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Author/Priority Lead:	Lorraine Hughes		
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This should be read in conjunction with: Best Start JSNA, Teenage Pregnancy JSNA

Executive Summary

What happens in pregnancy and early childhood lays the foundations of human development, physically, emotionally and intellectually. The impact of these early years can be life-long on many aspects of health and wellbeing, educational attainment and economic status. Providing the right support to families during the first few years of a child's life underpins the principle of giving every child the best start in life in order to reduce health inequalities across the life course. The benefits of positive interventions during the early years of childhood, including before birth, are realised both in the short term and over the entire life course.

The support provided in the early years needs to be sustained for school aged children and young people. This period of the life course can bring with it many changes and challenges and an element of risk taking behaviour which helps young people to try new things and form a sense of their own identity as they move toward the independence of adulthood.

The universal and targeted public health services provided by health visiting and school nursing teams are crucial to providing this support, improving outcomes and reducing inequalities. This is what underpins the Healthy Child Programme, which was developed by the Department of Health in 2009 and set out an evidence based programme of best practice, led by Specialist Community Public Health Nurses. Traditionally Health Visitors lead the 0-5 years element of the Programme and School Nurses lead for school aged children and young people aged 5 -19 years.

Many of the public health outcomes for maternity, early years, children and young people are worse or significantly worse in Sunderland than regionally and nationally.

This includes:

- Smoking during pregnancy
- Low birth weight
- Breastfeeding
- Oral health
- Alcohol specific hospital admissions
- Child obesity
- Teenage conceptions
- Hospital admissions for unintentional and deliberate injury
- Mental health

Commissioning high quality public health services for the 0-19 population contributes to the core public health offer for all children, with a focus on reducing health inequalities and improving public health outcomes through promoting and supporting good health and wellbeing, enabling positive choices and tackling the causes of ill-health.

Strategic Needs Assessment

1) Title of JSNA

0-19 Public Health Services

2) What is the need locally, both now and in the future?

A high level summary of need is provided for different age groups across the 0-19 population. A more detailed needs assessment can be found at 0-19 Public Health Services Needs Assessment .

Maternity and 0-5 Years

Child Poverty

In 2014, the number of children living in low income families (under 16s) in Sunderland was 12,615 (26%). Nationally this figure is 20.1%.

Looked after Children (LAC)

The number of LAC in Sunderland aged 0-2 is fairly stable at around 84. For 2-4 year olds, the number of LAC in 2016/17 was 69.

The number of LAC aged under 5 in Sunderland in 2016 was 160. This corresponds to a crude rate per 10,000 population aged under 5 of 102.6, compared with regional (65.3) and national (36.9) values.

Educational Attainment

In 2015/16, the percentage of children achieving a good level of development at the end of reception in Sunderland is 68.2%, which is similar to the regional value of 68.4% and the national value of 69.3%. If this figure is analysed in terms of gender, it shows 60.3% for males and 76.5% for females.

The percentage of children with free school meal status achieving a good level of development at the end of reception in Sunderland is 51.9% compared with 53.7% regionally and 54.4% nationally. The inequalities are even more stark when split by gender, with 41.9% of males with Free School Meal (FSM) status achieving a good level of development compared with 62.1% for females.

Low Birth Weight

Sunderland has the third worst figures for low birth weight (less than 2,500g) in the region and amongst statistical neighbours. The percentage of all live births at term with low birth

weight (less than 2,500 grams) in Sunderland is 3.5%, compared with an all-England average of 2.8%.

Infant and Child Mortality Rates

Between 2013-2015, there were 12 mortalities in infants aged under 1 year, which represents an infant mortality rate per 1,000 infants aged under 1 year of 4.1, compared with a north east rate of 3.6 and a national rate of 3.9. Infant mortality in Sunderland is now similar to the England average and is showing an upward trend (whereas historically Sunderland had a lower infant mortality rate than the national rate).

The child mortality rate (1-17 years) in Sunderland is 17.4 (directly standardised rate per 100,000 children aged 1-17 years, 2013-2015), compared with an England average of 11.9.

Smoking at Time of Delivery

This is decreasing for Sunderland (18%) and for England as a whole (10.6%).

Breastfeeding Initiation Rates

In 2014/15, the percentage of women initiating breastfeeding in Sunderland was 57.5%, compared with an England percentage of 74.3% and North-East figure of 60.1%.

Breastfeeding Levels at 6-8 Weeks

In Sunderland in 2015/16 this was 26.8% compared with a regional figure of 31.4% and a national value of 43.2%.

Oral Health

The mean number of decayed, missing and filled teeth (dmft) per 3 year-olds in Sunderland in 2012-13 was 0.54, compared with a figure of 0.36 for England. The proportion of 3 year-old children who were free from dental decay in Sunderland in 2012-13 was 81.6%, compared with a national figure of 88.4%.

The percentage of children who have visibly obvious incisor caries in Sunderland is 7.4, which is nearly twice the England figure of 3.9%.

In Sunderland the crude rate of hospital admissions for dental caries among children aged 1-4 years in 2012/13 – 2014/15 was 162.7 per 100,000 (aged 0-4 years), compared with an England average of 322.0.

