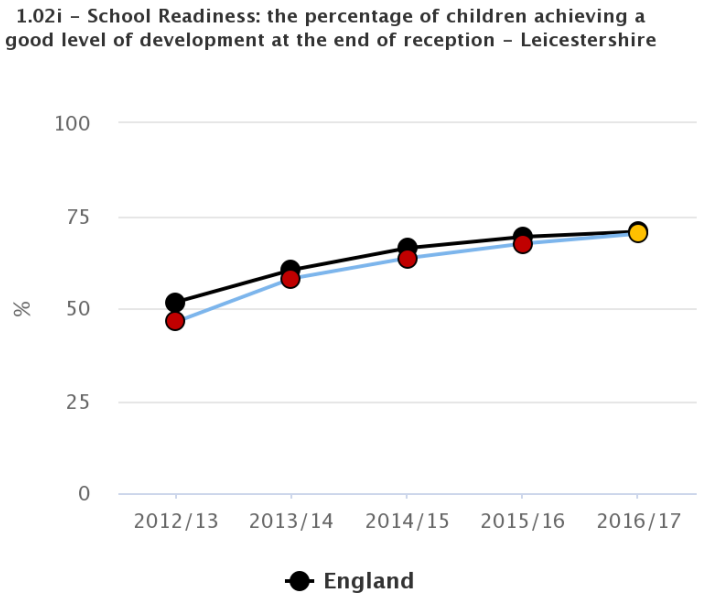
#### 2.2.3.1. Good Level of Development

School readiness is a key measure of early years' development across a wide range of developmental areas. Children from poorer backgrounds are at increased risk of poor development and the evidence shows that differences by social background emerge early in life.

Children are defined as having reached a good level of development if they achieve at least the expected level in the early learning goals in the prime areas of learning (personal, social and emotional development; physical development; and communication and language) and the early learning goals in the specific areas of mathematics and literacy.

In 2016/17 70.1% of children in Leicestershire achieved a good level of development at the end of reception class (the first year of school). This is similar to the England average (70.7%).[23] The percentage has significantly increased over the last five years from 46.3% in 2012/13 as shown in Figure 12.

**Figure 12: Trend in the percentage of children achieving a good level of development at the end of reception in Leicestershire**




There are inequalities between the genders in terms of development at this age with 64.1% of boys achieving a good level compared to 76.6% of girls in 2016/17. However for both measures, Leicestershire performs similar to England (64.0% for boys and 77.7% of girls nationally).[23]

School readiness is also measured for those children with free school meal (FSM) status. For this measure only 46.4% of children in Leicestershire achieve a good level of development in 2016/17, significantly worse than 56.0% nationally. This is considerably lower than school readiness for the overall population of the Leicestershire (70.1%). This indicator has performed significantly worse than the national average for the past five years, but despite this, improvements have been seen as the percentage has significantly increased from 24.7% in 2012/13.[23]

Despite females outperforming males in the good level of development FSM status indicator, the latest data in 2016/17 shows females with free school meal status in Leicestershire (50.4%) performs significantly worse than the national average of females with FSM status (64.4%), while males with FSM status in the county (43.0%) perform similar to the national average of males with FSM status (48.1%).[23]

## 2.3. Good health

### 2.3.1. Breastfeeding

The latest available data shows the proportion of women initiating breastfeeding in Leicestershire (70.9%) performed significantly worse than England (74.0%) in 2015/16. No data is available at a county level in 2016/17 due to data quality issues.[23]

At a district level in 2016/17, all districts in the county apart from Harborough performed significantly worse than the national average, ranging from 65.7% in North West Leicestershire to 71.1% in Charnwood. Harborough performed similar to the national average (74.5%) with a breastfeeding initiation percentage of 77.5%.[23]

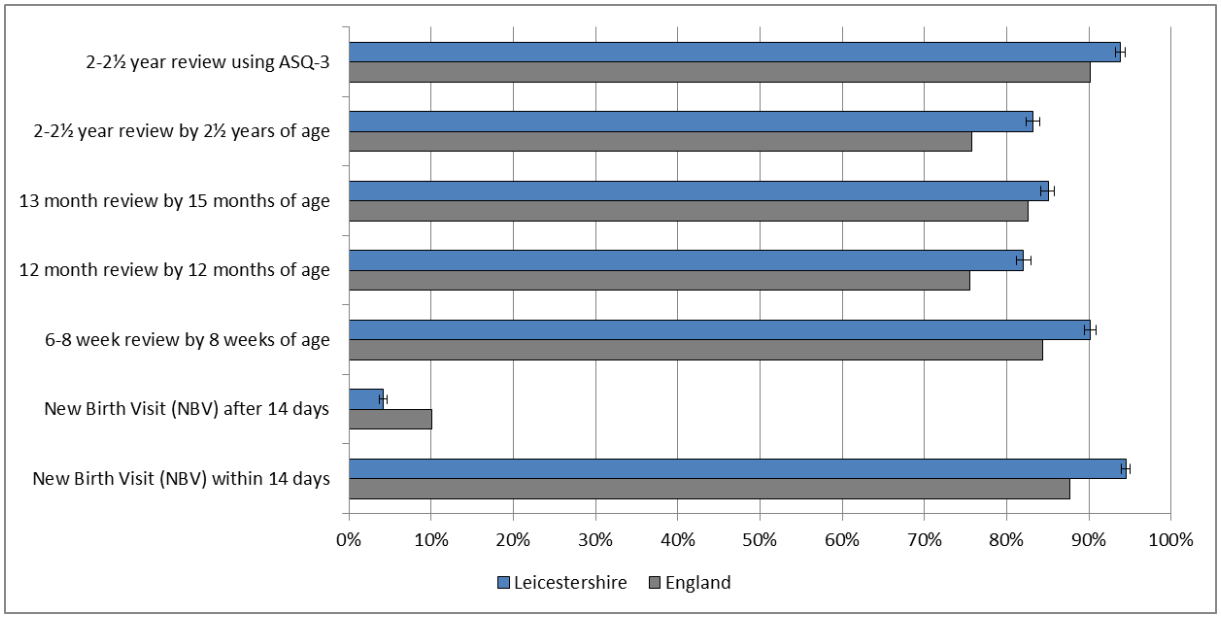
In 2017/18 45.0% of women in Leicestershire are breastfeeding at 6-8 weeks after birth, which is significantly better than England (42.7%). Local trend data is not available due to data quality issues.[23]

This data infers that although fewer women initiate breastfeeding in Leicestershire, those that do are able to maintain for longer which may be linked to better support.

### 2.3.2. Health visiting

Figure 13 shows the proportion of children who received their mandated health visitor check by age group. Leicestershire is performing significantly better than the national percentage at all checks in 2017/18.[44]

**Figure 13: Percentage of children seen by a health visitor at the mandated visits by the appropriate age, Leicestershire and England, 2017/18**




### 2.3.3. New-born screening and immunisations

#### 2.3.3.1. Screening

Historically, HIV coverage has been used as the proxy for all infectious diseases screening in pregnancy. The achievable standard for this Key Performance Indicator (KPI) is 95% and performance currently lies at 99.5% in 2016/17 for University Hospitals of Leicester NHS Trust.[45]

For newborn bloodspot, the "coverage" figure relates to the percentage of eligible children who have a result recorded within 17 days of birth. This coverage is classified as within a defined period of time. In 2016/17 the coverage was 96.5% across NHS East Leicestershire and Rutland and 95.3% across NHS West Leicestershire, which is above the acceptable standard of 95% for this KPI.[45]

**Table 4: Antenatal screening programme KPIs: Annual 2016 to 2017[45]**

| | | **Antenatal infectious disease screening** (145 maternity services) | | **Fetal anomaly screening** (145 maternity services) | **Antenatal sickle cell and thalassaemia screening** (145 maternity services) | | |
|---|---|---|---|---|---|---|---|
| | | Acceptable ≥ 95.0% | Acceptable ≥ 70.0% | Acceptable ≥ 97.0% | Acceptable ≥ 95.0% | Acceptable ≥ 50.0% | Acceptable ≥ 95.0% |
| | | Achievable ≥ 99.0% | Achievable ≥ 90.0% | Achievable = 100% | Achievable ≥ 99.0% | Achievable ≥ 75.0% | Achievable ≥ 99.0% |
| | | **HIV coverage (%)** | **Hepatitis B referral (%)** | **Laboratory form completion (%)** | **Coverage (%)** | **Timeliness of test (%)** | **Completion of FoQ (%)** |
| **Area** | **England** | **99.5** | **80.3** | **97.4** | **99.3** | **53.1** | **97.3** |
| | Midlands & East | 99.3 | 84.3 | 97.4 | 99.2 | 56.8 | 97.3 |
| | UHL | 99.5 | 89.5 | 93.1 | 99.4 | 61.8 | 100.0 |

**Table 5: Newborn hearing screening programme KPIs: Annual 2016 to 2017[45]**

| | | **Newborn hearing screening** (109 sites)[1] | |
|---|---|---|---|
| | | Acceptable ≥ 97.0% | Acceptable ≥ 90.0% |
| | | Achievable ≥ 99.5% | Achievable ≥ 95.0% |
| | | **Coverage (%)** | **Assessment within 4 weeks (%)** |
| **Area** | **England** | ***98.4*** | ***88.8*** |
| | Midlands & East | *98.5* | *90.2* |
| | Leicester | *99.4* | *97.1* |

**Table 6: Newborn blood spot screening programme KPIs: Annual 2016 to 2017[45]**

| | | **Newborn blood spot screening** (209 CCGs for NB1 and NB4; 145 maternity services for NB2) | | |
|---|---|---|---|---|
| | | Acceptable ≥ 95.0% | Acceptable < 2.0% | Acceptable ≥ 95.0% |
| | | Achievable ≥ 99.9% | Achievable ≤ 0.5% | Achievable ≥ 99.9% |
| | | **Coverage (%)** | **Avoidable repeat (%)** | **Coverage - movers in (%)** |
| **Region** | **England** | **96.5** | **2.9** | **87.1** |
| | Midlands & East | 97.2 | 2.7 | 86.2 |
| | NHS East Leicestershire and Rutland | 96.5 | - | 93.5 |
| | NHS West Leicestershire | 95.3 | - | 92.1 |
| | University Hospitals of Leicester NHS Trust | - | 5.0 | - |

### 2.3.1. Immunisations

Within Leicestershire, the population vaccination coverage in children performs higher than the benchmark for all but two of the indicators (Table 7). The World Health Organization (WHO) has set vaccination coverage targets at global and WHO regional levels, which have been adopted by the Department of Health at national and local levels. The 95% target for vaccination coverage is required nationally to ensure control of vaccine preventable diseases within the UK routine childhood vaccination programmes, with at least 90% coverage in each geo-political unit.[23]

In the MMR for two doses (5 years olds) the latest coverage percentage stands at 93.8% in 2017/18. Despite not reaching the 95% target, Leicestershire has the highest vaccination coverage for this indicator in the region and has shown a significant increase in trend over the last eight years. For the flu vaccine in 2-3 year olds in Leicestershire and Rutland (combined) in 2017/18, the coverage was 61.4%. This is lower than the target of 65% but Leicestershire and Rutland (combined) has the highest vaccination coverage for this indicator in the region.[23]

Hepatitis B is a targeted programme and therefore not a population programme. The variation is largely explained by the ability of the programmes to provide the data at the time. There is a Hepatitis B pathway across the East Midlands to account for the vaccine status of every child born to a Hepatitis B positive mother.[23]

**Table 7: Public Health Outcomes Framework indicators on childhood immunisations in Leicestershire**

| Indicator | Period | England | East Midlands region | Derby | Derbyshire | Leicester | Leicestershire | Lincolnshire | Northamptonshire | Nottingham | Nottinghamshire | Rutland |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 3.03i - Population vaccination coverage - Hepatitis B (1 year old) New data | 2017/18 | * | * | 100 | 100 | 96.6 | 91.7 | 100 | 100 | 90.0 | 100 | 0.0 |
| 3.03i - Population vaccination coverage - Hepatitis B (2 years old) New data | 2017/18 | * | * | 100 | * | 100 | 100 | 100 | 94.3 | 83.3 | * | 0.0 |
| 3.03iii - Population vaccination coverage - Dtap / IPV / Hib (1 year old) New data <90% 90% to 95% ≥95% | 2017/18 | 93.1 | 94.9 | 93.7 | 96.6 | 94.5 | 96.9 | 93.5 | 95.0 | 89.7 | 95.9 | 96.3 |
| 3.03iii - Population vaccination coverage - Dtap / IPV / Hib (2 years old) New data <90% 90% to 95% ≥95% | 2017/18 | 95.1 | 96.5 | 94.2 | 97.8 | 97.2 | 98.2 | 95.0 | 96.3 | 93.9 | 97.1 | 97.8 |
| 3.03iv - Population vaccination coverage - MenC <90% 90% to 95% ≥95% | 2015/16 | * | * | 96.3 | 98.1 | 96.4 | 98.1* | 96.8 | 97.3* | 94.1 | * | * |
| 3.03v - Population vaccination coverage - PCV New data <90% 90% to 95% ≥95% | 2017/18 | 93.3 | 95.0 | 93.6 | 96.7 | 94.7 | 97.0 | 94.0 | 95.2 | 90.1 | 95.8 | 95.4 |
| 3.03vi - Population vaccination coverage - Hib / MenC booster (2 years old) New data <90% 90% to 95% ≥95% | 2017/18 | 91.2 | 93.2 | 88.3 | 96.1 | 93.8 | 96.5 | 91.3 | 93.6 | 87.8 | 93.6 | 93.2 |
| 3.03vi - Population vaccination coverage - Hib / Men C booster (5 years old) New data <90% 90% to 95% ≥95% | 2017/18 | 92.4 | 93.2 | 90.9 | 96.2 | 90.1 | 95.9 | 90.2 | 94.0 | 89.2 | 94.4 | 94.3 |
| 3.03vii - Population vaccination coverage - PCV booster New data <90% 90% to 95% ≥95% | 2017/18 | 91.0 | 93.2 | 88.5 | 96.1 | 93.6 | 96.5 | 90.4 | 93.7 | 88.3 | 93.8 | 92.9 |
| 3.03viii - Population vaccination coverage - MMR for one dose (2 years old) New data <90% 90% to 95% ≥95% | 2017/18 | 91.2 | 93.1 | 88.2 | 95.9 | 93.7 | 96.2 | 91.2 | 93.5 | 87.9 | 93.5 | 92.9 |
| 3.03ix - Population vaccination coverage - MMR for one dose (5 years old) New data <90% 90% to 95% ≥95% | 2017/18 | 94.9 | 96.4 | 95.3 | 98.0 | 96.0 | 98.1 | 93.9 | 96.7 | 94.9 | 96.9 | 97.0 |
| 3.03x - Population vaccination coverage - MMR for two doses (5 years old) New data <90% 90% to 95% ≥95% | 2017/18 | 87.2 | 89.0 | 83.8 | 92.9 | 88.3 | 93.8 | 85.2 | 91.4 | 80.3 | 89.1 | 90.1 |
| 3.03xviii - Population vaccination coverage - Flu (2-3 years old) - current method <40% 40% to 65% ≥65% | 2017/18 | 43.5 | 51.5* | 46.0 | 54.7 | 41.3 | 61.4* | 55.5 | 49.3 | 44.5 | 50.0 | * |

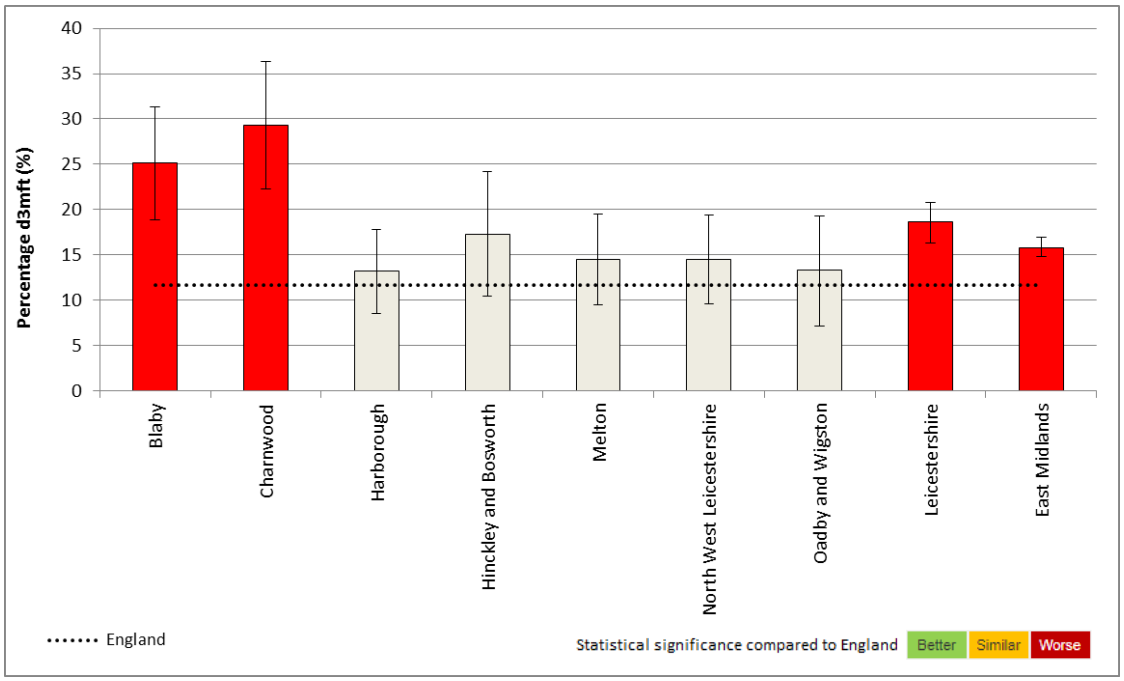
## 2.4. Tooth decay

### 2.4.1. Survey of three year olds

Findings from Public Health England's (PHE) 2013 national dental epidemiology survey of three-year old children showed in England, 11.7% of three-year-old children had experience

of obvious dental decay (caries), having one or more teeth that were decayed to dentinal level, extracted or filled because of caries (%d3mft>0). The East Midlands had the highest percentage of decay out of all the regions in England (15.3%) and the East of England, the lowest (8.2%). Leicestershire had a significantly higher percentage of decay compared to the national average (18.6%). This is the second highest percentage throughout the East Midlands behind Leicester only.[46] Blaby and Charnwood have been highlighted as relatively affluent lower-tier local authorities where caries prevalence was high: Blaby (25.1%), Charnwood (29.3%). The prevalence of d3mft>0 for all other districts in Leicestershire was based on fewer than 30 volunteers so the estimate was not considered robust.[46]

