RUTLAND JOINT STRATEGIC NEEDS ASSESSMENT 2018

THE BEST START IN LIFE – AGED 0 TO 5 YEARS

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FOREWORD

The purpose of the Joint Strategic Needs Assessment (JSNA) is to:

- To improve the health and wellbeing of the local community and reduce inequalities for all ages.
- To determine what actions the local authority, the local NHS and other partners need to take to meet health and social care needs, and to address the wider determinants that impact on health and wellbeing.
- To provide a source of relevant reference to the Local Authority, Clinical Commissioning Groups (CCGs) and NHS England for the commissioning of any future services.

The Local Authority and CCGs have equal and joint statutory responsibility to prepare a Joint Strategic Needs Assessment (JSNA) for Rutland, through the Health and Wellbeing Board. The Health and Social Care Act 2012 amended the Local Government and Public Involvement in Health Act 2007 to introduce duties and powers for Health and Wellbeing Boards in relation to JSNAs.

The JSNA has reviewed the population health needs for the people of Rutland in respective of a person's early years aged 0-4. This has involved looking at the determinants of health, the health needs of this population in Rutland, the impact of services, the policy and guidance supporting young children, and the existing services and the breadth of services that are currently provided. The unmet needs and recommendations that have arisen from this needs assessment are discussed.

The JSNA offers an opportunity for the Local Authority, CCG and NHS England's plans for commissioning services to be informed by up to date information on the population that use their services. Where commissioning plans are not in line with the JSNA, the Local Authority, CCG and NHS England must be able to explain why.

EXECUTIVE SUMMARY

- This chapter presents a comprehensive overview of children (aged 0-5 years) in Rutland. There are many factors that influence the health of a child during their pre-school years. This is a vital time for development of a child whether that be physically, emotionally or socially, and many of the factors influencing a child's health at this time can have an impact on their later life.

- The majority of indicators presented are from national sources so are subject to a time lag due to the time required for data collection, data analysis and publication. Where possible, comparisons have been made to national averages and local context has been included.

- There are proportionally fewer children known to social care in Rutland than in other local authorities in England with lower rates of Children in Need, Children Looked After and those subject to a Child Protection Plan in Rutland in 2016/17.

- School readiness is a measure of how prepared a child is to succeed in school cognitively, socially and emotionally. 'Good level of development' is used to assess school readiness. School readiness starts at birth with the support of parents and other caregivers, as children start to acquire these skills. School readiness at age 5 (the end of reception year) has a strong impact on future educational attainment and life chances.[1] In 2016/17, 75.7% of children in Rutland achieved a good level development (GLD) at the end of Early Years Foundation Stage (reception) compared to the England value of 70.7%.

- From 2014/15 to 2016/17 there has been a significant improvement in the percentage of children with obvious dental decay in Rutland (28.8% to 15.6%).

- The overarching recommendation of this chapter is: to provide support to aim for all children in Rutland to have a happy and healthy childhood, targeting resources in proportion to need and to those who are most vulnerable.

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1. Introduction

This chapter presents a comprehensive overview of children aged 0-4 years in Rutland. The majority of indicators presented are from national sources so are subject to a time lag due to the time required for data collection, data analysis and publication. Where possible, comparisons have been made to national averages and local context has been included. We appreciate that this document uses technical language. This is due to the nature of the JSNA, which is intended for use by commissioning organisations such as local authorities and the NHS in developing their commissioning plans. One example is the use of statistical significance. A statistical significant result ensures the result is not likely to be caused by chance, for a given statistical significance level. Using these statistical tests improves the reliability of our evidence base which will help strengthen our commissioning based decisions.

2. Who is at risk?

There are many factors that influence the health of a child during their pre-school years. This is a vital time for development of a child whether that be physically, emotionally or socially, and many of the factors influencing a child's health at this time can have an impact on their later life.

2.1. Children in poverty

The Marmot Review (2010) suggests there is evidence that childhood poverty leads to premature mortality and poor health outcomes for adults. It therefore follows that reducing the numbers of children who experience poverty should improve adult health outcomes and increase healthy life expectancy.

In England in 2013, 20.2% of children aged 0 to 4 years of age were in low income families (children living in families in receipt of out of work benefits or tax credits where their reported income is less than 60% median income). The figure for the East Midlands was 20.5% and the Rutland value was 9.6% which is significantly better than the England value.[2]

2.2. Homelessness

Homelessness often equates to severe poverty which is a social determinant of health. As a result, homeless children are often the most vulnerable in society.

