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Report of Director of Public Health

Report to Scrutiny Committee (Health and Wellbeing)

Date: 18th December 2013

Subject: Our Children Deserve Better: Prevention Pays. Annual Report of the Chief Medical officer 2012

Are specific electoral Wards affected? If relevant, name(s) of Ward(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☒ Yes	☐ No
Is the decision eligible for Call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: Appendix number:	☐ Yes	☒ No

Summary of main issues

The Annual Report of the Chief Medical Officer 2012 "Our Children Deserve Better: Prevention Pays" was published in October 2013. It focuses on the growing body of scientific knowledge which clearly establishes that events that occur as a foetus and in early life play a fundamental part in later life, and that prevention and early intervention are key to improving outcomes, both for this and future generations. The report poses 5 Top Questions for Local Authorities with respect to children and young people's health. This report summarises the position in Leeds in response to these questions.

Recommendations

The Scrutiny Board is asked to consider and note the contents of this report and identify any matters that warrant further and/or more detailed scrutiny in the future.

1 Purpose of this report

1.1 The purpose of this report is to summarise the position in Leeds in regard to the top 5 questions for Local Authorities posed by the Chief Medical Officer's Annual Report 2012.

1.2 These questions are:

1.2.1 How does local mortality, morbidity and inequality data compare to comparable areas?

1.2.2 How focused are we on early years?

1.2.3 How are local schools engaging with the health agenda eg creating school connectedness, building resilience, supporting health and wellbeing and encouraging physical exercise?

1.2.4 Are we enacting the Healthy Child Programme in full and are we prepared for the change in commissioning of this programme that is due shortly?

1.2.5 How do we know that our health and care organisations meet the needs of children and young people? Are we using "You're Welcome"?

2 Background information

2.1 The annual report of the Chief Medical Officer 2012 (CMO) is extremely welcome. It comes at moment when strategy and action in Leeds are well aligned with its key recommendations, and the report focuses a helpful spotlight on the importance of the preventative agenda. The report takes a life course approach, giving careful consideration to the evidence concerning effective prevention and early intervention at each life stage, and presenting the economic case for shifting investment. In this respect, it is complimentary to other key national reports which have shaped the Leeds agenda including: the Marmot report into health inequalities; the Graham Allen independent reports into early intervention; the Frank Field independent report into child poverty; and the recent WAVE report "Conception to 2 years: The Age of Opportunity".

2.2 This research and policy landscape has been pivotal in shaping the current strategic priorities in the Leeds. The Health and Wellbeing Board (HWB) has identified both the Best Start in life, and improving people's mental health and wellbeing, among its top 4 commitments within the joint H&WB strategy. Both of these commitments encompass multiple aspects highlighted in the CMO's report, such as maternal mental health, children and young people's emotional health and wellbeing, pre-conceptual and maternal health, reduction of infant mortality, delivery of the family offer through the integrated Early Start Service, and provision of nursery places for eligible 2s. The H&WB Board has received presentations on progress towards these commitments at its last two meetings. The Children and Young People's Plan priorities are complimentary, including: reduction in children entering care (intrinsically linked to the Best Start agenda); childhood obesity and free school meal uptake; teenage conception; alcohol and drugs; and educational attainment, all of which are highlighted in the CMO's report. The city's child poverty strategy and the work of the Citizens and

Communities Directorate are key to addressing the social determinants of health, with 23% of the city's children aged under 16 (31,000) living in poverty, and rates of child poverty as high as 38% in some more deprived wards.

3 Main issues

3.1 How does local mortality, morbidity and inequality data compare to comparable areas?

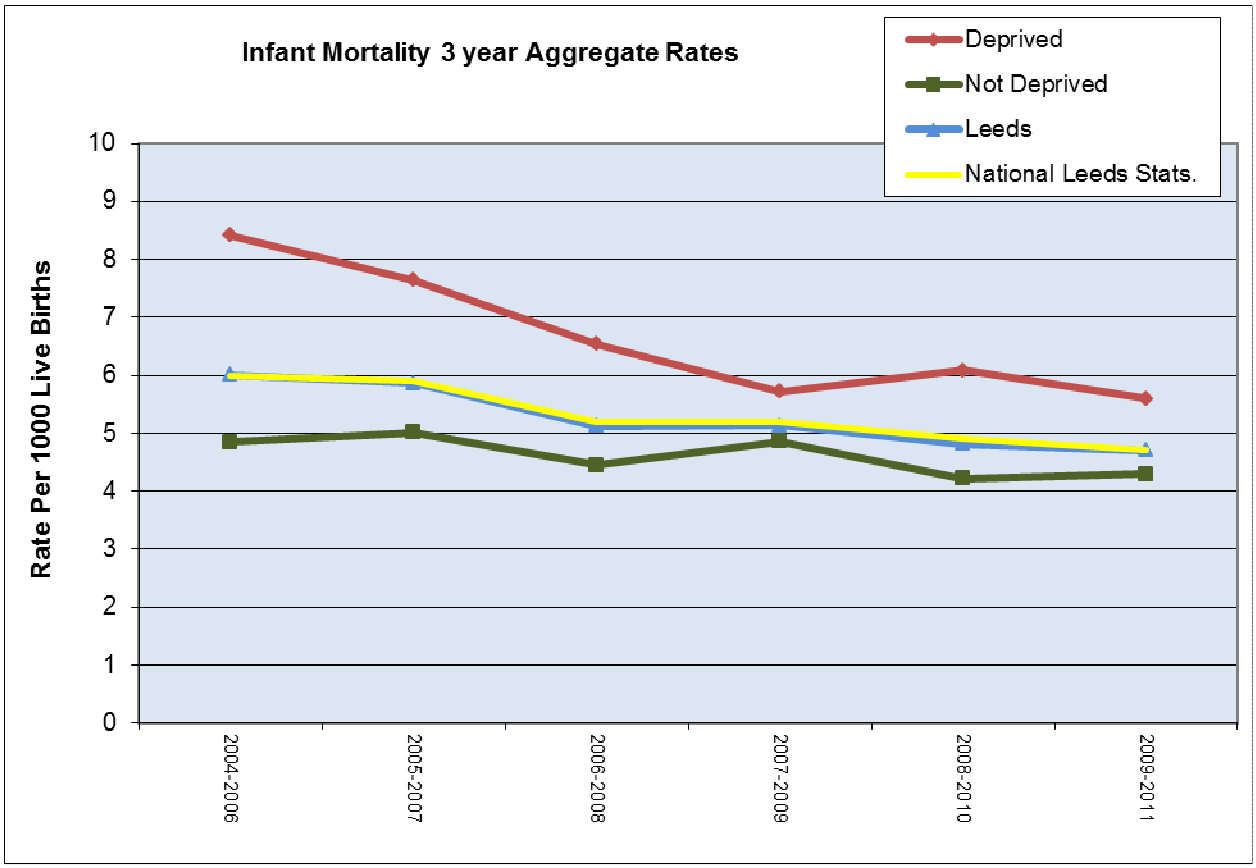
3.1.1 The ChiMat Child Health Profile (Appendix 1), published March 2013, gives an overview of child health in Leeds, and the final page provides an 'at a glance' summary of some key health and wellbeing outcomes for Leeds compared with England and with the region. The statistics presented in the profile are a close match to those in the Atlas of Variation appended to the CMO's report. The profile demonstrates that Leeds has some significant challenges. Table 1 (below) summarises the number of indicators for which Leeds is "green", "amber" or "red", and shows that over half the indicators for Leeds are significantly worse than England.

Table 1

Outcome areas	No. of indicators	Comparison with All England		
		Significantly worse (RED)	No significant difference (AMBER)	Significantly better (GREEN)
Preventable Mortality	2		2 (100%)	
Health Protection	4	1 (25%)		3 (75%)
Wider Determinants of Health	9	6 (67%)	2 (22%)	1 (11%)
Health Improvements	9	6 (67%)	3 (33%)	–
Prevention of ill-health	8	4 (50%)	2 (25%)	2 (25%)
Totals	**32**	**17 (53%)**	**9 (28%)**	**6 (19%)**

3.1.2 Child mortality rates for Leeds are similar to national rates and better than regional rates. Infant mortality (deaths of babies under 1 year old) has been the focus of a partnership programme of evidence-based action, led by Public Health, for the last 5 years, driven by the national inequalities target. It is also a headline indicator in the Leeds H&WB strategy. Interventions to reduce infant mortality are broad, covering many of the areas highlighted in the CMO's report, such as: child poverty; over-crowding; teenage pregnancy; maternal obesity; breastfeeding; sudden unexpected infant death and safe sleeping; early access to high quality maternity

care; maternal and child access to Healthy Start vitamins; and safeguarding. The local programme has successfully reduced the infant mortality rate in "deprived Leeds" by targeting high risk deprived communities, despite trends in the nature of the population with higher levels of ethnicity (babies of Pakistani and African origin are known to have higher infant mortality rates), and growing deprivation. The graph below shows the progress which has been made.



3.1.3 Mortality among older children (1 to 17 years) is again similar to the national rate, and lower than most other core cities (except Bristol and Newcastle). The causes of child death in the city are well understood, as every death of a child aged under 18 years is individually reviewed by the Child Death Overview Panel (CDOP), chaired by Public Health, and established under statutory Working Together to Safeguard Children guidance. The Child Death Overview Panel produces an annual report (available at http://www.leedslscb.org.uk/) which describes the causes of children's deaths in the city, identifies modifiable factors, and makes recommendations for preventative action. The CDOP has specifically recommended actions in respect of: safe sleeping to reduce sudden infant death; raising awareness of the risks of cousin marriage; action to reduce smoking in pregnancy; and a range of specific actions directed at particular issues including blind cord safety which is mentioned in the CMO's report.

