
FROM 0-19:

A CHILDREN'S NEEDS ASSESSMENT

Part of Harrow's Joint Strategic Needs Assessment (JSNA)

1 THIS JSNA REPORT

This 0-19 needs assessment supports the commissioning of the 0-19 public health nursing services.

It specifically aims to describe:

- the prevalence, trends and characteristics of children and young people aged 0-19;
- the current service provision with regards to health and social care and
- the evidence for interventions provided by health visitors and school nurses.

Data was collected from a number of sources including

- NHS Digital;
- Public Health England;
- 2011 census from the Office for National Statistics;
- Department for Education;
- and local data provided by the council, other stakeholders and providers.

The stakeholder and user voice was provided by interviews, focus groups and a stakeholder engagement event. Two on-line questionnaires were circulated – one for professionals and stakeholders and a second for those using the services including parents, carers and young people.

2 AUTHORS AND CONTRIBUTORS

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4 CONTENTS

1	This JSNA report	ii
2	Authors and contributors.....	ii
3	Acknowledgements	ii
4	CONTENTS.....	iii
5	Executive summary.....	1
5.1	Main findings.....	1
5.2	Recommendations	2
6	Introduction	3
6.1	Scope and definitions.....	3
6.2	Relation to commissioning.....	5
7	Population need	6
7.1	Population numbers.....	6
7.2	Births and fertility rates	6
7.3	Variation in child population.....	10
7.4	Ethnicity	11
7.5	Children with a disability.....	13
7.6	Young Carers	15
7.7	Mental Health	15
7.8	Children living in Poverty	20
7.9	Under 18 conception rates and trends	22
7.10	Maternal and Infant Health	23
7.11	Deaths in Childhood.....	26
7.12	Lifestyle: Childhood Obesity	28
7.13	Lifestyle: Physical Activity	31
7.14	Lifestyle: Tooth Decay	32

7.15 Lifestyle: Tobacco, alcohol and drugs	33
8 Local services.....	35
8.1 Children’s Services	35
8.2 Children Looked After	39
8.3 Young Carers	42
8.4 Youth Offending.....	43
9 Education	45
9.1 Preschool / Early Years.....	45
9.2 Schools	46
10 Health Services	55
10.1 . Immunisation	55
10.2 A&E Attendances	59
10.3 Hospital Admissions	59
10.4 Outcome and Performance measures	Error! Bookmark not defined.
10.5 Other Assets.....	Error! Bookmark not defined.
11 Evidence of what works	65
11.1 Healthy Child Programme 0-5.....	66
11.2 Transition to parenthood –healthy lifestyle, contraceptive and sexual health..	66
11.3 Transition to parenthood – smoking cessation	67
11.4 Transition to parenthood –secure attachment and bonding	67
11.5 Maternal Mental Health	68
11.6 Breastfeeding	68
11.7 Healthy Weight	69
11.8 Managing minor illnesses and accident prevention	69
11.9 Healthy two-year-olds and school readiness.....	70
11.10 The Healthy Child Programme (5-19)	70
12 User and other stakeholder views	72

12.1 Key themes and recommendations 72

13 Recommendations.....Error! Bookmark not defined.

13.1 Recommendations for commissioners **Error! Bookmark not defined.**

13.2 Further research..... **Error! Bookmark not defined.**

14 References 74

5 EXECUTIVE SUMMARY

5.1 MAIN FINDINGS

- Children and Young people aged 0-19 years make up around a quarter of the population of Harrow. This population will continue to grow over the next 10 and 20 years increasing by 4% and 9% respectively.
- Births continue to rise in Harrow with a 5% increase seen in the last 5 years over the next 10 years is estimated to increase by a further 4%. Fertility rates in Harrow are higher than the London and England averages
- More new mothers in Harrow are aged 30-34 than is seen nationally. Seven out of ten births in Harrow are to non-UK born mothers and almost 2 in 5 births are to first time mothers.
- The under 19 population reflects the increasing ethnic diversity in Harrow with the largest ethnic group being Asian Indian population, followed by the White British and then Other Asian
- The rate of children with learning disability know to schools in Harrow is similar to London but lower than the England average. 1.5% of primary pupils and 1.9% high school pupils have a statement/EHCP. Very few children under 5 have a statement/EHCP and almost all of the special school population had a statement/EHCP in 2016.
- The speech and language therapy active caseload has increased by 20% since 2014.
- 1.15% of children under the age of 15 provide unpaid care in Harrow slightly higher than the rates of London and England but we know there are likely to be many more that are unidentified.
- There are an estimated 3,171 children and young people aged 5-16 who have any mental health problem: the majority (1909) having conduct disorders and a further estimated 7,000 young people ages 16-25 who have either an eating disorder or ADHD. (These estimates come with broad caveats described in the text).
- Infant mortality, neonatal mortality and perinatal mortality rates have come down in recent years however, the key risk factors that still need to be addressed in Harrow include reducing children in poverty; reducing homelessness in families with children and in pregnant women; reducing overcrowding; reducing the rate of low birth weight babies; reducing late antenatal booking; and increasing vaccination rates by 1 year of age.
- The rate of tooth decay in young children is higher than the London average. This is amenable to preventive action to reduce pain discomfort and need for tooth extraction under anaesthetic.
- More than one in six reception year pupils, rising to one in three year 6 pupils have excess weight. Rates of obesity in year 6 and rates of obesity and overweight in reception children remain lower than the regional and national figures and are decreasing, but rates children who are overweight in year 6 have increased. Addressing childhood obesity needs to include work on healthy diets and on reducing increasingly sedentary lifestyles and increasing physical activity.
-

- Although smoking and drinking rates are lower than the national rate, recent use of cannabis has a higher rate than is seen nationally.
- In the last three years, the number of new CPPs has increased significantly in Harrow and is now in line with statistical neighbour average with emotional abuse being the largest category.
- In December 2016, 200 children were looked after, an increase of over 10% on the previous year. Rates of timely health assessments have been improving.
- A&E attendances for under 5s has increased dramatically but this is not accompanied by an increase in admissions. Further work is needed to identify the reasons for the attendances and identify the potential role for health visitors.
- Over 72% of children achieve a EYFS good level of development in early years settings.
- In 2015-16, there were over 35,000 pupils in Harrow's state-funded schools, a number that has been increasing annually. A further 160 primary and 80 secondary places are estimated to be needed by the 2018/19 school year. Harrow schools are very popular. There has been a significant increase in the number of children residing outside of Harrow attending Harrow schools.
- There has been a steady decline in the percentage of pupils eligible for free school meals in Harrow schools so only one in ten pupils are now eligible.
- The percentage of primary school children with persistent absences has decreased in Harrow and in secondary schools they remain much lower than the national average.

5.2 RECOMMENDATIONS

There are a number of areas highlighted by this needs assessment:

- The ethnic diversity of the population means that services need to be responsive to the needs of the population.
- Early pregnancy booking is vital in reducing both low weight babies and reducing risk of neonatal and infant mortality. Data needs to be collected and shared by the CCG.
- Clinicians need to be aware of potential young carers and refer into support services.
- Prevention measures need to focus on three main areas in the first instance:
 - reducing child excess weight, promoting healthy eating and physical activity;
 - reducing the incidence of dental caries and promoting good oral health; and
 - reducing the risk of accidents and injuries.
- Reducing the numbers of children presenting at A&E needs to be further explored and actions taken by health visitors e.g. by raising awareness of home treatment of minor ailments.

6 INTRODUCTION

Transition to parenthood and the first 1001 days from conception to age 2 is widely recognised as a crucial period that will have an impact and influence on the rest of the life course. So giving each child the best start in life and keeping them safe is essential¹ (Fair society, healthy lives The Marmot review 2010). Pregnancy and the first years of life is a time when parents are particularly receptive to learning and making changes. There is good evidence that the outcomes for both children and adults are strongly influenced by the factors that operate during pregnancy and the first years of life and the benefits of interventions during the early years of childhood are realised both in the short-term and over the entire life course of children.

6.1 SCOPE AND DEFINITIONS

6.1.1 SCOPE

This needs assessment looks at the population aged 0-19 and its needs with regards to school nursing (for children aged 5 and over) and health visiting (for parents and children under age 5). It considers the changing demography, the risk factors affecting children's health and wellbeing such as parental health and wellbeing, education, long term conditions and disabilities and health outcomes with particular reference to preventive actions.

This needs assessment does not cover health conditions in detail.

6.1.2 DEFINITIONS

Health Visitors	<p>Health Visitors are highly trained specialist public health nurses. Health Visiting teams lead and deliver the Healthy Child Programme (an early intervention and prevention public health programme) for all children aged 0-5.</p> <p>The scope of work involves a wide range of interventions and activities at a population and community level as well as at family and individual level. These are best described through</p> <ul style="list-style-type: none"> • the four stepped Health Visiting Service Model : • the five mandated checks of the Department of Health's Healthy Child Programme (HCP) 0-5 • and the Six High Impact Areas
Health Visiting Service Model	<p>A tiered approach dependent on levels of need.</p> <ul style="list-style-type: none"> • Community Action – links families to resources and builds community capacity • Universal Services – primary prevention services and early intervention as part of the HCP; • Universal Plus – time limited support on specific issues where a need has been identified or expressed • Universal Partnership plus – offered to families with a need for ongoing support and multiagency involvement
Healthy Child Programme (HCP)- 0-5	<p>A prevention and early intervention public health programme that aims to support parents, promote child development, improve child outcomes and ensure children at risk are identified at the earliest opportunity. It encompasses five mandated checks for all children the following stages –</p> <ul style="list-style-type: none"> • Antenatal;

	<ul style="list-style-type: none"> • 10-14 days; • 6-8 weeks; • 1 year; • 2.5 years
Six High Impact Areas	<p>The areas of intervention that have the biggest benefit on a child's life and future health:</p> <ul style="list-style-type: none"> • the Transition to parenthood • maternal mental health • breast feeding • healthy weight, nutrition and physical activity • Reducing minor illnesses and accidents • Health and wellbeing development of the child at age 2 – integrated review to ensure readiness for school.
School nurses	<p>School nurses are qualified and registered nurses or midwives many of whom have chosen to gain additional experience, training and qualifications to become specialist community public health nurses (SCPHN - SN). Their additional training in public health helps them to support children and young people in making healthy lifestyle choices, enabling them to reach their full potential and enjoy life. They deliver the Healthy Child Programme (HCP) – 5-19².</p>
Healthy Child Programme (HCP) – 5-19	<p>The Healthy Child Programme 5-19 is a good practice framework for prevention and early intervention services for children and young people aged 5–19 and 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 Healthy Child Programme (5-19) aims to:</p> <ul style="list-style-type: none"> • Help parents develop and sustain a strong bond with children; • Encourage care that keeps children healthy and safe; • Protect children from serious disease, through screening and immunisation; • Reduce childhood obesity by promoting healthy eating and physical activity; • Identify health issues early, so support can be provided in a timely manner; • Make sure children are prepared for and supported in education settings; • Identify and help children, young people and families with problems that might affect their chances later in life.

6.1.3 ROLE OF HEALTH VISITING SERVICES

Health Visitors use every opportunity they have with a family to review the welfare of the child taking into consideration the child's developmental needs, both physical and emotional; the parents' capacity to raise the child safely; and other family and environmental factors such as employment, housing, and social integration. They recognise the role of the father and other adults in the child's life and are alert to potential

abuse, domestic violence, mental health problems or substance misuse problems in the family.

Health Visitors have an important role in safeguarding at all levels: from early identification of potential risk, developmental delay and promoting healthy behaviours and home safety, to identification of high risk factors to supporting families with identified safeguarding issues. The Health Visitors work closely with colleagues from children's social care, staff in children's centres, GPs and their staff, and with school nurses on transition to school and where there are older siblings.

6.1.4 ROLE OF SCHOOL NURSING SERVICES

School nurses work across education and health, providing a link between school, home and the community. Their aim is improve the health and wellbeing of children and young people from five to nineteen. School nursing offers children and young people a schedule of health and development reviews, screening tests, immunisations, health promotion guidance and tailored support for children and families, with additional support when they need it most. They are usually linked to a school or group of schools providing the support outlined in the Healthy Child Programme 5-19.

School nurses have a significant role in safeguarding and in supporting vulnerable children and those children who are not in school, e.g. children in care, young carers, home educated children or young offenders. They support the refreshed health offer as part of the Troubled Families³ programme. They also advise on common childhood conditions such as asthma, diabetes and eczema, working closely with general practitioners, health visitors and other health and social care staff.

6.2 RELATION TO COMMISSIONING

This needs assessment was specifically requested to support the commissioning of a 0-19 nursing service, encompassing health visiting and school nursing. The information will also be useful to commissioners of other children's services such as paediatric/children's community nursing.

7 POPULATION NEED

7.1 POPULATION NUMBERS

7.1.1 KEY MESSAGES

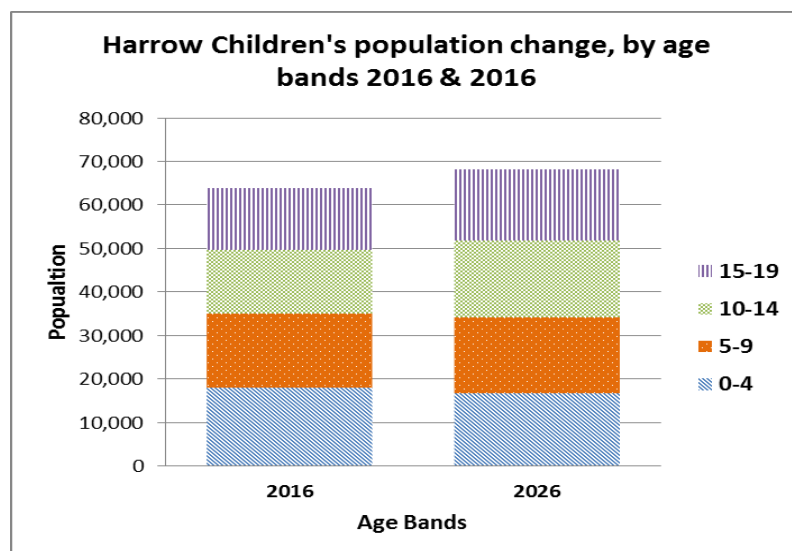
- Children and Young, 0-19 years make up around a quarter of the population of Harrow
- 0-19 population will continue to grow over the next 10 and 20 years increasing by 4% and 9% respectively

With around 63,900 children and young people, Harrow's 0-19 population makes up around 25% of the overall population. Within the 0-19 group, those aged 0-4 years make up the largest proportion.

We have used the Greater London Authority's short population projections, which are in line with the Office for National Statistics (ONS) sub national population estimates to look at the changes expected over the next 10 years to 2026. These show that the children and young people's population in Harrow is projected to increase by an overall 6% to 68,117.

Figure 1 presents the projections and shows an increase in each age band except the 0-4 years. However, these projections are updated on a regular basis and whilst the short term trend suggests a decline in number on the youngest group, the long term trend notes an increase of up to 9% over the next 20 years. This is supported by what we are seeing from the ONS records of births currently, and explained further in the analysis of births below.

FIGURE 1 POPULATION PROJECTIONS BY AGE BAND



SOURCE : GLA 2015 POPULATION PROJECTIONS

7.2 BIRTHS AND FERTILITY RATES

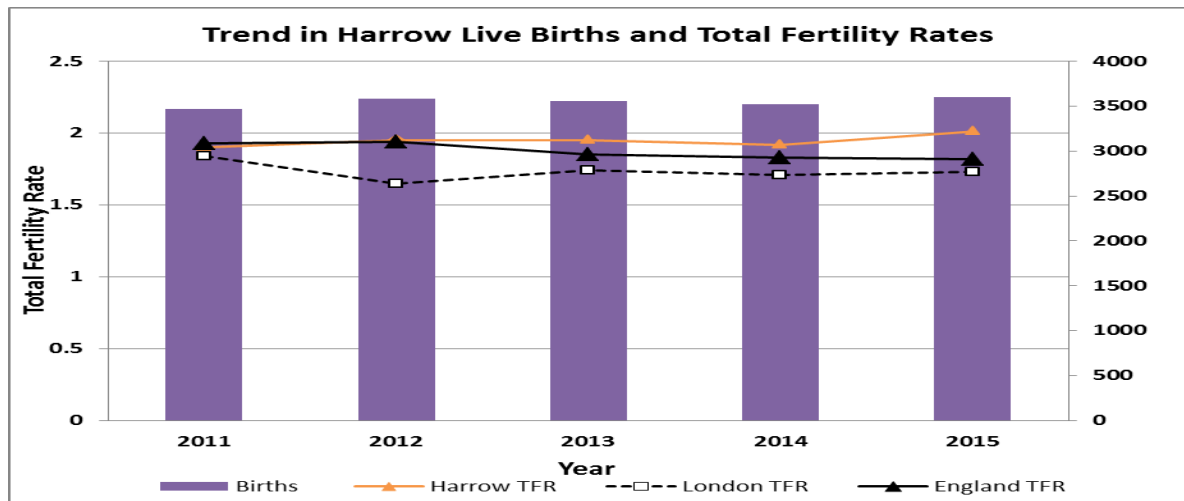
7.2.1 KEY MESSAGES

- Births continue to rise in Harrow with a 5% increase seen in the last 5 years
- Projected increase in births over the next 10 years is estimated to be around 4%

- Both Total Fertility Rates (TFR) and General Fertility rates (GFR) remain higher in Harrow than the London and England averages
- The highest GFR are seen in Queensbury, and Roxborne wards , where the rate of births per 1,000 women are 85.5 and 81.9 respectively
- A higher proportion of older mothers give birth in Harrow, age 30-34 account for 36%
- Seven out of ten births in Harrow are to non-UK mothers
- Almost 2 in 5 births are to first time mothers

The number of live births for Harrow continues to rise, from 2,581 in 2011, to 3,466 in 2011 and to 3,601 in 2015. The Total Fertility Rate (TFR)^{*} trend shows a slight increase in Harrow from 1.92 seen in 2011 to 2.1 in 2015. In 2015 the London TFR was 1.73 and England 1.82.

FIGURE 2 TREND IN BIRTHS AND FERTILITY RATES

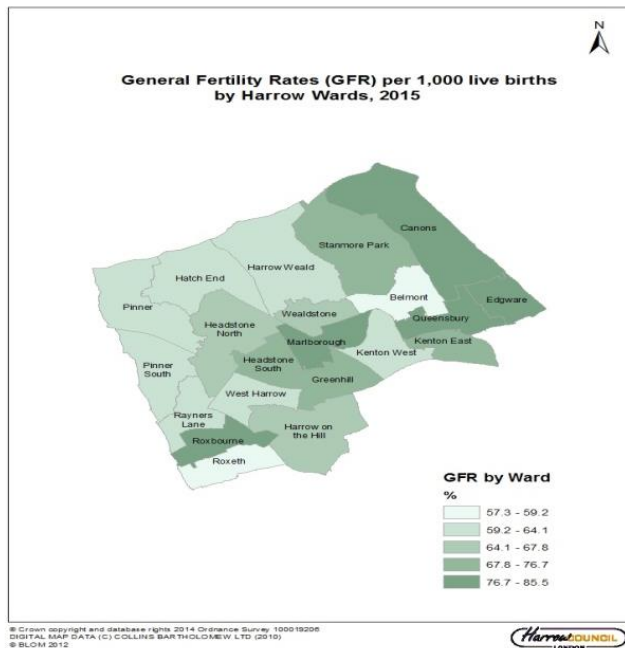


SOURCE : ONS BIRTH FILES 2011-2015

General Fertility Rate (GFR)[†] allows a more detailed look at birth rates at a ward level. Rates in 2015 were highest in Queensbury and Roxbourne wards, a change from 2011 when Edgware and Wealdstone had the highest rates. The lowest rates are seen in Belmont and Roxeth wards.

^{*} a single measure of fertility representing the average number of children each woman would be expected to have in a group of women if the current age-specific patterns of fertility persisted throughout their childbearing life
[†] the rate of births per 1,000 women of childbearing age

FIGURE 3 GENERAL FERTILITY RATE BY WARD

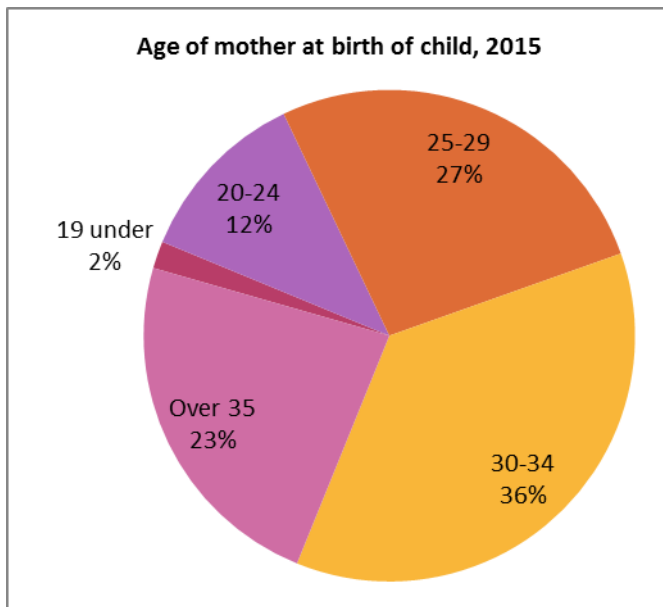


SOURCE : ONS BIRTH FILES 2011-2015

7.2.2 BIRTHS

In 2015, 3,601 babies were born to Harrow mothers. The highest proportion of deliveries was to women aged 30-34 years, accounting for 36% of all deliveries.

FIGURE 4 AGE OF MOTHERS 2015

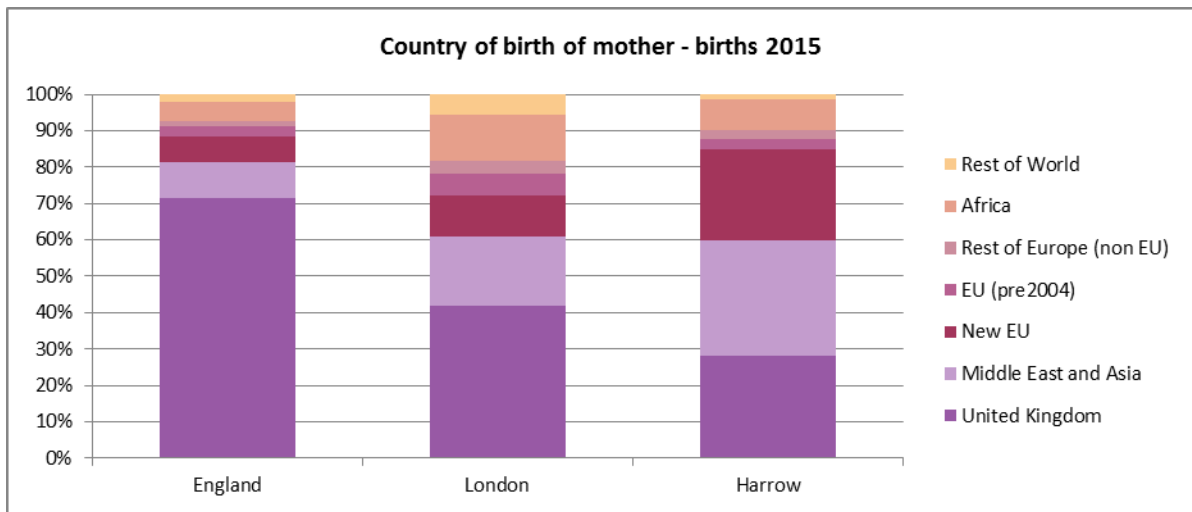


SOURCE: LOCAL ANALYSIS OF ONS BIRTH FILES

The picture for country of birth of mother shows a dramatic difference to the national picture. Seven out of ten births in Harrow were to non-UK born mothers compared to seven out of ten births to UK born women nationally and 4 in 10 in London. The three

categories, Middle East and Asia born, UK born and New EU[‡] born account for 85% of Harrow births.

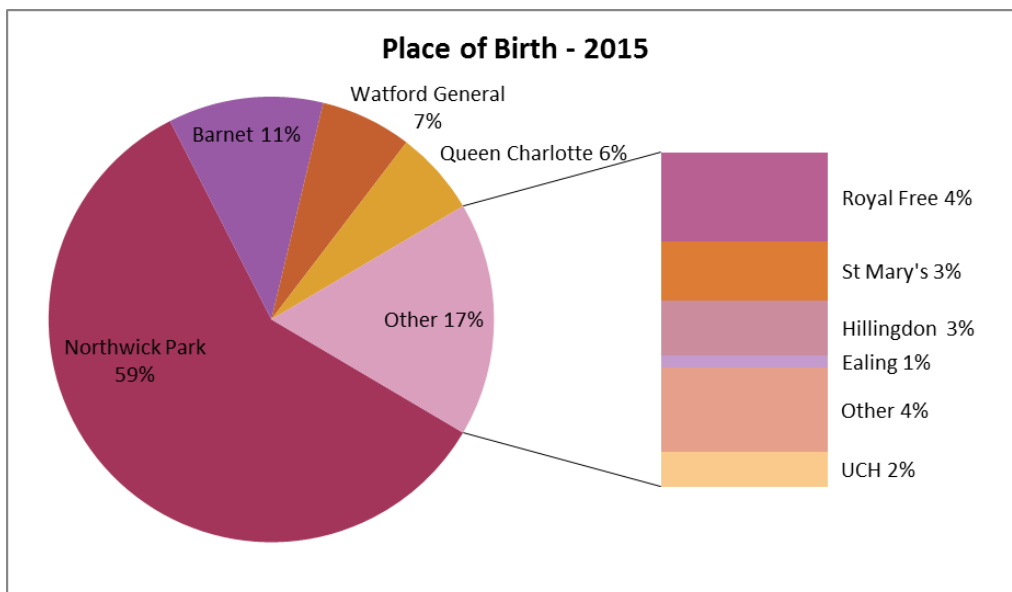
FIGURE 5 COUNTRY OF BIRTH OF HARROW MOTHERS GIVING BIRTH IN 2015



SOURCE: LOCAL ANALYSIS OF ONS BIRTH FILES

The majority of births, almost 60%, took place in Northwick Park Hospital’s maternity unit. Women in the east of the borough also use Barnet Hospital in the south east and Watford General in the north east. This pattern of births has been seen for a number of years. Home births are rare in Harrow. In 2015, only 33 births occurred at a private dwelling. Women who had home births have been combined with hospitals that have a very low number of births in the “other” category.

FIGURE 6 PLACE OF BIRTH OF BABIES BORN TO HARROW MOTHERS IN 2015



SOURCE: LOCAL ANALYSIS OF ONS BIRTH FILES

[‡] NEW EU constitutes the 12 countries which joined the EU between 2004 and 2012

7.2.3 IMPLICATIONS

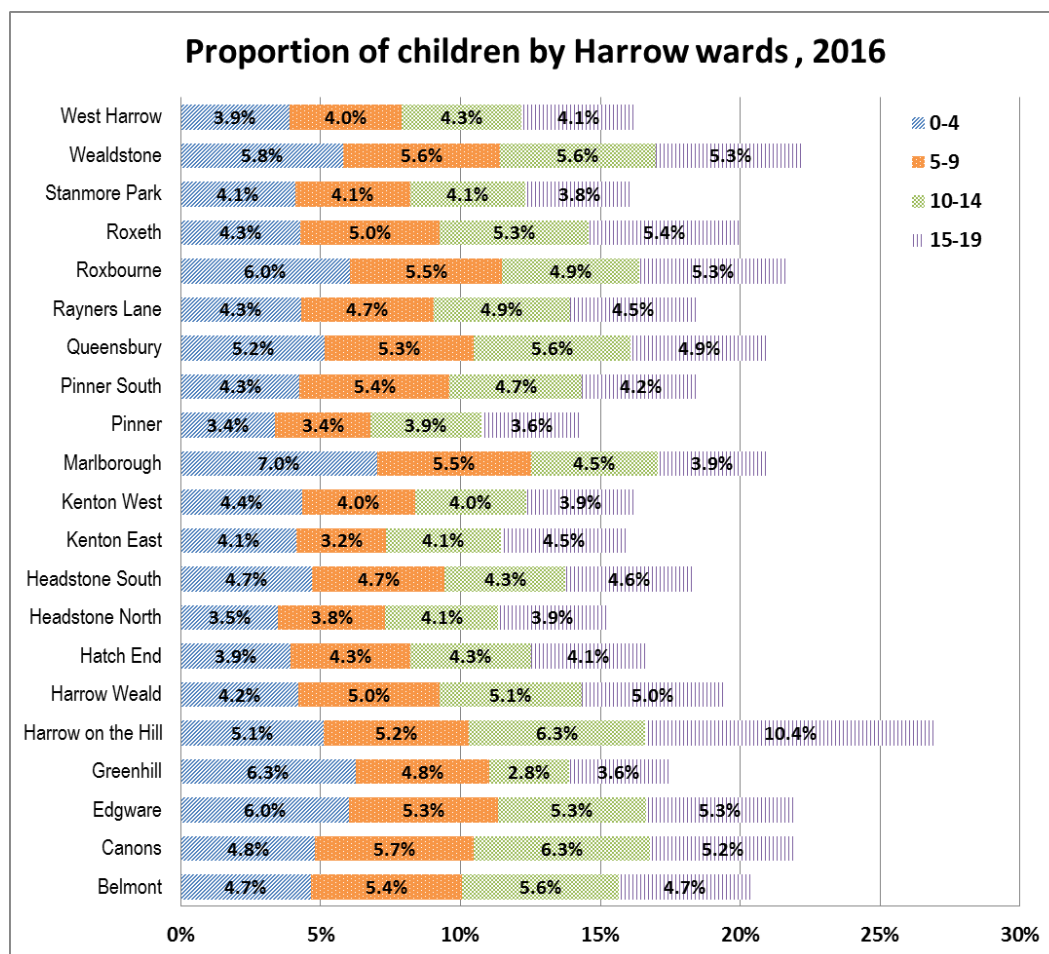
This increasing birth rate and projected increase in the children’s population will result in a need for extra school places. This is currently in line with the picture nationally where the Department of Education has forecasted a surge in the school population over the next 10 years and a need for more schools and school staff. This will have a direct impact on the workload of School Nurses across the borough in terms of supporting schools effectively.

There are a number of reasons why the ethnicity of mothers may have an influence on need. The experience and availability of healthcare including immunisation, and infectious disease e.g. HIV exposure, may be different as result of which their experience of health may differ from the UK norm. Furthermore, they may have different cultural practices, e.g. FGM, or expectations of services, or communication difficulties.

