THE STATE OF CHILD HEALTH IN EAST SUSSEX

Annual Report of the Director of Public Health 2017/18

FOREWORD

Good health and wellbeing in childhood and adolescence is the key to good health in adult life so this report aims to develop our understanding of the health of children and young people in East Sussex. The good news is that most children and young people in East Sussex are healthy. But it's not all good news, as the report identifies where East Sussex children and young people are experiencing poor health outcomes. There are two important messages that are repeated throughout this report:

- poor outcomes are mostly preventable;
- children and young people from a more deprived background do less well than their more affluent peers.

So the bottom line is that in East Sussex we could do more to improve children's health and wellbeing.

There is a need to reinforce the importance of intervening early in life on the determinants of child health. This includes: healthy behaviour and lifestyle of the child and the parents (for example nutrition, smoking); the families' ability to care for the child; education; the broader socio-economic conditions (i.e. poverty and inequity); and the environment. Child health (both physical and mental) is largely influenced by these broader determinants rather than the health care system, so there is a need to work with a range of professionals across the different sectors and organisations with a focus on children's health and wellbeing. Greater emphasis on prevention and proactive early intervention where every contact with a child and the family is used as an opportunity, are essential.

But why is this so challenging in reality? Local government and the NHS are facing significant financial constraints and pressures on services continue to build. However, prevention is part of the solution. It's not just about doing more prevention but also about doing it differently as well, and also by investing jointly across the health, public health and social care system. The challenge is that there is limited flexibility to shift investment away from treatment and social care services when the current demands on the health and care services are so great.

It's vital that we make the case for investment in prevention and early intervention as budgets continue to tighten. Prevention and early intervention measures are cost-effective, but the return on investment is likely to be medium to long-term and they do not produce immediate cashable savings. Few people would argue that stopping children from becoming overweight is not the right thing to do, rather than treating the morbidly obese for serious diseases and health conditions and with gastric surgery, even if in the short term there were no cashable savings from doing so. However, there is a need for immediate cost savings, given the pressures on budgets. It is important that we recognise these financial pressures, on all parts of the system, and that they necessitate prioritisation and choices to be made to get the greatest value from every penny of public money spent.

The benefits of intervening early and investing in the broader determinants of child health will lead to a reduction in the disease burden and therefore benefit adult health and care services. Investing in strategies that make a significant difference in outcomes for children come at a fraction of the cost of treating and caring for adults.

Cynthia Lyons,
Acting Director of Public Health

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This report is available in hard copy and also at www.eastsussexjsna.org.uk

CONTENTS

INTRODUCTION

'A vital and productive society with a prosperous and sustainable future is built on a foundation of healthy child development'

Centre for the Developing Child, Harvard[1]

This report is based on the 'State of Child Health 2017' published by the Royal College of Paediatrics and Child Health in January 2017. The State of Child Health 2017 brought together data for the first time on a comprehensive list of 25 measures of the health of UK children. The data provides 'an across the board' snapshot of child health and wellbeing in the UK. We have reproduced it for East Sussex presenting data at an East Sussex, district and borough, local authority (LA) and Clinical Commissioning Group (CCG) level and made comparisons to national data and to trend data where these are available. In some places where it is useful, we have also included some additional measures.

Chapter one examines mortality in infants under 1 year, children aged 1-9 years and young people aged 10-19 years. It shows that infant mortality in East Sussex is very much linked to levels of deprivation.

Chapter two outlines issues relating to conception, pregnancy and infancy with a focus on smoking and pregnancy, breastfeeding and immunisation.

Early years are picked up in chapter three, including healthy weight when starting school, healthy teeth and gums, hospital admissions due to injury and school readiness.

Chapter four covers topics within school age and adolescence and includes healthy weight at Year 6, Human Papilloma Virus (HPV) vaccination, smoking in young people, alcohol and drug use, mental health and wellbeing, suicide, road traffic injuries, sexual and reproductive health, and those children who are not in employment, education or training plus school absences and exclusions.

Family and social environment are picked up in chapter 5, including child poverty, family keywork, the child protection system and looked after children.

Chapter six explores the common health conditions of childhood including asthma, cancer, diabetes, disability and additional learning needs, epilepsy, palliative care and Autistic Spectrum Disorder.

EXECUTIVE SUMMARY

The Director of Public Health Annual Report 2017/18 focusses on the state of child health in East Sussex, from pre-conception through to adolescence: comparing East Sussex with national indicators; and for Clinical Commissioning Groups (CCGs) and Districts and Boroughs comparing them with England and also with East Sussex overall. This provides us with a valuable snapshot of the state of child health in East Sussex and identifies many areas where we can make improvements.

Overall the report shows that for many indicators, East Sussex performs well compared to national rates. However, there is marked variation at CCG and district and borough level, so even where indicators are similar or better than the national rate at county level, they may be worse at a more local level.

The picture is complex. The table below summarises how East Sussex compares to England and for each of the district and borough local authorities and clinical commissioning groups how they compare to England and to East Sussex.

TABLE KEY

	Similar to England/East Sussex
	Better than England/East Sussex
	Worse than England/East Sussex
	Higher than England/East Sussex
	Lower than England/East Sussex

Where data are available, the value for each indicator is shown at District, Borough and CCG level. This value has been statistically compared to England and East Sussex as shown below.

Sec	Indicator	Eng	E. Sx	Eastbourne			
				Eng		E. Sx	
1.1	Infant deaths, rate per 1,000	4.4	4.1		4.0		

Eastbourne value compared to England

Eastbourne value

Eastbourne value compared to East Sussex

Sec	Indicator	Eng	E. Sx	District/Borough												Clinical Commissioning Groups								
				Eastbourne			Hastings			Lewes			Rother			Wealden			EHS			H&R			HWLH		
				Eng		E. Sx	Eng		E. Sx	Eng		E. Sx	Eng		E. Sx	Eng		E. Sx	Eng		E. Sx	Eng		E. Sx	Eng		E. Sx
1.1	Infant deaths, rate per 1,000	4.4	4.1		4.0			5.3			3.4			4.6			3.2										
1.2	Child deaths 1-9 years, rate per 100,000	12.0	12.1																							
1.3	Child deaths 10-19 years, rate per 100,000	16.3	17.9																							
2.1	Maternal smoking, %	10.5	12.1		13.3			18.1			6.8			12.9			9.2			13.4			16.2			7.4	
2.2	Breastfeeding, %	44	48		46			38			50			42			55			49			40			54	
2.3	5 in 1 vaccine by age 1, %	93	94																	96			92			95	
2.4	MMR by age 5, %	88	89																	92			90			90	
3.1	Excess weight age 4-5, %	23	23		24			24			24			23			22			24			24			21	
3.2	Healthy teeth age 5, %	75	80		77			78			85			70			88										
3.3	Injury admissions age <5, rate per 10,000	130	148		158			176			105			170			135			154			180			116	
3.4	School readiness %	71	75		76			73			75			78			79			77			76			77	
4.1	Excess weight age 10-11, %	34	30		31			35			26			34			27			31			35			26	
4.2	2 doses HPV age 12-13, %	n/a	59																								
4.2	1 dose HPV age 13-14, %	89	81																								
4.2	2 doses HPV age 13-14, %	83	75																								
4.3	Smoking age 14-15, %	5.5	7.3																								

Sec	Indicator	Eng	E. Sx	District/Borough														Clinical Commissioning Groups								
				Eastbourne			Hastings			Lewes			Rother			Wealden			EHS			H&R			HWLH		
				Eng		E. Sx	Eng		E. Sx	Eng		E. Sx	Eng		E. Sx	Eng		E. Sx	Eng		E. Sx	Eng		E. Sx	Eng		E. Sx
4.4	Regular alcohol drinking age 15, %	6.2	7.8																							
4.4	Alcohol in last week age 15, %	n/a	36																							
4.4	Cannabis age 15, %	10.7	15.6																							
4.5	Positive life satisfaction age 15, %	64	62																							
4.6	Mental health admissions age <18, rate per 100,000	87	108		108			107			118			93			108		107			96			114	
4.7	Self-harm admissions age 10-24, rate per 100,000 (2015/16)	431	457																							
4.7	Self-harm admissions age 10-24, rate per 100,000 (2013/14 to 2015/16)	n/a	457		435			598			501			469			343										
4.8	Suicide age 15-19, rate per 100,000	4.8	n/a																							
4.9	KSI on roads age <16, rate per 100,000	17.1	21.5																							
4.9	KSI motorcyclists age 15-24, rate per 100,000	23	47																							
4.9	KSI car occupants age 15-24, rate per 100,000	29	54																							
4.10	Teenage conceptions, rate per 1,000	20.8	19.3		22.2			29.5			17.7			23.9			9.9										

Sec	Indicator	Eng	E. Sx	District/Borough														Clinical Commissioning Groups								
				Eastbourne			Hastings			Lewes			Rother			Wealden			EHS			H&R			HWLH		
				Eng		E. Sx	Eng		E. Sx	Eng		E. Sx	Eng		E. Sx	Eng		E. Sx	Eng		E. Sx	Eng		E. Sx	Eng		E. Sx
4.11	Overall school absence age 5-15, %	4.6	5.1																							
4.11	Persistent school absence age 5-15, %	10.5	12.4																							
4.12	NEET age 16-17, %	3.0	3.6		4.6			4.6			3.6			3.1			2.2									
5.1	Child poverty, %	20.1	18.6		21.0			28.7			15.8			19.2			11.4		19.0			25.0			12.0	
5.2	Child protection plan, rate per 10,000	43	45		32			120			22			38			24		35			84			18	
5.3	Looked after children, rate per 10,000	62	53		51			76			31			57			32		53			67			26	
6.1	Asthma admissions age <19, rate per 100,000	207	199																249			249			98	
6.2	Cancer incidence age <20, rate per 100,000	15.1	15.4																							
6.2	Cancer mortality age <20, rate per 100,000	2.5	3.3																							
6.3	Controlled diabetes, %	7	n/a																0			0			8	
6.4	Pupils with SEND, %*	14.4	13.3		12.3			14.4			14.2			12.7			10.6		12.0			13.7			12.3	
6.5	Epilepsy admissions age <19, rate per 100,000	74	89																113.2			101.9			50.4	
6.6	Autism Spectrum Disorder, rate per 1,000*	12.5	13.3		19.7			14.8			12.8			14.4			12.0		18.4			14.6			10.1	

n/a = not available * Data relating to a child's residency differs between national and local data making statistical comparison inappropriate

Mortality

There were 88 deaths in children under-one year in East Sussex between 2011 and 2015. This is an average infant mortality rate of 3.34 per 1,000 births and similar to the England rate of 3.85. This is lower than the rolling 10 year average rate (2006-2015) in East Sussex of 4.1 per 1,000 and of 4.4 per 1,000 in England.

Almost all of the most common causes of infant death are associated with inequalities. Babies born to mothers experiencing greater levels of deprivation are more likely to die than the babies of better-off mothers. Promotion of healthy lifestyles in women of childbearing age including advice about healthy weight, stopping smoking and reducing alcohol use will go some way to addressing infant mortality as will providing new parents' advice about safe sleeping and accident prevention.

After infancy, the highest rates of death in children and young people are in late adolescence. The majority of deaths are preventable. Deaths specifically due to road traffic injuries and suicide account for the majority of deaths among older adolescents. Focusing on preventing the two main causes of death among older adolescents will assist in reducing the number of deaths in this age group.

Conception, pregnancy and infancy

Pre-conception, pregnancy and infancy are all stages where lifestyle factors have a major role in the future health and wellbeing of babies and children. It is well documented how smoking, alcohol and substance use and exposure to domestic violence can all have a detrimental impact on the health status of the developing fetus and the baby/ child once born.

Smoking during pregnancy is one of the most important modifiable risk factors for improving infant health. The proportion of East Sussex women smoking at the time of delivery is 2% higher than the England average which is statistically significant.

Smoking in pregnancy is highest in Hastings followed by Eastbourne and related to deprived populations and in mothers under 20 years of age. Mothers from the most deprived quintile are five times more likely to smoke in pregnancy than mothers from the least deprived quintile. In addition to monitoring smoking status, all maternity services must ensure that smoking is addressed early in all pregnancies and that all women have access to equitable and tailored smoking cessation services which are appropriate to their needs.

Breastfeeding has physical and mental health benefits for mother and baby which last beyond the period of breast-feeding.

Breastfeeding at 6-8 weeks in East Sussex is 47.6% which is slightly higher than the England average of 44.4% though the rates are not increasing. Both younger women and women in more deprived areas are less likely to breastfeed. All women should be made aware about the benefits of breastfeeding before they give birth and provided with timely and adequate support to start and continue breastfeeding.

Early Years

Vaccination in early childhood is key in protecting children against serious and potentially fatal diseases. By 12 months of age, babies should have received several vaccinations, including three doses of the 5-in-1 vaccination (from August 2017 this became the 6-in-1 vaccination). At CCG level, Eastbourne, Hailsham and Seaford CCG achieve the national target of 95% coverage which is sufficient to provide herd immunity. High Weald Lewes Havens CCG achieves 94.6% coverage, but Hastings and Rother falls short of the target at 92.1%. Coverage of vaccination also varies by deprivation quintile and by GP practice. Uptake of two doses of Measles, Mumps and Rubella (MMR) vaccination by age 5 is lower than uptake of the 5-in-1 vaccination and is slightly higher than

the national rate. Practices with the lowest vaccination rates should be identified and plans put in place to improve coverage.

Weight when a child starts primary school is an important predictor of health outcomes later in life. Nearly one in four children in East Sussex are classified as overweight or obese during their reception year of primary school, similar to the England average. There has been minimal overall improvement in the proportion of East Sussex children classified as having a healthy weight during their reception year of primary school over the past decade. The overweight and obesity prevalence for children living in the most deprived areas in East Sussex is significantly greater than it is for those living in the least deprived areas. A range of interventions is required to promote healthy weight in children, including both access to healthy food and opportunities for physical activity; and to target critical periods in the life course. A programme to transform how nurseries and schools in East Sussex embed evidence -based health improvement activity into their work is being delivered.

Good oral health is an important component of overall health and wellbeing for children. Despite tooth decay being almost entirely preventable, and decay rates being lower in East Sussex than England, just over one in five children aged 5 years across East Sussex have evidence of tooth decay. Nationally rates are higher for those in deprived populations. Supervised teeth brushing at least twice a day, reduced sugar consumption and regular access to a dentist are crucial in preventing tooth decay.

Accidents are preventable, yet unintentional injuries are a major cause of ill health and disability in children in East Sussex and England. In 2015/2016 there were 419 injury-related hospital admissions across East Sussex for children under five years. This is a rate of 148 per 10,000 population, significantly higher than the England rates of 130 per 10,000. A total of 67% of non-traffic accidents in children aged under 5 requiring hospital admission in East Sussex were recorded as happening at home, although a further 18% are coded as unspecified, so the true figure could be higher.

Despite recent decreases, Hastings still has the highest admission rates in the county.

Injury reductions can be achieved at low cost through parent education, key staff group training and local coordination including the Home Safety Equipment Scheme.

School readiness is an important measure of early years development across a wide range of learning areas and has been linked with better academic outcomes from primary and secondary education as well as positive behavioural and social outcomes in adulthood. In East Sussex 75.4% of children reach a good level of development at the end of reception, significantly above the England average of 71%. All five districts and boroughs achieve above the national average. In East Sussex, fewer children eligible for free school meals (FSM) reach the expected level of achievement in phonics compared to their non-FSM peers. Boys eligible for FSM are further behind their non-FSM peers than girls eligible for FSM are.

School age/adolescence

Like weight earlier in childhood, weight at the end of primary school is an important predictor of health outcomes both in childhood and later in life. Currently, almost one third of children in East Sussex are classified as overweight or obese during their final year of primary school, with the percentage of Year 6 children in Hastings classified as overweight or obese being significantly worse than East Sussex. There has been minimal overall improvement in the proportion of East Sussex children classified as having a healthy weight during their final year of primary school over the past decade, although there was a decrease in the proportion of obese children in East Sussex in 2016/2017. The overweight and obesity prevalence for children living in the most deprived areas in East Sussex is significantly greater than it is for those living in the least deprived areas.

The promotion of healthy weight in children needs to include a range of interventions to both reduce the obesogenic environment and target critical periods in the life course.

The Human Papilloma Virus (HPV) vaccination during adolescence is a highly effective public health measure to prevent cervical cancer and genital warts. The national HPV immunisation programme was introduced in September 2008 with all girls in school year 8 (aged 12 to 13 years) offered the vaccine against HPV infection, with a 'catch-up' campaign for girls aged from 14 years to less than 18 years. In East Sussex we are currently below both the Surrey Sussex and national uptake rates for HPV. Due to problems with service delivery the schools-based and community vaccination service for children and young people is being re-procured by NHS England. Additionally, girls from a black and ethnic minority backgrounds, and girls not in mainstream education are less likely to take up or complete the vaccination course.

Smoking continues to be the greatest single cause of avoidable mortality in the UK. Starting to smoke during adolescence increases the likelihood of being a life-long smoker. Latest figures from a national survey show that more 15-year-olds in East Sussex smoke regularly (7.3%) than the South East or England (5.8%, 5.5%). A 2017 local survey showed that 11% of girls and 8% of boys in year 10 have had a cigarette in the last week. Significant inequalities in adolescent smoking persist, with higher rates of smoking in young people from deprived populations. Smoking is rarely initiated after adolescence so prevention during this critical period is essential. Tobacco control measures across the whole population are the most effective measures for reducing smoking and smoke exposure in children and young people.

Over the last 13 years alcohol and cannabis use in young people has reduced in East Sussex. However, compared to England significantly more young people drink regularly or have tried cannabis. 2017 local survey data suggest that rates are no longer falling. Health promotion activities at school are a vital opportunity for intervention, given that alcohol and drug use among school-aged children are linked with negative social and health outcomes into adulthood.

In East Sussex just over 61.6% of young people reported positive life satisfaction in a 2014/15 national survey, although life satisfaction appears to be higher in boys than in girls. Bullying and disruptive behaviours at school are linked with lower levels of wellbeing amongst young people whilst higher levels of life satisfaction are linked to physical activity, reducing screen time, nutrition, and good mental health.

Mental health problems during childhood and adolescence are associated with a wide range of adverse outcomes in later life, including higher rates of adult mental health problems, poor educational outcomes, unemployment, low earnings, teenage parenthood, marital problems, criminal activity, and shorter life expectancy. East Sussex has a similar rate of hospital admissions for mental health disorders to England (2015/16 data). Inpatient admissions for mental health disorders are indicative of early help for emerging mental health disorders not being available in a timely way or being effective. The self-harm admission rate for those aged 10-24 years in East Sussex is around 457 per 100,000. This has risen from around 275 per 100,000 in 2011/12 and is now similar to the England rate. Within East Sussex, rates of self-harm admissions are highest in Hastings and lowest in Wealden. The focus of preventive work should be on promoting resilience, and early recognition and provision of help, particularly in schools and colleges.

In East Sussex, suicide is the second most common cause of death in young people aged 15 to 19, and accounts for 18% of deaths. In young people, suicide is strongly linked with self-harm, bereavement, poor mental health, alcohol and drug misuse, abuse, academic pressures, and bullying. Suicide is preventable: improving emotional and mental health support and limiting access to the means of suicide are essential to reduce suicide rates amongst young people.

In East Sussex, road traffic accidents are the main cause of death in young people aged 15-19 years, accounting for 26% of deaths. East Sussex rates of children aged 0 -15 who are killed or seriously injured on the road are similar to England and have slightly reduced over the last five years. East Sussex has significantly higher rates of young people aged 15-24 years killed or seriously injured on the road in both cars and motorbikes compared to national rates. There is a two year Road Safety Programme to reduce those killed or seriously injured on East Sussex roads.

The sexual and reproductive health of young people is an important indicator of population health. In East Sussex, the teenage conception rate has been reducing since 1998 and this matches the national trend. Rates of teenage conception are linked to deprivation and vary by district and borough with Hastings Borough Council having a consistently higher rate and Wealden District Council having a consistently lower rate. In East Sussex we are promoting access to high quality relationship and sex education, as well as good access to young-people friendly sexual and reproductive health services. Early and coordinated support is needed for young parents to improve outcomes for themselves and their children.

Non-attendance at school or school absence is linked to academic underachievement, anxiety, challenging behaviour and further non-attendance. Truanting and non-attendance can also place children and young people at greater risk of Child Sexual Exploitation Overall absence (OA) rates in East Sussex are 5.1% which is slightly higher than England at 4.6%.

Young People who are not in education, employment or training are at greater risk of poor physical health, depression, low skilled jobs or unemployment and early parenthood compared to their peers who are actively engaged in learning or working. In East Sussex, 3.6% of 16-17 year olds are not in employment, education or training (NEET) which is a slightly higher proportion compared to England at 3.1%. However, East Sussex has a much lower proportion of young people of unknown status (0.9%) compared to England (2.8%). In the more deprived boroughs of Hastings and Eastbourne 4.5% of 16-17 year olds are NEET. East Sussex County Council (ESCC) Standards, Learning and Effectiveness Service commission the Youth Employability Service (YES) to work closely with schools to identify young people at risk of becoming NEET and provide additional support to those vulnerable groups during transition from school to further education or training.

Family and social environment

Children growing up in poverty are likely to do less well across a range of outcomes including health, cognitive and emotional development, and education. The effects of poverty last through the life-course and also influence long term social outcomes. Although child poverty rates in East Sussex are lower than England, nearly one in five children in East Sussex are living in poverty (18%).At a district and borough level, Hastings has highest level of children in poverty and Wealden the lowest. Hastings and Eastbourne have significantly higher rates of child poverty than East Sussex overall, and Lewes and Wealden significantly lower. Improving the health outcomes of children living in poverty requires provision of good quality, effective and universal prevention and health care services.

The Troubled Families programme (TF) was set up by the government to transform the way services work with families with multiple health or social problems including absence from school and worklessness. East Sussex is in the top 10% of local authorities for engaging families in the TF2 programme and for successfully achieving progress with families (2,192 families supported as of 31st July 2017). The average length of engagement with a family is eight months. For many families the TF programme acts as early intervention and improves outcomes for families as well as preventing the need for more costly involvement of statutory services. Households with young carers account for almost 1 in 4 of families involved in the TF programme in East Sussex.

A child protection (CP) plan is put in place when a child is considered in need of protection from neglect or physical, emotional or sexual abuse. In East Sussex between 2012 and 2017, the number of children in the child protection system decreased from 64.6 to 45.0 per 10,000 and is now similar to the England average. Rates are highest in Hastings and lowest in Lewes and Wealden. Children with CP plans are a vulnerable group at greater risk of physical and mental health issues. Good data is essential to support effective service delivery and to improve the health outcomes of children and young people in the child protection system.

In 2017 there were 53 children per 10,000 aged 0-17 years who were looked after by the local authority. There has been an overall decrease in numbers of Looked After Children (LAC) from 620

in 2012 to 560 in 2017. East Sussex is now below the England average and slightly below the South East average. There are large differences in the rate of LAC between districts and boroughs, with more deprived areas having higher rates. Children who are LAC generally have worse physical and emotional and mental wellbeing than their peers. Some LAC do not achieve their academic potential, particularly if they enter the care system when they are older. In East Sussex the Virtual School works to support LAC through education and improve outcomes.

Health conditions of childhood

Asthma is a common lung condition that often starts in childhood. Emergency admission rates for asthma in children vary across East Sussex. Admissions due to asthma for children and young people (0-18 years) are similar for East Sussex compared to the England average. Evidence suggests that up to 70% of all asthma admissions are preventable through better management in primary care.

Cancer in children under the age of 15 is rare and accounts for less than 1% of all new cancer cases in England. More than 8 out of every 10 children diagnosed with cancer will live for at least 5 years, and most of these children will be cured. The number of children surviving five years following a cancer diagnosis has doubled since the 1970s. This reflects improvements in treatment and care. Cancer causes only 1 in 100 (less than1%) of all deaths in children. Children's cancers mortality rates have decreased by 66% since the early 1970s in the UK. Services need to be able to consider each case of cancer individually, taking into consideration the clinical and wider needs of each child and young person, and their families and carers.

The incidence of type-1 diabetes is increasing and accounts for 97% of all children with diabetes in England. The UK has one of the highest rates of type-1 diabetes in the world, for reasons that are currently unknown. When diabetes is not well managed, it is associated with serious complications including heart disease, stroke, blindness, kidney disease and amputations leading to disability and premature mortality. Very few children and young people in East Sussex have glycated haemoglobin (HbA1c) levels below the maximum target of 48mmol/mol. Although a higher proportion have HbA1C levels below 58mmol/mol (the pre-2015 target) than nationally. There are higher emergency admission rates for children and young people with diabetes from more deprived areas in East Sussex. Schools have an important role to play in supporting children and young people with type-1 diabetes to manage their diabetes.

Local authorities have a statutory duty to identify and support children and young people with disabilities and learning difficulties. In East Sussex there are currently 13% of children and young people identified as having a special or additional educational need, compared to 14% in England. In line with the national trend, the recorded SEN population in all CCGs and Districts and Boroughs in East Sussex has declined, most rapidly since the start of the transitional stage to Education Health and Care (EHC) Plans in 2014. Children with special educational needs or disabilities (SEND) or additional support needs (ASN) are more likely to come from low income families. This may be partially linked to caring duties preventing parents from full employment.

Epilepsy is a common neurological disorder characterised by recurring seizures. The nature of epilepsy means that it can be difficult to diagnose accurately. There is a strong relationship between emergency epilepsy admission rates for children and deprivation across East Sussex. For many children and young people diagnosed with epilepsy the seizures can be controlled through treatment with an anti-epileptic drug or other interventions. Optimal management improves health outcomes and can help to minimise other impacts on children and young people's social relationships, educational outcomes and employment.

Autism is a lifelong developmental disability that affects how a person communicates with and relates to other people, and how they experience the world around them. Children and young people with autism are also at higher risk of some physical health conditions such as epilepsy, or stroke as well as mental health problems including anxiety. Children and young people with autism

often find it hard to access health services and may have co-morbid symptoms dismissed. Children with autism are also much more likely to be formally excluded from education that their peers (27% compared to 4%). Over one in four (26%) of those who do succeed in education and graduate remain unemployed. East Sussex has a higher rate of children recognised by schools as having Autism Spectrum Disorder (ASD) compared to the national average, but is below the average for the South East. Since 2013 there has been a steady increase in the rate of children recognised as having ASD by schools in East Sussex.

Palliative care for children differs from that of adults, and by comparison, the number of children dying is relatively small. New draft National Institute for Health and Care Excellence (NICE) guidance on best practice about end of life care has recently been issued for consultation. High-quality end of life care for children and young people requires a *holistic approach which recognises the needs of the child or young person and their families and* carers.

Recommendation

Nationally, the profile of children and young people's health and wellbeing within the new models of care has been relatively low yet they provide an opportunity to improve the quality of services for children and young people, increase efficiency and improve outcomes.

Improving children and young people's health and wellbeing is a top priority in the accountable care system in East Sussex to ensure that we are not just making gains in health outcomes now but improving the long-term outcomes of future adult populations.

So there is only one recommendation in this report:

Continue to implement the key actions agreed by partners as outlined in each chapter, and in doing so ensure a focus on prevention, as almost all poor outcomes are preventable, and on reducing inequalities, as the majority of poor outcomes have a relationship to deprivation.

In making this recommendation it is important to acknowledge the unprecedented financial pressures on all parts of the system and the need to get value for every penny of public money spent. When local authorities and National Health Service (NHS) organisations are under pressure to cut costs within reduced budgets, making the case for investment in prevention of any kind can be difficult.

We have to make sure that we are using resources efficiently now. Are we allocating resources to the right activities (the ones that achieve the best outcomes within the resource envelope) and are we delivering those outcomes in the most efficient way?

Investing in prevention and early intervention to support and maintain health and wellbeing and prevent ill-health will not produce immediate cash savings. However, it is vital for the long-term sustainability of the system. The financial challenge can only be tackled by adopting a system-wide approach, rather than budgets for prevention, treatment and care operating in silos. A system-wide approach is being adopted in East Sussex through **East Sussex Better Together** (the accountable care system being developed based on an integrated Primary and Acute Care System Model). We are building an accountable care system that integrates our whole system: primary prevention, primary and community care, social care, mental health, acute and specialist care for children and young people and adults. However, a system-wide approach still necessitates prioritisation and choices to be made and all parts of the system being open and honest in the debate on future levels and sources of funding.

CHAPTER 1
Mortality
1.1 Infants (under one year)

Number of infant deaths per 1,000 live births

Key messages

- Improvements in maternity and neonatal intensive care, as well as general health care, have led to a reduction in infant mortality since the 1970s.
- There were 88 deaths in children under-one year in East Sussex between 2011 – 2015. This is an average infant mortality rate (IMR) of 3.34 per 1,000 births and similar to the England rate of 3.85.
- Deaths of children under one year of age account for over 50% of all child deaths in East Sussex, and 40% of all child deaths were children under 28 days (April 2008 - March 2017 data).
- Maternal health and health behaviours are the most frequent cause of infant mortality (56%) in East Sussex, followed by chromosomal and genetic anomalies (25%).
- There is a statistically higher rate of infant mortality in the most deprived wards compared to the least deprived.

What is this indicator showing us?

This indicator shows the number of deaths under one year of age per 1,000 live births each year, also known as the infant mortality rate (IMR). Figure 1.1.1 shows the 5 year rolling average mortality rate.

Other important indicators focus on:

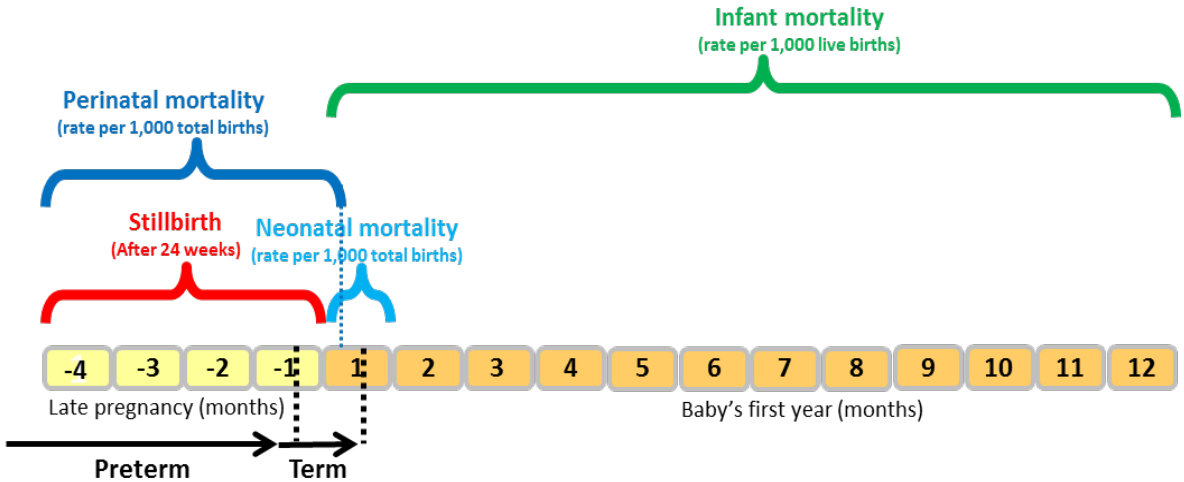
Perinatal mortality [PNMR]:

Perinatal mortality includes: stillbirths (a baby born without signs of life after 24 weeks gestation); and those babies who die within 7 days of birth. Stillbirths account for half of all perinatal deaths. Rates are calculated per 1000 total births.

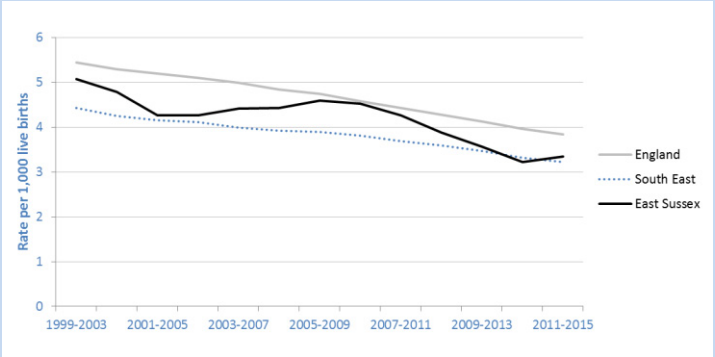
Neonatal mortality: Death before the age of 28 completed days after live birth. Rates are calculated per 1000 live births.

Infant mortality [IMR]: Deaths of infants in the period from birth to less than 1 year of age. Rates are calculated per 1000 live births.

Post neonatal mortality: Deaths of infants from 28 days to 364 days old. Rates are calculated per 1000 live births.



Infant mortality rates in East Sussex, South East and England

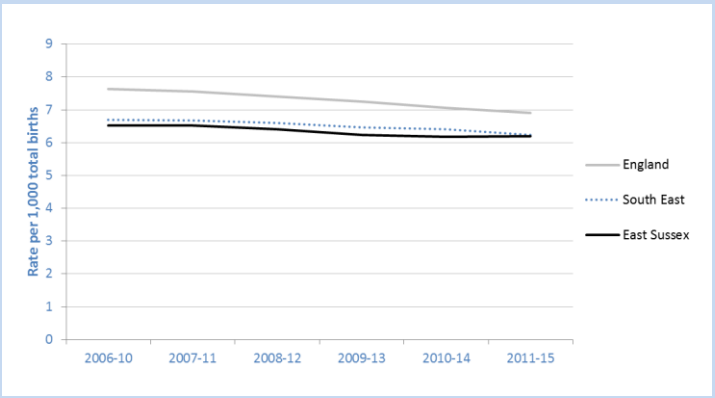


Latest data The2011- 2015 average IMR in England was 3.85 deaths per 1,000 live births compared to 3.34 deaths per 1,000 live births in East Sussex.

Trend: The IMR across the UK has been declining since 1999. However, in the year 2015 there was the first increase in the infant mortality rate in England and Wales since 2003. The rate rose to 3.7 deaths per 1,000 births from the record low of 3.6 in 2014, but remains low in historical terms.

Source: ONS, Vital Statistics

Figure 1.1.1: Infant mortality rates per 1,000 live births in East Sussex, (5 year moving average) 1999 to 2015

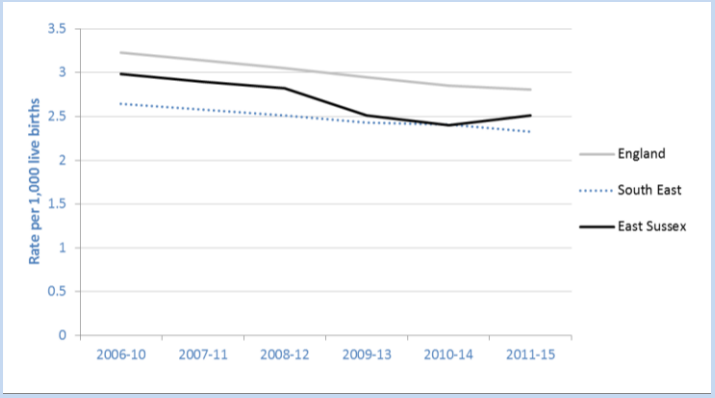


Latest data: The perinatal mortality rate [PNMR] is shown as a five year moving average rate between 2006 and 2015, in view of the small numbers. The PNMR in East Sussex for the period 2011-15 was 6.2 per 1,000 total births

Trend: The rate of perinatal deaths in the UK has declined over the past two years, largely driven by a drop in rates of stillbirth, particularly those occurring in late pregnancy. East Sussex has not seen the same decline.

Source: ONS, Vital Statistics

Figure 1.1.2: Perinatal mortality rates per 1,000 total births in East Sussex, South East Region and England (5 year moving average) 2006-2015

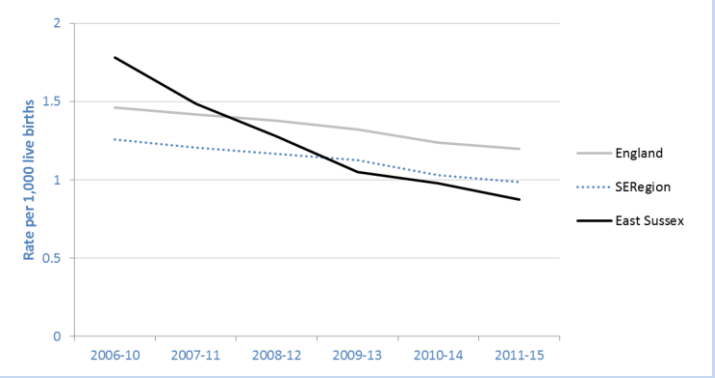


Latest data: The most recent published data are from 2015 and show East Sussex with a higher neonatal mortality rate than the South East but lower than England

Trend: In 2015 the neonatal mortality rate in East Sussex, increased but overall it is lower than it was in 2006-10 in parallel with the declining rate in England

Source: ONS, Vital Statistics

Figure 1.1.3: Neonatal mortality rates (deaths from 0-28 days of age) per 1,000 live births 2006-15 (5 year moving average)



Latest data: The most recent published data are from 2015.

Trend: There has been a steady decrease in the East Sussex post-neonatal mortality rate

Source: ONS, Vital Statistics

Figure 1.1.4: Post-neonatal mortality rate per 1,000 live births in East Sussex, (5 year moving average) 2006 to 2015

Why is this indicator important?

The IMR is frequently used as an indicator of wider population health and of access to, and quality of, healthcare services for children and mothers. Infant deaths account for the majority of all child deaths.

Infant deaths are categorised as neonatal (within the first 28 days of birth) or post neonatal (after 28 days but less than a year). Neonatal deaths count for between 70% and 80% of *infant* deaths, or around 50% of all child deaths nationally. The main causes of neonatal deaths are related to perinatal causes including maternal health and health behaviours e.g. smoking and obesity, followed by genetic or congenital anomalies. Premature babies tend to have a different pattern of causes of death from term babies.

Infant deaths after 28 days are due to a range of causes, including genetic anomalies and sudden infant death syndrome (SIDS). Unsafe sleeping arrangements and parental smoking are risk factors for SIDS which can be reduced through health promotion to parents.

Low birth weight (LBW, weight less than 2,500 grams) is one of the known risk factors for infant deaths. LBW babies have much higher IMR than babies of normal birth weight. In 2015 a smaller proportion of East Sussex babies were born with LBW (6%), compared to England (7.4%).

Nationally, IMR stratified according to birth weight in 2015 were:

- Very Low Birth Weight babies (under 1,500 grams) **159.6** deaths **per 1,000** live births.
- Low Birth Weight babies (under 2,500 grams) **31.6** deaths **per 1,000** live births.
- Birth weight (above 2,500 grams) **1.1** deaths **per 1,000** live births

Where are we now in East Sussex?

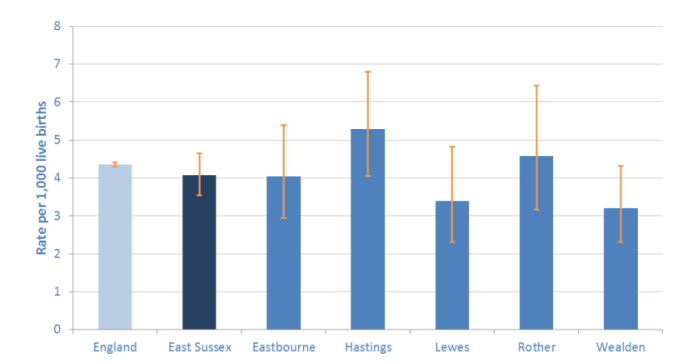
In the three East Sussex Clinical Commissioning Groups (CCGs) there were 53 infant deaths in total for the period 2013-15 which is an IMR of 3.4 per 1,000 births.

Table 1: Infant Mortality in East Sussex CCGs 2013-15

	Number of infant deaths	Rate per 1,000 live births
Eastbourne, Hailsham and Seaford CCG	18	3.3
Hastings and Rother CCG	24	4.4
High Weald Lewes Havens CCG	11	2.5
East Sussex	**53**	**3.4**

Source: PHE, Child Health Mortality Profiles

In East Sussex, the two constituents of the IMR, neonatal and post neonatal mortality, have both shown marked declines over the last ten years. However this progress cannot be taken for granted as the most recent figures (2015) show a slight increase in neonatal mortality rate. The post neonatal component of infant mortality has been declining more rapidly than the neonatal component.



Latest data: As the annual number of deaths per individual district or borough is low we use a ten year average IMR to make comparisons. Between 2006 and 2015 the East Sussex and the lower tier authority rates are not significantly different from the England rate of 4.4 per 1,000 live births. Furthermore, whilst the rate in Hastings 5.3 per 1,000 live births) is higher for the ten year period, it is not statistically significant.

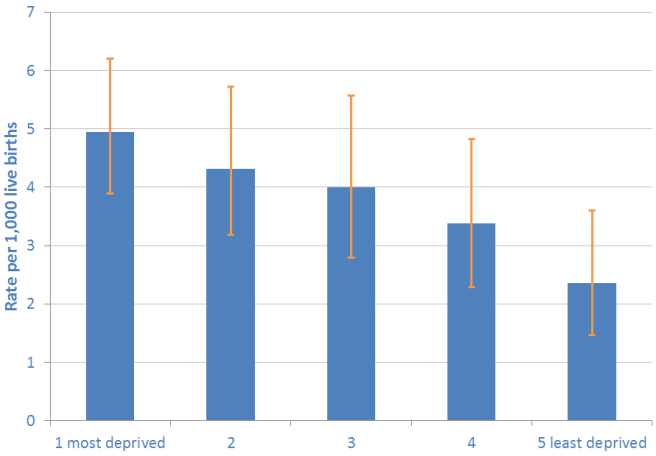
Source: ONS, Vital Statistics

Figure 1.1.5: Infant mortality rate per 1,000 live births in East Sussex by district and borough, (10 year average) 2006-15

Spotlight on inequalities

National data shows an association between higher deprivation and higher rates of infant mortality. In East Sussex this pattern can also be seen with a statistically higher rate of mortality in the most deprived wards compared to the least deprived. Almost all of the most common causes of infant death are associated with inequalities. Babies born to mothers experiencing greater levels of deprivation are more likely to die than the babies of better off mothers. Mothers from more deprived groups are more likely to experience a range of complex social factors which impact on their health and the health of their baby such as exposure to stress, smoking in pregnancy, poorer nutrition, and to substance misuse substances. These factors contribute to the increased risk of LBW for babies of mothers from more deprived groups. Being overweight or obese contributes to an increased risk of pre-term and induced pre-term birth. Rates of protective behaviours e.g. breastfeeding and recommended practices such as safe infant sleeping arrangements, including placing a baby on his or her back, are higher in more wealthy groups.[2]

There is an association between young maternal age and higher infant mortality, partially explained by very young mothers tending to come from more deprived backgrounds. The IMR for babies born to mothers under 20 is almost 80% higher than the IMR for babies born to mothers aged 25 to 29 years in England and Wales (6.1 deaths compared to 3.4 deaths per 1,000 live births). Overall the IMR across the UK has been declining. However, the rate has been rising for the poorest children since 2010, while continuing to fall for more advantaged groups, demonstrating widening inequalities.[3]



Latest data: Looking across the county of East Sussex over the past 10 years the IMR is statistically significantly higher in the most deprived wards [quintile 1] of the Income Deprivation Affecting Children Index [IDACI] compared with the least deprived wards [quintile 5].

Source: NHS Digital, Primary Care Mortality Database

Figure 1.1.6: Infant mortality rate per 1,000 live births in East Sussex by deprivation (IDACI quintiles), (10 year average) 2006-15

What does good look like?

Infant and neonatal mortality rates for East Sussex (3.4) are lower than rates for England but slightly higher than rates for the South East, whereas the perinatal mortality rate for East Sussex has been consistently lower than both the South East region and England rates. A quarter of areas in the country had an annual IMR of 3.1 or below in 2015, with the best in England being a rate of 2 per 1,000 in the London Borough of Havering.

The IMR in the UK has fallen over the last 20 years, but progress has not been as fast as in other wealthy European countries, which means that the UK is falling behind the best in Europe. One international study found that the UK was in the bottom 10% of comparable countries in 2008.

How can we improve?

There is much we can do to reduce IMR - tackling preventable risk factors and promoting exposure to protective factors will increase infant survival. Like many health improvement programmes, reducing infant mortality requires both policy changes to influence change at a population level, as well as individual and targeted changes in behaviour and practice.

Infant death rates are highest amongst the most economically and socially disadvantaged families, therefore Government actions to **reduce poverty and inequalities** are important for improving infant survival. The majority of policies which can be socially protective e.g. child care, housing, tax and welfare policies are set at a national level and not within the control of local health and social care systems.

Maximising the health and wellbeing of women before conception and both during and after pregnancy is essential. Services to promote healthy lifestyles including nutritional advice, weight management and smoking cessation are important preventative interventions. Reducing smoking during and after pregnancy is vital to reducing infant mortality as smoking is a major risk factor for poor pregnancy outcomes, including impaired foetal growth and development, increased risk of stillbirth, preterm birth, low birth weight, as well as the development of some congenital abnormalities (see Indicator 2.1 for further detail).

Underweight and overweight women are at increased risk of adverse outcomes during pregnancy. For overweight or obese mothers even a small increase in body mass index (BMI) leads to higher risk, and both obesity and gestational diabetes are strongly associated with an increased risk of stillbirth. Good pre-conceptual care includes folic acid supplements to prevent birth defects such as spina bifida, as well advice to ensure pregnant women have sufficient vitamin D, vitamin C, iron and calcium in their diets.

Implementing the recommendations of Better Births: the NHS plan to improve the choice and personalisation of local maternity services and the safety of maternity care[4].

Universal midwifery and health visiting services play an important role in supporting new mothers through advice and education about looking after their new baby**.** Health professionals **promote protective factors** such as **breastfeeding** and skin to skin care, particularly for babies born early. Not all mothers find it easy to breastfeed, or are discouraged by expectations of others, so non-judgemental infant feeding support is essential (see Section 2.2 for further detail). Working to **reduce risk factors** such as **unsafe sleeping** arrangements and **exposure to second hand smoke** also has a substantial role**.** Both are associated with Sudden Infant Death Syndrome [SIDS].

Maternal mental health has a strong influence on outcomes for both child and mother, as well as affecting the rest of the family. Raising awareness of symptoms, protective factors and how to get support are vital.

Vulnerable mothers: young mothers, first-time parents, and mothers exposed to domestic violence, substance misuse or mental health problems are all at increased risk of infant mortality (see Section 4.9 for approaches to reduce teenage pregnancy).

Research into practice: at a local level it is important to incorporate advances in knowledge of risk and protective factors into health and social care professional practice to reduce the preventable proportion of infant deaths. One recent example of research resulted in advice for women to fall asleep on their side, including daytime naps, in the last three months of pregnancy which may reduce the risk of having a stillbirth.

What are we doing in East Sussex?

Our multi-agency, partnership working across East Sussex through East Sussex Better Together (ESBT) and Connecting 4 You (C4Y) programmes includes a focus on prevention and activity to address infant and child mortality. Examples of activity include:

- We are **supporting women to lead healthy lifestyles in the pre-conception period** through targeted initiatives such as embedding preconception advice in sexual health and contraceptive clinics.
- All pregnant women who indicate they are smokers are provided **with advice and information on the importance of stopping smoking during pregnancy**, and automatically referred to stop smoking services ('opt – out' referral). Our maternal smoking pathways are being reviewed to ensure that effective ways of enabling women to stop smoking during pregnancy are embedded as part of routine maternal care.
- Health visitors and the integrated 0-5 children's service have **achieved level 2 UNICEF UK Baby Friendly Initiative (BFI) accreditation** for support of breastfeeding and healthy weaning.
- **Embedding of the Royal College approved Baby Buddy mobile phone application** for pregnant and new mums into local maternity and health visiting pathways. Baby Buddy provides accredited parent friendly information and advice for pregnant women, new mums and their partners to help women and their babies stay healthy and well. This includes breastfeeding and mental health advice and support for the healthy emotional and physical development of babies.
- **Advice on reducing risks for SIDS** are clearly communicated to new parents during routine midwife and health visitor contacts as well as through local safe sleeping campaigns.
- **Vulnerable mothers receive additional support from health visitors** with a focus on addressing identified risk factors and needs.
- In Hastings and Rother **enhanced ante-natal support for women most likely to experience health inequalities is being piloted** to support women in preparing for birth and parenthood.

Key actions going forward

- Review action to address maternal smoking **ensuring that every opportunity is taken to support women to stop smoking during pregnancy.**
- Continue to **protect and support health improvement and early intervention service**s such as universal midwifery and health visiting services for mothers, and expand provision of targeted support for younger mothers and vulnerable women.
- **Ensure that policy and strategies to improve maternal and child health are joined up locally**.
- Improve communication; **enable families to spot the signs of illness or failing health**. A recent example of this is the national campaign raising awareness of sepsis being led by Public Health England (PHE). Previous national campaigns have included raising awareness of the signs and symptoms of meningitis.
- Continue to **promote use of the Baby Buddy App** and evaluate uptake and impact.
- **Consider routinely including information on the impact of lifestyle on a healthy pregnancy** to women of childbearing age as part of routine health improvement advice.

CHAPTER 1
Mortality
1.2 Children (one to nine years)

Annual number of deaths of children aged one to nine years per 100,000 Population

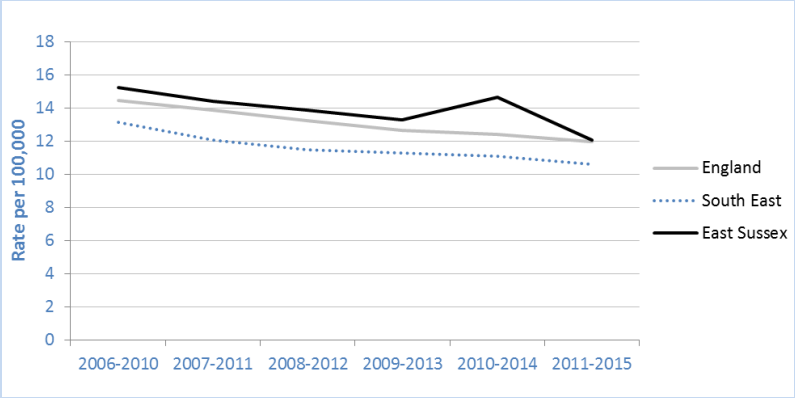
Key messages

- Over the last forty years, mortality rates for 1-9 year olds have reduced, but as rates get lower the reduction gets smaller. Since 2006 national rates fell from 14 to 11.6 per 100,000, and East Sussex rates from 15.2 to 12.1.
- Cancer, injuries and poisonings, congenital conditions, and neurological and developmental disorders are the main causes of death; however the effects of preterm births continue to influence mortality rates for up to 10 years after birth.
- In East Sussex, 40 children aged 1 to 4 and 28 children aged 5-9 died over the ten year period 2006 to 2015.
- Children from more deprived areas have a higher risk of death.
- The East Sussex Child Death Overview Panel (CDOP) reviews all deaths of children in and from East Sussex to identify if there were any modifiable factors which may prevent similar deaths in the future.

What is this indicator showing us?

This indicator shows the mortality rate of children aged one to nine years per 100,000 population of that age. Five and ten year average rates have been shown. There were four more deaths in 1 to 9 year olds in the period 2010-14 than in the previous period 2009-13. This accounts for the increase in the rate in 2010-14 which is not statistically significant.

Mortality rates for children aged one to nine in East Sussex, South East Region and England

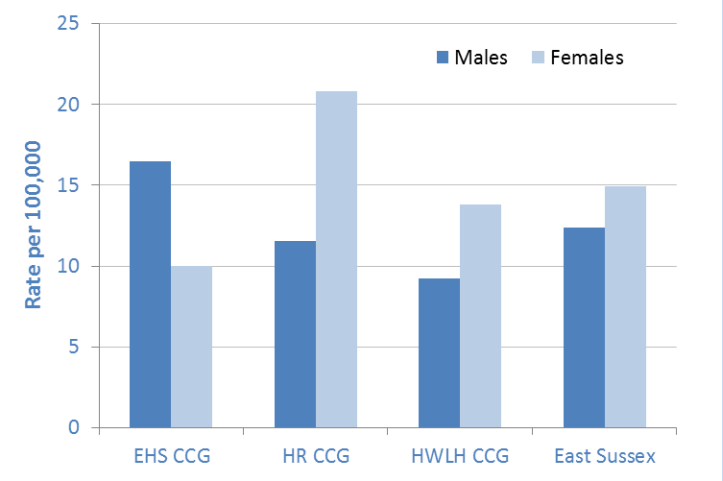


Latest data: The 2011-15 mortality rate was 12.1 per 100,000 in East Sussex and 11.6 in England.

Trend: Mortality rates [5 year moving averages] have declined over the period 2006 to 2015.

Source: ONS, Vital Statistics

Figure 1.2.1: Mortality rates per 100,000 population aged 1-9 in East Sussex, (5 year moving average) 2006 to 2015



Latest data: In East Sussex, the mortality rate for females aged one to nine is slightly higher than for males, although this is not statistically significant. By CCG, the rate for females is higher in Hastings and Rother and is lower in High Weald Lewes Havens and Eastbourne, Hailsham and Seaford CCGs. This is not statistically significant.

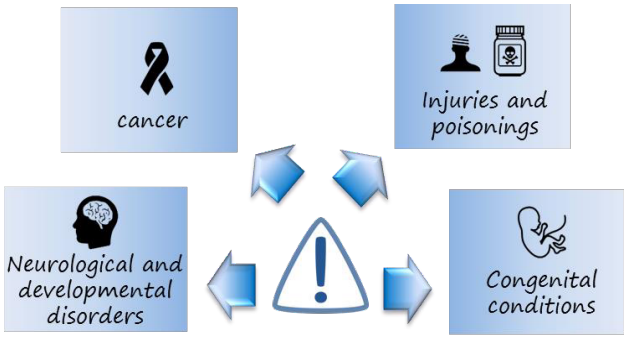
Source: NHS Digital, Primary Care Mortality Database

Figure 1.2.2: Mortality rates per 100,000 population aged 1-9 in East Sussex by CCG by sex, (10 year average) 2006-15

Why is this indicator important?

Although children's health and healthcare has improved over the last 40 years, with a corresponding reduction in the mortality rate, there are still improvements to be made. The UK's recent progress has been significantly lower than in other wealthy European countries. Monitoring the causes of death, analyzing trends and identifying common factors enables preventable causes to be recognized and changes made to practice to reduce deaths.

Factors that contribute to death during childhood differ from those which contribute to death during infancy or adolescence. The main causes of death amongst 1 to 9-year-olds are:



Nationally there are gender differences in the leading cause of death for children aged 1-4: boys die from injuries and poisonings, whereas cancer is the leading cause of death in girls of the same age.

Cancer is the leading cause of death for both boys and girls aged 5-9 years. Boys still remain more likely to die from injuries than girls.