**Figure 14: Percentage of three-year-old children with one or more teeth that were decayed to dentinal level, extracted or filled because of caries (%d3mft>0), 2012/13[46]**




In England, the average number of teeth per child affected by decay (decayed, missing or filled teeth (d3mft)) was 0.36. At the regional level this ranged from 0.24 in the East of England, to 0.47 in the North West. East Midlands had the second highest average number at 0.45. The average number of teeth affected by decay in Leicestershire was 0.39, lower than the East Midlands average. Figure 15 shows Charnwood had the highest average number of teeth per child affected by decay (d3mft) out of the Leicestershire districts, at 0.65, significantly higher than the national average. Harborough performs significantly better (0.21) than the national average, whereas all other districts in the county perform similar to the national average.[46]

**Figure 15: Average number of decayed, missing or filled teeth (d3mft) in three year olds, 2012/13[46]**

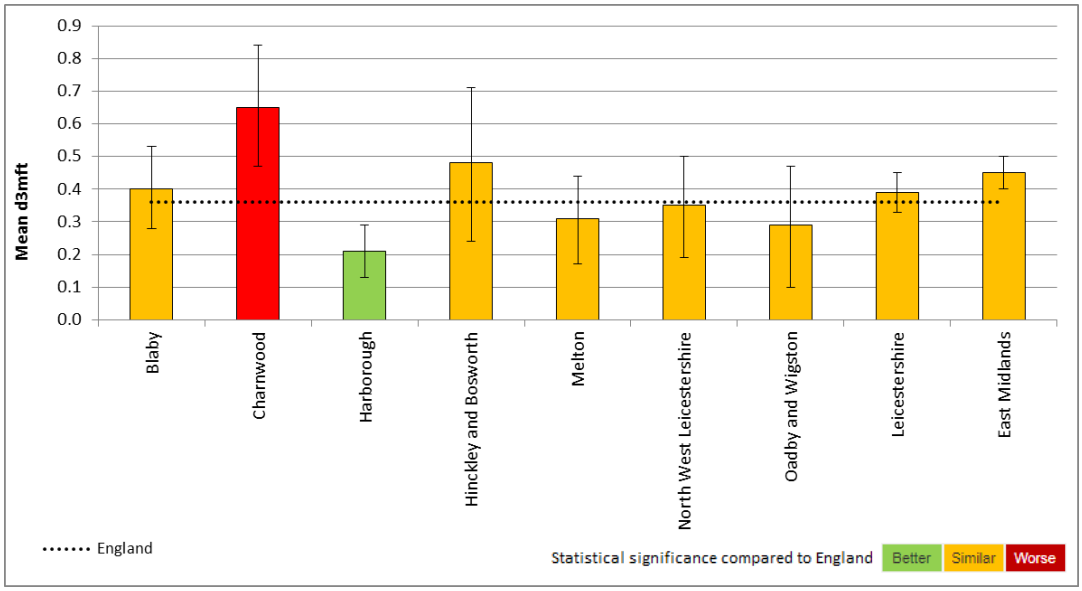
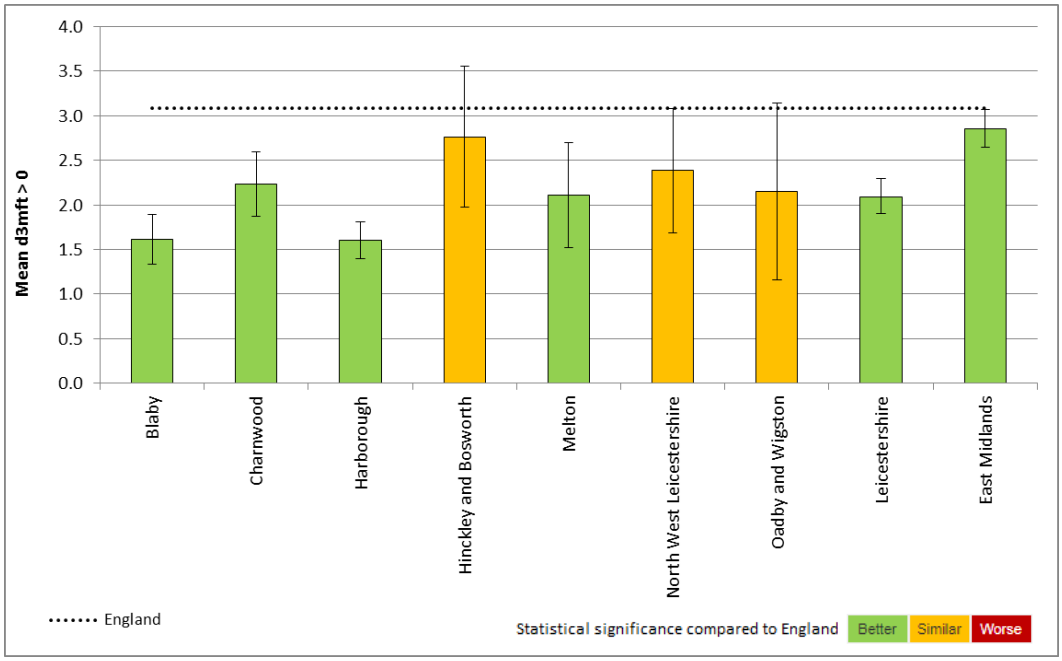



**Figure 16: The average number of decayed, missing or filled teeth (d3mft) among the three-year old children with decay experience, 2012/13[46]**

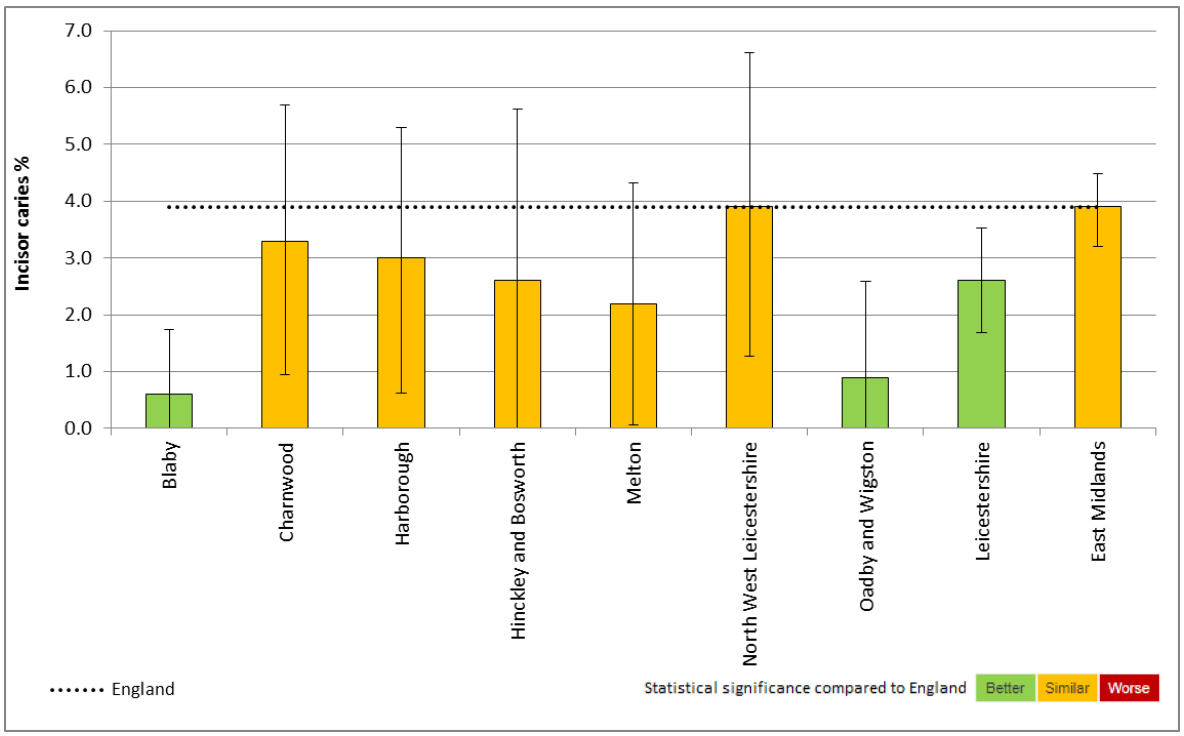



Among the children with decay experience, the average number of decayed, missing (due to decay) or filled teeth was 3.08 (most children have all 20 primary teeth present by age three). The East Midlands average was 2.85. Across upper-tier local authority level the variation of severity among affected children is wide, but Leicestershire had the lowest average at 2.09 d3mft with Bristol the highest (4.75). At lower-tier local authority, Blaby had

the lowest average of 1.61. Figure 16 shows four districts in Leicestershire performed significantly better than the national average. Three districts performed similar to the national average, these were Hinckley and Bosworth (2.76), North West Leicestershire (2.39) and Oadby and Wigston (2.15).[46]

Incisor caries is an aggressive form of tooth decay that affects upper incisors and can be rapid and extensive in attack. It is associated with long term bottle use with sugar-sweetened drinks, especially when these are given overnight or for long periods of the day. The percentage of 3-year-old children who have experienced incisor caries in Leicestershire was 2.6%, significantly better than the national percentage of 3.9%. Figure 17 shows there are two districts in Leicestershire that had a significantly lower prevalence than the national average, these are Blaby (0.6%) and Oadby and Wigston (0.9%). All other districts in Leicestershire perform similar to the national average.[46]

**Figure 17: Incisor caries prevalence in three year olds, 2012/13[46]**

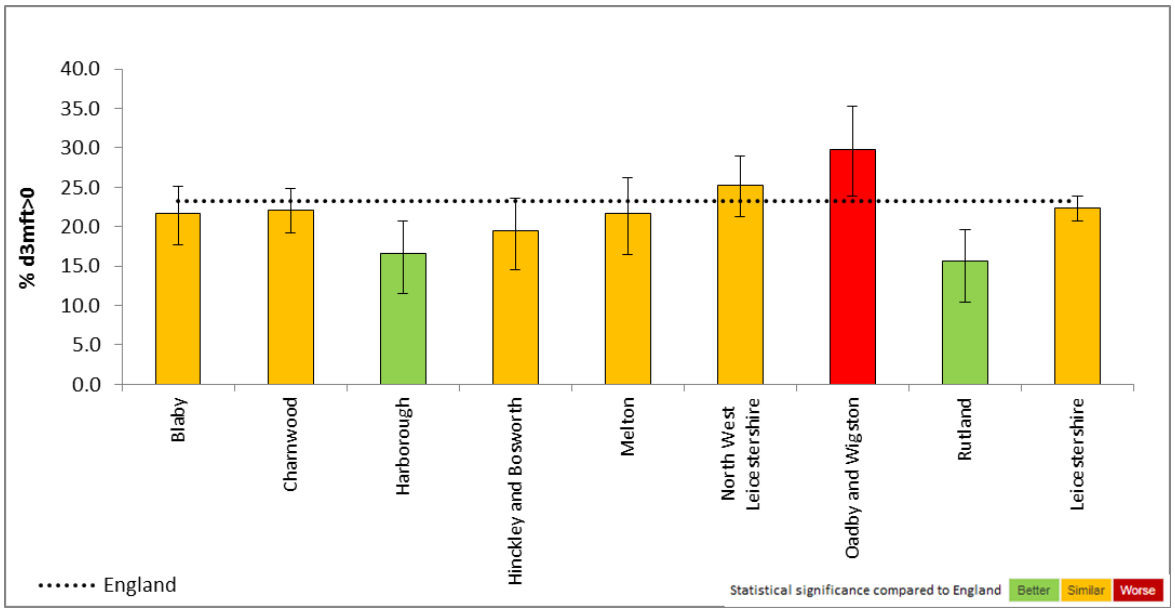



### 2.4.2. Survey of five year olds

Finding from PHE's 2017 national dental epidemiology survey of five-year-old children who attended mainstream, state-funded schools across Leicestershire during the 2016/17 academic year showed in England, 23.3% of five-year-old children had experience of obvious dental decay (caries), having one or more teeth that were decayed to dentinal level, extracted or filled because of caries (%d3mft>0). Out of all the regions in England, the East

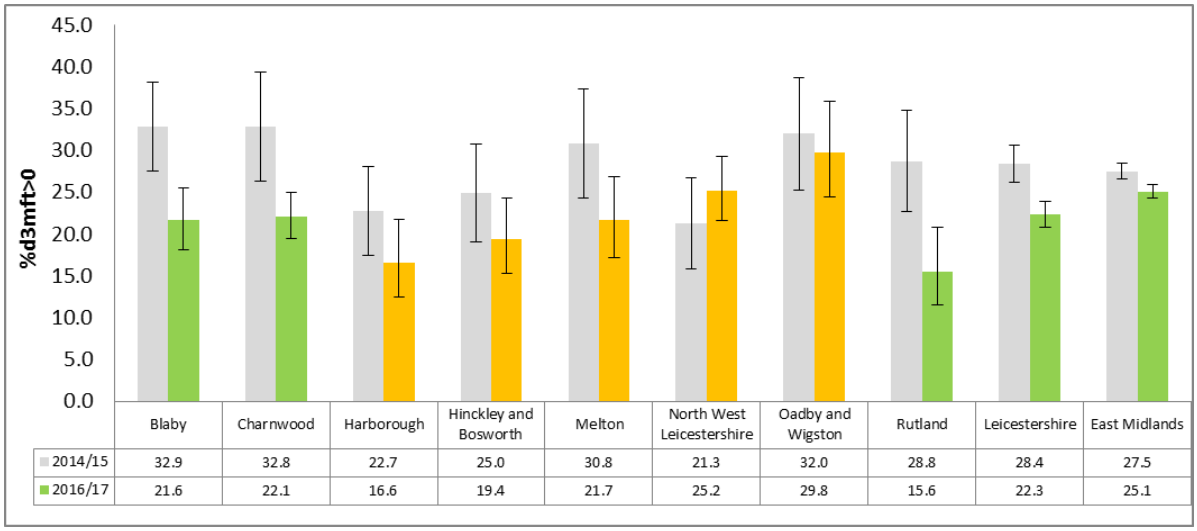
Midlands had the fifth highest percentage of decay (25.1%) with the North West recording the highest proportion (33.9%) and the South East of England the lowest (16.4%). In Leicestershire, the percentage of decay was 22.3%; this is similar to the England average. When examining the Leicestershire districts, Oadby and Wigston performed significantly worse (29.8%) than the national percentage and Harborough performed significantly better than nationally (16.6%). All other districts performed similar to the national average.[47]

**Figure 18: Percentage of five-year-old children with one or more teeth that were decayed to dentinal level, extracted or filled because of caries (%d3mft>0), 2016/17[47]**




From 2014/15 to 2016/17 there has been a significant improvement in the percentage of children with obvious dental decay (%d3mft>0) in Leicestershire (28.4% to 22.3%) and Rutland (28.8% to 15.6%). When examining Leicestershire districts, Blaby and Charnwood have both seen a significant improvement since the last survey moving from 32.9% to 21.6% and 32.8% to 22.1% respectively. All other districts have seen no significant improvement or decline. North West Leicestershire is the only district that has witnessed an increase in the percentage of children with obvious dental decay since the last survey from 21.3% to 25.2%, although this is not significant.[47]

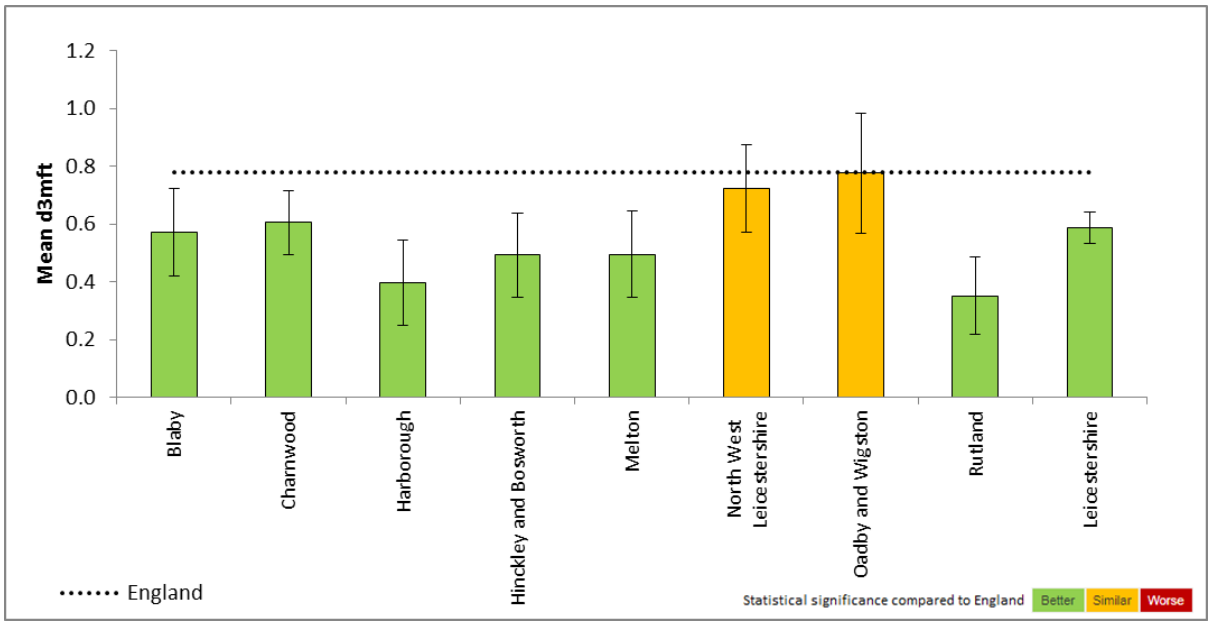
**Figure 19: Percentage of five-year-old children with one or more teeth that were decayed to dentinal level, extracted or filled because of caries (%d3mft>0), 2014/15 to 2016/17[47]**




| | Blaby | Charnwood | Harborough | Hinckley and Bosworth | Melton | North West Leicestershire | Oadby and Wigston | Rutland | Leicestershire | East Midlands |
|---|---|---|---|---|---|---|---|---|---|---|
| 2014/15 | 32.9 | 32.8 | 22.7 | 25.0 | 30.8 | 21.3 | 32.0 | 28.8 | 28.4 | 27.5 |
| 2016/17 | 21.6 | 22.1 | 16.6 | 19.4 | 21.7 | 25.2 | 29.8 | 15.6 | 22.3 | 25.1 |

