Director of Public Health
Annual Report 2011
Health through the life cycle: Report 1 - Children
Foreword

Welcome to my second annual report as Director of Public Health for Leicestershire and Rutland. Last year my annual report focused on health inequalities and the actions we need to take to reduce the gap between the healthiest people in our society and the least healthy. Addressing this issue remains a key priority and ensuring children and young people have a healthy start to life has a huge contribution to make to reducing inequalities as well as improving the overall health of the population.

This year’s annual report is the first in a series that is planned to work through the life course and focus on key health issues at different stages of our lives. The report looks at the important health issues before birth and for children and young people. The foundations of good health throughout life are laid down in childhood and even before birth. If we are to improve the health of our population further and more quickly we have to focus on the key issues in the early stages of the life course.

We have, as previously, included a chapter that focuses on protecting the population from infectious diseases. Although in recent times there has been a shift in the major killers from infectious disease to cancer and cardiovascular disease, we must not become complacent. Immunisation has been one of the triumphs of public health and vigilance to detect new or re-emerging infections and the ability to control them remain vital to ensuring our health.

This report comes at a time of great change in the public health system. Public health is returning to its roots in local government and there are huge opportunities to influence the determinants of health positively and to ensure much closer working between agencies. We must seize these opportunities and maximise the outcomes for the good of the communities that we serve. At the same time we must not lose the good things that have been achieved. We must recognise that the NHS makes an enormous contribution to the health of the population and public health must retain its links with the health service from its new home in local government.

Finally I would like to express my sincere thanks to all those who have contributed to this report, both within and outside the Public Health Directorate in Leicestershire and Rutland, it has been very much a team effort. In particular, I would like to acknowledge the contributions from the Health Protection Agency, East Midlands South and staff from Children and Young Peoples Services at Leicestershire County Council.

I hope the recommendations in this report are enacted so that we can make even greater strides in improving the health of the people of Leicestershire and Rutland.

Dr Peter Marks
Joint Director of Public Health Leicestershire and Rutland
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Introduction

1. Background

This is the first in a series of reports from Leicestershire and Rutland’s Director of Public Health reviewing health across the life cycle. This first report focuses on the health and wellbeing of children and young people. Future reports will focus on the health of adults and the health of older people.

This report reviews the challenges linked to improving the health and wellbeing of children set out in the Department of Health publication “Our Health and Wellbeing Today”1 and the challenge to deliver for children set out in the Public Health White Paper, “Healthy Lives, Healthy People”2. These two reports have been heavily influenced by the Marmot Review3 which emphasises the importance of working with children and, in particular, early intervention to address inequalities.

The report has been developed from an NHS perspective, focusing on the areas of child health for which the NHS has a specific responsibility for delivery. However, it is essential that the role of the wider partnerships in addressing child health is acknowledged. We have reviewed some of the key partnership projects with respect to delivering core NHS services but the role of the partnership in delivering improved health outcomes for children is far wider than the projects incorporated within this report.

This report is supported by the Joint Strategic Needs Assessments for Leicestershire County and Rutland County which both contain detailed information on the health and wellbeing needs of the population. 4 5

2. Key health policy drivers

There is a strong and growing body of evidence that emphasises the importance of health and wellbeing in early years and the long-term benefits of ensuring that all children have access to the best start in life. The key policy documents for health are listed below and explored in more detail throughout the report. The evidence proposes that a shift of resources into early years support will yield the greatest benefits both for individuals throughout their lives and for the population as a whole. The support for early years needs to be across all of the agencies that influence a child’s wellbeing, but a whole systems approach to child development will yield lasting and sustainable benefits throughout the life course.

The transfer of responsibility for public health to local authorities is a real opportunity to increase our joint responsibilities on the children’s agenda and to work together for maximum benefit. The key to
this will be collaboration between the Director of Public Health, local authorities, schools and other partners to facilitate development of local strategies for improving child health and wellbeing.

**Key Documents:**

“**Our Health and Wellbeing Today**”¹, the evidence base for the public health white paper, “Healthy Lives, Healthy People”. This report emphasises the fact that health and wellbeing needs evolve throughout our lives and the need to consider the influences on health at all stages of the life cycle. It demonstrates how the influences on health change at different stages in our life. Of particular importance, it highlights the long-term impacts of our health and wellbeing in early years and the long term impact this can have on our health in later life.

“**Healthy Lives, Healthy People**”² is the public health White Paper, published in November 2010. At its core is the driver to reduce inequalities and improve health at key stages of people’s lives. There is a particular focus on “giving every child in every community the best start in life”, underpinned by a continued commitment to reduce child poverty.

“**The Marmot Review, Fair Society, Healthy Lives – A Strategic Review of Health Inequalities in England post 2010**”³ drew attention to the evidence that social inequalities result in many lives being cut short and many people not living life to the full and enjoying opportunities open to them. The review reinforced the message that disadvantage starts before birth and accumulates throughout life. Therefore, the adoption of a life course approach is recommended to break the link between early disadvantage and poor health outcomes. **Giving every child the best start in life** was put forward as the Marmot Review’s highest priority recommendation.

“**Early Intervention, The Next Steps, The Graham Allen Review**”⁶ is an independent report on early years intervention from Graham Allen MP. This report emphasises the need for intervention in early years and the economic benefits of this. The report demonstrates that the earlier interventions are put in place, the greater the benefits, and the greater the opportunity to break down the inter-generational cycles of disadvantage.
3. Ensuring children get the best start in life

Health inequalities start in and before childhood and persist through to adulthood. The Acheson inquiry said that ‘while there are many potentially beneficial interventions to reduce inequalities in health in adults of working age and older people, many of those with the best chance of reducing future health inequalities… relate to parents, particularly present and future mothers, and children’ 7.

The foundations for virtually every aspect of human development - physical, intellectual and emotional - are laid in early childhood. What happens during these early years, starting in the womb, has lifelong effects on many aspects of health and wellbeing from obesity, heart disease and emotional health, to educational achievement and economic status. A child’s physical, social, and cognitive development during the early years strongly influences school-readiness and educational attainment, economic participation and health.

The Marmot Review ³ placed a renewed focus on early years. The review’s ultimate aims in relation to supporting mothers, families and children are to:

- close the gap in infant mortality between advantaged and disadvantaged communities
- improve maternal and child health, and child development, including through prevention
- improve early years support
- improve educational attainment.

The Department of Health paper “Our Health and Wellbeing Today”¹ sets out the challenges for good health through the life course. One of the key messages in this is the importance of supporting our populations in “starting well” by ensuring that mothers have the best access to health both before and during pregnancy and by supporting parents in making healthy choices for themselves and their families.

The years before children start school, particularly the 0-3 year old age range, are vital in providing children with the social and emotional bedrock for their lives. The report by Graham Allen, “Early Intervention, The Next Steps” ⁶ sets out:

- the economic value of targeted early intervention, set against the costs of later remedial intervention from child protection to criminal justice
- the need for selective targeted support for the most vulnerable families through schemes such as the family nurse partnership (focused on teenage parents and first time parents)
- the need for continuing early intervention at all ages, particularly through well targeted family support
- the vital importance for life chances of the earliest stages of infant brain development
- the need to address intergenerational disadvantage and inequalities by developing parenting awareness in secondary schools, before teenagers become parents themselves.
4. Improving opportunities for children

The health and wellbeing of women before, during and after pregnancy is an important factor in giving children a healthy start in life and laying the groundwork for good health and wellbeing later on. The key public health challenges in the very early stages of people’s lives are:

- preventing infant mortality (which, although improving, is high when compared internationally)
- encouraging and enabling the good health of mothers, both before and during pregnancy and after birth
- maximising early child development.

4.1. Infant Mortality in the East Midlands

Babies born to mothers in the East Midlands are more likely to die if the mother is from a routine and manual socio-economic group.  

The London Health Observatory’s Health Inequalities Intervention Toolkit has shown that between 2006 and 2008:

- the infant mortality rate (IMR) in routine and manual groups was 5.4 per 1,000 live births
- this compares with an England and Wales IMR of 4.5 per 1,000 live births
- the infant mortality gap is 0.85 per 1,000 live births.

The factors that contribute to the infant mortality gap have been modelled by the London Health Observatory and are presented in Figure 1. The most significant single driver for this gap is smoking in pregnancy, followed by sudden infant deaths. Other contributing factors are maternal obesity, being born to a teenage mother, failure to breastfeed and poverty.

**Figure 1: Factors contributing to the infant mortality gap**

<table>
<thead>
<tr>
<th>Factor</th>
<th>Percent</th>
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<tbody>
<tr>
<td>TP</td>
<td>2%</td>
</tr>
<tr>
<td>SUDI</td>
<td>20%</td>
</tr>
<tr>
<td>Smoking</td>
<td>28%</td>
</tr>
<tr>
<td>Obesity</td>
<td>6%</td>
</tr>
<tr>
<td>Poverty</td>
<td>1%</td>
</tr>
<tr>
<td>Not breast fed</td>
<td>1%</td>
</tr>
<tr>
<td>Other (factors not modelled)</td>
<td>42%</td>
</tr>
</tbody>
</table>

*Source: Health Inequalities Interventions Toolkit - Infant Mortality Tool; London Health Observatory*
4.2. Improving health and life chances through education

Poor levels of health and poor educational attainment interlink and restrict people from improving their socio-economic position and that of their families. Both health and educational attainment are strongly linked to socio-economic deprivation. Figure 2 illustrates the relationship between qualifications and limiting illness and clearly shows that the risk of limiting illness decreases as levels of qualification increase. The people at greatest risk of a limiting illness are those with no qualifications.

Marmot stresses the importance of focused investment to support families to achieve progressive improvements in early child development and providing good early years’ education and childcare proportionately across the social gradient.

Figure 2: Standardised limiting illness rates at ages 16-74, by education level recorded in 2001

Specifically the Marmot Review emphasises the importance of:

• ensuring that schools, families and communities work in partnership to reduce the gradient in health, wellbeing and resilience of children and young people.

• improving the access and use of quality life-long learning across the social gradient.

• guaranteeing that reducing social inequalities in pupils’ educational outcomes is a sustained priority.

• prioritising the reduction in social inequalities in life skills, by:
  - extending the role of schools in supporting families and communities and taking a ‘whole child’ approach to education
  - consistently implementing ‘full service’ extended school approaches
  - developing the school-based workforce to build their skills in working across school home boundaries and addressing social and emotional development, physical and mental health and wellbeing.

Source: Fair Society Healthy Lives: The Marmot Review
4.3. Maximising opportunities through early years interventions

One year on from the publication of Fair Society, Healthy Lives, the Marmot Review team has published new research which found that nearly half (44%) of five year olds are not considered by their teachers to have a good level of development.9

As a result of this, Sir Michael Marmot has stated his support for the early years. The evidence is very clear; investing in pre-school years pays most dividends. By the age of ten a child from a poorer background will have lost any advantage of intelligence indicated at 22 months, whereas a child from an affluent family will have improved his or her cognitive scores purely because of an advantaged background.

Positive parent-child relationships in the first year of life are associated with stronger cognitive skills in young children and enhanced competence and work skills in schools. Good quality early childhood education has enduring effects on health and other outcomes, particularly for those from disadvantaged backgrounds. Early cognitive ability is strongly associated with later educational success, employment, income, propensity to get involved in crime and better health. Early years are important for other skills such as application, empathy and self-regulation, which enable positive relationships and success.

4.4. Child poverty

The Government set out its approach to tackling child poverty in “A New Approach to Child Poverty: Tackling the Causes of Disadvantage and Transforming Families’ Lives”, published April 2011.10 At its heart are strengthening families, encouraging responsibility, promoting work, guaranteeing fairness and providing support to the most vulnerable. This strategy meets the requirements set out in the Child Poverty Act 2010, focuses on improving the life chances of the most disadvantaged children and sits alongside the Government’s broader strategy to improve social mobility. The core ways to achieve this are:

• a stronger focus on ensuring that families who are in work are supported to work themselves out of poverty, families who are unable to work are able to live with dignity and not entrenched in persistent poverty, and that those who can work but are not in work are provided with services that will address their particular needs and help them overcome barriers to work.

• a stronger focus on improving children’s future life chances, by intervening early to improve the development and attainment of disadvantaged children and young people throughout their transition to adulthood.

• a stronger focus on place and delivering services as close to the family as possible, by empowering local partners and ensuring that local diversity can be recognised, and developing strong local accountability frameworks.

The Child Poverty Act of 2010 required all local authorities to undertake a Child Poverty Needs Assessment and develop a Child Poverty Strategy. In Leicestershire, the strategy and needs assessment have been prepared in partnership with key agencies including Children and Young People’s Service (CYPs), Public Health, district councils, Job Centre Plus and the Community Budgets team. Leicestershire Together is the responsible body for approving and overseeing the implementation of strategy. The strategy and action plan were approved by the Leicestershire Together Board.11
Summary of Recommendations

It is proposed that the following strategic recommendations are incorporated into our future planning to ensure that children have the best start in life and maximise their access to good health outcomes.

**Shifting resources into early years support**

It has been demonstrated that shifting resources into early years support will yield the greatest benefits, both for individuals throughout their lives and for the population as a whole. It is recommended that this shift in resource is embedded into our planning for the health and wellbeing of our population.

**Starting well, through early intervention and prevention**

It is essential that we develop strong universal public health and early education. This needs to be accompanied by targeted interventions for disadvantaged families and children at risk of poor health outcomes. It is recommended that we:

- Increase the number of Health Visitors available to universally deliver the healthy child programme. This delivers a core programme of evidence-based preventative health care with additional care and support for those that need it. This is linked to the new service model set out by the department of health.

- Establish good working relationships within the changing school landscape with the development of academies to ensure that schools continue to support the delivery of key public health programmes.

- Ensure that all pregnant women have access to high quality care. This includes full compliance with National Institute of Health and Clinical Excellence (NICE) guidelines for the maternity pathway.

- Improve liaison between GPs, midwifery, health visitors and the wider children’s workforce to deliver high quality antenatal support to ensure the best possible start for babies.

- Ensure that we have the right services in place to support pregnant mothers to make healthy choices with regards to smoking, healthy eating, physical activity and substance misuse (including alcohol).
• Continue to develop Tobacco-free Leicestershire and Rutland (TLR). This is an alliance of partners involved in the tobacco agenda with a remit to reduce tobacco use across our community.

• Continue to increase access to our Stop Smoking Services by increasing the number of public sector employees trained in brief advice and interventions.

• Continue to develop the Smoking in Pregnancy Service to support pregnant mothers to stop smoking or to reduce their tobacco use.

• Progress the Baby Friendly Initiative accreditation ensuring that women are supported to make informed choices about feeding their baby.

• Review the implications of the change to breastfeeding providers across Leicestershire County and Rutland (LCR) and ensure that the withdrawal of La Leche League Peer Support Programmes does not have a negative impact on the uptake and continuation of breastfeeding across LCR.

• Continue to deliver the childhood immunisation programme and improve uptake. Specifically we need to:
  – Continue our implementation of the NICE public health guidance to improve uptake of immunisations across LCR.
  – Continue to increase uptake of vaccinations by working with general practices to increase uptake and target children that have not been immunised.
  – Develop increased awareness of the importance of childhood immunisations through the use of local and national media, raising awareness across a wide range of settings including children’s centres and developing leaflets and other materials to circulate to key agencies across Leicestershire and Rutland.

Developing well

We must continue our public health efforts to improve the health and wellbeing of school age children and aid their transition into healthy adulthood. It is essential that we continue to strive to reduce health inequalities within this group. It is recommended that we:

• Continue to work in partnership through the healthy child programme, making full use of the Sure Start children’s centres, and the Leicestershire Healthy Schools programme.

• Continue our programme of work to reduce childhood obesity. Specifically we need to:
  – Continue to develop the National Childhood Measurement Programme to increase early identification of children who are overweight or obese. When children become overweight, we need high quality, easily accessible NHS support services to support families and children to change lifestyle behaviour in a positive and sustainable way.
- Work with schools, through the Healthy Schools programme, to promote a ‘positive food and physical activity culture’ within schools where eating a healthy balanced diet and participating in physical activity becomes the ‘social norm’.

- Support schools to achieve measurable health and wellbeing outcomes for children and young people with regards to healthy weight through the implementation of the Healthy Schools enhancement programme.

- Routinely promote physical activity, including unstructured play at home, in school, in childcare settings and throughout the community, and ensure the children’s living environment encourages and facilitates these choices.