Unintentional and Deliberate Injuries

The crude rate of hospital admissions caused by unintentional and deliberate injuries in children aged under 5 years per 10,000 resident population aged under 5 years in Sunderland was 222.5, compared with an equivalent regional figure of 192.3 and a national figure of 129.6.

Local pooled ward data for hospital admissions due to unintentional and deliberate injury for children under 5 years show that between 2010/11 and 2014/15 10 wards have a rate higher than the overall Sunderland average, with Redhill and Sandhill wards having hospital admission rates of 308.0 and 303.7 per 10,000 population.

The rate of A&E attendances in Sunderland is 1358.3 per 1,000 population aged 0-4 years, which is the highest in the North East and 2.5 times greater than the rate for England, which is 540.5.

Childhood Obesity

The Child Health Profile for 2017 shows that children in Sunderland have worse than average levels of obesity. 11.4% of children aged 4-5 years.

Compared with the England average, Sunderland has a worse percentage of children in Reception (23.9%) who have excess weight.

Childhood Immunisations

Sunderland performs significantly better than the England average for vaccinations at 2 years old. In Sunderland the MMR immunisation rate is 96.6%. The immunisation rate for diphtheria, tetanus, polio, pertussis and Hib in children aged two is 98.7%.

Immunisations for children in care (not broken down by age band) were at 86.4% in 2015 and down to 62.2% in 2016 in Sunderland, below the England average of 87.2%, representing a worsening inequality for this group of children in Sunderland.

In Sunderland, the percentage of eligible children who had received one dose of MMR between the ages of 1 to 5 was 98% in 2015/16. The vaccination coverage for the second dose of MMR is 94.4% in 2014/15.

5-10 Years

Child Poverty

The number of children aged between 5-10 living in low income families as a proportion of all 5-10 year olds in Sunderland in 2013 is 23.6%. The national comparator is 18%.

Looked after Children

The number of LAC aged 5-9 inclusive in Sunderland in 2016 was 130. This corresponds to a crude rate per 10,000 population aged 5-9 inclusive of 84.1, compared with regional (63.7) and national (39.0) values.

Educational Attainment

The percentage of Year 1 pupils with free school meal status achieving the expected level in

the phonics screening check in Sunderland is 73.4%, higher than the England (68.6%) and regional (70.7%) averages.

The number of children in Key Stage 1 achieving the expected levels for reading, writing, maths and science are all above regional and national levels.

The number of persistent absentees at primary school level in 2014/15 in Sunderland was 1,698, representing 9.3% of primary school children, which is worse than national (8.4%) and regional (9%) figures. The number of primary school children with fixed period exclusions was 200, or 0.84%, which is better than the national average of 1.1%.

Oral Health

The proportion of 5 year old children free from dental decay in Sunderland was 59.9%, which is the worst level in the north east, which has achieved an overall level of 75.2%.

On average, five year-old children in Sunderland have had 1.52 decayed, missing or filled (dmft) teeth, based on 2014/15 data. This is the second worst figure in the region, and compares poorly against the England average of 0.84.

Unintentional and Deliberate Injuries

In Sunderland the rate of hospital admissions caused by unintentional and deliberate injuries amongst children aged 0-14 years is the highest across the North East, at 169.7 per 10,000 population aged 0-14 years. This compares to a rate of 104.2 per 10,000 population in England.

Hospital Admissions

The number of hospital admissions for children aged 0-9 for asthma was 148, equating to a rate of 480.6 per 100,000 children aged 0-9. This is significantly worse for Sunderland than for England as a whole (comparative rate of 280.1). Admission rates for diabetes and epilepsy amongst the same age group in Sunderland are similar to national figures.

Childhood Obesity

Compared with the England average (34.2%), Sunderland has a worse percentage of children in Year 6 (39.8%) who have excess weight.

24% of children aged 10-11 year are classified as obese, compared with 19.8% for England as a whole.

11 –19 Years

Looked after Children

The number of LAC aged 10-15 in Sunderland in 2016 was 165. This corresponds to a crude rate per 10,000 population aged 10-15 of 96.8, compared with regional (102.4) and

national (75.3) values.

The number of LAC aged 16+ in Sunderland in 2016/17 was 90. The crude rate of looked after children per 10,000 population aged 16-17 is 145, compared with a regional rate of 133.0 and national rate of 129.3.

Youth Justice System

In Sunderland in 2014/15, the rate of 10-17 year olds receiving their first reprimand, warning or conviction (first time entrants to the youth justice system) per 100,000 population was 637.7. This was the second highest rate in the region, second to South Tyneside (718.5). The regional rate is 440.1, and national rate is 368.6.

The number of children and young people aged 10-18 years who have formally entered the youth justice system is expressed as a rate per 1,000 population aged 10-18 years. In Sunderland the rate is 11.3, which represents 306 young people. The regional rate is 9.2, and national rate is 6.5. This rate is falling locally and nationally.