Family homelessness (applicant households eligible for assistance (1996 Housing Act) unintentionally homeless and in priority need) in 2016/17 was 1.9 per 1,000 households for England, and 1.6 per 1,000 households for the East Midlands. Rutland's rate was 1.2 per 1,000 households (19 households) which is significantly better than the England value.[3]

2.3. Children's Social Care in Rutland

There are proportionally fewer children known to social care in Rutland than in other local authorities in England with lower rates of Children in Need, Children Looked After and those subject to a Child Protection Plan in Rutland in 2016/17.

The number and profile of Children Looked After (CLA) in Rutland has remained fairly stable over recent years with an average of around 40 children and young people in care at any one time and around 50-55 children looked after over the course of a year. The number of CLA has increased slightly over recent years in line with population growth and mirroring the national trend (although it is expected to show a decrease for 2017/18). The number of Care Leavers is also stable at around 23 over each of the last three years.

Rutland is the smallest local authority in England and faces a different set of challenges to larger authorities in ensuring the best possible provision of services for children looked after and those leaving care. The profile of CLA in Rutland – and the cost of service provision – can fluctuate considerably due to the relative low number of children in the cohort at any one time. As such, the impact of a small number of sibling groups moving in or out of care can have a disproportionately large impact on the profile of the cohort, for example, in relation to age, gender, ethnicity, category of need or legal status. The same is true for other cohorts such as children subject to Child Protection Plans and Care Leavers.

The sections which follow describe the latest comparative data for Rutland and England in more detail.

2.3.1. Children in need

In Rutland in 2016/17, 504 children under the age of 18 were classified as children in need. This equates to a rate of 573 per 10,000 population; better than the England average of 612 per 10,000 population.[4]

The proportion of children in Rutland in 2017 in need due to abuse, neglect or family dysfunction was 71.7%. This is higher than the England average of 68.3%.[5]

The rate of children under the age of 18 years in need due to child disability or illness in Rutland in 2017 was 27.2 per 10,000 population (21 children). This is similar to the England value of 31.2 per 10,000 population.[6]

2.3.2. Children who are Looked After

In Rutland on 31 March 2017, 40 children under the age of 18 were classified as looked after. This equates to a rate of 51.8 per 10,000 population. This is significantly better than the England

average value of 62.0 per 10,000 population.[3] The rate of children who are looked after (CLA) per 10,000 children for Rutland has increased over the last five years from 40 per 10,000 in 2012 to 52 per 10,000 in 2017. The increase in the rate over the last five years has been greater for Rutland than for the national and regional comparators, with only a small increase regionally and the national figure remaining static over the last four years. This means that the increase over the last six years has brought Rutland's rate of CLA proportionate to its local population much closer to the regional and national pictures.

Rutland has the lowest number of CLA of any local authority in England; no other local authority has fewer than 100 CLA – Wokingham is the next smallest with 110 – and the average for a local authority is 649 children (average for all authorities over the last 5 years).

In 2017, 96.0% of eligible looked after school aged children (22 children) had an emotional and behavioural health assessment. This is higher than the England average value of 76.0%.[4] The proportion of eligible children considered 'of concern' in 2016/17 was 59.0% (13 children). This is worse than the England value of 38.0%.[4]

In 2017, 100.0% of looked after children under the age of 5 in Rutland (6 children) had up-to-date development assessments[4], and 100.0% of looked after children under the age of 18 (29 children) had an annual health assessment.[4]

In 2016/17, the rate of children leaving care for Rutland was 25.9 per 10,000 population. This is lower than the England average value of 26.5 per 10,000 population.[4]

In Rutland, the total spend on CLA increased by 56% over the last 5 years; up from £990,000 in 2011-12 to £1,546,000 in 2015-16. The spend on CLA in Rutland as a proportion of all spending on Children's Services over the same period (2011-12 to 2015-16) has gone up from 26.7% to 34.6%, so CLA now accounts for around a third of all spending on Children's Services in Rutland. However, it remains considerably lower than the comparative figure for the region (43.1%) or nationally (44.1%). The average cost per child looked after is also much lower in Rutland than the average for local authorities in England – around £14k lower – at £28,109 per child, compared to £41,785 per child nationally (2015/16). Thus, outcomes for CLA in Rutland are being achieved at a much lower cost than in other local authorities.