- We continue to improve the identification, treatment and prevention of mental health problems. Specifically we need to:
  
  - Ensure that, as services are combined across specialist Children and Adolescent Mental Health Services (CAMHS) and community children’s services, we maximise service quality and capacity. This includes the development of pathways to ensure that services are working together and are clearly specified (including attention deficit hyperactivity disorder (ADHD), autism, self harm, behaviour).

  - Provide support to schools to promote positive mental health and to capitalise on the legacy of the Targeted Mental Health in Schools Project (TaMHS) by disseminating the learning from nine Leicestershire County schools who participated in the project.

  - Maximise the mental health of vulnerable young people, including those who offend or are at risk of offending, are looked after, are homeless, or have a physical illness.

  - Ensure that good links with adult services are maintained in relation to transition from children to adult services and taking the whole family approach work forwards.

  - Ensure that interventions are developed at the earliest possible opportunity, maximising on the links between preventative infant mental health and post natal depression services through to school related services.

**Addressing risk taking behaviour in teenagers**

As teenagers go through their transition from childhood to adulthood the potential exists for the development of risk taking behaviours that may impact negatively on health. It is recommended that we:

- Continue to address this through the Healthy Schools programme, supporting children to make informed choices with regards to smoking, physical activity, healthy eating, sexual health and substance misuse.
• Continue to work with teenagers to ensure that they are able to make informed choices with respect to smoking. Specifically we need to:
  – Develop and expand the comprehensive school-based tobacco control program. This should focus on using social norming techniques and incorporate prevention and awareness education, accessible stop smoking support and youth advocacy.
  – Improve engagement with youth oriented agencies and voluntary organisations to increase access to harder to reach youths as well as more traditional school based programming.
  – Evaluate the effectiveness of trading standards service test purchasing programme and target specific future initiatives in the future to tackle underage and illicit sales.

• Continue to work with schools, youth services and families to raise awareness of the risks associated with alcohol and illicit drugs. As there is a strong correlation between the use of tobacco and substance misuse it is important to develop programmes that will address these issues simultaneously.

• Develop specific interventions that target groups of young people at greater risk of problematic substance misuse, particularly children in care, young offenders and children not attending school.

• Develop the tier 2 school substance misuse network of tier 2 trained school staff, the aim of which is to increase the number of young people receiving timely, appropriate high quality support and treatment in relation to their substance misuse problems.

• Continue to improve young people’s access to integrated sexual health services, with particular emphasis on improving access to the range of contraceptive options, including long-acting reversible contraception.

• Continue to increase chlamydia screening for 15-24 year olds in LCR and improve detection and treatment of the infection with the aim of reducing the prevalence of chlamydia.

• Continue to improve access to sexual health information for young people and those who provide information and support for young people.

**Safeguarding** the children at risk of harm through the Leicestershire and Rutland Local Safeguarding Children Board.
1. Overview of child health in Leicestershire County and Rutland

In February 2011 the Child and Maternal Health Observatory (ChiMat), in collaboration with the East Midlands Public Health Observatory, produced child health profiles for every upper tier local authority. The profiles for Leicestershire and Rutland are included in Appendix 1.

These profiles provide a snapshot of child health. They are designed to help the local authority and Primary Care Trust improve the health of children and tackle health inequalities.

Whilst the overall health of children in Leicestershire and Rutland is better than the average for England, there is still room to improve both the overall outcomes and the outcomes for children in communities where health outcomes are poorer, through both global programmes to improve health for all and targeted programmes in other areas of greatest risk.

1.1. Key findings for Leicestershire

- A quarter of the population of Leicestershire is under the age of 20. Around 14% of school children are from a black or minority ethnic group and 11% of children aged under 16 are living in poverty.

- The health of children in this area is generally similar to or better than the England average. Infant and child mortality rates are similar to the average, as are breastfeeding initiation levels.

- Children in Leicestershire have lower than average levels of obesity. One in thirteen (8%) children in Reception and one in seven (15%) of children in Year 6 are classified as obese. However, less than half (47%) of children participate in more than three hours of sport a week.

- Hospital admission rates for alcohol specific stays are lower than the England average. Hospital admission rates for substance misuse are similar to the England average. Hospital admission rates for injury are lower than the England average. The percentage of children who say they use drugs and who say they have been drunk recently is similar to the England average.
1.2. Key findings for Rutland

- A quarter of the population of Rutland is under the age of 20. Around 4% of school children are from a black or minority ethnic group and 8% of children aged under 16 are living in poverty - in both cases lower than the England average.

- The health of children in this area is generally similar to, or in some cases better than the England average. Infant and child mortality rates are similar to the average, and breastfeeding initiation levels are similar to the average.

- In Rutland, 7% of children in Reception and 18% of children in Year 6 are classified as obese, while 38% of children participate in more than three hours of sport a week.

- Hospital admission rates for alcohol specific stays are lower than the England average. Hospital admission rates for injury are lower than the England average. The percentage of children who say they have been drunk recently is similar to the England average.

2. Key statistics relating to children in Leicestershire County and Rutland

2.1. Demography

- In 2009 there were 7,206 births in Leicestershire County and Rutland (7,160 live births) (Office of National Statistics, Vital Statistics). 14

- The population has a general fertility rate (GFR) of 54 live births per 1,000 female population aged 15-44. This is significantly lower than the GFR for England, Wales and elsewhere of 64. 14

- LCR had 29,800 children aged 1 to 4 in 2009, of which 28,200 are within Leicestershire and 1,500 in Rutland (Office of National Statistics). 15

- In 2009, there were 77,600 children aged 5 to 14 in LCR (73,000 within Leicestershire and 4,600 within Rutland) (Office of National Statistics). 15
Table 1: Births in Leicestershire County and Rutland, 2009

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* General Fertility Rate - Live births per 1,000 women aged 15-44
** Stillbirths rate per 1,000 total live and stillbirths, numbers less than 5 are suppressed
*** Deaths under 1 year per 1,000 live births
**** Deaths under 4 weeks per 1,000 live births
***** Perinatal Mortality Rate - Stillbirths and deaths under 1 week (perinatal) combined per 1,000 total live and stillbirths

Source: VS1 BIRTHS AND MORTALITY 2009 SUMMARY, Office of National Statistics, August 2010, © Crown Copyright

2.2. Mortality in infancy and childhood

The statistics in this section have been derived from the Clinical and Health Outcomes Knowledge Base. 16

- Between 2007 and 2009 there were 83 deaths in the first twelve months of life in Leicestershire County and Rutland, an average of 28 deaths per year.
- The infant mortality rate is 3.9 deaths per 1,000 live births.
- The infant mortality rate in Leicestershire County and Rutland is lower than the England and Wales average but is not significantly different (Figure 3).
- Between 2007 and 2009 there were 17 deaths of children aged 1-4 years in Leicestershire County and Rutland. The age specific mortality rate from all causes for 1-4 year olds was 10.9 per 100,000 population for males (England 21.4) and for females it was 23.5 per 100,000 population (England 19.2).
- Between 2007-09 there were 24 deaths of people aged 5-14 years in Leicestershire County and Rutland. This gives an age specific mortality rate of 10.8 per 100,000 population for males (England 11.4) and 9.6 per 100,000 for females (England 9.5).
2.3. Hospital care in childhood

The number of hospital inpatient admissions and outpatient and emergency department attendances for children in Leicestershire County and Rutland in 2010/11 are illustrated in Table 2.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Attendances in Emergency Departments</th>
<th>Hospital Admissions</th>
<th>Outpatients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 1 year</td>
<td>2,615</td>
<td>3,143</td>
<td>4,290</td>
</tr>
<tr>
<td>1-4 Years</td>
<td>7,143</td>
<td>3,912</td>
<td>15,218</td>
</tr>
<tr>
<td>5-14 Years</td>
<td>11,918</td>
<td>5,087</td>
<td>40,946</td>
</tr>
<tr>
<td>15-17 Years</td>
<td>4,703</td>
<td>2,387</td>
<td>17,093</td>
</tr>
<tr>
<td>0-17 Years</td>
<td>26,379</td>
<td>14,529</td>
<td>77,547</td>
</tr>
</tbody>
</table>

Source: HERA Health, Evidence, Reporting, Analysis, NHS Leicester, Leicestershire and Rutland, extracted 11-07-11

Figure 3 demonstrates the level of activity that was accessed by each of the age groups in 2010/11. The reasons that children use hospital services change depending on their age, Figure 4 illustrates the reasons that children aged 1 year and over were admitted to hospital. It is clear that for pre-school children (1-4 years), diseases of the respiratory system are the biggest single cause of hospital admissions, followed by infections and injury. For the 5-14 year olds, respiratory disease and injury remain the top two causes, followed by symptoms and signs (admissions where no classifiable diagnosis was made). The profile of admissions changes in the 15-17 year olds with injury as the single biggest cause of hospital admission, followed by reasons relating to pregnancy and childbirth and symptoms and signs.
Figure 4: Hospital admission by top 3 causes, children in LCR, 2010/11

Figure 5 demonstrates the three main specialties that children using outpatients are accessing. In the younger age groups (1-4 and 5-14), children are seen in paediatrics, the pre-school age children also accessing ophthalmology and ENT. The 5-14 year olds also access ENT but their other significant specialty is child and adolescent psychiatry. Children aged 15-17 years have a different profile, their most significant specialty is child and adolescent psychiatry followed by trauma and orthopaedics and dermatology.

Source: HERA Health, Evidence, Reporting, Analysis, NHS Leicester, Leicestershire and Rutland, extracted 11-07-11
2.4. Congenital anomalies

A congenital anomaly is a condition that is present at the time of birth. These can be the result of a physical, metabolic or anatomic deviation from the normal pattern of development that is apparent at birth or detected during the first year of life.

In NHS Leicestershire County and Rutland the rate of congenital anomalies varies from 3.7 per 10,000 births for eye and ear anomalies to 66 per 10,000 births for urogenital anomalies. Rates for all congenital anomaly registrations are similar to the East Midlands and South Yorkshire Register, apart from urogenital anomalies where the rate is above the average. This is being reviewed with the East Midlands and South Yorkshire Congenital Anomalies Register.

Table 3: Congenital anomaly registrations 2004-2008, per 10,000 live births

<table>
<thead>
<tr>
<th>LCR</th>
<th>Rate</th>
<th>95% Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central Nervous System</td>
<td>19.1</td>
<td>(14.9-24.2)</td>
</tr>
<tr>
<td>Eye, Ear</td>
<td>3.7</td>
<td>(1.9-6.3)</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>50.3</td>
<td>(43.3-58.3)</td>
</tr>
<tr>
<td>Urogenital</td>
<td>66.1</td>
<td>(57.9-75.1)</td>
</tr>
<tr>
<td>Gastro-intestinal</td>
<td>30.1</td>
<td>(24.7-36.3)</td>
</tr>
<tr>
<td>Musculo-skeletal</td>
<td>64.7</td>
<td>(56.6-73.6)</td>
</tr>
<tr>
<td>Respiratory</td>
<td>5.3</td>
<td>(3.2-8.3)</td>
</tr>
<tr>
<td>Chromosomolal</td>
<td>56</td>
<td>(48.5-64.3)</td>
</tr>
<tr>
<td>Syndromes</td>
<td>3.7</td>
<td>(1.7-5.9)</td>
</tr>
</tbody>
</table>

Source: Congenital Anomalies in Births 2004 to 2008, East Midlands and South Yorkshire Congenital Anomalies Register
2.5. Disability in childhood

Disabled children aged 0–16 are the fastest growing group amongst the population of disabled people. Over the past ten years there has been a significant increase in the number of children with complex health needs, due to the survival of pre-term and low birth weight babies and advances in medicine leading to earlier diagnosis of congenital and genetic conditions. Children also now have better outcomes and longer life expectancy following severe illness or injury. It is estimated there are around 100,000 children in England with complex care needs, who need support from a wide range of services.

The number of disabled children in England is estimated to be between 288,000 and 513,000 by the Thomas Coram Research Unit. The mean percentage of disabled children in English local authorities has likewise been estimated to be between 3.0% and 5.4%. If applied to the population of Leicestershire County and Rutland this would equate to:

- between 4,332 and 7,799 children experiencing some form of disability (ChiMat).

2.6. Mental health in children

The prevalence of mental health problems in children and young people is increasing. An Office of National Statistics (ONS) study showed that 10% of children between 5 and 15 years of age experience a clinically defined mental health problem. Around 15% of lifetime mental illness starts before the age of 14 and it continues to have a detrimental effect on an individual and their family for many years. Potentially, a quarter to a half of mental illness is preventable through interventions during early years.

The estimated number of children across Leicester, Leicestershire and Rutland (LLR) with disorders is detailed in Table 4. It should be noted that the figures in this section include Leicester City. This is linked to planning for CAMHS services across LLR which follows this wider geography.

<table>
<thead>
<tr>
<th>Table 4: Estimated number of children with disorders.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Leicester, Leicestershire and Rutland</strong></td>
</tr>
<tr>
<td>Conduct disorders (5.8%) (2009)</td>
</tr>
<tr>
<td>8000</td>
</tr>
<tr>
<td>Emotional disorders (3.7%) (2009)</td>
</tr>
<tr>
<td>5103</td>
</tr>
<tr>
<td>Being hyperactive (1.5%) (2009)</td>
</tr>
<tr>
<td>2069</td>
</tr>
<tr>
<td>Less common disorders (1.3%) (2009)</td>
</tr>
<tr>
<td>1793</td>
</tr>
</tbody>
</table>

In addition to this:\textsuperscript{24}

- There are an estimated \textbf{1,400} cases of autism spectrum disorder in children aged 5-16 in LLR.
- There are an estimated average of \textbf{2} deaths from suicide or undetermined injury in young people in LLR per year.
- In Leicester, Leicestershire and Rutland there are \textbf{4,195} young people on the caseload of the Youth Offending Service – these young people will have significant health needs, including mental health needs.

There are a significant number of children who may experience mental health problems appropriate to a response from Child and Adolescent Mental Health Services (CAMHS). These are estimated in Table 4. Tier 4 services indicate the most severe level of need, tier 1 is the least severe. (See Case Study – Child and Adolescent Mental Health Services, for detailed definition of tiers, page 37)

\textbf{Table 5: Estimated number of children/young people (i.e. 17 years old and under) who may experience mental health problems appropriate to a response from CAMHS}

<table>
<thead>
<tr>
<th>Tier 1 (15%) (2009)</th>
<th>Leicester, Leicestershire and Rutland</th>
</tr>
</thead>
<tbody>
<tr>
<td>31732</td>
<td></td>
</tr>
<tr>
<td>Tier 2 (7.0%) (2009)</td>
<td>14808</td>
</tr>
<tr>
<td>Tier 3 (1.85%) (2009)</td>
<td>3914</td>
</tr>
<tr>
<td>Tier 4 (0.075%) (2009)</td>
<td>159</td>
</tr>
</tbody>
</table>


\textbf{2.7. Learning disability}

There were an estimated 642 children aged 5 to 14 with a learning disability in Leicester, Leicestershire and Rutland (LLR) in 2009. \textsuperscript{25}
Health Services

1. Child health services in Leicestershire County and Rutland

The health and wellbeing needs of Leicestershire and Rutland children are met through the delivery of the Healthy Child Programme. This is an integrated evidence based programme of support which starts in pregnancy and ends at 19 years. It is delivered in close partnership with GPs, midwives, Sure Start children centre teams and other local organisations. The core aim is to ensure that all children and families receive the support they need to get the best possible start in life.

The Healthy Child Programme offers every family a programme of screening tests, immunisations, developmental reviews and information and guidance to support parenting and healthy choices. It is led by health visitors and school nurses who are skilled public health nurses trained to work with communities, families and children.

The key objectives for improving child health through health services are to:

- Close the gap in infant mortality between advantaged and disadvantaged communities.
- Improve maternal and child health, and child development including through prevention.
- Improve early years support.
- Encourage healthy behaviours and prevent adoption of unhealthy behaviours.
- Identify, treat and prevent mental health problems.
- Address risk taking behaviour in teenagers.

The government has highlighted the shortage of health visitors in the workforce and announced an expansion plan to increase the workforce by 4,200 by 2015. The shortage of health visitors is an issue in Leicestershire County and Rutland and is linked to our overarching recommendation for this section.

Partnerships are essential to the delivery of child health initiatives across Leicestershire County and Rutland. In addition to the reforms that are taking place across the NHS, there are changes taking place across other parts of the public sector. Many of these will offer opportunities to improve partnership working and support delivery of the wider child health agenda. However, the impact of some of these changes is unknown.