Teenage Pregnancy

The Sunderland teenage pregnancy rate is significantly worse than the England average (34.6 compared with 20.8 per 1,000 females aged 15-17 in 2015.) After a number of years of a reducing rate, the rate is now increasing. This is the 6th highest rate in England.

The under-16 conception rate in Sunderland was 8.5 per 1,000 in 2015 (worst in the North East) compared with the England rate of 3.7. The is the 3rd highest rate in England

Immunisations

In 2013/14, 92.2% of all girls aged 12-13 in Sunderland were vaccinated against HPV. This is higher than the England average of 86.7%. HPV vaccination rates in Sunderland have decreased slightly from 2012/13 levels, when they were 94.8%.

Oral Health

By age 12, 57% have had no decay experience, compared with a national figure of 66.4%. On average 12 year-old children have had 1.10 decayed, missing or filled permanent teeth, compared with a national average of 0.74.

Educational Attainment

In 2016, 60.5% of pupils in Sunderland met the expected standard in reading, writing and maths at Key Stage 2. This is higher than the regional figure of 57.1% and national figure of 53.8%. When compared against Sunderland's statistical neighbours (CSSNBT), Sunderland ranks second only to Gateshead which achieves 61.4%.

In 2015/16, 53.9% of pupils in Sunderland achieved at least 5 GCSEs at grade A*-C,

including English and Maths. This is below the England average of 57.8%. For children with FSM status, the figure was significantly lower, at 27.4%, which is below the England (33.3%) and regional (30.5%) averages. This represents a significant inequality for this cohort.

In 2015, 5.9% of young people in Sunderland aged 16-18 were not in education, employment or training, which is a higher proportion than the England average of 4.2%. The proportion of 16-18 year olds whose current activity is not known is 4% in Sunderland, which is much lower than the rate for England of 8.4%.

School Absences and Exclusions

Primary School

The number of persistent absentees at primary school level in 2014/15 in Sunderland was 1,698, representing 9.3% of primary school children, which is worse than national (8.4%) and regional (9%) figures.

The number of primary school children with fixed period exclusions was 200, or 0.84%, which is better than the national average of 1.1%.

Secondary School

The number of persistent absentees at secondary school level in 2014/15 in Sunderland was 2,499, representing 16.8% of secondary school children, which is worse than national (13.8%) and regional (15.2%) figures.

The number with fixed period exclusions was 1,380, or 8.6%, which is worse than the regional average (8%) and national average (7.5%).

Unintentional and Deliberate Injuries and Hospital Admissions

In Sunderland in 2015/16, the rate of hospital admissions caused by unintentional and deliberate injuries amongst children aged 0-14 years is the highest across the North East, at 169.7 per 10,000 population aged 0-14 years. This compares to a rate of 104.2 per 10,000 population in England.

The number of hospital admissions caused by unintentional and deliberate injuries in young people aged 15-24 years has nearly halved through a steady decline in Sunderland since 2010, and is now in line with national figures. According to Hospital Episode Statistics, the crude rate of hospital admissions per 10,000 population was 133.5 in Sunderland, and 134.1 nationally.

The number of hospital admissions for asthma for children aged 10-18 is 229.4 per 100,000 children aged 10-18, which is higher than the figure of 138.7 for England.

Health Related Behaviours

The directly standardised rate per 100,000 of hospital admissions due to substance misuse for people aged 15-24 in 2015/16 in Sunderland is 113.6. This is not significantly different from the England average.

The rate of alcohol-specific hospital stays (under 18) in Sunderland is the highest in England for all persons and separately for males and females. The figures for Sunderland are getting worse. The crude rate per 100,000 population under 18 years in Sunderland is 115.1, compared with a regional rate of 66.9 and a national rate of 37.4. This is a massive problem for Sunderland, but only a relatively small number of people (188 in 2013/14- 2015/16) were directly affected.

The percentage of 15 year-olds who currently smoke in Sunderland in 2014/15 was 11.6, which was higher than regional (10.1) and national (8.2) figures.

Sexual Health

The chlamydia detection rate per 100,000 young people aged 15 to 24 in Sunderland in 2015 was 1,701. This is significantly worse than the regional (1,794) and national (1,887) position. However, there have been difficulties with reporting the data.

Chlamydia test coverage data for Sunderland shows that the proportion of the population aged 15-24 who were screened for chlamydia (measured separately in GUM and non-GUM settings) in 2015 was 18.7%, compared with regional and national figures, both at 22.5%.

Mental Health

In the 2012 Health Related Behaviour Survey (HRBQ), 67% of pupils in Years 8 and 10 reported that, in general, they were “quite a lot” or “very much” happy with their life.

The crude rate per 100,000 aged 0-17 years for hospital admissions for mental health in 2015/16 in Sunderland was 149.2, which is significantly worse than the national rate of 85.9. The rate for Sunderland showed a marked increase in 2015/16.

The estimated prevalence of mental health disorders in children and young people aged between 5 and 16 in Sunderland in 2014 was 10.4%. This is higher than both the regional (10.0%) and national (9.3%) prevalence.

Among young people aged 10-24 years there were 215 hospital admissions related to self-harm in Sunderland in 2015/16. This corresponds to a directly standardised rate of 439.6 per 100,000, which is similar to the England average of 430.5 per 100,000.