More detailed information on Children Looked After in Rutland is available in the Children Looked After and Care Leavers Strategy.[7]

2.3.3. Safeguarding of children

In Rutland at the end of March 2017, 20 children were subject of a child protection plan. This equates to a rate of 25.9 per 10,000 population. This is significantly lower than the England average value of 43.3 per 10,000 population.[4]

In Rutland during 2016/17, there were 32 new child protection cases for children aged less than 18 years of age, this is a rate of 46.6 per 10,000 population. This is lower than the England rate of 56.3 per 10,000 population.[3] In Rutland, 36.1% of children aged under 18 years of age (13 children) became subject of a child protection plan for a second or subsequent time. This is higher than the England value of 18.7%.[6]

2.3.4. Children social care workforce

There have been a number of changes to the way in which children's social care is delivered across Rutland in 2017/18. There was been a focused effort on reducing the number of agency staff and increasing the number of permanent employees to support consistency of practice and continuity of support for children and families. This has seen the number of permanent staff increase from around 50% in 2017 to 85% in 2017 (with a further increase expected in 2018 data).

Changes to staff and structure have coincided with a halving of the absence rate. For the children's social care workforce, the staff absence rate for Rutland in 2016 was 7.1%, around twice the National average of 3.5% (in 2016). In 2017 the absence for Rutland dropped to just 2.4% - two-thirds lower than the previous year – bringing it below the National average of 3.1%.[8]

2.4. Maternal influences

Factors relating to the mother and method of delivery of a newborn child can have an influence on the health needs of a child.

2.4.1. Young mothers

A child's long-term health can be impacted on as follows: children born to teenage mothers have 60% higher rates of infant mortality and are at increased risk of low birthweight. The mental health effects for a teenage mother are that they are three times more likely to suffer from post-natal depression and experience poor mental health for up to three years after the birth – this may impact on the child's health and development. Living in poverty, is also an increased risk for teenage parents and their children.

In 2015, the number of births to mothers aged less than 20 years of age in Rutland was 9, a proportion of 2.6%. This is similar to the England value of 3.4%.[9]

2.4.2. Older mothers

Higher rates of antenatal depression and anxiety have been found amongst older mothers. This may add to the risks for the newborn child.[10]

In 2015, the number of births to mothers aged 40 years and over in Rutland was 17. This equates to 5.0% of all live births. This is similar to the England value of 4.3%.[9]

2.4.3. Caesarean section

When maternal or infant problems arise, there may be a need for a child to be delivered by caesarean section. Following delivery, there may be further health problems associated with the procedure for the newborn infant.

In Rutland, in 2016/17, 90 deliveries were made by caesarean section. This equates to 28.8% of the total number of deliveries. This is similar to the England value of 27.1%.[3]

2.4.4. Postpartum psychosis

Any mental health problems that a mother has may impact on her ability to care for her infant.

In 2015/16, 5 women in Rutland were estimated to have postpartum psychosis, 10 were estimated to suffer from a severe depressive illness in the perinatal period and between 35 and 50 women were estimated to suffer from a mild-moderate illness and anxiety in the perinatal period.[9]

2.4.5. Deliveries of new-born children to mothers from Black and Minority (BME) groups

In Rutland in 2016/17, 6.7% of deliveries were to mothers from BME groups (21 deliveries). This is lower than the England proportion of 23.3%.[3] The 2011 Census tells us the percentage of the population from BME groups in Rutland is 2.9% whereas nationally the percentage is 14.6%. This infers that both locally and nationally mothers of a BME background may be having more children than those from a non-BME background.

2.5. School readiness

School readiness is a measure of how prepared a child is to succeed in school cognitively, socially and emotionally. 'Good level of development' is used to assess school readiness. It is measured at the end of the reception year and covers: communication and language; physical development; personal, social and emotional development; literacy; mathematics; understanding the world; and expressive arts, designing and making. School readiness starts at birth with the support of parents and other caregivers, as children start to acquire these skills. School readiness at age 5 (the end of

reception year) has a strong impact on future educational attainment and life chances.[11]

A child's performance in school is a key indicator of their early years' development. In 2016/17, 75.7% of children in Rutland achieved a good level development (GLD) at the end of Early Years Foundation Stage (reception) compared to the England value of 70.7%. Although attainment as measured by GLD remains above that seen nationally, however, there are inconsistencies in performance over time. Meanwhile, seven children with free school meal status achieved a good level of development at the end of reception (63.6%). This is similar to the England value of 56.0%.[2]

3. Level of need in Rutland

In 2016, Rutland's population of 0-4 year olds was estimated to be a total of 1,835 (887 females and 948 males). This is projected to stay the same by 2039.