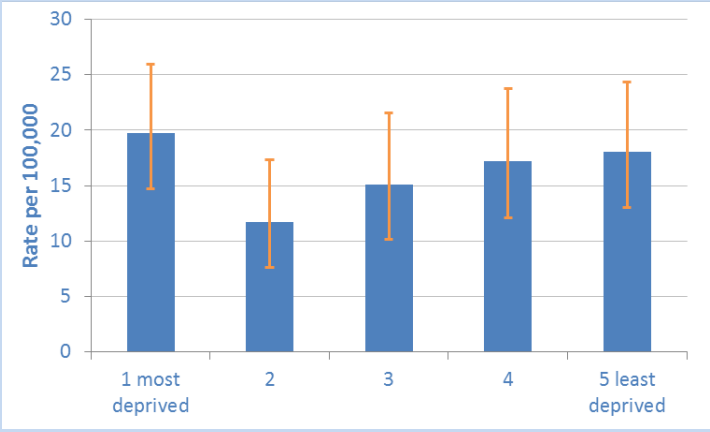
Another significant cause of mortality in children aged 1-9 is the impact of being born preterm. Preterm birth can cause breathing difficulties, difficulties in feeding, jaundice and insults to brain development. Some of these impacts can be permanent.

Where are we now in East Sussex?

Mortality rates for one to nine year olds in East Sussex have declined over the last ten years. The difference between boys and girls is not statistically significant, nor are differences between CCG areas.

Spotlight on inequalities

Nationally there is a strong association between deprivation and mortality during childhood, with social inequalities found to affect many of the leading causes of death among young children.[5] At a county level, as the numbers of deaths are relatively small, the following analysis looks at all deaths of 1-19 year olds over a ten year period. There were 68 deaths in total in 1 to 9 year olds and 97 deaths in total in 10 to 19 year olds in the period 2006 to 15. There is no clear relationship between deprivation and mortality.



Latest data: In East Sussex, when child mortality rates for one to nineteen year olds are viewed across the county over a ten year period there are no significant differences associated with deprivation, as defined by the Income Deprivation Affecting Children Index [IDACI] although there is at national level.

Source: NHS Digital, Primary Care Mortality Database

Figure 1.2.3: Mortality rates per 100 000 population aged 1-19 in East Sussex by deprivation (IDACI quintiles), (10 year average) 2006-15

What does good look like?

East Sussex has a similar mortality rate for 1-9 year olds to England.

In the 1970s the UK was in the best 25% of comparator countries for child mortality, but by 2008 UK child mortality rates were in the worst 25% of similarly economically developed countries. If the UK had the same rate of child mortality as the average of comparator countries it is likely there would be around 130 fewer deaths amongst 1-9 year olds each year.

How can we improve?

In order to reduce child mortality we need to understand the underlying influence and events leading up to the death as well as the immediate cause of death. It is important to identify those events which are **modifiable or preventable**. Some risk factors can be addressed at a local level, but others require national legislation. Healthcare services, familial, social and environmental factors as well as other services and organisations working with the child should all be considered.

Child Death Overview Panels (CDOP): These are statutory multi-disciplinary review panels which aim to understand *how* and *why* a child has died. Each local area has a CDOP and systematically considers comprehensive information about each child death for the purpose of identifying notable and potentially modifiable factors and making recommendations for system improvement. Specific local actions are taken based on local findings, and learning is shared nationally. In 2015/16 CDOPs across England identified **around one in four child deaths as having a modifiable risk factor**.[6]

How can we improve?

Medical causes accounted for 82% of all deaths reviewed by Child Death Review Panels in 2015/16 of which 16% had modifiable risk factors. Not surprisingly a much higher proportion of deaths from *non-medical causes* had modifiable risk factors (sudden unexplained death (65%), deliberately inflicted injury, abuse or neglect (60%), trauma and other external factors (56%). Only 3% of all child deaths resulted in a serious case review but over 50% of these were found to have modifiable risk factors.

Accident prevention: Many of the preventable deaths during childhood occur following accidents. Boys are at higher risk of mortality from injuries. Families should have access to information and support to **make the home safe from hazards** and to **teach their children how to manage hazards** in their community e.g. roads, railways, open water. Professionals such as healthcare workers, early years staff and teachers can also play a role in the provision of information and safety resources appropriate to a child's developmental stage. Managing safe play experiences at home and outside is important to help children learn about safety. See section 3.3 for more information

Knowledge and practice: Child death review processes could have even greater impact if there was a national database for sharing findings and using them to inform policy and practice nationally and locally.[7,8]

Looking at how a child interacts over time with their environment can help our understanding of childhood mortality. Different types of risks interact and can be described as:

- intrinsic [biological and psychological factors within the child e.g. prematurity, having a long term illness].
- the physical environment [housing, play areas, access to pools, ponds, rivers, the sea].
- the social environment [parental care, responding to health needs, parental smoking, parental age, social class, domestic abuse].
- factors relating to health and social care service delivery [unmet health needs, prevention, recognition of acute illness by health and social care professionals, follow up of those at risk, availability of support services].

Palliative care: Children with life limiting conditions should be able to access support and services and, as they reach the end of life, receive high-quality palliative care in the place of their and their family's choice (see section 6.7 for more information)

What are we doing in East Sussex?

- **East Sussex wide initiatives to improve access to advice and treatment** as part of urgent health care system improvements.
- **Promotion of "Spotting the sick child": approved web resources** and other relevant continual professional development (CPD) resources in local hospitals.
- East Sussex Healthcare NHS Trust (ESHT) use the Situation, Background, Assessment, Recommendation (SBAR) communication tool, an NHS Quality and safety initiative to **ensure relevant key information is communicated between health care teams during patient transfers and hand overs in hospital.**
- **Epilepsy individual care plans** and **asthma personal management plans** are in use.

What are we doing in East Sussex?

- **Each child with a long term condition has an individual health plan or an Education, Health and Care (EHC) plan** as appropriate for needs, produced by the school. School nurses can help with preparing individual health plans or the EHC plan in collaboration with the community paediatric team.
- **Promoting home safety via the 0-5 years integrated service** with Health Visitors.
- **Provision and fitting of targeted safety equipment and advice** to vulnerable families with young children across East Sussex.
- Have provided **accident prevention training to support early years professionals** to confidently raise the issue of home safety with families.
- As part of our Whole Systems Transformation Programmes, ESBT and C4Y, we are taking a settings approach to improving health. This includes a **whole schools transformation programme** whereby schools **develop a school health improvement plan**, and using a primary prevention and whole school approach, put in place actions to address health and wellbeing priorities (to include Road Safety) supported by a health improvement grant.
- **The Child Death Overview Panel reviews all child deaths in East Sussex**, identifies those with any modifiable factors **and ensures learning is disseminated** appropriately to parents and staff to reduce the risk of future deaths from the same factors.
- Health visitors, nurseries and other early years settings and staff ensure **weaning and healthy eating advice addresses the risk of choking from food** and advises parents on safe food preparation.

Key actions going forward

- **Further promote safety in the home**: Create safe environments, including access to information and safety equipment schemes to help the most disadvantaged parents ensure their homes are safe for children.
- **Further promote safety outside the home:** Improve safety for children travelling to and from school through driver awareness (see 4.9) and improve safety in leisure areas.
- **Ensure adequate support in schools** for children and young people **to manage their long-term conditions.**
- Ensure that clinical teams looking after children **make maximum use of tools to support improved communication, management and self-care**.
- **Ensure the maintenance of NHS England quality initiatives to improve the communication of key information between health and social care professionals** as part of the process of handing over responsibility for patients between shifts, and between staff working in primary and secondary care.
- **Continue to use setting based approaches developed through ESBT and C4Y to work with schools and early years settings** to enable them to take action to embed health improvement in their work.

CHAPTER 1
Mortality
1.3 Young People (10 to 19 years)

Annual number of deaths of young people aged 10 to 19 years per 100,000 Population

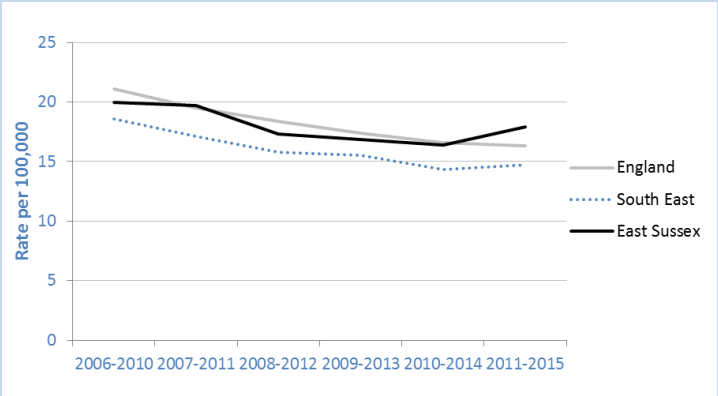
Key messages

- Young people aged 10-19 are most likely to die from injuries, violence and suicide, followed by cancer, substance misuse disorders, and nervous system and developmental disorders.
- The risk of mortality increases if deprivation or mental health problems are present.
- Death rates are much higher for 15-19 year olds, and young men are more likely to die than young women.
- In the ten year period 2006 to 2015 in East Sussex, 28 young people died aged 10 to 14, while 89 died aged 15 to 19. This is a rate of 17.9 per 100,000 10-19 year olds which is above but not statistically higher than the England rate of 16.3.
- More than 50% of adolescent deaths occur from external causes, with the potential for modifying these causes in many of the cases.
- Adolescent mortality rates in the UK have fallen in recent years, but not at the same rate as comparable wealthy countries. The difference is mostly due to higher rates of death from Non-Communicable Diseases in the UK.
- Families, communities, and schools must play a key role in promoting positive social interactions and reducing risk-taking behaviours in children and young people. This includes focusing on their behaviours and interactions when using the internet as well as in everyday life.

What is this indicator showing us?

This indicator shows the mortality rate of young people aged 10 to 19 years per 100,000 population of that age. The rate is shown as a five year moving average.

Mortality rates of 10-19 year old in East Sussex, South East and England



Latest data: The most recent published data are for 2015 and show a recent increase in East Sussex mortality rates.

Trend: Between 2006 and 2015, the mortality rate in 10 to 19 year olds decreased from 21.1 to 16.3 per 100,000 in England. The East Sussex was lowest in 2010-14. Although slightly higher in 2011-15, the East Sussex rate is not statistically significantly different from England.

Source: ONS, Vital Statistics

Figure 1.3.1: Mortality rates per 100,000 population aged 10-19 in East Sussex, (5 year moving average) 2006 to 2015

Why is this indicator important?

Mortality rates in late adolescence are higher than for younger children and adolescents (excluding infants under 1). Despite improvements in young people's health in the last 30 years, almost 1,300 young people die each year in the UK. Like younger age groups many deaths in this age group are preventable, and understanding causes and patterns of death can be used to change practice at a local level and policy at a national level.

Deaths in adolescence have different causes from those in younger children, and young men aged 15-19 have higher mortality rates than young women of the same age. Preventing avoidable deaths is key – rates of injuries, a frequent cause of mortality in 10-19 year olds and rates of suicide, more common in 15-19 year olds, can both be reduced through appropriate interventions.

Non-Communicable Diseases (NCD) risks begin to increase in adolescence as young people become more independent from their families and possibly engage in more risky behaviours. NCDs and injuries are the main causes of death in adolescence. As road traffic injuries and suicide account for the majority of deaths among older adolescents of both sexes there are sections on both these topics in this report (see sections 4.7 and 4.8).

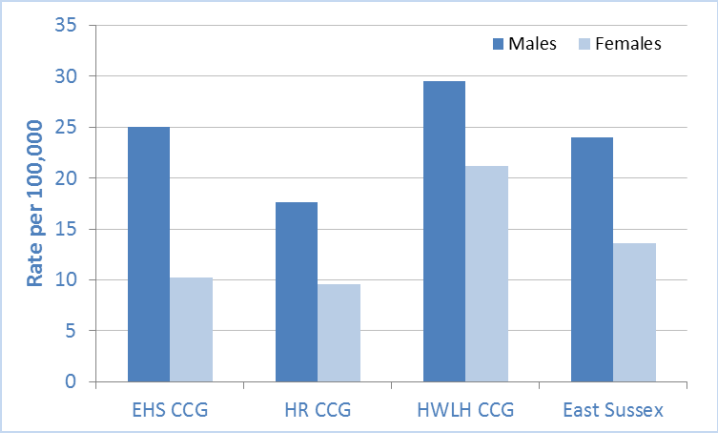
Other common causes of death of adolescents are cancer, substance misuse, epilepsy and neurodevelopmental disorders. Cancer and epilepsy are covered in more detail in sections 6.5 and 6.2 respectively.

Where are we now in East Sussex?

The mortality rate for 10 to 19 year olds in East Sussex has declined since 2006 although it has recently increased by a non-statistically significant amount. Boys in this age group in East Sussex had higher mortality rates than girls, due to much higher rates in males aged 15-19 years.

Between 2006 and 2015 in East Sussex, the mortality rates for young people were:

Differences between CCG areas are not statistically significant.



Latest data: In East Sussex, the mortality rate for males aged 10 to 19 is higher than for females. This is statistically significant. The rates for males and females are highest in High Weald Lewes Havens CCG and lowest in Hastings and Rother CCG but not significantly so.

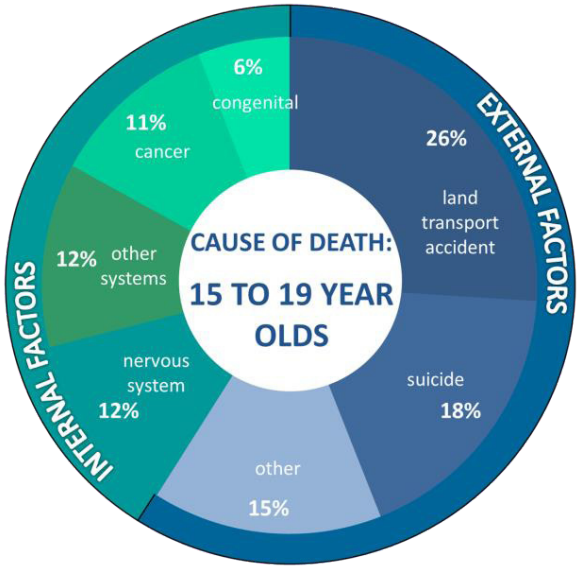
Source: NHS Digital, Primary Care Mortality Database

Figure 1.3.2: Mortality rates per 100,000 population aged 10-19 in East Sussex by CCG by sex, (10 year average) 2006-2015

For the period 2006-15 just under 60% (52/89) of deaths in 15-19 year olds in East Sussex were attributable to external causes.

East Sussex is an outlier (has higher rates than elsewhere in England) with regard to the rate of children being killed or seriously injured in road traffic accidents (see section 4.8).

Deaths due to suicide accounted for 18% (16 out of 89) of deaths of 15-19 year olds (see section 4.7)



Spotlight on inequalities

Nationally there is a strong association between increasing deprivation and increasing rates of death from injury in young people aged 15-19 years. Deaths from other causes are also related to inequality. More hazardous environments with high density housing, close proximity to high volumes of traffic, high levels of on-street parking and exposure to more hazardous and illegal driving, as well as educational level, parental mental health and low income all affect adolescents' risk of mortality.

The number of deaths in the 10 to 19 age group is too small to demonstrate an inequality relationship at county level (see section 1.2 Spotlight on inequalities for information on 0-19 mortality in East Sussex).

What does good look like?

East Sussex has a similar mortality rate to England. However, the UK has not reduced adolescent mortality rates as fast as other European countries. In 1970 the UK had one of the lowest adolescent mortality rates in Europe but by 2008 was in the middle of the group of comparable countries.[9]

The UK has low injury mortality among adolescents particularly for road traffic deaths. Rates of death by transport crashes for young people aged 10-19, for the period 2009-12, as compared with other European countries, show the UK has the sixth lowest rate (3.7 per 100,000). Lower rates in Spain, the Netherlands, Sweden, Portugal and Denmark, however, show that a considerable number of deaths can be prevented each year.

UK rates of mortality from long term conditions are in the worst quartile compared with other wealthy countries. Sections 6.1, 6.3 and 6.5 look at three common long term conditions: Asthma, Diabetes and Epilepsy.

How can we improve?

In order to reduce mortality in 10-19 year olds we need to understand the underlying influences and events leading up to the death as well as the immediate cause of death. It is important to identify events which are modifiable or preventable. Some risk factors can be addressed at a local level, but others may require national legislation. Healthcare services, familial, social and environmental factors as well as other services and organizations working with the child should all be considered.

Inequalities: Mortality rates in young people are higher in those from more deprived backgrounds, reflecting higher rates of suicide, injury and mortality from NCD. Reducing mortality rates in this age group requires national government efforts to reduce child and family poverty.[10]

Improving resilience, mental health and wellbeing (See 4.5 and 4.6)**:** young people with poor mental health are at a higher risk of substance misuse, injury and mortality from long-term conditions as well as suicide. Improving wellbeing will help reduce mortality rates.

Suicide (See 4.7): The promotion and fostering of wellbeing and positive mental health in young people can help to reduce suicide. Early access to support for emerging mental health problems is also key.

Road traffic injuries (See 4.8): These are a leading cause of death in this age group, and one of the most amenable to further prevention. East Sussex has high rates of deaths on the road compared to England.

Health: As young people with long term conditions (See 6.1, 6.3, 6.5) approach adulthood they often fall between paediatric and adult health services. It is important to plan transition or develop self-management programmes to enable teenagers to cope with less intensive support as an adult.

What are we doing in East Sussex?

- **East Sussex road safety** programme to reduce killed and seriously injured on roads (Section 4.9).
- **The East Sussex Suicide Prevention Group are working to actively prevent suicide** by better understanding the risk factors and promoting partnership working to address these.
- **The East Sussex ESBT and C4Y Children and Young People's Mental Health and Emotional Wellbeing Transformation Plan is working to improve prevention, identification and early intervention in mental health problems.** Actions include mental health training for health, social care and education professionals and promoting adolescent mental health and wellbeing in local schools (Section 4.6)
- As part of our work to transform how the places where people spend their time (settings) play an active role in improving **health we have rolled out a whole school health improvement programme. Through this 184 schools are participating in developing and delivering plans which include identifying the steps that schools can take in improving mental health** as an essential component.
- **Personal Social Health and Economic (PSHE) education hubs have been set up** for primary and secondary schools where best practice in PSHE education can be shared.
- **There is ongoing local care pathway development through transition for people with a learning disability, and long term conditions**. For example, young people with cystic fibrosis who attend joint local clinics with Kings College Hospital, the Regional Centre of Excellence, until they are 18.

Key actions going forward

- See also Sections 4.6, 4.7, 4.8, 6.7
- **Implementing prevention and early intervention, and improving access to mental health services** is a key priority in the ESBT and C4Y Children and Young People's Mental Health and Emotional Wellbeing Transformation Plan.
- Continue to **protect and support early intervention services and strategies**.
- **Embed activities developed through whole school health improvement programme into routine practice in schools.**
- **Continue to provide advice and support to schools and colleges to take action to improve mental health** through the School Health Service, East Sussex Behaviour and Attendance Support (ESBAS), Educational Psychology, Standards and Learning Effectiveness Service (SLES), and the Inclusion and Special Educational Needs and Disability (ISEND) service.
- **Continue to promote physical, mental and social health** through statutory, comprehensive, evidence-based PSHE in all schools.
- **Improve transition for children and young people with high needs to adult services**
- Provide **high-quality, end-of-life care** and access to appropriate palliative care.

CHAPTER 2
Conception, pregnancy and infancy
2.1 Smoking at time of delivery

Proportion of women smoking at time of delivery

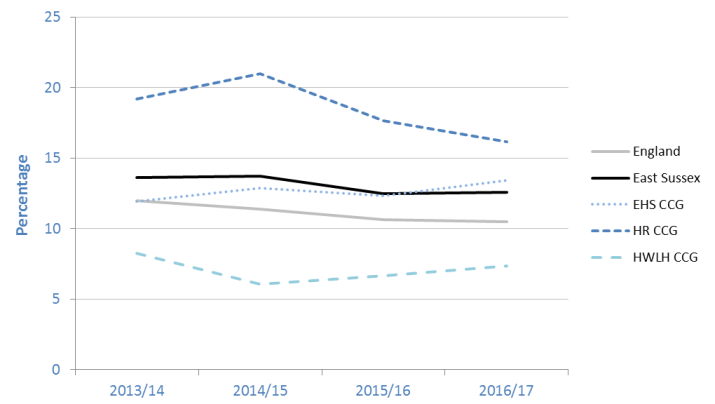
Key messages

- Smoking during pregnancy is an important and modifiable risk factor for poor birth outcomes and the future health of babies and children.
- The proportion of East Sussex women smoking at the time of delivery is 2% higher than the England average which is statistically significant.
- 18% of women from Hastings smoke at the time of delivery compared to 7% in Lewes. This is statistically significantly higher. Smoking during pregnancy is highest in deprived populations and in mothers under 20 years of age.
- Building smoking cessation support and monitoring into maternity pathways is essential to reduce the number of women smoking during pregnancy.
- Preconception and pregnancy are key opportunities to promote smoking cessation and support women to improve their own health as well as that of their baby.
- Parents who smoke are more likely to have children who smoke, not just as adults, but as children and teenagers.

What is this indicator showing us?

The indicator shows the proportion of pregnant mothers who reported smoking at the time when they delivered their baby.

East Sussex smoking at time of delivery, 2010/11 to 2016/17 - commissioner-based



Latest data: The percentage of mothers registered with a GP in East Sussex who were smoking at the time of delivery is 13%.

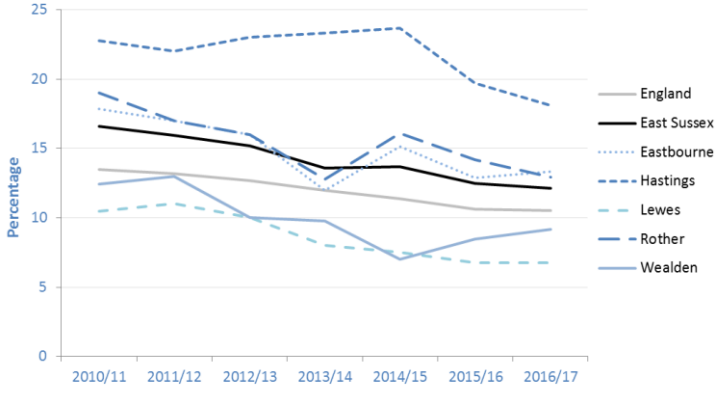
Trend: Both nationally and locally the rates are reducing and have been since 2010/11. However it would appear that since 2014/15 the rates are slightly increasing in both High Weald Lewes Havens CCG and Eastbourne, Hailsham and Seaford CCG.

Source: NHS Digital, Statistics on Women's Smoking Status at Time of Delivery

*Note that the East Sussex figures differ in this chart compared to the following chart due to different data sources and methodology used. The NHS view of the data (this chart) is commissioner-based and includes all women registered with an East Sussex GP practice (and are published figures from NHS Digital) whereas the local authority view of the data (chart below) uses local maternity unit data and are based on women who are residents of East Sussex.

Figure 2.1.1: Percentage of mothers smoking at time of delivery in East Sussex by CCG, 2010/11 to 2016/17

Resident-based



Latest data: The percentage of mothers resident in East Sussex who were smoking at the time of delivery is 12%. In Hastings a statistically significant higher proportion of women smoke compared to East Sussex, which leads to East Sussex having significantly worse rates of smoking in pregnancy compared to England.

Trend: Both nationally and locally the rates are reducing and have been since 2010/11.

Source: Data provided by East Sussex Healthcare NHS Trust, Brighton and Sussex University Hospitals NHS Trust and Maidstone and Tunbridge Wells NHS Trust

Figure 2.1.2: Percentage of mothers smoking at time of delivery in East Sussex by district and borough, 2010/11 to 2016/17

Why is this indicator important?

Smoking in pregnancy is the single most important modifiable risk factor for poor birth outcomes and a major cause of inequality in child and maternal health.

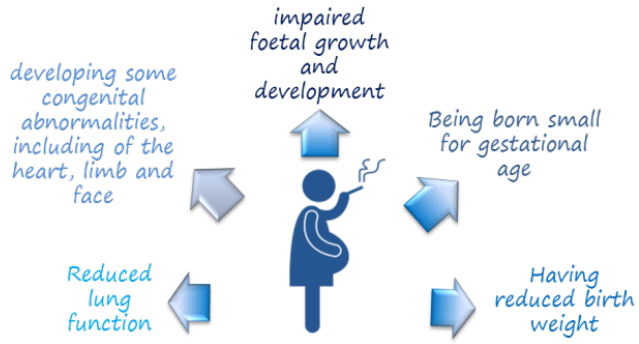
Maternal smoking during pregnancy is linked with an extremely wide range of problems during pregnancy, for the birth and for the child later in life.

Each year in the UK, Smoking during pregnancy has been suggested to cause around:

- **2,200** preterm births,
- **5,000** miscarriages and
- **300** perinatal deaths (babies who are stillborn or those who die before seven days of age)

Maternal smoking during pregnancy also places children at greater risk of mortality – e.g. Sudden Infant Death Syndrome (SIDS) and morbidity throughout their life.

Maternal smoking during pregnancy places unborn babies at an increased risk of:



Exposure to smoke in utero can affect brain development which reduces overall intelligence as well as increasing the risk of conduct disorder, attention deficit hyperactivity disorder (ADHD) and anxiety. Children of mothers who smoke are also at increased risk of asthma and obesity.

It is estimated that 57% of mothers who quit smoking during pregnancy are non- smokers six months after giving birth. This reduces the growing child's exposure to the detrimental effects of second hand smoke.

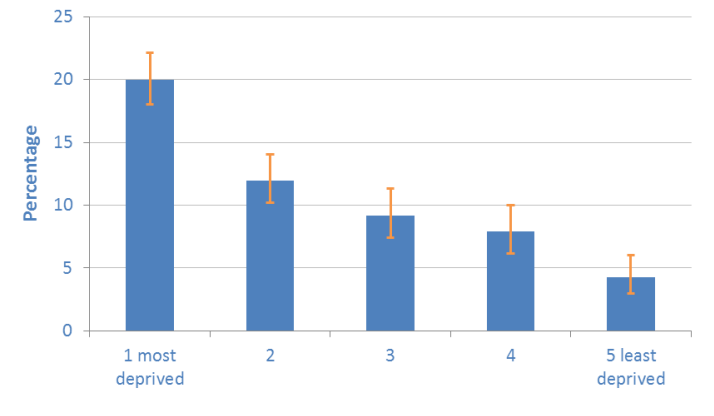
Preconception and pregnancy are key opportunities to promote smoking cessation and support women to improve their own health as well as that of their baby.

Where are we now in East Sussex?

There is no safe level of exposure to tobacco for an unborn baby. Quitting smoking before pregnancy is the ideal way to avoid any antenatal exposure to tobacco and will reduce the risk of adverse outcomes such as infant mortality. However quitting at any time brings benefits for mother and child.

Spotlight on inequalities

Smoking in pregnancy is strongly linked to deprivation, with higher rates of mothers smoking during pregnancy in more deprived areas.



Latest data: Mothers from the most deprived quintile are five times more likely to smoke in pregnancy than mothers from the least deprived quintile.

Source: Data provided by East Sussex Healthcare NHS Trust, Brighton and Sussex University Hospitals NHS Trust and Maidstone and Tunbridge Wells NHS Trust.

Figure 2.1.3: Percentage of mothers smoking at time of delivery in East Sussex by deprivation (IDACI quintiles), 2016/17

What does good look like?

Across England 10.6% of women are recorded as smoking at the time of delivery, with a quarter of areas having fewer than 7.6% women smoking at the time of delivery. The lowest rates of smoking in pregnancy are in Westminster which has an exceptionally low rate of 1.8%. In East Sussex 13% of women smoke at the time of delivery which is significantly higher than the England average.

How can we improve?

The National Institute for Health and Care Excellence (NICE) provide clear guidance on how health professionals can support women to stop smoking in pregnancy and after childbirth. NICE PH26 recommends routine **carbon monoxide (CO) monitoring from early pregnancy** in all maternity services. Routine screening for active smoking and exposure to passive smoke in pregnancy through CO monitoring (a non-invasive breath test) would improve the robustness of data on smoking during pregnancy and at time of delivery. Data is currently based on self-reporting so is likely to be an underestimate.

In addition to monitoring smoking status, all maternity services must ensure that smoking is addressed early in all pregnancies and that **all women have access to equitable and tailored smoking cessation services** which are appropriate to their needs.

What are we doing in East Sussex?

- Our whole systems transformation programmes, East Sussex Better Together (ESBT) and Connecting for You (C4Y), include a focus on addressing smoking in pregnancy. In addition to the continued efforts to reduce smoking across the population, additional targeted interventions include **actions to reduce the harm** caused by smoking in pregnancy and by exposure to second hand smoke.
    - **Local Stop Smoking Services have provided Carbon Monoxide (CO) monitors and training** to ensure midwives are correctly using them at booking and subsequent appointments and as part of routine care in pregnancy.
    - A social marketing organisation has been **working to make local services more accessible in the most deprived areas** by improving referral pathways and **engaging with pregnant women early** in their pregnancy. This has resulted in detailed insight work to better understand the target audience and the ability to **tailor support to their identified needs**, for example through amended treatment protocols.
    - Focussing on cross-agency work to **reduce access to illegal tobacco**.
    - Work has also been completed to better understand how **to reduce exposure and vulnerability to second hand smoke** in the most deprived parts of the county and inform a multi-agency action plan to protect communities and families from exposure to second hand smoke.

Key actions going forward

- **Ensure full implementation of the NICE Guideline PH26, Smoking: Stopping in pregnancy and after childbirth** across maternity services with a particular emphasis on routine CO testing, training of health care staff and the setting of local targets to monitor implementation.
- **Continue to work with midwifery** to incorporate the routine use of CO screening into maternity appointments.
- Ensure the detailed insight from social marketing is used to **ensure that smoking cessation services are accessible to pregnant women who experience health inequalities**.
- **Implement the multi-agency action plan to protect communities and families from exposure to second hand smoke**.

CHAPTER 2
Conception, pregnancy and infancy
2.2 Breastfeeding

Proportion of mothers recorded as breastfeeding at six to eight weeks post birth

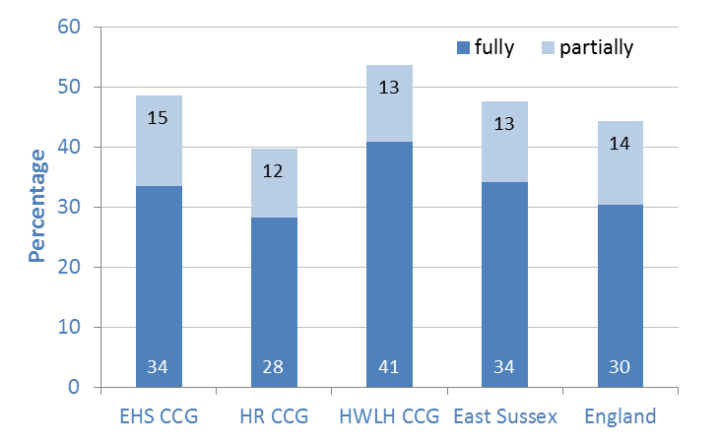
Key messages

- Breastfeeding has physical and mental health benefits for mother and baby which last beyond the period of breast-feeding.
- Breastfeeding rates in East Sussex are currently significantly higher than the England average. Latest data shows an improvement on a previously deteriorating trend. Some of this is down to improved data recording.
- Breastfeeding rates in England have not increased significantly since recording started and are lower than in many other European countries.
- Nationally new strategies for infant nutrition are needed to cover improvements in data collection, and approaches to support women to start and maintain breastfeeding of their new-born.

What is this indicator showing us?

This indicator shows the proportion of women recorded as breastfeeding at their six to eight week health visitor review following the birth of their baby. Breastfeeding is recorded as either fully (the infant is only receiving breastmilk) or partially (the infant is receiving a combination of breastmilk and infant formula).

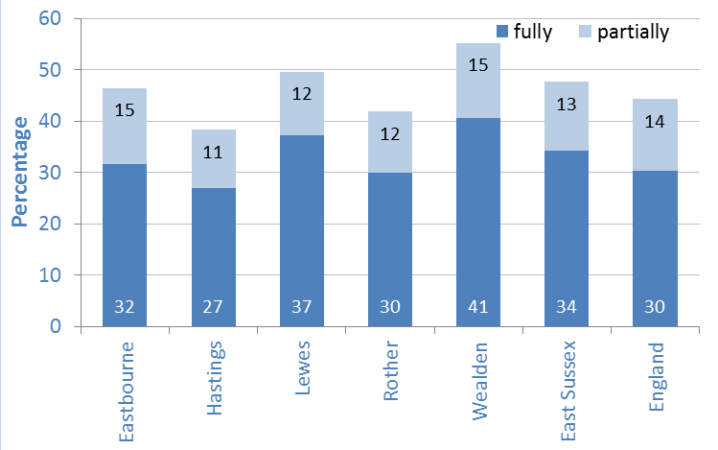
Breastfeeding in East Sussex



Latest data: 47% of women in East Sussex are recorded as fully or partially breastfeeding at the 6 to 8 week review. This is significantly better than for England (44%). Eastbourne, Hailsham and Seaford (49%) and High Weald Lewes Havens (54%) are both significantly better than England, whilst Hastings and Rother CCG (40%) is significantly worse.

Source: East Sussex Child Health Information System

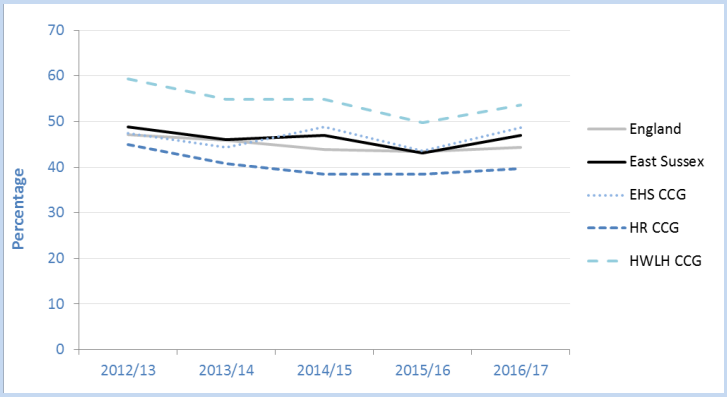
Figure 2.2.1: Percentage of infants at 6 to 8 week review who were recorded as being fully or partially breastfed in East Sussex by CCG, 2016/17



Latest data: At district and borough level Hastings (38%) is significantly worse that England, whilst Lewes (50%) and Wealden (55%) are significantly better.

Source: East Sussex Child Health Information System.

Figure 2.2.2: Percentage of infants at 6 to 8 week review who were recorded as being fully or partially breastfed in East Sussex by district and borough, 2016/17



Latest data: 47% of mothers in East Sussex were recorded as fully or partially breastfeeding at their 6 to 8 week health visitor review in 2016/17 in East Sussex.

Trend: Although East Sussex breastfeeding rates increased in 2016/17 there has been a slight overall downward trend since 2012/13.

Source: East Sussex Child Health Information System and PHE Breastfeeding Statistics.

Figure 2.2.3: Percentage of infants at 6 to 8 week review who were recorded as being fully or partially breastfed in East Sussex by CCG, 2010/11 to 2016/17

Why is this indicator important?

The benefits of breastfeeding extend beyond infancy throughout life. Fully breastfeeding is recommended for the first six months of a baby's life, in line with advice from the World Health Organisation. Breastfeeding provides protection to babies for a range of infections including gastrointestinal, respiratory and ear infections and may lead to a lower risk of being overweight in later life and developing Type 2 diabetes. There are also benefits for the mother, including protection against breast cancer and possibly ovarian cancer and Type 2 diabetes. For both baby and mother breastfeeding leads to improved bonding.

For premature babies, breastmilk is particularly important, reducing the risk of infections and potentially life-threatening conditions[11].

Some women are unable to breastfeed, and there are a small number of babies who cannot be breastfed for medical reasons, however the majority of women should be able to breastfeed with the right knowledge, encouragement and support.

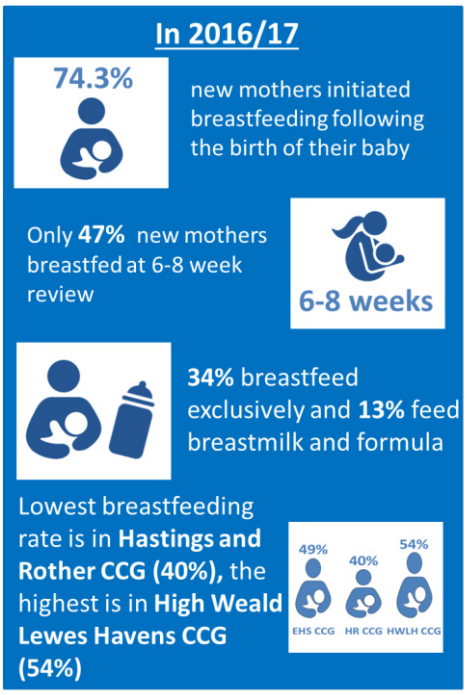
Nationally, breastfeeding rates increase with maternal age, with around a quarter (24%) of women under 20 years breastfeeding at six weeks compared with around two-thirds (67%) of women aged 35 and over .

Where are we now in East Sussex?

47% of new mothers were breastfeeding by the six to eight week review in East Sussex in 2016/17. This is substantially lower than the 74% of new mothers who were recorded as initiating breastfeeding during the same period following the birth of their baby.

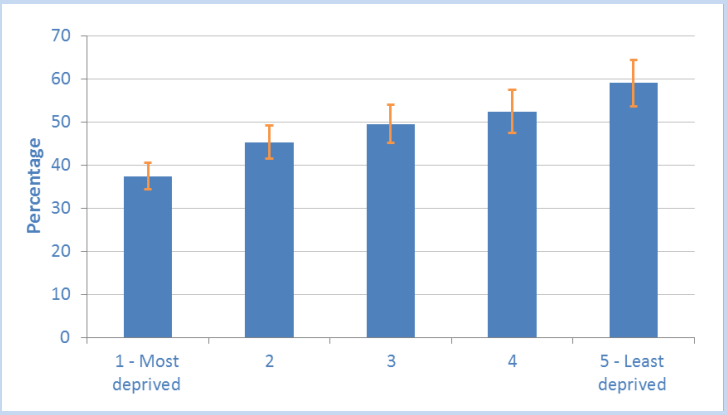
The variation in breastfeeding rate between Clinical Commissioning Groups (CCGs) is also reflected in the districts and boroughs level data. Eastbourne has the highest rates of partial feeding (15%) which is also reflected in the CCG figures (Eastbourne, Hailsham and Seaford CCG 15%).

In East Sussex there has been slight decrease in breastfeeding rates since 2012/13.



Spotlight on inequalities

There is a strong impact of deprivation on breastfeeding (fully or partially) at six weeks across the UK. The same pattern is seen in East Sussex.



Latest data: 37% of mothers in the most deprived areas in East Sussex breastfeed compared to 59% in the least deprived areas.

Source: Data from the East Sussex Child Health Information System.

Figure 2.2.4: Percentage of infants at 6 to 8 week review who were recorded as being fully or partially breastfed in East Sussex by deprivation (IDACI quintiles), 2016/17

What does good look like?

Across England, of areas who have been able to submit validated data on breastfeeding rates at 6-8 weeks, Lewisham is the highest at 76.8%. This is unusually high compared to the England average of 44%. East Sussex breastfeeding rates at 6-8 weeks are above the England average, and we would only need to increase breastfeeding rates from the current 47% to 48.6% to be in the top quartile of areas in England. Our neighbouring area Brighton and Hove has the second highest breastfeeding rate in England at 71.5%.

There are limited data available to compare trends in breastfeeding internationally and no local data on breastfeeding at six months. An international study found that in the UK only 34% of babies are still receiving some breastmilk at six months, compared to 71% in Norway.[12]

How can we improve?

Reasons for low breastfeeding rates are complex. They include k**nowledge about the benefits of breastfeeding** and **attitudes towards breastfeeding**. Rates are particularly low in young mothers and those from deprived groups. Some women also have **difficulty in establishing breastfeeding** after birth and have concerns about whether the baby is growing adequately and receiving enough milk. The attitudes of family, peers and the public all have an impact on rates of breastfeeding.

To improve rates, local services must ensure that all women are encouraged to start breastfeeding and are **supported to fully breastfeed**, including **access to timely support** if they are experiencing difficulties.

Education should begin in the antenatal period and continue through birth and beyond. Maternity services need to be equipped to **support women to make informed choices** about breastfeeding. This can be achieved through the UNICEF Baby Friendly Initiative (BFI) accreditation which provides an evidence-based framework for best practice[13].

Universal midwifery and health visiting services must continue to be commissioned and improved to help support breastfeeding initiation soon after birth and its subsequent continuation[14].

The evidence shows that the vast majority of women who breastfed during the initial 2 weeks said they would have **liked to have breastfed** for longer. There is an association with postnatal depression for women who while pregnant wanted to breastfeed, but did not initiate after giving birth.

Primary care and paediatric services also have a role and there should be **improved education of paediatric and primary care teams to support breastfeeding**.

What are we doing in East Sussex?

- **East Sussex maternity services** are **currently working towards UNICEF BFI accreditation**.
- The **0-5 year old integrated service** of health visiting, community nursery nurses and family key workers **achieved UNICEF level 2 Baby Friendly Initiative** accreditation in March 2017 and is working towards level 3 accreditation by March 2018.
- **To reduce inequalities in breastfeeding rates** between areas in East Sussex, Hastings and Rother CCG funds **additional breastfeeding support workers in the east of the county**. There is **a dedicated breastfeeding lead within the health visiting team** and a programme of **peer supporters across East Sussex** to help support breastfeeding continuation for all mums who wish to breastfeed.
- **Baby Buddy** is an award winning free mobile phone app to support women through pregnancy and the first six months of baby's life, including **modules specifically designed to support breastfeeding**. Baby Buddy is being **embedded in maternity and early years pathways in East Sussex**.
- East Sussex Healthcare NHS Trust, like many across England, has previously struggled to record the breastfeeding status of 95% of the eligible cohort, meaning that reported data was not considered by Public Health England (PHE) as valid. **Data recording has recently improved in order to meet BFI accreditation standards**.

Key actions going forward

- **An East Sussex wide strategy for infant feeding will be developed**, bringing together the approaches from midwifery, primary care and health visiting.
- **Maternity services should achieve and maintain UNICEF BFI accreditation** (All services should provide antenatal education and health promotion regarding breastfeeding to both parents). The integrated 0-5 Service are aiming for level 3 accreditation by April 2018.
- **Robust and comparable data collection will continue to be improved**: measuring breastfeeding initiation and recording breastfeeding at six to eight weeks.
- **Ensure delivery of universal midwifery and health visiting services to all mothers**.
- **Promote the Royal College of Paediatrics and Child Health (RCPCH) recommendation that healthy infant nutrition is taught as part of Personal, social, health and economic (PSHE) education** in secondary schools.

CHAPTER 2
Conception, pregnancy and infancy
2.3 Immunisation

Proportion of children who received the full course (three doses) of the 5-in-1 vaccination by 12 months and children who received two doses of Measles, Mumps and Rubella (MMR) vaccination by 5 years of age.

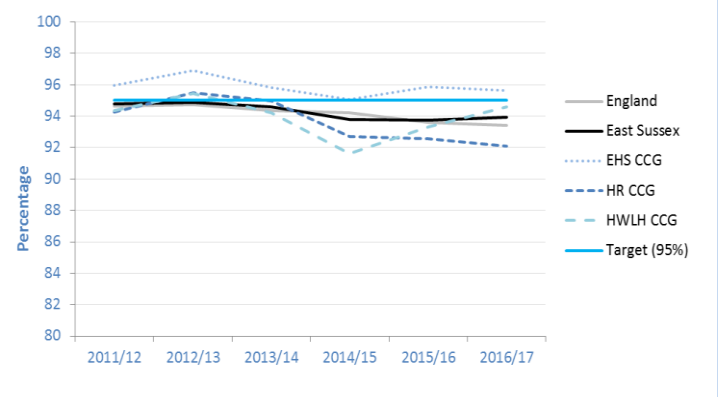
Key messages

- Vaccinations in early childhood are key in protecting children against serious and potentially fatal diseases.
- By 12 months of age, babies should have received several vaccinations, including three doses of the 5-in-1 vaccination.
- Uptake of the 5-in-1 vaccine by 12 months in East Sussex (94.0%) is similar to the England rate (93.4%) and falls below the national target of 95%.
- In the last four years the uptake of the 5-in-1 vaccine in East Sussex has reduced slightly from 94.8% in 2011/12 to 94.0% in 2016/17.
- By the age of five years, children should have had two doses of MMR to ensure full immunity.
- Uptake of both doses of the MMR vaccine in East Sussex has declined since 2013/14 and at 88.7% is below the national target of 95%.
- The East Sussex health system is working with Public Health England and NHS England to address barriers and improve uptake of both vaccines.

What are these indicators showing us?

These indicators show us the proportion of babies who, by 12 months of age, have received all three doses of the 5-in-1 vaccination to protect them against five communicable diseases: diphtheria, tetanus, whooping cough (pertussis), polio and Haemophilus influenza type b (Hib); and children who have received two doses of MMR by 5 years of age. There are multiple potential vaccination indicators; and these are the best proxies for system coverage.

Immunisation: 5-in-1 vaccination and Measles Mumps and Rubella (MMR) vaccination

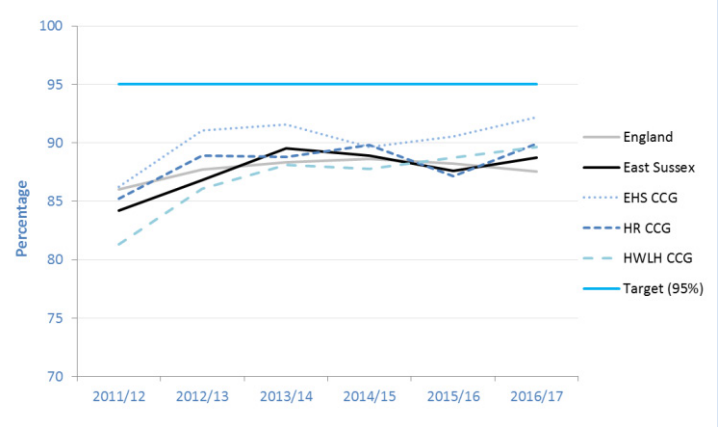


Latest data: In 2016/7 England's 5-in-1 immunisation rate was 93.4%, and East Sussex was 94.0%.

Trend: Since 2011/12, the uptake rate of the 5-in-1 vaccine in East Sussex has reduced slightly from 94.8% to 94.0% in 2016/17.

Source: NHS England, Child Immunisation Statistics

Figure 2.3.1: Percentage of children who have received the 5-in-1 vaccination by 12 months of age in East Sussex by CCG, 2011/12 to 2016/17



Latest data: The uptake rate for both doses of the MMR vaccine across East Sussex by age 5 years is 88.7%.

Trend: There has been a slight decrease in uptake of both doses of MMR in East Sussex from 88.9 % in 2013/4 to 88.7% in 2016/17.

Source: NHS England, Child Immunisation Statistics

Figure 2.3.2: Percentage of children who have received two doses of MMR by 5 years of age in East Sussex by CCG, 2011/12 to 2016/17

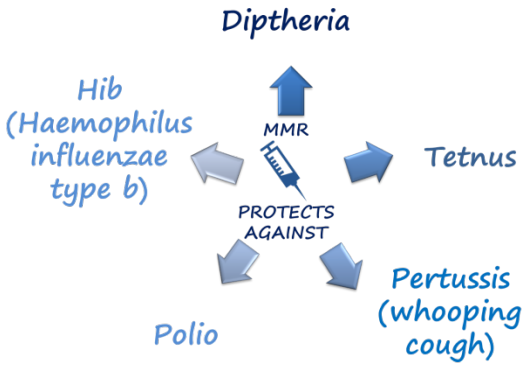
Why are these indicators important?

Immunisation is key for preventing illness and death linked to many communicable diseases.

Vaccination prevents an estimated 2.5 million deaths globally each year[15].

Achieving high rates of vaccination means that more of the population who cannot be vaccinated (either because they are too young or have particlar medical conditions) are protected (through herd immunity), and can also lead to the elimination of some diseases. Even when a disease is no longer common, without sustained high rates of vaccination it is possible for these diseases to return[16], as we have seen with measles outbreaks.

The 5-in-1 vaccine is a single injection administered on three separate occasions at 8, 12 and 16 weeks of age providing protection against five diseases[17]:

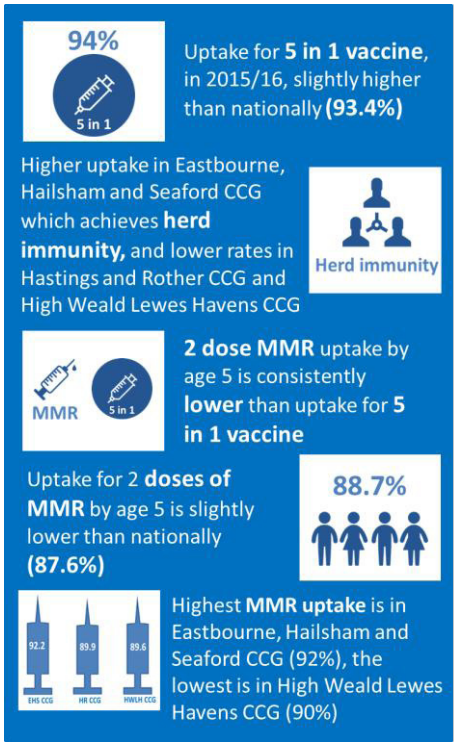


Apart from tetanus (which is not passed from person-to-person), these diseases are contagious and can cause severe illness and even death.

From August 2017 the 5-in-1 vaccine changed to the 6-in-1 vaccine, with the addition of hepatitis B, however for the purposes of this report the data relates to the 5-in-1 vaccine.

The first dose of the MMR vaccine is offered to children at one year of age with a second dose at three years four months.

Where are we now in East Sussex?

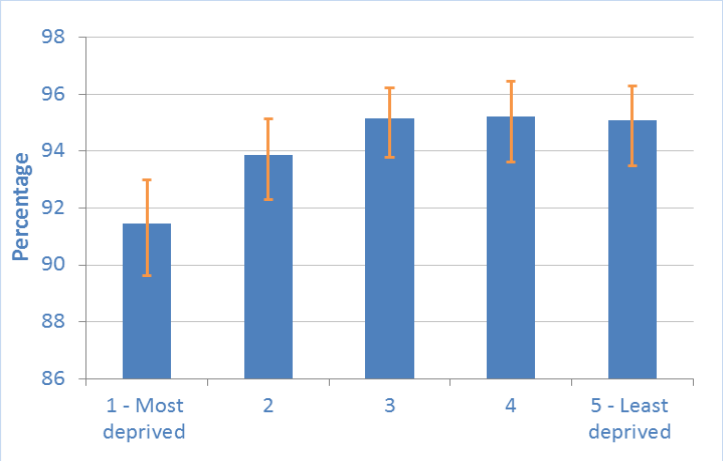


In East Sussex we are currently below the WHO recommended level of at least 95% uptake for the 5-in-1 and MMR vaccines. We should aim to increase vaccination coverage throughout the population, with a particular

focus on areas where rates are below the WHO threshold. Although there is variation between areas within East Sussex, Eastbourne, Hailsham and Seaford and High Weald Lewes Havens achieved target coverage of the 5 in 1 vaccine. No areas achieved sufficient coverage of MMR.

Spotlight on inequalities

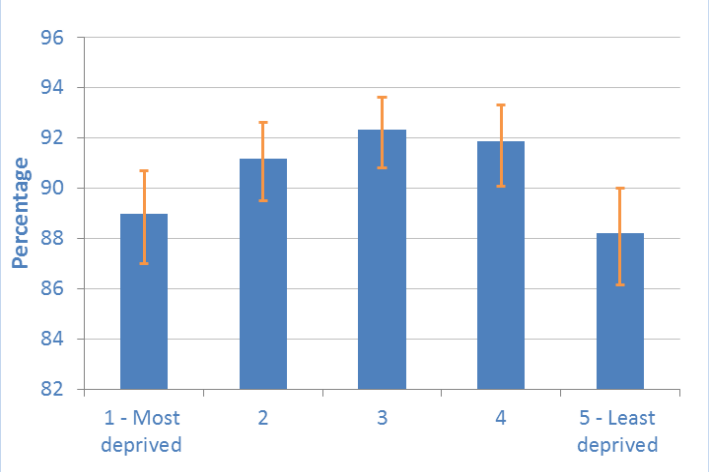
There is mixed evidence about the effect of deprivation on uptake of childhood vaccinations: Some studies have found that mothers of unimmunised infants are older and more highly qualified than those of partially immunised infants[18] . Issues linked to low uptake in more affluent areas include concerns about the safety of some vaccinations, including MMR. Other studies have shown lower uptake of vaccinations in more deprived groups and these are linked to having chaotic lifestyles, having larger families, language issues and access to vaccination clinics.



Latest data: The most deprived 20% of GP practices have a statistically significant lower coverage of the 5 in 1 vaccine compared to quintiles 3, 4 and 5, which represent the 60% of most affluent practices.

Source: NHS England, Child Immunisation Statistics

Figure 2.3.3: Percentage of children who have received the 5-in-1 vaccination by 12 months of age in East Sussex by deprivation (GP practices grouped by IDACI quintiles), 2016/17



Latest data: For coverage of two doses of MMR by 5 years of age, there is a mixed picture in East Sussex. Both the most deprived quintile and the least deprived quintile have lower rates of vaccine coverage compared to quintiles 2, 3 and 4. The data in both of these charts is supported by the evidence.

Source: NHS England, Child Immunisation Statistics

Figure 2.3.4: Percentage of children who have received two doses of MMR by 5 years of age in East Sussex by deprivation (GP practices grouped by IDACI quintiles), 2016/17

What does good look like?

For both MMR and the 5 in 1 vaccine East Sussex has very similar coverage levels to the England average at around 88% and around 94% respectively. The best in England for the 5 in 1 vaccine is a rate of 98.9% and for MMR it is 98.6%, both in North Tyneside. The top quartile is above 96.2%.

How can we improve?

An effective vaccination programme is one that achieves a high vaccination uptake in a timely way. If a sufficient proportion of the population are vaccinated against an infectious disease it will not be able to spread in the population. This will also provide protection to unimmunised infants and children as they will be very unlikely to come into contact with the disease.

We need to continue to **promote the importance of vaccination at every opportunity** including at antenatal appointments, and through primary care, midwifery, health visiting and school health services and in early years settings.

We need to **ensure that our data systems are robust and complement each other**: child health records should match GP practice data.

Children should be **invited to have their vaccine in a timely way**. GP practices should be reminded about children who appear to have missed vaccines.

School Health vaccination services could **screen children on school entry for their vaccination status** and provide advice and support to schools to encourage parents and children to be fully vaccinated.

There is currently limited evidence on ways to **successfully address vaccine refusal**[19]. We need to work with NHS England to consider strategies to increase uptake in families where a conscious decision has been made to not immunise their child in the absence of a medical indication and for those parents who are undecided about whether to have their child vaccinated or not.

What are we doing in East Sussex?