Alternative Provision

There were 33 children included on the alternative provision census that was conducted on 19 January 2017.

3) What are the effective interventions?

There is a vast volume of evidence and best practice which underpins the Healthy Child Programme, describing the type of interventions which should be delivered to improve outcomes for the 0-19 population.

The Healthy Child Programme is delivered through a universal, population based approach based upon the principles of proportionate universalism, which provides a framework for a targeted approach where additional needs, challenges and vulnerabilities are identified. The targeted work will vary in duration, depending on the issue. Core elements of the Healthy Child Programme are:

- health and development reviews;
- screening;
- immunisations;
- promotion of social and emotional development;
- support for parenting;
- effective promotion of and support for health and behaviour change for families, children and young people.

To effectively deliver the Healthy Child Programme on a universal basis it is important the workforce understands the local communities in which they work - in terms of needs, inequalities and community assets. Although delivery of the Healthy Child Programme is dependent on more than one workforce the 0-19 public health workforce, which is predominantly health visitors and school nurses, have responsibility for much of it and a wider leadership role across the system given their status as Specialist Community Public Health Nurses.

Guidance from the National Institute for Health and Care Excellence identifies a number of benefits which can be achieved through the commissioning of high quality *health visiting services*, although it should be noted they are also applicable to school nursing services. These are:

- building resilience and reducing costs in later life;
- identifying families with additional needs and providing support;
- improving wider factors which affect health and wellbeing;
- reducing numbers of children dying prematurely and living with preventable harm and ill health;
- supporting people to live healthy lifestyles and make healthy choices.

Recent Department of Health Guidance (2016) has identified a number of high impact areas

for early years and school aged years, which describe the areas health visitors and school nurses can have the greatest impact, and the interventions and ways of working which should be embedded to achieve this. Effective delivery of the Healthy Child Programme will contribute to improvements across a wide range of indicators in the Public Health Outcomes Framework.

3.1 Early Years High Impact Areas

Transition to Parenthood and the Early Weeks

There is a strong body of evidence which highlights the importance of sensitive attuned parenting to the development of a baby's brain and the establishment of secure attachment and bonding. Poor attachment and parenting issues can impact on the resilience of a child through into adulthood, as well as the physical, mental and socio-economic outcomes of a child in later life. Although the evidence for what is most effective for improving resilience is still developing the learning to date suggests the single most important factor for resilience in young people is a strong, secure relationship with at least one adult which reinforces the importance of attachment and positive parenting. Therefore preventing and intervening early to prevent such problems from manifesting will have an impact. Between conception and age 2 there is a unique opportunity to work with parents as that is when they are most likely to be receptive to behaviour change interventions, and where there is strongest evidence of effectiveness. Parenting programmes which start in pregnancy can also contribute to an improvement in outcomes.

In 2016 the Early Intervention Foundation published Foundations for Life, an evidence review of what works to support parent child interaction in the early years. This found that for attachment Family Nurse Partnership had the highest evidence rating (but also the highest cost rating), followed by Family Foundations. The evidence review also rated different programmes, including parenting programmes, for the effectiveness and cost-effectiveness on behaviour and cognitive development.

Validated tools, such as the Parent Infant Interaction Observation Scale , should be used to identify infants who may be at risk of poor attachment and parents who need additional support to bond and attune with their babies. Perinatal parenting programmes with a focus on attachment can support this. Health Education England recommends services should have specialist Health Visitors in perinatal and infant mental health and specialist training is available through the Institute of Health Visiting in these areas, on a train the trainer model. The existence of integrated local pathways for infant mental health will also support effective delivery.

Maternal Mental health

Through the training health visitors receive they are skilled in assessing mental health and

the recently introduced antenatal health visitor contact provides an opportunity for the health visitor to complete a holistic health assessment, which includes mental health. In this visit the health visitor should identify any past or present severe mental illness, previous or current treatment and any severe postpartum mental illness in a close relative. The NICE Guidance (QS115) Antenatal and Postnatal mental health should be reflected in working practice, with Whooley depression questions being asked within the general discussion to explore if people have been feeling down, depressed or hopeless or have little interest or pleasure in doing things. Anxiety should be screened for using the General Anxiety Disorder Scale (GAD-2). When a woman answers yes to the identification questions, or where there is clinical concern, there should be further assessment.

It is not uncommon to hear people talk of the 'baby blues', however where symptoms have not resolved at 10-14 days after birth women should be assessed, using formal measures such as the Edinburgh Postnatal Depression Scale (EPDS) or GAD-7, alongside referral to primary care or a perinatal mental health professional.

Across all contacts during pregnancy and the first year after birth the health visitor plays a pivotal role in screening for anxiety and depression, such as the measures above or the Patient Health Questionnaire (PHQ-9).

In addition to referral to other services the health visitor can provide reassurance, discuss treatment and provide support with early interventions to support good mental health, such as physical activity, peer support groups and ongoing support through extra contacts and referrals to Improving Access to Psychological Therapies (IAPT) services.