7.3 VARIATION IN CHILD POPULATION

Currently the largest proportion of 0-19 year olds (excluding Harrow on the Hill as the numbers are inflated by the 800 boys of Harrow School) is in Wealdstone ward, where more than 1 in 5 of the population is under the age of 19. The next highest proportion of under 19s are found in Edgware and Belmont.

FIGURE 7 CURRENT CHILD POPULATIONS BY ELECTORAL WARD



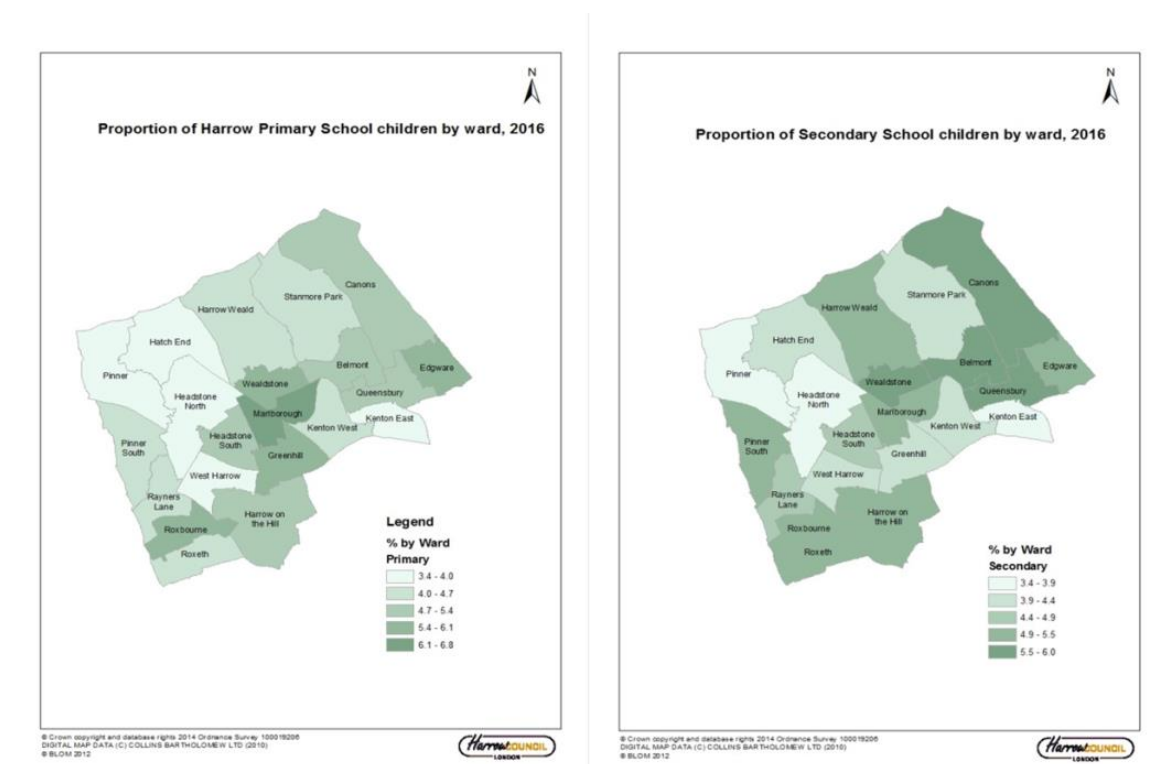
SOURCE : GLA 2015 POPULATION PROJECTIONS

However, this is not the whole picture. There are large differences in the difference age groups across the borough. It is notable that there are higher percentages of children under 5 in the more deprived part of the borough - 7% of the population in Marlborough compared to only 3.4% in Pinner. This has also been highlighted in the child poverty needs assessment⁴ as an area of concern.

In terms of school aged children, Cannons has the highest proportions of both 5-9 year olds and 10-14 year olds and Roxeth, Roxbourne and Wealdstone the highest proportion of 15-19 year olds.

The maps in Figure 8 show where the current primary (age 5-11) and secondary (12-16) school populations live in Harrow.

FIGURE 8 AREA OF RESIDENCE OF PRIMARY AND SECONDARY SCHOOL CHILDREN IN HARROW



SOURCE: ONS POPULATION DATA

7.4 ETHNICITY

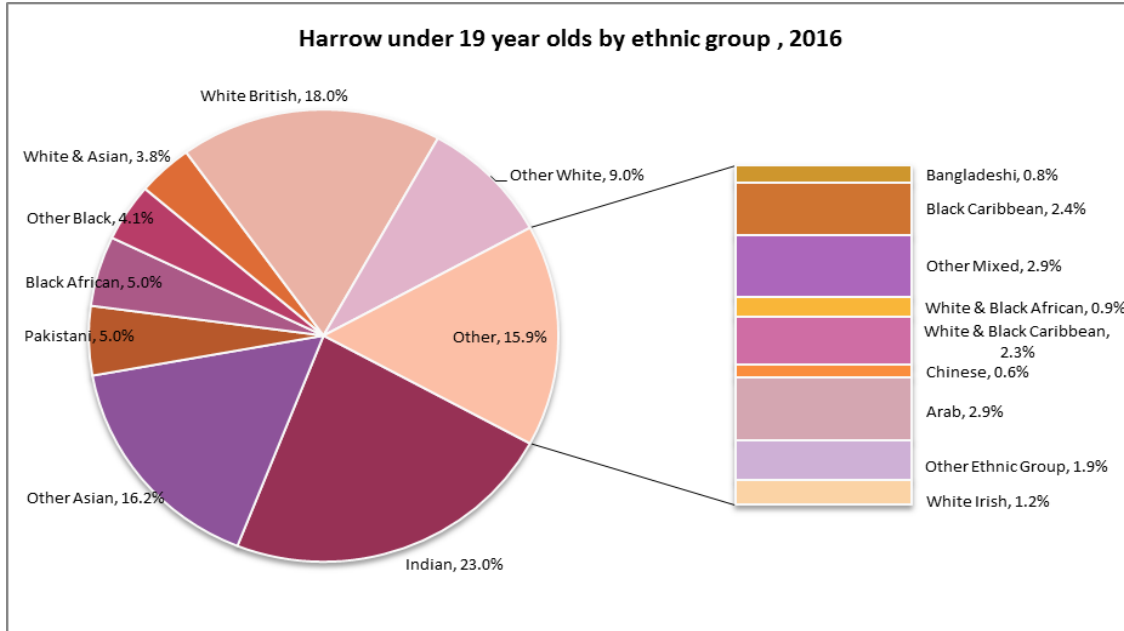
7.4.1 KEY MESSAGES

- The under 19 population reflects the increasing ethnic diversity in Harrow.
- The largest ethnic group represented in this age band is the Indian population, 23 %followed by the White British population , 18% and Other Asian Population, 16%

The ethnicity of the under 19 population reflects the ethnic diversity of the borough. 7 out of 10 of the under 19 population belong to a BAME group. The largest ethnic group represented in this age band is the Indian population, 23 %followed by the White British population at 18% and the Other Asian population at16%. In Harrow, the Indian population is predominantly Gujarati and the Other Asian group is predominantly Tamil.

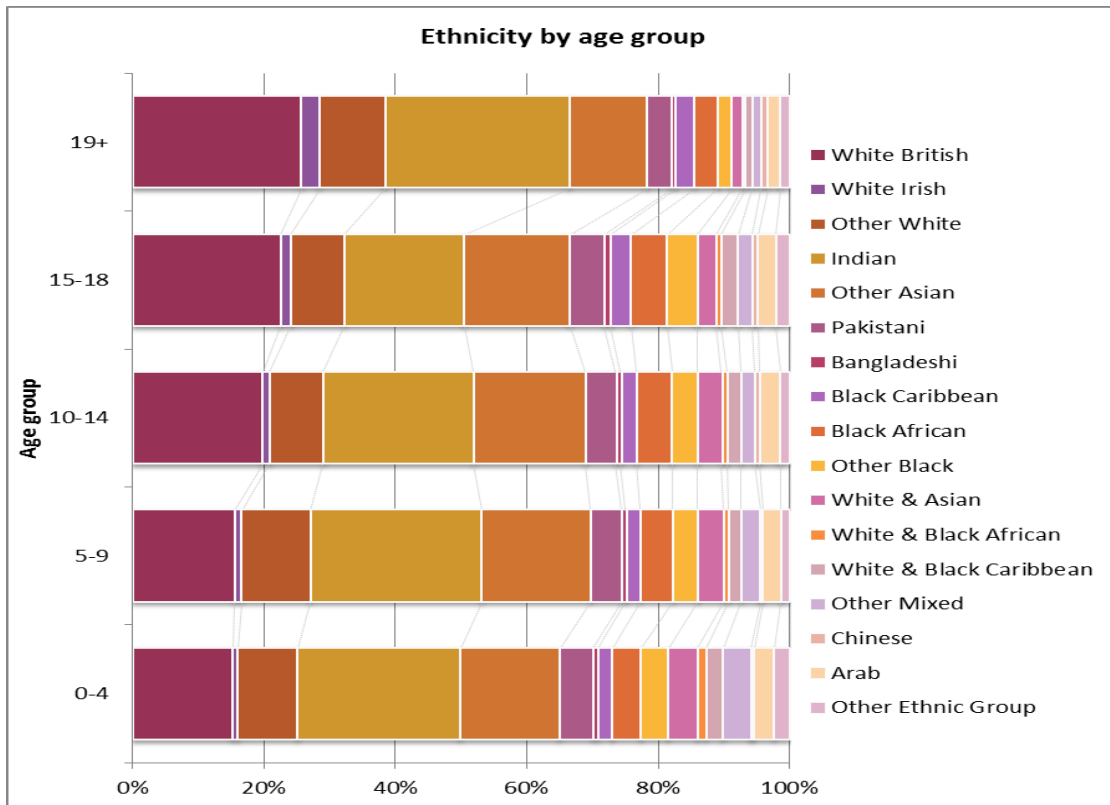
However, looking at the ethnicity by smaller age bands, we see that the ethnic diversity is growing. In the youngest age group (aged 0-4), only 1 in 6 are of White British ethnicity compared to 1 in 4 of the adult population.

FIGURE 9 ETHNICITY OF 0-19 YEAR OLDS IN HARROW



SOURCE : GLA 2015 ROUND OF DEMOGRAPHIC PROJECTIONS

FIGURE 10 ETHNICITY IN DIFFERENT AGE GROUPS IN HARROW



SOURCE : GLA 2015 ROUND OF DEMOGRAPHIC PROJECTIONS

7.5 CHILDREN WITH A DISABILITY

7.5.1 KEY MESSAGES

- The rate of children with learning disability known to schools in Harrow is 25.4 per 1000 which is similar to London but lower than the England average.
- Only 38 number of children aged 0 – 4 have a statement/EHCP in nursery settings.
- Primary pupils with SEN support dropped from 2,503 to 1,807 in 2016; This is below the national average rate.
- The percentage of primary pupils with SEN who have a statement/EHCP has remained steady at 1.5% in 2016.
- High school pupils with SEN Support dropped 10.5% in January 2016.
- The percentage of high school pupils with a statement/EHCP has remained stable at 1.9% in 2016 and is above the national average.
- 99.3% (418) of the special school population had a statement/EHCP in 2016.
- The speech and language therapy has an active caseload of 2206 children and young people – a 20% increase over 2015.

Disabled children and their families feel the effects of disability throughout their lives and its impact on all aspects of living. Their disabilities may range from mild to severe and from straightforward to complex. Without appropriate or effective intervention disabled children and those with complex health needs are at risk of living in poverty, facing social exclusion, discrimination, poor health and preventable early death.

The prevalence of disability rises with age: in 2011/12, 6% of children (0-16) were disabled (0.8 million), compared to around 16% of adults of working age (16-64) (5.8 million), and 45% of adults over state pension age (65 and over) (5.3 million). We have no direct data from the census or from a local prevalence study on the number of people with a disability. But by using the national estimate, we can say we expect there to be around 3,900 children with a disability in Harrow.

7.5.2 .LEARNING DIFFICULTY

There are four levels of learning difficulties: specific difficulties (like dyslexia), moderate learning difficulties, severe learning difficulties and profound and multiple learning difficulties. The indicator shows the number of children in every thousand who are recognised as having a moderate learning difficulty. These children have difficulty in all areas of learning. They may have speech and language delay. This indicator has implication for the commissioning of support services such as speech and language therapy for children with moderate learning difficulties.

Across England the data for 2016 suggest that most common primary types of needs have remained the same as in 2015. Twenty seven percent of pupils on SEN support have moderate learning difficulty as a primary type of need. For pupils with a statement or EHC plan, 25.9% have Autistic Spectrum Disorder as a primary type of need.

In 2014, the rate of children with any learning disabilities who were known to schools was 25.4 per 1000, which was lower than the English average of 33.7 per 1000 but similar to the regional average (26.4 per 1000).

In 2014, there were 21.4 per 1000 children with moderate learning difficulties and 4.02 per 1000 children with severe learning difficulties known to schools. Across London the rate of moderate learning difficulties (21.9 per 1000) was similar to that observed in Harrow while the rate of severe learning difficulties (3.09 per 1000) was higher in Harrow. The national rates were 28.6 per 1000 and 3.80 per 1000 respectively.

The Department for Education Statistical First Release also shows the following trends in Harrow when comparing the January 2015 data against January 2016:

- **Pre-Schools:** Only 38 number of children aged 0 – 4 have a statement/EHCP in nursery settings. The LA is not at present able to quantify the number of children aged 0-4 that receive SEN support in nursery settings. However, this is being addressed.
- **Primary Schools:** There was a significant decline in pupils with SEN support from 2,503 to 1,807; dropping from 11.8% in 2015 (below the national average of 13.0%) to 8.5% in 2016 (well below the national average of 12.1%). The percentage of pupils with SEN who have a statement/EHCP has remained steady at 1.7% in 2015 (1.4% nationally) and 1.5% in 2016 (1.3% nationally).
- **High Schools:** Pupils with SEN Support have dropped slightly from 11.0% in January 2015 to 10.5% in January 2016. The national picture similarly has declined from 12.4% to 11.0%. The percentage of pupils with a statement/EHCP has remained stable at 1.9% in both 2015 and 2016; this is above the 2016 national average of 1.7%, which has dropped slightly from 1.8% in 2015.
- **Special Schools:** The number of pupils with a statement/EHCP in 2016 is 418, representing 99.3% of the special school population. For the years that comparable national data is available the rate of increase of pupils with a statement/EHCP in Harrow has been higher than the national.
- **Further Education:** The number of young people in Further Education with a statement/EHCP is 135. This number will increase year on year due to the changes in SEN legislation.

7.5.3 PHYSICAL DISABILITY

In 2012, the estimated prevalence of physical disability among 16 – 64 year olds in Harrow was 10.6%, this compares to 9.9% across London and 11.1% nationally. Between 2013 and 2014 there were 3.0 per 1,000 population adults (18 to 64 years) with learning disabilities who were known to the local authority. This rate was lower than both the London (3.5 per 1,000) and England (4.3 per 1,000) averages.

7.5.4 SPEECH, LANGUAGE AND COMMUNICATION NEEDS

Speech, language and communication needs (SLCN) encompasses a wide range of difficulties related to all aspects of communication in children and young people. These can include difficulties with fluency, forming sounds and words, formulating sentences, understanding what others say and using language socially. Speech and language delay most common difficulty experienced by pre-school children (Law et al 2000).

One percent of children at school entry will have severe and pervasive speech, language or communication needs which will require long term specialist support and these communication needs will likely follow the child into adulthood. A further 7% of children at school entry will have significant speech, language or communication needs which will not improve without specialist intervention supporting the child and the parents. Children in this category may have long term needs but their access to learning can be improved with appropriate support. These children have SLCN which are associated with an underlying speech, language and communication impairment or as a secondary issue associated with other learning disability or complex needs. The prevalence in this group is not correlated with socio-economic factors or disadvantage.

An audit of the paediatric speech and language therapy services reported that on the 30th June 2016 the service had an active caseload of 2206 children and young people, reflecting a 20% increase and an additional 367 services users compared with 2014 (1839). The annual increase over the past 4 years has been 11%. The most common diagnoses are language delay (573), language disorder (334) and social communication disorder/difficulties (258).

7.6 YOUNG CARERS

A person is a provider of unpaid care if they look after or give help or support to family members, friends, neighbours or others because of long-term physical or mental ill health or disability, or problems related to old age. Children who care of parents are forced to grow up and take responsibility at an earlier age than their peers. The need for emotional and mental health support for children in this position is imperative. In Harrow, in 2011 5.98% of households in the borough had at least one person with a long-term health problem or disability and dependent children. Comparable proportions in London and England were 5.00% and 4.62%.

In 2011, 1.15% of children under the age of 15 provided unpaid care in Harrow compared to 1.07% in London and 1.11% in England.

7.7 MENTAL HEALTH

Good mental health starts in infancy and research shows that a baby who doesn't get to feel a healthy bond with a parent is at much higher risk of developing mental health problems than a child with a strong connection to the person who cares for them.

Child and adolescent mental health disorders are surprisingly common. The most recent UK estimate indicates that 10% of 5-16 year olds had a diagnosed mental health disorder. Some of the mental health problems that can affect children and young people include:

- Depression: This affects more children and young people today than in the last few decades, but it is still more common in adults. Teenagers are more likely to experience depression than young children.
- Self-harm: This is a very common problem among young people. Some people find it helps them manage intense emotional pain if they harm themselves, through cutting or burning, for example. They may not wish to take their own life.

- Generalised anxiety disorder (GAD): This can cause young people to become extremely worried. Very young children or children starting or moving school may have separation anxiety.
- Post-traumatic stress disorder (PTSD): can follow physical or sexual abuse, witnessing something extremely frightening or traumatising, being the victim of violence or severe bullying or surviving a disaster.
- Children who consistently behave impulsively and have difficulty paying attention may have attention deficit hyperactivity disorder (ADHD). Many more boys than girls are affected, but the causes of ADHD are not fully understood.
- Eating disorders usually start in the teenage years and are more common in girls than boys. The number of young people who develop an eating disorder is small, but eating disorders such as anorexia nervosa and bulimia nervosa can have serious consequences for their physical health and development.

One in ten children aged between 5 and 16 years has a clinically diagnosable mental health problem. About half of these (5.8%) have a conduct disorder, 3.7% an emotional disorder (anxiety, depression) and 1–2% severe Attention Deficit Hyperactivity Disorder (ADHD)⁵. The rates of disorder rise steeply in middle to late adolescence. By 11–15 it is 13% for boys and 10% for girls, and approaching adult rates of around 23% by age 18–20 years. At any one time, around 1.2–1.3 million children will have a diagnosable mental health disorder in UK. Half of those with lifetime mental illness (excluding dementia) first experience symptoms by the age of 14, and three-quarters before their mid-20s⁶. 11–16 year olds with an emotional disorder are more likely to smoke, drink and use drugs.

Around 60% of Looked After Children and 72% of those in residential care have some level of emotional and mental health problem⁷. A high proportion experience poor health, educational and social outcomes after leaving care⁸. Looked After Children and care leavers are between four and five times more likely to attempt suicide in adulthood and young people in prison are 18 times more likely to take their own lives than others of the same age.

One third of all children and young people in contact with the youth justice system have been looked after⁸. It is also important to note that a substantial majority of children and young people in care who commit offences had already started to offend before becoming looked after^{7, 9};

Self-harming in young people is not uncommon (10–13% of 15–16-year-olds have self-harmed) but only a fraction of cases are seen in hospital settings¹⁰

7.7.1 ESTIMATED PREVALENCE

Measured prevalence at borough level is not available. Estimates have been made based on the prevalence of different conditions given in the ONS survey and applied to the local population stratified by age, sex and socio-economic classification of the 'head of household'. However, these data do not take into account differences in other factors which may influence prevalence. The survey used to derive the estimates was carried out in 2004 and no adjustment has been made for possible change in prevalence over time.

Bearing these caveats in mind, there are an estimated 3,171 children and young people aged 5-16 who have any mental health problem: the majority (1909) having conduct disorders.

FIGURE 11 ESTIMATED PREVALENCE OF MENTAL HEALTH DISORDERS IN CHILDREN AND YOUNG PEOPLE IN HARROW

Estimated prevalence	Age group	Estimated number
Mental health disorders	aged 5-16	3,171
Emotional disorders	aged 5-16	1,232
Conduct disorders	aged 5-16	1,909
Hyperkinetic disorders	aged 5-16	533
Potential eating	aged 16 - 24	3,348
ADHD	aged 16 - 24	3,592

SOURCE: PHE CHILD MENTAL HEALTH PROFILES

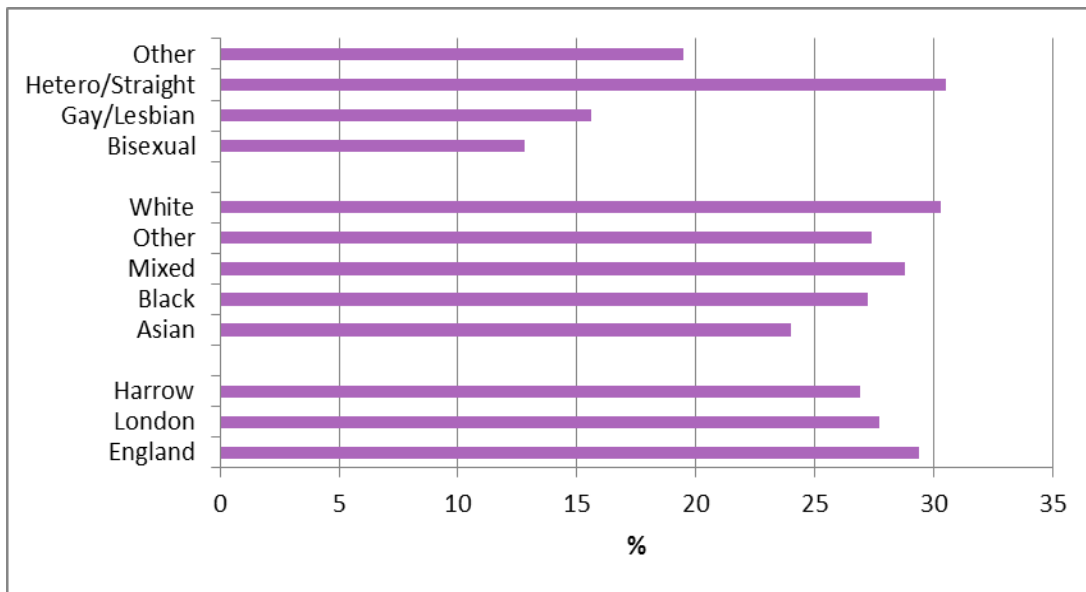
In the 16-24 age group there are an estimated 3,348 young people who meet the threshold to be assessed for an eating disorder. However, the APMS report says that there are major gaps in epidemiological data for eating disorder and the estimates may not be accurate. This data applies the same percentage to all areas to estimate numbers with eating disorder and thus does not make any adjustment for local characteristics which may impact on prevalence. However, they also say that there is a general under-detection of eating disorder.

There are a potential 3,592 young people aged 16-24 with ADHD. However, again this data comes with a broad caveat and is only included as there is an absence of other data on this subject. The survey used to derive the estimates was carried out in 2007 and no adjustment has been made for possible change in prevalence over time. It also applies the same percentage to all areas to estimate numbers with ADHD and thus does not make any adjustment for local characteristics which may impact on prevalence.

7.7.2 MENTAL WELLBEING OF 15 YEAR OLDS

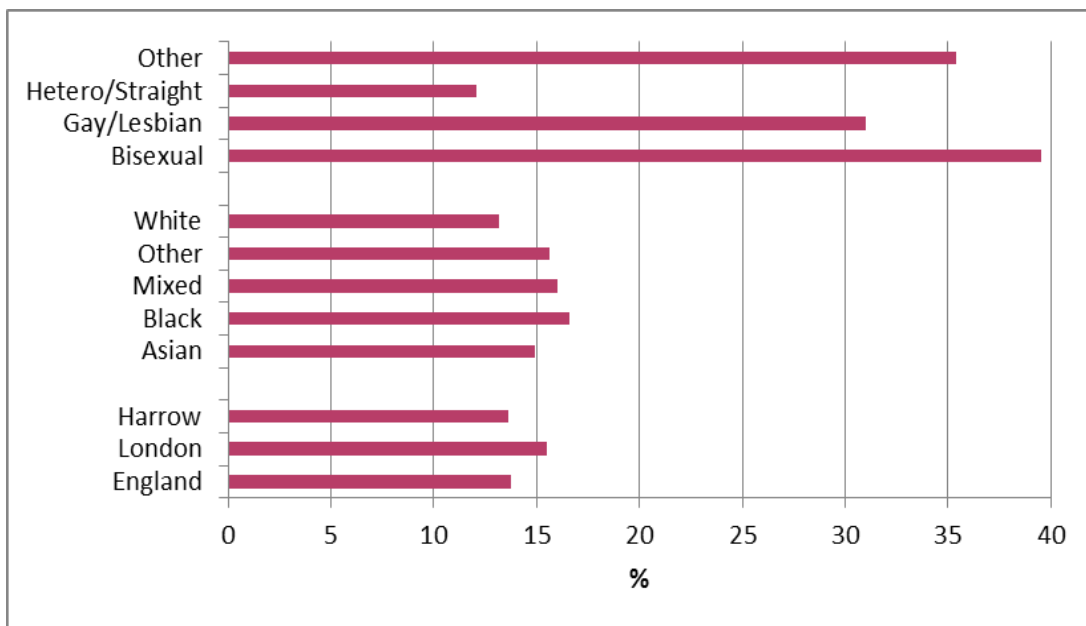
The What About Youth (WAY) survey gives us an insight into the health and wellbeing of 15 year olds. There is a marked difference in the self reported health nationally when equalities characteristics are taken into account. Asian young people are less likely to report excellent health than any other ethnic group and White young people are more likely to. When it comes to sexuality, the difference is even greater, with LGBT young people reporting significantly poorer health than their heterosexual counterparts. A similar pattern is seen in reported life satisfaction where Black, Mixed race young people and LGBT young people report higher levels of low life satisfaction. In Harrow, slightly lower rates of young people reporting excellent health are reported and similar rates of low life satisfaction compared to England.

FIGURE 12 PERCENTAGE OF 15 YEAR OLDS WHO REPORTED THEIR HEALTH AS EXCELLENT



SOURCE: WAY SURVEY

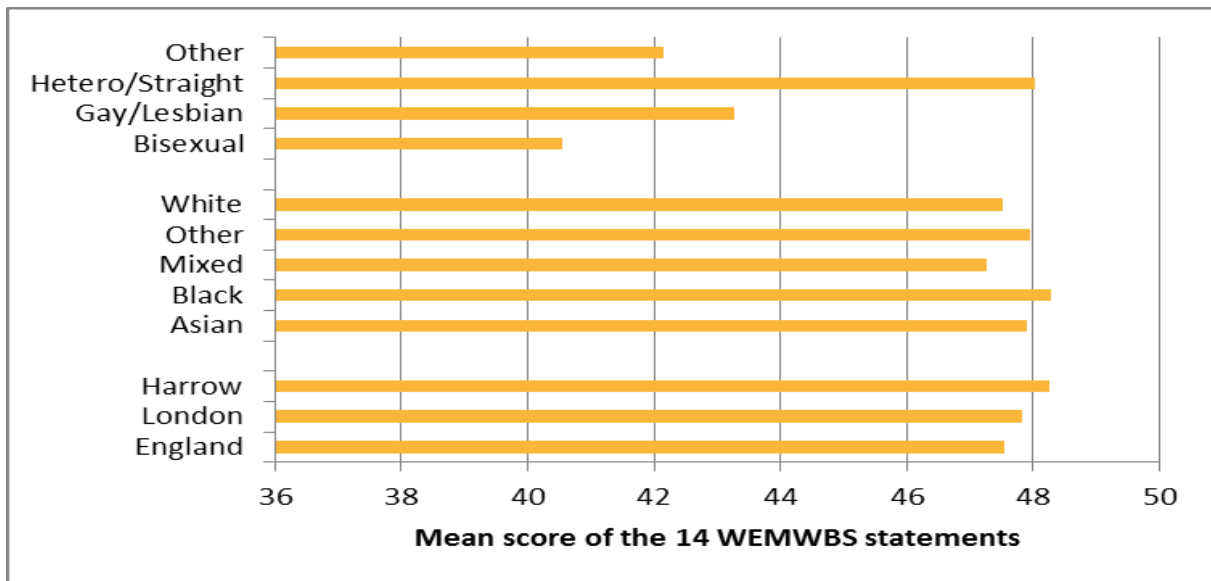
FIGURE 13 PERCENTAGE OF 15 YEAR OLDS REPORTING LOW LEVELS OF LIFE SATISFACTION



SOURCE: WAY SURVEY

The Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) is formed of 14 statements covering a range of feelings and attitudes towards life. Each participant is given a single score based on their responses to the 14 statements which ranges from 14 – 70 with higher scores showing a more positive attitude towards life.

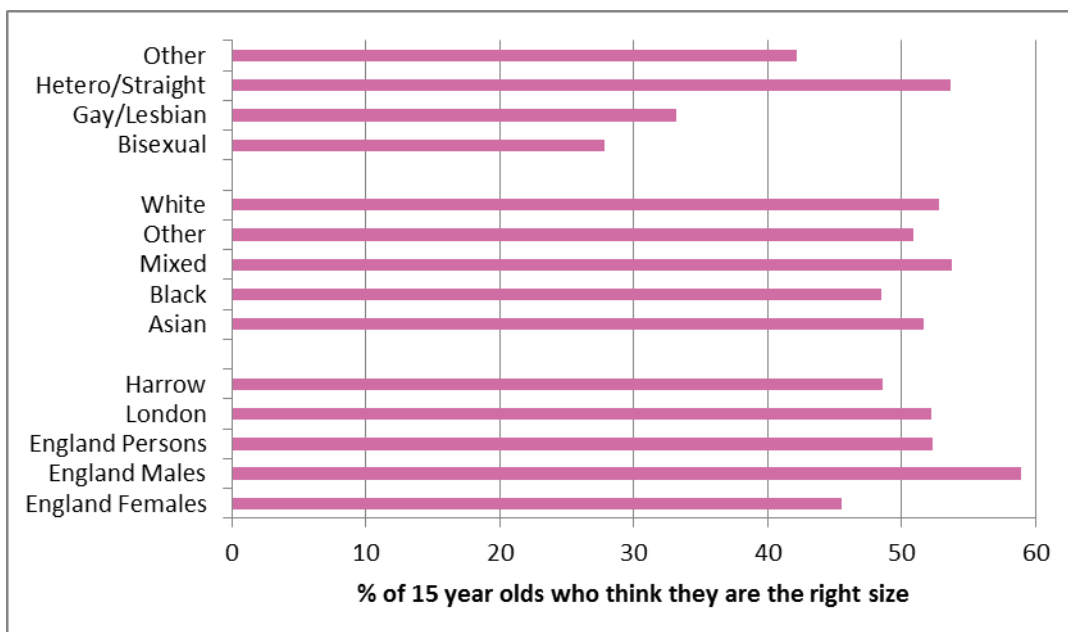
FIGURE 14 MEAN SCORE FOR THE WEMWBS QUESTIONNAIRE



SOURCE: WAY SURVEY

One of the pressures of modern “selfie culture” is the emphasis on body size and physical perfection. It is not surprising that around half of young people report that think they are not the right size. The rate in Harrow was slightly lower than the national and London rates. The survey did not explore this in further detail and so it is difficult to say in what respect they felt this. However, the gender differences are marked with more young women feeling they are not the right size than young men. There are smaller differences between the different ethnic groups with Black young people having lower rates. LGBT young people were significantly more likely to feel they were the wrong size.