For example, the organisation of schools across Leicestershire and Rutland is changing, with the development of academies locally. This will mean that the previous relationships between...
schools and the delivery of key health programmes such as the national childhood measurement programme, the HPV vaccination programme and the chlamydia screening programme will also change. Schools have a key role in the delivery of many public health programmes and it is essential that we continue to work in partnership with the leaders of the emerging academies to ensure that we are able to deliver good health outcomes for the children of Leicestershire and Rutland.

**It is recommended that we:**

- Increase the number of health visitors available to universally deliver the healthy child programme. This delivers a core programme of evidence based preventative health care with additional care and support for those that need it. This is linked to the new service model set out by the department of health.
- Establish good working relationships within the changing school landscape with the development of academies to ensure that schools continue to support the delivery of key public health programmes.

**2. The maternity pathway in Leicestershire County and Rutland**

In 2009 there were 7,200 births to people resident in Leicestershire County and Rutland. Hospital records in 2009/10 demonstrate that the main pattern of delivery for births in NHS hospitals is as follows: 74% of delivered in University Hospitals Leicester Trust, 7% at Burton, 6% at George Eliott and 5% at Nottingham University Hospitals. (Figure 6)

Overall, at University Hospitals of Leicester Trust there were: 27

- 10,355 recorded deliveries
- 4,889 (50%) women having their first antenatal assessment within 5 - 9 weeks of gestation and 8,308 (84%) within 12 weeks of gestation
- 6,379 (64% where known) deliveries at 38 - 40 weeks gestation length
- Spontaneous onset accounts for the greatest percentage of deliveries, representing 6,525 (approximately 66% where the method of onset is known).
It is recommended that we:
Ensure that all pregnant women have access to high quality care. This includes full compliance with National Institute of Health and Clinical Excellence (NICE) guidelines for the maternity pathway.

3. Sudden Infant Death Syndrome

Over the period of April 2009-March 2011, across Leicester, Leicestershire and Rutland, the Child Death Overview Process reviewed eight cases of children who died from sudden infant death syndrome (SIDS), also known as ‘cot death’. This is the sudden unexpected death of an apparently well infant, for which there is no explanation. Nine out of ten deaths from SIDS occur during the first six months of life. The risk is also greater for babies who are born prematurely, or who are born with a low birth weight. Since the introduction of our ‘reduce the risk of cot death’ campaign in 1991 the number of babies dying has fallen by 70%.²⁸

There are steps that can be taken to reduce the risk of SIDS:

- do not expose babies to tobacco smoke as this can dramatically increase the risk of SIDS and this includes smoking during pregnancy
- ensure homes are smoke-free environments
- placing babies on their back to sleep (and not on the front or side) and room temperatures kept between 16 and 20°C (61-68°F), ideally, 18°C (64°F) and avoid baby overheating
- never sleep with baby on a sofa or armchair
- the safest place for baby to sleep is in a crib or cot in a room with parents for the first six months.
The Child Death Review Process

The Child Death Overview Process has been established within Leicester, Leicestershire and Rutland since February 2009. Working Together to Safeguard Children (2006) outlined the duties of the Local Safeguarding Children Board (LSCB) to undertake a review of any child death resident within their area. Working Together to Safeguard Children (2010) re-emphasised the need to ensure a process is in place to undertake this work. The remit of the child death overview process is to review the deaths of any child between 0 and 18 years of age (the review does not include stillbirth notifications).

The process incorporates two interrelated pathways that enables expected and unexpected deaths to be reviewed, the purpose of which allow for,

“(a) collecting and analysing information about each death with a view to identifying-

- any case giving rise to the need for a review mentioned in Regulation 5(1)(e);
- any matters of concern affecting the safety and welfare of children in the area of the authority; and
- any wider public health or safety concerns arising from a particular death or from a pattern of deaths in that area;

(b) putting in place procedures for ensuring that there is a coordinated response by the authority, their Board partners and other relevant persons to an unexpected death.” (HM Government, 2006).

The child death overview panel is a sub group of both the Leicester LSCB and the Leicestershire and Rutland LSCB. It was established in February 2009, having been made a statutory requirement in April 2008. The LLR child death overview panel is chaired by a Consultant in Public Health from NHS Leicester City. The panel membership includes representatives from;

- Leicestershire Constabulary
- Leicester City Council
- Leicestershire County Council
- Rutland County Council
- Leicestershire Partnership Trust
- University Hospitals of Leicester NHS Trust
- East Midlands Ambulance Service
- Leicestershire Fire and Rescue Service
- Community Paediatricians
- Designated Nurse for Safeguarding

The child death overview process is not an investigation and does not replace the need for organisations to undertake their own reviews following the death of a child. It is intended that the child death overview process will incorporate issues identified within the serious case review (SCR) and serious incident learning process (SILP).
4. Early access for women to maternity services: 31

All women should access maternity services for a full health and social care assessment of needs, risks and choices by 12 weeks and 6 days of their pregnancy to give them the full benefit of personalised maternity care and improve outcomes and experience for mother and baby. Reducing the percentage of women who access maternity services late through targeted outreach work for vulnerable and socially excluded groups will provide a focus on reducing the health inequalities these groups face whilst also guaranteeing choice to all pregnant women.

Completion of the assessment empowers women, supporting them in making well informed decisions about their care throughout pregnancy, birth and postnatally. The national choice guarantees:

• choice of how to access maternity care
• choice of type of antenatal care
• choice of place of birth
• choice of place of postnatal care.

The aim is an increase in the percentage of women who have seen a midwife or a maternity healthcare professional for assessment of health and social care needs, risks and choices by 12 weeks and six days of pregnancy.

• In 2010/11 NHS Leicestershire County and Rutland booked 88% of women within 12 weeks and six days gestation. This was against a target of 87.8%.
• The PCT has increased the challenge against this indicator with a plan to book 88.7% of women by 12 weeks and six days in 2011/12, rising to 91.5% in 2013/14

Baby Beginnings

‘Baby Beginnings’ is a project delivered by a private antenatal education service based in Hinckley (Baby Dolly). It is funded through the Sure Start Children Centre Grant (now the Early Intervention Grant). The work of the project is commissioned by the Locality Partnership Group – a multi-agency planning and commissioning group leading on the implementation of the Hinckley and Bosworth Sure Start Children Centre Programme. The ‘Baby Beginnings’ service is provided for more ‘vulnerable’ women resident within Hinckley and Bosworth. It provides a tailored antenatal programme designed to improve their confidence and skills in early parenting.

It is recommended that we:

Improve liaison between GPs, midwifery, health visitors and the wider children’s workforce to deliver high quality antenatal support to ensure the best possible start for babies.

Ensure that we have the right services in place to support pregnant mothers to make healthy choices with regards to smoking, healthy eating, physical activity and substance misuse (including alcohol).
5. Reducing smoking in pregnancy: 32

Protecting an unborn baby from tobacco smoke is one of the most effective interventions to ensure a child has a healthy start in life. Every cigarette smoked in pregnancy will cause harm. Stopping smoking will benefit both mother and baby immediately, with:

- less morning sickness and fewer complications in pregnancy
- reduced risk of stillbirth and infant mortality
- reduced risk of prematurity
- reduced risk of low birth weight
- reduced risk of cot death (sudden infant death syndrome).

Babies whose parents smoke are more likely to be admitted to hospital for bronchitis and pneumonia during the first year of life. More than 17,000 children under the age of five are admitted to hospital every year because of the effects of second-hand smoke.

NHS Leicestershire County and Rutland is committed to reducing the rates of smoking in pregnancy:

- NHS Leicestershire County and Rutland had a smoking in pregnancy prevalence rate of 12.6% in 2010/11.
- it has plans to further reduce the prevalence of smoking in pregnancy to 12.4% in 2011/12 and 11.6% by 2013/14.
- this is considerably lower than the standard set by the Strategic Health Authority of lower than 15% by 2013/14.

NHS Leicestershire County and Rutland has developed a tobacco control strategy with a key object focused on reducing smoking in pregnancy. Within this strategy we have pledged to:

“ensure that all women who smoke and may be pregnant, or who are known to be trying to become pregnant, will be offered a stop smoking service as soon as they make contact with health care professionals such as GPs, midwives and pharmacists”. 33
**Case Study**

**NHS LCR Stop Smoking Services**

Nyki* is 16 years old and lives with her mum. She was preparing to sit her GCSEs when she discovered she was six weeks pregnant. It was a lot for everyone to take in but she was immediately concerned about smoking whilst pregnant and, with some difficulty, worked hard to cut down. At her first antenatal appointment she told the midwife about her struggles and was referred to the stop smoking service. Nyki had a lot going on with antenatal appointments and revision, plus her mum and boyfriend also smoked. In order for her to access stop smoking support more easily she was seen at home by a smoking cessation specialist who encouraged Nyki, her mum, and her boyfriend to stop together. Nyki’s main worry was about coping with the stress of her exams and nicotine withdrawal can make people feel anxious. In order to improve her chances of success, she chose to use a nicotine patch as well as an inhalator to help with situational urges to smoke. The advisor also discussed alternative strategies to help cope with stress such as taking regular revision breaks. Nyki tentatively set a quit date two days before her first exam and when it came round she was pleasantly surprised that she didn’t feel as anxious and stressed as first thought. This gave her confidence to continue on the day of her exam and she felt confident having the inhalator to use beforehand. One week later she disclosed how nice it was not to feel guilty about smoking anymore. Three weeks on and Nyki continues as a non-smoker. She has now had her first antenatal scan and just finished her exams. Certain situations when she would have smoked have been difficult, such as socialising with her friends, but regular appointments with stop smoking advisor meant she could discuss these situations and gain support and strategies to help cope with them.

*This is not her real name*

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**It is recommended that we:**

Continue to develop Tobacco-free Leicestershire and Rutland (TLR). This is an alliance of partners involved in the tobacco agenda with a remit to reduce tobacco use across our community.

Continue to increase access to our Stop Smoking Services by increasing the number of public sector employees trained in brief advice and interventions.

Continue to develop the Smoking in Pregnancy Service to support pregnant mothers to stop smoking or to reduce their tobacco use.

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**6. Initiation of breastfeeding and prevalence of breastfeeding at 6-8 weeks**

Breastfeeding has positive health benefits for both mother and baby in the short- and longer-term (beyond the period of breastfeeding). Breast milk is the best form of nutrition for infants and exclusive breastfeeding is recommended for the first six months (26 weeks) of an infant’s life.
For infants, it reduces the incidence of gastrointestinal and respiratory infections, otitis media (ear infections) and reduces the risk of allergies. There is also evidence that babies who are not breastfed are more likely to become obese in later childhood.

For mothers, it promotes maternal recovery from childbirth, reduces the risk of pre-menopausal breast cancer and possibly of ovarian cancer, accelerates weight loss and a return to pre-pregnancy body weight and prolongs the period of postpartum infertility.

Between January and March 2011 in NHS Leicestershire County and Rutland:

- 75% of all maternities initiated breastfeeding
- At 6-8 weeks 43% of infants were still being breastfed.

The PCT has targets to continually improve breastfeeding in the population. The plans set a prevalence of breastfeeding at 6-8 weeks of 44.7% in 2011/12 and 46.7% in 2013/14.

Breastfeeding support is delivered through a number of initiatives outlined in the case study below. Unfortunately, La Leche League, providers of peer support programmes across the county, has withdrawn as a provider of breast feeding services. This needs to be considered in terms of continuing to improve breastfeeding initiation and continuation rates across the PCT and to ensure that the PCT continues to meet its commitments with respect to delivery of challenging breastfeeding targets.

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**Case Study**

**Breastfeeding**

Leicestershire Partnership Trust (LPT) has been working with maternity and local authority services to increase both the initiation and continuation of breastfeeding. The aim is to achieve the standards of care as set out by the UNICEF/WHO Baby Friendly Initiative (BFI). Best practice in community settings is represented by the seven point plan for sustaining breastfeeding in the community. The aim is to provide mothers with consistent, evidence based care throughout their breastfeeding experience.

We have recently achieved Stage 1 of the BFI accreditation process which means:

- we have a joint breastfeeding policy
- we are committed to training all frontline staff to implement the policy
- in conjunction with the Children’s Centre Programme in Leicestershire, we have set up 21 breastfeeding support group across the County
- we have set up 6 La Leche League Peer Support Programmes across the County. This involves training up mothers to give mother to mother support for breastfeeding.

Also, we have been working to increase the uptake of the Healthy Start scheme, which is all about improving the nutrition of pregnant women and families on low income. We have seen an increase in the number of women and children receiving the healthy start vitamins.
It is recommended that we:

Progress the Baby Friendly Initiative accreditation ensuring that women are supported to make informed choices about feeding their baby.

Review the implications of the change to breastfeeding providers across Leicestershire County and Rutland (LCR) and ensure that the withdrawal of La Leche League Peer Support Programmes does not have a negative impact on the uptake and continuation of breastfeeding across LCR.

7. Childhood immunisations

Vaccination remains the most effective tool against infectious diseases. Diphtheria vaccines were first developed in the 1920s and introduced in the UK in the 1940s. Since then, development has continued for vaccines protecting against other diseases such as pertussis (whooping cough) in the 1950s. Now children are given combined vaccinations to reduce the number of injections they receive.

Vaccines are rigorously tested for quality, safety and immunogenicity and/or efficacy prior to being licenced. This is monitored by the Medicines and Healthcare products Regulatory Agency (MHRA)\textsuperscript{35}. There is no evidence to suggest that giving more than one vaccination at the same time is unsafe. Components of vaccines are designed to produce antibody responses at different times, regardless of whether they are given together.

Table 6 shows the current Childhood Immunisation Schedule for the UK (Nov 2010) and includes diseases that are still circulating in the world.
Table 6: Childhood immunisation schedule

<table>
<thead>
<tr>
<th>Age of immunisation</th>
<th>Which diseases this protects against</th>
<th>No. of injections</th>
<th>Where is it given</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 months old</td>
<td>Diphtheria, tetanus, pertussis (whooping cough), polio and Hib (Dtap/IPV/Hib) First of 4</td>
<td>One</td>
<td>Thigh</td>
</tr>
<tr>
<td></td>
<td>Pneumococcal infection (PCV) First of 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 months old</td>
<td>Diphtheria, tetanus, pertussis (whooping cough), polio and Hib (Dtap/IPV/Hib) Second of 4</td>
<td>One</td>
<td>Thigh</td>
</tr>
<tr>
<td></td>
<td>Meningitis C (MenC) First of 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 months old</td>
<td>Diphtheria, tetanus, pertussis (whooping cough), polio and Hib (Dtap/IPV/Hib) Third of 4</td>
<td>One</td>
<td>Thigh</td>
</tr>
<tr>
<td></td>
<td>Meningitis C (MenC) Last of 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pneumococcal infection (PCV) Second of 3</td>
<td>One</td>
<td>Opposite thigh (2.5 cm from first)</td>
</tr>
<tr>
<td>Before age 2</td>
<td>Between 12 and 13 months old – within a month of first birthday</td>
<td>Hib / Meningitis C (Hib/MenC booster) To boost the immunity</td>
<td>One</td>
</tr>
<tr>
<td></td>
<td>Measles, mumps and rubella (MMR before 2) First of 2</td>
<td>One</td>
<td>Thigh</td>
</tr>
<tr>
<td></td>
<td>Pneumococcal infection (PCV) Last of 3</td>
<td>One</td>
<td>Thigh</td>
</tr>
<tr>
<td>Before starting school</td>
<td>3 Years 4 Months to 5 years old</td>
<td>Diphtheria, tetanus, pertussis (whooping cough), polio (Dtap/IPV booster) Last of 4</td>
<td>One</td>
</tr>
<tr>
<td></td>
<td>Measles, mumps and rubella (MMR before 5) Last of 2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


The Department of Health (DH) asked the National Institute for Health and Clinical Excellence (NICE) to produce public health guidance on reducing the differences in uptake of immunisations, including targeted vaccinations amongst children and young people under 19 years old. The guidance was produced in September 200936 and recommendations are integrated into local action plans.
Table 7: Uptake of immunisations in Leicestershire County and Rutland

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Under 1 year old</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dtap/IPV/Hib</td>
<td>96</td>
<td>92</td>
<td>91</td>
<td>95</td>
<td>93</td>
<td>91</td>
<td>97</td>
<td>95</td>
<td>92</td>
<td>97</td>
<td>95</td>
<td>94</td>
</tr>
<tr>
<td><strong>Under 2 years old</strong></td>
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Source: Department of Health Statistical Bulletins on Immunisations, The NHS Information Centre

NHS Leicestershire County and Rutland is performing well on both a national and a regional scale for immunising children (Table 7). However, there is no room for complacency and the PCT has agreed challenging targets to continue to improve performance:

- by 2013/14, 95% of children at ages 1, 2 and 5 years will have received their scheduled vaccinations
- by 2013/14, 90% of girls aged 12-13 will have received their HPV vaccine
- by 2013/14, 90% of children aged 13-18 will have received their booster dose of tetanus, diphtheria and polio.
## Case Study

### Immunisation Programme in Leicestershire County and Rutland

Overall implementation of immunisation programmes is the responsibility of Public Health. It includes monitoring, providing advice, data management, and commissioning and partnership arrangements. This ensures that arrangements are in place for any adjustments or additions to delivery of immunisation programmes locally.