In England, the average (mean) number of teeth per child affected by decay (decayed, missing or filled teeth (d3mft)) was 0.8. At the regional level this ranged from 0.5 in the South East of England to 1.3 in the North West. The average d3mft in the East Midlands was 0.8. The average number of teeth affected by decay in Leicestershire was 0.6 which is significantly lower than the England average. North West Leicestershire and Oadby and Wigston were the only districts in the county to perform similar to the national average at 0.7 and 0.8 respectively. All other districts performed significantly better than the national average.[47]

**Figure 20: Average number of decayed, missing or filled teeth (dmft) in five year olds, 2016/17[47]**



Among the children with decay experience, the average number of decayed, missing (due to decay) or filled teeth (mean d3mft (% d3mft > 0)) in England was 3.4. The East Midlands average was 3.3. At upper-tier local authority level there is clear variation of this measure with affected children in Rutland and Wiltshire having only 2.3 teeth affected on average, while those in Harrow had 4.8. Leicestershire has a significantly lower average than the national at 2.6.[47]

**Figure 21: The average number of number of decayed, missing or filled teeth (d3mft) among the five-year old children with decay experience, 2016/17[47]**

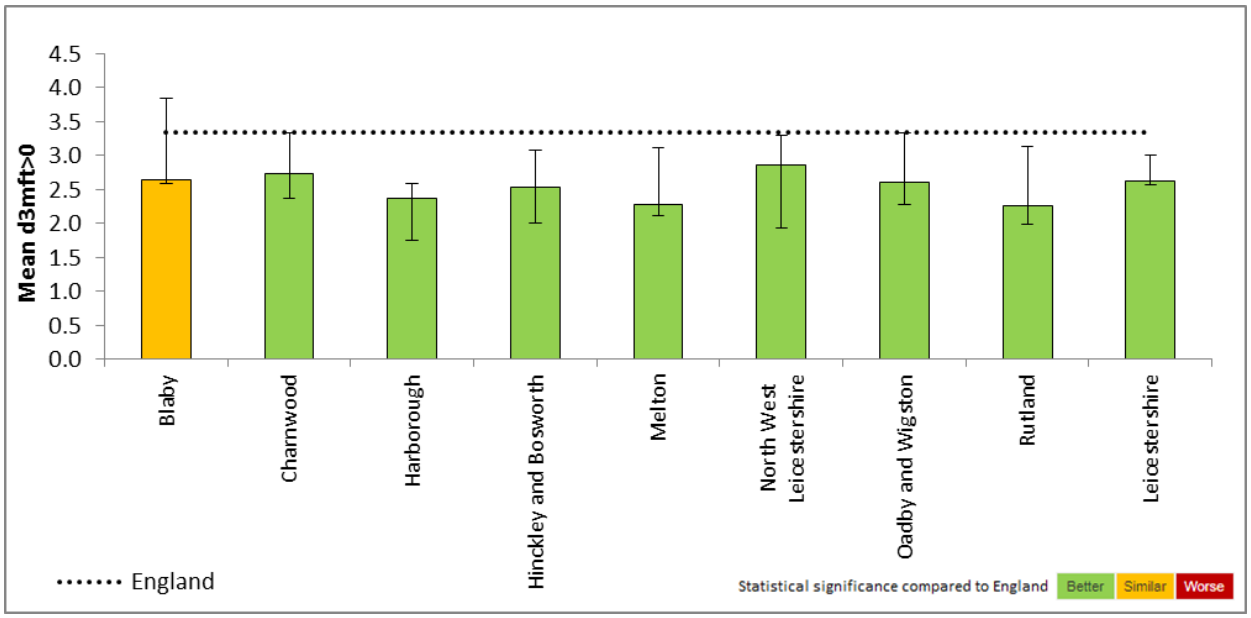


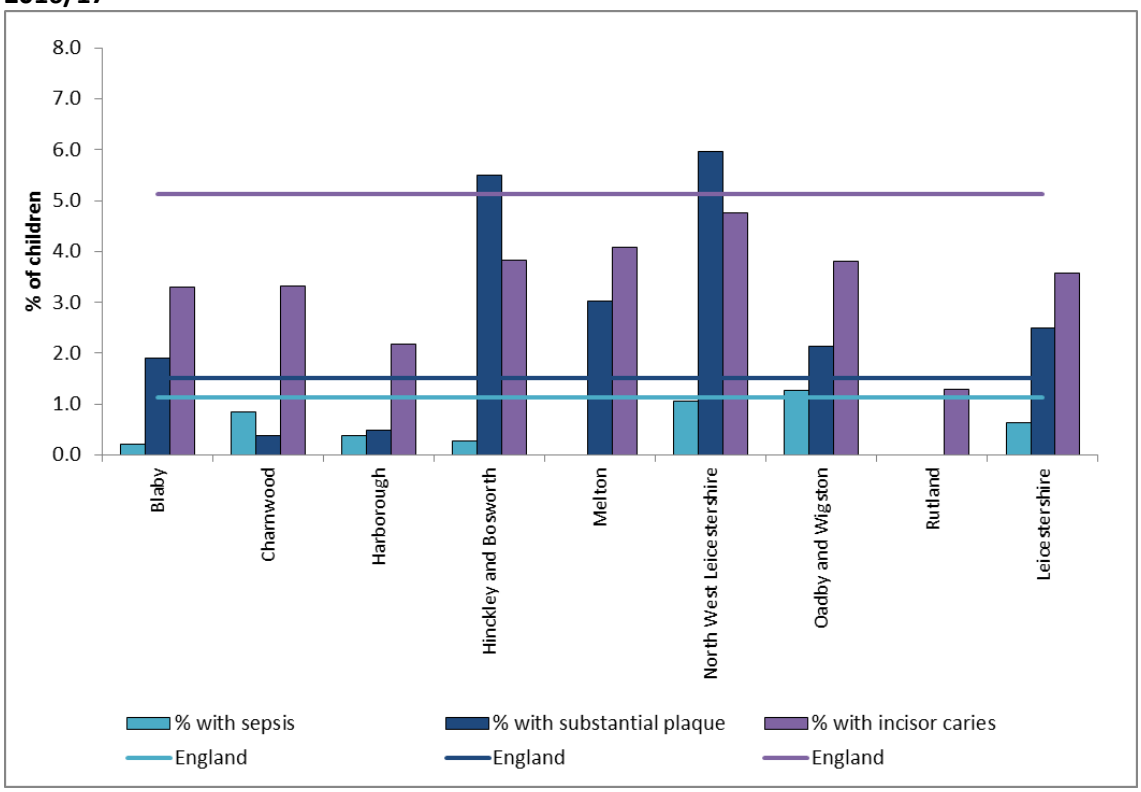

Figure 22 examines the percentage of children who have substantial plaque, and/or sepsis, and/or incisor caries in England, East Midlands and Leicestershire. The presence of substantial amounts of plaque compared with 'visible' or no plaque provides a proxy measure of children who do not brush their teeth, or brush them rarely. Such children cannot benefit from the protective effects of fluoride in toothpaste on dental decay. A 'substantial amount of plaque' was recorded for 1.5% of volunteers in England and in Leicestershire, 2.5% of volunteers had a 'substantial amount of plaque'. North West Leicestershire had the highest percentage of children with substantial plaque (6.0%) in the Leicestershire districts and Charnwood the lowest (0.4%).[47]

At the age of five-years, nearly all oral sepsis will be the result of the dental decay process rather than originating from gum problems. A small number of cases will be linked to traumatic injury of teeth, but no diagnosis of cause was recorded during this survey. Oral sepsis was defined in the protocol as the presence of a dental abscess or sinus recorded by

visual examination of the soft tissues. Oral sepsis was recorded for 1.1% of volunteers in England and 0.6% of children in Leicestershire. Nationally, the level was generally higher in those areas where there were higher levels of decay. Throughout the Leicestershire districts, Oadby and Wigston had the highest local reported percentage of children with sepsis (1.3%) with Melton the lowest (0.0%).[47]

It is useful to know what proportion of children had dental decay affecting one or more of their incisor (front) teeth. This type of decay is usually associated with long term bottle use with sugar-sweetened drinks, especially when these are given overnight or for long periods during the day. Overall, the national prevalence of incisor decay was 5.1% and varied by region, ranging from 3.3% in the South East to 7.9% in the North West. Comparison at upper tier local authority level shows far wider variation with a prevalence of 0.8% in North Somerset to 17.8% in Harrow. There is likely to be marked geographic variation as this type of decay is closely linked with specific health behaviours which are influenced by local cultural norms. Children with incisor decay are likely to have more teeth affected than is the case for general decay, so tackling this problem may lead to relatively higher benefits. In Leicestershire, 3.6% of children had dental decay affecting one or more of their incisor teeth. Throughout Leicestershire, North West Leicestershire had the highest local reported percentage of children with incisor caries (4.8%) and Harborough the lowest (2.2%).[47]

**Figure 22: Percentage of five-year-old children with substantial plaque, sepsis or incisor caries, 2016/17[47]**



### 2.4.3. Healthy weight – NCMP (4-5 years)

The National Child Measurement Programme (NCMP) measures the height and weight of children in Reception class (aged 4 to 5) and year 6 (aged 10 to 11), to assess overweight and obesity levels in children within primary schools. The latest data for the 2017/18 NCMP in Leicestershire has raised some data quality issues for Reception children. Due to this, the following data presented is for 2016/17 only.

In 2016/17, the proportion of pupils residing in Leicestershire with excess weight (classified as overweight or obese) in Reception (20.3%) was better than the national percentage (22.6%); this has been the case for four of the last five years. Compared to last year, the prevalence of excess weight in Reception children in Leicestershire has improved from 21.3% to 20.3%; this equates to a reduction in 56 pupils in the county classified with excess weight. This is due to a decrease in the prevalence of overweight Reception pupils from 13.3% to 12.3%. In contrast the prevalence of obesity in Reception remained reasonably stable from 8.0% to 7.9%.[48]

Table 8 shows the proportion of Reception pupils classified as overweight and obese in Leicestershire (20.3%) was significantly better than England average (22.6%). The prevalence of underweight (1.0%) and overweight (12.3%) pupils were similar to the England averages (1.0%, 13.0%). This data examines all children that reside in Leicestershire, regardless of where they attend school.[48]

**Table 8: Proportion of pupils classified as underweight, healthy weight, overweight or obese in Reception, Leicestershire and England 2016/17.**

| | Underweight | Healthy weight | Overweight | Obese | Overweight and obese |
|---|---|---|---|---|---|
| Leicestershire | 1.0% | 78.7% | 12.3% | 7.9% | 20.3% |
| England | 1.0% | 76.4% | 13.0% | 9.6% | 22.6% |

Significantly better than England
Not significantly different to England
Significantly worse than England

Figure 23 to Figure 27 compare the proportions of each BMI category in Reception pupils that reside in Leicestershire against the England average, over time since 2006/07. The proportion of underweight pupils in Leicestershire is likely to fluctuate due to the small numbers of pupils. In 2011/12, Leicestershire was significantly better than England but has

since increased year on year for the past five years and is now (non-significantly) higher than the national average. The proportion of obese pupils has remained significantly better in Leicestershire than England since 2009/10. The latest data shows the obesity prevalence decreased slightly from 8.0% to 7.9% between 2015/16 to 2016/17. The proportion of overweight pupils in the county has been similar to the national average for the last five years, however the prevalence of overweight pupils decreased by one percentage point in 2016/17, from 13.3% to 12.3%, compared to the previous year. The proportion of overweight or obese Reception pupils became significantly better than England in 2016/17 after increasing to be similar to the national average for the first time in seven years in 2015/16. This improvement is largely due to the decline in prevalence of overweight pupils in Leicestershire locally, but coupled with the year on year increase of the national prevalence of excess weight in Reception pupils.[48]

**Figure 23: Proportion of pupils classified as underweight in Reception in Leicestershire and England 2006/07 - 2016/17.**

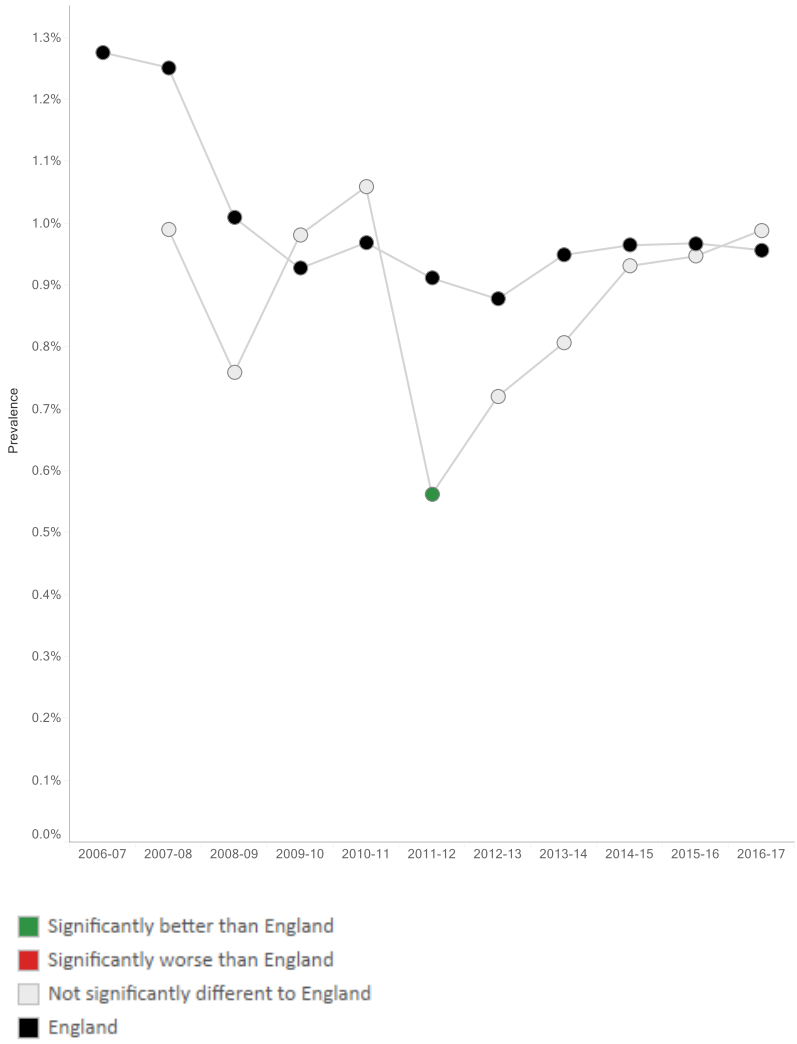


**Figure 24: Proportion of pupils classified as healthy weight in Reception in Leicestershire and England 2006/07 - 2016/17.**

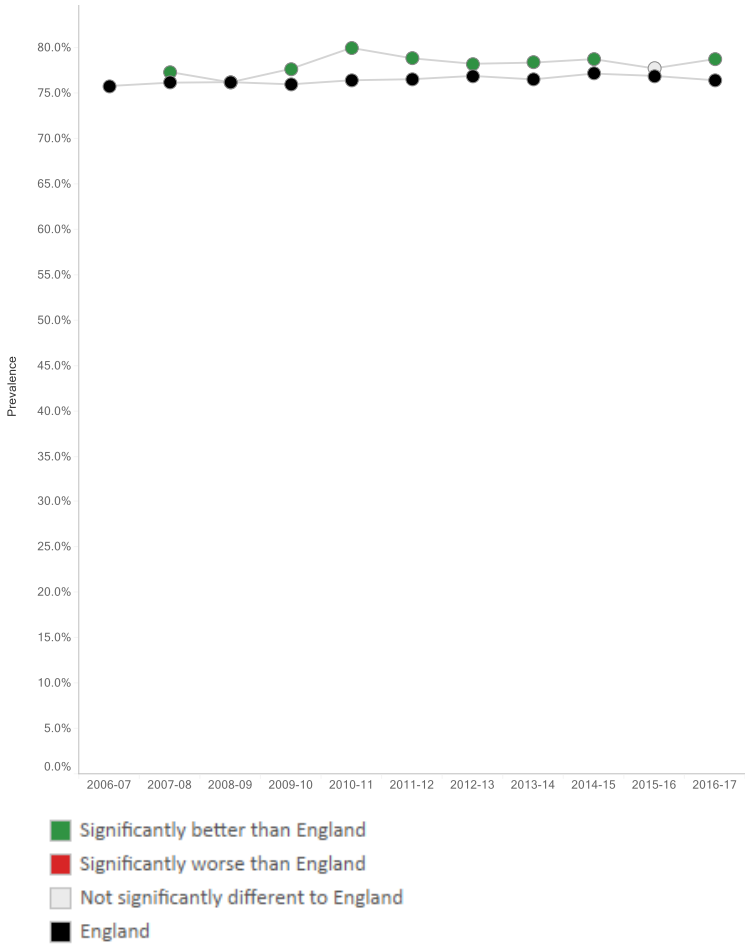


**Figure 25: Proportion of pupils classified as overweight in Reception in Leicestershire and England 2006/07 - 2016/17**