3.1.4 The profile indicates that Leeds clearly has some significant challenges in relation to particular health outcomes, notably teenage conceptions and sexual health, dental decay, self-harm, and admissions for drugs and alcohol. Each of these is subject to on-going programmes of work.

3.1.5 Teenage pregnancy and parenthood is a priority within the CYPP. The 10 year Teenage Pregnancy strategy ran in Leeds from 2001 to 2011. This was a nationally funded and supported programme of work that resulted in declining rates of teenage pregnancy locally. The baseline in 1998 was 50.4 per 1000 females aged 15-17. Over the subsequent years, the rate in Leeds fell to 38.1 per 1000 in 2011. Following a review by the Teenage Pregnancy Board the top two interventions from the strategy were identified as good quality sex education (whether at school, in the home or in the community) and access to good quality services including contraception.

3.1.6 Since the strategy ended, there has been a significant disinvestment in this area and it is acknowledged that rates have fluctuated recently, rising to 44.5/1000 in the first quarter of 2012/13, and then falling to 31.4/1000 in the most recent quarter. Nonetheless, a number of important activities have been maintained or planned:

(i) Children's Services Teenage Pregnancy and Parenting Team will work with the Health & Wellbeing service to provide support to priority schools through the delivery of core SRE sessions. The Team support over 100 school aged mothers and fathers a year, improving their confidence, self - esteem and wellbeing to ensure they remain engaged within education, increasing life chances for themselves and their children.

(ii) Work is underway, led by Public Health, to re-commission integrated sexual health services in targeted areas, and improve access and promotion by working with young people.

(iii) The Family Nurse Partnership Programme is being expanded. This is an intensive, evidence based home visiting programme for first time young mums aged 19 or under (and dads). A specially trained family nurse visits the young mum regularly from early in pregnancy until the child is two.

(iv) Public Health is working to provide fast track services and training for sexual health leads in children's homes.

(v) TPP Board has set up a risk and resilience working group whose first aim is to carry out a cluster OBA pilot and develop a locality model to improve outcomes.

(vi) Children's Services are working to ensure that all clusters that cover priority Middle Super Output Areas (MSOA) include teenage pregnancy within their action plan and have an identified Teenage Pregnancy/Targeted Service Lead.

(vii) The provision of a sexual health drop-in service in schools is under review.

(viii) TPPB is reviewing third sector contracts for sexual health and relationships work in order to ensure that this work is better co-ordinated and targeted.

Now that TPPB have the refreshed Teenage Pregnancy Data (this was not available for 6 months) there is a need to review the Teenage Pregnancy Action Plan in Leeds.

3.1.7 The issue of oral health is a concern to the city. The most recent survey of 5 year olds was done in 2011/12, and showed that the average number of decayed, missing and filled teeth (DMFT) for a 5 year old Leeds child is 1.19. This is higher than the England average DMFT of 0.94, but lower than the regional average of 1.23. In Leeds, 34% of 5 year olds have tooth decay, compared to England with a prevalence of 29%. This is an improvement from the 2007/8 survey which showed

that 40% of Leeds five year olds had tooth decay. Five year olds living in the most deprived communities of Leeds have the highest levels of disease, with those of Pakistani or Bangladeshi background having highest levels of caries, and those with African Caribbean background having the lowest level of caries. The most recent survey of 12 year olds took place in 2008/9 and showed an average DMFT of 1.1 (as illustrated in the Child Health profile at Appendix 1). The proportion of children with dental disease at age 12 was 46%, which was higher than the regional (45%) and national (33%) prevalence. 12 year olds living in the most disadvantaged communities in Leeds have the highest levels of caries, but at 12 it is the white community which proportionally has most disease.

3.1.8 Access to dental services and oral health promotion is hugely important. Around two third of Leeds children are registered with a dentist, which is higher than the national average. Not surprising, registration is lower in the younger age groups, with only around a quarter of 0-2 year olds being registered. Proportionally, registration is lower in more deprived areas. In terms of oral health promotion (OHP), Leeds has a small team (1.6WTE) of OHP specialists, which is commissioned by LCC Public Health following the NHS re-structure in April 2013. The team provides training and resources to a variety of professional groups such as early education and care providers and Early Start teams, including Health Visitors who then deliver the 'Brushing for Life' scheme which provides all children between 6-8 months with a toothbrush, toothpaste and oral health advice. Key programmes are directed to primary school age children including: the Dental Milk scheme; tooth brushing schemes; oral health education sessions and resources. Currently 9 schools provide tooth brushing schemes and 11 schools take part in the dental milk scheme (5500 children). The Community Dental Service (CDS), commissioned by CCGs, provides a mix of primary and secondary care. Children with special needs and who are 'looked after' by the local authority are seen by the CDS. The service also sees children who require dental treatment but have not been registered with a dentist by their parents.

3.1.9 Following the recent restructure of the Health Service, dental public health has moved to Public Health England. However, responsibility for commissioning oral health promotion now lies with the Local Authority. It is therefore proposed that LCC Public Heath should lead, with partners including experts from Public Health England, an oral health needs assessment and the development of a local child oral health promotion strategy during 2014.

3.1.10 Self-harm is currently the subject of a recently established multi-agency partnership group led by the CCGs, in light of perceived rising levels of self harm among teenagers, though data analysis suggests that the number of people attending A&E with self-harm has not changed over the last 3 years. Although the work is in the early stages, the group has developed a work programme which addresses two aspects: support to young people who are self harming; and support to the adults surrounding those young people (both parents/carers and professionals) in the form of training and resources to enable them to recognise and respond appropriately.

3.1.11 Drug and alcohol use among young people has recently been agreed as a priority in the CYPP. Nationally, alcohol consumption and substance use trends are downward for this adolescent group. More young people abstain from drinking now

than several decades ago and the proportion reporting that they have used illegal drugs has also been falling for at least a decade. However, local trends are not so positive. The child health profile for Leeds shows that hospital admission rates for alcohol are significantly worse than national and regional figures. Growing Up in Leeds (GUIL) survey data over the period 2009-13 shows that 30% of children and young people (11-15yrs) are choosing not to drink (an 8% increase over the period), whilst 9% drink regularly (a 5% decrease - though with a slight upturn in the most recent year). However, when young people *are choosing* to drink, data now indicate that 13% of 11-16 years olds surveyed reported that they were regularly drunk or drank to get drunk - an increase of 2% since 2011. Hospital admissions data for drugs also shows Leeds to be significantly worse than the national rate, and similar to the regional rate. GUIL data indicate 14% of young people (11-16yrs) report ever using illegal drugs, a 5% increase since 2011.

3.1.12 A key priority within the Leeds Drug and Alcohol Strategy and Action Plan (2013 – 2016) is to reduce the impact of drug and alcohol misuse on children, young people and families. Key activities to achieve this are:

(i) Increase public awareness and knowledge about the harm caused by alcohol and drugs eg cannabis awareness campaign in Spring 2014.
(ii) Early identification and support of people who want to change their alcohol and/or drug using behaviour eg A&E pathway for young people attending with alcohol related harm.
(iii) Tackle the availability of illegal drugs and the inappropriate availability of alcohol and other legal substances eg outreach service targeting city centre "Head Shops" to reduce harm caused by legal highs.
(iv) Improve quality and availability of drug and alcohol education in universal and targeted settings eg drug and alcohol education at transition from primary to secondary school.
(v) Protect children and young people from exploitation through drug and alcohol misuse eg child sexual exploitation protocol to be developed under LSCB.
(vi) Ensure young people's drug and alcohol treatment services work effectively with partner agencies to identify and respond holistically to the needs of children and young people eg city wide campaign to promote drug and alcohol services for young people following the sector review.
(vii) Effective identification and support for children, young people, and family members who are affected and harmed by the drug and alcohol misuse of others eg Early Start Team training to deliver early intervention work to reduce the impact of parental substance misuse on children.

3.1.13 Tobacco use among young people is also a priority within the CYPP. Overall the number young people who have ever smoked a cigarette has been slowly reducing in the last five years. According to the Growing up in Leeds Survey 2012/13, 48% of pupils have tried smoking compared to the national average of 45%. The number of regular smokers in year 11 (defined as least one cigarette per week) according to the survey is 27%, considerably higher than the national average of 10%. Pupils who receive free school meals have higher smoking rates than the Leeds average. This fits with the adult smoking prevalence where smoking is closely linked to deprivation. A higher number of pupils receiving free school meals live with a smoker compared to the Leeds average. This is particularly important as children who live with parents or siblings who smoke are

up to three times more likely to become smokers themselves than children in non-smoking households.

3.1.14 In order to reduce the number of young people smoking a number of actions identfied in the Leeds Tobacco Control Action Plan have been taken forward:

(i) The ASSIST programme has been commsioned and is currently in the process of recruiting schools. The ASSIST programme is an evidence-based[1] peer led intervention that targets year 8 pupils. Influential pupils are nominated by their peers and these pupils are trained to become peer educators. The training they receive includes knowledge about the health, financial and environmental impacts of tobacco use. They are then encouraged to have informal conversations with other year 8 students about the risks of smoking and the benefits of being smoke-free.
(ii) Brief advice training on how to talk to young people about smoking is going to take place for front line workers this year.
(iii) Trading Standards respond to all complaints in relation to underage sales of tobacco and do test purchasing.
(iv) There is a Leeds smoking cessation service for young people delivered by a young people's specialist worker.
(v) The Leeds primary and secondary PSHE tobacco education schemes of work are being updated and improved by the healthy schools team.
(vi) Dance action zone Leeds (DAZL) have worked with their young people to create a dance that demostrates the negatives of smoking for young people. They have performed to over 11,000 people. An event showcasing their work including a photography exhibit will be held at the Carriageworks in February.
(vii) Work is also underaway to make the children's play area in Middleton park the first smoke free play area in Leeds with support from the local community and primary schools. This will promote a healthy smoke free environment for children and will reinforce the smoke free norm.