Public Health deal with changes or additions to the programme, such as the introduction of the HPV (human papillomavirus) vaccination programme in 2008 for girls aged 12-13 years. The vaccination is to prevent cervical cancer in high risk HPV types 16 and 18. There was a catch up for all girls and young women up to the age of 18 and now the programme is routinely delivered in schools.

Uptake rates across Leicestershire and Rutland are relatively high for childhood immunisations, however, when fewer children are vaccinated, disease begins to spread. This has been highlighted recently with an outbreak of measles across Europe and more cases in the UK in the first quarter of 2011 than is usually seen in a year.

Vaccinations are not only important for the very young; they also protect those in the community who are unable to participate in the programme due to ill health or those for whom the programme was not available when they were children. Vaccine protects those travelling abroad, especially to countries where the diseases are prevalent.

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### It is recommended that we:

- Continue our implementation of the NICE public health guidance to improve uptake of immunisations across Leicestershire County and Rutland.
- Continue to increase uptake of vaccinations by working with general practices to increase uptake and target children that have not been immunised.
- Develop increased awareness of the importance of childhood immunisations through the use of local and national media, raising awareness within children’s centres, developing leaflets and other materials to circulate to key agencies across Leicestershire and Rutland.

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### 8. Obesity and physical activity

Tackling childhood obesity remains a high local and national priority, with recognition that this is a highly complex issue requiring a comprehensive, co-ordinated and sustained response.

The PCT is committed to reducing the levels of obesity in childhood with the aspirations indicated below:

- In 2009/10 13% of reception age children were overweight and 8.4% were obese (England – 13.3%; 9.8%).
- In 2009/10 13.9% of year six children were overweight and 15.4% were obese (England – 14.6%; 18.7%).
• The PCT plans to further reduce childhood obesity rates to 7.95% in reception age and 15.25% in year six by 2014.

Leicestershire and Rutland’s strategic approach to tackling childhood obesity is establishing a broad range of initiatives, from addressing the obesogenic environment to working on sustainable lifestyle change with individuals. Examples include:

• During 2011, new children’s obesity care pathways were developed for children age 0-2 and 2-19 years, involving all the relevant service providers in Leicestershire and Rutland. Pathways will assist health professionals and other key workers identify the most appropriate intervention or treatment to offer overweight individuals or families.

• A number of new multi-agency programmes have been developed in order to offer a range of treatments and services as part of the obesity care pathways. In 2010-11, Leicestershire Nutrition and Dietetics Service (LNDS) launched the Family Lifestyle Clubs (FLIC) in targeted neighbourhoods, specifically to support families with overweight children aged 4-8 years old. The FLIC programme will continue to expand across the county over the forthcoming year.

The PCT, Local Authorities and the voluntary sector continue to work in partnership to promote healthy food choices at home, nursery and school:

• Take up of healthy school meals continues to increase annually and has been matched by a positive food culture in schools which includes having a whole school food policy, food education, cooking in school, growing food, ‘grow, cook and eat’, a welcoming dining environment, access to palatable drinking water and positive adult role models.

• The Leicestershire Healthy Schools Team has developed guidance to help schools develop a healthy packed lunch policy. It ensures that schools adopt a ‘whole school approach’ to help families begin to make small changes towards ensuring that packed lunches alongside school meals are aligned to the new school food standards.

• Over 45 early year settings in Leicestershire have participated in the Pilot Healthy Early Years Programme – ‘The Leicestershire Healthy Tots Programme’ - and have achieved ‘Healthy Tots Status’ by fulfilling the criteria of the three core themes of healthy eating, physical activity and emotional health and wellbeing.

In addition, there have been a number of initiatives that are aimed at bringing physical activity into children’s lives:

• A number of local projects are currently focusing attention on the important area of physical literacy (the basic skills of stability, locomotion and manipulation, upon which later abilities such as sporting and social skills and educational attainment are built) and increasing opportunities for every day physical activity and sports participation.
• District based activities such as “Active tots” and “Start to play” schemes are being co-ordinated through 0-5 years physical activity co-ordinators in order to engage families with very young children, and increasingly we are seeing integration between healthy eating and physical activity programme delivery.

**Case Study**

**FLIC Programme**

• five year old girl
• BMI at beginning of the FLIC programme 20.4 (above the 98th BMI centile)
• measurements 10 months after the programme show a BMI of 18.9 (between the 91st and 98th BMI centile)
• 88% attendance
• increase in confidence regarding making positive changes to diet and activity for the family score
• healthy recipes prepared during the course of the programme had been made 15 times over the 8 weeks of the course
• maintained a minimum of 3-4 fruit/veg per day
• knowledge score increased

Parent comments included:

“More aware of portion sizes – now use smaller bowls and plate.”

**It is recommended that we:**

Continue to develop the National Childhood Measurement Programme to increase early identification of children who are overweight or obese. When children become overweight, we need high quality, easily accessible NHS support services to support families and children to change lifestyle behaviour in a positive and sustainable way.

Work with schools, through the Healthy Schools programme, to promote a ‘positive food and physical activity culture’ within schools where eating a healthy balanced diet and participating in physical activity becomes the ‘social norm’.

Support schools to achieve measurable health and wellbeing outcomes for children and young people with regards to healthy weight through the implementation of the healthy schools enhancement programme.

Routinely promote physical activity, including unstructured play at home, in school, in childcare settings and throughout the community, and ensure the children’s living environment encourages and facilitates these choices.
9. Identifying, treating and preventing mental health problems

Research tells us that a good level of mental health and emotional wellbeing for children and young people acts as a strong protector, enabling them to thrive and to achieve, throughout their childhood and into their adulthood.

Mental health, individual resilience to mental illness and social exclusion are all influenced by a range of factors along the course of a person’s life. Factors such as parenting, education and exposure to violence in childhood all have an impact. Relative deprivation is associated with increased risk of mental illness, with 15% of children whose families are in the lowest income levels experiencing mental ill health, compared with 5% at the highest income levels.

Poor mental health is associated with unemployment, lower educational attainment and lower income levels. It is also associated with increased risk taking behaviour, such as increased rates of smoking, consumption of alcohol and drug misuse; discrimination and stigma further compound inequality.

Across Leicester, Leicestershire and Rutland we want all children and young people to enjoy good mental health and emotional wellbeing. We want to:

- promote mental health and increase resilience in all children and young people
- ensure early identification of problems so that children and young people can access the appropriate service at the level they need
- ensure that multi agency services work together to provide support at the right level
- deliver services that are appropriate to the diverse needs of the area
- target services to meet priority needs
- improve access to specialist services for children and young people with complex mental health needs
- ensure children and young people are safe and protected.

The Leicester, Leicestershire and Rutland Child and Adolescent Mental Health Services Strategy, 2011-2014 has been developed through a multi-agency steering group called the Child and Adolescent Mental Health Services (CAMHS) Partnership for Leicester, Leicestershire and Rutland. It used the National Service Framework for Children and impetus from Young People and Maternity Services to move the delivery of all local children’s services more towards health improvement. The strategy also incorporates thinking from Every Child Matters which focused on achieving better outcomes for children under headings such as being healthy, staying safe, enjoying and achieving through learning, making a positive contribution to society and achieving economic wellbeing. The Children Act 2004 has also been useful in giving a particular role to local authorities in securing co-operation amongst local partners - health services, Youth Offending Teams, the police, district councils and others. The Act encouraged the involvement of schools, GPs, and the third sector in the co-operative arrangements. Schools are well placed to promote mental and emotional health and wellbeing, notably through the promotion of Social and Emotional Aspects of Learning and the Healthy Schools agenda.
The Common Assessment Framework fosters co-operation between professionals and has promoted more effective and earlier identification of additional needs and takes account of the role of parents, carers and environmental factors on the child’s development. It enables practitioners to be better placed to agree, with the child and family, any necessary and appropriate support.

The services offered to children with mental health problems in LLR include collaborative working between different professional groups, specialist Child and Adolescent Mental Health Services and a range of school based initiatives.

**Case Study**

**Child and Adolescent Mental Health Services**

CAMHS deliver local children’s mental health care services. They are structured in a tiered model. Tier 1 encompasses primary care services such as GPs, health visitors, school nurses, social workers and voluntary organisations. Tiers 2 to 4 comprise the specialist CAMHS services with tier 2 for instance including nurse specialists and clinical psychology and tier 4 offering highly specialist services such as residential facilities.

The latest Child and Adolescent Mental Health Services Joint Strategy 2011-2014, shows that referral across the different tiers exceeds the capacity within the services to deliver assessment, treatment and interventions in a timely manner.

This means that some children are waiting too long for services. We also know that there are some inappropriate referrals to our local specialist and non-specialist services, for example, approximately 35% of referrals to specialist CAMHS do not meet the specialist CAMHS threshold. A number of gaps in services were highlighted during the 2008 to 2011 strategy period and as a result new services were provided or redesigned in response.

**It is recommended that we:**

Ensure that, as services are combined across specialist CAMHS and community children’s services, we maximise service quality and capacity. This includes the development of pathways to ensure that services are working together and are clearly specified (including ADHD, autism, self-harm, behaviour).

Provide support to schools to promote positive mental health and to capitalise on the legacy of the Targeted Mental Health in Schools Project (TaMHS) by disseminating the learning from nine Leicestershire County schools who participated in the project.

Maximise the mental health of vulnerable young people, including those who offend or are at risk of offending, are looked after, are homeless, or have a physical illness.

Ensure that good links with adult services are maintained in relation to transition from children to adult services and taking the whole family approach work forwards.

Ensure that interventions are developed at the earliest possible opportunity, maximising on the links between preventative infant mental health and post-natal depression services through to school related services.
10. Smoking and young people

Tobacco use cannot be viewed as just a health issue, it is everyone’s priority because smoking creates major health, economic and social burdens within our communities. Whilst smoking rates in LCR are slightly below the national average, smoking related illnesses continue to claim 1 in 5 lives of all Leicestershire and Rutland residents. Tobacco control efforts need to be much more joined up. No one organisation can hope to successfully tackle the harm caused by tobacco on their own so we need everyone to take a strong line on smoking, become ambassadors for tobacco control and spread the message right across the community.

Great strides have been made towards reducing smoking rates in our society over the last decade. Thanks to the NHS Stop Smoking Services there are over two million fewer smokers in the UK now than a decade ago. Smoke free legislation introduced in 2007 has removed smoking in almost all enclosed public places, the age of sale for tobacco has been increased from 16 to 18 years and wide ranging bans exist on almost all aspects of tobacco advertising. 45 Illicit tobacco also affects community safety (if illicit tobacco is being sold often so are other illicit items) and encourages young people to smoke (illicit sellers won’t challenge for age and it’s much cheaper than manufactured brands).

It is important that we work with children to ensure that they have access to healthy choices with respect to smoking.

- The vast majority of smokers begin smoking regularly before they turn 18. In order to replace smokers who die or quit, the tobacco industry needs to recruit over 100,000 new smokers each year – young people represent a key market for the tobacco industry.46

- Young people are far more likely to smoke if they live with smokers.

- It is illegal to sell tobacco to under 18s.

- The addiction to nicotine can take hold in children after just a few cigarettes.

- Thousands of children each year are admitted to hospital from conditions related to second hand smoke
**Case Study**

**Tobacco-Free Leicestershire and Rutland**

Tobacco-Free Leicestershire & Rutland (TLR) is a partnership of local community organisations that are working towards a joint vision where all people in Leicestershire and Rutland lead healthier and longer lives. TLR came together as a partnership in early 2011 and includes representatives from Leicestershire County Council, NHS LCR, Leicestershire Fire and Rescue Service, Leicestershire Partnership Trust, Trading Standards (TSS), The Princes Trust, Healthy Schools and District Councils.

TLR is a good example of partnership working to tackle a complex issue. A specific example of join up is work between the Trading Standard Services (TSS) and public health leads for alcohol and tobacco to develop a community-based intelligence network alongside a more targeted approach to test purchasing for underage (under 18) and illicit sales of both alcohol and tobacco.

**Case Study**

**Healthy Schools and smoking**

**Aims of Project:** To use performance arts as a mechanism for delivering smoking prevention messages to students.

How did it work: The Community College was keen to focus on smoking prevention as a priority. With the support of school staff and a Performing Arts organisation, A-Level performing arts students created a performance aimed at promoting smoking prevention messages throughout the college. The piece was designed to be light-hearted and student friendly and was rolled out to other students as part of the college’s Health Day. The performance focused on how the Tobacco Industry aims to recruit young people as ‘replacement’ smokers. Following the performance, students took part in an ethical debate about the tobacco industry’s strategies and attitude towards young people.

Students were surveyed after the performance to find out whether or not they felt this was a successful way of delivering smoking prevention messages in school.

**Outcome/results:** The performance was rated as extremely successful by both students and staff at the college and has since been rolled out to a number of other schools in the County.

It is recommended that we:

Develop and expand the comprehensive school-based tobacco control program. This should focus on using social norming techniques and incorporate prevention and awareness education, accessible stop smoking support and youth advocacy.

Improve engagement with youth oriented agencies and voluntary organisations to increase access to harder to reach youths as well as more traditional school based programming.

Evaluate the effectiveness of trading standards service test purchasing programme and target future initiatives to tackle underage and illicit sales.
11. Substance misuse

Substance misuse, referring to drugs and alcohol, is a complex issue that can affect not just individuals, but their families, friends, communities and society. Effective treatment is important for tackling the harm that substance misuse can cause. It offers individuals the opportunity to manage their addiction and get on the road to recovery, and gives communities a break from related crime and antisocial behaviour.

Binge drinking and overall alcohol consumption are increasing amongst young people (in particular those aged under 18), with adolescents in the United Kingdom ranked in the top five of 30 countries for measures of alcohol misuse. Various studies indicate a strong relationship between alcohol misuse, precocious sexual behaviour and teenage pregnancy. A relationship has also been detected between teenage conceptions and teenage hospital admission rates for alcohol related harm.

The experience of drinking alcohol is widespread and in England:

- 70% of year 9 students and 89% of Year 11 students have had an alcoholic drink. Regular drinking is significantly lower amongst year 9 than year 11 students.
- The most common age for a first drink was 12 to 13; usually when with an adult and celebrating a special occasion.
- Year 9 students are most likely to have been drinking alcopops, beer or lager. By year 11, students are most likely to drink beer, lager, spirits or liqueurs.

While friends play a critical role, a parent or guardian has a particularly strong influence on their child’s behaviour. This ranges from the point at which alcohol is introduced, to exposure to adult drinking and drunkenness, to the amount of supervision placed on a young person (such as knowing where their child is on a Saturday evening or how many evenings their child spends with friends). There are critical points where a carefully timed intervention could generate a positive outcome by reducing the likelihood that a young person will drink frequently and drink to excess. These interventions require co-ordination at a national, local and frontline level involving families, schools and support services.

Young people’s substance misuse services work to an annual plan based on a detailed needs assessment. Substance misuse services for young people aim to both prevent young people from engaging in substance misuse but also to limit the harm experienced and support people to stop any misuse as quickly as possible. Services are currently delivered by a number of providers both within children and young people’s services and the specialist drug treatment sector. Leicestershire and Rutland has an established network of trained workers within schools and youth settings. Engagement with wider children’s services is essential to identify, screen and assess young people vulnerable to substance misuse.
Case Study

Social Norms and Alcohol

Schools can play a major part in correcting misperceptions regarding young peoples drinking. A recent Leicestershire healthy schools programme in a secondary upper school, set out to reinforce positive health behaviour by dispelling myths regarding drinking behaviour and promoting actual social norms. The norm of positive behaviour within the student population was encouraged through key messages emerging from a survey of student drinking. For example, the study identified that ‘9 out of 10 of students who drink alcohol do so no more than once a week’. Other frontline services could be engaged in delivering these key messages to parents via midwifery and health visiting services, parenting programmes, family interventions, schools and youth services.