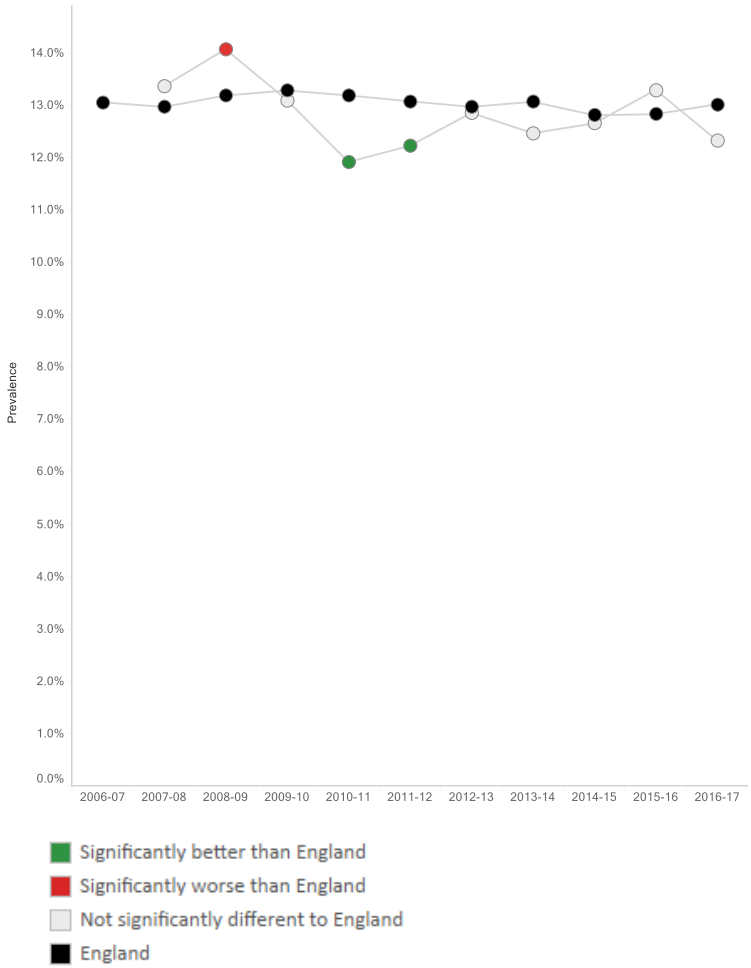
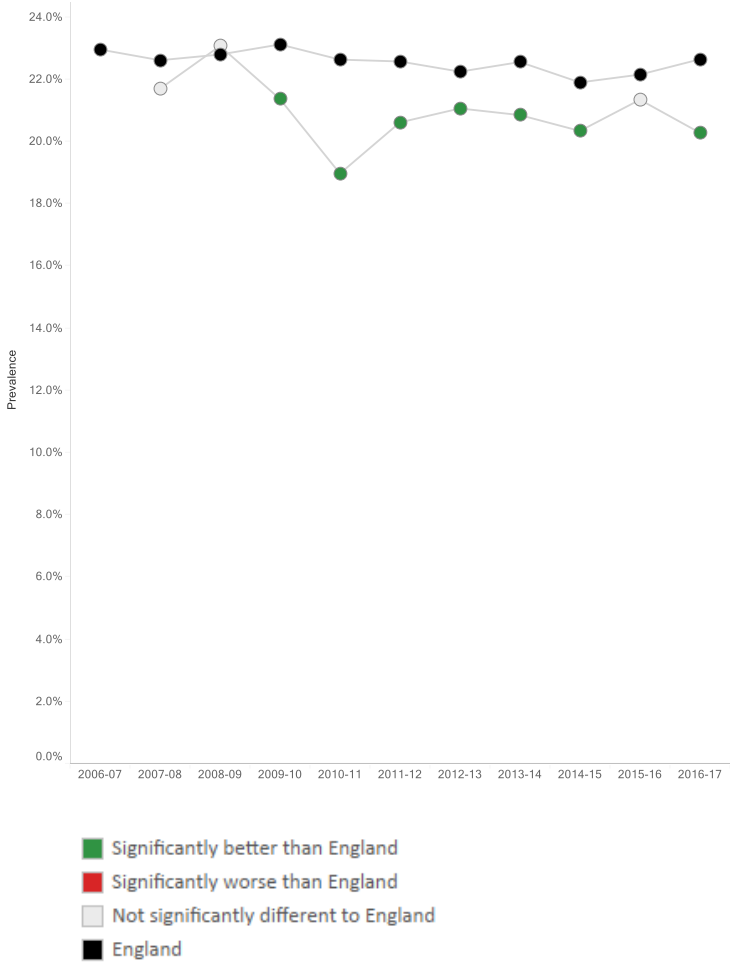


**Figure 26: Proportion of pupils classified as obese in Reception in Leicestershire and England 2006/07 - 2016/17**

**Figure 27: Proportion of pupils classified as overweight or obese in Reception in Leicestershire and England 2006/07 - 2016/17**




The proportion of Reception pupils classified as underweight was significantly worse in Oadby and Wigston (2.1%) compared to the national average (1.0%). Harborough (21.6%), Melton (21.6%) and Hinckley and Bosworth (20.7%) featured similar proportions of overweight and obese pupils, compared to England (22.6%). All districts in Leicestershire have a similar proportion of overweight pupils to the national average.[48]

**Table 9: Proportion of pupils classified as underweight, healthy weight, and overweight or obese in Reception, per Leicestershire district 2016/17**

| | Underweight | Healthy weight | Overweight | Obese | Overweight and obese |
|---|---|---|---|---|---|
| Blaby | 0.9% | 80.3% | 11.3% | 7.5% | 18.8% |
| Charnwood | 0.8% | 78.6% | 12.4% | 8.2% | 20.6% |
| Harborough | 0.4% | 78.0% | 13.5% | 8.1% | 21.6% |
| Hinckley and Bosworth | 1.0% | 78.3% | 12.4% | 8.3% | 20.7% |
| Melton | 1.2% | 77.2% | 13.0% | 8.6% | 21.6% |
| North West Leicestershire | 0.8% | 79.7% | 12.0% | 7.5% | 19.5% |
| Oadby and Wigston | 2.1% | 79.1% | 11.6% | 7.2% | 18.8% |
| Out of area | 2.7% | 79.5% | 11.4% | 6.4% | 17.8% |
| Leicestershire | 1.0% | 78.9% | 12.2% | 7.9% | 20.1% |
| England | 1.0% | 76.4% | 13.0% | 9.6% | 22.6% |

Significantly better than England
Not significantly different to England
Significantly worse than England

Table 10 and Table 11 lists the Leicestershire wards with significantly different proportions of pupils classified as underweight, and overweight or obese in Reception, compared to England and Leicestershire average. Proportions of healthy weight are not listed to assist in suppression of low counts of pupils.[48]

**Table 10: Leicestershire wards with significantly different proportions of pupils classified as underweight, and overweight or obese in Reception, compared to England average 2016/17**

| | | Underweight | Overweight | Obese | Overweight and obese |
|---|---|---|---|---|---|
| Charnwood | Birstall Wanlip | | 20.0% | 5.6% | 25.6% |
| | Loughborough Storer | | 23.5% | | 29.4% |
| | Rothley and Thurcaston | | 8.2% | | 12.3% |
| Harborough | Kibworth | | 6.4% | | 11.5% |
| | Misterton | | 33.3% | | 33.3% |
| Melton | Melton Warwick | | 22.6% | 16.1% | 38.7% |
| North West Leicestershire | Broom Leys | | | | 46.7% |
| Oadby and Wigston | Oadby Woodlands | 8.2% | | | 13.1% |
| Authority | Leicestershire | 1.0% | 12.2% | 7.9% | 20.1% |
| | England | 1.0% | 13.0% | 9.6% | 22.6% |

**Table 11: Leicestershire wards with significantly different proportions of pupils classified as underweight, and overweight or obese in Reception, compared to Leicestershire overall 2016/17**

| | | Underweight | Overweight | Obese | Overweight and obese |
|---|---|---|---|---|---|
| Charnwood | Birstall Wanlip | | 20.0% | 5.6% | 25.6% |
| | Loughborough Lemyngton | | 17.1% | 12.2% | 29.3% |
| | Loughborough Storer | | 23.5% | | 29.4% |
| | Sileby | | 16.7% | 11.8% | 28.4% |
| Harborough | Broughton Astley-Broughton | | | 17.6% | 29.4% |
| | Misterton | | 33.3% | | 33.3% |
| Hinckley and Bosworth | Hinckley Trinity | | 16.2% | 12.4% | 28.6% |
| Melton | Melton Warwick | | 22.6% | 16.1% | 38.7% |
| North West Leicestershire | Broom Leys | | | | 46.7% |
| Oadby and Wigston | Oadby Woodlands | 8.2% | | | 13.1% |
| Authority | Leicestershire | 1.0% | 12.2% | 7.9% | 20.1% |
| | England | 1.0% | 13.0% | 9.6% | 22.6% |

Table 12 shows the proportion of male (20.0%) and female (20.2%) pupils classified as overweight and obese was significantly better than England (22.6%). The same pattern was also observed in obese pupils, but not overweight pupils. The prevalence of underweight pupils was significantly higher amongst males (1.3%) compared to the England average (1.0%).[48]

**Table 12: Proportion of pupils classified as underweight, healthy weight, and overweight or obese in Reception, by gender in Leicestershire 2016/17.**

| | Underweight | Healthy weight | Overweight | Obese | Overweight and obese |
|---|---|---|---|---|---|
| Male | 1.3% | 78.7% | 12.1% | 7.9% | 20.0% |
| Female | 0.8% | 79.0% | 12.4% | 7.8% | 20.2% |
| Leicestershire | 1.0% | 78.9% | 12.2% | 7.9% | 20.1% |
| England | 1.0% | 76.4% | 13.0% | 9.6% | 22.6% |

Significantly better than England
Not significantly different to England
Significantly worse than England

Table 13 shows the proportion of Asian (5.4%) Reception pupils classified as underweight in Leicestershire to be significantly worse than the England average (1.0%). The proportion of Black pupils classified as overweight and obese (41.7%) and obese (25.0%) was significantly worse than the England averages (22.6%, 9.6%). White pupils, which account of 84.4% of all Reception pupils, have the same percentage of overweight pupils as England. White pupils

in Leicestershire have a significantly better proportion of pupils who are obese (7.7%) and excess weight (20.7%) compared to the national average.[48]

**Table 13: Proportion of pupils classified as underweight, healthy weight, and overweight or obese in Reception, by ethnicity in Leicestershire 2016/17.**

| | Underweight | Healthy weight | Overweight | Obese | Overweight and obese |
|---|---|---|---|---|---|
| Asian | 5.4% | 81.4% | 6.9% | 6.3% | 13.2% |
| Black | 0.0% | 58.3% | 16.7% | 25.0% | 41.7% |
| Chinese | 0.0% | 87.9% | 6.1% | 6.1% | 12.1% |
| White | 0.6% | 78.6% | 13.0% | 7.7% | 20.7% |
| Mixed | 1.3% | 81.3% | 8.5% | 9.0% | 17.5% |
| Any other ethnic group | 0.0% | 71.0% | 9.7% | 19.4% | 29.0% |
| Not stated | 1.9% | 85.2% | 7.4% | 5.6% | 13.0% |
| Leicestershire | 1.0% | 78.9% | 12.2% | 7.9% | 20.1% |
| England | 1.0% | 76.4% | 13.0% | 9.6% | 22.6% |

Significantly better than England
Not significantly different to England
Significantly worse than England

Figure 28 shows a deprivation gradient exists for excess weight in Reception children. The least deprived areas (National IMD deciles 8, 9 and 10) featured significantly better proportions of Reception pupils classified as obese (6.9%, 7.1%, 7.2%) compared to the England average (9.6%).[48]

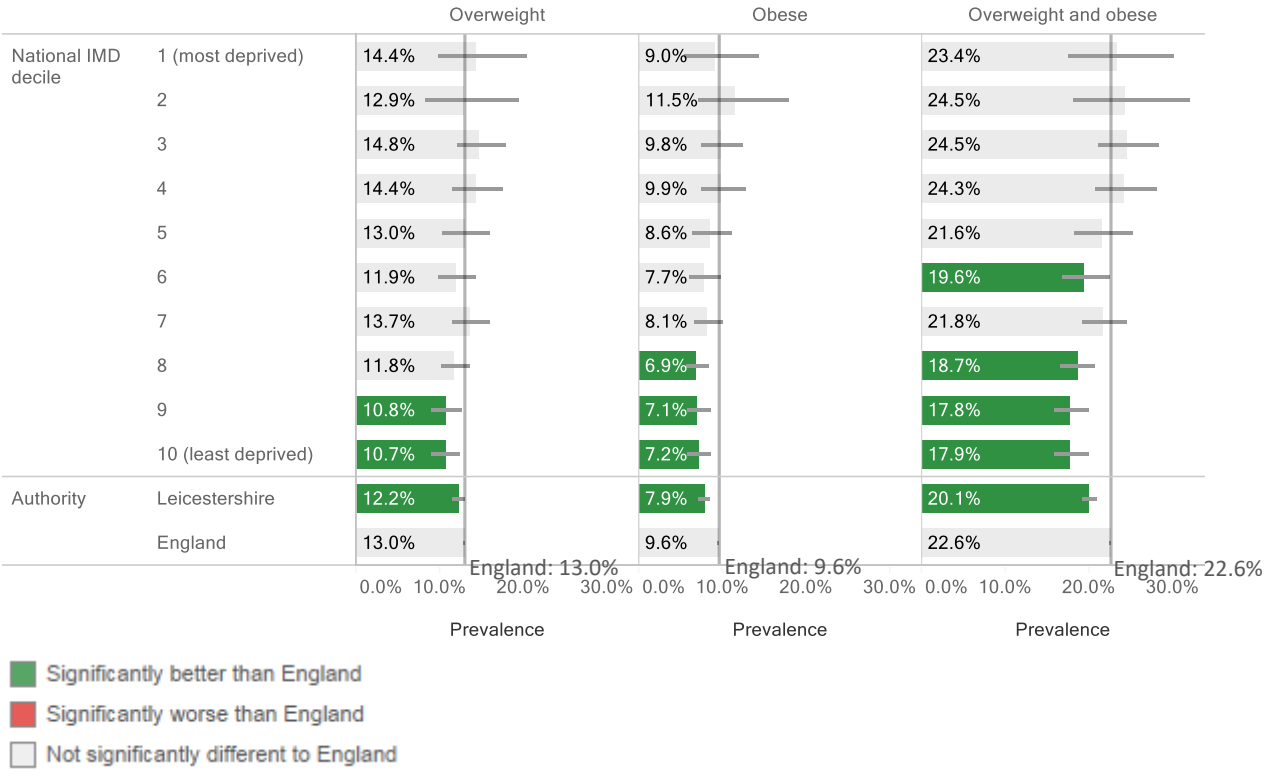
The prevalence gap between the least deprived and most deprived areas was -0.1 percentage points for underweight, +5.6 for healthy weight, -3.7 for overweight, -1.8 for obese, and -5.5 for excess weight. This suggests less deprived areas had a better prevalence of healthy weight and excess weight pupils than more deprived areas in Reception, but did not differ in the prevalence of underweight pupils.[48]

**Table 14: Proportion of pupils classified as underweight, healthy weight, and overweight or obese in Reception, per National IMD decile in Leicestershire 2016/17.**

| | Underweight | Healthy weight | Overweight | Obese | Overweight and obese |
|---|---|---|---|---|---|
| 1 (most deprived) | 1.2% | 75.4% | 14.4% | 9.0% | 23.4% |
| 2 | 2.2% | 73.4% | 12.9% | 11.5% | 24.5% |
| 3 | 1.1% | 74.4% | 14.8% | 9.8% | 24.5% |
| 4 | 1.7% | 74.0% | 14.4% | 9.9% | 24.3% |
| 5 | 0.7% | 77.7% | 13.0% | 8.6% | 21.6% |
| 6 | 1.3% | 79.1% | 11.9% | 7.7% | 19.6% |
| 7 | 0.9% | 77.3% | 13.7% | 8.1% | 21.8% |
| 8 | 0.9% | 80.5% | 11.8% | 6.9% | 18.7% |
| 9 | 0.7% | 81.4% | 10.8% | 7.1% | 17.8% |
| 10 (least deprived) | 1.1% | 81.0% | 10.7% | 7.2% | 17.9% |
| Leicestershire | 1.0% | 78.9% | 12.2% | 7.9% | 20.1% |
| England | 1.0% | 76.4% | 13.0% | 9.6% | 22.6% |

Significantly better than England
Not significantly different to England
Significantly worse than England

**Figure 28: Proportion of pupils classified as overweight, obese, or overweight and obese in Reception, per National IMD decile in Leicestershire 2016/17.**



There has been a deprivation gradient for excess weight in Reception for the last four years; deciles 9 and 10 have featured significantly better proportions of pupils with excess weight than England, whereas other deciles have been similar to the national average. It also appears the prevalence gap between the least deprived (decile 10) and most deprived (decile 1) areas has widened for excess weight in Reception; in 2013/14 the gap was -1.8 percentage points, and in 2016/17 was -5.5. The greatest difference between the IMD deciles in 2016/17 was observed in overweight pupils (-3.7 percentage points), rather than obese pupils (-1.8).[48]

#### 2.4.4. Physically active

The UK Chief Medical Officers' physical activity guidelines 2011 for early years' children (under 5s) stated children should be physical active for 180 minutes (three hours) spread throughout the day, once a child is able to walk. For children who are not yet walking, physical activity should be encouraged from birth, particularly through floor-based play and water-based activities in safe environments. In addition, all children and adults are advised to minimise the time spent being sedentary for extended periods.

The Health Survey for England 2015 found that only one in ten children aged 2-4 years met the CMOs' recommendations for physical activity, specifically 10% of boys and 9% of girls.[49]

#### 2.4.5. Emotional health

The Mental Health in Children's JSNA Chapter was published in August 2018. This gives a comprehensive picture of the level of need in this subject area, available at the following link: http://www.lsr-online.org/leicestershire-2018-2021-jsna.html

### 2.5. Safe from harm

#### 2.5.1. Safeguarding

Data on the number of looked after children are useful because many children are in care due to circumstances which are likely to have affected their wellbeing: "Decisive action is of key importance to the wellbeing of very young children who come into the care of local authorities. The majority are from families where parents are struggling with issues such as domestic violence, substance abuse, alcohol abuse and mental health problems, often in combinations."[37]

Many looked after children have suffered abuse or neglect, which can be very damaging to their development, wellbeing and attachment relationships[50]: "A substantial number of children and young people are placed in local authority care as a result of maltreatment.