FIGURE 15 PERCENTAGE OF YOUNG PEOPLE WHO THINK THEY ARE THE RIGHT SIZE

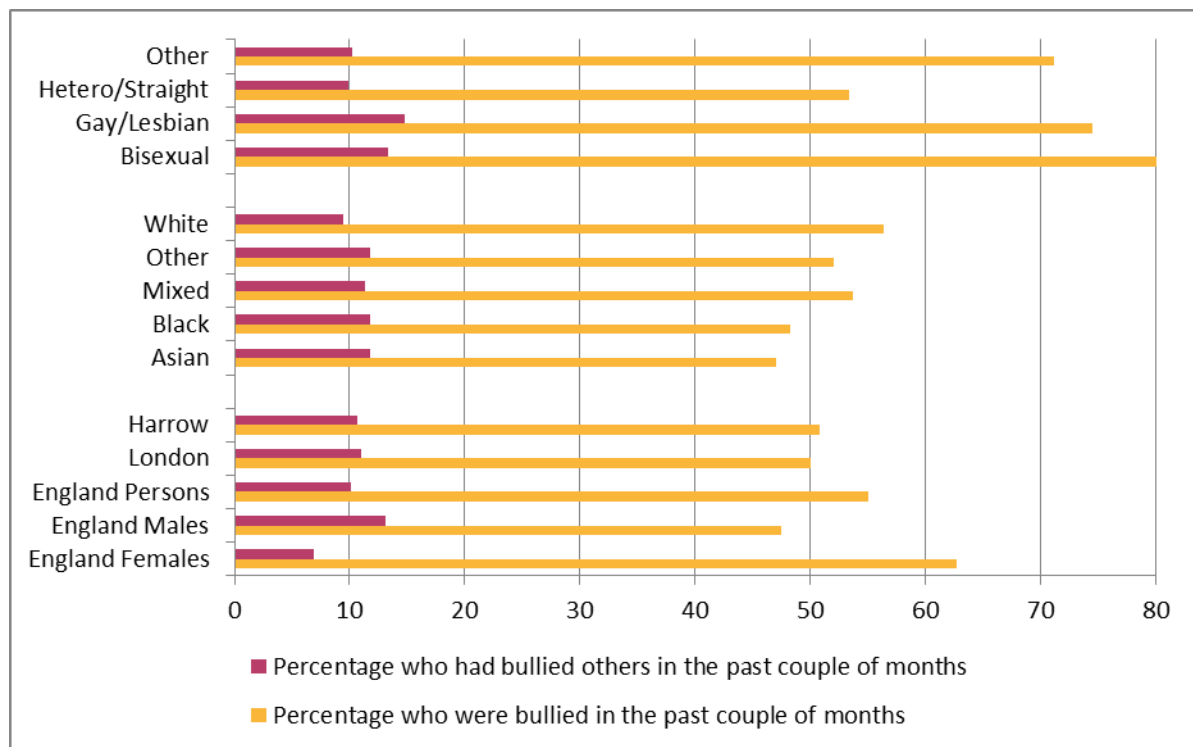


SOURCE: WAY SURVEY

Bullying is another factor affecting self esteem and mental health. Nearly 63% of young women and 47.5% of young men reported being bullied in the past couple of months. This is alarmingly high nationally. The rate in Harrow is lower than the national rate but half of Harrow’s 15 year olds reported being bullied. Rates of being bullied wehre highest in the White ethnic group and lowest in the Asian ethnic group. Over 80% of young bisexual people and 75% of young gay and Lesbian young people report being bullied.

One in ten young people say that they have bullied someone recently. Young men are more likely to bully someone than young women in this survey. Slightly higher rates of being a bully occur in the BAME groups than in the white group. There were also higher rates of bullying by LGBT young people.

FIGURE 16 THE EXPEREINCE OF RECENTLY BEING BULLIED AND OF BULLYING



SOURCE: WAY SURVEY

7.8 CHILDREN LIVING IN POVERTY

Social inequality and poverty have a big impact on the cognitive development of children. The British Cohort Study¹¹ followed the lives of people born in a single week in 1970. Children’s cognitive development was measured at different time periods beginning at 22 months and proceeding for 10 years. By the age of six (74 months), the ‘less bright’ children from higher socio-economic groups performed better in tests of cognitive-ability than ‘bright’ children from lower socio-economic groups. This early disadvantage for children in lower socioeconomic groups went on to predict final educational outcomes and therefore future life chances.

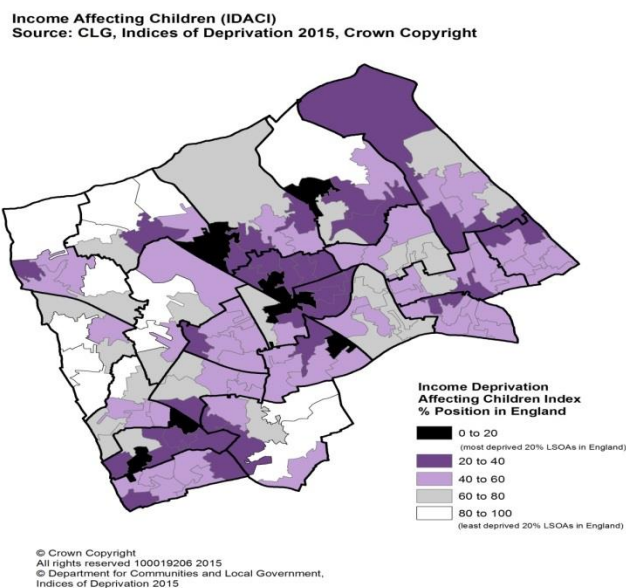
Children who grow up in poverty are four times as likely to become poor adults, becoming the parents of the next generation of children living in poverty. Harrow’s housing, transport and childcare costs make it harder for low income families and many low skilled workers to

survive on their incomes. Tackling child poverty needs to be a priority because of its short and long term consequences for children and for local areas. Tackling poverty is a key strategy to achieving successes in areas such as better health, education and economic development. Research estimates that poverty costs the UK £25 billion every year in reduced educational opportunities, lower taxes and higher service costs[§]

The 2015 Income Deprivation Affecting Children Index (IDACI) score shows the proportion of children in each LSOA that live in families that are income deprived, i.e. in receipt of income support, income based jobseeker's allowance or pension credit, or those not in receipt of these benefits but in receipt of Child Tax Credit with an equivalised income (excluding housing benefits) below 60% of the national median before housing costs. The IDACI scores are published as rates, so a score of 0.24, for example, means that 24% of children aged less than 16 in that area are living in families that are income deprived.

The IDACI shows that 16.24% of children in Harrow are living with families that are income deprived. The higher proportion of children living in poverty are in the Wealdstone corridor and in the south west of the borough.

FIGURE 17 INCOME DEPRIVATION AFFECTING CHILDREN



These persistent pockets of deprivation and child poverty in Harrow are often due to a combination of factors combined resulting in detrimental effects on a child's long term outcomes and life chances. Poor housing, unemployment, language barriers, debt and rent arrears, are all associated with poverty in Harrow.

[§] Joseph Rowntree Foundation, Estimating the Cost of Child Poverty (2008)

7.8.1 IMPLICATIONS

Living in poverty affects a child’s life and that of their family. It can increase the risk of poor maternal mental health and children are at an increased risk of poorer social, emotional and educational outcomes. These have significant costs throughout life, because conduct disorders, social care needs, use of child and adolescent mental health services and unemployment. Poverty increases the likelihood of the family needing additional support from health visitor, i.e. Universal Plus and the Universal Partnership Plus Offer within the Healthy Child Programme.

7.9 UNDER 18 CONCEPTION RATES AND TRENDS

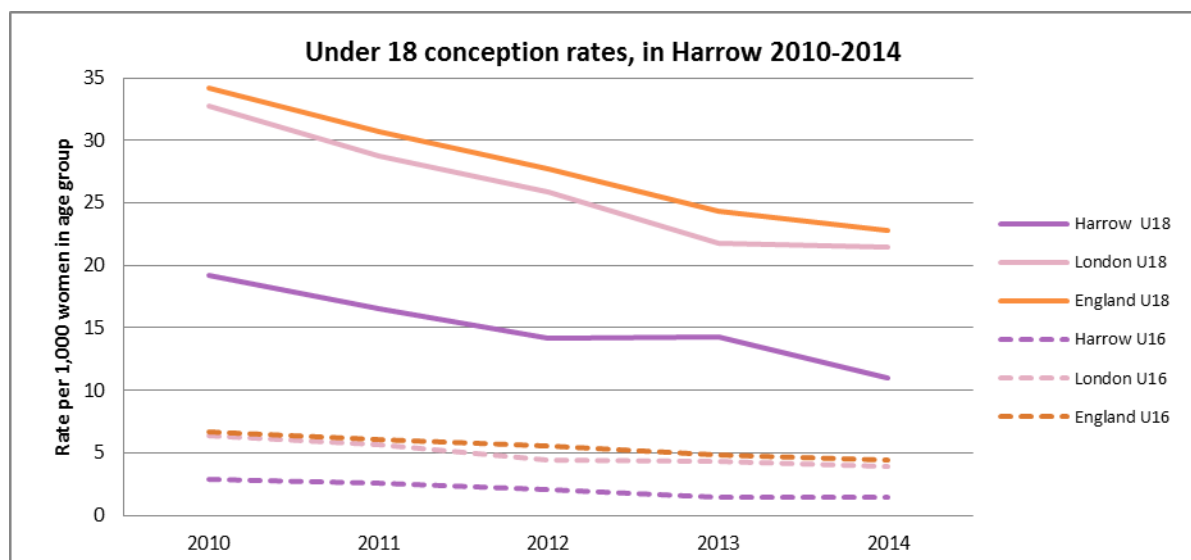
7.9.1 KEY MESSAGES

- Under 18 conceptions remain lower than London and England rates
- Similarly for under 16 conceptions, rates in Harrow are much lower than those for the regional and national averages
- The proportion of conceptions leading to termination of pregnancy also remains low for the under 18

7.9.2 UNDER 18 CONCEPTIONS

The rates of teenage conceptions in Harrow remain lower than the regional and national rates. Currently there are 11 per 1,000 population conceptions in young women aged under 18 and only 1.5 per 1,000 in the under 16s. These are half the London and England rates. The downward trend follows that of the national and London rates. Around two thirds of teenage conceptions lead to termination in under 18s and under 16s.

FIGURE 18 UNDER 18 CONCEPTIONS 2010-14



SOURCE : OFFICE OF NATIONAL STATISTICS 2015

7.9.3 IMPLICATIONS

Babies born to teen parents are at higher risk of Sudden Unexpected Death in Infancy (SUDI – or cot death). Lack of parenting experience will also require greater input from health visiting services from before the birth until the child is at least 2 years old. In some areas this is the role of the family nurse partnership (FNP) team.

7.10 MATERNAL AND INFANT HEALTH

Maternal health is health of women during pregnancy, childbirth and post-partum period, and there are strong links between the health of women and as a result Infant health. Mothers and their babies at the lower and upper age bands are at greater risk, older mothers present a series of different challenges, they have a greater chance of developing medical disorders such as diabetes, high blood pressure, or other chronic diseases, hence an impact on antenatal and postnatal services and the level of care and disease management they will require from the Health visiting teams.

Good maternal health and factors affecting it prevent complications during pregnancy and childbirth, and, as a result, disabilities in the infant. Raising awareness and prevention of such complications are easier to implement and more cost effective than managing high cost interventions during childbirth or setting up programmes to help aid disabilities in children.

7.10.1 KEY MESSAGES

- Smoking in Pregnancy remains lower than the London and England averages
- Low birth weight at 8.5% is higher than the London (7%) and England (7.2%) proportions
- Historically Breastfeeding rates have been high in Harrow which is reflected in Unicef Baby friendly level 3 status

7.10.2 SMOKING IN PREGNANCY

Smoking rates are low in Harrow and this is reflected in low smoking in pregnancy rates. Rates in Harrow have consistently been below 5% for over 2 years. The rate is generally slightly lower than the London rate and much lower than the England rate which exceeds 10%.

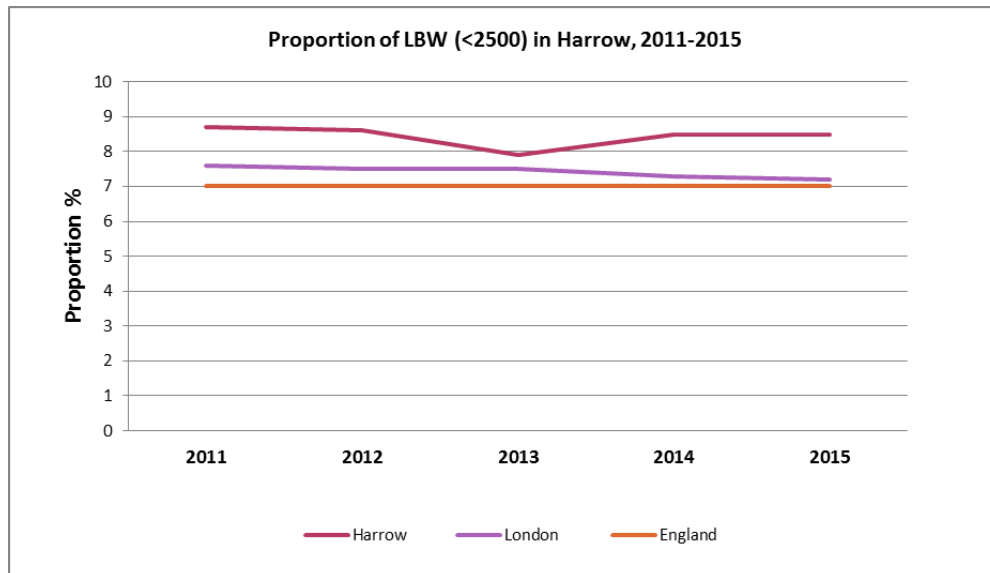
7.10.3 LOW BIRTH WEIGHT

A baby's low birth weight may be a result of either preterm birth, before 37 weeks of gestation or due to restricted foetal (intrauterine) growth. Low birth weight is defined by the WHO as weight less than 2,500g and very low birth weight as less than 1,500g. Advances in neonatal medicine have resulted in the increased survival of infants at lower and lower birth weight. While these medical successes highlight the effectiveness of medical technology to save many infants at birth, those born at very low birth weight have a higher risk of developing developmental problems and disabilities. However, the birth weight charts are based on a largely white, western population and they are almost certainly not reflective of different ethnicities. Canadian researchers have developed new birth weight curves for different ethnic groups which are used rather than a single weight threshold.

The percentage of live births (and still births) weighing less than 2,500g in Harrow have been consistently higher than the regional, and national rates (8.5% compared to 7.2% and 7% respectively). Prior examination of the issue of low birth weight in Harrow has not shown high rates of some of the risk factors identified nationally, e.g. early booking in pregnancy, rates of smoking in pregnancy and teenage parenthood. The majority of the low birth weight babies were to Asian mothers and we know that these babies tend to be smaller without having the additional risks.

Less than 1% of live births in Harrow were under 1,500g, i.e. classed as very low birth weight. These babies are in the high risk category for neonatal mortality, and for developmental problems and disability.

FIGURE 19 PROPORTION OF BABIES WHO WERE OF LOW BIRTH WEIGHT (<2,500g)



Source : Office for National Statistics 2015

7.10.4 IMPLICATIONS

The additional development needs of very low birth weight babies will need to be supported by Health Visitors initially and further by the School Nurse workforce.

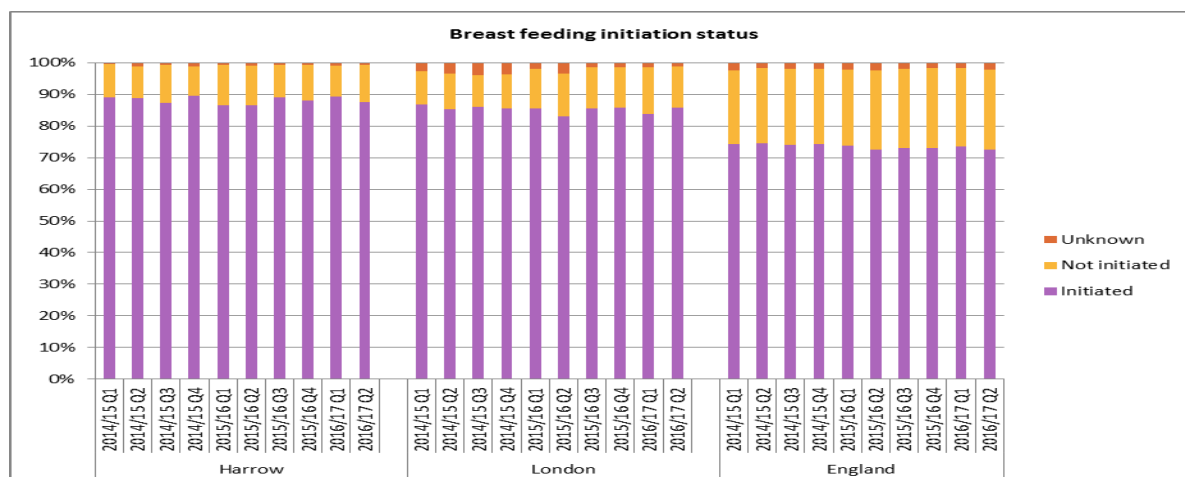
7.10.5 BREASTFEEDING

Breast feeding confers many benefits to both children and their mothers¹². Breastfeeding protects the health of babies and mothers, and reduces the risk of illness. In recent years, research has shown that infants who are not breastfed are more likely to have infections in the short-term such as gastroenteritis, respiratory and ear infections, and particularly infections requiring hospitalisation. In the longer term, evidence suggests that infants who are not breastfed are more likely to become obese in later childhood, which means they are more likely to develop type 2 diabetes, and tend to have slightly higher levels of blood pressure and blood cholesterol in adulthood. For mothers, breastfeeding is associated with a reduction in the risk of breast and ovarian cancers. A recent study also suggests a positive association between breastfeeding and parenting capability, particularly among single and low-income mothers.

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. Thereafter, breastfeeding should continue for as long as the mother and baby wish, while gradually introducing the baby to a more varied diet.

In Harrow, breastfeeding initiation rates have been consistently high at around 88%. The rates exceed those of London as a whole and are much higher than the England rates.

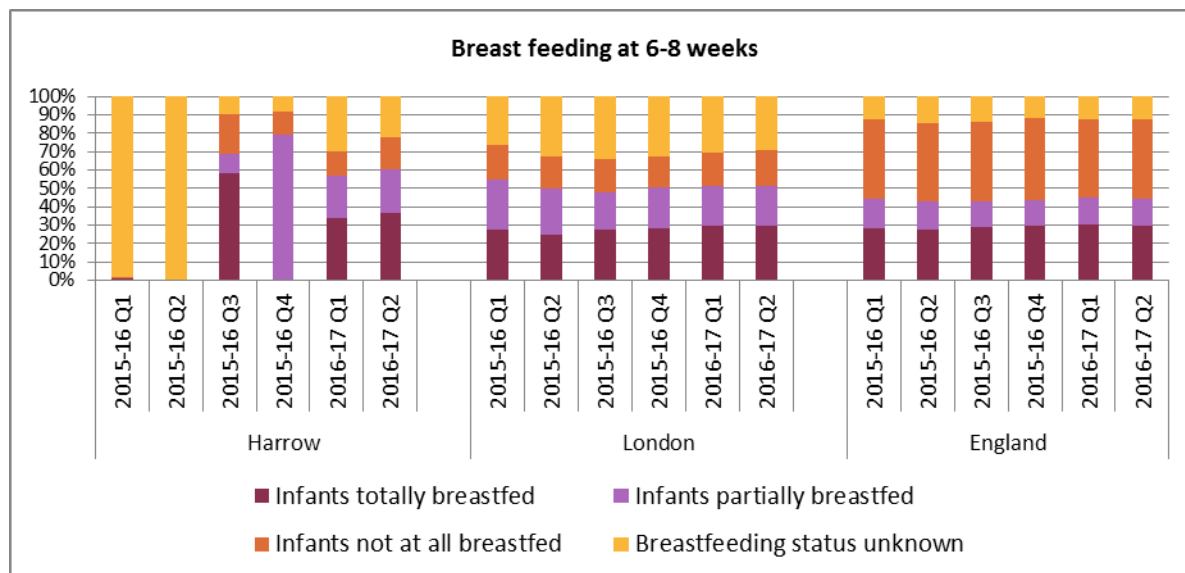
FIGURE 20 BREAST FEEDING INITIATION RATES Q1 2014/15 - Q2 2016/17



SOURCE: NHS ENGLAND STATISTICAL RELEASE: BREASTFEEDING INITIATION

The breast feeding data at 6-8 weeks for Harrow is incomplete due to problems when the Trust moved to a new computer system. Data is gradually improving and where it is more complete, the data shows that Harrow mothers are continuing to breast feed their babies at a higher rate than nationally and a slightly higher rate than London. The excellent record that Harrow has in breast feeding is shown by the UNICEF Baby-friendly accreditation in 2012. UNICEF assessed Harrow for its re -accreditation in 2014 and stated that it was the only local authority in the UK where breastfeeding was the ‘normal’ way to feed babies.

FIGURE 21 BREAST FEEDING AT 6-8 WEEKS



7.10.6 IMPLICATIONS

Breast feeding is an area where health visitors have a clear role. Encouraging women to breastfeed and signposting to additional support are vital. It is particularly important for mothers from low income groups, as it is known that they are less likely to breastfeed.

7.11 DEATHS IN CHILDHOOD

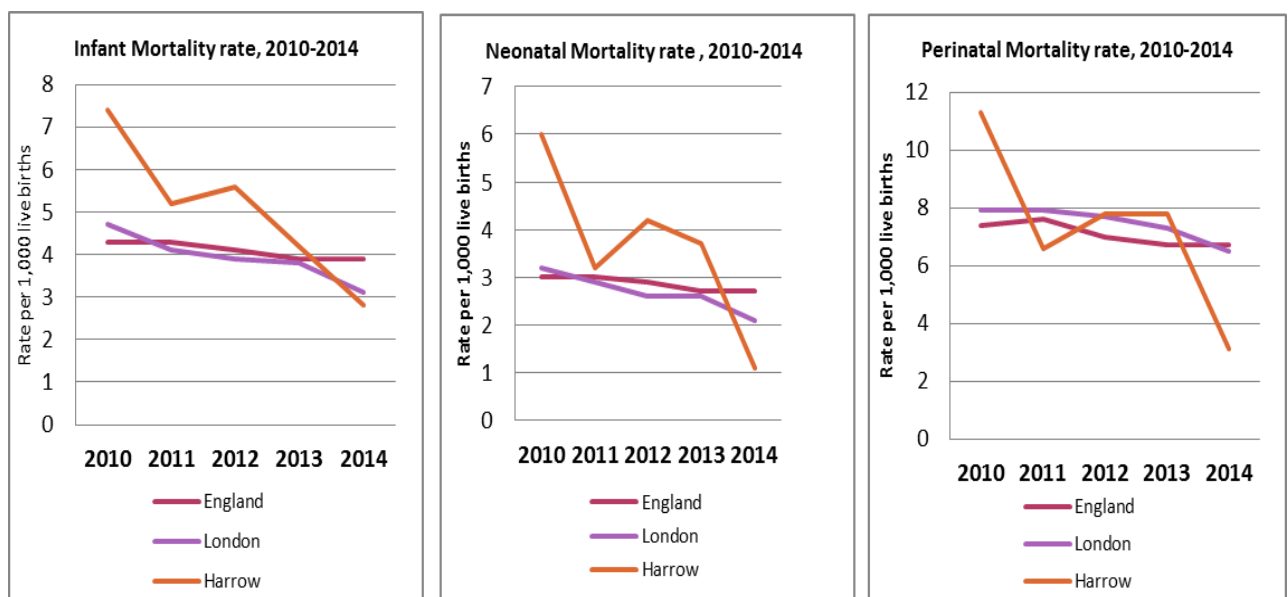
Death in childhood represents not only a tragedy for that child’s family but also a loss to wider society in terms of lost years of productive life.

7.11.1 INFANT MORTALITY

Infant mortality rates refer to the number of deaths within the first year of life per 1,000 live births. This data is further subdivided into neonatal mortality, i.e. those under 28 days, and perinatal mortality, i.e still births and deaths under 7 days. Infant Mortality is a sensitive marker for the wellbeing of a nation’s health and is a national indicator for tackling inequalities. Risk factors for infant mortality include both socioeconomic and health care factors.

Infant mortality rates in Harrow were found to be higher than the national and London rates in 2008 from the pooled 2005-07 data. A multiagency group was convened in 2008 by the Director of Public Health to look into this issue which met quarterly and infant mortality action plan was developed based on local and national evidence. This was implemented in 2009 and since this time the rate has steadily come down.

FIGURE 22 INFANT, NEONATAL AND PERINATAL MORTALITY RATES



Source : Office for National Statistics 2015

PHE’s ChiMat has looked into all the possible risks and has produced IMR profiles for each area in England. This shows that the key risk factors where Harrow is not performing that well were children in poverty, homelessness in families with children and in pregnant women, overcrowding, low birth weight babies, late antenatal booking and poor vaccination rates by 1 year of age.

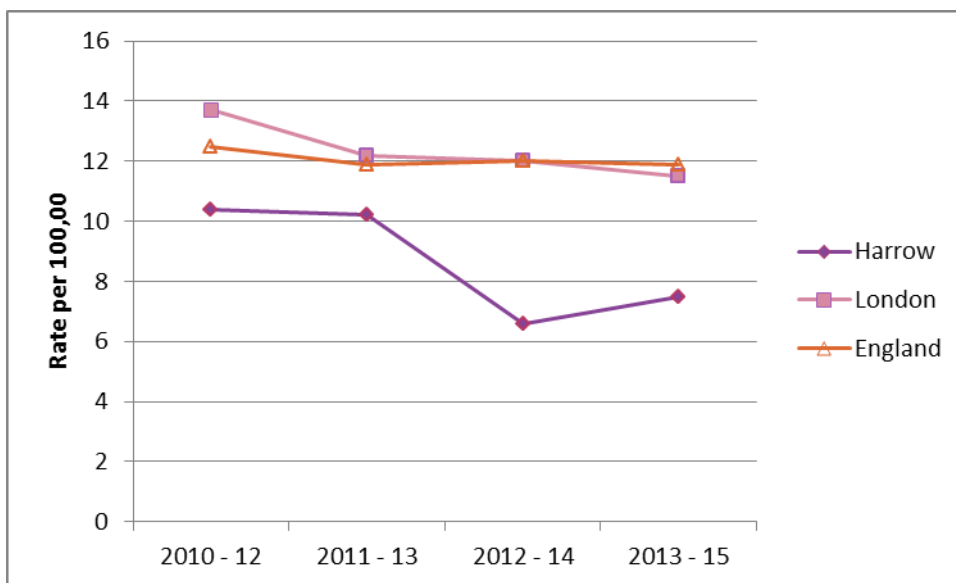
7.11.2 DEATHS IN CHILDREN AGE 1-17

After the age of one year, the commonest cause of death in children and young people is injuries. Many of these injury related deaths are potentially avoidable and understanding these injuries therefore, can help to alert 0-19 service providers of the topics of support required by parents in the borough.

In older children, road traffic accidents /collisions are a major cause of deaths in children becoming more common as children get older. Parents cite vehicle speed and volume as reasons why they do not allow their children to walk or cycle, thereby reducing opportunities for physical activity. These are factors that school nurses should be aware of as it has implications for road safety awareness campaigns and increasing physical activity safely.

The rate of deaths in children aged 1-17 in Harrow is lower than the rate for London and England and shows a decreasing trend since 2010 that exceeds the rate of decrease of London and England.

FIGURE 23 ALL CAUSE MORTALITY RATES FOR CHILDREN AGED 1-17

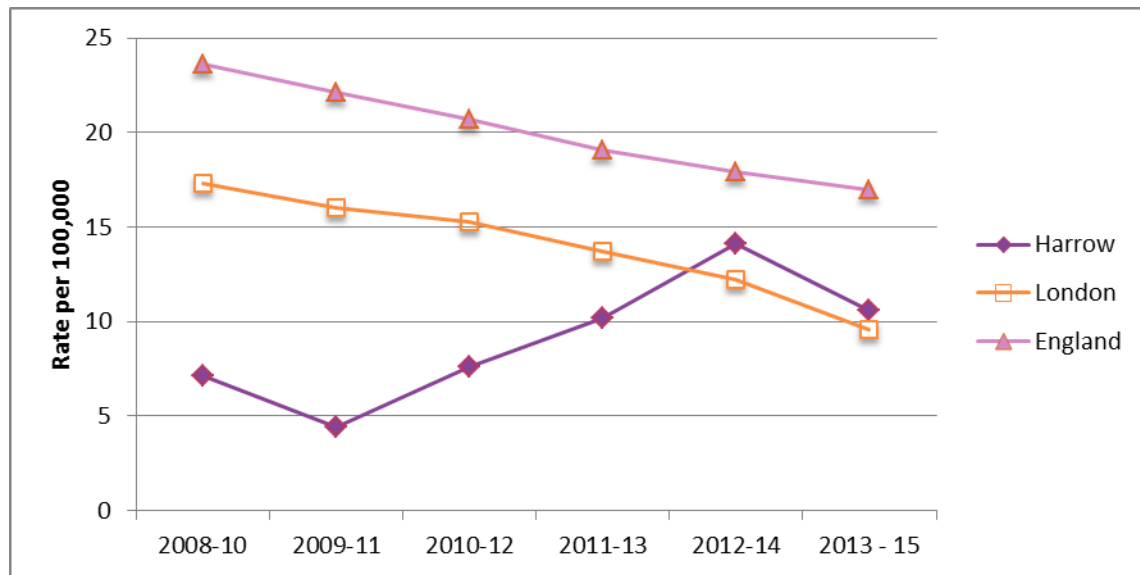


SOURCE: PHE CHIMAT

7.11.3 YOUNG PEOPLE KILLED AND SERIOUSLY INJURED IN ROAD TRAFFIC ACCIDENTS

As mentioned, deaths due to road traffic accidents increase with age, but even so, at a local level the numbers are small and difficult to interpret. To help us see trends we combine deaths and serious injuries over 3 years. These data show that rates have been decreasing steadily cross England and across London. However, although the Harrow rates are much lower than the national rates, the trend in Harrow was steeply increasing between 2010 and 2014 and by 2014 the rate exceeded the London average. The rate dropped in 2015 but remained above the London average.