The experience of young people using drugs is:

- The number of school age young people reporting ever having used illicit drugs has declined from 29% in 2001 to 22% in 2009.
- The prevalence of drug use increases with age, with 9% of 11 year olds reporting ever using drugs with a rise to 40% of 15 year olds. Use of drugs in the last month, an indicator of regular use, rises from 2% of 11 year olds to 17% of 15 year olds.
- Boys are slightly more likely to have ever used drugs than girls (23% and 21%).
- Cannabis remains the most commonly used drug by young people often in combination with alcohol.
- Vulnerable young people, including those who truant, offend, are in care or have parents with drug and alcohol problems, are more likely to take drugs regularly than those not classed as vulnerable (14% and 1% respectively) and are the only group where rates of drug use continue to rise.
- There is a strong correlation between drug use and the use of tobacco and alcohol, with those young people who report smoking and drinking more likely to have used illegal drugs.
- Young people’s first experience of drug use is most likely to be through friends, often of the same age. First experiences of drug use were positive for 45%, negative for 11%, and no effect 44%. Unsurprisingly, those that have positive first experiences of drug use are more likely to progress to more frequent use.

During 2009/10 in Leicestershire and Rutland, 186 young people received a tier 3 specialist drug treatment intervention. The number of young people accessing specialist services has been rising significantly over recent years due to increased accessibility of services. Nationally, nine out of 10 accessing substance misuse services are seeking help with alcohol and/or cannabis. The number of young people developing problems with heroin and crack cocaine is very small and declining.
Case Study

Healthy Schools Whole School Review Process

The Healthy School’s team has been working with senior management teams in secondary schools to raise their confidence and develop comprehensive policies for drug education and managing drug-related incidents. In one upper school, the Assistant Head and two members of staff attended training on drug education and policy development run by Healthy Schools. A draft policy was developed as a basis for consultation with the school community and a parents evening was held to discuss issues. When a drug related incident occurred in school, the Assistant Head was able to draw on recent training to identify the drug and involve the police and Young People’s Substance Misuse Team appropriately. Following investigation, the pupil was excluded for a drug-dealing offence.

The school commented that the training had enabled them to tackle what was a difficult situation and the Healthy Schools “whole school review” process ensured the drugs policy was up to date and useable in light of appeals to governors and local authority after the permanent exclusion.

It is recommended that:

We continue to work with schools, youth services and families to raise awareness of the risks associated with alcohol and illicit drugs. As there is a strong correlation between the use of tobacco and substance misuse it is important to develop programmes that will address these issues simultaneously.

We develop specific interventions that target groups of young people at greater risk of problematic substance misuse, particularly children in care, young offenders and children not attending school.

We develop the tier 2 school substance misuse network of tier 2 trained school staff, the aim of which is to increase the number of young people receiving timely, appropriate high quality support and treatment in relation to their substance misuse problems.

12. Sexual health and teenage pregnancy

The consequences of poor sexual health can have a long-lasting and severe impact on people’s lives. Poor sexual health can result in:

- unintended pregnancies and abortions
- high teenage pregnancy rates with poor educational, social and economic opportunities for teenage mothers and fathers
- poor psychological consequences of sexual coercion and abuse
- sexually transmitted infections (STIs) and HIV
- pelvic inflammatory disease, which can cause ectopic pregnancies and infertility
- cervical and other genital cancers
- hepatitis, chronic liver disease and liver cancer.
Young people are a group disproportionately affected by poor sexual health. The transition to adulthood involves encountering risk and making choices. Local research indicates that many young people seek good advice and make sensible decisions about their sexual health. However some young people will engage in behaviours that carry risks for their health. There are many barriers which hinder young people in making positive choices including stigma around talking about sexual health. Good access to sexual health information, services and support is a key factor in reducing unintended conception and transmission of sexually transmitted infection. Research also identifies a relationship between alcohol misuse and poor sexual health outcomes for young people. There is a need to make this link within health service provision.

The performance locally for teenage pregnancy in 2009 shows:

- Rutland is the second best performing local authority for teenage pregnancy with a rate of 13.7 per 1,000 female population aged 15-17 (17 conceptions).
- In 2009 LCR had the best teenage conception performance in the East Midlands, with the lowest overall rates in the region at 26.3 per 1,000 female population aged 15-17 (340 conceptions). Leicestershire had the greatest reduction in rate of all East Midlands local authorities.

**Figure 7: Comparison of national, regional and local teenage pregnancy rates**

Source: Office for National Statistics and Teenage Pregnancy Unit, 2009

Being sexually active results in risk of catching a sexually transmitted infection. Getting screened for sexually transmitted infections is easy and early detection and treatment prevents onward transition and health complications. Nationally, the number of STIs has increased recently, especially in the past two years.

In 2009/10, there were 10,000 first attendances in genitourinary medicine (GUM) clinics for residents of LCR. The under 24s had the highest rate of attendance with females higher than male in this age group.

In 2009/10, over 20% of the 15-24 year population in LCR were screened for chlamydia. Of those tested approximately 6% were diagnosed with chlamydia.
Figure 8: Percentage of girls aged 12-13 receiving HPV immunisations

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Source: Department of Health June Survey (data from 01/09/2008 to 30/06/2011)

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**Case Study**

**Improving access to long-acting reversible contraception (LARC).**

Local research was conducted in 2009/1060 61 which helped to inform the teenage pregnancy partnerships in relation to barriers for young people in choosing LARC. Information has been produced to inform young people about contraceptive choices and where these are available. This includes a sex and relationship resource pack to be used in further education settings.

A wide range of workers with young people have received training to enable them to give accurate information about LARC. 26 practitioners have been trained in Implant fitting in 2010-11, increasing the number of GP practices who offer this service to 65 practices in LCR.

**Chlamydia screening programme.**

The Leicester, Leicestershire and Rutland chlamydia screening programme has developed screening as part of a national programme to test the 15-24 year age group at highest risk of the infection. Chlamydia screening is available from a wide variety of settings including doctors’ surgeries, contraceptive services, education establishments, prisons, youth settings and social venues such as pubs and clubs. Postal kits are also available via www.haveigotit.co.uk. 17,172 15-24 year olds were tested in 2010-11 as part of the screening programme. Four years into the programme, young people have a much better awareness of chlamydia and the screening programme.
It is recommended that we:

Continue to improve young people’s access to integrated sexual health services, with particular emphasis on improving access to the range of contraceptive options, including long-acting reversible contraception.

Continue to increase chlamydia screening for 15-24 year olds in LCR and improve detection and treatment of the infection with the aim of reducing the prevalence of chlamydia.

Continue to improve access to sexual health information for young people and those who provide information and support for young people.
1. Safeguarding

Abuse can happen to a child at any age, from pre-birth up to the age of 18. It can happen in well-off families and in poor families; it can happen to children from any ethnic and cultural background; it can happen to children with or without disabilities; it can be deliberate or unintentional.

Children can experience abuse at home, at school, in leisure activities, in children’s homes - in fact anywhere. The abuse is usually caused by someone the child knows and rarely by a stranger.

Abuse can happen because of the way adults or other children and young people behave towards a child; it can also result from adults failing to provide proper care for the children they look after.

There are obvious risks to the health and wellbeing of children who suffer abuse, and in extreme cases a child may die if concerns are not acted on.

Abuse is likely to cause long-term damage to a child’s present and future life. It may lead to permanent physical and/or mental health problems, difficulty in achieving success in such areas as education, social relationships, job prospects and parenting ability.

In Leicestershire County and Rutland a multi-agency board has been established to co-ordinate partnership work to safeguard children from abuse.

Leicestershire and Rutland Local Safeguarding Children Board (LSCB) has been established to ensure that the child protection work of the police and social services together with that of all other professionals working with children and their parents is conducted according to Leicestershire and Rutland Local Safeguarding Children Board procedures. These are based on ‘Working Together to Safeguard Children’ (HM Government 2010). This is available on the Leicestershire and Rutland LSCB website: www.lrlscb.org.

The purpose of the Leicestershire and Rutland LSCB is:

• to co-ordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area of the authority by which it is established;

• to ensure the effectiveness of what is done by each such person or body for those purposes.
The Safeguarding Board includes representatives from Leicestershire County Council, Rutland County Council, the local health community (provider and commissioner), probation services, Leicestershire Constabulary, the Youth Offending Service and representatives from other agencies.

2. Children’s centres

The key to delivering opportunities for good health targeted to the children of Leicestershire is the Sure Start children’s centre programme.

Services delivered through the Leicestershire children’s centre programme are locality developed and tailored to the needs of individual localities and districts.

There are 36 children’s centres spread across the six localities of Leicestershire, providing county wide coverage. Children’s centres supplement services and activities in the local area. Targeted services are accessed via referral for vulnerable parents or families with additional needs – not for the wider public. Services provided will differ depending on the needs and priorities of the local area.

Some of the health specific / related services provided through the Sure Start children’s centre programmes are:

- child and family health services
- family support
- breast feeding support
- baby massage
- healthy eating advice
- early reading, speech and language development services
- training and employment services
- parenting support and advice
- drop-in for children and parent carers.

Sure Start children’s centres have two child/family health specific targets (improved uptake of infants continuing to be breastfed at 6-8 weeks and reduction in proportion of children in school reception year who are obese) and a wider set of health related outcomes that Ofsted inspections will include. Within localities and children centre reach areas, local priorities for the children centre programme are informed by a local analysis of needs. The range of health services that are directly delivered from children’s centres varies depending on local needs and the existing configuration of services. In most localities, children centre and health teams work closely through a named midwifery and health visitor link who take a lead role for liaison with the centre and the identification of families with additional needs.
needs. In some centres health visitor teams are collocated with children centre staff.

The health services offered by children centres fit with strategic and local priorities of the centres and their reach areas. They have traditionally been aligned to the public service agreement targets and national indicators, and partnership agreements at Children’s Trust Board have facilitated joint commissioning. Initiatives such as Better Outcomes Achieved Together have been used to promote agencies to have a shared understanding and unblock some of the barriers to working together.

At a locality level, senior health service managers are represented at the locality partnership forum. This enables community health services to fully contribute to the investment, commissioning and delivery of services at a local level. These decisions are based on local knowledge about identified needs within the centre reach areas, the take up of services and the impact services are having on outcomes for children and families.

Health service practitioners are members of informal multi agency networks/communities of practice that support integrated working. Children’s centre programmes have established “systemic points of contact” linked to the Healthy Child Programme targets, in order to improve the take up of the universal and targeted health service offer.

Under the supervision of children centre co-ordinators, and in some instances health visitors, family outreach workers work individually with targeted children and vulnerable families who are identified to need additional support. Family outreach workers also support families in gaining protective factors through contributing to child health clinics, breastfeeding support groups, baby massage, weaning groups and parenting courses. In recognition of the importance of predictive poor health outcomes for teen parents, bespoke programmes have been commissioned to support teen parents in parenting skills and in returning to education and training. Where needs indicate, dietetic support is commissioned through the children centre programme to support families with cook and eat sessions, deliver a Family and Lifestyle Intervention Club programme (FLIC) and promote healthy food within the centres. Physical activity programmes engage families in raising their activity levels and improve children’s physical literacy.

3. Families with complex needs

Leicestershire is one of 16 community budget areas, all focusing on families with complex needs, announced in the comprehensive spending review at the end of October 2010.

During 2010 and into 2011, Leicestershire local partners have been working together to plan the integration of service commissioning across all areas of public service, including those delivered by the voluntary and community sector. The local public service partnership, Leicestershire Together, has recognised that the community budget provides a further opportunity for Leicestershire local partners to ensure that the best possible outcomes can be achieved working with local people.
Current locally derived estimates indicate there are approximately 1,000 families with complex needs in Leicestershire as well as over 3000 families on the threshold of being complex. We will reduce the numbers of families developing complex needs over the next four years as well as helping the existing families with complex needs.

**The scope of the community budget for Leicestershire**

The community budget programme for Leicestershire will develop and implement an integrated service model that includes:

- targeted service provision at community, family and individual levels to support families and individuals defined as having complex needs to achieve more independence
- a focus on earlier intervention, preventing vulnerable families and individuals from becoming families with complex needs
- a focus at the community level to help lift communities who are most in need.

Leicestershire local partners support the findings of the Graham Allen review that targeted interventions at an early life stages (pre-natal to three years) are a prerequisite for improving outcomes.

‘Earlier intervention’ is also necessary at later life stages, particularly in preparing and supporting prospective parents at highest risk of being families with complex needs from perpetuating intergenerational cycles of deprivation.

In addition to improving the way we work with individuals, families and communities, Leicestershire partners recognise that significant changes to the way we work together are required. Achieving this requires us to ‘share sovereignty’ over a wide range of services. This approach will have a number of characteristics:

- a multi-skilled and proactive workforce using the benefits of co-location wherever possible
- co-ordinated generic, targeted and specialist resources
- aligned networks and teams of practitioners who are ‘empowered to solve problems effectively’ on the ground in a locality
- better information sharing – governance, practice and systems
- a number of service design models are possible, from individual agencies responding more quickly through referrals, through to commissioning of new ‘joined up’ services
- risk factors, life events and customer journey mapping for existing families with complex needs, in order to identify the appropriate point to offer services to improve outcomes
- a more dynamic risk assessment process would help ensure the right choices are being made, prevent people falling through service gaps, and service eligibility gaps, and also save money. This should also drive service improvement earlier in the intervention process.
There are many innovative and successful current initiatives in place across Leicestershire that are multi-agency, family focused and using evidenced based practice. All of these will form a key component to the place response in the Families with Complex Needs Programme. Such initiatives include a well developed Family Intervention Project, an Integrated Offender Management solution, sound youth crime prevention arrangements and multi-agency initiatives modelled on the children’s centre programme that all recognise the significance of providing both locality based and family centred solutions in priority neighbourhoods.

4. Disabled children

Being physically, mentally and emotionally healthy means:

- disabled children have equal and appropriate access to universal, targeted and specialist health care
- disabled children are empowered and supported to take as much responsibility for their own health and wellbeing as they are able to
- disabled children are supported to achieve maximum mobility and independence
- disabled children and their families have access to appropriate advice and support on their emotional wellbeing and mental health.

Through the “Aiming High” programme, Leicestershire is committed to the transformation and expansion of short break services for disabled children and their families, from inclusive universal services, to specialist provision. Leicestershire wants short break provision to support parent/carers to live everyday family lives to enable them to continue in their caring role.

Leicestershire will promote the participation and involvement of disabled children/young people and their carers throughout this process and work alongside partners in other agencies in developing this transformation.

5. The healthy schools programme

The National Healthy Schools Programme celebrated its 10th birthday in 2009 and in July 2010, the new coalition government confirmed its continuing commitment to Healthy Schools as a means to improve the health and wellbeing of children and young people. The programme supports the links between health, behaviour and achievement. The programme is about creating healthy and happy children and young people who, as a result, do better in learning and in life.

In Leicestershire, we have reached a landmark figure of having 100% of our schools participating in the programme and 98% of schools achieving national healthy school status by the end of March 2011 deadline. This means that the schools with status have the ‘foundation of health and wellbeing’ in place by having fulfilled the 41 criteria regarding the 4 core themes of healthy eating, physical activity, emotional health and wellbeing and personal social health education. This is an extraordinary achievement, Healthy Schools is a voluntary programme and its local success is through the hard work and dedication of schools across the county.

Up until March 2011, the Leicestershire Healthy Schools Programme was the ‘local dimension’ of the national programme. However, the National Healthy Schools Programme and National Healthy School Status have now ceased but, due to the excellent results of the programme, both nationally and locally, Leicestershire is continuing to develop the local programme with schools. A Quality Assurance Framework has been developed to ensure consistency in healthy school related work across all schools in Leicestershire and to identify, celebrate and disseminate effective
practice. Schools with status are now moving on to the next stage of the process ‘Healthy School Enhancement’. This next stage asks schools to reflect and build upon the 41 criteria which they have already met to become healthy schools and to achieve measurable health and wellbeing outcomes in relation to a selected health and wellbeing priority based on data about children and young people’s health and wellbeing needs. We have more than 20 schools in Leicestershire who have already achieved health and wellbeing outcomes regarding their selected priority and have therefore achieved ‘enhanced healthy school status’.