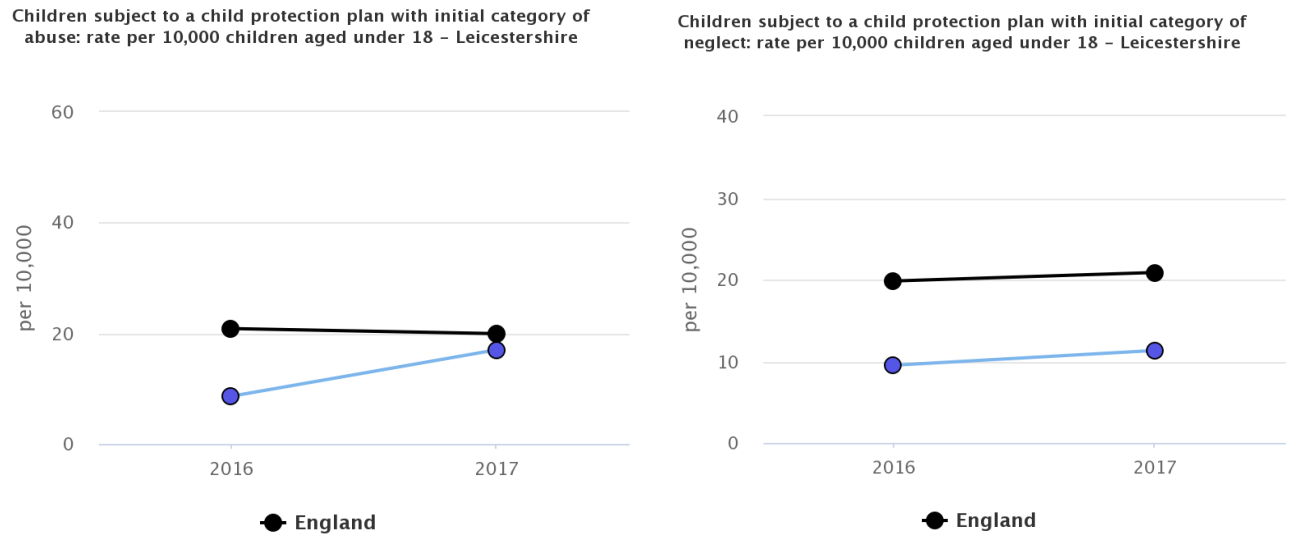
Many children suffer combinations of different forms of abuse and neglect and, as a result, experience the kind of care-giving in which key nurturing experiences are missing. In maltreated children, the child's primary attachment figure (usually the parent) is likely to be unavailable at times of need and may also be the cause of extreme fear and distress. This can lead to the development of insecure or disorganised attachment patterns and have an impact on brain development, which can in turn lead to impaired development.[50]"

Experiences of child maltreatment, whether in looked after children or others, can have very serious effects on a young child's development: "There is strong evidence of the harmful short- and long-term effects of child maltreatment. All aspects of the child's health, development and wellbeing can be affected.[51]"

Data on the number of children on a child protection plan can also give an indication of the numbers of children that have experienced maltreatment, although this will obviously only include those known to authorities.

Figure 29 shows for the last two years the rate of children subject to a child protection plan with initial category of neglect or abuse in Leicestershire has remained significantly lower than the national rate, however for both categories the rate has increased locally from 2016 to 2017. In 2017, 155 children were subject to a child protection plan with initial category of neglect and 233 children were subject to a child protection plan with initial category of abuse.[16]

**Figure 29: Trend of children subject to a child protection plan with initial category of abuse or neglect in Leicestershire**



### 2.5.2. Female Genital Mutilation (FGM)

Female Genital Mutilation (FGM) refers to procedures that intentionally alter or cause injury to the female genital organs for non-medical reasons. FGM has been illegal in the United Kingdom since 1985, with the law being strengthened in 2003 to prevent girls travelling from the UK and undergoing FGM abroad.

FGM data is collected by healthcare providers in England, including acute hospital providers, mental health providers and GP practices to present a national picture of the prevalence of FGM in the NHS in England. The majority of this data is collected in Midwifery and Obstetric services.

Between one and seven individual women (due to data suppression) resident in Leicestershire had an attendance where FGM was identified or a procedure related to FGM was undertaken at NHS trusts and GP practices in 2017/18. For all of these women, FGM was untaken in Africa.[52]

### 2.5.3. Child Sexual Exploitation (CSE)

Child sexual exploitation (CSE) is a type of child abuse. It happens when a young person is encouraged, or forced, to take part in sexual activity in exchange for something. In Leicestershire between 2017/18 there were 161 child sexual exploitation crimes and 336 child sexual exploitation incidents in the county.[53]

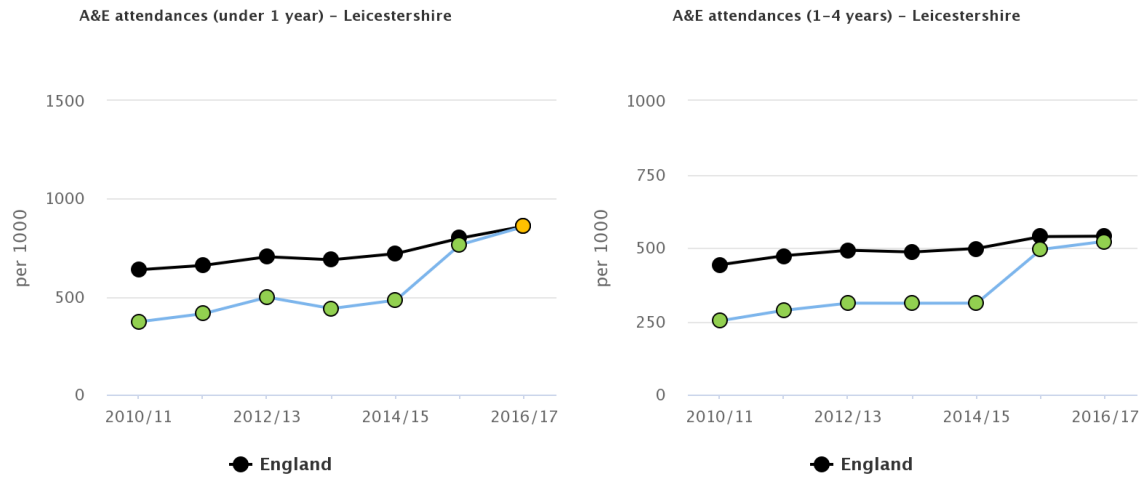
### 2.5.4. Managing minor illnesses

#### 2.5.4.1. Accident & Emergency Attendances

Both nationally and locally a significant increasing trend (over the last five years) has been witnessed in A&E attendances in those patients aged under one year. In Leicestershire the latest rate in 2016/17 performed similar to the national rate, whereas for the six previous years, Leicestershire performed significantly better than the national rate. Both nationally and locally a significant increasing trend (over the last five years) has also been witnessed in A&E attendances in those patients aged 1-4 years. However throughout this time in Leicestershire the rate has remained significantly better (lower) than the national rate.[40]

Within the A&E data set, Urgent Care Centres did not submit data to SUS pre April 2015. Nationally set guidance stated that all 'Type 3' departments should submit data from 2015/16, reflecting a jump in attendances from 2014/15.

**Figure 30: Trend in A&E attendances by age in Leicestershire[40]**



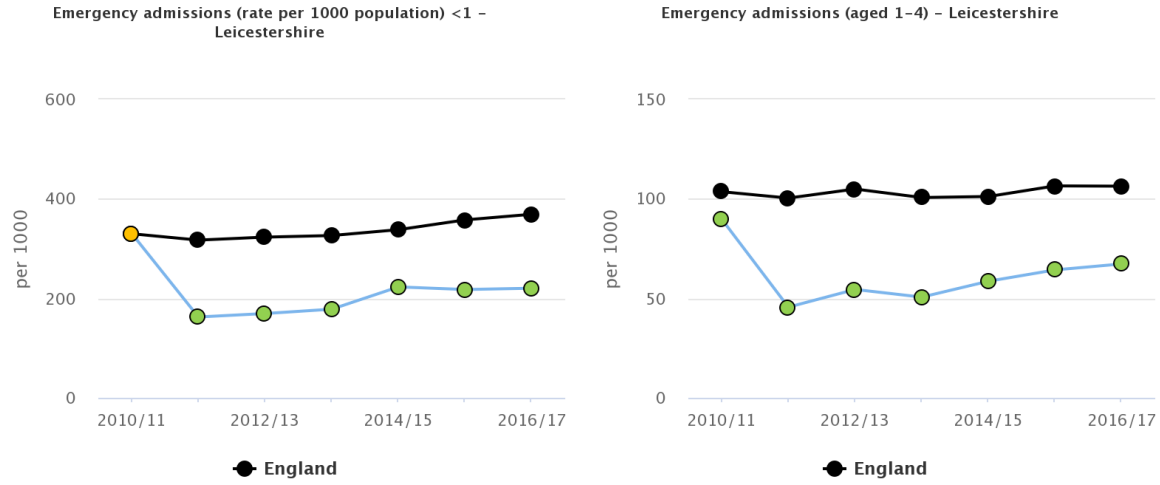

### 2.5.4.2. Emergency admissions

Approximately 35% of all admissions in the NHS in England are classified as emergency admissions, costing approximately £11 billion a year. Admitting a patient to hospital as an emergency case is costly and frequently preventable, yet the number of emergency admissions to hospital has been rising for some time. From a public health point of view, emergency admissions data gives an indication of wider determinants of poor health, linked to areas such as housing and transport.

Over one quarter of emergency hospital admissions in children aged under 5 years in 2014/15 was for respiratory infections. Factors such as smoking in the home and damp housing are known to increase the risk and severity of respiratory infections in young children.

Both nationally and locally a significant increasing trend (over the last five years) has been witnessed in emergency admissions in those patients aged under one year. However throughout this time in Leicestershire the rate has remained significantly better (lower) than the national rate. This pattern is replicated, both nationally and locally, for those patients aged 1-4 years.[40]

**Figure 31: Trend in emergency admissions by age in Leicestershire[40]**

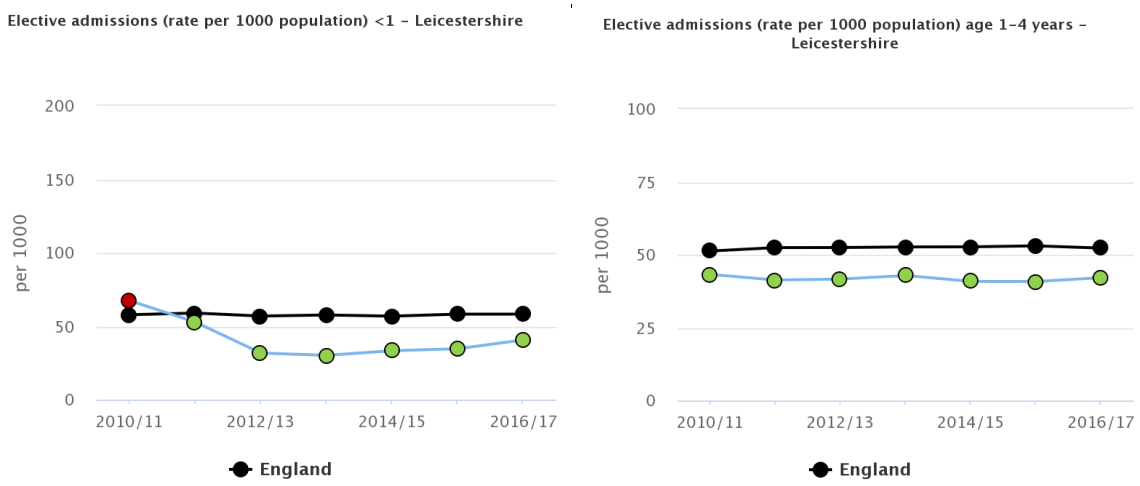



#### 2.5.4.3. Elective admissions

One third of elective admissions of babies aged under one year in 2014/15 related to a congenital abnormality. Effective antenatal screening can help plan demand for services. An additional 11% of elective admissions of infants nationally related to complications of pregnancy, labour and delivery. The Maternity Transformation Programme supports the Secretary of State's ambition to halve the number of stillbirths, neonatal and maternal deaths and brain injuries by 2030.

Both nationally and locally a significant increasing trend (over the last five years) has been witnessed in elective admissions in those patients aged under one year. However throughout this time in Leicestershire the rate has remained significantly better (lower) than the national rate. For those patients aged 1-4 years, the rate of elective admissions has remained stable over the last seven years, whereas nationally the rate has significantly increased. Throughout this time, the rate has remained significantly better (lower) than the national rate.[40]

**Figure 32: Trend in elective admissions by age in Leicestershire[40]**

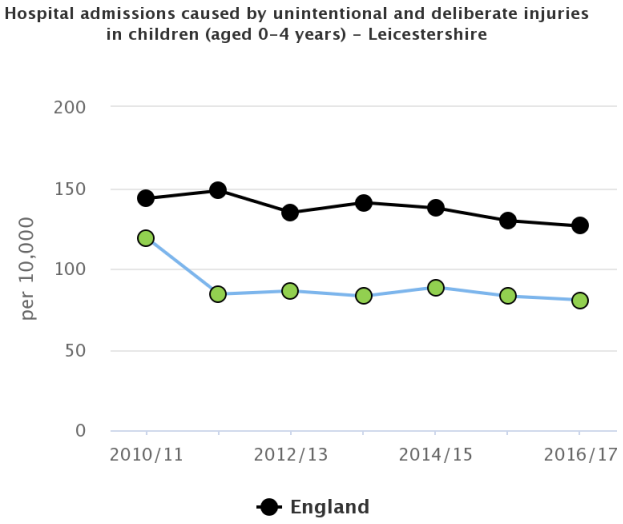



### 2.5.5. Accidents and deliberate injuries

Injuries are a leading cause of hospitalisation and represent a major cause of premature mortality for children and young people. They are also a source of long-term health issues, including mental health related to experiences.

Figure 33 shows the trend in emergency hospital admissions caused by unintentional and deliberate injuries in Leicestershire has remained significantly better (lower) than the national rate for the last seven data points (since recording). The rate in Leicestershire has shown a significant decline year on year since 2010/11, a pattern also witnessed both nationally and regionally. Despite this, in 2016/17 there were almost 300 (297) hospital admissions caused by unintentional and deliberate injuries in children aged 0-4 years in Leicestershire.[23]

**Figure 33: Trend in emergency hospital admissions caused by unintentional and deliberate injuries (rate per 100,000 resident population of children aged 0 to 4 years)**




### 2.5.5.1. Unintentional injuries in and around the home

Unintentional injuries in and around the home are a leading cause of preventable death for children under five years old and are a major cause of ill health and serious disability. They are linked to a number of factors including:

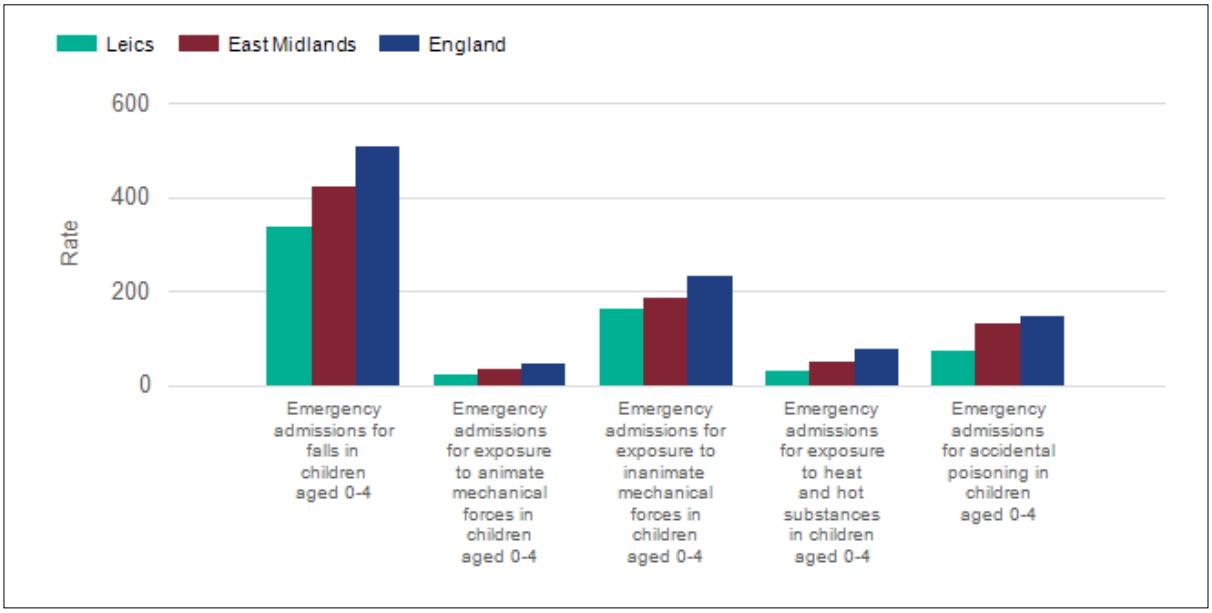
- child development
- the physical environment in the home
- the knowledge and behaviour of parents and other carers (including literacy)
- overcrowding or homelessness
- the availability of safety equipment
- new consumer products in the home

Nationally the five most common causes of emergency hospital admission for injury are falls, injuries from being hit, crushed or cut by physical objects, poisoning, burns and scalds and injuries caused by humans (not including assaults or self-harm) or animals. These causes account for over 90% of all emergency hospital admissions for unintentional injuries. Local, regional and national rates for these causes are shown in Table 15 below, for the three-year period 2014/15 to 2016/17. The count of emergency admissions is shown in brackets. The latest local data for each of these causes shows Leicestershire performs significantly better (lower) than the national rate in 2014/15-2016/17.[40]

**Table 15: The main causes of emergency hospital admissions for under-fives following unintentional injuries in and around the home in 2014/15-2016/17 (rate per 100,000 resident population of children aged 0 to 4 years)**

| | Emergency admissions for falls in children aged 0-4 | Emergency admissions for exposure to animate mechanical forces in children aged 0-4 | Emergency admissions for exposure to inanimate mechanical forces in children aged 0-4 | Emergency admissions for exposure to heat and hot substances in children aged 0-4 | Emergency admissions for accidental poisoning in children aged 0-4 |
|---|---|---|---|---|---|
| Leicestershire | 338.2 (391) | 19.9 (23) | 162.6 (188) | 28.5 (33) | 72.7 (84) |
| East Midlands | 420.6 (3,512) | 33.3 (278) | 183.5 (1,532) | 47.7 (398) | 131.0 (1,094) |
| England | 509.1 (52,412) | 43.3 (4,454) | 233.1 (23,992) | 77.6 (7,984) | 145.5 (14,976) |

**Figure 34: The main causes of emergency hospital admissions for under-fives following unintentional injuries in and around the home in 2014/15-2016/17 (rate per 100,000 resident population of children aged 0 to 4 years)**



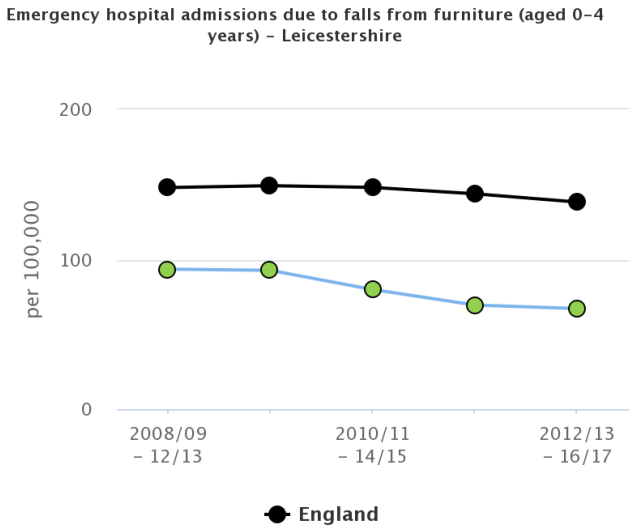

#### 2.5.5.1.1. Falls from furniture

Falls are the leading cause of injury related hospital admissions in the under-fives, with falls from furniture causing the highest number in this category. Deaths are infrequent, but even a fall from a high chair can have serious consequences including brain damage.