- **Maintaining high awareness of the importance of immunisation** across East Sussex
- Working across East Sussex Public Health, NHS England and the CCGs to:
  - Examine practice level rates and **recommend changes to improve uptake**.
  - **Ensure that there are no 'queues'** whereby children who are due their vaccination are not invited in a timely way.
  - **Ensure that data across GP practices** and the **Child Health Information System match** as closely as possible.
  - **Consider the use of outreach clinics in children's centre areas with low uptake** and also the **use of an expert phone line for parents** who are undecided and/ or sceptical about the safety of certain vaccines.

Key actions going forward

- **Continue to meet with NHS England and CCG Quality leads** to further review uptake data by CCG and by GP practice and identify those with the lowest rates.
- **Agree a shared plan to further improve rates**.
- **Ensure that robust processes are in place** to minimise the likelihood of 'queues' and to **ensure that data systems are as timely and accurate** as possible.
- Continue to work with NHS England to **ensure regular input to CCG Practice Nurse learning** events to ensure up-to-date information on vaccination coverage is available and disseminated to all those responsible for the immunisation of children and young people.
- **Promote the role of health visitors and school nurses in checking vaccine uptake** when they come into contact with children.

CHAPTER 3
Early Years
3.1 Healthy weight when starting school

Proportion of children at a healthy weight during their reception year of primary school

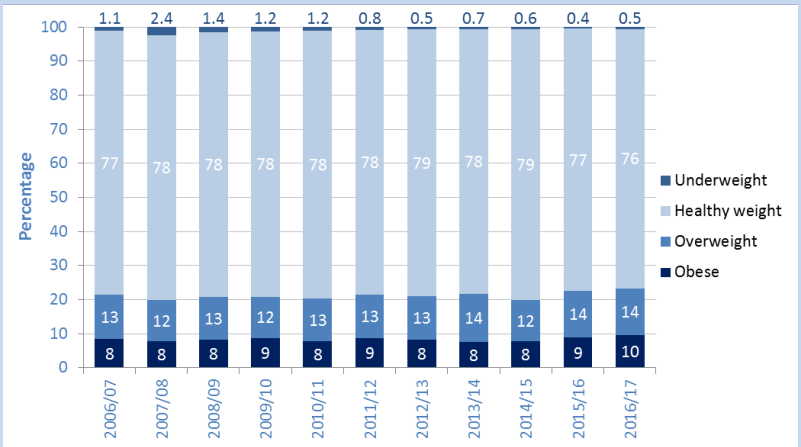
Key messages

- Weight when a child starts primary school is an important predictor of health outcomes later in life.
- Nearly one in four children in East Sussex are classified as overweight or obese during their reception year of primary school, similar to the England average.
- There has been minimal overall improvement in the proportion of East Sussex children classified as having a healthy weight during their reception year of primary school over the past decade.
- The overweight and obesity prevalence for children living in the most deprived areas in East Sussex is significantly greater than it is for those living in the least deprived areas.
- A range of interventions is required to promote healthy weight in children, including both access to healthy food and opportunities for physical activity; and to target critical periods in the life course.
- A programme to transform how nurseries and schools in East Sussex embed evidence -based health improvement activity into their work is being delivered.

What is this indicator showing us?

This indicator shows us the proportion of children who are a healthy weight (and underweight, overweight and obese) during their reception year of primary school, based upon the Body Mass Index (BMI) as a measure of weight for height relative to sex and age.

Reception Year children underweight, healthy weight, overweight or obese

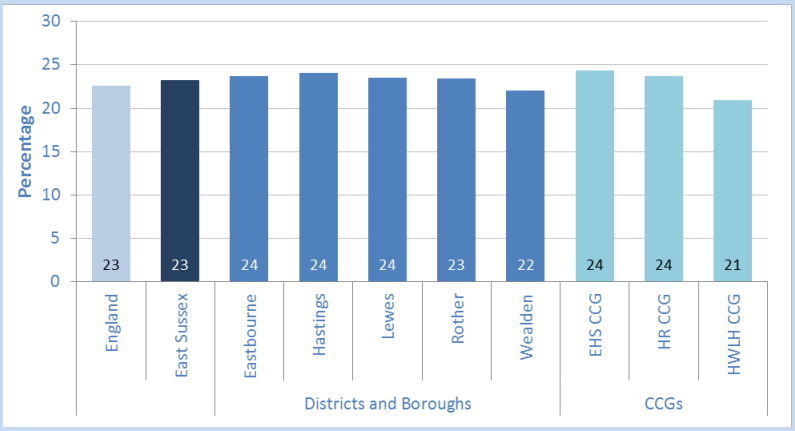


Latest data: The latest data shows that nearly one in 4 (24%) of reception year children (aged 4-5) are overweight or obese.

Trend: Over the last 11 years the rate has stayed more or less consistent with a slight increase from 21% of reception aged children classified as overweight or obese in 2006/07 to 24% in 2016/17.

Source: NHS Digital, National Child Measurement Programme Statistics

Figure 3.1.1: Percentage of reception year pupils (4-5 year olds) underweight, healthy weight, overweight or obese in East Sussex, 2006/07 to 2016/17



Latest data: Although there is variation between districts and boroughs and between Clinical Commissioning Group (CCG) areas in the proportion of reception year children overweight or obese, there are no statistically significant differences with the England average (23%).

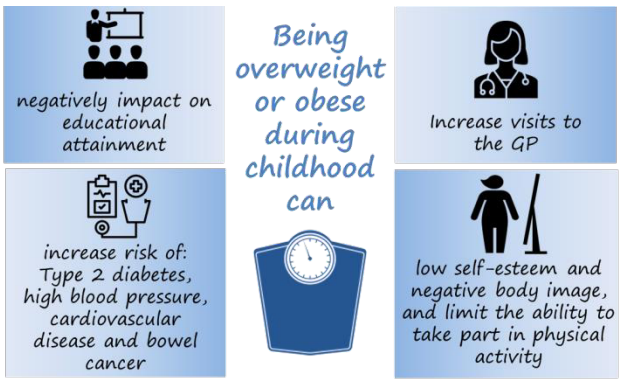
Source: East Sussex National Child Measurement Programme data and NHS Digital statistics

Figure 3.1.2: Percentage of reception year pupils (4-5 year olds) overweight (including obese) in East Sussex by district/borough and CCG, 2016/17

Why is this indicator important?

Childhood obesity is one of the greatest health threats to children and their future health as adults.

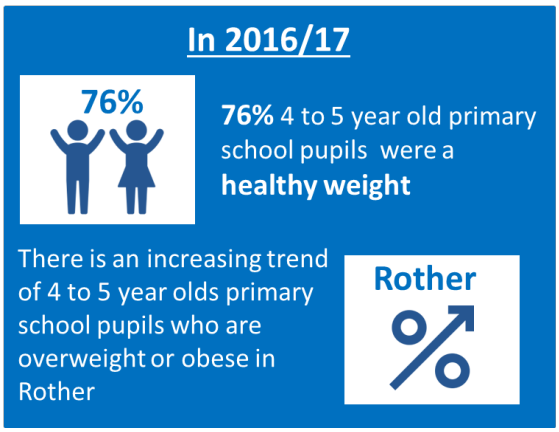
Not only does being overweight have a major impact on health and wellbeing in childhood, it is also an important predictor of being overweight and obese in later life and the associated risk to both physical and emotional health and wellbeing:



Assessing children's weight in schools is an important part of a co-ordinated approach in preventing childhood obesity. By identifying children in a systematic, timely way, we can offer guidance and support to encourage all children to maintain a healthy weight.

Where are we now in East Sussex?

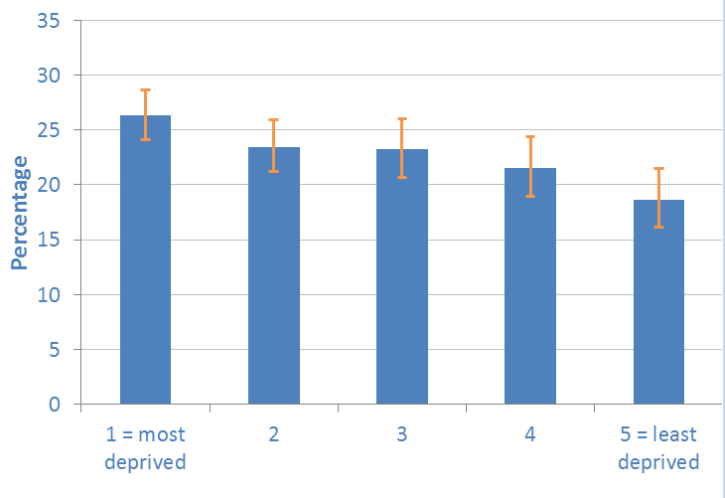
Nationally there is a target is to reduce the prevalence of obesity in reception aged children to 5%. Currently in East Sussex the prevalence of obesity in reception aged children is 10%, with 24% either overweight or obese.



There has been little change in the overall proportion of East Sussex children classified as either a healthy weight or carrying excess weight (overweight or obese) during their reception year of primary school since the National Child Measurement Programme (NCMP) was established in 2005. Since 2006/07, there has been no significant change in the proportion overweight and obese in Eastbourne and Wealden; an increasing trend in Rother and a decreasing trend in Lewes.

Spotlight on inequalities

Both national and local data show that there is a strong relationship between deprivation and overweight/obesity prevalence. Low income families may find it harder to afford a balanced diet with cheaper convenience food often being calorie dense and nutrient light. Limited time and cooking facilities are another challenge.



Latest data: Overweight and obesity prevalence for children living in the most deprived areas in East Sussex is significantly greater than it is for those living in the least deprived areas. For example, in 2016/17, 26% of Reception Year children living in the most deprived areas of East Sussex were classified as overweight or obese, compared with 19% of Reception Year children living in the least deprived areas of the county.

Source: East Sussex National Child Measurement Programme data.

Figure 3.1.3: Percentage of reception year children overweight (including obese) in East Sussex by deprivation (IDACI quintiles), 2016/17

What does good look like?

In England in 2016/17 the area with the lowest prevalence of obesity in reception aged children (4-5 years) was Kingston upon Thames with only 15% of children classified as overweight or obese. In East Sussex almost one in four children (23%) were classified as overweight or obese which is similar to the England average. The best 25% of local authorities in England had obesity rates of 8.4% or below.

Overall despite the proportion of children in East Sussex who are a healthy weight being similar to the England average, it is important to highlight that currently almost one in four children in East Sussex are carrying excess weight (overweight or obese) during their reception year of primary school, and to note that England has a comparatively high rate of obesity in reception aged children compared to our European counterparts.

How can we improve?

"Childhood obesity: a plan for action" is one of the few cross-government strategies to specifically and strategically address childhood obesity. Relevant priorities set out in the plan include:

- Helping all children to enjoy an hour of physical activity every day.
- Creating a new healthy rating scheme for primary schools.
- Making school food healthier.
- Supporting early years settings.
- Enabling health professionals to support families.

What are we doing in East Sussex?

The East Sussex Healthy Weight Partnership is a subgroup of the East Sussex Better Together (ESBT) and the Connecting 4 You (C4Y) Personal and Community Resilience steering group and brings partners from different sectors together to co-ordinate action to support healthy weight approaches across the county. The East Sussex Healthy Weight Plan 2016 – 2019 outlines an agreed vision for East Sussex, and sets out a programme of action which seeks to reduce the burden of excess weight and improve health outcomes across the county.

There are four thematic areas:

- **Environment** - creating a physical and social environment that promotes healthier lifestyle choices.
- **Workforce development** - developing the capacity and capability within the local workforce so that they are able to support others in achieving and maintaining a healthy weight.
- **Services and support** - ensuring the provision of quality services which support individuals to achieve and maintain a healthy weight and reduce their risk of developing a condition associated with excess weight.
- **Communications and engagement** - to enable people to understand the importance of a healthy weight and take action to address it.

Example activities that support achievement of healthy weight during the early years include:

- **Healthy Active Little Ones (HALO), East Sussex –** A workforce development and intervention programme to support nurseries to adopt a whole settings approach to obesity prevention and to enhance their approaches towards, and provision of, healthy food and physical activity.
- **Nursery Grants Programme** – A transformation programme building upon the approach and positive outcomes of the HALO – East Sussex programme, enabling every private and maintained nursery within eligible CCG areas to apply for a Grant of £5,000 to be used to fund evidence-based activities that seek to prevent/tackle childhood obesity.
- **Health Exercise Nutrition for the Really Young (HENRY)** -An innovative intervention to promote a healthy start in life and prevent child obesity, in which focuses on parenting, family lifestyle habits, nutrition, activity, and emotional wellbeing. The approach brings together workforce development, a preventive 8-week group parent programme, and targeted 1-to-1 support for families of children at risk of obesity or already overweight.
- **East Sussex School Health Improvement Grants** - A transformation programme enabling all state funded schools in East Sussex to access funds to develop a school health improvement plan, and using a primary prevention and whole school approach, put in place actions to address health and wellbeing priorities (including obesity) identified in the plan.
- **Beat the Street –** A community wide mass participation physical activity intervention designed to inspire communities to make small changes, such as walking or cycling to school or work every day, to improve their health, and to create lasting health benefits through creating a social norm around being active.
- **Amplification of national campaigns to promote healthy weight** (e.g. Start4Life, Change4Life, Our Healthy Year).

What are we doing in East Sussex?

- **East Sussex Health Promotion Resources Service** offers a **wide range of free resources** (leaflets, posters, teaching aids) **including those linked to tackling obesity** through heathy eating and physical activity. Resources are for use by any individuals in East Sussex who have a role in promoting health.
- **Maximising parental engagement as part of the NCMP**. The East Sussex School Health Service are currently piloting the impact of undertaking telephone calls with parents of overweight or obese children (both prior to and after receiving their child's NCMP results letter) in order to maximise behaviour change.

Key actions going forward

- **Implement the three year programme of action** from the East Sussex Healthy Weight Plan 2016-2019.
- **Ensure health visiting and school health services are maximising opportunities to support healthy weight** through diet and exercise advice to children and families.
- **Ensure that all opportunities to shape the environment to enable healthy weight are utilised** e.g. through developing healthy settings approaches in early years settings and schools and utilising planning and active travel approaches.
- **Increase availability and uptake of high quality, effective services which support increased healthy weight and reduced risk of conditions caused by excess weight:** ensuring services are targeted towards children and their families at all levels of need, especially in areas where the need is greatest.
- **Apply the Making Every Contact Count (MECC*) approach** across all organisations in East Sussex to ensure that staff and volunteers have the skills, competences and confidence to raise lifestyle issues with clients, provide brief advice and refer into services.

*MECC is

"an approach to healthcare that encourages all those who have contact with the public to talk about their health and wellbeing. It encourages health and social care staff to use the opportunities arising during their routine interactions with patients to have brief conversations on how they might make positive improvements to their health or wellbeing."

Health Education England

CHAPTER 3
Early Years
3.2 Healthy teeth and gums

Proportion of children with no obvious tooth decay at age five and average number of teeth affected by decay at age five.

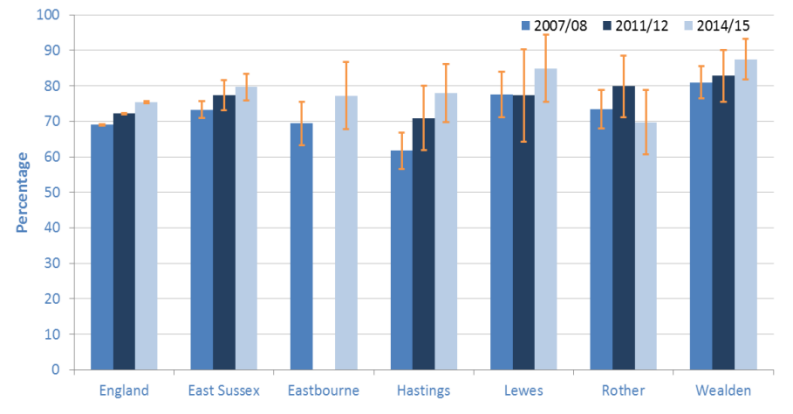
Key messages

- Good oral health is an important component of overall health and wellbeing for children. The measure can be an early indicator of the success of early years interventions e.g. weaning, diet, parenting skills.
- 80% of children in East Sussex are decay free. This is better than the England average of 75% decay free.
- Nationally, decay rates are higher for those in deprived populations; locally the differences are not statistically significant.
- For the just over 1 in 5 children in East Sussex with decay experience, on average 2.5 teeth have been affected by decay, which is fewer than the England average of 3.4 decayed teeth.
- Supervised teeth brushing at least twice a day, reduced sugar consumption and regular access to a dentist are crucial in preventing tooth decay.

What is this indicator showing us?

This indicator shows the proportion of 5-year olds with no decayed, missing or filled teeth ($d_3$mft).

5 years olds with no decayed, missing or filled teeth 2007/8, 2011/12 and 2014/15. England, East Sussex and districts and boroughs

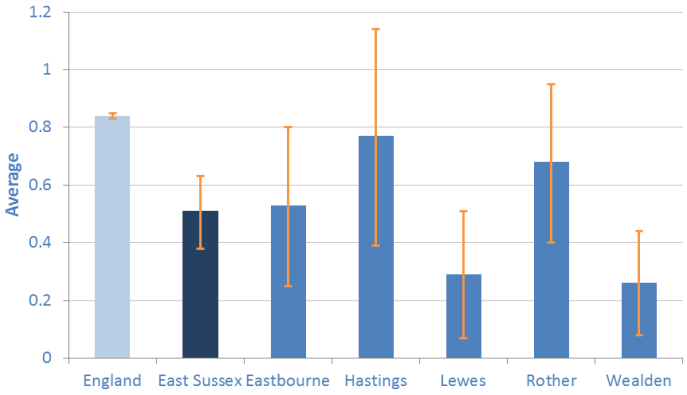


Latest data: 80% of 5 year olds in East Sussex had no decay versus 75 % in England. Rother had lowest rates of children who are decay free, significantly fewer than Wealden.

Trend: Oral health of 5 year olds has improved over the last 7 years, apart from in Rother where it has not changed significantly.

Source: PHE, Oral Health Surveys of five-year old children, 2007/08; 2011/12 and 2014/15

Figure 3.2.1: Percentage of 5 year olds with no decayed, missing or filled teeth in East Sussex by district and borough, 2007/08 to 2014/15



Latest data: The average number of $d_3$mft in East Sussex five year olds is 0.5. This is significantly lower than England average of 0.84 affected teeth. Average d3mft depends on the proportion of children affected by decay and the number of decayed teeth in those affected. Eastbourne, Wealden and Lewes have lower rates of d3mft than England.

Source: PHE, Oral Health Survey of five-year old children

Figure 3.2.2: Mean number of decayed, missing or filled teeth in five year olds in East Sussex by district and borough, 2014/15

Why is this indicator important?

Tooth decay is almost entirely preventable through good oral hygiene, fluoride toothpaste, reducing the amount and frequency of exposure to sugar and regular visits to the dentist.

Poor oral health can cause pain, infection and sepsis and may lead to problems with speech and swallowing. This can result in children missing days from school and parents losing work days. Oral health in five year olds can be considered a proxy indicator for a composite of good practice across various areas including weaning, diet and parenting skills .e.g. the ability to sustain a healthy daily routine.

Poor oral health may be an indicator of dental neglect. This is defined as 'persistent failure to meet a child's basic oral health needs, likely, to result in serious impairment of a child's oral or general health or development.' Where neglect is suspected this may raise other safeguarding concerns.

The cost of poor oral health to the National Health Service (NHS) and wider economy is significant. The NHS in England spends £3.4 billion per year on dental care.[20]

Where are we now in East Sussex?

We are aiming for a steady increase in the number of children with no tooth decay at age five across East Sussex, with an ultimate aim of eradicating tooth decay in almost all children. Early years work is important in providing the foundation for good oral health in adults.

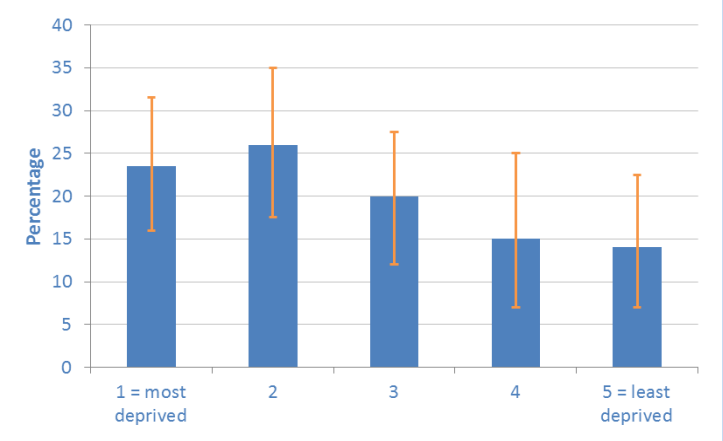
80% of children in East Sussex are decay free. Rother had the lowest proportion of decay free children in East Sussex while Lewes and Wealden had the highest proportions of decay free children.

Despite performing significantly better than the national average:

The average number of $d_3$mft in all five year olds in East Sussex is 0.5 teeth. Within East Sussex, five year olds in Eastbourne, Lewes and Wealden have the lowest mean numbers of $d_3$mft.

Spotlight on inequalities

National data shows a relationship between deprivation and decay, with children from more deprived areas having poorer oral health. Families who find it hard to manage daily routines e.g. tooth brushing and to set boundaries e.g. only consuming sugar at mealtimes are likely to have higher rates of decay. While there are not statistically significant differences, East Sussex data shows more children with decay in more deprived areas compared to less deprived areas.



Latest data: Based on PHE analysis of the 2015/16 oral health survey of 5 year olds in East Sussex, dental caries has some relationship with deprivation; however none of the differences between quintiles are statistically significant.

Source: PHE, Oral Health Survey of five-year old children

Figure 3.2.3: Percentage children aged 5 with decayed, missing or filled teeth in East Sussex by deprivation (Index of Multiple Deprivation (IMD) quintiles), 2015/16

What does good look like?

Across England the area with the highest proportion of five year olds with no dental decay is in South Gloucestershire (86%). East Sussex is amongst the best 25% of local authorities in the country with 80% of five year old children decay free compared to the England average of 75%.

Data from the 2015 dental epidemiology survey for five year olds shows that, similarly to survey findings in 2012, five year olds with decay experience in East Sussex have fewer affected teeth compared to England and the South East.

How can we improve?

Public Health England (PHE) guidance to local authorities for commissioning better oral health for children and young people recommends **putting children, young people and families at the heart of commissioning** and adopting a **proportionate universal approach** though **embedding oral health improvement into all children and young people's services**.

Interventions recommended include:

- Community action.
- Supporting consistent evidence informed oral health information.
- Supportive environments.
- Community based preventative services.
- Public policies e.g. sugar tax and increasing the availability of free drinking water.
- Oral health training for the wider health workforce.

What are we doing in East Sussex?

- A targeted community programme whereby **health visitors give out toothbrush packs and oral health advice** to parents at the universal 12 month and 27 month reviews.
- East Sussex Healthcare NHS Trust (ESHT) are **promoting oral health in the paediatric department** by extending coverage of the Mouth Care Matters* initiative as well as encouraging paediatricians to **include oral health as part of their overall assessment of a child**.
- The School Health Service delivers an **oral health promotion assembly in all primary schools** in East Sussex in term 4 to ensure that children are reminded how to look after their teeth.
- **The Local Safeguarding Children Board run *training on neglect* reminds professionals** of the importance of daily tooth brushing routines, a reduced sugar diet and attending dental appointments in preventing decay.
- Section 3.1 describes **interventions to improve nutrition** which **will reduce children's exposure to sugar** and improve oral health.

"Mouth Care Matters" is a Health Education England initiative across Kent, Surry and Sussex to improve the oral health of hospitalised patients by ensuring oral hygiene routines are not neglected during hospital stays, and oral health issues which are delaying recovery are treated.

Key actions going forward

- **Continue health visitor oral health programme** (handing out toothbrush packs and giving parents advice to register with a dentist at the 12 month check and 27 month).
- **Support the British Society of Paediatric Dentistry campaign** to promote dental checks by 1 year.
- **Develop oral health promotion resources for early years settings** to use alongside healthy eating activities to promote positive oral health behaviours.
- Ensure **oral health assessment** becomes **standard practice for ESHT paediatric inpatients**.
- Commission **oral health promotion training for all front-life staff working with children** in early years.

CHAPTER 3
Early Years
3.3 Hospital admissions due to accidents and injuries

Rate of emergency hospital admissions for unintentional and deliberate injuries in children under 5 years.

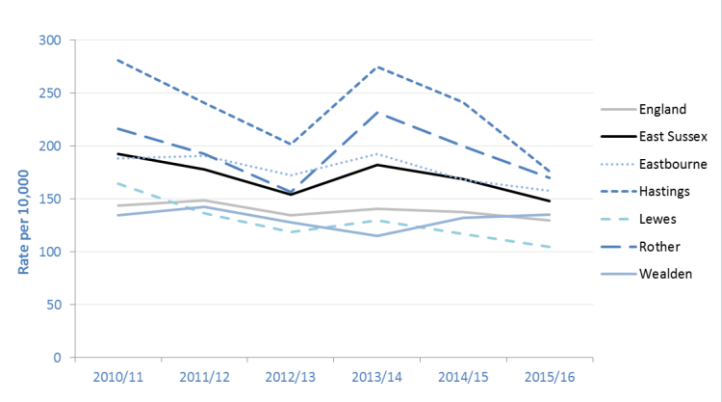
Key messages

- Accidents are entirely preventable, yet unintentional injuries are a major cause of ill health and disability in children in East Sussex.
- In 2015/2016 there were 419 injury-related hospital admissions across East Sussex for children under five years.
- Admission rates in East Sussex are significantly higher than England (148 versus 130 per 10,000).
- Despite recent decreases Hastings still has the highest admission rates in the county.
- 67% of non-traffic accidents in under 5s requiring hospital admission in East Sussex were recorded as happening at home.
- Injury reductions can be achieved at low cost through parent education, key staff group training and local coordination including the Home Safety Equipment Scheme.

What is this indicator showing us?

The rate of 0-4 year olds admitted to hospital due to accidents and injuries, per 10,000 population aged 0-4 years. Note this indicator is the Public Health Outcomes Framework indicator 2.07i.

Hospital admissions caused by unintentional and deliberate injuries, 0-4 years, rate per 10,000 population.

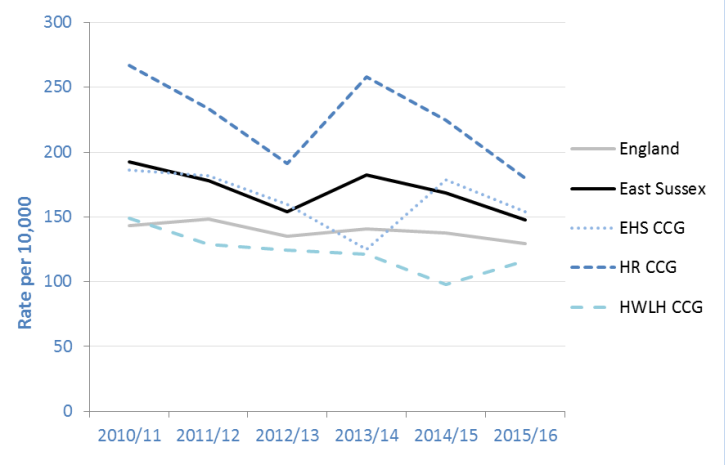


Latest data: In 2015/16 there were 148 admissions per 10,000.population aged 0-4 in East Sussex; significantly higher than for England (130 per 10,000).

Trend: Overall for East Sussex there has been a slight decrease in hospital admissions between 2010/11 and 2015/16 albeit with higher rates in intervening years.

Source: PHE, Public Health Outcomes Framework

Figure 3.3.1: Emergency hospital admissions per 10,000 population aged 0-4 for unintentional and deliberate injury in East Sussex by district and borough, 2010/11 to 2015/16



Latest data: In 2015/16 admissions were highest in Hastings and Rother CCG area, and lowest in High Weald Lewes Havens CCG area.

Trend: Despite the overall downward trend across East Sussex over the last six years, there have been large fluctations at a CCG level. By 2015/16 the difference in accident rates between Hastings and Rother and High Weald Lewes Havens was smaller than it was in 2010/11.

Source: PHE, Public Health Outcomes Framework

Figure 3.3.2: Emergency hospital admissions per 10,000 population aged 0-4 for unintentional and deliberate injury in East Sussex by CCG, 2010/11 to 2015/16

Why is this indicator important?

Accidents are almost entirely preventable and are a major cause of ill health and disability.

Accidents and injuries are one of the main causes of ill health, disability and death in children under five years in East Sussex and England. The majority of accidents and injuries take place in and around the home in this age group; hence home safety improvement is a key preventative factor.

Accident prevention will reduce costs to the health and social care system in East Sussex.

Accidents in children aged under 5 years are strongly linked to deprivation and so efforts to reduce accidents and injuries contribute to reducing inequalities in health across the county.

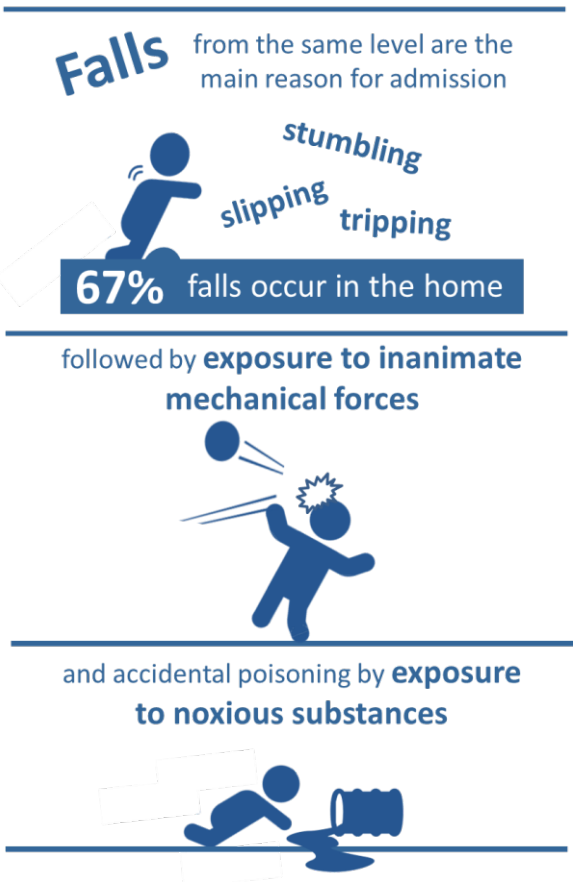
Where are we now in East Sussex?

There is no national target but an achievable target would be to reduce the rate of injuries across East Sussex to below the England rate.

Hospital admission rates are highest in Hastings and Rother CCG area and in Hastings borough and Rother district. Lewes district and High Weald Lewes Havens CCG have the lowest rates of admissions due to accidents across the county.

2015/16 data shows that the difference in accident rates between Hastings and Rother CCG and High Weald Lewes Havens CCG reduced due to a large decrease in Hastings and Rother rates and a slight increase in High Weald Lewes Havens.

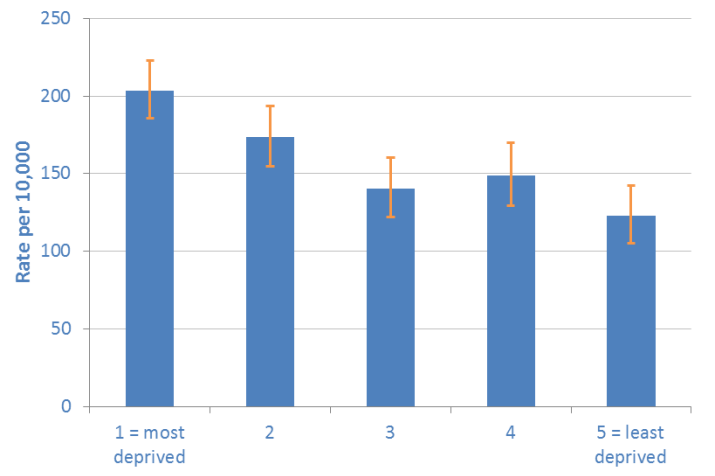
Admissions for accidents and injuries:



Source: Public Health analysis of SUS data.

Spotlight on inequalities:

Injuries are preventable and are strongly linked to levels of deprivation. There is a general increasing rate of hospital admission due to injuries with increasing levels of deprivation.



Latest: Children in the most deprived areas of East Sussex have significantly higher admission rates for accidents and injuries compared to those in the least deprived areas.

Source: East Sussex Public Health SUS extracts.

Figure 3.3.3: Emergency hospital admissions per 10,000 population aged 0-4 for unintentional and deliberate injury in East Sussex deprivation (IDACI quintiles), 2013/14 to 2015/16

What does good look like?

In England the lowest rate of admissions for unintentional and deliberate injuries in 0-4 year olds was 56 per 10,000 in Westminster, which is less than half the rate in East Sussex. The best 25% of areas in the country had admission rates below 104 per 10,000. East Sussex has significantly higher admission rates due to accidents than England with 148 versus 130 per admissions per 10,000.

How can we improve?

A **multi-sector approach** to reducing rates of accidents and injuries is required involving staff from health, education, social care, housing and emergency services. Targeted support, including equipment schemes, training and information has been shown to reduce the rates of accidents. Actions include:

- **Training key staff groups** such as health visitors, children's centre staff, early-years settings staff and early help staff to **prevent injuries** and **educate and support parents** in injury prevention and important safety practices such as safe bathing.
- Continuing to improve the promotion and distribution of a range of **home safety equipment** including safety locks for kitchen and bathroom cupboards, safety cords for blinds and curtains, stair gates, hot tap mixer valves and smoke alarms.
- **Paediatricians and hospital staff have a role to play in identifying children who may be at higher risk**, as well as **data collection on injuries**, and **supporting parents in preventing injuries**.

All of these **preventative measures are low cost and can lead to substantial cost savings** across the health and social care system.

What are we doing in East Sussex?

In addition to analysis of routine monitoring data an early alert system has been implemented at ESHT. This involves a Paediatric Liaison Nurse Service at the Trust recording data on the reasons for children (0-16 years) attending A&E in Eastbourne and Hastings. The data are sent to Public Health regularly to enable early identification of any emerging trends in accidents, allowing the relevant health and social care professionals to be alerted and additional advice to parents and preventative measures to be put in place. **Following a review of effective actions to address child accidents several activities have been commissioned** as part of a wider approach to support the reduction of hospital admissions /attendances due to injuries in children aged 0-4 years and to reducing inequalities in accidents across the county:

- **Accident prevention training** (to include Train the Trainer) for the Early Years (0-5) workforce to enhance their skills and confidence in raising the importance of measures to prevent accidents amongst families with young children. The training emphasises the importance of targeting those living in disadvantaged communities.
- Key staff groups, including health visitors, community nursery nurses, children's centre keyworkers and the Early Help Family Keyworkers carry out **home safety assessments** with families using a locally adapted Home Safety Checklist.
- **Practical support to create safer home environments** is available to targeted families with children 0-2 years. The *East Sussex Child Home Safety Advice and Equipment Service* fits home safety equipment and provides relevant evidence-based home safety education and advice at *Safe and Well* visits.

Key actions going forward

Support Health Visitors in their delivery of the Healthy Child Programme high impact area **"managing minor illness and reducing accidents".**

- **Continue to feedback A&E local data** to staff groups working with 0-5 years to **ensure accident prevention training and advice to parents is appropriate and targeted**.
- **Evaluate** the impact of **the Child Home Safety Advice and Equipment Service** and **ensure** that **interventions are reaching the families with most capacity to benefit**.
- Continue to **raise awareness of accident preventions amongst professionals** through **amplification of national safety campaigns** e.g. Child Accident Prevention Trust - Child Safety Week.

CHAPTER 3
Early Years
3.4 School readiness

Percentage of children achieving a good level of development by the end of reception (Early Years Foundation Stage).

Key messages

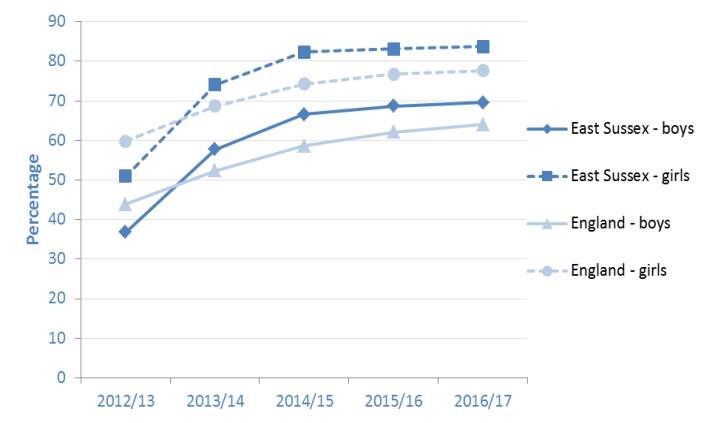
- School readiness is an important measure of early year's development across a wide range of learning areas and has been linked with better academic outcomes from primary and secondary education as well as positive behavioural and social outcomes in adulthood.
- School readiness starts at birth with the support of parents and caregivers, when young children acquire the social and emotional skills, knowledge and attitudes necessary for success in school and life.
- Pre-schools, nurseries and childminders play an important role in supporting child development and good early education experience can significantly support social mobility.
- In East Sussex 96.8% of early years providers are now rated good or outstanding by Ofsted: a 20.3% percentage point increase since 2013.This is above the national average.
- Since 2013/14 a greater proportion of children in East Sussex have achieved a good level of development compared to the England average.
- In East Sussex, fewer children eligible for free school meals (FSM) reach the expected level of achievement in phonics compared to their non-FSM peers. Boys eligible for FSM are further behind their non-FSM peers than girls eligible for FSM are.
- Every £1 spent on early years results in £13 of savings to tax payers in later years. For every £1 spent on early years education £7 has to be spent on adolescent education to get the same impact.

What is this indicator showing us?

This indicator shows the proportion of children who have reached the expected level of development (in a range of learning areas) by the end of a reception year at school and are therefore considered ready for school. School readiness is measured at the *end* of the reception year of school as this marks the end of the Early Years Foundation Stage.

The learning areas included are: personal, social and emotional development; physical development; communication and language and the early learning goals for maths and literacy.

Percentage of children achieving a good level of development at the end of reception

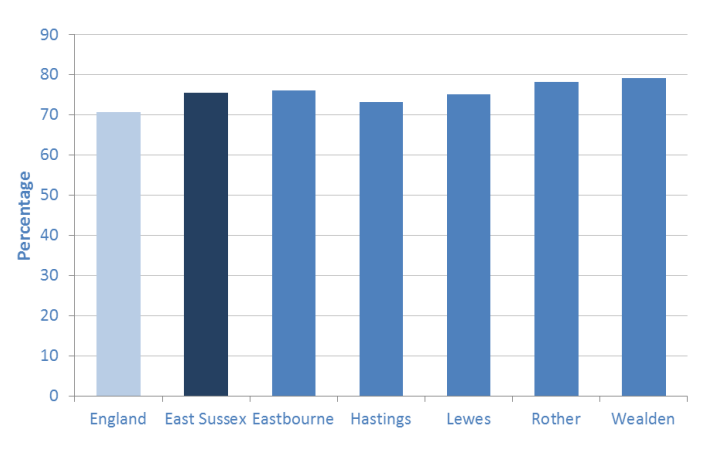


Latest: in 2016/17, 84% of girls and 70% of boys in East Sussex achieved a good level of development at the end of reception. This shows a rise for both boys and girls.

Trends: Since 2012/13 there has been an upward trend in the proportion of children achieving a good level of development at the end of reception.

Source: DfE, Early Years Foundation Stage Profile.

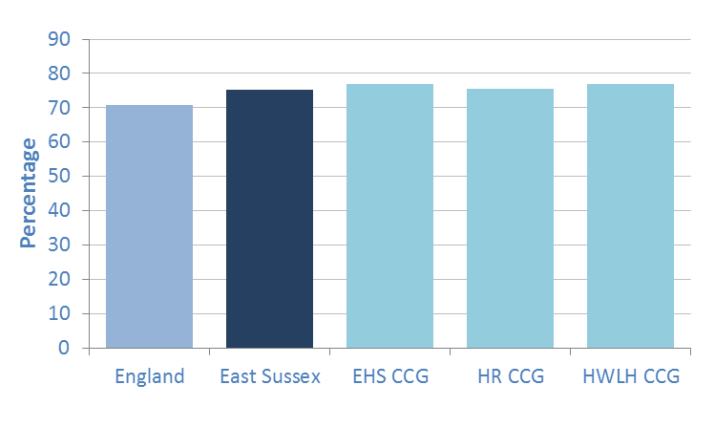
Figure 3.4.1: Percentage children achieving a good level of development by the end of reception in East Sussex by sex, 2012/13 to 2016/17



Latest: Wealden had the highest proportion of children with a good level of development (79%) and Hastings the lowest (73%). The England average was 71%.

Source: East Sussex JSNAA scorecard 2.16

Figure 3.4.2: Percentage children achieving a good level of development by the end of reception in East Sussex by district and borough, 2012/13 to 2016/17



Latest: In 2016/17 the proportion of children ready for school is very similar across all three East Sussex CCGs, ranging from 76% in Hastings and Rother CCG to 77% in High Weald Lewes Havens CCG and Eastbourne, Hailsham and Seaford CCG.

Source: East Sussex JSNAA scorecard 2.16

Figure 3.4.3: Percentage children achieving a good level of development by the end of reception in East Sussex by CCG, 2012/13 to 2016/17

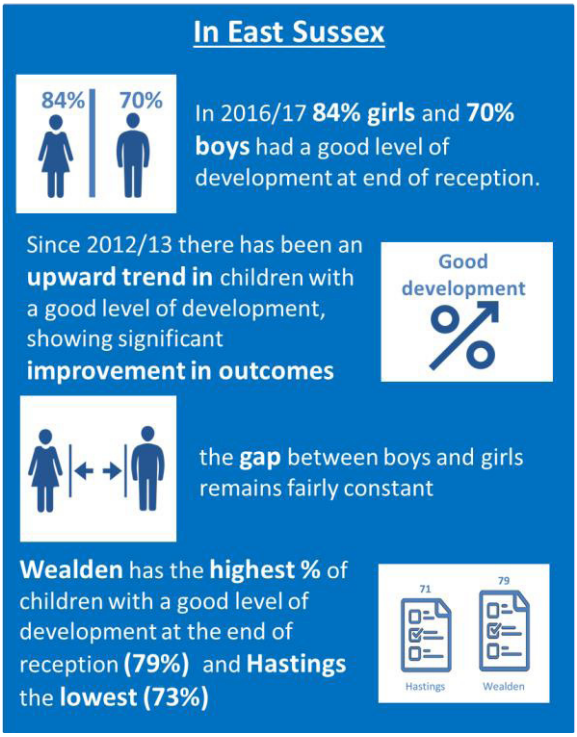
Why is this indicator important?

PHE report evidence indicates that school readiness at age five has a strong impact on later academic attainment, health, crime and life expectancy and is a cost effective intervention: £1 invested in quality early care and education saves taxpayers up to £13 in future costs. It has also been calculated that it costs £7 in adolescence to get the same impact as £1 in early years.[21]

Globally, improving school readiness is increasingly used as a viable strategy to close the learning gap between children from more deprived backgrounds and their wealthier peers, and thus contribute towards improving equity in achieving lifelong learning and full developmental potential among young children.[22]

Where are we now in East Sussex?

East Sussex has remained above the national average for the last four years for both the percentage achieving a good level of development and the average point score. However, the gap between boys and girls remains fairly constant.

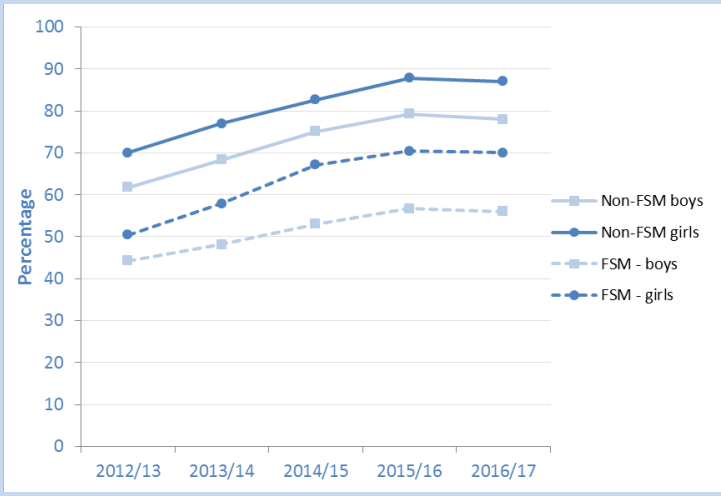


All five districts and boroughs have a higher proportion of children with a good level of development at the end of reception compared to England. Hastings is an area of significant economic inequalities, but the attainment of children at the end of the foundation stage has been consistently above the national average as a result of investment of additional resources in Hastings to tackle in equalities.

Spotlight on inequalities

Nationally, fewer children from disadvantaged backgrounds achieved a good level of development at the end of reception, compared to children from less disadvantaged background (2015). Although girls do better than boys overall, being eligible for free school meals has a significant impact on outcomes: girls who are eligible for free school meals are less likely to achieve the expected level of development in phonics* at the end of year 1 compared to boys not receiving free school meals. In East Sussex boys eligible for free school meals do worst of all.

***Phonics** is a method for teaching reading and writing of the English language by developing learners' ability to hear, identify, and manipulate speech sounds in order to teach the correspondence between these sounds and the spelling patterns that represent them.



Latest: Data from East Sussex shows that fewer children eligible for FSM achieve a good level of development than children not eligible for free school meals**.** The gap between boys and girls is greater for those eligible for free school meals.

Source: DfE, Phonics screening check statistical series

Figure 3.4.4: Percentage of pupils achieving the expected level in the phonics screening check in East Sussex by free school meal status by sex, 2012/13 to 2016/17

What does good look like?

Nationally 71% of children achieve a good level of development at the end of reception, and the best performing area (Lewisham) achieves 79%. At 75% East Sussex is in the top ten local authorities in England and is statistically significantly above average.

How can we improve?

School readiness can be seen as a result of ready families, ready children, ready communities and ready services[3] and thus **tackling factors related to deprivation** such as homelessness, teenage parenthood, low birth weight, poverty and access to funded early years education will improve school readiness.

The following **individual factors** are known to **increase the likelihood of school readiness**:

- Good maternal mental health.
- Parents using learning activities, including speaking to their baby and reading with their child.
- Enhanced physical activity programmes.
- Parenting support programmes.
- High quality early education.

A seamless foundation stage across all partners (nurseries, preschools and school across the public, private and voluntary sector) is key to supporting children through this key phase.

Early years settings who **work in partnership with parents and carers** to help develop the home learning environment will maximise each child's progress and help them make a better start at school.

Accurate and timely assessment of children's development is important – good early years providers will use assessment to understand a child's capacity, and be able to use a range of interventions to accelerate progress if needed.

What are we doing in East Sussex?

There are a wide range of services and interventions in place in East Sussex to support school readiness:

- As a result of additional funding from NHS England, the CCGs have invested in **additional perinatal mental health services.**
- Preventative measures include **embedding the free Baby Buddy[23] app** in maternity and early years pathways through a champions programme.
- The health visiting service uses the **five universal mandated checks to identify parents or children who would benefit from a range of targeted early years services** including mental health support, and advice on Health, Exercise and Nutrition for the Really Young (HENRY).
- Providing **free early education for the most disadvantaged 2 year olds** is a way of reducing the gap in development and progress between economically disadvantaged children, looked after children, children with disabilities and their peers. In East Sussex uptake of funded nursery places for 2 year olds is much higher than then national average at 81% compared to 71%.
- East Sussex was **an early adopter of the Integrated Progress Review for children aged 27 months** which brings together the mandatory check by health and the statutory assessment by Early Years providers. This enables early support and intervention to be agreed between agencies to help accelerate progress. Some other areas of the country have not yet started this work.
- **Nurseries across East Sussex have been supported to develop healthy eating physical activity programmes** through the Healthy Active Little Ones programme (HALO), alongside provision of the HENRY programme for children who need targeted support.
- The **Local Authority supports schools and settings in the transition into school** by providing a chart of the range of transition activities that should take place throughout the year.
- Settings also complete a **summative assessment form for each child**, which is moderated at local moderation groups. These records give a clear picture of the child including health referrals and attainment in the Early Years Foundation Stage, along with comments from the child and the parents to pass onto the schools to support transition.
- The **parenting support offer within East Sussex is being developed** with additional time limited funding from Public Health, and from the Hastings and Rother inequalities fund.
- Nurseries in East Sussex have received improved ratings from Ofsted.

Key actions going forward

- **Continue the Action Research Project on Transition to school** being delivered with Early Years Hubs for Excellence to improving school readiness. Aims of the project include to:
    - Agree a definition of `school readiness'.
    - Review the effectiveness of using the Moving On summative assessment and Transition documentation.
    - Improve the effectiveness of moderation between schools and pre-schools.
    - Evaluate the impact of this work on children's school readiness.
- **Continue to support good and outstanding nurseries for our most vulnerable** funded two year olds.
- Continue to roll out the Department for Education (DfE) Early Innovator Project to **implement the free early education offer for 3 and 4 years olds,** and the 30 hour offer to working parents from September 2017.
- Support the **continued embedding of baby buddy and parenting programmes** across pathways in East Sussex.
- **Continue the 0-5 Healthy Child Programme (led by health visitors),** the proportional universal approach of 5 mandated checks for all, tiered support for those with additional needs, and the integrated progress review at 27 months.
- **Continue the development of pathways from Early Years settings to additional support** services.
- **Continue the HALO programme** in nurseries and early years settings.
- Ensure that our partnership programmes through ESBT and C4Y continue to support health improvement in early years, for example by continuing to **embed the nursery health improvement settings programme.**

CHAPTER 4
School age/adolescence
4.1 Healthy weight at Year 6 (10 to 11 years)

Proportion of children at a healthy weight during their final year of primary school

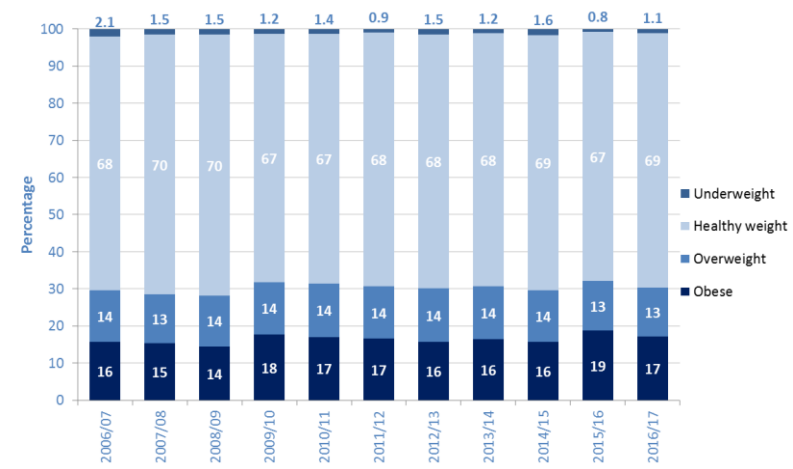
Key messages

- Like weight earlier in childhood, weight at the end of primary school is an important predictor of health outcomes both in childhood and later in life.
- Currently, almost one third of children in East Sussex are classified as overweight or obese during their final year of primary school, with the percentage of Year 6 children in Eastbourne classified as overweight or obese being significantly worse than East Sussex.
- There has been minimal overall improvement in the proportion of East Sussex children classified as having a healthy weight during their final year of primary school over the past decade, although there was a decrease in the proportion of obese children in East Sussex in 2016/2017.
- The overweight and obesity prevalence for children living in the most deprived areas in East Sussex is significantly greater than it is for those living in the least deprived areas.
- The promotion of healthy weight in children needs to include a range of interventions to both reduce the obesogenic environment and target critical periods in the life course.

What is this indicator showing us?

This indicator shows us the proportion of children who are a healthy weight, (underweight, overweight and obese) in their final year of primary school, using cut-offs based upon the Body Mass Index (BMI) as a measure of weight for height relative to sex and age.

Year 6 children underweight, healthy weight, overweight or obese



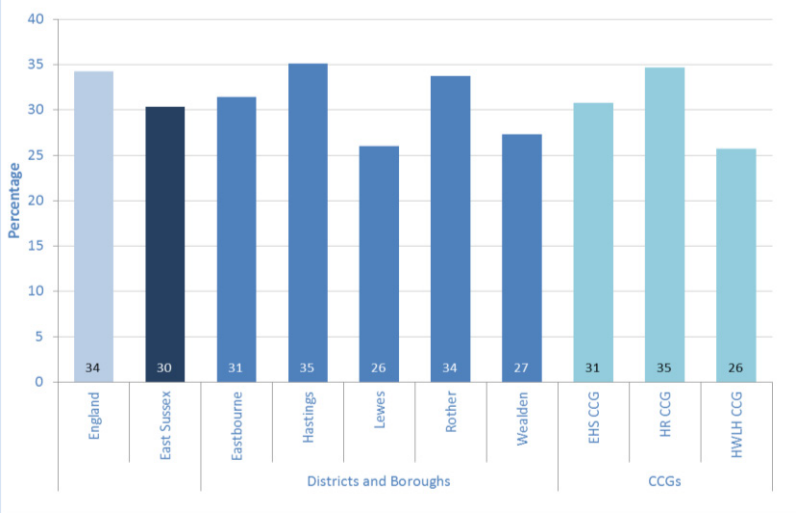
Latest data: The latest data show that just under 1 in 3 (30%) children aged 10-11 years are overweight or obese.

Trend: Over the last eleven years the trend has remained relatively constant with rates of overweight and obese children aged 10-11 ranging between 28% in 2008/09 and 32% in 2015/16.

Source: NHS Digital, National Child Measurement Programme statistics

Figure 4.1.1: Percentage of year 6 pupils (10-11 year olds) underweight, healthy weight, overweight or obese in East Sussex, 2006/07 to 2016/17

Year 6 children overweight or obese, by District / Borough and Clinical Commissioning Group (CCG)



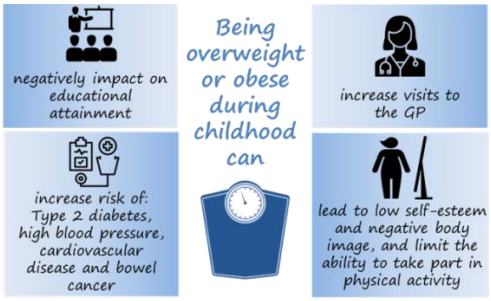
Latest data: The proportion of Year 6 children overweight or obese in East Sussex (30%) is significantly lower than the proportion in England (34%). Hastings (35%) is significantly higher than East Sussex but similar to England. In Lewes (26%) the proportion is significantly lower than both East Sussex and England averages. The proportion of Year 6 children in High Weald Lewes Havens and Eastbourne, Hailsham and Seaford CCG overweight or obese is significantly lower than the England average; with Hastings and Rother CCG similar to the England average.