Over the years, the Healthy Schools Programme has become one of the country’s most widely embraced initiatives in schools. Children and young people in Healthy Schools tell us that they feel healthier, happier and safer. Their parents tell us that they feel more involved in their child’s health and learning and often feel better themselves. Schools tell us that becoming a healthy school has meant fundamental changes for their school and it has changed the culture and atmosphere for the better. They say: “When you walk into the school you immediately pick up on the Healthy Schools ethos and the holistic approach to improving the physical, emotional and social health and wellbeing of our children. They are now making much better, more informed choices about food, exercise and friendships which are already having an impact on their ability to enjoy a healthy lifestyle”.

“We are now working on our identified health and wellbeing priorities in a bit more depth and are hoping to achieve some meaningful outcomes that will have a real impact on the health and wellbeing of the children who attend our school.”

**Case Study**

**Promoting health and reinforcing positive health related behaviour in relation to alcohol by using a Social Norms approach**

The social norms approach to preventing problem behaviour and promoting and reinforcing positive health related behaviour, put simply, is to dispel the myths about the problem being the norm among peers. It starts with gathering credible data from a population and identifying the actual norms regarding the attitudes and behaviour of concern. Then a social norms intervention intensively communicates the truth through media campaigns, interactive programmes, posters, bookmarks and a schedule of messages accessed on a computer desktop.

The students were invited to take part in a survey via a desk top message on their computer. Respondents were offered the opportunity to win a prize as an incentive for taking part in the survey. Those who followed the link were then presented with the online questionnaire which was split into five sections of demographics, alcohol consumption, cigarette use, sexual health and exercise.

The survey results are the key messages that are currently being promoted to students as being the ‘social norm’ in the college.

The survey will be repeated in a few months after to see if the students have responded to the social norm initiatives and have a more realistic perception of their peers and have consequently changed their health related behaviour in a positive way.
6. Supporting families, children and young people

The 5-19 Healthy Child Programme (HCP) sets out the practice framework for delivering services for children and young people aged 5-19. It recommends how health, education and other partners working together across a range of settings can significantly enhance a child’s or young person’s life chances. The programme stresses the importance of prevention and early intervention and these are particularly important in the area of influencing young people’s lifestyle choices around preventing obesity and risky behaviour around sex, drugs and alcohol.

Other key components include safeguarding, health development reviews, a comprehensive screening and immunisation programme, signposting services and developing environments that promote good health and support for parents and carers.

Case Study

Confidential Health and Teenagers

Confidential services are provided for key stage four students in a number of venues. These services are developed and promoted within the school community in partnership with parents/carers, young people, governors and the Safer Sex project. The service contributes to improved sexual health outcomes for school aged young people and offers individual and group sexual health and relationships advice, safer sex advice, the promotion of the delay message, condom education and provision, pregnancy testing, emergency hormonal contraception provision, Chlamydia screening, information and signposting for prevention of sexually transmitted infections and wider holistic health advice. Swift referrals for young people who need specialist advice are undertaken.
Health Protection and Children Aged 0-18

1. Introduction

The Health Protection Agency East Midlands South (HPA EMS) has an important role in protecting the public against infectious diseases, together with chemical, radiation and environmental threats. The HPA EMS covers NHS Leicestershire County and Rutland.

2. Notification of infectious disease (NOIDS)

The Health Protection Agency (HPA) collates notification of infectious diseases to monitor the incidence of infectious diseases and to detect any possible outbreaks and epidemics. In 2010 (Table 8), the NOIDS system reported a total of 285 notifiable diseases compared to 367 in 2009 and 268 in 2008 among persons aged 18 years and under. The top three infections were gastrointestinal infections (GI infections), vaccine preventable diseases (e.g. mumps and measles) and meningococcal disease. Table 8 shows the NOIDS data for 2008, 2009 and 2010 for comparison.

Table 8: Number of cases infectious disease reported to the HPA East Midlands South (provisional)

<table>
<thead>
<tr>
<th>Number of cases of infectious disease* reported to the HPA East Midlands South for Leicestershire County and Rutland PCT (18 years old and under only)</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Campylobacter</td>
<td>63</td>
<td>79</td>
<td>98</td>
</tr>
<tr>
<td>Cryptosporidium</td>
<td>21</td>
<td>52</td>
<td>37</td>
</tr>
<tr>
<td>E.Coli VTEC</td>
<td>6</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td>Giardia</td>
<td>15</td>
<td>13</td>
<td>23</td>
</tr>
<tr>
<td>Legionnaires disease</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Measles</td>
<td>38</td>
<td>43</td>
<td>19</td>
</tr>
<tr>
<td>Meningococcal disease (probable and confirmed)</td>
<td>26</td>
<td>14</td>
<td>13</td>
</tr>
<tr>
<td>Mumps</td>
<td>43</td>
<td>75</td>
<td>54</td>
</tr>
<tr>
<td>Pertussis (whooping cough)</td>
<td>24</td>
<td>24</td>
<td>6</td>
</tr>
<tr>
<td>Rubella</td>
<td>10</td>
<td>25</td>
<td>9</td>
</tr>
<tr>
<td>Salmonella</td>
<td>21</td>
<td>29</td>
<td>18</td>
</tr>
<tr>
<td>Shigella</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>TB (confirmed)</td>
<td>2</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

Source: Health Protection Agency East Midlands South

Note: This data should be considered as provisional as final verification of 2010 data is still in progress and therefore the figures in this report may vary slightly to future reports from the HPA.
2.1. Gastrointestinal infections (GI infections):

GI infections remain the most frequently notified infectious diseases in NHS LCR. Campylobacter and cryptosporidium were the most common causes (Table 8) of gastrointestinal infections among the notified cases to the HPA EMS in 2010. Figure 9 shows the number of campylobacter and cryptosporidium notifications by age groups.

Campylobacter is the most commonly reported bacterial cause of GI infections in England and Wales. HPA EMS data mirror this pattern, with campylobacter accounting for the majority (98) of all notified GI infections in 2010 with compared to 79 in 2009 and 63 in 2008. The reasons for this pattern are unclear. Transmission of infection is usually via ingestion of faecally contaminated food or water especially undercooked meat (especially poultry), unpasteurised milk and untreated water. For the majority of infections, however, the cause remains unexplained by recognised risk factors for disease.

What works?

GI infections could be prevented by good food and hand hygiene such as separating raw meat from other food, washing hand before eating food, after going to toilet, and after touching animals.

Exclusion of infected people for 48 hours from school, nursery or workplace from the last episode of diarrhoea to prevent further spread of infection.
Figure 9: Notifications of campylobacter and cryptosporidium 1:

![Graph showing notifications of campylobacter and cryptosporidium by age group]

Source: Health Protection Agency East Midlands South

Cryptosporidium is another major cause of GI infections nationally and locally. There were 37 cryptosporidium cases notified to HPA EMS during 2010 compared to 52 in 2009 and 21 in 2008 (Table 8). Transmission of cryptosporidium occurs usually through contact with infected animals or water contaminated with human or animal faeces and this contact with animals can occur through visits to petting farms. Nationally, outbreaks have also been associated with public water supplies and contaminated food. Most healthy people with cryptosporidiosis will recover without treatment; however, its main public health importance lies in the severe illness it can cause in immunocompromised individuals and potential for outbreaks, including large waterborne outbreaks as cryptosporidium oocysts can survive in water for prolonged periods and are resistant to standard chlorination.

2.2. Vaccine preventable infection

The two public health interventions that have had the greatest impact on the world’s health are clean water and vaccines. The aim of a vaccination programme is to reduce the incidence of, or to eliminate, a particular disease. Mumps and measles were the most commonly notified vaccine preventable diseases notified to HPA EMS in 2010. Although the cases of mumps and measles have come down nationally and locally following the introduction of MMR vaccine in 1988, we are still getting cases. In 2010, 54 mumps and 19 measles notifications were reported to HPA EMS. Figure 10 shows the number of mumps and measles notifications by age groups.

The highest number (20) of mumps cases were reported in the age group of 15 – 18 years followed by 19 cases amongst the 5 – 14 years old. The increase in mumps cases in these age groups could be due to not receiving MMR vaccination or receiving only one dose of MMR that provides only around 64% protection against mumps. There is also some limited evidence that the vaccine efficacy may wane overtime, which could explain some of the cases seen in these age groups.
The majority of the cases (11) of measles were reported amongst 1-4 year old children. The increase in measles among this age group could be as a result of not receiving MMR vaccination or receiving only one dose of MMR vaccine. Another contributory factor could be that some parents have chosen not to let their child have the MMR vaccine due in part to unfounded reports linking measles vaccine to autism and other disorders.

**Figure 10: Notifications of mumps and measles**

The prevention of meningococcal diseases (meningococcal meningitis and meningococcal septicaemia) remains a public health challenge amongst children and young people. Following the introduction of meningitis C vaccine in 1999/2000, many cases of meningitis caused by this serogroup have been prevented but cases caused by serogroup B still remain a challenge. Occasionally cases are due to other serogroups (A, Y, W135) of meningococcal bacteria. In 2010, there were 13 cases notified to the EMSHPU compared to 14 in 2009 and 23 in 2008. Out of 13 meningococcal disease notifications in 2010, 8 (62%) were caused by serogroup B. Figure 11 shows the number of meningococcal disease notification by age groups.

### 2.3. Meningococcal Disease

What works?

- Immunisation against meningitis C
- Prompt diagnosis and antibiotic treatment
- Offer of antibiotics to close contacts of a case to prevent spread of infection.
- Travel to the religious festivals of Hajj and Umrah require vaccination with a quadrivalent vaccine which protects against meningococcal disease caused by serogroups A, C, W135 and Y.
- Group B meningococcal vaccines are under development and are being tested but at present there is no available vaccine against serogroup B (currently responsible for the majority of meningococcal infections) in the UK.
Approximately 10% of the population carry neisseria meningitidis at some time, with the highest carriage (~25%) in 15 to 19 year olds. People carry meningococcal germs harmlessly, and only a very small number go on to become infected and develop serious disease. HPA EMS staff work proactively to prevent secondary cases of meningitis amongst contacts of the case. Close contacts are offered antibiotics as a precautionary measure to reduce the risk of them developing the disease and they may also be offered a vaccine, depending on whether the serogroup is vaccine preventable.

**Figure 11: Notifications of meningococcal diseases**

![Graph showing notifications of meningococcal diseases by age group](image)

*Source: Health Protection Agency East Midlands South*

### 3. Non-communicable environmental hazards

EMSHPU has an important role in advising and supporting responses to chemical and environmental incidents. Between January and December 2010, the HPA received notification of 26 incidents: 11 water incidents, nine chemical incidents and six fire incidents.

**What works?**

The management of chemical and environmental incidents depend on the type of incident.

- In the event of fire, the message to the public is usually “Go in”, “Stay in”, “Tune in”.
- For most water incidents, relevant water companies provide boil water notice and supply bottled water to the affected residents until the problem has been resolved.
Feedback from Actions for 2010

The 2010 DPH annual report focused on health inequalities within LCR and made a series of recommendations highlighting achievable actions to tackle these inequalities. The recommendations were grouped under 4 key headings and progress over the past 12 months is captured under these headings below:

1. Supporting families, mothers and children – to ensure the best possible start in life and break the inter-generational cycle of health

• The Maternity Services Liaison Committee has strengthened engagement with the public through public representation as part of its membership. The perspective of patients has been invaluable in shaping future services and reviewing current service delivery.

• NHS LCR has achieved breast feeding initiative standard 1 in early 2011. There is an action plan in place to achieve standard 2 by end of the year.

• A breastfeeding peer support programme to help women sustain exclusive breastfeeding is now in place.

• There has been much improved uptake of healthy start vouchers and vitamins across LCR (uptake of vitamins highest in East Midlands).

• There has been continued strong partnership working across the teenage pregnancy executive. NHS LCR now has the lowest teenage pregnancy rate in the East Midlands, combined with the largest reduction of any upper tier local authority in the East Midlands since 1998.

• NHS LCR is working to deliver early access to support services for families experiencing challenging behaviour in their children through delivery of the children’s centre programme including projects such as the Family Intervention Project.

• Leicestershire is one of 16 national pilot sites for community budgets. In Leicestershire this has a focus on ‘families with complex needs’. Over the next year the development of efficient support for children in this category will be a major focus for agencies across Leicestershire.
2. Engaging communities and individuals – to ensure relevance, responsiveness and sustainability

- In 2010/11 NHS LCR has consolidated work with a wide range of community and other groups to address health inequalities through liaison with the Local Authority (see below) and targeted work with seldom heard groups (see below), as well as targeted consultation and engagement about issues such as perinatal mental health.

- Social marketing techniques have been used to identify and target interventions at socially excluded groups/individuals, eg. bowel cancer symptoms and screening early awareness campaigns in North West Leicestershire and in Asian populations.

- Continued targeted areas of work with the BME community, people with learning disabilities (jointly with Leicestershire County Council), gypsy travellers and carers and exploring better working relationships with people with physical disabilities such as hearing and sight impairment.

- Strengthening of collaborative work with the local authority to address needs of the socially excluded through neighbourhood management and public health networks, including through the Shree Ram Centre in Loughborough, people with learning disabilities, and the various networks set up by Adult Social Care to address the needs of socially excluded people.

- Development of framework to ensure primary care is able to contribute to reduction of health inequalities through actively working with local practices to promote and develop Patient Participation Groups and to facilitate their connection with Local Involvement Networks to help meet health and social care needs.

- Continued to gather insight of needs and wants of existing socially excluded groups, eg, ‘Be healthy, be heard group’. These groups are used to test messages to ensure that services are meeting the needs of the ‘seldom heard’ populations.

3. Preventing illness and providing effective treatment and care

3.1. Smoking cessation and tobacco control

- Tobacco-free Leicestershire and Rutland (TLR), a community partnership came together in May 2011 to reduce the prevalence of tobacco use in Leicestershire and Rutland. TLR is working with a variety of community partners (Trading Standards, district councils, Rutland Council, voluntary sector agencies and the Stop Smoking Services) to deliver the tobacco control strategy.

- TLR also works with Healthy Schools, Trading Standards, and the Stop Smoking Service to provide a comprehensive tobacco control programme (social norming, prevention, cessation and youth empowerment) with a school focus and complimented by a targeted community component (Trading Standards/ enforcement, The SmokeScreen, The Prince’s Trust). This will stem the inflow of young smokers and increase the number of smoking youth who attempt to quit.

- In 2010/11 there was increased accessibility to Stop Smoking Services to priority, i.e. socially excluded groups, (eg, Pacesetter program focused on awareness and accessibility among Bangladeshi community).

- The Stop Smoking Service was able to surpass the ambitious four-week quitter targets as set for the 2010/2011 fiscal year.
3.2. Substance misuse including alcohol

- A new procurement process for non criminal justice alcohol and substance misuse treatment systems led to a new provider contract that commenced on 1 July 2011. This will deliver a recovery focused model that starts at the beginning of a person’s treatment journey. Building ‘recovery capital’ will be the bedrock of the treatment system in order for individuals to achieve successful, sustainable outcomes. This will necessitate close partnership working with organisations outside of the treatment system. The new provider has responsibilities to improve social integration and social functioning through promoting access into stable housing, employment, training, education and restored family or social networks.

- The following key Public Health alcohol harm initiatives have been incorporated into the new three year contract and will be monitored on a quarterly basis:
  - extending brief interventions in primary care settings, supporting GP’s to deliver brief interventions
  - reducing waiting times for alcohol referral
  - managing the shift of spending towards a fairer share of resources between drug and alcohol services over the life of the contract.

- The new provider has developed a single point of contact (SPOC) which will be responsible for the first contact service and will be the focal point for access into treatment for all substance misusers. The aim is to engage particular groups, e.g. young adults 18-25, services for BME groups, services for women and services for those with mental health problems.

3.3. Sexual Health

- Access to genitourinary medicine services in LCR is currently good with 99% of first attendances being offered an appointment and over 96% being seen within two working days (2009/10).

- Work is on-going to move towards an integrated sexual health service model across LCR. This is part of a longer term plan which will be implemented over the next two years.

- In 2010/11 the LCR chlamydia screening programme was redesigned to focus on delivery from core services such as GPs and contraceptive services, as well as targeting settings and localities with higher rates of positivity to maximise diagnosis rates. In LCR 17,172 screens were undertaken by 15-24 year olds as part of the national chlamydia screening programme. 5.1% of these were diagnosed with chlamydia. Partners were also offered treatment.