Prevention of these injuries largely fall under two categories. Firstly ensuring that furniture and play equipment are well maintained and that any safety harnesses on high chairs, swings and other seats are securely fitted and fastened. Secondly ensuring that babies and younger children are not left unattended on raised surfaces, particularly when changing nappies.

Figure 35 shows the trend in emergency hospital admissions due to falls from furniture in Leicestershire has remained significantly better (lower) than the national rate for the last five data points (since recording). The rate in Leicestershire has also declined year on year since 2008/09-12/13 whereas the national rate has declined over the last three time periods.[40]

**Figure 35: Trend in emergency hospital admissions due to falls from furniture (rate per 100,000 resident population of children aged 0 to 4 years)**



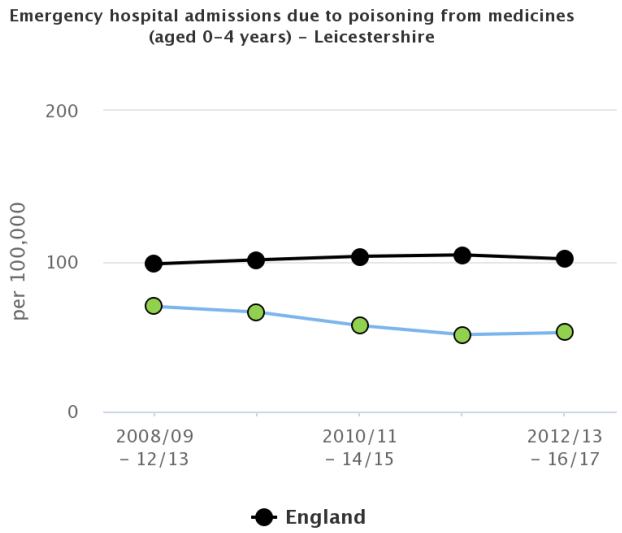

### 2.5.5.1.2. Poisoning from medicine

Medicines cause almost 70% of poisoning admissions in this age group. Medicines should be kept well out of reach of all children, preferably in a locked cupboard.

Figure 36 shows the trend in emergency hospital admissions due to poisoning from medicines in Leicestershire has remained significantly better (lower) than the national rate for the last five data points (since recording). The gap between the national and local rate has widened as the local rate has broadly declined and the national rate has broadly stabilised. The latest data shows there were 101 emergency hospital admissions due to poisoning from medicines in children aged 0-4 years in Leicestershire between 2012/13-

2016/17.[40]

**Figure 36: Trend in emergency hospital admissions due to poisoning from medicines (rate per 100,000 resident population of children aged 0 to 4 years)**



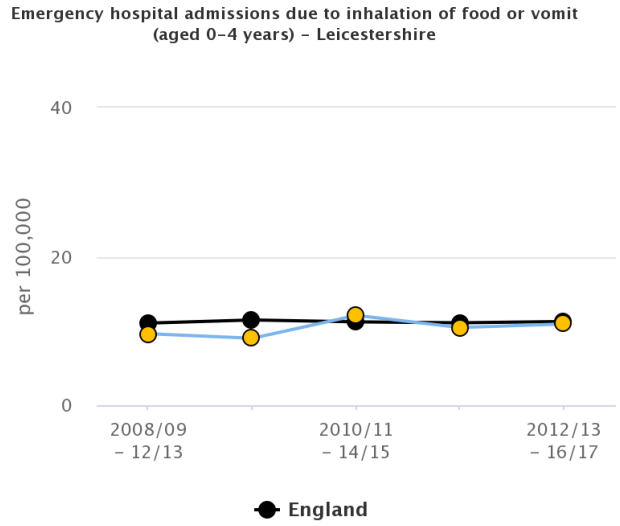

#### 2.5.5.1.3. Choking caused by the inhalation of food or vomit

Inhalation of food or vomit causes relatively low numbers of hospital admissions, but is a leading cause of death (45 nationally between 2012 and 2016).

Younger children should always be supervised while eating, and should sit to do so rather than run around or lie down. Foods like tomatoes, grapes and blackberries should be cut into quarters.

Figure 37 shows the trend in emergency hospital admissions due to inhalation of food or vomit in Leicestershire has remained similar to the national rate for the last five data points (since recording). The latest data shows there were 21 emergency hospital admissions due to this cause in children aged 0-4 years in Leicestershire and Rutland (combined) between 2012/13-2016/17.[40]

**Figure 37: Trend in emergency hospital admissions due to inhalation of food or vomit (rate per 100,000 resident population of children aged 0 to 4 years)**



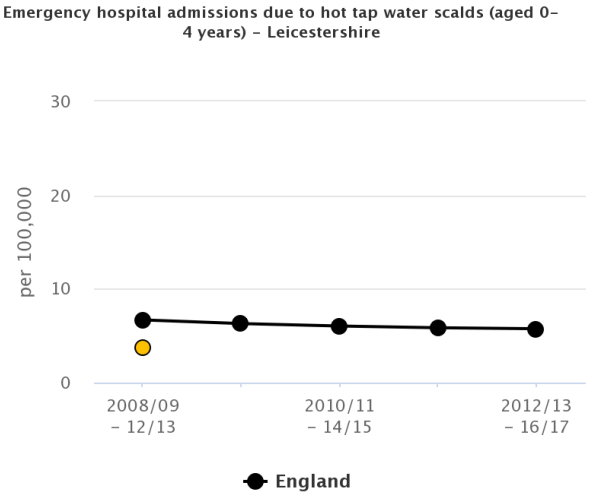

### 2.5.5.2. Scalds from the hot water tap

Scalds from hot water, usually involving the bath, cause few deaths but injuries can be very severe. The peak in admissions in this age group is around one year old.

Prevention opportunities mainly come in the form of awareness, with advice to always keep an eye on a child when the bath is running and while he or she is in the bath, and to properly check the temperature before putting a child in the water. Fitting a thermostatic mixing valve is recommended to control the water temperature.

No data is available for Leicestershire for the last four time periods due to data suppression. This means the count of admissions are less than five for all children aged 0-4 years in Leicestershire in each time period.[40]

**Figure 38: Trend in emergency hospital admissions due to hot tap water scalds (rate per 100,000 resident population of children aged 0 to 4 years)**



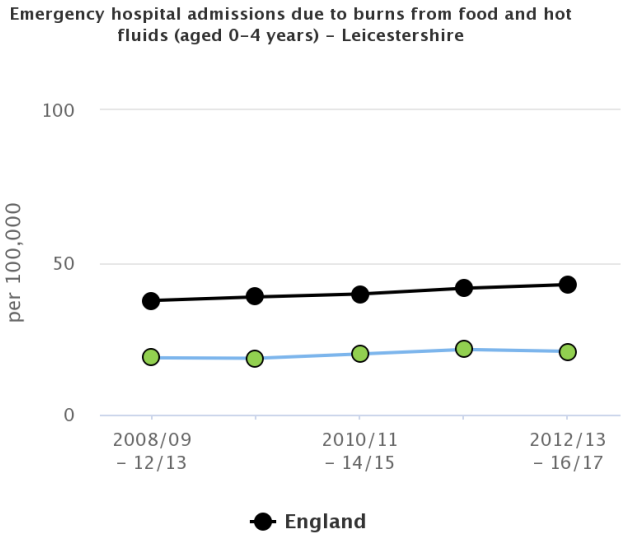

### 2.5.5.3. Burns from food and hot fluids

Burns from food and hot fluids mainly occur in the kitchen and, like bathwater scalds, these injuries can be quite severe.

Prevention opportunities include ensuring that hot drinks are out of reach of children, and that pans are kept on back burners where possible with handles turned inwards to keep them away from children's hands.

Figure 39 shows the trend in emergency hospital admissions due to burns from food and hot fluids in Leicestershire has remained significantly better (lower) than the national rate for the last five data points (since recording). The national rate has increased year on year since 2008/09-12/13 whereas locally the rate increased over the previous four time periods but the latest rate has stabilised. The latest data shows there were 40 emergency hospital admissions due to this cause in children aged 0-4 years in Leicestershire and Rutland (combined) between 2012/13-2016/17.[40]

**Figure 39: Emergency hospital admissions due to burns from food and hot fluids (rate per 100,000 resident population of children aged 0 to 4 years)**




### 2.5.6. Child mortality

Leicester, Leicestershire and Rutland (LLR) Child Death Overview Panel (LLR CDOP) undertakes a comprehensive and multi-agency review of all child deaths, in order to better understand how and why children across LLR die, with a view to detecting trends and/or specific areas which would benefit from further consideration. The LLR CDOP has been gathering data since 2009 and been producing annual reports which summarise the data collected in each year. However, detailed analysis and conclusions have been limited due to the fortunately small numbers reviewed on an annual basis.

#### 2.5.6.1. Infant mortality

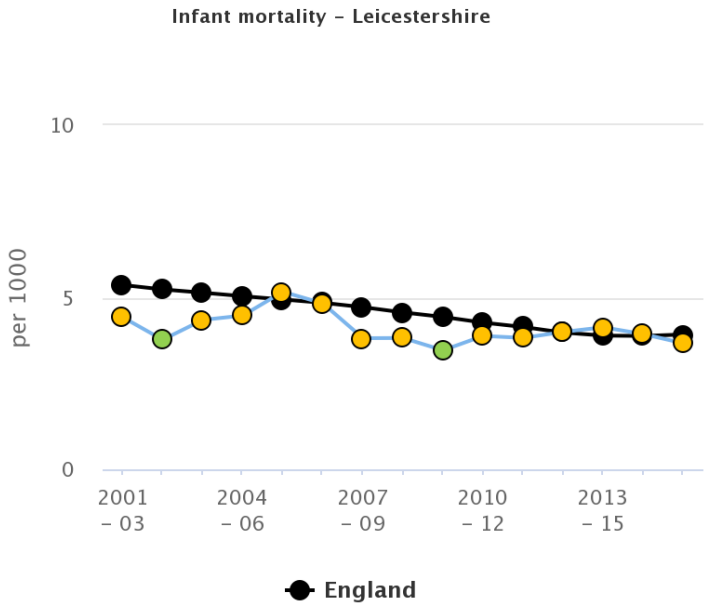
Infant mortality can be divided into neonatal deaths, (mortality up to 27 days after live birth) and post-neonatal mortality (deaths from 28 days to under one year).

In England and the East Midlands, the majority of infant deaths occur in the neonatal period, (74.2% in the East Midlands, compared to 70.6% in England). Between 2014 and 2016 there were 87 infant deaths in Leicestershire and Rutland (combined), 69 (79.3%) of these were neonatal deaths.[23]

Nationally the trend in infant mortality has declined year on year between 2001-03 and 2012-14. For the last three time periods, the rate has remained stable at 3.9 per 1,000 live births. The trend in Leicestershire has remained similar to the national average for all but two data points in 2002-04 and 2009-11, where it performed significantly better (lower) than the national rate. The latest infant mortality rate in 2015-17 in Leicestershire is 3.7 per

1,000 live births, equating 77 infant deaths throughout this time period.[23]

**Figure 40: Trend in infant mortality in Leicestershire**

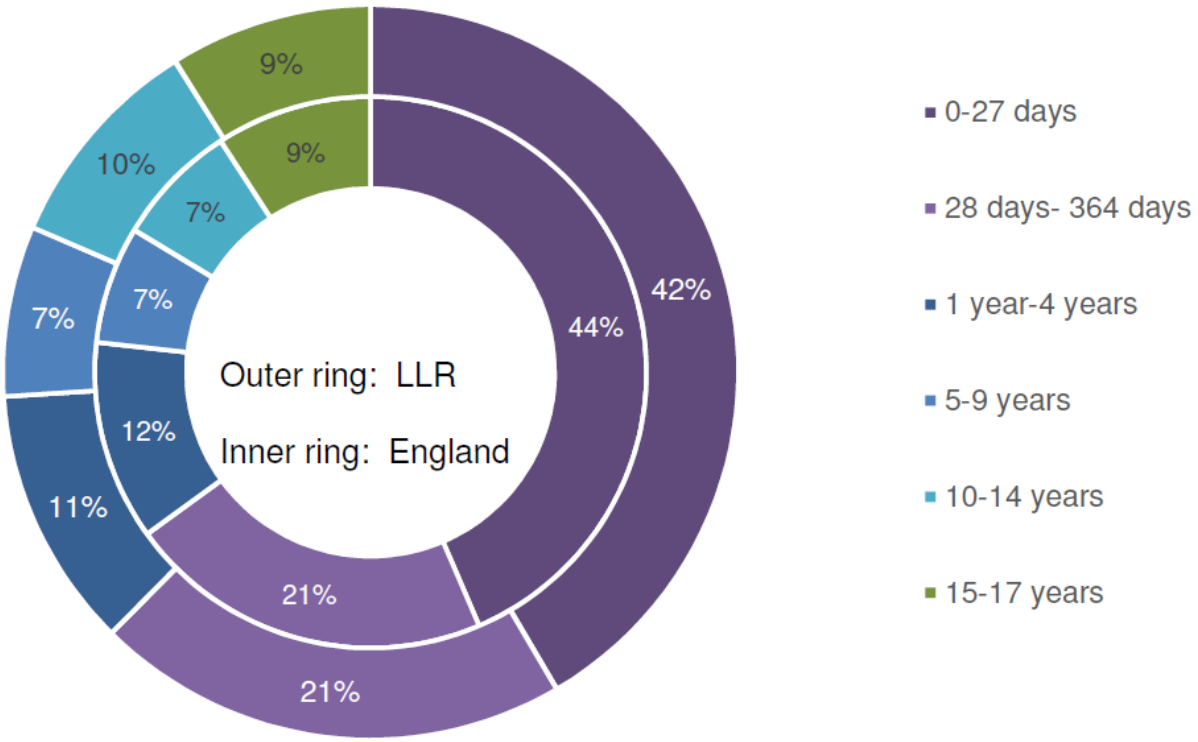



Further analysis shows that within Leicestershire between 2013-2017, almost three quarters (71.5%) of infant deaths were due to conditions originating in the perinatal period and 10.0% were due to congenital malformations, deformations and chromosomal abnormalities.[54]

#### 2.5.6.1. Child death reviews in LLR by age of child at death

Over the period 2011/12 to 2016/17, 42% child deaths in LLR were for infants under 28 days, a further 21% for infants aged 1-12 months and 12% aged between 1-4 years. These are not significantly different to England.[55]

**Figure 41: Child death reviews in Leicester, Leicestershire and Rutland by age of child at death (2011/12 to 2016/17)[55]**

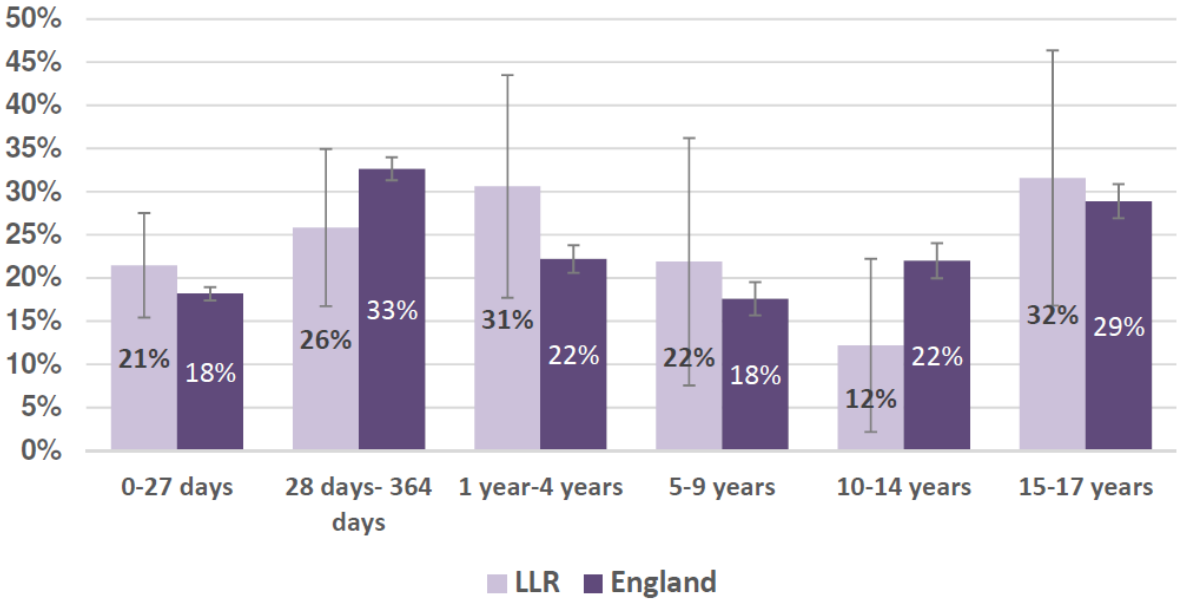



Factors which contribute to neonatal and infant deaths are generally recognised as poverty, infant nutrition, smoking in pregnancy, maternal and infant infections, obesity in mothers and early access to high quality, culturally sensitive maternity care.

Of the 177 cases of neonatal deaths (0-27 days) between 2011/12 to 2016/17, 124 (70%) of these deaths were babies born prematurely.

No age group in LLR has a proportion of modifiable factors which is significantly different to England. The highest proportion of modifiable factors (31%: 15 cases in total) in LLR were identified in children aged between 1-4 years old. In children aged 1-11 months old, 26% were identified as modifiable.[55]

**Figure 42: Child death reviews with modifiable factors by age of child at death (2011/12 to 2016/17)[55]**




## 3. How does this impact?

Investing in early years services can improve babies' and children's health outcomes including:

- early cognitive and non-cognitive development
- social development
- children's readiness for school
- later educational outcomes

This is a crucial time when parents have contact with health and early years services before, and after, the birth of their child and are especially receptive to offers of advice. It is an opportunity to support all families to give children the foundations for good health and extra support when needed. Identification and early intervention can identify families at risk of problems escalating into neglect and abuse. A failure to act early comes at great cost, not only to individuals but to society as a whole.