Source: East Sussex National Child Measurement Programme data and NHS Digital statistics

Figure 4.1.2: Percentage of year 6 pupils (10-11 year olds) overweight (including obese) in East Sussex by district/borough and CCG, 2016/17

Why is this indicator important?

Childhood obesity is one of the greatest health threats to children and their future in East Sussex. Not only does being overweight have a major impact on health and wellbeing in childhood, it is also an important predictor of being overweight and obese in later life and the associated risk to both physical and emotional health and wellbeing.



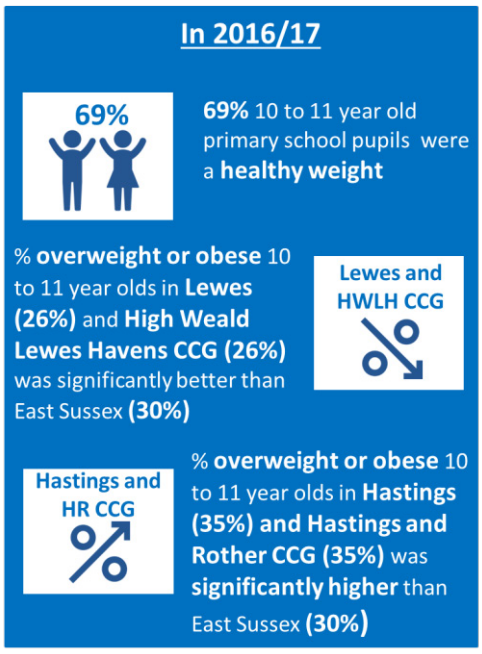
Assessing children's weight in schools is an important part of a co-ordinated approach in preventing childhood obesity. By identifying children in a systematic, timely way, we can offer guidance and support to encourage all children to maintain a healthy weight.

Currently, as children get older, the proportion who are a healthy weight falls from 76% in reception (see section 3.1) to 69% in year 6. The proportion of children who are overweight in reception and year 6 remains similar, but far greater proportions of year 6 children are obese (17% vs 10%).

By measuring child weight at school entry and Year 6 we can monitor trends, identify key times to intervene, and evaluate the effect of our actions to prevent children from becoming overweight and obese.

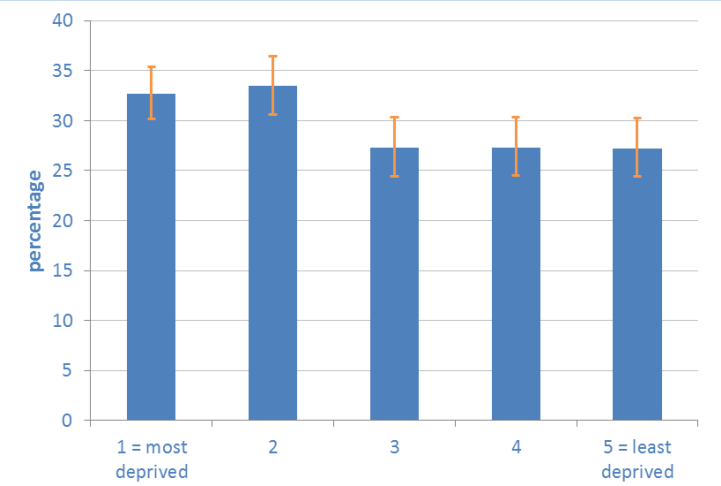
Where are we now in East Sussex?

There has been little change in the proportion of East Sussex children classified as either a healthy weight or overweight/obese during their last year of primary school since the NCMP was established in 2005.



Spotlight on inequalities

Both national and local data show that there is a strong relationship between deprivation and overweight/obesity prevalence. Low income families may find it harder to afford a balanced diet with cheaper convenience food often being calorie dense and nutrient light. Limited time and cooking facilities are another challenge.



Latest data: Data shows that overweight and obesity prevalence for children living in the most deprived areas in East Sussex (defined by East Sussex income deprivation affecting children index) is significantly greater than it is for those living in the least deprived areas. In 2015/16, 37% of Year 6 children living in the most deprived areas of East Sussex were classified as overweight or obese compared to 27% in the least deprived areas of the county.

Source: East Sussex National Child Measurement Programme data

Figure 4.1.3: Percentage of year 6 children overweight (including obese) in East Sussex by deprivation (IDACI quintile), 2015/16

What does good look like?

A national aspirational target for obesity is that 5% or fewer year 6 children are obese. The aim is to achieve a sustained downward trend in rates of excess weight in children by 2020. Despite East Sussex having lower rates of overweight and obesity (30%) than the England average (34%), and being 28th best out of 150 local authorities, it is important to highlight that currently more than three in every 10 children in East Sussex are carrying excess weight during year 6.

Richmond upon Thames has the lowest rates of overweight and obesity in England (25.3%). England has a slightly higher prevalence of overweight and obesity than other European countries.

How can we improve?

"Childhood obesity: a plan for action" is one of the few cross-government strategies to specifically address childhood obesity. Many of the significant actions identified are already underway and progress is being made across the county. Relevant priorities set out in the plan include:

- Helping all children to enjoy an hour of physical activity every day.
- Improving the co-ordination of quality sport and physical activity programmes for schools.
- Creating a new healthy rating scheme for primary schools.
- Making school food healthier.
- Enabling health professionals to support families. All children who are significantly underweight should have timely access to specialist child health services.

What are we doing in East Sussex?

Organisations in East Sussex are working together to transform outcomes for local people through the Personal Resilience and Community Resilience (PRCR) workstream of East Sussex Better Together (ESBT); and of Connecting For You (C4Y) in the west of the county. The PRCR workstream has a dedicated sub-group co-ordinating work across partners to address obesity. Agreed actions and priorities to address obesity are set out in the East Sussex Healthy Weight Plan 2016 – 2019. In order to achieve its aim, partners from across all sectors are currently working together with the population to achieve key objectives across four thematic areas:

- **Environment** - creating a physical and social environment that promotes healthier lifestyle choices.
- **Workforce development** - developing the capacity and capability within the local workforce so that they are able to support others in achieving and maintaining a healthy weight.
- **Services and support** - ensuring the provision of quality services which support individuals to achieve and maintain a healthy weight and reduce their risk of developing a condition associated with excess weight.
- **Communications and engagement** - enabling people to understand the importance of a healthy weight and take action to address it.

Example activities that support achievement of healthy weight in children and young people include:

- **East Sussex Whole School Health Improvement Transformation Programme** - A transformation programme enabling all state funded schools in East Sussex to access funds to develop a school health improvement plan, and using a primary prevention and whole school approach, put in place actions to address health and wellbeing priorities (with a specific focus on obesity) identified in the plan.
- **Delivery of healthy weight initiatives in schools** - such as the East Sussex Bikeability programme and Phunkyfoods programme.
- **Mass participation physical activity initiative (Beat the Street)–** A community wide physical activity intervention designed to inspire communities to make small changes, such as walking or cycling to school or work every day, to improve their health, and create lasting health benefits through creating a social norm around being active.
- **Target health improvement campaigns to address healthy weight** (e.g. Start4Life, Change4Life, Our Healthy Year).
- **East Sussex Health Promotion Resources** – Service offering a wide range of free resources (leaflets, posters, teaching aids), to include those linked to obesity, heathy eating and physical activity, for use by any individuals in East Sussex who have a role in promoting health.
- **Maximising parental engagement as part of the National Child Measurement Programme (NCMP)** – The East Sussex School Health Service are currently piloting the impact of undertaking telephone calls with targeted parents (both prior to and after receiving their child's NCMP results letter) in order to maximise behaviour change.

Key actions going forward

- **Implement the three year programme of action** from the East Sussex Health Weight plan 2016-2019, including:
    - **Ensure health visiting and school health services are maximising opportunities to support healthy weight** via diet and exercise advice to children and families.
    - **Ensure that all opportunities to shape the environment to enable healthy weight are utilised** e.g. through developing healthy settings approaches in early years settings and schools and utilising planning and active travel approaches.
    - **Increase availability and uptake of high quality, effective services which support increased healthy weight and reduced risk of conditions caused by excess weight**. Ensuring services are targeted towards children and their families at all levels of need, especially in areas where the need is greatest.
    - **Apply the Making Every Contact Count (MECC*) approach** across all organisations in East Sussex to ensure that staff and volunteers have the skills, competences and confidence to raise lifestyle issues with clients, provide brief advice and refer into services.

*MECC is

"an approach to healthcare that encourages all those who have contact with the public to talk about their health and wellbeing. It encourages health and social care staff to use the opportunities arising during their routine interactions with patients to have brief conversations on how they might make positive improvements to their health or wellbeing."

Health Education England

CHAPTER 4
School age/adolescence
4.2 Human Papilloma Virus (HPV) vaccination

Proportion of girls who have been fully immunised for Human Papilloma Virus (HPV)

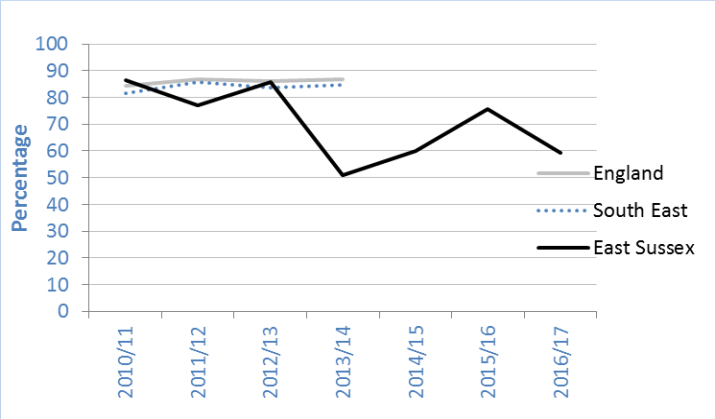
Key messages

- The HPV vaccination during adolescence is a highly effective public health measure to prevent cervical cancer and genital warts.
- In East Sussex we are currently below both the Surrey-Sussex and national uptake rates for HPV due to problems with service delivery.
- A catch up programme in schools is in place in community clinics to improve uptake ideally to the Surrey-Sussex rates.
- NHS England is reprocuring the whole schools based vaccination service which includes HPV vaccination.
- Girls from black and ethnic minority backgrounds, and girls not in mainstream education, are less likely to take up or complete the vaccination course.

What is this indicator showing us?

This measure tells us the percentage of adolescent girls that have been fully immunised against HPV (i.e. received all three doses of the vaccine until 2014, when it was changed to two doses) since the UK government's immunisation programme commenced in 2008.

12-13 year old girls who have been fully immunised for Human Papilloma Virus (HPV) East Sussex and in England



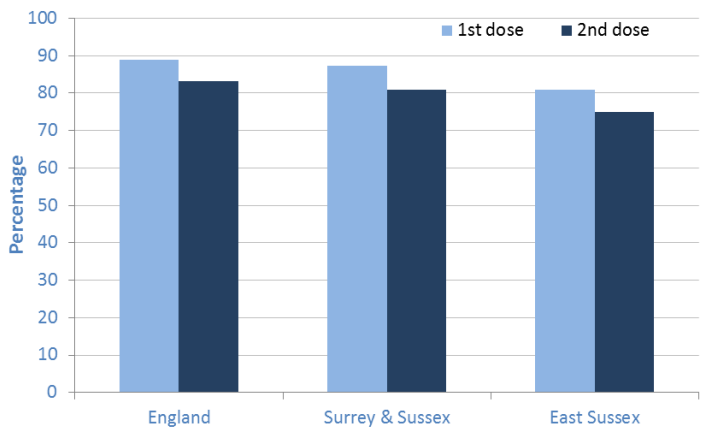
Latest data: In 2016/17 59% of 12 to 13 year olds girls in East Sussex were fully immunised for HPV vaccine. Data are not available for England for 2014/15 onwards as some local authorities have not provided data for the second dose.

Trend: The last available national data from 2013/14 showed around 86% of girls were fully immunised for HPV vaccine and this was matched in East Sussex in 2012/13. However, there was then a rapid drop off in HPV vaccination rates in East Sussex from 86% in 2012/13 to 51% in 2013/14. This recovered to 76% in 2015/16 but dropped to 59% in 2016/17.

Source: PHE, HPV statistics

Figure 4.2.1: Percentage of girls aged 12-13 who have been fully immunised for Human Papilloma Virus (HPV) in East Sussex, 2010/11 to 2016/17

13-14 year old girls who have received the HPV vaccination in East Sussex and in England by dose



Latest data: 81% of 13 to 14 year old girls received their first dose of HPV vaccination and 75% their second in 2016/17 in East Sussex. This is lower than regionally and nationally for both doses.

NB data is not available for lower level geographies.

Source: PHE, HPV statistics

Figure 4.2.2: Percentage of year 9 girls (13-14 year olds) who have received the HPV vaccination in East Sussex by dose, 2016/17

Why is this indicator important?

HPV is a group of common, contagious viruses. Sub-groups of these viruses are linked to cancer and genital warts. Some types of HPV are present in most cases of cervical cancer and a smaller proportion of other anogenital and head and neck cancers which can affect both men and women. By vaccinating girls for HPV infection, they are protected against the two types of HPV that are linked to around 70% of cervical cancers in the UK.

The national vaccination programme for HPV began in 2008, starting with girls aged 12 to 13 years in school.

The original vaccine was changed in 2012 to one that protects against a further two types of HPV that cause the majority of genital warts.

Where are we now in East Sussex?

81% of 13 to 14 year old girls received their first dose of HPV vaccination and 75% their second in 2016/17 in East Sussex. This is lower than regionally and nationally for both doses and is the result of problems with service delivery of the schools based and community vaccination service commissioned by NHS England.

Data is only available at an East Sussex level.

Spotlight on inequalities

Uptake data shows that girls who are less likely to take up the vaccine include girls from black and ethnic minority backgrounds; and those not being educated in mainstream schools (including those being home-schooled, those in special needs schools or those in a hospital or young offenders education unit)[24].

Those living in deprived areas are marginally less likely to have the vaccine.

What does good look like?

An effective vaccination programme relies on achieving as high an uptake as possible to ensure that the greatest number of girls and women are protected from HPV infection. Achieving a high uptake also protects both women and men who have not had the vaccine through herd immunity, meaning that the overall rate of the disease across the population is reduced.

Vaccination rates for HPV are as high as 97.3% in Sunderland. Vaccination rates for HPV are higher than in the U.S., Australia and Europe.

Large reductions in the number of women that would be diagnosed with cervical cancer and die from it were predicted based on studies modelling the long-term impact of the vaccine, based on coverage of 80%[25].

Data is not yet available to demonstrate the impact of HPV vaccine on cervical cancer rates in the UK. However, chlamydia screening data from sexually active women aged 16 to 18 years show that infection with cancer-causing HPV was 66% lower than before the vaccination was available.

How can we improve?

To achieve and maintain a vaccination rate above 80% we need **a well-functioning vaccination programme**, that although schools-based also allows the opportunity for 'mop up' in other community settings both for girls who miss their vaccine at school and for those who are not in mainstream school.

There must also be **continued promotion of the vaccination** to young people and families, including addressing the concerns such as the myth linking the vaccine to increased/ earlier sexual activity, which has now been shown to be false.

HPV vaccination status should be recorded on the Child Health Information System and GP records. Those who missed the vaccination before their 18th birthday can then be identified.

Furthermore, the **data will be used to link with the NHS Cervical Screening programme**, which may alter the way that women are invited for screening based on HPV vaccination status.

What are we doing in East

- **A catch up programme in schools is in place for Year 8 girls** and Kent Community Healthcare Trust are proactively offering community clinics for Year 9 girls to improve uptake ideally to the Surrey-Sussex rates.
- It is intended **that rates of uptake in East Sussex will mirror those across Surrey and Sussex and the national rates**.

Key actions going forward

- **Work closely with NHS England to continue to increase uptake of the full 2 doses of HPV** vaccine **to year 8 girls** and ensure that the community clinics provide additional resource to **vaccinate as many year 9 girls who have missed one or more doses**, as possible.
- **NHS England is re-procuring the whole schools and community based vaccination service** including HPV vaccination for Kent and Sussex for August 2018.

CHAPTER 4
School age/adolescence
4.3 Smoking in young people

Percentage of Year 10 pupils reported having at least one cigarette in the last seven days

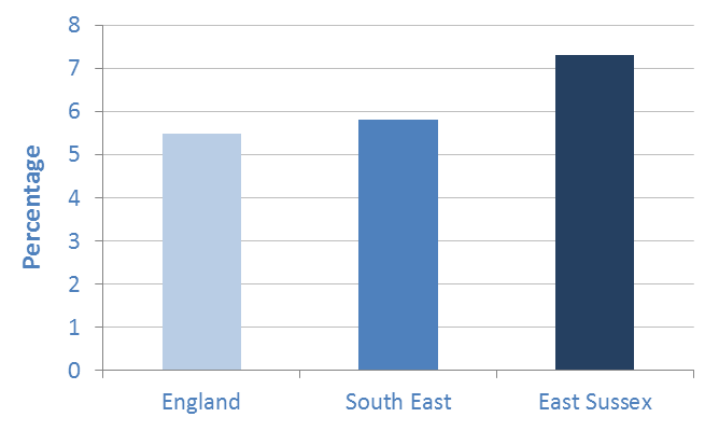
Key messages

- Smoking continues to be the greatest single cause of avoidable ill health and premature death in the UK. Starting to smoke during adolescence increases the likelihood of being a life-long smoker.
- Latest figures from a national survey show that more 15-year-olds in East Sussex smoke regularly (7.3%) than the South East or England (5.8%, 5.5%).
- A 2017 local survey showed that 11% of girls and 8% of boys in year 10 have had a cigarette in the last week.
- Significant inequalities in adolescent smoking persist, with higher rates of smoking in young people from deprived populations.
- Tobacco control measures across the whole population are the most effective measures for reducing smoking and smoke exposure in children and young people.

What is this indicator showing us?

The indicator shows the percentage of 15 year olds who regularly smoke. We have used two different data sources for this indicator.

Percentage of 15 year olds who regularly smoke East Sussex, South East and England, 2014/15



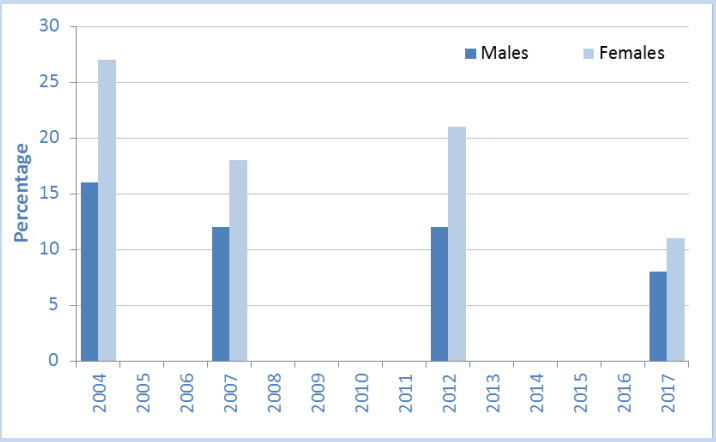
Latest: The percentage of 15 year olds who regularly smoke is 7.3%. This is higher than for England 5.5%.

Trend: The survey which provided this data has only been carried out once so nationally comparable trends are not available.

Source: PHE, WAY Survey.

Figure 4.3.1: Percentage of 15 year olds who report usually smoking at least one cigarette a week (regular smokers) in East Sussex, 2015

Year 10 pupils who have had a cigarette in the last week, by gender East Sussex



Latest data: In 2017 11% of girls and 8% of boys in year 10 say they have had a cigarette in the last week.

Trend: Over the last 13 years there has been a reduction in the proportion of young people who report smoking.

Source: East Sussex Health Related Behaviour Surveys

Figure 4.3.2: Percentage of year 10 pupils (14-15 year olds) who have had a cigarette in the last week in East Sussex by sex, 2004 to 2017

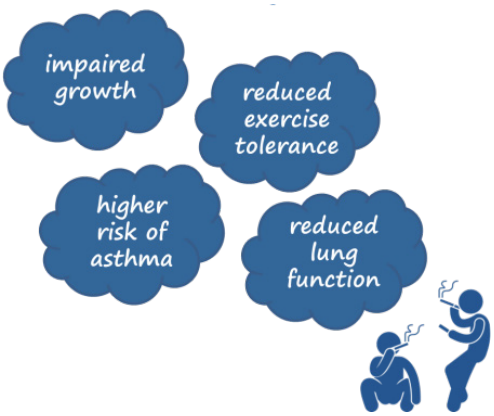
Why is this indicator important?

Smoking causes approximately 96,000 deaths in the UK each year, including;

- **80%** of all deaths from lung cancer.
- **80%** of deaths from bronchitis and emphysema.
- **14%** of deaths from heart disease.
- **>1/4** of all cancer deaths are related to smoking.

Although the main source of tobacco exposure for children is passive second-hand smoke, particularly from parents and carers, every year many young people in East Sussex start smoking.

Smoking has a range of negative effects on young people's health, including:



Stopping young people from starting smoking is a priority because smoking behaviour is almost always established during adolescence. Most adult smokers started smoking by 18 years, and 90% of lifetime smoking starts between the ages of 10 and 20 years.

Tobacco control measures have led to a 79% fall in children's exposure to second-hand smoke between 1998 and 2012 in England; however, around one-third of children still had evidence of smoke exposure in 2012.

Where are we now in East Sussex?

A national target to reduce regular and occasional smoking among 15-year-olds to 3% by 2022 has been suggested by the Department of Health. This is less aspirational than the Royal College of Paediatrics and Child Health who suggest aiming for a tobacco-free childhood meaning that no young people under 18 years of age take up smoking or being exposed to smoke from parents or others.

Data from a national survey found that the percentage of 15 year olds in East Sussex who are regular smokers is 7.3%. A large scale local Health Related Behaviour (HRB) survey of all year 10 pupils (14-15 year olds) in East Sussex which used a slightly different indicator found even higher rates of young people reporting smoking in the last week,

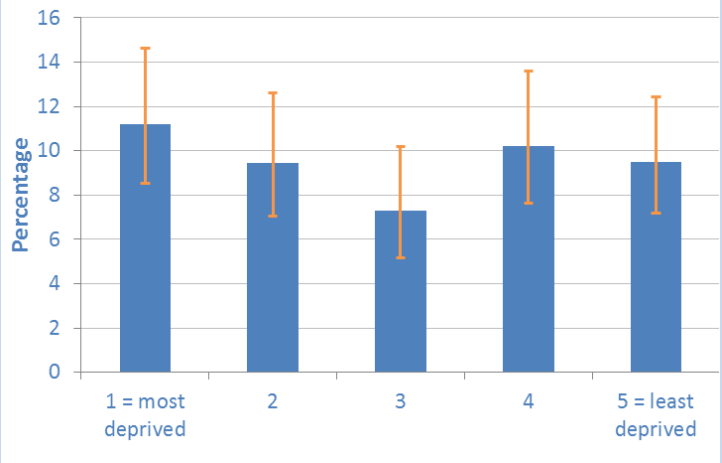
with 11% of girls and 8% of boys reporting having had a cigarette. It is notable that rates of self-reported smoking are substantially higher in girls compared to boys.

Although there has been a downward trend in the proportion of young people smoking since the last HRB survey, preliminary analysis suggests there has been a corresponding increase in the use of e-cigarettes

The differences between the two survey results are due to a combination of factors: The age groups are different with the local survey including some 14 year olds. The national survey contacts a sample of young people and responding is optional. Those who respond may have different health related behaviours to those who don't respond. The local HRB survey includes all the young people at school on survey day, including those who did not respond to the national survey. The national survey asks about "usually" smoking while locally we ask about the last week. The local survey is carried out in the summer term when it is more pleasant to be outside, compared to the national survey which was held in the autumn and winter. The cohort in the local survey may also have been slightly older which could account for increased rates of smoking.

Spotlight on inequalities

National evidence (What About YOUth (WAY) survey, 2014) indicates that smoking levels in young people are higher among those from deprived communities. Local data on smoking in young people does not show such a clear association between smoking and deprivation. The lowest percentage of regular smokers are in the middle quintile of deprivation (5%) compared to around 9% of young people in the two most deprived quintiles and the fourth quintile and 7.5% in the least deprived quintile. None of the differences are statistically significant.



Latest: The percentage of 15 year olds who are regular smokers at age 15 is substantially lower in the middle quintile of deprivation.

Source: East Sussex Health Related Behaviour Survey

Figure 4.3.3: Percentage of year 10 pupils (14-15 year olds) who had smoked a cigarette in the last week in East Sussex by deprivation (IDACI quintiles), 2017

Deprivation is a key factor in determining smoking rates in young people. Nationally, if rates of smoking in all young people aged 15 years in England were to equal those of the least deprived areas of England (i.e. 3%), there would be about 36,500 fewer young people smoking across the UK.

What does good look like?

It would appear from the national WAY survey data which included a sample of 15 year olds from East Sussex that the percentage of 15 year olds in East Sussex who regularly smoke is significantly higher than the regional and national average (7.3% vs 5.8% and 5.5%). Waltham Forest has the lowest reported smoking rates in the WAY survey at 1.3%. England has one of the lowest smoking rates in Europe, ranked 7th of 42 countries.

How can we improve?

Reducing adult smoking, particularly around children, and having **peer-led schools programmes against smoking** are the most effective ways to discourage smoking as a social norm in young people. Direct interventions with young people to reduce smoking initiation can have small individual effects that are important at the population level.

Services to stop smoking in pregnancy and for parents are essential in protecting children and young people's health (see section 2.1). Some of the most effective interventions have been peer-led.

Stopping young people from starting smoking is important both for the immediate benefit but also to contribute to reducing smoking across the population. Many young people experiment with smoking in early adolescence and are vulnerable to social influence, particularly from friends and adults and perceived status. Young people tend to establish nicotine addiction more quickly than adults. **Interventions must continue to reduce the accessibility and affordability of, and exposure to, cigarettes for children and young people.**

A high quality **Personal, social health and economic (PSHE) education programme** covers the personal and social risks and consequences of substance use and misuse, including the benefits of delaying the age at which risky behaviours commence and the **benefits of not smoking (and not harming others with second-hand smoke)**. It may inform children and young people about **how to access local health services**, such as stop smoking services, and other sources of support

Electronic cigarettes are not recommended for young people, and it is illegal to sell them to anyone under 18 or to buy them on their behalf in the UK. There is little evidence that nicotine replacement products are effective in helping young people to quit. **Young smokers who want to quit should be referred to specialist behavioural stop-smoking support.**

What are we doing in East Sussex?

In East Sussex we have translated the internationally recognised six strands of effective tobacco control into three areas of activity: **helping people to stop, preventing people from starting and protecting communities and families from second-hand smoke.** The work being undertaken in each of these work strands includes:

- **Helping people to stop:** the local evidence based stop smoking service, offering behavioural support and smoking cessation medication, is available in East Sussex to young people 12 and over. Services have recently been re-commissioned as part of an integrated lifestyle service (One You East Sussex) to increase access to and reach of services.
- **Preventing people from starting:** The availability of cheap tobacco products is recognised as a key factor in young people taking up smoking. We are using insight to implement targeted programmes to prevent young people from stopping smoking. For example both nationally and locally, those who sell illegal tobacco often target young people in the most deprived areas where smoking prevalence is already highest. Pregnant smokers in the most deprived of the county district and boroughs (Hastings) are likely to be younger and illegal tobacco activity in East Sussex is highest in Hastings. Alongside this many people do not realise that illegal tobacco is also often connected to criminal gangs and organised crime.
- **There is a comprehensive multi-agency approach to reducing harm from illegal tobacco** in East Sussex informed by detailed insight on the scale and location of local activity and the levers and drivers to changing behaviour (reducing demand and increasing reporting).
- **PSHE education** is delivered in schools and teaches children and young people **how to make informed choices about health and wellbeing** matters, including the impact of tobacco and smoking.
- **Four secondary schools are currently participating in a project which seeks to prevent/delay the uptake of risky lifestyle behaviours** in young people (Year 9 and 10 pupils). Using a social norms approach, this project gathers the current attitudes, perceptions and behaviours of young people in relation to a range of lifestyle/risky behaviours using an online survey and then, using a range of intervention activities that young people have been involved in developing, seeks to challenge the misperceptions that young people may have through promotion of the positive social norms message. Over the last two years eleven local secondary schools have participated in the project, and a number of schools have focused their interventions on delaying or preventing smoking.
- **Protecting communities and families from second-hand smoke:** East Sussex has adopted a targeted population level approach to reduce vulnerability and exposure of young people to second-hand smoke. This includes: detailed insight work to better understand how to reduce exposure and vulnerability to second-hand smoke in the most deprived parts of the county. The recommendations from this work will inform coordinated multi-agency action to protect communities and families from exposure to second-hand smoke.

Key actions going forward

- Increase knowledge and awareness of the harms of smoking amongst children and young people through evidence based, personal health education in schools.
- Use the 2017 HRB survey results and analysis of smoking at school level to target schools for 'health improvement interventions' around specific interventions for smoking.

CHAPTER 4
School age/adolescence
4.4 Alcohol and Drug Use

Percentage of 15-year olds who report that they are regular drinkers, proportion of 15 year olds who drank alcohol in the last week, and proportion of 15-year olds who have ever used cannabis.

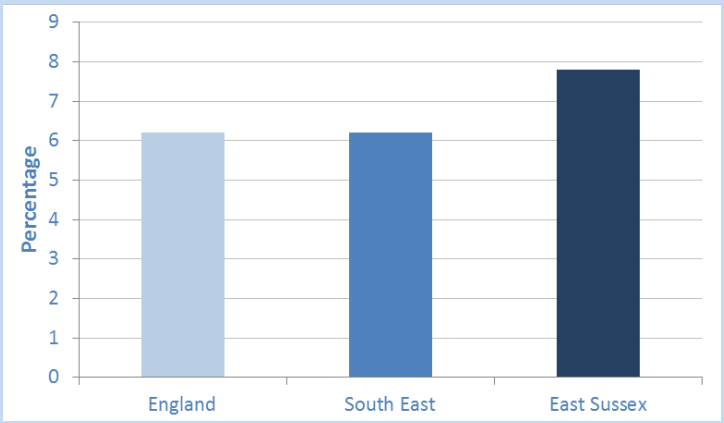
Key messages

- Alcohol and substance misuse are preventable problems and have major impacts on young people, families and East Sussex as a whole.
- Over the last 13 years alcohol and cannabis use in young people has reduced in East Sussex. However, compared to England significantly more young people drink regularly or have tried cannabis. 2017 local survey data suggest that rates are no longer falling.
- Health promotion activities at school are a vital opportunity for intervention, given that alcohol and drug use among school-aged children are linked with negative social and health outcomes into adulthood.

What are these indicators showing us?

These indicators are showing us what percentage of 15 year olds regularly drink, the percentage who had a drink in the last week, and the percentage of 15 year olds who have ever used cannabis.

Snapshot percentage of 15 year olds reporting drinking alcohol regularly, East Sussex, South East and England 2014/15



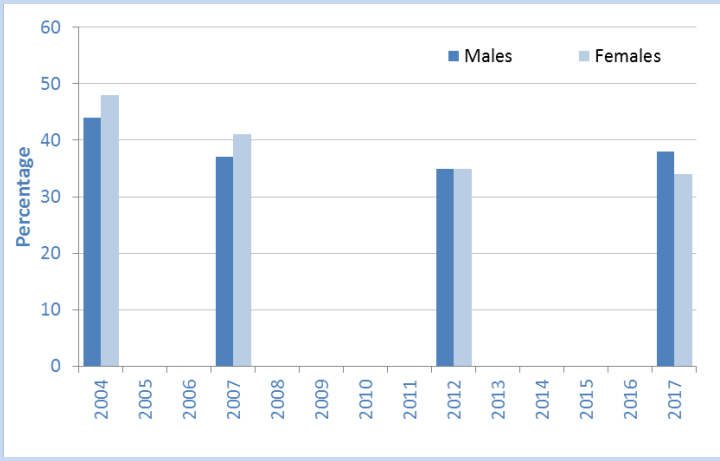
Current data: In 2014/15 7.8% of 15 year olds in East Sussex reported that they drink regularly This is significantly more than the proportion of 15 year olds from across the South East or England.

Trend: The WAY survey has only been carried out once.

Source: PHE, WAY Survey

Figure 4.4.1: Percentage of 15 year olds who reported regularly drinking alcohol in East Sussex, 2014/15

Trend: year 10 pupils reporting having had an alcoholic drink in the last week East Sussex



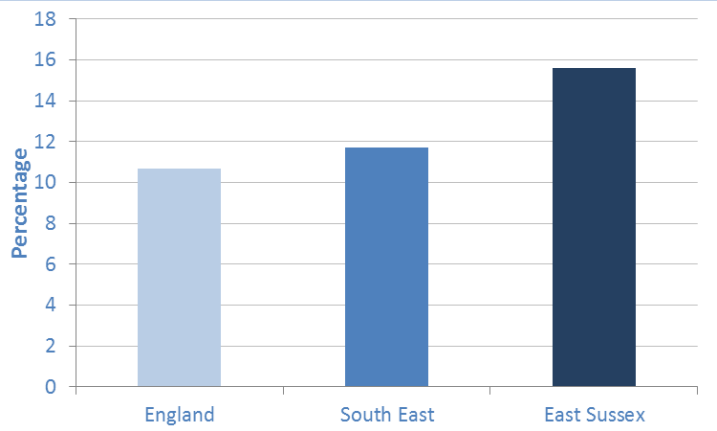
Current data: In 2017 38% of boys and 34% of girls in year 10 reported having an alcoholic drink in the last week.

Trend: The proportion of girls who drank alcohol in the last week continues to decline. Since 2012 there may have been a slight increase in the proportion of boys who have had a drink in the last week.

Source: East Sussex Health Related Behaviour Surveys

Figure 4.4.2: Percentage of year 10 pupils (14-15 year olds) who reported having had an alcoholic drink in the last week in East Sussex by sex, 2004 to 2017

Snapshot percentage of 15 year olds reporting ever having tried cannabis, East Sussex, South East and England 2014/2015



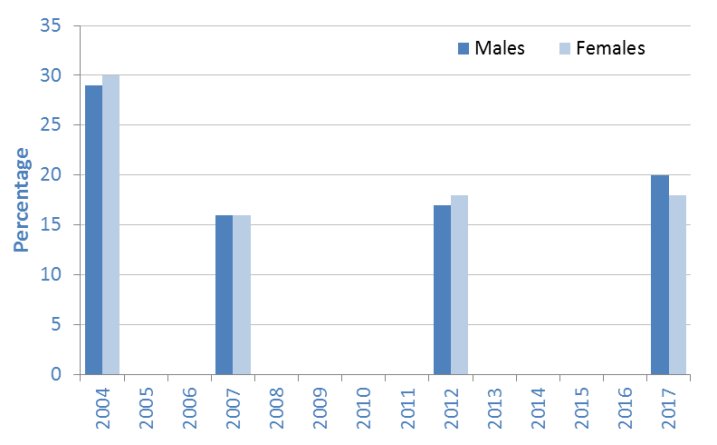
Current data: 15.6% of 15 year olds in East Sussex reported ever having tried cannabis this is significantly more than their peers across the South East and England.

Trend: The WAY survey has only been carried out once.

Source: PHE, WAY survey

Figure 4.4.3: Snapshot - Percentage of year 10 pupils (14-15 year olds) who reported ever having tried cannabis in East Sussex, 2014/15

Trend in year 10 pupils reporting ever having tried cannabis, East Sussex



Current data: In 2017, 20% of boys and 18% of girls in year 10 reported they had ever tried cannabis.

Trend: Following a 50% reduction in 2007, the proportion of young people who report having tried cannabis has increased slightly in 2012 and again in 2017.

Source: East Sussex Health Related Behaviour Surveys

Figure 4.4.4: Percentage of year 10 pupils (14-15 year olds) who reported ever having tried cannabis in East Sussex by sex, 2004 to 2017

Why are these indicators important?

Alcohol and substance misuse are preventable problems and have major impacts on young people, families and East Sussex as a whole.

Alcohol use can negatively impact upon every aspect of a young person's life including their short- and longer-term educational performance.

Evidence collated in the 2015 United Kingdom Drug Situation National Treatment Agency (NTA) demonstrated a strong correlation between disengagement from school, including truancy and exclusion and drug and alcohol misuse and other risky health behaviours. The NTA also found that early intervention in response to drug and alcohol incidents can reduce permanent exclusions and the risk of longer-term misuse.

Young people are more likely to binge drink which is linked with other health risk behaviours such as:

Alcohol is also a risk factor for many diseases later in life, including a range of cancers and liver cirrhosis. Those who start drinking alcohol at a young age are more likely to drink heavily in adulthood and face negative health and social outcomes.

Use of cannabis by young people is linked to poor mental health including depression, anxiety and even psychosis. It is also suggested that cannabis and alcohol use may lead to other drug use.

Although drug use in young people has reduced nationally since 2001, this decline has slowed since 2014.

Research indicates parents and other family members are the main influence for younger children in relation to drinking behaviour and for older children, friends become the main influence. Commercial advertising and social networking on drinking behaviour also have an impact.[26]

Where are we now in East Sussex?

In 2014/15

8%

8% of 15 year olds (sample 976) **regularly drink alcohol**, significantly higher than nationally (6 %)

16% of 15 year olds (sample 989) **have tried cannabis,** significantly higher than nationally (11%)

16%

Alcohol

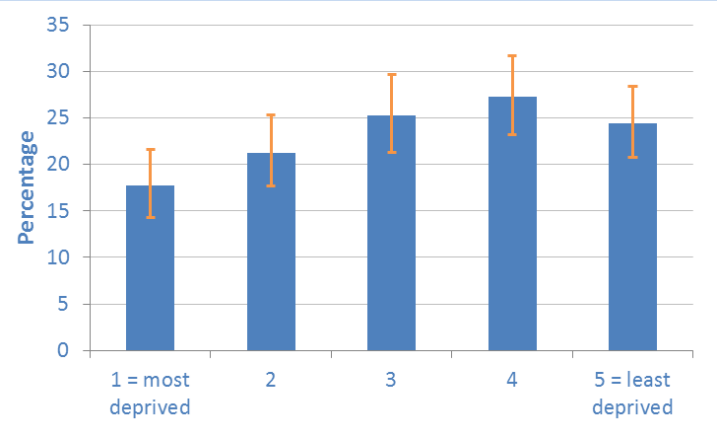
We do not have East Sussex trend data comparable to the England data, but the local HRB surveys show a decline in drinking behaviour amongst young people in East Sussex since 2004. 2017 data suggests there may be a slight increase in the proportion of boys from year 10 who have had an alcohol drink in the last week compared to 2012. The proportion of girls reporting that they have drunk continues to decline.

Cannabis

National survey data shows that significantly more young people in East Sussex report having tried cannabis than their peers across the south east and England. The 15.6% of young people from East Sussex is lower than local survey data which shows 19% have ever tried cannabis. The difference is likely to be that the larger local survey includes more young people who would be less likely to respond to a voluntary survey.

Spotlight on inequalities

Alcohol It would appear from national data that deprivation is not a factor in determining alcohol use and that, in fact alcohol use rates may be higher in more affluent groups, which may be related to status and access. However, there is evidence that there are higher rates of alcohol related harm in lower socio-economic groups, despite lower alcohol consumption. Data from the HRB Survey for East Sussex looks at the percentage of 15 year olds who had an alcohol drink in the week of the survey by (IDACI) quintile (population fifth) and shows a similar pattern, although the greatest percentage of young people having alcohol in the past week were from the second least deprived quintile.

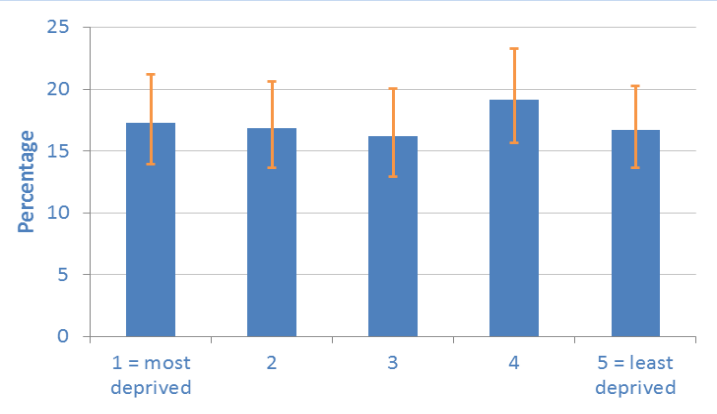


Latest: 27% of young people in the second least deprived quintile had an alcohol drink in the previous week compared to 18% in the most deprived quintile.

Source: East Sussex Health Related Behaviour Survey

Figure 4.4.5: Percentage of year 10 pupils (14-15 year olds) who have had an alcoholic drink in the last week in East Sussex by deprivation (IDACI quintiles), 2017

Cannabis In East Sussex there is no clear relationship between deprivation and having tried cannabis by year 10 although more young people in the second least deprived quintile report having tried cannabis, this difference is not statistically significant. Nationally, there is no clear relationship between deprivation and drug use in adults. However we do know that using drugs means children and young people are more likely to disengage with education.



Latest: Local data on the percentage of year 10 pupils who have ever tried cannabis do not show a clear relationship with deprivation: similar proportions (16-19%) of young people living in each deprivation quintile report having tried cannabis.

Source: East Sussex Health Related Behaviour Survey

Figure 4.4.6: Percentage of year 10 pupils (14-15 year olds) who have ever tried cannabis in East Sussex by deprivation (IDACI quintiles), 2017

What does good look like?

Because the negative health impact of alcohol and cannabis are well known we should be aiming for young people to not use cannabis at all and to minimise alcohol use. The Chief Medical Officer advised that an alcohol-free childhood is the healthiest and best approach, and that if children do drink alcohol, it should be at least not until the age of 15, infrequently, and with adult supervision.

Nationally, the 25% of local authorities with lowest levels of risky behaviours had between 1% and 4.4% of 15 year olds reporting regular alcohol drinking, and between 4.9% and 9.1% of 15 year olds having ever tried cannabis, with lowest alcohol drinking found in Leicester (1%) and lowest cannabis use found in Slough (4.9%).

How can we improve?

Because cannabis and alcohol use in young people is preventable we should **focus efforts on stopping young people from starting** rather than dealing with the consequences of their use later in life.

Prevention starts with **ensuring young people have the required knowledge and skills to make decisions for themselves** and so **drugs and alcohol should be a key part of PSHE** education in schools and peer led learning.

Once young people have initiated these behaviours, early intervention is crucial to ensuring that young people are able to access appropriate support to minimise ongoing harm.

What are we doing in East Sussex?

Effective approaches to addressing harmful drug and alcohol use in children and young people are being delivered through multiagency partnership working.

Specific health improvement activities delivered as part of ESBT and C4Y include:

- **Supporting delivery of high-quality PSHE education** in schools including alcohol and drug information.
- **Supporting the development of an East Sussex Drugs and Alcohol Protocol** for Schools.
- Commissioning a **social norms programme for secondary schools to prevent or delay** the uptake of risky lifestyle behaviours including drinking alcohol.
- Launching an **ambitious school grants programme to transform health and wellbeing** outcomes for children and young people.
- **Producing content on key health improvement topics (including alcohol) for** the East Sussex County Council (ESCC) website for **young people c360** with input and feedback from the ESCC Youth Cabinet.
- Reviewing findings of the East Sussex HRB survey to inform future work to address alcohol use in young people

East Sussex Alcohol Partnership Group (ESAPG) is working on two alcohol-related social marketing projects in Hastings:

- **A campaign to reduce drinking behaviour in 15-17 year olds** by highlighting to parents the impact of alcohol on brain development.
- **A service to reduce alcohol-related harm and alcohol-related A&E attendances in 17-25 year olds** through commissioning of a safe-space in central Hastings on Friday and Saturday nights.

What are we doing in East Sussex?

Hastings Borough Council has re-launched their Community Alcohol Partnership (CAP) which brings together a range of partners to tackle the problem of underage drinking and associated antisocial behaviour, partly through controlling the supply of alcohol to young people. **Eastbourne Borough council is planning to set up a CAP in 2017/18**. Challenge 25 (a proof of age scheme) is implemented across the county to reduce the availability of alcohol to young people.

For children and young people who develop drug or alcohol problems **East Sussex has a strong and well integrated multi-agency specialist drug and alcohol treatment service for people under 19** years. The school attendance service has also developed a specialist programme to work with pupils who are at risk of, or have been excluded from school due to use of alcohol or drugs.

A **substance misuse protocol for schools** has been developed, explaining the impact of drug and alcohol misuse on attendance and attainment, the impact of parental drug and alcohol misuse, and guidance on the preventative role of schools, as well as how they should deal with issues identified.

In line with best practice, and to enable primary care professionals to deliver extended brief interventions to young people aged 16 and 17 who are drinking harmfully, **MECC training is being delivered across the county and includes training in Alcohol Brief Interventions**.

In Hastings**, i-Rock a "one-stop shop",** run by a multi-agency team including ESCC key workers with access to mental health professionals, provides young people aged 14-25 access to a range of services including alcohol and drug advice.

East Sussex has adopted a **whole family response to parents presenting with problematic substance misuse** at level 3 (early help, and includes families within TF2) and level 4 (safeguarding) thresholds. Families at level 4 get a more specialist response. The aim for children is to enable them to cope in more adaptive ways i.e. not follow the pattern of their parents.

Key actions going forward

- **Implement the schools drug and alcohol protocol** through promoting to all schools and staff working in or with schools.
- **Ensure all schools adopt comprehensive, up to-date, evidence-based approaches to drug and alcohol education**, which incorporate peer-led learning and are in line with National Institute for Health and Care Excellence (NICE) guidance. This should be within statutory PSHE education.
- **Link specialist work to** reduce school absence amongst pupils with substance misuse problems into **broader school approaches to alcohol and drug education**.
- **Continue to support licensing to restrict availability of alcohol to young people** by ensuring purchasing of alcohol is made by individuals with valid forms of ID **e.g. Challenge 25** (a proof of age scheme).
- **Build on the social marketing work**, taking learning to other areas of the county.
- **Utilise findings from the East Sussex HRB survey** to further develop targeted interventions to address alcohol use in young people.

CHAPTER 4
School age/adolescence
4.5 Wellbeing

Percentage of young people aged 15 who report positive life satisfaction, by gender

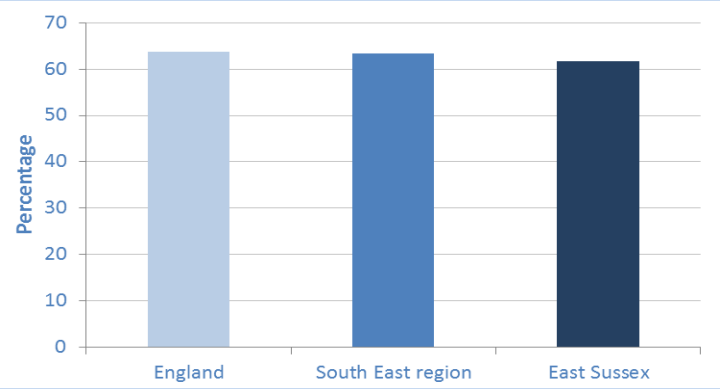
Key messages

- Wellbeing is a broad concept that has been defined as 'a dynamic state, in which individuals are able to develop their potential, work productively and creatively, build strong and positive relationships with others, and contribute to their community'.[27]
- Bullying and disruptive behaviours at school are linked with lower levels of wellbeing amongst young people, whilst higher levels of life satisfaction are linked to physical activity, reducing screen time (tv watching; computer gaming; internet surfing on tablet, iPad, or mobile phone), nutrition, and good mental health.
- Adverse childhood experiences (ACEs) such as bereavement, experiencing violence or parental substance misuse or poor mental health can reduce emotional wellbeing in the short term as well as having longer term impacts.
- In East Sussex just over 61.6% of young people reported positive life satisfaction in a 2014/15 national survey.
- In East Sussex, life satisfaction appears to be higher in boys than in girls.
- A range of interventions are being carried out to improve wellbeing in East Sussex including delivering parenting programmes, whole family approaches to tackle drugs and alcohol and domestic violence, and supporting the delivery of relationship and sex education in schools.

What is this indicator showing us?

We have used two different data sources for this indicator. The national What About Youth (WAY) survey data shows us the percentage of young people who report positive or high life satisfaction. The local HRB survey data shows the percentage of Year 10 pupils who report that they are 'quite happy' or 'very happy' with their life at the moment (in 2004/2007 the question was worded slightly differently).

Percentage of young people reporting positive life satisfaction in East Sussex, South East and England

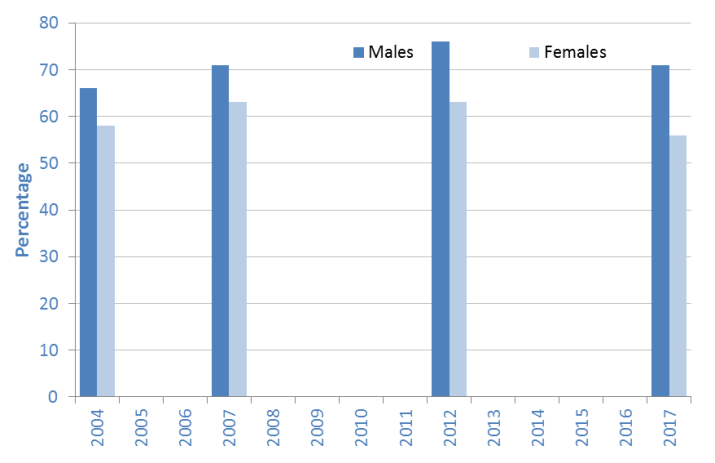


Latest data: In 2014/15, 61.6% of young people in East Sussex reported positive life satisfaction which is similar to England and South East.

Trends: Not available.

Source: PHE, WAY survey

Figure 4.5.1: Percentage of 15 year olds reporting positive life satisfaction in East Sussex, 2014/15



Latest data: In 2017, 63% of year 10 pupils in East Sussex reported positive life satisfaction. More boys (71%) than girls (56%) were satisfied with their life.

Trends: Fewer young people report positive life satisfaction compared to 2012. Fewer girls had positive life satisfaction in 2017 than in any previous local surveys.

Source: East Sussex Health Related Behaviour Surveys

Figure 4.5.2: Percentage of 15 year olds reporting positive life satisfaction in East Sussex by sex, 2004 to 2017

Why is this indicator important?

Children's wellbeing is an important issue as it is an indicator of young people's physical and mental health and it also reflects what is important to children and young people.

The Children's Society's Good Childhood report 2015 identifies that children with low wellbeing are reported to be

- **8x** as likely to feel there is conflict in their family.
- almost **5x** as likely to have been recently bullied.
- **3x** as likely to feel they do not have enough friends.
- **3x** as likely to feel they have a fewer resources than their friends.

Depression and other adverse health outcomes in later life are linked with having a low level of life satisfaction during adolescence.

ACEs such as bereavement, experiencing violence or parental substance misuse or poor mental health can reduce emotional wellbeing in the short term as well as having longer term impacts.

Where are we now in East Sussex?

In 2014/15 a slightly lower proportion of young people in East Sussex reported high wellbeing compared to the South East and to England, however the difference was not significant.

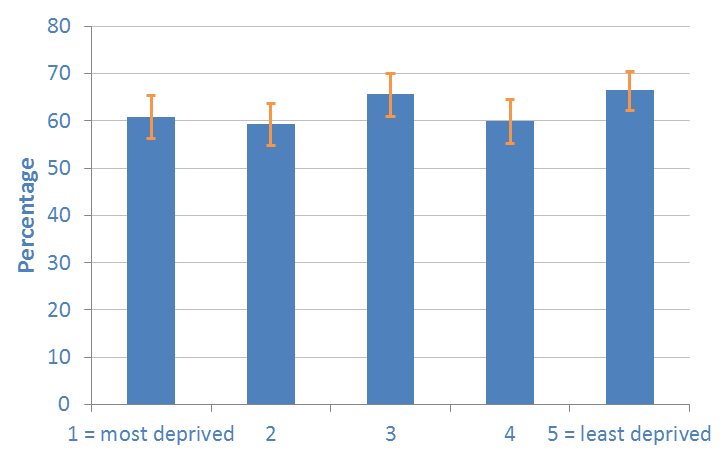
Data from the 2017 Health Related Behaviour survey of year 10 pupils shows that the percentage of pupils who are 'quite/very happy with life' has decreased over the last 5 years, with girls having lower levels of wellbeing than boys. Comparable data for England and the South East are not available.

Spotlight on inequalities

At national level there are differences in life satisfaction by age, sex and deprivation: The impact of gender is greater than that of deprivation with significantly more girls than boys having lower life satisfaction.

Age	Gender	Deprivation
there is a significant decline in levels of life satisfaction between ages 11 and 15 among girls	girls have a lower level of life satisfaction compared to boys – and this is seen in East Sussex	life satisfaction is lower in more deprived areas

At a local level there is a less clear relationship between deprivation and low life satisfaction



Latest: 2017 data do not show a strong relationship between deprivation and low life satisfaction with no statistically significant differences between quintiles.

Source: East Sussex Health Related Behaviour Survey

Figure 4.5.3: Percentage of year 10 pupils (14-15 year olds) who report that they are 'quite happy' or 'very happy' with their life at the moment in East Sussex by deprivation (IDACI quintiles), 2017

What does good look like?

The highest proportion of 15 year olds reporting positive life satisfaction in England is 70.4% (in Bath and Somerset). Reducing or eliminating differences in the proportion of people from different population groups who have low life satisfaction would be a good start. For example, more girls report low life satisfaction than boys, and young people from the most deprived decile are more likely to report low life satisfaction than those in the least deprived.

How can we improve?

Wellbeing is linked to all areas of health therefore **all of the actions outlined in this report will contribute to improving wellbeing** amongst children and young people. **Reducing inequalities is key** to improving wellbeing as is **promoting positive actions** which are associated with higher levels of life satisfaction: **Physical activity**; **reduced screen time** (screen time includes tv watching; computer gaming; internet surfing on tablet, iPad, or mobile phone); **good nutrition** and **good mental health** are all protective factors Figure 4.5.4 describes additional protective factors.

How can we improve?

Being bullied or displaying disruptive behaviours at school is linked with lower levels of wellbeing. Schools can ensure **robust anti-bullying programmes** are in place and work with children and young people to explore and address the reasons behind disruptive behaviours.