Breastfeeding

The benefits of breastfeeding for mother and baby are well documented, including providing the right nourishment; promoting emotional attachment between mother and infant; reducing the risk of different respiratory infections, gastroenteritis, ear infections and allergies; protecting against obesity, particularly for those genetically predisposed. There is also a lower risk amongst women who breastfeed of breast cancer, ovarian cancer and hip fractures from reduced bone density.

Breastfeeding should be promoted exclusively for babies up to six months old. Training health visitors in breastfeeding support has been shown to improve breastfeeding rates and health visitors should be providing leadership across the system by implementing UNICEF Baby Friendly Standards, supporting peer support groups and programmes and supporting the development of evidence based feeding policies.

Healthy Weight, Healthy Nutrition

Children who are overweight or obese are at increased risk of poor health outcomes, such

as type 2 diabetes and poor mental health, and around 80% of children who are overweight or obese will continue to be so into adulthood. This brings with it an increased risk of cardiovascular disease and other obesity related conditions.

Data from the National Child Measurement Progamme demonstrates a strong association between childhood obesity and inequality, which widens as children go through primary school. There are higher rates of childhood obesity in areas of disadvantage and some ethnic groups. In 2016 a national plan (Child Obesity: a plan for action) was published, with the aim of reducing childhood obesity by supporting healthier choices.

Healthy weight can be supported through encouraging good maternal diet, breastfeeding, timely and appropriate weaning onto solid foods, a healthy family diet and levels of physical activity which are in line with guidelines – for example, pre-school children should have 60 minutes of activity a day.

Health visitors can support early identification of emerging issues around healthy weight, and give advice and health promotion messages, throughout all of their contacts with families. Motivational interviewing techniques should underpin this approach. There are a number of actions health visitors can take, making every contact count. This can include supporting mothers to breastfeed for the first six months or as long as they choose, supporting the introduction of solid food and providing advice to ensure children have a nutritionally balanced diet, advising about drinks, bottle usage and oral health, providing sugar reduction advice, and encouraging positive family practices around food and physical activity.

Health visitors should monitor weight as part of the mandated checks and reviews, and where necessary provide extra advice or facilitate access to additional support where available. They should also explain to parents how to monitor healthy weight and development, using the guidelines in the Personal Child Health Record.

It is important that women planning a pregnancy, pregnant women, new mothers and children under the age of 5 use vitamin supplements to promote optimum nutrition. The Healthy Start vitamin scheme supports free access to vitamin supplements for those who are eligible, but all pregnant women, new mothers and children under 5 could benefit and provision should be made locally to facilitate access.

Managing Minor Illnesses and Reducing Hospital Attendance / Admissions

The leading causes of attendances at A&E departments and admission to hospital in the under 5's is illnesses such as gastroenteritis and upper respiratory tract infections and accidents in the home. Unintentional injury is also a leading cause of morbidity and premature mortality in children and young people. There is a strong correlation between unintentional injury and social deprivation.

The health visitor should provide appropriate advice to prevent illness and injury, and support parents to recognize the signs, symptoms and management or more serious diseases. At mandated visits safety and accident prevention measures should be discussed, reflective of the age and stage of the development of the child and the home environment. These messages can be reinforced at other contacts. There should be targeted follow up with families following A&E attendances which are accident related, and a chronology of significant events should be used and documented to inform discussion and intervention.

To support positive outcomes multi-agency staff should be trained in the prevention of accidents and managing minor illness.

Health, Wellbeing and Development of the Child Aged 2 and Support to be 'School Ready'

The age of 2 to 2.5 years is a crucial stage of development, and the point at which a range of problems such as speech and language delay, tooth decay or behavioural issues become apparent. When a child is attending an early years setting efforts should be made to complete an integrated health review.

Where problems are identified, the health visitor should co-ordinate early intervention before the child starts school, working with other services as appropriate, such as speech and language therapy and child and adolescent mental health services. Other early interventions could include strengthening parent-child interaction, improving communication skills, book sharing, modelling play, promoting access to children's centres and children's groups and encouraging uptake of free early education and childcare for those who are eligible.

3.2 School Aged Years High Impact Areas

Resilience and Emotional Wellbeing

Building resilience and wellbeing for children and young people requires a life course approach, with support from birth onwards. Good emotional wellbeing and resilience can be supported by:

- recognising and supporting the importance of good relationships with family, friends and others for building resilience;
- supporting parental wellbeing due to the impact this can have on a child;
- ensuring need is identified early, and family centred support is made available;
- be focused on key transition and trigger points, to identify risk;
- provision of early help and support when risk is identified.

Reducing Risky Behaviours

A normal part of growing up is trying new things and experimenting, and young people should be supported to do so safely. Ensuring young people are supported to make healthy and positive decisions and preparing them for adulthood can help them to successfully navigate this challenging time. Services should understand the local need in relation to risk taking behaviours and associated outcomes and provide intervention and support to young people in response, including 'Making Every Contact Count'. There should also be a mechanism for identifying those children and young people who have specific needs or are more vulnerable, to ensure they can receive additional support. Health reviews and assessment at key transition points through the 5-19 service can provide a valuable opportunity to work with children and young people to provide support to reduce risky behaviours. Some of this support should be provided by the service directly, with onward referral for more specialist support when needed. Where available NICE guidance should be followed, including Alcohol: school based interventions, Drug misuse prevention: targeted interventions and Smoking: preventing uptake in children and young people.