FIGURE 24 CRUDE RATE OF CHILDREN AGED 0-15 YEARS WHO WERE KILLED OR SERIOUSLY INJURED IN ROAD TRAFFIC ACCIDENTS PER 100,000 POPULATION



SOURCE: PHE CHILD HEALTH PROFILES

The increasing rates of road traffic casualties in Harrow is evidence of a need for health visiting and school nursing teams to work with the council, early years and schools to improve road safety education for children and support road safety campaigns.

7.12 LIFESTYLE: CHILDHOOD OBESITY

The national child measurement programme (NCMP) collects information on body mass index (BMI) of children in reception year (on children aged 4-5 years) and year 6 (on children aged 10-11 years). The programme was established in 2006 and, in Harrow, the School Nursing Service is currently responsible for carrying out the measurements in schools across the borough.

7.12.1 KEY MESSAGES

- Overall levels of obesity have decreased in both Reception and Year 6 school groups, and remain lower than the regional and national figures
- Reception year obesity at 8.2% , is the lowest recorded in the last 10 years since the data was first published (excluding 2010/11 when there was a data problem), and has decreased by 1% on the previous year 2014/15
- A decrease in obesity has also been seen in Year 6 children - 20.2% compared to 21.1% in 2014/15
- Whilst reception overweight levels have also decreased, 9.2% compared with 10.4% in 2014/15, Year 6 overweight levels have increased, 15.4% compared to 12.6% in the previous year
- The combined overweight and obesity figure for Reception year children therefore has also decreased to 17.4% compared to 19.6% in 2014/15.
- However, due to the increase in overweight prevalence noted in Year 6 children, the combined rate has increased from 33.7% to 35.6% for the Year 6 group in Harrow

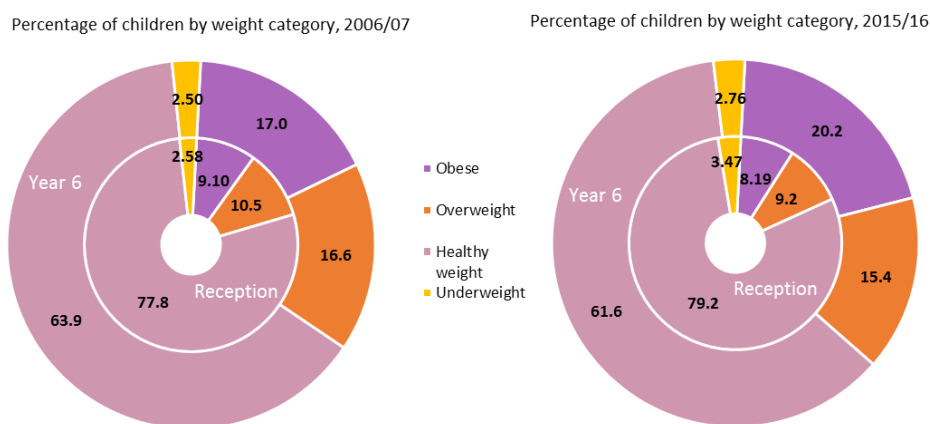
Instead of using fixed BMI thresholds to classify individuals (as used for adults) children's BMI is categorised using variable thresholds that take into account the child's age and sex. Many countries have their own population-specific thresholds for assessing BMI in children and comparison cannot be made when data calculated using different growth references. The child growth reference used for the NCMP is the British 1990 growth reference (UK90). The UK90 data comes from a study of over 32,000 children and young people and the NCMP compares each child's height and weight against this reference population. This allows children to be classified as being in one of four categories:

- Underweight: 2nd centile i.e. a lower BMI than 98% of the UK90 population
- Normal weight:
- Overweight: 85th centile i.e. a higher BMI than 85% of the UK90 population
- Obese: 95th centile i.e. a BMI which is in the highest 5% of the UK90 population

The programme now has 10 years of robust trend data, where participation rates remain high and in 2015/16 the rates were 95.7% and 93.6% for Reception and Year 6 respectively. Over the last 10 years, the proportion of children in the overweight and obese categories has decreased in reception year children. The proportion that is underweight has increased slightly.

In the Year 6 children, the proportion of children who are overweight has decreased slightly but the proportion that are obese has increased by over 3%.

FIGURE 25 A COMPARISON OF NCMP RESULTS OVER 10 YEARS OF THE PROGRAMME



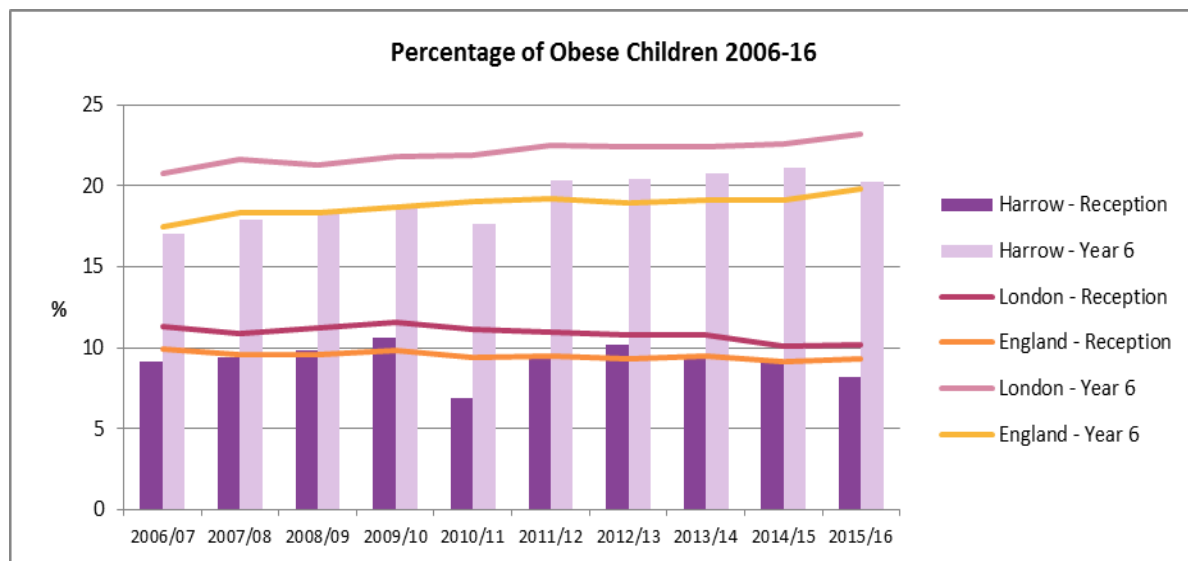
SOURCE: NATIONAL CHILD MEASUREMENT PROGRAMME

The 2015-6 data shows that 8.2% of reception age children were obese in Harrow. This is lower than the national (9.3%) and London (10.2%) averages. This is an overall decrease of 0.9 % since the programme first started in 2006/07 and around 1% decrease since the previous year (2014/15).

Obesity levels have seen some annual fluctuation since the programme began. In general rates of obesity in Harrow are similar to those of England and lower than those of London. Since 2011/12 there has been a decreasing trend in obesity rates in Reception children.

However, in the same time period there was an increase in obesity rates in Year 6 children, although the most recent year's data shows a decrease.

FIGURE 26 TRENDS IN OBESITY IN YEAR 6 AND RECEPTION CHILDREN



SOURCE: NATIONAL CHILD MEASUREMENT PROGRAMME

The rates of obesity in reception children can be influenced by health visitors and the early years workforce. Programmes such as Busy Feet and Change4Life’s 10 minute shake up and Food Smart can build physical activity and healthy eating into everyday life. Once a child goes to school, the teaching staff and school nurses can influence their rates of physical activity and promote healthy eating.

Best practice sees school nurses and teachers running the measurement day as a totally integrated element of a whole school approach to healthy lifestyles – and not as an interruption to the school routine. The Change4Life School Zone (<https://campaignresources.phe.gov.uk/schools>) has a range of resources to support schools and school nurses to do this: letters and presentation materials for parents, teaching resources appropriate for both reception and year 6, school assembly presentations. The “Our Healthy Year” materials give ideas for schools to be healthy throughout the whole school year, have plenty of great tips that schools can take on board and that support the key public health messages associated with maintaining a healthy weight.

When parents receive their feedback letters reporting on the weight status of their children, many local areas give school nurses or other health professionals as a contact point for seeking further advice. The NCMP therefore points the way to holding those important first conversations with children and their parents and families about how to regain a healthy weight status. Programmes such as HENRY (Healthy Eating and Nutrition for the Really Young) provide valuable training in how to support parents to integrate healthy eating into their families.

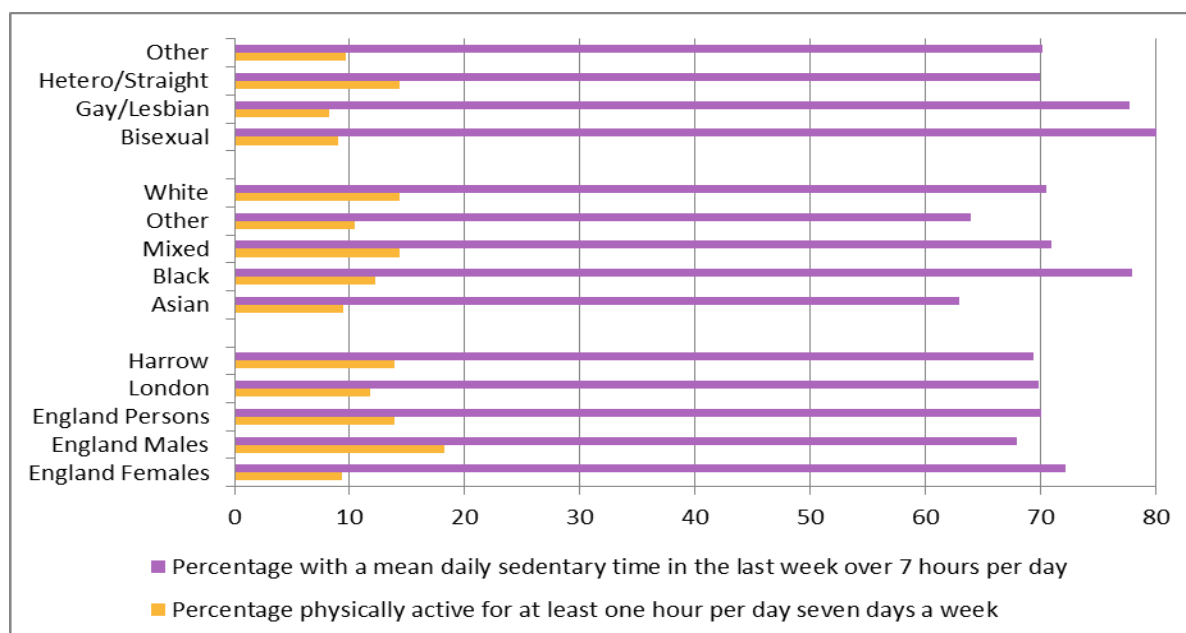
7.13 LIFESTYLE: PHYSICAL ACTIVITY

Regular moderate-to-vigorous physical activity (MVPA) has significant benefits to health: It is associated with increased musculoskeletal and cardiovascular health and has also been linked with psychological benefits, such as reduced anxiety and depression among children and adolescents. Good physical activity habits established in childhood and adolescence are likely to be carried through into adulthood, while lower levels of activity are associated with obesity. The World Health Organisation (WHO) guidelines on physical activity advise children to undertake at least an hour of MVPA daily. The evidence suggests, however, that a significant proportion of adolescents do not meet this minimum standard.

Young people who spend more time sedentary (i.e. activity with very low energy expenditure, undertaken primarily sitting or lying down) have greater fat mass, higher BMI and an increased risk of being overweight or obese, irrespective of their levels of physical activity when not sedentary. Therefore it is important to track levels of sedentary behaviour as well as physical activity.

A study by University of Essex found that the least fit child in a class of thirty tested in 1998 would be amongst the five fittest children in a class of thirty tested today.¹³ Despite the evidence for the effectiveness of physical activity in the prevention of obesity and in reducing the risk of a range of conditions from diabetes to depression, and the evidence for an increasingly sedentary generation of children, there are no national measurement programmes that look at the fitness of children or even the amount of physical activity undertaken. Measures of the amount of physical activity taken in schools have not included the amount of time for changing for sports or for sedentary activities within the physical activity periods and break times. There has been a call for the introduction of a fitness measure to be made alongside the National Child Measurement programme but so far this has not been introduced by the Government.

FIGURE 27 ACTIVE AND SEDENTARY BEHAVIOURS IN 15 YEAR OLDS (2014/5)



SOURCE: WAY SURVEY, PHE

The What About YOUth survey asked a number of questions to ascertain the number of hours per day that teenagers spend in sedentary behaviour (includes, watching TV, reading, playing computer games and using smart phones). The survey found that 70% of 15 year olds spent "about 7 or more hours a day" doing sedentary behaviours on weekdays. The Harrow, London and England rates are similar. Nationally, a greater proportion of females than males, LGBT than straight and Black young people than other ethnic groups were sedentary for 7 hours or more per day. Asian young people were much less likely to engage in excessive sedentary behaviour.

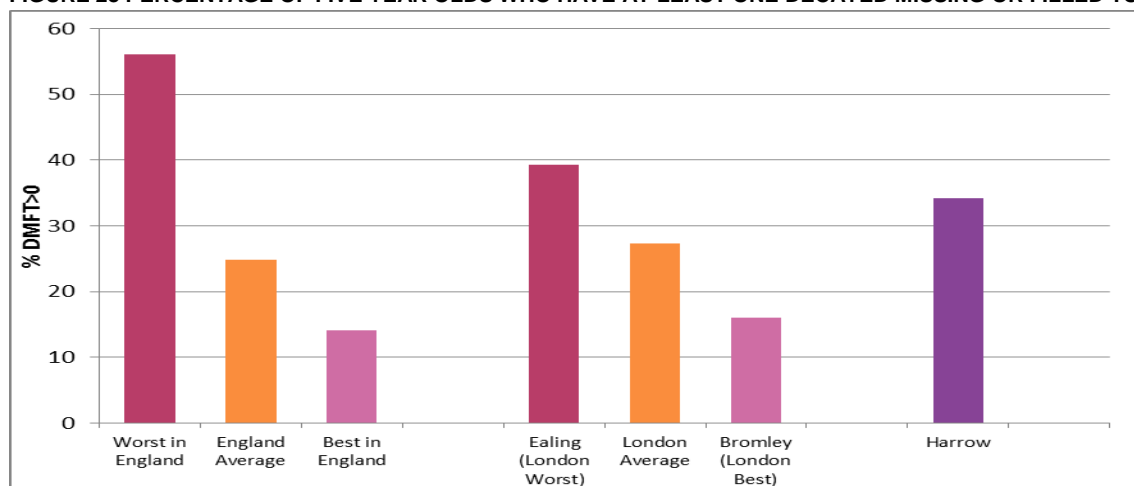
The survey also shows that only 14% of 15 year olds participate in one hour of exercise per day. The Harrow rate is the same as the England average and is higher than the London rate. The difference between males and females is more marked with twice as many young men doing at least an hour a day of physical activity than young women (18% compared to 9%). Fewer than one in ten Asian young people and LGBT young people did an hour of physical activity a day.

7.14 LIFESTYLE: TOOTH DECAY

Tooth decay is a predominately preventable disease and is a good albeit indirect, proxy measure of child health and diet as high levels of consumption of sugar-containing food and drink which contribute to tooth decay are also implicated as contributory factors in other issues of concern, e.g. childhood obesity.

Tooth decay remains a significant public health problem, particularly among young children in disadvantaged communities, with the associated dental problems of toothache, abscesses and extractions. At 5 years old, more than a third of Harrow children decayed or missing filled teeth (dmft). This is significantly higher than the London and England rates, and is fourth worst in London and 23rd worst out of 150 authorities England.

FIGURE 28 PERCENTAGE OF FIVE YEAR OLDS WHO HAVE AT LEAST ONE DECAYED MISSING OR FILLED TOOTH



SOURCE PHE NATIONAL DENTAL SURVEY

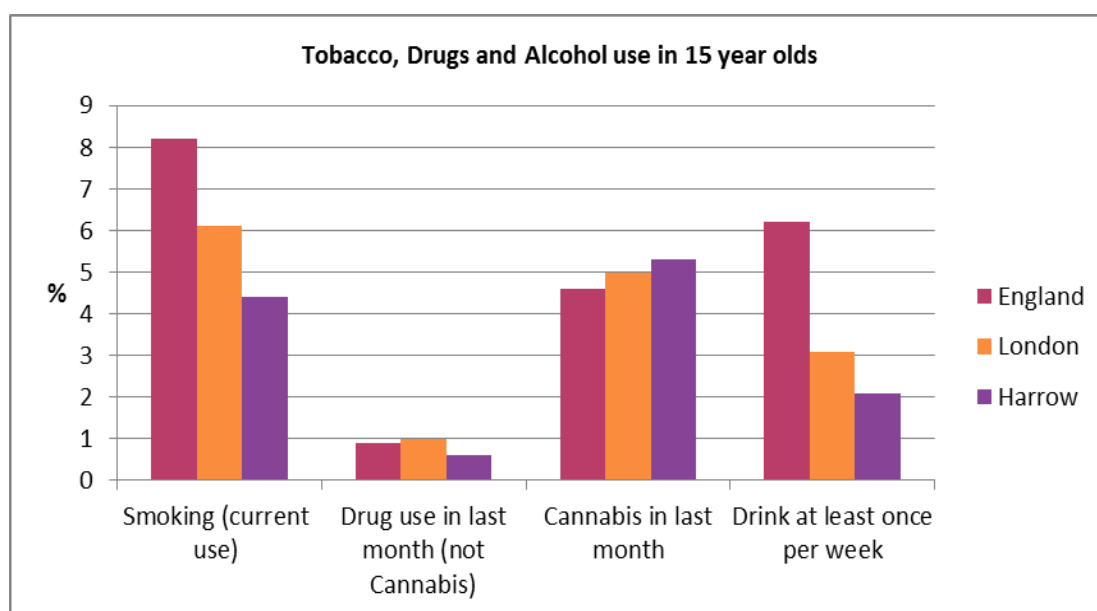
7.15 LIFESTYLE: TOBACCO, ALCOHOL AND DRUGS

7.15.1 TOBACCO

Children who live with parents that smoke are 3 times more likely to become smokers. Two thirds of adult smokers say they started smoking before they were 18. Children can become addicted to the nicotine in tobacco very quickly, even before they have started smoking daily and between a third and a half of young people that try smoking are likely to become regular smokers within two to three years.

The What About YOUth (WAY) survey in 2014/15 showed that 4.4% of young people aged 15 were current smokers in Harrow. This is lower than the London and England rates (6.1% and 8.2% respectively) and reflects the low prevalence of adult smoking in the borough (13.2%).

FIGURE 29 TOBACCO DRUG AND ALCOHOL USE IN YOUNG PEOPLE



SOURCE: WHAT ABOUT YOUTH (WAY) SURVEY 2014-15

7.15.2 DRUGS

Illicit drug use, particularly by young people, continues to be one of the most significant public health challenges in England and a key policy concern for the government. There is evidence to suggest that young people who use recreational drugs run the risk of damage to mental health including suicide, depression and disruptive behaviour disorders. Regular use of cannabis or other drugs may also lead to dependence. Among 10 to 15 year olds, an increased likelihood of drug use is linked to a range of adverse experiences and behaviour, including truancy, exclusion from school, homelessness, time in care, and serious or frequent offending. There have been several strategic initiatives in this area in recent years.

The What About YOUth (WAY) survey in 2014/15, asked a question about whether or not the young person had tried drugs other than cannabis. It then asked when the last time had been. In Harrow, 0.6% of 15 year olds answering the survey said that they had tried drugs (excluding cannabis) within the past month. This is slightly lower than the London and National rate (1% and 0.9% respectively).

However, the pattern for cannabis is reversed with 5.3% of 15 year olds in Harlow having taken cannabis in the past month; higher than the London and National rates (5% and 4.6% respectively). This suggests that cannabis is a bigger problem for Harlow than other illegal drugs.

Children and Young people are not just affected by their own drug use but also if they live in a household where an adult uses drugs. We do not have estimates of children living in households where there is substance/drug misuse. However, data is available to show the rate of parents who are attending treatment for substance misuse, who live with their child or children aged 0-15. In Harlow, the rate was 122.4 per 100,000, which was higher than the London and National rates (104.1 and 110.4 per 100,000 respectively)

7.15.3 ALCOHOL

Excessive alcohol consumption is a major health concern in England. The national Alcohol Strategy published in 2012 sets out proposals aimed at tackling the 'binge drinking' culture and its associated impacts, as well as to reduce the number of people who drink to damaging levels. Research has highlighted the fact that young people who start drinking alcohol at an early age tend to drink more frequently and more in total than those who start drinking later in their life; as a result, they are more likely to develop alcohol problems in adolescence and adulthood. In 2009, The Chief Medical Officer for England issued guidance that young people under 15 should not drink alcohol at all.

The What About YOUTH (WAY) survey in 2014/15 asked 15 year olds "How often do you usually have an alcoholic drink?". 2.1% of the young people in Harlow responded that they drink alcohol at least once per week. This is lower than the London level of 3.1% and much lower than the national rate of 6.2%.

8 LOCAL SERVICES

8.1 CHILDREN'S SERVICES

- At 31 December 2016, 1,753 children had been identified through assessment as being formally in need of a specialist children's service. This is a reduction from 1,827 at 31 March 2016.
- At 31 December 2016, 228 children and young people were the subject of a child protection plan (a rate of 40 per 10,000 children). This is an increase from 195 (34 per 10,000 children) at 31 March 2016.
- At 31 March 2016, six children lived in a privately arranged fostering placement. This is a small increase from a low number at 31 March 2015.
- In the past 2 years, three serious incident notifications have been submitted to Ofsted and two serious case reviews have been completed.
- At 31 December 2016, 200 children were being looked after by the local authority (a rate of 35 per 10,000 children). This is an increase from 180 (32 per 10,000 children) at 31 March 2016. Of this number:
 - 8 (34%) live outside the local authority area
 - 17 live in residential children's homes, all of whom live out of the authority area
 - a very small number live in residential special schools³ which are out of the authority area
 - 136 live with foster families, of whom 36% live out of the authority area
 - a very small number live with their parents in the authority area
 - 23 children are unaccompanied asylum-seeking children.

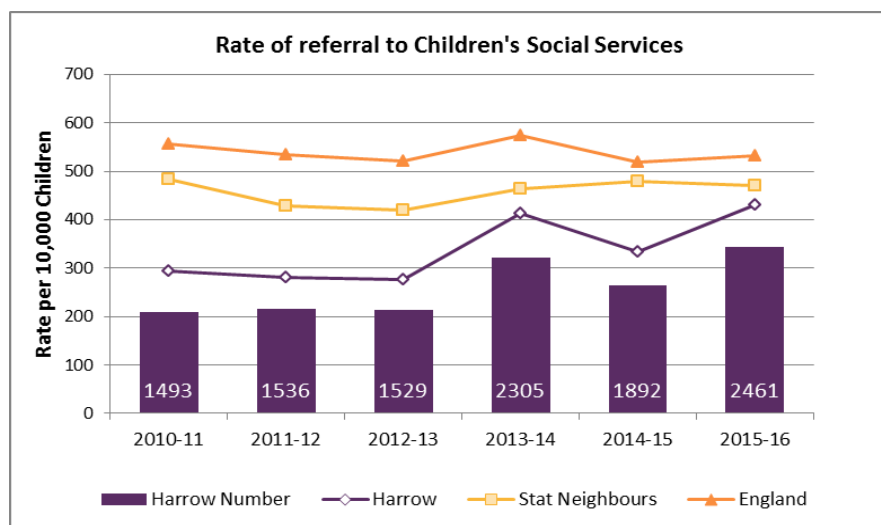
In the past 12 months:

- there have been nine adoptions
- 18 children became the subject of special guardianship orders
- 144 children ceased to be looked after, of whom 6% subsequently returned to be looked after
- 16 children and young people ceased to be looked after and moved on to independent living

8.1.1 REFERRALS

The number of referrals to children's social care has been increasing in recent years. Although the population has increased in this time, the increase cannot be put down to the number of children in the population as the rate of referrals is also increasing. Provisional 2016-17 data shows 2,469 referrals giving an estimated rate of 502.3 at year end. This is a significant increase and gives a rate above statistical neighbours for 2015-16.

FIGURE 30 RATE OF REFERRAL TO CHILDREN'S SERVICES 2010-2016

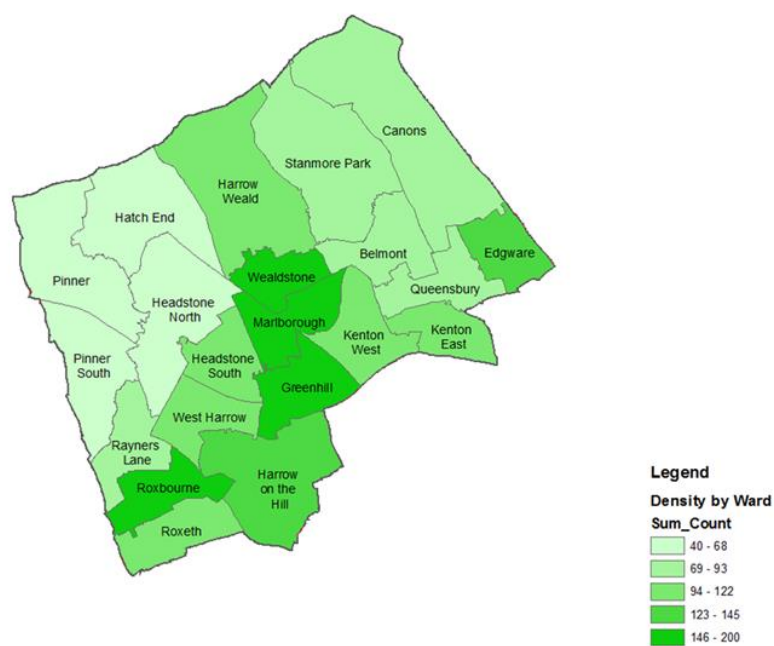


SOURCE: DEPARTMENT FOR EDUCATION: CHARACTERISTICS OF CHILDREN IN NEED IN ENGLAND

Although referrals come from every part of the borough, the highest number of referrals came from Wealdstone, Marlborough, Greenhill and Roxbourne wards.

FIGURE 31 RATE OF REFERRALS BY WARD – HARROW 2015-16

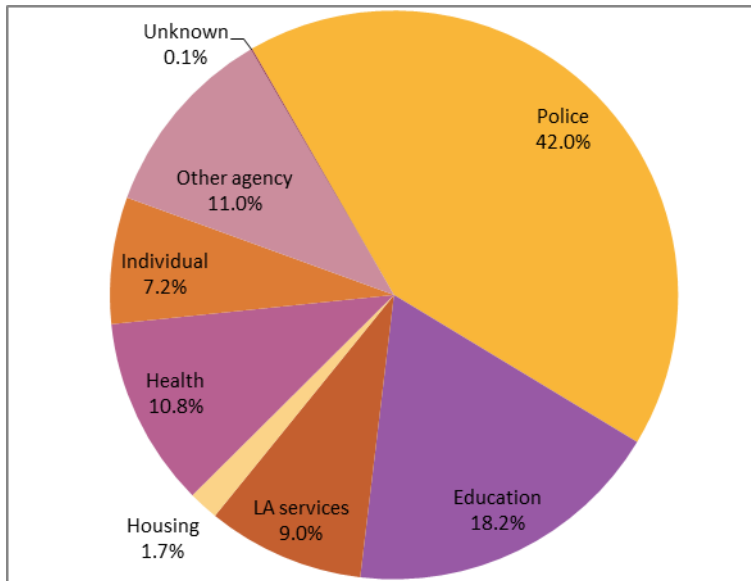
Referral to Targeted Services in 2015/16



SOURCE: LOCAL DATA

42% of referral came from the police, followed by education (predominantly schools), external agencies (e.g. other LAs, criminal justice system, immigration) and the health sector (e.g. GPs, hospitals ambulance services).

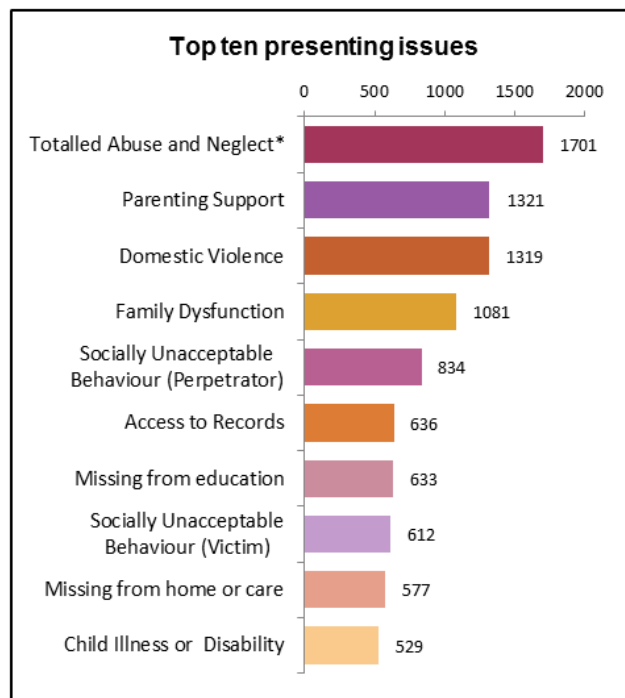
FIGURE 32 SOURCE OF REFERRALS



SOURCE: LOCAL DATA

There are a wide range of reasons for referrals but the local analysis shows that the top reasons for referrals were abuse and neglect; parental support and domestic violence. This pattern is consistent with previous years and with both statistical neighbours and England as a whole. The abuse and neglect category can be further refined and shows more than half in this category were for physical abuse, almost a quarter for neglect and the remainder split between sexual abuse and emotional abuse.