Further information regarding Rutland's population can be seen in the JSNA Population chapter.

3.1. Infant mortality

Several factors can influence a baby's chance of survival at birth, in their first few weeks of life and beyond.

Infant mortality is an indicator of the general health of an entire population. It reflects the relationship between causes of infant mortality and upstream determinants of population health such as economic, social and environmental conditions.

Reducing the gap between the richest and poorest groups, and infant mortality overall are part of the Government's strategy for public health (Healthy Lives, Healthy People: Our Strategy for Public Health November 2010)

Rutland had 5 deaths under 1 year of age in the period 2014-16 – a rate of 4.9 deaths per 1,000 live births. This is similar to England's rate of 3.9 deaths per 1,000 live births.[2]

3.1.1. Low birth weight

One contributing factor to the risk of childhood mortality and a child's developmental problems and their health in later life is low birth weight. Low birth weight is defined as a weight under 2500g and a gestational age of at least 37 complete weeks at birth.

A high percentage of low birth weight babies may indicate lifestyle issues of the mothers and/or issues with maternity services which could also impact on the health of the newborn.

The proportion of low birth weight babies was 2.67% for Rutland in 2016 (8 babies). This is similar

to the England value of 2.79%.[2]

3.1.2. Smoking in pregnancy

Smoking in pregnancy has detrimental effects for the growth and development of the baby and health of the mother. The encouragement of pregnant women to stop smoking during pregnancy may also help them kick the habit for good, and thereby provide health benefits for the mother and reduce exposure to smoke by the infant.

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

The Tobacco Control Plan contains a national ambition to reduce the rate of smoking throughout pregnancy to 6% or less by the end of 2022.

The smokers at the time of delivery indicator is only available as a combined figure for Leicestershire and Rutland, due to the small numbers involved in Rutland. The proportion of mothers known to be smokers at the time of delivery for Leicestershire and Rutland combined was 8.6% in 2016/17. This is better than the England rate of 10.7%. This is line with the latest smoking prevalence figures in Rutland where 8.6% of the adult female population smoke. This is significantly better than the national female smoking prevalence of 13.0% in 2017.[12]

3.1.3. Breastfeeding

Breastfeeding has been shown to have positive effects on an infant's health and development. Not only does breast milk provide excellent nutrition for babies, breastfeeding is associated with lower levels of gastro-intestinal and respiratory infection, and therefore lower chance of hospitalisation for such infections. Children that are breastfed are also less likely to become obese**.**

Breastfeeding also has positive effects for the mother, as mothers that do not breastfeed have an increased risk of ovarian and breast cancers, and they may also experience more difficulty in achieving their pre-pregnancy weight.

In 2016/17, 81.1% of mothers breastfed their babies within the first 48 hours of delivery, this is significantly better than the England value of 74.5%. In 2014/15, 52.8% of infants due a 6-8 week check were being either totally or partially breastfed. This is significantly better than the England value of 43.8%.[2]

3.2. Immunisation

Vaccination is offered to infants in order to protect them from the diseases and associated

complication, and also to minimise the spread of the diseases within the wider population. Vaccination coverage is measured against benchmarked targets.

3.2.1. MMR

Vaccination to protect against the infectious diseases measles. mumps and rubella can prevent children from not only contracting those diseases, but also complications associated with the diseases, such as meningitis, encephalitis and deafness.

The population vaccination coverage for children having received two doses of the MMR vaccine at 5 years old was 93.8% for Leicestershire and Rutland combined for 2016/17. This is within the benchmarked target range of 90% to 95%.[2]

3.2.2. Hepatitis B

Mothers infected with the hepatitis B virus (HBV) are at risk of passing on the HBV infection to their babies. Hepatitis B can lead to cirrhosis of the liver and liver cancer, so vaccination of babies born to infected mothers is important. In 2016/17, no children aged 1 and 2 years old received the vaccine for hepatitis B in Rutland.[2] This is likely to be due the low numbers of infants born to hepatitis B virus infected mothers that are at high risk of acquiring HBV infection themselves.