Improving Lifestyles

Health reviews and assessment support services to work with children, young people and families to stay healthy. Work should be taken forward to support positive choices and behaviour for smoking, oral health, nutrition, substance misuse, physical activity and sexual activity. This would include evidence based guidance for brief interventions, school based prevention and intervention, behaviour changes, stop smoking services, access to C-Card and promoting oral health messages. Many of these approaches support identification of risk, prevention strategies and whole school approaches.

A range of 'digital' badges are also available which services could use to support healthy lifestyles, including healthy eating, active lifestyle, me and my teeth and oral health.

Maximising Learning and Achievement

Health and wellbeing underpins a child's learning and school entry provides an opportunity to identify need and provide targeted support. Services should ensure early identification of need and vulnerability which may impact on a child's learning or school attendance, such as caring responsibilities, parental substance misuse or domestic violence. Where there are complex or additional health needs or disability services should ensure provision is put in place and schools are aware of the additional needs, working with SEN teams as required; provide support or onward referral for continence problems; ensure the child is socially and emotionally prepared; if learning needs are identified refer to other services; and provide support to children and young people who are part of the youth justice system, to ensure their health needs are supported.

Supporting Complex and Additional Health and Wellbeing Needs

Health, education and social care need to work together to support children and young people with complex and additional needs, working alongside the family. The school nurse may need to advocate for the child or young person. The school nurse (and health visitor) should work as part of the education, health and care plan assessment and review process.

Support should be provided to people with complex and additional needs at transition points, such as moving to secondary school. School nurses should also support pupils and schools where there are medical conditions, ensuring the school is able to support the child by working to statutory guidance.

Seamless Transition and Preparation for Adulthood

The school nurse service has a role in supporting and advising schools and colleges in the delivery of Personal, Social and Health Education sessions, supporting young people to be confident to access services and to know where and how to, and providing young people with strategies to manage stress and difficult situations, supporting resilience.

Young people also need to be supported around their sexuality and gender identity issues, and providing a confidential space in education settings for young people to discuss this with a health professional will help to do this.

Providing health drop-ins in schools, colleges and community settings will help young people to access confidential health information and support, and enhance the support provided through the other high impact changes.

3.3 You're Welcome Quality Standards

The You're Welcome Quality Standards provide different quality criteria to support health services to be young people friendly, helping them to 'get it right' for young people and it would be good practice for young people's services to achieve You're Welcome.

There are seven standards:

1. Involving young people in their care and in the design, delivery and review of services
2. Explaining confidentiality and consent
3. Making young people welcome
4. Providing high-quality health services
5. Improving staff skills and training
6. Linking with other services
7. Supporting young people's changing needs

3.4 Family Nurse Partnership (FNP)

FNP offers young mothers aged 19 and under who are having their first baby support at home from a Family Nurse, from 16 weeks of pregnancy until the child turns 2. This has been available in Sunderland since 2010. The service offers the Healthy Child Programme for this cohort and is a licensed intensive home-visiting intervention that involves up to 64 structured home visits from early pregnancy by specially recruited and trained staff.

The aims of the programme are to:

- support young mothers to have a healthy pregnancy;
- improve the child's health and development;
- help young parents to plan their own future.

The FNP has been subject to a Randomised Controlled Trial (RCT) over a number of site areas, which was published in 2015, and focused on assessing the effectiveness of the programme on improving infant and maternal outcomes up to 24 months after birth. Primary outcomes were smoking in late pregnancy, birth weight of the baby, proportion of women with a second pregnancy within 24 months of giving birth and emergency attendances and hospital admissions for the child in the first 2 years.

The findings of the RCT showed that overall FNP did not have an impact across the study's four main short term outcomes – pre-natal tobacco use, birth weight, subsequent pregnancy by 24 months and A&E attendances and hospital admissions in first two years of life. This is not to say there was no impact in these areas, but that the impact was no greater than that achieved from standard health visiting care.

The FNP programme did however appear to improve early child development, particularly early language development at 24 months, and may also help protect children from serious injury, abuse and neglect through early identification of safeguarding risks. There were also some small improvements in mothers' social support, relationship quality and self-efficacy. Young mothers were positive about the FNP programme, engaged very well with it and felt it helped to them to be good parents. They especially valued the close and trusting relationship with their family nurse. As noted above, the FNP has also been shown to be effective in supporting attachment.

The study also highlighted the apparently high levels of vulnerability amongst first time teen mothers and their children suggesting the case for additional support for this group remains strong. Of trial participants 48% were Not in Education, Employment or Training (NEET) at recruitment, 35% had previously been arrested, 46% had been suspended, expelled or excluded from school, 56% were smoking in late pregnancy and 40% had experienced domestic violence in the 12 months preceding their child's second birthday.