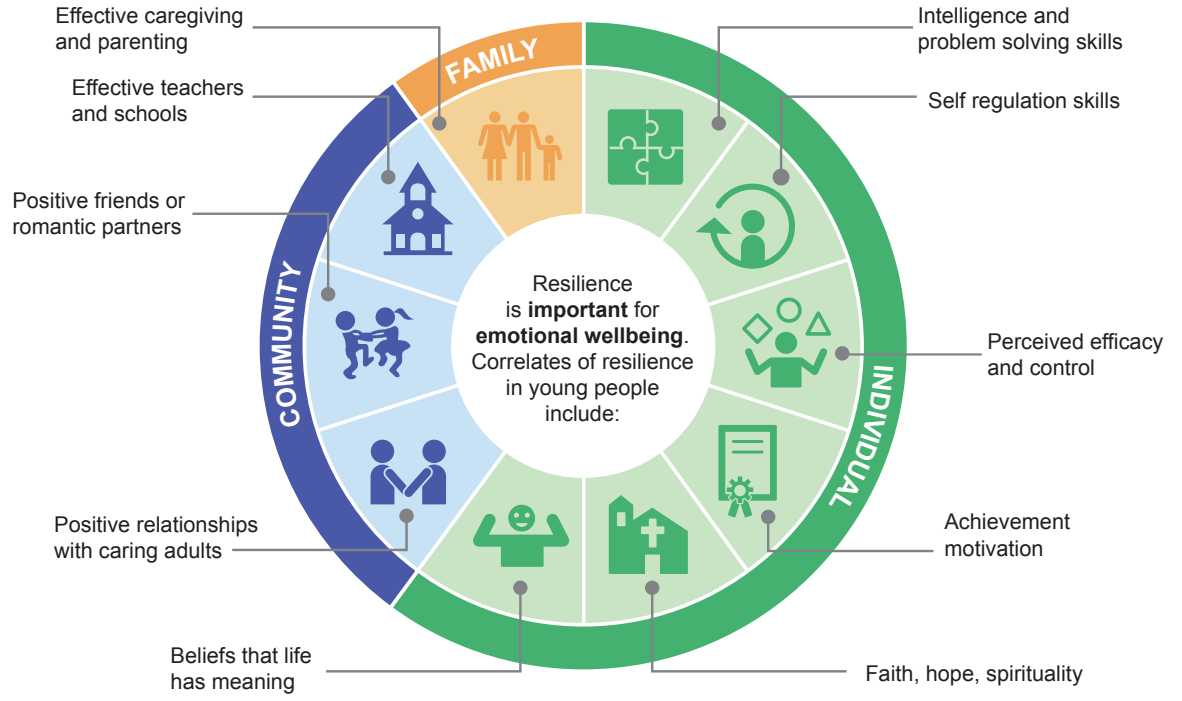
Ensuring that we have adequate services to support family relationships and also that children and young people are involved as far as possible in **helping to shape services** for them and that they have a 'voice' is a further key part of enhancing wellbeing.

Central to improving children's wellbeing is **gathering and acting upon information directly from children and young people** about their lives. The 2017 East Sussex Schools Health Related Behaviour Survey is key to this and it is important that the findings are acted upon.

The Children's Society recommends six priority areas that children and young people need to thrive:

- the right conditions to learn and develop.
- a positive view of themselves and a respect for their identity.
- enough of the items and experiences that matter to them.
- positive relationships with their family and friends.
- a safe and suitable home environment and local area.
- opportunities to take part in positive activities that help them thrive.

Resilience is the capacity to overcome adversity and to be able to identify and access resources which support wellbeing. The diagram below illustrates the factors associated with resilience. Enabling children and young people to access the protective factors and develop the required skills described below will improve wellbeing.



Source: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/575632/Mental_health_of_children_in_England.pdf

Figure 4.5.4 Building resilience (the ability to cope with adversity, adapt to change and navigate life in a way that brings the greatest reward)

What are we doing in East Sussex?

In addition to the work of the ESBT and C4Y Children and Young People's Mental Health and Emotional Wellbeing Transformation Plan (See 4.6), the following are some of the things we are doing to promote the positive mental health of children, young people and families in East Sussex:

- **Including mental health and wellbeing as priority areas in our ESBT and C4Y whole school health improvement transformation programme**.
- **Delivering parenting programmes** such as Triple P (Positive Parenting Programme) and HENRY (Healthy Exercise and Nutrition for the Really Young).
- **Supporting young people and their families where problems are identified through universal services and referring to Early Help**. More complex cases are referred to SWIFT (Safeguarding and Intensive Family Therapy) service.
- **Promoting an e-Learning module 'Understanding and Promoting Mental Health and Wellbeing'** produced by ESCC and available online for those working directly with families.
- **Anti-bullying work in schools.**
- **Supporting the delivery of high-quality PSHE education in schools** including relationships and sex education.

Key actions going forward

- **Promote protective and resilience factors** in young people's lives.
- **Consider the evidence-base for access to mindfulness** sessions in schools.
- Continue to **promote uptake of physical activity**.
- **Use the findings from the 2017 Schools Health-related Behaviour Survey** to shape further interventions.

CHAPTER 4
School age/adolescence
4.6 Mental health

Inpatient admission rate for mental health disorders in 0 to 17 year olds

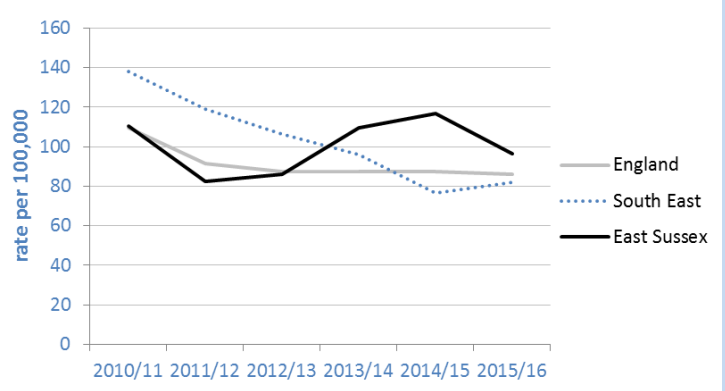
Key messages

- Mental health problems during childhood and adolescence are associated with a wide range of adverse outcomes in later life, including higher rates of adult mental health problems, poor educational outcomes, unemployment, low earnings, teenage parenthood, marital problems, criminal activity, and shorter life expectancy.
- Failure to treat mental health disorders in children can have a significant impact on their future; half of adults with long-term mental health problems experienced their first symptoms before the age of 14.
- Inpatient admissions for mental health disorders are indicative of early help for emerging mental health disorders not being available in a timely way or not being effective.
- East Sussex has a similar rate of hospital admissions for mental health disorders to England (2015/16 data).
- National data suggest that one in ten children aged 5-16 years has a clinically diagnosable mental health problem. There is on average a 10 year delay between young people displaying first symptoms and getting help.
- We are transforming mental health services for children through the East Sussex Children and Young People's Mental Health and Emotional Wellbeing Transformation Plan which is based on national guidance from 'Future *in Mind*'.

What is this indicator showing us?

This indicator shows the inpatient admission rate for mental health disorders per 100,000, 0 to 17 year olds in East Sussex.

Admission rates for 0-17 years for mental health disorders for East Sussex, South East and England.

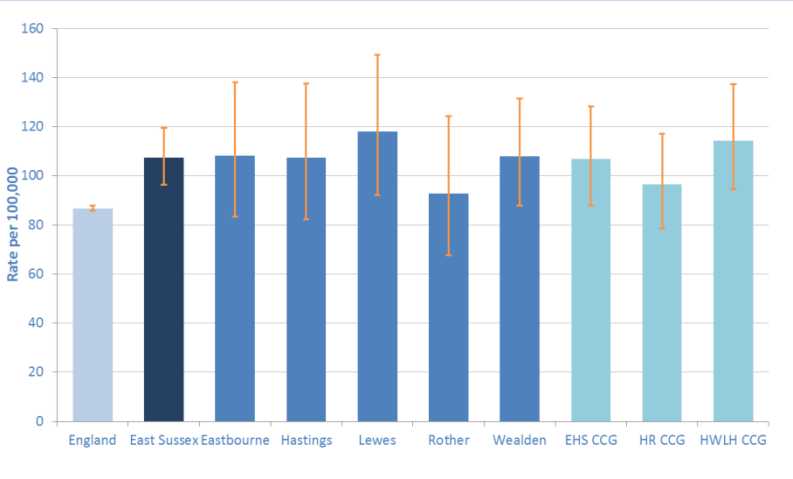


Latest data: The rate of hospital admissions for mental health disorders in East Sussex was 96 per 100,000, 0 to 17 year olds in 2015/16.

Trend: The rate in East Sussex was significantly higher than nationally between 2013/14 and 2014/15; although in 2015/16 the rate of admissions fell to a similar level to England.

Source: PHE, Child Health Profiles

Figure 4.6.1: Hospital admission rate per 100,000 population aged 0-17 for mental health disorders in East Sussex, 2010/11 to 2015/16



Latest data: District/Borough - between 2013/14 and 2015/16. Lewes had the highest rate of admissions of 0-17 year olds for mental health disorders (118 per 100,000), significantly higher than England (87 per 100,000), Rother had the lowest rate (93 per 100,000).

CCG: High Weald Lewes Havens CCG and Eastbourne, Hailsham and Seaford CCG (115 and 107 per 100,000) are significantly higher than England.

Source: NHS Digital, Hospital Episode Statistics (HES)

Figure 4.6.2: Hospital admission rate per 100,000 population aged 0-17 for mental health disorders in East Sussex by district/borough and CCG, (3 year average) 2013/14-2015/16

Why is this indicator important?

Poor adolescent mental health is the largest single health burden on children and young people, and part of the pathway for many causes of death in adolescence, most obviously suicide but also for many injuries and risky behaviours including substance use.

Efforts to improve resilience and mental health amongst young people are central to improving outcomes in this age group and in ensuring that young people can achieve their potential. Reducing exposure to ACE's is also important.

In the UK it has been estimated that:

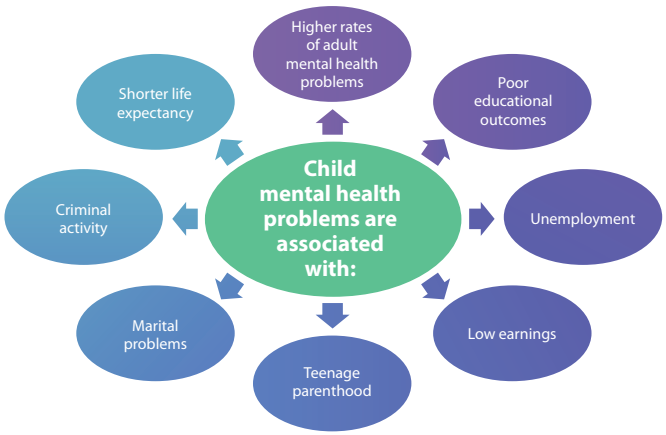
- **1 in 10** children (11% of boys and 8% of girls) aged 5 to 16 have a clinically significant mental health problem.
- **50%** of lifetime cases of diagnosable mental illness begin by age 14.
- **1 in 5** of those diagnosed with a mental disorder (1.9% of all children) have more than one category of mental disorder (co-morbidity).

These estimates are from the last comprehensive mental health survey in Great Britain in 2004. Much may have changed since this time and a new national survey is currently underway, with findings expected to be published in 2018.

A review of recent evidence of children and young people's mental health found that, on average, children wait up to 10 years between the first symptoms of a mental health problem and getting help. Although three quarters of parents of children with mental health problems seek help, only a quarter of children are reported to get help.

While any child can experience mental health problems, life events and circumstances mean that some children and young people are more vulnerable than others. Key risk factors include: living at the lowest income level, being a young offender, being a looked after child, being exposed to domestic violence, and having parents who misuse substances or who have mental health problems themselves.

Mental health problems during childhood and adolescence are also associated with a wide range of adverse outcomes in later life, including:



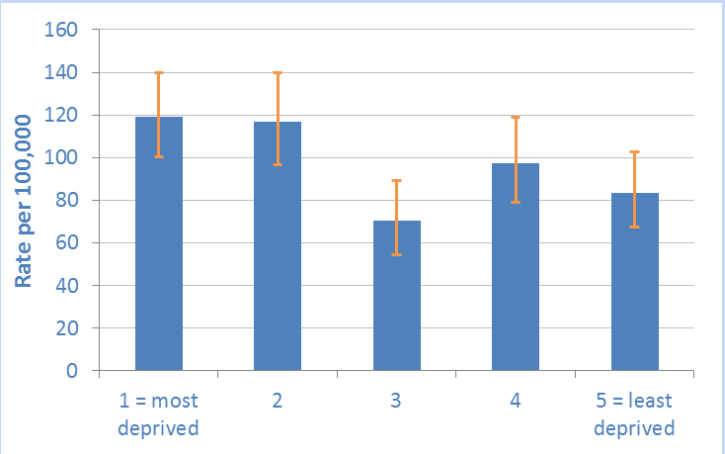
Public Health England (PHE) report that in 2012/13, NHS spend on child and adolescent mental ill health was estimated to be £700 million, 6% of the total mental health spend.

Where are we now in East Sussex?

Historically the rate of hospital admissions for mental health disorders amongst 0-17 year olds in East Sussex has been similar to the national average. However, in 2013/14 and 2014/15 the East Sussex rate was statistically significantly higher than England. In 2015/16 the admission rate for children and young people from East Sussex returned to being similar to the national rate.

Spotlight on inequalities

Children and young people who live in poverty have been found to have a higher chance of experiencing mental health problems and lower subjective wellbeing both as children, and as adults, compared to their wealthier peers. Children from the lowest income families have been found to be three times more likely to have a mental illness than children from the highest income families (15% vs 5%). The Marmot Review identified that the impact of growing up in poverty can also have long-term mental health consequences for children and young people, affecting educational attainment and social relationships, as well as leading to higher rates of depression and anxiety.



Latest data: There is no clear correlation between deprivation and admission rate for mental health reasons. Whilst admissions rates are higher in the two most deprived quintiles compared to the three least deprived, the only statistically significantly difference is quintile 3 having a significantly lower rate of admission compared to the most deprived two quintiles.

Source: Source: NHS Digital, Hospital Episode Statistics (HES)

Figure 4.6.3: Hospital admission rate per 100,000 population aged 0-17 for mental health disorders in East Sussex by deprivation (IDACI quintiles), (5 year average) 2010/11-2015/16

What does good look like?

Nationally areas in the lowest quartile of inpatient admissions for mental health disorders in 0-17 year olds have rates ranging from 33.8 (in Waltham Forest) to 66.3 per 100,000.

How can we improve?

Future in Mind published by the government's Children and Young People's Mental Health and Wellbeing Taskforce in March 2015, set out **proposals to reform services and improve outcomes for all children and young people including the most vulnerable**.

Prevention and early intervention were identified as key approaches to be adopted. These proposals informed the Five Year Forward View for Mental Health, which identifies the following as priorities to improve the emotional wellbeing and mental health of children and young people:

- A joint-agency approach, including action to intervene early, build resilience, and improve access to high-quality, evidence-based treatment for young people, their families and carers.
- A national target for the NHS to reach at least 70,000 more children and young people annually from 2020/21 should increase access to at least 35% of those with a diagnosable condition locally, based on current estimates.
- CCGs to commission improved access to appropriate, 24/7 crisis resolution and liaison mental health services in the community.
- By 2020/21 all areas to have evidence-based community eating disorder services; ensuring 95% of children in need receive treatment in one week for urgent cases, and four weeks for routine cases.
- In-patient stays will only take place where clinically appropriate, will have the minimum possible length of stay, and will be as close to home as possible to avoid inappropriate out of area placements. There will be no inappropriate use of paediatric and adult ward beds by 2020/21.
- Inappropriate placements to in-patient beds will be eliminated, including both placements to inappropriate settings and to inappropriate locations far from the family home by 2020/21.
- At least 1,700 more therapists and supervisors will need to be employed by 2020/21 to meet the additional demand.

Child and adolescent mental health is a key area in the State of Child Health report which makes the following recommendations:

- **All child health professionals** including those in primary care **should be trained** so they are confident **in dealing with children and young people presenting with mental health problems** wherever the setting.
- **Early identification of mental health difficulties and first level interventions** should be **established as a core capacity of all education, youth justice and social care professionals** who work with children – as well as health professionals in primary care and the community. This will require major investment into training and workforce development.
- In terms of services, there is a need for **better coordinated working across education, health, youth justice and social care** with all recognising the role they play in prevention and early intervention in emerging mental health problems.
- Further work is needed to **reduce the stigma of seeking help for mental health problems**, particularly amongst young men.
- **Increased capacity across the tiers of mental health services, including specialist Child and Adolescent Mental Health Services (CAMHS)** is a widely recognised need across the UK, with poor access, long waiting times and high symptom thresholds all identified as key issues needing to be addressed.

What are we doing in East Sussex?

The ESBT and C4Y Children and Young People's Mental Health and Emotional Wellbeing Transformation Plan is the CCG led multi-agency action plan, working to transform mental health services in East Sussex in line with the vision described in *Future in Mind* through the allocation of the additional NHS funding provided for children and young people's mental health services.

Workstreams of the Transformation Plan are:

Raising Resilient Children

- Supporting Schools to improve their wellbeing and mental health offer to pupils by ensuring mental health is a priority for senior leadership, communicating the offer available to schools, providing information and considering training needs. Alongside this the East Sussex whole school Health Improvement transformation programme has offered grants to all schools in East Sussex to develop and implement transformational plans to improve health and wellbeing and includes a priority area of mental health and wellbeing
- Improving access to early intervention e.g. Primary Mental Health worker drop in, and multiagency support I-Rock clinic with access to key workers, mental health, housing, drug and alcohol advice.
- Reducing waiting times and thresholds by increasing online support.

Supporting vulnerable children and young people

- Improving access to Sexual Assault Referral Centres and improving the offer of support to victims of sexual assault, abuse or exploitation.
- Providing access to mental health support for young people in the Youth Justice System.
- Service review of the offer to looked after and adopted children.

Single Point of Advice → Access

- Exploring benefits of a single referral point for safeguarding concerns, early help and referrals to CAMHS to streamline access to services and reduce duplicate referrals to different front doors.

Workforce Development

- Following a workforce competency audit, developing training plans to meet identified gaps in skills and knowledge.
- On-line learning modules available for schools, early help staff and social workers.

Implementing the NHS England Five Year Forward View

- Improving perinatal mental health services.
- Ensuring at least 35% of children and young people with a diagnosable mental health condition receive treatment from an NHS funded service by 2020.
- Provide 24/7 crisis resolution mental health services for children and young people.
- Developed a new community eating disorder service.

Communications and Engagement

- Ensuring children and families are aware of sources of help including online services.
- Sponsored production of top 10 tips for schools leaflet by the Youth Cabinet and Download (CAMHS service users) group.

Key actions going forward

- **Deliver the East Sussex Children and Young People's Mental Health and Emotional Wellbeing transformation plan**, in particular the training and workforce elements, and improving access to early interventions.
- **Ensure all health, social care, youth justice and education professionals who work with children and young people are equipped with the skills and knowledge** to ensure children and young people with mental health needs get the support they need as early as possible.
- **Promote healthy physical, mental and social health** through statutory, comprehensive, evidence-based personal health and social education in all schools.
- **Ensure that specialist CAMHS have sufficient capacity** to meet the needs of children and young people.

CHAPTER 4
School age/adolescence
4.7 Self-harm

Inpatient admission rates for self-harm in 10-24 year olds

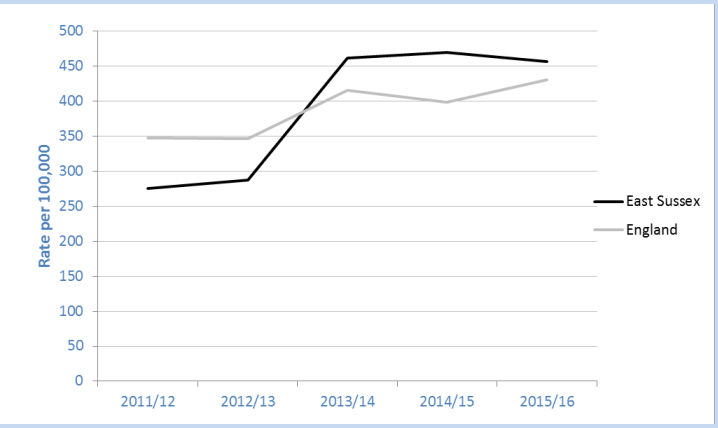
Key messages

- Self-harm, including attempted suicide, is the single biggest indicator of suicide risk.[28]
- People self-harm as a way of dealing with overwhelming mental or emotional distress such as exposure to domestic violence, bereavement or other adverse childhood experiences.
- There are many different ways of self-harming but the main reason for hospital admission is self-poisoning/overdose.
- The self-harm admission rate for East Sussex 10-24 year olds is around 457 per 100,000. This has risen from around 275 per 100,000 in 2011/12 and is now similar to the England rate.
- Within East Sussex, rates of self-harm admissions are highest in Hastings and lowest in Wealden.
- Self-harm is identified as a key issue in the East Sussex Suicide Prevention Action Plan and the East Sussex Young People's Mental Health and Emotional Wellbeing Transformation Plan.
- The focus of preventive work should be on promoting resilience, and early recognition and provision of help, particularly in schools and colleges.
- NICE guidance is available to guide management of those presenting in the National Health Service (NHS).

What are these indicators showing us?

These indicators show us the standardised hospital admission rate for self-harm per 100,000 young people aged 10-24 years in East Sussex and England for the period 2011/12 to 2015/16; and the rolling three year average hospital admission rate for self-harm per 10,000 young people aged 10-24 years in East Sussex and districts and boroughs for the period 2008/09-2010/11 to 2013/14-2015/16.

Hospital admission as a result of self-harm: per 100,000 age 10-24 years

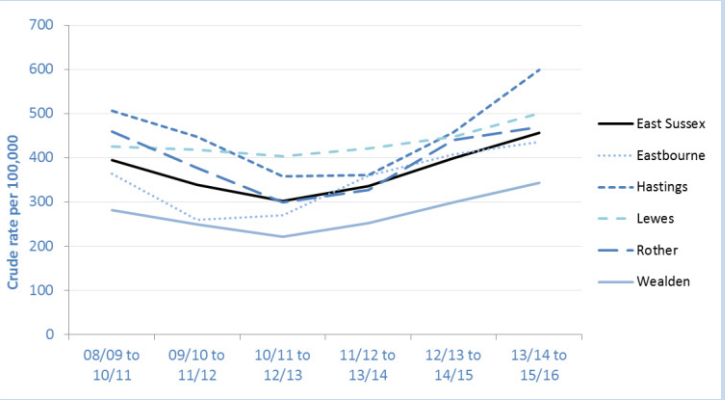


Latest data: In 2015/16 the East Sussex hospital admission rate for self-harm in 10-24 year olds was similar to that of England.

Trend: In 2011/12 the East Sussex hospital admission rate for 10-24 year olds was significantly lower than the rate for England. However, the East Sussex rate rose rapidly from 2012/13 and in 2013/14 and 2014/15 it was significantly higher than the England rate.

Source: PHE, Child Health Profile

Figure 4.7.1: Age-standardised hospital admission rate per 100,000 population aged 10-24 for self-harm in East Sussex, 2011/12 to 2015/16



Latest data: Admission rates for self-harm are highest in Hastings and lowest in Wealden. Rates in Wealden are significantly lower than East Sussex for all years shown whilst Hastings is significantly higher for the first two periods and the latest period. Lewes is significantly higher for the periods between 2010/11 and 2013/14.

Trend: three year average rates have increased in all districts and boroughs since 2011/12 with least variation in Lewes and most in Hastings.

Source: East Sussex Public Health SUS extracts.

Figure 4.7.2: Hospital admission (crude) rate per 100,000 population aged 10-24 for self-harm in East Sussex by district and borough, (3 year rolling average), 2008/09 to 2015/16.

Why is this indicator important?

Self-harm is when someone intentionally damages or injures their body when they are experiencing mental and emotional distress in order to deal with overwhelming feelings. Examples of distress include exposure to domestic violence, bereavement or other adverse childhood experiences, in addition to the risk factors listed below. It is a very common behaviour in young people and affects around one in 12 children in the UK, with 10% of 15-16 year olds self-harming.

Around 25,000 young people are sent to A&E every year as a result of their injuries from self-harming.[29] Whilst there may be initial emotional relief from self-harming, this does not last long, and does not address the underlying problems. Continuance of the behaviour can also stop the person learning more effective strategies for dealing with their feelings.

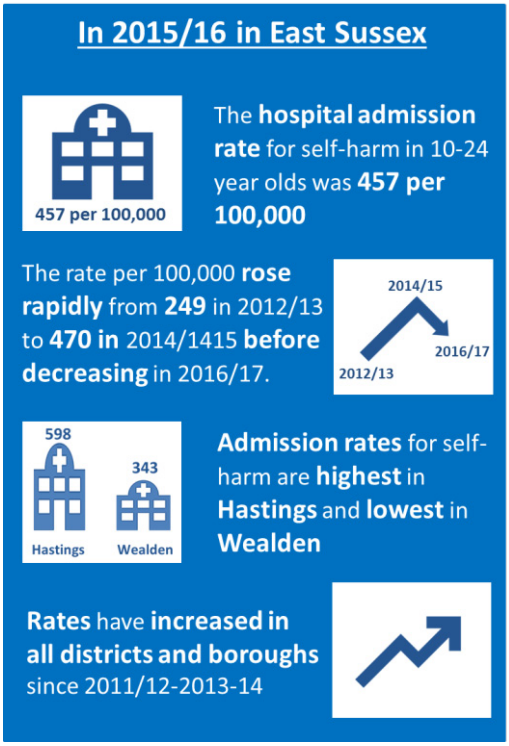
Some people are more likely to self-harm than others:

- Those with experience of a mental health disorder including depression, anxiety, borderline personality disorder, and eating disorders.
- LGBT people.
- Young person who are not under the care of their parents, or young people who have left a care home.
- Having been bereaved by suicide.

People who self-harm usually do not want to die; in fact they may be using self-harm as a way to help them go on living. However, self-harm, including attempted suicide, is the single biggest indicator of suicide risk. Approximately 50 per cent of people who have died by suicide have a history of self-harm, and in many cases there has been an episode of self-harm shortly before someone takes their own life.[30]

There are many different ways of self-harming but the main reason for hospital admission is self-poisoning/overdose. The latest national data show a higher prevalence of hospital admissions for self-harm in girls aged under 17 years compared to boys aged under 17 years. The impact of a young person's self-harm on the family can be devastating and can include emotional distress, shame, and helplessness.[31]

Where are we now in East Sussex?

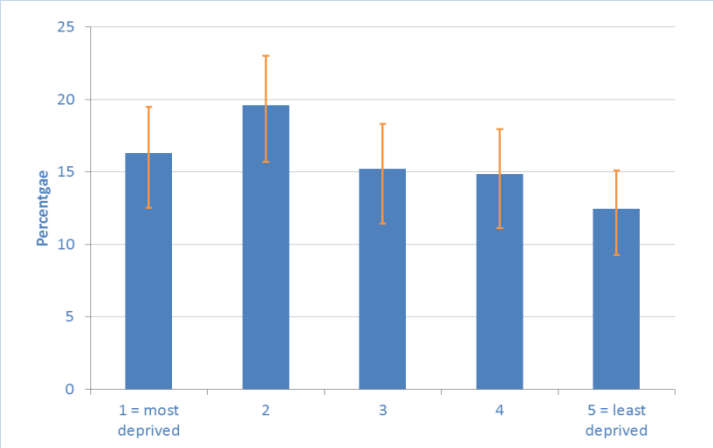


A review of local data by age group in 2013/14 – 2015/16 found that rates of A&E attendances and hospital admissions for self-harm are highest for young people (10-24 years) than the other age groups.

The most recent East Sussex Health-Related Behaviour Survey (June 2017) of Year 10 pupils asked a question about self-harm for the first time. Sixteen percent of Year 10 pupils (14–15 years old) admitted that they cut or hurt themselves sometimes, usually or always in response to a problem that worries them or when they are feeling stressed. This percentage was higher in girls (21%) than boys (11%). This finding reflects the concerns expressed over the last few years about the increase in self-harm amongst young people.

Spotlight on inequalities

There is some national and international evidence that deliberate self-harm is associated with deprivation particularly in urban areas



Latest data: Data from the 2017 East Sussex Health Related Behaviour Survey were analysed to see if deprivation was a factor in self-harm but there is no clear relationship with deprivation.

Source: East Sussex Health Related Behaviour Survey

Figure 4.7.3: Year 10 pupils who sometimes, usually or always cut or hurt themselves in response to a problem that worries them or when they're feeling stressed (by East Sussex IDACI quintile)

What does good look like?

The English region with the lowest rate of hospital admissions for self-harm is London (209.5 per 100,000) and that with the highest, the South West (597.8 per 100,000). Rates vary within each region: the Local Authority with the lowest rate in England is Thurrock (103 per 100,000) and that with the highest Blackpool (1,445 per 100,000). The East Sussex rate is somewhere in between these rates (457 per 100,000) and similar to the England rate of 431 per 100,000.

How can we improve?

From a population perspective, **primary prevention of self-harm is about promoting resilience** in children and young people (for example by teaching effective coping strategies) and reducing the risk factors for poor wellbeing and for mental ill-health (See Chapter 4.5 and 4.6).

Secondary prevention focusses on **early recognition** of self-harm and then **helping children and young people to address their underlying problems** (e.g. bullying, family issues) and teaching them alternative ways of coping.

The Care Quality Commission in their report *Right Here, Right Now*, highlighted the lack of sympathy and other negative experiences people reported from their contact with NHS professionals. NICE self-harm guidance and quality standards outline best practice in the short-term management following an act of self-harm.

The importance of undertaking psychosocial assessments for those presenting at A&E is emphasised.

The Prevention Concordat for Better Mental Health has developed a Return on Investment Tool which demonstrates the cost effectiveness of **investing in psychosocial interventions for people attending A&E as a result of a non-fatal self-harm event.**

In 2007 the Royal College of Psychiatry, Young Minds and the Charlie Memorial Trust (a charity which focuses on the mental health and wellbeing of young people) launched 'No harm done', a series of films and toolkits that set out practical steps for young people, parents and health professionals to identify, understand and address self-harm. These are available on the Royal College of Psychiatry web-site.

What are we doing in East Sussex?

The personal and community resilience programme focuses on improving health and wellbeing across East Sussex. The East Sussex Children and Young People's Mental Health and Emotional Wellbeing Transformation Plan has also focussed on raising resilient children.

- **Self-harm is identified as a key issue in the East Sussex suicide prevention action plan**. The need to embed best practice in self-harm prevention across all agencies is highlighted in the East Sussex Children and Young People's Mental Health and Emotional Wellbeing Transformation Plan. The Local Safeguarding Children's Board also have an interest in self-harm and suicide prevention.
- Initial work of the suicide prevention group has been on **raising awareness of self-harm and its links with suicide**. Earlier this year, the group held an exploratory meeting on self-harm, inviting representatives from a range of organisations including those working with children and young people.
- **Analysis of local self-harm data** (available on the Joint Strategic Needs and Assets Assessment (JSNAA) web-site) was used to illustrate the local picture and generate support for more work to prevent self-harm, and ensure effective assessment and treatment is provided in line with the NICE Quality Standard. Using the NICE guidelines as the benchmark, **a self-harm audit was conducted in the A&E department of Eastbourne District General Hospital** (EDGH) in 2013 and again in 2014.

Key actions going forward

- **Continue to promote children and young people's mental health and wellbeing** through the ESBT and C4Y personal and community resilience programme and the East Sussex children and young people's mental health and wellbeing transformation plan.
- **Ensure mental health awareness training is available** for those working with children and young people.
- **Review referral pathways for self-harm** in children and young people.
- **Conduct a self-harm audit in the Conquest Hospital**.
- **Conduct a re-audit of self-harm in EDGH** to establish whether the recommendations of previous audits have been implemented.

CHAPTER 4
School age/adolescence
4.8 Suicide

Suicide rate amongst young people aged 15 to 19 years

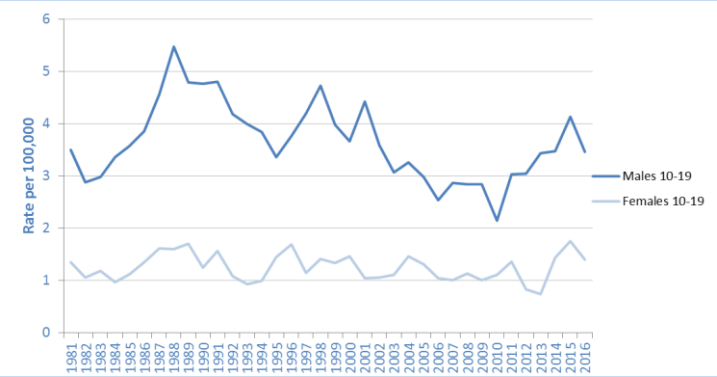
Key messages

- In East Sussex, suicide is the second most common cause of death in young people aged 15 to 19, and accounts for 18% of deaths (16 deaths from suicide in the last 10 years).
- In young people, suicide is strongly linked with self-harm, bereavement, poor mental health, alcohol and drug misuse, abuse, academic pressures, and bullying.
- Suicide is preventable: improving emotional and mental health support and limiting access to the means of suicide are essential to reduce suicide rates amongst young people.

What is this indicator showing us?

This indicator shows the rate of completed suicides amongst young people aged 15 to 19 years per 100,000. A three-year moving average has been used to smooth fluctuations due to small numbers in each year.

Suicide rates among males and females aged 10-19 in England and Wales

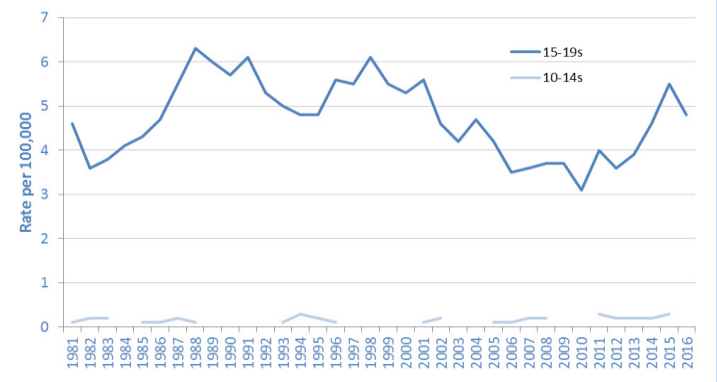


Latest data: Across England and Wales in 2016 there were 117 registered deaths as a result of suicide amongst 10-19 year olds. Rates are much higher amongst boys (3.5 per 100,000) than girls (1.4 per 100,000).

Trend: Rates of suicide amongst girls aged 10-19 have remained fairly static over the last 30 years. Rates amongst boys increased between 1983 and 2001 where they dropped to a rate of 2.1 per 100,000 in 2010. Rates then rose until 2015.

Source: ONS, Suicide Statistics

Figure 4.8.1: Suicide rate per 100,000 population aged 10-19 in England and Wales by sex, 1981 to 2016



Latest data: Suicide rates in England and Wales for 2015 were 0.3 per 100,000 for 10-14 year olds and 5.5 per 100,000 for 15-19 year olds.

Trend: Rates of suicide amongst 10-14 year olds have remained very low over the last 30 years. Rates amongst 15-19 year olds increased between 1982 and 2004 before dropping to a low of 3.1 per 100,000 in 2010. Rates then rose until 2015.

Source: ONS, Suicide Statistics

Figure 4.8.2: Suicide rate per 100,000 population aged 10-19 in England and Wales by age group, 1981 to 2014

Why is this indicator important?

Suicide is the second most common cause of death in people aged 15-19 years, accounting for 18% of deaths in this age group.

The suicide rate is one of the key indicators of the mental health of young people and is strongly linked to:

Suicide is considered a key measure of young people's mental health. At a national level, policy actions such as reducing paracetamol pack sizes, have contributed to reduced all-age suicide rates over the past two decades, although this reduction in national all-age rates has not been mirrored in East Sussex. Office of National Statistics (ONS) data show that over the past decade for all-age suicides, hanging has replaced self-poisoning as the most common method of suicide for both females (42%) and males (55%). Other methods include self-poisoning, drowning and falls.

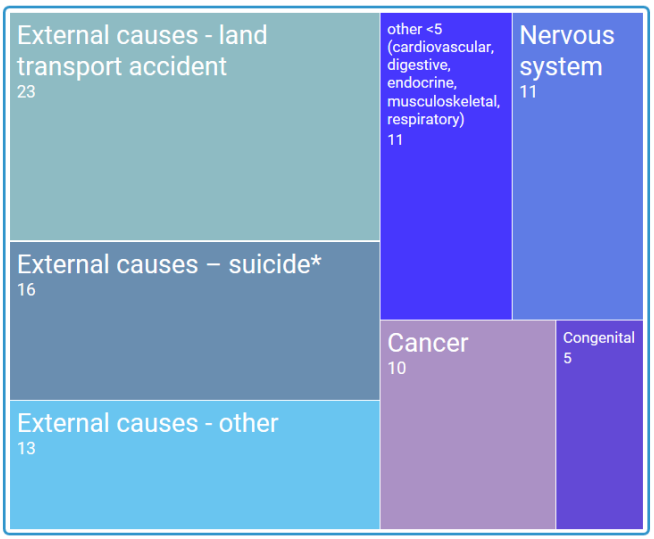
Not all young people in East Sussex who die due to suicide had been in contact with mental health services prior to their death, suggesting that services are not meeting the needs of young people.

Where are we now in East Sussex?

Suicide is preventable and the aim should be for no young person to die from suicide. In East Sussex, during the 10 year period 2006-2015 there were 16 deaths by suicide among 15-19 year olds, almost all of the deaths were of males.

After land transport accidents, suicide was the next most major cause of death (of the categories shown) for East Sussex males aged 15-19. Deaths due to suicide accounted for 18% of the deaths of all 15-19 year olds and 22% of the deaths of 15-19 year old males. The small numbers mean that rates of deaths are likely to change significantly if there is one additional or fewer deaths.

Deaths of East Sussex residents aged 15-19, 2006-2015 inclusive by cause of death



Source: NHS Digital, Primary Care Mortality Database

Spotlight on inequalities

Analysis of national data found that young males are, on average, three times more likely to take their own lives than their female counterparts. There is a strong link between suicide rates and deprivation, with those living in a deprived area having an almost 80% higher risk of suicide than those from the most affluent areas

The small number of suicide deaths among young people in East Sussex means that it is not possible to analyse these by deprivation.

What does good look like?

Across England in 2014 there were 142 suicide deaths (deaths as result of intentional self-harm and deaths registered as undetermined intent) of 15-19 year olds. The combined suicide rate for 2014 was 43.9 per million people aged 15-19 in England, this is lower than rates in Northern Ireland (122.9 per million), followed by Wales and Scotland (69 and 54.7 per million respectively)

How can we improve?

Suicide is preventable and actions should be implemented to support the aim for no young person in East Sussex to die due to suicide.

A national report looking at suicides in young people under 25 in 2014 and 2015 identified the following important themes:

- **support for family factors** e.g. poor parental mental health, physical health or substance misuse.
- childhood abuse.
- bullying, social isolation.
- mental ill-health, physical ill health and alcohol or drug misuse young people.

By **ensuring that young people are supported with the appropriate services** and that all **staff** who work with young people are **able to identify, support and signpost to effective mental health services**, we can reduce the number of suicides in young people in East Sussex. Many children who die from suicide receive inadequate mental health support services. A 2006 study by the Confidential Enquiry into Maternal and Child Health found many children did not have any contact with mental health services before death, while others did not receive appropriate follow-up care relating to previous mental health problems or self-harm.

There is a particular need to **increase targeted support services for young males**. Young men who die by suicide were less likely to have had contact with mental health services than young women, and they were also less likely to show signs of concern before death.[32]

Other support needs identified are **young people who have been bereaved** , **mental health services at colleges and universities**, mental health care for **looked after children** and mental health support for **LGBT young people** are also identified as important.

Flexible transition to adult services would also help prevent at risk young people falling out of contact with services.

The Royal College of Paediatrics and Child Health report *Why Children Die* recommends that the government take further steps to restrict children and young people's access to alcohol by the introduction of a minimum price per unit, regulation of marketing and availability, and action on under-age sales.

What are we doing in East Sussex?

- The East Sussex suicide prevention action plan is structured around the key actions of the national strategy and includes the consideration of suicide in young people.
- A project to **reduce suicide in men** has recently commenced. This includes a campaign to **reduce the stigma of help-seeking** which, although not specifically aimed at 15-19 year olds, should raise population awareness and reduce stigma.
- The East Sussex Children and Young People Mental Health and Emotional Wellbeing Transformation Plan aims to **increase the resilience and emotional wellbeing** of children and young people in East Sussex, and **improve prevention and early recognition of mental health problems**.
- There are plans to **skill up the wider children and young people's workforce**, including schools, to recognise emerging signs of mental health problems and to feel confident in supporting young people.
- **Support for young people in crisis** has been commissioned.
- East Sussex Early Help service has a family approach with built in **support for parents of children or young people who self-harm.**
- East Sussex Public Health commissions a range of programmes designed to transform health and wellbeing outcomes for children and young people:
- **High quality PSHE education support for all schools** through the PSHE Association which includes quality curriculum resources for teaching about mental health
- An ambitious school health improvement grants programme which provides funding and evidence-based recommendations to support schools to promote the emotional wellbeing and mental health of pupils.
- Section 4.4 of this report describes the work in place to reduce alcohol consumption in young people in East Sussex.

Key actions going forward

Ensure all health, social care, youth justice and education professionals who work with children and young people are equipped with the skills and knowledge to ensure children and young people with mental health needs get the support they need as early as possible.

- Support the role and importance of schools in relation to children and young people's health through providing clear information, advice and pathways.
- Ensure that paediatric and specialist CAMHS services have sufficient capacity to meet the needs of children and young people before they reach crisis.

CHAPTER 4
School age/adolescence
4.9 Road Traffic Injuries

Number of children and young people killed or seriously injured on the roads

Key messages

- In East Sussex, road traffic accidents are the main cause of death in young people aged 15-19 years, accounting for approximately 1 in 4 deaths in this age group.
- East Sussex rates of children aged 0-15 who are killed or seriously injured on the road are similar to England and have slightly reduced over the last five years.
- East Sussex has significantly higher rates of young people aged 15-24 years killed or seriously injured on the road in both cars and motorbikes compared to national rates.
- There is a two year Road Safety Programme to reduce those killed or seriously injured on East Sussex roads.
- Data sources may use the term "accident" although road safety professionals now use the terms "collision" or "crash" instead.

What are these indicators showing us?

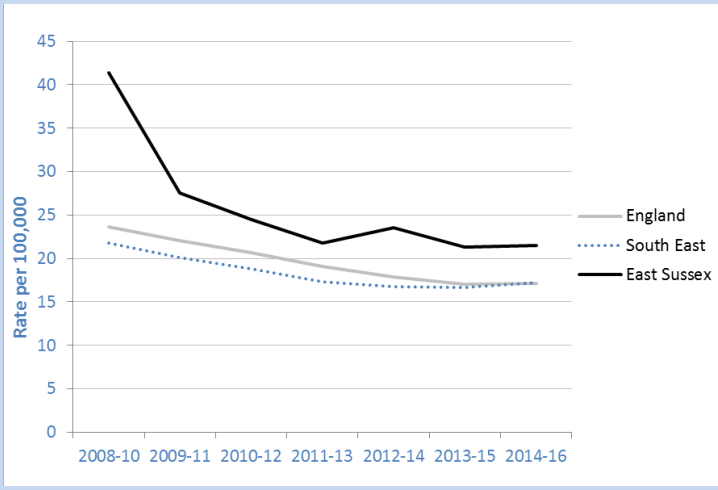
Three indicators have been used:

The number of children aged 0-15 who have been reported killed or seriously injured on England's roads per 100,000 population.

The number of young people aged 15-24 who were reported as motorcyclists killed or seriously injured in a road traffic accident per 100,000 population.

The number of car occupants aged 15-24 who were reported as killed or seriously injured in a road traffic accident per 100,000 population.

Road Traffic accidents and deaths involving children and young people



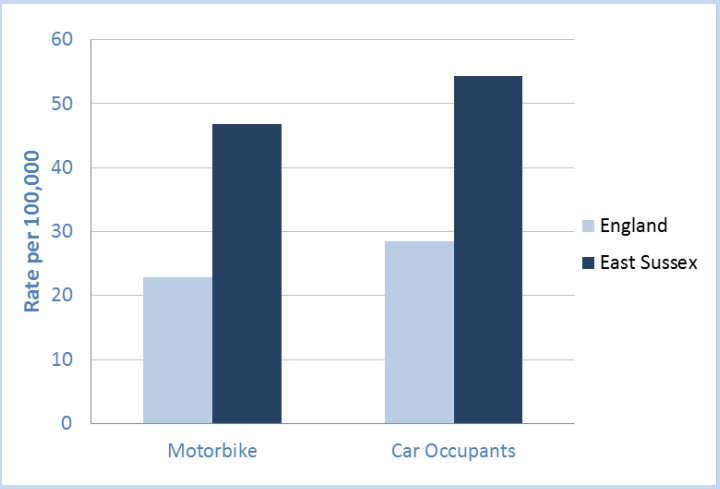
Latest data: 21.5 per 100,000 0-15 year olds were killed or seriously injured on the roads in East Sussex in 2014-2016.

Trend: Between 2008-10 and 2014-16 there has been a decrease in the rate of road traffic injuries and mortality in East Sussex, although from 2009-11 this has been a smaller rate of decrease.

Source: PHE, Unintentional Injuries Profile

Figure 4.9.1: Rate per 100,000 population aged 0-15 who were killed or seriously on the roads in East Sussex, 2008-10 to 2014-2016

15-24 year old motorcyclists and car occupants killed or serious injured in a road traffic accident, England and East Sussex, 2011-2015



Latest data: The rate of 15-24 year olds killed or seriously injured on motorbikes and the rate as car occupants in East Sussex are more than twice as high as the England rates for the period 2011-2015.

Source: PHE, Unintentional Injuries Profile

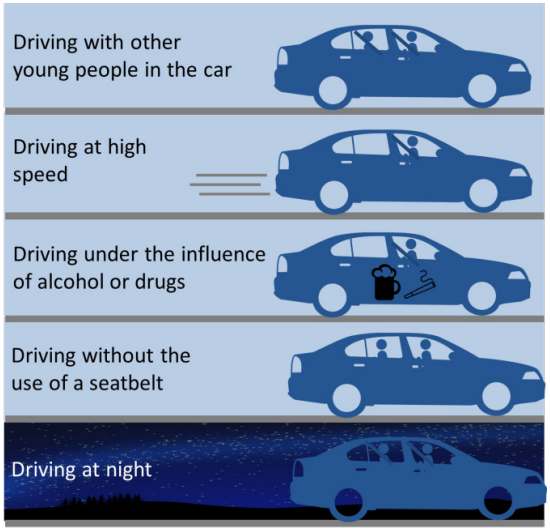
Figure 4.9.2: Rate per 100,000 population aged 15-24 who were killed or seriously injured in a road traffic accident in East Sussex by motor vehicle type, 2011-15

Why are these indicators important?

Road traffic injuries are the leading cause of death for people aged 15-19 years in East Sussex. We are an outlier nationally for the rate of those killed or seriously injured on the roads. Injuries sustained as a result of non-fatal collisions have major long-term implications for physical and mental health, as well as for educational attainment and employment prospects.

Although young drivers aged 17 to 19 years make up only 1.5% of full UK licence holders, nearly one in ten fatal and serious crashes involve a driver of that age.

As well as being young, male and inexperienced in handling driving situations, other factors contributing to increased risk of car injuries in young people are:



It is suggested that these factors relate to developmental immaturity in the adolescent brain, particularly in relation to having other young people in the car and the impact that has on decision-making.[33] Ongoing monitoring of those Killed or Seriously Injured (KSI) on the roads in East Sussex is vital for assessing the effectiveness of interventions designed to improve young driver safety.

Taking a wider perspective about the impact of traffic accidents on child health, concerns about traffic speed and the risk of accidents mean that many parents are reluctant to let children walk or cycle on daily journeys. This reduces children's ability to be physically

active and to gain the benefits of physical activity.

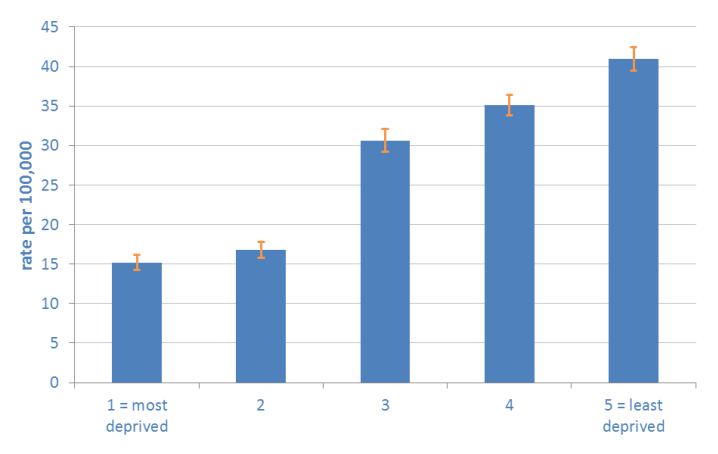
Where are we now in East Sussex?

KSI rates for 0-15 year olds in East Sussex have decreased since 2008-2010. Trend data are not available for KSI rates for 15-24 year olds. However, as this age group makes up a high proportion of all KSIs (24% in 2011-13), and the all age KSI rate for East Sussex increased between 2009-11 and 2013-15, it is unlikely that the KSI rate for 15-24 year olds is decreasing.

KSI rates for young people cannot be broken down by district and borough but we know that overall KSI rates are higher in Rother and Wealden, the more rural districts of the county.

Spotlight on inequalities

Social deprivation is linked to an increased risk for all types of road crashes and fatalities in children under the age of 15 years, including pedestrians and cyclists. These social gradients appear less for teenage drivers, with higher rates of injuries across all socioeconomic groups amongst this age group. For young people aged 15-24 there appear to be higher rates of death or serious injury in those from less deprived areas.



Latest: The killed and seriously injured rate for young people shows that car occupants from less deprived upper tier local authorities are more likely to be KSI than those from more deprived local authorities.

Source: PHE, Unintentional Injuries Profile

Figure 4.9.3: Car occupants aged 15-24 years killed or seriously injured in road traffic accidents rate per 100,000 population aged 15-24 in England by deprivation (IMD quintile), 2011-15

What does good look like?

East Sussex has significantly higher rates of KSI for both motorcyclists aged 15-24 years and for car occupants aged 15-24 compared to England during the five year period 2011-2015. The motorcycle KSI rate was 46.8 per 100,000 population, which is significantly higher than the England rate of 22.9 per 100,000. The rate of KSIs for 15-24 year old car occupants during the same period was 54.4/100,000 population, again significantly higher than the England rate of 28.5/100,000.

In contrast to the East Sussex data showing increased KSI rates in rural areas, the lowest KSI rates for motorcyclists and car occupants aged 15-24 are 5.9 and 1.5 in the London city areas of Newham and Westminster respectively. The lowest rate for 0-15 year olds killed or seriously injured in a road traffic accident is in Bracknell Forest (1.4 per 100,000).

How can we improve?

Road traffic injuries are preventable, and we must aim to reduce the incidence of road traffic deaths and injuries in young people, particularly in those aged 15-19 years.

There are many **aspects of road design and transport policy that would reduce traffic injuries** across all age groups, for example improving visibility at junctions where there have been accidents. Road safety experts have also **identified lack of driver attention and carelessness as key areas to address** to reduce accident rates.

What are we doing in East Sussex?

- Funding from the Public Health Grant has been provided to **implement a two year Road Safety Programme** aimed at supporting a reduction in the number of people KSI on East Sussex Roads and improving overall road safety.
- The focus is on projects designed to **change driver behaviour** alongside work to **improve road safety through targeted infrastructure and speed management schemes**. The national Behavioural Insights team have been employed to support the development of the programme. They have sought to understand what increases the likelihood of KSI collisions in East Sussex and to develop and support the **implementation of evidence-based behavioural interventions**.
- Young drivers (17-24 years), particularly **young male drivers**, have been identified as a priority group as they are both disproportionately likely to be involved in, and to cause, KSI collisions. Another key group are **motorcyclists**, which includes young men although research identified older men as one of the target groups in this category. The third priority group **are car drivers in general in relation to their behaviour around vulnerable road users** (motorcyclists, pedestrians, cyclists and horse riders), many of whom will be young people.
- The East Sussex Safer Roads Partnership introduced one of the first **permanent average speed cameras** in the country within Hastings.
- **Winter tyre checks** are being introduced following a similar successful campaign last year which won an Online Media Award.

Key actions going forward

- **Implement work on behaviour change** to address these key risk groups and any issues identified through detailed data analysis. For example, **testing the effect of different messages on young drivers' engagement** with road safety guidance as outlined in the Behavioural insight's team report.
- **Implement specific and evidence based road infrastructure schemes** focused on areas of high risk for collisions.

CHAPTER 4
School age/adolescence
4.10 Sexual and reproductive health

Number of conceptions per 1,000 females under 18 years of age

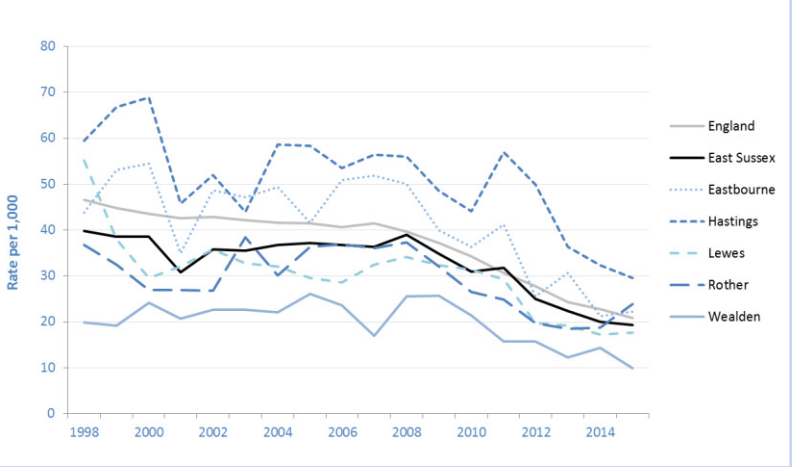
Key messages

- The sexual and reproductive health of young people is an important indicator of population health.
- In East Sussex, the teenage conception rate has been reducing since 1998 and this matches the national trend.
- Rates of teenage conception are linked to deprivation and vary by district and borough with Hastings Borough Council having a consistently higher rate and Wealden District Council having a consistently lower rate.
- In East Sussex we are promoting access to high quality relationship and sex education, as well as good access to young-people friendly sexual and reproductive health services.
- Early and coordinated support is needed for young parents to improve outcomes for themselves and their children.

What is this indicator showing us?

This indicator shows the number of conceptions per 1,000 females aged 15 to 17 years. This is known as the under-18 conception rate. Conceptions below age 15 years are rare.

Under 18 Conception rates England, East Sussex and ES districts and boroughs: 1998-2015



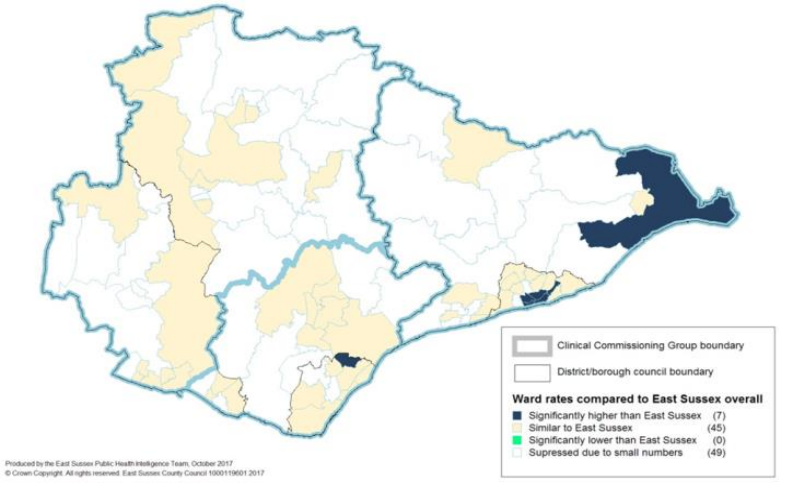
Latest data: In East Sussex in 2015 there were 20 conceptions in under 18 year olds per 1000 women aged 15-17 years. The rate in Hastings is statistically significantly higher than England, and Wealden significantly lower.