3.2.3. Dtap/IPV/Hib

This combined vaccine (Dtap/IPV/Hib) protects against diphtheria, pertussis, tetanus, haemophilus influenza type B and polio.

In 2016/17, in Leicestershire and Rutland combined, 97.3% of children aged 1 year old and 98.2% of children aged 2 years old had received the combined vaccine of Dtap/IPV/Hib. These proportions are better than the benchmarked target of 90% to 95%.[2]

3.2.4. Men C

Protection against infection by meningococcal group C bacteria is provided by the Meningococcal C conjugate (Men C) vaccine. Infection by meningococcal group C bacteria can cause meningitis and septicaemia. Boosted immunisations in the infant's second year provide immunity that lasts into adulthood.

The population vaccination coverage for children having received the completed course of the Men C vaccine by their first birthday was 98.1% for Leicestershire and Rutland combined for 2015/16. This is above the benchmarked target range of 90% to 95%.[2]

For 2016/17, the population vaccination coverage for children having received the Haemophilus

influenzae type b (Hib) and Men C booster vaccine by their second birthday was 96.1% for Leicestershire and Rutland combined. This is above the benchmarked target range of 90% to 95%.[2]

3.2.5. PCV

The PCV vaccination protects against pneumococcal infections that can cause pneumonia, septicaemia and meningitis.

The population vaccination coverage for children having received the completed course of the PCV vaccine by their first birthday was 97.3% for Leicestershire and Rutland combined for 2016/17. This is above the benchmarked target range of 90% to 95%.[2]

The population vaccination coverage for children having received a dose of the PCV booster vaccine by their second birthday was 96.2% for Leicestershire and Rutland combined for 2016/17. This is above the benchmarked target range of 90% to 95%.[2]

3.2.6. Influenza

Vaccination against influenza can prevent illness and hospitalisation. Vaccination is offered to those at risk of developing serious complications if they catch the virus.

The population vaccination coverage for children aged 2-4 years old was 49.3% for Leicestershire and Rutland combined for 2016/17. This is within the benchmarked target range of 40% to 65%.[2]

3.3. Excess weight

Being overweight at ages 4 to 5 years old can lead to a person being overweight in later life. This can lead to ill-health and associated problems.

The proportion of overweight (including obese) children in reception was 24.0% for Rutland for 2016/17 (82 children). This is statistically similar to the England value of 22.6%.[2]

3.4. Tooth decay

Oral health problems in children are largely preventable. Oral health is an important aspect of a child's overall health status and is seen as a marker of wider health and social care issues, including poor nutrition and obesity. A combination of healthy diet and practising good dental hygiene can help to ensure a child has healthy teeth and gums.

3.4.1. Three year olds

The average number of decayed, missing or filled teeth in three year olds in Rutland in 2012/13

was 0.33. This is statistically similar to the England value of 0.36.

High levels of consumption of food and drinks containing sugar (particularly long term bottle use) can lead to incisor caries. The prevalence of incisor caries in three year olds in the same time period was 1.8. This is better than the England value of 3.9.[13]

Meanwhile, the proportion of three year olds free from dental decay was 85.1% for Rutland in 2012/13. This is statistically similar to the England proportion of 88.4%.[13]

3.4.2. Five year olds

In England, 23.3% of five-year-old children had experience of obvious dental decay (caries), having one or more teeth that were decayed to dentinal level, extracted or filled because of caries (%d3mft>0) in 2016/17. d3mft is the standard measure of dental decay and refers to teeth that are decayed, missing and/or teeth with fillings. In Rutland, the percentage of children with obvious dental decay is significantly better than the national average at 15.6%. From 2014/15 to 2016/17 there has been a significant improvement in the percentage of children with obvious dental decay (%d3mft>0) in Rutland (28.8% to 15.6%).[13]

In England, the average (mean) number of teeth per child affected by decay (decayed, missing or filled teeth (d3mft)) was 0.8. In Rutland, the average number of teeth per child affected by d3mft was 0.4, half the national average. From 2014/15 to 2016/17 there has been a significant improvement in the average number of decayed teeth per child in Rutland (0.7 to 0.4).[13]

Among the children with decay experience, the average number of decayed, missing (due to decay) or filled teeth (mean d3mft (% d3mft>0)) in England is 3.4. At upper-tier local authority level there is clear variation of this measure with affected children in Rutland and Wiltshire having only 2.3 teeth affected on average, while those in Harrow had 4.8.[13]

3.5. Hospital attendances

There are many reasons why an infant may attend hospital, some of which might be preventable if mothers and their infants followed more healthy lifestyles or accessed primary care services.