A follow up study to age six is underway looking at child safeguarding, health and educational attainment outcomes and is due to be published in 2018. Following the publication of the RCT the national unit developed Accelerated Design and Programme Testing (ADAPT), to rapidly test further innovations for the purpose of improving outcomes.

4) What is being done to locally to address this issue and how do we know this is making a difference?

4.1 Current Provision

Currently the following services are commissioned to fulfil the 0-19 Public Health agenda:

Health Visiting Service - South Tyneside NHS Foundation Trust

This service consists of Health Visitors and Nursery Nurses. They are required to deliver:

- The Healthy Child Programme for 0-5 year olds, including five mandated universal visits. These are carried out at 28 weeks of pregnancy, 10-14 days from birth, 6-8 weeks from birth, 12 months old and 2-2/5 years to ensure that every child has access to a named health visitor, receives developmental checks and expert advice and guidance on health and well-being issues.

- A service for all children and families, based on a model of assessed levels of need whereby all families receive a universal service, with additional services and support provided for the most vulnerable families and those with specific needs and high risk factors.

- Work in accordance with local safeguarding procedures to ensure appropriate safeguards and interventions are in place to reduce risks and improve the health and wellbeing of children for whom there are safeguarding and child protection concerns.

Family Nurse Partnership (FNP) – South Tyneside NHS Foundation Trust

This service consists of specially qualified FNP Nurses and supervisors providing intensive support to first time young mothers, aged 19 years or under. The nurses visit the mother weekly, from the early stages of pregnancy until their child is two. At full staff capacity the current service is able to offer support to approximately 75% of all eligible mothers.

School Nursing Service – South Tyneside NHS Foundation Trust

This service consists of School Nurses, Staff Nurses and Health Care Assistants and should have at least one named qualified School Nurse per school cluster (secondary school and feeder primary schools).

They are required to deliver:

- The Healthy Child Programme for children aged 5-19, which is a universal service

appropriate for all children and young people of school age which protects and promotes health and wellbeing. This again uses a needs led approach to ensure those most vulnerable children and young people, and those with specific needs, receive addition services and support as necessary.

- Child centred health promotion, prevention and care services, including the provision of regular drop-in services in all secondary schools and colleges.
- Work with schools to identify the needs of the school population to support the delivery and targeting of services.
- The National Child Measurement Programme which measures children's weight at reception and year 6 of primary school.
- Basic hearing screening for reception aged children.
- Work in accordance with local safeguarding procedures to ensure the safety and wellbeing of children of school-age across the city and provide support and intervention where appropriate.

Vulnerable Young Persons Nurse – South Tyneside NHS Foundation Trust

This service provides specialist nursing for vulnerable groups which aims to:

- Embed Public Health principles and approaches into ways of working within the Youth Drug and Alcohol Project (YDAP) and Youth Offending Service (YOS) in Sunderland to help ensure that both services actively support and promote healthy lifestyles during their day to day work, as well as supporting them in reviewing and delivering effective practice in relation to the physical health needs of vulnerable young people.
- Deliver and coordinate healthcare interventions to young people whose substance misuse and / or other risk taking behaviours is impacting on their physical health, including the provision of physical health needs assessments of young people accessing the YOS and YDAP.
- Deliver/coordinate access to sexual health interventions, and offer advice, information and support to young people presenting with substance misuse issues, including harm reduction advice and information and assessment of risk for Hepatitis B, Hepatitis C and HIV

Health Contribution to the Initial Contact Referral Team (ICRT) – South Tyneside NHS Foundation Trust

This comprises nursing advice and administrative support to the ICRT. The ICRT is a co-located team made up of the three statutory child protection agencies: social care, the police

and health services. This model facilitates an environment where sensitive information can be shared securely and allows professionals to access their own agency's information about a child or family in order to facilitate effective information sharing and decision making. It enables a timely, appropriate response to safeguarding children in Sunderland.

The ICRT covers all initial contacts and referrals to Social Care received from the Customer Service Network at Sunderland City Council.

The ICRT Team also facilitates appropriate health representation at multi-agency meetings, focussing on the protection and promotion of the welfare and safety of individual children.

Activities of the Services

- The Health Visiting Service is well established and is delivering all key developmental visits. In particular it has been working with maternity services to ensure the service is notified early of pregnancy and help extend uptake of ante-natal visits.
- Breastfeeding continuation rates continue to remain low in Sunderland. In response the Health Visiting Service has been working with maternity services to develop an Action Plan to address this.
- There remains a high level of involvement in safeguarding cases for all services, with 762 children on Health Visitor caseloads (at 08.03.17) with Child in Need or Child Protection status. The School Nursing Service also report on high level of safeguarding involvement, with 49% of one to one contacts being related to safeguarding issues (from September 2016 to January 2017).
- The National Child Measurement Programme has been carried out by the School Nursing Service efficiently and effectively each year.
- Health promotion activities and drop in sessions within schools have increased over this academic year and actions are in place to continue to extend this work.

5) What is the perspective of the public on this issue?