3.1.15 Other areas of challenge include high numbers of children in care, entrants to the youth justice system, NEETs, and educational attainment. All of these are priorities in the CYPP, heralded by the "3 obsessions" (reducing children in care; reducing number of NEETs; and improving school attendance), and drawing on the approach that all these outcomes are inter-connected ('everything leads to everything'). Extensive plans are in place, led through Children's Services, in relation to these areas.

3.1.16 It should be noted (from both the ChiMat profile and Atlas of Variation) that there are also areas of good practice in which Leeds achieves comparably or better than the country as a whole. These include: immunisation coverage (DTP 98%, MMR 94%); health assessments for children looked after (93%); maintenance of breastfeeding (48%); and smoking in pregnancy (12%). This good performance is a tribute to hard work and commitment by people working in public health, the NHS, Local Authority and partner agencies. With regard to childhood obesity, rates in Leeds have stabilised over recent years at a rate comparable to the national rates (9% in 4-5 year olds; 20% in 10-11 year olds), and again this reflects an active and innovative programme of multi-agency intervention under the "Can't

[1] School-based interventions to prevent the uptake of smoking among children and young people. NICE Public Health Guidance 23. February 2010

Wait to be Healthy" strategy led by Public Health. However, although these areas compare more favourably with national performance and core cities (see Appendix 2), there remains much room for further improvement, and continued focus on these areas is essential.

3.1.17 Comparison with other core cities suggests that Leeds' performance is largely comparable. Appendix 2 provides a summary of the performance of core cities on a selection of "red" indicators for Leeds (Table 2, Appendix 2) and a selection of "green" and "amber" indicators for Leeds (Table 3, Appendix 2). There are some "red" indicators on which other core cities (Bristol, Nottingham and Sheffield) perform better than Leeds. Conversely, there are some "green" and "amber" indicators on which Leeds performs better than other core cities (notably Manchester, Nottingham and Birmingham). The "red" Leeds indicators which show most variation among core cities are sexually transmitted infections, hospital admissions due to injury and tooth decay.

3.1.18 The sexually transmitted infection indicator is based primarily on the rate of detection of chlamydia. This indicator is difficult to interpret, as it is influenced by the amount of testing done, and the nature of the population to which testing is offered. Leeds is very active in offering testing to its student population, and this will lead to a high detection rate. However, it also allows for active management of the condition and contact tracing. Public Health England recommends that local areas achieve a detection rate of at least 2,300 per 100,000 resident 15-24 year olds, a level which is expected to produce a decrease in chlamydia prevalence. The rate detected in Leeds is 2,667 per 100,000 ie above the national target. In Leeds, 28% of 15-24 year olds were tested for chlamydia with a 10% positivity rate. Nationally, 26% of 15-24 year olds were tested for chlamydia with an 8% positivity rate. Since chlamydia is most often asymptomatic, a high diagnosis rate reflects success at identifying infections. Some of the actions taken in Leeds to increase testing and treatment include:

(i) Training has been given to a large number of community projects (3 in 1 scheme) who come into contact with young people to promote and offer chlamydia testing.
(ii) CaSH and GUM offer an open access service with 100% of GUM appointments being available within 48 hours of which 94% are seen. For young people attending CaSH / GUM, an "opt out" service for chlamydia testing is offered.
(iii) Removing barriers to testing via free and confidential online testing service via the sexual health website "freetestme".
(iv) Men who have Sex with Men population are targeted via the community screening initiative via Yorkshire Mesmac.

3.1.19 An important area on which Leeds needs to focus is re-infection rates with Sexually Transmitted Infections (STIs). In Leeds, an estimated 10.5% of women and 12.5% of men presenting with an acute STI at a GUM clinic during the period 2009 to 2012 became re-infected within twelve months. Nationally, during the same period, an estimated 9.6% of women and 12% of men presenting with an acute STI at a GUM clinic became re-infected. Young people between 15 and 24 years old experience the highest rates of acute STIs. In Leeds, 68% of diagnoses of acute STIs were in young people aged 15-24 years. In Leeds, an estimated 12.2% of 15-19 year old women and 13.5% of 15-

19 year old men presenting with an acute STI at a GUM clinic during the four year period from 2009 to 2012 became re-infected with an STI within twelve months. The new integrated service specification, being developed as part of the re-procurement of CASH and GUM services, will have KPIs focused on repeat infections and partner testing.

3.1.20 The indicator for hospital admissions with injuries is also difficult to interpret, as it is heavily influenced by variation in practice between different hospitals. In Leeds, children with any injury beyond a minor injury are 'admitted' to the Children's Assessment Unit, thus removing them from the A&E environment into a more child-friendly space where they can be assessed by relevant paediatric specialists. This is a good practice model of care which is counted as an 'admission', but actually allows the child to return home after suitable observation, often without needing to spend a night in hospital, thereby avoiding long periods of assessment in the A&E department. This service model may explain the apparently high admission rate for injuries.

3.2 <u>How focused are we on Early Years?</u>

3.2.1 The Health and Wellbeing Strategy includes a commitment to give everyone the best start in life. The Children & Young People's Plan focuses on those at most risk of a poor start through its priority to reduce the number of children looked after. Local statistics show that the biggest proportion of children coming into care in Leeds is aged under 1 year old, and recent local research shows that the common factors associated with these families are: parental use of drugs and alcohol; domestic violence; maternal depression; maternal learning disabilities; and a parental history of having been in care. These two strategic priorities dovetail together through a programme of proportionate universalism (see section 3.4), as described in the CMO's report ie a programme of universal services underpinned by skilled professional risk assessment using restorative approaches, which can direct early help and support to those in most need, whilst responding quickly to safeguarding concerns.

3.2.2 Leeds hosted a major Best Start conference on 2nd October 2013, chaired by the Lead Executive Members for Health and Wellbeing and for Children. The aims of the conference were to raise awareness of the importance of Best Start among strategic leaders and professionals in the city, and to educate the Leeds community about the evidence and economic case for Best Start. Several of the most widely respected experts in the country came to Leeds to speak. The conference was quickly over-subscribed with 275 attendees and excellent evaluation.

3.2.3 This high level sign up to the Best Start is part of an essential culture-shift in the city if Leeds is to re-focus onto prevention and intervention early in the life course. The evidence is copious and the economic equation is irrefutable. If there is a real wish to level the gap with the best countries in the world, like Finland, and improve the health and wellbeing of our children and future generations, then Leeds must recognise that "the most important 4 years of a child's life are those up to age 3" (John Carnochan). It is vitally important that this commitment has been made in Leeds at the highest level by the Health and Wellbeing Board and the Children's Trust Board. The reality of this, in these times of economic constraint, will be challenging, but it is essential to maintain or re-direct investment into evidence

based early prevention. Leeds City Council has evidenced this through decisions, for example, to invest monies from the uplift of the public health grant in 2012 into infant mental health services and targeted antenatal support for vulnerable women, and in protecting investment into children's centres. The Commissioning Sub-Group of the Children's Trust Board has identified Best Start as a key strand of its refreshed commissioning programme, and will take forward work to identify and prioritise investment into this preventative programme, and to monitor the Leeds response to the Wave report recommendations.

3.2.4 Within the Best Start work programme, there are a number of important ongoing workstreams. In brief, these include:

(i) Embedding the integrated Early Start Service (comprising children's centres and health visiting) and the delivery of the 0-5 Healthy Child Programme.

(ii) Developing and implementing a series of care pathways as part of the 'Family Offer' eg maternal mental health pathway; economic wellbeing pathway; breastfeeding pathway; co-sleeping pathway and many more. (see 3.4.3)

(iii) Rolling out "Pregnancy, Birth and Beyond" across the city – a universal programme of community based antenatal and postnatal education and support for parents.

(iv) Developing a programme of targeted antenatal and postnatal support for vulnerable women and families, in collaboration with initiatives in the 3rd sector such as NSPCC 'Baby Steps' and Homestart 'New Start'.

(v) Investing in an Infant Mental Health Service for Leeds, in partnership between the NHS and Local Authority.

(vi) Supporting the development of the Family Nurse Partnership, currently commissioned by NHS England, but due to be commissioned by the LA from 2015.

(vii) Rolling out nursery places for eligible 2s.

(viii) Continuing the Infant Mortality programme which spans a range of other programmes (see para 3.1.2).

(ix) Work to increase Children Centre and EST team contribution to pre-birth assessments and enhance the support available to families.

(x) Developing high quality early education and childcare in areas of greater disadvantage to support early learning and families into work.

(xi) Ensuring services recognise and support families in financial hardship and building social capital in local communities.

3.2.5 The Best Start programme aligns closely with the Families First programme (known nationally as Troubled Families) within Leeds. Many of the factors which give babies a poor start and put them at risk of coming into care – such as parental alcohol and drug use, domestic violence, and parental mental ill health –

are the same factors which exist in families with vulnerable older children who are accessing Families First. This is now well recognised in Leeds, and recently closer working with adult public health services has been established, with a proposal to review the "Think Family" protocol for the city, and to ensure that consideration is given by adult services to the impact of parental risk taking behaviour on their children.

3.3 How are local schools engaging with the health agenda eg creating school connectedness, building resilience, supporting health and wellbeing and encouraging physical exercise?

3.3.1 Leeds is privileged to have an outstanding Healthy Schools Scheme, which has been established for over 10 years in the city. This reflects the commitment of both the Local Authority and NHS to fund and maintain this important preventative service. All state schools in the city can access this programme, though targeted schools serving the most deprived wards are given priority access to support and resources. Targeted schools are identified using a banding system that is shared with the school nursing team**.** The Teenage Pregnancy and Parenthood Team use the same banding system to offer support with delivery of sex and relationship education in schools.