FIGURE 33 MAIN REASON FOR REFERRAL



SOURCE: LOCAL DATA

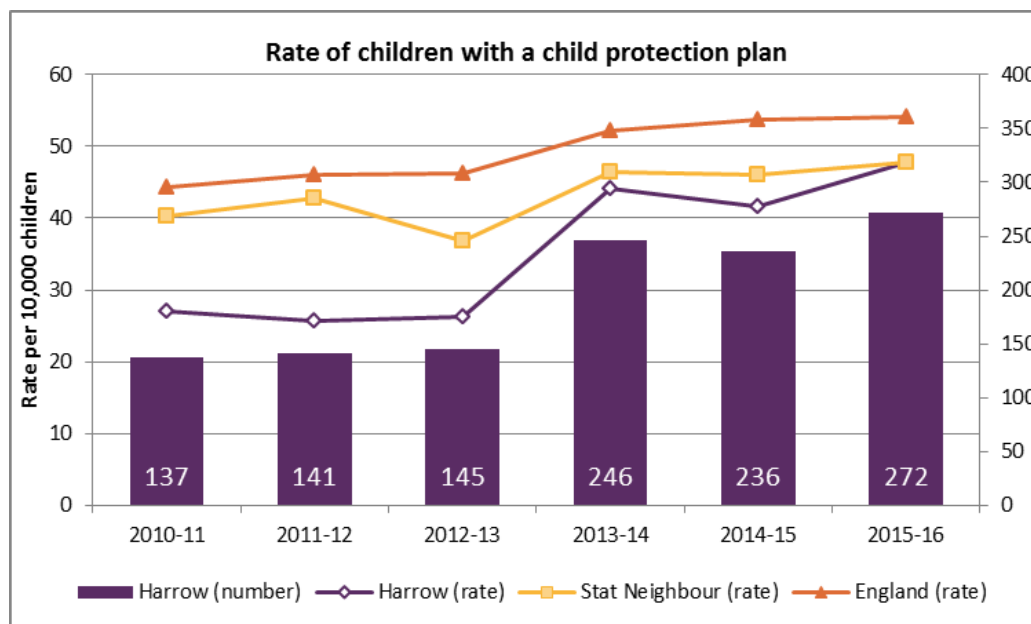
8.1.2 CHILDREN AT RISK

Children at risk may be made the subject of a child protection plan. Before April 2008, children at risk would have been placed on the child protection register. The child protection register no longer exists. Now, if a child is considered to be at risk, a child protection conference will be called. If, at the initial conference, it is agreed that the child is at risk of significant harm, and a decision is made that action needs to be taken to protect the child, an outline child protection plan will be agreed and a core group identified. The plan is a written record for parents, carers and professionals which sets out:

- who the key worker is - usually the social worker
- what work needs to be done to reduce the concern
- what needs the child has and how children’s services can help to meet them
- what needs the parent(s) have and in what ways children’s services can help
- concerns and why the work needs to happen
- a time frame for when the work should happen
- specific responsibilities of who should do the work

In the last three years, the number of new CPPs has increased significantly in Harrow and is now in line with statistical neighbour average. Estimated year end rate for 2016-2017 likely to be higher than our statistical neighbours and probably higher than the England average. In Harrow, 11.4% of children in need had a recorded disability. This is slightly higher than statistical neighbours (10.8%) and slightly lower than England (12.7%).

FIGURE 34 RATE OF CHILDREN WITH A CHILD PROTECTION PLAN 2010-2016



SOURCE: DFE CHARACTERISTICS OF CHILDREN IN NEED IN ENGLAND

In 2015-16, published data shows Harrow has a slightly lower proportion of children with a child protection plan under the category of ‘Neglect’, ‘Physical abuse’ and ‘Sexual Abuse’ and a significantly higher proportion under the category of ‘Emotional Abuse’. This pattern persists for Harrow in the 2016-17 data.

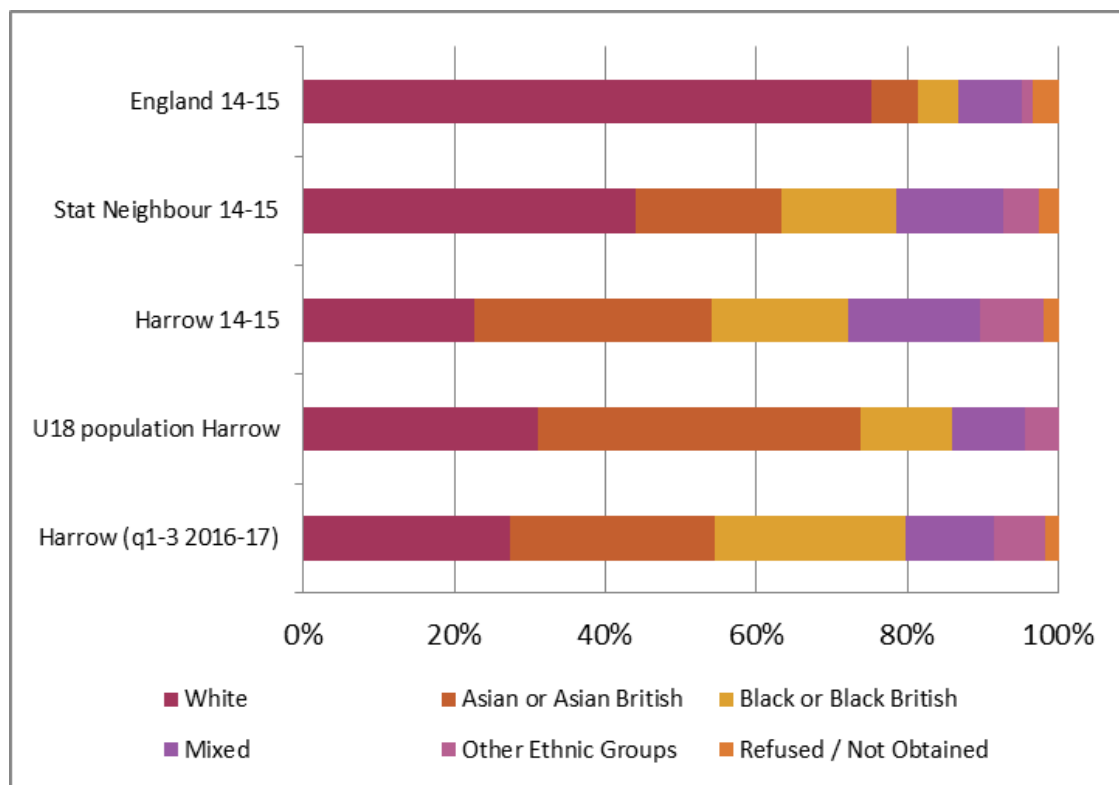
FIGURE 35 CHILDREN WHO BECAME THE SUBJECT OF A PLAN BY LATEST CATEGORY OF ABUSE, 2015-6

	Neglect	Physical Abuse	Sexual Abuse	Emotional Abuse	Multiple
Harrow	36.8%	6.3%	x	55.1%	x
Stat Neighbour	38.8%	10.0%	4.0%	45.7%	2.1%
England	43.8%	8.7%	4.6%	37.8%	5.1%

x – data suppressed to avoid deductive disclosure

Because of Harrow’s diverse ethnic population, it is not appropriate to compare the ethnicity of those referred to local services with the England data or even with the statistical neighbours. However, if we compare the data with the population of children in the borough in broad categories, it is apparent that Black/Black British children are over represented as are mixed race and the ‘Other’ ethnic group. White/White British and Asian/Asia British ethnicities are underrepresented compared to Harrow child population.

FIGURE 36 ETHNICITY OF CHILDREN WITH CHILD PROTECTION PLANS



SOURCE: DFE CHARACTERISTICS OF CHILDREN IN NEED IN ENGLAND; ONS POPULATION STATISTICS; AND LOCAL DATA

8.2 CHILDREN LOOKED AFTER

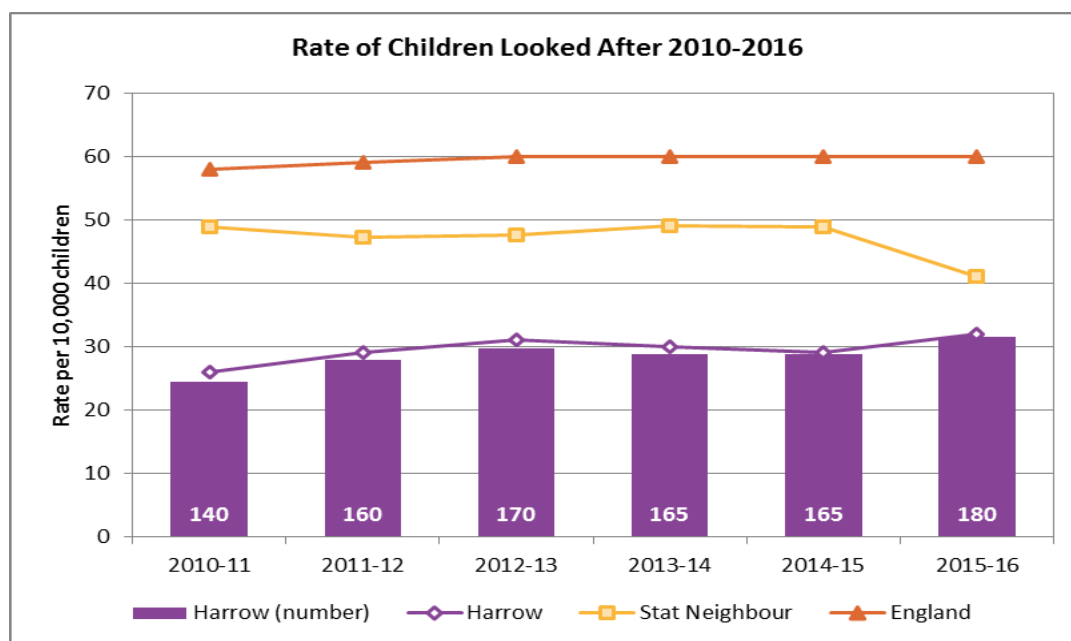
Children Looked After (CLA), also known as children in care, are children who are being looked after by their local authority. They might have been placed in care voluntarily by parents struggling to cope, or children's services may have intervened because a child was at significant risk of harm. Providing a secure, caring environment in care can help children and young people overcome their early life experiences. It can ensure that children in care are given best chances in life. CLA might be living:

- with foster parents
- at home with their parents under the supervision of social services
- in residential children's homes
- other residential settings like schools or secure units.

CLA numbers in Harrow have continued to increase throughout the current year with overall numbers showing a gradual increase from 2012. The rate of CLA per 10,000 is going up but continues to remain below the England and statistical neighbour averages. At 31 December 2016, 200 children were being looked after by the local authority (a rate of 35 per 10,000 children). This is an increase from 180 (32 per 10,000 children) at 31 March 2016. Of this number:

- 8 (34%) live outside the local authority area
- 17 live in residential children's homes, all of whom live out of the authority area
- a very small number live in residential special schools which are out of the authority area
- 136 live with foster families, of whom 36% live out of the authority area
- a very small number live with their parents in the authority area
- 23 children are unaccompanied asylum-seeking children.

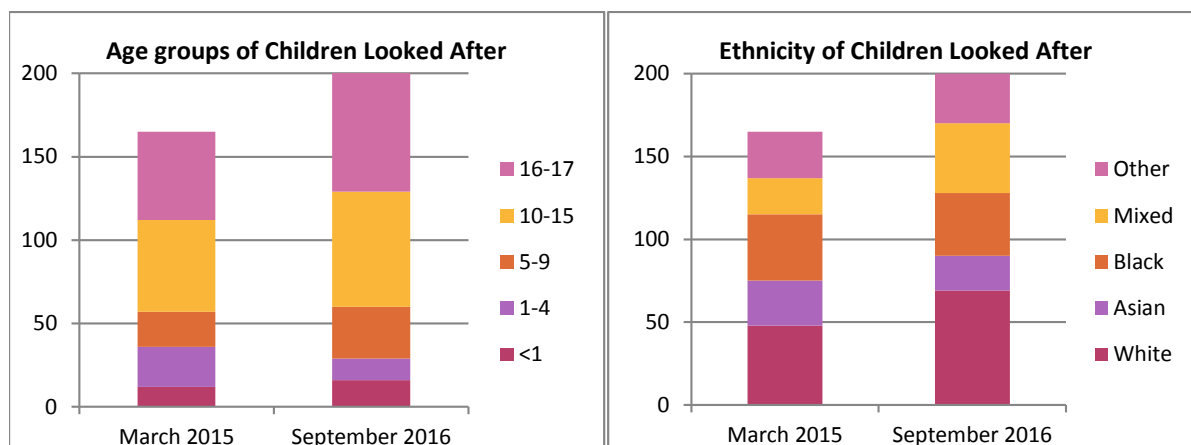
FIGURE 37 RATE PER 10,000 POPULATION OF CHILDREN LOOKED AFTER AS AT 31 MARCH 2016



SOURCE: DFE CHARACTERISTICS OF CHILDREN IN NEED IN ENGLAND

The largest group of CLA is the 16-17 year age group and the number of young people in this age group has increased in the two years. The number of children in the 1-4 age group has decreased over the same time. Black, Mixed race and the Other ethnic groups are over represented in the CLA group. There are significantly fewer Asian CLA than might be expected for the local population.

FIGURE 38 AGES AND ETHNICITY OF CHILDREN LOOKED AFTER IN HARROW



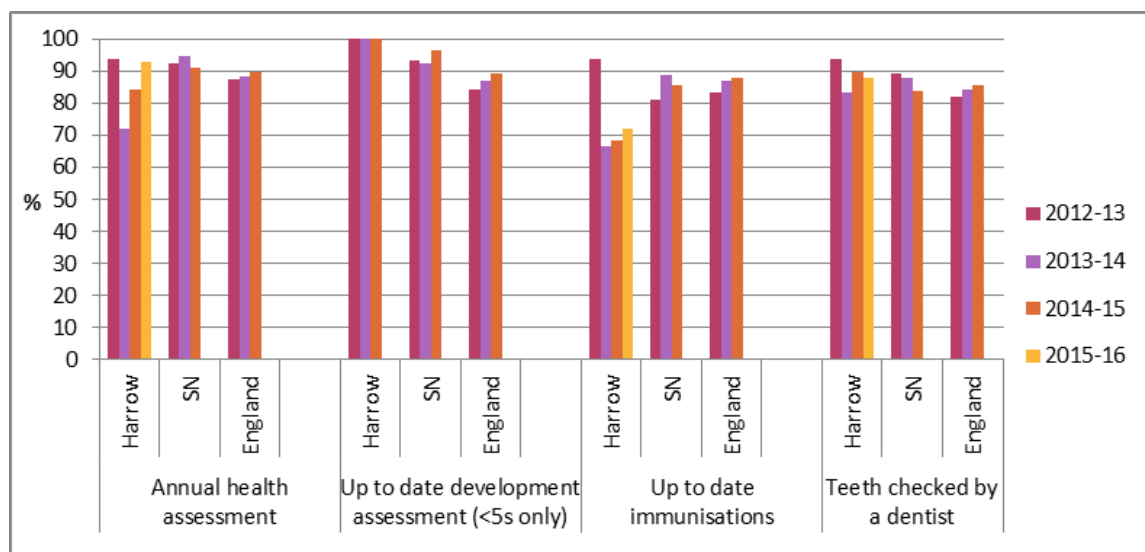
SOURCE: LOCAL DATA

Children can stop being Looked After in a variety of ways. In the past 12 months:

- there have been nine adoptions
- 18 children became the subject of special guardianship orders
- 144 children ceased to be looked after, of whom 6% subsequently returned to be looked after
- 16 children and young people ceased to be looked after and moved on to independent living
- 53 children and young people ceased to be looked after and are now living in houses of multiple occupation. All of these children are supported by providers who specialise in accommodation for young people either through on-site or floating support.

Children who become newly looked after require an initial health assessment within 20 working days. Annual health assessments had dropped in 2013-14 but has since improved and is currently slightly over the England rate. Development assessments are undertaken for children under 5. This group is the smallest in the Harrow CLA group and their development assessments are complete. Immunisation rates were excellent in 2012-13 but dropped dramatically when the change from PCT to NHS England responsibility, which suggests issues of data capture rather than performance. This has improved but remains well below the national average. Rates of dental checks have been higher than the National rate but are currently only slightly higher. Comparator data for 2016 has not yet been published for statistical neighbours (SN) or England.

FIGURE 39 HEALTH ASSESSMENTS FOR CHILDREN LOOKED AFTER

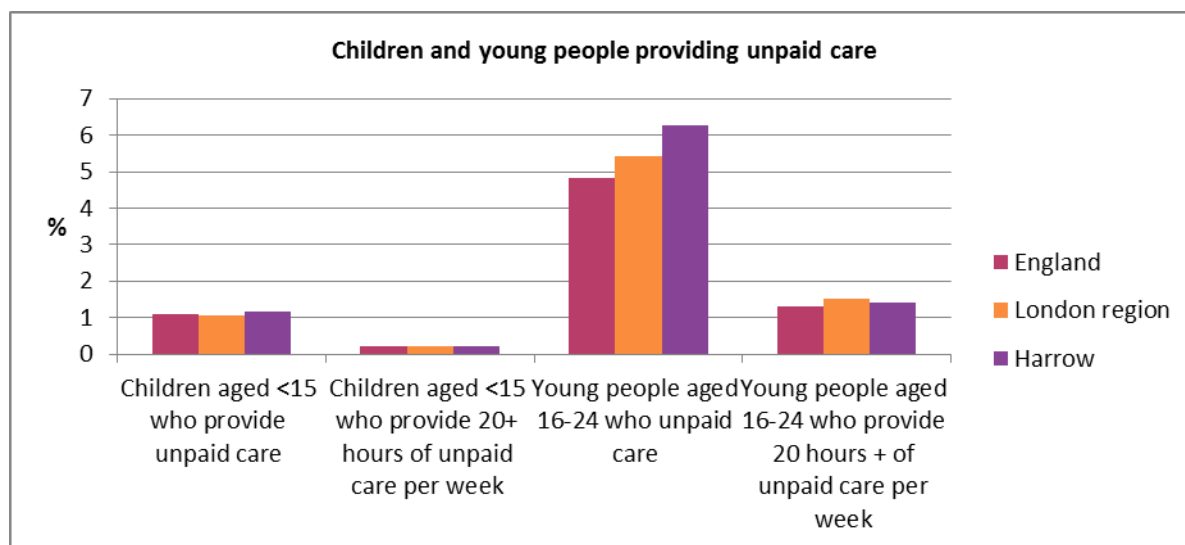


SOURCE: DFE CHARACTERISTICS OF CHILDREN IN NEED IN ENGLAND

8.3 YOUNG CARERS

A person is a provider of unpaid care if they look after or give help or support to family members, friends, neighbours or others because of long-term physical or mental ill health or disability, or problems related to old age. This does not include any activities as part of paid employment. Being a young carer can have an impact on the child/young person’s health, social life and self confidence. Many struggle to balance caring responsibilities with their education causing stress. Nationally, less than 40% of young carers said that no-one in their school was aware of their caring responsibilities and 1 in 20 have missed school because of them. Over a quarter have been bullied at school because they are a carer. In Harrow ,only 37% of young carers are meeting national standards in both maths and English.

FIGURE 40 PROPORTION OF CHILDREN YOUNG PEOPLE WHO ARE YOUNG CARERS (2011 CENSUS)



SOURCE: 2011 CENSUS

A Young Carer becomes vulnerable when the level of caregiving and responsibility to the person in need of care becomes excessive or inappropriate for that child, with risk to his/her emotional or physical wellbeing, social networks, educational achievement, and/or life chances. This brings them into the child in need category.

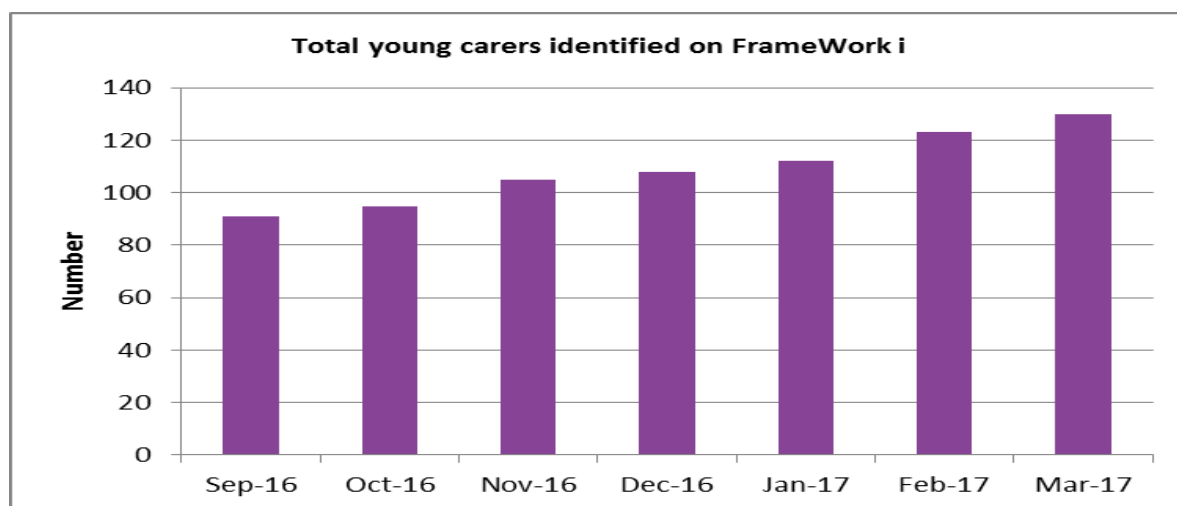
Nationally, many young carers are not identified. The reasons will vary but include a lack of awareness by the child or the parent that they are a young carer; a worry that the family will be split up and taken into care; not wanting to seem different from their peers; hidden parental illness so people don't realise they need help; and a feeling that there is no reason to share their experience as no one understands or can help.

Harrow is no different to this national picture and services are aware of only a small number of Young Carers. Some of these are not receiving support and/ or have not recently had their needs reviewed. There thought to be between at least 863 young carers in Harrow and possibly as many as 3631.

In 2014, the number of Young Carers identified by Harrow Primary Schools was just 1% of their pupil numbers. 11 out of 25 primary schools had identified no young carers at all. In a secondary school of 1000 pupils – there will be average 80 Young Carers. In 2014, Harrow Secondary Schools had identified between 0 and 28 Young Carers. In 2014, Harrow High Schools had identified 12% of the estimated number of Young Carers - 128 Young Carers had been identified out of an estimated 1043.

Data on young carers has been specifically identified on the council's computer system since September 2016. The data shows that on average 6 young carers are identified each month. The average age of the young carers is just under 12 years old.

FIGURE 41 NUMBER OF YOUNG CARERS KNOWN TO HARROW COUNCIL



SOURCE: LOCAL DATA – FRAMEWORK I

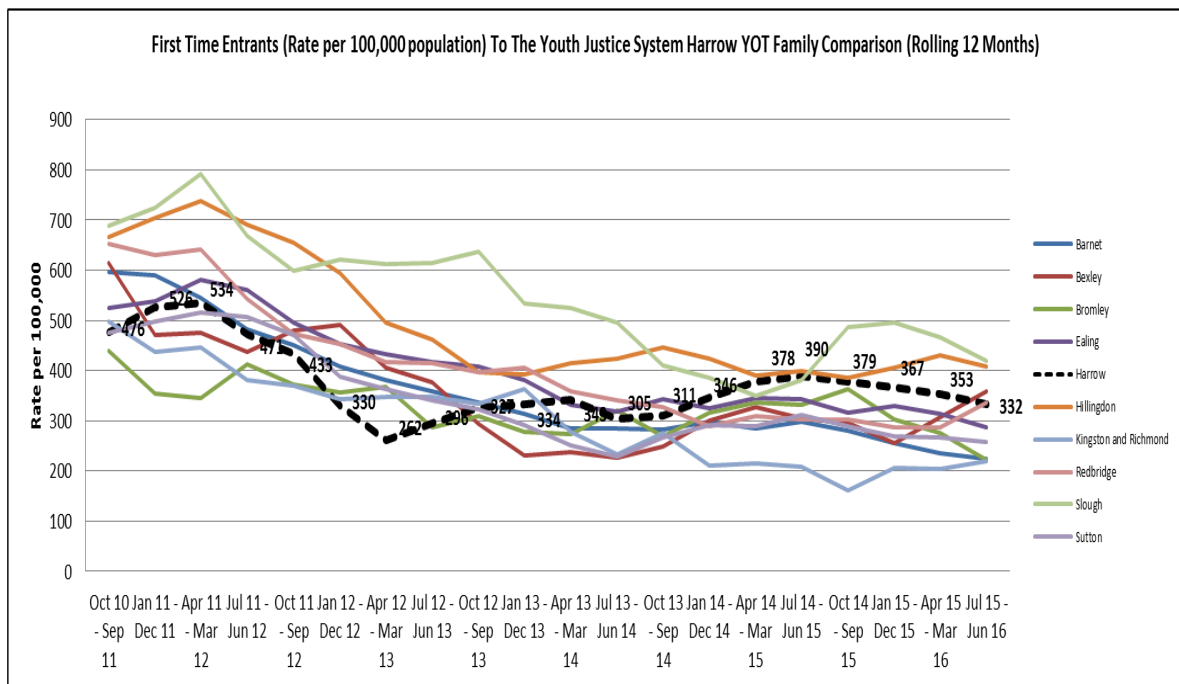
8.4 YOUTH OFFENDING

Adolescence, the transition from childhood to adulthood, is a period where young people develop their personal identity and independence. It is also a time where boundaries are tested and risks taken which results in some young people becoming involved in criminal or antisocial behaviour.

The rate of first time entrants (FTE) to criminal justice system allows for a comparison between areas. Compared to the YOT family (areas similar to Harrow), Harrow's latest FTE rate (Jul 2015 - Jun 2016) of 332 is the 5th highest with the average being 297.

After a decrease in FTE between January 2011 and Mar 2013, where it reached it's lowest rate, there was a gradual increase to June 2015. Thereafter rate have steadily fallen again to the current figure of 332 (Jul 15 - Jun 16) - a decrease of 14.4% on the same period in the previous year. London wide figures have fallen in the same period by 4.1% and YOT family averages have fallen by 7.7%.

FIGURE 42 FIRST TIME ENTRANTS TO YOUTH JUSTICE SYSTEM 2010-16

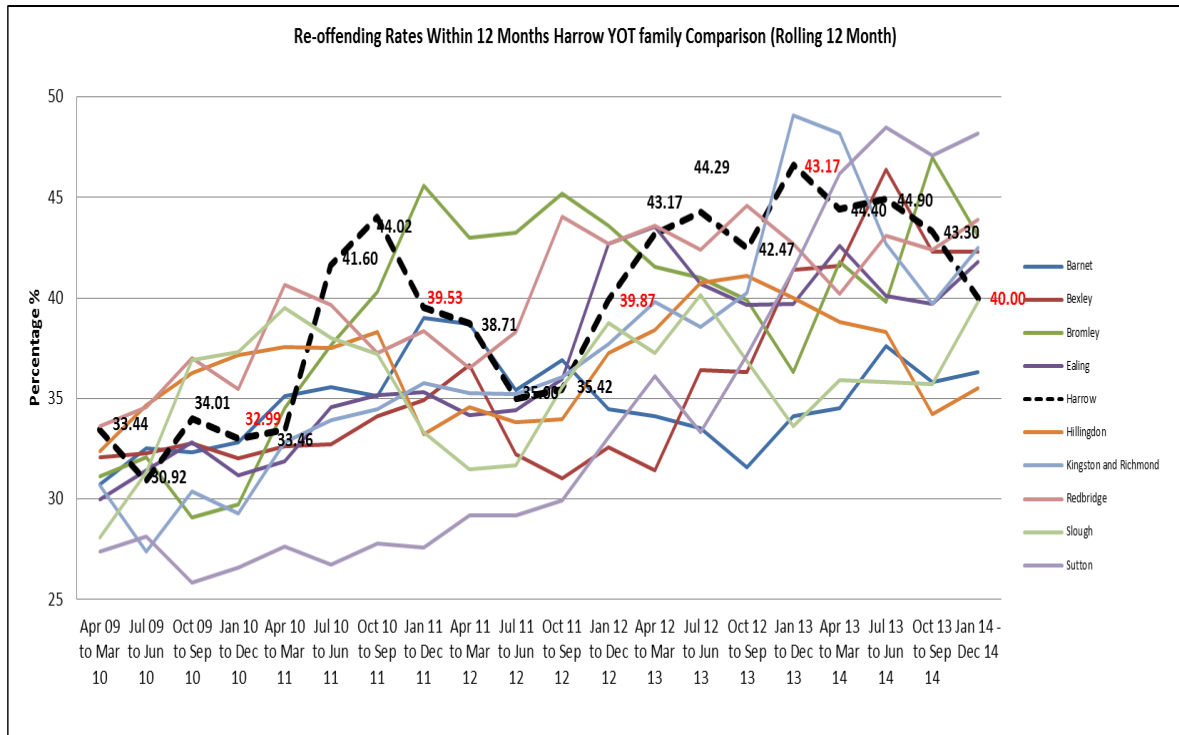


SOURCE: MINISTRY OF JUSTICE: YOUTH JUSTICE STATISTICS

Within Harrow's YOT family the general trend shows a considerable increase in the re-offending rate between the Jul 08 - Jun 09 cohort and the Apr 11 - Mar 12 cohort. This upward trend is also reflected in London wide and national figures. Harrow's re-offending rate has fallen significantly 40.0% (Jan 14 - Dec 14) from it's peak of 46.6% in the Jan 13 - Dec 13 - a 6.6% decrease. This decrease is not reflected in comparator figures with London and England figures remaining the same and YOT family figures increasing slightly (1.6%).

Harrows most recent re-offending rate of 40.0% comprises 50 re-offenders from a cohort of 125. Both the size of the cohort and the number of re-offenders had been decreasing consistently over time until 4 quarters ago (Jan 13 to Dec 14) when it started to rise again. However, the last 3 quarters are showing a steady decrease in both the size of the cohort and the numbers of reoffenders. The current figure represents a decrease in the cohort, down to 125 compared to 134 in the previous quarter. The numbers of re-offenders have also decreased in the current quarter down to 50 compared to 58 in the previous quarter.