3.5.1. A & E attendances

Accident & Emergency attendance are often preventable for children aged 0 – 4 years. Reasons for attendance are largely due to accidental injury or to minor illnesses which could be treated in primary care.

In Rutland, the rate of attendances at any Accident & Emergency (including walk in centres) from infants aged 0 – 4 years who are resident in Rutland was 607.6 per 1,000 population in 2016/17.

This is similar to the England rate of 601.8 per 1,000 population.[3]

3.5.2. Emergency Admissions

A healthy start in life and access to care and support for parents should minimise the occurrence of the majority of childhood emergency admissions. For example, by encouraging breast feeding, good diet and hygiene, better support for parents in the management of illness in their homes and the provision of health advice through primary care services.

There were 103 admissions from children aged under 1 year old as an emergency in 2015/16, a rate of 300.3 per 1,000 population. This is similar to the England rate of 357.7 per 1,000 population. In the same time period, there were 147 admissions from children aged 1 - 4 years old as an emergency in 2015/16, a rate of 103.3 per 1,000 population. This is similar to the England rate of 106.5 per 1,000 population. As this is a count of admissions, a child will be counted more than once if they have more than one admission.[14]

3.5.3. Admissions of babies under 14 days

Admissions of babies under 14 days of age are often related to the quality of health assessments before discharge after birth or to postnatal care once home. Other reasons for admission are related to problems with feeding, such as dehydration and jaundice.

In Rutland in 2016/17, 20 admissions to hospital from babies under 14 days. This equates to a rate of 64.1 per 1,000 deliveries and is similar to the England rate of 71.0 per 1,000 deliveries. In 2015/16 the rate of admissions of babies under 14 days in Rutland was significantly worse than the national average, equating to 32 admissions to hospital in the age range specified. It is important to note the numbers of admissions are small and are likely to fluctuate year on year.[15]

3.5.4. Unintentional and deliberate injuries

Injuries are a major cause of mortality for children. They can also be a precursor to long-term health issues, including mental health conditions as a result of the experience(s).

They were 19 hospital admissions caused by unintentional and deliberate injuries in 0 – 4 year olds in 2016/17. This equates to a rate of 103.5 per 10,000 population. This is a similar rate to the England value of 126.3 per 10,000 population.[2]

3.5.5. Emergency admissions for falls

The rate of emergency admissions for falls for children aged 0 – 4 years was 391 per 100,000 population for Leicestershire and Rutland combined for the period 2014/15 – 16/17. This is better than the England rate of 509 per 100,000 population.

Meanwhile, the rate of emergency admissions for falls from furniture for children aged 0 – 4 years was 67.1 per 100,000 population for Leicestershire and Rutland combined for the period 2012/13 – 16/17. This is better than the England rate of 138.2 per 100,000 population.[14]

3.5.6. Emergency admissions for accidental poisoning

The rate of emergency admissions for accidental poisoning for children aged 0 – 4 years was 72.7 per 100,000 population for Leicestershire and Rutland combined for the period 2014/15 – 16/17. This is better than the England rate of 145.5 per 100,000 population.

Meanwhile, the rate of emergency admissions for poisoning from medicines for children aged 0 – 4 years was 52.5 per 100,000 population for Leicestershire and Rutland combined for the period 2012/13 – 16/17. This is better than the England rate of 101.5 per 100,000 population.

Children aged 0 – 4 years suffering poisoning may indicate safeguarding issues.[14]

3.5.7. Admissions for respiratory conditions

The risk of a child having a respiratory tract infection is increased due to damp housing conditions and smoking in the home.

There were 15 admissions for respiratory tract infections for infants under 1 year of age in 2015/16, a rate of 437 per 10,000 population. This is statistically similar to the England rate of 582 per 10,000 population.[14]

3.5.8. Admissions for gastro-intestinal conditions

Diet, hygiene and support in management of infections can all minimise the risk of infants contracting gastroenteritis.