The economic case for investment in the early years is strong. Social Return on Investment studies showed returns of between £1.37 to £9.20 for every £1 invested. Furthermore, it is estimated that failing to deal adequately with perinatal mental health problems comes at a cost of £8.1 billion each year.[56]

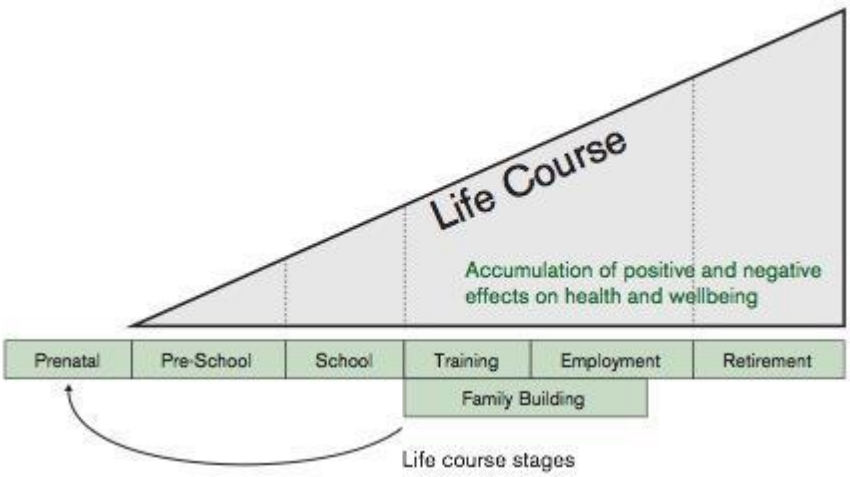
## 4. Policy and Guidance

All children deserve the best possible start in life but unfortunately not all children get this. It is important that we try to create a supportive environment to enable children and young people to thrive.

This supportive environment can be created through the delivery of key programmes and interventions informed through policy and guidance including:

The first years of life are a critical opportunity for building healthy, resilient and capable, young people and adults.

**The Marmot Review**[1] identifies 'Give every child the best start in life' as one of its six Policy Objectives to reduce health inequalities and is the highest priority objective in the report. Marmot recommends a 'Life Course Approach'




This Policy Objective aims to:

- Reduce inequalities in the early development of physical and emotional health, and cognitive, linguistic, and social skills.
- Ensure high quality maternity services, parenting programmes, childcare and early year's education to meet need across the social gradient.
- Build the resilience and well-being of young children across the social gradient.

The policy objective has a number of recommendations:

- Increasing the proportion of overall expenditure allocated to the early years,

- Supporting families to achieve progressive improvements in early child development, including: — Giving priority to pre- and post-natal interventions that reduce adverse outcomes of pregnancy and infancy

- Providing paid parental leave in the first year of life with a minimum income for healthy living

- Providing routine support to families through parenting programmes, children's centres and key workers, delivered to meet social need via outreach to families

- Developing programmes for the transition to school.

- Providing good quality early years education and childcare proportionately across the gradient. This provision should be: — Combined with outreach to increase the take-up by children from disadvantaged families — Provided on the basis of evaluated models and to meet quality standards.

**The Chief Medical Officer Annual Report (2012)[57] Our Children deserve better: Prevention Pays** focuses on giving children a good start and building their resilience. It encourages the use of a Life Course approach and recognises that events that occur in early life (indeed foetal life) affect health and wellbeing later and that it makes sense to intervene early and that the evidence still points to room for improvement. The CMO report recommends that everyone in the public services 'think family and children and young people' at every interaction.

**Public Health England** carried out a **Rapid Review to update the evidence for the Healthy Child Programme[58] in 2015**

The Rapid Review looks at the purpose of the high impact areas within the 0-19 Healthy Child Programme and helps to articulate the contribution of Public Health Nurses (health visitors) to the 0-5 agenda and school nurses to the 5-19 agenda and to describe areas where health visitors and school nurses have a significant impact on health and wellbeing and improving outcomes for children, families and communities.

The six early years high impact areas are:

- Transition to parenthood and the early weeks

- Maternal mental health

- Breastfeeding (initiation and duration)

- Healthy weight, healthy nutrition (to include physical activity)
- Managing minor illnesses and reducing hospital attendance/admissions

Health, wellbeing and development of the child aged 2: Two year old review (integrated review and support to be 'ready for school')

The High Impact Areas are informed by NICE guidance and underpinned by the 4 principles of public health nursing. The four contemporary principles were first published in 1977.

They are:

- search for health needs
- stimulation of an awareness of health needs
- influence policies affecting health
- facilitate health enhancing activities

They complement and are aligned with the **Early years foundation stage profile: 2016**[59] handbook and the resources for school aged children published in the school aged children profiles published by the **National Child and Maternal Health Intelligence Network in 2015**.[40]

### 4.1. The Key policy drivers for the 6 High Impact Areas were:

- **Health visitor implementation plan 2011-2015: A call to action, Department of Health, 2011**[60]

  This plan identifies the start of life as being a crucial time for children and parents. Good, well-resourced health visiting services can help ensure that families have a positive start, working in partnership with GPs, maternity and other health services, Sure Start Children's Centre's and other early years services.

- **Fair society, healthy lives, The Marmot review, 2010**
- **Chief Medical Officer's annual report 2012: Our children deserve better: Prevention pays, Department of Health, 2013**
- **Healthy lives, healthy people: Our strategy for public health in England, Department of Health, 2010**
- **Healthy lives, healthy people: Update and way forward, Department of Health,**

**2011**

- **Healthy lives, healthy people: Improving outcomes and supporting transparency, Department of Health, 2013**

- **Early intervention: The next steps, Department for Work and Pensions and Cabinet Office, 2011**

  A report by Graham Allen (former MP) about how intervention in children's earliest years can eliminate or reduce costly and damaging social problems. It examines how this could be done by giving children and parents the right type of evidence-based programmes, especially in the children's earliest years**.**

- **Five Year Forward View, NHS England, 2014**

  This report recognises that the future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a radical upgrade in prevention and public health. It acknowledges the recommendations of Derek Wanless' health review, which warned that unless the country took prevention seriously we would be faced with a sharply rising burden of avoidable illness.

- **NHS Long Term Plan: NHS England, 2019.** This new NHS Long term plan states that it aims to give everyone the 'best start in life'

- **From evidence into action: Opportunities to protect and improve the nation's health, Public Health England, 2014.** This strategic document set out Public Health England's (PHE) priorities for the next 5 years including: 'ensuring every child has the best start in life'

- **Healthy Child Programme 0-19: Health visitor and school nurse commissioning, Public Health England, 2016 and**

- **Best Start in Life and Beyond : Commissioning guidance Public Health England 2018**

  Both commissioning guidance documents emphasise all of the evidence and guidance highlighting the importance of ensuring every child has the best start in life.

- **Getting it right for children, young people and families: Maximising the contribution of the school nursing team: Vision and call to action, Department of Health, 2012**

This guidance highlights the best practice in school nursing and health visiting to support the delivery of the Healthy Child Programme.

- **Future in mind: Promoting, protecting and improving our children and young people's mental health and wellbeing, Department of Health and NHS England, 2012**

  This guidance states that it wants children to grow up to be confident and resilient and that parents and carers need the help they need to support their children.

- **National Study of Health and Wellbeing: Children and Young People NHS Digital 2017**

  The 2017 survey aims to find out about the health, development and wellbeing of children and young people aged between 2 and 19 years old in England. It will cover around 9,500 children and young people living in private households in England

4.2. **Key policy drivers for Maternity Care in England**

- **Better Births: Improving outcomes for Maternity Services in England: A Five Year forward view for Maternity Care. NHS England 2017**

  This highlights the need for: Better postnatal and perinatal mental health care, to address the historic underfunding and provision in these two vital areas, which can have a significant impact on the life chances and wellbeing of the woman, baby and family

  The local Better Births strategy is the LLR Transformation Plan for Maternity Services 2017-2021

- **Saving Babies' Lives: a care bundle for reducing stillbirth NHS England 2018**

  Saving Babies' Lives is designed to tackle stillbirth and early neonatal death. It brings together four elements of care that are recognised as evidence-based and/or best practice:

  1. Reducing smoking in pregnancy

  2. Risk assessment and surveillance for fetal growth restriction

  3. Raising awareness of reduced fetal movement

  4. Effective fetal monitoring during labour

- **EMBRRACE – UK Mothers and Babies reducing stillbirth: surveillance and confidential enquiry**

  EMBRRACE-UK: Saving Lives, Improving Mothers' Care Report (2018) reports on the lessons learned to inform maternity care from the UK and Ireland 2014-2016.

### 4.3. Policy Guidance Adverse Childhood Experiences

- **Routine Enquiry about Adverse Childhood Experiences (ACEs) Implementation pack pilot evaluation (final report) -** this report highlights strong associations between ACEs and poor social and health outcomes throughout the life course.

- **Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. Felitti et al 1998**

  This study found a strong graded relationship between the breadth of exposure to abuse or household dysfunction during childhood and multiple risk factors for several of the leading causes of death in adults.

### 4.4. Early Years Policy Guidance

- **Early Years Foundation Stage Statutory framework:**

  The Framework sets standards for the learning, development and care of children from birth to 5 years old. It includes details about assessment including a Progress Check at 2 years.

- **Life Chances Inquiry**

  **Submission from the Royal College of Speech and Language Therapists (RCSLT)** the submission supports the Government's policies which seek to improve children's life chances, with a strong focus on communication skills and language development in the early years and beyond.

  It highlights that Communication is a fundamental life skill, which directly impacts on children's school readiness, their academic achievement, wellbeing and life chances.

  Children from areas of social disadvantage are more likely to start school with speech, language and communication needs (SLCN), putting them at risk of a range of negative outcomes, including exclusion from school, mental health problems,

unemployment and involvement in the criminal justice system.

- **1001 critical days: The importance of the conception to the Age 2 period**

  The 1001 Critical Days manifesto highlights the importance of intervening early in the 1001 critical days between conception to age 2 to enhance the outcomes for children. It is a cross party manifesto, focusing on babies having the best start in life, and focuses on the importance of early intervention.

4.5. **Local Policy drivers include:**

- **The Leicestershire Children & Families Partnership Plan 2018-2021 including Priority 1 'Ensuring the best start in life'-** to develop an integrated early years pathway to ensure the needs of vulnerable children are identified and to develop a shared understanding of the importance of the first 1001 critical days and school readiness.

  **Priority 5 'Enable children to have a good physical and mental health'** – to develop a whole system approach to obesity based on 'Making obesity everyone's business' and to develop a partnership approach to emotional and mental wellbeing based on the Adverse Childhood Experience evidence base.

- **Strategy to Support Healthy Pregnancy, Birth & Babies in Leicester, Leicestershire & Rutland 2019-2024 and Action Plan (formerly Strategy for Reducing Infant Mortality in Leicester, Leicestershire and Rutland 2016-2019 and Action Plan)**
  This strategy encompasses health in relation to pre-conception, pregnancy and for the first year of a babies' life. The overall aim of this strategy is to ensure pregnancies and babies are as healthy as possible to keep women and babies safe. The principles which will guide this work are:

  - to make it everybody's business to support health in pregnancy and health for babies
  - to provide strategic leadership and accountability for the delivery against the agreed actions
  - to ensure a multi-agency partnership approach across the LLR is used to deliver the action plan
  - to promote the safety and welfare for all children and young people – implementing sound safeguarding practices and procedures and always adhering to the Local Safeguarding Children's Board Child Protection

Procedures

The Action Plan includes:

- Learning from good practice
- Promotional campaigns and communications including Safe Sleep week
- Support for strategic and partnership work
- Bespoke work with fosters/ kinship carers
- Cumulative impact of risk factors
- Modifiable risk factors relating to mothers
- Modifiable risk factors relating to the baby
- Modifiable risk factors relating to the living environment

- **LLR Infant Feeding Strategy 2016-2020:** The overall vision is that women in Leicester, Leicestershire and Rutland feel empowered to make informed decisions about how they feed their babies, with women and families feeling confident and supported to breastfeed and to make the transition from milk to healthy solid foods.

  The key aim of the LLR Infant Feeding Strategy is to protect, promote and support optimal nutrition for all infants and improve maternal health. This includes: the improvement of breastfeeding rates (initiation and longer term); the reduction of health inequalities in relation to breastfeeding; increase the uptake of Healthy Start provision and encourage appropriate weaning practices to support optimum nutrition and growth, healthy weight and good oral health.

  Implementing the strategy will ensure that women and families are offered information on the method of feeding their child along with support to implement their chosen method, in terms of breastfeeding and artificial feeding, when considering vitamin supplements, and when moving their child onto solid foods.

  The strategy's objectives include to:

  - Achieve and maintain full UNICEF UK Baby Friendly Initiative (BFI) accreditation for women and children's services in the acute and community settings.

- Develop LLR's breastfeeding support network to offer universal support to breastfeeding mothers.
- Implement workforce training and development in all maternity and early years' settings to increase knowledge of infant feeding.
- Develop a cross-organisational infant feeding pathway including pre-conception, pregnancy and children aged 0 to 5 years, to promote optimum nutrition.
- Engage and communicate the benefits of breastfeeding and infant nutrition to all populations in LLR.
- Create a culture where breastfeeding becomes the easier choice and use our collective influence to ensure this happens.

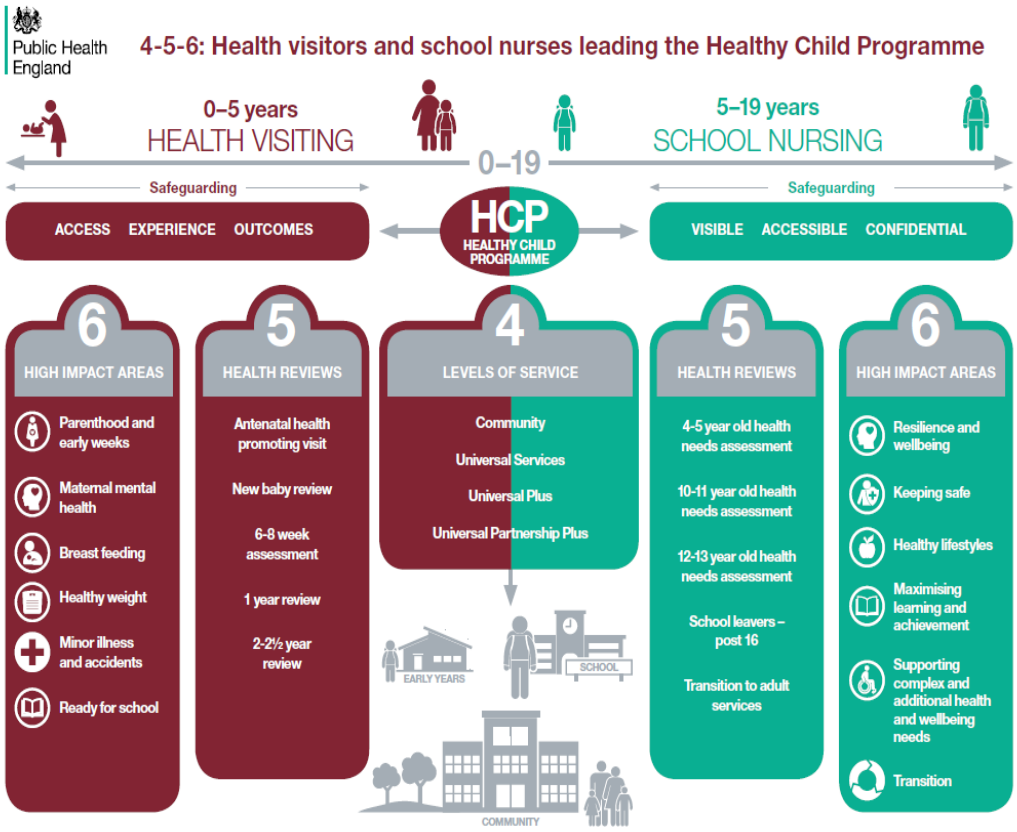
Key actions include: Attain full UNICEF BFI Accreditation for Maternity Services in LLR; Maintain full UNICEF BFI accreditation for Community Health Services in LLR, Achieve full UNICEF BFI accreditation for De Montfort University, Strengthen the Breastfeeding support networks, Finding out what influences the decision to breastfeed, continuing to breastfeed and weaning practices, Promote healthy weaning practices.

## 5. Current Services

### 5.1. Services commissioned by Leicestershire County Council's Public Health Department:

**The 0-19 Healthy Child Programme** is delivered by Leicestershire Partnership NHS Trust's 'Healthy Together' team in Leicestershire it is an evidence based programme delivered by Public Health Nurses (Health Visitors & School Nurses). It follows a 4-5-6 model:

**Figure 43: 4-5-6 Health visitors and school nurses leading the Healthy Child Programme**




**4. Levels of Service**: Community Universal/ Universal Plus/ Universal Partnership Plus

**5. Mandated Contacts**: Ante natal (from 28 weeks of Pregnancy) New Birth Visit ( 10-14 days) 6-8 weeks/

**6. High Impact Areas**: Parenthood & Early weeks, Maternal Mental Health, Breastfeeding, Healthy weight, minor illnesses and accidents, ready for school.

The high impact areas for 0-5 year olds can make a valid contribution to providing children in Leicestershire with the 'Best Start in Life'. Safeguarding is central to the 0-19 Healthy Child Programme. In addition, to the national high impact Area; Oral Health has been identified as a local high impact area for Leicestershire

### 5.1.1 The Core principles of the High Impact areas:

There are a number of core principles that are common and assumed in each of the high impact area documents:

Universal services are essential for primary prevention, early identification of need and early intervention. Universal services lead to harm reduction and enable early support pathways to be identified.

Early intervention evidence-based programmes should be used to ensure that needs are identified and met in a timely way.