FIGURE 43 REOFFENDING RATES WITHIN 12 MONTHS – YOUTH OFFENDING 2009-2014



SOURCE: MINISTRY OF JUSTICE: YOUTH JUSTICE STATISTICS

9 EDUCATION

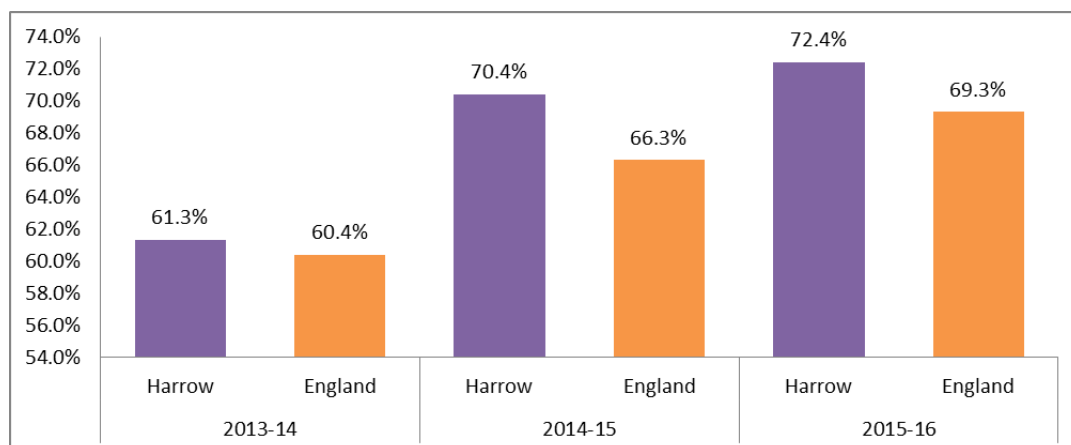
9.1 PRESCHOOL / EARLY YEARS

As at 6 January 2017, there were a total of 4,918 childcare places in Harrow, split between 4,087 PVI's** and 831 child-minders. Please note that child care places are only available as a daily figure, and hence, there is no historical data available.

The percentage of children achieving a good level of development at the Early Years Foundation Stage has significantly increased over the last three years, from 61.3% in 2013-14 to 72.4% in 2015-16, representing an increase of 11% compared to a national increase of 9%.

** PVI – Private Voluntary and Independent sector nurseries

FIGURE 44 PERCENTAGE OF PUPILS IN EYFS ATTAINING A GOOD LEVEL OF DEVELOPMENT: HARROW AND ENGLAND 2013/14 TO 2015/16.

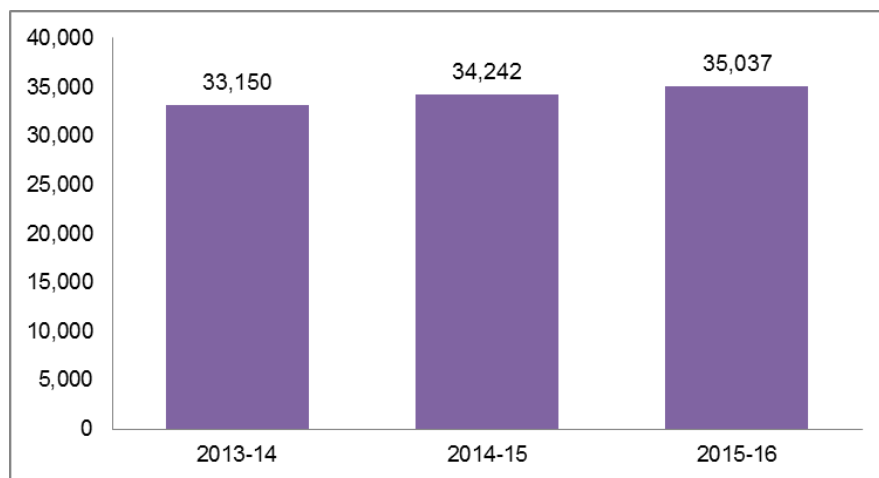


SOURCE: STATISTICAL FIRST RELEASE (SFR50 2016) – CONTAINS DATA FOR 2013/14 TO 2015/16

9.2 SCHOOLS

In 2015-16, there were over 35,000 pupils in Harrow’s state-funded schools. This number has been increasing year on year. Between 2013-14 and 2015-16, there was a 5.7% increase.

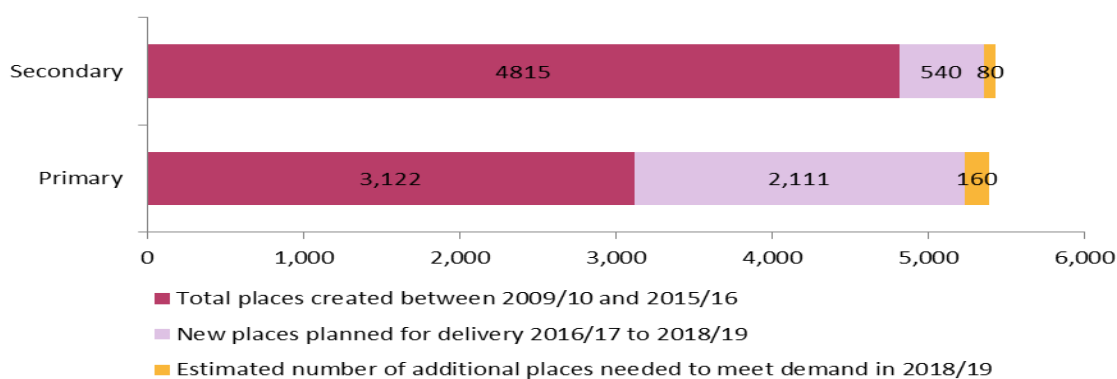
FIGURE 45 NUMBER OF PUPILS ON ROLL: HARROW 2013/14 TO 2015/16



SOURCE: STATISTICAL FIRST RELEASES (SFR15 2014, SFR16 2015 AND SFR20 2016).

However, this growth in the number of pupils is not just a recent occurrence. Growth in primary school pupil numbers have increased by 36% and in primary school pupils by 15% between 2009-10 and the estimated number planned to 2018-19. The Education Funding Agency estimate a further 160 places are needed to meet demand in primary schools and 80 in secondary schools by 2018-19. However, these figures do not take into account any changes in local population as a result of the vote to leave the European Union.

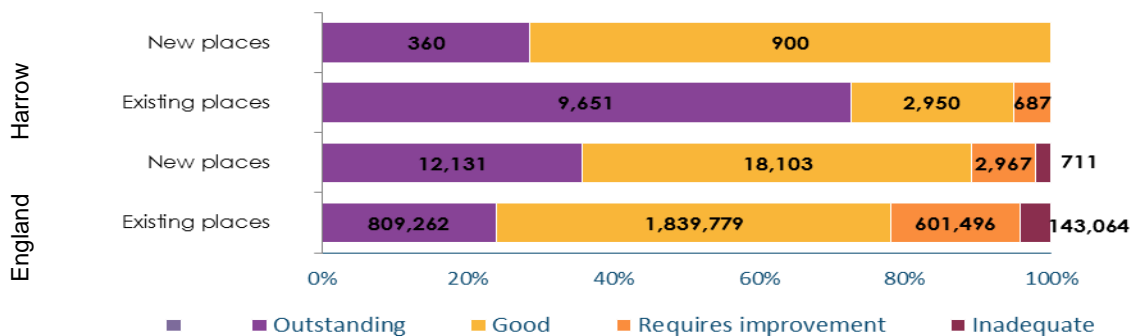
FIGURE 46 PLACES CREATED SINCE 2009/10, PLACES PLANNED TO 2018/19



SOURCE: EDUCATION FUNDING AGENCY: SCHOOL PLACES SCORECARD

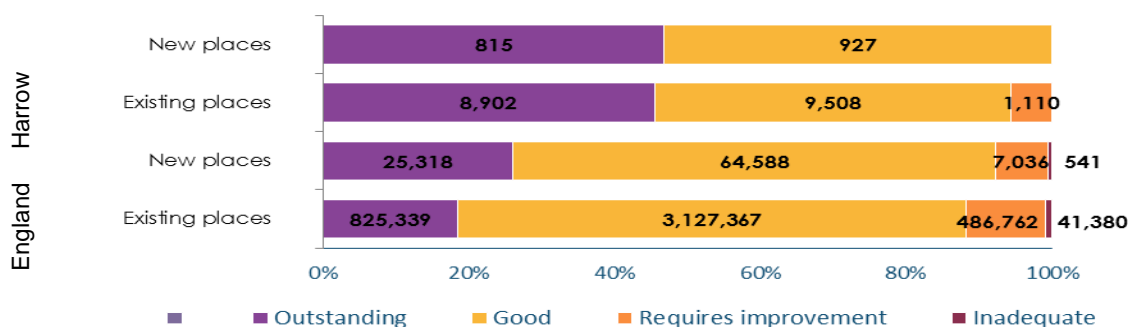
Of all of the new primary and secondary school places created in Harrow to 2015-16, all were created in schools that were classed as outstanding or good.

FIGURE 47 QUALITY OF PRIMARY PLACES CREATED BETWEEN 2014/15 AND 2015/16



SOURCE: EDUCATION FUNDING AGENCY: SCHOOL PLACES SCORECARD

FIGURE 48 QUALITY OF SECONDARY PLACES CREATED BETWEEN 2014/15 AND 2015/16



SOURCE: EDUCATION FUNDING AGENCY: SCHOOL PLACES SCORECARD

The number of primary schools in Harrow has decreased by four between 2013-14 and 2015-16 to 40. The number of high schools has increased by one to 12. Alongside Harrow’s one Pupil Referral Unit there is also a new Alternative Provision free high school. The number of state-funded special schools (4) has remained the same in the last three years recorded. The changes in the number of schools are overall in line with the national picture.

FIGURE 49 NUMBER OF SCHOOLS 2013-16

	2013-14		2014-15		2015-16	
	Harrow	England	Harrow	England	Harrow	England
Number of primary schools	44	16,788	44	16,766	40	16,778
Number of secondary schools	11	3,329	11	3,381	12	3,401
Number of special schools	4	1,033	4	1,040	4	1,039

SOURCE: STATISTICAL FIRST RELEASES (SFR15 2014, SFR16 2015 AND SFR20 2016).

Harrow schools are very popular. There has been a significant increase in the number of children residing outside of Harrow attending Harrow schools, increasing from 3,449 pupils in 2013-14 to 3,926 in 2015-16, representing 11.5% and 12.4%, respectively. This is very different to the national picture, where the percentage of pupils attending school from outside the borough has remained constant at around 5.7% from 2013-14 to 2015-16.

FIGURE 50 PERCENTAGE OF CHILDREN ATTENDING SCHOOL FROM OUTSIDE THE BOROUGH: HARROW AND ENGLAND 2013-14 TO 2015-16.



SOURCE: STATISTICAL FIRST RELEASES (2014-16); JANUARY 2014, 2015 AND 2016 SCHOOL CENSUS

Since 2013-14, Asians have remained the most common ethnic group in Harrow, representing nearly half of Harrow’s population, rising from 46.1% of pupils in 2013-14 to 46.7% in 2015-16. This is vastly different nationally, as Asian pupils only represented 10.0% and 10.4% in 2013-14 and 2015-16, respectively. Moreover, the percentage of Harrow’s Indian school population have increased year-on-year from 19.4% in 2013-14 to 20.6% in 2015-16, whereas, the percentage of Asians from other backgrounds has slowly decreased from 21.0% in 2013-14 to 20.2% in 2015-16. Nationally, Indian pupils only represent 2.7% and 2.8%, respectively, whereas Asians from other backgrounds represent 1.7% and 1.8%, respectively.

Only a quarter of Harrow’s pupil population is White, three times lower than the national. Furthermore, the percentage of White British has fallen steadily from 14.5% in 2013-14 to 12.1% in 2015-16, which falls in line with the national whereas; White pupils from other backgrounds have increased from 11.0% in 2013-14 to 13.8% in 2015-16. Despite the

nationwide decrease of Whites, White British remains most common ethnic group nationally, with steady declines from 77.1% in 2013-14 to 75.6% in 2015-16.

The number of Black African and Black Caribbean pupil's has declined since 2013-14, from 7.7% and 3.5%, to 7.0% and 3.2% in 2015-16, respectively. It should be noted that pupils coming from a Chinese or mixed background have remained constant throughout the last three years, with differences as little as $\pm 0.1\%$ per year.

FIGURE 51 ETHNICITY OF CHILDREN ON SCHOOL ROLL: HARROW AND ENGLAND: 2013-14 TO 2015-16.

	2013-14		2014-15		2015-16	
	Harrow	England	Harrow	England	Harrow	England
White	27.3%	77.1%	27.1%	76.2%	27.4%	75.6%
White British	14.5%	71.6%	13.3%	70.5%	12.1%	69.3%
White Irish	1.6%	0.4%	1.4%	0.3%	1.2%	0.3%
White Irish Traveller	0.2%	0.1%	0.2%	0.1%	0.2%	0.1%
White Gypsy Roma	0.0%	0.3%	0.0%	0.3%	0.0%	0.3%
Any other White background	11.0%	4.8%	12.2%	5.2%	13.8%	5.7%
Mixed	8.3%	4.9%	8.3%	5.0%	8.2%	5.3%
Mixed White Black Caribbean	1.9%	1.4%	1.8%	1.4%	1.7%	1.5%
Mixed White Black African	1.0%	0.6%	1.0%	0.6%	0.9%	0.7%
Mixed White Asian	2.3%	1.1%	2.4%	1.2%	2.4%	1.2%
Any other Mixed background	3.1%	1.7%	3.1%	1.8%	3.2%	1.9%
Asian	46.1%	10.0%	46.6%	10.3%	46.7%	10.4%
Indian	19.4%	2.7%	20.1%	2.8%	20.6%	2.8%
Pakistani	4.9%	4.0%	5.0%	4.1%	5.0%	4.2%
Bangladeshi	0.9%	1.6%	0.8%	1.6%	0.9%	1.7%
Any other Asian background	21.0%	1.7%	20.7%	1.7%	20.2%	1.8%
Black	12.4%	5.5%	11.9%	5.5%	11.4%	5.6%
Black Caribbean	3.5%	1.4%	3.4%	1.3%	3.2%	1.2%
Black African	7.7%	3.4%	7.3%	3.5%	7.0%	3.7%
Black Other	1.2%	0.7%	1.3%	0.7%	1.2%	0.8%
Chinese	0.6%	0.4%	0.5%	0.4%	0.5%	0.4%
Any other ethnic group	4.2%	1.6%	4.4%	1.7%	4.5%	1.7%
Unclassified	1.2%	2.3%	1.2%	2.0%	1.3%	2.0%

SOURCE: STATISTICAL FIRST RELEASES (2014-16); JANUARY 2014, 2015 AND 2016 SCHOOL CENSUS

9.2.1 CHILDREN WITH SPECIAL EDUCATIONAL NEED (SEN)

Speech, Language and Communication Needs has been the main primary need for Harrow's primary school pupils with a SEN, remaining steady at 35% from 2013-14 to 2015-16. The percentage of primary school pupils with the primary need Moderate Learning Difficulty (MLD) increased significantly from 14.8% in 2013-14 to 23.4% in 2014-15, and then dropped to 19.6% in 2015-16.

FIGURE 52 PERCENTAGE OF PRIMARY SCHOOL CHILDREN WITH A SEN BY PRIMARY NEED: HARROW AND ENGLAND: 2013-14 TO 2015-16

	2013-14		2014-15		2015-16	
	<i>Harrow</i>	<i>England</i>	<i>Harrow</i>	<i>England</i>	<i>Harrow</i>	<i>England</i>
<i>Speech, Language and Communications Needs</i>	35.8%	31.6%	34.0%	27.7%	35.3%	28.0%
<i>Moderate Learning Difficulty</i>	14.8%	19.1%	23.4%	24.6%	19.6%	25.0%
<i>Social, Emotional and Mental Health</i>	16.4%	18.4%	12.0%	15.6%	13.3%	15.5%
<i>Autistic Spectrum Disorder</i>	11.0%	8.3%	7.9%	6.5%	8.6%	6.3%
<i>Specific Learning Difficulty</i>	9.0%	8.7%	9.6%	10.5%	7.8%	10.1%
<i>Other Difficulty/Disability</i>	4.4%	4.3%	5.1%	4.4%	5.2%	4.3%
<i>Physical Disability</i>	3.0%	4.1%	2.3%	3.0%	2.8%	2.8%
<i>SEN support but no specialist assessment of type of need</i>	NA	NA	1.0%	3.6%	2.8%	4.1%
<i>Hearing Impairment</i>	3.0%	2.3%	2.6%	1.7%	2.6%	1.6%
<i>Visual Impairment</i>	1.6%	1.3%	1.2%	1.0%	1.0%	0.9%
<i>Severe Learning Difficulty</i>	0.3%	1.3%	0.5%	0.9%	0.3%	0.7%
<i>Profound & Multiple Learning Difficulty</i>	0.3%	0.4%	x	0.3%	0.3%	0.3%
<i>Multi-Sensory Impairment</i>	0.3%	0.2%	0.3%	0.2%	0.3%	0.2%

SOURCE: STATISTICAL FIRST RELEASES (2014-16); JANUARY 2014, 2015 AND 2016 SCHOOL CENSUS,

For 2014-15 and 2015-16 the main primary need of secondary pupils with a SEN is Specific Learning Difficulty, at 20.8% and 20.4%, respectively, compared to 20.9% and 21.4% nationally. The percentage of secondary school pupils with the primary need Other Difficulty/Disability increased significantly from 6.4% in 2013-14 to 19.6% in 2015-16. Nationally, the percentage of pupils with this primary need has remained steady at 6%, from 2013-14 to 2015-16. The primary need Social, Emotional and Mental Health has decreased significantly from 28.8% in 2013-14 to 18.7% in 2015-16. Harrow's trend is in-line with the national picture.

FIGURE 53 PERCENTAGE OF SECONDARY SCHOOL CHILDREN WITH A SEN BY PRIMARY NEED: HARROW AND ENGLAND: 2013-14 TO 2015-16

	2013-14		2014-15		2015-16	
	<i>Harrow</i>	<i>England</i>	<i>Harrow</i>	<i>England</i>	<i>Harrow</i>	<i>England</i>
<i>Specific Learning Difficulty</i>	17.5%	15.6%	20.8%	20.9%	20.4%	21.4%
<i>Other Difficulty/Disability</i>	6.4%	5.8%	15.3%	6.8%	19.6%	6.6%
<i>Social, Emotional and Mental Health</i>	28.8%	26.7%	20.1%	19.3%	18.7%	18.5%
<i>Moderate Learning Difficulty</i>	19.9%	20.3%	15.7%	24.9%	12.5%	25.2%
<i>Speech, Language and Communications Needs</i>	10.0%	11.0%	10.6%	9.8%	10.4%	10.3%
<i>Autistic Spectrum Disorder</i>	7.6%	10.7%	7.0%	8.3%	7.0%	8.3%
<i>SEN support but no specialist</i>	NA	NA	2.8%	2.4%	4.5%	2.6%

<i>assessment of type of need</i>						
Physical Disability	3.7%	4.0%	3.3%	3.0%	2.7%	2.9%
Hearing Impairment	3.3%	3.0%	1.9%	2.3%	2.1%	2.2%
Visual Impairment	2.5%	1.7%	1.7%	1.3%	1.5%	1.3%
Severe Learning Difficulty	X	0.9%	0.7%	0.6%	0.6%	0.5%
Profound & Multiple Learning Difficulty	0.0%	0.1%	0.0%	0.1%	0.0%	0.1%
Multi-Sensory Impairment	0.0%	0.1%	0.0%	0.1%	0.0%	0.1%

SOURCE: STATISTICAL FIRST RELEASES (2014-16); JANUARY 2014, 2015 AND 2016 SCHOOL CENSUS, x = suppressed data for data confidentiality and accuracy.

Severe Learning Difficulty and Autistic Spectrum Disorder have been the two main primary needs in Harrow's special schools between 2013-14 and 2015-16. The percentage of pupils with a Severe Learning Difficulty has fluctuated from 30.8% in 2013-14 to 33.8% in 2014-15, and 31.1% in 2015-16. Nationally, there has been a decline of just one per cent from 24.8% in 2013-14 to 23.8% in 2015-16. The primary need Autistic Spectrum Disorder has also fluctuated between 2013-14 (30.3%), 26.8% in 2014-15, and 27.6% in 2015-16. This is in contrast to the national picture, where there has been a steady increase from 22.5% in 2013-14 to 25.6% in 2015-16.

FIGURE 54 PERCENTAGE OF SPECIAL SCHOOL CHILDREN WITH A SEN BY PRIMARY NEED: HARROW AND ENGLAND: 2013-14 TO 2015-16

	2013-14		2014-15		2015-16	
	Harrow	England	Harrow	England	Harrow	England
Severe Learning Difficulty	30.8%	24.8%	33.8%	24.4%	31.1%	23.8%
Autistic Spectrum Disorder	30.3%	22.5%	26.8%	24.0%	27.6%	25.6%
Moderate Learning Difficulty	14.2%	17.2%	19.2%	16.2%	19.2%	15.6%
Profound & Multiple Learning Difficulty	9.7%	8.8%	9.3%	8.6%	8.8%	8.2%
Speech, Language and Communications Needs	6.9%	5.3%	4.3%	5.5%	5.7%	5.9%
Social, Emotional and Mental Health	3.1%	13.4%	3.8%	13.0%	2.6%	12.6%
Specific Learning Difficulty	0.8%	1.2%	1.0%	1.3%	1.4%	1.3%
Other Difficulty/Disability	1.0%	0.9%	1.0%	1.0%	1.4%	1.2%
Physical Disability	2.3%	3.5%	x	3.5%	1.0%	3.5%
Hearing Impairment	0.0%	1.4%	0.0%	1.3%	0.7%	1.3%
Visual Impairment	1.0%	0.8%	x	0.7%	0.2%	0.7%
Multi-Sensory Impairment	0.0%	0.2%	0.0%	0.2%	0.2%	0.2%
SEN support but no specialist assessment of type of need	NA	NA	0.0%	0.2%	0.0%	0.2%

SOURCE: STATISTICAL FIRST RELEASES (2014-16); JANUARY 2014, 2015 AND 2016 SCHOOL CENSUS, x = suppressed data for data confidentiality and accuracy.

9.2.2 FREE SCHOOL MEALS ELIGIBILITY

Overall, there has been a steady decline in the percentage of pupils eligible for free school meals in Harrow schools, decreasing by five per cent from 15.2% of pupils in 2013-14 to 10.2% in 2015-16, compared to 16.3% to 14.3%, nationally, representing a smaller drop of 2 per cent, thus widening the gap between Harrow and the national.

FIGURE 55 PERCENTAGE OF PUPILS IN STATE-FUNDED SCHOOLS ELIGIBLE AND CLAIMING FREE SCHOOL MEALS: HARROW AND ENGLAND: 2013-14 TO 2015-16



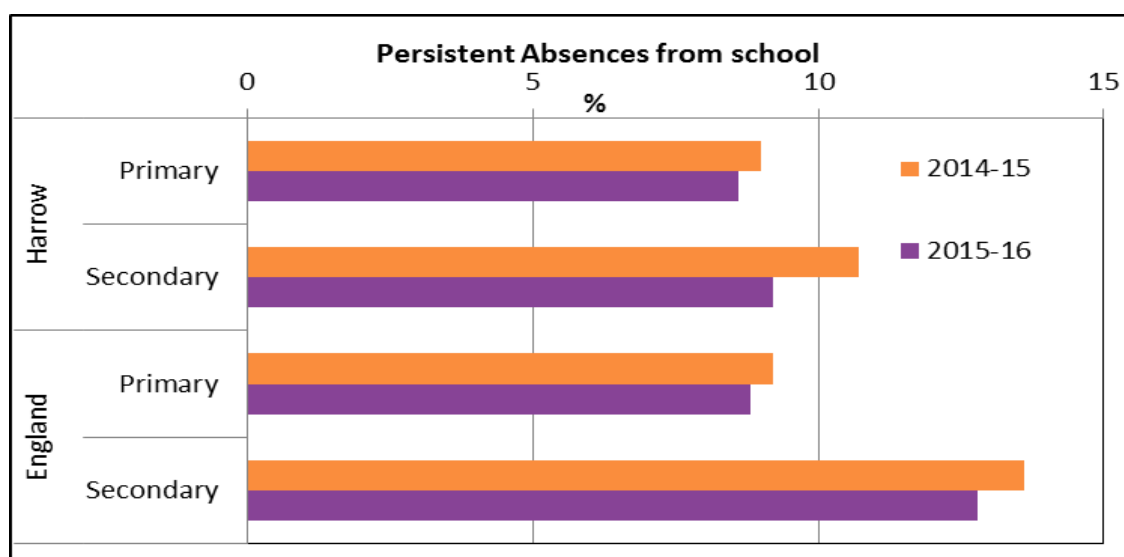
SOURCE: STATISTICAL FIRST RELEASES (SFR15 2014, SFR16 2015 AND SFR20 2016).

9.2.3 PERSISTENT ABSENCES

Persistent absence rates for primary aged pupils have been broadly consistent across Harrow’s schools and England, with slight changes in rates. The percentage of primary school children with persistent absences has decreased in Harrow declining from 9.0% in 2014-15 to 8.6% in 2015-16, compared to 9.2% and 8.8%, nationally.

Persistent absence rates for Harrow’s secondary aged pupils dropped from 10.7% in 2014-15 to 9.2% in 2015-16, this is significantly lower than the national averages of 13.6% and 12.3% respectively.

FIGURE 56 PERSISTENT ABSENCES FROM SCHOOL



SOURCE: STATISTICAL FIRST RELEASES (SFR AUTUMN & SPRING) 2013-14 TO 2014-15

9.2.4 EXCLUSIONS

Permanent exclusions in Harrow's school increased from 22 in 2013-14 to 35 in 2015-16; this rise slightly exceeds that expected simply from the increase in the size of the school population. Harrow's trend is in-line with the national picture.

FIGURE 57 PERMANENT EXCLUSIONS

Term	2013-14		2014-15		2015-16	
	Number of permanent exclusions	% of school population	Number of permanent exclusions	% of school population	Number of permanent exclusions	% of school population
Autumn	8	0.02%	9	0.03%	10	0.03%
Spring	8	0.02%	7	0.02%	8	0.02%
Summer	6	0.02%	9	0.03%	17	0.05%
Harrow	22	0.07%	25	0.07%	35	0.10%
England	4,950	0.06%	5,800	0.07%	6,685	0.08%

SOURCE: STATISTICAL FIRST RELEASES (SFR27 2015 & SFR26 2016) AND CAPITA ONE DATA – 2013/14 TO 2015/16

The number of fixed-term exclusions in Harrow's schools has risen from 725 in 2013-14, to 910 in 2014-15, and then dropped slightly to 888 in 2015-16. In 2013-14, fixed term exclusions represented just 2.16% of Harrow's school population but increased to 2.64% in 2014-15. Harrow's fixed term exclusions are in-line with the national trend.

FIGURE 58 FIXED TERM EXCLUSIONS

Term	2013-14		2014-15		2015-16	
	Number of fixed-term exclusions	% of school population	Number of fixed-term exclusions	% of school population	Number of fixed-term exclusions	% of school population
Autumn	247	0.74%	340	0.99%	256	0.73%
Spring	276	0.82%	281	0.81%	285	0.81%
Summer	202	0.60%	289	0.84%	347	0.98%
Harrow	725	2.16%	910	2.64%	888	2.52%
England	10,510	2.57%	12,150	3.07%	Not available	Not available

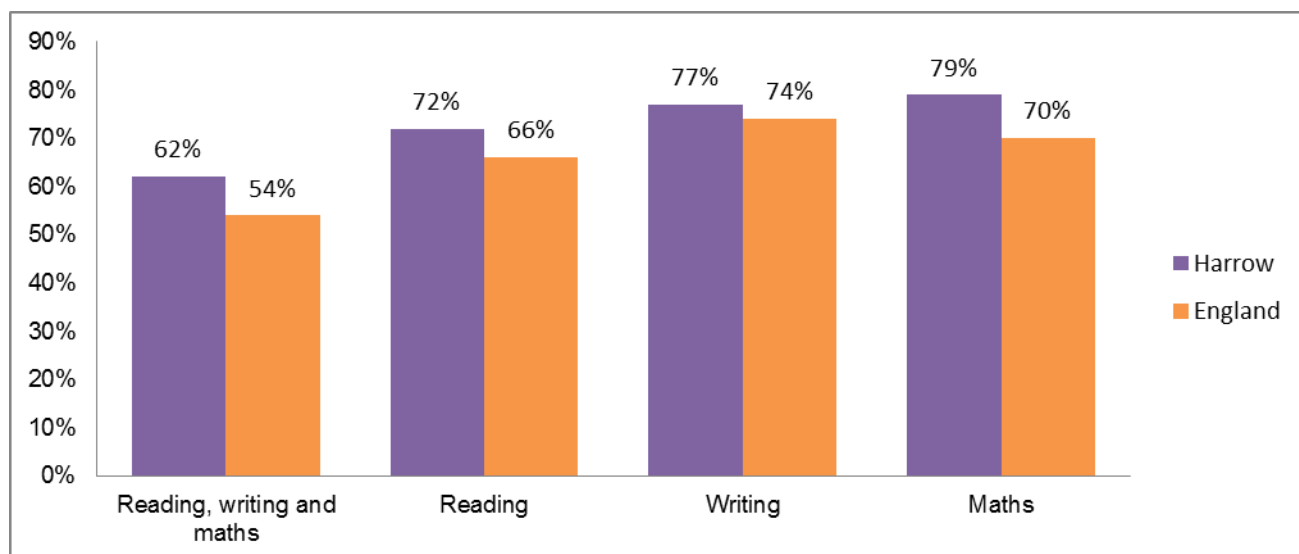
SOURCE: STATISTICAL FIRST RELEASES (SFR27 2015 & SFR26 2016) AND CAPITA ONE DATA – 2013/14 TO 2015/16

9.2.5 KEY STAGE 2: ATTAINMENT IN READING, WRITING AND MATHS

In 2016, KS2 assessments changed to assess the new, more challenging national curriculum which was introduced in 2014. This new framework for teacher assessment has been introduced to reflect the new syllabus; hence, 2015-16 figures cannot be compared to earlier years.

In 2015-16, 62% of Harrow's pupils achieved the expected standard at the end of Key Stage 2, higher than the national result of 54%. This is further reflected in the individual assessments, where the percentage of Harrow's pupils attaining the expected standard in reading (72%), writing (77%) and maths (79%) is higher than England's 66%, 74% and 70%, respectively.

FIGURE 59 PERCENTAGE OF PUPILS ATTAINING THE EXPECTED STANDARD IN KEY STAGE 2 (FINAL): HARROW AND ENGLAND 2016.



SOURCE: STATISTICAL FIRST RELEASE (SFR62 2016): 2015-16.