Trend: Locally the rate has been reducing since 1998 and this matches the national trend.

Source: PHE, Public Health Outcomes Framework

Figure 4.10.1: Under 18 conception rate per 1,000 females aged 15-17 in East Sussex by district and borough, 1998 to 2015

East Sussex ward map of under 18 conception rates 2012-2014



Latest data: in 2012-2014 there were 7 wards with significantly higher conception rates than East Sussex.

Source: ONS, Conception statistics

Figure 4.10.2: Under 18 conception rates in East Sussex by electoral ward, 2012-14

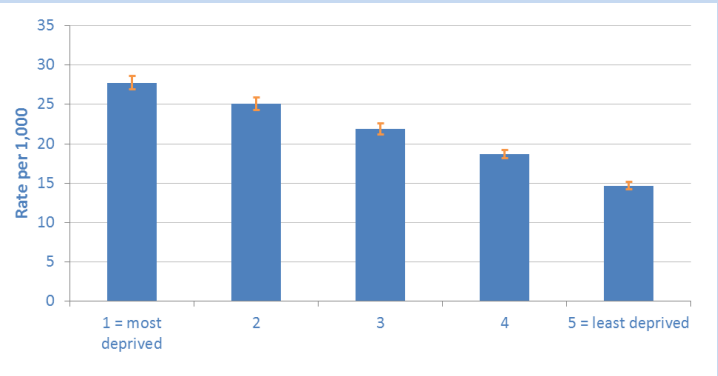
Why is this indicator important?

Teenage pregnancy is associated with poor outcomes for young women and their children. For mothers there is an increased risk of poor educational outcomes, poor physical and mental health, social isolation and socioeconomic deprivation**.** Risks for the children of young mothers include low birth weight (LBW) and pre-term birth, along with some evidence of developmental problems.

Where are we now in East Sussex?

Teenage conceptions in East Sussex show a continuing decline since recording started in 1998 and this follows the national trend. However there is much variation within this. Hastings, Rother and Eastbourne are all above the East Sussex rate; whereas Lewes and Wealden are below the county rate. The latest data (2012-14) shows that seven wards have significantly higher under 18 conception rates than East Sussex (Central St Leonards, Castle, Braybrooke, Gensing, Eastern Rother, Langney and Tressell)

Spotlight on inequalities



Latest: The most deprived 20% of local authorities have nearly twice the rate of under 18 conceptions compared to the least deprived 20%. NB the data use the local authority as a unit of analysis, not the individual child.

Source: PHE, Public Health Outcomes Framework

Figure 4.10.3: Under 18 conception rate per 1,000 females aged 15-17 in England by deprivation (IMD quintile for local authorities)

Socioeconomic disadvantage can be both a risk factor for and a consequence of teenage parenthood. The chart above indicates that the rates are highest in Hastings (30 per 1,000 women), which has some of the highest levels of deprivation; and lowest in Wealden (10 per 1,000) which has some of the lowest rates of deprivation. This data shows a three-fold difference in under 18 conception rates between our least deprived and most deprived districts and borough areas.

What does good look like?

Although East Sussex as a whole is below the national rate for conceptions in women under 18 (19.3 per 1,000 and 20.8 per 1,000 respectively),if we can reduce the rates in under 18s to be below the national rate across all of the East Sussex districts and boroughs we will be able to further reduce the East Sussex rate and also reduce inequalities within the county. Nationally, the top quartile of local authorities have fewer than 16.3 conceptions per 1,000 15-17 year olds with the best in England being Rutland which is considerably lower at only 5.7 conceptions per 1,000 15-17 year olds.

How can we improve?

- **Relationship and Sex Education (RSE) within schools** is key to ensuring young people have the knowledge and skills to make good decisions in relation to their sexual and reproductive health.
- **Good access to sexual health services both in rural and urban areas** is vital to ensure that young people are able to obtain reproductive and sexual health services. It is essential that the services are **widely promoted, young people-friendly, accessible** in a **timely** way and are **geographically available** across the county.
- Targeted provision is also important for young people at high risk of poor sexual health, including those in deprived areas.

What are we doing in East Sussex?

- **Supporting access to RSE within schools: a tiered, evidenced based programme of support** is in place to support schools to deliver age- appropriate, high quality RSE as part of a comprehensive PSHE education curriculum. Access to universal RSE support has been available to all schools in East Sussex through a service commissioned locally which is provided by the leading national body for PSHE education, the PSHE Association.
- **Age-appropriate resources** have been made available to **targeted primary schools** across the county to develop and deliver RSE, with over 30 schools accessing resources and training.
- **All secondary schools have been offered support** to develop their universal RSE curriculum through a varied programme of training and support.
- **Schools in more deprived areas**, and where trend data show that pupils have **higher rates of teenage conception**, have been participating in a **more intensive level of support** to develop and embed whole-school approaches to RSE. This targeted support includes the development of a targeted group work intervention for students at increased risk of teenage conception in these schools.
- **Ensuring good access to Sexual Health Services, especially for young people: evidence-based service based on need** - a local strategic commissioning plan was developed for East Sussex based on a comprehensive needs assessment, NICE and other national guidance.
- Specialist sexual health services consist of combined Genito-urinary Medicine and contraceptive care with combined assessment carried out by one dual qualified member of staff regardless of initial reason for attendance. Contraception is discussed with all patients attending the specialist service.

What are we doing in East Sussex?

- **Web-based access to sexual health services -** East Sussex has recently launched a new website http://www.eastsussesexualhealth.co.uk where people can access up to date information about the nearest most appropriate local services, including ordering home-based testing kits for sexually transmitted infections. The website has been widely promoted via social media. This is intended to increase access to emergency contraception and contraception advice and provision.
- **Condom distribution scheme – C-Card** - The East Sussex C-Card scheme is a free and confidential co-ordinated condom distribution network for young people aged 13 – 24. There are over 180 participating outlets including community pharmacies, school health services, education, housing, youth offending, youth centres and specialist sexual health services. C-Card outlets also **signposting to wider contraception and sexual health services**.
- **Young people specialist service**s - There are two young person specific sexual health services (called The Circle room) commissioned through primary care providers in Peacehaven and Lewes. http://www.thecircleroom.org/
- **Free access to Emergency Hormonal Contraception (EHC) for young** people - In East Sussex, EHC is available free for under 25 year olds via GP Practices, many community pharmacies, and specialist sexual health services.
- **School-based sexual health advice and** support - The school health service is able to provide advice and support access to contraception including emergency hormonal contraception.
- **Supporting good communication with young** people - Training courses are offered to the children and young people's workforce to enhance communication styles and provide up to date information on sexual health issues that affect young people. The training is offered to all staff working with young people so that they can increase their knowledge, skills and confidence in discussing relationships and sexual health in line with You're Welcome standards (quality criteria for young people friendly health services). Topics include confidentiality, delaying sexual activity, relationships, consent, contraception, STI's and access to local services.

Key actions going forward

- **Continue to evaluate and encourage sign up and use of C-Card** especially in deprived areas.
- Ensure **timely access to contraception** including emergency hormonal contraception both in specialist and other services including GP Practices and Community Pharmacies.
- Work with children's services to **support schools to raise aspirations** in young people, especially in deprived areas.
- Work with children's services to support schools **to close the gap in educational achievement** between those in receipt of the pupil premium and those not.
- **Ensure take up of targeted RSE support** especially among schools in the most deprived areas.
- **Ensure access to early and coordinated support for young parents** to improve outcomes for themselves and their children.

CHAPTER 4
School age/adolescence
4.11 School absences

Percentage of half day school sessions missed due to absence in pupils aged 5-15 years

Key messages

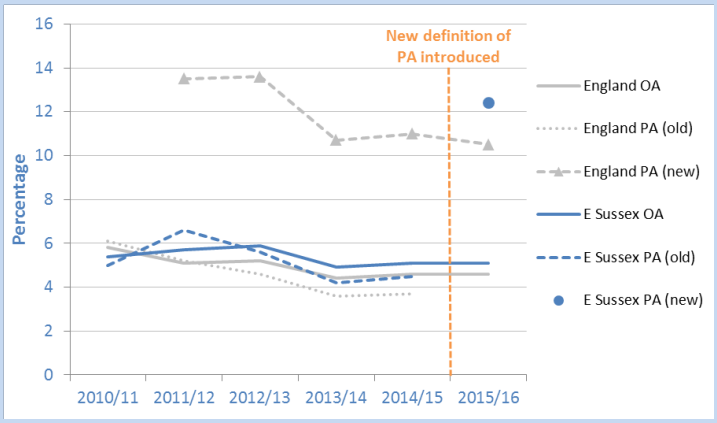
- Non-attendance at school is linked to academic underachievement, anxiety, relationship difficulties, challenging behaviour and school refusal. Truanting and non-attendance can also place children and young people at greater risk of Child Sexual Exploitation.
- Aside from authorised absences due to ill health, non-attendance at school can be a way of a child communicating an underlying Special or Educational Need or emotional or mental wellbeing need, and can also be an indicator of abuse.
- Overall absence (OA) rates in East Sussex are 5.1% which is slightly higher than England at 4.6%.In addition the proportion of persistent absence (PA) is also higher in East Sussex.
- There has been a decline in OA rates in England and East Sussex since 2013.
- In 2015/16 the criteria for classifying pupils as PA changed from missing 15% or more of all overall sessions, to missing 10% of sessions. This resulted in a threefold increase in the proportion of children considered to be PA.
- Both OA and PA rates are lowest in primary schools, higher in secondary schools and highest in special schools.
- We are continually promoting the importance of school attendance with schools, including the impact of poor attendance on academic, social and emotional progress.

What are these indicators showing us?

The overall absence (OA) rate is the total number of overall absence sessions (the sum of authorised and unauthorised absence) for all pupils on roll, expressed as a percentage of the total number of possible sessions for all pupils. There are two registration sessions in a school day; therefore one session is equal to half a school day. A four day absence would equate to eight sessions of absence. The Department for Education (DfE) and Ofsted use this calculation to compare a school's or Local Authority's overall absence rates to the National figure.

A 'persistent absentee' (PA) is a pupil who, at any point in the year, has accumulated absence at 10% or more of the available sessions, regardless of whether or not any of it is authorised. The DfE defines the persistent absence rate. As of 1 September 2015 every pupil/student is expected to attend 90% of sessions or they are considered persistently absent. Before September 2015, 85% attendance was required to avoid being considered persistently absent.

Persistent and overall absence from school rates in East Sussex and England

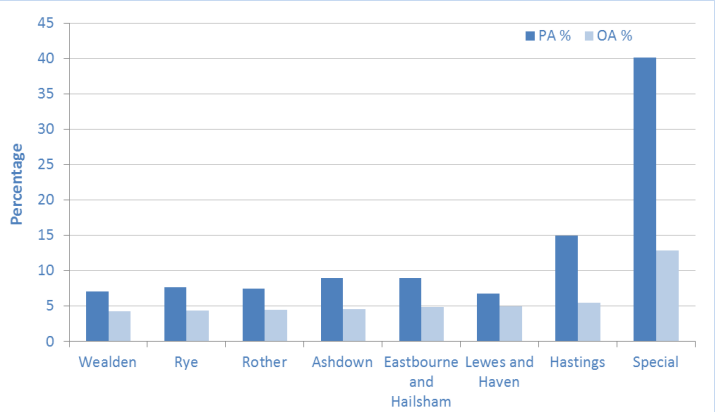


Latest data: In 2015/16 under the revised definition of persistent absence, 12.4% of pupils were recorded as persistently absent in East Sussex. The overall absence rate was 5.1%.

Trend: Overall absence rates have decreased in East Sussex since 2012/13. Persistent absences were also on a downtrend before the change of definition in 2015/16. NB Although historic England PA rates have been recalculated using the new definition, this is not available for local authorities.

Source: DfE, Pupil absence in schools statistics

Figure 4.11.1: Percentage of pupil sessions in school that were absences in East Sussex, 2010/11-2015/16



Latest data: In 2015/16 Persistent and overall absence rates were highest in special schools, and far higher than in any mainstream schools. Hastings Education Improvement Partnership has the highest PA and OA rates. PA rate of 15% is almost twice the next highest rate (Ashdown 7.7%). Wealden has the lowest rates of PA and OA.

Source: ESCC, Pupil absence data

Figure 4.11.2: Percentage of pupil sessions in school classed as persistent or overall absences in East Sussex by Education Improvement Partnership (EIP), 2015/16

Why are these indicators important?

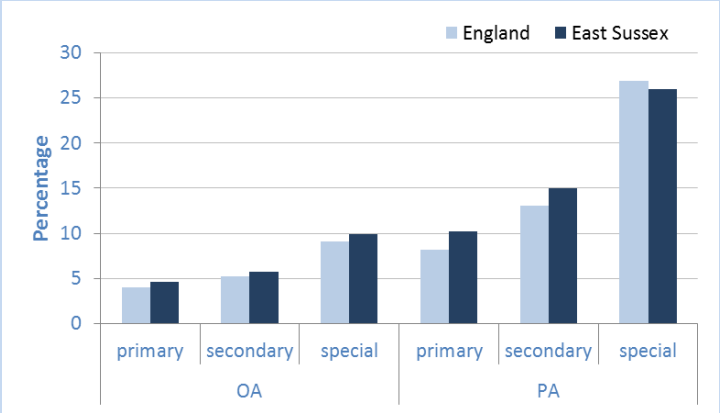
Attendance at school is related to better educational attainment – missing out on lessons leaves children vulnerable to falling behind. Only 3% of children who miss 50% of school attain 5 or more A*-C grades at GCSE compared to 73% of children who have 95% attendance[34]. Children who are persistently absent from school are more likely to be NEET (not in education, employment or training) after they reach school leaving age.

Good educational outcomes are associated with a range of other positive outcomes in adulthood and throughout life:

Children who are not home educated must attend school between their fifth birthday and the last Friday in June in the school year they turn 16. After this young people must still get an education or training until they reach their 18th birthday.

Non-attendance at school and disengagement from the education system could be a child's way of demonstrating an underlying special educational need or disability (SEND) or an emotional wellbeing need. Although absences from school can also be due to physical ill health, poor social, emotional or mental health is becoming an increasingly common reason for prolonged absence from school. The longer a young person is away from school, the harder it is for them to engage when they return, which means that prompt access to appropriate support is important. It is also important for schools to recognise the steps they can take to improve pupil wellbeing and prevent the development of some mental health disorders before they escalate to a level requiring intervention from specialist child and adolescent mental health services (CAMHS).

Other reasons for absence may include caring responsibilities for a family member.



Latest: The proportion of children who are PA is highest in special schools and lowest in primary schools. East Sussex has higher rates of PA compared to England except in special schools.

A similar pattern can be seen with OA, except that East Sussex had slightly higher rates compared to England for all categories.

Source: DfE, Pupil absence in schools statistics

Figure 4.11.3: Percentage of pupil sessions in school classed as persistent or overall absences in East Sussex by Education Improvement Partnership (EIP), 2015/16

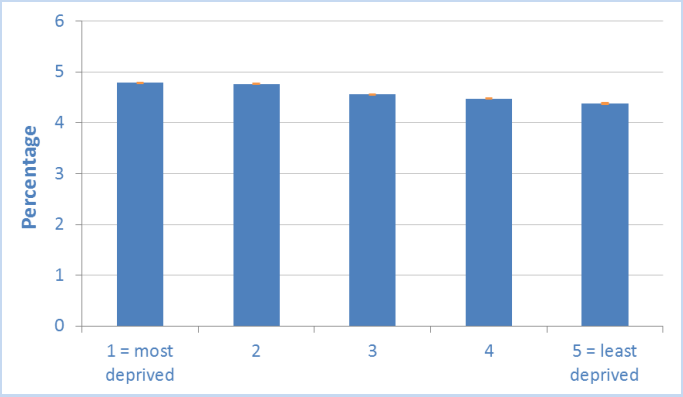
Where are we now in East Sussex?

There has been a downward trend in overall absence rates in East Sussex since 2013/14.Absence rates increase with the child's age; however children attending special schools have the highest rates of absence of all pupils. The difference in OA rates between East Sussex and England occurs across primary, secondary and special schools.

In terms of variation in absence rates in mainstream schools across the county, Hastings Education Improvement Partnership (EIP) has persistent absence rates which are almost twice that of the next highest EIP (Ashdown). OA rates are more similar ranging from 4.3% in Wealden to 5.5% in Hastings.

Spotlight on inequalities

High levels of deprivation in communities can create a lack of ambition and lead to education being viewed as unimportant. If education is not seen as valuable, parents do not always challenge their children when they say they are ill or do not want to go to school. There is some concern locally that schools may accept medical absence too readily and not challenge parents about whether it is symptomatic of a different underlying problem. In East Sussex, both PA and OA rates are highest in Hastings EIP which covers the most deprived parts of the county.



Latest: National data shows that absence rates are higher in the most deprived 40% of the population compared to the least deprived. Absence rates are lowest in the least deprived quintile (based on IMD 2015). NB the data use the local authority as a unit of analysis, not the individual child.

Source: PHE, Public Health Outcomes Framework

Figure 4.11.4: Percentage of half days missed by pupils due to overall absence (including authorised and unauthorised absence) in England by deprivation (IMD quintiles), 2015/16

What does good look like?

Although there has been a downward trend in overall absence rates in East Sussex since 2013/14, rates remain above the England average. Rutland has the lowest OA rate in the country at 3.23% in 2015/16, and has consistently been below the national average. The lowest quartile of areas have an OA rate below 4.25% in 2015/16. The East Sussex EIP with the lowest OA is Wealden at 4.26%.

Persistent absence rates follow a similar patter to overall absence rates when comparing East Sussex to England, with the exception that special schools in East Sussex have lower persistent absence rates than England.

It is important for schools to make an early response to poor attendance and identify the underlying factors behind the absence. Timely access to appropriate support will reduce absence rates from school and reduce the attainment gap between more vulnerable pupils and their peers.

How can we improve?

It is important to promote attendance at nursery and early years as this establishes good habits for life, and ensures children arrive at school ready to learn and at the same level as their peers (see section 3.4). By reception age, children from the poorest backgrounds, whose parents may also not have engaged with school, are already more likely to be behind their peers, and thus more likely to become disillusioned with school and subsequently not attend**. The promotion of the uptake of free nursery places for two year olds from the most deprived backgrounds** is designed to reduce this inequality gap.

Poor attendance at school might be a signal of family problems which could be identified at an early stage if s**chools were more robust in challenging parental explanations of absence**, and which would then reduce the need for more complex and costly social work later on.

What are we doing in East Sussex?

See also Sections: 3.4 on School Readiness; 4.6 for actions to improve the Mental Health of children and young people in East Sussex, and 5.2 Family Key work.

- We are continually **promoting the importance of school attendance with schools**, including the impact of poor attendance on academic, social and emotional progress.
- The TF2 programme plays a key role in supporting the families they work with to improve school attendance, promote the importance of school and establishing positive routines in daily family life
- Over the 2016-17 academic year the Inclusion and Special Educational Needs and Disability (ISEND) Education Support, Behaviour and Attendance Service (ESBAS) and School Learning Effectiveness Service (SLES) have **raised the profile of pupil attendance with the schools** they have supported.
- The **Head teacher Forums** have held **discussions on tackling poor pupil attendance**.
- ESBAS provide **whole school and individual support for children with attendance or behavioural difficulties**.
- Public Health funding has been used to develop **targeted interventions to improve school attendance and close the gap** in educational, and social and emotional outcomes **between vulnerable groups and their peers**. Specific targeted groups are: pupils with protracted poor school attendance; children with poor attendance waiting for Family Keywork interventions; children with protracted poor attendance in primary schools. This is with an aim of improving attendance both in primary and through transition into secondary schools.
- East Sussex Teaching and Learning Provision (TLP) provide **statutory education support for children who are absent from school for more than two weeks due to medical reasons**. A large proportion of East Sussex children who are too unwell to attend school have mental health problems. **TLP work to provide mental health as well as education support for this cohort** whilst they wait for treatment from CAMHS.

Key actions going forward

- All ISEND services will **ensure schools are aware that pupil absence can be communicating unmet needs** and the importance of addressing absence levels at an early stage.
- ESBAS will **continue to review their attendance offer with schools** to achieve the best results.
- ISEND will share the recently reviewed and **updated attendance guidance for schools** (developed with ESCC, police, Local Safeguarding Children's Boards (LSCB) and School Heads).
- **ESCC will deliver a publicity campaign created using pupil voice, to build resilience in students, and challenge parents to be less accepting of days off school**. The main message of the campaign is that there are no good reasons for missing school.
- ESBAS will hold an **attendance conference in the 2017-18** academic year to reinforce the messages and discussions, both at individual and whole school level to ensure improving attendance has a strong focus across school staff at all levels.
- The TF2 programme to continue to support the families they work with to improve school attendance

CHAPTER 4
School age/adolescence
4.12 NEET

16-17 year olds Not in Education, Employment or Training (NEET)

Key messages

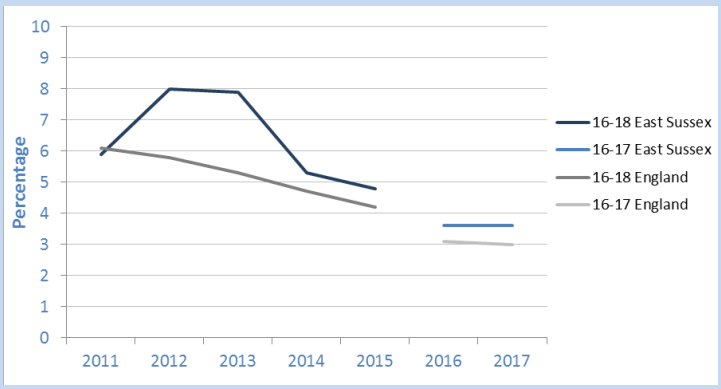
- Young People who are not in education, employment or training are at greater risk of poor physical health, depression, low skilled jobs or unemployment and early parenthood compared to their peers who are actively engaged in learning or working.
- In East Sussex, 3.6% of 16-17 year olds are NEET which is a slightly higher proportion compared to England at 3.1%. However, East Sussex has a much lower proportion of young people of unknown status (0.9%) compared to England (2.8%). In the more deprived boroughs of Hastings and Eastbourne 4.5% of 16-17 year olds are NEET.
- Young people who have been eligible for free school meals are more likely to be NEET than their peers. However the impact of special educational needs or disability, or having been in contact with the youth offending service has a multiplicative effect on the likelihood of being NEET.
- In 2016, East Sussex developed a 16-19 Strategy to engage and prepare young people for a competitive labour market with the aim of ensuring all young people, regardless of background or Special Educational Needs and Disability status are able to progress in their post-16 learning.
- ESCC Standards, Learning and Effectiveness Service commission the Youth Employability Service (YES) to work closely with schools to identify young people at risk of becoming NEET and provide additional support to those vulnerable groups during transition from school to further education or training.

What is this indicator showing us?

The estimated average proportion of 16-17 year olds* not in education, employment or training at 31 March each year.

*16-18 year olds prior to 2015/16.

Percentage of young people who are NEET: 2011 to 2015: 16-18 years, 2016 to 2017 :16-17 years

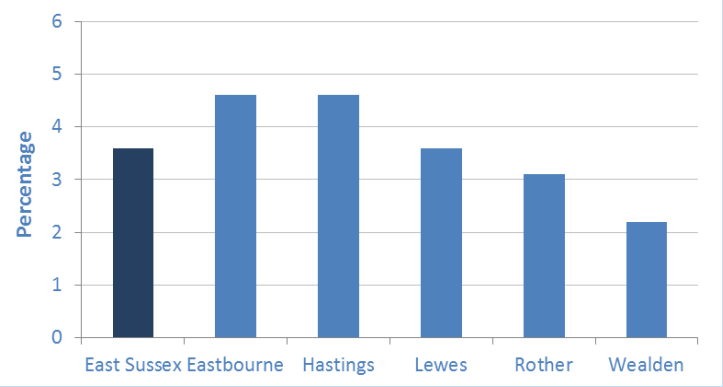


Latest data: In March 2017, 3.6% of 16-17 year olds in East Sussex were recorded as NEET.

Trends: There was a downward trend in the proportion of 16-18 year olds recorded as NEET, but not enough data are available to comment on trends for 16-17 year olds.

Source: PHE, Public Health Outcomes Framework and DfE, NEET Statistics

Figure 4.12.1: Percentage of young people not in education, employment or training (NEET) in East Sussex, as at 31 March. 2011 to 2015:16-18 years, 2016 to 2017: 16-17 years



Latest data: There is substantial variation in the proportion of young people who are NEET in each district and borough in East Sussex. Eastbourne and Hastings have almost twice the proportion of NEET as Wealden.

Source: East Sussex Client Caseload Information System.

Figure 4.12.2: Percentage of 16-17 year olds not in education, employment or training (NEET) in East Sussex by district and borough, as at 31 March 2017

Why is this indicator important?

Although many young people who are NEET do not remain so for long, young people who do remain as NEET are at greater risk of poor physical health, depression, low skilled jobs or unemployment and early parenthood compared to their peers who are actively engaged in learning or working.

The participation of young people in learning and employment not only makes a lasting difference to their individual lives by enabling each young person to fulfil their potential, but it is also central to maintaining the social and economic future of the county.[1]

East Sussex County Council has concerns about the lack of support on offer for 18 year olds, as not all will be registered or engaged with Job Centre Plus. Before the change in statutory responsibilities the YES worked with over 800 18 year olds per year but now works with less than half this number. There is therefore a risk that a proportion of 18 year olds may fall out of contact with services, be financially unable to support themselves and become vulnerable to exploitation.

The longer term impact of being NEET at 18 is to find it harder to become economically active, particularly in a productive, fulfilling career, compared to peers.

Where are we now in East Sussex?

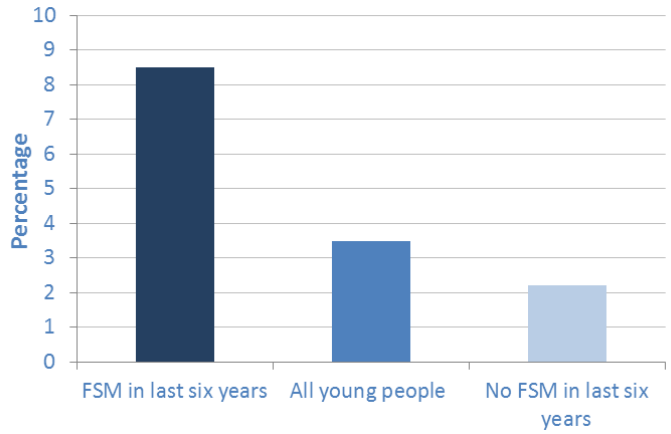
The proportion of 16-18 year olds in East Sussex who are NEET has continued to reduce over the last 5 years, although is slightly higher than the England average.

Since the statutory requirement for local authorities to track 18 year olds was removed in 2016 the DfE no longer collect information on the NEET/EET status of this cohort.

At a district and borough level, Hastings and Eastbourne have higher proportions of young people who are NEET than the East Sussex average and almost twice the rate of Wealden.

Spotlight on inequalities

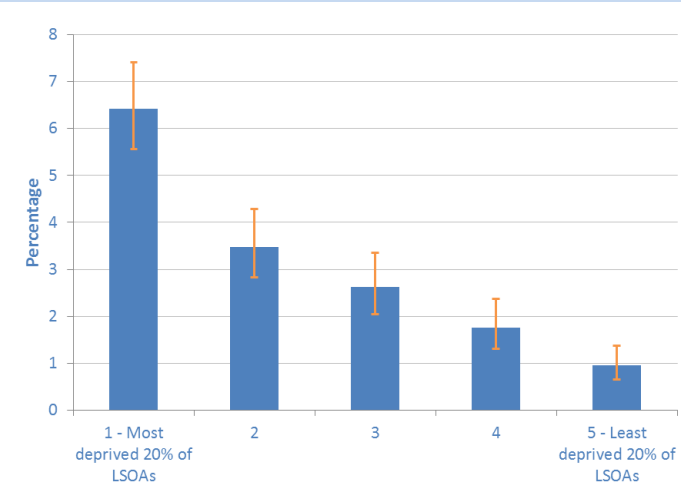
Young people from deprived backgrounds (as measured by eligibility for free school meals) are significantly more likely to be NEET than young people from less deprived backgrounds. Not being in education, employment or training at 16 or 17 increases the chances of a young person having a low level of skills in later life, to go on to be unemployed in the future, to earn less and to suffer from poor health or depression, which can have an impact well into adult life. Supporting young people who are NEET to move into education, employment or training will contribute to breaking the intergenerational impact of poverty.



Latest data: 16 and 17 year olds who were eligible for free school meals (FSM) in the last six years of statutory education are almost four times as likely to be NEET than those who were not eligible for FSM in that period.

Source: East Sussex Client Caseload Information System

Figure 4.12.3: Percentage of 16-17 year olds not in education, employment or training (NEET) in East Sussex by free school meal status in previous 6 years, as at 31 March 2017



Latest data: 6.4% of 16 and 17 year olds living in the most deprived 20% of lower super output areas in East Sussex are NEET compared to 0.9% in the 20% least deprived areas.

Source: East Sussex Client Caseload Information System

Figure 4.12.4: Percentage of 16-17 year olds not in education, employment or training (NEET) in East Sussex by deprivation (IDACI quintiles), as at 31 March 2017

What does good look like?

Nationally 3.1% of 16 and 17 year olds are NEET, compared to 3.6% of 16 and 17 year olds in East Sussex. In 2015 (when the indicator was for 16-18 year olds) the lowest rate in England was in the London Borough of Harrow where only 1.5% of young people were NEET. An international comparison carried out in 2013 found that rates of young people who are NEET in England are higher than in many other countries.[35]

How can we improve?

Working with schools to identify young people at risk of becoming NEET and developing programmes to keep them engaged, or which are flexible enough to **overcome barriers** such as teenage pregnancy or SEND,[36] have been shown to be effective at keeping young people in education.

An evidence review by Public Health England and UCL Institute of Health Equity identified the following factors which are shown to be effective in reducing the number of young people who are NEET:

- Early action
- Tackling barriers and obstacles
- Working across organisational and geographical boundaries
- Working with local employers
- Tracking people and monitoring progress
- Basing interventions on features of other successful programmes e.g.
    - Appropriate course content
    - Accreditation
    - Being different from school
    - Work with young people to develop interventions
    - Financial incentives or support
    - Flexibility and personalisation
    - Group size and one-to-one support

Other factors which have been shown to reduce the number of young people becoming NEETs are: access to **good, impartial, careers guidance**[37] to help pupils become aware of careers they may not have considered; **education and skills to meet the labour market** including basic literacy, numeracy and IT skills; Developing softer skills such as **team working, initiative, work ethic** and **communication**; having meaningful contact with employers through **work visits, work shadowing or work experience** can help improve work readiness, as well as **participating in social action programmes** such as the Duke of Edinburgh Award Scheme.

There should also be **support for the most vulnerable learners**: Pupils with SEND, eligible for FSM, young people with poor mental health, young carers, young people in the justice or care system, young parents or those living independently.

What are we doing in East Sussex?

The 16-19 strategy for East Sussex aims for all young people to be participating in learning or work appropriate to their needs and relevant to the local, regional and national economy by 2020. In 2016 stakeholders developed a multi-service strategy designed to engage and prepare all young people for a competitive labour market and to ensure all young people are able to progress in their post-16 learning in the forum most suited to them e.g. school sixth forms, colleges, and apprenticeships.

The 16-19 strategy is complemented by the Skills East Sussex (SES): the county's strategic body for employment and skills action plan. ESCC work with SES to ensure NEET young people are supported and given opportunities to develop their skills within the target growth sectors in East Sussex:

Engineering and advanced manufacturing	Construction	Health and social care	Creative and digital	Land based and visitor economy

16-19 Strategy key aims	SES Action plan
Education and skills that meet the needs of the labour market	- Helping young people become ready for the world of employment - Making sure that the curriculum is shaped by employers wherever there is scope for this to be done
Career Management	- Improving the quality and relevance of Careers Information Advice and Guidance for people of all ages - Addressing gender imbalance in employment and study in key industries/sectors
Support for vulnerable learners	From the Youth Employability Service.
Improving work readiness	Helping to stimulate the uptake of Apprenticeships

- **Early help and targeted interventions for NEET or those at risk of becoming NEET** are delivered through the Youth Employability Service (YES) run by a third sector organisation.
- YES **support young people to make a successful transition** from school to further education or training, and can also tackle issues of substance misuse, poor mental health. YES supported over 3500 young people across East Sussex last year.

Key actions going forward

- **ESCC will help drive forward the '16-19 Strategy East Sussex'**: All Young People Learning and Working, aligning with the Skills East Sussex priorities and action plan to ensure a joint approach which is co-ordinated and evidence based.
- **Priorities will be refreshed in 2018** based on the new and emerging situation.
- **Funding will be sought to support these actions**, including working with national commissioning bodies to help ensure that any contract awarded meets local East Sussex needs.

CHAPTER 5
Family and social environment
5.1 Child poverty

Proportion of children under 16 living in low income households

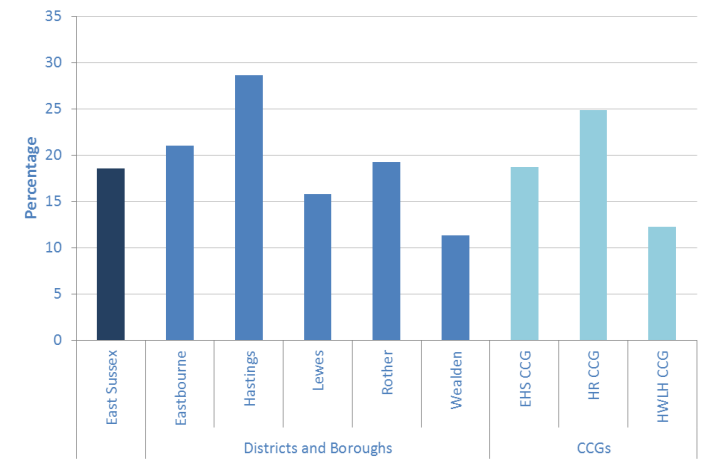
Key messages

- Children growing up in poverty are likely to do less well across a range of outcomes – health, cognitive and emotional development and in education. The effects of poverty last through the life-course and also influence long term social outcomes.
- Nearly one in five children in East Sussex are living in a low income household (18%) however this ranges from 11.4% in Wealden to 29% in Hastings.
- Nationally child poverty is predicted to increase and therefore actions to protect against the negative impact of poverty are needed[38].
- Improving the health outcomes of children living in poverty requires provision of good quality, effective and universal prevention and health care services[39].

What is this indicator showing us?

This indicator shows us the number of children living in low income households, defined as living in households where income is less than 60% of the national median household income. There are other measures of poverty but this is the most widely used definition.

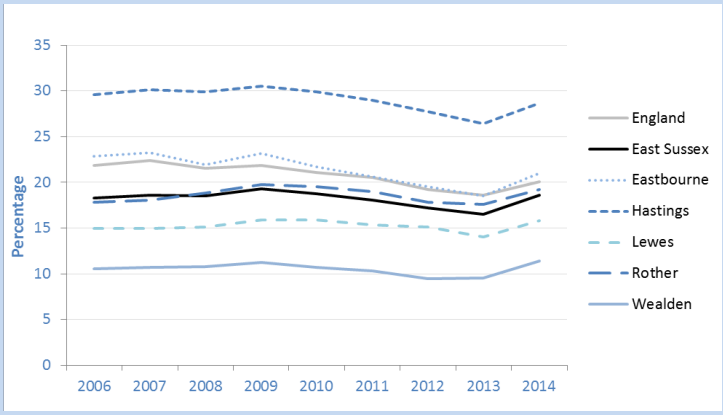
Proportion of children under 16 living in low income households



Latest data: At a Clinical Commissioning Group (CCG) level 1 in 4 children in Hastings and Rother were living in poverty compared to 19% in Eastbourne, Hailsham and Seaford, and only 12% in High Weald Lewes Havens. At a district and borough level, Hastings has highest level of children in poverty and Wealden the lowest. Hastings and Eastbourne have significantly higher rates of child poverty than East Sussex overall, and Lewes and Wealden significantly lower.

Source: East Sussex JSNAA scorecard 2.04

Figure 5.1.1: Percentage of children under 16 living in low income families in East Sussex by district/borough and CCG, 2014



Trend: The proportion of children living in low income families remained static or fell slightly between 2003 and 2013. In 2014 there was an increase nationally, for East Sussex and across all districts and boroughs

Source: PHE, Wider Determinants of Health Profile

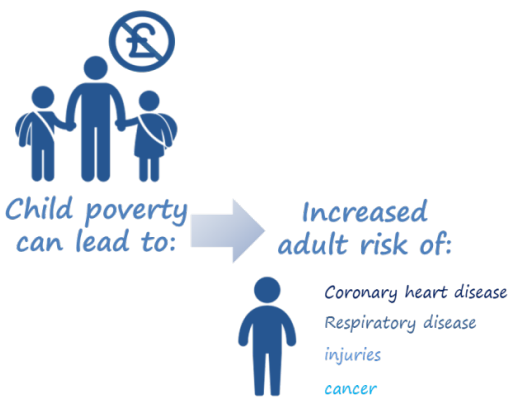
Figure 5.1.2: Percentage of children under 16 living in low income families in East Sussex by district and borough, 2006 to 2014

Why is this indicator important?

Children growing up in poverty are likely to do less well across a range of outcomes: health, cognitive development and in education. Children in poverty may also be more likely to have parents unable to work due to poor mental health or substance misuse, and be more likely to exposed to domestic violence. All of these factors increase the detrimental effects of poverty. The effects of poverty last through the life-course and also influence long term social outcomes.

The more time spent living in poverty, the greater the adverse effects. Chapter 1 of this report has already described how children born into more deprived backgrounds are less likely to survive childhood than their better-off peers, and other sections describe the increased risk of dental decay, obesity, accidents and chronic conditions such as asthma for children living in poverty.

Childhood poverty can lead to:



The majority of adults with long term mental health conditions first experienced symptoms in childhood. It is therefore important for services to mitigate against the impact of poverty to ensure equality of outcomes.

For many children and young people, healthy choices regarding food and drink and access to sports and exercise requiring specific equipment are seen as expensive choices, thus poverty affects the ability to make healthy choices.

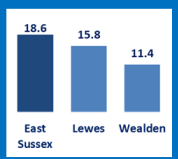
Where are we now in East Sussex?

In East Sussex

In **2014** the % of East Sussex children living in **low income families** was **18%,** slightly **higher than 2006.**

Between 2006 and 2014 **Hastings** has had a significantly **higher rate** of children living in low income families than the rest of East Sussex (29%)

Hastings



Wealden had a **much lower** rate of children in poverty **(11%)** and **Lewes** a **slightly lower** level **(16%)** than East Sussex.

What does good look like?

East Sussex has a smaller percentage of children living in low income families than England – approximately 18% compared to 20%. In a quarter of local authorities in England less than 15.3% of children live in low income families. The area in England with the lowest level of children affected by poverty is the Isles of Scilly with a rate of only 3.1%.

The average English rate of children living in low income families (20%) is relatively high compared to European neighbours with similar per capita income to the UK. A 2012 report from UNICEF[40] found that the UK ranked 22 out of 35 countries and four countries with similar levels of economic development and per capita income to the UK had rates of child poverty below 7.3%.

How can we improve?

Decisions by national governments can have an impact on the proportion of children living in poverty. At a local health and social care level we can be aware of the potential adverse effects of poverty and seek to reduce them through **appropriate preventative education, social and health care services**. Marmot[39] suggests that **universal childhood services should be delivered with additional intensity to those living in the most disadvantage** – an approach known as proportionate universalism.

The 2014-2017 national Child Poverty Strategy identifies three areas which will help reduce the number of children living in poverty and to reduce the impact of poverty on children:

- **Tackling child poverty now** – helping parents move into work, work enough hours and earn enough
- **Supporting families' living standards** – increasing incomes, reducing costs, preventing problem debt, and tackling poor housing
- **Preventing poor children becoming poor adu**lts – removing barriers to attainment, improving educational outcomes, raising aspirations and improving opportunities

What are we doing in East Sussex?

The East Sussex Children and Young People's Plan 2015-18 includes the statutory Child Poverty Strategy for East Sussex and identifies six areas for action:

- **Improving the school readiness** of young children, particularly early communication, language development and numeracy (See section 3.4).
- **Helping more parents enter, sustain and progress in work**.
- **Improving the quality of life of low income families** in other ways where possible.
- **Maintaining and strengthening early help for vulnerable families**; and ensuring effective safeguarding for all children and young people.
- **Improving skill levels of young people 14-19**, including through better access to a wider range of apprenticeship, vocational training and work experience opportunities as well as a strong academic route (see section 4.11).
- **Improving support to** children, young people and families to help maintain and enhance **emotional wellbeing and mental health** (see section 4.6).

What are we doing in East Sussex?

Some of the specific initiatives to support the aims above include:

- **The East Sussex welfare benefits service that helps residents to claim** what they are entitled to. Residents can access free telephone support from a Benefits Adviser, including help with initial claims and assisting with more complex issues such as reviews and appeals.
- **East Sussex Energy Partnership's (ESEP) fuel poverty reduction programme** aims to protect individuals and communities from the effects of living in a cold home through local implementation of a range of initiatives consistent with NICE guidance. Funding from the National Energy Agency will enable cold homes occupied by vulnerable households, including families with children and low incomes, to receive high cost major heating and insulation measures which would otherwise not be affordable.
- In East Sussex the 0-5 **Healthy Child Programme** is led by health visitors and delivered as part of an integrated early years' service which follows the principles of proportionate universalism.
- **Work to reduce the number of young people who are NEET** (4.12) will improve employment prospects of our population and ensure that the next generation of parents will be more likely to achieve better paying jobs.
- **Reductions in teenage parenthood** (4.10) will also help to reduce the number of children growing up in poverty.
- Hastings and Rother CCG Reducing Health Inequalities Fund aims to **reduce the impact of deprivation in Hastings** by funding a range of health improvement projects including encouraging smoking cessation in pregnancy, antenatal classes and breastfeeding support for younger mums which will help children in the most deprived part of East Sussex get the best start in life.

Key actions going forward

- Increase **awareness among health professionals of the impact of poverty on heal**th and support all professionals working with children to become advocates for their patients experiencing poverty.
- Ensure **universal early years' public health services** are prioritised and supported, with **targeted supports for children and families experiencing poverty**.
- Provide good quality, safe and effective prevention and care throughout the public health and healthcare service with a particular focus on primary care in order to mediate the adverse health effects of poverty.

CHAPTER 5
Family and social environment
5.2 Family Key Work (Troubled Families)

Number of households eligible under the government's Expanded Troubled Families programme receiving a family support intervention

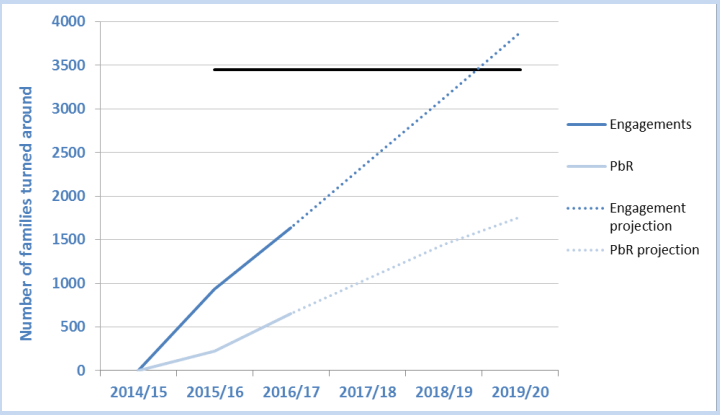
Key messages

- The Troubled Families programme (TF) was set up by the government to transform the way services work with families with multiple health or social problems including absence from school and worklessness.
- East Sussex is in the top 10% of local authorities for engaging families in the TF2 programme and for successfully achieving progress with families (2,192 families supported as of 31st July 2017).
- The average length of time between initial engagement with a family and achieving outcomes is eight months. This time lag must be taken into account when calculating the percentage of families turned around.
- For many families the TF programme acts as early intervention and improves outcomes for families as well as preventing the need for more costly involvement of statutory services.
- Households with young carers account for almost 1 in 4 of families involved in the TF programme in East Sussex.

What is this indicator showing us?

The number of households eligible under the government's TF programme receiving a family support intervention.

Actual and projected trajectory for Engagement and Payment by Results Performance

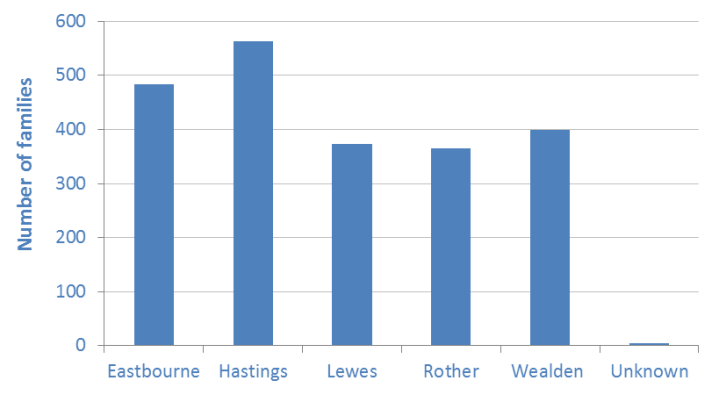


Latest data: At 31st July 2017 East Sussex has worked with 2192 families through the TF2 programme. The 2020 target is 3450 families. NB national comparator data is not available.

Trends: Engagement with families is on track to meet the 2020 target by 2019. The payment by results (PbR) performance continues to improve but will not meet the 2020 target for families turned around. The latest projection is 1761 families turned around by 2020.

Source: ESCC, Children's Services data

Figure 5.2.1: Target number of families to turn around in East Sussex through the Troubled Families Programmes, 2015 to 2020



Latest data: At 31 July 2017 there were 2192 families from East Sussex in the Troubled Families Programme. The largest number of families live in Hastings borough (563), followed by Eastbourne district.

NB National comparator data is not available.

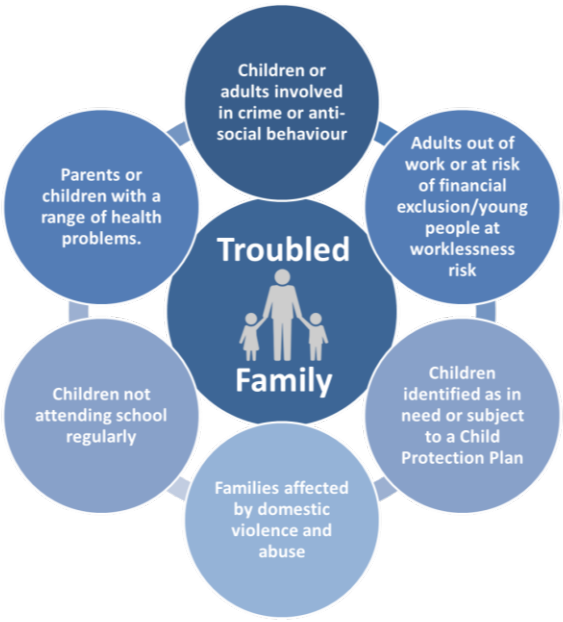
Source: ESCC, Children's Services data

Figure 5.2.2: Number of families engaged in TF2 in East Sussex by district and borough, as of 31 July 2017

Why is this indicator important?

TF was a programme set up by the government in 2012 to work with a small number of families with multiple disadvantages who were considered to be involved with a disproportionate number of public services, but without any improvement in outcomes. The purpose of TF was to incentivise local authorities to work differently with these families through transforming services and to improve outcomes while reducing costs to society.

Troubled Families 2 (TF2) was launched in 2015 with a slightly broader set of criteria for families to be included. Local Authorities (LAs) were asked to work with families who have been identified as having at least two of the following six problems and who had not already achieved TF1 outcomes:



Local authorities can claim £1000 funding for each family engaged, plus a further £800 for a family when they have "turned a family around" i.e.

Achieved significant and sustained progress, compared with all their problems at the point of engagement

OR

An adult in the family has moved off benefits and into continuous employment

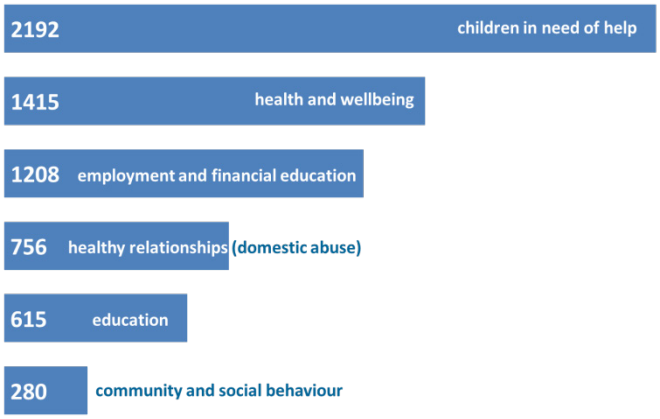
There are clear and measurable performance targets for TF2 to improve school attendance, and to reduce poverty by supporting adults into work and off benefits. In order to achieve these goals, it is often necessary to improve the mental health and emotional wellbeing of both parents and children.

Where are we now in East Sussex?

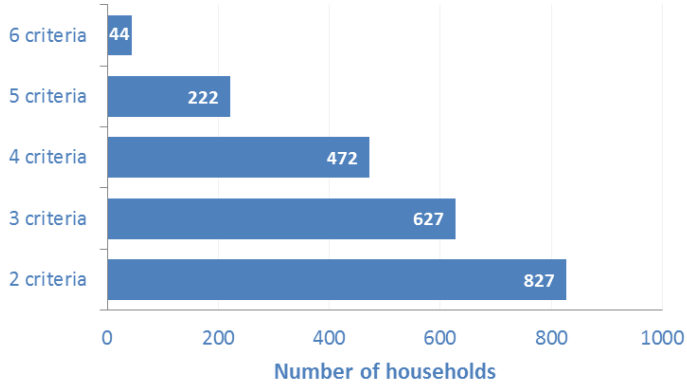
All 2,192 families engaged in the TF programme meet two or more of the eligibility criteria. Children in need of help, followed by health and wellbeing issues in the family are the two main reasons (also known as themes or eligibility criteria) for families being engaged in TF2 in East Sussex. Employment and financial exclusion is the third most common reason.

More of the families engaged in TF2 come from Hastings than any other area, with the second highest number of families coming from Eastbourne

Number of families meeting two or more eligibility criteria for TF2 in East Sussex, as at 31st July 2017



Source: ESCC, Children's Services data



Latest: Only a very small proportion of families engaged in TF2 meet all six criteria. A total of 37% of families engaged have two themes, and the number of families decreases as the number of themes increase.

Source: ESCC, Children's Services data

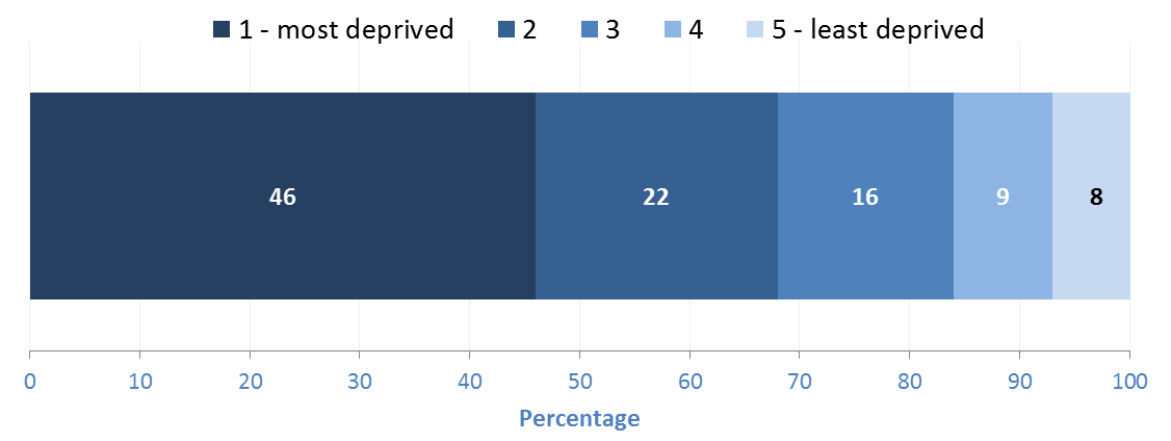
Figure 5.2.4: Number of households with multiple themes for TF2 in East Sussex, as of 31st July 2017

The amount the LA can claim for turning families around is determined by the evidence available to submit for the claim e.g. demonstrating continuous employment. Other indicators have a threshold performance which must be met before payment can made, regardless of the starting point of the family. School attendance is particularly challenging as in order to make a claim, it requires each child in the family to achieve 90% attendance at school for three full terms. This is often narrowly missed and does not recognise the significant progress that has been made with some children, for example by a child attending 85% whose previous attendance was closer to 20%. There is also a time lag of several months before outcome data is available to the TF2 team.

The main reasons for families in East Sussex not being eligible for payment by results (PbR) following engagement with TF2 is school attendance not reaching required levels, followed by parenting capacity not being improved.

Spotlight on inequalities

Almost half of the families participating in East Sussex TF2 come from the most deprived quintile of postcodes whereas families from the two least deprived quintiles of the population make up less than 20% of families in the programme. As unemployment and financial exclusion are criteria for being involved in the programme it would be expected that more people from deprived areas would be eligible. However as financial exclusion is only one of six criteria for participation in TF2, this both demonstrates that families in need are being identified for help, but also the impact of unequal distribution of wealth across the population on health and wellbeing, education, community and social behaviour, domestic abuse and children in need of help.



Source: ESCC, Children's Services data

Figure 5.2.5: Distribution of families engaged with TF2 in East Sussex by deprivation (IDACI quintiles), as at 31 July 2017

What does good look like?

East Sussex has performed strongly in TF2 compared to other areas of the country. A total of 2192 families are or have been engaged in the TF2 programme in East Sussex as of 31 July 2017. A total of 811 family PbR claims have been made, which puts East Sussex in the top decile of the 62 other local authorities who started the Troubled Families 2 programme at the same time.

East Sussex remains in the top decile of performance when compared to all local authority TF2 programmes regardless of start date (East Sussex ranks 11th out of 141 programmes).

On average around 55 new families are engaged each month, and families receive support for eight months. NB When calculating success rates for TF, the average 8 month period of engagement needs to be taken into account.