- All areas focussing on improving health outcomes and reducing inequalities at individual, family and community level
- Outcome measures align between health and education/other early years providers and there should be shared outcomes across the system
- Safeguarding is a thread throughout all of the high impact areas ranging from identification or risk and need, to early help and targeted work, through to child protection and formal safeguarding
- Clinical judgement will be used alongside formal screening and assessment tools
- Health visitors and school nurses have an important role as leaders of the Healthy Child Programme which should form part of the multi-professional care pathways and integration of services for children aged 0-5 and 5-19
- Public health, health promotion, prevention and safety is covered during every contact

### 5.1.2 Early Start Programme

Healthy Together Public Health nurses (Health visitors) deliver the Early Start Programme throughout Leicestershire. Up to 100 families are able to receive this intensive level of support in Leicestershire. The Early Start Programme (ESP) provides intensive early intervention and support for vulnerable first time parents with an infant 0-2 years living in Leicestershire. Informed by an outreach health visiting model, ESP is delivered by health visitors, early childhood practitioners and family nursing support staff and provides families with bespoke support. Support can start from 16 weeks pregnancy until the child's second birthday.

The aim of the Programme is to ensure all children in Leicestershire have the best start to life and prepare and equip vulnerable parents for parenthood. The objective of the programme is to ensure that participating parents and families have the skills, knowledge, confidence and capability to enable them to give their children the best possible physical, emotional, social and environmental outcomes.

There is information on 'The Best Start in Life 'issues on the 3 **Healthy Together websites** including:

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

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

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

### 5.1.3 Chat Health SMS Service

Parents of children and young people aged 0-19 years can access support and confidential advice about parenting, your child's behaviour, child development, emotional health & wellbeing or just general enquires through the Chat Health SMS Service 07520 615382

### 5.1.4 Oral Health Promotion service

The Oral Health Promotion Service (provided by Leicestershire County Council's Public Health Department) objectives include:

To increase awareness and knowledge around oral health promotion amongst the wider public health workforce, including dental practice staff, to ensure they are giving up to date and evidence based oral health messages

To ensure, in liaison with Public Health Nurses / Healthy Together team (health visitors), that all children receive their Healthy Teeth, Happy Smiles first tooth brush and paste pack

To promote access to dentists as soon as the child's teeth are evident and promote oral health preventative treatments in line with Delivering Better Oral Health

To improve the oral health of those groups with the poorest oral health (including children and young people in Special schools/ vulnerable adults)

**5.1.5 Baby Box** – the distribution of Baby Boxes to Teenage Mothers to be

- Provided by the Centre for Fun and Families
- The Baby box provides 'Teenage Mothers to be' with what they need to look after their baby
- The scheme helps to steer and refer pregnant women under 20 into relevant support services
- Consent from the 'mother to be' to share relevant data with the Teenagers with Babies Action Group
- More robust referral routes between agencies
- Young parents have access to, and engage readily with, information about local services in their areas and know how and when to access them.

### 5.1.5 Teenagers with Babies Action Group (TBAG)

**The Leicestershire County Council's Children & Families Wellbeing Service** coordinates the TBAG meetings across each district/ borough council area in the county. The Teenagers with Babies Action Groups aim to:

- Ensure early access of support for young parents/parents-to-be.
- Support the development and maintenance of seamless support pathways for young parents to ensure their engagement with appropriate services and a reduction in negative outcomes
- Improve access of educational opportunities for young parents.

### 5.1.6 Leicestershire Healthy Tots Programme

The Leicestershire Healthy Tots Programme is a healthy early years programme. (Provided by LCC's Public Health Department)

Participating Early year settings have to fulfil criteria around the three core themes: emotional and wellbeing/ healthy eating/ physical activity to achieve healthy tots status and to renew their healthy tots status.

Early year settings are supported by public health through the website and training:

Leicestershire Healthy Tots: www.leicestershirehealthytots.org.uk

Leicestershire Healthy Tots Training: on emotional health & wellbeing, healthy eating and purposeful physical play

### 5.1.7 Adverse Childhood Experiences – developing a trauma informed approach

- ACEs and developing a trauma informed approach to care is one of the Priorities of the Children & Family Partnership Plan 2018-2021[61]
- A stakeholder event will be taking place in May 2019 to raise awareness about ACEs and to develop a trauma informed approach across Leicestershire based on the REACH programme

## 5.2. Services commissioned by Leicester City Clinical Commissioning Group (CCG) on behalf of West Leicestershire CCG, East Leicestershire & Rutland CCG

### 5.2.1. Speech and Language Therapy

The service is provided by Leicestershire Partnership NHS Trust and commissioned by Leicester City CCG (on behalf of Leicester City, West Leicestershire, East Leicestershire & Rutland CCG). It provides a range of services for families, parents, carers to improve children and young people's progress if they have difficulties with:

- speech and language, communication skills
- eating drinking and swallowing skills

The aim is to improve children's progress in these areas to ensure that their potential for learning and social and emotional development is reached, working in partnership with key partners including Children Centres, early year settings etc.

## 5.3. SEND Local Offer

The Leicestershire Local Offer gives children and young people with special educational needs or disabilities (SEND) and their families' information about help and services in Leicestershire.

*Family Information Directory (FID)* includes information on: Disability and special educational needs groups (local offer)

## 5.4. Children & Family Wellbeing Service (Leicestershire County Council)

The new 0-19 Family and Well-being service from April 2019 will be delivered from 21 Children and Family Well-being Centres. This represents a significant change from the previous model of four separate services (Children's Centres, Youth Offending, Supporting Leicestershire Families and Early Help Information, Support and Assessment) offered through a total of forty different buildings (not including early years services provided by LPT which were delivered through these settings).

The new 0-19 Family and Well-being service will be modelled across 5 steps;

- Front door
- Information, advice and guidance
- Clinics and drop-ins – short-term pieces of work delivered in partnership with other

agencies

- Group work/brief intervention
- Intensive Family Support

There will be a 0-5 Core Offer as part of the 0-19 Family and Well-being service this will include;

- 0-2 Pathways
- Solihull (parenting programme)
- Freedom Programme (Domestic Abuse)
- Support for children with additional needs
- Young parents

### 5.5. **Mental Health (Child and adult)**

The Children & Families Wellbeing Service will continue to work in close partnership with Leicestershire Partnership NHS Trust and University Hospitals of Leicester to support, deliver and host mental health interventions (for children and adults) across the 0-19 cohort within the Children and Family Well-being Centres.

### 5.6. **Early Learning & Child Care Service (Leicestershire County Council)**

- developed school readiness shared definition for parents, providers and schools
- sent a leaflet to all parents whose child is due to start school in September with ideas to support their child with starting school
- developing a tool for school and providers for the early identification of children with additional needs
- in the very infancy of developing ideas for an eLearning tool for the workforce for identifying early identification of children who are at risk of delay of reaching their milestones (working in partnership with health)
- eLearning tool developed for home learning environment and language skills for 0-5 sector
- conference in March 2019 regarding school readiness for 0-5 sector where we will

launch a toolkit for the sector

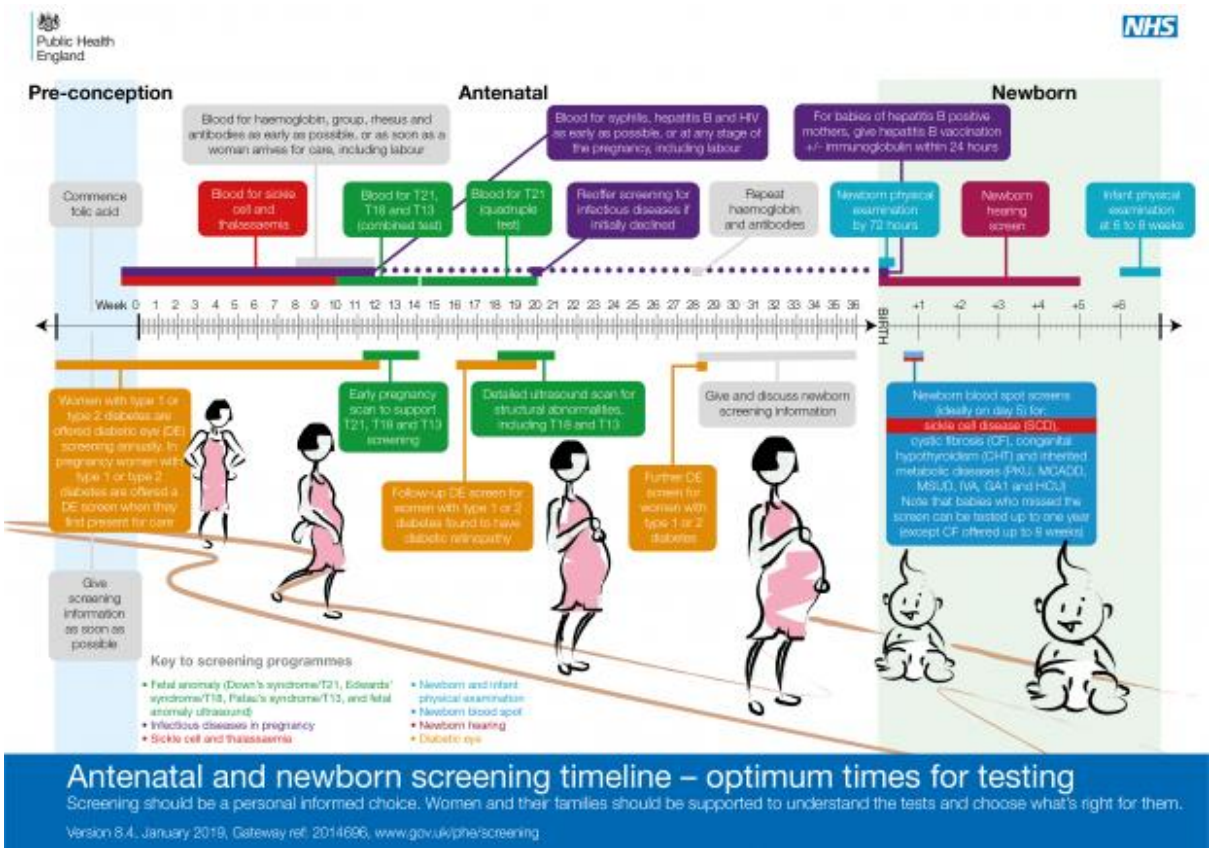
## 5.7. Maternity Services

UHL are implementing the **Better Births Action Plan** through the Leicester, Leicestershire & Rutland Local Maternity Systems Board. Within the LMS work stream, there is a focus on:

- Ensuring women have personalised care and choice
- Improving outcomes by early access to antenatal screening by 10 weeks
- Reducing intrauterine death, still births and infant mortality
- Improving access and ensuring women are offered antenatal and new-born screening in a timely manner
- Providing high quality, safe maternity and neonatal services based on best practice which are easily accessible by consolidating all women's acute and neonatal services on a single site supported by appropriate infrastructure and a flexible, multi-disciplinary workforce that responds to changes in volume and complexity
- Ensuring babies requiring specialist neonatal care, e.g. surgical or cardiac, are cared for in the right cot at the right time, as near to home as possible
- Developing robust transfer pathways to facilitate in-utero transfer of premature and sick infants
- Integrating pathways across primary, secondary and tertiary services
- Improving integrated perinatal mental health pathways to ensure early identification and treatment to improve outcomes
- Reducing the number of babies separated from their mother by reducing avoidable term admissions through implementing the ATAIN (Avoiding Term Admissions into Neonatal Units) recommendations and developing the transitional care services
- Ensuring adequate capacity, workforce and appropriate utilisation of regional neonatal transport services to support patient flows and guarantee that infants requiring specialist neonatal care (i.e. sick-term babies, premature babies, cardiac babies, and babies with neonatal surgical problems) are cared for in the right cot at the right time, as near to home as possible
- Better Births website http://www.leicestermaternity.nhs.uk/betterbirths/

- Leicester, Leicestershire & Rutland Maternity Services website: http://www.leicestermaternity.nhs.uk/

**Figure 44: NHS Antenatal and Newborn Screening and immunisations programme commissioned by NHS England**




**Ante natal screening includes:**

- Foetal anomaly, sickle cell anaemia and thalassaemia
- Infectious diseases – HIV, Hepatitis B and Syphilis

**New-born examinations and screening:**

- Newborn physical examination
- Newborn hearing screening
- Newborn bloodspot screens (9 conditions)
- Infant physical examination

**Immunisations during pregnancy:**

- Flu, Pertussis

**Immunisations for children 0-5 years**

- 6 in 1 , pneumo, rotavirus, Hib Men C , Children's Flu, MMR, 4 in 1 booster

#### 5.7.1. Healthy Start Vitamins - to eligible pregnant women and children

Pregnant women, women with a baby under one year old and children from four weeks old to their fourth birthday on Healthy Start can get green Healthy Start vitamin coupons (via a midwife or health visitor).

## 5.8. Voluntary Sector

Despite a difficult funding climate with less voluntary and community based services being commissioned, Leicestershire continues to be home for a number of innovative front line services ensuring children aged 0 to 5 years in the County have the best start in life. Examples include:

#### 5.8.1. Homestart Horizons

Provide a unique service; recruiting and training volunteers who themselves have parenting experience, to work with families in their own homes, building supportive relationship and responding directly to the family's individual needs so they can play a key role in giving their children the best start in life helping them to achieve their potential http://www.homestarthorizons.org.uk

#### 5.8.2. Early Years Alliance

Registered educational charity that provides support to early years providers deliver high quality, affordable and sustainable care and learning to families, and to ensure that all children, regardless of background, are given the best possible start in life https://www.eyalliance.org.uk

#### 5.8.3. Shepshed Toy Library

Supports child development through play by offering a range of quality toys to all children including those with disabilities for recreation, therapy and education to advance their intellectual, motor, personal and social development and to give them the best start in life https://shepshedtoylib.org.uk/

### 5.8.4. Community Managed Libraries

Leicestershire has a number of community managed libraries these provide a range of services including those that aim to give children the best possible start in life https://www.leicestershirecommunities.org.uk/cml

## 6 Unmet needs/Gaps

Despite Leicestershire being generally more affluent than the England average there are still significant numbers of children living in poverty, at risk of homelessness and exposed to the impacts of domestic violence. Further work is needed to both prevent and ameliorate the impact of these wider determinants of health and well-being.

Adverse Childhood Experiences (ACEs) has an emerging evidence base and increasing awareness of its impact on health and wider social and economic outcomes. However, there are both gaps in understanding and agreeing a whole systems approach to understanding need and developing trauma informed, trauma safe and trauma smart approaches.

A significant improvement in school readiness has been witnessed in Leicestershire over the past five years. However, work must continue in this area, particularly in relation to children with FSM status, as this measure has continued to perform significantly worse than the national average for the past five years. The latest data highlights females with free school meal status in Leicestershire (50.4%) performs significantly worse than the national average of females with FSM status (64.4%), while males with FSM status in the county (43.0%) perform similar to the national average of males with FSM status (48.1%). Further work should examine why variation in school readiness by gender exists in FSM children in the county.

The latest breastfeeding initiation data shows all districts in the county apart from Harborough performed significantly worse than the national average (77.5%), ranging from 65.7% in North West Leicestershire to 71.1% in Charnwood. However, the latest breastfeeding prevalence at 6-8 weeks after birth for the county performs significantly better than England. This infers that although fewer women initiate breastfeeding in Leicestershire, those that do are able to maintain for longer which may be linked to better support. Encouraging more women to initiate breastfeeding will not only improve health outcomes for both mother and baby but may also help to increase the prevalence of breastfeeding at 6-8 weeks.

The latest data examining maternal obesity highlights that the University Hospitals of Leicester NHS Trust has a higher percentage of women with an overweight and obese BMI at the time of their booking compared to nationally. The Maternal Obesity Health Needs

Assessment published by Public Health for LLR in 2017/18 confirmed both high level of prevalence and its significance as a risk factor for perinatal deaths and a wide range of poor health outcomes for both mothers and babies. It also identified significant gaps in knowledge and service provision and made a wide range of recommendations. An action plan has been developed to take this work forward[61] but there is still further work to do.

Oral health is still a significant health issue for 0-5 year olds and there is still a lack of knowledge around feeding young children especially the perception of what is 'healthy' e.g. fruit juice and dried fruit.

## 7 Recommendations

1. Continue to support the implementation of the LLR Healthy Pregnancy, Birth & Babies Strategy (formerly the LLR Infant Mortality Strategy and Action Plan (with oversight provided by the LLR Child Death Overview Panel), with a focus for Leicestershire on:
    - smoking in pregnancy and smoke free homes,
    - safe sleeping,
    - childhood poverty
    - and risk of homelessness.
2. Continue to support the implementation of the Leicestershire Children and Families Partnership Action Plan 2018-2021, with a particular focus on:
    - maternal obesity,
    - adverse childhood experience,
    - raising awareness of safety messages,
    - school readiness
    - and 1001 Critical days.
3. Improve multi-agency working to prioritise breast-feeding initiation and early support across Leicestershire.
4. Support the development of an oral health campaign using behavioural insights and social marketing as well as using the emerging evidence from NHS England's Starting

Well – Smile4Life programme.

## GLOSSARY OF TERMS

| | |
|---|---|
| ACEs | Adverse Childhood Experiences |
| ASQ-3 | Ages and Stages Questionnaire |
| ATAIN | Avoiding Term Admissions into Neonatal Units |
| BFI | Baby Friendly Initiative |
| BMI | Body Mass Index |
| CCG | Clinical Commissioning Group |
| CDOP | Child Death Overview Panel |
| CSE | Child Sexual Exploitation |
| d3mft | decayed, missing or filled teeth |
| ELGs | Early Learning Goals |
| EYFSP | Early Years Foundation Stage Profile |
| FGM | Female Genital Mutilation |
| FSM | Free School Meal |
| GFR | General Fertility Rate |
| KPI | Key Performance Indicator |
| JSNA | Joint Strategic Needs Assessment |
| JSA | Jobseekers Allowance |
| KS1 | Key Stage 1 |
| LAC | Looked After Children |
| LLR | Leicester, Leicestershire and Rutland |
| MSDS | Maternity Services Data Set |
| MSOA | Middle Super Output Area |
| NCMP | National Child Measurement Programme |
| NDTMS | National Drug Treatment Monitoring System |
| NHS | National Health Service |
| NICE | National Institute for Health and Care Excellence |
| NSPCC | National Society for the Prevention of Cruelty to Children |
| PHE | Public Health England |

| | |
|---|---|
| PTSD | Post-Traumatic Stress Disorder |
| SEN | Special Educational Needs |
| TBAG | Teenagers with Babies Action Group |
| TFR | Total Fertility Rate |
| WHO | World Health Organization |

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