  - During 2010/11 there has been a review of abortion services provided by University Hospitals Leicester to improve access to local abortion services and increase the number of abortions that take place under 10 weeks gestation.
3.4. Obesity/healthy weight

- From 2011 onwards, the Active Together programme will begin to specifically focus on addressing health inequalities through better targeting of activities to key communities and families.

- Proposals for a more comprehensive range of programmes, including improvements to exercise referral and cardiac rehabilitation programmes are being developed during 2011/12.

- Breastfeeding targets have been achieved in LCR in 2010/11.

- New proposals for the development of physical literacy programmes, targeting early years, are under development in 2011/12. All district councils have 0-5 years physical activity co-ordinators promoting early year’s physical activity and healthy play programmes.

- There has been a small increase in the number of LEAP and Counterweight weight management programmes offered during 2010/11. An extra £100,000 funding in 2011/12 will increase number of sessions run per year and increase the number of trained staff to deliver programmes.

- In 2011 NHS LCR carried out a Pacesetter project in Rutland aimed at increasing participation in exercise programmes by patients with learning difficulties.

3.5. Cardiovascular disease and diabetes

- On-going work around generic risk stratification is being examined, including tools that predict an individual’s risk of future hospitalisation.

- Sustained roll out of NHS Health Checks across LLR. Clinical Commissioning Groups will be responsible for developing and monitoring the service specifications for this programme.

- Further redesign of stroke care pathway to improve health outcomes including an evaluation of the current rehabilitation pathway and further development of Early Supported Discharge.

- Continued use of the diabetes ‘off the shelf’ scheme North West Leicestershire.

- Scoping work on-going to look how funding can be re-invested in a diabetes model in East Leicestershire and Rutland that will look to address current inequalities in service provision.

- NHS LCR works with GPs through the Quality and Outcomes Framework to improve the secondary prevention in patients with cardiovascular disease and diabetes.

3.6. Cancer

NHS Leicestershire has addressed later presentation of patients with bowel cancer and poorer uptake of bowel cancer screening in disadvantaged communities in LCR through:

- the Pacesetter project which targeted South Asian patients in Charnwood

- the national awareness and early diagnosis initiative which applied across LCR and involved social marketing and media campaigns.

3.7. Childhood Immunisation

The childhood immunisation action plan has been fully implemented. Actions achieved during 2010-11 include:

- Sending monthly data to general practices to allow them to follow up those children who remain unimmunised.
• Information on immunisation rolled out to children’s centres and highlighted to outreach workers who work with families.

• A training and competency framework has been signed off requiring all those who immunise to meet minimum standards.

• Partnership working continues with health visitors and school nurses to improve immunisation uptake.

4. Addressing the underlying (wider) determinants of health including income/poverty, housing, education, employment

4.1. First contact service

First contact enables agencies to work together to refer and signpost people to appropriate services in a coordinated way. The scheme applies to vulnerable adults aged 18+ who are resident within Leicestershire and Rutland and is run by Leicestershire and Rutland County Councils in partnership with the district councils, police service, the fire service, voluntary groups and other organisations that work with vulnerable adults. When a staff member from any of the agencies is in contact with a vulnerable adult they can offer to complete one simple checklist to find out if that person has any other particular needs and refer or signpost accordingly.

4.2. Debt management/financial sustainability

In Rutland, the Citizen’s Advice Bureau is a member of the Rutland Voluntary Sector Consortium, which has representation on the Rutland Health and Wellbeing Board.

4.3. Employment

Leicestershire County Council is developing a healthy workplace project for small and medium enterprises aimed at developing greater health and wellbeing at work and supporting employment retention and return to work.

4.4. Housing

Health and Wellbeing Boards in Leicestershire and Rutland have recognised housing (including affordable and warm homes) as being a cross-cutting issue. Housing is likely to be addressed through dedicated partnerships that link to other parts of the Local Strategic Partnership structure. Working with the private sector to increase the range of housing options has also been included in plans to support reablement and independent living (through prevention and early intervention strategies).

4.5. Transport

NHS LCR has contributed to the local transport plan for Leicestershire and has worked with local authority colleagues in relation to the public health benefits of active and sustainable travel.
Appendix 1: Child Health Profiles

Child Health Profile

Leicestershire

February 2011

This profile provides a snapshot of child health in this area. It is designed to help the local authority and primary care trust improve the health of children and tackle health inequalities. These profiles are produced by the Child and Maternal Health Observatory (ChiMat) working with East Midlands Public Health Observatory (EMPHO).

The child population in this area

<table>
<thead>
<tr>
<th></th>
<th>Local</th>
<th>East Midlands</th>
</tr>
</thead>
<tbody>
<tr>
<td>Live births in 2009</td>
<td>6,807</td>
<td>53,746</td>
</tr>
<tr>
<td>Children (age 0 - 4 years), 2009</td>
<td>35,000</td>
<td>260,300</td>
</tr>
<tr>
<td>% of total population</td>
<td>5.4%</td>
<td>5.8%</td>
</tr>
<tr>
<td>Children (age 0 - 19 years), 2009</td>
<td>152,200</td>
<td>1,056,500</td>
</tr>
<tr>
<td>% of total population</td>
<td>23.6%</td>
<td>23.7%</td>
</tr>
<tr>
<td>Children (age 0 - 19 years) predicted in 2020</td>
<td>156,000</td>
<td>1,102,900</td>
</tr>
<tr>
<td>% of total population</td>
<td>22.3%</td>
<td>22.6%</td>
</tr>
<tr>
<td>School children from black/ethnic minority group</td>
<td>11,548</td>
<td>92,310</td>
</tr>
<tr>
<td>% of school age population (age 5 - 16 years)</td>
<td>13.7%</td>
<td>16.3%</td>
</tr>
<tr>
<td>% of children (age 0 -15 years) living in poverty</td>
<td>11.3%</td>
<td>19.1%</td>
</tr>
</tbody>
</table>

Children living in poverty

Key findings

- A quarter of the population of Leicestershire is under the age of 20. Around 14% of school children are from a black or minority ethnic group and 11% of children under 16 are living in poverty.

- The health of children in this area is generally similar to or better than the England average. Infant and child mortality rates are similar to the average, as are breastfeeding initiation levels.

- Children in Leicestershire have better than average levels of obesity. 8% of children in Reception and 15% of children in Year 6 are classified as obese. 47% of children participate in more than 3 hours of sport a week.

- Hospital admission rates for alcohol specific stays are better than the England average. Hospital admission rates for substance misuse are similar to the England average. Hospital admission rates for injury are better than the England average. The percentage of children who say they use drugs and who say they have been drunk recently is similar to the England average.

For further information on the health of people in Leicestershire please see the overall Health Profile at www.healthprofiles.info and the Leicestershire Joint Strategic Needs Assessment at www.lsronline.org/reports/leicestershire_joint_strategic_needs_assessment.jsna1

Data sources: Live births, Office for National Statistics (ONS), 2009; population estimates, ONS mid year estimates 2009; population projections, ONS (based on 2008 mid year estimates); black/ethnic minority maintained school population, Department for Education (DfE), 2010; children living in poverty, HM Revenue and Customs (HMRC), 2008.
Percentage of children under 2 years old who have been immunised for MMR, 2009/10

The chart below looks at the percentage of children under 2 years old who have been immunised for measles, mumps and rubella (MMR) by local authority. Increasing and maintaining MMR immunisation levels are key to reducing the incidence of measles, mumps and rubella.

The charts below show the percentage of children classified as obese or being overweight in Reception (aged 4–5 years) and Year 6 (aged 10–11 years) respectively by local authority. The East Midlands has a similar percentage in Reception and Year 6 who are obese and overweight to the England percentage.

Notes: 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.

Summary of child health in Leicestershire

The chart below shows how children's health 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 beneath the chart. Please note: A green circle may still indicate an important public health problem.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Local no. per year</th>
<th>Local value</th>
<th>Eng. ave.</th>
<th>England range</th>
<th>Eng. best</th>
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<tr>
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<td>4.7</td>
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<td>Child mortality rate (age 1-17 years)</td>
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<td>14.7</td>
<td>16.9</td>
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<td>10.7</td>
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<td>Breastfeeding initiation</td>
<td>1303</td>
<td>74.3</td>
<td>74.6</td>
<td>35.7</td>
<td>95.9</td>
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<td>Obese children (age 4-5 years)</td>
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<td>8.2</td>
<td>9.8</td>
<td>14.7</td>
<td>5.5</td>
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<tr>
<td>Obese children (age 10-11 years)</td>
<td>974</td>
<td>15.3</td>
<td>18.7</td>
<td>28.6</td>
<td>12.1</td>
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<td>Participation in at least 3 hours of sport/P.E.</td>
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<td>46.7</td>
<td>49.6</td>
<td>25.0</td>
<td>79.1</td>
</tr>
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<td>Decayed, missing or filled teeth (age 5 years)</td>
<td>-</td>
<td>1.1</td>
<td>1.1</td>
<td>2.5</td>
<td>9.9</td>
</tr>
<tr>
<td>Children who have someone to talk to</td>
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<td>89.0</td>
<td>94.0</td>
<td>96.0</td>
<td>74.0</td>
</tr>
<tr>
<td>Teenage conception rate (age &lt;18 years)</td>
<td>391</td>
<td>32.1</td>
<td>41.0</td>
<td>74.5</td>
<td>15.4</td>
</tr>
<tr>
<td>Under 18 conceptions ending in abortion</td>
<td>212</td>
<td>54.2</td>
<td>49.7</td>
<td>74.6</td>
<td>35.3</td>
</tr>
<tr>
<td>Pupils who say that they have been bullied</td>
<td>-</td>
<td>52.0</td>
<td>23.0</td>
<td>38.0</td>
<td>15.0</td>
</tr>
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<td>Hospital admission rate due to injury (age &lt;18 years)</td>
<td>1771</td>
<td>1328.4</td>
<td>1443.2</td>
<td>2361.9</td>
<td>901.8</td>
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<tr>
<td>MMR immunisation (by age 2 years)</td>
<td>6674</td>
<td>92.7</td>
<td>88.2</td>
<td>73.0</td>
<td>96.7</td>
</tr>
<tr>
<td>Children in care immunisations</td>
<td>155</td>
<td>71.0</td>
<td>83.9</td>
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<tr>
<td>Percentage change in children killed/enously injured in RTA</td>
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<td>8.3</td>
<td>6.4</td>
<td>72.2</td>
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<td>Primary school exclusions</td>
<td>9</td>
<td>0.02</td>
<td>0.02</td>
<td>0.1</td>
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<tr>
<td>Secondary school exclusions</td>
<td>72</td>
<td>0.16</td>
<td>0.17</td>
<td>0.6</td>
<td>0.0</td>
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<tr>
<td>Children working securely at foundation stage</td>
<td>-</td>
<td>53.0</td>
<td>51.0</td>
<td>36.0</td>
<td>79.0</td>
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<tr>
<td>GCSE pass rate (5A*-C) - Male</td>
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<td>70.1</td>
<td>70.8</td>
<td>57.8</td>
<td>92.1</td>
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<tr>
<td>GCSE pass rate (5A*-C) - Female</td>
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<td>78.8</td>
<td>79.0</td>
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<td>91.6</td>
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<td>GCSE pass rate (5A*-C) for children in care</td>
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<td>81.1</td>
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<td>Hospital admissions due to alcohol specific conditions (&lt; 18 years)</td>
<td>64</td>
<td>51.8</td>
<td>64.5</td>
<td>168.6</td>
<td>43.0</td>
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<tr>
<td>Hospital admissions due to substance misuse (age 15-24 years)</td>
<td>51</td>
<td>58.4</td>
<td>62.8</td>
<td>175.5</td>
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<tr>
<td>Children and young people using drugs</td>
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<td>4.0</td>
<td>13.0</td>
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<tr>
<td>Children and young people using alcohol</td>
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<td>17.0</td>
<td>15.0</td>
<td>23.0</td>
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<td>First time entrants to the Youth Justice System</td>
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<td>915.0</td>
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<td>2090.0</td>
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<td>1.1</td>
<td>2.1</td>
<td>0.4</td>
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<tr>
<td>Participation in positive activities</td>
<td>-</td>
<td>88.3</td>
<td>65.8</td>
<td>48.6</td>
<td>90.4</td>
</tr>
<tr>
<td>Not in education, employment or training (age 16-18 years)</td>
<td>370</td>
<td>3.9</td>
<td>6.4</td>
<td>11.9</td>
<td>1.8</td>
</tr>
<tr>
<td>Rate of family homelessness</td>
<td>265</td>
<td>1.1</td>
<td>1.9</td>
<td>7.3</td>
<td>0.1</td>
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<tr>
<td>Percentage of children living in poverty (age &lt;16 years)</td>
<td>12890</td>
<td>11.3</td>
<td>21.6</td>
<td>55.3</td>
<td>7.1</td>
</tr>
</tbody>
</table>

Notes and definitions

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

1. Rate per 1,000 live births (age under 1 year), 2007-09. ONS
2. Directly standardised rate per 100,000 (age 1-7 years), 2001-09. ONS
3. % of mothers initiating breastfeeding where status known, 2010/11 (Q2). Vital Signs Monitoring Return. Department of Health (DH)
4. % school children in Reception year, 2009/10. NCPM. NHS IC
5. % school children in Year 6, 2009/10. NCPM. NHS IC
6. % of young people (Year 10) who have participated in any group activity led by an adult outside school lessons and/or claiming they participated in one or more structured activities. NI 110. Tellus4 survey. NFER.
7. Rate of proven re-offending by young offenders, 2009/10. NI 19. Youth Offending Team survey. NFER
8. % of children who reported that they have taken cannabis or skunk one or more times in the last four weeks, 2009. Tellus4 survey. NFER
9. % of children who reported that they have been drunk one or more times in the last four weeks, 2009. Tellus4 survey. NFER
10. % of pupils at the end of Key Stage 4 achieving 5 A*-C GCSEs, 2009/10 (provisional). DfE
11. % of pupils at the end of Key Stage 4 achieving 5 A*-C GCSEs, 2008/09 (provisional). DfE
12. % of female pupils at the end of Year 11 achieving 5 A*-C GCSEs, 2009/10 (provisional). DfE
13. % of children (years 8 and 10) who reported that they have taken cannabis or shabu one or more times in the last four weeks, 2009. Tellus4 survey. NFER
14. % of children who reported that they had been drunk one or more times in the last four weeks, 2009. Tellus4 survey. NFER
15. % of family homelessness receiving their first reprimand, warning or conviction per 100,000 population, 2008/09. DfE
16. % of young people (age 10-17 years) receiving their first reprimand, warning or conviction per 100,000 population, 2008/09. DfE
17. % of children permanently excluded from secondary school, 2008/09. DfE
18. % of pupils at the end of Key Stage 4 achieving 5 A*-C GCSEs, 2008/09 (provisional). DfE
19. % of pupils at the end of Key Stage 4 achieving 5 A*-C GCSEs, 2009/10 (provisional). DfE
20. % of pupils at the end of Key Stage 4 achieving 5 A*-C GCSEs, 2009/10 (provisional). DfE
21. % of female pupils at the end of Year 11 achieving 5 A*-C GCSEs, 2010. DfE
22. % of pupils at the end of Key Stage 4 achieving 5 A*-C GCSEs, 2009/10 (provisional). DfE
23. Alcohol specific hospital admissions, crude rate per 100,000, (age under 18 years), 2006-07-2008/09. Local Alcohol Profiles for England (LAPE)
24. Hospital admissions due to substance misuse, directly standardised rate per 100,000, (age 15-24 years), 2005/06-2008/09. HES
25. % of children (years 8 and 10) who reported that they have taken cannabis or shabu one or more times in the last four weeks, 2009. Tellus4 survey. NFER
26. % of children who reported that they had been drunk one or more times in the last four weeks, 2009. Tellus4 survey. NFER
27. % of young people (age 10-17 years) receiving their first reprimand, warning or conviction per 100,000 population, 2008/09. DfE
28. % of young people (age 10-17 years) receiving their first reprimand, warning or conviction per 100,000 population, 2008/09. DfE
29. % of young people (Year 10) who have participated in any group activity led by an adult outside school lessons and/or claiming they participated in one or more structured activities. NI 110. Tellus4 survey. NFER
30. % of school children in Year 1 to Year 6, 2010/11. ONS/Teenage Pregnancy Unit
31. % of school children in Year 1 to Year 6, 2008/09. NCPM. NHS IC
32. % of school children in Year 1 to Year 6, 2009/10. NCPM. NHS IC
33. % of school children in Year 1 to Year 6, 2009/10. NCPM. NHS IC
34. % of school children in Year 1 to Year 6, 2009/10. NCPM. NHS IC
35. % of school children in Year 1 to Year 6, 2009/10. NCPM. NHS IC
36. % of school children in Year 1 to Year 6, 2009/10. NCPM. NHS IC
Child health summary for the East Midlands by local authority

This table provides a snapshot of child health in the region. It shows how each local authority compares to the England average across the range of indicators used in the profile. A square is coloured according to the difference between the local authority and the England average. The key to the colours is explained beneath the chart.