East Sussex achieves a relatively high proportion of closed cases where PbR have been possible (the conversion rate) compared to other areas. We have been able to evidence that almost 6 out of ten (59%) families who engaged in the TF programme either achieved sustained and significant improvement compared to their problems at the beginning of the programme, or an adult family member moved from benefits to continuous employment.

How can we improve?

National feedback from the Troubled Families pilots 2012-2015 found that the following **factors were needed for a successful programme:**

- A dedicated key worker, dedicated to a family and acting as a single point of contact
- Practical 'hands-on' support
- A persistent, assertive and challenging approach
- Considering the family as a whole – gathering all the intelligence
- Common purpose and agreed action
- Links between Job Centre Plus advisers and LA Troubled Families teams, to offer help to families in finding work

The Department for Communities and Local Government (DCLG) has developed a Service Transformation Maturity Model (STMM), against which all LAs will be required to **self-assess their Troubled Families Programme and action plan for the remaining years of the programme.** Local authorities are also expected **to participate in the annual cycle of peer review** regarding service transformation.

Alongside the STMM, DCLG is working on a Data Maturity Model. There will be an increased focus on accessing data held by other agencies such as the police, for the purposes of identifying families at risk of requiring high-cost interventions in the future.

Future developments within the TF programme include a focus on families with adults out of work for complex reasons such as long term physical or mental health conditions. Programmes will also be encouraged to **focus on providing evidence-based interventions to strengthen relationships between parents.** To drive this work forward a joint Department for Work and Pensions (DWP) and DCLG Assurance Board has been set up to herald the DWP's *Improving lives: Helping Workless Families* programme. Information on how local areas are expected to implement these new initiatives has not been provided to date.

What are we doing in East Sussex?

- East Sussex County Council is aiming to engage with 3450 families between 2015 and 2020.
- East Sussex delivered service transformation through the Thrive programme in TF1, which has contributed to a successful start to TF2. Across the country the national TF team is still encouraging areas to engage in service transformation to deliver outcomes. The development of the Family Keywork Service has been a vital part of the TF programme in East Sussex and through working with families at an earlier stage we have been able to reduce the number of children requiring more costly interventions including child protection plans or becoming looked after children.
- To support people into employment East Sussex County Council has three seconded employment officers from DWP working within TF2 who have been very successful in getting people into work and work-related activities.
- East Sussex continues to submit data quarterly for inclusion in the National Impact Study (NIS), a longitudinal evaluation of the impact of the TF2 programme upon the lives of individuals in participating families led by the Office of National Statistics (ONS). No meaningful data has been published yet, as it is at a relatively early stage.

Key actions going forward

- **Engage and support over 800 v**ulnerable households in 2017/18 to improve outcomes and reduce the numbers of families requiring formal social work support.
- **Review TF2 East Sussex against the Service Transformation Maturity Model** to identify whether there are areas of programme we could further improve.
- **Actively engage in the peer review programme** for TF2

CHAPTER 5
Family and social environment
5.3 Children in the child protection system

Number of children subject to a child protection plan

Key messages

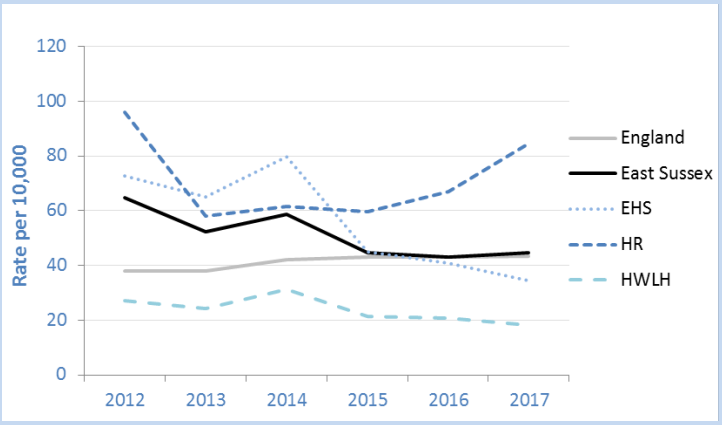
- The number of children with a child protection (CP) plan is one of the measures used to keep track of children in the child protection system.
- A CP plan is put in place when a child is considered in need of protection from at least one of the following: neglect, physical, emotional or sexual abuse. The CP plan identifies and describes the main areas of concern, the actions to be taken and by whom in order to reduce concerns, as well as being clear how progress will be monitored.
- In England the number of children in the child protection system increased between 2004 and 2016 from 24 to 43.1 per 10,000.
- In East Sussex between 2012 and 2017, the number of children in the child protection system decreased from 64.6 to 45.0 per 10,000.
- The group of children who have a CP plan are a vulnerable group and at greater risk of physical and mental health issues compared to children not in the child protection system.
- Good data is essential to support effective service delivery and improve the health outcomes of children and young people in the child protection system.

What is this indicator showing us?

This indicator shows the rate of children aged 18 or under (per 10,000) subject to a CP plan in England[41] and in East Sussex from 2004 to 2016 (2017 for East Sussex).

CP data only includes children who have been identified as at risk of or experiencing harm, and therefore it is unlikely that it captures the true number of children who are at risk.

Children subject to child protection plans

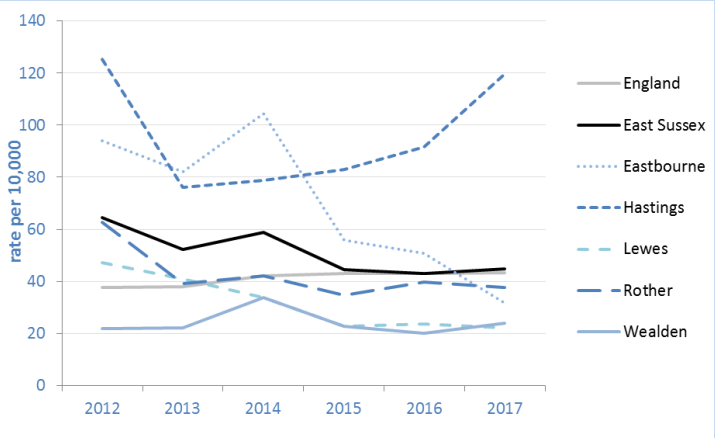


Latest data: At 31 March 2017 the rate of children on a CP plan in East Sussex had increased slightly from the previous year. England data had remained the same. In 2017, Hastings and Rother CCG had higher rates of children on CP plans compared to England, whilst Eastbourne, Hailsham and Seaford CCG was similar, and High Weald Lewes Havens CCG lower than England.

Trends: Since 2012 East Sussex rates have fallen from being considerably higher than England to similar. Over this period rates for England have risen slightly. Since 2015 rates of children on CP plan have increased significantly in Hastings and Rother CCG.

Source: East Sussex JSNAA Scorecards and DfE, Children in need Statistics

Figure 5.3.1: Rate per 10,000 population aged 0-17 of children who were subject to child protection plans in East Sussex by CCG, 2012 to 2017



Latest data: In 2017 rates of children on a CP plan in Hastings were significantly higher than England, and Lewes and Wealden were significantly lower.

Trends: Overall since 2012 East Sussex rates of children on CP plan have fallen across all districts and boroughs. However, the rate in Hastings has increased each year since 2013.

Source: East Sussex JSNAA Scorecards and DfE, Children in need Statistics

Figure 5.3.2: Rate per 10,000 population aged 0-17 of children who were subject to child protection plans in East Sussex by district and borough, 2012 to 2017

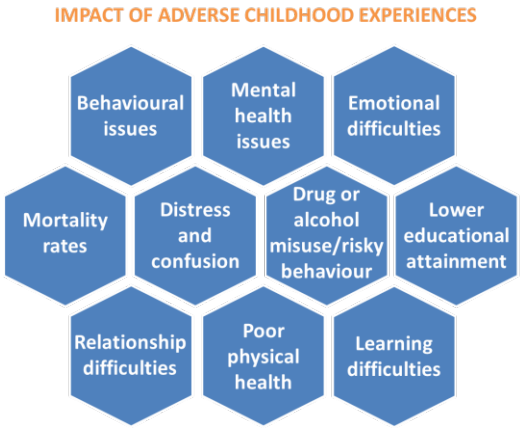
Why is this indicator important?

The number of children with CP plan is one of the indicators used to keep track of children in the child protection system. If a CP plan is not successful then a child may need to be taken into the care of the local authority i.e. become a looked after child. Children will not be given a protection plan until their situation has been reviewed at a multidisciplinary case conference. This means that only substantiated instances of abuse are included in these statistics.

Understanding the numbers of and reasons for children being in the care system in East Sussex is important as this gives an indication of the total number of children at risk of harm, as well as helping to plan the services to meet their health and social care needs. The indicator is only as accurate as systems of notification and processing, so there may be children at risk presently unknown to services. Early identification and intervention through a CP plan is more effective than identifying children at risk at a later stage. An effective CP plan can reduce the number of children becoming looked after.

The emotional and physical impact of childhood abuse can last into adulthood[42]. Factors such as experiencing sexual, physical or emotional abuse or growing up in a household with damaging experiences e.g. parental substance misuse or domestic violence are considered to be adverse childhood experiences (ACEs)

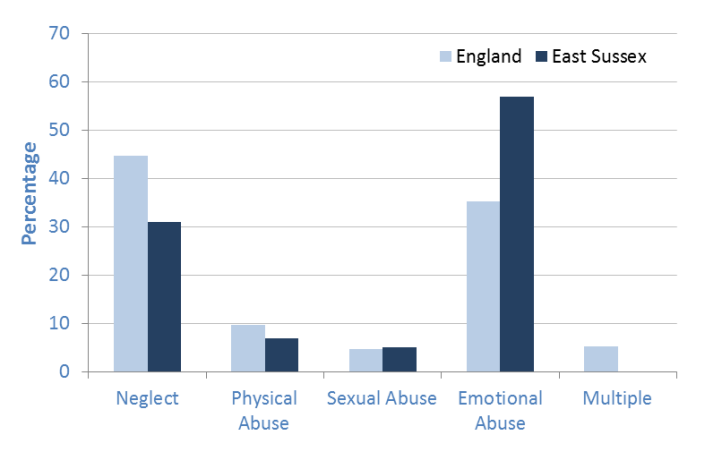
There is evidence that children exposed to four or more ACE's are at greater risk of range of poor outcomes as an adult, including increased mortality rates.



Preventing neglect and abuse in childhood is far more cost effective than addressing the impacts in adulthood - **"It is easier to build strong children than to mend broken men"**[43].

Where are we now in East Sussex?

In 2017, East Sussex rates of children on a CP plan were 45 per 10,000, a slight increase from 2016 (43 per 10,000). However there is considerable difference between districts and boroughs. Rates in Hastings are 120 per 10,000 compared to 22 and 24 in Lewes and Wealden respectively.



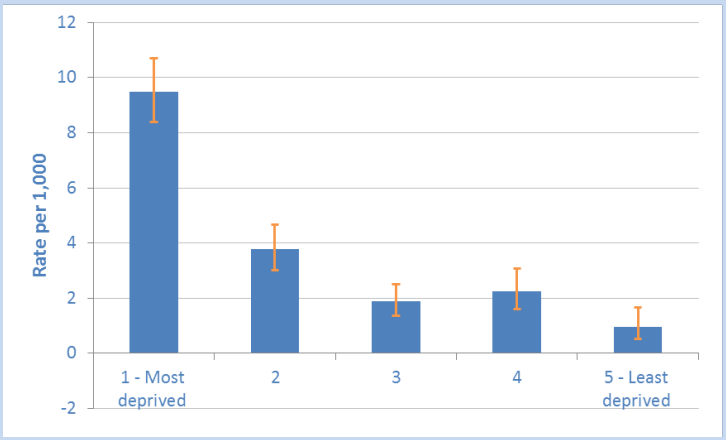
Latest data: Emotional abuse and neglect are the two most common primary reasons for children in East Sussex being on a CP plan. A higher proportion of CP plans in East Sussex are due to emotional abuse compared to England and a lower proportion due to neglect. No children in East Sussex had multiple forms of abuse recorded as the initial category of abuse.

Source: DfE, Children in need Statistics

Figure 5.3.3: Initial categories of abuse for which children were subject to a child protection plan in East Sussex, as at 31st March 2016

Spotlight on inequalities

Local data shows significantly higher rates of children from the most deprived wards on a CP plan compared to the rest of East Sussex. Deprivation explains the higher rates of children on CP plans in Hastings compared to more affluent Lewes or Wealden. These children are likely to have been subject to numerous ACEs meaning they are more vulnerable to a range of poor health, education and social outcomes in later life.



Latest data: Children living in the most deprived quintile of wards in East Sussex are more than twice as likely to be on a CP plan compared to the East Sussex average or children in the next most deprived quintile. Children from the least deprived 60% of wards are significantly less likely to be on a CP plan.

Source: ESCC, Children's Services data

Figure 5.3.4: Rate per 1,000 population aged 0-17 who were subject to child protection plans in East Sussex by deprivation, as at 31st March 2016

What does good look like?

Since 2012 the prevalence of local children on a CP plan has decreased from 70% above the England average to a very similar rate to England. National data is not yet available for 2017, so it is not possible to comment on whether the increase in East Sussex rates is reflective of a national trend.

All children have a right to protection from neglect, abuse, violence and exploitation[44].

The number of children in the child protection system alone does not tell us everything about the prevalence of child abuse in an area. This is because it is not easy to identify the exact number of children who are at risk of being abused or neglected across an area as this depends on recognition and systems to assess and capture information about risk. A low reported number of children on a CP plan may not just be a reflection of low levels of abuse but of too high thresholds for recognition.

It is more important that the right children are on CP plans for the right amount of time, than for reported numbers to improve at the expense of children who need protection.

The area with the lowest rate of children with CP plans is Milton Keynes with only 13.9 children per 10,000 on a CP plan. A quarter of local authorities have fewer than 35 children per 10,000. However these statistics must be interpreted in light of the caveats described above.

The number of CP plans does tell us how many children are known to local services as being in need of protection, and this enables service planning and performance management e.g. if there is an increase in the number of children subject to a CP plan does it reduce the number of children being taken into care?

How can we improve?

An effective early help system from birth through to 18 can strengthen and support families and reduce the number of children requiring protection plans. Such a system relies on having an appropriately trained front line and multi-disciplinary early help and child protection workforce. **Health professionals working with children and young people are a key part of the system** and should be appropriately trained in recognising safeguarding concerns and knowing how to support children at risk of, or experiencing, harm e.g. health visitors, nursery nurses, GPs.

Parenting programmes and the **Personal, Social, Health and Economic education** (PSHE), particularly the Relationships Sexuality Education (RSE) curriculum taught in schools all help children, young people and their families to learn about healthy relationships, appropriate behaviour and how to seek help if needed.

Local Safeguarding Children Boards (LSCBs) play an important role in protecting and safeguarding children in England through co-ordinating and holding to account local area multi-agency arrangements to keep children safe, for example through requiring impact evaluations and ensuring practitioners are using evidence-based models to support best practice.

What are we doing in East Sussex?

- East Sussex Local Safeguarding Children Board (LSCB) **provides training to support the multi-agency workforce in their safeguarding role**, including identification of neglect and abuse. This is monitored via audits of safeguarding training by the Designated Safeguarding Nurse. Auditing of casework on a multi-agency basis explores whether the training is having an impact.
- The county council **supports the safeguarding role of schools** and encourages Designated Safeguarding Leads (DSL) in schools to participate in DSL networks across the county. The aim of the DSL networks is to identify strengths and weaknesses within schools, facilitate professional development, and build capacity for school-to school support in safeguarding practice which includes the identification of children in need of protection.
- The recent **LSCB focus on sexual exploitation and on neglect practice** may have contributed to better identification of children at risk in East Sussex resulting in more children subject to plans and in some cases for plans to last longer.
- **A locally developed Continuum of Need (CoN) to assess the children and families** worked with is used in East Sussex. East Sussex has also been using Government funding from the Troubled Families initiative **to strengthen and increase Early Help services**.
- **Links between Early Help Services and Social Care Teams** have been improved to prevent the need for a protection plan if possible and **to help maintain improvements in families once the need for a plan has come to an end**.
- **The Family Drug and Alcohol Court in East Sussex and Brighton/Hove is a specialist family court** designed to provide an **alternative to the removal of children from their parent**/carer once the case has met the legal threshold for removal. The local service is jointly delivered with the Family Justices via a designated Judge, legal services for the LA and parents and a small multidisciplinary team within SWIFT (Safeguarding and intensive family therapy). The court provides oversight from a family judge combined with an intensive assessment and intervention offer for the whole family.
- In East Sussex **all secondary schools and some targeted primary schools** are provided with **Relationships and Sex Education (RSE) support services** who deliver training and development opportunities to design and embed high quality, age appropriate RSE into schools.
- Parents can access support through the Triple P parenting programme, or through more intensive family work if required.

Key actions going forward

- Protect and continue to support the provision of early help services.
- The East Sussex LSCB Training Programme continues to provide a wide range of courses to keep up-to-date with current local and national safeguarding concerns. Courses are free to LSCB member organisations. Uptake of safeguarding training by all partner organisations is monitored by the LSCB through regular audit.
- In addition to current provision the RSE service is preparing East Sussex secondary schools to teach RSE as a statutory subject from September 2019.

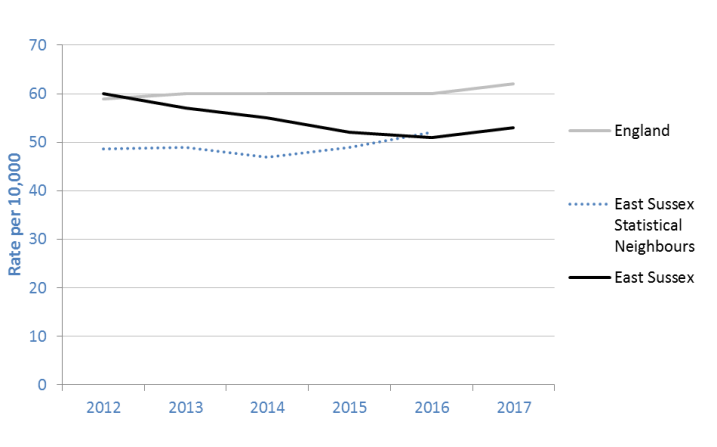
CHAPTER 5
Family and social environment
5.4 Looked after children

Number of children looked after by the local authority (LA)

Key messages

- In 2017 there were 53 children per 10,000 aged 0-17 who were looked after by the LA. There has been an overall decrease in numbers of looked after children (LAC) from 620 in 2012 to 560 in 2017. East Sussex is now below the England average and slightly below the South East average.
- There are large differences in the rate of LAC between districts and boroughs, with more deprived areas having higher rates: Hastings 76 per 10,000, Rother 57 per 10,000 and Eastbourne 51 per 10,000, compared to 31-32 per 10,000 in Lewes and Wealden.
- Changes in legislative frameworks have increased the numbers of children who become LAC e.g. Unaccompanied Asylum Seeking children (UASC). There were 24 UASC in East Sussex in March 2017.
- Around half of LAC in England are reported to have emotional and behavioural difficulties[3]. The work of LAC Mental Health Services in East Sussex are highly regarded by carers, professional staff and children alike, although there are challenges with capacity.
- Some LAC do not achieve their academic potential, particularly if they enter the care system when they are older. In East Sussex the Virtual School works to support LAC through education and improve outcomes.
- **What is this indicator showing us?**

The indicator shows the rate of children aged 0-17 per 10 000 who are in the care of the LA. Usually this will be with foster carers, but some looked after children might stay in a children's home or boarding school, or with an extended family member. The term 'looked after children' includes unaccompanied asylum seeking children (UASC), children placed in friends and family placements by the Courts, and those children where the agency has authority to place the child for adoption but the child is not matched with adopters as yet.

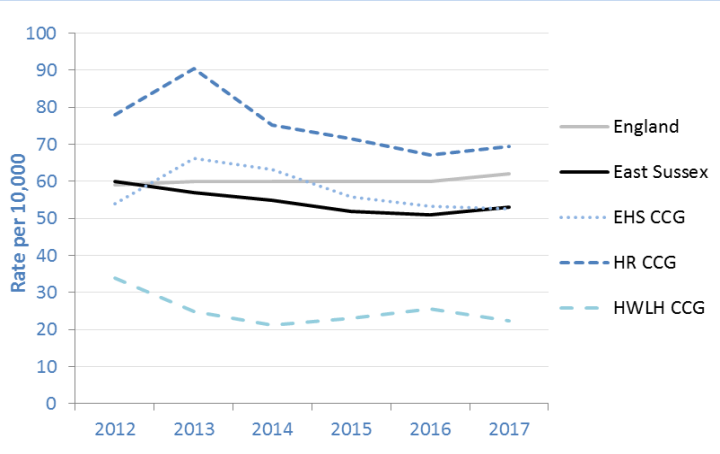


Latest data: On 31 March 2017 the rate of LAC in East Sussex had decreased slightly from the previous year. England data and statistical neighbours' data is not yet available.

Trends: Since 2012 East Sussex rates of LAC have fallen from being considerably higher than England to similar. Over this period rates for England have risen slightly, whilst the statistical neighbour rate has increased above East Sussex.

Source: DfE, Looked after children statistics

Figure 5.4.1: Rate of looked after children per 10,000 population aged 0-17 in East Sussex, 2012 to 2017

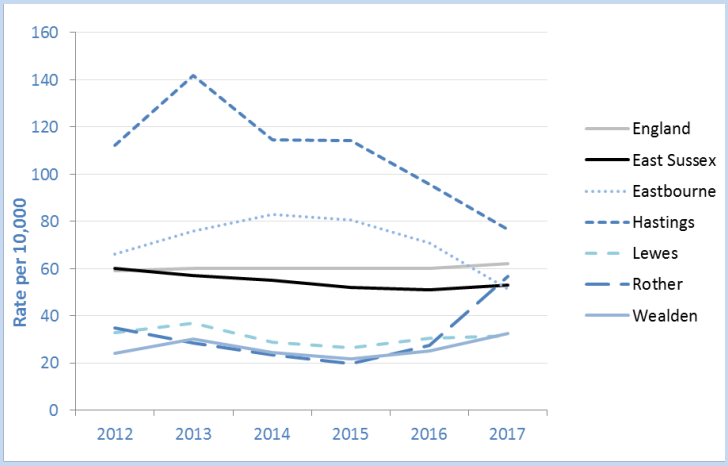


Latest data: In 2017, Hastings and Rother CCG area had a higher rate of LAC compared to England and East Sussex whilst High Weald Lewes Havens CCG had a much lower rate.

Trends: Rates of LAC have decreased between 2012 and 2016 for all three East Sussex CCGs but in 2017 the rate in Hastings and Rother increased and remains above the national rate.

Source: East Sussex JSNAA scorecards and DfE Looked after children statistics

Figure 5.4.2: Rate of looked after children per 10,000 population aged 0-17 in East Sussex by CCG, 2012 to 2017



Latest data: In 2017, rates of LAC in Hastings were higher than England, whilst rates in Lewes and Wealden were significantly lower.

Trends: Since 2012 overall East Sussex rates of LAC have fallen with the largest decrease in Hastings offsetting slight increases in Eastbourne and Wealden. However Hastings is still significantly higher than England.

Source: East Sussex JSNAA scorecards and DfE Looked after children statistics

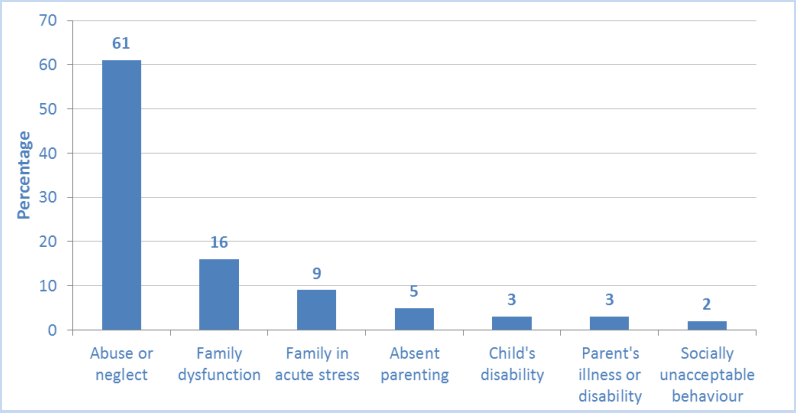
Figure 5.4.3: Rate of looked after children per 10,000 population aged 0-17 in East Sussex by district and borough, 2012 to 2017

Why is this indicator important?

Experiences in childhood have lifelong consequences. Children who become part of the care system often come from families who have experienced extreme hardship and upheaval, including poverty, neglect, parental mental health problems or substance misuse, and relationship breakdown. Adverse childhood experiences such as those just described lead to higher levels of risky health behaviours in adulthood, mental and physical ill health and premature mortality[45].

LAC are more likely to have mental, social and physical health problems compared to their non-looked after peers. Around half of LAC in England are reported to have emotional and behavioural difficulties[3]. Disruption to home life often means that looked after children do not achieve their academic potential.

A large number of children coming into care will have a history of physical, sexual or emotional abuse. Some may have suffered the death of a parent, or have parents who can't look after them properly because of illness. Others may have disabilities and many different needs. A very small number are in care because they are remanded by a court because of crimes they have committed.



Latest: Nationally, over 60% of children who are taken into care have experienced abuse or neglect. The second most frequent reason is family dysfunction.

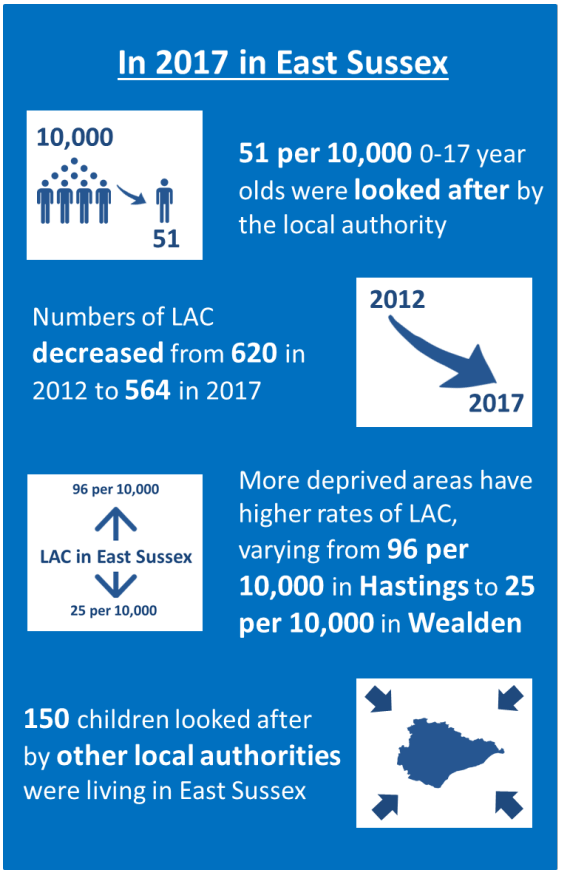
Source: House of Commons library, Briefing paper 04470

Figure 5.4.4: Distribution of causes of concern leading to children in England being taken into care, as of 31st March 2015

Where are we now in East Sussex?

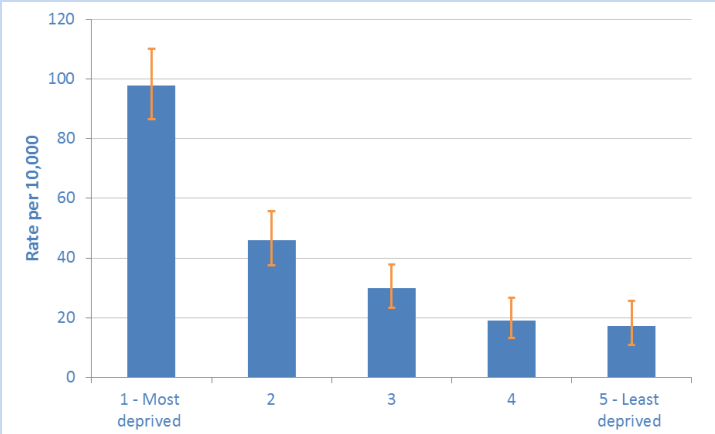
The total number of LAC in East Sussex in 2017 (560)was slightly higher than in 2016 (545), however if the 24 UASC are not included, then 2017 represents a slight decrease in numbers of LAC in East Sussex.

There are also a number of children who are looked after by other local authorities who live in East Sussex. While the placing authority retains responsibility for them, services in East Sussex may still support these children. At the end of March 2017 East Sussex County Council (ESCC) were aware of 150 children looked after by other local authorities living in East Sussex.



Spotlight on inequalities

Local data shows significantly higher rates of looked after children from the most deprived wards compared to the rest of East Sussex. Deprivation explains the higher rates of looked after children from Hastings compared to more affluent Lewes or Wealden. These children are likely to have been subject to numerous adverse childhood experiences and fewer protective factors prior to becoming looked after.



Latest data: In East Sussex there is a clear relationship between deprivation and LAC status. Around twice as many children originally living in the most deprived Income Deprivation Affecting Children Index (IDACI) quintile are looked after compared to the next most deprived ward. This is almost five times as many children compared to the least deprived 20% of wards.

Source: ESCC, Children's Services data

Figure 5.4.5: Rate of looked after children per 10,000 population aged 0-17 in East Sussex by deprivation (IDACI quintiles), as at 31st March 2016

What does good look like?

The IDACI expected (a measure in terms of population profiles and deprivation levels) rate of LAC for East Sussex is 56.6 per 100,000. East Sussex has fewer LAC (51 per 100,000) compared to this expected rate and to local authorities with a similar population and deprivation. Nationally, a quarter of local authorities have fewer than 44.5 looked after children per 100,000, and the LA area with the lowest rate has only 21.5 children per 100,000 (Wokingham in Surrey).

How can we improve?

The Children and Families Act 2014[46] set out **reforms designed to improve the life chances of LAC** and young people, including **tackling delays to the adoption process** through the introduction of 'fostering for adoption' placements. In addition the Act gave children in care the option to stay with their foster families until they turn 21; improved the quality of children's residential care; and changed the arrangements for contact between LAC and their birth families.

The Act also required **every LA to have a virtual school head to champion the education of children in care** with the aim of reducing inequalities in outcomes between LAC and non-LAC. LAC with additional needs might benefit from the Act's introduction of the requirement for **a single Education, Health and Care (EHC) plan for children with special educational needs and disabilities**. EHC plans can cover young people up to the age of 25 and ease the transition to adult services.

How can we improve?

National Institute for Health and Care Excellence (NICE) Public Health Guidance 28 recommends that local plans and strategies for children and young people's health and wellbeing fully reflect the needs of looked-after children and young people by setting out through the Joint Strategic Needs and Asset Assessment (JSNAA) how their needs will be met. Specifically local areas should identify how they will:

- meet the changing needs of looked-after populations and provide high-quality care.
- provide services that meet the emotional health and wellbeing needs of children and their carers, including child and adolescent mental health services (CAMHS), core health services (for example, immunisation) and enhanced services (for example, paediatrics).
- promote healthy lifestyles.
- provide access to extra-curricular activities.
- improve the stability of placements and education.

What are we doing in East Sussex?

- ESCC makes a **pledge to children in its care** as part of the Council's Corporate Parenting role. This pledge covers aspects such as **promoting contact with birth families**, **providing safe accommodation** and **supporting educational outcomes**.
- Elected members meet on a quarterly basis as a Corporate Parenting Panel to receive reports related to LAC. **The Annual Report for the LAC service is presented to the cabinet and to Full Council**.
- Given the increased vulnerability of this group of children, the **East Sussex LSCB receives and reviews an annual report from the Heads of Service for LAC** to ensure that services are meeting the needs of the local population. The performance of the **Looked After Children Mental Health Service (LACMHS) is also monitored closely**.
- **Health Services for LAC have recently been recommissioned** resulting in a change of provider. It is intended that the new provider will provide **more rapid assessments** than in the past and link more closely to the LAC nursing service.
- The Virtual School provides support for educational issues for LAC. **In 2015/16 Educational outcomes for LAC in East Sussex continued to improve overall**, especially at Key Stage 4 (when pupils study for GCSEs).
- Pupil Premium funding enabled the school to **enhance its provision to schools, carers, individual LAC** and recruit a bank of specialist tutors. In addition, the Head of the Virtual School fostered excellent working relationships across the council and the local community which resulted in LAC being prioritised for a range of complementary services.

Key actions going forward

- **Monitor the performance of the new health service for LAC** to ensure that health checks are received in a timely manner, and appropriate plans put into place. Services will be reviewed against guidance to ensure best practice is being followed.
- To continue to **ensure** that the **right children** are in the **right placements** for the **right amount of time.**
- To secure the **best outcomes possible within the available resources.**

CHAPTER 6
Health conditions of childhood
6.1 Asthma

Emergency hospital admission rate for asthma for children and young people aged 0-18 years

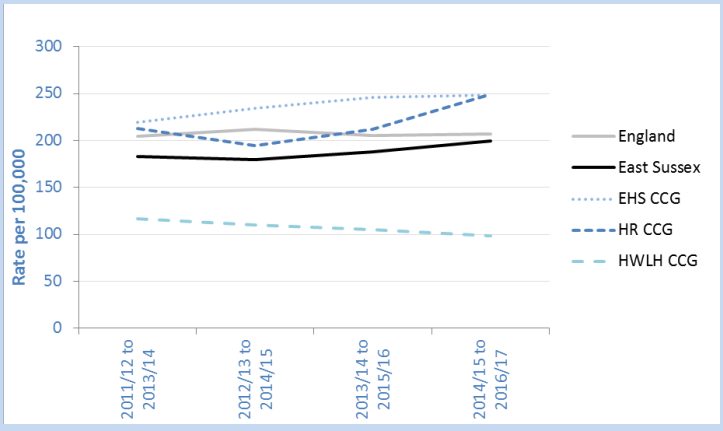
Key messages

- Asthma is a common lung condition that often starts in childhood. Over one million children in the UK are receiving treatment for asthma, 1 in 11.
- The UK has among the highest prevalence rates of asthma symptoms in children worldwide.
- Admissions due to asthma for children and young people (0-18 years) are similar for East Sussex compared to the England average.
- Emergency admission rates for asthma in children vary across East Sussex.
- Evidence suggests that up to 70% of all asthma admissions are preventable through better management in primary care.
- East Sussex Better Together (ESBT) is developing a comprehensive approach to asthma care in primary care.

What is this indicator showing us?

This indicator shows the rate of emergency admissions to hospital for asthma of children and young people under 19 years of age (per 100,000 children) in East Sussex. Children and young people seen in the emergency department but not admitted are not included in this indicator.

Emergency hospital admissions for asthma in children aged 0-18 years



Latest data: Over the three years 2014/15 to 2016/17 there were 670 emergency admissions to hospital of children under 19 with asthma in East Sussex, a rate of 199 per 100,000. At CCCG level rates vary with High Weald Lewes Havens CCG having statistically significantly lower rates than the rest of East Sussex.

Trend: Since the period 2011/12 to 2013/14 there has been a small increase in the rate of emergency admission for asthma in children aged 0-19 years in East Sussex. Eastbourne, Hailsham and Seaford CCG has seen a consistent increase in emergency admissions over this period, with Hastings and Rother CCG rates increasing rapidly between 2012/13 to 2014/15 and 2014/15 to 2016/17.

Source: NHS Digital, Hospital Episode Statistics

Figure 6.1.1: Emergency hospital admission rate for asthma per 100,000 children (0-18 years) in East Sussex by CCG, 2011/12 to 2016/2017 (5 year rolling average)

Why is this indicator important?

Over a million children in the UK are currently receiving treatment for asthma. The UK has one of the highest prevalence of asthma worldwide.[47]

Many children with asthma have poor control of their condition; this may lead to exacerbations and hospital admissions, and prevent them from leading a normal life. Emergency admissions indicate a loss of control of the condition, and many of these could be avoided through early identification and effective and proactive management of their asthma. The goal of treatment is for patients to be free of symptoms, and able to lead a normal, active life.

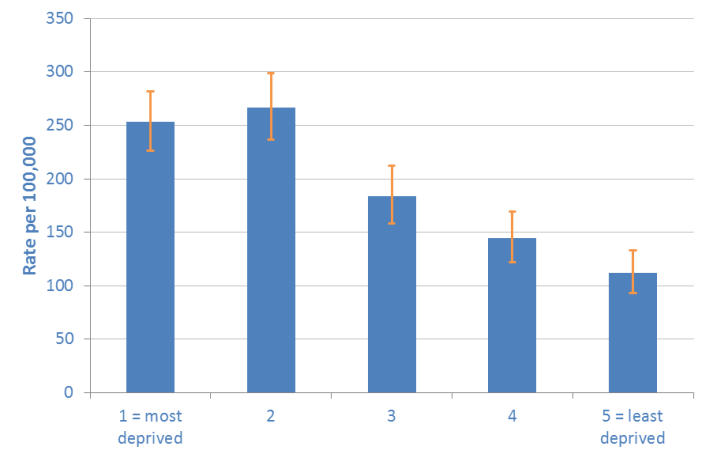
Approximately £1 billion is spent by the NHS annually on treating people with asthma, half of which is for emergency care. Of all emergency admissions for asthma up to 70% may be preventable.

Where are we now in East Sussex?

In East Sussex the emergency admission rate for asthma in children aged 0-19 years has increased from 183 to 199 per 100,000 children over the 6 year period (2011/12 – 2016/17). Emergency admission rates in High Weald Lewes Havens CCG are significantly lower than the East Sussex average. East Sussex Better Together CCGs emergency admission rates have remained higher than the East Sussex average.

Spotlight on inequalities

There is a clear relationship between deprivation and the number of emergency admissions for asthma. Children from more deprived areas are more likely to be admitted as an emergency for asthma than children from less deprived areas. There are a number of factors which may contribute to this, including potential variations in prevalence, exposure to triggers (high levels of internal and/or external air pollution, smoking (active or passive) etc.) or to differences in how asthma is managed.



Latest data: Emergency admission rates for asthma are significantly higher in the two most deprived quintiles of East Sussex compared to the two least deprived quintiles in East Sussex.

Source: NHS Digital, Hospital Episode Statistics

Figure 6.1.2: Emergency hospital admission rate for asthma per 100,000 children by IDACI quintile, in East Sussex 2012/13 to 2016/17

What does good look like?

According the Public Health England (PHE) Fingertips tool, across England the lowest rate of emergency admissions from asthma in 2015/16 was in Kensington and Chelsea with 84 admissions per 100,000 0-18 year olds. The top quartile of areas across the country had emergency admission rates below 149 per 100,000. Using the same data, in 2015/16 the crude emergency admission rate for children with asthma in East Sussex was 232 per 100,000 aged 0-18 years which is significantly worse than the English (202) and regional (166) averages.

Mortality from asthma is higher in the UK than many other European countries. In their most recent National Review of Asthma Deaths the Royal College of Physicians (RCP) found that in almost half of all childhood deaths the standard of care was inadequate.[48] They also identified that there were potentially patient/family avoidable factors in almost two thirds of deaths.

How can we improve?

Although the aetiology and risk factors for asthma are not fully understood the link with some risk factors, such as maternal smoking, are well established. Actions such as **supporting women to stop smoking** (see Indicator 2.1), **encouraging breastfeeding** (see Indicator 2.2) and **reducing the impact of environmental smoke and air pollution** are all important preventative approaches to reducing the risk of children developing asthma.

Poor recognition of triggers for asthma attacks is an important avoidable factor for children. In their review of asthma deaths the RCP found 39% of the children reviewed were exposed to second-hand smoke. **Exposure to allergens and second-hand smoke should be minimised** wherever possible (see Indicator 2.1).[49] There needs to be **better education** to enable children and their families to understand what triggers their symptoms and support to help them avoid these triggers and self-manage their condition.

An **integrated approach to provision of services** is fundamental to the delivery of high quality care to children and young people with asthma. The NICE quality standard for asthma requires that services should be commissioned from and coordinated across all relevant agencies encompassing the whole asthma care pathway. **Treatment should be personalised to the individual** and should be supported by a structured review by a healthcare professional with specialist training in asthma, at least annually. It is important that all healthcare professionals who provide asthma care to children and young people should have specific knowledge, skills and training in children's asthma and in supporting young people to self-manage their condition.[50]

Children and young people with asthma should be provided with **individually personalised personal action plans.** Written personalised action plans, given as part of structured education, can improve outcomes such as self-efficacy, knowledge, and confidence for people with asthma, particularly for children and young people with moderate to severe asthma whose condition is managed in secondary care. For children and young people with asthma who have had a recent acute exacerbation resulting in admission to hospital, written personalised action plans may reduce readmission rates.

Schools play an important role in supporting children and young people with long-term conditions such as asthma. It is essential for people who work with children and young people with asthma to know how to recognise the signs of an asthma attack and what to do if children have an attack.

Seventy percent of emergency admissions are considered preventable. Better management, including treatment tailored to the individual and ensuring patients and families are aware of, and reduce exposure to, triggers that provoke their symptoms are essential for providing excellent asthma care.

What are we doing in East Sussex?

Asthma pathways are being reviewed as part of the work of ESBT. This work aims to develop a programme **for promoting optimal asthma care**, including **patient education** and **self-management plans** across the county. It will also inform a **more comprehensive county-wide approach to childhood asthma care in primary care**.

Key actions going forward

- Ensure full implementation of asthma guidelines from both NICE and British Thoracic Society (BTS) and Scottish Intercollegiate Guidelines Network (SIGN) across healthcare settings.
- Improve asthma education for children, families and healthcare professionals.
- Improve training for healthcare professionals in working with young people.
- Work with schools to develop their responsibilities in relation to children with asthma.

CHAPTER 6
Health conditions of childhood
6.2 Cancer

Incidence and mortality for malignant cancers in children and young people (under 19 years)

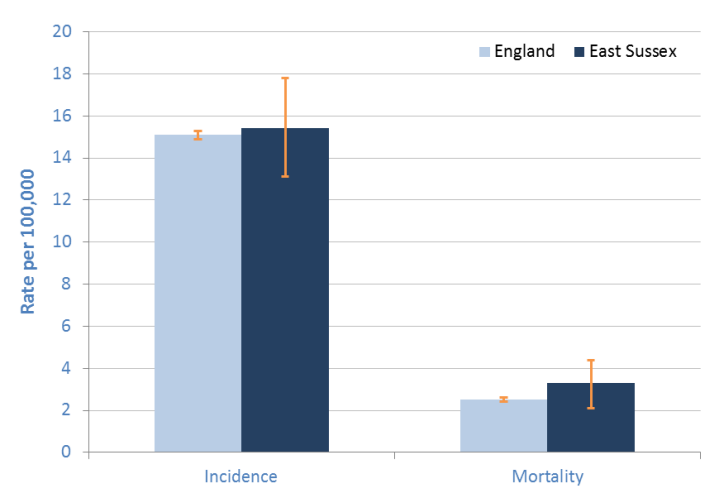
Key messages

- Cancer in children under the age of 15 is rare and accounts for less than 1% of all new cancer cases in England. Nationally around 1,400 children are diagnosed with cancer each year.
- More than 8 out of every 10 children diagnosed with cancer will live for at least five years, and most of these children will be cured.
- The number of children surviving five years following a cancer diagnosis has doubled since the 1970s. This reflects improvements in treatment and care.
- Cancer causes 1 in 100 (less than1%) of all deaths in children.
- Children's cancer mortality rates have decreased by 66% since the early 1970s in the UK.

What is this indicator showing us?

This indicator shows the age standardised incidence and mortality rates for malignant cancers in children and young people aged 0–19 years in East Sussex.

Age-sex standardised incidence and mortality rate for malignant cancers in people aged under 19



Latest data: For the 10-year period 2005-14 there were 181 cases of cancer in children and young people aged under 19 years in East Sussex. During this same period there were 38 childhood deaths due to cancer in the county. Childhood cancer incidence and mortality rates in East Sussex for the period 2005 to 2014 were not significantly different to the England rates.

Source: PHE, CancerStats Tool

Figure 6.2.1: Age-sex standardised incidence and mortality rate for all malignant cancers for 0-19 year olds in East Sussex, 2005-2014

Why is this indicator important?

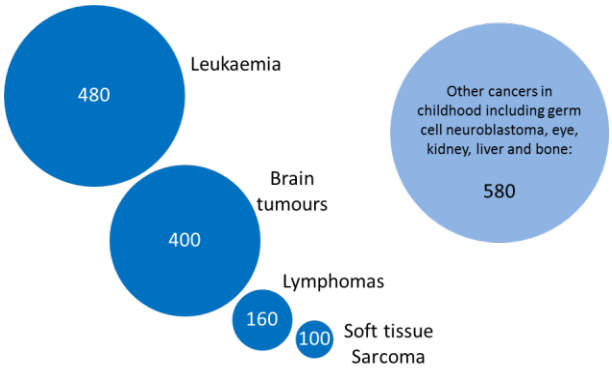
There are many different types of childhood cancer. The cancers that affect children can be quite different from cancers affecting adults, as they tend to occur in different parts of the body to adult cancers.

A person's risk of developing cancer depends on many factors, including age, genetics, and exposure to risk factors (including some potentially avoidable lifestyle factors). However, lifestyle risk factors probably have less impact on cancer risk in childhood than adult cancer risk, because children have had

less time to be exposed to these factors. In general, children's cancer risk factors are not well understood, mainly because this group of cancers are relatively rare and diverse.

The most common type of cancer is leukemia, which accounts for about a third of all cases in both boys and girls. A further quarter of cancer cases were brain tumours. No other type of cancer accounts for more than 15%.[51]

Common types of cancer in childhood in the UK (number of diagnoses per year)



What does good look like?

Childhood cancer incidence and mortality rates for East Sussex are not significantly different to the rate in England for the period 2005-2014. Survival rates are not reported at an East Sussex level, but survival rates in the UK are reported to be amongst the best in Europe for most, but not for all cancers.[52]

How can we improve?

Early diagnosis of cancer reduces mortality and morbidity. However, childhood cancers often present with non-specific symptoms similar to those of other conditions, leading to delays in the diagnosis and initiation of appropriate treatment. In order to ensure childhood cancers are diagnosed early children presenting with the signs and symptoms outlined in NICE's 2015 guideline *suspected cancer: recognition and referral* should be referred urgently for specialist review.[53] Persistent parental anxiety is sufficient reason for referral, even where a benign cause is considered most likely. Additionally, urgent referral should take place when a child or young person presents several times) with the same problem, but with no clear diagnosis.

It should be noted that there are associations between Down's syndrome and leukaemia, between neurofibromatosis and central nervous system tumours, and between other rare syndromes and some cancers. Clinicians should be alert to the potential significance of unexplained symptoms in children with such syndromes.

Childhood cancer is rare and a typical GP will see only one or two cases across their entire career. It is essential that **primary care practitioners are supported to access training on identifying cancer in children and young people**.

Because cancers in children and young people are rare and often complex, services need to be able to **consider each case of cancer individually**, taking into consideration the clinical and wider needs of each child and young person, and their families and carers.

How can we improve?

The NICE quality standard for children and young people with cancer specifies that services should be commissioned from and coordinated across all relevant agencies encompassing the whole cancer care pathway. A person-centred, integrated approach to providing services is fundamental to delivering high-quality care to children and young people with cancer.

This includes consideration of the psychological and social needs of children and young people with cancer, and their families. As well as planning for agreed follow-up and monitoring of children who survive cancer.

What are we doing in East Sussex?

Children with suspected cancers get their care from specialist hospitals such as Great Ormond Street Hospital for Children NHS Trust, with a shared care protocol locally. Locally, hospice care is also commissioned on a case by case basis (see section on children with progressive, life-shortening illnesses).

Key actions going forward

- Ensure children and young people are fully involved in decisions about their cancer treatment and care.
- Improve training of primary care professionals in identification and early diagnosis of childhood cancers.

CHAPTER 6
Health conditions of childhood
6.3 Diabetes

Proportion of children and young people with type-1 diabetes meeting recommended targets for blood glucose control

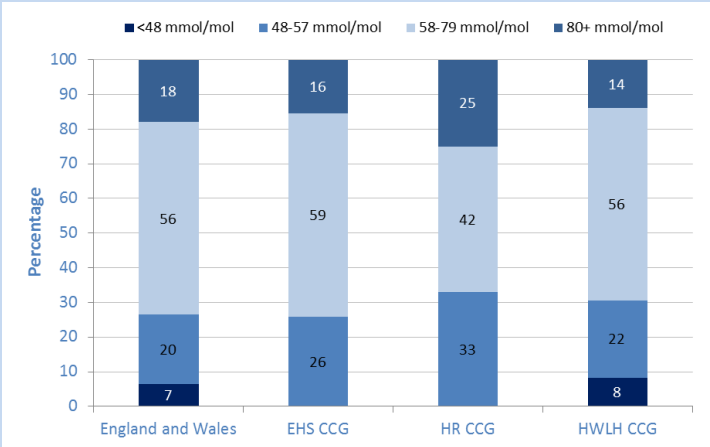
Key messages

- The incidence of type-1 diabetes is increasing and accounts for 97% of all children with diabetes in England.
- The UK has one of the highest rates of type-1 diabetes in the world, for reasons that are currently unknown.
- When diabetes is not well managed, it is associated with serious complications including heart disease, stroke, blindness, kidney disease and amputations leading to disability and premature mortality.
- Very few children and young people in East Sussex have glycated haemoglobin (HbA1c) levels below the target of 48mmol/mol.
- There are higher emergency admission rates for children and young people with diabetes from more deprived areas in East Sussex.

What is this indicator showing us?

This indicator shows the proportion of children and young people with type-1 diabetes meeting the 2015 NICE target value of HbA1c levels below 48mmol/mol, indicative of good control. Pre-2015 NICE recommended HbA1c target of less than 58mmol/mol. HbA1c refers to glycated haemoglobin and is used to estimate average blood glucose exposure over the previous two months.

Blood glucose control in children and young people with type-1 diabetes



Latest data: In 2015/16 only 7% of children and young people had HbA1c levels below NICE recommended levels. High Weald Lewes Havens CCG has 8% of children and young people achieving this target, but 0% in Eastbourne, Hailsham and Seaford CCG or Hastings and Rother CCG achieved the 48mmol/mol target.

Source: Source: National Paediatric Diabetes Audit 2015/16

Figure 6.3.1: Proportion of children and young people with Type-1 diabetes by HbA1c level in England and East Sussex CCGs, 2015/16

Why is this indicator important?

There are about 31,500 children and young people under the age of 19 with diabetes in the UK. Type-1 diabetes accounts for 97% of all children and young people with diabetes.[54]

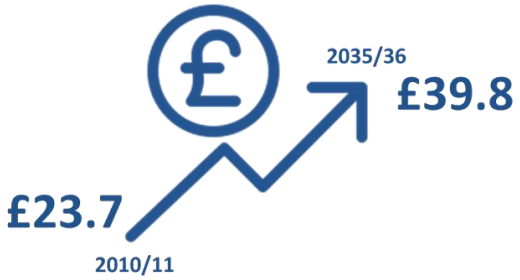
The incidence rate of type-1 diabetes is 28 per 100,000 in the UK, the sixth highest rate in the world. Incidence is increasing by about four per cent each year, particularly in children under-five, with a five percent increase each year in this age group over the last 20 years.

Type-1 diabetes occurs when the body doesn't produce any insulin. There's no cure for diabetes, so treatment aims to keep blood glucose levels as normal as possible and to control symptoms and prevent health problems developing later in life.

Poor diabetes control is associated with damage to small and large blood vessels, and nerves. Over time this damage can result in blindness, kidney failure, heart disease, stroke, and amputations. With good diabetes care and blood glucose control, the risks of complications are markedly reduced, enabling children and young people to enjoy a healthy and longer life.

The costs of all diabetes care in the UK (direct and indirect) are increasing. In 2010/11 the figure was £23.7 million, this is estimated to increase to £39.8 million by 2035/36 - although much of this is driven by increases in treatment and care associated with type-2 diabetes.

Estimated direct and indirect costs of treating diabetes:



Where are we now in East Sussex?

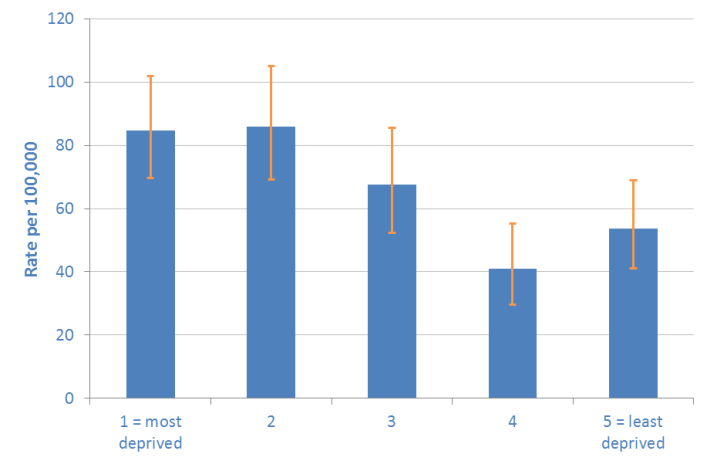
The National Paediatric Diabetes audit reports at centre level (i.e. hospital site) rather than county. In the most recent audit (2014) East Sussex Healthcare NHS Trust (ESHT) identified 114 cases. There may be additional East Sussex children who receive their diabetes care in other paediatric diabetes units.

At the individual level, the aim should be to have all children with type-1 diabetes reaching national HbA1c target levels of 48mmol/mol or less. Data are not reported for the county as a whole. At CCG level the percentage of children with type-1 diabetes with HbA1c levels below the target value was 8% in High Weald Lewes Havens CCG but in the East Sussex Better Together CCGs no children with type-1 diabetes were reported as meeting the 48mmol/mol target.

The pre-2015 target was HbA1c levels below 58mmol/mol. Within East Sussex CCGs achievement is: Hastings and Rother CCG (33%), High Weald Lewes Havens CCG (30%), and Eastbourne, Hailsham and Seaford CCG (26%).

Spotlight on inequalities

At a national level there are differences in HbA1c target outcomes associated with age, deprivation, gender and ethnicity. In general, children and young people with type-1 diabetes have poorer outcomes if they live in a deprived area, are of non-white ethnicity, are adolescent, or are female. Maintaining HbA1c control involves establishing good daily routines which is often harder for children growing up in more deprived areas where the family already face a greater range of daily challenges



Latest data: Although we do not have information on HbA1c control by deprivation group locally, there is a gradient seen in emergency admissions for diabetes (type-1 only). Those from the two most deprived groups have significantly higher emergency admission rates for diabetes than the two least deprived groups.

Source: NHS Digital, Hospital Episode Statistics

Figure 6.3.2: Emergency admissions due to diabetes by East Sussex deprivation quintile, 0-18 year olds, rate per 100,000, 2012/13 to 2016/17

What does good look like?

Nationally, only 7% of children and young people with type-1 diabetes had HbA1c levels less than the 2015 NICE threshold of 48mmol/mol in 2015/16. In East Sussex only a small percentage from High Weald Lewes Havens CCG were achieving the target threshold for HbA1c control. It is important that all children and young people receive appropriated education about the management of their diabetes from specialist multidisciplinary diabetes teams.