In 2015/16, there were 8 admissions for gastroenteritis for children aged 2, 3 and 4 years in Rutland. This was a rate of 74.1 per 10,000 population and is statistically similar to the England rate of 53.7 per 10,000 population.[14]

3.5.9. Elective admissions

Elective admissions in infants are often related to congenital conditions, or complications relating to pregnancy and delivery. After a child's first birthday, dental caries are a significant reason for elective admission.

For Rutland, 51.5 per 1,000 children aged under 5 years were admitted electively in 2015/16. This is statistically similar to the England rate of 54.0 per 1,000 population.[16] Of these elective admissions, over a third (36%) had a primary diagnosis of cancer and almost a fifth (18%) were due

to congenital malformations, deformations and chromosomal abnormalities. Over half (58%) of these admissions went to University Hospitals of Leicester NHS Trust and a quarter (25%) went to Peterborough and Stamford NHS Trust.

4. How does this impact?

A model developed in 2007, estimated that "the total cost of preterm birth to the public sector was £2.9 billion. The incremental cost per preterm child surviving to 18 years compared with a term survivor was £22,885. The corresponding estimates for a very and extremely preterm child were substantially higher at £61,781 and £94,740, respectively.[17]"

Increasing breastfeeding not only decreases the chance of the mother developing breast cancer, but it also decreases the chances of the infant developing gastrointestinal and respiratory tract infections.

"Treating the four acute diseases in children costs the UK at least £89 million annually. The 2009–2010 value of lifetime costs of treating maternal BC is estimated at £959 million. Supporting mothers who are exclusively breast feeding at 1 week to continue breast feeding until 4 months can be expected to reduce the incidence of three childhood infectious diseases and save at least £11 million annually. "

"The same increase could result in NHS savings of around £21 million related to breast cancer over the course of a first-time mothers' lifetime.[18]"

5. Policy and Guidance

The central piece of legislation guiding Children' Social Care is the 1989 Children Act. The key element of it for this chapter is its focus on a 'Child in need' and a 'Child in need of protection'. Section 17 of the Act places a general duty on all local authorities to 'safeguard and promote the welfare of children within their area who are in need.' A 'child in need' is a child who needs additional support from the local authority to meet their potential.

Section 47 of the Act requires the local authority to investigate the child's circumstances where they have 'reasonable cause to suspect that a child … is suffering, or is likely to suffer, significant harm,' and to 'take any action to safeguard or promote the child's welfare'. Local authorities have a duty to provide a level and range of services to safeguard children and promote their welfare. Consequently, a local authority has to investigate any concerns or allegations that suggest a child is likely to suffer physical, emotional or sexual abuse, or neglect, and to take action to prevent this.

The way that agencies and organisations should work together to carry out their duties and responsibilities under the 1989 Children Act and other legislation is set out in a document called

Working Together to Safeguard Children.[19] It sets out the responsibilities of all agencies in the protection of children. The Early Help Strategy[20] in Rutland draws on existing best practice locally and nationally, with a vision, shared by the partners of Rutland's Children's Trust, to improve outcomes for our children and young people.

The Children's Centre services are governed by statutory guidance from the Department for Education. This means that recipients must have regard to it when carrying out duties relating to children's centres under the Childcare Act 2006. Children's Centres currently have a key role to play in early intervention, particularly given their established work in the early years when the support has the biggest impact on long-term outcomes. Centres are also well placed to provide a wider range of services as Family Hubs, for any parent (including fathers) to access services or information about all family-related matters. The multi-agency Children's Centre Governance Group is exploring how the opportunities offered by the integrated Children Centre and Library can deliver the intentions of a Family Hub.

An integrated 0-19 (years) Healthy Child Programme service is now being delivered in Rutland, provided by Leicestershire Partnership Trust's 'Healthy Together Service'. The 5-19 healthy child programme services transferred from the former Primary Care Trust to Local Authorities in April 2013. More recently the 0-5 healthy child programme services transferred from NHS England to local authorities in October 2016. This enables coverage of the five mandated services described in legislation as universal health visitor reviews (antenatal, new birth, 6-8 weeks, 1 year and 2 to 2½ years). It also delivers the health outcomes as they as described in the Public Health Outcomes Framework where the data flows directly from health visiting activities, such as breast feeding at 6-8 weeks and an assessment of child development at 2 to 2½ years using the ages and stages questionnaire.