3.3.2 By 2011, 267 out of 268 schools in Leeds had successfully achieved National Healthy school status. Since then, schools have continued to revalidate every three years. Uptake is very successful, and since September 2012, 44 schools have completed the newly revised Leeds Healthy School Status - using the online School Health Check. A further 78 schools are working towards this. Schools judge the quality of preventative provision in 4 areas: Personal Social and Health Education (PSHE), healthy eating, physical activity, and emotional health. The new Leeds version includes a set of criteria that support staff health, and have been well received by teacher unions. As part of the award, schools are asked to develop whole school approaches to ensure effective, distributive leadership (including young leaders and pupil voice) and sustainability through policy change. School councils play a key role and there are many examples of how young people have had significant voice and influence in change processes.

3.3.3 Leeds Healthy Schools Plus is an outcome focused model intended to further the school's role in promoting lasting health and well-being behaviour changes, with additional focus on providing targeted support for those who are most at risk. This is a 'mark two' simplified version of the 2011 national healthy school enhancement model and so far 46 schools are actively engaged in the revised model. Healthy Schools Plus provides a web based 'waved approach' to city health priorities, and an online action plan allows schools to set measurable baselines and targets to impact on the following city wide health priorities: childhood obesity; sexual health and teenage pregnancy; drugs, alcohol or tobacco; and emotional health. Schools are encouraged to work together with cluster partners wherever possible, in order to achieve a whole locality approach, and as part of a longer term rolling plan.

3.3.4 To assist individual schools with development work, there is a comprehensive range of training courses, advisory support, and resources available for each of the health themes of PSHE, healthy eating, physical activity and emotional health. These also cover the broader curriculum, for example, to improve breakfast, lunch, breaktime experiences, develop after school clubs and run whole school

campaigns involving/led by pupils such as the Be Healthy! Programme and School Food Ambassadors. Additional programmes that support the aims and principles of healthy schools include the Sustainable Schools Programme which promotes healthy eating, growing and cooking and the Investors in Pupils programme which is a vehicle for developing pupil voice, influence and responsibility.

3.3.5 A recently formed risk and resilience group - a sub group of the Teenage Pregnancy and Parenthood Partnership Board - has begun to develop a cluster model that uses a menu of recommended activities within a locality. This will incorporate the healthy schools programmes on offer. Similarly, partners working on the new CYPP drugs and alcohol and tobacco priority have commenced a pilot cluster project using outcome based accountability (OBA) methodology and a recommended menu of local activities. New drug education resources that involve engagement with parents and families for primary school children are also being rolled out to primary schools.

3.3.6 The Ofsted inspection framework and schedule of judgements, which exert a strong influence over development priorities chosen by Head Teachers, omitted, in 2011, all previously included references to healthy lifestyles. However as of September 2013, Ofsted subsidiary guidance requires inspectors to ask school leaders questions about the dining experience, how they help to ensure a healthy lifestyle for children and, specifically, whether their dietary needs have been considered. Inspectors are also required to consider the impact of the new primary school sport funding on pupils' lifestyles and physical wellbeing and greater awareness amongst pupils about the dangers of obesity, smoking and other such activities that undermine pupils' health. Although the questions do not result in a grade for this area, inspection reports are now evidently reflecting this new development.

3.3.7 The national Ofsted PSHE subject inspection report, 'Not yet good enough: personal, social, health and economic education in schools' (May 2013) points to a range of factors that need to be improved in the 40% of schools that were judged 'requires improvement' or 'inadequate' . PSHE remains a non-statutory subject and where it is not working well this is due to a lack of investment in: staff development; leadership and management; assessment; focus on 'skills development' as opposed to knowledge acquisition; and lack of a spiral curriculum.

3.3.8 In Leeds specific PSHE training programmes do cover aspects raised by Ofsted - content is in the process of being checked and updated in the light of this report. Additionally, a spiral curriculum has been developed for Leeds schools: the Primary and Secondary PSHE schemes of work (including drug education and sex and relationship education) with complete sets of lesson plans. A new post 16 toolkit was introduced to all secondary schools and FE providers in Spring 2013. These are regularly updated to reflect new developments – for example a new, well evaluated sex and the media training course ran successfully in summer 2013, and provided new PSHE resources for Leeds schools. New drugs modules were added in autumn 2013. A PSHE teacher network meeting occurs every term, where guest speakers are invited and best practice is shared.

3.3.9 The TaMHS (Targeted Mental Health in Schools) project in Leeds (managed by the Health and Wellbeing service) is recognised nationally for exemplary practice

and contributes significantly to the early intervention, evidence based approach of the city. Through matched funding arrangements, TaMHS has enabled commissioning of specialist mental health services within cluster multi-professional teams. In addition, using the same waved approach as the healthy school programme, schools are supported to develop and implement plans that improve universal and targeted provision - for example, emotional literacy training for staff who work with targeted groups, and improving curricular provision for SEAL (a whole school spiral-based curriculum and framework for teaching social, emotional and behavioral skills in primary schools). Selected outcomes of the last two years of TAMHS (with 9 clusters of schools: 99 schools) include measurable improvements in mental health of pupils who received support, school emotional health development and accelerated improvements in the CYPP indicators. As a result a further £1,828,456 is being invested over the next 2 years by the local authority, NHS Leeds, School's Forum and schools in a further 13 clusters (133 schools). A triage model linking with GPs is currently being piloted in identified clusters.

3.3.10 Because schools have a central role to play in both health promotion and modifying exploratory behaviours, a local school-based survey of young people's health related behaviours, "Growing Up in Leeds" (GUIL) has been in place for several years, supported by the Healthy Schools programme. Results of the survey are analysed at school level to allow schools to identify their own priorities, and also at cluster and city wide level to allow monitoring of progress and inform service development. From these results, Leeds appears to reflect the same trends referred to in the CMO's report, with some improvement in respect of prevalence of smoking, drinking and use of illegal drugs, but some decline around healthy eating with only around a quarter of primary school pupils saying that they eat 5 portions of fruit and vegetables a day, and similarly around physical activity, with only around a fifth doing 5 hours per week.

3.3.11 The Leeds "Can't Wait to be Healthy" childhood obesity strategy has been in place for several years, and oversees an broad programme of both healthy eating and physical activity initiatives, many targeted into areas of deprivation, including the two childhood obesity demonstration sites. A key focus of the strategy is on early engagement of families (pregnancy and pre-school) using the evidence based Henry programme. The strategy is due to be reviewed in early 2015. There is also significant work in place to promote free school meals, which is a priority target within the Children and Young People's Plan. More recently, the national School Food Plan has been launched, which takes a 'whole school' approach, covering not only quality and uptake of school meals, but wider aspects such as cooking skills, breakfast clubs, 5 a day, environment and links to the curriculum. It is anticipated that more local work will now be directed towards implementation of the School Food Plan in Leeds, in response to the continued concern about the level of childhood obesity, which has been successfully stabilised, but is not yet on a downward curve. The School Food Plan provides the policy context for the introduction of the following from September 2014: universal free schools meals for all children in reception, year 1 and year 2; free school meals for entitled post 16 students in FE or colleges; statutory cooking in the curriculum for KS1 through to KS3; and simplified, statutory school food standards. The DfE will be issuing further information about this in December 2013.

3.3.12 Increasing physical activity is an integral component of the obesity strategy. The recent CMO report "Start Active, Stay Active" recommends that 5-18 year olds should do at least 60 minutes of vigorous exercise daily. Local data suggest that less than a fifth of children in Leeds are achieving this. There are several initiatives in place to promote physical activity among school aged children:

(i) Active Schools: PE and School Sport - LCC has recently invested in this city wide programme which aims to provide a cohesive offer to schools to improve the quality of school PE and access to physical activity for the less active. This is mainly funded by the School Sport premium, new government funding which comes directly to primary schools. School games organisers will have an additional 2 days a week to promote and increase physical activity and will also be rolling out 50 Change4Life Clubs funded by the Youth Sports Trust to engage the least active. 150 schools are currently auditing and planning against their PE, sport and physical activity provision. Physical activity, for this purpose, is defined as activities which are delivered during and outside curriculum time, including active travel, clubs, Change4Life activities and leadership/volunteering activities - there is an emphasis on enjoyment, engagement and exercise

(ii) Leeds Let's Get Active **–** this programme offers free access to leisure centres for a few hours a day. While mainly focussed on engaging inactive adults, it does include some opportunities for free family swims and family based activities.

(iii) Bikeability **-** A programme encouraging children to cycle to school which offers cycle training for up to 5000 children a year and is delivered through LCC Educational Sustainable Travel team.

(iv) Active4Life programme – Public Health commissions the Active4Life programme which aims to engage inactive children from disadvantaged areas in physical activity to improve their health and wellbeing. This programme is delivered by four organisations and includes dance, football, multi-sports and free-sports, and engages over 10,000 primary school age children per year**.**

3.4 <u>Are we enacting the Healthy Child Programme in full and are we prepared for the change in commissioning of this programme that is due shortly?</u>

3.4.1 The Healthy Child Programme spans the age range 0 to 19, comprising an evidence based programme of contacts and interventions at particular stages of pregnancy and a child's life. These include: assessment of physical, social and emotional development; screening; immunisations; health promotion; and progressive interventions. Delivery of the programme from age 0-5 is led by the Health Visitor, and delivered by a broad spectrum of practitioners including Children's Centre staff and primary health care teams and midwifery. Delivery of the programme from 5-19 is led by School Nurses in collaboration with a range of professionals who support the school aged child.