9.2.6 KEY STAGE 4: ATTAINMENT 8 AND PROGRESS 8

In October 2013, the government announced that a new secondary school accountability system would be implemented from 2016. It includes two new headline measures, Attainment 8 and Progress 8. Progress 8 aims to capture the progress a pupil makes from the end of primary school to the end of secondary school. It is a type of value added measure, which means that pupils' results are compared to the actual achievements of other pupils with the same prior attainment.

Attainment 8 measures the achievement of a pupil across 8 qualifications including mathematics (double weighted) and English (double weighted), 3 further qualifications that count in the English Baccalaureate (EBacc) measure and 3 further qualifications that can be GCSE qualifications (including EBacc subjects) or technical awards from the DfE approved list.

10 HEALTH SERVICES

10.1. IMMUNISATION

There are a range of immunisations that should be given in childhood. These begin at 2 months and go up to age 14. The majority of immunisations are given by GPs but school age flu vaccination and the HPV vaccination are given in schools, usually by school nurses.

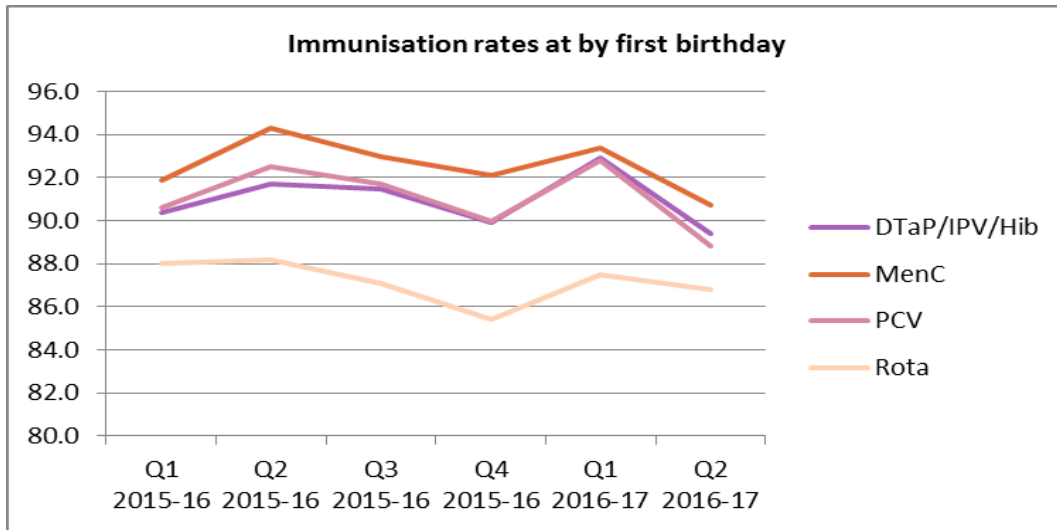
FIGURE 60 UK 2016 IMMUNISATION SCHEDULE

AGE	Immunisation
2 months	<ul style="list-style-type: none"> • DTaP/IPV(polio)/Hib (diphtheria, tetanus, pertussis (whooping cough), polio, and Haemophilus influenzae type b) - 5-in-one injection • PCV (pneumococcal conjugate vaccine) - in a separate injection • Rotavirus - oral route (drops). • Meningitis B
3 months	<ul style="list-style-type: none"> • DTaP/IPV(polio)/Hib 5-in-one injection, 2nd dose; • Rotavirus - oral route (drops).
4 months	<ul style="list-style-type: none"> • DTaP/IPV(polio)/Hib 5-in-one injection, 3rd dose • PCV 2nd dose - in a separate injection. • Meningitis B 2nd dose
Between 12 and 13 months	<ul style="list-style-type: none"> • Hib/MenC (combined as one injection) - 4th dose of Hib and 1st dose of MenC • MMR (measles, mumps and rubella) - combined as one injection • PCV 3rd dose - in a separate injection. • Meningitis B 3rd dose
2-7 years	<ul style="list-style-type: none"> • Nasal flu spray annually - For children aged 2, 3 and 4, this is usually given in the GP surgery. Children in school years 1, 2 and 3 may have this at school.
3 years and four months	<ul style="list-style-type: none"> • Preschool booster of DTaP/IPV(polio). 4-in-one injection • MMR 2nd dose - in a separate injection.
12-13 years (girls)	<ul style="list-style-type: none"> • HPV (human papillomavirus types 16 and 18) - two injections. The second injection is given 6-12 months after the first one.
14 years	<ul style="list-style-type: none"> • Td/IPV(polio) booster. 3-in-one injection • Men ACWY: combined protection against meningitis A, C, W and Y

10.1.1 PRIMARY IMMUNISATION

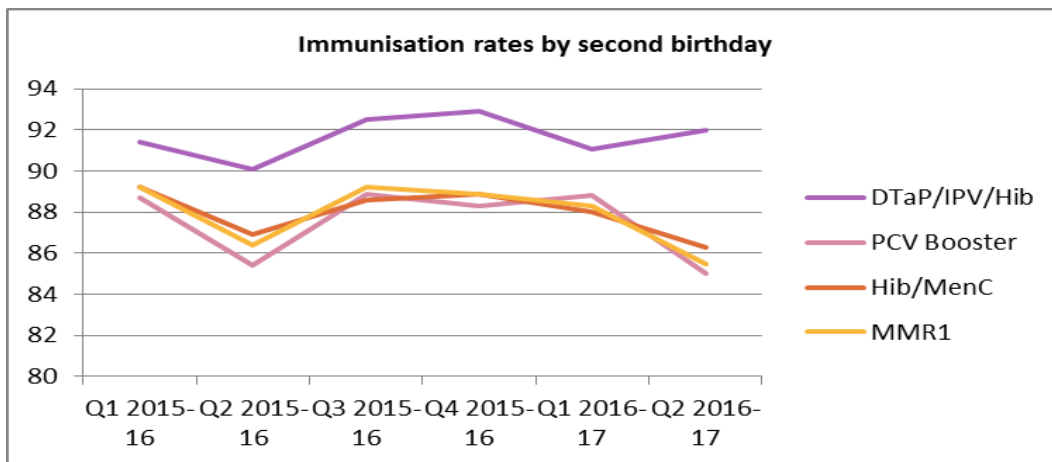
The coverage of primary immunisations in Harrow is slightly lower than the national rate and showed a decrease in mid 2016-17.

FIGURE 61 IMMUNISATION RATES AT CHILD'S FIRST BIRTHDAY



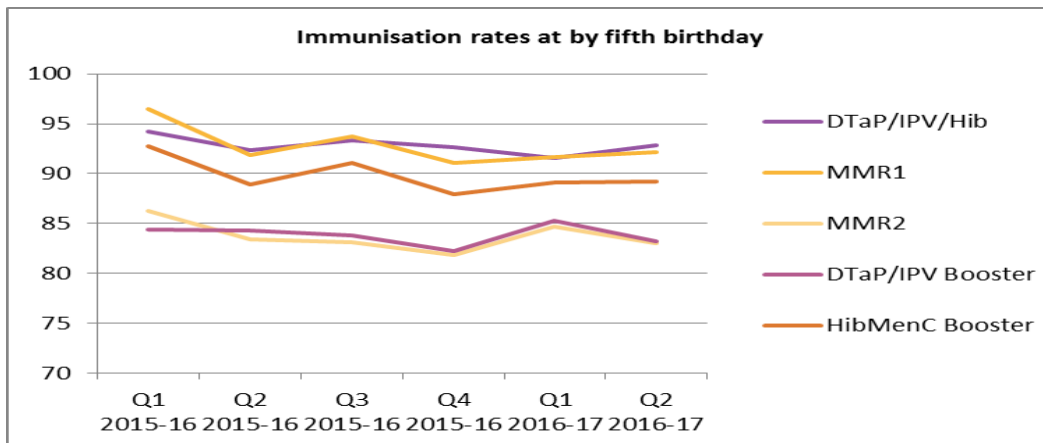
SOURCE: PHE COVER STATISTICS

FIGURE 62 IMMUNISATION RATES AT CHILD'S SECOND BIRTHDAY



SOURCE: PHE COVER STATISTICS

FIGURE 63 IMMUNISATION RATES AT CHILD'S FIFTH BIRTHDAY



SOURCE: PHE COVER STATISTICS

In addition to the vaccines given to infants and children, a new programme was introduced to immunise pregnant women against pertussis (whooping cough) to reduce the incidence and impact of the disease in neonates.

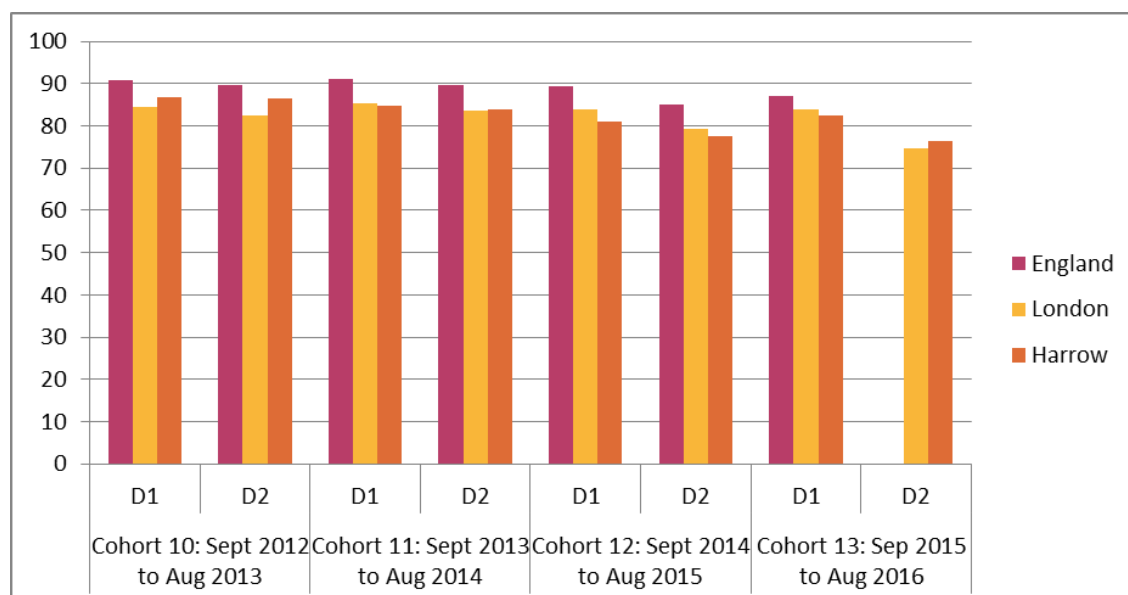
10.1.2 NEONATAL BCG

London has also been rolling out BCG vaccination of all new born babies to reduce the incidence of TB. However, a worldwide shortage of vaccine has meant that this is currently only available in high incidence boroughs, including Harrow, and for babies with parents or grandparents from high incidence countries. All Harrow resident babies are to be offered neonatal BCG and for those born out of the area or for home births, the CLCH immunisation team will run a monthly catch up clinic.

10.1.3 SCHOOL AGE VACCINATION

HPV vaccination is given to girls in year 8. Harrow performs similarly to the London rate but is lower than the national rate.

FIGURE 64 HPV VACCINATION COVERAGE



SOURCE: PHE ANNUAL HPV VACCINE COVERAGE

The Men ACWY vaccination protects against four types of Meningitis. This is the first year that statistics have been gathered on Men ACWY uptake in schools. In London, 63.1% of the routine cohort Year 10 were vaccinated (compared to England's 77.2%), 76% of routine cohort Year 9 (England had 84.1%) and 55.9% of the catch up Year 11 (compared to England's 71.8%). In Harrow the uptake rate was 75.6% for Year 10 and 74.7% for Year 11.

FIGURE 65 MEN ACWY VACCINATION RATES 2016

	Harrow	London	England
Routine cohort Year 9		76%	84.1%
Routine cohort Year 10	75.6%	63.1%	77.2%
Catch up Year 11	74.7%	55.9%	71.8%

SOURCE: PHE

10.1.4 FLU VACCINATION

The child ‘flu vaccine (Fluenz) programme for 2-4 year olds is given in general practice and the school age programme is delivered by community providers for those in school years 1-3. London, England and Harrow exceeded the lower threshold of 40% for uptake for children in the school programmes. However, uptake in preschool children remains low.

FIGURE 66 FLU VACCINE UPTAKE 2016-17 SEASON

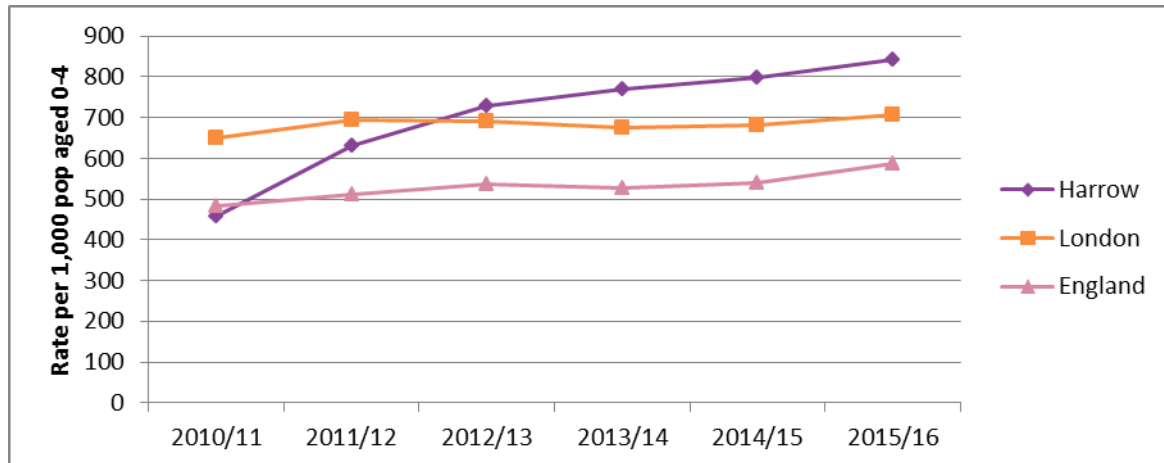
	% of 2 year olds	% of 3 year olds	% of 4 year olds	% of year 1	% of year 2	% of Year 3	% of pregnant women
Harrow	27.4	29.5	21.6	54	47.6	46.2	36.5
London	30.3	32.6	24.9	45.8	43.6	42	39.6
England	38.8	41.6	33.8	57.6	55.3	53.3	44.8

SOURCE: PHE

10.2 A&E ATTENDANCES

A&E attendances in children aged under five years are often preventable, and commonly caused by accidental injury or by minor illnesses which could have been treated in primary care. In 2010/11, the rate of attendances at A&E in this group was lower than the England average and similar to the London rate. Over the past 6 years, the rate has increased year on year and now Harrow's rate is significantly higher than London and the England average.

FIGURE 67 RATE OF A&E ATTENDANCE IN CHILDREN AGED 0-4



SOURCE: PHE CHILD HEALTH PROFILES

10.3 HOSPITAL ADMISSIONS

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

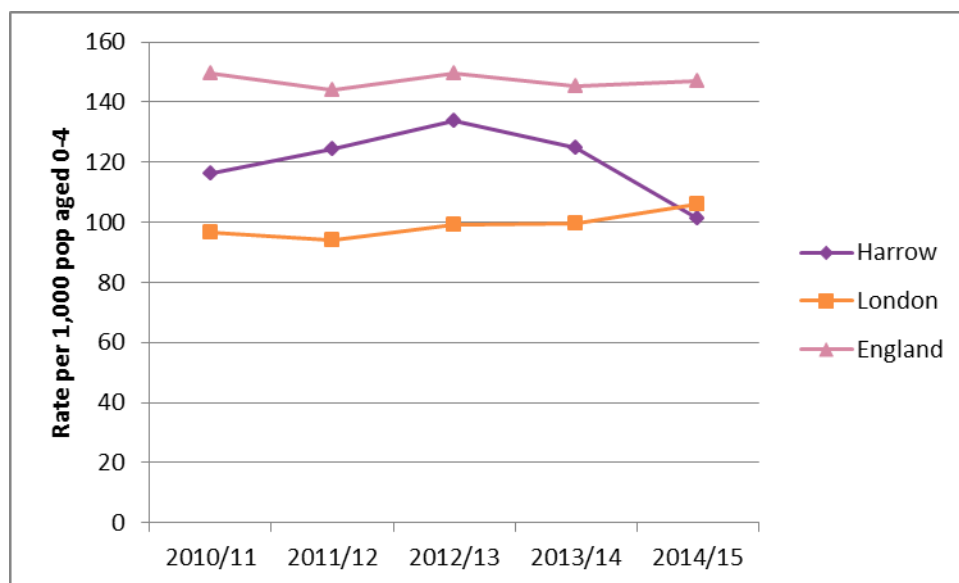
10.3.1 ADMISSIONS UNDER 14 DAYS

High levels of admissions of either mother or babies soon after birth can suggest problems with either the timing or quality of health assessments before the initial transfer or with the postnatal care once the mother is home. Dehydration and jaundice are two common reasons for re-admission of babies and are often linked to problems with feeding. The rate of admission of babies under 14 days old in Harrow is lower than the rates for London or England (36.7 per 1,000 deliveries compared to 48.7 and 60.7 for London and England respectively)

10.3.2 ADMISSIONS IN CHILDREN UNDER 5

The rate of admissions of children under 5 in Harrow is below the national rate and was increasing between 2010 and 2013. Rates have since decreased and are now below the rate seen in 2010. This data suggests that the increase in A&E attendances in this age group (see above) is largely due to either issues that could be dealt with in general practice, by pharmacists or are minor ailments not requiring medical interventions.

FIGURE 68 RATE OF ADMISSIONS IN CHILDREN UNDER 5



SOURCE: NHS DIGITAL: COMPENDIUM OF HEALTH INDICATORS

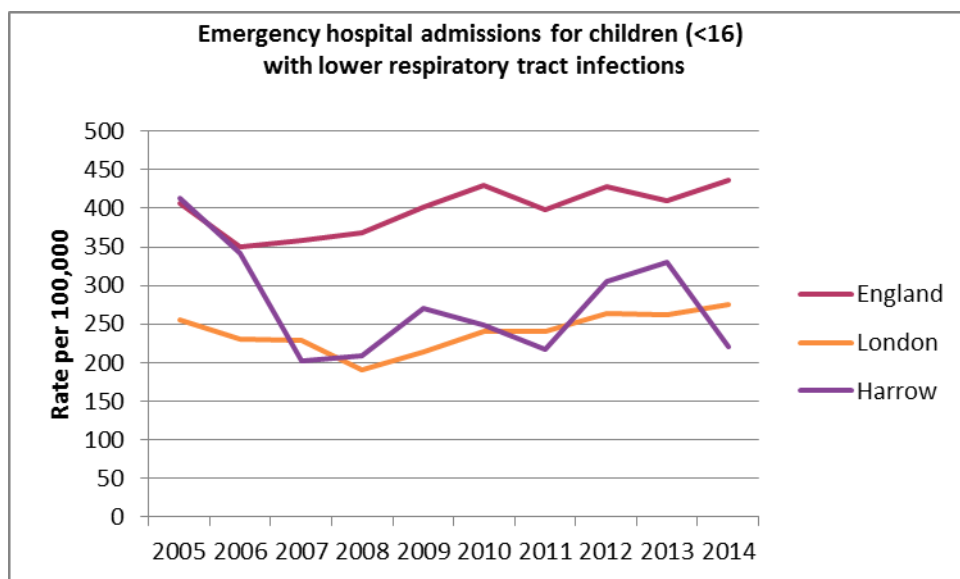
Over one quarter of emergency hospital admissions in children aged under 5 years in 2014/15 was for respiratory infections. Factors such as smoking in the home and damp housing are known to increase the risk and severity of respiratory infections in young children.

10.3.3 EMERGENCY HOSPITAL ADMISSIONS: CHILDREN WITH LOWER RESPIRATORY TRACT INFECTIONS

The most common virus that causes bronchiolitis is an airborne virus called respiratory syncytial virus or RSV. A third of babies will have had at least one RSV infection by their first birthday. Most of them will only have cold-like symptoms, but some children will develop bronchiolitis, bronchopneumonia or pneumonia. Emergency admissions to hospital for children with lower respiratory tract infections can be avoided if local systems are put in place firstly to identify those at risk prior to attendance and target primary care services, encourage smoking reduction especially in young mothers, encourage breast feeding and offer better support for young parents in the care of their children and in management of lower respiratory tract infections in the home.

Emergency admissions for children with lower respiratory tract infections have shown a general increase nationally and across London. In Harrow, there was a steep decrease between 2005 and 2007 but thereafter an increase at a similar rate to the national and regional rates. Although there was a decrease in 2014, it remains to be seen if this was a statistical blip or a true decreasing trend.

FIGURE 69 INDIRECTLY STANDARDISED RATE OF EMERGENCY ADMISSIONS FOR LOWER RESPIRATORY TRACT INFECTIONS IN CHILDREN UNDER 16

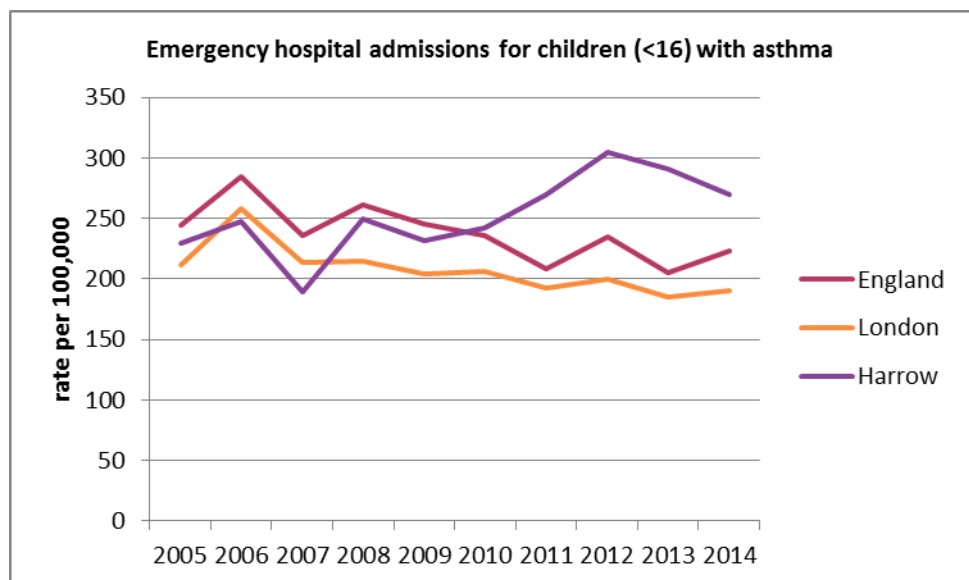


SOURCE: NHS DIGITAL: COMPENDIUM OF HEALTH INDICATORS

10.3.4 EMERGENCY HOSPITAL ADMISSIONS: CHILDREN WITH ASTHMA

Asthma is a long term condition that can require considerable medical support if not well managed. Although the national and London rates have shown a small decrease over the 10 years 2005-2010, the rate of admissions in Harrow had increased over the same time.

FIGURE 70 INDIRECTLY STANDARDISED RATE OF EMERGENCY ADMISSIONS FOR ASTHMA IN CHILDREN UNDER 16



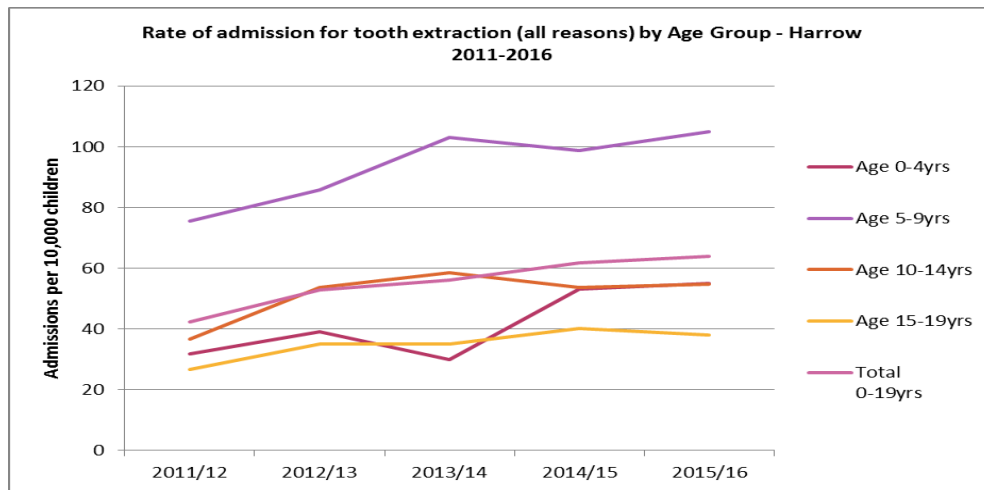
SOURCE: NHS DIGITAL: COMPENDIUM OF HEALTH INDICATORS

10.3.5 HOSPITAL ADMISSIONS DUE TO TOOTH EXTRACTION

The rate of admissions for extraction of primary or permanent teeth in children is increasing year on year. This includes surgical removal and simple extraction. The rate in younger age groups is driving this increase. In the 15-19 age group, two thirds of extractions were

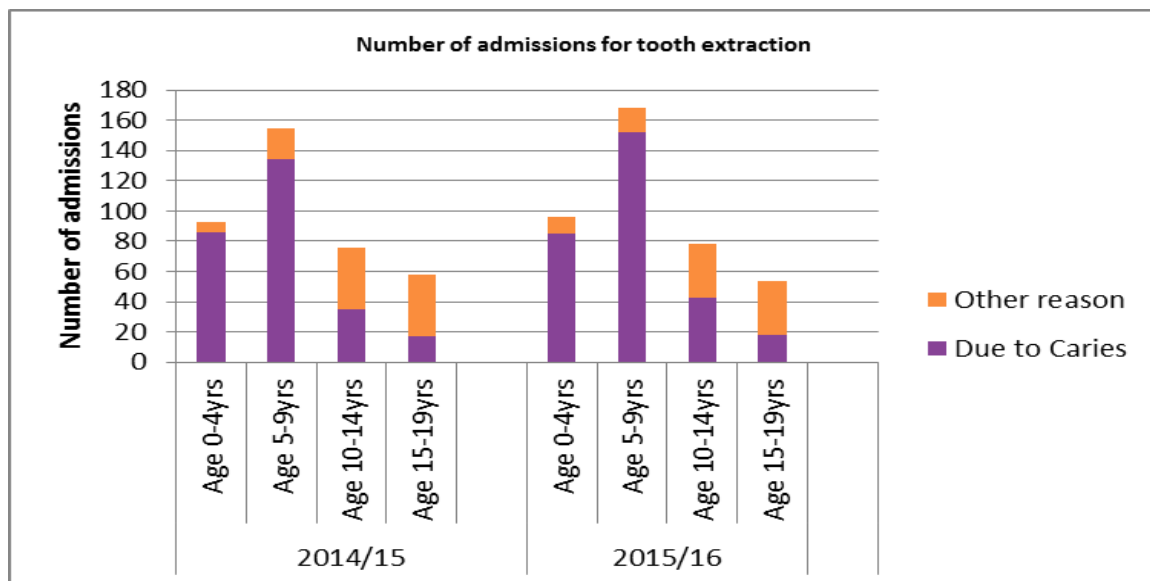
not due to caries but to other reasons, e.g. wisdom tooth extraction. However, in the younger age groups, around 90% of admissions for tooth extraction were due to caries.

FIGURE 71 RATE OF ADMISSIONS FOR TOOTH EXTRACTION



SOURCE: PHE – DENTAL PUBLIC HEALTH

FIGURE 72 NUMBER OF HOSPITAL ADMISSION FOR TOOTH EXTRACT DUE TO CARIES OR OTHER REASON



SOURCE: PHE – DENTAL PUBLIC HEALTH

10.3.6 EMERGENCY HOSPITAL ADMISSIONS: CHILDREN WITH GASTROENTERITIS

Gastroenteritis in children is a very common condition that causes diarrhoea and vomiting. Although they can be caused by bacterial or viral infections, in most cases these conditions are caused by rotaviruses. These viruses are spread very easily through person to person contact although it’s not always possible to avoid getting gastroenteritis there are personal and food hygiene practices that will reduce contamination and transmission.

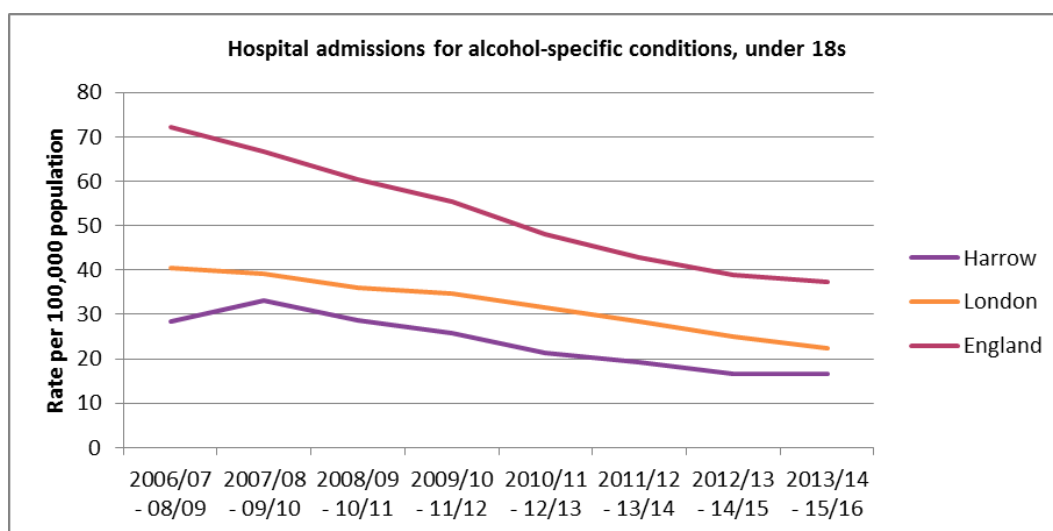
During 2014/15, the crude rate of emergency admissions for gastroenteritis in infants aged less than 1 year in Harrow was 81.4 per 10,000 which much lower than the England average at 173.1 per 10,000.

10.3.7 ADMISSIONS DUE TO ALCOHOL AND DRUGS

Alcohol misuse at any age has health and social consequences. Alcohol misuse in young people is a major contributor to criminal and antisocial behaviour. Although evidence suggests that the number of teenagers who drink has decreased in recent years, the amount drunk by young people who do drink has increased. For young people under the age of 18, the rate of admissions to hospital due to alcohol specific conditions has been decreasing across the country and across London. The rate in Harrow has consistently been lower than the national and London rate and is also decreasing.