Please note: A green box may still indicate an important public health problem.

<table>
<thead>
<tr>
<th></th>
<th>Be healthy</th>
<th>Stay safe</th>
<th>Enjoy and achieve</th>
<th>Making a positive contribution</th>
<th>AEWB</th>
</tr>
</thead>
<tbody>
<tr>
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<tr>
<td>Derby</td>
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<td>Derbyshire</td>
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<td>Leicester</td>
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<td>Leicestershire</td>
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<td>Lincolnshire</td>
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<td>Northamptonshire</td>
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<td>Nottingham</td>
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<tr>
<td>Nottinghamshire</td>
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<tr>
<td>Rutland</td>
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</tbody>
</table>

Limitations of profiles

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<table>
<thead>
<tr>
<th>Indicator</th>
<th>Derbyshire</th>
<th>Leicester</th>
<th>Leicestershire</th>
<th>Lincolnshire</th>
<th>Northamptonshire</th>
<th>Nottingham</th>
<th>Rutland</th>
</tr>
</thead>
<tbody>
<tr>
<td>Be healthy</td>
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<td>Infant mortality rate (age 1-17 years)</td>
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<tr>
<td>Breastfeeding initiation (age 0-1 year)</td>
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<tr>
<td>Decayed, missing or filled teeth (age 5 years)</td>
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<tr>
<td>Children who have someone to talk to</td>
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<tr>
<td>Teenage conception rate (age &lt;18 years)</td>
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<tr>
<td>Under 18 conceptions ending in abortion</td>
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<tr>
<td>MMR immunisation (by age 2 years)</td>
<td></td>
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<td>Children in care immunisations</td>
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<tr>
<td>Children killed/seriously injured in RTA</td>
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<tr>
<td>Primary school exclusions</td>
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<td>Secondary school exclusions</td>
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<td>Children working securely at foundation stage</td>
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<tr>
<td>GCSE pass rate (5 A*-C)</td>
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<tr>
<td>GCSE pass rate (5 A*-C) - Male</td>
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<tr>
<td>GCSE pass rate (5 A*-C) - Female</td>
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<tr>
<td>Hospital admissions due to alcohol specific conditions (&lt; 18 years)</td>
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<tr>
<td>Hospital admissions due to substance misuse (age 15-24 years)</td>
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<tr>
<td>Participation in positive activities</td>
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<tr>
<td>Not in education, employment or training (age 16-18 years)</td>
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<td>Ace Matriculation</td>
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<tr>
<td>Rate of family homelessness</td>
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<td></td>
</tr>
<tr>
<td>Percentage of children living in poverty (age &lt;16 years)</td>
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<td></td>
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<td></td>
<td></td>
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<tr>
<td>Limitations of profiles</td>
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<td></td>
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</tbody>
</table>

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Acknowledgements

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Child Health Profile

Rutland

February 2011

This profile provides a snapshot of child health in this area. It is designed to help the local authority and primary care trust improve the health of children and tackle health inequalities.

These profiles are produced by the Child and Maternal Health Observatory (ChiMat) working with East Midlands Public Health Observatory (EMPHO).

The child population in this area

<table>
<thead>
<tr>
<th></th>
<th>Local</th>
<th>East Midlands</th>
</tr>
</thead>
<tbody>
<tr>
<td>Live births in 2009</td>
<td>353</td>
<td>53,746</td>
</tr>
<tr>
<td>Children (age 0 - 4 years), 2009</td>
<td>1,800</td>
<td>260,300</td>
</tr>
<tr>
<td>% of total population</td>
<td>4.7%</td>
<td>5.8%</td>
</tr>
<tr>
<td>Children (age 0 - 19 years), 2009</td>
<td>10,600</td>
<td>1,056,500</td>
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<tr>
<td>% of total population</td>
<td>27.6%</td>
<td>23.7%</td>
</tr>
<tr>
<td>Children (age 0 - 19 years) predicted in 2020</td>
<td>10,700</td>
<td>1,102,900</td>
</tr>
<tr>
<td>% of total population</td>
<td>25.5%</td>
<td>22.6%</td>
</tr>
<tr>
<td>School children from black/ethnic minority group</td>
<td>186</td>
<td>92,310</td>
</tr>
<tr>
<td>% of school age population (age 5 - 16 years)</td>
<td>4.2%</td>
<td>16.3%</td>
</tr>
<tr>
<td>% of children (age 0 -15 years) living in poverty</td>
<td>7.7%</td>
<td>19.1%</td>
</tr>
</tbody>
</table>

Children living in poverty

Data sources: Live births, Office for National Statistics (ONS), 2009; population estimates, ONS mid year estimates 2009; population projections, ONS (based on 2008 mid year estimates); black/ethnic minority maintained school population, Department for Education (DfE), 2010; children living in poverty, HM Revenue and Customs (HMRC), 2008

Key findings

- A quarter of the population of Rutland is under the age of 20.
- Around 4% of school children are from a black or minority ethnic group and 8% of children under 16 are living in poverty - in both cases lower than the England average.
- The health of children in this area is generally similar to, or in some cases better than the England average. Infant and child mortality rates are similar to the average, and breastfeeding initiation levels are similar to the average.
- Children in Rutland have average levels of obesity. 7% of children in Reception and 18% of children in Year 6 are classified as obese. 38% of children participate in more than 3 hours of sport a week.
- Hospital admission rates for alcohol specific stays are better than the England average. Hospital admission rates for injury are better than the England average. The percentage of children who say they have been drunk recently is similar to the England average.

For further information on the health of people in Rutland please see www.rutland.gov.uk, and the overall Health Profile at www.healthprofiles.info
Percentage of children under 2 years old who have been immunised for MMR, 2009/10

The chart below looks at the percentage of children under 2 years old who have been immunised for measles, mumps and rubella (MMR) by local authority. Increasing and maintaining MMR immunisation levels are key to reducing the incidence of measles, mumps and rubella.

The charts below show the percentage of children classified as obese or being overweight in Reception (aged 4–5 years) and Year 6 (aged 10–11 years) respectively by local authority. The East Midlands has a similar percentage in Reception and Year 6 who are obese and overweight to the England percentage.

Children classified as obese or overweight, Reception (aged 4 – 5 years), 2009/10

Children classified as obese or overweight, Year 6 (aged 10 – 11 years), 2009/10

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

## Summary of child health in Rutland

The chart below shows how children’s health 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 beneath the chart. Please note: A green circle may still indicate an important public health problem.

## Indicator Details

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Local no.</th>
<th>Local value</th>
<th>England range</th>
<th>Eng. back</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Infant mortality rate</td>
<td>2</td>
<td>4.7</td>
<td>8.5</td>
<td>2.2</td>
</tr>
<tr>
<td>2. Child mortality rate (age 1-17 years)</td>
<td>1</td>
<td>13.5</td>
<td>16.9</td>
<td>38.0</td>
</tr>
<tr>
<td>3. Breastfeeding initiation</td>
<td>68</td>
<td>74.3</td>
<td>74.6</td>
<td>35.7</td>
</tr>
<tr>
<td>4. Obese children (age 4-5 years)</td>
<td>24</td>
<td>6.8</td>
<td>9.8</td>
<td>14.7</td>
</tr>
<tr>
<td>5. Obese children (age 10-11 years)</td>
<td>53</td>
<td>17.8</td>
<td>18.7</td>
<td>28.6</td>
</tr>
<tr>
<td>6. Participation in at least 3 hours of sport/PE</td>
<td>1707</td>
<td>38.1</td>
<td>49.6</td>
<td>5.0</td>
</tr>
<tr>
<td>7. Decayed, missing or filled teeth (age 5 years)</td>
<td>-</td>
<td>0.7</td>
<td>1.1</td>
<td>2.5</td>
</tr>
<tr>
<td>8. Children who have someone to talk to</td>
<td>69.0</td>
<td>64.0</td>
<td>56.0</td>
<td>74.0</td>
</tr>
<tr>
<td>9. Teenage conception rate (age &lt;18 years)</td>
<td>19</td>
<td>15.4</td>
<td>41.0</td>
<td>74.5</td>
</tr>
<tr>
<td>10. Under 18 conceptions ending in abortion, 2006-08. ONS/Teenage Pregnancy Unit</td>
<td>13</td>
<td>71.4</td>
<td>49.7</td>
<td>74.6</td>
</tr>
<tr>
<td>11. Pupils who say that they have been bullied</td>
<td>-</td>
<td>20.0</td>
<td>23.0</td>
<td>38.0</td>
</tr>
<tr>
<td>12. Hospital admission rate due to injury (age &lt;18 years)</td>
<td>95</td>
<td>1012.5</td>
<td>1443.2</td>
<td>2351.9</td>
</tr>
<tr>
<td>13. MMR immunisation (by age 2 years)</td>
<td>6674</td>
<td>92.7</td>
<td>88.2</td>
<td>73.0</td>
</tr>
<tr>
<td>14. Children in care immunisations</td>
<td>10</td>
<td>100.0</td>
<td>83.9</td>
<td>0.0</td>
</tr>
<tr>
<td>15. Percentage change in children killed/seriously injured in RTA</td>
<td>-900.0</td>
<td>6.4</td>
<td>72.2</td>
<td>0.1</td>
</tr>
<tr>
<td>16. Primary school exclusions</td>
<td>9</td>
<td>8.0</td>
<td>0.0</td>
<td>0.1</td>
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<tr>
<td>17. Secondary school exclusions</td>
<td>-</td>
<td>0.1</td>
<td>1.6</td>
<td>0.0</td>
</tr>
<tr>
<td>18. Children working security at foundation stage</td>
<td>-</td>
<td>67.0</td>
<td>51.0</td>
<td>36.0</td>
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<tr>
<td>19. GCSE pass rate (5A*-C)</td>
<td>371</td>
<td>66.6</td>
<td>74.6</td>
<td>63.3</td>
</tr>
<tr>
<td>20. GCSE pass rate (5A*-C) - Male</td>
<td>175</td>
<td>69.7</td>
<td>73.4</td>
<td>57.8</td>
</tr>
<tr>
<td>21. GCSE pass rate (5A*-C) - Female</td>
<td>202</td>
<td>83.8</td>
<td>79.0</td>
<td>65.7</td>
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<tr>
<td>22. GCSE pass rate (5A*-C) for children in care</td>
<td>-</td>
<td>9.8</td>
<td>26.1</td>
<td>0.0</td>
</tr>
<tr>
<td>23. Hospital admissions due to alcohol specific conditions (&lt; 18 years)</td>
<td>-</td>
<td>14.3</td>
<td>64.5</td>
<td>168.6</td>
</tr>
<tr>
<td>24. Hospital admissions due to substance misuse (age 15-24 years)</td>
<td>-</td>
<td>62.6</td>
<td>175.5</td>
<td>21.3</td>
</tr>
<tr>
<td>25. Children and young people using drugs</td>
<td>1</td>
<td>4.0</td>
<td>13.0</td>
<td>0.0</td>
</tr>
<tr>
<td>26. Children and young people using alcohol</td>
<td>-</td>
<td>16.0</td>
<td>15.0</td>
<td>23.0</td>
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<tr>
<td>27. First time entrants to the Youth Justice System</td>
<td>15</td>
<td>270.0</td>
<td>1472.0</td>
<td>2900.0</td>
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<tr>
<td>28. Reoffending rates</td>
<td>-</td>
<td>-</td>
<td>1.1</td>
<td>2.1</td>
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<tr>
<td>29. Participation in positive activities</td>
<td>-</td>
<td>69.6</td>
<td>65.8</td>
<td>48.6</td>
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<tr>
<td>30. Not in education, employment or training (age 16-18 years)</td>
<td>10</td>
<td>1.8</td>
<td>6.4</td>
<td>11.9</td>
</tr>
<tr>
<td>31. Rate of family homelessness</td>
<td>34</td>
<td>2.3</td>
<td>1.9</td>
<td>7.3</td>
</tr>
<tr>
<td>32. % of children in poverty (age &lt;16 years)</td>
<td>465</td>
<td>7.7</td>
<td>21.6</td>
<td>55.3</td>
</tr>
</tbody>
</table>

### Notes and definitions

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

1. Rate per 1,000 live births (age under 1 year), 2007-09. ONS.
2. Directly standardised rate per 100,000 (age 1-17 years), 2001-09. ONS.
4. % of school children in Reception year, 2009/10, NCMP. NHS IC.
5. % of children in Year 6, 2009/10, NCMP. NHS IC.
6. % of children participating in at least 3 hours per week of high quality PE and sport at school (age 5-16 years), Annual Survey of School Sport Partnerships, 2008/09 via APHO health profiles.
7. Average (mean) number of teeth per child which were actively decayed, filled or had been extracted (age 5 years), 2007/08. Dental Observatory via APHO health profiles.
8. % of children who reported that they can talk to their mum or dad when they are worried, 2007. TellSure survey, National Foundation for Educational Research (NFER).
9. Under 10 conception rate per 1,000 females (age 15-17 years), 2006-08. ONS/Teenage Pregnancy Unit.
10. % of children who reported that they had been bullied most days at school, 2009. TellSure survey, NFER.
11. Hospital admissions following all injury (age 0-17 years) crude rate per 100,000, 2006/07-2009/10. Hospital Episode Statistics (HES).
12. % of children immunised against measles, mumps and rubella (MMR) (age 2 years), 2009/10. NHS IC.
13. % of children in care whose immunisations were up-to-date, 2008, DfE.
14. % of children permanently excluded from primary school, 2008/09. DfE.
Child health summary for the East Midlands by local authority

This table provides a snapshot of child health in the region. It shows how each local authority compares to the England average across the range of indicators used in the profile. A square is coloured according to the difference between the local authority and the England average. The key to the colours is explained beneath the chart.

Please note: A green box may still indicate an important public health problem.

<table>
<thead>
<tr>
<th></th>
<th>Be healthy</th>
<th>Stay safe</th>
<th>Enjoy and achieve</th>
<th>Making a positive contribution</th>
<th>AEWB</th>
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<tbody>
<tr>
<td>Infant mortality rate</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Child mortality rate</td>
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<td></td>
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<tr>
<td>Breastfeeding initiation</td>
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<td>Child Renal Failure</td>
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<tr>
<td>Participation at age 5</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Diabetes at age 3</td>
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<tr>
<td>Obesity at age 10-11</td>
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<td></td>
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<tr>
<td>Under 18 conceptions</td>
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<td>MMR immunisation</td>
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<tr>
<td>Hospital admission rate</td>
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<td></td>
</tr>
<tr>
<td>Hospital admissions due to alcohol specific conditions</td>
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<tr>
<td>Children working securely at foundation stage</td>
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<td></td>
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<tr>
<td>Participation in positive activities</td>
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<td>Full time exclusion up to Foundation Stage</td>
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<tr>
<td>Not in education, employment or training (age 16-18 years)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Rate of family homelessness</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of children living in poverty (age &lt;16 years)</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Limitations of profiles**

This profile is intended to give an overview of child health outcomes in a local area at the time of analysis. Inevitably there will be gaps in our knowledge and ambiguities in certain fields of data for which we apologise. For the most recent data available, you should visit Data Atlas on ChiMat’s website.

**Acknowledgements**

These profiles are loosely based on child health profiles for the East of England (ERPHO) and APHO’s national health profiles which we acknowledge as a valuable contribution.
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51 National Drug Treatment Monitoring System 2011


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IMMUNISATION

Is your child protected?

Immunisations are essential – not scary!

Protect your child from measles, meningitis, pneumonia and other serious diseases

Keep your child’s immunisation schedule up to date

Find out more from your doctor, practice nurse, health visitor, school nurse or visit www.immunisation.nhs.uk