3.4.2 The Healthy Child Programme is fully in place in Leeds. For the 0-5s, Leeds is at the forefront as an "early implementer" site for the new model of Health Visiting Services, through its innovative approach to the establishment of an Early Start Service, which brings together the staff of Children's Centres with the Health Visiting Service into an integrated service. This exciting piece of work was commenced in 2011, using Organisational Development Services (ODS) methodology in order to identify the essential tasks undertaken by both services and the necessary competency levels to deliver those roles. The Healthy Child

Programme was central to the ODS project which enabled the agreement on a 0-5 pathway, with an agreed schedule of contacts, delivered by the new Early Start Service.

3.4.3 The Early Start Service is underpinned by a shared Service Description, a joint Implementation Board, and a shared Performance Dashboard. At practitioner level, a series of "care pathways" are being developed to furnish the Early Start Handbook. Each evidence based pathway is developed by a multi-agency group of experts, and takes a proportionate universal approach, by clarifying the universal service, and then the additional services for those with higher levels of vulnerability or need. Each pathway will be implemented with appropriate workforce development support. The pathways to date, at various stages of development, include:

i) Economic wellbeing
ii) Breastfeeding
iii) Co-sleeping
iv) Healthy Weight
v) Alcohol and substance use
vi) Domestic violence
vii) Tobacco
viii) Maternal mood
ix) Responsive parenting
x) Inclusion
xi) Infant mental health
xii) Care of the acutely ill child

3.4.4 The commissioning of Health Visiting transferred from the PCT to NHS England in April 2013, under the NHS re-organisation, mainly in order to ensure continued national growth in Health Visitor numbers. The national intention is for the commissioning to transfer again from April 2015 to the Local Authority, potentially under the ring-fenced grant which has been extended to 2015-16. Since Leeds previously had a jointly commissioned Early Start Service with a joint service specification and performance dashboard, this transfer to NHS England was not ideal. However, all parties have worked hard to minimise any disruption. NHS England is using a national Health Visiting service specification and national performance framework. However, a local Implementation Board involving all commissioner and provider partners (including NHS England) continues to meet to oversee integrated delivery and performance, and is developing a refreshed 'service description'. In preparation for the transfer of commissioning, NHSE has hosted a series of workshops and maintains open communication with Local Authority Public Health. It is anticipated that the transfer of commissioning in April 2015 will proceed smoothly, as Public Health was closely involved in commissioning the service in the previous PCT prior to April 2013, and continues to be deeply involved in the Implementation Board and in the development of care pathways. The contract itself should move smoothly into the block contract which has been established between LCC Public Health and Leeds Community Healthcare.

3.4.5 The 5-19 Healthy Child Programme is fully in place in Leeds, led by the School Nursing Service in collaboration with a range of professionals. The School Nursing Service has been strengthened by additional public health investment

over the last 2 years, so the service is well placed to respond to recent national strategy "Getting It Right for Children, Young People and Families: A Call to Action" (March 2012). The commissioning of School Nursing transferred to the Local Authority in April 2013 as a Public Health function. The transfer has been achieved smoothly, as commissioning was already led by Public Health within the previous PCT. This is now part of a block contract between LCC Public Health with Leeds Community Healthcare. The service is undertaking a major review in light of the new national strategy and the additional investment, and this will underpin the development of a new local service specification for 2014-15. Public Health commissioners have also worked closely with the service to develop a Performance Dashboard which provides quarterly information about activity and performance, thus giving assurance that the Council is commissioning a comprehensive, high quality service.

3.5 <u>How do we know that our health and care organisations meet the needs of children and young people? Are we using "You're Welcome"?</u>

3.5.1 "You're Welcome" is a set of quality standards for young people friendly health services issued by the Department of Health published in April 2011[2]. The quality criteria for health providers cover 10 themes:

(i) Accessibility eg access by public transport, convenient times
(ii) Publicity eg information about the service, how to compliment or complain
(iii) Confidentiality and consent eg policies are explained to young people, staff are trained
(iv) Environment eg areas are young people friendly
(v) Staff training, skills, attitudes and values
(vi) Joined up working eg co-location or information about other local services
(vii) Young people's involvement in monitoring and evaluation of the patient experience
(viii) Health issues and transition eg clear procedure for transition to adult health services
(ix) Sexual and reproductive health services eg availability of easy to understand information, staff suitably trained to talk about sexual health issues
(x) Specialist child and adolescent mental health services eg staff are appropriately trained to talk about mental health issues, information and advice available to help young people to make decisions.

A self-review tool is available to support services to implement the standard.

3.5.1 <u>Leeds Children's Hospital, LTHT</u>

3.5.1.1 Within Leeds Children's Hospital, a variety of methods are used to engage with children, young people and their families and to understand their needs and experiences. A main focus is via patient stories and individual feedback cards in some clinical areas. In the Neonatal Intensive Care Unit, work has been done

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2 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216350/dh_127632.pdf

alongside BLISS (the Premature Baby Charity) in order to seek views of families and carers about the quality of care that their premature baby has received and their overall experience. Work is also done with the Teenage Cancer Trust and CLIC Sargent in gaining the experiences of children, young people and their families within the Oncology/Haematology service. Finally, Leeds Children's Hospital contributes to the national Young Patients survey for both inpatient and outpatient services run by PICKER. This allows the hospital to gain feedback on all aspects of service and look at improvements year on year. There is also the capability of benchmarking this information with other similar Children's Hospitals.

3.5.1.2 Moving forward the Head of Nursing, in conjunction with the Clinical Director and General Manager, plans to undertake further engagement work. This will comprise of a Youth Forum and a Child's Forum. This would be made up of children who have or currently use the service as well as looking for interested young people from colleges or local schools who may have an interest in health and designing services for their peers. This will also be a forum whereby the Children's Hospital can use this group for sense checking any developments, policies and procedures to ensure that the Children's Hospital is delivering services appropriate to their needs. The Children's Hospital in conjunction with Leeds Teaching Hospitals NHS Trust is also investigating the development of electronic devices to capture feedback from service users that are consistent across all the wards and departments and are child and young person focussed.

3.5.1.3 Leeds Children's Hospital does not use the "You're Welcome" guidance but it is planned to review this as part of our engagement with children, young people and their families moving forward.

3.5.2 <u>Leeds Community Healthcare Trust</u>

3.5.2.1 Leeds Community Healthcare Trust (LCH) has a membership of more than 7,000 people over the age of 14. The membership age was reduced to 14 to take into account the number of services the trust provides for children and young people. Recruitment of younger members has been very successful with almost 400 of the trust's members aged between 14 and 18. It was acknowledged, however, that whilst there is a young membership they were rarely getting involved in membership activities. For this reason a LCH Youth Forum has been established. The Youth Forum is for anyone between the ages of 11 and 18 in Leeds. Activity to date has included: two 15 year olds sitting on an interview panel for a new paediatric consultant; four young people between the ages of 13 and 16 interviewing CAMHS staff to allocate training places; an away day at the trust for fifteen 13 year olds; and there has been one takeover day (for ten local high school children) with another planned in late November 2013 (with eight children from a different school).The first meeting of the Youth Forum has also taken place during November 2013.

3.5.2.2 LCH is signed up to supporting: the Child Friendly City initiative; the 3 behaviours of practitioners (OBA; restorative practice; listening to children); and integrated working to support early help and early intervention. Other activities LCH has in place to help determine if the needs of children and young people are being met include:

- All LCHT services undertake a Public & Patient Satisfaction Survey including across children's services. The satisfaction rate is running at 95-97%. This includes asking children and young people who are using the services and not just their parents/carers.
- CAMHS is part of the national Centre for Healthcare Innovation (CHI) collaborative which includes asking all service users their thoughts about the service and what could be improved.
- All services have obtained the bronze standard for involvement - including for children and young people - and all services are working to the silver standard.
- There are examples of good practice of young people involvement e.g. users involved in interview process of staff (Family Nurse Partnership, Consultant Paediatricians), and in designing new or reviewing current services (school nursing, Health visiting, looked after children).
- LSCB section 11 audit is completed yearly which contains evidence of users' involvement in safeguarding.

3.5.2.3 The You're Welcome standard is not formally used by all LCH services, but is supported as an organisational policy in terms of the 10 criteria and using the toolkit. However, LCH does ensure parts e.g. strong consent policy which allows young people to control their own consent. You're Welcome is in place in all sexual and reproductive health service sites across LCH and is regularly monitored and reviewed.

3.5.3 Leeds City Council

3.5.3.1 Leeds City Council is working with a wide range of partners, including third sector organisations and businesses, towards its shared ambition to become a more child friendly city. The launch of Leeds as a Child Friendly City by HRH the Queen and the recent hosting of a large Children's BBC event in the centre of the city demonstrated the commitment both locally and nationally. A key part of this vision is to increase the voice and influence of children and young people in Leeds. In 2011, thousands of children and young people shared their views about what would make this city more child friendly and this consultation led to the 12 wishes: http://www.leeds.gov.uk/c/Pages/childFriendlyCity/12-wishes-for-child-friendly-Leeds.aspx.

3.5.3.2 Wish 7 highlights children and young people's priority to have the support and information they need to make healthy lifestyle choices. Currently the Voice and Influence Team is working with a group of Child Friendly Leeds Young Advisors (9-13 year olds), who will be writing articles and researching health web sites they feel other young people will find useful.
http://www.breezeleeds.org/pg/287/Child_Friendly_Leeds

3.5.3.3 The Voice and Influence team in Children's Services provide a central role in bringing together organisations and services that aim to increase voice and influence of children and young people. The Strategic Voice and Influence Partnership Group aims to improve participation practice across the city and provides a two way channel of communication for children and young people and decision makers. The group is accountable to the Children's Trust Board and reports on progress and future actions via the six monthly Voice and Influence Report Card. Health representatives on the group include colleagues from Health

watch, CCGs, Leeds Teaching Hospitals and Leeds Community Healthcare. The group's work is supported by a citywide network of Voice and Influence link staff from all schools, youth groups, clusters, children's centres, children's homes, third sector organisations etc who all receive and contribute towards a bi monthly voice and influence update. The update provides children and young people with the opportunity to share how they have had their voices heard and influenced change. In addition we have established two voice and influence working groups to ensure we are addressing the specific needs of children and young people with additional needs and SEN, and those who are looked after or care leavers.