The 0-19 Healthy Child Programme recognises that the first years of life are a critical opportunity for building healthy, resilient and capable young people and adults. It follows Marmot's 'Life Course Approach' from the Marmot Review,[21] and complies with the Chief Medical Officer view in the Annual Report (2012) **'**Our Children Deserve Better: Prevention Pays'[22]: events that occur in early life (indeed in foetal life) affect health and wellbeing later, so it makes sense to intervene early. Public Health England carried out a Rapid Review to update the evidence for the Healthy Child Programme[23].

6. Current services

The 0-19 Healthy Child Programme is delivered by Leicestershire Partnership NHS Trust's 'Healthy Together' team in Rutland, it is an evidence based programme delivered by Public Health Nurses (Health Visitors & School Nurses). It follows a 4-5-6 model: 4 Levels of Services, 5 Mandated Contacts, 6 High Impact Areas[24]. Safeguarding is central to the 0-19 Healthy Child Programme. The

high impact areas for 0-5 year olds can make a valid contribution to providing children in Rutland with the 'Best Start in Life'. In addition Oral Health has been identified as a local high impact area for Rutland. There is also a focus on Children & Young People's Mental Health and Military families in Rutland.

The Early Start Programme (ESP) provides intensive early intervention and support for vulnerable first time parents with an infant 0-2 years living in Rutland. It is delivered by Public Health nurses (Health Visitors) to up to 10 families at a time in Rutland.

There is information on 'The Best Start in Life' issues on the 3 Healthy Together websites including:

Health for under 5's: https://healthforunder5s.co.uk/

Health For Kids: https://www.healthforkids.co.uk/

Health for Teens: https://www.healthforteens.co.uk/

6.1. Children's Social Care services

Children's Social Care will assess a child and their family's circumstances before the child can receive a service. The complexity of a child and family's situation determines the type and timescale of the assessment. Further assessments are repeated periodically to assess effectiveness of services and interventions and to respond to unmet or changes in need.

100% of all children under 5 years in Rutland are registered with the Children Centre. The Children's Centre also offers targeted early help to families in their homes and on the two MOD sites; this is delivered by family support practitioners. The Centre supports families to access their 2 year old childcare funding, which supports parents back to work and enables children's early education and preparedness for school.

The integration of the Special Educational Needs and Disability (SEND) and Inclusion service with Early Intervention results in the identification of children's needs at the very earliest stages.

7. Unmet needs/Gaps

Regular early health screening checks are in place but the area would benefit from the findings being formally shared routinely across the partnership to help join up responses to families. Although services are quick and responsive the impact of therapeutic services provided to children following referral is not always demonstrated as they are not yet routinely evaluated, this means we cannot be fully confident that some early support is effective in preventing the escalation of needs which is being addressed.

8. Recommendations

These recommendations reflect those in the Rutland's Health and Wellbeing Strategy, where applicable[25]

- To provide support to aim for all children in Rutland to have a happy and healthy childhood, targeting resources in proportion to need and to those who are most vulnerable.
    - Providing early help through the Children's Centre and the 0-19 Healthy Child Programme
- Target resources in proportion to need to address the needs of any children living in poverty.
- Increase numbers of children being active, and encourage them to be active for longer.
- Outcomes should be measured in line with national outcome frameworks and commissioning reporting requirements. However other reporting requirements and measures need to be locally determined including outcomes regarding oral health and improving the health & wellbeing of children and young people from military families.
- Additional outcome measures (including the Local High Impact Areas) should not add burden to data collection, should be collected within current systems and align to national reporting requirements.
- Engagement with the whole family is an important component of the Healthy Child Programme and should apply across the whole system.
    - Support and encourage healthy behaviour in pregnancy and beyond including maternal smoking, alcohol use, healthy eating and physical activity.
    - Scale up support to families through parenting programmes and ensure that they are delivered to high quality standards.
- Consider a review of access to, and use of, maternity services by Rutland residents.

GLOSSARY OF TERMS

BME	Black and Minority Ethnic Groups
CCG	Clinical Commissioning Group
CLA	Children who are Looked After
ESP	Early Start Programme
GLD	Good Level Development
HBV	Hepatitis B Virus
Hib	Haemophilus influenzae type b
LSOA	Lower Super Output Area
Men C	Meningococcal C
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
PHE	Public Health England
SEND	Special Educational Needs and Disability

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