Nationally there has been an increase in the proportion of children and young people with HbA1c levels below the 58 mmol/mol threshold and a corresponding fall in proportions with poor control (>80mmol/mol) since 2010/2011. The data are not available at CCG level.[55]

How can we improve?

The 2015 NICE guidance for the diagnosis and management of diabetes (type-1 and type-2) in children and young people introduced recommendations for strict blood glucose control to reduce the long-term risks associated with the condition.[56] **Children and young people with glycated haemoglobin (HbA1c) levels of less than 48mmol/L are less likely to develop complications related to their diabetes.** This tight control may be achieved by intensive insulin management (multiple daily injections or insulin pump therapy) from diagnosis, accompanied by carbohydrate counting. Improved diabetes control and patient satisfaction can also be achieved by access to more intensive diabetes regimens, such as insulin pumps and continuous glucose monitoring. However, access to such technologies varies.

How can we improve?

The treatment and care of children and young people with type-1 diabetes should address the key priorities area outlined in NICE guidance, including:

- Provision of appropriate and relevant **education and information** for children and young people and their families.
- **Insulin therapy**.
- **Dietary management**.
- Blood glucose and HbA1c targets and **3-monthly monitoring**.
- Support for **self-testing for ketonaemia** if they are ill or have hyperglycaemia.
- Provision of **psychological support** to children, young people and their families and carers.
- **Early and prompt testing** of children without known diabetes who exhibit signs or symptoms of diabetic ketoacidosis.

Transition from paediatric to adult service is a time of risk for diabetes management as the services have different models of care and evidence bases. If a young person is moving between paediatric and adult services, care **should be planned and managed effectively**.

Schools have an important role to play in supporting children and young people with type-1 diabetes to manage their diabetes. Diabetes can affect learning, and if it's not well managed a child can have difficulties with attention, memory, processing speed, planning and organising and perceptual skills, meaning they might not achieve their full academic potential.

What are we doing in East Sussex?

ESHT and Brighton and Sussex University Hospitals NHS Trust (BSUH), our main paediatric diabetes centres, are part of the national paediatric network for diabetes. Insulin pump therapy and continuous glucose monitoring is prescribed as per NICE guidance.

Both trusts participate in the National Paediatric Diabetes Audit, commissioned by the Healthcare Quality Improvement Partnership (HQIP). This audit collects information from about the care received by the children and young people with diabetes, including information on HbA1c control.

The effectiveness of diabetes care is measured against NICE guidelines and includes treatment targets, health checks, patient education, psychological wellbeing and assessment of diabetes related complications.

Key actions going forward

- **Improve diabetes education** for children, young people, families and healthcare and educational professionals **to decrease stigma and discrimination**.
- **Ensure full implementation of updated NICE guidance for HbA1c levels**, along with the recommendations from the NPDA regarding care management.
- **Ensure joined-up care which meets the wider needs of children with diabetes**, including appropriate transition to adult diabetes services.

CHAPTER 6
Health conditions of childhood
6.4 Disability and additional learning needs

Percentage of pupils with Special Educational Needs and Disabilities (SEND) / Additional Support Needs (ASN)

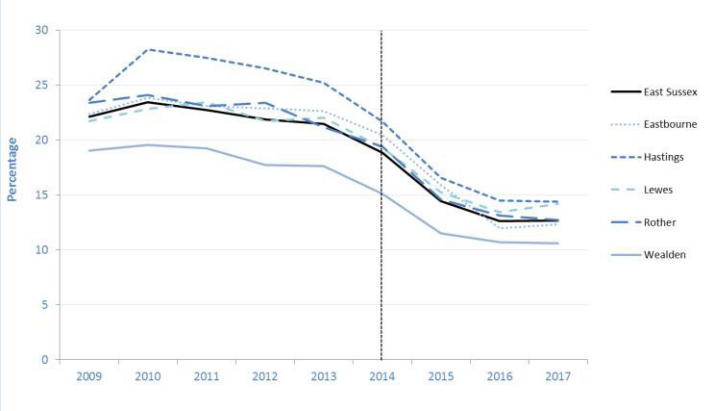
Key messages

- Local authorities have a statutory duty to identify and support children and young people with disabilities and learning difficulties.
- In East Sussex there are currently 13% of children and young people identified as having a special or additional educational need, compared to 14% in England.
- In line with the national trend, the recorded SEN population in all CCGs and Districts and Boroughs in East Sussex has declined, most rapidly since the start of the transitional stage to Education Health and Care (EHC) Plans in 2014.
- Children with SEND or ASN are more likely to come from low income families. This may be partially linked to caring duties preventing parents from full employment.
- In East Sussex we are improving data systems to monitor and support schools to record the identification, intervention and evaluation of support. We are also increasing the number of local special school places.

What is this indicator showing us?

This indicator shows the percentage of pupils identified with Special Educational Needs and Disabilities (SEND).

Percentage of children and young people with SEND in East Sussex and England



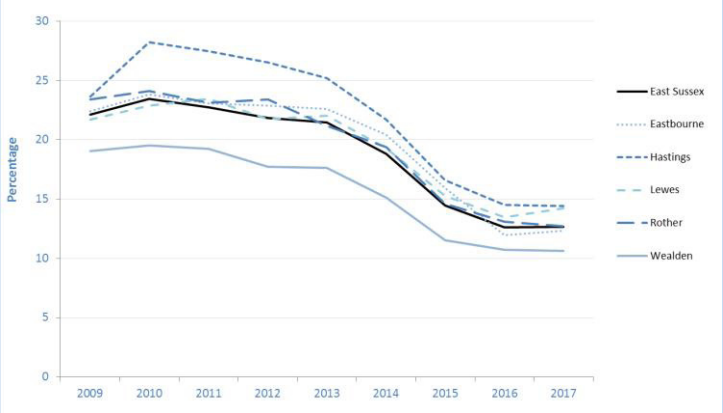
Latest data: The percentage of children and young people enrolled in education with an identified SEND In East Sussex is 12.7% as of January 2017. This compares with 14.4% of pupils in England.

Trend: Until January 2017 there had been a steady decline in the percentage of children and young people identified as having SEND since 2011. There has been a greater decline in East Sussex in this period (10.2%) than in England (6.2%) (Note the change in system in England in 2014).

Source: DfE, SEN statistics and ESCC, Children's Services data

(.....) Indicates change in system to transitional stage

Figure 6.4.1: Proportion of children in England and East Sussex enrolled in education identified with SEND, January 2007 to January 2017



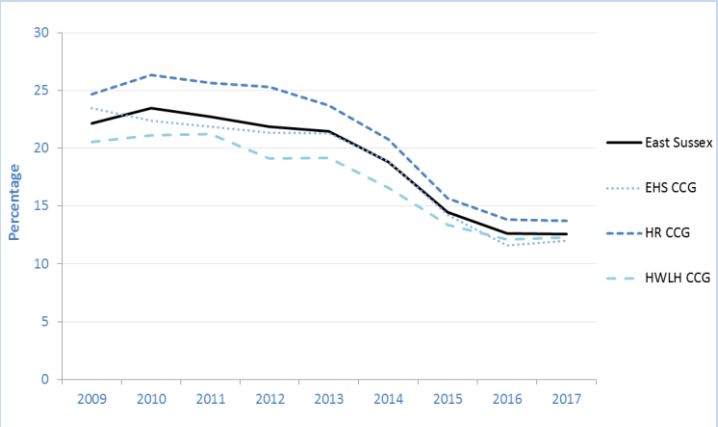
Latest data: The percentage of East Sussex resident children and young people enrolled in education with an identified SEND in East Sussex is highest in Hastings (14.4%) and lowest in Wealden (10.6%) as of January 2017.

Trend: There has been a steady decline in the percentage of children and young people identified as having SEND since 2010. The greatest decline has been in Hastings (13.6% since 2010) and the smallest in Wealden (8.7%) (Note the change in system in England in 2014).

Source: ESCC, Children's Services data.

In 2014 there was a change in system to transitional stage

Figure 6.4.2: Percentage of East Sussex resident children enrolled in East Sussex schools identified with SEND, January 2009 to January 2017\by districts and boroughs



Latest data: The percentage of children and young people enrolled in education with an identified SEND in East Sussex is highest in Hastings and Rother CCG (13.7%) and lowest in Eastbourne, Hailsham and Seaford CCG (12 %) as of January 2017.

Trend: There has been a steady decline in the percentage of children and young people identified as having SEND since 2010. The greatest decline has been in Hastings and Rother CCG (12.6% since 2010) and the smallest in High Weald Lewes Havens CCG (8.8%) (Note the change in system in England in 2014).

Source: ESCC, Children's Services data. In 2014 the system changed to transitional stage.

Figure 6.4.3: Percentage of East Sussex resident children enrolled in East Sussex schools identified with SEND, January 2009 to January 2017: by CCG

Why is this indicator important?

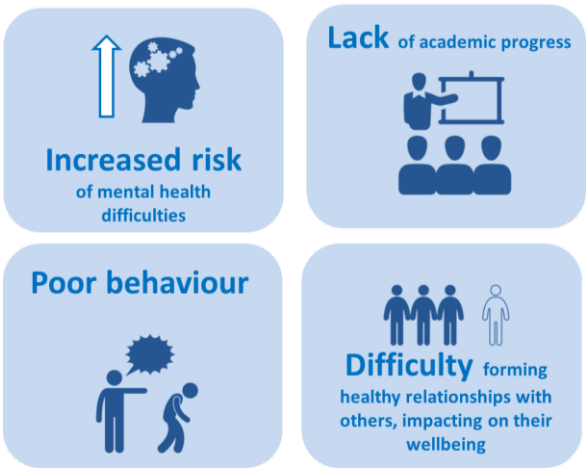
This indicator provides a measure of the number of children in the UK identified as having a disability and/or other learning impairment. Children with additional needs will require more support than their mainstream peers to ensure that they are able to fully benefit from education and go on to achieve good health, developmental and social outcomes before they become adults.

The SEND code of practice defines what is considered to be a special or additional need or disability. This means that some children who are less able than average will not be included in this indicator.

The data may also not capture all children who are not enrolled in formal education (many of whom may have very complex needs). Children with unidentified needs are likely to have a range of poorer outcomes.

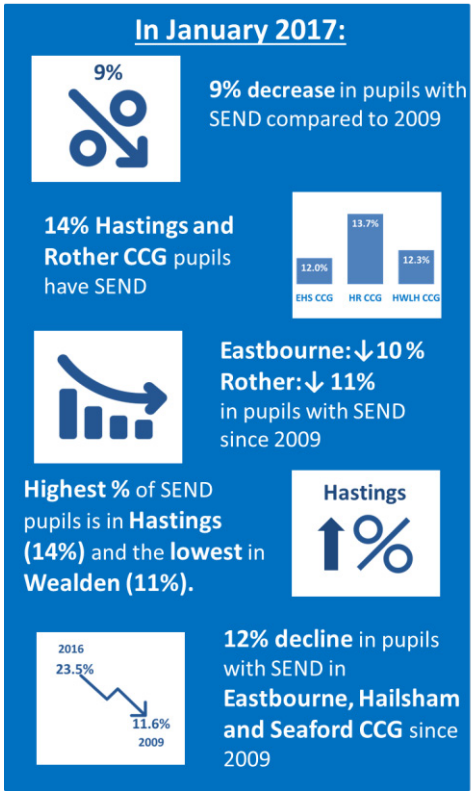
The Education Union carried out a survey of teachers and support staff in England which was published in 2016. 83% reported they felt that children with SEND were not getting the support required for them to maximise their potential.[57]

Those with incorrect, unidentified or insufficiently supported needs are more likely to experience:



Where are we now in East Sussex?

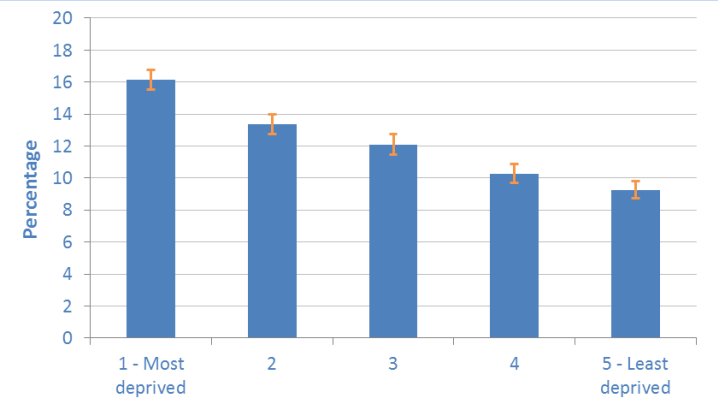
The proportion of children in East Sussex identified with SEND in January 2017 was 12.7%. Included within this category are those with complex needs who require a Statement of Special Educational Need (Statement) or an Educational Health and Care (EHC) Plan. This proportion has fallen from a peak of 4% in 2014 to 3.7% in 2015, in parallel with the reform of the system which began in 2014.



Since the start of the transition period into the new system, the number of pupils with SEND has decreased at a faster rate in secondary schools in East Sussex than in primary schools. The proportion of SEND pupils in secondary schools is now below the proportion in primary schools for the first time since 2007.

Spotlight on inequalities

Low income is associated with higher rates of SEND prevalence: 16% of children in the most deprived quintile in East Sussex have an identified SEND compared to only 9% in the least deprived quintile. The national picture is similar: far more children with an identified SEND are eligible for free school meals than children without an identified SEND (27.2% compared to 12.1%). There is an intergenerational cycle of deprivation as children with SEND are more likely to come from a deprived background and do less well at school, which in turn increases the risk of low income as an adult. Support costs, adaptations required as well travel costs and time off work to attend hospital appointments mean it can be much more expensive to raise a child with disabilities. This is an additional burden for families who are already more likely to have a low income.



Latest data: The percentage of children and young people enrolled in education with an identified SEND in East Sussex is closely correlated to deprivation quintile in East Sussex, with a significantly higher percentage of pupils with SEND in the most deprived quintile.

Source: ESCC, Children's Services data

Figure 6.4.4: Percentage of children in East Sussex enrolled in education identified with SEND in January 2016 by deprivation quintile

What does good look like?

A good system for children with special education needs and disabilities is one which can accurately identify needs in a timely manner and provide appropriate support for children and young people when a need has been identified. The proportion of children identified as having SEND is not just related to the efficiency of the system but also to the definition used and the thresholds set for the provision of support. A good system would have the following characteristics:

- always centred around the needs of the child and family and be able to make long-term plans for care including transition to adult services if needed.
- well-trained and professional staff working across service boundaries.
- able to identify needs as they emerge and put appropriate support in place.
- multi-professional clinical and care networks working together to share learning and expertise.

How can we improve?

The Children's and Families Act 2014 created a statutory duty for local authorities to **ensure appropriate education provision is available for all children and young people with an identified SEND**. The local authority must also put in place measures to support children and young people with medical conditions. Ofsted and CQC carry out joint inspections of local authorities' provision for children with SEND.

Frequently children with SEND or ASN are not identified until a child starts school. It may be that their needs do not emerge earlier but **health visitors and early years' staff have an important role in helping assess and identify the needs of the child at an early stage**. Once at school teachers and educational professionals take on this role. All **staff working with children must be trained to identify, assess and fully support all children and young people**, whatever their learning needs are.

Data on the needs of children and young people with SEND are needed to inform forward planning, allocation of resources and ensure children and young people with special or additional educational needs are not forgotten. Using **consistent methods of data collection** across the country as well a common vocabulary and indicators would make comparison between areas more robust.

Disability Matters is a free set of guidance and learning resources available to local authorities and produced by the Royal College of Paediatrics and Child Health to support the needs of children and young people with SEND.

What are we doing in East Sussex?

- The vast majority of schools in East Sussex including Special Schools are judged by Ofsted as Good or Outstanding. **SENCO's, school leaders and Governors state that the Local Authority (LA) specialist services provide useful and appropriate support**. They particularly value the East Sussex SEND Matrix - a detailed and informative guide for professionals improving the consistency of their work and informing earlier planning, meaning that an increasing proportion of pupils needs are met effectively.
- Outcomes for pupils with SEND continue to rise. **East Sussex is currently engaged in a review of the High Needs Block funding** as part of a national consultation.
- In East Sussex **there are a range of systems in place to help identify children and young people in need of additional support in mainstream school environments** (Front Door) including assessment, to ensure that thresholds are equitable and support is provided in a timely way in relation to the identified need of the child or young person.
- **The Early Years' service receives very positive feedback from parents** and this was formalised in the recent Reform Implementation Area Inspection undertaken by Ofsted and the CQC.
- The **CDS and Transition team work closely with Continuing Care colleagues** to jointly assess levels of need and provide where appropriate joint packages of support.
- The Joint Agency Placement Panel (JAPP) determines appropriate levels of funding for non-maintained school placements and has representation from Health, Social Care and Education.
- The LA has a **core offer in place to support staff in maintained schools** and can, if requested, work with non-maintained schools on a traded basis. Where there are concerns about provision in schools the LA will actively intervene to make improvements.
- The LA has developed a forecasting tool to support future provision planning and is the process of developing a specialist school nursing service.

Provision in East Sussex includes:

- A service to provide interim packages of education for school aged children too unwell to attend school (both physical and mental health). The service includes three teaching centres, an e-learning service and support workers.
- Clear pathways for prompt referral to a range of early support services.
- The CCGs have a contract with Chailey Heritage non maintained school regarded as a Centre of Excellence for children and young people with complex medical conditions.
- East Sussex uses the Department for Education (DfE) definitions which are used in the school census in relation to data collection.

Key actions going forward

- **Strengthen data systems to monitor** and support schools in appropriate identification, intervention and evaluation, and recording of **all** children with SEND on their SEND registers.
- **Ensure statutory provisions are in** place for children and young people with SEND and ASN, in particular those with additional medical needs.
- **Build capacity and inclusive ethos in mainstream schools** – targeted interventions with mainstream schools, and work through Education Improvement Partnerships, to improve Quality First Teaching and confidence in supporting more children with higher levels of need.
- **Improve parental confidence in local provision** – ensuring that parents receive consistent messages from schools and support services around the ability of local schools to support their children appropriately, within their local community.
- **Robustly implement the East Sussex post-16 pathways and ceasing EHC plans at age 16 where they are not required for the young person's chosen pathway.** Targeting as appropriate the young people age 12-15 to strengthen their targets for independence and academic progression to ensure that they are ready for transition at the age-appropriate date without the need for an ongoing EHC plan.
- **Increase the number of local special school places** – increasing the number of places through the development of specialist facilities in mainstream schools, Free Schools or Capital Programme.
- **Working with partners, ESBT and C4Y, to take a joined up approach to planning the use of resources available**.

CHAPTER 6
Health conditions of childhood
6.5 Epilepsy

Emergency hospital admission rate for epilepsy in children and young people aged 0-18 years

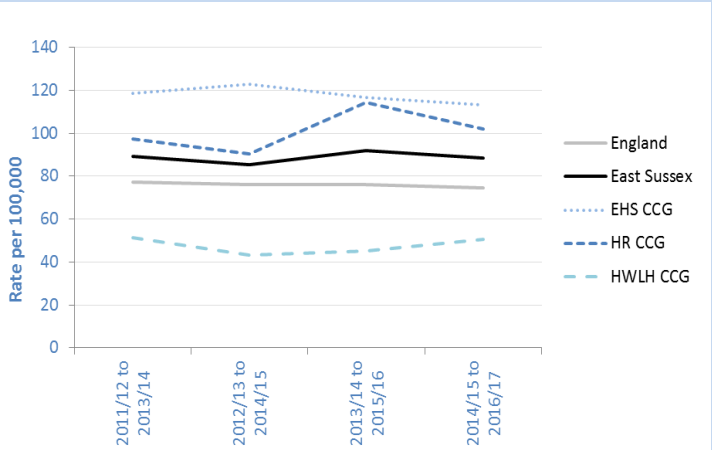
Key messages

- Epilepsy is a common neurological disorder characterised by recurring seizures.
- The nature of epilepsy means that it can be difficult to diagnose accurately.
- There is a strong relationship between emergency epilepsy admission rates for children and deprivation across East Sussex.
- For many children and young people diagnosed with epilepsy the seizures can be controlled through treatment with an anti-epileptic drug or other interventions. Optimal management improves health outcomes and can help to minimise other impacts on children and young people's social relationships, educational outcomes and employment.
- In East Sussex we are improving epilepsy education for children and young people, families and professionals and increasing the use the patient-held plans.

What is this indicator showing us?

This indicator shows the rate of emergency admissions to hospital for epilepsy for children and young people aged 0-18 years in East Sussex (rate per 100,000 children under 19). Children and young people who are seen in the emergency department but not admitted are not included in this indicator. Admissions for febrile convulsions are not included.

Emergency hospital admissions for epilepsy in children aged 0-18 years



Latest data: Over the three years 2014/15 to 2016/17 the rate of emergency admissions was 89 per 100,000 children aged 0-18. This was significantly higher than England (74). At CCG level rates were significantly higher than England in Eastbourne, Hailsham and Seaford CCG (113) and Hastings and Rother CCG (102) and were significantly lower in High Weald Lewes Havens CCG (50).

Trend: Since the period 2011/12 to 2013/14 the rate of emergency admission for epilepsy in children aged 0-18 years has not changed significantly in East Sussex. Rates have been consistently higher than England in the East Sussex Better Together CCGs over the whole period.

Source: NHS Digital, Hospital Episode Statistics

Figure 6.5.1: Emergency hospital admission rate for epilepsy per 100,000 children (0-18 years) in East Sussex by CCG 2011/2012 to 2016/2017

Why is this indicator important?

Epilepsy is a neurological condition where a person has a tendency to have seizures that start in the brain. Two-thirds of people with active epilepsy have their epilepsy controlled satisfactorily with anti-epileptic drugs, although surgical treatment is sometimes required. Optimal management improves health outcomes and can also help to minimise other, often detrimental, impacts on social, educational and employment activity.

Epilepsy is considered to be an ambulatory-sensitive condition, meaning that better management in the community or primary care setting can effectively avoid visits to the emergency department and hospital admissions. Many hospital admissions for epilepsy are unnecessary and expensive and a significant proportion of epilepsy deaths are potentially avoidable.

An estimated:

- **18%** of patients are having unnecessary seizures as a result of not receiving optimal treatment,
- **52%** of patients are seizure free
- **18%** have refractory epilepsy, where seizures are uncontrolled

With effective management we should see a decrease in the number of emergency admissions, a reduction in the geographical variation in admissions and in the number of epilepsy deaths

It is estimated that 34,000 children and young people in England with a diagnosis of epilepsy are currently receiving anti-epileptic drugs.

There are more than 40 different types of epilepsy, with 40 different associated seizure types. However, the nature of epilepsy means that it can be difficult to diagnose accurately. NICE estimates that in 5–30% of people diagnosed with epilepsy the diagnosis is incorrect. [58]

Epilepsy is a common neurological disorder in childhood. Seizures and epilepsy affect infants and children more than any other age group. Epilepsy is about twice as common in children as in adults.

For many children and young people diagnosed with epilepsy the seizures can be controlled through treatment with an anti-epileptic drug or other interventions. Optimal management improves health outcomes and can help to minimise other, impacts on children and young people's social relationships, educational outcomes and employment.

Deaths from epilepsy are rare with 44 registered deaths of children aged 0-17 years with epilepsy recorded as the underlying cause in 2014 across England and Wales. In East Sussex epilepsy was recorded as the underlying cause of death in seven children aged 1-19 year over the ten year period 2006-2015.

In this section unplanned admission rates act as a proxy for seizure control. The quality of local acute pathways impact on quality of life. It is recognised that a comprehensive measure of epilepsy outcomes would include a range of indicators, including deaths (especially potentially avoidable deaths and sudden unexplained death), school attendance, educational and mental health outcomes, and wider quality of life measures. However, unplanned admissions offer the best current available single indicator of epilepsy clinical outcomes for this purpose.

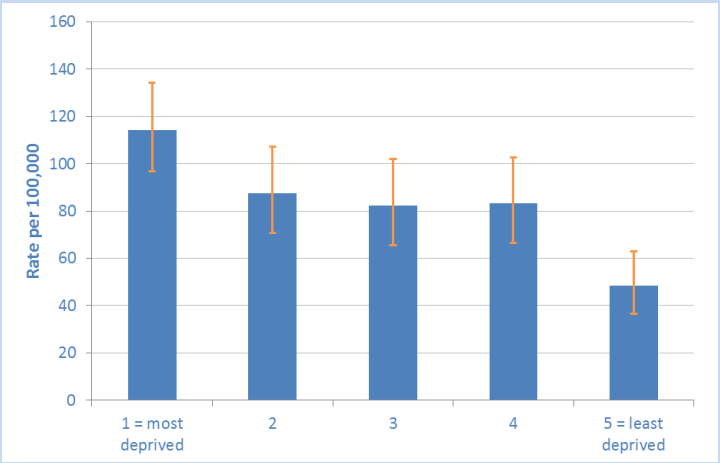
Where are we now in East Sussex?

Over the three years 2014/15 to 2016/17 there were 298 emergency admissions to hospital of children aged 0-18 years with epilepsy in East Sussex. This is a rate of 89 emergency admissions per 100,000 children aged 0-18 years. The three year average rate of admissions per CCG (2014/5-2016/17) varies across East Sussex.

Since the period 2011/12 to 2013/14 rates of emergency admissions for epilepsy in children aged 0-18 have remained at similar levels. Rates in East Sussex Better Together CCGs have been consistently higher than East Sussex and High Weald Lewes Havens CCG have remained consistently lower.

Spotlight on inequalities

Admission rates for children and young people with epilepsy are higher in more deprived areas compared to more affluent areas. There is little evidence to suggest that the incidence and prevalence of epilepsy is related to deprivation, rather this variation is associated with the quality and co-ordination of care, diagnostic accuracy and ongoing management.



Latest data: In East Sussex there is a strong correlation between the emergency admission rate for epilepsy in children and deprivation. The rate in the least deprived quintile is significantly lower than more deprived quintiles.

Source: NHS Digital, Hospital Episode Statistics

Figure 6.5.2: Emergency admissions due to epilepsy by East Sussex IDACI quintile, 0-18 year olds, rate per 100,000, 2012/13 to 2016/17

What does good look like?

The England average rate of emergency admissions for epilepsy in 0-19 year olds is 75 per 100,000 (2014/15). East Sussex, at 102 per 100,000 was statistically significantly higher than England in 2014/15, but had been similar in the previous two years.

How can we improve?

An **integrated approach to commissioning services for people with epilepsy** will ensure that people receive the recommended level of high-quality care and relevant information to reduce misdiagnosis rates, epilepsy-related deaths and avoidable emergency hospital admissions.

Diagnosing epilepsy can be complex, and it has been estimated that misdiagnosis occurs in 5-30% of people. It is therefore **essential that specialists are involved early in diagnosing epilepsy** and that they take great care to establish the correct diagnosis.

The care and management of childhood epilepsy has improved over recent years with the **introduction of Epilepsy 12**, a national audit of epilepsy services for children and young people, **and the Royal College of Paediatric Health's *epilepsy passport***. All children, young people and adults with epilepsy should have **regular review with their care team and have a comprehensive care plan** that is agreed between the person, their family and/or carers as appropriate. A care plan is an important tool in ensuring that all aspects of a person's life that could be affected by their epilepsy syndrome and the treatment they are receiving are considered and addressed.[59]

Families who have a child with epilepsy have a right to clear, accurate and appropriate information about the condition including type of epilepsy, its treatment and the implications for everyday living. Surveys of people affected by epilepsy have reported that up to 90% of them want more information and this needs to be appropriate for children and young people themselves, as well as parents and carers.

What are we doing in East Sussex?

ESHT provide a specialist paediatric epilepsy team with dedicated consultant and nurse input. Outpatient clinics and emergency care are delivered from both main sites of Eastbourne District General Hospital (EDGH) and the Conquest Hospital. In-patient care is available at the Conquest Hospital. Regular specialist neurological clinics are run jointly with a consultant from the Evelina Children's Hospital London.

Key actions going forward

- **Improve epilepsy education** for children, young people, families and healthcare and educational professionals to decrease stigma and discrimination.
- **Increase use of the epilepsy passport** or similar patient-held care plans.
- **Ensure joined-up care which meets the wider needs of children with epilepsy**, including timely access to mental health services.
- Develop new methods of **collecting and sharing data** to facilitate delivery of **more integrated, person-centred care**.
- **Ensure full implementation of NICE and SIGN guidelines** and the recommendations from the Epilepsy12 programme.

CHAPTER 6
Health conditions of childhood
6.6 Autism Spectrum Disorder

Rate of pupils recognised, diagnosed and recorded with Autism Spectrum Disorder (ASD) per 1,000 pupils

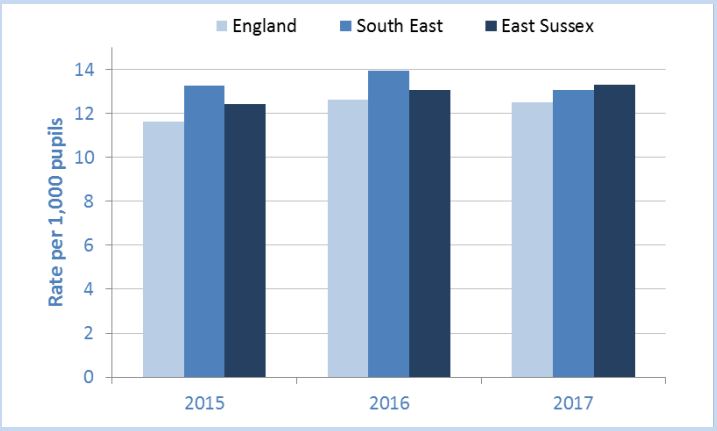
Key messages

- Autism is a lifelong developmental disability that affects how a person communicates with and relates to other people, and how they experience the world around them. Children and young people with autism are also at higher risk of some physical health conditions such as epilepsy, or stroke as well as mental health problems including anxiety.
- Children and young people with autism often find it hard to access health services and may have co-morbid symptoms dismissed. Children with autism are also much more likely to be formally excluded from education that their peers (27% compared to 4%). Over one in four (26%) of those who do succeed in education and graduate remain unemployed.
- East Sussex has a higher rate of children recognised by schools as having ASD compared to the national average, but is below the average for the South East. Since 2013 there has been a steady increase in the rate of children recognised as having ASD by schools in East Sussex.
- We are using the NICE quality standards and clinical guidance to ensure best practice for the recognition of need, referral, diagnosis, support and management of children and young people with autism.

What is this indicator showing us?

This indicator shows the rate of children with autism who have been recognised, diagnosed and recorded as having ASD by schools.

Rate of pupils recognised, diagnosed and recorded with ASD per 1,000 pupils in East Sussex, England and the South East

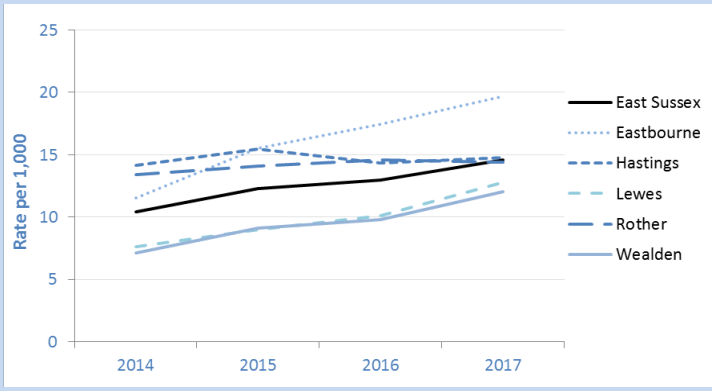


Latest data: In 2017 the ASD rate for children attending East Sussex schools was 13.3 per 1,000 pupils known to schools compared to 12.5% in England.

Trend: Between 2015 and 2017, the rate of pupils recorded with ASD has risen in East Sussex from 12.4 to 13.3 per 1,000.

Source: DfE, SEN Statistics

Figure 6.6.1: Rate of pupils recognised, diagnosed and recorded with ASD per 1,000 pupils in East Sussex, England and the South East

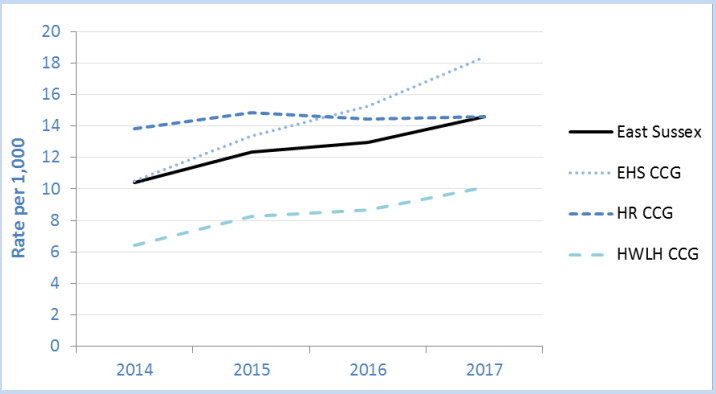


Latest data: As of January 2017 Eastbourne had the highest rate of children and young people identified with ASD in East Sussex (19.7 per 1,000). Wealden had the lowest rate (12 per 1,000).

Trend: There has been a steady increase in the rate of pupils identified as having ASD since 2014.

Source: ESCC, Children's Services data

Figure 6.6.2: Rate of pupils recognised, diagnosed and recorded with ASD per 1,000 East Sussex residents attending East Sussex schools, by District and Borough 2014 to 2017



Latest data: The rate of children and young people enrolled in education with identified ASD in East Sussex is highest in Eastbourne, Hailsham and Seaford CCG (18.4 per 1,000) and lowest in High Weald Lewes Havens CCG (10.1 per 1,000) (January 2017).

Trend: There has been a steady increase in the rate of pupils identified as having ASD since 2014 across all CCGs with the exception of Hastings and Rother CCG where there has been a slight decline.

Source: ESCC, Children's Services data

Figure 6.6.3: Rate of pupils recognised, diagnosed and recorded with ASD per 1,000 East Sussex residents attending East Sussex schools, by CCG, 2014 to 2017

Why is this indicator important?

Autism Spectrum Disorder (ASD) refers to a group of conditions including Asperger syndrome, high functioning autism, and Kanner syndrome or classic autism. Autism occurs early in life and is developmental in nature, not a mental illnesses or a learning disability. Autism can cause marked difficulties with social communication, social interaction and social imagination. Some people with a diagnosis of autism will be able to live an independent life with little support, whilst for other people autism may be one of multiple disabilities that will require specialist support.

Children with autism have the same health needs as other people in the population, but are also at higher risk for some conditions, as well as often requiring reasonable adjustments to enable them to access health services.

Children with ASD have higher risk of:

Physical health conditions [60]
including epilepsy, stroke, respiratory conditions and heart

Intellectual disability (IQ below 70) [61]
is estimated to occur in around half of all young people with autism

Mental health conditions [62]
most commonly anxiety, attention deficit hyperactivity disorder (ADHD) and oppositional defiant disorder (ODD)

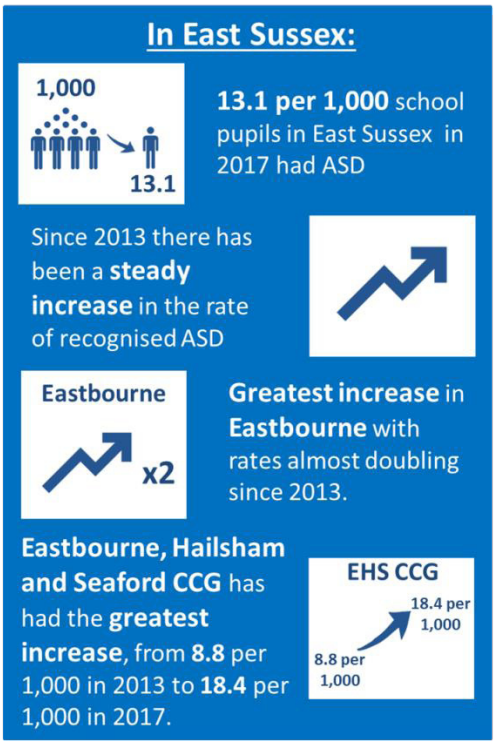
Not accessing services [63]
for reasons including limited communication to explain health difficulties, symptoms being dismissed as 'autistic behaviours' rather than signs of comorbid conditions, and sensory overload in health care settings (e.g. bright lights and noisy equipment)

Children with autism can also face a number of other challenges, for example:

- **27%** formally excluded from school, compared with **4%** of children without autism[64]
- **One third** "informally excluded" from school on at least one occasion – asked not to attend but no formal record is kept. This has no basis in law and should not be happening[65]
- **26%** of graduates with autism are unemployed, the highest percentage for any disability group[66]

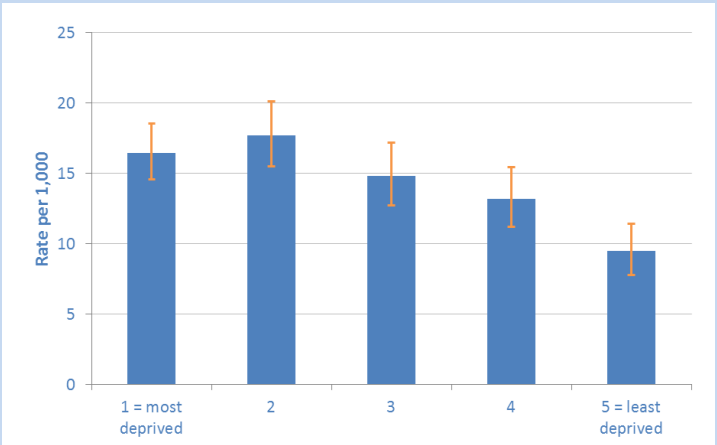
Where are we now in East Sussex?

The British Association for Child and Community Health (BACCH) has created a calculator of expected service demands for certain clinical conditions including ASD based on a local areas child population and birth rate.[67] According to the calculator, the prevalence of ASD amongst children in the UK is 1.57% (including previously undiagnosed cases). In total within the 5-18 year old population of East Sussex we would expect approximately 1,320 children and young people to have ASD, with an incidence (expected new cases) of 80 per year.



Spotlight on inequalities

Research suggests families affected by autism have a higher incidence of unemployment (up to 20% higher than other families), and many parents of children with autism give up full-time employment to care for their child. As a result of this, family income can be up to 12% lower in families affected by autism. Families affected by autism have also been found to be 6% more likely to live in deprived areas.[68] East Sussex data shows that the rate of ASD in East Sussex pupils is significantly lower in the least deprived quintile of ward compared to the three most deprived quintiles.



Latest data: Generally as deprivation decreases, so does the rate of ASD amongst East Sussex pupils. There is a significant difference between children in the most deprived areas (16.5 per 1,000) and the least deprived areas (9.5 per 1,000).

Source: ESCC, Children's Services data.

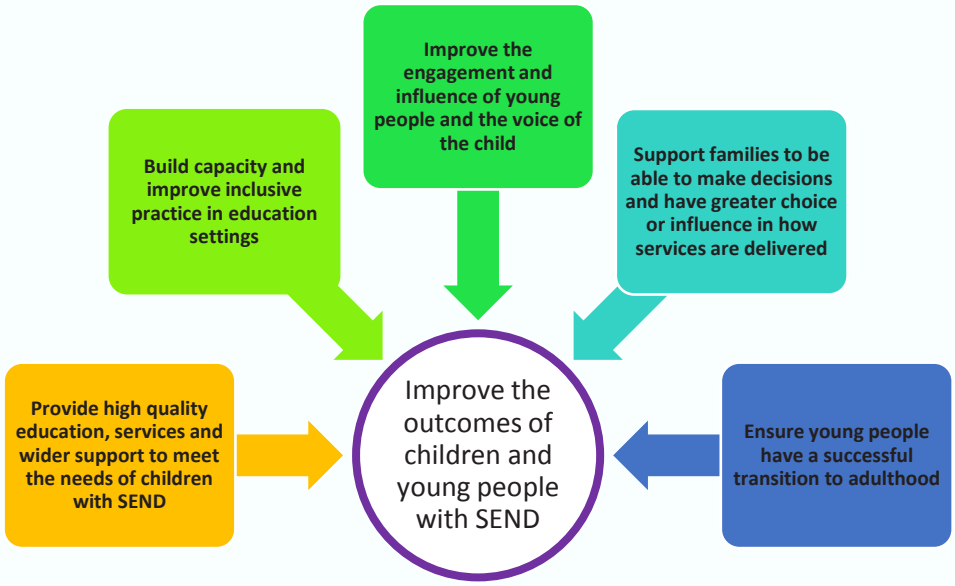
Figure 6.6.4: Rate of ASD by East Sussex IDACI quintile, rate per 1,000 pupils, 2017

What does good look like?

In the 2017 school census there were 978 pupils in East Sussex recorded as having ASD: a rate of 13.3 per 1,000 pupils. This compares to a rate of 13.1 per 1,000 for the South East and 12.5 per 1,000 in England in 2017. The rate of recognised ASD is affected by identification and diagnosis services as well as the underlying prevalence in the population. There is no gold standard population benchmark for comparison. In terms of ensuring children's needs are met, higher rates of recognised ASD could be considered better than lower rates.

How can we improve?

NICE Quality Standard [QS51] outlines the statements surrounding gold standard for diagnosis and management. To continue to improve outcomes for all children and young people with SEND the Inclusion Special Education and Disabilities Service (ISEND) Strategy works to the follow aims:



At the heart of the Education, Inclusion and SEND Division for East Sussex is a set of core values:

- All children and young people, irrespective of background or needs, are entitled to a good education that enables them to fulfil their potential.
- Settings, schools, colleges, academy sponsors and the local authority share responsibility for children's and young people's educational outcomes.
- The local authority's advocacy for children and young people includes providing challenge on the performance of settings, schools and colleges, and being willing to use powers of intervention where particularly rapid improvement is needed.
- Working in partnership and jointly brokering appropriate high quality support for children with special educational needs and disabilities, from a range of providers, as the key to sustainable improvement and making a real difference to schools, children and families.
- Support is provided based on a sound understanding of the local context and interventions are flexible enough to meet the particular needs of schools, children and families.

What are we doing in East Sussex?

East Sussex County Council and partners follow the appropriate NICE quality standards and clinical guidance to ensure best practice for the recognition of need, referral, diagnosis, support and management in meeting the needs of children and young people with autism. In addition East Sussex works to the following principles.

- The **child/young person with autism attends their local school**, feels **welcomed** and **valued** and **is fully included** in the school community.
- **Reasonable adjustments are made by the school** to include the child/young person in their learning and in the wider school community, including clubs and extra-curricular activity.
- **The curriculum and learning environment are effectively differentiated to overcome barriers** to learning, and the child/young person makes good progress academically, socially and emotionally.
- **The school/setting work closely** with parents and the child/young person **to ensure child/young person voice is central to planning and decision-making**. Needs are managed though the Assess Plan Do Review cycle and SEND Code of Practice 2015.
- **A multi-agency group which includes parents of children with autism are reviewing the East Sussex ASD Referral and Diagnostic Assessment pathway** for children to ensure equality of access and a consistent journey. The Autism Pathway Review and Implementation Group (APRIG) have identified and are addressing areas for improvement: co-produced accessible information for parents; information on post-diagnostic support and clearer information on locally agreed professional responsibilities.

Strategic change through service redesign is working to deliver good outcomes for children and young people with ASD and the most cost-effective use of public resource:

- We are **building capacity in mainstream schools** to ensure the early identification and successful management of children and young people with Speech Language and Communication Needs (SLCN) and/or ASD.
- **East Sussex County Council (ESCC) are moving to in house provision of a Communication Learning and Autism Support Service** (CLASS) **for all schools** which will result in streamlining by reducing the number of agencies and referral routes. This approach will release resources for additional advisers and practitioners to work directly with schools and families.
- We are **developing closer multiagency working** by co-locating a network of ISEND professionals to provide SLCN support of social, emotional and mental health (SEMH) needs for children with SLCN. The Children's Integrated Therapies Service (CITS) will provide specialist training for the identification and management of more complex SLCN such as selective mutism and dysfluency.
- The Local Authority **supported parents and academies with the submission of free school bids to the DfE with the result that two new special schools will be funded in East Sussex**: The Flagship School, for children aged 9-16 years, with places for 56 pupils with High Functioning Autism and pupils with social, behavioural and communication difficulties; and Summerdown, for children aged 5-18 years with places for 84 pupils with autism and speech language and communication needs.

Key actions going forward

- APRIG group to meet quarterly to maintain the close joint-working between Education, Health and Social Care around the autism agenda, and to monitor the data and child/parent experience as children move through the pathway.
- To extend the membership of APRIG to include representatives from Adult Social Care with the aim of one pathway for birth to adult.
- To continue to review and improve the information available to parents around autism, including the Local Offer. Parenting provision for families with Autism will continue to be provided across the county.
- For the outreach consultation outcomes to be implemented and embedded to improve outcomes for children and young people with autism and/or SLCN needs.
- To support the parents and academies to take forward the free schools according to the timetable agreed with DfE.

CHAPTER 6
Health conditions of childhood
6.7 Palliative care

Place of death for children and young people (aged 1-19 years)

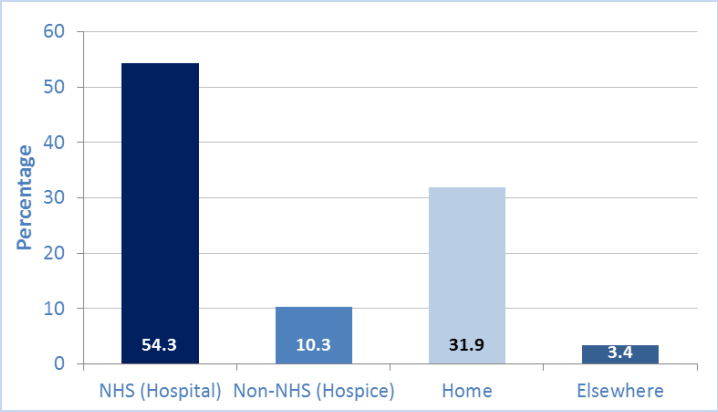
Key messages

- Palliative care for children differs from that of adults, and by comparison, the number of children dying is relatively small.
- New draft NICE guidance on best practice about end of life care has recently been issued for consultation.
- High-quality end of life care for children and young people requires a holistic approach which recognises the needs of the child or young person and their families and carers.

What is this indicator showing us?

This indicator is showing the place of death for children and young people (1-19 years), excluding deaths from external causes of mortality over the period 2006-2015 in East Sussex.

Place of death for children and young people (aged 1-19 years) in East Sussex, 2006 to 2015



Latest data: Over the period 2006 to 2015 there are small numbers of deaths, 324 in children and young people aged 1-19 years. For children and young people aged 1-19 over half of deaths (54%) occurred in hospital, about a third (32%) at home and approximately 1 in 10 (10%) in a hospice.

Source: NHS Digital, Primary Care Mortality Database

Figure 6.7.1 Place of death for children and young people (1-19 years), excluding external causes, in East Sussex, 2006 to 2015.

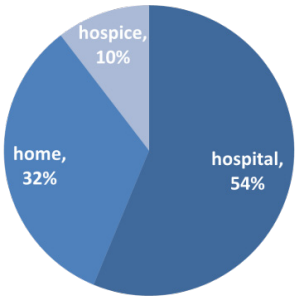
Why is this indicator important?

Life-limiting conditions are those that are expected to result in an early death, either for everyone with the condition, or for a specific person. Approximately 40,000 children and young people aged 1-19 years in England are living with a life-limiting condition and may need palliative care.[69] Their needs may vary widely, with over 300 conditions that could be classed as life-limiting or life-threatening within this age group. Many have severe disabilities and multiple complex health and social care needs.

End of life care combines a broad range of health and other care services, including hospitals, hospices, primary care and community professionals, ambulance services, dedicated palliative care teams, and other support providers. Services span across a number of sectors including the public sector and charities.

For children who may only get a chance to lead short lives the care provided at the end of their lives is a measure of not only the health and social care services but also of our society as a whole. There must be a holistic approach to care, embracing physical, emotional, social and spiritual elements where services communicate and work together.

For children and young people aged 1-19 their place of death was:



What does good look like?

NICE has recently consulted on draft quality standards for the management of the terminally ill child. Within the consultation there were six quality statements covering end of life care for infants, children and young people (from birth to 18 years) who have a life-limiting condition.[70] The quality standards also cover support for family members and carers.

NICE draft quality standards for end of life care for infants, children and young adults

1. Infants, children and young people with a life-limiting condition and their parents or carers are involved in developing an Advance Care Plan.
2. Infants, children and young people with a life-limiting condition have a named medical specialist who coordinates their care.
3. Children and young people with a life-limiting condition are given information about emotional and psychological support and how to access it.
4. Infants, children and young people approaching the end of life have any unresolved, distressing symptoms assessed by the specialist paediatric palliative care team.
5. Parents or carers of infants, children and young people approaching the end of life are offered bereavement support when their child is nearing the end of their life and after their death.
6. Infants, children and young people approaching the end of life and being cared for at home have 24-hour access to paediatric nursing care and advice from a consultant in paediatric palliative care.

How can we improve?

Palliative care for children is different from that of adults and, by comparison, the number of children dying is relatively small. Many children's illnesses mean that palliative care needs can extend over many years. Although the number of children with complex needs has remained fairly static there appears to be a new population of young children with very complex needs presenting to services. This change in the profile presents a challenge to the services.

The current provision of services across East Sussex is mixed. The quality of end of life care for children and young people can vary depending upon disease or condition, local facilities and the child or young person's GP. In order to implement a holistic personalised care pathway approach in this area we need to improve co-ordination between agencies and services, including the voluntary sector. Future service planning should be informed by the views and experiences of local children and their families.

What are we doing in East Sussex?

Care for children with life-threatening and life-limiting conditions, and their families and carers, is provided by a range of providers including: in-hospital services, community services, hospice, respite and other services across East Sussex and beyond.

Organisations providing services for children with life-threatening and life-limiting conditions in East Sussex

Type of service	Providers	Location(s)
Hospital inpatient and outpatient care	East Sussex Healthcare NHS Trust	Eastbourne District General Hospital and Conquest Hospital
	Brighton and Sussex University Hospitals NHS Trust	Royal Alexandra Children's Hospital - Brighton
	Maidstone and Tunbridge Wells NHS Hospitals Trust	Tunbridge Wells Hospital
Community Services	East Sussex Healthcare NHS Trust	Hospital at home/outreach - community paediatric nursing services
	East Sussex County Council	Children's services disability team
	Sussex Community NHS Foundation Trust	Clinical services outreach team at Chailey Heritage
	Brighton and Sussex University Hospitals NHS Trust	Outreach and community nursing for children and young people
	Guy's and St Thomas' NHS Foundation Trust	Demelza specialist paediatric palliative care team for children with very complex needs
	Chestnut Tree House	Children's Hospice
Respite care/short breaks/other facilities	Sussex Community NHS Foundation Trust and Chailey Heritage Foundation	Chailey Heritage clinical services and school
	Demelza East Sussex	Community hospice at home service for children and young people
	Chestnut Tree House	Children's Hospice covering East and West Sussex, Brighton and Hove, and South East Hampshire

Key actions going forward

- Ensure joined-up care which meets the wider needs of children and young people with life limiting conditions, and their families, including timely access to all support services.
- Ensure end of life care is planned and delivered in full consultation and partnership between the child and family and service providers.
- Improve end of life education and information for children, young people, families and healthcare and educational professionals.

Develop new methods of collecting and sharing data to facilitate delivery of more integrated, person-centred care.

LIST OF ABBREVIATIONS

ACEs	Adverse Childhood Experiences
ADHD	Attention Deficit Hyperactivity Disorder
APRIG	Autism Pathway Review and Implementation Group
ASD	Autism Spectrum Disorder
ASN	Additional Support Needs
BACCH	British Association for Child and Community Health
BFI	Baby Friendly Initiative
BMI	Body Mass Index
BSUH	Brighton and Sussex University Hospitals NHS Trust
BTS	British Thoracic Society
C4Y	Connecting For You
CAMHS	Child and Adolescent Mental Health Services
CAP	Community Alcohol Partnership
CCG	Clinical Commissioning Group
CDOP	Child Death Overview Panels
CITS	Children's Integrated Therapies Service
CLASS	Communication Learning and Autism Support Service
CO	Carbon Monoxide
CoN	Continuum of Need
CPD	Continual Professional Development
CP (plan)	Child Protection
D3MFT	Decayed, Missing or Filled Teeth
DCLG	Department for Communities and Local Government
DfE	Department for Education
DSL	Designated Safeguarding Lead
DWP	Department for Work and Pensions
EDGH	Eastbourne District General Hospital
EHC	Emergency Hormonal Contraception
EHC (plan)	Education, Health and Care
EIP	Education Improvement Partnership
ESAPG	East Sussex Alcohol Partnership Group
ESBAS	East Sussex Behaviour and Attendance Support
ESBT	East Sussex Better Together
ESCC	East Sussex County Council
ESEP	East Sussex Energy Partnership
ESHT	East Sussex Healthcare NHS Trust
FSM	Free School Meals
HALO	Healthy Active Little Ones
HbA1c	Glycated haemoglobin
HENRY	Health Exercise Nutrition for the Really Young
HES	Hospital Episode Statistics
Hib	Haemophilus influenza type b
HPV	Human Papilloma Virus
HQIP	Healthcare Quality Improvement Partnership
HRB	Health Related Behaviour
IDACI	Income Deprivation Affecting Children Index
IMD	Index of Multiple Deprivation
IMR	Infant Mortality Rate
ISEND	Inclusion and Special Educational Needs and Disability

JAPP	Joint Agency Placement Panel
JSNAA	Joint Strategic Needs and Assets Assessment
KSI	Killed or Seriously Injured
LA	Local Authority
LAC	Looked After Children
LACMHS	Looked After Children Mental Health Service
LBW	Low Birth Weight
LSCB	Local Safeguarding Children Boards
MECC	Making Every Contact Count
MMR	Measles, Mumps and Rubella
n/a	Not available
NCD	Non-communicable Diseases
NCMP	National Child Measurement Programme
NEET	Not in Employment, Education or Training
NHS	National Health Service
NICE	The National Institute for Health and Care Excellence
NIS	National Impact Study
NTA	National Treatment Agency
OA	Overall Absence
ONS	Office of National Statistics
PA	Persistent Absence
PbR	Payment by Results
PHE	Public Health England
PNMR	Perinatal Mortality Rate
PRCR	Personal Resilience and Community Resilience
PSHE	Personal, Social, Health and Economic Education
RCP	Royal College of Physicians
RCPCH	Royal College of Paediatrics and Child Health
RSE	Relationship and Sex Education
SBAR	Situation, Background, Assessment, Recommendation tool
SEMH	Social, Emotional and Mental health
SEND	Special Educational Need or Disability
SES	Skills East Sussex
SIDS	Sudden Infant death Syndrome
SIGN	Scottish Intercollegiate Guidelines Network
SLCN	Speech Language and Communication Needs
SLES	Standards and Learning Effectiveness Service
STMM	Service Transformation Maturity Model
SWIFT	Safeguarding and Intensive Family Therapy
TF	Troubled Families
TLP	Teaching and Learning Provision
UASC	Unaccompanied Asylum Seeking Children
WAY	What About YOUth
YES	Youth Employability Service

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