3.5.3.4 Children and young people have the opportunity to be involved in a range of youth forums in the city, these include the Leeds Youth Council, Care Leavers Council and Children in Care Council (Have a Voice). All groups play a key role in shaping and improving services across the city. Last year we also established a Junior Safeguarding Board which works in partnership with the LSCB. All four youth forums decide at the start of the year what they want to achieve and the campaign or issue they want to address. We also have over 300 Child Friendly Leeds Young Advisors (5-19 year olds) who are involved in a variety of different opportunities including recruitment panels, reporting at events, website development, consultations and running training and events. Healthwatch and the CCGs are just establishing youth forums and youth volunteering opportunities. The Youth Offer team are currently working in partnership with Area Committees to help them establish local area youth forums which will help prioritise how grants are spent on youth activities. Thousands of children and young people vote every year for who they want as their children's mayor and this year's winner aims to encourage more people to cycle. In February, young people from across Leeds will vote for their regional representative members of Youth Parliament by choosing which of their manifestos they feel will most address the issues they feel are important.

3.5.3.5 Strategically, the CYPP reflects the priorities identified through the local joint strategic needs assessment. Measurement of progress is supported by partnership use of shared data scorecards. The CYPP is set against the twelve 'Children's Wishes' for the city and a 'Care Promise' developed by children who are looked after. Annually, the Growing Up in Leeds survey provides a representative overview of children's perception of their lives across education, social and health domains. It records their experiences, their needs and the pressures they feel in their lives. It provides a baseline with which the CTB measure progress at the population level. The Children's Trust Board has committed to adhere to national quality standards for children's involvement including the Care Leavers Charter and Every Disabled Child Matters. Leeds has adopted the use of the Lilac Inspection, a nationally recognised benchmark that uses the views of care experienced children to evaluate care settings. This standard was passed by the city with noted improvements across social care services.

3.5.3.6 From a commissioning and service planning perspective, young people are directly involved in evaluating and awarding commissioning programmes such as Short Breaks for children with complex needs, Information Advice and Guidance services for young people in transition to adulthood, and foster care and residential home contracts. This approach is being replicated in the new public health

commissioning responsibilities of the local authority in the recommissioning of sexual health provision. A co-production approach is being used with children and their parents in the redesign of the health and social care response to children with complex needs as the basis for our "Pioneer" city status for innovation in the integration of these services. Leeds has developed a reference group of children and young people to act as both sounding board ('young citizens panel') and as young inspectors to review the effectiveness of services. Leeds uses innovative approaches with young people to quality assure and improve services eg a secret shopping initiative of sexual health provision for young people identified key development areas such as confidential arrangements for space in waiting rooms.

4 Corporate Considerations

4.1 Consultation and Engagement

4.1.1 The work cited in the report references a range of consultation and engagement undertaken by services with children, young people and their families. Both NHS and Council services have structures and mechanisms in place for ongoing engagement.

4.2 Equality and Diversity / Cohesion and Integration

4.2.1 The paper refers to key issues around inequalities, and describes a proportionate universal approach to delivery of services in order to target increasing resource on those with greatest need.

4.3 Council policies and City Priorities

4.3.1 Issues covered relate to key priorities in the Health and Wellbeing Strategy and the Children and Young People's Plan.

4.4 Resources and value for money

4.4.1 The CMO's report presents the economic case for a shift of investment into prevention.

4.5 Legal Implications, Access to Information and Call In

4.5.1 None.

4.6 Risk Management

4.6.1 None.

5 Conclusions

5.1 The responses to the important questions posed by the CMO highlight a number of key issues for Leeds. Many are being addressed already, and some need to be taken forward. The key issues identified in the report include:

5.1.1 The Atlas of Variation contained in the CMO's report, and the Child Health Profile for Leeds, both illustrate that Leeds has a number of challenges in relation to child

health. These challenges include: oral health; sexual health and teenage pregnancy; self harm; and drugs and alcohol. Programmes of work are either in place or planned to address these. In relation to wider determinants of health, Leeds performs poorly in relation to educational attainment, number of young people who are NEET, and numbers of looked after children. These issues are the focus of the "3 obsessions" of the Children and Young People's Plan.

5.1.2 The importance of the Best Start agenda is highlighted as a preventive priority for the city. Good work is already underway in response to evidence about Best Start, but this will benefit from being pulled together into a co-ordinated strategy. It is proposed to establish a Strategy Group which will account to both the Health and Wellbeing Board and Children's Trust Board, to develop and oversee implementation of this vital work programme. The Infant Mortality Programme in Leeds has achieved a significant impact on the rates of infant deaths in 'deprived' Leeds. This important work should continue under the banner of the Best Start programme.

5.2.3 The delivery of the Healthy Child Programme is in place in the city, and Leeds is at the forefront of integration of its children's services through the Early Start Team. Effective delivery will depend upon continued investment into services which deliver the Healthy Child Programme, such as health visiting, school nursing and children's centres. Smooth transfer of commissioning of health visiting services from 2015 is anticipated.

5.2.4 The thriving Healthy Schools Scheme in Leeds means that Leeds is well placed to maximise the role of schools in influencing healthy behaviours and modifying exploratory behaviours.

5.2.5 Some good work is taking place in both Leeds Children's Hospital and Leeds Community Healthcare Trust to engage with children, young people and their families, and to understand and respond to their needs and experiences. Further work is planned, and this should be supported, including review of the use of You're Welcome standards. Leeds City Council has an exciting developing programme of active participation by children and young people via the Voice and Influence and the Child Friendly Cities initiatives.

6 Recommendations

6.1 The Scrutiny Board is asked to consider and note the contents of this report and identify any matters that warrant further and/or more detailed scrutiny in the future.

7 Background documents[3]

None

[3] The background documents listed in this section are available to download from the Council's website, unless they contain confidential or exempt information. The list of background documents does not include published works.

APPENDIX 1: Child Health Profile for Leeds published by ChIMat 2013

www.chimat.org.uk

Child Health Profile

ChiMat
Child and Maternal Health Observatory

Leeds

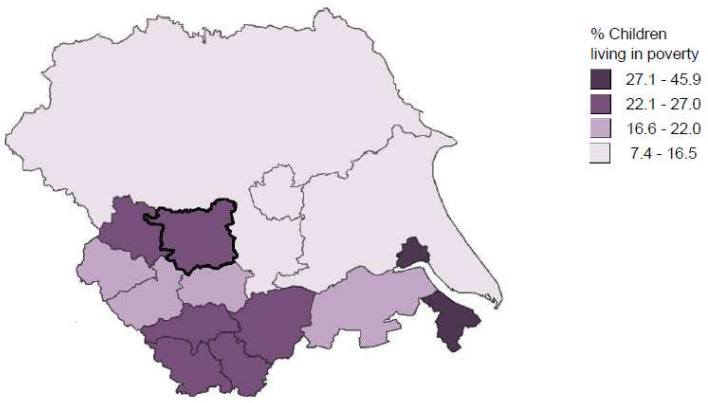
March 2013

This profile provides a snapshot of child health in this area. It is designed to help the local authority and health services improve the health and well-being of children and tackle health inequalities.This profile is produced by the Child and Maternal Health Observatory (ChiMat) which is part of Yorkshire and Humber Public Health Observatory (YHPHO).

The child population in this area	Local	Yorkshire and the Humber	England
Live births in 2011	10,127	66,451	688,120
Children (age 0-4 years), 2011	48,100	329,000	3,328,700
% of total population	6.4%	6.2%	6.3%
Children (age 0-19 years), 2011	179,800	1,277,000	12,710,500
% of total population	24.0%	24.1%	23.9%
Children (age 0-19 years) in 2020 (projected)	192,316	1,329,772	13,575,943
% of total population	23.1%	23.6%	23.7%
School children from black/ethnic minority groups	23,765	134,675	1,661,440
% of school population (age 5-16 years)	25.7%	20.3%	25.6%
% of children living in poverty (age under 16 years)	23.0%	22.0%	21.1%
Life expectancy at birth			
Boys	77.9	77.7	78.6
Girls	82.2	81.8	82.6

Children living in poverty

Map of Yorkshire and the Humber, with Leeds outlined, showing the relative levels of children living in poverty.



Data sources: Live births, Office for National Statistics (ONS) 2011; population estimates, ONS 2011 Census mid-year estimates; population projections, ONS interim 2011-based subnational population projections; black/ethnic minority maintained school population, Department for Education 2012; children living in poverty, HM Revenue & Customs (HMRC) 2010; life expectancy, ONS 2008-10

Key findings

24.0% of the population of Leeds is under the age of twenty. 25.7% of school children are from a black or minority ethnic group.

The health and well-being of children in Leeds is generally worse than the England average. Infant and child mortality rates are similar to the England average.

The level of child poverty is worse than the England average with 23.0% of children aged under 16 years living in poverty. The rate of family homelessness is better than the England average.

Children in Leeds have average levels of obesity. 9.3% of children aged 4-5 years and 19.7% of children aged 10-11 years are classified as obese. 52.3% of children participate in at least three hours of sport a week which is worse than the England average.