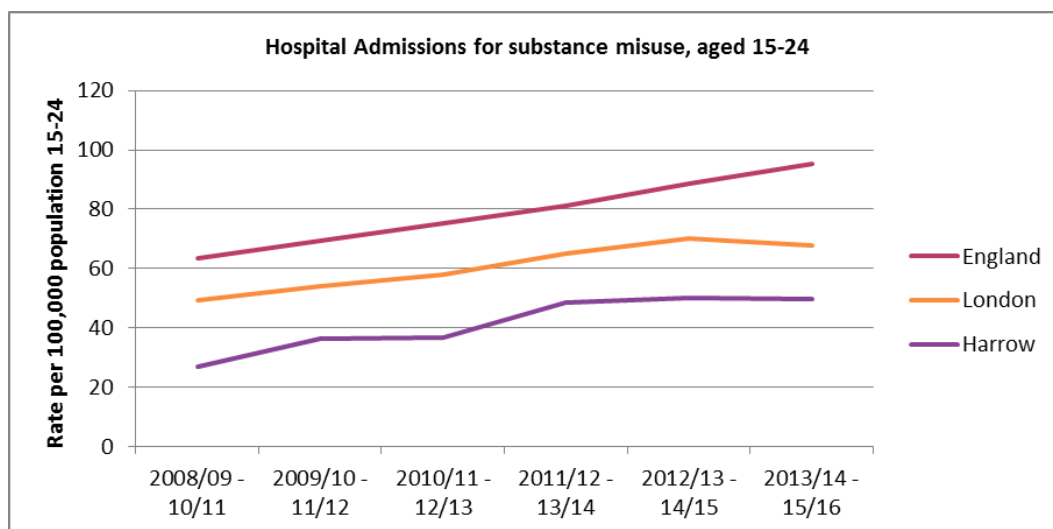
Rates of admission for substance misuse in 15-24 year olds in Harrow have also been consistently lower than those of London and England. Rates of admission for substance misuse have been increasing locally, across London and across England. However, in Harrow the rates seem to have plateaued for the last 3 - 4 years.

FIGURE 73 THREE YEAR POOLED RATES FOR ALCOHOL SPECIFIC ADMISSIONS IN UNDER 18S



SOURCE: PHE

FIGURE 74 THREE YEAR POOLED RATES FOR SUBSTANCE MISUSE ADMISSIONS IN 15-24 AGE GROUP



SOURCE: PHE

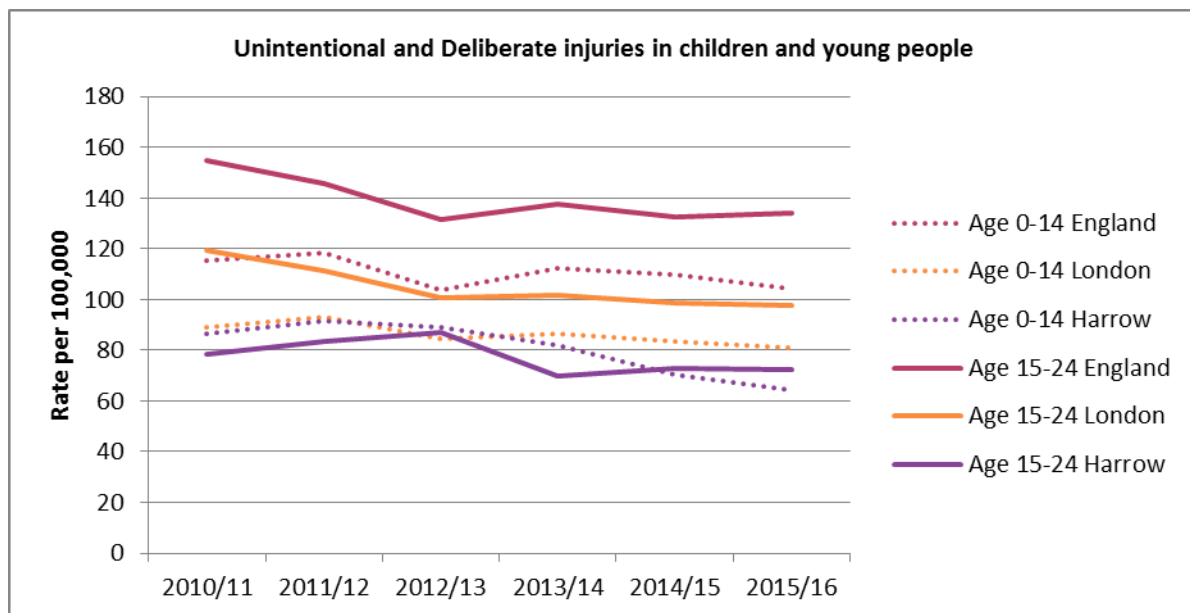
10.3.8 HOSPITAL ADMISSIONS DUE TO ACCIDENTS AND INJURIES

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

Accidents in Harrow have remained fairly stable since 2010/11. The rate of hospital admissions caused by unintentional and deliberate injuries in young people aged 15-24 per 10,000 in the Harrow population was 73.0 during 2014/15. This was a rate that was significantly better than England (131.7) and London (98.6).

Admissions to hospital due to unintentional and deliberate injuries are lower in Harrow than in London and England. Rates in the 0-14 age group are lower in London and England than in the 15-24 age group. However, in Harrow the 0-14 age group had higher rates than the 15-24 age group until 2015-16. Rates are slowly decreasing across the board .

FIGURE 75 TREND IN RATE OF ADMISSION FOR UNINTENTIONALS AND DELIBERATE INJURIES IN THE 0-14 AND 15-24 AGE GROUPS



SOURCE: PHE

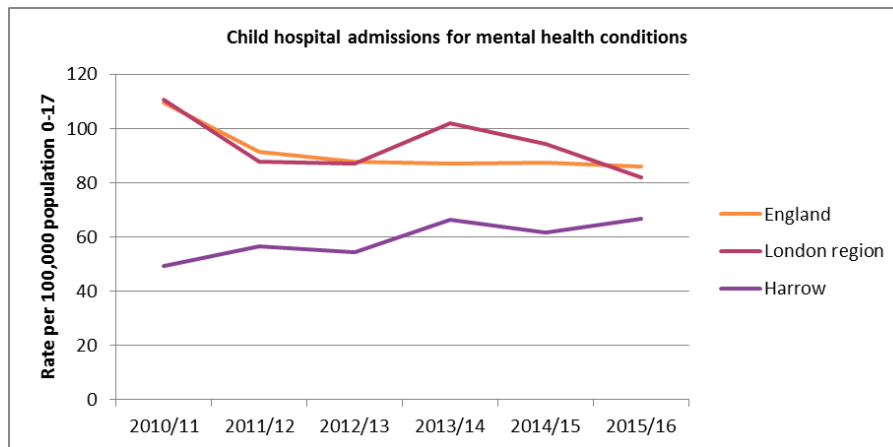
Having a measure of how Harrow compares with other areas and against the national picture for this indicators helps school nursing work with NHS services in Harrow to understand what and where targeted interventions should be placed. By understanding what accidents and injuries are occurring contact could be made via health visiting with parents to prevent these accidents from occurring in the first place.

10.3.9 ADMISSIONS FOR MENTAL HEALTH CONDITIONS

Admissions for mental health condition in children and young people have been decreasing across the country and in London. In Harrow however, there has been an increase between 2010-11 and 2015-16. The rates are still lower than London and England but if trend continue, the rates could converge in 2017-18. There may be many reasons for this change. The first is that there is an increasing problem in Harrow with child and adolescent mental health but equally likely is that the increase is due to having more beds available for

admission after having previously under provided for this group or due to a change in local policy from a community based service to a hospital based one.

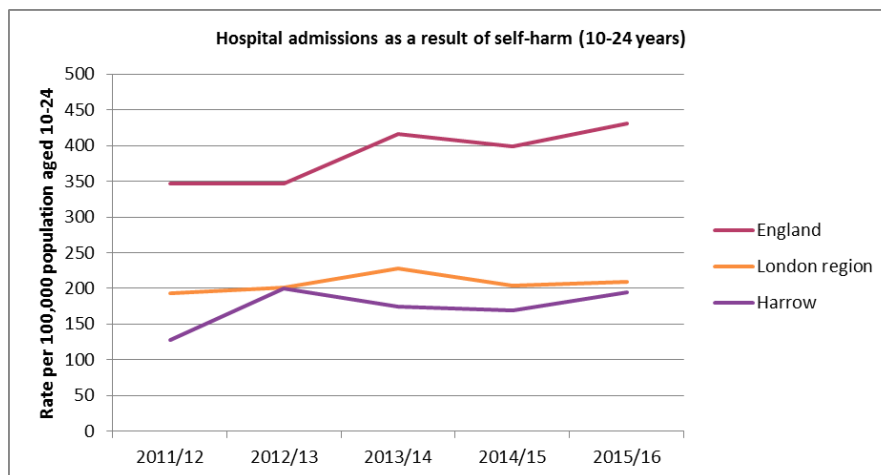
FIGURE 76 ADMISSIONS FOR MENTAL HEALTH CONDITIONS IN CHILDREN UNDER 18



SOURCE: PHE CHILD AND ADOLESCENT MENTAL HEALTH PROFILES

Hospital admissions for self-harm in children have increased in recent years across England, with admissions for young women being much higher than admissions for young men. With links to other mental health conditions such as depression, the emotional causes of self-harm may require psychological assessment and treatment. The rates of admission for self harm in Harrow are lower than those on England and are similar the London rate.

FIGURE 77 RATE OF ADMISSION FOR SELF HARM IN 10-24 YEAR OLDS



SOURCE: PHE CHILD AND ADOLESCENT MENTAL HEALTH PROFILES

11 EVIDENCE OF WHAT WORKS

The transfer of commissioning of public health services for children aged 0 to 5 years to local authorities took place in October 2015. This transfer included the mandate until March 2018 of the 5 universal checks of the Healthy Child Programme from pregnancy to age 2 and a half. The Department of Health commissioned a review¹⁴ of the 5 mandated checks which considered the:

- impact of this transfer
- support for existing and continued regulation
- evidence of service transformation
- risks to sustainability from a range of perspectives using data from different sources

The review found widespread support for the regulation of these services to continue and for future arrangements to be considered alongside other regulated public health services.

11.1 HEALTHY CHILD PROGRAMME 0-5

Health visitors lead delivery of the Healthy Child Programme (HCP) and work in partnership with maternity services, local authority-provided or commissioned early years services, voluntary, private and independent services, primary and secondary care, schools, health improvement teams, Family Nurse Partnership (FNP) colleagues and children's social care services. The HCP is the key universal public health service for improving the health and wellbeing of children through health and development reviews, health promotion, parenting support, screening and immunisation programmes. The current programme for 0-5 year-olds is based on the evidence available at the time of the last update of the HCP 0-5 years in 2009.

As local authorities took on the commissioning of the HCP 0-5 years and its delivery via the universal health visiting service on 1 October 2015 the evidence underpinning the programme was subject to a rapid review¹⁵. The purpose of the review was to update the evidence about 'what works' in key areas: parental mental health; smoking; alcohol/drug misuse; intimate partner violence; preparation and support for childbirth and the transition to parenthood; attachment; parenting support; unintentional injury in the home; safety from abuse and neglect; nutrition and obesity prevention; and speech, language and communication.

11.1.1 RETURN ON INVESTMENT

The review identified the pressing need for information on the economic case for investing in early intervention, specifically the financial and other gains that potentially derive over a child's lifetime from improving outcomes when they are aged 0-5 years. However, the review acknowledged that trials of interventions typically only measure outcomes in the short term (i.e. within a year or two of the completion of the intervention). For trials of interventions in the early years, this means that the long-term effects of the intervention are not directly measured. However, the long-term outcomes are more likely to have economic implications for the children, their families, and society.

11.2 TRANSITION TO PARENTHOOD –HEALTHY LIFESTYLE, CONTRACEPTIVE AND SEXUAL HEALTH

Health visitors through contact with the family in both the antenatal and postnatal period, work with families to promote secure attachment, positive parental and infant mental health and parenting skills using assessment scales¹⁶. This includes the promotion of breastfeeding, healthy nutrition and healthy lifestyles, working with families to support behaviour change leading to positive lifestyle choices. Health visitors lead delivery of evidence-based antenatal and postnatal groups to promote attachment, for example, parenting classes/groups and Preparing for Pregnancy and Beyond. Lead delivery, in

partnership with other agencies, of evidence-based parenting programmes for toddlers and pre-school children such as the Incredible Years Pre-school basic programme and other evidence-based programmes. Through this work they identify early signs of developmental and health needs and signpost and/or refer for investigation, diagnosis, treatment, care and support.

11.2.1 EVIDENCE

For antenatal education there is no evidence of impact on low birthweight; limited evidence of impact on parental health behaviours, including personal responsibility for healthcare, exercise, and nutrition; and no evidence of impact on the onset of depression, but some evidence to show that group-based social support, including antenatal preparation for parenthood classes, can be effective in supporting women with sub-threshold symptoms of depression and anxiety¹⁵.

11.3 TRANSITION TO PARENTHOOD – SMOKING CESSATION

National Institute for Clinical Evidence (NICE) says all pregnant women who smoke –and all those who are planning a pregnancy or who have an infant aged under 12 months – should be referred for help to quit smoking. Smoking during pregnancy is strongly associated with a number of factors including age and social economic position. In addition, women with partners who smoke find it harder to quit and are more likely to relapse if they do manage to quit. Health visitors are key in providing smoking cessation advice and referring mothers and fathers to specialist smoking cessation services in both the antenatal and postnatal period.

11.3.1 EVIDENCE / RETURN ON INVESTMENT

Smoking during pregnancy can cause serious pregnancy-related health problems. These include: complications during labour and an increased risk of miscarriage, premature birth, still birth, low birth-weight and sudden unexpected death in infancy.

The total annual cost to the NHS of smoking during pregnancy is estimated to range between £8.1 and £64 million for treating the resulting problems for mothers and between £12 million and £23.5 million for treating infants (aged 0–12 months) Children exposed to tobacco smoke in the womb are more likely to experience wheezy illnesses in childhood. In addition, infants of parents who smoke are more likely to suffer from serious respiratory infections (such as bronchitis and pneumonia), symptoms of asthma and problems of the ear, nose and throat (including glue ear). Exposure to smoke in the womb is also associated with psychological problems in childhood such as attention and hyperactivity problems and disruptive and negative behaviour¹⁷. In addition, it has been suggested that smoking during pregnancy may have a detrimental effect on the child's educational performance

11.4 TRANSITION TO PARENTHOOD – SECURE ATTACHMENT AND BONDING

Transition to Parenthood and the first 1001 days from conception to age two is widely recognised as a crucial period that will have an impact and influence on the rest of the life course¹⁸. There is a significant body of evidence that demonstrates the importance of sensitive attuned parenting on the development of the baby's brain and in promoting secure attachment and bonding. Preventing and intervening early to address attachment issues

will have an impact on resilience and physical, mental and socio-economic outcomes in later life. Health visitors undertake a holistic assessment of the family and parental capacity to meet their infant's needs, enabling early identification of needs and risk. This period is an important opportunity for prevention and early intervention. The contacts during the antenatal period and early weeks inform the level and type of support needed, including safeguarding concerns, potential and actual mental health issues, domestic violence and abuse and alcohol and drug issues.

11.4.1 EVIDENCE

This period provides opportunities for involvement because it is the time when parents are the most receptive to messages. There are better outcomes when parenting programmes start in pregnancy, parents can be supported to understand and communicate their concerns¹⁷.

11.5 MATERNAL MENTAL HEALTH

During pregnancy, depression and anxiety affects a significant number of women. Postnatal depression or anxiety is often preceded by depression or anxiety during pregnancy. The task of improving maternal mental health is important in terms of its impact not only on the mother but also on both the foetus and infant/child. Poor maternal mental health during pregnancy can affect foetal development, including cellular growth and brain development, with consequences for child physical, cognitive, emotional and behavioural outcomes after birth and through childhood. In the postnatal period, maternal mental health can influence the quality of parent-child interactions and children's socio-emotional development during infancy and childhood. It is therefore essential to support women's mental health during pregnancy and postpartum. Health visitors are key to the identification, prevention and treatment of depression and anxiety in the antenatal and postnatal period. The way in which the assessment, preventative and treatments are delivered are outlined in NICE guidance on antenatal and postnatal mental health^{19, 20}. The guidelines include the assessment of mother baby relationship, drug and alcohol misuse as well as eating disorders

11.5.1 EVIDENCE

Outcomes are currently only measured in the short term (i.e. number of mothers detected and successfully treated as a result of the health visitor intervention). This means that the long-term effects of the intervention are not directly measured.

11.6 BREASTFEEDING

There is much evidence that demonstrates breastfeeding contributes to the health of both the mother and child in the short and longer term²¹. Health visitors in particular are thought to be well positioned to support mothers with breastfeeding because of their continued and active engagement with mothers after childbirth. They provide advice on breastfeeding and medication and have a key role in developing or signposting mothers to breastfeeding peer support programmes, as well as promoting the benefits of health visiting with fathers.

11.6.1 RETURN ON INVESTMENT

The health risk associated with not breastfeeding is beyond doubt. Both the mother's and the baby's health will be enhanced by breastfeeding in all circumstances where the mother

chooses to do so. Peer support which achieves a relatively high increase in breastfeeding rates actually saves the NHS money in the long run, because levels of hospitalisation of babies drop, breastfed babies grow up into healthier children and adults, fewer women develop breast cancer, and less has to be spent on infant formula. This is achieved at an estimated 20 percentage point increase in breastfeeding initiation²². For example, where only 20% of mothers currently initiate breastfeeding, an increase to 40% or more would be cost saving. So too would be the increase from 60% to 80% or more. However, where the initiation rate currently exceeds 80% further increase is unlikely to be cost saving, as more than 100% of women would need to breastfeed.

11.7 HEALTHY WEIGHT

Good nutrition during infancy has multiple positive outcomes for health during childhood and later life, and breastfeeding is strongly associated with a range of health and wider (e.g. cognitive) benefits for the child. Adolescent mothers and women from socio-economically disadvantaged backgrounds are least likely to start or continue breastfeeding. Recent research has focused on identifying effective strategies for supporting breastfeeding decision-making for women in these groups, as well as supporting positive nutrition for all families¹⁵. Nutritional habits formed in early life influence food choices and subsequent nutrition during childhood. Increasing rates of obesity, particularly in childhood, have given rise to a wide range of efforts to promote healthier eating increased physical activity amongst young children. Risk factors for obesity in children include diet, exercise, family history and socio-economic factors. Health visitors have a key role in delivering antenatal and postnatal strategies to promote breastfeeding, and interventions to prevent and treat being overweight or obese during early childhood, including early identification of issues, supporting health promotion and change management around healthy lifestyles¹⁶.

11.7.1 EVIDENCE

The review of individual and group breastfeeding support (both face-to-face and via the telephone) in the antenatal and postnatal period showed an increase in the duration of any breastfeeding¹⁵. Interventions for parents of young children whether from professionals, paraprofessionals or trained peer supporters, were found to be successful in improving children's diet.

11.8 MANAGING MINOR ILLNESSES AND ACCIDENT PREVENTION

Illness such as gastroenteritis and upper respiratory tract infections, along with injuries caused by accidents in the home, are the leading causes of attendances at A&E and hospitalisation among the under 5s. Parenting interventions, most commonly provided by the health visitor within the home, are effective in reducing child injury and improving home safety²³. Home safety education increases the use of home safety practices and there is some evidence that it can reduce overall injury rates. There remains some conflicting evidence regarding the provision of home safety equipment in terms of its impact on safety practices and injury rates. Home safety interventions improve poison-prevention practices such as the safe storage of medicines and cleaning products, increasing stair-gate use and reducing baby-walker use. Health visitors provide education, advice, and information about safety during home assessments. Home safety assessments and interventions should be followed up to see if there are any new requirements, and to assess whether the equipment installed is still functional and appropriate

11.8.1 EVIDENCE

Health visitors are a trusted source of knowledge, advice and information for parents and are often the first point of contact for parents who are unsure on the best course of action when their child is unwell. As such they play an important role in the primary care team and can help to reduce the burden on busy GP surgeries and A&E departments.

11.9 HEALTHY TWO-YEAR-OLDS AND SCHOOL READINESS

Measures of 'school readiness' show that the poorest 20% of children are more likely to display conduct problems at age 5 than children from more affluent backgrounds. Most opportunities to close the gap in behavioural, social and educational outcomes occur when the child is preschool age. Health visitors assess and care for children under 5 for any risks that may pose a risk to the child's social and emotional wellbeing. If factors that may pose a risk to a child's social and emotional wellbeing are identified during these key face-to-face contacts, early action can be taken to prevent or reduce the potential impact on the child.

Age 2–2½ is a crucial stage when problems such as speech and language delay or behavioural issues etc. become visible and can be addressed by the health visitor before the child starts school. It is also a time when health visitors can support toilet training. Children and young people with communication difficulties are at increased risk of social, emotional and behavioural difficulties and mental health problems. So, identifying their speech and language needs early is crucial for their health and wellbeing. Many young children whose needs are identified early do catch up with their peers.

11.9.1 RETURN ON INVESTMENT

Early intervention can provide a good return on investment^{24, 25}. The cost of not intervening to ensure (or improve) the social and emotional wellbeing of children and their families are significant, for both them and wider society. For example, by the age of 28, the cumulative costs for public services are much higher when supporting someone with a conduct disorder, compared to providing services for someone with no such problems.

11.10 THE HEALTHY CHILD PROGRAMME (5-19)

The Healthy Child Programme (5-19)^{26, 27} focuses on school aged children up to the age of 19 and is commissioned by Local Authorities. It offers children and young people a schedule of health and development reviews, screening tests, immunisations, health promotion guidance and tailored support for children and families, with additional support when they need it most.

The Healthy Child Programme (5-19) provides a framework to support collaborative work and more integrated delivery. The Healthy Child Programme (5-19) aims to:

- Help parents develop and sustain a strong bond with children;
- Encourage care that keeps children healthy and safe;
- Protect children from serious disease, through screening and immunisation;
- Reduce childhood obesity by promoting healthy eating and physical activity;
- Identify health issues early, so support can be provided in a timely manner;
- Make sure children are prepared for and supported in education settings;
- Identify and help children, young people and families with problems that might affect their chances later in life.

The Healthy Child Programme 5-19 years was developed nationally. There is strong evidence supporting delivery of all aspects of the Healthy Child Programme, which is based on Health for All Children²⁸, the recommendations of the National Screening Committee, guidance from the National Institute of Health and Clinical Excellence (NICE) and a review of health-led parenting programmes by the University of Warwick²⁹.

11.10.1 SOCIAL AND EMOTIONAL WELLBEING

NICE guidance³⁰ makes it clear that schools not only have a role in educating children academically but also in encouraging children's social and emotional wellbeing. School nurses have an important role in supporting a 'whole school' approach to children's social and emotional wellbeing by:

- creating an ethos and conditions that support positive behaviours for learning and for successful relationships,
- providing an emotionally secure and safe environment that prevents any form of bullying or violence,
- supporting all pupils and, where appropriate, their parents or carers (including adults with responsibility for looked after children),
- providing specific help for those children most at risk (or already showing signs) of social, emotional and behavioural problems,
- offering teachers and practitioners in schools training and support in how to develop children's social, emotional and psychological wellbeing.

12 USER AND OTHER STAKEHOLDER VIEWS

A large stakeholder engagement exercise was carried out by the Public Health team in early 2017. Two surveys were produced specifically tailored for professionals and service users. The surveys closed on the 19th March 2017 and were live for 5 weeks. The engagement work was carried out by a team of people from public health who sit on the regular Health Visiting and School nursing steering group held regularly and chaired by public health. A combination of qualitative and quantitative analysis was used primarily through

- Focus groups
- Survey for professionals
- Survey for service users
- 1:1 meeting with service areas.

The detailed findings of the stakeholder engagement are available in a separate report³¹ but the key themes are given below.

12.1 KEY THEMES AND RECOMMENDATIONS

Key themes that have emerged from the consultations include:

- To improve **data sharing** between professionals and systems e.g. cannot see CLA children and SEND but good links reported with early intervention and children's centres.
- Children in Need cases and **safeguarding cases have increased** in Harrow capacity to deal with this and also the public health messages / support to PSHE
- **Red-book used as the key tool for sharing information** for under-fives, suggestions to expand this for older children.
- **NCMP contact to be better** used for other health checks including oral health, vision, hearing and links to transition record for 4-5 year olds.
- Supporting vulnerable children works well but demand has increased. **Issues with roles and responsibilities** between school nursing and community nursing.
- **Key health concerns:** Asthma, mental health especially bullying shifted to digital, speech and language, occupational health, vision and hearing, support to special educational needs and disabilities.
- **Referrals to CAMHS** thresholds are high so in response New - Like-minded service Barnardo's in Harrow take lower level 2.5 tier mental health referrals, 20 schools currently bought in
- **Aware that obesity is an issue** but concerns over what to do next after NCMP carried out, nothing to refer / support
- **Referrals to IAPT** for anyone needing mental health support including mothers with post natal depression
- **Key health promotion messages:** breastfeeding support, oral health, healthy eating, immunisations, healthy start vitamins, emotional wellbeing

- **Concerns over capacity** and role of health visitors and school nurses in CP meetings for 0-19 model. Currently 50% of CP meetings cancelled, school nurses not always informed.
- Referrals to service works well in most cases **but feedback from service does not always happen**
- **Lack of visibility** of service to families in Harrow. Better understanding from parents of what service provides, e.g. 6-8 week check with GP and HV, what a school nurse does
- **Well received and continuity of training from respiratory and diabetic nurses** for example. More training and encouraging joint professional development. 2 year old reviews and integrated working.
- **Increase in demand for support to families with language barriers** due to increase in number of families in the area from non-English speaking countries.
- **Improving transitions from early years to schools and from children to adults** (PVI's, early support hubs – links with data sharing)
- **Introduce standardised protocols** of different pathways and service agreements
- **Improve access and choice for service users to contact service**, face to face, telephone, online and social media
- **Support from schools for buy back** (as long as in advance and clear what universal service provides)
- **Better understanding of what the voluntary and community sector provide** e.g grass root organisations

13 REFERENCES

- ¹ UCL Institute of Health Equity (2010), Fair Society , Healthy Lives The Marmot review. Strategic review of health inequalities in England post 2010. www.ucl.ac.uk/marmotreview
- ² https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/492086/HCP_5_to_19.pdf
- ³ <https://www.gov.uk/government/publications/troubled-families-supporting-health-needs>
- ⁴ Harrow Council (2016) Child Poverty Needs Assessment for Harrow
- ⁵ Green,H., Mcginnity, A., Meltzer, Ford, T., Goodman,R. 2005 Mental Health of Children and Young People in Great Britain: 2004. Office for National Statistics.
- ⁶ Kessler RC, Berglund P, Demler O, Jin R, Merikangas KR, Walters EE. (2005). Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62 (6) pp. 593-602. doi:10.1001/archpsyc.62.6.593.
- ⁷ NICE: *Promoting the quality of life of looked-after children and young people*. NICE public health guidance 28. 2010.
- ⁸ DCSF: *Children looked after in England (including adoption and care leavers) year ending 31 March 2009*.
- ⁹ Darker et al: *An Analysis of Offending by Young People Looked After by Local Authorities*, Youth Justice vol-8 No2 134-148 (2008)
- ¹⁰ Hawton K, Rodham K, Evans E and Weatherall R (2002) *Deliberate self harm in adolescents: self report survey in schools in England*. British Medical Journal 325: 1207-1211.
- ¹¹ Feinstein, L. (2003) Inequality in the Early Cognitive Development of British Children in the 1970 Cohort. *Economica*, 70(1), 73-97.
- ¹² National Institute for Health and Clinical Excellence (NICE), *Improving the nutrition of pregnant and breastfeeding mothers and children in low-income households*, London: NICE, 2008.
- ¹³ Sandercock, GRH., Ogunleye, AA., & Voss, C. (2015) Six year changes in body mass index and cardiorespiratory fitness of English schoolchildren from an affluent area. *International Journal of Obesity*
- ¹⁴ Public Health England (2017), *Review of mandate for the universal health visiting service*
<https://www.gov.uk/government/publications/universal-health-visiting-service-mandation-review>
- ¹⁵ Public Health England (2015) *Healthy Child Programme: rapid review to update evidence*
<https://www.gov.uk/government/publications/healthy-child-programme-rapid-review-to-update-evidence>
- ¹⁶ NHS England (2014) *Health visiting service specification 2015/16*
<http://www.nhsemployers.org/news/2015/01/nhs-england-publishes-health-visiting-service-specification-2015-16>
- ¹⁷ Department of Health (2014), *Early Years High Impact Area - Transition to parenthood and early weeks*
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/563915/Early_years_high_impact_area1_transition_to_parenthood.pdf
- ¹⁸ Department of Health (2009), *Healthy Child Programme: Pregnancy and the First 5 Years of Life*
<https://www.gov.uk/government/publications/healthy-child-programme-pregnancy-and-the-first-5-years-of-life>
- ¹⁹ National Institute for Health and Care Excellence (2014) *Antenatal and postnatal mental health: Clinical management and service guidance*, CG192
- ²⁰ National Institute for Health and Care Excellence (2007) *Antenatal and postnatal mental health: Clinical guidance*, CG45
- ²¹ National Institute for Health and Care Excellence (Published 2013 -updated June 2015), *Postnatal care up to 8 weeks after birth*, Quality Standard 37
- ²² National Institute for Health and Care Excellence (2007), *Maternal Child Health Programme: Modelling the cost effectiveness of support to promote breastfeeding*
- ²³ National Institute for Health and Care Excellence (January 2016), *Preventing unintentional injuries in the home among children and young people under 15*, Quality standard 107
<https://www.nice.org.uk/guidance/qs107>
- ²⁴ National Institute for Health and Care Excellence (2012), *Social and emotional wellbeing: early years*, Guideline (PH40) Recommendation 2
- ²⁵ National Institute for Health and Care Excellence (2016), *Early years: promoting health and wellbeing in under 5's*, Quality Standard 128

²⁶ Healthy Child Programme – 5-19 years (DH, 2009 – amended August 2010)

²⁷ Healthy Child Programme – The two year review (DH, 2009)

²⁸ Hall, D. and Elliman, D. (2006) Health for All Children (revised 4th edition). Oxford

²⁹ University of Warwick. (2008) Health-led Parenting Interventions in Pregnancy and Early Years Research Report DCSF-RW070 <http://dera.ioe.ac.uk/8573/1/DCSF-RW070.pdf>

³⁰ National Institute for Health and Care Excellence (20??) Social and emotional wellbeing in primary education (PH12)

³¹ Lagos A & Hill-Brown J. 0-19 Consultation Report, July 2017. Harrow Council