To inform the review of 0-19 Public Health services NWA Social and Market Research were commissioned to carry out stakeholder and service user engagement during 2016. This work collected the views of around 1200 members of the public (including children and young people) and other stakeholders. 250 individuals took part in detailed qualitative discussions. The engagement explored questions in relation to maternity services (including breastfeeding and stop smoking services), Health Visiting, the School Nursing Service, the Vulnerable Young Peoples Nursing Service and the Family Nurse Partnership. They asked respondents about their experiences of using or working with the services, what they saw as priorities in terms of health and wellbeing and what issues and services were important in

the future.

Feedback from stakeholders regarding the Health Visiting Service, the Family Nurse Partnership and Vulnerable Young Peoples Nursing Service were generally positive and there was a high level of awareness of their services. Positive feedback included:

- Good knowledge of families and family dynamics
- Strong links with Children's Centres, Strengthening Families and GPs
- Early intervention and prevention work
- Multi-agency working
- Targeted intensive work (FNP)
- Assessing needs of vulnerable young people
- Enabling links to other health specialists.

There was less awareness of the offer of the School Nursing Service.

The majority of parents/carers of young children (0-5 years) felt well-informed about health and wellbeing issues, and the majority felt they received enough support from maternity and health visiting services, particularly from the breastfeeding support service. However, this did reduce with parents of 2-4 year olds.

The older the child, the less well-informed parents felt, and the lack of awareness of Public Health services increased, as the age of the child increased.

Again, the older the child/student, the less aware they were of Public Health services. The majority of children who had accessed the School Nursing service gave positive feedback about that service. There was a perceived lack of visibility of Public Health services in secondary schools and colleges, although a lot of students recognised the value of a School Nurse in providing confidential advice and guidance.

There were a number of emerging themes that become clear throughout the engagement amongst stakeholders, schools, staff, parents and young people. The themes are summarised below:

- Access, communication and engagement – participants felt that there was a need to increase awareness of what support School Nursing Services provide and who is identified as the School nurse in each school.
- A good working relationship with schools and the need for young people to get to know the School Nurse were seen as vital.
- A need for a variety of communication methods was emphasised and more flexibility of

access arrangements.

- Participants highlighted the need for continuous engagement with service users and stakeholders also came out strongly, especially to enable the services to establish levels of need required within schools and community settings etc.

- Health Promotion and child development – mental health and wellbeing was highlighted as being very important and of great concern to a lot of respondents, with perceived gaps in service provision. Of 27% of new mothers who reported themselves as feeling low, only 46% reported receiving any support. Stakeholders and schools also expressed concern about the waiting times for mental health support and children and young people highlighted it as an important area of support.

- Other key themes that were seen as important to address were anti-bullying, healthy weight and body image, sexual health and relationships, substance misuse and smoking. Bullying and healthy eating/weight were mentioned most frequently by younger children whilst mental health and sexual health were particularly highlighted by older children, parents and stakeholders.

- School readiness was seen as important for parents of pre-school children.

- Some inconsistencies in breastfeeding advice were reported amongst parents of younger children.

- Safeguarding – service staff felt there was a high level of work in relation to safeguarding, putting pressure on their ability to fulfil the other elements of their role.

- Managing vulnerabilities and transition – the need to continue with targeted work for vulnerable groups was seen as important by staff and stakeholders, including the work of the Family Nurse Partnership. Managing key transition points was highlighted as important to get right, including the transition between the Health Visiting and School Nursing Services

- Partnership working – this was seen as important amongst stakeholders and schools.

6) Recommendations for commissioning and further needs assessment work

Please note – an EIA must be undertaken as recommendations are implemented.

Any future commissioning of services should seek to embed the high impact changes and evidence base in delivery. Specifically, the following recommendations should be considered.

1. Provide opportunities to improve attachment and parenting, as a building block for best start in life.
2. Achieve full Unicef Baby Friendly Initiative Accreditation.

3. Achieve You're Welcome Accreditation.
4. Develop a mechanism for identifying need and risk taking behaviour at an aggregate population level and an individual level, to support intervention and planning of work programmes.
5. Transition between services and across key stages should be supported and informed by need through health assessments and reviews.
6. Ensure the local service offer is based on need, with a focus on improving public health outcomes, particularly smoking, breastfeeding, mental health, alcohol, teenage pregnancy, oral health, accident prevention and healthy weight.
7. Ensure provision is able to meet the needs of groups who are more vulnerable or have greater level of need, including teenage parents, young carers, looked after children, LGBT, young people within the youth justice system and children with complex and additional health needs.
8. Continue to provide dedicated support for teenage parents, learning from ADAPT and future evaluation of FNP.
9. Services should be visible and delivered in a range of settings (home, school, community) and provided at days and times which are accessible to service users, using a range of communication methods e.g. face to face contact, drop-ins, text messaging, websites and social media.
10. Ensure availability of Healthy Start Vitamins.
11. Ensure that as children get older they, and their parents / carers, are aware of the public health offer and other services, and how to access.

7) Key contacts

Lorraine Hughes, Consultant in Public Health (Acting), lorraine.hughes@sunderland.gov.uk

Karen Lightfoot Gençli, Public Health Commissioning Specialist, karen.lightfoot-gencli@sunderland.gov.uk

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