The MMR immunisation rate is higher than the England average. Immunisation rates for diphtheria, tetanus, polio, pertussis and Hib in children aged two are higher than the England average.

There were 1,475 children in care at 31 March 2012 which gives a higher rate when compared to the England average. A higher percentage of children in care are up-to-date with their immunisations and GCSE achievement is similar to the England average for this group of children.

YHPHO
YORKSHIRE & HUMBER PUBLIC HEALTH OBSERVATORY

NHS

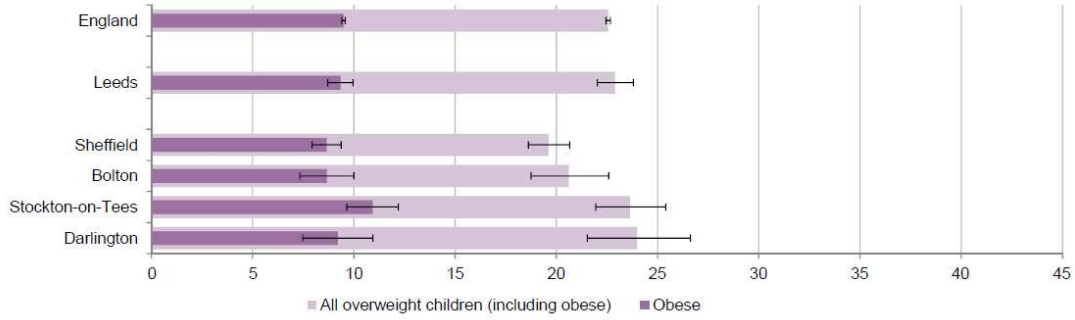
ChiMat is funded by the Department of Health and is part of YHPHO.
This profile is produced by ChiMat on behalf of the Public Health Observatories in England.

Leeds Child Health Profile — March 2013

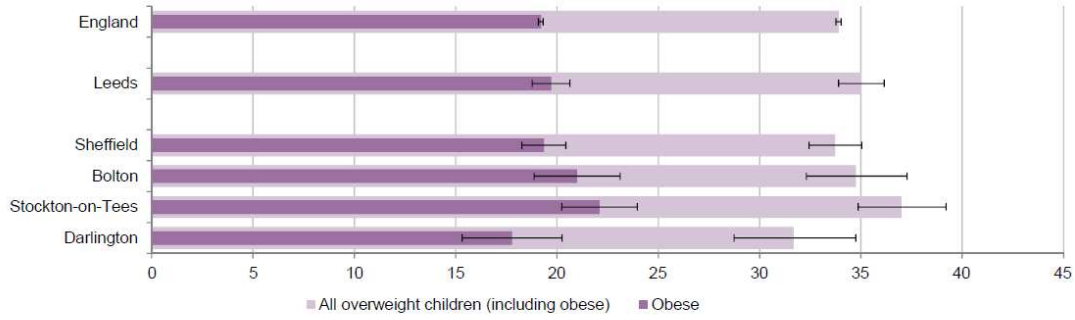
Childhood obesity

These charts show the percentage of children classified as obese or overweight in Reception (aged 4-5 years) and Year 6 (aged 10-11 years) by local authority compared to their statistical neighbours. This area has a similar percentage in Reception and a higher percentage in Year 6 classified as obese or overweight compared to the England average.

Children aged 4-5 years classified as obese or overweight, 2011/12 (percentage)



Children aged 10-11 years classified as obese or overweight, 2011/12 (percentage)



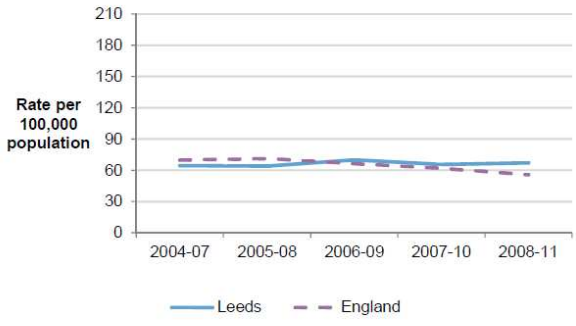
Note: This analysis uses the 85th and 95th centiles of the British 1990 growth reference (UK90) for BMI to classify children as overweight and obese.
I indicates 95% confidence interval.

Data source: National Child Measurement Programme (NCMP), The Information Centre for health and social care

Young people and alcohol

Young people aged under 18 admitted to hospital with alcohol specific conditions (rate per 100,000 population aged 0-17 years)

In comparison with the 2004-07 period, the rate of young people under 18 who are admitted to hospital because they have a condition wholly related to alcohol such as alcohol overdose remains broadly similar in the 2008-11 period. Overall rates of admission in the 2008-11 period are higher than the England average.

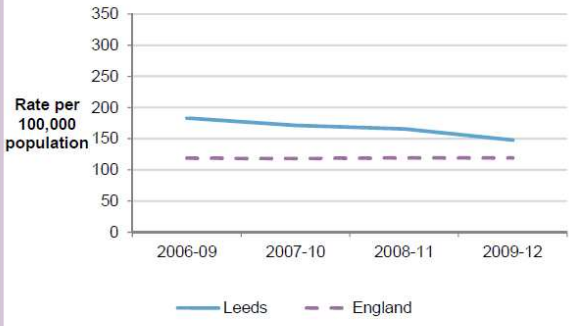


Data source: Local Alcohol Profiles for England, North West Public Health Observatory

Young people's mental health

Young people aged under 18 admitted to hospital as a result of self-harm (rate per 100,000 population aged 0-17 years)

In comparison with the 2006-09 period, the rate of young people under 18 who are admitted to hospital as a result of self-harm has decreased in the 2009-12 period. Overall rates of admission in the 2009-12 period are higher than the England average*. Nationally, levels of self-harm are higher among young women than young men.



*Information about admissions in the single year 2011/12 can be found on page 4

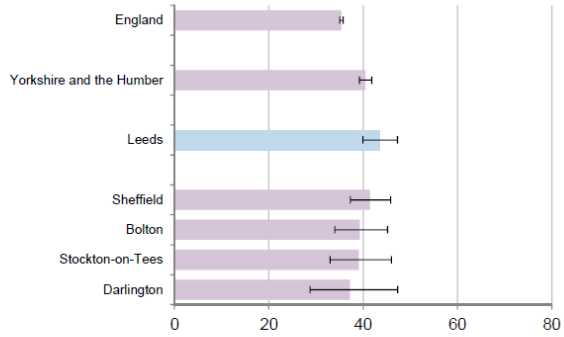
Data source: Hospital Episode Statistics, The Information Centre for health and social care

APPENDIX 1: Child Health Profile for Leeds published by ChIMat 2013

Leeds Child Health Profile — March 2013

These charts compare Leeds with its statistical neighbours, the England and regional average and, where available, the European average.

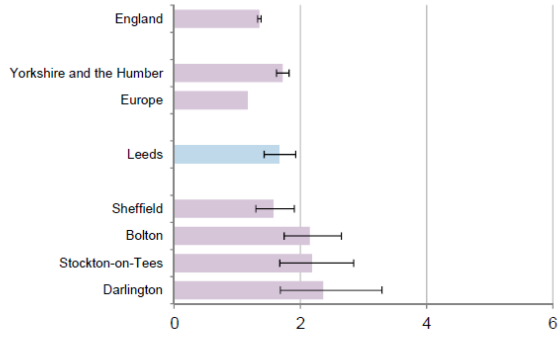
Teenage conceptions in girls aged under 18 years, 2010 (rate per 1,000 female population aged 15-17 years)



In 2010, approximately 44 girls aged under 18 conceived for every 1,000 of the female population aged 15-17 years in this area. This is similar to the regional average. The area has a higher teenage conception rate compared to the England average.

Data source: Department for Education

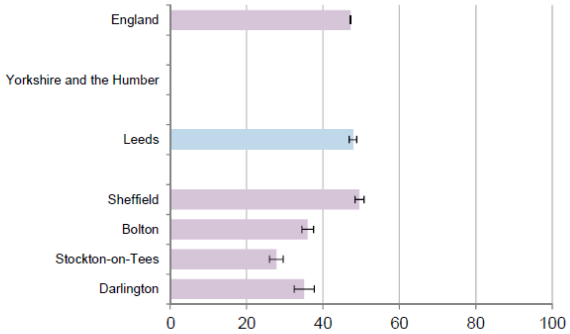
Teenage mothers aged under 18 years, 2011/12 (percentage of all deliveries)



In 2011/12, 1.7% of women giving birth in this area were aged under 18 years. This is similar to the regional average. This area has a higher percentage of births to teenage girls compared to the England average and a higher percentage compared to the European average of 1.2%*.

Data source: Hospital Episode Statistics, The Information Centre for health and social care
* European Union 27 average, 2009. Source: Eurostat

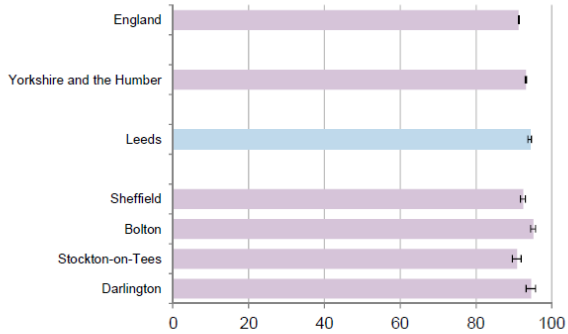
Breastfeeding at 6 to 8 weeks, 2011/12 (percentage of infants due 6 to 8 week checks)



In this area, 47.8% of mothers are still breastfeeding at 6 to 8 weeks. This is similar to the England average. 69.5% of mothers in this area initiate breastfeeding when their baby is born. This area has a lower percentage of babies who have ever been breastfed compared to the European average of 89.1%*.

Data source: Department of Health
* European Union 21 average, 2005. Source: Organisation for Economic Co-operation and Development (OECD) Social Policy Division

Measles, mumps and rubella (MMR) immunisation by age 2 years, 2011/12 (percentage of children age 2 years)



A higher percentage of children (94.2%) have received their first dose of immunisation by the age of two in this area when compared to the England average. By the age of five, the percentage of children who have received their second dose of MMR immunisation is lower with 89.1% of children being immunised. This is higher than the England average. In Yorkshire and the Humber, there were 38 laboratory confirmed cases of measles in young people aged 19 and under in the past year.

Data source: The Information Centre for health and social care, Health Protection Agency

Note: Where no data are available or have been suppressed, no bar will appear in the chart for that area.

APPENDIX 1: Child Health Profile for Leeds published by ChIMat 2013

Leeds Child Health Profile — March 2013

Summary of child health and well-being in Leeds

The chart below shows how children's health and well-being in this area compares with the rest of England. The local result for each indicator is shown as a circle, against the range of results for England which are shown as a grey bar. The red line indicates the England average. The key to the colour of the circles is shown below.

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

England average — 25th percentile — 75th percentile

range of values that differ significantly from the average

	Indicator	Local no. per year	Local value	Eng. ave.	Eng. worst	Eng. best
Preventable mortality	**1** Infant mortality rate	48	4.7	4.4	8.0	2.2
	2 Child mortality rate (age 1-17 years)	20	13.7	13.7	23.7	7.5
Health protection	**3** MMR immunisation (by age 2 years)	9,481	94.2	91.2	78.7	97.2
	4 Diphtheria, tetanus, polio, pertussis, Hib immunisations (by age 2 years)	9,827	97.6	96.1	85.7	98.8
	5 Children in care immunisations	1,045	92.9	83.1	0.0	100.0
	6 Acute sexually transmitted infections (including Chlamydia)	5,380	43.1	35.6	75.2	19.9
Wider determinants of ill health	**7** Children achieving a good level of development at age 5	5,576	62.9	63.5	51.5	76.5
	8 GCSE achieved (5A*-C inc. Eng and maths)	4,408	55.0	59.4	40.9	79.6
	9 GCSE achieved (5A*-C inc. Eng and maths) for children in care	14	14.7	14.6	0.0	40.0
	10 Not in education, employment or training (age 16-18 years)	1,970	8.1	6.1	11.8	1.6
	11 First time entrants to the Youth Justice System	666	1,004.4	876.4	2,436.3	342.9
	12 Children living in poverty (aged under 16 years)	30,955	23.0	21.1	45.9	7.4
	13 Family homelessness	333	1.0	1.7	7.4	0.1
	14 Children in care	1,475	95.0	59.0	150.0	19.0
	15 Children killed or seriously injured in road traffic accidents	39	29.1	22.1	47.9	4.4
Health improvement	**16** Low birthweight	786	7.7	7.4	11.0	5.0
	17 Obese children (age 4-5 years)	794	9.3	9.5	14.5	5.8
	18 Obese children (age 10-11 years)	1,374	19.7	19.2	27.8	12.3
	19 Participation in at least 3 hours of sport/PE	48,257	52.3	55.1	40.9	79.5
	20 Children's tooth decay (at age 12)	-	1.1	0.7	1.5	0.2
	21 Teenage conception rate (age under 18 years)	555	43.5	35.4	64.7	6.2
	22 Teenage mothers (age under 18 years)	166	1.7	1.3	2.8	0.3
	23 Hospital admissions due to alcohol specific conditions	102	67.1	55.8	138.3	16.9
	24 Hospital admissions due to substance misuse (age 15-24 years)	118	86.3	69.4	186.3	25.7
Prevention of ill health	**25** Smoking in pregnancy	1,268	12.2	13.2	29.7	2.9
	26 Breastfeeding initiation	7,251	69.5	74.0	41.8	94.3
	27 Breastfeeding at 6-8 weeks	4,915	47.8	47.2	19.7	82.8
	28 A&E attendances (age 0-4 years)	24,291	517.6	483.9	1,187.4	136.3
	29 Hospital admissions due to injury (age under 18 years)	2,417	156.3	122.6	211.1	72.4
	30 Hospital admissions for asthma (age under 19 years)	302	182.0	193.9	484.4	73.4
	31 Hospital admissions for mental health conditions	66	42.7	91.3	479.7	22.6
	32 Hospital admissions as a result of self-harm	235	151.9	115.5	311.9	26.0

Notes and definitions - Where data are not available or have been suppressed, this is indicated by a dash in the appropriate box.

1 Mortality rate per 1,000 live births (age under 1 year), 2009-2011
2 Directly standardised rate per 100,000 children age 1-17 years, 2009-2011
3 % children immunised against measles, mumps and rubella (first dose by age 2 years), 2011/12
4 % children completing a course of immunisation against diphtheria, tetanus, polio, pertussis and Hib by age 2 years, 2011/12
5 % children in care with up-to-date immunisations, 2012
6 Acute STI diagnoses per 1,000 population aged 15-24 years, 2011
7 % children achieving a good level of development within Early Years Foundation Stage Profile, 2012
8 % pupils achieving 5 or more GCSEs or equivalent including maths and English, 2011/12
9 % children looked after achieving 5 or more GCSEs or equivalent including maths and English, 2011/12 (provisional)
10 % not in education, employment or training as a proportion of total age 16-18 year olds known to local Connexions services, 2011
11 Rate per 100,000 of 10-17 year olds receiving their first reprimand, warning or conviction, 2010/11
12 % of children aged under 16 living in families in receipt of out of work benefits or tax credits where their reported income is less than 60% median income, 2010
13 Statutory homeless households with dependent children or pregnant women per 1,000 households, 2011/12
14 Rate of children looked after at 31 March per 10,000 population aged under 18, 2012
15 Crude rate of children age 0-15 years who were killed or seriously injured in road traffic accidents per 100,000 population, 2009-2011
16 Percentage of live and stillbirths weighing less than 2,500 grams, 2011
17 % school children in Reception year classified as obese, 2011/12
18 % school children in Year 6 classified as obese, 2011/12
19 % children participating in at least 3 hours per week of high quality PE and sport at school age (5-18 years), 2009/10
20 Weighted mean number of decayed, missing or filled teeth in 12 year olds, 2008/09
21 Under 18 conception rate per 1,000 females age 15-17 years, 2010
22 % of delivery episodes where the mother is aged less than 18 years, 2011/12
23 Crude rate per 100,000 under 18 year olds for alcohol specific hospital admissions, 2008-11
24 Directly standardised rate per 100,000 (age 15-24 years) for hospital admissions for substance misuse, 2009-12
25 % of mothers smoking at time of delivery, 2011/12
26 % of mothers initiating breastfeeding, 2011/12
27 % of mothers breastfeeding at 6-8 weeks, 2011/12
28 Crude rate per 1,000 (age 0-4 years) of A&E attendances, 2010/11
29 Crude rate per 10,000 (age 0-17 years) for emergency hospital admissions following injury, 2011/12
30 Crude rate per 100,000 (age 0-18 years) for emergency hospital admissions for asthma, 2011/12
31 Crude rate per 100,000 (age 0-17 years) for hospital admissions for mental health, 2011/12
32 Crude rate per 100,000 (age 0-17 years) for hospital admissions for self-harm, 2011/12

CORE CITIES: COMPARISON FOR INDICATORS SHOWING "RED" FOR LEEDS
(ie indicators for which Leeds is statistically worse than England)

	Sexually Transmitted Infections	GCSEs grades A*-C incl English & Maths	Not in Education, Employment or Trainings 16-18	Children killed or seriously injured in road traffic accidents	Children's tooth decay age 12 (dmft*)	Teenage conception rate under 18	Hospital admissions due injury age under 18
Leeds	43.1	55.0	8.1	29.1	1.1	43.5	156.3
Bristol	33.9	51.6	8.8	14.3	1.1	42.2	118.1
Newcastle	46.2	55.8	11.8	35.1	0.8	46.8	64.3
Liverpool	37.2	56.8	11.5	35.5	1.3	44.5	135.6
Sheffield	30.9	55.6	8.2	28.8	1.0	41.4	118.3
Manchester	40.3	53.2	7.0	30.7	1.1	57.2	122.6
Nottingham	32.0	49.6	5.4	29.7	0.9	54.4	121.8
Birmingham	38.4	60.1	6.9	32.9	0.7	43.3	124.1

Source: ChIMat Child Health Profiles for 2013
*Note: dmft is number of teeth decayed, missing or filled

Table 3

CORE CITIES: COMPARISON FOR INDICATORS SHOWING "GREEN" OR "AMBER" FOR LEEDS
(ie indicators for which Leeds is statistically better or similar to England)

	Infant mortality rate	MMR immunisation by age 2	Children in care immunisations	Children in care GCSE A* to C incl English & Maths	Obese children age 10-11	Smoking in pregnancy	Breastfeeding at 6-8 weeks
Leeds	4.7	94.2	92.9	14.7	19.7	12.2	47.8
Bristol	2.8	8.8	60.4	17.0	19.0	10.6	55.1
Newcastle	3.1	92.8	81.5	14.3	24.9	18.7	40.1
Liverpool	4.9	95.1	89.8	15.3	23.1	18.3	26.2
Sheffield	5.1	92.4	81.2	No info	19.4	14.1	49.5
Manchester	5.9	89.1	77.0	21.5	23.8	14.6	No info
Nottingham	6.2	88.8	85.1	0.0	22.2	18.5	46.6
Birmingham	7.5	88.5	80.8	16.9	24.3	11.6	No info

Source: ChIMat Child Health Profiles for 2013